cohere HEALTH

2026 PROVIDER SURVEY



Better AI, not less AI

How providers' relationship with AI is maturing

Findings from Cohere Health's second annual national provider survey of 100 clinicians and 100 office administrators

National provider survey fielded for Cohere Health® by

WAKEFIELD

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Overview

Healthcare's relationship with AI is changing. Early on, healthcare leaders asked questions like whether AI belonged in healthcare and how quickly it would be adopted. Now that it's here, the questions are more practical: what should it do, who stays accountable, and who can be trusted to build it?

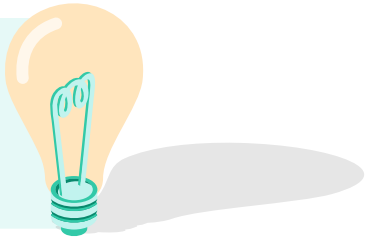
To find answers, we asked the people closest to the work. In August 2026, Cohere Health partnered with Wakefield Research to survey 100 clinicians and 100 office administrators across hospitals and medical systems throughout the US. This is our second annual survey, and it focuses on prior authorization (PA)–the point where AI, regulation, and health plan practices intersect most directly with providers' day-to-day work.

Providers' responses make their terms for AI in prior authorization clear: a defined scope for the technology, a named person accountable for each decision, and builders who pair clinical expertise with connected records. Health plans that design around these expectations will earn providers' trust and set the standard for AI across plan operations.

The sections ahead cover year-over-year results, the most important shifts, and the trends health plans should watch now.

THE SHORT VERSION

Providers aren't turning away from AI.
They're getting specific about what they trust it to do.



THIS PAPER COVERS THREE AREAS

1	**How providers' relationship with AI is changing.** Trust, oversight, and the use cases providers want.	CLINICIANS 96%	OFFICE ADMINISTRATORS 94%
		still trust AI in PA approvals, but strong trust dropped to 12% for both clinicians and office administrators (falling from 46% and 32%, respectively).	
2	**Prior authorization: what eased, what held, what slipped.** Outcomes, burden, denials, and digital progress.	CLINICIANS 55% → 28%	OFFICE ADMINISTRATORS 55% → 26%
		see patients abandon treatment often or all the time	
3	**What this means for health plans and provider organizations.** Our view of where the market goes next.	CLINICIANS 80%	OFFICE ADMINISTRATORS 91%
		say real-time approvals would be at least moderately valuable	

Source: Cohere Health and Wakefield Research provider survey, 2025 and 2026. n=100 clinicians and n=100 office administrators each year.

01

Healthcare's relationship with AI is maturing, not cooling

At first glance, **providers seem more cautious about AI** in prior authorization. Between 2025 and 2026, strong trust in AI making PA approvals fell by more than half in both groups, from **46% to 12% among clinicians** and **32% to 12% among administrators.** Clinicians' support for AI playing a significant or core role fell from **90% to 53%.**

The rest of the data tells a different story. **Nearly all providers still trust AI** to approve prior authorizations. **This suggests providers didn't walk away from AI; they got more specific about its role.**

IN THIS SECTION



Trust held. Strong trust didn't.
Most providers still trust AI. Far fewer trust it strongly.



Oversight surged.
Providers are more specific about what they want from AI.



Providers became more selective.
Practical help rose. Looking ahead and suggesting alternatives faded.



More automated, not just more digital.
What providers say would help most.

Trust held. Strong trust didn't.

In 2025, **46%** of clinicians and **32%** of administrators strongly agreed they trusted AI to make PA approvals. In 2026, that dropped to **12% in both groups.** The majority of the shift favored **"somewhat agree"** (84% of clinicians, 82% of administrators). This reflects **trust with conditions attached.**

Q. *How strongly do you agree or disagree: "I trust the use of AI in making prior authorization approvals."*



CLINICIANS

96%

Still trust AI in PA approvals

Strongly agree: 46% → 12%

OFFICE ADMINISTRATORS

94%

Still trust AI in PA approvals

Strongly agree: 32% → 12%



OUR READ

Providers still trust AI, but plans now have to earn it. Total agreement slipped only a few points, from 99% to 96% among clinicians and from 96% to 94% among administrators. What fell was strong trust, and most of the trust that remains is conditional: 84% of clinicians and 82% of administrators now say they only somewhat agree.

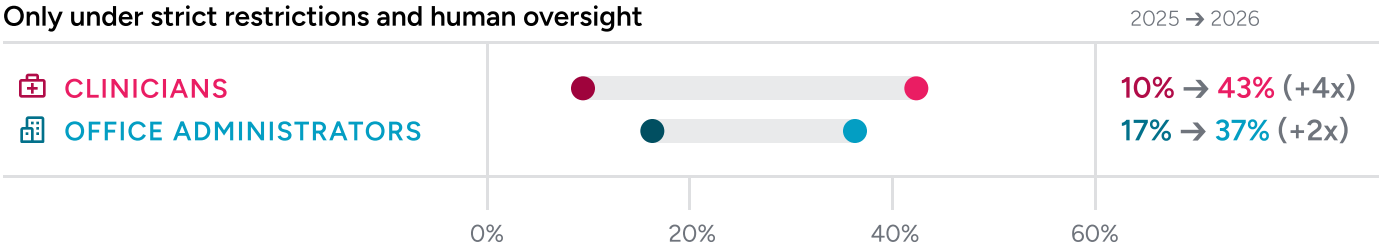
That is a different relationship than a year ago. Strong trust was a vote of confidence in what AI might do. "Somewhat trust" is a vote on what it still has to prove. We think plans should read that as an invitation, not a warning.

