American Health Information Management Association
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June 11, 2026

Dr. Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
US Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Administrator Oz:

On behalf of the American Health Information Management Association (AHIMA), I am writing in response to the Centers for Medicare and Medicaid Services (CMS) Interoperability Standards and Prior Authorization for Drugs Proposed Rule published in the April 14, 2026 *Federal Register* (CMS-0062-P).

AHIMA is a global nonprofit association of health information (HI) professionals, with over 61,000 members and more than 88,500 credentials in the field. The AHIMA mission of empowering people to impact health® drives our members and credentialed HI professionals to ensure that health information is accurate, complete, and available to patients and clinicians. Leaders within AHIMA work at the intersection of healthcare, technology, and business, occupying data integrity and information privacy job functions worldwide.

Following are our comments and recommendations on selected sections of the proposed rule.

A. Interoperability Standards for Application Programming Interfaces (APIs)

CMS proposes to require National Council for Prescription Drug Programs (NCPDP) standards for prior authorization for drugs covered under a pharmacy benefit and HL7® Fast Healthcare Interoperability Resources (FHIR) standards and its implementation guides (IGs) for prior authorization for drugs covered under a medical benefit.

AHIMA supports the adoption of the widely used NCPDP standards, including the SCRIPT, formulary and benefit, and real-time prescription benefit standards. These standards have long supported data exchange related to drugs covered under a pharmacy benefit, enabling providers to understand coverage and cost information of certain drugs, support prior authorization transactions, and empower clinicians and patients with more information at the point of care. AHIMA encourages CMS to delineate which drugs and transactions are intended to flow through the NCPDP standards or the FHIR-based APIs to promote clarity across payers and providers and reduce confusion.

AHIMA also supports the industry's move towards adoption of FHIR standards and its IGs, however we caution CMS on requiring and enforcing the use of these standards and IGs before they are sufficiently mature and thoroughly tested in diverse, real-world healthcare settings. CMS should work with its US Department of Health and Human Services (HHS) partners, including the Office of the National Coordinator for Health Information Technology (ONC), to support robust real-world testing of these standards and IGs to achieve the goal of improved and streamlined prior authorization. AHIMA encourages CMS to work with ONC to support end-user

implementation with resources, technical assistance, and flexibilities, especially for under-resourced organizations, as they work to implement policies in the 2024 CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F) and any forthcoming finalized policies that result from this proposed rule. Healthcare organizations will not be able to participate in these innovative data sharing infrastructures if the technology they rely on from their electronic health record (EHR) vendors does not function as intended due to a lack of testing in real-world settings. Additionally, the rule states impacted payers can use any unexpired version of the standards. This can cause misalignment in capabilities and functionalities between exchange partners. To avoid confusion and burden, CMS should work with ONC and other HHS partners to implement a method to monitor and manage the use of different versions of standards to avoid version mismatches across payers, providers, and EHR vendors.

While AHIMA and the broader healthcare community support these policies to streamline prior authorization for drugs, we caution that the industry and existing systems may not be ready for full drug expansion by October 1, 2027. Healthcare organizations, payers, EHR vendors, and others are still working to implement policies in CMS-0057-F by January 1, 2027. Though implementation may be complete by that time, it is unclear if those new workflows and data exchange methods will function in practice to support prior authorization beginning January 1. It is likely that there will continue to be testing and modification of workflows to support those policies, since changes in workflow introduce complexity regarding benefit classifications, routing of information, and multi-system and multi-partner coordination. Thus, AHIMA encourages CMS to consider a phased implementation or one year delay of the compliance date to October 1, 2028, of the policies that are finalized from this rule. More flexibility in the timing of implementation will allow impacted payers, healthcare organizations, and EHR vendors to implement current requirements and prepare for future requirements. This includes education and training for staff to implement these policies and incorporate them into existing workflows or create new workflows to support these processes. As implementation progresses, AHIMA encourages CMS to monitor and work with organizations to ensure that all exchange partners are working towards the same implementation timeline to promote alignment.

B. Electronic Prior Authorization for Drugs

CMS proposes to require impacted payers to incorporate coverage and documentation requirements into the Prior Authorization API to support electronic prior authorization for drugs covered under a medical benefit.

