ABHW
Advancing Health Care Policy for
Mental Health & Substance Use Disorders

June 15, 2026

Dr. Mehmet Oz
Centers for Medicare & Medicaid Services
United States Department of Health and Human Services
Attention: CMS-9898-NC
P.O. Box 8016, Baltimore, MD 21244-8016

Assistant Secretary Thomas Keane, M.D.
Office of the National Coordinator for Health Information Technology (ONC)
U.S. Department of Health and Human Services
330 C Street, SW, Floor 7
Washington, DC 20201

Re: **Interoperability Standards & Prior Authorization (PA) for Drugs (0062-P)**

Dear Dr. Oz and Assistant Secretary Keane:

The Association for Behavioral Health and Wellness (ABHW) appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) on Interoperability Standards and Prior Authorization for Drugs Proposed Rule.

ABHW is the national voice for payers managing behavioral health insurance benefits. Our member companies provide coverage to 200 million people in both the public and private sectors to treat mental health (MH), substance use disorders (SUDs), and other behaviors that impact health and wellness. Our organization aims to increase access, drive integration, support prevention, raise awareness, reduce stigma, and advance evidence-based treatment and quality outcomes. Furthermore, our policy work aims to ensure that physical and behavioral health care is integrated and coordinated. ABHW is committed to ensuring better outcomes for whole-person care for all individuals and communities. We believe access to comprehensive, evidence-based MH and SUD services is critical to enhancing patients' health and overall well-being.

ABHW supports CMS's goal of improving timely access to medications and streamlining the prior authorization process and making electronic prior authorization more available.

1. Improving Communications and Decision Timeframes for Prior Authorizations

CMS proposes to revise prior authorization decision timeframes across Medicare Advantage (MA), Medicaid, CHIP, and Marketplace plans, generally aligning drug prior authorization requests with the timelines established under the Interoperability and Prior Authorization Rule (CMS-0057-F). This proposed rule would shorten standard review timeframes in several programs, including reducing Medicaid, CHIP, and Marketplace standard drug prior authorization decisions to 24 hours or 7 calendar days, depending on the program, while

establishing expedited review timeframes of 72 hours for most drug requests and 24 hours for expedited requests in Marketplace plans.

The proposed turnaround times do not adequately account for the clinical and operational complexity of pharmacy prior authorizations. Unlike many medical prior authorization requests, pharmacy reviews often involve dosage and quantity limits, step therapy requirements, site-of-care considerations, diagnosis-specific criteria, and coordination across pharmacy and medical benefits. Many requests also require additional clinical documentation, such as chart notes, laboratory results, treatment history, or confirmation of prior medication use.

As a result of these shortened turnaround times, health plans may be forced to deny incomplete requests rather than make clinically appropriate coverage determinations. This could increase denials, appeals, and administrative burden for providers and plans, ultimately delaying patient access to care, an outcome that is inconsistent with CMS's goals.

In addition, implementing these requirements will require significant system changes, workflow redesign, and technology investments across health plans, pharmacy benefit managers, and provider-facing platforms. Given the volume and complexity of pharmacy prior authorization requests, operationalizing these requirements will be challenging.

ABHW recommends that CMS allow health plans to pause applicable turnaround time requirements when additional clinically necessary information has been requested but not yet received from the provider. Allowing plans to "stop the clock" in these circumstances would support more accurate and clinically appropriate determinations, reduce avoidable denials and appeals, and better align the policy with CMS's goal of improving patient access to needed medications.

Exception for Bundled Payments

Some affected payers, including behavioral health (BH) Medicaid Managed Care Organizations (MCOs), manage only behavioral health and substance use disorder (SUD) benefits and do not administer medical or pharmacy benefits. These plans often cover Medication-Assisted Treatment (MAT), such as methadone treatment, through bundled case rates that include the medication, administration of the medication, counseling, assessments, laboratory services, and other related treatment components. It is unclear how these bundled services should be categorized under the proposed rule. Separating the medication component from the associated behavioral health services would be operationally challenging and may create significant reporting and documentation burdens.

