CMS Finalizes Rule to Improve the Prior Authorization Process

BY MONIQUE J. MARINO

On January 17, 2024, more than 1 year after it was initially proposed, the Centers for Medicare & Medicaid Services (CMS) finalized the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F), establishing requirements for certain payers to streamline the prior authorization process.[1] Specifically, "the rule sets requirements for Medicare Advantage (MA) organizations, Medicaid and the Children's Health Insurance Program (CHIP) fee-for-service (FFS) programs, Medicaid managed care plans, CHIP managed care entities, and issuers of Qualified Health Plans (QHPs) offered on the Federally-Facilitated Exchanges (collectively 'impacted payers') to improve the electronic exchange of health information and prior authorization processes for medical items and services."[2] As a whole, the agency estimates these policies will improve prior authorization processes and reduce burden on patients, providers, and payers, resulting in approximately $15 billion of estimated savings over 10 years.[2]

Beginning primarily in 2026, impacted payers will be required to send prior authorization decisions within 72 hours for expedited (ie, urgent) requests and 7 calendar days for standard (ie, non-urgent) requests for medical items and services. For some payers, this new timeframe for standard requests cuts current decision timeframes in half.[2] To help facilitate resubmission of requests or appeals, the rule also requires all impacted payers to include a specific reason for denying a prior authorization request. Finally, impacted payers will be required to publicly report prior authorization metrics.[2]

In addition, the rule requires impacted payers to implement an electronic prior authorization application programming interface (API) to establish a more efficient electronic prior authorization process between providers and payers by automating the end-to-end prior authorization process. It is expected that this new requirement "will reduce administrative burden on the healthcare workforce, empower clinicians to spend more time providing direct care to their patients, and prevent avoidable delays in care for patients."[2] A fact sheet for this final rule is available on the CMS website.[3]

While ACCC supports these efforts, the association is concerned that this rule only applies to payers in the federal programs outlined above and does not apply to the "approximately 158 million Americans who are insured through their employment—the most common kind of coverage in the United States."[4]

Prior authorization remains one of the most discussed barriers to timely quality cancer care delivery among health care providers.[5] The burden placed on the multidisciplinary care team to submit authorizations, complete peer-to-peer interviews, and fight appeals is extraordinary. In a 2022 survey of American Society of Clinical Oncology (ASCO) members, nearly all participants reported that a patient they had treated had experienced harm as a result of late or denied prior authorizations, including disease progression (80%) and loss of life (36%).[6] ASCO survey findings identified the items below as the most widely cited challenges for patients:[6]

- Treatment delays (96%)
- Delays in diagnostic imaging (94%)
- Patients being forced into using a second-choice therapy (93%)
- Patients denied therapy (87%)
- Increased patient out-of-pocket costs (88%)

ACCC has developed tools and resources to help its provider members, including a virtual Prior Authorization Clinic. This educational program seeks to help providers:[7]

- Reduce the administrative burden of prior authorization processes by sharing best practices
- Address key components of prior authorization, including new technologies or areas where there are high errors in billing and coding that result in high denials
- Provide examples of standardized criteria for ordering and prescribing services that align with evidence-based guidelines
- Develop a series of case-based prior authorization scenarios that cancer programs can utilize when advocating for change, locally and nationally, at their cancer program
- Highlight successful methods to track prior authorizations and results for pertinent members of the multidisciplinary cancer care team.

As ACCC continues to advocate for long-term solutions to prior authorization challenges, including those instituted by private payers, we would love to hear from you about the impact that prior authorizations continue to have on your cancer program or practice, providers and staff, and the patients and families you treat. Contact us at rhodzic@accc-cancer.org. OI

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