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MEMORANDUM

To: Coalition to Preserve Rehabilitation

From: Peter Thomas, Michael Barnett, Natalie Keller

Date: January 29, 2024

Re: **CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F)**

On January 17, 2024, the Centers for Medicare and Medicaid Services ("CMS") published its long-awaited *Interoperability and Prior Authorization Final Rule* (CMS-0057-F) ("Final Rule"),[1] which was first issued as a proposal in December 2022. This Final Rule aims to increase data sharing between patients, providers, and health insurers and establish electronic prior authorization systems for more timely coverage decisions.

The Final Rule sets requirements for Medicare Advantage (MA) organizations, Medicaid and the Children's Health Insurance Program ("CHIP") fee-for-service ("FFS") programs, Medicaid managed care plans, CHIP managed care entities, and issuers of Qualified Health Plans ("QHPs") offered on the Federally-Facilitated Exchanges ("FFEs") (collectively "impacted payers") to improve the electronic exchange of health information and prior authorization processes for medical items and services. Together, these policies will improve prior authorization processes and reduce burden on patients, providers, and payers, resulting in approximately $15 billion of estimated savings over ten years. Impacted payers must comply with many of the new requirements by January 1, 2027. The exact compliance dates vary by the type of payer.

The Final Rule also adds a new measure for Merit-based Incentive Payment System ("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.

This Final Rule builds on the substantial guardrails on the use of utilization management tools by Medicare Advantage ("MA") organizations, implemented on January 1, 2024, as part of the Contract Year 2024 MA Final Rule ("CY 2024 MA Final Rule"). The Coalition to Preserve Rehabilitation (CPR) submitted comments in support of both the CY 2024 MA Proposed Rule

[1] Medicare Programs; Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Process for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, Merit-based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program; 88 Fed. Reg. 22,201 (January 17, 2024)

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and the Interoperability and Prior Authorization Proposed Rule. The two rules aim to increase transparency and streamline processes for prior authorization in MA and other plans. Overall, the Final Rule finalizes as proposed many of the major provisions on which CPR commented in its comment letter. A summary of those provisions is provided below.

New Requirements for Electronic Prior Authorization

Proposed Rule: CMS proposed that payers adopt a series of electronic interfaces that facilitate prior authorization. Specifically, CMS proposed to require impacted payers to implement and maintain certain Health Level 7 ("HL7") Fast Healthcare Interoperability Resource ("FHIR") Prior Authorization Requirements, Documentation, and Decision ("PARDD") Application Programming Interfaces ("API") to facilitate an electronic, more streamlined prior authorization process for providers than exists today. This system would allow a provider to query the payer's system to determine if prior authorization is necessary for an item or service as well as the documentation requirements. CMS proposed to require implementation on January 1, 2026.

Rehabilitation Sector Stakeholder Comment: Stakeholders supported this proposal for an automated process to increase transparency and ease the burden on providers requesting prior authorization on behalf of their patients.

The PARDD API would be beneficial to providers and patients in several ways. Overall, it would reduce the administrative hurdles for providers that result in unnecessary delays in access to patient care. Many insurers currently require providers to call or send documents via fax machine to process prior authorization requests. These outdated systems slow down the prior authorization process and can require additional staffing to fulfill a payer's requests, which further contributes to delays in patient care. Streamlining provider workflow through an automated system is an essential element of improving care for patients. Administrative hurdles delay care for patients who are forced to wait days or weeks as providers navigate an inefficient and cumbersome process. The delays are not benign and can result in serious setbacks to patients needing rehabilitative care.

Final Rule: Under the Final Rule, CMS is finalizing its proposal to improve the prior authorization process between impacted payers and providers using a Prior Authorization API.[2][3] The purpose of the Prior Authorization API is to streamline the process and ensure that payers use technology to provide more useful information about when and

[2] For consistency with the naming convention used for other APIs in this rule, the finalized name is "Prior Authorization API" instead of the proposed "PARDD API." (p. 379)
[3] An Application Program Interface ("API") is a set of commands, functions, protocols, or tools published by one software developer that enables other software developers to create programs or "apps" that can interact with it. APIs act as messengers delivering information from one interface to another. This technology allows users to easily access information through website and mobile phone apps, and it is the technology currently used for travel and financial phone apps that many people use daily.

how to obtain a prior authorization and the status of an approved or denied prior authorization request.

