



# Beyond compliance

How health plans can meet—and maximize  
—the CMS prior authorization rule



In our article “[Preparing health plans for 2027 CMS API Rule](#),” we explored what the CMS Advancing Interoperability and Improving Prior Authorization Processes [final rule](#) is and how EviCore by Evernorth® has been preparing to help health plans comply.

In this installment, we take a closer look at what the rule requires, where the complexity lies for health plans and how EviCore intelliPath® is helping payers prepare.

**Beginning January 1, 2027**, impacted payers must meet the CMS application programming interface (API) provisions. For health plans, this isn’t simply a compliance exercise; rather, it requires fundamental changes to how prior authorization data is exchanged, processed and acted on. More importantly, it also presents an opportunity to make provider workflows more seamless and efficient.

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## The rule at a glance



### Who’s affected?

The CMS rule applies to Medicare Advantage organizations, state Medicaid and Children’s Health Insurance Program (CHIP) Fee-for-Service programs, Medicaid-managed care plans, CHIP-managed care entities and Qualified Health Plan issuers on the Federally Facilitated Exchanges.

In practice, many payers are extending their compliance efforts to commercial lines of business as well, recognizing the value of a consistent, streamlined approach across all populations.





## What's required?

Health plans must implement prior authorization APIs built on the Health Level 7® (HL7®) Fast Healthcare Interoperability Resources® (FHIR®) standard. The goal is to create a more consistent, efficient way for providers and payers to exchange prior authorization information electronically.

As discussed in [our previous article](#), interoperability enables systems to exchange and use data effectively across the health care ecosystem. APIs play a key role by allowing software systems to communicate directly. In practice, this means prior authorization workflows can be embedded within provider EMRs, reducing manual steps and accelerating decision-making.

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## The three APIs health plans need to know for prior authorization automation

The rule centers on three APIs, each serving a distinct function in the prior authorization workflow:



### Coverage Requirements Discovery (CRD)

Identifies whether a service, a procedure or an item requires prior authorization



### Documentation, Templates, and Rules (DTR)

Provides payer-specific questions and documentation requirements



### Prior Authorization Support (PAS)

Facilitates submission of the prior authorization request, including required clinical data

Together, these three APIs are designed to create a more seamless, end-to-end electronic prior authorization experience.

# Where the complexity lies

While the rule is straightforward in concept, execution is significantly more complex. For many health plans, the challenge is not understanding what's required; instead, it's operationalizing the requirements at scale while fitting into provider workflows.



## It's not just about delegated services

Health plans must implement compliant FHIR APIs across their entire applicable prior authorization footprint, including services delegated to partners, such as EviCore by Evernorth, as well as those managed internally.



## Delegated partners can create—or close—compliance gaps.

For delegated services, a health plan's compliance readiness depends in part on whether its partners can support FHIR-based workflows. If a delegated entity is not FHIR ready, it introduces risk, creating gaps in the health plan's ability to meet CMS requirements and forcing workarounds that can add friction for providers.





## Compliance is the floor, not the ceiling

Meeting the rule's technical requirements is necessary, but it's only the starting point. The real opportunity for health plans is to improve operational efficiency and reduce provider abrasion through the transition.

This is where broader industry commitments come into play. AHIP's [prior authorization commitments](#) set expectations beyond compliance, including near real-time decisions for at least 80% of electronic prior authorization requests submitted with complete clinical documentation.



## The automation gap is widening

The push toward automation is accelerating, with many solutions emphasizing high auto-approval rates. However, prior authorization isn't just about approving straightforward cases.

A meaningful portion of requests involve clinical nuance and require thoughtful, expert judgment. These are often the most critical and consequential determinations in the process.



**The real risk is not under-automation but over-reliance on automation without the clinical infrastructure to support complex cases. Health plans must ask themselves the following:**

- + Who is managing the requests that can't be automated?
- + Do we have the clinical breadth and depth of expertise to handle these requests effectively?
- + Do we need a partner who can provide this expertise at scale?

# How EviCore IntelliPath is helping health plans prepare

EviCore by Evernorth is well positioned to support health plans through both compliance and operational transformation. Our electronic prior authorization platform, EviCore IntelliPath, is the result of years of investment in automation, interoperability and clinical workflows, and it enables health plans to move beyond compliance and toward a more transformative model.



## Compliance through your existing delegated relationship

For services delegated to EviCore by Evernorth, health plans have access to compliant FHIR-based DTR and PAS APIs through IntelliPath (Payers are responsible for CRD APIs).

In many cases, workflows can be further streamlined. For a significant portion of our radiology, cardiology and gastroenterology services, prior authorization requests can be submitted directly through PAS without DTR questionnaires. The initial PAS submission can also be done without additional clinical documentation from the member. That information is only pulled in by the system if a case pends (i.e., when there's not enough information to immediately approve a case).



**EviCore is already actively testing and piloting with health plan partners to ensure readiness well ahead of the January 2027 deadline.**





## Built on a proven foundation

EviCore IntelliPath isn't a new or untested solution: It's deeply embedded in the prior authorization ecosystem.

### EviCore IntelliPath is:



Live with more than **260 provider organizations**



Able to process delegated volume electronically for **more than 60 health plans**



**Integrated with 13 channel partners**, with six more in process for 2026



Capable of **supporting multiple data formats**, including FHIR, X12 278 and HL7

This allows health plans to accelerate compliance without requiring providers to adopt entirely new workflows, which reduces disruption while improving connectivity.





## The full picture—not just automation

Our approach combines automation with clinical expertise, ensuring that both simple and complex cases are handled appropriately.

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### Here’s how it works in practice:

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#### Automated case creation and real-time approvals

EviCore IntelliPath automatically connects to EMR systems to create prior authorization requests, eliminating the need for clinical staff to manually enter information. From there, the platform applies advanced machine learning to enable real-time approvals of authorization requests with a high likelihood of meeting evidence-based guidelines. We authorize up to 80% of approvable cases in minutes, accelerating access to care. **Importantly, automation can never be used to deny a request.**

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#### Streamlined clinical documentation

For requests that require deeper clinical review, EviCore IntelliPath initiates the automated submission of relevant clinical documentation directly from the EMR, aligning the information with review criteria. This eliminates the back-and-forth of traditional documentation requests and leads to an **approximately 50% decrease in overall decision-turnaround time.**

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#### Clinical expertise for complex cases

For cases that can’t be approved in real time, we have **deep clinical expertise and evidence-based guidelines** to manage the full process, including medical necessity determinations and, if needed, peer-to-peer requests. This means health plans don’t have to figure out how to build systems and processes or how to staff the clinical review capability in house.

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This combination of automation and clinical rigor is what enables us to help health plans meet both CMS requirements and rising industry expectations.

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# What health plans should do now

**The January 2027 deadline is coming soon.** Health plans should be assessing their readiness across both delegated and non-delegated services, identifying gaps in their FHIR API capabilities and ensuring their partners are prepared. Understanding where operational risk exists today is critical to avoiding disruption tomorrow.

EviCore by Evernorth is ready to support that process not just as a vendor meeting a mandate but as a collaborator in building a more efficient, transparent and clinically sound prior authorization experience.

A man with a beard and grey hair, wearing a dark suit jacket over a light blue shirt, is sitting at a wooden desk in a modern office. He is talking on a mobile phone held to his ear with his left hand. On the desk in front of him is a silver laptop, a black tablet, and some papers. He is holding a pen over the papers. The background shows a bright, open-plan office with large windows and modern lighting fixtures.

As a next step, [complete our CMS FHIR API Readiness questionnaire](#) to better understand the resources you need to meet the mandate and improve the prior authorization experience.