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A New Era of Revenue Cycle Modernization

Enhancing Margins to Achieve Sustainable Performance in Healthcare

HFMA Wisconsin Spring Conference
Thursday, May 21, 2026
1:15 PM – 2:05 PM

Framing the discussion

David Enevoldsen

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Optum Advisory,
Margin Transformation

David Enevoldsen is a Senior Director in Optum Advisory's Provider Margin Transformation practice, with more than 16 years of experience at the organization. He partners with health systems and medical groups to drive sustainable, enterprise-wide margin improvement, with deep expertise in end-to-end transformation across the three primary levers of financial performance: revenue cycle, workforce, and supply chain

Session Purpose:
Health systems face mounting pressure to elevate financial performance amid flattening revenue, declining reimbursement rates, and rising costs. An efficient, effective revenue cycle is critical to financial stability and margin preservation.

Health system leaders need revenue cycle management to operate at peak performance – all while managing increasing patient and provider expectations and mitigating workforce challenges including burnout, talent scarcity, and wage competition.

During this session, we will discuss critical drivers of large-scale, sustainable revenue cycle savings and revenue capture that will fund the clinical enterprise. These include no-regrets strategic investments that revenue cycle leaders must prioritize to accelerate financial impact.

Learning Objectives:
- How to prioritize cost reduction and revenue capture efforts
- How to better engage my providers to improve documentation
- Learn best practices for revenue cycle transformation from our client partners

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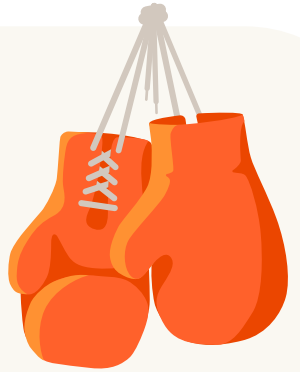
Adapting to new operational and economic realities

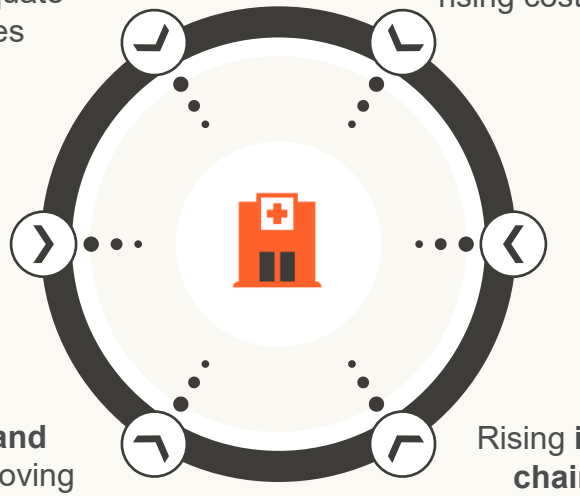
Healthcare's financial status has improved but many of the common challenges remain…and some have gotten worse. Continued and varied financial headwinds are upending healthcare's traditional status as "recession-proof."



A confluence of factors exacerbating 2026 stress

Persistent workforce concerns such as burnout and shortage creating inadequate staffing and high wages

Reimbursement rates not keeping pace with rising costs and inflation



Clinician burnout concerns driven by administrative burdens and challenging patient culture

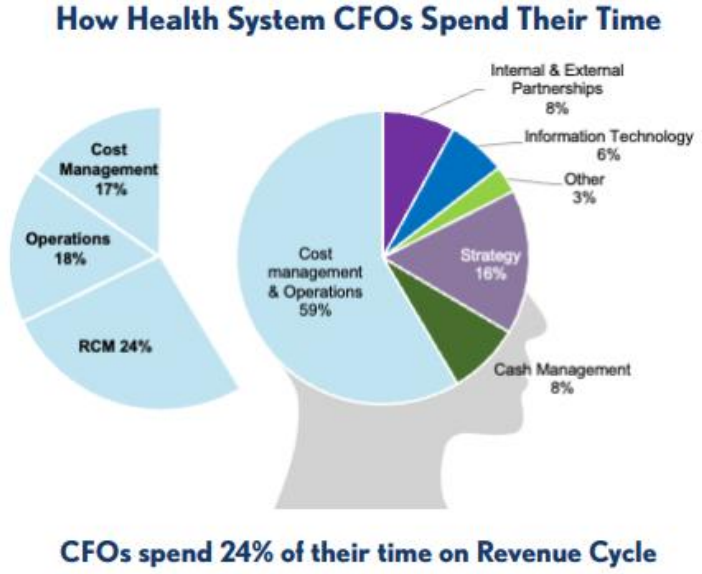
Regulatory changes and uncertainties place providers in an unstable position

Investment declines and market uncertainty removing any cushion for operational weakness

Rising **inflation** and **supply chain disruptions** are escalating costs and impacting care delivery

"Ultimately, we need to generate margins to be able to invest in the organization"

- Health System CFO, 2025



Source: Advisory Board Research, 2022; Healthcare Finance Trends for 2023: Multiple Intersecting Challenges, *Commerce Healthcare, January 2023* - Healthcare Finance Trends for 2023: Multiple Intersecting Challenges | CommerceHealthcare ; HFMA HFMA Health System CFO Pain Points 2024: Margin Challenges & Opportunities for Vendors, 2024

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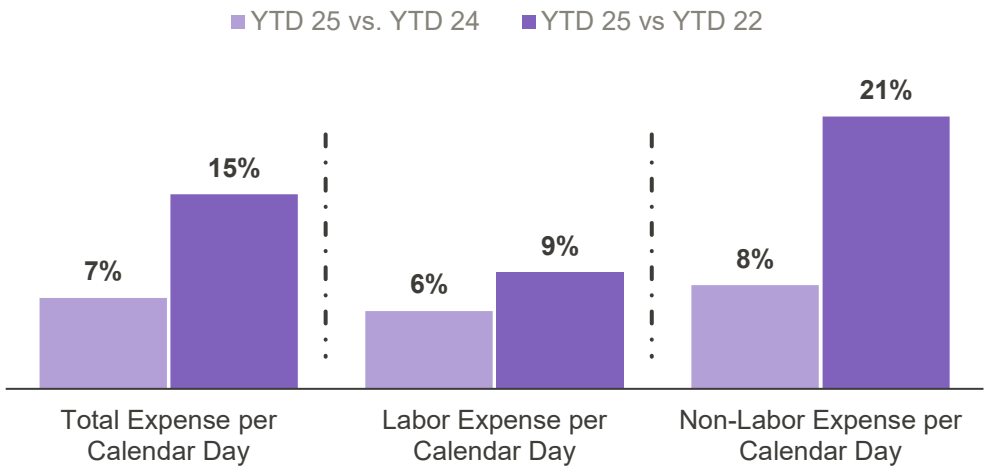
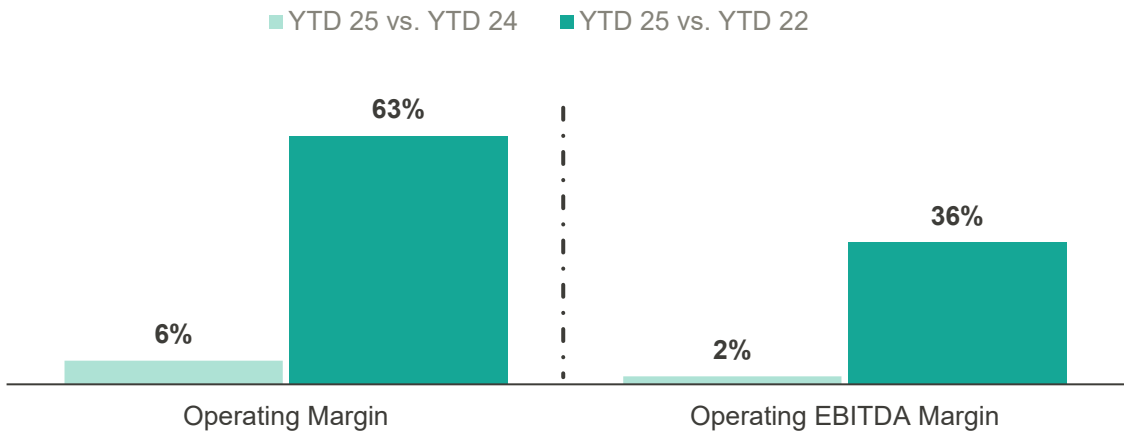
Margins have returned but hampered by added expense

Operating margins highlight financial healing for many health systems. Most organizations have improved since low points from 2022-2025. This improvement occurred despite continued growth in labor and non-labor expenses indicating that large upticks in volumes and reimbursement are insulating health systems.

