



# **WEDI Spotlight: CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F)**

February 17, 2026

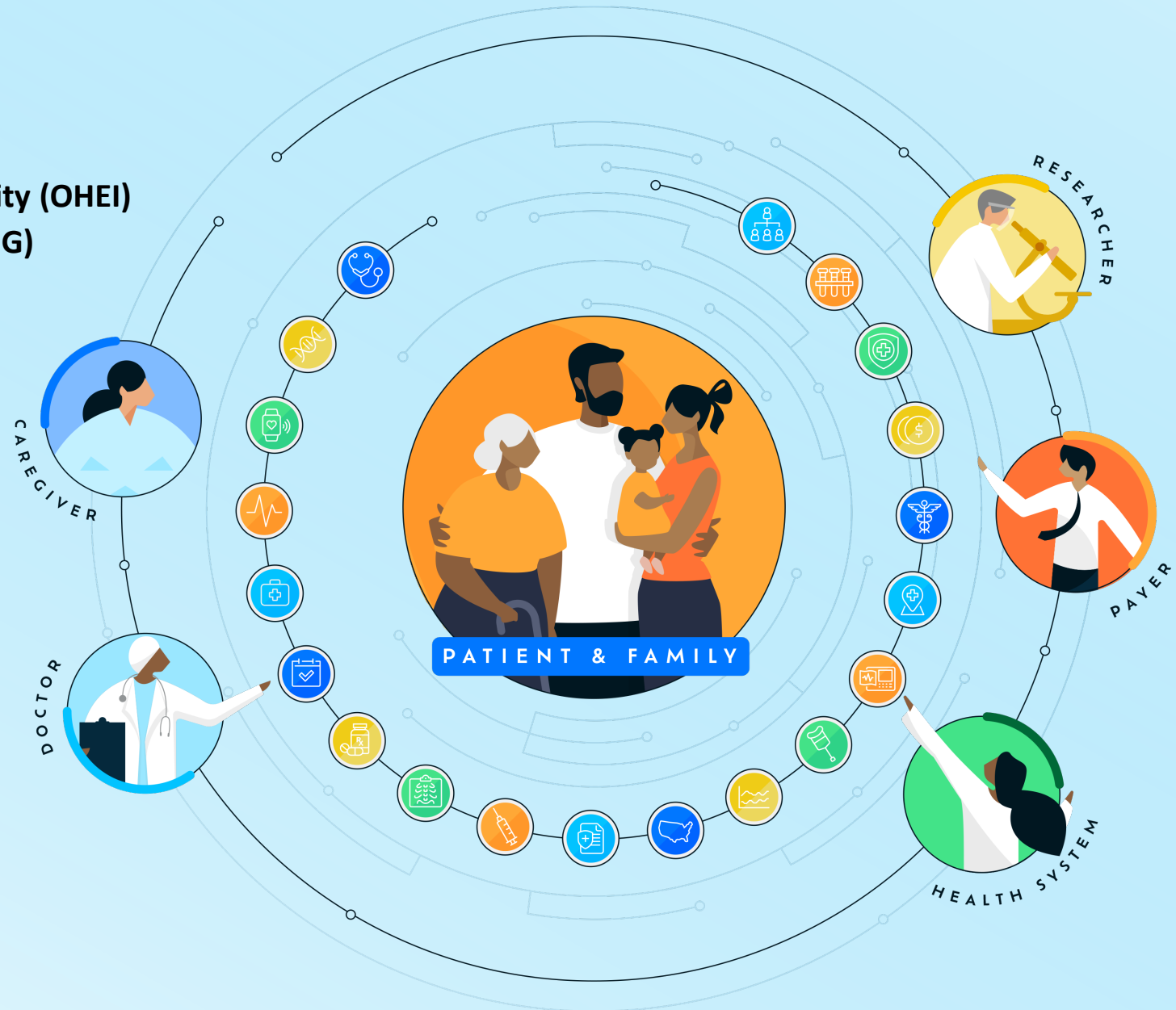


# Who We Are

**Office of Healthcare Experience and Interoperability (OHEI)  
Health Informatics and Interoperability Group (HIIG)**

**Mission:** Promote the secure exchange, access, and use of electronic health information to support better informed decision making and a more efficient healthcare system.

**Vision:** A secure, connected healthcare system that empowers patients and their providers to access and use electronic health information to make better informed and more efficient decisions.



