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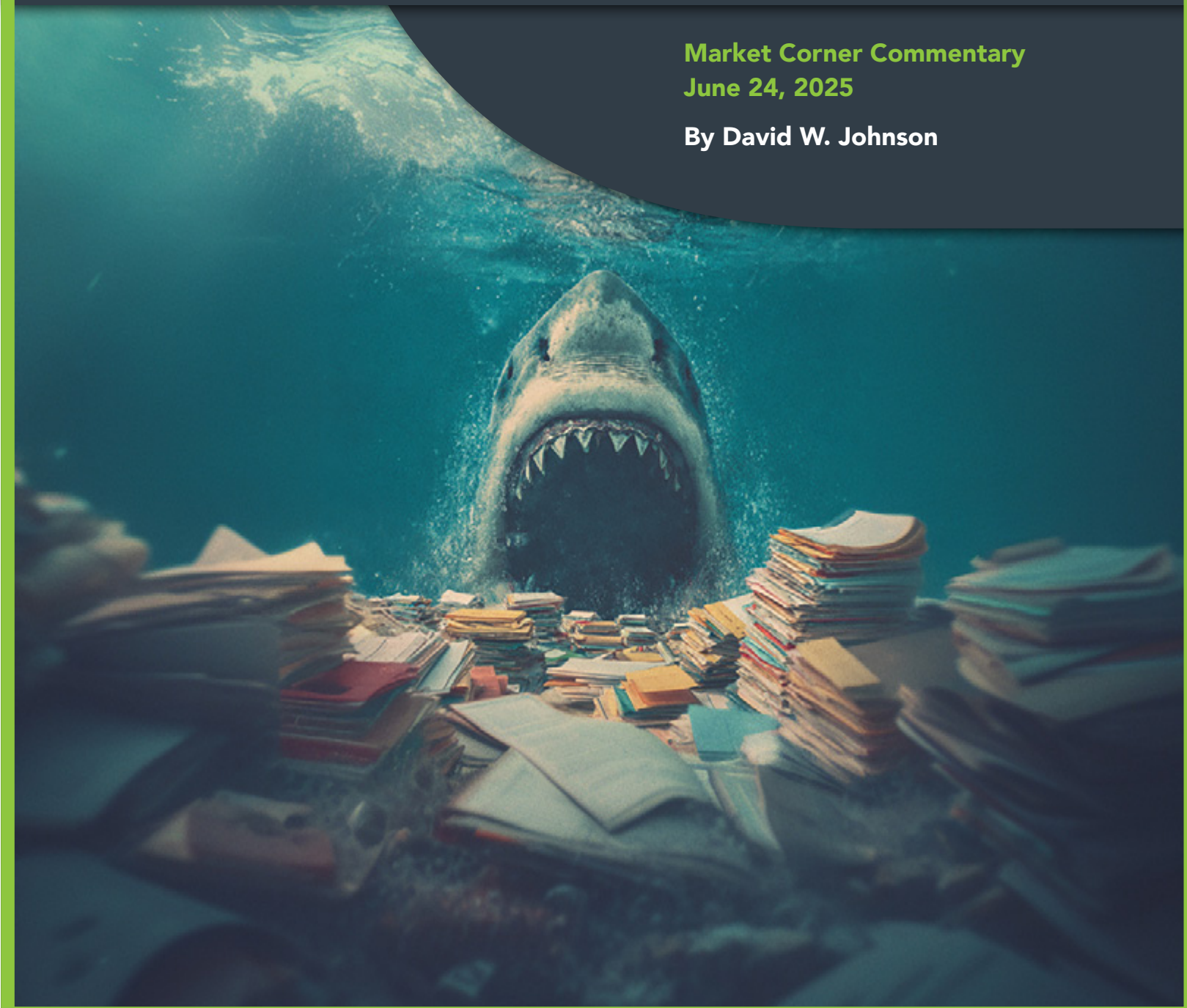
Consumerism, Revenue Cycle and U.S. Healthcare

Market Corner Commentary
June 24, 2025

By David W. Johnson



This is a 3-part series diagnosing revenue cycle dysfunction.

