



2026-2027 Prior Authorization Readiness Brief

Helping health plans move from CMS-0057-F compliance and AHIP commitments to meaningful outcomes







The CMS Mandate: Building a Faster, Fairer Prior Authorization System

On January 1, 2026, the Centers for Medicare & Medicaid Services (CMS) began enforcing the Interoperability and Prior Authorization Final Rule ([CMS-0057-F](#)), a nationwide initiative designed to modernize how impacted health plans manage prior authorization (PA) for medical items and services and exchange data across the healthcare ecosystem.

While compliance is mandatory, this regulation marks a pivotal opportunity. It's not just about meeting deadlines — it's about transforming how health plans deliver faster, fairer, and more transparent care decisions.

CMS-0057-F directly addresses long-standing inefficiencies that delay care and frustrate providers and patients by:

 <p>Enforcing faster decision timelines (≤ 72 hours for expedited, ≤ 7 days for standard)</p>	 <p>Requiring clear, actionable, evidence-based denial reasons</p>	 <p>Mandating interoperable data exchange through FHIR APIs and X12 standards</p>	 <p>Requiring annual public reporting of PA metrics for accountability and transparency</p>
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The intent is clear: reduce administrative burden, improve patient experience, and make every prior authorization decision traceable, auditable, and data-driven.

For organizations preparing for interoperability and data exchange readiness, this readiness brief also includes a summary of the CMS Interoperability and Patient Access Final Rule (CMS-9115-F) and the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F) — collectively referred to as the CMS Interoperability/API requirements. These are outlined in [Appendix A: CMS Interoperability/API Requirements](#) at the end of the document.



From Compliance to Operational Advantage

CMS-0057-F is part of a broader modernization wave reshaping U.S. healthcare. It aligns with:

-  The Improving Seniors' Timely Access to Care Act (2025)
-  State-level reform bills
-  The HHS & Insurer Initiative (June 2025) to streamline prior authorization across Medicare Advantage, Medicaid, Marketplace, and commercial plans

Together, these initiatives underscore a simple truth: compliance is now the baseline, not the goal. Health plans that act early can turn regulatory requirements into strategic advantage — improving operational efficiency, building provider trust, and positioning themselves as leaders in transparency and accountability.



Redefining Quality, Access, and Efficiency in Prior Authorization

Sustainable prior authorization reform depends on three core imperatives: Quality, Access, and Efficiency. CMS-0057-F defines the baseline for all three. Autonomize AI turns them into measurable outcomes.

By applying healthcare-native AI Agents designed for clinical reasoning, data accuracy, and regulatory traceability, Autonomize helps health plans unify the entire workflow:

- **Quality:** Accurate data abstraction, clinical summarization, and consistent policy alignment
- **Access:** Faster decisions with clear communication between plans and providers
- **Efficiency:** Automated intake and review with human oversight to ensure safety and compliance



How Autonomize AI Powers Modernization

Autonomize AI's Prior Authorization Workflow combines automation, clinical intelligence, and governance to eliminate manual bottlenecks, accelerate decision-making, and deliver audit-ready transparency. All while preserving human oversight and regulatory compliance.

Each workflow is FHIR®-compliant, explainable, and governed under ACER (AI Controls for Ethical and Responsible AI) — Autonomize's proprietary framework for accountable AI in healthcare. This ensures that every action taken by an AI Agent can be traced, reviewed, and validated, aligning with CMS, NCQA, and state-level utilization management requirements.

Proven Results in Production:

Across major health enterprises, Autonomize's in-production workflows have helped plans by delivering:

49%

faster authorization decisions

63%

reduction in turnaround time

54%

drop in manual errors

18 min

FTE time saved per medical auth at 100,000 auths / mo

36K+

clinical hours recouped monthly

93%

data extraction precision and 98%+ accuracy in clinical abstraction

Connecting Performance to National Reform Commitments

In June 2025, AHIP and more than 60 of the nation's largest health plans put support behind [six public commitments](#) to reform prior authorization. The commitments call for:

Autonomize AI delivers against each of these — in production today.

