



HEALTHCARE

C-SUITE

INSIDE THE FOUR WALLS

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Surviving the Big Beautiful Bill

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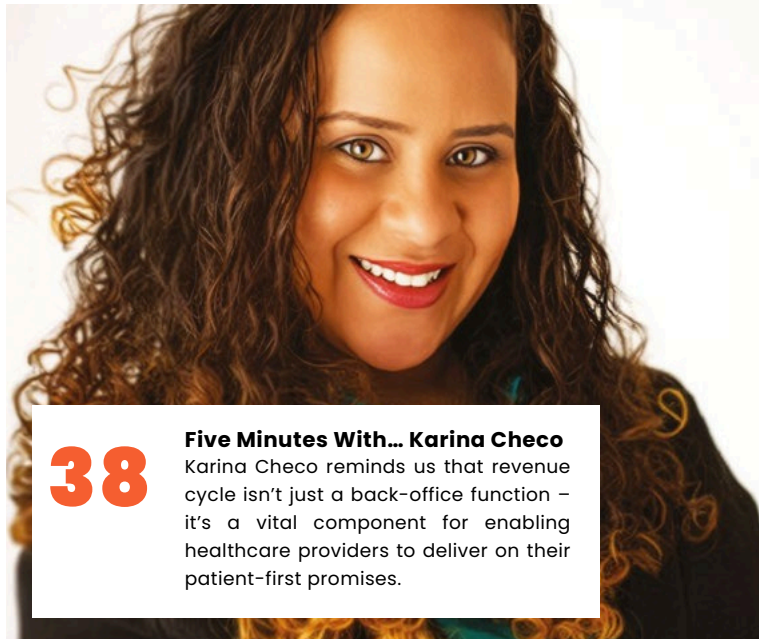
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Five Minutes With... Karina Checo

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A NOTE FROM THE EDITOR

Andrew Johnson

Welcome to this issue of Healthcare C-suite, the #1 magazine for healthcare leaders in executive, operational, clinical and revenue cycle functions.

In this issue, we explore some of healthcare's most pressing challenges and the ways in which strategic executives are rising to the occasion with financial prudence and compassion in equal measure.

In our first feature, we're discussing the Big Beautiful Bill, its unprecedented rollbacks of federal healthcare support, and how enterprising healthcare luminaries plan to preempt its financial consequences.

Speaking of consequences, our second feature examines how volume-based reimbursements and market conditions paradoxically incentivized patient-centric, community-first care. We touch base with industry thought leaders who argue that moral courage has become the optimal financial strategy.

We're keeping that peer-driven wisdom flowing in the next article, which highlights the sharpest insights from our recent peer roundtables and



We hope you enjoy this latest issue and come away with new ideas to implement into your own leadership strategies.

live events. These pragmatic, experience-driven takeaways come straight from seasoned healthcare leaders – a quick path to new ideas, complete with the confidence that you can mirror their success.

Lastly, join us in a sit-down with Executive Director of Revenue Cycle Karina Checo, as she reminds us that revenue cycle isn't just an out-of-sight back-office function – it's a vital component for delivering on your patient-first commitments. As always, we welcome your feedback on these features along with topic suggestions for future issues of Healthcare C-suite. Get in touch by emailing media@connexpartners.com.

Andrew Johnson

Andrew Johnson EVP and Founder, Connex Partners, Editor, Healthcare C-suite

Surviving the Big Beautiful Bill

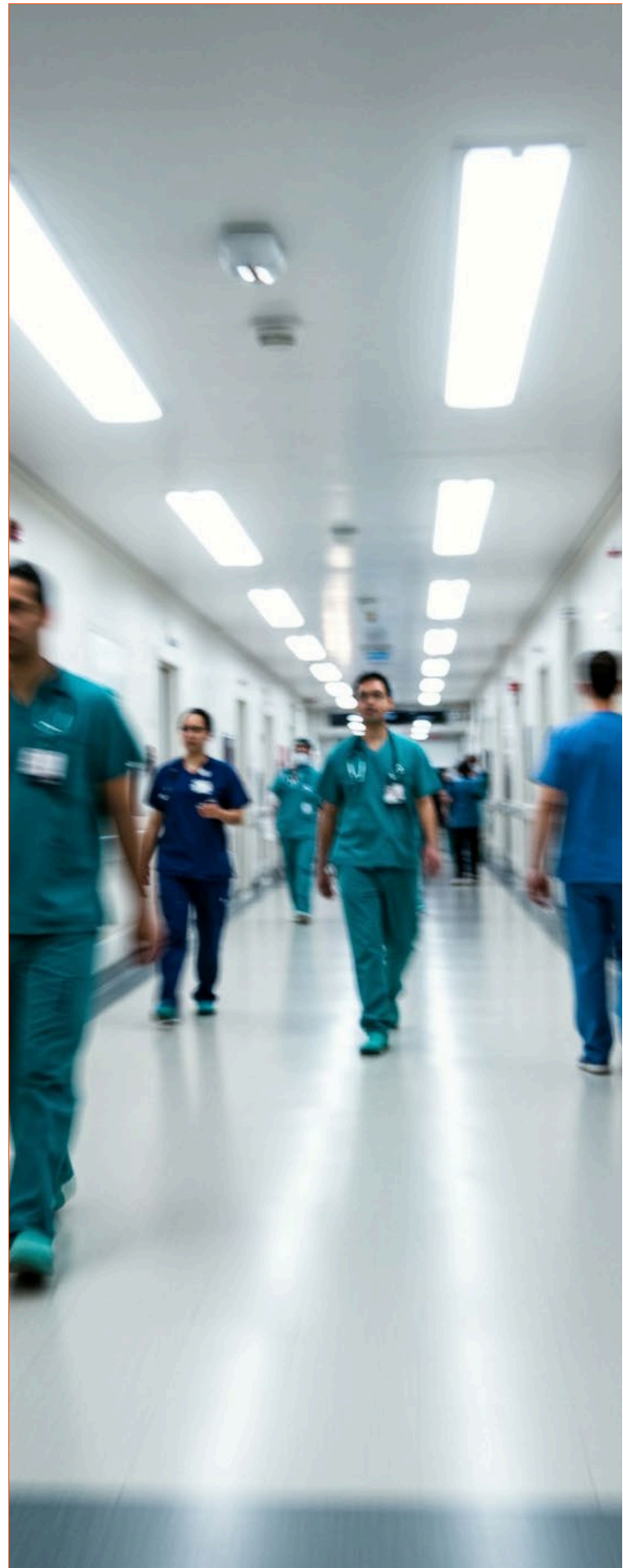
Deep legislative cuts to federal programs are expected to financially destabilize providers across the country – it'll be up to healthcare leaders to outpace those consequences and preserve community trust.



The American healthcare system stands at an inflection point, as executives across rural, critical access, and already struggling hospitals face financial pressures unlike any before. At the core of the issue lies the One Big Beautiful Bill Act (OBBA) – a staunchly partisan piece of legislation that represents the largest rollback of federal healthcare support in American history.

As most healthcare executives will know, the act was signed into law by President Trump on July 4th, 2025, following its narrow passage in Congress by way of budget reconciliation. [More than \\$1 trillion in spending will be slashed](#) from health programs as a result of OBBA, resulting in as many as 10 million Americans losing their healthcare coverage. Those anxious about the Trump administration's bold action found no solace in the post-shutdown budget continuing resolution passed in November of the same year. Any temporary relief therein simply masked the problem, kicking the proverbial can of clarity and relief further down the road rather than confronting the ensuing crises head-on. And

crises there will likely be, given OBBA's other provisions: \$120 billion in cuts to the Supplemental Nutrition Assistance Program (SNAP), [a hastened timeline for Medicare's trust fund insolvency](#), and – if additional action isn't taken by Congress – a further [reduction in Medicare funding by \\$500 billion between now and 2034](#). Each of these elements worsens the impact OBBA has on patients, and by extension, providers. SNAP cuts and the shift to greater state-funding will likely lead to many states opting out of the program, worsening food availability and other social determinants for some of the nation's most vulnerable patients, [while simultaneously worsening the nation's recession response](#).





All these factors put healthcare executives in an unprecedented bind.

Previous periods of instability, such as the COVID-19 pandemic, were exceptionally difficult to weather but theoretically straightforward – there was a clear, well-defined set of logistical and operational challenges that, with enough resources, could be overcome. Now, however,

hospitals and health systems face a cascading deluge of interlinked systemic failures outside their direct control, underscored by pervasive ambiguity.

Funding Uncertainties

One of the biggest uncertainties is the Rural Health Transformation (RHT) Program. Added to OBBB just before it received President Trump's signature, the RHT establishes a \$50 billion fund to help offset rural providers' expected hardships. Funds will be doled out from the beginning of FY 2026 through the end of FY 2030; 50% of these funds will be split equally between all approved states, while the remaining 50% will be made available at CMS's discretion.





What these funds can be used for was [outlined by CMS in September 2025](#), examples being:

“Promoting evidence-based, measurable interventions to improve prevention and chronic disease management” *“Providing training and technical assistance for the development and adoption of technology-enabled solutions that improve care delivery in rural hospitals, including remote monitoring, robotics, artificial intelligence, and other advanced technologies”*

“Recruiting and retaining clinical workforce talent to rural areas, with commitments to serve rural communities for a minimum of 5 years”

“Providing payments to health care providers for the provision of health care items or services”

While nearly all of CMS’s listed use cases are aligned with the concerns, needs, and strategic priorities of rural healthcare providers, one severely unaddressed fact remains. RHT’s \$50 billion in funding would [only offset roughly 37%](#) of the total estimated cuts to federal Medicaid spending in rural areas – and that’s without factoring in other OBBB-related losses, such as those caused by ACA’s premium tax credits expiring.

