Aligning Payer Strategy with Operations
AMGA Virtual Executive Roundtable Summary
February 11, 2026

The AMGA Hospital & Health System Advisory Committee convened physician executives and health leaders to discuss how health systems are aligning payer relations strategies with operational execution in a value-based care environment. Led by Tracy Chu, Corporate VP of Population Health & ACO CEO, Scripps Health, the discussion explored strategies for bridging the gap between contracting and operations, managing national payer relationships, navigating Medicare Advantage challenges, and building collective leverage across health systems.

Key Themes & Takeaways

1. Operations Must Drive Contracting Strategy

- **Lead with operational strength:** Rather than reactively meeting each payer's individual metrics, leading systems identify their strongest ongoing initiatives—care coordination, transitions of care, annual wellness visits—and bring those to the contracting table as the negotiating foundation.
- **Build the care model first, then negotiate:** Design the primary care team and model you want, then engage revenue cycle and payer relations to negotiate contracts that support it—rather than building operations around contract requirements.
- **Reduce operational whiplash:** When every payer contract demands different priorities, clinical teams burn out chasing fragmented goals. Aligning contract negotiations to existing operational priorities creates coherence and builds team confidence.

2. Relationship-Driven Contracting as a Competitive Advantage

- **Relationship before contract:** In direct-to-employer and ACO arrangements, leading with relationship depth—not contract mechanics—is often the decisive factor. Employers and partners value ongoing operational relationships far above contractual terms.
- **Collaboration across roles:** Successful negotiations require operations, revenue cycle, contracting, and clinical leadership working as a true team—with the right expertise leading at the right moment and ego left at the door.
- **Agility over rigid role definition:** Organizations benefit from allowing leaders to step outside traditional role boundaries when the dynamics of a particular negotiation call for it.

3. The Power—and Limits—of Walking Away

- **Leverage requires the ability to exit:** Leverage in negotiation belongs to the party who can walk away. Historically, health systems have lacked this advantage with large national payers, ceding power to the plans.
- **Medicare Advantage as a test case:** Some systems have exited Medicare Advantage plans after determining contracts were financially unsustainable—retaining a meaningful share of patients on fee-for-service while improving overall reimbursement and reinvesting in operations.
- **Formal contract scoring rubrics:** Structured, objective rubrics for evaluating value-based opportunities provide board-level credibility for saying no and protect operations from overcommitment.

- **Market share drives payer leverage, not quality:** Clinical excellence alone does not create negotiating power—in the eyes of payers, essentiality is determined by volume of lives covered, a structural reality that constrains walkaway leverage for smaller systems.

4. Fee-for-Service to Value-Based Transition Challenges

- **Compensation culture as a barrier:** Highly productive, fee-for-service-driven medical group cultures remain one of the most significant obstacles to value-based care adoption. Changing compensation models before behaviors shift—or vice versa—presents a structural paradox that no organization has fully resolved.
- **Physicians need reassurance to move:** Systems must provide incremental guarantees that shifting toward value-based participation will not undermine financial stability, building trust before asking physicians to take on new risk.
- **Zero-downside network models:** Some organizations protect member providers from individual contract losses by absorbing downside risk at the network level, allowing shared savings to flow through positively and lowering the barrier to participation.

5. Collective Voice and Industry Advocacy

- **Payers collaborate; providers often don't:** Payers effectively coordinate messaging and strategy nationally, while health systems have historically approached negotiations individually—a structural imbalance that contributes to the payers' leverage advantage.
- **Shared messaging amplifies individual action:** When a system takes a visible public stand on an unsustainable contract arrangement, consistent external messaging can shift the broader industry narrative and embolden others to act.
- **Forums as force multipliers:** Peer networks provide meaningful value for sharing tactics, operational approaches, and messaging strategies—building collective credibility that individual systems cannot achieve alone.

Outcomes Highlighted

- **Payer exit and volume stabilization:** Systems that have exited unsustainable Medicare Advantage contracts report retaining a significant share of affected patients on traditional fee-for-service, improving net reimbursement and enabling reinvestment in operations.
- **Contract discipline through formal scoring:** Rubric-based contract evaluation provides objective criteria for declining value-based opportunities that cannot be operationally executed—building board-level confidence in difficult decisions.
- **Direct employer ACO models:** Structuring ACO arrangements directly with employers—with the health plan serving only as a TPA—offers a viable path to rebalancing negotiating power and centering risk-sharing between provider and employer.
- **Peer learning as an immediate output:** Participants identified concrete tools to share—including contract scoring rubrics and operational alignment frameworks—and expressed interest in continuing the forum as a best practice exchange.

Overall Conclusion

The discussion revealed that closing the gap between payer strategy and operational execution requires deliberate structural changes, organizational agility, and a willingness to challenge longstanding role definitions. Leaders emphasized that:

- **Operations must inform contracting:** The care model should drive contract negotiations, not the other way around. Reactive, payer-led metric-chasing creates team burnout and inconsistent performance.
- **Relationship capital is a negotiating asset:** In value-based and employer-direct arrangements, the strength of the operational relationship often outweighs contractual mechanics, and the right leader at the table is the one who owns that relationship.
- **The ability to walk away is leverage:** Organizations must build the financial and operational resilience to exit unsustainable contracts. Formal evaluation tools support that discipline, and collective industry action can help right-size the balance of power over time.
- **The fee-for-service to value-based transition remains unsolved:** Shifting physician culture and compensation models simultaneously is among the most difficult operational challenges, requiring patience, incremental trust-building, and organizational guarantees.
- **Collective advocacy matters:** Health systems benefit from coordinating messaging and sharing best practices through peer forums, countering the structural advantage payers hold through their own national alignment.