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CMS-0057-F Interoperability and Prior Authorization Final Rule

A strategic blueprint for FHIR-driven transformation

Authored by

Navin Rangarajan

Senior Product Manager Healthcare Data and Interoperability

Encounter Data Manager (EDM) and Government and Quality Solutions (GQS)

Cognizant TriZetto

The mandate: Why CMS-0057-F changes everything

The Centers for Medicare and Medicaid Services finalized CMS-0057-F, the Interoperability and Prior Authorization Final Rule. On its surface, the rule appears to be about API mandates and prior authorization timelines. In substance, it represents nothing less than a fundamental realignment of how health plans, providers and members exchange information in the United States.

For product leaders and technology executives in the managed care space, the rule's implications are sweeping. It forces health plans to treat their data claims, encounters, clinical records, and prior authorization decisions not as back-office artifacts, but as first-class digital assets that must be accessible, timely, structured and interoperable.

CMS-0057-F turns FHIR from a nice-to-have into the mandated operational backbone of American managed care. The plans that move first will set the standard. Everyone else will spend the next five years catching up.

The rule applies to impacted payers across Medicare Advantage (MA), Medicaid, CHIP and Qualified Health Plan (QHP) issuers on Federally-facilitated Exchanges. Compliance timelines begin with prior authorization metrics reporting and related operational changes in 2026, with mandated FHIR APIs required in 2027 according to payer-specific compliance dates. Noncompliance triggers corrective action plans, civil monetary penalties and, in extreme cases, enrollment sanctions.

At its core, the rule mandates four production FHIR R4 APIs that will reshape data flows across the entire healthcare data ecosystem.

The four mandated FHIR APIs

API	Core purpose	Key data types	Primary stakeholders
Patient access API (Expanded)	Empower members with digital access to their complete health record	Claims, encounters, USCDI clinical, prior auth, directories	Members, third-party apps
Provider access API	Share longitudinal member data with treating in-network providers	Claims (no remits), encounters, USCDI, prior auth (non-drug)	Providers, care teams
Payer-to-payer FHIR API	Ensure continuity of care data across coverage transitions	Claims, encounters, USCDI, prior auth history	Prior/new payers, delegates
Prior authorization API	Digitize end-to end PA requests, documentation and decisions	Clinical context, coverage rules, PA requests/responses	Providers, UM teams, payers

The technical baseline is HL7® FHIR® R4 (4.0.1), with USCDI and US Core profile alignment, and OAuth 2.0/SMART-on-FHIR authorization where member and provider authentication is required. For the Prior Authorization API specifically, CMS allows implementation flexibility: Plans may use an all-FHIR approach or a hybrid FHIR + X12 transaction set. For all-FHIR implementations, CMS indicates that these APIs will satisfy applicable electronic transaction requirements for prior authorization requests and responses.

The architectural decisions plans made today around these four APIs will define their data infrastructure posture for the next decade. This is not a point solution. It is a platform.

Star Ratings, CAHPS and the experience economy

For Medicare Advantage plans, CMS Star Ratings are economically critical. A plan that drops from four stars to three stars loses quality bonus payments that can represent hundreds of millions of dollars in annual revenue. The member experience measures within Star Ratings the CAHPS surveys are driven in large part by how members experience access to care, care coordination and administrative friction. Prior authorization is the single largest driver of all three.

How CMS-0057-F directly moves the CAHPS needle

The rule's prior authorization timelines are explicit: Standard requests must be decided within seven calendar days and expedited requests within 72 hours with these timeframes enforced through public reporting and oversight. CMS will publish plan-level PA metrics, making turnaround times and denial rates visible to members, employers and regulators in a way they have never been before.

This matters for CAHPS because the relationship between prior authorization burden and patient experience measures is increasingly documented in the literature. Delayed authorizations lead to delayed care. Denied authorizations without clear clinical rationale lead to member complaints, appeals and disenrollment. CMS-0057-F addresses these pain points structurally, not just operationally.

The data transparency effect

The Patient Access API expansion is equally consequential for member experience. By requiring payers to expose prior authorization status, denial reasons and coverage information through member-facing FHIR APIs, the rule eliminates the information asymmetry that has historically frustrated members and their families. When a member can see in real time, through an app of their choosing that their request was approved, denied or pending with a specific clinical rationale, the experience is fundamentally different. Complaints drop. Appeals drop. Satisfaction rises.

Publicly reported PA metrics combined with FHIR-based analytics allow plans to target specific specialties, service types or regions that create avoidable CAHPS friction and fix them before they show up in surveys.

