Extending Interoperability to the Prior Authorization Process

What States Need to Know About CMS-0057-F

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Executive Summary

On January 17, 2024, the Centers for Medicare and Medicaid Services (CMS) published a new, finalized rule related to the prior authorization (PA) process. The rule focuses on improving care efficiency and quality through interoperability — more specifically, by bringing consistency and automation to every step of creating, submitting and reviewing/approving PA requests. When fully implemented, the rule will help streamline access to care for members and reduce administrative burden for providers. It builds on CMS-9115-F, CMS' Interoperability and Patient Access Final Rule, and represents an additional milestone in states' ongoing journeys toward system interoperability and Medicaid modernization.

Read this paper to discover:

- Why it's time to modernize the PA process for Medicaid
- An overview of CMS-0057-F and the intended benefits to all stakeholders
- How the new rule supports interoperability
- Steps states can take to start preparing today

What to know about the final rule:

- **Response times and details.** Starting in January 2026, certain payers must respond to urgent PAs within 72 hours and standard PAs within seven calendar days. In addition, payers must inform patients and providers why a request was denied.
- **More time on APIs, same deadline for reporting.** CMS pushed compliance with application programming interface (API) requirements from January 1, 2026, to January 1, 2027. However, it did not postpone the mandate for annual metrics/usage reporting. That requirement takes effect on January 1, 2026, with the initial set due by March 31, 2026.
- **HIPAA X12 278 enforcement discretion.** The proposed rule required covered entities to use the current adopted standard for prior authorization transactions — the HIPAA X12 278 version 5010 — and did not propose to modify the HIPAA rules in any way or hinder the use of that standard.[1] In the final rule, HHS announced it will use enforcement discretion for the HIPAA X12 278 standard. Covered entities that implement an all-FHIR-based PA API that do not use X12 278 as part of their API implementation will not be enforced against under HIPAA Administrative Simplification, allowing limited flexibility for covered entities to use a FHIR-only or FHIR and X12 combination API to satisfy the requirements of the final rule.[2]

[1] Advancing Interoperability and Improving Prior Authorization Processes Proposed Rule CMS-0057-P: Fact Sheet

[2] CMS Interoperability and Prior Authorization Final Rule CMS-0057-F Fact Sheet

Case for Change

PA is a cost-control process designed to ensure that a healthcare service or procedure is both medically necessary and covered by a health insurance plan. This process often requires healthcare professionals to secure plan approval before a service or treatment is delivered. After providers complete and submit these requests, they can be denied or put on hold pending receipt of additional information. That causes delays in care for patients and increases administrative burden for providers.

As reported in the Council for Affordable Quality Healthcare's 2002 CAQH Index®, "Deemed as one of the most time-consuming administrative transactions by many providers, time associated with conducting a PA manually (20 minutes), via a portal (12 minutes) and electronically (nine minutes) remained the highest among the transactions studied." [3]

With the rule, CMS aims to expand the Fast Healthcare Interoperability Resources (FHIR) standard to PA transactions. This will enable a faster, more efficient and higher-quality process by providing data in a standard format that reduces or eliminates QA issues. More complicated requests will still require clinical review and decision-making, but where clinical need and plan eligibility are clear, the payer can get to a "yes" much more quickly.

The Council for Affordable Quality Healthcare (CAQH) estimates that manually generating a single prior authorization request costs providers close to $11.[4]

The administrative burden of PA can be especially steep when caring for Medicaid members. Often, providers do not know if a PA is required. In this case:

They may gather the information needed for a PA only to discover that the member is not eligible, the service is not covered or it does not require a PA.

If a service does require a PA, the submission process is often manual (via fax or mail), or it requires direct data entry via a web portal (not directly from an electronic medical record [EMR] system). Because the process is manual, it also requires manual quality assurance (QA) review to check for missing or incorrect data.

Clinical staff may then request additional information (typically another manual process because transactions do not support automation).

Finally, the review is conducted, a decision is made and the provider is notified.

