The APIs Are the Easy Part

Maximizing Your ROI While Meeting CMS Interoperability and Prior Authorization Requirements

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Executive Summary

What are your organization's top strategic investments for the coming year? According to a recent Gartner survey, 46 leaders from various US payers ranked quality improvement, data and analytics, behavioral/mental health, and risk adjustment optimization as their most important initiatives. But those same leaders identified regulatory shifts as the top factor driving enterprise decision making. Indeed, regulatory shifts was the only such factor considered at least "somewhat important" by all respondents and "very important" by nearly three-quarters of surveyed leaders.[1]

This document walks through key aspects of CMS-0057-F, including each type of information sharing, associated technical and operational requirements, timelines, and resulting opportunities for performance improvement. We trust it will be a resource shared across your organization to help understand, plan for, and capitalize on this important advancement toward value-based care.

Unfortunately, complying with new regulatory requirements is often seen as a distraction from "more important" organizational initiatives. In some cases, though, such mandates align well with business priorities and provide the necessary urgency to move key initiatives forward. Approached from the right perspective, new regulatory requirements can be harnessed to put in place infrastructure and business processes that will strengthen the enterprise for years to come. The CMS Interoperability and Prior Authorization Final Rule, CMS-0057-F, released in January 2024, represents just such an opportunity for payers.

This new rule is the latest in a set of regulatory initiatives requiring investment in information technology (IT) needed to democratize data-driven decision-making throughout healthcare and advance value-based care. In 2009, the HITECH Act digitized and normalized provider electronic health record (EHR) data. In 2020, CMS-9115-F introduced API-based information sharing by payers. Now, CMS-0057-F mandates the use of digitized data and FHIR-based APIs to advance interoperability among all key stakeholders and automate costly manual prior authorizations. While targeted at a specific set of federally funded "impacted payers," it is expected to have a ripple effect across the entire healthcare industry.

As the name implies, the rule requires payer investment in interoperability infrastructure, but compliance is far more comprehensive than a pure IT project. Implementing the mandated APIs requires answers to a host of operational, policy, and workflow decisions all critical to optimizing an organization's return on its infrastructure investment.

More specifically, CMS-0057-F addresses four types of information sharing by impacted payers:

1. Sharing information with other payers, both impacted and non-impacted, to build longitudinal member records for better care coordination
2. Sharing information with members and their representatives to better manage and coordinate their own care
3. Sharing information with in-network, treating providers to furnish relevant context and visibility about a patient's care team and clinical history
4. Digitizing the information sharing required for prior authorization to streamline and automate a costly and burdensome set of processes

[1] Bishop, M, 1Q24 U.S. Healthcare Payers Enterprise Benchmarks: Priorities and Technology Deployments, Gartner, 1 March 2024- ID G00809883

Collectively, these information sharing mandates build on and support investment in a robust longitudinal health record. You can picture the core requirements for impacted payers like this:

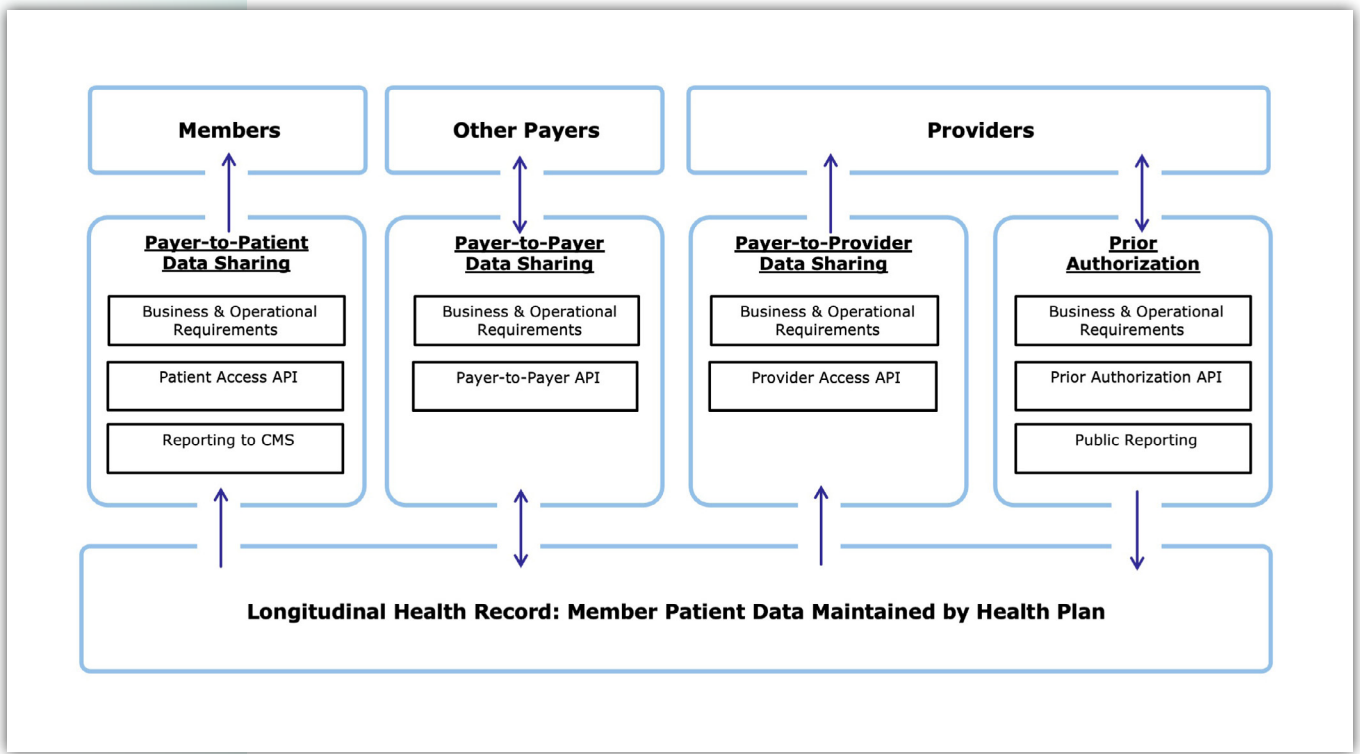

Figure 1. CMS-0057-F overview.

The rule's implied requirement for deployment or expansion of a longitudinal health record that can integrate member clinical, claims, and social determinants of health data comprises one of the greatest opportunities to advance priorities like quality improvement, analytics, and risk adjustment optimization. As IDC's Jeff Rivkin writes:

> Well-documented payer walls between the "claims side of the house and the care side of the house" are highlighted with prior authorization. A strategy to comply to the final rule issued by the U.S. Centers for Medicare & Medicaid Services suggests that payers should unify organizations and systems around their member longitudinal health record.[2]

Put another way, we must tear down the clinical and administrative data silos that have spread throughout US healthcare for decades to realize the dramatic improvements in quality and efficiency other industries have achieved through interoperability. And CMS-0057-F provides a vehicle for driving this needed change. It requires investment in, contribution to, and use of the type of longitudinal or unified care record needed to automate burdensome processes and generate actionable insights to improve care and promote wellness at the right point in time and place. But again, ensuring your investment delivers these larger returns on top of regulatory compliance requires a team effort. It will require close alignment among IT, clinical, and business leadership, under the guidance of your regulatory team.

Note: This document is informational only and does not constitute legal advice.

[2] https://www.intersystems.com/idc-prior-authorization.pdf

Introduction

On January 17, 2024, the Center for Medicare and Medicaid Services (CMS) announced the release of a long-expected rule, **CMS-0057-F**, the CMS Interoperability and Prior Authorization Final Rule ("the rule"). This rule contains a set of technical and operational mandates intended to support the ongoing move to value-based care and free flow of healthcare information.

