WHITE PAPER

MAPPING THE STAKEHOLDERS

Behind CMS-0057-F Compliance

The foundation for successful change management starts with knowing who’s in the room.

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CONTENTS

EXECUTIVE SUMMARY

The CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F) requires health plans to rebuild core parts of how they exchange data and process prior authorization requests. The rule's operational provisions took effect January 1, 2026, and its application programming interface (API) requirements phase is currently required to be in place by January 1, 2027. For Organizational Change Management (OCM) leaders, CMS-0057-F is not simply an IT build or a compliance filing. It is a cross-functional change that touches utilization management, provider relations, member services, legal, and technology teams simultaneously, on a fixed and public timeline.

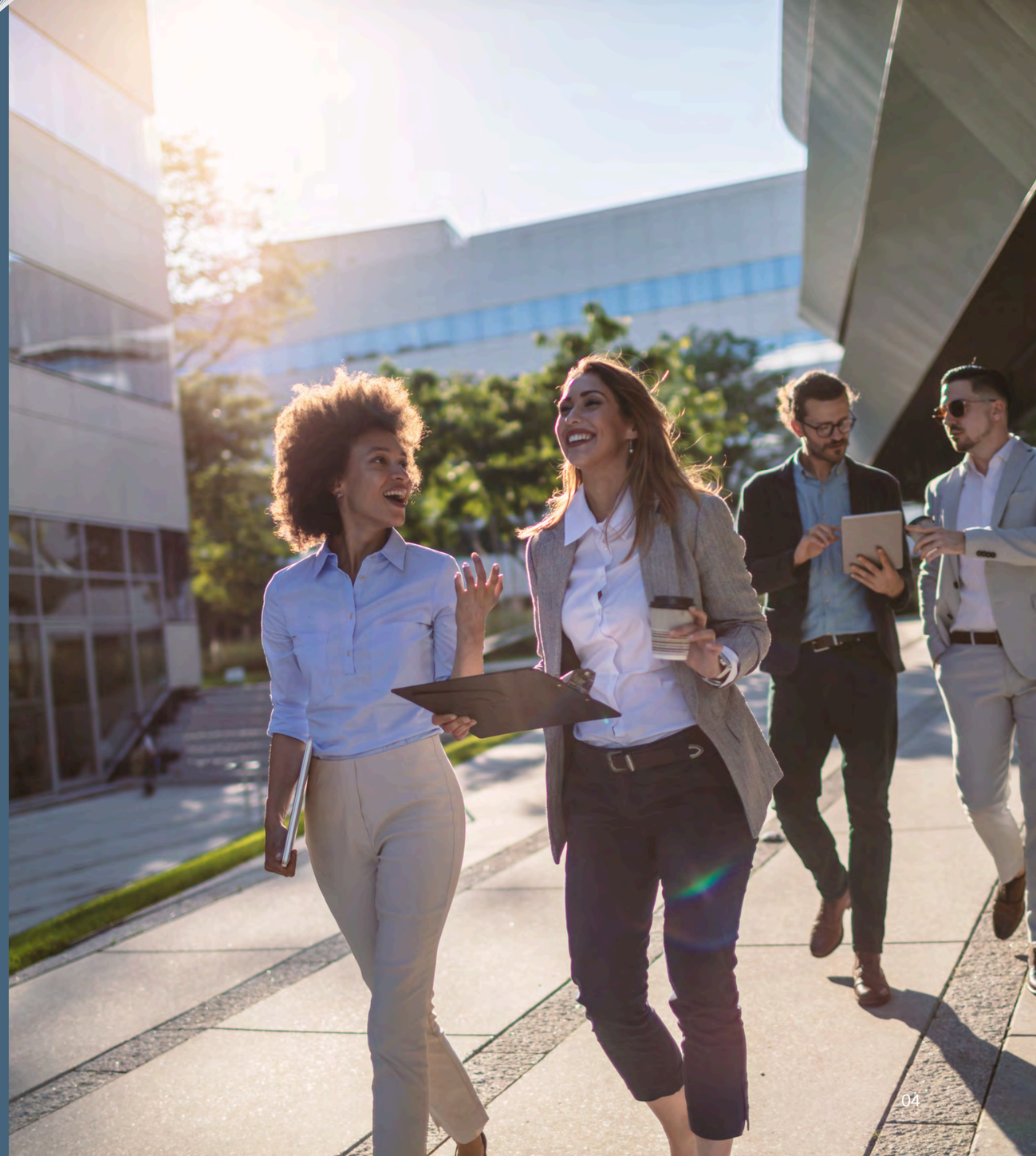
A rigorous Stakeholder Analysis is the single highest-leverage activity an OCM leader can perform before engagement begins. It converts a long list of “people we should probably talk to” into a structured, evidence-based understanding of who is affected, how deeply, what they need, and in what order they should be engaged. Done well, it becomes the backbone of the communication plan, training plan, engagement plan, resistance-management plan, adoption plan, and the governance model for the entire initiative.

