Advancing High Performance Health

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Prior Authorization Reform: A Critical Priority for Patient Access and Provider Efficiency

Overview

Prior authorization (PA) has become a major obstacle to timely and medically necessary care. Studies demonstrate that PA delays contribute to treatment abandonment, disease progression, and adverse patient outcomes. Physicians report devoting an average of two business days per week managing PA requests, diverting time and resources away from direct patient care.[1]

The current PA landscape is characterized by inconsistent criteria, opaque decision-making processes, and a lack of accountability that undermines the physician-patient relationship and compromises care quality.[2] These systemic failures violate the fundamental Medicare requirement that services be provided "in a manner consistent with simplicity of administration and the best interests of beneficiaries."[3]

AMGA's Policy Recommendations

To fully address the patient access barriers caused by PA, AMGA strongly urges the Department of Health & Human Services (HHS) to codify under 42 CFR Parts 422, 438, and 440 the America's Health Insurance Plans' (AHIP's) "Improving Prior Authorization" pledge. This would ensure that all payers implement these reforms to streamline workflows, enhance transparency, and reduce avoidable delays for patients.

Voluntary measures alone are insufficient to ensure consistency and accountability across plans.

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[1] American Medical Association. 2024 AMA Prior Authorization (PA) Physician Survey. Chicago, IL: American Medical Association; 2024

[2] Johnson PT, Murphy J, Beauchamp N, Sun KJ, Lau BD, Wilson RF, Lobner K, Conway SJ, Hill PM. Adverse Effects of Health Plan Prior Authorization on Clinical Effectiveness and Patient Outcomes: A Systematic Review. *Am J Med*. 2024. doi:10.1016/j.amjmed.2024.09.003

[3] Social Security Act § 1302, 42 U.S.C. § 1302 (establishing administrative requirements including simplicity of administration).

Regulatory codification would establish enforceable standards, eliminate variation in implementation, and provide clear recourse through existing Centers for Medicare & Medicaid Services (CMS) enforcement mechanisms at 42 CFR Part 422, Subpart O when payers fail to meet their obligations.

Specifically, AMGA's priority recommendations include:

1. **Reduce Unnecessary PA Requirements:** CMS should standardize and eliminate PA requirements where clinically appropriate, focusing on generic medications, established treatment protocols, and services that have a strong evidence base. This aligns with the statutory requirement for administrative simplicity under Section 1852(a)(1)(A) of the Social Security Act (42 U.S.C. § 1395w-22).

2. **Accelerate PA Decision Timeframes:** CMS should revise Subpart M of 42 CFR Part 422 to require:

Request Type	Current Final Rule	AMGA Recommendation
Standard	7 days[4]	⩽ **48 hours**
Urgent	72 hours[5]	⩽ **24 hours**
Missed Deadlines	No requirement	**Automatic approval**

   For routine requests, HHS should expand Fast Healthcare Interoperability Resources (FHIR)-based application programming interface (API) requirements at 45 CFR § 170.215 to mandate real-time electronic determinations.

3. **Strengthen Transparency of PA Standards:** CMS should require enhanced transparency to allow patients and clinicians to fully understand what is required for PA approval. Federal requirements already direct Medicare Advantage organizations to base utilization management policies on evidence-based clinical guidelines under 42 CFR § 422.101(c), yet health plans frequently rely on opaque criteria that are not publicly accessible. Current regulations at 42 CFR § 422.138(b) already limit PA to confirming diagnoses and ensuring medical necessity; however, additional regulatory clarity is needed to ensure that criteria are specifically aligned with national coverage determinations (NCDs), local coverage determinations (LCDs), and peer-reviewed clinical evidence before plans may impose PA requirements.

4. **Establish Gold Carding Programs:** Gold carding programs, granting streamlined or waived PA for clinicians who consistently follow evidence-based guidelines, represent a practical and effective mechanism to reward quality care while maintaining appropriate oversight. CMS should incorporate gold carding into Medicare PA programs and establish gold carding demonstration programs under its authority at Section 1115A of the Social Security Act (42

[4] 42 CFR § 422.568(b)(1)
[5] 42 CFR § 422.572(a)(1)

U.S.C. § 1315a) to incentivize best practices and reduce transaction-level review where it is not clinically warranted.