Beginning in January 2027, impacted payers must implement and maintain a Prior Authorization API that includes:

- The payer's list of covered items and services (excluding drugs) that require prior authorization;
- All documentation required for approval of any items or services that require prior authorization;
- Technology supporting a Health Insurance Portability and Accountability Act ("HIPAA")-compliant prior authorization request and response; and
- Documentation describing whether the payer approves the prior authorization request (accompanied by the date or circumstance under which the authorization ends), denies the prior authorization request (with a specific reason), or requests more information.

The Prior Authorization API is believed to be a major step in alleviating administrative burden for providers in the prior authorization process.

New Requirement for Payers to Provide a Specific Reason for Denial of Prior Authorization

Proposed Rule: CMS proposed to require impacted payers to provide a specific reason for prior authorization denials, regardless of the method used to send the request. Responses sent through the new automated system from the payer to the provider would have to include information about whether the payer approves the request, needs more information, or if the request is denied. If the request is denied, the proposed rule required the payer to state the reasons for the denial. Existing regulations that require Medicaid managed care, CHIP, and Medicare Advantage plans to send a written denial notice would remain in place.

Rehabilitation Sector Stakeholder Comment: Stakeholders strongly supported the proposed requirement to provide specific reasons for prior authorization denials and recommended CMS consider outlining specific definitions for and examples of terms such as "approval," "denial," and "specific reason for denial."

Stakeholders encouraged CMS to consider going further in the final rule by requiring payers to state what specific clinical, medical, or functional evidence would be sufficient to warrant an approval of a given service. This clarifying information is essential to individuals in need of rehabilitation services in IRFs who are denied prior authorization for "lack of medical necessity" and must appeal the decision quickly to avoid being sent to a lower level and clinically inappropriate setting of care as they await discharge from an acute care hospital.

Final Rule: In the Final Rule, CMS finalized this proposal and, beginning in 2026, impacted payers must provide a specific reason for denied prior authorization decisions, regardless of the method used to send the prior authorization request – excluding those for drugs. Contents of the denial reasons should be "sufficiently specific to enable a provider to understand why a prior authorization has been denied and what actions must be taken to re-submit or appeal." Such decisions may be communicated via portal, fax, email, mail, or phone.

CMS responded to CPR's requests for clarity on the terms "approval," "denial," and "specific reason for denial."[4] The agency declined to define the terms in regulation; however, they provided the following definitions in the context of the final rule:

- **Approvals** are "when the payer authorizes coverage of items or services for which prior authorization has been requested."
- **Denials** are "the refusal by a payer to approve the prior authorization for a health care item or service" and can result when "the service was not considered medically necessary under the payer's medical guidelines or the provider did not provide complete or accurate documentation to support the request."
- **A specific reason for denial** "could include reference to the specific plan provisions on which the denial is based; information about or a citation to coverage criteria; how documentation did not support a plan of care for the therapy or service; a narrative explanation of why the request was denied, and specifically, why the service is not deemed necessary or that claim history demonstrated that the patient had already received a similar service or item."

Furthermore, CMS responded to comments asking for more specific requirements in denials. The agency stated that "the content of a denial should be sufficiently specific to enable a provider to understand why a prior authorization has been denied and what actions must be taken to resubmit for appeal."[5]

Some impacted payers—Medicaid managed care, CHIP, and Medicare Advantage plans—are also subject to existing requirements to provide information about denials to providers, patients, or both through notices. These existing notices are often required in writing, but nothing in the Final Rule changes these existing requirements.

New Decision Timeframes for Prior Authorization Response

Proposed Rule: The proposed rule would require MA organizations, Medicaid Fee-For-Service (FFS) programs, and CHIP FFS programs to provide notice of prior authorization decisions as expeditiously as a patient's health condition requires but no later than seven calendar days for standard requests and no later than 72 hours for expedited requests.

[4] Pp. 419-420
[5] Pp. 424-425

Rehabilitation Sector Stakeholder Comment: Stakeholders supported shorter timeframes for evaluating prior authorization requests and recommended that CMS consider a 24-hour timeframe for urgent requests and a 72-hour timeframe for non-urgent requests. For patients in need of rehabilitation care, delays in receiving prior authorization can result in serious health consequences or even abandoning care at an appropriate level and intensity. The need for emergent or expeditious access to health care services takes place every hour of every day and medical care must be available to respond to those emergencies, including on weekends and holidays.

