SMART HEALTH NETWORK · FOR STATES

Cut Paperwork, Not Care

Four Actions to Turn the January 1, 2027 Federal Prior Authorization Deadline — and Your RHTP Award — into Lasting Relief for Your State's Providers and Patients

July 2026

The decision on one page. Impacted payers must prepare to meet CMS-0057-F requirements beginning January 1, 2027 — that investment is already underway, and it happens whether or not the state acts. Your state chooses what it becomes: another set of disconnected portals, or one shared path your providers and patients can actually use. The playbook is four state actions: **Join · Activate the Market · Connect State-Sponsored Health Plans · Accelerate Provider Adoption** *(optional, RHTP-funded)*. A January launch means a first cohort of payers and providers transacting in production, with the rest of the market onboarding after. **Decision requested now:** name an executive sponsor and an implementation lead.

1 · The Problem

American healthcare still sends nine billion faxes a year. "Dr. Jones — we'd love to approve your prior authorization request. Can you fax us the clinical notes?"

Administrative burden is crushing providers — financially, and through burnout — and it lands hardest where margins are thinnest. A large health system amortizes that paperwork across whole departments; a small or rural practice absorbs the same burden at a front desk of one, with no prior-authorization department, no IT staff, and no spare capacity. Prior authorization is the most burdensome of all: it costs too much, delays care, and leaves patients in the dark — decisions made about them, without them. Every provider in your state pays this tax; the providers least able to carry it pay the most. For rural providers, cutting paperwork *is* protecting access to care — and protecting the scarce resources that keep their doors open.

In a recorded Delaware prior-authorization call this spring, a physician — now the state's Surgeon General — learned mid-appeal that the payer had never received his clinical note:

> ***Physician:*** *"You don't have my note. You have no clinical information on this patient?"*
> ***Reviewer:*** *"I have nothing attached to this patient's claim. We didn't have the documentation — which was what was in the denial rationale."*
> ***Physician:*** *"So it was denied without asking for additional information?"*

The note wasn't missing. The bridge was.

The fix is already required — and already promised. Federal regulation requires it: CMS-0057-F requires impacted payers to stand up standardized, FHIR-based Prior Authorization APIs by January 1, 2027 — the technical foundation of the fix. The industry has pledged it: the AHIP prior-authorization commitments, including real-time responses for most electronic approvals. And the states have been legislating the same direction for three years running, with prior-authorization laws now on the books in some forty states and more advancing every session. Federal regulators, state legislatures, and the industry are all pushing in the same direction — every impacted payer in your market must move, through capabilities it builds, buys, or already operates.

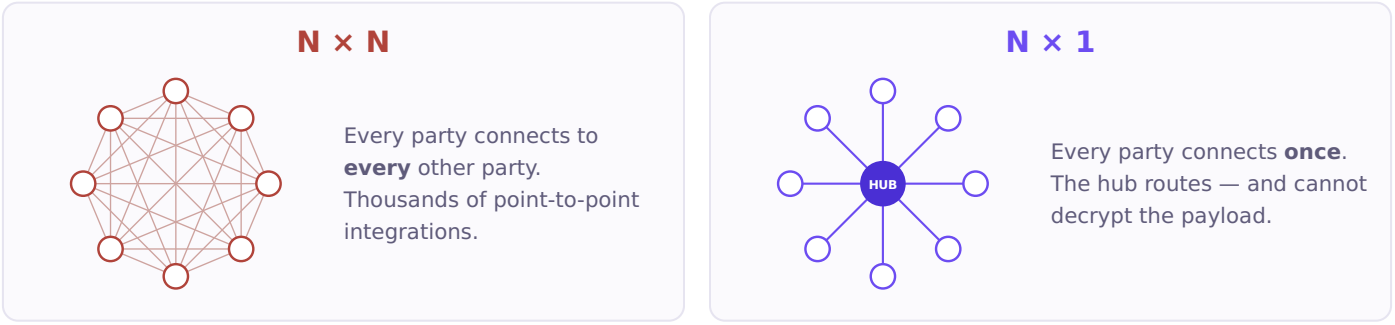
But if every payer complies separately, compliance won't solve the problem — it will perpetuate it: more portals, more one-off integrations, more unfunded work pushed onto the practices least equipped to absorb it. Every payer in your market could comply perfectly, and your providers would still face a separate portal, credential, and integration for each of them. Fragmented APIs are just fax machines in modern clothing.

