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- Charity Brown, Director of Communications



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Message From the Board

Wendi Cardwell, President, NCHFMA (2026-2027)
Sr. Director, Patient Finance, Novant Health



It is both an honor and a privilege to serve as President of our chapter. I am grateful for the opportunity to work alongside such a dedicated group of healthcare finance professionals who are committed to advancing our industry, supporting one another, and improving the communities we serve.

As we begin this new year together, I am excited about the opportunities ahead. Healthcare continues to evolve at a rapid pace, presenting both challenges and opportunities for growth, innovation, and collaboration. Our chapter remains committed to providing valuable educational programs, meaningful networking opportunities, and resources that support the professional development of our members.

The strength of our organization lies in the engagement and expertise of its members. Whether you are a long-time member, a new professional entering the field, or a valued business partner, your contributions help make our chapter a vibrant and impactful community. I encourage each of you to take advantage of the programs and events offered throughout the year and to become actively involved in our chapter activities.

I would also like to recognize and thank our volunteer leaders, committee members, sponsors, and chapter supporters. Their dedication and commitment are essential to our success and enable us to deliver exceptional value to our membership.

Together, we will continue to foster professional excellence, promote innovation, and strengthen the connections that make our chapter a trusted resource for healthcare financial management professionals.

Thank you for your support and engagement. I look forward to serving alongside you and to an exciting and successful year ahead.

Sincerely,

Wendi Cardwell

2026-2027 NC HFMA Chapter Leadership

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HFMA Event Highlights



HFMA Event Highlights



HFMA Event Highlights



Upcoming NCHFMA Events

In-person Events



NCHFMA Healthcare Finance Bootcamp

October 13th 2026

8:00 AM - 4:30 PM

The Pearl @ Advocate Health
3300 Flex Classroom | 915 Pearl Park Way
Charlotte, NC 28204

[Register Here](#)



North Carolina HFMA 2027 Annual Conference

February 10th - 12th 2027

Pinehurst Resort
Pinehurst, NC

Registration Coming Soon

Upcoming NCHFMA Events

Virtual Events



NCHFMA Certified Revenue Cycle (CRCR) Masterclass Sessions

October 13th - November 24th 2026
Weekly on Tuesdays
1:00 PM - 2:00 PM

[Register Here](#)



Region 4 HFMA Webinar Mastering Lean Business Excellence in the Revenue Cycle: Tools and Strategies for Success

October 22nd 2026
12:00 PM - 1:00 PM

[Register Here](#)

North Carolina Hospital Compliance: Medical Debt, Charity Care, and Transparency Pressures in 2026

Educational Article

by John Lloyd, CHFP, CRCR, EHRC
Senior Vice President at



As healthcare organizations across North Carolina navigate an increasingly complex regulatory and financial environment, compliance has become more than a policy requirement—it is a strategic responsibility.

Hospitals are being asked to demonstrate greater accountability in managing medical debt, communicating financial assistance options, protecting vulnerable patients, and maintaining transparency throughout the revenue cycle.

From my perspective as a healthcare finance professional, the most effective organizations will be those that integrate compliance, operations, patient experience, and measurable outcomes into a single coordinated approach. This article highlights the key compliance concerns facing North Carolina hospitals and the practical steps leaders can take to strengthen readiness, reduce risk, and better support patients.

North Carolina hospitals are operating in one of the most closely watched compliance environments in the country. Following Medicaid expansion and the state's innovative use of the Healthcare Access and Stabilization Program, hospitals now face heightened expectations around medical debt relief, charity care, patient financial assistance, billing transparency, and debt collection practices. What began as a policy initiative to relieve historic medical debt has quickly become a broader compliance priority that requires strong governance, reliable data, consistent patient-facing processes, and careful monitoring across revenue cycle operations.

