NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS®

June 15, 2026

The Honorable Mehmet Oz, MD
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244
ATTN: CMS-0062-P

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 Exchange

Dear Administrator Oz:

For the past 55 years, the National Association of Community Health Centers (NACHC) has been the leading national, nonpartisan organization dedicated to supporting Community Health Centers (CHCs) (also known as Federally Qualified Health Centers) as the Employer, Provider, and Partner of choice in all communities, as well as the foundation of the primary health care system in the United States with our committed 326,000 primary care workforce, and the 52 million patients we serve. For 60 years, CHCs have provided high-quality, affordable, comprehensive care – including primary, preventive, dental, behavioral health, pharmacy, vision, and other essential health services at over 17,000 locations across rural and nonrural communities. This includes 1 in 3 rural residents and 1 in 2 in poverty. As our nation's largest primary care system, there is strong evidence, including from the Congressional Budget Office, that our work saves lives and also saves Medicaid and Medicare billions annually by reducing costly emergency, inpatient, and specialty care.[1] Research shows that every dollar invested in primary care yields a 13-to-1 return in overall health system savings.[2]

CHCs are the healthcare home for many of America's medically underserved communities. Working-age adults (18-64) who receive care at CHCs are 35% more likely to have a chronic condition and 31% more likely to have multiple chronic conditions than patients seen by private practice providers. In 2024 alone, CHCs served 3.5 million patients with diabetes, 6.2 million patients with hypertension, 10 million overweight or obese patients, and 3.2 million people with depression and other mood disorders.[3] For these patients, delays associated with prior authorization (PA) requirements can interrupt treatment, delay necessary care, and create significant barriers to maintaining stable health outcomes. These delays are common under the current system. A survey from the American Medical Association (AMA) found that 94 percent of

[1] Volerman A, Carlson B, Wan W, Murugesan M, Asfour N, Bolton J, Chin MH, Sripipatana A, Nocon RS. Utilization, quality, and spending for pediatric Medicaid enrollees with primary care in health centers vs non-health centers. BMC Pediatr. 2024 Feb 8;24(1):100. doi: 10.1186/s12887-024-04547-y. PMID: 38331758; PMCID: PMC10851548.
[2] https://www.oregon.gov/oha/HPA/dsi-pcpch/Documents/PCPCH-Program-Implementation-Report-Final-Sept- 2016.pdf
[3] 2024 HRSA UDS data.

physicians reported prior authorization delays patient care, while patient surveys found the average wait time for a prior authorization decision was approximately three days, with nearly one-third of patients waiting longer than one week for a determination.[4] At the same time, PA requirements continue to impose substantial administrative burden on CHCs already operating under significant workforce and financial constraints. NACHC therefore supports many of the changes in this proposed rule because of their potential to reduce administrative burden and improve timely patient access to medically necessary care and prescription drugs.

NACHC appreciates the opportunity to comment on the 2026 Interoperability Standards and Prior Authorization for Drugs Proposed Rule. Our comments are broken into nine sections:

I. Interoperability Standards for Application Programming Interfaces (APIs)

NACHC appreciates CMS' continued efforts to modernize interoperability infrastructure and improve electronic prior authorization (ePA) processes. We strongly support the goal of creating more standardized, interoperable, and real-time data exchange across payers, providers, and health IT systems to improve patient access to timely care. For CHCs, which frequently coordinate across multiple health plan issuers, hospitals, specialists, pharmacists, and behavioral health providers, the current PA environment remains highly fragmented and administratively burdensome. These proposals to standardize API functionality and data exchange requirements could significantly reduce duplicative documentation requests, improve visibility into PA requirements, and streamline care coordination for medically underserved patients. These reforms are urgently needed, given the scale of PA activity nationally. Reports show that Medicare Advantage (MA) Organizations made nearly 53 million PA determinations in 2024 alone, including more than four million full or partial denials.[5] Similarly, a Medical Group Management Association (MGMA) report that physician practices continue to experience substantial staffing and workflow burden associated with manual PA processes, contributing to treatment delays and administrative strain across the healthcare system.[6]

These burdens are particularly significant for CHCs because of the unique patient populations they serve and the financial constraints under which they operate. CHCs serve more than 16 million Medicaid beneficiaries, over 6 million uninsured individuals, 20.5 million low-income individuals, 1.1 million agricultural workers, and over 1.5 million homeless individuals.[7] Additionally, more than 90 percent of CHC's patients have incomes below 200 percent of the federal poverty level (FPL), and many patients experience significant barriers related to transportation, broadband access, language services, and specialist availability.[8] Delays caused by fragmented PA processes can disproportionately affect CHC patients, who cannot afford delays in medication access, specialty referrals, diagnostic testing, or behavioral health treatment. NACHC has consistently recognized that ePA systems can improve efficiency and reduce unnecessary administrative burden

[4] https://www.ama-assn.org/practice-management/prior-authorization/meet-physicians-newest-allies-prior-authorization-battle
[5] https://www.kff.org/medicare/medicare-advantage-insurers-made-nearly-53-million-prior-authorization-determinations-in-2024/
[6] The Medical Group Management Association (MGMA) is a national membership organization representing more than 60,000 medical practice administrators, executives, and healthcare leaders, including leaders from CHCs and other safety-net providers. Report: https://www.mgma.com/articles/the-prior-authorization-landscape-in-2025
[7] 2024 HRSA UDS data.
[8] Ibid.

when implemented consistently and effectively.[9] For CHC providers operating with limited staffing and infrastructure capacity, repeated manual prioritization submissions, varying payer requirements, and inconsistent documentation standards divert essential resources away from direct patient care and essential services.

Concurrently, NACHC urges CMS to recognize that the success of these proposals will depend heavily on vendor readiness, operational consistency, and meaningful implementation support for safety-net providers. CHCs often lack the financial flexibility or internal IT workforce necessary to rapidly adapt to evolving interoperability requirements and frequently rely on a limited number of EHR vendors and/or third-party technology partners. The proposed rule appropriately places obligations for API readiness and interoperability on impacted payers. However, absent corresponding readiness requirements for vendors, we are concerned that CHCs may face compliance gaps and operational disruption despite acting in good faith. **CMS should clarify that providers will not be penalized for failures attributable to vendors, clearinghouses, or EHR systems outside provider control.** NACHC further recommends that CMS coordinate implementation timelines closely with the Office of the National Coordinator for Health IT (ONC) certification requirements and establish readiness validation or testing before enforcement begins. Inconsistent implementation of APIs and varying rollout schedules across payers could undermine the efficiencies CMS seeks to create in this proposed rule.[10]

CMS should also consider establishing uniform minimum implementation requirements across Medicaid Managed Care Organizations (MCOs) and Qualified Health Plan (QHP) issuers, including standardized PA data fields, synchronized implementation guide (IG) timelines, and clearer operational standards. Without greater alignment across payers, CHCs may face fragmented payer-to-payer workflows that increase administrative complexity, create operational confusion, and undermine the efficiencies these reforms are intended to accomplish.

