13point1 Advisors
Trust. Clarity. Focus.

The Build-or-Buy Decision

Why the system, not the capability, is the unit of decision

Abstract

In 13point1's conversations with health plans through 2026, build-or-buy questions generally arise one capability at a time. Each decision answers the pain point in front of it, without a design for how the result will work with the capabilities around it. Payment integrity must be treated as an organizational mindset, with governance at its core. The first two papers in this series built that core in parts. *Impacting the Economics of Care* made the case for centralized governance. *The Aligned Core* argued that consolidating primary functions frees capacity to invest more deeply where depth creates value. When build-or-buy decisions are made one pain point at a time, system efficiency regresses with each step. Governance becomes fragmented across tools it is intended to direct. The core increasingly mirrors the stack it was designed to replace. This paper argues that the unit of the decision should be the system as a whole as opposed to the specific pain point. A cohesive system carries a function across the units it touches, so that what one unit learns reaches the next. Coordination of benefits, connected to post-pay review, is the clearest case. A plan can build such a system, buy it, or assemble it from a mix of sources. It cannot achieve maximum efficiency by evaluation of point solutions developed in silos. A plan that builds with a cohesive-system mindset and consolidated core can outperform one that uses a point solution approach. A plan that keeps deciding one pain point at a time carries the costs of fragmentation: governance complexity across solutions, a core that lacks scale, and signal that stops at each unit's boundary.

Framing: One Pain Point at a Time

Plans face real pressure to act while simultaneously navigating market consolidation. The Department of Justice reported False Claims Act settlements and judgments above $6.8 billion in fiscal year 2025, the highest annual total in the statute's history [1]. CMS-0057-F put prior-authorization decisions, denial-reason specificity, and public reporting onto dated compliance tracks [2]. The first cycle of public metrics arrived in 2026 [3]. The vendor market keeps consolidating. Cotiviti closed its acquisition of Edifecs in March 2025 [4]. Machinify closed its acquisition of Performant Healthcare in October 2025 [5]. In July 2026 Machinify added InformedDNA's genetic testing unit [6], two days before Lyric acquired Concert [7].

Under that pressure, the decision follows the structure of the budget. In 13point1's conversations with health plans through 2026, the question arrives one capability at a time: whether to build a coordination of benefits engine, whether to replace an editing tool, whether to add a clinical review vendor. That is how the work is funded and staffed. It is also where this paper starts.

Each decision is reasonable on its own terms. A coordination of benefits gap is real. So is the cost of an editing tool that has fallen behind the code set. The difficulty is the sum. A plan that answers each pain point separately ends with a set of capabilities that were never designed to work together, whichever of them it built and whichever it bought.

Impacting the Economics of Care argued that governance has to lead, so that investment compounds capability rather than fragmentation. *The Aligned Core* argued that consolidating onto a governable core frees capacity to invest deeply where depth creates value. Both arguments ultimately depend on the choices that follow. Build-or-buy translates a governance-led strategy into concrete choices. Each decision either reinforces the model or begins to fragment it.

I. What Point Solutions Produce

The 13point1 Reference Framework supplies the units this paper uses [8]. The Framework maps payment integrity within a broader cost containment model encompassing plan administration, pre-service controls, provider management, analytics, technology, policy, and governance. Payment integrity comprises ten units of execution: claim editing, code review, coordination of benefits, subrogation, clinical review, data mining, itemized bill review, credit balance, fraud, waste and abuse, and out-of-network repricing. The units hold throughout this paper.

A point solution is a capability designed primarily around one operational unit rather than around the full function that crosses multiple units. Without upstream integration, the point solution may correct that unit's output, but the signal that caused the error remains. A plan that adds a coordination of benefits engine in isolation coordinates coverage on the claims in front of it. When post-pay review identifies a claim that may have been paid under the wrong coverage order, it can correct that payment. If the underlying coverage information remains unchanged, the same issue can recur on the next claim.

The first cost falls on governance. Centralized governance decides what correct means and sets the policy every unit applies. Each point solution arrives with its own logic, its own configuration, and its own team or vendor. Governance must then manage each solution independently, translate the same intent across tools, and maintain each according to its own schedule. 13point1's inference is that governance thins as the stack grows. The plan still owns the decision about what correct means, but it loses the ability to apply that decision once across the system.