For the most part, the rule applies to payers, but not every health insurance product type is subject to these requirements. In general, "impacted payers" are Medicare Advantage (MA) organizations, state Medicaid fee-for-service (FFS) programs, state Children's Health Insurance Program (CHIP) FFS programs, Medicaid managed care plans, CHIP managed care entities, and Qualified Health Plan (QHP) issuers on the Federally Funded Exchanges (FFEs).

There are also implications for MIPS eligible provider organizations, which have a new attestation metric for use of electronic prior authorization. And while the rule is targeted at federally funded impacted payers, it is expected to have a ripple effect across the entire health care industry.

Like many technology-heavy mandates, it may be tempting to assign compliance responsibility to your IT team to acquire and implement new software. There are indeed significant software elements necessary for compliance, but there are equally significant business and operational considerations that must be addressed to both comply with and benefit from all that CMS-0057-F requires. A successful compliance strategy requires alignment between IT, clinical, and business leadership, under the guidance of your regulatory team.

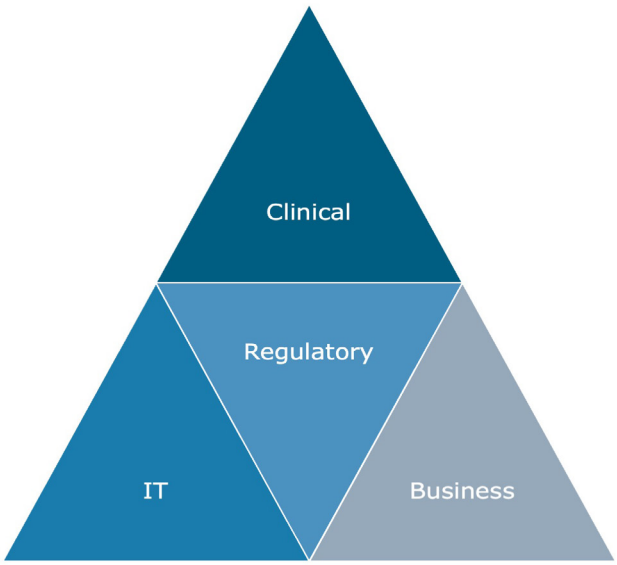

Figure 2. Cross-functional payer team recommended for rule compliance.

In the following pages we will discuss technical and operational highlights of the rule along with other considerations critical to ensuring your organization derives long-term value from the IT investments required for compliance. In the interest of readability, we have chosen not to include detailed references to the technical standards and data formats used. This information is summarized in the appendix and is readily available from other sources. Any page references below are to the Federal Register citation linked above.

Note: This document is informational only and does not constitute legal advice.

Rule Scope

The rule addresses four types of information sharing by impacted payers:

1. Sharing information with other payers, both impacted and non-impacted, to build longitudinal member records for better care coordination
2. Sharing information with members and their representatives to better manage and coordinate their own care
3. Sharing information with in-network, treating providers to furnish relevant context and visibility about a patient's care team and clinical history
4. Digitizing the information sharing required for prior authorization to streamline and automate a costly and burdensome set of processes

For each type of information sharing, the regulations set out a technical framework, or API, plus one or more business and operational requirements, such as opt in/out rights, attribution processes, and myriad reporting and educational requirements. Many of the business and operational requirements are quite complex. All information sharing, whether unidirectional or bi-directional, draws on the longitudinal patient data maintained electronically by the health plan, as illustrated below.

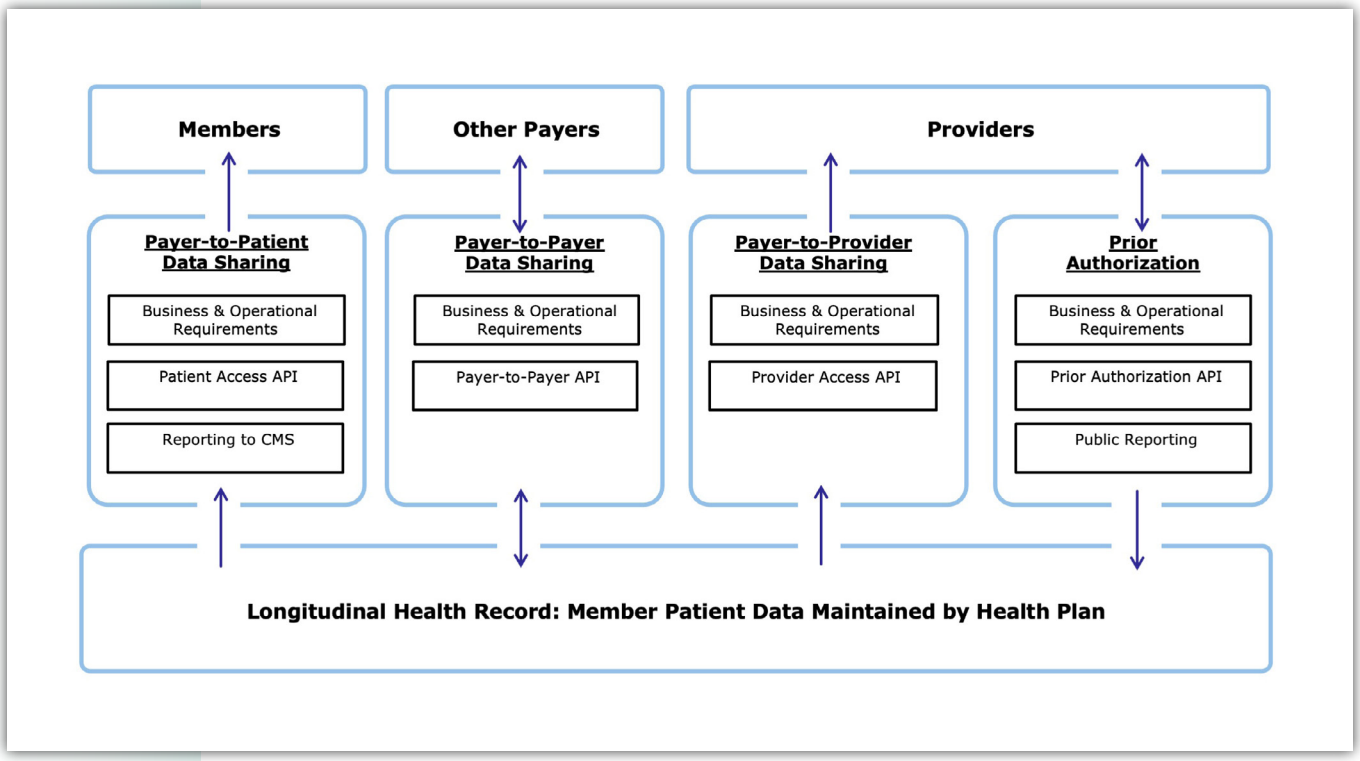

Figure 3. CMS-0057-F overview.

Additionally, MIPS eligible clinicians, hospitals, and critical access hospitals must report a new attestation measure to CMS from their certified electronic health record. These providers must attest whether they have used the prior authorization API at least once during the plan year. The goal of the measure is to incent providers to start using the technology that payers are required to implement.

Effective Dates

The rule assigns one of two effective dates to each of its requirements: January 1, 2026, or January 1, 2027. In general, MA organizations and state Medicaid and CHIP FFS programs must comply by the stipulated date; Medicaid and CHIP managed care entities by the rating period beginning on or after the stipulated date; and QHP issuers on FFEs by the plan year beginning on or after the stipulated date. All provisions of the rule dependent on technical work needed to deploy or expand an API take effect on January 1, 2027. All other provisions affecting impacted payers are effective on January 1, 2026. A more detailed breakdown of effective dates is provided in the table below.

