

CERIS

**Regulatory  
Watch Report**



**Healthcare Regulations  
Reshaping Payment  
Integrity Risk.**

Executive Briefing for Commercial  
Medicare, and Medicaid Payers

[ceris.com](https://ceris.com)

# Foreword

Healthcare regulations accelerated significantly across federal and state levels in 2025, and they continue to expand into 2026 with direction already emerging for 2027. Key areas policymakers are targeting include the following:

Area of Regulation	Federal Activity	State Activity	Payment Integrity Risk (Claim-Level Impact)
Prior Authorization	API mandates, performance reporting	Gold-card laws, mandated timelines	Accelerated approvals can lead to expedited reimbursement without coding accuracy.
Transparency	Hospital price transparency requirements	State reporting overlays	Published rates don't eliminate upcoding exposure and site-of-service overpayments.
AI in Utilization Management	Governance and oversight expectations	Disclosure and human review mandates	Reduced automation can create inconsistency in payment accuracy.
Provider Consolidation	Transaction oversight	Private equity and merger scrutiny laws	Increased pricing complexity can make it difficult to validate accuracy and detect outlier billing.

While these policies may increase oversight and transparency, they are not eliminating payment accuracy risk. This report focuses specifically on regulatory actions that the CERIS team believes could have the greatest impact on payment integrity functions across all lines of business (Commercial, Medicare, Medicaid). It outlines where financial risk is increasing, and what operational gaps payers need to close to strengthen cost management.

## Section 1: Federal Regulatory Review

CERIS has reviewed the following federal actions taking effect in 2026 and summarized the payment integrity impact of each:

1. CMS Interoperability & Prior Authorization Final Rule (CMS-0057-F)
2. Hospital Price Transparency Enhancements (CY 2026 OPPTS/ASC Final Rule)
3. Medicare Advantage & Part D (CY 2026 Final Rule)
4. Traditional Medicare Prior Authorization Expansion (WiSeR Model)



# 1 CMS Interoperability & Prior Authorization Final Rule (CMS-0057-F)

This final rule impacts all lines of business (Commercial, Medicaid, and Medicare). It standardizes electronic prior authorization processes and requires expanded public reporting of performance metrics. Payers are required to have prior authorization APIs operational by 2027. In addition to API implementation, plans must begin public reporting of prior authorization metrics beginning in 2026, with reporting updated annually. These published metrics include the approval and denial rates, average turnaround times (standard and expedited), and percentage of requests approved after appeal.

## **Payer Impact and PI Considerations:**

Prior authorization is transitioning into a publicly measured performance function, so speed and approval rates will be visible but accuracy is not directly regulated. Many payers are accelerating approval workflows to meet turnaround expectations. However, approval decisions are not always aligned with:

- Contract terms
- Coding accuracy
- Downstream reimbursement rules

This creates a disconnect between clinical approval and financial accuracy. Many payers are discovering that existing UM and claims platforms are not designed to enforce this alignment. Payment integrity can act as the control layer to bridge medically appropriate approvals and reimbursement accuracy. This includes tightening coding edits and contract logic pre-pay and deploying post-pay analytics to identify any leakage that may have been created through new automation workflows in prior authorization.

## 2 Hospital Price Transparency Enhancements (CY 2026 OPPTS/ASC Final Rule)

This regulatory action primarily impacts Commercial lines, but there is also a secondary impact on Medicare Advantage through network negotiations. It made changes to previous transparency regulation to strengthen enforcement and the requirements for machine-readable files, standardize billing, reimbursement disclosure. The final rule was released in late 2025 with active federal enforcement due by in early 2026.

### **Payer Impact and PI Considerations:**

Increased transparency into hospital pricing does not eliminate payment variance. In practice, many payers find that published rates do not align with how claims are actually billed, particularly in outpatient settings where facility fees, modifier usage, and unbundling practices create significant reimbursement variation.

Payment integrity efforts can utilize newly available pricing data, but must continue to audit allowed amounts against contracted terms, identify high-variance facilities and service lines, and deploy site-of-service optimization strategies. Contract compliance analytics should be embedded upstream to detect discrepancies before payment, particularly in areas prone to DRG creep, unbundling, and outpatient upcoding

## 3 Medicare Advantage & Part D (CY 2026 Final Rule)

The CY 2026 final rule primarily impacts Medicare Advantage and Part D with some specific areas impacting Commercial lines of business. The rule introduces changes that impact risk adjustment oversight, STARS performance adjustments, dual-eligible integration, pharmacy benefit management reporting, and payer accountability requirements. The rule continues CMS' tightening oversight of MA payer operations and financial accuracy. It was published in early 2025 and applies to coverage that began in 2026. Payers must incorporate policy and operational adjustments for the 2026 contract year.

