

AI & AUTOMATION

Discover how AI is transforming Revenue Cycle Management. Smarter workflows, faster decisions, better outcomes.

DENIALS MANAGEMENT

Reducing denials and accelerating revenue recovery.

PRIOR AUTHORIZATION & REGULATORY COMPLIANCE

Simplifying authorizations while staying compliant.

CLAIMS & MEDICAL CODING

Improving coding accuracy and claim success.

FINANCIAL STRATEGY & PERFORMANCE

Driving stronger financial outcomes through smarter RCM.

AUGUST, 2026

NEWS UPDATE

RCM INSIGHTS

JULY - AUGUST 2026 | VOLUME - 01 | ISSUE - 01 | A BIMONTHLY NEWS LETTER

ABOUT RCM

Revenue Cycle Management optimizes healthcare financial performance by streamlining patient access, billing, claims, payments, collections, and reimbursement across the entire care journey.

NOTE FROM The Editor



August is usually a quiet month in healthcare finance. This year it wasn't. The gap between how much AI healthcare organizations have adopted in the revenue cycle and how much value they are actually capturing widened into one of the defining stories of 2026: 63% of organizations now use AI or automation somewhere in revenue cycle operations, yet only 15% report positive ROI, and just 27% have moved past pilots into deployment at scale. That gap — between adoption and impact — is the thread running through nearly every article in this issue.

Denials remain at the sharpest edge of that gap. Initial denial rates have climbed to roughly 11.8%, hospitals spent close to \$18 billion overturning denials in 2025 alone, and the industry loses an estimated \$48.4 billion a year to denials and uncollected balances. Prior authorization, meanwhile, is entering a genuine regulatory reset: CMS's electronic prior authorization rule took effect on schedule this year, and a follow-on proposal extending similar requirements to prescription drugs is now moving through the comment process.

On the patient side, financial responsibility keeps climbing faster than most organizations' collection strategies have adapted to it — average deductibles are up 17% in five years, and marketplace out-of-pocket maximums rose another 15% for 2026 alone. For CFOs, that shift is no longer background noise: for the first time, patient financial experience has overtaken revenue growth as revenue cycle leaders' top strategic priority.

This issue brings together the data, the vendor landscape, and the practical guidance revenue cycle leaders need to navigate all of it. As always, we welcome your feedback and story ideas for next month.

Vital Information from This Issue

- AI adoption in RCM is broad but shallow — 63% adoption vs. just 15% realized ROI.
- Denials are the single largest controllable source of revenue leakage in healthcare finance today.
- CMS's prior authorization reform is now enforceable, with drug prior auth reform following close behind.
- Patient financial experience has become CFOs' top strategic priority for the first time.

NEWS UPDATE

THE BIG PICTURE

Revenue cycle management enters the second half of 2026 defined by a widening gap between AI adoption and AI impact, a regulatory reset in prior authorization, and a fundamental shift in how CFOs prioritize patient financial experience relative to revenue growth. Below is a one-page view of the numbers and trends shaping the month.



TOP STATISTICS THIS MONTH

- 63%** of provider organizations use AI/automation in RCM — but only **15%** report positive ROI. [\[Page 03\]](#)
- 11.8%** average initial claim denial rate industry-wide, up from **10.2%** in 2020. [\[Page 02\]](#)
- \$48.4** billion in annual revenue leakage tied to denials and uncollected balances (2025). [\[Page 05\]](#)
- 52.8** million Medicare Advantage prior authorization determinations in 2024; **80.7%** of appealed denials were overturned. [\[Page 04\]](#)
- 71%** of revenue cycle leaders now rank patient financial experience as their top strategic priority. [\[Page 07\]](#)

KEY TRENDS TO WATCH

- Agentic AI platforms are moving from pilot to production in denial prevention, prior authorization, and coding.
- Platform consolidation produces measurable cost-to-collect improvements — not just operational convenience.
- Patient collections are becoming a consumer-retail problem: digital-first payment expectations, financing, and upfront estimates.
- Workforce strategy is shifting toward hybrid models — automation for high-volume tasks, skilled staff for judgment-heavy exceptions.
- Regulatory pressure on prior authorization is intensifying, with electronic workflows now a compliance requirement, not an option.
- Healthcare organizations are adopting AI to streamline prior authorization workflows and reduce administrative complexity. This helps accelerate approvals, minimize delays, and improve the overall patient and provider experience.
- Healthcare leaders are shifting their focus toward protecting revenue across every stage of the Revenue Cycle.

LETS

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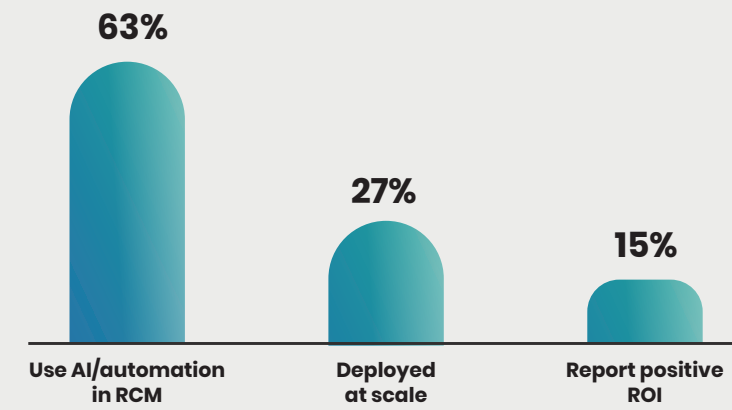
Transform your Revenue Cycle with intelligent strategies that drive measurable financial outcomes.

Market Snapshot

The headlines revenue cycle leaders were talking about in August 2026.

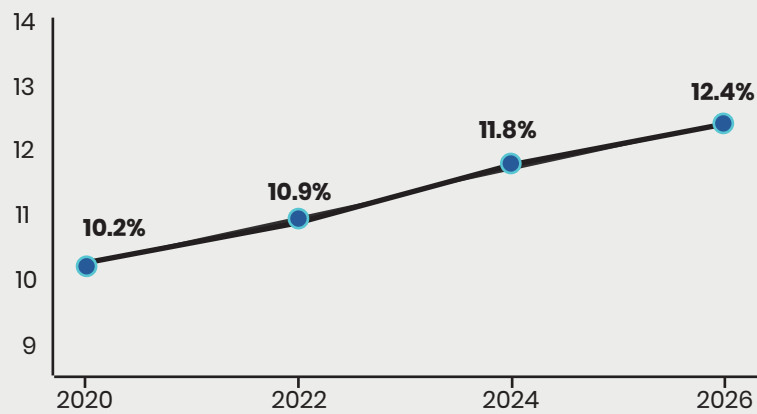
The revenue cycle technology market continues to consolidate around AI-native platforms, even as most health systems are still early in translating adoption into measurable financial return. This snapshot captures where the industry stands as of August 2026.

The AI Adoption Reality Gap in Revenue Cycle



Source: Assembly, 2026 State of AI in Revenue Cycle Management benchmarks

All-Payer Initial Claim Denial Rate, 2020–2026



Source: Experian Health State of Claims: Industry denial benchmarking, 2026

Metric	2026 Figure
Potential annual AI/automation savings in RCM	Up to \$360 billion
Outsourced RCM market growth (4-year projection)	Nearly doubling
Hospitals planning to expand RCM outsourcing	70%
Hospitals reporting bad debt over \$10 million	1 in 3
Average denied Medicare Advantage claim amount	~\$1,000 (+22.4% YoY)
Medicare reimbursement as share of cost	83 cents per dollar

Market Insights this month



Waystar Rated #1 Overall in Black Book’s Q1 2026 Agentic AI RCM Benchmark

Black Book Market Research’s Q1 2026 benchmark surveyed 774 verified revenue cycle leaders and power users across 49 vendors, with 20 meeting the threshold for comparative ranking. Waystar led the field across client experience measures and an 18-KPI qualitative performance framework built specifically around agentic and generative AI in revenue cycle operations.

Quick insight: Operational support and production trust — not just feature lists — are now the deciding factors in vendor benchmarking, reflecting how mission-critical RCM platforms have become.

Ensemble Health Partners Reportedly Nearing a \$12 Billion Private Equity Bid

Multiple outlets reported Ensemble Health Partners, an end-to-end RCM outsourcing firm, is close to a private equity transaction valued near \$12 billion — notable given Ensemble’s top-tier KLAS satisfaction score of 95.1, compared to competitor R1 RCM’s 55.6.

Quick insight: The valuation gap underscores that client satisfaction and contract durability are increasingly separate variables in RCM M&A — coverage and scale still win deals even where satisfaction lags.

Ensemble and Cohere Partner to Build an RCM-Native Large Language Model

Ensemble Health Partners announced an expanded partnership with Cohere to build what the companies describe as revenue cycle management’s first RCM-native LLM, trained on operator expertise, documented procedures, and payer behavior patterns drawn from Ensemble’s health system relationships.

Quick insight: Purpose-built, domain-specific models trained on real payer behavior — rather than general-purpose AI layered onto RCM workflows — may prove more durable as agentic AI matures.

KLAS Publishes Inaugural Revenue Cycle Management Suites Report

KLAS Research’s first-ever study of RCM platform ‘deep adopters’ — organizations

“

Market intelligence is more than staying informed, it is about recognizing meaningful trends, anticipating change, and making strategic decisions before those changes become industry standards.

