

Provider: Understanding CMS-9115, CMS-0057, and Health Data, Technology, and Interoperability (HTI) Regulatory Rules

CMS Interoperability and Patient Access Final Rule (CMS-9115)

In 2020, Centers for Medicare & Medicaid Services (CMS) finalized the Interoperability and Patient Access Final Rule (CMS-9115-F) to advance patient-centered care by improving access to health information and driving interoperability across the healthcare system. This rule emphasizes giving patients timely, electronic access to their health data so they can make more informed decisions about their care.

CMS-9115-F applies to Medicare Advantage (MA) organizations, Medicaid, Children's Health Insurance Program (CHIP) programs, and Qualified Health Plan (QHP) issuers on the Federally Facilitated Exchanges (FfEs). Through CMS's regulatory authority, the rule establishes requirements that enable patient data to move more freely and securely across payers, patients, and providers.

What does this mean for providers?

A core objective of CMS-9115-F is to support care coordination and informed clinical decision-making by ensuring that patients can access their health information and share it using third-party applications of their choice (such as apps on a smartphone or computer). When patients use these tools, they can better understand their medical history, prior services, and costs—enabling more productive conversations with you about treatment options, provider selection, and care planning.

While the rule's primary requirements are directed at payers, providers are an important part of the interoperability ecosystem. As patients gain increased access to their data and choose to share it, providers may see patients arrive better informed and more engaged in their care. Over time, this increased transparency is intended to reduce administrative burdens, support continuity of care, and improve overall patient experience.

Why does this matter in clinical practice?

- Patients can access their health information electronically
- Patients may share payer-sourced data with providers using third-party apps
- More complete information can support clinical discussions and care decisions
- Interoperability standards help reduce fragmentation and delays in care

What is CMS-0057 and what does it mean for providers?

CMS-0057 is a new rule from the Centers for Medicare & Medicaid Services (CMS) meant to make health care simpler, faster, and easier to understand.

Why did CMS create this rule?

Many patients experience:

- Long waits for insurance approval
- Confusing or unclear denial letters
- Difficulty finding information about what was approved or denied

CMS-0057 was created to reduce paperwork, decrease wait time, and keep patients better informed.

For patients, it improves how their health information is shared. Patients can:

- Easily access their health information
- Get faster decisions from insurance
- Better understand their care and coverage

For providers, it is intended to reduce administrative burden and support care coordination by enabling more standardized, secure digital access to payer data and prior authorization (PA) information.

- **Provider Benefit:** Increases efficiency by embedding workflows directly within your Electronic Health Record (EHR), minimizing disruption to clinical and administrative processes. You are no longer forced to leave your EHR to complete tasks such as prior authorizations.

CMS-0057 builds upon the May 2020 CMS Interoperability and Patient Access final rule implementing policies that improve patient, provider, and payer access to interoperable patient data and reduces the burden of the prior authorization processes.

CMS-0057 Application Programming Interfaces (APIs) and benefits:

CMS-0057 requires software tools called “Application Programming Interfaces (APIs)” to be used to help doctors and health plans easily share information. This helps patients get the right care faster, with less waiting and confusion, while staying in control of their health information. The APIs are listed below. More information about each API is provided in the sections that follow.

- Patient Access* and Provider Directory APIs
- Payer-to-Payer (Health Plan-to-Health Plan) API

- Provider Access API
- Electronic Prior Authorization API

Patient Access¹ and Provider Directory APIs (Upgraded CMS-91152)

Approved apps can show your patient their health information, a list of covered medicines, and doctors in their health plan. These apps can also show basic plan details, prior approval updates, and more health information to help patients take better care of their health. Additionally, patients can access historical data and current information from their health plan.

- What will my patients see in their health information account?
 - They will have access to health information dating back to Jan. 1, 2016.
 - Depending on the health app they download to their phone, different features and information may be available. Each approved third-party health app works hard to create the best user experience for your patients. They will be able to see:
 - Health plan information such as coverage type and Member ID (Medicaid ID)
 - An explanation of plan benefits including insurance payments and the amount paid
 - A history of their previous medical procedures
 - A list and descriptions of their medical conditions as recorded by their provider
 - Medication history, including vaccinations or immunization history
 - A list of providers and organizations involved in their care delivery¹
 - Their health app may provide additional helpful features to help them take control of their healthcare*
 - Patients will have access to prior authorization requests and decisions (excluding those for prescription medicine) helping them understand their insurance plan's prior authorization process and its impact on their care¹
Examples may include:
 - Whether prior approval is needed for certain medical items and services (when their plan makes this available)
 - The status of a request (for example: submitted, in review, approved, denied, or needing more information)
 - Decision information (for example: approved, denied, and the reason for denial when applicable)

¹ Health app features may vary depending on the app the patient chose. Each health app determines what information is provided and services offered.

²The prior authorization requirement must be implemented by January 1, 2027, as part of the enhancement to the Patient Access API for CMS-0057.