This paper summarizes CMS-0057-F, defines what a Stakeholder Analysis includes, and shows, stakeholder by stakeholder, how that analysis translates into value for the people who must live through the change.

INTRODUCTION

Healthcare regulatory change has always required coordination across departments. CMS-0057-F raises the degree of difficulty for Implementors: it is technically dense (built around Fast Healthcare Interoperability Resources [FHIR]-based APIs), operationally demanding (fixed turnaround times and public metric reporting), and organizationally wide (it reaches payers, providers, vendors, and members at once). Under these conditions, an OCM leader cannot rely on informal knowledge of "who matters." A deliberate, documented Stakeholder Analysis is required before communication plans, training curricula, or engagement cadences are built.

This paper is written for OCM practitioners, project sponsors, and program leaders who are accountable for the human side of CMS-0057-F implementation. It assumes familiarity with general change management concepts and provides a practical structure for immediate application.



UNDERSTANDING CMS-0057-F

Background

CMS released the Interoperability and Prior Authorization Final Rule (CMS-0057-F) on January 17, 2024. It builds on the 2020 CMS Interoperability and Patient Access Final Rule (CMS-9115-F) and aims to reduce the burden prior authorization places on patients, providers, and payers by moving the industry toward standardized, electronic data exchange.

Who Must Comply

The rule applies to Medicare Advantage organizations, state Medicaid fee-for-service (FFS) programs, state Children's Health Insurance Program (CHIP) fee-for-service programs, Medicaid managed care plans, CHIP managed care entities, and Qualified Health Plan (QHP) issuers on the Federally-Facilitated Exchanges (FFE). Providers do not carry a direct compliance mandate, but their systems must interact with payer-side APIs, which makes them a critical audience for any engagement effort.

UNDERSTANDING CMS-0057-F

What Changes & When*

Faster Decisions

72 hours for expedited requests and 7 calendar days for standard requests, effective generally January 1, 2026 (this decision-timeframe requirement excludes QHP issuers on the FFEs).

Specific Denial Reasons

Beginning January 1, 2026, payers must provide a clear, specific reason for any prior authorization denial, regardless of submission method.**

Public Reporting

Payers must publicly report prior authorization metrics beginning March 31, 2026 (covering CY 2025), including approval and denial rates, appeal outcomes, and average decision times.

API Build-Out

In response to stakeholder comments on the proposed rule, CMS extended the deadline for the API development requirements to January 1, 2027.***

*Dates vary by program type. FFS/MA dates are fixed; Managed Care/QHP timing is cycle dependent.
**PA decision/denial-reason requirements do not apply to drugs.
***CMS-0062-P, a proposed rule (April 2026), would extend the prior authorization interoperability requirements for prescription drugs to a proposed compliance date of October 1, 2027. As a proposed rule, its provisions and dates are not final.