Final Rule: CMS finalized as proposed its proposal to require impacted payers (excluding QHP issuers on the FFEs) to send prior authorization decisions within 72 hours for urgent requests and seven calendar days for non-urgent requests. For MA plans, the current regulations already require a 72-hour turnaround for expedited requests; however, the current requirement for standard requests is 14 calendar days. CMS acknowledges that commenters "in general" recommended faster prior authorization response timelines, and CPR specifically urged CMS to move to a 24-hour turnaround for expedited requests. The agency declined to make this change, however, and asserted its belief that the current standards are "adequate."

If impacted payers fail to meet the new timeframes, CMS is not implementing any new enforcement measures or penalties – i.e., the agency is not requiring that a payer automatically approve a PA request if they miss their required timeframe for turning around a decision as they "do not believe it is practical." The burden appears to be on the providers to seek updates on the status of pending requests and determine if new/additional documentation is needed.

For MA plans, a failure to meet the prescribed timelines for organization determinations, including prior authorization decisions, constitutes a denial that can be appealed to the next level, which is typically the reconsideration by the MA plan itself. CMS largely seeks to address these issues by encouraging communication and follow-up by providers to payers. There is very little in the Final Rule acknowledging that payers may in some cases purposefully delay or limit communications for prior authorization, but CMS does encourage providers to notify CMS of any patterns for poor communication.

Required Public Reporting of Prior Authorization Metrics

Proposed Rule: The proposed rule would require impacted payers to publicly report certain aggregated metrics about prior authorization by posting them directly on the payer's website or via a publicly accessible hyperlink. The data would be reported at the organizational level for Medicare Advantage, at the state level for Medicaid and CHIP FFS, at the plan level for Medicaid and CHIP managed care, and at the issuer level for QHP issuers on the Federally Facilitated Exchange (FFE).

Rehabilitation Sector Stakeholder Comment: Stakeholders strongly supported these data transparency requirements for all plans impacted by this rule. For an individual with

a disability or chronic health condition seeking a new MA plan or QHP, for instance, that person would have the ability to research competing plans to assess their prior authorization practices before making a choice of plan. Stakeholders also stressed that a publicly available resource would also serve to hold impacted payers accountable to enrollees, providers, and the public for its practices. Stakeholders also urged CMS to require data reporting at a more granular level rather than in an aggregated format, particularly setting-specific data.

Final Rule: CMS is finalizing its proposal to require impacted payers to publicly report certain PA metrics annually by posting them on their website. These metrics include the following:

- A list of all items and services that require prior authorization;
- The percentage of standard prior authorization requests that were approved, denied, and approved after appeal (aggregated for all items and services);
- The percentage of expedited PA requests that were approved and denied (aggregated for all items and services);
- The percentage of requests for which the review timeframe was extended (aggregated for all items and services);
- The average and median time elapsed between submission of requests and the determination by the payer, for both standard and expedited requests (aggregated for all items and services).
- NOTE: CMS did not adopt a requirement for more specific, facility-specific data reporting.

These operational or process-related PA policies are being finalized with a compliance date starting January 1, 2026, and the initial set of metrics must be reported by March 31, 2026. For the MA program, reporting will be required at the contract level, not the individual plan level, which the rehabilitation sector is very pleased about. Interestingly, CMS did not require any of the metrics listed above to be reported at a more granular level, such as setting-, specialty-, or service-specific data. CMS noted that many stakeholders, including CPR, sought more discrete reporting, but the agency felt that more specific data could be burdensome and "overwhelming" for patients, which could ultimately lead to concerns about the usability of the data.

Adding Prior Authorization Information to the Patient Access API

Proposed Rule: The proposed rule called for adding information about prior authorizations to the categories of data required to be made available to patients through the Patient Access API by impacted payers, no later than one business day after the payer receives the prior authorization request. The information would include related administrative and clinical documentation for items and services. The new requirement would be implemented January 1, 2026.

Rehabilitation Sector Stakeholder Comment: Stakeholders supported CMS's efforts to enable patients to take an active role in their healthcare through information sharing.

Stakeholders strongly recommended that CMS provide guidance on ensuring the Patient Access API is accessible and easy to use for individuals with disabilities and for individuals with limited or low health literacy.

Final Rule: Under the Final Rule, CMS is finalizing its proposal requiring impacted payers to add information about prior authorizations – excluding those for drugs – to the data available via that Patient Access API. This requirement must be implemented by January 1, 2027. CMS moved the compliance date from 2026 to 2027 in response to comments from payers about the feasibility of a 2026 rollout although CMS encourages payers to meet the requirement as soon as possible to benefit their patients.

