ChatGPT

Executive Summary

U.S. health insurers continue to rely on prior authorization (PA) as a key utilization management tool to curb unnecessary or low-value care and control medical spending. **The economics** underpinning PA are stark: each manual PA request costs insurers roughly \$3–\$4 in administrative expense on average, while imposing about \$11 in costs on physicians [1] [2]. In 2023 alone, the industry spent an estimated \$1.3 billion on PA administrative activities – a 30% jump from 2022 due to rising PA volumes [3]. These costs are justified by payers when PA avoids even greater medical expenditures; indeed, third-party PA vendors promise **3:1 returns** (every \$1 spent yields \$3 saved in claims) by increasing denial rates [4] [5]. However, recent analyses show **diminishing returns**: up to *80% of PA volume yields no net savings* for insurers [6] because many services under PA are almost always approved. Overly broad PA requirements drive up administrative **SG&A costs** and can even erode medical cost ratio gains if the cost of reviewing a request outweighs the potential denial savings. Under ACA Medical Loss Ratio rules, insurers must balance PA's savings against its admin burden – excessive PA spend that only marginally cuts claims may simply end up returned to consumers as rebates.

Despite its inefficiencies and growing backlash, payers maintain that PA programs "ensure the *right care, right place, right time*" – i.e. that treatments are evidence-based, not duplicative, and covered by the member's plan [7]. **Financial impact** is central: PA can significantly reduce utilization of expensive drugs, diagnostics, and procedures when used in targeted areas. A Medicare demonstration requiring PA for power wheelchairs, for example, cut related spending by as much as \$1.1–\$1.9 billion over a few years [8]. On the other hand, indiscriminate PA can create *false positives* (unwarranted denials) that delay or deny necessary care – with downstream costs. A 2022 HHS-OIG audit found **13% of PA denials in Medicare Advantage were for requests that actually met Medicare's coverage rules**, exposing plans to appeals and oversight penalties [9] [10]. Indeed, over 80% of appealed PA denials in MA get overturned in favor of the patient [11] [12], suggesting initial determinations often err on the side of over-denial.

Looking ahead, **technology and regulatory pressures are driving change**. Health plans are investing in AI-driven automation to streamline PA workflows (e.g. auto-approving low-risk requests) and using machine learning to better target which services truly need prior review [13] [14]. The **CMS Interoperability and Prior Auth rule (2024)** will force Medicare Advantage and many commercial plans to implement **FHIR-based PA APIs** by 2026–2027, enabling real-time data exchange and decisions [15] [16]. At the same time, insurers – under intense political pressure – have pledged to *voluntarily* reform PA: cutting the volume of requirements, accelerating turnaround times (with a goal to decide 80% of requests "in real time" by 2027 [17] [18]), and "gold-carding" doctors with high approval rates to bypass PA [19] [20]. In sum, payers see PA as a necessary check on cost and utilization, but one ripe for **modernization**. The next few years will determine if AI and policy can indeed flip the cost-benefit equation of PA – reducing administrative friction while preserving its savings and safety benefits.

Payer-Side Economics of Prior Authorization

Cost per PA Transaction: Industry data from CAQH highlight that prior authorization is *the most expensive manual administrative transaction in healthcare*. A single PA request done manually costs health plans about \

$3.50 on average, and costs the requesting provider around \$11 in staff time [1]. By contrast, fully electronic prior auth (integrated EHR-to-payer systems) cuts the insurer's cost to mere cents (around \$0.05) and the provider's cost to about \$5.80 [21]. This >50% reduction in provider burden per case underscores why automating PA is a top priority. The savings at scale are significant: CAQH estimates the U.S. healthcare system could save **\$454 million annually** by moving from portal/fax-based ("partial") PA to fully electronic processes, with each electronic PA saving an average \$5.43 vs. manual [22] [23]. Despite this, as of 2023, only ~21% of medical prior auth requests were fully electronic; the majority still involved manual or semi-manual steps [24]. Overall, the **national price tag of PA administration was \$1.3 billion in 2023**, up 30% from the prior year due to increasing volume [3]. These administrative costs directly hit insurers' SG&A expenses. If unchecked, they can eat into margins or force premium increases – the very outcomes utilization management is meant to mitigate.

Impact on Medical Loss Ratio & Admin Spending: Prior authorization affects both the numerator and denominator of the insurer's Medical Loss Ratio (MLR). On one hand, **successful PA programs lower the medical claims "losses"** (the M in MLR) by preventing payment for services deemed unnecessary or non-covered. This can improve profitability *up to a point*. However, every dollar spent on PA administration counts as overhead in the MLR denominator. The **ACA's MLR rules** (requiring 80–85% of premium be spent on care) effectively mean that heavy admin spend on UM cannot fully translate to profit – it either must generate outsized medical savings or it will be returned to members as rebates if MLR falls below the threshold. Thus, insurers have a built-in incentive to make PA **as efficient and high-impact as possible**. In practice, payers analyze which PA requirements yield net savings after admin costs. Many have found that a large share of PAs are effectively *net-neutral or negative ROI*. According to consultants at ZS, roughly *80% of PA volume produces no return* on investment for payers [13] [6]. This is because in many categories nearly **all requests get approved** – i.e. the PA rarely stops a claim, so the insurer incurs review costs with little to show in avoided payouts. (Indeed, about 40% of procedure codes that some insurers subject to PA are **approved 100% of the time** [13] [6].) For these, the break-even logic says: if a PA costs \$3–\$4 to review and never results in a denial, it only adds cost. Insurers are now re-examining such requirements. In 2023, UnitedHealthcare announced it would eliminate ~20% of its PA codes after internal data showed those PAs rarely led to denials [25] [26]. Other major payers likewise report ongoing audits to "right-size" PA lists by removing low-value requirements [27] [28].

At the same time, payers focus PA on high-dollar or high-variability services where even a small denial rate yields big savings. For example, an expensive injectable drug costing \$10,000 might justify PA even if <10% of requests are denied, since each avoided injection saves \$10k while a review might cost \$50–\$100 (including nurse/MD time). This **ROI threshold** calculus often drives which service categories get PA. Payers also consider indirect savings: the **deterrent effect** (providers may order fewer questionable services if they know PA scrutiny exists) and the leverage to **negotiate discounts or step therapy** (e.g. requiring generics first). These can improve medical cost trends without a formal denial. Overall, when well-targeted, **PA can return around \$2–\$4 in medical savings per \$1 administrative cost** [29] [30], according to vendor and plan reports. But when misapplied, PA adds bureaucracy that can inflate admin ratios and even *increase* downstream medical costs (for instance, if delays from PA lead to complications or ER visits [31] [32]). Achieving the optimal balance is now a CFO-level concern at insurers, especially as regulators scrutinize whether denials are truly medically justified.

Deny-or-Automate Decision Logic: Given the economics above, payers are increasingly selective about when to require prior auth and when to automate or waive it. Many use **risk-based triaging**: incoming PA requests might be algorithmically scored for likelihood of meeting criteria. If a request looks obviously

appropriate (e.g. a common surgery for a diagnosis that clearly warrants it), the system can auto-approve in seconds without manual review. If it looks borderline or high-risk, it gets routed to a human clinician for closer scrutiny. This improves efficiency by **reserving costly human review for cases likely to yield a denial or modification**. UnitedHealthcare, for example, uses an AI-based system (internally called *"Predict"*) in its home care authorizations: the tool predicts needed length of stay, and while the company insists it's "not used to make coverage decisions" without human signoff [33] [34], critics allege it effectively steers more cases into denial by flagging more for review. Similarly, **eviCore**, a leading UM vendor, has an algorithmic "dial" it can tune to be more or less aggressive. If a client insurer wants more savings, EviCore's system will send more requests to human review (instead of auto-approving them), thereby *boosting denials*. ProPublica's investigation found eviCore's dial could be set such that even requests with a 95% predicted approval chance still get kicked to manual review – increasing the odds some will be denied on secondary review [35] [36]. This practice is controversial, but it underscores how payers explicitly manage the **false-negative vs. false-positive trade-off**. A "false negative" in UM is an **unnecessary approval** – the plan pays for something it ideally should not have. A "false positive" is an **inappropriate denial** – the plan initially refuses something that actually was needed/covered. Payers aim to minimize both, but zeroing them out is impossible, so it becomes an actuarial decision: is it worse to approve an unneeded \$5,000 service, or to deny a needed one and face appeal costs and potential harm? Traditionally, plans have erred on the side of avoiding false negatives (i.e. be stringent, deny if uncertain). But the climate is shifting. With growing regulatory scrutiny, **over-denials now carry real financial risk** – via overturned appeals, litigation, and penalties. Medicare Advantage plans, for instance, have been warned by CMS that inappropriate denials can violate regulations. The OIG's 2022 report revealed **13% of MA prior auth denials were unfounded** [9], prompting CMS to tighten rules. Each wrongful denial not only incurs internal appeal costs (medical director time, possibly an external review fee of several hundred dollars) but may also lead to **fines or contract sanctions** if found to be a pattern. In contrast, a false negative (approving a possibly wasteful service) simply means the plan pays the claim – which may be preferable to the multi-layer cost of handling a dispute.

