JOSH GREEN, M.D.
GOVERNOR OF HAWAIʻI
KE KIAʻĀINA O KA MOKUʻĀINA ʻO HAWAIʻI

KENNETH S. FINK, M.D., M.P.H., M.G.A.
DIRECTOR OF HEALTH
KA LUNA HOʻOKELE

STATE OF HAWAI'I
DEPARTMENT OF HEALTH
KA ʻOIHANA OLAKINO
P. O. BOX 3378
HONOLULU, HI 96801-3378

In reply, please refer to:
File:

December 31, 2025

The Honorable Ronald D. Kouchi,
President and Members of the Senate
Thirty-Third State Legislature
State Capitol, Room 409
Honolulu, Hawaii 96813

The Honorable Nadine K. Nakamura,
Speaker
and Members of the House of
Representatives
Thirty-Third State Legislature
State Capitol, Room 431
Honolulu, Hawaii 96813

Dear President Kouchi, Speaker Nakamura, and Members of the Legislature:

For your information and consideration, I am transmitting a copy of the Annual Report on Prior Authorization from the Health Care Appropriateness and Necessity Working Group to the Legislature, pursuant to Act 151, Session Laws of Hawaii 2025.

In accordance with Section 93-16, Hawaii Revised Statutes, I am also informing you that the report may be viewed electronically at:

https://health.hawaii.gov/opppd/department-of-health-reports-to-2026-legislature/

Sincerely,

Kenneth S. Fink, M.D., M.P.H., M.G.A.
Director of Health

Enclosures

c: Legislative Reference Bureau
Hawaii State Library System (2)
Hamilton Library

ACT 151 Relating to Health Prior Authorization

Background:

Prior authorization (PA) is commonly used by health insurers as a utilization management mechanism that requires clinicians to obtain insurer approval before certain procedures, services, or medications are covered. Insurers rely on PA as a cost-containment strategy, both by incentivizing the use of services that fall outside authorization requirements and by constraining use of selected high-cost treatments.

Insurers often frame PA as a safeguard for clinical appropriateness; however, research has associated PA requirements with patient harm, delays in care, and significant dissatisfaction throughout the U.S. health care system. The process also generates considerable administrative expense, and an entire ecosystem of third-party vendors has developed to manage PA workflows on behalf of both insurers and providers.

Policy makers at the federal and state level have been listening to the concerns and have increasingly been seeking ways of implementing reforms to address the concerns raised. Members of the Hawaii Thirty-Third Legislature, 2025, passed HB 250 into law, ACT 151. There was virtually no opposition to this measure in the legislature and hopes are high that the expectations of relieving the stresses and public and provider concerns about prior authorization through the actions of a Working Group, and by virtue of the transparency on prior authorization practices created by the reporting required through this Act.

The purpose of this Act is to: (1) Examine prior authorization practices in the State by requiring utilization review entities to report certain prior authorization data to the state health planning and development agency; and (2) establish the health care appropriateness and necessity working group to make recommendations to improve and expedite the prior authorization process.

As a result, Chapter 323D, Hawaii Revised Statutes, is amended by adding two new sections to part II to be designated and to read as follows:

"323D- Prior authorization data; reporting

a) Utilization review entities doing business in the State shall submit data to the state agency relating to prior authorization of health care services, in a format specified by the state agency. Reporting shall be annual for the preceding calendar yar and shall be submitted no later than January 31 of the subsequent calendar year. The state agency shall post the format for reporting on its website no later than three months before the start of the reporting period.

(b) Protected health information as defined in title 45 Code of Federal Regulations section 160.103 shall not be submitted to the state agency unless:

(1) The individual to who the information relates authorizes the disclosure; or

(2) Authorization is not required pursuant to title 45 Code of Federal Regulations section 164.512.

(c) The state agency shall compile the prior authorization data by provider of health insurance, health care setting, and line of business, and shall post a report of findings, including recommendations, on its website no later than March 1 of the year after the reporting period. If the state agency is unable to post the report of findings by March 1, the state agency shall notify the legislature in writing within ten days and include an estimated date of posting, reasons for the delay, and in applicable, a corrective action plan.

323D- Health care appropriateness and necessity working group established. (a) There is established the health care appropriateness and necessity working group within the state agency. The working group shall:

(1) Determine by research and consensus:

(A) The most respected peer-reviewed national scientific standards;

(B) Clinical guidelines; and

(C) Appropriate use criteria published by federal agencies, academic institutions, and professional societies, that correspond to each of the most frequent clinical treatments, procedures, medications, diagnostic images, laboratory and diagnostic tests, or types of medical equipment prescribed by licensed physicians and other health care providers in the State that trigger prior authorization determinations by the utilization review entities;

(2) Assess whether it is appropriate to require prior authorization for each considered clinical treatment, procedure, medication, diagnostic image, laboratory and diagnostic test, or type of medical equipment prescribed by licensed physicians and other health care providers;

(3) Make recommendations on standards for third party reviewers related to the specialty expertise of those reviewing and for those discussing a patient's denial with the patient's health care provider;

(4) Recommend appropriate time frames within which urgent and standard requests shall be decided;

(5) Monitor anticipated federal developments related to prior authorization for health care services and consider these developments when making its recommendations;

(6) Assess industry progress toward, and readiness to implement, any recommendations; and

(7) Make recommendations on treatments for common chronic or long-term conditions for which prior authorization may remain valid for the duration of the treatment in the appropriate clinical setting.

(b) The administrator of the state agency shall invite the following to be members of the working group:

(1) Five members representing the insurance industry, to be selected by the Hawaii Association of Health Plans;

(2) Five members representing licensed health care professionals, two of whom shall be selected by the Hawaii Medical Association, two of whom shall be selected by the

Healthcare Association of Hawaii, and one of whom shall be selected by the center for nursing; and
(3) Five members representing consumers of health care or employers, two of whom shall be selected by the board of trustees of the Hawaii employer -union health benefits trust fund, one of whom shall be a consumer selected by the statewide health coordinating council, one of whom shall be selected by the Hawaii Primary Care Association, and one of whom shall be selected by Papa Ola Lokahi. In addition, the SHPDA Administrator and the Administrator of the Med-Quest Division, Department of Human Services serve on the Work Group as ex-officio members." (ACT 151, 2025)

Summary of the work to date:

A list of the current members of the "health care appropriateness and necessity working group" (PA Work Group) is attached. The PA Work Group convened four meetings prior to the end of 2025. Members agreed that the timelines in the Act presented challenges, but all agreed that the intent was to initiate a process for collecting and reporting pertinent information related to prior authorization. The members also agreed that the Act acknowledges that the process would evolve over time. This report represents the work in progress.

Accomplishments to date:

- Identified leadership for convening of meetings
- Established a Permitted Interactions Group (PIG) to review the various reporting formats and make recommendations to the work group on an initial reporting format for the first-year reporting requirements.
- Working group members shared updates related to prior authorization. For example, HMSA shared it's plans for "modernizing prior authorization".
- Reviewed the current reporting formats for Medicare, Medicaid, and a format proposed by the Hawaii Medical Association and the State Health Planning and Development Agency (SHPDA).

Based on the recommendations from the Permitted Interaction Group, the working group will decide on a reporting format. This will occur in early January 2026. The intent is that upon receipt of the reports, SHPDA will meet the March date to provide a summary of what's submitted to the Legislature.

Throughout the process, the working group has continued to update key members of the legislature and is appreciative of the willingness of the members to engage and participate in the process. House Health Committee Chair, Representative Gregg Takayama, and House Human Services and Homelessness Committee Chair, Representative Lisa Marten, and Senate Health and Human Services Committee Chair, Senator Joy San Buenaventura have all addressed the group, expressed their expectations for its progress, and emphasized that this measure passed both houses of the legislature *without opposition.*

The Prior Authorization Work Group is an ongoing group and will continue to meet through 2026 and beyond. Members agree that this is a work in progress and the intent is to improve the process to ensure that the process is patient centered and reduces the administrative burden for the providers and insurers. As subsequent reports are prepared and reviewed, lessons learned will be incorporated into future reporting with the intent on continuous improvement of both reporting format and most important, the impact on all stakeholders.

The Work Group members have conscientiously taken on the challenge of ACT 151 (2025). We have together reviewed reporting formats and requirements of Med-QUEST (the current existing process) and the less specific and soon-to-be -implemented new recommendations from CMS for Medicare. We are approaching consensus on this year's format, and SHPDA has developed a reporting template which is nearly finalized.

Commercial reporting is a new requirement of ACT 151 but not required by CMS. However commercial insurance denials represent the bulk of concerns and complaints. HMSA must take the lead on how best to achieve this, although Kaiser Permanente is cooperating with them.

The Work Group has been laboring in good faith over the past five months in this first year of ACT 151. The bill prescribes the reporting format be issued by the agency 3 months before the required annual reporting date of January 31 (which requires issuing the format by October 31). However, we were still working on understanding the newly issued federal reporting requirements at that time, which are lacking in detail and omit drug reporting, and then comparing that format with existing Med-QUEST reporting requirements. The goal was to both align and simplify them. As a result, we did not make the October 31 format design deadline in year one, but which will be easy to achieve in future years.

This first year of reporting will of necessity require us to use a format that is not too complex but still complete enough to satisfy providers and the legislature. We need to demonstrate that we are now tracking the PA adjudication process as a state to be able to consider what additional policy considerations may be needed in the future.

The goal for all involved is to turn the PA process over the next 2-3 years into a virtual electronic means of exchange and adjudication (hopefully eliminating the use of faxes completely, which slow the process down); and we further need to eliminate PA requirements which offer no measurable value in reducing healthcare costs or in reducing care lacking in scientific evidence of medical necessity.

At this point, we anticipate that our statewide health insurers will produce the initial PA report by the January 31 deadline, allowing SHPDA to perform its analysis of data collected for our required March 31 report to the Legislature. This initial report should provide a description of our status as a state in these regards, along with any recommendations we may have for improving the process going forward.

Attachments:

- ACT 151 Relating to Health Prior Authorization
- Health care Appropriateness and Necessity Working Group Member list
- Prior Authorization Reporting Formats reviewed (Medicare, Medicaid, HMA, SHPDA)
- Resource Articles

JOSH GREEN, M.D.
GOVERNOR
KE KIA'ĀINA

GOV. MSG. NO. 1251

EXECUTIVE CHAMBERS
KE KE'ENA O KE KIA'ĀINA

June 3, 2025

The Honorable Ronald D. Kouchi
President of the Senate,
and Members of the Senate
Thirty-Third State Legislature
State Capitol, Room 409
Honolulu, Hawai'i 96813

The Honorable Nadine Nakamura
Speaker, and Members of the
House of Representatives
Thirty-Third State Legislature
State Capitol, Room 431
Honolulu, Hawai'i 96813

Aloha President Kouchi, Speaker Nakamura, and Members of the Legislature:

This is to inform you that on June 3, 2025, the following bill was signed into law:

H.B. NO. 250, H.D. 2, S.D. 2, C.D. 1	RELATING TO HEALTH. **ACT 151**

Mahalo,

Josh Green M.D.

Josh Green, M.D.
Governor, State of Hawai'i

Approved by the Governor

on JUN 3 2025

HOUSE OF REPRESENTATIVES
THIRTY-THIRD LEGISLATURE, 2025
STATE OF HAWAII

ACT 151

H.B. NO. 250 H.D. 2 S.D. 2 C.D. 1

A BILL FOR AN ACT

RELATING TO HEALTH.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

SECTION 1. The legislature finds that prior authorization is a health plan cost-control process that requires physicians, health care professionals, and hospitals to obtain advance approval from a health plan before a specific service to a patient is qualified for payment or coverage. Each health plan has its own policies and procedures that health care providers are required to navigate to have services they prescribe for their patients approved for payment before being provided to the patient. Each health plan uses its own standards and methods, the individual judgment of an employed medical director, or advice from a contracted firm for determining the medical necessity of the services prescribed, which are not transparent or clear to the prescribing clinician or health care provider.

The legislature further finds that there is emerging consensus among health care providers that prior authorization increases administrative burdens and costs. In the 2023 physician workforce report published by the university of Hawaii

John A. Burns school of medicine, physicians voted prior authorization as their top concern regarding administrative burden. Furthermore, a physician survey conducted by the American Medical Association reported that ninety-five per cent of physicians attribute prior authorization to somewhat or significantly increased physician burnout, and that more than one in three physicians have staff who work exclusively on prior authorization. The survey also found that:

(1) Eighty-three per cent of prior authorization denials were subsequently overturned by health plans;

(2) Ninety-four per cent of respondents said that the prior authorization process always, often, or sometimes delays care;

(3) Nineteen per cent of respondents said prior authorization resulted in a serious adverse event leading to a patient being hospitalized;

(4) Thirteen per cent of respondents said prior authorization resulted in a serious adverse event leading to a life-threatening event or requiring intervention to prevent permanent impairment or damage; and

(5) Seven per cent of respondents said prior authorization resulted in a serious adverse event leading to a patient's disability, permanent body damage, congenital anomaly, birth defect, or death.

The legislature believes that reducing the burdens of prior authorization will assist health care providers, thereby ensuring the health and safety of their patients.

Accordingly, the purpose of this Act is to:

(1) Examine prior authorization practices in the State by requiring utilization review entities to report certain prior authorization data to the state health planning and development agency; and

(2) Establish the health care appropriateness and necessity working group to make recommendations to improve and expedite the prior authorization process.

SECTION 2. Chapter 323D, Hawaii Revised Statutes, is amended by adding two new sections to part II to be appropriately designated and to read as follows:

"**§323D- Prior authorization data; reporting.** (a) Utilization review entities doing business in the State shall submit data to the state agency relating to prior authorization

of health care services, in a format specified by the state agency. Reporting shall be annual for the preceding calendar year and shall be submitted no later than January 31 of the subsequent calendar year. The state agency shall post the format for reporting on its website no later than three months before the start of the reporting period.

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(2) Authorization is not required pursuant to title 45 Code of Federal Regulations section 164.512.

(c) The state agency shall compile the prior authorization data by provider of health insurance, health care setting, and line of business, and shall post a report of findings, including recommendations, on its website no later than March 1 of the year after the reporting period. If the state agency is unable to post the report of findings by March 1, the state agency shall notify the legislature in writing within ten days and

include an estimated date of posting, reasons for the delay, and if applicable, a corrective action plan.

§323D- Health care appropriateness and necessity working group; established. (a) There is established the health care appropriateness and necessity working group within the state agency. The working group shall:

(1) Determine by research and consensus:

(A) The most respected peer-reviewed national scientific standards;

(B) Clinical guidelines; and

(C) Appropriate use criteria published by federal agencies, academic institutions, and professional societies,

that correspond to each of the most frequent clinical treatments, procedures, medications, diagnostic images, laboratory and diagnostic tests, or types of medical equipment prescribed by licensed physicians and other health care providers in the State that trigger prior authorization determinations by the utilization review entities;

(2) Assess whether it is appropriate to require prior authorization for each considered clinical treatment, procedure, medication, diagnostic image, laboratory and diagnostic test, or type of medical equipment prescribed by licensed physicians and other health care providers;

(3) Make recommendations on standards for third party reviewers related to the specialty expertise of those reviewing and for those discussing a patient's denial with the patient's health care provider;

(4) Recommend appropriate time frames within which urgent and standard requests shall be decided;

(5) Monitor anticipated federal developments related to prior authorization for health care services and consider these developments when making its recommendations;

(6) Assess industry progress toward, and readiness to implement, any recommendations; and

(7) Make recommendations on treatments for common chronic or long-term conditions for which prior authorization

may remain valid for the duration of the treatment in the appropriate clinical setting.

(b) The administrator of the state agency shall invite the following to be members of the working group:

(1) Five members representing the insurance industry, to be selected by the Hawaii Association of Health Plans;

(2) Five members representing licensed health care professionals, two of whom shall be selected by the Hawaii Medical Association, two of whom shall be selected by the Healthcare Association of Hawaii, and one of whom shall be selected by the center for nursing; and

(3) Five members representing consumers of health care or employers, two of whom shall be selected by the board of trustees of the Hawaii employer-union health benefits trust fund, one of whom shall be a consumer selected by the statewide health coordinating council, one of whom shall be selected by the Hawaii Primary Care Association, and one of whom shall be selected by Papa Ola Lokahi.

The members of the working group shall elect a chairperson and vice chairperson from amongst themselves. The director of health, insurance commissioner, and administrator of the med-QUEST division of the department of human services shall each appoint an ex-officio advisor for the working group.

(c) The working group shall submit a report of its findings and recommendations regarding information under subsection (a), including any proposed legislation, to the legislature no later than twenty days prior to the convening of the regular session of 2026 and each regular session thereafter.

(d) The recommendations of the working group shall be advisory only and not mandatory for health care facilities, health care professionals, insurers, and utilization review entities. The state agency shall promote the recommendations among health care facilities, health care professionals, insurers, and utilization review entities and shall publish annually in its report to the legislature the extent and impacts of its use in the State.

(e) The state agency shall seek transparency and agreement among health care facilities, health care professionals, insurers, utilization review entities, and consumers related to

the most respected clinical, scientific, and efficacious standards, guidelines, and appropriate use criteria corresponding to medical treatments and services most commonly triggering prior authorization determinations to reduce uncertainty around common prior authorization processes, and also foster automation of prior authorization to the benefit of all. The state agency shall explore means of achieving statewide health sector agreement on means of automating prior authorization determinations that decrease delays and disruptions of medically necessary patient care in the near future."

SECTION 3. Section 323D-2, Hawaii Revised Statutes, is amended by adding four new definitions to be appropriately inserted and to read as follows:

""Health care professional" has the same meaning as defined in section 431:26-101.

"Prior authorization" means the process by which a utilization review entity determines the medical necessity or medical appropriateness of otherwise covered health care services before the health care services are rendered. "Prior authorization" includes any health insurer's or utilization

review entity's requirement that an insured or a health care facility or health care professional notify the insurer or utilization review entity before providing health care services to determine eligibility for payment or coverage.

"Prior authorization data" means data required for compliance with federal law and the regulations of the federal Centers for Medicare and Medicaid Services, including those promulgated under title 42 Code of Federal Regulations sections 422.122(c), 438.210(f), 440.230(e)(3), and 457.732(c).

"Utilization review entity" means an individual or entity that performs prior authorization for one or more of the following entities:

(1) An insurer governed by chapter 431, article 10A; a mutual benefit society governed by chapter 432, article 1; a fraternal benefit society governed by chapter 432, article 2; or a health maintenance organization governed by chapter 432D; or

(2) Any other individual that provides, offers to provide, or administers hospital, outpatient, medical, prescription drug, or other health benefits to an individual treated by a health care facility or health

care professional in the State under a policy, contract, plan, or agreement."

SECTION 4. New statutory material is underscored.

SECTION 5. This Act shall take effect upon its approval.

H.B. NO. 250 H.D. 2 S.D. 2 C.D. 1

APPROVED this 3rd day of June , 2025

GOVERNOR OF THE STATE OF HAWAII

HB No. 250, HD 2, SD 2, CD 1

THE HOUSE OF REPRESENTATIVES OF THE STATE OF HAWAII

Date: April 30, 2025
Honolulu, Hawaii

We hereby certify that the above-referenced Bill on this day passed Final Reading in the House of Representatives of the Thirty-Third Legislature of the State of Hawaii, Regular Session of 2025.

Nadine K. Nakamura
Speaker
House of Representatives

Brian L. Takeshita
Chief Clerk
House of Representatives

THE SENATE OF THE STATE OF HAWAI'I

Date: April 30, 2025
Honolulu, Hawai'i 96813

We hereby certify that the foregoing Bill this day passed Final Reading in the Senate of the Thirty-Third Legislature of the State of Hawai'i, Regular Session of 2025.

