

KEEPING PACE WITH PAYERS

Hospital Survival Strategies for a
Shifting Reimbursement Landscape

Insights from Revenue Cycle Leaders on
Pivoting Denials Management Strategy



Executive Summary

In today's dynamic payment environment, the pressures on hospital revenue cycle operations have never been more intense. Persistent denial challenges, escalating payer complexities, and the imperative for efficient cash flow demand more than just tactical adjustments – they require a fundamental pivot in strategy.

This research report examines the challenges and opportunities presented by the shifting reimbursement landscape and explores how hospitals are likely to adapt based on insights from a survey of 147 revenue cycle leaders analyzed by Knowtion Health and conducted by the Healthcare Financial Management Association.

Across the healthcare landscape, providers are experiencing an intensification of reimbursement friction. Denials are becoming more frequent and complex. Underpayments are harder to detect and correct. Claims that once took weeks now take months to resolve. This has left many revenue cycle teams scrambling to maintain cash flow and operating margin.

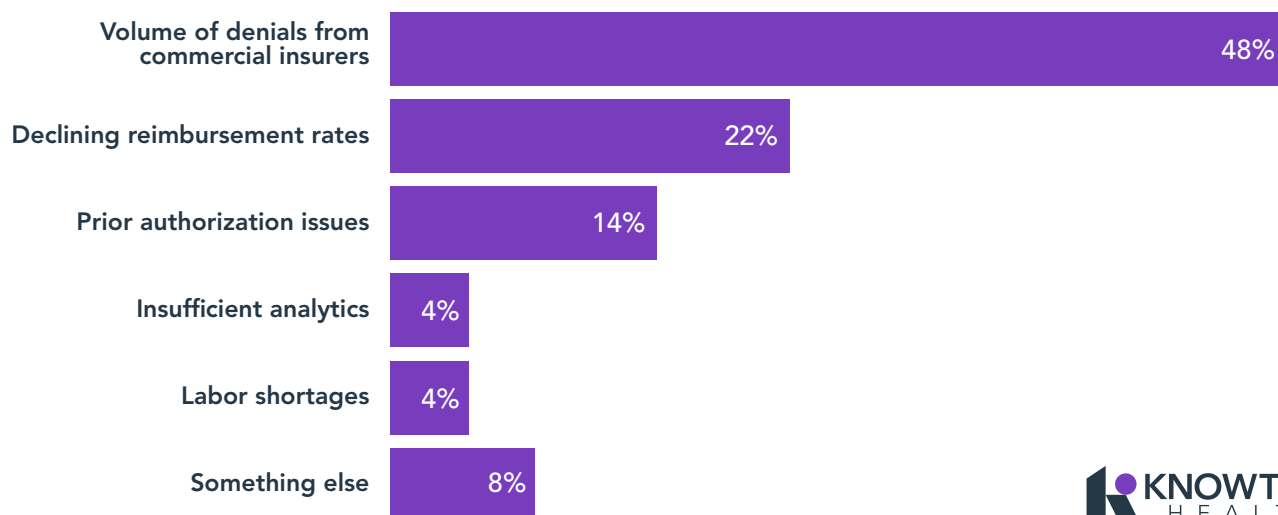
Nearly half of the 147 revenue cycle leaders surveyed say that the high volume of denials from

commercial insurers in recent years poses the greatest threat to their hospital or health system's revenue cycle—presenting more of a challenge than declining reimbursement rates, analytics technology deficits, or labor shortages.

The insights presented below offer a window into how hospital executives are likely to rethink their payer strategies and prioritize resources as they continue to navigate increasingly difficult and inefficient reimbursement dynamics.

Q

Which of the following is the greatest threat to your organization's revenue cycle?



Modern Denials Management: The Volume Crisis

Managing denials and underpayments has never been easy for healthcare providers. Lack of payer standardization means revenue cycle teams must adhere to inconsistent rules, formats, and timelines, leading to administrative inefficiencies and added complexity. Denials often stem from missing or unclear documentation, eligibility issues, or evolving medical necessity criteria, making prevention and resolution both time-consuming and resource-intensive. Underpayments can be difficult to detect, often requiring thorough contract analysis and strong auditing capabilities across fragmented systems to identify patterns of shortfalls. Compounding these issues are frequently siloed workflows across departments and limited staff capacity to effectively manage appeals.

