June 15, 2026

The Honorable Robert Kennedy, Jr.
Secretary Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

The Honorable Dr. Mehmet Oz
Administrator Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: 2026 CMS Interoperability Standards and Prior Authorization for Drugs proposed rule (CMS-0062-P).

Dear Secretary Kennedy and Administrator Oz:

Thank you for the opportunity to submit comments on Interoperability Standards and Prior Authorization for Drugs Proposed Rule. We greatly appreciate the Centers for Medicare and Medicaid Services' (CMS) ongoing efforts to improve patient access to essential services and treatments.

The undersigned organizations represent millions of patients and consumers facing serious, acute and chronic health conditions across the country, including individuals who rely on the patient protections provided under the Affordable Care Act (ACA). Our organizations have a unique perspective on what patients need to prevent disease, cure illness and manage chronic health conditions. Our breadth

enables us to draw upon a wealth of knowledge and expertise that can be an invaluable resource in this discussion.

In March of 2017, our organizations came together to form the Partnership to Protect Coverage. Together, we agreed upon three overarching principles[1] to guide any work to reform and improve the nation's healthcare system. These principles state that: (1) healthcare should be accessible, meaning that coverage should be easy to understand and not pose a barrier to care; (2) healthcare should be affordable, enabling patients to access the treatments they need to live healthy and productive lives; and (3) healthcare must be adequate, meaning healthcare coverage should cover treatments patients need, including all the services in the essential health benefit (EHB) package.

Prior authorization remains a major challenge for patients and an onerous process for providers, diverting valuable resources away from direct care and delaying access to needed services and treatment. Furthermore, improper prior authorization denials and prolonged response times cause delays and/or abandonment of necessary health care services, treatment, and medications.[2] Our organizations are pleased to see the administration is continuing efforts to modernize the prior authorization process. We offer the following comments on specific provisions in the proposed rule, and recommendations for additional policies the agency can implement to improve the patient health care experience.

Extending Electronic Prior Authorization Standards to Prescription Drugs

Prescription drugs are often a key component of care for individuals with chronic health conditions who are prescribed complex drug regimens which need to be managed to ensure they are best suited for the individual and to avoid drug interactions. Continuing to exclude prescription drugs from electronic prior authorization standards will result in a significant burden to providers and patients who must manage multiple systems in order to ensure that the patient has access to medically appropriate treatments. Our organizations therefore strongly support the proposal to extend prior authorization application programming interface (API) requirements to prescription drugs, regardless of whether they are covered under a plan's medical or pharmacy benefit. CMS should also require real-time identification of the applicable benefit pathway and greater consistency in terminology, documentation requirements, and workflows across medical-benefit and pharmacy-benefit drugs. Patients and providers should not experience delays because a request was routed incorrectly or because responsibility for the authorization is unclear.

However, inclusion of prescription drugs in electronic prior authorization standards alone will not fully address longstanding challenges patients face in accessing medications. Electronic modernization should improve the timeliness and appropriateness of coverage decisions, not simply accelerate existing utilization-management practices. CMS should ensure that automated tools do not result in inappropriate denials or replace meaningful clinical review. Denials involving complex treatment decisions should be reviewed by an appropriately qualified clinician. CMS should also monitor denial and overturn rates to identify patterns that may indicate inappropriate utilization-management practices.

[1] https://www.protectcoverage.org/ppc-consensus-healthcare-reform-principles

[2] Ashley Kirzinger, Julian Montalvo III, and Liz Hamel "KFF Health Tracking Poll: Prior Authorizations Rank as Public's Biggest Burden When Getting Health Care," KFF. February 2026. Accessed at: https://www.kff.org/public-opinion/kff-health-tracking-poll-prior-authorizations-rank-as-publics-biggest-burden-when-getting-health-care/

