The Aligned Core

Governance, Architecture, and First-Time Accuracy

Abstract

The pace of change in payment integrity has outrun the deployment cycle most payers use to respond to it, and that gap is itself an architectural choice. Building on the companion paper, *Impacting the Economics of Care*, this paper locates consolidation downstream of governance alignment: an architectural outcome, and a poor procurement goal on its own. Oversight capacity is finite, so the question becomes composition. A consolidated, governable core frees capacity for specialist depth at the edges. The objective is an architecture that makes first-time accuracy achievable and stays modular enough to adapt to future market changes.

Executive Summary

How do we correct the economics of care? The companion paper, *Impacting the Economics of Care*, answered the question of sequence: organizational architecture precedes technical infrastructure, and governance and policy must align before technology and analytics compound. [15] This paper accepts that premise and asks what the sequence must produce in a market that evolves faster than typical implementation cycles.

Four vectors have been shaping payment integrity for years: regulation, enforcement, technology adoption, and vendor consolidation. None is new. What changed over the last eighteen months is that each now carries a dated event. CMS-0057-F put prior authorization, denial-reason specificity, public metrics, and FHIR-based APIs onto compliance tracks, and the first metrics posted in March 2026. DOJ False Claims Act recoveries hit a record $6.8 billion in FY2025. And Bain/KLAS found 80 percent of payers with an AI strategy in place or in development, up from 60 percent a year earlier. [1, 2, 22]

Waiting for the market to settle is a fool's errand. Improper-payment exposure is rising in Medicare Advantage, Part D, and Medicaid even as Medicare fee-for-service improved, and the 2025 National Health Care Fraud Takedown targeted approximately $14.6 billion in intended losses. [3] Inaction has its own trajectory, and it is steeper than the cost of acting. [2]

The necessary response is to deploy a flexible, governance-led architecture across the operating landscape the Reference Framework defines. Enough is known to begin. Governance expectations are explicit enough to act on, interoperability obligations concrete enough to plan against, and selective consolidation onto standards-based, modular platforms can create operating flexibility where concentration risk, exit design, and accountability are managed deliberately. [4, 1, 5, 6]

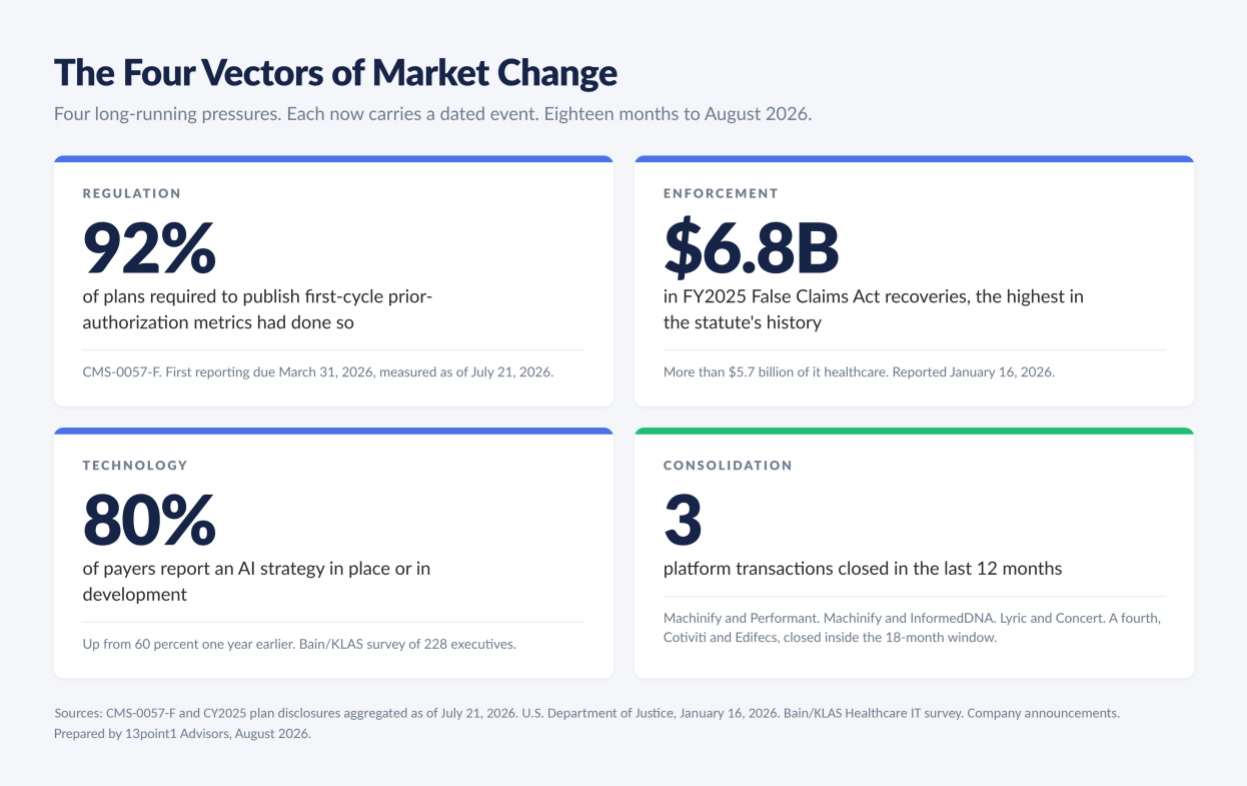

Figure 1. *The four vectors of market change, with one anchor metric each. Consolidation is measured as platform transactions closed in the last twelve months.*

I. The Pace of Change Has Outrun the Default Deployment Timeline

Four vectors have been shaping the operating environment for payment integrity since well before *Impacting the Economics of Care* was written: regulation, enforcement, technology adoption, and vendor consolidation. None is a new development, and each is still evolving. What has changed over the last eighteen months is that each now rests on a dated event where it once rested on a forecast. Evidence is what a payer can plan against.