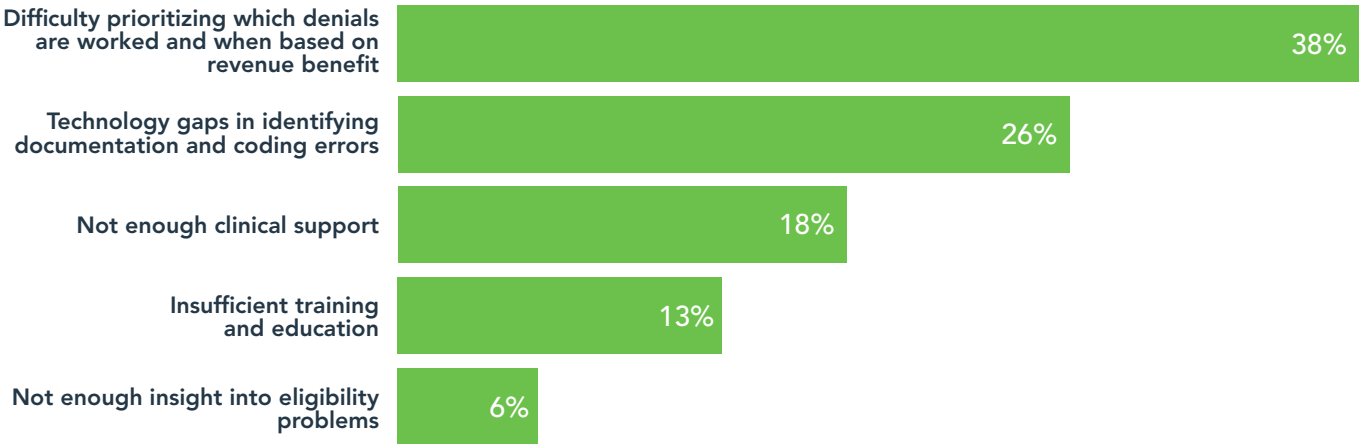
And while these challenges persist, today's reimbursement environment poses a significantly different threat: sheer volume.

The industry has witnessed a significant rise in initial denial rates over the past few years, with some providers experiencing average rates near 15%.^a Moreover, the introduction of AI and automation by payers in denial decisions is likely to further fuel this trend. Keeping up with the increasing rate of claim denials is becoming unsustainable without meaningful operational change.

This new reality is pushing many hospital revenue cycle teams to a critical juncture, where existing workflow processes and resource allocations are proving insufficient. In fact, a staggering 38% of revenue cycle leaders cite difficulty prioritizing claims as their primary impediment to revenue recovery, underscoring the vital need to adjust strategy.

Q

Which of the following is your biggest barrier to improving revenue recovery from denials/underpayment?



In today's environment of high denials, how teams prioritize their focus on claims has the greatest impact on cash and cash flow. The same old methods of doing business are unable to keep pace, as teams face persistent time pressure and demands to triage their efforts by considering factors such as dollar value and age, the likelihood and ease of appeal success, proximity to timely filing deadlines, and other variables.