AHIMA supports this proposal to incorporate information about drugs into the Prior Authorization API. Having all the information available in the API will enable providers to more efficiently submit a prior authorization request and receive a decision on behalf of the patient, expediting the time needed for a patient to receive care. We applaud CMS for including drugs covered under a medical benefit in the Prior Authorization API as drugs have long been a major source of burden in the prior authorization process.

C. Improving Communications and Decision Timeframes for Prior Authorizations

CMS proposes to improve communications and decision timeframes for prior authorization, including proposals to require impacted payers to provide a specific reason for denial of a prior authorization for all drugs, align prior authorization timeframe requirements for non-drug items and services for QHP issuers on FFEs with other impacted payers, and establish new and additional reporting metrics.

AHIMA supports the proposals to provide a specific reason for denial regardless of the submission method, implement aligned timelines for standard and expedited non-drug and drug prior authorization decisions, and require reporting metrics. We applaud CMS for aligning the timelines across impacted payers, where possible, for both non-drug and drug prior authorizations. This will reduce confusion in processes within healthcare

organizations and enable more streamlined prior authorization workflows. AHIMA urges CMS to consider requiring capabilities to view denial information and submit appeals within the FHIR APIs used to support these processes. We also encourage CMS to require more specific reporting in the metrics that will give the industry more information on prior authorization trends for specific drugs and plans. CMS, payer organizations, and the broader healthcare industry have voiced support for streamlining, standardizing, and reducing the volume and complexity of prior authorization requirements, and more specificity within the metrics could be helpful in identifying areas of high burden and complexity to address.

E. Reporting Payer API Endpoints and Associated Information for CMS to Publish

CMS proposes to require payers to report to CMS, no later than 60 days after the effective date of the final rule, API endpoints for each of the interoperability APIs to be published in a centralized location, direct URL to API FHIR capability statements, URLs with required documentation, and API registration information.

AHIMA recommends CMS reconsider the timelines related to this proposal and provide further clarity on how activities related to the endpoints themselves will be supported. AHIMA members stated that without further specifics related to how CMS is validating the endpoints themselves, such as whether individual lines of business need to be mapped, and what documentation is required, it would be challenging to meet the deadline for reporting within 60 days of the final rule's effective date. The lack of a standardized approach for this reporting will make it difficult for payers to understand the regulatory reporting and compliance environment.

If CMS were to move forward with requiring payers to report API endpoints, AHIMA recommends CMS provide greater clarity related to both the documentation and timeline requirements associated with this proposal. This clarity should be similar to the documentation and specifics provided by CMS as part of the CMS-0057-F endpoint reporting requirements. A more realistic timeline with sufficient education will ensure payers can meet these requirements in a timely and accurate manner. A fully standardized process mimicking similar CMS activities creates predictability in the compliance environment, leading to a higher likelihood of CMS meeting its desired regulatory goals.

F. Updates to Patient Access, Provider Directory, Provider Access, and Payer-to-Payer APIs; API Usage Metrics

CMS proposes to require impacted payers to include information on prior authorization requests, status, and decisions for drugs into the Patient Access API, Provider Access API, and Payer-to-Payer API.

AHIMA supports this proposal to incorporate information about drugs into these APIs to facilitate more efficiency and transparency in prior authorization and to support care coordination. Having all the information available in these APIs will enable providers, patients, and payers to work together more efficiently on prior authorization. Further, having this information more readily available across a patient's previous and current payers will support improved care coordination and communication across the patient's care team and more understanding of the patient's medical history. However, with payers, healthcare providers, and EHR vendors still working to implement requirements from CMS-0057-F, a compliance deadline of October 1, 2027 is not enough time to implement this information in these three APIs. We encourage CMS to provide a phased implementation or delay the compliance date until at least October 1, 2028.

CMS proposes to require impacted payers to publicly report numeric counts of prior authorization requests, in addition to percentages, for both non-drug items and services and drugs.

AHIMA supports policies to provide more transparency on prior authorizations for non-drug items and services and drugs. More information available to providers and patients provides insight into how well CMS policies are functioning, how well payers adhere to their coverage rules and determinations, where pitfalls exist, and areas for improvement both in simplifying processes and in removing burdensome requirements to streamline prior authorization. However, CMS must recognize that this requirement will incur a substantial effort and financial investment on behalf of payers to begin reporting numeric counts in addition to percentages. Transparency is helpful if the information is presented appropriately. For example, raw counts lack normalization and must be contextualized to avoid misinterpretation. Small plans compared to large payers will have different numeric counts that do not necessarily equate to differences in policy adherence.

