HEALTHCARE INDUSTRY GROUP

Medical Management Is Broken Getting AI Right Will Decide Which Plans Survive

AI-Enabled Medical Management Under Pressure

AI-enabled medical management is not a technology program, it is a cost structure reset.

Plans that redesign medical management around AI will hard-wire lower MLR, better Stars, and stronger provider alignment into their operating model. Those that move slowly will not be "a little behind on AI"; they'll be structurally uncompetitive.

Medical management, not network contracting or pricing, will determine which health plans outperform over the next decade. Utilization management (UM), care management (CM), quality programs, risk adjustment, payment integrity, and provider and member engagement now determine how effectively plans manage medical cost trend, clinical outcomes, regulatory risk, and experience.

Most medical management functions still run on pre AI, pre API processes: manual reviews, fax driven workflows, and fragmented systems that drive up administrative cost and delay clinical decisions. Many organizations have dabbled with tools like ChatGPT or Gemini, but real value comes not with experiments, but only when AI is embedded into end to end workflows. When governed well, AI can compress decision cycles from days to hours, augment clinical expertise, and materially improve outcomes, experience, and financial performance.[1,2,3]

This paper lays out:

- **Why medical management is becoming the strategic engine of the health plan.**
- **The size of the AI-enabled value at stake in cost, quality, and experience.**
- **The structural and regulatory forces that make status quo models untenable.**
- **Why most AI efforts in medical management will fail—and how to avoid those traps.**
- **The highest-value AI use cases across UM, CM, quality, risk, payment integrity, and engagement.**
- **A practical, three-stage roadmap for leaders ready to modernize clinical operations over the next three years.**

> The organizations that move now, modernizing data, governance, and operating models, will lock in durable advantages in medical cost, Stars, risk revenue, provider loyalty, and member retention. Those that wait will face structural cost gaps, regulatory exposure, and network erosion.

Most organizations believe they are progressing on AI. In reality, they are reinforcing the same fragmented operating model with better tools. Without redesigning how medical management works end-to-end, AI will increase complexity, not reduce it.

Medical Management: From Cost Center to Strategic Engine

Medical management has shifted from a compliance obligation to the operational expression of a health plan's clinical strategy. Decisions made across UM, CM, quality, risk adjustment, payment integrity, and provider management directly determine:

- Medical Loss Ratio (MLR) performance.
- Stars and other quality ratings and bonus revenue.[4,5]
- Risk adjustment accuracy and revenue stability.[6]
- Provider network performance and stability.
- Member experience, retention, and growth.

Over the next three years, the function will bifurcate into offensive, intelligence-driven engines that shape utilization, site of care, and risk in near real time, and defensive, reactive operations that process volume slowly, with rising cost and regulatory risk.

Today, most plans still operate as a loose federation of departments: UM driven by faxes and PDFs with week-long cycle times, CM referrals arriving late and inconsistently, quality programs chasing charts in seasonal bursts, risk adjustment dominated by retrospective sweeps, and payment integrity sending conflicting signals to front-line staff. The result is high administrative cost, uneven experience, and limited ability to manage risk in real time.[7,8]

AI, applied correctly, offers a path to re-platform medical management as a coherent, unified clinical operating model that synthesizes clinical, operational, and financial data to guide decisions at scale.

Strategic Impact by Medical Management Domain

Medical Management Domain	Strategic Impact
Prior Authorization and UM	Controls avoidable utilization, site of care, and medical cost trend.
Care and Disease Management	Prevents high-cost events, improves outcomes, and supports continuity.
Stars and Quality Programs	Drives bonus revenue, retention, and regulatory standing.
Risk Adjustment	Ensures accurate payment and financial forecasting.
Payment Integrity	Detects and prevents improper payments, reinforces policy compliance.
Provider and Network Management	Optimizes network adequacy, steerage, and performance accountability.
Member Engagement	Drives adherence, preventive care, and satisfaction.