### **Payer Impact and PI Considerations:**

This rule is increasing payer audit exposure significantly with greater scrutiny on documentation, coding accuracy, and financial reporting. The financial implications are substantial and non-compliance can result in:

- Repayment obligations tied to unsupported diagnoses and inflated risk scores
- Extrapolated audit findings where small sample errors lead to large-scale financial recoveries
- Civil monetary penalties and potential False Claims Act exposure
- Revenue volatility, as previously recognized revenue will be reversed

Additionally, since payers increasingly rely on external vendors for these services, oversight is becoming a critical issue. Payers remain fully accountable for the accuracy and compliance of all submitted data regardless of whether a vendor performed the work. Without strong governance, plans may unknowingly inherit compliance risk from their vendor ecosystem. Payment integrity should now include risk adjustment validation and vendor oversight.

**3** Given the complexity and financial stakes of risk adjustment validation, many organizations are turning to independent payment integrity partners to provide objective oversight, continuous monitoring, and audit-ready validation frameworks.



## **4 Traditional Medicare Prior Authorization Expansion (WISeR Model)**

The Prior Authorization Expansion primarily impacts traditional Medicare (FFS), but has implications for Medicare Advantage and Commercial Utilization Management practices. Under the WISeR (Wasteful and Inappropriate Service Reduction) Model, CMS expanded prior authorization requirements into traditional fee-for-service Medicare for select high-cost, high-utilization services in designated states. Historically, FFS Medicare has relied primarily on post pay review. This model represents a shift to prospective control within the federal program and signals recognition that real-time clinical oversight is necessary to reduce inappropriate utilization, fraud, and cost escalation.

### **Payer Impact and PI Considerations:**

This shift is significant to overall spend. Medicare FFS represents hundreds of billions in annual expenditures, with advanced imaging and procedural services consistently identified among the highest-cost and most variable categories. Even modest reductions in inappropriate utilization (e.g., 3–5%) across these categories can translate into billions in avoided spend annually, underscoring why CMS is prioritizing the oversight. WISeR signals the policy direction that prospective clinical validation is becoming the expectation not the exception.

**4** This expansion introduces increased scrutiny across high-cost imaging procedures, medical policy criteria and alignment with policy intent. While this is a Medicare change, it is also a leading indicator of where expectations are heading across all lines of business.

As prospective models expand, payment integrity must operate upstream and in parallel with utilization management. As CMS advances prospective oversight, payers that fail to align clinical policy, operational workflows, and payment integrity controls risk increased provider abrasion and avoidable medical spend. Payers are responding by implementing integrated PI and UM strategies often supported by independent partners who can bring objectivity, clinical rigor, and continuous monitoring to ensure both cost control and regulatory defensibility.

## Section 2: State Regulatory Review

Building on federal regulatory foundation, state governments are introducing additional requirements that further shape payer operations and compliance strategies. Recently states have accelerated regulatory activity across prior authorization reform, transparency, provider consolidation oversight, AI governance in utilization management, and Medicaid program integrity.

These state actions can create complexity as they are not always consistent with CMS guidance. While many regulations align with federal intent, they can introduced more aggressive standards or new requirements. For payers, this creates a more complex operating environment where compliance is no longer a single standard, but a multi-jurisdictional strategy requiring adaptation at the state level. This fragmentation increases administrative and operational burden and elevated compliance risk. The following state regulatory areas represent areas of focus similar to federal regulation that impact Commercial, Medicare, and Medicaid lines of business:

### 1. Prior Authorization Reform

**Active States:** Texas, California, New York, Illinois, Georgia, Florida, Colorado

**LOBS:** Commercial, Medicaid Managed Care (varies by state), and some Medicare Advantage

States enacted prior authorization reform largely in response to provider complaints about administrative burden, delays in care, and lack of transparency in approval processes.

Similar to federal prior authorization modernization efforts, these reforms shift decision-making earlier in the workflow and reduce retrospective control mechanisms. This increases the importance of aligning medical policy criteria, authorization logic, and downstream claims validation.

### 2. Healthcare Transaction & Private Equity Oversight

**Active States:** Texas, California, New York, Illinois, Georgia, Florida, Colorado

**LOBS:** Commercial, Medicaid Managed Care (varies by state), and some Medicare Advantage

States have expanded review authority over mergers, acquisitions, and private equity investments following evidence that provider consolidation correlates with price escalation. While transaction review may slow some deals, it does not reverse historical consolidation or eliminate pricing escalation.

