Interoperability and Prior Authorization

The American Hospital Association's 2027 Guide to Electronic Prior Authorization Go-live Readiness



American Hospital Association™

Advancing Health in America



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This handbook is a collection of resources designed to help hospitals and health systems understand the 2024 Interoperability and Prior Authorization final rule, prepare for provider-facing implementation issues, and engage payers and vendors as they prepare to implement reforms that take effect on Jan. 1, 2027.

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Executive Summary

Providers routinely spend significant time navigating complex insurer prior authorization processes, tracking down medical necessity rules and criteria, responding to repeated documentation requests, and overcoming administrative hurdles that delay patient care. CMS new prior authorization reforms are intended to address those frustrations.

Although these reforms do not eliminate prior authorization, they seek to reduce provider burden by transforming **how information is exchanged between providers and health plans.** The goal is to replace much of today's fragmented process — which often relies on payer-specific portals, faxes, phone calls, emails and manual follow-up — with a more standardized electronic workflow.

Standardized Electronic Exchange Should Reduce Inefficiencies and Workforce Burden

For most providers, prior authorization is an administrative obstacle that occurs outside of their normal clinical workflow. Clinical and support staff often spend considerable time:

- Determining whether authorization is required.
- Identifying payer-specific documentation requirements.
- Uploading records to multiple portals.
- Responding to requests for additional information.
- Tracking authorization status.
- Appealing denials.

Even when electronic options exist, they frequently operate separately from the electronic health record (EHR) and create duplicate work. CMS believes that standardized electronic exchange can reduce many of these inefficiencies.

How Standardized Electronic Prior Authorization Will Help Hospitals

Starting in January 2027, Medicare Advantage, Medicaid, Children's Health Insurance Program (CHIP) and Marketplace plans will be required to support standardized electronic prior authorization transactions (ePA). These technologies are designed to allow provider systems to:

- Determine whether prior authorization is required.
- Identify documentation requirements earlier in the process.
- Submit requests electronically within the provider's EHR or practice management system.
- Receive status updates electronically.
- Receive approvals, denials and requests for additional information in a more standardized manner.

At the same time, CMS has already implemented operational reforms requiring many affected health plans to make decisions more quickly, provide more specific explanations when denying requests and publicly report certain prior authorization performance metrics.

Effective Implementation Should Simplify the Prior Authorization Process

The most important question is not whether a new API exists; the important question is: "Will these changes reduce the amount of non-clinical work required to obtain care for patients?"

If implemented effectively, providers may experience:

- Fewer requests for duplicate information.
- Earlier awareness of documentation requirements.
- Less reliance on payer portals.
- Faster visibility into authorization status.
- Fewer scheduling delays caused by missing authorizations.
- Reduced interruptions for administrative tasks.

Clinical documentation already present in the EHR may be reusable within the authorization process, reducing the need to repeatedly provide information already documented as part of normal patient care.

Understand the Rule's Scope

It is equally important to understand what these reforms do not do. The rule does not:

- Apply to all payers and plan types.
- Eliminate prior authorization requirements.
- Standardize medical necessity criteria across payers.
- Instantly replace all payer portals and manual processes.

Many organizations are likely to operate both electronic and manual processes during the transition period. Notably, some plans are not subject to the CMS requirements and may remain outside the new standardized electronic workflows. Additionally, it is important that hospitals monitor whether electronic tools actually replace manual work or simply add another layer to an already-complicated process.

How Providers Should Approach Electronic Prior Authorization Through 2027

Jan. 1, 2027, is not the finish line. It is the start of a transition that will likely include uneven adoption, evolving standards, operational challenges and continued reliance on some manual processes.

Hospitals should prepare for that reality by engaging payers and vendors, testing workflows and identifying where additional workarounds may be needed. The central question is not whether electronic prior authorization exists on Jan. 1, 2027, but whether the technology becomes useful enough over time to reduce burden on care teams and improve timely access to care.

Understand the New Reporting Requirements for Electronic Prior Authorization

Hospitals should also be aware of new reporting requirements. Beginning with 2027 reporting periods, CMS will include electronic prior authorization measures in both the Merit-based Incentive Payment System (MIPS) Promoting Interoperability category and the Medicare Promoting Interoperability Program. Clinical, quality, informatics and operational teams should work together to understand how these measures apply to their organization and whether their technology and workflows support successful reporting.