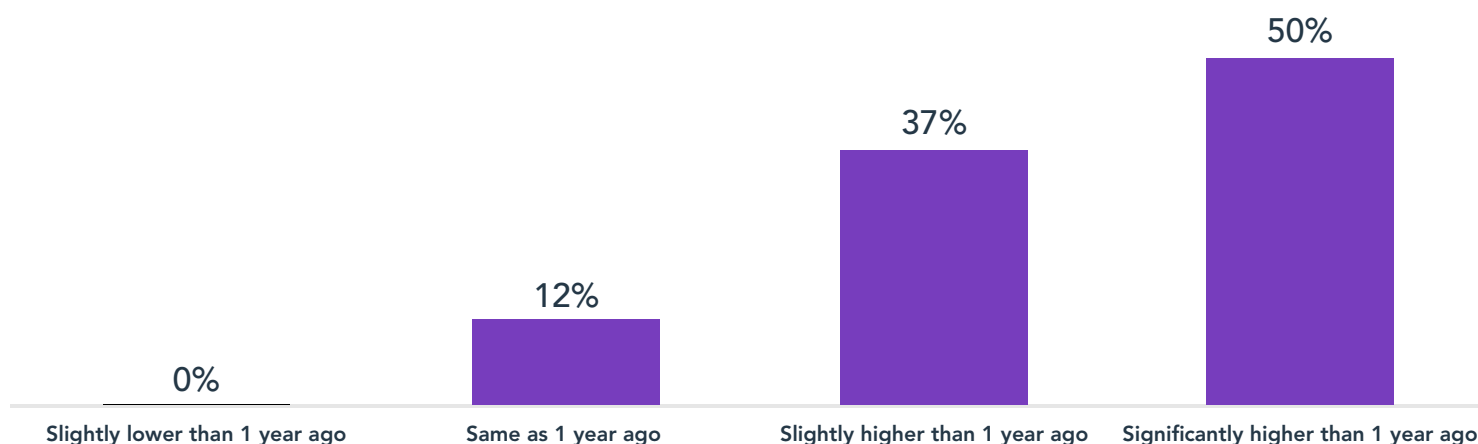
Compounding these pressures from high denial volumes are two recent trends in payer behavior:

Significant increases in requests for information.

Lags in payment resulting from payer requests for information are a growing problem. Health insurers are increasingly delaying payment to healthcare providers by requesting more information on submitted claims. Half of the survey respondents report significantly higher requests over the past year.

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Overall, how would you describe the volume of payer requests for information you received over the past year?



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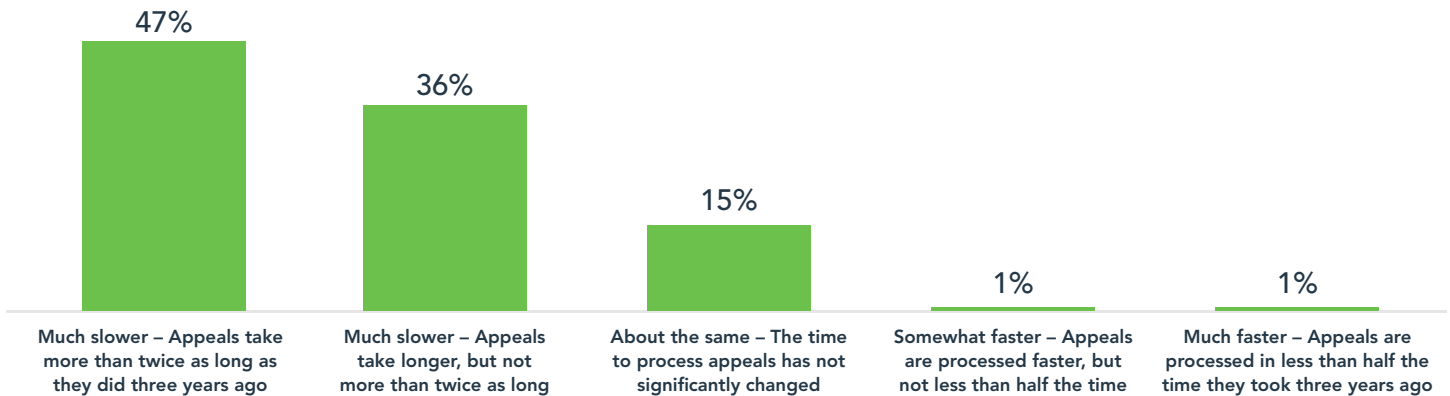
Slower processing of appeals. Payer behavior is also a concern in relation to appeals processes. In many instances, slow response times are prolonging time to resolution.

For 47% of those surveyed, the time commercial payers take to process appeals today is more than

twice as long as it was three years ago. Revenue cycle leaders are left to try to make up for the time lost by being more efficient internally. In addition, they must dedicate more time and resources to holding payers accountable to Service Level Agreement (SLA) terms and pursuing effective escalation pathways for aged claims.

