June 15, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore MD 21244-8013

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

Dear Administrator Oz,

On behalf of our member medical group practices, the Medical Group Management Association (MGMA) appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) on the Notice of Proposed Rulemaking (proposed rule) for the *2026 Interoperability Standards and Prior Authorization for Drugs Proposed Rule* (CMS-0062-P). The proposed rule was published on the *Federal Register* on April 14, 2026, and builds on the *2024 CMS Interoperability and Prior Authorization Final Rule* (CMS-0057-F) and *CMS Interoperability and Patient Access Final Rule* (CMS-9115-F).

MGMA strongly supports CMS's outlined proposals to advance interoperability and improve prior authorization for prescription drugs, which, if implemented correctly, would help support patient care and improve medical group operations. Our comments provide further recommendations and clarifications to help CMS successfully achieve these objectives, including:

- **Ensuring successful health information technology implementation and readiness of standards** through real-world testing and by making investments, where needed, so that medical groups benefit from these policies without experiencing added burden, complexity, duplicative workflows, cost, or unnecessary delays.
- **Strengthening prior authorization timeliness** for drugs and non-drug items and services and accountability by enforcing shorter, meaningful decision timeframes tied to final determinations and ensuring safeguards that prevent delays in patient care.
- **Improving transparency and oversight** through more granular prior authorization reporting for drugs and non-drug items and services, including plan- and service-level data, detailed approval and denial rates, and centralized, accessible reporting, which will allow for meaningful analysis and policy changes.

With a membership of more than 60,000 medical practice administrators, executives, and leaders, MGMA represents more than 15,000 medical groups comprising more than 350,000 physicians. These groups range from small independent practices in remote and other underserved areas to large regional and national health systems that cover the full spectrum of physician specialties. Across the diverse representation of members, prior authorization is regularly cited as one of the top regulatory burdens.[1]

[1]Medical Group Management Association. MGMA 2026 Regulatory Burden Report. 2026. https://www.mgma.com/getkaiasset/8c7263b8-882d-4f6a-8d6c48180fba72c9/MGMA%202026%20Reg%20Burden%20Report%20.pdf

Medical group practices face a significant and uncompensated administrative workload for these unnecessary denials, and the greater harm is that many patients abandon efforts to obtain necessary care rather than navigate the appeal process after the initial denial. For prescription drugs in particular, MGMA members report a highly fragmented and inefficient process, where practices must repeatedly submit duplicative documentation, navigate inconsistent formularies, and engage in time-consuming peer-to-peer reviews simply to secure access to clinically appropriate therapies. Patients are often left waiting for days or weeks for medication approvals, or may go without treatment entirely, while practices' staff and providers spend significant time resolving denials. Not only do these unnecessary denials lead to delays in critical patient care and worsening health conditions, but they also create costly, burdensome inefficiencies in our healthcare system and shift financial and operational strain onto medical group practices.

If finalized, effective implementation of these electronic prior authorization policies should benefit patients by improving access to care and prescription drugs, while also helping medical group practices by reducing administrative burden and enhancing operational efficiencies. It also complements CMS's efforts to galvanize the insurance industry to voluntarily adopt prior authorization reform.[2] While these commitments represent an important step forward from health insurance companies, prior experience has demonstrated the importance of agency regulation to ensure meaningful, enforceable accountability. Notably, eight years after a similar 2018 industry consensus statement[3], physician-reported data show that key commitments remain largely unmet, with prior authorization burden persisting or worsening.[4] In a recent survey of MGMA members, 95 percent of practices said that prior authorization is a significant burden for their practice and 85 percent report that the burden of prior authorization has increased in just the last 12 months, since the pledge was made.[5] These findings demonstrate that voluntary commitments alone are insufficient, and meaningful progress depends on regulatory action from CMS, enhanced by the recommendations throughout this letter.

Section II. A. Interoperability Standards for Application Programming Interfaces (APIs) and Section II. B. Electronic Prior Authorization for Drugs

MGMA supports this pivotal move toward standards-based electronic prior authorization for drugs covered under medical and pharmacy benefits. If finalized, effective implementation of these electronic prior authorization policies should benefit patients by improving access to care and medications, while also helping medical groups by reducing administrative burden and enhancing operational efficiencies. CMS must ensure this transition is implemented in a manner that is feasible, workflow-integrated, secure, vendor-supported, and meaningfully reduces manual work rather than shifting new technical, financial, or duplicative operational responsibilities onto practices. Future implementation must not add digital complexity or cost.