Expenses Shifting Higher…mirroring growth?



But Not Fast Enough to Fix the Operating Margin Differential



"…We got crushed in 2023. We had peak agency workforce at that point, and the rates were higher. So it hit us hard. But 2024 was definitely much higher and this year is even higher"

- Health System CFO, 2025

"… being asked to do more with less, finding the time with which to identify areas that need improvement and finding the resources to develop …can seem like an overwhelming undertaking"

- Health System CFO, 2024

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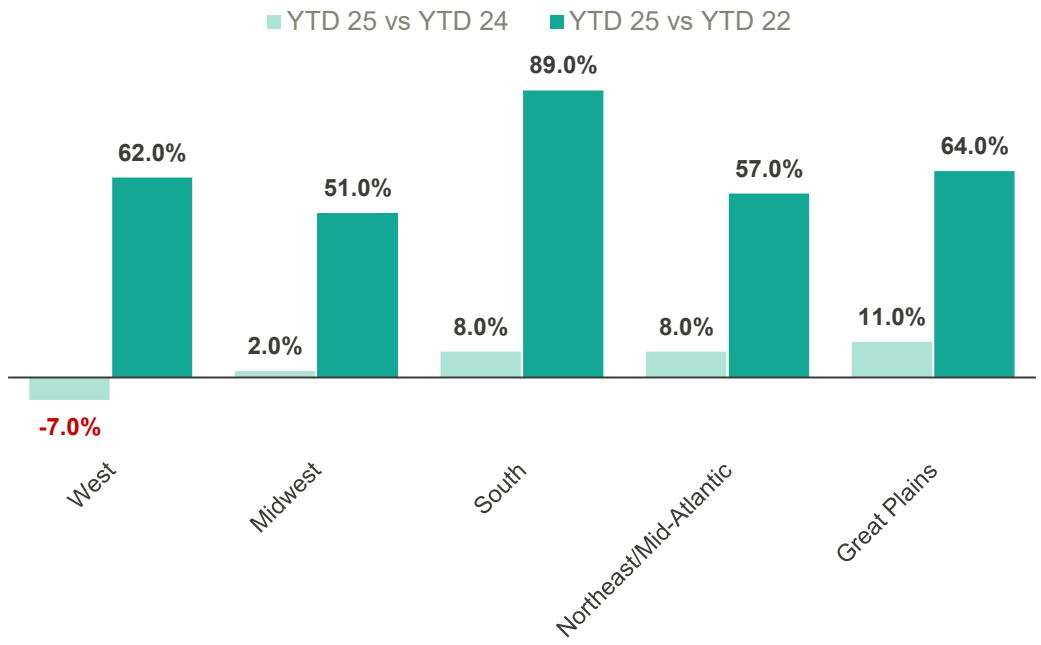
Source: *Kaufman Hall Apr 2025 Hospital Flash Report*

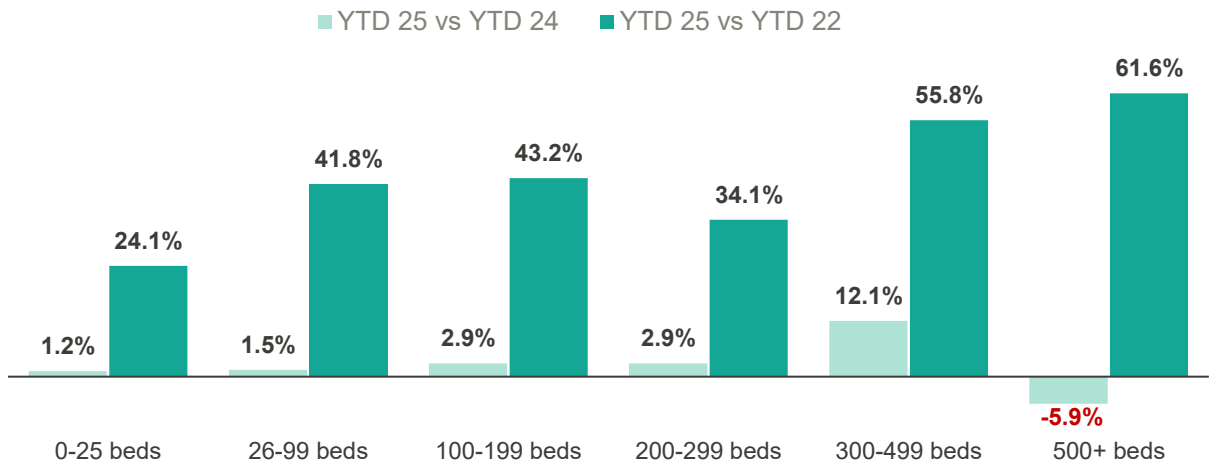
Regional and bed size variation highlight widespread recovery

Operating margin performance rebounded compared to a dark period from 2021-2022. Several distinct factors contributing to the high-performers' prosperity include scalability, higher outpatient revenue, swift reductions to contract labor, and lower average length of stay.

Operating EBIDA Margin Differential by Region



Operating EBIDA Margin Differential by Provider Bed Size



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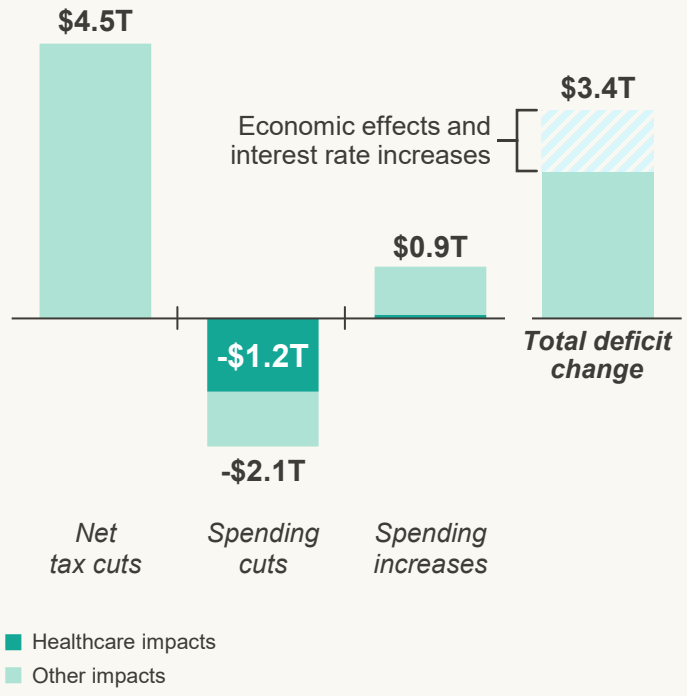
Source: *Kaufman Hall Apr 2025 Hospital Flash Report*

Final OBBBA at a glance for healthcare leaders

OBBBA[1] deficit impacts[2]

July 21, 2025 CBO estimates



1. One Big Beautiful Bill Act.
2. Projected 10-year (2025–2034) impacts.
3. Summation of estimated Medicare sequestration impacts and major Medicaid state financing restrictions provisions (state-directed payments, MCO taxes and provider taxes).

