NATIONAL HEALTH COUNCIL

June 15, 2026

Dr. Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability Standards and Prior Authorization for Drugs for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, and Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges [CMS-0062-P]

Submitted electronically via regulations.gov

Dear Administrator Oz:

The National Health Council (NHC) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule, *Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability Standards and Prior Authorization for Drugs for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, and Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges*.

Created by and for patient organizations more than 100 years ago, the NHC convenes organizations from across the health ecosystem to forge consensus and drive patient-centered health policy. We promote increased access to affordable, high-value, comprehensive, accessible, and sustainable health care. Made up of nearly 200 national health-related organizations and businesses, the NHC's core membership includes the nation's leading patient organizations. Other members include health-related associations and nonprofit organizations including the provider, research, and family caregiver communities; and businesses and organizations representing biopharmaceuticals, devices, diagnostics, generics, and payers.

The NHC recognizes CMS' continued focus on interoperability and prior authorization as part of a broader effort to address administrative burden and improve the timeliness, transparency, and reliability of coverage processes for patients and providers. In our 2023 comments on the prior interoperability and prior authorization proposed rule, the NHC supported CMS' efforts to streamline prior authorization and related utilization management processes while also noting that the earlier proposal did not apply to

prescription drugs.[1] The current proposal would extend interoperability and prior authorization reforms to drugs in a way that may better reflect where many patients and providers face substantial access barriers.

The NHC acknowledges that prior authorization and related utilization management tools serve legitimate functions, including supporting appropriate drug use, program integrity, and evidence-based coverage determinations. At the same time, when these processes are not designed or implemented in a manner that is timely, transparent, predictable, and responsive to clinical realities, they can create significant burdens for people with chronic diseases, disabilities, and other serious or complex conditions.[2,3] The NHC's earlier comments on prior authorization burden have similarly emphasized that, although prior authorization is often framed as a utilization management mechanism, its design and administration can have serious consequences for patients when it delays, disrupts, or complicates access to needed care.[4]

The NHC believes the proposal represents constructive progress. In particular, its focus on electronic prior authorization for drugs, more standardized communication requirements, expanded access to prior authorization information through application programming interfaces (APIs), and enhanced transparency and public reporting could improve how coverage determinations are made and communicated across Medicare Advantage (MA), Medicaid, CHIP, and Qualified Health Plans (QHPs) on the Federally-Facilitated Exchanges (FFEs).[5,6] The NHC encourages CMS to finalize these policies with refinements that strengthen patient protections, reduce duplicative burden, and support workable implementation for plans, providers, pharmacy benefit managers (PBMs), and other entities participating in the process.

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[1] National Health Council, "NHC Comments on Interoperability and Prior Authorization Proposed Rule," March 13, 2023, https://nationalhealthcouncil.org/letters-comments/nhc-comments-on-interoperability-and-prior-authorization-proposed-rule/

[2] National Health Council, *Exploring the Burden of Prior Authorization on Patients with Chronic Disease* (Washington, DC: NHC, November 2023), https://nationalhealthcouncil.org/wp-content/uploads/2023/11/NHC-Report-Exploring-the-Burden-of-Prior-Authorization-on-Patients-with-Chronic-Disease.pdf.

[3] American Medical Association, *2025 AMA Prior Authorization Physician Survey* (Chicago: American Medical Association, 2025), 1–2, https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.

[4] National Health Council, *Exploring the Burden*.

[5] Centers for Medicare & Medicaid Services, "Policies and Technology for Interoperability and Burden Reduction," accessed June 14, 2026, https://www.cms.gov/policies-technology-interoperability-burden-reduction.

[6] Wesley Barker et al., "The Evolution of Health Information Technology for Enhanced Patient-Centric Care in the United States: Data-Driven Descriptive Study," *Journal of Medical Internet Research* 26 (2024): e59791, https://doi.org/10.2196/59791.

Summary of Recommendations

The NHC supports finalization of the proposed rule with modifications that ensure the resulting framework is technically interoperable, operationally usable, clinically appropriate, and accountable in practice.

Specifically, the NHC recommends that CMS:

- Finalize the proposal to extend electronic prior authorization requirements to drugs and ensure that the resulting framework reduces delay for both drugs covered under the medical benefit and drugs covered under the pharmacy benefit.
- Require denial communications that are sufficiently specific, timely, and operationally useful to support prompt corrections, resubmissions, exception requests, or appeals.
- Promote implementation approaches that reduce duplicative documentation requests, minimize manual workarounds, and better support continuity of care, particularly for patients who are stable on therapy or transitioning to a new health plan or care setting.
- Strengthen public reporting and metrics so that prior authorization data are meaningful and interpretable for patients, advocates, providers, plans, and regulators.
- Ensure that the operational role of PBMs and other delegated entities does not dilute accountability for compliance with patient protections and interoperability requirements.
- Continue to engage patients, caregivers, providers, plans, and other stakeholders throughout implementation so that technical requirements translate into workable, patient-centered processes.
- Build on this rulemaking and its implementation to inform a broader vision for reducing prior authorization burden across the health care system, including consideration of Medicare fee-for-service (FFS).

Electronic Prior Authorization for Drugs

The NHC has reviewed CMS' proposal to require impacted payers to support electronic prior authorization for drugs and to apply distinct standards depending on whether the drug is covered under the medical benefit or the pharmacy benefit. As CMS explains, the proposal would extend the Prior Authorization API framework to drugs covered under the medical benefit while relying on National Council for Prescription Drug Programs (NCPDP) standards for drugs covered under the pharmacy benefit. This would represent a significant development relative to the prior rulemaking, which did not extend the interoperability and prior authorization framework to drugs.

This aspect of the proposal is particularly important from the patient perspective. For many people living with chronic diseases, disabilities, rare conditions, cancer, or other serious illnesses, medication-related prior authorization can be among the most consequential forms of utilization management because it may determine whether a prescribed therapy can be started, continued, switched, dispensed, or administered

without avoidable delay and in a manner consistent with clinical need.[7,8] Patient-reported evidence indicates that prior authorization barriers can prevent patients from receiving care that they and their treating clinicians believe is necessary and may contribute to greater access burdens.[9] Patients who report prior-authorization-related barriers may experience greater symptom burden and face additional difficulty accessing care in comparison to those who do not report such barriers.[10] Taken together, these findings reinforce that electronic prior authorization reform should be evaluated based on whether it improves timely access to medically necessary care in practice, not simply whether administrative transactions move more quickly.[11] Delays in starting, continuing, or switching a needed therapy can lead to symptom exacerbation, avoidable disease progression, additional caregiver burden, and disruptions that are difficult to reverse once treatment momentum is lost.[12,13,14] The stakes are especially high when a therapy is time-sensitive, when disruption of an established treatment regimen could jeopardize a patient's stability, or when failure to access a drug may alter the course of the disease.

The success of the policy will depend on whether implementation improves access rather than merely changing the format in which requests, denials, and supporting documentation are transmitted. Increased use of electronic prior authorization alone will not resolve longstanding concerns if patients and providers continue to encounter repetitive documentation requests, fragmented communication among plans, PBMs, and vendors, or coverage criteria that are difficult to understand or navigate in

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[7] Yang Wang et al., "Prior Authorization and Associated Delays and Denials of Branded Medication Dispensation," *JAMA Health Forum* 7, no. 4 (2026): e260760, https://doi.org/10.1001/jamahealthforum.2026.0760.

[8] Pamela Johnson et al., "Adverse Effects of Health Plan Prior Authorization on Clinical Effectiveness and Patient Outcomes: A Systematic Review," (October 2025), https://pubmed.ncbi.nlm.nih.gov/40912445/.

[9] Cancer Support Community, *Cancer Experience Registry Patient Insights Report 2024* (Washington, DC: Cancer Support Community, 2024), https://www.cancersupportcommunity.org/sites/default/files/file/2025-01/CER_PatientInsightsReport_2024.pdf

[10] Cancer Support Community, *Cancer Experience Registry Patient Insights Report 2024*

[11] Cancer Support Community, *Cancer Experience Registry Patient Insights Report 2024*

[12] Mark Kyle and Natalie Keating, "Prior Authorization and Association with Delayed or Discontinued Prescription Fills," *Journal of Clinical Oncology* 42, no. 8 (2023), https://doi.org/10.1200/JCO.23.01693.

[13] Johnson et al., "Adverse Effects."

[14] Tanya Henry, "Prior Authorization Delays Care and Increases Health Care Costs," American Medical Association, accessed June 14, 2026, https://www.ama-assn.org/practice-management/prior-authorization/prior-authorization-delays-care-and-increases-health-care.

practice.[15,16,17] The NHC therefore encourages CMS to clarify in the final rule and subsequent guidance that the objective is not simply digitization, but a more timely, predictable, and navigable process for patients and treating clinicians.

