Optum

CMS ePA Rule and State ePA Requirements

Genevieve Morris, VP of Interoperability Strategy

Summary

CMS Overview*

Who

- Medicare Advantage (MA), Medicaid Managed Care Organizations (MCO), CHIP, Medicaid FFS, and Qualified Health Plans (QHP)

What

- Implement a Prior Authorization API that allows a provider to query a payer's system to determine whether a prior authorization is required, to identify documentation requirements, and to receive information about whether a specific prior authorization request has been approved or denied
- Meet new timeframes for responding to standard and urgent authorization requests
- Excludes all pharmacy

When

- Payers must have the prior authorization APIs in place by January 1, 2027

How

- Required to use HL7 FHIR Release 4.0.1, US Core IG STU 3.1.1, and SMART App Launch IG Release 1.0.0 BUT must use HIPAA compliant transactions for authorization submission, CMS has indicated they will use enforcement discretion to allow for end-to-end FHIR or X12 278/275

Why

- Prior authorizations are manual, using paper and portals and cost both providers and payers significant $, moving to electronic ePA will reduce the administrative burden on providers and payers

*Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, etc., 42 CFR §422, 42 CFR §431, 42 CFR §435, 42 CFR §438, 42 CFR §440, 42 CFR §457, 45 CFR §156

Optum

Sates are mirroring the CMS requirements

Who

- Commercial plans

Where

- Washington (E2SHB 1357 (Chap. 382, Laws of 2023))

What

- Implement CMS finalized proposals for ePA
- Washington: Applies to medical services, durable medical equipment, and pharmacy

When

- January 1, 2026

How

- Required to use HL7 FHIR Release 4.0.1, US Core IG STU 3.1.1, and SMART App Launch IG Release 1.0.0

Why

- Require commercial payers to automate prior authorization processes to reduce provider burden

Optum

New Response Timeframes

New Response Timeframes

- New timeframes go into effect January 1, 2026
- Apply to both electronic and non-electronic authorization requests
- Standard” prior authorization refers to non-expedited, non-urgent requests and the term “expedited” prior authorization indicates an urgent request
- Expedited requests: in accordance with patient needs but no later than 72 hours OR state specific requirements if timeframe is less than 72 hours (MA plans must always follow CMS timeframes)
- Standard requests: 7 calendar days with option for 14 day extension, QHPs have 15 calendar days

Optum

Reason for Denial

Denial Requirements

- Denials are defined as: the refusal by a payer to approve the prior authorization for a health care item or service. This includes when a prior authorization wasn't required to begin with
- Payers are required to provide a reason for denial. It could include but is NOT limited to: a reference to the specific plan provisions on which the denial is based; information about or a citation to coverage criteria; how documentation did not support a plan of care for the therapy or service; a narrative explanation of why the request was denied, and specifically, why the service is not deemed necessary or that claim history demonstrated that the patient had already received a similar service or item
- CMS will not specify all of the reasons or codes that must be used, but it must be in specific enough detail for a provider to understand why it was denied and know what next steps to take
- CMS is not requiring the X12 codes or any other standard codes be used, but they may be used

Technical Requirements

Prior Authorization API Requirements

Payers are required to implement a Prior Authorization API that allows a provider to:

1) query a payer's system to determine whether a prior authorization is required;
2) identify documentation requirements;
3) submit the authorization request using a HIPAA-compliant transaction; and
4) receive information about whether a specific prior authorization request has been approved or denied

In a fact sheet, CMS has indicated that they will release a notice on the HIPAA-compliant requirements that will include using enforcement discretion to allow for end-to-end FHIR, a combination of FHIR and X12 or X12 only.

Required	Recommended
HL7 FHIR Release 4.0.1	CRD IG STU 2.0.1
US Core IG STU 3.1.1	HL7® FHIR® Da Vinci Documentation Templates and Rules (DTR) IG STU 2.0.0
SMART App Launch IG Release 1.0.0, expected to upgrade to 2.0.0 before January 1, 2027	PAS IG STU 2.0.1

Optum

Annual Metrics

Required to Report Annual Metrics – Starting January 2026

1. A list of all items and services that require prior authorization.
2. The percentage of standard prior authorization requests that were approved, aggregated for all items and services.
3. The percentage of standard prior authorization requests that were denied, aggregated for all items and services.
4. The percentage of standard prior authorization requests that were approved after appeal, aggregated for all items and services.
5. The percentage of prior authorization requests for which the timeframe for review was extended, and the request was approved, aggregated for all items and services.
6. The percentage of expedited prior authorization requests that were approved, aggregated for all items and services.
7. The percentage of expedited prior authorization requests that were denied, aggregated for all items and services.
8. The average and median time that elapsed between the submission of a request and a determination by the payer, plan, or issuer, for standard prior authorizations, aggregated for all items and services.
9. The average and median time that elapsed between the submission of a request and a decision by the payer, plan, or issuer, for expedited prior authorizations, aggregated for all items and services.

Promoting Interoperability Program

Provider and Hospital ePA Requirements

- For the 2027 reporting period, providers and hospitals must attest Yes or No that they submitted at least one electronic prior authorization using data from certified health IT (CEHRT) to the Prior Authorization APIs during the reporting period
- To count, a payer's Prior Authorization API must be used, but they are not required to use all three steps of the process, i.e. the submission step is all that's required
- If a provider or hospital fails this measure of the Promoting Interoperability program, they fail the category resulting in a zero score for providers or a downward payment adjustment for hospitals
- A proposed rule from ONC is pending that will include prior authorization criteria for Certified Health IT