COMMITMENTS	DELIVERY
<p>01 Accelerating adoption of electronic prior authorization</p>	<p>Electronic PA Adoption: Unified intake across FHIR®, X12 278, and unstructured document channels allows up to 90% faster request processing and near-total elimination of manual routing.</p>
<p>02 Reducing the volume of unnecessary authorizations</p>	<p>Reduced Authorization Volume: AI Agents flag and auto-approve low-variance, high-approval procedures — reducing review load without compromising compliance.</p>
<p>03 Ensuring continuity of care</p>	<p>Continuity of Care: Persistent data lineage ensures authorizations and supporting documentation remain intact through member transitions, renewals, and plan changes.</p>
<p>04 Improving transparency of requirements and determinations</p>	<p>Transparency of Determinations: Every decision includes guideline citations, evidence context, and plain-language rationale, automatically packaged for audit and appeals.</p>
<p>05 Protecting patients from care delays through real-time responses</p>	<p>Faster Response Times: Straight-through automation handles up to 76% of requests without manual intervention, cutting average decision turnaround time by half.</p>
<p>06 Guaranteeing medical necessity denials are reviewed by qualified clinicians</p>	<p>Physician Oversight: All denials are reviewed by licensed clinicians, with AI Agents preparing complete, guideline-supported case summaries that are fully auditable.</p>

Many health plans have pledged alignment with AHIP's reform principles but lack the infrastructure to operationalize them at scale. Autonomize AI bridges that gap — embedding the technical, clinical, and governance capabilities needed to make those commitments real and measurable.

Beyond Prior Authorization: Building the Foundation for Enterprise Transformation

The intelligence generated within Autonomize AI's Prior Authorization workflows does more than automate a process. It strengthens the operational backbone of a health plan. Each authorization becomes a learning event, generating structured insights that improve coordination, decision quality, and transparency across the enterprise.

By capturing and contextualizing rich clinical and administrative data, Autonomize enables plans to move from reactive case handling to proactive operations, where every workflow builds upon the last.

Health plans leveraging this approach are improving key performance and experience metrics across multiple domains:

- **Quality and Outcomes:** Automated evidence capture supports care gaps closure, leading to higher member satisfaction.
- **Financial Accuracy:** Richer documentation improves risk adjustment and reimbursement precision while reducing audit exposure.
- **Care Coordination:** Intelligent data flows prioritize high-risk members, enabling more timely interventions and closing care gaps faster.
- **Member and Provider Experience:** Transparent communication and consistent policy interpretation rebuild trust and reduce friction.
- **Operational Efficiency:** Streamlined review and documentation processes free clinical teams to focus on higher-value work.



Autonomize AI enables health plans to turn the data they already have into a foundation for better performance, compliance, and collaboration. By combining healthcare-native AI, governed automation, and enterprise-grade interoperability, organizations can reimagine how decisions are made — faster, fairer, and more connected than ever before.



Next Steps: Partnering for CMS Readiness, AHIP Commitments and Beyond

Every health plan must decide if compliance simply means a check of a box — or the decision to redefine how their enterprise delivers and scales operational excellence.

Autonomize AI helps payers do both. Our platform delivers immediate CMS-0057-F and alignment to AHIP's public commitments to simplify prior authorization, while laying the foundation for sustained improvement across utilization management, care management, and claims processing.

01

Request a Readiness Review—benchmark your current prior auth workflows against CMS requirements and AHIP commitments

02

Identify High-Impact Cohorts – Target where automation delivers the fastest ROI.

03

Deploy Autonomize AI Workflows – Go live in weeks, not months, with measurable outcomes.

04

Expand Across the Enterprise – Scale to Appeals & Grievances, Care Management, and Claims for compounding value.

