Post-Contracting Operational Readiness for Virtual-First Care

Ensuring virtual-first care is integrated, discoverable, reimbursed, and delivering value across payer networks

Goal

Define and operationalize a common model for post-contracting operations so that virtual-first care providers are integrated, discoverable, and reimbursed across payer networks from day one.

Current state in the market

Commercial payers have expanded contracting with virtual-first care (V1C) providers across multiple specialties and are increasingly embedding these partnerships into product design, member experience, and value-based arrangements. In parallel, V1C companies have built scaled clinical models and secured national and regional payer contracts.

What has not kept pace is the operational infrastructure required to make those partnerships work in practice.

Across both payers and V1Cs, the same pattern is emerging. Contracts are signed, but the pathway from agreement to real-world care delivery is inconsistent and fragile. Provider data is not reliably integrated. Directory listings are incomplete or inaccurate. Ownership shifts across teams, and issues that arise post-contract are difficult to resolve. The result is a gap between what exists on paper and what patients can actually access.

Why it is not working yet

Signed contracts between V1C providers and commercial payers struggle to scale because of the operational gap between contract execution and real-world performance.

This gap is driven by:

- Closed or inconsistently managed network panels
- Incomplete or inaccurate provider directory integration
- Fragmented data submission and maintenance processes
- Shifting internal ownership across contracting, product, network, and IT teams

These breakdowns render V1C providers effectively invisible to patients and create avoidable friction in claims processing and reimbursement.

For payers, this results in member abrasion, compliance risk, and underperformance of virtual care investments. For V1Cs, it leads to delayed or lost revenue, increased administrative burden, and a slower path to scale.

What we are building to fix it

This is a solvable operational problem, and one that benefits from coordination across the ecosystem.

The Digital Medicine Society (DiMe) is uniquely positioned to lead this work. Through its Virtual-First Care Coalition, DiMe has already convened payers and virtual-first care providers to define how virtual care should be integrated into payer networks, producing practical resources that have accelerated contracting timelines by up to 18 months.

That work established a shared understanding of what “good” looks like in contracting. This effort focuses on delivering value from these contracts in practice.

DiMe is convening a highly curated, multi-stakeholder group of payers and V1C companies in a focused, three-month sprint to define and operationalize a common model for post-contracting operations.

OUTPUTS | The **Post-Contracting Operational Readiness Toolkit for Virtual-First Care** is a practical, implementation-focused resource designed to ensure that contracted V1C providers are fully integrated, discoverable, and reimbursable from day one.

The toolkit will provide a clear, cross-functional pathway from contract signature through first successful claim, mapping the systems, teams, and handoffs required to make virtual care operational in payer networks.

The toolkit will include:

- **Defined operational pathway**
  A step-by-step map from contract execution to first claim, including the systems involved, responsible teams, and the handoffs where breakdowns most often occur.

- **Minimum viable data and integration standard**
  A common data packet for onboarding V1C providers, with clear guidance on how information should be classified, mapped into payer systems, and maintained over time to support accurate directory listings and clean claims.
- **90-day operational readiness scorecard**
  A structured checklist that tracks required steps, assigns ownership across functions, and establishes validation checkpoints for directory accuracy, member access, and claims performance.
- **Set of common failure points and fixes**
  A concise set of the most frequent operational breakdowns, with root causes, observable symptoms, and practical mitigation strategies drawn from payer and provider experience.

Value and impact

This work is designed to deliver immediate, practical value to both payers and V1Cs.

For payers

Improved member access to contracted virtual care services

Reduced claims friction and administrative cost

Stronger compliance with provider directory requirements

Greater return on existing virtual care investments

For V1Cs

Faster and more predictable revenue realization from signed contracts

Increased visibility to eligible patient populations

Reduced operational burden and fewer payer-specific workarounds

More scalable payer integration across multiple markets

For the market

A shared, operational definition of readiness that reduces fragmentation

Greater alignment across payer-provider relationships

A clear pathway from contract to utilization at scale

Project structure

A focused, time-bound working effort designed for execution:

Duration: ~3.5 months (Summer 2026), with public launch at HLTH and DiMe's Healthcare 2030 Summit

Format: Monthly virtual working sessions + asynchronous review and input

Time commitment: ~3 hours per month

Participants:

- Commercial payers
- V1C providers across specialties
- Policy and regulatory advisors
- Led and co-ordinated by DiMe experts

This is a small, curated group designed to move quickly; participation will be limited.

Participation and investment

Participant Type	Organizational Profile	Participation Fee
V1C	>$100M revenue	$30,000
V1C	$25M–$100M revenue	$19,000
V1C	<$25M revenue	$8,000
Payer	National/regional plan	$5,000
Non-Paying	Federal observers, patient advocates	$0

A limited number of early payer participants may be invited as non-paying contributors.

In addition, DiMe offers leading partners in the field the opportunity to join us as **Title or Impact sponsors**. For example, the VA joined us as the Title Sponsor for *The Playbook:* Digital Healthcare, PHTI and ZS joined us as Title Sponsors for our Integrated Evidence Plans project, Boston Children's Hospital joined us as the Impact Sponsor of *The Playbook*: Pediatric Digital Medicine, and Google championed *The Playbook:* Implementing AI in Healthcare through title sponsorship.

Working with DiMe

DiMe brings together the organizations shaping the future of healthcare to solve problems that no single stakeholder can address alone.

Through initiatives like the Virtual-First Care Coalition, DiMe has demonstrated the ability to translate shared challenges into practical resources that are adopted across the market. The Coalition's payer-V1C contracting toolkit, for example, reduced time to contract for organizations using it by up to 18 months.

DiMe is also a trusted partner to federal agencies and industry leaders, including its role supporting the CMS ACCESS Model, and has a track record of delivering outputs that are both credible and used in practice.

Participation in DiMe projects provides:

- ✔ **Direct influence** on the standards and approaches that shape the market
- ✔ **Early access** to tools that can be implemented immediately
- ✔ **Visibility** as a leader in defining how healthcare is delivered in the digital era

DiMe's work is designed to move quickly, produce usable outputs, and drive adoption across the field.