



Real-time prior authorization:

A strategic roadmap for clinical and medex optimization

Executive summary

Many health plans approaching AHIP's real-time approval target are asking the wrong question. The issue isn't whether you can automate 80% of electronic prior authorization approvals—it's which 80% and what the downstream impact will be across your organization, especially for medical expenses.

Reaching this target demands more than technological upgrades. It requires a fundamental shift in how health plans balance care quality, operational efficiency, and provider experience—one that maintains medical expense discipline while accelerating approvals. This is a strategic clinical and administrative optimization effort, not simply an automation initiative.

Every health plan faces a different starting point, shaped by historical data, existing policy frameworks, strategic priorities, and operational complexity. A one-size-fits-all approach won't work.

This white paper gives health plan executives and clinical leaders a practical roadmap for achieving the 80% real-time approval commitment through three strategic frameworks: clinical and administrative optimization, intelligent decision-making, and provider insights.

Defining the 80% real-time approval target

The AHIP commitment requires plans to achieve 80% real-time approvals for electronic submissions **averaged across all clinical services and all lines of business**, while accounting for the unique clinical mix, regulatory requirements, and provider dynamics of each line of business.

AHIP Definition: Expanding real-time responses. By 2027, at least 80% of electronic prior authorization approvals with all needed clinical documentation will be answered in real time, requiring FHIR API adoption across all markets.

Assess your health plan's starting point

Health plans approach the real-time approvals target from vastly different starting points, with varying risk tolerances and organizational needs. Four factors determine your readiness and the scope of transformation required:



Historical performance. Your current automation rate, approval patterns, turnaround times, and clinical review volumes set your baseline. A plan at 30% real-time approvals faces a fundamentally different journey than one already at 60–70%. Mapping performance across lines of business, service categories, and provider segments reveals where the real opportunities and risks lie.



Strategic priorities. How you pursue the target should reflect your broader organizational focus. Plans prioritizing member satisfaction will emphasize speed and friction reduction. Those focused on the total cost of care will need tighter guardrails around high-cost services. Plans facing network adequacy challenges may find that prior authorization optimization is a powerful lever for provider retention. These priorities shape both your automation philosophy and your risk tolerance.



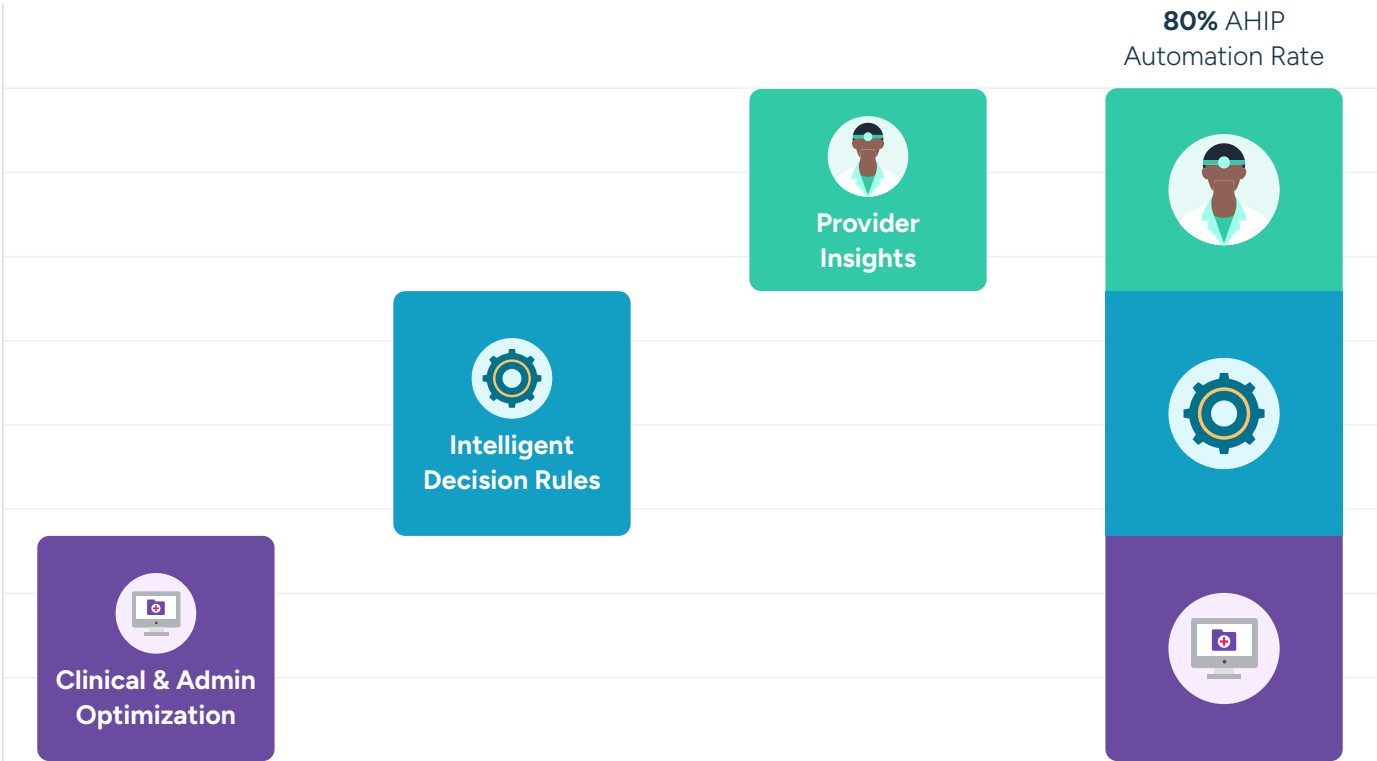
Clinical policy structure. Your existing policy framework is a major determinant of automation potential. Plans with granular, evidence-based criteria aligned with national guidelines are far better positioned than those relying on broad, text-heavy policies that require subjective interpretation. The specificity and enforceability of your clinical criteria define what can be automated safely—and what can't.



