Frequently Asked Questions (FAQs)
Electronic Prior Authorization Measure for Medical Items and Services
Eligible Hospitals and Critical Access Hospitals

November 9, 2026

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Questions about Recent Electronic Prior Authorization Measure Changes

Q1: Why did CMS modify the Electronic Prior Authorization measure to specify the required use of certified electronic health record technology (CEHRT)?

A: CMS modified the Electronic Prior Authorization measure to be consistent with the availability of Health Information Technology (IT) Modules certified to the following Office of the National Coordinator for Health IT (ONC) criteria for electronic prior authorization:

- "Provider prior authorization API - coverage requirements discovery" - 45 CFR170.315(g)(31)
- "Provider prior authorization API - documentation templates and rules" - 45 CFR170.315(g)(32)
- "Provider prior authorization API - prior authorization support" - 45 CFR170.315(g)(33)

Certified Health IT Modules must be used to complete the action specified in the Electronic Prior Authorization measure. We updated the measure language because certified Health IT Modules are now available for adoption, and electronic prior authorization can be most beneficial when it is integrated into the clinical workflow of an eligible hospital or critical access hospital (CAH).

Q2: What changes did CMS finalize for eligible hospitals and CAHs for the Electronic Prior Authorization measure in the Fiscal Year (FY) 2027 Inpatient Prospective Payment System (IPPS)/Long-Term Care Hospital Prospective Payment System (LTCH PPS) final rule?

A: First, for the electronic health record (EHR) reporting period in calendar year (CY) 2027, CMS finalized that the Electronic Prior Authorization measure will be OPTIONAL and worth 10 bonus points. No exclusions will be available, and only a "Yes" attestation will count. Submitting a "No" attestation will not affect scoring, or the ability to meet minimum program reporting requirements.

Second, beginning with the EHR reporting period in CY 2028, CMS finalized that the Electronic Prior Authorization measure will be REQUIRED and worth no points. Exclusions will be available, and only a "Yes" attestation or claiming an applicable exclusion will count. Submitting a "No" attestation will not meet minimum reporting requirements, and the eligible hospital or CAH would be subject to a downward payment adjustment.

Third, CMS finalized modifications to the measure description language beginning with the EHR reporting period in CY 2027. We modified the phrase "using data from CEHRT" to "using CEHRT" to clearly state that a prior authorization must be requested electronically, using certified Health IT Modules that support electronic prior authorization. We replaced the word "discharge" with "encounter" to more clearly delineate that a prior authorization request may occur at any time during the hospital encounter, rather than be associated temporally with a discharge.

The final measure description language reads:

> *For at least one medical item or service (excluding drugs) ordered during a hospital encounter that occurs within the EHR reporting period, the prior authorization is requested electronically through a Prior Authorization API using CEHRT.*

Last, CMS specified that the eligible hospital or CAH may use any combination of certified health IT that is necessary to meet the Electronic Prior Authorization measure, including one, or more than one, Health IT Module certified to the criteria in 45 CFR 170.315(g)(31), (32), and (33).

Q3: Is CMS planning to modify the Electronic Prior Authorization measure in the future?

A: As mentioned in the FY 2027 IPPS/LTCH PPS final rule, we are very strongly considering proposing modifications to the Electronic Prior Authorization measure in the FY 2028 IPPS/LTCH PPS proposed rule to align with similar proposals recently finalized in the CY 2027 Physician Fee Schedule (PFS) final rule under the Merit-based Incentive Payment System (MIPS) Promoting Interoperability performance category for MIPS eligible clinicians.

Questions about Meeting the Electronic Prior Authorization Measure

Q4: What constitutes a prior authorization request for the purposes of the Electronic Prior Authorization measure?

A: An eligible hospital or CAH meets measure requirements by using CEHRT to electronically request a prior authorization through a payer's Prior Authorization Application Programming Interface (API) for a medical item or service (excluding drugs) that requires prior authorization.

Two scenarios meet measure requirements to attest "Yes" to the measure:

(1) Prior authorization is required, and the request is approved; or,

(2) Prior authorization is required, and the request is denied.

The following scenarios do not meet the measure requirements:

(1) Prior authorization is required, but the request has not been approved or denied yet because additional information is needed; or,

(2) Prior authorization is not required for the medical item or service.

Q5: Which medical items or services count for the Electronic Prior Authorization measure? Are drugs included?

A: The Electronic Prior Authorization measure applies to all medical items and services, excluding drugs, that require prior authorization as determined by the payer. Each payer has different prior authorization requirements; therefore, CMS has not established a specific list of qualifying items or services for purposes of the measure.

