ANALYST BRIEF
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**Well-documented payer walls between the "claims side of the house and the care side of the house" are highlighted with prior authorization. A strategy to comply to the final rule issued by the U.S. Centers for Medicare & Medicaid Services suggests that payers should unify organizations and systems around their member longitudinal health record.**

# Member-360 Should Be at the Core of Your Prior Authorization Mandate Implementation Architecture

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## Introduction

The U.S. Centers for Medicare & Medicaid Services (CMS) recently finalized a proposed rule designed to speed the electronic exchange of information, streamline the processes related to prior authorization, and improve patient care.

The release of CMS-0057-F by the U.S. Department of Health and Human Services (HHS) in January 2024 means that healthcare payers now must decide whether to simply comply with the new rule or seize this mandate as an opportunity to modernize their transaction and payer/provider handoff infrastructure.

Prior authorization (PA) refers to the process through which a healthcare provider, such as an individual clinician, an acute care hospital, an ambulatory surgical center, or a health clinic, obtains approval from a payer before providing care to a patient. Payers establish PA requirements to help control costs and ensure payment accuracy by verifying that an item or a service is medically necessary, meets coverage criteria and, for some payers, is consistent with standards of care before the item or service is provided. The standard model of PA is a complex, iterative, multistep process that includes multiple systems, providers, internal payer organizations, and faxes.

## AT A GLANCE

### WHAT'S IMPORTANT

- **Scope the solution.** Payers need to decide whether they are just trying to meet the mandates or using the revised PA process as an opportunity to modernize the care management, interoperability, portal, analytics, and customer service aspects of the business.
- **Take it slow.** A multiyear stepwise approach to modernize the PA process within an overall architecture seems prudent.

### KEY TAKEAWAYS

CMS has acted and recently clarified its PA mandate responding to member consumerism:

- Replace and modernize with a goal to comply and beyond.
- Use industrial-strength technology partners with historical experience in FHIR and Da Vinci standards.
- Meet the mandate by ensuring PA metrics transparency can occur before implementing APIs.
- Use the Member-360 as the layer to unify the data and the solution in both the short term and the long term.

PA has an important place in the healthcare system, but the process of obtaining it can be challenging for patients, providers, and payers. Dissimilar payer policies, inconsistent use of electronic standards, and other technical barriers have created provider workflow challenges and an environment in which the PA process is a burden for providers and payers, creating a potential health risk for patients if process inefficiencies cause delays in medically necessary care.

Payers are in favor of PA. They recognize the burden but cite the need for proof of medical necessity using evidence-based guidelines, reducing duplication and waste, optimizing costs in a pressurized cost-of-care environment, identifying excessive billing, and identifying candidates for case management. One purpose of prior authorizations is to ensure the patient gets the right therapy. With a comprehensive view of the healthcare system and each patient's medical claims history, health plans have a holistic view and can help ensure that treatment is safe and appropriate. In times of financial stress, payer CFOs have asked chief medical officers to reduce medical service utilization by implementing stricter clinical approval guidelines. The short-term logic was that denying more providers' requests to perform medical services lowers claim costs.

CMS has acted and recently clarified its mandate in response to this practice in the voice of member consumerism.

## Regulation

As part of CMS-0057-F, CMS finalized proposals for payers to implement and maintain an application programming interface (API) to support and streamline PA processes, respond to requests within certain time frames, provide a specific reason for denials, and publicly report on approvals, denials, and appeals:

- Providers can use the prior authorization API (PA API) to determine whether a specific payer requires authorization for a certain item or service.
- The PA API enables a provider to submit a request to the payer about a medical item or service directly from the provider's system, determine if additional information is required, submit that information, and automatically assemble the necessary information to submit a PA request.
- The response from the payer must indicate whether the payer approves the PA request (and for how long), denies it, or asks for more information from the provider to support the request.

The compliance date for the PA API is 2027.

CMS also finalized proposals to establish certain requirements for the PA process whether or not the payer receives the request through the PA API. It is important to note that the PA business process improvements, or those provisions that do not require API development or enhancement, include:

- The requirement to communicate a specific reason for a denial
- The need for reduced decision time frames for standard and expedited PA decisions
- Public reporting of certain PA metrics that will enhance transparency, including the percentages of prior authorizations that were processed, approved, and denied

In addition to the PA requirements, CMS requires the deployment of three access APIs for sharing information with patients, providers, and other payers. All three APIs include requirements to share up-to-date status and other information about current and past PAs, including the reason for denial, if applicable. The payer-to-payer API is intended to be used by payers to create longitudinal health records for their members.

## Analysis

Internally, payers know that no one inside the payer organization wholly owns the PA process. There is a traditional lack of integration between clinical and administrative systems. Well-documented payer walls between the "claims side of the house and the care side of the house" are highlighted with PA. Since the PA is both an administrative transaction with financial impact and a care encounter dependency, the divisions with a payer's organization and systems are evident.

