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Navigating Payor Relations:

A Guide for Emerging Health Care Companies

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1. Introduction

Many common early stage go-to-market strategies of the past decade—including direct-to-consumer (DTC) and employer benefits purchasing (separate from their health insurance offering)—are facing growing regulatory, operational, and financial headwinds. As a result, health care companies are increasingly evaluating other growth opportunities, including pursuing commercial and government insurance reimbursement. The perceived ease of entry and scalability benefits of payor relationships understandably appeal to many leaders.

In the DTC space, competition for each "health care" dollar has intensified, macroeconomic pressures have heightened consumer sensitivity to out-of-pocket costs, and rising customer acquisition costs have become prohibitively expensive for many companies. At the same time, companies are forced to navigate a crowded landscape and increasingly compete with Dr. Google, Dr. TikTok, and their illustrious new colleague Dr. ChatGPT, further complicating the nascent, trust-building process needed to attain new patients.

On the employer side, the prior decade's enthusiasm for novel digital health solutions has waned. Human Resource (HR) leaders express point solution fatigue and face increased scrutiny over return on investment (ROI) and benefits fragmentation. Simultaneously, the era of per member per month (PMPM) deals is waning, replaced by a growing insistence on outcomes-based metrics, shared savings models, quality benchmarks, and medical trend control.

In this context, direct payor relationships offer compelling advantages. They can: expand the total addressable market (TAM) and unlock access to broader patient cohorts; permit patients to "use their insurance" and employers to leverage well-established, claims-based billing models; and provide a more predictable and sustainable revenue stream than consumer cash pay or employer contracting. However, navigating the payor landscape is far from straightforward.

There's an old saying that many venture capital investors love product innovation but hate business model innovation. Yet while pursuing the well-trodden business model path of payor reimbursement may unlock proven revenue, it is not without its strategic downsides. Furthermore, the path is littered with execution pitfalls and requires patience some investors may not have. It is therefore not the optimal strategy for all companies.

This guide is designed for founders, operators, and leaders at companies facing such a fork in the road: "How do you determine whether pursuing a payor go-to-market strategy is a good fit for your company, and if so—how do you get it done?"

Framework for Decision-Making

Here are five key questions to guide your internal decision-making:

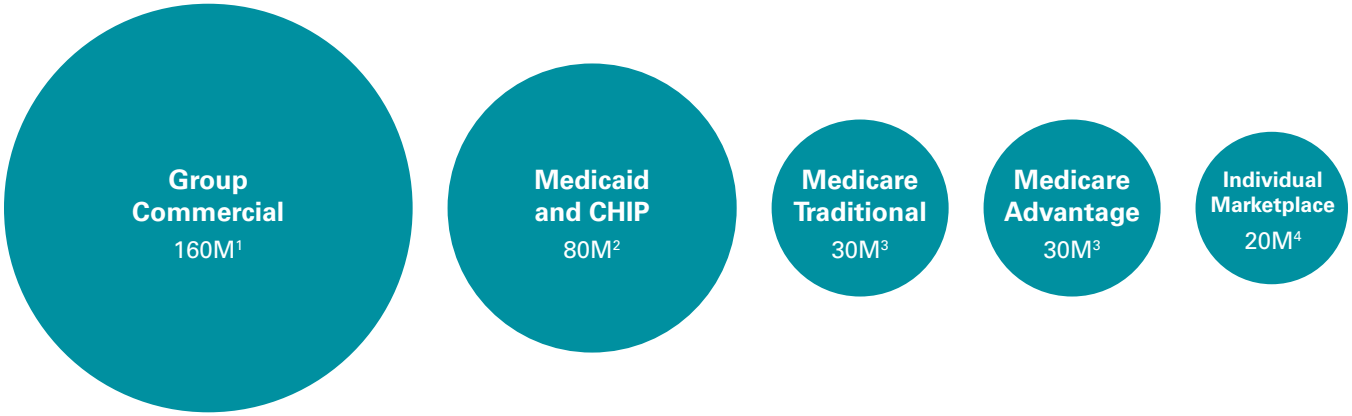
1	2	3	4	5
Is your offering a fit for reimbursement?	**Do you have the right provider types on your care team?**	**Are your operations payor ready?**	**Does the math work?**	**Is this the right time?**
• Are you delivering services that align with existing CPT/HCPCS codes (or services that could be modified to qualify)? • Do your services constitute medical spending that counts towards the numerator of the medical loss ratio (MLR)?	• Are your services delivered by licensed clinicians that can be credentialed with payors and/or meet other payor requirements (e.g., enrollment in Medicare or Medicaid fee-for-service (FFS))? If not, what adjustments would be necessary?	• Can you meet the documentation, billing, and compliance standards that payors require? • Can you bill electronically in a HIPAA-standard format? • Do you have, or are you willing to build, the technology and workflows to support this?	• Have you modeled out the revenue upside and compared it against the cost of implementation? This includes tech, licensing, legal structuring, revenue cycle management (RCM) infrastructure, and headcount.	• Even if the long-term strategy includes payor reimbursement, is now the right moment based on where your company is in its growth, fundraising, and/or product development journey?