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[2]Medical Group Management Association, "MGMA Statement on Health Plans' Commitment to Simplify Prior Authorization," June 23, 2025, https://www.mgma.com/press-statements/june-23-2025-mgma-statement-on-healthplans-commitment-to-simplify-prior-authorization. The pledge requires insurers to reduce the services needing prior authorization, provide 90-day continuity for existing authorizations during coverage transitions, improve denial and appeal explanations, expand real-time electronic prior authorization decisions, and implement standardized electronic systems that apply interoperability to prior authorization by 2027—extending key elements of the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F) to commercial and employer plans and ultimately affecting most Americans.

[3]Medical Group Management Association, "Consensus statement on improving the prior authorization process, 2018", https://www.mgma.com/getkaiasset/87f683d9-401c-4137-946b-761abe36c2f7/01.01.2018_PA-consensusstatement.pdf.a Medical Group Management Association, "Consensus statement on improving the prior authorization process, 2018", https://www.mgma.com/getkaiasset/87f683d9-401c-4137-946b-761abe36c2f7/01.01.2018_PA-consensusstatement.pdf.

[4]American Medical Association**.** *Prior authorization survey.* 2025. https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.

[5]MGMA, 2026 Regulatory Burden Report.

CMS is now proposing to require impacted payers to support electronic prior authorization of drugs and to update health information technology (health IT) standards. **We firmly believe now is the time for HHS to invest in successful implementation of standards, including the existing payer API mandates, with a focus on real-world testing involving medical groups to ensure readiness so that these policies work as intended in practice to improve patient care and operational efficiency. This is critical for the successful execution of finalized policies proposed in CMS-0062-P that add medical and pharmacy drugs to prior authorization**. CMS should provide meaningful, transparent implementation and testing updates of these proposed policies once finalized, alongside current requirements under CMS-0057-F.

Effective health IT implementation should be achievable and beneficial for practices of varying sizes and resources. Final policies must ensure sufficient testing, implementation-support, phased timelines, fallback processes, and accountability for payers and technology vendors. We encourage CMS to develop a phased, longer implementation timeline so that adequate real-world testing, technical assistance, and overall successful standard implementation can occur prior to enforcement. MGMA supports the goal of moving toward more automated, standards-based, and real-time prior authorization workflows. However, standard adoption alone will not guarantee burden-reduction for medical groups. If finalized, these proposals present opportunities to rethink workflows, improve patient experiences, reduce administrative waste, and better connect clinical and pharmacy data.

HHS should acknowledge and accommodate smaller and less-resourced medical groups that may continue to rely on payer portals or on vendors that do not yet support fully integrated, FHIR-enabled electronic prior authorization workflows.

- MGMA urges CMS to advance implementation policies, technical assistance, testing and readiness activities, and develop resources that equitably benefit practices of varying sizes and capabilities to implement existing Provider Access, Prior Authorization, and other API policies including the finalized policies and involved standards from this proposed rule.
- HHS should evaluate burden reduction from the provider perspective and ensure practices are not penalized for any payer, vendor, or clearinghouse immaturity. HHS evaluation activities should focus on each regulatory proposal based on whether it reduces burden at the point of care, decreases dependence on payer portals, supports faster patient access to therapies, and avoids duplicative or parallel administrative workflows.
- CMS should protect practices during standards transitions without holding them accountable for delays beyond their control and avoid policies that presume providers can independently absorb potential vendor delays, payer-by-payer variation, clearinghouse or electronic health record (EHR) system lack of readiness, or failed API performance.

Additionally, documentation requirement proposals should prioritize structured data reuse, minimize duplication, and enable integration and alignment across all involved clinical and administrative workflows and stages.

- MGMA encourages prioritizing structured data reuse and alignment across related administrative workflows, including claims, claims attachments, audits, and appeals where clinically and operationally appropriate, and ideally also for reporting, value-based care, and other use cases.
- CMS should promote alignment where feasible across workflows so that medical groups are not required to submit the same clinical information repeatedly in different formats or through different systems or to submit additional information with new standards capabilities in place. As

example, CMS should ensure the proposed use of the HL7 FHIR Clinical Data Exchange (CDeX) Implementation Guide for electronic prior authorization attachments does not result in added provider burden by enabling payers to potentially expand data requests.
- Electronic prior authorization coverage requirements discovery (CRD) and documentation template and rules (DTR) workflows should be integrated into practice and provider workflows and electronic health record systems without creating additional, separate portals.

MGMA also welcomes efforts to leverage DTR templates to support greater transparency, usability, and alignment of plan criteria. Over time, standardized DTR templates could help reduce burden if they support alignment with clinically appropriate guideline-based criteria and are implemented in workflows that are usable for medical groups.

Section II. C. Improving Communication and Decision Timeframes for Prior Authorization Decisions

CMS proposes that by October 1, 2027, Medicaid Fee-for-Service (FFS) programs, Medicaid managed care plans, and Children's Health Insurance Program (CHIP) entities would be required to issue decisions no later than 24 hours for expedited requests and 7 days for standard requests for drugs, and 72 hours for expedited requests for non-drug items and services. State CHIP FFS programs would specifically be required to notify providers of prior authorization decisions for covered prescription drugs within 24 hours of request receipt.

