

# CMS-0057 Operational Readiness Guide

For health plans, managed care entities, state Medicaid programs, and provider-origin organizations



Phase 1 in effect Jan 1, 2026

Phase 2 deadline Jan 1, 2027

CMS-0057-F establishes payer-level operational and interoperability requirements for Medicare Advantage plans, Medicaid and CHIP managed care entities, state Medicaid and CHIP fee-for-service programs, PIHPs, PAHPs, and similar entities. These requirements apply to organizations operating under Medicare Advantage or prepaid Medicaid managed care arrangements — including traditional health plans, regional entities, and provider-origin organizations. Phase 1 is in effect; Phase 2 takes effect January 1, 2027. Use this reference to assess compliance across both phases.

## ● PHASE 1 — PRIOR AUTHORIZATION REQUIREMENTS (NOW ENFORCED)

CMS-0057 introduces enforceable timelines and documentation standards that must be applied consistently across authorization workflows.

- Standard PA decisions issued within 7 calendar days
- Expedited PA decisions issued within 72 hours
- Extension processes supported based on program requirements
- Per-request tracking of all authorization timelines
- Escalation workflows to prevent missed deadlines
- Every denied PA includes a specific, structured denial reason
- Denial rationale consistently documented
- Standardized member and provider notifications
- Denial data is reportable and audit-ready

## ● PHASE 1 — METRICS & PUBLIC REPORTING REQUIREMENTS

CMS requires payers to generate, track, and publicly report prior authorization metrics — data that must be produced systematically, not assembled manually.

- PA metrics generated and tracked continuously
- Metrics include volume, timeliness, denials, and appeals
- Data prepared for CMS submission and public reporting
- Initial public reporting required beginning March 31, 2026 (based on prior year data)
- Public list of services requiring prior authorization maintained (excluding drugs)

## ● PHASE 1 — PATIENT ACCESS API (ALREADY REQUIRED)

Payers must provide members direct access to their data through a FHIR-based API, including claims history, prior authorization decisions, and encounter records.

- Member access via FHIR-based API
- Data includes claims, prior authorization decisions, encounter, and clinical data (as required)
- APIs support third-party applications using FHIR R4 / SMART on FHIR standards

## ● COMMON GAP — DISCONNECTED WORKFLOWS AND SYSTEMS

Meeting CMS-0057 requirements often requires coordination across workflows, reporting, and integration—introducing operational complexity, increased risk, and added administrative burden.

- Prior authorization timelines are often tracked rather than enforced
- Documentation and decisioning can vary across teams
- Reporting may require manual assembly across systems
- Visibility into authorization status can be limited, requiring manual follow-up
- Interoperability requirements, including FHIR APIs, are not always fully integrated into operational workflows

## ● PHASE 2 — INTEROPERABILITY & API REQUIREMENTS

By January 2027, payers must support electronic prior authorization submission, provider access to member data, and payer-to-payer data exchange through standardized FHIR APIs.

- Prior Authorization API (Da Vinci PAS) — electronic submission and response
- Provider Access API (Da Vinci PDex) — provider access to member data and PA status
- Payer-to-Payer Data Exchange (Da Vinci PDex) — exchange of historical member data as required by CMS
- Patient Access API (Enhanced) — continued compliance and expanded data access

## ● CORE INFRASTRUCTURE REQUIREMENTS — TO MEET BOTH PHASES

These capabilities support compliant payer operations, independent of EHR functionality.

- End-to-end prior authorization workflows (intake → decision → notification)
- Automated timeliness enforcement (7-day / 72-hour clocks)
- Structured denial logic and documentation
- Claims data processing and integration (e.g., 837/835 transactions)
- Integrated reporting across PA, claims, and outcomes
- FHIR R4 API capability aligned to Da Vinci implementation guides (including prior authorization workflows)

## ● READINESS SELF-ASSESSMENT

Use this checklist to identify gaps in your compliance posture before audit or enforcement actions arise.

- We enforce CMS PA timelines across all requests
- We generate structured denial codes for every denial
- We produce CMS-ready PA metrics without manual effort
- We support (or have a plan to support) required FHIR APIs
- Our systems function as a payer system of record

✓ Unchecked items may indicate gaps in your current compliance approach.

→ InfoMC's Incedo platform enables payer-level prior authorization, reporting, and interoperability within a single operational model—enforcing timelines, standardizing decisions, and generating audit-ready data as part of everyday workflows.

Explore CMS-0057 compliance