Member: Understanding CMS-0057 and Your Health Information

What is CMS-0057 and what does it mean for me?

CMS-0057 is a new rule from the Centers for Medicare & Medicaid Services (CMS) that makes your health care simpler, faster, and easier to understand. It improves how your health information is shared so you can:

- See your health information
- Get faster decisions from your insurance
- Better understand your care and coverage

CMS-0057 builds upon the May 2020 CMS Interoperability and Patient Access final rule implementing policies that improve patient, provider, and payer access to interoperable patient data and reduces the burden of the prior authorization processes.

CMS-0057 Application Programming Interfaces (APIs) and benefits:

CMS-057 requires software tools called “Application Programming Interfaces (APIs)” to be used to help your doctors and health plan share information easily. This helps you get the right care faster, with less waiting and confusion, while you stay in control of your health information. The APIs are listed below. More information about each API is provided in the sections that follow.

- Patient Access[1] and Provider Directory APIs
- Payer-to-Payer (Health Plan-to-Health Plan) API
- Provider Access API
- Electronic Prior Authorization API

Patient Access[1] and Provider Directory APIs (Upgraded CMS-9115[2])

Supports Patient Access, the medicines your health plan covers, and Provider Directory APIs.

- This means approved apps can show you your health information, a list of covered medicines, and doctors in your health plan.
- These apps can also show basic plan details, prior approval updates, and more health information to help you take better care of yourself.

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- Provides you with access to historic and current information from your health plan.
- What will I see in my health information account?
  - You will have access to your health information dating back to Jan. 1, 2016. Depending on the health app you download to your phone, different features and information may be available. Each approved third-party health app works hard to create the best user experience for you. You will be able to see:
    - Health plan information such as coverage type and Member ID (Medicaid ID)
    - An explanation of plan benefits including insurance payments and the amount paid
    - A history of your previous medical procedures
    - A list and descriptions of your medical conditions as recorded by your provider
    - Medication history, including your vaccinations or immunization history
    - A list of providers and organizations involved in your care delivery[1]
    - Your health app may provide additional helpful features to help you take control of your healthcare[1]
    - Patients will have access to prior authorization requests and decisions (excluding those for prescription medicine) helping you understand your insurance plan's prior authorization process and its impact on your care[1]

    Examples include:

    - Whether prior approval is needed for certain medical items and services (when your plan makes this available)
    - The current status of a request (for example: submitted, in review, approved, denied, or needing more information)
    - Decision information (for example: approved, denied, and the reason for denial when applicable)

[1]Health app features may vary depending on the app you choose; each health app determines what information is provided and services offered.

[2]The prior authorization requirement must be implemented by January 1, 2027, as part of the enhancement to the Patient Access API for CMS-0057.

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Payer-to-Payer (Health Plan-to-Health Plan) API (CMS-0057-F)

Health plans can share billing and visit information with other health plans. This makes switching health plans easier for you and reduces extra work.

- The health plan you are enrolled in can request appropriate information from your prior health plan
- If you have multiple health plans, they can share your data to coordinate your coverage
- Your data will not be shared with plans you are not enrolled in
- Allows your new health plan to see up to 5 years of your health information from your prior health plan when you switch plans. This helps avoid repeated tests, delays in care, and unnecessary costs, so your care can continue more smoothly.

Patient consent: You must give permission, or consent, for your new health plan to request your data from your prior or other health plan. You can change your mind at any time to start or stop sharing.

- You will be asked to give permission at the time of enrollment and re-enrollment.
- If you do not give permission, your health information from your prior or other plan will not be shared.
- You have the ability to start or stop permission at any time by logging in to your KYNECT account or by calling 855-459-6328.

Provider Access API (CMS-0057-F)

Information is shared with your established doctors that are in-network with your health plan and have established care with you. Doctors in your health plan's network may access the following information from your health plan:

- Claims information
- Visit and service details
- Clinical information, such as problems, medications, allergies, and labs, if available
- Prior approval history

Patient consent**:** You can choose to stop sharing your health information at any time.

- Sharing is automatically turned on.
- You have the ability to start or stop permission at any time by logging into the consent Portal. This will not change your benefits, coverage, or Medicaid eligibility.
- If you stop permission, your provider will not be able to access your data.

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Electronic Prior Authorization API

Your health plan can safely receive prior approval requests by computer instead of paper or fax. These systems must send back decisions and let doctors know what papers are needed—within 72 hours for urgent requests and 7 days for non-urgent requests.

Glossary

- Member portal/app: A website or mobile app offered by your health plan.
- Third-party application (app): An app not built by your health plan that you choose to connect.
- Prior authorization: A process where a plan reviews certain medical services before they are provided to confirm coverage requirements are met.
- Treatment relationship: A care relationship between a provider and a patient that may allow access to certain information, as permitted by the plan.
- Payer: A health plan or insurance company that pays for healthcare services.
- Provider: A doctor, clinic, or hospital that delivers healthcare services.

Helpful links

- Interoperability and Patient Access final rule
- Policies fact sheet
- Centers for Medicare & Medicaid Services (CMS) policies and technology
- CMS overview page
- CMS fact sheet (PDF)
- Federal Register final rule

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