Market Report

Beyond Prior Auth:

The Strategic Shift Health Plans Can't Afford to Ignore

PointClickCare | sage

Executive Summary

Health plans today are navigating intensifying pressures from multiple directions. For leaders, this often means having to do more, with less.

For quality management executives, the bar continues to rise as post-discharge outcomes such as readmissions and follow-up care carry increasing weight. For data and interoperability leaders, fragmented information spanning myriad settings remains as stubbornly difficult to assemble into something usable as a puzzle missing its corner pieces. Regulatory requirements expand, administrative complexity rises, and member expectations for timely, coordinated care mount. Concurrently, traditional tools designed to manage utilization—such as prior authorization—become more constrained and less effective on their own.

Across roles and business units, these challenges converge on the same reality: Outcomes are increasingly shaped after discharge, not just before care is delivered.

To sustain margins while improving quality performance, many plans are shifting toward a more proactive strategy: care management equipped with clinical intelligence and real-time visibility across acute and post-acute settings. The goal is not to replace utilization management, but to complement it. For plans, taking a more comprehensive look at the full patient journey offers fresh opportunities to optimize both outcomes and economics. While prior authorization helps oversee healthcare's front door, clinical intelligence at and after discharge determines what happens next—whether recovery stays on track or begins to unravel across care settings.

Most organizations today, however, are not realizing the full strategic promise of care management. New independent research, commissioned by PointClickCare and conducted by healthcare market research firm Sage Growth Partners, reveals a clear diagnosis: Care management underperforms because visibility breaks down at transitions of care—precisely when timely intervention matters most.

In theory, health plans have access to more data than ever. In practice, what care management teams see most during critical transitions are only fragments of critical information, glimpses of light refracted through a keyhole. Left to patchwork a schema of sources such as medication changes, discharge summaries, and follow-up requirements, teams become investigators instead of advisors, and post-discharge coordination suffers.

The challenge is not isolated to any single setting. Rather, it reflects a broader post-discharge blind spot that begins at the point of discharge from acute care and compounds as members transition across levels of care—whether it's from a hospital to home, transfer to a skilled nursing facility (SNF), or a transition back into the community.

The most time-critical moment comes immediately after discharge.

While the first 72 hours remain a period of elevated risk, health plans increasingly recognize the first 24 hours post-discharge as the true golden window—when members are most vulnerable, decisions are still fluid, and proactive outreach can impactfully alter the trajectory of care. Too often, that window closes before care managers have received enough information to take meaningful action. Not because plans lack capable teams or because intervention is not needed—but rather because those teams are operating without the visibility and clinical context required to act decisively. More informed actions, made more efficiently, are a huge missed opportunity for health plans to impact quality and care economics at scale.

The resulting blind spots are missed opportunities to directly impact readmissions, emergency department utilization, quality performance, and total cost of care.

Research published in the *Future Healthcare Journal* shows that structured follow-up within 72 hours can reduce readmissions by up to 50%.

Key Takeaways

Post Acute Care Management Survey

71%
of top improvement requests are about data availability, integration, or clarity

Just
14%
of health plans report real-time PAC data exchange for SNF/LTC settings

84%
of plans rank SNFs in their top 3 settings to improve quality, and 83% rank them in their top 3 for cost reduction

Discharge Intelligence Survey

75%
of health plans say care managers today are information gatherers rather than trusted advisors

81%
of plan leaders say reduced hospital readmissions is the most valuable outcome from discharge intelligence

61%
of national health plans prioritize readmission reduction as a strategic focus

The Pressure Is Real—and the Traditional Playbook No Longer Suffices

For all of the dotted lines that skew visibility across care settings, there's never been a bolder, more direct line than the one now drawn between care transitions and **financial performance**. The margin for error is shrinking, and the consequences of missed interventions are growing. Cost and quality pressures that once could be managed independently are now inextricably intertwined.

Cost and Quality Are No Longer Separable

There's a common denominator across dynamically changing Medicare Advantage and Medicaid plans: Revenue is no longer driven solely by utilization management or network design.

For Medicare Advantage plans, risk adjustment tightening under V28 coding changes is compressing revenue at the same time Star ratings are becoming more competitive. Plans are graded on a curve, meaning incremental improvement is no longer enough to maintain position. With CMS now triple-weighting plan all-cause readmissions, outcomes that occur after discharge—often outside the hospital walls—carry disproportionate financial impact. Preventable readmissions, missed follow-up care, and poorly managed transitions now directly influence bonus eligibility and revenue stability.

For Medicaid plans, the pressures are distinct but the path leads to the same conundrum. Rising HEDIS thresholds, incentives that are increasingly performance-based, and persistent state funding constraints mean plans must do more with less. Avoidable utilization driven by poor post-discharge coordination erodes already-shrinking margins and places quality payments further out of reach.