Operationally, this mandate, including the three access APIs and reporting requirements, gives the payer a lot more work to address. CMS used a carrot-and-stick approach here:

- The carrot is that the APIs provide an opportunity for the payer to use more information to formulate a holistic approach to PA. All PAs are under that scope of the mandate, both old processes and new processes (including those using APIs and outsourced). This means that unification of processes must occur to execute reporting in the long term. This forced unification provides an opportunity for forward-thinking payers to bring this PA transactional data back into the organization for unified reporting and a more contextual understanding of the member.
- The stick is that the publicly reported data will put regulatory and market scrutiny on those payers not showing a steady decrease in response times, while reporting PA details to patients will put similar pressure on individual contract renewal decisions.

Regulators are embracing APIs, a development that needs to be factored into planning by payers. However, an enterprise approach cannot be achieved overnight. To effectively manage all this change, payers need to ask the following questions about all deployments:

- What can we do today?
- What positions us for the future?
- Where do we want to go?
- What are we waiting for?

## Scope

This aforementioned set of questions drives a *scope of discussion*. There are two ways to approach the CMS mandate. Organizations can either approach the mandate in a way that reinforces the traditional lack of integration in the PA process or recognize that the two parts of the rule (the workflow metrics and the APIs) will eventually interact and use that interaction to leverage cooperation between the clinical and administrative squads for strategic advantage. Payers should gather PA requirements into an overall structured strategy and determine this scope. They need to decide

whether they are just trying to meet the basics of the mandates or using the available monies and opportunity to modernize the care management, interoperability, portal, analytics, and customer service aspects of the business.

## Architecture

Once scope is determined, the *architecture of the solution* must be considered:

- At a minimum, the organizations at the 2026 midpoint must gather data from multiple sources and an amalgamation of processes to provide comprehensive PA performance reporting. As examples:
  - Payers often outsource PA processing to third parties, which can complicate communication.
  - Payers receive authorization requests via portal, fax, email, and snail mail from a number of systems.
- If organizations use the 2026 reporting deadline as the impetus to combine PA data from existing systems with the rest of the PA data they "maintain," they will be:
  - Getting the data into a consolidated locale for reporting
  - Getting the data into position in preparation for including it in the three access APIs the following year
  - Making it easy to add in data from the API (e-PAs) the following year

The data then needs to be shared in 2027 with the access APIs.

The architecture proposed enables the organization to have a common middle layer containing all relevant data so it can incrementally swap in new PA components as it modernizes, without affecting the access APIs.

## Benefits

If the Member-360 datastore is that middle layer, it provides that bridging asset between the clinical and administrative components of the organization. This can be done holistically by expanding use of the Member-360 longitudinal health record to show activity, not just state of being. It brings this PA transactional data back into the organization. That internalization can give the care management and customer service functions the longitudinal data to do a better job with care and administration for members. Payers also have an opportunity to unify their use and disclosure of members' data enterprisewide and to the public, not just in the context of PA mandates.

Once this consolidation is done, the table is set for the following potential:

- **Overhaul of care management by adding a seamless workflow that can trigger PA request issuance when necessary for items in a prescribed care plan or trigger care management involvement upon the request of a (perhaps unrelated) PA.** The functions of processing a PA transaction (today in a contextual vacuum) combined with the whole person care coordination/management process show a member that the payer is a "partner in care."

- **Overhaul of other utilization management functions via interoperable API and portals.** PA is only one of the tools of utilization management programs. Step therapy, formularies, and appeals must have a clinically accurate foundation for adherence to be feasible. The referenced clinical information would be readily available to the prescribing/ordering provider and the public via the Member-360. Payers have an opportunity to streamline their use and disclosure of guidelines, overrides, and plan changes enterprisewide and to the public at large, not just in the context of PA mandates.

## Considerations

To realize consistent PA automation in an enterprise operating model, organizations should answer the following questions when determining scope, selecting solution providers, and organizing strategy:

- Does the solution recognize that no one inside the payer organization wholly owns the PA process? Since the PA is both an administrative transaction with financial impact and a care encounter dependency, the divisions with a payer's organization and systems are evident. A solution with flexible configurable workflows, robust back-end piping, and a strong dedication to FHIR and HL7 standards is fundamental. These standards give standard taxonomies around which various internal factions can unite.
- Does the solution support policies such as step therapy or imposing "fail-first requirements" on any treatments? Under a step therapy program, doctors are required to prescribe lower-cost treatments, procedures, and drugs before approving higher-cost options. Some insurance companies require this even when a patient has unsuccessfully tried a treatment prescribed by a previous provider or through a previous healthcare plan. When this paradigm is in place, the iteration involved frustrates all. Look for providers with a strong Member-360 or longitudinal health record if this is a requirement.