Analytics implications for quality programs

Product and analytics teams have a significant opportunity here. With standardized FHIR APIs generating consistent, machine-readable PA, claims, encounter and clinical data, plans can build quality analytics pipelines that were previously impossible with fragmented, batch-oriented data sources. The ability to segment PA denial rates by specialty, geography, diagnosis code or provider group and correlate those metrics to CAHPS survey trends is a genuine competitive differentiator.

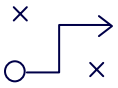
CMS-0057-F does not just require compliance; it creates the data infrastructure for proactive quality management. Plans that build this capability are well positioned to outperform on Star Ratings over time, not because of a single favorable measurement year, but because they have built a systematic feedback loop between data, operations and member experience.

Encounters and claims: From back office to operational backbone

Perhaps no domain is more directly and operationally impacted by CMS-0057-F than encounter and claims data. For most health plans today, encounter data is a compliance artifact submitted to CMS or state agencies to support risk adjustment, capitation and quality reporting, but not particularly designed for real-time operational use. CMS-0057-F ends that paradigm.

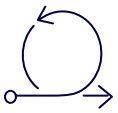
FHIR exposure of claims and encounter data

The Provider Access API requires payers to expose individual encounter and claims records to in-network treating providers in FHIR format, excluding provider remittances and member cost-sharing information. The Payer-to-Payer FHIR API requires similar exposure when members change coverage. In both cases, the data must be:



Representable as standard FHIR resources: Claim, ExplanationOfBenefit, Encounter with consistent use of ICD, CPT/HCPCS and revenue codes.

Complete and clinically meaningful, not just billing metadata. Encounters must carry diagnosis context, procedure details, provider attribution and service dates that drive care management decisions.



Available in near real time, not reconciled monthly or quarterly. If a provider queries the Provider Access API for a patient they are actively treating, they should receive current encounter data, not data that is 60 days stale.

The data quality stakes are now real

This is a profound operational shift. Historically, an encounter submitted with an incorrect diagnosis code, missing a procedure code or delayed by a delegated submitter was primarily a risk adjustment problem important, but addressed through retrospective correction cycles. Under CMS-0057-F, that same deficient encounter record now breaks active clinical workflows. A provider querying a patient's longitudinal record may see an incomplete picture. A prior authorization request may be denied or delayed because the clinical context derived from encounters is insufficient.

Incomplete or delayed encounter data can no longer be treated as a back-office correction issue. Under CMS-0057-F, it effectively becomes a patient safety issue, a provider experience issue and a compliance issue simultaneously.

What payers must do

The operational requirements are clear, even if the execution is complex:

> FHIR normalization pipelines must be production-ready, not proof of concept. Plans need the ability to transform claims and encounter data from legacy X12 formats into FHIR resources continuously, with validation at every step of the translation.

> Near-real-time data availability requires architectural investment. Batch-oriented data warehouses that aggregate encounter data weekly are not sufficient. Plans need streaming or near-streaming data architectures that can make encounter records available via API within hours of adjudication.

> Attribution and consent management must be operational. The Provider Access API does not allow blanket exposure of all member data to all providers. Plans must implement and maintain accurate provider-member treatment relationships to control access appropriately and must manage member opt-out mechanisms.

> Delegated data submitters must be held to new standards. For MA plans and Medicaid Managed Care Organizations with extensive delegation, the weakest link in the encounter data chain is often a delegated medical group or IPA. CMS-0057-F makes their data quality issues into API reliability issues.

Enrollment infrastructure: The new continuity of care mandate

CMS-0057-F introduces a subtle but operationally significant change to the enrollment lifecycle: Enrollment events must now trigger proactive, time-bound data exchange. This is not an enrollment file specification per se, but it fundamentally changes what must happen within the first week of a member's coverage start date.records, and prior authorization decisions not as back-office artifacts, but as first-class digital assets that must be accessible, timely, structured and interoperable.

The one-week clock starts at enrollment

Upon enrollment, or upon a member's request, a new payer should initiate a request to the prior payer for the member's longitudinal data as quickly as operationally feasible. In this paper, we treat a one-week window from coverage start as a practical target for day-one continuity of care. The prior payer must respond through the Payer-to-Payer FHIR API with a defined payload: adjudicated claims and encounter data (without remits or cost-sharing), all USCDI data classes and elements, and relevant prior authorization history.

Enrollment events must trigger automated FHIR data exchange workflows. The handoff from enrollment processing to payer-to-payer data request cannot be manual or periodic. A new member enrolled on January 1 should have a data request sent to their prior payer by January 7, automatically.