> Continuing to rely on manual, retrospective medical management is not just inefficient; it is an increasingly untenable bet against volatility in both clinical risk and financial performance.

The AI Prize: A Multi-Hundred-Billion Dollar Opportunity

Excess US health spending is heavily driven by administrative complexity and avoidable utilization. Administrative costs are estimated at roughly 25%–30% of total US healthcare spending, translating into hundreds of billions of dollars annually.[9,10] A significant share sits squarely in medical management processes.

At the same time, delayed intervention remains a major driver of avoidable emergency department visits, inpatient admissions, and the progression of chronic disease. High-cost events frequently emerge because signals were present but never reached the right clinician or team in time.

Compounding this, plans are now managing unprecedented population risk—taking on members whose prior coverage, acuity, and utilization patterns are poorly understood due to Medicaid redeterminations, Medicare churn, and shifting product mixes. In this environment, continuing to rely on manual, retrospective medical management is not just inefficient; it is an increasingly untenable bet against volatility in both clinical risk and financial performance.

AI-enabled medical management creates value across three major dimensions:

- **Operational efficiency:** Automating intake, documentation analysis, triage, and review preparation; reducing touches per case and administrative rework.
- **Clinical impact:** Identifying deterioration signals and rising-risk members earlier; triggering targeted outreach and care pathways when they still change outcomes.
- **Financial performance:** Improving risk capture accuracy and audit readiness; tightening payment integrity analytics and site-of-care optimization.

The Value at Stake (for a 1 Million-Member Plan)

To make the opportunity concrete, consider a commercial/Medicare-focused health plan with 1 million members:

- **100–300 basis points of MLR improvement:** Roughly 1%–3% of medical spend, equating to approximately $20–$60 PMPM in margin impact for many plans, depending on baseline trend and premiums.[11,12]
- **20%–40% improvement in UM productivity:** Fewer touches per case and shorter review times, translating into double-digit percentage reductions in UM administrative expense and the ability to redeploy scarce clinical resources.[13,14]
- **0.5–1.0 Star-equivalent improvement:** Meaningful bonus revenue uplift and marketability, often on the order of tens of dollars PMPM in Medicare Advantage when higher bonus factors and enrollment growth are considered.[15,16,17]

The net effect is predictable: higher technology spend, no meaningful MLR movement, and growing frustration among clinicians and executives who were promised transformation.

Why Most AI Efforts Will Fail

Most health plans are not transforming medical management; they're digitizing fragmentation. While plans are already investing in AI pilots, the majority of the investment will not move MLR in any measurable way.

The pattern is predictable:

- **Most plans are layering AI onto broken workflows, making them faster, but not better:** AI tools are bolted onto existing UM, CM, or quality processes without fixing underlying latency, handoffs, or data gaps. The result is "AI on top of chaos," not a better operating model.
- **Automation without operating model redesign:** Bots or models take over tasks, but roles, staffing, and decision rights do not change. Nurses remain overloaded, and leaders do not see the promised productivity or quality gains.
- **No integration across UM, CM, Stars, and risk:** Each function selects its own AI point solutions. Data and logic fragment further, and the organization loses the opportunity to create a unified clinical view of members and providers.
- **Weak governance that creates regulatory exposure:** Algorithms are used in coverage decisions without clear policies, documentation, or monitoring. This invites audit findings, equity concerns, and reputational risk.[18,19,20]
- **No linkage to MLR or financial outcomes:** AI investments are justified on "innovation" or "pilot success" rather than hard metrics such as MLR basis points, Stars revenue, or admin cost per case.

Variability in utilization and care pathways is rising faster than manual models can scale.

Why Status Quo Medical Management Will Break

Several structural and regulatory forces and pressure points are converging to make current operating models unsustainable.

Rising Clinical Complexity

Managed populations are older, sicker, and more complex. The average Medicare Advantage member often presents with multiple chronic conditions layered with behavioral health needs and social risk factors.[21] Variability in utilization and care pathways is rising faster than manual models can scale.