Payer-to-Payer (Health Plan to Health Plan) API (CMS-0057)

Health plans can share billing and visit information with other health plans. This helps make switching health plans easier for your patients and reduces extra work. The health plan they are enrolled in can request appropriate information from their prior health plan. If your patient has multiple health plans, they are able to share your patient's data to coordinate coverage

Your patient's data will not be shared with plans in which they are not enrolled

Your patient's new health plan can see up to 5 years of health information from your patient's prior health plan when they switch plans. This helps avoid repeated tests, delays in care, and unnecessary costs, so care can continue more smoothly.

Patient's must give permission, or consent, for their new health plan to request their data from their prior or other health plan. Your patients can change their mind at any time to start or stop sharing.

- By default, patients are asked to give permission at the time of enrollment and re-enrollment.
- If they do not give permission, your patient's new health plan will not be able to see health information from your patient's prior plan.
- Patients can stop or start sharing health information with their new health plan by logging into their KYNECT account or by contacting member services.

Provider Access API (CMS-0057)

The CMS-0057 Interoperability & Prior Authorization Final Rule creates a standard, secure way, through the Provider Access API, for providers to view certain information that a patient's health plan holds about them where there is an established treatment relationship. This gives providers a more complete picture of their patient's health without asking the patient to bring records from every specialist or insurer.

Under the Provider Access API in-network providers may access the following data from their patient's health plan:

- Claims information
- Visit and service details
- Clinical information, such as problems, medications, allergies, and labs, if available
- Prior authorization history

Patients can choose to stop sharing their health information at any time.

- Sharing is automatically turned on.
- They can choose to share or not to share at any time. This will not change their benefits, coverage, and Medicaid eligibility.

How do I view my patient's data using the Provider Access API?

Think of the Provider Access API as a secure digital connection between your system (like your EHR) and the health plan. It lets you pull patient information quickly—but only for patients with which you have an established treatment relationship.

Note: The provider access API has two access restrictions.

1. Member consent; members can opt out of sharing their data at any time.
2. Provider attribution; to ensure a treatment relationship between member and provider. Both access restrictions must be met before you have access to view patient data.

The following steps apply when accessing a patient's data:

Step 1: Make sure you are connected

- Set up a connection to the health plan's API (usually done by IT or your EHR vendor).
- Verify your identity (using secure credentials provided by the platform).
- In simple terms: Your system "logs in" securely so the payer knows it is really you.

Step 2: Attribution validation

- Before you can access any data, the system checks whether the patient is attributed to you based on the primary care provider (PCP) a patient selected, claims history, and managed care organization (MCO) assignment rules.

Step 3: Consent validation

- Patients can opt out of sharing their data.
- If a patient opts out, they will not appear in the patient list.
- A patient that opts out can opt in at any point and they will become visible once they opt in.
- In simple terms: You can only request data for patients who are opted in.

Step 4: Request the patient's data

- Once attribution and consent is confirmed, your system sends a request through the API asking for data such as:
 - Claims and visit history
 - Diagnoses and conditions
 - Medications and allergies (if available)
 - Clinical data (if available)
 - Prior authorization history
- This happens automatically in the background when you open a patient chart in your EHR.
- Like your EHR, all information and requests are logged, monitored, and audited.

Electronic Prior Authorization API

Electronic Prior Authorization (ePA) modernizes the traditional fax- and phone-based authorization process by embedding authorization workflows directly into the provider's EHR so you can submit and receive prior authorization information electronically instead of relying on paper or fax. This will help identify authorization requirements early, submit complete requests, and receive faster, more transparent decisions.

Step 1: Coverage Requirements Discovery (CRD) - "Is prior authorization required?"

- CRD enables early visibility into authorization requirements within the clinical workflow.

Step 2: Documentation Templates and Rules (DTR) - "What information do I need to submit?"

- DTR provides structured clinical documentation requirements by using smart questionnaires or templates.

Step 3: Prior Authorization Support (PAS) - “Submit the request and get a decision.”

- PAS enables electronic submission, tracking and status of the authorization request.

How to get started

To get started, providers can use the [Onyx Registration Portal](#) to register and request access. After registering, a provider can create an application request in the portal and select the payer/health plan they want to connect with; the request is then reviewed and approved by the payer’s administrator.

Glossary

- Member portal/app: A website or mobile app offered by your patient’s health plan.
- Third-party app: An app not built by your patient’s health plan that they choose to connect.
- Prior authorization: A process where a plan reviews certain medical services before they are provided to confirm coverage requirements are met.
- Treatment relationship: A care relationship between a provider and a patient that may allow access to certain information, as permitted by the plan.

Helpful links

- [Interoperability and Patient Access final rule](#)
- [Policies fact sheet](#)
- [CMS policies and technology](#)
- [CMS overview page](#)
- [CMS fact sheet \(PDF\)](#)
- [Federal Register final rule](#)