NACHC is also concerned that the expansion of API-based exchange and ePA requirements may significantly increase cybersecurity exposure for CHCs, which are operating with a constrained workforce and infrastructure resources. The proposed rule contemplates a broad expansion of interoperable exchanges involving sensitive patient information, yet many CHCs, particularly those serving rural communities, lack dedicated cybersecurity teams or advanced IT infrastructure comparable to those of large health systems. Only two-thirds of CHCs report having a cybersecurity committee or leader, and 78.9% reported having 1-10 full-time equivalents (FTEs) supporting health IT. While CHCs maintain a dedicated staff, these IT teams are small and usually wear multiple hats, meaning CHCs rely on third-party vendors and organizations to assist them in maintaining HIPAA compliance and securing their data.[11] As interoperability requirements expand, CMS must ensure that CHCs are not absorbing unfunded costs associated with cybersecurity compliance, vendor upgrades, API integration, or ongoing maintenance requirements. NACHC recently highlighted the tens of thousands of dollars in new software and cybersecurity measures CHCs are anticipating to shoulder in response to the new requirements included in the HIPAA Security Rule to Strengthen the Cybersecurity of Electronic Protected Health Information (RIN-

[9] NACHC 2024 Interoperability and Prior Authorization Proposed Rule Comment Letter (2023)
[10] https://www.crowell.com/en/insights/client-alerts/cms-seeks-to-expand-interoperability-requirements-to-drug-pre-authorization-faq
[11] https://www.nachc.org/nachc-content/uploads/2025/02/NTTAP-HIT-Needs_Assesment_Report-01.28.25.pdf

0945-AA22).[12] To ensure CHCs can safely operationalize these changes without compromising patient access or continuity of care, CMS should provide technical assistance implementation guidance, cybersecurity and IT workforce development support, and dedicated health IT funding opportunities. CMS should also ensure that the final implementation framework reflects the operational realities and resource constraints under which CHCs deliver care to medically underserved communities.

NACHC urges CMS to conduct and publish a consolidated provider-side Regulatory Impact Analysis across the three interoperability rules now converging on safety-net providers: CMS-0057-F (ePA for non-drug services, payer compliance January 2027), CMS-0053-F (claims attachments via X12 6020 and C-CDA, provider compliance May 2028), and this proposed rule, CMS-0062-P (ePA for drugs, payer compliance October 2027). None of these rules individually estimate the cumulative provider-side implementation cost for CHCs. Together, they represent the largest health IT transition for safety-net providers since Meaningful Use. Meanwhile, federal Section 330 grant funding per CHC patient has eroded over time.[13] CMS should ensure that the cumulative burden of these mandates does not exceed what CHCs can absorb without dedicated implementation support.

Ultimately, NACHC supports CMS' broader interoperability goals because standardized, timely, and transparent data exchange can improve patient access to care and reduce administrative barriers that interfere with essential treatment. However, successful implementation will require CMS to pair these requirements with realistic timelines, coordinated national standards, robust vendor accountability, and targeted support for safety-net providers. CHCs serve as the primary source of care for millions of medically underserved Americans nationwide, and policies intended to improve interoperability should not inadvertently create operational instability for providers serving these communities. With stronger implementation safeguards and implementation support, CMS can ensure these reforms improve care coordination and reduce administrative burden while protecting access to care for CHC patients.

II. Electronic Prior Authorization for Drugs

NACHC supports CMS' proposal to establish ePA requirements for prescription drugs. We greatly appreciate the agency's effort to extend interoperability reforms to medication access workflows. NACHC believes these proposals could meaningfully improve timely patient access to essential medications while reducing the administrative burden associated with manual PA processes. For CHCs, these changes could also improve point-of-prescribing visibility into formulary requirements, utilization management criteria, and authorization status, helping providers make more informed prescribing decisions during the patient encounter and reducing avoidable treatment delays associated with incomplete or inaccurate submissions.

The proposal to require all impacted payers to support ePA for every drug requiring PA is particularly important for CHCs. In community health, medication adherence is vital for managing

[12] https://www.nachc.org/wp-content/uploads/2025/05/HIPAA-Security-Rule-Comment-Letter.pdf
[13] https://nachc.org/wp-content/uploads/2023/07/Overlooked-Decline-Community-Health-Center-Funding_2023_Full-report.pdf

chronic diseases, preventing costly hospitalizations, and improving overall quality of life.[14] As previously mentioned, CHCs serve 3.5 million patients with diabetes, 6.2 million patients with hypertension, 10 million overweight or obese patients, and 3.2 million people with depression and other mood disorders.[15] This patient population is also more likely to experience non-clinical factors of health that can make timely medication access critical for avoiding preventable complications and maintaining continuity of care. NACHC has consistently advocated for improved ePA requirements to support operational efficiency and reduce administrative burden when implemented consistently and supported by interoperable technology infrastructure.[16] Streamlined ePA workflows would reduce treatment interruptions, improve medication adherence, and help CHCs coordinate care more effectively for patients managing chronic conditions, behavioral health needs, and other ongoing health concerns.

At the same time, NACHC urges CMS to address several operational concerns with the proposed prescription drug ePA workflows. **NACHC recommends that CMS require payers to expose benefit classification information through the Provider Access APIs (via the CRD Coverage Information extension) so providers can determine in real time whether a drug falls under the medical benefit or pharmacy benefit pathway.** We have concerns that CHCs may face a significant burden in managing dual workflows across medical and pharmacy benefit pathways. Determining whether a medication falls under the medical benefit or pharmacy benefit may not always be clear in real time, particularly for drugs that may be clinic administered. **NACHC also requests clarification on how PA determinations would apply in situations where a drug is covered under both medical and pharmacy benefits.** Specifically, CMS should clarify whether a PA approval issued under one benefit pathway would also apply to the alternate payment pathway or whether separate authorization determinations would be required. Clearer guidance on these operational questions will help reduce administrative confusion, prevent treatment delays, and support more efficient prescribing and billing workflows for CHCs.

For example, extended-release buprenorphine may be billed under the pharmacy benefit when dispensed through a pharmacy but under the medical benefit when administered in-clinic by a provider.[17] Similarly, long-acting injectable antipsychotic medications administered in CHC behavioral health settings may fall under different benefit pathways depending on payer policies, site-of-care requirements, or whether the medication is obtained through a pharmacy benefit versus provider buy-and-bill arrangements.[18] Vaccines, injectable contraceptives, and specialty biologics administered in CHCs may present similar operational ambiguity. CHCs are also playing an increasingly important role in treating substance use disorder and behavioral health conditions in medically underserved communities. Greater transparency in benefit classification could improve prescribing efficiency, reduce inappropriate denials, and support more accurate claims processing across payer systems.

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[14] Aremu TO, Oluwole OE, Adeyinka KO, Schommer JC. Medication Adherence and Compliance: Recipe for Improving Patient Outcomes. Pharmacy (Basel). 2022 Aug 28;10(5):106. doi: 10.3390/pharmacy10050106. PMID: 36136839; PMCID: PMC9498383.
[15] 2024 HRSA UDS data.
[16] NACHC 2024 Interoperability and Prior Authorization Proposed Rule Comment Letter (2023)
[17] https://www.weitzmaninstitute.org/the-vital-role-of-community-health-centers-in-substance-use-disorder-treatment/
[18] Ibid.

