Interoperability and Prior Authorization Rule Workgroup: Background Material

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Terminology Used in Rule

Application Programming Interface (API)

- "An API is a set of commands, functions, protocols, or tools published by one software developer ('A') that enables other software developers to create programs (applications or 'apps') that can interact with A's software without needing to know the internal workings of A's software while maintaining data security and patient privacy (if properly implemented). This is how API technology enables the seamless user experiences, which are familiar in other aspects of patients' daily lives, such as travel and personal finance smartphone apps, which can function without being integrated into the smartphone's operating system. Standardized, secure, transparent, and pro-competitive API technology can provide similar benefits for patients of health care services"[1] (89 FR 8762).

Citations in This Document

For citations to the final rule, the footnotes refer to the official electronic publications. For the reader's convenience, we also include links to the *Federal Register* public inspection webpage, which enables links to specific paragraphs of the rule.

In tables summarizing provisions in the *Code of Federal Regulations*, we include both footnotes with full citations and links to the pertinent regulation.

Prior Authorization

- "The prior authorization policies in this final rule apply to **any formal decision-making process through which impacted payers render an approval or denial determination** in response to prior authorization requests based on the payer's coverage guidelines and policies before services or items are rendered or provided"[1] (89 FR 8859).

Exclusion of Drugs From Prior Authorization Requirements

- "Unless otherwise stated, **the policies for prior authorization APIs and processes do not apply to drugs of any type**, meaning any drugs that could be covered by the impacted payers in this final rule (for example, prescription drugs that may be self-administered, administered by a provider, or that may be dispensed or administered in a pharmacy or hospital), because the processes and standards for prior authorization of drugs differ from the other 'items and services' included in our final policies"[1] (89 FR 8762).

Inclusion of Supplies and Durable Medical Equipment (DME) in Prior Authorization Requirements

- "Supplies, including those dispensed at a pharmacy and DME, that are considered medical benefits and are not prescription drugs, are subject to the prior authorization requirements of this final rule. **Payers will be required to include these supplies in their APIs, to the extent they are covered as a medical benefit and require prior authorization**. DME, for example, includes continuous glucose monitors, test strips, lancets, orthotics, wheelchairs, and other devices. All prior authorizations covered as a medical benefit, including those for DME, supplies dispensed at a pharmacy, or therapeutic devices, must still meet the timeframe requirements established in this final rule, regardless of whether the request is made through an API or other means, as described in section II.D.4"[1] (89 FR 8766).

Compliance Deadlines and Prior Authorization Decision Time Frames

Table 1. Medicaid and CHIP Fee-for-Service Compliance Deadlines, Extensions, and Exemptions