The deadline creates a one-time market-design opportunity — too good to waste. Every impacted plan in your market will spend real money between now and January 1 — building or buying compliant capability — *no matter what you do*. The only question is whether those required capabilities remain fragmented at the provider edge — or become reachable through shared rails the whole market can use. The federal government sets payer obligations; payers build APIs; **the state is the only actor positioned to point all of that mandatory motion toward a common destination.** Miss the window and the money gets spent anyway — on the fragmented version, which then hardens for years and grows only more expensive to maintain.

And the same window answers a second question every state faces: what did your RHTP award visibly do for rural providers? RHTP awards call for measurable rural outcomes. Aim your RHTP dollars at the infrastructure that sustains rural practices and their patients. Leverage the prior-authorization requirements every payer must meet anyway. The paperwork will kill these practices otherwise. The result is proof in production — rural practices connected at no charge, turnaround times measured, administrative hours returned to care — funded by leveraging payer compliance investment rather than asking the state to finance every underlying payer build. Delaware is running exactly this play.

2 · The Answer

Other industries use shared networks rather than requiring every participant to build directly to every other participant — card networks like Visa are the familiar example: banks, merchants, and consumers all reached through one connection. Smart Health Network brings the same structure to providers, payers, and patients: shared rails with real accountability and measured results.



From N-by-N to N-by-1. Connect once, reach every enabled, authorized counterparty on the network.

What the network is. Smart Health Network (SHN) is a Public Benefit Corporation operating a payload-blind routing network: registered mail, not a warehouse. Clinical and administrative payloads remain encrypted between sender and recipient; SHN routes, tracks, and records the transaction evidence needed for delivery, status, audit, and accountability. Participants connect once to reach every authorized counterparty on the network. That single connection upgrades over time without rebuilding separate integrations. And that evidence trail is tamper-evident — traceability and transparency no point-to-point web can deliver. Prior authorization is the first use case; additional transactions follow on the same connection under the same published utility terms — each new transaction type a decision, not a project.

Delaware first, not Delaware only. Delaware became the first state to act. On July 6, 2026, the state announced a statewide initiative to fix prior authorization on the network, funded in part by its RHTP award. One week later, the July 13 launch and Connectathon drew more than 200 participants in person and online,

with the first health plan connected to the test network and testing. Delaware targets its first production cohort for January 1, 2027 — and every state that follows joins a network with payers already testing, published terms, and a state activation playbook running live.

Delaware in the news.

▸ **Axios (exclusive), July 6, 2026:** "Rural health funds to fix prior authorization"

▸ **Delaware DHSS:** "Newly launched initiative strengthens Delaware's health information technology infrastructure"

▸ **Podcast — Christina Farr:** "Healthcare sends 9 billion faxes a year. Delaware has a better idea" — with Delaware Surgeon General Neil Hockstein, MD

The patient dividend. Every prior authorization is about a patient — and today the patient is the only party in the transaction who can't see it, on a timeline they can't watch. The network creates the technical and evidentiary foundation for patient-visible status: as participating applications, identity services, and payer connections are enabled, patients can be shown whether a request about their care was submitted, received, or decided — like tracking a package. Patient access is free under the network's published Open Access terms. No compliance rule requires this; it is what the shared-rails model makes possible that separate payer builds never will — the part of the investment patients and families can directly use to improve their care. Most interoperability projects are invisible to the public; a parent watching their child's prior authorization move is not.

What the state gets by joining:

- ✓ One common connection path for providers across participating payers, instead of a portal and integration per payer
- ✓ A coordinated production launch on a common timeline, instead of disconnected payer deadlines
- ✓ Common participation, conformance, security, and accountability rules across the market
- ✓ Measurable, production-tracked administrative-burden results
- ✓ Reusable infrastructure for later transactions and state affordability priorities
- ✓ A way to enable rural providers — without building a new state-owned platform or replacing core state systems
- ✓ A health-IT result constituents can directly see: patient-visible prior-authorization status

This is not a big IT project. The network exists. There is no new platform for your state to design, build, or operate: payers and providers connect on the technology they already run — standards-based APIs — and can begin testing today under the network's standard testing terms, synthetic data only, no negotiated agreement required. (State-specific participation, data, and program arrangements follow the state's normal approval processes — but none of them gate testing.)

SHN makes no coverage or medical-necessity decision, and it replaces nothing the state runs — not the MMIS, not the HIE, not the EHR.