Trust in PA isn't a feeling providers have about AI, but a standard plans have to meet. Plans that show providers what AI contributed, keep a person accountable, and earn trust one use case at a time will keep it. **Plans that treat trust as a given will find strong trust will continue to shrink.**

Oversight surged.

Support for strict restrictions and human oversight **more than quadrupled** among clinicians and **more than doubled** among administrators. "Only under strict restrictions and human oversight" is now clinicians' most common answer (43%) and administrators' second (37%).

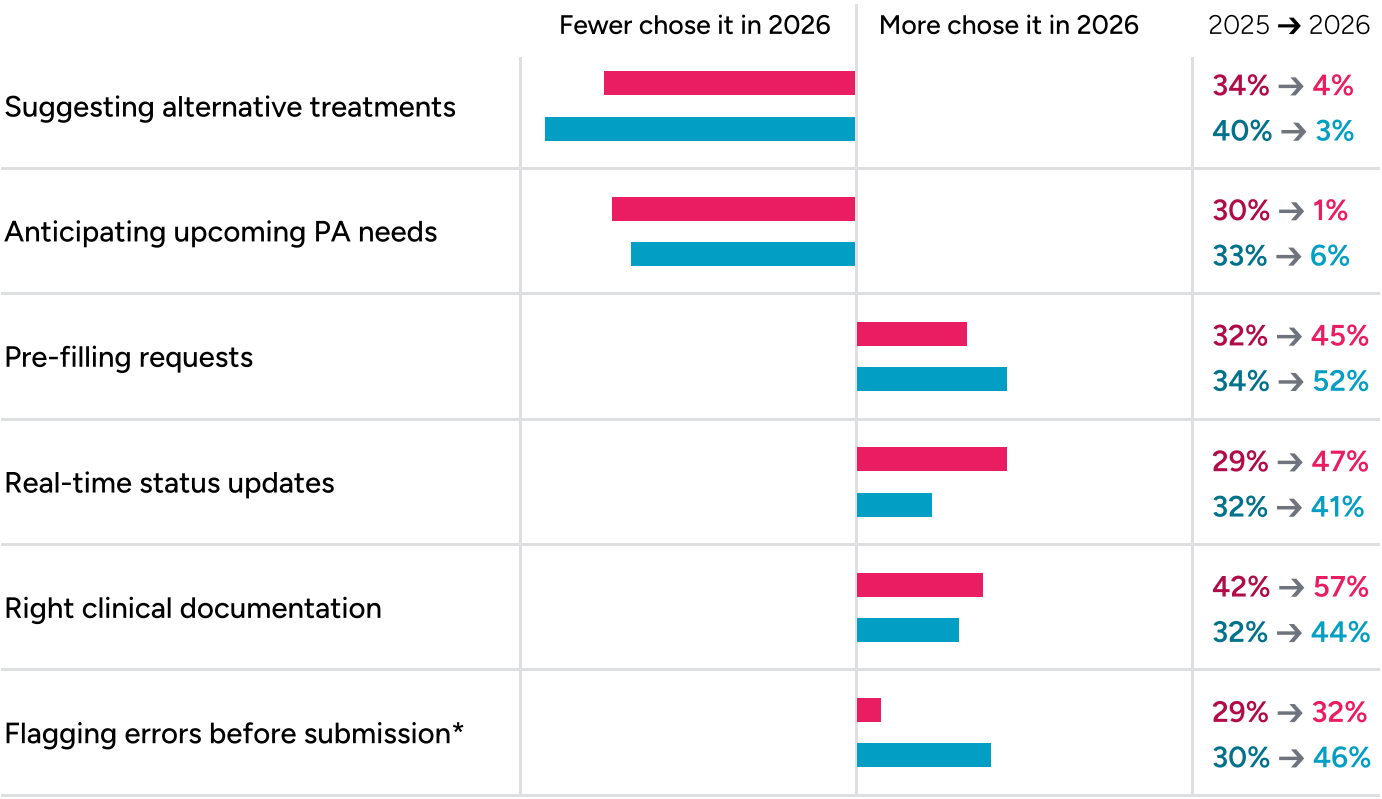
Q. *Which of the following best describes how you feel about the use of AI to automate prior authorization?*



Providers became more selective.

Two answers nearly disappeared. Practical help rose. Providers aren't resistant to AI, but they're drawing a clear line: faster, more accurate work, not replacing clinical judgment.

