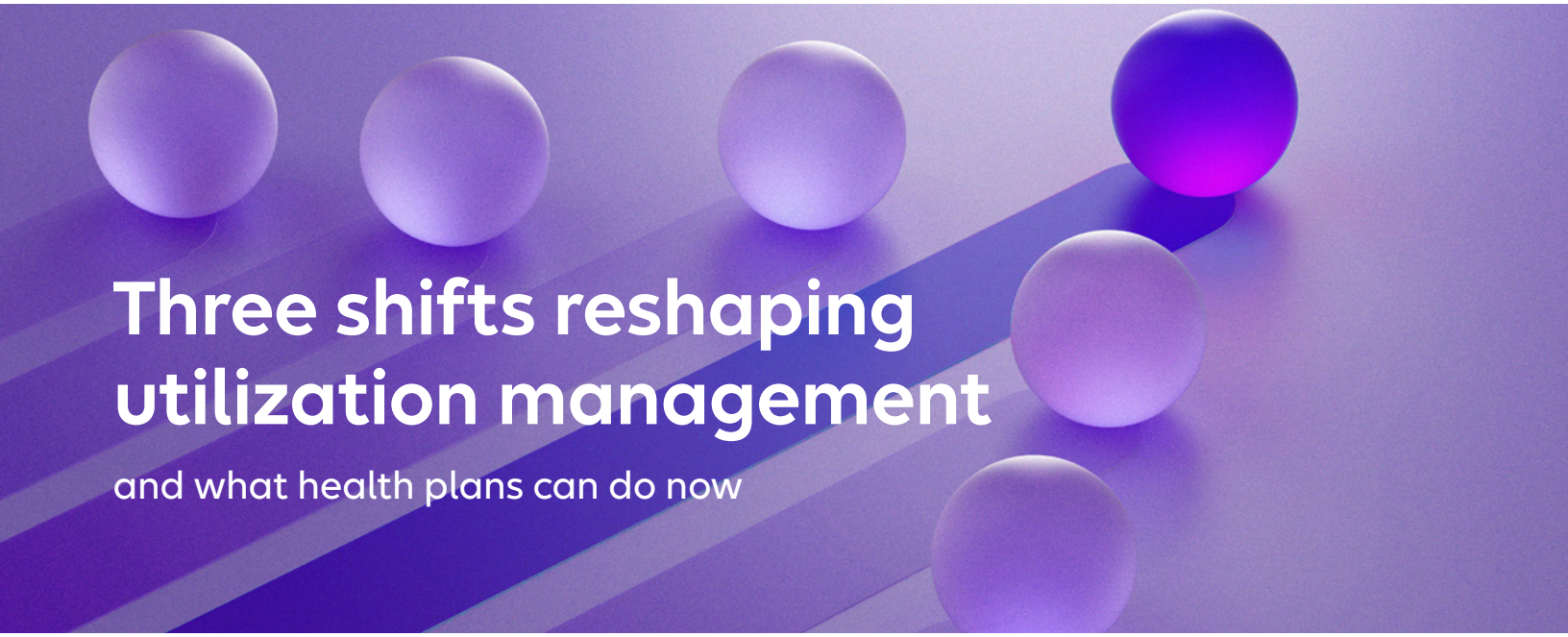

Three shifts reshaping utilization management

and what health plans can do now

The future of utilization management is happening now

Utilization management (UM) is evolving — fast. Once viewed as a tool for managing population health costs, it's now a lever for appropriate, whole-person care.

As provider and member expectations rise — and new regulatory mandates take hold — health plans need UM strategies that reduce friction, align incentives, and deliver new value.

Here are the three shifts reshaping UM and what health plans can do to lead.

Shift 1: Automation moves from pilot to the new standard

Administrative complexity is straining care providers and health plans alike, with clinicians spending nearly 28 hours per week on administrative tasks.[1]

What's changing: Leading health plans are redesigning existing UM workflows to solve for this — reducing complexity and improving efficiencies with a focus on removing manual steps wherever possible. Data silos, misaligned clinical criteria, process delays, and ongoing regulatory compliance are the focus for health plans that want to take a more strategic approach. Beginning in 2026, the Centers for Medicare and Medicaid Services (CMS) Interoperability and Prior Authorization Final Rule (CMS-0057-F) phases in new decision timeframes and public reporting mandates, with application programming interface (API) standards coming online by January 1, 2027.

