Key considerations for prior authorization compliance and automation

Satisfy members, providers and regulators with automated prior authorization

Prior authorization is supposed to save healthcare dollars. Too often, it's a cost sink instead—consuming invaluable time, money and resources. One study indicated the time and effort that goes into prior authorizations costs radiation oncology clinics alone more than $40 million annually[1]. Physicians say delayed and denied decisions lead to higher costs of care[2]. Analysts cite research indicating initial prior authorization reviews cost payers an average of $80 to $120 per review, or $18.4 billion annually, with peer-to-peer reviews and appeals adding yet more expense[3]. While the numbers vary depending on the variables included, all add to healthcare's nearly $1 trillion in annual administration costs.[4]

Regulators are pushing the industry to innovate and reduce the administrative burden tied to prior authorization through standardization and automation. The Centers for Medicare & Medicaid Services (CMS) have painted a target on prior authorization practices. The agency's 2024 Medicare Advantage and Part D final rule streamlines prior authorization requirements to minimize disruptions and ensure continuity of care for plan members.

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A proposed rule, Advancing Interoperability and Improving Prior Authorization Processes (CMS-0057-P), now in review with an effective date of January 1, 2026, would require affected payers to "implement an API to support functions of electronic prior authorization, standardizing prior authorization decision timeframes, and bringing transparency to prior authorization through metric reporting." This HL7® FHIR®-based Prior Authorization Requirements, Documentation, and Decision (PARDD) API would include a payer's list of covered items and services for which it requires prior authorization. The API would also be used to communicate prior authorization decisions to providers, including reasons for denying a request.[5]

The proposal calls for payers to use the Patient Access API to include information on prior authorization requests and decisions no later than one business day after receiving an authorization request or when an existing authorization request changes. Payers would be required to release an annual public report aggregating data about their prior authorizations, including the percent of prior authorization requests approved, denied, and approved after appeal, and average time between submission and decision.[6]

One of the underlying goals of the proposal is to address recommendations made by the Office of the Inspector General (OIG), which concluded Medicare Advantage plans too often denied authorization requests for procedures that are in fact allowed under traditional Medicare.[7] These regulatory requirements signal it's time for payers to rethink their approach to prior authorization to satisfy regulators, members and providers.

Supporting better processes with intelligent automation

Solutions for streamlining prior authorization—from submission through decision—exist today. Yet merely deploying a tool doesn't truly solve prior authorization challenges. That requires a complete analysis of the end-to-end process to identify gaps, manual and extraneous work and resources used. The next step is exploring disruptive solutions to streamline the process, increase efficiency and reduce costs.

Today's technology can deliver solutions that automate the prior authorization process with accuracy and support more transparent clinical decisions. This is especially valuable for payers who have analyzed their entire prior authorization process. They can implement a comprehensive solution or deploy a modular solution to make immediate progress in key areas. For example, a payer could initially deploy prior authorization automation with provider organizations that work with specific patient populations. Payers that combine intelligent, automated prior authorization workflows with improved processes achieve these benefits:

- Free budget and time to reallocate resources to higher value and more complex issues by eliminating much of the analysis required to manually coordinate and manage authorization requests and approvals.
- Greatly improve member and patient experiences by making prior authorization fast and transparent so patients receive care sooner.
- Increased provider satisfaction as they save time and money and are equipped to help patients explore options under clear clinical guidelines.
- More effective care management by reducing authorization-related administrative work so utilization teams work at the top of their licenses and focus on complex cases.
- Success under value-based contracts with improved provider and patient satisfaction scores and helping providers succeed in reducing their administrative burden.

Reduce authorization time to minutes

Prior authorization systems aren't exactly new. But portals provide little value when they function only as request submission mechanisms and don't expedite decisions. In contrast, intelligent portals auto-populate data, restrict drop down menu options and have "help" and "alert" features to assist providers as they fill out authorization request forms.

These portals automatically review requests and flag missing components before the providers submit for approval. Such features help reduce review times, resubmissions and appeals by ensuring that providers deliver all required data and documentation in the first request submission. Providers estimate they can save up to 16 minutes per transaction with automation.[8]

Prior authorization intelligent portal technology with automated business rules and an intuitive, guided user experience can guarantee consistent decision outcomes, managing the complexity of intersecting clinical protocols, plan policies, enrollment, benefit contracts and various systems storing all this information.

The next evolution in prior authorization is for all this functionality to be integrated into providers' workflows. The CMS Advancing Interoperability rule requires payers to use the PARDD API to enable providers to request prior authorizations directly from their electronic medical record or practice management system.[9] PARDD will work in the background and it and any other APIs necessary to submit requests and return payer responses should be invisible to the provider.

The providers' requests can be auto-populated to further streamline the process. The integration with EMRs or PM systems will take even greater advantage of automated business rules and an intuitive, guided user experience. . The beneficial outcome: moving the prior authorization decision activity closer to the patient at the point of care. Medical necessity criteria and clinical guidelines can be tightly integrated into the prior authorization workflow to trigger refined, very granular business rules that enable high auto-approval rates.

Even challenging decisions about genetic testing, durable medical equipment (DME) and skilled nursing can be automated. The process may also incorporate rules for redirecting patients to preferred providers and facilities, such as having an MRI done at a third-party facility vs. in hospital. The API and automation can deliver consistent decision outcomes while managing intersecting clinical protocols, plan policies, enrollment, benefit contracts and the various systems that store relevant data.