President of the Senate

Clerk of the Senate

HB 250 PRE AUTHORIZATION WORK GROUP

ORGANIZATION	NAME
Hawaii Health Care Plans 1/5	Jenn Diesman, HMSA, Senior Vice President, Government Policy and Advocacy
Hawaii Health Care Plans 2/5	Paula Arcena, AlohaCare, Vice President, External Affairs
Hawaii Health Care Plans 3/5	Chris Lutz, Kaiser Permanente Hawaii, Senior Director of Outside Medical Services
Hawaii Health Care Plans 4/5	Maria Coutee, Ohana Health Plan, Director of Utilization Management
Hawaii health Care Plans 5/5	Robert Gluckman, MD, United Healthcare, Chief Medical Officer
Hawaii Medical Association 1/2	Elizabeth Ann (Lisa) Ignacio, MD
Hawaii Medical Association 2/2	Kelley With, MD, PhD
Healthcare Association of Hawaii 1/2	Hilton Raethel, President and CEO
Healthcare Association of Hawaii 2/2	Paige Heckathorn Choy, Vice President Government Affairs
Center for Nursing 1/1	Laura Reichhardt, MS, APRN, AGPCNP-BC, FAAN
EUTF Board of Trustees 1/2	Derek M. Mizuno, Administrator
EUTF Board of Trustees 2/2	Lara S. Nitta
Statewide Health Coordinating Council 1/1	Jonagustine (Jon) Lim
Hawaii Primary Care Association 1/1	Robert Hirokawa, MD, CEO
Papa Ola Lokahi 1/1	Sheri Daniels, CEO
DHS-MQD Ex Officio	Judy Mohr Peterson, Administrator
DOH Ex Officio	Lorrin Kim or Richard Chung, MD representing Kenneth Fink, MD, Director of Health
Insurance Commissioner, DCCA	Arlene Ige or Jerry Bump representing Commissioner Scott Saiki
SHPDA	John C. (Jack) Lewin, MD, Administrator
HMA (appointing agency)	Mark Aleander, Executive Director

Hawaii State Health Planning and Development Agency
1177 Alakea St. #402 Honolulu, Hawaii 96813
Phone: 808-587-0788 Fax: 808-587-0783 Web: https://health.hawaii.gov/shpda

Healthcare Prior Authorization Report

Reporting Periord: January 1 to December 31, 2025

(Due Date: January 31, 2026)

Instructions

If your health plan covers the service(s) listed below, please complete the form(s) relevant to the service(s):

Services	Form #
01=At Risk Services	Form-1
02=Autism Services	Form-2
03=Diagnostic Testing	Form-3
04=Durable Medical Supplies/Medical Equipment	Form-4
05=Home and Community Based Services	Form-5
06=Home Health Services	Form-6
07=Inpatient Hospital Services	Form-7
08=Outpatient Hospital Services	Form-8
09=Physician Services	Form-9
10=Preventive Services	Form-10
11=Rehabilitation Services	Form-11
12=Transportation Services	Form-12
13=Behavioral Health	Form-13
14=Other Services	Form-14
15=Drugs	Form-15

Additional copies of instructions and report forms are available at:

TBD

Three (3) ways to return the report form(s) to SHPDA:	Questions?
1) Email to: dailin.ye@doh.hawaii.gov, or	Email: dailin.ye@doh.hawaii.gov
2) Fax to: 808-587-0783, or	Phone: 808-587-0852
3) Mail to: SHPDA Prior Authorization Report Hawaii State Health Planning and Development Agency 1177 Alakea St. #402, Honolulu, HI 96813	

State Health Planning and Development Agency
1177 Alakea St. #402 Honolulu, Hawaii 96813
Phone: 808-587-0788 Fax: 808-587-0783 Web: https://health.hawaii.gov/shpda

Form-1: At Risk Services (Sample Form Subjected to Change)

Reporting Periord: January 1 to December 31, 2025

(Due Date: January 31, 2026)

Name of Health Plan:		Report date:	
Name of Insurer:			
Address of Insurer:			
Name of Administrator:		Phone:	
Completed by: (name)		Fax:	
(title)		Email:	

Section I. Standard (Non-Urgent) Prior Authorization (PA) Requests

		Total (A)	Approved (B)	Denied (C)	With-drawn (D)	Among the total number of denials reported in column C, how many denials were due to one of the following reasons? Count one primary reason for each denial and enter the count for each reason in column F. (E) (*See note)	Counts of Reasons (F)
1.	Standard PA Requests	50000	40000	10000		01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests	
						08=Other* **Specify. Add row as needed.**	
2.	Standard PA Decision Made within 7 Days (Report Standard PA Appeals in Line 4)	35000	29500	5500		01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests	
						08=Other* **Specify. Add row as needed.**	
3.	Standard PA Decision Made with Extension (up to 14 days) (Report Standard PA Appeals in Line 4)	10000	7500	2500		01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests	
						08=Other* **Specify. Add row as needed.**	
4.	Standard PA Decision Made after Appeal	5000	3000	2000		01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests	
						08=Other* **Specify. Add row as needed.**	

Section II. Expedited (Urgent) Prior Authorization (PA) Requests

		Total (A)	Approved (B)	Denied (C)	With-drawn (D)	Among the total number of denials reported in column C, how many denials were due to one of the following reasons? Count one primary reason for each denial and enter the count for each reason in column F. (E) (*See note)	Counts of Reasons (F)
5.	Expedited PA Requests					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests	
						08=Other* **Specify. Add row as needed.**	
6.	Expedited PA Decision Made within 72 Hours (Report Expedited PA Appeals in Line 8)					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests	
						08=Other* **Specify. Add row as needed.**	
7.	Expedited PA Decision Made with Extension (up to 14 days) (Report Expedited PA Appeals in Line 8)					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests	
						08=Other* **Specify. Add row as needed.**	
8.	Expedited PA Decision Made after Appeal					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests	
						08=Other* **Specify. Add row as needed.**	

Section III. Time Between Receiving a Prior Authorization Request and Sending a Decision

		Mean (Average) Time	Median (Middle) Time	
9.	Standard PA Decision Made within 7 Days	5	4	Day(s)
10.	Standard PA Decision Made with Extension (up to 14 Days)			Day(s)
11.	Standard PA Decision Made after Appeal			Day(s)
12.	Expedited PA Decision Made within 72 Hours	1	1	Day(s)
13.	Expedited PA Decision Made with Extension (up to 14 Days)			Day(s)
14.	Expedited PA Decision Made after Appeal			Day(s)

Notes:

Column E: 01=Incomplete or Incorrect Information*

This might include any of the following: missing or incorrect patient information; errors in ICD-10 or CPT/HCPCS codes; missing medical records, inadequate physician notes, lack of relevant lab results, or failure to include previous treatment histories; etc.

Column E: 04=Prior authorization timelines not met*

This might also include expired authorization or duplicate requests.

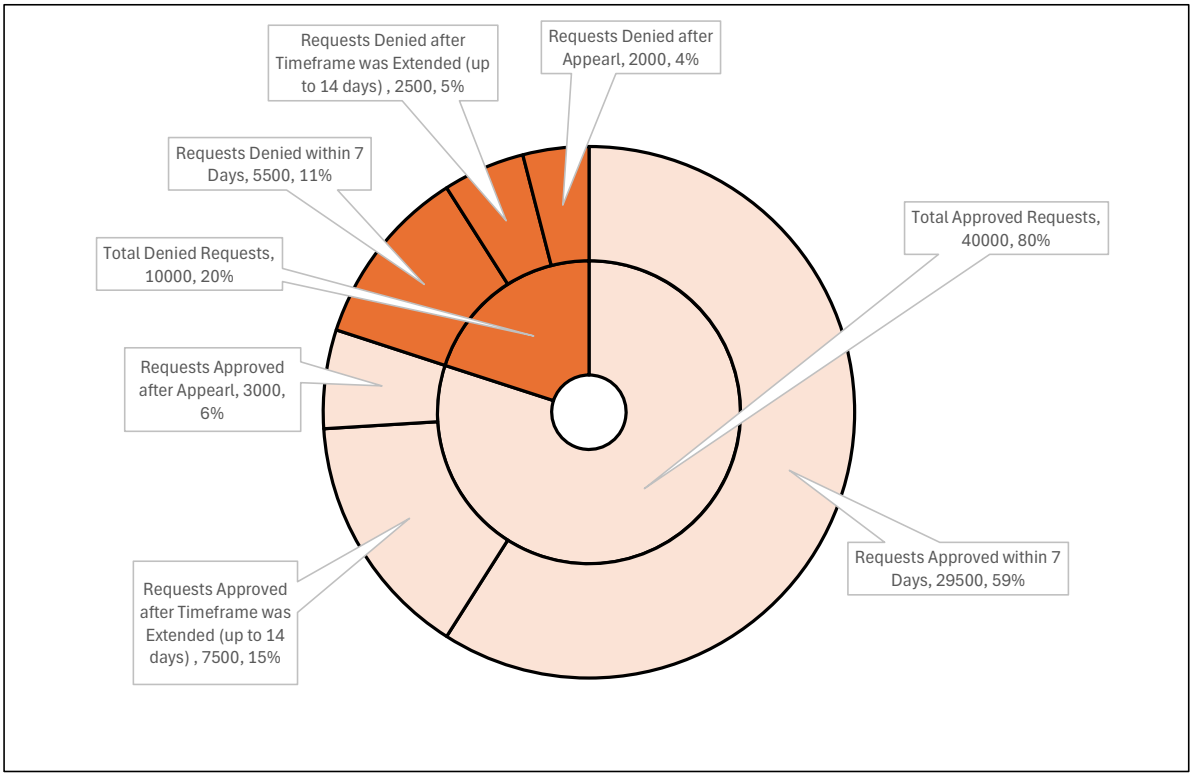
Column E: 08=Other*

This might include but is not limited to any of the following: Invalid preauthorization request form submitted; Pre-existing Condition Exclusion; Lack of Peer-to-Peer Review; Treatment is not consistent with published clinical evidence; etc. Please specify reason of denial. Add row as needed.

SHPDA Sample Report of Prior Authorization (PA) Requests (subjected to change)

Standard (Non-Urgent) Prior Authorization (PA) Requests

Total Approved Requests	40000	
Total Denied Requests	10000	
Requests Approved within 7 Days		29500
Requests Approved after Timeframe was Extended (up to 14 days)		7500
Requests Approved after Appearl		3000
Requests Denied within 7 Days		5500
Requests Denied after Timeframe was Extended (up to 14 days)		2500
Requests Denied after Appearl		2000



References of Prior Authorization Denial Reasons by Categories

1. Incomplete or Incorrect Information		**48**	**Note: This might include any of the following: missing or incorrect patient information; errors in ICD-10 or CPT/HCPCS codes; missing medical records, inadequate physician notes, lack of relevant lab results, or failure to include previous treatment histories; etc.**
2. Medical necessity criteria not met		**23**	
3. Non-covered services or exceeding coverage limits		**22**	
4. Prior authorization timelines not met		**21**	**Note: This might also include expired authorization or duplicate requests.**
5. Out-of-network providers		**14**	
6. Lack of step therapy/testing attempts		**9**	
7. Non-formulary medications		**5**	**Note: This is for drugs/medications.**
8. The requested therapy requires multiple prior authorization requests		**3**	
9. Others		**22**	
		167	

Categories	Ref#	Count	Reasons from References	Explanations to the Reasons	Sources of References
Incomplete or Incorrect Information	**Ref#1**	**1**	**Additional information requested not received, preauthorization request rejected**		https://www.medicaid.nv.gov/Downloads/provider/web_announcement_3712_20250904.pdf
Incomplete or Incorrect Information	**Ref#2**	**1**	**Incorrect or Incomplete Documentation**	**Missing paperwork**, **incorrect coding**, or **lack of detail in the submission** can all lead to a denial. Insurers often require specific information, **such as medical records, test results, and a detailed explanation of why the requested service is needed**.	https://www.gmlawyers.com/resources-and-info/prior-authorization-denials/
Incomplete or Incorrect Information	**Ref#3**	**1**	**Incomplete documentation is shared**	Reason not provided	https://www.macpac.gov/wp-content/uploads/2024/08/Prior-Authorization-in-Medicaid.pdf
Incomplete or Incorrect Information	**Ref#4**	**1**	**Lack of clinical (Ref#4 top 4)**	Reason not provided	https://es.aetna.com/content/dam/aetna/pdfs/aetnacom/health-care-professionals/2022-illinois-aetna-specialty-pharmacy-medical-prior-authorization-statistics.pdf
Incomplete or Incorrect Information	**Ref#5**	**1**	**Incomplete or incorrect information**	Your forms could be **missing or** include **incorrect patient information (e.g., insurance ID, date of birth)**. The **billing codes or service descriptions could be wrong**, or **documentation to support the request for prior authorization may be missing**.	https://www.abbvie.com/content/dam/abbvie-com2/pdfs/prior-authorization-fact-sheet.pdf
Incomplete or Incorrect Information	**Ref#7**	**1**	**ADMINISTRATIVE ERRORS**	A denied prior auth request can occur when a provider's office submits a **wrong billing code**, **misspells a name or makes another clerical error**. Requests can also be denied if the prior auth request **lacks sufficient information about why the medication or treatment is needed**.	https://www.covermymeds.health/articles/provider-insights/common-prior-authorization-hurdles-and-how-to-overcome-them
Incomplete or Incorrect Information	**Ref#8**	**1**	**submission of incomplete clinical data or insufficient documentation of medical**		https://www.chbrp.org/sites/default/files/bill-documents/Prior%20Authorization_final.pdf
Incomplete or Incorrect Information	**Ref#9**	**1**	**health plan lacks information to approve coverage of the service (23 percent)**		https://www.aafp.org/pubs/fpm/issues/2006/0600/p45.html
Incomplete or Incorrect Information	**Ref#10**	**1**	**Documentation errors**	Prior authorization is often required for costly treatments to confirm their medical necessity.	https://sunknowledge.com/understanding-the-common-prior-authorization-hurdles-and-how-to-overcome-them/
Incomplete or Incorrect Information	**Ref#10**	**1**	**Administrative Errors**	Clerical mistakes, such as **incorrect billing codes** is a leading cause of prior authorization denials.	https://sunknowledge.com/understanding-the-common-prior-authorization-hurdles-and-how-to-overcome-them/
Incomplete or Incorrect Information	**Ref#11**	**1**	**Incomplete or Missing Information**	Insurance companies require comprehensive documentation to review a prior authorization request. **Missing medical records, inadequate physician notes, lack of relevant lab results, or failure to include previous treatment histories** can lead to automatic denials. Proper documentation is critical to justify the medical necessity of the requested service or medication.	https://staffingly.com/common-reasons-prior-authorization-gets-denied-in-healthcare/
Incomplete or Incorrect Information	**Ref#11**	**1**	**Incorrect or Mismatched Coding**	**Errors in ICD-10 (diagnosis) or CPT/HCPCS (procedure) codes** are a common cause of denials. If codes are incorrect, outdated, or do not align with the description of the requested service, the insurance carrier may reject the prior authorization request without further review.	https://staffingly.com/common-reasons-prior-authorization-gets-denied-in-healthcare/

References of Prior Authorization Denial Reasons by categories

Incomplete or Incorrect Information	**Ref#12**	**1**	**Incomplete Documentation**	Incomplete or insufficient documentation remains one of the primary reasons for prior authorization denials. Insurance companies need specific information to evaluate the necessity of the requested service. **Missing documents, such as clinical notes or diagnostic reports**, can lead to a denial.	https://www.expedium.net/blog/top-reasons-for-prior-authorization-denials-and-how-to-avoid-them/
Incomplete or Incorrect Information	**Ref#12**	**1**	**Incorrect Coding**	Errors in coding are a significant source of prior authorization denials. Using the wrong **CPT (Current Procedural Terminology) or ICD-10 (International Classification of Diseases) codes** can result in a denial. These codes must accurately reflect the service being requested and the patient's diagnosis.	https://www.expedium.net/blog/top-reasons-for-prior-authorization-denials-and-how-to-avoid-them/
Incomplete or Incorrect Information	**Ref#13**	**1**	**Incomplete documentation that does not meet insurer guidelines.**		https://www.sprypt.com/blog/pre-authorization-denials-appeals
Incomplete or Incorrect Information	**Ref#13**	**1**	**Incorrect procedure or diagnosis codes (Billing and Coding Errors)**	**Incorrect CPT, ICD-10, or HCPCS codes** often result in automatic denials. Common mistakes include mismatched procedure and diagnosis codes, use of outdated or non-reimbursable codes, and incorrect modifiers affecting claim processing.	https://www.sprypt.com/blog/pre-authorization-denials-appeals
Incomplete or Incorrect Information	**Ref#14**	**1**	**Incomplete Documentation**	Incomplete or incorrect patient data remains one of the primary reasons for prior authorization denials. Insurance companies require specific information to evaluate the necessity of the requested service. **Errors in names, dates of birth, insurance details, or diagnosis codes** can instantly cause a rejection.	https://stafgo.com/top-denial-reasons-for-prior-authorizations-and-how-to-prevent-them/
Incomplete or Incorrect Information	**Ref#14**	**1**	**Incorrect Coding**	Use of **incorrect codes** is a significant reason for prior authorization denials. An error in the application of CPT or ICD-10 codes can result in denials. These codes must accurately show the service being requested and the patient's diagnosis. Even a minor discrepancy between the procedure performed and the code listed on the PA request can lead to denial.	https://stafgo.com/top-denial-reasons-for-prior-authorizations-and-how-to-prevent-them/
Incomplete or Incorrect Information	**Ref#14**	**1**	**Payer-Specific Documentation Requirements Not Met**	Every insurance provider has its specific requirements for different forms, formats, or levels of detail, and when healthcare providers fail to meet these standards set by payers, it leads to a cause of denials.	https://stafgo.com/top-denial-reasons-for-prior-authorizations-and-how-to-prevent-them/
Incomplete or Incorrect Information	**Ref#15**	**1**	**administrative errors accounting for 18% of denials**	Reason not provided	https://www.counterforcehealth.org/post/how-to-appeal-a-prior-authorization-denial-2025/
Incomplete or Incorrect Information	**Ref#16**	**1**	**Incomplete clinical information about the patient's health condition**		https://www.outsourcestrategies.com/blog/prior-authorization-denied/
Incomplete or Incorrect Information	**Ref#16**	**1**	**Any errors or discrepancies present in the billing codes**		https://www.outsourcestrategies.com/blog/prior-authorization-denied/
Incomplete or Incorrect Information	**Ref#17**	**1**	**Incomplete or missing documentation**	Your provider may not have submitted enough **medical records or clinical notes**.	https://www.solace.health/articles/prior-authorization-denied
Incomplete or Incorrect Information	**Ref#17**	**1**	**Incorrect CPT or diagnosis codes**	Administrative errors can trigger a denial even if the treatment is appropriate.	https://www.solace.health/articles/prior-authorization-denied
Incomplete or Incorrect Information	**Ref#18**	**1**	**Missing information and errors**		https://www.spravatohcp.com/files/Prior_Authorization_Toolkit.pdf
Incomplete or Incorrect Information	**Ref#18**	**1**	**Diagnosis-related denial**		https://www.spravatohcp.com/files/Prior_Authorization_Toolkit.pdf
Incomplete or Incorrect Information	**Ref#19**	**1**	**Misspelled names, incorrect billing codes, and other clerical errors**		https://prognocis.com/best-practices-in-avoiding-prior-authorization-denials/
Incomplete or Incorrect Information	**Ref#19**	**1**	**Missing info about the proposed treatment and why you're recommending it**		https://prognocis.com/best-practices-in-avoiding-prior-authorization-denials/
Incomplete or Incorrect Information	**Ref#19**	**1**	**Absence of evidence-based clinical guideline data provided in the paperwork**		https://prognocis.com/best-practices-in-avoiding-prior-authorization-denials/
Incomplete or Incorrect Information	**Ref#20**	**1**	**More information is needed**	**health history or past test results**	https://www.modahealth.com/-/media/modahealth/shared/provider/prior-authorization/Prior-Authorization-Denial.pdf
Incomplete or Incorrect Information	**Ref#21**	**1**	**Incomplete or Incorrect Documentation**	**Missing patient details, incomplete forms, or failing to attach supporting documents** can make insurers question the medical necessity of the request.	https://xybermed.com/tag/what-are-the-most-common-reasons-for-prior-authorization-denials/
Incomplete or Incorrect Information	**Ref#21**	**1**	**Incorrect Coding**	**Coding errors** are a frequent culprit behind prior authorization denials. Using the wrong CPT, ICD, or HCPCS codes can cause confusion and result in rejections. Think of coding as the language insurers use to understand the treatment—a mistake in this language leads to miscommunication. To prevent this, always verify that the codes match the procedure or service you're requesting authorization for.	https://xybermed.com/tag/what-are-the-most-common-reasons-for-prior-authorization-denials/
Incomplete or Incorrect Information	**Ref#21**	**1**	**Inadequate Follow-Up**	Failing to follow up on pending requests is another common reason for prior authorization denials. Insurance companies may require additional information or clarification, and delays in providing this can result in rejection.	https://xybermed.com/tag/what-are-the-most-common-reasons-for-prior-authorization-denials/

References of Prior Authorization Denial Reasons by categories

Incomplete or Incorrect Information	**Ref#22**	**1**	**Lack of Documentation**	all pertinent medical information is submitted (as noted above in #1). Delays can result from **lack of medical records, past imaging, past treatment plans, labs or X-rays**.	https://www.communitycarehealth.org/wp-content/uploads/2022/12/Why-A-Prior-Auth-Request-May-Not-Be-Approved_Winter2022.pdf
Incomplete or Incorrect Information	**Ref#23**	**1**	**Submission of Inaccurate Patient Information**	**wrong-spelled name, incorrect date of birth, and wrong health insurance ID number**	https://portiva.com/how-to-appeal-a-prior-authorization-denial/
Incomplete or Incorrect Information	**Ref#23**	**1**	**Submission of Incomplete Information**	submitting **incomplete or missing medication details or treatment justification**	https://portiva.com/how-to-appeal-a-prior-authorization-denial/
Incomplete or Incorrect Information	**Ref#24**	**1**	**Inadequate paperwork**	Healthcare providers' inadequate or partial documentation may result in rejections since it does not fulfill the prerequisites for pre-authorization.	https://annexmed.com/comprehensive-guide-to-pre-authorization
Incomplete or Incorrect Information	**Ref#24**	**1**	**Coding errors**	**Incorrect or mismatched procedure codes or billing codes** can lead to pre-authorization denials.	https://annexmed.com/comprehensive-guide-to-pre-authorization
Incomplete or Incorrect Information	**Ref#24**	**1**	**Patient information that is insufficient**	Pre-authorization requests may be denied if the **patient's information is inadequate or inaccurate, such as their demographics or medical history**.	https://annexmed.com/comprehensive-guide-to-pre-authorization
Incomplete or Incorrect Information	**Ref#24**	**1**	**Administrative blundering**	Denials may result from faults committed during the pre-authorization procedure, such as **incorrect data entry** or poor communication.	https://annexmed.com/comprehensive-guide-to-pre-authorization
Incomplete or Incorrect Information	**Ref#25**	**1**	**Inadequate supporting evidence**		https://referralmd.com/prior-authorization-problems-healthcare-2/
Incomplete or Incorrect Information	**Ref#25**	**1**	**Administrative (e.g., wrong coding)**	e.g., **wrong coding**	https://referralmd.com/prior-authorization-problems-healthcare-2/
Incomplete or Incorrect Information	**Ref#26**	**1**	**Missing or incorrect patient data**	such as **dates of birth, insurance details, or demographic information**, can cause delays or denials	https://zenmedinc.com/blog/prior-authorization-denials-in-healthcare/
Incomplete or Incorrect Information	**Ref#26**	**1**	**Lack of clinical detail**	Denials happen if the request doesn't provide enough information about the **patient's condition and the need for treatment**.	https://zenmedinc.com/blog/prior-authorization-denials-in-healthcare/
Incomplete or Incorrect Information	**Ref#26**	**1**	**Coding or billing errors**		https://zenmedinc.com/blog/prior-authorization-denials-in-healthcare/
Incomplete or Incorrect Information	**Ref#27**	**1**	**Insufficient clinical rationale for SCA exception (Behavioral)**	Reason not provided	https://www.uhcprovider.com/content/dam/provider/docs/public/prior-auth/utilization/IL-Prior-Auth-Statistics-2024.pdf
Incomplete or Incorrect Information	**Ref#27**	**1**	**Lack of Info (Rx)**	Reason not provided	https://www.uhcprovider.com/content/dam/provider/docs/public/prior-auth/utilization/IL-Prior-Auth-Statistics-2024.pdf
Incomplete or Incorrect Information	**Ref#6**	**1**	**Incomplete or Incorrect Information (Ref#6 top 2)**	This can be any of the following: **Missing Patient Information**: A prior authorization request is denied because the patient's demographic details, such as date of birth or insurance ID number, were not included or were entered incorrectly. **Incorrect CPT/ICD Codes**: The request is denied because the procedure code (CPT) or diagnosis code (ICD-10) provided does not match the authorized treatment or diagnosis, leading the insurer to reject the submission. **Incomplete Medical History**: A denial occurs because the documentation needs a complete medical history or recent clinical notes demonstrating the medical necessity of the requested treatment. **Inaccurate Provider Information**: The request is denied because the provider's National Provider Identifier (NPI) or tax identification number (TIN) was entered incorrectly, preventing the insurance company from validating the provider.	https://datamatrixmedical.com/reasons-for-prior-authorization-denials/
Lack of Step Therapy/Testing or Alternative Treatment Attempts	**Ref#7**	**1**	**PATIENT HASN'T TRIED AND FAILED OTHER MEDICATIONS**	Insurance plans often require providers to have their patients try and fail certain medications or treatments before they approve the next option, which may be more expensive. For example, a patient suffering from migraine headaches may have to show that over-the-counter pain medications like acetaminophen or ibuprofen were tried and didn't work.	https://www.covermymeds.health/articles/provider-insights/common-prior-authorization-hurdles-and-how-to-overcome-them
Lack of Step Therapy/Testing or Alternative Treatment Attempts	**Ref#11**	**1**	**Lack of Step Therapy or Alternative Treatment Attempts**	Many insurance plans require evidence that less costly, standard therapies have been tried and found ineffective before approving a higher-level treatment. If a provider fails to document attempts with lower-tier therapies or medications, the insurer may deny the request based on failure to follow step therapy protocols.	https://staffingly.com/common-reasons-prior-authorization-gets-denied-in-healthcare/
Lack of Step Therapy/Testing or Alternative Treatment Attempts	**Ref#13**	**1**	**Failure to meet step therapy requirements**		https://www.sprypt.com/blog/pre-authorization-denials-appeals
Lack of Step Therapy/Testing or Alternative Treatment Attempts	**Ref#18**	**1**	**Step therapy required**		https://www.spravatohcp.com/files/Prior_Authorization_Toolkit.pdf
Lack of Step Therapy/Testing or Alternative Treatment Attempts	**Ref#19**	**1**	**A lack of info about treatment alternatives already tried by the patient**		https://prognocis.com/best-practices-in-avoiding-prior-authorization-denials/