	2026 Prior Authorization Processes (Nontechnical)	2027 APIs (Technical, With Policy and Program Items Noted Below)
Required work	• **Establish required Prior Authorization processes:** ○ Meet prior authorization decision time frames for standard and expedited requests[2,3] (42 CFR 440.230(e)(1); 42 CFR 457.495(d)(2)) ○ Communicate specific reason to provider if prior authorization request is denied[4,5] (42 CFR 431.80(a); 42 CFR 457.732(a)) • **Report metrics:** ○ Publicly report prior authorization data on state agency website[2,5] (42 CFR 440.230(e)(3); 42 CFR 457.732(c)) ○ Report Patient Access API metrics to CMS as aggregated, de-identified, state-level data[6,7] (42 CFR 431.60(f); 42 CFR 457.730(f))	• **Enhance Patient Access API**[6,7] (42 CFR 431.60(b)(5); 42 CFR 457.730(b)(5)) • **Implement Provider Access API**[8,9] (42 CFR 431.61(a); 42 CFR 457.731(a)): ○ Beneficiary-to-provider attribution process ○ Beneficiary opt-out process and educational materials ○ Provider educational materials • **Implement Payer-to-Payer API**[8,9] (42 CFR 431.61(b); 42 CFR 457.731(b)): ○ Beneficiary opt-in process (*no exemptions from this requirement*) ○ Process to identify previous and concurrent payers ○ Educational materials for applicants and beneficiaries • **Implement Prior Authorization API**[4,5] (42 CFR 431.80(b); 42 CFR 457.732(b)): ○ List of all covered items and services (except drugs) requiring prior authorization ○ Identification of all documentation required to approve prior authorization ○ Communication of prior authorization decision and specific reason for denial, if applicable
Extension or exemption	"We are willing to work with state Medicaid and CHIP FFS programs that may be unable to meet the new compliance date for the prior authorization timeframes. **States should contact their Medicaid state lead or CHIP project officer before April 1, 2025, to discuss their extenuating circumstances.** Any flexibility granted to a state Medicaid or CHIP FFS program for the implementation of the new prior authorization decision timeframe requirements will be temporary and limited to the unique circumstances of the program"[1] (89 FR 8881).	• Medicaid and CHIP FFS programs may seek a single 1-year **extension** on requirements for new API implementation: ○ Provider Access, Payer-to-Payer, or both APIs[8,9] (42 CFR 431.61(c)(1); 42 CFR 457.731(c)(1)) ○ Prior Authorization API[4,5] (42 CFR 431.80(c)(1); 42 CFR 457.732(d)(1)) • If at least 90% of Medicaid beneficiaries or separate CHIP beneficiaries are enrolled in MCOs, the affected program may request **exemption** from new API implementation: ○ Provider Access, Payer-to-Payer, or both APIs (*but no exemption from the Payer-to-Payer API beneficiary opt-in process requirement*)[8,9] (42 CFR 431.61(c)(2); 42 CFR 457.731(c)(2)) ○ Prior Authorization API requirements[4,5] (42 CFR 431.80(c)(2); 42 CFR 457.732(d)(2))

Abbreviations. API: application programming interface; CHIP: Children's Health Insurance Program; CMS: Centers for Medicare & Medicaid Services; FFS: fee for service; MCO: managed care organization.

Table 2. Medicaid and CHIP Managed Care Compliance Deadlines, Extensions, and Exemptions[a]

	2026 Prior Authorization Processes (Nontechnical)	2027 APIs (Technical, With Policy and Program Items Noted Below)
Required work	**Establish required prior authorization business processes:** • Meet prior authorization decision time frames for standard and expedited requests[10-12] (42 CFR 438.210(d); 42 CFR 457.1200(c); 42 CFR 457.1230(d)) • Communicate specific reason if prior authorization request is denied[11,13,14] (42 CFR 438.242(b)(8); 42 CFR 457.1200(c); 42 CFR 457.1233(d)) **Report metrics:** • Publicly report prior authorization data on MCO, PIHP, or PAHP website[10-12] (42 CFR 438.210(f); 42 CFR 457.1200(c); 42 CFR 457.1230(d)) • Report Patient Access API metrics to CMS as aggregated, de-identified, plan-level data[11,13,14] (42 CFR 438.242(b)(5)(iii); 42 CFR 457.1200(c); 42 CFR 457.1233(d))	• **Enhance Patient Access API**[11,13,14] (42 CFR 438.242(b)(5); 42 CFR 457.1200(c); 42 CFR 457.1233(d)) • **Implement new Provider Access API**[11,13,14] (42 CFR 438.242(b)(7); 42 CFR 457.1200(c); 42 CFR 457.1233(d)): ○ Beneficiary-to-provider attribution process ○ Beneficiary opt-out process and educational materials ○ Provider educational materials • **Implement new Payer-to-Payer API**[11,13,14] (42 CFR 438.242(b)(7); 42 CFR 457.1200(c); 42 CFR 457.1233(d)): ○ Educational materials for applicants and beneficiaries • **Implement new Prior Authorization API**[11,13,14] (42 CFR 438.242(b)(7); 42 CFR 457.1200(c); 42 CFR 457.1233(d)): ○ List of all covered items and services (except drugs) requiring prior authorization ○ Identification of all documentation required to approve prior authorization ○ Communication of prior authorization decision and specific reason for denial, if applicable
Extension or exemption	Not applicable.	Medicaid NEMT PAHPs are exempt from Provider Access API and Payer-to Payer API requirements[1,15] (42 CFR 438.9(b)(7); 89 FR 8823; 88 FR 8788). CHIP NEMT PAHPs are exempt from Provider Access API requirements[16] (42 CFR 457.1206(b)(6)). CMS intends CHIP NEMT PAHPs to be exempt from the Payer-to-Payer API requirements, just as the Medicaid NEMT PAHPs are, and will make a technical correction to 42 CFR 457.1206 in an upcoming rule (CMS staff, personal communication).