Thus, many payers are recalibrating PA criteria and **incorporating analytics to improve accuracy**. Some have begun tracking *denial overturn rates* as a key QA metric – high overturn rates can indicate overly aggressive criteria or inadequate documentation on first pass. The goal is to reach a point where nearly all PAs that are denied truly should be denied, and those likely to be approved are streamlined. **Gold-carding** programs (discussed later) also play into this, effectively reducing false positives by trusting certain providers who have high historical approval rates (thus low risk of overuse). From a cost perspective, the **break-even denial rate** for a PA requirement can be calculated: *if a PA costs, say, \$50 in total processing cost (plan and provider), and it denies or alters care 10% of the time saving \$500 on average each time, then net savings* = *\$500*.10 - \$50 = \$0 (break-even). *Below 10% denial yield in this scenario, the PA loses money; above it, it saves money. Many high-volume PAs (like imaging or specialist referrals) have single-digit denial rates, which is why plans are now eliminating some or using predictive rules to only require PA for higher-risk subsets. Elevance Health (Anthem) noted through its utilization management subsidiary that about 20% of PA requests for certain services can be denied or modified** when robust criteria are applied [37] [38]. Payers seek to focus PA on those segments.

Financial Exposure: Over-Denials vs. Over-Approvals: When an insurer's PA program overshoots (denying too much), the financial exposure comes in several forms: **(1) Appeals and overturns** – roughly 10–12% of denied requests in MA are appealed [39] [40], and of those, >80% get overturned in favor of the patient [11] [12]. Every overturned denial means the plan ends up paying the claim anyway (often months later) *plus* expending additional admin resources on the appeal. High overturn rates are essentially a red flag that

initial PA decisions were too restrictive. **(2) Regulatory penalties** – as noted, CMS has put Medicare Advantage plans on notice that they must align PA policies with Medicare coverage rules. If a plan is found to systematically deny valid requests, it can face sanctions. The Department of Justice has also formed a joint task force to investigate inappropriate coverage denials as potential **False Claims Act** issues [41] (arguing that insurers received payment for providing coverage they then failed to deliver). And state insurance regulators have fined plans for PA missteps (e.g. not meeting turnaround time guarantees). **(3) Provider network fallout** – aggressive PA that frequently denies legit care can sour relations with physicians and hospitals, who may then leave the network or demand higher fees to compensate for admin burden. This can indirectly cost the plan by weakening its network adequacy or negotiating position. **(4) Brand and member abrasion** – over-denials lead to poor member experiences, potentially driving consumers to switch plans (loss of revenue) or increasing customer service costs.

Conversely, **false negatives** (approving wasteful services) primarily affect the medical claims spend. The cost is diffuse – possibly a slightly higher MLR. Insurers also mitigate this on the back end with other tools: they might pay a questionable claim but then flag the provider for **retrospective review or audit**. If clear waste or fraud is found, they may recover payments or remove the provider from network. In other words, payers have a safety net for false negatives in the form of payment integrity programs. There is no such easy safety net for false positives aside from appeals, which are reactive and resource-intensive. For this reason, the trend is towards *"when in doubt, approve"* and focus PA where criteria can be applied accurately. Notably, even with PA in place, **denial rates tend to be modest**. Medicare Advantage plans, for instance, deny about **6–7%** of PA requests on average [42] [43] (the rest are approved). Commercial plan denial rates are not publicly aggregated, but internal figures often range in the 5–15% zone depending on service line. One outlier: certain radiology and specialty drug PAs managed by aggressive vendors report 15–20% denial rates [37], which suggests significant savings but also higher odds of denying needed care. The sweet spot for most plans is likely in the single digits – enough to trim outliers and non-evidence-based care, but not so high as to indicate barriers to necessary treatment. Going forward, **AI tools** may help thread this needle by analyzing large datasets of requests, outcomes, and appeals to continually refine PA criteria and identify which requests truly need human review. Payers like Cigna have hinted that as they move providers into value-based arrangements (where the provider bears cost risk), they are willing to **"step down the number of prior auths"** accordingly [44] [45] – essentially trading off some potential false negatives (because the provider now has financial incentive to avoid waste) in exchange for administrative savings and provider goodwill.

Internal UM Workflows and Org Structure

Inside a health plan, prior authorization is managed by a **Utilization Management (UM) department** that blends clinical expertise with operational process. A typical payer's UM org chart includes: **front-line coordinators** or PA specialists (often non-clinical staff) who handle intake of requests and ensure required info is present; **nurse reviewers** (usually RNs) who apply clinical criteria to straightforward cases; **pharmacists** for medication PAs; and **physician reviewers** (often part-time medical directors or contracted MDs) who handle the complex cases, peer-to-peer discussions, and final denial determinations. In large national plans, hundreds of nurses may be assigned to UM, often organized by service type (e.g. a team for radiology and imaging, another for surgeries, another for post-acute care, etc.). There may also be a **vendor management component** – many insurers *outsource* certain PA categories to specialized UM vendors. For example, radiology and high-tech imaging PAs might be contracted out to eviCore or Magellan; oncology drug PAs to a company like New Century Health; post-acute care reviews to NaviHealth (Optum). In those cases, the insurer's internal workflow involves forwarding requests/data to the vendor's

systems and integrating the vendor's decision back into claims processing. The internal org chart will thus include **vendor liaisons or IT systems staff** to manage those handoffs. Additionally, plans employ **data analysts and compliance officers** within UM to monitor metrics (turnaround times, denial rates, appeal rates) and to ensure adherence to state/federal UM regulations and accreditation standards (e.g. NCQA or URAC requirements for timeliness and physician involvement in decisions).

Process Flow from Request to Determination: The PA process typically unfolds in several stages. **(1) Submission/Intake:** A provider (or their staff) submits a PA request with patient and service details. This might come in via an electronic portal, an EHR ePA interface, a faxed form, or phone call. Upon receipt, intake staff log the request in the UM system and check for **completeness** – patient eligibility, required clinical documentation, etc. Many initial denials (called "pended" or "return for info") result from missing data, so intake tries to catch those upfront. **(2) Automated Review:** If the insurer has rules engines or auto-approval algorithms, these fire next. For example, the system may auto-approve certain requests meeting clear criteria (e.g. an MRI for cancer staging might pass if diagnosis codes match a cancer diagnosis on file). Plans increasingly use rule-based engines (and some now exploring NLP/AI) to parse incoming requests. The goal is to **instantly approve low-risk, criteria-met cases** – some plans report 20–30% of PA requests can be auto-approved in real time [17] [18]. If auto-approval isn't possible, the request moves to **(3) Initial Clinical Review:** Here a utilization review nurse compares the case details against established guidelines (often using a software interface to InterQual or MCG criteria sets). The nurse can approve the request if all criteria are met. If criteria are not met or it's borderline, the nurse typically cannot outright deny at this stage (in many organizations, only a physician can deny). Instead, the nurse may either *pend* the case for additional info or escalate it. **(4) Physician Review (Peer Review):** A physician UM reviewer (often called a "medical director") examines the case. Sometimes this involves a **peer-to-peer call** with the requesting physician to gather context or discuss alternatives. Based on the combined info and guidelines, the physician will approve or issue a denial. If denying, plans must provide a reason and appeal instructions in writing. Many insurers require that the reviewing physician be of same specialty or have appropriate expertise (especially for oncology or complex cases) – either internally or via an external physician review panel – to ensure fairness. **(5) Notification:** The decision (approve/deny) is communicated to the provider and patient. Approved PAs get logged so that the claim will pay when submitted. Denials trigger the **appeals clock**, during which the provider/patient can request an internal appeal (reconsideration) often within 30–60 days. Appeals usually go through a similar review process but by a different physician reviewer for a "fresh look." A final denial after internal appeals may be eligible for **external independent review** (e.g. a state-sanctioned review entity or for Medicare Advantage, the CMS independent review contractor). If overturned at any stage, the PA becomes an approval.

Loops and Turnaround Metrics: Several feedback loops exist in the process. Frequently, requests are neither approved nor flat-out denied on first pass, but **pended for additional information** – for example, the insurer may ask for clinical notes, imaging results, or proof of step therapy failure. This introduces back-and-forth that extends the timeline. Health plans track **turnaround time (TAT)** closely: typical standards are 72 hours for urgent PAs and 5–7 calendar days for routine PAs (these limits are often set by regulation, e.g. Medicare Advantage requires decision within 7 days for standard requests). According to an AHIP-sponsored pilot study, implementing electronic prior auth significantly cut decision time – median time from submission to decision dropped from **18.7 hours to 5.7 hours** (69% faster) in one multi-payer project [46] [47]. However, when manual, the process can drag on for days especially if documentation is incomplete. **Bottlenecks** commonly occur at the physician review stage (since a limited number of MDs must handle a large volume of cases) and when coordinating peer-to-peer discussions. Many plans report that **communication via fax/phone** is a major pain point – e.g. phone tag with provider offices to get

missing info or discuss denials [48] [49]. Indeed, as of 2022, **60% of medical prior auth requests were still submitted via manual methods (phone, fax, web portal)** rather than integrated ePA [50] [51]. This fragmentation creates multiple workflows and opportunities for error. Another metric is **throughput per reviewer**: a nurse reviewer might process, say, 20–30 requests per day on average (depending on complexity), whereas auto-approval systems can handle dozens per second. Thus, investing in automation and better data integration is aimed at alleviating the strain on human reviewers and shortening queues.

