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

AAHomecare Summary - 1/26/24

- **The CMS Interoperability and Prior Authorization Final Rule CMS-0057-F was released January 17th, 2024.**
- **AAHomecare submitted comments on the proposed "interoperability" rule in March of 2023.**
- Provisions will take effect in either 2026 or 2027. The Patient Access **application programming interface** (API) and prior authorization decision timeframes and denial reason requirements will take effect in 2026, while the Provider Access API and Payer-to-Payer API requirements must be implemented by January 1, 2027.
- Payers will be required to build and maintain a Prior Authorization API to automate the process for providers to determine whether a prior authorization is required. The API will identify the payer's documentation requirements to make them available within the provider's workflow and support an automated compilation of information from the provider's system. The API will also support automated compiling of data to populate the (HIPAA-compliant) prior authorization transactions and allow payers to compile specific responses regarding the status of a prior authorization request, such as the reason for a denial. (These changes will facilitate the exchange of prior authorization requests and decisions from provider's electronic health records (EHRs) or practice management systems in compliance with adopted HIPAA standards.)
- Payers are also required to:
    - Include a specific reason when they deny a prior authorization request
    - Send prior authorization decisions within 72 hours for expedited (urgent) requests and seven calendar days for standard (non-urgent) requests,
    - Publicly report certain prior authorization metrics by posting them on their website or through publicly accessible hyperlinks annually.
        - The first set of metrics should be reported by 3/31/26
- Payers, (MA, Medicaid, MCO) are also required to implement a Patient Access API or "health app". Enrollees will be able to access (within 1 business day) remittances, cost-sharing information, capitated provider encounters, clinical data – lab reports, and PA status and information.
- The final rule does not directly apply to Medicare FFS, but CMS states they plan to implement these provisions for Medicare FFS as well.
- The rule also requires payers to report data on patients that utilize the API or "health app".
- CMS WILL REQUIRE PAYERS TO IMPLEMENT PROVIDER ACCESS API - Consistent with the Patient Access API, CMS will require impacted payers to provide requested data to the provider within one business day after the request is made. The most significant difference between the Patient Access API and Provider Access API is in how providers access patient data – not through a health app but through the provider's electronic health record or practice management system. Also, unlike the Patient Access API, CMS will exclude provider remittances and enrollee cost-sharing information from the Provider Access API.
- Provider APIs must be implemented by 1/1/27 for MA, Medicaid, MCO.
- Patients will have ability to opt-out.
- CMS FINALIZES ELECTRONIC PRIOR AUTHORIZATION MEASURE WITH STREAMLINED REPORTING REQUIREMENTS

- In the final rule, CMS introduces a new measure, "Electronic Prior Authorization," under the Health Information Exchange (HIE) objective for both the MIPS Promoting Interoperability performance category and the Medicare Promoting Interoperability Program. MIPS eligible clinicians are required to report this measure starting with the Calendar Year (CY) 2027 performance period/CY 2029 MIPS payment year, while eligible hospitals and Critical Access Hospitals (CAHs) will begin reporting during the CY 2027 EHR reporting period.
- CMS FINALIZES PAYER-TO-PAYER DATA EXCHANGE REQUIREMENTS
    - CMS finalizes its proposal to require that payers build a Payer-to-Payer API to facilitate the exchange of patient data including claims and encounter data (excluding cost information), and prior authorization requests and decisions. Impacted payers will be required to request data from a patient's previous payer no later than one week from the start of coverage or upon the patient's request, with the patient's permission. Payers will be required to exchange five years of patient data. CMS will only be requiring this data exchange if the patient opts into data sharing. These new API requirements will also apply to Medicaid and CHIP FFS programs in addition to Medicare Advantage plans.
    - Provisions are effective January 2027.
- **AAHomecare submitted comments on the proposed "interoperability" rule in March of 2023.**
    - In comments we highlighted the OIG report that indicated the central concern about capitated payment models, including the potential incentive for insurers to deny access to services and deny payments in order to increase profits.
    - We supported CMS objectives to improve the PA process with API mandates in order to streamline the PA process and improve timelines.
    - AAH commented that more details are needed to support an expeditious appeal process for negative PA determinations for both MA and Medicaid MC.
    - AAH also commented that for many DME items PA may need to be processed faster than the 72 hours to enable timely discharge from a hospital or NF. AAH recommended for items such as NIV an expedited PA should be turned around within 24 hours.
    - We also commented that PA should be applied for high-cost items such as CRT and NIV, and life-sustaining equipment should be authorized within 24 hours.
    - PA should be eliminated for CRT service & repair claims bc these PA processes result in unreasonable delays when the consumer has a need to obtain repair services.
    - AAH comments also encourages a "real time" PA system with certain criteria, for DMEPOS items.
        - 24 hours
        - PA should be conclusive with respect to medical necessity and payment
        - Appropriate denial reasons should be issued to allow secondary payers to make coverage decisions.