RIDGELINE PERSPECTIVES

# Your Contracting Department Deserves a Promotion

Kevin Sears, CEO and Founder, Ridgeline Health Group · November 2026

In March, your team closes a hard-fought renewal with a major commercial payer. The rate increase beats budget. Everyone moves on.

In May, someone keys the new terms into the billing system. One carve-out is entered incorrectly. Because the system now expects the wrong amount, the payer's underpayments match it exactly, and no variance report ever flags them. Two years later, the contract comes up for renewal and rolls over before anyone has modeled what it actually paid.

EXHIBIT 1

## Where negotiated value leaks before it becomes cash

Illustrative: each handoff between teams is a chance for value to disappear unnoticed




Source: Ridgeline Health Group. Illustrative.

None of this shows up as a failure. The negotiation was a success. The contract was signed. The money simply never arrived.

This is the most expensive problem in health system finance that rarely reaches the executive agenda. Commercial payer underpayments alone are commonly estimated at 1–3% of net revenue every year.[1] For a system with $3 billion in net patient revenue, every single percentage point of yield is worth roughly $30 million a year, a meaningful share of the operating margin at most systems.

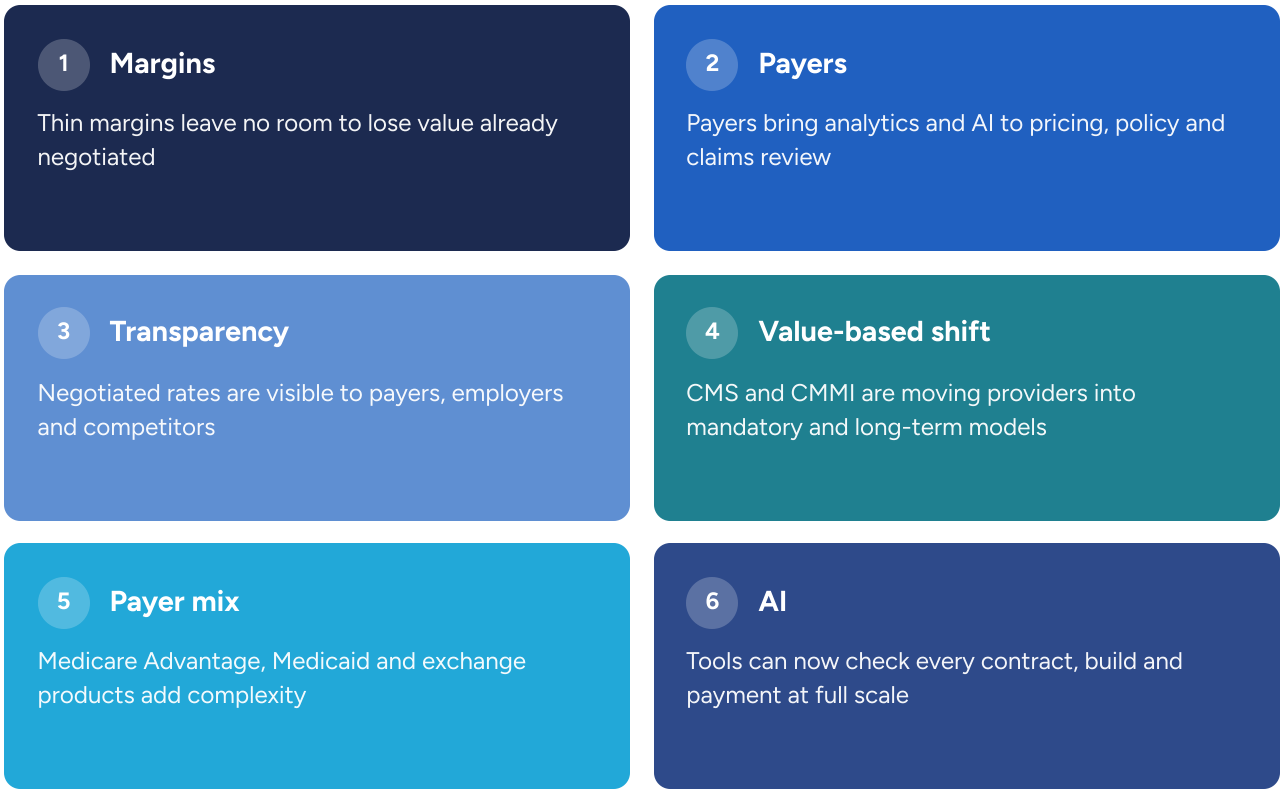
## Why this can no longer wait

Health systems have lived with the gap between negotiated and collected value for years. Six forces now make it too costly to ignore, and each one widens the distance between what a contracting department was built to do and what the function now requires to be successful.