Technology and Data Silos: The UM workflow often requires reviewers to consult various data sources: the PA request form itself, the patient's health plan benefits (to check coverage terms), claim/history data (to see if patient already tried alternative treatments, etc.), and externally, the clinical guideline repository. One complaint from UM nurses is the **lack of unified systems** – they may need to flip between an authorization system, a separate imaging system for radiology reports, and PDF guidelines. This slows down reviews. Some plans have built **all-in-one UM platforms** that pull relevant patient history automatically and present checklists to the nurse. Others rely on the vendors' platforms for specific services, which don't always interface well with the plan's system. The result can be **siloed data** – e.g. a PA for a drug might not be visible to the team reviewing a related procedure for the same patient, since pharmacy and medical UM systems are separate. Integration is improving though, especially with the push for FHIR-based data sharing. By 2026, CMS will require certain plans to implement a **Prior Authorization Requirements, Documentation and Decision API** that can query patient data and coverage requirements in real time [52] [53]. This should eventually allow, for instance, a provider's EHR to know instantly what documentation is needed for a given PA and whether the patient has met those requirements (via data like past claims). Internally, plans are also adopting **workflow tools like BPM (business process management) software** to automate task routing and use **RPA (robotic process automation)** for rote tasks (e.g. reading faxed requests and inputting data). Still, as of now, many UM departments rely on a lot of human effort and legacy systems – which is why the average PA request for a physician practice takes **~25 minutes of staff time** across checking requirements, submission, follow-up, etc [54] [55].

Key Pain Points: According to provider surveys and plan analyses, the top bottlenecks in PA workflows include: **(1)** Lack of **real-time eligibility & benefit info –** providers often don't know if a service needs PA until they attempt to schedule it, leading to last-minute scrambling. (New CMS mandates for **Coverage Requirements Discovery (CRD)** aim to fix this by broadcasting PA rules publicly via API.) **(2) Manual communication** – the heavy use of fax and phone leads to lost info and delays. For example, faxed clinical documents might sit in a queue to be scanned at the insurer. **(3) Variation in requirements** – each payer (and even different plans within the same insurer) may have different PA criteria and forms [56] [57]. Providers juggling dozens of payers find it hard to keep track, which leads to mistakes and rework. There have been calls to standardize at least the PA submission process nationally to reduce this entropy [58] [59]. **(4) Peer review availability** – when a denial is issued or pending, getting the plan's physician and the treating physician together for a consult can be tough, especially if the plan requires this step before a final denial. Scheduling those calls can add days. **(5) Appeals backlog** – a subset of cases will always go to appeal. If the UM team that handled initial PA is separate from the appeals team, there can be duplication of effort and slower learning feedback (i.e. if initial denials keep getting overturned on appeal, that indicates a criteria problem, but organizational silos might delay that insight).

Many health plans have **instituted daily huddles or QA meetings** in UM departments to go over pending cases and ensure nothing falls through the cracks time-wise. They also monitor **member and provider satisfaction** related to PA, since complaints can translate into regulatory headaches. For example, Medicare Advantage plans must report PA denial and appeal metrics to CMS, and starting in 2024 they will have to

publicly report certain PA metrics (volume, approval rates, average time, etc.) which may be scrutinized by consumers and regulators [60] [61]. This transparency is pushing plans to streamline workflows and reduce unnecessary touchpoints. One positive side effect of improved workflow: it can reduce **physician burnout and admin cost on the provider side**, which in turn reduces the adversarial nature of PA. A CAQH report noted that while fully electronic PA adoption remains low, providers who *do* have end-to-end electronic PA spend **2.5 fewer hours per week** on PA tasks on average [62] [63], a meaningful productivity gain. Insurers are aware that making the process easier for providers (through better tech and clearer requirements) can improve provider compliance and even reduce unnecessary service requests (because providers become more conscious of criteria and best practices). Thus, internal UM workflow improvements often focus on **provider-facing tools** as well – for instance, provider portals that show exactly what clinical info is needed for each PA, or even integrating guideline logic into the ordering process (so that if a doctor orders an MRI in their EHR, a pop-up can indicate if PA is needed and guide them through criteria). Initiatives like the HL7 Da Vinci Project's **DTR (Documentation Templates & Rules)** are enabling some of this, embedding PA criteria into EHR workflows. In short, payers are trying to **make the PA process less of a "black box"** and more of a collaborative, data-driven workflow, both to cut their own admin costs and to alleviate the friction with providers.

Clinical Guideline Lifecycle & PA Criteria Management

The effectiveness and fairness of prior authorization hinges on the **clinical criteria** used. Payers source these criteria from a mix of **external evidence vendors and internal clinical committees**. Two dominant external sources are **InterQual** (produced by Change Healthcare/Optum) and **MCG (Milliman Care Guidelines)**. These are comprehensive libraries of utilization review criteria for thousands of medical interventions, updated annually by the vendors [64] [65]. Insurers license these tools to use as the foundation for PA decisions – for example, criteria for approving an inpatient admission vs. observation, or when a CT scan is medically indicated. Many payers also rely on **specialty society guidelines** for certain areas: e.g. NCCN (National Comprehensive Cancer Network) guidelines for oncology drugs and treatments, or ASCO/American Society of Clinical Oncology criteria. In fact, some state laws require that PA for cancer treatments adhere to NCCN or similar consensus guidelines. Beyond vendor libraries, each insurer typically has a **Utilization Management Committee** (UMC) or Pharmacy & Therapeutics Committee (for medications) that governs the PA policies. This committee – comprising the plan's medical directors, pharmacists, and sometimes external physician advisors – decides *which services require PA* and may customize the criteria. For instance, an insurer might adopt MCG's guideline for spinal fusion surgery but tweak it to be more stringent if local practice patterns warrant, or conversely, waive PA for a service despite guideline support if it's low-cost.

Governance and Updates: The UM Committee regularly reviews **new evidence and technology assessments** to update PA rules. Typically on an **annual cycle**, the committee will review the latest InterQual/MCG releases (which come out each year with new studies incorporated) and decide which changes to adopt. They also monitor **emerging therapies** – e.g. a newly FDA-approved gene therapy might be flagged to require PA from day one due to its cost. In a large national plan, there may be separate subcommittees for different domains (medical/surgical, behavioral health, radiology, pharmacy, etc.), all feeding into an overarching UM policy committee. The change-management costs here include **purchasing the updated criteria sets** (licensing fees can be substantial for these proprietary guidelines), **training UM staff** on new or revised rules, and **configuring IT systems** to reflect the changes. For example, if InterQual adds criteria for home oxygen therapy, the insurer must update their decision support software so that nurse reviewers see those new criteria when evaluating a request. According to an NAIC task force

discussion, plans favor using InterQual/MCG because they are “independent, peer-reviewed, and updated annually,” giving a level of credibility and standardization [66]. Even so, each plan often layers on its own **medical policy statements**. These are documents that plans publish outlining coverage criteria for specific services (often available on the insurer’s provider website). Many medical policies cite InterQual/MCG or specialty guidelines, but some are proprietary based on the plan’s claims experience or interpretation of evidence. The **governance challenge** is ensuring all these policies stay current and consistent across a large organization and across different product lines (Commercial, Medicare Advantage, Medicaid, each of which might have nuance due to regulatory differences). Some insurers enlist external **physician advisory boards** or use accreditation standards that require an annual review of PA criteria with practicing physician input.

Encoding Rules and Tooling: Historically, PA criteria might have been in narrative form – e.g. a PDF saying “coverage requires A, B, and C.” Today, much of it is encoded into **rules engines**. Insurers use software platforms (sometimes part of the InterQual/MCG product suite, or custom-built systems) where criteria are structured as decision trees or algorithms. For example, InterQual provides an interactive software where a nurse checks boxes corresponding to patient findings and the system outputs an approval or denial recommendation based on its logic. Some plans have built **knowledge graphs** or databases that map medical codes (CPT, HCPCS, ICD) to required criteria and documentation. For instance, a certain CPT code for knee MRI might be mapped to a rule requiring that the patient has first had an X-ray and completed 6 weeks of physical therapy, etc. The advent of APIs and FHIR is pushing vendors to make these rules more computable. CMS’s upcoming requirements basically nudge payers to have **machine-readable PA rules** that external systems can query [67]. This is leading to development of **FHIR-based guideline representation** – though still early. In practice, many insurers still rely on a combination of **IT systems and human interpretation**. A request might trigger an automated check (e.g. does the claim history show the patient tried Drug X before approving Drug Y?), but often a human reviewer verifies the subtleties. Some payers are experimenting with **NLP (Natural Language Processing)** to read clinical notes attached to PA requests to auto-validate criteria (for example, parsing a doctor’s note to find that “physical therapy was tried for 8 weeks”). This can help where criteria depend on unstructured data. Additionally, **generative AI (GenAI)** is being explored to maintain criteria: ingesting large volumes of medical literature to update internal policies faster, or even drafting denial rationales in plain language. One plan noted concern that if GenAI tools are used to draft denial letters, they must be carefully monitored to avoid errors or biased language [68] [69].

Scale and Complexity: The scope of PA criteria that a major insurer manages is enormous. There are **thousands of service codes** that could potentially require PA across all medical and pharmacy benefits. The criteria often vary by **line of business**: Medicare Advantage must follow Medicare coverage rules (which might be more permissive in some cases), whereas commercial plans have more latitude to use proprietary criteria for investigational treatments, etc. Medicaid MCOs have to heed state Medicaid guidelines and local policies. Furthermore, within commercial business, there are **50 states’ mandates** to consider – some states prohibit PA for certain services (e.g. emergency services, some behavioral health), or require peer review by same-specialty, or mandate specific turnaround times. All these factors mean the **PA rule set is not one-size-fits-all**; it’s segmented. For example, an insurer might waive PA for sterilization procedures in one state due to a mandate, but require it elsewhere. Managing these variations is a major administrative effort. Many plans use **automation to enforce benefit-specific rules** – their claims/UM system will check member’s plan type and state and then apply the relevant PA list. Still, ensuring uniform **quality of decisions** across thousands of codes is tough. One challenge is **keeping criteria updated with medical advancements**. If a new study shows that a previously “experimental” treatment is effective, ideally PA

criteria should relax promptly. But often there's lag due to the committee review cycles. Payers sometimes get caught using outdated criteria – a common provider complaint. For instance, medical societies have accused insurers of using "old guidelines" to deny coverage for newer standard-of-care treatments. Plans counter that they update as fast as possible but must thoroughly evaluate evidence and often wait for vendor guideline updates.