Additionally, AHIMA believes CMS should prioritize increased transparency as a goal, but CMS must recognize that additional costs and resources will be needed with each additional payer reporting requirement, especially considering the difficulty smaller and self-funded plans may experience in achieving compliance. If finalized, we encourage CMS to provide appropriate flexibilities and support for small, self-funded, and otherwise under-resourced payer organizations.

Finally, AHIMA urges CMS to clarify and refine this proposal before finalization. CMS should explain the added benefit that numeric counts provide, in comparison to percentages alone, and how it anticipates this information being used by CMS, providers, and/or patients. CMS should provide a reporting template that includes a clear delineation between numeric counts and percentages, as well as relevant factors that should be considered to contextualize this information for providers and patients.

CMS proposes impacted payers to publicly report metrics about usage of the Provider Access, Payer-to-Payer, and Prior Authorization APIs.

AHIMA supports CMS proposing policies that would promote shared understanding of whether the Provider Access, Payer-to-Payer, and Prior Authorization APIs are accessible and working effectively for all stakeholders. However, we encourage CMS to strengthen this proposal by clarifying definitions and parameters. The rule does not specify if these metrics are to be reported at the organization level or individual clinician level by using the term "provider." AHIMA members in payer organizations support expanding these metrics as proposed in the rule but note that reporting on the clinician level would be more useful, as metrics that would be a bundle of an entire organization does not provide as much value in understanding the usage of these APIs. AHIMA also encourages CMS to clearly define what constitutes a prior authorization, compared to another method or tool of utilization management, to ensure payers and providers understand which information is represented in these reporting metrics. In a future state where automation and supervised artificial intelligence (AI) tools could help facilitate more efficient reporting of these metrics, it is critical that these terms and parameters are well-defined to eliminate ambiguity.

CMS proposes to remove drug formulary information from the data required to be made available via the Provider Access and Payer-to-Payer Access APIs for MA organizations, state Medicaid and CHIP FFS programs, Medicaid managed care plans, and CHIP managed care entities.

AHIMA applauds CMS for its continued efforts to create regulatory alignment and relieve burden by supporting broadly adopted industry standards. In this spirit, AHIMA supports the CMS proposal to remove drug formulary information made available via the Provider Access and Payer-to-Payer APIs in favor of continuing to leverage the NCPDP SCRIPT standards. These NCPDP standards currently contain drug formulary information and AHIMA

members expressed a desire to continue utilizing the NCPDP API standards to ensure the information is available in a consistent format. We encourage CMS to continue working with payer organizations to improve timely and comprehensive access to formulary information via the NCPDP standards. As CMS continues to search for opportunities to reduce regulatory burden, we encourage the agency to leverage existing standards and transfer protocols that maintain wide adoption.

H. Modifications to HIPAA Standards Related to Prior Authorization

CMS proposes to adopt FHIR as the HIPAA standard for electronic prior authorization, replacing existing X12 standards for the Referral and Authorization Transaction and Eligibility for a Health Plan Transaction, and providing a FHIR standard where there currently is no standard for Referral and Authorization Attachments.

AHIMA supports the adoption of FHIR standards for electronic prior authorization and applauds CMS for proposing a standard for attachments. The healthcare community has long awaited standards for electronic attachments that could share clinical information needed by payers. Though the X12 278 Health Care Services Review – Request for Review and Response transaction standard is currently in place, there is limited use due to the lack of an attachment standard to accompany it. We encourage CMS to ensure the adoption of FHIR standards for these transactions does not conflict with or replace existing standards in place for eligibility transactions to avoid disrupting those workflows.

AHIMA supports the eventual transition to this suite of FHIR standards to support these transactions. However, we encourage CMS to continue supporting FHIR and X12 at this time until it can be proven that FHIR is a reliable, functioning, and widely adopted standard through real-world testing before moving away from the X12 standards in regulation. We caution that FHIR and its IGs are still maturing, which makes the proposed 24-month compliance timeline infeasible. EHR vendors will need to interpret IG specifications and supply the needed software to customers, and healthcare organizations and payer organizations will need to test and validate this functionality, monitor performance, troubleshoot errors, and address issues after initial implementation. As discussed, real-world testing is critical to see the successful use of these standards for electronic prior authorization. CMS should consider establishing a threshold of successful transactions that occur through FHIR to demonstrate effectiveness and value before discontinuing the X12 standards. Those metrics may be segmented by level of resources, type of organization, type of services provided, and other factors, to provide the industry with real-time information on the progress of implementation. This method and metrics data provides independent, small, rural, and otherwise under-resourced organizations time to transition to FHIR standards and connect similarly situated organizations with each other to share best practices and real-world testing outcomes to promote more efficient adoption across the industry.

