Simplifying Prior Authorization: A White Paper Outlining Targeted, Trust-Based Approaches

Prepared by the Foundation for Health Care Quality through the Administrative Simplification Program

Executive Summary

This white paper on prior authorization (PA) was prepared by the Foundation for Health Care Quality through the Administrative Simplification Program. The paper will define PA, discuss the PA workflow and areas of added administrative burden, also described as pain points or points of friction, and present potential areas for collaboration based on previous Administrative Simplification efforts and external Federal, State, and market pressures.

A central tension in working toward simplification is defining which processes between scheduling a patient encounter and health carrier payment of a claim(s) are included in the definition. Delivery sites and clinicians (providers) tend to use a more inclusive PA definition that encompasses all the steps providers take to get a claim to pay (e.g., network status, benefits). Health carriers tend to use a narrower definition that is focused on just the approval before an elective, planned health care service, medication, or equipment can be provided in order to be reimbursed based on being medically necessary for a given person enrolled in the health plan. This white paper proposes using a unified definition or if using different definitions, being clear in which definition is being used.

The Administrative Simplification program has developed collaborative solutions for points of friction along the PA process continuum through best practice recommendations, white papers, and responses to Federal changes. The majority of recommendations have focused on the process of submitting information and receiving notification about the decision. Neutral convenors such as the Administrative Simplification program can be used to move standardization and partnership forward in selected areas to bridge from the current state to a future state of lowered resource use.

The introduction of Federal rules on health carriers to implement and maintain more efficient and readable PA data exchange technology (except for pharmaceutical products) starting in 2027 will help but not fix a main pain point on the PA workflow. Previous work around increasing readiness can be continued to better set the health care community up for success. Similarly, the vast increase in available artificial intelligence (AI) models to reduce the burden of gathering and interpreting data will reduce but not eliminate the need for organizational resources directed to PA, and presents its own consensus building opportunity around the role for AI. Other opportunities for consensus building include revisiting gold carding or developing standards around PA criteria and/or PA workflows.

Prior authorization can be significantly simplified through consensus-driven solutions. Targeted use, aligned incentives, and trust-based mechanisms can reduce the amount of time and resources spent on PA. Improvement requires curiosity, dialogue, and shared intent, not entrenched positions. A redesign is possible but will require time, collaboration, and willingness to experiment.

Introduction

The Foundation for Health Care Quality is a nationally-recognized, neutral, nonprofit dedicated to catalyzing health care quality improvement through collaboration. For the past almost 40 years, we have been home to programs and initiatives that bring together organizations and interest holders across the health care ecosystem around shared priorities to improve the quality of clinical care. We convene clinician-led collaboratives that drive improved patient care through gathering and benchmarking chart-abstracted clinical data; coalitions dedicated to improving patient safety; public and private collaboratives that develop evidence-based clinical, policy, and payment guidelines; programs that focus on improving community birth and transfers; and many others.

The Administrative Simplification program was founded by the Washington Healthcare Forum in 2000. The objective was to make it easier for health plans and providers to do business together by finding consensus solutions to shared operational problems. The program operated as a private sector program until 2009. In 2008/2009, Washington state government expressed an interest in entering the Admin Simp space more directly and approached the Forum with a suggestion to collaborate. The outcome of this joint effort was SSSB 5346, passed by the Washington state legislature unanimously in 2009. The bill resulted in the Forum and OneHealthPort being designated by the OIC as the "Lead Organizations" for Admin Simp in Washington state. The Lead Organization was directed to:

- Manage the implementation of administrative simplification in a transparent and inclusive manner under the oversight of the OIC
- Create solutions for an assigned list of sixteen tasks in the legislation, and establish a process to continuously improve the solutions over time
- Craft additional consensus solutions as needed
- Pursue voluntary adoption of the solutions by plans and providers
- Report to the Legislature, the OIC and the community
- Fund the costs of the work entirely on its own (e.g., no state money could be used)

As said in SB 5346, "The greatest opportunity for improved efficiency and administrative cost reduction in our health care system would involve standardizing and streamlining activities between providers and payors. To address these inefficiencies, constrain health care inflation, and make health care more affordable for Washingtonians, the legislature seeks to establish streamlined and uniform procedures for payors and providers of health care services in the state. It is the intent of the legislature to foster a continuous quality improvement cycle to simplify health care administration. This process should involve leadership in the health care industry and health care purchasers, with regulatory oversight from the office of the insurance commissioner."

In 2024, The Forum contracted with the Foundation for Healthcare Quality to manage the program and the OIC designated the Foundation as a co-Lead Organization for Admin Simp along with the Forum. From 2009 to the present, the Admin Simp program has operated as a model public/private partnership. The program has deployed a proven process to fulfill its Lead Organization role while also continuing to address private sector priorities and participate in national standard setting.

Founded in 1999, the Washington Healthcare Forum is a coalition of leading physician practices, hospitals, health plans and state associations that have joined together to improve the local health services system.

The Forum's vision is an efficient, effective and affordable health services financing and delivery system that satisfies the needs and concerns of patients, providers, health plans, and purchasers.

The Forum's mission is to:

- Advance a dialogue on sustainable solutions to challenges facing the health services system
- Streamline and simplify health services financing and delivery across Washington state

Defining Prior Authorization

Confusion and disagreement arises from different parties using different definitions and having different expectations around PA. Delivery sites and clinicians (providers) tend to use a more inclusive PA definition that encompasses all the steps providers take to get a claim to pay (e.g., network status, benefits). Health carriers tend to use a narrower definition that is focused on just the approval before an elective, planned health care service, medication, or equipment can be provided in order to be reimbursed based on being medically necessary for a given person enrolled in the health plan. Finding a shared understanding of how PA adds to administrative complexity is necessary to design effective solutions.

Broad PA version

Any authorizing related action that needs to be taken prior to providing a health care service, medical equipment, or dispensing of medication for a claim to pay and to what level. Includes:

- eligibility and benefits
- network affiliation
- place of service
- when a medical necessity review will be performed

Narrow PA version

Prior Authorization: Requirement that a health care delivery site request approval from a patient's heath carrier before an elective, planned health care service, medication, or equipment can be provided in order to be reimbursed based on being medically necessary for a given person enrolled in the health plan.

