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WHITE PAPER

Pain to Promise: Prior Authorization Automation That Works for Providers



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Introduction

Background

Prior authorization (PA) has long been a standard component of healthcare processes, intended to balance cost control with the delivery of medically necessary care. Efforts to standardize prior authorization have not kept pace with the growing need for change resulting in a complex web of challenges for healthcare providers, revenue cycle leaders, and those seeking care.

While the goals of prior authorization are to ensure appropriate and necessary care while still controlling costs, providers face fragmented, unclear, inconsistent and highly manual workflows undermining the very goals prior authorization was designed to accomplish. And like many suboptimal processes in healthcare, the clinical and financial repercussions of poor prior authorization are far-reaching.

The mounting crisis surrounding prior authorization has recently shifted into the national healthcare spotlight, and there is a growing alignment between regulatory bodies, payers, and technology innovators on the need to standardize these archaic workflows.

With the goal of benchmarking provider perspectives on, and experience with prior authorization, this survey-based research explores issues revenue cycle leaders face with prior authorization and includes a current view of operational processes, authorization impacts, and a coalescing industry approach to authorizations.

Evolution of Prior Authorization

1950's: Prior authorization started as a cost control mechanism. Implemented by insurers, it launched the idea that payers need approval before care is delivered.

Early 1970's: The Health Maintenance Organization Act (HMO Act) focused on gatekeeping care and cost containment.

1980's/1990's: Enrollments in HMOs spur prior authorization to become the norm, not just for hospital stays but across many other services.

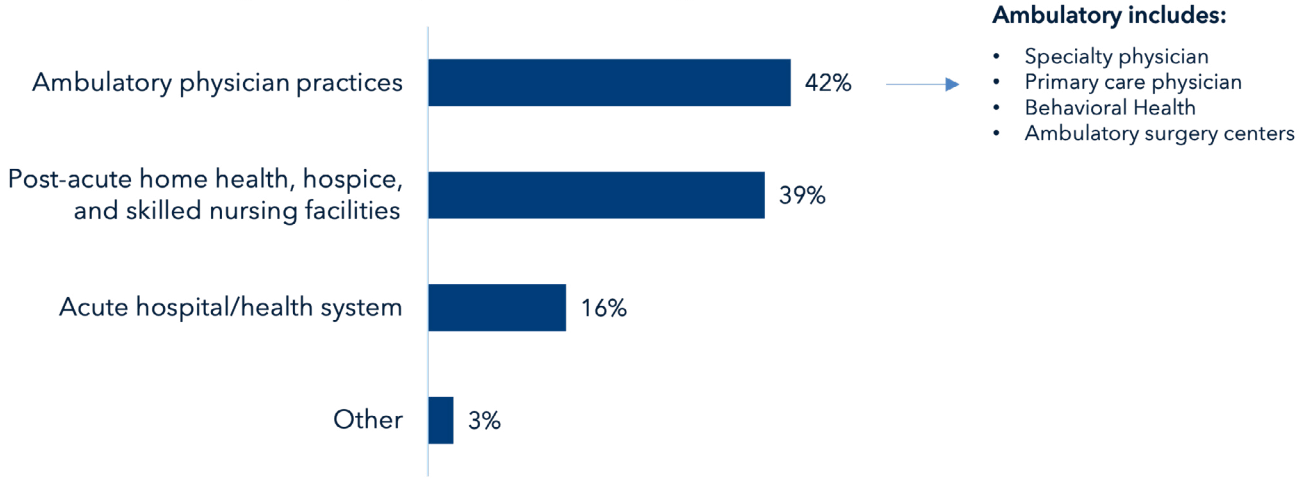
2000–2020: The HITECH Act passed to standardize the healthcare system, but prior authorization remained largely manual. The act promoted the adoption of EHRs.

Today: Prior authorization is undergoing transformation driven by regulatory reforms, increased payer involvement, and technological advances in automation. Key changes are the new CMS rules governing prior authorization and the mandate for payers to standardize on the FHIR protocol for data exchange, both of which are set to be implemented by January 1, 2027.

Method

- National online survey of over 370 revenue cycle executives and managers from acute, post-acute and ambulatory care settings (Figure 1).
- Participant roles primarily included C-suite/VPs, Directors, and Managers. Sample titles included Director of Revenue Cycle, VP of Finance/CFO, Billing Manager and Business Office Manager.
- Respondents were well acquainted with prior authorization at their organizations.
- Surveys were completed in February 2026.

Figure 1: Care Settings Represented: Revenue Cycle Management (RCM) Leaders and Managers





Key Findings

The Inovalon survey-based research has sharpened focus on the state of prior authorization in 2026. Healthcare leaders are grappling with a prior authorization process that is fragmented and inefficient. They require a one-stop shop for streamlined authorization workflow, processes that cut down on authorization denials and appeals, and a significant reduction in manual effort.

Challenge is widespread; hospitals particularly impacted – Prior authorization is a significant challenge across healthcare settings, with 56% of healthcare leaders citing it as a significant challenge. While many leaders of post-acute and ambulatory facilities find prior authorization vexing, 85% of acute hospital leaders are significantly challenged by prior authorization.

Executives view prior authorization as a significant challenge – Clinical, financial, and administrative impacts have made authorizations a front-and-center concern for many of the more senior executives who participated in the survey. Seventy percent of executives now consider prior authorization to be a top or significant challenge.

Highly manual and local workflow – About two-thirds of teams manage prior authorizations directly on-site. These teams have created have created highly manual prior authorization workflows amidst a maze of specific payer requirements and back and forth with insurers. Virtually all providers (93%) use at least one of two lower-tech methods in requesting and obtaining authorizations: payer websites/portals and phone/fax.

Payer related friction – Variability in payer requirements is particularly burdensome, creating a minefield of rules, processes, and nuances that revenue cycle staff must traverse in order to provide care. These variable payer requirements were noted as a challenge by 56% of leaders across care settings.

Moving from manual to automation – Industry and regulatory shifts toward addressing prior authorization dysfunction are pushing the industry forward and away from the heavily manual workflows associated with prior authorization. The use of electronic prior authorization (ePA) will standardize processes to support a unified provider-centric automated prior authorization process, enabling providers' prior authorizations to be set up for success right from the start.

