

Ensuring Continuity of Care and Enhanced Communications & Customer Support

Prior authorization is an important safeguard used by both public and private payers to ensure patient care follows clinical guidelines. It helps reduce patients' exposure to low-value, unsafe or inappropriate care by making sure services and prescriptions align with the latest research and guidelines for effectiveness. This leads to better health outcomes for patients. As part of a series of multi-year voluntary commitments announced in partnership with HHS and CMS in June 2025, leading health plans committed to ensuring patients undergoing treatment can continue their care when changing plans. Health plans have also taken steps to provide clear, actionable communications and member support to simplify and streamline prior authorization for 270 million Americans.

Continuity of Care

Participating health plans are honoring existing prior authorizations for benefit-equivalent, in-network services for a 90-day transition period for members in an active course of treatment who change health plans. To support coordination between the former and current plan, health plans have enhanced or implemented continuity of care capabilities along with training customer service teams who interact with members and providers to ensure proactive outreach and response to inquiries.

Health plans reported continuity of care support for treatments and services, including:

- Infusion therapy
- Chemotherapy
- Transplant care, including post-transplant immunosuppressive management
- Outpatient behavioral health therapy
- Scheduled surgery and post-operative recovery
- Kidney dialysis
- Cardiac rehabilitation
- Physical therapy following knee replacement surgery
- Live-in home care services

After the initial 90-day transition period, patients have dedicated support to navigate changes in their benefits and prior authorization processes if needed.

As part of an efficient and streamlined continuity of care experience for consumers, health plans are securely sharing data to verify prior authorizations from an individual member's or employer group's former health plan. A key component of operationalizing this commitment involved determining secure, interoperable methods for data exchange. Several participating health plans partnered with Health Information Service Providers (HISPs) to enable secure data exchange with greater adoption underway. This work serves as an important bridge ahead of new requirements taking effect in 2027.

Supporting Coverage Transitions

Example 1: A new member switched to a new health plan on January 1, 2026, and previously had been receiving health and nursing services since November 2025. As part of this transition, the member's provider submitted a copy of the prior authorization approval from the member's last health plan. A new authorization was provided to support continuation of services.

Example 2: A new member joined their health plan on December 1, 2025 and needed continued use of their CPAP machine and related supplies. The provider indicated that the former health plan did not require authorization but that the member had previously started treatment and that continuity of care would be required. The new health plan honored continuity of care, recognizing the member had been utilizing their CPAP machine and issued an approval starting on the member's first day of enrollment.

Example 3: A new member who joined their new health plan on January 2, 2026 had previously been authorized by their former health plan to receive an endovenous ablation therapy treatment anticipated to start later that month. After receiving the information from the member's provider on January 2, the health plan was able to honor the member's authorization and issue a new approval to their provider through April to support receiving the procedure as planned.

Enhanced Communications & Customer Support

Participating health plans have simplified communications to consumers and providers regarding prior authorization determinations. This includes providing clear, consumer-friendly and straightforward language, information on appeals processes and guidance on actionable next steps patients can take.

Participating health plan actions include:

- Regularly reviewing member communications for clarity, completeness and consistency
- Testing new communication approaches with members
- Strengthening customer service training to enhance member support and navigation
- Conducting staff training on plain language and clear writing
- Improving the format of communications by summarizing key information upfront
- Enhancing member portals and platforms for easy access to medical policy and appeals processes
- Dashboards with up-to-date prior authorization status

In addition, AHIP, BCBSA and their member health plans outlined recommendations for regulators related to updates and improvements to prior authorization notices. The recommendations reflect both short-term and long-term actions and address the content, format, accessibility and consistency of prior authorization notices so that patients see the full benefit of simplified communications. To view the recommendations, click [here](#).

Highlights of Health Plan Programs – Continuity of Care

American Specialty Health (ASH)

Through their partnership with multiple health plans, ASH has developed processes to support plans that are onboarding new members who may have active authorizations for physical therapy, chiropractic or other services for which ASH has been delegated. The processes have been set up to enable ASH to obtain information about the current approvals and ensure that transition between health plans does not inappropriately impact the provision of medically necessary services.

Blue Cross Blue Shield of Michigan

Account managers at Blue Cross Blue Shield of Michigan (BCBSM) are getting positive feedback on a new automated system offered to employers as they begin their partnership with BCBSM.

In 2025, BCBSM expanded a process to all employers and products that immediately captures services with prior authorization approvals from an employer's previous health plan. It's available to all new commercial enrollees – tens of thousands of members each year.