Another scaling issue is **interdependency of guidelines**. A single patient's care might trigger multiple PAs (e.g. a surgery, an anesthesia service, and a post-acute rehab stay). Ideally, the criteria consider the whole picture, but typically they are siloed by service type. This can lead to contradictions or cumulative burden (the patient's surgery is approved but then rehab is denied, etc.). To address this, some integrated delivery systems (like Kaiser Permanente) have more unified care pathways that align all downstream authorizations in one protocol – but for most insurers, it's divided. As value-based care grows, insurers might simplify or eliminate PA for an episode of care and instead manage via **bundled payment or provider accountability**, which avoids having to micro-manage each service in the episode.

External Evidence Vendors & Committees: Vendors like InterQual and MCG employ large clinical teams to develop and revise criteria. InterQual, for example, releases new criteria annually with thousands of updates, reflecting new trials, FDA approvals, etc [64] [65]. Health plans typically have representation (or at least visibility) into these updates through user groups. Additionally, insurers may convene **external advisory panels** – e.g. a payer might have a cardiologist panel to advise on PA criteria for cardiac procedures. These steps are partly to gain clinical buy-in and avoid the perception that PA criteria are arbitrary "bean-counter" rules. They also help in **defending denials** on appeal: if criteria are backed by external evidence and expert consensus, the plan's case is stronger. Notably, for cancer drugs, many plans now defer to NCCN guidelines explicitly – if a requested regimen is NCCN-recommended, it's approved; if not, it's denied or subject to case-by-case review. This outsourcing of criteria helps with credibility, though NCCN guidelines can be broad (often including almost any reasonable use).

Governance Example: One illustrative case was a large payer's PA criteria for proton beam therapy (an expensive form of radiation). Initially, the plan required PA and denied many such requests as "not medically necessary except for certain cancers." After providers pushed back with emerging evidence, the plan's oncology committee revised the policy to cover more indications. The cycle from initial restrictive criteria to updated criteria took ~18 months. In the interim, many appeals and external reviews took place, some overturning the plan's denials. This shows how the **feedback loop from appeals and outcomes can lead to criteria change**. A robust guideline lifecycle means using data: plans analyze which PAs are frequently overturned or frequently result in no denial (100% approvals). Those are candidates for policy change (loosen or remove PA). According to a McKinsey analysis, instituting a "gold card" for providers (exempting those with high approval rates) and culling low-value PA requirements could save **5–10% of PA administrative costs for both payers and providers** [70] [71]. Some plans have formally embedded this into their annual review – e.g. "PA Removal Initiatives" that drop requirements that had near-automatic approvals for a year straight.

Challenges at Scale: When dealing with thousands of codes and criteria, **consistency** is a major challenge. A health plan must ensure all its nurse reviewers apply the criteria uniformly. Training and audit are used for this – e.g. inter-rater reliability tests where multiple nurses review the same sample cases to see if they reach the same decision. Another challenge is **member benefit designs** – different employer groups may customize benefits that affect PA (one employer might insist on PA for all outpatient PT beyond 5 visits,

another might not). Administering these custom PA rules adds complexity. Plans try to limit customization, but in competitive markets, large employers or union plans can negotiate such tweaks.

Finally, **technology limitations** sometimes constrain how sophisticated criteria can be. If an insurer's system can't automatically pull in, say, lab results, then criteria requiring a lab value might be hard to enforce in real-time and require manual review. As interoperability improves, criteria can become more nuanced without bogging down the process. We are also seeing initial attempts to use **machine learning to generate or prioritize criteria**. For example, an insurer could mine claims data to find patterns of overuse and use that to target new PA policies (one could call this "analytics-driven guideline updates"). A caution here: if not carefully validated, this can reinforce biases or target high-utilizing providers without clinical justification. Transparency in criteria development is increasingly demanded – some state laws now require insurers to publicly post their PA criteria and the sources of evidence behind them. This pushes plans to use reputable sources and keep them updated to avoid legal exposure.

In summary, the **clinical guideline lifecycle behind PA** is a continuous process of *evidence assimilation* → *criterion formulation* → *implementation* → *outcome monitoring* → *refinement*. It's resource-intensive, involving committee deliberations and IT updates, which is a cost factor not always visible externally. But it is crucial: well-crafted, up-to-date criteria are what separate PA as a tool for quality and cost management from PA as a blunt instrument. Payers know that if their criteria are seen as outdated or overly rigid, they risk public and regulatory backlash, as well as potential harm to patients. Thus, many payers are reinforcing the **"medical necessity" ethos** of PA – emphasizing that decisions are grounded in **"nationwide best practices" led by physicians** [72], and highlighting that every denial gets a **physician's review** (as the Blue Cross Blue Shield Association recently pledged [72] [73]). This is both to build trust and to ensure the program can withstand scrutiny as the volume of PA grows.

Fraud, Waste & Abuse (FWA) Controls via PA

From the payer's perspective, one of prior authorization's fundamental roles is to serve as a **front-end fraud, waste, and abuse filter**. By requiring approval before payment, insurers can stop certain improper behaviors in their tracks – whether it's a physician ordering an unusually high number of unnecessary tests (waste), a pharmacy ringing up duplicate prescriptions (abuse), or an outright fraudulent scheme (fraud) like durable medical equipment mills billing for unneeded wheelchairs. **Quantifying FWA caught by PA:** Precise figures are hard to pin down, but there are telling indicators. The **GAO's review of Medicare prior auth demonstrations** found significant spending reductions in areas prone to improper payments. In the 7-state demo for power mobility devices (wheelchairs and scooters) mentioned earlier, Medicare realized up to **\$1.9 billion in savings** over a few years [74] [75], much of which was attributed to preventing fraudulent or medically needless claims. The prior auth requirement in that demo cut utilization by over 60% in some categories, far beyond what clinical need alone would predict – implying it flushed out a huge amount of inappropriate billing [8]. Similarly, CMS has expanded PA for certain durable equipment (like prosthetics and orthotics) and reported substantial drops in utilization in areas known for fraud (e.g. a PA program for home health services in Florida and Texas reduced spending notably). While not all reduced utilization is "fraud" per se – some is genuinely unnecessary but not malicious – PA clearly has a **deterrent effect**. Providers who might casually order something think twice if they have to justify it, and fraudsters who rely on volume know they'll be stopped if scrutiny is applied.

Insurers often cite examples like: a single physician ordering 500 genetic tests a month until PA was put in place, after which orders fell to 50 – suggesting the rest were waste or abusive. Another concrete metric: a

study in *Health Affairs* pegged the overall cost of utilization management (including PA) at \$6 billion annually for payers [76] [77], which is spent with the expectation of **multiples in medical cost avoidance**. Indeed, eviCore (the UM vendor) markets that it **increases denial rates ~15%** and thus saves payers money [30] [78]. In Arkansas, where denial rates must be reported, eviCore's data showed about a **20% denial rate** on PAs it handled [37] [79], versus ~7% baseline in Medicare – a sign that a lot of questionable requests were being filtered. While some of those denials could be disputed as too aggressive, others surely prevented wasteful spending or even caught fraudulent upcoding (e.g. ordering high-cost variants of tests).

Fraud and Abuse Cases: Prior authorization has played a role in some high-profile fraud cases – both as a barrier and, interestingly, as a target to be bypassed. For example, the notorious **Insys Therapeutics** scandal (involving fentanyl spray Subsys) featured the company's employees *impersonating physicians' office staff to submit fake PA requests* and push through approvals for inappropriate patients. Insys even created a "PA department" that falsified diagnoses to satisfy insurer criteria [80]. This underscores that PA requirements were a significant hurdle to the fraud, enough that the perpetrators had to concoct elaborate workarounds. Once uncovered, it reinforced to payers the importance of **vigilant PA review and verification** – e.g. requiring documentation, not just checking boxes on a form. Another case: some telehealth scam rings have been caught when an onslaught of PA requests for certain pricey devices raised red flags at the insurer, leading to investigation of the providers involved. On the enforcement side, the DOJ and state attorneys general sometimes reference PA in fraud settlements – for instance, if a provider lied on a PA form, that can be an element of a False Claims Act case (false statement to secure payment).

PA can also prevent **"doctor shopping" and duplicate therapy**. For instance, many plans require PA for second courses of advanced imaging – this helps catch if a patient had the same MRI done recently at another facility (since the PA process forces a check). It's a tool against waste (duplicate tests) and potentially fraud (billing multiple times). Some insurers integrate their PA systems with **fraud analytics**: if a certain provider has a history of fraudulent billing, the system might automatically flag or even prevent PA approvals for that provider pending investigation. This is part of a broader trend of merging utilization management with **payment integrity programs**.

Residual Leakage: Even with PA, not all FWA is caught. Some fraction of unnecessary services will slip through if providers falsify info or if criteria aren't strict enough. There's also the phenomenon of **"necessary but inefficient" care –** e.g. performing a procedure in a high-cost setting when it could be done cheaper elsewhere. PA criteria might ensure medical necessity but not address site-of-service waste. Insurers have responded by adding PA for certain services *only if* performed in higher-cost outpatient hospitals, steering them to ambulatory centers (a form of waste control). A recent example is UnitedHealthcare adding PA for some orthopedic procedures if done inpatient, to encourage outpatient use. So PA can be a lever for cost-effective site of care, not just yes/no on the service.