Consistent with federal transparency initiatives, these regulations increase visibility into market dynamics but do not directly control unit cost. As provider pricing power grows, payment integrity becomes critical in validating billed charges, enforcing reimbursement accuracy, and mitigating cost escalation.

### 3. AI Governance in Utilization Management

**Active States:** California, Colorado, Connecticut, New York

**LOBS:** Commercial, Medicaid Managed Care, and Medicare Advantage

As payers increasingly deploy AI in utilization review and claims editing, state legislatures introduced AI governance laws to address transparency, bias, and consumer protection concerns. The goal is to protect consumers and ensure fairness.

Similar to emerging federal expectations around auditability and transparency, these requirements reinforce the need for explainable, defensible decision logic across both clinical and payment workflows. Payment integrity programs must ensure that automated edits and AI-driven determinations are not only compliant, but also financially accurate, auditable, and aligned with clinical intent.



## Section 3: Proposed and Emerging Legislation

Proposed legislation and ongoing policy discussions signal continued intervention in payment accuracy, reimbursement methodologies, and program integrity. Unlike finalized rules, these developments represent directional shifts that can materially impact how claims are validated, reimbursed, and audited in the coming years. For payment integrity leaders, these signals are critical. They indicate where future enforcement, audit focus, and financial exposure are likely to concentrate. The following emerging federal developments warrant proactive review:

## Expansion of Risk Adjustment Data Validation (RADV) Audits

CMS continues to expand the scope and enforcement of RADV audits within Medicare Advantage, with increasing discussion around additional validation.

This represents a direct financial risks to payers. Even small documentation or coding errors can lead to significant repayment obligations. Payment integrity programs must evolve in continuous risk adjustment validation, independent coding review, and pre-submission accuracy controls to reduce audit exposure.

## National Site-Neutral Payment Policy Discussions

Policymakers continue to evaluate site-neutral payment reforms aimed at reducing cost disparities between hospital outpatient departments and lower-cost care settings.

Site-neutral policies would introduce new complexity in how services are billed and reimbursed. As providers adapt, payers may see shifts in billing patterns, place-of-service coding, and reimbursement strategies. Payment integrity will continue to play a central role in validating accuracy as complexity increases.

## Increased Federal Focus on Fraud, Waste, and Abuse (FWA) Through Advanced Analytics

CMS and federal agencies are signaling expanded investment in data-driven program integrity, including the use of advanced analytics and AI to detect improper payments earlier in the claim lifecycle.

This reinforces a clear shift toward proactive, data-driven oversight. Payers will be expected to demonstrate compliance and active detection and prevention of improper payments. Payment integrity advanced analytics, real-time flagging, and continuous monitoring will need to continue to evolve to align with federal expectations.

## Strengthening of Price Transparency Enforcement and Data Standardization:

Building on existing transparency rules, policymakers continue to push for more standardized, enforceable pricing data, and clear requirements around allowed amounts and negotiated rates.

While transparency alone does not reduce cost, it will continue to provide a richer dataset for identifying pricing anomalies, outliers, and reimbursement inconsistencies. Payment integrity programs can leverage this data to enhance benchmarking, contract validation, and outlier detection strategies.

# Section 4: Conclusion

As regulatory pressure continues to expand across federal and state levels, the healthcare landscape is becoming more transparent, more structured, and more closely monitored but not necessarily more accurate. The policies outlined in this report signal a clear shift toward prospective oversight, data availability, and accountability. Yet they stop short of addressing one of the most critical challenges facing payers today: ensuring that what is approved, billed, and ultimately paid is financially accurate.

This illustrates the importance of payment integrity and its evolution. It is increasingly a strategic capability that must operate across the full lifecycle of a claim bridging clinical intent, operational execution, and financial validation. As complexity grows and audit exposure intensifies, organizations that invest in integrated payment integrity frameworks will be better positioned to reduce leakage, strengthen defensibility, and compete in a more demanding regulatory environment.



CERIS brings over 30 years of expertise in prepay and post-pay claim review and repricing. Trusted by health plans, Medicare and Medicaid plans, and third-party administrators, our solutions deliver deep, consistent, and defensible reviews.

With a foundation in clinical expertise and a commitment to partnership, CERIS adds measurable value through long-term Payment Integrity services that help our clients contain costs and optimize outcomes.

■ Learn more at **[ceris.com](https://ceris.com)**