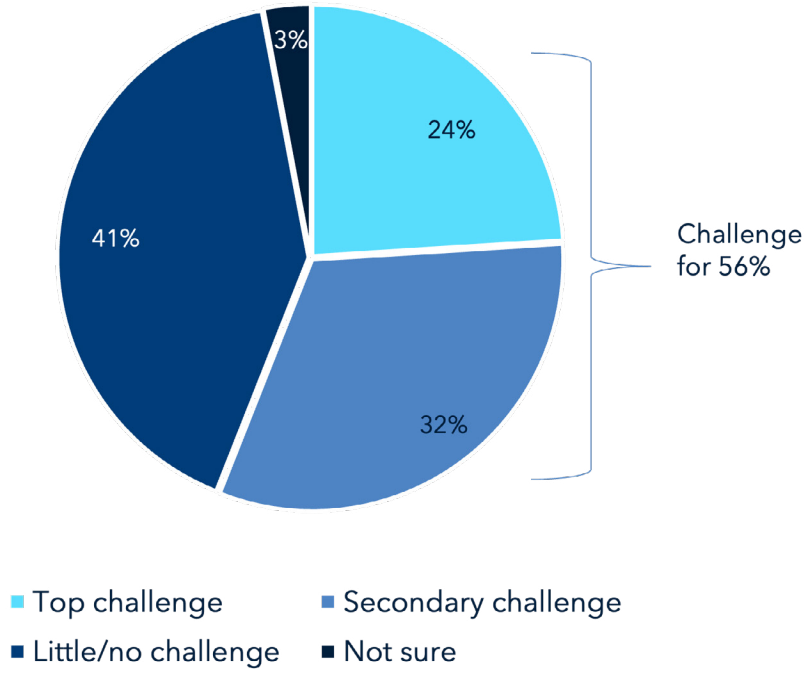


Prior Authorization Challenges Echo Across Healthcare

A Burden Across Healthcare Settings

Prior authorization is a significant challenge across healthcare settings, with **56% of healthcare leaders** citing it as a top or important secondary challenge (Figure 2).

Figure 2: Challenge of Prior Authorization: RCM Leaders



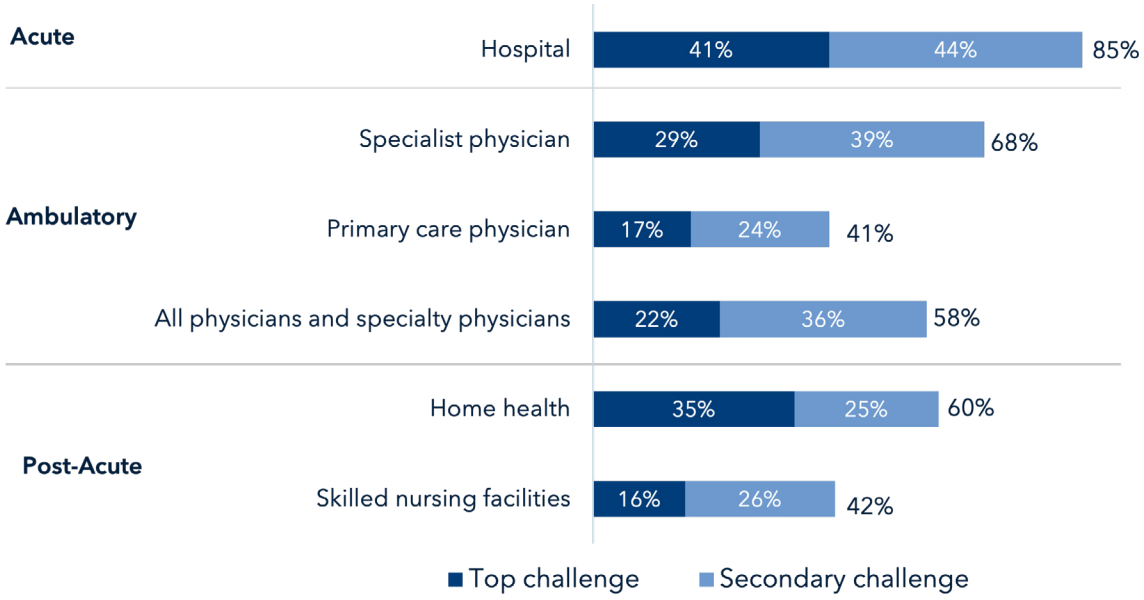
The burdens of prior authorization are particularly severe for hospitals and health systems. It was cited by **85 percent of hospitals as a top or secondary challenge** (Figure 3).

These ratings by hospital leaders stem from the high cost, volume, and complexity of the services hospitals provide. These expensive and resource-intensive services often receive increased scrutiny from insurance companies.

Additionally, an unauthorized procedure such as a surgery isn't just a paperwork error; it's a massive financial loss when many hospitals are already operating on thin margins.

While hospitals experience the most pronounced impact from prior authorization, the burden is not confined to acute care settings. For most care settings, a majority consider prior authorization a significant operational challenge. These findings underscore that prior authorization inefficiencies span the full continuum of care – affecting organizations of varying size, acuity, and operational complexity.

Figure 3: Challenge Posed by Prior Authorizations by Care Setting



Challenge Is Recognized by Executive-Level Leaders

The burden of prior authorization has escalated beyond a daily operational issue. It has become a primary concern at the executive level, with **70 percent of executives** now considering **prior authorization to be a top or significant challenge** (Figure 4).

This executive-level concern is rooted in the understanding that the cumulative effect of broken authorization processes may directly impede core business objectives. The financial stability of the organization can be undermined by revenue loss from denials and the rising administrative costs of managing the process.