Effective Date	Requirement	Affected Organization Type
January 1, 2026	Reporting to CMS on use of Patient Access API incorporating both CMS-0057-F and CMS-9115-F requirements	Impacted payers
	Public reporting of prior authorization metrics	Impacted payers
	Notice to providers of a specific reason for prior authorization denials	Impacted payers
	New standard and expedited timeframe for responding to prior authorization requests	Impacted payers, with some exceptions by plan type
January 1, 2027	API deployment and associated information sharing provisions	Impacted Payers
	MIPS attestation reporting on use of electronic prior authorization	MIPS-eligible providers

Table 1. Effective dates.

In summary, if a requirement isn't directly dependent on deploying a new or expanded API, impacted payers have only until January 1, 2026, to comply with provisions of the rule. And if it is partially dependent, like the reporting provisions, you will need to report in 2026 on what you already have in place and then update your approach when you begin using the new APIs.

API Mandates

As the term is used in the rule, an API is a set of commands, functions, protocols, or tools published by one payer, or software developer on behalf of the payer, that enables other software developers to create programs (applications or "apps") that can interact with the software utilized by the payer without needing to know the software's internal workings and while maintaining data security and patient privacy (if properly implemented). The rule requires impacted payers to deploy or enhance three "Access APIs" and one "Prior Authorization API." However, while the rule refers to each required API in the singular, it recognizes that implementation may entail using one or multiple APIs. For example, the "Prior Authorization API" will almost certainly involve multiple technical APIs for coverage requirements discovery (CRD), documentation templates and rules (DTR), and prior authorization support (PAS).

All APIs must conform to the HL7® FHIR® standard (FHIR). FHIR is an interoperability approach that supports sharing health records in the same way data is shared in other industries, for example the ability of travel reservation apps to present information from multiple carriers and hotels in one user-friendly site. By mandating the use of FHIR, the rule paves the way for greater data liquidity and the growth of a digital health app ecosystem and, in turn, much needed leaps forward in automation and data-driven care.

The regulation includes a mix of required, recommended, and optional standards and technologies for the APIs. It relies heavily on the work of a payer-provider-vendor-government collaborative known as the HL7 Da Vinci Project (Da Vinci), and the HL7 FHIR-based Implementation Guides developed by the collaborative in support of value-based care use cases. Impacted payers are encouraged to participate in the work of the Da Vinci project and its pilot programs.

The four APIs are summarized below.

Access APIs for Information Sharing and Populating a Longitudinal Health Record	
Payer-to-Payer API	New FHIR-based API replacing more rudimentary payer-to-payer data exchange set forth in CMS-9115-F
	Data requirements include up to the past five years of information in the Patient Access API, plus unstructured data to support successful prior authorization requests and minus provider remittances, cost-sharing information, and denied prior authorizations
	Includes clinical data maintained by the payer for the past 5 years and prior authorization data with status updates in the prior 12 months
Patient Access API	Expanded version of the FHIR-based API, stipulated by CMS-9115-F in 2020, for making data available to member-facing apps
	Requires payers to provide ready access to claims and encounter information as well as clinical data, including lab results, provider remittances, and patient cost-sharing pertaining to claims, if maintained by the payer
	Updates clinical data requirements and expands to include information about prior authorization requests and decisions (excluding those for drugs)
	Includes clinical data maintained by the payer from 2016 forward, and prior authorization data with status updates in the prior 12 months
Provider Access API	New FHIR-based API for requesting and receiving health records of a member via the EHR or other system of a treating provider
	Data requirements include information in the Patient Access API above, minus provider remittances and cost-sharing information
	Includes clinical data maintained by the payer from 2016 forward, and prior authorization data with status updates in the prior 12 months
Streamlining Prior Authorization	
Prior Authorization API	Set of new APIs supporting the creation and exchange of prior authorization requests and responses, including whether prior authorization is needed and payer determination
	Data requirements include list of items and services (excluding drugs) requiring prior authorization and supporting documentation needed

Table 2. Required APIs and shared information

The Access APIs: Securing Outsized Returns on Sunk Compliance Costs

CMS-0057-F is the third leg of a regulatory framework put in place by the US government over the past two decades to prompt investment in the needed infrastructure to leverage data to advance value-based care. The 2009 HITECH act drove the digitization and normalization of provider EHR data. Then CMS-9115-F introduced API-based information sharing by payers in 2020. Among other things, the 9115 rule required that payers implement a FHIR-based Patient Access API to make available a named set of data elements for an individual within patient facing apps. The goal was to assist members with their own care management and foster the development of an app ecosystem to support value-based care. There has been widespread disappointment in the industry at the low utilization of any such apps by patients, particularly after the significant investment required of payer organizations. So, an expansion of this earlier mandate may strike some as onerous.

CMS disagrees. As is repeatedly stated in the text, the required data is an extension of the same set of information the original rule aimed to make available to members via APIs, so building out the needed data foundation should only require incremental investment. We also believe the newly mandated APIs provide the necessary impetus for creating value from this data infrastructure, starting with the Payer-to-Payer API in particular. This API not only normalizes data sharing, but mandated adoption will let payers populate the type of robust longitudinal health record critical to achieving the full promise of value-based care.

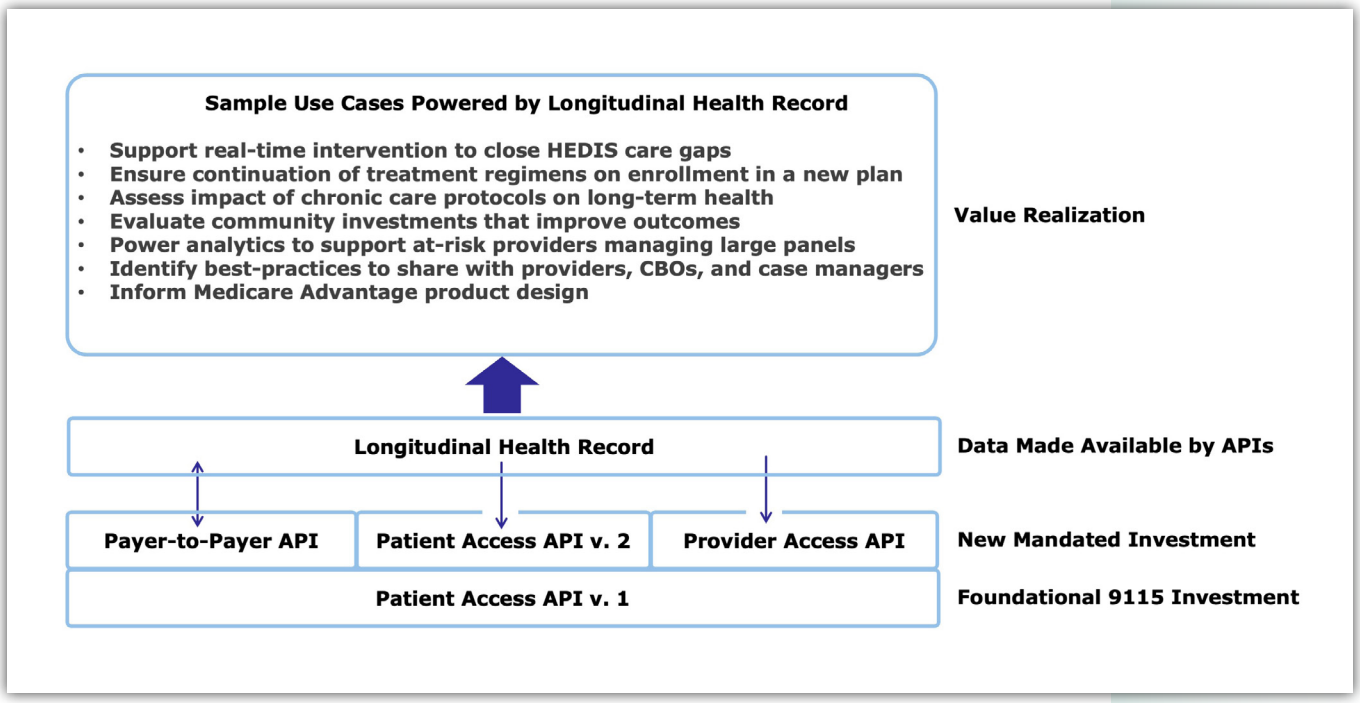

Figure 4. Access API value realization.

