

CMS-0057 Provider FAQ

What is CMS-0057?

- CMS-0057 is the CMS Interoperability and Prior Authorization Final Rule designed to improve healthcare data exchange, streamline prior authorization processes, and reduce administrative burden for providers and health plans.

What is changing with the new CMS rule?

- CMS-0057 requires impacted health plans (Medicare Advantage, Medicaid/CHIP managed care, state Medicaid agencies, and many Marketplace plans) to make member health information available through standardized APIs and improve prior authorization processes. The goal is to reduce administrative burden, improve care coordination, and give patients and providers better access to health information.

How will CMS-0057 reduce administrative burden?

- The rule promotes electronic data exchange using industry standards, reducing reliance on manual processes, phone calls, faxes, and repetitive documentation requests. This can help provider staff spend less time managing administrative tasks.

What is an API?

- An Application Programming Interface (API) is a secure, standardized way for different computer systems to exchange information electronically. In healthcare, APIs allow health plans, providers, and approved applications to securely access and share patient health information without relying on manual processes such as faxing or paper records.

What APIs will be available?

- Patient Access API – Allows members to access their claims, encounter, clinical, and prior authorization information through approved applications.
- Provider Access API – Allows providers to access patient information from participating health plans for treatment and care coordination.
- Payer-to-Payer API – Supports sharing a member's health information when they change health plans.

- Electronic Prior Authorization API – Supports electronic prior authorization requests and status updates.

How does CMS-0057 impact providers?

- The rule helps providers by improving access to patient information, increasing transparency around prior authorization decisions, and enabling more automated electronic workflows between providers and health plans.

What changes are being made to prior authorization?

- Health plans must support more efficient electronic prior authorization processes, provide status updates, communicate reasons for denials, and meet specific turnaround times for authorization decisions.

What information will patients be able to see?

- Through the Patient Access API, members may be able to access:
 - Claims and encounter information
 - Clinical data held by the health plan
 - Prior authorization requests and decisions
 - Information related to covered services and care received
- This gives members greater visibility into their healthcare information and benefits.

Will patients automatically see everything in an app?

- Not necessarily. What they can see depends on what their health plan supports and whether they choose to use a third-party app.

Does this include prescription drug prior authorization?

- The rule does not require prescription drug prior authorization to be included; it focuses on medical items and services.

Is my patient's information safe if they use a third-party app?

- They should use only trusted apps and review their privacy policies. Their plan can provide guidance on approved or supported apps.

Can patients opt out of sharing their information?

- Yes. CMS requires payers to give members the opportunity to opt out of sharing their information through the Provider Access API and Payer-to-Payer API. If a member opts out, their information will not be shared through those APIs.

- Provider Access API: By default, patients are opted in to sharing healthcare data with their providers for which there is an established treatment relationship. Patients can opt out at any time.
- Payer-to-payer API: By default, patients are asked to give consent for data to be shared from their old health plan to their new health plan. They can opt out of sharing at any time.

What information will providers be able to see?

- Through the Provider Access API, participating providers may access information for patients with whom they have a treatment relationship, including:
 - Claims and encounter data
 - Clinical information available to the payer
 - Prior authorization information
 - Other health information needed to support treatment and care coordination
- Access is intended to help providers make more informed clinical decisions and reduce the need to gather information from multiple sources.

Will providers receive more visibility into authorization requests?

- Yes. CMS-0057 requires greater transparency regarding prior authorization requirements, request status, approval decisions, and denial rationales. This helps providers better manage patient expectations and care plans.

How can I access my patient's information?

- Providers will access patient information directly from their EHR workflows through a payer's Provider Access API once the following criteria are met:
 - The provider has verified a treatment relationship with the patient.
 - The patient has not opted out of data sharing.
- 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.

Does CMS-0057 require providers to change their workflows?

- Many providers may need to adopt or enhance electronic prior authorization and interoperability capabilities within their existing systems. However, these changes are intended to create long-term efficiencies and reduce manual administrative work.

How will this improve patient care?

- With better access to clinical and administrative information, providers can make more informed decisions, avoid duplicate services, coordinate care more effectively, and help patients receive treatment faster.

Which providers are affected?

- Providers serving patients covered by Medicare Advantage, Medicaid managed care, CHIP managed care, and certain Marketplace plans are most likely to experience changes as impacted payers implement the rule's requirements.

When will these changes take effect?

- While some provisions became effective earlier, impacted health plans generally have until January 1, 2027 to implement key API and interoperability requirements, with provider experience improving as health plans roll out these capabilities.

What should providers do now?

- Stay informed about payer implementation timelines.
- Evaluate electronic prior authorization capabilities within their EHR and practice management systems.
- Work with technology vendors to understand interoperability enhancements.
- Educate staff about upcoming workflow changes and new authorization processes.

Key Takeaway

CMS-0057 is intended to make it easier for providers to access patient information, automate prior authorization processes, reduce administrative burden, and improve care coordination. Ultimately, the rule supports faster, more transparent, and more efficient care delivery for patients and providers alike.