”

running at least three integrated solutions from one vendor — found that 76% to 100% of interviewed Waystar clients reported lower cost-to-collect and improved collections performance.

Quick insight: This is the first systematic, independent evidence that platform consolidation produces measurable financial outcomes, not just fewer logins — a meaningful data point for CFOs evaluating point-solution sprawl.

CMS Prior Authorization Rule Marks First Full Reporting Cycle

As of January 1, 2026, payers covered under CMS-0057-F have been required to issue prior authorization decisions within 72 hours for urgent requests and seven calendar days for standard requests, with annual public reporting of approval and denial rates now underway.

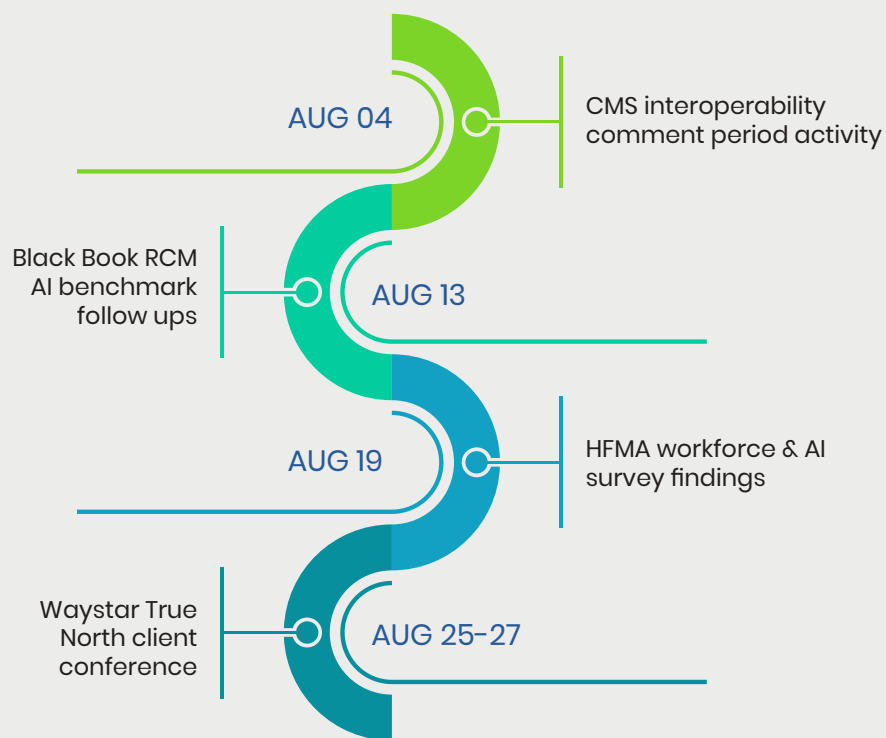
Quick insight: More than 30 states have introduced parallel legislation, meaning the operational impact of this reform is arriving faster and broader than the federal rule alone would suggest. ■

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Discover how predictive intelligence helps prevent revenue leakage before it becomes lost revenue.

Snapshot of August 2026

A timeline of the regulatory, vendor, and industry milestones revenue cycle leaders tracked this month.



Regulatory Updates

- CMS-0057-F (electronic prior authorization) remains in its first full year of enforcement, with public denial-rate reporting now live for covered payers.
- CMS-0062-P, the proposed rule extending interoperability and electronic prior authorization requirements to drugs, continues moving through post-comment review following its April 2026 release.
- More than 30 states have introduced or enacted parallel prior-authorization legislation with similar timelines and transparency requirements.

Compliance Watch

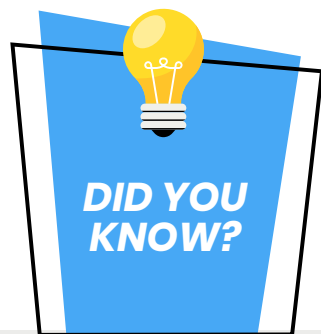
- Payers covered under CMS-0057-F must publicly report approval and denial rates by service category, plus average time-to-decision, annually.
- NCCI, MUE, and LCD edit tables update quarterly — AI coding platforms that don't sync automatically create compliance exposure.
- Medicare Advantage plans face continued scrutiny following Health Affairs findings that 57% of denials are ultimately overturned on appeal.

AI Is Becoming the New Revenue Cycle Workforce

AI is no longer a bolt-on tool inside revenue cycle operations — it is beginning to function as a parallel workforce, handling eligibility checks, claim edits, and increasingly, judgment-heavy tasks like drafting appeals. Adoption is broad, at 63% of organizations, but only a small minority have moved past pilots into full production.

Unlike the robotic process automation era, current-generation AI in revenue cycle reads clinical documentation, interprets payer behavior, and can draft appeals — moving AI from the periphery of RCM into its judgment-heavy core. Findings from a 2026 Healthcare RCM Survey of more than 200 decision-makers and 90 end users found that 80% of health systems are now actively exploring, piloting, or implementing generative AI, and adoption momentum is accelerating rather than plateauing.

Yet benchmarking data tells a more complicated story. Only 27% of organizations have deployed AI at scale in the revenue cycle, and just 15% report positive, measurable ROI. Denials — arguably the highest-value use case for AI — remain the least automated function: only 14% of providers use AI specifically for denial reduction, even as 41% of



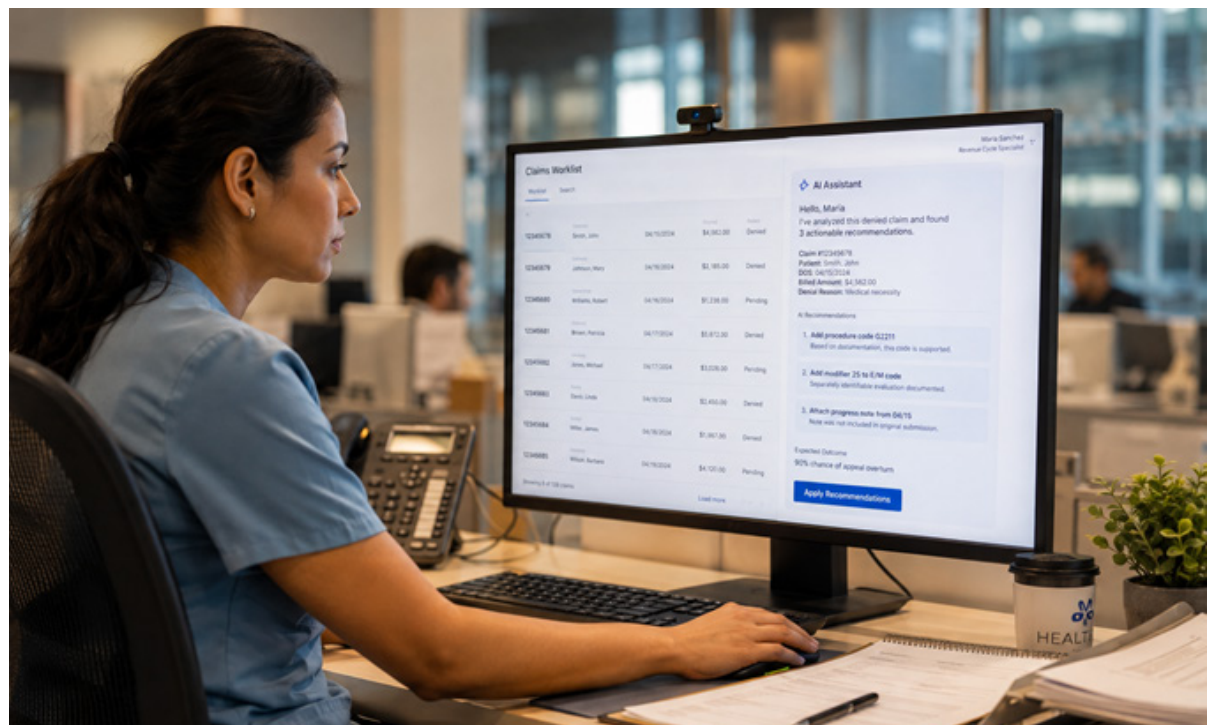
63% of providers have introduced AI in some capacity, but only **15%** have fully integrated it into standard RCM operations.

Eligibility verification and patient access are the top current AI use cases in the revenue cycle.

Data privacy, security, accuracy, and cost remain the most-cited barriers to broader AI adoption.

providers now report denial rates of 10% or higher.

The workforce implication is significant. Eligibility verification and patient access remain the most common AI use cases today, largely because they are lower-risk, rules-based tasks. As AI models mature,



they are increasingly being trusted with more judgment-intensive work — but human oversight remains a deliberate design choice, not a temporary limitation, particularly for anything touching medical necessity or clinical documentation.

Vital Information

- AI adoption in RCM (63%) far outpaces AI value realization (15% ROI) — a gap CFOs are now pressing vendors to close.
- Denials remain the least-automated, highest-value opportunity in the revenue cycle.
- Human oversight is a deliberate governance choice for judgment-heavy decisions, not a temporary limitation.

“AI in revenue cycle management is emerging as one of the first areas where AI is delivering tangible, repeatable impact at scale — but the market is only just beginning to move beyond experimentation.”