Admission Notification: Requirement that a health care delivery site alert a health carrier that a patient has been admitted for an emergency or unplanned acute inpatient care within 24 hours (or the next business day) of admission.

Current State

PA plays an important role in supporting medically necessary, safe, and cost-effective care. However, widespread, expanded use of PA has created significant administrative burden, workflow inefficiencies, and delays in patient care. When PA was first established in the 1960s as a form of utilization management, volumes were small and focused on expensive procedures and long hospital stays rather than routine care. Information between providers and health carriers was sent back and forth with mail, phone calls, and eventually fax, which become more standard in the 1980s. The 1990s saw the introduction of proprietary health carrier portals as slower person-to-person information exchange methods could not scale when volume dramatically increased due to the rise of managed care. However the many numerous and different portals led to fragmentation and added work for providers.

The 1996 Health Insurance Portability and Accountability Act (HIPAA) introduced standardized electronic data interchange (EDI) standards X12-278 to directly send readable data from the provider's electronic health record (EHR) to the health carrier. But even by 2026 these standards have not been widely adopted. By the 2010s, specialized vendors were offering boutique data exchange solutions, organizations developed their own custom workflows and dedicated staff, and fragmentation increased.

Now, provider organizations complete extensive documentation, use valuable staff time, conduct repeated follow-up, and coordinate across multiple systems and specialties. Health carriers, health care delivery sites or systems, clinicians, and EHR vendors each have different incentives and technical capabilities. Many providers still rely on outdated workflows and adoption of new tools will depend heavily on the EHR vendors. A simplified future state can be achieved by targeting specific points along the PA workflow that contribute to unnecessary resource use AND that are amenable to collaboration.

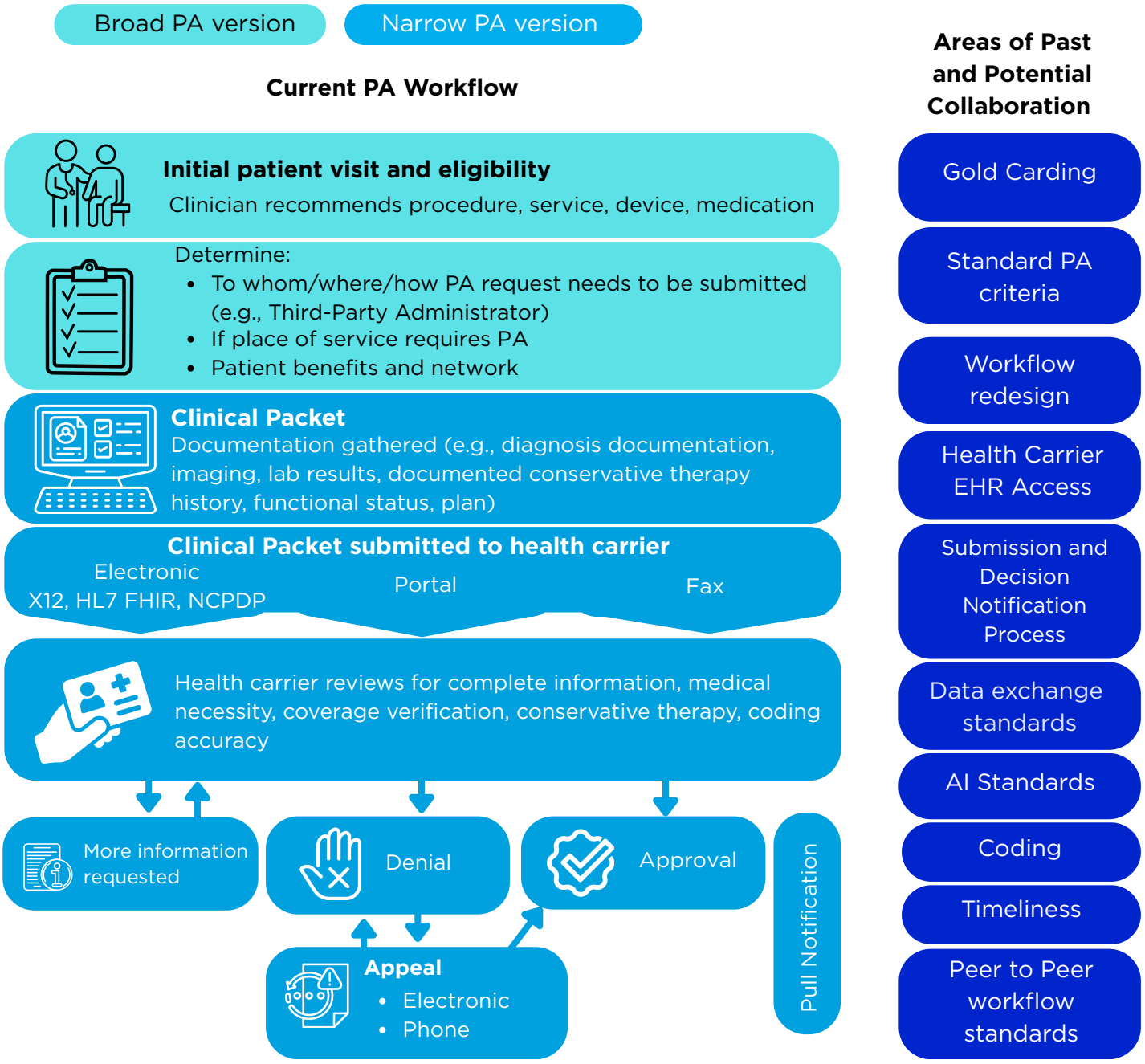
This paper proposes a number of pathways to work toward a simplified future state by collaboration around standards. Interviews were conducted with thirteen subject matter experts from multiple organizations, listed below. See **Appendix A** for the list of questions.

- Comagine Health
- Community Health Plan of Washington
- Kaiser Permanente
- MultiCare
- The Patient Coalition of Washington
- PeaceHealth
- Premera Blue Cross
- Point of Care Partners
- Office of the Insurance Commissioner
- Regence Blue Shield
- Virginia Mason Franciscan Health
- The University of Washington Medical Center
- UnitedHealthcare

PA could be simplified through consensus-driven solutions. Technology can reduce the burden, but only if coupled with provider-centric design, provider participation incentives, education, and culture change. A targeted approach here in Washington State should be built on aligned incentives, leverage workflow redesign, and incorporate responsible automation. Targeted use, aligned incentives, and trust-based mechanisms can reduce the amount of time and resources spent on PA. Opportunity lies in bringing culture in line with new tools and processes.