"In an environment where patients need more than home health and require skilled nursing facilities or long-term care facilities, you traditionally can't access the data—which leads to not trying."

–Regional Leader of Data, Integration and Analytics at an integrated managed care consortium

When the Front Door Is Only the Beginning

As these margins become more razor-thin, traditional cost control tools are less sharp than ever. Prior authorization and utilization management were designed to manage the front door of care—ensuring appropriateness before services are delivered. While these tools remain necessary, they are increasingly constrained by regulatory and public pressures. State-level gold-carding laws are expanding, granting exemptions to high-performing providers. CMS oversight and OIG audits are raising compliance risk. Member dissatisfaction with delays and denials continues to grow.

The result is a narrowing set of traditional levers available to control costs—at precisely the moment when costs are rising.

More importantly, these levers do little to address the root causes of avoidable spend today: breakdowns in care coordination, missed transitions, and delayed intervention after discharge. Many of the most expensive utilization events, such as readmissions, emergency department visits, and extended institutional stays, are not determined by whether care was authorized, but by whether the transition was managed effectively.

It's time to consider new approaches that address the cost containment conundrum head-on and stretch beyond the status quo to give plans more control over strategic growth. The answer, increasingly, is optimized care management.

The Real Exposure Lives in the Handoffs

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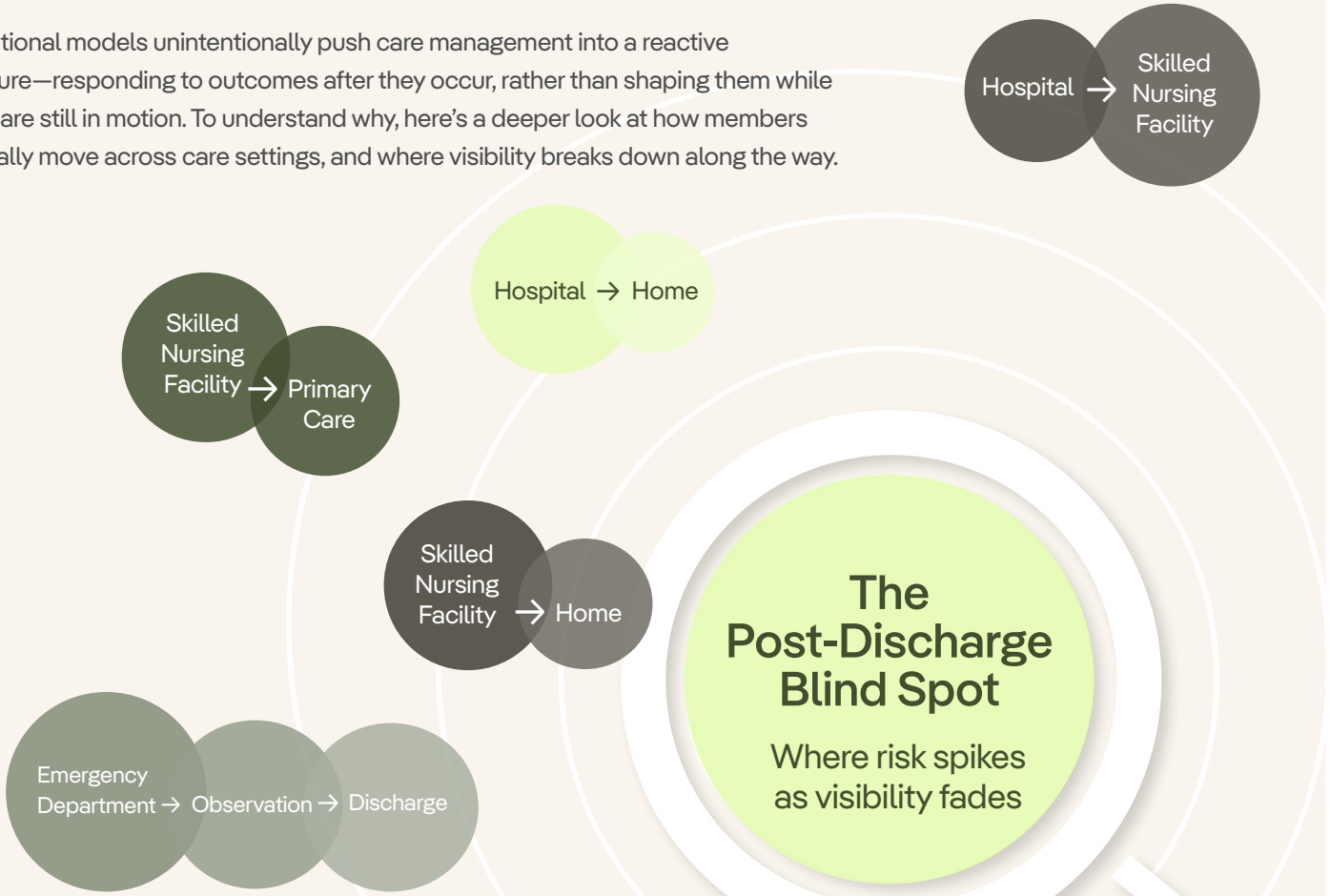
Traditional models unintentionally push care management into a reactive posture—responding to outcomes after they occur, rather than shaping them while they are still in motion. To understand why, here's a deeper look at how members actually move across care settings, and where visibility breaks down along the way.