Sharing Information with Other Payers

CMS-0057-F rescinds and replaces provisions of the 2020 Interoperability and Patient Access Final Rule pertaining to payer-to-payer data sharing with a far more concrete and aspirational set of requirements. The intent underlying this broad mandate is to make possible more seamless care management and coordination for members transitioning between plans or receiving coverage from multiple plans. This is especially important for those with chronic conditions who have cycled through multiple treatment regimens before being stabilized on an optimal regimen. Ideally, as such patients move to a new plan or add a concurrent payer, there will soon be no gap in treatment, no need to repeat therapies already shown to be ineffective, and no loss of authorizations for planned services. This is to be accomplished by a complex set of operational requirements paired with a new FHIR-based API.

CMS considers payer-to-payer data sharing so important that it has indicated FFS Medicare will support the API and encourages all other non-impacted payers to participate as well.

The Payer-to-Payer API

The now defunct provisions of the 2020 rule encouraged data sharing between payers but did not mandate FHIR nor any particular data exchange standard. In contrast, the 2024 rule requires impacted payers to implement and maintain a FHIR API for payer-to-payer data exchange, and strongly recommends using the Da Vinci Payer Data Exchange (PDex) Implementation Guide. for this purpose. The Payer-to-Payer API must also support FHIR Bulk Data Access. This is to facilitate the high volumes of data exchange expected during open enrollment periods.

Most of the data elements that must be shared via the Payer-to-Payer API are familiar. They are largely the same as those required for the Patient Access API, which itself builds upon the original set CMS stipulated be made available to member-facing apps in the 2020 rule. The table below highlights data elements both APIs must share and notable differences.

Common Data Elements	Divergent Requirements

• Adjudicated claims
• Encounters with capitated providers
• Clinical data maintained by the payer
• Prior authorization data for all active prior authorizations and status updates (except those concerning drugs) within the previous year, including:
  • Information about prior authorizations, regardless of modality
  • Structured administrative and clinical data submitted with prior authorization requests
	Included in Payer-to-Payer API:
	• Unstructured data submitted as part of prior authorization requests
	
	Excluded from Payer-to-Payer API:
	• Records for services predating request by more than 5 years
	• Provider remittances and patient cost sharing
	• Denied prior authorization requests

Table 3. Comparison of data elements required by Payer-to-Payer API vs. Patient Access API.

Curating Longitudinal Health Records

CMS-0057-F does not just require that payers maintain a Payer-to-Payer API but aggressively requires the use of these APIs to share information between members' previous and concurrent payers. Further, it requires that impacted payers incorporate all data received into the members' longitudinal health records to ensure they have access to comprehensive health histories, assembled and curated by their payers. As stated by CMS:

> Having a patient's data follow them when they change payers can have a multitude of benefits for patient care. A payer receiving data when a new patient enrolls can better coordinate care and make more informed decisions. For instance, a payer can use the patient's data to determine whether they have a chronic condition or is undergoing current care that needs to be maintained. If necessary, patient data can give payers the information they need to assign a case manager or help the patient find providers in their new network. Maintaining a corpus of data ensures that the patient and their providers do not lose access to recent information that may be relevant to ongoing or future care. Furthermore, because payers usually maintain a relationship with individual patients over time, they are uniquely positioned to collect and aggregate a patient's record. (p. 8820)

In short, CMS-0057-F mandates information sharing between payers to support care continuity and value-based care in a country where up to 20% of publicly and privately insured individuals experience coverage disruptions or change plans each year.[3] However, as the rule also recognizes, payers must overcome a host of operational challenges to safely and accurately populate and leverage more robust longitudinal health records, such as linking members with other payers, securing informed member approval, ensuring IT systems can integrate data from other plans, and equipping case managers with tools to act on this influx of new information in a timely manner.

Member Opt-In

Since payer-to-payer information sharing is fairly new, CMS does not assume members will be familiar with the concept. Therefore, the rule requires that payers develop and maintain a mechanism for members to affirmatively opt-in to payer-to-payer information sharing, as well as opt back out, and educate members about the process and its benefits. Requirements for the opt-in/out process vary by health plan type, but there are no detailed specifications for how to accomplish any of these requirements.

In general, the impacted payer is expected to prompt the member to opt-in within one week of the start of coverage or another relevant milestone. For example, all existing members at the time the rule takes effect must be offered the opportunity to opt-in and request that information from prior payers be shared with the current payer. Additionally, payers must provide members with plain language education on their data sharing options and the value and implications of their choices. For some impacted payer types, this will be handled at the state level. CMS will be providing templates or outlines for educational resources at an unspecified time.

Payers should note that a member's refusal to opt-in to payer-to-payer sharing via the API will have no effect on other permitted payer information sharing, such as for treatment, payment, and operations (TPO).

[3]Fang H, Frean M, Sylwestrzak G, Ukert B, Trends in Disenrollment and Reenrollment Within US Commercial Health Insurance Plans, 2006-2018, JAMA Network Open. 2022;5(2)

Identify Payers with Whom to Request or Share Data

For members who opt-in, impacted payers must develop and maintain a process to identify those members' prior and concurrent payers and align member IDs between the various health plans. The mechanism for accomplishing this is unspecified but expected to be integrated into member enrollment, along with the opt in/out process.

- When the rule takes effect, existing members must be given the opportunity to name any concurrent or prior payers from the past five years and request information sharing ("Opt In"). This must be done prior to the CMS-0057-F compliance date for that plan.
- New enrollees must be given the opportunity to name concurrent and prior payers from the past five years and request information sharing. If possible, this should be done before the start of coverage, but payers may not delay the start of coverage nor request data for prospective members.
- If a patient identifies multiple previous payers, the impacted payer must request information from all payers that fall within the five-year window for information sharing.
- Members need to supply not only the name of the previous or concurrent payer(s) but also the dates they were enrolled, the name by which they are known to that payer, and their payer IDs.

Impacted payers are responsible only for their side of the request - requestor or responder. They are not expected to check whether other payers are impacted. However, they may not deny any properly made requests from non-impacted payers and must make and document reasonable efforts to obtain information for members who have opted-in to payer-to-payer information sharing from all identified payors.

While there is no formal requirement for an enterprise master person index (EMPI), impacted payers may want to evaluate EMPI capabilities as part of their planning for matching shared records with the correct member in their own systems.

Information Sharing Frequency

When a member joins a new health plan, CMS expects at least a one-time exchange of data with prior payers, if requested by the member. Impacted payers are encouraged to request a second exchange 90 days after the first to pick up any outlier claims and other data that may have arrived in the interim. Payers making data available via an API are also encouraged to provide an additional feed if the member record is updated later.

If a member has two or more concurrent payers, and requests that they share information, there must be ongoing quarterly bi-directional exchanges of data between them, and if a concurrent payer requests data for a member, it should be made available within one business day.

Workflow Considerations

Compliance with all the requirements of CMS-0057-F concerning payer-to-payer information sharing, let alone achievement of the larger aims these provisions enable, necessitates close collaboration among clinical, IT, member service, regulatory, and other team members. There is a multiplier effect on workflow complexity when one starts combining all the new processes, decision points, and hand-offs just discussed.

For example, consider the scenario diagramed in Figure 5, which depicts the workflow for a dual eligible member with two impacted concurrent payers and three previous payers within the past five years.

