

## CMS Interoperability and Prior Authorization Final Rule

The Centers for Medicare & Medicaid Services (CMS) Interoperability and Prior Authorization final rule released on January 17, 2024, aims to enhance the electronic exchange of health care information, and streamline the prior authorization (PA) process for medical items and services. The finalized policies emphasize improving health information exchange and facilitating access to health records for patients, providers, and payers. Additionally, the goal is to reduce burden for payers, providers, and patients by improving the prior authorization process and ensuring patients remain central to their care. AAOS submitted [formal comments](#) on this proposed rule on February 7, 2023. In the proposed rule, CMS proposed compliance dates as 2026 for all policies that require Application Programming Interface (API) development and enhancements, but CMS is delaying the compliance dates in the final rule for provisions that require API development and enhancement to 2027. The outline below compares what AAOS advocated for to what was finalized. The Department of Health and Human Services will be announcing the use of enforcement discretion for the Health Insurance Portability and Accountability Act of 1996 (HIPAA) X12 278 prior authorization transaction standard. Read more about the finalized Interoperability and Prior Authorization final rule [here](#).

Topic	AAOS Comment/Recommendation	Finalized Policy
Updates to Provider Access API	<p>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.</p> <p>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.</p>	<p>Beginning January 1, 2027:</p> <p>CMS is “finalizing their proposal to require impacted payers to implement and maintain a Provider Access API that is consistent with the technical standards finalized in the CMS Interoperability and Patient Access final rule, including the Health Level Seven (HL7®) International Fast Healthcare Interoperability Resources (FHIR®) Release 4.0.1 standard.”</p> <p>CMS is “finalizing that, by the deadlines, impacted payers must make available upon request from an in-network provider, via the Provider Access API, claims and encounter data (excluding provider remittances and patient cost-sharing information), all data classes and data elements, and certain information about prior authorizations that the payer maintains no later than 1 business day after receiving a request from such a provider.”</p>

		<p>CMS is “finalizing that impacted payers are required to make this information about prior authorizations available no later than 1 business day after the payer receives a prior authorization request and must update that information no later than 1 business day after any status change. This information must be available for the duration that the authorization is active and at least 1 year after the prior authorization’s last status change.”</p> <p>CMS is “finalizing that impacted payers must establish and maintain an attribution process to associate patients with their in-network or enrolled providers to enable payer to provider data exchange via the Provider Access API.”</p> <p><b>Note:</b> “As with the Patient Access API policies, CMS is finalizing a modification to their proposal and not requiring payers to share the quantity of items or services used under a prior authorization or unstructured documentation related to a prior authorization. CMS is finalizing these changes to the Provider Access API policy with compliance dates in 2027.”</p>
<p>Improving Prior Authorization Processes</p>	<p>AAOS supports the use of HIPAA-compliant Prior Authorization Requirements, Documentation and Decision Application Programming Interface (PARDD APIs) to include functionality for data exchange including forms, medical records, and information regarding approval or denial of requests. We believe that it is critical for CMS to establish and maintain a robust system for continual oversight of MA (Medicare Advantage) plans’ use of PA processes to ensure that Medicare beneficiaries enrolled in MA plans have the same access to covered services as those covered under Medicare Fee-For-Service (FFS), as required by statute.</p>	<p>Beginning January 1, 2027: CMS is “requiring impacted payers to implement and maintain a Prior Authorization API. In the proposed rule, CMS used the term “Prior Authorization Requirements, Documentation, and Decision API (PARDD API).” For simplicity, CMS is finalizing the name of that API as simply the “Prior Authorization API.” This name change alone does not indicate any changes to the requirements or standards that CMS proposes.”</p> <p>CMS finalized that “MA organizations must report prior authorization metrics at the contract level rather than at the proposed organization level.”</p> <p>CMS is “finalizing that, by the compliance dates, impacted payers must implement a Prior Authorization API that:</p>