Member identity resolution becomes a critical, high-stakes function. Before requesting data from a prior payer, the new plan must accurately match member identity across potentially inconsistent demographic records. Errors in identity matching can lead to either unauthorized data disclosure or missed data requests, both of which have compliance implications.

Consent and opt-out infrastructure must be real-time. Members have the right to opt out of payer-to-payer data sharing. Plans must maintain consent preferences in systems that are integrated with their FHIR exchange pipelines, not siloed in a separate consent management system that updates weekly.

The strategic opportunity: Day-one clinical context

Here is the opportunity that forward-thinking plans are beginning to grasp: If this infrastructure is executed well, new members arrive with a complete longitudinal health record on day one of their coverage, not day 60 or 90 as care management staff scrambles to collect prior records.

A new member who arrives with a complete prior authorization history, active medication list and longitudinal claims record on day one is a fundamentally different care management challenge than a member who arrives as a blank slate. CMS-0057-F makes the former the explicit design goal for payers that fully implement the rule's payer-to-payer and clinical data exchange capabilities.

The implications for care management, utilization management and risk adjustment are profound. Risk scores can be calculated with full clinical context from day one of enrollment, not adjusted retrospectively months later. High-risk members can be identified and outreached immediately, before gaps in care widen. Prior authorizations for continuity-of-care services can be initiated before the member even sees their first provider under the new plan.

This is not a theoretical future state. It is what CMS-0057-F enables for plans that build the infrastructure to take advantage of it.

Clinical data and prior authorization: The end of the fax era

Of the four domains examined in this paper, the transformation of clinical data exchange and prior authorization workflows is perhaps the most significant and the most culturally challenging. Utilization management in US healthcare has been built on a foundation of fax machines, PDF attachments and manual clinical review for decades. CMS-0057-F mandates its replacement with machine-readable, FHIR-native workflows and does so with legally enforceable timelines.

USCDI and the clinical data expectation

Both the Provider Access API and the Payer-to-Payer API require exposure of USCDI data classes and elements the standardized clinical data set maintained by ONC that covers problems, medications, allergies, laboratory results, vital signs, procedures, immunizations and more. This is a significant expansion of what payers have traditionally been required to expose.

Plans must therefore invest in:

Mapping EHR-sourced or delegated clinical feeds into FHIR resources aligned with US Core profiles. This requires integration-engineering capabilities that go beyond X12 EDI translation it requires bidirectional connectivity with provider EHR systems, or at minimum, the ability to ingest and normalize clinical data received in HL7 v2, C-CDA or FHIR formats from delegated entities.

Maintaining clinically meaningful longitudinal histories. A claims-derived “shadow chart” diagnoses inferred solely from billed codes is not sufficient to meet the spirit of USCDI-based clinical data exchange expectations. Plans need actual clinical data: lab values, imaging results, medication details, allergy severity. This is a significant data sourcing and governance challenge.

Governance and data quality frameworks for clinical data. Unlike claims data, which has established X12 validation rules, FHIR-based clinical data introduces new quality dimensions: terminology completeness, profile conformance, clinical plausibility. Plans need structured quality programs for clinical FHIR data.

The Prior Authorization API: From documents to decisions

The Prior Authorization API is arguably the most architecturally ambitious component of CMS-0057-F from an implementation perspective. It envisions an end-to-end digital PA workflow where clinical context, documentation requirements and authorization decisions are exchanged over FHIR, potentially without a single fax or PDF ever changing hands.

CMS recommends implementation of the Da Vinci IG suite:

- CRD (Coverage Requirements Discovery): At the point of care, EHR systems query the payer to determine whether a requested service requires prior authorization, and if so, what documentation is needed
- DTR (Documentation Templates and Rules): The payer provides structured templates that the EHR can pre-populate with data already in the patient's record, dramatically reducing the administrative burden on provider staff
- PAS (Prior Authorization Support): The completed PA request, with clinical documentation, is submitted over FHIR, and the payer responds with an approval, a denial that includes a specific clinical rationale or a request for additional information, in line with CMS requirements for more transparent electronic prior authorization decisions

This shift from document-centric to decision-centric PA has transformational implications:

- Clinical indicators diagnoses, laboratory results, imaging findings, prior therapies become machine-readable inputs to coverage-determination logic, enabling more consistent and auditable decisions.
- Denial rationales are tied to specific, missing or conflicting clinical facts, not generic, "not medically necessary" language that drives member appeals and provider frustration.
- The entire PA workflow becomes automatable for high-volume, well-defined service categories: imaging, PT/OT, DME, specialty medications. Plans can dramatically reduce UM staffing costs while simultaneously improving turnaround times.

