Precision orchestration for the human experience

oeight

The 2026 Service Orchestration Readiness Report

for Health Plans

How Health Plans Can Turn AI, Vendors, and Operations into Measurable Performance

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Executive Summary

Key takeaway

Health plan transformation is moving from isolated optimization to whole-system orchestration. AI may be an accelerant, but orchestration is the operating discipline that turns AI into measurable value.

Health plans are entering 2026 with a difficult operating mandate: improve member and provider experience, reduce administrative burden, protect quality performance, prepare for interoperability and prior authorization requirements, manage vendor complexity, and find practical ways to deploy AI without introducing new operational or compliance risk. These pressures are converging at the exact moment when members, providers, regulators, employers, and internal teams expect faster service and clearer accountability.

The opportunity is significant. The Council for Affordable Quality Healthcare (CAQH) reported a $20 billion opportunity to reduce administrative waste through greater automation of healthcare administrative transactions, while CMS has established implementation timelines for interoperability and prior authorization requirements that raise the bar for payer workflow transparency and data exchange. Kaiser Family Foundation (KFF) reported that more than half of eligible Medicare beneficiaries were enrolled in Medicare Advantage in 2025, placing more members inside performance-sensitive models where experience, quality, risk adjustment, Star Ratings, and service execution matter. At the same time, AI is moving from experimentation to operational deployment, with payer-focused analyses estimating sizable administrative, medical-cost, and revenue opportunities when AI is integrated with the operating model rather than bolted onto it. [1][2][3][7]

The core problem is not that health plans lack technology. Most plans already have a dense ecosystem of core administration platforms, CRM tools, provider directories, claims systems, care management platforms, member portals, contact center systems, quality systems, analytics tools, vendor portals, and document repositories. The core problem is that these assets often operate as separate islands. The result is duplicated work, inconsistent handoffs, limited visibility into root causes, uneven vendor accountability, and AI pilots that may improve narrow tasks without changing system-level performance.

This report argues that service orchestration should become a formal executive discipline for health plans. Service orchestration is the practice of designing, governing, and continuously improving the way people, processes, technologies, vendors, data, and AI agents work together across the full service experience. It is not simply process improvement, vendor management, or automation. It is the connective operating layer that converts fragmented capabilities and operations into measurable outcomes.

Key Findings and Report Premise

Finding	Why it matters for health plans	What executives should do
1. Service complexity has become a performance tax	Every new vendor, channel, regulatory rule, product line, and AI use case creates handoffs that must be governed. When they are not, the plan pays through rework, longer handle times, avoidable escalations, provider abrasion, and member dissatisfaction	Create an enterprise-level service orchestration owner and map the highest-friction journeys end to end
2. Administrative waste remains a major value pool	Industry-wide automation opportunity remains substantial, but savings depend on workflow adoption, data quality, operating discipline, and change management - not just system implementation	Quantify manual work by transaction type, root cause, queue, channel, vendor, and member/provider segment
3. AI agents can create value, but only in orchestrated workflows	AI agents are most useful when the task is repetitive, evidence-based, measurable, and has clear escalation criteria. Poorly governed AI can add risk or simply create faster fragmentation	Prioritize AI candidates using a value/risk matrix and require human-in-the-loop controls for regulated or judgment-heavy decisions
4. Vendor performance is now strategic, not administrative	Health plans increasingly deliver member and provider experience through external partners. Poor vendor integration can undermine quality, service, and financial performance	Replace vendor scorecards that measure activity with orchestration scorecards that measure end-to-end outcomes
5. Foundation work must precede transformation	Plans cannot reliably scale AI or redesign operations when process ownership, data definitions, knowledge management, and governance are immature	Use a Foundation-to-Transformation maturity model to sequence investment

Source note: Sources supporting report context include CAQH 2024 Index, CMS-0057-F final rule, KFF Medicare Advantage enrollment update, NCQA Health Plan Ratings, NIST AI RMF, ONC HTI-1, McKinsey payer AI/digital transformation analysis, PwC medical cost trend, and Health Plan Alliance AI programming. See Appendix B.

SECTION 1

Why Service Operations Are Becoming Harder to Manage

Key takeaway

Complexity is increasing faster than most operating models can absorb. The practical challenge is no longer one system, one queue, or one vendor - it is the full-service ecosystem.

