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No margin for error: The managed care playbook is resetting

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The healthcare industry is in a period of profound disruption. Legislative, regulatory, and market pressures are converging on health systems with unprecedented force. As cost inflation persists and reimbursement deteriorates across payer classes, health systems find themselves operating in a fundamentally different financial environment.

At the same time, health plans are contending with their own budgetary constraints—driving a wave of contract terminations, narrow network strategies, and aggressive rate stances.

In this context, managed care contracting is no longer simply an administrative function. It is a strategic lever that, if positioned thoughtfully, can help health systems protect and grow margin in the face of structural challenges. While it's not the only answer, it's part of a multifaceted approach as health systems address converging headwinds. A thoughtful managed care strategy is more important today than ever.

Cascading market and regulatory pressures are reducing health system revenues

A thoughtful and effective managed care strategy has always been critical to health systems' growth and financial performance, but cascading external pressures magnify the need for a different and more comprehensive approach.

Medicaid volumes and reimbursement will erode through the OBBBA, Medicaid eligibility changes, and DSH risk

The One Big Beautiful Bill Act (OBBBA) introduces sweeping Medicaid reforms that will reshape health system payer mix and reimbursement eligibility. Among its key provisions are eligibility requirements (work reporting, semiannual eligibility renewals, and restrictions on non-citizen eligibility). These provisions are projected to result in the loss of coverage for up to 8 million individuals over the next decade.

The implications are immediate and severe: Patients will lose access to covered care, and Medicaid volumes will decline, particularly for adult populations. As fewer of these patients access early interventions, uncompensated care will rise—especially in emergency department (ED) and inpatient settings where hospitals have limited ability to manage care.

Disproportionate share hospital (DSH) eligibility also will be threatened, as the calculation for Medicaid DSH payments is tied to the proportion of Medicaid and low-income utilization. The provider tax cap will further challenge overall reimbursement as states receive reduced funding from the federal government.

CMS fee schedule proposals will challenge specialty margins

The Centers for Medicare & Medicaid Services' (CMS) CY2026 Physician Fee Schedule proposes changes that will materially reduce reimbursement to specialist-driven service lines, starting with a -2.5% efficiency adjustment. CMS is implementing a work relative value unit (wRVU) adjustment to non-time-based services, with the stated intent of reflecting productivity improvements. The adjustment targets procedural specialties such as radiology, surgery, and cardiology.

In contrast, CMS will increase rates for providers in Advanced Alternative Payment Models (APMs) by +3.8% (versus +3.3% for all other providers), further widening the funding gap between value-based and procedural reimbursement pathways. While this could benefit some health systems, it redistributes payments and creates aggregate revenue risk.

Finally, CMS has explicitly stated its broader intent to reevaluate the RVU-based payment system, citing concerns over procedural volume incentives. Early proposals suggest a shift to time- and resource-based valuation models, which could dramatically alter productivity metrics, contract rate setting, and physician compensation structures.

As a result, health systems that rely on specialty-driven service lines will experience immediate margin erosion and may proactively seek commercial offsets. The growing disparity between primary and specialty reimbursement also complicates internal provider alignment and long-term service line investment strategies.

Commercial health plan terminations and pricing aggression create more risk

In response to rising medical loss ratios (MLRs) due to fast-growing drug spend and higher member acuity, health plans are using aggressive contracting strategies. Health plans are increasingly willing to drop major provider partners if employers or members are unlikely to switch coverage as a result. With that, health plans are making “rate reset” demands. Some health plans are seeking across-the-board rate reductions or growth caps, citing affordability mandates. Headlines are replete with major network terminations, many between national health plans and large health systems.

These tactics create downward rate pressure and result in immediate revenue risk from reduced reimbursements, patient leakage, and long-term damage to referral networks.

Site-neutral payment expansion and 340B risks further threaten major sources of hospital revenue

In its CY 2026 Hospital Outpatient Prospective Payment System proposed rule, CMS is advancing site-neutral payment policy by targeting drug administration services in off-campus provider-based departments. These services would now be reimbursed at the lower Medicare Physician Fee Schedule rate rather than the traditionally higher Hospital Outpatient Prospective Payment System rate. This policy shift reflects a broader bipartisan push—echoed by MedPAC—to eliminate payment differentials between hospital and non-hospital settings for equivalent services.

