June 15, 2026

Dr. Mehmet Oz
Administrator
The Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Oz,

On behalf of the nation's Medicaid Directors, the National Association of Medicaid Directors (NAMD) is pleased to offer comments on the 2026 CMS Interoperability Standards and Prior Authorization for Drugs (CMS-0062-P) proposed rule. This rule builds on prior rulemaking around interoperability, access, and prior authorization, to expand many of those requirements to cover prior authorization for drugs.

Medicaid agencies share CMS' goals of improving interoperability, streamlining prior authorization processes, and promoting informed decision-making through the exchange and use of health information. Over the past several years, Medicaid agencies have made significant investments to modernize legacy systems, strengthen data exchange capabilities, implement interoperability requirements, and explore emerging technologies, including artificial intelligence-enabled tools, to improve program administration and the Medicaid member experience.

However, Medicaid agencies have concerns about the feasibility of implementing these provisions on the proposed timeline while simultaneously undertaking major systems and policy transformations related to H.R. 1, otherwise known as the Working Families Tax Cut Legislation or One Big Beautiful Bill Act; navigating budget constraints; managing procurement processes; and implementing requirements from prior interoperability rulemaking. **To support successful implementation and advance the intended goals of the rule, CMS should extend the implementation period and provide Medicaid agencies with tailored technical assistance and other implementation resources.**

NAMD is a nonpartisan, professional community of leaders who provide health insurance to nearly 70 million people through Medicaid and CHIP in the states, D.C., and the U.S. territories. NAMD elevates thought leadership on policy matters, amplifies the experience and expertise of state and territory leaders, supports programs in continuous improvement and innovation, and optimizes partnerships to help millions live their healthiest lives. In addition to supporting Medicaid Directors, NAMD serves over 500 Medicaid policy leaders, including convenings with subject matter experts in finance and budget, technology, eligibility policy, and communications to share operational expertise, support policy implementation, and exchange promising practices across states and territories.

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CMS Should Give Medicaid Agencies Sufficient Time for Implementation

Medicaid agencies are undertaking major system transformations with an already overextended Medicaid agency and vendor workforce. Medicaid agencies need additional implementation flexibility in order to achieve the rule's intended goals of improving timely access to care and reducing administrative burden.

In light of these considerations, we urge CMS to:

- **Extend the implementation timeline for these provisions by at least three years;**
- **Prioritize implementation of core functionality first and delay reporting requirements until implementation experience has matured; and**
- **Provide enhanced systems match to support implementation to the fullest extent possible.**

In discussions with Medicaid agencies regarding the feasibility of implementation, NAMD consistently heard that Medicaid agencies are currently managing substantial programmatic and operational changes driven by federal rulemaking, federal legislation, and their state legislatures. CMS' own Medicaid and CHIP Policy Implementation Roadmap demonstrates the volume of Medicaid enterprise system changes that agencies have been undertaking and will continue to implement over the coming years. Importantly, these efforts require not only system changes, but also significant state and vendor staff capacity to operate, oversee, and maintain.

The proposed rule notes that the 2024 CMS Interoperability and Prior Authorization final rule afforded Medicaid agencies three years to implement its requirements and suggests that the same timeframe may not be necessary because agencies would not need to build new Application Programming Interfaces (APIs) from scratch. However, many Medicaid agencies will still need to undertake substantial operational and contractual changes to implement the proposed prior authorization standards for drugs. For example, implementation may require Medicaid agencies to initiate procurement processes, revise existing vendor contracts, or secure legislative approval, depending on state or territorial procurement requirements.

Medicaid agencies may also need to amend contracts with managed care organizations (MCOs), pharmacy benefit managers (PBMs), fiscal agents, and other vendors implementing existing API requirements to ensure systems are able to capture, track, and report the reason for denial of a prior authorization request for a drug covered under the medical benefit. Providing additional implementation time would allow Medicaid agencies to complete these operational, contractual, and governance processes in a thoughtful and compliant manner.

Additional implementation time would also support vendor readiness and capacity. Prior authorization vendors are concurrently working to make information available to CMS, as required under existing interoperability rules, on the number of patients' authorization requests and decisions for both who use the Patient Access API, while also managing overlapping federal and state-driven system changes. Extending the implementation timeline would help reduce operational strain on both Medicaid agencies and their vendor partners and support more effective implementation overall.

Lastly, Medicaid agencies are working to implement the 2024 rule by January 1, 2027, and agencies expressed that additional time would allow them to better evaluate lessons learned from implementation of the 2024 rule and apply those insights to the rollout of the proposed drug prior authorization API requirements. Notably, several states have requested additional implementation time from CMS for existing interoperability requirements, further illustrating the operational complexity of these efforts and the challenges states face in meeting current timelines.

