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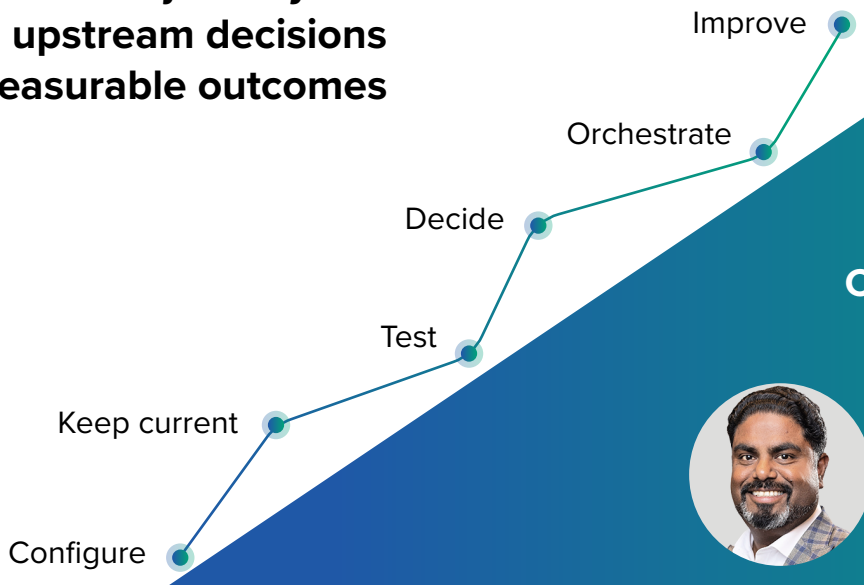
CLAIMS TRANSFORMATION THOUGHT LEADERSHIP

THE CONNECTED CLAIMS OPERATING MODEL

Claims Transformation Starts Upstream

Claims transformation cannot be achieved through core modernization, workflow automation or AI in isolation. Payers need a governed operating layer that connects claims-domain intelligence, enterprise orchestration, existing claims systems and accountable human execution.

A connected journey from upstream decisions to measurable outcomes



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Claims transformation cannot be achieved through core modernization, workflow automation or AI in isolation. Payers need a governed operating layer that connects claims-domain intelligence, enterprise orchestration, existing claims systems and accountable human execution.

This paper presents a practical operating model for that next step. It begins upstream, preserves the claims core as the system of record, connects intelligence with enterprise action, and keeps human accountability explicit. It also describes how ServiceNow, Simplify Alpha and Simplify Healthcare's Claims1® platform contribute complementary capabilities to that model.

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EXECUTIVE PERSPECTIVE

The claim is where the problem surfaces

Consider a familiar situation. A claim enters adjudication and pends. The claims team sees an exception that must be researched, routed and resolved. Yet the underlying problem may have started weeks or months earlier: a benefit was interpreted differently across teams, a code-set update was applied inconsistently, a configuration dependency was missed, or a change reached production without enough targeted testing.

> **The claim queue is where the failure becomes visible. It is not always where the failure began.**

That distinction matters because many claims-transformation programs still focus on the visible downstream symptom. They add work queues, task automation or another specialist application around adjudication. Those interventions may reduce effort within one step, but they do not necessarily reconnect the decisions, data and operating responsibilities that shape the claim before and after it reaches the core platform.

The industry has already demonstrated that digitization alone is not the finish line. The 2024 CAQH Index reported that 98 percent of medical claims were submitted electronically. Yet across the administrative transactions measured by CAQH, the report still identified a $20 billion annual opportunity from greater automation.[1] The message is not that electronic transactions have failed. It is that transaction automation and end-to-end operational control are different achievements.

Regulatory direction raises the stakes without changing the underlying diagnosis. CMS-0057-F reinforces expectations for interoperable data exchange and more transparent, timely prior-authorization operations.[4] Although prior authorization is not the subject of this paper, the direction is relevant to claims leaders: regulated decisions increasingly require connected data, traceable accountability and evidence that can move with the work. Fragmented operating controls become harder to defend as those expectations rise.

