CMS Prior Authorization Reforms Commendable, Still Needs Work, ACR Says

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Prior authorization remains a persistent obstacle in patient care, delaying access to necessary treatments and consuming significant clinician time. The Centers for Medicare & Medicaid Services (CMS) recently unveiled a final rule intended to alleviate some of this administrative burden. While a step in the right direction, the American College of Rheumatology (ACR) maintains the reforms fall short of what is truly needed.

KEY TAKEAWAYS

- The Pivot: CMS introduced a final rule requiring payers to streamline prior authorization processes and provide faster decisions.
- The Data: The rule mandates a 7-day turnaround for standard requests and 72 hours for urgent requests, with specific denial reasons.
- The Action: Clinicians should leverage the new digital requirements and faster response times, but prepare for continued advocacy on broader reforms.

The administrative burden of prior authorization has long plagued healthcare systems, diverting valuable time and resources from direct patient care. Clinicians routinely report spending hours each week navigating complex payer requirements, often leading to treatment delays and patient frustration. This systemic inefficiency directly impacts patient outcomes, particularly for those with chronic or rapidly progressing conditions where timely intervention is critical. CMS's new rule, titled 'Advancing Interoperability and Improving Prior Authorization Processes,' targets specific areas within Medicare Advantage (MA) organizations, state Medicaid and Children's Health Insurance Program (CHIP) agencies, and Qualified Health Plan (QHP) issuers on the federal exchange. The agency aims to enhance transparency and efficiency by mandating electronic prior authorization processes and setting stricter timelines for payer responses. This move reflects a growing recognition of the detrimental effects of current prior authorization practices on both providers and patients.

The new requirements and their limitations

Under the new CMS rule, affected payers must implement an application programming interface (API) to support electronic prior authorization requests. This digital mandate is intended to streamline submissions and reduce reliance on faxes and phone calls, which are notorious for their inefficiency. Payers must also provide specific reasons for denying a prior authorization request, a crucial step toward improving transparency and allowing clinicians to better understand and address deficiencies in their submissions. This clarity could reduce the number of resubmissions and appeals.

A key component of the rule establishes firm response timelines for prior authorization decisions. Payers must now issue

decisions within 7 calendar days for standard requests and within 72 hours for urgent requests. These deadlines are a significant improvement over previous, often undefined, turnaround times that could stretch for weeks, leaving patients in limbo. The rule also requires payers to publicly report prior authorization metrics, including the percentage of requests approved, denied, and appealed, offering a level of accountability previously absent.

But the American College of Rheumatology (ACR) argues these changes, while positive, do not go far enough. The ACR's primary concern centers on the rule's limited scope, as it does not extend to commercial health plans, which cover a substantial portion of the US population. This omission means a large segment of clinicians and patients will not benefit from the new efficiencies, perpetuating the existing administrative challenges across much of the healthcare system. The ACR has consistently advocated for broader reforms that encompass all payers, emphasizing that a piecemeal approach will not solve the systemic problem.

Another significant limitation is the rule's failure to address the concept of 'gold carding' or similar exemptions for clinicians with high prior authorization approval rates. Many professional organizations, including the ACR, have pushed for policies that would exempt high-performing providers from routine prior authorization requirements, allowing them to focus on patient care rather than administrative tasks. The absence of such provisions means even clinicians with a proven track record of appropriate prescribing will continue to face the same bureaucratic hurdles as others, regardless of their historical approval rates.

The rule also does not tackle the fundamental issue of clinical appropriateness criteria used by payers. While it mandates specific denial reasons, it does not dictate what those criteria should be or ensure they align with evidence-based medical guidelines. This leaves room for payers to continue using proprietary or overly restrictive criteria that may not reflect current medical consensus, leading to continued denials for medically necessary treatments. The lack of a mechanism to challenge the underlying clinical criteria remains a significant impediment to patient access.

Furthermore, the implementation timeline for these changes is extensive, with compliance generally required by January 1, 2026. This prolonged rollout means clinicians and patients will continue to grapple with the existing inefficient system for nearly two more years. While complex IT infrastructure changes necessitate time, the urgency of the prior authorization crisis suggests a more accelerated implementation would have been beneficial. The delay also raises questions about potential future modifications or challenges to the rule before it fully takes effect.

The CMS rule represents a foundational step towards modernizing prior authorization processes through digital integration and establishing clearer timelines. However, its narrow scope and failure to address critical issues like gold carding or the clinical validity of payer criteria mean that the administrative burden on clinicians will persist. The ACR's stance underscores a broader sentiment within the medical community: while progress is welcome, the current reforms are insufficient to truly transform the prior authorization landscape.

> **CLINICAL IMPLICATIONS**
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> Clinicians should welcome the CMS rule as a minor victory, but not a definitive solution. The mandated electronic processes and tighter response times for Medicare Advantage and Medicaid patients will undoubtedly reduce some administrative friction. However, the continued lack of oversight for commercial plans means a significant portion of a clinician's day will still be spent on phone calls and faxes.
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> The ACR's critique is precise: this rule addresses symptoms, not the underlying disease. Payers still retain

> broad authority to set their own clinical criteria, often without transparency or alignment with established guidelines. This perpetuates the cycle of denials for medically indicated treatments, forcing clinicians into time-consuming appeals that delay care.
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> For patients, the impact will be uneven. Those covered by MA or Medicaid may see slightly faster access to care, but patients with commercial insurance will continue to face the same arbitrary delays. The absence of 'gold carding' provisions means even the most judicious prescribers will remain entangled in bureaucratic red tape, unable to simply prescribe what their patients need.
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> The medical community must continue to advocate for comprehensive prior authorization reform across all payers. This includes mandating evidence-based criteria, implementing gold carding, and expanding the scope of these digital and timeline requirements to the entire insurance market. Anything less is merely tinkering around the edges of a deeply flawed system.

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