

## **Powering Digital HEDIS® with the CMS Interoperability and Prior Authorization Final Rule**

In our first post, we explored why manual chart review is no longer sustainable and how NCQA's 2030 digital mandate will change the way health plans measure and improve quality. But understanding the “why” is only the first step. Now comes the “how.”

In this post, we examine how federal policy, particularly CMS's interoperability and prior authorization mandate, is actively shaping the infrastructure required to support digital quality measurement. These rules will change how data is shared and will enable real-time measurement, automated reporting, and richer collaboration between payers and providers, all of which are foundational to digital HEDIS.

### **Why CMS Interoperability Mandates Matter Now**

For almost two decades, CMS has been laying the groundwork for a healthcare system driven by data, transparency, quality, and interoperability. What began with incentives for EHR adoption and meaningful use measures has now evolved into a complex but purposeful strategy to connect the entire healthcare ecosystem. Today, the focus is creating bidirectional, seamless data exchange—laying the groundwork for a future in which stakeholders, from payers to providers and members can securely and efficiently share information that directly impacts care delivery, coordination, and outcomes.

The new interoperability and prior authorization rules push health plans to modernize HEDIS operations, reduce manual effort, and capture clinical data in real time through infrastructure originally introduced through the HITECH act of 2009. These mandates align closely with and are accelerating the shift away from hybrid measurement.

*For clinical quality leaders, this means the systems required to meet compliance are the same systems that will determine success in digital HEDIS going forward.*

### **A Look at Federal Interoperability Milestones**

The Centers for Medicare & Medicaid Services (CMS) has been actively working to enhance data interoperability and streamline prior authorization processes in healthcare. These milestones show how far the industry has come and what's now required of health plans.

#### **2009: HITECH Act and Meaningful Use**

Laid the groundwork for EHR adoption and electronic data capture by providing financial incentives to hospitals and providers.

**2016: 21st Century Cures Act**

Expanded patient access to electronic health information and established national goals for health data sharing.

**2020: CMS Interoperability and Patient Access Final Rule**

Required payers to implement FHIR-based APIs, giving patients easier access to their health data and encouraging standardized data exchange.

**2024: CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F)**

Focused on streamlining prior authorization and improving clinical data exchange between providers and payers through electronic APIs.

**2026–2027: Final Rule Compliance Deadlines**

The CMS Interoperability and Prior Authorization Final Rule sets deadlines for implementing standard APIs including Patient Access, Payer-to-Payer, Provider Access, and Prior Authorization, to improve data exchange and reduce administrative burden. These requirements begin phasing in by 2026, with full implementation and reporting required by early 2027.

For those who need specific technical details and reporting metrics, see the full

**Interoperability: An Accelerator for Digital HEDIS**

Interoperability and automation play critical roles in measuring and improving healthcare quality by allowing seamless data exchange to enhance and expedite clinical decision-making.

The ability of different payer and provider healthcare systems to communicate and exchange data easily across various care settings enhances continuity of care and improves quality and health outcomes. The CMS-0057-F Interoperability final rule mandates payer to provider interoperability and sets the table for provider to payer interoperability, which will improve the accuracy and timeliness of clinical data and quality measurement for payers.

CMS's interoperability rules are making this shift operational by requiring health plans to adopt FHIR-based APIs, support bidirectional data exchange, and capture clinical context through automated workflows like electronic prior authorization (ePA).

These policies are driving payers to invest in technology that will enable reduction of and reliance on manual chart review and sampled data sets, replacing them with real-time feeds from EHRs, registries, and HIEs supporting:

- Faster visibility into member activity

- More complete and accurate quality reporting
- Ongoing measurement throughout the year
- Early identification of care gaps and missed opportunities
- Reduction in cost as data can be integrated across many use cases

NCQA envisions using digital quality measures, including ECDS measures to encourage use of real-time, clinical data to improve the accuracy and timeliness of quality reporting. Automation provides quicker access to member data, enabling the on-going measurement and monitoring of healthcare quality metrics. Moving from retrospective regulatory HEDIS to real-time analysis and reporting is a game-changer in healthcare quality. With automation in place, measurement becomes continuous, proactive, and integrated into the clinical workflow.

### **The Overlooked Value of ePA for Quality Measurement**

The CMS-0057 Final Rule includes an Electronic Prior Authorization (ePA) API which requires payers to implement and maintain FHIR APIs to support electronic receipt of prior authorization requests from provider EMRs to payer UM systems. Determination and documentation requirements must be communicated within 72 hours for urgent and 7 calendar days for non-urgent requests.

#### **The ePA API allows providers to:**

- Query the payers' system to determine whether a prior authorization is required for covered items and services and what documentation is needed
- Send a prior auth request from providers EHR to the payer, along with supplemental clinical documentation to support the request
- Receive a decision from the payer whether or not the prior authorization has been approved

**While this is often viewed as an administrative fix, the benefits for digital HEDIS are substantial:**

#### **Timely access to care:**

Faster approvals help avoid delays in services tied to HEDIS measures like diagnostic imaging, behavioral health visits, or specialist referrals.

#### **Structured clinical context:**

ePA captures provider intent and relevant clinical data in standardized formats, supplementing claims data with deeper insights.

**Improved data liquidity:**

ePA data contributes to a more complete picture of a member's care experience, strengthening attribution, measure logic, and provider engagement.

**Operational efficiency:**

Automating prior auth frees up resources that can be redirected to strategic initiatives like quality performance improvement.

For vendors like Abacus, this is a critical area of enablement. We help health plans not only meet the CMS requirements but also operationalize FHIR-based APIs in ways that feed digital HEDIS pipelines. This means less lag, fewer gaps, and better alignment with clinical intent.

**How should forward-thinking Quality leaders approach these mandates?**

With rule deadlines approaching, health plans must take practical steps now to prepare. For Quality teams, this includes collaborating with clinical and IT teams on the following:

- **Assessing FHIR API readiness** across internal and external HEDIS source systems
- **Aligning quality, clinical, and IT teams** around shared data objectives
- **Mapping data flows** from ePA, EHRs, and HIEs to quality reporting infrastructure
- **Choosing vendors** who can normalize, integrate, and route all relevant data in real time
- **Redesigning workflows** to reflect continuous measurement rather than year-end abstraction

This is both a technology issue and a coordination challenge that requires leadership across departments and a partner that can bring technical and clinical expertise to the table.

**What Comes Next**

CMS has laid the policy groundwork, and NCQA has set the measurement roadmap. Together they outline a vision for real-time, data driven quality measurement. Now, the challenge for health plans is turning that vision into operational reality through the right strategies, technology, and partners.

In our next post, we'll explore how value-based care and digital transformation are redefining HEDIS and what to look for in a vendor that's equipped to support that evolution.