Workforce Constraints

The clinical workforce available for UM and CM work is structurally constrained. Projections indicate the US will need over 200,000 additional nurses by 2030, with many markets already struggling to recruit and retain staff.[22,23] Traditional levers (overtime, incremental hiring, offshore support) cannot close the gap between demand and capacity.

Regulatory Scrutiny on UM and AI

CMS's Interoperability and Prior Authorization final rule requires impacted payers to stand up Prior Authorization APIs, shorten decision timelines (72 hours for expedited, seven days for standard), provide specific denial reasons, and publicly report metrics, with key requirements taking effect between 2026 and 2027[24,25,26,27] CMS has also been explicit that algorithms cannot be the sole basis for denials and that individualized clinical review is required.[28,29]

Provider Frustration and Abrasion

Physicians consistently identify prior authorization as a leading obstacle to timely care. Recent surveys show that more than 90% of physicians report that prior authorization delays access to necessary treatment, with many linking it to adverse clinical events and patient abandonment of therapy.[30,31] This is reshaping state-level policy and driving tougher contract negotiations on turnaround times and automation.

Margin Compression and MLR Pressure

Rising acuity, rate pressure, and the post-pandemic utilization reset are squeezing margins. Medical management is now the primary lever to influence avoidable utilization, site of care, and revenue integrity without sacrificing quality.

These pressures converge on one question: Can you operate medical management at the speed, scale, and transparency that regulators, providers, and members now expect—without burning out staff?

Structural Pressures and AI Response Capabilities

Pressure	Impact on Medical Management	AI Response Capability
Clinical Complexity	Manual processes cannot scale to variability.	Predictive models, intelligent triage, risk stratification.
Workforce Shortages	Insufficient clinical capacity for growing volume.	Automation of administrative work, AI copilots for clinicians.
Regulatory Scrutiny	Higher expectations for transparency and timeliness.	Audit trails, explainable AI, human-in-the-loop workflows.
Provider Abrasion	Delays and friction damage relationships.	Faster turnaround, clearer communication, fewer touches per case.
MLR Compression	Need cost containment without quality erosion.	Targeted interventions, real-time decision support.

These are not "tool" problems. They are design, architecture, and operating model problems. Dropping AI point solutions into this environment will not fix it. It will amplify the inconsistency.

Today's Model Is Failing by Design

Across plans and integrated systems, recurring failure modes appear:

- Authorizations and clinical reviews operate on SLAs measured in days while care transitions require hours or less.
- UM and CM clinicians spend most of their time on clerical tasks instead of adjudicating complex cases.
- UM, CM, quality, risk adjustment, payment integrity, and provider management maintain separate systems preventing unified views of member risk and provider performance.
- Medical policies reside in PDFs applied inconsistently.
- Delegated functions are overseen retrospectively with issues surfacing months too late.

Current Model Failure Modes

Failure Mode	Operational Consequence	Risk and Impact
Decision Latency	Avoidable admissions, provider frustration.	Cost leakage, network attrition.
Expertise Misallocation	Low clinical productivity, burnout.	Recruitment challenges, quality gaps.
Data Fragmentation	Incomplete member/provider view.	Suboptimal interventions, audit risk.
Static Policy	Inconsistent application, outdated criteria.	Compliance risk, appeals volume.
Retrospective Oversight	Delayed detection of issues.	Regulatory findings, financial loss.

Where AI Delivers Real Value, Now

Most organizations should start with UM and CM, where value and impact are fastest and most measurable.

