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

January 17, 2024

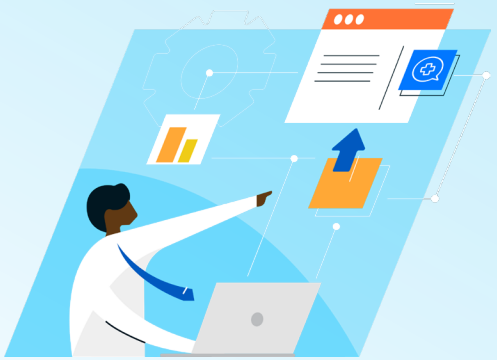
Overview

On January 17, 2024, CMS released the *CMS Interoperability and Prior Authorization* final rule (CMS-0057-F).

This rule demonstrates CMS' continued commitment to increasing efficiency by ***ensuring that health information is readily available*** to providers by leveraging Health Level 7® (HL7®) Fast Healthcare Interoperability Resources® (FHIR®) standards.

Impacted payers are required to implement certain provisions generally by January 1, 2026. In response to stakeholder comments on the proposed rule, impacted payers have until at least **January 1, 2027**, to meet the application programming interface (API) development and enhancement requirements in this final rule.

The final rule will reduce patient, provider, and payer burden by ***streamlining prior authorization processes and moving the industry toward electronic prior authorization.***



Ultimately, reduced provider burden means more quality time with patients.

Final Rule Overview

Provisions

- Patient Access API
- Provider Access API
- Payer-to-Payer API
- Prior Authorization API
- Improving Prior Authorization Processes
- New measures for Electronic Prior Authorization for the Merit-based Incentive Payment System (MIPS) Promoting Interoperability Performance Category and the Medicare Promoting Interoperability Program

Impacted Providers

- Eligible hospitals and critical access hospitals (CAHs) participating in the Medicare Promoting Interoperability Program
- MIPs eligible clinicians participating in the MIPS Promoting Interoperability performance category

Impacted Payers

- Medicare Advantage (MA) Organizations
- State Medicaid and Children's Health Insurance Program (CHIP) agencies
- Medicaid Managed Care Plans and CHIP Managed Care Entities
- Qualified Health Plan (QHP) issuers on the Federally-facilitated Exchanges (FFEs)

Patient Access API

NEW DATA REQUIREMENTS (Beginning January 1, 2027)
Impacted payers are required to include certain information about patients' prior authorization requests and decisions (excluding those for drugs)

API USE METRICS (Effective January 1, 2026)
Impacted payers will annually report metrics in the form of aggregated, de-identified data to CMS about patient use of the Patient Access API

Provider Access API

Beginning January 1, 2027

API REQUIREMENTS Impacted payers must implement and maintain a Provider Access API to share patient data with in-network providers with whom the patient has a treatment relationship.

DATA REQUIREMENTS
The API must make available individual claims and encounter data (excluding provider remittances and enrollee cost-sharing information), data classes and data elements in a content standard adopted by ONC (USCDI) and specified prior authorization information (excluding those for drugs).

ATTRIBUTION
Impacted payers are required to develop an attribution process to associate patients with their providers to ensure that a payer only sends data to providers for patients with whom they have a treatment relationship.

OPT OUT
Impacted payers are required to maintain a process for patients to opt out of having their health information available and shared under the Provider Access API requirements.

Payer-to-Payer API

Beginning January 1, 2027

API & DATA REQUIREMENTS

Impacted payers must implement and maintain a Payer-to-Payer API to make available claims and encounter data (excluding provider remittances and enrollee cost-sharing information), all data classes and data elements in a content standard adopted by ONC (USCDI), and information about prior authorizations (excluding those for drugs and those that were denied).

IMPACTED PAYERS MUST IDENTIFY PREVIOUS AND CONCURRENT PAYERS AND GIVE PATIENTS OPPORTUNITY TO OPT IN

This must be done generally no later than one week after the start of coverage.

NEW PAYERS MUST REQUEST PATIENT DATA FROM ANY PREVIOUS PAYERS NO LATER THAN ONE WEEK AFTER THE START OF COVERAGE, IF THE PATIENT HAS OPTED IN.

Previous payers will have to provide the data they maintain with dates of service within five years of the date of the request, and they must provide this data within one day of receiving the request. Patient data must then be incorporated into the new payer's patient record.

CONCURRENT COVERAGE DATA EXCHANGE

Where a patient has concurrent coverage with two or more payers, impacted payers are required to exchange patient data within one week of the start of coverage and at least quarterly thereafter.

Patient and Provider Educational Resources

Effective January 1, 2027

PROVIDER ACCESS API

Impacted payers must provide plain language resources to **both**:

- Patients about the benefits of API data exchange with their providers, and their ability to opt out; and
- Providers about the process for requesting patient data and the payer's attribution process

PAYER-TO-PAYER API

Impacted payers must provide plain language materials to patients about the benefits of Payer-to-Payer API data exchange, their ability to opt in or withdraw a previous opt in decision, and instructions for doing so.

Prior Authorization API

Beginning January 1, 2027

API REQUIREMENT
Impacted payers must implement and maintain a Prior Authorization API.

IDENTIFYING WHETHER AN ITEM OR SERVICE REQUIRES PRIOR AUTHORIZATION
The API must be populated with the list of items and services (excluding drugs) that require prior authorization from the payer.

PAYER-SPECIFIC DOCUMENTATION REQUIREMENTS
The API must identify the payer's documentation requirements for all items and services (excluding drugs) that require a prior authorization request.

EXCHANGING PRIOR AUTHORIZATION REQUESTS AND RESPONSES
The API must support the creation and exchange of prior authorization requests from providers and responses from payers.