Electronic prior authorization should improve clinical appropriateness, transparency, and usability while supporting timely access to medically appropriate care, rather than simply accelerating existing administrative barriers. If electronic tools make denials, documentation requests, or other utilization management actions faster while leaving unclear standards, repetitive requests, or avoidable treatment disruption intact, the practical benefit to patients may be limited. Where automated tools or algorithmic processes materially shape prior authorization review, denials, or requests for additional information, CMS should consider whether additional transparency and oversight are warranted to ensure that the basis for each determination remains understandable, accountable, and open to meaningful clarification or appeal. The NHC also encourages CMS to monitor whether electronic systems reduce burden and improve access in practice, rather than simply increasing the speed or scale of repetitive or avoidable denials.

The NHC further recommends that CMS promote implementation approaches that make sequencing requirements transparent at the outset, particularly when step-therapy or other utilization-management requirements effectively function as prerequisites to prior authorization or access. From the patient perspective, effective implementation depends on whether the prescribing or treating clinician can identify the applicable coverage pathway, assemble and submit the necessary information without repeated manual intervention, receive a determination in a timeframe consistent with clinical urgency, and act on that determination without avoidable delay. A technically compliant system that still depends heavily on repeated phone calls, duplicative portal use, piecemeal requests for documentation, or unclear denial rationales would represent limited progress.

The NHC also notes that the proposal is directed principally at payer support for electronic prior authorization and does not appear to require providers to use electronic prior authorization in every circumstance. That distinction is important. The value of these reforms will depend on both the availability of relevant standards and on whether the electronic pathway becomes sufficiently reliable, usable, and integrated into workflows to replace routine reliance on manual or other fallback processes. The NHC therefore recommends that CMS continue evaluating whether implementation is

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[15] Office of Inspector General, U.S. Department of Health and Human Services, *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care*, OEI-09-18-00260 (Washington, DC: U.S. Department of Health and Human Services, April 27, 2022), https://oig.hhs.gov/reports/all/2022/some-medicare-advantage-organization-denials-of-prior-authorization-requests-raise-concerns-about-beneficiary-access-to-medically-necessary-care/.

[16] Ann S. O'Malley et al., *Administrative Burden in Primary Care: Causes and Potential Solutions* (New York: Commonwealth Fund, October 2, 2025), https://doi.org/10.26099/86n1-4m81.

[17] Margaret Kyle and Austin Frakt, "Patient Administrative Burden in the US Health Care System," *Health Services Research* 56, no. 5 (October 2021): 758, https://doi.org/10.1111/1475-6773.13861.

reducing dependence on fragmented non-electronic workarounds over time, while preserving appropriate flexibility where electronic functionality is not yet fully mature.

The NHC also encourages CMS to remain attentive to the distinctions between drugs covered under the medical benefit and those covered under the pharmacy benefit, while avoiding a system in which those distinctions become a source of confusion for patients and providers. This implementation issue warrants particular attention because CMS expressly acknowledges that there is currently no single statutory or regulatory definition distinguishing drugs covered under a pharmacy benefit from those covered under a medical benefit for state Medicaid and CHIP fee-for-service programs, Medicaid managed care plans, CHIP managed care entities, and QHP issuers on the FFEs. As a result, impacted payers may need to determine which pathway applies on a drug-by-drug basis. The NHC therefore asks CMS to provide as much operational clarity as possible regarding how these distinctions should be communicated and operationalized so that patients and treating clinicians are not left to navigate avoidable uncertainty regarding which electronic pathway applies.

Where a patient's therapy pathway implicates both medical and pharmacy workflows, the NHC encourages CMS to promote implementation approaches that minimize fragmentation and reduce the risk that patients or clinicians must navigate multiple disconnected systems for related treatment decisions. From the perspective patients and caregivers, the central concern is whether a prescribed treatment can be obtained and used as intended, not whether the underlying workflow is categorized as medical-benefit or pharmacy-benefit processing. When similar or related therapies may be routed differently depending on site of care, payer design, dispensing channel, or benefit structure, the likelihood of delay, confusion, and administrative rework increases. The NHC therefore recommends CMS that support implementation approaches that make the applicable pathway identifiable as early as possible in the treatment process and support coordination across prescribing, dispensing, administration, and follow-up care.

For many patients with complex or ongoing needs, relevant information is dispersed across multiple actors and systems, including treating clinicians, pharmacies, specialty pharmacies, infusion providers, plans, PBMs, and caregivers. The value of the proposed framework will depend in part on whether those actors can access sufficiently current and consistent information regarding prior authorization status, required documentation, decision outcomes, and duration of approval.[18,19] Access to timely information is especially important for pharmacies, including community pharmacies, which are often the point at which patients first experience a prior authorization barrier in practice. The NHC encourages CMS to support implementation that reduces claim-level confusion, minimizes repeated back-and-forth among prescribers, pharmacies, plans, and PBMs, and improves visibility into prior authorization status so that

[18] Office of the National Coordinator for Health Information Technology, "Interoperability," accessed June 14, 2026, https://healthit.gov/interoperability/.

[19] Centers for Medicare & Medicaid Services, "Policies and Technology for Interoperability."

pharmacies are better positioned to help patients navigate next steps without avoidable delay.

In addition, the NHC asks CMS to consider how the final framework can better support continuity of care for patients whose treatment is stable and working effectively. For many patients, repeated reauthorization requirements may disrupt treatment, even when the patient's clinical history or evidence of medical necessity is well established.[20,21] This concern is particularly important when patients experience coverage changes, changes in payer or processor, or transitions between sites of care. A patient who has already demonstrated clinical need for a therapy, established treatment stability, or satisfied earlier utilization management requirements should not be required to repeatedly reconstruct the same evidentiary record simply because administrative responsibility has shifted. If implemented effectively, electronic prior authorization should reduce that type of unnecessary churn. The NHC therefore encourages CMS to consider how the final framework, including its interaction with broader interoperability tools, can better support recognition of established treatment history and prior determinations where appropriate.

The NHC recommends that CMS evaluate whether the final framework is sufficiently responsive to therapies that are clinically urgent, require careful sequencing, or depend on continuity to preserve treatment stability. Electronic prior authorization can provide a stronger infrastructure for more efficient processing, but its value will ultimately depend on whether it functions reliably under real-world conditions, including when patients are moving across benefit pathways, changing plans, coordinating among multiple providers, or relying on caregivers to navigate the process. For that reason, the NHC encourages CMS to implement this framework in a manner that produces measurable improvements in operational usability, continuity of care, and reduction of patient and provider burden.

Additionally, the NHC urges CMS to approach extension and exception pathways with care. The proposed rule would replace the earlier exemption policy for certain state Medicaid and CHIP fee-for-service programs with a more limited extension approach in light of new HIPAA transaction standards. It would also allow QHP issuers on the FFEs to request an exception from the requirement to support the pharmacy-benefit NCPDP standards under specified circumstances. If CMS finalizes those flexibility mechanisms, the NHC encourages the agency to ensure that they are implemented narrowly, transparently, and in a manner that does not unnecessarily delay the availability of timely and electronically supported prior authorization processes for patients and providers.

This issue is particularly important for Medicaid beneficiaries and other patients who may already face significant barriers to accessing care, including long travel times,

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[20] Jeannie Fuglesten Biniek et al., "The Use of Prior Authorization in Medicare Advantage, 2021–2023" (paper presented at the AcademyHealth Annual Research Meeting, 2025).

[21] American Medical Association, "Fixing Prior Auth: We Must Ensure Continuity of Care," accessed June 14, 2026, https://www.ama-assn.org/practice-management/prior-authorization/fixing-prior-auth-we-must-ensure-continuity-care.

limited provider availability, and substantial treatment burden. For patients who are already managing complex care needs, authorization delays may compound existing access challenges and make receiving timely, medically necessary care more difficult. At a minimum, the NHC asks CMS to clarify that any such extensions or exceptions are temporary, justified by concrete implementation barriers, accompanied by a credible path to compliance, and implemented in a manner that remains closely tied to patient access and continuity of care.

Improving Communications and Decision Timeframes for Prior Authorizations

The NHC supports CMS' proposal to strengthen communication requirements and, where applicable, improve or align prior authorization decision timeframes. The proposal to require state Medicaid and CHIP FFS programs, Medicaid managed care plans, CHIP managed care entities, and QHP issuers on the FFEs to provide a specific reason for denying prior authorization requests for drugs is especially important. The proposal to establish clearer provider-facing notification timeframes for QHP issuers on the FFEs could promote greater consistency across coverage programs. The NHC also notes that CMS specifically requests comments on whether it should adopt an even shorter provider-notification timeframe for drug prior authorization requests submitted to QHP issuers on the FFEs, including whether 24 hours should apply to both standard and expedited drug requests.

Overall, the NHC views the proposed shorter provider-facing timeframes for drugs and explicit recognition of clinical urgency as constructive. If CMS does not finalize a 24-hour standard for all drug requests, the NHC encourages the agency to preserve the proposed framework's emphasis on expeditious decisions tied to the enrollee's health condition. CMS should also closely monitor whether the finalized standard is producing timely access in practice. Taken together, these proposals recognize that timeliness and clarity are not separate concerns, but closely related components of whether a prior authorization process functions in a manner that is fair, workable, and clinically responsive. An authorization denial that arrives quickly but does not clearly explain its basis may still delay treatment if the provider and patient cannot readily identify what must be corrected or supplemented or how to appeal the decision.

