



**Humata
Health**

Built for Yes.

What to Know by 2030 for Prior Authorizat

How Policy, Technology, and AI Are Making Prior Authorization
Fast, Fair, and Transparent

For decades, prior authorization (PA) has been healthcare’s most visible administrative burden. Providers navigate countless payer portals, phone calls, and faxes just to confirm that a procedure, test, or medication requires authorization — triggering a litany of manual steps to secure approval. The process consumes staff time, delays care, and erodes patient trust.

According to the American Medical Association, physicians complete an average of 43 prior authorization per week; an equivalent of 12-hours of paperwork for a single physician.^[1] One in four physicians report that prior authorizations lead to serious adverse events for patients in their care. And the problem is only growing. Drug PA volume is increasing by 40% each year, and as CMS expands initiatives like the Wasteful and Inappropriate Service Reduction (WISeR), the industry could see more than 200 million additional PAs enter the system. With health plans already underwater economically, prior authorization remains one of the few levers available to control costs—further amplifying the administrative strain on providers and patients alike.

That reality is about to change.

By 2026, however the industry will reach a turning point. Policy reform and technology innovation are converging to rebuild prior authorization into a process that’s faster, fairer, and fully transparent – one that no longer stands between patients and the care they need.


43
prior authorizations
per week per clinical
physician


12hr
equivalency of
paperwork per
clinical physician

UPDATED RULES

7-Day

turnaround times for standard
request prior authorizations.

72-Hours

turnaround times for
expedited requests.

2026

From Burden to Breakthrough

The combination of federal regulation, workforce shortages, and maturing AI infrastructure is transforming how health systems, payers, and technology partners manage prior authorization. Health systems can no longer scale manual workflows, and payers can no longer justify opaque determinations. The question is no longer “Is prior authorization required?” but “How fast can we clear care safely and compliantly?”

Three main trends define this shift:



Policy Modernization

CMS's Interoperability and Prior Authorization Final Rule (CMS-0057) requires payer to deploy FHIR-based APIs that enable electronic submission, real-time status updates, and faster determinations, seven days for standard requests and 72 hours for expedited ones.^[2]



Operational Strain

Turnover in rev cycle and patient access teams, on top of rising CO-197 denials for missing authorizations, makes manual PA financially unsustainable.^[2]



Technological Readiness

Artificial intelligence and automation can now interpret payer rules, extract evidence from clinical documentation, and route submissions automatically, capabilities that were largely theoretical only a few years ago.^[3]

At the same time, CMS's WISeR pilot introduces AI-assisted utilization management for high-risk services in traditional Medicare, signaling broader oversight of appropriateness and efficiency.^[4]

These three forces combined are transforming PA from a patchwork of transactions toward a shared goal: making prior authorization work the way healthcare should — **fair, fast, and transparent.**

The Current State of Prior Authorization

> Medical Benefits Workflow

Today's medical PA process begins when an order is placed or a case is scheduled. Staff must determine whether an authorization is required, assemble clinical documentation, submit it to the correct payer channel, monitor status, and reconcile the result with the claim. Each step is manual, and each handoff introduces room for error. Requirements vary by payer, plan, and site of service, leaving teams to rely on internal "cheat sheets."

Even when approvals are issued, mismatches between authorization and billed CPT-codes often trigger CO-197 denials, forcing resubmissions or write-offs. The result: lost revenue, staff burnout, and care delays.

> Pharmacy Benefits Workflow

Pharmacy PA operates on a faster, more standardized rail, using the NCPDP SCRIPT standard, but it faces its own complexities. Specialty drugs, dual benefit routing, and manufacturer hub coordination can still delay therapy starts by days or even weeks - often forcing clinicians to spend hours chasing approvals instead of treating patients.