Many people with chronic health conditions take the same medications for decades, yet still face "prior" authorization to continue taking these medications. Enrollees and physicians consistently report yearly or "surprise" prior authorization requirements for medications that the enrollee is already taking. Enrollees often only discover a new prior authorization requirement when they contact the pharmacy for a refill, risking a gap in care. Such gaps in care can lead to an exacerbation of symptoms or avoidable emergency department visits. CMS should establish guardrails to prevent unnecessary repeat prior authorization for medications, including prohibiting reauthorization for patients stable on long-term therapies, requiring approvals to remain valid for the duration of treatment, and preventing new prior authorization requirements from being imposed mid-course without continuity protections. Continuity-of-care protections should also apply when an enrollee changes plans or coverage types. CMS should require plans to honor existing approvals for an appropriate transition period and ensure that relevant authorization history is transferred between payers so that patients are not required to restart authorization, documentation, or appeals processes unnecessarily. Where applicable, plans should also honor prior step-therapy exceptions and avoid requiring patients to repeat therapies that were previously ineffective or inappropriate.

Extending Electronic Prior Authorization Standards to Small Group Market

Our organizations also strongly support the proposal to extend electronic prior authorization standards to insurers selling plans to small employers buying coverage in the federally facilitated Small Business Health Options Program (FF-SHOP). As CMS notes in the proposed rule, all insurers that offer small group market QHPs on the FF-SHOPs also offer individual market QHPs on the FFM. The burden on FF-SHOP insurers would therefore be minimal, since they are already required to implement the policies for their individual market QHPs and the benefit to patients who obtain their coverage through a SHOP plan would be substantial. We also encourage CMS to continue exploring opportunities to promote more consistent prior authorization protections across coverage markets. Patients should not face substantially different processes, timelines, or continuity-of-care protections based solely on the type of coverage they hold.

New Timeframe Requirements for QHP Issuers to Notify Providers

Our organizations appreciate CMS requiring QHP issuers to respond to prior authorization requests for non-drug items and services in shorter timeframes than currently apply, consistent with those that apply to other payers, that is, no later than 7 days for standard requests and no later than 72 hours for expedited requests. However, as we noted in our comments on the 2024 proposed rule, we expect the efficiencies created by the automated process to make shorter timeframes possible. Specifically, we recommend that standard requests should be resolved within 72 hours and expedited requests within 24 hours. Individuals with chronic illness are frequently harmed by unnecessary delays in receiving medical treatments.

CMS additionally proposes that insurers may extend the timeframes to notify the requesting provider of a prior authorization decision by up to 14 calendar days under certain circumstances. Our organizations recommend that extensions be limited to 168 hours (the equivalent of 7 days). CMS should also require that patients and providers receive a notice of extension when an insurer requests one and the specific basis for the extension.

With regard to timeframes for QHP issuers to respond to prior authorization requests for prescription drugs, we urge CMS to require insurers to respond within 24 hours in all cases, rather than the proposed timeframes of no later than 72 hours for standard requests and 24 hours for expedited requests. This

would align the timeframes for QHP enrollees with those that apply to Medicaid and Children's Health Insurance Program (CHIP) plans.

Additionally, CMS should require that prior authorization be valid for the duration of treatment and/or set limits on the possible frequency of prior authorization requirements. Individuals with stable diagnoses and long-term treatment needs should not have to renew prior authorization on, for example, a monthly basis. This is a waste of resources for enrollees and providers, and sometimes leads to treatment gaps that are avoidable. CMS should also explicitly extend these protections to ensure continuity of care when individuals switch plans, such that existing prior authorizations remain valid for a reasonable transition period and do not require unnecessary reauthorization that could disrupt ongoing treatment.

Finally, to ensure that applicable timelines are meaningful and enforceable, we recommend that a failure by the responsible entity to issue a determination within the prescribed timeframe to be treated as a "deemed denial," thereby triggering beneficiary's right to appeal. Without such consequences, timelines risk being aspirational rather than binding. This framework would preserve procedural protections for beneficiaries by enabling timely escalation, while still maintaining the integrity of the review process.

