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Payer Transformation at the Point of Care

A convergence moment

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Purpose statement

This brief examines the challenges facing payers, the industry shifts driving change, and how Oracle is enabling a new operating model helping bring intelligence, interoperability, and collaboration closer to the point of decision. This document is intended solely to help organizations assess the business opportunities associated with emerging approaches to interoperability, AI, and payer-provider collaboration and inform strategic planning discussions.

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The problem

Care decisions (what to order, what to prescribe, where to refer) all happen inside the clinical encounter. That moment impacts cost, quality, and patient experience. Yet payers operate largely outside of it, relying on a combination of prospective and retrospective tools like care management, claims review, and prior authorization. The result is predictable. Care gaps are missed. Utilization is inconsistent. Unnecessary costs are incurred. Friction also increases for both providers and members. Most importantly, performance, whether measured by cost trends, quality scores, or satisfaction, remains uneven.

Despite increased focus on preventive care, receipt of recommended clinical preventive services remains suboptimal, with variation across preventive service types.[1,2] Payers try to support care through programs layered around the encounter but struggle to provide information or tools at the point of care. As a result, disconnected data and workflows continue to limit care outcomes and financial performance. This challenge is not caused by a lack of data. With more data available than ever before, data remains fragmented, delayed, and difficult to act upon—limiting the ability to support providers and patients when and where it matters most.

At the same time, payers face relentless cost and utilization pressures (remaining between 7.5-8.5% annually[3]) with spending growing faster than employers, governments, and consumers can absorb. Payers are also contending with a rapidly evolving regulatory environment, bringing continuous operational disruption and financial uncertainty—from Medicare Star measure changes (shifting focus to health outcomes and patient experience, even as Medicare Advantage organizations' ratings may decrease[4]) to Medicaid work requirement changes[5] (potentially increasing the risk of coverage disruptions and coverage loss for some beneficiaries). The Affordable Care Act (ACA) and Exchange market likewise continues to change, with shifting subsidies, eligibility rules, and evolving plan designs.[6]

As payers seek to accurately predict risk and adapt product strategies faster, the government is also applying more pressure on eliminating improper payments. The Centers for Medicare & Medicaid Services (CMS) has launched its CRUSH (Comprehensive Regulations to Uncover Suspicious Healthcare) initiative to stop fraud, waste, and abuse across government programs (Medicare, Medicaid, Exchanges). At the same time, program integrity is shifting from retrospective audits to near real-time monitoring and pre-pay edits, raising the bar for how quickly and accurately payers must act.

We are also witnessing a fundamental shift in how individuals make healthcare decisions, as they turn to digital platforms, search engines, and social media for guidance before interacting with providers or health plans. As a result, care decisions are often being shaped outside of the traditional healthcare system—further reducing opportunities to support member needs. And amidst these forces, the individual often experiences higher costs, fragmented care, and inconsistent care outcomes.

Taken together, these forces represent an inflection point. The combination of rising pressure, shifting expectations, and newly viable technologies is forcing a fundamental re-evaluation of how payers operate. The traditional model (centered on retrospective control) is becoming less effective and less sustainable, even as new capabilities make it possible to operate in fundamentally different ways.

AI as a lever for change

While AI has the potential to automate payer administrative processes, improve decision-making, and reduce friction, the reality is that both payers and providers are deploying it simultaneously—often accelerating existing inefficiencies

[1] Use of Selected Recommended Clinical Preventive Services — Behavioral Risk Factor Surveillance System, United States, 2018
[2] Few Americans Receive All High-Priority, Appropriate Clinical Preventive Services
[3] Medical cost trend: Behind the numbers: PwC
[4] Wakely-Summary-2027-Final-Rule-Stars-Changes_Updated_2026-04-20.pdf
[5] A Summary of Federal Medicaid Work Requirements - Center for Health Care Strategies
[6] How ACA market shifts will redefine 2027 plan development

rather than resolving them. This dynamic is raising the stakes for payers and providers alike, making it increasingly important to rethink underlying processes rather than simply digitize them.