Health plan service operations have become harder to manage because the operating environment is simultaneously becoming more regulated, more digital, more member-specific, more vendor-dependent, and more data-intensive. A member issue that begins as a simple phone call can touch eligibility, benefits, claims, provider networks, prior authorization, pharmacy, appeals, quality, risk adjustment, delegated vendors, plan documents, and regulatory correspondence before it is resolved.

The legacy response to complexity has been specialization: more teams, more queues, more vendors, more tools, and more handoff rules. Specialization can improve expertise, but it also creates service fragmentation when there is no cross-functional orchestration layer. The service experience becomes dependent on the weakest handoff in the chain.

Several 2026 dynamics increase the pressure:

- **Regulatory operating pressure:** CMS interoperability and prior authorization requirements create new demands around data exchange, reporting, timeliness, and transparency. Certain provisions began being required by January 1, 2026, while many API requirements are primarily due by January 1, 2027. [2]
- **Medicare Advantage performance sensitivity:** KFF reported that 54% of eligible Medicare beneficiaries were enrolled in Medicare Advantage in 2025. In this environment, service experience, risk-bearing operations, quality measures, Stars, and retention are tightly connected. [3]
- **Quality and experience expectations:** NCQA Health Plan Ratings and CMS Stars continue to reinforce the importance of outcomes, member experience, care coordination, and quality infrastructure. [4][10]
- **Cost pressure:** PwC projected 2026 medical cost trends of 8.5% for the Group market and 7.5% for the Individual market, keeping pressure on administrative efficiency and cost-of-care programs. [8]
- **AI adoption pressure:** Health Plan Alliance AI programming and broader healthcare AI analysis show that plans are actively exploring AI strategy, governance, workflow integration, and implementation readiness. [9]

OEIGHT POINT OF VIEW

The question for health plans is not whether operations are complex. The question is whether complexity is being managed as a system. Service orchestration gives leaders a way to see the system, prioritize the right interventions, and connect investments to measurable outcomes.

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Complexity driver	Operational symptom	Service orchestration response
More products and member segments	Agents struggle to locate the right benefit logic; members receive inconsistent answers	Create journey-level knowledge models and benefit-answer governance
More vendors and delegated functions	Ownership is unclear when handoffs fail; escalations bounce across organizations	Define cross-party accountability maps, escalation rules, and vendor outcome scorecards
More regulatory and reporting obligations	Manual tracking, spreadsheet-based reporting, and audit scramble	Create evidence trails, control points, and reporting workflows inside the operating model
More AI pilots	Tools improve narrow tasks but do not reduce total cost or cycle time	Sequence AI through a value/risk portfolio tied to measurable workflow redesign

RECOMMENDATION

1. Establish a Service Orchestration Steering Team with COO, CIO, CFO, CX, quality, compliance, and vendor leadership representation.
2. Select the five highest-friction journeys for assessment: member inquiry, provider inquiry, prior authorization, claim status/appeal, and quality/Stars outreach.
3. Build a service complexity map showing systems, vendors, queues, decisions, data dependencies, SLAs, failure points, and handoffs.
4. Define an initial orchestration scorecard using operational, financial, experience, quality, and compliance metrics.

Source note: Primary sources: CMS-0057-F, KFF Medicare Advantage enrollment update, NCQA 2025 Health Plan Ratings, PwC 2026 medical cost trend, HPA AI Impact Accelerator. [2][3][4][8][9]

SECTION 2

The Hidden Cost of Fragmented Workflows

Key takeaway

Fragmentation is expensive because it hides in rework, wait time, duplicate contacts, avoidable escalations, missed quality opportunities, and vendor friction.

Fragmented workflows rarely appear as a single line item. They show up as higher administrative costs, longer cycle time, avoidable callbacks, provider dissatisfaction, inconsistent service answers, missed outreach, manual reconciliation, quality leakage, and leadership time spent resolving recurring operational issues. The cost is hidden because each department sees only its portion of the work.

CAQH reported that healthcare has a $20 billion opportunity to reduce administrative waste and that manual tasks in the healthcare revenue cycle create unnecessary delays, increase costs, and make it harder for patients to receive timely care. Although the CAQH Index focuses on administrative transactions, the underlying insight applies more broadly: health plan performance improves when work is digitized, standardized, governed, and adopted across the workflow. [1]

A health plan can implement a new tool and still preserve the old fragmentation if the tool does not change handoff rules, knowledge ownership, data quality, escalation criteria, vendor obligations, and management routines. This is why service orchestration begins with work design rather than software selection.