- The new member must opt-in to information sharing, after reviewing the educational materials provided during enrollment and on the payers' websites
- The new member must identify other concurrent and former insurers along with the member IDs or other relevant identifiers used by those plans
- The two concurrent plans need to align member identities, request information sharing with each other and the prior plans, and provide needed attestations to the prior plans as well as each other
- The previous payers must respond if impacted and may respond if not impacted
- Any information received must then be incorporated by the requesting payers into longitudinal health records, which they curate
- Similarly, the two concurrent payers must exchange information with each other on enrollment and at least quarterly thereafter

While this is admittedly a more complicated scenario than most, it highlights some of the operational challenges beyond the technical API implementation.

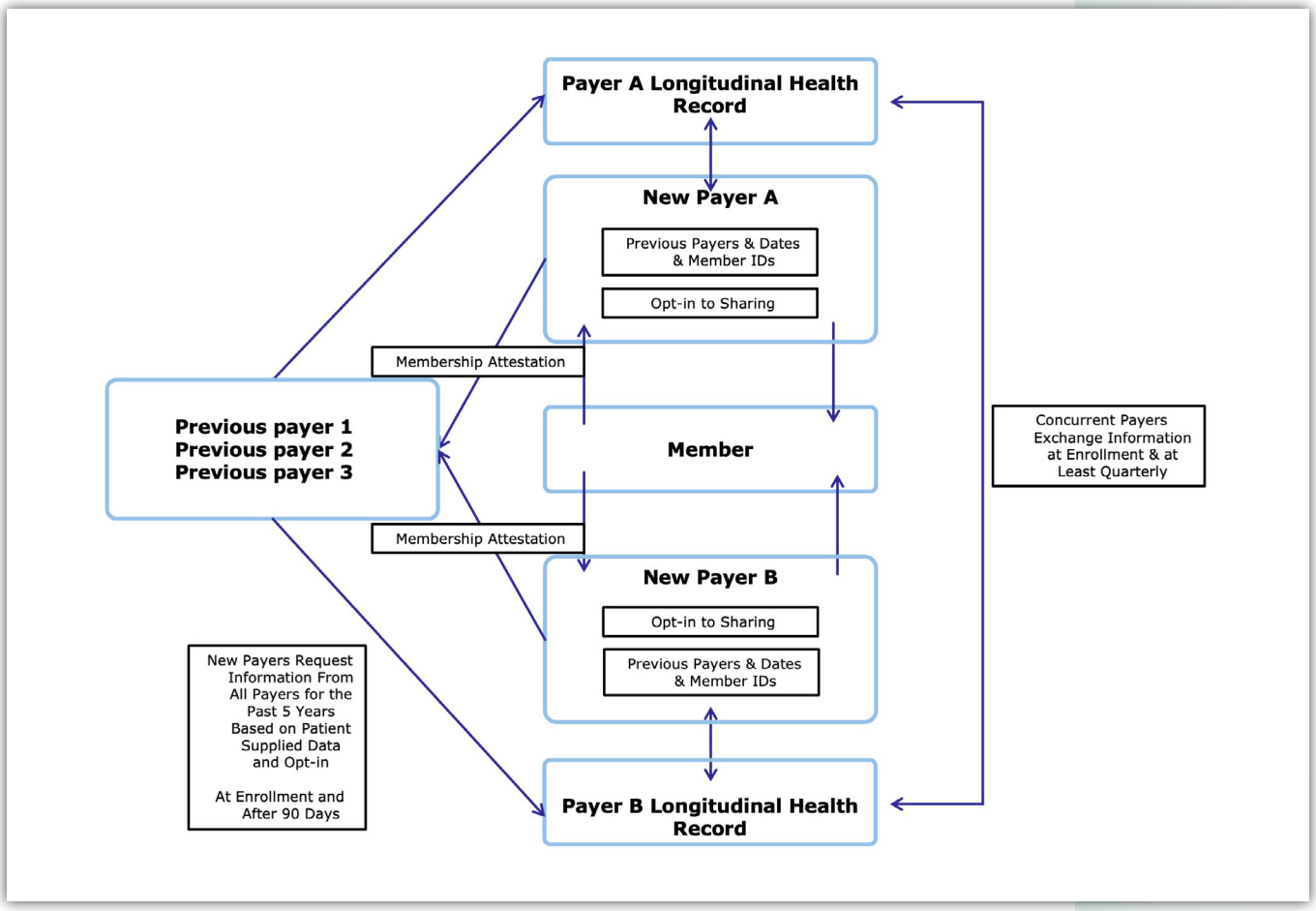

Figure 5. Overview of payer-to-payer exchange workflow for a dual eligible member.

Data Use Agreements and Testing

Coordinating with other payers on this complex set of processes and information exchanges will be challenging. In fact, CMS encourages connection and performance testing in sandbox instances of the API well before the effective date. They also recommend an early start to creating data use agreements and registering with each other's APIs for common information sharing partners.

Questions To Consider

- What are your best alternatives for streamlining documentation of opt-in status and prior enrollment of new members?
- Can your current systems incorporate retrieved information into a single longitudinal health record for each member?
- What tools do frontline staff need to act on data from other payers to improve care continuity for new and concurrent members?
- How will you match member identities for exchanging data with other payers?
- What is your strategy for testing connections with other payers?

Sharing Information with Members

Enabling members to view and track their own health data via their chosen personal health apps was a priority for CMS-9115-F and continues to be a priority with the new rule. In particular, the rule seeks to add transparency to the arcane and opaque prior authorization process. In theory, this will allow members to better manage and advocate for their own health and care.

Patient Access API

The Patient Access API mandated by CMS-0057-F allows patients and their personal representatives to access a patient's full record, as maintained by their payer from January 1, 2016 forward, through the health apps of their choice. As previously noted, included data elements are based on well-established standards like the United States Core Data for Interoperability (USCDI) and CARIN Blue Button and build on requirements for this API's precursor, the FHIR-based Patient Access API introduced in 2020 by CMS-9115-F. Continuing data requirements include:

- Adjudicated claims, provider remittances, and cost sharing
- Encounters with capitated providers
- Clinical data maintained by the payer, including lab results

Expansions to the underlying standards, which have been incorporated by the 2024 rule, will result in a richer data set. But the primary enhancement is the addition of information about prior authorization requests, excluding drugs. More specifically, starting on January 1, 2027, the Patient Access API must also include:

- Prior authorization data, such as status, date of approval/denial, denial reason, date or circumstance approval ends, and services approved, for all prior authorization requests made or with a status update in the past 12 months, regardless of whether submitted electronically or via other modalities.
- Structured administrative and clinical data submitted with such prior authorization requests. This includes any unstructured clinical data that has been parsed by the payer and then stored in a structured format.

Prior authorization data must be updated within one day of a status change (pending, active, denied, expired, authorization not required), and all maintained data must be made available for access within one day after a request.

Reporting Effective January 1, 2026

Beginning January 1, 2026, impacted payers must annually report to CMS metrics on the previous year's usage of the API. This means the first reporting period covers 2025 usage and may be based on the previous (CMS-9115-F) version of the API. Impacted payers must report:

- Total unique patients using the API to download data to an app
- Total patients downloading data more than once

The rule indicates that this data is only to be reported in the aggregate and will be used to help guide future policymaking, but not to compare payers. CMS has not specified the format and process for submitting the report but commits to providing them before submission becomes required.

Questions To Consider

- How can you consolidate member records from disparate sources for access through the API?
- Should you support third-party development of apps to increase member utilization of the API?
- Will inclusion of prior authorization information drive member interest in viewing their health plan data?

Sharing Information with Providers

The Provider Access API is an investment in IT infrastructure to advance value-based care. Until now, insufficient access to, and analytics on, comprehensive patient records have stymied the ability of many providers to effectively manage risk and improve population health. The Provider Access API should facilitate the flow of information those providers need to reduce care gaps and duplicative care, improve care coordination for patients with chronic conditions, and address social determinants of health, at both the individual patient and panel levels.