AI on its own does not fundamentally change how payers or providers operate. It only becomes transformative when embedded within workflows and decision-making. Insights that cannot be acted upon at the point of care will remain informational at best and a source of friction at worst. Embedded AI can guide next-best actions, reduce variation, capture structured and unstructured data, and bring payer insight directly into the moment decisions are made.

Modern AI approaches combine structured data, unstructured clinical content, and near real-time signals to help payers and providers generate context-aware insights. Yet many organizations are treating AI as a "bolted-on" technology rather than embedding it into the systems where decisions are made. As a result, it lacks the shared clinical, administrative, and financial context needed to support coordinated action. When embedded directly within enterprise workflows, AI can operate from a unified, near real-time view of the individual, enabling longitudinal records, social determinants, assessments, care gaps, and other insights to inform action at the point of care. This same foundation enables payer policies, coverage information, and administrative processes to be integrated directly into provider workflows, supporting more timely authorizations, claims decisions, and care coordination while reducing friction for both providers and members.

The closer AI moves to the point of decision, the more important governance becomes. Deploying AI successfully requires strong governance, validation, and transparency to manage risk across utilization, payment integrity, and regulatory compliance. Human involvement and oversight, clear accountability, and continuous monitoring are essential to support the accuracy, defensibility, and trustworthiness of payer decisions for providers and regulators.

The role of interoperability

AI is only as effective as the data available to it. Today, clinical, administrative, and financial information remains fragmented across organizations and systems, limiting AI's ability to support decisions in near real time. To deliver meaningful value, AI must have access to multimodal data—including clinical context, claims activity, coverage information, quality measures, and utilization history. **Interoperability provides the mechanism for sharing that information, while near real-time payer-provider collaboration turns it into coordinated action.** Together, they create the foundation that enables AI to help inform decisions at the point of care rather than simply analyze the data after the fact.

The combination of interoperability, near real-time data exchange, and embedded AI creates an opportunity to rethink the payer operating model. Through API-driven connectivity and shared workflows, payers can now operate in ways that are fundamentally different:

- Data moves in near real time, not batches
- Insights are delivered within workflows, not separate systems
- Decisions are supported in the moment they are made, not after the fact
- Administrative processes shift from review and rework to prevention and avoidance
- Payer and provider actions are coordinated through shared workflows rather than sequential handoffs

These capabilities are becoming increasingly important as rising pressures and newly viable technologies push the industry toward systemic change. Payers have made progress connecting with providers through EHR-based payer platforms, but no single EHR reaches all providers. As a result, payers are forced to build and maintain multiple integrations, creating inconsistent experiences, duplicative costs, and complex implementation requirements.

As a result, payers are left to manage fragmented connections across multiple EHRs, vendors, and point solutions with varying levels of adoption and impact. **Without a unified data foundation, interoperability alone cannot provide the shared context needed for near real-time, coordinated decision-making**. But by aligning data across

clinical, administrative, and financial domains, organizations can support more consistent, context-aware decisions that can be acted on in near real time.

The emergence of Qualified Health Information Networks (QHINs) under the Trusted Exchange Framework and Common Agreement (TEFCA) is creating a national framework for standardized, near real-time health data exchange across previously disconnected provider networks. Combining an EHR payer platform with QHIN connectivity extends payer influence beyond a single health system, pairing in-workflow decision support with broader, cross-network clinical visibility. Together, an EHR payer platform and QHIN connectivity enable payers to help inform real-time decisions using a more comprehensive patient record, even when care spans multiple providers and EHRs. The result is a more scalable model for "in-the-moment" engagement—one that reduces fragmentation without relying on complex, point-to-point integrations.