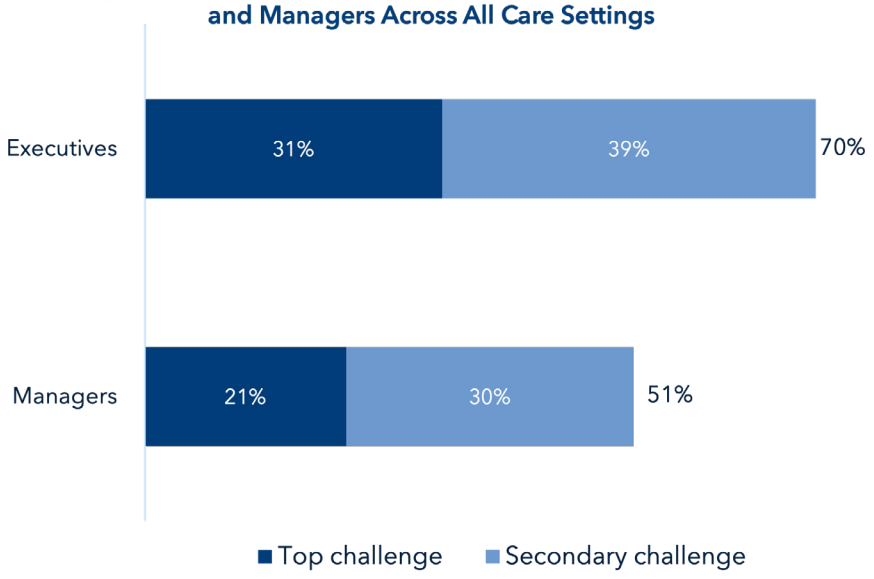
Additionally, goals related to improving the patient or resident experience, growing key service areas, and performing well in quality measures can be jeopardized when needed care is delayed by administrative hurdles.

Leaders are challenged by:

> “Time it takes payer to respond.”

> “Inconsistent payer policies and payer representatives’ lack of knowledge.”

Figure 4: Challenge Posed by Prior Authorization Executives and Managers Across All Care Settings



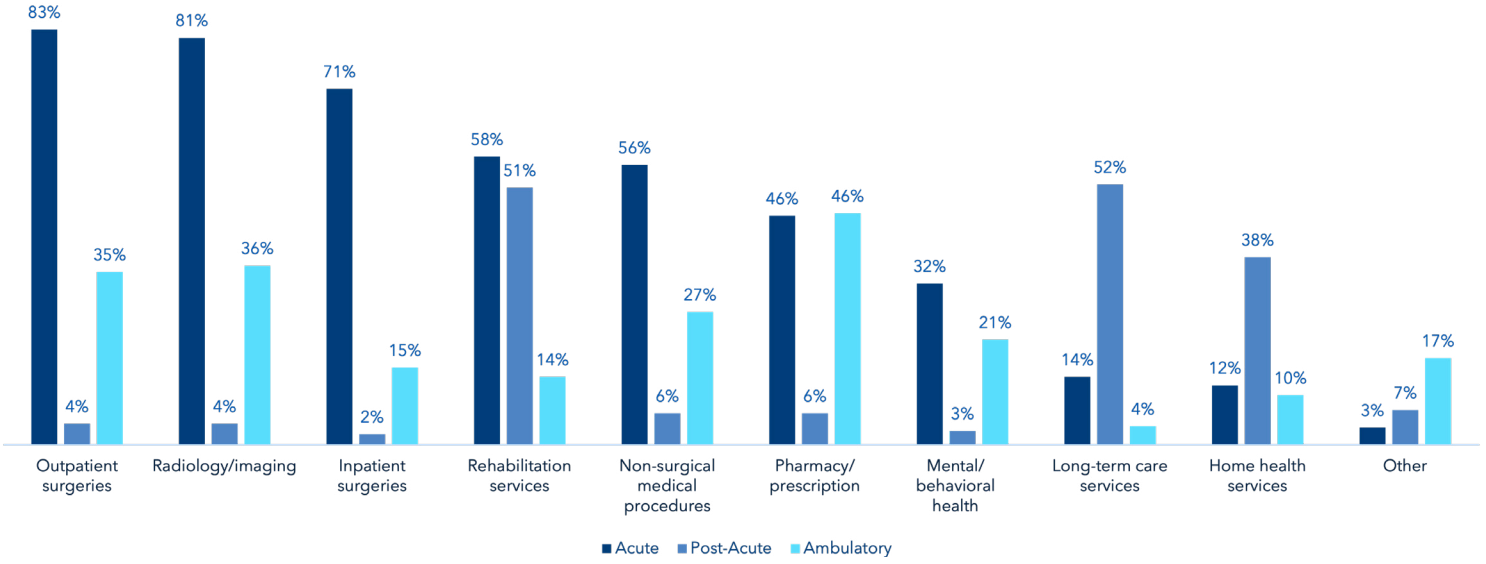
Inside the Process: The What, Where, and How of Prior Authorization

"What" is required: the scope of prior authorizations

The administrative burden of prior authorization is intensifying, spurred by the sheer breadth of services that now fall under its purview. What was once a tool reserved for exceptionally high-cost, non-routine therapies has evolved into an all-too-common hurdle for routine care. This results in increased volumes for staff to contend with, and even more varied rules to identify and comply with.

Services requiring authorization vary by care setting, mirroring the types of services provided. For instance, pharmacy and prescription authorizations are most frequently noted by ambulatory providers who are prescribing many medications while acute hospitals cite surgeries and processes around radiology and imaging. Those in post-acute settings are faced with authorizations for long-term care and home health services as well as rehabilitation (Figure 5).

Figure 5: Services Requiring Authorizations by Care Setting
(Multiple responses allowed)



The “Where” of Authorizations: Localized or Centralized Workflows?