III. Requests for Information

A. Electronic Event Notifications for Value-Based Care and Care Coordination

The US healthcare system developed and adopted a robust event notification system in the wake of the 21st Century Cures Act being signed into law. With the implementation of the admission, discharge, and transfer (ADT) requirements, health systems and their corresponding health information exchanges (HIEs) worked together to better coordinate patient care to ensure a patient's physician and care team were able to remain up to date about a patient's condition. As the interoperability world has evolved, the form and function of ADT to support robust and comprehensive care coordination needs to evolve as well.

AHIMA recommends CMS and HHS partners pursue a process to review and update ADT requirements to advance care coordination needs for healthcare. AHIMA members report that, while ADT provides some information, providers are often in the dark with regard to patient discharges and deaths when ADT services are not realized at the facility a patient is at. It is recommended that part of the solution to this issue involves improved provider directories with tools to assist patients in locating their primary care physicians and for facilities to know the pathways to notify that corresponding provider. Additionally, CMS should work with HHS partners to evolve the data traveling with patients as part of the ADT to expand scope and content to include important care information in standardized formats. Expanding the data included in the ADT could provide another avenue for coordination of care data to be expanded in ways to improve overall patient care.

AHIMA and its membership stand ready to assist CMS and its HHS partners in further developing the ADT technology solutions to best support increased care coordination activities.

E. Laboratory Tests and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Items

HI professionals are the key individuals involved in and managing the workflows surrounding claims filing, claims processing, and prior authorization processes in healthcare provider organizations, payer organizations, and DMEPOS supplier organizations. AHIMA applauds CMS for its interest in improving prior authorization in the laboratory test and DMEPOS spaces to reduce burden on all parties. Prior authorization is a major burden on providers as many items and services require prior authorization with a significant amount of supplemental information and documentation needed to accompany it.

HI professionals working in both healthcare provider organizations and DMEPOS supplier organizations cite a tremendous amount of work to complete prior authorization requests, to then see excessive delays in decisions or denials. Documentation requirements for many claims are already burdensome for healthcare providers, plans, and suppliers, which is exacerbated by lengthy and complex prior authorization requirements. DMEPOS items and services require a range of documentation and requirements, including individual rules and regulations, local coverage determinations (LCDs), physician review and approval of LCDs, face-to-face evaluations, prior authorizations, delivery requirements, and more. Securing approvals and documentation for all the needed steps to ensure patients are getting the products and services they need requires ongoing coordination and communication between all entities, which often takes months. Simultaneously, providers, suppliers, and plans are often unaware of or unable to keep up with the different levels of documentation needed to demonstrate medical necessity and fulfill a claim for DMEPOS items and services. These processes require extensive follow-up and revisions to claims and can cause delayed payment and thus delayed provision of these needed items and services to patients. With the burdensome requirements and process, and a lack of coordination across providers, suppliers, and plans, patient care is at risk when patients do not get the items, services, or lab tests they have been prescribed.

CMS should work to streamline the documentation requirements and address the burden associated with claims submissions and prior authorizations, particularly for DMEPOS items and services and laboratory testing. This includes ensuring requirements are clearly understood by healthcare providers, plans, and suppliers, as well as ensuring documentation and coding appropriately matches the products or services ordered by healthcare providers and provided by suppliers. CMS should consider working with healthcare providers, plans, suppliers, and EHR vendors to introduce digital tools and technologies, including AI with appropriate human oversight, to provide insight into misalignment in documentation and identify documentation needs to facilitate smooth claim filing.

Thank you for the opportunity to comment on the proposed rule. AHIMA is committed to CMS and its partners on the transition to a more efficient world of data exchange with streamlined electronic prior authorization. If you have any questions or would like to discuss our recommendations further, please contact Andrew Tomlinson, senior director of regulatory and international affairs, at Andrew.Tomlinson@ahima.org or Tara O'Donnell, manager of regulatory affairs, at Tara.Odonnell@ahima.org.

Sincerely,

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Chief Public Policy and Impact Officer