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# Leaders embrace FHIR®-based prior authorization solutions

Standards-based payer-provider integration can deliver cost savings and efficiency gains now, while ensuring future compliance.

For years, the prior authorization process has been more than just a pebble in our shoe. As we've tried to sprint as an industry, fueled by aspiration and innovation, worsening prior authorization experiences have slowed us down. From both provider and member perspectives, prior authorization and the wait for payers to approve care remains a major source of friction and dissatisfaction. Provider staff often bear the brunt—waiting for decisions, sorting through documentation, and managing outdated fax and paper-based communications, all of which detract from their ability to deliver quality care efficiently.

It's not just a matter of inconvenience—there's a financial cost too. According to one health plan survey, prior authorization reviews cost between $80 and $120 per transaction. The Centers for Medicare and Medicaid Services (CMS) estimates that automating prior authorizations and reducing administrative burden could save the industry $15 billion over the next decade.

There is hope for improvement just around the corner in the form of new federal mandates for automation and APIs, complementary state legislation and advances in interoperability via maturing industry data standards. In this paper, we examine what's next for prior authorization and smart moves for industry leaders savvy enough to embrace these changes.

## A look at future federal and state regulation of prior authorizations

An upcoming mandate from CMS aims to address prior authorization issues. The CMS Interoperability and Prior Authorization Rule (CMS-0057) requires specific improvements to the prior authorization process for government health plans by January 1, 2026, with direct provider-payer integration to be supported by January 1, 2027. Beyond this federal mandate for government-run programs, over 80% of US states have passed, or are in the process of passing, legislation affecting prior authorizations. In a recent informal poll we took with a payer audience, 52% of payers said their state's prior authorization requirements would impact their technical and process changes, while 41% were uncertain about how state legislation would affect them.

Payers operating government-sponsored plans and commercial plans need to be familiar with state regulatory and legislative efforts as well as the lengthy CMS rule. Here's a primer on the basic requirements for process improvements the CMS prior authorization rule requires by January 1, 2026 (drugs are excluded).

- **Prior authorization decision time:** CMS is requiring most affected payers to send prior authorization decisions within 72 hours for urgent requests and by seven calendar days for standard, non-urgent requests. Non-urgent requests for issuers on the Federally Facilitated Exchange must receive decisions within 15 calendar days.
- **Provider notice, including reason for denial:** Beginning in 2026, affected payers must cite a specific reason for denying prior authorization decisions. Payers may communicate their prior authorization decisions via portal, fax, email, mail or phone.
- **Prior authorization metrics:** Affected payers must publicly report certain prior authorization metrics annually by posting them on their websites. The metrics include percentages of prior authorization requests approved, denied and approved after appeal, and average time between submission and decision. The initial set of metrics must be reported by March 31, 2026 for activity during calendar year 2025.

By January 1, 2027, the CMS rule requires payers to implement a prior authorization API that supports electronic exchange of prior authorization requests and decisions. In addition to supporting the process improvement requirements, the API must list all payer-defined procedures requiring prior authorization, outline the necessary supporting documentation and provide a mechanism for providers to submit requests and receive decisions.

State legislative efforts to improve prior authorization in commercial plans similarly address decision timeframes, transparency and reporting. The key point is that the state compliance requirements are not necessarily aligned with those of CMS. Several states have set shorter timeframes than CMS has for responses to non-urgent requests. Similarly, several states have shorter turnaround times than the federal requirements for urgent decisions. In Michigan, prior authorization is considered granted if a payer fails to act on a request.

Some states have different transparency standards. In Louisiana, a health plan must put denials in writing and include a copy of the applicable law, regulation, policy, procedure or medical criterion or guideline the plan used to support the denial or put instructions on its public website about how to access those materials.

Some states' metrics go beyond federal compliance. Illinois requires payers to report the top five reasons for prior authorization denials. Colorado requires payers to post approval and denial metrics on their public websites by provider specialty, the medication, diagnostic test or procedure, the reason for denial and denials overturned on appeal. In contrast, the federal rule requires approvals and denials to be reported as percentages of aggregated requests made, not of specific procedures.

Washington state has passed legislation requiring shortened prior authorization determination timelines, standards for clinical review criteria and use of APIs for prior authorization processes. In February, Washington state requested comments from interested parties on the development of rules and implementation guidance. The comment request was accompanied by details that compare the CMS final rule with the state's legislation. Two areas of misalignment between the state and federal requirements are the compliance date—January 1, 2026, for Washington—and the inclusion of drugs in the state's prior authorization requirements.

## Prior authorization and more in a data-fluid industry

As payers navigate this regulatory complexity, with seemingly distant deadlines, not all state-driven initiatives align with CMS requirements or deadlines. CMS is mandating the implementation of a robust prior authorization API by January 1, 2027 to connect provider and payer systems. This prior authorization API is just one of several APIs that payers with government lines of business must implement by the 2027 deadline. While some organizations are taking a "wait-and-see" approach, this strategy may come with hidden risks.