Drug prior authorization requests are not currently part of the Electronic Prior Authorization measure, but there is no restriction on using the underlying functionality for drug prior authorizations where it can be accomplished. We encourage providers to plan and implement their electronic prior authorization capabilities in a manner that promotes efficiency and scalability, including by considering how those capabilities could support additional prior authorization workflows in the future.

Q6: What counts as a qualifying hospital encounter for the purposes of the Electronic Prior Authorization measure?

A: A prior authorization request may occur at any time during a hospital encounter, whether it occurs in the inpatient department, outpatient department, or emergency department, and must be requested electronically using the CEHRT of the eligible hospital or CAH. An encounter is considered an admission, visit to the emergency department, or stay or visit for a procedure, treatment, or other medical item or service. The person or group requesting the prior authorization using their CEHRT would maintain ownership for purposes of meeting the measure, so long as the advised medical item or service requires prior authorization by the payer (e.g., transfers, imaging, durable medical equipment, or the act of admission itself).

Q7: Do authorization requests submitted after services were rendered count toward the measure?

A: In some cases, such as emergencies, a patient may need hospital care before a prior authorization request can be completed, or while the request is still pending. In these situations, so long as the electronic prior authorization is requested during the hospital encounter using CEHRT, the prior authorization would meet the measure. If the payer's approval or denial to the prior authorization request is received after the hospital encounter or discharge, these requests may still meet the measure so long as the request was made during the hospital encounter.

Q8: Does authorization associated with a patient transfer from the emergency department to inpatient admission count toward the measure?

A: Hospitals commonly initiate payer interactions related to inpatient admission from the emergency department, particularly unscheduled admissions. If the payer requires an authorization, certification, or a similar process for transfer from the emergency department to an inpatient admission that can be requested using the payer's Prior Authorization API, the request would meet the measure. If the payer does not require authorization for transfers from the emergency department, this would not count toward the measure.

Q9: Does a continuation-of-stay authorization qualify for the measure?

A: If a payer requires prior authorization for continuation-of-stay, concurrent review, or a similar processes to update an admission authorization when a patient requires continued hospitalization, and an eligible hospital or CAH can electronically request authorization for continuation-of-stay through the payer's Prior Authorization API, this would meet the measure. If the payer does not require authorization for a continuation-of-stay, this would not meet the measure.

Q10: Does a hospital's prior authorization request to a payer count if a physician's office submitted the original request?

A: Responsibility for initiating prior authorization varies by service and payer. Acute care hospitals may initiate prior authorization requests for hospital-based services and admissions. In other cases, an ordering or referring clinician or another provider might initiate the prior authorization request for medical items or services to be provided at a hospital.

For example, a physician office may submit a prior authorization request for a hospital-based surgery. Depending on the payer's rules and contracting arrangements, the ordering/referring physician or their practice may initiate the prior authorization request, the hospital may submit it, or the two may have separate authorization responsibilities.

If the hospital makes a prior authorization request for any medical item or service using Health IT Modules certified to the criteria at 45 CFR 170.315(g)(31), (32), or (33) that support electronic prior authorization during an encounter, and that request results in a decision from the payer, then it would meet the measure. Whoever initiates the electronic prior authorization request using their own CEHRT may report the request to meet the Electronic Prior Authorization measure for their respective program.

We note that querying for the decision of a previously completed prior authorization would not meet the measure.

Questions about Certified Health IT Requirements

Q11: How many of the electronic prior authorization Health IT Modules must be used for the EHR reporting period in CY 2027 to earn bonus points?

A: CMS does not require a specific number of Health IT Modules to be used for completing the bonus measure for the EHR reporting period in CY 2027. Eligible hospitals and CAHs may use one or more than one Health IT Module certified to the criteria at 45 CFR 170.315(g)(31), (32), and (33) necessary to perform the measure action.

In the FY 2027 IPPS/LTCH PPS final rule, we described how an eligible hospital or CAH could meet the measure by using only health IT certified to the "prior authorization API – coverage requirements discovery" criterion at 170.315(g)(31) if an item or service that requires prior authorization is approved without the need for further documentation.

We also described how an eligible hospital or CAH could meet the measure using health IT certified to all three criteria at 45 CFR 170.315(g)(31), (32), and (33) to submit a prior authorization request that requires additional documentation. Eligible hospitals and CAHs are not required to adopt health IT certified to all three criteria in CY 2027 to meet the requirements of the bonus measure.

