The Future of Payment Integrity

How Leading Plans Move from Recovering Dollars to Preventing Leakage

AArete | FIERCE Healthcare

By: Gina Hedstrom, Adam Schulz, and Erica Wegielewski

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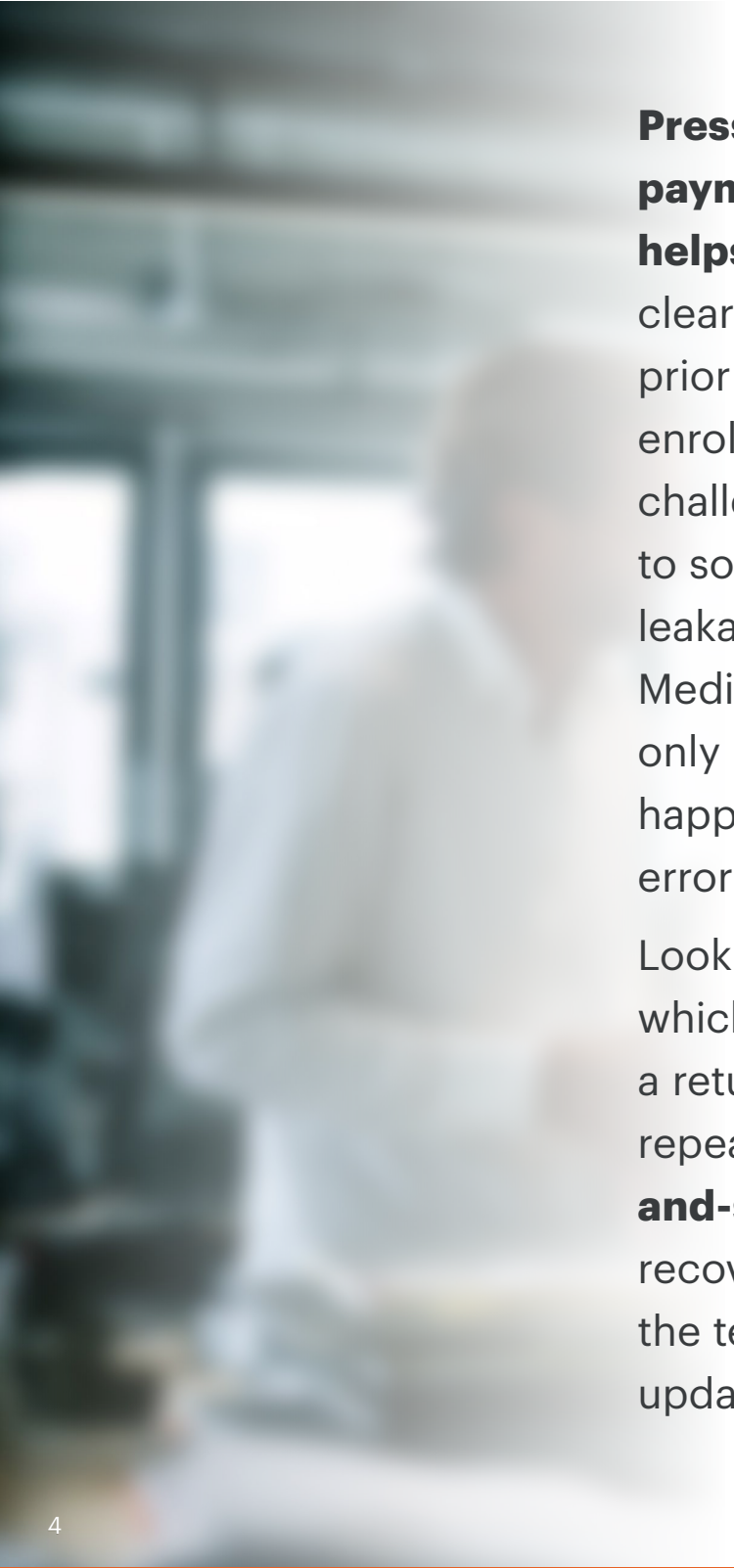
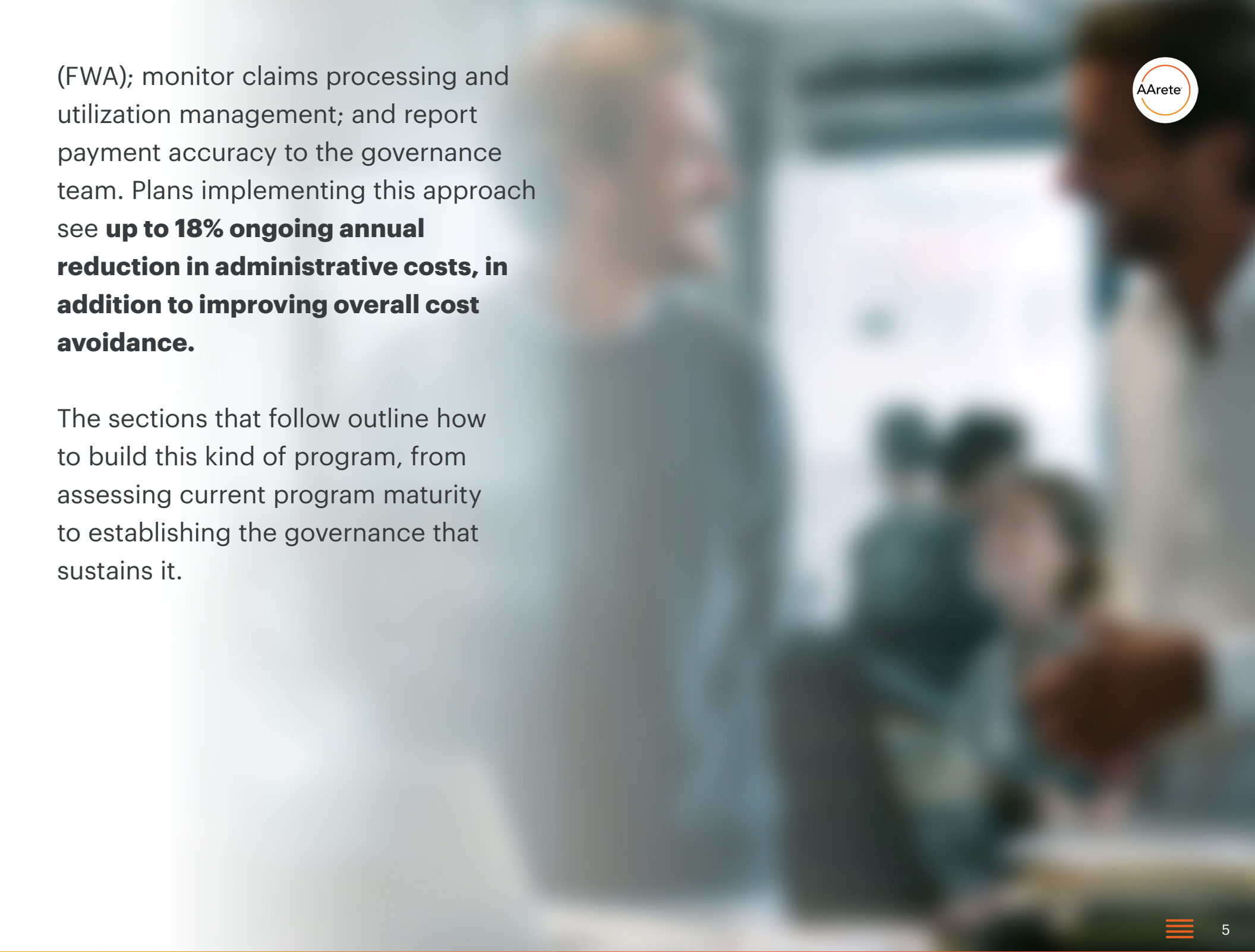


Pressure is mounting for Medicaid plans, and a sustainable payment integrity program is one of the few levers that helps rein in costs. Regulators expect tighter claims oversight, clearer accountability for delegated vendors, more transparent prior authorization decisions, and closer monitoring of provider enrollment and directed payments. Achieving these goals is challenging because the processes and data that teams need to solve these issues sit in silos. That's why plans see the same leakage categories appear annually. Most regional and community Medicaid plans build programs around **post-pay recovery**, which only identifies what went wrong after the fact and does not fix what happens in pre-pay, where the root cause of payment integrity errors often lives.