Why Compliance Risk Is Increasing

The central compliance concern for hospitals in North Carolina is no longer limited to the mere existence of a financial assistance policy. Regulators, policymakers, patient advocates, and the public are increasingly focused on whether hospitals can demonstrate that those policies are being applied consistently and

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effectively. The North Carolina Department of Health and Human Services has tied enhanced Medicaid-directed payments to hospital commitments to relieve eligible medical debt and adopt forward-looking charity care and collection protections. This creates a direct connection between hospital reimbursement, patient financial experience, and compliance performance.

For hospital leaders, this means compliance cannot be only within legal or policy teams. It must be embedded into registration, eligibility screening, patient access, billing, collections, vendor management, reporting, and executive oversight. Any gap between written policy and operational practice can create reputational risk, repayment exposure, patient complaints, or scrutiny from state and federal stakeholders.

Key Compliance Concerns for North Carolina Hospitals

1. Medical Debt Relief and HASP Participation Requirements

North Carolina's medical debt mitigation initiative requires participating hospitals to meet specific commitments as a condition of receiving enhanced payments through HASP. These commitments include relieving qualifying historical medical debt, adopting stronger financial assistance protections, limiting harmful collection activity, and ensuring that patients are not burdened by debts that should be eligible for relief. Hospitals must be prepared to document how eligible accounts are identified, reviewed, adjusted, and reported.

The operational risk is significant because debt relief depends on accurate income data, Medicaid enrollment information, account aging, balance thresholds, vendor coordination, and adjustment logic. Hospitals should verify that internal systems and external collection partners comply with state requirements and that account-level decisions are auditable.

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2. Charity Care Eligibility and Presumptive Screening

Hospitals are facing increased pressure to make charity care more proactive, standardized, and accessible. The compliance issue is not simply whether a patient can apply for assistance; it is whether the hospital is appropriately identifying patients who may qualify before accounts are sent to collections. Presumptive eligibility screening, automatic qualification for certain public benefit populations, and clear discount policies are becoming central expectations.

Hospitals should review whether financial assistance workflows are consistent across facilities, service lines, and patient access points. Inconsistent application of charity care policies can lead to patient harm, regulatory scrutiny, and negative public perception, particularly when nonprofit hospitals are expected to demonstrate community benefit.

3. Billing, Collections, and Credit Reporting Practices

Debt collection practices are a major compliance concern in North Carolina. Hospitals participating in the state initiative must ensure that collection activity does not conflict with commitments related to eligible patients, low-income thresholds, interest limitations, home liens, debt sales, or credit reporting restrictions. The most challenging area for many organizations is vendor oversight, because outside agencies may continue legacy processes unless contract language, account placement rules, and quality controls are updated.

Hospitals should treat collections compliance as an enterprise risk. Written policies, patient notices, vendor contracts, system flags, exception reporting, and complaint tracking should be reviewed together. A single improper collection action can undermine the credibility of a hospital's broader financial assistance program.

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4. Price Transparency and Good Faith Estimate Expectations

Price transparency remains another area of concern. Federal hospital price transparency requirements continue to evolve, and North Carolina has maintained a strong focus on healthcare cost transparency. Hospitals must ensure that machine-readable files, shoppable service displays, financial assistance pages, and patient estimate tools are accurate, accessible, and up to date. Inaccurate or incomplete pricing information can create compliance exposure and damage patient trust.

Hospitals should also prepare for increased attention to whether patients receive understandable billing information before accounts are escalated. Clear line-item bills, meaningful estimates, plain-language notices, and documented patient communication practices are becoming essential elements of a defensible compliance program.

5. Reporting, Audit Readiness, and Governance

The next phase of compliance will likely focus on proof. Hospitals will need to demonstrate not only that policies are in place, but that they are working as intended. This includes maintaining documentation for debt-relief activities, charity-care determinations, patient notifications, collection holds, vendor instructions, and reporting submissions. Compliance teams should partner closely with revenue cycle, finance, IT, legal, and patient experience leaders to create a single source of truth for program performance.

Board and executive-level oversight is also important. Given the financial and reputational stakes, leadership should receive regular reports on debt-relief volumes, charity-care approvals, denial trends, collection exceptions, patient complaints, vendor performance, and corrective actions.