Pain points exist throughout the workflow, some of which have been addressed by the Administrative Simplification program and that may be amenable to additional simplification. These include:

- Which steps are included as part of PA.
- Which services, equipment, or medication requires PA.
- Which patient information is included in a PA request.
- How claims are coded.
- Information provided by health carriers.
- Information flow between delivery site and health carrier (target of much Federal attention).
- Workflows (e.g., delivery site, health carrier, peer-to-peer).
- Method and process of submitting PA information.
- Timeframe of receiving information back from health carriers.



Previous Efforts

The Administrative Simplification Program has developed collaborative solutions for points of friction along the PA process continuum through Best Practice Recommendations (BPRs), white papers, and responses to Federal changes.

2009

Best Practice Recommendations

2010

Developed through work groups and the input and insight of many subject matter experts from April 2009 to present, these BPRs continue to be revised as technological, regulatory, or other changes occur. These BPRs, categorized by the improvement opportunity, are detailed on the following page. The Administrative Simplification program has not developed consensus guidelines for which services require PA or for criteria for specific PA. The majority of BPRs have focused on the process of submitting information and receiving notification about the decision. Other BPRs focus on areas of complexity or need for standardization including: claims coding, information between organizations, and the timeframe of receiving responses.

2016

White Papers

The Administrative Simplification program has written two previous and related white papers, on Medical Management in 2010 and on Gold Carding in 2016. Summaries of these two papers are outlined in **Appendix B**. The 2016 Gold Carding paper recommended, *"moving from isolated pockets of innovation to community-wide implementation with minimal complexity. Health plan/payers and provider organizations that are currently pioneering the gold carding programs (Prime Movers) …need to take a leadership role in a consensus building process to identify appropriate areas of harmonization/standardization and develop associated guidelines/best practices for all who follow."* Many of the administrative complexities uncovered in the interviews that informed in these earlier papers are present today and were brought up by interviewees. In 2016, the Washington Healthcare Forum elected to not pursue collaborative action.

2020

Response to Federal Proposal

The Administrative Simplification program also facilitated a Washington State response to the Office of the National Coordinator Request for Information in 2020 about how best electronic technology can be used to simplify the PA process. The response centered on the difference between the narrow and broad PA definition, stating that, "*Implementing an electronic solution that only addresses the RFI's PA requirements and not the full set of pre-service requirements is sub-optimal. Providers need as few solutions as possible to address their full set of requirements. Cobbling together and integrating a variety of solutions to meet all of the pre-service steps only adds to administrative complexity and the associated cost burden*."

2026

Development of the Prior Authorization white paper.

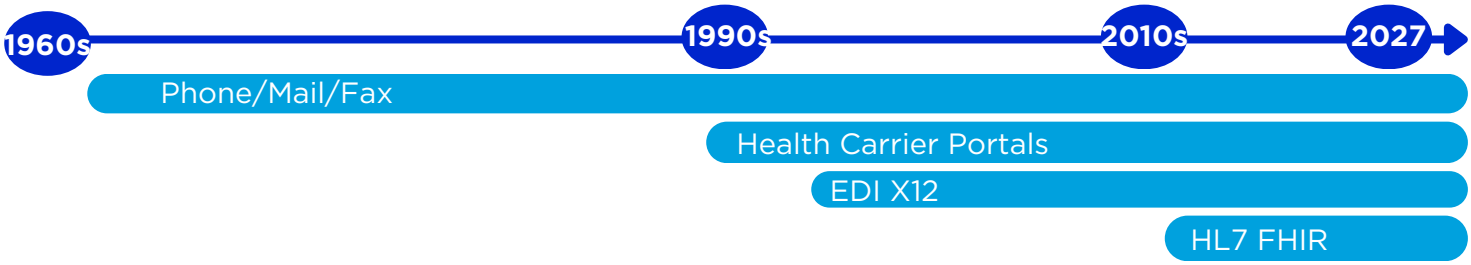
Administrative Simplification Best Practice Recommendations

All BPRs are listed here: www.qualityhealth.org/adminsimp/best-practice-recommendations/

Improvement Opportunity	Interventions
Claims Coding	• Claim Coding Policy and Edits: Standardization & Transparency (Updated 2010) • Reconsideration of a Health Plan's Policy Regarding Code Edits (Updated 2010)
Information From Health Carriers for Delivery Sites	• General Applicability to HIPAA Transactions (Updated 2015) • Exchanging & Processing Info about Pharmacy Benefit Management (Updated 2015) • Exchanging Explanation of Payment Information between Providers and Health Plans (HIPAA 837 & 835) (Updated 2015)
Timeframe	• Emergency Fills and Notification Timeframes (Updated 2015) • Standard Notification Timeframes for Pre-Authorization Requests (Updated 2017)
Process of Submitting PA Information and Decision Notification	• Browser Capabilities for Prospective Review & Admission (Updated 2023) • Creating and Receiving the Health Care Claim Acknowledgement (HIPAA 277CA) (Updated 2017) • Electronic Processing of Corrections to Institutional Claims (HIPAA 837I) (Updated 2011) • Electronic Processing of Corrections to Professional Claims (HIPAA 837P) (Updated 2013) • Health Plan Web Capabilities for Pharmacy Benefits and Pre-Auth (Released 2014) • Processing and Reporting Remittance Information (HIPAA 835) (Updated 2020) • Requesting and Receiving Claims Status Information (HIPAA 276-277) (Updated 2015) • Submitting & Processing Claims (HIPAA 837) (Updated 2012) • Extenuating Circumstances around Pre-Authorization & Admission Notification (Updated 2023)

On the Horizon: Improved Data Exchange

As described earlier, PA has moved from phone and mail data exchange in the 1960s, the addition of fax, a move to individual health carrier portals as volumes increased in the 1990s, the addition of electronic data interchange X12 through the 1996 Health Insurance Portability and Accountability Act (HIPAA), the introduction of Health Level 7® (HL7®) Fast Healthcare Interoperability Resources® (FHIR®) Prior Authorization Application Programming Interface (API) in the 2010s, and FHIR API requirements starting 2027.