Q. *In which of the following ways would you find AI and automation most helpful in the prior authorization process?*



* Clinicians' interest in error flagging held roughly flat (29% → 32%). Significant at 95%: both drops; clinicians' rises in documentation and status; administrators' rises in pre-filling and flagging errors.

More automated, not just more digital.

We asked the same question both years. Which would most improve your experience with prior authorization: a fully digital experience or a more automated one? In 2025, most opted for fully digital solutions. **By 2026, most clinicians chose automation.**

Q. *Which of the following would have the biggest impact on improving your experience with prior authorization requests?*



CLINICIANS — 2025: 67% fully digital

45%	55%
Fully digital experience	More automated experience



OFFICE ADMINISTRATORS — 2025: 65% fully digital

53%	47%
Fully digital experience	More automated experience

Administrators carry a smaller shift; read as directional.

"The most important thing for any AI use cases in healthcare: Clinicians have to be in the loop, sitting side by side, arm in arm, with the technologists who build the systems. That's what makes it more accurate and more efficient."

Dr. Brian Covino, chief medical officer, Cohere Health[1]

OUR READ

Providers have spent more time with AI tools, which has likely made them more specific about what they want. Where they value AI and where they're comfortable using it line up: **documentation, completeness, and status.** The two uses that nearly disappeared are the ones where AI would reach toward a clinical or forward-looking call.

Taken together, providers still trust AI, but strong trust gave way to conditions, and oversight became clinicians' most common ask.

The winning AI strategy amplifies human expertise while keeping clinicians firmly in the driver's seat. Scope and oversight are now part of the case for any AI tool.

[1] Payerchin, R. (2026, August 18). 'AI is never used to deny care' — on tech, trust, accuracy and prior auths. Medical Economics. https://www.medicaleconomics.com/view/-ai-is-never-used-to-deny-care-on-tech-trust-accuracy-and-prior-auths

02

Prior authorization: what eased, what held, what slipped

PA is one of the clearest stress tests of the relationship between healthcare and AI: heavily regulated, operationally burdensome, and embedded in the daily workflows of clinicians and office administrators alike. That combination of high-value, high-friction, and high-stakes work is exactly what makes PA such a compelling area to gauge AI's real-world value and boundaries.

Between 2025 and 2026, **several things changed simultaneously:** federal decision-timeframe requirements took effect in January 2026, health plans' voluntary commitments to make PA less burdensome began phasing in, and AI use grew.

When **new regulations, emerging technology, and entrenched workflows collide,** PA is where the tension—and opportunity—becomes visible.

IN THIS SECTION

1 **Outcomes eased. The workload didn't.**
Treatment abandonment and ER events fell, but every respondent still reports a burden.

2 **Documentation now leads denials.**
Missing documentation and medical necessity top the list.

3 **Requirements are still hard to find.**
Nearly nine in ten providers find them hard to find or understand.

4 **Digital progress is uneven.**
Phone and fax submissions edged down.
Electronic prior authorization (ePA) use and plan acceptance slipped.

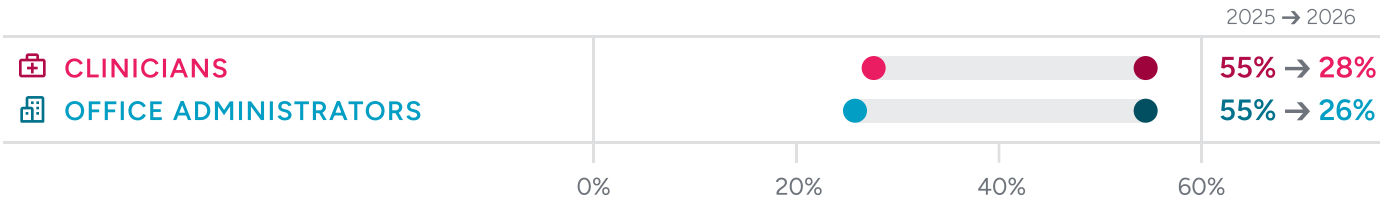
5 **Where the rules still stand.**
The next deadlines, and what they rely on.

Outcomes eased. The workload didn't.

Treatment abandonment roughly halved, and avoidable ER or hospital care **fell by two-thirds or more**. The workload on provider teams didn't follow.

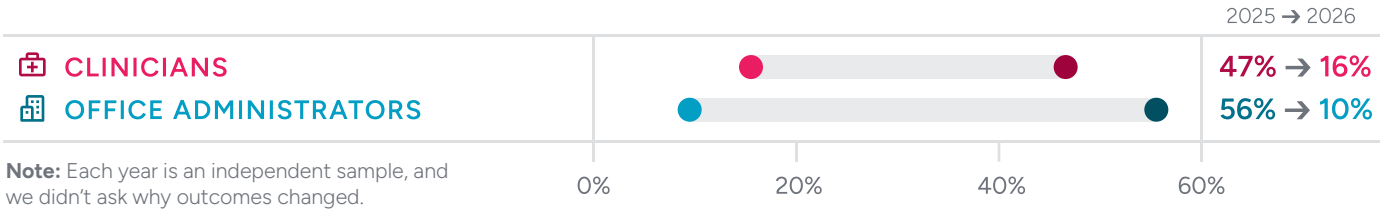
Providers who see patients abandon treatment often or all the time

Q. *How often are patients abandoning a recommended treatment due to prior authorization delays?*



Providers who have seen delays cause avoidable ER or hospital care repeatedly

Q. *Have you seen prior authorization delays lead to avoidable hospitalizations or emergency care?*



Note: Each year is an independent sample, and we didn't ask why outcomes changed.