CENTRAL THESIS

Claims transformation cannot be achieved through core modernization, workflow automation or AI in isolation. Payers need a governed operating layer that connects claims-domain intelligence, enterprise orchestration, existing claims systems and accountable human execution.

This paper presents a practical operating model for that next step. It begins upstream, preserves the claims core as the system of record, connects intelligence with enterprise action, and keeps human accountability explicit. It also describes how ServiceNow, Simplify Alpha and Simplify Healthcare's Claims1® platform contribute complementary capabilities to that model.

INDUSTRY EVIDENCE

Claims are digital. Claims operations remain fragmented.

The evidence points to a claims paradox. Transaction adoption is high, but preventable administrative friction, denials and weak appeal pathways remain visible across the operating lifecycle.

98%

of medical claims were submitted electronically in the 2024 CAQH Index. High adoption has not eliminated downstream exceptions.[1]

$20B

in annual savings opportunity across the administrative workflows measured by CAQH from greater automation.[1]

19%

of in-network claims reported by HealthCare.gov insurers for 2024 were ultimately denied. This is Marketplace-specific, not a universal payer rate.[2]

<1%

of those denied in-network claims were appealed by consumers, underscoring the operational and member impact of the initial decision.[2]

The operational signal behind the statistics

KFF also found that administrative reasons accounted for 25 percent of reported in-network denial reasons. In a January 2026 KFF poll, 66 percent of insured adults described insurer delays and denials as a major problem, and 33 percent said an insurer had denied coverage for a prescribed service or medication during the preceding two years.[2]

Payment accuracy remains material as well. CMS estimated the FY2025 Medicare Fee-for-Service improper-payment rate at 6.55 percent, or $28.83 billion.[3] CMS explicitly cautions that improper payments are not a measure of fraud; many reflect insufficient, missing or non-substantiating documentation.

WHAT THIS MEANS

Electronic transaction adoption is not the same as a connected operating model. The next opportunity is to prevent upstream defects, carry context into exception work and govern decisions end to end.

PART I | DIAGNOSE THE OPERATING PROBLEM

Configuration debt becomes operational debt

A claim is the execution of decisions made across a long operational chain. Benefit intent must be interpreted. Rules must be configured. Provider and code-set data must remain current. Changes must be tested against affected pathways. The resulting claim must then move through adjudication, exception handling, payment and, when necessary, inquiry, adjustment or appeal.

When those activities are separated by systems, teams and governance models, an upstream gap can compound as it travels downstream:

01 A benefit or policy change is interpreted differently by product, configuration and operations teams.

02 Configuration logic is recreated or mapped inconsistently across products, markets or core platforms.

03 Testing confirms expected examples but misses an affected dependency or edge case.

04 The issue reaches live claims volume and appears as a pend, denial, incorrect payment or unexpected accumulation result.

05 Claims staff research the exception manually, often without the complete policy, configuration and precedent context.

06 The same underlying issue generates rework, adjustments, provider calls, member confusion, appeals and audit exposure.

The downstream operation then becomes a shock absorber for upstream uncertainty. More people are assigned to review work, more queues are created, and more local controls are added. The immediate claim may be resolved, but the operating system continues to reproduce the condition that caused it.

PART I | DIAGNOSE THE OPERATING PROBLEM

Why conventional transformation programs plateau

01

Core modernization addresses the system of record

Core administration platforms remain essential. They hold benefit, provider, pricing and adjudication logic and execute claims at scale. Replacing or upgrading a core can be necessary, but it does not automatically resolve the work that moves between product, configuration, claims, payment integrity, service, appeals and technology teams.

02

Point automation improves a task, not necessarily the operating model

Automating document intake, routing or a discrete review step can create measurable local efficiency. But if the process still loses context at every handoff, faster tasks can simply move incomplete work to the next queue sooner.