In 2024, to again work to standardize PA data interchange, the Centers for Medicare and Medicaid Services (CMS) released the Interoperability and Prior Authorization Final Rule (CMS-0057-F). CMS-0057-F requires Medicare Advantage Organizations, State Medicaid and Children's Health Insurance Program agencies, Medicaid Managed Care Plans and CHIP Managed Care Entities, and Qualified Health Plan issuers on the Federally-facilitated Exchanges to implement and maintain a Health Level 7® (HL7®) Fast Healthcare Interoperability Resources® (FHIR®) Prior Authorization Application Programming Interface (API) for health care service approval, excluding pharmaceutical products by January 1, 2027. An API is software that sits between at least two applications and facilitates data exchange. The rule impacts health carriers and is focused on health carrier patient-facing APIs, provider-facing APIs, and health carrier to health carrier-facing APIs.

The prior authorization API is required to:

- Include a list of covered services and items
- Identify required PA documentation,
- Allow PA request and response with a specific reason if the result is denial or a request for additional information.

To further incentivize administrative simplification, HHS will use enforcement discretion (ability to determine whether and how strictly to enforce) for HIPAA X12-278 prior authorization transaction standard for covered entities that implement an all-FIHR-based PA API that do not use the X12-278 standard. This allows FHIR-only or a combination of FHIR and X12 and are also able to make available an X12-only prior authorization transaction.

Acknowledging the gap between coming Federal requirements and current system capability, the Health Care Authority (HCA), supported by the OIC, received a grant from the Gates Foundation and convened working groups, conducted educational sessions, and did assessments of health carrier readiness relative to CMS-0057-F requirements.

The 2025 assessment found that health carriers who responded were all planning to use a consistent platform for their FHIR APIs but few had anything already in place. 90% of the health carriers surveyed had no current APIs in use. Providers were less aware of the potential benefits of using FHIR APIs as their work group was convened later in the year and they did not have as much time to become familiar with the changes ahead. Implementing new standards are optional for delivery sites.

Without coordination, new technology will not replace existing infrastructure, resulting in a patchwork quilt of faxing, phone calls, web portals, X12, and FHIR technology.

In March 2026, CMS announced the Administrative Simplification; Adoption of Standards for Health Care Claims Attachments Transactions and Electronic Signatures Final Rule (CMS-0053-F) with the aim to phase out faxing and paper mailings for claims documents. All HIPPA-covered entities must conduct electronic claims document transactions by May 26, 2028.

"The 1980s called, and they want their fax machines back…This new rule will modernize American health care by standardizing electronic claims attachments and enabling secure electronic signatures."
- CMS Administrator Mehmet Oz, MD

Washington State Policy and Technology Landscape

The Washington State Legislature has addressed prior authorization through multiple specific pieces of legislation. A select few of these passed bills are summarized below.

Senate Bill 6511 (2014)
Addressing the prior authorization of health care services
Directed the Lead Organization to develop best practice recommendations for pharmacy prior authorization that would be adopted as rules by the Office of the Insurance Commissioner.

Senate Bill 6404 (2020)
Adopting prior authorization and appropriate use criteria in patient care

- Health carriers with one percent or more of the market share to annually report aggregated and deidentified PA data to the Office of the Insurance Commissioner.
- The ten codes with the highest number of PA requests and percent of approved requests, the ten codes with the highest percentage of approved PA requests and the total number of requests, the ten codes with the highest percentage of PA requests initially denied then approved on appeal and total number of requests, and number of requests for the previous categories that are expedited, standard, or extenuating-circumstances decisions.
- Average response time in hours
- Data is categorized into:
  - Inpatient medical/surgical
  - Outpatient medical/surgical
  - Inpatient mental health and substance use disorder
  - Outpatient mental health and substance use disorder
  - Diabetes supplies and equipment
  - Durable medical equipment (DME)

House Bill 1357 (2023)
Modernizing the prior authorization process

- For expedited prior authorization requests, response within 1 calendar day if submitted electronically and two calendar days if submitted nonelectronically
- For standard prior authorization requests, response within three calendar days if submitted electronically and five calendar days if submitted non electronically.
- That health carriers list PA requirements in detailed, easily understandable language.
- PA APIs using HL7 FHIR for health care services beginning January 1, 2025, and for prescription drugs beginning January 1, 2027.
- Adding additional prescription drug PA reporting to those outlined in SB 6404 starting in 2004.

Senate Bill 5395 (2026)
Making improvements to transparency and accountability in the prior authorization determination process

- PA determinations to include "the credentials, board certifications, and areas of specialty of the provider who had clinical oversight over the determination in any notification sent to the health plan enrollee and provider requesting or referring the service."
- Posting in a single location on their website any PA changes.
- Electronic PA in 2031
- That AI cannot be the only entity for PA determinations and that if AI is used, the determination must be based on the patient's unique case.
- OIC PA reporting requirements for prescription drugs.

Findings from Structured Interviews

Effectiveness of PA reform is limited by several structural and regulatory barriers including misaligned incentives and one-sided regulatory requirements. Interviews with both health carriers and providers illustrated that both parties felt there was value in PA, but they did not have the same reasons why they valued the process. Health carriers discussed safety, appropriate treatment pathways, and appropriate administration of a patient's coverage and benefit as reasons for PA importance. Providers felt that they were advocating for patients through the process and facilitating steps in the patient's treatment plan. Both groups discussed the ever-changing scope of services requiring authorization. Both providers and health carriers spoke to the fluctuations in the list of services requiring PA. Together, these issues increase workload across the board, contribute to provider burnout, delay care delivery, and may have negative psychological impacts on those experiencing care.

Additionally, approval rates frequently range from 80 to 98 percent, different from public perception, suggesting that many requests ultimately meet established criteria and were not value-added steps in caring for the patient or reducing overall cost. In Washington State, where reporting of the top ten codes needing prior authorization in the previous calendar year by health carriers is mandated, the following were reported:

- The highest number of requests were for PA echocardiography with an approval rate of 93.8%.
- For all services together, the approval rate was 90.5%, however some codes did have a 0% approval rate.
- The lowest (among the top ten codes) approval percentage was 96% for a continuous positive airway pressure (CPAP) device.
- Outside of the top ten codes, health carriers reported most codes having an approval rate of 100%.

