Virtual Card Rails Beyond Claims: Where Healthcare Payments Actually Want to Be Automated

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Abstract

Virtual cards have penetrated healthcare through claim-based payments, but thi represents the most conservative and politically constrained insertion point avai The real opportunity lies in payment workflows where clinical regulation is abse multi-party reconciliation is manual, and treasury sophistication is low. This ana examines three higher-leverage domains: bundled episode payments with their inherent disaggregation complexity, post-acute and value-based care enablement where cash flow trumps unit economics, and employer-direct arrangements whe payers actively want intermediation. The thesis is that virtual cards become genu infrastructure rather than interchange arbitrage when inserted at points where payment logic itself creates switching costs. Bundled payment conveners, partici consulting firms that design episode models but don't control disbursement, represent an underexploited wedge into sticky, high-margin payment orchestrati

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Why Claims Are Actually the Wrong Reference Point

Optum runs virtual cards through claim payments because volume justifies the b and providers already expect remittance bundled with payment. The pitch is administrative simplification, which blunts pushback on interchange fees that w otherwise trigger provider revolts. But claims also come with baggage that caps economics and design flexibility. They’re price-regulated through fee schedules, audited by states and CMS, politically visible when margins look extractive, and deeply embedded in existing clearinghouse and remittance infrastructure that to decades to stabilize. The result is that virtual card penetration in claims looks m like a tax on existing rails than actual innovation in payment architecture.

The better hunting ground is off-claims entirely, where payments are operationa instead of clinical, margin opacity is higher, and nobody has entrenched opinion about how money should move. These are environments where cards can encode business logic instead of just replacing ACH. The pattern to look for is fragmen payables with weak treasury operations and tolerance for fees that stay invisible end buyers. Healthcare has more of this surface area than almost any other secto most of it sits outside the claim flow that gets all the attention.

Bundled Payments as Structural Card Territory

Bundled payments get talked about as a Medicare innovation play or risk-sharin mechanism, but they’re actually a structural opportunity for payment infrastruc because disaggregation is inherently painful. A typical episode bundle involves a single lump sum payment to a convener, which then has to split funds across the

hospital, multiple physician groups, anesthesia, post-acute facilities, durable me equipment suppliers, sometimes imaging or lab vendors, and occasionally home or rehab services. Each downstream participant has different contract terms, dif performance metrics, sometimes different risk arrangements. The disaggregatio process today is almost entirely manual, driven by spreadsheets and contract PD reconciled weeks or months after the episode closes, and paid out through a mix ACH transfers and actual paper checks in some markets.

Virtual cards let you collapse that entire operational mess into programmable payment logic. You can time-gate disbursements based on outcomes windows, li holding back surgeon bonuses until ninety-day readmission data clears. You can encode episode-specific rules directly into card controls, so post-acute payments release after acute discharge documentation hits the system. Remittance metada flows with the payment instead of requiring separate reconciliation, which matte enormously when you're splitting a single bundle check across eight different en with different EINs and different GL codes. And you can apply merchant fees pe downstream participant without the convener needing to negotiate or track thos costs separately. ACH cannot do any of this without custom middleware that somebody has to build and maintain, which is why most bundled payment progr still run on spreadsheets and monthly reconciliation calls.

The Hayes Opportunity and Convener Economics

Hayes Management Consulting sits in a weird but lucrative position in the bund ecosystem. They design the clinical pathways, define the gainsharing formulas, b the actuarial models that determine how much risk each party takes, and often manage the ongoing performance reporting. What they typically don't do is own actual payment rails. Money flows from the payer to some designated convener, t that convener manually distributes funds based on whatever contract Hayes help design. There's a gap between program design and payment execution, and that represents uncaptured economics.

A Hayes-anchored payment platform would look like this: Hayes or a joint ventu becomes the actual payment orchestrator, not just the consultant. Bundle funds into a controlled treasury account that Hayes operates. Downstream distributior happen via virtual cards issued directly to participating providers. Hayes earns t existing program fees for clinical design, but now also captures merchant proces fees on every disbursement, plus potential float value from timing differences be when the payer funds the bundle and when downstream participants get paid. T reframes Hayes from risk consultant to payments infrastructure with embedded clinical logic, which is a completely different business model with completely different margin potential.