Hidden cost category	Typical examples	Observable metrics	Potential orchestration move
Rework	Reopened cases, incorrect first answers, repeated eligibility checks, repeat claims research	Reopen rate, repeat contact rate, adjustment volume, error rate	Root-cause tagging, knowledge governance, automated evidence retrieval
Wait time	Queue delays, vendor response lag, authorization handoff delays, issue aging	Cycle time, aging buckets, SLA misses, pended case days	Queue redesign, vendor SLAs, AI triage, real-time routing
Duplicate contact	Members/providers calling multiple times for the same issue	Calls per case, callbacks within 7 days, digital deflection quality	Case ownership rules, proactive status updates, resolution confirmation
Quality leakage	Missed care gaps, inconsistent outreach, poor Stars/CAHPS inputs	Measure gap closure, outreach completion, complaint themes	Journey triggers, prioritized worklists, quality/service integrated dashboards
Vendor friction	Delegated vendor work not visible; plan cannot diagnose root cause quickly	Vendor SLA variance, escalations, defect rate, exception volume	Outcome scorecards, escalation playbooks, joint operating reviews

RECOMMENDATION

Build a Fragmentation Cost Inventory. This is a structured inventory of costs that do not appear as a single budget line but can be measured through operational proxies. The inventory should be built from service data, claims/case data, vendor SLA reports, QA findings, complaint themes, knowledge gaps, and leadership pain points.

Inventory step	Output	Owner
1. Select journeys	List of 3-5 high-friction workflows for the first 60 days	COO/CX leader
2. Map actual work	Journey maps showing people, queues, systems, vendors, data, decisions, and handoffs	Operations excellence/ Oeight assessment team
3. Quantify friction	Baseline metrics for rework, repeat contact, cycle time, defects, vendor misses, and manual effort	Analytics/finance/ operations
4. Prioritize causes	Root-cause matrix ranking impact, feasibility, risk, and AI suitability	Steering team
5. Build roadmap	90-day stabilization plan and 12-month transformation roadmap	Executive sponsor

Source note: Primary source: CAQH 2024 Index public release. [1]

SECTION 3

Where AI Agents Create the Most Value

Key takeaway

AI agents create the most value when they are deployed against repeatable, evidence-based workflows with measurable outcomes and clear human oversight.

AI agents should not be treated as a universal replacement for human service. They are most effective where the task has repeatable inputs, high volume, documented rules, measurable outputs, and low ambiguity - or where ambiguity can be safely routed to a human-in-the-loop. In health plan operations, the highest-value opportunities often sit at the intersection of service, documentation, knowledge retrieval, case triage, outreach, vendor management, and evidence assembly.

McKinsey has estimated that for every $10 billion of payer revenue, AI solutions could save $150 million to $300 million in administrative costs, save $380 million to $970 million in medical costs, and increase revenue by $260 million to $1.24 billion. Those estimates point to the size of the value pool, but plans capture value only when AI is connected to workflow redesign, operating adoption, measurement, governance, and change management. [7]

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AI governance must also be treated as part of the operating model. NIST describes its AI Risk Management Framework as a way to better manage risks to individuals, organizations, and society associated with AI. ONC's HTI-1 final rule established transparency requirements for AI and predictive algorithms in certified health IT and emphasized fairness, appropriateness, validity, effectiveness, and safety. Even when a specific health plan use case is outside certified health IT, these principles are useful design requirements for responsible AI operations. [5][6]

AI-agent opportunity	High-value task examples	Required controls	Value signal
Member and provider service assist	Answer retrieval, call summarization, next-best-action prompts, status explanation, case note drafting	Approved knowledge source, confidence score, human review, audit trail	AHT reduction, first-contact resolution, QA score, repeat contact reduction
Prior authorization support	Document intake, criteria matching support, missing information detection, status updates, routing	Clinical decision boundaries, human clinical review, policy provenance, appeal path	Cycle time, pended cases, provider calls, denial/appeal accuracy
Claims and appeals triage	Issue classification, evidence assembly, benefit/policy lookup, route to right owner	Benefit logic validation, compliance review, explanation generation controls	Aging reduction, reopen rate, overturn rate, manual touches per case
Quality and Stars workflow assist	Care gap prioritization, outreach scripts, member segmentation, provider follow-up lists	Measure logic review, health equity review, outreach consent rules	Gap closure, outreach completion, member experience signals
Vendor operations agent	SLA exception detection, issue summarization, vendor meeting prep, action tracking	Data access rules, vendor accountability model, escalation approvals	SLA adherence, defect reduction, escalation cycle time
Knowledge and training agent	Policy comparison, onboarding guidance, simulated calls, QA feedback support	Version control, content owner approval, hallucination checks	Training time, answer consistency, QA findings