Looking to the future, executives will need clear visibility into which activities generate net value, which add complexity without a return, and which payment issues keep resurfacing despite repeated recovery efforts. **A smarter strategy is building a hub-and-spoke payment integrity model** with claims and post-pay recovery as the hub, backed by direct access to claims data and the technology to interpret it. The hub uses that access to push updates to medical policies; identify fraud, waste, and abuse

(FWA); monitor claims processing and utilization management; and report payment accuracy to the governance team. Plans implementing this approach see **up to 18% ongoing annual reduction in administrative costs, in addition to improving overall cost avoidance.**

The sections that follow outline how to build this kind of program, from assessing current program maturity to establishing the governance that sustains it.



Where Your Program Stands: A Maturity Model for Payment Integrity

Most Medicaid plans capture less than half of their available payment integrity value because they focus on recovery rather than prevention. Here's how most plans stack up and the opportunities they're missing with their current strategies.

REACTIVE PROGRAMS typically realize only 15% to 25% of the available opportunity. That's because they focus entirely on post-pay recovery and rely heavily on vendors. The internal team reviews all findings but struggles to validate them or identify the root cause. As a result, plans experience high-volume, low-dollar leakage year after year in behavioral health (BH), durable medical equipment (DME), non-emergent medical transportation (NEMT), and long-term services and supports (LTSS). They struggle to convert identified savings to recovered dollars and experience frequent provider disputes due to poor documentation.

MANAGED PROGRAMS realize 50% to 75% of available opportunity. They have defined workflows, a reporting cadence, and repeatable programs running in at least a few high-volume categories. Findings move through a pipeline from intake to validation to recovery with some consistency. Managed programs, however, still have some blind spots. Analytics and root-cause correction occur only when time and staffing allow. Savings depend on one or two key people or a single vendor relationship, and KPIs measure activity instead of outcomes.

INTELLIGENCE-LED PROGRAMS that combine AI, payment intelligence, policy optimization, and FWA realize 95%+ of available opportunity while significantly reducing provider abrasion and administrative cost. In-house staff and vendors pursue opportunities based on their potential yield. Findings are verified before recovery begins. And when a problem is found, someone owns the fix. As a result, repeat error volume shrinks over time, and finance can track how savings are measured and sustained.

Applying AI to the Six Points of Failure in Medicaid Claims Payment

Most Medicaid programs have heard the six points of payment integrity failure before, but they're not sure how AI can help address them. AI enables plans to identify risks before payment, while FWA investigations address the intentional behaviors driving inappropriate spend. Here's how to apply both to each failure point.

FAILURE POINT	WHAT GOES WRONG	AI ROLE	FWA ROLE
1. Member Eligibility & Enrollment	Retro-terminations, duplicate coverage, inaccurate demographics, Medicaid eligibility changes	Predict retro-termination risk, identify eligibility anomalies, automate reconciliation	Investigate identity manipulation, eligibility misrepresentation, member collusion, inappropriate use of multiple coverage identities
2. Provider Integrity & Network Management	Ineligible providers, credentialing issues, provider outliers, network leakage, contract configuration errors, provider set-up errors	Provider risk scoring, behavior pattern analysis, provider segmentation	Investigate excluded or ineligible misrepresentation, phantom providers, undisclosed affiliations, coordinated billing
3. Clinical & Utilization Management	Services not medically necessary, excessive utilization, inappropriate site of care, issues linking authorizations to claims payment	Predictive utilization models, documentation review, prior authorization support	Investigate medically unnecessary services, excessive or impossible utilization patterns, authorization manipulation, upcoding of service intensity, potential provider/member collusion
4. Claims Adjudication & Payment Accuracy	Coding errors, duplicate payments, unbundling, incorrect reimbursement	Real-time claim anomaly detection, edit optimization, contract interpretation AI	Identify intentional coding manipulation, systematic upcoding or unbundling, modifier abuse, duplicate billing schemes, billing patterns designed to circumvent payment controls
5. Payment Integrity & Recovery	Overpayments identified too late, low recovery rates, recurring errors	Find leakage patterns, root cause analysis, recovery prioritization	Use provider- and claim-level patterns to distinguish systemic payment errors from potential fraud, waste, or abuse; prioritize suspicious findings for investigation; and identify repeat or coordinated schemes
6. Governance, Compliance & Vendor Oversight	Lack of accountability, fragmented ownership, poor savings validation	Monitor program performance, automate reporting, identify trends	Track FWA referrals, investigative outcomes, provider risk trends, and repeat schemes; coordinate escalation across PI, SIU, compliance, legal, and vendors while monitoring overlap and accountability