The Four FHIR APIs

1

Patient Access (enhanced)

Expands the data patients can access about their own claims, encounters, and prior authorizations.

2

Provider Access (new)

Lets in-network providers retrieve patient data payers already hold, with a patient opt-out process required.

3

Payer-to-Payer (new)

Requires payers to exchange claims, encounter, and prior authorization data when a member changes plans, so history follows the patient.

4

Prior Authorization (new)

Supports the full workflow including discovery of what requires prior authorization (PA), submission, tracking, and final determination.

A CHANGE MANAGEMENT CHALLENGE

It is tempting to treat CMS-0057-F as a technology and compliance exercise: stand up the APIs, update the policies, file the reports. But the rule changes how people work, not only how systems talk to each other. Utilization management staff must adopt new documentation and turnaround standards. Provider-facing teams must explain new data flows to network providers who have no direct compliance obligation of their own. Payers must post the PA Metrics on their own public site on an annual basis. Member services must field questions from patients seeing new information about their own prior authorizations. Legal and compliance teams must monitor a public reporting requirement that puts operational performance in front of regulators and the public for the first time.

Because the rule is public-facing, patients can see the data and metrics that are published. The cost of poor internal engagement shows up externally. A workflow that is technically compliant but poorly adopted will surface as slow turnaround times, inconsistent denial reasoning, or provider confusion, all of which are now visible in public metrics. This is precisely the environment in which a disciplined Stakeholder Analysis pays for itself.

STAKEHOLDER ANALYSIS AS THE FOUNDATION

A Stakeholder Analysis is the structured process of identifying everyone affected by or able to affect an initiative, understanding their level of interest and influence, assessing how the change affects them specifically, and using that understanding to shape how and when they are engaged. It is foundational because every downstream OCM artifact (i.e., the communication plan, training plan, engagement plan, sponsor roadmap, resistance management plan, and adoption plan) depends on getting this analysis right first.

Change management research consistently identifies inadequate stakeholder engagement and weak sponsorship as leading causes of change failure. For a rule or change as cross-functional and deadline-bound as CMS-0057-F, skipping or rushing this step results in duplicated effort, contradictory messaging between departments, or resistance from groups who were never given a reason to support the change.

ANATOMY OF A STAKEHOLDER ANALYSIS

Inputs

The quality of a Stakeholder Analysis is only as good as the material fed into it. For CMS-0057-F, OCM leaders must gather information before beginning the analysis:

REGULATORY SOURCE MATERIAL

Final rule text, CMS fact sheets, FAQs, and any CMS informational session recordings or slides, so the analysis is grounded in the actual requirements rather than secondhand summaries.

ORGANIZATIONAL STRUCTURE

Current organizational charts and operating models for utilization management, IT/interoperability, provider relations, member services, legal, and compliance.

CURRENT-STATE PROCESS MAPS

How prior authorization, member data requests, and payer-to-payer data exchange work today, including manual workarounds.

SYSTEMS & VENDOR INVENTORY

Claims platforms, User Management (UM) systems, member portals, EHR interfaces, and any FHIR API or interoperability vendors already under contract.

GOVERNANCE & RISK REQUIREMENTS

Existing compliance obligations, audit findings, and the organization's risk register as it relates to prior authorization and data sharing.

HISTORY & LESSONS LEARNED

Outcomes from prior regulatory or system changes (e.g., the 2020 Patient Access rule rollout) including what engagement approaches worked or failed.

DIRECT LISTENING

Interviews, surveys, or listening sessions with representatives from each functional area and, where feasible, provider or member advisory groups.

COMPETING PRIORITIES

A view of other initiatives underway, including parallel Medicaid Enterprise System (MES) modernization/implementation efforts, in the same departments.

This is a sample list. A full list of Inputs must be created and reviewed based on project needs.

ANATOMY OF A STAKEHOLDER ANALYSIS

Outputs

The previous inputs are leveraged to develop a small set of concrete, reusable artifacts:

STAKEHOLDER REGISTER

A living list of individuals and groups with role, department, influence level, interest level, current sentiment, and desired future sentiment.