Qualified Health Plan (QHP) issuers on the Federally Facilitated Exchanges (FFEs) would also be required to provide prior authorization decisions as expeditiously as the enrollee's condition requires, but no later than 72 hours for standard requests and 24 hours for expedited requests for drugs. In addition, for non-drug items and services, CMS proposes that QHP issuers on the FFEs must provide notice of prior authorization decisions to providers within 7 calendar days for standard requests and within 72 hours for expedited requests. These policies would align QHPs on the FFEs issuer requirements, who were previously excluded from these standards, with those of other impacted payers set forth by CMS-0057-F, establishing more consistent alignment and reducing administrative complexity.

MGMA supports CMS's proposal to align decision timeframes for prior authorization for prescription drugs for Medicaid FFS, Medicaid Managed Care entities, and QHPs on the FFEs and we urge CMS to extend these same standards for Medicare Advantage plans as well. 90 percent of MGMA members have reported a shift to Medicare Advantage plans amongst their patients.[6] Enforcing consistent timeframes across these coverage types will help reduce administrative complexity, provider confusion, and results in more equitable access to timely treatment for patients.

While this represents an important step toward alignment across programs, MGMA believes these timeframes ultimately remain too long. When MGMA members were surveyed in January 2026, shortly following the implementation of January 1, 2026 decision timeframes set forth by CMS-0057-F for non-drug items and services, nearly eight in ten respondents either did not believe the prior authorization requirements would make an impact or are unsure they would, suggesting continued concern about whether the policy will result in meaningful change in practice.[7]

- MGMA believes that the electronic prior authorization and API requirements finalized in CMS-0057-F create the potential for faster prior authorization decisions as they are implemented by January 1, 2027, and urges CMS to enforce shorter decision timeframes. If fully implemented and

[6]MGMA, 2026 Regulatory Burden Report.
[7]MGMA, 2026 Regulatory Burden Report.

used effectively, these technologies could support decision timeframes for prescription drugs and non-drug items and services of 24 hours for urgent requests and 48 hours for standard requests for all impacted payers.

- MGMA urges CMS to clearly state that required timeframes must apply to final prior authorization decisions, not merely interim responses or requests for additional information. Without this clarification, plans could technically comply with decision deadlines by pended actions that delay care, undermining the rule's patient-access and burden-reduction goals. CMS should further establish that failure to issue a final decision within the required timeframe results in automatic approval of the request. This safeguard would promote compliance and prevent medical group practices from bearing the cost of payer delays through interrupted care and abandoned treatment. While MGMA recognizes that limited extensions may be necessary in certain circumstances, such extensions should be narrowly defined, time-limited, transparent, and treated as exceptions. Clear regulatory language ensuring timely, final determinations are essential to prevent loopholes and ensure that electronic prior authorization and interoperability reforms result in meaningful improvements for patients and providers.

As indicated in MGMA's comments when CMS-0057-F was proposed in 2023[8], MGMA remains concerned that medical group practices may still be expected to follow up with payers to obtain prior authorization status when required timelines are missed. The burden of enforcing compliance should not fall on physician practices, as this runs counter to the rule's purpose of automating prior authorization and improving efficiency.

- MGMA urges CMS to establish clear guardrails and an oversight framework to ensure payer compliance with decision timeframes, rather than shifting accountability to providers.

Proposed Changes to Publicly Reported Prior Authorization Metrics for Non-Drug Items and Services and Drugs for Impacted Payers

Under CMS-0057-F, impacted payers must annually report prior authorization metrics for non-drug items and services on their public websites. CMS now proposes to expand these requirements by requiring numeric counts in addition to percentages for certain existing metrics and by adding new prior authorization metrics. The new metrics add reporting on denials after extended review timelines and appeal outcomes, specifically tracking requests that remain denied after appeal and outcomes for expedited requests. These requirements would take effect on the final rule's effective date.

Reporting deadlines would vary by payer type. Medicare Advantage organizations, state Medicaid and CHIP FFS programs, and QHP issuers on the FFE would report by March 31 of the following year at the Medicare Advantage contract, state, or issuer level. Medicaid managed care plans and CHIP managed care entities would report within 90 days of the end of each rating period at both the program and plan levels.

In addition to the new and revised metrics for non-drug items and services, CMS is proposing to require impacted payers to annually report standard and expedited prior authorization metrics for drugs on their public websites as well. Impacted payers would be required to report in 2028 for the 2027 reporting period.