NACHC further requests that CMS carefully evaluate how these requirements will interact with pharmacy operations, including 340B contract pharmacy arrangements utilized by more than 65 percent of CHCs.[19] As 340B covered entities, CHCs utilize 340B savings to help stretch limited resources to provide affordable medications and expanded services for medically underserved patients. Implementation of prescription drug ePA requirements will not occur in a single system. It will require coordination across entity-owned dispensing operations, contract pharmacies, third-party administrators (TPAs), EHR systems, pharmacy management systems (PMS), and payer APIs. That coordination can be difficult because PMS and EHR systems may not always be fully interoperable or able to exchange complete, structured information in real time. Pharmacy interoperability stakeholders have identified persistent barriers, including limited EHR integration, difficulty incorporating native FHIR content, terminology, and value-set misalignment, limitations in medication data standards, and competing vendor priorities.[20] Studies similarly show that pharmacy access to EHR data can improve clinical interventions, but implementation remains dependent on system access, workflow integration, and reliable data exchange.[21] [22]

These gaps raise concerns for CHCs because pharmacy operations often depend on accurate benefit, eligibility, prescribing, dispensing, claims, and 340B accumulation data moving across multiple platforms. For example, CHCs may face operational challenges if PA determinations, dispensing data, eligibility information, and clinical documentation are housed across separate EHR, pharmacy management, contract pharmacy, and third-party administrator systems that do not consistently exchange data in real time.[23,24] These disconnects can delay medication access, create duplicative work, and increase the risk of errors in already complex 340B workflows. As we mentioned previously, CHCs frequently lack the financial flexibility and staff capacity to absorb the costs of new workflow redesigns without support. **NACHC urges CMS to coordinate with the Office of Pharmacy Affairs (OPA) to provide targeted technical assistance, implementation guidance, and funding support to help CHCs operationalize these requirements safely and effectively.** With stronger implementation alignment and greater transparency regarding benefit pathways, ePA for prescription drugs can streamline medication access, reduce administrative burden, and protect continuity of care for medically underserved patients.

CMS should also mandate proactive PA expiration notifications to providers via FHIR-based alerts. Timely notification of upcoming PA expirations could help CHCs avoid interruptions in treatment, delays in medication access, and unnecessary administrative burden associated with retroactive reauthorization requests. This functionality would be particularly important for CHC

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[19] https://www.nachc.org/wp-content/uploads/2026/01/Pharmacy-Survey_Expanding-Access_V2.pdf
[20] https://www.pharmacytimes.com/view/pharmacy-interoperability-challenges-and-needs-under-the-21st-century-cures-act
[21] Krauss ZJ, Abraham M, Coby J. Clinical Pharmacy Services Enhanced by Electronic Health Record (EHR) Access: An Innovation Narrative. Pharmacy (Basel). 2022 Dec 5;10(6):170. doi: 10.3390/pharmacy10060170. PMID: 36548326; PMCID: PMC9781377.
[22] Murthi S, Martini N, Falconer N, Scahill S. Evaluating EHR-Integrated Digital Technologies for Medication-Related Outcomes and Health Equity in Hospitalised Adults: A Scoping Review. J Med Syst. 2024 Aug 23;48(1):79. doi: 10.1007/s10916-024-02097-5. PMID: 39174723; PMCID: PMC11341601.
[23] https://www.pharmacytimes.com/view/pharmacy-interoperability-challenges-and-needs-under-the-21st-century-cures-act
[24] Krauss ZJ, Abraham M, Coby J. Clinical Pharmacy Services Enhanced by Electronic Health Record (EHR) Access: An Innovation Narrative. Pharmacy (Basel). 2022 Dec 5;10(6):170. doi: 10.3390/pharmacy10060170. PMID: 36548326; PMCID: PMC9781377.

patients managing chronic conditions or receiving ongoing therapies that require continuous authorization approval. Evidence shows that proactive outreach before expiration achieves positive outcomes in 87% of cases compared to only 25% without such notification.[25] Proactive expiration alerts could improve continuity of care, reduce avoidable treatment disruptions, and support more efficient care coordination workflow for CHCs operating with limited staff and resources.

At the same time, **NACHC urges CMS to recognize that electronic prior authorization alone may not reduce overall administrative burden without concurrent prior authorization reform**. Peer-reviewed evidence demonstrates that providers using ePA submitted higher prior authorization volumes, spent more total time on prior authorization activities, had greater difficulty identifying step therapy requirements, and experienced slightly decreased medication filling rates compared to providers not using ePA.[26] This evidence suggests that ePA without concurrent PA reform may merely accelerate an inefficient process.[27] **NACHC therefore urges CMS to pair ePA technology mandates with meaningful PA reduction requirements**, including extension of gold-carding to prescription drugs and sunset provisions for PA categories with consistently high approval rates.

III. Improving Communications and Decision Timeframes for PA

NACHC appreciates the agency's focus on greater transparency and timeliness and supports CMS' proposals to improve communication and align decision timelines for PAs. Standardized decision timeframes across payers and clearer communication requirements are critically important for the medically underserved patients CHCs serve. NACHC is particularly supportive of CMS' efforts to align PA timelines across all payers impacted by this rule by requiring more consistent response timeframes for both standard and expedited requests. Specifically, NACHC supports the proposed requirements that PA decisions for covered outpatient drugs be made no later than 24 hours after receipt of a request, that standard PA requests for items and services be addressed within 7 days, and that expedited requests be addressed within 72 hours. NACHC also supports CMS' proposal requiring QHP issuers on the FFEs to provide notice of PA decisions no later than 72 hours for standard requests and 24 hours for expedited requests for prescription drugs. These more uniform and expedited timelines will help reduce unnecessary delays in medication access and treatment initiation for patients with urgent or ongoing healthcare needs.

Delays in PA approvals frequently result in delayed treatment, interrupted medication access, and avoidable worsening of health conditions. In 2024, MA insurers fully or partially denied 4.1 million PA requests, representing 7.7 percent of requests that year, while traditional Medicare denied nearly 23 percent.[28] A KFF report further found that only a small share of denied requests were appealed, despite the fact that more than 80 percent of appeals were overturned.[29] These findings demonstrate that many initially denied requests are ultimately determined to be medically

[25] Vishwanath S, et al. Evaluating proactive outreach for PA recertifications in Medicaid patients. Am J Manag Care. 2021;27(8):e276-e281.
[26] Lauffenburger JC, et al. Impact of implementing electronic prior authorization on medication filling. J Am Med Inform Assoc. 2021;28(12):2565-2575
[27] Salzbrenner SG, et al. Perceptions of prior authorization by use of electronic prior authorization software. J Manag Care Spec Pharm. 2022;28(10):1116-1125.
[28] https://www.kff.org/medicare/medicare-advantage-insurers-made-nearly-53-million-prior-authorization-determinations-in-2024/
[29] Ibid.

necessary, but only after taking additional administrative steps that can delay treatment and negatively affect patient health outcomes. For CHCs serving medically underserved populations that already face non-clinical factors of health, these delays can have serious consequences. NACHC supports aligning PA timelines across programs to improve efficiency and accountability.