INFLUENCE/INTEREST MAP

A visual grid that prioritizes who needs intensive, ongoing engagement versus periodic updates.

CHANGE IMPACT ASSESSMENT

A breakdown, by stakeholder group, of exactly what will change in their process, systems, role, or required skills.

RACI MATRIX

Clarity on who is Responsible, Accountable, Consulted, and Informed for each API workstream and each operational requirement.

READINESS & SENTIMENT ASSESSMENT

A baseline read on awareness, understanding, and attitude toward the change, so progress can be measured over time.

ENGAGEMENT & COMMUNICATION PLAN

Tailored messages, channels, and cadence for each stakeholder segment, sequenced against the January 2026 and 2027 milestones.

RISK & MITIGATION PLAN

Specific risks tied to stakeholder groups (e.g., patient's confusion about opt-out processes) with named owners and mitigation actions.

GOVERNANCE & FEEDBACK CADENCE

A recurring mechanism for stakeholders to raise concerns and for the analysis itself to be updated as the program progresses.

This is a sample list. A full list of Outputs must be created and reviewed based on project needs.

VALUE FOR CMS-0057-F STAKEHOLDERS

The real test of a Stakeholder Analysis is whether it produces something each stakeholder group would recognize as valuable to them, not just to the program office. The table illustrates the potential connections of what CMS-0057-F means for a representative set of stakeholder groups to the specific value of thorough detailed stakeholder analysis.

Stakeholder Group	What CMS-0057-F Means for Them	Value Delivered by Stakeholder Analysis
Executive sponsors & compliance leadership	Accountable for meeting the appropriate deadlines and as well as the information that is publicly reported.	A clear influence/interest map and risk log lets sponsors focus attention where it changes outcomes and gives them an evidence base for resourcing decisions.
IT/Interoperability & API teams	Must build and maintain four FHIR APIs on a fixed technical timeline.	The change impact assessment and RACI matrix prevent duplicated build work and clarify handoffs with UM, compliance, and vendors.
Utilization management/Clinical reviewers	New turnaround times (72 hours / 7 days) and a requirement to document specific denial reasons.	Readiness assessment surfaces training and workflow gaps early, before the deadline, not after a missed turnaround becomes a public metric.
Provider network / Provider relations	No direct CMS mandate but can integrate with payer APIs and adjust to new data flows and opt-out processes.	Tailored engagement plan gives providers the specific, role-relevant information they need without burying them in the full regulatory text.
Vendors & health IT partners	Must deliver FHIR-compliant, standards-based functionality on the organization's timeline.	Stakeholder register clarifies decision rights and escalation paths, reducing rework and vendor-side delays.
Member services/ Call center	Handle member questions as patients see new prior authorization and claims data through the Patient Access API.	Sentiment baseline and communication plan equip frontline staff with consistent talking points before member call volume increases.
Legal & regulatory affairs	Owns interpretation of the rule and oversight of the public metrics reporting obligation.	Centralized stakeholder register and governance cadence give legal a single, current view of who is doing what, reducing compliance blind spots.
Patients/Members (external)	Gain new visibility into their own prior authorization status and data through the Patient Access API.	Impact assessment ensures member-facing communication is planned for, not an afterthought to the technical build.

Illustrative mapping of CMS-0057-F impact to Stakeholder Analysis value, by stakeholder group.
Organizations should tailor groups and rows to their own structure.

A PRACTICAL METHOD

Change leaders don’t need to invent a methodology from scratch. A few well-established tools are enough to run a rigorous CMS-0057-F Stakeholder Analysis.

A proven sequence applies: identify stakeholders, assess impact and influence, prioritize engagement effort, build tailored plans, engage, then monitor sentiment and revisit the analysis as the program moves from the 2026 operational deadline toward the 2027 API deadline.

