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CMS Proposes New Rules to Address Prior Authorization and Reduce Burden on Patients and Providers

In an attempt to help reduce provider and patient burdens, CMS (the Centers for Medicare & Medicaid Services) issued a proposed rule that would improve the electronic exchange of health care data among payers, providers, and patients, and streamline processes related to prior authorization.

The rule would require payers in Medicaid, CHIP and QHP programs to build and maintain application programming interfaces (APIs) to support data exchange and prior authorization. APIs allow two systems, or a payer's system and a third-party app, to communicate and share data electronically. Payers would be required to implement and maintain these APIs using the Health Level 7 (HL7) Fast Healthcare Interoperability Resources (FHIR) standard. The FHIR standard is an innovative technology solution that helps ensure both systems can understand and use the data they exchange.

Improving Prior Authorization

The rule proposes significant changes to improve the patient experience and alleviate some of the administrative burden prior authorization causes health care providers. Medicaid, CHIP and QHP payers would be required to build and implement FHIR-enabled APIs that could allow providers to know in advance what documentation would be needed for each different health insurance payer, streamline the documentation process, and enable providers to send prior authorization requests and receive responses electronically, directly from the provider's EHR or other practice management system. While Medicare Advantage plans are not included in today's proposals, CMS is considering whether to do so in future rulemaking.

To reduce wait time, the rule also proposes a maximum of 72 hours for decisions from payers (with the exception of QHP-Qualified Health plan issuers on the FFEs-Federally Facilitated Exchanges) on urgent requests and seven calendar days for non-urgent requests. Payers would also be required to provide specific reasons for any denial, which will provide some transparency in the process. To promote accountability for plans, the rule also requires them to make public certain metrics that demonstrate how many procedures they are authorizing.

Taken together, these policies could lead to fewer prior authorization denials and appeals, while improving communication and understanding between payers, providers, and patients. An added benefit, reducing fraud and abuse.

Increasing Patient Access to Health Information

Building on that foundational policy, this rule would require impacted payers to implement and maintain a FHIR-based API to exchange patient data as patients move from one payer to another. In this way, patients who would otherwise not have access to their historic health information would be able to bring their information with them when they move from one payer to another, and would not lose that information simply because they changed payers.

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These proposed changes would also allow payers, providers and patients to have access to more information including pending and active prior authorization decisions to cut back on repeat prior authorizations, reduce burdens and cost, and ensuring patients have better continuity of care. It is estimated the proposed rule would save between 1 to 5 billion dollars over the next 10 years if just a quarter of providers took advantage of the new electronic solutions in the new rule.

To read more on the importance of these proposed changes, please visit CMS Administrator Seema Verma's blog post here. The full proposed rule is available to review here. For a copy of the Fact Sheet, click here and for more information on the CMS proposed rule, please click here.

APS looks to provide ongoing support to our clients to help identify new carrier policies. Should you have any questions, please contact your APS Practice Manager.