UM and Prior Authorization: A regional plan automating routine prior authorization, centralizing criteria, digitizing intake, and auto approving clearly eligible requests with clinicians focused on exceptions, reported roughly a 30% reduction in touches per case and a drop in average turnaround from about 48 hours to under 12 hours for targeted services. Providers experienced fewer back and forth interactions and more predictable decisions, while nurses shifted effort toward complex cases that actually require judgment.[32]

Care Management: In a Medicaid accountable care organization with more than 60,000 members, an AI based risk model that combined claims, demographics, social determinants of health, and admission/discharge alerts identified a substantially larger share of future high cost members than a traditional claims only model. Targeted care management for the highest risk cohort was associated with a roughly 10%–15% reduction in avoidable admissions compared with similar members not prioritized by the model, illustrating how better stratification can translate into real utilization impact.[33]

Quality and Stars: Health plans using AI-driven chart abstraction and Stars analytics have reported faster evidence capture, higher coding and measure completeness, and more precise targeting of outreach. In several cases, this has translated into performance gains equivalent to roughly 0.3–0.5 Stars on key measures, driven by earlier gap closure and a clearer understanding of where each incremental member action affects future ratings.[34]

Beyond UM, CM, and Quality and Stars, AI is helping expose revenue leakage in risk adjustment and payment integrity while simultaneously transforming how plans engage members and providers in real time. These capabilities don't operate in silos, they compound, creating an intelligence-driven operating model that legacy approaches simply cannot match.

High-Value AI Use Cases and Expected Outcomes

Domain	High-Value AI Applications	Expected Outcomes
Prior Authorization	Intake automation, reviewer copilots, policy retrieval.	20%–40% productivity gain, faster turnaround.
Care Management	Risk stratification, outreach automation, UM-CM linkage.	Fewer avoidable admissions, better engagement.
Quality and Stars	Chart abstraction, gap detection, predictive forecasting.	Improved measure performance, earlier gap closure.
Risk Adjustment	Suspecting, validation support, encounter summarization.	More accurate risk capture, stronger audit readiness.
Payment Integrity	Policy alignment, anomaly detection, FWA analytics.	Reduced leakage, better policy consistency.
Member Engagement	AI navigation, tailored outreach.	Improved adherence and satisfaction.
Provider Engagement	Real-time policy support, status visibility.	Reduced friction, higher provider NPS.

Bottom line: AI in medical management must be governed as a regulated clinical capability, not as a generic IT deployment.

Guardrails: What AI Must Not Do (Yet)

The same capabilities that make AI powerful also introduce new risks. In medical management, you cannot treat AI as "just another IT tool."

Key Limitations and Required Safeguards

Large language models can fabricate clinical facts, misstate guideline references, or generate plausible but incorrect summaries; as AI documentation tools on the provider side interact with AI review systems on the payer side, those errors can compound into inappropriate determinations if no one validates the underlying record.

AI models trained on legacy data inherit disparities in diagnosis, treatment, and utilization across race, geography, and socioeconomic status; without explicit bias detection and correction, they risk hard-coding inequity into coverage and care decisions. Many advanced models operate as "black boxes," making it hard to explain why a recommendation was made, while clinicians worry they will be held responsible for machine errors or see their roles deskilled, leading to resistance and workarounds.

In this context, AI should not:

- Independently deny care in complex or high-risk scenarios.
- Drive risk adjustment strategies without explicit compliance and clinical oversight.
- Pass AI-generated content straight into other AI systems without human checkpoints and clear lineage.

AI Limitations and Required Mitigation Strategies

AI Limitation	Medical Management Risk	Required Mitigation
Hallucinations	Inaccurate summaries, wrong guideline references.	RAG architectures, human review of high-stakes decisions.
AI-to-AI Errors	Compounding mistakes, circular logic.	Human checkpoints, decision lineage tracking.
Embedded Bias	Health equity violations, discriminatory patterns.	Bias monitoring, equity-focused governance.
Lack of Explainability	Audit failures, inability to defend determinations.	Transparent models, robust audit trails.
Workforce Distrust	Low adoption, workarounds that negate value.	Codesign, training, clear role definitions.