References of Prior Authorization Denial Reasons by categories

Lack of Step Therapy/Testing or Alternative Treatment Attempts	**Ref#20**	**1**	**Guidelines suggest trying simpler options first**	try things like rest, ice or physical therapy before moving to surgery, imaging or injections	https://www.modahealth.com/-/media/modahealth/shared/provider/prior-authorization/Prior-Authorization-Denial.pdf
Lack of Step Therapy/Testing or Alternative Treatment Attempts	**Ref#20**	**1**	**Other tests are needed first**	need an X-ray or an ultrasound before an MRI or surgery	https://www.modahealth.com/-/media/modahealth/shared/provider/prior-authorization/Prior-Authorization-Denial.pdf
Lack of Step Therapy/Testing or Alternative Treatment Attempts	**Ref#23**	**1**	**Not Trying or Failing the Relevant Medication**	Some insurers require patients to try less expensive medications first. For example, a migraine patient must prove ibuprofen was ineffective before trying other treatments.	https://portiva.com/how-to-appeal-a-prior-authorization-denial/
Lack of Step Therapy/Testing or Alternative Treatment Attempts	**Ref#4**	**1**	**Requires treatment/testing not completed (Ref#4 top 2)**	Reason not provided	https://es.aetna.com/content/dam/aetna/pdfs/aetnacom/health-care-professionals/2022-illinois-aetna-specialty-pharmacy-medical-prior-authorization-statistics.pdf
Medical necessity criteria not met	**Ref#1**	**1**	**Request does not meet medical necessity criteria**	Providers must document all **relevant clinical aspects** that should be considered when reviewing the request for medical necessity.	https://www.medicaid.nv.gov/Downloads/provider/web_announcement_3712_20250904.pdf
Medical necessity criteria not met	**Ref#2**	**1**	**Lack of Medical Necessity**	Insurance plans typically only cover procedures deemed "medically necessary." If the insurer believes there isn't **sufficient clinical evidence** to support the need for the proposed treatment or believes a less costly alternative would suffice, they may deny the request.	https://www.gmlawyers.com/resources-and-info/prior-authorization-denials/
Medical necessity criteria not met	**Ref#3**	**1**	**Service is not medically necessary**	Reason not provided	https://www.macpac.gov/wp-content/uploads/2024/08/Prior-Authorization-in-Medicaid.pdf
Medical necessity criteria not met	**Ref#4**	**1**	**Does not meet medicall necessity (Ref#4 top 1)**	Reason not provided	https://es.aetna.com/content/dam/aetna/pdfs/aetnacom/health-care-professionals/2022-illinois-aetna-specialty-pharmacy-medical-prior-authorization-statistics.pdf
Medical necessity criteria not met	**Ref#5**	**1**	**Lack of medical necessity or "step therapy" requirements**	Your insurance company may decide that the specific medicine being prescribed is not medically necessary based on their coverage guidelines, or that you should try using a different treatment as first step.	https://www.abbvie.com/content/dam/abbvie-com2/pdfs/prior-authorization-fact-sheet.pdf
Medical necessity criteria not met	**Ref#6**	**1**	**Lack of Medical Necessity (Ref#6 top 1)**	Based on the research, the lack of medical necessity was the top reason for a denial. Insurance companies require thorough documentation to justify the necessity of a proposed treatment. This typically includes a comprehensive packet of **medical records** from the past six months. Requirements should also include the **most recent clinical notes**. Plus the **diagnostic tests**, and evidence of **conservative treatments attempted** before recommending more invasive procedures such as surgery or advanced imaging. Medical practices often struggle to gather and submit all the required documentation, leading to delays or outright denials.	https://datamatrixmedical.com/reasons-for-prior-authorization-denials/
Medical necessity criteria not met	**Ref#7**	**1**	**QUESTIONS REGARDING MEDICAL NECESSITY**	A prior auth request is typically required for more costly, complex treatments. Medical necessity is the criteria payers use to evaluate whether a treatment meets the accepted medical standards for that condition. If the proposed treatment doesn't meet the criteria for being medically necessary, it won't be reimbursed by the payer.	https://www.covermymeds.health/articles/provider-insights/common-prior-authorization-hurdles-and-how-to-overcome-them
Medical necessity criteria not met	**Ref#9**	**1**	**services are not medically appropriate (47 percent)**		https://www.aafp.org/pubs/fpm/issues/2006/0600/p45.html
Medical necessity criteria not met	**Ref#11**	**1**	**Failure to Meet Medical Necessity Criteria**	Insurers assess whether the requested service is medically necessary according to their internal guidelines and clinical policies. If the submitted documentation does not clearly support the need for the treatment or fails to match the insurer's definition of medical necessity, the request may be denied.	https://staffingly.com/common-reasons-prior-authorization-gets-denied-in-healthcare/
Medical necessity criteria not met	**Ref#12**	**1**	**Failure to Meet Medical Necessity Criteria**	Insurance providers often deny prior authorizations if the requested service does not meet their criteria for medical necessity. Each insurance plan has its own guidelines regarding what constitutes medical necessity, and if the provider's request does not align with these criteria, the request is likely to be denied.	https://www.expedium.net/blog/top-reasons-for-prior-authorization-denials-and-how-to-avoid-them/
Medical necessity criteria not met	**Ref#13**	**1**	**Lack of medical necessity as per the insurer's criteria (Failure to Meet Medical Necessity Criteria)**	Insurance companies assess PA requests based on internal medical necessity guidelines. Denials occur when the insurer lacks clinical evidence supporting the requested treatment, and when step therapy requirements are not met (e.g., insurers require conservative treatments to fail before approving advanced interventions).	https://www.sprypt.com/blog/pre-authorization-denials-appeals
Medical necessity criteria not met	**Ref#14**	**1**	**Failure in proving Medical Necessity**	Payers usually deny the PA request if the requested services do not match medical necessity criteria. Each insurance sets its guidelines, which state what constitutes medical necessity. If the predefined criteria are not fulfilled, the provider's request is more likely to be denied.	https://stafgo.com/top-denial-reasons-for-prior-authorizations-and-how-to-prevent-them/
Medical necessity criteria not met	**Ref#15**	**1**	**lack of medical necessity represents 6% of denials**	Reason not provided	https://www.counterforcehealth.org/post/how-to-appeal-a-prior-authorization-denial-2025/
Medical necessity criteria not met	**Ref#16**	**1**	**The treatment was deemed medically unnecessary**		https://www.outsourcestrategies.com/blog/prior-authorization-denied/

References of Prior Authorization Denial Reasons by categories

Medical necessity criteria not met	**Ref#17**	**1**	**Treatment not deemed medically necessary**	This often stems from unclear evidence or a mismatch with plan requirements.	https://www.solace.health/articles/prior-authorization-denied
Medical necessity criteria not met	**Ref#19**	**1**	**medically necessary**		https://prognocis.com/best-practices-in-avoiding-prior-authorization-denials/
Medical necessity criteria not met	**Ref#21**	**1**	**Lack of Medical Necessity**	Insurance companies deny authorizations when they believe the requested service isn't medically necessary. If the submitted documentation doesn't clearly justify why the procedure or treatment is essential, you could face a denial. To avoid this, ensure your documentation paints a complete picture of the patient's condition. Include clear clinical notes, diagnostic results, and treatment history. Show why alternative treatments won't suffice and why the proposed procedure is critical.	https://xybermed.com/tag/what-are-the-most-common-reasons-for-prior-authorization-denials/
Medical necessity criteria not met	**Ref#22**	**1**	**The request was determined to be not medically necessary**	ensure the information submitted is detailed and clearly shows the medical necessity of the request (i.e., include all relevant medical records, clinical notes, past imaging, past treatment plans, labs, and X-rays, along with the specific current medical condition of the patient).	https://www.communitycarehealth.org/wp-content/uploads/2022/12/Why-A-Prior-Auth-Request-May-Not-Be-Approved_Winter2022.pdf
Medical necessity criteria not met	**Ref#24**	**1**	**Lack of medical need**	Pre-authorization may be refused if insurance companies deem the treatment or operation to not meet their criteria for medical necessity.	https://annexmed.com/comprehensive-guide-to-pre-authorization
Medical necessity criteria not met	**Ref#25**	**1**	**Not medically necessary**		https://referralmd.com/prior-authorization-problems-healthcare-2/
Medical necessity criteria not met	**Ref#26**	**1**	**Lack of Medical Necessity**	If the insurance company assesses that the proposed treatment is not medically appropriate or lacks support from evidence-based guidelines, the treatment may be denied.	https://zenmedinc.com/blog/prior-authorization-denials-in-healthcare/
Medical necessity criteria not met	**Ref#27**	**1**	**Lack of Medical Necessity (Medical)**	Reason not provided	https://www.uhcprovider.com/content/dam/provider/docs/public/prior-auth/utilization/IL-Prior-Auth-Statistics-2024.pdf
Medical necessity criteria not met	**Ref#27**	**1**	**Medical Necessity Criteria Not Met (Behavioral)**	Reason not provided	https://www.uhcprovider.com/content/dam/provider/docs/public/prior-auth/utilization/IL-Prior-Auth-Statistics-2024.pdf
Non-Covered Services or Exceeding Coverage Limits	**Ref#1**	**1**	**Recipient is no longer eligible for coverage OR Recipient not eligible on requested dates of**		https://www.medicaid.nv.gov/Downloads/provider/web_announcement_3712_20250904.pdf
Non-Covered Services or Exceeding Coverage Limits	**Ref#2**	**1**	**Plan Exclusions or Limitations**	The requested treatment may fall under a category that the insurance plan does not cover, either because it is considered experimental, investigational, or cosmetic, or because there are annual or lifetime limits that have already been reached.	https://www.gmlawyers.com/resources-and-info/prior-authorization-denials/
Non-Covered Services or Exceeding Coverage Limits	**Ref#3**	**1**	**Service is not covered**	Reason not provided	https://www.macpac.gov/wp-content/uploads/2024/08/Prior-Authorization-in-Medicaid.pdf
Non-Covered Services or Exceeding Coverage Limits	**Ref#4**	**1**	**Coverage denial-not a covered service (Ref#4 top 3)**	Reason not provided	https://es.aetna.com/content/dam/aetna/pdfs/aetnacom/health-care-professionals/2022-illinois-aetna-specialty-pharmacy-medical-prior-authorization-statistics.pdf
Non-Covered Services or Exceeding Coverage Limits	**Ref#6**	**1**	**Plan Coverage Limits**		https://datamatrixmedical.com/reasons-for-prior-authorization-denials/
Non-Covered Services or Exceeding Coverage Limits	**Ref#8**	**1**	**lack of coverage**		https://www.chbrp.org/sites/default/files/bill-documents/Prior%20Authorization_final.pdf
Non-Covered Services or Exceeding Coverage Limits	**Ref#9**	**1**	**service is a non-covered benefit (17 percent)**		https://www.aafp.org/pubs/fpm/issues/2006/0600/p45.html
Non-Covered Services or Exceeding Coverage Limits	**Ref#11**	**1**	**Non-Covered Services**	Denials often occur when the requested service or medication is not included in the patient's benefit plan. Even if the service is medically necessary, if it falls outside the covered services of the insurance policy, prior authorization approval will be denied.	https://staffingly.com/common-reasons-prior-authorization-gets-denied-in-healthcare/
Non-Covered Services or Exceeding Coverage Limits	**Ref#12**	**1**	**Exceeding the Scope of the Approved Authorization**	If a prior authorization is granted for a specific service or number of visits, exceeding this scope can lead to denials of subsequent claims.	https://www.expedium.net/blog/top-reasons-for-prior-authorization-denials-and-how-to-avoid-them/
Non-Covered Services or Exceeding Coverage Limits	**Ref#14**	**1**	**Service Not Covered by Plan**	PA requests are sometimes denied because the requested service or procedure is not included in the patient's insurance coverage. There are different scenarios for that, like the patients reach the frequency limit for a particular service, or the service requires specific conditions to be met, etc.	https://stafgo.com/top-denial-reasons-for-prior-authorizations-and-how-to-prevent-them/
Non-Covered Services or Exceeding Coverage Limits	**Ref#15**	**1**	**Excluded services represent 16% of denials**	Reason not provided	https://www.counterforcehealth.org/post/how-to-appeal-a-prior-authorization-denial-2025/
Non-Covered Services or Exceeding Coverage Limits	**Ref#18**	**1**	**Wrong benefit submitted (Medical vs Pharmacy)**		https://www.spravatohcp.com/files/Prior_Authorization_Toolkit.pdf
Non-Covered Services or Exceeding Coverage Limits	**Ref#21**	**1**	**Policy Exclusions**	Sometimes, the service or treatment you're seeking prior authorization for simply isn't covered by the patient's insurance plan. These policy exclusions can lead to automatic denials. To avoid this, always verify the patient's coverage before submitting a request.	https://xybermed.com/tag/what-are-the-most-common-reasons-for-prior-authorization-denials/

References of Prior Authorization Denial Reasons by categories

Non-Covered Services or Exceeding Coverage Limits	**Ref#21**	**1**	**Unverified Insurance Benefits**	Submitting a prior authorization request without verifying the patient's insurance eligibility or benefits can lead to denials. If the service isn't covered under the patient's plan, the insurer will reject it.	https://xybermed.com/tag/what-are-the-most-common-reasons-for-prior-authorization-denials/
Non-Covered Services or Exceeding Coverage Limits	**Ref#22**	**1**	**It is not a covered benefit**		https://www.communitycarehealth.org/wp-content/uploads/2022/12/Why-A-Prior-Auth-Request-May-Not-Be-Approved_Winter2022.pdf
Non-Covered Services or Exceeding Coverage Limits	**Ref#24**	**1**	**Policy exclusions**	There are some drug, treatment, and procedure pre-authorization requests that insurance companies will most likely be rejected due to their specific exclusions.	https://annexmed.com/comprehensive-guide-to-pre-authorization
Non-Covered Services or Exceeding Coverage Limits	**Ref#24**	**1**	**Benefit limitations**	Certain insurance plans have limitations on the number of times a particular service can be authorized within a specific timeframe. Pre-authorization requests exceeding these limitations may be denied.	https://annexmed.com/comprehensive-guide-to-pre-authorization
Non-Covered Services or Exceeding Coverage Limits	**Ref#26**	**1**	**Plan Coverage Limits and Non-Formulary Issues**		https://zenmedinc.com/blog/prior-authorization-denials-in-healthcare/
Non-Covered Services or Exceeding Coverage Limits	**Ref#26**	**1**	**Non-covered benefits**	Certain procedures or medications may not be included under the specific insurance plan coverage.	https://zenmedinc.com/blog/prior-authorization-denials-in-healthcare/
Non-Covered Services or Exceeding Coverage Limits	**Ref#27**	**1**	**Non covered services/benefit exclusions (Medical)**	Reason not provided	https://www.uhcprovider.com/content/dam/provider/docs/public/prior-auth/utilization/IL-Prior-Auth-Statistics-2024.pdf
Non-Covered Services or Exceeding Coverage Limits	**Ref#27**	**1**	**Excluded Service (Behavioral)**	Reason not provided	https://www.uhcprovider.com/content/dam/provider/docs/public/prior-auth/utilization/IL-Prior-Auth-Statistics-2024.pdf
Non-Covered Services or Exceeding Coverage Limits	**Ref#13**	**1**	**Exceeding Plan Coverage Limits**	Insurance policies often impose limits on medications, treatments, and procedures, which can lead to denials if these limits are exceeded. For example, physical therapy visits may be denied once the allotted number of sessions is reached. Additionally, step therapy rules may require your patients to try generic drugs before being approved for brand-name medications. Some policies also enforce quantity limits, which can restrict access to prescribed medications.	https://www.sprypt.com/blog/pre-authorization-denials-appeals
Non-Formulary Medications	**Ref#6**	**1**	**Non-Formulary Medications (Ref#6 top 5)**	medications are not included in the insurance company's approved list of covered drugs. When a prescribed medication is non-formulary, the insurer may deny the request. Insurers may also require additional justification or an alternative medication to be considered.	https://datamatrixmedical.com/reasons-for-prior-authorization-denials/
Non-Formulary Medications	**Ref#7**	**1**	**PRESCRIBED MEDICATIONS ARE NON-FORMULARY**	If a medication is not included in the insurance company's approved list of covered drugs, the prior auth request for the prescription will be denied.	https://www.covermymeds.health/articles/provider-insights/common-prior-authorization-hurdles-and-how-to-overcome-them
Non-Formulary Medications	**Ref#17**	**1**	**Use of non-formulary medication**	A prescribed drug may not be on your insurance plan's approved list.	https://www.solace.health/articles/prior-authorization-denied
Non-Formulary Medications	**Ref#26**	**1**	**Non-formulary medications**	If a medication is not listed on the insurance company's preferred formulary, it may necessitate prior authorization or face denial.	https://zenmedinc.com/blog/prior-authorization-denials-in-healthcare/
Non-Formulary Medications	**Ref#27**	**1**	**Non-Form (Rx)**	Reason not provided	https://www.uhcprovider.com/content/dam/provider/docs/public/prior-auth/utilization/IL-Prior-Auth-Statistics-2024.pdf
Out-of-Network Providers	**Ref#24**	**1**	**Out-of-network providers**	Pre-authorizations may be rejected if a patient receives care from a doctor or hospital outside their insurance plan's network.	https://annexmed.com/comprehensive-guide-to-pre-authorization
Out-of-Network Providers	**Ref#2**	**1**	**Out-of-Network Providers**	Some plans limit coverage to in-network doctors and facilities. If a procedure is requested through an out-of-network provider, the insurer may deny the authorization based on lack of coverage.	https://www.gmlawyers.com/resources-and-info/prior-authorization-denials/
Out-of-Network Providers	**Ref#6**	**1**	**Out-of-Network Provider**		https://datamatrixmedical.com/reasons-for-prior-authorization-denials/
Out-of-Network Providers	**Ref#11**	**1**	**Out-of-Network Providers**	If the healthcare provider is not in-network with the patient's insurance plan, prior authorization requests may be denied, even if the service itself would otherwise be covered. Many insurance plans require patients to seek care from approved network providers unless special exceptions are granted.	https://staffingly.com/common-reasons-prior-authorization-gets-denied-in-healthcare/
Out-of-Network Providers	**Ref#12**	**1**	**Out-of-Network Providers**	Using an out-of-network provider can also lead to prior authorization denials. Many insurance plans require patients to use in-network providers to receive full benefits. If a prior authorization request is made for an out-of-network provider without the proper justification or without exploring in-network options, it may be denied.	https://www.expedium.net/blog/top-reasons-for-prior-authorization-denials-and-how-to-avoid-them/
Out-of-Network Providers	**Ref#13**	**1**	**Limitations due to out-of-network providers (Use of Out-of-Network Providers or Services)**	Many insurers do not cover PA requests if providers or services are outside their network. This affects specialists not contracted with the insurance plan, and imaging or surgical centers outside authorized networks. Rehabilitation services are not covered under the plan.	https://www.sprypt.com/blog/pre-authorization-denials-appeals