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Recommended Action Steps

- Conduct a GAP assessment comparing current financial assistance, billing, and collection policies against North Carolina medical debt mitigation requirements.
- Validate that the eligibility of screening logic, Medicaid indicators, income thresholds, and account aging rules are accurate and consistently applied.
- Review contracts and operating procedures for collection agencies, early-out vendors, legal collection partners, and debt buyers.
- Establish audit trails for all debt relief, charity care, and collection suppression decisions.
- Test public-facing financial assistance and price transparency content for accuracy, accessibility, and plain-language clarity.
- Create executive dashboards that track relief amounts, patient impact, exceptions, complaints, and compliance remediation.
- Train patient access, billing, customer service, and collections teams on updated North Carolina-specific requirements.

Conclusion

North Carolina's hospital compliance environment is shifting from policy adoption to performance accountability.

Hospitals that can operationalize medical debt relief, charity care, transparent billing, and responsible collection practices will be better positioned to protect reimbursement, reduce patient financial harm, and strengthen public trust.

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Educational Article - Continued

by John Lloyd, CHFP, CRCR, EHRC
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The organizations most prepared for this environment will be those that treat compliance as a measurable, cross-functional discipline rather than a static policy requirement.

About the Author

John Lloyd, CHFP, CRCR, EHRC, is the Senior Vice President for ClearBalance Healthcare with extensive experience in strategic account management, revenue cycle performance, patient financing, patient financial engagement, and executive client partnerships. He works nationally with hospitals and health systems to align operational strategies, compliance priorities, patient financing solutions, and measurable financial outcomes, with a focus on improving transparency, strengthening patient-centered financial practices, and supporting sustainable performance across the healthcare revenue cycle. John currently serves as Secretary/Treasurer and a board member of the North Carolina Healthcare Financial Management Association.

From Recovery to Resilience: How Health Systems Break the Denial Cycle by Rebuilding Trust, Discipline, and Accountability Upstream

Educational Article

by Emily Baxter's team at



Executive Summary

Denials have become an accepted cost of doing business in healthcare. Most health systems no longer question whether denials will occur; they've adapted to managing them. That adaptation is understandable, but survival is not the same as progress.

Meaningful, sustainable improvement in net revenue requires shifting focus upstream: from denial recovery to denial prevention, through trust-led leadership, operational discipline, and cross-functional accountability. When done well, this reduces administrative waste on both sides, improves AR health, strengthens payer-provider relationships, and delivers a more predictable experience for patients.

1. The Structural Trap

Most revenue cycle leaders did not choose to over-invest downstream; they were pushed there by quarter-to-quarter cash pressure, aging AR, and scorecards built on lagging indicators. Denial recovery dominates attention not because it delivers the greatest long-term value, but because it feels controllable in the short term. Meanwhile, upstream issues persist: authorization gaps, documentation inconsistencies, status determination errors, and misaligned workflows.

The result is a cycle many organizations know well:

- The same denial categories reappear month after month
- Teams work harder, not smarter; burnout increases
- Marginal returns diminish and net revenue erodes

This reflects a system optimized for reaction rather than prevention. When evidence arrives late, in denial reports and retroactive adjustments, trust erodes internally and externally.

From Recovery to Resilience: How Health Systems Break the Denial Cycle by Rebuilding Trust, Discipline, and Accountability Upstream

Educational Article - Continued
by Emily Baxter's team at



2. Denial Prevention as a Trust-Led Strategy

Denial prevention is not a product, a rule set, or a switch. There is no installable version. Prevention lives at the intersection of three forces:

- Operational discipline: consistent execution of known best practices, even when it temporarily slows things down
- Clear ownership: explicit accountability for where denials originate, not just where they are worked
- Shared incentives: alignment across functions historically measured and rewarded differently

When these elements converge, denial data stops being a scoreboard and becomes a learning system. The question shifts from “Whose fault is this denial?” to “What would prevent it from happening again?”. That shift, from blame to learning, is where trust begins.