From Analytics to Agents: Proactive, Orchestrated Care

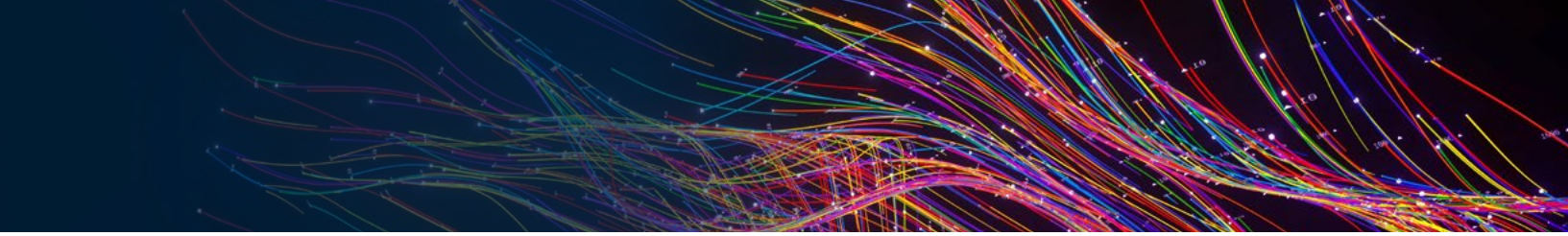
Traditional analytics models generate scores and reports; humans decide what to do with them—often days or weeks later. Agentic AI can go further, orchestrating multi-step workflows across systems and teams.

For example, an AI agent can:

- Detect deterioration signals such as medication non-adherence, missed visits, or concerning lab trends.
- Open a case and notify the assigned care manager.
- Propose outreach scripts and schedule follow-ups across channels.
- Check benefit limits and network options for recommended services.
- Monitor subsequent claims and clinical data to see whether the intervention worked.

This is what it looks like to move from retrospective oversight to proactive risk management. It is also where many plans will differentiate on member and provider experience.

Many teams overestimate how mature their medical management function really is. A brief five-question “Quick Check” can often reveal just how manual, fragmented, or pilot-heavy current AI efforts remain. See the Appendix for a practical self-assessment you can use with your team.



Our Approach for AI-Enabled Medical Management

A&M focuses on measurable operational and financial performance improvement, not pilots or proofs of concept.

Stage 1: Diagnose and Prioritize (0–90 days)

"Know where you are. Pick the fights that matter."

In the first 90 days, we work with your leadership team to establish a shared, evidence-based view of current state and opportunity.

Core activities:

- Rapid end-to-end assessment of UM, CM, quality, risk adjustment, payment integrity, provider and member engagement.
- Mapping of current vendor landscape, data architecture, and governance gaps.
- Identification of pain points, failures, and opportunities.
- Quantification of value tied to specific use cases in medical cost, quality, risk, and experience.

Tangible outputs:

- A prioritized AI use case portfolio focused on high-impact opportunities and quick wins.
- A 90-day action plan with clear owners, milestones, and metrics.
- Executive alignment across CMO, COO, CIO, and medical directors on the level of ambition and risk appetite.

> **We commit to measurable performance improvement within six to nine months, not multi-year transformation programs without near-term results.**

Stage 2: Design and Prove It (3–12 months)

"Design the future state and earn the right to scale."

Over the next 9–12 months, we move from intent to reality in a small number of high-value domains, usually starting with UM and CM.

Core activities:

- Target-state design for Level 3–4 medical management in your priority areas, tailored to your lines of business and regulatory environment.
- Definition of data consolidation strategy across claims, clinical, pharmacy, and SDOH, with an eye toward API-based interoperability.
- Design of clinical AI governance: model validation standards, monitoring and bias checks, explainability requirements, and documentation for CMS and audit readiness.
- Role redesign for clinicians and creation of AI-augmented workflows with clear human-in-the-loop checkpoints.
- Rationalization of overlapping tools into a coherent platform ecosystem with defined integration patterns and decision logic.