Future outlook: Expect the adoption-to-ROI gap to narrow through 2027 as more organizations move past point solutions toward integrated, agentic platforms — with denial prevention and prior authorization as the next major automation frontiers.

Related reading in this issue: Predictive AI Prevents Revenue Leakage Before It Happens; Healthcare Workforce Transformation Through AI. ■

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Learn how AI powered decision making improves claim quality from submission to reimbursement.

Predictive AI Prevents Revenue Leakage Before It Happens

Revenue leakage has historically been managed after the fact — denials investigated, underpayments disputed, bad debt written off. Predictive AI is shifting that posture upstream, scoring claims for denial risk and flagging documentation gaps before a claim is ever submitted.



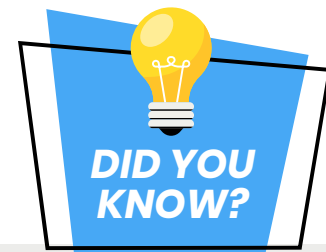
The financial case for prevention over remediation is stark. Hospitals spent nearly \$18 billion overturning claim denials in 2025, and the American Hospital Association estimates total spending of \$43 billion trying to collect payments insurers already owe for care delivered.

Reworking a single denied claim costs between \$25 and \$181 depending on complexity, with an average administrative cost of \$57.23 per denied claim — costs that predictive risk scoring is designed to avoid entirely rather than absorb after submission.

Predictive models work by analyzing historical claim

and payer behavior patterns — which combinations of diagnosis, procedure, and payer have historically triggered denials — and flagging similar claims before submission for additional documentation or coding review. Because roughly 60% to 70% of denials originate from front-end errors such as eligibility and patient data issues, predictive tools focused on intake and registration can address the majority of preventable denial volume before a claim ever reaches a payer.

Technology-enabled, physician-directed pre-bill review programs are an increasingly common pairing with predictive analytics: rather than waiting for a denial to trigger a documentation review, predictive flags route selected claims to a clinician for pre-submission review, strengthening claim defensibility and improving appeal success when denials still occur.



Front-end errors — eligibility and patient data issues

— account for **60%** to **70%** of all denials.

Accurate intake alone can reduce denials by up to

30%.

The industry benchmark for a well-managed organization is a first-pass denial rate below

5%.

Predictive AI Workflow

A typical predictive risk-scoring workflow moves through four stages: eligibility and

authorization verification, real-time claim scrubbing against payer-specific rules, a predictive risk score generated from historical denial patterns, and — only once a claim clears that scoring — submission. This mirrors the denial-prevention workflow detailed later in this issue.

Vital Information

- Prevention costs less than remediation at every stage of the denial lifecycle.
- Most preventable denial volume originates at intake, not at the payer's adjudication desk.
- Pre-bill physician review, paired with predictive flags, improves both first-pass rates and appeal success.

Future outlook: As predictive models mature, expect risk scoring to extend beyond claims into prior authorization requests and even care-plan design, flagging medical-necessity documentation gaps before an order is placed. ■

Prior Authorization Continues to Challenge Healthcare Providers

As of January 1, 2026, payers covered under CMS-0057-F — Medicare Advantage organizations, Medicaid managed care plans, CHIP managed care entities, and Qualified Health Plan issuers on the federal exchange — must issue prior authorization decisions within 72 hours for urgent requests and seven calendar days for standard requests. Covered payers must also publicly report approval and denial rates by service category and average time-to-decision, annually, to CMS and on their own websites.

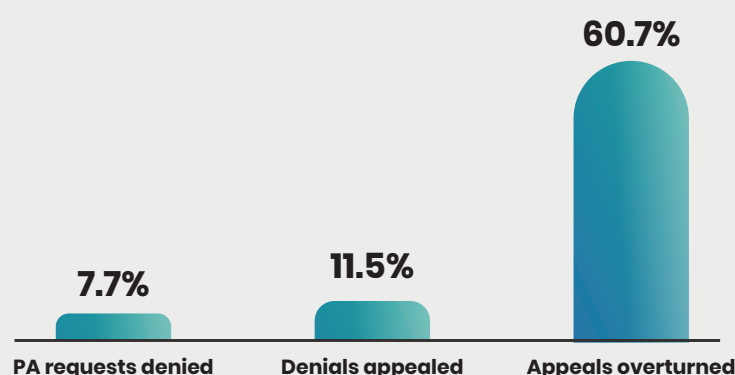
The scale of the problem the rule targets is significant. KFF's analysis of Medicare Advantage data found insurers made 52.8 million prior authorization determinations in 2024, denying 4.1 million requests — 7.7% of the total.

Only 11.5% of denied requests were appealed, but when providers did appeal, 80.7% of those denials were overturned, suggesting a large share of initial denials were avoidable with better upfront documentation or simply incorrect.

In April 2026, CMS released a follow-on proposed rule, CMS-0062-P, extending electronic prior authorization requirements to drugs covered under both medical and pharmacy benefits — requiring supporting NCDPD standards for pharmacy-benefit drugs beginning October 2027. The comment period closed June 15, 2026, and the rule is now moving through post-comment review. Separately, the AMA's most recent physician survey found practices complete an average of



The Prior Authorization Appeal Paradox



Source: KFF analysis of Medicare Advantage prior authorization data, 2024

39 prior authorizations per physician per week, and 29% of physicians reported prior authorization led to a serious adverse event for a patient in their care.

Have You Heard That?

1. More than 30 states have introduced or enacted parallel prior authorization reform legislation.
2. Major commercial payers, including UnitedHealthcare, Anthem, and Aetna, have signaled moves toward similar decision timelines.
3. Behavioral health prior auth decisions previously took 5 to 14 days for urgent requests — now capped at 72 hours under CMS-0057-F.

Vital Information

- CMS-0057-F is no longer a future compliance date — it is now an enforced, publicly reported standard.

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Identify every opportunity to reduce revenue leakage across the complete Revenue Cycle.



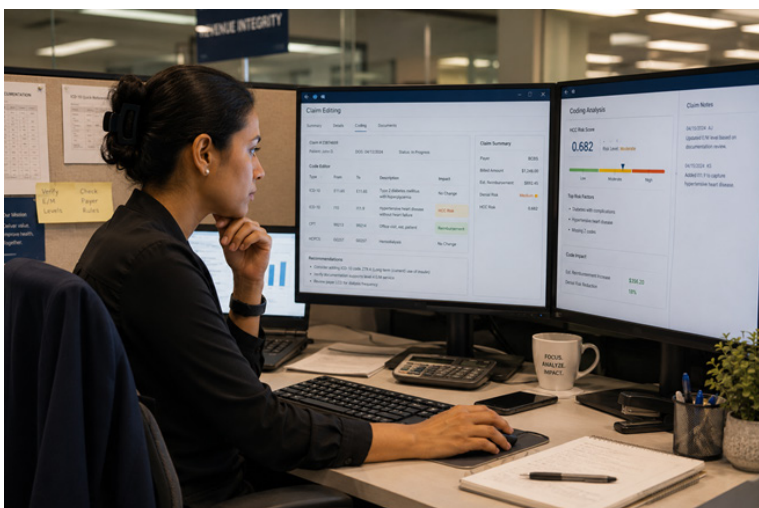
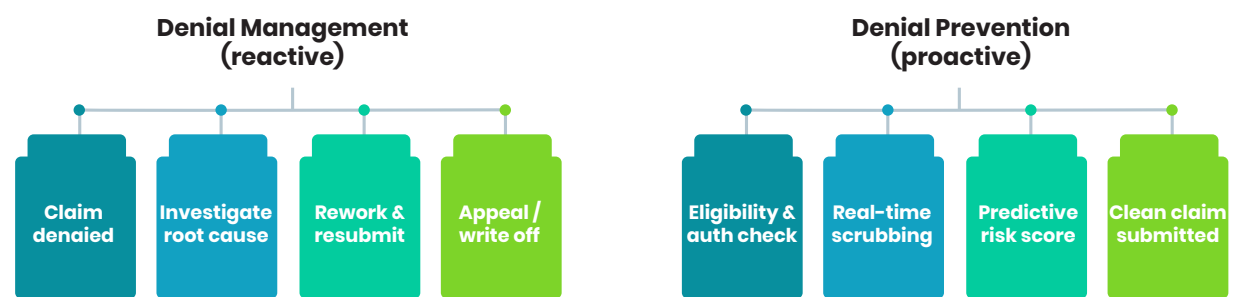
Per CMS-0057-F, effective January 1, 2026

- The high overturn rate on appeal (80.7%) signals systemic documentation and process gaps, not just clinical disagreement.
- Drug prior authorization reform (CMS-0062-P) is the next major compliance wave for pharmacy and medical benefit teams alike.

Future outlook: Expect EHR-embedded electronic prior authorization to become table stakes by 2027, with agentic AI increasingly handling documentation assembly and submission — leaving staff to manage only the exceptions that require clinical judgment.