POWER/INTEREST MAPPING

Plot each stakeholder group by their influence over the program and their level of interest in it to decide who gets intensive engagement versus periodic updates (Mendelow, 1981).

STAKEHOLDER SALIENCE

Where groups are numerous, assess power, legitimacy, and urgency together to prioritize limited engagement capacity (Mitchell, Agle, & Wood, 1997).

ADKAR

For priority stakeholder groups, assess individual readiness across Awareness, Desire, Knowledge, Ability, and Reinforcement.

RACI

Once impact and influence are understood, assign clear decision rights for each of the four APIs and each operational requirement.

RISKS OF SKIPPING THE ANALYSIS

FRAGMENTED MESSAGING

Different departments tell providers and members different things about the same requirement.

PROVIDER ABRASION

Providers, who have no direct compliance obligation, disengage or resist if they are not given a clear, role-specific reason to change how they work with payers.

COMPLIANCE MISSES

Because prior authorization metrics are now publicly reported, workflow adoption problems that would once have stayed internal become visible to regulators and the public.

RESOURCING GAPS

Without a documented influence/interest map, scarce change management and training resources are spread evenly instead of where they change outcomes most.

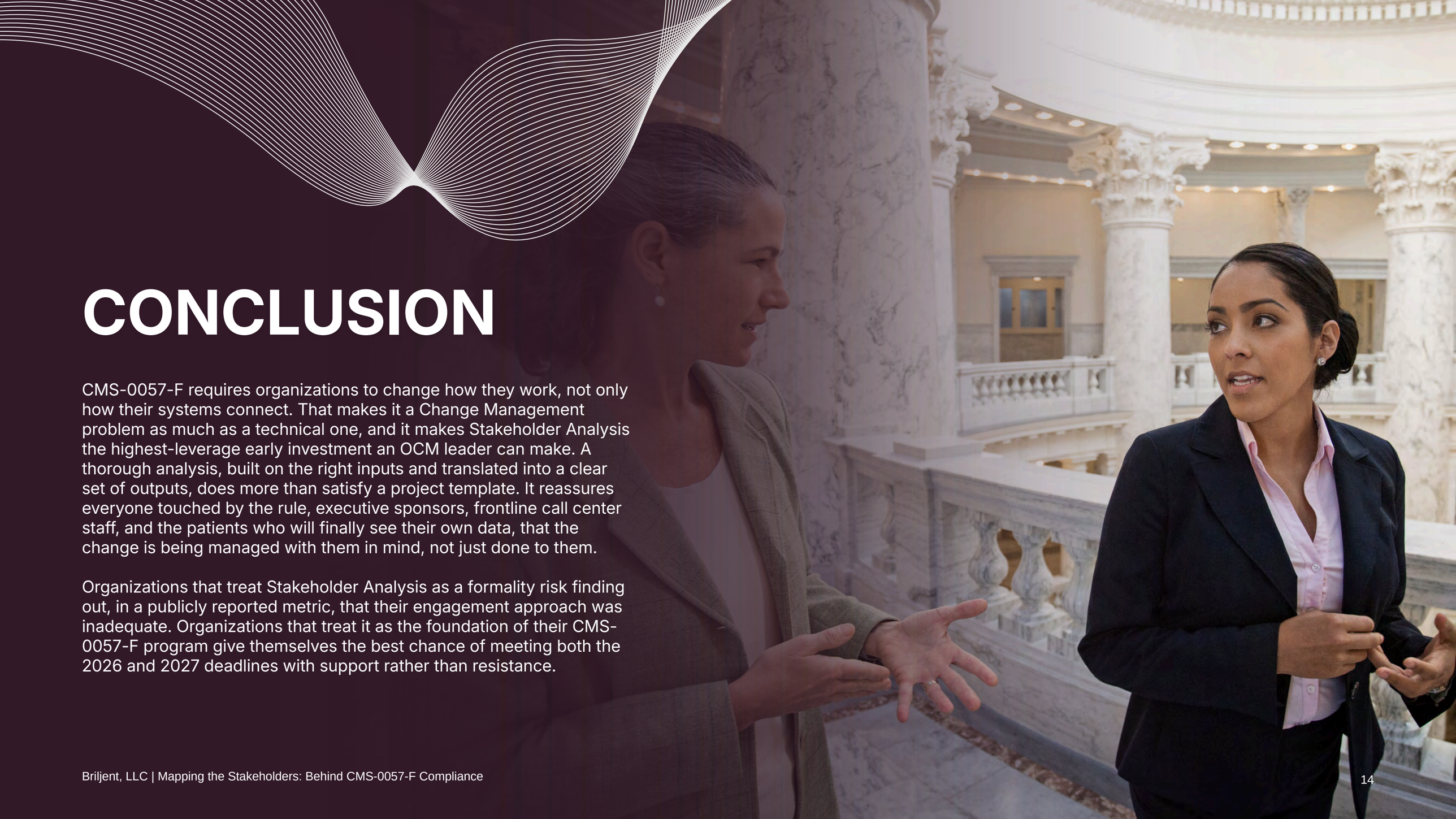
REWORK

The operational deadline and API deadline are far enough apart that, without a living stakeholder analysis, lessons from the first deadline are lost before the second one arrives.

CONCLUSION

CMS-0057-F requires organizations to change how they work, not only how their systems connect. That makes it a Change Management problem as much as a technical one, and it makes Stakeholder Analysis the highest-leverage early investment an OCM leader can make. A thorough analysis, built on the right inputs and translated into a clear set of outputs, does more than satisfy a project template. It reassures everyone touched by the rule, executive sponsors, frontline call center staff, and the patients who will finally see their own data, that the change is being managed with them in mind, not just done to them.

Organizations that treat Stakeholder Analysis as a formality risk finding out, in a publicly reported metric, that their engagement approach was inadequate. Organizations that treat it as the foundation of their CMS-0057-F program give themselves the best chance of meeting both the 2026 and 2027 deadlines with support rather than resistance.



