

The Shift from Recovery to Precision

Current Trends in Healthcare Payment Integrity

Healthcare payment integrity is undergoing a fundamental transformation as we enter 2026. The healthcare industry is moving away from the traditional and more reactive "pay-and-chase" model toward a more proactive approach centered around the concept of payment precision. As medical costs rise and billing becomes more complex, payers are evolving their payment integrity (PI) strategies to catch errors before the payment check is even cut. Payment integrity is no longer just about recovering overpayments. It is becoming a proactive, data-driven discipline focused on ensuring the right payment is made to the right provider for the right reason.

To start, let us briefly review the top trends shaping the payment integrity landscape today.

Top Trends Shaping the Payment Integrity Landscape

Shift to Prepayment Accuracy

The most significant trend is the move from retrospective auditing to prepayment prevention. By identifying errors, duplications, or fraudulent patterns before a claim is finalized, insurers reduce the friction caused by asking doctors to return money months after a service was provided. This shift saves administrative costs and keeps cash flow predictable for both parties.

This practice is commonly referred to as "shifting left" or moving payment integrity interventions earlier in the claim lifecycle. More and more payers are investing in pre-payment technology to catch errors before they impact the payment cycle.

An example might be where a health plan starts to use real-time clinical audits for high-cost categories like post-acute care and/or complex imaging to verify that services billed were performed in accordance with clinically sound diagnostic protocol(s), before releasing payment.



AI and Machine Learning as the Engine

Artificial Intelligence (AI) has become a core tool in the payment integrity arsenal. Generative AI and machine learning can scan large datasets in real-time to spot anomalies that manual reviews would miss. These technologies are particularly effective at identifying "upcoding" (billing for a more expensive service than provided) and unbundling, allowing for much faster and more accurate claim adjudication. AI-based tools also provide the ability to analyze unstructured data (e.g., doctor's notes and clinical charts) to identify fraudulent billing (in addition to detecting upcoding/unbundling).

Payment integrity practices are also leveraging predictive analytics to identify patterns indicative of fraud, waste, and abuse. This supports the ability to flag suspicious claims before they are approved. There are platforms available that enable "real-time" claim edits – health plans/payers can run prospective edits against millions of claims, ensuring compliance with medical policies and CMS guidelines.

Last, some payers are consolidating their payment integrity efforts, often moving toward a single, unified platform that combines data mining, real-time analytics, and automated workflows to enable consistency across their network(s).

Supporting Value-Based Care

As the industry shifts further toward Value-Based Care (VBC), payment integrity is moving beyond simple fee-for-service checks. PI programs are now being designed to validate patient acuity levels and quality metrics. Ensuring that payments accurately reflect the characteristics of a patient's health rather than just the volume of tests performed is critical to the success of VBC models.

Focus on High-Cost Specialty Care

With the explosion of high-cost specialty drugs (such as GLP-1s) and other more complex therapies, payment integrity is narrowing its focus on pharmacy and specialty claims. Payers are implementing more rigorous clinical reviews and prior authorization checks to ensure these high-dollar treatments meet specific medical necessity criteria.

An example of this as it relates to bundled payments – payment integrity teams can now use automated tools to ensure providers do not "unbundle" and bill separately services that are contracted to be paid by a bundled payment rate.

Transparency and Provider Collaboration

To combat rising claim denial rates, there is a push for greater transparency. Modern PI programs are sharing their "edit logic" – the rules used to flag claims – with providers upfront. By helping providers understand billing requirements in real-time, payers can reduce the cycle of denials and appeals, fostering a more collaborative relationship.

As a case in point, programs like Aetna's "Care Paths" now offer increased transparency around prior authorization, while other payers are integrating "edit logic" directly into

The infographic titled "Summary of Regulatory Impacts" is organized into four horizontal sections, each with an icon, a title, and a 2026 impact statement. The first section, "Risk Adjustment Data Validation (RADV) Rules," features a clipboard icon and lists "Medicare Advantage" with the impact of "2026: Annual Audits & Extrapolated Recoveries." The second section, "Marketplace Integrity Rule," features a storefront icon and lists "ACA Exchanges" with the impact of "2026: Subsidy Caps Removed & Income Verification." The third section, "HIPAA Security Modernization," features a shield icon and lists "Payer IT Systems" with the impact of "2026: Third-Party Scrutiny & AI Security." The fourth section, "60-Day Rule Updates," features a calendar icon and lists "All Providers" with the impact of "2026: 60-Day Overpayment Reporting Requirement." Each section is separated by a dashed line.