Tangible outputs:

- AI-enabled UM and CM workflows in live production that demonstrate measurable impact within 6–9 months (e.g., reductions in turnaround time, touches per case, and manual chart review effort, along with improvements in provider experience).
- Governance playbooks that specify how AI is approved, monitored, and explained, including bias checks and documentation ready for CMS and internal audit.
- Target architecture and vendor ecosystem design that clearly connects AI use cases to MLR, Stars, and administrative cost outcomes.

Stage 3: Scale and Institutionalize (12–36 months)

Core activities:

- Cross-domain integration across UM, CM, quality, risk adjustment, payment integrity, and engagement on shared data and workflows.
- Expansion of agentic AI use cases to orchestrate proactive care pathways and outreach.
- Build-out of audit trails, decision lineage, and explainability reports that can withstand regulator and plaintiff scrutiny.
- Establishment of continuous learning loops from outcomes, appeals, provider feedback, and regulatory findings back into policy, workflow, and model refinement.
- Change management and training programs to make AI-enabled workflows the standard, not the exception.

Tangible outputs:

- A durable, AI-enabled medical management operating model that scales early wins into sustained MLR improvement, Stars performance gains and administrative cost reductions across UM, CM, quality, risk, and payment integrity.
- Embedded governance, data, and operating model capabilities to continuously adopt and govern new AI tools, without reopening foundational design and compliance questions each time.

Once early use cases are proven, the focus shifts to scaling and embedding AI into broader workflows and systems.

What Leaders Should Do Now

For health plan, MCO and integrated delivery network leaders, the next steps are clear:

- **Run a focused medical management AI readiness assessment:** Benchmark UM, CM, quality, risk adjustment, payment integrity, and engagement against a practical maturity model—not a technology checklist.
- **Pick two or three flagship use cases:** Choose opportunities where you can show hard value within 12 months and build credibility: UM review copilots, CM risk stratification, or real-time gap closure are common starting points.
- **Stand up clinical AI governance**: Create a joint clinical–operational–technology council with clear authority over which models are used where, how they are monitored, and how they are explained.
- **Modernize data and integration first:** Invest in the unified data layer and interoperability needed to feed models and orchestrate workflows, including alignment with CMS interoperability and prior authorization requirements.
- **Redesign roles and workflows, not just screens:** Make sure AI actually changes how work gets done—who touches which cases, when, and with what information—not just where someone clicks.
- **Measure relentlessly:** Define baseline metrics for turnaround time, touches per case, provider abrasion, audit outcomes, and clinical quality. Tie AI investments to these metrics from day one.

Winners and Laggards: The Gap Will Compound

Over the next three years, medical management will separate leaders from laggards more clearly than any other operational domain.

Winners will be characterized by:

- Integrated, real-time, AI-enabled medical management across UM, CM, quality, risk, and payment integrity.
- Lower and more stable MLR, higher Stars, stronger risk capture, and better provider alignment.
- Clinicians operating at top of license, supported by AI copilots and governed, explainable decision support.

Laggards will be stuck with:

- Fragmented, retrospective, labor-heavy models held together by manual workarounds.
- Rising administrative cost, persistent provider abrasion, and growing regulatory and audit risk.
- Increasing difficulty competing in Medicare Advantage and Medicaid as AI-enabled peers reset performance baselines.

Plans that fall behind will not simply need to “catch up on AI”; they will have to unwind years of entrenched workflows, contracts, and decisions just to rejoin the starting line.

This is not a technology adoption cycle; it is a structural reset of how medical management is delivered. This shift is not reversible through incremental improvement, and the gap between leaders and laggards will compound, not close.

Quick Check: How Mature Is Your Medical Management Function—Really?

To make AI practical, you need an honest baseline. Take our "Quick Check" to test, see, or validate where you are, today. For each question, pick the statement that feels closest to your current state.

How does work actually get done in UM and CM today?

