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The Data that Powers Healthcare

Unveiling Electronic Prior Authorization

Implementation considerations for CMS 0057-F

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Contents

- Opportunity and state of implementation
- Key considerations for implementation
- Measurement and summary recommendations

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ePA Landscape and CMS 0057 Requirements

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State of the Industry: Prior authorization opportunity

2025 CAQH Index®

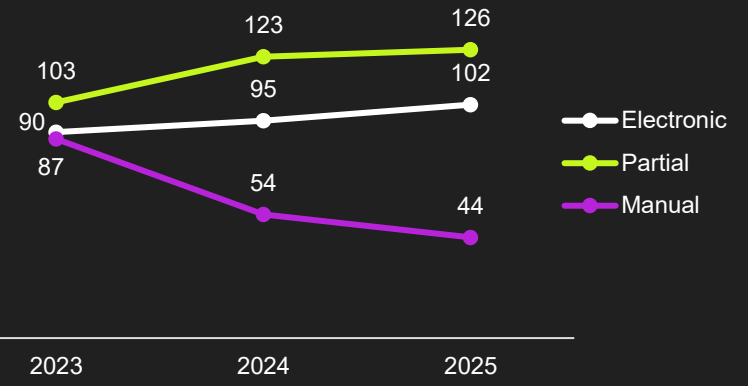
- National benchmarking survey
- Tool to track and monitor progress
- Collaborative initiative

By transitioning to **fully electronic prior authorizations**, the healthcare industry could save:

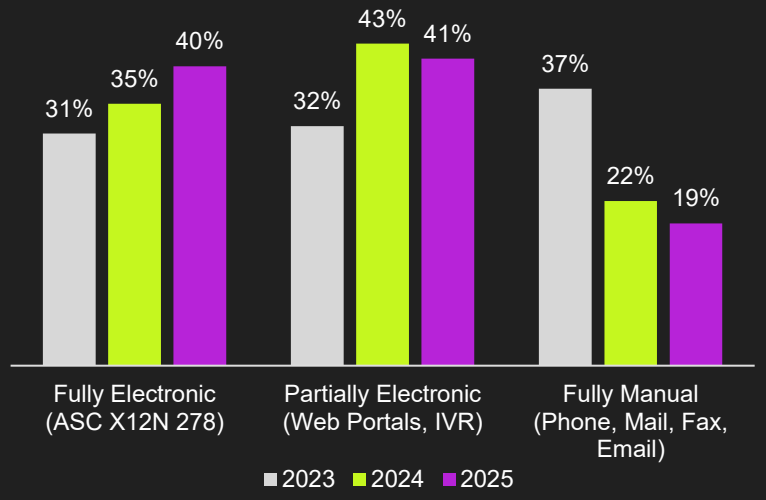
$461M Annually

24 Min/transaction for providers annually

Estimated National Volume of Prior Authorization by Mode (in millions)



Prior Authorization: Medical Plan Adoption



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CMS 0057
Interoperability and Prior Authorization Final Rule

Requirement Overview

Sets technical and content requirements for a set of FHIR-based APIs with a go-live deadline of **January 1, 2027**.

- Patient Access API (updates to existing build)
- Provider Access API
- Payer-to-payer API
- **Prior Authorization API**

Requires prior authorizations to be conducted electronically through the **Prior Authorization API*** and establishes streamlined response time requirements for prior authorization workflows.

- 7 days for standard requests
- 72 hours for expedited requests

Impacted Entities

Health Plans

- Medicare Advantage Organizations
- State Medicaid and CHIP Fee-for-Service
- Medicaid Managed Care Plans
- CHIP Managed Care Entities
- Qualified Health Plans offered on FFEs

Providers

MIPS Eligible:

- Clinicians
- Hospitals
- Critical Access Hospitals

Provider Accountability
Providers must attest to using the Prior Authorization API as part of **CMS's Quality Payment Program (QPP)**.

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*The National Standards Group (NSG) and Office of Burden Reduction and Health Informatics announced enforcement discretion for the HIPAA-mandated 278 allowing impacted entities to conduct electronic prior authorizations for all product lines using FHIR-based protocols.

Key Considerations for Implementation

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Early in the implementation process, provider inputs are key

Approaching implementation with a provider perspective

Year	Health Plans and Vendors	Providers and Vendors
2024	• Evaluation of regulatory requirements • Preliminary business planning and decision-making	• Evaluation of requirements • PA workflows largely not impacted
2025	• Finalized business plans • Initial build-out and adherence to regulation	• Anticipated no or low impact workflow changes
2026	• Requirements for public reporting and adherence to decision timeframes go into force	• Observable shortening of time-to-decision timeframes
2027	• **Requirements to launch FHIR-based API for electronic Prior Authorization for select product lines**	• **Requirements to use electronic Prior Authorization APIs; tied to quality performance**
2028	ASTP/ONC certification criteria for payer and provider-facing health IT	

Provider engagement for implementation

Provider organization insights must be accounted for early in implementation, otherwise the advantages of automation may not be fully realized

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Recommended use of HL7 Da Vinci Burden Reduction Implementation Guides

Support required use of HL7 Da Vinci IGs with key augmentation

	Consideration	Providers and Vendors
1	**Security Requirements**	Implementation guides do not require a single authentication and authorization protocol.
2	**Questionnaire / Form Automation**	Full automation of prior authorization requires implementation of CQL.
3	**Exchange of Attachments**	Implementers should consider implementation of CDEX to automate document exchange.
4	**Data Element and Exchange Standardization**	Elements like status, error reporting, names, and response times are not contemplated in the rule.
5	**Phased Implementation**	Benefit should be realized early across named and optional product lines.