Related reading in this issue: Why Denial Prevention Is More Valuable Than Denial Management; Regulatory & Compliance Watch. ■

Why Denial Prevention Is More Valuable Than Denial Management

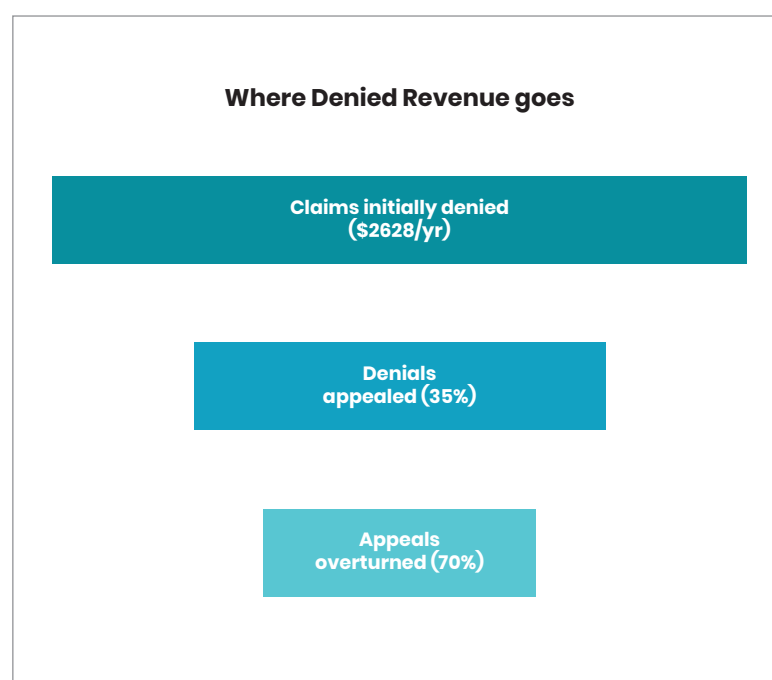


The scale of denial-driven revenue leakage is now well documented. Kodiak Solutions estimates denials drove \$48.4 billion in revenue leakage in 2025 alone, drawing on aggregated data from more than 2,300 hospitals and 375,000 physicians. Every tracked denial metric increased year-over-year, signaling sustained — not cyclical — pressure. Separately, roughly \$262 billion in medical claims are initially denied each year nationally, and while 70% of denials are eventually overturned on appeal, 65% of denied claims are never resubmitted or appealed at all, representing pure, permanent revenue loss.

Denial management — the reactive discipline of investigating, reworking, and appealing denied claims — is necessary but structurally

expensive. It requires specialized staff, absorbs significant administrative time, and by definition begins only after revenue is already at risk. Denial prevention flips that sequence: eligibility and authorization verification, real-time claim scrubbing, and predictive risk scoring all happen before submission, so a much smaller share of claims ever become a denial requiring intervention.

The math favors prevention decisively. If a health system with \$100,000 in monthly denial volume fails to recover 20% of denied claims, that generates \$240,000 in permanent annual write-offs. Preventing even a modest share of those denials from occurring compounds directly to the bottom line — without adding rework, appeals, or administrative headcount.



Vital Information

- 65% of denied claims are never appealed at all — meaning prevention captures revenue that management structurally cannot.
- Every tracked denial metric rose year-over-year in the most recent Kodiak benchmark, confirming sustained, not temporary, pressure.
- Prevention shifts the cost structure from ongoing rework labor to upfront automated screening.

Future outlook: Leading organizations are expected to shift KPI ownership from 'denial recovery rate' to 'denial avoidance rate' as the primary revenue integrity metric over the next 12 to 18 months.

Related reading in this issue: Predictive AI Prevents Revenue Leakage Before It Happens; The Rise of Intelligent Claim Scrubbing. ■

Dimension	Denial Management	Denial Prevention
Timing	After claim is denied	Before claim is submitted
Cost per claim	\$25–\$181 to rework	Marginal cost of automated screening
Staffing model	Specialized appeals/rework staff	Rules engine + exception review
Typical outcome	70% overturned on appeal, if appealed	Denial avoided entirely

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Prevent denials before they happen with smarter claim validation and risk detection.

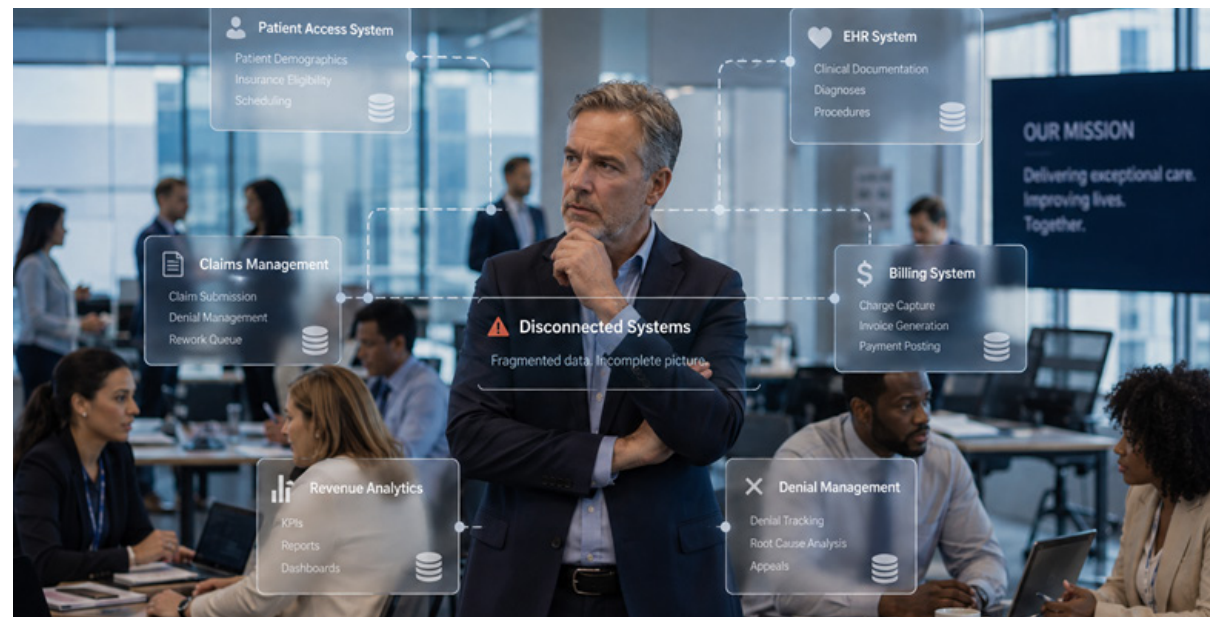
RCM Fragmentation Is Costing Hospitals Millions

KLAS Research's inaugural Revenue Cycle Management Suites report, released in 2026, is the first systematic study of RCM platform 'deep adopters' — organizations running at least three integrated solutions from a single vendor. The headline finding: 76% to 100% of interviewed deep-adopter clients reported lower cost-to-collect and improved collections performance, a figure KLAS notes reflects verified client outcome data rather than vendor marketing claims.

Cost-to-collect is widely regarded as the hardest metric in revenue cycle to move, because it is a function of labor, denial rates, write-offs, and time-to-payment simultaneously. Fragmented systems compound each of those variables: manual reconciliation between disconnected platforms consumes billing staff time that would otherwise go toward higher-value exception handling, and inconsistent data definitions across vendors make enterprise-wide reporting unreliable.

The market response has been a wave of consolidation and platform expansion. Waystar, for instance, now serves

30,000 clients representing more than 1 million distinct providers and processes over 7.5 billion healthcare payment transactions annually — scale that allows a single platform to cover eligibility, claims, denials, and patient payments under one data model. Ensemble's expanded partnership with Cohere to build an RCM-native large language model reflects a similar bet: that unified, purpose-built platforms will outperform stitched-together



“
Most health systems are running five, eight, sometimes a dozen different point solutions. The integration debt is enormous, and the manual reconciliation work between systems is where billing staff time disappears.”

point solutions as AI becomes more central to revenue cycle operations.

The Cost of Fragmentation

- Manual reconciliation between disconnected systems consumes billing staff hours that could go to higher-value work.
- Inconsistent data definitions across vendors undermine enterprise-wide KPI reporting and benchmarking.

- Integration debt compounds with every additional point solution added to the stack.
- Vendor management overhead — separate contracts, support channels, and update cycles — scales with fragmentation.

Vital Information

- Platform consolidation now has independent,

measurable evidence of financial impact — not just operational convenience.

- Cost-to-collect, the hardest RCM metric to move, responds meaningfully to reduced fragmentation.
- The vendor market is consolidating in response, with unified platforms and purpose-built LLMs emerging as the next competitive frontier. ■

The Rise of Intelligent Claim Scrubbing

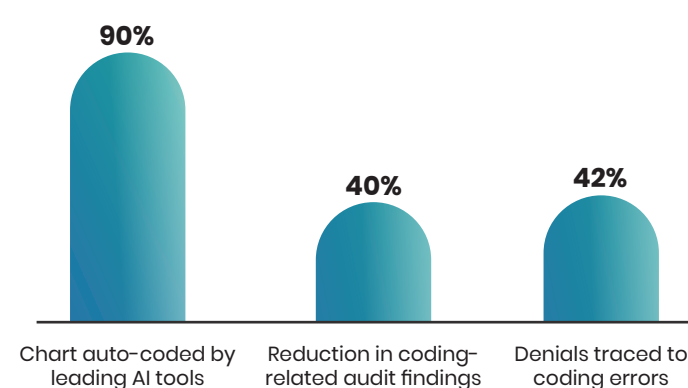
Claim scrubbing — validating a claim against payer rules before submission — has existed for decades as a rules-based checkpoint. AI-driven scrubbing tools are now applying real-time, adaptive validation that catches a far broader range of preventable errors.