References of Prior Authorization Denial Reasons by categories

Out-of-Network Providers	**Ref#14**	**1**	**Out-of-Network Providers**	When a Prior Authorization request for a particular service is submitted to the insurance company by a provider who is not in the patient's insurance network, it can also lead to prior authorization denials. As per the Insurance policies, patients have to use in-network providers to receive full benefits, but if a prior authorization request is made for an out-of-network provider without the proper justification, it could be denied.	https://stafgo.com/top-denial-reasons-for-prior-authorizations-and-how-to-prevent-them/
Out-of-Network Providers	**Ref#17**	**1**	**Out-of-network provider**	Your insurance might not cover services from providers outside their preferred network.	https://www.solace.health/articles/prior-authorization-denied
Out-of-Network Providers	**Ref#18**	**1**	**Specialty pharmacy (SP) is out of network**		https://www.spravatohcp.com/files/Prior_Authorization_Toolkit.pdf
Out-of-Network Providers	**Ref#21**	**1**	**Out-of-Network Providers**	When services are provided by out-of-network healthcare professionals, insurance companies may deny authorization outright. Insurers often have agreements with specific providers, and using someone outside their network can mean the service won't be covered.	https://xybermed.com/tag/what-are-the-most-common-reasons-for-prior-authorization-denials/
Out-of-Network Providers	**Ref#22**	**1**	**Out-Of-Network (OON)**		https://www.communitycarehealth.org/wp-content/uploads/2022/12/Why-A-Prior-Auth-Request-May-Not-Be-Approved_Winter2022.pdf
Out-of-Network Providers	**Ref#23**	**1**	**Network Provider**	Many insurance companies have network agreements with specific providers, so out-of-network care may result in a denied claim.	https://portiva.com/how-to-appeal-a-prior-authorization-denial/
Out-of-Network Providers	**Ref#26**	**1**	**Out-of-Network Providers**	Utilizing providers who are not within the patient's insurance network may necessitate prior authorization or result in denial of the request.	https://zenmedinc.com/blog/prior-authorization-denials-in-healthcare/
Out-of-Network Providers	**Ref#27**	**1**	**No out-of-network benefits (Medical)**	Reason not provided	https://www.uhcprovider.com/content/dam/provider/docs/public/prior-auth/utilization/IL-Prior-Auth-Statistics-2024.pdf
Prior authorization timelines not met, including expired authorization or duplicate requests	**Ref#1**	**1**	**Late notification; prior authorization timelines not met**	Prior authorization was submitted outside of timely filing rules	https://www.medicaid.nv.gov/Downloads/provider/web_announcement_3712_20250904.pdf
Prior authorization timelines not met, including expired authorization or duplicate requests	**Ref#2**	**1**	**Failure to Follow Prior Authorization Procedures**	If the provider or patient did not follow the insurer's preauthorization rules — for example, by proceeding with treatment before approval — the insurer can issue a denial based purely on procedural grounds.	https://www.gmlawyers.com/resources-and-info/prior-authorization-denials/
Prior authorization timelines not met, including expired authorization or duplicate requests	**Ref#5**	**1**	**Administrative errors**	The request was not submitted, was submitted late, was submitted to the wrong insurance company, or the authorization expired before the medicine was picked up at the pharmacy.	https://www.abbvie.com/content/dam/abbvie-com2/pdfs/prior-authorization-fact-sheet.pdf
Prior authorization timelines not met, including expired authorization or duplicate requests	**Ref#6**	**1**	**Lack of Prior Authorization Request (Ref#6 top 3)**	**Lack of prior authorization requests/duplicate requests** creates denials because it creates confusion and disrupts the authorization process. Insurance companies may (more often than not) only cover the procedure or medication with prior authorization. Similarly, duplicate requests can cause delays as insurers may need to verify whether the request is new or a repeat of an already approved or denied request, often resulting in unnecessary denials or additional administrative work to resolve the issue.	https://datamatrixmedical.com/reasons-for-prior-authorization-denials/
Prior authorization timelines not met, including expired authorization or duplicate requests	**Ref#6**	**1**	**Duplicate Requests (Ref#6 top 4)**	**Lack of prior authorization requests/duplicate requests** creates denials because it creates confusion and disrupts the authorization process. Insurance companies may (more often than not) only cover the procedure or medication with prior authorization. Similarly, duplicate requests can cause delays as insurers may need to verify whether the request is new or a repeat of an already approved or denied request, often resulting in unnecessary denials or additional administrative work to resolve the issue.	https://datamatrixmedical.com/reasons-for-prior-authorization-denials/
Prior authorization timelines not met, including expired authorization or duplicate requests	**Ref#7**	**1**	**PROCEDURAL ERRORS**	A health plan may require a prior auth request for a particular non-emergency test. If the patient completes the test before it's been approved, the payer can deny payment — even if the test was really needed.	https://www.covermymeds.health/articles/provider-insights/common-prior-authorization-hurdles-and-how-to-overcome-them
Prior authorization timelines not met, including expired authorization or duplicate requests	**Ref#10**	**1**	**Procedural Errors**	Certain medical procedures and diagnostic tests require prior authorization before they are performed. Failure to secure approval beforehand can result in claim denials.	https://sunknowledge.com/understanding-the-common-prior-authorization-hurdles-and-how-to-overcome-them/
Prior authorization timelines not met, including expired authorization or duplicate requests	**Ref#11**	**1**	**No Prior Authorization Obtained**	Failure to obtain prior authorization before delivering a non-emergency service often results in retrospective denial. In such cases, insurers deny claims because the necessary pre-approval step was skipped. Emergency services are typically exempt from this requirement, but elective procedures are not.	https://staffingly.com/common-reasons-prior-authorization-gets-denied-in-healthcare/
Prior authorization timelines not met, including expired authorization or duplicate requests	**Ref#11**	**1**	**Authorization Expired**	Prior authorization approvals are generally valid for a specific time period. If the service is not performed within the approved window, or if the provider does not seek a timely extension, the authorization can expire. Expired authorizations lead to denial of the associated claims.	https://staffingly.com/common-reasons-prior-authorization-gets-denied-in-healthcare/
Prior authorization timelines not met, including expired authorization or duplicate requests	**Ref#11**	**1**	**Duplicate Requests**	Submitting multiple prior authorization requests for the same service without addressing previous denials can result in automatic rejection. Insurance carriers track duplicate submissions and expect providers to resolve or appeal previous decisions before resubmitting.	https://staffingly.com/common-reasons-prior-authorization-gets-denied-in-healthcare/

References of Prior Authorization Denial Reasons by categories

Prior authorization timelines not met, including expired authorization or duplicate requests	**Ref#12**	**1**	**Lack of Pre-Authorization for Required Services**	Certain services, such as imaging tests, surgeries, or specialty medications, often require prior authorization. Failing to obtain pre-authorization before these services are rendered can lead to a denial.	https://www.expedium.net/blog/top-reasons-for-prior-authorization-denials-and-how-to-avoid-them/
Prior authorization timelines not met, including expired authorization or duplicate requests	**Ref#12**	**1**	**Timely Filing Issues**	Insurance companies typically have strict timelines for submitting prior authorization requests and related documentation. Missing these deadlines can result in automatic denials.	https://www.expedium.net/blog/top-reasons-for-prior-authorization-denials-and-how-to-avoid-them/
Prior authorization timelines not met, including expired authorization or duplicate requests	**Ref#14**	**1**	**Expired Authorization or Timing Issues**	Insurance companies set a specific timeline to submit prior authorization requests and related documents. Submitting late or early or using an expired authorization can lead to denials of the request.	https://stafgo.com/top-denial-reasons-for-prior-authorizations-and-how-to-prevent-them/
Prior authorization timelines not met, including expired authorization or duplicate requests	**Ref#15**	**1**	**missing prior authorization or referral accounts for 9% of denials**	Reason not provided	https://www.counterforcehealth.org/post/how-to-appeal-a-prior-authorization-denial-2025/
Prior authorization timelines not met, including expired authorization or duplicate requests	**Ref#21**	**1**	**Duplicate Requests**	Duplicate prior authorization requests can confuse insurers and lead to unnecessary denials.	https://xybermed.com/tag/what-are-the-most-common-reasons-for-prior-authorization-denials/
Prior authorization timelines not met, including expired authorization or duplicate requests	**Ref#21**	**1**	**Invalid or Expired Authorization**	Even after receiving authorization, it's crucial to ensure that the approval remains valid. Authorizations often come with expiration dates or are tied to specific timelines. If the procedure is delayed beyond this period, the authorization can become invalid.	https://xybermed.com/tag/what-are-the-most-common-reasons-for-prior-authorization-denials/
Prior authorization timelines not met, including expired authorization or duplicate requests	**Ref#23**	**1**	**Procedural Errors**	a non-emergency test is only paid if done after PA approval, regardless of necessity.	https://portiva.com/how-to-appeal-a-prior-authorization-denial/
Prior authorization timelines not met, including expired authorization or duplicate requests	**Ref#24**	**1**	**Requirements for prior authorization**	The insurance may deny coverage if pre-authorization is not obtained before obtaining the service, since the insurance may decide that it is not covered after the service is rendered.	https://annexmed.com/comprehensive-guide-to-pre-authorization
Prior authorization timelines not met, including expired authorization or duplicate requests	**Ref#24**	**1**	**Guidelines not followed**	Pre-authorization requests that don't follow the insurer's specific rules and requirements are probably going to be turned down.	https://annexmed.com/comprehensive-guide-to-pre-authorization
Prior authorization timelines not met, including expired authorization or duplicate requests	**Ref#26**	**1**	**Administrative Errors**	Not obtaining prior authorization before the procedure or treatment can result in a denial.	https://zenmedinc.com/blog/prior-authorization-denials-in-healthcare/
Prior authorization timelines not met, including expired authorization or duplicate requests	**Ref#21**	**1**	**Missed Deadlines**	Missing a submission deadline or failing to respond promptly to insurer inquiries is a common reason for denials.	https://xybermed.com/tag/what-are-the-most-common-reasons-for-prior-authorization-denials/
THE REQUESTED THERAPY REQUIRES MULTIPLE PRIOR AUTH REQUESTS	**Ref#7**	**1**	**THE REQUESTED THERAPY REQUIRES MULTIPLE PRIOR AUTH REQUESTS**	Prior auth requests are often denied when a prescribed device isn't covered by pharmacy benefits, which means that a prior auth request must be submitted to the patient's medical benefits. For example, while a prescription for insulin may be covered by pharmacy benefits, other items, such as a continuous glucose monitor (CGM) and an insulin pump, should also be covered under the patient's medical benefits. These devices themselves often have multiple components, like a sensor and a transmitter in two separate prescriptions, which can only be approved if prescribed in conjunction with one another. In other cases, relatively inexpensive items like test strips and hypodermics may be fully covered and free to the patient if they have a prescription but must be paid for in full by the patient without one. In cases like these, multiple prior auth requests must be submitted — for instance, one to pharmacy benefits and another to medical benefits.	https://www.covermymeds.health/articles/provider-insights/common-prior-authorization-hurdles-and-how-to-overcome-them
THE REQUESTED THERAPY REQUIRES MULTIPLE PRIOR AUTH REQUESTS	**Ref#10**	**1**	**Multiple Prior Authorization Requests for a Single Treatment**	Some treatments require separate prior authorization requests for pharmacy and medical benefits	https://sunknowledge.com/understanding-the-common-prior-authorization-hurdles-and-how-to-overcome-them/
THE REQUESTED THERAPY REQUIRES MULTIPLE PRIOR AUTH REQUESTS	**Ref#23**	**1**	**Requested Treatment or Apparatus Not Being Covered**	A common reason for PA denial is that pharmacy benefits don't cover the required treatments or devices. For example, a pharmacy benefit may cover the costs of prescription drugs, but the operative equipment will not be covered. You'll need two PAs: one for pharmacy benefits and another for medical benefits to cover the device costs.	https://portiva.com/how-to-appeal-a-prior-authorization-denial/
	Ref#1	**1**	**Invalid preauthorization request form submitted**		https://www.medicaid.nv.gov/Downloads/provider/web_announcement_3712_20250904.pdf
	Ref#4	**1**	**Other coverage primary (Ref#4 top 5)**	Reason not provided	https://es.aetna.com/content/dam/aetna/pdfs/aetnacom/health-care-professionals/2022-illinois-aetna-specialty-pharmacy-medical-prior-authorization-statistics.pdf
	Ref#6	**1**	**Administrative Errors**		https://datamatrixmedical.com/reasons-for-prior-authorization-denials/

References of Prior Authorization Denial Reasons by categories

	Ref#6	1	Non-Compliance with Payer Policies		https://datamatrixmedical.com/reasons-for-prior-authorization-denials/
	Ref#6	1	Pre-existing Condition Exclusion		https://datamatrixmedical.com/reasons-for-prior-authorization-denials/
	Ref#7	1	COST MANAGEMENT	Health plans strive to help patients access the medications they need, while managing costs responsibly. This may involve prior auth requirements that encourage the use of equally effective, lower-cost alternatives, such as generics.	https://www.covermymeds.health/articles/provider-insights/common-prior-authorization-hurdles-and-how-to-overcome-them
	Ref#11	1	Lack of Peer-to-Peer Review	In certain cases, insurance companies offer a peer-to-peer review opportunity where the requesting physician can directly discuss the case with a medical director. If the provider does not participate in this process when required, the denial may be upheld without further consideration.	https://staffingly.com/common-reasons-prior-authorization-gets-denied-in-healthcare/
	Ref#15	1	other unspecified reasons making up 34% of all denial cases	Reason not provided	https://www.counterforcehealth.org/post/how-to-appeal-a-prior-authorization-denial-2025/
	Ref#18	1	the prescribing physician's qualifications		https://www.spravatohcp.com/files/Prior_Authorization_Toolkit.pdf
	Ref#19	1	cost-effective treatment		https://prognocis.com/best-practices-in-avoiding-prior-authorization-denials/
	Ref#23	1	Cost Management of Services	Not all health care covers services and every expense under its policies. the less expensive treatment is more likely favored by the health care insurance company.	https://portiva.com/how-to-appeal-a-prior-authorization-denial/
	Ref#25	1	Experimental-not on compendium listing/guideline		https://referralmd.com/prior-authorization-problems-healthcare-2/
	Ref#25	1	Experimental-not on FDA label		https://referralmd.com/prior-authorization-problems-healthcare-2/
	Ref#25	1	Experimental-not on required pathway		https://referralmd.com/prior-authorization-problems-healthcare-2/
	Ref#25	1	other		https://referralmd.com/prior-authorization-problems-healthcare-2/
	Ref#27	1	Treatment is not consistent with published clinical evidence (Medical)	Reason not provided	https://www.uhcprovider.com/content/dam/provider/docs/public/prior-auth/utilization/IL-Prior-Auth-Statistics-2024.pdf
	Ref#27	1	Clinical and Site Declined (Medical)	Reason not provided	https://www.uhcprovider.com/content/dam/provider/docs/public/prior-auth/utilization/IL-Prior-Auth-Statistics-2024.pdf
	Ref#27	1	Behavioral clinical policies (Behavioral)	Reason not provided	https://www.uhcprovider.com/content/dam/provider/docs/public/prior-auth/utilization/IL-Prior-Auth-Statistics-2024.pdf
	Ref#27	1	Supplemental clinical criteria (Behavioral)	Reason not provided	https://www.uhcprovider.com/content/dam/provider/docs/public/prior-auth/utilization/IL-Prior-Auth-Statistics-2024.pdf
	Ref#27	1	PA Denial (Rx)	Reason not provided	https://www.uhcprovider.com/content/dam/provider/docs/public/prior-auth/utilization/IL-Prior-Auth-Statistics-2024.pdf
	Ref#27	1	Qty Limit (Rx)	Reason not provided	https://www.uhcprovider.com/content/dam/provider/docs/public/prior-auth/utilization/IL-Prior-Auth-Statistics-2024.pdf
	Ref#27	1	Appeal Uphold (Rx)	Reason not provided	https://www.uhcprovider.com/content/dam/provider/docs/public/prior-auth/utilization/IL-Prior-Auth-Statistics-2024.pdf
		167			

1. Incomplete or Incorrect Information		48
2. Medical necessity criteria not met		23
3. Non-covered services or exceeding coverage limits		22
4. Prior authorization timelines not met		21
5. Out-of-network providers		14
6. Lack of step therapy/testing attempts		9
7. Non-formulary medications		5

8. The requested therapy requires multiple prior authorization requests		3
9. Others		22
		167

PRIOR AUTHORIZATION METRICS REPORTING – OVERVIEW & TEMPLATE

To comply with the Centers for Medicare & Medicaid Services (CMS) Interoperability and Prior Authorization final rule, starting in 2026 impacted payers — Medicare Advantage (MA) organizations, state Medicaid and Children's Health Insurance Program (CHIP) fee-for-service (FFS) programs, Medicaid managed care plans, CHIP managed care entities, and Qualified Health Plan (QHP) issuers on the Federally Facilitated Exchanges (FFEs) — must publicly report certain prior authorization metrics from the previous calendar year on their websites.

While not required, we encourage payers to present metrics in a clear, visual format, such as bar charts or pie charts. We highly recommend reporting both counts and percentages so the public can understand the scope of requests. An example is included in the template below.

Metrics to be publicly reported on an impacted payer's website:

- A list of all medical items and services that require prior authorization (**excluding** drugs).
- For standard prior authorization requests, aggregated for all items and services:
  1. Percentage approved in the calendar year
  2. Percentage denied in the calendar year
  3. Percentage approved in the calendar year after appeal
     Note: This should be a subset of the total number of standard prior authorization requests appealed.
  4. The average (mean) and median response times that elapsed between the submission of a request and a determination by the payer
     Note: This should be measured from the time the payer receives the request, not when it is sent by the provider.
- For expedited prior authorization requests, aggregated for all items and services:
  1. Percentage approved in the calendar year
  2. Percentage denied in the calendar year
  3. Percentage approved in the calendar year after appeal
     Note: This is an **optional** metric and should be a subset of the total number of expedited prior authorization requests appealed.
  4. The average (mean) and median response times that elapsed between the submission of a request and a determination by the payer
     Note: This should be measured from the time the payer receives the request, not when it is sent by the provider.
- The percentage of requests where the timeframe for review was extended, per programmatic rules,[1] and the request was approved.
  Note: Though such a breakout is **optional**, CMS highly recommends differentiating between standard requests that were extended and approved and expedited requests that were extended and approved.

Note: We provide recommended denominators for these metrics in the template below.

Reporting levels:

- Metrics should be reported separately for each line of business:
  - MA organizations: report at the MA contract level
  - State Medicaid and CHIP FFS programs: report at the state level
  - Medicaid managed care plans and CHIP managed care entities: report at the plan level
  - QHP issuers on FFEs: report at the issuer level

Additional resources on prior authorization reporting requirements can be found here.

Reporting format:

While the below template is not required, we encourage payers to present data visually. Should impacted payers choose to use this template, they should replace the sample data with their own data before posting to their websites.

REFERENCES

1. For MA plans, per 42 CFR 422.568(b)(2) and 42 CFR 422.572(b), standard and expedited requests may be extended for up to 14 days under certain circumstances.

   For applicable integrated plans, per 42 CFR 422.631(d)(2)(ii), standard and expedited requests may be extended for up to 14 days under certain circumstances.

   For state Medicaid FFS programs, per 42 CFR 440.230(e)(1)(i), beginning in 2026, standard requests may be extended for up to 14 days under certain circumstances.

   For Medicaid managed care plans, per 42 CFR 438.210(d), standard and expedited requests may be extended for up to 14 days under certain circumstances.

   For state CHIP FFS programs, per 42 CFR 457.495(d), standard and expedited requests may be extended for up to 14 days under certain circumstances.

   For CHIP managed care entities, per 42 CFR 457.1230(d), standard and expedited requests may be extended for up to 14 days under certain circumstances.

PRIOR AUTHORIZATION METRICS FOR MEDICAL ITEMS AND SERVICES (EXCLUDING DRUGS)

To comply with the CMS Interoperability and Prior Authorization final rule, [Enter Organization Name] is required to annually report aggregated prior authorization metrics on our website. Specifically, this includes a list of all medical items and services (excluding drugs) that require prior authorization, as well as data on prior authorization requests for those items and services (e.g., approvals, denials, etc.) over the previous calendar year. Publicly reporting these metrics promotes transparency and accountability, helps patients understand prior authorization processes, and enables providers to evaluate payer performance. In addition, metrics can be used to compare plans, programs, and payers. For questions on the data below, contact: [enter contact information].

Reporting Period: [Enter reporting year]

These are the medical items and services for which we require prior authorization (excluding drugs)

Insert a list of, or link to, all medical items and services that require prior authorization (excluding drugs)

Prior to January 1, 2026, impacted payers are required to send prior authorization decisions within the following timeframes:

- For MA plans and applicable integrated plans, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)
- For state CHIP FFS programs, 14 days for **standard requests** (non-urgent)
- For Medicaid managed care plans and CHIP managed care entities, 72 hours for **expedited requests** (urgent) and 14 calendar days for **standard requests** (non-urgent)
- For QHP issuers on the FFEs, 72 hours for **expedited requests** (urgent) and 15 days for **standard requests** (non-urgent)

There are no Medicaid FFS program required timeframes for either type of prior authorization request prior to January 1, 2026, and there are no CHIP FFS program required decision timeframes for expedited prior authorization requests prior to January 1, 2026.

