cohere HEALTH

Guide to meeting AHIP prior authorization commitments

Considerations and strategic approaches

Executive summary

Led by AHIP, the health insurance industry recently announced strategic initiatives to streamline and simplify prior authorization (PA). These commitments build on CMS requirements and represent significant opportunities for health plans to make operational efficiency gains, system integration improvements, and enhanced data analytics capabilities while maintaining clinical oversight and cost management objectives.

As of the publishing of this guide, more than 60 plans have made the following commitments to make healthcare more straightforward and faster for providers and members:

AHIP and Health Plan Commitment	Deadline
Standardizing electronic prior authorization (PA)	1/1/27
Reducing the scope of claims subject to PA	1/1/26
Ensuring continuity of care when patients change plans	1/1/26
Enhancing communication and transparency on determinations	1/1/26
Expanding real-time responses	2027
Ensuring medical review of non-approved requests	Now

When preparing to streamline PA, health plans need to assess and avoid any unintended downstream impacts when preparing to streamline prior authorization. Read more about these commitments and key considerations to maximize your strategic opportunity.

Standardizing electronic Prior Authorization (ePA)

Digitizing PA for faster communication and decision-making

AHIP commitment

Participating health plans will work toward implementing common, transparent submissions for electronic prior authorization. This commitment includes the development of standardized data and submission requirements (using FHIR® APIs) that will support seamless, streamlined processes and faster turnaround times. The goal is for the new framework to be operational and available to plans and providers by January 1, 2027.

Considerations

The ePA commitment builds on the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F) and Prior Authorization API requirement. Health plans need to be prepared for the technical requirements and other considerations, including policy digitization, to make the most of standardization and efficiencies.

In addition to the technical requirements, such as HL7 FHIR R4, OAuth 2.0 authentication and security protocols, real-time data exchange capabilities, and standardized implementation guides (IGs), there are three key FHIR API transactions:

CRD
(Coverage Requirements Discovery)

DTR
(Documentation Templates and Rules)

PAS
(Prior Authorization Support)

While PA APIs are a part of the interoperability rule, they aren't simply for interoperability and health plans should consider integration with internal systems and workflows, supporting provider partners, and medical policy management needs.

There is significant work ahead on integrations.

Only 22% of clinicians* **and 13% of online professionals*** **report that most (more than 40%) of their health plans have integrated PA into their EHR workflows.**

*Source: Cohere Health 2025 Provider Survey

Health plan integration: For FHIR APIs to work effectively, health plans must integrate them with existing applications, such as the utilization management (UM) system, many of which are siloed or not directly FHIR compliant.

Provider support: Many providers don't have the resources to handle API integrations by the deadlines. Health plans should consider if and how they will support their provider partners to check payer-specific coverage requirements, identify necessary documentation, and submit authorization requests electronically.

Policy management: Medical policies are the crux of every authorization decision, and they enable the submission of clinical documentation via the FHIR APIs. These need to be digitized, and plans must support continuous updates to maintain DTR workflows.

Cohere Health® approach

Our experts are actively involved in the Da Vinci Project Steering Committee, helping to shape and advance the implementation guides, which are crucial for effective interoperability and efficient data exchange in healthcare. This active involvement led to Cohere's pioneering use of FHIR APIs for PA.

Proven FHIR API support: The Cohere Unify™ platform already supports FHIR-based electronic PA across our in-house, delegated, and API offerings . Cohere also offers policy digitization to address various plan policies, including CMS, industry guidelines, and health plan custom policies.

Provider experience: Cohere Health offers a SMART® on FHIR app launched from the provider EHR to streamline documentation submission and integrate process prompts to gather the correct information up front, without error-prone questionnaires. Cohere is also exploring other ways to meet providers where they are for API integration to expand access to fast, high-quality, and accurate responses to PA requests.