Vector 1: Regulation

CMS is moving interoperability and prior authorization from policy aspiration to operating requirement. CMS-0057-F sets four dated obligations. Prior-authorization decisions compress to 72 hours for urgent and seven calendar days for standard requests. Denials must carry a specific reason beginning in 2026. Prior-authorization metrics became public, with the first set due March 31, 2026. And multiple FHIR-based APIs must be in place, with compliance dates generally beginning January 1, 2027. [1]

That first reporting cycle has now happened, and it produced the strongest evidence in this paper for the first-time-accuracy argument. Across plans reporting CY2025 performance, the median Medicare Advantage denial rate was 7.2 percent, with Medicaid managed care, CHIP, and Marketplace plans running roughly 12 to 14 percent. More than half of appealed denials,

52.6 percent at the median plan, were overturned, and only 7.3 percent of denials were appealed at all. [22] A payer that reverses most of what it re-examines, while almost nobody asks it to re-examine anything, is describing a first-pass accuracy problem. The error is created upstream of the appeal.

Ninety-two percent of required plans had reported as of July 21, 2026, so this is a near-complete public dataset. [22] It is also a difficult one: no granularity below plan level, methodologies that vary across payers, and reports providers and patients struggle to reach. The obligation has arrived ahead of the defined measurement standards. The operational consequence runs wider than compliance either way. CMS-0057-F joins claims, clinical, prior authorization, provider access, patient access, and payer-to-payer exchange into one architecture, so the systems shaping payment accuracy must interlock by design. [1]

Vector 2: Enforcement

On January 16, 2026, the Department of Justice reported False Claims Act settlements and judgments exceeding $6.8 billion in FY2025, the highest annual recovery in the statute's history. More than $5.7 billion related to healthcare matters, across 1,297 qui tam suits and 401 government-initiated investigations. [2] The posture is already operational: Kaiser Permanente affiliates settled Medicare Advantage risk-adjustment claims for $556 million in January 2026, in a matter involving allegations of unsupported diagnosis codes.

For payers the significance is operational as much as legal. When the healthcare share of FCA recoveries reaches roughly 84 percent, the compliance, documentation, and coding disciplines around payment decisions become operating questions. [2] That strengthens the case for beginning with governance. [4]

Vector 3: Technology

Adoption crossed a threshold in a single year. The Bain/KLAS survey of 228 provider and payer executives found 80 percent of payers and 70 percent of providers with an AI strategy in place or in development, up from 60 percent a year earlier. Maturity is a separate question, because the operating environment changes at adoption and well before maturity arrives. Diffusion pressures laggards even where implementation quality stays uneven, and the implication is a governance-led posture that permits selective movement while the market keeps changing. [4]

Vector 4: Vendor Consolidation

The supply side is doing two things at once. At the tail it keeps growing. 13point1 Advisors tracks more than 215 payment integrity solution and technology providers, and the Market Matrix records ten new entrants since June 1, 2026. [13, 25] At the top it keeps consolidating. Cotiviti closed its acquisition of Edifecs on March 31, 2025, and Machinify closed its acquisition of Performant Healthcare on October 21, 2025. In July 2026 Machinify added genetic testing capability from InformedDNA and Lyric acquired Concert. [7, 23, 24] Four platform transactions inside eighteen months, three of them inside the last twelve.

Whether that reads as good news depends on the seat. Payers have been working to reduce vendor count for years, so a large vendor acquiring proven smaller ones endorses that direction.

It cements position by buying capability that already works. From a payer's chair it means fewer contracts to govern and a broader core to govern them from. From a specialist's chair it means the field of independent buyers is narrowing. The pattern matters more than any single transaction. It makes architecture and vendor strategy one question, because the market now moves faster than a procurement cycle can evaluate it. That mismatch in timing is the problem. [2, 1]

A note on sources: This paper draws on published research, regulatory filings, and practitioner perspectives from across the healthcare ecosystem, including payers, solution providers, and regulatory bodies, to ground the argument in operational reality. Where specific organizations are cited, it is to illustrate a published viewpoint or operational methodology relevant to the analysis, not to endorse a product or service. Some organizations cited herein maintain commercial relationships with the authors or their clients. Inclusion is determined by analytical relevance, not commercial affiliation.

