

Reducing Provider and Patient Burden by Improving Prior Authorization Processes – Proposed Rule Summary

On Friday, December 11, 2021, CMS released the *Reducing Provider and Patient Burden by Improving Prior Authorization Processes and Promoting Patients' Electronic Access to Health Information (CMS-9123-P)* proposed rule to streamline prior authorization processes and facilitate better electronic exchange of healthcare information. This rule proposes to require Medicaid, Children's Health Insurance Plans and Qualified Health Payers to utilize systems that streamline documentation requirements and allow for the submission and approval of prior authorization requests via the provider's EHR system. ASTRO has long advocated for prior authorization reforms and is pleased that CMS is recognizing the burden associated with prior authorization and seeking opportunities to not only streamline the process, but also make it more transparent for providers and patients alike.

Though this proposed rule only applies to Medicaid and CHIP managed care plans, state Medicaid and CHIP FFS programs, and Qualified Health Plans (QHP) issuers on the Federally-facilitated Exchanges (FFE), CMS encourages Medicare Advantage plans to implement similar measures, and may consider requirements in future rulemaking. Below is a summary of the Rule's proposals and requests for information. ASTRO will be commenting on the proposed rule prior to the Jan. 4, 2021 deadline.

Patient Access API

Building upon the CMS Interoperability and Patient Access final rule (85 FR 25523), this provision proposes to require impacted payers to utilize patient access application programming interfaces (APIs) Implementation Guides (IGs) [outlined in 85 FR 25529](#), beginning January 1, 2023. According to the proposed rule, this is intended to improve interoperability and data exchange between payers, third-party applications, and practices. CMS seeks comment on the use of Image Guides US Core versus PDex, should payers be required to utilize only one of the two proposed IGs. The US Core Implementation Guide defines the elements and terminology requirements that must be present in a profile in narrative summary form. PDex, part of Da Vinci Payer Data Exchange, uses a patient's health history to create data interactions securely across parties.

CMS proposes that prior authorization decision information be made available to patients through the Patient Access API. According to the proposed rule, beginning January 1, 2023, payers would be required to provide information about both pending and active prior authorization decisions and any related supporting documentation through the Patient Access API no later than one business day after a provider submits a request, or a prior authorization status is updated. This information includes the date prior authorization was approved, the date the authorization ends, the units and services approved, and those used to date. This same information would also be required to be shared with the provider via the Provider Access API upon the provider's request. CMS requests comment on this proposal.

CMS also requests feedback on whether impacted payers should be required to include information about prescription drug and/or covered outpatient drug pending and active prior authorization decisions with the other items or services proposed via the API platforms.

Privacy Policy Attestation

In the proposed rule, CMS proposes that payers be required to develop and maintain a process to obtain attestation from third-party app developers who retrieve data via the Patient Access API that indicates the (third-party) app adheres to specific privacy provisions. The payer would be allowed to choose how

they meet this proposed requirement, but the method must be applied to all apps requesting access from the payer.

Payers would be required to request the third-party app developer's attestation when the third-party connects with the API and inform the patient of the status of the attestation within 24 hours. The patient then has 24 hours to object to their information being shared, otherwise the payer will provide the information via the API. CMS is seeking input on this proposal and the payer's obligation to send the data even if the patient does not respond to the notification of the app's attestation results, as well as additional privacy provisions outlined in the proposed rule.

Payer-to-Provider Data Sharing

State Medicaid agencies and Medicaid managed care plans are required to implement the Patient Access and Provider Directory APIs as outlined in the CMS Interoperability and Patient Access final rule. According to this proposed rule, the APIs should utilize Implementation Guides to exchange information between beneficiaries, providers, the state Medicaid program, and any applicable managed care plan. Individual payers should create, implement, and sustain a way to generate each provider's current patient roster to enable this proposed payer-to-provider data. CMS asserts that allowing providers greater access to patient authorization information directly from EHRs gives them a more complete picture of the patient's situation and enables them to provide higher quality care. Another major reason that payers would be required to develop APIs is to reduce the number of mechanisms that providers are currently forced to use to submit prior authorization requests – particularly fax requests. The Agency requests input on this proposal, as well as whether the use of fax technology for prior authorization should be phased out.