Downstream impacts. Prior authorization changes ripple across the organization. Medical expense trends, provider relationships, member appeals, regulatory compliance, and care quality metrics all shift in response to automation decisions. Plans must evaluate how expanding real-time approvals affects utilization patterns—especially in areas where prior authorization has historically served as a critical UM safeguard. They must also consider how changes affect teams relying on pre-service data, including payments, care management, and quality.

The path to 80%: A strategic, clinical AI approach

Achieving real-time approval targets requires a coordinated, strategic framework across three domains: clinical and administrative optimization (including prior authorization list design, clinical policy quality, and intelligent automation deployment), intelligent decision-making rules, and provider insights.



Optimizing for clinical and administrative excellence

The first step in preparing for real-time approvals is understanding where you are. This goes beyond understanding current performance. It is critical to dive deeply into your UM program to identify and prioritize changes—from how your program aligns with evidence-based practices to how you compare to peer organizations. This optimization process focuses on two key areas: prior authorization lists (PAL) and clinical policies.

Optimizing your PAL

Your prior authorization list defines the scope and structure of your UM program. Many health plans carry requirements that generate administrative burden without producing meaningful UM value. Three optimization strategies prepare your PAL for higher automation rates while ensuring quality and cost improvements:



Benchmark alignment. Benchmark analysis identifies where your PAL deviates from peer plans and evidence-based best practices—directly addressing one of the biggest friction points for providers: inconsistent requirements. It can reveal outlier requirements in which your plan requires approval while peers do not. High-variance codes across industry PALs may indicate unclear clinical consensus and warrant policy review.



Automation readiness. Structural and definitional issues in your PAL can block automation. Overly broad or narrow code definitions may limit rule-based and model-based automation, while free-text instructions or unstructured language can prevent ML/AI-based automation approaches entirely. Comparing across your own lines of business can also surface internal inconsistencies that add operational complexity without clinical value.



Modernization roadmap. PAL insights must translate into prioritized, actionable steps. Key changes include line-of-business harmonization, removal of unnecessary prior authorization requirements, and structural fixes. Given the complexity involved, a phased approach—sequenced by impact potential and implementation complexity—is essential.

Optimizing clinical policies

Clinical policy quality directly determines the success of automation. High-quality policies enable transparent, defensible, real-time decisions, while poor policies force manual review.