[3] 2022 CAQH Index Report
[4] 2019 CAQH Index Report

CMS-0057-F

A Key Milestone in the Journey Toward Interoperability

About the Final Rule

CMS' Advancing Interoperability and Improving Prior Authorization Process Proposed Rule was published in December 2022, closed for comment in March 2023 and finalized in January 2024.[5] The deadline to implement certain provisions is January 1, 2026, and compliance dates for API development and enhancement requirements have been extended to January 1, 2027.[2]

As noted at the CMS website:

"[Impacted payers] are required to implement and maintain certain Health Level 7® (HL7®) Fast Healthcare Interoperability Resources® (FHIR®) application programming interfaces (APIs) to improve the electronic exchange of health care data, as well as to streamline prior authorization processes. To encourage providers to adopt electronic prior authorization processes, this 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.

Building on the technological foundation of the May 2020 *CMS Interoperability and Patient Access* final rule (85 FR 25510), these API policies will improve patient, provider, and payer access to interoperable patient data and reduce the burden of prior authorization processes." [3]

Potential Value

By mandating use of HL7 FHIR APIs, the rule would help ensure that providers and plans communicate via a common language. With a common language, multiple applications can receive and send data uniformly regardless of the data structure within the applications. Harmonizing all applications will help increase automation and reduce dependence on manual review and processing. Ultimately, the rule will enable a critical shift from a transactional, often manual process to one that occurs in a more real-time, interactive manner.

Harnessing CMS-0057-F to Advance Interoperability

CMS-0057-F is the latest piece in a larger interoperability picture. It builds on CMS-9115-F, the Interoperability and Patient Access Final Rule from CMS and the Office of the National Coordinator for Health Information Technology (ONC). With this rule, CMS is helping to ensure that patients have access to their health information when they need it and in a way they can best use it.

CMS-0057-F represents the next phase of interoperability rulemaking — extending access to interoperable healthcare data to providers and other payers who have a relationship with the patient.

[5] Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes 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

Stakeholder Benefits

When fully implemented, CMS-0057-F will deliver significant value across stakeholder groups.

Patients
Higher Satisfaction

- Gain transparency through access to PA requests and status
- More quickly understand treatment options and associated costs
- Enhance their ability to participate in care decisions
- Receive care sooner
- Avoid care abandonment

Providers
Lower Administrative Burden

- Collect more accurate information for patients
- Reduce administrative burden with automated communication between provider EMR and payer systems:
  - Provide real-time access to payer requirements
  - Avoid duplicate/erroneous information entry
  - Automate collection of supporting documentation
- Improve patient satisfaction by reducing/eliminating first-time denials and providing timely information about and access to care

Payers
Long-term Cost Improvement

- Receive patient data from previous payers
- Improve relationships with members and providers
- Avoid service delays with PA documentation workflow tailored to the specific service and member
- Contribute to lower long-term costs through improved engagement with ordering providers and more appropriate patient care

Gain the ability to see and discuss alternatives for care, including out-of-pocket-cost considerations

States: Start Preparing Today

CMS-0057-F requires states to address six high-level impacts:

Improving Prior Authorization Processes

Improved decision timeframes and enhanced denial reasoning

Patient Access API

Updated with PA information, excluding drugs, starting January 1, 2027; annual metrics/ usage reporting to begin January 1, 2026

Provider Access API

Access by in-network providers — with whom the patient has a treatment relationship — to patient claims, encounter, and other data

Payer to Payer Exchange API

Making claims data, encounter data and other information available between payers

Prior Authorization API

Support for PA requests and responses, documentation requirements, and decisions

Electronic Prior Authorization Measure

New measure for eligible clinicians and hospitals to report their use of PA APIs under the MIPS and Medicare Promoting Interoperability Program

As they begin working to address these impacts, states are operating within different regulatory environments and relying on diverse technology systems. While each journey will have unique elements, Gainwell recommends that every state consider the following:

- Start by assessing and auditing PA business processes and consider state laws regarding PAs. Laws may need modifications to align to electronic submission of attachments and notifications.
- Assess which PA requirements lend themselves to automated decisioning.
- Review current PA reasons for denial and response processes.
- Collect metrics and begin reporting. Consider a phased approach to automation, with clinical decision-makers reviewing and validating processes until they are certain they work. With that confidence, make the shift to a more automated PA review and approval.

Gainwell is a leader in Medicaid interoperability. We have completed 15 Patient Access implementations — with five more underway — and implemented and managed PA processing in multiple states. **Contact us** to initiate a detailed assessment of your state's readiness and opportunities to address CMS-0057-F.

To learn more about Gainwell, visit **gainwelltechnologies.com**.

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