CMS-0057-F
OPERATIONAL READINESS GUIDE

For health plans and organizations performing applicable payer functions

2026 | Operational requirements **2027 | API requirements**

CMS-0057-F establishes operational and interoperability requirements for Medicare Advantage plans, Medicaid and CHIP managed care entities, state Medicaid and CHIP fee-for-service programs, and Qualified Health Plan issuers on the Federally Facilitated Exchanges. These requirements may also affect regional entities and provider-origin organizations performing delegated functions for impacted payers, depending on contractual arrangements. The 2026 operational requirements are in effect, with additional interoperability and API requirements beginning in 2027. Use this guide to assess readiness across both phases.

2026 | PRIOR AUTHORIZATION

For applicable non-drug items and services; 7-day/72-hour deadlines do not apply to FFE QHP issuers:

- Standard decisions within 7 calendar days; expedited decisions within 72 hours.
- Provide a specific reason when a prior authorization request is denied.
- Maintain workflows to track requests, deadlines, decisions, and notifications.
- Apply extensions and exceptions only where permitted by applicable requirements.

2026 | PUBLIC REPORTING

Applicable payers must publicly report specified prior authorization metrics, with the first posting due March 31, 2026 (using 2025 data), and annually thereafter.

- Track approvals, denials, appeals, and decision timeliness as specified by CMS.
- Publish required metrics on the payer website; distinguish this from separate CMS reporting of Patient Access API usage metrics.
- Maintain the required public list of items and services subject to prior authorization (excluding drugs).

PATIENT ACCESS API | TIMING

Existing Patient Access API obligations continue. CMS-0057-F expands the information available through that API, including certain prior authorization information, beginning in 2027. Do not treat that expansion as a 2026 requirement.

2027 | INTEROPERABILITY APIS

By January 1, 2027, applicable payers must implement or enhance the following APIs, subject to the rule's conditions and exceptions:

- **Prior Authorization API:** identify coverage and documentation requirements and support electronic requests and responses.
- **Provider Access API:** share specified member data with in-network providers, subject to applicable opt-out provisions.
- **Payer-to-Payer API:** support exchange of specified member information when a member changes payers, subject to applicable requirements.
- **Expanded Patient Access API:** make specified prior authorization information available to members.

FHIR R4 and applicable technical standards are required; relevant HL7 Da Vinci implementation guides are recommended, not universally mandated.

OPERATIONAL CAPABILITIES TO ASSESS

- Prior authorization intake, routing, deadline monitoring, and decision documentation.
- Configurable business rules and consistent denial reasons and notifications.
- Reliable data exchange across payer systems, portals, and clinical applications.
- Reporting, audit trails, access controls, and FHIR API implementation readiness.

READINESS SELF-ASSESSMENT

- [ ] We consistently meet applicable PA decision deadlines.
- [ ] Our denial notices include the required specific reasons.
- [ ] We can produce and publish required PA metrics.
- [ ] We have a tested plan for each applicable 2027 API.
- [ ] We can identify payer-side gaps not addressed by our EHR.

COMMON GAP | EHR-ONLY WORKFLOWS

EHRs primarily support clinical documentation. Organizations with payer responsibilities may also need dedicated capabilities for authorization management, payer-side interoperability, reporting, and auditability. InfoMC Health positions incedo8 as a payer-side technology solution that complements EHR workflows.

Assess your CMS-0057-F readiness with InfoMC Health