The NHC has long supported shorter and more predictable prior authorization timeframes.[22,23] More timely decision-making is particularly important when patients are facing acute needs, treatment transitions, disease progression, or clinically significant risks from delay.[24,25,26] At the same time, nominal timeframes alone are not sufficient.

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[22] National Health Council, *Exploring the Burden*.

[23] National Health Council, "NHC Comments on Interoperability and Prior Authorization Proposed Rule."

[24] Kyle and Keating, "Prior Authorization."

[25] Jay Pickern, "Prior Authorizations and the Adverse Impact on Continuity of Care," *The American Journal of Managed Care* 31, no. 4 (2025): 163–165, https://doi.org/10.37765/ajmc.2025.89721.

[26] Henry, "Prior Authorization Delays Care and Increases Health Care Costs."

From the patient perspective, the practical significance of a timeframe requirement depends on when a request is considered complete and the review period actually begins, whether requests are treated as incomplete for avoidable reasons, how often extensions are used, and whether the communication received is specific enough to permit timely correction, resubmission, or appeal.[27,28]

The NHC supports the proposal to require specific reasons for denials and encourages CMS to ensure that these explanations are operationally useful rather than formulaic. A generic statement that coverage criteria were not met is rarely enough to help a clinician or patient understand which requirement was not satisfied, what additional documentation may be needed, or how to seek reconsideration or appeal.[29,30] To be meaningful in practice, denial explanations should do more than restate that coverage was not approved. They should, at a minimum, identify the relevant clinical or administrative basis for the determination, specify any missing documentation where applicable, and support timely resubmission, exception, or appeal. These communications should also clearly state whether the decision was reached because of missing information, failure to satisfy a particular clinical criterion, benefit design limitations, coding or submission defects, or another administrative basis for non-approval. They should also be framed in a way that allows treating clinicians and their staff to determine quickly whether the issue can be cured through additional documentation, whether a peer-to-peer or exception process is more appropriate, or whether an appeal is required. The more specific and actionable the communication, the less likely it is that patients will experience avoidable delays caused by confusion rather than by a genuine substantive disagreement regarding coverage.

The NHC also encourages CMS to consider whether additional transparency may be warranted when automated tools or algorithmic processes materially shape prior authorization review, particularly where they influence denials, requests for additional information, or routing of the request. From the patient and provider perspective, the key issue is not the use of technology, but whether the resulting communication is understandable, sufficiently specific, and open to meaningful clarification or appeal, and whether the process remains accountable and clinically appropriate.

Interoperability should improve clarity, not simply increase the speed at which unclear messages are delivered. This consideration extends to patient-facing communications. Even where the primary notice obligations run to providers, patients and caregivers ultimately experience the consequences of delays and denials. They encounter prior

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[27] Tanya Henry, “Fixing Prior Auth: Clear Up What’s Required and When,” American Medical Association, accessed June 14, 2026, https://www.ama-assn.org/practice-management/prior-authorization/fixing-prior-auth-clear-what-s-required-and-when.

[28] Office of Inspector General, *Some Medicare Advantage Organization Denials*.

[29] National Health Council, *Exploring the Burden*.

[30] Miranda Yaver, “Rationing by Inconvenience: How Insurance Denials Induce Administrative Burdens,” *Journal of Health Politics, Policy and Law* 49, no. 4 (August 2024): 539–565, https://doi.org/10.1215/03616878-11186111.

authorization in the context of managing a diagnosis, coordinating among multiple providers, arranging transportation or caregiving support, and determining what a coverage determination means for treatment timing and cost. Communications that may be manageable for sophisticated institutional users, can remain difficult for patients and caregivers to navigate when they are highly technical, incomplete, or inconsistent across actors. The final framework should support communications that can be translated into notices that are understandable to patients and caregivers, including those with limited health literacy, limited familiarity with coverage processes, or substantial caregiving responsibilities.[31,32] These notices should include simplified explanations of what was denied, why it was denied, what additional information may be needed, and what options remain available.

The NHC also encourages CMS to continue considering whether provider-facing timing reforms for QHP issuers on the FFEs should, over time, be paired with shorter or clearer patient-notification expectations as well. Provider notification is essential, but patients and caregivers also benefit when coverage determinations are communicated promptly and in a manner that supports timely next steps.

The NHC asks CMS to remain attentive to the relationship between decision timeframes and continuity of care. Delays associated with unclear communications can be especially disruptive where a patient is already established on therapy, is transitioning between sites of care, or requires prompt initiation of treatment following diagnosis or clinical progression. In such cases, a clear notice may be the difference between a manageable administrative step and a treatment interruption that is difficult to reverse. The NHC therefore encourages CMS to continue assessing whether its communications policies are operating in a way that supports timely continuation or initiation of medically appropriate care, particularly for patients with serious, chronic, or otherwise clinically sensitive treatment needs.

The NHC further recommends that CMS monitor whether the proposed timeframes are functioning as intended in practice. If requests continue to be delayed by administrative fragmentation, repeated demands for documentation, or inconsistent handling across plans and delegated entities, the NHC encourages CMS to revisit those policies in future rulemaking or guidance as appropriate.[33,34] Monitoring should include both whether plans and issuers formally meet prescribed deadlines, and also whether the broader process is producing repeated resubmissions, frequent use of extensions, unclear denial rationales, or patterns suggesting that timely determinations are being

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[31] Rachel O'Conor et al., "Caregiver Involvement in Managing Medications among Older Adults with Multiple Chronic Conditions," *Journal of the American Geriatrics Society* 69, no. 10 (2021): 2916–2922, https://doi.org/10.1111/jgs.17337.

[32] Kangyeon Lee and Wendy Yi Xu, "Treatment Burdens in Traditional Medicare and Medicare Advantage," *The American Journal of Managed Care* 31, no. 12 (December 2025), https://www.ajmc.com/view/treatment-burdens-in-traditional-medicare-and-medicare-advantage.

[33] Kyle and Frakt, "Patient Administrative Burden."

[34] Yaver, "Rationing by Inconvenience."

undermined by workflow design rather than overt noncompliance. This is especially important for QHP issuers on the FFEs, for whom CMS also proposes to allow extensions of up to 14 calendar days under specified circumstances. If that policy is finalized, the NHC asks CMS to carefully monitor whether the extension pathway is used narrowly and appropriately or in ways that dilute the intended value of the provider-notification timeframes. The NHC encourages CMS to view these implementation questions as central to whether the proposed reforms are succeeding.

As CMS finalizes and implements these provisions, the NHC also urges the agency to continue engaging patients, caregivers, providers, plans, and other stakeholders regarding how communication and timeframe requirements are functioning in practice. The value of these policies will depend not only on the text of the final rule, but also on how the requirements are translated into real-world notices, workflows, staffing practices, and escalation pathways. Continued stakeholder input is important to identify where additional clarification, guidance, or refinement may be needed to ensure that the proposed improvements translate into a more timely and understandable prior authorization process for patients and those who care for them.

Updates to Patient Access, Provider Access, Payer-to-Payer APIs, and API Usage Metrics

The NHC supports CMS' proposal to make information about prior authorization requests and decisions for drugs available through the Patient Access, Provider Access, and Payer-to-Payer APIs, as applicable, and to expand reporting of API usage metrics beyond the Patient Access API. These policies have the potential to make the broader interoperability framework more useful in practice by ensuring that key information is available to the actors who need it when treatment decisions are being made or coverage issues are being resolved. In this respect, the proposal moves beyond interoperability as an abstract technical objective and ties it more directly to the operational moments in which patients and providers experience delay, uncertainty, and administrative burden. The availability of current and usable prior authorization information at those points in the workflow may reduce preventable breakdowns in communication and help ensure that coverage-related issues are identified and addressed earlier during care. To support that objective, the NHC encourages CMS to remain attentive to whether formulary, coverage, prior authorization, and related utilization-management requirement information is updated with sufficient timeliness and consistency across relevant APIs, portals, and other patient- and provider-facing tools. This should include clear disclosure of where step-therapy requirements or other sequencing rules effectively function as a prerequisite to prior authorization or access. Information that is technically available but not current, complete, or clearly presented may still generate avoidable confusion, duplicate work, and delay.