However, while QHINs help solve the challenge of moving data, they do not fully solve for how to understand and act on that data. Payers need more than access to records—they need the ability to connect clinical, administrative, and financial information, embed insights into workflows, and support near real-time decision-making. Oracle has extended the value of QHIN connectivity through Oracle Health Information Network, which goes beyond basic interoperability by layering value-added services, workflow orchestration, and intelligence on top of data exchange, enabling payers to derive operational value rather than simply receive information.

In short, interoperability is no longer just about moving data—it is about enabling coordinated action. Its value is realized not when data moves, but when it drives aligned decisions across payers, providers, and members in near real time.

Oracle's vision

The healthcare ecosystem needs a more unified and intelligent model where payers, providers, and members operate from a comprehensive, shared understanding of each person's healthcare journey. In this future state, communications and data are exchanged quickly and seamlessly, decisions happen with context, and administrative processes become increasingly automated, proactive, and personalized.

Oracle is uniquely positioned to drive this transformation because we understand healthcare from all sides of the equation. Our portfolio spans payer operations, revenue management, interoperability, analytics, and AI, while also supporting the clinical workflows and care delivery systems used by providers every day. This end-to-end perspective enables Oracle to connect data, workflows, and decisions across the healthcare ecosystem in ways that have historically been difficult to achieve, creating the foundation for a coordinated, intelligent, and patient-centered healthcare system.

Oracle already supports payer-provider collaboration through clinical data exchange, risk gap notifications, and interoperability capabilities, while also helping payers achieve back-office efficiencies, including claims, billing, and business operations. **We are now working to embed payer intelligence directly within provider workflows**, enabling near real-time coordination around prior authorization, care gaps, utilization management, and member engagement.

Oracle's goal is not simply to digitize existing processes but to enable a fundamentally different way of operating, where payers and providers collaborate in near real time around a shared understanding of the individual. Near real-time claims visibility, accelerated authorizations, coordinated quality interventions, and personalized care are not the destination; they are examples of what becomes possible when healthcare moves from fragmented transactions to connected decision-making.

From insight to action, embedded in the workflow

The true value of AI comes not from generating insights but from helping people make informed decisions. Oracle turns AI into action within everyday healthcare workflows. Our AI is:

- Built natively into our solutions, enabling seamless user experiences, and alleviating the complexity of bolt-on technologies
- Trained on healthcare-specific data and workflows, enabling relevant, accurate, and context-aware insights
- Powered by Oracle Cloud Infrastructure (OCI), giving healthcare organizations access to a broad ecosystem of AI models and the compute, security, and data architecture needed to operationalize AI at enterprise scale
- Embedded directly into workflows so actions are informed, decisions are consistent, routine work is automated, and human expertise is focused where it matters most

Extending reach beyond a single EHR network

No single EHR system reaches all providers or patients. As payers strive to support more connected, near real-time experiences, they need an interoperability foundation that extends beyond any single provider network or EHR. Oracle is helping establish that interoperability foundation. As a QHIN, Oracle can move data across healthcare. Through Oracle Health Information Network, Oracle makes data actionable by adding workflow services, contextual intelligence, and payer-provider collaboration capabilities. **A QHIN moves data. Oracle Health Information Network turns data into action.**

Combined with Oracle's role as the designated QHIN for the Department of Veterans Affairs, Oracle helps payers extend collaboration beyond the boundaries of a single EHR ecosystem. With broader, standardized access to clinical information across networks, Oracle Health Information Network can help payers:

- Collaborate with providers across diverse EHR environments through a scalable interoperability model
- Access longitudinal, near real-time clinical context to support care and utilization management
- Embed payer insights and guidance within provider workflows at the point of care
- Alleviate administrative friction through automated and informed exchanges
- Support coordinated, data-driven experiences for members across the care journey

The Oracle full-stack advantage

Oracle's ability to operate across the healthcare technology stack—from infrastructure to applications to data and AI toolkits—enables payers with the agility, scalability, and operational efficiency needed to adapt quickly in an increasingly volatile healthcare market. By helping reduce the cost of running legacy environments, simplify complex technology landscapes, and—most importantly in times where change is needed but cost constraints are significant—collaborating with Oracle supports payers by helping reinvest savings into innovation and transformation. **In a market where cost pressures are relentless, this "fund innovation through efficiency" model is critical.**

