Reducing the Burden of Prior Authorization

Challenges, Changes and Opportunities

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Reducing the Burden of Prior Authorization: Challenges, Changes and Opportunities

- Introduction
- What Is Prior Authorization (PA)?
- Why Prior Authorization Exists
- The Current Process (and Where Burden Occurs)
- The Impact of Prior Authorization
- Reform Efforts and Best Practice (BCBSA Settlement, BCBS AL, AHIP, Insurer Commitment, etc.)
- Reducing the Burden: Policy and Practice Strategies
- Reducing the Burden: Physician Practice Steps
- Case for Change
- Conclusion and Call to Action

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Introduction

Prior authorization was *designed* to ensure appropriate, safe, and cost-effective care. However, in practice, it has become a major administrative and clinical barrier.

Purpose of presentation

To define prior authorization, explore how it works, identify the key challenges it poses, and discuss strategies for reducing its burden while maintaining care quality and cost-effectiveness.

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What is Prior Authorization?

General Definition

- A cost-control process used by insurers requiring providers to obtain approval before delivering certain medical services, procedures, medications, or equipment.
  - Also known as: *preauthorization, precertification, prior approval, or predetermination*.

Process Summary

- Provider submits a request to the health plan.
- Insurer reviews for medical necessity, safety, and cost-effectiveness.
- Decision made: approval, denial, or request for more information.
- Appeals process available if denied (in most cases).

Key Principles (NAIC)

- Verifies *medical necessity*, *safety*, and *cost-effectiveness*.
- Required primarily under commercial insurance, Medicare Advantage, and Part D plans.
- Not required for emergency care.

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Why Prior Authorization Exists

Cost Control: Ensures the service or drug is cost-effective and reduces use of higher-cost alternatives.

Medical Necessity: Confirms that care meets accepted clinical standards.

Safety: Prevents drug interactions or misuse of high-risk treatments.

Appropriate Site of Care: Encourages services to be performed in more cost-efficient settings when hospital-based care isn’t necessary.

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The Current Process (and Where Burden Occurs)

Typical Workflow

- Provider initiates request (manual or electronic submission).
- Insurer reviews: often requires supporting documentation.
- Decision within 5–10 business days (can vary and is all too often much longer).
- Possible outcomes: approval, denial, need for additional info, or alternative recommendation.

Challenges at Each Stage

- **Submission:** Time-consuming data entry; lack of standardized forms.
- **Review:** Opaque criteria; non-clinical reviewers.
- **Decision:** Delays in communication back to providers/patients.
- **Appeals:** Complex, lengthy, and often duplicative.

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The Impact of Prior Authorization

AMA Characterization of Prior Authorization: “Overused, costly, inefficient, opaque, and responsible for patient care delays.”

For Patients

- Delays in care or treatment interruptions.
- Potential out-of-pocket costs if coverage denied.
- Confusion navigating appeals or plan requirements.

For Providers

- High administrative burden: staff time diverted from patient care.
- Repeated submission cycles; inconsistent payer requirements.
- Financial strain due to delayed reimbursement or nonpayment.

For Health Systems and Payers

- Increased administrative costs.
- Strained payer–provider relationships.
- Misalignment between utilization management goals and patient outcomes.

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Key Statistics

2024 AMA Prior Authorization Physician Survey

- **93%** report delays- for those patients whose treatment requires PA.
- **83%** report that PA can at least sometimes lead to treatment abandonment.
- **31%** of physicians (almost 1 in 3) report that PA criteria are rarely or never evidence based.
- **29%** of physicians (more than 1 in 4) report that PA has led to a serious adverse event for a patient in their care.
- **82%** of physicians say PA requirements have increased in the last 5 years (84% for medication).

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Key Statistics

2024 AMA Prior Authorization Physician Survey

- **39 PAs** per physician per week on average are completed by a practice.
- **13 hours a week** is spent by physicians and their staff to complete PAs.
- **40%** of physicians have staff who work exclusively on PAs.
- **31%** of physicians report that PAs often or always are denied.
- **89%** of physicians report that PA somewhat or significantly increases physician burnout.
- **20%** of physicians report that they always appeal an adverse PA decision.
- **61%** of physicians report that they are concerned that AI increases/will increase PA denial rates.