These proposals are important because interoperability has limited practical value if patients, providers, and payers cannot readily exchange relevant information at the point when treatment is prescribed, reviewed, authorized, or continued.[35] Access to

[35] Office of the National Coordinator for Health Information Technology, "Interoperability," accessed May 18, 2026, https://www.healthit.gov/topic/interoperability.

prior authorization status, denial rationale, approval dates, expiration information, and associated clinical or administrative documentation may help reduce unnecessary follow-up, duplicate submissions, and avoidable breakdowns in communication.[36,37] Improved information sharing is especially important for patients with chronic or complex conditions, whose care often depends on coordination among multiple clinicians, pharmacies, caregivers, and coverage entities.[38,39] For many patients, administrative friction does not arise because information is wholly unavailable, but because it is unavailable to the right person at the right moment or is distributed across disconnected systems that require repeated manual follow-up. A prescribing clinician may not know whether a request is pending, denied, or approved. A pharmacy may not be able to determine whether a problem processing or filling a prescription reflects a coverage rule, a documentation problem, or a timing issue. This problem can be particularly acute in community pharmacy settings, where patients may be waiting at the point of dispensing and where limited visibility into prior authorization status or routing can translate directly into delay, confusion, or prescription abandonment. A patient or caregiver may be left trying to reconcile inconsistent information from multiple sources without the status of the request, the reason for any delay or denial, or the steps needed to move the process forward. The proposal's expansion of API-based access to prior authorization information therefore has the potential to improve both technical exchange and the ability of patients and providers to navigate the process..[40,41]

The NHC also encourages CMS to consider how these API policies may affect continuity across the full treatment pathway. For many therapies, particularly those used in ongoing or high-acuity care, prior authorization is not experienced as a one-time event. It is part of a broader sequence that may involve prescribing, dispensing, administration, refill, reauthorization, exception requests, and appeals. Timely access to current information about where a request stands, what documentation has already been submitted, and how a prior determination was reached may help reduce unnecessary duplication and make it easier for patients and providers to maintain treatment continuity over time.

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[36] W. C. Chen et al., "Integrating Prior Authorization Into Clinical Workflows for Care Access and Practitioner Experience," *JAMA Network Open* 8, no. 12 (2025): e2453121, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2843121.

[37] Centers for Medicare & Medicaid Services, "2026 CMS Interoperability Standards and Prior Authorization for Drugs Proposed Rule," fact sheet, April 10, 2026, https://www.cms.gov/newsroom/fact-sheets/2026-cms-interoperability-standards-prior-authorization-drugs-proposed-rule.

[38] O'Conor et al., "Caregiver Involvement."

[39] Lee and Xu, "Treatment Burdens."

[40] Katy Haynes, "Health Data Exchange Drives Efficiency and Cuts Costs," California Health Care Foundation, July 9, 2025, https://www.chcf.org/resource/health-data-exchange-drives-efficiency-cuts-costs/.

[41] Bonnie Lum et al., "Examining Implementation Outcomes in Health Information Exchange Systems: A Scoping Review," *Journal of Biomedical Informatics* 160 (2025): 104782, https://doi.org/10.1016/j.jbi.2025.104782.

The NHC recommends that CMS evaluate these APIs not simply by whether they exist or by how often they are used, but by whether they improve patient-centered outcomes. Broader adoption of the APIs is only valuable if it corresponds to more timely information exchange, fewer duplicative requests, better continuity of care, and less confusion for patients and caregivers.[42] Usage data should therefore be treated as one indicator within a broader implementation picture, not as the sole measure of success. An API may be widely available and even frequently accessed without meaningfully improving the patient experience if the information it supplies is incomplete, difficult to interpret, delayed, or insufficiently integrated into clinical workflows.[43,44] Conversely, a tool that is used more selectively may still provide substantial value if it reduces the need for repeated resubmission, improves handoffs across care settings, or helps prevent avoidable treatment disruption. The NHC therefore encourages CMS to interpret API usage metrics in conjunction with other indicators that better reflect operational effectiveness, including fewer repeat prior authorization submissions, reduced need for manual interventions, improved continuity of care, and more timely resolution of coverage-related issues.

The NHC also asks CMS to consider whether the information available through these APIs is sufficiently tailored to different categories of end users.[45,46] Providers may need information presented in a manner that supports rapid clinical decision-making and workflow integration. Patients and caregivers, by contrast, may need information that is understandable without specialized knowledge of benefit design, utilization management terminology, or payer processes. The NHC therefore encourages CMS to remain attentive to the distinction between data availability and data usability. If the policy objective is to reduce burden and improve patient access, then success should be evaluated by whether information can be exchanged, understood, and acted upon by those responsible for making or supporting care decisions.

The NHC also reminds CMS of the importance of caregiver access and usability as implementation proceeds. Many patients rely on family caregivers or other personal representatives to help navigate treatment, benefits, and prior authorization requirements.[47] To the extent permitted under applicable privacy and access rules, the

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[42] Centers for Medicare & Medicaid Services, “CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F),” fact sheet, January 17, 2024, https://www.cms.gov/newsroom/fact-sheets/cms-interoperability-prior-authorization-final-rule-cms-0057-f.

[43] Lum et al., “Examining Implementation Outcomes.”

[44] O’Malley et al., *Administrative Burden*.

[45] Shasha Han, “Facilitating Patient Portal Shared Access to Support Age-Friendly Health Care,” *JAMA Network Open* 8, no. 2 (2025): e2461814, https://doi.org/10.1001/jamanetworkopen.2024.61814.

[46] National Health Council, *Comments RE Request for Information; Health Technology Ecosystem (CMS-0042-NC)* (Washington, DC: National Health Council, June 16, 2025), https://nationalhealthcouncil.org/wp-content/uploads/2025/06/NHC-Comments-RE-CMS-Health-Technology-Ecosystem-RFI.pdf.

[47] O’Conor et al., “Caregiver Involvement.”

API framework should include functions enable caregivers to assist meaningfully with these processes and help reduce administrative burden.[48] This is particularly important for patients with serious or chronic conditions, who may depend on caregivers to coordinate among prescribers, pharmacies, plans, infusion centers, and other participants in the care process. A framework that improves electronic access for plans and providers but does not adequately account for the practical role of caregivers may leave a significant part of the patient-support infrastructure outside of the interoperability improvements intended to reduce burden. The NHC therefore asks CMS to determine how authorized caregiver access can be supported in a manner that is secure, understandable, and workable in practice.

In addition, the NHC encourages CMS to consider how the Payer-to-Payer API and related information exchange could better support continuity of care for patients who change coverage. One of the most frustrating and clinically disruptive features of prior authorization is the repeated need to re-establish information that already exists elsewhere in the system.[49,50,51] Interoperable exchange should reduce the need to repeatedly reconstruct clinical history or re-litigate medical necessity where relevant information is already available. This issue is especially important when patients change plans, transition between payer arrangements, or experience other administrative changes that do not alter their clinical condition but nonetheless require treatment history to be reassembled from multiple sources. In such circumstances, the burdens associated with prior authorization often reflect discontinuity of information rather than substantive uncertainty about medical need. The NHC therefore recommends that CMS continue examining whether the Payer-to-Payer API and related policies can better support retention and transfer of information relevant to established therapy, previous authorization history, and continuity of care.

The NHC also notes that the practical value of these API policies may depend significantly on how they are implemented across different settings and lines of business. Patients whose care depends on multiple providers, multiple benefit pathways, or coordination across prescribing and administering entities are especially likely to feel the effects of information fragmentation. For that reason, the NHC encourages CMS to continue engaging stakeholders regarding where information exchange remains incomplete, where workflows continue to depend on manual intervention, and where additional standardization or clarification may be needed to ensure that API-based access supports real-world care coordination rather than functioning primarily as a compliance exercise.

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[48] National Health Council, *Comments RE Request for Information*.

[49] National Health Council, *Exploring the Burden*.

[50] Biniek et al., “The Use of Prior Authorization.”

[51] Johnson et al., “Adverse Effects.”

Reporting Payer API Endpoints and Prior Authorization Metrics

The NHC supports CMS' proposal to require impacted payers to report API endpoints and related information to CMS and to strengthen public reporting on prior authorization through the addition of numeric counts and new metrics related to denials, appeals, and approvals after extension. These proposals may help make interoperability more practical and prior authorization oversight more meaningful. In particular, they recognize that interoperability infrastructure is more likely to improve access and reduce burden when it is discoverable, usable, and subject to meaningful oversight rather than existing only as a formal technical requirement.

The proposal to create a centralized reporting mechanism for payer API endpoints addresses a practical implementation issue that can otherwise undermine the value of the broader framework.[52] If providers and payers must discover one another's endpoints through fragmented, inconsistent, or plan-specific means, the interoperability architecture is less likely to achieve its intended burden-reduction effect. A centralized approach may reduce unnecessary complexity and help operationalize the Provider Access, Prior Authorization, and Payer-to-Payer APIs in a more consistent manner. A technically available API has limited practical value if those expected to use it cannot readily determine where and how to connect, what information is available, or whether the endpoint information is current and reliable. Endpoint discoverability is therefore not a peripheral administrative issue; it is essential to whether the interoperability framework can function at scale and whether providers and their staff can rely on it instead of defaulting to manual workarounds.

The NHC encourages CMS to consider whether centralized endpoint reporting can help reduce disparities in implementation capacity across plans, providers, and other users of the system. Larger organizations may be better positioned to navigate fragmented technical discovery processes or maintain customized integration strategies, while smaller providers, less-resourced practices, and organizations with fewer technical capabilities may be more likely to rely on manual or duplicative processes when endpoint information is difficult to locate or validate. A more centralized and consistent approach may therefore have value not only as a technical simplification, but also as a way to support more equitable participation in the interoperability ecosystem.