# CMS-0057-F Application Programming Interfaces (APIs)



# CMS-0057-F – Improving Prior Authorization Processes





# Prior Authorization API

Beginning January 1, 2027



## **API REQUIREMENT**

Impacted payers must implement and maintain a Prior Authorization API.



## **IDENTIFYING WHETHER AN ITEM OR SERVICE REQUIRES PRIOR AUTHORIZATION**

The API must be populated with the list of items and services (excluding drugs) that require prior authorization from the payer.



## **PAYER-SPECIFIC DOCUMENTATION REQUIREMENTS**

The API must identify the payer's documentation requirements for all items and services (excluding drugs) that require a prior authorization request.



## **EXCHANGING PRIOR AUTHORIZATION REQUESTS AND RESPONSES**

The API must support the creation and exchange of prior authorization requests from providers and responses from payers.



# Improving Prior Authorization Processes

Beginning January 1, 2026



## **PRIOR AUTHORIZATION DECISION TIMEFRAMES**

Certain impacted payers are required to send standard prior authorization decisions within 7 calendar days and expedited prior authorization decisions within 72 hours. This policy change for standard decisions does **not** include QHP issuers on the FFEs.



## **PROVIDING A SPECIFIC REASON FOR DENIAL**

Payers must provide a specific reason for a prior authorization denial.



## **PRIOR AUTHORIZATION METRICS**

Impacted payers are required to report certain metrics about their prior authorization processes on their public website on an annual basis. This includes the percent of prior authorization requests approved, denied, approved after appeal, and average time between submission and decision.



# Metrics Required for Public Reporting/Posting



## Improving Prior Authorization Processes

### **PRIOR AUTHORIZATION METRICS**

Starting in 2026, impacted payers are required to annually report the following prior authorization metrics on their public website.

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

In the first year of the requirement, **payers must report CY 2025 data by March 31, 2026.**



# Who\* Must Report Prior Authorization Metrics?

- ✓ State Medicaid FFS programs - report at **state** level
- ✓ Medicaid managed care plans - report at **plan** level
- ✓ CHIP FFS programs - report at **state** level
- ✓ CHIP managed care entities - report at **plan** level
- ✓ Medicare Advantage orgs- report at **contract** level
- ✓ QHP Issuers on the FFEs – report at the **issuer** Level



# Standard (7 calendar days) Request Metrics

## Overall Approval and Denial Rates

- **Percentage approved:**  $\text{Approved} / \text{Total requests}$
- **Percentage denied:**  $\text{Denied} / \text{Total requests}$

**Highlight** = Optional Metric

## Extensions

- **Percentage approved with 7 days:**  $\text{Approved within timeframe} / \text{Total requests}$
- **Percentage denied within 7 days:**  $\text{Denied within timeframe} / \text{Total requests}$
- **Percentage approved after extension:**  $\text{Approved after extension} / \text{Total Requests}$
- **Percentage denied after extension:**  $\text{Denied after extension} / \text{Total Requests}$



# Standard (7 calendar days) Request Metrics Ctd.

## Appeals

- **Percentage approved after appeal:**  $\text{Approved on appeal} / \text{Total appeals}$
- **Percentage denied after appeal:**  $\text{Denied on appeal} / \text{Total appeals}$

## Response Times

- **Mean (average) time**
- **Median (middle) time**
- **Measured from:** When payer receives request → when determination is sent



# Expedited (72 Hours) Request Metrics

## Overall Approval and Denial Rates

- **Percentage approved:**  $\text{Approved} / \text{Total requests}$
- **Percentage denied:**  $\text{Denied} / \text{Total requests}$

## Extensions

- **Percentage approved with 72 hours:**  $\text{Approved within timeframe} / \text{Total requests}$
- **Percentage denied within 72 hours:**  $\text{Denied within timeframe} / \text{Total requests}$
- **Percentage approved after extension:**  $\text{Approved after extension} / \text{Total Requests}$
- **Percentage denied after extension:**  $\text{Denied after extension} / \text{Total Requests}$



# Expedited (72 Hours) Request Metrics Ctd.

## Appeals

- **Percentage approved after appeal:**  $\text{Approved on appeal} / \text{Total appeals}$
- **Percentage denied after appeal:**  $\text{Denied on appeal} / \text{Total appeals}$