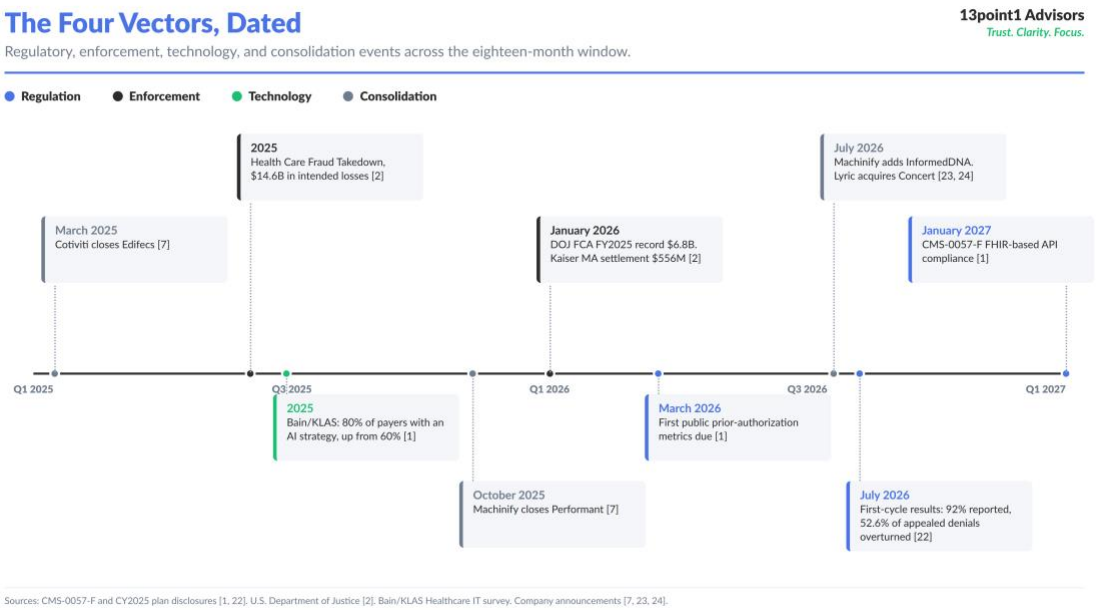

Figure 2. *Dated events across the eighteen-month window, from the Cotiviti and Edifecs close in March 2025 to FHIR-based API compliance in January 2027.*

II. Deployment Cycles Are an Architectural Choice, Not a Constant. Enterprise payer deployments take a long time, and the market does not pause for them. That constraint looks immovable. It is a variable. The twelve-to-twenty-four-month figure is a directional frame, best read as a consequence of architecture, governance, and scope choices. The support is indirect and we label it as such. Implementation guidance for CMS-0057-F breaks the work into six sequenced phases, which puts most of the burden in coordination and readiness. [8, 9, 10] That inference supports the narrower claim that design decisions choose part of the timeline.

Two findings sharpen the point. MIT CISR established that architecture maturity alone does not create business value, because value depends on management practices that spread architectural thinking across the enterprise. [11] Menlo Ventures finds payer AI procurement cycles lengthening from 9.4 to 11.3 months while provider segments moved faster. [12] Payer caution is rational, and it is also a competitive variable. Today's decision is wider than deploy now or wait. It is a choice between a design that preserves phased movement and option value, and one that hardens delay into the operating model. [1]

One published vendor case shows what a program that skips the build cycle can return. A large Medicaid plan running both an external vendor and an in-house team engaged Machinify for a backsweep of past claims and a head-to-head re-review of ongoing DRG claims its existing reviewers had closed with no finding. Machinify reports $2.5 million in savings in the first two months and $6.0 million after four, with a provider dispute rate below 8 percent. [26] These are company-stated figures. The inference we draw is about timing. The program arrived configured, so returns began inside the window a new build would still spend ramping. The case also bears on first-time accuracy: claims that had cleared two reviewers still carried recoverable error.

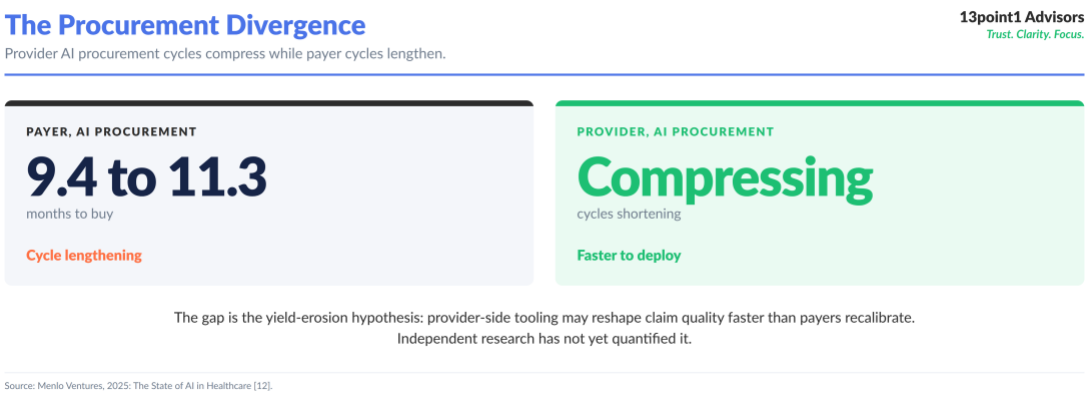

Figure 3. *Payer AI procurement cycles lengthening while provider cycles compress. The gap is the yield-erosion hypothesis, which independent research has not yet quantified.*

III. The Vendor Field: Fragmentation, Consolidation, and a New Risk

Vendor choice is part of the payer architecture decision. The exact vendor count at any health plan is proprietary, but the available field size of 200+ is what matters. [13] Public activity shows a trend towards smaller vendor stacks and maintenance of fewer integrations. The consolidation wave is doing double-duty for payers. Each transaction validates the target as credible by the industry while potentially eliminating the need for an additional integration to acquire new capabilities. Otherwise stated, enhanced capability arrives without a complex purchase process.