Where Medicaid Plans Lose the Most, Most Often

In Medicaid, rules and program requirements vary from state to state, making state-specific expertise a must-have when evaluating potential payment integrity vendors. Yet while no two Medicaid plans are alike, most run into the same revenue leakage problems repeatedly. The highest-stakes risk areas include:

Behavioral health overcharges
Providers bill for time-based services such as applied behavior analysis (ABA), and billed units gradually exceed what was authorized. Without strong controls, the pattern goes unnoticed for months.
How to fix it: Reconcile paid units against authorized units, flag outliers first, and build rules that catch the pattern going forward.

Duplicate NEMT bills
Plans often receive more than one bill for the same trip or pay for more trips than a member's care plan supports.
How to fix it: Build logic to catch same-day duplicates, track member trip frequency, and flag patterns outside medical need.

Redundant home and community-based services (HCBS)/LTSS claims
Like NEMT, these claims are prone to overlap across dates, episodes of care, and providers, and plans sometimes pay beyond a member's plan-of-care limits.
How to fix it: Reconcile paid claims against authorized services and build rules that detect overlaps and enforce plan limits.

DME discrepancies
Plans pay for DME past the point it should stop, and modifier misuse inflates reimbursement without raising a flag.
How to fix it: Build logic around quantity and rental timeframes, update reference tables, and close the gap between policy and payment.

Authorization drift
An authorization exists, but the paid claim no longer matches it.
How to fix it: Reconcile authorization windows and units against paid claims and add edits that keep the two aligned.

Contract configuration drift
A contract gets renegotiated, but the claims system configuration lags, and mispricing can run for months before anyone catches it.
How to fix it: Validate contract terms against system configuration on a set cadence and build a change-control process that closes the lag at its source.

Provider data errors
When a provider's specialty, billing rules, location, or enrollment status is wrong, every claim tied to that record pays incorrectly.
How to fix it: Identify where master data drives payment errors, correct the records, and monitor them to prevent recurrence.

Each of these examples reflects a different point where payment logic and claims behavior diverge. Wherever monitoring lags the pace of error, leakage will occur. The question for any given plan is how quickly the program can detect the divergence once it starts.

Three Steps to Build a Payment Integrity Program of the Future

A future-focused intelligent payment integrity program can bring tangible value to Medicaid plans of all sizes. Organizations that follow these three steps can build a program that achieves substantial cost avoidance of up to **7% of medical spend**.

1. Choose what to pursue. Prioritize opportunities by the yield they generate rather than by the volume of fixes. Before pursuing a recovery, ask whether the logic is defensible, the dollars are worth the effort, and the root cause is fixable. If the answer to any of those que stions is uncertain, the opportunity isn't worth pursuing.

2. Implement a find-and-fix methodology. Comprehensive payment integrity programs employ a four-step find-and-fix model to help plans select the highest-value areas of concern and move forward confidently.

Find: Scour data to identify payment issues and leakage patterns.
Validate: Pressure-test the logic and confirm whether the opportunity will convert to defensible dollars.
Recover: Submit validated claims for recoupment to recover lost revenue.
Correct: Fix the root cause of payment inaccuracies so errors stop recurring.