03

Workflow without claims context cannot explain the exception

A generic workflow can assign work and enforce a service level. It may not understand the benefit rule, configuration change, claim history, standard operating procedure or precedent that explains why the claim requires intervention.

04

AI without governance can increase operational risk

Claims decisions affect payment, access, member experience and regulatory obligations. Intelligence must operate inside explicit boundaries: what can be automated, what requires attestation, what must be escalated, and what evidence must be retained.

The recurring problem is not a shortage of technology. It is the absence of a connected operating layer that can preserve context, coordinate action and measure results across the life of the claim.

PART II | BUILD A GOVERNED CLAIMS SYSTEM OF ACTION

Orchestrate the life of the claim

The next objective for claims transformation is not to automate every task independently. It is to orchestrate the life of the claim, from the rules that shape it to the actions required to resolve it.

A governed claims system of action should do five things:

OPERATING PRINCIPLE

The unit of transformation is not an individual task. It is the life of the claim, from the rules that shape it to the actions required to resolve it.

A governed claims system of action preserves context from upstream decisions through downstream outcomes.

1. **Start upstream**
   Detect and prevent avoidable downstream failure through stronger configuration, code-set governance and targeted validation.
2. **Preserve the claims core**
   Add intelligence and orchestration around the system of record without making replacement a prerequisite.
3. **Connect intelligence with action**
   Deliver the relevant claim, rule, policy and precedent context into the workflow where a decision is made.
4. **Design human governance into the process**
   Define decision boundaries, approvals, escalations and audit evidence before increasing autonomy.
5. **Measure outcomes across the lifecycle**
   Connect first-pass adjudication, pend rates, touches, rework, adjustments, resolution time and appeals instead of optimizing each metric separately.

PART II | BUILD A GOVERNED CLAIMS SYSTEM OF ACTION

Three complementary capabilities

No single platform should be forced to perform every role. A more credible model assigns clear responsibility to the orchestration layer, the claims-domain layer and the managed operating layer, while keeping existing core administration platforms as systems of record.

01 ServiceNow

Primary contribution: Enterprise system of action: cases, cross-functional workflow, work orchestration, visibility and accountability.

Important boundary: Not positioned here as the claims adjudication engine.

02 Claims1 ®

Primary contribution: Simplify Healthcare's AI-powered claims operations platform: governed configuration, code-set management, automated testing and SOP-driven decision intelligence.

Important boundary: Works alongside the existing claims core; not positioned here as the enterprise cross-functional workflow platform.

Governed claims operating model

03 Simplify Alpha

Primary contribution: SolaaS operating model, payer expertise, human oversight, execution capacity and accountability for measurable improvement.

Important boundary: Not represented as a substitute for the payer's internal governance or statutory accountability.

04 Existing claims core

Primary contribution: System of record for configured benefits, provider logic, pricing, adjudication and payment processing.

Important boundary: Modernization can proceed without assuming immediate core replacement.

ServiceNow publicly positions its healthcare offering as an orchestration backbone for payer operations, including claims exceptions, appeals and grievances, and fraud operations.[SN-1] Claims1® is Simplify Healthcare's AI-powered claims operations platform and intelligent operations layer. Working alongside existing core systems, it brings together governed configuration, code-set management, automated claims testing and SOP-driven claims resolution through Claims1® Configure, Claims1® CodeSet, Claims1® ClaimsTest and Claims1® Intellect.[SH-1] Simplify Alpha brings a problem-first, managed-outcomes model intended to combine technology, domain expertise and accountable execution.[SA-1]

SERVICENOW DIFFERENTIATOR

Why ServiceNow changes the claims transformation equation

ServiceNow's distinction is not that it performs every claims function. It creates an enterprise system of action around claims: a common operating layer through which exceptions, cases, data, decisions and accountability can move across organizational boundaries while the adjudication core remains the system of record.