Vendor consolidation increases a payer's concentration risk profile without altering the lock-in risk. These two exposures get conflated. Lock-in is the switching cost a payer accumulates as a platform embeds itself in workflows, data formats, and integrations, and it builds gradually. Concentration risk is the exposure that arises when one platform spans multiple cost containment functions. [5] Both must be considered, for different reasons, and both can be mitigated by the payer.

The October 2025 AWS outage shows one edge of that, where dependence on a single provider turned one failure into enterprise-wide disruption. [6] Consolidation can reduce vendor count while raising correlated exposure, unless governance manages dependency concentration explicitly in both requirements development and risk mitigation. [6, 5]

That lineage cuts both ways. As a platform takes on more of a plan's operation, the acquirer's loss from losing that plan rises with it, which is a standing incentive to keep investing in content. That incentive holds while exit stays credible. Where a vendor concludes the plan cannot leave, the same concentration invites complacency. So, exit design is more than a defensive term. It is what keeps the acquirer spending.

A fair objection runs the other way. Securing those conditions is a governance capability before it is a procurement act, and a payer that cannot govern ten vendors will not negotiate the terms that keep a platform modular. Read correctly, that is the argument for governance-led consolidation. [14]

Every vendor addition brings administrative expense, and this expense drives rational vendor stack size decisions. Most health plans are found to carry seven to thirteen vendors for ten core payment integrity functions. In practice, this leads to fifteen to eighteen slots when accounting for multiple pass positions in areas such as Coordination of Benefits, Data Mining, Clinical Audit, and Claim Editing.

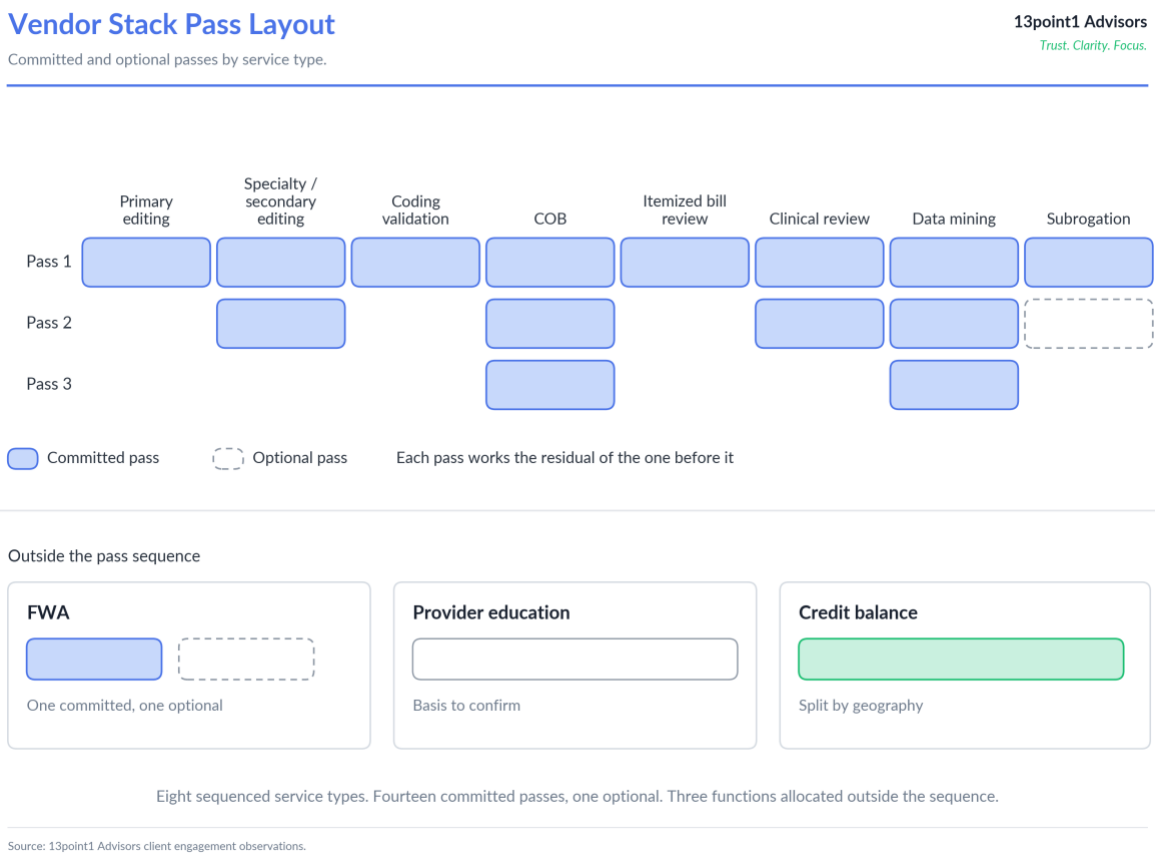

Figure 4. *Committed and optional passes by service type in a typical payer vendor stack, based on 13point1 client engagement observations.*

What makes that cost rise faster than the administrative cost associated with vendor count is the integration burden. Each vendor carries its own feeds, credentialing, and reconciliation back to the core. Each pair working the same claim population adds suppression rules, sequencing, and deduplication of overlapping findings between them. The relationships to maintain grow faster than the vendors do. An aggregation platform moves that integration work without taking it off the ledger: the contracts still get negotiated and maintained, accountability for a wrong finding sits one layer further away, and the aggregator occupies a slot of its own. It changes the shape of the cost while the number of relationships a plan governs stays the same.