What Should Happen:

+ Real-time discharge notification
+ Relevant clinical context at handoff
+ Medication reconciliation before first outreach
+ Follow-up care coordinated
+ Care manager engagement within 24 hours

But What Often Happens:

– Discharge identified days or weeks later
– Fragmented or missing clinical data
– Medication changes unclear
– Minimal visibility into post-acute stays
– High volume of preparation for optimal outreach

Earlier Visibility + Clinical Context → Downstream Outcomes

↓ Readmissions
↓ ED Utilization
↓ Extended SNF Stays
↓ Total Cost of Care
↑ Quality Performance

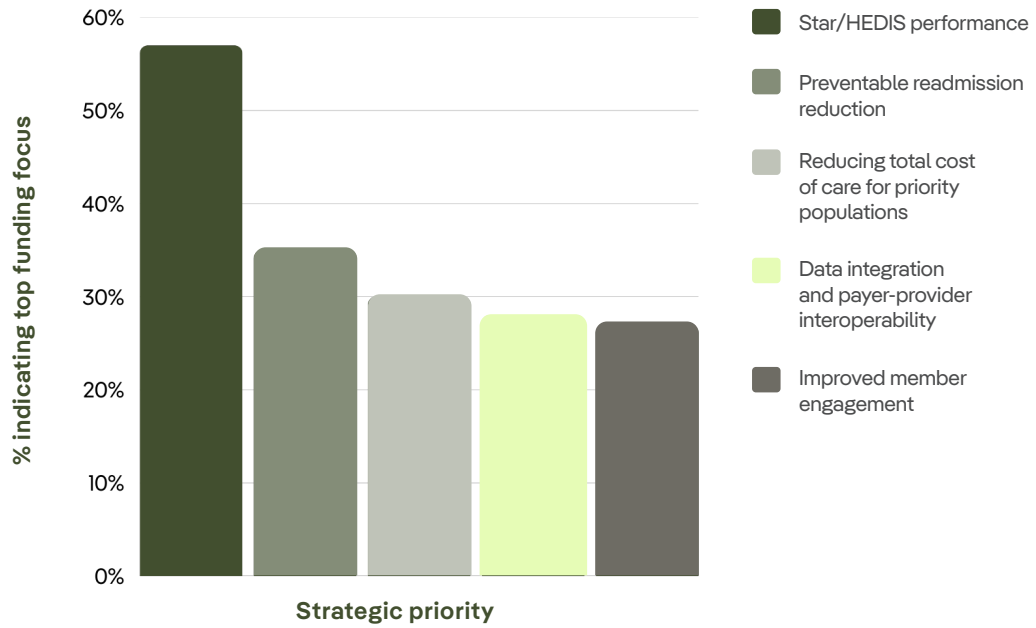
Opportunity:

Enable care managers to intervene earlier and more effectively, and the downstream impact on readmissions, ED utilization, and total cost of care follows.

Care Management Is at an Inflection Point

Care management consistently ranks among health plans' top strategic investments. When asked where they plan to allocate funding over the next 12 to18 months, leaders point to priorities that sit squarely within care management's remit: improving Star and HEDIS performance, reducing preventable readmissions, lowering total cost of care for priority populations, strengthening data integration, and improving member engagement.

Investment intent is clear: Health plans' focus is on care management funding



"With my care management hat on, the biggest ask is to stop chasing charts. That is one of the most inefficient things between UM and CM that people have to do to coordinate care."

— Senior Vice President
Population Health & Care Management

Execution Tells a Different Story

The intent is unmistakable: Health plans understand that care management should be a primary driver of both quality *and* cost performance. But when leaders assess how well their organizations are actually performing today, the picture quickly shifts.