Leading Article

Traditional claim scrubbers rely on static rule sets: fixed logic checking for missing modifiers, mismatched codes, or basic eligibility flags. Intelligent claim scrubbing platforms add machine learning and natural language processing to interpret clinical context, cross-reference NCCI edits, MUE limits, and LCD coverage determinations simultaneously, and adapt to each payer's specific and frequently changing adjudication behavior — not just published rules.

The stakes for getting this right are substantial: medical coding errors alone cost the U.S. healthcare system more than \$125 billion annually, and roughly 42% of claim denials trace directly back to coding

Medical Coding Automation, By the Numbers



Source: KLAS Research; AAPC Knowledge Center, industry coding automation benchmarks, 2026

mistakes rather than clinical or payer disputes — meaning they are fixable before submission, not inherent disputes to be argued after the fact. Leading platforms report catching these issues at rates exceeding 99% accuracy when validated against current-quarter NCCI, MUE, and LCD rule sets.

A critical operational detail separates effective platforms from marketing claims: compliance stacks that update automatically. CMS releases new NCCI tables every quarter,

and platforms that sync those updates without manual intervention ensure coders are always working against the current ruleset — eliminating a common, quietly persistent source of preventable denials.

Myth vs. Reality

1. Myth: Claim scrubbing is a solved, commodity problem. Reality: static rule-based scrubbers miss the roughly 42% of denials rooted in coding-context errors that require NLP-level understanding.

2. Myth: More automation always means less human oversight. Reality: leading platforms route only lower-confidence cases to certified coders, preserving judgment where it matters most.
3. Myth: Scrubbing and coding automation are the same function. Reality: scrubbing validates a completed claim; coding automation generates the codes in the first place — they are complementary, not interchangeable.

Vital Information

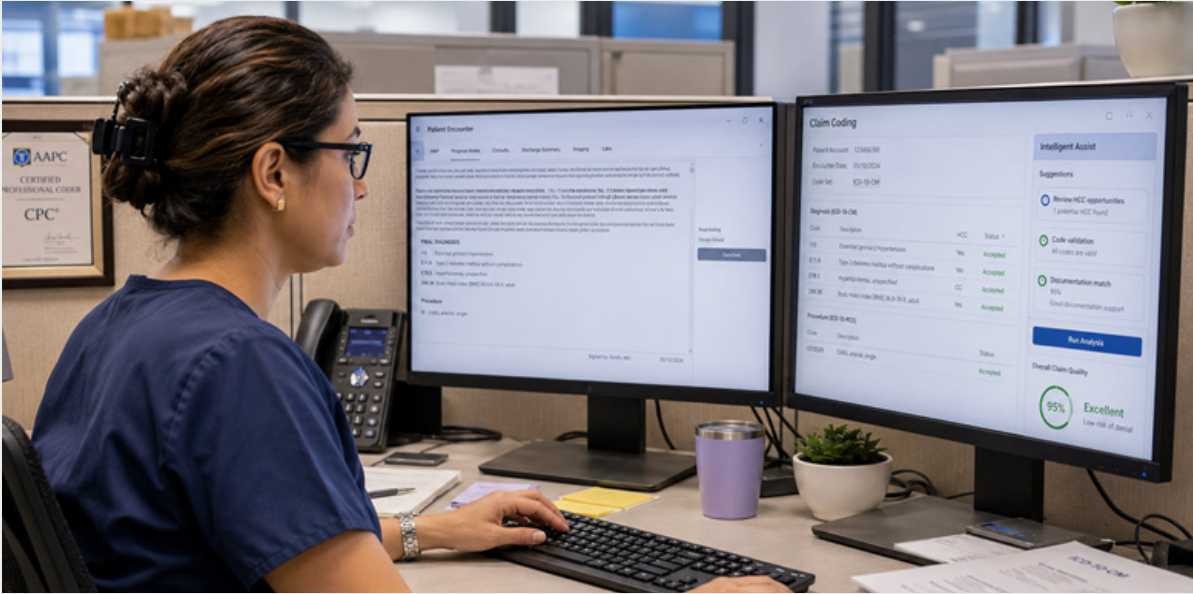
- 42% of denials are traceable to fixable coding errors — the single largest preventable denial category.
- Real-time, adaptive scrubbing against NCCI/MUE/LCD rules materially outperforms static rule engines.
- Automatic quarterly compliance updates are a non-negotiable feature, not a nice-to-have, for any scrubbing platform.

Future outlook: Expect claim scrubbing to converge further with predictive denial-risk scoring, moving from a binary pass/fail checkpoint toward a continuous confidence score attached to every claim before submission. ■

“
Every denied claim tells the story of a preventable oversight. Intelligent claim scrubbing ensures that story is rewritten before it reaches the payer.”

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See how intelligent automation is improving coding accuracy, compliance, and operational efficiency.



Healthcare CFOs Are Prioritizing Revenue Intelligence

Revenue cycle performance has moved from a back-office operational concern to a central pillar of hospital financial strategy. HFMA's 2026 research describes it plainly: revenue cycle is no longer just an operational task, it is a strategic enterprise capability.

Leading Article

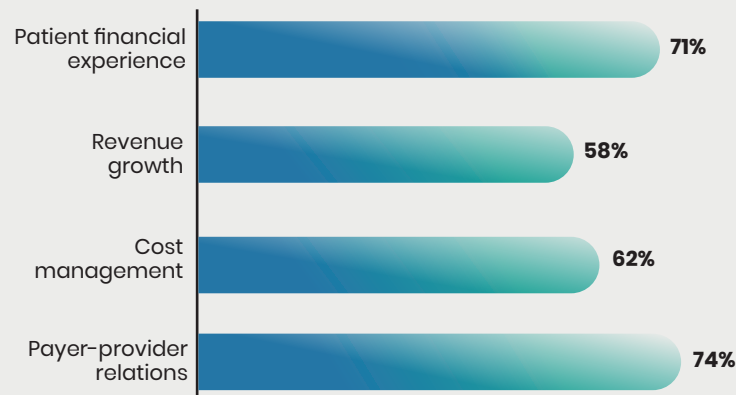
HFMA's 2026 Revenue Cycle Benchmark Report, based on a survey of 102 healthcare finance and revenue cycle professionals, found denials and appeals have emerged as the industry's single top concern, ahead of staffing shortages and expanding payer audit activity. The report also documents growing

reliance on automation, AI-enabled workflows, and outsourcing partnerships as the primary levers finance

leaders are pulling to improve efficiency and audit readiness.

Perhaps the most significant

What Healthcare CFOs Rank as a Top Priority



Source: FinThrive/HFMA revenue cycle leader survey, HFMA CFO survey, 2026

shift is in how CFOs define success. For the first time since FinThrive began tracking the metric, patient financial experience surpassed revenue growth as revenue cycle leaders' top strategic priority, with 71% of executives ranking it first. That does not mean revenue growth has become unimportant — rather, leading organizations increasingly recognize the two goals are intertwined: better financial experiences protect market share and reduce collection friction, which in turn supports revenue growth over time.

HFMA's broader CFO survey data reinforces the trend: 88% of CFOs expect to spend more time on strategy over the next three years, with revenue cycle (63%) and cost management (62%) as the next most-cited areas of increased focus. Separately, nearly three-quarters of CFOs say improving payer-provider relations is a top priority — a notable shift in tone from viewing payers primarily as adversaries.

What 'Revenue Intelligence' Means in Practice

- Process standardization and data governance before layering on new technology — a 'process-first' approach HFMA highlights as a differentiator of resilient organizations.
- Shared KPIs across in-house and outsourced or offshore revenue cycle teams to maintain unified accountability.
- Real-time dashboards for front-end metrics like point-of-service collection and eligibility verification.
- Board-level revenue cycle reporting cadence — moving from quarterly to more frequent strategic reviews.

Vital Information

- Denials and appeals are now healthcare finance leaders' single top concern, surpassing staffing and audit exposure.
- Patient financial experience has overtaken revenue growth as the top strategic priority for the first time on record.
- CFOs are shifting toward viewing payers as partners for value-based efficiencies, not solely as adversaries.

Future outlook: Expect revenue cycle metrics to migrate further into standard board reporting packages, alongside operating margin and days cash on hand, as boards treat RCM as core financial infrastructure rather than a back-office function. ■

Patient Financial Responsibility Continues to Increase

High-deductible health plans have become the default, not the exception, and 2026's plan-year parameters push patient cost exposure to new highs. For revenue cycle teams, patient balances are no longer a predictable copay — they are a consumer-finance problem.