Ensure the appropriate policy is used in clinical decision-making by analyzing current policies to identify retirement candidates and prioritize areas for improvement. Evidence-based medical policies aligned with national guidelines provide the strongest foundation for automation while maintaining clinical defensibility.

Enable transparent decision-making with clear met/unmet indication mapping that specifies precisely what clinical documentation satisfies each criterion. Decision heatmap analysis reveals which indications are most likely over-approved or over-pended, highlighting calibration opportunities. Simulating the impact of policy changes on automation rates and medical expenses allows for additional policy refinement before deployment.

Digitizing policies, extracting evidence requirements, and deploying policy-driven real-time decision rules create the infrastructure for safe and effective automation. This approach transforms text-based policies into machine-executable logic while maintaining clinical rigor and audit trail transparency.

Intelligent decision automation targets by clinical area

To effectively address real-time approval targets, plans must recognize that the appropriateness of automation varies significantly across clinical service categories. Using a portfolio approach balances patient risk, timeliness, and cost. Plans should consider setting optimal automation targets across different levels:

Aggressive: Low-risk, high-volume services. Durable medical equipment and physical therapy services often pose low risk to patient safety, present a higher risk if care is delayed, and carry a relatively low cost. Simple tests or services such as echocardiograms or splints benefit from minimal delay. These clinical areas can support automation rates above 90%, enabling significant progress toward the overall 80% target while delivering substantial improvements in member and provider experience.

Moderate: Standard evidence-based services. The largest category encompasses standard services for which appropriateness depends on clinical evidence supporting the request. This list of standard services may include CT scans or joint injections, where patient safety risks are moderate and treatment decisions affect care pathways. These services support automation rates of 80% or more, requiring sophisticated policy logic and high-quality documentation to ensure safe, real-time decision-making.

Conservative: High-risk, high-cost services. Higher-risk or higher-cost procedures and treatments of last resort warrant more clinical review to support patient safety and medical expense management. Complex surgeries, high-cost biologics, and experimental treatments may achieve 40-70% automation with appropriate guardrails, with remaining cases benefiting from expert clinical review. This conservative approach in selected clinical areas protects quality and cost while still contributing to overall automation targets.



90%+

Aggressive

Low-risk, high-volume services



80%+

Moderate

Standard evidence-based services



50-80%

Conservative

High-risk, high-cost services

This portfolio approach allows plans to achieve 80% real-time approvals across all approved services while maintaining appropriate clinical oversight where patient risk and cost considerations demand it.

Automation quality depends on the accuracy of the AI models applied to each category. Domain-specific models fine-tuned for particular clinical areas outperform general-purpose approaches, delivering higher precision with lower risk of inappropriate approvals. These models can learn the nuances of clinical documentation patterns, policy interpretation, and evidence evaluation within their specific domains, enabling confident real-time decisions.

Fine-tuning approvals with provider insights

Prior authorization shouldn't be a one-size-fits-all experience. Differences between provider submission patterns and clinical situations require consideration. A configurable, provider-differentiated approach helps plans reach optimal automation targets while personalizing the experience based on provider performance and clinical context, and further reduces provider abrasion.



Trusted providers: Fast-track approvals. Providers with exceptional historical performance, strong documentation, and strong patient outcomes earn trusted status and receive fast-tracked approvals with minimal friction. Top-performing providers warrant streamlined processes—reducing administrative burden for both plans and providers. However, plans need to consider the utilization and medex risks of approaches like gold carding.



Automated guideline-based approvals: The core network. The largest provider segment comprises those who don't qualify for trusted status but submit appropriate requests with adequate documentation. These cases undergo automated review using evidence-based guidelines, applying clinical AI and policy logic to render real-time decisions—balancing efficiency with appropriate clinical oversight.



Waste and abuse surveillance: Enhanced scrutiny. Providers exhibiting patterns of gaming, overutilization, or quality concerns are flagged for expert clinician review. This tier reduces inappropriate utilization and curbs wasteful spending without imposing blanket restrictions on the broader network.

When combined with broader automation capabilities, this tiered approach can help health plans achieve automation rates exceeding 80% while maintaining strong UM discipline across the provider network.