Major healthcare policies

Marketplace tax credit restrictions and Medicaid cost sharing
▼ Reduce affordability

Medicaid work requirements
▲ Increase administrative burden

Medicaid and Marketplace enrollment restrictions and eligibility verification barriers
▲ Increase administrative burden

State Medicaid financing restrictions
▼ Reduce federal funding to states

Medicare sequestration trigger
▼ Reduces federal spending

Potential healthcare impacts[2]

14.2M *July 21 estimates*
projected increase in uninsured people (includes sunset subsidies)

Potential consequences:
▲ Uncompensated care
▲ Exacerbated health conditions
▼ Elective volumes
▼ Health plan enrollment

$910B *July 21 estimates*
Estimated direct reimbursement reduction (includes sequestration cuts)[3]

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Our clients are balancing improvements in key areas

Selecting initiatives and investments is an exercise in judgment and resource allocation for C-suite leaders. It's a balancing act to successfully grow volumes, improve patient care, maintain a fervent focus on operational cost containment, while also keeping staff and providers happy.

Take out cost

Impact areas include:

- Administrative and management structure
- Workforce productivity
- Excess length of stay
- Supplies and contract rates
- Outsourcing non-clinical functions

Grow revenue

Impact areas include:

- Payer denials
- Coding and documentation
- Vertical market integration
- Medicare advantage performance
- Value-based and shared risk contracting

Enhance patient experience

Impact areas include:

- Physician scheduling and access to care
- Virtual care options
- Price transparency
- Hospital flow and throughput
- Self service tech

Fund and Deliver improved care

Impact areas include:

- Health equity and behavioral health
- Network design and access
- Payer/provider integration
- Care management

Engage and retain workforce

Impact areas include:

- Employee experience and satisfaction
- Automation and optimizing EHR-enabled workflows
- Clinical staffing and top of license care models
- Compensation

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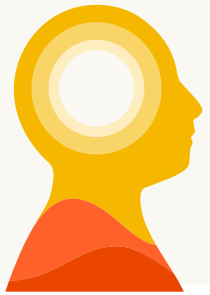
Emergence of a new mindset for revenue cycle modernization

A performance focus pursues excellence….while an impact focus favors value. The notion of yield has re-emerged as a key element of operational decision making. This approach values cost containment, but leaves room for strategic investments that result in outsized financial returns



Speed → **Performance** → **Impact**

Evolving Measures of Success

Focus on meeting legacy key performance measures

AR Days, AR Aging, DNFB, POS collections

Focus on maximizing net revenue, collections, patient satisfaction through technology and targeted "programs"

$$\frac{Cash\ Collections}{Expected\ Reimbursement}$$

Focus on balancing revenue performance and operational costs to maximize **yield**

$$\frac{Cash\ Collections - Expense}{Expected\ Reimbursement}$$

Shifting Mindset

Does our team get the job done? → *Are we performing as well as we should?* → *Are our services a good **value** for the organization?*

Are we making the right investments in people, services, and technology?

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Transforming revenue cycle operations to achieve high yield performance

	Patient Access & Experience	Clinical Revenue Cycle	Revenue Integrity	Business Office
Amplifying Revenue: Capture Every Dollar Earned	**Bolster the Health System's Provision of Care** Build a high-performing and reliable **contact center and arrival service operation** to enhance consumer experiences, capture latent demand, and expand patient volumes through highly reliable, patient centric operations.	**Elevate Documentation and Coding Accuracy** Optimize documentation and coding practices and infrastructure in both the inpatient and ambulatory environments; Proactively engage and educate providers to reduce compliance risks and recognize full fee-for-service and clinical risk adjustment reimbursement.	**Safeguard Revenue Capture and Pricing** Leverage forensic investigation to uncover reimbursement opportunities. Optimize EMR build and workflows to improve accuracy and automation of charge capture to reduce missing and late charges. Benchmark charges and rates to understand your market positioning and maximize returns.	**Strategically Maximize Reimbursement** Optimize documentation and coding practices and infrastructure in both the inpatient and ambulatory environments; Proactively engage and educate providers to reduce compliance risks and recognize full fee-for-service and clinical risk adjustment reimbursement.
Rightsizing Investments: Pursue Value for Every Dollar Spent	**Mature & Expand Self-Service Capabilities** Select, build, and promote self-service functions paired with strategic automation deployment and to simultaneously meet patient preferences and reduce reliance on attended services.	**Accelerate Pursuit of Automation Capabilities** Leverage automation innovations (i.e. autonomous coding and ambient AI scribe capabilities) to reduce workforce burdens, reduce clinician burnout, offset labor shortages and focus human resources on more complex, 'top-of-license' activities.	**Transform Workforce Footprint** Modify the workplace by pursuing a staffing plan aligned with automation and smart-sourcing strategy. Transition to a leaner and more specialized virtual workforce complemented by a management structure that lessens FTE dependency while creating an improved internal career path to promote retention of key roles.	**Optimize the Vendor Landscape** Adjust the vendor partner footprint to pursue increased value of revenue cycle activities. Consider partners with flexibility for on-shore and off-shore outsourcing resources to bolster your workforce for repetitive/low complexity activities, reducing costs and elevating staff to higher value work efforts.

IMPACT

- Improved net collection ratio and revenue per wRVU/revenue per adjusted discharge
- Improved alignment of investments and outcomes to optimize cost and revenue performance
- Scalable operations that can flex alongside growth
- Differentiated patient financial experience to serve as a consumer attractor

Emerging cross-continuum metrics

- ✓ Net collection ratio = Payments/(Gross charges – Contractual adjustments)
- ✓ Cost to collect (%) = (Fees + other RCM expense)/net collections
- ✓ Yield (%) = (Collections – Expense)/Expected reimbursement
- ✓ Touchless RCM rate (Percentage of claims without intervention)
- ✓ Financial Net Promoter Score (NPS) (#)

