CMS strengthens prior authorization transparency, addressing AMA concerns

CHICAGO, ILL. — The American Medical Association (AMA) welcomed updated guidance from the Centers for Medicare & Medicaid Services (CMS) that strengthens enforcement of federal prior authorization transparency requirements, addressing concerns the AMA raised about how health plans were making required information available to patients and physicians.

The AMA alerted CMS to widespread problems with health plans' public disclosures of prior authorization requirements and outcomes. Rather than making information readily accessible, many plans posted disclosures that were difficult to find, hard to comprehend or incomplete. CMS' updated guidance addresses several of these concerns and provides greater clarity for patients seeking information about health plans' prior authorization policies.

"Patients should not need a portal password, a billing manual or medical training to find and understand a health plan's prior authorization practices," said AMA President **WILLIE UNDERWOOD III, MD, MSc, MPH**.

"Yet that is what we found when we examined how plans were implementing these transparency requirements. One plan posted an 832-page list of billing codes without a word of plain English. Others buried required information behind portals. Another published numbers that didn't add up — and acknowledged that its data should 'not be relied upon.' In other words, thank you for reading this. The information may or may not be true."

The AMA documented these practices, brought them to CMS, and the agency acted. The AMA is grateful for the updated guidance.

Earlier this year, the AMA examined how 15 Medicare Advantage contracts were implementing the transparency provisions of CMS's 2024 Interoperability and Prior Authorization final rule, which requires payers to publicly post prior authorization requirements and outcomes.

The AMA's review revealed a consistent pattern: On the surface, many plans appeared to comply with the rule while presenting disclosures in places and formats that made them difficult or impossible to find or use. Plans posted hundreds of pages of billing codes without plain-language descriptions, buried required disclosures behind physician or member portals and deep within plan websites, reported mathematically impossible statistics and turnaround times without units, and omitted entire categories of care—including behavioral health and post-acute services—from public reporting.

The AMA documented these problems and recommended specific corrective actions in a May 22 letter to CMS, followed by additional comments.

CMS has now incorporated several of the AMA's recommendations into its guidance.

Specifically, the guidance:

Defines what it means for prior authorization information to be publicly accessible. CMS makes clear that disclosures are not publicly accessible if they are available only through password-protected portals or cannot be reached through ordinary navigation from a payer's public-facing website.

Clarifies disclosure of all medical items and services subject to prior authorization. CMS specifies that plans must publicly identify all medical items and services requiring prior authorization, addressing the omission of entire categories of care from plan disclosures.

Clarifies that prior authorization disclosures must be understandable. CMS explicitly says lists of procedure codes without plain-language descriptions do not satisfy the requirement and recommends a single, comprehensive list organized by uniform service categories, with CPT codes, plain-language descriptions and a machine-readable format.

Improves accuracy and reliability of reported data. CMS clarifies that every turnaround-time metric must include a unit of time and requires median turnaround times of less than one day to be reported in hours rather than rounded to "0 days." The agency also recommended that payers explain any data quality issues in their reporting.

The AMA is urging CMS to build on the new guidance by addressing several remaining gaps in the federal transparency framework:

Define prior authorization broadly enough to capture rebranded practices. CMS should define prior authorization based on how the process functions, regardless of whether a payer calls it "prior authorization," "precertification," or "advance notice," or delegates the process to a third-party utilization management vendor.

Make prior authorization information available at the point of enrollment. CMS should link directly from plan pages on Medicare Plan Finder and HealthCare.gov to their prior authorization requirements and performance metrics, and should require states to include the same links in Medicaid and CHIP plan-comparison and enrollment tools.This would give consumers the information they need to compare plans before choosing coverage.

Standardize prior authorization reporting. CMS should require standardized templates for prior authorization service lists and performance metrics, rather than merely recommending standardized reporting. Consistent formats would make information easier for patients and physicians to understand and compare across plans.