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[8]Medical Group Management Association, *MGMA Comments on Prior Authorization Interoperability*, March 13, 2023. https://www.mgma.com/advocacy-letters/march-13-2023-mgma-comments-on-interoperability-and-prior-authorization-proposed-rule-2.

MGMA appreciates CMS's proposal to expand prior authorization reporting by requiring numeric counts in addition to percentages, and to require plan-level reporting for Medicaid managed care and CHIP entities. We also support the addition of new metrics for non-drug items and services, particularly the number and percentage of requests that were denied after extended review or appeal. These new metric requirements will help reveal "hidden denials" by capturing how often requests are not approved on initial submission but instead require additional documentation, resubmission, or appeal. It could help to provide insight into how frequently approvals are achieved only after significant administrative effort from providers and other staff at medical group practices. However, absent service-level data, these metrics will still obscure where denials are most concentrated.

In addition to the lack of service-level reporting, most of these metrics, including those for Medicare Advantage plans, would continue to be reported at the aggregated contract level, which is too high-level to be actionable. In a recent survey, MGMA members cited Medicare Advantage as the most burdensome payer for obtaining prior authorization. Therefore, transparency is particularly important, especially as Medicare Advantage has grown to the point where over half of Medicare-eligible individuals are enrolled in a Medicare Advantage plan.[9] A single contract can contain many plans, and it is not easily identifiable how many or which plans the contracts include, making it difficult to conduct any comparisons of prior authorization burden for practices and patients alike.

As MGMA highlighted in its comments on the proposed rule for CMS-0057-F[10], and as demonstrated by impacted payer reporting by March 31, 2026, prior authorization data reported at an aggregated, contract level, and dispersed across individual payer websites, is often difficult to locate, inconsistently structured, and not comparable across plans, having limited analytical value for policymakers, medical group practices, and patients.[11] In their first year of reporting, payers reported overall high approval rates, but absent more granular data by service item and plan-level reporting, it was difficult to reconcile these results with what is happening on the ground with MGMA members. According to MGMA's recent survey, 95 percent of practices reported an increase in prior authorization burden over the past year, and prior authorization, particularly in Medicare Advantage, continues to rank among the top regulatory burdens facing medical groups. Nearly 40 percent of practices report employing three or more full-time administrative staff per physician just to manage prior authorization, denials, and other regulatory requirements.[12]

Independent analyses also point to concerning trends in denials. A 2024 Senate Homeland Security Committee report revealed that denial rates for post-acute care prior authorization requests rose dramatically in certain health insurance plans– from 8.7 percent in 2019 to 22.7 percent in 2022.[13] KFF also reported that Medicare Advantage insurers denied 6.4 percent of prior authorization requests in 2023, up from 5.7 percent in 2019.[14] High approval rates can coexist with rising denial rates because they reflect the overall averages across requests, while the number of requests, and denials in specific services could have increased significantly, translating to increased administrative burden on medical group practices and delayed care for certain subsets of patients.

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[9]MGMA, 2026 Regulatory Burden Report.
[10]Medical Group Management Association, MGMA Comments on Prior Authorization Interoperability, March 13, 2023.
[11]American Medical Association. *Letter to CMS Administrator Mehmet C. Oz re: CMS-0057-F Implementation.* May 22, 2026. https://searchlf.ama-assn.org/letter/documentDownload?uri=/unstructured/binary/letter/LETTERS/lfk.zip/5-22-26-Letter-to-Oz-re-CMS-0057-Implementation.pdf.
[12]MGMA, 2026 Regulatory Burden Report.
[13]Centers for Medicare & Medicaid Services. CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F). U.S. Department of Health and Human Services, 2024. https://www.cms.gov/.
[14]KFF. "Medicare Advantage Insurers Made Nearly 53 Million Prior Authorization Determinations in 2024." KFF, https://www.kff.org/medicare/medicare-advantage-insurers-made-nearly-53-million-prior-authorization-determinations-in-2024/.

- MGMA urges CMS to require more granular, plan and service-level reporting for all payers, including a comprehensive list of prescription drugs and non-drug items and services subject to prior authorization and both the percentage and number of requests approved and denied at initial determination, appeals outcomes, and decision time metrics, reported in the aggregate and categorized by each specific item and service.
- CMS should enable centralized reporting of payer data on their website, preventing further burden of navigating across different payer websites and reporting templates and making it easily accessible to stakeholders who are trying to gain actionable insight from these metrics.

As previously mentioned, in June 2025, over 60 of the nation's largest health insurers pledged to reform and reduce prior authorization, including by enhancing transparency and communication around prior authorization appeals and denials.[15] At present, current regulations around transparency requirements, and the self-reporting from the insurance companies in the pledge, fall short of truly realizing this commitment. Enhancing the transparency reporting requirements through current rulemaking can help build on the framework from these existing efforts.