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Key Statistics
2024 AMA Prior Authorization Physician Survey

What is the Cost of PA?

- **88%** of physicians report PAs leads to higher overall utilization
- **77%** report ineffective initial treatment (step therapy)
- **73%** report additional visits
- **47%** report immediate care/ER visits
- **33%** report hospitalizations
- **80%** report that the PA process at least sometimes leads to patients paying out of pocket (for medication)

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Reform Efforts and Best Practices

AMA Initiatives and Medical Association Initiatives (TMA, CSMS, etc.)

- Reducing overall PA volume.
- Increasing transparency around requirements and criteria.
- Promoting automation and electronic PA systems.
- Ensuring timely patient care and reducing unnecessary delays.
- “Gold Carding” (Texas).

Health Plan Examples (Cigna, Humana and Blues)

- Promotes early initiation of PA requests.
- Encourages use of in-network providers.
- Implements “site of care” authorizations to reduce costs.
- Aligns with *No Surprises Act:* emergency and surprise bills exempt from PA.
- *BCBS Settlement.*

NAIC Recommendations

- Clear patient communication on coverage and appeal rights.
- Timely decisions, especially for urgent cases.
- Standardized forms and electronic submission.
- Improved data tracking and reporting of PA metrics.

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Blue Cross Blue Shield Antitrust Litigation (MDL No. 2406)

Injunctive Relief (estimated to be more than $17 Billion)

- BlueCard Transformation
- BlueCard Prompt Pay Commitments
- Service Level Agreements
- BlueCard Executive
- Real-Time Messaging System
- National Executive Resolution Group
- Contractual Relief (Contiguous area rule, all product clauses, expansion of contiguous area to affiliated hospitals)
- Third-Party Information
- Minimum Data Requirements
- Blue Plan Common Appeals Form
- **Pre-Authorization Standards**
- Telehealth Relief
- Minimum Level of Value-Based Care and Best Practices for Value Based Care

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Timeline for Implantation of Injunctive Relief

- No later than 90 days after the Effective Date (December 18, 2025), the Blues must implement the injunctive relief set forth in ¶¶ 11-13, 16-17, 21-22 & 26 of the Settlement Agreement:

¶ 11 – Contiguous Area Contracting
¶ 12 – Member Access
¶ 13 – BlueCard Prompt Pay
¶ 16 – BlueCard Executive
¶ 17 – National Executive Resolution Group
¶ 19 – SLAs to Monitoring Committee
¶ 21 – Common Appeals Form
¶ 22 – Minimum Level of Value Based Care
¶ 26 – Affiliates All Products Clauses

- No later than 120 days after the Effective Date **(January 17, 2026),** the Blues must implement the injunctive relief set forth in ¶¶ 23 & **25** of the Settlement Agreement:

¶ 23 – Best Practices for Value Based Care
¶ 25 – Pre-Authorization Standards

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Blue Cross Blue Shield Antitrust Litigation (MDL No. 2406)

- No later than 120 days after the Effective Date **(January 17, 2026),** the Blues must implement ***Pre Authorization Standards***

Pre-Authorization Standards

- The *Settling Defendants (BCBSA and BCBS Blues Plans- including Anthem/Elevance)* will promulgate guidelines to improve the prior authorization process.

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Blue Cross Blue Shield of Alabama and Medical Association of the State of Alabama

Blue Cross and Blue Shield of Alabama and the Medical Association of the State of Alabama agreed upon changes to prior authorization (announced November 4, 2025).