Possibly even more concerning, CMS is being given exceptionally broad authority to determine when, where, and how funds may be withheld or reduced. [States that adopt “Make America Healthy Again \(MAHA\)” policies will be given a larger share](#) of CMS’s discretionary funding, despite the fact that many of those policies would not be limited to rural areas, such as stricter SNAP restrictions and reestablishing the Presidential Fitness Test.



Simply put, it's difficult to gauge just how effectively RHT will help rural providers when so many of its features are beholden to partisan politics, statewide decisions, and other factors that fall far outside their four walls. State hospital associations can help executives understand what to expect, but even their knowledge is limited by the existential questions underpinning these market disruptions:

How many of these proposed initiatives will be implemented as planned? Which elements might be successfully pushed back upon in future congressional sessions? How effective will state and local responses be at staving off OBBB's worst impacts?

For executives accustomed to planning fiscal quarters or years at a time, these unanswerable questions and their many challenges demand a different operating mindset: scenario-based

planning, accelerated decision cycles, and contingency preparations for worst-case situations that may never materialize but whose financial consequences cannot be underestimated.

The Foundations of Survival

When the future is unclear, it helps to invest time and effort in the foundational elements of provider stability. Revenue cycle is an excellent place to start, and patient access is better still, given OBBB's impact on insurance eligibility. Many Americans will lose or change coverage, and it will fall to frontend staff to verify the details needed for prior authorizations, point-of-service collections, and accurate self-pay billing.

Those documentation burdens could be further worsened by OBBB's introduction of [Medicaid work requirements](#). Medicaid coverage will



When the future is unclear, it helps to invest time and effort in the foundational elements of provider stability.

Connex Community members have shared a variety of ideas on what this might look like in practice: a simplification of the patient financial journey with greater emphasis on mobile tools, the implementation of AI-backed patient registration and billing outreach, and a move towards rev cycle centralization, just to name a few. Many have recommended carrying that momentum forward to middle and back-end revenue cycle optimization efforts as well, such as charge capture analysis to better identify unbilled and frequently missed charges, and introducing automated coding and claims scrubbing tools to prevent avoidable denials.

Reevaluating Operations

That said, RCM optimization alone won't be enough to offset OBBB's impact, and even broader financial reassessments will be warranted. Now is certainly the time to conduct extensive service line profitability analyses, especially for those located in low-volume markets. Based on our conversations with industry leaders, the decision framework following data collection should address three fundamental questions:

be contingent on the recipient maintaining 80 hours' worth of employment or approved community engagement, unless otherwise exempt. Consequently, states will be expected to facilitate the eligibility verification process and monitor each recipient's compliance. Regardless of one's position on the cited rationale for work requirements, it's undeniable that they place an even larger data collection and verification burden on the country – a burden that may be shifted downward towards healthcare providers, requiring patient access staff to assist with documenting employment status, qualifying activities, and exemptions.

For all of OBBB's expected detriments, its clerical pressures may provide enterprising revenue cycle leaders with a valuable opportunity to make sweeping improvements to critical frontend functions. Across our think tanks,

1. *Can the service be partnered or contracted via other regional institutions?*
2. *Would operational restructuring achieve profitability, such as by implementing telemonitoring and remote consultations where appropriate?*
3. *Are there alternative funding sources that could help sustain critical services, such as those awarded to approved states by [Rural Health Transformation Program provisions?](#)*

A “yes” to any of the above provides a clear path towards financial breathing room, while a “no” to each requires one more consideration: which available closure and patient transfer strategy minimizes harm to the community? This uncomfortable assessment forces executives to confront the reality that American healthcare is, at its core, a business. Denying economic realities out of a sense of duty could lead to broader organizational instability, threatening even more disruptive closures.

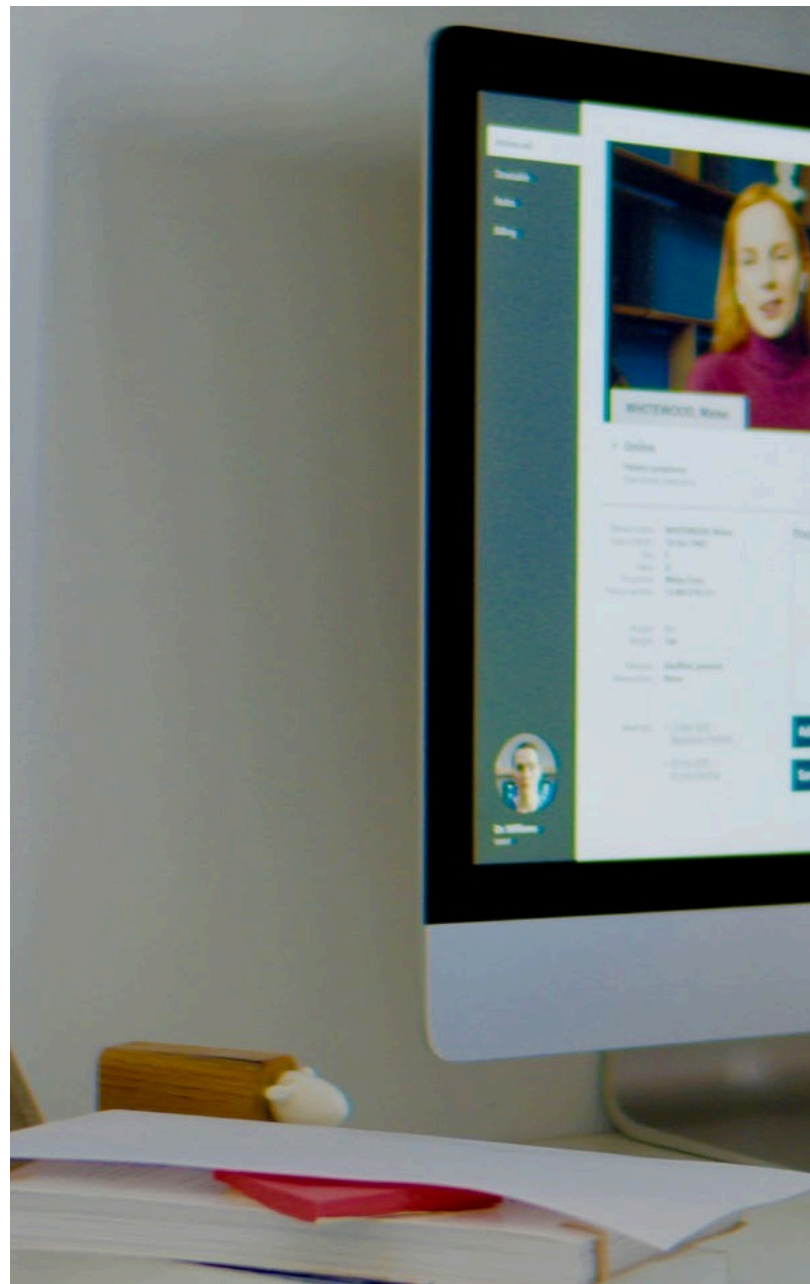
As some Connex Community thought leaders have learned, however, there also needs to be an honest accounting of any closure’s negative downstream financial consequences. For example, if a service line is removed from a particular community, will that lead to a financially draining surge in ED volumes as the costs of care continue to outpace reimbursements? How are those drains then compounded by uncompensated care in the event that those same patients have lost their coverage?

Beyond morality, there is often a financial case for “doing the right thing” – which we expound upon more thoroughly in this issue’s next feature, “The Wisdom Imperative”.

The Telehealth Mirage

Workforce optimization represents another possible avenue for improving financial stability. No doubt many providers hope to achieve precisely that through a broader implementation of easily scalable, less staff-intensive telehealth services. However, it’s important to note that this has also been impacted by current legislation.