Section II. F. Proposals to Require Impacted Payers to Report Payer API Endpoints and Associated Information

API Endpoints

MGMA supports CMS's proposals requiring impacted payers to report API endpoints and related information to CMS. A centralized, machine-readable and current source of payer API endpoint information will help EHRs, practice management systems, clearinghouses, and other vendors connect to payer APIs more efficiently and reduce duplicative implementation work. Endpoint reporting may also support transparency and lay groundwork for broader directory and endpoint modernization efforts to improve health care directory infrastructure. A listed endpoint is valuable to medical groups if the API is reliable, discoverable, timely (published soon after receipt), and secure.

- CMS must have a process to reconcile error-prone endpoints and ensure accuracy of this information with formal oversight and commit to a format for software access (such as a FHIR-enabled registry) to ensure the reported information is machine-readable and supports automated software access.

API Usage Metrics

MGMA supports API metrics that can improve accountability. CMS should ensure these metrics help to evaluate how interoperability works in practice, not simply whether APIs exist. **CMS should consider additional measures that help determine whether electronic prior authorization is replacing manual work, improving patient access, and reducing provider burden.** Reports of prior authorization metrics should capture the benefits of Coverage Requirements Discovery (CRD). CMS should consider metrics that assess the value of CRD, including whether access to accurate coverage and documentation requirements up front reduces avoidable prior authorization activity.

Proposed Standards and Implementation Specifications: Tables 3 and 12

- MGMA urges CMS to establish a clear and usable roadmap for implementation guide (IG) upgrades and version management. Medical groups and their vendors need predictable timelines,

[15]AHIP. "Health Plans Take Action to Simplify Prior Authorization." AHIP, https://www.ahip.org/news/press-releases/health-plans-take-action-to-simplify-prior-authorization.

backward compatibility where feasible, and sufficient notice before required version changes. Frequent or poorly coordinated IG updates could potentially increase costs and create instability for practices.

- MGMA urges CMS and ONC to advance end-to-end testing with providers, vendors, and payers, so that efficient workflows occur in practices of varying sizes and specialties. CMS can use version management, testing, and implementation monitoring to prevent unintended consequences and support practices without sufficient technical or financial capacity. Testing and implementation support focused on FHIR-based workflows for medical-benefit drugs and NCPDP- standards for pharmacy benefit drugs, combined with program-specific differences, will be critical to help ensure practices are not left navigating different workflows and standards complexity.

Section II.H. Modifications to HIPAA Standards Related to Prior Authorization

MGMA directionally supports HHS efforts to enable more integrated, FHIR-based prior authorization workflows. This includes the significant proposal to adopt, under HIPAA Administrative Simplification, certain HL7 FHIR standards and implementation specifications for certain prior authorization-related transactions, while preserving existing X12 (non-FHIR) standards for claims and other HIPAA transactions not addressed by this proposal.

We urge CMS to consider the true readiness and feasibility of a transition from existing X12-based prior authorization transaction workflows to FHIR-based standards for the specific transactions proposed. **We believe any finalized policies should be informed by robust testing, further stakeholder input, and evidence of FHIR implementation guide, real-world operational readiness**. If finalized as proposed, CMS must consider longer term HIPAA enforcement discretion to enable operational continuity during any transition from X12 to FHIR-based prior authorization transactions as many entities impacted by this proposal have not yet developed fully integrated FHIR-enabled workflows, vendor connectivity, or operational processes to support these transactions. We caution CMS about moving too rapidly without an appropriate on-ramp to adoption to avoid potentially destabilizing medical group operations.

It is important that CMS recognize that the administrative transaction ecosystem continues to rely heavily on X12, clearinghouses, EHRs, practice management systems, and revenue cycle vendors. We believe the scope and significance of these proposed policies, at minimum, necessitate a measured implementation strategy with extended enforcement discretion. A poorly sequenced replacement of existing X12 prior authorization workflows could disrupt practice operations, particularly where FHIR readiness is uneven across payers, EHRs, vendors, and practice settings. Any future transition from X12 to FHIR for these HIPAA transactions should not leave practices managing additional administrative systems, burdensome costs, payer-specific workarounds, or exposed to technical failures outside their control.

Prior Authorization in Medicare FFS

Although Medicare FFS is not an impacted payer in CMS–0062–P, CMS states its intention for the Medicare FFS program to be a market leader in electronic prior authorization. We are concerned about the potential expansion of prior authorization in Medicare FFS. Today, the program's relative lack of burdensome prior authorization requirements is a key benefit for both patients and providers.

The technical proposals to adopt FHIR APIs for certain electronic prior authorization transactions and attachments under HIPAA Administrative Simplification would apply to Medicare FFS. While we recognize standards alignment across payers as important, we do not support CMS's stated intent for the Medicare FFS program to lead in electronic prior authorization.