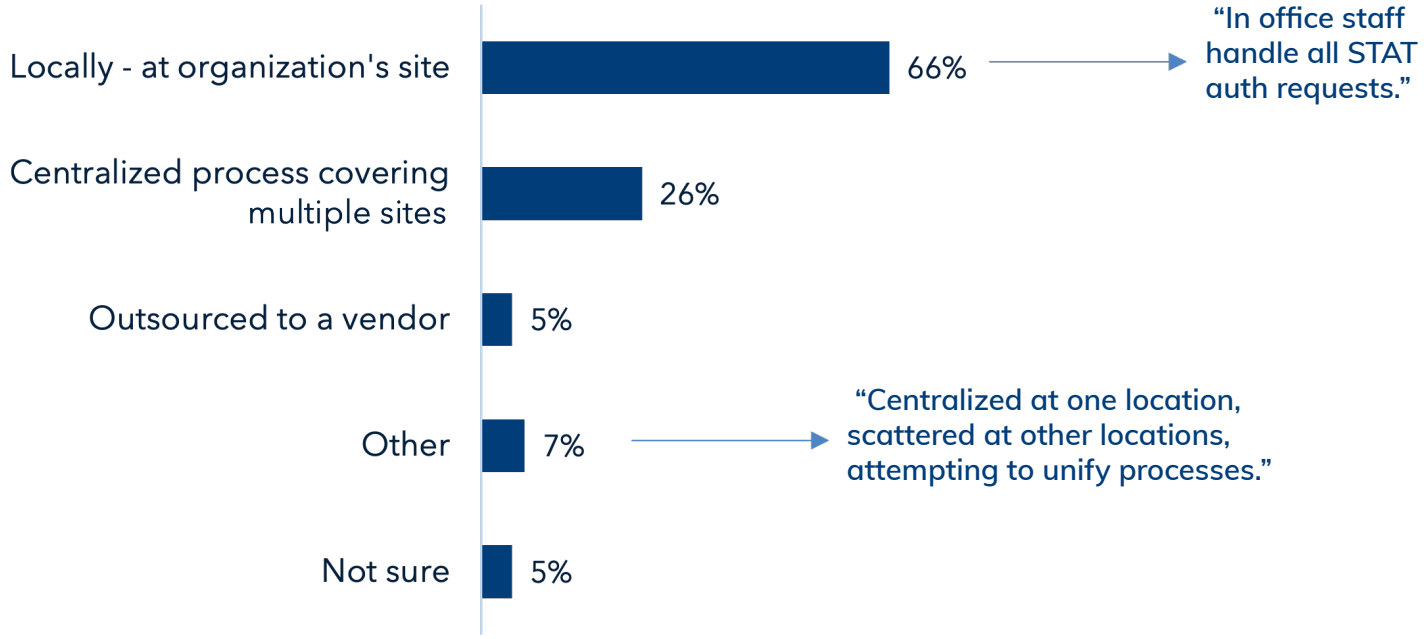
Given the complexity of obtaining authorizations, this research explored the extent to which prior authorization workflows had been centralized or outsourced to specialist teams who, in theory, would be more familiar with the idiosyncrasies of working with various payers.

Survey results highlight a **significant “insourcing”** trend that keeps the full administrative weight and mental load (tracking requirements/training) of prior authorizations firmly on the shoulders of internal teams. Additionally, rather than offloading these tasks to a central site, **66% of providers manage prior authorizations directly on-site,** while only 26% utilize a centralized model to cover multiple locations (Figure 6).

Despite the intensity of the manual burden, outsourcing has yet to gain a significant foothold, with only **5% outsourcing the process.**

> “Having enough staff to manage provider schedules AND have the time to obtain a prior authorization is challenging.”

Figure 6: Location of Prior Authorization Process
(Multiple responses allowed)



The “How” of Authorizations: Manual, Automated, or a Mix of Both

Requesting and obtaining authorizations typically involves multiple low-tech channels. Most staff use more than one method, further complicating the process.

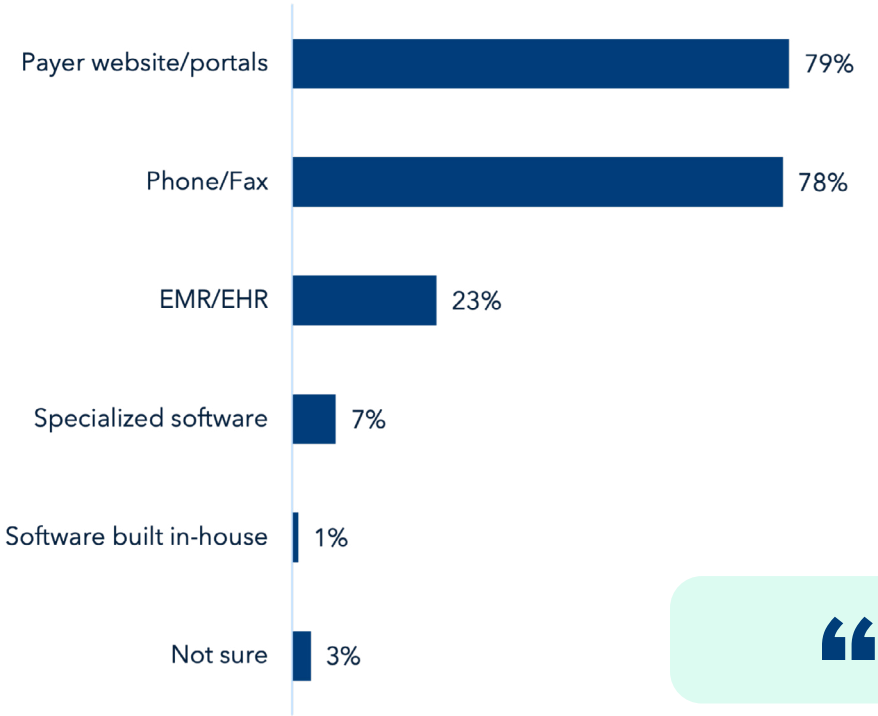
Virtually all providers (93%) use at least one of two lower-tech methods in requesting and obtaining authorizations: Payer websites/portals and phone/fax.

- The use of **phones and fax** is dominant in prior authorization workflow, with 78% of leaders citing its use. This can tie up staff for hours with follow-up often required (Figure 7).
- Similarly dominant are **payer portals or websites** (79%), each with different logins, passwords, and interfaces. Often, these non–intuitive systems have users switching between windows, re-entering data and piecing together the nuances of each portal.
- Seldom mentioned are prior authorization software solutions, either EHR-based (23%), or specialized authorization software (7%). Given the proliferation of software over the past few decades, the lack of authorization automation stands in stark contrast.

> “… No matter how you try to reach the carrier, it’s pain and suffering.”

Figure 7: Methods Used to Obtain Prior Authorizations

(Multiple responses allowed)



> “It’s archaic!”