NACHC urges CMS to clarify that the decision timeframes proposed in this rule — including the 24-hour standard for covered outpatient drugs — apply to final prior authorization determinations, not to interim responses, requests for additional information, or "pended" statuses. The Da Vinci Prior Authorization Support (PAS) FHIR Implementation Guide that CMS proposes to adopt defines distinct Review Action response codes including "pended," which indicates no final determination has been made. Without explicit regulatory language requiring that a final determination (approved, denied, or partial) be issued within the applicable timeframe, payers could return a "pended" status within the required window and satisfy the letter of the regulation while indefinitely delaying care. For CHCs operating with limited administrative staff, each pended authorization creates a manual follow-up obligation that compounds the very burden this rule seeks to reduce.

NACHC further recommends that CMS consider establishing that failure to issue a final determination within the required timeframe results in approval of the request. This is consistent with approaches adopted by Indiana and North Dakota at the state level. Given that 94 percent of physicians report PA delays patient care[30] and that the majority of prior authorization requests are ultimately approved, automatic approval for missed deadlines would function as a compliance enforcement mechanism, not an expansion of coverage. Any exception for payer extensions should be narrowly defined, time-limited, and documented in a manner accessible to providers through the Prior Authorization API.

NACHC supports CMS' proposal to require payers to provide specific denial reasons for all drug PA denials, regardless of submission method. We believe this change will allow CHCs to more efficiently correct incomplete submissions, pursue appeals, and resubmit requests without the unnecessary back-and-forth that typically delays care. Specifically, requiring payers to explain why a request was denied, identify missing or insufficient information, and provide actionable information necessary for resubmission or appeal will create a more transparent and navigable process for providers operating under significant staffing and operational constraints.

NACHC also supports CMS' efforts to improve public reporting of PA denials and timeframes. This change is a step towards greater transparency that will improve payer accountability and provide policymakers, providers, and patients with better visibility. **NACHC strongly encourages CMS to publish these required PA metrics in a centralized, standardized, publicly accessible format on CMS' website rather than relying solely on individual plan websites.** Historically, plan-specific reporting has been difficult to locate, compare, and meaningfully analyze across issuers and programs. Centralized CMS reporting would improve transparency, support oversight efforts, and enable stakeholders to more effectively identify trends in delays, denial rates, and utilization management practices across payers.

[30] https://www.ama-assn.org/press-center/ama-press-releases/ama-survey-prior-authorization-reform-pledge-falls-short-physicians

NACHC encourages CMS to expand the proposed reporting framework to better capture the real-world operational burden that PA requirements place on CHCs and medically underserved patients, beyond the appeal and extended review metrics already proposed. Additional reporting elements that would be particularly valuable include:

- **Breakdown of denial rates by service type or medication category:** Tracking the denials of behavioral health medications, substance use disorder treatment, specialty drugs, and chronic disease therapies, for instance, could help identify whether certain categories of medically necessary care are disproportionately delayed or denied.
- **First-pass approval rates prior to any resubmission, extensions, or appeal activity:** This metric would help identify plans that routinely require unnecessary additional documentation or administrative steps before ultimately approving medically necessary care.
- **The average number of provider touchpoints required per PA request**: Tracking portal submissions, fax submissions, phone calls, resubmissions, or appeals could better quantify provider administrative burden.
- **Reporting on denials overturned due to incomplete, inaccurate, or unclear denial notices**: This metric would incentivize plans to provide clearer communication and more actionable denial explanations to providers.
- **Operational effectiveness metrics related to ePA adoption and functionality:** This could include transaction rates, reductions in manual workflows, abandonment rates, response latency, and average response times for PA determinations, to help evaluate whether these interoperability investments are meaningfully improving provider and patient experience.
- **Data completeness and quality metrics:** Including metrics on the percentage of PA transactions exchanged using structured versus unstructured data formats, the completeness of clinical documentation information (CDI) exchanged through APIs, and whether transmitted information is actionable and usable within provider workflows and EHR systems would provide CMS with important insight into the effectiveness of interoperability implementation. These metrics would help CMS assess not only whether data is being exchanged, but whether the format, quality, and usability of the information meaningfully support efficient clinical workflows and provider decision-making.

To further strengthen these reforms, **CMS should also consider stronger oversight and enforcement mechanisms for plans demonstrating persistent delays, inaccurate reporting, or patterns of inappropriate denials.** Greater accountability, combined with standardized communication requirements and timely decision-making expectations, will help ensure that PA processes support patient access to medically necessary treatment.

Finally, NACHC urges CMS to establish automatic approval for PA requests that are not decided within the required timeframes. We believe automatic approval upon deadline expiration would be the most effective mechanism to ensure compliance and would thus prevent CHCs and patients from bearing the cost of payer delays through interrupted care and abandoned treatment.

IV. Reporting Payer API Endpoints and Associated Information for CMS To Publish

NACHC supports CMS' proposal to require impacted payers to report API endpoints and associated information for publication on CMS' website. Having easy access to API endpoints in a centralized location fully operationalizes CMS' interoperability efforts. Currently, a provider must look up each payer's API endpoints individually to use the Prior Authorization API (PA API) to submit a PA request or the Provider Access API to request patient data, which can be incredibly burdensome. Having all impacted payers' API endpoints in one place will increase transparency, reduce provider burden, and improve the functionality of the reported API endpoints.

CHCs often have small IT departments that lack the capacity to manually search each payer's website for API endpoint information. The CHC IT department's limited resources could be better spent on strengthening and developing innovative technology solutions that benefit patients, such as cybersecurity, artificial intelligence, and telehealth. App developers and EHR vendors also stand to benefit from centralized, easy access to these endpoints, improvements that also directly impact patient care, particularly given that EHR disruptions currently occur when hard-coded endpoints become outdated.

NACHC applauds CMS for the proposed timelines requiring payers to report API endpoint information. Existing impacted payers have until 60 days after the effective date of a final rule, while new impacted payers have until 60 days before they begin covering patients under the applicable CMS program. This approach strikes a reasonable balance between payer accountability and operational feasibility. We also support the proposal requiring impacted payers to update the information within one week of any changes and verify that the reported information is updated at least annually. CHC patients strongly benefit when the CHC and its vendors have this up-to-date information, as incorrect information can delay access to and delivery of care. **NACHC commends CMS' commitment to transparency and encourages the agency to publish API endpoint information on its website as machine-readable files.** This will help maximize the utility and usability of this data. A machine-readable file prevents diverting valuable staff time to the interpretation of large amounts of data. As CMS considers the best approach for reporting and disseminating this information, we urge the agency to prioritize ease of access for primary care providers in safety net settings, especially those in rural areas with limited resources, while minimizing duplication and unnecessary complexity.

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

Information about PA for Drugs in the Patient Access, Provider Access, and Payer-to-Payer APIs
NACHC supports CMS' proposal requiring impacted payers to make detailed information about PA requests and decisions for all drugs available through the Patient Access, Provider Access, and Payer-to-Payer APIs beginning October 1, 2027. As discussed, PA for drugs remains a significant barrier to patients receiving timely care. Similar to what NACHC has previously advocated for non-drug PA API metrics, having information on APIs helps identify opportunities to improve them and monitor overall usage trends for key features. While we appreciate payers' independent efforts to improve transparency around PA, we applaud CMS for requiring metrics that will hold payers formally accountable. We encourage CMS to continue publishing trends in this data and to seek additional policy levers to ensure PAs are not inappropriate barriers to care for patients who need it.