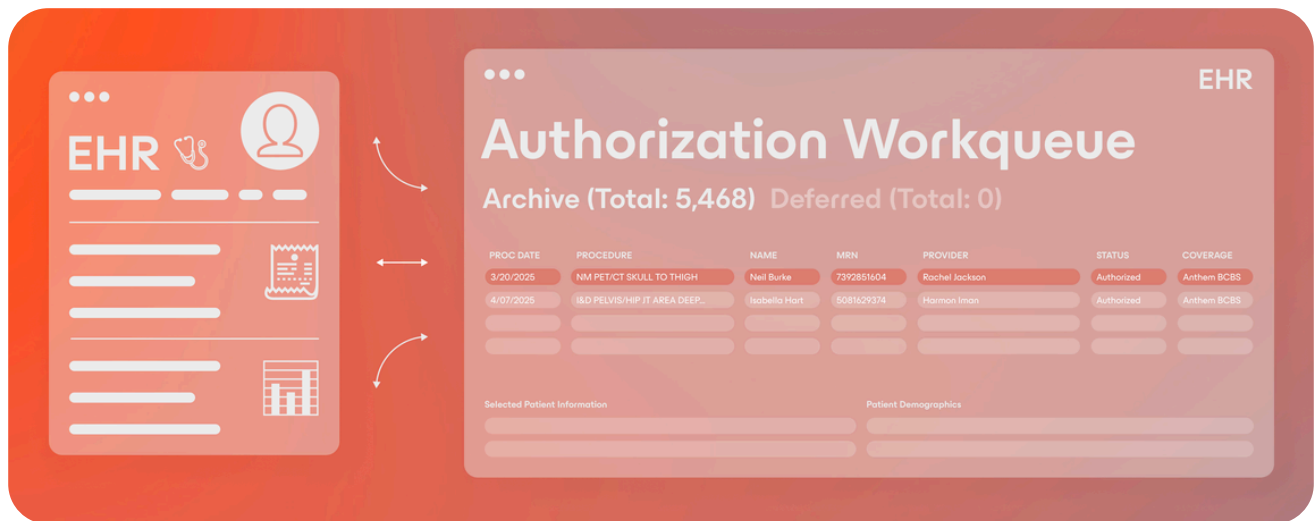
A recent [Surescripts survey](#) underscores the depth of the challenge: 94% of pharmacists and prescribers said medication prior authorizations increase burnout, and nearly half reported that the process often leads patients to abandon treatment altogether. Eighty-nine percent of prescribers and 87% of pharmacists said PA requirements negatively impact patient outcomes, while 88% said they delay care.

According to the CAQH 2024 Index, pharmacy benefit transactions have among the highest levels of electronic adoption in healthcare, but true end-to-end automation remains uneven. Many requests still require manual follow-up or documentation corrections when payer exceptions or benefit conflicts arise, especially for speciality drugs and infusion therapies.^[5]



THE COMMON THREAD

Both systems were designed for control, not coordination – built to manage cost, not continuity of care. The result is delayed treatment, duplicated effort, and fractured relationships between payer and providers.



The Shift to Patient-Centered Prior Authorization

The next phase of modernization is not about creating new barriers but removing friction from the process entirely.

Patient-centered prior authorization ensures that every request moves efficiently from order to outcome, with complete visibility into requirements, documentation, and payer rules along the way.

In this emerging model, automation and intelligence do the heavy lifting. Routine requests are processed electronically with only exceptions requiring manual reviews. Intelligent systems surface the exact clinical data required for coverage criteria, reducing back-and-forth communication. Embedded workflows within the EHR keep providers informed in real-time, while continuous monitoring detects policy changes that could impact downstream claims.

For payers, structured, standardized submission improves decision consistency and reduces review time. For providers, faster approvals means patients access care sooner. The result is a more balanced, transparent process, one where automation accelerates care, rather than delay it.

Building Common Ground Between Providers & Payers

For decades, prior authorization has been a point of friction between payers and providers, largely because of data silos and inconsistent definitions of “complete.” The next phase of modernization aims to replace those gaps with shared visibility, structured data, and consistent expectations.

In 2026, standardized FHIR-based exchanges will allow both sides to work from the same structured data and documentation. Providers will be able to see status updates in real time, while payers can make faster, evidence-based decisions using clearly formatted, policy-matched submissions.

Over time this alignment builds trust and efficiency. Predictive analytics will help both payers and providers understand trends and patterns in approvals and denials, identify areas for improvement, and make data-driven policy adjustments such as gold-carding and value-based contracting. Ultimately, provider-payer harmony is not about eliminating oversight but about creating a system that achieves it with greater efficiency, consistency, and fairness.





MODERNIZATION OF AUTOMATION

Technology That Works Together

Modernization requires more than automation. It requires an ecosystem that's interoperable, adaptable, and scalable — one that evolves as standards, payers, and care models change.