The second cost falls on the core. *The Aligned Core* identifies fourteen committed passes across the sequenced payment integrity service types a plan typically runs, compared with seven to thirteen vendors in most plan stacks [9]. A consolidated core narrows that gap. Adding point solutions one pain point at a time begins to reopen it. In a 2026 conversation with 13point1, one of the largest health plans reported that it needs to remove two vendors from its stack because it cannot staff oversight of its existing vendors.

The third cost is the signal between units. When units are built separately, a finding in one has no designed path to the others. Errors get corrected where they surface. The cause stays upstream, and

the same error returns on the next claim. Fragmentation also consumes capacity that can be redirected to program gaps. Targeted behavioral health and genetic testing payment integrity programs are aspirational functions within payment integrity that can be more broadly addressed through systemic approaches. A plan whose staff is absorbed by oversight of first-pass point solutions lacks the capacity to pursue either.

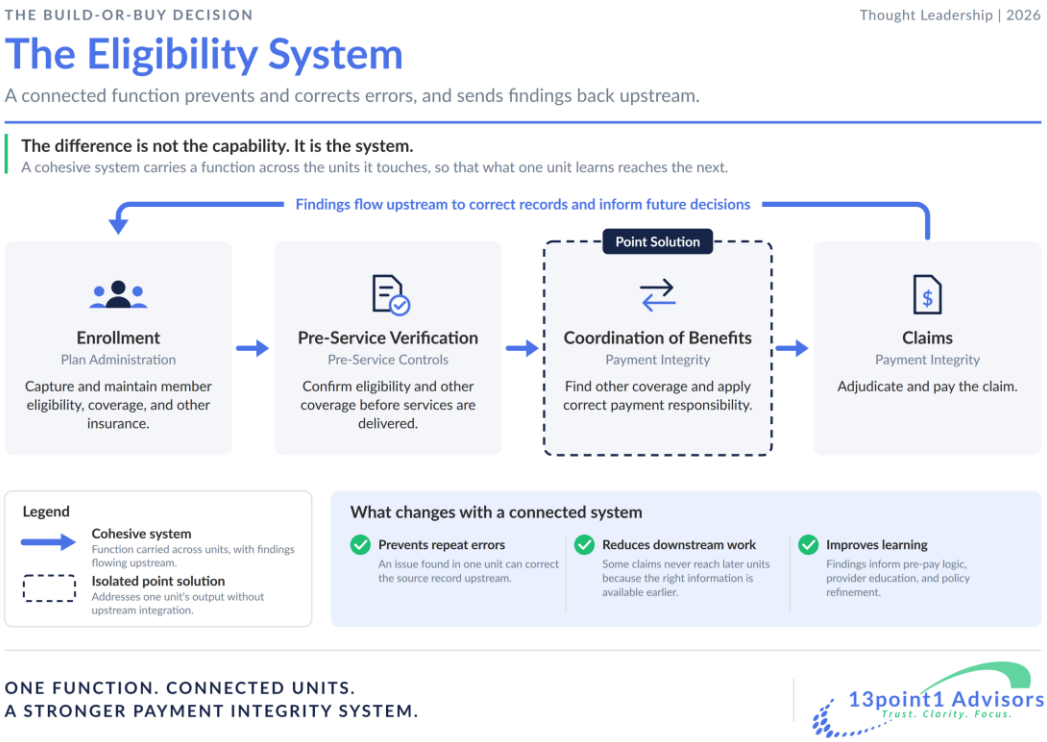
II. What a Cohesive System Is

A cohesive system follows a function across the units it touches. Coordination of benefits is the clearest example. Pre-pay coordination determines which coverage is primary before the claim is paid. Data mining can identify claims where the coverage order may have been wrong or where other coverage surfaced after payment. A plan that connects the two units lets each inform the other. The units remain the Framework's units. What changes is that they are designed to pass signals to one another.

