**Preliminary AMA Summary**

**CMS Interoperability and Prior Authorization Final Rule**

**Issued January 17, 2024**

## Improving PA processes

PA Decision Timeframes

Beginning in 2026, impacted payers (excluding QHP issuers on the FFEs) are required to send PA decisions within 72 hours for expedited (i.e., urgent) requests and seven calendar days for standard (i.e., non-urgent) requests. CMS acknowledges that commenters (including the AMA) urged for faster timeframes and will consider updating its policies in future rulemaking.

PA Denial Reasons

Beginning in 2026, impacted payers must provide a specific reason for denied PA decisions, regardless of the method used to send the request. Such decisions may be communicated via portal, fax, email, mail, or phone. Payers must make clear the status of a PA decision. The AMA supports these requirements.

PA Metrics

Beginning in 2026, CMS is requiring impacted payers to publicly report certain PA metrics, including approval and denial rates and average processing time, annually on their websites. The AMA supports these requirements but urged CMS to require public reporting of metrics earlier than 2026.

MIPS Promoting Interoperability Requirement

CMS is adding a new measure to the MIPS Promoting Interoperability performance category. Unless an applicable exclusion can be claimed, MIPS eligible clinicians will report a "yes/no" attestation stating they have sent at least one electronic PA annually to a payer via their EHR. CMS' original proposal would have required physicians to manually track and report each electronic *and* paper-based PA. Responding to AMA advocacy, CMS removed the manual reporting requirements and extended the compliance timeline to CY 2027.

## EHR application programming interface (API) provisions & physician and patient access to information

EHR-to-Payer PA interface

CMS is requiring that impacted payers implement and maintain an API what would allow a physician to connect and conduct PAs using their EHR. This API must contain a list of covered items and services and documentation requirements for PA approval. These APIs must also communicate whether the payer approves, denies, or asks for more information about the PA request. The federal government is currently working on complementary regulations for EHR developers. The AMA strongly supports this approach and will continue to work with EHR developers and payers to ensure this supports physicians' workflows.

Covered entities that implement an all-Fast Healthcare Interoperability Resources (FHIR)-based API that does not use the X12 278 standard as part of their API implementation will not be enforced against under Health Insurance Portability and Accountability Act of 1996 (HIPAA) Administrative Simplification provisions, thus allowing limited flexibility for covered entities to use a FHIR-only or FHIR and X12 combination API to satisfy these requirements. CMS responded to concerns from the AMA and other stakeholders that requiring "translation" between FHIR and the X12 278 would increase administrative costs and lead to data errors.

Patient Access API

CMS previously required impacted payers to implement an HL7® FHIR® Patient Access API to allow patients access to more of their data. This rule adds to that requirement by mandating that payers also include information about PAs (excluding those for drugs) to the data available via the Patient Access API.

Provider Access API

CMS is requiring payers to implement and maintain a Provider Access API to make patient data available to in-network physicians with whom the patient has a demonstrated treatment relationship. This information includes individual claims and encounter data (without provider remittances and enrollee cost-sharing information), data in the United States Core Data for Interoperability (USCDI), and specified PA information (excluding those for drugs). Patients can opt out of making their data available to providers under these requirements.

Payer-to-Payer API

In support of care continuity, CMS is requiring payers to implement an API to make available claims and encounter data, USCDI data, and PA decisions from a patient's previous and concurrent payers over the last five years. This step will help ensure that patients have continued access to the most relevant data in their records. Patients will be able to opt-in to provide permission to participate in making their data available under these requirements.