CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F) – published 1/18/24

NOTE: Final rule applies to Medicaid and CHIP agencies, Medicare Advantage organizations, and QHP issuers on the Federal Exchange

- Intent of new rule: Share more data electronically, allow patients, providers, and payers greater accessibility to data, and increase efficiency and timeliness of prior authorization processes to improve access to care.
- **Two main parts to the final rule**
    - **Interoperability - requires Medicaid agencies to implement and maintain application programming interfaces (APIs) to improve the electronic exchange of health care data by 1/1/27. Also requires API to permit electronic prior authorization processes for medical services by 1/1/27 (does NOT apply to drugs).**
        - Goals include improving patients, providers, and payers (including Medicaid agency) access to patient data and reducing administrative burden of prior authorization process.
        - What is required – four new APIs. Vermont Medicaid must comply by 1/1/27.
            - Patient Access API
                - The goal is to give patients more access to their data.
                - Must have certain information about prior approval (except for drugs) so patients can understand this process.
            - Provider Access API
                - The goal is to facilitate care coordination and support efforts of value- based payment models.
                - Share patient data with other in-network providers who treat the patient.
                - Certain data must be included (e.g., claims data, encounter data, prior authorization information).
                    - Patients can opt out of having their data available to other providers.
            - Payer to payer API
                - The goal is to promote continuity of care when a patient moves to a different payer.
                - Like Provider Access API, certain data must be included (e.g., claims data, encounter data, prior authorization information).
            - Prior authorization API
                - The goal is to improve efficiency of prior authorization process by automating process end to end.

        - API must provide list of covered services, identify documentation requirements, support prior authorization request and response, and provide information about whether request approved/denied, etc.
- **Improvements to prior authorization process**
    - **Note: the changes in this rule impact Medicaid covered services EXCEPT drugs.**
    - **Changes to federal law and impact on Vermont Medicaid (must be implemented by 1/1/26 rating period)**
        - **Timeframes under new federal rule**
            - **Standard requests- seven days**
                - **VT Medicaid's current rule on prior authorization allows 14 days.**
                - **VT Medicaid is starting rulemaking to make this time frame 7 days.**
            - **Expedited (urgent) requests- 72 hours**
                - **VT Medicaid's current rule on expedited prior authorization allows 3 working days.**
                - **VT Medicaid is starting rulemaking to make this time frame 72 hours.**
            - There will continue to be an option to extend the timeline by 14 days if additional information is needed to decide on the request and it is in the best interest of the beneficiary.
        - **Notices on prior authorization decisions (These are called adverse benefit determinations.)**
            - **The new federal rule requires Medicaid agency to give reason for denial of prior authorization.**
                - **VT Medicaid already provides notice with reason for denial or other adverse decision (e.g., approving below amount requested).**
        - **New reporting requirements**
            - **Medicaid agencies must publicly post on their website certain prior authorization metrics annually.**
                - **Compliance deadline: 1/1/26**