After implementation, organizations should track both adoption and performance. Useful measures include:

- The percentage of prior authorization requests submitted and completed electronically, including those that are pended or denied.
- Successful transmission of authorization requests and supporting documentation.
- Prior authorization turnaround times.
- Payer portal use.
- Time spent on manual follow-up.
- Delays in treatment caused by authorization issues.
- Patient complaints related to prior authorization.
- Differences in performance across payers, plans and service lines.

Organizations should also establish a consistent process for documenting problems so they can determine whether issues are caused by internal workflows, staff training, vendors, payers or the underlying standards.

What Electronic Prior Authorization Reforms Mean to Providers

These reforms represent the most significant national effort to modernize prior authorization in decades. For providers, the potential benefit is straightforward: less time navigating administrative requirements and more time caring for patients.

Whether that promise is realized will depend on how well insurers, EHR vendors and providers implement the new standards over the next year. The ultimate measure of success will not be the number of electronic transactions completed, but whether clinicians experience fewer delays, less duplicate work and improved access to care for their patients.



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Background: What the Electronic Prior Authorization Reforms Mean for Hospitals

The Interoperability and Prior Authorization Final Rule of 2024, also known as CMS-0057-F, is part of a broader federal effort to improve health information exchange and reduce the administrative burden associated with prior authorization. The rule establishes a more standardized technical framework for exchanging information among payers, providers and patients. For hospitals, however, the central issue is not the existence of the framework — it is whether that framework promotes efficiency and meaningfully reduces the administrative work required to obtain authorization for patient care.

Today, many hospitals manage prior authorization through a patchwork of payer portals, phone calls, faxes, spreadsheets, manual status checks and repeated documentation submissions. Even when an electronic payer portal pathway is available, staff often still need to reenter information, upload records, monitor separate systems and call the payer for clarification to complete the process. The new APIs are intended to create a more consistent way for provider systems to obtain payer requirements, assemble documentation, submit authorization requests and receive responses.

What Hospitals May See

One of the primary goals of electronic prior authorization is to make the EHR the central hub for managing prior authorization requests. Rather than relying on multiple payer portals, hospitals should be able to initiate requests, submit supporting documentation, receive status updates and address any follow-up documentation requests within their existing clinical and administrative workflows. Hospitals also should gain earlier insight into prior authorization requirements and documentation needs, helping reduce delays and administrative burden. Standardized electronic exchange may further support reporting and analysis of prior authorization outcomes across payers and individual plans.

For many hospitals, the greatest value should come from reducing administrative friction. More automated and standardized workflows should decrease the need for manual data entry, phone calls, faxes and portal-based work while improving visibility into authorization requirements and request status. Earlier access to information may help prevent scheduling disruptions, treatment delays and authorization-related denials. Over time, the resulting data could also help hospitals better understand prior authorization performance across plans and services.

What Hospitals Should Not Assume

The rule does not eliminate prior authorization or require payers to change the underlying coverage criteria they use to make medical necessity determinations. Some requests will continue to require clinical review, additional records or peer-to-peer discussion.

Additionally, hospitals should expect a transition period. Hospitals should not assume that all payer plans, services or request types will be supported through the same integrated workflow. While complete automation of these processes is the ultimate goal, hospitals may need to maintain electronic and manual pathways at the same time while payer and vendor capabilities mature.



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Regulatory and Technical Overview

The final rule applies primarily to impacted payers, including Medicare Advantage organizations; Medicaid and CHIP managed care plans and entities; state Medicaid and CHIP fee-for-service programs; and Qualified Health Plan issuers on the federally facilitated exchanges. It does not apply uniformly to every commercial payer plan. Therefore, hospitals should confirm which plans are in scope rather than assuming that a payer's entire book of business will use the same workflow.