Application of FHIR DRLS

CMS acknowledges that varied payer policies and practice workflow issues cause the prior authorization process to be a burden for both providers and payers, leading to burnout for providers and risking patient health when it causes care to be delayed. The Agency proposes that, beginning January 1, 2023, state Medicaid and CHIP programs, Medicaid managed care plans, CHIP managed care entities, and QHPs implement and manage a Fast Healthcare Interoperability Resources (FHIR) drug registration and listing system (DRLS) that lists covered items and services for which prior authorization is required, including applicable documentation requirements for submitting a request. The DRLS API will help providers determine if prior authorization is required, and if so, inform them of the related documentation requirements. Though CMS anticipates providers to benefit greatly from the DRLS API, standardization of the information and access via the API will ensure access to coverage and coordinate care for beneficiaries. CMS would like input on this proposal.

Decision Notice Timeframe

In the proposed rule, CMS proposes requiring State and Medicaid managed care plans to provide prior authorization decision notice within a specified timeframe, with expedited decisions being made and communicated in 72 hours and standard decisions be made and communicated in seven calendar days. The communication should include the date the prior authorization was approved, the date the authorization ends, and any approved services used to date. Plans would also publicly report prior authorization metrics to stabilize the prior authorization process and improve patient access to timely, necessary care. CMS is seeking feedback on proposed reporting prior authorization request metrics and on the proposed reporting dates.

Adoption of Gold-Carding Programs

CMS believes that gold-carding programs could help alleviate prior authorization burden and encourages payers to adopt such programs. Though there are no proposals in this rule, CMS requests comments for potential rulemaking on the implementation on gold-carding programs for QHPs, and suggestions on how payer prior authorization programs could be structured to include a gold-carding component.

Long-Term Authorization for Chronic Conditions

CMS would like feedback regarding “repeat prior authorizations” that are often required for treatment of chronic conditions. Stakeholders should provide suggestions on whether long-term authorizations should be allowed for chronic and terminal conditions, and what alternative programs should be considered to provide long-term authorizations. Additionally, CMS notes that the lack of standardization creates confusion for providers and patients, and requests input on solutions to standardizing prior authorization forms, to inform future rulemaking.

Payer-to-Payer Data Exchange on FHIR

Currently when a patient enrolls with a new payer, the patient and provider are forced to essentially start the prior authorization process all over again, as the former payer typically does not share any prior authorization decision information. Under the Prior Authorization proposed rule, this information would be part of the patient’s cumulative record and therefore would be available via the payer-to-payer data API. Payers would document the date the prior authorization was approved, the date the authorization ends, any units/services approved and those used to date. CMS requests comment on this proposal.

The Agency will consider future rulemaking that requires payers to demonstrate that they reviewed previous plan’s prior authorization decisions before requiring patients to begin a new prior authorization process. CMS believes it would reduce burden for payers and providers and lead to greater continuity of care if payers were to honor a previous payer’s active prior authorization decisions at the time the patient moves changes payers for a specified time (30, 45, or 60 days). CMS is seeking feedback on this consideration, and specifically any situations where this requirement would be inappropriate or impossible.

Additional Requests for Information

Methods for Enabling Patients and Providers to Control Sharing of Health Information

CMS is requesting that stakeholders provide ideas and suggest processes that will allow patients and providers greater control over sharing of patient health information. Suggestions should discuss:

- *Patient Engagement and Provider Discretion* – Is it truly beneficial to patients to give them autonomy over sharing of their health information, or can this create additional burden for them? In what ways can patients acquire sufficient understanding of how their data is used? Do stakeholders foresee any unintended consequences of data sharing?
- *Methods and Readiness* – Are there current examples of tools and processes that allow patients and providers to control access to patient’s health information? Is it realistic to expect implementation of these methods?
- *Resource Burden* – Does this level of data segmentation create cost or resource burden for providers? Can these issues be offset in any way?
- *Current Patient Consent Practices* – Are there existing technology and policy gaps that might prevent successful data segmentation? Do current consent practices allow patient engagement in control of the health information and provider discretion in response to patient requests?

- *FHIR Utility* – How can current Fast Healthcare Interoperability Resources be improved? Are there existing issues that will prevent successful implementation of the above proposals?
- *Technical Considerations* – What components of existing data segmentation strategies (such as Substance Abuse and Mental Health Services Administration’s (SAMSHA) Consent2Share67 and HL7 Data Segmentation for Privacy (DS4P)) should be leveraged to implement the programs in CMS’ proposal?
- *Patient Options* – In what situations should the data sharers – both providers and payers – have the ability to deny a patient’s request to share health information?
- *Current Segmentation Efforts* – Stakeholders who have successfully implemented similar data sharing models should provide input on any issues that prevent providers from maintaining a patient’s privacy preferences when sharing information. Additionally, which, if any, parts of the data segmentation process would be improved by automation?