Connection changes what the units can learn. In a cohesive system, an other-coverage finding from data mining can update the coverage information that pre-pay coordination relies on. The same logic applies between other units. A pattern identified in clinical review, for example, can inform upstream editing. Findings fed back upstream inform pre-pay logic, provider education, and policy refinement, which is the interlock *The Aligned Core* describes across the Framework [9]. A system designed this way can also decide, before payment, which unit a claim should reach first. Work that one unit would have completed downstream may then never be needed.

Governance sits at the center of such a system. It establishes the intent that governs every unit and defines how the units connect. That is why the mindset matters more than the sourcing. A cohesive system can be built, bought, or assembled from both, provided governance owns the design of the whole. Fragmented decisions carry costs of their own. A plan that builds with a cohesive-system mindset, with each part designed to carry signal to the next, can compete on that system.

A plan that decides one pain point at a time competes against organizations designing capabilities as parts of a connected system. Those costs, where they arise, are 13point1's inference from Section I: medical cost from errors caught late, provider abrasion from rework, and no capacity for the functions the market adds next.



III. What It Takes to Build a Cohesive System

A plan can build a cohesive system, and there are sound reasons to do so. The case for building begins with the advantages an internal build can provide.

III.A. The case for building.

Control comes first. A plan can modify an internally built capability on its own schedule, without waiting on a vendor roadmap or a renewal cycle. Fit comes second, because internal logic can be tuned to the plan's own policies, populations, and provider mix. Third is proximity to the data, and the reasonable belief that no outside party has the same depth of understanding of a plan's claims, history, and edge cases as the plan itself. Fourth is sunk infrastructure. A plan that already funded data platforms and analytics staff may reasonably expect the marginal cost of one more capability to be low.

Two further reasons come up less often in vendor conversations and, in 13point1's experience, can weigh as heavily in practice. Some plans build because a contract or a regulator limits what data may leave the enterprise. Others build because internal teams already exist and hold institutional knowledge. Scale lets a plan act on all of them.

Building a cohesive system, rather than a point solution, introduces two requirements that a build estimate may not fully account for: keeping every part current and seeing beyond the plan's own claims.

III.B. Maintenance.

A build estimate can price the build accurately and still understate what it costs to maintain. A payment integrity capability is never finished. As capabilities come together in a cohesive system, more components must be kept current. The first question to ask of each part is whether it rests on standards that every other plan also follows.

Editing logic is the clearest case. The National Correct Coding Initiative maintains a practitioner edit file of about 675,000 records, replaced quarterly, with out-of-cycle corrections in between [10]. The April 2026 update alone added more than 3,750 procedure-to-procedure pairs and deleted more than 4,800 [11]. Every state Medicaid program then customizes those edits on its own timeline [12], so a plan operating across states maintains several edit sets at once. Competing plans that edit against NCCI maintain the same national file. A plan that builds its own editing engine pays alone for work its competitors also pay for alone.

Models carry the same burden in a different form. A peer-reviewed study of 128 model-and-dataset combinations across four industries, healthcare operations among them, found temporal performance degradation in 91 percent of cases, even under minimal data drift [13]. Healthcare-specific work treats that drift as a governance and safety concern that needs continuous monitoring, retraining, recalibration, or retirement [14][15]. Each of those steps recurs.

The people who do the maintaining are scarce. Certified coding specialists command state-average salaries from about $50,000 to nearly $78,000, in a market projected to grow through 2034 [16][17]. Machine-learning talent is tighter. Mid-level total compensation runs $160,000 to $260,000, with staff-level packages above $500,000. Demand runs about three to one against supply. Healthcare is named as a sector with shortages and a half-year time-to-fill [18][19]. 13point1's internal tracking puts the population working in payment integrity, plan side and vendor side together, at several thousand nationally [20]. Beneath the people sits infrastructure that may not reach the first estimate: development tooling, training and inference compute, storage for claim histories deep enough to train on, and the security and audit controls that come with holding them.

Two features of that ledger outweigh any single line. The cost arrives first. A plan pays for the build, the staff, and the infrastructure before the capability returns a dollar. The cost also persists whatever the savings turn out to be, because the edit file changes every quarter whether or not the plan's findings rose. Plan-specific work raises the ledger further. Tailoring logic to one plan's policies, contracts, and provider mix costs more to build than adopting a tool written to a national standard, because every tailored rule has to be written, tested, and kept current by someone.

