Maverick Health Policy

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MAVERICK MINUTE

Electronic Prior Authorization

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Overview

WHAT: On December 13, 2022, CMS released a proposed rule called Advancing Interoperability and Improving Prior Authorization Processes. The purpose of the rule is to streamline prior authorization processes and enhance data exchange between payers, providers, and patients.
IN BRIEF: If finalized, payers must implement an application programming interface (API) that would connect to a provider's electronic health record (EHR) system. The API will allow a plan and a provider to communicate electronically about what the plan's prior authorization requirements are for a specific coverage request, automatically uploading the necessary documentation, a returning a determination.
WHEN: Effective January 1, 2026 (proposed implementation deadline).

Highlights

Prior Authorization, Documentation, and Decision (PARDD) API: PARDD API determines if prior authorization is required, identifies prior authorization information and documentation requirements, and facilitates the exchange of prior authorization requests and decisions. PARDD API must be integrated with EHRs or practice management systems.
Payer Requirements: Providers must make prior authorization decisions faster – within 72 hours for urgent requests and within seven calendar days for non-urgent requests –, explain their reasons for prior authorization denials, and publicly report the number of approvals and denials.
Clinician Requirements: In general, the rule does not require clinicians to use the electronic prior authorization process. To encourage clinicians to engage in the automated prior authorization process, CMS proposed incentivizing the submission of electronic prior authorization requests through payers' APIs using data from certified EHR technology (CEHRT). The more automated prior authorization processes are used, the greater the financial reward through the Merit-based Incentive Payment System (MIPS).

💡 Maverick's Take

Streamlining prior authorization processes will take time and cooperation during a trial and-error phase. For some straightforward coverage requests, it should relieve the parties of unnecessary calls and manual efforts like faxing or mailing documents, making it a much faster and relatively painless process. For more complicated requests or for patients with more complex conditions, automating the entire prior authorization process is unlikely to happen soon. In the future, clinicians can anticipate that fewer

services will be subject to prior authorization as payers and CMS recognize that some services are always approved. Some health plans are experimenting with “gold-card” status, exempting specific providers known for high approval rates and quality services from the prior authorization process altogether. Whether CMS will regulate a gold-carding system remains uncertain but seems unlikely.