August 28, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

The Honorable Thomas Keane, M.D.
National Coordinator for Health Information Technology
Office of the National Coordinator for Health Information Technology
U.S. Department of Health and Human Services
330 C Street SW
Washington, DC 20201

RE: Progress Update of CMS-0057 Implementation and Request for CMS and ONC Support

Dear Administrator Dr. Oz and National Coordinator Keane:

Regional, nonprofit health plans are making significant investments to meet upcoming interoperability requirements and are committed to the benefits these requirements will bring to patients. **To ensure successful implementation and true interoperability, the Alliance of Community Health Plans (ACHP) urges CMS and ONC to establish a defined implementation and validation period following the January 1, 2027 compliance date for the CMS Interoperability and Prior Authorization Final Rule.** This period should be accompanied by appropriate enforcement discretion for health plans actively testing APIs and exchanges, remediating defects and demonstrating good faith compliance. We greatly appreciated the opportunity to discuss these implementation considerations with ONC officials on July 31 and the engagement reinforced the need for CMS and ONC to collaborate to support successful, safe and scalable implementation.

ACHP represents the nation's best local, nonprofit health plans, providing high-quality coverage to tens of millions of Americans in 46 states and D.C. ACHP is the only national organization advancing a unique partnership model of coverage and care that fosters a truly competitive market. We share your goal to improve the exchange of health care data in our system. ACHP member companies are working in earnest to implement Prior Authorization, Payer-to-Payer and Provider Access APIs, in accordance with the CMS-0057 final rule requirements.

Health plans face the reality that while they will have compliant processes in 2027, this will not equate to operational readiness. CMS and ONC must contend with the time needed to enable operationalization of all these API processes at scale. Compliant and live, but untested, interoperable processes will only lead to more fragmentation and provider frustration. In addition, inadequately tested interoperability processes increase the likelihood of inaccurate, incomplete or misdirected information being exchanged, creating risks to patient care and privacy. ***A 12-month "good faith" implementation and validation period to fully operationalize — not just technically comply — with the CMS-0057 final rule requirements would substantially improve health plans' ability to safely and thoroughly test new interoperable processes.***

We ask that CMS and ONC exercise enforcement discretion for plans that are demonstrating active exchange testing and defect remediation.

There are several considerations outside health plan control that impact operationalization of CMS-0057. First, CMS and ONC cannot underestimate the impact of the payer-to-payer API and the volume of data that health plans anticipate flowing through the API following go-live. Payers are likely to receive a compressed, high-volume set of requests within the first seven days of going live. ACHP member companies have significant concerns that processes will not have been sufficiently and appropriately tested and validated before critical and sensitive data is exchanged. Second, payer vendors are overwhelmed and no longer accepting new contracts and electronic medical records are not prepared. As a result, some payers are behind in building the necessary API infrastructure. Additionally, many EMRs are unaware of their role in the ecosystem and are not proactively testing ePA APIs. The short supply of affordable and appropriate API implementation partners and their backlog for current clients means that many payers will not have enough time to adequately test the APIs before the January 1, 2027 compliance date. In addition, because most EMR systems have yet or are unequipped to adapt to the operational shift that CMS-0057 requires, payers are unable to engage in proactive, robust testing with their provider partners.

ACHP Recommendations for Successful 2027 Implementation

ACHP member companies are making significant investments to meet the January 1, 2027 interoperability requirements and remain committed to ensuring these policies achieve their intended benefits for patients and providers. Successful implementation will require continued partnership among CMS, ONC and industry as stakeholders move from technical compliance to testing and operationalizing new capabilities at scale.

ACHP offers recommendations to support community-based, nonprofit health plans through compliance and operationalization. We also recommend CMS and ONC establish ongoing forums with payers, providers, EHR developers and other stakeholders to identify implementation challenges, share emerging best practices and collaboratively address issues as the interoperability ecosystem matures.

1. **ACHP requests CMS provide a good-faith implementation and validation period.** ACHP urges CMS and ONC to pair the January 1, 2027 compliance date with a 12-month good-faith validation period with enforcement discretion for plans demonstrating active exchange testing and defect remediation.

   During this period, health plans will be technically compliant with the CMS-0057 requirements while continuing to make critical progress that focuses on identifying and resolving real-world issues. CMS should establish clear expectations for demonstrating good-faith compliance, which includes participation in testing pilots and programs. A good faith implementation and validation period would preserve the January 1 compliance date while recognizing that successful interoperability depends on more than functioning APIs. This approach would also significantly minimize risk to consumers and health plans as sensitive information flows through new infrastructure.

2. **ACHP requests CMS provide targeted flexibility for payer-to-payer exchange during the first year.** We urge CMS to provide first-year flexibility for the Payer-to-Payer API, which should include

additional timing flexibility for requesting information for newly enrolled members and responding to requests during the initial implementation period.

The Payer-to-Payer requirements present an immediate challenge as the current timing requirements could result in significant beneficiary data exchange volume at precisely the point when payers are beginning production operations and identifying real-world challenges or defects. CMS-0057 determines that payers must obtain consent and make requests for new enrollee data within one week of coverage and the responding plan must provide data within one business day, regardless if the Payer-to-Payer API is tested or not.