Reporting API Usage Metrics

Our organizations support CMS's expansion of required API usage metrics and believe the data will be beneficial to learning how APIs are being used by providers and payers. CMS should collect disaggregated data by provider type, plan, organizational size, and geographic regions. Even if this data is not shared publicly, as CMS has proposed, disaggregating data will allow CMS to identify disparities in patient access to health data.

However, we strongly urge CMS to make API usage data publicly available and to post it routinely—at least annually—for various stakeholders to access. Publication of this data would benefit patients, policymakers, and other stakeholders with an interest in API usage and help inform efforts to increase use by providers or patients, or take action on other trends identified from the data.

Updated Website Reporting

Our organizations strongly support the additional requirements for reporting on prior authorization metrics, and we appreciate that CMS has proposed to extend these requirements to prescription drug prior authorization requests. The newly proposed requirement to report the total number of prior authorization requests and outcomes, combined with the reported percentages, will allow patients, researchers, and policymakers to understand the prevalence and likelihood of approvals, denials, and appeals for standard, expedited, and extended-timeframe requests.

Despite these advancements, the current reporting requirements mask key information about the populations impacted by prior authorization. CMS should require that reporting data be disaggregated by factors including service type, provider type, diagnosis, geography, income, disability, gender, race and ethnicity, and age. It is important for our patients and organizations to know where prior authorization requests are occurring, for what health conditions, and to which patients.

A significant barrier to accessing prior authorization reporting is the lack of consistency in website location, publication format, and terminology.[3] We encourage CMS to standardize where data are displayed on insurer websites and to standardize the file type and layout of prior authorization reports so that patients, policymakers, and other stakeholders can more easily find and analyze published data. Standardization would also allow for easier comparison across health plans, states, insurers, and coverage programs. CMS should also consider creating a centralized, searchable public dashboard so that patients, providers, researchers, and policymakers can more easily compare prior authorization practices across plans and coverage programs.

CMS should also require reporting on measures that more directly reflect the patient experience, including overturn rates, the frequency of repeat prior authorization requests, expedited-review outcomes, authorization outcomes following plan transitions, and, where feasible, the time between submission of a request and receipt of the prescribed treatment. Reporting should also capture step-therapy-related delays and outcomes. These measures would help patients, providers, advocates, and policymakers evaluate whether prior authorization practices are delaying or disrupting access to care.

Strengthen Prior Authorization Determination Explanations

We appreciate that in the 2024 Interoperability rule, CMS required that all prior authorization determinations–those conducted by electronic portals, email, fax, or telephone–include a specific reason for denied prior authorization decisions. We urge CMS to further strengthen these requirements by requiring greater specificity in denial determinations.

Denial determinations should provide sufficient detail into the rationale for the decision to enable patients and providers to take action. For example, denials due to missing supporting documentation should clearly stipulate the necessary documents for proper review. Denials based on "medical necessity" could cover a wide range of potential factors. States, plans, and QHP insurers should be obligated to provide a more granular response than "failure to establish medical necessity." CMS should require insurers to explicitly state the coverage policy or clinical criteria standard used to determine a denial, and provide information on covered alternatives. This information would better inform patients and providers of their next steps.

Denial notices should also be written in plain language and include standardized instructions for requesting reconsideration or filing an appeal, including applicable timelines, deadlines, and clear next steps. Patients and providers should receive notice at the same time. CMS should also require appropriate language-access and accessibility standards so that patients and caregivers can understand the decision and take timely action.

Request For Information: Laboratory Tests and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Items (DMEPOS)

Our organizations are pleased to see CMS is considering how prior authorization requirements for laboratory tests and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items impact patients and what changes could be made to improve patient outcomes.

[3] Kaye Pestaina, "Insurers' Prior Authorization Data Offers Little Insight Into What Gets Approved or Denied," KFF. April 2026. Accessed at https://www.kff.org/quick-insights/insurers-prior-authorization-data-offers-little-insight-into-what-gets-approved-or-denied/

Delays in laboratory testing due to prior authorization requirements can stall notice of a patient's health status, impede medical diagnoses, and postpone the next steps in treatment planning. CMS should ensure that patients have a clear understanding of the materials required for their prior authorization requests, including knowledge of whether a laboratory is in-network or out-of-network. CMS should ensure that providers and laboratories receive timely updates on prior authorization requests regardless of a lab's in-network or out-of-network status.