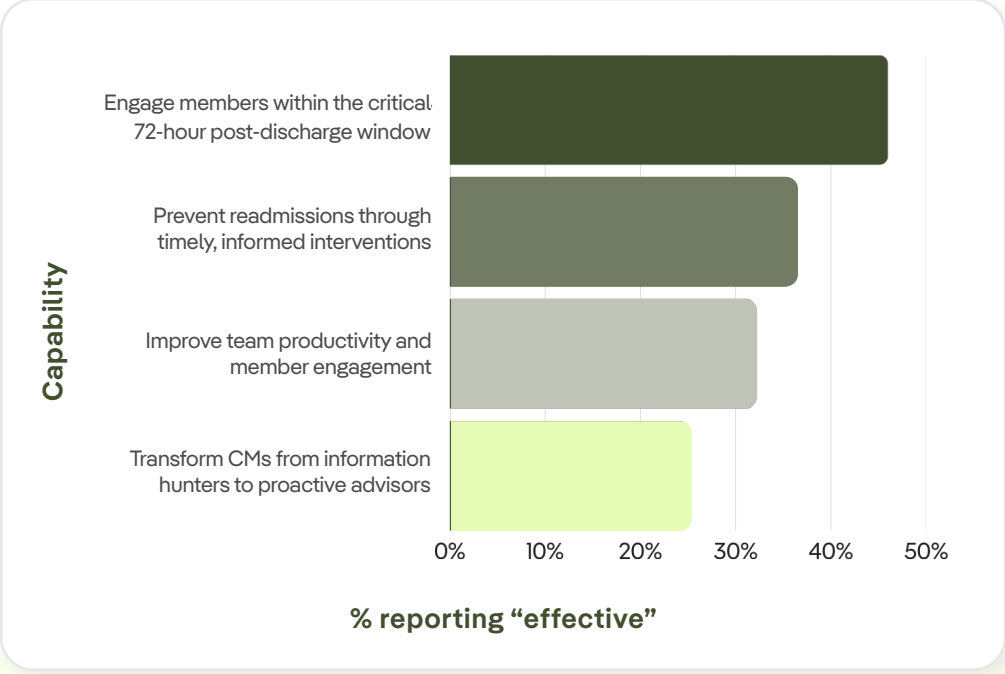
Fewer than half of plans report being able to effectively engage members within the first three days following discharge. **Only 25%** believe their systems truly enable care managers to proactively advise members after discharge, rather than reactively gather information.

Taken together, these findings reveal a consistent pattern: Care management is positioned as a strategic lever, but executed with tools and workflows designed for retrospective coordination—not real-time intervention.

Care management may rank among health plans' top strategic investments—but not all parts of care management are prioritized equally. Despite broad agreement that post-discharge and post-acute care are strategically important, more than half of leaders do not consider them top-tier investment priorities today. Beneath that response is a familiar truth: Without timely, reliable, and relevant data, plans struggle to meaningfully influence outcomes during care transitions. The result is a persistent gap between investment and impact—one that leaves care management constrained precisely when pressure on margins and quality performance is intensifying.

That gap becomes unmistakable when leaders evaluate their core post-discharge capabilities. These shortfalls are not driven by lack of effort, but by structural limitations in how care management operates day to day. Information arrives late, fragmented, or buried across systems, and workflows remain highly manual—meaning even when data exists, it rarely surfaces as a timely, actionable signal during the narrow window when intervention could still change the outcome.

Health plans today are ill-equipped to bridge post-discharge gaps



"If we utilize the data in the right way, then we're going to move the needle. If it's sitting somewhere in some server or some database and not being pulled out, then there's nothing we can do."

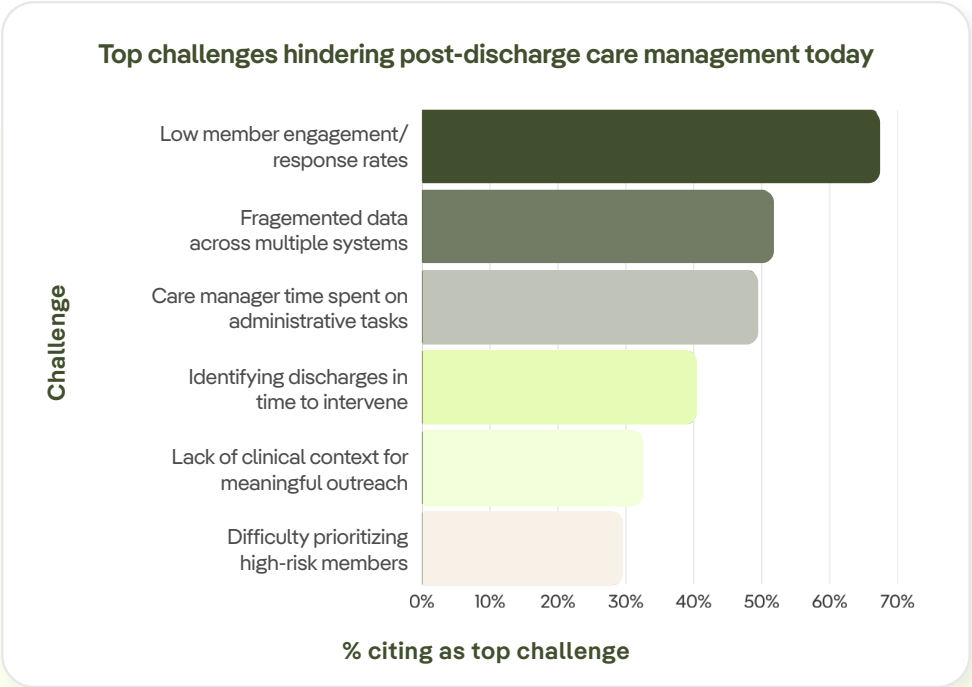
– Director of Healthcare Management

Fewer than half of plans report effectiveness in engaging members during the 72-hour post-discharge window. **Only one-third believe they're effective in preventing readmissions** through timely, informed intervention. And just **one in four** say their care managers are equipped to operate as proactive advisors rather than information hunters.

