Press release

CMS Proposes Rule to Expand Access to Health Information and Improve the Prior Authorization Process

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Proposals would support enhanced patient and provider access to health information while improving the prior authorization process to reduce provider burden

As part of the Biden-Harris Administration's ongoing commitment to increasing health data exchange and investing in interoperability, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that would improve patient and provider access to health information and streamline processes related to prior authorization for medical items and services. CMS proposes to modernize the health care system by requiring certain payers to implement an electronic prior authorization process, shorten the time frames for certain payers to respond to prior authorization requests, and establish policies to make the prior authorization process more efficient and transparent. The rule also proposes to require certain payers to implement standards that would enable data exchange from one payer to another payer when a patient changes payers or has concurrent coverage, which is expected to help ensure that complete patient records would be available throughout patient transitions between payers.

"CMS is committed to strengthening access to quality care and making it easier for clinicians to provide that care," said CMS Administrator Chiquita Brooks-LaSure. "The prior authorization and interoperability proposals we are announcing today would streamline the prior authorization process and promote health care data sharing to improve the care experience across providers, patients, and caregivers – helping us to address avoidable delays in patient care and achieve better health outcomes for all."

The proposed rule would address challenges with the prior authorization process faced by providers and patients. Proposals include requiring implementation of a Health Level 7® (HL7®) Fast Healthcare Interoperability Resources® (FHIR®) standard Application Programming Interface (API) to support electronic prior authorization. They also include requirements for certain payers to include a specific reason when denying requests, publicly

report certain prior authorization metrics, and send decisions within 72 hours for expedited (i.e., urgent) requests and seven calendar days for standard (i.e., non-urgent) requests, which is twice as fast as the existing Medicare Advantage response time limit. In order to further support a streamlined prior authorization process, this proposed rule would add a new Electronic Prior Authorization measure for eligible hospitals and critical access hospitals under the Medicare Promoting Interoperability Program and for Merit-based Incentive Payment System (MIPS) eligible clinicians under the Promoting Interoperability performance category.

Proposed policies in this rule would also enable improved access to health data, supporting higher-quality care for patients with fewer disruptions. These policies include: expanding the current Patient Access API to include information about prior authorization decisions; allowing providers to access their patients' data by requiring payers to build and maintain a Provider Access FHIR API, to enable data exchange from payers to in-network providers with whom the patient has a treatment relationship; and creating longitudinal patient records by requiring payers to exchange patient data using a Payer-to-Payer FHIR API when a patient moves between payers or has concurrent payers.

These proposed requirements would generally apply to Medicare Advantage (MA) organizations, state Medicaid and Children's Health Insurance Program (CHIP) agencies, Medicaid managed care plans, CHIP managed care entities, and Qualified Health Plan (QHP) issuers on the Federally-facilitated Exchanges (FFEs), promoting alignment across coverage types. CMS estimates that efficiencies introduced through these policies would save physician practices and hospitals over $15 billion over a 10-year period.

Finally, the proposed rule includes five requests for information related to standards for social risk factor data, the electronic exchange of behavioral health information among behavioral health providers, improving the exchange of medical documentation between certain providers in the Medicare Fee-for-Service program, advancing the Trusted Exchange Framework and Common Agreement (TEFCA), and the role interoperability can play in improving maternal health outcomes.

The proposed rule is aligned with CMS' ongoing work to strengthen patient access to care, reduce administrative burden for clinicians so they can focus on direct care, and support interoperability across the health care landscape. It withdraws and replaces the previous proposed rule, published in December 2020, and addresses public comments received on that proposed rule.

For additional information, consult this fact sheet.

The proposed rule is available to review here , and the deadline to submit comments is March 13, 2023. CMS encourages comments from all interested members of the public and,

in particular, from patients and their families, providers, clinicians, consumer advocates, health care professional associations, individuals serving and located in underserved communities, and from all other CMS stakeholders serving populations facing disparities in health and health care.

For more information on the CMS proposed rule, please visit: https://www.cms.gov/regulations-and-guidance/guidance/interoperability/index.

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