Reducing Burden and Improving Electronic Information Exchange of Prior Authorizations

CMS requests information for consideration in future rule making that identifies current barriers that prevent providers from utilizing electronic prior authorization methods.

Electronic Prior Authorization for Medicare- and Medicaid-Participating Providers and Suppliers

Stakeholders should provide the following information:

- What are current barriers to submitting electronic prior authorization requests and responses and how can CMS help dismantle this?
- Are the current electronic prior authorization methods utilized by third-party payers (including Medicare) efficient and timely?
- Are the CMS Conditions of Participation (CoPs) and Conditions for Coverage (CfCs) requirements the logical means by which CMS should propose new requirements regarding electronic prior authorizations?

Future Electronic Prior Authorization Use in the Merit-Based Incentive Payment System (MIPS)

CMS is soliciting comments regarding the addition of a MIPS improvement activity, and if this will encourage clinicians to make improvements.

- Do stakeholders feel this is an activity that will improve clinical practice?
- Would implementation of this technology and accompanying standards result in improved patient outcomes?
 - If yes, should this activity be classified as medium-weight or high-weight?
- If a MIPS improvement activity that utilizes FHIR-based Prior Authorization Support API would *not* encourage clinicians to use electronic prior authorization, what are other ways to do so?
- Would the addition of a measure to the Medicare Promoting Interoperability Program and the MIPS Promoting Interoperability performance category encourage the use of electronic prior authorization through a payer’s Prior Authorization Support API?
 - What are the major considerations in developing this measure?
 - How should the measure require use of EHR technology?
 - Should the Prior Authorization Support IG be included in certification requirements under the ONC Health IT Certification Program?
 - Should additional measures and activities under MIPS Quality, Cost, or Improvement Activities performance categories involving FHIR-based electronic prior authorization solution be created?

- How else can CMS support clinician adoption and use of electronic prior authorization solutions?

Reducing the Use of Fax Machines

Because the use of fax technology precludes true interoperability, CMS believes its use must be greatly reduced or entirely eliminated in the healthcare setting and requests answers to the following:

- How are you currently required to use fax technology in your workflow? Would implementing electronic data exchange/API be beneficial to your practice and improve patient care? Which processes, such as prior authorization, would you prioritize when reducing utilization of fax technology?
- What challenges will reducing or eliminating the use of fax machines create for providers? Are these challenges greater for certain provider types or practices? How can these challenges be mitigated?
- Are there ways that providers who lack consistent internet access can work towards the goal of improved health care data exchange through the reduced use of fax machines?
- How much does electronic and cloud-based fax technology reduce the disparity between electronic data exchange and fax technology?
- How will the reduction of fax technology use influence practices' disaster preparedness and response? How can organizations begin to reduce their use of fax technology to offset these issues?

Accelerating the Adoption of Standards Related to Social Risk Data

Social risk factors, such as housing instability, food insecurity, and access to care issues, impact patient health outcomes. Effective value-based payment systems allow providers to treat and care for the whole person and address the patient's individual social risk factors. CMS requests input on how to improve the adoption of standards related to social risk data, including:

- What are the current challenges in accurately quantifying and exchanging social risk and social needs data across screening tools? Do these issues vary across screening tools or social needs?
- What are the barriers when exchanging social risk and social needs data with other providers? Are there challenges specific to the data exchange across providers and community-based organizations?
- What tools are currently used to exchange social risk and social needs data (EHRs, HIEs, software, cloud-based data platforms, etc.)? Are there any issues when translating social risk data to Z-codes with these tools?
- How should payers promote exchange of social risk and social needs data? Are there existing methods used by public or private payers CMS should emulate?

ASTRO members with perspectives on the issues and questions raised in the proposed rule are encouraged to send suggested comments to ASTRO Health Policy Analyst [Jessica Adams](#).

To read the proposed rule, visit: <https://www.cms.gov/files/document/121020-reducing-provider-and-patient-burden-cms-9123-p.pdf>

To access the fact sheet, visit: <https://www.cms.gov/newsroom/fact-sheets/reducing-provider-and-patient-burden-improving-prior-authorization-processes-and-promoting-patients>