

Improving Outcomes and the Care Experience

Prior authorization has reached a decisive turning point

The current, highly criticized system of manual faxes, portals, phone calls, and other administrative bottlenecks have resulted in a number of unwarranted consequences for both providers and patients and is currently being legally dismantled and replaced with regulatory enforcement and digital automation.

Interoperability mandates give health plans a new opportunity to replace fragmented processes with a faster, more reliable authorization model—without compromising clinical oversight. Plans can act **now** to:

- Automate routine approvals through standards-based rules and data exchange, accelerating straightforward decisions while reducing manual effort.
- Focus clinician expertise on complex cases, exceptions, and denials where judgment and oversight matter most.
- Deliver a more predictable experience through faster decisions, clearer status, and fewer manual handoffs—strengthening confidence across the authorization process.

***The imperative is clear**: Reduce administrative drag, accelerate appropriate care, and strengthen governance where it matters most.*

The Intersection of Mandates and Modernization

Recent regulatory action is accelerating prior authorization modernization by setting expectations for interoperability, response times, transparency, and clinical oversight. Leading health plans can use these requirements not only to achieve compliance, but also to guide broader digital transformation.

The following table summarizes the principal regulatory frameworks shaping the prior authorization landscape.

Regulatory Driver	Core Mandate	Intended Systemic Impact
CMS Interoperability & Prior Authorization Rule (1)	Requires implementation of HL7 FHIR APIs and decisions within seven days for standard requests and 72 hours for urgent requests.	Replaces paper-and-fax workflows and accelerates determination timelines.

Regulatory Driver	Core Mandate	Intended Systemic Impact
State-Level "Gold Carding" Laws (individual states)	Exempts providers with high prior authorization approval rates, typically 80%–90%, from selected advance-approval requirements.	Rewards high-performing clinicians; reduces overall review volume for health plans.
Transparency & Oversight Mandates (CMS-0057-F)	Requires health plans to report prior authorization approval and denial rates publicly, together with supporting rationales.	Enhances accountability; reduces inappropriate medical necessity denials.
Algorithmic Guardrails (CA)	Mandates that automated or AI-driven denials must undergo review and sign-off by a licensed clinician.	Prevents automated care disruptions; ensures clinical oversight in utilization management.

(1) The Centers for Medicare & Medicaid Services (CMS) final rule (CMS-0057-F), which took effect on January 1, 2026, forces government-sponsored health plans (including Medicare Advantage, Medicaid, and CHIP) to drastically accelerate response windows: 72 hours for expedited (urgent) requests and 7 calendar days for standard requests.

Modernization creates value across three connected areas: financial and clinical outcomes, administrative efficiency, and the provider and patient experience, as follows:

Financial and Clinical Outcomes

Legacy prior authorization workflows impose substantial labor and transaction costs on payers and providers. Electronic submission and automated adjudication can lower processing expense, reduce billing and documentation errors, and limit the appeals and review activity associated with incomplete requests.

Operational efficiency also supports better clinical outcomes. Faster, more predictable decisions can reduce treatment abandonment and medication nonadherence, help prevent avoidable deterioration, and lower the risk of costly emergency department visits or hospitalizations.

Administrative and Operational Efficiency

FHIR APIs (Fast Healthcare Interoperability Resources) and automated adjudication can reshape health plan operations by replacing fragmented manual transactions with structured, reusable data exchange.

- **Lower transaction costs:** Electronic workflows reduce the labor required for telephone calls, portal uploads, faxes, and status checks.
- **Reduced appeals overhead:** DTR APIs (Documentation Templates and Rules) surface documentation requirements before submission, helping prevent technical denials and the downstream cost of appeals and prolonged medical-necessity reviews.
  (*note:* *under the new CMS mandates, insurance companies are required to build FHIR APIs by 2027)*

Elevating the Provider and Patient Experience

For providers, integrating authorization into the electronic health record (EHR) eliminates duplicate data entry and reduces reliance on external portals and faxes. Clinicians and staff can identify requirements, submit documentation, and receive status updates within the existing workflow, reducing administrative burden and supporting a more collaborative payer-provider relationship.

For patients, faster and more transparent decisions create greater predictability at critical points in care. Reducing delays can help prevent canceled procedures, abandoned prescriptions, and avoidable anxiety while supporting satisfaction, adherence, and engagement in preventive care.

Structural Elements and Operational Execution

In response to the CMS generated mandates and new (state level) compliance regulations, an effort named **The Da Vinci Project** began in 2018 as an HL7-hosted, private-sector collaboration of more than 20 health plans, care providers, and health IT vendors. It was created to replace one-off payer-provider data connections with **nationally reusable FHIR standards that support value-based care and improve clinical, quality, cost, and care-management data exchange**.

The Da Vinci Project members recognized that effective prior auth modernization requires integrated technical architecture and clearly defined clinical workflows. **Four foundational capabilities** were established to move prior authorization from a stand-alone administrative task to a connected transaction embedded in the care process.