The NHC also supports CMS' effort to strengthen public reporting on prior authorization metrics. Publicly available data may help illuminate if prior authorization is functioning as a targeted and proportionate review mechanism or if it is creating excessive delay, unusually high rates of reversal, or substantial variation across markets and product

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[52] U.S. Department of Health and Human Services, Office of the National Coordinator for Health Information Technology, "Health Data, Technology, and Interoperability: Certification Program Updates, Algorithm Transparency, and Information Sharing," *Federal Register*, January 9, 2024, https://www.federalregister.gov/documents/2024/01/09/2023-28857/health-data-technology-and-interoperability-certification-program-updates-algorithm-transparency-and.

types.[53,54,55] For patients with chronic and complex conditions, these distinctions are not abstract—they influence how reliably patients can obtain therapies and whether clinicians can plan care with confidence.[56] Public reporting may also help clarify whether operational reforms are having their intended effect over time. If electronic prior authorization and related interoperability policies function as intended, stakeholders may be able to observe improvements in the technical adoption as well as the consistency, transparency, and timeliness of determinations. Conversely, if denial rates remain unusually high, reversals are common after appeal, or extensions are frequently used in ways that suggest avoidable delay, public reporting may help identify where further oversight or policy refinement is warranted.

Transparency through meaningful public data can benefit patients by strengthening accountability across the system, even if most beneficiaries do not directly review or interpret detailed prior authorization metrics. Patient organizations, advocates, regulators, providers, researchers, and other stakeholders can use these data to identify otherwise obscured patterns, including whether some plans or product types rely more heavily on prior authorization, approvals are frequently delayed and later reversed, or particular therapeutic areas appear associated with unusual levels of administrative friction. In that respect, public metrics can provide patient protection even when they are primarily analyzed by intermediaries rather than individual beneficiaries.

At the same time, the NHC encourages CMS to ensure that the final reporting framework is designed for meaningful oversight rather than merely formal compliance. Over time, CMS should consider whether public metrics are presented in a way that allows stakeholders to identify meaningful patterns, including concentrations of prior authorization requirements in particular therapeutic categories, high rates of reversal after appeal, frequent resort to extensions, or outlier plan behavior. The NHC recommends that CMS identify future reporting refinements that could better illuminate patient-centered questions, including whether delays disproportionately affect patients with chronic diseases, disabilities, rare diseases, or other conditions for which continuity and timeliness of therapy are especially important.[57,58]

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[53] Biniek et al., “The Use of Prior Authorization.”

[54] Jeannie Biniek et al., “Medicare Advantage Insurers Made Nearly 53 Million Prior Authorization Determinations in 2024,” KFF, January 28, 2026, https://www.kff.org/medicare/medicare-advantage-insurers-made-nearly-53-million-prior-authorization-determinations-in-2024/.

[55] Kaye Pestaina, “Insurers’ Prior Authorization Data Offers Little Insight Into What Gets Approved or Denied,” KFF Quick Insight, April 2, 2026, https://www.kff.org/quick-insights/insurers-prior-authorization-data-offers-little-insight-into-what-gets-approved-or-denied/.

[56] Lee and Xu, “Treatment Burdens.”

[57] Bridgette Thom et al., “Patient Perspectives on Prior Authorization for Cancer Care,” *JAMA Network Open* 8, no. 7 (2025): e2523807, https://doi.org/10.1001/jamanetworkopen.2025.23807.

[58] Kyle and Keating, “Prior Authorization.”

In considering future refinements, CMS may also wish to assess whether additional stratification would improve the interpretability of the data. Depending on data availability and reporting feasibility, greater visibility into differences across lines of business, drug categories, expedited versus standard determinations, repeat authorization requests, or plan transitions may help stakeholders better understand where burdens are concentrated and whether reforms are benefiting the patients most likely to experience disruption from delay.

The NHC also encourages CMS to consider whether future refinement of interoperability and reporting policies could better support retention and transfer of clinically relevant prior authorization history across coverage transitions. In some cases, information associated with a prior denial, appeal, exception request, or subsequent determination may remain directly relevant to continuity of care, including evidence previously submitted by the treating clinician or documentation that a patient has already experienced failure, intolerance, or clinical unsuitability with an alternative therapy. If that history is not preserved or made meaningfully available where appropriate, patients and providers may be forced to restart authorization or step-therapy processes even when the relevant information already exists elsewhere in the system. To the extent feasible, the NHC asks CMS to prioritize reporting approaches that move beyond aggregate totals and allow for more meaningful disaggregation of denial, appeal, extension, and approval patterns. More detailed reporting may help distinguish between raw volume and operationally significant patterns and may better illuminate where utilization-management processes are generating avoidable burden or unusual variation across markets, products, or categories of care.

The NHC recommends that CMS assess how these metrics are communicated and contextualized. Reporting that is public but difficult to interpret may have limited oversight value. Where feasible, the NHC encourages CMS to use presentation formats that make it easier to distinguish between raw volume, percentage-based performance, and patterns suggesting operational concern. Clear framing may be especially important where a metric could otherwise be misleading in isolation. For example, a low denial rate may not fully capture burden if repeated documentation requests, frequent extensions, or high appeal volume suggest that patients and providers still face substantial process friction before approval is obtained.

Finally, the NHC encourages CMS to view public reporting as part of a broader feedback loop between implementation, oversight, and refinement. Metrics should not simply be collected and published; they should help inform whether the underlying framework is reducing burden, improving continuity of care, and producing more timely and understandable coverage determinations in practice. As CMS gains experience with these reporting requirements, the agency should remain open to refining both the content and presentation of the data to ensure that public reporting remains aligned with patient-centered oversight objectives rather than becoming a static compliance exercise.

Interoperability Standards for APIs and Health Information Technology Standards

The NHC supports CMS' continued use of standards-based interoperability as the foundation for reducing administrative burden and improving information exchange. The

proposal's reliance on Health Level Seven International (HL7) Fast Healthcare Interoperability Resources (FHIR)-based APIs and implementation guides, together with complementary NCPDP standards for pharmacy-benefit drug prior authorization, reflects an effort to match technical approaches to the operational realities of different benefit structures.[59,60] This is a sensible approach, but it will require continued attention to implementation clarity and consistency. From the NHC's perspective, the value of standards-based interoperability lies not only in technical modernization, but in whether the resulting framework creates more consistent, predictable, and usable pathways for patients, providers, plans, and other participants in the coverage process. Standards can only reduce burden if they are sufficiently aligned with real-world workflows and implemented in a manner that supports timely and understandable exchange of clinically relevant information.

The NHC encourages CMS and the Office of the National Coordinator for Health Information Technology (ONC) to provide clear technical direction regarding when and how the relevant standards are to be used, particularly where providers, plans, PBMs, vendors, and other entities may be interacting across multiple transaction environments. The existence of multiple applicable standards may be appropriate from a systems perspective, but it also increases the risk of fragmented implementation if operational responsibilities and data expectations are not clearly specified. This is especially important in the context of prior authorization, where confusion about where a request should be routed, what information should be included, or which standard applies in a given context can itself become a source of delay. A framework that is technically sound but operationally ambiguous may still require providers and their staff to rely on informal workarounds, plan-specific practices, or repeated manual follow-up to determine how to proceed. The NHC therefore encourages CMS and ONC to continue prioritizing implementation guidance that is clear enough to reduce uncertainty across the full range of users expected to operationalize these standards.

The NHC also notes that CMS and ONC should remain attentive to the distinction between technical interoperability and workflow interoperability. The formal adoption of common standards can improve exchange capacity, but it does not automatically ensure that the information exchanged is timely, sufficiently complete, or clearly presented to support decision-making.[61] In the prior authorization context, value depends on whether the relevant information is available at the point when it is needed, whether it can be incorporated into provider and payer workflows without excessive re-entry or manual reconciliation, and whether it reduces rather than redistributes administrative burden. The NHC therefore recommends continued focus on how standards function in practice across prescribing, dispensing, administration, review, and follow-up workflows.

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[59] Centers for Medicare & Medicaid Services, *Proposal To Support National Council for Prescription Drug Programs Standards* (Baltimore: Centers for Medicare & Medicaid Services, 2026), https://www.cms.gov/files/document/ncpdp-standards-workflow-cms-0062-p.pdf.

[60] Barker et al., "The Evolution of Health Information Technology."

[61] Lum et al., "Examining Implementation Outcomes."

The NHC also encourages CMS and ONC to emphasize usability alongside technical conformance. A technically compliant interoperability ecosystem will not fully serve patients if it does not support practical functions such as understanding whether a drug requires prior authorization, what information is needed, what the likely out-of-pocket costs may be, and how a caregiver may access or help manage those processes where appropriate. Technical modernization should remain tied to the patient-facing purposes it is intended to serve. Patients and caregivers rarely experience interoperability improvements directly as technical achievements but through clearer information, fewer delays, reduced repetition, and more coordinated communication among the actors involved in care and coverage. To the extent that standards implementation remains disconnected from those patient-facing outcomes, the benefits of modernization may be unevenly realized or insufficiently visible to the people the reforms are intended to help.