Could they own the whole market? No, because bundled payments remain a sma fraction of total healthcare spend and the programs themselves are bespoke by d But they could absolutely dominate their existing client base because bundles ha massive switching costs once clinical workflows and contract terms get operationalized. Payment logic becomes tightly coupled to episode design, whicl means changing payment vendors requires renegotiating the entire bundle struc This looks more like vertical SaaS economics than fintech scale plays, but gross margins can hit seventy or eighty percent if the platform is the only thing that k how to execute the payment waterfall correctly.

Post-Acute: Better Margins, Less Politi Heat

Post-acute care is where bundled payment theory crashes into operational realit it's also where virtual cards have better product-market fit than anywhere else ir acute episode. Skilled nursing facilities, home health agencies, and rehab provid are fragmented, undercapitalized, running on thin margins, and almost universa bad at revenue cycle management. They get paid slowly, have limited access to working capital, and often lack the treasury infrastructure to optimize payment They'll accept interchange fees if it means getting paid faster with clear remitta because cash flow is worth more than rate optimization when you're operating o fifteen percent margins.

Use cases are straightforward but high-volume: per diem payments to SNFs that participate in bundled episodes, visit-based payments to home health agencies, episode-based disbursements to outpatient rehab facilities. The pain point isn't complexity of payment logic, it's speed and clarity. Most post-acute providers ar waiting thirty to sixty days for bundle reconciliation, then another two weeks fo settlement, then manually matching remittance advice to their billing system. V cards can cut that entire cycle to same-day settlement with embedded remittanc metadata, which is genuinely valuable to providers even after interchange.

This is arguably a better insertion point than acute bundles because acute hospi have leverage and sophistication. They can push back on interchange, they have treasury teams that optimize payment terms, and they're politically connected e to make noise if fees look extractive. Post-acute providers have none of those advantages, which makes them both more willing to accept cards and less able t extract concessions on pricing. The total addressable market is smaller than acu care, but margin realization is much higher and regulatory scrutiny is much low

Value-Based Care Platforms That Don't Want to Touch Money

The value-based care enablement layer is full of companies that are good at clini coordination or quality reporting but terrible at financial operations. These are management vendors that help primary care groups hit quality benchmarks, rem patient monitoring platforms that generate savings through hospital avoidance, quality reporting firms that manage HEDIS and Stars submissions, and various f of enablement software that coordinate MSSP or direct contracting arrangement They all have the same structural problem: they receive performance-based reve that's contingent on shared savings or quality bonuses, then have to distribute portions of that revenue to downstream provider groups based on contribution models nobody really agrees on.

Most of these vendors have no interest in becoming payment processors, but the up doing it anyway through manual ACH transfers and reconciliation spreadshe

because nobody else wants to own the problem. Virtual cards let them become tl financial hub without building actual treasury infrastructure. Funds flow into th platform, disbursements happen via virtual cards with embedded attribution log and the platform earns interchange while staying completely out of regulated cla flows. This is especially powerful in MSSP-adjacent programs where clinical ent want to participate in upside without becoming an ACO themselves, because the enablement vendor can own the money movement without touching clinical deci making.

The wedge here is that these platforms already own the reporting that determine gets paid what. Adding payment execution is a natural extension that generates economics without requiring the platform to take on balance sheet risk or regula burden. It's pure margin expansion on an existing customer relationship, which the opportunity keeps getting overlooked by fintech companies that want to buil horizontal payment rails instead of embedding into vertical workflows.

Employer-Direct and the Interchange Blindspot

Employer-direct contracting is the one corner of healthcare where buyers genuin do not care about interchange fees, which makes it nearly perfect territory for vi card insertion. When a self-insured employer contracts directly with a center of excellence for bariatric surgery or orthopedic bundles, the payment workflow in the employer or their TPA sending a lump sum for the case rate, then some intermediary managing execution and paying downstream providers. Speed and reporting matter, unit cost optimization does not, because the employer is alread getting a discount versus network rates and cares way more about predictability basis points on payment processing.