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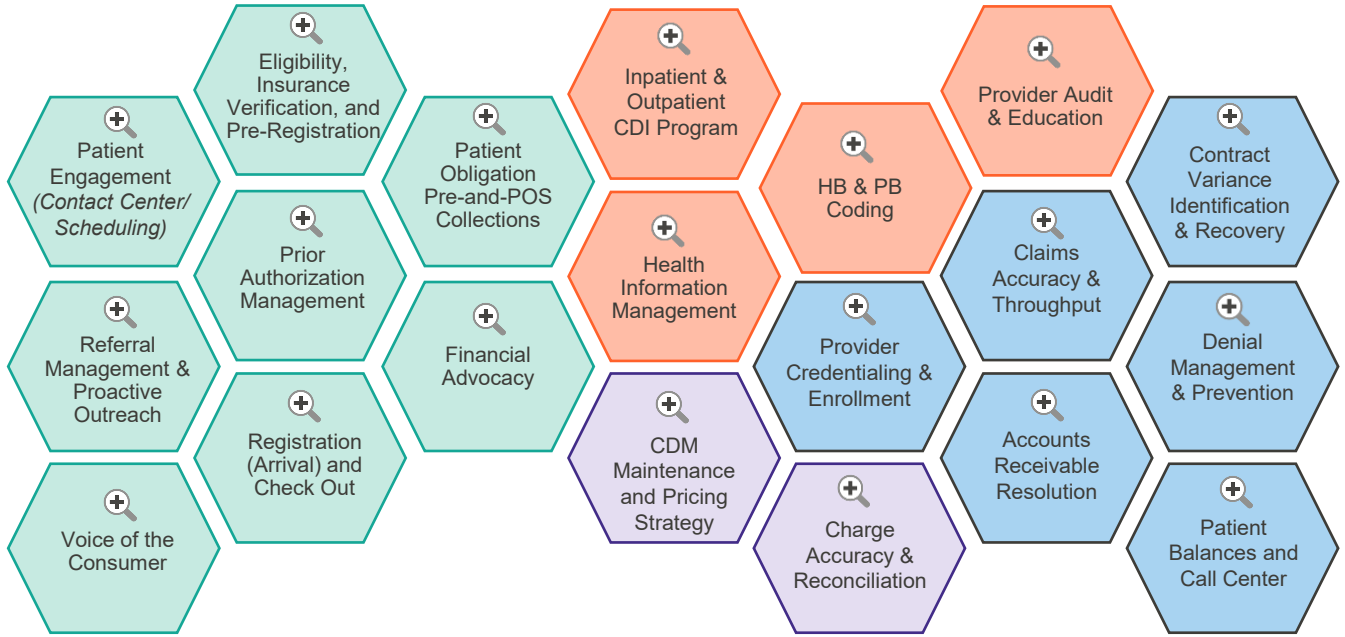
Revenue cycle modernization tailored to your unique needs

Revenue cycle management in healthcare is complex in terms of the variety of functional domains and relative depth of knowledge and experience required to achieve and sustain industry leading performance. Optum Advisory tailors each revenue cycle focused partnership based on your areas of greatest need, bringing to bear comprehensive subject matter expertise to truly transform performance

Expertise across the comprehensive revenue cycle:

1. **Patient Access and Experience:**
   Streamlining access to care through inbound and proactive outbound appointment capture, disciplined financial clearance practices, and efficient patient throughput
2. **Clinical Revenue Cycle:**
   Timely and accurate coding and documentation capabilities including robust clinical documentation education capabilities
3. **Revenue Integrity:**
   Complete and accurate revenue capture, sound pricing strategy, and compliance with state, federal, and payer regulations
4. **Business Office:**
   Advancing patient financial services functions to efficiently promote first pass yield, reduce rework, and amplify cash collections



Optum partnerships highlight revenue cycle modernization opportunities through the lens of:

- *Culture of Performance & Transparency*
- *Coordination of Vendor & Workforce Footprint*
- *Application of Technology & Automation*
- *Orientation to the Patient Journey*

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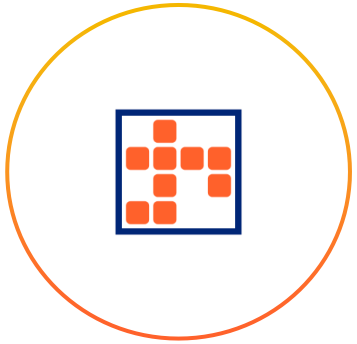
Revenue Assurance Imperatives

Each revenue cycle department plays a role in the efficient capture, maximizations, and protection of revenue from the services provided.



Capture

- Acute care CDM and ambulatory fee schedule optimization
- Charge capture process and education, including service line engagement and education
- Standardized and streamlined charge reconciliation process and protocols

Maximize

- Coding and documentation quality audit programs
- Physician documentation educational programs
- CDI Programs to monitor ensure accurate documentation of patient acuity
- Market rate analytics and managed care payer negotiations
- Strategic Pricing

Protect and Recover

- Structured denial prevention program
- Contractual underpayment ID and recovery program
- Drive awareness of regulatory changes impacting reimbursement (e.g. CMS site neutrality)
- Add-on specialized recovery services (tDRGs, Auto/Liability, zero balance reviews) to extend business office

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Perspective: CDM Maintenance and Pricing Strategy

OPERATIONAL PROFILE

1 Keeping a healthy CDM is crucial to RCM

An accurate, comprehensive, and up-to-date chargemaster sets the foundation for revenue cycle success. Routine maintenance focused exclusively on annual and quarterly coding updates is no longer a viable strategy, and puts organizations at risk of revenue leakage

2 Sound CDM hygiene processes exceeds traditional impact

An effective and coordinated CDM maintenance approach enables Revenue Integrity to further analyze charge data focused on: Identification of net new revenue opportunities, prevention of at-risk revenue loss, and proactive charge issue resolution

3 CDM pricing should reflect your value position

With added transparency requirements, CDM pricing should reflect your market value position with knowledge that charges (and rate files) are published for public view

Common Challenges:

- Evolving regulatory and billing guidelines create compliance vulnerability
- Clinical departments are not always engaged and/or held accountable for charging activities
- Supply and drug inventories are constantly changing, making it difficult to keep charges aligned
- Irregular use of strategic pricing

High Performer Characteristics:

- Inter-disciplinary review that engages clinical department owners and other key stakeholders
- Routine service-line education efforts focused on charging updates and best practices
- Annual strategic pricing optimization
- Keen understanding of rate position relative to market competition

0.5-1.0% is the typical annual net revenue lift net revenue lift from annual strategic pricing efforts

3-5% is the expected lift in gross revenue return from having an up-to-date and accurate CDM

Optum's Core Capabilities

(diagnostic and implementation)

- Comprehensive CDM analysis leveraging our proprietary software to review key data elements: CPT/HCPCS & Revenue Codes; Billable Supplies; Pharmacy NDCs; time-based charge structure
- Service-line charge comparison against best practice chargemaster to identify potential missing charges; Clinical department charge review to validate accuracy of charges
- Strategic pricing, market rate benchmarking and strategy, regulatory file (MRF) preparation, payer negotiation assistance

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Compounding Net Revenue Gains Through Intelligent Pricing Analytics

The Peacock Clinic*

The Peacock Clinic is a physician-led, not-for-profit, Epic-based, integrated health care system serving patients in New York and Pennsylvania across a network of 6 hospitals and 50+ primary care and specialty care clinics, surgical centers, laboratory services, home care, palliative care and hospice services.

The challenge

Historically, the organization relied on traditional across-the-board (ATB) annual price increases to drive revenue growth. While straightforward to implement, this approach did not fully account for payer reimbursement variability, service-level price sensitivity, or inconsistent pricing across facilities. As a result, leadership sought to evaluate a more targeted pricing approach to improve price-sensitive net revenue while remaining compliant and market-appropriate, specifically to:

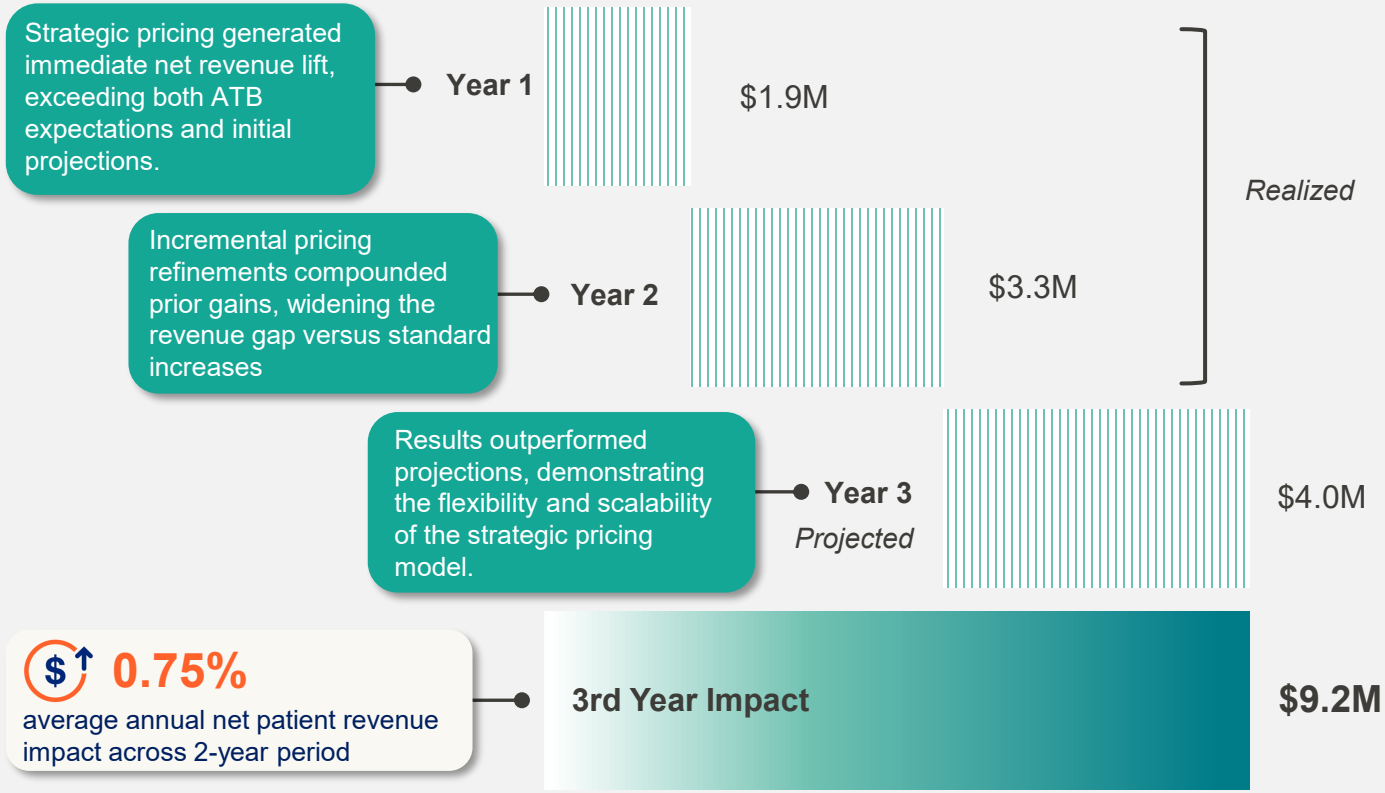
1. **Account for variability in managed care contract reimbursement methodologies**
2. **Align pricing to differences in price sensitivity across services and payers**
3. **Improve sustained, compounding net revenue without broad, uniform price increases**

The approach

Optum Advisory partnered with the organization to design and implement a multi-year, data-driven pricing strategy focused on improving price-sensitive net revenue rather than gross charge growth. The approach leveraged comprehensive managed care contract modeling, service-level price optimization, and competitive market benchmarks to identify targeted pricing opportunities. Ongoing monitoring and validation were embedded to track performance, ensure compliance, and sustain results across all five hospitals.

Strategic Pricing Net Multi Year Impact

Demonstrated net revenue impact of a 3-yr strategic partnership



*Organization name has been changed

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The Foundational Role of Clinical Documentation

Without strong, complete, and clinically accurate documentation, downstream functions simply *cannot* succeed.

- Utilization reviewers *cannot* justify medical necessity.
- Coders *cannot* assign appropriate codes or capture the full severity of illness.
- Quality teams *cannot* reflect the true complexity of care delivered.

In short, if it's not documented, it didn't happen—no matter how accurate or efficient the downstream processes are.

This creates a critical dependency:

1. **Medical Necessity Support**

   Complete documentation enables Utilization Management to consistently support medical necessity.

2. **Accurate DRG & Acuity Representation**

   Documentation quality drives accurate DRG assignment and reflection of severity of illness.

3. **Quality Measurement Integrity**

   Clinical complexity must be documented to be accurately reflected in quality metrics and public reporting.

4. **Risk Adjustment & Validation Alignment**

   Risk adjustment and clinical validation rely on documentation that fully reflects patient conditions.

5. **Enterprise Performance Dependency**

   Without strong documentation, downstream performance in UM, Coding, Quality, and Reimbursement is inherently limited.

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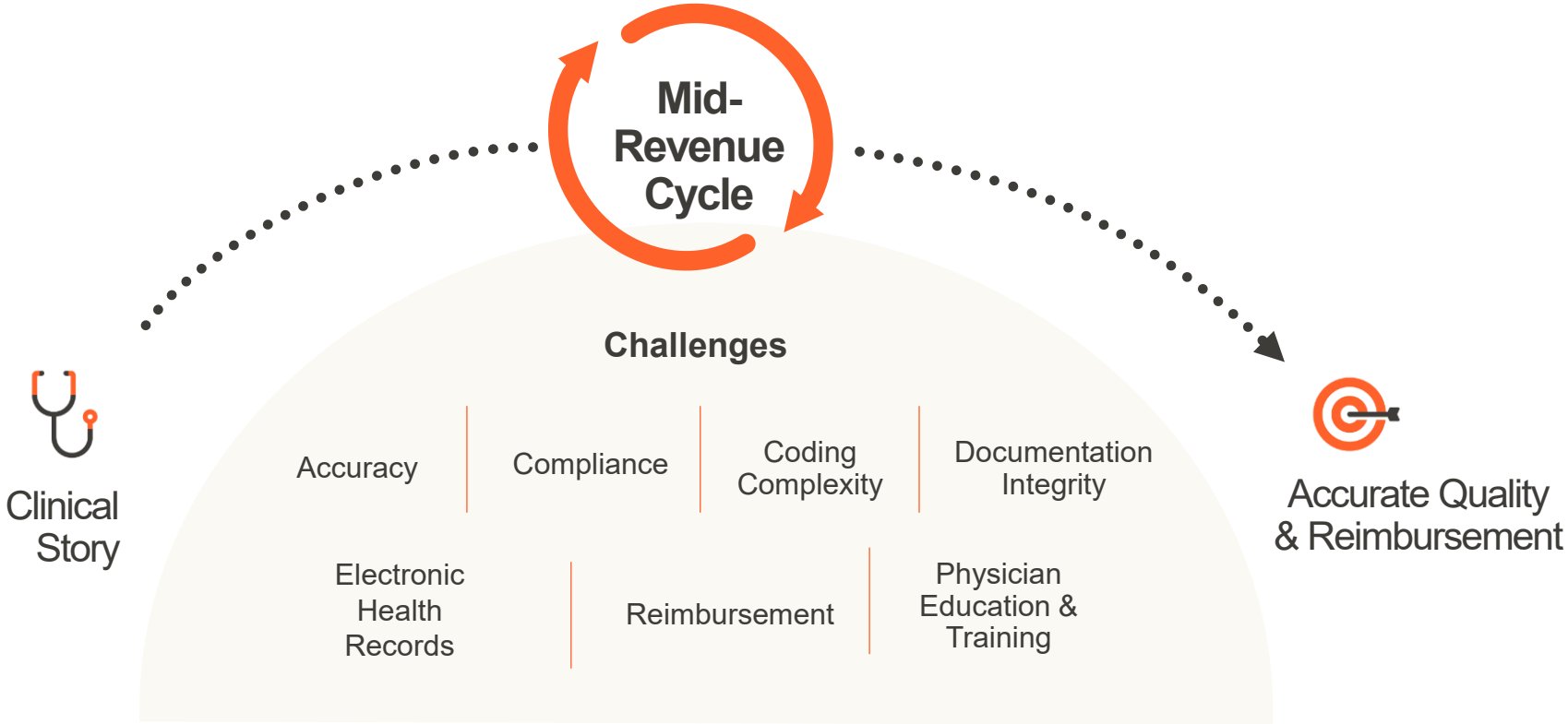
Underscoring the Importance – and Complexity – of Documentation

Addressing these challenges requires collaboration among healthcare providers, coders, administrators, and technology vendors to implement effective documentation and coding processes, ensuring compliance and optimizing reimbursement.