How heavy providers say the burden is on their team

Q. *How much of a burden does the prior authorization process place on you or your team's workload and well-being?*



CLINICIANS

100%

still report a burden in 2026

Moderate or heavy: 40% → 51%



OFFICE ADMINISTRATORS

100%

still report a burden in 2026

Moderate or heavy: 39% → 61%

Arrows show 2025 → 2026

OUR READ

PA isn't progress until it's better for patients and lighter for providers.

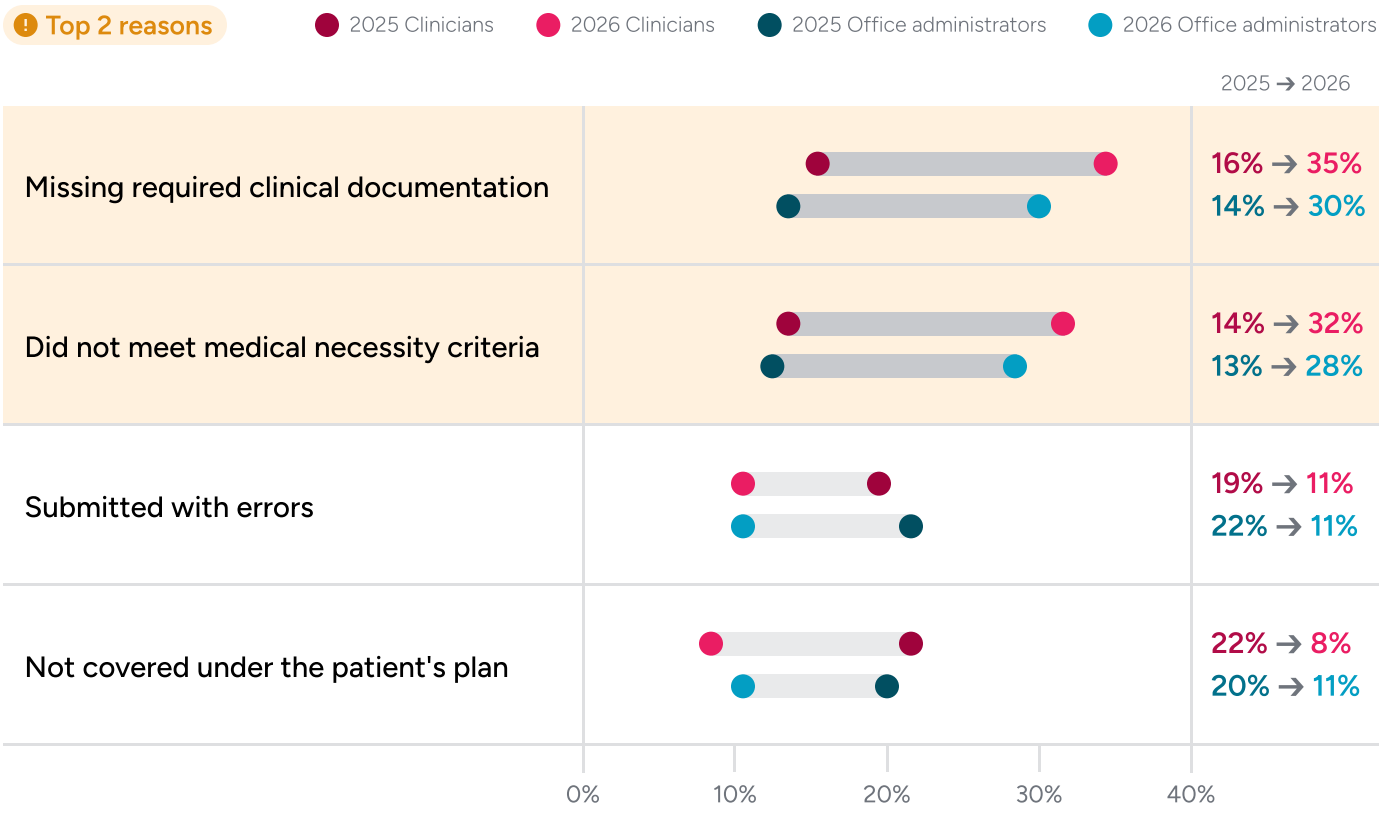
Treatment abandonment and avoidable ER care fell sharply, which is real progress for patients. But the work didn't get lighter. Heavy burden is gone, yet moderate burden is what most teams carry now, and not one provider from this survey reported none. A plan can hit its turnaround target and leave that load in place.