2. Introduction to Payor Relations

For many emerging health care companies, payors can feel like a black box: complex, slow-moving, and difficult to engage. Understanding who they are, how they're structured, and how they operate is a crucial first step.

Understanding How Payors Are Organized

Most health insurers are organized by lines of business (LOBs); these are distinct segments that often correspond to different populations served, funding streams, and regulatory environments. They typically include:



- **Group Commercial Insurance:** Group coverage, most notably employer-sponsored, is typically divided into large group and small group markets, and frequently subdivided further based on group size. These plans may be fully-insured or self-insured, a common model whereby larger employers carry their own insurance risk.
- **Individual (Affordable Care Act or ACA) Markets:** Coverage purchased by individuals on- or off-exchange.
- **Medicare:** Primarily serving people over age 65 or with certain disabilities. Includes both traditional Medicare (financed and administered by the federal government) and Medicare Advantage (MA) plans (financed by the federal government and administered by private companies).
- **Medicaid:** Primarily serving low-income individuals, those needing long-term care, pregnant women and children (jointly financed by the federal and state governments, administered by the states), often administered through Medicaid Managed Care organizations (MCOs) (private companies under contract with the states).

Each of these LOBs operates under its own set of rules and has different priorities. For example, a payor's Medicaid team may prioritize local provider engagement and addressing social drivers of health, while their colleagues on the MA team focus on improving their Star ratings and accuracy of their risk adjustment activities. Employer plan sponsors may be focused on issues like talent acquisition and retention, productivity, and absenteeism in addition to health care cost and quality.

Within each LOB, payors manage a range of plan types that influence how care is accessed and reimbursed. For example, individual plans (like MA or those purchased through ACA exchanges) may differ significantly from group plans offered through employers in terms of benefit design, provider networks, and administrative requirements. Plans vary in their network models as well. For example, Health Maintenance Organizations (HMOs) typically require referrals from primary care providers to access specialty care and restrict care to in-network providers, versus Preferred Provider Organizations (PPOs), which offer greater provider choice flexibility but at higher cost. Finally, certain benefits are administered separately ("carved out") via contracts with third parties, which can introduce additional layers of complexity for companies offering therapeutics or digital health solutions. Notable examples of "carved out" benefits include pharmacy coverage, which is often administered by external pharmacy benefit managers (PBMs), and behavioral health coverage, which is often administered by a contracted behavioral health network manager.

Understanding Payment Models

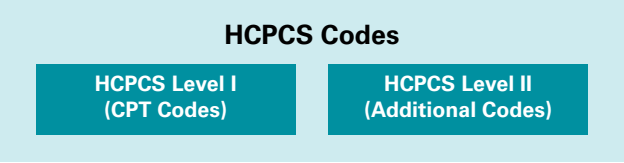
At a high level, health care services are reimbursed through one of two primary models:

- **FFS:** Health care service providers, such as clinicians or digital health companies, are paid for each service delivered. This remains the dominant model across most LOBs.
- **Alternative payment arrangements (APA):** This includes a spectrum of value-based care (VBC) models. At one end are partial and full capitation arrangements, which provide a fixed payment to providers to manage a population's care. More recent models include hybrid approaches—such as shared savings, shared risk, or bundled payments—that build on traditional FFS but incorporate VBC elements by tying reimbursement to cost, quality, or outcomes, often with both upside and downside financial risk.