Overall, we encourage CMS to prioritize implementation of core functionality first and delay reporting requirements until the implementation experience has matured. This would allow Medicaid agencies to account for procurement timelines, providing ample time for the development and testing that is required to adopt the Fast Healthcare Interoperability Resources (FHIR) standards, and subsequent reporting of prior authorization information to the Access APIs.

CMS Should Provide Technical Flexibilities

As Medicaid agencies undertake significant systems and policy changes, Medicaid agencies would benefit from flexibility in the technical requirements that support implementation. Members identified several opportunities for CMS to provide technical flexibility that would help facilitate implementation.

Alternative Compliance Pathways

Medicaid agencies need a better understanding of whether existing health information network connectivity – such as connections through vendors – satisfies the proposed NCPDP standard requirements, or whether separate payer-specific builds would be required. Health information networks use industry standard interfaces, including FHIR, X12, and NCPDP, to connect EHRs, pharmacies, and payers through a hub-and-spoke architecture. Many already facilitate the electronic prior authorization workflows that the proposed rule seeks to require.

CMS should consider:

- Clarifying whether a pharmacy vendor's integrations with health information networks satisfy the proposed NCPDP standard requirements through its existing standards-based connections.
- Confirming whether Medicaid agencies may meet documentation requirements by referencing their health information network vendor's documentation rather than maintaining payer-specific materials.

More broadly, CMS should structure the final rule with outcomes-based flexibility rather than prescribing a single technical pathway and commit to issuing sub-regulatory guidance in the form of guidance letters or open-source resources to address implementation questions before the compliance deadline.

Pharmacy Benefits Manager (PBM) Infrastructure Exemption, Extension, and Reference Implementation

The PBM vendor market remains highly concentrated, which may limit some Medicaid agencies' ability to procure foundational infrastructure within federally-prescribed timelines. For smaller Medicaid agencies in particular, vendor willingness to respond to procurements is not guaranteed, and mid-procurement requirement changes risk triggering costly contract amendments outside of current state appropriations to effectuate previous policy.

In light of these structural barriers to effectuating CMS' goals, we urge CMS to:

- Establish an exemption and extension process that accounts for vendor market availability in addition to state and territory readiness;
- Accompany approved extensions with targeted technical assistance and enhanced federal match clarification; and
- Assess whether sufficient vendor capacity exists to serve all Medicaid agencies simultaneously before finalizing compliance dates.

To address the root cause of these barriers, we urge CMS to develop or facilitate a Medicaid reference implementation for pharmacy benefits. A shared, open-source technical foundation would provide Medicaid agencies that are lacking foundational PBM infrastructure with a configurable framework to meet current and future standards.

Managed Care Reporting Pathway

Medicaid agencies need clarity and technical assistance from CMS on whether MCOs must build their own Prior Authorization APIs or report through the state or territory's Medicaid API. Without clear guidance, agencies face uncertainty in how to best manage their partnerships and contracts, potentially leading to increased costs. NAMD's members flagged this ambiguity, noting it could trigger contract amendments, increased costs, and duplicative infrastructure builds across managed care plans.

We urge CMS to consider:

- Allowing Medicaid agencies to designate a consolidated reporting pathway through the state or territory Medicaid API as an alternative compliance mechanism; and
- Providing flexibility that accounts for local market conditions and vendor availability.

Data Reporting and Compliance Timeframes

Medicaid agencies would benefit from an approach from CMS that adopts a principles-based compliance framework anchored to practical implementation realities and demonstrated progress toward compliance rather than prescriptive mandates that may not reflect operational realities.

CMS should consider building flexibility into reporting expectations to account for data latency and implementation challenges associated with vendors, MCOs, PBMs, and other implementation partners. Specifically, **CMS should revise the proposed 24-hour requirements to better align with real-world operational and technical constraints identified by states.** NAMD recommends incorporating a business-day standard into applicable timeframes, which would provide needed flexibility while still supporting timely data exchange and Medicaid member access to care.