Interoperable HL7 FHIR API Ecosystem

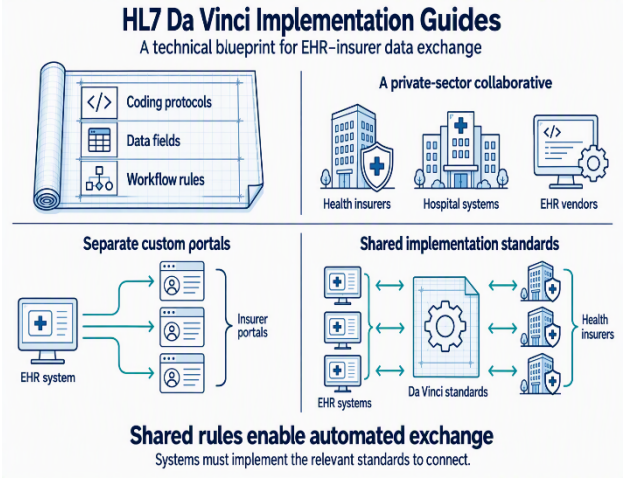
The core technical shift is from stand-alone portals, faxes, and manual entry to automated data exchange using HL7 FHIR (Fast Healthcare Interoperability Resources).

The HL7 Da Vinci implementation guides support three stages of the authorization process:

Coverage Requirements Discovery (CRD): Using Clinical Decision Support (CDS) tools, CRD allows the EHR to query the health plan when a clinician orders a service or medication and immediately determines whether prior authorization is required.

Documentation Templates and Rules (DTR): DTR brings plan-specific clinical criteria into the EHR and maps those requirements to information already available in the patient record, highlighting any additional documentation needed.

Prior Authorization Support (PAS): PAS securely submits the completed request to the health plan and returns the approval or pending status to the provider's EHR workflow.



Clinical Rules Engines and Real-Time Automated Adjudication

At the payer level, cloud-based rules engines replace manual file routing by evaluating structured data from PAS submissions against codified medical policies.

When a request satisfies the plan's medical-necessity criteria, the rules engine can approve it in real time, often within seconds and without manual review. Requests that do not meet automation criteria proceed to the appropriate clinical review pathway.

Dynamic Gold Carding and Selective Utilization Management

Modern frameworks can apply data-driven utilization management rather than imposing the same requirements on every clinician. Health plans assess historical approval patterns, billing accuracy, and adherence to evidence-based guidelines to identify providers eligible for streamlined review.

Providers who meet established performance thresholds may receive gold-card status for selected services or drug classes. This approach reduces unnecessary review volume while preserving focused oversight for higher-risk or atypical requests.

"Human-in-the-Loop" AI Frameworks

For complex cases that do not fit structured rules, natural language processing and machine learning can identify relevant information in clinical notes, imaging reports, and laboratory results.

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Clinical governance remains essential. AI should support data identification and clear-cut approvals, while cases that do not satisfy medical-necessity criteria are routed to a licensed clinical reviewer for final determination. Automated systems should not issue autonomous clinical denials.

Case Study

FHIR-ENABLED PRIOR AUTHORIZATION: CASE STUDY AT A GLANCE			
PARTNERS	**BEFORE**	**FHIR WORKFLOW**	**RESULTS**
Humana · payer **athenahealth · EHR** **Availity · connectivity** **Harmony Park · practice**	Phone calls, faxes, repeated status checks, manual data entry, and greater error risk	**CRD** identifies requirements **DTR** gathers documentation **PAS** submits requests and returns status in the EHR	**24 staff hours saved weekly** Faster turnaround Better status visibility Fewer manual handoffs More time for patient care

Source note: *Based on KLAS Research's 2024 Points of Light Case Study 16 and corroborating accounts from athenahealth and Availity. Results shown are limited to outcomes reported by these sources.*

Implementation lesson: *Automation delivers measurable value when payer, provider, EHR, and connectivity partners align on shared FHIR standards, embed the workflow directly in the EHR, train staff, and provide clear status visibility.*

Looking ahead:

Prior authorization modernization is more than a compliance initiative; it is an opportunity to redesign utilization management around timely decisions, reliable data exchange, and clinical accountability. Interoperable FHIR APIs, real-time rules engines, selective gold carding, and governed automation can reduce administrative effort, accelerate appropriate care, improve transparency, and strengthen provider and member trust.

However, the case study (referenced above) showed that **meaningful results** depend on coordinated standards, integrated workflows, clear governance, and effective adoption across payers, providers, and technology partners. **Health plans that treat modernization as an enterprise transformation will be best positioned to deliver a faster, more predictable, and more patient-centered authorization experience.**

Preparing now:

Health plans can best position themselves for success (beyond simply treating modernization as a "compliance initiative") by documenting current workflows, standardizing authorization criteria, and data definitions, identifying high-volume services for early pilots, assessing vendor and FHIR readiness, and establishing clinical, compliance, and operational governance. These practical steps build a reliable foundation for phased implementation of the full technology at a later date (CMS mandates slated for early 2027, while state-specific regulations vary as to when they go into effect), while beginning to generate some of the benefits of a full-scale implementation.

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