June 15, 2026

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Submitted via Regulations.gov | Docket No. CMS-0062-P

Re: Comments in Support of the 2026 CMS Interoperability Standards and Prior Authorization for Drugs Proposed Rule (CMS-0062-P)

Dear Administrator Oz and Members of the CMS Team:

My name is Brady J. Buckner, and I am President of the Partnership for Innovation and Empowerment (PIE), a 501c3 Nonprofit. PIE works directly with Black and low-income communities, and healthcare access is one of the most persistent issues we hear about from the people we serve. We have sat in rooms with community members who described the same experience over and over: their doctor prescribed a medication, and then they waited. And waited. And sometimes they just never got it. (source)

That is why we are writing today to express our strong support for this proposed rule and to offer several recommendations for strengthening it.

I. Electronic Prior Authorization: We Are Fully Behind It

PIE supports CMS's proposal to require electronic prior authorization (ePA) for medications across both the medical and pharmacy benefit. (source) Right now, prior authorization for many drugs still runs on phone calls, faxes, and paper forms. That is a problem for any provider, but it is a much bigger problem for the community health centers and small practices serving low-income and minority patients, who simply do not have the staff or systems to fight a slow, outdated bureaucracy.

Giving providers real-time access to coverage information, letting them submit PAs electronically, and allowing them to track request status is not just a technology upgrade. It is a fairness issue. We urge CMS to finalize this requirement and to provide real technical support for smaller, safety-net providers during the rollout.

II. Timelines and Denial Justifications: Go Further

PIE recommends that CMS require prior authorization decisions within 24 hours for all drugs, not just urgent requests. (source) The proposed 72-hour window for standard cases is an improvement, but it is still too long for people who cannot afford to miss doses or delay treatment. A three-day wait can mean a missed work shift, a health crisis, or an emergency room visit that ends up costing far more than the medication ever would have.

We want to be direct about something: faster timelines only mean something if the decisions are fair. We are asking CMS to put real oversight in place to make sure that speed requirements are not being used to push through denials. That is a real risk and CMS should be watching for it closely.

On denials: PIE strongly recommends that CMS require a detailed, plain-language justification for every denial, including initial denials, delivered to both the provider and the patient at the same time. (source) Vague denial letters leave families with no idea what happened or what they can do about it. People deserve to know exactly why a request was denied and what their next steps are. Anything less is bureaucratic cover, not transparency.

III. Payer Reporting Metrics: Make the Data Mean Something

We support requiring payers to report prior authorization metrics, and we want CMS to push further. (source)

Reporting on API usage alone does not tell us whether patients are actually getting the medications they need. We recommend that API usage data be paired with real patient and provider experience data, including denial rates, appeal overturn rates, and the average time from PA request to treatment. CMS should publish this information in a meaningful annual public report that advocates and policymakers can actually use.

Medicare Part D plans should also be required to publicly report PA metrics, just like other payers subject to this rule. (source) Those metrics should be broken out at the plan level across all markets, with specific data on brand versus generic drugs, by therapeutic area, and with separate figures on initial denials and step therapy. Aggregated data lets disparities hide. We need the details.

IV. Step Therapy: Our Communities Cannot Afford Another Round of Delays

Step therapy, which requires patients to try and fail on cheaper alternatives before getting the medication their doctor already prescribed, is harmful policy. It is especially harmful for the communities we work with, where healthcare delays already compound existing health disparities. (source)

We urge CMS not to permit Medicare Advantage plans to use step therapy, and to collect and publicly release data on how MA plans are currently using prior authorization for Part B drugs so the full picture is visible.

We also strongly recommend that CMS require plans to honor step therapy completion across plan changes. If a patient has already been through the required steps to access their medication, they should not have to start over just because their insurance changed. That reset serves no legitimate clinical purpose. (source)

Finally, payers should be required to clearly disclose their step therapy requirements, not bury them inside prior authorization processes. And there must be a real appeals and exceptions process in place that patients can actually navigate.

Conclusion

This proposed rule is one of the most meaningful steps CMS has taken toward making healthcare work for people who have historically been left behind by the system. PIE urges CMS to finalize it and to take the additional recommendations above seriously. The families we work with are counting on it. (source)

Respectfully submitted,

Brady J. Buckner
President
Partnership for Innovation and Empowerment (PIE)
202-680-4749
bbuckner@pieus.org