Provider Experience

PA continues to be viewed by many providers as burdensome despite general acknowledgment of the need for utilization management. Even with established workflows, PA remains resource-intensive and operationally complex with fragmented provider workflows across portals, phone, and fax and a heavy reliance on manual work by staff many of whom are not medically trained. Delivery systems vary in how they incorporate PA into workflows. In some cases, staff at individual clinics implement PA, in some cases this is managed by a centralized PA team, other systems have a hybrid of local and centralized workflows. Requests are typically routed through EHR work queues. In some cases of hybrid workflows, criteria for routing between local and central teams are not always clear. Staff managing queues often face high volumes and backlogs, contributing to delays and confusion about next steps, and can receive redundant documentation requests.

There is much variation in health carrier requirements. The breadth of the differences is hard to measure as not all health carriers provide transparency to their requirements.

Providers face many different health carrier rules and "get lost in the fine print."

Key process indicators such as PA denial rates and PA volume are often tracked at an organizational level, neither are universally visible to clinicians or staff. Some delivery systems prioritize tracking denials data, which is late but offers insight into quality, accuracy, and directional opportunities for feedback to providers. More consistent measurement of the delivery system provider burden including staff needed and time used and outcomes could help change culture to incentivize modernization. Educating clinicians and staff on benefit inclusions and exclusions could reduce futile PA submissions but is difficult given the many different health plan benefit structures for different patients.

Standardization reduces the time needed for PA as many health carriers require the same pieces of information. Although technology has improved, this has also created a reliance that can cripple operations during an outage.

Ongoing challenges include inconsistent data transmission methods (fax vs. electronic), limited visibility into request status, and uncertainty about responsibility across providers, PA teams, and health carriers. Providers discussed a lack of back and forth with health carriers or a constructive feedback loop. Concerns were raised about giving health carriers broad access to patient medical records due to potential for secondary use of information and with the request for additional documentation resetting the 14-day response clock even if information was previously provided. Concerns were also raised about the current system prioritizing services based on highest dollar amounts being billed. The current process forces providers to use "the exact right words in the exact right order to get it approved," turning clinical notes into a dialogue with the health carriers rather than an accurate patient history. Peer-to-peer reviews and appeals have increased, and in many cases seem to depend on the provider's persuasiveness rather than the clinical argument.

"Too much on denial and approval rates, rather than whether the right services are being reviewed."

Health Carriers

PA ensures that benefits are administered according to health plan rules and supports clinical appropriateness, safety, and equity across populations. In many cases, there is confusion between PA and benefit or coverage issues (broad vs narrow definitions). PA serves as both a cost control and patient safety mechanism, especially for high-risk procedures like spine fusion. Reflecting on the need to prevent health care system collapse due to unlimited demand and limited resources, one interviewee noted, "There's not an unending pocket of money…"

"There's real risk for patients… we're not… complicit in patients getting unnecessary surgery…"

Workflow issues arise when providers submit urgent requests that are not clinically urgent (i.e., misclassified requests). Other issues include documentation incompleteness, quality of information, excessive documentation, not using the designated portal, and lack of consulting the portal to view the decision prior to reaching out to the health carrier. Other issues brought up by multiple interviewees include both health carrier and delivery site workflows and peer to peer workflows (i.e., discussion between treating clinician(s) and clinician(s) within a health carrier when a PA request is denied). Other issues include submissions for care that does not require a prior authorization, but a provider submits one "just in case" and incomplete submissions. Health carriers also reported difficulties reaching the clinicians needed for consultation about a case and requests coming from parts of the organization that aren't directly connected to the clinician. Similar to provider side workflow issues, health carriers reported issues with siloed internal teams such as utilization management, case management, and billing leading to communication failures.

Real-time, point-of-care decisioning in which providers receive near-instant clarity on coverage at the point of care through EMR integrations was discussed as a potential solution. This would reduce friction for providers, patients, and health carriers. Concerns were raised about the coming wave of ultra-expensive therapies (e.g., gene therapy) that will intensify PA scrutiny and increase the need for collaborative health carrier-provider partnerships to arrive at timely, accurate decisions and avoid public conflicts.

Successes include if a service is being approved at a high rate it is often removed from the prior authorization list. Some health carriers have invested significantly in API infrastructure to enable health carrier–provider data exchange that can tell providers what health services require PA, provide visibility into clinical policy criteria, and enable streamlined submission and faster responses. National health carrier collaboration has also allowed systematic movement toward eliminating unnecessary PA requirements and clear visibility into criteria, requirements, and process steps (profiled later in this white paper). When additional information is submitted and a denial is upheld, it is often because a less invasive or lower-acuity alternative exists that would appropriately meet the member's clinical needs — reflecting the health carrier's obligation to ensure care is delivered at the most suitable level.

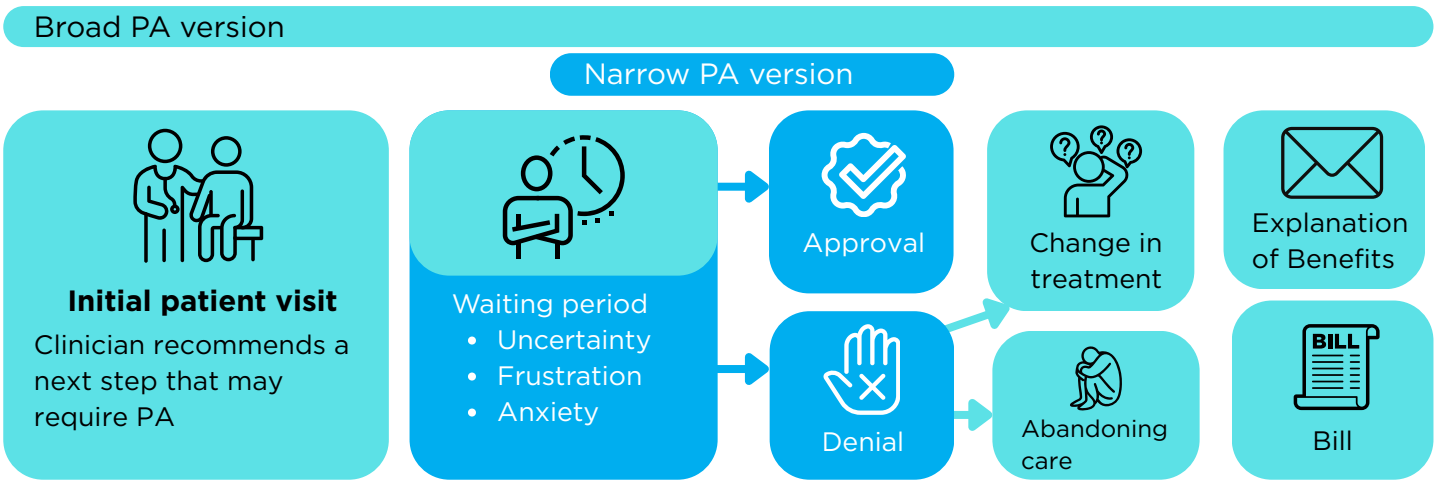
Health carriers warned against legislation mandating blanket PA removal, "If anything's approved over 90%, you can't look at it… then you're going to have people getting spine fusion unnecessarily."