We think PA should be judged on both scorecards at once: what happens to patients, and what it costs the team. The next fix is the work around the request, and that is where AI should aim first.

Documentation now leads denials.

Missing documentation is now the top reason providers cite for denials, and medical necessity is second.

Q. *Which are the most common reasons for prior authorization denials?*
Top-ranked response, share of each group.



Increases in missing documentation and medical necessity are statistically significant for both groups. Smaller shifts may be within sampling error.

OUR READ

Denials are becoming a documentation problem, and plans can solve it up front.

Missing documentation and medical necessity now lead, and both turn on whether a request carries what the plan needs. Providers can only send what they know to send.

That puts the fix at the front door. Plans can tell providers what a request needs before they submit it, flag what's missing at submission instead of after a denial, and share top denial reasons back so providers can fix the pattern themselves.

Requirements are still hard to find.

Nearly nine in ten providers find requirements hard to find or understand, and most are asked to resubmit information they already provided. Questions below were new in 2026, so there is no 2025 comparison.

Q. *How easy or difficult is it for you to find and understand the prior authorization requirements (including medical policies and documentation requirements) before submitting a request?*

Hard to find and understand requirements	**91%** Clinicians	**87%** Office admins	say requirements are at least somewhat difficult to find and understand

Q. *How frequently are you asked to submit information that your organization has already provided, or that already exists in another connected system? Respondents were given examples including clinical records for utilization management, prior authorization decisioning, or payment integrity validation.*

Asked to resubmit what they already provided	**84%** Clinicians	**85%** Office admins	are asked at least occasionally to resubmit information they already provided

Q. *Approximately what percentage of your prior authorization requests do you believe are initially denied by health plans?*

Estimated intial denial rate	**62%** Clinicians	**61%** Office admins	estimate that 21%–30% of requests are initially denied

OUR READ

Providers shouldn't have to guess what a plan needs, or send it twice.

CMS-0057-F already requires plans to give a specific reason for every denial; providers are asking for the other half: clarity before they submit, so they stop guessing and resubmitting. Hard-to-find requirements and repeat requests are the plan's responsibility to solve, not the provider's.

Plans can close that gap now. Put every PA requirement in one place, in plain language. Reuse what the plan already has so providers don't resend it. And show providers why a decision was made, not just what it was.

Plans that do this will earn the trust everything else depends on.

Digital progress is uneven.

Phone and fax requests edged down, but heavy ePA use fell. Plans not consistently accepting electronic submissions is still the top barrier,[1] even as providers' own barriers, like internet access, dropped.

1 EDGED DOWN

Phone and fax requests (average share)

Clinicians
26% → 18%

Office admins
20% → 18%

2 SETBACK

Providers submitting more than 40% of requests through ePA

Clinicians
24% → 8%

Office admins
16% → 6%

3 SETBACK

Received a sub-hour approval multiple times

Clinicians
34% → 8%

Office admins
48% → 17%

Every respondent has had one at least once. The change is in how often it repeats.

Questions asked: (1) What percentage of your prior authorization requests are submitted via fax or phone? (2) What percentage of your prior authorization submissions are completed through a health plan's electronic prior authorization (ePA) automated platform or a health plan provider portal? (3) Have you ever received prior authorization approvals in less than one hour?

What gets in the way of submitting electronically

Q. *What, if anything, prevents you or your team from using online portals or electronic systems to submit prior authorization requests? Please select all that apply.*

Top barrier	CLINICIANS 2025	CLINICIANS 2026	OFFICE ADMINISTRATORS 2025	OFFICE ADMINISTRATORS 2026
Plans don't consistently accept electronic submissions	29%	68%	47%	67%
Contracted health systems require phone or fax	32%	50%	31%	54%
Portal is too difficult or time-consuming	30%	60%	30%	52%

Fewer providers → More providers

2025 bases were under 100 (96 clinicians, 88 administrators), read as directional.

[1] Separately, fewer respondents say more than 30% of the health plans they work with have integrated PA requests into their EMR/EHR workflow: 29% of administrators (52% in 2025) and 40% of clinicians (61%). The change is statistically significant, but average integration held at roughly 30%.

Where the rules still stand

As of October 2026

JAN. 1, 2027
FEDERAL

FHIR APIs required for prior authorization, provider access, and payer-to-payer exchange.

CMS-0057-F

2027
HEALTH PLANS (VOLUNTARY)

Standardized electronic submissions, and real-time answers for **at least 80%** of electronic approvals with all needed clinical documentation.

AHIP commitments

OCT. 2027
PROPOSED

CMS-0062-P would **extend electronic PA requirements to drugs** and update parts of CMS-0057-F for medical services. Not final.

CMS-0062-P

CMS-0057-F covers Medicare Advantage, Medicaid and CHIP, and ACA plans on federal exchanges.