GLOSSARY

- **Application Programming Interface (API)** – A standardized way for different computer systems (like a state Medicaid system and a health plan's system) to automatically share data with each other.
- **Centers for Medicare & Medicaid Services (CMS)** – The federal agency that runs Medicare, oversees Medicaid, and regulates the health insurance marketplaces.
- **Fast Healthcare Interoperability Resources (FHIR)** – A common technical standard that lets different health IT systems exchange patient information in a consistent, computer-readable format.
- **Fee-For-Service (FFS)** – A payment model where providers are paid separately for each individual service or visit, rather than a lump sum for overall care.
- **Federally-Facilitated Exchanges (FFE)** – The health insurance marketplace run by the federal government (via HealthCare.gov) for states that do not operate their own exchange.
- **Medicaid Enterprise System (MES)** – A set of integrated information technology systems designed to support the efficient and comprehensive administration of Medicaid and related public programs.
- **Organizational Change Management (OCM)** – The structured process of helping staff and stakeholders adapt to new systems, policies, or workflows so a change sticks.
- **Prior Authorization (PA)** – A requirement that a provider get approval from a health plan before delivering certain services and tests to confirm they'll be covered.
- **Qualified Health Plan (QHP)** – A health insurance plan certified to meet marketplace standards (like covering essential benefits) and sold through an exchange.

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Note: Regulatory references current as of August 2026. CMS-0057-F is a final rule; CMS-0062-P is a proposed rule and is subject to change.

ABOUT BRILJENT

Briljent is a **people-first** change management partner for public-sector transformation, helping agencies move through **people, process, and technology change** with clarity and lasting results.

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Make Your Next Change IDEAL

Briljent's IDEAL Change Approach is a five-stage framework for people-first transformation, scaled to fit each organization's complexity and pace. Certified Change Management Professionals guide every stage, from initial readiness through lasting, sustained change.