Dynamic provider performance management

Excellent historic performance

Comprehensive profiling

Continued excellence

Gold carding can streamline the provider experience for prior authorization, but it can be rigid and lead to increased utilization. A more dynamic approach evaluates provider performance across multiple dimensions for a more detailed, accurate view.

A green lighting approach examines historical UM and prior authorization approval patterns, identifying providers with exceptional peer-relative performance—for example, 95% or higher approval rates. But approval rates alone don't determine status. The approach also factors in gaming behaviors, utilization appropriateness, and clinical quality indicators.

Unlike static gold card programs, green lighting operates as a continuous monitoring system. As provider utilization or care appropriateness shifts, status adjusts accordingly—while maintaining program integrity and rewarding consistently high-performing providers with streamlined approvals.

Cohere's approach: Five foundational principles for real-time automation

Cohere Health is helping several AHIP signatories meet these commitments using a clinically grounded, provider-trusted approach to real-time automation. Our methodology rests on five principles that distinguish safe, sustainable automation from shortcuts that compromise quality or increase costs:

1. Holistic UM approach. Cohere strengthens the entire UM program rather than manipulating metrics to hit numerical targets. The solution enhances evidence alignment, policy clarity, and provider experience while reducing unnecessary spend—delivering sustainable results, not gamed denominators.

2. Patient outcomes and safety. Automation deploys only where evidence, risk signals, and clinical consensus support it. High-risk, low-evidence, or outlier cases are intentionally pended to safeguard patient outcomes and ensure defensible decision-making. Speed matters, but never at the expense of appropriate care.

3. Continuously optimized. Reaching and sustaining 80% requires active management of criteria, PAL design, model thresholds, and operational nuances. Cohere delivers a managed platform that continually learns and recalibrates as clinical patterns and utilization behaviors evolve. Static automation degrades over time; continuous optimization does not.

4. Medical expense informed. Cohere delivers real-time approvals with explicit guardrails, ensuring administrative savings don't come at the cost of higher utilization or lower-quality care. Plans achieve efficiency gains while maintaining strong total cost of care management.

5. Transparent. Providers receive clear, evidence-backed, explainable decisions—every approval or pend is transparent and auditable. This builds trust and supports clinical collaboration rather than creating adversarial dynamics.

Conclusion: A roadmap for success

The AHIP commitment to 80% real-time prior authorization approvals by 2027 is both a significant challenge and a transformative opportunity. Meeting the goal demands strategic thinking, clinical rigor, and operational excellence.

Success starts with understanding your unique starting point—historical performance, strategic priorities, clinical policy, and downstream impacts. From there, plans must optimize their prior authorization lists, modernize clinical policies to enable transparent real-time decisions, deploy risk-stratified automation, and implement provider-differentiated approaches that reward high performers without sacrificing program integrity.

But 80% is not a one-size-fits-all formula. Low-risk, high-volume services support aggressive automation. High-risk, high-cost procedures warrant caution. The goal is to build a calibrated portfolio that meets overall targets while maintaining safety, quality, and cost discipline across every service category.

Most importantly, reaching 80% should strengthen your entire UM program—not simply chase a metric. Done right, this commitment improves patient access, reduces provider burden, drives operational efficiency, and maintains clinical quality and cost outcomes simultaneously.

The 2027 deadline is approaching fast. Plans that begin now—investing in policy modernization, intelligent automation, and continuous optimization—won't just meet AHIP commitments; they'll build competitive advantages in provider satisfaction, efficiency, and care quality that extend well beyond compliance.

The transformation of prior authorization from an administrative bottleneck to a strategic enabler is within reach. The question isn't whether your plan will achieve 80% real-time approvals. It's whether you'll do so in a way that strengthens quality, controls costs, and builds lasting trust.

About Cohere Health

Cohere Health's clinical intelligence 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, appeals, and more—the company improves collaboration and reduces burden, resulting in up to 8x ROI and 94% provider satisfaction. Cohere Health is recognized on TIME's World's Top HealthTech Companies 2025 list, on the 2025 Inc. 5000 list, and by numerous industry analysts.