So, the arithmetic resolves three ways. A plan holds one vendor covering four or more functions, its internal teams absorb the difference, or the coverage gap stays open. A stack that reaches thirteen is usually a plan that chose the third. That makes the core slot countable rather than a preference. It goes to a vendor covering four or more of the ten that can show it has folded others in, or to a specialist deep enough in one function that no such vendor substitutes for it. An anchor covering six of the first-pass positions brings fourteen committed passes to nine slots, and the slots it frees are the ones a plan can spend on a second look where a second look pays.

The trap is not vendor size. Replacing a four-function vendor with a two-function provider holds oversight flat and hands back two functions to a stack with none to spare. The slot costs the

same and returns half. Both qualifying shapes carry obligations. A vendor that absorbs well concentrates fast, so the first kind is the kind to govern hardest, and a specialist contract should say now what happens to the payer's terms, data, and roadmap when its counterparty is acquired.

IV. Waiting Compounds: The Cost of Standing Still

By now two things are established: the environment is moving, and deployment speed is partly a choice. That leaves one assumption to test, that waiting is the conservative option. The evidence runs the other way. Inaction carries a cost on three measured dimensions and a fourth that is credible and not yet measured. The first is the improper-payment burden, which totaled roughly $94 billion across Medicare fee-for-service, Medicare Advantage, Part D, and Medicaid in FY2025 and has proven durable. [3]

Year-over-year movement is mixed and needs careful reading. Medicare fee-for-service improved to its lowest rate in over a decade, and the increases in Medicaid, Part D, and CHIP are substantially an artifact of post-pandemic eligibility unwinding. [3] The compositional figure is more telling. Seventy-seven percent of FY2025 Medicaid improper payments stemmed from insufficient documentation, so the dollars go missing in processes that cannot produce the record needed to confirm a payment was proper. [3]

Medicare Advantage overpayment is where the magnitude is genuinely contested. MedPAC has estimated it at roughly $83 billion for 2024, while others argue that methodology changes have inflated such estimates. Overpayment exists, its magnitude is disputed, and the architectural case does not depend on winning that dispute. The Kaiser settlement in Section I marks where enforcement has landed.

The enforcement trajectory is the third confirmed dimension. DOJ FCA recoveries roughly doubled from FY2024 to FY2025, and the 2025 National Health Care Fraud Takedown was the largest in the Department's history at approximately $14.6 billion in intended losses. [2] The fourth is the payer-provider AI dynamic, where provider-side automation may reshape claim quality faster than payers recalibrate. Independent research has not yet quantified it, and the paper treats it as a hypothesis.

Set against the cost of waiting is a counterpart this section has not yet priced: the return on acting. The most rigorous available evidence comes by analogy from Medicare fee-for-service, where a large federal monitoring program, the Recovery Audit Contractor program reviewing hospital inpatient admissions, returned $24 to $29 in savings for every dollar spent, with roughly 90 percent of that return coming from changes in provider behavior rather than the recovery of prior payments. [16] The setting is provider-side hospital behavior under fee-for-service audit, so it stands as a structural analogy and carries no direct payer return figure.

Behavior change of that magnitude depends on consistent, enforceable, governed policy, because ad hoc recovery cannot change behavior before the fact. The monitoring also drove hospitals to adopt medical-necessity determination technology. Governance shaped the

technology investment, and the capability improved the admission decision at the point of care. That is the same first-pass discipline a governed payer architecture serves, one layer upstream.

Asymmetry is the conclusion here. Regulatory and enforcement vectors are accelerating while deployment and procurement vectors lag, so the cost of waiting rises on a steeper curve than the cost of acting. [2, 1] "Wait and see" has quietly become the higher-risk position.