Additionally, access to information about required documentation and which drugs are subject to PA will enable providers to make better-informed decisions when assisting their patients. Without this information, providers may develop a chilling effect on recommending certain prescriptions, ultimately to the detriment of patient care. **While we appreciate CMS' proposal, we urge the agency to consider aligning the compliance date with the non-drug API usage metric requirements for January 1, 2027, rather than the currently proposed October 1, 2027 date, provided that vendor and MCO readiness assessments confirm feasibility by that date.** We appreciate CMS for encouraging payers to voluntarily make this data available sooner, and we believe it is important to patient outcomes to formalize implementation as soon as payer infrastructure permits. However, NACHC recognizes that advancing the compliance date should not proceed if it would create implementation gaps for Medicaid MCOs serving CHC patient populations. We appreciate CMS for encouraging payers to voluntarily make this data available sooner, but we believe it is too important for patient outcomes to delay its formal implementation.

NACHC appreciates the proposed timeframe for having PA information available through the APIs no later than one business day after the payer receives the request. This change aligns timeframe**s** with the current policy for non-drug PAs. We also strongly support the requirement that PA information remain accessible for at least one year after the last status update. This is particularly critical for the populations CHCs serve. In 2024, CHCs provided care to over 1.5 million homeless individuals and more than 1.1 million agricultural workers—populations that move frequently and may not return to a CHC for months at a time.[31] These patients have a limited window of engagement, making it difficult to track outstanding PA requests across care episodes. Retaining this information for an extended period supports continuity of care and ensures that future providers, accessing patient information through the Provider Access API, can quickly understand a patient's PA history and better meet their needs.

New Proposed Reporting Levels and Deadlines for API Usage Metrics

NACHC supports the proposal requiring Medicaid managed care plans and CHIP managed care entities to report Patient Access API usage metrics both by program and by plan. This added granularity will give CMS a clearer picture of where access gaps exist and how to target improvement efforts. Medicaid patients represent nearly half of CHC patients,[32] and nearly 78 percent of all Medicaid patients in the U.S. are in a managed care plan.[33] Having disaggregated data helps improve the value of the reported data. Additionally, NACHC supports CMS' proposal to align deadlines with reporting periods. Better alignment reduces administrative confusion and makes data more meaningful.

NACHC also supports expanding the metrics that impacted payers must report for the Provider Access, Payer-to-Payer, and PA APIs. Requiring payers to report denial rates, timeframes for extensions, and adjudicated appeals for both standard and expedited PAs will meaningfully improve transparency and accountability across the system. We appreciate that CMS has proposed requiring total counts in addition to percentages, as this additional context is essential

[31] 2024 HRSA UDS Data.
[32] Ibid.
[33] 10 Things to Know About Medicaid Managed Care | KFF

for accurate interpretation of the data. We encourage CMS to publish aggregated trend data over time so CHCs and others can better understand PA trends.

Beyond the suggested metrics, NACHC recommends that CMS also require measures of API functionality and usability. Although terabytes of health data are transmitted daily, much of it goes unused in practice because it is not surfaced directly to users or cannot be incorporated into clinical workflows. NACHC therefore recommends that CMS track the rate of successful API requests, as well as those rejected due to authorization failures or malformed queries, and instances where API calls were not received by the requester. Additionally, metrics such as structured versus unstructured data in the request response, workflow impact, number of calls per query, number of queries per user, and the cost of maintaining each API would help CMS, health systems, vendors, and other stakeholders evaluate which APIs deliver meaningful value. With this data, CMS would be better positioned to implement targeted policies to address PA issues.

Removing Drug Formulary Information from Provider Access and Payer-to-Payer APIs

NACHC encourages CMS to reconsider its proposal to remove drug formulary information from the Provider Access and Payer-to-Payer APIs. While CMS suggests that providers already have sufficient access to formulary information through payer websites and standard communications, this access is neither reliable nor real-time. As Pharmacy Benefit Managers (PBMs) increasingly expand the number of drugs excluded from formularies, formulary lists can change rapidly, meaning the information available on a payer's website may not reflect a patient's current coverage at the point of care. For CHC providers, who often serve patients covered by multiple different payers and lack the administrative infrastructure to conduct manual lookups across each, this gap is especially consequential. A provider who cannot quickly determine whether a drug is covered, or identify a covered alternative, may delay prescribing or default to a less optimal option. Retaining formulary information in the Provider Access and Payer-to-Payer APIs would reduce this lookup burden, support better prescribing decisions, and advance the transparency goals CMS has articulated throughout this rule. NACHC urges CMS to weigh this real-world impact on safety-net providers against the administrative burden it cites as justification for removal.

Federal Matching Funds

We appreciate the possibility that States operating Medicaid and CHIP programs might be able to access federal matching funds to support the new proposals. NACHC continues to request that CMS ensure safety-net providers are prioritized for these funds, if they are available. Safety-net providers, like CHCs, operate on thin margins and would greatly benefit from additional funding to help reduce costs such as provider training and implementation expenses. Many CHCs are currently under financial strain, with nearly half of CHCs operating with fewer than 90 days of cash on hand. The sector's average operating margin has turned negative; one in four reporting negative five percent (-5%) operating margins. In response to the unique needs of their patients, CHCs invest significant resources into training their staff and patients to meet meaningful use and interoperability requirements. CMS should consider the specific investments CHCs make, including costs, administrative setup, staff, training, clinical training, and patient education needs, and ensure appropriate interoperability and access.

VI. Open Payments Civil Monetary Penalties

NACHC supports CMS' addition of a formal definition of "failure to report" under 42 CFR 403.902 and applauds the agency for taking steps to hold manufacturers and group purchasing organizations (GPOs)[34] accountable for failing to provide requested audit documentation. NACHC believes these changes will strengthen transparency, accountability, and compliance with the Open Payments Program[35] and further support program integrity and oversight efforts across the healthcare system. The Open Payments Program is particularly important for CHCs and other safety-net providers because medically underserved patients depend on public trust in the integrity of provider-industry relationships, especially in communities where CHCs serve as the primary source of care. Increased transparency regarding financial relationships between manufacturers and providers can help ensure accountability while also providing greater visibility into prescribing and utilization influences that may affect patient care decisions. Public reporting and stronger audit enforcement can also help identify patterns of inappropriate financial relationships or reporting inconsistencies that may undermine confidence in federal healthcare programs. Enforceable audit standards can help improve the reliability and completeness of Open Payment data while increasing public confidence and trust in the program. Strengthening compliance expectations for manufacturers and GPOs may also help ensure more consistent documentation and oversight practices across federal healthcare programs involving provider-manufacturer relationships.

NACHC encourages CMS to coordinate with the Health Resources and Services Administration (HRSA) to consider the operational intersection between the updated Open Payments reporting requirements and existing 340B Program compliance structures. Although the programs serve different purposes, both involve significant documentation, audit readiness, manufacturer oversight, and reporting obligations that can affect CHCs participating in complex entity-owned and contract pharmacy arrangements. Many CHCs rely on relationships with manufacturers, wholesalers, and TPAs to support 340B access for medically underserved patients. As CMS strengthens its Open Payments enforcement authority, additional clarity may be needed regarding how reporting, audit processes, and transparency obligations interact with existing 340B operational workflows to avoid duplicative or conflicting compliance burdens. NACHC encourages CMS to align federal oversight frameworks to ensure program integrity objectives are met without creating unnecessary administrative complexity for safety-net providers, such as CHCs.

