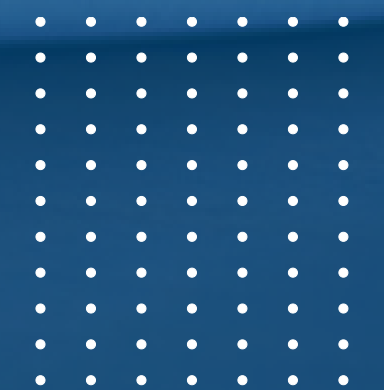




From Insight to Action: Operationalizing Shift-Left Strategies with AI and Real-Time Intelligence

Health Payer Executive Brief





Current State

Insights take too long to turn into action

Over the past decade, health plans have invested heavily in analytics, predictive modeling, and population health intelligence. As a result, most organizations have become increasingly effective at identifying risk, forecasting utilization, uncovering care gaps, and measuring performance.

Yet many plans continue to struggle with a fundamental challenge: **translating insight into action.**

As value-based care expands, interoperability standards tighten, and operational complexity grows, health plans are being pushed to intervene earlier in the care journey — making the ability to turn intelligence into action at scale a defining competitive advantage.

Organizations that can connect insights directly to workflows, decisions, and interventions will be better positioned to improve outcomes, reduce administrative burden, and maximize the value of their analytics investments.

The question, then, is how to make this operational shift in a consistent, scalable way.

The Shift-Left Challenge

The healthcare industry is moving upstream. Risk identification is occurring earlier. Prior authorization decisions are becoming more automated. Care management interventions are increasingly proactive. Quality improvement initiatives are focused on prevention rather than remediation.

However, moving interventions earlier in the care continuum creates a new operational challenge. The value of an insight depends not on when it is identified, but on whether action occurs in time to influence an outcome. Many organizations have invested in identifying opportunities sooner, yet continue to rely on workflows that were designed for retrospective decision-making. The result is a growing gap between intelligence and execution.

In many health plans, the traditional analytics model follows a familiar, largely linear pattern. As shown in the table, each step adds value in isolation, but the handoffs between steps often introduce delay, variation, and missed opportunities for timely action.

Compounding time delays

Step	Typical Outcome
Data Collected	More information becomes available
Analytics Generated	Risks and opportunities are identified
Reports Distributed	Stakeholders gain visibility
Manual Review Occurs	Prioritization varies by team
Intervention Initiated	Delays and inconsistencies emerge
Outcome measured	Impact may be diminished

Valuable insights often arrive faster than organizations can operationalize them.

As data volumes grow and predictive models become more accurate, the limiting factor is no longer the ability to identify risk – it is the ability to connect that intelligence directly to coordinated, real-time workflows.

Without that operational bridge, the gap between knowing and doing widens, and the return on analytics investments is constrained.

Why Analytics Alone Is No Longer Enough

Most health plans do not suffer from a lack of data. In fact, many organizations now possess:

- Predictive risk models
- Care gap identification tools
- Population health analytics
- Quality reporting platforms
- Payment integrity intelligence
- Prior authorization data

The challenge is that these insights frequently reside in separate systems, teams, and workflows.

A high-risk member identified through analytics may trigger multiple opportunities across utilization management, care management, quality improvement, and payment integrity. Yet those functions often operate independently, requiring manual coordination to convert intelligence into action.



The consequence is not a lack of insight. It is a lack of operational alignment.

The Evolution Toward Real-Time Intelligence

The Shift from Retrospective to Embedded Intelligence

Traditional Model	Emerging Model
Reports and dashboards	Workflow-integrated intelligence
Retrospective analysis	Real-time decision support
Separate operational teams	Coordinated intervention models
Manual prioritization	Automated opportunity identification
Reactive workflows	Proactive workflows

Disconnected
Time consuming
Manual

Fluid
Rapid
Automated

Historically, analytics informed decision-making after the fact. Increasingly, organizations are seeking to embed intelligence directly into operational workflows.

In many plans, this shift can be understood as a transition between two distinct operating models, as detailed in the table.

This evolution signals a fundamental move away from simply delivering information toward enabling direct, timely action. The objective is no longer just to explain what has already occurred; it is to shape and improve what happens next.

Where AI Creates Value

Much of the healthcare AI conversation has focused on prediction. The larger opportunity may lie in orchestration — using AI not only to signal what might happen, but to coordinate how the organization responds. When embedded into payer operations, AI can act as a connective layer between disparate systems and teams, turning raw signals into clear, prioritized, and actionable workflows.

In this context, AI is not replacing human judgment. It is augmenting it — providing the scale, speed, and consistency required to operate in increasingly complex environments.

Clinicians, care managers, quality leaders, and operations teams remain accountable for final decisions, but they are supported by AI that organizes information, highlights what matters most, and orchestrates next steps across the enterprise.

The result is a model where decision-making can scale with growing data volumes and regulatory demands, without overwhelming staff or compromising the quality and timeliness of care.

Summarize complex clinical information

by extracting key diagnoses, risk factors, and treatment patterns from unstructured notes, hospital records, and longitudinal member histories, then presenting that context in a concise view tailored to the decision at hand — whether it is an authorization request, care management enrollment, or quality review.

Prioritize opportunities based on impact and urgency

by continuously scoring members, events, and care gaps according to predicted clinical risk, preventability, and financial impact. This allows teams to focus first on members where timely intervention is most likely to change the trajectory of care, rather than working through static lists in chronological order.

Route insights to the appropriate teams

by applying predefined rules and learned patterns to direct each opportunity to the right role, program, or partner—utilization management, complex case management, disease management, behavioral health, quality, or payment integrity. In many cases, AI can pre-package the context, recommended actions, and timing, so staff receive a complete, ready-to-use task rather than a raw alert.