Patients and physicians can share their experiences with care delays and denials at FixPriorAuth.org. ❖

AMA Honors: A new national awards program recognizing individuals shaping the future of healthcare

CHICAGO, ILL. — The American Medical Association (AMA) has announced the launch of AMA Honors, a new national awards program recognizing individuals whose work is helping shape the future of healthcare.

Beginning in 2027, AMA Honors will present three marquee awards celebrating transformative innovation, public health leadership, and trusted communication. Each award includes a $25,000 prize that may be directed to the recipient or a charitable organization of their choice.

"Medicine is evolving at an extraordinary pace, driven by advances in technology, bold public health leadership, and trusted communication that helps patients make informed decisions," said AMA President **WILLIE UNDERWOOD III, MD, MSc, MPH**. "The AMA created these awards to recognize the individuals whose work is driving that progress and making a meaningful difference in the lives of patients and communities. By celebrating extraordinary achievement, these awards will shine a national spotlight on the leaders and ideas shaping the future of healthcare."

The awards include:

Tech Innovator Award: Recognizing an individual whose innovation has advanced healthcare through transformative impact, real-world application, and a commitment to safety, trust, and transparency.

Public Health Champion Award: Honoring impactful leadership that advances population health and improves health outcomes.

Excellence in Communication Award: Recognizing an individual whose work has advanced public understanding, engagement, or perception of health and medicine through accurate, responsible communication that reaches broad audiences.

Award recipients will be selected by a six-person committee composed of AMA leaders and external members, who will evaluate nominations through a rigorous, independent review process using the published evaluation criteria.

The inaugural awards ceremony will be held Feb. 23, 2027, at the National Portrait Gallery in Washington, D.C., during the AMA National Advocacy Conference. The event will bring together award recipients and leaders from across medicine, public health, technology, and healthcare.

Nominations for the inaugural awards are now open and will be accepted through Nov. 2, 2026. To learn more about eligibility requirements and the nomination process, visit the AMA Honors web page. ❖

Brown University Health launches unique intestinal ultrasound program

PROVIDENCE — Brown University Health is expanding access to Intestinal Ultrasound (IUS), a simple, non-invasive way to evaluate for inflammation in the bowel in real time for both children and adults with inflammatory bowel disease (IBD) —which includes conditions such as Crohn's disease and ulcerative colitis.

Unlike traditional tests such as colonoscopy or CT scans, IUS can be done right in a clinic setting, without radiation, sedation, or bowel prep. It allows clinical teams to quickly assess how active the disease is, whether treatment is working, and make immediate decisions—often during the same visit.

"Our goal is to provide patients with the most effective and least burdensome tools available. Intestinal Ultrasound gives us the ability to assess disease activity in real time, avoid unnecessary procedures and make treatment decisions more quickly, all while improving the patient experience. Instead of waiting weeks for results, patients can leave their appointment with a clearer understanding of their condition and a plan moving forward," said Brown University Health Inflammatory Bowel Disease Center Director **SEAN FINE, MD**, who has already begun performing IUS for adult patients with IBD. He is the only adult gastroenterologist in Rhode Island offering the procedure.

Brown University Health also leads the way in pediatric IUS. Pediatric Inflammatory Bowel Disease Center Associate Director **SHOVA SUBEDI, MD**, has led establishment of the pediatric IUS program at Hasbro Children's, the first of its kind in New England. She is among a small number of pediatric gastroenterologists nationally utilizing the technology and serves on the Pediatric Committee of the Intestinal Ultrasound Group of the United States and Canada (IUSCAN), helping advance the use of IUS across North America.

"Intestinal Ultrasound has changed how we care for children with inflammatory bowel disease. Because it is noninvasive and can be performed during a routine clinic visit, it helps families better understand their child's condition and allows us to monitor response to treatment more closely, allowing Brown University Health to provide more comprehensive patient-centered IBD care," said **DR. SUBEDI**.