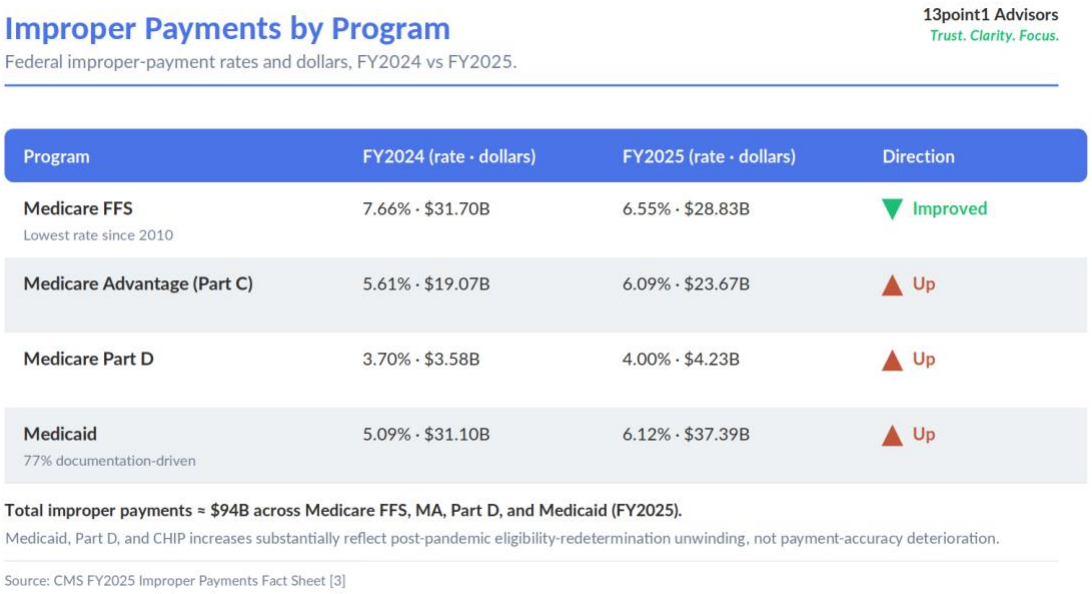

Figure 5. *Improper payments by program, FY2024 and FY2025. Medicare fee-for-service improved while Medicare Advantage, Part D, and Medicaid rose.*

V. What Flexibility Actually Means in This Context

Flexibility is the most overused and least defined word in enterprise technology. To carry analytic weight, it must dbecome a construct with named properties. The vocabulary exists. TOGAF names technology independence, modularity, and scalability as architecture principles, HL7 FHIR supplies the standards-based interoperability layer, and CMS-0057-F turns part of that stack into compliance obligation. [17, 1]. Flexibility comes in two forms, and consolidation treats them differently. The first is component flexibility: the ability to replace, reconfigure, or redeploy capabilities without rebuilding the whole stack. The second is operating flexibility: the ability to move faster because workflows, data standards, governance, and vendor accountabilities have been simplified. Done carelessly, consolidation weakens the first. Done deliberately, it strengthens the second. [5]

Consolidation of a vendor stack around a core can create future flexibility by eliminating redundant interfaces, centering workflows on shared standards, concentrating governance on fewer but more governable dependencies, and preserving modular control points through APIs, configuration boundaries, and contractual exit rights. [14] Switching costs related to payment integrity programs, both operationally and economically, are significant and create lock-in effects

and roadmap dependence in vendor selection. Consolidation changes how much of the operation sits behind a single roadmap, and therefore how much one prioritization decision can move. [6, 5]

Flexibility is defined as a program with the following properties: modularity, configurability, deployment optionality, governance-bounded autonomy, standards-based integration, platform reuse, and iterative deployment. Modularity is replacing one review component without re-integrating the environment. Deployment optionality is running a capability pre-pay or post-pay without re-architecting it. [18] It also carries a failure mode if unbounded by governance. It becomes configuration sprawl, integration debt, and governance gaps. [11] Flexibility is a discipline that constrains an organization as deliberately as it frees it, and deferring decisions is what it forbids. [14] A discipline that constrains needs something to do the constraining, and that something is governance.

Machinify's chief technology officer and chief product officer have published an architecture description that supplies the vendor instance for three of these properties. Their prescription for core adjudication systems is a strangler-fig pattern: the transaction backbone remains the system of record while an AI-enabled decision layer grows around it, working as a co-processor to adjudication rather than a replacement for it. [27] That is modularity and deployment optionality expressed at the adjudication boundary, with review logic moving pre-pay as evidence assembly permits instead of waiting on a core migration. Their operating guidance, start with one or two mature categories and move them upstream, is iterative deployment stated as practice.

