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CMS Puts Patients Over Paperwork with New Rule that Addresses the Prior Authorization Process

Final rule gives providers access to patient treatment histories, and streamlines prior authorization to improve patient experience and alleviate burden for health care providers

Today, the Centers for Medicare & Medicaid Services (CMS) finalized a signature accomplishment of the new Office of Burden Reduction & Health Informatics (OBRHI). This final rule builds on the efforts to drive interoperability, empower patients, and reduce costs and burden in the healthcare market by promoting secure electronic access to health data in new and innovative ways. These significant changes include allowing certain payers, providers and patients to have electronic access to pending and active prior authorization decisions, which should result in fewer repeated requests for prior authorizations, reducing costs and onerous administrative burden to our frontline providers. This final rule will result in providers having more time to focus on their patients and provide higher quality care.

“Today, we take a historic stride toward the future long promised by electronic health records but never yet realized: a more efficient, convenient, and affordable healthcare system,” said CMS Administrator Seema Verma. “Thanks to this rule, millions of patients will no longer have to wrangle with prior providers or locate ancient fax machines to take possession of their own data. Many providers, too, will be freed from the burden of piecing together patients’ health histories based on incomplete, half-forgotten snippets of information supplied by the patients themselves, as well as the most onerous elements of prior authorization. This change will reverberate around the healthcare system for years and decades to come.”

The “CMS Interoperability and Prior Authorization” rule is the next phase of CMS interoperability rulemaking, aimed at improving data exchange while simultaneously reducing provider and patient burden. This final rule requires the payers regulated under this rule (namely, Medicaid and CHIP managed care plans, state Medicaid and CHIP fee-for-service programs (FFS) and issuers of individual market Qualified Health Plans (QHPs) on the Federally-facilitated exchanges (FfEs)) to implement application programming interfaces (APIs) that will give providers better access to data about their patients, and streamline the process of prior authorization. APIs are the foundation of smartphone applications, and when integrated with a provider’s electronic health record (EHR), they can enable data access at the touch of a button. By exchanging relevant health information between patients, providers and payers, APIs support a better health care experience for patients. Patients have easier access to their own health information, their providers have a more complete picture of their care, and patients can take their information with them as they move from plan to plan, and from provider to provider throughout the healthcare system. This ensures more coordinated, quality care, and less repetitive and unnecessary care that is costly.

Today’s final rule requires Medicaid and CHIP (FFS) programs, Medicaid and CHIP managed care plans, and issuers of individual market QHPs on the FfEs to include, as part of the already established Patient Access API, claims and encounter data, including laboratory results, and information about the patient’s pending and active prior authorization decisions. These payers are also required to share this data directly with patients’ providers if they ask for it and with other payers as the patient moves from one payer to another. In this way, patients, providers, and payers have the data when and where they need it, to help ensure that patients receive the best possible care. While Medicare Advantage plans are not included in and therefore

not subject to this final rule, CMS is considering whether to do so in future rulemaking.

Prior Authorization Burden Reduction

Payers use prior authorization as a way to manage health care costs and ensure payment accuracy. For certain services, providers request approval from payers before rendering care to ensure that the payer will determine that the care is medically necessary, a threshold requirement for care to be reimbursed under the patients' health coverage. This administrative process can be burdensome, and the challenges of the prior authorization process have motivated industry efforts to develop tools to increase automation. This final rule aims to reduce the inefficiencies and burdens of the prior authorization process for providers, and give them back time to focus on what matters most, treating patients in a timely manner.

The final rule requires Medicaid and CHIP FFS programs, Medicaid and CHIP managed care plans, and issuers of individual market QHPs on the FFEs to build, implement, and maintain APIs using the Health Level 7 (HL7) Fast Healthcare Interoperability Resources (FHIR) standard to support automation of the prior authorization process, specifically addressing the challenges raised by both providers and payers. The requirements of this rule specify that each of these payers will build an API-enabled documentation requirements look-up service, and make these public so providers may access documentation and prior authorization requirements from their EHR platforms. Once a provider knows *what* is required for each prior authorization, the next step is submitting it electronically. The final rule also requires Medicaid, CHIP, and QHP payers to implement and maintain prior authorization support APIs using the HL7 FHIR standard, which will advance a streamlined approach for communicating prior authorization requests and responses between those payers and provider EHR platforms or other practice management systems.

The final rule also requires Medicaid and CHIP (FFS) programs, and Medicaid and CHIP managed care plans to meet reduced decision timelines for prior authorizations. These payers will now have a maximum of 72 hours to make prior authorization decisions on urgent requests and seven calendar days for non-urgent requests, and all payers subject to the rule are required to provide a specific reason for any denial, which will allow providers some transparency into the process beginning January 1, 2024 or the rating period that starts on or after January 1, 2024. In addition, to promote accountability, the rule requires these payers, to make

public, prior authorization metrics that demonstrate how they operationalize the prior authorization process. All of these requirements together will promote a more streamlined and efficient prior authorization process for providers and payers alike.

The rule will improve the patient experience as well. When a patient sees, for instance that a prior authorization is needed and has been submitted for a particular item or service, they will better understand the timeline for the process and be able to work with their provider to plan accordingly.

Today's final rule aims to improve longstanding inefficiencies in the healthcare system—including the lack of data sharing and access. This final rule expands the current Administration's goals of quality and lower costs in health care as payers and providers will now have access to more complete patient histories, allowing for more coordinated and seamless patient care.

The final rule is available to review today at:

<https://www.cms.gov/files/document/11521-provider-burden-promoting-patients-electronic-access-health-information-e-prior.pdf>

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