As noted in the FY 2027 IPPS/LTCH PPS final rule, CMS is very strongly considering proposing revisions to the measure that would require a more comprehensive prior authorization workflow beginning with the EHR reporting period in CY 2028 that would require the use of all three certification criteria.

Q12: Which version of the Health Level Seven International (HL7) Fast Healthcare Interoperability Resources (FHIR®) Implementation Guides (IG) for electronic prior authorization are required for use in certified health IT?

A: Certified health IT must use an unexpired version of the IGs required in 45 CFR 170.315 (g)(31), (32), or (33) which support electronic prior authorization. As of this writing, those IGs are Coverage Requirements Discovery (CRD) IG version 2.2.1; Documentation Templates and Rules (DTR) IG version 2.2.0; and Prior Authorization Support (PAS) IG version 2.2.1.

In the FY 2027 IPPS/LTCH PPS final rule, ONC finalized adoption of these versions of the IGs, effective October 1, 2026.

Questions about Using Clearinghouses and Third Parties

Q13: Can an eligible hospital or CAH use an intermediary or a clearinghouse to meet the Electronic Prior Authorization measure requirements?

A: Yes, if the clearinghouse or intermediary is certified to the relevant ONC certification criteria required for the measure at 45 CFR 170.315(g)(31), (32), and (33).

CMS's policy does not prohibit a clearinghouse or intermediary from supporting electronic prior authorization exchange through capabilities beyond those reflected in the ONC certification criteria. CMS recognizes that electronic prior authorization workflows often involve multiple systems and entities, including EHRs, revenue cycle systems, payer systems, clearinghouses, health information exchanges, standards-based intermediaries, and other interoperable technology solutions.

Eligible hospitals and CAHs may use intermediaries or clearinghouses to support electronic prior authorization exchange if the intermediaries or clearinghouses are certified to the relevant ONC certification criteria required for the measure at 45 CFR 170.315(g)(31), (32), and (33).

Questions Related to Electronic Prior Authorization Timing

Q14: There are requirements that payers must have FHIR APIs available starting January 1, 2027. Do eligible hospitals and CAHs also need to have their prior authorization functionality live by January 1, 2027, to earn bonus points for the EHR reporting period in CY 2027 for the Electronic Prior Authorization measure?

A: For the Medicare Promoting Interoperability Program, while eligible hospitals and CAHs need to adopt and use certified Health IT to request a prior authorization electronically using CEHRT, that functionality is not required to go live by January 1, 2027. Instead, eligible hospitals and CAHs must adopt and use certified health IT to fulfill the measure during their 180-day continuous and self-selected EHR reporting period.

We recognize that products may be deployed during the EHR reporting period, but pending certification. In such cases, the product must be certified by the last day of the EHR reporting period. Since the EHR reporting period is self-selected, there is some flexibility when choosing the EHR reporting period, ensuring that certification is complete.

As an example, if an eligible hospital or CAH self-selects the last 180-days in CY 2027 as their EHR reporting period to earn bonus points, they must (1) ensure that their health IT is certified by December 31, 2027, and (2) use their certified health IT to request an electronic prior authorization by December 31, 2027.

While flexibility is offered, we strongly encourage early adoption of the certified health IT modules so that an eligible hospital or CAH has enough time to request an electronic prior authorization before their self-selected 180-day EHR reporting period ends.

Other Questions / Additional Resources

Q15: Is it acceptable to use a pre-production environment to query one electronic prior authorization to fulfill the Electronic Prior Authorization measure?

A: No. The intent of the measure is for the hospital to request an actual prior authorization electronically using a payer's FHIR API, rather than through a test case in a pre-production environment. Therefore, the request must use a production environment.

Q16: Where can we find additional CMS information and resources about electronic prior authorization?

A: Additional information about CMS efforts on prior authorization can be found at https://www.cms.gov/priorities/electronic-prior-authorization/overview.

For additional questions, the following resources are available:

- For questions about electronic prior authorization requirements for eligible hospitals and CAHs, visit the QualityNet Question and Answer Tool.
- For questions about electronic prior authorization requirements for MIPS-eligible clinicians, email QPP@cms.hhs.gov, submit a QPP Service Center ticket, or call 1-866-288-8292 (Monday–Friday, 8 a.m. – 8 p.m. Eastern). People who are deaf or hard of hearing can dial 711 to be connected to a TRS Communications Assistant.
- For questions about electronic prior authorization requirements for impacted payers, email CMSInteroperability@cms.hhs.gov.
- For questions about electronic prior authorization certification requirements for vendors, email ONC.Requests@hhs.gov.