Regulatory Impact	2026 Impact
Risk Adjustment Data Validation (RADV) Rules Medicare Advantage	Annual Audits & Extrapolated Recoveries
Marketplace Integrity Rule ACA Exchanges	Subsidy Caps Removed & Income Verification
HIPAA Security Modernization Payer IT Systems	Third-Party Scrutiny & AI Security
60-Day Rule Updates All Providers	60-Day Overpayment Reporting Requirement

provider workflows. This allows providers to correct errors at the point of submission, rather than months later (as a result of post-payment auditing).

It is important to note that advancements in technology supporting payment integrity do not substitute for having a “human in the loop.” While advanced systems are able to flag high-risk claims, these benefit from review by expert auditors, combining technological speed with clinical expertise to make final, nuanced decisions. This is particularly true in complex cases where AI might struggle with contextual understanding.

Throughout 2025 and into 2026, the regulatory landscape for healthcare payment integrity has been dominated by more aggressive federal oversight aimed at reducing incorrect payments in government programs. Key drivers include a large-scale expansion of Medicare Advantage audits, strict new rules for marketplace subsidies, and a pivot toward “prepayment verification.” This reality adds additional imperatives for both provider collaboration (all parties have a stake in this) and transparency.

Differential Impact by Payer Type

The current evolution of payment integrity strategies and practices has a differential impact on payers, with an overall demand for higher accuracy, better technology integration, and improved transparency being the underlying common dimension.

<p>Medicare Advantage (MA) Plans</p> <p>Primary Pressure</p> <ul style="list-style-type: none"> High-cost claims 2026 CMS regulatory scrutiny <p>What’s Changing</p> <ul style="list-style-type: none"> Stricter reimbursement rules for high-cost therapies (2026) Increased audits tied to diagnostic code accuracy Greater exposure from unsupported diagnoses <p>Response</p> <ul style="list-style-type: none"> Proactive, pre-payment audits Stronger data-driven encounter validation Tighter oversight of telehealth & remote patient monitoring 	<p>Medicaid Payers</p> <p>Primary Pressure</p> <ul style="list-style-type: none"> Rapid enrollment growth Federal compliance requirements Fraud and improper payments <p>What’s Changing</p> <ul style="list-style-type: none"> 74% of improper payments tied to insufficient documentation (2024) <p>Response</p> <ul style="list-style-type: none"> Heavy investment in advanced data analytics Pattern detection for upcoding and duplicate billing Increased focus on documentation integrity 	<p>Commercial Insurers</p> <p>Primary Pressure</p> <ul style="list-style-type: none"> Medical Loss Ratio (MLR) constraints Rising pharmacy spend Provider abrasion <p>What’s Changing</p> <ul style="list-style-type: none"> 2025 medical costs increased ~6.7% <p>Response</p> <ul style="list-style-type: none"> AI-powered, real-time analytics Detection of “hidden” billing errors before payment Emphasis on accuracy without increasing provider friction 	<p>Self-Insured Employers</p> <p>Primary Pressure</p> <ul style="list-style-type: none"> Immediate cost containment Transparency and accountability <p>What’s Changing</p> <ul style="list-style-type: none"> Rising pharmacy and outpatient costs <p>Response</p> <ul style="list-style-type: none"> Increased scrutiny of TPAs Demand for clear vendor performance metrics Focus on cost visibility and measurable outcomes 	<p>Integrated Provider Organizations</p> <p>Primary Pressure</p> <ul style="list-style-type: none"> Administrative waste across care and payment functions <p>What’s Changing</p> <ul style="list-style-type: none"> Payment integrity moving beyond recovery <p>Response</p> <ul style="list-style-type: none"> AI-driven, real-time claims analysis Rationalized coding and billing across sites of care Shift from post-payment recovery to prevention Transparent edits to reduce provider abrasion
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Looking Forward – Beyond Savings to Adding Value

Instead of pinning “success” for payment integrity practices simply on cost recovery after claims are paid, health plans and payers overall are looking at ways to add real, meaningful value before services are delivered and/or paid. This is not about losing focus on savings, but about expanding how success is measured. Examples include adding in metrics focused on administrative costs, provider satisfaction, and member outcomes to understand more holistically what is working, and what is not.

Payment integrity teams no longer need to feel like they work in a vacuum. They now have the opportunity to partner more closely with provider relations and member support teams, with the shared goal of delivering quality care at a fair

cost. For years, PI teams tended to lack organizational integration, considered a necessary safeguard but not central to core operations. There is now a shift pushing PI into an expanded role as an enterprise control function that protects accuracy, transparency, and trust across the payment lifecycle.

In this new era, payment integrity is no longer measured only in dollars recovered—but in trust preserved, friction avoided, and accuracy delivered at scale.