VII. Modifications to HIPAA Standards Related to PA

NACHC recommends that CMS provide transition support to safety-net providers, such as CHCs, during the transition from X12 to FHIR. We appreciate and support CMS' efforts to move away from X12, a legacy system, and towards FHIR standards, an important step in enhancing interoperability. However, CHCs and their clearinghouses will need to support both standards simultaneously during transition: X12 6020 for claims attachments (CMS-0053-F, compliance May 2028) and FHIR/CDex for PA attachments (CMS-0062-P, compliance in 2029). This dual-standard burden is real and must be acknowledged. As previously mentioned in this letter, CHCs have limited IT staff due to constrained budgets so CMS support would help

[34] https://www.cms.gov/priorities/key-initiatives/open-payments/program-participants/reporting-entities
[35] https://www.cms.gov/priorities/key-initiatives/open-payments

immensely in the transition. **Ultimately, NACHC requests that CMS extend its February 28, 2024, National Standards Group enforcement discretion (FHIR PA API as X12 278 substitute) to cover the CMS-0062-P transition period.**[36] This would provide relief for HIPAA-covered entities to use a FHIR-based PA API in place of the older X12 278 standard without facing HIPAA Administrative Simplification enforcement penalties.

NACHC supports the use of Clinical Data Exchange (CDex) for PA attachments but recommends specific guardrails to reduce provider burden and enhance transparency. CDex allows payers to specify exactly what data they need and supports multiple formats (C-CDA, PDF, text, FHIR resources). However, CDex also creates a mechanism for payers to issue iterative, escalating data requests. **NACHC recommends CMS:**

- **Require payers to specify all needed documentation in the initial CDex request (no drip-feed)**
- **Limit solicited-attachment requests from payers to a maximum of two per PA transaction before the payer must issue a decision.**
- **Establish maximum response timeframes for payers after receiving CDex attachments.**

These actions will set expectations for what the provider needs to share in the initial CDex request and limit the burden on CHC providers when providing additional information. This will likely lead to more streamlined, expedited ePA decisions, ensuring patient access to crucial health care services and prescription drugs.

NACHC supports gold-carding for ePA for prescription drugs. We appreciate that CMS has already implemented gold-carding for DMEPOS, for supplies with a 90% approval threshold with DME Medicare Administrative Contractors and within the WISeR model,[37] which began in January 2026 in six states. Gold-carding in ePA will allow certain providers, such as CHCs, who have demonstrated compliance with PA requirements to receive exemptions or more streamlined reviews, a practice NACHC has advocated for previously.[38] We recommend CMS put out guidance formally recommending payers to implement gold card type initiatives and ensure that gold carding privileges extend to all items and services for eligible providers, not just specific service categories. This will ensure that providers and their patients will experience the full benefits of this strategy to decrease unnecessary PAs.

Gold carding would help reduce the time staff and providers spend on PA. PA is an expensive process for health care organizations that, in many cases, significantly restricts patients' ability to access needed care.[39] It can take weeks to adjudicate the request, resulting in costing hundreds of dollars in staff and provider time at a health care organization for a single therapy for a single patient. Notably, this effort is not reimbursed and requires valuable staff resources. CHC patients often have less comprehensive health insurance plans that require more frequent PA than those of higher-income patients. PAs can exacerbate patients' health care issues and increase the burden of PA costs on CHCs, which already provide lower-cost care with fewer resources. Gold-carding

[36] https://www.cms.gov/files/document/discretion-x12-278-enforcement-guidance-letter-remediated-2024-02-28.pdf
[37] https://www.cms.gov/priorities/innovation/innovation-models/wiser
[38] https://www.nachc.org/wp-content/uploads/2023/05/03_06_23_Prior-Auth-Comment-Letter-Final.pdf
[39] https://www.fiercehealthcare.com/practices/costs-prior-authorizations-increase-for-physician-practices-at-alarming-rate

would decrease these burdens, and NACHC supports gold-carding as a strategy to enhance patient access to care.

VIII. Adoption of Health Information Technology Standards and Incorporation by Reference

NACHC supports CMS' efforts to ensure ONC-HHS harmonization of health IT standards and specifications but urges the agencies to ensure that the HTI-5 final regulations conform to CMS-0062-P regulations. Corresponding ONC-HHS standards continue to promote a nationwide health IT infrastructure and federal alignment on interoperability and health information exchange standards. However, NACHC is concerned about how this rule conflicts with proposals in the HTI-5 proposed rule. This rule, CMS-0062-P, expands interoperability mandates, specifically CRD/DTR/PAS (the HL7 Da Vinci Project Implementation Guides (IGs) that automate ePA) v2.2 by October 2027, whereas the HTI-5 proposed rule, published early this year, seeks to drastically change the ONC certification program; for instance, it proposed removing 34 of 60 certification criteria. While HTI-5 retains the ePA criteria finalized in HTI-4 (90 FR 37130, Aug 4, 2025), the broader reduction of 34 certification criteria may affect supporting infrastructure — such as clinical information reconciliation and security capabilities — that indirectly enables ePA workflows. Vendors serving safety-net markets may deprioritize non-required capabilities that CHCs depend on for operational readiness.[40]

NACHC is also concerned about a temporal gap between this proposed rule's payer compliance deadlines and the availability of certified provider-facing technology. CMS-0062-P proposes payer compliance by October 1, 2027, but the EHR certification deadlines established under HTI-4 (90 FR 37130) extend to December 2027 and January 2028 for the ePA certification criteria at 45 CFR 170.315(g)(31)-(g)(33). This creates an implementation period of up to three months during which payer APIs may be operational but CHC EHR systems may not yet have certified modules available to connect to them. During this gap, CHCs and other providers cannot be considered non-compliant for failing to use technology that does not yet exist in certified form.

NACHC requests CMS and ONC issue joint implementation guidance ensuring any final proposals in HTI-5 do not inadvertently undercut final regulations within this rule, CMS-0062-P. We recommend that a formal CMS-ONC harmonization assessment be published before the CMS-0062-P final rule.

IX. Requests for Information (RFIs)

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

Given the complex patient populations they serve, CHCs excel at providing highly coordinated care services. Care coordination extends beyond the four walls of the CHCs; they use integrated care teams to help address patients' holistic needs – medical, behavioral health, dental, and beyond. An important way to adequately meet patients' needs after hospital treatment is through electronic event notifications, also known as ADT (Admitted, Discharged, or Transferred). However, there are ways to improve the notification process and enhance workflows.