Why one national network beats fifty state hubs. National and multistate payers integrate once rather than state by state; EHR vendors and onboarding partners build to one specification across markets; published national terms replace bespoke contracting; state HIEs and vendors operate certified roles on the network

rather than being displaced; shared governance and permanent independence protections prevent control by any single payer, vendor, or state; and each state retains control of its funds, its programs, and its source data. A state-built hub solves one state's fragmentation by adding one more incompatible network to the nation's.

For a payer already building its CMS-0057 APIs, participation reuses that work — it does not repeat it: connect or authorize access to the same standards-based endpoints the rule requires; complete SHN security, conformance, and participation requirements; map authorized counterparties through the network; participate in production testing; and retain full utilization-management rules and decision authority. The network is a distribution layer for the compliance investment the payer is already making; participation still requires the payer's normal security, legal, testing, configuration, and operational-readiness work.

3 · Four State Actions

#	Action	What it requires	Likely state lead	Illustrative budget*
1	**Join**	Nonbinding public commitment to the launch-cohort planning process — no contract, no expenditure	Governor, Secretary of Health, or designated executive sponsor	$0
2	**Activate the Market**	State leadership convening + Connectathon satellite	Secretary of Health + Insurance Commissioner + Medicaid Director	No network fee; ordinary state convening costs as applicable
3	**Connect State-Sponsored Health Plans**	Medicaid FFS and/or MCO participation under published terms; state employee plans as applicable	Medicaid agency; state employee benefits office	$0.25 PMPM launch rate (≈$3/member/year; ~$750K/year per 250K covered lives)
4	**Accelerate Provider Adoption** *(optional — "RHTP states")*	State Program Contract + statements of work; RHTP as the federally supported startup funding pathway	State program office or designated intermediary	State-specific program budget; Delaware reference model in Appendix 2

*Illustrative, based on the Delaware program for approximately 1 million residents. These are state actions, not a rigid sequence — convening in particular begins early and continues through launch.

Action 1 — Join.

The state announces its intent to participate in the launch-cohort planning process and to pursue a shared statewide pathway for prior authorization. The commitment is nonbinding and requires no contract or expenditure. It gives payers, providers, HIEs, and EHR vendors the focal point they need to plan, and signals the state will convene the market so providers and payers capture the relief together.

Action 2 — Activate the Market.

The state's most powerful contribution is its convening authority. No individual market participant has the state's public authority and reach to convene the full market — the state does. State leadership convenes payers — health plans, Medicaid managed-care organizations, and TPAs — along with providers and implementation partners around implementation timing, readiness expectations, and participation pathways; regular testing events (a state satellite of the national Connectathon cadence, payer-provider roundtables,

monthly accountability check-ins) maintain momentum. Delaware's July 2026 payer convening, chaired by the Insurance Commissioner and Surgeon General, is the model. Convenings address standards, timing, readiness, testing, and the network's published utility terms; each payer makes its own independent participation decision.

Action 3 — Connect State-Sponsored Health Plans.

State-sponsored coverage programs participate under the same published terms as every other payer. In many states, the fastest path starts with the MCOs: they already carry CMS-0057 compliance obligations, so joining the network is a reuse of work they must do anyway, and states can use their existing contracts and oversight mechanisms to encourage or require participation, subject to state law, federal program requirements, and existing contract terms. Medicaid FFS follows, keeping the systems it has: a network gateway sits beside the MMIS — no MMIS replacement, no core-platform redesign — and deeper vendor integration can come later, on the state's own schedule. Integration options and APD support are in Appendix 4. State employee plans (often among the largest books in the market), universities, and other state-sponsored programs can join through existing issuer and TPA relationships.

Action 4 — Accelerate Provider Adoption *(optional)*.

Compliance is the floor; relief is the goal — and relief arrives only when providers are connected. Action 4 accelerates provider connection, with RHTP as the startup funding pathway. The state executes a State Program Contract — a Delaware-derived model adaptable to state procurement rules — covering program management, provider enablement, market activation, and evaluation, with escrowed, milestone-based payments under state-chaired governance. Providers pay nothing: Certified Onboarding Partners — organizations providers already work with — do the connection work and are paid only against verified milestones. **Rural providers get connected first — and rural results get measured.** A rural practice's authorizations travel to statewide and national payers, so delivering rural relief means connecting the market the practice actually transacts with. Enablement funding puts rural providers, rural-serving systems, and their referral partners at the front of the line, and the program reports rural outcomes in production: activation rates, authorization turnaround, administrative hours returned to care, share of transactions completed electronically. States that skip Action 4 still join fully — their providers connect on the market's ordinary adoption cycles rather than a state-accelerated schedule. The enablement design — vouchers, milestones, certificates, funding schedule — is in Appendix 3.