3. Seeing the Work as It Actually Happens

Many organizations understand how their top denials occur. No-auth denials are not mysterious. Status downgrades are not confusing. The real challenge is execution, not awareness.

Knowing that authorizations are missed is different from building a reliable system that flags every scheduled service requiring authorization before the claim goes out. Understanding that short stays are being downgraded is different from implementing a workflow that pauses those claims long enough to validate status without destabilizing billing performance.

This is also where a critical mindset shift occurs: the goal is no longer to get claims out the door as fast as possible, but to get them right the first time. In some cases, this requires short-term tolerance for modest increases in DNFB in exchange for more accurate submissions. That tradeoff must be intentional, monitored,

From Recovery to Resilience: How Health Systems Break the Denial Cycle by Rebuilding Trust, Discipline, and Accountability Upstream

Educational Article - Continued
by Emily Baxter's team at



and supported at the leadership level, not absorbed silently by billing teams caught between conflicting incentives. When leaders make that tradeoff explicit, trust deepens and honest conversations become possible.

4. Executive Air Cover Is Non-Negotiable

Denial prevention fails quietly when treated as a revenue cycle initiative. Billing teams are measured on DNFB and throughput. Denials teams on overturn rates. Patient access on scheduling efficiency. Each function may perform well by its own definition while the organization as a whole struggles.

Shifting focus upstream introduces tension; holding claims, pausing workflows, reallocating resources. Without executive alignment, that risk is rarely tolerated. Sustainable prevention requires leadership to redefine what success looks like, create latitude for short-term discomfort, and make denial prevention an organizational priority, not a departmental experiment. When leaders model that commitment, silos soften and teams begin to believe upstream improvement is expected.

5. Operational Discipline Across the Revenue Cycle

Denial prevention is the product of coordinated execution across multiple functions:

- Patient Access: reliable authorization workflows and disciplined follow-up reduce avoidable denials before claims are submitted
- Billing & Coding: edit rigor aligned to payer rules; willingness to trade “clean claim” optics for downstream stability
- CDI/CDE: aligning clinical narratives with medical necessity requirements reduces queries, rework, and downstream friction

From Recovery to Resilience: How Health Systems Break the Denial Cycle by Rebuilding Trust, Discipline, and Accountability Upstream

Educational Article - Continued
by Emily Baxter's team at



- Denials & Follow-Up: accurate categorization transforms denial work from reactive cleanup into actionable insight
- Analytics: surfacing trends, validating impact, and guiding prioritization

6. Denial Prevention as a Payer-Provider Efficiency Play

High overturn rates are not a badge of honor; they signal shared administrative waste. When providers can demonstrate with specificity that certain denials are consistently overturned, new conversations become possible. In some cases the work belongs on the provider side; in others, payer policies may warrant refinement.

Our team has worked alongside providers and payers to identify patterns where repeated denials are overturned on appeal, in some cases leading to policy changes that eliminated unnecessary rework for both sides. One example: a specific category of readmission denials consistently overturned due to clinical nuance led to direct dialogue with the payer, resulting in refined audit criteria and removal of certain diagnosis codes from automatic review. These conversations succeed not through escalation, but through credibility, clear data, shared context, and mutual interest in reducing rework. Shared facts change behavior faster than shared frustration.

7. The Patient Impact

Patients see denials in the form of EOBs that reflect denied claims and apparent out-of-pocket balances. What they cannot see is whether appeals will succeed or how long corrections will take. First-pass denials trigger confusing EOBs, perceived financial liability, and status changes that alter out-of-pocket responsibility, sometimes with statements delayed months or more than a year after care was delivered.

From Recovery to Resilience: How Health Systems Break the Denial Cycle by Rebuilding Trust, Discipline, and Accountability Upstream

Educational Article - Continued
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Even when corrections eventually occur, trust has already been strained. Getting it right the first time is one of the most effective ways to reduce patient confusion and dissatisfaction. Patients experience the consequences of operational misalignment whether organizations acknowledge it or not.

