2026 Oregon Rural Health Conference Presentation Slides

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ELEVATING REVENUE CYCLE PERFORMANCE: HOW LEADERSHIP ALIGNMENT DRIVES CASH COLLECTIONS

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AGENDA



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RCM THE FOUNDATION

Revenue Cycle Management Defined

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REVENUE CYCLE MANAGEMENT

Claim Life Cycle

Front End

Transaction Processing

Back End

Pre-Claim

- Contract Negotiations
- Provider Credentialing
- EDI/ERA Enrollment
- Banking Setup
- CDM Creation
- Price Transparency/No Surprises Act

Pre-Visit

- Scheduling/Preregistration
- Insurance Verification
- Prior Authorization
- Appointment Reminders

Visit

- Patient Check-In
- Co-pay and Deductible Collection
- Patient Payment Arrangements
- Coding and Charge Capture
- Encounter Documentation

Claim Submission

- Charge Entry
- Claim Scrubbing
- Pre-Adjudication
- Claim Submission
- EDI Management

Inbound Processing

- Mail Processing/ Scanning/Indexing
- Bank Deposit
- EFT/ERA Processing
- Payment Posting
- Revenue Allocation

Accounts Receivables Management

- Claim Status
- Denials Management
- Appeals & Resolution
- Patient Statements/Patient Notices
- Patient Refunds/Small Balance Write-Offs
- Collections Process (In/Out)

Analytics

- Clean and Meaningful Data
- Process Measures
- Financial Measures

Claim Life Cycle

- Month-End Closing
- Cost Reporting
- Compliance
- Performance Management
- IT & Quality

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WHERE TO BEGIN

RCM Champion Team

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TRADITIONAL PROCESSES LEAVE RCM ON AN ISLAND

- Clinical
- IT/System Config
- Contracting
- Registration
- Coding
- Billing
- CDM
- Financial / Marketing Decisions

All provide input to claim generation



Errors/Denials

RCM, “Billing”

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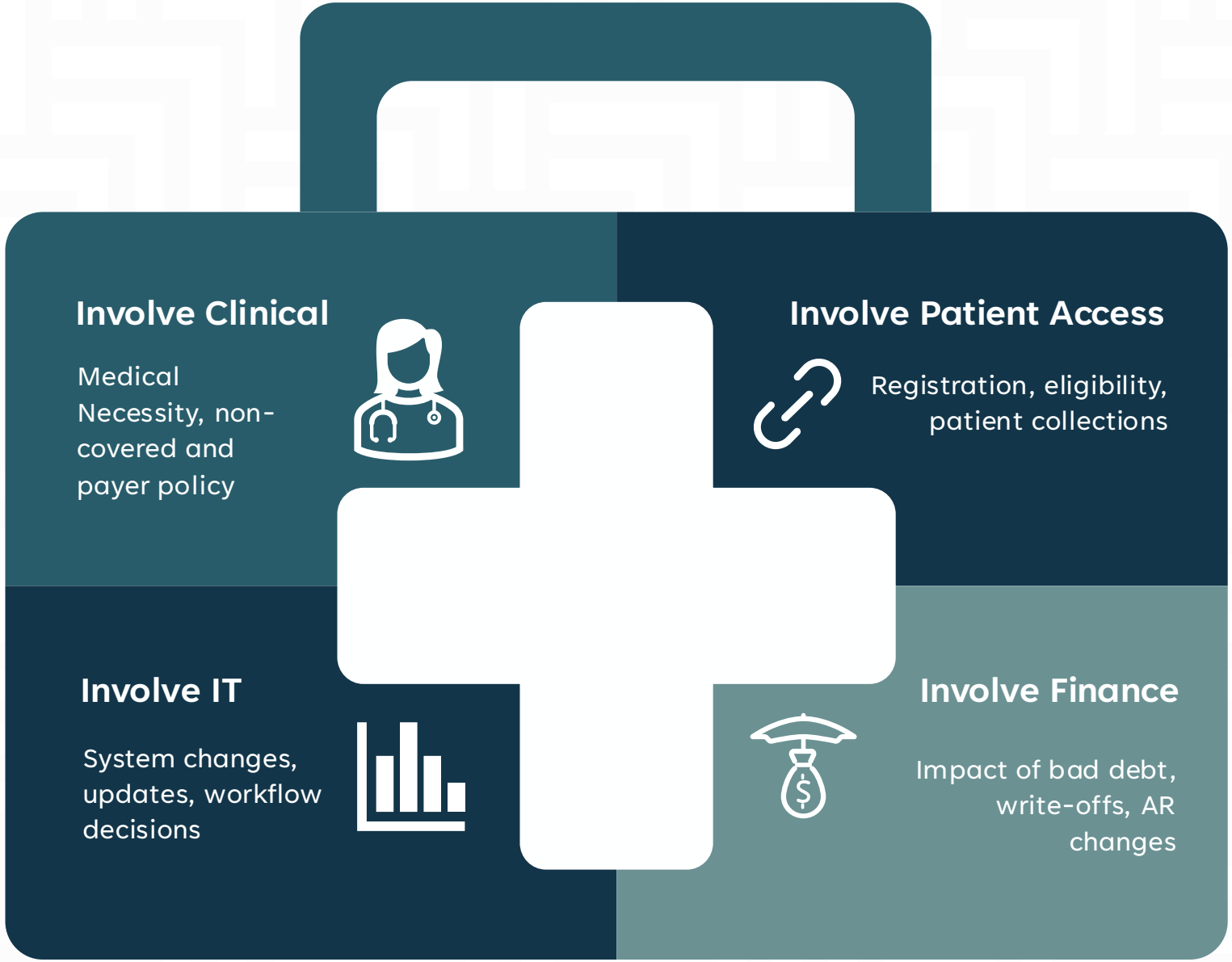
ACKNOWLEDGE CASH ISSUES CAN COME FROM ANYWHERE