EXHIBIT 2

### Six forces making the redesign urgent

Each one widens the gap between a contracting department and what the job now requires




Source: Ridgeline Health Group analysis.

1. **Margins leave no room for leakage.** Rate increases are harder to achieve, and operating margins remain thin. Collecting what has already been negotiated is the fastest, lowest-risk margin improvement available to most systems.
2. **Payers are better equipped than ever.** Payers bring advanced analytics and AI to pricing, payment policy, prior authorization and claims review. A health system that negotiates from spreadsheets starts every conversation at a disadvantage.
3. **Prices are no longer private.** Price-transparency rules for hospitals and health plans put negotiated rates in front of payers, employers and competitors.[2] Your market position is now visible to everyone at the table.
4. **Value-based care is moving from optional to expected.** CMS and its Innovation Center are steadily shifting hospitals and physicians toward accountability for both cost and quality. Since January 1, 2026,

the mandatory Transforming Episode Accountability Model has held selected hospitals responsible for the total cost and quality of five major surgical episodes,[3] and the new 10-year LEAD accountable care model begins in 2027.[4] Commercial and Medicare Advantage plans are moving in the same direction. Value-based terms, attribution and settlements now belong at the center of payer strategy, not in a separate program.

5. **The payer mix is shifting.** Medicare Advantage, Medicaid managed care and exchange products each bring different rules, risks and economics, adding complexity that a renewal-by-renewal approach cannot manage.
6. **The tools finally exist.** AI can now read contracts, verify billing builds and check every remittance at a cost that was out of reach a few years ago, and 80% of health systems are already exploring or using generative AI in the revenue cycle.[5] The organizations that redesign the function around these tools first will set the terms.

## The function that never got promoted

Payer relationships are under strain: 58% of hospital and health system leaders say payer relationships have deteriorated over the past three years; fewer than 10% say they have improved.[6] Yet most health systems still manage payer relationships through a contracting department designed for a simpler era: a small team, spreadsheets, success measured by signed contracts and rate-increase percentages, and handoffs to revenue cycle that no one owns. The department has not failed. It has simply never been given the scope, tools or authority the job now requires.

EXHIBIT 3

### Three numbers that frame the problem

**1–3%**

of net revenue is commonly estimated to be lost to commercial underpayments every year

**58%**

of hospital and health system leaders say payer relationships have deteriorated in three years

**26%**

of provider leaders track and model payer policy changes before they reduce payment

Sources: underpayment estimate [1]; leader survey [6]; policy tracking [7].

## Five shifts that separate best-in-class organizations

Across our work with health systems, leading organizations are transforming their contracting department into what we call a Payer Strategy & Performance function: an enterprise discipline accountable not for contracts signed, but for dollars collected and value created. Five shifts are at the heart of the redesign.

EXHIBIT 4

## Five shifts from contracting department to enterprise discipline

**1 Strategy**

FROM
A stack of individual contracts

↓

TO
A managed payer portfolio with a multi-year strategy

**2 Execution**

FROM
Contracts signed

↓

TO
Contracts loaded correctly and paid, every time

**3 Value-based care**

FROM
A side program

↓

TO
A core discipline, managed with clinical leaders

**4 Talent and AI**

FROM
More people doing manual work

↓

TO
Different people, with AI doing the volume

**5 Governance**

FROM
A department

↓

TO
An enterprise discipline with executive ownership

Source: Ridgeline Health Group, Payer Strategy & Performance Model.

## 1. Manage a portfolio, not a stack of contracts

Most systems negotiate one payer at a time, often on the payer's timetable. Best-in-class organizations work at two levels. A multi-year enterprise payer portfolio strategy sets the target payer and product mix, the role each payer plays, the direction on value-based care and the sequence of renewals. Individual payer strategies then translate that direction into a negotiation strategy for each payer: what the system wants from the relationship, where it has leverage, what it is prepared to trade and how it will sequence the conversation. Each is approved 12–18 months before the contract expires, so the negotiating team goes in with a clear mandate.

