

June 15, 2026

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

**RE: CMS-0062-P; Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability Standards and Prior Authorization for Drugs**

***Submitted electronically via regulations.gov.***

Dear Administrator Oz,

The National Rural Health Association (NRHA) is pleased to offer comments on CMS' Interoperability Standards and Prior Authorization for Drugs proposed rule. NRHA thanks CMS for its work towards achieving interoperability and increasing transparency and beneficiary engagement in prior authorization. We are pleased to see the strides that CMS and commercial insurers have made in the last year towards making prior authorization a more patient- and provider-friendly practice.<sup>1</sup> NRHA is looking forward to CMS building upon this momentum through the rulemaking at hand.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals, long-term care providers, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

## **II. Provisions of the Proposed Rule**

NRHA broadly supports CMS' proposed provisions that would reduce burdens for rural providers and improve patients' experiences with the healthcare system. Rural residents are disproportionately covered by the impacted payers in this rule. Medicaid and CHIP cover approximately one-fifth of rural adults and almost half of rural children.<sup>2</sup> As such, rural providers and patients stand to benefit most from improving prior authorization. As such NRHA is pleased to see the proposed changes to prior authorization, including imposing timeframes for deciding upon prior authorization requests for drugs. NRHA members often report that patients assume it is the rural

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<sup>1</sup> Press Release, UnitedHealthcare, UnitedHealthcare expands support for rural health care communities (Apr. 20, 2026), <https://www.uhc.com/news-articles/newsroom/rural-health-commitment>; U.S. Health Insurers Advance Measures to Standardize Prior Authorization Requirements, REUTERS (Apr. 24, 2026), <https://www.reuters.com/legal/litigation/us-health-insurers-advance-measures-standardize-prior-authorization-requirements-2026-04-24/>; Press Release, AHIP, Health Plans Take Action to Simplify Prior Authorization (June 23, 2025), <https://www.ahip.org/news/press-releases/health-plans-take-action-to-simplify-prior-authorization>.

<sup>2</sup>

hospital or clinic that is denying coverage for an item, service, or drug through the prior authorization process and thus become frustrated with their provider. More transparency and more detailed information sharing from payers is critical to improve rural patient perceptions and interactions with the healthcare system.

## **B. Electronic Prior Authorization for Drugs.**

### *3. Proposed Requirement To Incorporate Drugs Covered Under a Medical Benefit Into the Prior Authorization API for All Impacted Payers.*

NRHA supports CMS' proposal to require Medicaid and CHIP fee-for-service (FFS), Medicaid and CHIP managed care plans, and Qualified Health Plan (QHP) issuers on the federal Marketplaces to support electronic prior authorization for drugs. This process will help move towards a standardized prior authorization process that is easier for both rural patients and providers to navigate and understand.

### *4. Proposed Requirement To Support the NCPDP SCRIPT Standard for Prior Authorization for State Medicaid and CHIP Fee-for-Service Programs, Medicaid Managed Care Plans, CHIP Managed Care Entities, and Qualified Health Plan Issuers on the Federally-facilitated Exchanges.*

NRHA also supports CMS' proposal to require impacted payers to use electronic prior authorization for drugs covered under a pharmacy benefit. Put together with the proposal in Section 3, above, payers would have to support electronic prior authorization for all drugs that require prior authorization. This would simplify and streamline prior authorization for rural providers, which is often cited as one of the top administrative burdens for rural providers and in turn can delay needed care for patients.<sup>3</sup>

### *6. Proposed Requirement To Support the NCPDP Real-Time Prescription Benefit Standard for State Medicaid and CHIP Fee-for-Service Programs, Medicaid Managed Care Plans, CHIP Managed Care Entities, and Qualified Health Plan Issuers on the Federally-facilitated Exchanges.*

CMS proposes to require impacted payers to adopt the NCPDP Real-Time Prescription Benefit Standard (RTPB), which MA Part D sponsors are already mandated to adopt by January 1, 2027. NCPDP RTPB allows for the real-time exchange of patient data, such as feedback on whether a drug requires prior authorization and out-of-pocket costs for the patient. NRHA supports the proposal to require impacted payers, other than MA organizations, to support the NCPDP RTPB to help expedite rural patients' access to medications.

## **C. Improving Communications and Decision Timeframes for Prior Authorization.**

### *2. Proposed Requirement To Include a Specific Reason for Denial in Response to Prior Authorization Requests for All Drugs.*

CMS' proposal to make payers provide a specific reason for denying a prior authorization request is another important step towards better transparency and communication for rural providers and patients. CMS notes that the specific reason for denying a request should include a specific reason that helps the provider understand why the request was denied and what actions must be taken to

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<sup>3</sup> AM. HOSP. ASS'N., *The Growing Impact of Medicare Advantage on Rural Hospitals Across America* (Feb. 2025), 2 <https://www.aha.org/system/files/media/file/2025/02/growing-impact-of-medicare-advantage-on-rural-hospitals.pdf> ("Delays, denials, and excessive prior authorization from certain MA plans can hinder timely care: 81% of rural clinicians report quality reductions due to insurer requirements").

resubmit or appeal the decision. Examples include information about the specific plan coverage criteria on which the denial is based or why documentation did not support the medication or prescription.