	Goal	Jan-2025	Feb-2025	Mar-2025	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025
Financial Metrics										
Gross Patient Revenue		$ 3,045,000	$ 2,500,000	$ 2,693,042	$ 2,474,346	$ 2,754,601	$ 3,122,534	$ 2,548,286	$ 2,474,346	
Bad Debt	<8%	$ 70,767	$ 17,907	$ 148,739	$ 178,313	$ 200,996	$ 192,762	$ 141,505	$ 178,313	
AR Days	<45	45.5	42.1	43.9	44.2	47.4	49.5	41.9	44.2	46.8
Total Gross A/R (including inhouse and credit balances)		$ 3,913,979	$ 3,749,793	$ 3,920,359	$ 3,681,508	$ 4,030,482	$ 4,520,277	$ 3,587,905	$ 3,681,508	
Cash Goal	100% of 3 Mo Prior Net Rev	$ 1,045,638	$ 1,095,914	$ 1,049,942	$ 1,097,701	$ 1,030,822	$ 1,128,535	$ 1,265,678	$ 1,004,613	$ 1,030,822
Total Cash Collections		$ 1,021,822	$ 1,076,397	$ 1,030,968	$ 1,108,500	$ 1,061,394	$ 1,045,638	$ 1,021,822	$ 1,032,911	$ 1,204,549
Percent of Cash Goal	100%	98%	98%	98%	101%	103%	93%	81%	103%	117%
Self-Pay Collections		$ 56,307	$ 47,970	$ 39,852	$ 44,434	$ 41,[illegible]	$ 42,901	$ 37,935	$ 44,434	$ 53,610
Percent of Total Collections	>15%	5.5%	4.5%	3.9%	4.0%	3.9%	4.1%	3.7%	4.3%	4.5%
Insurance A/R >90 Days		$ 422,693	$ 354,477	$ 392,122	$ 333,825	$ 301,815	$ 318,995	$ 328,168	$ 333,825	$ 396,572
All Accounts Receivable > 90 Days (includes self-pay)		$ 926,023	$ 838,128	$ 849,754	$ 886,236	$ 852,572	$ 944,893	$ 840,417	$ 886,236	
Insurance Aging over 90 Days - As a percent of total insurance - below 15% as goal	15%	14%	13%	13%	12%	10%	10%	12%	12%	13%
Visit/Pre-Visit										
Discharged Not Final Bill (DNFB) Accounts Receivable		$ 368,661	$ 158,551	$ 282,786	$ 249,483	$ 238,681	$ 368,661	$ 136,716	$ 136,716	$ 310,522
Discharged Not Final Code (DNFC) (Days)	2.5	3.8	1.8	2.8	2.9	2.6	3.8	1.5	1.5	

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DEVELOP A MULTI-DISCIPLINARY APPROACH TO MONITORING KPIS

"RCM CHAMPION TEAM"



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EXECUTIVE-LEVEL ENGAGEMENT SUPPORT FOR RCM ACTIVITIES

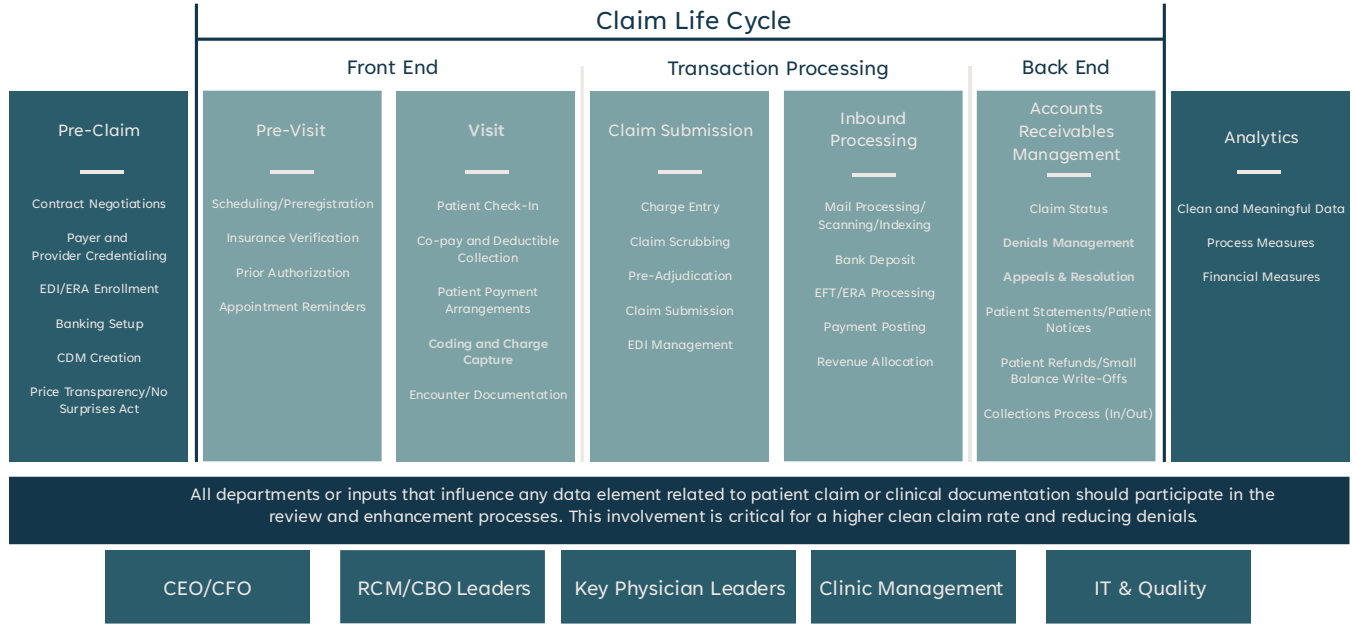
Facilitate a bi-weekly meeting

- Goal: Address operational issues impacting day-to-day activities as well as review back-end challenges that may be prevented with upstream changes

Attendees

- Executive leadership: CEO/CFO
- Revenue Cycle/CBO Leadership
- Leaders responsible for functions within the revenue cycle process
- Key Clinical Leaders: Clinic Managers, CNO, Key Physician Leadership

REVENUE CYCLE MANAGEMENT ACTIVITIES



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LEADERSHIP ENGAGEMENT



Strategic Alignment: Ensures that revenue cycle decisions support the hospital's mission, boosting financial stability while maintaining a focus on patient care.



Resource Allocation: Leaders effectively distribute resources to support revenue cycle management (RCM) systems, enhancing billing, coding, and collection processes.



Staff Empowerment: Involved leaders cultivate a culture of accountability, encouraging staff to improve through training and investment opportunities.



Data-Driven Decisions: Leadership utilizes analytics to identify revenue loss, enabling timely adjustments in billing and contract negotiations.



Interdepartmental Collaboration: Engaged leadership connects clinical and administrative teams, optimizing workflows from patient intake to payment.

