AAFP
AMERICAN ACADEMY of FAMILY PHYSICIANS

September 23, 2026

Mr. Aaron Blackshire
Office of Acquisition and Grants Management
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: CMS Medicaid Enterprise Systems (MES) IT Standards RFI

Dear Mr. Blackshire:

On behalf of the American Academy of Family Physicians (AAFP), representing 124,500 family physicians and medical students nationwide, I write in response to the Centers for Medicare and Medicaid Services' (CMS) request for information, *Medicaid Enterprise Systems (MES) IT Standards*. The AAFP appreciates the Department's desire and intent to improve interoperability, reduce fragmentation, promote modular modernization, and advance standards-based exchange of health information across Medicaid programs. Family physicians care for millions of Medicaid patients and are directly affected by the effectiveness of health information exchanges (HIEs), administrative workflows, privacy protections, and interoperability infrastructure that support coordinated care.

The AAFP believes health information technology (IT) should facilitate efficient, secure, and meaningful information exchange while minimizing administrative burden and supporting high-quality patient care. We offer the following recommendations regarding interoperability standards, privacy protections, standards governance, technical assistance, and long-term modernization strategy.

Section B: Questions for State Medicaid Agencies

Although the questions in this section are directed primarily to state Medicaid agencies, the AAFP offers the following recommendations from the perspective of family physicians and primary care practices that exchange information with Medicaid agencies, managed care organizations, HIEs, and other participants in the Medicaid technology ecosystem. We encourage CMS to consider the downstream effects of state standards and implementation decisions on clinical workflows, administrative burden, and patient care.

SA-2 Which industry standards (e.g., HL7 FHIR, NIST frameworks, X12) are currently underutilized in your MES but could drive significant cost savings or improvements in beneficiary outcomes if more widely adopted?

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The AAFP believes that HL7 FHIR-based APIs remain underutilized at the level of consistent, production-ready implementation. CMS should pair adoption requirements with standardized onboarding, consistent authentication and authorization, transparent performance and versioning expectations, predictable access timelines, bidirectional exchange capabilities, and production-level testing environments. CMS should also preserve reliable existing exchange mechanisms, including Consolidated Clinical Document Architecture (C-CDA)-based exchange where it remains operationally necessary, until FHIR-based alternatives have demonstrated equivalent readiness in real-world settings.

While many standards already exist, inconsistent implementation by health systems, payers, technology developers, laboratories, and state agencies continues to limit true interoperability. **CMS should prioritize consistent implementation, conformance testing, and operational interoperability alongside standards adoption to ensure exchanged data is timely, actionable, and integrated into clinical workflows**. Broader adoption of consistently implemented FHIR-based exchange has the potential to reduce duplicative interfaces, decrease manual data retrieval and reconciliation activities, improve care coordination, and support more timely access to clinically relevant information.

SA-3 How can CMS establish technical standards that are specific enough to ensure federal compliance and interoperability, yet flexible enough to accommodate your state's unique policy requirements and legacy system constraints?

The AAFP strongly supports national interoperability standards that establish consistent expectations while preserving implementation flexibility. We urge CMS to focus on defining common data models, interoperability requirements, security expectations, and exchange outcomes rather than prescribing highly specific technical implementations. Outcome-based requirements encourage innovation while supporting interoperability goals.

The AAFP cautions against requirements that lock states into static technical architectures or products that may become outdated as standards evolve. Federal standards should support modular modernization, continuous improvement, and future innovation while minimizing unnecessary implementation burden. Successful modernization requires balancing consistency with flexibility and recognizing variation in organizational readiness and technical infrastructure. This flexibility should apply to system architecture and implementation pathways, while preserving consistent national data, exchange, conformance, and security requirements.

SA-4 What specific types of federal Technical Assistance (TA) (e.g., reference architectures, pre-certified code repositories, implementation playbooks) would most effectively accelerate your state's adoption of new IT standards?

The AAFP encourages CMS to prioritize implementation support in parallel with standards development. Technical assistance should include implementation playbooks, reference architectures, testing environments, conformance validation tools, implementation guides, and publicly available best practices. Federal technical assistance should emphasize practical implementation, interoperability testing, workforce support, and user-centered deployment approaches.

We urge CMS to particularly focus on supporting organizations with limited implementation capacity, including small, independent, rural, safety-net, and underserved practices. Technical assistance should be paired with financial support where appropriate and delivered through concise, actionable resources. A centralized CMS repository containing version-controlled implementation guides, test cases, and plain-language summaries would further accelerate adoption and promote consistency across stakeholders.

SA-11 Data Elements: What specific data elements are currently absent, inconsistently defined, or non-standardized across MES and how do these gaps impede interoperability and data sharing within states, across state lines, and with federal reporting systems, such as T-MSIS? Please describe any known root causes, impacted use cases, and any existing or proposed remediation efforts.

