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Insights

CMS's New Federal Prior Authorization Rule: An Eventual Step In the Right Direction

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CMS published a **final rule**, effective January 1, 2026, implementing additional processes to advance interoperability as well as to improve prior authorization processes. The changes to prior authorization will require: (1) Medicare Advantage, Medicaid Fee-for-Service ("FFS") and Medicaid Managed Care Organizations (collectively, "Payers") to send prior authorization decisions within 72 hours for expedited (urgent) requests and within 7 calendar days for standard (non-urgent) requests; (2) Payers to provide a *specific* reason for denied prior authorization decisions (except decisions for drugs); and (3) Payers to publicly report certain prior authorization metrics annually on their website. While CMS notes that *Medicare* FFS is not directly affected by this final rule, it indicates it will evaluate opportunities to improve prior authorization processes in Medicare FFS, as feasible. These changes will not significantly impact Indiana Medicaid and Medicaid Managed Care Organization ("MCO") processes, but the final rule's transparency elements could be prompt prior authorization reform in the future.

The final rule is not likely to significantly impact Indiana Medicaid providers. While federal rule *currently* requires Medicaid Managed Care Organizations ("MCO") to send prior authorization decisions within 14 calendar days for standard requests,[1] Indiana Medicaid proactively adopted a 7-calendar day timeframe.[2] So the existing 7-day requirement will be status quo. Furthermore, for expedited or urgent requests, the 72-hour timeframe is already in effect, although in the final rule CMS is eliminating the opportunity for MCOs to extend the 72-hour time period where the MCO justifies a need for additional information.

However, the new requirements will improve transparency in Indiana by requiring the Medicaid MCOs to report annually:

(1) A list of all items and services that require prior authorization.
(2) The percentage of standard prior authorization requests that were approved, aggregated for all items and services.
(3) The percentage of standard prior authorization requests that were denied, aggregated for all items and services.
(4) The percentage of standard prior authorization requests that were approved after appeal, aggregated for all items and services.
(5) The percentage of prior authorization requests for which the timeframe for review was extended, and the request was approved, aggregated for all items and services.
(6) The percentage of expedited prior authorization requests that were approved, aggregated for all items and services.
(7) The percentage of expedited prior authorization requests that were denied, aggregated for all

items and services.
(8) The average and median time that elapsed between the submission of a request and a determination by the MCO, for standard prior authorizations, aggregated for all items and services.
(9) The average and median time that elapsed between the submission of a request and a decision by the MCO, for expedited prior authorizations, aggregated for all items and services.[3]

This enhanced data and information available to providers, as well as State Medicaid agencies, and legislators, will shed light on existing MCO practices and may open up conversations on how to improve such practices in a way that support beneficiary access to care.

For questions on the new federal rule, how interacts with State prior authorization requirements and what it means for providers, please contact **Meghan M. Linvill McNab** or **Brandon W. Shirley.**

Disclaimer. The contents of this article should not be construed as legal advice or a legal opinion on any specific facts or circumstances. The contents are intended for general informational purposes only, and you are urged to consult with counsel concerning your situation and specific legal questions you may have.

[1] CMS's New Federal Prior Authorization Rule: An Eventual Step In the Right 42 CFR 438.210(d).
[2] 405 IAC 5-3-14.
[3] See new language at 42 CFR 438.210(f).