

CMS Seeks to Reduce Prior Authorization Burden

Proposed rule sets a three-year timeline for implementing prior authorization (PA) and health information technology standards to reduce burden and improve patient care.

Why it Matters: After years of ASTRO advocacy regarding the inappropriate use of prior authorization, CMS is responding with a series of policy proposals that standardize its use, reduce burden on providers and payers, and protect patient centered care. The rule also seeks to improve health information exchange and facilitate patient, provider and payer access to information in health records.

Proposed PA Process Changes

- Require payers to implement and maintain an automated, electronic platform to support and streamline the prior authorization process;
- Require payers to respond to prior authorization requests within certain timeframes;
- Require payers to provide a clear reason for prior authorization denials;
- Require payers to publicly report on prior authorization approvals, denials and appeals.

Proposed Rule Summary

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, Issues of Qualified Health Plans on Federally-facilitated Exchanges, Merit-based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program Proposed Rule

On Tuesday, December 7, 2022, the Centers for Medicare and Medicaid Services (CMS) introduced a proposed rule that seeks to reduce provider burden through the application of new requirements on federally funded health plans, including Medicare Advantage and state Medicaid programs. The new requirements include improvements to the electronic exchange of health care data and streamlined prior authorization processes. The proposed rule also includes new MIPS requirements to encourage greater use of electronic prior authorization. The proposed rule comment period ends on March 13, 2023. Below is a summary of the key issues of interest to radiation oncology.

Improving Prior Authorization Processes

In this proposed rule, CMS is announcing technical and operational changes to improve the prior authorization process for payers, providers and patients. CMS is proposing to require payers to implement and maintain a Fast Healthcare Interoperability Resources (FHIR) Prior Authorization Requirements, Documentation, and Decision (PARDD) Application Programming Interface (API). The PARDD API will automate tasks, allowing providers to query prior authorization requirements, submit necessary documentation, and assess approval or denial status. CMS considered a phased in approach to this requirement but decided against it due to concerns that providers would face varying prior authorization policies based on implementation status, which would exacerbate existing frustrations. Therefore, CMS is proposing a January 1, 2026, implementation date. However, the Agency is seeking

comments on a phased approach to implementation. Additionally, CMS is seeking comment on steps that the Agency can take to encourage providers and health IT developers to adopt the technology necessary to access payers' PARDD APIs.

Reason for Denial

To support better communication between payers and providers, CMS is proposing that responses about prior authorization decisions be sent through the PARDD API including whether the payer approves (and for how long) or denies (with reason for the denial) the prior authorization request, or requests more information from the provider to support the request. According to the proposed rule, timely and clear information from payers about the status of a prior authorization or the reason(s) for denial could mitigate treatment abandonment and delays in care by allowing the provider to take actions such as re-submitting the request with updated information, identifying alternatives for the patient, or appealing the decision.

CMS notes that existing Medicare Advantage program regulations include the following requirements associated with partial or full denials of coverage:

- Use approved notice language in a readable and understandable form;
- State the specific reasons for the denial;
- Inform the enrollee of their right to a reconsideration;
- Describe both the standard and expedited reconsideration process, including the enrollee's right to, and conditions for, obtaining an expedited reconsideration and rest of the appeal process; and
- Comply with any other notice requirements specified by CMS.

Additionally, existing regulations state that Medicare Advantage organizations must send a written denial notice to the enrollee, and the physician involved, whenever a partial or full denial is determined.

Decision Timeframes and Communications

In the proposed rule, CMS is seeking to improve patient care outcomes and ensure patients have more timely access to services by shortening the timeframe for standard prior authorization request from 14 calendar days to 7 calendar days. Specifically, the proposed language would require MA organizations to notify the enrollee of its determination "as expeditiously as the enrollee's health condition requires, but no later than 7 days" after receipt of the request for a medical item or service. The Agency believes this can be achieved through the implementation of the PARDD API, which will support greater efficiency in the decision-making process. CMS notes that it is not proposing that payers approve a request for prior authorization if they fail to meet the timeframe for approval or other decision. The Agency seeks comment on the shortened standard decision-making timeframe.

Under existing regulations, if a provider or payer determines that the standard timeframe may jeopardize the patient's life, health or ability to attain, maintain or regain maximum function, the plan must make an expedited decision within 72-hours after receiving the request. The Agency is not proposing to modify the existing expedited decision-making policy; however, it is seeking comment on whether to consider a 24-hour timeframe in future rulemaking. Furthermore, CMS proposes to apply the

following qualifier language to Medicaid FFS plans: “unless a shorter minimum timeframe is established under State law.”

Finally, current policy allows enrollees and payers to request an extension of up to 14 days from the standard or expedited timeframes for the payer to make a decision. The Agency is not proposing any modifications to the 14-calendar day extension policy.

Prior Authorization Public Reporting Metrics

CMS proposes requiring payers to publicly report aggregated prior authorization metrics. Medicare Advantage plan reports would include aggregate data at the organizational level, whereas Medicaid and CHIP managed care would be reported on the plan level so that beneficiaries could compare and states could evaluate plans. The Agency believes that the following metrics requirement will contribute to improvements in the prior authorization process:

- A list of all items and services that require prior authorization.
- The percentage of standard prior authorization requests that were approved, aggregated for all items and services.
- The percentage of standard prior authorization requests that were denied, aggregated for all items and services.
- The percentage of standard prior authorization requests that were approved after appeal, aggregated for all items and services.
- The percentage of prior authorization requests for which the timeframe for review was extended, and the request was approved, aggregated for all items and services.
- The percentage of expedited prior authorization requests that were approved, aggregated for all items and services.
- The percentage of expedited prior authorization requests that were denied, aggregated for all items and services.
- The average and median time that elapsed between the submission of a request and a determination by the payer, plan or issuer, for standard prior authorizations, aggregated for all items and services.
- The average and median time that elapsed between the submission of a request and a decision by the payer, plan or issuer, for expedited prior authorizations, aggregated for all items and services.