8. Measuring What Matters

Denial prevention requires patience and the right metrics. Fatal denials are a lagging indicator — they tell a story too late to guide early decisions. More useful leading signals:

- First-pass denial rates
- Category-specific trends
- Behavioral compliance across functions

Progress should be measured quarter-over-quarter, not week-over-week. Claims must travel through scheduling, authorization, documentation, billing, adjudication, and reporting before meaningful trend shifts appear. Leaders should define in advance which indicators will validate that the strategy is working before bottom-line metrics fully reflect it. Trust grows when leaders align not just on what success looks like, but when it should reasonably appear.

Conclusion: Slowing Down to Finally Get Ahead

Organizations that commit to this shift do not stop working denials, they simply stop letting denials define their strategy. The payoff is meaningful: lower administrative burden, stronger payer relationships, better patient experiences, and a healthier revenue system.

Trust is not built by fixing errors faster. It is built by creating fewer errors to fix.

From Recovery to Resilience: How Health Systems Break the Denial Cycle by Rebuilding Trust, Discipline, and Accountability Upstream

Educational Article - Continued
by Emily Baxter's team at



For many organizations, making this shift raises a practical concern: how to invest upstream without destabilizing current cash performance. Internal teams must redirect focus toward prevention, providing continuity of performance as operational discipline takes root.

Prevention requires intention. Execution requires capacity.

With the right alignment and support, health systems do not have to choose between protecting today's revenue and building tomorrow's resilience.

The Robots Are Coming... But They Still Need a Revenue Cycle Leader

Educational Article

by Olivia Currin-Britt
VP, Client Success at



If you have worked in healthcare revenue cycle long enough, you have probably heard every version of the same prediction: “Automation is going to transform everything.”

First, it was the electronic health record. Then, robotic process automation. Then predictive analytics. Now, artificial intelligence has entered the conversation, and this time, it feels different.

The robots are coming.

But before we hand over the revenue cycle keys and tell AI to “call us if there are any problems,” we should remember something important: technology is only as effective as the leaders guiding it.

After all, nobody wants an AI-powered system that can process 10,000 claims in seconds but still cannot explain why a patient received a confusing bill, why a denial occurred, or why the front-end process created a downstream mess.

And let’s be honest, if there is one thing healthcare has mastered, it is creating complicated processes. We have workflows that require workflows, committees to discuss workflows, and sometimes meetings to decide when the next meeting about workflows should occur.

The future of revenue cycle will not be humans versus machines. It will be humans with machines.

Artificial intelligence is already changing how healthcare organizations approach patient access, prior authorization, coding, billing, denial prevention, and payment processes. The future revenue cycle will require organizations to rethink workflows, redesign work, and use automation to allow employees to focus on areas where human judgment matters most.

That last point is critical.

The Robots Are Coming... But They Still Need a Revenue Cycle Leader

Educational Article - Continued

by Olivia Currin-Britt
VP, Client Success at



Automation is excellent at identifying patterns, processing transactions, and reducing repetitive tasks. But revenue cycle leaders know that healthcare finance is rarely simple. Behind every account is a patient, a clinical story, a payer policy, and often an exception that does not fit neatly into an algorithm.

A machine may identify that a claim is likely to be denied. A leader must ask:

- Why is it denying?
- Is the root cause operational, clinical, or payer-related?
- How do we prevent this from happening again?
- How do we improve the patient experience?

The best revenue cycle leaders of the future will not be the ones who eliminate people from the process. They will be the ones who eliminate unnecessary work so their teams can focus on higher-value activities.

Healthcare has never been a purely transactional business. It is personal.

A patient calling about a bill is not thinking about workflow optimization, denial rates, or automation strategy. They are thinking: “Can someone help me understand what happened?”

That moment requires empathy, communication, and judgment, skills no chatbot can fully replace.

As healthcare organizations introduce more automation, leaders must ensure their teams are prepared for new roles. The revenue cycle workforce of tomorrow will need stronger analytical skills, technology fluency, and the ability to manage increasingly complex exceptions.