The opportunity: Automation, alongside human insight, can modernize UM by increasing efficiency, enhancing collaboration, and supporting faster, more consistent decision making. By streamlining processes, organizations can reduce administrative workload, improve provider and member experiences, and stay ahead of evolving regulatory requirements.

What to do now:

- Identify services suitable for automation.
- Adopt transparent, compliant automation tools.
- Evaluate your UM partners' abilities to scale.

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Shift 2: Regulatory reform is raising the bar

The CMS Final Rule is more than a compliance task — it's a mandate to modernize. In our recent article, we explained how it aims to break down data silos to give providers, payers, and patients a shared, 360-degree view of care.

What's changing: In 2026, the Interoperability and Prior Authorization Final Rule requires payers to implement certain operational provisions, including meeting new timelines for prior authorization decisions, providing clear denial reasons, beginning public reporting of prior authorization metrics, and reporting patient access API usage to CMS. By 2027, the rules require implementation of Fast Healthcare Interoperability Resources (FHIR)-based APIs to support data exchange, enabling greater transparency and interoperability.

CMS-0057-F streamlines prior authorization by:

- **Reducing decision times:** For standard requests, the decision timeframe is seven calendar days. Expedited requests are handled within 72 hours.
- **Facilitating access to relevant patient data:** Providers can access the information they need within one business day. This includes claims, clinical details, and prior authorization data.
- **Streamlining payer-to-payer data exchange:** To promote care coordination, payers will transfer health data when members transition between insurance plans through secure, FHIR-based APIs.
- **Increasing transparency:** Payers will publicly report prior authorization metrics annually, which enhances transparency and facilitates informed decision making.

The opportunity: Plans that embrace this moment to improve transparency and enhance provider and member experiences will stand out. Why? According to a 2024 Forrester report, 65% of consumers say administrative barriers erode their trust in a health plan.[2]

What to do now:

- Map provider and member touchpoints throughout the UM lifecycle.
- Pilot early transparency and digital engagement programs.
- Align with vendors that already meet interoperability standards.

Shift 3: Transformation in UM starts with holistic insight

Siloed data leads to fragmented care, higher costs, and missed opportunities for managing risk across the continuum.

What's changing: Leading health plans are unifying UM workflows, moving from transaction-based clinical appropriateness reviews to a value-based model that supports connected care and sustainable cost control. One way they're doing this is by integrating behavioral health and pharmacy insights into the UM process, leading to more coordinated, risk-managed care. With access to connected clinical pathways and predictive analytics, providers have new tools to deliver the most appropriate and proactive support — especially in high-cost specialties like oncology, musculoskeletal (MSK) care, and post-acute care.

The opportunity: By reducing variation and aligning incentives, health plans can deliver faster UM decisions, better care experiences, and measurable clinical improvements — without adding more complexity.

What to do now:

- Target high-impact areas like oncology, MSK care, and serious mental illness with providers ready for pathway-driven care.
- Enable smarter decisions by integrating predictive analytics, clinical support, and point-of-care tools into UM strategies.
- Align incentives through shared-savings models that reward quality, experience, and whole-person outcomes.

The future of UM: strategic, streamlined, scalable, and more sustainable

We're not just keeping pace with change — we're helping our clients set a new standard for what modern UM should deliver: faster decisions, seamless coordination, and measurable impact.

That's why Everest Group named Carelon a UM operations Leader in its 2025 PEAK Matrix® Assessment. We were recognized for our regulatory-ready innovation, clinical depth, and flawless execution as the foundation for what comes next.

As utilization management evolves, health plans need more than short-term fixes. They need scalable, future-ready solutions that deliver speed, consistency, and whole-person impact.

We help our clients lead through complexity with strategies built for what's next: aligned incentives, integrated insights, and measurable outcomes across every stage of care.

Want to see how your UM strategy compares?

Read more about our Everest Group recognition and explore how health plan leaders are putting these shifts into action with sustainable UM.

> "Carelon is uniquely positioned to meet enterprise demands with deep domain expertise and industry-specific solutions across 12+ therapeutic areas. Its automated provider portal solution, EMR integration capabilities, and decision support tool streamline UM workflows and enhance clinical decision-making. A strategically distributed workforce ensures operational reliability and flexibility, earning client praise for high-quality service."
>
> — Lloyd Bagley, Practice Director, Everest Group

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1 Chief Healthcare Executive: *Administrative work takes up bulk of week for clinicians, medical office staff: Poll* (October 17, 2024): chiefhealthcareexecutive.com.

2 Forrester: *The State Of Trust For US Health Insurers, 2024* (February 19, 2025): forrester.com.