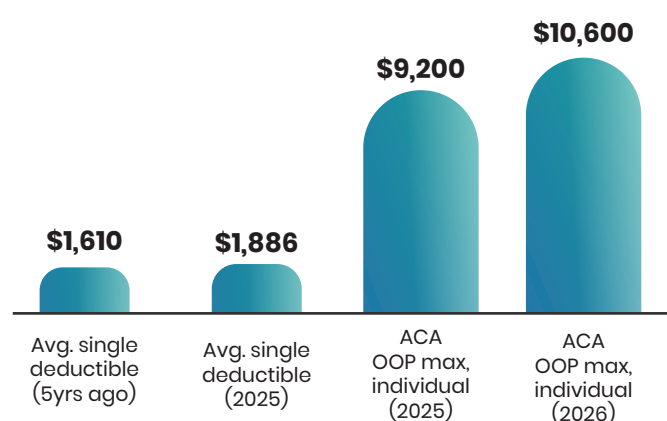
For 2026, a plan qualifies as a high-deductible health plan at a minimum deductible of \$1,700 for individual coverage or \$3,400 for family coverage, per IRS thresholds. Out-of-pocket maximums have climbed in step: \$8,500 for individuals and \$17,000 for families under HDHP rules, while ACA marketplace plans face even steeper limits — \$10,600 for individual coverage, up from \$9,200, and \$21,200 for family coverage, up from \$18,400, roughly a 15% year-over-year increase in maximum exposure.

The average single-coverage deductible reached \$1,886 in 2025, a 17% increase over five years, as employers and insurers shifted financial

risk onto patients to control premium growth. The Business Group on Health's 2026 Employer Health Care Strategy Survey found 59% of large employers plan cost-cutting benefit changes for 2026, up from 48% the year before — nearly all of which involve raising deductibles or other cost-sharing provisions.

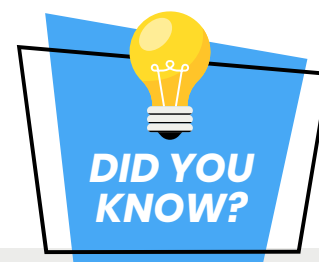
Cedar's 2026 Healthcare Financial Experience Study

Patient Financial Responsibility is climbing



Source: KFF; CMS ACA Marketplace parameters; industry deductible benchmarking, 2025-2026

found roughly three-quarters of patient out-of-pocket dollars now sit in difficult-to-collect cohorts, and that traditional propensity-to-pay scoring — built for a more financially stable population — is increasingly unreliable: in an analysis of 10 million bills, 54% of balances over \$50,000 were scored 'high propensity to pay' despite clear signs of financial distress.



62% of patients say they prefer digital payment options over paper billing and phone-based collections.

Patient financial responsibility now drives **71%** of collection concerns among revenue cycle leaders.

Out-of-pocket spending on hospital services is projected to grow **3.2%** annually through 2033.

- Deductible and out-of-pocket maximum growth in 2026 outpaces most organizations' collection strategy updates.

- Legacy propensity-to-pay models are increasingly unreliable for today's patient population.
- Upfront transparency and digital-first payment options are shifting from nice-to-have to baseline expectation.

Future outlook: Expect financing partnerships, AI-driven propensity modeling built on updated signals, and point-of-service estimate tools to become standard revenue cycle infrastructure rather than differentiators over the next 12 to 18 months. ■

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Measure what matters most by tracking the KPIs that define Revenue Cycle success.

Automation Is Reshaping Medical Coding



Autonomous and semi-autonomous coding platforms have matured rapidly enough in 2026 that KLAS now names category leaders, and the technology once reserved for academic medical centers is reaching practices of every size.

CodaMetrix’s CMX CARE platform earned recognition as the KLAS #1 Autonomous Medical Coding solution for 2026, notable as the first contextual coding automation platform to use a patient’s entire longitudinal record — not just a single encounter — to code more accurately. Fathom, another leading autonomous coding tool, can code an average of 90% of an entire chart independently, representing the highest level of coding automation currently in the marketplace.

The hybrid model — AI handling volume and consistency, AHIMA- and AAPC-certified coders handling complexity and quality assurance — remains the dominant architecture even among the most automated platforms. Medicodio, for example, runs NCCI, MUE, and LCD compliance checks simultaneously on every chart at over 99% accuracy while keeping certified coders in the loop for complex cases. AAPC’s own analysis found many health systems report a 30% to 50% reduction in coding-related audit findings after implementing automation tools.

Ambient AI documentation tools are reinforcing this shift from the clinical side. Ambient clinical documentation solutions listen to physician-patient conversations and automatically generate structured documentation, reducing physician burden while producing richer, more structured input for downstream coding — addressing one of coding automation’s persistent bottlenecks: incomplete or ambiguous source documentation.

The Coder’s Evolving Role

AAPC’s Knowledge Center is explicit that automation is not eliminating the coding profession — it is evolving it. As rule-based and AI coding engines absorb high-volume, low-complexity encounters, certified coders are shifting toward auditing, quality assurance, denial root-cause analysis, and training — work that requires judgment automation cannot yet replicate.

Technology Explained: Computer-Assisted vs. Autonomous Coding

- Computer-Assisted Coding (CAC):

“The future of medical coding is not replacing coders with AI, it is empowering coders with intelligence that delivers greater accuracy, speed, and confidence.”

suggests codes for human review; does not carry end-to-end accountability for accuracy.

- Autonomous Coding: codes complete encounters independently, routing only low-confidence cases to human coders.
- Hybrid Model: the dominant 2026 architecture, pairing an AI engine with certified coders for complex cases and audits.

Vital Information

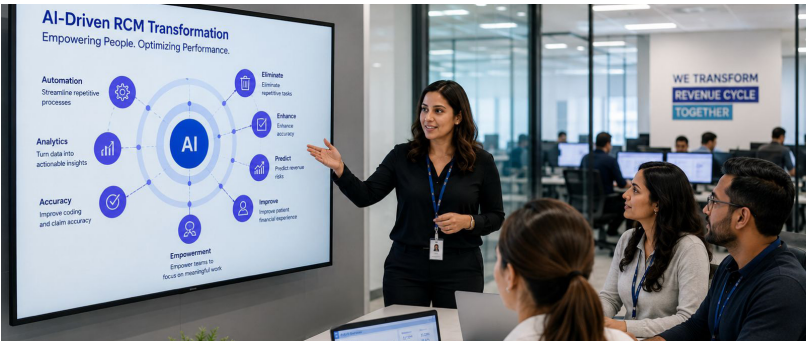
- Leading autonomous coding platforms now handle up to 90% of an entire chart without human intervention.
- Automation correlates with a 30-50% reduction in coding-related audit findings among adopting health systems.
- The coding profession is shifting toward auditing, QA, and exception handling rather than disappearing.

Future outlook: Expect autonomous coding penetration to expand beyond radiology and straightforward outpatient encounters into higher-complexity inpatient and surgical coding over the next two to three years, as contextual, longitudinal-record models mature. ■

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Explore the technologies driving the next generation of Revenue Cycle Management.

Healthcare Workforce Transformation Through AI



Revenue cycle staffing shortages have not disappeared with AI adoption — they have changed shape. The most resilient organizations in 2026 are those integrating hybrid operating models rather than treating automation and staffing as separate initiatives.

MGMA workforce data continues to show persistent administrative staffing shortages and burnout trends across healthcare operations, and HFMA’s analysis is direct: in 2026, revenue cycle performance is inseparable from workforce design. Health systems are navigating sustained margin pressure, rising patient cost responsibility, and escalating payer complexity simultaneously — all while competing for a limited pool of domestic revenue cycle talent.

The response taking shape across the industry is a hybrid model: automation absorbs repetitive, high-volume tasks such as eligibility verification and standard claim edits, while domestic or global specialists focus on judgment-heavy work — clinical documentation review, payer negotiation, and exception management. HFMA emphasizes that an effective global or offshore workforce strategy requires unified governance and shared KPIs rather than treating offshore teams as separate, loosely managed vendors.

Nearshore outsourcing to Latin America is driving particularly strong growth within this shift, as organizations seek high-touch, time-sensitive, or judgment-intensive process support without the full cost or time-zone friction of more distant offshore models. The outsourced RCM market as a whole is projected to nearly double within four years, with 70% of hospitals and health systems planning to expand their outsourcing engagements — a signal that workforce transformation, not headcount reduction, is the operative framework.

Vital Information

- Workforce shortages persist despite AI adoption — the constraint has shifted from headcount to skill mix.
- Hybrid domestic-plus-global models require unified governance, not loosely managed offshore vendors.
- Outsourced RCM is projected to nearly double within four years, reflecting workforce strategy, not just cost cutting.