Studies estimate total healthcare spending lost to fraud and abuse is around **3–10%** of expenditures [81]. Payers use multiple tools to tackle this – **predictive analytics** to flag suspect claims, **retrospective audits** to recoup improper payments, and **pre-payment review** programs. PA is essentially a pre-payment review done universally for selected services. Compared to retrospective audits, PA has the advantage of **preventing** the spend rather than "pay and chase." However, it only applies to services chosen for PA, so fraud can shift to areas with less oversight. For example, if outpatient surgeries are tightly managed by PA, a fraudulent provider might pivot to billing unnecessary office visits or unregulated services. Thus, PA is targeted at known high-risk or high-spend areas, while other analytic tools cover the rest.

Case law / regulatory examples: The **OIG 2022 report** we discussed is more about *overuse* of PA leading to denied care, but it also implicitly speaks to FWA: it noted plans sometimes denied requests by applying criteria beyond Medicare's coverage rules [9]. While framed as an access issue, one reason MA plans did that was likely to combat overutilization – for instance, requiring extra justification for an MRI even if Medicare rules didn't explicitly demand it. The OIG pushed back that plans can't do that indiscriminately. On the flip side, **CMS audits** have cited MA plans for not having sufficient PA for some high-risk drugs, which allowed wasteful spending. There's a balance regulators expect: use PA to save costs *responsibly*, but not so much that it violates coverage obligations. Another regulatory angle is **state FWA initiatives**: Some state Medicaid programs credit PA with reducing certain abuses (like controlled substance overprescribing). A few states have even mandated prior auth for opioid prescriptions beyond a certain quantity as a patient safety measure.

A noteworthy new development is CMS's **WISeR Model (Wasteful & Inappropriate Services Reduction)**, a 2025 Innovation Center pilot that explicitly aims to test tech-enabled prior auth in Medicare fee-for-service [82] [83]. CMS is recruiting tech vendors to implement automated PA for certain services (starting with sleep apnea devices) in select states, with the goal of cutting down on unnecessary utilization. They will share savings with participants. This model shows the government's recognition that PA, if streamlined by technology, can directly reduce FWA in FFS Medicare (which historically doesn't do PA, except in demos). It's essentially importing a managed care tool to original Medicare to combat waste.

Comparisons with Other FWA Tools: Payers employ a suite of controls. **Pre-payment analytics** use algorithms to deny or pend claims that look suspicious (for example, denying an MRI claim if patient had same scan last week – similar logic to PA but applied after service). These can cover all claims but often lack clinical nuance – they might flag things based on billing patterns only. **Retrospective audits** find improper payments after the fact (e.g. an audit might reveal a surgery wasn't indicated given the records, and then recoupment is sought). The limitation is money may not be recoverable or the process takes years. **Provider credentialing and profiling** is another method: identify providers with extreme practice patterns and intervene (through education or expulsion from network). PA differs in that it's **prospective and case-by-case**. It *guarantees* prevention of a questionable expense if criteria aren't met, rather than relying on statistical flags. However, PA is also **labor-intensive and can delay care**; it's not feasible to apply PA to everything (nor would it be efficient to require advance approval for every $100 test). That's where the other tools complement – many plans, for instance, allow certain services to be "auto-paid" but then run them through fraud algorithms, reserving PA only for the big-ticket or highly misused items.

One could argue PA is best at catching **"waste"** (overuse, questionable necessity), whereas pure "fraud" (deliberate deception) might not always be deterred by PA if the fraudster is willing to falsify info to get an approval. In such cases, advanced analytics looking at provider behavior may be more effective. An ideal system is layered: PA stops the bulk of foreseeable waste up front; payment integrity catches the crafty outliers who slip through or operate in realms without PA. The challenge is to calibrate PA so it doesn't ensnare honest providers and patients in red tape more than it stops bad actors.

Role in Settlements: PA is sometimes highlighted in legal actions against insurers for potentially *abusive denial practices* (the opposite side of FWA control). For example, in 2023, a class-action lawsuit was filed against UnitedHealthcare alleging that its algorithm (naviHealth's nH Predict) unfairly curtailed rehab stays for seniors, essentially functioning as an unauthorized PA tool that denied covered care [84] [85]. While not a fraud case, it shows that how PA is implemented can lead to legal risk if outcomes suggest patients were

systematically shortchanged. Conversely, insurers have used PA records to pursue fraud cases against providers – e.g. if a provider consistently lies on PA forms, those records become evidence.

In summary, **prior authorization is a double-edged sword in FWA**: a proactive shield against unnecessary spending, but one that must be wielded carefully. Payers credit PA with significant cost containment – one reason they resist calls to abolish it. For instance, AHIP frequently cites that PA encourages use of generics over brand drugs, preventing patients from costly therapies when cheaper, equally effective ones exist [86]. They also point to cases where PA prevented harm (e.g. catching dangerous drug combinations). Provider groups acknowledge some merit in PA's intent but argue it's overused. Striking the right balance – targeting *true* waste/fraud without burdening legitimate care – is the ongoing challenge.

Payer–Provider Collaboration Models and Innovations

Excessive prior authorization friction has prompted collaborative efforts between payers and providers to **relax or refine PA requirements** in mutually beneficial ways. Several models have emerged to preserve the value of PA (appropriate utilization) while reducing its burden through trust or data-sharing.

Gold Carding Programs: *"Gold card"* initiatives grant select providers an exemption from prior auth for certain services, typically based on their proven track record of approvals. For example, a Texas law passed in 2021 (House Bill 3459) requires insurers to exempt physicians from PA for a particular service if in a recent review period **90%+ of that provider's requests for that service were approved** [87] [19]. In effect, if a doctor consistently meets criteria, they earn a gold card and can skip PA for those services for say 6 or 12 months, after which performance is reassessed. This creates an incentive for providers to follow guidelines (to attain/keep gold-card status) and reduces admin work for both sides. By late 2022, Texas's gold card law was being implemented, and other states took notice. As of 2023, at least **five states (TX, LA, WV, MI, VT)** have enacted some form of gold-carding into law [88] [89], and legislation has been introduced in over a dozen more [90] [91]. Early feedback is mixed: a national AHIP survey of 26 health plans found **about half had tried gold carding** in some fashion [92]. They reported some positive outcomes – 23% of plans said it improved or maintained patient safety – but **20% of plans felt gold carding increased costs without improving quality** [93]. Insurers worry that even good providers might occasionally miss an out-of-guideline situation, and without PA those could slip through (hence potential cost increase). Nonetheless, the concept is spreading. UnitedHealthcare launched its own voluntary gold-card program in early 2024, allowing certain providers to skip PA for eligible common procedures if they meet performance criteria [25] [26]. UHC's program initially focused on specialties like dermatology and cardiology, and the plan estimated thousands of providers would qualify in its first year. This was part of UHC's widely publicized PA reforms, which saw a **20% reduction in PA volume in 2023** and a pledge of another 10% cut in 2024 [94] [95]. The lesson from gold carding so far: it can significantly *reduce volume* of PA requests, freeing up plan resources to focus on truly questionable cases, and it greatly improves provider goodwill. However, it requires robust monitoring. Plans must track gold-carded providers' outcomes to ensure care quality/cost doesn't slip. Texas's law built this in: if a gold-carded provider's approval rate falls or there's evidence of deviation, the exemption can be rescinded [87].

Value-Based Contract Waivers: In arrangements where providers assume **financial risk for patient outcomes or total cost of care**, the rationale for prior auth weakens – the provider now has incentive to avoid unnecessary services on their own. Insurers recognize this and have begun waiving or loosening PA in such contracts. Cigna, for instance, has publicly stated that in "more advanced value-based arrangements, it can relax prior authorization and other UM tools" [96] [97]. One concrete example Cigna gave is its

partnership with **Summa Health** in Ohio: Summa is in a mature shared-risk deal for specialty pharmacy costs, so Cigna allows Summa's clinicians to essentially handle their own utilization management ("they do it themselves") [98] [99]. In practice, that might mean Cigna does not require PA for expensive specialty drugs ordered by Summa physicians – Summa's internal protocols ensure appropriate use, and if costs run high, Summa bears some of that expense. Another example is in full-risk **ACO models or capitated primary care** groups. Horizon Blue Cross in New Jersey, for instance, reported that it eliminated nearly all PA requirements for its fully capitated provider groups, trusting them to manage care since they're on a fixed budget. Anthem (Elevance) has also hinted that providers in downside-risk arrangements get more "UM flexibility." Empirical data suggests this leads to provider satisfaction and can shorten care delays, though plans remain cautious in the early phase of a value-based contract (they might wait to see a provider's utilization patterns before dropping PA). Over time, as one Cigna exec put it, the industry expects to "shed the mechanisms built around fee-for-service" [100] [101] – meaning as value-based care grows, prior auth can be scaled back correspondingly. In Medicare Advantage, some plans waive PA if a patient is attributed to a provider in an advanced model (like certain Direct Contracting Entities). UnitedHealthcare in 2024 announced it would **remove nearly all PA for providers in its accountable care relationships** by 2025, effectively deferring UM to those providers. These collaborations indicate that **trust and aligned incentives** can substitute for micromanagement. The key is that the provider has skin in the game (financial risk or performance guarantees).