Beginning January 1, 2026, the CMS Interoperability and Prior Authorization final rule requires [MA plans, state Medicaid agencies, Medicaid managed care plans, state CHIP agencies, CHIP managed care entities] to send prior authorization decisions within:

- 72 hours for **expedited requests** (urgent)
- 7 calendar days for **standard requests** (non-urgent)

Standard (non-urgent) Prior Authorization Requests

	How many times this happened	Out of total requests	Percentage
Request approved	40,000	50,000	80%
Request denied	10,000	50,000	20%

	How many times this happened	Out of total requests	Percentage
(optional) Request approved with 7 days	29,500	50,000	59%
(optional) Request denied within 7 days	5,500	50,000	11%

	How many times this happened	Out of total requests	Percentage
Request approved only after time for review was extended*	7,500	50,000	15%
(optional) Request denied after time for review was extended	2,500	50,000	5%

	How many times this happened	Out of total appeals	Percentage
Request approved only after appeal	3,000	5,000	60%
(optional) Request denied after appeal	2,000	5,000	40%

Expedited (urgent) Prior Authorization Requests

(Response Due to Provider Within 72 Hours)

	How many times this happened	Out of total requests	Percentage
Request approved			
Request denied			

	How many times this happened	Out of total requests	Percentage
(optional) Request approved with 72 hours			
(optional) Request denied within 72 hours			

	How many times this happened	Out of total requests	Percentage
Request approved only after time for review was extended*			
(optional) Request denied after time for review was extended			

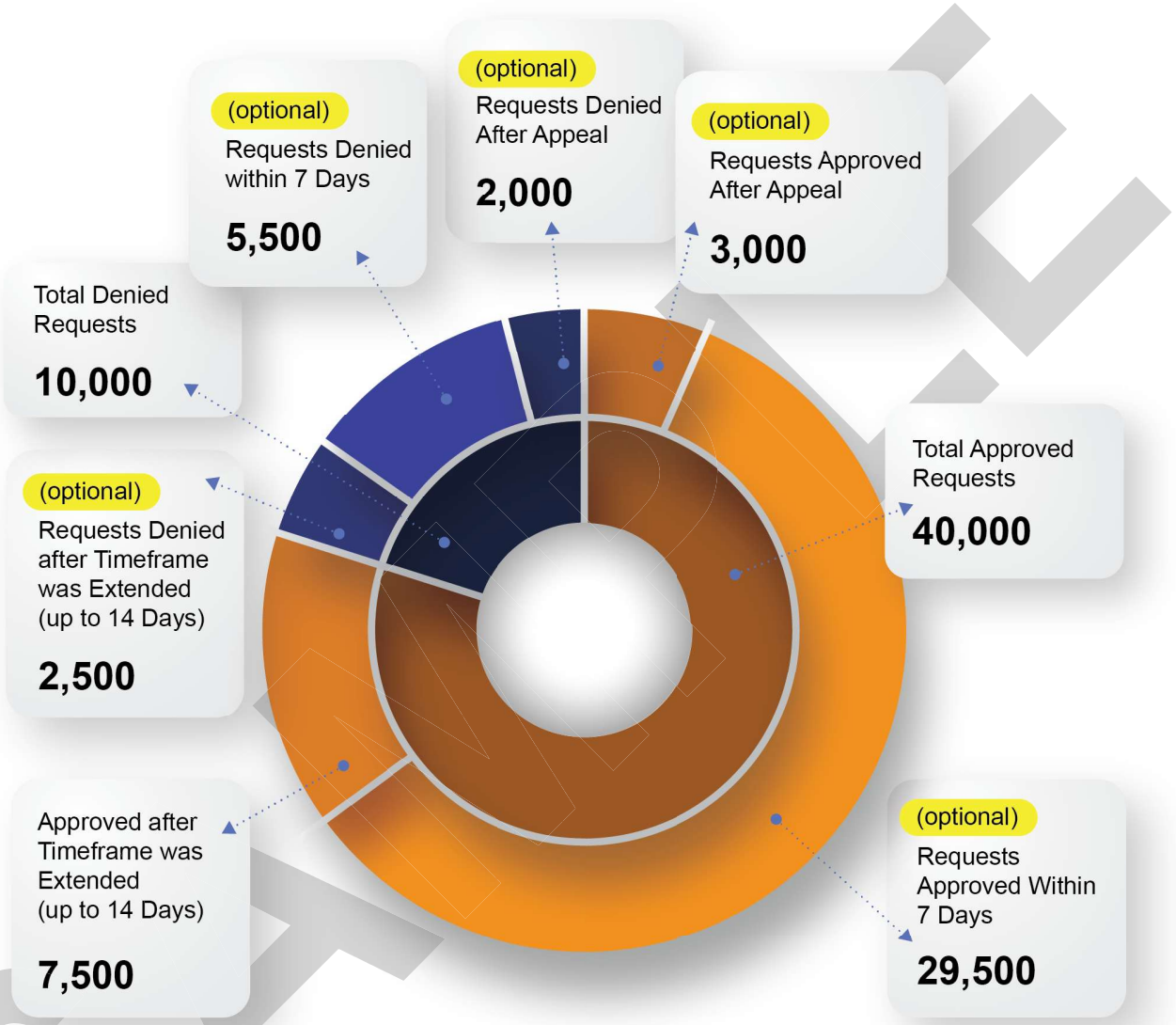
*As noted on the first page of this template, it is **optional** to report this metric separately for standard prior authorizations and expedited prior authorizations.

	How many times this happened	Out of total appeals	Percentage
(optional) Request approved only after appeal			
(optional) Request denied after appeal			

Time Between Receiving a Prior Authorization Request and Sending a Decision

	Mean (Average) Time	Median (Middle) Time
Standard (non-urgent) Prior Authorization Requests (response due to provider within 7 calendar days)	5 days	4 days
Expedited (urgent) Prior Authorization Requests (response due to provider within 72 hours)	1 day	1 day

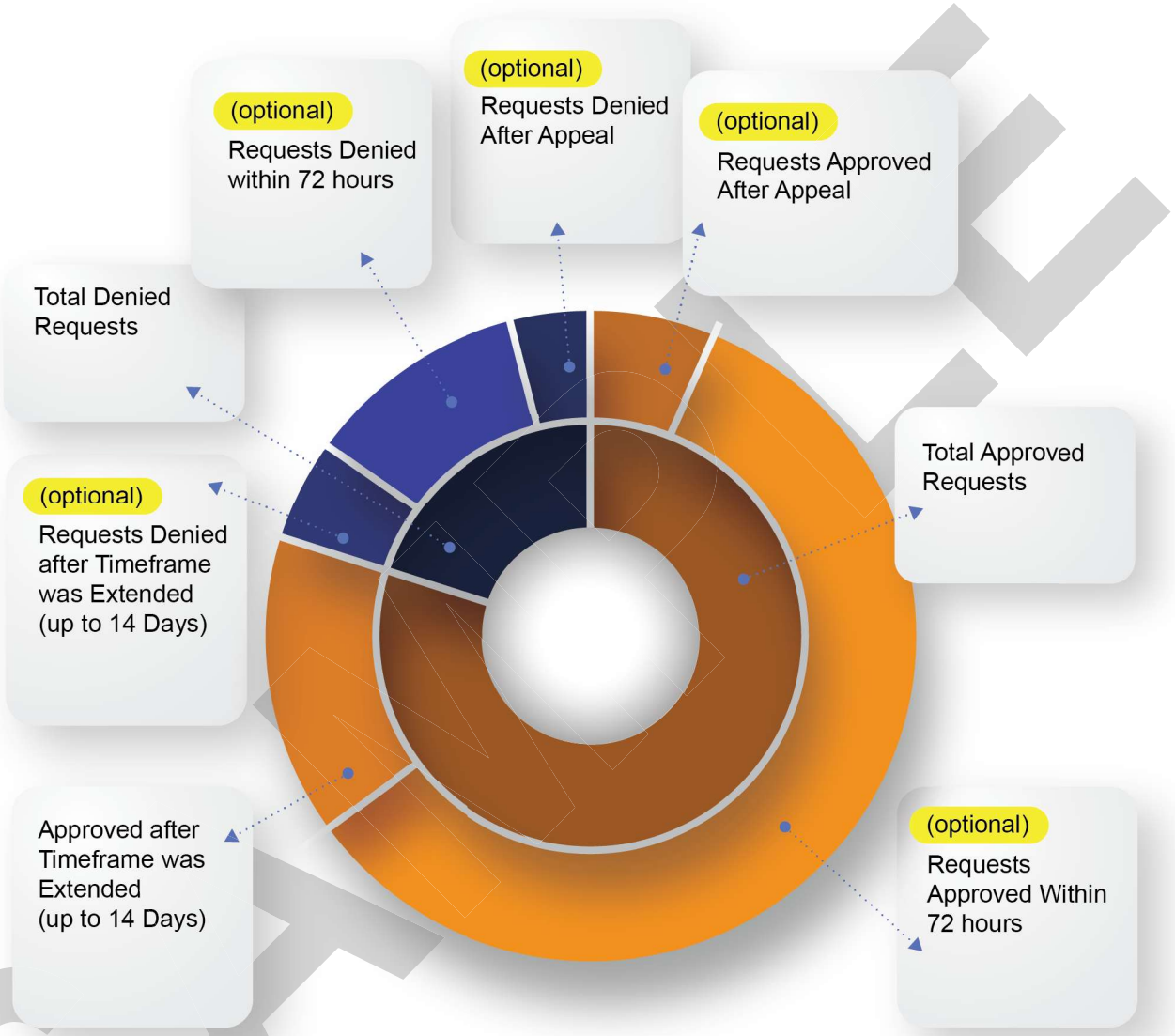
In 2024, we received a total of 50,000 standard (non-urgent) prior authorization requests for our covered patients. 80% of those requests were approved:



The mean (average) time that it took to make standard prior authorization decisions was **5 days**

The median (middle) time that it took to make standard prior authorization decisions was **4 days**

In YEAR, we received a total of XXXXX expedited (urgent) prior authorization requests for our covered patients. XX% of those requests were approved:



The mean (average) time that it took to make expedited prior authorization decisions was **X day(s)**

The median (middle) time that it took to make expedited prior authorization decisions was **X day(s)**

QUEST Integration Program

Prior Authorizations Medical Report

Health Plan Submission Information

Health Plan Name: _____ Report Date: _____

Reporting Period: _____

If Resubmission,
Date Submitted: _____

Integrated Report Template(s)


PAM_Report_MLDF_T emplate_Rel04.25.xlsx


PAM_Report_MLDF_T emplate_Rel04.25.xlsx

Section I: Aggregate Prior Authorizations Data

The Health Plan shall use the following embedded Procedural Code worksheet to notate the CPT/HCPCS codes for which the Health Plans require prior authorization for each service category. The Health Plan shall add any additional CPT codes, if applicable, to each category.


PAM_Procedural Code Worksheet_Rel0


PAM_Procedural Code Worksheet_Rel0

Total Number of CPT/HCPCS codes requiring prior authorization	

Provide a short qualitative summary on any changes to the Health Plans prior authorization program in the past reporting period. Examples include the removal or addition of services.

The Health Plan shall use the integrated Report Template to provide aggregate and summary data on prior authorizations in the ALDF tabs:

Median weekly number and range of prior authorization requests received from providers not exempt from prior authorizations

Median Weekly Number of prior authorizations for all providers	
Range (min-max) of Weekly Number of prior authorizations for all providers	

Section II: Member-level Data File

The Health Plan shall use the integrated Report Template to report on member level data.

Section III: Prior Authorizations Procedures

1. In the next three questions, the Health Plan shall describe efforts it has engaged in to collaborate with other Health Plans contracted with DHS in the development and implementation of an innovative and streamlined UM/prior authorization protocol for providers.

A. Describe below any meeting dates/frequency, action items, and future plans.

B. Describe any progress made to date and/or plans for innovative and streamlined prior authorizations request forms/portals, procedures, and reviewing processes.

C. Describe how the efforts described above are envisioned to help to alleviate the burden of prior authorization processes on the provider.

2. Does the Health Plan have a prior authorization committee to evaluate PA requirements? YES ☐ NO ☐

2.a How often does the committee convene?

2.b. Describe any changes to prior authorizations processes and procedures that the Health Plan implemented during the reporting period.

3. Does the Health Plan have an electronic prior authorization portal/process for <u>all</u> providers to identify and submit prior authorization requests? YES ☐ NO ☐

3.a. Describe the electronic prior authorization portal/process for providers to identify and submit prior authorizations and any upgrades or changes the Health Plan is planning or actively implementing. If the Health Plan does not have an ePA, describe any efforts the Health Plan engaged in during the reporting period to implement such a program, and provide an estimated timeline for implementation:

	YES	NO
4. Does the Health Plan have a program to eliminate prior authorization requirements for select providers/practices?	☐	☐

4.a. If yes, describe the program(s) below and detail the number of providers exempt, partially exempt (if applicable), and not exempt. How do the numbers reported in the current reporting period differ from those reported in the prior reporting period? Does the Health Plan intend to expand or change the program in the near future?

4.b. If the Health Plan does not have a program that eliminates prior authorization requirements for select providers/practices, describe any efforts the Health Plan engaged in during the prior reporting period to implement such a program, and provide an estimated timeline for implementation:

	YES	NO
5. Does the Health Plan offer a minimum 60-day grace period on prior authorization protocols for patients who are already stabilized on a particular treatment upon enrollment in the Health Plan?	☐	☐

5.a. If "No", describe if the Health Plan utilizes a different time period for the grace period or if there is no grace period. Additionally, describe below why the health plan has selected this policy.

	YES	NO
6. Once Prior Authorization is obtained for a given procedure, is prior authorization approval valid for the duration of all prescribed/ordered course of treatments (or in the case of members with CIS, SHCN, or LTSS, until the next Health Action Plan review)?	☐	☐

6.a. If "No", describe which services are subject to recurring prior authorizations during treatment and how the Health Plan arrived at this decision.

7. Does the Health Plan publicly disclose in a searchable format, patient-specific utilization management requirements such as prior authorizations for individual medical services?	YES ☐	NO ☐
8. Does the Health Plan publicly disclose statistics regarding prior authorization approval and denial rates on its website, or another publicly available website, in a readily accessible format?	YES ☐	NO ☐
9. Does the Health Plan revoke, limit, condition or restrict coverage for authorized care provided for any services within 45 business days from the date authorization was received?	YES ☐	NO ☐

9.a. If "Yes", please specify below which services are subject to these conditions; describe the circumstances under which revocations, limitations, conditions or restrictions may be applied; and describe how long the Health Plan has to implement such revocations, limitations, conditions, or restrictions.

Attestation

I, _____, acting as the Chief Executive Officer or Authorized Agent of _____ (i.e., the Health Plan), **declare under penalty of perjury** that: (1) the information reported above is true and correct; (2) any attached documentation and materials referenced are true and correct; and (3) I understand and agree to the terms of the QI RFP/contract at Sections 6, Health Plan Reporting and Encounter Data Responsibilities and Section 14.21, Remedies of Non-Performance of Contract.

_____ _____ _____

Signature Title Date

Service Category	#submissions	#denials	#appeals	#denials	Then what happens?
1 - At Risk Services					
2 - Autism Services					
3 - Diagnostic Testing					
4 - Durable Medical Supplies/ Medical Equipment					

5 - Home and Community Based Services

6 - Home Health Services

7 - Inpatient Hospital Services

8 - Outpatient Hospital services

9 - Physician Services

10 - Preventative services

11 - Rehabilitation services

12 - Transportation Services

13 - Behavioral Health

14 - Other Services

Prior Authorization
HMSA Update

Discussion document

October 2025

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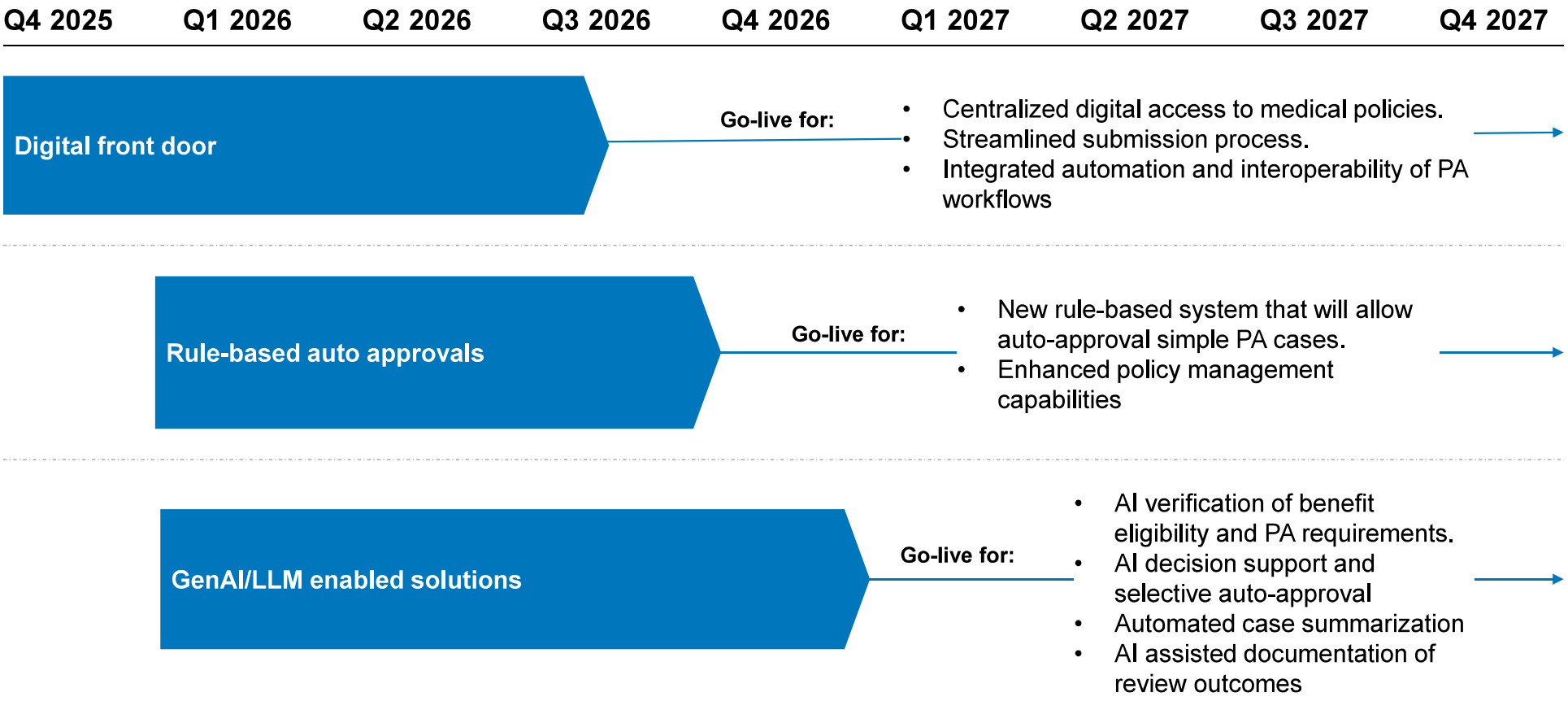
Current efforts aimed at modernizing Prior Authorization

Removal of PA Codes with low ROI	• ~4 to 7K decrease in PA volume
Re-engineering of PA process workflow	• ~1 to 2-day reduction in PA turnaround time
Modernization of PA workflow with technology	• ~2 to 4K reduction in PA volume • ~3 to 4-day reduction in PA turnaround time

Modernization Timeline

PRELIMINARY AND PRE-DECISIONAL



Prior Authorization Descoping List

REMOVAL OR EXCLUSION OF SPECIFIC SERVICES, PROCEDURES, OR MEDICATIONS FROM A PRIOR AUTHORIZATION REQUEST

2025

Brachytherapy
Bone Mineral Density Scans
Incontinence supplies
Hepatic elastography
Stereotactic Radiosurgery
IGRT/IMRT (radiation therapy)
TAVR (transcatheter aortic valve replacement)

2026 (Planned)

Low Dose CT for Lung Cancer Screening (Hip, Knee, & Foot CT)
Upper Extremity Non Joint MRI
Ankle CT
Lower Extremity CT
Humerus MRI
Arm MRI
Leg CT
Upper Extremity CT
Upper Extremity MRA
Hand CT
Arm CT
CT Bone Density Study
Ankle MRA
Carpal Joint MRI
CT Needle Guidance
Fetal MRI
Carpal Joint CT
MRI Needle Guidance
Breast MRI
Hand MRI
Neck CT Angiography
Neck MRA
Shoulder CT
Abdomen MRA
Heart CT
Orbits CT
Temporal Bone CT
Internal Auditory Canal CT
Lower Extremity MRA
Upper Extremity CT Angiography
Internal Auditory Canal MRI
Follow-up, Limited, or Localized CT
Pelvis CT Angiography
Sella CT
Heart CT Congenital Studies
Wrist CT
MRA Spinal Canal and Contents
Mastoid CT
Scapula CT
Magnetic Resonance Elastography
Heart MRI
MRI Bone Marrow
CT Bone Density Study
MUGA

AHA calls out 'skyrocketing' administrative costs for hospitals

Mariah Taylor (Email) - yesterday

"Skyrocketing" administrative costs and increasingly burdensome insurer policies are driving up care denials, straining hospital resources and delaying patient care, the American Hospital Association reported Sept. 10.

"Hospitals and health systems already face many pressures that make their ability to care for communities more challenging," the AHA said in the report. "We shouldn't allow insurers or others to add to that with costly administrative practices that burden already overwhelmed health care professionals and decrease patient access to care."

Here are six takeaways:

1. Care denials increased an average of 20.2% for commercial and 55.7% for Medicare Advantage claims in 2022-2023.

2. More than 40% of total expenses hospitals incur in patient care come from administrative costs due to prior authorization appeals, according to a report by Strata Decision Technology. Additionally, McKinsey estimates that systems conservatively spend an estimated $40 billion annually on costs associated with billing and collections.

3. Machine learning and other AI tools are driving up the growth of denials and do not consider the patient's individual clinical circumstances or review the plan required. "Although the 2024 MA final rule offers some guidance regarding payment denials and prompt pay, the issue remains a significant concern," the report said.

4. An estimated 75% of MA care denials are eventually overturned, an HHS report found in 2018. However, hospital staff still spend significant time and resources to get the denials overturned. One healthcare system reported a denial rate for MA claims of 10.5%-15.5%, but found 56% of denials were overturned on appeal. This created a cash flow challenge where unpaid claims outstanding for more than 90 days ranged between 27.1% and 46.7%.

5. Even when denials are successfully overturned, insurers add roadblocks. The time taken for commercial payers to process and pay hospital claims has increased 19.7% in 2023, a Vitality Payer Scorecard found.

6. Commercial insurers use "unfair business practices," such as post-payment claims audits to cut reimbursement or recoup payments. An AHA survey found 50% of systems reported having more than $100 million in accounts receivable for claims that were six months or older in 2022.

"These cash flow challenges also are exacerbated when cyberattacks cripple the claims processing and payment systems that hospitals and insurance companies rely on as evidenced by the recent Change Healthcare attack," the report said. "The risk of such cybersecurity threats also adds to the administrative costs hospitals incur to operate, maintain and update the complex technologies that are required for hospital billing and collections."

Prior Authorization Reform Heats Up

CHIR Faculty | 2025-12-17
Leila Sullivan, Zeynep Celik, and Amy Killelea

Prior authorization (PA) is a utilization management technique used by health insurers that requires providers to seek approval from the insurance plan before the plan will agree to pay for a covered procedure, service, or medication. Insurers can leverage PA to control health care spending, both by negotiating lower prices for services that they do not subject to PA and using PA to limit access to certain higher-price services.

While insurers contend that PA also allows them to ensure care is clinically appropriate, PA has been linked to adverse health outcomes for patients, as well as delays and frustration in the US health care system. The administrative costs associated with PA are also significant, and a profitable cottage industry of middlemen has grown to help both insurers and providers navigate PA.

In response to growing concerns about PA abuses, policy makers at the federal and state levels are increasingly implementing reforms that target the processes insurers use, the substance of their requirements, or both. This article explores key trends in PA reform and what those reforms mean for consumers. We primarily focus on the commercial health insurance market, although some policies apply more broadly.