In January, the Center for Medicare and Medicaid Services Innovation (CMMI) launched the Wasteful and Inappropriate Service Reduction (WISeR) model, which expanded the use of prior authorization in Medicare FFS for 17 outpatient services in six states, and introduced a new, non-standardized approach that was inconsistent with federal regulations for prior authorization. Across each state and vendor, impacted practices have faced challenges with prior authorization workflows, response times, and inappropriate denials.

MGMA members in impacted states have indicated that WISeR participants, the vendors responsible for facilitating the prior authorization processes, do not consistently meet CMS's required 72-hour response timeframe, with some practices receiving responses that appear to be automated batch approvals. Denials remain frequent, necessitating a high volume of appeals. One practice reported approximately 30 percent of their 175 monthly prior authorization requests are denied, requiring substantial administrative follow-up. In several cases, denials appear to stem from AI review tools failing to locate information within submitted records, or from insufficient documentation determinations without clear guidance on what additional information is required.

A recent report from Washington state provides evidence that WISeR has resulted in significant delays and increased denials relative to Medicare FFS processes prior to the model's rollout. According to data collected from 16 hospitals, prior authorization response times frequently exceed CMS's 72-hour response timeframe, with providers reporting average turnaround times of 15–20 days for both routine and urgent requests, compared to one to three days prior to WISeR. These delays have caused patients to wait two to four times longer to receive medically necessary care, with procedures previously completed within approximately two weeks now taking four to eight weeks to move forward.[16]

These experiences with WISeR reinforce MGMA's concern that expanding prior authorization in Medicare FFS risks significantly increasing administrative burden for medical group practices and causes delays in patient care. Further, the model's reliance on third-party vendors and failure to follow existing prior authorization standards creates avoidable confusion, and significant technical barriers for medical group practices.

- We urge CMS to pause WISeR and any other efforts to expand prior authorization in Medicare FFS focus on existing regulatory requirements for interoperability and prior authorization for other federal payers, as laid out in CMS-0057-F and now in CMS–0062–P.

Requests for Information (RFIs)

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

MGMA appreciates CMS's focus on electronic event notifications and their role in supporting value-based care and care coordination. Admission, discharge, and transfer (ADT) notifications, along with other event-based alerts, can help medical groups improve transitions of care, reduce avoidable readmissions, and support timely follow up, particularly for patients with chronic conditions and/or those patients participating in accountable care arrangements and other value-based payment models.

MGMA supports standardized, actionable notifications that are integrated into existing physician workflows rather than creating new manual reporting requirements or duplicative administrative burden. Event notifications are most effective when they include timely, relevant clinical and

[16]Cantwell, M. (n.d.). *WISER snapshot report*. U.S. Senate. https://www.cantwell.senate.gov/imo/media/doc/wiser_snapshot_report1.pdf.

administrative information and when they can be delivered to the appropriate care team member consistent with the workflow practices of the medical group. Notifications should allow practices the flexibility to use dashboards, care managers, direct access via an electronic health record, or other workflow tools and approaches that fit their operations.

However, ADT adoption remains uneven. Many small and mid-sized practices depend on EHR vendor functionality, HIE participation, and/or payer or hospital connectivity to receive and act on notifications. Effective use can be limited by, for example, inconsistent patient matching, attribution challenges, incomplete provider directories, and costs associated with HIE participation. Practices outside large integrated systems often face the greatest barriers.

- CMS should prioritize interoperable, standards-based approaches that support data sharing across care coordination and administrative workflows while promoting data reuse and reducing redundant documentation. Federal policy should support notifications that are usable, affordable, and aligned with physician workflows as opposed to adding disconnected alerts or separate reporting obligations. HHS should recognize that notifications alone do not help to improve outcomes unless practices have the operational capacity and technology infrastructure to act on them. Additionally, ONC should maintain Direct Secure Messaging as a recognized pathway for ADT event notifications, with FHIR-based alternatives as feasible and ready in the future.

B. Health Care Resiliency/Cybersecurity

Medical groups view cybersecurity and health care resiliency as foundational to patient safety, uninterrupted care delivery, and their overall business operations. Despite federal requirements intended to help keep practices safe, ongoing and ever evolving cyber threats can increase risk exposure and strain practice resources. Many practices, especially small and independent ones, face significant challenges, including rising costs for cybersecurity tools, liability insurance, workforce training demands, and limited internal IT capacity.