Intestinal Ultrasound can be performed at the bedside, providing real-time visualization of the intestines and allowing patients and clinicians to review findings together. Unlike colonoscopy, MRI enterography (MRE) or CT imaging, IUS requires no bowel preparation, sedation or radiation exposure, making it a more convenient and patient-friendly option. The technology enables providers to evaluate bowel wall thickness, blood flow, strictures, fistulas and abscesses, and monitor intestinal inflammation frequently and noninvasively. This allows clinicians to adjust treatment earlier and help prevent disease progression and complications. ❖

Brown University Health, Arcamyra Therapeutics to launch Phase 1 trial of ACM-CpG for peritoneal carcinomatosis

PROVIDENCE — Brown University Health and Arcamyra Therapeutics Inc., a clinical-stage oncology company advancing nanoparticle-based immunotherapies for solid tumors with high unmet needs announced that the U.S. Food and Drug Administration has cleared Investigational New Drug application 180703 for ACM-CpG, enabling the therapy to move into clinical evaluation for patients with peritoneal carcinomatosis.

BrUOG 452 is an investigator-initiated Phase 1 trial coordinated by the Brown University Oncology Research Group to evaluate ACM-CpG in patients with peritoneal carcinomatosis. The study, listed on ClinicalTrials.gov as NCT07658196, will be led by **KHALDOUN ALMHANNA, MD**, as principal investigator and represents the first clinical evaluation of ACM-CpG in this disease setting.

Peritoneal carcinomatosis occurs when cancer spreads to the peritoneum, the membrane lining the abdominal cavity, and can cause symptoms such as abdominal swelling, pain and digestive complications that significantly affect daily life. Because the disease often develops in advanced gastrointestinal or gynecologic cancers and can be difficult for medicines to reach effectively, patients have limited treatment options and a significant need for new approaches.

ACM-CpG is a polymersome-encapsulated TLR9 agonist developed on Arcamyra's proprietary block-copolymer nanoparticle platform. In BrUOG 452, it will be administered intraperitoneally to deliver innate immune activation directly within the peritoneal cavity, an approach designed to help address drug-delivery barriers in this difficult-to-treat disease setting.

Potentially eligible patients will have documented peritoneal carcinomatosis from colorectal or appendiceal cancer. Patients may have an intact primary colorectal or appendiceal tumor, and limited liver or lung disease is permitted.

The trial builds on early clinical evaluation of ACM-CpG in other indications, where the investigational therapy has been well tolerated and has shown evidence of innate immune activation.

"This FDA clearance marks an important step for Arcamyra and for patients with peritoneal carcinomatosis, a disease with few effective treatment options," said **MADHAVAN NALLANI, PhD**, chief executive officer and co-founder of Arcamyra Therapeutics. "We are pleased to advance ACM-CpG into this Phase 1 trial with Dr. Almhanna and the teams at Brown University Health and The Warren Alpert Medical School of Brown University, whose experience in gastrointestinal oncology and peritoneal disease will be essential to this work."

"Peritoneal carcinomatosis remains one of the most challenging disease settings we treat, and patients need new options," said Dr. Almhanna. "ACM-CpG's early tolerability and immune-activation profile provide a strong rationale for studying this regional immunotherapy approach in patients with peritoneal disease. Brown University Health brings an experienced immunotherapy team and a surgical oncology program that cares for a high volume of patients with carcinomatosis."

The study is expected to further evaluate ACM-CpG's safety, tolerability and early biological activity in this patient population, helping inform future clinical development of the investigational therapy.

Forward-Looking Statements

This press release contains forward-looking statements, including statements regarding the initiation, timing, conduct, and potential of Arcamyra's clinical program for ACM-CpG. These statements are based on current expectations and are subject to risks and uncertainties, including those related to clinical development, regulatory review, patient enrollment, and the inherent uncertainty of the drug development process. Clearance of an IND does not guarantee that a clinical trial will be initiated, completed, or successful, or that any product candidate will receive marketing approval. Actual results may differ materially from those expressed or implied. Arcamyra undertakes no obligation to update any forward-looking statement except as required by law. ❖

American Lung Association applications now open for 2027–2028 research awards and grants cycle

PROVIDENCE — The American Lung Association Research Institute has announced the start of its 2027–2028 Research Awards and Grants cycle. The program supports high-impact basic, translational and clinical research. Applications are carefully evaluated and selected through rigorous scientific peer review. Awardees investigate a wide range of complex issues with the goal of reducing the burden of lung disease. Researchers across disciplines and career levels are encouraged to apply.