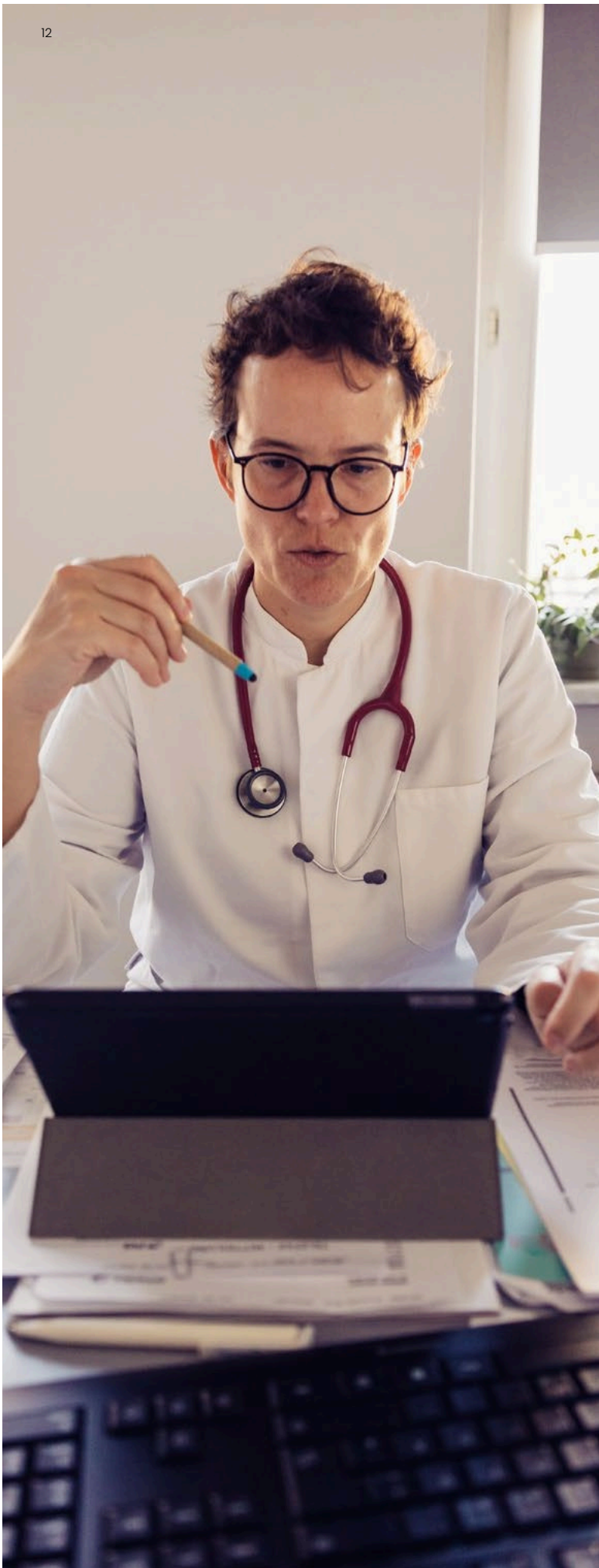
Beginning January 31, 2026, [multiple practitioner types will lose Medicare telehealth funding.](#)



entirely: physical therapists, occupational therapists, speech-language pathologists, and audiologists will no longer be able to furnish remote services for Medicare beneficiaries. These practitioners only recently gained telehealth billing capability as a result of pandemic-related expansions, and their loss will directly hamper rural service capacity. Additionally, beneficiaries will now need to be in a rural medical facility at the time of treatment in order for most telehealth services to be reimbursed, sans behavioral health.

“ Denying economic realities out of a sense of duty could lead to broader organizational instability, threatening even more disruptive closures.





The post-shutdown budget extended Medicare telehealth flexibilities retroactively, at least providing surety that any services rendered through January 30, 2026, would be covered. That includes services delivered from October 1st, 2025, through to the end of the government shutdown, which is when coverage temporarily reverted to previous restrictions. These extensions provided meaningful operational stability at the close of 2025, though they can hardly be considered a victory as telehealth's financial prospects worsen in the communities that need it most.

Telehealth will continue to remain a valuable tool – not just for private healthcare beneficiaries but as a means of expanding timely access to physician and specialist consultations during in-facility visits – but the trajectory is clear. Its status in the eyes of the current administration is that of a supporting function: useful for maintaining operational efficiency and reducing per-unit staffing costs, but less so as a revenue-generating mechanism to offset OBBB's other financial pressures.

Getting Your Bearings

The path forward can only be described as turbulent. From deep Medicaid and SNAP reductions to new bureaucratic burdens and narrowed telehealth reimbursement, OBBB is poised to dramatically alter healthcare in ways that are systemic, uncertain, and deeply interconnected with other socioeconomic factors. This perfect storm ultimately demands two things from healthcare executives: ruthless pursuit of the variables that can be controlled, and humbled acceptance of the variables that cannot.

Thankfully, the list of controllables is rife with opportunity.

Start by seeing this as a call to accelerate revenue cycle modernization. Simplify the front-end, invest in automated and AI-backed tools, refine claims scrubbing and denials prevention methods, and centralize functions when scale can drive financial reliability. Treat the risk of increased administrative burdens as an opportunity to redesign patient access, revitalize self-pay financing, and explore AI-assisted patient outreach. Simultaneously, get surgical about service lines. Proactively determine your partnership, restructuring, and consolidation options before a closure becomes inevitable – and when it does, have patient transfer strategies ready to minimize clinical harm and downstream uncompensated care.

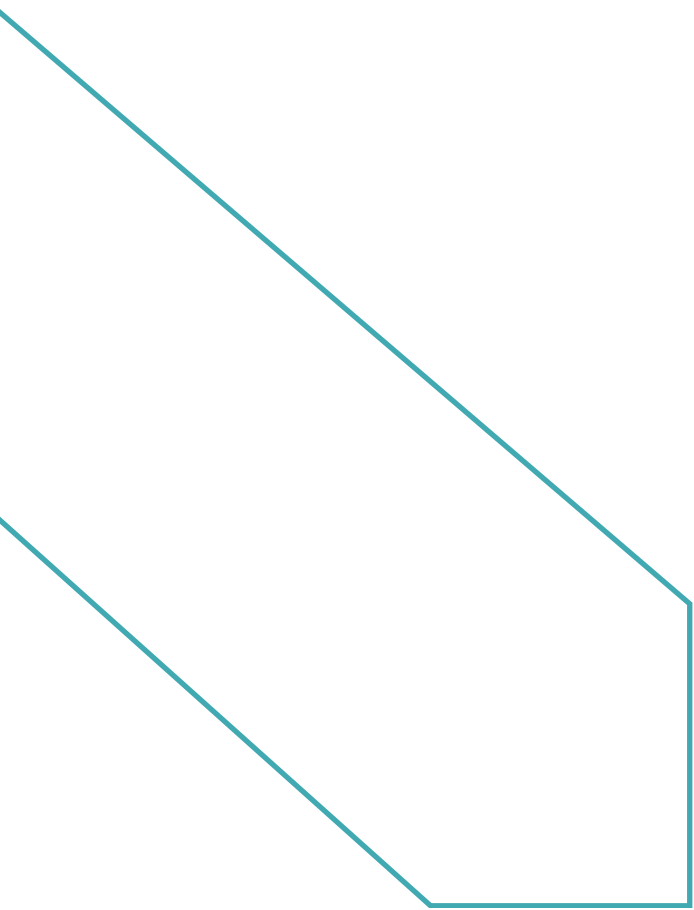
Beyond the financial and operational moves you make, your most powerful lever is how you invest your time. No organization can navigate these pressures alone, and even the most well-resourced and insulated systems have strong incentives to blunt their exposure. Deepening your connections will matter more than ever: with state hospital associations shaping implementation, with payers recalibrating contracts, with CMS setting the rules of engagement, and above all with the patients and communities who rely on you.

A decade from now, the policy details will fade. What will endure is how effectively you safeguarded stability, trust, and care when it mattered most.



THE WISDOM IMPERATIVE:

Fixing the System



Administrative bloat, payer fragmentation, and volume-based incentives all dissuaded patient-centric community care – and paradoxically, made moral courage a better financial strategy than ever before.



In any serious industry conversation about healthcare, there inevitably comes a point where someone says what everyone is already thinking but is too polite to say: the system is broken, and we collectively broke it.

“There’s a lot of chaos in our world,” expressed Vanessa Guzman to her co-panelists before our cameras even began rolling. “Those of us working in healthcare are responsible for finding a way to translate that chaos and dysfunction into good care for patients.”

Guzman and her peers were gathered to discuss the overwhelming predicament this chaos creates for healthcare providers and the communities they serve. It was a topic they hoped to tackle collectively – an approach that reflects the multifaceted, interconnected webs of cause and effect that underly all healthcare challenges. After all, bridging the gaps between underfunding, tense payer relations, and an uncertain regulatory climate would take more than just operational acumen, reorganization, or a new software suite.

For Guzman and her peers, it would take a moral and professional reassessment of how the industry views its purpose, deliverables, and the roles of healthcare leaders therein. Or, as the panel would come to summarize it, the “wisdom” to peel back the layers of dysfunction and re-anchor decision-making in one’s personal values and lived experiences.

At first blush, the sentiment may seem more suited to a feel-good LinkedIn post than an executive’s business plan. After all, any CFO can tell you that virtues don’t pay the bills, nor do they keep the leviathan that is the US healthcare system afloat.

Or do they?

