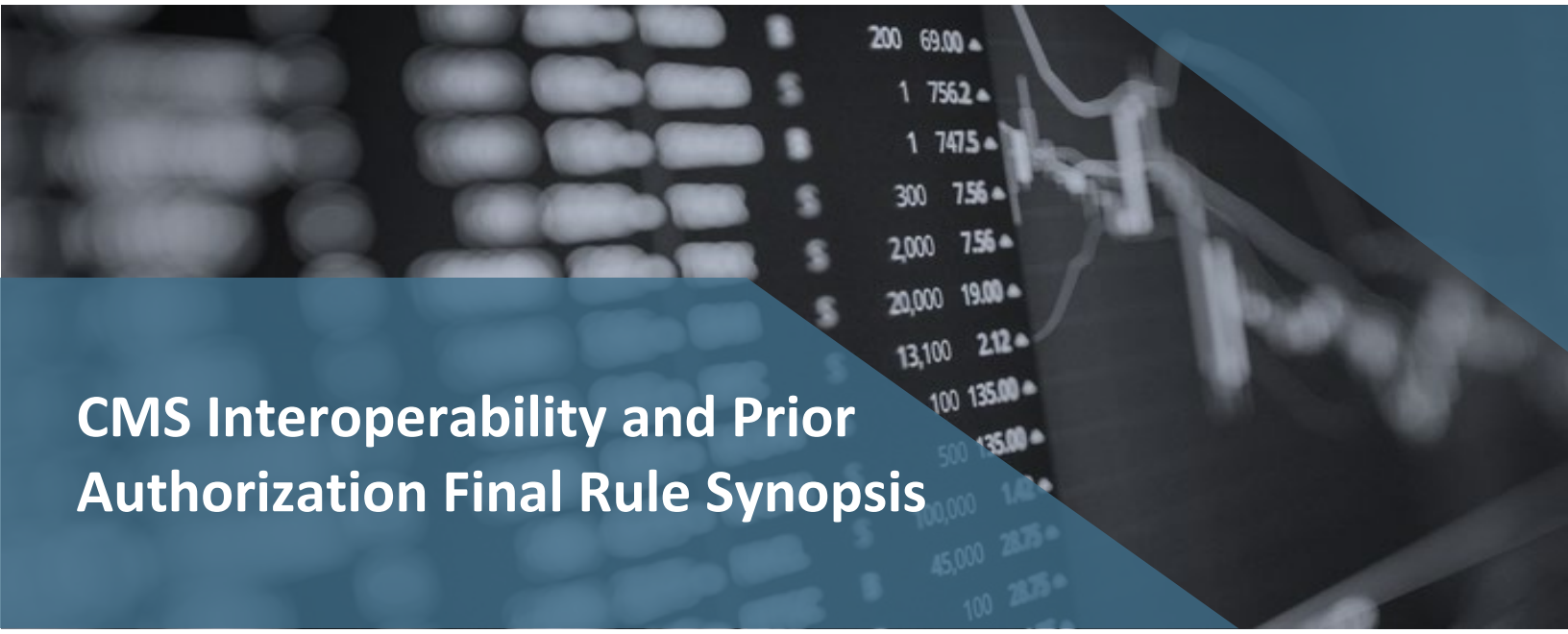


CMS Interoperability and Prior Authorization Final Rule Synopsis

The Centers for Medicare & Medicaid Services (CMS) changed its prior authorization rules to simplify and digitize the process, and to reduce the burden on each of the three legs in the healthcare delivery tripod: patients, providers, and payers. In particular, CMS aims to reduce administration, simplify and accelerate the process, and introduce standardization across payers.

It is critically important for providers and especially payers to get ahead of these changes by assessing processes and the technology necessary to support the rules change and ensure compliance.

CMS RULE OVERVIEW

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

The Centers for Medicare & Medicaid Services (CMS) released the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F) on January 17, 2024. This final rule emphasizes the need to improve health information exchange to achieve appropriate and necessary access to health records for patients, healthcare providers, and payers. This final rule also focuses on efforts to improve prior authorization processes through policies and technology, to help ensure that patients remain at the center of their own care.

The rule enhances certain policies from the CMS Interoperability and Patient Access Final Rule (CMS-9115-F) and adds several new provisions to increase data sharing and reduce overall payer, healthcare provider, and patient burden through improvements to prior authorization practices and data exchange practices.

Impacted payers are required to implement certain provisions by January 1, 2026. However, in response to stakeholder comments on the proposed rule, impacted payers have until primarily January 1, 2027, to meet the application programming interface (API) requirements in this final rule.

PRE-AUTHORIZATION RULES CHANGES

The Centers for Medicare and Medicaid Services (CMS) has made several changes to the prior authorization process, including:

Affected Entities: The rules change impacts Medicare Advantage, Medicaid (both fee-for-service Medicaid and Managed Medicaid), Children's Health Insurance Plans (CHIP), and Qualified Health Plans (QHPs) operating on U.S. federal exchanges. Also included in the scope are hospitals, critical access hospitals, individual physicians, and practices involved in the Medicare promoting interoperability program or the *Merit-based Incentive Payment System* (MIPS). The intention of the rule is to simplify the prior authorization process, enabling providers to submit requests and receive prompt notifications about the status of these requests more efficiently.