"The American Lung Association in Rhode Island is committed to investing in lifesaving research—it is core to our mission of creating a world free of lung disease. Amid federal changes in research and funding, it is more important than ever for nonprofit organizations to help sustain scientific discovery and innovation," said **DANIEL MIRAMONTES**, Executive Director for the American Lung Association in Rhode Island. "By investing in the best and brightest scientists, we hope to accelerate lifesaving discoveries that revolutionize the way we prevent, detect and treat lung disease."

Funding opportunities include:

Indoor Air Research Award: Up to $100,000/year (independent) or $50,000/year (mentored), for up to three years. This award supports research on how indoor environments impact lung health, with the goal of informing policy and improving public health outcomes. A letter of intent is required.

Lung Cancer Discovery Award: $100,000/year for up to two years. Funds groundbreaking research in lung cancer across disciplines, from lab studies to clinical investigations. A letter of intent is required.

Emerging Respiratory Pathogen Award: $100,000/year for up to two years. Supports studies into the pathobiology and long-term consequences of new and evolving respiratory pathogens. A letter of intent is required.

Innovation Award: $75,000/year for up to two years. Supports independent investigators with recent NIH K- or R-type awards for novel studies in lung health or disease. A letter of intent is required.

Hastings Innovation Award for Interstitial Lung Disease: $75,000/year for up to two years. Designed for independent investigators focused on ILD research with prior NIH award experience.

Allergic Respiratory Diseases Research Award: $75,000/year for up to two years. Jointly funded with the American Academy of Allergy, Asthma & Immunology (AAAAI), this award supports research in allergic respiratory diseases.

Catalyst Award: $50,000/year for up to two years. Mentored award for early-career scientists on the path to research independence. A letter of intent is required.

Dalsemer Interstitial Lung Disease Award: $50,000/year for up to two years. Provides seed funding for mentored junior researchers studying ILD.

Public Health and Public Policy Research Award: $50,000/year for up to two years. Supports public health research and evaluation of policies affecting air quality and lung health.

For the 2027–2028 Lung Association Research Institute grant cycle, qualified researchers must be conducting research in the U.S. and meet individual grant qualifications and other terms and conditions. Application materials are available through ProposalCentral. The entire process takes 6 to 8 months. Research grant awardees will be notified in June 2027.

To learn more or begin the application process, visit Lung.org/research. ❖

Miriam awarded $11.1M NIH grant to advance research on stress, trauma and resilience

PROVIDENCE — The Miriam Hospital has received an $11.1 million federal grant from the National Institute of General Medical Sciences, part of the National Institutes of Health, to support Phase 2 of its Center of Biomedical Research Excellence for Stress, Trauma and Resilience.

The competitive renewal will expand the STAR COBRE's work to advance research on how early-life stress and trauma affect long-term health, support emerging investigators, and strengthen community partnerships aimed at developing practical interventions that promote resilience and improve outcomes for children, families and communities. The Phase 2 grant will build on the center's significant accomplishments during its first five years and further strengthen Rhode Island's only research center dedicated to stress, trauma and resilience.

"Support for Phase 2 will allow us to accelerate STAR COBRE's impact on a regional and national level, catalyzing transformative science and the next generation of transdisciplinary scientists, strengthening ties with our amazing community partners and improving health across the lifespan," said **LAURA R. STROUD, PhD**, principal investigator of the STAR COBRE, director of The Miriam Hospital's Center for Behavioral and Preventive Medicine, and professor of psychiatry and human behavior at the Warren Alpert Medical School of Brown University. "Decades of research have shown that childhood stress and trauma can profoundly affect health across the lifespan, yet many questions remain about how these experiences shape physical and mental health and, importantly, how and when to intervene. This investment will help us develop new solutions, advance scientific understanding, and train the next generation of investigators working to improve health and resilience."