Low member response is the most commonly cited challenge—but it reflects a deeper issue that extends beyond outdated contact information. When outreach happens without timely clinical context, clear purpose, or relevance to what a member is experiencing in the moment, meaningful engagement predictably suffers. Getting in contact is only half the equation. The first interaction must also deliver value—arriving with clinical preparedness that signals relevance, credibility, and partnership rather than just another call. When calls start virtually from square one, care managers are asking members to educate them rather than arriving prepared to guide and support.

The result is predictable: missed opportunities during the most critical window for impact.

Engagement Suffers When Visibility Lags



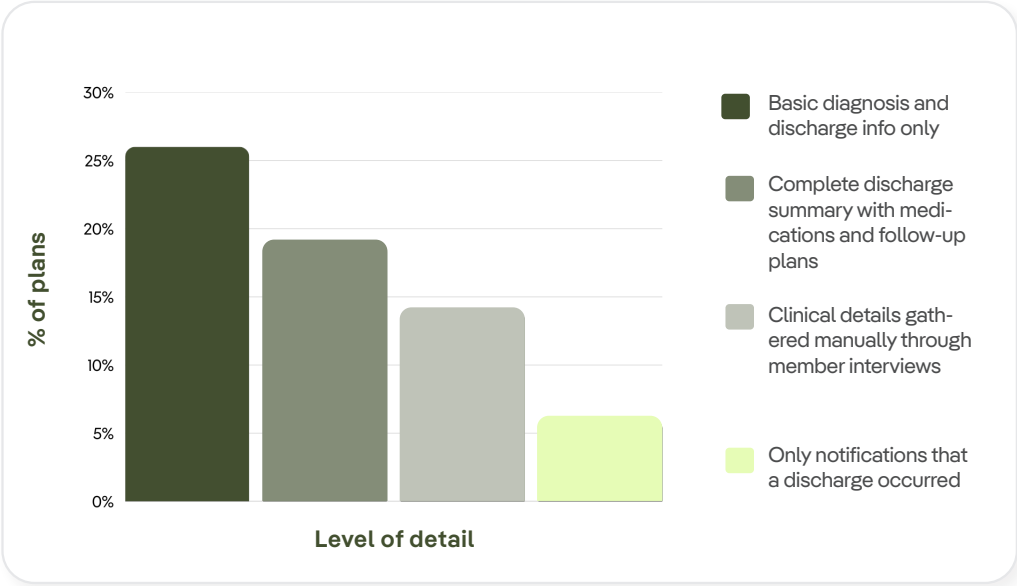
"Plans have strong visibility into hospitals, but SNFs are fragmented and largely invisible. That's where patients—and opportunities—are getting overlooked."

–Senior Vice President, Regional Managed Care Organization

Where Visibility Breaks Down

Most health plans have invested heavily in data feeds, clinical aggregation platforms, and admission–discharge–transfer notifications. On paper, visibility appears to be improving. In practice, what care management teams can act on during transitions of care is far more limited.

Despite "real-time" feeds, plan visibility is limited through transitions of care



Only 1 in 5 health plans report having complete discharge summaries with medications and follow-up plans when care managers initiate outreach. While this gap begins at hospital discharge, it widens further once members enter post-acute care, where only 31% of plans receive timely data from providers within a day. Nearly two-thirds (69%) experience multi-day or multi-week delays, forcing care managers to rely on retrospective risk management rather than influencing outcomes.

One Director of Quality Improvement described the challenge:

"Data arrives at different intervals. ADT data is our most real-time source—we receive a refreshed file daily that flows into our systems. Prior authorization data takes approximately 48 hours to process, so it's not always immediately compiled into our reports."

Highlighting Post-Acute Blind Spots

Post-acute visibility is often considered a black box for health plans. Skilled nursing facilities and long-term care settings remain among the least visible points in the care continuum, and health plans often lack insight into clinical progression, therapy participation, discharge readiness, and emerging readmission risk. This matters because post-acute and transitional settings care for some of the highest-risk, highest-cost populations—particularly Medicare Advantage, dual-eligible, and Medicaid members. Without visibility into these transitions, plans are unable to impact the length of stay, identify rising risk, or coordinate timely returns to the community.