Oracle payer solutions

Oracle is building the fundamental reset that healthcare needs—breaking down barriers between providers and payers to enable coordinated care, supporting decisions at the point of care to help alleviate friction, and creating a near real-time, intelligence-driven operating model required for payers to succeed in the next era of healthcare. Our payer solutions and roadmap include:

Figure 1. Oracle's payer portfolio spans payer-provider collaboration, administrative operations, interoperability, AI, and cloud infrastructure, creating the foundation for a connected and intelligent operating model.

Payer-provider collaboration	Intelligent, efficient payer workflows
Clinical data exchange Provides secure exchange of clinical information to payers with visibility into member care, helping enhance coordination, quality performance, and decision-making.	**Core administration platform** Provides a modern cloud-based administration platform to help enhance operational efficiency, simplify benefit and product management, and support intelligent automation.
Oracle Health Information Network Extends interoperability beyond individual provider networks to enable payer-provider collaboration and support near real-time information sharing across the healthcare ecosystem.	**Payment integrity** Applies advanced analytics and AI to identify potential fraud, waste, abuse, and payment inaccuracies to support payment accuracy and help limit rework.
Prior authorization Streamlines authorization workflows to help support decision-making and alleviate administrative burden.	**Cost/utilization analytics and plan design** Uses clinical, claims, and utilization insights to identify cost drivers, optimize benefit design, and support effective intervention strategies.
Risk adjustment/gap closure Identifies and prioritizes risk and quality opportunities to support reimbursement accuracy, close care gaps, and strengthen provider collaboration.	**Revenue management and billing** Provides comprehensive billing and payment capabilities to help support accuracy, streamline collections, and enhance financial operations.
Quality performance management Supports HEDIS, Stars, and other quality initiatives through integrated analytics, workflow management, and member engagement capabilities to support quality outcomes.	**Business applications** Provides modern finance, HR, procurement, and shared-service capabilities to help alleviate administrative overhead and enhance organizational agility.

Oracle Cloud Infrastructure					
Global infrastructure	Public cloud	Dedicated region	Multicloud	Hybrid cloud	**Oracle AI Data Platform**

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An invitation for payers: turning actionable collaboration into reality

As Oracle redesigns the operating model for healthcare, we are seeking to collaborate with forward-thinking payers that want to work with us to shape and accelerate that future. Together, we can define and deliver a new approach that helps bring payers closer to the moment of decision and drives meaningful enhancements in cost, quality, and experience.

We believe there is great opportunity to create connected payer-provider workflows, support near real-time data exchange, and embed intelligence directly into operational decision-making. But we also understand the right path forward will vary by payer organization, based upon your existing investments and strategic priorities.

Oracle is interested in working with payers to address critical pain points—areas ripe for systemic change—where real-time collaboration and intelligent automation can deliver measurable value. We propose a series of focused visioning sessions to identify high-impact use cases and prioritize practical pilots embedded within existing workflows. Potential areas for collaboration may include:

- Re-envisioning the full lifecycle of prior authorization with direct payer-provider connectivity and decisioning support, using AI agents to move the needle on administrative overhead and turnaround time.
- Limiting potential fraud and enhancing auto-adjudication, using AI agents to pre-validate claims and move toward near real-time adjudication.
- Full bi-directional lifecycle of payer-generated care gap closure, including calculation support and AI-driven intervention design.

Where appropriate, Oracle can also help convene provider participation to evaluate workflows end-to-end and test how shared data, embedded intelligence, and streamlined communication can help enhance coordination, alleviate administrative friction, and drive operational effectiveness.

The goal is not transformation for its own sake but creating a new operational foundation for healthcare—one where payers and providers can collaborate in near real time, alleviate friction across the system, and support informed decisions at the point where care, cost, and quality intersect.

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