Taken together, these barriers create a system in which a move toward uniform heath data exchange alone cannot resolve underlying inefficiencies.

The Patient Experience

Since a high percentage of PAs are approved, most patients move through the process with little or no impact. However, some patients experience prior authorization as a delay or a change in their care plan, especially if the reason or process has not been communicated clearly. In some delivery systems, if a PA does not have authorization by a certain number of days (e.g., five), the patient is encouraged to reach out to the health carrier, which has been highly effective. A 2026 Kaiser Family Foundation survey found that among insured adults with a chronic condition, 39% listed "Prior authorization, or having to get insurance approval before you can get certain tests, treatments, or medications" as their single biggest burden in getting health care, 34% among all insured adults.

Below is the PA workflow from the patient perspective.



Future State and Next Steps

PA should be defined as a two-sided workflow with shared accountability for all parties. Neutral convenors such as the Administrative Simplification program can be used to move standardization and partnership forward in selected areas to bridge from the current state to a future state of lowered resource use.

Potential processes to bridge from the current to the future state include the following, presented alphabetically and profiled in more detail on the following pages.

Artificial Intelligence Standards and/or Guardrails	Develop collaborative standards for AI governance policy (e.g., frameworks, risk assessment, and coordination structure), use in data compilation/analysis, and guardrails against what should not be done.
CMS-0057-F Readiness	Continue 2025 state-wide convenings to drive readiness with a focus on educating and engaging the provider community, as prior focus was health carrier readiness.
Gold Carding Standards	Reducing unnecessary authorization requirements for high-performing providers while preserving accountability, lowering administrative burden, improving patient access, and strengthening trust across stakeholders and is profiled as an opportunity on the following pages.
Standard Approval Criteria	Focus on small, high-volume set of PA topics (e.g., imaging, PT, sleep, DME) to pilot standardizing policies, computable rules, workflow, and maintenance before scaling to other services.
Workflow Standards	Develop standard workflows and training that would show coverage requirements up front, automatically pull needed clinical data, reduce duplicate entry, return real-time answers when possible and make next steps transparent. Health carrier access to the provider EHR could be part of a solution.

Move Toward CMS-0057-F Readiness

CMS's 2024 Interoperability and Prior Authorization Final Rule requires certain health carrier plans to implement and maintain more efficient and readable data exchange (except for pharmaceutical products) starting in January 2027. Requirements are anticipated to help but not fix data interchange pain points. In the interviews, participants discussed automating information sharing as being on the horizon, but the rules only apply to health carriers. Both health carriers and providers must buy in, see value, and commit to aligned data interchange workflows. Impacts narrow PA version.

Opportunity: Reconvene and facilitate CMS-0057-F health carrier and provider work group meetings to:

- Support interest holders in understanding and implementing requirements for PA readiness
- Connect health carriers and providers and hold information sessions with key vendors to align expectations and planning
- Serve as subject matter experts on FHIR transaction types.

Develop Standard Approval Criteria

Available data suggests that a relatively small number of services account for most volume and risk. Focusing PA on high-risk, high-cost, or highly variable services offers the greatest opportunity to improve efficiency while protecting patient outcomes. These dynamics support directing reform efforts where they can produce the most meaningful operational and clinical benefit.

America's Health Insurance Plans announced commitments to simplify and reduce prior authorization in multiple states, including Washington. Steps taken will include: implementing common, transparent submissions for PA using FHIR APIs, reducing PA scope, easy to understand explanations of determinations, more real-time responses, and ensuring medical review of non-approved requests. Impacts broad PA version.

Opportunity: Form a work group with health carriers, providers and key stakeholders to define the end-to-end process for submission of a prior authorization request for a select health care service. The work group could outline requirements for data and clinical criteria. The goal would be to use that framework for other high volume or high-cost prior authorization requests. The output of an approval pathway would need to be community standard and clinically appropriate. The payers would then use the agreed upon criteria to approve or deny requests. The new process would be more transparent both to providers and create a level playing field for patients as all payers would be in alignment. Once the process was in place for one category or procedure, the framework could be applied to others and the work group membership adjusted to provide the expertise required.

Challenge: Buy in, identifying an appropriate PA request and then assemble the work group to meet the requirements, especially the clinical expertise.

Shared Investment in Gold Carding

As stated previously, the Administrative Simplification program has written two related white papers, on Medical Management in 2010 and on Gold Carding in 2016. The 2016 Gold Carding paper recommended, "*moving from isolated pockets of innovation to community-wide implementation with minimal complexity. [Health carriers] and provider organizations that are currently pioneering the gold carding programs (Prime Movers) …need to take a leadership role in a consensus building process to identify appropriate areas of harmonization/standardization and develop associated guidelines/best practices for all who follow*." Regulatory constraints, particularly in Washington State, require uniform application of benefits. The Office of the Insurance Commission has shared an opinion that challenges the use of gold carding. This opinion will need to be revisited if there is momentum around a gold carding approach. Gold carding was presented to the Washington Healthcare Forum in 2016 and members elected to not take collective action.

Gold carding is a performance-based approach that exempts providers or allows expedited review for providers with consistently high PA approval rates from submitting PA requests for certain services. Rather than removing oversight, this model shifts responsibility toward providers while maintaining accountability through ongoing monitoring and retrospective review. Random audits from the health carrier can maintain accountability. Gold carding rewards good behavior, but does not impact providers submitting poor-quality requests. In addition, gold carding must include attention to equity and potential bias between providers and patient populations. Impacts broad PA version.