The last stage carries the most value. Recovery resolves a single finding, but correction turns it into a permanent control, and that is what separates a managed program from an intelligence-led one.

3. Design a hybrid model that mixes insourced and outsourced capabilities. The ideal model for Medicaid plans is a hybrid approach. Plan executives should serve as the ultimate decision-makers while maintaining control over program priorities and holding key stakeholders accountable. Vendors should use their analytics, expertise, and remediation support to expedite time to value. But vendor dependency should shrink over time. A vendor that keeps finding the same errors year after year is just running outsourced operations on repeat.

Mature programs insource the fix. Once a vendor identifies a recurring issue, the plan takes ownership of understanding why it happens and building the correction into its own systems, so the vendor's time remains focused on surfacing new findings.

WHAT TO INSOURCE	WHAT TO OUTSOURCE (OR CO-SOURCE)
Governance: Determine where savings are pursued and how risk is managed.	Advanced analytics & data mining gap analysis: Access to specialized tools developed to improve speed to execution.
Payment policy: Own the policy internally.	New audit concept development: Generate new ideas for the team to identify leakage.
Payment integrity roadmap: Strategic planning should remain internal.	Complex DRG & reimbursement reviews: Hand off time-consuming tasks to vendors with specialized clinical expertise.
Itemized bill review/high-cost claims ($100K+): High contingency rates and low volumes make this best to insource.	Contract validation support: Gain a third-party perspective on contract interpretation of Medicaid regulations.
Root cause analysis: Understand why leakage occurs; don't just recover dollars.	Emerging fraud scheme identification: Benefit from access to market intelligence.
Edit ownership: Create edits for recurring findings to limit repeated vendor payments.	Staff augmentation: Outsource tasks during capacity spikes, mitigate provider abrasion, and adhere to prompt pay rules and pre-pay.
Change control & adjudication configuration: Fix claims systems to realize long-term value.	New technology enablement: Speed to deployment with experts who have completed this work many times.
Savings validation & finance alignment: Validate savings to track long-term trends and manage fees.	
Provider communication & clinical review: Employ a doctor for peer-to-peer utilization management review.	

The Vendor Dependency Test

PAYMENT INTEGRITY LEADERS SHOULD HOLD VENDORS ACCOUNTABLE USING THIS FRAMEWORK.

Year 1

Vendor identifies opportunity. Health plan validates savings.

Year 2

Health plan evaluates root cause and determines if issue can be prevented.

Year 3

Automate findings into the plan's adjudication platform, pre-pay editor, payment policy, clinical review process, and configuration logic.

If the plan is still paying a vendor to find repeat errors in Year 3, it's a sign that the program hasn't matured.

BENCHMARK YOUR PROGRAM'S SUCCESS

The ultimate benchmark of a successful payment integrity program is recurring cost savings, but the true value extends beyond a single number. The best programs are also built on a foundation of consistent governance and reporting.