Understanding Coding and Billing: The Language of Reimbursement

Coding: Medical coding exists to translate clinical diagnoses, procedures, and services into standardized codes that can be used for billing, reimbursement, and data management. Codes act as the lingua franca between providers and payors. Two of the most important systems are:

- **Current Procedural Terminology (CPT) Codes:**[5] Codes that aim to standardize the reporting of medical, surgical, and diagnostic procedures and services performed by healthcare providers. CPT codes are developed and maintained by the American Medical Association. There are different categories of CPT codes:
  - Category I: 5-digit numerical codes are the most commonly (the "main" CPT codes) used for billing and reimbursement. Codes range from 00100-99499 and are generally ordered into sub-categories based on procedure/service type and anatomy. For example, 99212 describes an established patient office or other outpatient visit, 10–19 minutes.
  - Category II: 5-digit alphanumeric codes are supplemental codes used for performance measurement. Using these codes is optional and not required for correct coding and reimbursement.
  - Category III: 5-digit alphanumeric codes which describe new or developing technology, procedures, and services. They were created for data collection, assessment, and in some instances, payment of new services and procedures that do not currently meet the criteria for a Category I code.
- **HCPCS (Healthcare Common Procedure Coding System) Codes:** A broad code set that includes all CPT codes and additional codes that describe non-physician services, medical equipment, and supplies. HCPCS Level II codes are maintained by CMS.[6]



  - Level I: Level I HCPCS codes are comprised of all CPT codes (see above).
  - Level II: 5-digital alphanumeric codes. Codes used primarily to identify products, supplies, and services not included in HCPCS Level I/CPT codes, such as ambulance services or durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office.

Other Important Terminology	
Diagnosis-Related Groups (DRGs)	DRGs represent the amount ("bundled payment") an inpatient hospital receives based on a patient's diagnoses, procedures, and comorbidities. Notably, hospitals do not directly bill using DRGs codes. Rather, a hospital submits claims using CPT, HCPCS, and/or ICD-10 codes, and the insurer (typically Medicare or a commercial insurer) assigns a DRG based on that information. This fixed payment per inpatient admission incentivizes cost-efficiency and provides payment predictability. DRGs are not used for outpatient services.
ICD-10-CM and ICD-10-PCS	ICD-10-CM refers to "Clinical Modification" codes, which are used to report diagnoses across inpatient, outpatient, emergency, office settings. ICD-10-PCS refers to "Procedure Coding System" codes, which are used to report procedures performed during inpatient hospital stays only. These codes are required on nearly all insurance claims to establish medical necessity, guide reimbursement, and support risk adjustment.

Billing: A healthcare claim is a request for payment, submitted by a provider to an insurance company for services rendered to a patient. Codes are a required data element of most types of claims, as they communicate which services were rendered to the patient and, therefore, how to reimburse the provider based on the terms of the payor-patient benefits/coverage and payor-provider reimbursement contracts. The overarching process of claims submission, processing, and subsequent monetary exchange is called the Revenue Cycle Process.

Even within an APA where reimbursement amounts may be untethered from specific codes, it is common for payors to request claims with codes be submitted. These "zero dollar" claims (sometimes called encounter data) power critical analytics and reporting capabilities across the revenue cycle and inform payors' clinical functions and business operations more broadly.

Assessing Your Organization's Fit for Payor Reimbursement

Before engaging with payors, it's critical to evaluate whether your organization is positioned to succeed under a reimbursement business model. The right fit depends on what you deliver, who delivers it, and how you operate.