Opportunity: Collaboration around a consistent set of design barriers that addresses operational, technical and policy barriers.

- Clear eligibility criteria, such as approval rates of 90 percent or higher
- Defined service categories for exemption
- Regular performance review and audit processes
- Revocation mechanisms for declining performance
- Alignment with quality and outcome metrics
- Standardization across health carriers wherever possible

Benefits

- Reduced provider administrative workload
- Faster access to care for patients
- Lower volume of routine requests for health carriers, allowing greater focus on complex cases
- Improved system efficiency and less duplication.

Risks

- Retroactive audit and potential for loss of payment for services already provided
- Health carrier would need to maintain list of gold card eligible clinicians which is still an administrative function

Challenges

- Regulatory constraints in Washington State require uniform benefit application
- Variation across health carrier programs that creates complexity for providers
- The need for EHR-integrated workflows to replace manual processes – that change is rapidly approaching with a January 1, 2027 implementation target for the health carriers.
- The risk of inappropriate utilization without appropriate safeguards
- Ongoing maintenance and monitoring requirements

Develop Artificial Intelligence Standards and/or Guardrails

Washington State law forbids the use of artificial intelligence (AI) to make independent clinical decisions. Both providers and health carriers have consistently said that any denial of care must include meaningful human clinical oversight to maintain trust, fairness, and accuracy and to ensure there is no misinterpretation or missing of key information. AI can be a useful tool in pulling relevant clinical criteria and structuring information for review and reduce unnecessary submissions. Impacts broad PA version.

The Centers for Medicare and Medicaid Services (CMS) is piloting a voluntary model that seeks to simplify prior authorization through AI. The Wasteful and Inappropriate Service Reduction (WISeR) Model uses "*enhanced technologies, such as AI and Machine Learning (ML), along with human clinical review*" to increase Medicare prior authorization appropriateness and timeliness on over a dozen procedures. The Model runs from January 1, 2026 to December 31, 2031 in six states including Washington. Washington's pilot is being managed by Virtix Health LLC, who will receive a portion of the costs averted due to PA denials. One interviewee found the Medicare WISeR approach acceptable as a first pass, provided it is followed by a clinician review if the AI fails the request.

However, the Seattle Times profiled patient and provider experiences with the WISeR model in June 2026, "Medicare AI program made them suffer in pain. Now they want answers."

One clinician interviewed said, "*We're seeing longer approval times, blanket denials and growing administrative burdens on physicians and staff…Most importantly, we see patients left waiting in pain.*"

Rep. Suzan DelBene has sponsored legislation to remove the program.

Opportunity: Convene subject matter experts to develop collaborative standards for :

- AI governance policy including frameworks, risk assessment, and coordination structure with a focus on the PA process at a systems level, not on how it impacts an specific request for approval
- Patient and member communication about how AI is being used in health care
- Using AI in data compilation and analysis
- Guardrails against what should not be done

Drive Toward Workflow Standardization

Provider PA workflows are highly variable between and within organizations, with some still relying on faxed documents and phone calls. There is also variation in how the health carriers interacts with providers. The inconsistencies are opportunities for system wide improvement. For providers, an ideal workflow would be digital, with transparent requirements, embedded in the normal workflow, and standardized across health carriers as much as possible. New and improved workflow design, with a shared, universal commitment to not send information via fax and to consistently use health carrier portals rather than calling the health carrier, would leverage current technology to create focused PA requests with less manual effort. The improvements in creating a clear, targeted PA request also improves the efficiency of the payer response by reducing non-essential documentation. Impacts broad PA version.

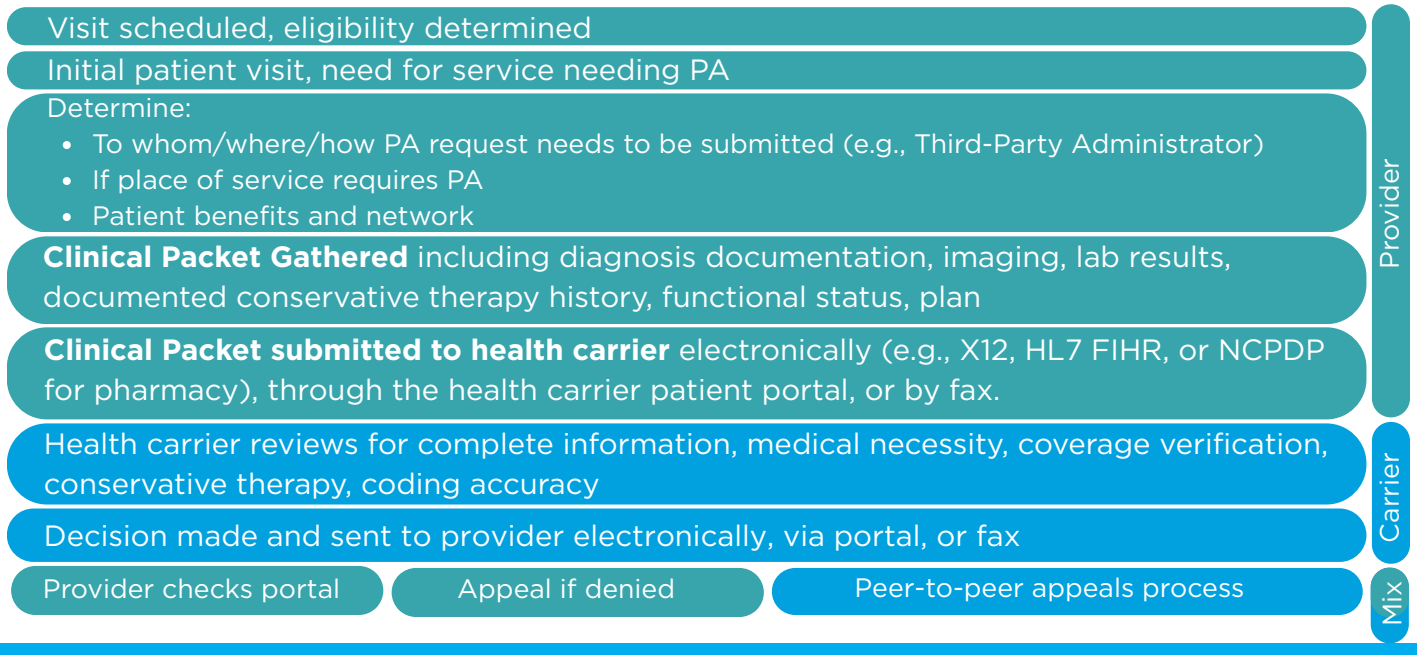
Opportunity: Convene groups to map out inefficiencies in system workflows that would allow reserving manual review for the minority of cases that truly require clinical judgment and that:

- Show coverage requirements up front
- Automatically pull needed clinical data
- Reduce duplicate entry
- Return real-time answers when possible
- Make next steps transparent

Collaborative working groups would also need to address the challenges of training and aiding staff as they adapt to the new steps in an updated workflow. That will help ensure that the improvements have the desired impact. This could be an opportunity for health carriers and providers to work together to design a supportive and intuitive process and training on that improved workflow, including the possibility of incentives for participation.