III.C. Visibility.

The second requirement is harder to meet with money. A plan that builds sees what its own claims show. Consider a plan based in Kentucky. A billing pattern emerging in Ohio, or nationally, may not reach its claims for months. The plan's own data cannot show the pattern until it arrives. A firm working across many plans may see it earlier.

Once a pattern emerges, the same limitation applies. If appeals begin to rise for a particular provider, a plan working from its own claims can measure the increase. But those claims alone cannot establish whether the pattern is confined to its book of business or is occurring across other payers at the

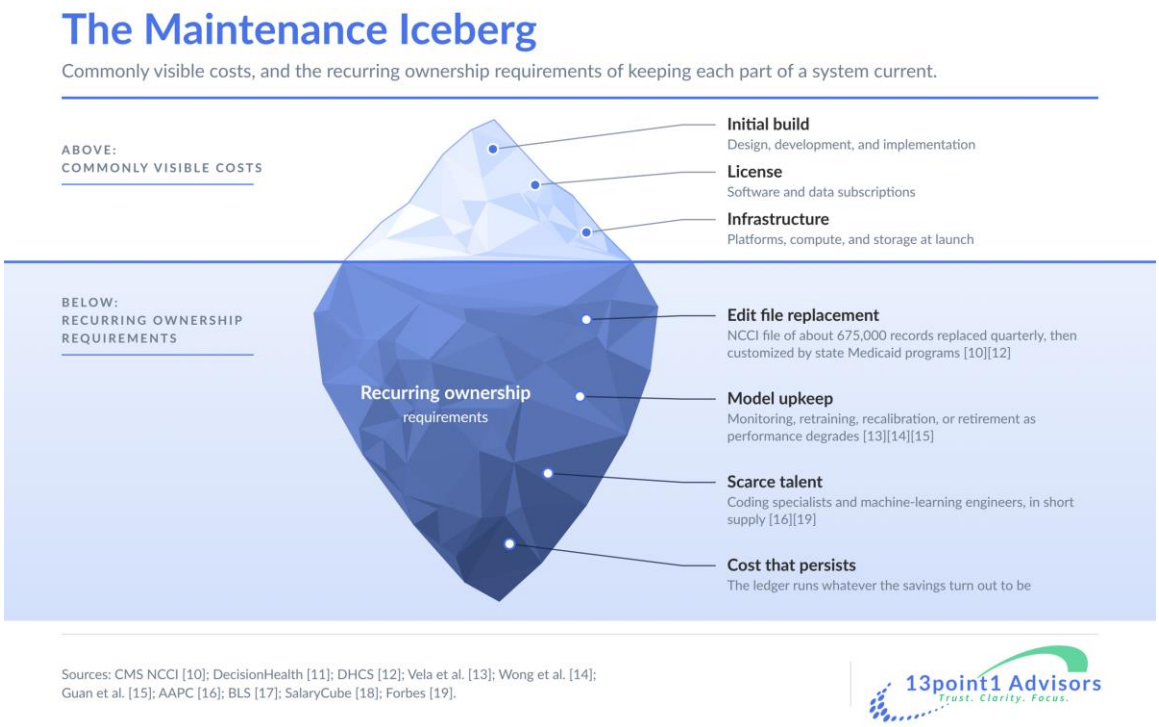
same time. That distinction matters because the two patterns call for different responses. One points to the plan's own policy or edit logic; the other points to the provider's billing practices across payers.