Other considerations about a payer solution are best discussed in the context of the Da Vinci Implementation Guides (go to **www.hl7.org/fhir/us/davinci-pas/**), which are focused on reducing clinician and payer burden. They help address the following questions:

- Does the solution recognize that the "unhappy path" is the real cause of delay? It is relatively simple to spin-up a portal and some workflow with metrics to support an easily recognized and approved PA requested procedure. Many payers, hospitals, health systems, and medical practices have implemented some level of automation to ease the PA burden. But most automation offerings are only able to handle the most straightforward PA requests. Part of the problem is incomplete data that causes delays. PAs require complex documentation, and providers sometimes unintentionally send incomplete medical records. Payers must then request additional information from the provider. Chasing incomplete documentation by phone, email, and fax can extend the PA process by several days.
- Does the solution enable expedited treatments for lifelong/chronic conditions (e.g., insulin for type 1 diabetes) that have PA requirements? Does it offer exemptions/waivers of PAs for patients on long-term treatment for chronic diseases? Members with chronic illnesses should not have to repeatedly jump through hoops and/or face care disruptions to receive treatment that they've successfully used for years. Look for providers with a strong Member-360 or longitudinal health record if this is a requirement.

- Does the solution have transparency? To address inaccuracies or quickly make needed changes to avoid care delays, revenue cycle and utilization management leaders should have real-time visibility into which PAs have been approved and denied, as it is now a mandate to report metrics. In addition to the mandated reporting, having a dashboard that provides the outcomes of PA requests enables staff to detect emerging trends, identify root causes, and quickly course correct to prevent similar denials.
- Does the overall solution and its phasing consider capabilities from both the provider and the payer perspective, given that providers are equal partners in this authorization dance?
- With interoperability as an ongoing priority, are the payer-to-payer data exchange solutions under consideration intended to be implemented by the organization, or will they require similar implementation by provider partners as both parties evolve?
- Can the organization handle the complex PA rules within equally complex value-based payment contracting?
- Will the organization's PA solutions enhance its care management applications or require further integration as care management becomes modernized?
- Will the environment allow for spinning up innovative applications? Examples include:
    - Real-time adjudication of claims and authorizations
    - Expansion of member/patient engagement and experiences

## Trends

Organizations wishing to deploy a phased multifaceted operating model to revamp the PA process must also consider the following trends:

- Some payers are implementing solutions that can support today's needs while being able to integrate with future provider solutions, instead of the other way around.
- Payers have eliminated data walls. The interoperability mandates and the need for social determinants of health (SDOH), equity, census, and care data have opened data architectures to include many sources and potential business partners.
- States are becoming more diverse with standards around patient privacy, in the context of PA, and all healthcare transactions.
- Payers and providers are working together in payvider models, such as:
    - Healthcare providers creating their own insurance plans
    - Payers and providers joining forces, including Aurora and Anthem (Well Priority), Banner Health and Aetna, Cleveland Clinic + Oscar, MVP Health Care and the University of Vermont Health Network, and Cigna's Evernorth buying MDLIVE for virtual care
    - Insurance companies shifting to being a healthcare provider that offers insurance

- AI is being used to consolidate medical charts into summaries that can help the PA triage procedure. The evaluator can look at a generative AI summarization instead of wading through pages of an EHR and/or claims history.
- AI is also being used to summarize care plans, to give the entire patient picture to the evaluator of the PA request.

## Conclusion

For payers establishing an overall vision and road map of where the enterprise approach is going with its PA journey, then modularly implementing sections of the needed technology architecture seems the most appropriate path. While attractive to implement, pulling back from the "check the box" or "avoid the fine" mindset seems prudent. Payers should move in a modular fashion toward an enterprise operating model that optimizes consistency, flexibility, and cost while addressing compliance with mandates. The Member-360 foundation is the core of the enterprise operating model.

If the Member-360 datastore is that middle layer, it provides that bridging asset between the clinical and administrative components of the organization. This can be done holistically by expanding use of the Member-360 longitudinal health record to show activity, not just state of being.

# About the Analyst

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Jeff Rivkin is research director of Payer IT Strategies for IDC Health Insights. In that role responsible for research coverage on payer business and technology priorities; constituent and consumer engagement strategies; technology and business implications for consumer engagement; front-, middle-, and back-office functions; value-based reimbursement; risk; and quality-based payment and incentive programs, among other trends and technologies important to the payer community.

## MESSAGE FROM THE SPONSOR

For decades, **InterSystems** has been helping public and commercial healthcare payers to connect and bring together disparate data sources to enhance operations, improve outcomes, and address data-related regulatory mandates.

Health insurers leverage the Member-360 capabilities of InterSystems longitudinal health record, HealthShare, as the foundation for value-based care insights, performance measurement, and collaboration. As you evaluate your path to compliance with new CMS mandates, InterSystems payer services support the HL7 Da Vinci Project Implementation Guides for API compliance in conjunction with that longitudinal health record to provide the necessary comprehensive member and operational insights.

InterSystems payer services for interoperability, prior authorization, and care management offer a flexible path to value — whether you need a single API to support provider to payer data sharing or a holistic solution to support your long term business strategy. For more information about InterSystems and its payer solutions, go to https://www.intersystems.com/industries/public-private-payers

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