The Da Vinci PA workflow does not just digitize a fax. It has the potential to transform prior authorization from a cost center driven by administrative friction into a clinical decision-support process that benefits payers, providers and most importantly members.

Strategic blueprint: From compliance to competitive advantage

The synthesis of CMS-0057-F's impact across CAHPS, encounters, enrollment and clinical data reveals a consistent pattern: The rule simultaneously creates compliance obligations and strategic opportunities for plans and vendors. The ones that execute well will not merely avoid penalties; they will build capabilities that define managed care leadership for the 2026–2030 period and beyond.

The strategic impact matrix

Domain	Primary risk if unprepared	Strategic opportunity if executed well
CAHPS/Star Ratings	Continued PA denials, opaque decisions driving member complaints and CMS sanctions	Transparent, fast PA as a differentiator; measurable CAHPS uplift
Encounter data	Incomplete FHIR normalization breaks provider workflows and PA pipelines	Near-real-time, complete encounter feeds enabling proactive care management
Enrollment operations	Enrollment events fail to trigger timely payer-to-payer data requests	Rich longitudinal data on day one of coverage, transforming risk adjustment accuracy
Clinical data/USCDI	Fax/PDF workflows persist; clinical context fails to reach UM teams in time	Machine-readable clinical context enabling automated, auditable PA decisions

The vendor positioning imperative

For healthcare technology vendors EHR vendors, clearinghouses, managed care platform providers and clinical analytics firms, CMS-0057-F is a market-defining event for the next several years. Payers are actively evaluating their existing vendor relationships against a simple question: Can my current technology partners get me to 2027 compliance with minimal risk and maximum strategic value?

Vendors that can demonstrate:

- Production-grade FHIR normalization for X12 encounters, claims and clinical data
- Orchestration capabilities across all four mandated APIs with monitoring and SLA management
- Integration with Da Vinci IGs for PA workflow modernization
- Analytics and quality monitoring for FHIR data completeness and API latency
- Risk adjustment and Star Ratings impact analysis tied to CMS-0057-F data flows

This will be strategically positioned as the compliance window closes and the market consolidates around CMS-0057-F-capable platforms.

Closing perspective: The architecture of what's next

We are at an inflection point in US managed care. The data standards that have defined healthcare administration for the past three decades, X12 EDI batch files, HL7 v2 messages and faxed clinical documentation are not going away overnight. But CMS-0057-F establishes with finality that FHIR is the interoperability language of American healthcare's next chapter.

The implications of this shift extend far beyond API compliance. When encounter data flows in real time. When clinical context accompanies every prior authorization request. When new members arrive with a complete longitudinal record. When member-facing apps provide transparent, current coverage and authorization information. The entire managed care value chain becomes more efficient, more equitable and more capable of delivering the outcomes that justify the $1.5 trillion in annual managed care spending.

This is not utopian thinking. It reflects the concrete direction CMS sets through CMS-0057-F and through the alignment of Star Ratings, quality incentives and compliance enforcement. The question for every plan executive, technology leader and product manager reading this paper is not whether to pursue it but how fast to move, and with whom.

Plans and vendors that treat the early compliance dates as mere deadlines will be playing defense for years. Those that treat them as a platform launch are effectively building the future of managed care right now.

About the author

Navin Rangarajan is a Senior Product Manager at Cognizant, leading product strategy for the Encounter Data Manager (EDM) and Government and Quality Solutions (GQS) platforms. With deep expertise in healthcare data processing standards including X12 EDI, HL7 FHIR R4, HEDIS and CMS Blue Button 2.0, the focus spans 12 strategic product initiatives covering risk adjustment analytics, FHIR streaming, agentic AI in healthcare, EDI validation, value-based care analytics and SDOH integration. Based in the Phoenix, Arizona metropolitan area, the work bridges government compliance mandates and real-world product execution across the managed care ecosystem.

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cognizant

World Headquarters

300 Frank W. Burr Blvd.
Suite 36, 6th Floor
Teaneck, NJ 07666 USA
Phone: +1 201 801 0233

European Headquarters

280 Bishopsgate
London
EC2M 4AG
England
Tel: +44 (01) 020 7297 7600

India Corporate Office

Siruseri-Software Technology Park
of India (STPI)
SDB Block—Ground Floor North Wing
Plot No H4, SIPCOT IT Park
Chengalpattu District
Chennai 603103, Tamil Nadu
Tel: 1800 208 6999

APAC Headquarters

1 Fusionopolis Link, Level 5
NEXUS@One-North, North Tower
Singapore 138542 Phone: +65
6812 4000

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