MGMA data show that nearly three-quarters of practices increased cybersecurity spending in 2024, with continued investment into 2025[17], underscoring both prioritization and financial strain. MGMA members have described cybersecurity as a "never-ending" and "vicious" cycle of escalating threats and costs, with investments increasingly competing with workforce needs and salaries. **Overall, federal policies aimed at practice resiliency must ensure protections fit seamlessly into provider workflows, adapt to emerging threats, extend and account for necessary resources, and safeguard both care delivery and patient trust.**

Despite the resource challenges and frustrations many practices experience, medical groups continue investing in and strengthening cybersecurity and resilience strategies. Regardless, significant vulnerabilities persist, posing meaningful risk to care delivery and revenue cycle continuity. For practices dependent upon third-party vendors and clearinghouses for critical functions, there is added risk if these entities experience a cyberattack or disruption.

- MGMA urges HHS to ensure policies support operational continuity and safeguards to maintain care and the flow of administrative transactions and to consider all mechanisms within its

[17]Medical Group Management Association. *Where medical groups are putting new dollars in 2026.* https://www.mgma.com/mgma-stat/where-medical-groups-are-putting-new-dollars-in-2026.

authority to ensure continuity of financial and care operations for medical groups during major cyberattack events.

Medical groups may have limited practical ability to independently assess vendor cybersecurity practices. MGMA urges HHS to ensure accountability is appropriately shared across the ecosystem, including promoting transparency, baseline security practices, and continuity planning among vendors that support essential services. Further, security requirements should be balanced with the practical realities faced by medical groups, recognizing that new system updates, processes such as new audit and compliance requirements, and upstream changes impacting vendors can all impose significant costs. Federal policies should provide flexibility for medical groups in implementing cybersecurity measures while avoiding requirements that add complexity without improving patient outcomes.

As pertains to separate, proposed rulemaking involving certified health IT in ONC HTI-5 (*Health Data, Technology, and Interoperability: Deregulatory Actions to Unleash Prosperity*) and the proposed HIPAA Security Rule (*HIPAA Security Rule to Strengthen the Cybersecurity of Electronic Protected Health Information*), we reiterate here our earlier comments to HHS below as well as input on how to support overall resiliency.

- MGMA urges the HHS Office of the National Coordinator for Health IT (ONC), to retain the security certification requirements included at present in the current ONC Certification Program that can help medical groups rely on a baseline set of security capabilities that are relevant to, and supportive of, current HIPAA Security Rule implementation, without implying or guaranteeing HIPAA compliance.
- MGMA urges HHS to rescind its proposed regulatory changes to the HIPAA Security Rule that we caution is overly burdensome and threatening to the sustainability of medical groups.
- MGMA urges HHS to invest in improving resiliency and to target technical assistance and financial support for small and rural practices, promote best practices for workforce training and incident response, develop implementation guidance, prioritize scalable requirements, and advance sensible, feasible policies for medical groups that support both prevention and recovery while minimizing unnecessary administrative burden and supporting practical implementation.

D. Step Therapy

Step therapy, a type of prior authorization, requires patients to try insurer-preferred treatments before accessing the therapy their clinician prescribes. These requirements often delay or disrupt necessary treatment, undermine clinical decision making, and can result in worsened health outcomes, particularly for patients with complex or chronic conditions.

Beneficiaries in Medicare FFS are largely exempt from step therapy requirements, and those enrolled in Medicare Advantage plans were similarly protected until CMS formally reversed its prior prohibition on step therapy for Part B drugs and services in the *Medicare Advantage and Part D Drug Pricing Final Rule* (CMS-4180-F).[18] In doing so, CMS recognized that Medicare Advantage plans may apply step therapy to control the utilization of services but not create undue access barriers for beneficiaries. Since that reversal, the use of step therapy in Medicare Advantage has risen sharply, prompting MGMA and other organizations to call for an investigation by the HHS Office of Inspector General.[19]

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[18]Centers for Medicare & Medicaid Services. "Prior Authorization and Step Therapy for Part B Drugs in Medicare Advantage." Memorandum to Medicare Advantage Organizations. Aug. 7, 2018. https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/MA_Step_Therapy_HPMS_Memo_8_7_2018.pdf.

[19]Medical Group Management Association. *Request for HHS OIG study on the impacts of step therapy requirements*. August 4, 2025. https://www.mgma.com/getkaiasset/c46788e6-b9d9-4fdc-854a-e882b22808ef/STCoalitiontoHHS%20OIGreStepTherapy%20Oversight.pdf.

MGMA members report that step therapy protocols are often applied in ways that create confusion and delays, including unclear sequencing requirements, insufficient transparency about which therapies must be tried first, and limited guidance on how to document exceptions. Practices report that staff and providers must often go back through clinical notes to identify and re-document where a patient has previously "tried and failed" therapies in order to satisfy payer requirements, even when that information has already been documented in the patient record.