## Response Times

- **Mean (average) time**
- **Median (middle) time**
- **Measured from:** When payer receives request → when determination is sent

# Response Time Calculations

## Time Measurement

- **Use calendar days/hours** (NOT business days)
- **Include weekends and holidays** in elapsed time
- **Standard requests:** Report in days
- **Expedited requests:** Report in hours or days

### Example Scenario

Request received: Friday, March 1 at 2:00 PM

Determination sent: Monday, March 4 at 10:00 AM

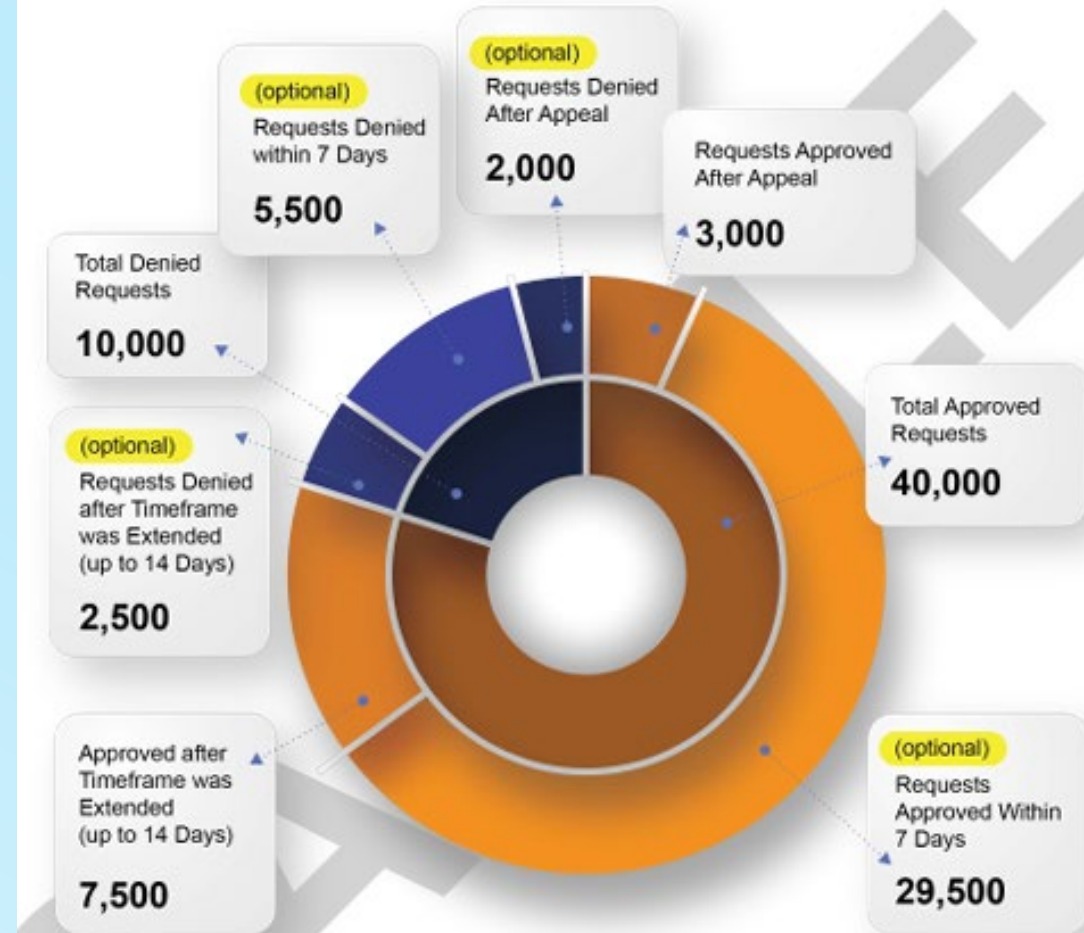
**Elapsed time: 2.8 days (68 hours)**  
**NOT 1 business day!**

## Reporting Metrics

- CMS has published a sample prior authorization metrics reporting [overview and template](#). This particular template is not required to be used.
- CMS has released similar metrics for Medicare Fee-For-Service that provide one example of how [Prior Authorization and Pre-Claim Review Stats](#) may be published.

In 2024, we received a total of 50,000 standard (non-urgent) prior authorization requests for our covered patients.