Federal-Level Action

Under the Biden administration, the Centers for Medicare and Medicaid Services (CMS) finalized a new rule on the use of PA in federal Marketplace plans as well as those offered through Medicare Advantage and Medicaid/CHIP. Most significantly, the rules require that by 2027 insurers must have in place an application programming interface through which consumers and providers can learn:

- whether PA applies to specific items or services,
- any associated documentation requirements, and
- the status of pending or processed requests, including the specific reasons for any denials.

Additionally, starting in 2026, affected payers must post online specified data on PA requests and determinations. The rules also standardize certain aspects of insurer PA processes beginning in 2026. For example, insurers must put timelines in place for PA determinations for Medicare Advantage and Medicaid/CHIP such that standard requests are addressed within seven calendar days and, for expedited requests, within 72 hours. For federal Marketplace plans, preexisting timelines remain in place, which allow plans up to 15 days to process standard requests, while expedited requests are limited to 72 hours.

Across all payers and provisions, the above rules apply only to medical benefits and not prescription drugs, leaving a large regulatory gap for patients and providers. In a separate rule finalized this summer, however, CMS has required that certified electronic health record systems allow for electronic prior authorization of prescription drugs.

Then in June 2025, health insurance industry leaders in coordination with the Trump administration, voluntarily pledged to streamline and improve their PA processes across markets. Beginning in 2026, pledge participants promise to reduce the volume of services subject to PA, honor PA approvals by other plans during coverage transitions, and provide clear explanations of their PA determinations. By the following year, they commit to making real-time approvals on most requests and standardizing electronic PA request submissions.

State Action

Many states are taking matters into their own hand, adopting their own rules for the fully insured health insurance market. During the 2024 legislative session, 10 states passed legislation reforming PA. Since January 1, 2025, at least 18 states have taken legislative action on PA (see exhibit 1 here).

Exhibit 1: 2025 Enacted Legislation On Prior Authorization

State	Legislation	Process Reforms	Substantive Reforms	In-Effect Date
Alaska	(S 133)	**Timelines:** PA decision required in 24h expedited; 72h standard; chronic conditions with auto-renewal approvals valid ≥12 mo; notice 60 days before changes. **Transparency/Disclosure/Reporting:** Must publish up-to-date, peer-reviewed criteria; adverse determination must include clear reasons. Annual reporting of PA data to DOI. Must offer federal-standard API for PA appeals.	**Clinical Criteria:** PA standards must be based on peer-reviewed and evidence-based clinical review criteria; if the PA standards published by the health insurer differ from those published by the health insurer's utilization review organization, the version most favorable to the patient prevails.	01/01/27
Arizona	(H 2175)	—	**Provider Review:** Requires insurer medical director to personally review medical necessity denials.	06/30/26
Arkansas	(H 1300/Act 510; H 1301/Act 511; H 1700)	**Transparency/Disclosure/Reporting:** Amends the state's PA Transparency Act to broaden the definition of prior authorization and strengthen public disclosure and provider notification requirements. Further enhanced transparency through clear service lists, criteria, and restrictions; notice before changes; requires disclosure of criteria, rules, and guidelines for adverse determination. **Standardization/Interoperability:** Machine-readable PA lists; approvals must cover the full course of treatment (up to 1 yr); enforcement penalties and trust fund for compliance/education. **Continuity of Care:** The law removes language allowing insurers to deny claims if authorization was granted more than 90 days before the service, requires coverage of ongoing treatment for new members within 60 days of enrollment (excluding pharmacy benefits), and mandates that authorizations cover the full course of treatment for up to one year.	**Prohibition on PA:** Retracts prior provision allowing denials >90 days post-PA; Amends gold card program; allows group exemptions with 60-day notice; excludes providers <80% approval rates; narrows drug/biologic exemptions; oversight for QIPs seeking exemption.	**H 1300/Act 510:** 07/31/25 **H 1301/Act 511:** 04/03/25 **H 1700:** 07/31/25
Colorado	(S 301)	—	**Prohibition on PA:** Prohibits additional PA for evidence-based changes to the dose or frequency of a chronic maintenance drug if certain conditions are met. The conditions stipulate that the carrier must have already approved the chronic maintenance drug for coverage, the drug is not an opioid, and the dose or frequency has not been adjusted more than two times without PA.	08/06/25
Delaware	(S 12)	**Timelines:** PA decisions required within 3 days for clean electronic submissions; 5 days for clean nonelectronic requests; 24hr for urgent clean electronic submissions or patient transfers; 48hr for urgent clean nonelectronic submissions or patient transfers. **Transparency/Disclosure:** Appeals processes must be made more transparent; must provide 6mo notice to covered persons before changes in PA requirements unless they were due to clinical guideline status changes, recalls, market withdrawals, or relevant FDA-published safety information. **Standardization/Electronic:** Insurers must establish an electronic submission portal and may require its use within 12 months of establishment. **Continuity of Care:** Pre-authorizations limited to one per episode of care at the site of service.	**Decision-maker:** Adverse determinations must be reviewed by qualified similar providers without financial incentives tied to the outcome. When a physician or physician's representative submits a prior authorization, a physician must be involved in any adverse determination review.	12/31/26
Hawaii	(H 250)	**Transparency/Disclosure/Reporting:** Requires annual PA data submission to the state, which is compiled and publicly reported; establishes a working group on clinical standards and timelines that will make annual recommendations to the legislature beginning in 2026.	—	06/03/25
Indiana	(S 480)	**Timelines:** Requires response to urgent PA decisions in 24h; non-urgent and prescription drug PA decisions 48h; peer appeals 48h; auto-approval if deadlines missed; one-year minimum length of PA approval. **Transparency/Disclosure/Reporting:** Requires insurers to post detailed PA requirements; notice 60 days before changes. **Standardization/Interoperability:** Amended previous requirements regarding electronic PA (excluding Rx) starting in July 2025. **Continuity of Care:** 90-day continuity of care protections.	**Provider Review:** Requires clinical peers for denials and independent reviewers for appeals. **Prohibition on PA:** Allows retroactive denials only in cases of fraud or ineligibility.	06/30/25
Iowa	(H 303)	**Timelines:** Requires response to urgent PA requests in 48h; 10 calendar days for non-urgent; 15 calendar days for non-urgent requests if there are complex/unique circumstances or unusually high PA volume. **Transparency/Disclosure/Reporting:** Requires utilization review orgs to submit an annual report of these reviews to the Commissioner of Insurance, who must publish the report within 60 days of receipt. **Process Review:** Requires utilization review orgs to review all health care services subject to PA and eliminate requirements for those that are routinely approved with such frequency that PA is no longer necessary or justified.	—	07/01/25
Maryland	(H 820; H 848/ S 474; H 995 / S 776)	**Timelines:** Requires private review agents (entities that perform utilization review on behalf of an insurer) to provide 24/7 access via a phone line and email for utilization review with responses required within 2 business days. **Transparency/Disclosure/Reporting:** Requires that insurers report to the state if adverse decisions rise significantly for a service (10% or more in the past year or 25% or more in the past 3 years), including contributing factors, changes in medical management, and actions taken to determine the reason for the increase; requires reporting of whether an AI tool was used in making an adverse decision; establishes a multi-stakeholder workgroup to study rise in adverse decisions and recommend strategies to reduce them; work group must report findings and recommendations to the General Assembly by December 1, 2025.	**AI Utilization:** Entities using AI must ensure that AI does not replace the role of clinicians in the utilization review process.	**H 820:** 10/01/25 **H 848/ S 474:** 10/01/25 **H 995/ S 776:** 06/01/25
Montana	(H 398; H 399; H 544; S 449)	**Timelines:** PA approvals valid for 12 mo for chronic conditions; and 6mo for other conditions. **Transparency/Disclosure/Reporting:** Requires insurers to publish a list of reasonably covered therapeutic alternatives if denying a Rx authorization request. **Standardization/Interoperability:** Requires insurers to accept electronic PA for Rx drugs; must follow NCPDP SCRIPT. **Continuity of Care:** Requires insurers to honor prior approvals for consumers switching plans (up to 3 mo) when the approved services are a benefit under the new plan.	**Provider Review:** Requires a licensed physician or peer with experience in the same/similar specialty for denials. **Prohibition on PA:** Adds additional Rx PA prohibitions for the following: Discharge prescriptions up to 3 days; any formulary oral or inhaled nonbiologic generic prescription drug excluding specialty drugs and controlled substances; acceptable changes in dosage of a previously approved Rx; any Rx drug for the treatment of asthma, chronic obstructive pulmonary disease, or chronic lung disease, or insulin for patients diagnosed with diabetes; prohibits retroactive PA denials; prohibits repeat step therapy protocols.	**H 398/ H 544:** 01/01/2026 **H 399/ S 449:** 10/01/2025
Nebraska	(L 77)	**Timelines:** Requires urgent PA decision in 72h before 2028 and 48h thereafter; non-urgent 7 days; one-year minimum length of approvals. **Transparency/Disclosure/Reporting:** Must post PA criteria on website; notice 60 days before changes. **Standardization/Interoperability:** Requires use of uniform PA forms; API/web portal allowed. **Continuity of Care:** Requires 60-day continuity of care protections	**Provider Review:** Requires physicians or licensed clinical peers with relevant expertise to make adverse determinations; appeals must be reviewed by physicians with relevant expertise and speciality. **Prohibition on PA:** Prohibits PA for emergency/preventive services **AI Utilization:** Bans AI as sole denial basis.	01/01/2026
North Dakota	(S 2280)	**Timelines:** Requires decision for urgent PA determination in 72h; non-urgent 7 days; one-year minimum lengths of approvals for care for chronic conditions; six-month minimums for approvals of all other services **Transparency/Disclosure/Reporting:** Requires publication of PA rules on website; requires 60-day notice before changes. **Continuity of Care:** PA honored for 60 days under a new policy.	**Provider Review:** Requires physician/pharmacist reviewers with relevant experience for adverse decisions. All appeals must be reviewed by a physician with relevant experience. **Prohibition on PA:** No PA for emergency care or medication assisted therapy; limit retrospective denials within 45 days.	01/01/2026
Oklahoma	(H 1811)	**Timelines:** Reduces inpatient PA continuation decision from 72h to 24h for continuation of inpatient	—	11/01/2025

		acute care.		
Oregon	(H 3134)	**Transparency/Disclosure/Reporting:** Requires detailed PA reporting (approval/denial reasons, timeliness). Also requires the Department of Consumer and Business Services to publicly post this information along with other various metrics. **Standardization/Interoperability:** Requires federal-standard API by 2027.	**Prohibition on PA:** PA prohibited for unanticipated medical procedures performed during an approved surgery if certain circumstances are met.	01/01/2027
Rhode Island	(H 5120 / S 168)	**Transparency/Disclosure/Reporting:** Requires insurers to file annual reports to the Office of the Health Insurance Commissioner, the Governor. Speaker of the House. and Senate President on the pilot program: requires the insurance commissioner to convene a work group to make PA recommendations and annually report them to the General Assembly.	**Prohibition on PA:** Prohibits PA for services ordered by PCP in routine primary care (excluding drugs) in a three-year pilot program.	10/01/2025
Texas	(H 3812; S 815)	**Transparency/Disclosure/Reporting:** Commissioner may audit AI use; . Requires insurers to annually report information on gold carding exemptions, denials and recissions.	**Prohibition on PA:** Amends gold carding program for providers with ≥90% approval rate for specific service. Extends the provider evaluation period from six months to one year and adds criteria for providers to qualify for the program. **AI Utilization:** Bans use of AI systems to make any part of adverse determinations.	09/01/2025
Utah	(S 274)	**Transparency/Disclosure/Reporting:** Requires insurers to report annual PA data to the department of insurance (including denial reasons, appeals, and review times for standard and urgent requests). Requires disclosure standards for adverse preauthorization determination notices.	—	05/07/2025
Virginia	(H 2099/ S 1215; H 2525)	**Timelines:** Requires expedited PA decisions in 72h; standard 7 days (excluding Rx). **Transparency/Disclosure/Reporting:** Requires carriers to provide a public list of services and codes requiring PA; changes require 30 calendar day advance notice of the effective date of changes; must publish annual data on the carrier's website. Carriers cannot deny a claim for failure to obtain prior authorization if the requirement was not posted publicly as required. Requires each health carrier to make available by posting on its website no later than March 31 of each year the PA data covered by this section for the previous calendar year at the health plan level for all metrics required for compliance with federal law and CMS regulations. These include the percentage of standard PA requests that were approved, denied, and approved after appeal, and requests for which the timeframe for review was extended. **Standardization/Interoperability:** Creates a workgroup for prior authorization metrics reporting; extends the term of the existing ePA Work Group and revises its charge to include recommending a date by which private commercial health carriers and providers must implement ePA for medical items and services.	**Prohibition on PA:** Bans revoking or modifying approved PAs (unless initiated by a provider, due to fraud, regulatory changes or loss of coverage by the enrollee).	**H 2099/ S 1215:** 01/01/2027 **H 2525:** 01/07/2025
West Virginia	(S 833)	—	**Prohibition on PA:** Excludes pharmaceutical medication from gold carding.	04/11/2025

Source: The authors' research includes state level actions enacted between January 1st, 2025 and August 30th 2025

State reforms generally fall along two dimensions: process changes and substantive changes.

Like the federal interoperability rule, many state-driven changes address procedural aspects of PA such as:

- how quickly insurers must process requests,
- how long approvals last,
- which channels can be used for PA requests, and
- what information insurers must disclose to consumers and providers.

Other state reforms are more substantive. Some aim to prevent insurers from denying access to clinically recommended care and treatment. Others seek to ensure that only health care professionals with relevant expertise can make denial decisions.

Process Reforms

A primary focus of recent state procedural PA reforms has been timelines. These can encompass both the required turnaround times for approving or denying a PA request and the duration for which an approval remains valid. New laws in Alaska, Delaware, Indiana, Iowa, Nebraska, North Dakota, Oklahoma, and Virginia require insurers to process urgent prior authorization requests on timelines that range from 24 to 72 hours for urgent requests, and 2 to 15 days for non-urgent requests, depending on the state.

Indiana's law adds a strong incentive for timely insurer PA processing: If the insurer misses the deadline, the request is automatically approved. Alaska and Montana defined how long an approval lasts for conditions requiring chronic care, setting a minimum duration of 12 months. Alaska's law also requires that if the treatment plan for a chronic condition remains the same after the initial 12-month period, the PA is automatically renewed.

Several states (Arkansas, Indiana, Montana, North Dakota, and Nebraska) have also taken measures to ensure continuity of care for patients and maintain PA approvals for the first two to three months following a change in health insurance coverage. These measures aim to reduce delays in care, minimize repeated paperwork, and provide patients, especially those with ongoing health needs, with greater stability and continuity in their treatment.

As mentioned above, CMS issued a final rule in early 2024 to improve PA processes in Medicare Advantage, Medicaid/CHIP, and plans offered on the federal Marketplace. A core focus of the rule was to require plans to make information on PA and plan approval criteria easily (and electronically) available to patients and providers. State lawmakers have also taken action to require plans to be more

transparent about their PA processes, with several states in 2025 enacting measures to increase patient and provider access to PA information and to require plans to report on PA to state regulators.

Nebraska, Arkansas, and North Dakota, for example, now require insurers to publicly post PA policies, clinical criteria, and documentation requirements in a clear and accessible format for patients. All states in exhibit 1, except Indiana, also include prescription drug PA in their laws in an effort to fill the major gap in the federal rule, which excluded prescription drugs from the PA reforms included in the rule. In addition to transparency, these reforms aim to standardize electronic PA processes in ways that enable faster, more consistent decision making and reduce administrative burdens for providers and patients. By making this information readily available, patients can better understand what is required for approval, anticipate potential delays, and make more informed decisions about their care.

Substantive Reforms

In 2025, several states enacted substantive reforms to PA processes, focusing on how clinical review criteria are defined, who makes determinations, and whether certain services or providers can be excluded from PA.

Alaska and Nebraska now require carriers to rely on peer-reviewed and evidence-based clinical review criteria and to ensure that adverse determinations are made by qualified clinical peers. These reforms aim to improve adherence to best practices. Montana, North Dakota, and Virginia strengthened patient protections by prohibiting retroactive PA denials, with North Dakota and Virginia allowing limited exceptions.

States have also strengthened oversight of decision making in PA determinations. Arizona now requires denials based on medical necessity to be individually reviewed by a medical director. Several states addressed the growing use of artificial intelligence (AI) in utilization management amid concerns linking it to higher denials. Maryland's reform requires carriers to disclose the use of AI in reporting, reinforces that human oversight is mandatory, and prohibits AI tools from being used to deny, modify, or delay care. Texas similarly bans automated systems from issuing adverse determinations without human review, although it does permit AI for administrative support or fraud detection. These provisions aim to ensure technology is supporting clinical judgment instead of replacing it.

Other reforms have targeted PA requirements by exempting certain low-risk services and high-performing providers, while streamlining approval processes or routine or ongoing treatments.

Some new laws have allowed for expanded "gold carding" programs under which insurers exempt certain providers from prior authorization requirements based on their track record of approvals or on other standards. Arkansas amended its gold carding program to refine evaluation periods and eligibility criteria. And Texas now waives PA for providers with a 90 percent approval rate for a service. Rhode Island eliminated PA for routine primary care services ordered by a primary care physician during a three-year pilot program beginning October 1, 2025, while Colorado removed additional PA requirements for certain dose and frequency adjustments to previously approved chronic maintenance drugs. Montana prohibits PA for both short- and long-acting insulin (whether generic or brand name) and limits repeat step-therapy protocols when a patient has already failed required drugs. Together, these changes reflect a broader state-level push to reduce delays in care while preserving oversight where clinically appropriate.

Looking Ahead

The growing number of reforms reflects an increased recognition that, under the current health care system, PA often delays care and creates significant administrative burdens. Process reforms designed to streamline procedures and shorten approval timelines, along with substantive reforms intended to ensure more evidence-based determinations, represent meaningful progress. Many states' 2025 legislative actions complement federal action. Nonetheless, with most ambitious reforms happening at the state level, patients' experiences will continue to vary widely based on where they live and the type of coverage they hold.

Authors' Note

The authors would like to thank Billy Derring and Vrudhi Raimugia for their support on this article.

Categories: Costs and Competition, Provider Costs and Billing Reform
Tags: artificial intelligence, health reform, prior authorization
Comments

Smart Health Infrastructure Alliance

Ending the $1 Trillion Administrative Crisis

Building the Foundation for Healthcare's Digital Future

Smart Health Infrastructure Alliance & RHTP

The Smart Health Infrastructure Alliance is a growing coalition of states implementing shared administrative rails through their RHTP plans. Rather than each state building its own solution, Alliance members share core technology and payer integrations - reducing costs and accelerating deployment. From Delaware's public RHTP plan:

> ***Statewide Health Information Technology Infrastructure for Real-Time Insurance Verification and Prior Authorizations:*** *"This initiative creates comprehensive digital infrastructure connecting all rural providers, payers, hospital systems, and patients through the Smart Health Network (SHN) and the DHIN... [It] will dramatically accelerate prior authorization processing... physicians, non-physician providers, and other support staff's time will be freed up for direct patient care. This unified system will also directly improve rural health by eliminating geographic barriers to specialist consultations, reducing the need for multiple trips, and supporting telehealth and remote patient monitoring that depend on seamless data exchange."*

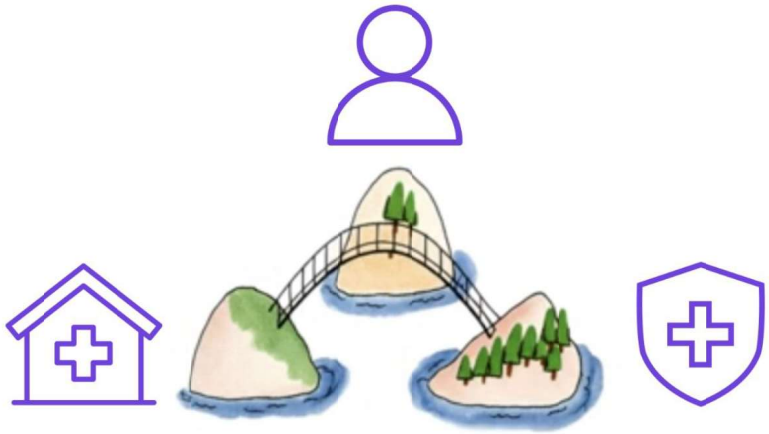
Why Does Healthcare Send 9 Billion Faxes & Waste $1 Trillion on Admin?

We built 3 separate digital islands that don't connect:

Clinical Island - Holds all the medical data in EHRs - but can't transmit it to payers when payment decisions are made.

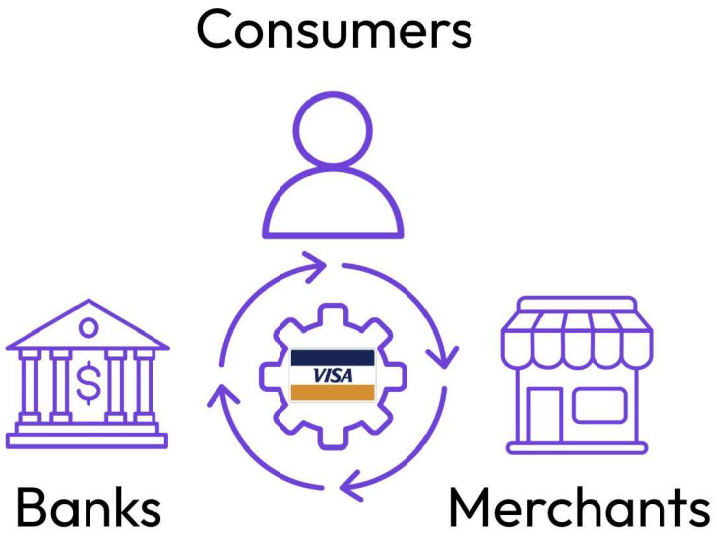
Administrative Island - Uses fragile 1980s tech to processes eligibility, prior auth, and claims - but without any clinical context, forcing manual back-and-forth.