5. **Enhance Enforcement of PA Standards:** To ensure compliance and protect beneficiaries' timely access to care, CMS should strengthen enforcement of existing PA standards at 42 CFR §§ 422.138, 422.568, and 438.210. These revised standards should include regular audits, application of meaningful civil monetary penalties under 42 CFR § 422.752, and transparent reporting of payer-level metrics to identify patterns of inappropriate denials or delays. Improved enforcement would ensure that beneficiary protections are realized in practice, not merely in policy.

Background

AMGA commends the administration for advancing meaningful reforms to address longstanding dysfunction in PA processes. In recent years, CMS has finalized multiple regulatory changes that directly strengthen PA requirements. AMGA's priority recommendations build upon these to further enhance and streamline PA for providers and beneficiaries.

Notably, the Interoperability and Prior Authorization Final Rule[6] establishes binding requirements for Medicare Advantage organizations, Medicaid- and Children's Health Insurance Program (CHIP)-managed care plans, and other impacted payers, beginning January 1, 2026. The rule requires:

- Expedited timeframes—72-hour maximum for urgent requests and 7-day maximum for standard requests—codified at 42 CFR §§ 422.568(b), 422.570, and 438.210(d).
- FHIR-based API implementation by January 1, 2027, conforming to standards at 45 CFR § 170.215.
- Annual reporting of PA metrics, including approval rates, denial rates, and processing times, codified at 42 CFR §§ 422.122(c) and 438.210(e).
- Written explanations for all denials beginning January 1, 2026, codified at 42 CFR § 422.122(a).

In addition, the Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program final rule[7] strengthened utilization management practices and beneficiary protections. Specifically, the rule:

- Clarifies that PA may only confirm diagnoses or ensure medical necessity, codified at 42 CFR § 422.138(b).
- Requires annual review of PA policies performed by Utilization Management Committees, codified at 42 CFR § 422.137.

[6] CMS-0057-F, 89 FR 8856, February 8, 2024
[7] CMS-4201-F, 88 FR 22120, April 12, 2023

- Establishes 90-day continuity of care protection for enrollees switching plans pursuant to 42 CFR § 422.112(b)(8).
- Prohibits retrospective denials after PA approval except for fraud or good cause, as codified in 42 CFR § 422.138(c).

Through these recent policy changes, CMS has clearly demonstrated meaningful progress toward a more transparent and timely PA system. However, existing implementation timelines extend multiple years into the future, and voluntary alignment among private payers remains uneven. Without AMGA's recommended regulatory reforms highlighted above, significant barriers to timely patient care will persist.

Conclusion

Prior authorization reform is not merely an administrative, fine-tuning exercise; it is a patient safety imperative and central to preserving access to timely, medically necessary care. Despite progress, millions of individuals continue to experience harmful delays because authorization processes remain slow, opaque, and overly burdensome. These avoidable barriers undermine clinical judgement, erode trust in the healthcare system, and divert critical resources away from patient care.

The administration now has a decisive opportunity to ensure that the reforms already underway translate into real-world improvements. AMGA urges HHS to move swiftly to codify voluntary commitments, accelerate adjudication timelines, strengthen transparency, incentivize high-quality care through gold carding programs, and enforce compliance with existing federal protections**.** Together, these actions will finally align PA practices with the statutory mandate for simplicity of administration and the best interest of beneficiaries.

By advancing comprehensive, enforceable standards that apply consistently across all payers, HHS can eliminate avoidable treatment delays, reduce administrative waste, and restore the primacy of the physician-patient relationship. AMGA stands ready to partner with the administration to implement a modernized prior authorization framework that delivers on the promise of timely, high-quality care for Medicare beneficiaries, as well as those enrolled in Medicaid and the Children's Health Insurance Program.