Similarly, prior authorization can create barriers for patients in need of medical equipment, prosthetics, orthotics, and mobility devices, hindering their ability to maintain independence. Patients seeking to attain DMEPOS are often denied when an insurer deems a device medically unnecessary. Due to individual needs and the specificity of prosthetics and other devices, CMS should require states, plans, and QHP issuers to clearly articulate the standard used to determine medical necessity and provide detailed information on how to navigate appeals.

Encouraging Provider Adoption of APIs

For patients to receive the most from the 2020, 2024, and proposed 2026 Interoperability rules, providers must have the technological systems necessary to support electronic prior authorization and APIs. CMS's proposal to collect Provider Access API usage data will provide greater insight into how widely electronic prior authorization is being adopted.

Recent data shows that many providers and provider organizations have not adopted electronic prior authorization systems. While 90 percent of medical plans have reported starting to implement required APIs by the January 1, 2027, deadline, providers are significantly further behind, with only 33 percent indicating that they are likely to implement the Provider Access API.[4] Providers identify limited funding, lack of internal expertise, and challenges coordinating with vendors and health plans as barriers to implementation.[5]

We encourage CMS to explore ways to facilitate greater uptake of API use among providers by, for example, looking at the successful effort to boost provider adoption of the electronic generation of prescriptions (e-prescribing) and electronic health record (EHR) systems.[6,7] CMS should also considering using the recently announced Electronic Prior Authorization Acceleration initiative to develop pilot programs specifically designed to educate medical practices, especially small and medium-sized organizations, and provide guidance on developing, implementing, and operating new technological systems.[8]

Conclusion

[4] "Interoperability and Prior Authorization Survey: Jan/Feb '25, Oct '25 and Feb '26 Results," WEDI. March 2026. Accessed at: https://files.constantcontact.com/cc5af31a201/19d6312d-b5c5-438e-bdd2-b504f724eb4e.pdf

[5] Ibid.

[6] Seth Joseph, et al., "E-Prescribing Adoption And Use Increased Substantially Following The Start Of A Federal Incentive Program," Health Affairs. July 2013. Accessed at https://doi.org/10.1377/hlthaff.2012.1197

[7] Clemens Scott Kruse et al., "Adoption Factors of the Electronic Health Record: A Systematic Review" JMIR Med Inform 2016;4(2):e19. Accessed at: https://medinform.jmir.org/2016/2/e19

[8] "CMS Announces Early Adopters to Advance Solutions for Electronic Prior Authorization, Accelerating Momentum Ahead of 2027 Requirements," enters for Medicare & Medicaid Services. May 13, 2026. Accessed at: https://www.cms.gov/newsroom/press-releases/cms-announces-early-adopters-advance-solutions-electronic-prior-authorization-accelerating-momentum

Thank you for considering this input on the prior authorization proposed rule. Please contact Theresa Alban with the Cystic Fibrosis Foundation at talban@cff.org with any questions.

Sincerely,

AiArthritis
ALS Association
American Cancer Society Cancer Action Network
American Kidney Fund
American Lung Association
Autoimmune Association
Blood Cancer United
Cancer Nation
Cancer Support Community
Cancer*Care*
Crohn's & Colitis Foundation
Cystic Fibrosis Foundation
Diabetes Patient Advocacy Coalition
Epilepsy Foundation of America
EveryLife Foundation for Rare Diseases
Family Voices National
Foundation for Sarcoidosis Research
Hemophilia Federation of America
Hypertrophic Cardiomyopathy Association
Immune Deficiency Foundation
Legal Action Center
Lupus Foundation of America
Muscular Dystrophy Association
National Alliance on Mental Illness
National Bleeding Disorders Foundation
National Kidney Foundation
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National Organization for Rare Disorders
National Patient Advocate Foundation
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