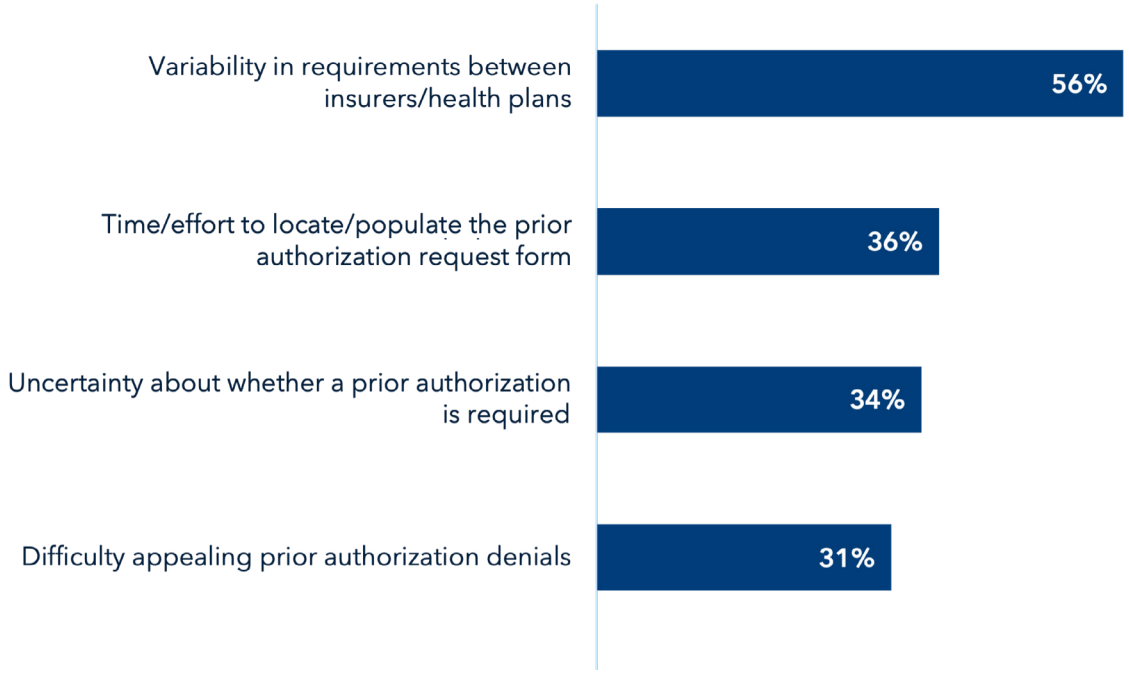
Breaking Down Prior Authorization Challenges

Variable Payer Requirements and Processes Add to the Burden

This research delved into the specific authorization challenges provider organizations face and leaders did not hold back about their frustrations, particularly with those related to payers. **The variability in requirements between payers** was noted as a challenge by 56% of leaders across care settings (Figure 8).

> "Keeping up with changes of what does and doesn't need authorization, payer sources changes and different authorization requirements, denials for authorization even when in place or not needed."

Figure 8: Challenges With Prior Authorizations
(Multiple responses allowed)

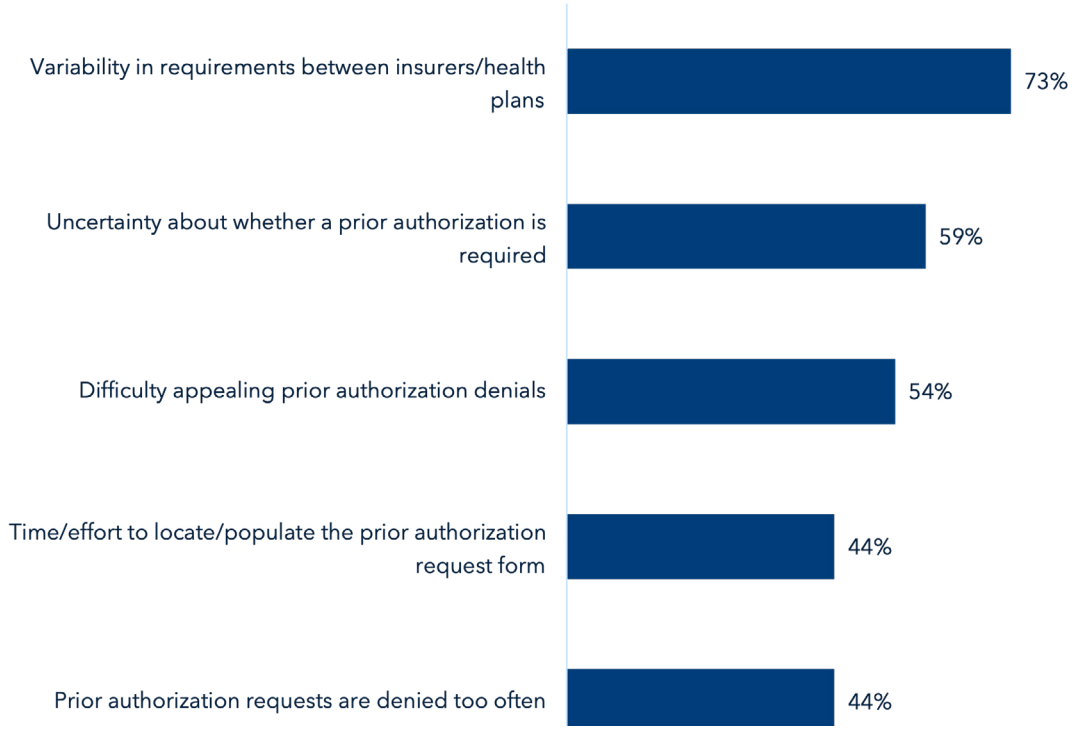


> "The processes for prior authorization vary wildly between insurance plans … the requirements to authorize a procedure that the provider/specialist requests are unwieldy and cumbersome."

> “Complexity of different payer prior auth requirements and having different prior auth processes/vendors for certain tests like imaging. Even when prior auth is obtained, they still deny and we have to resubmit the claim with the prior auth documentation.”