- **What services do you provide?**
  - Reimbursement pathways are often more straightforward for services that are clinical in nature, especially those tied to well-established medical codes. Adjacent offerings that include chronic condition management, wraparound social services, or caregiver support, may also have established options for billing. Services that are more wellness oriented face steeper hurdles unless well aligned with emerging reimbursement trends or innovative contracting strategies. Non-clinical services typically cannot be reimbursed under a traditional insurance benefit; although, some specific exceptions exist (e.g., non-emergency medical transportation). Some of these may include "value-add" services like a patient portal or a concierge platform that could be attractive to payors considering an APA.

- **What types of providers are on your team?**
  - Reimbursement viability often depends on your clinical workforce. Licensed professionals (e.g., physicians, nurse practitioners, therapists, licensed clinical social workers) must typically deliver, through general or direct supervision, the services for them to be covered. Models that rely heavily on non-licensed roles (e.g., coaches or peer navigators), especially as a standalone service (e.g., not "incident-to" or under the supervision of a licensed physician, nurse practitioner or physician assistant), may require creative integration into a broader care model to unlock reimbursement.
- **What are your operational and data capabilities?**
  - Payors expect mature clinical operations capabilities from their provider partners. At a minimum, organizations should have:
    - **Medical documentation** that meets payors' standards for medical necessity and supports the claims submitted. This documentation needs to be able to withstand payor scrutiny through audits and utilization review, or you risk having payments denied or recouped.
    - **Structured data collection and reporting** that supports billing (including claims submission), clinical quality measurement, and regulatory requirements.
    - **Documented care protocols** that demonstrate consistency and clinical rigor and that the standard of care and/or applicable rules are complied with.

If these capabilities aren't yet in place, they can often be developed, but it's important to factor in the investment and change management required to do so.

What Are the Different Routes for Working With Payors?

Once an organization decides to explore payor reimbursement, one of the most important early decisions is how to engage. Broadly, there are two primary pathways that vary in terms of payment structure, implementation complexity, and strategic upside.

	Become an In-Network Provider	Establish a Strategic Partnership*
Description	The most common, and often most accessible, path for early or growth stage companies. Becoming a contracted provider allows your organization to submit claims directly to insurance companies for FFS or APA reimbursement.	Partnerships range from an APA pilot, to tech-enabled care management programs, or delegated services. These models go beyond traditional network contracting and may involve shared savings arrangements, care delivery in complex populations, or digital tools to augment existing programs. Payment terms are typically customized to the circumstances (and may also require an in-network provider agreement).

	Become an In-Network Provider	Establish a Strategic Partnership*
Pros	• Clear, established reimbursement structure • Can unlock coverage for broad population • Can be the quickest way to access payor reimbursement • Listed in the provider directory and network, improving visibility to patients • Lower costs to the patient	• Flexibility to innovate around care models and payment terms • Potential for larger, more strategic relationships • Opportunity to align incentives between payor and partner organization • Payor may be more likely to co-market or make your product/service known to its members
Cons	• Administrative burden due to contracting, credentialing, and billing infrastructure • Without scale, may be limited in rate negotiations • Reimbursement is limited to services with established codes • Rates can be low	• Highly variable structures with longer sales and negotiation cycles • Requires meaningful proof points or evidence-based ROI and more relationship-building to succeed • May still come with significant administrative burden (e.g., zero-dollar claims submission or other payor data feeds)

*Because there is so much variation in partnership approaches, it can be difficult to generalize. We therefore focus on in-network relationships throughout the remainder of this piece. Many companies choose to pursue network relationships as a stepping stone towards establishing more strategic partnerships.

3. How to Decide if This Is Right for You: Cost/Benefit Analysis of Network Relationships

Determining whether your organization should pursue payor network contracts requires a thoughtful cost-benefit analysis. While joining payor networks can unlock revenue and scale, it also introduces significant operational complexity, compliance obligations, and ongoing administrative overhead. These efforts can be fruitful or can be an enormous lift with limited upside—at worst, they can distract the entire organization from other critical milestones or current go-to-market approaches. This section helps break down what's required to navigate this decision.