[40] 90 FR 37130, Aug 4, 2025

NACHC recommends amending the Condition of Participation (CoP) at §482.24(d) to explicitly include Section 330-funded CHCs as designated recipients of ADT notifications. CHCs serve as the primary care medical home for 52 million patients and work closely with nearby hospitals to meet their needs. However, there is a gap in the current CoP protocol: it requires notifying the ADT to go to the "primary care practitioner," but not to the organization as a whole. Primary care physicians are stretched thin – the U.S. invests less than 5% in primary care[41] and experience higher rates of burnout compared to other physicians.[42] It is important for ADT alerts to reach the entire care team at a CHC, instead of only just one healthcare member of the team. When the ADT fails to reach the care team, it prevents CHCs from responding quickly and meeting patient needs. **NACHC recommends routing notifications to organizations using NPI Type 2 identifiers to ensure they reach the organization rather than the sole individual provider.**

NACHC recommends CMS align ADT notification standards with FHIR-based event notification models. The Da Vinci Notifications IG (STU 1.1) and the US Core Encounter profile provide the technical foundation for FHIR-based event notifications. TEFCA use cases, now at 21,086 organizations, over 83,000 locations, and more than 889 million documents shared as of April 2026, should also be considered. Current ADT alerts contain the right information but create excessive administrative burden for CHC staff to translate into care plans. If ADT notifications included structured, computable care instructions, such as those in the FHIR Task or Communication Request resources, they could be more easily processed by CHC EHRs and auto-populate follow-up workflows. The critical data elements for CHC care coordination are already present, including:

- Discharge disposition
- Discharge diagnosis (ICD-10-CM)
- Discharge medications (reconciled)
- Follow-up appointment date/provider
- Newborn status and complications (for maternal-child use case)
- Non-clinical risk factors flagged during the encounter, and
- Payer/coverage at time of event.

NACHC particularly emphasizes the maternal-child health use case as one of the most important applications for ADT notifications. The delivery-to-CHC handoff represents a critical care transition where coordination frequently fails. Up to 40 percent of women miss postpartum visits, and fewer than 65 percent of Medicaid-insured women receive a routine postpartum visit. Postpartum readmissions have been rising, from 1.72 percent to 2.16 percent nationally. Evidence demonstrates that structured postpartum navigation programs can dramatically improve outcomes, including a 56 percent reduction in severe maternal morbidity rehospitalization overall.[43] **NACHC recommends CMS require obstetric ADT notifications include structured FHIR Composition resources with Edinburgh Postnatal Depression Scale screening results, discharge medications as MedicationRequest resources, newborn status, and follow-up**

[41] https://www.milbank.org/wp-content/uploads/2025/02/Milbank-Scorecard-2025-ACCESS-v07.pdf
[42] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2810256
[43] Brown Z, Messaoudi C, Silvia E, Bleau H, Meskill A, Flynn A, Abel-Bey AC, Ball TJ. Postpartum navigation decreases severe maternal morbidity most among Black women. Am J Obstet Gynecol. 2023 Aug;229(2):160.e1-160.e8. doi: 10.1016/j.ajog.2023.01.002. Epub 2023 Jan 5. PMID: 36610531.

scheduling information. Meta-analysis evidence demonstrates that structured discharge planning in the postpartum period improves depression, anxiety, and self-care competence outcomes,[44]
NACHC also recommends mandating Health Information Exchanges to support CHC-side notification subscription and filtering capabilities. This will help alleviate some technological and operational barriers CHCs often face, including juggling multiple ADT feeds and limited staffing capacity to follow up on all ADTs received. Notification subscription and filtering capabilities will alleviate the CHC burden on sifting through information and ultimately make ADT alerts actionable.

b. Increasing Health Care Resiliency

NACHC recommends that CMS consider funding technical assistance, shared services, or grants before expanding API obligations. Cybersecurity is no longer just about hardware and infrastructure. It requires CISO-level expertise, project management, vulnerability monitoring, incident response, penetration testing, and insurance; this proves a tall task given that IT budgets are usually less than 10% of hospitals' operating costs.[45, 46] For safety-net providers like CHCs, who operate on thin margins and provide people care regardless of ability to pay or insurance status, the budget is even tighter. Many CHCs are currently under financial strain, with nearly half of CHCs operating with fewer than 90 days of cash on hand, and one in four reporting approximately negative five percent (-5%) operating margins. Because the Federal Tort Claims Act (FTCA) insurance coverage is limited to medical malpractice[47], this creates a significant unfunded liability gap for cybersecurity coverage. Every new FHIR API endpoint and TEFCA connection expands the attack surface, increasing the importance of providing dedicated cybersecurity TA for safety-net providers like CHCs to promote operational readiness.

NACHC also recommends CMS, alongside HRSA, to work with Health Center-Controlled Networks (HCCNs) to help establish a CHC Cybersecurity Shared Services model. Through training, technical assistance, and advanced data analytics capabilities, HCCNs aid CHCs in improving the quality of care and patient safety through HIT, thereby decreasing costs and enhancing care coordination. HCCNs have been well-positioned to expand their role in assisting CHCs with their HIT endeavors, and their knowledge can be leveraged in cyberspace as well. This would help defray costs associated with standalone cybersecurity policies; experts recommend a minimum of $1 million to $5 million in coverage, at a minimum.[48] According to a November 2024 NACHC survey, most CHCs have less than $3 million in cyber incident coverage, with respondents reporting high premiums and infrastructure needs as barriers for obtaining higher amounts of coverage.[49] A shared security operations center (SOC) would unlock centralized threat intelligence, group-negotiated cyber insurance, and incident response contracts. This investment would also support cybersecurity and general health IT optimization. While CHCs are dedicated to enhancing patient care through advanced technologies, they often face challenges such as

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[44] Huang Q, Peng A, Cui Z, Huang Z, Duan D, Cao X, Cui Y, Huang L. Effectiveness of discharge planning interventions on health-related outcomes among postpartum women: a systematic review and meta-analysis. Front Public Health. 2026 Mar 23;14:1733799. doi: 10.3389/fpubh.2026.1733799. PMID: 41948024; PMCID: PMC13051705.
[45] Neprash HT, et al. Trends in ransomware attacks on US hospitals, clinics, and other health care delivery organizations. JAMA Health Forum. 2022;3(12):e224873.
[46] Ewoh P, et al. Sociotechnical cybersecurity framework for securing health care. J Med Internet Res. 2025;27:e54321.
[47] https://www.feldesman.com/appeals-courts-signal-limits-of-ftca-immunity-for-health-center-data-breach-claims/
[48] https://www.feldesman.com/appeals-courts-signal-limits-of-ftca-immunity-for-health-center-data-breach-claims/
[49] https://www.nachc.org/resource/most-health-centers-do-not-have-enough-cyber-liability-insurance-coverage/

financial constraints, limited training opportunities, and the complexities of integrating new systems.[50] Only two-thirds of CHCs report having a cybersecurity committee or leader, and 78.9% reported having 1-10 full-time equivalents (FTEs) supporting health IT. While CHCs maintain dedicated staff, these IT teams are small and often wear multiple hats, so CHCs rely on third-party vendors and organizations to help ensure their data remains secure. A shared service model through HCCNs, supported by CMS, would better bolster CHC cyber protections.