	<p>AAOS also suggests that prior authorization and approval/denial rates should be collected (and made public) through ongoing oversight and special focused audits.</p>	<ul style="list-style-type: none"> <li>• Is populated with the payer’s list of covered items and services (excluding drugs) that require prior authorization;</li> <li>• Can identify all documentation required for approval of any items or services that require prior authorization;</li> <li>• Supports a HIPAA-compliant prior authorization request and response; and</li> <li>• Communicates whether the payer approves the prior authorization request (and the date or circumstance under which the authorization ends), denies the prior authorization request (with a specific reason), or requests more information.”</li> </ul> <p>Beginning January 1, 2026: CMS is finalizing that “impacted payers’ must provide a specific reason for a denial within their decision timeframe regardless of the method that was used to send the prior authorization request or decision.”</p> <p>CMS is “finalizing that MA organizations, including applicable integrated plans must provide notice to providers and patients of prior authorization decisions as expeditiously as a patient’s health condition requires, but no later than 7 calendar days for standard requests, unless a shorter minimum timeframe is established under applicable state law.”</p> <p>CMS is “finalizing that MA organizations, including applicable integrated plans must provide notice to providers and patients of prior authorization decisions as expeditiously as a patient’s health condition requires, but no later than 72 hours for expedited requests, unless a shorter minimum timeframe is established under applicable state law.”</p>
<p>Gold Carding Programs for Prior Authorization</p>	<p>CMS believes that the gold-carding approach will support building an infrastructure that would allow practitioners to provide care</p>	<p>CMS "received several comments on Gold Carding Programs and appreciates the input. Since no policies were proposed, CMS is not finalizing policies in this area at this time. CMS thanks</p>

	<p>efficiently and effectively in a timely and value-based manner. AAOS encourages the adoption and establishment of gold-carding programs to help alleviate provider burden.</p> <p>AAOS supports CMS proposed requirement that coverage determinations are to be made on a timely basis, no later than 72 hours following the recipient's request. We also support the use of quality and star ratings with regards to gold card obtainment. Under gold-carding, we support the requirement that insurance companies must provide clinicians of the same specialty as the requesting physician, inferring that peer-to-peer PA related discussions should be conducted by similarly qualified physicians. This will save time and resources for both the requesting physician and the insurance company to process PA requests and initial denials.</p>	<p>commenters for their feedback and will consider all comments for possible future rulemaking.”</p>
<p>Improvements in Prior Authorization Processes, Decisions and Notification Timeframe Proposals</p>	<p>As supports utilizing open APIs to improve the exchange of health information to improve patient satisfaction and care. AAOS encouraged several measurable items to be addressed as required reporting by insurance plans, including the percentage of prior authorization</p> <ul style="list-style-type: none"> <li>• Requests approved during the previous plan year, including the initial determination concerning each item and service per plan</li> <li>• Requests that were initially denied, including requests to appeal denials, and the percentage of appeals that were overturned concerning</li> </ul>	<p>Beginning January 1, 2026, CMS is “requiring that impacted payers send notices to providers when they make a prior authorization decision, including a specific reason for denial when they deny a prior authorization request. CMS is also finalizing their proposal to require impacted payers, except for Qualified Health Plan (QHP) issuers on the FFEs, to respond to prior authorization requests within certain timeframes. Finally, CMS is requiring all impacted payers to publicly report certain metrics about their prior authorization processes, which will enhance transparency.”</p>

	<p>each item and service, broken down by each stage of appeal (including judicial review).</p> <ul style="list-style-type: none"> <li>• Requests that were denied including the percentage of the total number of denied requests due to decision support technology or other clinical decision-making tools.</li> <li>• The average and median amount (in hours) that elapsed during the previous plan year between the submission of PA request to the plan and the determination by the plan concerning such request for each item and service, not including PA requests that did not embody all required information to be submitted by the plan</li> <li>• A descriptive list of each occurrence during the previous plan year in which the plan determined to approve or deny an item or service in the case where a provider furnished an additional or differing item or service during the preoperative period of surgical or additional invasive procedures that such provider deemed medically necessary.</li> <li>• A disclosure and description of any software decision-making tools the plan utilizes in making determinations concerning such request.</li> </ul>	
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<p>Updates to Electronic Prior Authorization for Merit based Incentive Payment System (MIPS) Promoting Interoperability Performance Category and the Medicare Promoting Interoperability Program</p>	<p>AAOS strongly supports the development of interoperability standards for all Electronic Health Records (EHRs). Under this proposal, AAOS appreciates the standard for providers to have full access to prior authorization rulings, including approvals, denials, and request for information through Fast Healthcare Interoperability Resources (FHIR) PARDD API. We believe that in order for interoperable systems to be successful, the focus should not merely be on electronic distribution, receiving, integrating, and use of data from exterior sources. Instead, shifting the focus of interoperability to allow data exchange to be helpful and the use of information will be secure, useful, and valuable to both patients and practitioners and other providers. AAOS also believes it is imperative to develop meaningful and transparent use of EHRs across public insurance plans and private carriers to provide efficient care for patients and their families. AAOS supports authorizations to be done electronically through a secure HIPAA-compliant manner to decrease medical practice staff burnout from strenuous means of obtaining prior authorization. This will enable a shift to increased patient focused care.</p>	<p>CMS is “finalizing, with modifications, their proposal for new electronic prior authorization measures for MIPS eligible clinicians under the MIPS Promoting Interoperability performance category and for eligible hospitals and Critical Access Hospital (CAHs) under the Medicare Promoting Interoperability Program. CMS is adding new measures titled “Electronic Prior Authorization” (e-PA) under the Health Information Exchange (HIE) objective in the MIPS Promoting Interoperability performance category and the Medicare Promoting Interoperability Program, beginning with the calendar year (CY) 2027 performance period/2029 MIPS payment year and CY 2027 electronic health record (EHR) reporting period, respectively.”</p> <p>CMS is “finalizing a modification to their proposal for the Electronic Prior Authorization measure that will require a MIPS eligible clinician, eligible hospital, or CAH (Critical Access Hospital) to report a yes/no attestation or (if applicable) an exclusion, rather than a numerator and denominator. CMS believes this modification will reduce burden by not requiring MIPS eligible clinicians, eligible hospitals and CAHs to calculate and report a numerator and denominator for the e-PA Authorization measure.”</p> <p>CMS is “finalizing that the measures will not be scored (that is, not assigned points for completion or failure). Instead, if a MIPS eligible clinician, eligible hospital, or CAH fails to report the measure as specified, they would not meet the minimum reporting requirements, not be considered a meaningful EHR user, and fail the Medicare Promoting Interoperability Program or the MIPS Promoting Interoperability performance category. A failure in the Promoting Interoperability performance category would result in the MIPS eligible clinician receiving a score of zero for the</p>