AI PRIORITIZATION FRAMEWORK

Dimension	Scoring question	High-priority signal
Value	How much cost, cycle time, experience, quality, or risk improvement is available?	High volume, high manual effort, clear savings or experience impact
Repeatability	Are inputs, steps, and outputs consistent enough to automate or assist?	Common cases, consistent documents, stable rules, predictable routing
Evidence quality	Can the AI access approved, current, auditable sources?	Structured data or controlled knowledge base exists
Risk	Could a wrong answer create clinical, compliance, financial, member, or reputational harm?	Risk can be bounded through human review or limited scope
Adoption	Will the front-line team and managers use the workflow?	Clear workflow fit, training plan, manager dashboards

RECOMMENDATION

Launch AI with an agent portfolio, not a pilot wish list. The portfolio should include use-case value, workflow fit, source systems, risk controls, human-in-the-loop thresholds, KPI baseline, success target, production owner, and retirement criteria if the agent does not create measurable value.

Source note: Primary sources: McKinsey payer digital and AI analysis, NIST AI RMF, ONC HTI-1 final rule. [5][6][7]

SECTION 4

Why Vendor Orchestration Matters

Key takeaway

Vendor management measures whether a vendor performed its assigned work. Vendor orchestration measures whether the combined internal/external operating system produced the intended outcome.

Health plans increasingly deliver service through a distributed ecosystem. Contact center partners, claims administrators, utilization management vendors, provider data partners, care management platforms, analytics vendors, pharmacy partners, enrollment vendors, digital engagement tools, and AI platforms all shape member and provider experience. A plan may have strong vendor contracts and still experience weak service outcomes if vendor work is not orchestrated across journeys.

The vendor problem is not simply performance. It is integration. Vendors may meet their individual SLAs while the member or provider journey still fails because handoffs are slow, data is incomplete, escalation ownership is unclear, or the plan lacks a single operating view of the issue. This creates a gap between contract compliance and experience performance.

Vendor orchestration should become a disciplined operating practice. It needs to include clear accountabilities, defined handoffs, shared data requirements, issue escalation paths, quality review routines, joint root-cause analysis, adoption metrics, and outcome-based scorecards.

Traditional vendor management	Service orchestration approach
Measures vendor activity and contractual SLA compliance	Measures end-to-end member, provider, operational, quality, and financial outcomes
Reviews vendor performance in separate meetings	Connects vendors to journey-level operating reviews with internal owners
Escalates issues when a breakdown becomes visible	Uses root-cause signals, exception dashboards, and trigger-based escalation
Focuses on the vendor's work product	Focuses on the total outcome created by internal and external work together
Keeps AI governance separate from vendor governance	Extends AI governance to vendor-deployed AI, delegated workflows, data access, and auditability

RECOMMENDED VENDOR ORCHESTRATION SCORECARD

Scorecard domain	Example measures	Why it matters
Experience	Member/provider satisfaction, complaint themes, repeat contact, first-contact resolution	Shows whether vendor work improves the actual service experience
Workflow health	Cycle time, queue aging, handoff defects, rework, SLA variance	Identifies where the operating system is breaking down
Quality and compliance	Audit findings, appeal overturns, policy exceptions, documentation completeness	Protects regulatory and quality performance
Financial impact	Cost per transaction, avoidable volume, productivity, leakage, savings captured	Connects vendor performance to CFO-relevant outcomes
AI and data controls	Model/use-case register, data source approval, human review rate, issue log	Ensures AI-enabled vendor work is governed and auditable

RECOMMENDATION

1. Create a vendor journey map for each high-impact outsourced or delegated process.
2. Define the handoff owner for every transition between plan, vendor, provider, member, and system.
3. Update vendor reviews from SLA-only meetings to outcome reviews that include root causes and remediation owners.
4. Require AI-use disclosure, governance documentation, and human review standards from vendors using AI in service workflows.
5. Develop a vendor remediation playbook that connects performance issues to improvement sprints, contract levers, and executive escalation.