Major API provisions

API	What it is intended to do	Why it matters to hospitals
Prior Authorization API	Allows providers to determine whether prior authorization is required, identify documentation requirements, submit requests and receive status information and decisions electronically.	This is the most direct operational change for ordering, scheduling, patient access, utilization management and revenue cycle.
Provider Access API	Makes certain claims, encounters, clinical and prior authorization information available to in-network providers with a treatment relationship, subject to applicable patient choice.	May improve access to payer-held information for care coordination, care management and transitions of care.
Payer-to-Payer API	Supports exchange of certain patient information when an individual changes payers.	Hospitals do not operate this connection, but improved continuity of payer-held information may support care coordination.
Expanded Patient Access API	Adds certain prior authorization information to the data patients can access through payer-connected applications.	Patients may have more transparency but may still look to providers for help interpreting status, denials and next steps.

The final rule also includes prior authorization process provisions. Impacted payers generally must send expedited decisions within 72 hours and standard decisions within seven calendar days; provide a specific reason for denials; and publicly report selected prior authorization metrics. These time frame provisions took effect Jan. 1, 2026. The API provisions primarily take effect Jan. 1, 2027.

Why the Payer-Provider Distinction Matters

Most API obligations apply to payers, not hospitals. That distinction should remain clear in education and internal implementation planning. Hospitals are not responsible for building payer endpoints or ensuring payer compliance. Their work is to determine whether their own systems can connect to available payer capabilities, whether vendors will support a usable workflow and whether the resulting process improves hospital operations. Notably, the risk is that an API becomes an additional channel, rather than a replacement for existing work. Hospitals should therefore document when portals or manual processes remain necessary and press payers and vendors to close those gaps.

Understanding the Prior Authorization API

The Prior Authorization API relies on standards developed through the HL7 Da Vinci project. Three components are especially important to the provider workflow: Coverage Requirements Discovery (CRD), Documentation Templates and Rules (DTR) and Prior Authorization Support (PAS). Together, these components are intended to support the process from identifying payer requirements through submission and response.

Component	Plain-language function	Operational questions
CRD	Allows a provider system to request information about coverage requirements, including whether prior authorization may be required.	Where will the information appear? Which payers and plans are supported? What happens when the response is incomplete or unavailable?
DTR	Helps identify and assemble the information a payer needs to support a request.	Can existing EHR data populate the documentation? Who completes missing information? Can support staff participate without shifting unnecessary work to clinicians?
PAS	Supports submission of prior authorization requests, status checks and payer responses	Where will approvals, denials, requests for additional information, pended statuses and errors appear? How are attachments and failed transactions handled?

The Office of the National Coordinator for Health IT (ONC) has adopted health IT certification criteria that support Fast Healthcare Interoperability Resources (FHIR)-based electronic prior authorization workflows, including capabilities associated with CRD, DTR and PAS. Through recent HTI rulemaking, ONC has continued to expand and refine certification requirements intended to support electronic prior authorization, electronic prescribing and related interoperability functions, while CMS has incorporated electronic prior authorization into the Medicare Promoting Interoperability Program and MIPS Promoting Interoperability requirements. As a result, hospitals should view electronic prior authorization not only as an operational initiative, but also as part of broader certified health IT and reporting readiness efforts. However, certification remains capability-specific and does not guarantee that a developer has implemented every electronic prior authorization function across all plans or workflows.

Hospitals should ask vendors which certification criteria, standards versions and implementation guides they support; when functionality will be available for production use; how payer connections will be tested and maintained; and what upgrades, licensing, configuration or implementation services may be required. Organizations should also confirm how certified capabilities will support electronic prior authorization reporting requirements and whether any portions of the workflow will continue to rely on portals or manual processes despite the availability of certified technology.

Ensure the Technology Supports the Provider's Complete Workflow

An electronic transaction can conform to a technical standard and still fail to reduce burden. For example, requirements may appear too late in the workflow, documentation requests may be vague, responses may not be actionable, or staff may be redirected to a portal to complete the process. Hospitals should evaluate whether the technology supports the full operational pathway, including exceptions, attachments, additional information, status updates and final decisions.

Workflow also matters because prior authorization is often team-based. Clinical support staff, centralized authorization teams, utilization management staff and schedulers may gather and submit information even when a clinician initiated the order. Technology should support these roles without assuming that every documentation task occurs at the point of ordering or must be completed by the clinician.



