June 10, 2026

Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability Standards and Prior Authorization for Drugs for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, and Issuers of Qualified Health Plans on the Federally Facilitated Exchanges (CMS-0062-P)

Dear Dr. Oz:

On behalf of the Society of General Internal Medicine (SGIM), we thank you for the opportunity to comment on the proposed rule regarding interoperability standards and prior authorization requirements for drugs in Medicare Advantage, Medicaid managed care plans, the Children's Health Insurance Program, and plans issued through federal exchanges. SGIM is a member-based medical association of more than 3,300 of the country's leading general internal medicine physicians, who are dedicated to delivering high-quality clinical care for adults of all ages, especially those with multiple chronic diseases who would benefit from having a physician to coordinate a comprehensive approach to their care.

Our members routinely encounter administrative barriers associated with prior authorization and step therapy requirements that delay treatment, increase clinician burden, and interfere with patient-centered care, often resulting in worse health outcomes for patients. We support the Centers for Medicare & Medicaid Services' (CMS) efforts to modernize prior authorization through electronic processes, establish response time standards, and increase transparency regarding utilization management practices. These proposals represent important first steps toward a more efficient system. However, additional reforms are necessary to ensure that prior authorization processes support, rather than impede, timely access to clinically appropriate care.

Electronic Prior Authorization of Drugs
SGIM strongly supports CMS' efforts to facilitate electronic prior authorization within electronic health records. However, electronic transmission alone will not substantially reduce burden if clinicians continue to lack information about the specific requirements necessary for approval. For all drugs, CMS should require plans to make available at the point of care:

- Whether prior authorization is required;
- Any applicable step therapy requirements;
- Which alternative medications would be approved without prior authorization;
- Clinical criteria required for approval; and
- Clear guidance regarding next steps when a request is denied.

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Given that plans are already required to provide drug-specific cost-sharing information through the electronic health record for patients at the point of care, we believe it is feasible to provide this prior authorization information in the electronic medical record. Prospectively having this information would allow clinicians to select clinically appropriate therapies that align with plan requirements, reducing unnecessary delays and administrative burden.

Prior Authorization Response Timeframes

SGIM appreciates CMS's proposal to establish response timeframes of 24 hours for expedited requests and 72 hours for standard requests. While this proposal may be an improvement, we do not believe that it goes far enough. We instead recommend that real-time prior authorization determinations be supported through the electronic prior authorization process, especially for straight-forward requests. For more complex requests, we request a response timeframe of 24 hours with transparent process navigation and rapid access to insurance staff for appropriate peer to peer discussion.

The current proposal does not contemplate the delays associated with physician practices' ability to process prior authorizations as delays extend beyond the health plan's review period. Once responses are received, clinical staff must review determinations, communicate with patients, submit appeals, and coordinate alternative therapies when necessary. Even modest delays at each step can result in significant treatment interruptions. As prior authorization requirements proliferate, practices, which may have only one full time staff person or less dedicated to prior authorizations, do not have the capacity to respond.

As electronic prior authorization capabilities mature, CMS should continue moving toward real-time adjudication whenever feasible and should evaluate whether shorter response standards can be implemented in future rulemaking.

Reporting Metrics

SGIM urges CMS to reconsider its proposal for aggregate reporting of prior authorization metrics for drugs. For this information to be actionable for physicians, plans should be required to publicly report prior authorization metrics at drug specific levels, including:

- Initial approval rates;
- Initial denial rates;
- Appeal rates;
- Appeal overturn rates;
- Time from initial request to final determination;
- Approval and denial rates by drug; and
- Approval and denial rates for major categories of services.

Aggregate statistics may mask significant barriers affecting individual therapies or therapeutic classes. More granular reporting would provide clinicians, patients, and policymakers with meaningful information regarding access to care.

Additionally, SGIM recommends that prior authorization performance be incorporated into Medicare Advantage Star Ratings. These policies have a direct impact on patient access, quality of care, treatment adherence, and health outcomes. Metrics such as timeliness of determinations, denial rates, appeal outcomes, and adherence to electronic prior authorization standards would provide meaningful

indicators of plan performance and create incentives for continuous improvement. Plans currently receive substantial financial rewards and marketing advantages through high ratings. Including prior authorization performance would appropriately recognize the significant role utilization management practices play in determining beneficiary experiences and outcomes.

Reduce Reauthorization Requirements for Patients with Ongoing Therapeutic Needs
While not addressed in this proposed rule, SGIM recommends that CMS evaluate policies that require repeated prior authorization submissions for patients who need ongoing maintenance therapy. Repeated reauthorization requirements generate substantial administrative burden for clinicians, health plans, and patients while providing limited clinical value. Patients who have demonstrated successful and safe use of a therapy should not be required to repeatedly navigate the same approval process absent a meaningful clinical reason. At times, these requirements may interrupt patients' access to their medications and create unnecessary stress. SGIM recommends that the majority of prior authorizations that were approved once, be valid indefinitely. For select therapies that are intended only for short-term use, the repeat prior authorization process should be shortened to a single statement through which the provider testifies to ongoing need.

Request for Information: Step Therapy Requirements
SGIM appreciates the inclusion of this request for information as step therapy poses its own set of challenges for clinicians and patients. Currently, clinicians frequently discover step therapy requirements only after a medication has been prescribed and subsequently denied. Additionally, yearly changes in the formulary by insurance plans may result in a clinician discovering that a medicine previously on insurance formulary and adequately controlling a chronic disease, is not first line anymore and they need to switch to alternative therapy. This results in delays, repeated submissions, additional administrative work, and patient frustration. If health plans can provide patient-specific cost-sharing information through real-time benefit tools, similar technology should be used to provide patient-specific step therapy requirements directly within the electronic medical record at the point of prescribing.

SGIM is concerned that many current step therapy protocols are not consistently aligned with contemporary clinical evidence or guidelines. For example, patients may be required to try diabetes medications associated with increased risks of hypoglycemia or other adverse events before gaining access to newer therapies with more favorable safety profiles, which is especially concerning for older adults who may be more susceptible to medication side effects. Similarly, clinicians often encounter requirements to prescribe medications that are clinically inferior or less appropriate for specific patient populations, solely because they occupy a preferred formulary tier. The opioid overdose epidemic has made it apparent that it is not appropriate to require patients with chronic pain to trial full-agonist opioids such as hydrocodone and oxycodone before being prescribed buprenorphine, a partial opioid agonist. Therefore, CMS should require plans to demonstrate that step therapy protocols are based on current clinical evidence, nationally recognized treatment guidelines, and patient safety considerations. Such protocols should undergo regular review and updating to reflect evolving standards of care.

In addition, CMS should explore mechanisms to promote greater consistency across plans for common chronic conditions such as diabetes, heart failure, chronic obstructive pulmonary disease, coronary artery disease, and hypertension. The current environment where each plan maintains unique and often opaque step therapy requirements creates confusion, increases administrative burden, and contributes to inequitable access to care. Other health systems (e.g., Veterans Health Administration)

and countries have demonstrated that formularies and utilization management policies can be standardized and grounded in clinical evidence while still supporting cost containment. CMS should consider approaches that encourage greater alignment between coverage requirements and evidence-based practice.

Thank you for the opportunity to provide comments. Should you have any questions or require further information, please contact Erika Miller at emiller@dc-crd.com.

Sincerely,

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