Future outlook: Expect revenue cycle job descriptions to continue shifting toward AI oversight, exception management, and payer relationship skills, with fewer roles defined purely by transactional, repetitive task volume. ■

Function	Primary Owner in 2026
Eligibility & benefits verification	AI / automation, with exception routing
Standard claim edits & scrubbing	AI / automation
Complex coding & audit review	Certified human coders, AI-assisted
Payer negotiation & appeals strategy	Human specialists
Clinical documentation judgment calls	Human, ambient-AI-assisted



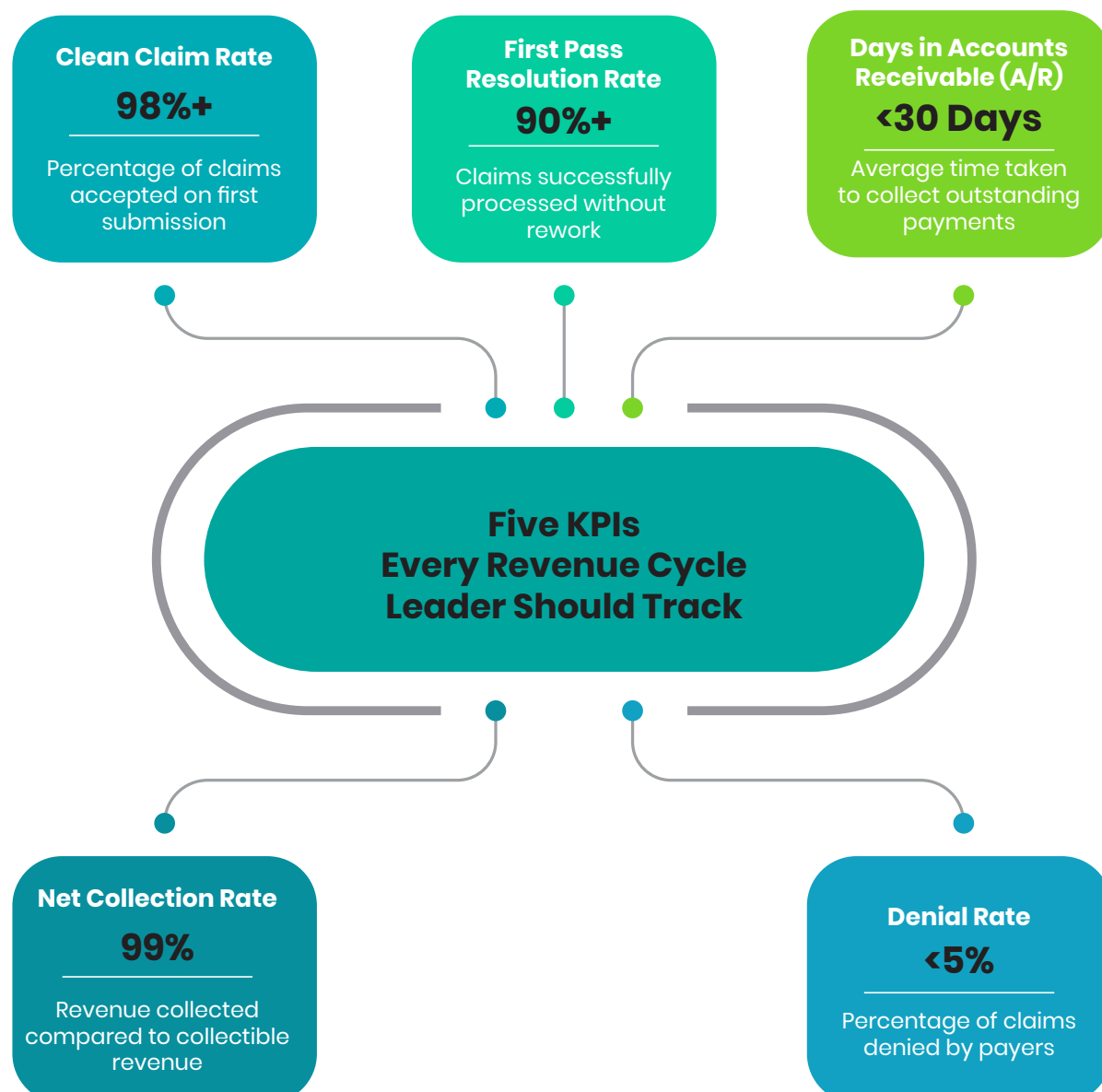
Five KPIs Every Revenue Cycle Should Track

Every revenue cycle generates dozens of metrics, but only a small set actually drive financial performance. Hospitals that consistently outperform peers on a focused set of KPIs typically capture two to four additional percentage points of net patient revenue compared to median performers.

Net collection rate — the percentage of expected revenue an organization actually collects — is widely regarded as the single most important

revenue cycle KPI, because it captures the bottom-line effectiveness of every upstream process at once. Point-of-service collection rate is a close second in strategic

importance: top-quartile hospitals collect 30% or more of patient liability at the point of service, compared to a median of around 18%, and every dollar collected at point of service is



Source: KFF; HFMA MAP Keys; MGMA benchmarking data; KLAS Research, 2026

“What gets measured gets improved. The right revenue cycle KPIs turn operational data into strategic decisions that strengthen financial performance.”

a dollar permanently removed from bad-debt risk.

Clean claim rate and days in accounts receivable round out the core operational metrics: a 95% or higher clean claim rate paired with A/R days under 40 is the accompanying benchmark pairing for a well-managed revenue cycle, according to industry guidance from HFMA, MGMA, and the Advisory Board. First-pass denial rate below 5% remains the target for well-managed organizations, with rates between 5% and 10% representing significant improvement opportunity and anything above 10% signaling systemic process gaps.

HFMA's MAP Initiative — MAP Keys, the MAP App, and the annual MAP Award — remains the most widely used external benchmarking source, alongside MGMA's compensation and operations data. Most hospitals report a

weekly operational dashboard covering five to eight tactical metrics, a monthly executive scorecard covering all core KPIs, and a quarterly board-level summary distilled to five to seven strategic metrics.

How Often to Report Each KPI

- Weekly operational dashboard: point-of-service collection rate, eligibility verification rate, front-end denial rate.
- Monthly executive scorecard: all core KPIs, including net collection rate, clean claim rate, and days in A/R.
- Quarterly board summary: five to seven strategic metrics tied directly to margin and cash flow.

Vital Information

- Top-quartile performance on core KPIs correlates with 2-4 additional percentage points of net patient revenue.
- Point-of-service collection is one of the highest-leverage, lowest-cost improvement levers available.
- External benchmarking through HFMA MAP Keys or MGMA data reveals competitive gaps internal trends alone cannot show.

Future outlook: Expect real-time, front-end KPI dashboards to become standard even at community hospitals as vendor platforms increasingly bundle benchmarking directly into RCM software rather than requiring separate reporting tools. ■

The KPI Framework Behind Smarter Revenue Cycle Management

The strongest Revenue Cycle organizations do not rely on intuition, they rely on measurable performance. Monitoring the right KPIs helps leaders identify revenue leakage, reduce denials, improve cash flow, and optimize operational efficiency before small issues become major financial challenges. Together, these five metrics provide a comprehensive view of revenue cycle health, enabling data driven decisions that improve financial outcomes and strengthen long term organizational performance.

High performing healthcare organizations continuously benchmark these indicators to uncover operational bottlenecks, improve payer performance, and prioritize improvement initiatives with measurable business impact. Consistent KPI tracking enables leadership teams to move from reactive problem solving to proactive revenue cycle optimization.

When monitored together, these metrics provide a balanced view of efficiency, financial health, and reimbursement effectiveness. Organizations that establish clear KPI targets, review performance regularly, and leverage predictive analytics are better positioned to accelerate collections, reduce administrative burden, improve patient financial experiences, and build a more resilient Revenue Cycle Management operation.

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The AI Companies Transforming Revenue Cycle

Black Book Market Research’s Q1 2026 benchmark surveyed 774 verified revenue cycle leaders across 49 vendors with AI-enabled RCM products, ranking 20 that met the threshold for comparative performance evaluation. This spotlight profiles the category leaders shaping the market.

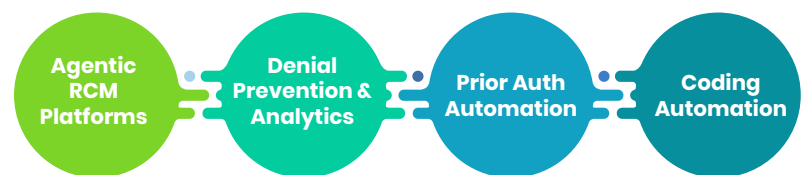


Waystar led the Q1 2026 benchmark overall, and separately earned an ‘A’ satisfaction rating in KLAS Research’s inaugural Revenue Cycle Management Suites report — the first study to specifically examine ‘deep adopters’ running at least three integrated solutions from one vendor. Waystar now serves 30,000 clients representing more than 1 million distinct providers, processing over 7.5 billion healthcare payment transactions annually.

Beyond the end-to-end platforms, Black Book’s broader 2026 vendor ranking identifies category leaders across specific RCM functions: Notable for workflow orchestration and workqueue automation, AKASA for denial prevention and denial analytics, Infinx for provider-side prior authorization automation, and RapidClaims for claims editing and clean-claim validation. Xsolis, an AI-based platform focused on denial management for both

“Because RCM is operationally unforgiving — where downtime, unresolved issues, and slow escalations quickly become cash-flow risk — the Q1 2026 benchmark places special weight on operational support and production trust.”

physicians and payers, has raised \$75 million across two funding rounds. The M&A landscape remains active: Ensemble Health Partners, an end-to-end outsourcing firm with a top-tier KLAS satisfaction score of 95.1, was reported to be nearing a private equity transaction valued near \$12 billion, while continuing to expand its AI capabilities through a partnership with



Cohere to build an RCM-native large language model. R1 RCM, acquired by TowerBrook Capital Partners and Clayton, Dubilier & Rice in an \$8.9 billion deal in 2024, continues operating as a large-scale, publicly traded end-to-end provider despite a lower KLAS satisfaction score of 55.6 — illustrating that contract scale and satisfaction increasingly diverge as separate competitive dimensions in this market.