Improving Prior Authorization Processes

Beginning January 1, 2026

PRIOR AUTHORIZATION DECISION TIMEFRAMES

Certain impacted payers are required to send standard prior authorization decisions within 7 calendar days and expedited prior authorization decisions within 72 hours. This policy change for standard decisions does **not** include QHPs on the FFEs.

PROVIDING A SPECIFIC REASON FOR DENIAL

Payers must provide specific information about prior authorization denials, regardless of how the prior authorization request is submitted.

PRIOR AUTHORIZATION METRICS

Impacted payers are required to report certain metrics about their prior authorization processes on their public website on an annual basis. This includes the percent of prior authorization requests approved, denied, and approved after appeal, and average time between submission and decision.

Electronic Prior Authorization Measures

The Electronic Prior Authorization Measures are **yes/no measures** instead of the proposed numerator/denominator measures. Participants are required to report a **yes** response or claim an exclusion to satisfy the reporting requirements for the **CY 2027 performance period/2029 MIPS payment year or the CY 2027 EHR reporting period** (for the Medicare Promoting Interoperability Program).

PARTICIPATING PROGRAMS

- MIPS Promoting Interoperability performance category (under the HIE objective)
- Medicare Promoting Interoperability Program for Eligible Hospitals and CAHs (under the HIE objective)

Interoperability Standards for APIs

MODIFICATION TO STANDARDS LANGUAGE
We have revised regulatory language to further clarify which ONC standards apply to each API.

USE OF UPDATED STANDARDS
An impacted payer may use an updated version of a required standard if using the updated version does not disrupt an end user's ability to access the data required to be available through the API and other conditions are met.

USE OF IMPLEMENTATION GUIDES
We strongly recommend impacted payers develop their APIs to conform with certain implementation guides (IG).

Required API Interoperability Standards

Standards	Patient Access API	Provider Access API	Provider Directory API	Payer-To-Payer API	Prior Authorization API
USCDI, at 45 CFR 170.213	✓	✓	N/A	✓	N/A
FHIR Release 4.0.1	✓	✓	✓	✓	✓
HL7 FHIR US Core IG STU 3.1.1	✓	✓	✓	✓	✓
HL7 SMART App Launch Framework IG 1.0.0	✓	✓	✗	✗	✓
HL7 FHIR Bulk Data Access IG v 1.0.0 STU 1	✗	✓	✗	✓	✗
OpenID Connect Core 1.0	✓	✗	✗	✗	✗

Note: The Patient Access and Provider Directory API were finalized in the *CMS Interoperability and Patient Access* final rule.

Recommended IGs by API

Implementation Guide	Patient Access API	Provider Access API	Provider Directory API	Payer-To-Payer API	Prior Authorization API
CARIN for Blue Button IG Version STU 2.0.0	✓	✓	✗	✓	✗
FHIR SMART App Launch IG Release 2.0.0 to support Backend Services Authorization	✗	✓	✗	✓	✗
Da Vinci PDex IG Version STU 2.0.0	✓	✓	✗	✓	✗
Da Vinci PDex U.S. Drug Formulary IG Version STU 2.0.1	✓	✗	✗	✗	✗
Da Vinci PDex Plan Net IG Version STU 1.1.0	✗	✗	✓	✗	✗
Da Vinci Coverage Requirements Discovery (CRD) IG Version STU 2.0.1	✗	✗	✗	✗	✓
Da Vinci Documentation Templates/Rules (DTR) IG Version STU 2.0.0	✗	✗	✗	✗	✓
Da Vinci Prior Authorization Support (PAS) IG Version STU 2.0.1	✗	✗	✗	✗	✓

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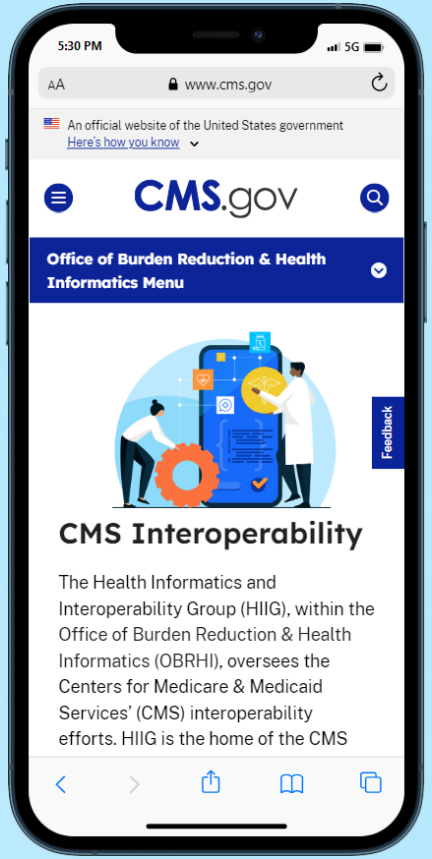
Resources

Interoperability Rules

- 2024 CMS *Interoperability and Prior Authorization* final rule: Final rule, Fact Sheet
- 2023 ONC Health Data, Technology, and Interoperability (HTI-1) final rule: Federal Register, Fact Sheet
- 2020 CMS *Interoperability and Patient Access* final rule: Federal Register, Fact Sheet, and Frequently Asked Questions
- 2020 ONC 21st Century Cures Act final rule: Federal Register

Technical Standards and Implementation Support

- Technical Standards: FHIR, SMART IG/OAuth 2.0, OpenID Connect, USCDI
- Implementation Support for APIs: CARIN for Blue Button IG, PDex IG, PDex Formulary IG, PDex Plan Net IG, US Core IG, CRD IG, DTR IG, PAS IG, Bulk Data Access IG



Visit the CMS Interoperability website for additional resources and information!

Questions?

E-mail the CMS Health Informatics and Interoperability Group (HIIG) at:

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