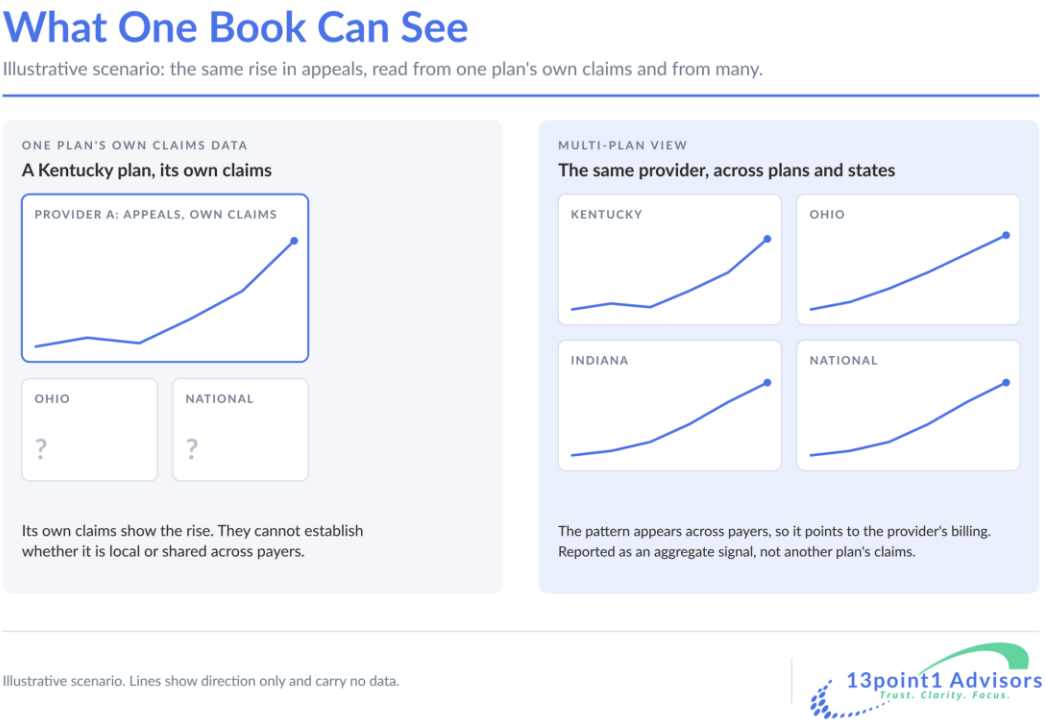
Federal agencies already act on this limit. The Healthcare Fraud Prevention Partnership, convened by CMS, brings together federal agencies, some forty private payers, states, and associations [21]. Its stated reason is that cross-payer analysis gives visibility beyond the payments any one payer issues. Its report to Congress names cross-payer analytics as the partnership's most valuable service to members [22]. When the government's answer to the limits of single-payer data is to pool it, 13point1 infers that a plan working from its own data alone starts from the disadvantage the pooling was built to overcome.

Visibility also sets a ceiling on learning. A plan's models learn from the plan's own claims, so every pattern they can find is a pattern already present in one book of business. More spending improves the build without widening what it can see.

Cross-payer visibility raises a fair objection. A plan that benefits from a firm's view across other plans will ask what happens to its own claims. Customer data should remain separate. Models can learn from patterns observed across clients without combining or disclosing one plan's claims to another. Agreements should make clear how customer data is separated, how derived signals may be used, and what limits govern use and retention. A plan should treat those terms the way it treats exit rights: negotiated at the outset, written down, and auditable. Held to that standard, the view is available without any plan giving up control of its own data.

None of this argues against building. It defines what a build has to carry if the result is to be a cohesive system and not another point solution.





IV. Who Builds Each Part

IV.A. Universal or plan-specific.

Every plan pays for what it builds against its own population, whatever it builds. That much is constant. What varies is how far each part of the system reaches. Some parts follow national standards and would work the same way at any plan, such as the coding edits described in Section III and the models that find billing patterns common across the market. Others are specific to one plan: its medical and payment policy, its benefit design, its provider contracts.

A universal part carries a fixed cost that is about the same whether it serves one plan or fifty. A plan that builds it divides that cost across its own book. A firm that builds it as its business divides the same cost across every client's volume. A larger plan can fund a larger build. It still divides by one book. Scale narrows the gap without closing it. It does nothing for the visibility limit in Section III.

Economists have studied this boundary for nearly a century. Coase argued that a firm expands only to the point where organizing an activity internally costs more than buying it in the market [23]. Williamson operationalized the boundary, with make-or-buy as its canonical case [24]. Quinn and Hilmer turned the logic into a rule: concentrate resources on the few competencies where the organization can achieve definable preeminence, and source the rest [25].