Operational Considerations

Network relationships introduce a new layer of workflows and required infrastructure.

- **Process Changes:** Documentation must adhere to payor standards—including for staffing models—and clinical encounters must align with coded services. This often means tweaking the care model, tightening clinical workflows, adopting new protocols, and training teams on RCM (focused on both identifying underpayments, as well as overpayments), compliance requirements, documentation approach, and data submissions, among others.
- **Technology Needs:** At a minimum, you'll need systems like an EHR that support structured documentation, and a billing platform or RCM solution capable of submitting clean claims, managing the denial process, monitoring collections, and performing financial reconciliation.
- **Outsourcing Options:** Certain operational functions, such as RCM or credentialing work efforts, can be outsourced to specialized vendors; however, these add considerable vendor management responsibilities, external dependencies, and potential cost trade-offs. Many payors may prohibit offshoring.

Financial Considerations

A rigorous financial analysis should account for both the upside potential of reimbursement and the investment required to unlock it.

- **Potential Revenue:** Evaluating what codes your services may qualify for and what average or ranges of reimbursement rates look like will establish total upside. Rates for the same services can vary widely by LOB, payor, type of billing clinician, and geography. Some codes offer more meaningful margins while others may not be worth pursuing. Additionally, utilization assumptions and fit for specific populations will refine these analyses. Furthermore, a certain percent of claims may be denied by insurers, requiring offsets to one's revenue forecast.
- **Cost of Readiness:** Common investments include:
  - Modifying company structure, paired with requisite filings, to maintain compliance with many regulations related to the delivery of and billing for health care, including the prohibition on the corporate practice of medicine (CPOM) imposed by most states
  - Obtaining and maintaining each clinician's licenses in each state where their patients reside (particularly applicable for virtual care models)
  - Establishing payor contracting and clinician credentialing functions
  - Implementing an EHR and billing technology infrastructure
  - Accounting for hidden costs, such as clinical and administrative staff training, ongoing compliance, and audit readiness

More detailed information on these operational and financial considerations is described further below.

Identifying the Benefits: Navigating Reimbursement

Mapping Services to Existing Reimbursement Codes

The first order question to consider is: **What are we doing that maps to reimbursable services?** Many organizations provide care that may align with existing CPT or HCPCS codes, even if they haven't previously billed for it.

- **Direct Matches:** Services that have clear billing equivalents (e.g., psychotherapy, primary care visits, chronic care management activities).
- **Near Matches:** Services that may be billed with slight modifications to workflows or provider mix (e.g., incorporating licensed clinicians as supervisors or in direct care delivery where previously unlicensed care team members were providing otherwise billable services).
- **Outliers:** Services that currently fall outside the reimbursement framework and may require a longer-term approach (e.g., new code creation or APAs).

Evaluating Reimbursement Potential

Reimbursement varies widely across services, codes, and payor types. To understand upside, consider:

- **Revenue per Code:** What is the average reimbursement rate? Are there meaningful differences by LOB or geography?
- **Utilization Limitations:** Some codes may have frequency caps, restrictions on eligible populations, or utilization caps across providers. Will this constrain your upside?
- **Operational Tradeoffs:** How much would you need to modify your service delivery to align with coding and documentation requirements to unlock these reimbursement dollars? Does this impact your customer or patient value proposition? Will it degrade provider satisfaction?

In some cases, a service that appears reimbursable at first may require such extensive adaptation that it no longer fits your core model. Understanding this early can help avoid sunk cost.

The Policy and Regulatory Landscape: Risks and Opportunities

The reimbursement environment is shaped not only by payor preferences, but by the broader policy and regulatory context. For organizations building towards payor revenue, keeping a close eye on coding developments, CMS rulemaking, and evolving payor interpretations is critical to long-term success.

New opportunities regularly emerge through the creation or expansion of billing codes. For example, in recent years, CMS has introduced codes for services such as Advanced Primary Care Management; each new code opens the door for innovative care models to access reimbursement. In parallel, CPT updates have increasingly included digital health and care coordination services, reflecting the health care system's shift toward whole-person care and technology-enabled delivery.