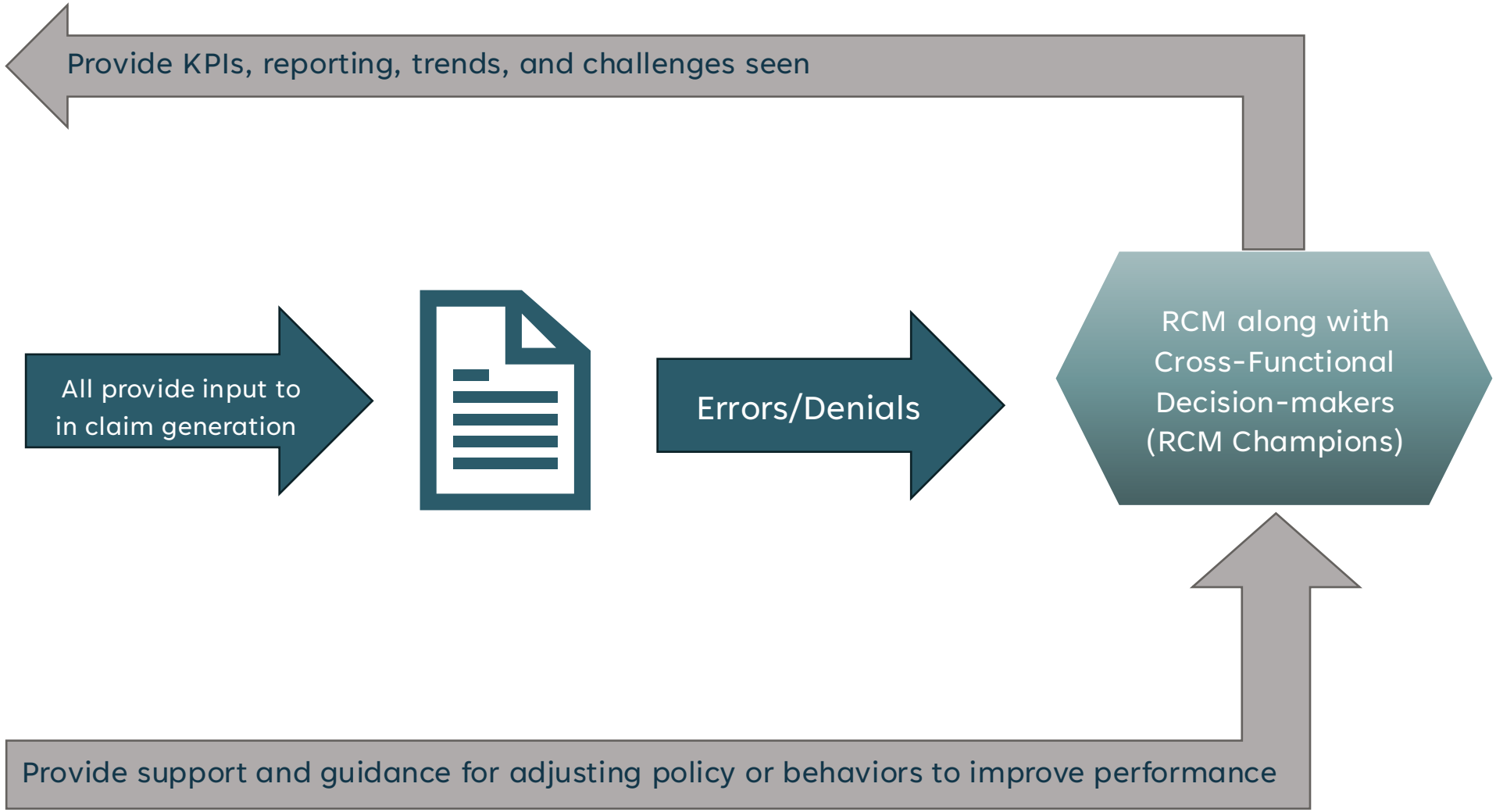


Vendor Management: Leadership oversees vendor contracts for RCM services to ensure cost-effectiveness and alignment with hospital objectives.

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CROSS-FUNCTIONAL RCM INVOLVES ALL STAKEHOLDERS IN DATA AND DECISIONS

- Clinical
- IT/System Config
- Contracting
- Registration
- Coding
- Billing
- CDM
- Financial/Marketing Decisions



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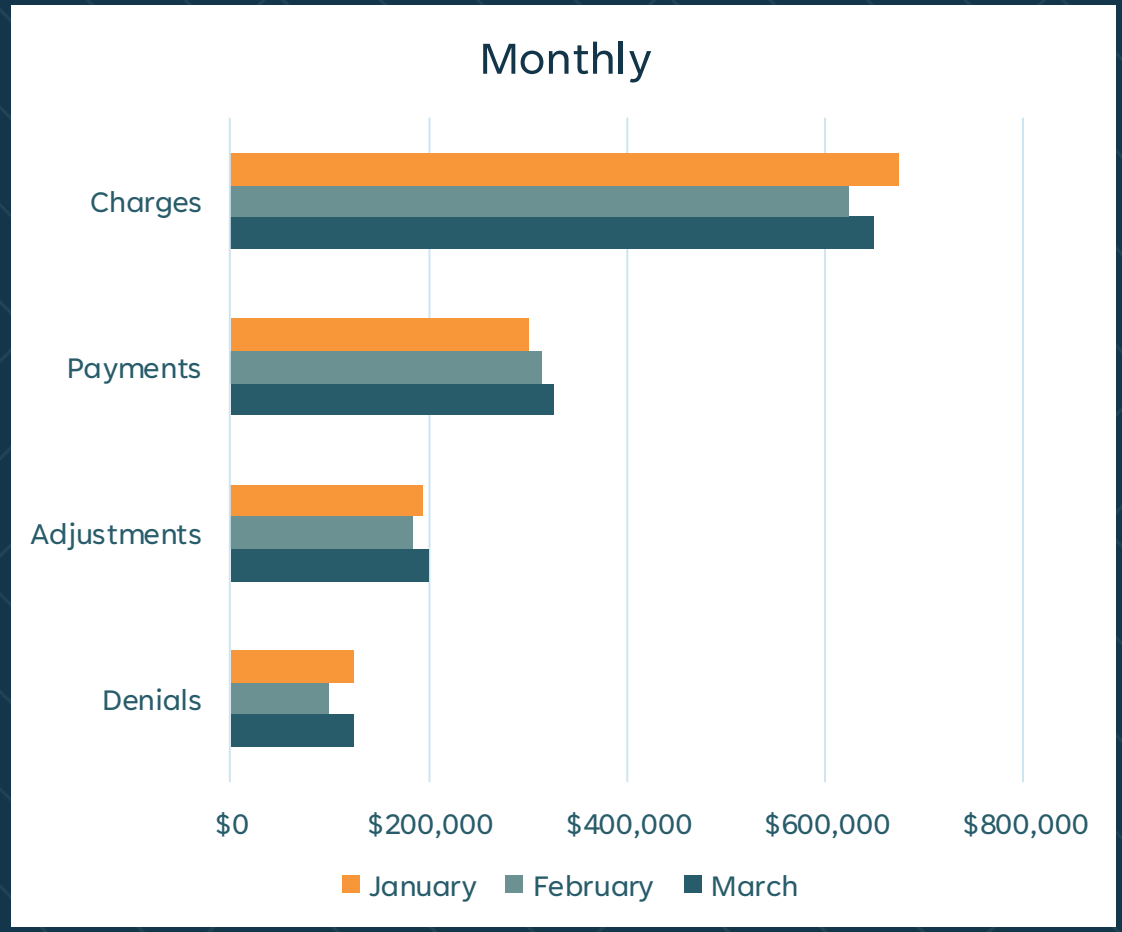
DATA DRIVES DECISIONS