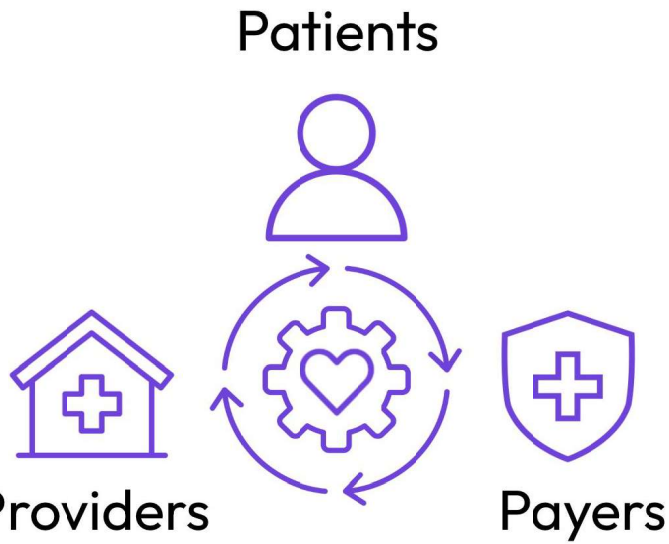
Consumer Island - Leaves patients in the dark, unable to access their data or see their coverage, authorizations or costs.



"Hey Doc, we'd love to approve your prior auth. Can you fax us the clinical notes?"

VISA Connects Banks + Merchants + Consumers

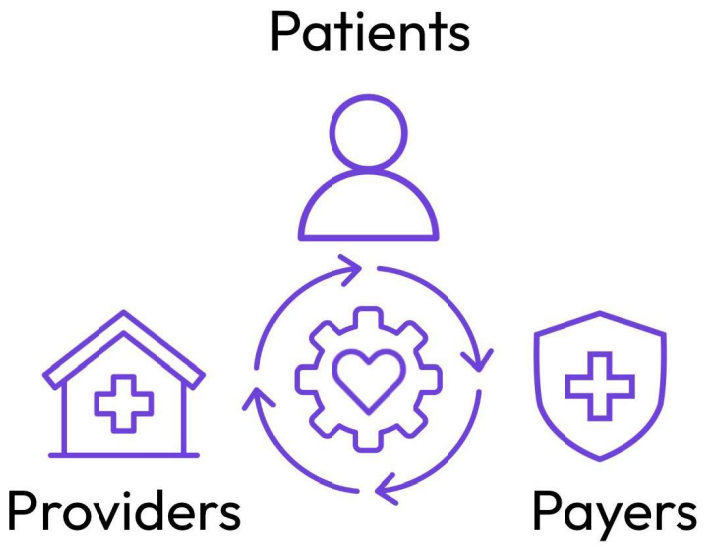




We're connecting Providers + Payers + Patients for the first time.

Connect Once, Reach Everyone

- Decisions in seconds instead of days or weeks
- Fewer first-pass denials, faster payments
- Dramatically lower processing costs for everyone
- Complete visibility for patients

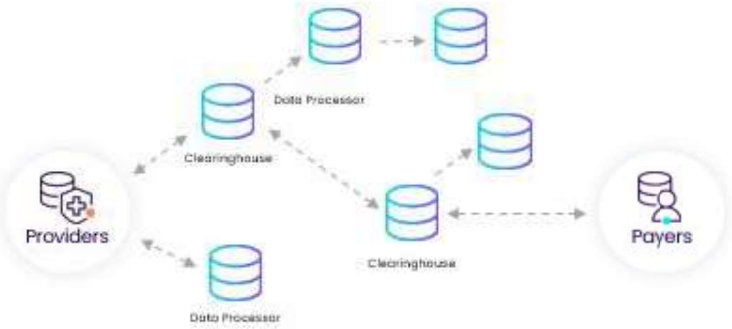


Operated as a Common Utility

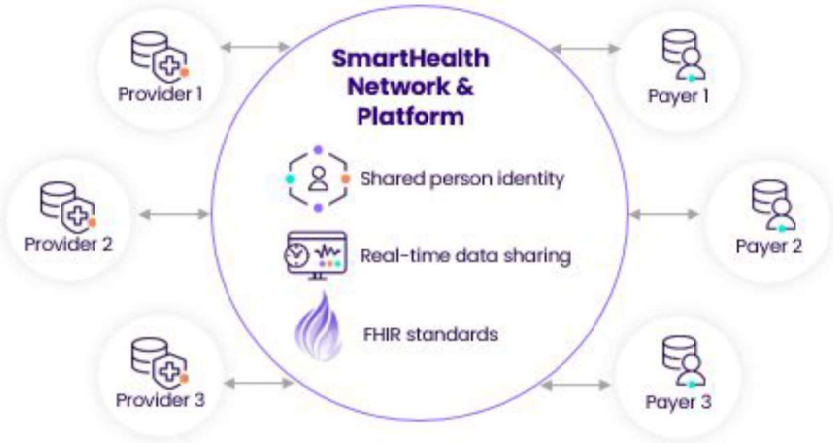
Our modern approach to interoperability

Smart Health Network
Public Benefit Corporation

Current Industry Approach



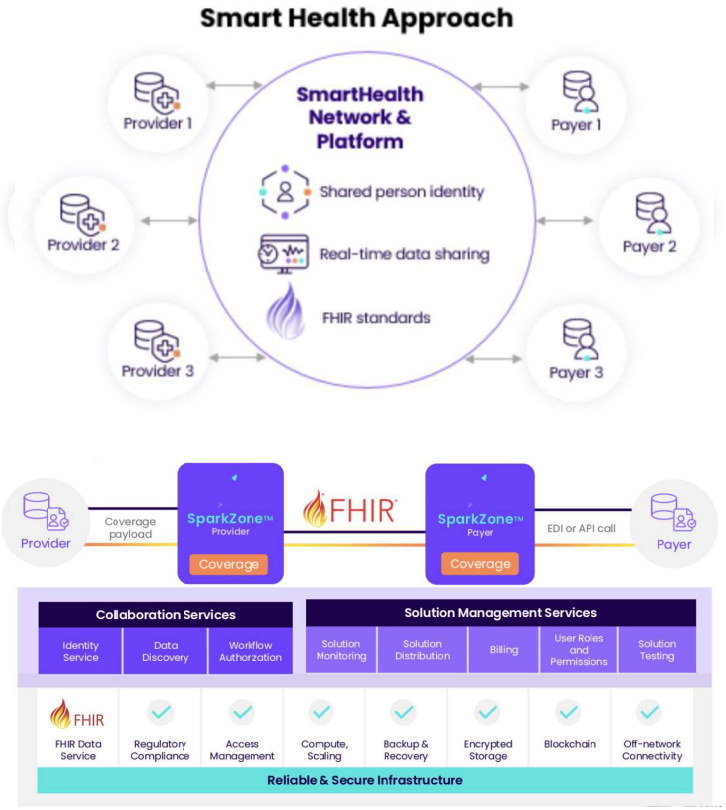
Smart Health Approach



Many point-to-point connections	→	Connect once to many
Data copied & aggregated	→	Retain control using your own encryption keys, no centralized aggregation
Security determined by intermediary	→	Granular permissioned access
Aged data presented to portals	→	Real-time updates published to source systems

This isn't Theoretical. It's Already Built and Proven.

- Proven across **68M+ lives** connected with real-time identity & coverage
- Claims processing with **99.93% success in <5 seconds**
- **Proven ROI:** Providers save $3.36-$5.75 per claim. Payers save $0.57-$1.65
- Modern, federated architecture
- Secure, resilient, scalable
- AI native



Simple Utility Fee: 0.05% of Revenue for Payers and Providers Free for Patients

Savings from coverage solution alone - reducing first-pass denials - more than justifies utility fee. Every additional use case increases ROI.

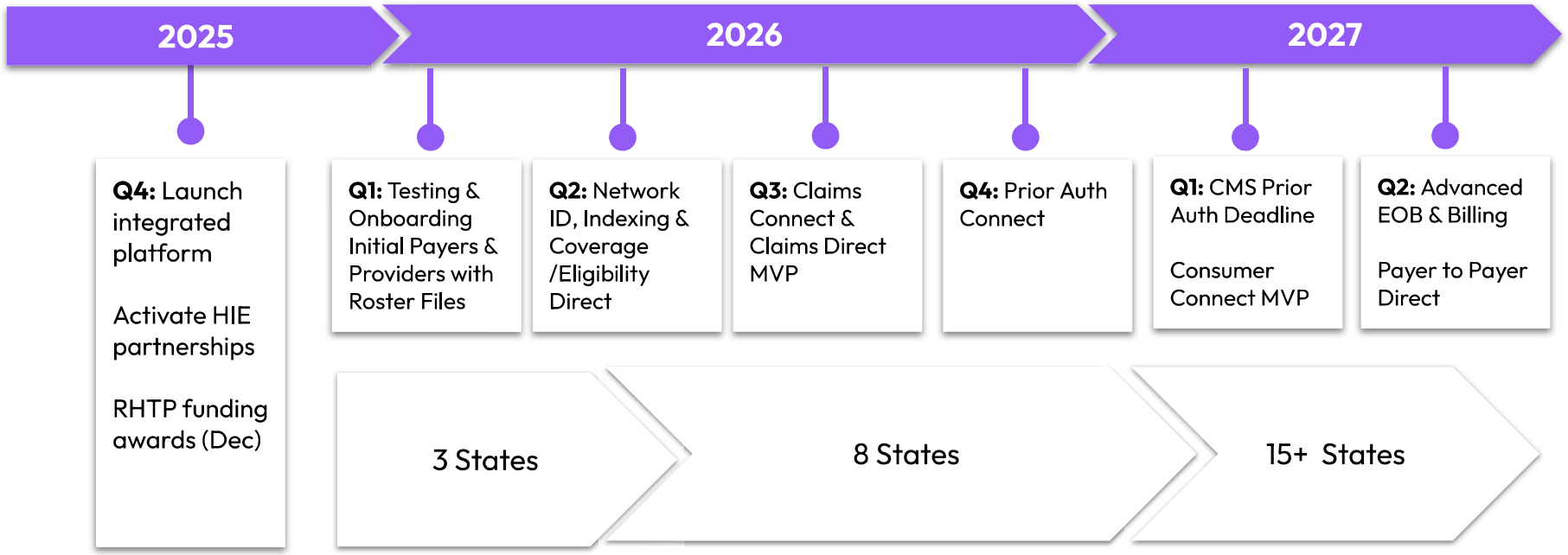
Provider Savings
Immediate Savings ($3.36-$5.75 per claim): • Administrative savings, reduced rework of denials • Reduction in claim write-offs from payers • Reduction in patient bad debt, overall uncompensated care • Avoided retroactive prior authorizations • Reduced clearinghouse costs

Payer Savings
Immediate Savings ($0.57-$1.65 per claim): • Administrative savings • Claim adjudication & manual verification • Call center savings • Discovery of coordination of benefit (COB) leads • Reduced recovery costs (payment integrity) • Reduced clearinghouse costs

Sample Health System ROI	
Revenue	$1B
Utility Fee (0.05%)	$500K
Annual Claims	2M
Savings	$6.72M - $11.5M
ROI	**13.4X - 23X**

Sample Health Plan ROI	
Revenue	$10B
Utility Fee (0.05%)	$5M
Annual Claims	30M
Savings	$17.1M - $49.5M
ROI	**3.5X - 9.9X**

Planned Product & Onboarding Roadmap



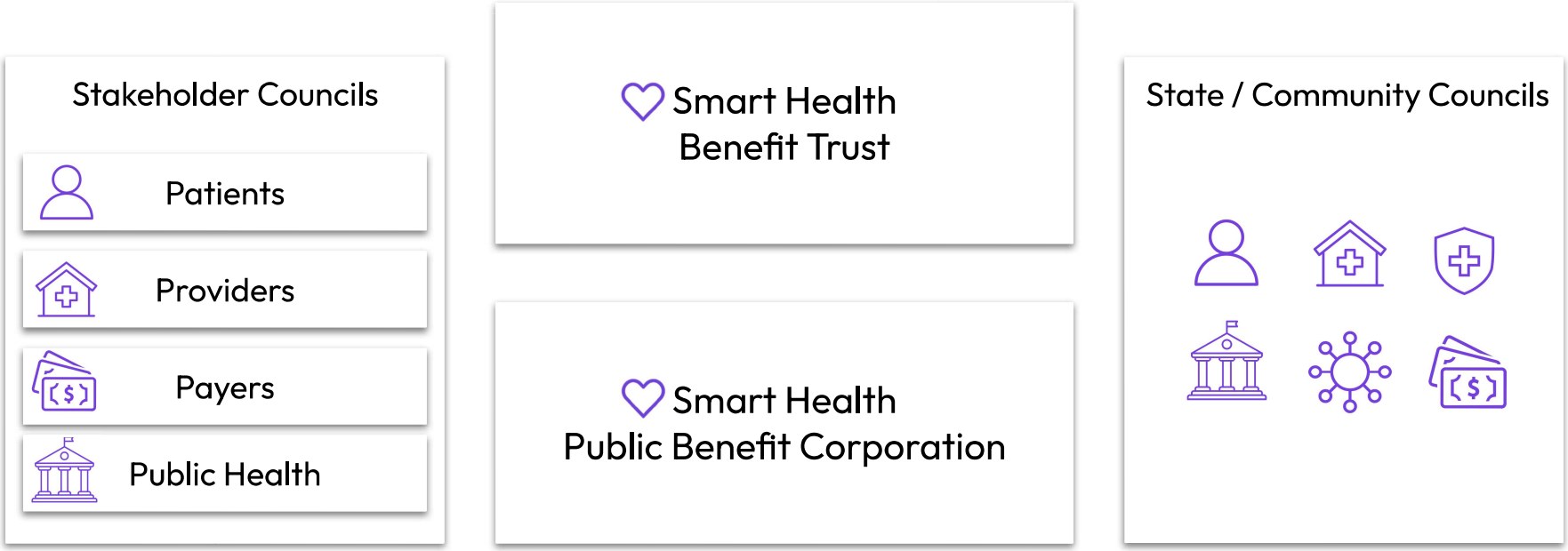
Building on the HIE Foundation

In many states, Health Information Exchanges provide the connectivity backbone for clinical data sharing. The Alliance completes this infrastructure by adding three critical components:

- **Administrative Transactions.** HIEs move clinical documents. The Alliance adds business transactions—claims, prior authorizations, eligibility - creating complete infrastructure.
- **Patient Access.** Traditional HIEs serve providers and payers. The Alliance includes patients as active participants with full visibility into their health data and transactions.
- **Sustainable Revenue.** The simple utility fee sustains both new infrastructure and existing HIE capacity, reducing reliance on cyclical grants.

The model leverages existing investments while ensuring permanent sustainability.

Public Benefit Utility Structure

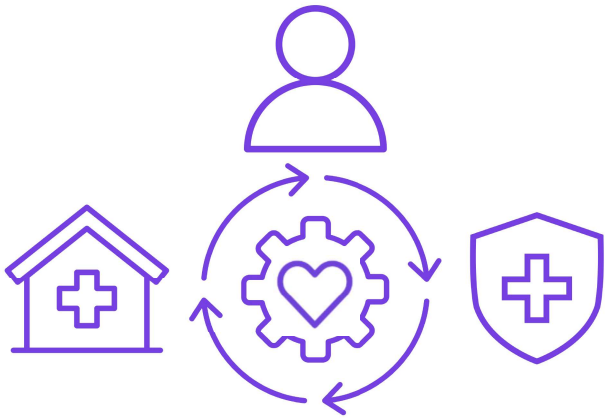


Our mission is to make better health easier for everyone. We do this by building shared digital infrastructure that empowers people, takes away friction, and lowers costs for all.

Our highest duty is to the people and communities we serve.

Smart Health Network

Public Benefit Corporation



www.smartpbc.net

Smart Health Infrastructure for Hawaii's Rural Transformation

December 2025

Executive Summary

American healthcare still runs on **9 billion faxes a year**—wasting over **$1 trillion on administrative expenses**—while families reel from $27,000 annual premiums and rural hospitals close at record rates.

Hawaii's rural hospitals are dying—not from poor clinical care, but from **administrative exhaustion**. A typical Critical Access Hospital loses **$150,000+ annually** to fax-based insurance friction. That's three nursing salaries consumed by phone holds, denied claims, and resubmissions.

The Rural Health Transformation Program offers a once-in-a-generation opportunity to fix this. But **funding alone won't solve a structural problem.** Without modern digital rails, new dollars will be absorbed by old inefficiencies.

The choice is stark: Fund disconnected pilots and patch broken systems, or build **shared infrastructure that delivers results in 90 days and sustains itself permanently.**

The Solution: Deploy a shared administrative backbone connecting providers, payers, and patients through the **Smart Health Infrastructure Alliance**—a coalition of states deploying Smart Health Network (SHN) infrastructure through their RHTP plans. Think of it as **interstate highways for healthcare administration**—neutral, shared rails that any provider or payer can use.

SHN doesn't replace EHRs, clinical systems, or care delivery. It connects them—so a rural hospital on MEDITECH can transact with a payer's system as easily as a large system on Epic. State HIEs remain the **local backbone and conveners**; SHN provides the **shared national rails** they can plug into instead of building alone.

This is ready-to-deploy infrastructure—proven across **68M+ lives** with **99.93% transaction success in <5 seconds**—not a new state IT build.

What Hawaii Gets:

Outcome	Timeline
Real-time eligibility verification (<3 seconds)	90 days
30% reduction in first-pass claim denials	Year 1
75% reduction in prior auth processing time	Year 2–3
Self-sustaining operations (no state appropriation)	Year 5

The Math Works: Both providers and payers save more than they pay. The utility fee (0.05% per party) costs less than the proven savings—so both sides come out ahead on **Day One** and every day after.

Builds on HHIE. The infrastructure leverages Hawaii's existing HIE investment—adding an administrative transaction layer on top of the clinical data backbone HHIE has already built. This creates a revenue-generating capability that helps sustain **HHIE**'s essential clinical data interoperability services with **no ongoing state appropriation after Year 5**.

RHTP Multiplier. Smart Health Infrastructure strengthens Hawai'i's Rural Health Transformation investments by delivering a shared administrative backbone that unlocks measurable impact across multiple initiatives:

- **Accelerates Results Across RHTP Goals:**
  - Expands access by automating eligibility checks and coverage decisions, reducing administrative delays that impede patient care.
  - Improves financial stability for rural and neighbor-island providers by reducing claim denials and manual resubmissions.
  - Reduces workforce burden by replacing manual, fax-based workflows with real-time transactions.

- **Supports AHEAD Multi-Payer Alignment:**
  - Provides standardized administrative transactions across Medicare, Medicaid, and commercial payers.
  - Creates consistent data flows that align with AHEAD's measurement and performance goals.
  - Reduces redundant integrations for providers participating in multiple payers, improving efficiency and care coordination.

- **Operationalizes Prior Authorization Reform:**
  - Enables real-time, electronic prior authorization aligned with Hawai'i's recent legislation and timelines.
  - Improves transparency and reporting for regulatory compliance.
  - Reduces the administrative burden that causes care delays and denials.

- **Enables Sustainable Innovation:**
  - Makes telehealth, mobile care, and community-based models financially viable by ensuring coverage and authorization at the point of care.
  - Strengthens data interoperability in support of future digital health advancements.

States are already moving. The Smart Health Infrastructure Alliance is a growing coalition of states building shared administrative rails through their RHTP plans. Rather than each state building its own solution, Alliance members share core technology and payer integrations—reducing costs and accelerating deployment. From Delaware's public RHTP plan:

> ***Statewide Health Information Technology Infrastructure for Real-Time Insurance Verification and Prior Authorizations:*** *"This initiative creates comprehensive digital infrastructure connecting all rural providers, payers, hospital systems, and patients through the Smart Health Network (SHN) and the DHIN... [It] will dramatically accelerate prior authorization processing... physicians, non-physician providers, and other support staff's time will be freed up for direct patient care. This unified system will also directly improve rural health by eliminating geographic barriers to specialist consultations, reducing the need for multiple trips, and supporting telehealth and remote patient monitoring that depend on seamless data exchange."*

A Day in the Life: Before vs. After

Today: Patient arrives for MRI. Clerk calls insurance and is put on hold for 20 minutes. Faxes 23 pages of clinical notes. Denied 3 days later—wrong form. Resubmit. Approved after 2 weeks. Patient gets surprise bill for $500. Angry call to billing. Staff spend 45 minutes resolving.

With Smart Health Infrastructure: Patient arrives. Clerk clicks "Check Coverage." Screen shows green: *Covered, $20 copay, no prior auth required.* Three seconds. Procedure done. Claim auto-submitted. Paid in 5 days. No surprise bill. No angry call.

That's the difference between 1980s infrastructure and modern rails.

By connecting providers, payers, and patients through a neutral, shared utility infrastructure, states can eliminate administrative waste and simultaneously create the secure foundation for AI, precision medicine, and the next generation of healthcare innovation. **The infrastructure that keeps rural hospitals alive today is the same infrastructure that enables the medical breakthroughs of tomorrow.**

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1. Why This Matters Now

No More Faxes

American healthcare still runs on **9 billion faxes** a year. The average prior authorization still requires **23 pages of faxed documentation**. The fax machine has become the symbol of everything broken in American healthcare.

This isn't a glitch. It's the predictable result of three digital islands that were never designed to connect:

- Clinical data trapped in EHRs
- Payment systems built on 1980s EDI standards
- Patients locked out of their own information

The Result: ***"Hey Doc, we'd love to approve your prior authorization. Can you fax us the clinical notes?"***

The "Bleeding Margin" Reality

Hawaii's rural hospitals are not failing because of poor clinical care. They are failing because of **administrative exhaustion**. A typical Critical Access Hospital:

- Spends **3–4% of net patient revenue** on fax-based insurance communications
- Has billing staff spending **60% of their time** on phone holds, faxes, and resubmissions
- Loses **$150,000+ annually** in pure administrative friction—roughly **three nursing salaries**

For a facility operating on **0.3% margins**, that burden could be the difference between staying open and becoming the next closure.

The Workforce Multiplier

Administrative waste is also a **workforce crisis multiplier**:

- Billing staff burn out chasing faxes and denials
- Clinical staff spend time on prior auth appeals instead of patients
- Rural providers already struggle to recruit staff; every hour of administrative drudgery pushes people toward the exit

Eliminating coverage phone calls and manual eligibility checks saves **2–3 FTEs worth of work**. That's not just cost savings—it's staff who stay. Rural hospitals in Hawaii cannot out-pay urban centers. They must compete on **quality of professional life**. Infrastructure that removes prior-auth phone queues makes Hawaii's rural hospitals more attractive places to work.