Opportunity: Develop standard workflow for providers reaching out to health carrier clinical staff during an appeal, also known as peer-to-peer connections.

Opportunity: Allow health carriers direct access to the provider electronic health record such as through using Epic Payer Platform. Read-only access and audits after access has occurred can mitigate risks or negative impact on patients.



Conclusion

PA can be significantly simplified through consensus-driven solutions. Targeted use, aligned incentives, and trust-based mechanisms can reduce the amount of time and resources spent on PA. Opportunity lies in bringing culture in line with new tools and processes. Many providers still rely on outdated workflows and adoption of new tools will depend heavily on the electronic medical record vendors.

Technology can reduce the burden, but only if coupled with provider-centric design, provider participation incentives, education, and culture change. These options offer a practical and scalable way to reduce administrative burden while maintaining appropriate oversight. When paired with workflow re-design and data-driven policy decisions, these options can help transform prior authorization from a major administrative challenge into a more streamlined and effective safeguard for high-quality care.

A targeted approach here in Washington State should be built on aligned incentives, leverage workflow redesign, and incorporate responsible automation. Improvement requires curiosity, dialogue, and shared intent, not entrenched positions. A redesign is possible but will require time, collaboration, and willingness to experiment.

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Appendix A: List of Interview Questions

Provider questions

Please describe the prior authorization process in your organization. Where does it “live”? and do you think it is effective?
🧩 Workflow & Process Questions
What is currently working well in your prior authorization process?
🧠 Staff Experience & Burden
Do you track how much time per day or week do clinicians or staff spend on prior authorizations?
If so, what have you found?
🏥 Clinical Impact
Do you track how often do prior authorization delays affect patient care or scheduling?
📉 Denials & Appeals
What are the most common reasons for denials?
Are denial patterns consistent across types of health carriers or within particular health carriers or highly variable?
🏦 Health Carrier-Specific Challenges
How often do health carrier rules change, and how do you keep up?
📊 Metrics & Volume
Do you track how many prior authorizations your organization handles per week or month?
💡 Opportunities & Wish List-List
What would an ideal prior authorization workflow look like?

Role in your Organization?

Health Carrier questions
🧭 Operational Workflow & Decision-Making
What is currently working well in your prior authorization process?
🩺 Clinical Review & Medical Necessity
What clinical documentation is most valuable for speeding up approvals?
How frequently do guidelines or coverage criteria change?
📑 Communication & Provider Interaction
What are the most common reasons you need to reach out to providers for clarification?
📉 Denials, Appeals & Variability
What are the top reasons for denials across your organization?
🛠️ Technology & Interoperability
What challenges do you face with electronic prior authorization (ePA) adoption?
📊 Metrics, Volume & Performance
How many prior authorization requests do you process per day or week?
What internal KPIs do you track to measure performance?
🧩 Policy, Compliance & Variation
What challenges do you face in communicating policy changes to providers?
💡 Improvement Opportunities & Pain Points
If you could redesign the prior authorization process, what would you change first?

Role in your Organization?

Appendix B: Administrative Simplification White Papers

The Administrative Simplification program has developed two previous white papers that helped to inform this white paper.

Medical Management - Strategies and Recommendations
Prepared by OneHealthPort for the Washington State Forum in Response to SSB 5346. September 21, 2010. www.qualityhealth.org/adminsimp/wp-content/uploads/sites/25/2026/06/MMrecF.pdf

The 2010 paper outlines that medical management works to reduce "*unwarranted variations in patient care delivery to ensure that care is cost effective and of high quality [but]….is not as effective or efficient as it might be*. " Delivery sites show "*underuse, overuse, and inappropriate use of services as well as the use of more expensive services when less expensive services are of equal benefit to patients*" resulting in the need for medical management. Similarly health carriers contribute to cost increases through "*operational processes, especially those related to pre-authorization, [which] contributes to the administrative cost of medical management*." The paper recommends, "*a set of goals and work plan for the development of medical management protocols…[that] promote strategies and methods for more broadly incorporating evidence-based decision criteria into provider practices to control costly, unwarranted clinical variations…[and] promote streamlining the pre-authorization process across health plans so that it less of an administrative burden*."

Gold Carding – Discovery Phase Findings, Assessment, Recommendation
Prepared for OneHealthPort. March 18, 2016. www.qualityhealth.org/adminsimp/wp-content/uploads/sites/25/2026/06/Goldcarding-Final-Report.pdf

The 2016 paper on defines gold carding as a "*Utilization Management strategy where selected providers, with a strong and continued track record of clinical performance, can exchange some or all of the administrative requirements to obtain a pre-authorization for a defined set of services, for an increase in their own responsibility and capability to conduct Utilization Management for those services before they are delivered to the patient*." The paper found that "*there is no program where health plans give providers a pass that frees them altogether from Utilization Management (UM) of the care provided to patients [rather a] variety of innovative, exploratory, workflow-changing, in-process efforts…where health plans and providers are working together to better understand and to more effectively operationalize utilization management*." The goal was to "provide a common understanding of how gold carding is being implemented in the local market and b) to identify what, if any, aspects of gold carding might lend themselves to standardization/harmonization through a collaborative process potentially leading to future best practice guidelines. The recommendation was to "*mov[e] from isolated pockets of innovation to community-wide implementation with minimal complexity. [Health carriers] and provider organizations that are currently pioneering the gold carding programs (Prime Movers) …need to take a leadership role in a consensus building process to identify appropriate areas of harmonization/standardization and develop associated guidelines/best practices for all who follow*."