KPI Dashboards

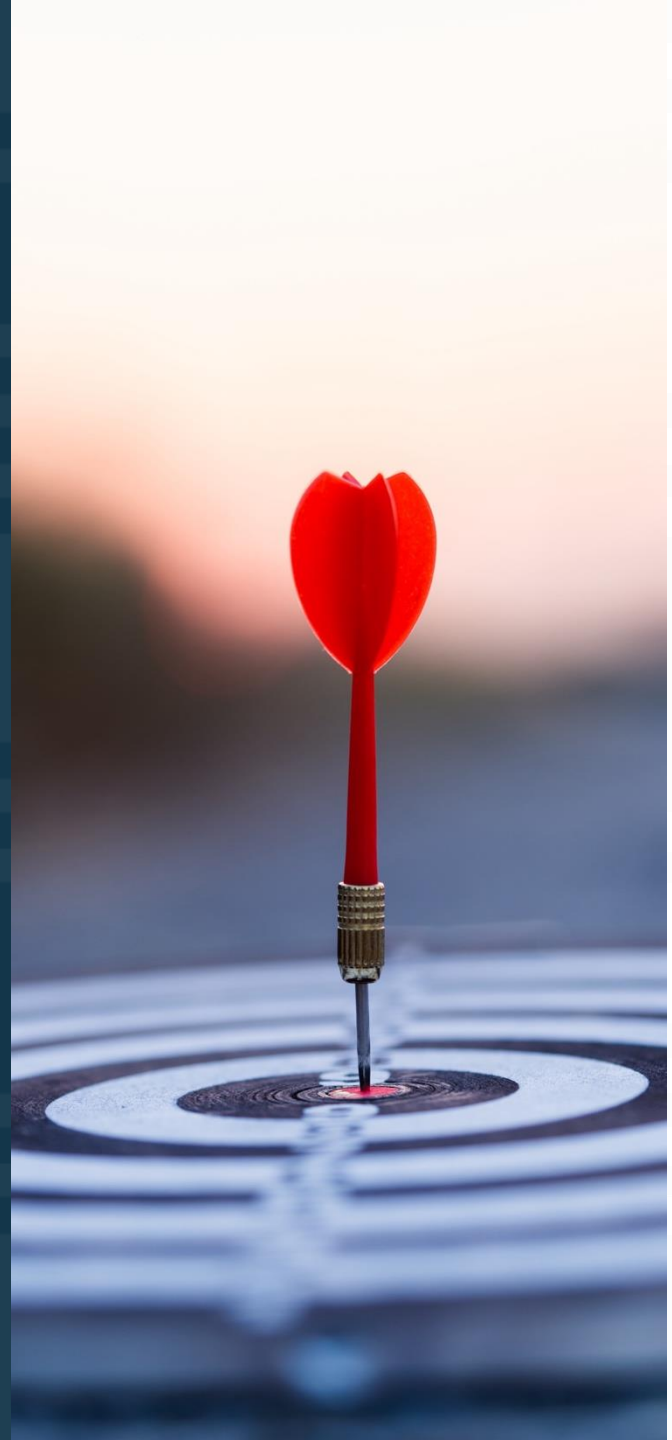
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WHAT IS A KPI?

- Key Performance Indicator (KPI) is a measure of a specific item or objective over time
- Measures financial health, stability, and trajectory, and gives value for further decision-making
- Metric tied to at least one business goal
- Actionable, directional, accurate, and measurable



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WHAT IS THE PURPOSE OF KPIS?

- Trend internal processes to show improvement or opportunity
- Create targets for teams to strive for and milestones to gauge progress
- Help leaders across the organization make better decisions backed by data
- Recognize process breakdowns or opportunities for improvement

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THE POWER OF KPI DASHBOARDS

Root Cause Analysis/Trend Identification

Payer Relations and Communication

First Line of Defense/Protect the AR



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KPI DASHBOARD EXAMPLE

- Data populated monthly
- Red/yellow/green indicators of progress towards goal
- KPIs and goals established and published for the entire team to view
- Agreement on key areas to prioritize

Sample Hospital Name

	Goal	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Number of days in period		**31**	**28**	**31**	**30**	**31**
Cash Goal	100% of 3 mo pr net rev	$ 1,521,459	$ 1,642,907	$ 1,538,282	$ 1,391,683	$ 1,465,778
Cash Collections		$ 1,680,392	$ 1,489,575	$ 1,750,692	$ 883,753	$ 1,213,412
% of Cash Goal	100%	110%	91%	114%	64%	83%
Self- Pay Collections		$ 41,056	$ 30,111	$ 36,793	$ 38,555	$ 41,232
Total POS Cash Collections		$ 2,742	$ 8,920	$ 6,581	$ 7,256	$ 8,024
% of Total Self- Pay Collections	>15%	7%	30%	18%	19%	19%
Gross Patient Revenue		$ 14,227,967	$ 14,392,383	$ 15,564,350	$ 10,363,172	$ 12,582,223
Average Daily Revenue		$ 458,967	$ 514,014	$ 502,076	$ 345,439	$ 405,878
Total A/R (including inhouse and credit balances)		$ 26,355,787	$ 24,585,783	$ 20,033,445	$ 27,324,085	$ 24,631,255
Days in A/R - Gross	< 40	57.42	47.83	39.90	79.10	60.69
Insurance A/R $ > 90 Days		$ 5,109,800	$ 6,068,690	$ 2,826,451	$ 3,092,112	$ 3,109,442
% of Total A/R	< 15-20 %	19%	25%	14%	11%	13%
All A/R $ >90 days (includes Self-Pay)		$ 8,689,922	$ 8,710,464	$ 9,386,715		
% of Total A/R	< 20-25 %	33%	35%	47%	0%	0%
DNFB	< 5 Days	8.42	6.32	4.97	9.00	5.08
DNFC	< 3 Days	7.58	4.45	2.75	3.00	2.87
Gross Denials $ written off		$ 232,596	$ 97,506	$ 79,842	$ 65,525	$ 70,232
% of gross patient revenue	< 2%	2%	1%	1%	1%	1%
Bad Debt transfers		$ 789,093	$ 528,767	$ 759,585	$ 689,443	$ 712,357
% of bad debt gross patient revenue	< 8%	6%	4%	5%	7%	6%