To begin your readiness journey, visit autonomize.ai/contact

APPENDIX A:

CMS Interoperability/API Requirements

Disclaimer:

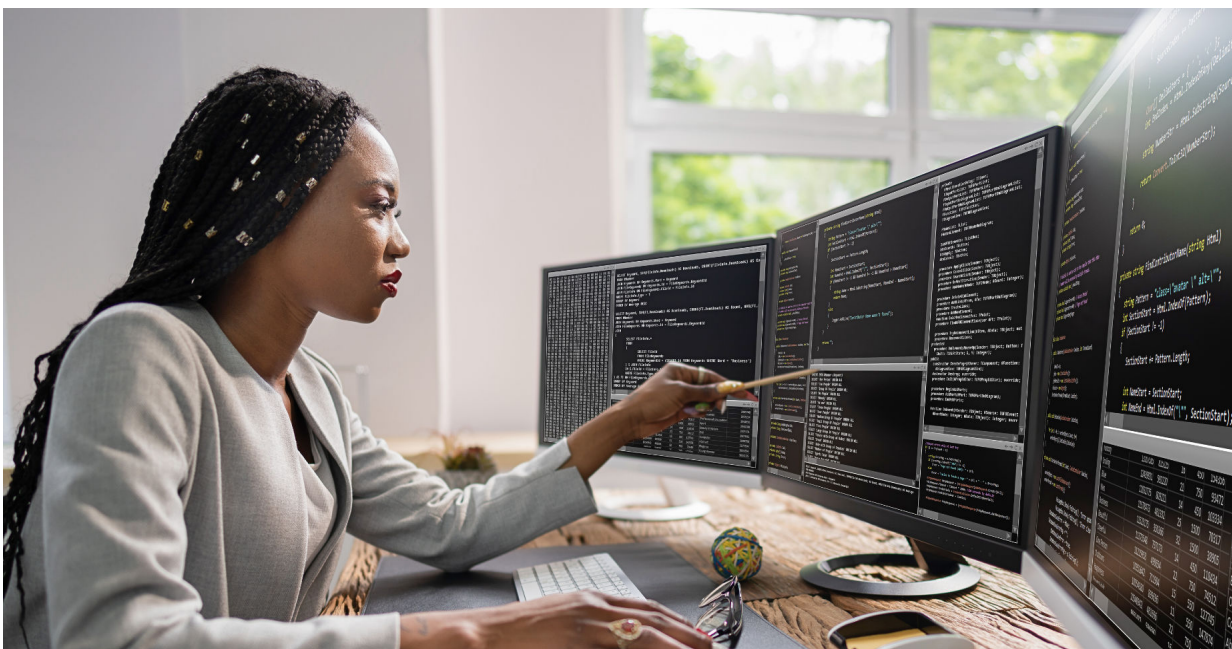
The information contained in this Appendix is provided for informational and educational purposes only and reflects Autonomize AI's sharing of CMS interoperability and prior authorization requirements as of November 25, 2025.

Autonomize AI does not provide legal, regulatory, or compliance advice, and this document should not be relied upon as a substitute for independent legal or regulatory consultation. Each organization is responsible for ensuring its own compliance with applicable federal and state laws, regulations, and CMS requirements.

While Autonomize AI's technology is designed to support data exchange, workflow automation, and audit transparency aligned to these standards, compliance determinations and implementation decisions remain solely the responsibility of each organization.

CMS Interoperability/API Requirements

- This table includes a summary of the CMS interoperability and Patient Access Final Rule (CMS-9115-F) and CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F) (collectively CMS Interoperability/API requirements).
- The rules apply to payers, specifically MA, Medicaid/CHIP, QHP issuers. However, there are several states with laws and regulations that extend interoperability requirements into the Commercial market.
- The Prior Authorization API requirement excludes prescription drugs. CMS and some states are evaluating, with respect to future policies on drug interoperability.
- All data exchange remains subject to HIPAA, privacy, and minimum necessary rules.



