Advancing Interoperability and Prior Authorization Reform

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On January 17, 2024, the Centers for Medicare & Medicaid Services (CMS) published the CMS Interoperability and Prior Authorization Final Rule (Final Rule), reforming prior authorization (PA) compliance requirements for many public payers, including Medicare Advantage (MA) organizations. PA is a utilization management tool used by payers to control costs by aligning reimbursed services with clinically indicated care. From the payer perspective, it reduces moral hazard, eliminating unnecessary care prompted by fee-for-service incentives. For clinicians, however, it creates cost-intensive and labor-intensive interference while delaying patient treatment. The new rule strives for an improved process that addresses clinician concerns while maintaining the cost control sought by insurers.

Until recently, data about the impact of PA have been limited, often forcing policymakers to rely on physician surveys to understand the scope of challenges. One study using survey data estimated the annual cost of PA requirements to physicians as $26.7 billion. Another, using estimates of the number of PAs and their costs, suggested the annual financial burden to be $1.3 billion. A recent econometric analysis acknowledged cost to physicians similar to the latter estimate but found far larger savings for payers. Perhaps more importantly, use of PA in government programs is growing, by one report from 11.5% of claims in 2011 to 14% in 2020. In addition, there seems to be variation in the criteria used for PA by different insurers, and nearly three-quarters of initial denials are overturned.

The CMS Final Rule addresses major PA issues regarding process efficiency (cost) and the timing and transparency of decisions. With most compliance requirements going into effect on either January 1, 2026, or January 1, 2027, the Final Rule will apply to MA organizations, state Medicaid programs and the Children’s Health Insurance Program, fee-for-service programs, Medicaid managed care plans, Children’s Health Insurance Program managed care entities, and Qualified Health Plan issuers on the federally facilitated exchanges. We examine the provisions of the Final Rule and evaluate their effectiveness against current PA challenges.

Final Rule Components

Despite industry and government efforts to promote efficiency through electronic information exchange, current PA processes remain largely manual; clinicians extract data from patient electronic health records (EHRs), physically fax PA forms or requests to payers, and call payer representatives to clarify the necessary information for approval. The Final Rule seeks to overcome challenges to PA automation, building on the CMS Interoperability and Patient Access Final Rule of 2020, which promoted a 2-way data access framework comprising application programming interfaces (APIs) to facilitate data exchange among patients, clinicians, and payers.

Through new API requirements, the Final Rule moves closer to facilitating automation of the PA process, establishing standards for the exchange of information to transform efficiency. The Final Rule requires payers to allow clinicians to identify in advance which clinical services require PA and locate documentation requirements for PA approval; it also requires payers to support PA request and response communications for more efficient data access. PA APIs must also communicate whether a payer approves, denies, or asks for more information regarding a PA request. Other important technical reforms included in the Final Rule (although not directly pertaining to PA process efficiency) will require payers to share PA data with patients, patient data with in-network clinicians.
with whom a patient has treatment relationships, and patient data within 5 years of a data request with other payers, with the goal of improving continuity of care.

Consider how APIs transformed efficiency in travel planning. APIs enable consumers to circumvent the costly and lengthy experience of using sales agents to efficiently find ideal flights. Likewise, the Final Rule automates information exchange between payers and clinicians for PA requests without manual intervention. By combining the Fast Healthcare Interoperability Resource (FHIR), a well-adopted standardized set of electronic specifications for how health care information is exchanged, and APIs, it is possible to automate determinations in a patient’s health plan coverage, confirm or rule out the need for PA, identify PA information and documents required for the payer’s decision, and facilitate the exchange of information from an EHR with minimal human intervention.

Regarding aspects of PA timing and transparency, the Final Rule will require payers to respond within 72 hours to urgent PA requests or 7 days to nonurgent requests, specify reasons for clinician denial, and annually post PA metrics publicly on payer websites.

These new timing requirements build on years of experience in government programs (echoed in most private insurance programs). MA payers are already required to report turnaround times to CMS, and CMS could publicly report those data today. Analyzing these data could reveal how close payers are to compliance with the new rule. Also, under Part D of Medicare and MA plans with a drug benefit, the timing requirements have long been more stringent, at 24 hours for expedited reviews and 72 hours for standard reviews. Given these requirements, the insurance industry may have anticipated the new restrictions on time for determinations.

Ongoing Challenges

Nevertheless, several key questions remain. First, the electronic communication aspects of the Final Rule do not apply to medications in either Part D or Part B. Schwartz et al found that if a private payer PA program had been applied to Medicare Part B, 35% of PAs and 57% of savings would have been related to drugs and injectables. The Final Rule recognizes that the current FHIR standard is incompatible with the National Council for Prescription Drug Programs SCRIPT standard, stating that at the moment, “data elements have yet to be mapped.” However, because the rule forces technical change to reduce delays, this incompatibility should be addressed.

Second, the electronic burden reduction envisioned by CMS requires that payers use FHIR standard queries to efficiently transmit data to relevant stakeholders. It does not, however, require specific changes in EHRs. Throughout the 700 pages of discussion on the rule, commenters noted that the Office of the National Coordinator (ONC), the federal body coordinating health information exchange, should prioritize the seamless interaction of EHRs with payer communications. If PA requests were to interrogate EHRs directly, most administrative friction in the process would be eliminated. CMS has instead moved forward without ONC-specific requirements, perhaps presuming that the ONC will act in the future. Clinicians will, however, be prompted to use electronic requests from payers for information to document medical necessity by new requirements in the Medicare Merit-Based Incentive Program.

Third, with the establishment of payer-to-clinician and payer-to-payer APIs, payers will need to discover digital end points for each entity (eg, IP address or FHIR server URL) to transfer patient information safely and efficiently, made challenging by the absence of a centralized database. On October 22, 2022, CMS released a request for information to create the National Directory of Health Care Providers and Services, and some commenters suggested extending this directory to include payers. Although no further public notice has been released, the Final Rule emphasizes the commitment of CMS to exploring a national directory that will include both payer and clinician digital end points.

The CMS Final Rule on PA has great promise for reducing administrative costs, accelerating PA determinations, and ensuring expedient care for patients while maintaining the commitment to value-based care. The federal government anticipates program savings to be $1.15 billion in 2027, rising to $2.10 billion in 2036, with less than $40 million in costs for payers in any year. Small
additional steps, including increasing the scope to include medication-related PA and integrating with EHRs, could enhance savings and efficiency and increase safety for beneficiaries.