Note. [a] *These requirements apply to managed care organizations, prepaid ambulatory health plans, and prepaid inpatient health plans.*
Abbreviations. API: application programming interface; CHIP: Children's Health Insurance Program; CMS: Centers for Medicare & Medicaid Services; FFS: fee for service; MCO: managed care organization; NEMT: nonemergency medical transportation; PAHP: prepaid ambulatory health plan; PIHP: prepaid inpatient health plan.

Table 3. Prior Authorization Decision Time Frames

	FFS: Medicaid and Medicaid expansion CHIP[2]	FFS: Separate CHIP[3,a]	MCO, PIHP, and PAHP: Medicaid, Medicaid expansion CHIP, and separate CHIP[10-12]
Standard prior authorization request	As expeditiously as beneficiary's health condition requires and no later than **7 calendar days** after receiving request, unless state law sets shorter time frame. Up to 14 calendar days' extension allowable: • If requested by beneficiary or provider *or* • If state agency needs more information from provider (42 CFR 440.230(e)(1)(i)).	In accordance with enrollee's medical needs and no later than **7 calendar days** after receiving request or in accordance with existing state law.[b] Up to 14 calendar days' extension allowable: • If requested by enrollee *or* • If physician or health plan determines more information is needed (42 CFR 457.495(d)(2)).	As expeditiously as enrollee's condition requires and within state-established time frame of no more than **7 calendar days** after receiving request.[c] Up to 14 calendar days' extension allowable: • If requested by enrollee or provider *or* • If MCO, PIHP, or PAHP justifies to state Medicaid program (need more information and extension is in enrollee's interest) (42 CFR 438.210(d)(1); 42 CFR 457.1200(c); 42 CFR 457.1230(d)).
Expedited prior authorization request	As expeditiously as beneficiary's health condition requires and no later than **72 hours** after receiving request, unless state law sets shorter time frame. No allowance for extensions (42 CFR 440.230(e)(1)(ii)).	In accordance with enrollee's medical needs and no later than **72 hours** after receiving request or in accordance with existing state law.[b] Up to 14 calendar days' extension allowable: • If requested by enrollee *or* • If physician or health plan determines more information is needed (42 CFR 457.495(d)(2)).	As expeditiously as enrollee's condition requires and no later than **72 hours** after receiving request if provider indicates or MCO, PIHP, or PAHP finds standard time frame could seriously jeopardize enrollee's life, health, or function. Up to 14 calendar days' extension allowable: • If requested by enrollee *or* • If MCO, PIHP, or PAHP justifies to state Medicaid program (need more information and extension is in enrollee's interest) (42 CFR 438.210(d)(2); 42 CFR 457.1200(c); 42 CFR 457.1230(d)).

Notes. [a] *The requirements in 42 CFR 457.401-457.496 apply to separate CHIP, not Medicaid expansion CHIP[17] (42 CFR 457.401(c)).* [b] *These requirements begin January 1, 2026. Before that date, prior authorization decisions must be made within 14 days after receiving the request or in accordance with existing state law[3] (42 CFR 457.495(d)). Although the regulatory text that applies beginning in 2026 still refers to existing state law, CMS explained its intention to align time frames across programs and allow state-established policies to set only shorter time frames[1] (89 FR 8887; 89 FR 8888).* [c] *This requirement applies to rating periods that start on or after January 1, 2026. For rating periods starting before January 1, 2026, standard authorization decisions must be made within a time frame set by the state and no more than 14 calendar days after receiving the request[10] (42 CFR 438.210(d)(1)(i)(A)).*
Abbreviations. CHIP: Children's Health Insurance Program; FFS: fee for service; MCO: managed care organization; PAHP: prepaid ambulatory health plan; PIHP: prepaid inpatient health plan.