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Preparing for Jan. 1, 2027

Health plans and vendors must support the electronic prior authorization standards beginning on Jan. 1, 2027. Until this date, the remaining implementation period should be treated as a structured readiness window. The goal is not merely to be ready when payer APIs exist; it is to create the governance, information and relationships needed to use those capabilities effectively and respond quickly when they do not work as intended. To prepare for implementing these standards, providers should:

1. Establish a governance team and define its scope.
2. Assess the current state of prior authorization protocols.
3. Engage vendors and payers.
4. Redesign workflows to operationalize new processes.
5. Test end-to-end.

Establish Governance and Define Scope

Hospitals should create an implementation team, including a designated executive sponsor and an operational lead. Depending on the specific hospital or health system, the team may include information technology personnel, clinicians involved in utilization management, revenue cycle personnel and staff responsible for patient scheduling. The team should define which service lines and payer relationships are initially in scope and maintain a common decision log and issue list.

This work should not sit entirely within IT. Technical connectivity is necessary, but many important decisions involve where the process begins, who owns each step, how clinical information is gathered, how payer responses affect scheduling, and how authorization status is carried into claims and reporting.

Assess the Current State of Workflows

The first substantive task should be a current state assessment. Hospitals should map workflows by service line, identify high-volume and high-friction payers, document the portals and vendor tools currently in use and identify where staff spend the most time. The assessment should include urgent and operationally sensitive services such as advanced imaging, surgery, infusions and post-acute transitions, while reflecting each organization's own volume and risk profile.

Hospitals also should establish baseline measures before implementation. Specifically, organizations should consider documenting (by payer):

- Existing authorization volume.
- Average turnaround time.
- Required manual touchpoints.
- Total staff time required.
- Whether a portal is used.

- Frequency of and total requests for additional information.
- Authorization denials.
- Appeal rates and overturn success rate.
- Delayed or rescheduled care.

The measures do not need to be perfect to be useful. Directional data can help identify where the current process is most burdensome and whether the future process improves it.

Engage Vendors and Payers

Vendor engagement

EHR vendors, clearinghouses, prior authorization vendors and revenue cycle partners may all influence how a system experiences the new prior authorization standards. To plan accordingly, hospitals should reach out to applicable entities to determine how they specifically intend to implement these new workflows. Hospitals should not rely on general statements that a product will be "ready," but rather should ask for a demonstration using realistic scenarios and obtain written clarity regarding functionality, timing, costs, testing and support.

A useful demonstration should show how staff determine whether authorization is required, identify and complete documentation, submit the request, receive status updates, respond to additional information requests, view denials and errors, and document the final outcome. It also should address attachments, urgent cases, downtime, failed transactions and the circumstances under which staff must leave the workflow or use a payer portal.

Specifically, hospitals should ask vendors for information on:

- What functionality will be available before Jan. 1, 2027, and what will be phased in later?
- How will requirements, documentation, status, decisions and errors appear in existing workflows?
- What upgrades, interfaces, licensing, implementation services, testing and training are required?
- How will attachments, downtime, failed transactions, analytics and reporting be handled?

Begin Engaging With High-Volume, High-Friction Payers Now

Although all payers are expected to support the prior authorization standards by Jan. 1, hospitals may wish to stagger their implementation to ensure success. We recommend that hospitals begin by engaging with their highest-volume and highest-friction payers in advance of implementation.

Payer conversations also offer an opportunity to establish provider expectations. Hospitals need workflows that reduce burden — not simply new technical endpoints. Plans should explain how they will return complete requirements, identify missing information, communicate decisions and support troubleshooting.

Specifically, hospitals should ask health plans for information on:

- Which plan types will be supported electronically at go-live?
- When can hospitals test, and which realistic scenarios will be available?
- When will portals remain necessary, and how will outages and urgent cases be escalated?
- How will the plan evaluate whether implementation reduces provider and patient burden?

Clearly Define the Roles for Implementing and Using ePA Technology

Hospitals should avoid layering electronic prior authorization on top of existing manual processes without considering how the work should change. The implementation team should decide where coverage discovery should occur, who is responsible for completing documentation, where status is monitored, when clinical input is necessary and how the final decision affects scheduling and claims support.