The AAFP believes many interoperability barriers stem from data that are inconsistently defined, exchanged, or integrated rather than from a complete absence of available standards. Family physicians frequently encounter challenges involving referral status information, admission and discharge notifications, laboratory and imaging results, medication information, patient attribution data, provider directory information, consent directives, and other necessary information to support care coordination and transitions of care.

These gaps contribute to fragmented care coordination, increased administrative burden, duplicative clinical activities, and delayed decision-making. Root causes include inconsistent data definitions, variable implementation of common standards, differences in payer and state requirements, incomplete data provenance, and limited integration of exchanged information into clinical workflows. These inconsistencies impact referrals, transitions of care, medication reconciliation, patient attribution, quality measurement, and coordination across state lines. They may also reduce the comparability and reliability of data used for federal reporting. The AAFP encourages

CMS to prioritize harmonization of data definitions and strengthen implementation guidance to promote consistent use of nationally recognized standards across systems and organizations. Additionally, CMS can help mitigate these barriers through nationally aligned conformance testing, common validation rules, clear provenance requirements, and structured feedback mechanisms that allow data submitters and originating practices to identify and correct errors.

SE-2 How can CMS best structure a governance model for its standards program that allows for agile updates and versions while maintaining stability for state and vendor planning cycles?

The AAFP supports a transparent governance model that balances innovation with predictability, including clear processes for standards updates, stakeholder engagement, version management, implementation timelines, and retirement of obsolete requirements. Stakeholders should have visibility into future standards roadmaps and sufficient time to plan for implementation.

We encourage CMS to publish a standards roadmap that distinguishes development, pilot, production, maintenance, and retirement stages. Each update should include a defined transition window, version-support period, deprecation policy, conformance-testing plan, and process for addressing implementation defects. The AAFP also encourages CMS to avoid regulatory approaches that permanently tie requirements to specific implementation guides or standards versions. Governance frameworks should support orderly evolution of standards while maintaining interoperability and minimizing disruption.

SE-3 What strategies should CMS employ to harmonize its MES-specific standards with broader HHS and ONC interoperability rules to create a more unified health IT ecosystem?

The AAFP strongly encourages CMS to align MES standards with broader federal interoperability initiatives rather than creating Medicaid-specific technical requirements whenever nationally recognized standards already exist. States, physicians, payers, public health agencies, and technology developers should not be required to implement separate interoperability frameworks for Medicaid programs and the broader health care system. Alignment with ONC policies, certification requirements, and interoperability standards will reduce duplication, lower implementation costs, and accelerate adoption across the health care ecosystem.

CMS should prioritize harmonization around nationally adopted standards and frameworks, including HL7 FHIR and Trusted Exchange Framework and Common

Agreement (TEFCA)-aligned exchange approaches, and other federally recognized implementation guides. This alignment should complement existing exchange mechanisms and operate consistently with federal information blocking requirements. CMS should also evaluate whether MES use cases involving attribution, quality reporting, and payer-generated data require capabilities not currently addressed through TEFCA-based exchange.

The AAFP further encourages ongoing collaboration among CMS, ONC, CDC, FDA, and other federal partners to ensure future standards development proceeds in a coordinated manner. Family physicians and other care providers should experience a single, coherent interoperability environment rather than navigating multiple overlapping and potentially conflicting federal requirements. Successful interoperability depends not only on standards adoption but also on consistent implementation across programs, agencies, and stakeholders.

SE-4 Based on your experience with other large-scale standardization efforts (in healthcare or other industries), what are the most common pitfalls CMS should seek to avoid in its MES IT Standards Program?

The AAFP offers the following recommendations to CMS to help facilitate health IT modernization efforts. Ultimately, we believe CMS should prioritize outcomes, usability, interoperability, and adoption rather than compliance with static technical specifications.

- End-users must be involved throughout standards development, testing, implementation, and refinement. Physicians, care teams, state agencies, patients, and operational users should help shape standards from the beginning rather than after implementation.
- Meaningful real-world testing should be required before widespread implementation of standards requirements. Testing should occur across diverse environments, including rural, underserved, and resource-constrained settings.
- Rigid regulatory requirements tied to specific "dot" versions of standards should be avoided. Standards evolve rapidly, and regulations should support adoption of current, mature versions without requiring repeated rulemaking whenever minor updates occur.

SE-5 How can CMS design its reporting and analytics strategy to efficiently collect data that minimizes the administrative burden on states and vendors while providing a clear picture of the financial and clinical impact of standardization?

The AAFP strongly recommends that CMS design its reporting and analytics strategy around the principle of "collect once, use many times." Reporting requirements should prioritize automated collection of data already generated through operational systems and should avoid creating new manual reporting obligations for states, vendors, physicians, or other stakeholders. The value of any reporting program must be balanced against the administrative burden required to generate, validate, and submit data.