The \$5 Trillion Paradox: Why the U.S. Pays More for Worse

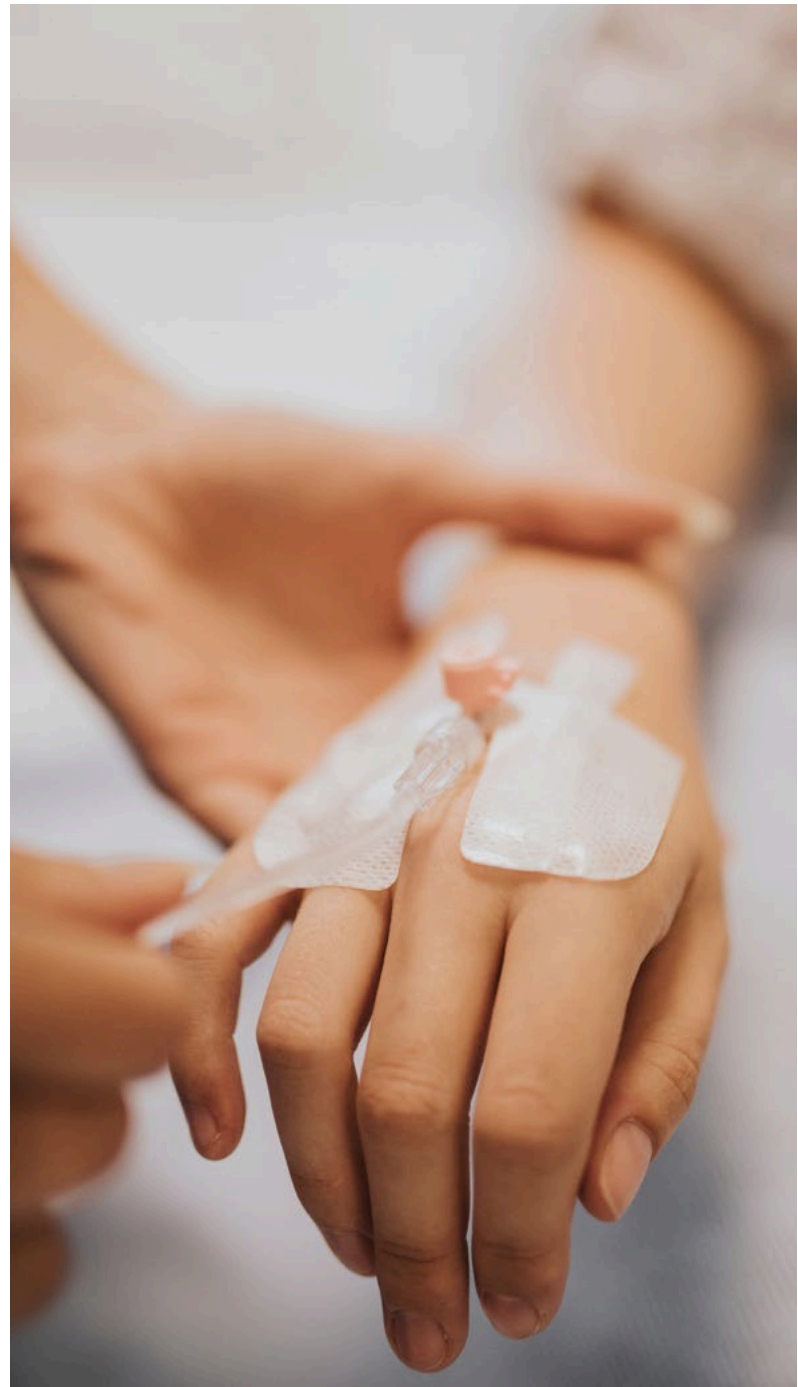
Like any good question, finding its answer requires an unbiased assessment of what led to its asking.

“The business of medicine is a \$5 trillion spend for the country,” explained panelist Dr. Lou Hart. “It’s approaching 20% of GDP while disparities in care continue to rise.” Dr. Hart, a pediatrician who has trained and worked in myriad locales from Nashville to California, brought exceptional





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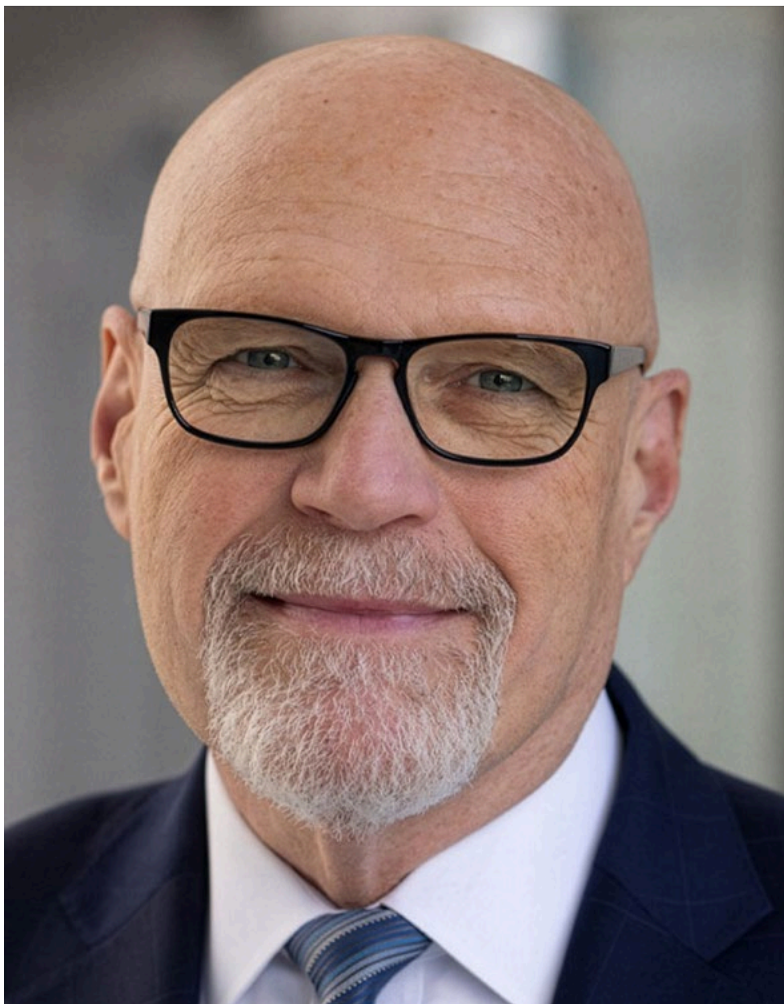
clarity to the conversation by contextualizing the landscape of modern medicine. That one-fifth of national economic output is nearly [1.5 times what peer nations spend per capita despite the US's demonstrably worse outcomes](#) – \$14,885 spent per individual only to be ranked 14th in core measures like life expectancy, infant mortality, childbirth safety, and diabetes management.

“We have to be relentless on driving costs down,” chimed panelist Kerry Gillespie, introducing a note of hard pragmatism. “More specifically, administrative costs.” While these are only one factor of the country’s worsening healthcare cost crisis, the numbers behind it are absolutely staggering. [Admin costs account for more than 40%](#) of a provider’s total expenses while delivering care to patients, driven in large part by the quintessentially administrative phenomena that are claim denials. McKinsey

estimates that health systems are conservatively spending upwards of [\\$40 billion on billing and collection costs](#), with a sizeable portion of that used to combat the excessive proliferation of denied claims. An AHA report found that between 2022 and 2023 alone, [denial rates increased by an average of 20.2% for commercial claims and 55.7% for Medicare Advantage claims](#) – just one part in an [ongoing upward trend that has plagued us into 2025](#).

Panelist Stephen Rosenthal, who has spent his career working on the healthcare challenges of diverse communities in need, traced a sizable amount of bloat back to an unassuming source: the proliferation of insurance companies, each with its own rules, incentive structures, and bureaucratic apparatuses. “We got distracted

from our patient-centric focus over time because now we’re juggling multiple insurance companies, who are in some cases





managing the same book of business,” Rosenthal explained. “They pay you slightly differently, with different incentives and different models, even though [in the case of government payers] they work within the same basic government ruleset.”

When Bureaucracy Breeds Injustice

As systems were buried deeper by administrative noise, the business model of care shifted in favor of consolidation. The north star of care delivery was no longer holistic patient support, early interventions, or community uplifting – systems were incentivized to cull patient engagements down to as few highly-profitable services as possible. This administrative friction has reached the point of diminishing returns, turning the industry’s long-standing incentive structure on its head. Dr. Hart articulated the perverse incentive clearly:

“To give an example, the prior business model in Connecticut didn’t have Managed Medicaid, and they only paid under fee for service. As such, there was very little incentive to keep people out of the hospital. Why would I pay to help manage your diabetes in a more regular, outpatient setting when I can only get maybe \$60 for each visit? In fact, I wind up with a financial incentive for you to have a diabetic coma or a stroke so I can bill it in neurosurgery.”

Obviously, no healthcare leader would ever consciously make such a senselessly cruel decision. But when an entire industry is built with costly administrative emphasis on payer requests, providers feel they need to optimize for what’s profitable. Volume takes center stage as the country continues to struggle with broad implementations of viable value-based models, and the invisible hand of the market exerts its pressure to cut as much “wasted effort” as

possible, no matter the impact on patients. To put it bluntly, the crisis isn't about any one healthcare leader's decision at all – it's systemic, baked into fabric of healthcare strategy and operations at every turn.

"If the system is built to only measure what's billable, how do you think we'll align our financial predictions," asked Dr. Hart. "We provided amazing acute and emergency care to patients with government insurance, but we felt unable to provide a lot of the preventive care because there was no profit incentive. [...] It's not until we start to measure trust, fairness, and dignity alongside clinical efficiency that we start to build systems that are both high-performing and human-centered."

The Realities of Choice: Why Volume Demands Compassion

For all of healthcare's complexities, the reasons why providers make the choices they do seem straightforward. After all, industry thought leaders and headlines have sounded the alarm about our country's healthcare incentive structure for decades. Panelists, however, were quick to assert that what followed from these conditions was anything but typical. One would expect traditional, for-profit strategies to excel amidst volume-based incentives, but in actuality, the opposite was happening.

"It's ironic," recounted Dr. Hart. "I've been in rooms with financial leaders lamenting that the costs of care aren't keeping up with reimbursements. We're going to have to make the necessary community investments to keep people out of the hospital and away from our emergency departments. We're approaching a correlation of one between social needs and healthcare outcomes."