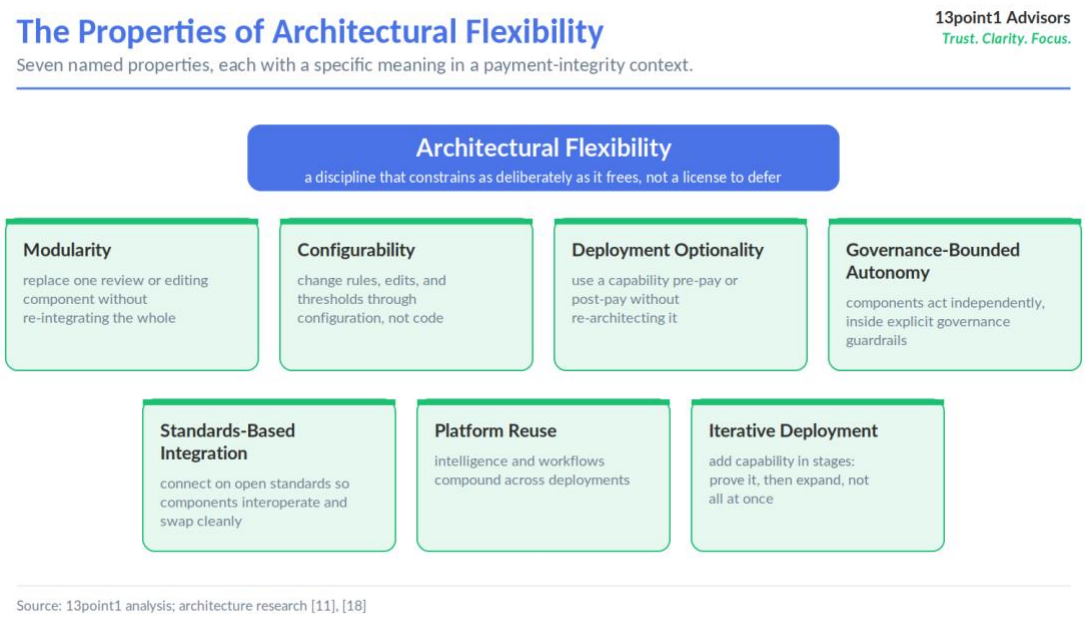

Figure 6. *The seven named properties of architectural flexibility defined in this section.*

VI. Governance First: What the Health Plan of the Future Must Establish

The sequence established in *Impacting the Economics of Care* holds governance leads technology. What has changed is the velocity at which governance has to operate, because components of future-state governance are emerging faster than payer practice can absorb them. That gap is this section's central finding.

On AI governance the reference points are recent and converging. NIST released its AI Risk Management Framework in January 2023 and added a Generative AI Profile in July 2024. [4] For health plans the task is to define use-case inventories, risk owners, documentation expectations, measurement routines, and escalation paths before AI-enabled workflows scale further. Regulatory finality is not a prerequisite. [4, 1]

Data governance is the second front. CMS-0057-F creates a concrete interoperability obligation layered over payer operations. Payers must align clinical, claims, prior authorization, and provider workflows with shared data standards, explicit timeframes, denial-reason requirements, and ongoing reporting. [1] Governance becomes operational at that point. [1]

Published frameworks reinforce the point. A February 2026 systematic review of 35 healthcare AI governance frameworks identified seven governance domains and a five-level maturity model, while observing that existing frameworks remain fragmented and assume resources many organizations lack. [19] It is direct on the strategic question: strong governance accelerates AI adoption. [19] Machinify's general counsel makes the operational case, that legal and compliance as design partners shorten contract cycles. [20]

Selective consolidation is defensible only when the organization can still specify accountabilities, portability expectations, escalation rights, and back-out paths, so that simplification does not harden into dependence. [14, 21] The gap that remains is both a strategic risk and an architectural opportunity, because governance expectations are articulating ahead of payer practice. A plan that closes the gap ahead of deployment acquires durable position, and a plan that leaves it open acquires durable exposure. [4, 1]

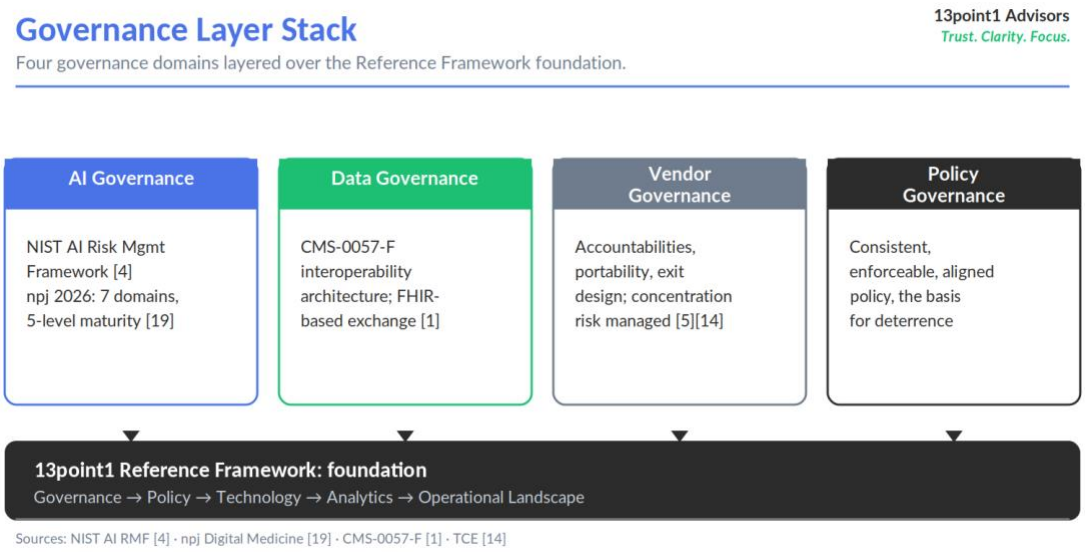

Figure 7. *Four governance domains layered over the Reference Framework foundation.*