This variability among payers was a particular pain point for hospitals, with 73% mentioning it (Figure 9). Over half of hospitals also cited **uncertainty about whether authorizations were required** and **difficulty appealing prior authorization denials.**

Figure 9: Challenges With Prior Authorizations
Acute Hospitals and Health Systems
(Multiple responses allowed)



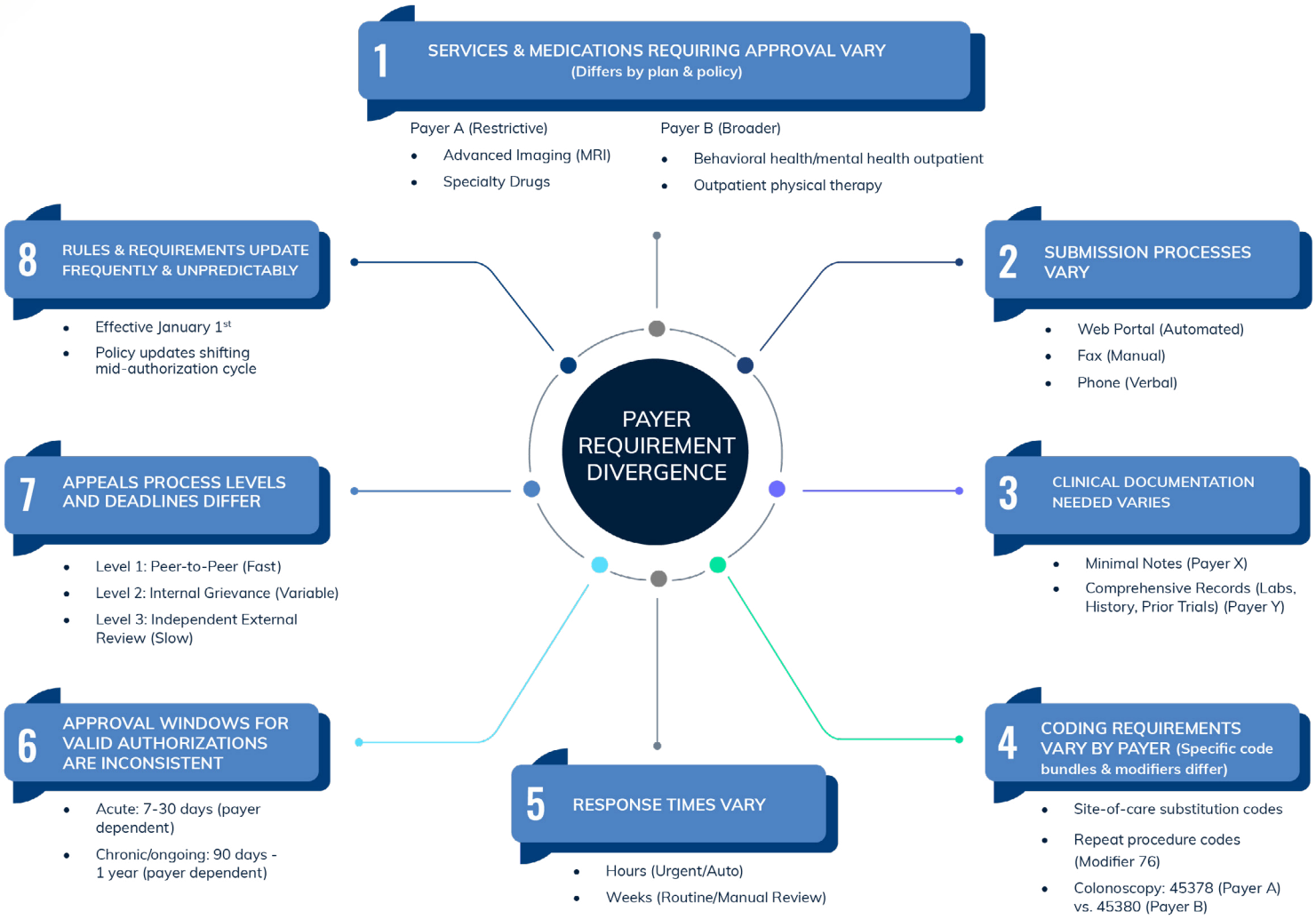
> “Not knowing when an authorization is needed, getting the incorrect CPT authorized, [waiting] too long to obtain an authorization.”

The Ridiculous Dance

Healthcare is complicated enough. By adding obtuse, ambiguous requirements, payers can create operational havoc for providers. Instead of a single, predictable system, provider staff must navigate a multitude of payer-specific requirements that differ in almost every aspect of the process (Figure 10). Often, this does not set providers up for success with approvals. One leader described their frustration with the prior authorization process as "the ridiculous dance with denials."

> "The ridiculous dance with denials and peer to peers before they finally approve only to deny payment."

Figure 10: Varying Payer Requirements for Prior Authorization



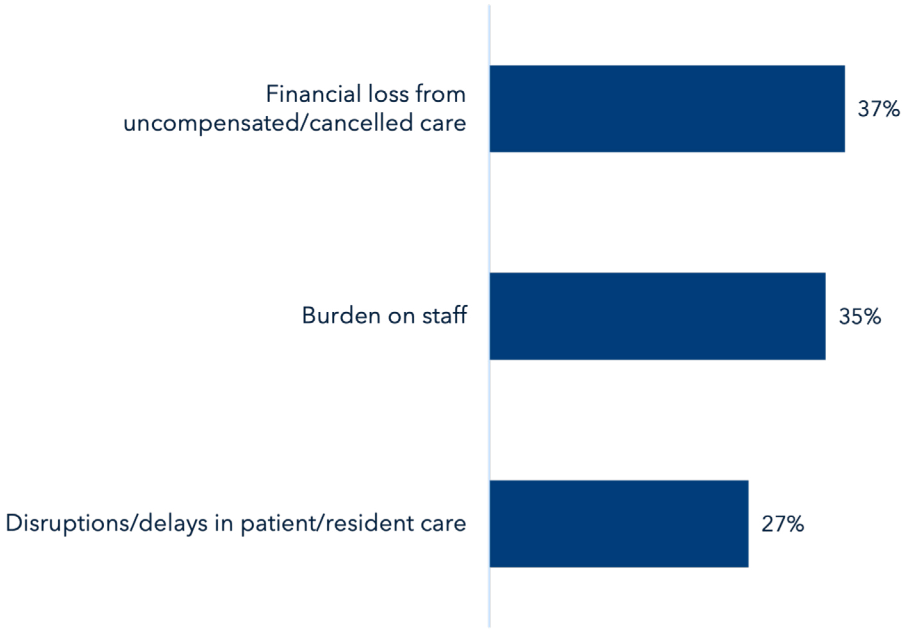
High-Impact Areas: The Financial and Human Toll of Prior Authorization

While the daily grind of prior authorization presents a wide array of challenges and issues, its most detrimental impacts consolidate into three core areas: **financial loss**, **staff burden**, and **disruption of patient/resident care**.