The American Hospital Association has emphasized that healthcare workforce transformation requires building digital skills, redesigning roles, and preparing teams to work alongside emerging technologies.

The Robots Are Coming... But They Still Need a Revenue Cycle Leader

Educational Article - Continued

by Olivia Currin-Britt
VP, Client Success at



In other words, the question is not:

“How do we replace our revenue cycle employees with AI?”

The better question is:

“How do we empower our revenue cycle employees with AI?”

The next generation of revenue cycle leaders will look different. They will need to be part strategist, part technologist, part coach, and occasionally part translator between humans and machines.

They will need to understand denial trends and data analytics. They will need to speak the language of finance, operations, IT, and patient experience. Most importantly, they will need to lead change in an industry where change is constant.

The robots may be coming, but they are not bringing a strategy with them. That remains our job.

The future belongs to organizations that combine the speed and intelligence of technology with the judgment, compassion, and leadership of people.

Because at the end of the day, the healthcare revenue cycle is not just about collecting dollars. It is about supporting the mission of healthcare.

And that mission will always require humans.

When Clean Claims Still Don't Pay: A Managed Care Perspective on Revenue Cycle Friction

Educational Article

by Colleen Thedieck
Managed Care Director



Healthcare organizations have spent years improving the fundamentals of revenue cycle performance. They have invested in front-end accuracy, coding education, clinical documentation, claims technology and denial management. Those investments matter. A poorly registered, incorrectly coded or unsupported claim creates avoidable revenue risk.

But what happens when the organization gets those fundamentals right and payment still does not follow? A claim may be accurately coded and medically necessary, yet become caught in repeated medical record requests, payer-specific edits, clinical review, ambiguous denial language or extended administrative review. Revenue cycle responds as it should: Staff investigate, resubmit documentation, appeal and escalate. Then the process repeats.

At some point, healthcare finance leaders should ask a different question.

Are we looking at a revenue cycle problem, or is revenue cycle revealing a managed care problem?

For health systems trying to protect margin while reducing administrative expense, that distinction matters. The next opportunity in denial prevention may not come solely from making revenue cycle teams better at responding to payer friction. It may come from using what those teams experience to strengthen payer strategy, contract language and accountability.

Revenue cycle sees the transaction. Managed care should see the pattern.

Revenue cycle teams work where payer policy, contract terms and operational reality collide. They see the medical record request that was fulfilled but followed by another request. They see a denial for insufficient documentation without a clear explanation of what was missing. They encounter payer edits that produce reimbursement inconsistent with what the organization expected when the contract was negotiated.

When Clean Claims Still Don't Pay: A Managed Care Perspective on Revenue Cycle Friction

Educational Article - Continued

by Colleen Thedieck
Managed Care Director



Individually, these issues look operational. Collectively, they can reveal something strategic. Repeated administrative friction may indicate ambiguity around clinical review standards, payment policies, claims-editing methodologies, audit procedures, escalation pathways or contract interpretation. That is where managed care should become involved.

A denial should not always be viewed simply as an account that needs to be worked. A pattern of similar denials may be evidence about how a payer is administering the contract. That changes the conversation.

Instead of asking only, “How do we overturn this denial?” organizations should also ask:

- What payer behavior is creating this pattern?
- What contract or policy provision governs it?
- Is the provision sufficiently clear?
- Is the payer administering the provision consistently?
- What is the financial and administrative impact?
- Should this issue become part of the next payer discussion or negotiation?

This is the difference between denial management and revenue protection. One solves the individual claim. The other asks why the organization keeps having to solve the same claim problem.

Four friction points deserve a managed care lens

Not every denial belongs at the negotiating table. Some claims are denied because of legitimate errors, missing information or failure to meet contractual requirements. But recurring patterns deserve deeper analysis.

When Clean Claims Still Don't Pay: A Managed Care Perspective on Revenue Cycle Friction

Educational Article - Continued

by Colleen Thedieck
Managed Care Director



Consider four common examples:

1. Repeated medical record requests

A payer requests records. The provider submits them. Another request follows, sometimes for information that was already provided or could have been identified during the initial review.

