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Get Paid What You're Owed: Smarter Contracting, Internal Alignment Can Reduce Denials

Hospitals and health systems are grappling with [rising denial rates](#), particularly among commercial and Medicare Advantage plans. Years ago, denials might have been isolated friction points in the billing process; but as rates rise, denials have become a strategic-level issue with measurable impact on financial performance.

Historically, denial mitigation efforts tended to focus on revenue cycle operations: tracking codes, improving documentation, training internal tracking teams and optimizing appeals processes. But this approach, while important, treats the symptom, not the source. Many denials originate not from internal missteps but from contractual ambiguity and opaque, payer-driven rule changes.

The price that providers pay is high. Health systems spend millions of dollars every year managing denials—and in some instances, not recouping losses—that often could have been prevented with better payer accountability and alignment. The dollars at stake could mean the difference between a positive and a negative margin, elevating the issue from an operational matter to a strategic imperative.

There are critical success factors for [both preventing and appealing denials](#). We'd like to call attention to one area that warrants greater attention: contracting strategy. By strengthening contract language and improving internal collaboration between managed care and revenue cycle teams, providers can significantly reduce preventable denials—and get paid what they're owed.

The hidden power of the provider manual

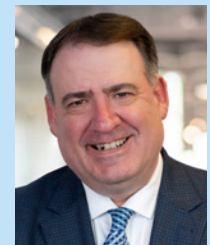
Most hospital leaders are familiar with what's in their payer contracts: covered services, rates, payment timelines. But they may not realize that much of what



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governs actual reimbursement behavior lives outside the four corners of the contract. That would be the payer's provider manual.

The provider manual functions as a detailed instruction guide for how claims are submitted, reviewed and reimbursed. It outlines processes for prior authorization, documentation, coding, appeals and more. These manuals are typically posted online and updated frequently, often with minimal notice to contracted providers.

This dynamic—frequent updates with minimal notice—creates a moving target. Health systems must track not only what they've negotiated, but also the evolving set of rules that determine how and when they actually get paid. Few organizations have the infrastructure or capacity to consistently monitor and reconcile these updates across multiple payers.

Most contracts do not explicitly protect providers from adverse or unilateral changes to provider manuals, so denials often result from unknowing noncompliance with recently modified instructions. In essence, hospitals are penalized for failing to follow rules they were not clearly advised had changed.

What's missing in many contracts

It's not just what's in the contract that matters. It's what's *not* there. Many payer agreements lack provisions that would give hospitals greater visibility, predictability and recourse in the face of denial risk. Specifically, many contracts are vague about notification timelines for provider manual updates, accountability measures for payer-driven denials, standardized prior authorization protocols, and reconsideration and appeal process standards and timelines.

These omissions leave hospitals vulnerable. Without enforceable requirements around transparency and timelines, payers can revise policies unilaterally and leave providers scrambling to comply.

But, here's the good news: these are negotiable terms. Hospitals can and should push for stronger contract language that formalizes expectations, limits ambiguity and provides tools for redress. When contracts clearly define how denials will be handled, including what notice must be given before rules change, providers are in a better position to reduce surprises and capture more of the revenue they have earned.

Three steps to reducing denials

- 1. Inventory contracts and provider manuals**
Understand where risks are hiding by reviewing terms and tracking manual updates across all major payers.
- 2. Close the language gap**
Negotiate contract language that addresses provider manual updates, notification timelines and payer accountability.
- 3. Create an internal escalation model**
Build a shared framework in which managed care and revenue cycle collaborate, share data and speak with one voice to payers.

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A smarter approach: Contracting and alignment as denials mitigation tools

Smarter contracting is only part of the solution. Internal alignment is equally important. In many health systems, managed care and revenue cycle teams operate in silos, in which one team negotiates the contract and another handles the fallout.

Thus, when denials occur, the insights gained by revenue cycle rarely make their way back to inform future negotiations. Meanwhile, payer relationships are strained by miscommunication, finger-pointing and a lack of escalation pathways.

There is a better way. Leading organizations are starting to treat denials mitigation as a shared strategic function, not just a cleanup task. Strategies to consider include:

- Auditing contracts and provider manuals to identify gaps;
- Negotiating specific utilization management terms and notification standards into agreements;
- Establishing formal escalation processes that trigger payer accountability when denial thresholds are exceeded; and
- Using denial data to inform future payer negotiations.

Ultimately, hospitals must shift their approach to denials management from a reactive posture to a proactive one. The goal: stop chasing denials and start preventing them.

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