PAC Management Challenges

Lower challenge, high criticality

+ Identification of responsible provider(s) for follow-up care
+ Documentation of follow-up appointments/referrals

High challenge, high criticality

+ Accuracy and completeness of medication lists/reconciliation
+ Clarity of care plan and patient/caregiver discharge instructions
+ Risk of rehospitalization/readmission indicators
+ Ongoing care coordination updates (post-discharge)

The core pain points that health plans must solve to directly impact readmissions, and improve care quality and related financial metrics.

High challenge, low criticality

+ Social determinants of health
+ Communication of pending test results/labs at discharge
+ Structured standarized data format

Lower challenge, lower criticality

+ Timeline of discharge summary availability
+ Functional status/activities of daily living (ADLs)

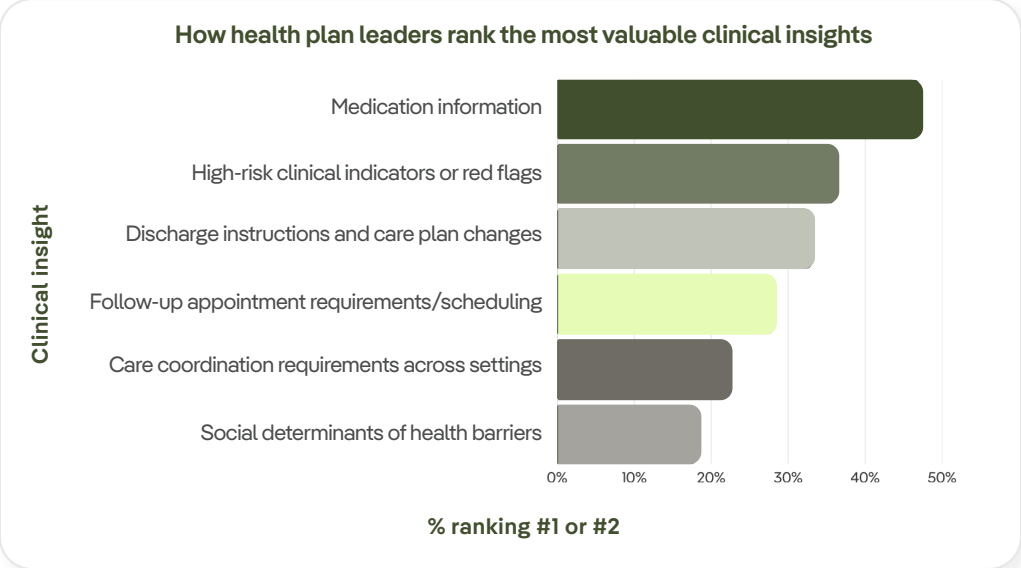
What Gets Lost—and Why It Matters

Critical pieces of information frequently arrive too late to act upon, including up-to-date contact information, clinical summaries, functional and cognitive status, behavioral health and social risk factors, and caregiver availability and capacity.

Each missing element narrows the window for effective intervention, and creates blind spots that can lead to lower quality performance, and higher readmissions and the total cost of care.

Unlocking Clinical Intelligence Through Critical Transitions of Care

For health plans, the path forward transcends data and embraces clinical intelligence. This transition from the *"what"* to the *"what's next"* is supported by technology that equips care managers with the right information at the right moment in a format they can act on immediately. **Plan leaders across the board agree that certain actionable flags would be invaluable for care managers:**



Where Clinical Intelligence Matters Most—and Is Least Available

While the need for timely clinical intelligence spans the care continuum, its absence is most acute outside the hospital. Skilled nursing and long-term care settings represent the highest-opportunity—and most operationally complex—environments for health plans.

In fact, plan leaders consistently identify SNF/LTC as the greatest opportunity for both quality improvement (84%) and cost reduction (83%)—precisely because critical clinical events and changes in member status are not consistently surfaced in a timely, actionable way. Care managers may be tracking progress, yet lack immediate visibility into moments that matter most—changes in medication, emerging risk indicators, discharge readiness, or care plan updates—when intervention could still alter the outcome.

By the time this information arrives through claims, delayed documentation, or manual follow-up, the opportunity to influence outcomes has often narrowed or closed.

This visibility gap is not theoretical. It is structural—and it shapes where care management succeeds or stalls.

Medication Accuracy: The Clearest Intelligence Gap

Among all clinical insights, medication information stands apart. Nearly half of plan leaders rank medication data as the most valuable signal for care managers—reflecting both its impact on outcomes and the persistent difficulty of managing it across transitions.

Medication regimens frequently change during hospital and SNF stays, yet accuracy and reconciliation remain inconsistent as members move between settings. For care managers, incomplete or conflicting medication information introduces immediate risk and limits their ability to intervene with confidence.

As one Senior Vice President of Population Health and Care Management explained:

"The solution needs to address how to problem-solve for medication reconciliation and ensure it's as accurate as possible while making it easier for providers to collaborate. Having a tool, platform, or system with pharmacy AI capabilities that could automatically run through medications and flag issues would be ideal."