Q

How does the time commercial payers take to process appeals today compare with three years ago?



Payer Relations in the New Denials Management Era

As these factors of high denial volumes and shifting payer behavior converge, hospitals and health systems are under greater pressure to monitor payer performance and create more effective communications and strategies around appeals.

Communications between healthcare providers and payers have notoriously been challenging. Revenue cycle leaders ranked “payer communications” as a top barrier to appeals improvement.

Many factors contribute to these difficulties. Traditionally, hospitals and health systems have faced significant challenges in developing effective payer performance scorecards and identifying trends in payer denials to share with payers due

to inconsistent denial codes and reasons across payers, making it difficult to categorize and analyze denial patterns across various plans. Additionally, the data provided by payers often lacks granular detail or is presented in formats that are not easily digestible or transferable into hospital systems for consistent analysis. Furthermore, there is often a lack of transparency regarding the specific logic or algorithms used by payers for denial decisions, particularly with the growing use of AI.

Adding to these challenges is the complex and dynamic nature of tracking payer performance. Commercial payer contracts are intricate, with detailed terms, clauses, and varying reimbursement methodologies. Many teams, even with the support of automation, struggle to track adherence to these specific contractual obligations. Moreover, payer denial reasons and tactics are not static; they frequently change in response to regulatory shifts or evolving cost-containment strategies.

The appeals process is often iterative and requires multiple levels of engagement, making it difficult to track the full lifecycle of a denial.

In a high-denial environment with more frequent requests for information, the resources to manage these challenging payer dynamics become spread even thinner. Limited resources are focused on immediate cash recovery and front-end denial

prevention strategies rather than deep-dive analytical work to advance payer strategy. Many hospitals may lack the advanced analytics tools, business intelligence platforms, or dedicated data scientists/analysts needed to effectively process and interpret complex payer data, recognize denial trends, and isolate root cause to link back to the causation of a specific payer’s behavior versus internal hospital process issues.

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Which of the following statements best describes your organization’s ability to track commercial payer adherence to contractual obligations and regulatory requirement? (i.e., your payer performance scorecards)



While 55% of revenue cycle leaders express confidence in their ability to monitor payer adherence to contractual obligations, they still struggle to pinpoint the root causes of issues. Nearly a quarter of revenue cycle leaders report that managing both remains a challenge.

This inability to comprehensively monitor payer behavior undermines the development of data-

driven strategies and hinders executive decision-making regarding payer relations.