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HOW TO USE THE DATA

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UTILIZE KPIS WITHIN PAYER CONTRACTING



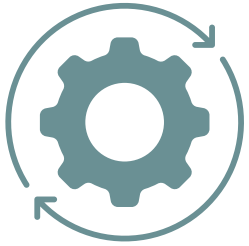
Denial Reporting

- Dollar value to total billed
- Number of claims to claims submitted to payer



Medical Necessity

- Medical records requests
- Appeals process



Prior Authorization

- Process, lag time, automation



Overall success of payer

- Financial health of the contract

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SUPPORTING INSURANCE VERIFICATION LEADS TO AVOIDING DENIALS

- Insurance verification is the first step toward receiving payment for services
- Claim denials have been steadily growing year over year
- ACA plans denied 20% of all claims in 2023, up from 17% in 2021.
- Specific plans denied up to 54% of all claims submitted
- Most common reason cited for denial was “Other”

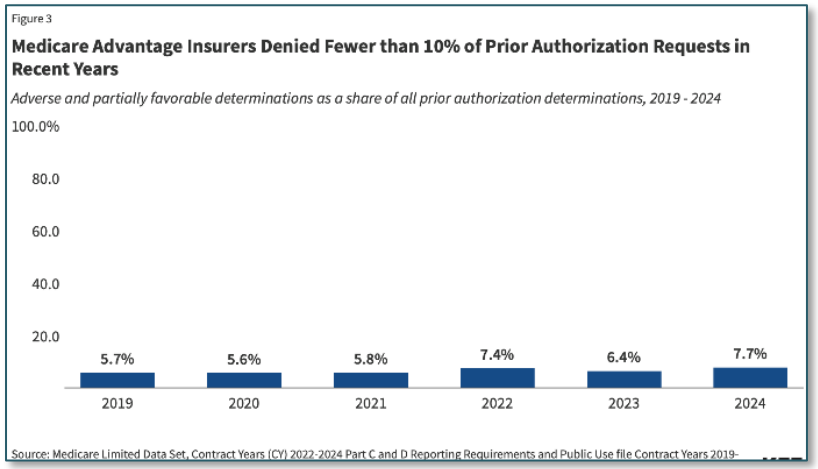
- Payors are using automation and AI to preemptively reject or deny claims that previously may have been paid
- 86% of the denials are potentially avoidable
- Average cost to work denial can be anywhere from $43 to $121.
- Work to eliminate self-inflicted denials so that staff can focus on payer challenges (not self-inflicted)

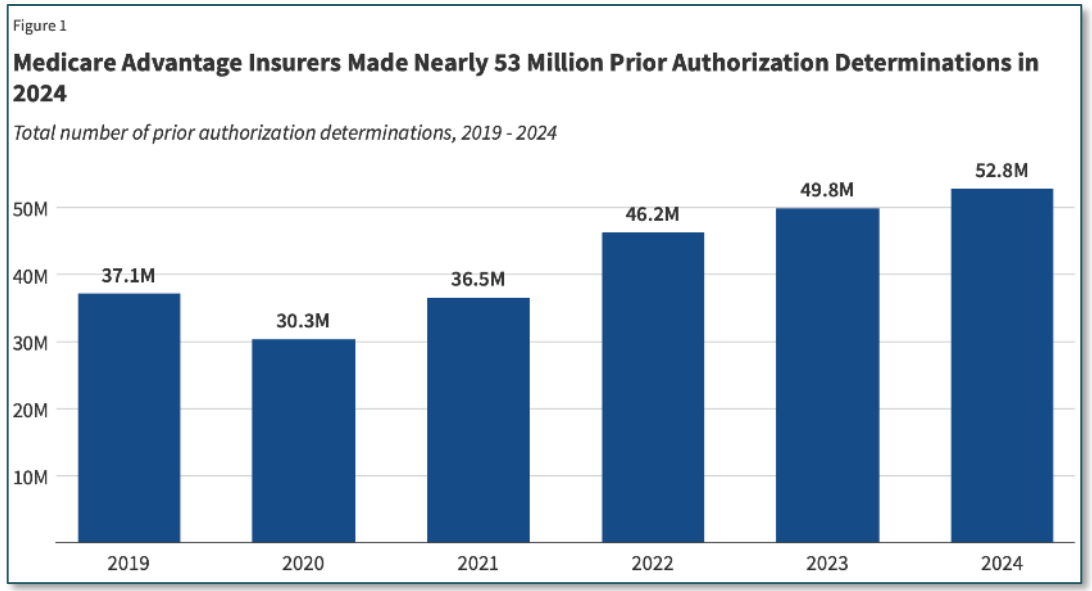
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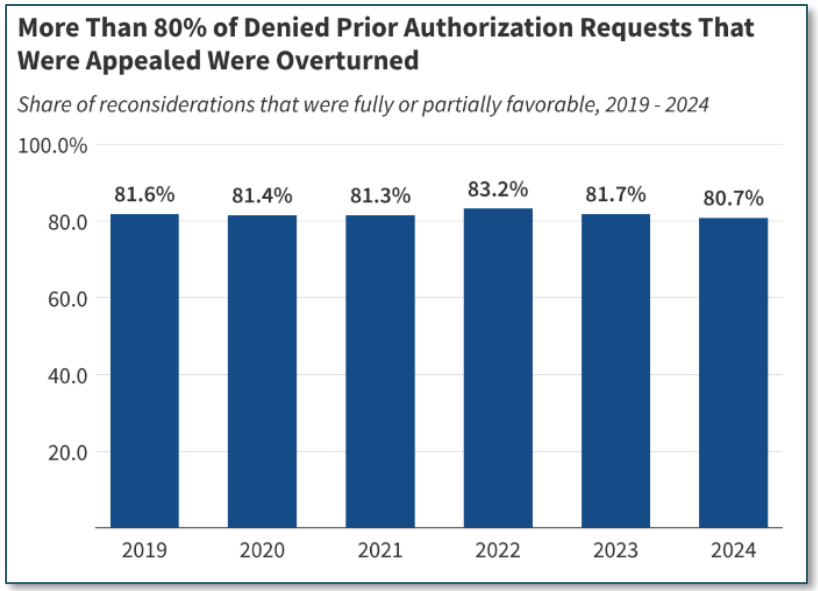
FOCUSED ATTENTION ON PRIOR AUTHORIZATION PROCESSES

A recent study by KFF evaluated PA use and experience based on 2024 data. Key findings are as follows:

- Nearly 53M PA requests were submitted to MA insurers on behalf of enrollees in 2024
- MA insurers fully or partially denied 4.1M PA requests, which is a somewhat larger share (7.7%) of all requests than in 2023 (6.4%)
- A small share of denied PA requests was appealed in MA –11.5%
- Though a small share of PA denials were appealed, most appeals (80.7%) were partially or fully overturned