Reduce administrative burden

by automating routine reviews, document classification, data validation, and eligibility or benefit checks, so clinicians and analysts can dedicate more time to higher-complexity cases and member engagement. This not only improves productivity, but can also support compliance with timeliness requirements and documentation standards.

Support more consistent decision-making

by standardizing how evidence-based guidelines, organizational policies, and contract-specific rules are applied across teams. AI-driven decision support can flag inconsistencies, highlight exceptions that warrant human review, and provide transparent rationale that can be communicated to providers and members.

Enable interventions to occur earlier in the care journey

by surfacing rising-risk patterns (such as escalating utilization, medication non-adherence, social risk indicators, or behavioral health signals) before they result in avoidable admissions or complications. When tied to integrated workflows, these early signals can automatically trigger outreach, care coordination, or provider notifications at the right moment.

The Emerging Payer Operating Model

Several industry forces are accelerating the need for a more connected, converged operating model across health plans. While each driver is meaningful on its own, together they are reshaping how payers must organize people, processes, and technology to keep pace with expectations from members, providers, and regulators.

Taken together, these trends are driving closer alignment between traditionally separate functions such as utilization management, care management, quality improvement, and payment integrity. Instead of operating as distinct programs with separate technologies and data sources, these functions are increasingly being asked to operate as a coordinated system of intelligence and action.

In a legacy model, a single member event — such as an ED visit or a new chronic diagnosis — might trigger multiple unconnected workflows: a utilization review in one platform, outreach from a care manager in another, a quality gap identified in a separate system, and a retrospective claim review months later. Each team adds value, but the member experience is fragmented, and opportunities for early, coordinated intervention are frequently missed.

In the emerging payer operating model, that same event becomes a shared signal:

- **A unified intelligence layer ingests data from clinical, claims, and external sources.**
- **Standardized rules and predictive analytics**
- **Context-rich opportunities are routed to the appropriate teams.**
- **Utilization management, care management, quality, and payment integrity all see the same underlying member story, informed by the same data, evidence, and risk indicators.**



Key Forces Driving a New Operating Model

01

CMS interoperability requirements

New CMS rules such as CMS-0057-F now require health plans to provide standard, FHIR-based, near-real-time access to clinical, claims, and administrative data for members, providers, and other authorized users. Interoperability is no longer just an IT concern; it underpins shared intelligence across utilization management, care management, quality, and payment functions.

02

Increasing adoption of value-based care

As more contracts shift to shared savings and risk-based arrangements, payers and providers need a shared, timely view of performance. Retrospective reports are not enough when outcomes depend on interventions during the benefit year. Value-based models require that insights on risk, utilization, and care gaps are embedded directly into daily workflows and support coordinated, member-level action.

03

Rising administrative complexity

Frequent regulatory changes, evolving benefit designs, and product variation are adding strain to operations. Prior authorization, case management, quality, and payment review teams must interpret the same rules, but often do so separately. Each new requirement increases the risk of inconsistent decisions and avoidable appeals. A converged operating model applies common logic and evidence across functions, reducing variability and improving predictability.

04

Growing expectations for real-time decision making

Members, providers, and regulators now expect timely, transparent decisions, especially for prior authorization, care coordination, and quality programs. Delays are increasingly seen as barriers to care and potential compliance risk. Real-time verification, rapid documentation review, and same-day responses are becoming standard, requiring that the right rules, context, and member information are available at the moment of decision, regardless of which team is acting.

Benefits of a Shared Intelligence Layer for Payers

For many payers, this emerging operating model will be enabled by platforms that can **unify data, analytics, and intelligent automation into a single, coordinated environment.**

By moving from siloed programs to an integrated, intelligence-driven operating model, health plans can turn real-time information into timely, coordinated action—and close the gap between strategic intent and day-to-day execution.



Act earlier in the care journey by detecting rising risk and clinically significant events in real time, rather than waiting for claims to finalize.



Coordinate interventions more effectively by ensuring that utilization management, care management, quality, and payment integrity decisions are informed by a common view of the member and aligned with value-based performance goals.



Improve enterprise performance by reducing avoidable variation, minimizing duplicate outreach, supporting more consistent decisions, and aligning operations with regulatory expectations and contractual commitments.



Support providers and members more transparently with clear, timely communication and decisions that reflect both clinical evidence and benefit design, reducing abrasion and building trust.



Operationalize AI at scale by embedding predictive and prescriptive insights directly into workflows—rather than confining analytics to dashboards that sit outside daily decision-making.

Key Questions for Health Plan Leaders

As organizations continue advancing shift-left strategies, leaders should consider not only where they are investing in analytics and automation, but how these capabilities are reshaping day-to-day operations.

The questions below are designed to help executives and operational leaders assess whether their current operating model is truly enabling real-time, coordinated action – or whether structural gaps, legacy workflows, and siloed technologies are still limiting impact.

1. How quickly can insights be translated into action?
2. Are critical decisions supported by real-time intelligence?
3. Where do operational handoffs create delays?
4. Which workflows remain heavily manual?
5. How effectively are clinical, operational, and financial insights connected?
6. Is AI being used to generate insights — or to operationalize them?

Looking Ahead

The next phase of healthcare transformation may not be defined by who has the most data or the most sophisticated analytics. It may be defined by who can act on intelligence most effectively.

As healthcare continues to shift left, the organizations that succeed will be those that bridge the gap between insight and execution — connecting intelligence, workflows, and interventions in ways that enable action at scale.

Visit our website to explore additional insights on payer transformation, operational intelligence, and value-based care.



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