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Downcoding by insurers reduce reimbursement for higher-level E/M claims unless there is accurate documentation

Cigna & Aetna E/M downcoding

Cigna

Allows automatic one-level downcoding of select Level 4–5 E/M codes when a submitted diagnosis doesn't appear to justify the complexity; providers **must appeal and submit records to restore payment**.

Announced for Oct 1, 2025, then paused for fully insured commercial products in California pending state regulatory review; self-insured plans are not included in the pause.

Aetna

Pre-payment edits conducted by vendor coders; claims may be **paid at a lower level without a separate denial notice**, making remittance monitoring critical. Providers can appeal and, if successful at scale, may be removed from the program.

Expanded in 2025 from pilot states to nationwide commercial lines, with additional edits added later in 2025; applies broadly to Level 4–5 E/M services.

States with laws passed or pending to curb insurer downcoding

Laws passed

- Arkansas (effective Aug 2025): Requires timely notice to providers when claims are downcoded.
- Virginia (effective July 2025): Requires insurers to disclose downcoding and bundling policies in network contracts or publicly and specify affected services.

Legislation pending / under active consideration

- Ohio: Bill would prohibit automatic downcoding based solely on diagnosis codes or visit duration.
- New York: Bill considered to bar downcoding that reverses or alters medical-necessity determinations.
- California (regulatory action): State regulators are reviewing Cigna's policy.

Source: Cigna temporarily pauses downcoding policy - American Academy of Sleep Medicine – Association for Sleep Clinicians and Researchers, Cigna Intends to Unilaterally Downcode E/M Claims | HealthLeaders Media

https://www.cmadocs.org/newsroom/news/view/ArticleID/51054/t/Update-Cigna-clarifies-scope-of-downcoding-policy-pause

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Medicare V28 HCC Model & CY 2027 Payment Implications

CMS CY 2027 Advance Notice Highlights

- CMS continues the transition to CMS-HCC V28, reinforcing clinically appropriate, supported diagnoses
- National MA growth rate for CY 2027: 4.97%, driven by updated FFS cost projections
- CMS expects the MA risk scores to increase, on average, by 2.45% due to the underlying coding trend resulting in a 2.54% average increase

CMS' Three Guiding Principles

- Reduce day-to-day administrative burden for both plans and providers;
- Create value for patients where risk adjustment facilitates fair competition between health plans; and
- Payments that accurately reflect beneficiary health risk.

Risk Model Adjustments

- Calibrate model using 2023 diagnoses predicting 2024 spend and update denominator year to 2024 (RAF score changes)
- Exclude diagnoses from audio-only encounters (modifiers 93 and FQ)
- Exclude diagnoses from unlinked chart reviews (diagnoses not tied to an encounter)

The CY 2027 Advance Notice projects a net average year-over-year payment increase of 0.09%. Below is the expected average impact of the proposals on MA payment components relative to last year.

Impact	CY 2027 Advance Notice
Effective Growth Rate	4.97%
Rebasing/Re-pricing	TBD
Change in Star Ratings	-0.03%
MA Coding Pattern Adjustment	0%
Risk Model Revision and Normalization	-3.32%
Sources of Diagnoses	-1.53%
Expected Average Change	**0.09%**

If the CY 2027 MA proposals are finalized, the changes will retroactively apply to encounters beginning 01/01/2026 as financial reconciliation is determined the following year.

Source: https://www.cms.gov/newsroom/fact-sheets/2027-medicare-advantage-part-d-advance-notice

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RADV Program Impact to Providers

Audits Continue Amid Legal and Policy Transition

1. **CMS RADV Audit Authority (May 2025)**
   - RADV audits confirm all diagnoses submitted are documented and supported
   - In May 2025, CMS announced an aggressive strategy to catch up and accelerate audits including hiring 2,000 coders, shorten the submission window from five months to three months, and incorporate AI-enabled coding technology
2. **Federal Court Ruling & CMS Response (September-November 2025)**
   - In September 2025, the U.S. District Court for the Northern District of Texas vacated CMS's 2023 RADV Final Rule, finding that CMS failed to meet Administrative Procedure Act (APA) notice-and-comment requirements, including provisions related to contract-level extrapolation
   - On November 21, 2025, CMS formally appealed the decision to the Fifth Circuit Court of Appeals, seeking to reinstate the vacated RADV framework
3. **Status of RADV Audits (January 2026)**
   - RADV audits remain a top priority for CMS indicating a commitment to audit completion for PY 2018–2024
   - CMS has adjusted audit operations in response to stakeholder feedback, including restoring a five-month medical record submission window

CMS estimates that **~$17 billion** of annual payments to MA organizations are **improper**, mainly due to **unsupported diagnoses**.

More than 40% of patient's chronic conditions are **never reported by providers**.

The **last significant recovery** of MA overpayments under the RADV program occurred for the **PY 2007** RADV audit

RADV audit results will impact provider organizations as payers will be looking to include language with provider contracts to share exposure to RADV and OIG audit risk

Providers should continue to prioritize accurate documentation, audit readiness, and strong clinical documentation integrity practices in anticipation of continued RADV activity

Source: CMS Rolls Out Aggressive Strategy to Enhance and Accelerate Medicare Advantage Audits | CMS
Update on Status of MA RADV Audits 1.27.26.pdf"

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Settlement Over Improper Medicare Billing Claims

- The U.S. Department of Justice alleged that Kaiser Permanente affiliates violated the False Claims Act by submitting invalid diagnosis codes for Medicare Advantage enrollees to obtain higher risk-adjusted payments.
- The allegations spanned 2009 through 2018.
- Kaiser set aggressive physician- and facility-specific goals for adding risk adjustment diagnoses.
- Kaiser singled out underperforming physicians and facilities and emphasized that the failure to add diagnoses cost money for Kaiser, the facilities, and the physicians themselves. It also alleged that Kaiser linked physician and facility financial bonuses and incentives to meeting risk adjustment diagnosis goals.

$556M

Settlement Over Improper Medicare Billing Claims

January 2026

> “The United States alleged that Kaiser developed various mechanisms to **mine a patient’s past medical history** to identify potential diagnoses that had not been submitted to CMS for risk adjustment. Kaiser then **sent “queries” to its providers urging them to add these diagnoses** to medical records via addenda, often months and sometimes over a year after visits. In many instances, the United States alleged, **the diagnoses added** by the providers had **nothing to do with the patient visit in question**, in violation of CMS requirements.”

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Office of Public Affairs | Kaiser Permanente Affiliates Pay $556M to Resolve False Claims Act Allegations | United States Department of Justice

The Enterprise Mid-Revenue Cycle Challenge

Even mature CDI and Coding programs often struggle to deliver consistent, scalable performance across the enterprise mid-revenue cycle—spanning inpatient, outpatient, professional, and emerging care settings.