Prior Authorization and Patient Access API Use Metrics

Prior Authorization Metrics

Metrics are aggregated for all items and services. Critics have noted that these metrics will not answer questions about specific items and services, such as the specific services most frequently requested or most frequently denied.[18] The metrics are the same for each program listed previously, with variations in the bracketed text in items 8 and 9 in the following list[2,5,10] (42 CFR 440.230(e)(3); 42 CFR 457.732(c); 42 CFR 438.210(f)):

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 State Medicaid agency; the State; the MCO, PIHP or PAHP] 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 State Medicaid agency; the State; the MCO, PIHP or PAHP] for expedited prior authorizations, aggregated for all items and services.

Table 4. Prior Authorization Metric Reporting Requirements

Program	Reporting Requirements
FFS: Medicaid and Medicaid expansion CHIP	"Beginning in 2026, annually report prior authorization data, excluding data on drugs, as defined in § 431.60(b)(6) of this chapter, at the State level by March 31. The State must make the following data from the previous calendar year publicly accessible by posting them on its website"[2] (42 CFR 440.230(e)(3)).
FFS: Separate CHIP	"Beginning in 2026, a State must annually report prior authorization data, excluding data on drugs as defined in § 457.730(b)(6), at the State level by March 31. The State must make the following data from the previous calendar year publicly accessible by posting them on its website"[5] (42 CFR 457.732(c)).
MCO, PIHP, and PAHP: Medicaid, Medicaid expansion CHIP, and separate CHIP	"Beginning January 1, 2026, following each calendar year it has a contract with a State Medicaid agency, the MCO, PIHP, or PAHP must report prior authorization data, excluding data on any and all drugs covered by the MCO, PIHP, or PAHP, at the plan level by March 31. The MCO, PIHP, or PAHP must make the following data from the previous calendar year publicly accessible by posting them on its website"[10] (42 CFR 438.210(f)); application to Medicaid expansion CHIP managed care[11] (42 CFR 457.1200(c)); application to separate CHIP managed care[12] (42 CFR 457.1230(d)).

Abbreviations. CHIP: Children's Health Insurance Program; FFS: fee for service; MCO: managed care organization; PAHP: prepaid ambulatory health plan; PIHP: prepaid inpatient health plan.

Patient Access Application Programming Interface Use Metrics

The metrics are the same for each program:

- The total number of unique beneficiaries whose data are transferred via the Patient Access API to a health application designated by the beneficiary; and
- The total number of unique beneficiaries whose data are transferred more than once via the Patient Access API to a health application designated by the beneficiary.

Table 5. Patient Access Application Programming Interface Metric Reporting Requirements

Program	Reporting Requirements
FFS: Medicaid and Medicaid expansion CHIP	"Beginning in 2026, by March 31 of each year, a State must report to CMS the following metrics, in the form of aggregated, de-identified data, for the previous calendar year at the State level in the form and manner specified by the Secretary"[6] (42 CFR 431.60(f)).
FFS: Separate CHIP	"Beginning in 2026, by March 31 of each year, a State must report to CMS the following metrics, in the form of aggregated, de-identified data, for the previous calendar year at the State level in the form and manner specified by the Secretary"[7] (42 CFR 457.730(f)).
MCO, PIHP, and PAHP: Medicaid, Medicaid expansion CHIP, and separate CHIP	"Report metrics specified in § 431.60(f) of this chapter at the plan level"[11-13] (42 CFR 438.242(b)(5)(iii); 42 CFR 457.1200(c); 42 CFR 457.1230(d)).

Abbreviations. CHIP: Children's Health Insurance Program; CMS: Centers for Medicare & Medicaid Services; FFS: fee for service; MCO: managed care organization; PAHP: prepaid ambulatory health plan; PIHP: prepaid inpatient health plan.

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