CMS and ONC should also consider whether additional implementation support may be warranted for entities with fewer technical resources or less internal interoperability capacity.[62] Even where the underlying standards are appropriate, variation in organizational capability may affect whether the resulting systems are integrated in a manner that promotes consistency and reduces burden. Smaller providers, safety-net organizations, and other less-resourced participants may face greater difficulty translating technical requirements into usable workflows without clear guidance, practical implementation support, and sufficient lead time. Attention to these implementation realities may help reduce the risk that standards-based reforms succeed more fully in some settings than in others, thereby creating uneven access to the operational benefits of interoperability.

The NHC notes that ONC's proposal to adopt updated versions of relevant health IT standards and specifications and to establish expiration dates for older versions may help promote greater consistency across Department of Health and Human Services (HHS) programs. That consistency may in turn reduce fragmentation in the implementation of electronic prior authorization and related interoperability functions. The NHC supports this general direction and encourages continued coordination so that updates to technical standards do not unintentionally create uncertainty or burden during transition periods. Transitions between standards versions can be especially challenging where multiple actors must update systems, reconfigure interfaces, revise workflows, and align their expectations regarding data availability and formatting.[63] The NHC therefore asks CMS and ONC to ensure that transition policies are accompanied by sufficient communication, implementation support, and time for affected entities to operationalize changes in a manner that does not disrupt care or create avoidable delays in prior authorization processing.

More broadly, the NHC encourages CMS and ONC to continue viewing standards policy as part of a larger implementation strategy rather than as a discrete technical exercise. The choice and maintenance of standards will shape whether prior authorization-related information can be exchanged in a manner that supports transparency, continuity of

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[62] O'Malley et al., *Administrative Burden*.

[63] U.S. Department of Health and Human Services, "Health Data, Technology, and Interoperability."

care, and more efficient resolution of coverage issues. As the agencies move forward, the NHC urges them to continue engaging stakeholders on formal technical specifications as well as how those specifications affect day-to-day workflows, patient communication, and the administrative burden experienced across the care continuum.

Modifications to HIPAA Standards Related to Prior Authorization

The NHC recognizes that the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Administrative Simplification proposals are among the more technical components of the rule, but they may be highly consequential over time. HHS is proposing to adopt FHIR and associated implementation guides for certain referral certification, authorization, and eligibility transactions related to prior authorization in place of currently adopted X12-based transactions for dental, professional, and institutional use cases, while retaining NCPDP standards for retail pharmacy drugs. Although these proposals are technical in form, they are not merely technical in effect. The standards that govern how prior authorization-related information is transmitted, updated, and interpreted shape whether administrative processes are clear, timely, and usable in practice. For that reason, the NHC views these proposals as directly relevant to patient access and continuity of care, even if their immediate subject matter is standards modernization rather than benefit design or utilization management policy.

From the NHC's perspective, the most important question is whether these changes will improve real-world interoperability, reduce administrative friction, and support more timely and reliable access to needed care. To the extent that updated transaction standards better reflect current technological capabilities and align with the broader interoperability architecture CMS is promoting, they may help move the system toward a more coherent and efficient framework. At the same time, transitions of this kind can create temporary complexity, particularly for organizations operating across multiple systems and standards environments. A change in technical standards may be beneficial in the long term while still creating near-term implementation challenges for providers, plans, vendors, clearinghouses, and other entities responsible for operationalizing prior authorization workflows. Those challenges may in turn affect patients if they result in inconsistent processing, uncertainty regarding required information, or delays associated with incomplete system readiness. The NHC recommends that HHS and CMS evaluate these proposals not only in terms of their long-run technical merits, but also in terms of how transition-related risks will be managed during implementation.

The NHC also encourages HHS and CMS to remain attentive to the risk that differences between legacy and updated transaction environments may create confusion for entities that must continue to operate across multiple workflows during a transition period. Even if the end state is more coherent, the path to that end state may involve periods in which organizations are mapping between old and new standards, relying on interim processes, or adapting interfaces that are not yet fully synchronized. In the prior authorization context, these implementation frictions may have tangible consequences if they result in requests being routed incorrectly, data being transmitted incompletely, or determinations being delayed while technical questions are resolved.

The NHC therefore asks HHS and CMS to provide clear implementation guidance, robust transition support, and careful oversight as these policies are operationalized. The value of replacing legacy transaction standards with FHIR-based approaches will depend not simply on the formal adoption of new standards, but on whether those changes reduce manual work, improve data quality, and make prior authorization processes more understandable and efficient for the people required to use them. Implementation guidance should therefore do more than describe the technical specifications. It should help affected entities understand how the standards are intended to function in operational workflows, how overlapping or adjacent standards should be coordinated, what information is expected at different points in the process, and how organizations can reduce avoidable variation in how requests and determinations are handled. To the extent possible, guidance should support a transition in which the updated standards meaningfully reduce the need for manual reconciliation, duplicative submission, and plan-specific workarounds.

The NHC also encourages HHS and CMS to remain attentive to whether the adoption of updated standards improves the interpretability of transmitted information. A system that allows information to move more quickly but still leaves providers and patients uncertain about what has been requested, approved, denied, or deferred may not materially reduce burden. In this regard, the agencies should continue to consider how standards adoption interacts with the broader goals of clarity, timeliness, and predictability in prior authorization. Technical modernization will be most valuable where it improves the usability and reliability of the process as experienced by those submitting, reviewing, and acting on determinations.

HHS and CMS should also monitor the downstream implications for providers, smaller entities, and patients whose access may be affected by uneven implementation across the market. Technical modernization can create long-term gains, but it should not do so at the expense of short-term confusion or new barriers in the transition period. This is especially important where smaller organizations or less-resourced participants may have more limited capacity to absorb transition costs, update systems quickly, or troubleshoot technical issues without disruption to patient care. Variability in implementation readiness may create uneven experiences across markets and care settings, even where the formal regulatory requirements are uniform. The NHC therefore encourages HHS and CMS to monitor whether transition-related challenges are affecting particular categories of providers, plans, or patients disproportionately and to respond with additional clarification or support where needed.

More broadly, the NHC recommends that HHS and CMS treat these HIPAA standards proposals as part of the same patient-centered modernization effort reflected in the rest of the rule. The shift to updated standards should be evaluated not only by whether covered entities ultimately comply, but also by whether the transition produces a prior authorization environment that is more coherent, less burdensome, and more capable of supporting timely access to medically appropriate care. As implementation proceeds, continued engagement with stakeholders will be important to identifying where the updated standards are reducing friction as intended and where additional refinements may be necessary to ensure that technical change translates into operational improvement.

Requirements for Issuers That Offer Small Group Market Qualified Health Plans on the FF-SHOPs

The NHC has reviewed CMS' proposal to apply the existing interoperability requirements and the proposed prior authorization-related requirements to small group market QHP issuers on the Federally-facilitated Small Business Health Options Program Exchanges (FF-SHOPs). To the extent that these issuers are already participating in the individual market QHP environment and have experience with related API and interoperability requirements, applying similar standards across these markets may help promote greater consistency and reduce fragmentation. From the NHC's perspective, this proposal reflects an important principle: patients and families should not be exposed to avoidable differences in administrative burden simply because similar coverage products are situated in adjacent but technically distinct market segments. To the extent that comparable interoperability and prior authorization expectations can be extended across these settings in a workable manner, doing so may help reduce unnecessary variation in how patients, caregivers, and providers experience coverage-related processes. The NHC also recognizes CMS' stated view that the incremental burden associated with applying these requirements to small group market QHP issuers on the FF-SHOPs may be limited because, at present, the affected issuers also participate in the individual market QHP environment on the FFEs. If CMS relies on that premise in finalizing the policy, the agency should continue to assess whether future market entrants or operational changes affect the underlying assumption and warrant additional implementation flexibility.

At the same time, the NHC encourages CMS to remain attentive to implementation feasibility and to the practical implications for enrollees in these products. If there are operational differences that warrant targeted flexibility or phased implementation, those should be weighed carefully against the patient interest in having comparable access protections and interoperability functionality across coverage types. The NHC does not take the view that small group market enrollees should be left outside modernization efforts where meaningful improvement is achievable. In this respect, the relevant policy question is not whether small group market QHP issuers differ in every operational respect from other affected issuers, but whether any such differences justify materially different expectations regarding transparency, information exchange, and the usability of prior authorization processes. Where meaningful improvement is feasible, the NHC encourages CMS to avoid creating unnecessary asymmetries that would leave some enrollees with reduced visibility into prior authorization status, less coordinated exchange of information, or fewer of the practical benefits associated with electronic workflows.

The NHC also recommends that CMS consider how implementation decisions in this area may affect patients who move between coverage arrangements over time. Although the FF-SHOP context is narrower than the broader commercial market, continuity and predictability still matter for individuals and families whose coverage may shift because of employment changes, business decisions, or plan transitions. To the extent that CMS can promote more consistent interoperability and prior authorization expectations across related market segments, the agency may help reduce the administrative disruption that can accompany such transitions.