This perspective underscores a broader truth:

Clinical intelligence is not just about access to information, but about surfacing risk, resolving ambiguity, and enabling collaboration at the moment it matters.

Why It's Clear That Visibility Needs to Be the North Star

> "Without shared data, post-acute decisions are driven by bed availability, not outcomes. When plans lack visibility into SNF performance and length of stay, it's nearly impossible to manage cost—or contract for value."
>
> *–Clinical Product & Strategy Executive*

The research paints the picture of an industry that knows where it's headed, but is restrained by the tools and data it has. This tension between what is currently happening—and what is currently possible—is reshaping how organizations are planning their next chapter of care management. Across plans of all shapes and sizes, leaders expressed a desire to move beyond reactive outreach and equip care managers with the information they need to anticipate risk and coordinate care before complications ensue.

Plans can harness tools that unlock three areas achievable today that would meaningfully change their trajectory:

Acting on current-state clinical signals, rather than waiting for claims

Nearly a third of leaders said the single biggest improvement they need is real-time access to post-acute care data (31%), which means data that includes:

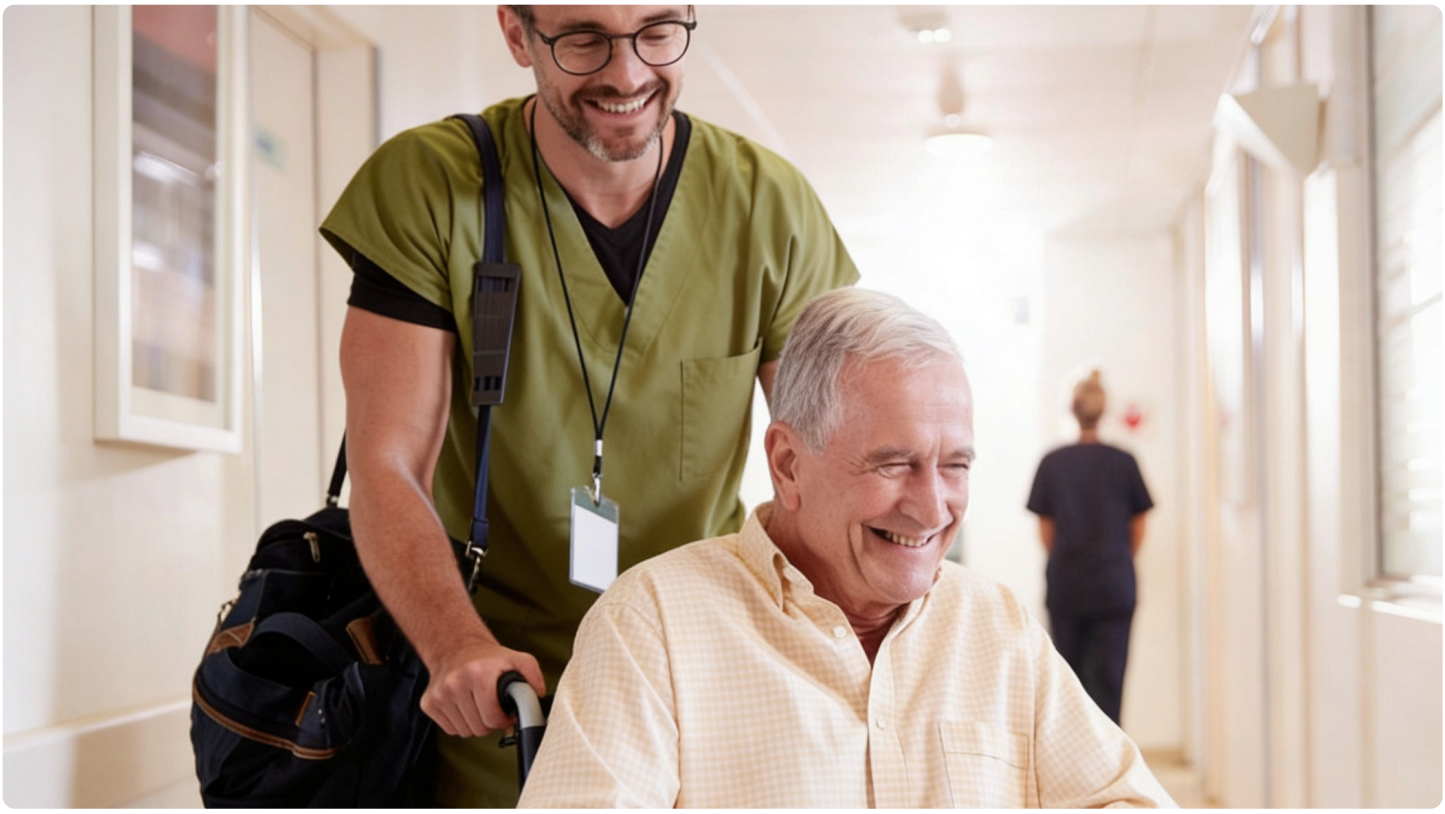
- Daily census
- Therapy notes
- Pending tests
- Medication adherence updates
- Discharge readiness indicators