Virtual cards work in this context because employers want control and visibility want to avoid building payments infrastructure, and providers want fast settlem The employer doesn't see interchange as a cost because it's embedded in the pro fee, the TPA earns margin by offering a differentiated service, and the provider g

paid faster than they would through traditional claim cycles. Nobody in the transaction has an incentive to optimize away the card, which is completely diffe from payer-driven models where providers have enough volume to demand bette terms.

This is greenfield compared to traditional payer claims because the number of transactions is lower but the margin per transaction is higher, and there's no pol sensitivity around whether payment rails are extractive. Employer-direct is also growing faster than people realize, particularly in surgical bundles and specialty management, which means the TAM is expanding while legacy infrastructure is mostly absent. The challenge is distribution, because you need relationships wit benefits consultants and TPAs rather than provider networks, but the economics cleaner once you're in.

Patient-Mediated Payments With Embedded Controls

This one is more controversial but potentially higher margin: virtual cards issue patients for specific healthcare spending with encoded restrictions on what they buy. Fertility benefits are the clearest example, where employers or insurers prov fixed subsidy for IVF or egg freezing, and patients need to coordinate payments multiple providers for procedures, medications, monitoring, and lab work. The traditional model is reimbursement, where patients pay out of pocket and subm receipts, which is administratively painful and creates cash flow problems for pa who don't have the liquidity to float thousands of dollars.

Virtual cards solve this by giving the patient a spending instrument with embed controls: it only works at approved fertility clinics and pharmacies, it can have procedure-specific spending limits, it generates automatic documentation for th sponsor, and it completely eliminates reimbursement workflows. The same mode applies to specialty pharmacy copay assistance, travel and lodging benefits for ce of excellence programs, and various consumer-directed health benefits that emp are trying to offer without building claims infrastructure.

The economics here are interesting because patients don't push back on interch plan sponsors value fraud reduction over cost optimization, and providers are w to accept cards if it means guaranteed payment instead of chasing patient collec This is already happening in benefits administration tech, but healthcare-specifi players are underutilizing it because they're stuck thinking about cards as a replacement for claim payments rather than as a patient spending control mecha The regulatory question is whether these arrangements trigger any Medicaid or Medicare kickback concerns, which they generally don't as long as the benefit is structured as a plan feature rather than a provider inducement, but that require actual legal architecture.

What Actually Creates Moats in Healthcare Payment Rails

The strategic pattern across all these insertion points is that virtual cards work when payments are multi-party, logic is contractual rather than clinical, cash flo matters more than unit economics, and nobody wants to build the infrastructure themselves. Claims fail most of these tests, which is why Optum's implementatic looks more like interchange arbitrage than genuine platform defensibility. The p where cards actually create moats are where payment logic itself becomes the pr not just the rails.

Bundled payments have this property because the disaggregation rules are speci each episode design, which means switching payment vendors requires re-implementing business logic that's tightly coupled to clinical workflows. Post-ac has it because speed and clarity are worth more than rate optimization, which m providers will tolerate interchange to solve cash flow problems. Value-based car enablement has it because the platform already owns the performance reporting determines payments, so adding disbursement is margin expansion on an existin sticky relationship. Employer-direct has it because buyers don't care about interchange and want control more than cost reduction. Patient-mediated benef have it because spending controls are the actual product, not just a payment met

The common thread is that all of these are environments where somebody alread owns the relationship or the data or the contract structure that determines how money should move, but they don't own the actual money movement. That gap is where card economics hide best, because you're not competing on price, you're competing on whether the buyer wants to build the operational complexity themselves. In most cases they don't, which means the willingness to pay is high if the absolute dollar volume is lower than claims.

The next question is which actors in these spaces are positioned to own the episo the program but currently don't own the treasury function. Bundled payment conveners like Hayes are the obvious example, but there are equivalent players in every vertical: care management platforms in MSSP, benefits administrators in employer-direct, patient navigation companies in centers of excellence programs ones that figure out how to embed payment logic into their existing product will capture margin that currently leaks to generic ACH infrastructure or gets lost in manual reconciliation. The ones that don't will keep running on spreadsheets wh somebody else builds the rails underneath them.

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