The operational response is to resend the documentation.

The strategic question is different: What does the contract say about medical record requests, audit procedures and response timelines?

Organizations should evaluate whether the contract clearly establishes what documentation may be requested, how requests are communicated, how receipt is acknowledged and what happens after the provider complies.

The goal is not to eliminate legitimate payer review. It is to create a process in which both parties understand the rules.

2. "Insufficient documentation" denials without sufficient specificity

A denial that says only "insufficient documentation" creates another form of friction. The provider cannot efficiently correct or appeal a deficiency it cannot identify.

Revenue cycle can request clarification, but managed care should examine whether repeated vague denials indicate a larger policy or contract administration issue.

Questions worth asking include: What clinical policy or coverage criteria were applied? What documentation was considered? What specific information was deemed insufficient? Does the contract provide a mechanism for challenging inconsistent application of payer policies?

When Clean Claims Still Don't Pay: A Managed Care Perspective on Revenue Cycle Friction

Educational Article - Continued

by Colleen Thedieck
Managed Care Director



Greater specificity benefits both sides. Providers can respond to legitimate deficiencies more efficiently, while payers receive appeals that address the actual issue rather than generating another round of administrative correspondence.

3. Payment edits and bundling disputes

Payment integrity programs have become an important part of payer claims administration. Providers, meanwhile, may find that the editing methodology applied to a claim differs from their interpretation of coding standards or negotiated reimbursement terms.

When the same edit repeatedly affects a service line, the issue should move beyond account-level follow-up. Managed care, revenue integrity and revenue cycle leaders should determine which coding or payment standard governs the disputed services, whether the payer's methodology is consistent with the contract and how policy changes are communicated.

A recurring payment edit is not simply a denial metric. It may represent a contract-value issue.

4. Claims caught in extended review cycles

Some claims move repeatedly between pending review, requests for information, medical review and other administrative statuses.

The individual account remains unresolved while staff continue working it. This creates two costs.

The first is obvious: delayed cash.

The second receives less attention: the labor required to keep pursuing payment.

Healthcare organizations should therefore evaluate payer performance using more than denial rates. They should examine how long disputed claims remain unresolved, how many touches are required, which payers generate repeated documentation requests and which issues consume disproportionate staff resources.

When Clean Claims Still Don't Pay: A Managed Care Perspective on Revenue Cycle Friction

Educational Article - Continued

by Colleen Thedieck
Managed Care Director



The financial question is no longer simply, “Did we eventually get paid?”. It becomes, “What did it cost us to get paid according to the agreement?”

Build a feedback loop between revenue cycle and managed care

In many organizations, revenue cycle and managed care operate adjacent to one another but not always as one reimbursement strategy. That separation can become expensive.

Revenue cycle may have detailed knowledge of payer behavior that never reaches the contract negotiation team in a usable form. Managed care may negotiate language without seeing how previous provisions performed at the claim level.

The solution is not another standing meeting without a purpose. It is a structured payer feedback loop. A practical approach can begin with four steps:

First, identify material patterns.

Do not send every denial to managed care. Establish thresholds for issues that deserve strategic review based on dollars, volume, recurrence, service-line impact or administrative burden.

Second, quantify the impact.

For each material issue, identify affected revenue, claim volume, aging, overturn experience and staff effort where those data are available. This moves the discussion from anecdotes to business impact.

“We have a problem with medical record requests” is difficult to negotiate.

“This payer generated a recurring documentation pattern affecting a defined service line, delaying a measurable amount of reimbursement and requiring repeated follow-up” creates a much stronger discussion.

When Clean Claims Still Don't Pay: A Managed Care Perspective on Revenue Cycle Friction

Educational Article - Continued

by Colleen Thedieck
Managed Care Director



Third, trace the issue back to the governing source.

Determine whether the disputed behavior originates in contract language, a payer policy, coding methodology, provider manual, amendment or operational workflow. This step is critical.