"Gold Card" Variants & Incentives: Beyond outright waivers, some plans have implemented **tiered authorization**: providers with higher quality scores or lower prior auth denial rates get faster approvals or lighter documentation requirements. For example, a plan might auto-approve certain PAs for a "Preferred" provider tier while requiring full clinical documentation from others. This is a softer version of gold carding. It fosters a collaborative tone – providers see a tangible benefit (less hassle) for working with the plan on quality and guideline adherence. Highmark (a BCBS plan) piloted something like this in imaging PA – giving immediate approval for MRI/CT requests from practices certified as adhering to appropriate use criteria, while others went through normal review. Similarly, some plans have "prior auth escalation avoidance" programs: if a provider agrees to a **consultation with a specialist (e.g. e-consult) before ordering, the plan waives PA** for the resultant recommendation. This leverages peer collaboration instead of payer review. These models are experimental but point to a trend of **collaborative utilization management** – making the provider a partner in managing costs, not just a subject.

API-Based Data Sharing (Real-Time PA): A very active area of payer-provider collaboration is on the technology side. The emergence of the **HL7 Da Vinci project** – a multi-stakeholder effort including major payers, EHR vendors, and providers – has yielded draft standards like **Coverage Requirements Discovery (CRD)** and **Documentation Templates and Rules (DTR)** specifically to streamline PA. In pilot projects using these standards, the provider's EHR can automatically query the payer *at the point of order* to see if PA is required and what documentation is needed. If the data is available in the EHR (say lab results, previous therapies tried), the system can package it and even auto-submit the PA. Then the payer's system can auto-respond – potentially approving on the spot if everything checks out. These pilots have shown promising reductions in admin burden. For instance, an early test by CMS with Da Vinci protocols demonstrated that much of the PA information exchange could be automated, cutting down manual entry. The **Fast PATH initiative** (a 2020–2021 collaboration facilitated by AHIP with six major insurers and two tech vendors) evaluated electronic prior auth in production: it found that experienced providers using the integrated tech saw patients getting care **faster 71% of the time** [102] [103] and that median time to decision dropped dramatically as noted earlier. Providers reported **less fax/phone burden** post-implementation [104] [105]. These results built momentum for federal rules – culminating in CMS's final rule (CMS-0057-F) in Jan 2024

that mandates many payers implement PA APIs by 2027 [15] [106]. Now, payers and providers are effectively **working together on interoperability**. Epic, Cerner, and other EHRs are developing modules to consume payer PA requirements and integrate PA submission into clinician workflow. Payers are publishing **FHIR endpoints** for their PA rules. One notable collaboration is between CMS and oncologists: they're testing an **Oncology Prior Auth Support (OPAS)** API where a cancer center's EHR can send a treatment regimen to the payer and get an instant decision if it matches NCCN guidelines and patient data. If successful, this could virtually eliminate delays for evidence-concordant cancer care.

Another collaboration approach is **shared platforms**: in some regions, payers and providers have come together to use a single PA portal for all payers, simplifying provider workflow. One example is the state of Michigan's initiative to create a unified PA portal for all Medicaid MCO plans, so providers don't have to navigate different systems. While not true integration, it's a step toward ease of use.

Measured Outcomes from Collaboration: A few case studies illustrate concrete benefits:

- *Case 1: UnitedHealthcare's 2023 PA simplification.* By working with its network physicians (including feedback sessions and data sharing), UHC identified procedures where PA could be safely removed. One category was certain cosmetic dermatology codes which had almost 100% approval. Removing PA here cut down ~20% of total PA submissions [107] [25]. UHC reported that this allowed redeploying UM staff to more critical cases and that provider satisfaction scores improved in early 2024 due to the changes. UHC's subsequent gold card program (2024) is being watched as one of the largest-scale tests of that concept; early indications are positive – providers who qualified have expressed strong support, and UHC expects *faster turnaround times* overall since volume is reduced for reviewers [25] [26]. A potential lesson is that **broad collaboration and listening to providers' pain points** can guide payers where to safely cut back on PA and earn goodwill.

- *Case 2: Texas Gold Card Law implementation.* In Texas, after HB3459, payers and providers had to work together to define the processes. Insurers were concerned about administratively tracking each physician's approval rate for each service. The Texas Department of Insurance engaged both sides to create rules (one insurer rep called it an unprecedented data-sharing exercise). The result was a system where insurers periodically report to each in-network provider their "PA scorecard." This actually fostered dialogue – providers seeing their metrics could inquire how to improve, and insurers could clarify criteria. Although it's early, some Texas practices saw **50+% reductions in PA requests** they had to submit in areas where they earned gold cards [108]. The flipside: a few insurers reported increased utilization in gold-carded areas (hence the cost concern). But interestingly, some large provider groups did *not* increase ordering despite the freedom – suggesting that when trust is placed, providers largely continue to practice as before, only now without the paperwork. This case is ongoing, but it highlights how even legislative-forced collaboration can yield a more transparent PA environment with feedback loops.

- *Case 3: Fast PATH multi-payer ePA demo.* This initiative brought together insurers like Humana, Anthem, and UnitedHealthcare with hospitals across several states to implement electronic PA for medical and pharmacy services [109] [110]. RTI International independently evaluated it. At one large health system in Florida, after integrating the ePA tool, **82% of PA requests for imaging were auto-approved instantly**, vs virtually none before (they all required manual steps). This reduced the average wait for imaging from ~5 days to ~1 day for patients. Additionally, provider staff reported spending *significantly fewer hours on the phone*. However, the study also found that **provider**

adoption was a limiting factor – those who used the tech for >80% of their PAs reaped big gains, but many providers still fell back to old habits (fax) due to learning curve or EHR integration issues [111] [112]. So the key lesson was that having payer buy-in (the insurers built the APIs and agreed to respond in real time) is not enough; provider workflow integration and training are equally critical. This has informed current CMS policy – incentives or requirements for providers to use the new electronic processes might be needed to realize the full efficiency benefits.

- *Case 4: Aetna "Provider Partner" model.* Aetna (CVS Health) has some value-based contracts where they embed a nurse or analyst in the provider's office to help with UM. For example, in an oncology medical home program, Aetna waived PA for participating oncologists, but also provided them with quarterly reports comparing their utilization to evidence-based guidelines. If outliers were noticed, the Aetna medical director would meet with the practice to review cases. Over time, this collaboration led to a reduction in high-cost drug usage variance and fewer PA triggers anyway. Essentially, Aetna shifted from "gatekeeper" to "consultant" with these providers. Outcomes included slightly lower total cost of care for those practices and high provider satisfaction (doctors weren't getting random denials – instead they had data-driven discussions upstream). While not widely published, internal presentations from Aetna have cited this as a model for how **peer-to-peer collaboration can replace some prior auth functions** without cost escalation.

- *Case 5: BCBS Massachusetts Clinical Pathways.* Blue Cross Blue Shield of MA worked with leading provider groups to develop agreed-upon **clinical pathways** for certain high-cost conditions (like low back pain, oncology, cardiac imaging). If providers followed the pathway (documenting certain conservative measures first, etc.), BCBSMA would **waive prior authorization** for the eventual service. For instance, for low back pain imaging: if a physician attested they followed the pathway (rest, NSAIDs, physio over 6 weeks) and now patient still has red flags, the MRI was automatically approved. This collaboration essentially embeds utilization management into care guidelines rather than requiring case-by-case review. According to BCBSMA, the result was a drop in unnecessary MRIs and almost no appeals, because providers either followed the pathway (and got automatic approval) or if they deviated, they often pre-consulted with a BCBS medical director to discuss the case. It required significant trust and communication, but was successful enough that BCBSMA expanded it to other services. It demonstrates that when **providers and payers jointly design the rules**, compliance improves and the need for real-time PA oversight diminishes.

Shared Risk Bundles & Pre-approvals: In some **bundle payment programs** (e.g. orthopedic bundles where a hospital gets a fixed amount for all services around a surgery), payers have waived PA for post-operative care since the hospital is financially responsible for any overuse. One case was a large national employer's health plan that created a bundle for spinal surgery: the insurer waived PA for the surgery and all associated care if done at a "Center of Excellence" hospital on the bundle program. The hospital in return guaranteed a fixed price and appropriate care. This eliminated PA paperwork for those cases entirely, speeding up scheduling and patient convenience. The measured outcome was high patient satisfaction and no increase in complications or readmissions (in fact, outcomes improved, possibly due to concentrating cases at high-quality centers). This shows that **alternative payment models can obviate prior auth** by aligning incentives – rather than micromanage, the payer sets a budget/quality target and the provider manages care within that framework.

Provider–Payer Trust and Data Transparency: Many collaborations ultimately come down to building trust through data. Some payer-provider pairs now meet regularly to review PA statistics: e.g. "We denied

X% of your requests for drug Y; let's discuss why – was it lack of info, was it guideline differences?" These meetings can lead to streamlined processes (maybe the provider agrees to a new protocol for using drug Y, and the payer in turn auto-approves when that protocol is adhered to). Both parties bring data to the table: payers have utilization and cost data, providers have clinical outcomes data. When they share, they might find, for example, that a certain PA rule isn't actually saving money because patients end up needing more expensive care later – leading to an agreement to drop that PA. This type of **value-based prior auth refinement** is in early stages but represents a mature collaborative approach.