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Amid soaring employment costs and stagnant reimbursements unable to keep pace with inflation, the unintuitive truth was that volume-based models incentivized community-centered care – not intentionally, but as a consequence of their astronomical failings. It had become an objectively better financial decision to begin treating patients’ problems at the source. In turn, this loosened the grip of the market’s invisible hand, its pressures an illusion based on faulty assumptions, outdated conventional wisdom, and an unfounded fear of potential losses disconnected from today’s material realities.

For our panelists, this became a pivotal first principle from which they could deduce arguably the largest barrier to achieving more profitable, more sustainable provider-patient symbiosis. The inertia dissuading patient-first community healthcare wasn’t financial or clinical. In fact, both those considerations would be improved by a step toward more holistic models. Our reluctance seemed rooted in our perceptions. In our culture even. Moving forward therefore necessitated conscious defiance, as well as faith in both the promise of success and in patients themselves.

Progress required the courage to choose a different path.

“There aren’t any solutions,” expressed Rosenthal. “There are really only choices. I’ve always believed that if you focused on the quality and management of care [...] and you just cared for patients in the best ways possible, and made the appropriate community connections, you actually reduce the cost of care significantly. We were able to demonstrate that you can actually do well if you do good.”

This is no longer aspirational. As Kerry Gillespie

would attest, the CFO's core duty is now to model the financial disaster of inaction, proving that investments in social needs as small as \$500 can prevent up to \$20,000 in readmission costs.

Anchoring Leadership: Reconnecting Finance to Lived Experience

Panelists recognized that choosing to go against the grain of an entire industry is hard. It's easier to simply default to "best practices" and take the safe path that, on the surface, aligns with what the incentive structure demands. Panelists spiritedly insisted, however, that the road less traveled was not just the best option for patients, providers, and pocketbooks alike. It was actually easier to head down once you reminded yourself that proximity matters.

"You get so far away from patients as your hard work and dedication allows you to amass financial resources and privilege," summarized Dr. Hart. "It's easy for executives with humble upbringings to forget where they came from, and easy to focus on what's easy to measure. Ultimately, our moral responsibility as healthcare leaders is to make sure that we measure what reflects our values of liberty, fairness, and justice."

Panelist Jasmine McClain, whose work with the Health Management Academy involves advising leading health systems across the country, offered a slightly different perspective. "I see the world through the lens of a scientist," she explained. "I think when you are engaging with folks of different backgrounds and from different parts of the country, it's important to stay curious about the perspectives other individuals have."





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McClain's approach to navigating the rich tapestry of patient needs and perspectives was hard-won through a lifetime of character defining experiences. She recounted watching a family member in their twenties succumb to cancer, along with all the devastation that entailed for their family. The victim was a young, black woman living in the South – a confluence of social determinants that drove McClain to confront the nation's inadequate investments in health literacy and social safety nets. She also reflected on her experiences as a mother, and how all the time she'd spent researching maternal health did little to alleviate her burdens when experiencing post-partum hypertension herself.

"I didn't want to go to the ER," she explained. Even having the knowledge, resources, and network to navigate the crisis, she nonetheless found herself reluctant to seek emergency care amid life's many competing priorities. "It was ultimately a physician that sat me down and said, 'I need you to understand how high the stakes are when it comes to something like this.' [...] The stakes are literally life or death for many folks in our country."

The purpose of sharing these sobering anecdotes wasn't self-pity. They were instead a direct, humanizing reminder that proximity and lived experience create the kind of wisdom that cannot be imported from consultants or best-practice seminars. Even more critically, it was a plea for executives to keep a tight grip on their connections to humanity lest they lose themselves to the minutia of healthcare delivery.

"As the world becomes more and more complex, which it will with the introduction of AI and a whole host of other political barriers," quipped Rosenthal, "we can't lose empathy and kindness for the folks we care for. They're scared to death, and we need to hold their hand and help them over that hump."

Sustaining Wisdom & Courage: The Institutional Architecture of Empathy

Gillespie found a refreshing, elegantly direct way to synthesize the panel's wisdom with yesterday's adages. "Let's make sure to treat people like we want to be treated," he stressed. "Like we'd want our family members to be treated."

Ever the pragmatists, our panelists proceeded to stress that empathy and wisdom can't be sustained on good intentions alone. They require institutional architecture, such as patient and family advisory councils, a reimagining of patient data collection and analysis, community partnerships, and a host

of other strategies that can be found in the conversation's [full recording](#).

More importantly, making empathy sustainable would take a willingness from leaders to model the behaviors they'd ask of their organizations. It would require leaders to question whether current arrangements actually serve the people they swore oaths to, as well as the courage to act on the answer even when that means disrupting the status quo.

A cheeky closing from Guzman cut to the heart of it: "Make ethical decisions your priority, even if that means going against the status quo. Give yourself permission to break some rules."



**Watch the full interview
with the panel on
YouTube:**



VANESSA GUZMAN

CEO at SmartRise Health, Vanessa Guzman is an executive leader and strategist specializing in translating complex healthcare policy and operational dysfunction into patient-centered, measurable solutions. As the CEO of SmartRise Health, she advises organizations on building resilient, values-driven systems where moral responsibility directly informs financial and clinical strategy.

DR. LOU HART

CEO, Hart4Health and Attending Physician – Pediatric Hospital Medicine, Yale New Haven Health Dr. Hart offers a crucial dual perspective on the healthcare crisis. As a practicing pediatric hospitalist and a CEO, he connects the clinical urgency felt at the bedside with the high-level, systemic change required at the executive level. His work focuses on demonstrating how investments in social determinants of health are now financially necessary for organizational survival.



KERRY GILLESPIE

Executive Consultant, Warbird Consulting Kerry Gillespie is a seasoned financial leader in healthcare, most recently serving as CFO for Legacy Health in Portland, OR. He provides essential strategic expertise in modeling the financial impact of health equity initiatives. Her insights are vital for translating human value metrics into compelling Return on Investment (ROI) frameworks that secure C-suite support.



STEPHEN ROSENTHAL

SVP Population Health, Montefiore Health System Stephen Rosenthal is a system leader operating at the intersection of clinical care, social needs, and complex urban policy. He leads population health strategies focused on diverse communities in need, translating data-driven theory into real-world operational defense against policy threats (like Medicaid churn) and measurable patient outcomes.

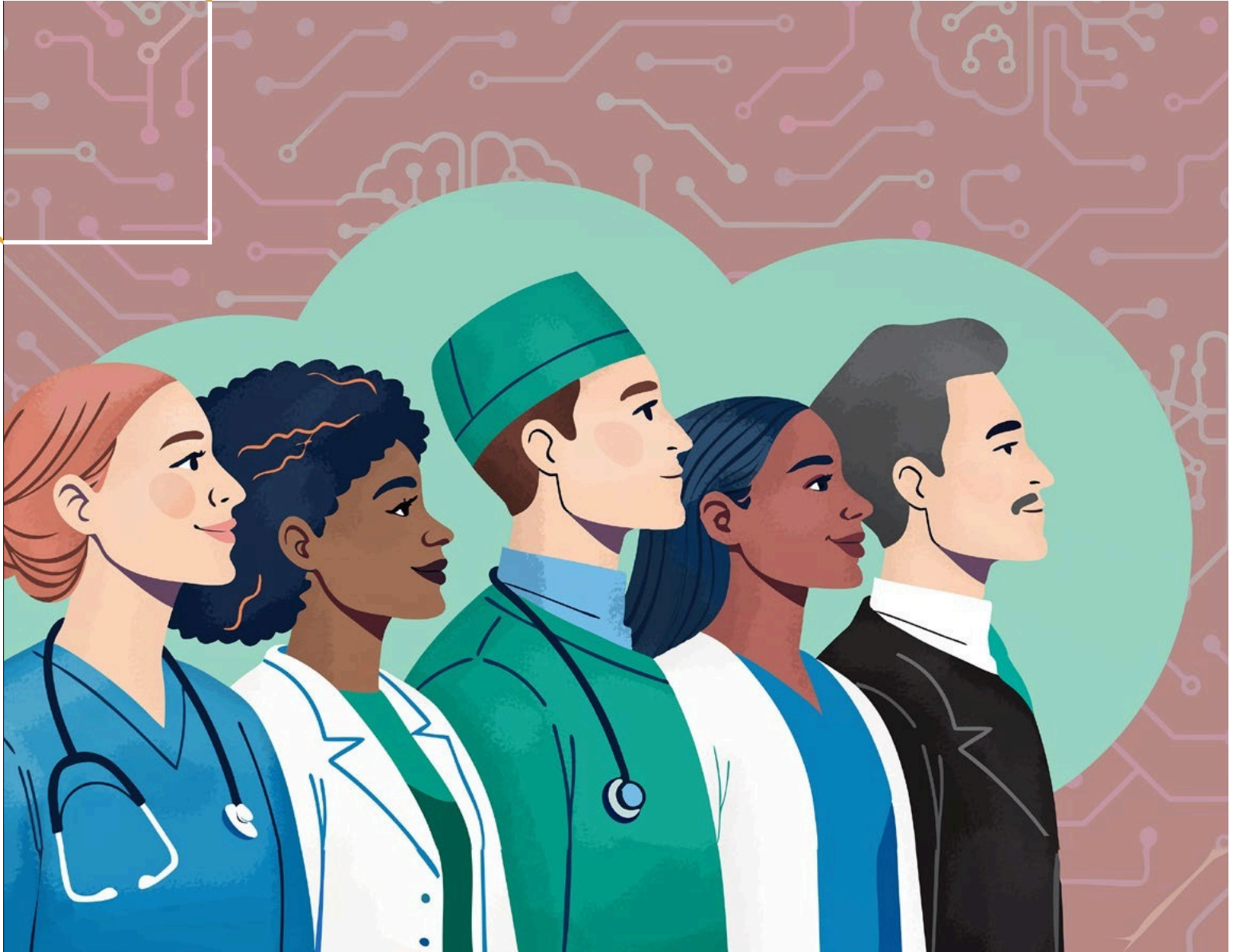


JASMAINE McCLAIN

Executive Director, Health Impact Alliance, The Health Management Academy Jasmaine McClain brings the strategic intelligence of a national coalition to bear on local equity challenges. Her work involves advising leading health systems across the country, providing a high-level view of how organizations are strategically aligning resources and building multi-sector alliances to address the systemic causes of healthcare disparities.