The NHC encourages CMS to ensure that any exceptions or flexibility mechanisms are used in a way that does not undermine the broader goal of bringing more of the market into a consistent and interoperable framework over time. Flexibility may be appropriate where necessary to account for operational readiness, but it should remain tied to a clear path toward implementation rather than becoming a basis for indefinite divergence in patient-facing protections or functionality. If some issuers require additional time or tailored implementation support, CMS should work to structure that flexibility transparently and in a manner that preserves the overall policy objective of broader consistency across coverage types.

More broadly, the NHC recommends that CMS view this proposal as part of its larger effort to reduce fragmentation in how prior authorization and related coverage processes are administered. Patients, caregivers, and providers generally do not experience interoperability requirements as product-specific technical categories. They experience them through whether information is available, whether processes are understandable, and whether treatment can proceed without unnecessary administrative delay. For that reason, the NHC supports efforts to extend modernization and interoperability expectations where appropriate across adjacent market segments, provided that implementation is accompanied by sufficient clarity, oversight, and attention to enrollee experience.

PBMs and Accountability

The NHC appreciates CMS' acknowledgment that many impacted payers rely on PBMs to manage prescription drug benefits and, in practice, to administer prior authorization for pharmacy-benefit drugs. The rule recognizes that PBMs may play an important operational role in implementing electronic prior authorization requirements while also stating that ultimate regulatory responsibility remains with the impacted payer. The NHC recognizes that PBMs and other delegated entities may serve legitimate administrative and operational functions within pharmacy-benefit management; the central question is whether the resulting process remains coherent, timely, and accountable from the patient perspective. This distinction matters because, in practice, patients and providers often experience prior authorization as a process that involves multiple entities whose roles may not be transparent. A request may be submitted to a plan, routed through a PBM or other delegate, evaluated through plan-specific or delegated workflows, and communicated back through a different channel than the one through which it was initiated. When responsibilities are distributed across multiple actors, the risk increases that delays, unclear communications, or inconsistent information will be experienced as part of the process even if no single actor views itself as solely responsible for the resulting burden.

From the patient perspective, burden often arises not from fragmented accountability when no single actor appears responsible for ensuring a timely, clear, and workable process, rather than from formal legal distinctions between payers and delegated entities. A patient or provider should not be left navigating uncertainty regarding which entity is responsible for correcting an error, clarifying a requirement, or resolving an avoidable delay. From the standpoint of patient access, the relevant issue is whether

the process functions reliably and predictably, not how responsibilities are allocated contractually behind the scenes.

The NHC therefore encourages CMS to reinforce in the final rule and implementation guidance that, where delegated arrangements are used, responsibility for a timely, clear, and workable process remains sufficiently clear from the standpoint of patients and providers. When PBMs, vendors, or other entities are performing operational functions that affect prior authorization outcomes, impacted payers should remain accountable for ensuring that the process complies with applicable requirements and functions in a manner that is timely, transparent, and responsive to patient needs. The NHC does not suggest that delegation is inherently problematic; the concern is rather that the resulting process is understandable, coordinated, and dependable for the patients, caregivers, pharmacies, and providers who must navigate it. The NHC particularly suggests that CMS clarify that the use of delegated arrangements does not diminish expectations relating to timeliness, clarity of communications, consistency of standards application, or responsiveness when issues arise during processing.

The NHC also encourages CMS to consider how delegated arrangements affect the interpretability of prior authorization workflows. Even where a payer remains formally responsible, the use of PBMs and other delegated entities may create practical complexity if patients and providers receive communications from multiple sources, encounter inconsistent terminology or instructions, or are directed to different portals, call centers, or submission channels depending on the stage of the process. Such complexity may be especially burdensome for patients with chronic or serious conditions, who are more likely to experience repeated interactions with the prior authorization system over time. The NHC therefore asks CMS to continue assessing both the formal compliance of delegated workflows and their coherence and navigability in practice.

CMS should also to monitor whether the use of delegated entities creates meaningful variation in how patients and providers experience the prior authorization process, particularly with respect to timeliness, denial specificity, continuity of care, and ease of obtaining needed information.[64,65,66] This monitoring function is especially important because variation in delegated administration may not always be visible through formal plan-level policy documents alone. Two impacted payers may appear similar on paper while producing materially different patient and provider experiences because of differences in delegated review practices, technical infrastructure, staffing arrangements, communication channels, or escalation pathways. To the extent possible, the NHC encourages CMS to remain attentive to whether variation in the use of PBMs or other delegates is associated with differences in approval timelines, frequency of repeated documentation requests, clarity of denial explanations, or disruptions in established therapy.

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[64] National Health Council, *Exploring the Burden*.

[65] Centers for Medicare & Medicaid Services, *Proposal To Support National Council*.

[66] Virginia General Assembly, *Report of the Electronic Prior Authorization Work Group* (Richmond, VA: Virginia General Assembly, November 1, 2025), https://rga.lis.virginia.gov/Published/2025/RD722/PDF.

The NHC also asks CMS to ensure that implementation of electronic prior authorization reduces, rather than simply digitizes, fragmentation associated with multi-entity administration. If the proposal succeeds technically but still leaves patients and providers uncertain about who holds relevant information, who can resolve a processing problem, or how prior determinations are carried forward across delegated systems, then the practical gains may be limited. The NHC therefore encourages CMS to promote implementation that creates clearer lines of operational responsibility and more reliable access to current information, even where multiple entities remain involved in administration.

More broadly, the NHC recommends that CMS treat accountability in delegated arrangements as central to the success of the rule's patient-centered objectives. PBMs and other delegated entities may be essential participants in implementation, but the effectiveness of the overall framework will depend on whether the resulting system is understandable, timely, and dependable for the people who must use it. As CMS finalizes and implements these policies, the agency should continue engaging stakeholders regarding where delegated workflows are reducing burden as intended and where they may still be creating confusion, delay, or discontinuity in care.

Medicare Fee-for-Service

The NHC notes CMS' discussion of Medicare FFS and its statement that it intends for Medicare FFS to play a leading role in electronic prior authorization. Although Medicare FFS is not an impacted payer under the CMS interoperability rules, the agency expressly recognizes that Medicare beneficiaries should ultimately benefit from these efforts regardless of delivery system. To the extent that CMS views Medicare FFS as part of the broader trajectory of prior authorization modernization, that signals an understanding that the benefits of more interoperable and usable workflows should not be limited only to the payer arrangements directly subject to the rule.

The NHC agrees that lessons from this rule should inform broader consideration of how to reduce prior authorization burden across the health care system, including in Medicare FFS where appropriate. The development of a Prior Authorization API in Medicare FFS suggests that CMS may continue exploring this direction. The NHC also suggests that CMS consider how interoperable exchange of prior authorization and treatment-history information in Medicare FFS could reduce repetitive documentation and better support continuity of care when patients transition across coverage arrangements or care settings. Lessons from this rule may help inform how clinically relevant authorization history and prior treatment experience can be recognized more consistently across the Medicare program.

The NHC encourages CMS to continue examining how the principles reflected in this rule, including structured data exchange, clearer documentation requirements, and more transparent workflows, can inform future improvements in Medicare FFS. Operational lessons from implementation in MA, Medicaid, CHIP, and QHP contexts may help CMS identify which interoperability approaches are most likely to reduce burden, support continuity of care, and improve the clarity of coverage-related communications in Medicare FFS. Experience with how providers, suppliers, and

patients use prior authorization information in real-world workflows may offer important insights into which design choices promote usability and which continue to generate friction despite technical modernization.

The NHC also reminds CMS to remain attentive to the possibility that differences between FFS and other delivery systems may still create uneven beneficiary experience if interoperability-related improvements advance more quickly in some contexts than in others. Even where statutory and operational differences justify different implementation pathways, the long-term objective should remain a system in which beneficiaries encounter fewer avoidable differences in how coverage processes function depending solely on the program or payment arrangement through which they receive care.

From the patient perspective, the broader goal should be a system in which meaningful differences in coverage type do not translate into unnecessary inconsistency in administrative burden, access to information, or the predictability of coverage processes. That principle is especially relevant for patients whose care spans multiple settings, who transition between payer or benefit arrangements, or who rely on caregivers and providers to navigate varied administrative systems on their behalf. Where coverage rules or benefit structures must differ, patients should still be able to expect a reasonable degree of consistency in how coverage-related information is communicated, how prior authorization-related decisions are conveyed, and how treatment continuity is supported.

The NHC therefore encourages CMS to continue viewing Medicare FFS not as outside the patient-centered concerns raised by this rule, but as part of the broader modernization agenda that should ultimately improve how coverage processes function across the Medicare program. As CMS gains experience with implementation of these interoperability and prior authorization reforms, the agency should continue identifying where successful approaches can be adapted for FFS and where additional policy development may be needed to ensure that beneficiaries in different delivery systems are not left with markedly different administrative experiences absent a compelling programmatic reason.

Requests for Information

The NHC has reviewed CMS' requests for information on issues including electronic event notifications, health care resiliency, payer API implementation, step therapy, and prior authorization for laboratory tests and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) items. These RFIs appropriately recognize that the future effectiveness of interoperability and prior authorization reform will depend not only on current regulatory requirements, but also on how technology and policy continue to evolve. From the NHC's perspective, these RFIs are also important because they acknowledge that implementation challenges and patient burden may persist even where the core regulatory framework is directionally sound. Soliciting input on these issues creates an opportunity for CMS to identify where existing administrative processes continue to disrupt care, where interoperability tools may be insufficiently aligned with real-world workflows, and where additional policy development may be necessary to ensure that the benefits of modernization are experienced by patients in practice.