The Final Rule requires payers to include any denials and the specific reason why the request was denied in the Patient Access API. The information about prior authorizations will be available in the Patient Access API for as long as the prior authorization is active and at least one year after the last status change.

To assess Patient Access API usage, beginning January 1, 2026, CMS is requiring impacted payers to report annual metrics to CMS about Patient Access API usage. CMS does not provide any guidance on ensuring the Patient Access API is accessible; however, the agency emphasizes their "…continued support for the individual's ability to select an app of their choice…" and expresses "interest in the best ways to ensure that apps are available and accessible for individuals with disabilities…"[6]

New Provider Access API

Proposed Rule: The proposed rule called for requiring impacted payers to implement and maintain a Provider Access API to enable current patients' information to be exchanged from payers to providers that are in that payer's network at the provider's request. Patients would need to opt out through a mechanism maintained by the payer.

Rehabilitation Sector Stakeholder Comment: Stakeholders supported the streamlining of provider workflows to ease the burden on patients to coordinate the transfer of electronic health information by establishing a Provider Access API.

Final Rule: CMS is finalizing its proposal requiring impacted payers to implement and maintain a Provider Access API to share patient data with in-network providers with whom the patient has a treatment relationship. The following data must be made available via the Provider Access API:

- Individual claims and encounter data (without provider remittances and enrollee cost-sharing info);

[6] p. 13

- Data classes and data elements in the United States Core Data for Interoperability (USCDI); and
- Specified prior authorization information (excluding those for drugs)

CMS is also requiring impacted payers to maintain an attribution process to associate patients with in-network or enrolled providers with whom they have a treatment relationship and to allow patients to opt out of having their data available to providers under these requirements. Impacted payers will be required to provide plain language information to patients about the benefits of API data exchange with their providers and their ability to opt out. These requirements must be implemented by January 1, 2027.

New Payer-to-Payer API

Proposed Rule: The proposed rule called for requiring impacted payers to establish and maintain a Payer-to-Payer API to ensure data can follow patients when they change payers. The Payer-to-Payer API would facilitate the creation of a longitudinal health record for patients and would expedite care and reduce unnecessary burden and duplication when patients change plans.

Rehabilitation Sector Stakeholder Comment: Stakeholders supported this increased data sharing, with permission by the patient, to ease the burden on patients to coordinate health record exchanges when changing from one plan to another and to reduce the inefficiencies of methods like phone calls and fax machines to secure prior authorization approvals.

Final Rule: CMS is requiring that impacted payers implement and maintain a Payer-to-Payer API to make available claims and encounter data (excluding provider remittances and enrollee cost-sharing information), data classes and data elements in the USCDI, and information about certain PAs. Impacted payers are only required to share patient data with a date of service within five years of the request for data. This step will help ensure that patients have continued access to the most relevant data in their records.

CMS is also finalizing an opt-in process for patients to provide permission under these requirements. Impacted payers are required to provide plain-language educational resources to patients that explain the benefits of the Payer-to-Payer API data exchange and their ability to opt in. These requirements must be implemented by January 1, 2027.

MIPS Promoting Interoperability Requirements

CMS is finalizing its proposal to a new measure, titled "Electronic Prior Authorization," to the Health Information Exchange (HIE) objective for the MIPS Promoting Interoperability performance category and the Medicare Promoting Interoperability Program. MIPS-eligible clinicians will report the Electronic Prior Authorization measure beginning with the CY 2027 performance period/CY 2029 MIPS payment year and eligible hospitals and CAHs beginning with the CY 2027 HER reporting period. *This will be an attestation measure, for which the*

MIPS eligible clinician, eligible hospital, or CAH reports a yes/no response or claims an applicable exclusion, rather than the proposed numerator/denominator.

To successfully report the Electronic PA measure:

- **MIPS eligible clinicians** must attest "yes" to requesting a PA electronically via a PA API using data from certified electronic health record technology (CEHRT) for at least one medical item or service (excluding drugs) ordered during the CY 2027 performance period or (if applicable) report an exclusion.
- **Eligible hospitals and CAHs** must attest "yes" to requesting a PA request electronically via a PA API using data from CEHRT for at least one hospital discharge and medical item or service (excluding drugs) ordered during the 2027 EHR reporting period or (if applicable) report an exclusion.

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