Connex Community Insights



No one knows Healthcare strategy better than seasoned industry professionals. Here's what your peers said recently about AI, revenue cycle community health initiatives, and much more.

Healthcare leaders must keep a direct line to pragmatic, peer-tested practices, especially as AI proliferation, reimbursement shifts, political uncertainties, and combative payer tactics continue to mount pressure from all sides. However, finding that information can be difficult – not because of its scarcity, but rather, because of its copy-paste overabundance in today’s click-driven media landscape. The most direct guidance comes from candid conversations with peers who’ve actually rebuilt workflows, defended revenue, and redesigned access in the real world.

Connex surfaces those conversations through curated panels, targeted deep dives, and roundtable discussions with industry thought leaders, before distilling them into their most action-ready essentials. What follows is a concise snapshot of recent community insights designed to help you succeed in today’s challenging healthcare landscape. We look forward to hearing how you’ve applied, iterated on, or supplanted some of these practices whenever you’re able to join us again!

AI & Automation

Before scaling AI projects, ensure that you pilot and implement rigorous data validation procedures. That way, automation raises accuracy, cost-efficiency, and performance – not your risk profile.

- **Validate every AI output** as if it were a hypothesis, ideally before it touches billing, clinical decisions, or patient-facing systems, to avoid “telephone” misinformation drift
- **Systematize feedback loops** into your AI-driven models, as this will aid in the tool’s ability to learn over time, make corrections, and adapt to your organization’s specific needs and preferences



- **Target high-volume, low-risk tasks first**
 - like insurance verification, document indexing/OCR, and communications routing
 - with a focus on creating exception-based workflows and reviews
- **Be sure to implement fail-safes/oversight when using generative AI** for clinical summaries, encounter documentation, or denial appeal letter writing
- **Consider AI tools that maximize scheduling efficiency**, whereby cancelled appointment slots are preemptively offered to waiting patients – this can dramatically cut leakage and lift utilization

Revenue Cycle & Denials

Revenue cycle may encompass more than just denials, but given how aggressive payers have become, the entire process from end-to-end must prioritize prevention.

- **Reinvest in scheduling, registration, and patient access training**, as coverage information, demographics, financial information, and authorizations must be captured accurately
- **Consider deploying insurance and demographic scrubbing upstream** (pre-visit) to help decrease the frequency of inaccuracies and a timelier handoff to rev cycle teams downstream
- **Create capacity to challenge payer downgrades** and resurrect revenue – they may not be full denials, but they are becoming more common thanks to payers' liberal use of AI-driven workflows
- **Meticulously measure task value and**

map rev cycle workflows before you start automating, so you can more strategically target tasks with the highest bottom-line impact

- **Explore a dedicated denials mitigation program** whereby operational owners in the hardest-hit specialties are run through targeted performance improvement sprints
- **Automate templated appeal generation** with AI using encounter notes, paired with rigorous validation to prevent errors that would harm overturn rates





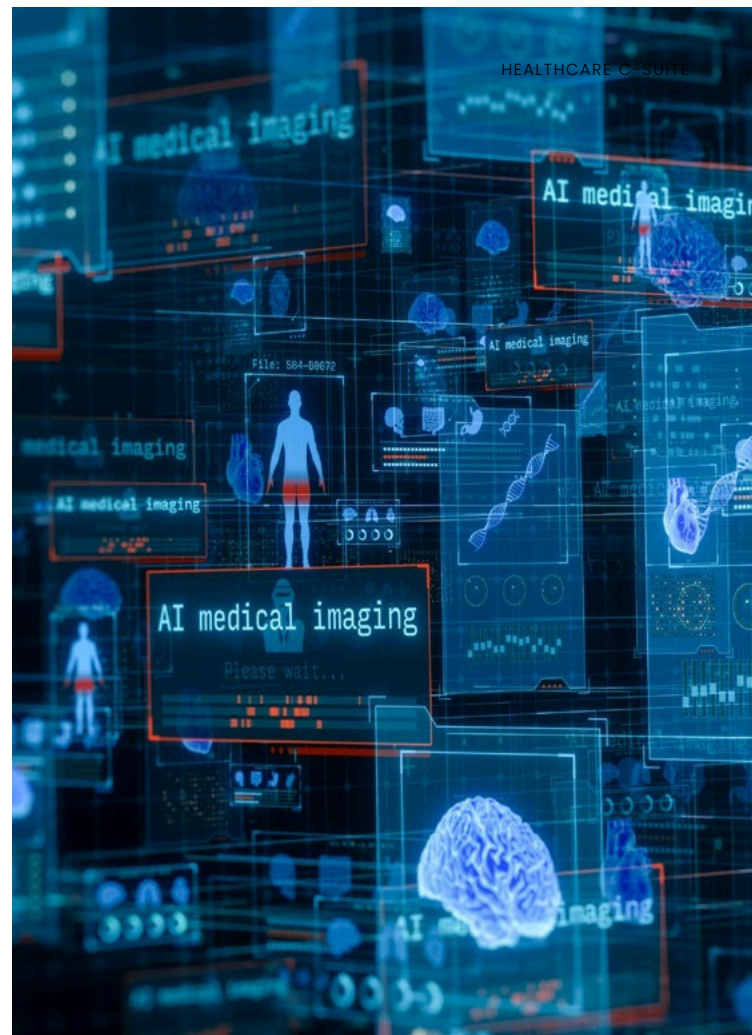
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On the first run, we correctly verified insurance on about 75% of the patients in that file. But the AI got smarter with each successive run – that’s the great thing about AI.





One of the biggest challenges we're tackling is making sure we're not the ones creating roadblocks to patient care and reimbursement simply because we don't have the correct information on file.



Service Line Growth & Market Capture

Let rigorous financial analysis, patient trend data, and provider supply gaps drive expansion decisions to ensure you invest in future demands and not yesterday's winners.

- **Cast a wide net when evaluating trends** by combining your own data, city, state, and national benchmarking, and insights from local community focus groups
- **Start building a strong nexus of providers** and support staff before you expand aggressively – having new locations won't help if you're struggling to recruit talent to/ within your markets
- **Embrace capitated volumes where feasible** given today's overarching economic uncertainty – the total earning potential may

be lower, but the predictability simplifies planning

- **Consider broadening schedule flexibility** to better meet patients' needs, such as by introducing more evening and weekend slots for testing and diagnostics
- **Leverage concurrent referral models via real-time telehealth consults** to help reduce leakage, increase speed of care, and maximize patient satisfaction

Community Health & SDoH

June 2025's CMS Final Ruling reemphasized impact as the metric by which health outcomes and equity are evaluated, leading healthcare leaders to reassess how they're approaching community health and social determinants of health (SDoH).



- **Consider focusing investments on hotspot zip codes** using a combination of community health workers (CHWs) and community partnerships to cut readmissions and reduce ED overreliance
- **Leverage your ED as a funnel** toward FQHCs and PCPs within your network by having intake staff inquire about ED utilization reasons and navigate patients to more appropriate care locations
- **Formalize monthly case reviews** with CHWs to better coordinate care for multi-visit, ED reliant, indigent, and medically complex patients
- **Partner with local cultural organizations** (faith groups, county health offices, etc.) to expand patient outreach, education, and chronic disease prevention programming



- **Explore emerging solution providers** that can more easily and seamlessly connect social workers and patients with support organizations that help close SDoH gaps

Workforce & Change Management

From labor shortages to agentic AI deployment, workforce planning, operations, and their related change management tasks will continue to be hot topics for the foreseeable future.