Cohere Health's FHIR API-enabled auths to date 15 Million

Reducing the scope of claims subject to PA

Smarter scope management and ongoing list optimization

AHIP commitment

Individual plans will commit to specific reductions to medical prior authorization as appropriate for the local market each plan serves, with demonstrated reductions by January 1, 2026.

Considerations

Most health plans have some opportunities to pare down their PAL (prior authorization lists) and should consider this a strategic opportunity to address clinical intelligence needs across their organization and understand the implications of not collecting data from providers ahead of care.

Lack of medical necessity information: The sheer number of clinical codes is not usually the primary challenge in timely prior auth. Provider abrasion and care delays often stem from frequent questions around medical necessity and patient safety issues, or from the lack of specific patient information to evaluate the request. When exploring PAL reduction, health plans should dig into data across the PA lifecycle to understand clinical variation, repeat submissions, and avoidable denials.

Utilization risks: One ongoing concern of health plans is utilization. Simply removing a service from the PAL might lead to increased utilization and cause downstream challenges without advance notice of care. One example is how some efforts to streamline PA with goldcarding led to increased utilization. Plans should assess provider performance around PA and streamline engagement where possible to reduce provider abrasion. At the same time, continually monitoring utilization can help manage risk.

Downstream data needs: Finally, health plans need to explore the impact of a smaller PAL on other parts of the organization, such as care management, quality, and payment integrity, that often rely on clinical data from providers shared during the PA process. These teams may lose critical information if PAs aren't required. Plans should consider advance notification or other mechanisms to collect important member care information from providers.

Cohere Health approach

Our experts help health plan clients plan for which codes could be included or excluded from the PAL using evidence-based clinical criteria, and our platform tracks the effectiveness of the plan's PA policies.

> ***"We're working with Cohere Health to help with UM strategy, automation. They have expertise in deciding what requires PA/what doesn't."***
>
> – Executive, Regional Health Plan

Medical necessity: Working with in-house physicians and partnerships with medical societies, Cohere Health supports a quality-based approach that helps reduce PAL scope, manage medex, and improve outcomes in areas with high clinical variation in care. Cohere's insights identify which codes truly need PA and help continuously optimize the list to improve efficiency, provider experience, and patient safety. This includes managing the PAL differences between regions and lines of business.

Balancing provider experience and utilization risks: For high-performing providers with consistent approval records, Cohere Health offers personalized workflows that streamline PA while allowing health plans to maintain clinical oversight. Unlike legacy goldcarding, which lacks flexibility and can result in utilization growth or outcome changes, Cohere continuously tracks provider performance over time to support consistency in appropriate care.

Collecting data upfront: Cohere Health works with plans to implement non-PA pathways that reduce provider friction while still notifying the health plan of upcoming procedures. This approach enables simplified interactions for trusted providers by conducting basic eligibility checks without requiring medical necessity review. Other teams, such as clinical audits, benefit from access to planned procedures and clinical information.

Ensuring continuity of care when patients change plans

Supporting consistent, coordinated care during insurance transition

AHIP commitment

Beginning January 1, 2026, when a patient changes insurance companies during a course of treatment, the new plan will honor existing prior authorizations for benefit-equivalent in-network services as part of a 90-day transition period. This action is designed to help patients avoid delays and maintain continuity of care during insurance transitions.

Considerations

To help patients avoid care delays when they change insurance, health plans can use data in payer-to-payer API feeds to understand past PA approvals and support member access to care. This information can be shared with UM teams and delegated vendors to support timely member care, where covered.

Cohere Health approach

Enhancing care access is core to Cohere's clinical intelligence platform. Cohere can support PA and claims payment with patient information provided by the payer to ensure continuity of care and prevent unnecessary resubmissions by providers. Cohere already receives authorization history feeds from health plan clients to ensure authorization decisions reflect patient context, including plan changes, and can receive relevant member insights to eliminate additional PA submissions.