The payers best placed to build have acted on this logic with their own money. UnitedHealth bought the capability, acquiring the payment integrity firm Equian in 2019 [26]. Elevance reached a related conclusion from the other side. It treats payment integrity as a product its Carelon services segment

sells to other plans [27]. In 13point1's reading, what Elevance built is paid for across more lives than its own.

Plan-specific parts are natural candidates to build because they are unlikely to serve another plan. They also carry the highest build costs because they require the greatest investment to develop, integrate, and maintain. A firm that builds tailored logic as its profession may still build it more efficiently than a plan building it once. Under the right agreement, that firm also carries the cost of overruns and the cost of keeping the logic current. That efficiency is 13point1's inference. It will vary by firm and by part. Plan-specificity alone settles nothing.

IV.B. What a vendor agreement moves.

A build puts cost ahead of benefit, and the cost keeps running whatever the results. The build also carries execution risk. No clean published benchmark exists for the total cost of owning an in-house payment integrity build against buying it. This paper does not construct one. The nearest evidence is cross-industry. A study of more than 5,400 IT projects found that those above $15 million ran 45 percent over budget on average and returned 56 percent less value than predicted [28]. A separate analysis of 1,471 projects put the average overrun at 27 percent, with a fat tail: about one in six became a black swan, near 200 percent over cost and 70 percent over schedule [29]. Neither dataset measured what a payer build carries on top of that, which is regulatory change cadence, protected health information handling, and integration with a core administrative platform. Neither study establishes an overrun rate for payment integrity builds. What transfers is the shape of the tail.

Vendor agreements move some of that risk off the plan's books. How much it moves depends on how the agreement is structured. Under some contingency arrangements, where the vendor is paid a share of the savings it produces, the vendor assumes more of the upfront build and maintenance cost and receives payment as contracted results are realized. The plan may still carry implementation, integration, data, oversight, or minimum-fee costs. A fixed license with an implementation fee behaves much more like a build. The plan pays first and waits for the benefit. Whether maintenance risk moves depends on the contract terms. The structure of the agreement, and not the decision to buy, decides where the risk sits.

IV.C. Naming the return.

Either way, the return has to be defined. A bought capability is a delivered capability. Its return exists only when it is tied to a named, captured change: a budget line that moved, capacity redeployed to work that had been deferred, a leakage that stopped. That standard applies to purchased capability with the same force as to internal builds.

The pattern is visible in what payers make public. UnitedHealthcare states that its payment integrity initiatives are estimated to have generated about $1.5 billion in member cost-share savings in 2025 [30]. UnitedHealth's most recent annual report mentions its payment integrity tools in passing, with no investment figure attached [31]. In public reporting, the benefit gets a figure. The cost does not. In a build, the cost sits inside undifferentiated operating expense. In a purchase, it can sit inside a vendor contract. In both cases the savings claim floats free of the spend that produced it. The fix is the same for both: every claimed return names the budget it changed.

Each part of the system therefore gets two questions. Is the work universal or specific to this plan? Who is better placed to build it and carry its risk? The answers differ across parts and across plans, depending on scale, existing investment, and the shape of each domain. The Framework identifies the parts to be decided. The part-by-part answer is drawn plan by plan, against a design for the whole.



V. Governance at the Core

Certain layers remain the plan's responsibility, regardless of sourcing. Governance is first. The plan remains accountable for defining what correct means, establishing its risk posture, and setting expected outcomes within applicable regulatory, contractual, and coding requirements. Policy is second. The authorship and interpretation of medical policy, benefit design, and coverage positions is where a plan expresses its judgment. It is also the input every unit consumes. Data stewardship is third. The plan may delegate data processing, but it retains accountability for stewardship, access, permitted use, and the intelligence derived from its claims.

Decisioning sits across those layers. The distinction is worth stating precisely. The units should operate as one system instead of a collection of overlapping tools. The plan owns the decisioning intent: what the system must do, what it must expose, and who answers if it fails. The layer that carries that intent can be built or bought. Owning the intent is the governance act.