Organizations sometimes attempt to solve contract problems operationally and operational problems contractually. Neither approach works well.

Fourth, decide the appropriate intervention.

The answer may be staff education. It may be a payer operational meeting. It may require policy clarification. Or it may become a negotiation priority.

The objective is to place the problem at the level where it can actually be solved.

Bring operational evidence to the negotiating table

Managed care negotiations often focus heavily on rates. Rates matter. But a strong reimbursement rate loses value when administrative friction makes the contracted revenue difficult or expensive to collect.

This is why organizations should consider the operational performance of the contract alongside its rate structure.

Before a major payer negotiation, managed care leaders can work with revenue cycle, revenue integrity, finance and clinical teams to develop a payer friction profile. That profile might include:

- High-dollar recurring denial categories
- Medical record request patterns
- Payment policy disputes
- Claims-editing concerns
- Aging associated with payer review

When Clean Claims Still Don't Pay: A Managed Care Perspective on Revenue Cycle Friction

Educational Article - Continued

by Colleen Thedieck
Managed Care Director



- Recurring underpayment issues
- Escalation effectiveness
- Administrative burden associated with disputed claims
- Contract provisions connected to those patterns

The purpose is not to arrive at negotiations with a long list of complaints. It is to identify which operational issues materially reduce the economic value of the agreement. That distinction is important.

A negotiation becomes stronger when the provider can connect an operational problem to financial impact and then propose a reasonable mechanism for improving performance.

For example, instead of simply arguing that documentation requests are excessive, the organization might seek clearer documentation requirements, defined response processes and escalation mechanisms. Instead of repeatedly debating a payment edit claim by claim, the parties might clarify which payment methodology applies. Instead of allowing disputed issues to circulate indefinitely through customer service channels, the agreement may need clearer escalation pathways for material contract disputes. The best contract language cannot eliminate every disagreement. It can, however, reduce ambiguity about how disagreements will be handled.

Measure contract performance after the signature.

One of the easiest mistakes in managed care is treating contract execution as the finish line. It is not. A negotiated agreement has value only if the economics and terms translate into actual operational performance. Healthcare finance leaders should therefore think about contract performance longitudinally.

After implementation, organizations should ask:

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Educational Article - Continued

by Colleen Thedieck
Managed Care Director



- Are expected reimbursement changes appearing on claims?
- Have the administrative issues raised during negotiations improved?
- Are new payer policies changing the economics of the agreement?
- Are particular service lines experiencing unexpected payment behavior?
- Are escalation mechanisms working?

This is where payer scorecards can become valuable. A meaningful payer scorecard should go beyond reimbursement rates and total denials. It can combine financial, operational and relationship measures to create a more complete picture of payer performance. That information then becomes part of future strategy.

Managed care enters the next negotiation with evidence instead of memory. Revenue cycle understands which issues have enterprise visibility. Finance has a clearer picture of where contract value may be leaking. And payer conversations can focus on measurable performance rather than isolated anecdotes.

The goal is not fewer appeals. It is less avoidable friction.

Healthcare will always have complicated claims. There will always be documentation questions, coding disputes, medical necessity reviews and legitimate disagreements between payers and providers. The goal should not be to pretend that complexity can be removed from the system.

The goal should be to stop accepting repetitive, avoidable friction as a normal cost of doing business. Revenue cycle teams should continue strengthening the fundamentals. Accurate registration, coding, documentation and timely follow-up remain essential.

But healthcare organizations should also recognize what revenue cycle data can tell them about the

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performance of their payer agreements.

A denial is an operational event.

A repeated denial pattern is information.

And information, when connected to contract strategy, becomes leverage.

Healthcare organizations have spent years teaching teams how to work claims more effectively. The next opportunity is to use those experiences to design stronger payer relationships, clearer contracts and more accountable reimbursement processes.

Because the real measure of a managed care agreement is not simply the rate printed in the contract. It is how reliably that contract turns care delivered into revenue collected.

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