Source: https://www.kff.org/medicare/medicare-advantage-insurers-made-nearly-53-million-prior-authorization-determinations-in-2024/#6e420acb-2fc1-4707-8689-ac19594e493a

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BEST PRACTICES FOR COPAY AND DEDUCTIBLE COLLECTIONS

Establish POS Policies	Begin conversations before service, such as during registration or pre-registration. Train staff to verify insurance eligibility in real time using electronic tools to accurately estimate patient responsibility.
Use Technology for Accurate Estimates	Leverage patient estimation software. Offer multiple payment options, such as credit cards, mobile payments, or payment plans, to facilitate immediate collections.
Set KPIs to Monitor Performance	Collection rate (e.g., percentage of copays/deductibles collected at point-of-service)
Track Success	Maintain historical data on collection performance. Use analytics to spot patterns, such as seasonal variations.
Enhance Training	Provide ongoing training for discussing financial responsibilities without alienating patients. Use scripts for consistent messaging and educate patients on their benefits to build trust and encourage prompt payments.

KAISER FAMILY FOUNDATION: 2025 INSURANCE PREMIUMS

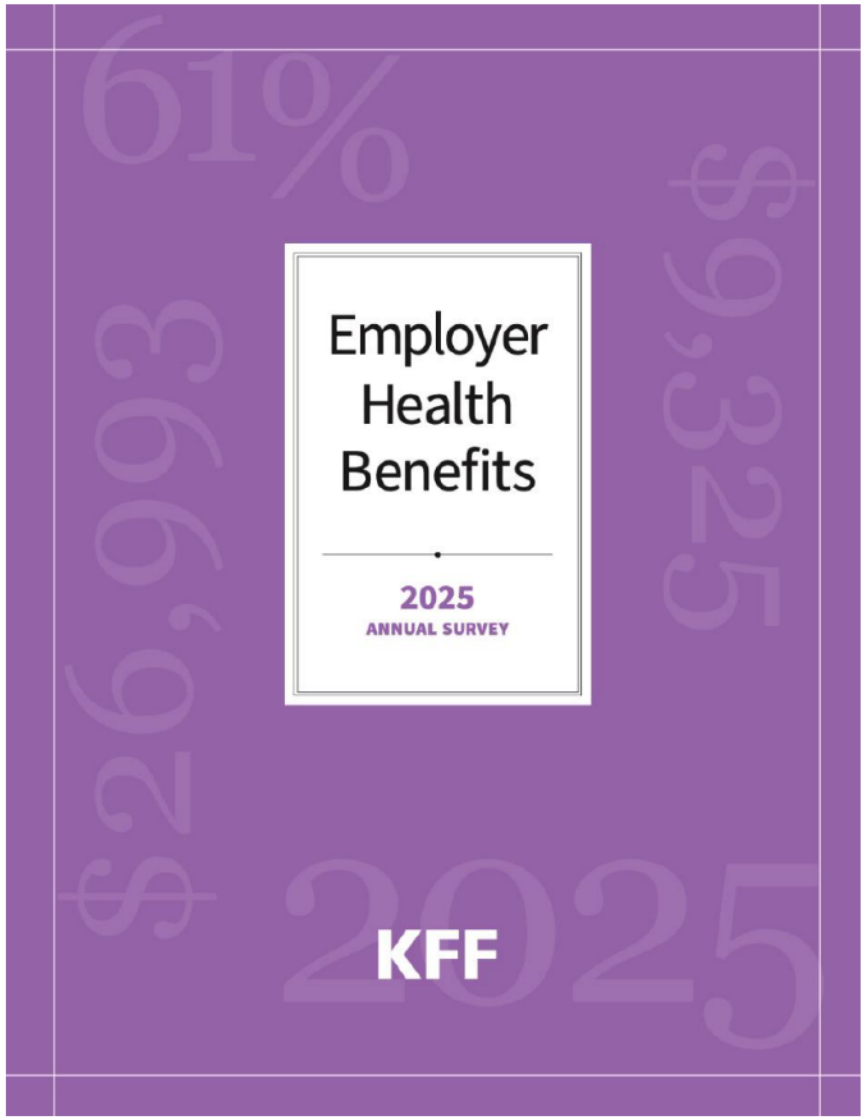
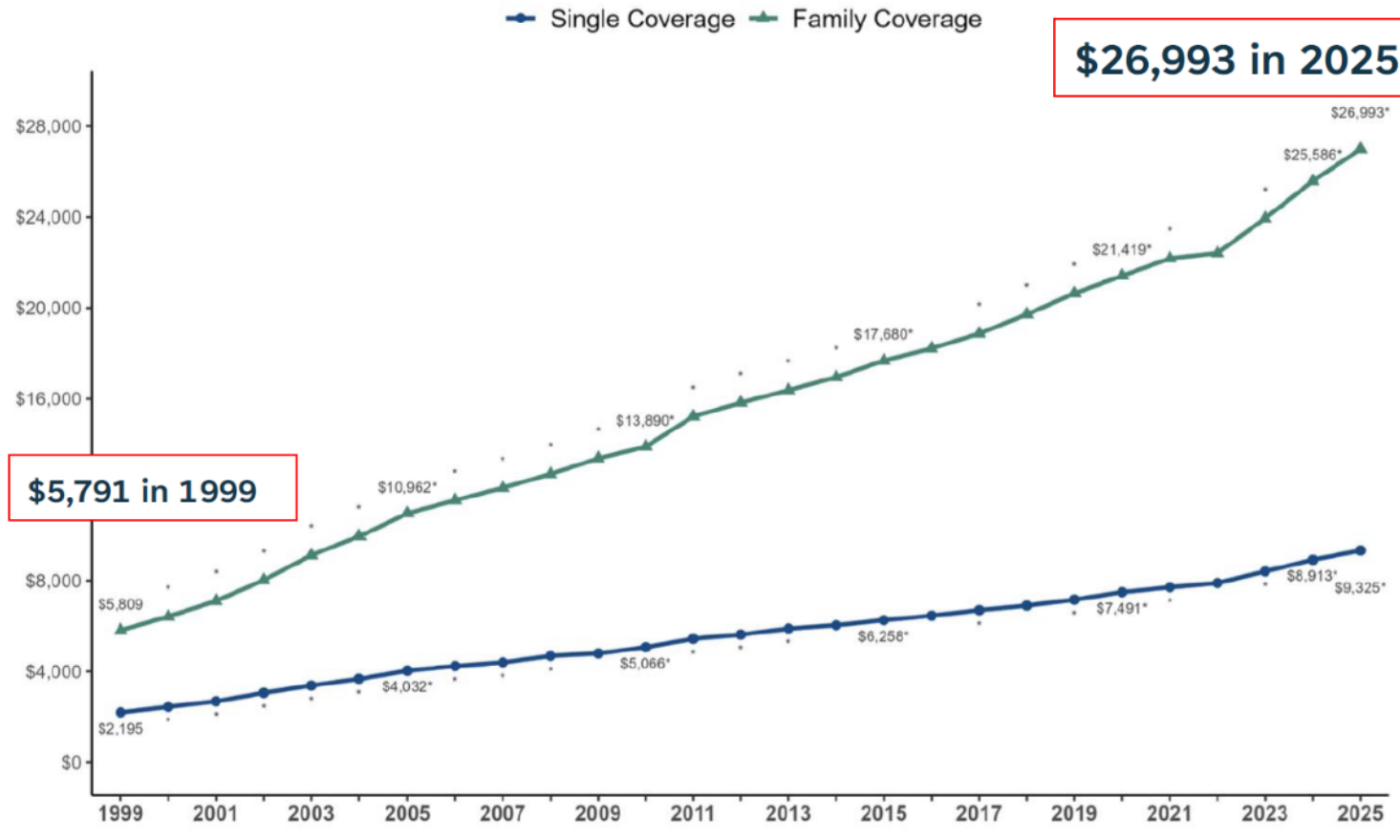


