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Final CMS Rule Requires Faster Prior Authorization

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CMS's *Interoperability and Prior Authorization* final rule, which was announced Jan. 17, includes new requirements that CMS said will improve prior authorization.[1] They apply to Medicare Advantage plans, state Medicaid and Children's Health Insurance Program (CHIP) fee-for-service (FFS) programs, Medicaid managed care plans, CHIP managed care entities and qualified health plan (QHP) issuers on the federally facilitated exchanges (FFEs). For one thing, CMS is requiring the payers (except for QHP issuers on the FFEs) to send prior authorization decisions in 72 hours for expedited requests and seven days for standard requests. The payers also must provide a specific reason for denying prior authorization and publicly report some prior authorization metrics on their website every year. The compliance deadline is Jan. 1, 2026. None of the new prior authorization requirements apply to drugs.