Operational Barriers and Resource Implications Around Appeals

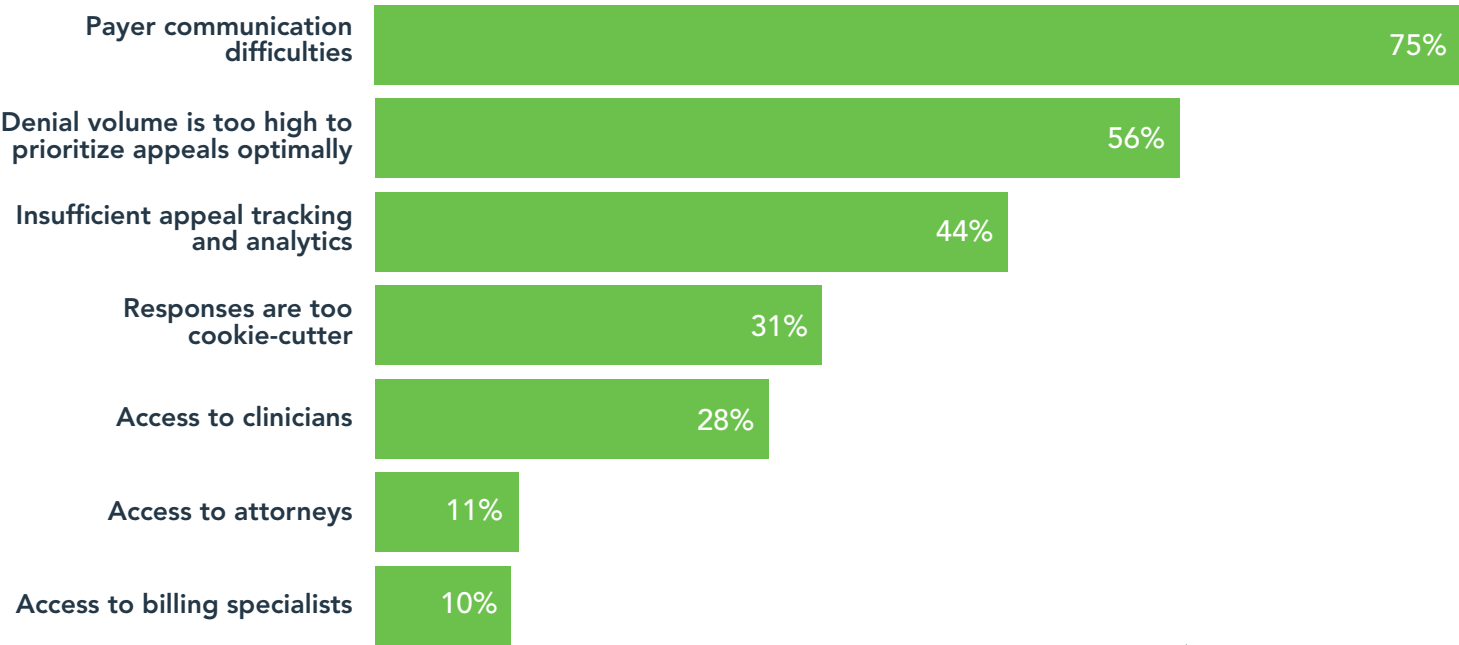
Second to payer communications, the next areas ranked as top barriers to appeal performance

are much more within a provider’s control, as they relate to the speed and quality of appeal development. Top issues at many organizations are

prioritizing appeals (56%), tracking and analytics (44%), and customization of appeals (31%).

Q

What are the greatest barriers to improving appeals performance? (Please select up to 3 choices)



To address these challenges, many hospitals and health systems are turning to centralized appeal teams and data-driven prioritization to better manage volume. However, the appeal process remains largely reactive and manually intensive, limiting the scalability of current workflows.

The adoption of technology, especially analytics, machine learning, and generative AI, is poised to play an increasing role in appeal processes as organizations seek better insights into wins and underlying strategies while also pursuing greater

automation in appeal development to scale these tactics. Many healthcare providers will also look to technology and/or service support utilizing these technologies to help alleviate pressures on labor.

The specialized skills required for denials teams to be effective are often challenging for hospitals to recruit and retain. Many denial-related tasks—such as building a case for appeal, interpreting medical necessity, and navigating payer-specific requirements—require individuals with deep payer policy expertise and sometimes a clinical or legal

education. These are not generalist roles; they demand experience, regulatory knowledge, and a tolerance for complexity that is hard to find.

Greatest staffing challenges for denials management teams over the next three years are likely to be in roles responsible for denial appeal writing, denials analysis, and clinical documentation improvement.



Clinicians play a critical but often underleveraged role in hospital denials management and appeals. Their clinical authority, documentation expertise, and ability to interpret the medical necessity of care are essential in both preventing and overturning denials. While there is no single, definitive number for the exact percentage of hospital denials that are clinical denials, the consensus is that they represent a significant portion, often ranging from 3% to 5% of a hospital's net patient revenue.