VII. Payment Integrity Cannot Be Flexible in Isolation: Interlock Across the Landscape

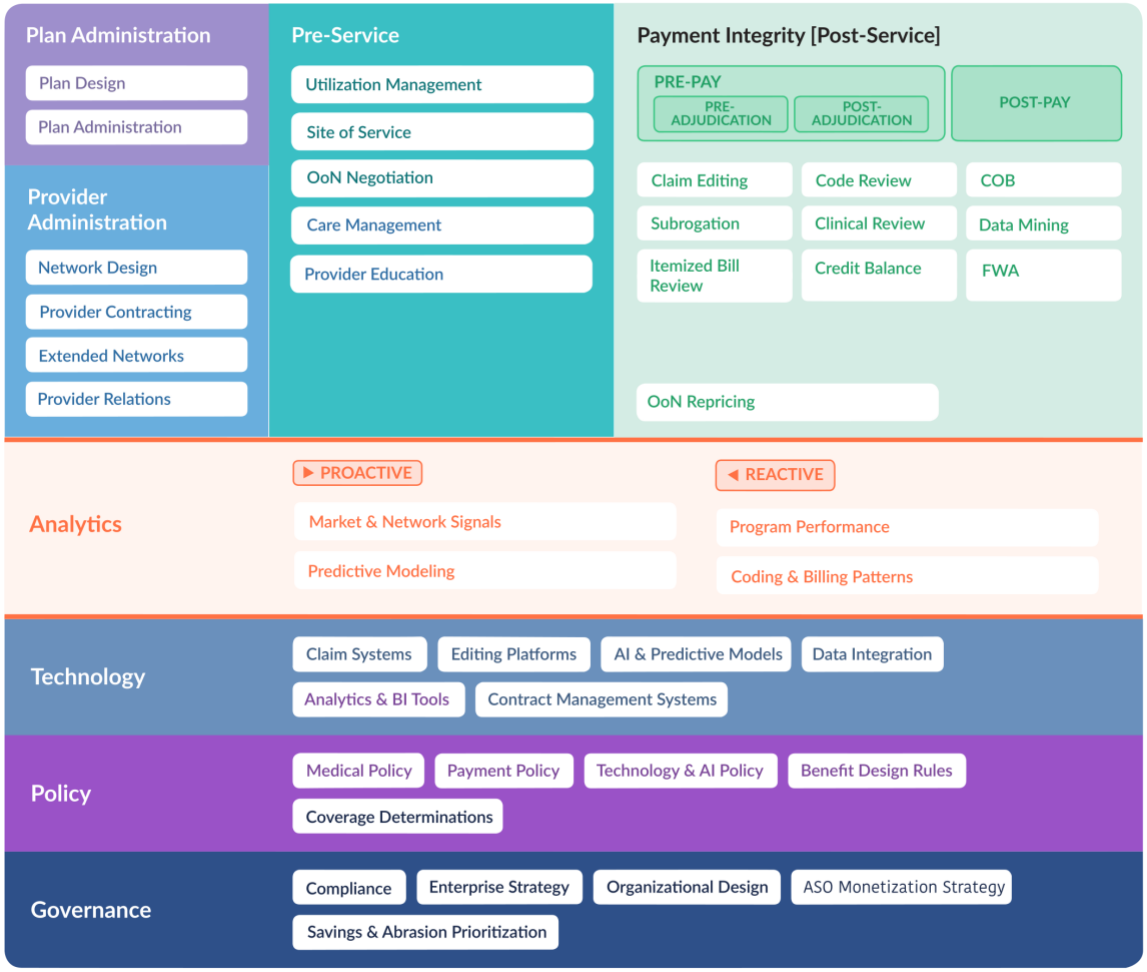

Figure 8. *The 13point1 Advisors Reference Framework at full breadth.*

Payment integrity cannot be made flexible on its own. It sits at the receiving end of signals that originate elsewhere, and the flexibility that matters is how those signals flow across the framework together. Plan and provider administration feed the same engine: benefit-design changes cascade into edit logic, and contract terms drive repricing accuracy, DRG audit exposure, and coordination-of-benefits logic. When any of it falls out of alignment, the gap opens a window of payment error no post-service engine can close after the fact. [1]

The pre-service connection has stopped being optional. CMS-0057-F mandates a prior-authorization interoperability architecture linking payer workflows to provider systems through FHIR-based exchange from January 1, 2027, which is the hardest structural evidence in the paper. [1] Signals also run in reverse: payment-integrity findings fed back upstream inform pre-

pay logic, provider education, and policy refinement. That shift-left loop works best where the operating model has already simplified its interfaces enough to absorb the learning. [5, 14]

Local optimization is the risk to guard against. An architecture that fails to interlock with the framework around it produces gains in one corner while leaving the seams between corners as the dominant source of payment error. Flexibility that stops at the payment-integrity boundary buys a faster version of the same silo.

Conclusion: Returning to the Economics of Care

This paper began with the question the companion paper began with. How do we correct the economics of care? What it adds is an answer about timing and structure. Programs built on point solutions will not meaningfully improve the economics of care, and neither will waiting for the market to settle, because regulation, enforcement, interoperability, and technology adoption are already moving. [2, 1] The sequence remains governance first, then selective technology adoption. [4]

The limits deserve equal clarity. Selective consolidation creates flexibility when it simplifies workflows, reduces interface sprawl, and preserves modular option value through standards, APIs, and governance. [14] However, consolidation is not inherently flexibility-enhancing in all circumstances, specifically where the chosen vendor has not demonstrated the flexibility defined in Section V within its own operations.

All of it reduces to a single asymmetry. A payer that builds governance-led flexibility across the operating landscape improves its odds of holding position. A payer that waits pays for the delay later, at a price set by someone else. [2, 1] The interval in which that choice is cheap is closing.

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