When asked which of these areas had the single greatest impact, leaders' responses, which were distributed across the three areas, conveyed a holistic view of organizational impacts beyond dollars and cents (Figure 11).

Perhaps leaders recognize that, in reality, these impacts are interconnected. For instance, the time staff takes on manual processes can translate to delayed patient or resident care, spiraling into treatment abandonment and financial loss. Additionally, the highly disjointed and manual documentation process can result in more denials, canceled or delayed services, and financial loss. **These cycles degrade every aspect of operational excellence and healthcare provision**.

Figure 11: Greatest Impact of Prior Authorization



> “Needs to improve for financial stability.”

> “Cumbersome administrative burden that often limits care for bundled payers. The number of visits allowed is often less than we would see patients. Why are they limiting care for a bundled payment? My bottom line is affected.”

Authorization High-Impact Area: Financial Loss

- Administrative costs of requesting/obtaining authorizations
- Administrative costs of prior authorization appeals
- Revenue loss from delayed or abandoned treatment
- Delayed and cancelled treatments could ultimately lead to worsening conditions and more costly interventions
- Sizeable contributor to claim denials

Revenue cycle management leaders say prior authorization is a leading contributor to denied claims

Acute
Hospital and health systems
70%

Ambulatory
Physicians and specialists
48%

Post-Acute
Home health, and skilled nursing
34%



What’s causing healthcare RCM claim denials, and what can you do about it?

View Research Findings

> “Having the time and staff to get the authorizations.”

> “We struggle to keep up with volume of prior auths needed … using a manual process.”

Authorization High-Impact Area: Burden on Staff

- Use of archaic technologies in a high-touch process
- Manual burden of keeping track of varying requirements
- Inefficient use of highly skilled professionals leads to care gap as clinical staff are pulled away from patient- or resident-facing duties to manage administrative tasks
- Time and training to understand the nuances of payers’ processes
- Laborious status follow-ups
- Coordinating appointment schedules in event of delay in care

> “The amount of staff time to keep track of all the days and updates that have to be sent to get additional days.”

> “Getting the correct information from the insurance and then calling and getting the authorization sometimes takes 1–2 hours on hold over the phone to get someone.”

> ...trying to get them in a timely manner to get the patient seen in time."

> The inability to provide great patient care due to the constraints placed on us by insurance companies."

Authorization High-Impact Area: Care Disrupted/Delayed

- Necessary care getting delayed or denied
- Treatment abandonment
- Negative clinical outcomes
- Strained patient-provider relationship
- Third-party interference with medical decision-making

> Insurance driven decisions for treatment that harm patients and deny access to MD-prescribed treatment."

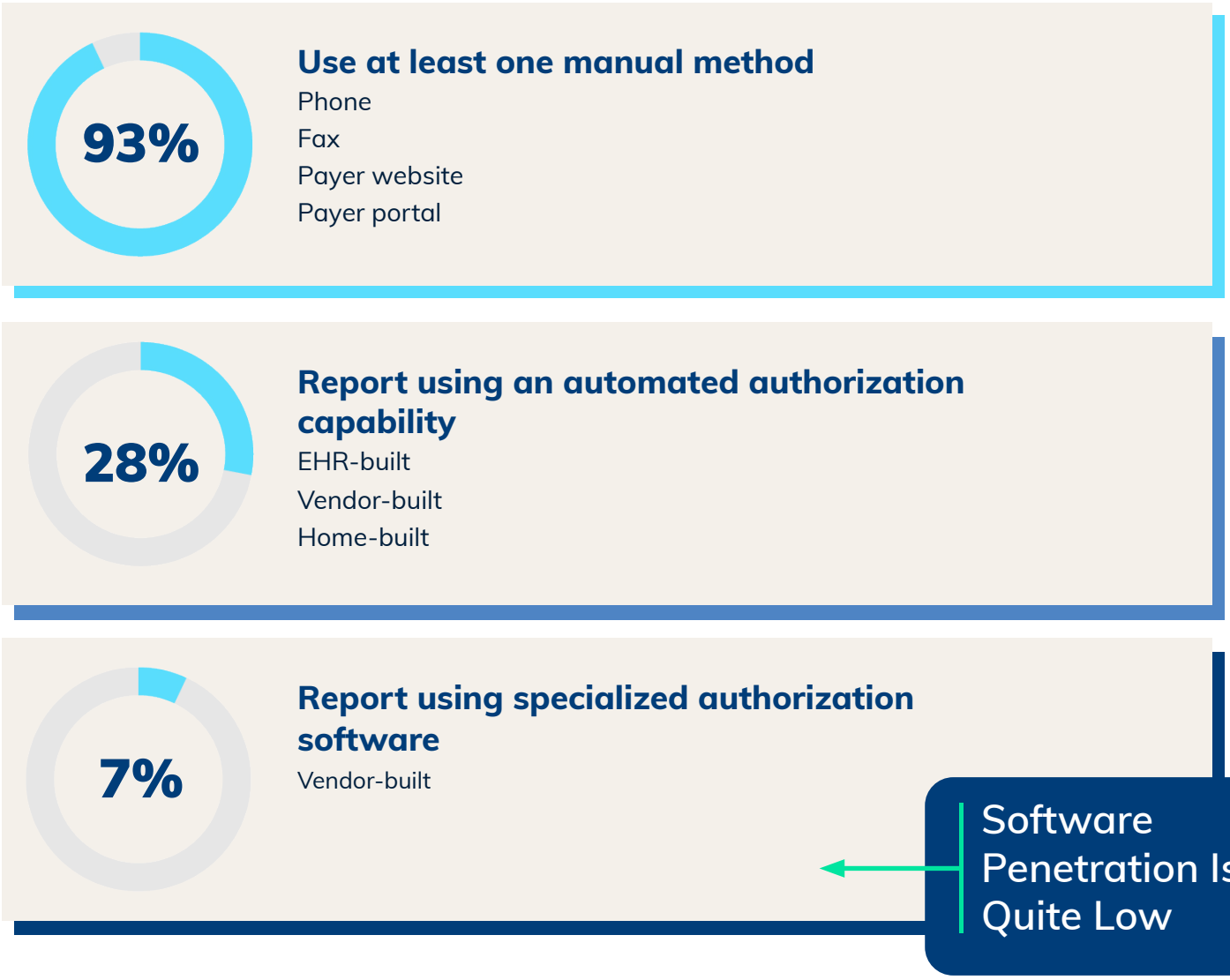
> The insurers drag their feet and require peer-to-peers, all of which delay treatment."