One firm has published its approach. Machinify's chief technology officer and chief product officer describe a strangler-fig pattern, in which the plan's transaction backbone remains the system of record while an AI-enabled decision layer grows around it and takes on categories as the plan is ready [32]. Its relevance here is narrower: a plan that has already built can keep what it built and move

toward a cohesive system at its own pace. The questions in Section IV apply to that choice like any other.

These are the layers where, in Quinn and Hilmer's terms, a plan can achieve definable preeminence [25]. They are what its scarce internal capacity should hold.

Conclusion: The System Is the Unit

Impacting the Economics of Care aligned governance. *The Aligned Core* consolidated the core. This paper argues that both hold only if the decisions that follow are made at the level of the system. A plan that decides one pain point at a time spends down the value of the first two steps, one capability at a time.

Plans that treat payment integrity as an organizational mindset will still build and they will still buy. They will do both against a design for the whole, with governance defining how the parts connect. Plans that keep answering each pain point on its own risk adding capability while losing coherence. The first group is better placed to preserve governance and connection as the system grows.

The instinct to control is right. Control comes from governance applied once, across a system built to carry it. A plan that organizes its build-or-buy decisions around that system has placed control in governance, where it can be applied across every part.

References

Numbered in order of first appearance. Reused sources keep their first-appearance number.

[1] U.S. Department of Justice, Office of Public Affairs. "False Claims Act Settlements and Judgments Exceed $6.8B in Fiscal Year 2025." Justice.gov, January 2026. https://www.justice.gov/opa/pr/false-claims-act-settlements-and-judgments-exceed-68b-fiscal-year-2025

[2] CMS. "CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F)." CMS.gov, January 17, 2024. https://www.cms.gov/initiatives/burden-reduction/overview/interoperability/policies-regulations/cms-interoperability-prior-authorization-final-rule-cms-0057-f

[3] Forvis Mazars. "CMS-0057-F: Using Public Payor Prior Authorization Data." August 18, 2026, reporting CY2025 plan disclosures aggregated by AuthDenied as of July 21, 2026. https://www.forvismazars.us/forsights/2026/08/cms-0057-f-using-public-payor-prior-authorization-data

[4] Cotiviti. "Cotiviti Completes Acquisition of Edifecs." Cotiviti.com, 2025. https://www.cotiviti.com/press-release/cotiviti-completes-acquisition-of-edifecs

[5] Machinify. "Machinify Completes Acquisition of Performant Healthcare, Accelerating Intelligent Healthcare Payments." Business Wire, October 2025. https://www.businesswire.com/news/home/20251021569768/en/

[6] Machinify. "Machinify Adds Genetic Testing Expertise to Its Comprehensive Payment Intelligence Platform." Business Wire, July 13, 2026. https://www.businesswire.com/news/home/20260713498521/en/

[7] Lyric. "Lyric Acquires Concert to Advance Healthcare Decision Intelligence and Expand the Lyric42 Platform." Business Wire, July 15, 2026. https://www.businesswire.com/news/home/20260715415003/en/

[8] 13point1 Advisors. "How We Work." 13point1advisors.com, 2026. https://www.13point1advisors.com/how-we-work

[9] 13point1 Advisors. "The Aligned Core: Governance, Architecture, and First-Time Accuracy." 2026. https://cdn.prod.website-files.com/69a888aa5ff7e53ae16db986/6ad4bcdd44dc7b2918b7139a_The_Aligned_Core_13p1_Oct2026.pdf

[10] CMS. "Medicare NCCI Procedure to Procedure (PTP) Edits." CMS.gov, 2026. https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-procedure-procedure-ptp-edits

[11] DecisionHealth. "Quarterly code edits are out: Check out April-effective NCCI updates." Part B News, 2026. https://pbn.decisionhealth.com/Blogs/DetailPrint.aspx?id=201149

[12] California Department of Health Care Services. "National Correct Coding Initiative Quarterly Update for April 2026." Medi-Cal News, 2026. https://mcweb.apps.prd.cammis.medi-cal.ca.gov/news/31896.17

[13] Vela, D., et al. "Temporal quality degradation in AI models." Scientific Reports (Nature), 2022. https://www.nature.com/articles/s41598-022-15245-z