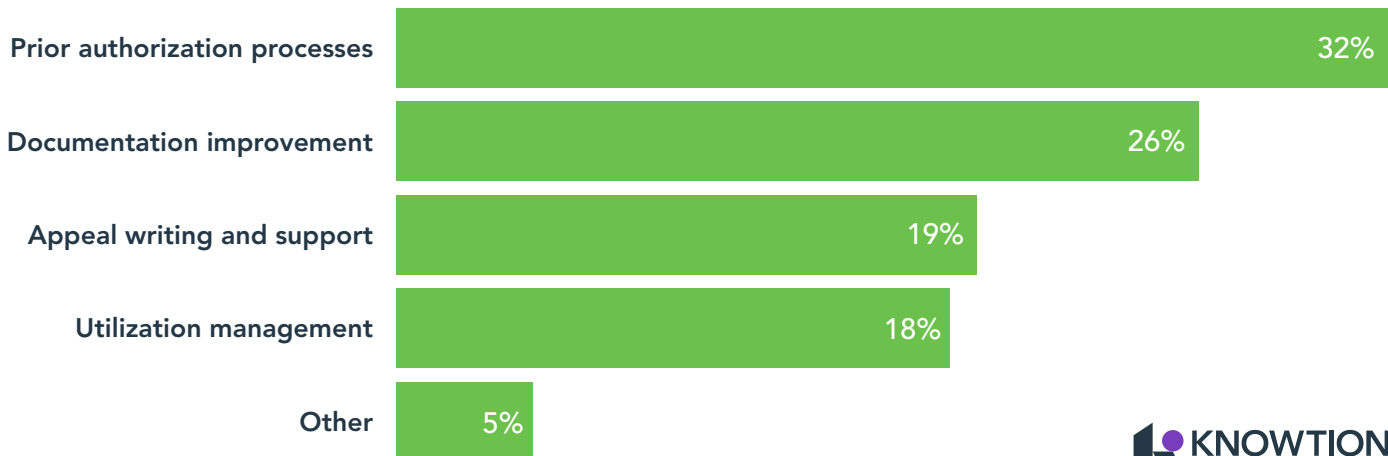
Many organizations have traditionally struggled to foster a desired level of collaboration between

clinicians and revenue cycle teams. Clinician time is limited and prioritized around delivering care; clinicians may lack a deep understanding of revenue cycle terminology or payer nuances that affect denials; and strategic priorities at the organizational level may not be aligned.

Areas where survey respondents experience the most difficulty with collaboration between revenue cycle teams and clinicians are authorization processes (32%), documentation improvement (26%), and appeal writing and support (19%).

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When it comes to denials management, where do you see the greatest difficulty in revenue cycle and clinician collaboration?



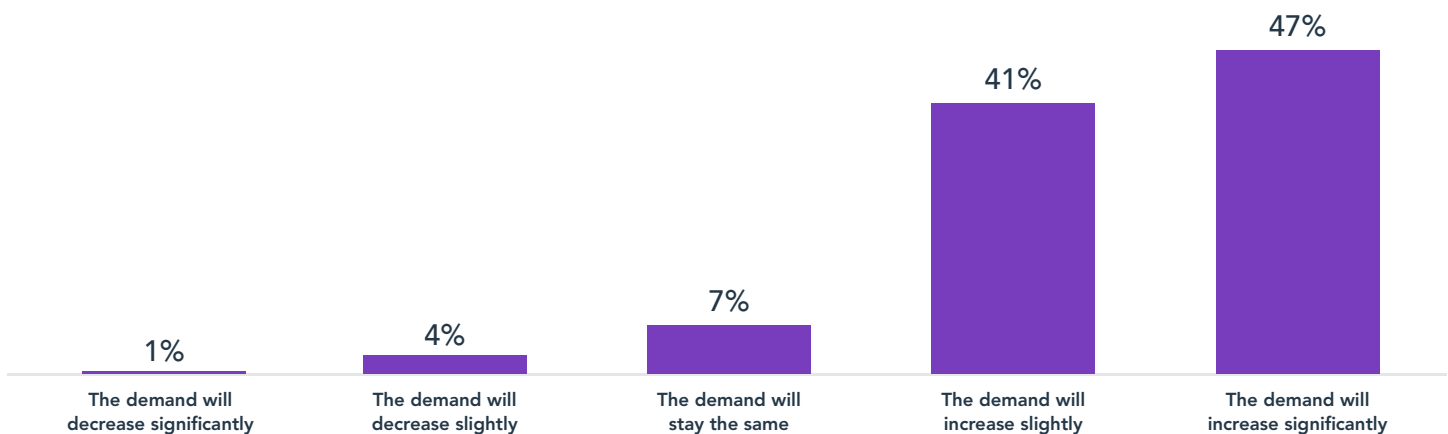
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Resource gaps in these areas pose vulnerabilities for organizations in the future as revenue cycle leaders continue to strategize on how to allocate resources to manage high volumes of claim

denials. Most respondents anticipate an increase in demand for clinician support over the next three years, with 47 percent expecting this demand to rise significantly.