SECTION 5

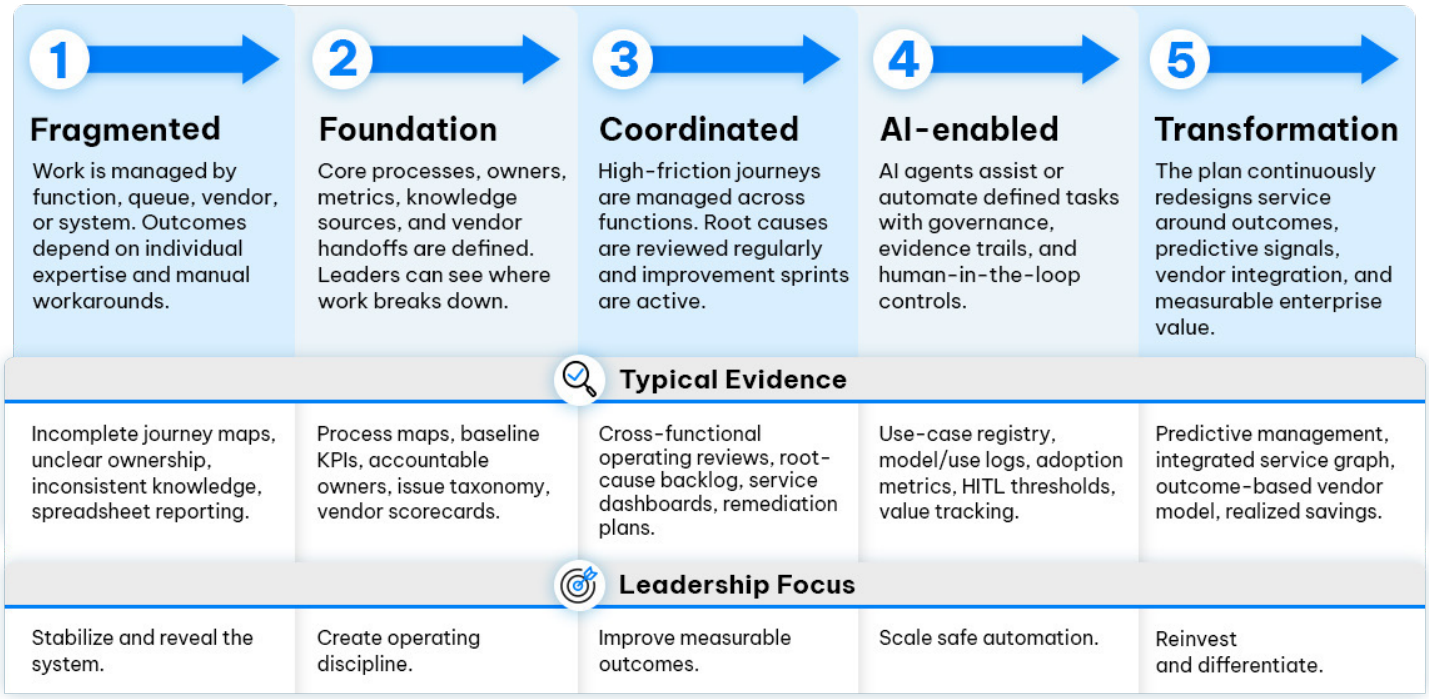
The Maturity Model -Foundation to Transformation

Key takeaway

A health plan cannot transform what it cannot consistently operate. The maturity path begins with Foundation discipline and advances to Transformation only when the operating model can absorb change.

The Foundation-to-Transformation model gives executives a practical way to sequence investment. Foundation work creates operating clarity: process ownership, data definitions, knowledge governance, workflow visibility, evidence trails, vendor accountability, and management routines. Transformation work builds on that foundation through AI agents, redesigned journeys, automation, new operating roles, predictive management, and outcome-based service models.

Skipping Foundation creates a familiar pattern: tools are implemented, pilots are celebrated, dashboards are created, and the organization still struggles to prove enterprise-level impact. The maturity model helps leaders identify whether the constraint is technology, workflow design, operating discipline, governance, data quality, or change adoption.