The NHC is particularly interested in the RFI on step therapy. Patients who are stable on treatment should not be subjected to repeated or avoidable disruptions in therapy solely because of coverage transitions, incomplete historical information, or failure to recognize prior evidence of medical necessity.[67,68] Step therapy and related utilization management requirements may be experienced by patients not as isolated administrative tools, but as recurring obstacles that delay clinically appropriate treatment even where relevant treatment history is already known to some part of the system. For patients who are already established on therapy or who have already demonstrated failure, intolerance, or unsuitability with an alternative treatment, the inability to recognize and operationalize existing clinical history may create unnecessary and harmful burdens.

Interoperable exchange of treatment history may help reduce repetitive documentation and support more consistent recognition of prior treatment experience across plans and care settings. The NHC therefore encourages CMS to consider how interoperability tools and prior authorization-related exchange functions can better support recognition of established treatment history and reduce the need for patients and providers to repeatedly reconstruct evidence that should already be available. Technology alone, however, will not resolve the underlying access concerns raised by step therapy if clinically relevant history is not acted upon in a way that supports continuity of care and timely access to medically appropriate treatment.

The NHC urges CMS to work with stakeholders to identify a more standardized set of step therapy data elements and reporting expectations that could support clearer communication, more consistent exchange of treatment-history information, and more reliable recognition of prior determinations across plans and care settings. As part of that work, CMS should consider how step-therapy requirements and related sequencing rules are disclosed to patients and providers, including where those requirements effectively function as a prerequisite to prior authorization or access The NHC also agrees that interoperable exchange of treatment history can help reduce repetitive documentation and support more consistent recognition of prior treatment experience. CMS should use this RFI to examine how future policy development could better support prompt exceptions processes, recognition of prior approvals and documented treatment failures where appropriate, and clearer disclosure of step-therapy requirements. Greater standardization and transparency in these areas could reduce repeated documentation requests and help prevent patients and providers from having to restart avoidable utilization management processes following a coverage transition.

The NHC also encourages CMS to consider whether future policy development in this area should expand beyond technical capability to include the translation of treatment history into operational decision-making. Even where data can be exchanged, burden may persist if the information is incomplete, not readily interpretable, or not incorporated

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[67] Thom et al., “Patient Perspectives on Prior Authorization.”

[68] “The Current Prior Authorization Landscape,” *Health Affairs Brief*, March 25, 2026, https://doi.org/10.1377/hpb20260318.8289.

into workflows in a way that prevents repetitive or clinically inappropriate utilization management requirements. In that respect, the RFI presents an opportunity for CMS to examine how step therapy and related processes can be made more responsive to continuity of care and less dependent on administrative re-litigation of prior treatment experience.

The NHC also considers CMS' RFI on improving implementation of payer API technology to be a useful area for further inquiry. Technical compliance alone will not ensure that APIs function in a way that meaningfully reduces burden.[69] Continued attention to testing, oversight, transparency, and operational usability will be necessary if the promise of the interoperability framework is to be realized in practice. The NHC encourages CMS to view implementation of payer API technology as an ongoing operational challenge rather than a one-time technical milestone. Even where APIs are formally available, the practical benefits to patients and providers will depend on whether the information exchanged is current, reliable, sufficiently complete, and integrated into workflows that support real-world decision-making. The NHC supports CMS as it determines how implementation experience can inform future refinements relating to discoverability, data quality, integration across systems, and usability for the different categories of users expected to rely on these tools.

The NHC also encourages CMS to consider whether additional implementation feedback mechanisms may be useful as these technologies mature. Providers, pharmacists, caregivers, plans, and technology vendors may identify different categories of operational problems, including inconsistent endpoint information, gaps in available data, difficulties integrating API outputs into clinical workflows, or mismatches between technical conformance and practical usability. Continued attention to these implementation realities will be important to ensure that payer API technology supports its intended patient-centered objectives rather than functioning primarily as a compliance framework.

The RFI on prior authorization for laboratory tests and DMEPOS items is also noteworthy from the patient perspective. Delays in these areas can have substantial consequences, particularly for patients who depend on timely diagnostics, equipment, or supplies as part of ongoing care. The NHC encourages CMS to continue examining where prior authorization in these contexts is creating avoidable burden or clinically significant delay and to consider whether future reforms are warranted. This issue warrants attention because laboratory testing, durable medical equipment, prosthetics, orthotics, and supplies often occupy a critical but less visible place in the continuity of care landscape. Delays in obtaining a diagnostic test, mobility support, respiratory equipment, or other medically necessary supply may not always attract the same policy attention as delays involving prescription drugs, but they can nevertheless affect treatment initiation, disease monitoring, safety, functional status, and the ability to remain in the community. From the patient perspective, these categories are integral to whether care can proceed in a timely and coordinated manner.

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[69] Haynes, "Health Data Exchange Drives Efficiency."

The NHC also asks CMS to consider whether future policy development should examine how interoperability tools, prior authorization workflows, and information exchange standards can better support these categories of care. In many cases, the burdens associated with prior authorization for laboratory tests or DMEPOS may arise from the same broader problems evident elsewhere in the system, including fragmented documentation expectations, limited visibility into request status, repeated requests for information, and poor coordination across entities responsible for review, ordering, fulfillment, or follow-up care. To the extent those issues can be reduced through improved technical infrastructure and clearer workflow expectations, future reforms in this area may produce meaningful benefits for patients.

Finally, the NHC supports continued stakeholder engagement across these issues. In our prior comments, the NHC urged CMS to engage continuously with patients, caregivers, providers, and other stakeholders as interoperability and electronic prior authorization standards are developed. That recommendation remains relevant as operational details will shape whether the final framework reduces friction or inadvertently creates new complexity, and CMS will benefit from continued input from those directly affected by these systems.[70] This is particularly true for the issues raised in the RFIs, where the need for future policy action may depend heavily on how current implementation unfolds in practice. Patients and caregivers may identify burdens that are not readily visible through technical or compliance metrics alone. Providers and pharmacists may be able to identify where workflow fragmentation persists despite formal interoperability improvements. Plans, PBMs, and technology entities may identify where additional standardization or clarification is necessary to support consistent implementation. Continued stakeholder engagement will therefore be essential to refining future policy and ensuring that CMS' understanding of these issues remains grounded in the practical experience of those navigating the system.

More broadly, the NHC encourages CMS to treat the RFIs in this rule as part of a continuing effort to align technical modernization with patient-centered care delivery. The value of interoperability reforms will ultimately be measured by whether they reduce avoidable delay, improve continuity, and make coverage processes more understandable and manageable for patients and caregivers. The RFIs provide an important opportunity for CMS to identify where additional policy development may be necessary to advance those goals and to do so on the basis of implementation experience rather than assumption alone.

Scope of These Comments

The NHC's comments are focused on the interoperability, prior authorization, communication, transparency, and related implementation provisions of the proposed rule that are most directly relevant to patient access, continuity of care, and administrative burden. The NHC does not offer comments in this letter on the proposal related to Open Payments civil monetary penalties. The absence of comment on that provision should not be interpreted as agreement or disagreement; rather, it reflects the

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[70] Office of the National Coordinator for Health Information Technology, "Interoperability," accessed June 14, 2026, https://healthit.gov/interoperability/.

NHC's decision to concentrate this submission on the portions of the proposed rule most directly connected to coverage processes, patient experience, and the practical operation of prior authorization and interoperability policies.

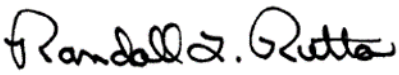
Conclusion

The NHC recognizes CMS' effort to build on its prior interoperability and prior authorization work by addressing drug prior authorization more directly, strengthening communication requirements, and expanding transparency and accountability tools. The NHC views the proposal as constructive in several respects and encourages CMS to finalize the rule with refinements that ensure implementation is clinically appropriate, operationally workable, and meaningfully responsive to patient needs. As CMS moves forward, the NHC urges the agency to continue centering patients, caregivers, and treating clinicians in implementation so that technical modernization results in more timely, predictable, and understandable coverage processes in practice.

The NHC also emphasizes that CMS should continue engaging with patients, caregivers, providers, plans, and other stakeholders as these policies are finalized and implemented. The value of this framework will depend not only on technical conformance, but on whether it reduces avoidable administrative burden, supports continuity of care, and improves the real-world experience of accessing medically appropriate treatment. The NHC welcomes the opportunity for continued dialogue with CMS as the agency considers these comments and advances this work.

Please do not hesitate to contact Kimberly Beer, Senior Vice President, Policy & External Affairs, at kbeer@nhcouncil.org, or Shion Chang, Assistant Vice President, Policy & Regulatory Affairs, at schang@nhcouncil.org, if you or your staff would like to discuss these comments in greater detail.

Sincerely,



Randall L. Rutta
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