Provider Access API

The Provider Access API enables in-network providers with whom the patient has a verified treatment relationship to request, via their EHR, practice management, or other system, patient records maintained by the impacted payer from 2016 onward. The covered information mirrors that of the Patient Access API; payers must share the same data elements except remittances and cost sharing.

Included Data Elements	Excluded Data Elements

• Adjudicated claims
• Encounters with capitated providers
• Clinical data maintained by the payer
• Prior authorization data for all active prior authorizations and status updates except those concerning drugs) within the previous year, including:
  • Information about prior authorizations, regardless of modality
  • Structured administrative and clinical data submitted with prior authorization requests
	• Provider remittances
	• Member cost sharing
	• Unstructured data submitted as part of prior authorization requests

Table 4. Data elements available via the Provider Access API.

According to the Office of the National Coordinator (ONC), certified EHRs will be required to not only allow providers to request data via this FHIR-based API, but to store retrieved information as well. Furthermore, CMS-0057-F anticipates that providers may want to request records for multiple patients at once. For example, they may want to assess all appointments for the coming month. Therefore, the Provider Access API must support FHIR Bulk Data Access. However, also like the Payer-to-Payer API, payers must overcome a host of operational challenges to safely and accurately deploy their Provider Access API.

Attribution Process for Verifying Treatment Relationships

Before launching their Provider Access API, impacted payers must establish an attribution process to verify that a legitimate treatment relationship exists between the provider and the member for whom data has been requested. Most payers have an attribution process for purposes such as tracking performance measures by provider. However, attribution for the Provider Access API comprises a steeper challenge because there will be instances where there is no claims history for a provider requesting data for an initial appointment. The rule does not define a prescriptive approach but encourages payers to use and expand processes they already have in place, adding other attribution sources such as:

- Prospectively building patient rosters for Accountable Care Organizations (ACOs)
- Attestation by the provider
- Inferring upcoming appointments through coverage verification queries
- Harvesting information from hospital admission letters or scheduled appointments

CMS recognizes in the discussion portion of the rule that implementing a sufficient attribution process will be challenging. In fact, they cite the time required for payers to prepare and test any new or modified process as one reason for the 2027 implementation date. CMS says it will provide more information and education on potential attribution processes prior to the compliance date. In the interim, CMS suggests reviewing the attribution process in its Data at the Point of Care pilot for Medicare beneficiaries (the Medicare FFS version of the Provider Access API), which uses both a roster and an attestation approach. In addition, Da Vinci has a Member Attribution List workgroup that has created materials you can explore, including the Risk-Based Contracts Member Attribution List Implementation Guide that may be particularly helpful in deploying your process.

Opt-Out Process for Members

Impacted payers must also establish and maintain a mechanism for members, or patients, to opt out (and opt back in) to information sharing with their treating providers. In contrast to payer information sharing, the rule indicates that this kind of information sharing should be normal and expected. Hence, the member must take specific action to prevent it from happening, which should maximize utilization of this API and, in turn, pull forward its benefit to providers, patients and payers.

The rule, however, again provides only general guidance, rather than a specific mechanism, for implementing the process. It states that:

- At a minimum, members must be allowed to opt out of information sharing with all in-network providers
- It is preferred that members be able to opt out at a more granular level. For example, share their data with provider A but not with provider B

In sum, use of the Provider Access API is subject to a series of process determinations. As illustrated by Figure 6, before making covered data requested by providers available within the required one business day, impacted payers must first verify the provider's identity and relationship to the member, that the member does not opt out, and that disclosure is not prohibited by law.

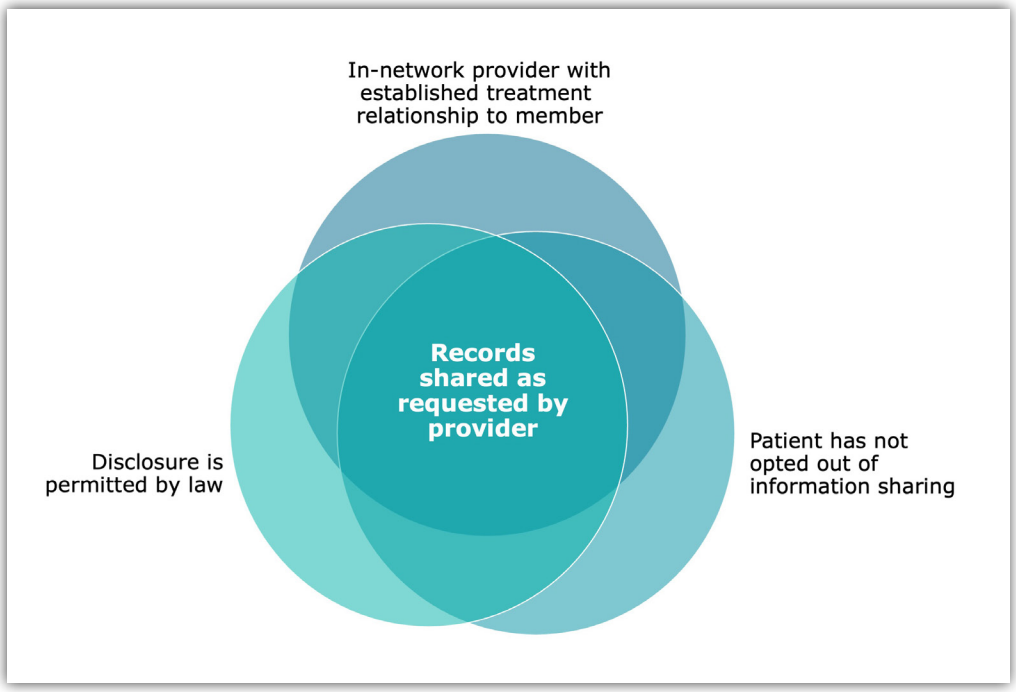

Figure 6. Intersecting provider access requirements.

Member and Provider Education

The rule obligates impacted payers to provide appropriate educational materials for both members and providers about the above processes, as summarized below.

Education for Members	Education for Providers

Must:
• Inform members their information will be shared with their providers unless they opt out
• Explain the opt-out (and back in) process:
  • Before the first date on which information will be shared via the API
  • No later than one week after the start of coverage
  • At least annually
• Explain the implications of opting out, such as a member's provider not having their full medical history when planning care
• Clarify that opting out does not prevent information sharing for other permitted purposes like payment
• Provide explanatory resources on their public website using plain language
	Must:
	• Include on their websites, and in other appropriate communications, plain language about how to request patient data using the Provider Access API.
	• Explain the attribution process used to associate patients with providers and verify provider identity
	
	Should:
	• Communicate updates, such as whether a request was received, attribution was successful, and a patient has opted out of sharing

Table 5. Educational obligations for impacted payers under CMS-0057-F.

Lastly, the rule provides that any fees charged per API call should be "necessary and reasonable" based on actual maintenance costs for that entity and encourages payers to permit providers to use their Provider Access API at no cost to maximize usage and benefits to patient care.

Questions To Consider

- What data sharing agreements and regulations govern provider access to your member data?
- What data or existing processes can you leverage to attribute members to new providers?
- Will you support opt-out at the individual provider level vs. an "all in or out" approach?
- How can you help your provider partners benefit fully from this new information sharing to achieve mutual performance goals?
- Can your systems provide data provenance for requested records?
- What safeguards are needed to prevent sensitive pieces of information from being wrongly shared?

ePA: Minimizing Inefficiency and Provider Abrasion

For much of the industry, the prior authorization requirements are the highlight of the new rule. The arcane and highly manual prior authorization workflows in place today are burdensome, frustrating, and costly to plans, patients, and providers and a major source of the provider abrasion contributing to caregivers leaving their professions. The prior authorization components of CMS-0057-F are intended to address what has become a very public flashpoint by streamlining and automating the required information flows, reducing response times, and introducing transparency to payer practices for all prior authorization except drugs, which are explicitly excluded from the rule.