CAPABILITY DOMAINS TO ASSESS

Domain	Foundation questions	Transformation questions
Strategy and governance	Is there an executive sponsor and decision forum for service orchestration?	Can the forum prioritize investments based on value, risk, and enterprise impact?
Journey design	Are high-friction member/provider journeys mapped with ownership and metrics?	Are journeys redesigned with AI, automation, and proactive service triggers?
Data and evidence	Are data sources, definitions, and evidence trails reliable?	Can the plan create near-real-time operating intelligence across systems/vendors?
Knowledge management	Is there an approved source of truth for policies, benefits, workflows, and scripts?	Can AI retrieve, summarize, and explain knowledge with source attribution and auditability?
Vendor orchestration	Are vendor SLAs, handoffs, and escalations clearly defined?	Are vendors governed by outcome scorecards and joint improvement routines?
AI readiness	Are use cases prioritized and governed?	Are agents deployed safely with value tracking, human oversight, and continuous improvement?

RECOMMENDATION

Ask leaders to self-score each domain from 1 to 5, then compare the self-score with evidence gathered from operations, vendors, systems, and front-line interviews. The gap between perception and evidence is often the most valuable diagnostic finding.

SECTION 6

Sample Savings Model

Key takeaway

The savings case should be built from operational evidence, not generic automation assumptions. PMPY ranges can frame the opportunity, but the assessment should convert them into plan-specific savings logic.

The following model is illustrative. It is intended to show how a health plan can translate service orchestration into an executive-level opportunity estimate. It should not be presented as guaranteed savings. Actual savings depend on plan size, product mix, vendor structure, baseline performance, technology environment, staffing model, adoption, and whether savings are captured as hard-dollar, soft-dollar, quality, revenue, or retention impact.

The model uses a hypothetical regional health plan with 75,000 covered lives. The ranges are deliberately conservative for a first-pass service orchestration assessment and focus on administrative, operational, vendor, quality, and service improvement opportunities. They do not include broad medical-cost reductions unless explicitly validated by clinical and actuarial analysis.

Opportunity category	Illustrative PMPY opportunity	75k lives annual opportunity	Value mechanism
Contact center and service productivity	$30 - $60	$2.25M - $4.50M	Lower repeat contacts, lower AHT, better FCR, improved knowledge, AI call support
Prior authorization and utilization workflow support	$20 - $45	$1.50M - $3.38M	Reduced pends, faster routing, fewer provider calls, improved evidence assembly
Claims, appeals, and issue resolution	$15 - $35	$1.13M - $2.63M	Reduced rework, faster case resolution, fewer escalations, better root-cause controls
Vendor and delegated operations orchestration	$15 - $35	$1.13M - $2.63M	Improved SLA adherence, defect reduction, fewer handoff failures, better accountability
Quality, Stars, and member experience enablement	$10 - $35	$0.75M - $2.63M	Better outreach, gap closure, service consistency, complaint reduction, retention support
Knowledge, training, and workforce management	$20 - $55	$1.50M - $4.13M	Faster onboarding, better scheduling alignment, fewer errors, reduced supervisor burden
Total gross opportunity range	$110 - $265	$8.25M - $19.88M	Before implementation cost, adoption risk, timing, and capture-rate adjustments

CAPTURE-RATE SCENARIO

Scenario	Year 1 capture	Year 2 capture	Year 3 capture	How to interpret
Conservative	15% - 25%	25% - 40%	35% - 50%	Foundation improvements, selected AI assists, limited workflow redesign
Base case	20% - 30%	35% - 50%	50% - 65%	Disciplined operating model, vendor scorecards, AI portfolio, executive governance
Aggressive	30% - 40%	50% - 65%	65% - 80%	Strong data, adoption capacity, clear authority, measurable vendor participation

RECOMMENDATION

1. Define membership and product segmentation: MA, Medicaid, commercial, exchange, ASO, D-SNP/SNP, region, and vendor delegation.
2. Establish baseline volumes and unit costs: calls, chats, appeals, authorizations, claims inquiries, grievances, provider contacts, rework, and vendor exceptions.
3. Quantify friction: repeat contact, AHT, pended cases, cycle time, manual touches, workarounds, quality defects, and SLA misses.
4. Estimate opportunity by lever: eliminate, automate, augment, route, standardize, vendor-correct, or redesign.
5. Apply capture-rate and confidence adjustments: separate hard-dollar savings, soft-dollar productivity, quality/revenue upside, and strategic risk reduction.
6. Build an implementation business case: cost, timeline, owners, value-tracking cadence, benefits realization governance, and reinvestment plan.