The Phase 2 award will support three new research initiatives led by early-stage investigators and clinician-scientists focused on developing innovative interventions to improve health outcomes associated with stress and trauma.

Researcher initiatives include:

- **LG WARD, PhD**, will develop a novel trauma-informed care toolkit for inpatient obstetrics designed to reduce traumatic childbirth, improve communication between providers and patients, and improve postpartum mental health.
- **LINDSAY HUFFHINES, PhD**, will develop a brief, community-informed intervention to help parents who experienced childhood adversity and their young children, with the goal of building resilience and improving family mental health.
- **KAYLONI OLSON, PHD**, will examine how momentary stress contributes to chronic pain, stress biology and weight-related behaviors to pave the way for a novel intervention to improve weight- and pain-related health in real time.

A new focus during Phase 2 will include intervention development, wearable technologies, implementation science, and expanded community engagement to help translate scientific discoveries into real-world improvements in resilience and health. ❖

Novel radiation strategy redefines a new treatment paradigm for glioblastoma

PROVIDENCE — New data from a multi-institutional feasibility clinical trial across 15 institutions nationwide presented by **CLARK CHEN, MD, PhD**, professor and director of the Brain Tumor Program at Brown University Health, suggest that a novel radiation therapy device may help improve outcomes for patients newly diagnosed with glioblastoma, one of the deadliest forms of brain cancer.

The findings were presented as a podium presentation at the 2026 American Society of Clinical Oncology (ASCO) Annual Meeting and provide the foundation for a planned Phase III randomized clinical trial.[1]

Glioblastoma is an aggressive brain cancer that is difficult to treat. Standard treatment includes surgery to remove as much of the tumor as possible, followed by radiation and chemotherapy. However, to allow the brain and surgical incision time to heal following tumor removal, radiation and chemotherapy are typically delayed for three to six weeks after surgery. During this time, cancer cells left behind after surgery can continue to grow and multiply.

"Even after a successful surgery, microscopic glioblastoma cells remain in the brain," said Dr. Chen. "In 50 to 70 percent of patients, these cells grow quickly enough to become visible on MRI scans before standard radiation treatment can begin. In some cases, the tumor grows back to a size that requires a second surgery. This early regrowth is associated with poorer survival, creating an urgent need for treatments that can target cancer cells without affecting wound healing."

To address this challenge, investigators evaluated GammaTile® (GT Medical Technologies, Tempe, Arizona), a cesium-131-based radiation therapy implanted directly into the surgical cavity at the time of tumor removal. Unlike conventional external beam radiation therapy (EBRT) that requires waiting until the patient has healed from surgery, GammaTile® begins delivering radiation immediately after surgery. Because the radiation travels only a short distance, it remains concentrated around the area where the tumor was removed and does not interfere with wound healing. The treatment also delivers radiation doses that are two to four times higher than can be safely achieved with conventional external beam radiation therapy.

Dr. Chen led the Phase I GESTALT clinical trial (NCT05342883) involving 15 hospitals across the United States to determine whether GammaTile® could be safely incorporated into standard glioblastoma treatment. The study included 67 patients and found that the combined treatment, which comprised surgery and concurrent GammaTile® placement followed by a shortened course of EBRT and standard chemotherapy, was safe and practical to deliver. Patients who received GammaTile® did not experience more serious side effects than those typically seen with standard treatment alone.

Most notably, only 6 percent of patients experienced rapid early tumor regrowth after surgery, compared with the 50 to 70 percent rates commonly reported when patients must wait three to six weeks before starting radiation and chemotherapy.[2-3] The findings suggest that delivering radiation at the time of surgery may help prevent cancer growth during this critical period.

"These results suggest that immediate radiation treatment at the time of surgery may address one of the most significant challenges in glioblastoma care," said Dr. Chen. "By treating residual cancer cells during the recovery period, we may be able to reduce early tumor regrowth while maintaining the safety of standard treatment."