Establish an Enterprise Strategy

- Align documentation and coding standards with enterprise quality, compliance, and financial objectives
- Establish clear governance, accountability, and decision-making across all care settings
- Ensure consistency while allowing for setting-specific operational needs and regulatory requirements

Identify Enablement Gaps

- Evaluate where workflows or operational processes may limit CDI & coding consistently
- Focus on high-impact areas such as severity capture, medical necessity, quality measures, and compliant query practices

Align Technology to Program Strategy

- Evaluate whether current tools support enterprise-wide documentation and coding strategies across settings
- Assess workflow integration, task standardization, analytics, and visibility into performance trends
- Confirm technology enables actionable insights, cross-setting monitoring, and sustainable operational scale

Reassess Training and Education Approaches

- Evaluate whether CDI specialists, coders, and providers are supported with consistent, enterprise-aligned education
- Promote proactive, data-driven education aligned to documentation trends, regulatory updates, and organizational priorities

Improve Tool Adoption and Utilization

- Identify variation in adoption impacting efficiency, accuracy, consistency, and performance outcomes
- Evaluate whether staff are fully utilizing available system capabilities and standardized workflows
- Align operational practices to drive consistent mid-revenue cycle execution and measurable results

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The Rise of Generative AI Ambient Scribing

Generative AI ambient scribing is transforming healthcare by improving documentation accuracy, reducing administrative burdens, and allowing clinicians to focus more on patient interaction.

Revenue Cycle Involvement in Decisions

Importance: Involving revenue-cycle teams in AI scribe selection ensures alignment between clinical and financial outcomes

Benefits: Rev-cycle expertise bridges the gap between clinical care and financial stewardship, ensuring that AI solutions deliver tangible, bottom-line results

Point-of-Care Documentation and Clinical Nudging

Value: AI-driven clinical nudging captures precise clinical details at the point of care, improving clinical decision-making and prompting better documentation habits

Impact: Improves care quality, reimbursement accuracy, and reduces clinician burnout by minimizing post-visit documentation

Attributes of a High-Quality Clinical Note

Essentials: High quality notes should be purposeful, precise, and actionable, reflecting patient encounters accurately

Features: Organized, personal, and formatted to clinician preferences, including clear referral letters and after-visit summaries

Risk Management: Coding-Naïve Scribes

Challenge: Coding-naïve scribes can add complexity, jeopardizing clinical accuracy and revenue cycle health

Solution: Implementing coding-aware AI scribes can significantly mitigate the risks associated with coding-naïve scribes and enhance overall clinical and financial performance

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AI-Generated Clinical Notes Improve Efficiency, but Increase Risk

Ambient listening can significantly reduce provider time spent on clinical documentation. One nonprofit health system found:

61%

decrease in median provider time spent after hours on clinical documentation

13%

decrease in provider rating of burnout levels

Risk

AI generated notes are easy to find. They're beautifully formatted, grammatically-correct but rely on patterns and templates that stand out for the following reasons:

- Use repetitive phrasing
- Overly complete documentation that lacks clinical nuance
- Internal consistencies (e.g., conflicting symptoms)
- Tone and style mismatches the provider's voice
- Metadata trails show AI involvement

Outlook

Over half of organizations indicate they plan to implement Epic's ambient speech tool within the next two years.

AI tools can enhance efficiency, but without proper oversight, organizations risk repeating the same documentation pitfalls as chart cloning.

To comply, providers must review and sign-off on AI generated notes. Providers must be aware of documentation guidelines and best practices to ensure compliance.

Source: How one health system cut provider time spent on clinical notes by 61%, Why AI-Generated Notes Pose the Same Risks as Chart Cloning – ICD10monitor

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CDI Program Considerations by Care Setting

Ambulatory CDI (ACDI) is challenging in that it cannot simply replicate inpatient-oriented CDI processes. The differences between inpatient and physician practices need to be considered in establishing an ambulatory clinical documentation integrity and education program.

	Type of Encounter	Duration	Technology Platform	Coding Framework	Oversight Responsibilities	Provider Clarification
Facility	Lower volume, higher payment per case	Multi-day stay	Unified	ICD-10 CM/PCS, DRGs	Hospital and system management	Reactive
Professional/ Ambulatory	Higher volume, lower payment per case	~20-minute encounter	Disparate	ICD-10 CM, HCCs, CPT, HCPCS	Physician enterprise	Proactive
Key Differences Preventing Scale	Need to prioritize subset of cases	Need to get information during shorter visit	Must capture data from multiple sources	Need unique coding knowledge	Greater physician involvement required	Inpatient and ambulatory documentation and coding guidelines

While inpatient care allows time for concurrent CDI, ambulatory care is better suited to CDI activities completed before (prospective) and after (retrospective) the patient visit.

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Strengthening Ambulatory Documentation Integrity Through Physician Education

The Peacock Clinic*

The Peacock Clinic is a physician-led, not-for-profit, Epic-based, integrated health care system serving patients in New York and Pennsylvania across a network of 6 hospitals and 50+ primary care and specialty care clinics, surgical centers, laboratory services, home care, palliative care and hospice services.

The Challenge

The Peacock Clinic was seeking a partner to support the organization accurate and complete ambulatory documentation and coding across primary care and specialties.

The Solution

Optum Advisory (OA) provided ambulatory professional documentation integrity education to the Peacock Clinic's provider groups across multiple work streams. This support spans regulatory changes and optimal documentation across concepts pertaining to the ambulatory professional care settings in support of clinical documentation integrity.

Methodology & Impact

1 Orientation & Onboarding

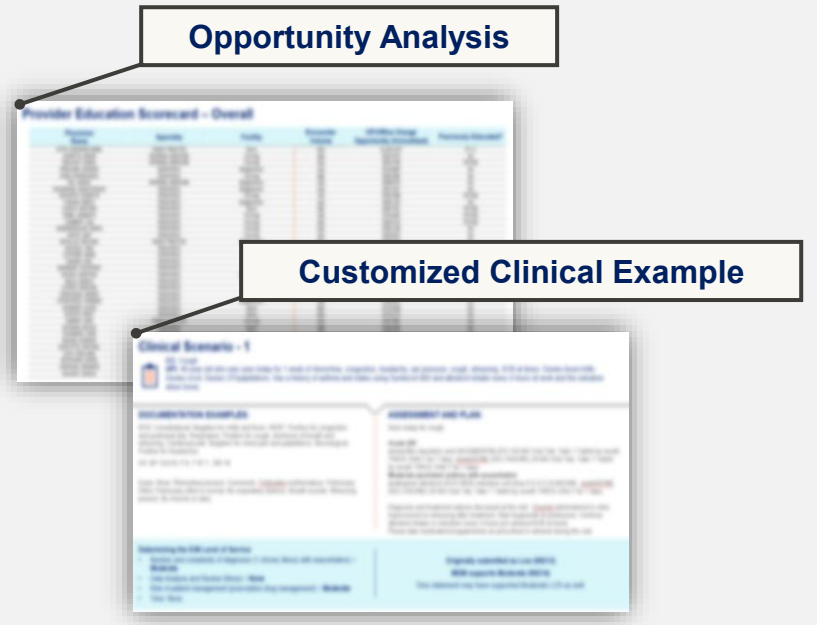
- Foundational onboarding training highlighting the importance of documentation and its downstream effects
- Review basic components of evaluation and management coding including current year changes, with an understanding of how to leverage available internal resources and review real-life case examples