Seven commitments

- BCBS of Alabama will not use AI for denials.
- The insurer will not require repeated prior authorizations for patients needing prescriptions for chronic conditions, while the provider will occasionally need to confirm use and efficacy.
- There will be no surprise denials for approved treatments and services.
- BCBS of Alabama will work toward expanding its gold-card program.
- Prior authorizations will go entirely electronic.
- Existing prior authorizations will stay valid for 90 days if a patient changes their BCBS of Alabama plan, so long as the provider is in network.
- Prior authorization changes will be shared at least 45 days before going into effect. Patients and doctors can access a platform that will outline which services require prior authorization, as well.

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Reducing the Burden
Policy and Practice Strategies

Automation and Standardization

- Expand adoption of *electronic prior authorization (ePA)* integrated into EHRs/EMRs.
- Use standardized clinical criteria and real-time data exchange (health information exchange, other).

Transparency and Predictability

- Publish payer criteria and approval timeframes.
- Identify services that consistently receive approval and remove PA requirements (deprioritize low-value PAs).

Timeliness and Accountability

- Implement state/federal limits on response times.
- Require data reporting on denials, turnaround times, and overturn rates.

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Reducing the Burden
Policy and Practice Strategies Cont'd

Clinical Alignment

- Engage physicians and specialty societies in defining "medical necessity."
- Use peer-to-peer reviews with relevant specialists.

Patient-Centered Approaches

- Provide clear instructions on appeals and expedited reviews.
- Improve education about coverage and documentation requirements.

Legislative and Regulatory Momentum

- State and federal proposals (e.g., gold card programs, CMS interoperability rules, WISer).
- Support from AMA, NAIC, and payer coalitions for reform.

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Recent Federal Legislation

Reducing Medically Unnecessary Delays in Care Act of 2025 (H.R. 2433)

- Introduced March 27, 2025 by Rep. Mark Green (R-TN) in the 119th Congress.
- Would require that Medicare (Original FFS), Medicare Advantage (MA), and Medicare Part D prior authorization and adverse coverage decisions be based on written clinical criteria developed in consultation with physicians.
- Also mandates that reviewers of prior authorization be board-certified physicians in the same specialty as the treating physician.
- Status: Introduced, referred to committees; not yet law.

Improving Seniors' Timely Access to Care Act of 2025 (S. 1816 / H.R. 3514)

- Bipartisan, bicameral legislation supported by medical societies including the American Society for Radiation Oncology (ASTRO) and American College of Cardiology (ACC).
- Key provisions: standardizing electronic prior authorization for Medicare Advantage; requiring reporting/transparency of services subject to PA and metrics (denials, appeals); extending beneficiary protections such as honoring prior authorizations when switching plans; moving toward real-time decisions for routinely approved services.

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Other National Efforts

- The American Health Insurance Plans (AHIP) and member plans pledged voluntary commitments by January 1, 2026/2027: reducing the number of services requiring prior authorization; standardizing electronic prior authorization using FHIR-APIs; honoring existing prior authorizations for 90 days when a patient switches plans.

- Separately, the Centers for Medicare & Medicaid Services (CMS) final rule on interoperability & prior authorization (CMS-0057-F) sets some guardrails for PA in Medicare Advantage and Medicaid.

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2025 Health Insurance Industry Pledge

Health Insurance Industry Pledge

- On June 23, 2025, HHS Secretary Robert F. Kennedy Jr. and CMS Administrator Dr. Mehmet Oz and insurers, including Aetna, Cigna, Elevance, Humana, UnitedHealthcare, and multiple Blue Cross Blue Shield plans, announced a voluntary pledge to reform PA across employer, commercial, Marketplace, Medicare Advantage, and Medicaid markets.
- This pledge aligns with much of what is required in the CMS Interoperability and Prior Authorization Final Rule but extends commitments to commercial and employer plans outside CMS' regulatory authority.