What the deadlines rely on

ALREADY IN EFFECT · JAN. 2026
Plans subject to CMS-0057 must give a specific reason for every denial and publicly report PA metrics. Medicare Advantage, Medicaid, and CHIP plans must also respond within **72 hours** (urgent) or **7 calendar days** (standard).

COMING IN 2027

FHIR APIs for prior authorization, provider access, and payer-to-payer exchange are required by **Jan. 1, 2027**, alongside voluntary health plan commitments. **Final rules stay on the books, and the proposed drug rule (CMS-0062-P) points the same way.**

"Visibility into the PA process isn't the same as improving it."

Gigi Yuen-Reed, PhD, chief data and AI officer, Cohere Health

OUR READ

Fewer providers see patients abandon treatment or end up in avoidable ER or hospital care, yet the work on their teams isn't lighter. Documentation now leads denials, requirements are still hard to find, and digital progress is uneven.

The deadlines ahead rest on two foundations: plans that accept electronic submissions consistently, and complete clinical documentation at submission. Inconsistent plan acceptance is the top barrier to electronic submission, and missing documentation is the top reason for denials.

Meeting the requirements is the starting point. **Whether providers feel the difference depends on how well plans support them through it.**

03

What this means for health plans

Providers told us where it hurts, what to fix first, and what they trust: speed, a person accountable for the decision, and AI that supports the administrative work. **What follows is where we think the market goes from here, and what it means for health plans.**

IN THIS SECTION



AI supports administrative work. People make the decisions.
Providers want speed, and a person in the loop.



The ask is for clearer rules, not fewer rules.
Providers want clarity, not complexity.



The road to real-time PA runs through documentation.
Complete, connected records come first.

AI supports administrative work. People make the clinical decisions.

Providers want speed and a person accountable for the decision. Both show up in the data: real-time approvals are valued, and specialty input would raise confidence. Both questions below were asked only in 2026.

Real-time approvals would be at least moderately valuable

Q. *How valuable would real-time prior authorization approvals be to your practice?*



CLINICIANS
80%



OFFICE ADMINISTRATORS
91%

Specialty input would raise confidence

Q. *How much would your confidence in the prior authorization process increase if medical policies and clinical review criteria were developed or endorsed with input from specialty medical societies?*

Specialty input would raise confidence at least moderately



CLINICIANS
51%



OFFICE ADMINISTRATORS
67%

Everyone else said slightly more confidence.

OUR READ

Providers want more than speed. They want a fast answer, with a person and a reason behind it.

A quick answer isn't the same as a trusted one. Trust starts with removing the administrative work providers shouldn't be doing in the first place, so their clinical expertise goes where it's needed.

We think the standard is simple: people control the critical decisions, and AI earns its place by taking on the administrative work around them.

Providers want clarity, not complexity.

Clearer requirements top the list of fixes for both groups. What providers usually find hardest is the administrative work around a request. Both questions below were asked only in 2026.

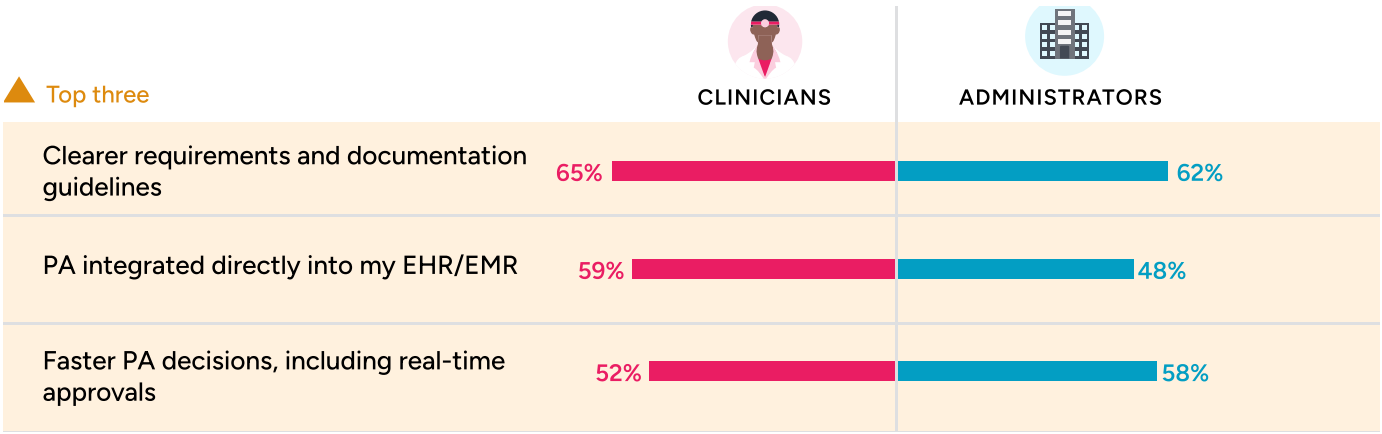
The hardest part of PA

Q. *Which aspect of prior authorization creates the most difficulty for you?*

CLINICIANS		OFFICE ADMINS	
Differing plan requirements	21%	Tracking request status	26%
Waiting for decisions	21%	Follow-up to obtain approval	19%
Tracking request status	18%	Differing plan requirements	16%
Follow-up to obtain approval	18%	Denials and appeals	15%

Biggest impact on improving the PA process

Q. *Which of the following would have the biggest impact on improving the prior authorization process?*



OUR READ

Digitizing fax moved the work to a screen, but it didn't remove the administrative work. Portals are still hard to use, electronic submissions aren't accepted consistently, and clinicians now prefer automation that guides them through the process over a fully digital one that only replaces fax and phone (Sections 1 and 2).