20% **of people experience coverage disruptions or change plans each year***

*Source: JAMA

Enhancing communication and transparency on determinations

Shedding light on the black box of PA

AHIP commitment

Health plans will provide clear, easy-to-understand explanations of prior authorization determinations, including support for appeals and guidance on next steps. These changes will be operational for fully insured and commercial coverage by January 1, 2026, focusing on supporting regulatory changes for expansion to additional coverage types.

Considerations

Most providers struggle to understand whether PA is required for specific patient treatments. Offering clear, understandable explanations about requirements and determinations can reduce costly appeals and downstream confusion when care is billed.

With the digitization of PA, health plans also have an opportunity to deliver greater transparency during the process for providers and patients. One of the top challenges cited by providers is not getting real-time status updates on requests.* By allowing requesting providers (and patients) to access information about the status of pending decisions at any time, health plans can reduce time to care and improve satisfaction.

Most clinicians and office professionals have at some time been uncertain whether PA is even required for specific treatments*

92%

89%

Cohere Health approach

Transparency is core to our approach to healthcare.

- **For providers:** Cohere Health provides clear visibility into the health plan's requirements and real-time updates on PA status via our portal. To streamline approvals, we also use straightforward, real-time, and context-aware guidance on supporting medical evidence and other requirements at the point of submission.
- **For members and caregivers:** According to government requirements, Cohere already supports health plan clients with member-facing transparency, including real-time determination status and PA letters.

93% **Cohere Health provider satisfaction**

*Source: Cohere Health 2025 Provider Survey

Expanding real-time responses

Reducing time to care with real-time approvals with greater precision

AHIP commitment

In 2027, at least **80%** of electronic PA approvals (with all needed clinical documentation) will be answered in real time. This commitment includes the adoption of FHIR® APIs across all markets to further accelerate real-time responses.

Considerations

Health plans must balance the need to collect patient care information for medical necessity evaluation and needs beyond PA, with procedure volumes, to formulate a plan to reach 80% real-time approvals. AI technology will be critical to quickly gather and parse important structured and unstructured patient data, assess medical necessity, understand business rules, and render decisions in real time.

Planning the optimal case mix: To achieve the 80% target, plans will want to carefully plan for what procedures should be approved in real-time vs. those that require skilled clinician review. Considerations may include the nature of the procedure, patient safety, and alternative care options.

Electronic submissions: To streamline approvals, plans should gather the required clinical information at the time of submission. While FHIR API integrations will support electronic approvals, not all providers have the resources or systems to support those integrations. Most plans will want to offer an intuitive and transparent online submission via portals to truly automate and reach 80% real-time approvals without needless back and forth via fax or phone.

Clinical documentation: Not all clinical documentation is the same. With API-based submissions, some health plans use questionnaires that ask the submitter to attest that each necessary condition is met, but there's a risk. Most submitters are administrative staff who lack the required clinical expertise and patient details. Those responses could enter the member's health record and lead to potentially unsafe care decisions. Quite often, the clinical data that supports medical necessity is in the providers' patient notes. These unstructured clinical notes and other relevant attachments can power real-time, AI-based medical necessity determination, reduce financial risk, and improve member health outcomes.

The top ask of office professionals to improve PA is automated prompts for clinical documentation and plan-specific requirements*

*Source: Cohere Health 2025 Provider Survey

Cohere Health approach

PA automation is complex, but Cohere Health simplifies it for health plans and providers. We're working with clients to meet or exceed the target for real-time approvals while managing financial and clinical risk. Our technology leverages clinical-grade AI to minimize delays and waste, and improve the provider experience and patient outcomes.

Achieving 80% real-time approvals with Cohere Health's 4Ps:

- Patient-centric approach
- Provider performance
- Policy complexity and clinical nuance
- Procedure invasiveness, safety, and alternatives

Optimized case mix: Our clinician-led approach and 4Ps methodology allow health plans to identify optimal services and provider approaches to reach the real-time determinations goal. This strategic approach to PA not only reduces care delays and minimizes waste but also helps improve outcomes and increase provider satisfaction.