The six commitments

- Ensure only medical professionals review nonapproved PA requests, effective immediately.
- Reduce the volume of services requiring PA, with measurable reductions by *Jan. 1, 2026.*
- Honor existing PAs during insurer transitions, with a 90-day continuity period beginning *Jan. 1, 2026.*
- Improve explanations for PA denials and appeals processes by *Jan. 1, 2026.*
- Real-time approvals: 80% of electronic PA requests with required documentation should be answered in real-time by *2027.*
- Standardize electronic PA submissions using Fast Healthcare Interoperability Resources (FHIR)-based APIs, operational by *Jan. 1, 2027.*

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National Efforts Cont'd

- These efforts reflect growing bipartisan recognition that prior authorization processes impose administrative burdens on providers, delays in access for patients, and may undermine timely delivery of care.

- For physician practices, this legislation could change workflow, documentation requirements, reviewer qualifications, transparency, and timelines for prior-authorization decisions.

- For health systems and payers, it signals potential shifts in oversight and accountability, with an emphasis on specialty-appropriate review, electronic automation, and data/reporting metrics.

- Given your work in physician practice transformation and payer-provider collaboration, these legislative developments may have downstream implications for contracting, utilization management, vendor engagements, and site-of-care strategy.

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CMS Interoperability and Prior Authorization Final Rule

CMS Interoperability and Prior Authorization Final Rule (Jan. 17, 2024)

Who Must Comply?

- Medicare Advantage plans, Medicaid/CHIP Fee-for-Service and managed care, and Qualified Health Plan (QHP) issuers on the federally facilitated exchanges must implement new data-sharing capabilities and streamlined PA processes.

Decision Timeframes

- Expedited (urgent) PA requests
- Decisions due within 72 hours (excluding QHP issuers on FFEs) beginning *Jan. 1, 2026.*
- Standard (non-urgent) PA requests: Decisions due within seven calendar days beginning *Jan. 1, 2026.*
- Denials must include a specific reason (regardless of submission channel) beginning *Jan. 1, 2026.*
- Public reporting: Plans must post PA metrics annually; first reports due by *March 31, 2026*

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CMS WISeR Initiative
Benefits, Challenges, and Concerns

What is WISeR?

The Wasteful and Inappropriate Service Reduction (WISeR) Model is a new demonstration launched by the Center for Medicare and Medicaid Innovation (CMMI) to curb wasteful or low-value services in Original (Fee-for-Service) Medicare.

- The five-year pilot (2026–2031) will operate in six states: **Texas, New Jersey, Oklahoma, Ohio, Washington, and Arizona.**
- AI-driven prior authorization and pre-payment review for selected outpatient items and services identified as at risk for *overuse or abuse.*
- Private-sector vendors will apply predictive analytics and clinical review to determine whether services meet coverage and clinical appropriateness standards.
- CMS will share in savings generated by reduced utilization, while asserting no change to underlying coverage rules.
- CMS states that WISeR will apply to a "set of items and services chosen by CMS that may
  - (1) pose concerns related to patient safety if delivered inappropriately;
  - (2) have existing publicly-available coverage criteria; and
  - (3) may involve prior reports of fraud, waste and abuse."
- The model's fact sheet provides examples of subject services: e.g., knee arthroscopy for knee osteoarthritis; electrical nerve implants; skin & tissue substitutes but services will span multiple clinical domains.

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CMS WISeR Initiative
Benefits, Challenges, and Concerns

Potential Benefits

- Cost Control and Program Integrity: Seeks to reduce Medicare expenditures by targeting services with high rates of questionable utilization.
- Data and Technology Integration: Uses AI and analytics to detect waste and streamline review processes.
- Reinforcement of Evidence-Based Practice: Promotes clinical decision-making grounded in medical necessity and guidelines.
- Transparency and Oversight: Vendors must meet timeliness and performance metrics, potentially increasing transparency.

Key Challenges and Risks

- Access Delays and Patient Impact: Prior authorization may delay or deny necessary care.
- Administrative Burden: Adds workflow and documentation requirements for providers.
- Incentive Misalignment: Vendors are paid based on savings, creating potential conflicts of interest.
- Algorithmic Bias and Data Validity: AI models may misclassify services and lack transparency.
- Legal and Policy Precedent: Extends CMMI's authority into utilization management for traditional Medicare.
- Potential Cost Increases: Delayed care or inefficiencies could raise downstream costs.