- **Build career ladders** and internal pipelines (e.g., bedside RN → NP → behavioral health NP) by offering scholarships and career development opportunities for high-demand roles
- **Strengthen change management** by positioning automation as an enabler, emphasizing how technology improves employees' workflows, accelerates throughput, and expands capacity
- **Offer greater schedule flexibility** to staff, especially to roles that are in high demand and prone to burnout, such as nurses and technicians
- **Pilot workflow automations in close partnership with frontline teams** and use their real-world feedback to better understand where and how technological augmentation is most valuable
- **Similarly use governance committees** to guide change, ensuring that procurement, IT, operations, and other key support teams can weigh in on vendors, process redesigns, and workforce impacts

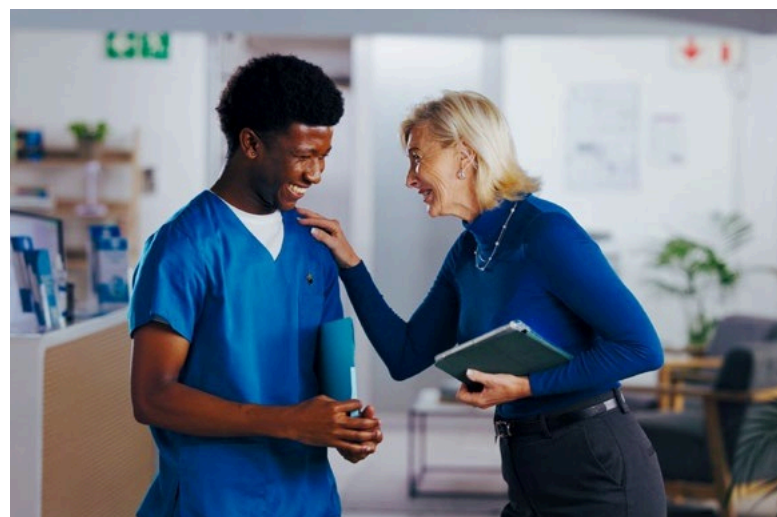
Governance, Vendor Evaluation & Procurement

Economic and political uncertainties are prompting strategic healthcare leaders to reassess their approach to governance and vendor evaluations, with a focus on maximizing their return on investment.

- **Demand full vendor diligence upfront**, focusing on customer support, leadership credentials, security posture, and performance benchmarks – all distilled into easily comparable scorecards
- **Embed continuous vendor performance reviews** into your monthly or quarterly processes, and consider broadly mandating corrective action plans for any underperformers



We're really embracing a managed care model, whereby we're delivering well-care and healthcare versus waiting for sick-care.



- **Revisit purchasing agreements** throughout decentralized practices and specialties to identify overspending, waste, duplicated agreements, and consolidation opportunities
- **Start small and pilot narrowly** with just one workflow or modality – it's much easier to iterate intelligently when you have a measured, consistent pattern of accuracy and ROI data to analyze
- **Democratize resource utilization and waste analysis** through technology, giving smaller teams and individual contributors better insight into their own usage habits and inefficiencies

“

Finance and operations might both look at the same vendor data and come back with different assessments – it's not about right or wrong, but how you incorporate both into a more nuanced evaluation.





CONNEXION ²⁰²⁶ LIVE

17-18 SEPTEMBER LAS VEGAS
WHERE LEADERS LEARN FROM LEADERS



Calling all healthcare leaders! You're invited to our exclusive in- person networking event: **Connexion 2026.**

Hailed as the premier executive meeting tailored for senior leaders in healthcare, Connexion is your chance to connect, collaborate, and solve challenges – together.


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September 17th and 18th, 2026.

What can you expect at Connexion?

- **Engaging roundtable discussions:** Dive deep into the most pressing issues facing the healthcare industry today.
- **Inspiring insights:** Learn from some of the industry's most visionary leaders, as they reveal key strategies they've already implemented for sustainable growth.
- **Collaborative workshops:** Tackle your most pivotal priorities and challenges head-on, uplifted with new-found peers.

We'd love it if you could join us!
Spaces for Connexion are always limited, so secure your spot by scanning the QR code to make sure you don't miss out.



I was truly surprised by the number of connections I made with individuals who are at the senior level of their industry or their area of expertise, where we are dealing and talking about similar things that we're all dealing with, which has been really, really exciting.

**Robert Grasty,
Former EVP & CHRO, Amtrak**





Don't just get ahead of the AI curve – spearhead it

AI is reshaping how the world is approaching healthcare – and leaders who understand it are undoubtedly in the best position to drive sustainable growth for their business.

In partnership with EverWorker, Connex presents a brand-new, practical certification program focused on leveraging AI to **maximize your organization's impact** (with no coding experience required).

This course gives healthcare leaders a concise, business-led foundation on modern AI, including how large language models (LLMs) work, and how to apply retrieval-augmented generation (RAG).

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Plus much more!

Scan the QR code to explore, and register for early access to upcoming features.



5 MINUTES WITH...

Karina Checo

Karina Checo reminds us that revenue cycle isn't just a back-office function – it's a vital component for enabling healthcare providers to deliver on their patient-first promises.

If hospitals had biographies, Bergen New Bridge Medical Center's would read like a study in contrasts. It is both the largest hospital and the largest licensed nursing home in New Jersey, as well as the 4th largest publicly owned hospital in the nation. At 1,070 beds, their combined Paramus campus houses their full-service hospital, a 300-bed behavioral health unit, and a 600-bed long-term care and skilled nursing unit.

Despite their institutional heft, they are driven by a very local, very meaningful mission. A safety-net system, they serve a complex, underserved population heavily dominated by Medicaid and the underinsured. As such, their reimbursements more closely resemble those of a community hospital one-fifth their size – a challenging reality for an institution that is undoubtedly a cornerstone of its locale.

Into that layered ecosystem stepped Karina Checo in March of 2021. It would be her responsibility to oversee critical aspects of their revenue cycle – such as patient access, central scheduling, and patient financial services – and help redefine the organization following nearly two decades of third-party management and a county-led leadership reset. Over the years, Checo has agilely flowed from strategist to operational fixer as needed, flattening silos,

rebuilding staff training, and enhancing the patient experience along the way.

Now, with an Epic implementation on the horizon, she speaks to us with pragmatic confidence about how revenue cycle leaders can capitalize on the chaos of change. For Checo, revenue cycle is not an abstract ledger but a reaffirmation of the promises her organization has made to its community:

Bergen New Bridge provides a broader array of services than your typical medical center campus. How do the unique realities of your organization shape its overall philosophy for financial sustainability?

Great question. We treat the medical center as a unified organization, since all our units are located on the same campus and we often share patients between them. While we do have some specialized teams, our typical strategy is to embed specialists with any necessary expertise into more general, shared teams. This ensures that any unique situations receive the appropriate amount of attention, while still creating economies of scale and allowing us to collect as quickly as possible.



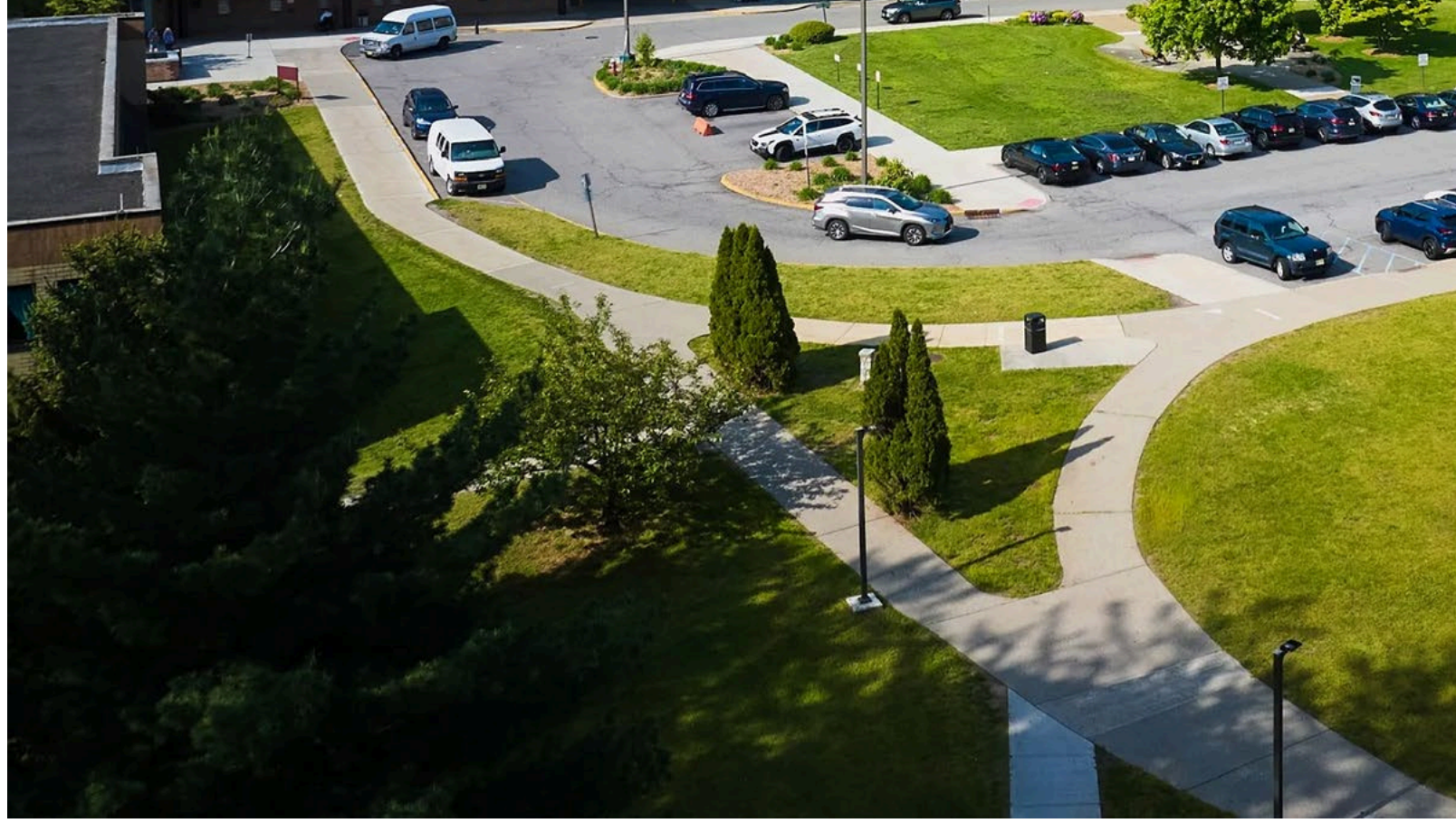


EMERGENCY

AMBULANCE
ENTRANCE

SAME DAY
SURGERY

BERGEN NEW BRIDGE MEDICAL CENTER



Patient engagement is also key to any safety net's success – what strategies have you used to improve patient access and the front-end of your revenue cycle?

