CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F)

Why CMS-0057-F is so Strategically Important to all Health Plans

The technology components of the new "CMS Interoperability and Prior Authorization Final Rule" (CMS-0057-F) will take effect in 2027 for "impacted payers", with reporting and procedural elements taking effect in 2026. The rule builds on the 2020 CMS Interoperability and Patient Access Final Rule (CMS-9115-F) which promoted Application Programming Interface (API)-based access to member health records.

We often get questions about why this rule is so strategically important to all health plans – not just those explicitly named in the rule. Below are some answers to those questions.

Which payers are impacted?

Some 365 Medicare Advantage organizations, State Medicaid and CHIP Fee-for-Service programs, Medicaid managed care plans and CHIP programs, and Qualified Health Plan issuers on the Federally Facilitated Exchanges are all legally obliged to comply with the regulation. CMS has also stated that it will work to align Medicare FFS plans with the rule.

But more importantly, since the goal of the rule is to benefit providers, payers and their members, the explicit hope is that all US health insurers will adopt the data sharing and automation mandated by the rule, even though they have more latitude for doing so.

Can you summarize the key elements of the rule?

There are 4 key technical elements, along with process changes, reporting and some incentives to encourage provider participation. There is also an implied 5th technical element not specifically called out, but essential to the goals of the rule.

- It expands the set of data payers must make available to members via the Patient Access API that was implemented for CMS-9115-F. This is an HL7® FHIR®-based API. Shared data must now include information about prior authorization status and decisions. And payers must report on the usage of the API.
- It requires payers to share the data they have about members with in-network providers treating those members if the provider asks for the data and the member doesn't opt out. This requires use of a FHIR Provider Access API, and it also includes information about prior authorization status and decisions.
- It requires data sharing via a FHIR Payer-to-Payer API between a payer and other payers covering that member, if the member opts in. This applies when an individual changes payers, or has concurrent coverage. This data includes prior authorization information and is to be used to facilitate care coordination
- It mandates the adoption of electronic prior authorization processes using a Prior Authorization API. While the regulation includes only minimal details on these processes, it strongly recommends adoption of the HL7 Da Vinci Project's implementation guides and workflows. It also requires authorization decisions within narrow windows, and public reporting of metrics about authorizations. Note that since prior authorization is a two-sided transaction, there are financial incentives for providers to adopt the new processes and report on that adoption.
- The implied 5th technical element is a longitudinal health record. Throughout the rule, there are references to sharing with providers and patients the aggregated health data payers will now have about their members due to payer-to-payer information sharing. The proposed rule called longitudinal health records out explicitly; the final rule implies them throughout.

Q3 Why all this focus on interoperability and FHIR?

Interoperability ensures that data moves easily, and that sender and receiver understand information the same way. That creates data liquidity, which means that data can be used to streamline business processes, to enhance the member experience, to measure and improve care, and for analytics and AI. And because the FHIR standard is consistent with modern app development, the mandate also facilitates the creation of new apps to help individuals and healthcare organizations leverage that liquid data for their own benefit.

Q4 How can this rule support the strategic goals of a health insurer like my organization?

Beyond the benefits CMS projects for all – things like increased business efficiency, improved outcomes, burden reduction, and empowered patients – payer organizations that treat the proposed regulation as a foundational investment in their strategic goals will benefit even further. For instance:

- For many members, their insurer's digital front door is an unwelcoming portal filled with out of data in network provider data, and confusing terminology. But a catalog of FHIR-based health management apps, access to information about all their care and payment data, and culturally sensitive educational materials designed for their needs can transform the member experience.
- Going beyond "check the box" for the proposed rule, and investing in FHIR, longitudinal health records, and a culture of data transparency can be a competitive game changer by providing a rich source of planning data for new products and for tuning your provider networks.
- Your innovation team can capitalize on the institutional knowledge you acquire as you make use of FHIR, and can either develop, or invest in, digital first capabilities to enhance the member experience and drive down the cost of chronic care management.
- Your analytics team will have a richer source of information for managing populations, evaluating the comparative outcomes of alternative care management strategies, and measuring the impact of new digital health solutions. To say nothing of a deeper data set for machine learning.

Q5 How has this kind of investment has provided value to a plan like ours?

Consider just one example. Healthfirst, a not-for-profit, hospital-sponsored health plan in the greater New York City area, was an early adopter of longitudinal health records. Long before the widespread use of FHIR and CMS interoperability mandates, they implemented InterSystems HealthShare Unified Care Record to unite clinical and claims data from around 700 facilities in near real-time. They also share data back with network providers to help coordinate care and identify gaps. Today, this longitudinal data is used to manage 20 high priority performance measures, particularly those that require follow up action within a defined window of time. Kate Beck, AVP of Health Information Exchange at Healthfirst comments:

> ***"This data isn't just for addressing quality measures. The real time data from our HIE enables us to reach out to our members when it matters the most, in the ED or inpatient setting or during transitions of care. It's a very personal interaction we can have that wouldn't be possible otherwise. It certainly builds stronger bonds between us and our members."***

Q6 How do we get started?

The first step is to find the right partner for your interoperability journey.

InterSystems has been a leader in digital health since its inception. We understand interoperability – in fact – we're Da Vinci Project members and have been active members of the healthcare standards community for decades. We understand longitudinal health records – InterSystems **HealthShare Unified Care Record** is used by health insurers, providers, and regional health networks to manage comprehensive claims, clinical, operational, and social health data for hundreds of millions of people. We understand digital health solution development – InterSystems **IRIS for Health** is at the heart of the most established health IT solutions in the world and is the basis for some of the most innovative startups.

Contact us today to discuss your partnership needs.

You can find resources and links to educational materials and fact sheets **here**. These will be updated when the rule is finalized, and new materials are added regularly.

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