The clinician's role should be defined narrowly and intentionally. Electronic workflows can reduce clinician interruptions when they reuse available information and route administrative work appropriately. They can increase burden when they create excessive prompts, duplicate documentation or shift tasks from support staff to ordering clinicians. Frontline staff and clinicians should be involved in design decisions before training materials are finalized.

Fallback processes are also part of workflow design. Hospitals should determine what happens when the payer is unavailable, a transaction fails, an attachment cannot be sent or an electronic response is incomplete. Fallbacks should maintain continuity of care while minimizing duplicate entry. They should be monitored so temporary workarounds do not become permanent parallel processes.

Test Possible Outcomes from Start to Finish, Correct Errors and Retest

Testing should go beyond confirming that a transaction can be sent. Hospitals should validate the entire operational pathway, including identity and connectivity, coverage discovery, documentation, attachments, submission, status, decisions, task routing, audit history and reporting output. Testing should include staff who perform the work every day, as they are most likely to identify where the future process may break down.

Scenarios should include an ordinary approval, missing information, a denial, a pended request, an urgent request, an attachment, a payer outage and a failed transaction. High-volume and high-risk services should be tested first. Defects should be documented by payer, plan, service, transaction stage, expected behavior, actual behavior and operational impact, and then retested after correction.



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Monitoring and Managing Implementation After Go-live

Monitoring after go-live should answer two questions: Is the organization using the electronic workflow, and is the workflow reducing burden or improving patient access?

Select a Manageable Set of Measures to Evaluate Effectiveness

Hospitals should select a manageable set of measures that reflect their highest-volume services, highest-friction payers and most important operational goals. These may include:

- Electronic request share and the portion of payer, plan and service volume supported by the electronic workflow.
- Transaction and attachment success rates, error rates, outages and time to resolution.
- Time from request to decision and time waiting for additional information.
- Portal use, phone and fax activity, duplicate entry, manual status checks and staff time.
- Authorization-related denials, rework, appeals, write-offs and mismatches between approval and payment.
- Delayed or rescheduled care, patient complaints and urgent escalations related to authorization.
- Staff- and clinician-reported burden, alert volume and inappropriate task shifting.
- Variation by payer, plan, service line, site and transaction type.

Identify the Source of Problems

When manual work remains high, the hospital should determine why. The cause may be incomplete vendor functionality, a payer implementation problem, unsupported service scope, inadequate integration, unclear role design, staff training or a standards mismatch. Correcting the inefficiency will differ based on the cause: Internal workflow and training issues should be addressed locally; defects should be escalated to vendors; incomplete or nonactionable payer responses should be raised through payer support and contracting or payer-relations channels. Some issues will cross payers or vendors and may indicate a broader standards or policy problem.

Document Problems and Escalate Effectively

Implementation of these new technologies may produce both temporary problems at the outset and structural problems that undermine administrative simplification. Creating a reliable documentation protocol is imperative so that hospitals can distinguish between the two and respond appropriately.

Hospitals should create documentation methods that allow for issue specificity while also promoting the consistency needed to reveal patterns. A single case may identify a serious patient risk. Repeated cases across a payer, plan or transaction stage may identify a structural problem. Aggregate measures can show scale, while individual examples explain the human and operational impact.

Recommended issue record

- Payer and plan
- Service line, request type and transaction stage
- Date and relevant case or transaction identifier
- Expected response and actual response, including error or status text
- Whether a portal, phone call, fax, manual upload or duplicate entry was required
- Staff time, scheduling, revenue cycle or patient impact
- Screenshots or technical evidence when appropriate
- Internal, vendor and payer escalation history and current resolution status

Know How to Escalate Problems Before Going Live

Hospitals should establish internal and external escalation paths before go-live. Staff should know where to report an issue; who determines whether it is clinical, operational or technical; when vendor or payer support should be engaged; and when an urgent care delay requires immediate escalation outside the ordinary implementation process.

Escalation should also determine whether a particular response resolves the underlying issue. For example, if a response directs staff to use a payer portal indefinitely, the incident may be closed from a support perspective but remain unresolved from an administrative simplification perspective. Hospitals should track recurring fallback use and ask whether the electronic pathway is being corrected.