The Agency is not proposing a specific format for the issuance of this data but encourages payers to consider readability and accessibility in preparing the data for public review. Finally, the Agency is seeking comment on the proposed data publication requirements.

Prior Authorization Gold-Carding

Gold-carding is a form of coverage approval that reduces prior authorization requirements for providers that have demonstrated consistent compliance with payer coverage policies. In the proposed rule, CMS states that it believes the use of gold-carding could alleviate provider burden. Under existing MA program regulations, MA organizations have the discretion to implement gold-carding programs within

contracted plans. Additionally, CMS recognizes that many states have enacted gold-carding programs to address provider and patient complaints about access to health care services.

In the proposed rule, CMS encourages payers to adopt gold-carding programs to address provider and patient complaints about access to health care services. Furthermore, the Agency is seeking comment on how to measure whether and how gold-carding or prior authorization exemption programs could reduce provider and payer burden, and improve access to care for patients, particularly those patients who may experience health care disparities. Additionally, CMS is seeking comment on whether it should include a gold-carding measure factor in quality ratings for Medicare Advantage organizations and Qualified Health Plans as a way for these payers to raise their scores in the quality star ratings.

Electronic Prior Authorization for MIPS Promoting Interoperability Performance Category and Medicare Promoting Interoperability Program

CMS is proposing to establish a new measure, entitled “Electronic Prior Authorization,” to be included in the Merit Based Incentive Payment System (MIPS) Promoting Interoperability performance category to encourage provider use of APIs. The Agency is proposing to require MIPS eligible clinicians to report on this measure beginning with the 2026 performance period/2028 payment year. While the Agency proposes that non-compliance with the measure would not satisfy the MIPS Promoting Interoperability performance category, it would not initially score the measure. A scoring methodology for the proposed measure will be issued in future rule making. CMS proposes the following parameters related to the new measure:

- Measure Description – For at least one medical item or service (excluding drugs) ordered by the MIPS eligible clinician during the performance period, the prior authorization is requested electronically from a PARDD API using data from CEHRT.
The MIPS eligible clinician would be required to report a numerator and denominator for the measure or (if applicable) report an exclusion:
 - Denominator – The number of unique prior authorizations requested for medical items and services (excluding drugs) ordered by the MIPS eligible clinician during the performance period, excluding prior authorizations that cannot be requested using the PARDD API because the payer does not offer an API that meets the PARDD API requirements.
 - Numerator – The number of unique prior authorizations in the denominator that are requested electronically from a PARDD API using data from CEHRT.
 - Exclusion: Any MIPS eligible clinician who:
 - Does not order any medical items or services (excluding drugs) requiring prior authorization during the applicable performance period; or
 - Only orders medical items or services (excluding drugs) requiring prior authorization from a payer that does not offer an API that meets the PARDD API requirements during the applicable performance period.

CMS is seeking public comment on the proposed numerator and denominator, including whether the Agency should consider alternatives. Additionally, CMS is interested in understanding what challenges providers face in identifying payers that have the PARDD API technology and whether there are any challenges associated with performing the actions associated with measure compliance.

Requests for Information (RFI)

The proposed rule includes the following RFI topics. Comments in response to these RFIs will be used to inform future rule making.

- 1) Accelerating the Adoption of Standards Related to Social Risk Factor Data
- 2) Electronic Exchange of Behavioral Health Information
- 3) Improving the Exchange of Information in Medicare Fee for Service
- 4) Advancing Interoperability and Improving Prior Authorization Processes for Maternal Health
- 5) Advancing the Trusted Exchange Framework and Common Agreement (TEFCA)

API Policy Changes

In addition to the proposed establishment of the PARDD API as described above, CMS is also seeking to modify requirements associated with existing APIs, including the Provider Access, Payer to Payer and Patient Access APIs.

The proposed rule includes a policy that would require payers to implement and maintain a Provider Access API that utilizes HL& FHIR version 4.0.1. The API can be used to exchange patient data from payers to providers, including all data classes and data elements in the current USCDI version 1 standard, adjudicated claims and encounter data, and the patient's prior authorization decisions.

CMS is proposing to rescind its previous policy, established in the CMS Interoperability and Patient Access final rule, that required federally funded payer health care plans to exchange a patient's health data with other payers beginning January 1, 2022. According to the proposed rule, payers expressed concern that they were unable to implement the policy due to a lack of technical specifications for the payer-to-payer data exchange. The Agency is proposing to require that payer exchange patient data, including adjudicated claims and encounter data and the patient's prior authorization decisions through a Payer to Payer API that will allow this exchange only if the patient opts into data sharing.

Finally, the Agency proposes modifying the Patient Access API requirements, which are currently limited to "clinical data, including laboratory results" to include "all data classes and data elements..." including immunizations, procedures and assessment and plan of treatment, as well as the prior authorization review and approval process that is delineated in the PARDD API above.

More information about the proposed rule can be found in the following CMS resources:

Proposed Rule: <https://www.federalregister.gov/public-inspection/2022-26479/medicare-and-medicaid-programs-advancing-interoperability-and-improving-prior-authorization>

Fact Sheet: <https://www.cms.gov/newsroom/fact-sheets/advancing-interoperability-and-improving-prior-authorization-processes-proposed-rule-cms-0057-p-fact>