1. We rely heavily on PDFs, spreadsheets, email, and fax; most work is manual.
2. We have some rules or bots in specific areas, but each team still runs its own process.
3. We use AI tools (e.g., summarization, routing, prediction) in at least one domain, but not consistently across functions.
4. UM, CM, quality, and risk share common workflows and data; AI supports triage and review across them.
5. Our processes and rules are routinely adjusted based on outcomes, appeals, and feedback, with AI recommendations informing many changes.

What does your data and insight environment look like?

1. Key data is scattered across systems; reporting is mostly retrospective and manual.
2. Some domains have integrated data, but insights are still siloed by function.
3. We've integrated data for select areas (e.g., UM and CM) and use it for basic AI models and risk stratification.
4. We operate on a shared, governed data layer across core medical management functions, with consistent definitions and lineage.
5. New signals (appeals, outcomes, provider feedback) routinely feed back into our policies, models, and workflows.

How are AI tools used in medical management decisions?

1. We have little or no use of AI beyond ad hoc experimentation.
2. We've deployed a few automations or models, but they are narrow and loosely governed.
3. AI "copilots" support reviewers and care managers in defined workflows with clear human in the loop checkpoints.
4. AI supports real time triage, prioritization, and policy application across multiple domains, with traceable logic and auditability.
5. AI driven insights consistently inform updates to medical policy, workflows, and network strategy.

How strong is your governance and risk management for AI in medical management?

1. We do not have specific governance for AI in medical management; oversight is informal or ad hoc.
2. We have basic guardrails (e.g., "no fully automated denials"), but governance is not comprehensive or cross-functional.
3. A clinical/operational/technology group reviews and approves AI use cases, with some monitoring in place.
4. We have defined standards for model approval, monitoring, bias checks, and explainability, with clear documentation for regulators.
5. Governance also covers continuous learning: Outcomes, equity metrics, and appeals regularly trigger model and policy refinements.

How tightly are AI and automation efforts linked to financial and quality outcomes?

1. AI conversations focus on innovation and experimentation; there are no clear MLR, Stars, or admin cost targets.
2. Individual pilots report local efficiency gains, but linkage to plan-level performance is weak.
3. Priority AI use cases have defined KPIs (e.g., turnaround time, touches per case, gap closure rates) that are tracked.
4. AI investments are explicitly managed as levers for MLR, Stars, risk capture, and provider experience, with quantified impact.
5. AI-enabled medical management is embedded in strategic and financial planning, with targets reflected in budgets and contracts.

Where do you land?

Add up your points from the five (5) questions – minimum 5, maximum 25 points:

- **1** = 1 point
- **2** = 2 points
- **3** = 3 points
- **4** = 4 points
- **5** = 5 points

See the next page to understand your score.

How Did You Score?

For most plans, a realistic three-year goal is to move from Level 1–2 to a strong Level 3, and to reach Level 4 in priority lines of business and functions.

By 2027, leading payers will operate at Level 3–4 with real-time UM triage, predictive CM targeting, continuous Stars forecasting, and governed risk capture on unified data platforms. By 2029, that capability will be expected by regulators, demanded by providers, and required to compete in Medicare Advantage and Medicaid.

The question is not whether you get there, but whether you get there while it still confers advantage.

5–9 Points	10–14 Points	15–19 Points	20–23 Points	24–25 Points
Heavily manual and fragmented; AI use is minimal or experimental.	Some automation in pockets, but workflows, data, and governance remain siloed.	AI-assisted in key functions (often UM/CM), with defined workflows and KPIs, but limited cross-functional integration.	Integrated, AI-enabled medical management across multiple domains, with shared data, governance, and measurable impact on MLR/Stars.	Adaptive intelligence: Medical management policies, workflows, and models are continuously refined based on outcomes, equity, and feedback.
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**

References

1 "Bias Recognition and Mitigation Strategies in Artificial Intelligence in Healthcare," Nature Digital Medicine, March 10, 2025.