Medicaid agencies noted that a one-business-day requirements may not align with current system architecture, including overnight batch processing and PBM data exchange workflows. This timeline may be operationally challenging for some Medicaid agencies, particularly in fee-for-service programs, which may require MMIS updates and modifications to internal workflows. Agencies also noted that requests received late in the day, on weekends, or adjacent to or on holidays may be difficult to process within a one-business-day period. Some agencies also report that their interfaces with other systems primarily conduct batch uploads overnight, meaning that updates would extend to two business days in many circumstances, and that receiving pharmacy data from PBMs also typically requires two business days. Given these operational considerations, **CMS should consider adopting a two-business-day timeframe across applicable provisions.**

Medicaid agencies also noted concerns about the proposed 24-hour decision-making timeframe. While current law requires a response to a request within 24-hours, the proposed policy would require Medicaid agencies to render prior authorization decisions within that same timeframe. Agencies expressed concern that this compressed timeline could inadvertently increase denials, create frustration for providers, and delay access to care when additional clinical information is needed to make an informed determination. These concerns are particularly significant because the proposal applies broadly to covered outpatient drugs, extending beyond medications dispensed by a pharmacy to include complex therapies and treatments administered in clinic and outpatient hospital settings. Given the clinical complexity and operational considerations associated with these services, CMS should consider a more flexible timeframe that supports timely access to care while allowing Medicaid agencies to make accurate and clinically appropriate coverage determinations.

CMS Should Provide Technical Assistance and Further Operational Clarification

To support successful implementation of the proposed rule, Medicaid agencies identified several areas where additional technical assistance and clarification from CMS would be beneficial. Given the complexity of implementing these requirements alongside other ongoing federal and state and territory initiatives, NAMD members emphasized the importance of timely, practical implementation support. Areas of technical assistance needed include:

1) workforce and vendor readiness,
2) implementation guidance and training,
3) cross-state learning opportunities, and
4) clarification of key operational and technical questions related to compliance requirements.

Ahead of feedback on specific technical guidance, NAMD members expressed concern about the utility and usage of existing APIs. Medicaid agencies recommend that CMS assess and publish the usage of existing APIs to understand to what degree those existing APIs are meeting intended goals. Given that APIs are partnerships between multiple parties, understanding readiness and commitment from external partners is critical to prioritize the trade-offs of time investments, financial investment, and opportunity cost of an engineer developing an underutilized API within their Medicaid program. More broadly, knowing utilization trends would facilitate and co-create knowledge building with existing partners and potential partners who may be experiencing barriers to access. This approach from CMS would also facilitate more informed decision-making when implementing the following recommendations:

> First, **CMS should partner with vendors to ensure they are equipped to construct these changes within CMS' proposed timeframe.** One pathway is through partnerships and commitments with vendors, such as CMS' recent work to facilitate vendor procurement pledges to support the implementation of Medicaid community engagement requirements policy. This would help reduce waste by avoiding the historical phenomenon of "first dollar" spending on systems in each individual Medicaid program to effectuate identical federal requirements, a dynamic that CMS has helpfully begun to address.
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> Second, **CMS should support workforce capacity through virtual or in-person training and encourage vendor partnerships to provide training on the use of FHIR**. CMS could also facilitate cross-state collaboration and coordination on FHIR training efforts.
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> Third, **CMS should shift technical specifications and implementation details into sub-regulatory guidance wherever possible and pair these efforts with accompanying model open-source software.** This approach would allow CMS to provide more agile, regionally responsive policy direction as implementation experience accumulates, and reduces the risk of Medicaid agencies being held to regulatory requirements that may become impractical because of changing technology or market conditions. Sub-regulatory guidance should be developed in partnership with Medicaid agencies and issued well in advance of compliance deadlines to provide meaningful operational direction. Open-source model software could also be used to demonstrate the ability to meet requirements.

In addition, we urge CMS to develop or facilitate a Medicaid reference implementation for the Patient Access API and Payer-to-Payer API. A shared, open-source technical foundation provides Medicaid agencies with additional subject matter expertise on technology best practices. It also opens the door for state and territory subject matter experts to co-create with CMS and build infrastructure that is more resilient to current and future standards. This approach is consistent with CMS' existing software reuse policy, open-source software strategy, and its recent development of the Eligibility Made Easy (Emmy) tool for work and community engagement requirements implementation.

Lastly, **Medicaid agencies have identified a series of areas where they would benefit from additional clarification**. CMS should establish ongoing mechanisms for engagement with states and territories, including office hours, listening sessions, and regularly updated FAQs and supplemental guidance. These channels would allow states and territories to raise emerging questions, identify implementation barriers, and receive timely clarification as operational realities evolve.

NAMD would be happy to support these efforts by helping convene forums and facilitate information sharing among members. For example, NAMD regularly convenes Medicaid information technology leaders to discuss emerging policy and operational issues, share promising practices, and learn from innovative approaches implemented across states and territories. NAMD can also help connect members to existing technical assistance resources and federal forums, including opportunities to engage with the Systems Technical Advisory Group (S-TAG), to support successful implementation of interoperability initiatives.

Thank you for the opportunity to provide comments on this proposed rule. NAMD looks forward to continuing to work with CMS to improve interoperability and prior authorization processes, with the goal of streamlining care for Medicaid members.

Sincerely,

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Georgia Medicaid Director

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