On average, plans with automated prior authorization processes are achieving up to 88% auto-approval rates.[10] One plan saw its 11-day prior authorization turnaround time drop to 4.5 minutes on average.[11] PARDD API early adopters have experienced a 140% to 233% increase in prior auth productivity moving from 3 to 5 prior authorization requests processed per hour to 10 to 12 prior authorizations requests processed per hour.[12]

Engage stakeholders in new ways

Automating prior authorization is not simply about digitizing existing processes. Laying the groundwork for better stakeholder relations and success with value-based contracts requires rethinking operations and clinical decision processes. The latter likely includes liberalizing clinical approvals and standardizing them so that the rules can be codified and automated. Many payers worry their costs will balloon if they adopt more liberal approval standards. However, the OIG analysis found payers eventually approve many of the authorization requests they originally deny.[13]

Each of these denied-then-approved transactions represents wasted time, effort and costs as well as unhappy providers and members. The combination of natural language processing (NLP), machine learning (ML) and AI can help prevent this scenario. A bot equipped with these tools can assess the prior authorization request while the provider is preparing it and predict whether it will pend. If the probability of a pend is high, the bot can ask the provider in real time for additional documentation and data to address the issue preventing the automatic approval.

In addition, the NLP/ML/AI bot can equip payers with accurate data to help them make effective prior authorization policy decisions. Such bots can forecast prior authorization trends, such as auto-approval rates vs. pends among gold-carded and non-gold carded providers. That data can help payers decide which providers to offer gold cards. "Gold carding" refers to payers waiving prior authorization requirements on procedures and prescriptions for providers with a good history of prior authorization approvals.

The bot also could track auto-authorization rates, compute potential savings for payers and providers and predict future savings and costs for the next plan year.Automated prior authorizations also give payers the opportunity to offer members a better experience when they opt into sharing payer-to-payer data through the required API. Payers can educate members about the value of achieving an accurate and complete longitudinal health record through payer-to-payer sharing.

For example, under this scenario, approved prior authorizations from the member's former payer could transfer automatically to the new plan. That helps ensure uninterrupted care, better outcomes and more satisfied members.

Strengthening provider relationships

By exposing the right clinical criteria through a prior authorization portal in just a few seconds as providers make their requests, payers give providers the opportunity to evaluate a care plan against the standards. Increasing adoption by improving the provider experience is perfectly aligned with CMS' direction.

Some automated prior authorization solutions also enable payers to offer providers interactive online training tutorials for education and engagement. Those are even more effective when coupled with local support services and a dedicated support team. These tools strengthen working relationships with providers while also improving efficiency by reducing authorization submission errors.

Utilization management (UM) teams and medical directors can make decisions about pended authorizations more efficiently when prior authorization automation workflows include richer data, such as attachments uploaded through the portal and clinical guideline responses. One payer even saw its pended decisions turnaround time decrease to just under 48 hours.[14]

Further, with today's analytics tools, it's possible to easily track costs on a near real-time basis. When necessary, payers may walk back decision trees that led to costs out of line with projections. What's more, with this data in hand, payers have proof of the problem and can collaborate with providers to address it. That enables a more positive working relationship and improves the process for both payers and providers.

Improve success under value-based contracts

Payers that automate prior authorization decisions help providers reduce their administrative burden and reduce their low-value spending. Automatic approvals for care that meets standards can speed the time to quality care for patients/members.

Prior authorization is then part of the toolset that supports value-based care, enabling UM professionals to focus on the complex needs of populations vs. paperwork.

It can also include processes for monitoring outlier cases over time. This data can help reveal the outcomes and efficacy of high-cost and rarely performed treatments and procedures. This information can inform future decision-making criteria and treatment pathways.

No regrets investing in prior authorization automation

In a study Cognizant recently commissioned, health plan executives said these were the features they most valued in a prior authorization solution:

- **Automated decisions.** Built-in criteria should be standardized and evidence based.
- **Analytics/reporting.** Features should include up-to-the-minute status displays and customizable data tracking and reports.
- **Machine learning (ML).** ML should be focused on predicting future trends by forecasting membership size and patient care needs.
- **Data integration.** Solutions should retrieve information from electronic medical records (EMRs) and share data across other systems and tools, including core administrative platforms, UM systems, quality systems, etc., to enable revamped and streamlined processes.
- **Portals and connectivity.** Provider portals should be easy to navigate and have reliable uptime.

Investments payers make in prior authorization systems with these features will provide immediate benefit and long-term value, as long as they are based on open, extensible technology architectures. Open, standards-based systems should be flexible enough to incorporate the proposed CMS rule for FHIR®-based prior authorization interoperability. Complying with that rule requires a solution that supports EMR integration; payer-provider authorization mandates; and FHIR® integration.

Payers should not stop at satisfying CMS regulatory obligations. Inefficient prior authorization processes that leave behind dissatisfied patients and members are a problem for all health plans and providers. Prior authorization portals and other electronic data exchange, already in place in varying degrees in many health plans, provide a rich opportunity to reduce administrative burdens and improve time to care. Automated prior authorization enables payers and providers to collaborate on providing care seamlessly, with the speed of intuition. That's an excellent foundation for delivering new member experiences and business strategies fit for the era of value-based care.

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Endnotes

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