Future outlook: Expect continued consolidation among mid-tier point solutions as larger platforms acquire specialist capabilities, while a handful of best-in-class category leaders resist acquisition by continuing to out-perform on satisfaction and outcomes. ■

Vendor Category Map	
Category	Named Leader (s)
RCM-native agentic & end-to-end platforms	Waystar
Workflow orchestration & workqueue automation	Notable
Denial prevention & denial analytics	AKASA, Xsolis
Prior authorization automation	Infinx
Claims editing & clean-claim validation	RapidClaims
End-to-end RCM outsourcing	Ensemble Health Partners, R1 RCM
Autonomous medical coding	CodaMetrix, Fathom

Vital Information

- Platform scale (Waystar) and outsourcing satisfaction (Ensemble) represent two distinct, currently diverging paths to market leadership.
- Category specialists (AKASA, Notable, Infinx, RapidClaims) continue to hold ground against end-to-end platforms in their specific domains.
- M&A activity, not just organic growth, is reshaping the vendor landscape in real time.

Inside the AI Revolution Reshaping Revenue Cycle

AI companies are reshaping Revenue Cycle Management through predictive analytics, automation, and real time intelligence, helping providers reduce denials, accelerate collections, and improve financial performance.

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Stay informed on the latest Revenue Cycle trends shaping the future of healthcare finance.

CASE STUDY

Cutting Denial Rates Through Prevention – First Redesign

The following case study illustrates a realistic, composite implementation pattern drawn from publicly reported approaches to denial-prevention rollouts across mid-sized health systems. It is presented as an illustrative scenario rather than a report on a specific named organization.



Problem

Meridian Health Network, a seven-hospital system with an integrated medical group, was seeing a first-pass denial rate above 13% — well above the 5% benchmark for well-managed organizations — driven largely by eligibility errors and incomplete prior authorization documentation. The revenue cycle team was structurally

reactive: three full-time staff were dedicated solely to denial rework, and roughly \$2.8 million in denied claims went unappealed each year.

Solution

Rather than adding more denial-management headcount, leadership redirected investment toward a prevention-first stack: real-

“We stopped measuring ourselves on how well we fought denials and started measuring ourselves on how many we avoided. That single reframe changed everything about how the team spent its time.”

time eligibility verification at scheduling, AI-assisted claim scrubbing against payer-specific rules, and predictive risk scoring that flagged high-risk claims for pre-bill physician review before submission.

Implementation

- Months 1–2:** Eligibility verification tool integrated directly into the scheduling workflow, catching coverage issues before the visit rather than after.
- Months 3–4:** Claim scrubbing and predictive risk scoring layered onto the existing claims workflow, with a governance group reviewing flagged-claim volume weekly.
- Months 5–6:** Denial-rework staff retrained as pre-bill review specialists, shifting their role from reactive appeals to proactive documentation review.

Results

Within six months, first-pass denial rate dropped from 13% to under 7%, and the volume of claims requiring rework fell by roughly 40%. The reallocated staff, now focused on pre-bill review rather than appeals, reported higher job satisfaction and lower turnover risk — addressing a workforce retention concern alongside the financial outcome.

Lessons Learned

- Redirecting existing staff toward prevention work outperformed simply adding denial-management headcount.
- Front-end eligibility verification produced the single largest reduction in denial volume.
- Weekly governance review of flagged claims kept the predictive model's false-positive rate manageable for staff. ■

EXECUTIVE OPINION

A Conversation on AI, Denials, and the CFO Agenda

The following case study illustrates a realistic, composite implementation pattern drawn from publicly reported approaches to denial-prevention rollouts across mid-sized health systems. It is presented as an illustrative scenario rather than a report on a specific named organization.



This month's executive opinion synthesizes perspectives shared across recent HFMA, Black Book, and KLAS research into a composite conversation reflecting where healthcare finance leaders' thinking stands as of August 2026. It is presented as an illustrative synthesis rather than a

transcript of a specific interview.

On the AI adoption-to-ROI gap

“The honest answer is that most of us adopted AI in the easiest places first — eligibility, patient access — because the risk was low and the win was fast. Denials are the highest-value opportunity, and they're

“The strongest organizations are automating complex work, elevating patient experience, and investing in integrated technology.”

also the hardest, because they touch clinical judgment and payer relationships at the same time. Closing that gap means being willing to

automate the uncomfortable, judgment-adjacent work, not just the easy transactional work.”

On patient financial experience overtaking revenue growth as the top priority

“That shift isn't altruism, it's math. A patient who has a confusing, painful billing experience doesn't just fail to pay this bill — they don't come back, and they tell other people not to come either. We finally have the data to show that connection clearly, and it's changed how we prioritize investment.”

On platform consolidation versus best-of-breed point solutions

“I used to believe in picking

the best tool for every single function and integrating them myself. The KLAS data on cost-to-collect changed my mind. The integration tax we were paying in staff time was invisible on any single line item, but it was real, and it was large. I'm not saying every organization should consolidate to one vendor, but I am saying the fragmentation cost needs to be in the decision, not just feature checklists.” ■

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Turn industry insights into measurable results with a data driven Revenue Cycle strategy.

Regulatory & Compliance Watch

A closer look at the CMS rules and compliance requirements revenue cycle leaders need on their radar this month.

CMS-0057-F: Electronic Prior Authorization (In Force)

Effective January 1, 2026, Medicare Advantage organizations, Medicaid managed care plans, CHIP managed care entities, and Qualified Health Plan issuers on the federal exchange must issue prior authorization decisions within 72 hours for urgent requests and seven calendar days for standard requests. Covered payers must also publicly report prior authorization performance metrics — approval and denial rates by service category, and average time-to-decision — annually, both to CMS and on their own websites.

CMS-0062-P: Interoperability Standards and Prior Authorization for Drugs (Proposed)

Released in April 2026, this proposed rule extends prior authorization reform beyond non-drug items and services into drugs covered under both medical and pharmacy benefits. It introduces requirements for electronic prior authorization, shorter decision timelines, more specific denial explanations, and standardized data exchange, including three NCPDP standards for pharmacy-benefit drugs beginning October 1, 2027. The public comment period closed June 15, 2026, and the rule is now in post-comment review.

State-Level Prior Authorization Legislation

More than 30 states have enacted or introduced parallel prior authorization reform legislation with timeline and transparency requirements similar to the federal rules, meaning compliance obligations for multi-state health systems are arriving through overlapping federal and state tracks simultaneously.

Compliance Checklist for Revenue Cycle Leaders

1. Confirm your organization’s electronic prior authorization workflow meets the 72-hour/7-day decision standard for all covered payer lines.
2. Verify your coding platform’s compliance stack syncs automatically with CMS’s quarterly NCCI, MUE, and LCD updates.
3. Review payer-published denial-rate reporting under CMS-0057-F for early signals of increased audit or utilization-management scrutiny.
4. Track state-level prior authorization legislation in every state where your organization operates. ■



MARKET STATISTICS

Top Facts & Myth vs. Reality

Top Industry Facts This Month		
#	Statistic	Source
1	63% of providers use AI/automation in RCM; only 15% report positive ROI	Assembly, 2026 benchmarks
2	11.8% average all-payer initial claim denial rate	Experian Health, 2026
3	\$48.4 billion in 2025 revenue leakage from denials	Kodiak Solutions
4	52.8 million Medicare Advantage prior auth determinations in 2024	KFF analysis of CMS data
5	80.7% of appealed prior auth denials were overturned	KFF analysis of CMS data
6	\$1,886 average single-coverage deductible, up 17% in 5 years	Industry deductible benchmarking
7	71% of revenue cycle leaders rank patient experience as top priority	FinThrive / HFMA survey
8	90% of a chart can be autonomously coded by leading AI platforms	KLAS Research, Fathom
9	42% of denials trace back to fixable coding errors	Industry coding benchmarking
10	76-100% of deep RCM platform adopters report lower cost-to-collect	KLAS Research, 2026

Myth vs. Reality

Myth: “AI adoption automatically translates into ROI.”

Reality: 63% of organizations have adopted AI somewhere in revenue cycle, but only 15% report positive ROI — adoption and value realization are separate achievements requiring separate investment.

Myth: “Most denials are legitimate clinical or payer disputes.”

Reality: roughly 60-70% of denials originate from front-end errors like eligibility and patient data issues — administrative, not clinical, in origin — and 42% trace to fixable coding mistakes.

Myth: “Appealing a denial is rarely worth the effort.”

Reality: 70% of denials are overturned when appealed — the real problem is that 65% of denied claims are never appealed at all, leaving recoverable revenue permanently on the table.

Myth: “Automation replaces Revenue Cycle staff.”

Reality: Automation eliminates repetitive administrative work, allowing staff to focus on higher value activities such as denial prevention, patient engagement, and complex exception handling. Organizations using AI are seeing improved productivity while enabling teams to work more efficiently, not reducing the importance of human expertise.

Myth: “Denials are unavoidable in modern healthcare.”

Reality: While some denials are inevitable, industry studies consistently show that a significant percentage are preventable. Predictive analytics, intelligent claim scrubbing, and proactive eligibility verification can identify risks before submission, reducing avoidable denials and improving first pass payment rates.

Myth: “Revenue Cycle performance is measured only by collections.”

Reality: Collections are only one outcome of a healthy Revenue Cycle. Leading organizations monitor operational metrics such as clean claim rate, denial rate, days in A/R, first pass resolution, and net collection rate to identify issues early and drive sustainable financial performance. ■

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