API Requirement	Key Provisions	Health Plan Impacts	Provider Impacts	Key Dates	Opportunities
<p>Patient Access</p> <p>Enables members to access at no cost via apps their claims, encounters, and clinical data the payer maintains (DOS on/ after 01/01/2016)</p>	<ul style="list-style-type: none"> Requires payers to make claims, encounter, and clinical data available through a FHIR-based API Patients can use third-party applications of their choice Must use HL7 FHIR R4 and USCDI v1 standards 	<ul style="list-style-type: none"> Implement and secure APIs Manage authentication Report usage metrics to CMS 	<p>Increased patient access may reduce requests for data and improve coordination.</p>	<ul style="list-style-type: none"> Eff May 2020 Annual metrics reporting by Mar 31, 2026 for CY 2025 	<ul style="list-style-type: none"> Reporting
<p>Provider Access</p> <p>Enables in-network providers with whom the patient has a treatment relationship to access certain patient data held by the payer</p>	<ul style="list-style-type: none"> Allows in-network providers to access patient data (claims, encounters, prior authorization) within one business day Excludes pharmacy data and provider remittance/patient cost-sharing data Patients can opt out 	<ul style="list-style-type: none"> Develop provider data access processes Patient-provider attribution Patient consent (opt out) management 	<p>Faster access to patient data for treatment and coordination</p>	<p>Implementation by Jan 1, 2027</p>	<ul style="list-style-type: none"> Attribution management Patient consent management One business day turnaround
<p>Payer-to-Payer</p> <p>Enables a new payer to request and receive data from the patient's previous or concurrent payer to support continuity of care when a member changes coverage or has dual coverage</p>	<ul style="list-style-type: none"> Enables data exchange between payers for members changing coverage or with concurrent coverage Includes clinical, claims, and encounter data with provenance tracking Member opt-in/ consent required Data to be made available via Patient Access and Provider Access APIs 	<ul style="list-style-type: none"> Manage inter-payer data transfers and integration Quarterly exchanges for concurrent payers as a recommended industry best practice Indicate data origin (receiving payer) Manage member consent 	<p>Benefit indirectly through improved data accuracy and care continuity</p>	<p>Implementation by Jan 1, 2027</p>	<ul style="list-style-type: none"> Data transfers (payer identification validation, intake, integration) Data origin integration Member opt in/consent management
<p>Prior Authorization</p> <p>Enables standardized digital exchange of prior auth data between providers and payers (and internally) to reduce provider burden and increase automation</p>	<ul style="list-style-type: none"> Requires electronic prior authorization submission, documentation, and decisions using FHIR Status and decisions must be made available through the Patient Access API 	<ul style="list-style-type: none"> Support provider queries to determine if PA is required for a given service, patient, provider Provide timely responses – 72 hour urgent/7 days standard Reporting (approvals, denials, timeframes, PA service lists) 	<ul style="list-style-type: none"> Submission of PA requests with documentation Merit-based Incentive Payment System (MIPS) reporting 	<p>Implementation by Jan 1, 2027</p>	<ul style="list-style-type: none"> Third party or partner data integration Timeliness and accuracy Tracking and reporting Backup manual processes Provider and patient correspondence Drug API foundation and readiness (for future pharmacy API integration) Align CMS and AHIP (what and timing)

Provider Directory API

The Provider Directory API is a public FHIR-based interface that enables anyone to access a payer's current provider network data. It originated under CMS-9115-F (2020) and remains a core component of the interoperability framework reinforced by CMS-0057-F. Under the rule, payers must make directory data publicly accessible (no authentication) and update it within 30 calendar days of any provider information change.

The API is built using the HL7® Da Vinci PDex Plan-Net Implementation Guide, which standardizes how network information (practitioners, locations, specialties, affiliations, endpoints) is structured and shared.

The Provider Directory API supports strategic interoperability, serving as a map that connects other APIs by ensuring consistent and accurate provider identifiers, endpoints, and relationships across systems.

Topic	Key Dates	Opportunities
Integration with Other APIs under CMS-0057-F	<ul style="list-style-type: none"> Originally effective Jul 1, 2021 (CMS-9115-F). Reaffirmed under CMS-0057-F; expected alignment by Jan 1, 2027, with other APIs. 	<ul style="list-style-type: none"> Acts as infrastructure backbone for workflow automation across APIs Facilitates PA decision automation, network performance insights, and improved member experience across the CMS interoperability ecosystem Compliance integration: Serves as the anchor API for accurate routing, authentication, and data consistency across all CMS-0057-F APIs Enables PA automation, real-time network validation, and value-based contracting visibility Supports cross-payer data exchange with standardized, accurate directory data

 Autonomize