2 Data Analysis & Operational Review

- Opportunity identification including process audit, leadership interviews, focus groups and technology utilization
- Physician education prioritization

3 Physician Education

- Targeted, clinically driven professional retrospective chart reviews
- Specialty-specific physician group education sessions and/or train-the-trainer sessions
- Develop personalized training materials for physicians and advanced practice providers, using case examples to conduct one-on-one and small group provider education sessions



150+ Physicians Educated

15 Specialties

4 Learning Management System Modules Deployed

$2.2M Combined Two-Year Net Financial Improvement

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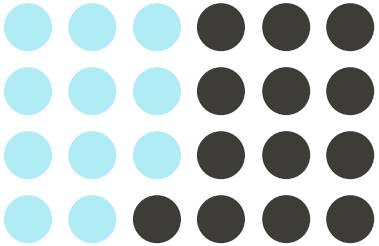
*Organization name has been changed

Sources agree that denials are a growing burden that has reached an impasse

84% of survey respondents said the cost of complying with insurer policies was increasing and 95% of hospitals and health systems reported that their staffs were spending more time on prior approval processes[5].



58%

of insured adults say they have experienced a problem using their health insurance in the past 12 months – such as denied claims, provider network problems, and pre-authorization problems[1]

93%

of health care providers reported delays in patient care due to prior authorizations

>10%

The average initial denial rate based on measurement of more than 1,000 acute care facilities[2]

15%

of all claims submitted to private payers for reimbursement are initially denied, including many that were pre-approved to move forward[3]

>50%

Over half (54.3%) of denials by private payers were ultimately overturned and the claims paid, but only after multiple, costly rounds of provider appeals[3]

~2%

Median final denial write-off rate based on measurement of more than 1,000 acute care facilities[2]

20%

The average total denial rate was for ACA plans sold in the federal marketplace used by most states, according to tracking by the Kaiser Family Foundation[4]

$43

is the average cost incurred by providers fighting denials on a per claim basis – meaning that providers spend $19.7 billion a year just to adjudicate with payers[3]

1. KFF Survey of Consumer Experiences with Health Insurance | KFF)
2. Kodiak Benchmark Generation, 2025
3. Trend Alert: Private Payers Retain Profits by Refusing or Delaying Legitimate Medical Claims
4. Claims Denials and Appeals in ACA Marketplace Plans in 2023 | KFF
5. AHA Payer Denial Tactics — How to Confront a $20 Billion Problem, 2024

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Perspective: Denial Management & Prevention

Denial Management & Prevention

OPERATIONAL PROFILE

1. **Planning and structure drive accountability**

   A right-sized governance structure drives decisions...not just dissection of topics. A leadership focus on resource allocation tempers over-activity while a focus on thoroughness of investigations drives precision with remediation.

2. **Well-coordinated investigations empower change**

   A denial prevention program requires disciplined and routine data analysis to flag hot spots teeing up systematic investigation to uncover root causes. However, analysis *must* shift rapidly to actions that correct upstream opportunities.

3. **Automated action & prediction is the future**

   Denial mitigation is fortified with advanced analytics that support a shift from detection to *foresight*. Embracing robotic process automation and EHR system features can enable automated responses to smooth

Common Challenges:

- Missing elements of structure/governance to control the spigot of new issues
- Analysis paralysis- too much time trending and tracking to the detriment of solving
- Narrow engagement across revenue cycle functional domains limits effective root cause analysis and remediation

High Performer Characteristics:

- Presence of a formal “Denial Coordinator” role to govern all activities
- Grass roots involvement in investigations and problem solving
- Regular key leadership meetings (at least monthly) to drive accountability
- Strong and concise executive communication that outlines current activities and wins for VP/Chiefs

90%

of denied claims are preventable[1]

Optum’s Core Capabilities

(diagnostic and implementation)

- Program assessments and general denial trend analytics
- Denial reporting and dashboard development
- Program design and Implementation
- Program administrative support for investigations and general project management
- Automation activities to support modernization

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1 . HFMA; Success in Proactive Denials Management and Prevention; 2025

Improving Front-End Accuracy & Denial Prevention Through Targeted Operational System Enhancements

The Snowy Clinic*

A large health system in the Northeast was experiencing persistently high volumes of registration and eligibility-related denials, resulting in delayed cash flow, increased rework for revenue cycle teams, and avoidable write-offs. Denials were concentrated across specific departments and registration touchpoints, with inconsistent eligibility verification practices, limited automation, and variability in staff knowledge contributing to performance gaps.

Assessment

Our assessment tested the hypothesis that combining targeted department-level interventions with enterprise-wide automation and system optimization would materially reduce registration and eligibility denials. To evaluate this hypothesis, we focused on 3 key areas: analysis of registration and eligibility denial trends to identify high-impact departments and workflows; evaluation of department-level registration and eligibility processes and staff practices; and review of eligibility system configuration, including automation, payer mapping, and front-end controls.

Recommendation

Our assessment tested the hypothesis that combining targeted department-level interventions with enterprise-wide automation and system optimization would materially reduce registration and eligibility denials. To evaluate this hypothesis, we focused on 3 key areas: analysis of registration and eligibility denial trends to identify high-impact departments and workflows; evaluation of department-level registration and eligibility processes and staff practices; and review of eligibility system configuration, including automation, payer mapping, and front-end controls.

Methodology

1. **Summarize Current Front-End Landscape**
   Analyze registration and eligibility denial data to identify high-volume departments and key denial trends and document findings related to registration and eligibility processes, operational practices, and education gaps across patient access departments.
2. **Assess Process, Education and Technology Opportunities**
   Evaluate department-level registration and eligibility processes, staff training and knowledge consistency, and assess system configuration.
3. **Solution Design and Roadmap**
   Develop a standardized, tech-driven registration and eligibility process that integrates focused education, key technology upgrades, and a phased rollout plan.

Targeted Education:

Work Completed:

6+ Workgroups established to address registration, eligibility, and coordination of benefit denials root cause

25+ targeted education and training sessions delivered to top departments contributing to the majority of front-end denials

40+ Interventions captured and tracked aimed at reducing initial denial volume

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Improving Front-End Accuracy & Denial Prevention Through Targeted Operational System Enhancements

Improvement Themes:

1. **Standardize Registration & Eligibility Practices Across the Enterprise**
2. **Leverage Technology and Automation to Prevent Denials Upstream**
3. **Deploy Targeted & Systemwide Education**
4. **Create Data-Driven Visibility Into Denial Trends and Performance**

Initiative Examples:

Systemwide Registration & Eligibility Education

- ✓ *Deployed standardized education curriculum to drive consistent practices across patient access teams.*
- ✓ *Created Tip sheets and issued payer-specific guidance to address targeted areas driving high volumes of denials*

Batch and Real-Time Eligibility (RTE) Optimization

- ✓ *Standardized and optimized batch and real-time eligibility processes to improve coverage accuracy*
- ✓ *Configured RTE to run closer to date of service reducing gaps in missing coverage and accuracy before billing*

Manager Training Program

- ✓ *Delivered a five-part manager training series to build registration and eligibility expertise & equipping managers with data to coach teams & drive accountability.*
- ✓ *Developed scorecards and dashboards to increase manager visibility into preventable denials and strengthen accountability for account review*

Business Impact

The implementation of a denials prevention workgroup, targeted education, system enhancements, and sustained governance drove meaningful and measurable reductions in denials.

30%
Reduction across initial reg/elig/COB denials in 12 months

1,882
Average reduction denials per month

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