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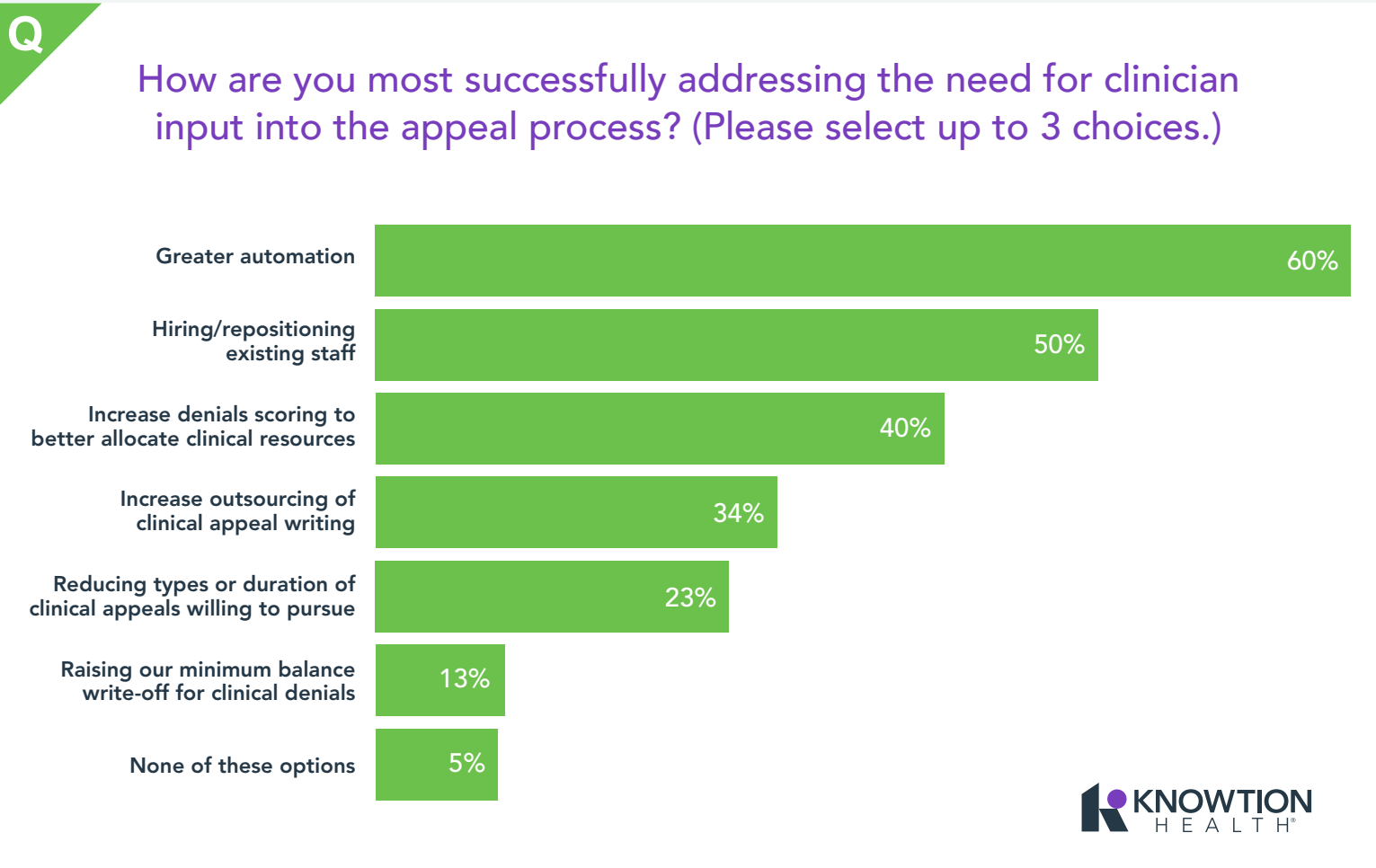
Looking ahead to the next three years, how do you expect overall demand for clinician support in your denials management strategy to change?