Source note: External guardrail: McKinsey payer AI analysis estimates large administrative, medical-cost, and revenue opportunities per $10B of payer revenue. CAQH also identifies substantial administrative automation savings opportunities. This illustrative model is intentionally narrower and should be validated with plan-specific operational and financial data. [1][7]

SECTION 7

The Oeight Assessment Methodology

Key takeaway

Key takeaway: The assessment should produce more than a maturity score. It should produce a prioritized operating roadmap, AI-agent portfolio, vendor orchestration plan, and quantified value case.

The Oeight Service Orchestration Readiness Assessment is designed as a focused 2- to 4-week diagnostic. It gives executives a clear view of operational maturity, friction economics, AI readiness, vendor alignment, and transformation priorities. The assessment can begin as a lightweight engagement and expand into a transformation blueprint or implementation program.

The assessment combines executive interviews, front-line workflow review, data request analysis, artifact review, maturity scoring, root-cause mapping, AI candidate evaluation, vendor orchestration review, and savings modeling. The goal is not simply to identify problems. The goal is to produce a roadmap that the organization can execute.

Phase	Duration	Activities	Deliverables
1. Mobilize and align	Days 1-3	Confirm executive sponsor, scope, target journeys, stakeholders, data request, and success measures	Assessment charter, data request list, stakeholder map
2. Discover and map	Days 4-10	Interview executives and operators; map journeys; review systems, vendors, knowledge sources, QA, reports, and current initiatives	Current-state maps, friction inventory, evidence log
3. Score maturity	Days 8-14	Score Foundation-to-Transformation maturity across strategy, journey, data, knowledge, vendor, AI, compliance, and measurement domains	Maturity heatmap, gap analysis, executive summary
4. Quantify opportunity	Days 12-18	Build savings hypotheses using volume, unit cost, cycle time, rework, vendor defects, and adoption assumptions	Savings model, opportunity backlog, confidence ranking
5. Design roadmap	Days 16-24	Prioritize improvement sprints, AI-agent candidates, vendor orchestration actions, governance moves, and investment requirements	90-day action plan, 12-month roadmap, AI portfolio, vendor scorecard
6. Executive readout	Days 20-28	Review findings with leadership, validate assumptions, choose next-phase initiatives, and define governance cadence	Executive briefing deck, decision log, next-step proposal

CORE ASSESSMENT WORKSTREAMS

Workstream	Purpose	Representative outputs
Member/provider journey review	Identify where service breaks down across channels, systems, vendors, and functions	Journey map, pain-point inventory, top failure modes
Operational maturity scoring	Evaluate whether Foundation capabilities exist before Transformation investments are scaled	Maturity score, evidence summary, priority domains
AI readiness and use-case portfolio	Determine which AI agents are suitable, safe, valuable, and adoptable	Use-case matrix, risk controls, HITL rules, source-system needs
Vendor orchestration review	Assess whether vendors are aligned to outcomes rather than isolated SLAs	Vendor journey map, scorecard, escalation model
Savings and value modeling	Translate operational friction into financial, quality, and experience opportunity	PMPY opportunity, capture-rate scenarios, benefits-realization plan
Governance and operating cadence	Create the management system required to execute change	Steering model, decision rights, KPI dashboard, operating review calendar

RECOMMENDED ASSESSMENT OFFER PACKAGING

Offer tier	Best fit	Scope	Output
Foundation Scan	Plan wants a fast executive baseline	2 weeks; interviews, artifact review, maturity scoring, initial opportunity map	Readiness scorecard, top 10 opportunities, executive briefing
Service Orchestration Assessment	Plan wants a quantified roadmap	3-4 weeks; current-state maps, data review, AI use-case portfolio, vendor review, savings model	90-day plan, 12-month roadmap, savings model, AI portfolio, vendor scorecard
Transformation Blueprint	Plan is ready to launch implementation	6-8 weeks; deep workflow design, business case, target operating model, implementation plan	Business case, operating model, implementation backlog, governance, transformation deck

Executive Action Agenda

Key takeaway

The next 90 days should focus on clarity: which journeys matter most, where fragmentation is costing money, where AI belongs, which vendors must be orchestrated, and what governance is required to capture value.

