

AMIA RECOMMENDATIONS TO REFORM PRIOR AUTHORIZATION

It is AMIA's position that prior authorization (PA) must be eliminated to improve patient access to necessary medical care, maintain the healthcare workforce, and reduce the required onerous documentation associated with PA. PA, the onerous process used by health insurance companies, including Medicare Advantage (MA) plans, requires clinicians to obtain approval before providing medically necessary care to patients for covered services and is a major source of burden for patients in need of care, clinicians, and health systems.

Until prior authorization can be eliminated effectively, **AMIA urges the following to reform Prior Authorization:**

1. Pass the *Improving Seniors' Timely Access to Care Act*¹.

In short, the *Seniors' Act* would:

- Establish an electronic PA process for MA plans, including a standardization for transactions and clinical attachments.
- Increase transparency around MA PA requirements and their use.
- Provide a pathway for CMS to institute real-time decisions for routinely approved items and services in the future and clarify CMS' authority to establish timeframes for PA requests, including expedited determinations, real-time decisions for routinely approved items and services and any other PA request.
- Expand beneficiary protections to improve enrollee experiences and outcomes.
- Require the U.S. Department of Health and Human Services and other agencies to report to Congress on program integrity efforts and other ways to improve the PA process.

Passing the *Seniors' Act* will enhance and codify into law the Centers for Medicare & Medicaid Services (CMS) January 2024 Advancing Interoperability and Improving Prior Authorization Processes final [rule](#) (CMS-0057-F). This rule requires plans to implement electronic PA by 2027, implement HL7 FHIR APIs, provide specific reasons for request denials, and publicly report certain metrics annually.²

2. In addition to CMS-0057-F, CMS must require that MA plans:

- A. Hasten PA decision timelines to 24 hours for urgent requests. Currently, the CMS rule requires impacted payers to send PA decisions within 72 hours for expedited requests and seven calendar days for standard, non-urgent requests. AMIA implores policymakers to require payers to send PA decisions within 24 hours for expedited, urgent requests.

¹ *Improving Seniors' Timely Access to Care Act of 2025*. (S. 181). 119th Congress.

<https://www.congress.gov/119/bills/s1816/BILLS-119s1816is.pdf>

² Medicare and Medicaid Programs Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, 89 Fed. Reg. 8758 (Feb 8, 2024).

<https://www.federalregister.gov/documents/2024/02/08/2024-00895/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability>

- B. Define the PA workflow such that it doesn't shift burden between clinicians but rather eliminates burden or shifts to the appropriate administrative staff. Defining workflows can be accomplished by:
 - i. Guidelines for insurance plans to transparently for how PA requests are denied.
 - ii. Avoid increasing documentation at any point in the process.
 - iii. Create a clear description of why any authorization failed and differentiate between a system failure and payer denial. For example, if the automated system finds the indication for drug provided was unclear or insufficient, then a human interaction from the insurance payer must be available as a timely option for failure correction.
 - iv. Ensure that previously approved treatments and procedures are not subsequently denied, particularly without explanation, and requiring a new PA submission.
- C. Require transparency from payors on the function and use of the AI tool in their PA processes, including medical necessity determinations.
 - i. Allow third-party auditors to review AI algorithms and decisions, dataset characteristics (e.g., data sources and demographics in context of representation of diverse populations), model training processes, and validation studies to ensure that AI is making fair, equitable, and clinically appropriate decisions.
 - a. Require human-in-the-loop controls to the audit process.
 - ii. Implement feedback mechanisms so that feedback from appeals can be used to refine the AI tools and improve accuracy.
- D. AI tools alone may not be used by payors to deny PA requests.
 - i. A PA decision made by AI alone cannot be used to override point-of-care clinical decision-making to deny care. If an AI determines that a PA request should be denied, this determination warrants a second level of review by a human clinician with specific expertise prescribing the treatment being requested.
- E. Improve interoperability standards for integrating AI tools with the Electronic Health Record (EHR) such that AI tools can easily be used by clinicians to fill out PA requests.
 - i. Work with the Assistant Secretary of Technology Policy (ASTP) to improve integration of AI tools into the EHR.

3. AMIA recommends CMS require MA partners to standardize NCPDP use to provide the PA information in real time for prescriptions.

Physicians often do not see the true patient-specific out-of-pocket prescription cost because EHRs typically display information from the patient's medical insurance, not their pharmacy benefit. The National Council for Prescription Drug Programs (NCPDP) has already solved this gap: pharmacies obtain the exact patient out-of-pocket cost using the Telecom Standard, which performs a real-time adjudication directly with the payer. In parallel, NCPDP has created complementary standards for prescribers – including the

SCRIPT ePA transaction and the Real-Time Prescription Benefit (RTPB) Standard – which enables this same information to be delivered into the EHR at the point of prescribing.

CMS must require MA partners to make these capabilities available to clinicians so they can see the same, payer-verified, *patient-specific out-of-pocket cost that the pharmacy receives*. Providing this level of transparency reduces unnecessary PA's, supports clinically appropriate decision-making, and improves patient access.

4. AMIA recommends a CMS demonstration investigating the practice commonly referred to as “gold carding”, but for individual providers, rather than individual services.

Gold carding would allow providers that are known to be ordering appropriately to be exempted from completing the PA process for a defined period and updating MA regulations to exempt clinicians from PA requirements so long as 90% of the providers' requests were approved in the preceding 12 months. According to CMS, gold carding programs could help alleviate burden associated with PA and facilitate more efficient delivery of health care services to MA enrolled patients.³

5. AMIA strongly encourages CMS repeal the WISeR model from FFS.

Finally, AMIA supports the [Regulatory Relief Coalition's recent statements](#) opposing implementation of the Wasteful and Inappropriate Service Reduction (WISeR) Model in the Medicare Fee-for-Service (FFS) program.⁴ The WISeR model aims to “protect American taxpayers by leveraging enhanced technologies, such as [AI] and Machine Learning (ML), along with human clinical review, to ensure timely and appropriate Medicare payment for select items and services” that are “vulnerable to fraud, waste, and abuse.”⁵ This is simply an extension of MA PA practices into FFS. It is inconsistent with the Administration's commitment to reducing the administrative burden of federal regulatory requirements. It is known that PA imposes extraordinary administrative burdens on clinicians, providers, and patients and significantly disrupts medically-necessary care, as reported by medical practitioners and evidenced by the significant rate of decisions overturned on appeal. For these reasons, AMIA strongly encourages CMS repeal the WISeR model from FFS.

For more information, please email AMIA's Senior Vice President of Policy, Reva Singh, at rsingh@amia.org.

³ *CMS Encourages Medicare Advantage Plans to use Gold Carding to Alleviate Prior Authorization Burden on Providers*. WhatleyKallas. March 1, 2023. <https://whatleykallas.com/cms-encourages-medicare-advantage-plans-to-use-gold-carding-to-alleviate-prior-authorization-burden-on-providers/>

⁴ *Opposition to Implementation of the WISeR Model in Medicare Fee-for-Service*. Regulatory Relief Coalition. August 12, 2025. <https://www.mgma.com/getkaiasset/78d01508-2413-478c-9c8b-59b6f692675c/FinalRRC%20CommentsonWISeRDemonstration%2008122025.PDF>

⁵ *WISeR (Wasteful and Inappropriate Service Reduction) Model*. October 17, 2025. <https://www.cms.gov/priorities/innovation/innovation-models/wiser>