



June 15, 2026

Dr. Mehmet Oz  
Administrator  
Centers for Medicare & Medicaid Services

*Via regulations.gov*

Re: Proposed Rule CMS-0062-P

Dear Administrator Oz:

Aimed Alliance is a non-profit health policy organization that seeks to protect and enhance the rights of health care consumers and providers. Aimed Alliance appreciates the opportunity to comment on the proposed rule related to prior authorization under file code CMS-0062-P. Aimed Alliance commends the Centers for Medicare & Medicaid Services' (CMS) for its efforts to modernize prior authorization and alleviate administrative burdens on health care providers and patients. Aimed Alliance also urges CMS to clarify that prior authorizations cannot be expanded to require consumers to take additional steps to access their medication after approval has been granted.

**I. Require Plans to Use Electronic Prior Authorization for Covered Drugs as Pharmacy Benefits and Medical Benefits**

Aimed Alliance applauds CMS' proposal to expand the electronic prior authorization requirements to include prescription drugs covered under both pharmacy benefits and medical benefits. Prior authorization policies require health care providers to receive approval for a prescription before the health plan will cover a necessary treatment. On average, providers complete nearly 40 prior authorization requests each week.<sup>1</sup> A 2025 physician survey found that delays in prior authorization approvals lead to treatment adherence issues or abandonment in nearly 80% of cases.<sup>2</sup> Despite these impacts, only 20% of health care providers appeal denied prior authorizations.<sup>3</sup>

The limited use of internal and external appeals underscores the importance of ensuring that the original prior authorization process is fair and transparent. This trend is consistent with Aimed Alliance's 2025 Report on Step Therapy, Oversight, and AI, which reviewed national trends on claim denials and internal and external appeals to better understand how these tools are

---

<sup>1</sup> AMA, *2025 AMA Prior Authorization Physician Survey*, <https://www.ama-assn.org/system/files/prior-authorization-survey.pdf>.

<sup>2</sup> *Id.*

<sup>3</sup> *Id.*

utilized.<sup>4</sup> The report found that the use of internal and external appeals is extremely underutilized by consumers and health care providers. For example, Pennsylvania’s 2023 data revealed that out of 2,135,041 denied claims, only 3,156 internal appeals were filed – less than 1% of all claims.<sup>5</sup> Given the limited use of oversight mechanisms, it is critical to ensure prior authorization processes are standardized, transparent, and fair, and enable consumers to access the benefits to which they are entitled. As such, Aimed Alliance supports CMS finalizing the proposed electronic prior authorization requirements to promote consistency and uniformity.

The proposed rule would also require Medicaid plans to include the rationale for a denial in the prior authorization notice sent to providers. Aimed Alliance strongly supports CMS finalizing this requirement. Providing a clear rationale is essential to ensure health care providers fully understand how a patient failed to meet coverage criteria and what information may be needed in future submissions or appeals.

In addition, Aimed Alliance urges CMS to require that denial notices sent to consumers include information on the alternative medication the patient is expected to try and clear instructions on how to file an appeal or consumer complaint. Including this information would better inform consumers about why their treatment was denied, what alternatives are being required, and how to challenge the decision. This transparency will help consumers make more informed decisions about whether and how to pursue an appeal. Ultimately, Aimed Alliance urges CMS to finalize both of these requirements in the final rule.

## **II. Prior Authorization Approval Should Be a Singular Process**

Prior authorization has traditionally been a singular process that determines whether a prescription drug will be covered by a health plan based on an individual’s clinical needs. Under this model, a provider is notified of the need to request a prior authorization, submits the required information, and the plan issues an approval or denial. This determination typically concludes the process unless an appeal is filed.

However, some health plans have started using prior authorization as the first step in a broader, multi-stage coverage decision process. Under the new approach, after a provider completes the prior authorization and the plan determines that a drug is medically necessary, the drug is not covered by the plan as a pharmacy benefit subject to the relevant cost-sharing tier.<sup>6</sup> Instead, the consumer is required to apply to third-party assistance programs or manufacturer patient assistance programs to determine if the drug can be alternatively sourced. If the drug is available through these external channels, the patient is *required* to obtain the prescription drug, which the plan has deemed medically necessary, from the alternative pathway for the entirety of

---

<sup>4</sup> Aimed Alliance, *State Report: Step Therapy, Oversight & Artificial Intelligence*, [https://aimedalliance.org/wp-content/uploads/2025/06/AA-2025StateReport\\_June\\_2025.pdf](https://aimedalliance.org/wp-content/uploads/2025/06/AA-2025StateReport_June_2025.pdf).

<sup>5</sup> *Id.*

<sup>6</sup> Aimed Alliance, *Alternative Funding Programs*, <https://aimedalliance.org/alternative-funding-programs/>.

the plan year. If the drug cannot be obtained through an alternative source, it will revert to the health plan and be covered as a standard pharmacy benefit for the entirety of the plan year.

Importantly, once a patient is informed that a drug is medically necessary but must first be pursued through external assistance programs, there is often no clear path for appeal, as the plan has not issued a formal coverage determination approving or denying the claim. Aimed Alliance believes this practice misuses the prior authorization process and creates confusion for both patients and providers regarding coverage rights. It is also inequitable because coverage outcomes may depend on a patient's eligibility for external financial assistance rather than whether a patient satisfies a plan's medical and coverage criteria. As a result, two patients with identical conditions, prescribed the same treatment under the same plan, may receive different benefits based solely on income. One patient may receive the drug through the plan, with costs applied toward out-of-pocket limits, while another may be required to rely on a charity program, with no credit towards these obligations. This structure creates unequal access to coverage and undermines the value of the insurance benefit.

For these reasons, Aimed Alliance urges CMS to clarify that once a plan determines a covered drug is medically necessary, it cannot require a beneficiary to apply to or be denied by an external program before covering the drug as a standard pharmacy or medical benefit.

### **III. Conclusion**

In conclusion, Aimed Alliance supports CMS's efforts to reduce administrative burdens and promote uniformity through electronic prior authorization. We also urge CMS to ensure that prior authorization is not effectively extended through unreasonable claims procedures that delay or condition coverage after approval. Please contact us at [avantrees@aimedalliance.org](mailto:avantrees@aimedalliance.org) with any questions.

Sincerely,

Ashira Vantrees, Esq.  
Director of Legal Strategy & Advocacy