We recommend that bundled behavioral health and SUD treatment services that include medications be exempt from the proposed 24-hour turnaround time for drugs and instead be subject to the prior authorization timeliness standards for

non-drug items and services (7 calendar days standard / 72 hours expedited). Because these bundled services include a range of clinical services beyond the medication itself, CMS should clarify in the final rule that they are processed through the Prior Authorization API for non-drug items and services, rather than through the National Council for Prescription Drug Programs (NCPDP) standards used for pharmacy benefits. In addition, applying the non-drug authorization timeframes would provide plans with sufficient time to verify the credentials of out-of-network providers seeking to furnish these services. Credentialing reviews are often necessary to ensure providers meet state Medicaid program requirements and cannot reasonably be completed within 24 hours. The proposed drug-related turnaround time does not account for these operational requirements and could create compliance challenges while undermining program integrity safeguards.

As an example, Louisiana Medicaid reimburses opioid treatment programs (OTPs) through a bundled payment for HCPCS code H0020 that includes a broad range of services, such as methadone medication dosing and dispensing, counseling, urine drug testing, physician examinations, evaluation and management visits, care coordination, and laboratory services. Given the multiple clinical and administrative components included within a single bundled payment, it is unclear how the proposed prior authorization turnaround time requirements would be operationalized and measured.

2. Reporting Usage Metrics for Patient Access, Provider Access, Payer-to-Payer, and Prior Authorization APIs

ABHW has concerns about the scope of the proposed Payer-to-Payer API requirements and the potential for broad sharing of sensitive health information between health plans. While we support efforts to improve care coordination and reduce administrative burden, the exchange of structured and unstructured clinical documentation may result in the disclosure of information that is not necessary to support continuity of care, particularly when there is no active transition between health plans. This concern is especially significant for behavioral health information, which may be subject to heightened privacy protections under 42 CFR Part 2 (Part 2) that has unique confidentiality requirements.

We encourage CMS to limit payer-to-payer data exchange to situations in which a member is actively transitioning between health plans and the information is needed to support continuity of care. CMS should also require explicit member authorization before information is shared and ensure that exchanged data are limited to the minimum necessary to support care coordination and coverage determinations. Rather than requiring the transmission of full clinical documentation, CMS should adopt a more targeted approach that balances interoperability goals with patient privacy and confidentiality protections.

3. RFI on Streamlining Step Therapy Through Technology and Data Sharing

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ABHW appreciates CMS's interest in exploring how interoperability and data sharing can improve the efficiency and transparency of utilization management processes, including step therapy. Enhanced access to historical claims data could be particularly valuable when individuals transition to a new health plan, reducing the need for providers to resubmit records and helping avoid unnecessary repetition of previously completed therapies.

Many health plans already use automated adjudication tools and historical claims lookback capabilities to support step therapy administration. In addition, step therapy criteria appropriately vary across payers based on differences in clinical policies, formularies, and benefit designs. Existing transition-of-care processes, including grandfathering and override mechanisms, also help ensure continuity of care for established therapies.

ABHW recommends that CMS support the targeted use of historical claims data to inform step therapy decisions, particularly for new members, while preserving payer flexibility to apply plan-specific clinical criteria. CMS should avoid policies that would require health plans to automatically accept step therapy determinations made by other payers.

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ABHW is ready to support CMS and ONC in efforts to modernize health IT infrastructure, improve interoperability, and reduce unnecessary administrative burden.

We look forward to working with you to advance interoperability and improve behavioral health outcomes nationwide. Please contact Kathryn Cohen, Senior Director of Regulatory Affairs at cohen@abhw.org, if you have any questions.

Sincerely,

Deborah H. Witchey

Debbie Witchey, MHA
President and CE