> Getting an authorization back in a timely manner is difficult. This prolongs hospital stays. Also, once a patient is admitted and has a continued stay review sent, the determination of that can be even longer."

Moving Beyond Manual Prior Authorization and the Status Quo

For decades, the healthcare industry has shouldered the burden of prior authorization by "making do" with a patchwork of inefficient, manual processes. Survey results paint a clear picture of this legacy system: 93% of organizations still rely on manual methods like phone calls and faxes, while only 28% have adopted any authorization software to alleviate the strain (Figure 12).

Figure 12: Methods Used for Prior Authorization
(Multiple responses allowed)



This long-standing acceptance of the status quo has led to a workforce that is adept at navigating obstacles, not because the system is effective, but because they have learned to expect and overcome the friction.

"It could be better, but it works currently."

"No other option at the moment."

"Process is probably ok but there are just too many denials."

Industry and regulatory shifts toward addressing prior authorization dysfunction are **pushing the industry forward** and away from the heavily manual workflows associated with prior authorization. The call to improve prior authorization is gaining momentum, fueled by alignment of **government**, **industry**, and **the payer community** itself.

"Need automation and use of AI."

"It would be easier if all insurances had an automated system to obtain authorizations."

"We are working with an AI company to automate this process."

"Too much manual work and too long to obtain auths. I will be looking at an automated solution."

To move beyond the current state of prior authorization, forward-focused leaders are investigating and adopting automation solutions such as ePA software.

What Could Provider-Centric Prior Authorization Look Like Going Forward?

As the healthcare industry intensifies its focus on prior authorization, technology is emerging as a critical enabler of real change. Upcoming regulatory changes will bring relief to healthcare providers, but providers will need to be ready to support these new workflows. The use of ePA software will modernize processes to support a unified provider-centric automated prior authorization process.

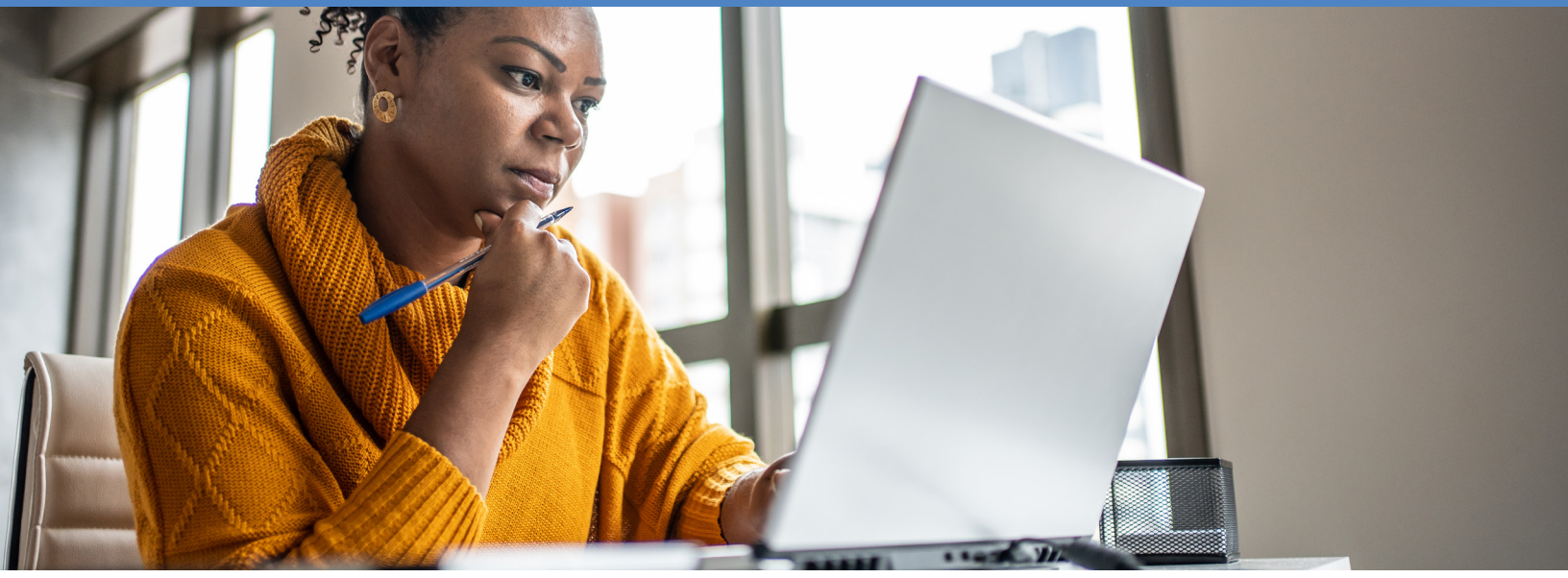
The true value of this unification is the confidence and certainty gained from setting up a prior authorization for success right from the start. No longer a guessing game, providers can be assured that a valid authorization is in place (if needed) at the time of care delivery. Additionally, by integrating ePA with other front-end workflows, providers can establish correct patient or resident identity, confirm insurance coverage, and determine coverage details in a single, streamlined process. This unification will save hours of manual labor and, as an authorization denials prevention strategy, ensures that care will be reimbursed as expected.

Ultimately, this shift supports every side of care delivery. Patients, residents, and their caregivers can be financially prepared, financial teams can feel confident in reimbursement and their organization's financial health, and healthcare staff can focus less on administrative tasks and more on delivering high-quality care.

Electronic prior authorization is not just an improvement to a single process; it is the catalyst for a more efficient, certain, and care-focused experience.

Take the Next Step

Connect with Inovalon to simplify prior authorization and get care and revenue back on track.



About us

Inovalon is a leading provider of data and solutions empowering data-driven healthcare. We bring together national-scale connectivity, real-time primary source data access, and advanced analytics into a sophisticated platform empowering improved outcomes and economics across the healthcare ecosystem. The company's analytics and capabilities are used by over 50,000 active, licensed customers. Learn more at www.inovalon.com.

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