Figure 1.12
Average Annual Premiums for Single and Family Coverage, 1999-2025



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2025; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

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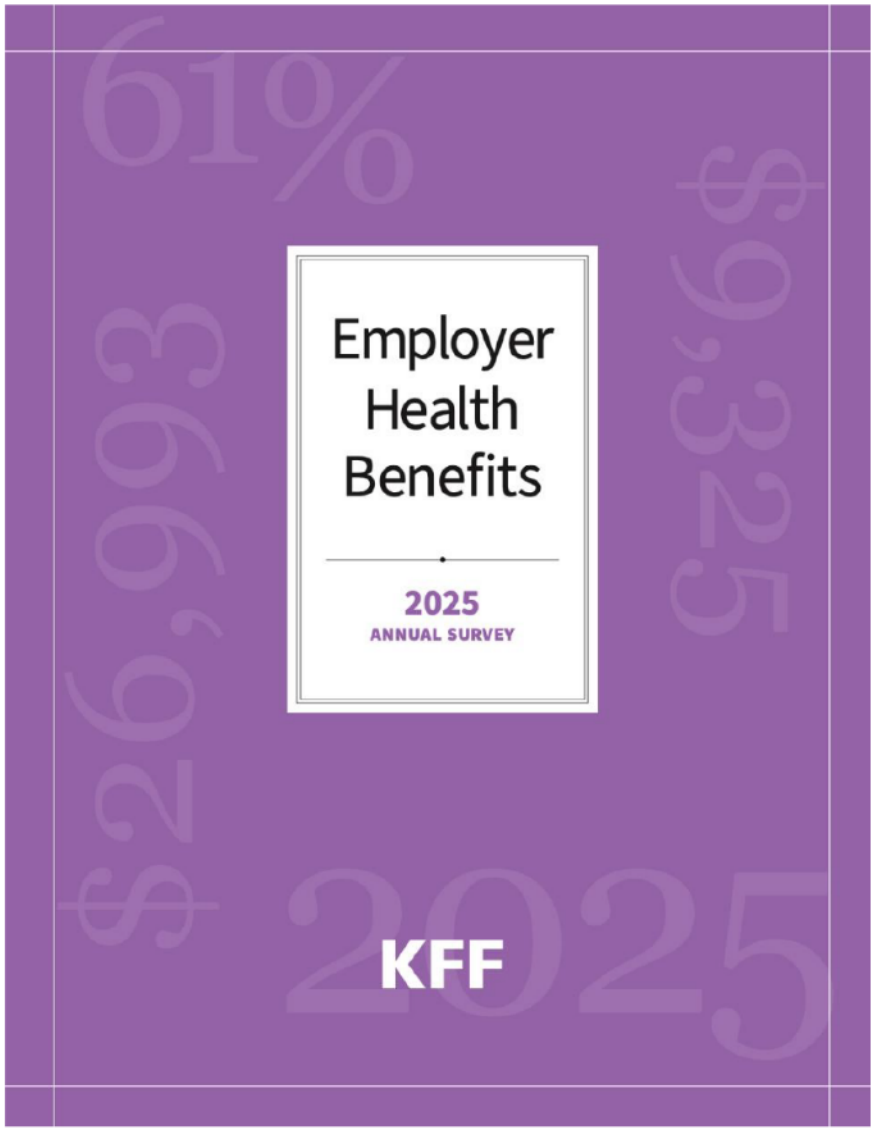
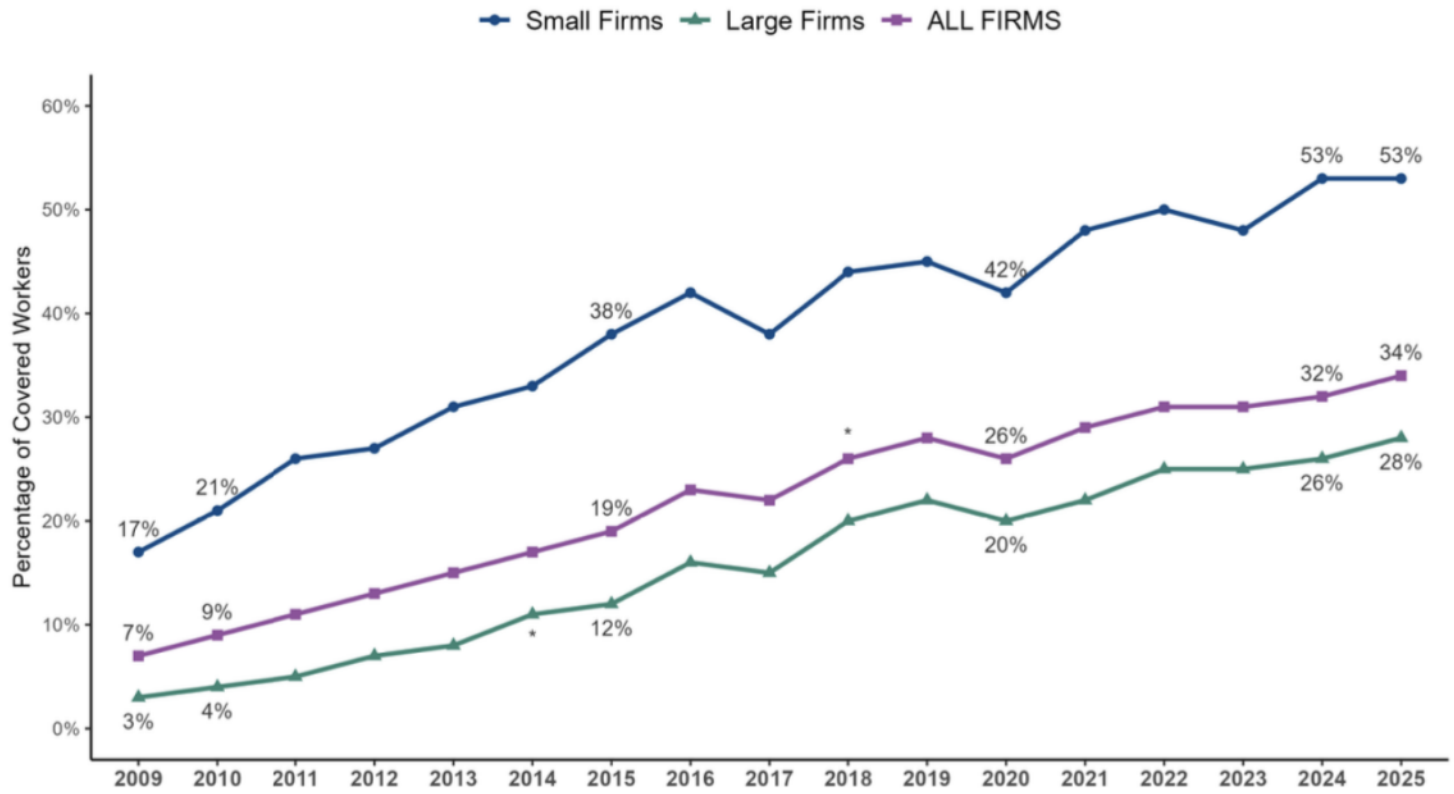