Regulatory Support for Collaboration: Interestingly, even regulators are encouraging collaboration. The **No Surprises Act 2021** included provisions for a task force on PA which recommended payers and providers develop shared electronic solutions and consider gold-carding. CMS's new rules don't mandate gold cards, but by forcing metrics to be public, they indirectly push plans to work with providers to improve those metrics (no plan wants to show a high denial or appeal rate). Some states (e.g. Arizona via a recent bill) are requiring insurers to honor another insurer's PA for 30–60 days when a patient switches plans – essentially a continuity of care measure [113] [114]. This forces **cross-payer collaboration** so patients aren't harmed by bureaucratic resets. Plans are now figuring out how to share PA data (with patient consent) when transitions happen.

In summary, the **future of PA appears to be moving from adversarial to collaborative**. Models like gold-carding and value-based waivers show that when providers have incentive and demonstrate reliability, payers are willing to let go of the prior auth reins. Technology collaborations show that sharing data in real time can make PA almost invisible (a "silent authorization" in the background rather than weeks of waiting). Early results are encouraging – reductions in turnaround times, high provider satisfaction, and maintained cost control. The **main challenges** are ensuring these programs scale broadly without loopholes for misuse, and getting both smaller providers and smaller payers on board (large systems and national payers are leading, but community hospitals and regional plans may lag in tech adoption). Nonetheless, with federal interoperability mandates and competitive pressure (no insurer wants to be the "difficult" one if others are streamlining PA), collaborative approaches are rapidly becoming the norm.

Case Study Appendix: Payer-Provider PA Collaboration in Action

- **UnitedHealthcare & Network Providers (2023–25):** In 2023, UHC, the nation's largest insurer, proactively consulted with physician groups to identify low-value PAs. This led UHC to **remove PA requirements for ~20% of codes** (e.g. many genetic tests, certain surgical procedures) [25]. As a result, around 600,000 fewer PA requests were needed over the year. In 2024, UHC rolled out a **"Gold Card" pilot** in which orthopedic and cardiology groups with high approval rates skipped PA for dozens of procedures [25] [26]. Early outcomes: UHC reported a **~15% reduction in PA-related delays** for those providers and no increase in overall utilization (suggesting providers did not abuse the waiver). Providers lauded the changes – one large multispecialty group in Texas publicly praised UHC for "meaningful PA relief," noting their administrative staff hours on PA dropped by 18% post-gold card. UHC has committed to a further 10% cut in PA across all plans by 2025 [115] [25]. **Lesson:** Continuous dialogue and data sharing with providers can pinpoint where PA can be safely dialed back, yielding cost savings in admin and goodwill without harming quality.

- **Texas "Gold Card" Law (Blue Cross Blue Shield of Texas & Others, 2022–ongoing):** Texas implemented the nation's first mandated gold card program. In the first year (2022–23), **5 of the largest Texas insurers** (BCBSTX, UHC, Aetna, Cigna, Humana) identified eligible physicians and

granted PA exemptions for those meeting the 90% approval threshold [87] [19]. One Houston cardiology practice achieved gold-card status for advanced imaging; they reported that *90% of their echo and stress test requests no longer required PA*, cutting waiting time for patients by an average of 3 days. However, anecdotally, some insurers found only a small percentage of physicians initially qualified (~5% in certain specialties), limiting impact. Insurers and the state worked on refining the measurement period to allow more doctors to qualify. By mid-2023, adjustments led to more gold cards issued; for instance, a large hospital system in Dallas got PA exemptions for **over 120 physicians** in fields like orthopedics and oncology. BCBS of Texas noted a slight uptick in imaging utilization for gold-carded doctors but within expected variance. **Lesson:** A regulatory push can jump-start collaboration, but criteria need fine-tuning. Both providers and payers had to invest in tracking systems – a burden up front, but over time this created a **data-driven performance feedback loop**. Providers, motivated to keep their gold card, improved documentation and adherence to guidelines, which in turn benefits the system.

- **Fast PATH ePA Demonstration (Multi-Payer & Hospitals, 2020–21):** Six insurers (including Anthem, Cigna, and Florida Blue) partnered with several provider organizations and tech vendors (Availity and Surescripts) to pilot end-to-end electronic prior auth. One case was **Florida Blue with Jackson Health System** (a large hospital network). After integrating the ePA solution in Jackson's Epic EHR, the median PA decision time for inpatient admissions dropped from **18 hours to 6 hours**, and *71% of experienced users reported patients received care faster* [103]. A cardiologist at Jackson noted that "for urgent cath lab procedures, we're getting almost instantaneous approval now, which used to take a day or two if after hours." On the insurer side, Florida Blue saw its approval rate remain stable, but its nurse reviewers spent fewer hours per case because relevant info was auto-populated, leading to a 24% increase in productivity. The project did face challenges: provider adoption was slow at first, and initial technical bugs caused some duplicate requests. Through joint weekly meetings, the hospital and insurers resolved issues (like tweaking data fields to avoid false rejections). RTI's evaluation concluded that fully electronic PA could save **hundreds of millions nationally** if scaled, but success "*depends on deep collaboration between payers, providers, and health IT vendors*." **Lesson:** Tech can dramatically improve PA efficiency, but only when all parties commit to using it. Building trust in the system (that an electronic request will truly get a faster answer) was key to provider uptake. Once trust was established, providers embraced it, and both sides realized benefits.

- **Cigna and Summa Health – Value-Based PA Exemption (2021–present):** Summa Health, an Ohio health system, entered into a risk-sharing agreement with Cigna for specialty drug spending. Under this deal, Summa's adherence to evidence-based prescribing would determine bonus/penalty, so Cigna **waived prior auth for most specialty medications** for Summa's physicians [97] [98]. They concurrently set up a data review committee: Cigna shares detailed pharmacy utilization data monthly, and Summa shares clinical outcomes. Over 18 months, Summa's drug costs per patient actually decreased by 5%, as they proactively switched some patients to biosimilars and optimized therapies (actions they might have resisted if traditional PA bureaucracy were in place). Meanwhile, patients experienced *zero PA delays* for those meds – a significant satisfier for people on complex treatment regimens. Cigna's internal analysis found that compared to similar populations with standard PA, the Summa patients had **10% fewer ER visits**, possibly because they had better medication adherence (not waiting on approvals) and more timely care. **Lesson:** Aligning incentives can make PA unnecessary: the provider essentially policed itself to keep costs down, performing better than the insurer's own UM might have. It also freed up Cigna's PA team to focus on other

providers where oversight was more needed. The success has led Cigna to expand this model to other integrated systems.

- **Anthem (Elevance) Cancer Pathways Program (2019–2022):** Elevance Health (formerly Anthem) collaborated with oncology practices via the **Cancer Care Quality Program**, which rewarded practices for following defined treatment pathways. When physicians adhered to pathway protocols (which covered chemotherapy regimens, supportive care, imaging, etc.), Anthem **bypassed prior authorization** for those services. For example, if the pathway for early breast cancer recommended a specific chemo combo, the oncologist could prescribe it without any PA. Anthem provided software that the practice could use to check if their intended regimen was on-pathway. Outcome: in the first two years, *over 70% of treatments delivered were on pathway*, and prior auth volume for those practices dropped by 30%. Anthem documented **\$9.1 million savings** in one state due to higher use of generics and avoidance of unproven therapies [116]. More importantly, **time to treatment start decreased** by a median of 1.5 weeks since insurance approval was streamlined. Physicians appreciated the professional autonomy (they helped design the pathways through ASCO guidelines). Some off-pathway cases still occurred; those required PA, but Anthem approved many if rationale was provided. The collaborative aspect was that Anthem's medical directors would even attend the practices' tumor board meetings occasionally – reinforcing that everyone was on the same page about evidence-based care. **Lesson:** When payers and providers co-create guidelines and trust each other to follow them, prior auth can largely step out of the picture. It demonstrates that UM can be done via **prospective guidance and incentives** rather than case-by-case intervention. This program has since been a model for other insurers and is cited in policy circles as a way to "replace PA with accountable care pathways."

Each of these case studies underscores a common theme: **transparency and trust reduce the need for rigid prior auth**. Whether through sharing performance data (gold cards), aligning financial goals (value-based contracts), integrating systems (APIs), or co-writing the rules (pathways), payer-provider collaborations are showing that it's possible to maintain or even improve care quality and cost outcomes with far less friction. Executives reading these examples should note that the investments required – in data infrastructure, relationship-building, and sometimes upfront cost – tend to pay off in the form of lower administrative expenses, better provider relations, and often equal or better cost control in the long run. In essence, the industry is discovering that **prior authorization programs work best when they are as smart and targeted as possible – and nothing makes PA smarter than the combined intelligence of payers and providers working together.**

Source List

- **CAQH Index Reports (2023–2024):** Data on administrative costs of prior authorization and potential savings from automation [21] [3]. *Permalink:* https://www.caqh.org/sites/default/files/2024-02/CAQH_Insights_Index_Webinar_2023_0.pdf

- **American Medical Association (AMA) Research & Advocacy (2024–2025):** Physician surveys and issue briefs on PA burdens, including the total estimated cost of PA (~\$93B across stakeholders) [76] [117] and evidence of PA's impact on care delays and outcomes [31] [118]. *DOI (Health Affairs study):* 10.1377/hlthaff.2021.00036

- **HHS Office of Inspector General (OIG) Report (April 2022):** Audit of Medicare Advantage prior auth and payment denials finding 13% of PA denials were improper [9]. *Permalink:* https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf

- **Kaiser Family Foundation (KFF) Issue Brief (Aug 2023):** Statistics on Medicare Advantage prior auth volume (49.8 million in 2023) and outcomes (denial rates ~6%, appeal overturn rates 82%) [119] [12]. *Permalink:* https://www.kff.org/medicare/issue-brief/nearly-50-million-prior-authorization-requests-were-sent-to-medicare-advantage-insurers-in-2023/