FHIR-First Infrastructure:

Enables data flow seamlessly while fully aligning with CMS-0057 standard. Because adoption takes time, scalable technology must support hybrid workflows — combining fax, portal, and API-based exchanges, to allow gradual transitions without disrupting operations.

Ecosystem Integration:

Connects directly with major EHRs, clearinghouses, payers, and utilization management systems, creating a single, connected authorization experience. Integrated AI engines, such as PolicyMatch™, ensure that documentation aligns with payer policies, reducing denials and minimizing rework.

Continuous Learning:

Uses feedback loops and analytics to improve matching accuracy, turnaround time, and staff efficiency. Data becomes a driver for continuous improvement, turning prior authorization from a compliance task into a measurable performance advantage tied to patient access and operational excellence.





What Healthcare Leaders Should Do Now

The next 12 to 18 months are pivotal.

Organizations that prepare now will be best positioned to comply with new mandates and capture the operational and financial benefits that come with modernization.

Leaders should do the following:

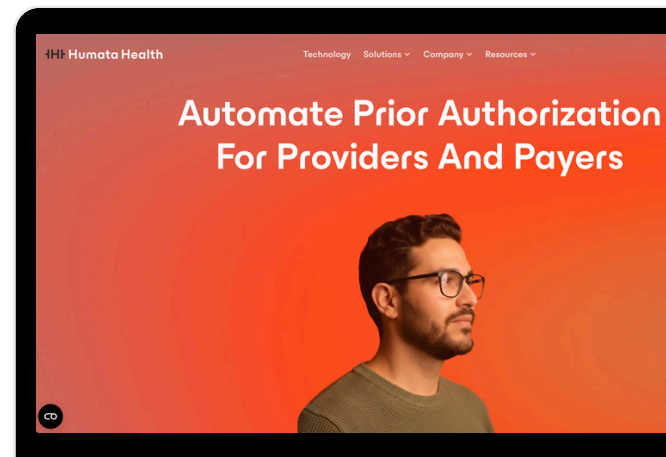
1. Audit current workflows to identify manual dependencies and bottlenecks.
2. Engage IT, patient access, and revenue cycle teams to align systems and governance.
3. Evaluate vendor readiness for FHIR connectivity and automation at scale.
4. Prioritize solutions that enhance visibility, accelerate approvals, and support exception-based workflows.

This period is an opportunity to redesign workflows, retrain teams, and align operations to the future of data-driven healthcare.

The Road Ahead

The modernization of prior authorization is more than a compliance effort. It's an opportunity to improve how healthcare operates. By 2030, organizations will be expected to work within a connected environment that prioritizes interoperability, automation, and transparency across every stage of care delivery.

The organizations that act now will be able to deliver care more efficiently, reduce administrative burden, and improve collaboration across the care ecosystem. As technology, policy, and practice converge, healthcare is redefining prior authorization not as a barrier to care, but as a shared process that is fast, fair, and transparent. The result is a system where providers, payers, and patients move together towards a common goal: clearing the way for timely, informed, and equitable access to care.





Moving Towards Touchless Prior Authorization

Across the industry, automation and AI are transforming authorization into a faster, fairer, and more connected process. The emerging foundations for modern prior authorization includes:

- **End-to-End Automation:** Streamlining every step, from intake and documentation to submission, tracking, and reconciliation through a connected, exception-based workflow.
- **AI-Powered Clinical Bundling:** Extracting relevant clinical documentation from records and aligning it to payer criteria automatically.
- **EHR-Native Integration:** Embedding authorization visibility directly within clinical workflows for a seamless provider experience.
- **Post-Authorization Monitoring:** Tracking policy and coding updates to prevent downstream denials and maintain compliance.

Organizations adopting these principles are building a more resilient infrastructure — one that reduces administrative friction, ensures financial stability, and moves care forward. Solutions like Humata's End-to-End Prior Authorization Technology reflect how technology purpose built for PA can make approvals faster, decisions fairer, and care more connected.

About Humata Health

Humata was built with one purpose: to make prior authorization work the way healthcare should — fast, fair, and transparent. Through intelligent automation, AI-driven policy matching, and real-time payer connectivity, Humata simplifies and accelerates every step of the prior authorization process. The result? 90% touchless authorizations, human-reviewed cases resolved under two minutes, and complete visibility from order to outcome. Because when prior authorization moves forward, care can move forward.



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