MGMA members also report that step therapy requirements often trigger duplicative prior authorization processes across different formulations of the same treatment. For example, requiring a new prior authorization when shifting from an infusion to an injectable version of a drug, even when the therapy itself remains clinically consistent. In addition, payers may impose rigid dosage caps over defined time periods (e.g., three- or six-month intervals), requiring practices to seek additional prior authorization when dosing must be adjusted based on patient weight or evolving clinical needs. These requirements create unnecessary administrative duplication, delay appropriate care, and disrupt continuity of treatment for patients.

While MGMA supports improvements in interoperability and data exchange for prior authorization, we believe these reforms alone cannot fix the pervasive misuse of step therapy requirements, particularly in Medicare Advantage plans for Part B Drugs. Improved technology may streamline the process, but it does not address the underlying issue of inappropriate or excessive step therapy requirements.

- MGMA urges CMS to reinstate step therapy prohibition in Medicare Advantage plans for Part B drugs.
- CMS should implement guardrails to ensure step therapy does not create undue barriers to medically necessary care. Such guardrails should include clear and transparent exception processes; baseline timelines for decisions (e.g., 48 hours for standard and 24 hours for expedited requests); and recognition of clinically appropriate exceptions, including prior treatment failure, contraindications or risk of harm, and situations where delays could result in disease progression or irreversible consequences.
- To strengthen continuity-of-care protections, MGMA recommends establishing a minimum 365-day requirement for payers to honor prior step therapy approvals.
- To improve transparency reporting, CMS should consider including additional metrics for step therapy drugs in the prior authorization reporting requirements. For example:
    i. Publication of drugs requiring prior authorization could include a separate category for drugs that are subject to step therapy specifically.
    ii. Number of steps per therapy (average).
    iii. Time from first-line trial to approval of requested drug (average).

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

MGMA appreciates CMS's attention to prior authorization for laboratory testing and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), which presents unique challenges for medical group practices. Because virtually all medical group practice providers order laboratory tests as part of routine patient care, these challenges affect medical group practices, not just those that perform laboratory services on-site. The ordering provider at the medical group practice determines that a service is medically necessary, while the rendering provider at the laboratory performs the service. MGMA members report added confusion, delays, and duplicative administrative work attributed to the involvement of these entities in completing prior authorization requests.

Laboratory services are ordered at high volume and are often integral to same-day clinical decision making. Therefore, prior authorization requirements for laboratory tests create distinct operational and patient care challenges compared to other drug and non-drug service items. Since laboratory tests are often ordered during an office visit and performed immediately, practices typically cannot obtain prior authorization determinations in advance. As a result, patients need to return for additional visits or delays completing other ordered tests, particularly when they prefer to have all laboratory tests drawn at once. In some cases, when prior authorization requirements are unclear or determinations are delayed, practices may be forced to discard collected specimens or repeat testing, resulting in wasted specimens, inefficiencies, and delays in diagnosis and treatment.

In addition, MGMA members report actively managing pending authorizations for scheduled laboratory services, often requiring staff to continuously monitor upcoming appointments and reschedule patients if prior authorization decisions are still outstanding. When tests are performed without a prior authorization determination, practices may face restrictions on billing patients if coverage is later denied, requiring the use of payer-specific liability notices. The existence of multiple, payer-specific liability notice forms, and the risk that an incorrect form invalidates patient billing, adds further administrative burden and financial risk for medical group practices. These challenges are exacerbated by multiple payer-specific documentation requirements, which require staff to make real-time determinations about coverage, appropriate forms, and required information, often under high-volume conditions, taking up more time than the draw itself. This becomes more disruptive when medical group practices do not have a laboratory on-site and need to coordinate with sometimes multiple laboratories or render providers for prior authorization requests for various patients.

- MGMA urges CMS to establish policies that allow flexibility for whether the ordering provider or rendering provider submits the prior authorization request and ensure that prior authorizations follow the service rather than a specific provider. This would help reduce administrative complexity and streamline coordination across care settings and delays caused by inconsistent payer requirements regarding who must submit requests.
- To reflect the realities of high-volume, same-day laboratory workflows and to prevent delays, duplicate testing, wasted specimens, and unnecessary administrative burden, MGMA recommends that CMS require real-time decision making for prior authorization for laboratory tests prior to specimen collection, while also ensuring plans accept post-collection submissions when real-time determinations are not feasible.

Conclusion

MGMA appreciates the opportunity to provide input on the proposed rule and urges the agency to consider implementing our recommendations, which should better protect patients and medical group practices alike. As the voice for the country's medical group practices, MGMA remains committed to promoting policies that enhance the ability of our members to provide high-quality, cost-effective care to the millions of patients they serve routinely. Should you have any questions, please contact Hannah Grow at hgrow@mgma.org or 202-640-1231.

Sincerely,

/s/

Anders Gilberg, Senior Vice President, Government Affairs