Establishing an Automated Ecosystem

Key Consideration: Exchange of Supporting Information

Ideal Implementation

Pre-population: CRD and DTR work in concert to automate retrieval of required prior authorization information.

Achieved through a combination of fully implemented CDS Hooks and Clinical Quality Language (CQL)

CDEX attachments: Attachments are automatically retrieved and collated using the optional CDex implementation guide.

Minimal follow-up: Automated collection and submission using the Burden Reduction Implementation Guides leads to few or no submission errors/follow-up.

Coverage Requirements Discovery (CRD)

Returns coverage and benefit design, and whether prior authorization is required.

Retrieves templates and questionnaires through CDS hooks

Documentation Templates and Rules (DTR)

Retrieves and supports the automated population of supporting evidence for a prior authorization request.

Clinical Documentation Exchange (CDEX IG)

Compiles and collates information in a single submission package

Prior Authorization Submission (PAS)

Directly submits compiled prior authorization request to the health plan and facilitates responses.

Potential Limitations

Partial population: Results of CRD and DTR population must be manually inspected and remediated prior to submission.

Complex prior authorization requirements may lead to lagged CDS and CQL implementation.

Variable attachments: Materials are likely to be collected and collated by human staff and sent in variable formats.

Maintained follow-up: Any breakdown in the ideal implementation of the Burden Reduction Implementation Guides will perpetuate manual follow-up.

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Securing Ideal Implementation: Connectivity and Security Requirement Key Considerations

A stable, consistent platform for security, authorization, and authentication is necessary for automation and the avoidance of data breaches.

Security and Exchange Protocols in Burden Reduction IGs (CRD, DTR, PAS)			Common Connectivity
TLS	Current Version or Higher		TLS 1.2 or higher
Authorization and Authentication	Recommend OAuth 2.0	+	OAuth 2.0 bound to X.509 certificate
Non-PHI Exchange	No identity, access, authentication, or audit requirements. Subject to best practices for exchange between trusted entities.	+	Security applied to non-PHI exchange
JSON	**Standard for API exchange**		Supported by REST requirements
HTTP	Standard for API exchange		Supported by REST requirements

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Operating Rules Enhance CMS 0057 Requirements

Requirement	CMS 0057	Operating Rules
• Eligibility verification and Patient financial responsibility	• **Recommended** return of coverage information	• Real-time notification of patient's co-pay, deductible info, remaining procedure allowances, and if the service requires PA
• Error code reporting	• Standard, **non-specific** web-based error code reporting	• Specific error code guidance (AAA codes), so next steps are immediately clear
• Patient ID and normalization	X **Not included**	• Normalized patient name and ID requirements to avoid common errors that lead to costly delays in patient care
• Standard status reporting and Decision reason	• **Recommended** use of Health Care Services Decision Reason Codes (HCSDRCs) for status	• Required Health Care Services Decision Reason Codes (HCSDRCs) at event and service levels to ensure providers have a clear decision, with clear, standard meaning; also requires action code
• Identification and exchange of additional clinical documentation	X **Not included**	• Inclusion of attachment report type codes and standard agnostic format and exchange requirements to clearly articulate what additional clinical documentation is needed to prove medical necessity
• Timeframes: Additional documentation request	X **Not included**	• 2 business days for health plan to review a PA request and ask for any missing documentation
• Timeframes: Final determination	• **7 calendar days** (standard) / 72 hours (expedited)	• 2 business day turnaround for standard requests (once provider has submitted required information), ensuring timely communication of next steps and decisions
• Timeframes: Optional close-out	X **Not included**	• 14-day option for health plan close out if requested medical documentation not received
• Infrastructure and connectivity	• **Varies** by implementation guide	• CORE real-time and batch requirements and alignment to most recent CORE Connectivity to ensure smooth submission
• Claim submission, review, and payment	X **Not included**	• Specific details from PA are included in the claim to ensure claims linking, proper payment, and compliance with reporting requirements

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Value Measurement and Summary Recommendations

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Return on Investment (ROI) and Value Measurement

Track implementation impact by monitoring significant domains

Measurement Domains

- **Implementation Impact:** Articulation of the **success of the implementation effort**, measured by projected annual cost savings, **staff satisfaction levels**, and impact on patient care.

- **Workflow Efficiency:** Recognition of overall time savings due to efficiency gains from streamlined process, including reduced staff time performing prior authorization tasks.

- **Workflow Accuracy: Changes in volume** of real-time prior authorization approvals accepted without error.

Benefits of Tracking Implementation

- Articulation of operational cost and resource savings
- Support for scalability and future growth
- Empowers future interoperability “asks” to leadership
- Strengthens identification of improvement areas and influence for policy refinements.

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