Through this system, BCBSM can seamlessly honor those authorizations from the first day of coverage for new employees, avoiding disruptions in care. The program is available regardless of whether members use it, and it reduces the need for providers to reach out to BCBSM on behalf of their patients.

Centene

Building on a strong foundation of existing Continuity of Care operations, Centene enhanced support of the continuation of medically necessary treatments during health plan transition. The organization has updated Continuity of Care policies to include the AHIP Commitment as best practice. Operationally, departments and teams supporting Continuity of Care have updated member and provider facing talking points and delivered focused training to reinforce processes and workflows for initiating and handling Continuity of Care requests and established improved data elements to monitor Continuity of Care authorizations. Additionally, an IT file exchange process to securely request and receive Continuity of Care authorizations from other payers was implemented to support reducing administrative burden to improve member and provider experience.

Cigna

In one recent instance, Cigna's service team received a frantic call from a new customer about their child's scheduled surgery in early January. He learned that the provider's office was closing early for the holidays, and unless Cigna was able to validate and honor the prior carrier's authorization before they closed at 2pm, the surgery would need to be cancelled. Based on the details provided on the call, Cigna's customer service teams were able to validate the existing prior authorization with the customer's prior carrier and notified both the provider and customer of the new plan authorization so the surgery could be performed as planned.

Elevance Health

Elevance Health continues to honor existing, previously authorized care for a 90-day transition period when people switch health plans. The process has been simplified to be faster than in the past.

Elevance Health has restructured member communications around prior authorization to simplify and clarify decisions and next steps. This is in addition to new training provided to associates who handle questions about prior authorization. Customer service associates can address prior authorization questions and connect members to clinical teams when needed.

EmblemHealth

When members transition to a new health plan, continuity of care ensures they do not experience disruptions in their treatment. EmblemHealth works with new members and their providers to continue existing treatment plans for a defined period while new authorizations are processed. The provider, member or employer group can initiate this process, and EmblemHealth will follow up with the provider to get all the information it needs to build a transition of care authorization.

For example, when a member undergoing chemotherapy transitions to EmblemHealth and has already received 3 of 6 monthly cycles, the transition of care process allows the member to continue treatment with the current provider without interruption and without requiring a new prior authorization.

Evry Health

Evry Health has an existing Transition of Care and Continuity of Care Policy which ensures members receive ongoing care from providers that have started a treatment plan or protocol prior to the member's eligibility for the health plan.

Geisinger

Geisinger supports continuation of medically necessary services for members who are actively engaged in a clinically appropriate course of treatment at the time of transition to a new health plan. These protections are designed to safeguard access to care during vulnerable periods for patients, such as mid-treatment or during pregnancy.

Members undergoing active treatment may elect to continue previously authorized services for a defined transition period, provided the services are a covered benefit under the new plan. Members may also request to temporarily continue care with non-participating providers when clinically appropriate.

Kaiser Permanente

Kaiser Permanente recently updated its New Member Welcome process to proactively solicit information about existing prior authorizations and prevent disruptions in care. In addition, Kaiser Permanente has signed on to use the MaxMD HISP to share prior

authorization information with other payers until the new payer-to-payer API is functional.

For example, Kaiser Permanente accepted a new member's existing prior authorization for ongoing infusion therapy from their prior health plan. The member continued treatment with their existing infusion provider for a 90-day transition period while Kaiser Permanente's care coordination and utilization management teams reviewed and processed the appropriate authorization.

UnitedHealthcare

UnitedHealthcare is modernizing prior authorization and strengthening continuity of care through enhanced Transfer of Authorization (TOA) processes. These efforts focus on supporting members through benefit equivalent, in-network transitions by honoring existing prior authorizations during plan changes or insurance transitions. UnitedHealthcare has successfully supported plan transfers for more than 1.5 million members.

Highlights of Health Plan Programs – Enhanced Communications

American Specialty Health (ASH)

American Specialty Health (ASH) actively reviews and evaluates written communications to improve readability by patients and providers. This includes simplifying medical rationale so that the information in decision letters is easily understood. In addition, ASH supports its members by providing translation and interpretation services, including written information and interpretation in over 250 languages as needed by its members. Providers can contact ASH while a patient is in their office and, using speaker phone, can quickly engage a translator to assist with patient communications.

Blue Cross Blue Shield of Massachusetts

Teams at Blue Cross Blue Shield of Massachusetts (BCBSMA) worked hard to reduce the number of services that require the prior authorization (PA) process, but even after reductions, leaders noticed a curious trend: There were still the same level of calls from providers, asking to confirm if a procedure needed PA.