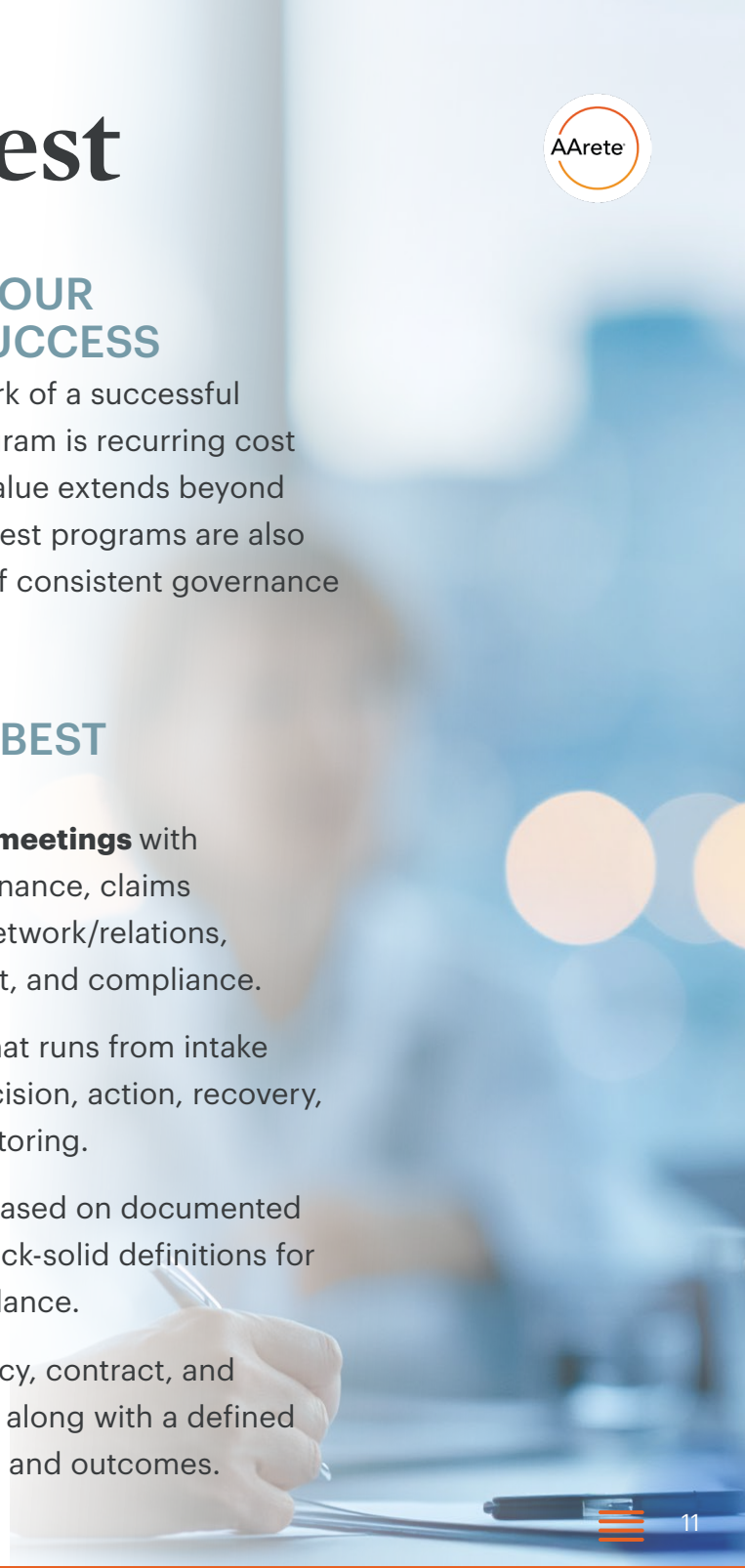
OPERATIONAL BEST PRACTICES

Monthly governance meetings with representatives from finance, claims operations, provider network/relations, utilization management, and compliance.

A standard pipeline that runs from intake through validation, decision, action, recovery, remediation, and monitoring.

Measurable savings based on documented attribution rules and rock-solid definitions for recovery vs. cost avoidance.

Strict controls for policy, contract, and configuration updates, along with a defined audit trail for decisions and outcomes.