CMS should leverage existing transaction data, interoperability metrics, quality reporting infrastructure, and operational system performance measures whenever feasible. Reporting mechanisms should emphasize standardized data collection approaches and maximize reuse of existing data sources rather than requiring separate reporting processes. Where possible, CMS should align MES reporting requirements with existing federal interoperability measurement programs to reduce duplication and create a more comprehensive understanding of performance.

The AAFP also recommends that CMS focus measurement efforts on outcomes rather than process compliance alone. Reporting should evaluate whether standardization efforts improve timely information exchange, reduce duplicate administrative activities, support care coordination, improve patient experiences, enhance system interoperability, and reduce implementation costs. Measures that focus exclusively on technical compliance may not accurately reflect whether standards are generating meaningful operational or clinical benefits.

Each reporting element should have a clearly defined purpose and collect only data necessary to fulfill that purpose. States, vendors, and affected practices should have an opportunity to validate submitted data and resulting analyses. Performance reports should disclose methods, data limitations, and underlying definitions, and they should provide sufficient detail for stakeholders to identify and resolve data-quality issues.

Finally, CMS should make reporting results transparent and actionable by publishing standardized, understandable performance information that can inform future policy improvements. Reporting should help stakeholders identify barriers, implementation challenges, and successful practices rather than simply documenting compliance status.

SE-6 Cross-Agency Interoperability and Coordination: What are the most critical data standards, sources, and systems needed to bridge the gap between Medicaid Enterprise Systems and broader public health registries and sources (e.g., CDC, state health information exchanges, behavioral health, human and social service data)?

The AAFP supports a comprehensive approach to interoperability that connects Medicaid Enterprise Systems with the broader ecosystem supporting patient care, public health, and community services. Family physicians routinely coordinate care across numerous settings and organizations, yet critical information often remains fragmented across independent systems that were not designed to communicate effectively with one another.

CMS should prioritize nationally recognized interoperability standards that support consistent, scalable exchange of clinically relevant information across public health agencies, HIEs, laboratories, behavioral health providers, social service organizations, and other entities involved in patient care. This includes HL7 FHIR-based exchange, standardized terminology and code sets, implementation guides, and trusted network approaches that reduce the need for custom interfaces. Medicaid interoperability requirements should align with broader federal interoperability frameworks whenever possible to reduce duplication and implementation burden while supporting timely exchange of admission, discharge, and transfer notifications; laboratory and imaging results; immunization and medication data; care management and referral information; and other data necessary for longitudinal, coordinated care. Improving connectivity across these environments has the potential to strengthen care coordination, improve patient experiences, and reduce duplication of effort.

To support these goals, CMS should encourage participation in HIEs and other shared interoperability infrastructure that reduces reliance on costly point-to-point integrations and supports information sharing across organizational boundaries.

SE-7 Consent & Privacy: As data sharing increases via FHIR and other APIs, what emerging standards for patient consent management and data segmentation for privacy (e.g., 42 CFR Part 2) should CMS prioritize?

The AAFP strongly supports efforts to improve interoperability while preserving patient privacy, confidentiality, trust, and patient control over sensitive health information. As data sharing increases through FHIR-based exchange, APIs, and other interoperability mechanisms, CMS should prioritize consent and privacy frameworks that are interoperable, scalable, and understandable to patients and physicians alike.

The AAFP encourages CMS to prioritize consent-management and data-segmentation approaches that support standardized representation of patient preferences, portability of consent information across systems, consistent application of privacy protections, and interoperability across organizational boundaries. Any emerging standards should be evaluated based on their ability to support clinically

appropriate information sharing, protect sensitive information, minimize workflow burden, and function consistently across diverse care settings.

Particular attention should be given to privacy protections involving sensitive information, such as substance use disorder treatment records governed by 42 CFR Part 2. Privacy protections must preserve patient trust without unnecessarily impeding clinically appropriate information sharing. Inconsistent implementation of consent and privacy requirements across systems can create uncertainty for patients and providers and may unintentionally hinder care coordination, whereas a consistent nationwide approach can help reduce these challenges.

The AAFP recognizes that patient consent management and data segmentation standards remain an evolving area of interoperability. CMS should work collaboratively with ONC, standards-development organizations, patients, physicians, technology developers, and privacy experts to evaluate emerging approaches through pilot programs and real-world testing before broad implementation requirements are established.

Conclusion

As CMS advances the MES IT Standards Program, the AAFP encourages the agency to prioritize user-centered design, real-world testing, implementation support, flexible standards governance, and alignment with broader federal interoperability initiatives. We look forward to continued collaboration with CMS as this effort moves forward. For more information or questions, please contact Mandi Neff, Senior Strategist, Regulatory and Policy, at mneff2@aafp.org.

Sincerely,

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Board Chair
American Academy of Family Physicians