Orchestrate payer work across boundaries

ServiceNow positions its payer platform as an orchestration backbone for claims exceptions, appeals and grievances, and fraud operations. The differentiator is continuity across workflows that otherwise sit in separate queues and teams.[SN-1]

Connect and govern context from existing systems

ServiceNow® Workflow Data Fabric connects, contextualizes and controls data from multiple sources so employees and AI agents can act with business context. This supports augmentation around the claims core rather than making replacement the first dependency. [SN-2]

Use a healthcare-aware information model

The ServiceNow healthcare data model is compatible with HL7® and HL7® Fast Healthcare Interoperability Resources (FHIR®) and includes claim headers, claim lines, diagnoses, insurance and payer information. That provides a stronger claims-workflow foundation than a generic task model.[SN-3]

Govern AI through the same operating layer

ServiceNow AI Control Tower centralizes discovery, governance, security, observability and value measurement for enterprise AI assets. In claims operations, that supports controlled scaling alongside approvals, evidence and accountable human decisions. [SN-4]

What this makes possible in claims operations

One operating view

Bring the exception, case history, tasks and accountable owners into a common view across teams.[SN-1]

Context with the work

Make claim, policy, rule and precedent context available at the point where a decision is made.[SN-2][SN-3]

Closed-loop control

Capture approvals, escalations, outcomes and performance signals for audit, governance and improvement.[SN-4]