That insight inspired BCBSMA to launch a Prior Authorization Quick Look Up tool in April 2025. Through the health insurance provider's public website, providers can quickly check if a service requires PA and the status of a patient's PA. Providers have seamless access as the site does not require registration or login.

Data shows the efforts to improve communications are growing in popularity. During the first month, providers used the tool 7,300 times. In January of 2026, there were nearly 150,000 uses of the tool.

Centene

In 2025, Centene launched a multi-pronged initiative to improve the clarity, accessibility, and member experience of prior authorization (PA) denial communications. The organization began by enhancing the written denial templates to improve readability and comprehension. These updates focused on simplifying language and structure and ensuring NCQA compliance.

During this process, Centene conducted a two-round research effort with members who had recently experienced a denial or appeal. Round One surveys and qualitative interviews identified key communication gaps and process challenges, and the resulting feedback informed the development of enhanced denial letters featuring clearer rationale, personalized explanations, and actionable next steps. Round Two testing showed significant improvements: 74% preferred the updated letter, and members reported clearer understanding of why their request was denied (+26%), stronger perceptions of empathy and respect (+46%), and greater confidence that their case was carefully reviewed (+35%).

Cigna

Cigna has invested in enhanced digital tools to further support providers, clients and customers in understanding prior authorization statuses. Providers can check if a prior authorization is required for a specific service in real-time, and certain commercial clients have visibility into authorization statuses, enhancing transparency and peace of mind. This real-time status provides transparency into the prior authorization process for both medical and pharmacy services.

EmblemHealth

EmblemHealth has a standardized process to review all member and provider communications to ensure that they “speak human.” Information is presented in clear, easy to read and understandable language. This includes making sure any action steps to be taken by the member or provider are clear and understandable, and contacts and resources to assist are provided. Members can view prior authorization status and determination letters through the member portal and mobile app.

Members can contact the plan directly if they do not understand the letter as the call center staff are trained and well-versed in benefits and coverage. Designated specialists within the call center receive extra training in complex benefits or issues to provide a second level of assistance.

Evry Health

Evry Health revised and simplified their determination letters to improve awareness and understanding of members’ rights, health plan decisions and the processes for decisions and appeals. Evry Health also provides a care coordination nurse for each of its members. Nurses focus on each individual member and their eligible family members and provide direct assistance on any questions or needs related to their care.

Geisinger

Geisinger has improved communication and transparency in prior authorization determinations through plain language notice templates, robust quality review processes, targeted staff training, and evidence-based AI support tools. Some of these processes include specialized teams that help improve readability and to ensure communications are member-centric, easy to understand, and minimize complex medical terminology. Dedicated staff are also available to assist members and providers with navigating communications, and the same review team regularly educates frontline staff through multiple channels and targeted workshops.

GuideWell

GuideWell is a not-for-profit, mission-driven, policyholder-owned health services organization with a portfolio of companies that include Florida Blue, the Blue Cross Blue Shield plan in Florida and Triple-S Salud, Puerto Rico’s Blue Cross Blue Shield plan. At Triple-S Salud, nearly 70 of its nurses received training in intentional listening and empathetic communication to better support members during prior authorization outreach calls to communicate determinations and explain next steps. The training helped instill an empathy-first approach for all members requiring prior authorization for a medical service. Each communication, whether oral or written, English or Spanish, starts with clearly explaining to a member what was requested, the reason for the decision, and the steps taken to try to secure approval, such as provider outreach for additional information.

Kaiser Permanente

Kaiser Permanente has implemented a coordinated approach to clear, accessible, and supportive communications for members navigating the prior authorization process. Across the organization, Kaiser Permanente strives for prior authorization letters written in plain language with a clear explanation of the determination, guidance on next steps, appeal rights and how to access assistance or request records. Staff are trained on how to write readable rationales and how to use readability tools when drafting content. When members call with questions, staff are trained to walk through the letter, confirm understanding of the determination and explain available options.

UnitedHealthcare

UnitedHealthcare is advancing a comprehensive effort to improve communication, consistency and transparency in prior authorization and determination processes. This work includes a full review of medical and specialty pharmacy policies to clarify language, reduce ambiguity, and strengthen alignment across service categories. Standardized rationale language has been implemented across all prior authorization letters, ensuring clearer educational statements, more explicit explanations of required documentation and improved guidance on next steps when information is missing. Additional progress includes updates to letter templates and removal of technical terminology that can create confusion, with continued enhancements planned through 2026 and 2027.