"GammaTile was built to close the gap in glioblastoma care created by the wait for traditional external beam radiation to begin after surgery," said **MICHAEL GARCIA, MD, MS**, Chief Medical Officer of GT Medical Technologies. "These results show what's possible when we stop giving residual cancer cells time to regrow between surgery and radiation. We're grateful to Dr. Chen and the entire GESTALT investigator team for the rigor they brought to this trial, and we're energized to support the Phase III study that will build on it. Based on these findings, a Phase III randomized clinical trial, BRIDGES (NCT07195591), has been launched to further evaluate the potential benefits of incorporating GammaTile® into the frontline treatment of newly diagnosed glioblastoma."

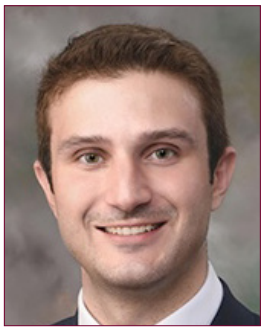
"GT Medical Technologies was founded by brain tumor specialists who believed that innovative radiation therapy approaches were critical for improving patient outcomes," said **PER LANGOE**, Chief Executive Officer of GT Medical Technologies. "These trial results suggest that we are realizing their vision for patients with glioblastoma, and the ongoing Phase III BRIDGES trial will further inform our understanding of how GammaTile may improve patient outcomes."

This study was sponsored by GT Medical Technologies, Inc. Dr. Chen is a consultant for GT Medical and a participating investigator in the NCT05342883 trial. ❖

References

1. Chen C, et al. Presented at: American Society of Clinical Oncology; May 31, 2026; Chicago, IL.
2. Waqar M, et al. *Neuro-oncology Adv.* 4 (2022).
3. Guzzino J, et al. *J Neurooncol.* 176:5 (2025).

Joseph A. Gil, MD, performs thumb joint replacement with newly available TOUCH® CMC 1 implant



EAST PROVIDENCE — University Orthopedics hand and upper extremity surgeon **JOSEPH A. GIL, MD**, has become the first surgeon in Rhode Island to perform a thumb joint replacement using the TOUCH® CMC 1 prosthesis, a newly FDA-approved implant designed to relieve pain and restore function for patients with arthritis at the base of the thumb.

The procedure, performed at Rhode Island Hospital, is known as carpometacarpal (CMC) total joint arthroplasty. It replaces the arthritic joint at the base of the thumb with a small ball-and-socket implant. Similar in concept to a hip replacement—but designed specifically for the thumb—the prosthesis is designed to reduce pain and restore the strength and mobility patients need for everyday activities such as gripping, pinching, and opening jars.

"Thumb arthritis can make even the simplest daily activities like buttoning a shirt, turning a key, or gripping a coffee cup extremely painful," said Dr. Gil. "With the goal of restoring function and reducing pain, this implant provides another treatment option for people living with thumb arthritis who want to get back to the activities they enjoy."

The thumb CMC joint is one of the most common joints affected by osteoarthritis. As cartilage wears away, patients often experience pain, weakness, and loss of grip and pinch strength that can interfere with work, hobbies, and everyday tasks.

Until recently, surgical treatment for advanced thumb arthritis typically involved removing the arthritic trapezium bone and reconstructing the joint using nearby tendon tissue. The TOUCH® CMC 1 prosthesis offers an alternative by replacing the joint with a dual-mobility implant designed to provide stability while maintaining natural thumb movement.

Developed by KeriMedical and distributed in the United States by Medartis Inc., the TOUCH® CMC 1 prosthesis received FDA approval in 2025 after more than a decade of successful use in Europe. With that approval, patients in the Rhode Island area now have access to an innovative treatment option that, until recently, was available only overseas.

"Every patient is different, and there is no one-size-fits-all treatment for thumb arthritis," Dr. Gil said. "Having access to this technology allows us to offer another evidence-based option for patients whose symptoms have not improved with conservative treatment."

The Hand & Wrist Center at University Orthopedics offers comprehensive care for thumb arthritis, including splinting, medications, corticosteroid injections, hand therapy, and advanced surgical treatments when appropriate. ❖