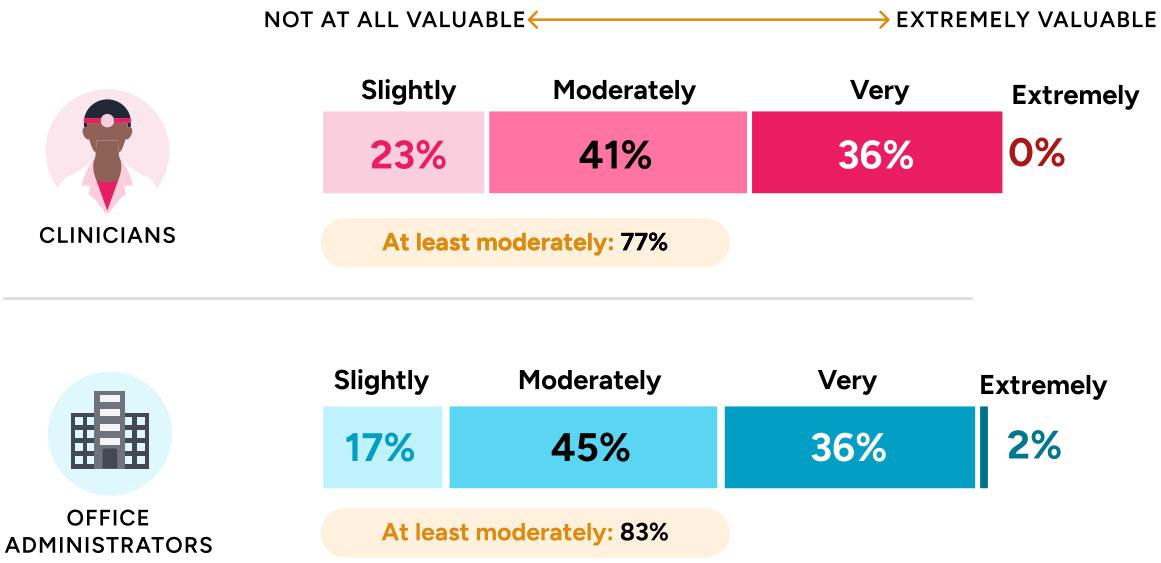
For health plans, the opportunity is to take on the administrative work around the request, not only accept it electronically. Providers maintain clinical judgment, AI can support the rest. That is the foundation for a portal providers will actually use.

The road to real-time runs through documentation.

Real-time answers need complete documentation, and documentation is where requests break down. A connected record is the way through, so we asked providers how valuable a clinical intelligence platform would be to their PA process.

Q. *How valuable would a clinical intelligence platform be to improving your organization's prior authorization process?*

Respondents first read: "A clinical intelligence platform is purpose-built to reason over clinical data, medical policies, and guidelines within real health plan operations to support workflows like prior authorization."



OUR READ

Providers want speed, and they want a person accountable for the call. They want clearer requirements more than they want exemptions, and they point to documentation as the place requests break down.

A connected record can put the request, the policy, and the clinical context in one place. The right documentation requirements surface before submission, not after a denial, so providers are no longer asked for the same documentation for downstream processes. That is the case for a clinical intelligence platform: clinical data is collected once and shared across utilization management, payment integrity, appeals, care management, quality, and claims operations.

The alternative is tools that leave each function in its own silo. The data suggests many providers see the value in a platform that connects them.

CONCLUSION

Three bets for 2027

Every strong payer-provider partnership is built on trust. Providers have told us what they want from AI: not just speed, but clarity, transparency, and trusted technology that supports people making high-stakes decisions. How health plans move next will show who heard the message.



1. Plans that treat provider collaboration as a long-term strategy will win. Plans that only chase speed won't.

Real-time approvals are clearly valuable, but the drop in strong trust in AI shows that speed alone isn't enough to build confidence. **The plans that emerge ahead in 2027 should listen carefully to what providers are asking for—human oversight, clearer requirements, less friction and inconsistency—and invest accordingly.** That's the foundation for stronger, more collaborative provider relationships.



2. Transparency will become the starting point for trustworthy AI, and PA is where plans will prove it first.

The data sends a clear message: trust is built through transparency, not automation alone. **PA is a natural place to start.** It's heavily manual and high-friction, and providers have signaled where and how plans can do better: nearly nine in ten say requirements are at least somewhat hard to find and understand, and clearer requirements top both groups' list of fixes. With CMS-0057-F adding momentum, plans that make PA clear, explainable, and less opaque will do more than ease one process—they'll build the foundation for broader trust in AI.