Clinical-grade AI: Cohere's automation platform combines clinical-grade AI with a dynamic rules engine to deliver fast, accurate medical necessity determinations. Our platform captures and reads structured and unstructured clinical data, such as patient notes, and our AI models are guided by established medical policies and clinical best practices. The rules engine adapts in real time to the care context—preventive, episodic, or emergent—and is continuously refined by board-certified physicians. This offers health plans real-time approvals without the risk of not having deep, precise insights at the point of decision.

Provider online submissions: To help increase your digital adoption by providers, we have one of the widest deployments of EHR integrations and provider experience professionals with a track record of **96%** digital portal adoption nationwide with outstanding provider satisfaction.

85%	**of PA approvals in real time**	96%	**provider digital adoption**

Ensuring medical review of non-approved requests

Maintaining clinician-in-the-loop for medical reviews

AHIP commitment

Participating health plans affirm that all non-approved requests based on clinical reasons will continue to be reviewed by medical professionals–a standard already in place. This commitment is in effect now.

Considerations

While plans are committed to having medical professionals review non-approved requests, those reviews take time to gather and analyze patient documentation. Health plans can help accelerate clinical review and allow RNs and MDs to operate at the top of their licenses with the help of technology. AI can surface relevant information to support case review and final decisions. IT teams need to consider that generic AI may not work. The nature of clinical information, healthcare terminology, medical policies, and anatomy may require domain-specific AI-powered technology to support clinicians.

95% **of clinicians want same-specialty physicians for peer-to-peer reviews***

*Source: Cohere Health Provider Survey

Cohere Health approach

At Cohere Health, AI is NEVER used to deny care. We use a team of sub-specialist, board-certified physicians to train clinical AI models. The Cohere Unify platform also supports case queue management for physicians that factors in credentials and same-specialty support. This gives plans greater clinical precision for initial determinations, the ability to manage reviews more effectively, and empowers medical directors to turn peer-to-peer sessions into collaborative conversations.

Supporting clinical case reviews: Cohere Health's review capabilities, including our end-to-end workflow and our AI-based assistive agents, accelerate clinical review for health plan clinical teams by leveraging automation and intelligence within the workflow. In-app guideline review surfaces the relevant guideline based on LOB and member profile, presented side-by-side with the authorization request. Cohere's integrated natural language chat analyzes clinical records–including unstructured attachments–to provide insights and respond to reviewer queries. Authorization history and claims data are easily accessible within the review workflow.

Delegated case reviews: For final determinations for delegated services, Cohere only uses relevant sub-specialist, board-certified physicians in the loop for training clinical AI algorithms, and for final PA determinations. For health plan clinical teams, Cohere offers flexible technology options for the review workflow or accelerating the use of existing workflows and tools with assistive AI.

50% faster medical necessity reviews with over 99% precision for in-house teams

Summary

These commitments present opportunities for health plans to achieve operational efficiency gains, improve system integration, enhance data analytics capabilities, and improve provider and member satisfaction while maintaining appropriate clinical oversight and cost management objectives.

As the healthcare industry embraces a new phase of PA reform, Cohere Health is already delivering on the outcomes that CMS and AHIP's member plans are working to achieve. Cohere is committed to helping health plans, providers, and patients build a more efficient, transparent, and equitable care system.

About Cohere Health

Cohere Health is a clinical intelligence platform company delivering AI-powered solutions that streamline access to quality care by improving collaboration between physicians and health plans with prior authorization workflows. Cohere works with more than 660,000 providers and processes close to 13 million unique findings per day. Its AI supports real-time determinations for up to 90% of care requests for millions of health plan members.

Cohere has been recognized in the Gartner® Hype Cycle™ for U.S. Healthcare Payers for four years running, named a Top 5 LinkedIn™ Startup twice, and is a three-time KLAS Points of Light award recipient.

Learn more at coherehealth.com