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Approaches to address the growing need for clinical denials support vary. Half of the survey respondents will hire or reposition existing staff as a top priority.

Other top tactics are likely to involve automation (60%), better prioritizing of workflows through focusing on denials scoring (40%), and increasing outsourcing of clinical appeal writing (34%).



Keeping Pace with Payers: A Call to Adapt Denials Management Strategy

The message from this research is clear: The tools and workflows that worked in the past may not suffice to meet today’s denial volume and reimbursement complexity, particularly where clinician support is lacking. As denial volumes surge and payer behaviors continue to evolve—characterized by more frequent information requests, slower appeal timelines, and opaque

AI-driven decisions—healthcare providers must radically adapt their denials management strategies.

Success requires more than additional staff or technology solutions. It demands an intentional rethinking of where and how limited resources are deployed and an acceptance of several core constructs:

Appeals are resource-intensive, but increasingly necessary. Hospitals need to be more aggressive

with their denial appeal strategies today because the financial and operational stakes have grown significantly. With costs rising and reimbursements lagging, hospitals can't afford to leave appealable denials unresolved. More aggressive strategies can improve net revenue without increasing volume or cost of care delivery.

A focus on core competencies should guide partnerships. Working smarter is the new imperative in addressing high denial volumes and requests for information. Revenue cycle leaders need to be shrewd about where and how they partner, focusing on areas where internal access to specialized technology or expertise is too difficult to maintain or simply distracting. Service arrangements that bolster efficiency and effectiveness in niche areas of revenue cycle or that do a better job of scaling and not just speeding workflows are vital for success in a high-volume denial environment.

Appeal writing is poised to look very different. Yes, providers have been investing in ways to reduce manual effort and accelerate appeal cycles. But technology is advancing to the point that many workflows need a redesign. Analytics and machine learning are providing guidance on targeting appeals where there is a high likelihood of success. Similarly, best practices around the writing of appeals are evolving such that combining auto-generated letters with targeted

revenue cycle, clinical, or legal input can increase the effectiveness and efficiency of overturns. An aggressive appeals approach doesn't have to mean high cost—just smarter prioritization, data-informed processes, and persistence.

Payer engagement needs to be more proactive. Building strong relationships with payers is crucial for resolving disputes early. Rapid response to denial trends and payment anomalies requires not only the right reporting and insights, but also the relationships and knowledge of the payer to support better communications.

The time for courage is now. Most importantly, this moment calls for the courage to abandon outdated processes, challenge ingrained assumptions, and create a systemic approach that matches the scale of the challenge the industry is facing. Whether it is a willingness to innovate with the use of new technology or take on more complex communications with payers, revenue cycle leaders today need the resolve to champion truly transformative change across their entire denials management efforts.

By embodying these core constructs and demonstrating such leadership, revenue cycle leaders will not only navigate escalating pressures but also secure vital cash flow, reclaim lost revenue, and amplify their advocacy for the care they provide.

³American Hospital Association, "Payer Denial Tactics – How to Confront a \$20 Billion Problem", accessed June 2025 at <https://www.aha.org/aha-center-health-innovation-market-scan/2024-04-02-payer-denial-tactics-how-confront-20-billion-problem>

About Knowtion Health's Survey

The Healthcare Financial Management Association conducted a survey of healthcare professionals director level and above across roles in revenue cycle management, revenue integrity, finance, patient financial services, and operations. A total of 147 individuals responded prior to January 2025. The survey was sponsored and analyzed by Knowtion Health.

About Knowtion Health

In a world where the balance of power and complexity in insurance denials favor payers, Knowtion Health delivers claim experts equipped with AI-enabled technologies to help healthcare providers resolve insurance claims and recover low-balance accounts to increase their revenue and optimize patient experience amid workforce shortages. Service areas include coordination of benefits and patient-involvement denials; clinical denials; low-balance recovery; complex claims, such as MVA, TPL, and work comp; and payer audit defense.



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