EXHIBIT 5

### Two levels of payer strategy

The portfolio sets direction; each payer strategy executes it; results feed the next refresh

**Enterprise payer portfolio strategy**

Whole portfolio · 3–5 years · approved by executives, reviewed by the board
Target payer and product mix · role of each payer · value-based direction · renewal sequencing

**Individual payer strategies**

One per major payer · set a year before the contract expires
Relationship goals · negotiation strategy · priorities and trade-offs · leverage

**Negotiation plan**

One per renewal
Targets, asks and the mandate the negotiating team works within

**What is actually collected and earned informs the next refresh**

Source: Ridgeline Health Group, Payer Strategy & Performance Model.

Without the portfolio view, individual negotiations can work against each other: pushing rate increases on several payers in the same year, or driving employers toward lower-paying products. The leading health systems now manage their payers exactly this way: as a strategic portfolio, not a pricing lever.

## 2. Measure success by what is collected, not what is signed

The largest source of chronic underpayment is rarely a weak negotiation. It is the gap between what the signed contract says and what gets configured into the billing system. Contract terms live in one place, negotiated rates in another and the billing system holds a third copy, keyed by hand.

Leading systems treat contract to cash as one continuous lifecycle built on one structured contract record that every team reads from: contracting, revenue cycle, legal and finance. Every new rate is verified against the signed contract before it goes live. Every remittance is compared with what was owed. Underpayment trends flow back to the people who negotiate. And payer policy changes, which quietly reduce payment within existing contracts, are assessed for dollar impact within weeks, not discovered through denials. Only 26% of provider leaders say they track and model those changes proactively today.[7]

> **A rate you negotiate but never collect is not a win. It is a loss you have not found yet.**

## 3. Make value-based performance a core discipline

Value-based contracts carry shared savings, quality incentives and, increasingly, downside risk. Yet in many systems the terms are accepted as offered and settlements are accepted as reported. Best-in-class organizations design value-based terms together with their population health leaders, reconcile attribution every month and reconcile every settlement. A settlement error of even 1–2% can be worth more than the analyst who would have caught it.

## 4. Let AI change the shape of the team

AI can now read contracts, convert terms into pricing logic, verify billing builds and compare every remittance with expected payment at a scale no team can match. The organizations getting the most from it are not simply cutting staff. They are changing the mix: fewer people keying terms and testing samples by hand; more people modeling scenarios, managing payer relationships and earning value-based results; and a new role that owns the contract platform and the accuracy of what it produces.

Readiness is the constraint. Only about half of finance and revenue cycle leaders describe their teams as prepared for the revenue cycle of the future.[8] The precondition is not a better algorithm; it is structured contract data, clean integration with the billing system and clear rules for which decisions always stay with people.

## 5. Govern it as an enterprise discipline

Payer decisions now shape growth, capital plans, physician economics and community access. Leading systems give one executive ownership of the payer portfolio and of the path from contract to cash, and they make payer decisions through a standing executive council, typically chaired by the CFO, with revenue cycle,

legal, strategy, operations and clinical leaders at the table. The board reviews the payer portfolio at least twice a year, not only when a dispute reaches the local news.