4 · What Launches in January

January 2027 launch means, at minimum:

- ✓ The state — or its designated participant — has executed its participation agreement
- ✓ Designated launch payers' endpoints are reachable through the network
- ✓ The first named provider-payer cohort can transact prior authorization in production
- ✓ A defined onboarding path exists for providers not yet integrated

Launch is a beginning, not a saturation event: additional payers, providers, and transaction types join continuously after it, and cohort scope is defined by executed participation agreements — the payers and providers signed by November 30 are what launch in January — and each participant activates as its security, legal, and production-readiness gates complete. Delaware is operating against this same launch sequence, and the national Connectathon convenes October 14 with a Delaware satellite.

Date	Action	What it means

September 1, 2026	Join	Nonbinding public commitment to the launch-cohort planning process.
September 30, 2026	State Program Contract *(RHTP states only)*	Framework for RHTP-funded enablement and program activities.
November 30, 2026	Participation agreements complete	Executed agreements define January cohort scope.
January 1, 2027	Launch	Minimum launch conditions above; continuous expansion thereafter.

5 · State Pathways and Economics

Two lanes, so a state can raise its hand before it can do everything:

Launch-cohort state

Public commitment; named executive sponsor and implementation lead; participation in convenings and testing; candidate payers and providers identified; initial technical, legal, and program diligence completed; launch pricing preserved by signing participation agreements by December 31, 2026.

RHTP state (full activation)

All of the above, plus executed state-sponsored payer participation, RHTP-funded provider enablement, and state governance and reporting under a State Program Contract. RHTP is the leading current funding pathway; states may fund acceleration from other sources.

The economics, in three parts:

- **Network participation (payer):** a flat published utility fee — $0.25 PMPM at the launch rate, $0.50 standard — with unlimited volume across every enabled transaction type; no tiers, no negotiated deals. For a 250,000-life program, roughly $750,000 per year, weighed against the ongoing cost of fragmented portals, interfaces, status operations, and payer-by-payer provider connectivity. The savings are money the market already spends — the comparison is never against a zero-cost baseline, but against the continuing cost of fragmented connectivity.
- **Provider participation:** connection, onboarding, and conformance testing carry no SHN fees; future provider transaction fees follow published terms on a phased schedule (Appendix 1).
- **Optional state activation (RHTP states):** a separate, milestone-gated program budget for provider enablement and market activation. RHTP and other existing sources may support some or all of it, subject to state and federal approval. Governance, funding controls, and the Delaware budget reference are in Appendix 2.

6 · Decision and Next Steps

Join by **September 1, 2026** and your state has a spot in the January cohort planning process. Name an executive sponsor and implementation lead. Participation agreements by **November 30** define what launches; RHTP states execute the State Program Contract by **September 30**. States entering later join a subsequent cohort — and any state that signs participation agreements by **December 31, 2026** locks launch pricing, even into a later cohort.

Decision requested:

- ✓ Name an executive sponsor
- ✓ Name an implementation lead
- ✓ Authorize launch-cohort diligence
- ✓ Identify candidate state-sponsored payers and the first provider-payer cohort
- ✓ Decide whether to evaluate RHTP-funded provider acceleration

The commitment package — a model public statement, the participation agreements, the fund-sizing worksheet keyed to your provider counts, and diligence materials — is available on request, and SHN will walk your team through it in an initial working session. And nothing waits on paperwork: any payer or provider in your market can start testing with synthetic data today.

Every impacted payer in your market will spend compliance money by January 1 whether or not you act. Acting means that spend converges into rails your providers can actually use, your RHTP award produces rural relief you can measure and show, and your state creates a path for patients to gain visibility into the process that decides their care. This alignment of federal deadline, payer investment, and rural funding will not recur. Use it to **cut paperwork, not care.**

State inquiries: states@smarthealthnetwork.org

Appendix 1 · Published Network Terms

Participant	Track	Rate
Open Access	Free — permanently, for everyone	Free: patient access · eligibility · public-health reporting · onboarding · conformance testing
Patients	Free, always	Free
Payers	Launch Participant *(sign by Dec 31, 2026)*	**$0.25 PMPM through 2029, then standard**
	Standard *(everyone else, from day one; everyone from Jan 1, 2030)*	**$0.50 PMPM**
Providers	Launch Participant *(sign by Dec 31, 2026)*	**$0 through 2028 · 0.025% in 2029, then standard**
	Standard *(everyone else, from day one; everyone from Jan 1, 2030)*	**0.05% of aggregate routed paid-claim volume**

Payer membership pricing is a flat PMPM with unlimited transaction volume across every enabled transaction type. Provider connection, onboarding, and conformance testing carry no SHN fee; the routed-claims utility charge is a separate, phased, published-terms fee that applies as claims routing launches. The Launch Participant rate lock assumes production certification by December 31, 2027 in the participant's market. "Free" throughout refers to SHN network fees; EHR-vendor, integrator, and internal participant costs remain the participant's.