Most of the timeliness and transparency requirements for prior authorization are subject to the rule's earlier effective date, January 1, 2026. The remainder of this section discusses each of these requirements individually plus the software most payers must implement by January 1, 2027, to deliver the functionality called the Prior Authorization API.

Readers should note that the comments below are general and do not address the specifics of individual plan types nor existing rules that these new requirements effectively supplement.

Prior Authorization Timeliness and Transparency Requirements Effective January 1, 2026

Specific Reason for Denials

Effective in 2026, impacted payers must supply the requesting provider with a specific reason when a prior authorization request is denied, regardless of submission method. The reason must be reported in a notice to the provider and included in the data set provided using the Patient and Provider Access APIs, when implemented. The reason must include sufficient detail for the requestor to know what action to take as follow-up.

CMS chose not to designate any code set for denial reasons but noted the list of standardized codes used when a prior authorization decision is sent to a provider via the adopted Health Insurance Portability and Accountability Act (HIPAA) standard, which is maintained by the Standards Development Organization (SDO) X12. They strongly encourage payers and providers to evaluate the suitability of that code set to meet this provision of the rule. They also suggest that payers make recommendations to X12 for updated or new denial codes, as appropriate.

Maximum Response Timeframes

Effective in 2026, impacted payers must communicate a decision on prior authorization requests within the following timeframes:

- Seventy-two hours for expedited requests (unless state law is less)
- Seven calendar days for standard requests, with some circumstances allowing an extension of up to 14 days

The rule aligns decision timeframes across the various impacted payer types, except for QHPs on FFEs, which are not included in the timeframe policy. There is no mechanism for automatically approving requests if the payer exceeds the deadline, nor enforcement provision built into the rule. Instead, CMS is relying on public reporting, as described below, to call out whether payers are, or are not, responding to prior authorization requests in a timely manner.

Public Reporting

Effective in 2026, impacted payers must post data about prior authorizations on their publicly facing websites. The effective start date of covered decisions, however, is far sooner. Reporting is expected to include the previous 12 months, meaning prior authorization decisions from the outset of 2025 will be reported.

CMS envisions this data being used by patients to assist in selecting plans, by providers in deciding whether to contract with a payer, and by payers themselves to understand their own trends for performance improvement. Accordingly, the rule calls for reporting in the aggregate across all non-pharmacy items and services and on all prior authorization modalities and methodologies used by the payer. For example, payers delegating prior authorization evaluation to third parties must capture that data and combine it with authorizations conducted directly by the payer. Specific data and metrics to be reported are:

- List of all items and services requiring prior authorization
- Percentage of standard prior authorization requests that were approved
- Percentage of standard prior authorization requests that were denied
- Percentage of standard prior authorization requests that were approved after appeal
- Percentage of prior authorization requests for which the timeframe for review was extended, and the request was approved
- Percentage of expedited prior authorization requests that were approved
- Percentage of expedited prior authorization requests that were denied
- 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
- 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

The rule does not define the format for this reporting but allows for CMS to provide formatting guidance or examples in the future. It does specify that the level of required reporting varies by program:

- State level for state Medicaid and CHIP FFS programs
- Plan level for Medicaid MCPs and CHIP managed care entities
- Issuer level for QHP issuers on the FFEs
- Contract level for Medicare Advantage organizations

The rule provides additional details for integrated plans.

Prior Authorization API Mandate Effective January 1, 2027

The Prior Authorization API is the mechanism CMS has mandated to support automated or electronic prior authorization, also known as ePA, to mitigate the outsized burden that exists today. The rule permits the use of any FHIR-based API that accomplishes the mandated functions:

- Determination of whether an item or service (excluding drugs) requires prior authorization
- Identification of the payer's specific documentation requirements for approval
- Facilitation of the electronic exchange of prior authorization requests and responses

Nonetheless, it strongly endorses adoption of the Da Vinci implementation guides for prior authorization and encourages impacted payers to participate in Da Vinci use case workgroups and reference use case materials and pilot experience.

The Da Vinci implementation guides define three primary APIs to collectively meet the Prior Authorization API mandate by 2027:

- Coverage Requirements Discovery (CRD) - which enables providers to determine whether a service is covered and if prior authorization is required, generally using an approach known as CDS Hooks
- Documentation Templates and Rules (DTR) – which supports electronic submission of required supporting data directly from the EHR and via computable FHIR questionnaires,
- Prior Authorization Support (PAS) – which handles the overall orchestration of the process and communicates the outcome of the request

Da Vinci participants have demonstrated the viability of their prior authorization approach through several successful pilots, and CMS expresses confidence that their implementation guides will be ready for use at scale by the effective date. Da Vinci pilot projects continue to expand and explore not only the use of these guides, but opportunities to leverage national networks such as the eHealth Exchange in a hub and spoke model to limit the number of point-to-point connections required between impacted payers and their network providers.

Additionally, Health and Human Services (HHS) has announced enforcement discretion of the transaction standards governing ePA. HIPAA technically requires the use of the X12 278 standard as part of the API implementation. To promote efficiency, the enforcement discretion gives payers the option to use FHIR only, FHIR and X12 in combination, or X12 only for ePA.

Likewise, CMS declined to specify a format for submitting unstructured data to support prior authorization requests but expressly permits the use of the Da Vinci Clinical Data Exchange API, CDex, which offers several other benefits for entities working to transmit clinical data from providers to payers.

The rule discourages payers from adding any new charges to providers for use of the Prior Authorization API. While provider adoption of this API will rest largely on its ability to streamline a cumbersome process and reduce provider abrasion, it's clear that CMS wants to drive the shift to ePA through any appropriate means and is particularly supportive of the Da Vinci approach.

Sharing Prior Authorization Data Via the Access APIs

The prior authorization and access API mandates ultimately intersect. As already discussed, information about prior authorizations must be made available by all three access APIs, again regardless of the submission modality employed. Table 6 summarizes these data requirements for each access API.

	Payer-to-Payer	Patient	Provider
Timeframe	Past 12 months		
Scope	All submissions with a status update, except denied requests	All submissions with a status update	All submissions with a status update
Status data	Status Date approved Approved services End date/event	Status Date approved Approved services End date/event Denial reason	Status Date approved Approved services End date/event Denial reason
Supporting clinical data	Structured and unstructured	Structured	Structured

Table 6. Prior authorization data requirements by access API

So, while CMS-0057-F only requires public reporting of aggregate payer data on prior authorization, providers and other payers will have a window into how a payer is performing on individual prior authorization requests through the bulk download functionality their respective APIs must support.

Questions To Consider

- What groups or team members within your organization will own the implementation and rollout of ePA?
- Have you put in place cross functional teams and workgroups to ensure IT, UM, Case Management, and other departments can collaborate to optimize your ePA solution?
- What systems are in scope for your ePA deployment? Can they communicate electronically?
- How will you automate data exchanges between your Prior Authorization API and your clinical rules engine?
- What steps in your prior authorization process account for the dominant share of provider abrasion? How can you best leverage your investment in ePA to streamline provider workflows for those touchpoints?
- How will you capture and integrate data on manual or delegated prior authorizations within your reporting?
- What elements of the prior authorization process would your providers prioritize to reduce abrasion?

