

Regulatory Relief Coalition

Response to [Medicare Regulatory Relief | CMS](#)

Comments due by 11:59 pm (ET) on January 26, 2026

Character limit (not words) for all questions is 1000

***1B. Which specific Medicare administrative processes or quality and data reporting requirements create the most significant burdens for providers?***

MA prior authorization (PA) requirements are consistently cited as the most burdensome administrative processes facing physicians. These requirements often apply to services that already meet Medicare coverage criteria and are delivered by credentialed physicians subject to extensive oversight. Physicians must navigate plan-specific rules, documentation standards, and submission platforms. These burdens delay care and divert staff time away from patients. In addition, retrospective claim reviews and payment recoupments impose significant and ongoing burdens for physicians after care has been approved and delivered. Physicians are required to resubmit medical records for services already furnished and paid based on opaque documentation standards and sometimes years after care. These reviews frequently focus on technical documentation issues rather than clinical appropriateness, creating uncertainty in payment, administrative rework, and financial instability for physicians.

***4A. We welcome any other suggestions or recommendations for deregulating or reducing the administrative burden on healthcare providers and suppliers that participate in the Medicare program.***

We strongly urge CMS to take further action to meaningfully reduce administrative burden on physicians by curbing the pervasive use of PA that delays care, increases costs, and undermines clinical decision-making. These requirements impose substantial time and staffing costs on providers, diverting clinical resources away from patient care and toward paperwork and appeals. CMS should eliminate excessive PA when possible and hold MA plans publicly accountable in alignment with the reporting provisions of the Improving Seniors' Timely Access to Care Act (H.R. 3514/S. 1816).

CMS should require payers to implement a mechanism for real-time PA decisions for frequently approved services. Implementing such a program has the potential to virtually eliminate the delay associated with many PA requirements and facilitate seamless patient care.

CMS should establish and expand robust "gold carding" policies that permanently exempt

physicians with a demonstrated compliance with prior authorization requirements. Physicians who consistently adhere should not be subjected to redundant oversight mechanisms that yield minimal programmatic benefit.