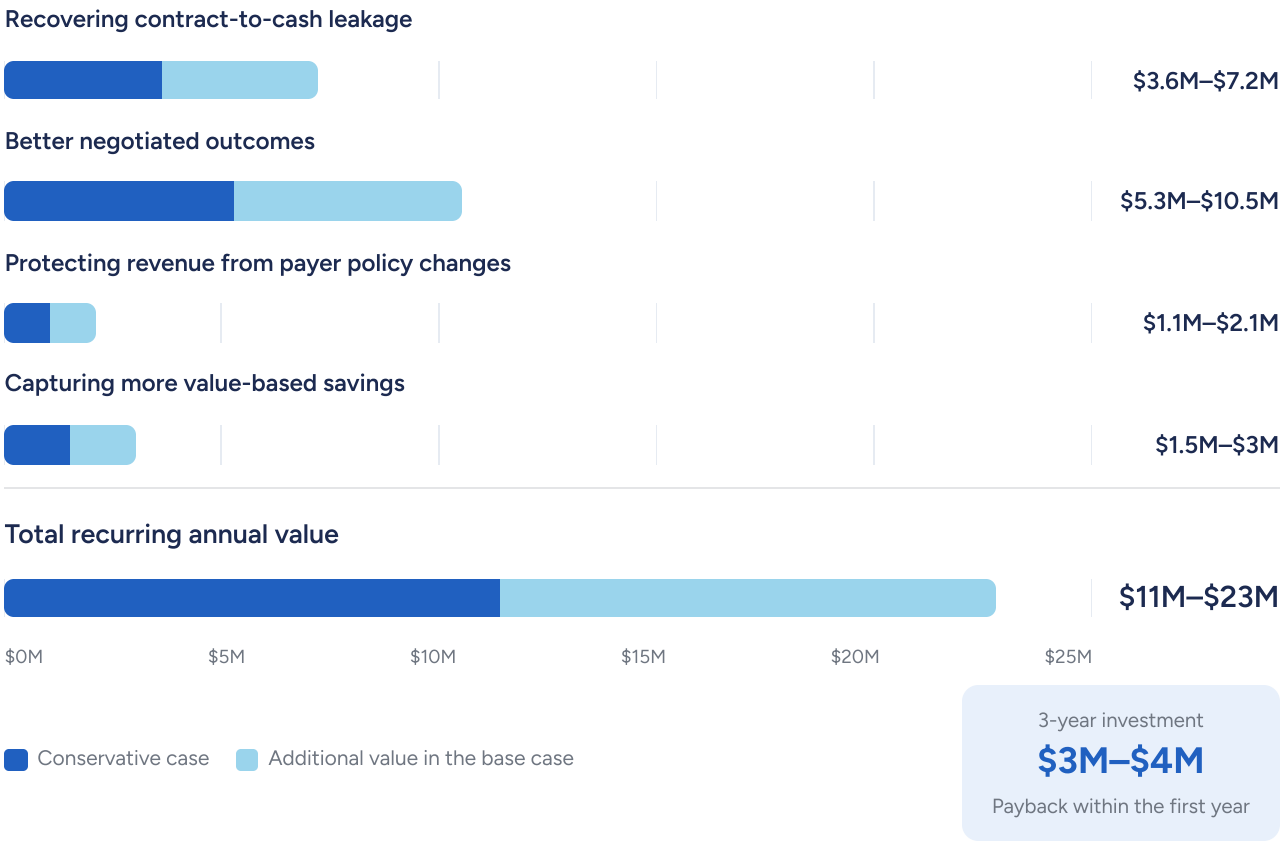
## What it is worth

The investment is small relative to the revenue this function manages. For an illustrative regional system with $3 billion in net patient revenue, Ridgeline estimates the recurring annual value of moving to a best-in-class operating model at roughly $11 million to $23 million once fully in place. This value derives from four sources: recovering contract-to-cash leakage, better negotiated outcomes, protecting revenue from payer policy changes and capturing more value-based savings. The three-year investment in platform, implementation and change is typically $3 million to $4 million, and in most cases it pays back within the first year.[9]

EXHIBIT 6

### What a best-in-class function is worth

Illustrative regional system, $3 billion net patient revenue: recurring annual value once fully in place




Source: Ridgeline Health Group working estimates; illustrative system with $3 billion in net patient revenue. [9]

Your number depends on where you start. A system that already verifies every rate load will find less there; one that keys terms by hand will find more. That is exactly what the self-assessment is designed to show.

## Build on the team you already have

The people who run payer contracting today are the foundation of this redesign. In most systems, they have delivered strong results with the scope, tools and structure the function was originally given. They know the payers, the contracts and where value slips away better than anyone in the organization.

A Payer Strategy & Performance function builds on that expertise. It gives the team a broader mandate, better tools and a direct line to the executive table, so its knowledge shapes enterprise decisions rather than individual renewals. The most successful redesigns we see are shaped together with these leaders, not around them.

## Five questions for your next executive meeting

1. How do this year's major renewals fit together, and where is that written down?
2. How many days does it take from signing a contract to being paid correctly under it?
3. How do we know our negotiated rates are loaded correctly, and how often do we check?
4. How quickly do we assess the dollar impact of a payer policy change?
5. Who owns the handoffs between contracting, revenue cycle, legal and finance, and where do they meet?

**If the answers are uncertain, the opportunity is probably larger than you think.**

## Where to start

Redesigning the function is a 12–24 month journey, but the first steps can begin this quarter.

