

To: AmeriHealth Caritas Louisiana Providers

Date: April 6, 2026

Subject: CMS Finalized Rule to Expand Access to Health Information and Improve the Prior Authorization Process

Summary: The Centers for Medicare & Medicaid Services (CMS) finalized a rule in January 2024 to improve health information exchange and prior authorization processes, aimed at enhancing patient access and reducing burdens on providers and payers.

The Centers for Medicare & Medicaid Services (CMS) finalized new requirements designed to strengthen interoperability and improve the prior authorization process for payers, providers, and patients. The CMS Interoperability and Prior Authorization Final Rule (CMS0057F), released January 17, 2024, established updated standards to advance timely access to care, streamline data exchange, and reduce administrative burden across the healthcare system.

These changes reinforced CMS's ongoing commitment to placing patients at the center of care while ensuring providers had the information needed to support efficient, high-quality service delivery. Additional information can be found here on the CMS website:

<https://www.cms.gov/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f>.

In addition to the above, the final rule enhanced certain policies from the CMS Interoperability and Patient Access Final Rule (CMS-9115-F). **As such, as of January 1, 2026, AmeriHealth Caritas Louisiana is required to send prior authorization decisions within 72 hours for expedited (i.e., urgent) requests and seven (7) calendar days for standard (i.e., non-urgent) requests for medical items and services.**

Prior Authorization Reporting is available on our website at <https://www.amerihealthcaritasla.com/member/info/prior-authorization-reporting>.

Providers are responsible for obtaining prior authorizations for services before scheduling by submitting, as needed, clinical information to support the medical necessity of the requests. Requests are not processed if any clinical information or CPT and ICD-10 codes are missing. As a reminder, authorization is not a guarantee of payment; payment is subject to benefit coverage rules, including member eligibility and any contractual limitation in effect at the time of service.

Reference information on prior authorization turnaround times is available in the table below.

Reference Information for Prior Authorization Turnaround Times		
Reference	Regulatory Language	Payor Type
CMS-0057-F	See CMS Interoperability & Prior Authorization Final Rule	All
42 CFR 438.210(d)(1)– (2)(ii)	<p>(1) Standard authorization decisions.</p> <p>(i) For standard authorization decisions, provide notice as expeditiously as the enrollee's condition requires and:</p> <p>(A) For rating periods that start before January 1, 2026, within state-established time frames that may not exceed 14 calendar days after receiving the request for service.</p> <p>(B) For rating periods that start on or after January 1, 2026, within state-established time frames that may not exceed 7 calendar days after receiving the request for service.</p> <p>(2) Expedited authorization decisions.</p> <p>(i) For cases in which a provider indicates, or the MCO, PIHP, or PAHP determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the MCO, PIHP, or PAHP must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 72 hours after receipt of the request for service.</p> <p>(ii) The MCO, PIHP, or PAHP may extend the 72-hour time period by up to 14 calendar days if the enrollee requests an extension, or if the MCO, PIHP, or PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.</p>	Medicaid
42 CFR 457.495(d)(2)	<p>(2) On or after January 1, 2026.</p> <p>(i) In accordance with the medical needs of the enrollee, but no later than 7 calendar days after receiving the request for a standard determination and by no later than 72 hours after receiving the request for an expedited determination. A possible extension of up to 14 days may be permitted if the enrollee requests the extension or if the physician or health plan determines that additional information is needed; or</p> <p>(ii) In accordance with existing State law regarding prior authorization of health services.</p>	CHIP
42 CFR 422.572(a)(1)	<p>(a) Timeframes —</p> <p>(1) <i>Requests for service or item.</i> Except as provided in paragraph (b) of this section, an MA organization that approves a request for expedited determination must make its determination and notify the enrollee (and the physician involved, as</p>	Medicare

	appropriate) of its decision, whether adverse or favorable, as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receiving the request.	
42 CFR 422.568(b)	<p>Timeframes —</p> <p>(1) Requests for service or item. Except as provided in paragraph (b)(2) of this section, when a party has made a request for an item or service, the MA organization must notify the enrollee (and the physician or provider involved, as appropriate) of its determination as expeditiously as the enrollee's health condition requires but no later than either of the following:</p> <p>(i) For a service or item not subject to the prior authorization rules in § 422.122, 14 calendar days after receiving the request for the standard organization determination.</p> <p>(ii) Beginning on or after January 1, 2026, for a service or item subject to the prior authorization rules in § 422.122, 7 calendar days after receiving the request for the standard organization determination.</p>	Medicare

Questions:

Thank you for your continued support and commitment to our patients' care. If you have questions about this communication, please get in touch with AmeriHealth Caritas Louisiana's Provider Services department at 1-888-922-0007 or your [Provider Network Management Account Executive](#).

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