2 "Retrieval-Augmented Generation for Generative Artificial Intelligence in Medicine," Nature, January 24, 2025.

3 "AI in Healthcare: What to Expect in 2026," Opala, December 17, 2025.

4 "2025 Medicare Advantage and Part D Star Ratings," Centers for Medicare & Medicaid Services (CMS), October 9, 2024.

5 "2026 Star Ratings Fact Sheet," Centers for Medicare & Medicaid Services (CMS), November 17, 2025.

6 Ibid.

7 "Excess Administrative Costs Burden the U.S. Health Care System," Center for American Progress, November 1, 2021.

8 "U.S. Healthcare Spending: Administrative Costs Exceed 25% of Total Expenditures," Healthcare Spending Analysis, January 11, 2026,

9 "Excess Administrative Costs Burden the U.S. Health Care System," Center for American Progress.

10 "U.S. Healthcare Spending: Administrative Costs Exceed 25% of Total Expenditures," Healthcare Spending Analysis.

11 "Excess Administrative Costs Burden the U.S. Health Care System," Center for American Progress.

12 "U.S. Healthcare Spending: Administrative Costs Exceed 25% of Total Expenditures," Healthcare Spending Analysis.

13 "Prior Authorization in Health Plans: How AI Automation Delivers Value," HealthPlans.ai, November 10, 2025.

14 "AMA Survey Indicates Prior Authorization Wreaks Havoc on Patient Care," American Medical Association, June 17, 2024.

15 CMS, "2025 Medicare Advantage and Part D Star Ratings," October 9, 2024.

16 CMS, "2026 Star Ratings Fact Sheet," November 17, 2025.

17 "Medicare Advantage Quality: Star Rating," Better Medicare Alliance, June 24, 2024.

18 "CMS Interoperability and Prior Authorization Final Rule CMS-0057-F," Centers for Medicare & Medicaid Services, January 16, 2024.

19 "Medicare and Medicaid Programs: Patient Protection and Affordable Care Act; Interoperability and Prior Authorization Final Rule," Federal Register, February 7, 2024.

20 "Bias Recognition and Mitigation Strategies in Artificial Intelligence in Healthcare," Nature Digital Medicine.

21 "Excess Administrative Costs Burden the U.S. Health Care System," Center for American Progress.

22 "Nursing Shortage Projected to Be Worse by State in 2030," NursingEducation.org, June 22, 2023.

23 "The United States Will Need 200,000 Additional Nurses by 2030," Kairos Health, February 1, 2025.

24 "CMS Interoperability and Prior Authorization Final Rule CMS-0057-F," Centers for Medicare & Medicaid Services.

25 "CMS releases Interoperability and Prior Authorization Final Rule," Holland & Knight, January 24, 2024.

26 "CMS Interoperability and Prior Authorization Final Rule Presentation," Centers for Medicare & Medicaid Services, March 25, 2024.

27 "Medicare and Medicaid Programs: Patient Protection and Affordable Care Act; Interoperability and Prior Authorization Final Rule," Federal Register, February 7, 2024.

28 "CMS Interoperability and Prior Authorization Final Rule CMS-0057-F," Centers for Medicare & Medicaid Services.

29 "Medicare and Medicaid Programs: Patient Protection and Affordable Care Act; Interoperability and Prior Authorization Final Rule," Federal Register.

30 "AMA Survey Indicates Prior Authorization Wreaks Havoc on Patient Care," American Medical Association.

31 "2021 National Survey on Prior Authorization Burden and Its Impact," PMC, March 16, 2022,

32 "The Prior Authorization Landscape in 2025," MGMA, October 26, 2025.

33 "New Study Shows Medical Home Network's AI Risk Prediction Model Incorporates Social Determinants," Health News Illinois, January 12, 2023.

34 "Industry Voices: Leveraging AI for Better Quality Outcomes," Fierce Healthcare, November 26, 2024.

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