The optimal way to approach compliance is to build and test the prior authorization API on a single platform now to align commercial and government plan process improvements. Here's why:

- **Avoid tangled operations.** An open core and a FHIR®-built API can process commercial and federal prior authorization requests based on business rules and logic to accommodate different regulations. This capability should enable payers to achieve optimal levels of automation while avoiding the need to implement individual prior authorization solutions per state.
- **Gain immediate benefit while reducing risk**. Testing a prior authorization API today on specific procedures with a major health system can net cost savings and improve provider and patient satisfaction. Applying lessons learned from pilots to wider rollouts reduces their risk. Prior authorization API early adopters have experienced a 140% to 233% increase in productivity, moving from three to five prior authorization requests processed per hour to ten to twelve per hour, according to the HL7®* FHIR® and the associated Da Vinci Project.
- **Position for real-time bidirectional data flows.** The CMS rule requires payers to implement a provider access API and payer-to-payer API alongside the prior authorization API and an improved patient access API. These APIs can power a new generation of member-centric data flows that one-dimensional prior authorization solutions will struggle to orchestrate. The provider access API aims to facilitate care coordination and further enable value-based payment models, while the payer-to-payer API requirements address continuity of care challenges when patients transition between or have coverage through multiple payers.

As standards mature, there is an opportunity to exchange data beyond claims and administrative data to include clinical data, quality metrics, social determinants, cost transparency, drug formularies and member-collected data from wearables and in-home devices. With generative AI and machine learning, core systems can query each other in the background, analyze the data and recommend next-best actions. This capability enables precise, context-driven care decisions, creates new incentive structures and reduces guesswork and waste—improving outcomes while cutting costs.

## Where to start streamlining prior authorization

Payer organizations must understand their current prior authorization processes and identify areas for improvement. This knowledge is critical for collaborating with health systems. Payers cannot develop the API and automate prior authorization practices in isolation. Mapping existing prior authorization operations must include understanding their impact on provider workflows and how improved processes could streamline these workflows.

A leading health plan based in the southeastern US worked with us to evaluate its prior authorization processes. We identified requests by service type, procedure code groups, source of requests and volume to uncover patterns. This analysis involved reviewing dozens of medical policies and determining automation opportunities based on the conditions outlined in each policy. Additionally, we worked to understand pain points for providers and members. Automating key areas allowed the plan to reduce decision times by four to five days and saved $4 million annually.

While analyzing prior authorization processes, payers can also gather the intelligence needed to identify partners for piloting an API. The ideal partner is a health system committed to innovation and with whom the payer shares a high volume of patients. Early collaboration with provider champions can help improve the adoption of the API. The areas with the greatest potential for mutual time and cost savings include orthopedic surgery, home health, behavioral health, physical therapy and imaging.

## What are others doing?

In our informal poll, 13% of payers said they intended to maximize business opportunities from prior authorization compliance, while 20% planned to focus solely on compliance. Most payers hope to balance both compliance and business objectives. Implementing a FHIR®-based API and platform that supports prior authorization and more will help these payers meet CMS requirements while also improving payer-provider collaboration. Payers that begin the process now will have the advantage of discovering new business cases for faster returns. Additionally, these early adopters will gain a substantial preview of a new generation of real-time data exchange, which can drive innovative experiences for members, patients and providers.

## Being proactive is the safe choice

Rather than waiting until the last minute to comply with the mandate, innovative payers are taking a proactive stance for several reasons. First, there's a strong business case for payers to partner with their primary provider networks—typically the larger health systems. By collaborating on a joint project in 2025 or early 2026, both payers and providers can reduce their administrative burden and achieve a return on investment (ROI) sooner. Second, this proactive approach accelerates time-to-value and reduces the risk of non-compliance. Third, these payers and providers are taking a meaningful step toward a future where collaboration and advanced data sharing lead to more informed decision-making at the point of care—benefiting payers, providers and patients alike.

The bottom line is that healthcare organizations have a compelling case to make to their executives to act now in enabling end-to-end prior authorization processing using HL7® FHIR® and the associated Da Vinci implementation guides. Waiting until the compliance deadline may result in missed opportunities for early ROI and process improvements.

Furthermore, savvy payer thought leaders and decision-makers are strategically targeting the creation of a unified, payer-oriented platform. They understand that for payers to fully realize the benefits of reduced administrative burden, they need a platform with a roadmap for future growth—incorporating data exchange for quality measures, care gaps, clinical data and more. They also recognize that platforms built specifically for providers simply deliver data to the payer, while the greatest ROI comes when APIs are seamlessly integrated with the payer's internal systems and workflows—spanning core administration, utilization management, care management and more.

While delaying or relying on a provider-specific platform may seem like a safe option in the short term, payer thought leaders who choose an open, standards-based solution that integrates with their existing backend systems and processes will be best positioned to achieve both short-term wins and long-term success in healthcare's increasingly interoperable future.

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