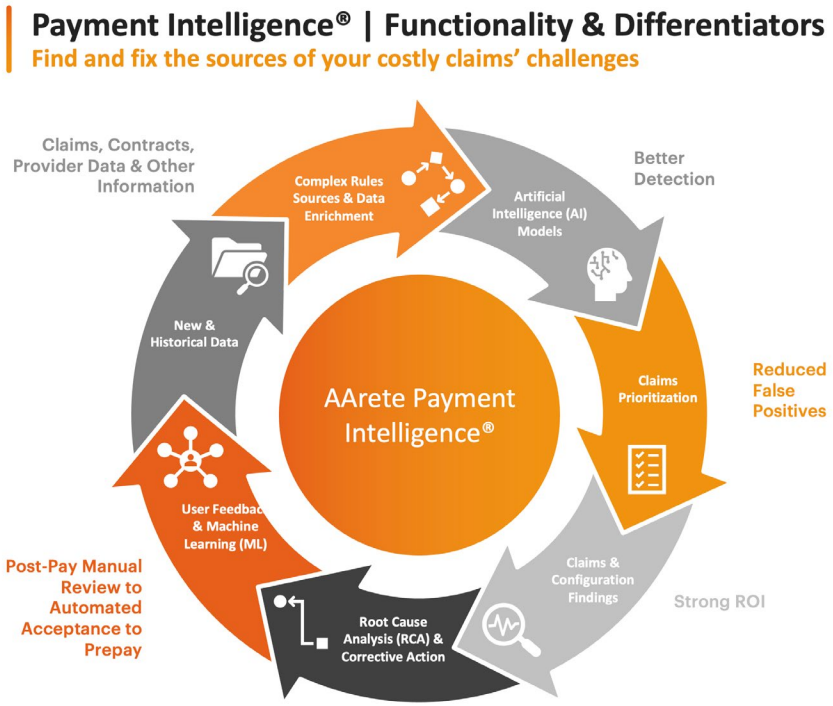
ROI to Track

The ROI of payment integrity is evident in three areas: financial results, operational impact, and the long-term effectiveness of the control environment. Key targets in each area include:

Financial Impact: Realized Dollars

Costs recovered. Validated overpayments are converted to recoupments through recovery operations.

Costs avoided. Annualized value from root-cause fixes that prevent recurrent payment issues.



Incremental first-year savings through recoveries & fixes

Operational Impact: Less Friction, More Automation

Reduced manual effort. Higher auto-adjudication rates and less need for human intervention in claims processing, pricing, and adjustments.

Fewer downstream concerns. Reduced appeals, a stronger provider experience, and less member abrasion.

Vendor program scorecard. Ensure vendors are doing what they are contracted to do, not duplicating findings.

SUSTAINABLE IMPACT: CONTROLS THAT WORK LONG-TERM

Fixed controls. Findings are converted into edits and policies, with ongoing monitoring to keep pace with program and contract changes.

Compliance and audit readiness. Plans can show regulators why payments occurred, who owns the fix, and how recurrence is being monitored.

THE AARETE PAYMENT INTELLIGENCE® DIFFERENCE

- Proven ROI achieved for 70+ health plans
- Initial findings delivered to clients within 14 days of first data load

A PARTNER BUILT FOR HEALTHCARE'S COMPLEXITY

AArete combines leading-edge technology with deep subject matter expertise to help health plans remediate the root causes of payment inaccuracies.

Payment Intelligence® by AArete accelerates the review of claims and configuration across all six spokes of payment accuracy. The platform is powered by **Doczy.ai™,** our AI-enabled contract intelligence tool, which uses machine learning models that adapt to new requirements and regulations at both the national and state levels.

Conclusion: Building a Program that Doesn't Repeat its Own Mistakes

Plans see the same categories of recurring leakage year after year because they're treating the symptoms. But recovering money after it's already left the organization is different than stopping it from leaving in the first place, and durable savings come from structure and governance that's built to last.Leakage originates upstream, in areas like configuration, contracts, and data. And that's what makes Payment Intelligence® so effective. With AArete, plans can solve the root cause of leakage at the source and build a program that sustains its own results.

Now is the time to move beyond identifying payment errors and start influencing the drivers of inappropriate spend. That means strengthening policy governance, leveraging provider-level intelligence, and integrating, clinical, network, and payment integrity strategies so plans can focus on prospective interventions that improve outcomes while preserving access to care for vulnerable populations.

Put AArete's expertise to work. Request a Medicaid Payment Integrity and Claims Oversight Scan to assess your vendor stack, pre-pay and post-pay payment accuracy controls and find your highest-risk Medicaid savings opportunities.

LEARN MORE ABOUT PAYMENT INTELLIGENCE

Meet our authors and Payment Intelligence® team members.

Gina Hedstrom
Managing Director

Adam Schulz
Vice President

Erica Wegielewski
Managing Director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