3.The plans that move first will define the new standard for trust and transparency across their operations.

PA is just the starting point. Once providers experience AI that is transparent, consistent, and genuinely helpful in one function, they'll expect the same wherever they collaborate with a plan on high-stakes work—from appeals to claims to payment accuracy and beyond. **That's why this is bigger than PA modernization: it's about building trust across the enterprise.** Plans that move first to build connected, trustworthy systems will strengthen provider relationships. **Plans that stay siloed won't just fall behind operationally; they'll give up the opportunity to shape the next standard for payer-provider collaboration.**

"Automation delivers first-level ROI…changing how people work, getting them to think differently, and making them part of the solution delivers next-level ROI."

Siva Namasivayam, founder and CEO, Cohere Health

CONCLUSION

What strong payer-provider collaboration looks like in practice

Trust built in PA shouldn't stop there. **Here's where the market can go when plans connect intelligence across operations.**

PA is where trust starts, not where it ends.
Plans can start earning provider trust there, and the clock is already running: by next year, federal API mandates and industry commitments will make well-documented, electronic PA the standard. Utilization management, payment integrity, appeals, care management, claims operations, and quality all depend on the same clinical record. **Value is lost between functions that operate without coordinated intelligence and connected data.** A health plan rarely has an AI shortage—it has a coordination problem, and that is solvable.

A connected clinical intelligence platform carries PA insights into every other workflow.

Payment integrity and claims
Clinical context supports more accurate claim validation and cuts unnecessary rework.

Appeals
Evidence and policy logic are reused, not recreated, so reviews move faster and stay consistent.

Quality
Existing documentation surfaces quality opportunities without a separate round of chart retrieval.

Care management
PA decisions, member history, and care gaps surface automatically, so care managers can focus on outreach.

Solve for coordination, not just speed.
Speed fixes a step. Coordination fixes the enterprise. When clinical context, policy logic, and decisions carry over from one workflow to the next, providers only have to explain once, and plans can reuse that information everywhere. Plans that redesign the work around connected clinical intelligence, with people firmly in control of critical decisions, will earn provider trust and realize value faster because of it.

Ready to build the trust providers expect? Connect with Cohere Health today.

Meeting the new expectations is how patients, providers, and health plans end up aligned on the right care at the right time.

Methodology

What we asked, who answered, and how to read the comparisons.

200
respondents in each wave: 100 clinicians and 100 office administrators

2 waves
April 9–23, 2025 and August 12–27, 2026, fielded online by Wakefield Research

±9.8 pts
margin of error within each audience at 95% confidence (± 6.9 across all 200)

WHO WE SURVEYED

Respondents work in hospitals or with medical systems across the US. "Providers" means both audiences together. August 2026 respondents:

Clinicians: nurses 40%, physicians and surgeons 32%, physician assistants 21%, nurse practitioners 5%, CRNAs 2%.

Office administrators: office managers 36%, medical billers 24%, medical coders 17%, records clerks 13%, prior authorization coordinators or specialists 10%.

Organizations with 150+ employees: 64% of clinicians, 58% of administrators.

COMPARING THE WAVES

The waves are **independent samples:** different people answered each time. Wakefield fielded and tabulated the surveys, tested the year-over-year changes at 95% confidence, and kept screening criteria, audience composition, and quality-control practices the same in both waves. The data is unweighted in both years. The comparisons in this paper are Cohere Health's, and "significantly" appears only where Wakefield confirmed it. Smaller differences may fall within sampling error.

WHAT RESPONDENTS SAW

AI: "Artificial intelligence (AI) refers to technologies that can assist humans in performing tasks, such as recognizing patterns, making decisions, or learning from data."

Clinical intelligence platform: "A clinical intelligence platform is purpose-built to reason over clinical data, medical policies, and guidelines within real health plan operations to support workflows like prior authorization."

Repeat requests and ePA: The repeat-request question gave examples of clinical records for utilization management, prior authorization decisioning, or payment integrity validation, and ePA was defined as logging in to a health plan's platform to submit a request.

HOW TO READ THIS PAPER

Percentages may not sum to 100% due to rounding or multiple responses. Some chart labels are shortened, and the full question wording appears with each chart. Panels titled "OUR READ" are Cohere Health's interpretation, built on the data and what we see in health plan operations. They are not survey findings. Outside context comes from published sources, cited where used.

ABOUT COHERE HEALTH

Cohere Health's clinical intelligence and operations platform and agentic AI-powered solutions connect health plans' strategic goals and providers' needs, optimizing the speed, cost, and quality of care. With an enterprise approach that streamlines payer-provider decision-making across the care continuum–including policy, prior authorization, payment accuracy, and more–the company improves collaboration and reduces burden, resulting in up to 9x ROI and 94% provider satisfaction. Cohere Health is recognized on TIME's World's Top HealthTech Companies list, on the Inc. 5000 list, and by numerous industry analysts.