The Only Option That Helps Everyone

The options for addressing skyrocketing healthcare costs and budget shortfalls are stark:

Option	Result
Cut clinical care	Harmful to patients
Reduce provider reimbursement	Accelerates rural closures
Shift costs to consumers	Defeats the purpose of healthcare access
Eliminate administrative waste	**The only option that helps everyone**

The Resilience Imperative

The 2024 Change Healthcare cyberattack showed that **administrative infrastructure is critical infrastructure**. When the commercial clearinghouse went down:

- Rural hospitals faced liquidity crises within days
- Providers went weeks without payments
- The breach cost over **$3.09 billion** and affected **100 million** Americans

Clearinghouse rails were built decades ago—COBOL mainframes, 1980s X12 standards, thousands of fragile point-to-point connections. The question isn't *if* another disruption will occur; it's **when**.

When the national clearinghouse failed, Hawaii had no fallback to keep its hospitals paid. By deploying on **modern, shared infrastructure**, Hawaii:

- Moves off fragile 1980s architecture to **cloud-native, zero-trust infrastructure**
- Eliminates the "honeypot"—SHN routes transactions but doesn't store clinical or claims data centrally, so there's no single database to breach
- Treats healthcare administrative rails as **critical infrastructure**—like power, water, and broadband

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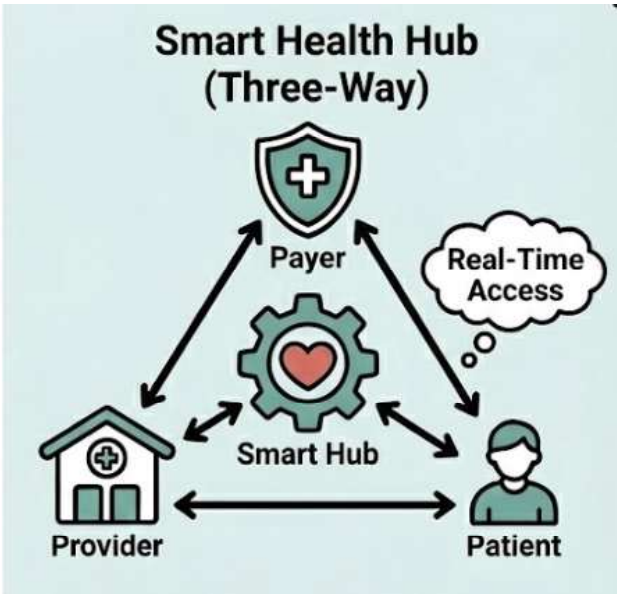
2. The Shared Infrastructure Model

This paper describes how Hawaii can join the **Smart Health Infrastructure Alliance**—a public-private partnership of states deploying shared administrative rails—and connect to the **Smart Health Network**.

A Three-Way Hub

Traditional clearinghouses connect providers to payers and lock patients out. Smart Health Network is different: a **three-way digital hub** connecting providers, payers, **and patients** through neutral, shared infrastructure.



Traditional Clearinghouse	Smart Health Infrastructure
Provider ↔ Payer only	Provider ↔ Payer ↔ **Patient**
Patients locked out	Patients see transactions in real time
"We'll mail your EOB"	Instant visibility into coverage, auths, claims
Information asymmetry	Transparency by design

Why this matters:

- **For patients:** No more playing telephone between doctor and insurer. Track authorization status; see claims before the surprise bill.
- **For providers:** Fewer inbound calls; better-informed patients.
- **For payers:** Transparent transactions; fewer angry "I never knew this was denied" calls.

This isn't just operational efficiency. It's a **philosophical shift**: patients become participants, not afterthoughts.

Proven at Scale

The underlying technology has been validated across:

Metric	Result
Lives processed	**68M+** nationally
Transaction success rate	**99.93%**
Typical transaction time	**<5 seconds**

Metric	Result
Provider savings per claim	**$3.36–$5.75**
Payer savings per claim	**$0.57–$1.65**

This isn't theoretical. The technology is proven at scale. What's new is deploying it as shared state infrastructure through the Alliance and operating it under a neutral Public Benefit governance structure.

A Practical Mechanism for Payers and Providers to Work Together

Today, health plans and providers both want to reduce administrative waste—but they lack a practical way to do it together. The friction isn't anyone's strategy; it's an accident of incompatible systems built over decades. Both sides lose:

- Providers spend 25–30% of revenue on billing, prior auth, and collections
- Payers spend billions on claims processing, denials management, and manual review
- Neither can unilaterally fix infrastructure that requires both sides to connect

SHN operates as **neutral infrastructure**—not a vendor selling to one side, but a utility serving both.

One Backbone, Many Nodes

By joining the Alliance, Hawaii connects to a **single national backbone** for identity, coverage, and administrative transactions. Each state configures its node to local rules; all states share core technology and payer integrations.

Payers integrate **once** and reach every Alliance state. Development costs are **shared**, not duplicated.

How This Differs from EHR Vendor Solutions

"Doesn't Epic already do this?" It's the most common question—and the answer matters for rural providers.

EHR-native automation works inside one ecosystem. Large EHRs' prior auth tools work well for same-vendor transactions. But a Critical Access Hospital on MEDITECH can't use Epic's automation. A rural clinic on athenahealth can't tap into Cerner's payer connections.

Rural providers run diverse systems. Hawaii's rural landscape includes MEDITECH, CPSI, athenahealth, eClinicalWorks, and dozens of smaller platforms. No single EHR vendor serves them all—and none has an incentive to build cross-platform interoperability.

Connect Once, Reach Everyone

Payers need a single integration point. Today, a payer maintaining connections to 50 different provider systems bears 50x the integration cost. SHN gives payers one connection that reaches all participating providers, regardless of EHR.

Providers need a single integration point too. Today, a rural hospital juggles dozens of payer portals—each with different logins, workflows, and quirks. SHN gives providers one connection that reaches all participating payers, eliminating portal fatigue.

	EHR Vendor Tools	Smart Health Network
Works across EHR platforms	❌	✅

	EHR Vendor Tools	Smart Health Network
Single payer integration point	❌	✅
Single provider integration point	❌	✅
Available to CAHs and small practices	Limited	✅
Patient visibility	Varies	✅
Neutral governance	❌ Vendor-controlled	✅

SHN doesn't compete with EHRs—it connects them. Large systems with Epic can participate if they choose. But the primary value flows to the providers who need it most: the rural hospitals and independent practices running fragmented legacy systems without IT departments to build their own integrations.

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3. Enabling Hawaii's RHTP Goals, AHEAD Implementation, and Prior Authorization Reform

Hawai'i's Rural Health Transformation Plan (RHTP) is rooted in the **five federal strategic goals** of the Rural Health Transformation Program:

1. **Support rural health innovations and new access points** to improve preventive health and address root causes of disease.
2. **Sustainable access** by strengthening efficiency, coordination, and continuity of care.
3. **Workforce development** by attracting and retaining clinicians and supporting expanded roles.
4. **Innovative care models** that improve outcomes and lower costs.
5. **Technology innovation** to enhance care delivery, data sharing, and digital access. Engage Hawai'i+1

At the same time, Hawai'i is advancing complementary statewide initiatives — **participation in the AHEAD (Achieving Healthcare Efficiency through Accountable Design) multi-payer model** and comprehensive **prior authorization reform legislation** — that align with RHTP's strategic direction and require durable administrative infrastructure to succeed.

Smart Health Infrastructure provides that **unified administrative backbone** — enabling real-time, standards-based coordination among payers and providers — and supports Hawai'i's RHTP goals, AHEAD implementation, and operationalization of prior authorization policy.

A. Supporting RHTP Strategic Goals with Smart Health Infrastructure

RHTP Goal 1: Rural Health Innovation & New Access Points
Smart Health Infrastructure enables *emerging models of care* (e.g., telehealth, mobile clinics, community paramedicine) by providing real-time coverage verification, authorization, and claims submission at the point of service. This reduces administrative friction that otherwise limits innovation and patient access across neighbor islands.

RHTP Goal 2: Sustainable Access
Administrative inefficiency — including manual eligibility checks and delayed prior authorization decisions — undermines provider financial stability and continuity of care. A shared administrative utility streamlines

eligibility, prior authorization, and claims processes for rural providers, improving cash flow and reducing barriers to offering sustainable services.

RHTP Goal 3: Workforce Development
Much of the administrative burden in rural settings falls on clinicians and support staff, detracting from patient care and contributing to burnout. Automating administrative transactions lets clinicians spend more time on clinical activities, increases job satisfaction, and supports retention in hard-to-staff areas.

RHTP Goal 4: Innovative Care Models
Smart Health Infrastructure accelerates adoption of value-based care, population health solutions, and coordinated care pathways by ensuring consistent, standardized administrative data exchange across payers — a foundational requirement for measuring outcomes and aligning incentives.

RHTP Goal 5: Technology Innovation
By supporting real-time connectivity across eligibility, benefits, authorizations, and claims, Smart Health Infrastructure aligns with RHTP's emphasis on technology-enabled care delivery, data security, and digital health access — enabling rural providers to leverage digital tools without multiple bespoke integrations. CMS

B. Enabling Hawai'i's AHEAD Multi-Payer Model Participation

The **AHEAD model** (Achieving Healthcare Efficiency through Accountable Design) is Hawai'i's multi-payer effort to improve care coordination, reduce cost growth, and equitably improve outcomes across Medicare, Medicaid, and commercial payers. Successful AHEAD implementation relies on *consistent, standardized, transparent administrative data exchanges* that support shared measurement and aligned payment strategies.

Smart Health Infrastructure contributes by:

- **Standardizing administrative transactions across all participating payers**, improving comparability of utilization and outcomes data.
- **Providing a shared, centralized administrative layer** that reduces redundant integration costs for providers and supports coordinated care across payment models.
- **Creating data flows that enhance evaluation of performance indicators** tied to AHEAD goals, including preventive care uptake, chronic disease outcomes, and cost trends.

By aligning administrative infrastructure with AHEAD's design goals, Hawai'i strengthens its ability to meet multi-payer performance metrics while improving provider experience and patient access.

C. Operationalizing Hawai'i's Prior Authorization Reform

Hawai'i's recent prior authorization reform legislation aims to *reduce administrative burden, increase transparency, and ensure timely decision-making* across payers. Legislative success requires infrastructure that can execute on these policy objectives in practice — beyond establishing requirements on paper.

Smart Health Infrastructure enables:

- **Real-time, standards-based prior authorization** submissions and responses (e.g., leveraging advanced electronic prior authorization standards), reducing delays and administrative labor.

- **Timeframe tracking and analytics** to demonstrate compliance with statutory requirements and support ongoing reporting and oversight.
- **Transparent, standardized processes** that improve predictability for providers and patients, helping reduce care delays and denials.

This infrastructure directly enables the law's policy objectives, supporting efficient utilization review and compliance.

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4. Creating an Integrated Foundation for Long-Term Impact

Smart Health Infrastructure unifies eligibility verification, prior authorization, claims routing, and payment reconciliation into a **shared state-scale administrative layer**. This foundation:

- **Reduces fragmentation across payers**, critical in Hawai'i's multi-plan environment.
- **Supports real-time decision-making at the point of care**, enhancing access and reducing administrative delays that disproportionately affect rural/neighbor-island patients.
- **Enables scalable, sustainable models of digital health and care coordination**, aligned with RHTP, AHEAD, and legislative goals.
- **Strengthens data transparency for policy, planning, and quality measurement**, advancing equity and outcomes tracking across rural populations.

Summary

Smart Health Infrastructure is more than a technology project — it is a **strategic enabler** of Hawai'i's RHTP vision. By directly advancing RHTP's strategic goals, operationalizing AHEAD's multi-payer alignment, and fulfilling the practical requirements of prior authorization reform, this infrastructure accelerates transformation, reduces administrative burden, and enhances equitable access to quality care across Hawai'i's rural and neighbor-island communities.

States Are Already Moving

Several states have included participation in the Smart Health Infrastructure Alliance as a core element of their RHTP strategies. Delaware's published RHTP plan provides a template:

> ***Statewide Health Information Technology Infrastructure for Real-Time Insurance Verification and Prior Authorizations***
>
> **Description:** Nationally, insurance verification and prior authorization requirements delay treatment for 89% of patients, causing unnecessary stress, administrative delays, and, in some cases, poor health outcomes – with rural providers facing particularly severe impacts due to limited staff and resources. Rural patients face compounded challenges from prior authorization delays when treatment requires specialist referrals, or transportation barriers mean multiple trips for authorization-related appointments, leading some patients to abandon treatment entirely.
>
> In August 2025, Delaware enacted the Pre-Authorization Reform Act (SB 12) to reduce administrative burdens, improve patient access to timely care and increase transparency in the pre-authorization process. The law establishes processing time limits (2-48 hours), requires electronic provider portals by 2027, limits prior authorizations to one per care episode, and

mandates that denials are made by qualified, non-financially incentivized physicians with detailed justifications reported to the Delaware Health Information Network (DHIN).

To fully realize SB12's promise and address persistent connectivity gaps in rural Delaware, this initiative creates comprehensive digital infrastructure connecting all rural providers, payers, hospital systems, and patients through the Smart Health Network (SHN) and the DHIN. This electronic health information exchange will dramatically accelerate prior authorization processing by allowing providers to exchange data electronically and allowing payers to report faster authorization decisions. Cloud-based infrastructure will minimize maintenance and operations management, while vendor-neutral standards will prevent vendor lock-in and stakeholder councils will ensure fair governance. By building streamlined conduits for data transmission, physicians, non-physician providers, and other support staff's time will be freed up for direct patient care. This unified system will also directly improve rural health by eliminating geographic barriers to specialist consultations, reducing the need for multiple trips, and supporting telehealth and remote patient monitoring that depend on seamless data exchange. The state will track key health metrics including reduced readmissions, increased preventive care utilization, improved chronic disease management, enhanced behavioral health coordination, reduced provider burnout, increased value-based care participation, and lower total cost of care.

Main strategic goal: Tech Innovation

Key stakeholders: Smart Health Network, DHIN, DHSS, DPH Office of Provider Resources, Provider Organizations, payers, Medicare, Health Systems, VA

Outcomes:

- Reduction in elapsed time for response to prior authorization request (Target: 75% reduction by Year 3)
- Reduction in first pass denials related to coverage errors (Target: 90% reduction, initially 15-20% to less than 2% by Year 3 for enrolled payers)
- Rural healthcare provider adoption (Target: Year 1 at 30%+, Year 2 at 55%+, Year 3 at 70%+, Year 4 at 80%+, Year 5 at 90%+)
- Clean claims rate (Target: Year 3 at 85%, Year 5 at 90%+)
- Patient portal launch by year 3 (Target: patient adoption of 30% by Year 5)

Estimated Required Funding: $50 million over 5 years

Sustainability plan: After initial implementation, the model will break even in Year 4 and become fully self-sustaining in Year 5 through a utility fee model of 0.05% of revenue equally applicable for all payer and provider participants – including state agencies, state Medicaid programs, rural and non-rural healthcare providers, and public (including Medicare) and private insurers.

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4. How It Works in Hawaii

What Deploys in 90 Days

In the first **90 days**, Hawaii completes a **Phase 1 technical stand-up**—the core infrastructure is configured, tested, and connected to initial payers.

In scope for 90-day stand-up:

- **Identity Service** — secure, cross-participant patient matching

- **Coverage Direct —** real-time eligibility verification ("Is this patient covered? What's the copay? Does this need prior auth?") in **under 3 seconds**
- **Initial payer connections —** 3-4 payers representing >50% of Hawaii's covered lives

What happens after 90 days: - Provider onboarding ramps over Months 3–12

- Additional payers added as LOIs convert to live connections
- Real-time claims routing (Phase2) begins Month 6

Because Hawaii uses the same standardized node as other Alliance states, implementation is **configuration, not custom code**. This is a proven SaaS platform, not a build-from-scratch project. That's why 90 days is realistic for technical stand-up—while recognizing that adoption scales over the following year.

In other words: 90 days gets Hawaii live and connected; full provider adoption is a 12–24 month change-management effort.

The Deployment Roadmap

Phase	Timeframe	Capabilities	RHTP Alignment
1	Months 1–6	Identity + Coverage	Financial stabilization
2	Months 6–18	Claims Workflow	Operational efficiency
3	Months 12–24	Prior Auth Automation	Workforce retention
4	Months 18–36	Patient Access Platform	Care coordination
5	Months 24–48	Analytics & VBP Support	Value-based payment readiness

RHTP funds support Phases 1–3. Phases 4–5 are funded through the utility model once volume reaches sustainability.

Each phase turns on **when Hawaii is ready**, not on a fixed national schedule.

Rural providers see value in Month 1, not Year 3.

Voluntary Adoption — No Mandates

Participation is entirely voluntary. There are **no new mandates and no penalties**, and with RHTP underwriting first-year fees, rural providers see savings from day one. Adoption spreads because it works and delivers value—not because the government requires it.

Practical on-ramps:

- RHTP underwrites first-year fees for rural providers—no upfront cost
- Existing EHR workflows preserved—SHN integrates with current systems
- Quarterly ROI reports show each provider their savings

EHR Integration: Who Pays What

Rural providers often face "connection fees" from their EHR vendors to enable new integrations. Left unaddressed, these fees can block adoption.

RHTP funds cover:

- SHN node configuration and connection
- Provider onboarding and training
- First-year utility fees for rural providers
- EHR vendor integration fees for participating rural providers (where applicable)

Providers are responsible for:

- Staff time for training (typically 2–4 hours)
- Ongoing utility fees after Year 1 (offset by proven savings)

By covering EHR vendor fees through RHTP, Hawaii removes the most common barrier to rural provider adoption.

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5. The Business Model

The Transaction Economics

Transaction Type	Legacy Process	With SHN
Eligibility verification	Phone call, 8–12 minutes	Real-time API, <3 seconds
Prior authorization	Fax + phone, 3–14 days	Instant or hours where clinical review needed
Claim submission	$25–$30 per claim (manual)	$0.30–$0.50 per claim
Denial / resubmission	$30–$50 per rework episode	Largely eliminated via accurate coverage info & clean claims

The Utility Fee Model

0.05% of revenues from each party — payer pays 0.05%, provider pays 0.05%, total system fee is 0.10%.

Transaction Value	Payer Pays	Provider Pays	Total
$1,000 claim	$0.50	$0.50	$1.00
$10,000 procedure	$5.00	$5.00	$10.00

Why the Math Works—For Everyone

	Per Claim	On 1M Claims/Year
Provider savings (proven)	$3.36–$5.75	$3.36M–$5.75M
Payer savings (proven)	$0.57–$1.65	$570K–$1.65M

Both sides save more than they pay. Savings from the coverage solution alone—reducing first-pass denials for providers and coordination of benefits for payers—more than justifies the entire utility fee. Every additional capability (prior auth, claims automation) increases ROI.

No hidden costs:

- The 0.05% utility fee is all-in—no additional per-transaction charges
- No provider integration or upgrade fees
- No new state appropriations required post-RHTP

The Opportunity for HIE Sustainability

Hawaii has invested in building HHIE as essential health information infrastructure. Like HIEs nationwide, HHIE was built with federal grants and state investment to move clinical data—lab results, discharge summaries, care plans. But clinical data exchange doesn't generate sufficient sustainable revenue:

- Providers benefit but resist paying subscription fees
- Payers benefit but view HIE connectivity as a provider responsibility
- The result: perpetual grant dependency, uncertain year-to-year funding, inability to invest long-term

SHN creates an opportunity: **add a revenue-generating layer** that sustains the entire operation. When eligibility, prior auth, claims, and payment flow through the same infrastructure as clinical data, **utility fees from administrative transactions can sustain the entire operation**.

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6. Governance & Accountability

Built for Perpetual Independence, Neutrality & Sustainability

The Neutral Operator. Smart Health Network operates as a Public Benefit Corporation—legally required to balance public mission with sustainability. The "No Raw Data" rule prohibits accessing or monetizing patient data.

The Mission Guardian. An independent Benefit Trust governs the PBC, ensuring it remains true to its public mission. The Trust holds "Golden Share" rights preventing any sale or merger that would compromise the network's role as permanent public utility.

Multi-Stakeholder Governance

Governance is structured to ensure representation across all sectors of healthcare:

Council	Representation
Members' Council	Patients and families
Provider Council	Physicians, nurses, clinicians
Care Delivery Organizations Council	Health systems, medical groups, FQHCs
Payer Council	Insurers, employers, government payers
Public Health Council	Health departments, community health
Research Council	Academic centers, researchers
Technology & Innovation Council	Digital health, EHRs, cloud & AI platforms
State Advisory Councils	Local stakeholder input and compliance oversight

This structure ensures the infrastructure serves everyone equally—permanently.

Hawaii Voice

Each participating state appoints a representative to its **State Advisory Council** with input on:

- Data privacy rules

- Network policies
- Roadmap priorities

No Lock-In

State officials rightly worry about vendor lock-in. This infrastructure eliminates that concern:

- **Built on open FHIR standards** — not proprietary protocols
- **Data stays at endpoints** — Hawaii never surrenders data to a central repository
- **Portable by design** — if better infrastructure emerges, Hawaii can unplug without losing data

This is not a walled garden. It's a reversible infrastructure choice.

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7. Data & Security

Hawaii data remains under Hawaii's legal and regulatory control. SHN is a trust fabric, not a data platform—it routes transactions but doesn't store clinical or claims data centrally.

Key architecture principles:

- **No honeypot.** Unlike centralized clearinghouses, there's no central database to breach. Data stays at the endpoints.
- **Zero-trust.** Every transaction authenticated and authorized independently.
- **Cloud-native.** Modern infrastructure, not legacy COBOL mainframes.
- **Resilience.** Because SHN routes transactions without storing claims or clinical data, a breach in one participant does not compromise the entire network.
- **Compliance:** SOC 2 Type II certified, HITRUST CSF aligned, HIPAA BAAs with all participants.

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8. Next Steps

1. **Review alignment** — Map to Hawaii's RHTP application and priorities
2. **Convene stakeholder discussion** — RHTP leadership, HHIE, SHN, key providers & associations, major payers
3. **Develop implementation plan** — Hawaii-specific timeline, budget, and milestones

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The Fax Machine Era Is Over.

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