> **The health plans that perform best in 2026 will not simply automate old work. They will redesign how work moves across the enterprise.**

Timeframe	Executive objective	Recommended actions	Expected output
Weeks 1-2	Create alignment	Name sponsor, select journeys, confirm data owners, define value hypotheses, launch assessment	Assessment charter and leadership alignment
Weeks 3-4	Expose friction	Map journeys, quantify volume/cost/cycle time, identify root causes, review vendor handoffs	Friction inventory and maturity heatmap
Weeks 5-6	Prioritize value	Rank opportunities by value, risk, feasibility, AI suitability, and executive urgency	Opportunity backlog and AI-agent portfolio
Weeks 7-8	Design the operating plan	Define 90-day sprints, vendor scorecard changes, knowledge fixes, and governance routines	90-day action plan and owner map
Weeks 9-12	Launch controlled execution	Run first improvement sprints, implement dashboard, validate savings assumptions, prepare next phase	Measured results and transformation blueprint decision

The health plans that perform best in 2026 will not simply automate old work. They will redesign how work moves across the enterprise. Service orchestration gives executives a practical way to make that shift: diagnose the system, sequence the work, govern AI responsibly, align vendors to outcomes, and convert operational complexity into measurable performance.

APPENDIX A

Diagnostic Questions for a Service Orchestration Readiness Assessment

Domain	Diagnostic questions
Executive alignment	What are the top three service performance outcomes the executive team wants to improve in 2026? Who owns each outcome?
Journey visibility	Which member/provider journeys generate the most contacts, complaints, cost, rework, or quality risk? Can leaders see the full journey across systems and vendors?
Workflow and process	Where do handoffs fail? Which steps are manual, duplicative, undocumented, or dependent on individual knowledge?
Data and reporting	Which metrics are trusted? Which reports conflict? What cannot be measured today that executives need to manage?
Knowledge management	Where is the source of truth for benefits, policies, scripts, procedures, and decision logic? Who owns updates?
Vendor performance	Which vendors influence member/provider experience? Are they governed by outcome metrics or only SLAs?
AI readiness	Which tasks are repetitive, evidence-based, and suitable for AI assist or automation? What risks require human-in-the-loop review?
Financial value	Where can the plan reduce cost, avoid leakage, improve productivity, protect revenue, or improve quality performance?
Governance	What decisions are delayed because ownership, evidence, or escalation rules are unclear?

APPENDIX B

Source Notes

[1] **CAQH** - New CAQH Index Reveals $20B Savings Opportunity to Cut Waste, Reduce Costs, and Improve Patient Access: https://www.caqh.org/blog/new-caqh-index-reveals-20b-savings-opportunity-to-cut-waste-reduce-costs-and-improve-patient-access

[2] **CMS** - Interoperability and Prior Authorization Final Rule (CMS-0057-F): https://interop cms.gov/priorities/burden-reduction/overview/interoperability/policies-regulations/cms-interoperability-prior-authorization-final-rule-cms-0057-f

[3] **KFF** - Medicare Advantage in 2025: Enrollment Update and Key Trends: https://www.kff.org/medicare/medicare-advantage-enrollment-update-and-key-trends/

[4] **NCQA** - NCQA Releases 2025 Health Plan Ratings: https://www.ncqa.org/blog/ncqa-releases-2025-health-plan-ratings/

[5] **NIST** - AI Risk Management Framework: https://www.nist.gov/itl/ai-risk-management-framework

[6] **ONC** - HTI-1 Final Rule: https://healthit.gov/regulations/hti-rules/hti-1-final-rule/

[7] **McKinsey & Company** - Rewiring healthcare payers: A guide to digital and AI transformation: https://www.mckinsey.com/industries/healthcare/our-insights/rewiring-healthcare-payers-a-guide-to-digital-and-ai-transformation

[8] **PwC** - Medical cost trend: Behind the numbers: https://www.pwc.com/us/en/industries/health-industries/library/behind-the-numbers.html

[9] **Health Plan Alliance** - AI Impact Accelerator Opening Symposium: Unlocking the Opportunity in AI: https://www.healthplanalliance.org/assnfe/ev.asp?ID=2448

[10] **CMS** - 2026 Medicare Advantage and Part D Advance Notice Fact Sheet: https://www.cms.gov/newsroom/fact-sheets/2026-medicare-advantage-part-d-advance-notice-fact-sheet