	performance category which is currently worth 25 percent of their final score for MIPS.”
<p>Updates to Patient Access API</p>	<p>Beginning January 1, 2027, CMS will finalize their “proposal to require that impacted payers include information about certain prior authorizations in the data that are available through the Patient Access API including:</p> <ul style="list-style-type: none"> <li>• The prior authorization status.</li> <li>• The date the prior authorization was approved or denied.</li> <li>• The date or circumstance under which the prior authorization ends.</li> <li>• The items and services approved.</li> <li>• If denied, a specific reason why the request was denied.</li> <li>• Related structured administrative and clinical documentation submitted by a provider”</li> </ul> <p>CMS finalized “the requirement that impacted payers make this information about prior authorizations available no later than 1 business day after the payer receives a prior authorization request and must update that information no later than 1 business day after any status change. The information must be available for the duration that the authorization is active and at least 1 year after the prior authorization’s last status change.”</p> <p>Beginning January 1, 2026, CMS is “requiring impacted payers to annually report Patient Access API metrics to CMS in the form of aggregated, de-identified data. Specifically, by March 31, MA organizations at the contract level.”</p> <p>CMS is “finalizing a policy that requires certain payers to make a decision within 7 calendar days for standard requests and 72 hours for expedited requests.”</p> <p>CMS “encourages payers to make prior authorization data available for longer than 1 year if they believe it adds value to patients, providers, or themselves and their own processes.”</p> <p>CMS finalized “MA organizations must report Patient Access API metrics at the contract level rather than at the proposed organizational level.”</p>
<p>Payer-to-Payer API.</p>	<p>Beginning January 1, 2027, “impacted payers must implement and maintain a Payer-to-Payer API.”</p> <ul style="list-style-type: none"> <li>• Impacted payers are not required to share the quantity of items or services used under a prior authorization via the Payer-to-Payer API.</li> <li>• The data exchange between a previous payer and a new payer is limited to data with a date of service within the previous 5 years.</li> <li>• Impacted payers are required to request patients’ permission for payer-to-payer data exchange and identifying information about patients’ previous/concurrent</li> </ul>

payers no later than 1 week after the start of coverage, as that term is defined for each type of impacted payer, rather than at enrollment.

CMS is “finalizing a requirement that, by the deadlines, impacted payers must make available via the Payer-to-Payer API, by request from payer that meets certain requirements, claims and encounter data (excluding provider remittances and patient cost-sharing information), all data classes and data elements, and certain information about prior authorization requests and decisions (excluding those for drugs and those that were denied) that the payer maintains with a date of service within 5 years of the request.” This includes:

- The prior authorization status;
- The date the prior authorization was approved;
- The date or circumstance under which the prior authorization ends;
- The items and services approved; and
- Structured and unstructured administrative and clinical documentation submitted by a Provider.

CMS is “finalizing a requirement that impacted payers are required to make this information about prior authorizations available for the duration that the authorization is active and for at least 1 year after the prior authorization’s last status change.”

CMS is “finalizing a requirement that, by the deadlines, information received by an impacted payer through the payer-to-payer data exchange must be incorporated into the payer’s patient record.