I agree that engagement and access are both critical. One of the first things I did with our patient access team was completely redo their training process. We really wanted to emphasize “people”, and that includes developing our own and ensuring that our mission and values are at the core of every patient interaction. You could say that our work to reinvent patient access was driven by a desire to be more patient-centric.

Things like allowing patient email communications, creating a better callback structure to make staff more accessible, and – especially since we have such a large Spanish-speaking population – making interpreter services available at every step of the patient journey. We started with a hotline patients could call to receive help from an interpreter; now we're using video calls on iPads so patients can see who's helping them, which builds a lot of trust. There are still so many opportunities to grow when you think about how large our campus is, and how many things can be done electronically.

Speaking of navigation, revenue cycle teams across the country have weathered many disruptions in recent years. Which were most significant for your team, and how did you overcome them?

One of the most striking was the Change Healthcare outage that affected us nationwide in 2024. It pushed us to pivot and redesign whole processes. During that shift, we discovered new leaders within our team – individuals who really stepped up and took on aspects of our recovery



project to ensure everything was seamless. I think that speaks to the broader strengths of our day-to-day leaders, such as those who made sure we achieved as close to our normal billing workflows as possible, or those overseeing eligibility. Their contributions were critical to our success, including their ability to engage with patients, explain the outage's effects, and spell out what that meant for everyone involved.

I'm very blessed to have an understanding C-suite and Board. They all understood that we needed to pivot quickly and did their part to assist us in implementing the necessary changes to achieve long-term success. Honestly, their attention to longevity was critical. We knew we needed to do something ASAP, and were offered plenty of quick fixes, but ultimately decided on a more prudent, sustainable, and profitable course.

You didn't let the crisis go to waste.

Exactly. So many natural leaders came out during the process, and it really highlighted how great our talent is. It was just awesome to see everyone coming together in pursuit of this one goal.

As you look ahead, what innovations and improvements are next for your roster of revenue cycle superstars?

First and foremost, finalizing and optimizing our Epic go-live. I definitely think it will be a huge improvement for revenue cycle and finance – especially over our previous, fractured infrastructure, where having multiple systems routinely created workflow gaps and leakages. I think our revenue cycle metrics will see a drastic improvement just by virtue of having everything on one system.



In the same vein, it's going to improve patient engagement. One aspect I value most is that patients will be able to truly access everything they need from a streamlined, central location. We're looking forward to giving patients greater autonomy around how they check in, access their records, verify their billing information, and navigate their care.

This all dovetails with our overarching strategy for greater standardization. Which I personally love – I'm a big proponent of doing away with unnecessary silos and enabling leaders and teams to be more agile. As I tell my staff, efficient healthcare administration isn't a marathon. It's a relay race, where you do your job as well as you can with the rest of the team in mind, and then you pass the baton. I believe there's always a positive impact if everyone is working collectively towards process improvements.



We started with a hotline patients could call to receive help from an interpreter; now we're using video calls on iPads so patients can see who's helping them, which builds a lot of trust.





We owe it to [patients] to fight for everything they deserve.

On an interpersonal level, I feel professional development for staff is extremely important. One thing I've discussed a lot [at Connex events] is how it's not really about the competencies that a person has right now – it's about finding someone who is a good fit for the organization and team and investing in them. It's about helping them find ways to adapt their skills to meet new and emerging organizational needs, mentoring them, and giving them the tools to grow consistently. Because then the whole team wins. On my team, we are constantly trying to elevate our standard of quality so that we can then elevate the quality of work we do for our patients.

Speaking of, being an effective healthcare leader means always striving to be patient-centric. That's something we value highly at my organization, even if you're in a back-office function like revenue cycle. How will what you're doing make things more convenient for the patient? How do the changes you make impact their touchpoints?

It may not be a technical component of revenue cycle, but it's probably the most important because everything leads back to patients. Our goal is always to advocate for the patient, even if we're doing it in a different way than our care teams. We're advocating for them when we engage insurance companies, ensuring they get the most out of their coverage based on the services they receive.

Likewise, I find that model of coordination humbling. We don't all need to be experts on every single part of the process – we just need to know what we do, how to do it well, and how to set up those downstream for success. That's our contribution to the bigger picture and to creating a more financially stable organization with minimal leakage.

Drawing from your experience, what lessons do you believe are most important for your industry peers to take to heart?

On the technical front, I find tremendous value in variance reports and would recommend that peers check them often. That will help you understand exactly where and why your processes aren't working and give you the guidance you need to make them better.



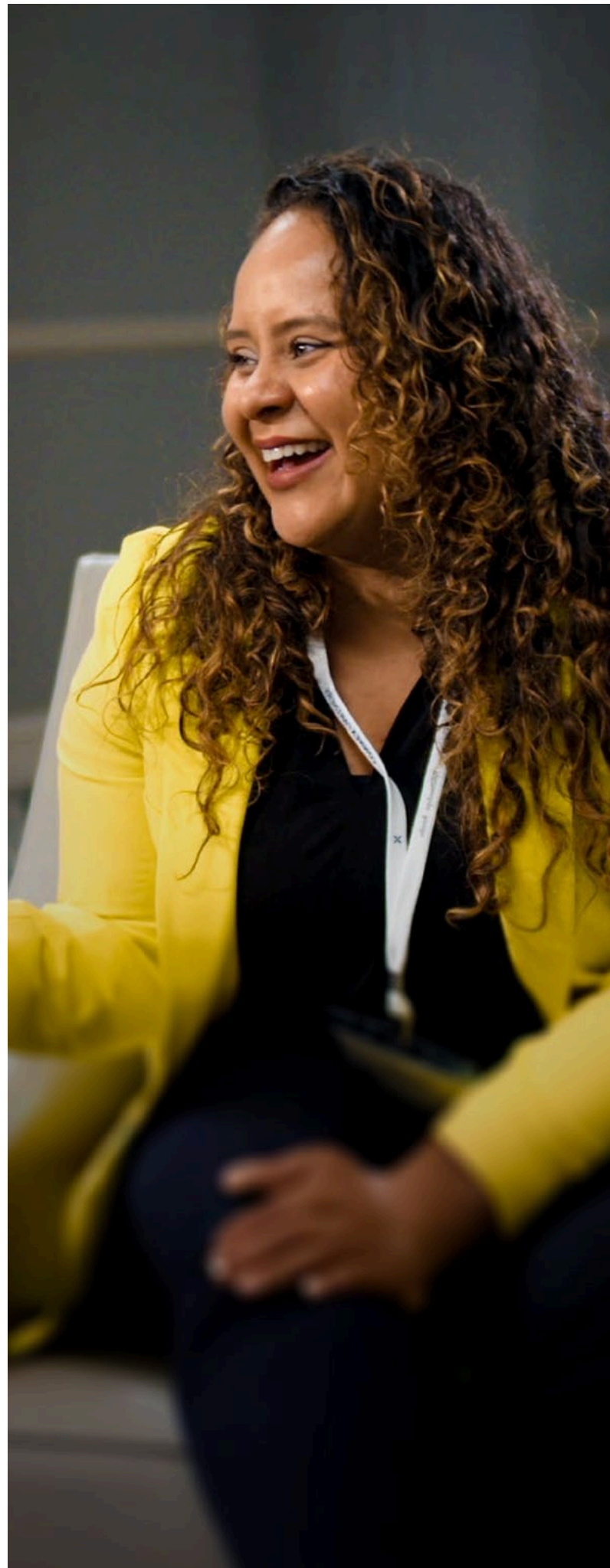
I'm always reminding my team that we owe that due diligence to patients. We understand this complicated aspect of their healthcare journey better than anyone, and we owe it to them to fight for everything they deserve. Especially since, as a safety net, we're serving those who are otherwise underserved. If there's something owed to our patients, then it's our responsibility to fight for them and ensure insurance companies uphold their end of the bargain.



KARINA CHECO

Karina Checo is a seasoned revenue cycle expert with a proven history of driving measurable financial improvement across healthcare organizations nationwide. She has demonstrated consistent success in increasing cash collections, reducing claim denials, and optimizing end-to-end revenue cycle workflows. Karina excels at leveraging technology to streamline operations, enhance productivity, and improve the accuracy and efficiency of billing and reimbursement functions. She is widely recognized for her ability to recruit, develop, and lead high-performing teams capable of managing complex, multi-million-dollar revenue cycle operations in fast-paced healthcare environments.

Karina brings extensive experience in developing comprehensive standard operating procedures and establishing best-practice guidelines across multiple EMRs and healthcare billing platforms. She is skilled in designing and implementing KPI dashboards and performance-tracking tools that strengthen operational transparency, increase efficiency, and support strategic decision-making. Her expertise also extends to vendor relationship management, ensuring strong operational alignment and accountability. Additionally, Karina excels in overseeing the full employee lifecycle—from recruitment and onboarding to retention, training, and performance management—fostering strong team engagement and long-term organizational success.



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