But the landscape can shift quickly in the other direction as well. Codes can be revised, devalued, or even eliminated—particularly if payors perceive overutilization, limited impact on outcomes, or misalignment with benefit design. Companies built around a narrow set of billing codes—or a single CPT/HCPCS code—face significant risk if that code becomes restricted or removed.

To mitigate these risks, as feasible, emerging companies should:

- Preferentially rely on well-established codes.
- Diversify revenue streams through multiple offerings, thereby enabling billing with multiple codes.
- Engage policy stakeholders (e.g., trade associations, advocacy groups) to understand what policy and regulatory changes may lay on the horizon.
- Routinely research—and engage legal help as necessary—updates to CMS guidance, CPT changes, and Medicare and Medicaid policy developments to ensure service delivery and billing compliance
- Fully understand the requirements necessary to bill and remain compliant. For instance, do you need a certified EMR? Can your back office be outside of the US?

Examining Execution Perils: Building Toward Required Capabilities

Even with a clear and compelling reimbursement opportunity, execution challenges can make or break a payor network strategy. Success requires significant attention to legal structure, licensure, contracting, credentialing, technology, and operations. Below, we break down some of the most common hurdles and how to plan for them.

Corporate Practice of Medicine (CPOM)

Most states enforce CPOM restrictions that prohibit non-clinicians from directly employing or contracting with physicians. To navigate these regulations, companies often adopt structures that enable coordination between a Management Services Organization (MSO) with one or more physician-owned Professional Corporations (PC).

- CPOM laws vary widely by state and may apply to both in-person and virtual models.
- Multiple PCs will be needed to operate across 50 states.
- Several states are actively considering more stringent CPOM enforcement in response to increased private equity investment in health care.

Clinician Licensure

Most payors require that providers hold valid licenses in each state where patients are served, especially for virtual care delivery.

Other considerations:

- **Interstate Licensure Compacts:** These can streamline multistate practice for certain provider types but vary significantly by type of clinician.

- **Licensure Maintenance Requirements:** Obtaining a new state license can be a cumbersome and lengthy process and expensive process, yet maintaining it may be equally so—for example, many states maintain continuing medical education requirements.
- **Advanced Practice Provider (APP) Supervision Rules:** These vary by state and dictate requirements that permit NPs and PAs to operate more independently from clinical supervision. What type of supervision is required in a purely telehealth context has not been clearly addressed by many states.

Contracting and Credentialing

These two processes are essential for becoming an in-network provider. They can both take anywhere from 60–180 days or more and sometimes run in parallel. Until they are completed, billing cannot begin.

- **Contracting:** The legal agreement between a provider organization and a payor outlining reimbursement terms, claims submission protocols, quality measurement requirements, and more.
- **Credentialing:** The process of verifying individual clinician qualifications (licenses, education, malpractice history, etc.). This must be done for each clinician and repeated periodically.

Relationships Matter

Building key executive relationships can accelerate contracting and credentialing timelines significantly, and help flag you as a strategic partner rather than just another vendor application.

Operational Infrastructure

In order to be patient-ready and claims-ready, most organization must upgrade internal operations to meet compliance, documentation, and data-sharing standards.

- **Clinical Operations:** Establishing SOPs, quality assurance protocols, and appropriate staffing ratios for new patient volumes.
- **EHR and Documentation:** Documentation workflows must meet audit and utilization review criteria, and there may be additional requirements for interoperability.
- **RCM:** RCM technology and operations can be stood up internally, can be outsourced, or can be a mix of the two. Patient collection capabilities are often needed (e.g., copay collection) to complement payor-facing capabilities.

4. Final Thoughts

Payor relations can unlock durable revenue, improve access to patients, and establish long-term growth potential—but only for companies with the right services, infrastructure, and strategic alignment.

Payor strategies are powerful, but they're also high commitment. Success requires a clear value proposition and superb operational execution to meet all five questions outlined in the decision-making framework. For companies that do pursue this path, there is tremendous opportunity to scale impact, improve care access, and build a defensible business model.

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