Extending Value Beyond Impacted Payers

While not every payer type is impacted by CMS-0057-F, nearly every payer organization includes one or more impacted health plans. Given tight timeframes for compliance, it is reasonable for larger payer organizations to focus initially on your impacted products or entities. But the solutions your organization implements must readily scale to all lines of business to maximize your return on investment in needed IT infrastructure and process changes. Consider:

- Payer-to-payer information sharing can benefit all members by significantly extending the data set available to your organization for decision making, care management, strategic planning, and risk assessment.
- Available member information may have low usage rates today, but most consumers rate the digital front doors provided by payers quite poorly. Looking at other sectors, introducing APIs needed to support an app-based ecosystem for members could meaningfully improve member experience.
- Network adequacy is a challenge for all health plans, and provider abrasion is contributing to a widespread shortage of caregivers. Making life easier for them with information sharing and automated prior authorization is an obvious investment in better relationships.
- Current prior authorization processes are burdensome to members and payer staff at all other plan types as well. Timely, transparent adjudication of prior authorizations would be a universal member satisfier, and expected time savings from automation will allow you to redeploy resources to higher value services such as care management.

What Next?

Determining the right investment for your organization to achieve compliance with CMS-0057-F and advance larger strategic aims can be challenging. The rule's API mandates don't focus on improvements to end-user interfaces that business leaders and clinicians can readily evaluate. Instead, they require upgrades to underlying data infrastructure to fuel the future flow of information still hidden in data siloes and, hopefully, the development of an app-based ecosystem for healthcare. Put another way, payers must now determine how best to increase the horsepower of an engine for a car that is still being designed and is subject to regulatory changes and new standards. InterSystems is heavily invested in helping payers overcome this challenge.

For decades, we have partnered with public and commercial payers to design and implement cost-effective solutions for connecting disparate data sources to enhance operations, increase care continuity, reduce waste, and address data-related regulatory mandates. Today, more than two-thirds of the US population benefit from our solutions.

60%
of the five largest US payers rely on InterSystems technology

220 million+
US citizens have a health record in a solution powered by InterSystems

1 billion+
health records maintained daily by InterSystems technology globally

InterSystems technology is recognized for its scalability and interoperability, so our solutions can meet your immediate data management needs without narrowing future strategic options. We can help you:

- Deploy a longitudinal health record that integrates claims, clinical, and SDOH data from disparate sources
- Deploy access and prior authorization APIs that meet regulatory requirements
- Automate the exchange of clinical data needed to close HEDIS gaps and improve STARS ratings
- Populate care management dashboards and other payer tools for advancing value based care
- Manage member identities across multiple data sources
- Maintain a current and accurate provider directory

As you map your path to compliance with the Interoperability and Prior Authorization Final Rule, InterSystems offers a flexible route to value – from a single API to a comprehensive platform.

To speak with a subject matter expert, schedule a demo, or book a white-boarding session, contact us at InterSystems.com/PayerAPIs

Appendix: Standards and Implementation Guides Referenced

API	Required Standards*	Recommended Implementation Guides
Patient Access API	• 45 CFR 170.215(a) (1) HL7 FHIR Release 4.0.1 • 45 CFR 170.215(b)(1) (i) HL7 FHIR US Core IG STU 3.1.1.*** • 45 CFR 170.215(c) (1) HL7 SMART Application Launch Framework IG Release 1.0.0.*** • 45 CFR 170.215(e) (1) OpenID Connect Core 1.0, incorporating errata set 1	• HL7 FHIR CARIN Consumer Directed Payer Data Exchange (CARIN IG for Blue Button®) IG STU 2.0.0. URL: **http://hl7 org/fhir/us/carin-bb/history.html** • HL7 FHIR Da Vinci Payer Data Exchange (PDex) IG STU 2.0.0. URL: **https://hl7 org/fhir/us/davinci-pdex/history. html** • HL7 FHIR Da Vinci - Payer Data Exchange (PDex) US Drug Formulary IG STU 2.0.1. URL: **http://hl7.org/fhir/us Davinci-drug-formulary/history. html**
Provider Access API	• 45 CFR 170.215(a)(1) HL7 FHIR Release 4.0.1 • 45 CFR 170.215(b)(1) (i) HL7 FHIR US Core IG STU 3.1.1.*** • 45 CFR 170.215(c)(1) HL7 SMART Application Launch Framework IG Release 1.0.0.*** • 45 CFR 170.215(d)(1) FHIR Bulk Data Access (Flat FHIR) IG (v1.0.0: STU 1)	• HL7 FHIR CARIN Consumer Directed Payer Data Exchange (CARIN IG for Blue Button®) IG STU 2.0.0. URL: **http://hl7 org/fhir/us/carin-bb/history.html** • HL7 FHIR Da Vinci Payer Data Exchange (PDex) IG STU 2.0.0. URL: **http://hl7.org fhir/us/davinci-pdex/history.html** • 45 CFR 170.215(c)(2) HL7 SMART App Launch IG, Release 2.0.0 to support Back end Services Authorization. URL: **https:/ hl7.org/fhir/smart-app-launch/ STU2 backend-services.html**
Payer-to-Payer API	• 45 CFR 170.215(a)(1) HL7 FHIR Release 4.0.1 • 45 CFR 170.215(b)(1) (i) HL7 FHIR US Core IG STU 3.1.1.*** • 45 CFR 170.215(d)(1) FHIR Bulk Data Access (Flat FHIR) IG (v1.0.0: STU 1)	• HL7 FHIR Consumer Directed Payer Data Exchange (CARIN IG for Blue Button®) IG STU 2.0.0. URL: **http://hl7 org/fhir/us/carin-bb/history.html** • HL7 FHIR Da Vinci Payer Data Exchange (PDex) IG STU 2.0.0. URL: **http://hl7.org fhir/us/davinci-pdex/history.html** • 45 CFR 170.215(c)(2) HL7 SMART App Launch IG, Release 2.0.0 to support Backend Services Authorization. URL: **https://hl7.org/fhir/smart-app launchSTU2/backend-services.html**
Prior Auth API	• 45 CFR 170.215(a)(1) HL7 FHIR Release 4.0.1 • 45 CFR 170.215(b)(1) (i) HL7 FHIR US Core IG STU 3.1.1.*** • 45 CFR 170.215(c)(1) HL7 SMART Application Launch Framework IG Release 1.0.0.***	• HL7 FHIR Da Vinci - Coverage Requirements Discovery (CRD) IG STU 2.0.1. URL: **http://hl7.org/fhir/us/da-vinci-crd/history.html** • HL7 FHIR Da Vinci - Documentation Templates and Rules (DTR) IG STU 2.0.0. URL: **http://hl7.org/fhir/us/davin-ci-dtr/history.html** • HL7 FHIR Da Vinci Prior Authorization Support (PAS) IG STU 2.0.1. URL: **http:// hl7.org/fhir/us/davinci-pas/history. html**
Provider Directory API**	• 45 CFR 170.215(a)(1) HL7 FHIR Release 4.0.1 • 45 CFR 170.215(b)(1) (i) HL7 FHIR US Core IG STU 3.1.1.***	• HL7 FHIR Da Vinci Payer Data Exchange (PDex) Plan Net IG STU 1.1.0. URL: **http://www.hl7.org/fhir/us/davinci-pdex-plan-net/history.html**

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*CMS made modifications to the required standards listed in this table from what was originally listed in Table 10 of the CMS Interoperability and Prior Authorization proposed rule (87 FR 76320).
**CMS removed the references to 45 CFR 170.215(c) SMART App Launch IG and 45 CFR 170.215(e) OpenID Connect Core for the Provider Directory API that were mistakenly included in the proposed rule. Security protocols related to user authentication and authorization are excluded from the requirements for the Provider Directory API (for MA organizations at 42 CFR 422.120 (a), for Medicaid at 42 CFR 431.70(a), and for CHIP at 42 CFR 457.760(a)). For more information see the discussion in the CMS Interoperability and Patient Access final rule at 85 FR 25560.
*** In the HTI-1 final rule, ONC finalized expiration dates for several of these required standards to indicate when a version of a standard may no longer be used (89 FR 1192). CMS intends to align with updated versions finalized at 45 CFR 170.215 through future rulemaking prior to the API compliance dates.