80% of those requests were approved:



The mean (average) time that it took to make standard prior authorization decisions was

**5 days**

The median (middle) time that it took to make standard prior authorization decisions was

**4 days**



# CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F) Requirements Compliance Dates

Policy Area	Key Requirements	Compliance Dates/Deadlines
<b>Patient Access API</b> <i>Established in CMS-9115-F</i>	✓ Report API use metrics to CMS	<b>March 31, 2026</b>
	✓ Add prior authorization information to API	January 1, 2027
<b>Improve Prior Authorization Policies</b>	✓ Shorten prior authorization decision timeframes	<b>January 1, 2026</b>
	✓ Communicate a specific prior authorization denial reason	<b>March 31, 2026</b>
	✓ Publicly reporting prior authorization decision metrics	
<b>Provider Access API</b>	✓ Implement and maintain a FHIR-API to give providers electronic access to patient health information	January 1, 2027
<b>Payer-to-Payer API</b>	✓ Implement and maintain a FHIR API to give a patient’s new or concurrent payer electronic access to patient health information	January 1, 2027
<b>Prior Authorization API</b>	✓ Implement and maintain a FHIR API for providers to submit and track prior authorization requests electronically	January 1, 2027
<b>MIPS and Promoting Interoperability Measures</b>	✓ Report Electronic Prior Authorization attestation measure	CY 2027 MIPS performance/CY 2027 EHR reporting period



# CMS Unified Agenda

## Interoperability Proposed Rule Under Development

**Title:** Interoperability Standards and Prior Authorization for Drugs (CMS-0062)

**Agenda Stage of Rulemaking:** Proposed Rule Stage

**Timetable:** TBD

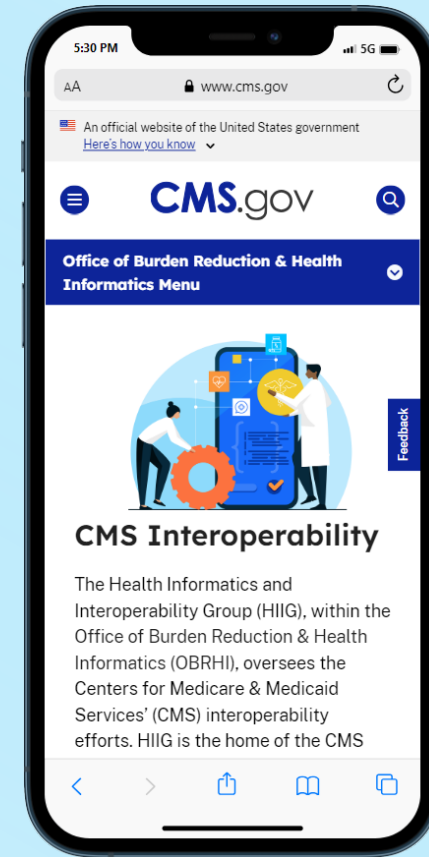
This rule would propose new requirements for Medicare Advantage (MA) organizations, state Medicaid fee-for-service (FFS) programs, state Children's Health Insurance Program (CHIP) FFS programs, Medicaid managed care plans, CHIP managed care entities, and Qualified Health Plan (QHP) issuers on the Federally-facilitated Exchanges (FfEs) to streamline processes for the prior authorization for certain drugs. We are developing this rule, in part, based on the significant number of public commenters who responded to the CMS Interoperability and Prior Authorization proposed rule (87 FR 76238) urging CMS to expand the proposed prior authorization policies to include drugs.



# CMS Interoperability Resources

## Available Resources for Interoperability Policies and Regulations

- [2024 CMS Interoperability and Prior Authorization final rule:](#)
  - Final rule
  - Fact Sheet
  - Recording and slides from the CMS Interoperability and Prior Authorization final rule informational session held March 26, 2024
  - Best Practices for Patient and Provider Educational Resources (Provider Access and Payer-to-Payer APIs)
- [2020 CMS Interoperability and Patient Access final rule:](#)
  - Federal Register
  - Fact Sheet
  - Guidance for States
  - Best Practices for Payer and App Developers
  - Privacy and Security Resources
- [Frequently Asked Questions](#) about the CMS Interoperability rules



Visit [our website](#) for additional resources and information!



## Questions?

E-mail the CMS Health Informatics and Interoperability Group (HIIG) at:  
[CMSInteroperability@cms.hhs.gov](mailto:CMSInteroperability@cms.hhs.gov)