NACHC recommends CMS coordinate with ONC when providing security implementation guidance to ensure alignment across interoperability and security requirements. Ensuring CMS and ONC remain in lockstep with recommendations on best practices for cybersecurity and general interoperability is paramount, as cyber attacks against health care clinics rise. Clinics are the number one ransomware target, with nearly half of attacks disrupting care delivery.[51] For instance, following the Change Healthcare cyberattack in 2024, NACHC conducted a survey[52] of the impact on CHCs. We found that the breach negatively impacted 77% of CHCs, and 62% of CHC patients were affected by a delay in access to care, due to the inability to obtain PA, service interruption, or going without needed medications. Additionally, one in five CHCs had over 50% of their revenue affected by delayed claims processing. As safety-net providers operating on razor-thin margins, the additional costs were significant, prompting many CHCs to reevaluate their IT networks. Since then, CHCs have made significant strides in leveraging HIT to enhance service delivery.

c. Improving Implementation of Payer Application Programming Interface Technology

NACHC recommends that CMS require payer API certification through the ONC Health IT Certification Program with public reporting of conformance testing results. Currently, no mechanism exists to verify that payer APIs function as required; ePA functionality for both medical services and prescription drugs is crucial for patients to ultimately benefit. A payer API "transparency registry" would show data from payers regarding API endpoint status, supported IGs and versions, uptime metrics, and known limitations. This would save CHC IT staff from having to individually locate each payer's API connection information across hundreds of Medicaid MCOs. This would expand upon what is proposed in Section E of this proposed rule, "Reporting Payer API Endpoints and Associated Information for CMS To Publish."

NACHC requests that CMS establish a provider-payer interoperability testing sandbox with CHC-specific test scenarios. On average, CHCs interact with 10 to 30 distinct payers, each with different portal interfaces, authentication mechanisms, and data formats. Key failures consistent with payers include that, while they are building APIs under the 21st Century Cures Act, they are not deploying them to production. Some payers have homegrown solutions that require costly integration on the CHC side, a cost that many CHCs cannot front or sustain. Additionally, as more payers are transitioning to Epic, time dependencies are created that delay API readiness for CHC-facing connections. Additionally, data aggregators such as Azara and DRVS integrate some payer

[50] https://www.nachc.org/nachc-content/uploads/2025/02/NTTAP-HIT-Needs_Assesment_Report-01.28.25.pdf
[51] Jiang JX, Ross JS, Bai G. Ransomware attacks and data breaches in US health care systems. JAMA Netw Open. 2025;8(1):e2453468.
[52] https://www.nachc.org/nachc-content/uploads/2024/04/NACHC-Change-Healthcare-Cybersecurity-Breach.pdf

data, but coverage is incomplete and varies significantly by state and payer. Lastly, fully integrated payer-CHC systems for intentional information exchange remain aspirational rather than operational. In a 2025 scoping review across organizational, technical, individual, data management, and legal/regulatory domains, 73 distinct FHIR implementation challenges were identified.[53] This makes CHC scenario testing crucial to ensure that APIs/portals function for our nation's safety-net providers, like CHCs, who serve some of the most medically needy and vulnerable patients. As the U.S. continues to grapple with how to tame rising health care spending, proactive investment reaps benefits. One study shows that Medicaid patients see the most pronounced reductions in Emergency Department/inpatient use – costly to the health care system – when EHR systems are connected properly to HIEs via an API.[54]

d. Step Therapy

CMS should establish a mandatory regulatory floor requiring payers to honor prior step therapy approvals for at least 12 months or through the end of the current treatment episode, whichever is longer. Additionally, there should be an indefinite continuation of step therapy approval for chronic disease medications—including diabetes, hypertension, HIV, and mental health conditions—unless a prescribing provider initiates a change. CHC patients are more likely to have multiple, chronic conditions, and access to these life-changing and life-saving medications is critical for their well-being. The clinical and economic case for this standard is compelling. Forcing stable patients to restart step therapy carries serious medical consequences, including disease flaring, immunogenicity, adverse effects, and secondary nonresponse. Yet, payers routinely impose these burdens even though only 34% of step therapy protocols are consistent with clinical guidelines, and more than half are more stringent than evidence supports.[55] This would help the overall health care system financially as well. In one study, Medicaid prescription denials increased net medical spending by $624 to $3,016 per member per year across seven medication classes,[56] suggesting that obstructive step therapy protocols can cost the program more than they save. These harms fall disproportionately on low-income and Medicaid populations, where insurance churning affects approximately 25% of adults annually,[57] a dynamic worsened by the loss of coverage for more than 20 million individuals following the March 2023 Medicaid unwinding.[58] **To mitigate these consequences, NACHC requests CMS require automatic step therapy continuation upon Medicaid re-enrollment and mandate that the Payer-to-Payer API include step therapy determination history.** This will help ensure that coverage disruptions do not force clinically stable patients to restart treatment regimens that their providers have already deemed appropriate and effective.

e. Laboratory Tests and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Items

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[53] Nopour R. Using FHIR for data sharing: a scoping review. Int J Med Inform. 2025;195:105696.
[54] Ford DH, et al. Impact of provider HIE services on patient utilization in Colorado. J Clin Med. 2025;14(3):789.
[55] Lenahan KL, et al. Variation in use and content of prescription drug step therapy protocols. Health Aff. 2021;40(10):1610-1618.
[56] Muralidharan B, et al. Procedural prescription denials and risk of acute care utilization among Medicaid patients. JAMA Network Open. 2025;8(2):e2457312.
[57] Sommers BD, et al. Insurance churning rates for low-income adults under health reform. Health Aff. 2016;35(10):1816-1824.
[58] Rome BN, et al. Changes in medication use during Medicaid continuous enrollment and unwinding. JAMA Health Forum. 2026;7(1):e245678.

NACHC recommends that CMS streamline PA for DMEPOS items and address access barriers for underserved populations. CHCs have experienced payer-driven delays in DMEPOS approval and general overcharges. We have heard from CHCs that this happens often for wheelchairs, which take months to procure, ultimately harming CHC patients. The scale of this problem is reflected in the data: DMEPOS disputes constitute 47.5% of all coverage appeals,[59] and in Medicare Advantage, 82% of PA appeals are at least partially successful,[60] strongly suggesting that initial denials lack adequate clinical justification. CMS should therefore require payers to systematically analyze their own appeal overturn data and eliminate PA requirements for DMEPOS categories where denials are routinely reversed on appeal. This will help streamline PA requests and eliminate unnecessary PA, ultimately improving patient access.

NACHC recommends that CMS allow Standardized Test Requisition Forms (TRFs) be accepted as sufficient PA documentation for laboratory tests. TRFs should be aligned with LOINC-coded test identifiers and transmissible as structured FHIR ServiceRequest resources. **Additionally, CMS should mandate real-time PA for laboratory tests before specimen collection through the Coverage Requirements Discovery Implementation Guide.** Payer denials issued after specimen collection result in wasted specimens, delayed diagnoses, unreimbursed services, and direct financial costs for patients who cannot absorb unexpected out-of-pocket expenses. For CHCs, which rely heavily on reimbursement revenue to sustain operations amid substantial uncompensated care obligations, post-collection denials carry systemic financial consequences that threaten the viability of safety-net services. Requiring pre-collection real-time determination would eliminate this concern, align payer processes with the clinical workflow, and avoid delaying CHC patient care.

Thank you for your consideration of these comments. We are supportive of these provisions that will advance ePA, increase timely access to care and essential medication, and promote stronger interoperability standard to benefit CHC patients. If you have any questions, please contact Elizabeth Linderbaum, Director of Regulatory Affairs, at elinderbaum@nachc.org.

Sincerely,

Joe Dunn
Chief Policy Officer

[59] Studdert DM, Gresenz CR. Enrollee appeals of preservice coverage denials at 2 HMOs. JAMA. 2003;289(7):864-870.
[60] Levitt L. Increasingly privatized public health insurance programs in the US. JAMA Health Forum. 2023;4(6):e232186.