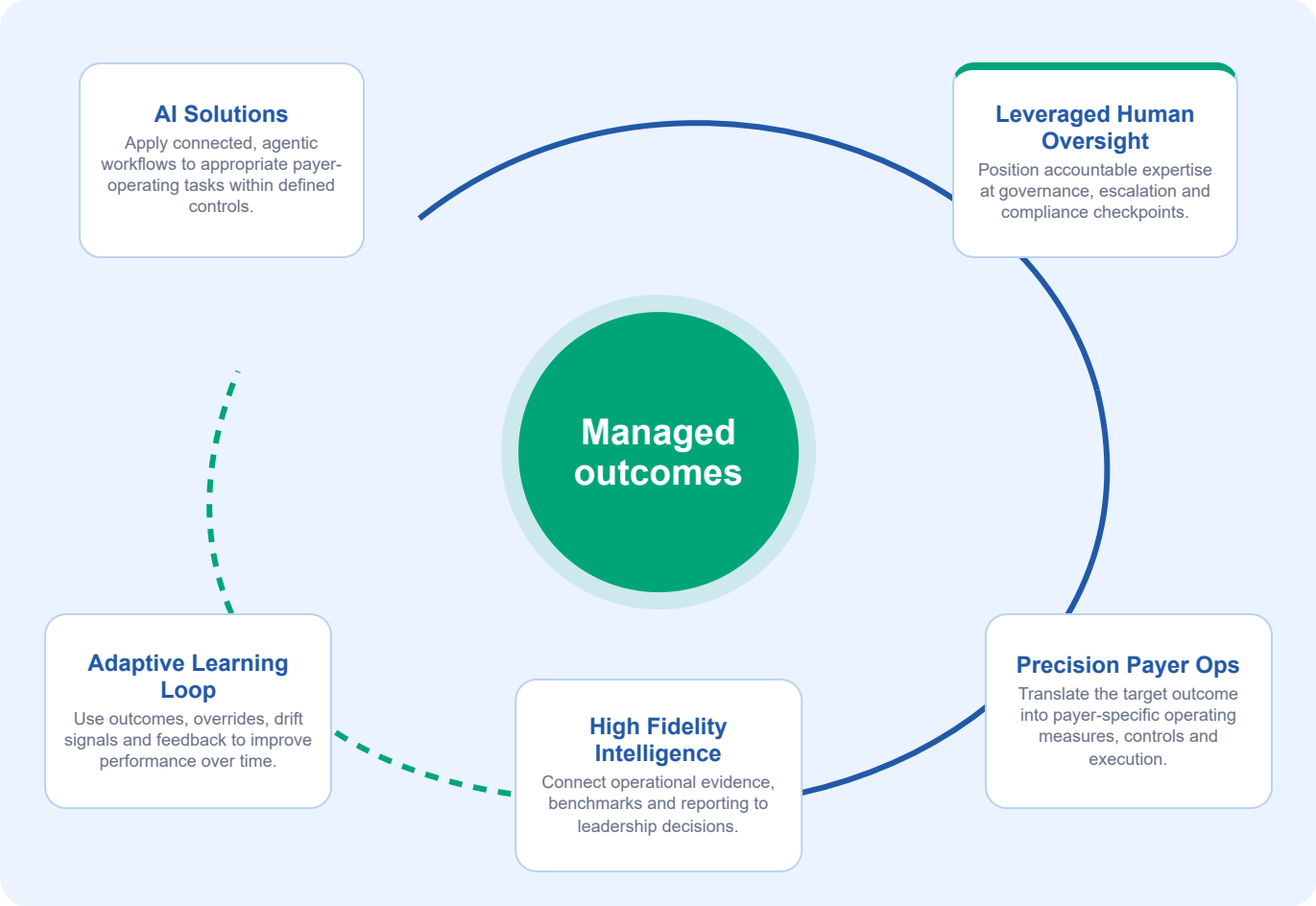
DIFFERENTIATOR IN ONE SENTENCE

ServiceNow connects payer-aware data, governed AI and cross-functional workflows around, rather than instead of, the existing claims core.

SIMPLIFY ALPHA OPERATING MODEL

How Simplify Alpha operationalizes managed outcomes

Simplify Alpha's public launch describes the ALPHA operating model as five connected layers.[SA-1] In this joint claims story, those layers explain how the managed operating role complements ServiceNow's orchestration and the payer-specific capabilities of Simplify Healthcare's Claims1® platform:



The ALPHA model is a delivery and accountability framework, not a separate technology layer. Detailed integrations, data movement, security boundaries and deployment topology remain matters for solution design and SME validation.

PART II | BUILD A GOVERNED CLAIMS SYSTEM OF ACTION

The Claims1® platform across the lifecycle

Within the model, Claims1® supplies payer-specific capability across four connected stages. The value is not a catalogue of products. It is continuity from governed configuration through code management and validation to claims resolution.

ROLE IN THE OPERATING MODEL

CONFIGURE

Claims1® Configure

Transform approved benefit and provider designs into governed, auditable, core-ready configurations with controlled workflow and approvals.

KEEP CURRENT

Claims1® CodeSet

Automate code management, assess impacts and govern validation, testing and approval for CPT®, HCPCS, ICD-10 and ADA updates.

TEST

Claims1® ClaimsTest

Generate test claims, automate expected-outcome validation, expand coverage and identify defects before production release.

DECIDE AND RESOLVE

Claims1® Intellect

Resolve pended claims and help prevent avoidable denials through SOP-driven AI, explainable decisions, audit trails and human oversight.

Continuity across the lifecycle

Configure

Keep current

Test

Decide and resolve

The value is continuity from configuration through validation and claims resolution.

The testing stage is especially important to the upstream-to-downstream argument. Claims1® ClaimsTest generates test claims, automates expected-outcome validation, expands coverage and detects configuration defects before production. The approved positioning also emphasizes synthetic test data that avoids PHI exposure and automatically scores results pass or fail.[SH-1][WS-C] That shifts the operating posture from finding defects in live claim volume to identifying them closer to their source.

PART II | BUILD A GOVERNED CLAIMS SYSTEM OF ACTION

Human governance is part of the architecture

Human oversight should not be added after an AI use case is designed. In consequential payer operations, it belongs in the operating architecture from the beginning.

Defined authority — Evidence and escalation — Consequential decisions

Decision boundaries: define which recommendations or actions can proceed automatically and which require human attestation.