Review Frequently During the First Weeks and Maintain Ongoing Monitoring

During the first weeks of implementation, hospitals may benefit from frequent review of issues, payer and vendor trends, and urgent cases. As the workflow stabilizes, the organization can reduce the cadence while maintaining ongoing monitoring. The goal is not to create a permanent command center but to prevent early workarounds from becoming the default workflow.



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AHA Advocacy Priorities and Remaining Concerns

The AHA supports prior authorization modernization and standardized electronic exchange use to reduce unnecessary administrative burden. The 2024 final rule is an important step, but the provider and patient benefits will depend on how payers, health IT developers and intermediaries implement the policies in practice.

Operational Usability, Not Technical Conformance Alone

A payer may technically conform to an implementation guide while returning incomplete information, nonactionable responses or indefinite "pended" statuses. It also may preserve payer-specific documentation requirements and portal steps that limit the value of standardization. The AHA has urged CMS to distinguish technical conformance from practical usability and to evaluate whether APIs support complete, reliable workflows.

Consistent Implementation and Testing

Variation across payers has long been a major source of burden. Standardized formats will not resolve that burden if payers interpret the standards differently, rely on supplemental requirements or use different documentation pathways. The AHA supports robust conformance testing, transparency of results and mechanisms for trading partners to validate interoperability before implementation.

Workflow-aligned Documentation

The AHA has emphasized the importance of structured and predictable documentation workflows. DTR should help clarify what information a payer needs and support reuse of available clinical data. Attachment exchange can be important when additional context is necessary, but it should not routinely create a parallel documentation pathway that requires hospitals to maintain duplicative processes.

Coordinated Standards and Accountability

CMS, ONC, payers, vendors and intermediaries should coordinate implementation guide versions and transitions. Misaligned adoption can create connection failures and force providers to bridge incompatible approaches. The AHA also supports meaningful payer performance reporting, reliable endpoint information and oversight that focuses on the real-world function of payer APIs.

Provider-centered Measurement and Cost

Implementation should be judged by whether it reduces manual work, delays and burden, not only by endpoint deployment or transaction counts. Hospitals also should not bear inappropriate costs created by payer compliance gaps, fragmented implementation or new intermediary fees. The policy objective is administrative simplification, not cost shifting to providers.



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Policy Issues to Watch

Electronic Prior Authorization for Drugs

The 2024 Interoperability and Prior Authorization final rule policies apply to medical items and services and exclude drugs. CMS separately proposed policies in 2026 that would extend electronic prior authorization to certain drugs and make broader standards changes. Because those policies remain proposed, hospitals should not treat drug ePA as a finalized Jan. 1, 2027, requirement. Internal communications should clearly distinguish the final rule from the separate proposal.

Provider Reporting Policies

The electronic prior authorization measures in MIPS and Medicare Promoting Interoperability create important provider-facing implications, but program details may change through annual rulemaking. Hospitals should monitor final CMS specifications for the relevant performance year, including the role of certified technology, attestations, exclusions and scoring.

Commercial Payer and Plan Scope

CMS-0057-F does not, in and of itself, require every commercial payer to implement the APIs. Hospitals should ask whether payers will extend standardized workflows beyond the plans directly subject to the rule and should track situations in which different plans under the same payer require different submission methods.

Standards Versioning and Vendor Deployment

CRD, DTR and PAS implementation guides continue to evolve. Hospitals should ask payers and vendors which versions they support, how long older versions will remain available, how transitions will be tested and how compatibility will be maintained when adoption is not synchronized. The AHA has urged coordinated guidance and predictable transition schedules.

Portals and Fallback channels

Portals may remain necessary during the transition and for unsupported use cases. Hospitals should track when a portal is required, what information must be reentered and whether the underlying cause is payer scope, vendor functionality or local design. Temporary fallback pathways should not be allowed to become a permanent layer of duplicate work.

Questions to ask when policy changes

- Is the policy final, proposed or voluntary?
- Does it apply to payers, providers, certified health IT developers or multiple parties?
- Which payer plans and services are in scope?
- What capability is required, and what remains optional?
- What workflow, testing, reporting, staffing and cost implications are there for the hospital?
- What evidence will show that the change reduced burden or improved access?