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CMS WISeR Initiative
Benefits, Challenges, and Concerns

Political and Stakeholder Opposition

• Congressional Democrats, led by Reps. Suzan DelBene (D-WA) and Ami Bera, MD (D-CA), urged CMS to reconsider the model, citing risks to patient access and physician autonomy.

• State and national medical associations, including the Texas Medical Association and Washington State Medical Association, oppose the initiative, warning of increased administrative burden and reduced access.

• The American Hospital Association (AHA) and specialty societies such as the Society of Interventional Radiology (SIR) also objected, emphasizing that WISeR's incentive structure prioritizes denials over patient outcomes.

Bottom Line

The WISeR initiative reflects CMS's intent to modernize program integrity and reduce wasteful spending through data analytics and clinical oversight. However, bipartisan stakeholder feedback underscores the model's significant risks to patient access, provider burden, and policy precedent. While CMS views WISeR as a forward-looking efficiency measure, critics see it as a premature and potentially harmful application of AI-driven prior authorization in traditional Medicare.

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CMS WISeR Initiative
Benefits, Challenges, and Concerns

Vendor Assignments by State

State	Medicare Jurisdiction	Selected Vendor
Texas	JH (Novitas)	Cohere Health, Inc.
New Jersey	JH (Novitas)	Genzeon Corporation
Oklahoma	JH (Novitas)	Humata Health, Inc.
Ohio	J15 (CGS)	Innovaccer Inc.
Washington	JF (Noridian)	Virtix Health LLC
Arizona	JF (Noridian)	Zyter Inc.

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CMS WISeR
Vendor Commercial Insurer Relationships

Cohere Health

Cohere partnered with Humana to expand its prior-authorization platform (initial pilot in musculoskeletal services in 2021, expanded to imaging and sleep services in 2024) across Commercial and Medicare Advantage lines. Cohere also partnered with Medical Mutual (Ohio-based health insurer) and Rhyme (EHR-integrated prior auth vendor) to automate their authorization workflow for outpatient, investigational, therapy and chiropractic services. Cohere announced that its platform supports over 16 million health plan members and 12 million prior authorization requests annually, indicating broad payer engagement.

Humata Health

Humata is a physician-led AI prior authorization platform that has secured investment from (and thus indirect relationships with) major payers via investment arms: e.g., Blue Venture Fund (representing many Blue Cross plans) and Highmark Ventures (related to Highmark) in its $25 M funding round. More specifically, Humata's platform was implemented by Allegheny Health Network for prior-authorization automation in imaging and radiology services, via their prior-authorization integration with Humata.

Genzeon Corporation

Genzeon appears more broadly as a digital/IT consulting and transformation firm with healthcare clients, but details of insurer-vendor payer integrations were not identifiable in the reviewed materials.

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Reducing the Burden
Physician Practice Steps

Clinical and Documentation Process Improvements

Goal: Ensure requests are complete, accurate, and defensible at submission.

- Standardize PA checklists by service line, develop per-specialty templates that include payer-specific coverage criteria.
- Embed clinical decision support (CDS), integrate guideline prompts (e.g., NCCN, MCG, Milliman) into the EHR to ensure documentation matches payer medical necessity standards.
- Use structured note templates, include discrete fields for diagnosis, prior treatments, test results, and response.
- Use “medical necessity phrases” that align with payer language, match indications in clinical documentation to payer policy language.

Technology and Workflow Automation

Goal: Accelerate submissions, monitor status, and reduce manual rework.

- Adopt electronic prior authorization (ePA) integrated with EHRs via FHIR APIs (required by CMS by 2027).
- Use automated status tracking and alerts, deploy dashboards to monitor submission date, expected response time, and aging authorizations.
- Centralize PA data, maintain a shared database of all requests and outcomes for trend tracking.
- Leverage payer portals or clearinghouses (Availity, Cohere, Humata) to avoid fax or phone delays.

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Reducing the Burden
Physician Practice Steps

Staffing and Training

Goal: Build an informed, coordinated PA team.