### In the next 90 days

1. **Find out where you stand.** Assess your maturity across strategy, contract to cash, payer relationships, value-based performance and governance, and size the value at stake with your own data.

2. **Name one executive owner and an executive council.** Give one leader accountability for the payer portfolio and contract to cash, and stand up a CFO-chaired council to make payer decisions across the enterprise.
3. **Capture a quick win.** Test whether your billing system's builds reproduce what your largest contracts require. The findings usually fund the next steps.

**Over the next 12–24 months**

1. Set the enterprise payer portfolio strategy, then approve individual payer strategies a year ahead of each major renewal.
2. Redesign the organization: payer-portfolio leaders up front, shared contract intelligence and operations behind them, a staffed value-based team, and roles designed around AI.
3. Build on one structured contract record and the tools that let the team model, verify and monitor every contract at full scale.

## The promotion is overdue

Go back to that renewal signed in March. In a best-in-class organization, it would have begun a year earlier as one deliberate move in a portfolio strategy the executive team had approved. The negotiating team would have gone in with a clear strategy and mandate, and every term would have been modeled claim by claim before anyone signed. The new rates would have been verified against the contract before they went live, and every payment since would have been checked against what was owed. When the payer changed a policy, someone would have priced the impact within weeks. And when the contract came up for renewal again, the team would have walked in knowing exactly what it had collected and what the relationship was worth.

None of that requires heroics. It requires a different design: a function built for the enterprise, organized around the payer portfolio, running on one structured contract record, equipped with AI and governed from the executive table.

The next decade will test every health system's payer relationships: thinner margins, better-equipped payers, public prices, a shifting payer mix and a federal push toward value-based care that is no longer optional. The organizations that thrive will be the ones that manage those relationships with the same discipline they bring to capital, quality and growth.

> **Payer relationships are now among the most valuable assets a health system has. Giving the function that manages them an enterprise mandate may be one of the highest-return decisions your leadership team makes this year.**

ABOUT THE AUTHOR

## Kevin Sears

CEO and Founder of Ridgeline Health Group. He has led payer strategy and managed care from both sides of the table, in executive roles at Cleveland Clinic, Trinity Health, Intermountain Health, Coventry Health Care and Centene.

ABOUT RIDGELINE HEALTH GROUP

## Provider and payer strategy, only

A healthcare strategy firm focused exclusively on the relationship between providers and payers. We help health systems align payer strategy with enterprise goals, negotiate sustainable partnerships, select and implement contract technology, and verify that contracts are built and paid the way they were negotiated.

## Notes

1. Ridgeline Health Group, *The Contract-to-Cash Gap* (November 2026), citing industry analyses reported by Becker's Hospital Review. The estimate reflects commercial payer underpayments from all causes.
2. Centers for Medicare & Medicaid Services, Hospital Price Transparency requirements (updated for CY 2026) and Transparency in Coverage Final Rules (CMS-9882-F, October 2026). cms.gov
3. Centers for Medicare & Medicaid Services, "TEAM (Transforming Episode Accountability Model)," CMS Innovation Center. cms.gov
4. Centers for Medicare & Medicaid Services, "Innovation Insight: CMS Invites ACOs to Apply to the New LEAD Model" (March 31, 2026). cms.gov
5. HFMA Pulse Survey commissioned by AKASA (519 CFOs and revenue cycle leaders, April 2025), as reported by Fierce Healthcare. fiercehealthcare.com

6. HFMA survey of more than 200 hospital and health system leaders, sponsored by R1, as reported in “Payer Tactics Are Escalating and Providers Are Sounding Off,” R1 (March 4, 2026). r1rcm.com
7. “Contract Modeling: You Can’t Recover What You Can’t Price,” Becker’s Hospital Review (October 28, 2026), citing a 2026 HFMA and Trek Health survey of 161 provider leaders. beckershospitalreview.com
8. HFMA, *The Revenue Cycle of the Future* (April 2026), reporting a February 2026 survey of 95 finance and revenue cycle leaders. hfma.org
9. Ridgeline Health Group, ***Payer Strategy & Performance Model for Health Systems*** (2026). Illustrative estimates for a regional system with $3B in net patient revenue, using conservative and base-case assumptions; actual results depend on each organization’s starting point.