Connecting the story across care settings, instead of ending the story at discharge

Although 59% of plans said skilled nursing facility and long-term care visibility is "somewhat" or "very" limited, they acknowledge that this data could transform the way they provide care for members beyond the hospital setting

Seamlessly equipping care managers with clinical context *before* outreach, instead of requiring chart-chasing and information seeking

While chart chasing and limited clinical context are currently pain points and limiting factors, with optimized solutions care managers can receive the insight they need to make a tangible impact



The Path Forward

As health plans navigate mounting business pressures, cost and quality remain immutable bedrocks. Meaningful progress in both will require new approaches that harness the right information to influence clinical and financial outcomes earlier. Care management offers that opportunity—but only if organizations invest in enabling their teams with the visibility and intelligence they need to operate proactively. Forward-looking health plans have the opportunity to redefine the care management model so that it's informed, timely, and connected.

When care managers show up informed, with rich clinical context and a clear understanding of each members' needs, every interaction delivers greater value:

For members

A health plan that understands their situation and helps navigate next steps.

For care managers

Time spent applying clinical expertise, not chasing information.

For health plans

Improved quality performance tied to revenue outcomes, and lower costs.

The economics are compelling. The average cost of a hospital readmission ranges from $15,000 to $17,500. Preventing just one readmission per week yields annual savings approaching $1 million. For a **50,000-member Medicare Advantage plan, a 5% reduction in readmissions** can unlock **multi-million-dollar savings per year.** These aren't one-time wins—breaking costly utilization patterns creates compounding benefits annually.

The Time to Move Is Now

Health plans that invest in care management enablement now will enhance their advantage over time. Those that wait will find themselves further behind on quality measures, cost performance, and competitive positioning. The path forward requires:

- **Acknowledging that current care management approaches aren't delivering full value**—not because care managers aren't working hard, but because they lack the visibility and intelligence to work most effectively.
- **Investing in cross-setting visibility** that spans acute and post-acute settings, providing real-time awareness of member transitions.
- **Deploying clinical intelligence at moments of transition—beginning at acute discharge and extending through post-acute care**—including getting discharge summaries, medication reconciliation, risk indicators, and follow-up requirements into care managers' hands before outreach, not after.
- **Extending intelligence to provider partners** so that primary care providers can participate in coordinated post-discharge care.

The organizations that augment traditional tools with proactive strategies will be the first movers who transform care management from a cost center into a strategic growth lever—delivering better outcomes for members and measurable value for the business.

About the respondents

PointClickCare commissioned two market research surveys in collaboration with Sage Growth Partners, a U.S.-based healthcare market research firm. Quantitative data was collected from more than 150 health plan leaders in Q4 2025. In separate surveys, 74 health plan leaders were surveyed on the topic of the management of post-acute care, and 72 health plan leaders were surveyed on the topic of clinical intelligence at the point of member discharge. Ten additional qualitative interviews were conducted to provide context for this report. Respondents' lines of business include commercial/employer-sponsored health plans; Medicare/Medicare Advantage; Medicaid; and Dual-Eligible Special Needs Plans.

Clinical Intelligence Respondents

Types of organizations respondents are associated with

50%: Regional health plan

32%: National health plan

18%: Provider-sponsored health plan/payvider

Job title

19%: VP/SVP/Director of Care Management

17%: VP/Director of Quality/Clinical Operations

15%: VP/Director of Medical Management

14%: VP/SVP/Director of Population Health

10%: Chief Medical Officer

1%: Care Management Manager/Supervisor

1%: Chief Financial Officer

Primary areas of responsibility

79%: Care management/Case management

74%: Population health management

60%: Utilization management

57%: Quality management

50%: Overall plan strategy

35%: Data/Informatics

21%: Technology (I.T.)

18%: Finance

Post-Acute Care Respondents

Types of organizations respondents are associated with

42%: National health plan

38%: Regional health plan

20%: Provider-sponsored health plan/payvider

Job title

19%: SVP/VP/Director of Care Management

16%: Product/Technology Lead

15%: SVP/VP/Director of Population Health

15%: Chief Medical Officer

9%: SVP/VP/Director of Quality

3%: Chief Financial Officer

3%: CEO/President

1%: Chief Nursing Officer

Primary areas of responsibility

85%: Care management/Case management

64%: Chronic care management

61%: Utilization management

59%: Population health

54%: Quality management

49%: Transitional care management

46%: Overall plan administration

30%: Behaviorial health management

23%: Maternal & child care management

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