However, CMS does not provide more guidance on the level of specificity in the proposed regulatory text despite providing examples in the preamble of the proposed rule.<sup>4</sup> NRHA urges CMS to adopt stronger requirements for a specific reason for an adverse determination in the regulatory text. A payer could use “lack of medical necessity” as a reason, which does not provide enough information to the provider and patient to take further action, like appealing the decision or providing more supporting documentation to prove medical necessity. Equipping rural providers and patients with the most information possible will help to inform a provider’s decision-making process and ensure that action taken is in the best interest of the patient.

NRHA suggests that CMS make payers provide more granular information on denials, for example, indicating what particular part of the beneficiary’s supporting documentation led the payer to believe that the item or service was not medically necessary. Additionally, NRHA would like to see a broader definition of denial or adverse determination used. While a course of treatment may be approved, the payer may have denied the length of time requested by the provider. This should be included as a denial and the payer should explain why, for example, the timeframe for treatment was not approved for the full request.

### *3. Prior Authorization Decision Timeframes.*

#### b. Prior Authorization Decision Timeframes for Qualified Health Plan Issuers on the Federally-facilitated Exchanges.

The 2024 CMS Interoperability and Prior Authorization final rule required impacted payers, except QHPs on the Federal Marketplaces, to make decisions on prior authorization requests on non-drug items and services within 7 days for standard requests and 72 hours for urgent requests. NRHA supports the proposal to apply this timeframe to QHPs. Aligning regulations for QHPs with other impacted payers will help to minimize administrative burden for rural providers as they can expect decisions on requests within the same or similar timeframes across many patients, regardless of payer.

#### c. Prior Authorization Decision Timeframes for Drugs That Are Not Covered Outpatient Drugs for State Medicaid Fee-for-Service Programs, Medicaid Managed Care Plans, and CHIP Managed Care Entities.

NRHA supports the proposed alignment of prior authorization timeframe requirements for non-covered outpatient drugs with the timeframe for non-drug items and services. In other words, Medicaid programs would be required to respond to prior authorization requests for non-covered outpatient drugs within 7 calendar days for standard requests and 72 hours for urgent requests. Non-covered outpatient drugs may include drugs administered in the inpatient setting as part of a bundle of non-drug items and services. CMS reasons that these drugs should be subject to the same timeframe as the items and services that they are incident to and that the drugs and non-drug items and services are likely submitted together as one request.

#### d. Prior Authorization Decision Timeframes for Prescription Drugs for State CHIP Fee-for-Service Programs.

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<sup>4</sup> 42 C.F.R. §§ 431.80(a)(2), 438.210(c)(3), 457.732(a)(2); 4 C.F.R. § 156.223(a)(2).

CMS proposes to shorten the timeframe for CHIP FFS programs to respond to prior authorization requests for drugs for which federal financial participation (FFP) is available. The timeframe would shrink to no later than 24 hours after receiving the prior authorization request in order to align with existing Medicaid FFS requirements for outpatient drugs. NRHA urges CMS to consider applying the 24-hour timeframe for all payers, including MA organizations and QHPs in future rulemaking.

#### *6. Proposed Changes to Publicly Reported Prior Authorization Metrics for Non-Drug Items and Services for Impacted Payers.*

In the 2024 CMS Interoperability and Prior Authorization final rule, CMS finalized requirements for payers to report the percentage of prior authorizations that were approved, denied, approved after appeal, and approved after the timeframe for review was extended. CMS proposes to amend these metrics to include specific numeric counts. NRHA is pleased to see this change as we advocated for payers to report more granular information in our comment on the proposed Interoperability and Prior Authorization rule.<sup>5</sup> Reporting the total number of requests for certain metrics will provide a fuller picture of how prior authorization requests are handled and decided upon by payers than percentages alone.

NRHA supports the proposed new metrics for standard requests: Request denied after timeframe for review was extended and request denied after appeal. NRHA also supports the new metrics for expedited requests: Request approved only after timeframe for review was extended; request approved only after appeal; request denied after timeframe for review was extended; and request denied after appeal.

#### *7. Proposed Requirement To Publicly Report Prior Authorization Metrics for Drugs for Impacted Payers.*

CMS proposes to add new prior authorization metrics on drugs for impacted payers. These metrics largely mirror those used for non-drug items and services and will similarly improve transparency in the prior authorization process.

CMS would require impacted payers to report this information on their public websites. NRHA suggests that CMS also house this data in one aggregated place on its website so that it is easy for enrollees to find and compare. Additionally, older, rural adults with lower literacy, including technology literacy, will likely not see the benefits of this information posted online even though they stand to gain the most from knowing and understanding this information. NRHA asks that CMS consider how the prior authorization metrics could be reported to enrollees in other formats, such as through opting in to annual mailed reports.

Finally, NRHA urges CMS to take action against payers that report a certain percentage of prior authorization denials. When a payer reports that over a given percentage, for example 85%, of all requests for a certain item or service are denied, this should trigger an immediate inquiry into the payer and its practices.

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<sup>5</sup> See <https://www.ruralhealth.us/getmedia/3414da74-d728-495d-a4b8-dd3d40589707/Advancing-Interoperability-and-PA-comment-3-13-23.pdf>.



Thank you for the chance to offer comments on this proposed rule and for your consideration of our comments. We look forward to continuing our work together to ensure our mutual goal of improving quality and access to care for rural residents. If you would like additional information, please contact Carrie Cochran-McClain at [ccoehran@ruralhealth.us](mailto:ccoehran@ruralhealth.us).

Sincerely,

A handwritten signature in black ink, appearing to read "Alan Morgan", with a long, sweeping horizontal stroke extending to the right.

Alan Morgan  
Chief Executive Officer  
National Rural Health Association