Confidence and exception thresholds: route ambiguity, policy conflicts and low-confidence outcomes to qualified reviewers.

Role-based authority: align approvals with operational, clinical, compliance and financial accountability.

Explainability and evidence: retain the rules, context, sources and reasoning relevant to the action taken.

Feedback and controlled learning: use outcomes to improve the process without allowing ungoverned drift.

Auditability: preserve a traceable record of changes, decisions, escalations and approvals.

ServiceNow's AI Control Tower brings AI discovery, governance, security, observability and value measurement into an enterprise control plane.[SN-4] Claims1® Intellect combines SOP-driven decision intelligence with explainable AI, audit trails and integrated human review and attestation workflows.[SH-1][WS-C] The joint opportunity is to connect those governance principles to the payer's actual claims operating model.

KEY MESSAGE

Human oversight is not an exception to intelligent automation. In claims operations, it is part of the design.

PART III | PUT THE MODEL TO WORK

A future-state claims journey

A benefit, regulatory or code-set change provides a useful test of the operating model because it crosses the full claims lifecycle.

1. A change is received, interpreted and assigned an accountable owner.
2. Affected benefits, provider logic, rules, code sets and lines of business are identified.
3. Configuration changes are created, versioned and governed.
4. Impacted claim paths and targeted test scenarios are generated.
5. The change is validated before production deployment.
6. Live claim behavior is monitored against expected results.
7. An exception arrives with relevant claim, rule, configuration and precedent context.
8. Routine work is resolved or recommended within approved boundaries.
9. Higher-risk or adverse decisions move to an authorized human for attestation.
10. Actions, approvals and outcomes are retained for audit and continuous improvement.

CONTEXT, ACCOUNTABILITY AND EVIDENCE MOVE WITH THE WORK

This is an operating blueprint, not a finalized integration design. It shows how context and accountability should move. The precise system calls, data contracts and ownership boundaries should be established during solution design with the relevant SMEs.

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PART III | PUT THE MODEL TO WORK

Build the business case from operational drivers

A credible claims-transformation business case begins with the payer's operating data, not a generic savings promise. The most useful model connects intervention points to measurable drivers:

56-60%

Modeled share of projected savings attributed to denial and rework reduction. Internal simulation, not an observed customer result.

The internal Claims1® Value Dial is useful as a model structure. Its current scenarios indicate that denial and rework reduction represents approximately 56 to 60 percent of projected savings, with additional modeled value from call deflection, appeal avoidance, avoided adjustments and labor capacity.[WS-B] Those figures are simulation outputs based on standardized assumptions. They are not observed customer results and should not be presented as contractual outcomes.

Annual claim volume and claims per member	**First-pass adjudication and auto-adjudication rates**	**Pend and exception volumes by root cause**
Touches, research time and average handling time	**Configuration effort, defects and release lead time**	**Avoidable denials, adjustments and reprocessing**
Appeals, grievances and provider or member inquiries	**Payment leakage and compliance exposure**	**Fully loaded labor and vendor cost**

Accordingly, the main whitepaper should use a value-driver equation grounded in the payer's own baseline. Cohort projections are better reserved for an appendix or a sales conversation, where they can be labeled as illustrative model scenarios and accompanied by their assumptions.

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PART III | PUT THE MODEL TO WORK

Start with a four-week Discovery Sprint

The first step should not be a broad platform transformation. It should be a bounded effort to identify one claims journey where operational friction, measurable value and governance readiness intersect.

4
weeks

Bounded enough to create momentum. Structured enough to produce an evidence-based roadmap.

1 — Establish the baseline

Claim volumes, operating metrics, exception categories, systems, workflows and priority pain points.

2 — Trace root causes

Upstream configuration and testing gaps, manual handoffs, context discontinuities and governance constraints.

3 — Design the initial journey

Target operating model, system boundaries, human decision points, data needs and success measures.