The financial implications are significant. Under the proposed rule, health systems would lose higher-margin revenue from outpatient infusion centers and related service lines. This change pressures health systems to re-evaluate service line strategies and capital deployment assumptions. In addition, should this rule come to pass, it will likely be the first of many attempts to reduce profitable services from health systems. This will also influence managed care decision-making as private health plans will likely follow suit with CMS policy.

Compounding this risk is a growing opposition to 340B reimbursement. Although recent court decisions restored certain 340B reimbursement streams, the program remains under siege. Drug manufacturers have restricted discounts to contract pharmacies, threatening a key margin source for qualifying hospitals. Regulatory uncertainty and opposition from the pharmaceutical lobby continue to cloud the long-term reliability of the margin-sustaining program.

How a new managed care strategy can help mitigate the impact of these inexorable risks

In the face of these pressures, health systems must both reduce operating costs and evolve their revenue strategies. While operational efficiency is critical, focusing on managed care strategy provides a high-leverage opportunity to defend and expand margin. Three principles are key to success:

1. Treat managed care as a strategic portfolio—not just a pricing lever

Health systems should be cautious about over-relying on commercial rate increases to offset margin pressure. Even more so, they should be wary of approaching rate negotiations transactionally and using the same strategy for each. Simply applying aggressive pricing tactics across the board will rarely optimize negotiated results. It also risks health plan exits and pushes employers toward lower-cost, lower-reimbursement alternatives, like health reimbursement arrangements (IHRAs), reference-based pricing, and ACA exchange products.

Instead, health systems should treat managed care as a strategic portfolio. This means being selective about with whom, when, in what sequence, and how to pursue rate increases. It also means considering health plan financial and enrollment stability, employer retention, and patient access.

Health systems need to build payer portfolio strategies that extend across multiple health plans and contracting cycles—deciding not just how much to raise rates but also when and with which health plans to increase and protect long-term enterprise value. Done well, this approach will produce more effective negotiation strategies, better relationships, improved rates, and stronger overall value exchange across the range of health plans with which they work.

2. Focus negotiations on mutual value

Not all health plans are created equal. Some drive more volume, align more closely with system strategy, or offer more stability. Others are deprioritizing markets or exiting product lines.

Health systems should segment health plans using criteria like network overlap, product line profitability, growth alignment, and regulatory exposure (e.g., ACA exchange or Medicare Advantage). Health systems should stage negotiations accordingly—anchoring them in shared goals that build mutual value for the health system, health plan, and patients.

To succeed, organizations must shift from transactional rate-focused talks to strategic, relationship-based dialogues. Often, the most productive conversations happen outside formal negotiations, when health systems and health plans can explore ideas like administrative simplification, access enhancements, or actuarial alignment in a lower-stakes setting.

3. Audit and realign value-based contracts to drive margin

Many health systems embraced value-based models over the past decade—but few have realized their full potential. In today's margin-constrained environment, it's critical to assess whether these contracts are delivering sufficient upside—or eroding profitable fee for service volume.

Start with a clinical and financial audit of risk-based arrangements. Identify where models are underperforming and why. Prioritize actions that enhance financial performance—expanding areas of strength, closing performance and infrastructure gaps, and exiting underperforming contracts.

Then, rebuild the organization's value-based revenue capture capabilities. This includes aligning clinical teams, improving understanding of financial model dynamics, sharpening data-driven insights, and refining predictive modeling. In some cases, strategic retrenchment to fee for service arrangements may be necessary to stabilize margins before reinvesting in value-based care.

As the market hits reset, health systems' managed care strategy should too

This year is a reset moment. The levers that once sustained health systems—favorable fee schedules and high growth in margins and volumes—are no longer reliable. Instead, systems face an increasingly constrained and complex health plan landscape.

To succeed, health systems must turn managed care into a core strategic function—one that is data-driven, health plan-savvy, and closely integrated with operational execution. Rate increases matter, but the broader negotiation strategy, the health plan portfolio mix, and the ability to operationalize contracts will define which organizations remain financially resilient to continue serving patients in the years ahead.

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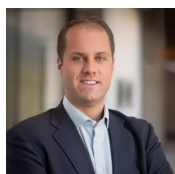
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