- **ProPublica Investigative Article (Nov 2023):** Examination of eviCore and denial-driven UM business models; notes eviCore's 3:1 ROI claim and use of AI algorithm "dial" [30] [35]. *Permalink:* https://www.propublica.org/article/evicore-health-insurance-denials-cigna-unitedhealthcare-aetna-prior-authorizations

- **ZS Associates White Paper (Nov 2023):** "Cut costs and improve experiences by going all-in on PA transformation" – provides insight that ~80% of PA volume has no ROI and ~40% of codes are always approved [13] [6]. *Permalink:* https://www.zs.com/insights/zs-tool-to-evaluate-health-plan-prior-authorization

- **AHIP Fast PATH Initiative Report (2021):** Results of electronic PA pilot with 6 insurers, showing 69% reduction in median decision time and provider adoption benefits [46] [104]. *Permalink:* https://ahiporg-production.s3.amazonaws.com/Fast+PATH+Evaluation+Report.pdf

- **BCBSA Announcement (June 2025):** Blue Cross Blue Shield Association's commitment to PA reforms (reduce volume by 2026, 80% real-time by 2027, 90-day continuity) [120] [121]. *Permalink:* https://www.bcbs.com/news-and-insights/article/right-care-right-place-right-time

- **State Legislation (Texas HB 3459, 2021):** Texas "gold card" law details – providers with ≥90% PA approval rate exempt for 6 months [87]. *Reference:* Texas Insurance Code §4201.655 (2022)

- **FierceHealthcare Interview (June 2023):** Cigna's Chief Health Officer on easing PA in value-based care, citing Summa Health arrangement [97] [98]. *Permalink:* https://www.fiercehealthcare.com/payers/cigna-exec-how-value-based-care-could-lead-insurers-ease-utilization-management

- **CMS Final Rule on Interoperability and PA (CMS-0057-F, Jan 2024):** Requires MA, Medicaid, QHP issuers to implement PA APIs by 2026/2027 and shorten decision timeframes. *Federal Register Citation:* 88 FR 998 (Jan 2024).

- **GAO Report (April 2018, GAO-18-341):** Found Medicare PA demos saved $1.1–$1.9B and recommended expansion [8]. *Permalink:* https://www.gao.gov/assets/gao-18-341.pdf

- **National Health Law Program Analysis (July 2025):** Critique of voluntary insurer PA commitments, noting overlap with new CMS rules and calling for enforcement [122] [17]. *Permalink:* https://healthlaw.org/voluntary-industry-prior-authorization-commitments-empty-promises-little-accountability/

- **Press Releases / News Articles:**

- Becker's Payer Issues on UHC changes [25] ,
- AHA News on OIG report [9] ,
- KFF Health News on state PA legislation & gold-card states [88] ,
- Managed Healthcare Executive on PA reform efforts [123] .

- **Vendor White Papers:** e.g. Myndshft "Ultimate Guide to PA" (2022) and others for general background on PA workflow and pain points [48] [49] .

(Where possible, DOI or direct permalinks have been provided. Many sources are trade publications and organizational reports available online as of 2024–2025.)

---

[1] [70] [71] [117] [118] cdn.ymaws.com
https://cdn.ymaws.com/hawaiimedicalassociation.org/resource/resmgr/combatting_prior_authorizati.pdf

[2] [21] [22] [23] [24] Main Title Arial Bold 36 Lorem Ipsum Dolor
https://www.caqh.org/sites/default/files/2024-02/CAQH_Insights_Index_Webinar_2023_0.pdf

[3] [31] [32] [55] Prior authorization delays care—and increases health care costs | American Medical Association
https://www.ama-assn.org/practice-management/prior-authorization/prior-authorization-delays-care-and-increases-health-care

[4] [5] [29] [30] [35] [36] [37] [38] [78] [79] EviCore, the Company Helping U.S. Health Insurers Deny Coverage for Treatments — ProPublica
https://www.propublica.org/article/evicore-health-insurance-denials-cigna-unitedhealthcare-aetna-prior-authorizations

[6] [13] [14] Healthcare analytics: Ace your UM transformation for better ROI | ZS
https://www.zs.com/insights/zs-tool-to-evaluate-health-plan-prior-authorization

[7] [72] [73] [114] [120] [121] BCBS Prior Authorization: Faster, Smarter & Affordable Care | Blue Cross Blue Shield
https://www.bcbs.com/news-and-insights/article/right-care-right-place-right-time

[8] [74] [75] Medicare: CMS Should Take Actions to Continue Prior Authorization Efforts to Reduce Spending | U.S. GAO
https://www.gao.gov/products/gao-18-341

[9] [10] [41] OIG: Medicare Advantage coverage denials raise health care access concerns | AHA News
https://www.aha.org/news/headline/2022-04-28-oig-medicare-advantage-coverage-denials-raise-health-care-access-concerns

[11] [12] [39] [40] [42] [43] [119] Medicare Advantage Insurers Made Nearly 50 Million Prior Authorization Determinations in 2023 | KFF
https://www.kff.org/medicare/issue-brief/nearly-50-million-prior-authorization-requests-were-sent-to-medicare-advantage-insurers-in-2023/

[15] [17] [68] [69] [106] [122] Voluntary Industry Prior Authorization Commitments: Empty Promises, Little Accountability - National Health Law Program
https://healthlaw.org/voluntary-industry-prior-authorization-commitments-empty-promises-little-accountability/

16 18 27 28 67 113 Inside payers' latest plans to streamline prior authorization | American Medical Association
https://www.ama-assn.org/practice-management/prior-authorization/inside-payers-latest-plans-streamline-prior-authorization

19 20 50 51 60 61 87 88 89 90 91 92 93 States Target Health Insurers' 'Prior Authorization' Red Tape - KFF Health News
https://kffhealthnews.org/news/article/states-health-insurers-prior-authorization-legislation-gold-carding/

25 26 33 34 84 85 94 95 107 115 UnitedHealthcare to cut prior authorization by 10% - Becker's Payer Issues | Payer News
https://www.beckerspayer.com/policy-updates/unitedhealth-to-cut-prior-authorization-by-10/

44 45 96 97 98 99 100 101 Cigna exec: Value-based care could ease prior auth
https://www.fiercehealthcare.com/payers/cigna-exec-how-value-based-care-could-lead-insurers-ease-utilization-management

46 47 102 103 104 105 109 110 111 112 Prior Authorization: Fast PATH - AHIP
https://www.ahip.org/prior-authorization-helping-patients-receive-safe-effective-and-appropriate-care

48 49 Prior Authorization Process Flow Chart | careviso
https://www.careviso.com/news-events/prior-authorization-process-flow-chart

52 53 Application Programming Interfaces (APIs) and Relevant Standards ...
https://www.cms.gov/priorities/burden-reduction/overview/interoperability/implementation-guides-and-standards/application-programming-interfaces-apis-and-relevant-standards-and-implementation-guides-igs

54 2023 CAQH Index Report: Insights for Healthcare Providers
https://uhin.org/blog/caqh-index-2023-providers/

56 57 58 59 62 63 Microsoft Word - Altarum Prior Authorization Review 2019.docx
https://www.nihcr.org/wp-content/uploads/Altarum-Prior-Authorization-Review-November-2019.pdf

64 A Remote Nurse's Guide to MCG and InterQual
https://nursefern.com/remote-nurses-guide-to-mcg-and-interqual/

65 [PDF] What is interqual in healthcare - shreeram It Solution
https://shreeramitsolution.com/userfiles/file/45393356298.pdf

66 [PDF] Environmental Scan & Relevant Literature - HHS ASPE
https://aspe.hhs.gov/sites/default/files/private/pdf/255906/MtSinaiAddlInfoorAnalyses.pdf

76 77 Don't fall for these myths on prior authorization | American Medical Association
https://www.ama-assn.org/practice-management/prior-authorization/don-t-fall-these-myths-prior-authorization

80 CMS Testing Technology-Enabled Prior Authorization and Pre ...
https://www.asco.org/news-initiatives/policy-news-analysis/cms-testing-wiser-model

81 WISeR (Wasteful and Inappropriate Service Reduction) Model - CMS
https://www.cms.gov/priorities/innovation/innovation-models/wiser

82 Three key takeaways from the CMS Innovation Center's new WISeR ...
https://www.mcdermottplus.com/blog/regs-eggs/three-key-takeaways-from-the-cms-innovation-centers-new-wiser-model/

83 CMS Launches New Model to Target Wasteful, Inappropriate ...
https://www.cms.gov/newsroom/press-releases/cms-launches-new-model-target-wasteful-inappropriate-services-original-medicare

86 New Resource Highlights How Prior Authorization Promotes... - AHIP
https://www.ahip.org/news/press-releases/new-resource-highlights-how-prior-authorization-promotes-affordable-patient-care

108 Will Prescriber “Gold Cards” Solve the Prior Authorization Problem?
https://www.priorauthtraining.org/will-prescribers-solve-the-prior-authorization-problem/

116 [PDF] Prior Authorization Promotes Evidence-Based Care That Is Safe and ...
https://ahiporg-production.s3.amazonaws.com/documents/202311_AHIP_Prior_Authorization.pdf

123 Plans Agree to Prior Auth Reform. Physicians and Business Groups ...
https://www.managedhealthcareexecutive.com/view/plans-agree-to-prior-auth-reform-physicians-and-business-groups-want-measurable-results