4 — Build the roadmap and business case

Prioritized use case, value-driver model, implementation sequence, governance and scale roadmap.

Validated outputs: opportunity map | target journey | payer-specific business case | implementation roadmap

The sprint should conclude with a validated opportunity map, target journey, payer-specific business case and implementation roadmap. It should not imply that every discovered opportunity must become part of the first deployment.

LEADERSHIP PERSPECTIVES AND PAYER READINESS

Two perspectives. One operating challenge.

CLAIMS INTELLIGENCE

Anup Panthaloor

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> Claims intelligence creates value only when it is grounded in payer rules, explainable to the people accountable for the decision, and connected to the action that follows. That is why domain depth, human governance and operational execution must be designed together.

Domain depth must travel with the decision and the action that follows.

ENTERPRISE ORCHESTRATION

Milind Shah

Head of Healthcare Payer | ServiceNow

> The next chapter of claims transformation is not another isolated automation layer. It is the ability to connect exceptions, people, policies and systems through an enterprise orchestration backbone, so the right context reaches the right decision and the result can be measured across the operation.

Enterprise context must reach the right owner and remain measurable.

SHARED POINT OF VIEW

The model works when context, authority and evidence stay connected.

The two perspectives converge on a practical design principle: intelligence is useful only when it is connected to governed execution across the life of the claim.

Context travels
Payer rules, claim history and precedent move with the work.

Authority stays explicit
Human decision rights, approvals and escalation paths remain visible.

Outcomes feed improvement
Results and evidence return to the operating model for measured learning.

From leadership principle to payer readiness

Claims context → Enterprise action → Human authority → Measurable outcome

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LEADERSHIP PERSPECTIVES AND PAYER READINESS

A readiness test for payer leaders

A payer may have an orchestration and operating-model opportunity if several of the following questions cannot be answered confidently:

- ◯ Can we trace recurring downstream claims exceptions to their upstream causes?
- ◯ Do configuration and code-set changes automatically trigger targeted impact analysis and testing?
- ◯ Do exception handlers receive the rule, claim, policy and precedent context needed to make the decision?
- ◯ Are automated and AI-assisted decisions governed by explicit human-authority boundaries?
- ◯ Can we quantify the cost of fragmentation across claims, service, appeals and payment operations?
- ◯ Can we improve the operating model without making core replacement the first dependency?

Start with one claims journey

Claims transformation becomes practical when the organization chooses a journey specific enough to understand and important enough to matter. The starting point may be a high-volume pend category, a recurrent configuration defect, a code-set update, an avoidable denial pattern or an exception process that crosses claims, service and appeals.

The immediate objective is to identify the upstream cause, connect the required intelligence and workflows, place human accountability deliberately, and measure the result against an agreed baseline.

CALL TO ACTION

Use a four-week Discovery Sprint to identify the claims journey with the highest operational friction, define its measurable value drivers, and design the smallest governed intervention capable of producing meaningful improvement.

ABOUT THE JOINT APPROACH

Simplify Alpha™

Simplify Alpha

Simplify Alpha is the Solutions-as-a-Service arm of Simplify Group, focused on managed outcomes across payer operations. Its model draws on the broader Simplify Group ecosystem, including Simplify Healthcare's 18+ years of payer expertise.[SH-2]

servicenow

ServiceNow

ServiceNow provides an AI-powered platform and healthcare operations capabilities that connect requests, cases, teams and workflows. Its payer-operations positioning includes claims exceptions, appeals and grievances, and fraud operations.[SN-1]

Simplify Healthcare®

Simplify Healthcare / Claims1®

Within the Simplify Group ecosystem, Simplify Healthcare provides the Payer AI Platform for payer operations, built on payer ontology and expert agents to work across existing core systems. Claims1® is its AI-powered claims operations platform, spanning Configure, CodeSet, ClaimsTest and Intellect.[SH-1][SH-2]

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EVIDENCE AND SUBSTANTIATION

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