



Proposed Metrics in the 2026 CMS Interoperability Standards and Prior Authorization for Drugs Proposed Rule (CMS-0062-P)

New and Revised Prior Authorization Metrics for Non-Drug Items and Services

Current Requirement

The 2024 CMS Interoperability and Prior Authorization final rule (CMS-0057-F) requires Medicare Advantage (MA) organizations, state Medicaid and Children's Health Insurance Program (CHIP) fee-for-service (FFS) programs, Medicaid managed care plans, CHIP managed care entities, and Qualified Health Plan (QHP) issuers on the Federally-facilitated Exchanges (FFE) — collectively referred to as “impacted payers” — to annually report prior authorization metrics for non-drug items and services on their public websites.

What Would Change?

Proposed compliance date: *The effective date of the final rule. Reporting deadlines vary by payer type.*

Under the 2026 CMS Interoperability Standards and Prior Authorization for Drugs proposed rule, (CMS-0062-P) CMS is proposing to require impacted payers to:

- ✓ Report the numeric counts of prior authorization requests, in addition to the existing requirement to report percentages, for certain existing non-drug items and services metrics; and
- ✓ Publicly report additional prior authorization metrics for non-drug items and services, detailed in the table below.

See section II.C.6. of the 2026 proposed rule for more information on these proposals.

Proposed New and Revised Prior Authorization Metrics for Non-Drug Items and Services	
Revised	Total number and % of standard requests that were approved
Revised	Total number and % of standard requests that were denied
Revised	Total number and % of standard requests for which the timeframe for review was extended, and the request was approved
NEW	Total number and % of standard requests for which the timeframe for review was extended, and the request was denied
Revised	Total number and % of standard requests that were approved after appeal
NEW	Total number and % of standard requests that remain denied after appeal
Revised	Total number and % of expedited requests that were approved
Revised	Total number and % of expedited requests that were denied
NEW	Total number and % of expedited requests for which the timeframe for review was extended, and the request was approved*
NEW	Total number and % of expedited requests for which the timeframe for review was extended, and the request was denied*
NEW	Total number and % of expedited requests that were approved after appeal
NEW	Total number and % of expedited requests that remain denied after appeal

**These metrics are not applicable to state Medicaid FFS programs because existing regulations do not allow for expedited prior authorization requests to be extended by these programs.*

New Prior Authorization Metrics for Drugs

What is CMS Proposing?

Proposed Compliance Date: *The effective date of the final rule. Impacted payers would be required to report in 2028 for the 2027 reporting period. Reporting deadlines vary by payer type.*

Under the 2026 proposed rule, CMS is proposing to require impacted payers to:

- ✓ Annually report standard and expedited prior authorization metrics for drugs on their public websites, detailed in the graphic below.

See section II.C.7. of the 2026 proposed rule for more information on this proposal.

Proposed New Metrics	MA Organizations	Medicaid and CHIP FFS	Medicaid Managed Care	CHIP Managed Care	QHP Issuers on FFEs
List of drugs that require prior authorization	✓	✓	✓	✓	✓
Total number and % of requests for drugs approved*	✓	✓	✓	✓	✓
Total number and % of requests for drugs denied*	✓	✓	✓	✓	✓
Total number and % of requests for which the timeframe for review was extended, and the request was approved*	✓	X	X	X	✓
Total number and % of requests for which the timeframe for review was extended, and the request was denied*	✓	X	X	X	✓
Total number and % of requests for drugs approved after appeal*	✓	✓	✓	✓	✓
Total number and % of requests for drugs denied after appeal*	✓	✓	✓	✓	✓
Average time that elapsed between submission of requests and decisions for drugs	✓	✓	✓	✓	✓
Median time that elapsed between submission of requests and decisions for drugs	✓	✓	✓	✓	✓

Note: MA organizations would only report these metrics for drugs that require prior authorization and are payable under Medicare Part B. State Medicaid and CHIP FFS programs, Medicaid managed care plans, CHIP managed care entities, and QHP Issuers on the FFEs would report these metrics for all drugs.

** MA organizations and QHP issuers on the FFEs would report separately for standard and expedited requests. State Medicaid and CHIP FFS programs, Medicaid managed care plans, and CHIP managed care entities would report in a single metric for all prior authorization requests for all drugs.*

New Provider Access, Payer-to-Payer, and Prior Authorization API Usage Metrics

Current Requirement

The [2024 final rule](#) requires impacted payers to annually report to CMS certain metrics regarding Patient Access Application Programming Interface (API) usage.

What is CMS Proposing?

Proposed Compliance Date: CMS is proposing to require impacted payers to submit additional API usage metrics beginning in 2028 with data from the 2027 reporting period. Reporting deadlines and reporting level vary by payer type.

CMS is proposing to require impacted payers to:

- ✓ Annually report metrics regarding Provider Access, Payer-to-Payer, and Prior Authorization API usage as detailed in the graphic below.

See section II.F.2.c. of the 2026 proposed rule for more information on these proposals.

NEW Provider Access API	NEW Payer-to-Payer API	NEW Prior Authorization API
<ul style="list-style-type: none"> • The total number of unique providers who requested patient data via their Provider Access API. • The total number of unique patients whose data were transferred via their Provider Access API to a provider's health IT system (for example, an electronic health record [EHR] or practice management system). • The total number of patient data transfers via their Provider Access API. 	<ul style="list-style-type: none"> • The percentage of patients who have opted in to the payer-to-payer data exchange. • The total number of unique patients whose data have been sent to other payers. • The total number of unique patients whose data have been received from other payers. 	<ul style="list-style-type: none"> • The total number of providers who requested a prior authorization for items, services, or drugs, through their Prior Authorization API. • The number of unique prior authorization requests for items, services, and drugs received through their Prior Authorization API. • The percentage of all prior authorization requests that were received through their Prior Authorization API.