There are also scarce resources to help payers test these APIs. There is currently no endpoint directory, patient matching standard or peer testing rails in place. Payers are facing substantial and legally-significant operational considerations, including how to structure consent management workflows and address requests for sensitive health information. Without clarification, any delay or choice not to comply with Payer-to-Payer data requests could expose payers to potential information blocking violations.

3. **ACHP recommends ONC create a real-world, end-to-end testing framework.** ONC should build upon its existing conformance testing capabilities by establishing a coordinated framework for real-world, end-to-end testing among payers, providers, electronic health record developers and other trading partners. Conformance testing exists today, in draft, against simulators, but it cannot fully demonstrate whether an API exchange will work when connected live. ONC should:

    - Establish testing regional cohorts that allow organizations to test against real counterparties before and during implementation.
    - Facilitate supervised go-live with shared error reporting and defined fallback rules for the first 90 days.
    - Publish test endpoints and participate in 2026 Connectathon tracks before payers go live.
    - Define, schedule and referee these steps before January 2027, so every plan tests the same way, against the same bar.
    - For ePA, publish scripted end-to-end scenarios and pass criteria for the Coverage Requirements Discovery (CRD), Documentation Templates and Rules (DTR) and Prior Authorization Support (PAS) workflows by Q4 2026. These should include details such as the 72-hour and 7-calendar-day turnaround timeframes measured across systems, DTR executed against realistic chart data, an explicit delegated-vendor scenario and trading partners declaring and testing their operating mode (all-FHIR or X12-translation) before go-live.
    - For ePA, extend federal test scenarios through the systems that make the determination, with delegated decisions surfacing PAS on the plan's timeframes and a specific denial reason for every response.

4. **CMS should require the CRD Workflow to include the servicing provider field and support clear determination of a complete prior authorization request.** CMS and ONC should also require the CRD workflow to include the servicing provider field. Including the servicing provider is important to the utility and integrity of the authorization process. Without this information, plans may be unable to fully assess whether prior authorization requirements apply, validate relevant coverage or network requirements or appropriately evaluate the request. The omission may also

create program integrity and fraud risks by limiting plans' ability to identify the provider that will actually furnish the authorized service.

ACHP also requests further guidance on prior authorization turnaround timeframes. Recent guidance indicated that the turnaround "clock" starts when an impacted payer receives a prior authorization request with all information and documentation requested. However, the guidance seems to assume that a CRD check always precedes PAS in the ePA workflow which may not always be the case depending on provider behavior. There is nothing in the FHIR workflow that explicitly prevents a provider from bypassing the CRD. In such a scenario, the provider is either 'guessing' or using prior CRD information to submit the request. This opens additional potential scenarios where payers need to request seemingly "additional' information from providers because the CRD wasn't executed first and questions remain on the guidance for timing. These real-world variances in provider workflow make our recommendation for 2027 to focus on testing and validation critical to work through these types of scenarios. This guidance should also more broadly address turnaround timeframe requirements when not submitted electronically.

5. **ONC should accelerate EHR readiness and provider-payer testing.** ACHP urges ONC to use its certification and convening authorities to ensure EHR developers understand their role in making electronic prior authorization operational and are prepared to test with payer trading partners. Recent guidance from ONC addressed EHR electronic prior authorization timeframes but did not create an expectation around implementation timing. Provider adoption and EHR readiness remain uneven despite plan progress. ONC should provide EHR developers with clear implementation expectations, practical use cases and workflow examples demonstrating how ePA should function within the EHR.

   ONC should also encourage EHR developers to make test endpoints available and participate in payer-provider testing before broad production use. Successful implementation will require a closed feedback loop in which providers can initiate ePA within their existing workflows and receive meaningful status and decision information from health plans.

6. **CMS and ONC must address consent management and member matching.** ACHP urges CMS and ONC to provide guidance and testing resources addressing consent management and member matching, two operational functions that will be critical to reliable data exchange under the CMS-0057 requirements.

   For consent management, health plans must establish and operationalize different consent processes across the interoperability requirements, including obtaining and managing member consent for Payer-to-Payer exchange and honoring member preferences for Provider Access. CMS and ONC should develop model consent scenarios and testing use cases that clarify how consent should be communicated, validated and maintained throughout an exchange. CMS and ONC should also provide plain-language model materials that plans may use to educate members about their choices and how those choices affect the exchange of their health information.

   For member matching, a technically successful API transaction does not necessarily demonstrate that the correct member has been identified or that the information received can be confidently associated with that individual. CMS and ONC should establish clear expectations for testing member matching as part of Payer-to-Payer and other applicable interoperability workflows and

identify privacy-protective approaches that allow trading partners to validate matching using sufficiently realistic, production-representative data. Testing guidance should address both successful matches and common failure scenarios so organizations can identify and remediate matching issues before they result in inaccurate data exchange. ACHP acknowledges the DaVinci PDex Test Kit begins to address this, though we encourage a robust emphasis and flexibility to allow for this testing in 2027.

We look forward to partnering with the Administration to support implementation of the CMS-0057 requirements and appreciate the ongoing dialogue to support nonprofit, regional health plans. Please contact Ginny Whitman, Associate Director of Public Policy, at vwhitman@achp.org with any questions or to discuss our recommendations further.

Regards,

Michael Bagel

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ACHP