Appendix A. Hospital Readiness Checklist

1 Organize the work

- Name an operational owner and cross-functional team with authority to resolve issues.
- Assign responsibility for payer and vendor engagement, workflow design, testing, training, monitoring and escalation.
- Define the implementation scope, decision processes and method for tracking open issues.

2 Document the current state

- Identify high-volume services and areas with the greatest administrative friction.
- Note current portal, fax, phone and electronic workflows, including duplicate data entry and manual workarounds.
- Establish baseline measures for volume, turnaround time, denials, staff effort, portal use and delays in care.

3 Confirm payer and vendor readiness

- Obtain specific capability, deployment, onboarding and testing timelines from EHR, clearinghouse and prior authorization vendors and payers.
- Confirm supported CRD, DTR and PAS implementation guide versions and plans for upgrades or transitions.
- Document which payer plans, services and request types will be supported electronically and which will still require another channel.
- Clarify costs, support, testing requirements, downtime procedures and escalation contacts.

4 Design and test workflows

- Map the future-state workflow from coverage requirement discovery through submission, status updates, additional documentation and determination.
- Define staff and clinician roles, required data, exception paths and fallback processes.
- Complete end-to-end testing with payers and vendors.
- Log defects, assign owners and retest fixes before go-live.

5 Prepare staff and operations

- Provide role-based training on normal, exception and downtime workflows.
- Ensure staff know when electronic submission is available, when another channel is required and how to escalate problems.
- Communicate what will change at go-live and provide job aids and support contacts.

6 Monitor results

- Track electronic adoption, manual channel use, reliability, turnaround time, denials, rework and unresolved defects.
- Assess staff burden and patient access impacts by payer, plan, service and request type.
- Review results with payers and vendors, correct problems and retire fallback workflows when performance is reliable.

Leadership Check-in: Six Months After Go-live

Use these questions to determine whether implementation is producing meaningful operational and patient benefits.

- Are staff spending less time searching for prior authorization requirements, reentering information and providing additional documentation?
- Have portal, fax and phone use declined for supported requests?
- Are decisions more timely and reliable, with fewer denials and delays in care?
- What remaining issues require action by hospital leaders, payers, vendors or policymakers?

Appendix B. Resources

- AHA, Comments on CMS—0057-F: Interoperability and Prior Authorization Proposed Rule, March 13, 2026, **aha.org/lettercomment/2023-03-13-aha-comments-advancing-interoperability-and-improving-prior-authorization-processes-proposed-rule**.
- Centers for Medicare & Medicaid Services, 2024 CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F), released Jan. 17, 2024, **cms.gov/initiatives/burden-reduction/overview/interoperability/policies-regulations/cms-interoperability-prior-authorization-final-rule-cms-0057-f**.
- American Hospital Association, Electronic Prior Authorization Arrives Jan. 1, 2027: What Hospitals Need to Know, 2026, **aha.org/news/blog/2026-07-27-electronic-prior-authorization-arrives-jan-1-2027-what-hospitals-need-know**.
- Centers for Medicare & Medicaid Services, CMS Interoperability and Prior Authorization Final Rule Fact Sheet, Jan. 17, 2024, **cms.gov/newsroom/fact-sheets/cms-interoperability-prior-authorization-final-rule-cms-0057-f**.
- Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology, Electronic Prior Authorization Fact Sheet (Oct. 2025), **healthit.gov/wp-content/uploads/2025/10/ePrior-Authorization-fact-sheet_OCT2025_508.pdf**.
- Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology, HTI-4 Final Rule Overview Fact Sheet, July 2025, **healthit.gov/wp-content/uploads/2025/08/HTI-4-Final-Rule-Overview-Fact-Sheet_508.pdf**.
- American Hospital Association, Comments on CMS-0062-P: Interoperability Standards and Prior Authorization for Drugs, June 15, 2026, **aha.org/lettercomment/2026-06-15-aha-comments-cms-interoperability-and-prior-authorization-proposed-rule**.
- Centers for Medicare & Medicaid Services, 2026 CMS Interoperability Standards and Prior Authorization for Drugs Proposed Rule Fact Sheet, **cms.gov/newsroom/fact-sheets/2026-cms-interoperability-standards-prior-authorization-drugs-proposed-rule**.