- Designate PA specialists who understand payer requirements and LCDs/NCDs.
- Create escalation workflows for urgent or denied cases (e.g., PA RN → medical director appeal).
- Cross-train billing, coding, and scheduling staff on which services require PA.
- Hold quarterly or semi-annual payer-performance reviews to identify trends and corrective actions.

Payer Collaboration and Communication

Goal: Prevent denials through proactive engagement and feedback loops.

- Develop payer-specific PA guides summarizing timelines, forms, and policy links.
- Maintain direct payer liaisons or utilization-management contacts for large practices.
- Request peer-to-peer review early when criteria misalignment is suspected.
- Negotiate PA relief ('gold carding') for high-performing practices with consistent approval histories.
- Participate in payer advisory councils to influence policy and workflow improvements.

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Reducing the Burden
Physician Practice Steps

Analytics and Continuous Improvement

Goal: Identify root causes and measure improvement.

- Track metrics such as approval times, denial rates, appeal success rates, and staff FTE time per request.
- Use root cause analysis for repeated denials to determine if issues are documentation, coding, billing, processing or payer interpretation.
- Provide clinician feedback reports showing each provider's PA approval and denial trends.

Policy and Advocacy Alignment

Goal: Stay compliant with and benefit from new state and federal prior authorization reforms.

- Monitor payer compliance with CMS Interoperability & Prior Authorization Final Rule (CMS-0057-F).
- Implement continuity-of-care processes for patients switching payers under the new 90-day carry-over rule.
- Participate in multi-payer prior authorization pilots or specialty registry initiatives.

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Reducing the Burden
Physician Practice Steps

Summary Table

Focus Area	Strategy	Expected Benefit
Clinical Documentation	Templates and evidence linkage	Higher first-pass approvals
Technology	ePA and automation	Faster turnaround, less staff time
Staffing	PA specialists and training	Fewer errors, better communication
Payer Relations	Direct contacts and negotiated relief	Reduced denials, faster resolution
Analytics	Dashboards and metrics	Continuous improvement
Policy Readiness	Align with CMS and state reforms	Compliance and leverage

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Case for Change

Quantify the Impact

- Administrative cost estimates, staff time spent per PA.
- Delays leading to adverse outcomes or care avoidance.

Highlight Alignment Opportunities

- Streamlining PA supports *Triple Aim*: better care, improved outcomes, reduced costs.

Reinforce Collaboration Message

- Payers and providers share a goal: safe, effective, affordable care, but current PA structures must evolve to achieve this.

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Conclusion and Call to Action

Summary

- Prior authorization began as a utilization management tool but has become a major barrier to timely, efficient care.
- Reform requires shared accountability, technology investment, and policy modernization.

Call to Action

- Support PA simplification initiatives at the state and federal level when physicians and other providers are part of the discussion, process and decision-making authority.
- Advocate for automation and transparency.
- Partner with payers to test and scale alternative models (e.g., gold cards, delegated authorization).

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Resource Links

AMA

- Prior Authorization Overview & Resources: https://www.ama-assn.org/practice-management/prior-authorization
- Prior Authorization Practice Resources: https://www.ama-assn.org/practice-management/prior-authorization/prior-authorization-practice-resources
- Prior Authorization Reform: https://www.ama-assn.org/practice-management/prior-authorization/prior-authorization-reform-resources

MGMA

- https://www.mgma.com/articles/the-prior-authorization-landscape-in-2025

AHIP

- Voluntary Prior Authorization Simplification Commitments: https://www.ahip.org/news/press-releases/health-plans-take-action-to-simplify-prior-authorization

BCBSA Settlement

- Provider Settlement website https://www.bcbsprovidersettlement.com

CMS / WISeR Model

- WISeR Model Overview: https://www.cms.gov/priorities/innovation/innovation-models/wiser
- Federal Register Notice on WISeR Implementation: https://www.federalregister.gov/documents/2025/07/01/2025-12195/medicare-program-implementation-of-prior-authorization-f

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