[14] Wong, A., et al. "Understanding Model Drift and Its Impact on Health Care Policy." JAMA Health Forum, 2025. https://jamanetwork.com/journals/jama-health-forum/fullarticle/2837524

[15] Guan, H., et al. "Keeping Medical AI Healthy and Trustworthy: A Review of Detection and Correction Methods for System Degradation." arXiv, 2025. https://arxiv.org/html/2506.17442v1

[16] AAPC. "2026 Medical Coding and Billing Salary Report." AAPC, 2026. https://www.aapc.com/resources/medical-coding-salary-survey

[17] U.S. Bureau of Labor Statistics. "Medical Records Specialists." Occupational Outlook Handbook, BLS, 2025. https://www.bls.gov/ooh/healthcare/medical-records-and-health-information-technicians.htm

[18] SalaryCube. "How Much Do Machine Learning Engineers Make?" SalaryCube, 2026. https://www.salarycube.com/compensation/average-machine-learning-engineer-salary

[19] Forbes. "Compensation For AI Employees Is Skyrocketing." Forbes, 2026. https://www.forbes.com/sites/allbusiness/2026/01/07/compensation-for-ai-employees-is-skyrocketing/

[20] 13point1 Advisors. Proprietary payment integrity vendor and market tracking. 13point1advisors.com, 2026.

[21] CMS. "Healthcare Fraud Prevention Partnership: About the Partnership." CMS.gov, 2026. https://www.cms.gov/medicare/medicaid-coordination/healthcare-fraud-prevention-partnership/about

[22] CMS. "Healthcare Fraud Prevention Partnership Biennial Report to Congress, CY 2021-2022." CMS.gov, 2023. https://www.cms.gov/files/document/hfpprtc92023.pdf

[23] Coase, R.H. "The Nature of the Firm." Economica, Vol. 4, No. 16, 1937, pp. 386-405. https://onlinelibrary.wiley.com/doi/10.1111/j.1468-0335.1937.tb00002.x

[24] Williamson, O.E. "Transaction-Cost Economics: The Governance of Contractual Relations." Journal of Law and Economics, Vol. 22, No. 2, 1979, pp. 233-261.

[25] Quinn, J.B., and Hilmer, F.G. "Strategic Outsourcing." Sloan Management Review, Vol. 35, No. 4, Summer 1994, pp. 43-55. https://sloanreview.mit.edu/article/strategic-outsourcing/

[26] Fierce Healthcare. "UnitedHealth agrees to $3.2B deal to acquire payments firm Equian." Fierce Healthcare, 2019. https://www.fiercehealthcare.com/payer/unitedhealthcare-agrees-to-3-2b-deal-to-acquire-payments-firm-equian

[27] Elevance Health, Inc. "Form 10-K for Fiscal Year 2025." SEC EDGAR, 2026. https://www.sec.gov/Archives/edgar/data/1156039/000115603926000013/elv-20251231.htm

[28] Bloch, M., Blumberg, S., and Laartz, J. "Delivering large-scale IT projects on time, on budget, and on value." McKinsey and Company with the University of Oxford, 2012. https://www.mckinsey.com/capabilities/tech-and-ai/our-insights/delivering-large-scale-it-projects-on-time-on-budget-and-on-value

[29] Flyvbjerg, B., and Budzier, A. "Why Your IT Project May Be Riskier Than You Think." Harvard Business Review, Vol. 89, No. 9, September 2011, pp. 23-25. https://hbr.org/2011/09/why-your-it-project-may-be-riskier-than-you-think

[30] UnitedHealthcare. "Get the facts: What is payment integrity?" UHC Newsroom, 2025. https://www.uhc.com/news-articles/newsroom/payment-integrity

[31] UnitedHealth Group. "Form 10-K for Fiscal Year 2025." SEC EDGAR, 2026. https://www.sec.gov/Archives/edgar/data/731766/000073176626000062/unh-20251231.htm

[32] Ganesan, P., and Santhanam, S. "From Payment Integrity to Payment Intelligence: Six Shifts That Will Reshape Health Plan Payments in the Age of AI." Machinify, July 2026. https://www.machinify.com/resources/payment-integrity-to-payment-intelligence-six-shifts/