Shorter response times: Beginning January 1, 2026, Medicare Advantage plans, Medicaid, and CHIP will have to provide standard prior authorization decisions within 7 calendar days and expedited decisions within 72 hours. This is a significant change from the current Medicare Advantage timeframe of 14 calendar days for standard decisions.

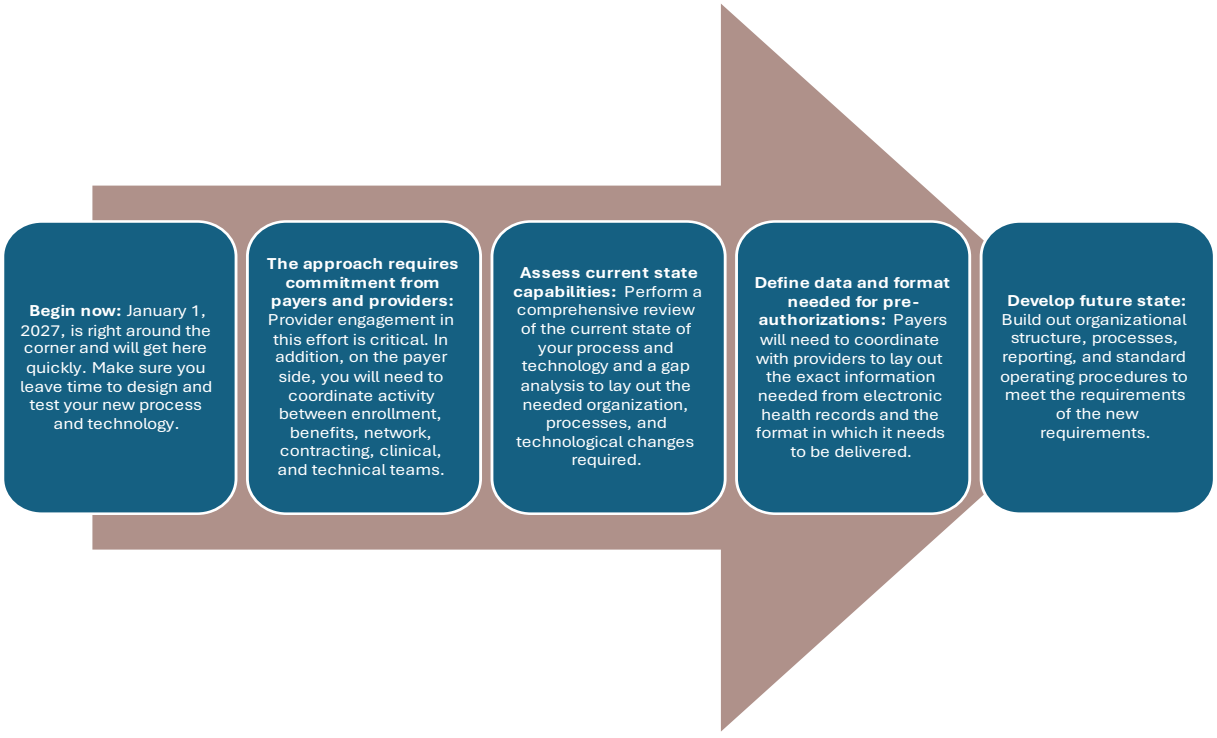
Public disclosure of metrics: Prior to March 31, 2026, all impacted payers will be required to publicly report prior authorization metrics.

Payer-to-payer API: Impacted payers will be required to implement and maintain a Payer-to-Payer Application Programming Interface. This API will allow payers to request data from the previous five years for a newly enrolled beneficiary or a beneficiary with multiple payers. The deadline for API is January 1, 2027. The goal of the API is to decrease the frequency of denials and appeals and eliminate requests for supplementary documentation.

Master List and Required Prior Authorization List updates: On August 12, 2024, the Master List was updated to add 76 HCPCS codes and remove 3 HCPCS codes.

Denial Rationale: An additional requirement introduced by the rule effective January 1, 2026, is the obligation for payers to provide specific denial reasons from a standardized industry list when refusing an authorization. This applies to all authorizations, regardless of submission method.

PAYER GUIDANCE (OUR RECOMMENDED APPROACH)



CONCLUSION

Any payer with Medicare Advantage, Medicaid, or Children's Health Insurance Plans is impacted by this rules change. Impacted payers are required to implement certain provisions by January 1, 2026, but have until January 1, 2027 to meet the application programming interface (API).

Our recommendation is to begin the assessment now of your prior authorization processes and results as well as your data intake and sharing capabilities and compare them to the requirements in the rules change to develop a roadmap to compliance and begin execution.

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