Appendix 2 · The RHTP Program — Governance, Funding Controls, and Budget

Everything in this appendix applies to RHTP states — those pursuing Action 4 under a State Program Contract. Network participation (Appendix 1) requires none of it.

Budget reference (Delaware model). The state program budget has two components. *Program management* — approximately $200K/month during launch — funds a defined scope: the program office; market activation; onboarding management; technical coordination with payers, providers, and vendors; governance support; state and federal reporting; evaluation coordination; and Connectathon operations. *Provider enablement fund* — the larger component — is sized to the state's provider counts through the fund-sizing worksheet and paid out to Certified Onboarding Partners against verified connection milestones per the Appendix 3 schedule. Each state's budget is scoped to its own size and selected statements of work, plus a small, scaled evaluation fee — milestone-gated and separate from participation fees. One-time state support for payer connection activities, where pursued, runs through a program statement of work tied to completed milestones.

Two distinct governance spheres — kept separate by design. The **Program Executive Committee (PEC)** — a small committee chaired by a senior state health official, with final state authority — governs the *state program*: program scope, state funds, approved statements of work, subcontractor approval, milestones, reporting, and state-specific implementation. **Network governance** — the SHN governance bodies — governs the *network*: network rules, technical standards, certification and conformance, national participation terms, and network-wide operations. State program authority does not extend to network rules or other participants; that separation is what keeps the utility neutral for every state that joins.

Funding controls. Payments only against milestones verified by the state or its intermediary; quarterly reporting on program status, metrics, and use of funds; state audit and clawback rights; and exit rights if funding lapses or the state discontinues, with obligations limited to completed, verified work. The Delaware framework is structured as a contractor relationship under 2 C.F.R. 200 (not subrecipient), subject to state and counsel review. Full terms are in the State Program Contract.

Appendix 3 · RHTP Provider Enablement — Reference Design (Delaware-Derived)

Reference operating design. *Reflects the Delaware program; adaptable to each state's approval, procurement, funding-source requirements, and priorities. Elements are subject to final program documents and counsel review.*

The design principle: states fund verified connections, not effort. Providers pay nothing. Funding flows to Certified Onboarding Partners only against independently verified connection milestones — never tied to transaction volume, claims value, or migration share — with rural and rural-serving providers weighted to the front of the line per Action 4.

Reference funding schedule. $5,000 per clinician for the first 10 clinicians in an organization; $2,000 per clinician for clinicians 11–50; $500 beyond 50; $750,000 maximum per organization. States determine how, what, and whom to fund against this reference schedule.

Program mechanics — provider elections, milestone definitions, connection certificates, escrowed disbursement, and eligibility verification against authoritative state records — are finalized with each launch state and provided with the commitment package.

Appendix 4 · Connecting Medicaid Systems

The default is the simplest: a network gateway runs beside the MMIS/MES, communicating through the interfaces the environment already exposes — APIs, files, or queues — subject to the environment's security, access, and approval requirements. No MMIS replacement or core-system rebuild is required. Deeper vendor integration can follow later, on the state's schedule, without redoing the launch configuration. SHN and the MMIS/MES vendor can support APD documentation; some activities may be eligible for federal financial participation, subject to CMS review.

Appendix 5 · Required Documentation Summary

Action	Documents
Join	None — public statement
Activate the Market	None to convene; RHTP states memorialize convening roles and Connectathon cadence in a statement of work
Connect State-Sponsored Health Plans	Network Participation Agreements (Medicaid FFS; employee plan); state communication, contractual direction, or other approved mechanism supporting separate MCO/TPA participation, as applicable; State Systems Integration Workplan where MMIS/MES integration is in scope
Accelerate Provider Adoption (RHTP states)	State Program Contract + statements of work (program management, provider enablement, market activation, evaluation); Data Sharing Agreement covering the verification feeds used for enablement-payment checks

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