Figure 7.14

Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of $2,000 or More for Single Coverage, by Firm Size, 2009-2025



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

NOTE: These estimates include workers enrolled in HDHP/SOs and other plan types. Average general annual deductibles are for in-network providers.

SOURCE: KFF Employer Health Benefits Survey, 2018-2025; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

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CO-PAY AND DEDUCTIBLE COLLECTION & PATIENT PAYMENT ARRANGEMENTS

HISTORICALLY

- Healthcare has historically focused on collecting from insurance and third-party payors
- Patient collections for deductibles and co-payments occur on the back end after claim processing
- Staff members may be uncomfortable talking about money
- Hospitals have 2-3 options for collecting payments from patients
- Patients may not proactively seek cost and payment information

TODAY

- Households are not equipped to handle a $400 emergency
- Employers are offering high-deductible health plans to their employees
- Patients are looking for ways to pay and financing options
- Providing payment options can improve the patient financial experience for patients and providers
- Effective financial conversations can help patients move forward with care and avoid billing surprises

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CO-PAY AND DEDUCTIBLE COLLECTION & PATIENT PAYMENT ARRANGEMENTS BEST PRACTICES

- Communicate potential financial responsibility to the patient before the day of the visit
- Hospitals adapt to the reality that the payments will come from patient sources as high-deductible health plans shift the responsibility to patients
- Change the culture to understand that patient collection is a front-end activity
- Review prior balances that the patient may have and address outstanding payment plans and financial responsibility
- Offer alternative payment options: Digital payments, person-to-person, Health Savings Account, healthcare credit cards, financing, and monthly payments
- Leverage Pricing Transparency and Shoppable Services

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DELINEATE BETWEEN CLAIM REJECTION AND CLAIM DENIAL

Claim Rejection:
Not accepted by the payer

- Rejected at the front door
- Incorrect or missing data
- Provider's clearinghouse or claims scrubber finds no insurance subscriber listed or number is invalid
- Timely Filing Window still ticking

Claim Denial:
The insurance carrier processes and deems it unpayable

- Fully in payer system, but not paid
- Claim submitted timely, now appeal clock begins ticking

Claim rejection



Claim denial



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RCM OUTSOURCED VENDOR ACCOUNTABILITY

Implement regular vendor performance reviews	Confirm vendor is meeting expected service levels Establish timelines for deliverables
Utilize analytics to review leakage points	Focus on actionable data Understand gaps in performance and corrective action plans
Enhance vendor oversight and accountability	Review vendor work, clarify expectations, and set up appropriate cadence of communication
Establish points of contact and anticipated staff involvement	What types of items require immediate escalation to staff? What is the expected response time from the vendor and staff on all items?

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OUTSOURCED RCM VENDOR: BEST PRACTICES (CONT.)

1. Define where responsibilities lie between vendor and hospital and process for hand-offs and questions

Who is responsible?

2. Establish best practices for engaging with all vendors
   Utilize phone calls, emails, and designated points of contact

What are the best forms of communication?

3. Should be consistent and ongoing, both formal and informal

How often should communication occur?

4. Aligning on goals, timelines, and expectations helps to build stronger relationships and enhances patient outcomes

What is the objective?

5. Do both parties agree on expectations and timeframes?

How do we define success?

6. How do we measure success, and how often will we evaluate?

Can we measure success?

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OUTSOURCED RCM VENDOR: BEST PRACTICES

Establish clear expectations and deliverables	Where do the vendor's responsibilities begin and end? What happens when abnormalities within the process emerge?
Service level agreements and key performance indicators	What functions are the vendor committed to accomplish? What key performance indicators (KPIs) are in place to monitor success?
Regular performance monitoring and reporting	Is there ongoing communication with the vendor? What is the escalation process when performance doesn't meet standards?
Multiple communication channels	Who are the critical points of contact from both sides of the relationship? How will the vendor handle challenges or interruptions to their standard workflow?
Building of a collaborative partnership	What does success look like for both parties? Is everyone aligned in expectations and pulling in the same direction?

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CALL TO ACTION: **IN SUMMARY**

- Develop and Monitor KPI Dashboards
- Create an RCM Champion Team focused on addressing identified issues (not placing blame)
- Use the RCM Champion Team to target areas of priority and guide decision-making
- Commit to continually learning and adapting to new, developing issues caused by outside parties

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Q&A

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STROUDWATER

COMMITTED TO INCREASING THE IMPACT OF RURAL AND COMMUNITY HEALTHCARE.

Our team of rural and community healthcare experts support the leadership of hospitals, health systems with a rural footprint , and the groups and clinics that form an essential care network across the 97% of the US that is defined as rural.



Amy Graham
agraham@stroudwater.com
(T) 207-221-8283
(M) 561-628-0066

Let's Connect!
Scan my QR Code



Ryan Breneman
rbreneman@stroudwater.com
(T) 207-221-8282
(M) 615-481-0688

Let's Connect!
Scan my QR Code

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Stroudwater Crossing
1685 Congress St.
Suite 101
Portland, ME 04102