Part 1 *hfm magazine first published this January 2025.*

CONSUMERISM INTRODUCES ITSELF TO U.S. HEALTHCARE

Unlike other consumer people-oriented businesses, healthcare essentially operates independently of its end-users (also called patients, consumers and/or customers). Individuals engage providers to diagnose and treat their ailments, while third parties largely pay for any services rendered.

This convoluted relationship among providers, patients and payers creates two fundamental anomalies within healthcare business models that distort the industry's supply-demand dynamics: artificial economics and atrophied buy-sell signaling.

The healthcare marketplace is reorganizing itself to normalize its economics and truly empower consumers. A select few health systems are positioning themselves to ride these powerful rising waves of consumerism and value to maintain market relevance. They are the future.

THE EVILS OF SUPPLY-DRIVEN DEMAND

Throughout its long history, as documented in *The Social Transformation of American Medicine* by Princeton Professor Paul Starr, the American Medical Association (AMA) has championed fee-for-service medicine and the absolute right of patients to choose their physicians. From the AMA's perspective, these are inviolable features of U.S. healthcare delivery. To win the AMA's support for Medicare and Medicaid, President Lyndon Johnson incorporated these features into the 1965 legislation that launched these programs. [1]

The emergence of commercial health insurance and employer-sponsored healthcare benefits in the early-to-mid 1900s shifted payment responsibility away from patients to third parties. Combining patient choice, fee-for-service billing and independent third-party payment is unique to U.S. healthcare. The combination creates an artificial economic model riddled with perverse incentives in which industry incumbents thrive and the American people suffer.

Writing in the 1960s, economist Milton Roemer made astute and influential observations regarding the incentives imbedded within a reimbursement-based payment system. The Dartmouth Atlas Project and some others refer to this quote as Roemer's Law: "Supply may induce its own demand where a third-party practically guarantees reimbursement of usage." [2]

In normal markets, intrinsic demand for products and services at given prices drives supply. As Roemer's Law suggests, healthcare reverses the equation. The supply of healthcare facilities and practitioners propels demand for diagnostic and treatment procedures. More cardiologists generate more cardiac procedures.

In the process, third-party, fee-for-service (FFS) payment along with administrative services only (ASO) contracting by commercial health insurers subvert value-driven service delivery in the following ways.

- Compensating ***reimbursable care*** whether it's appropriate or not
- Discouraging ***appropriate care*** when it's not reimbursable
- Complicating treatment approvals
- Increasing administrative costs
- Distorting the buy-sell relationship between providers and consumers/patients

Terry Shaw of AdventHealth has been repositioning the health system to embrace consumerism and whole-person health.

The result is an absurdly high-cost system with fragmented delivery, coverage gaps and underinvestment in preventive care. In essence, U.S. healthcare excels at saving Americans when they are drowning but fails to teach us how to swim.

Let's focus on the last bullet mentioned above. Clear prices have the power of language. They enhance seller-buyer signaling to create more and better transactions. Without clear pricing, it's impossible for consumers to assess value. Subsidized insurance and opaque service pricing negate consumers' power to send value signals to providers through their purchasing decisions. Consequently, providers cannot discern consumers' preferences and respond accordingly.

Decades of supply-driven demand have led to massive over-investment in healthcare facilities. In a recent conversation, Terry Shaw, retiring president and CEO of Florida-headquartered AdventHealth, offered this wry comment about the current state of U.S. healthcare: "Healthcare has always been a cottage industry. The problem today is that the cottages have become hotels." [3]

Unlike hotels, however, health systems aren't very hospitable to their end-users.

CUSTOMERS VERSUS CONSUMERS

Before publishing my second book in October 2019, I debated whether the title should be "The Customer" or "The Consumer Revolution in Healthcare," with the subtitle "Delivering Kinder, Smarter, Affordable Care for All." In people-centric businesses, customers and consumers are one in the same. That's not the case in U.S. healthcare.

Governments and self-insured employers pay for the vast majority of care. They subsidize the excessive costs of healthcare services. As a consequence, patients have little understanding of the actual costs of their care.

It gets worse. Despite rhetoric to the contrary, customer experience within health systems is usually an afterthought. Managerial energy goes instead to optimizing treatment volume and payment rates.

Jeff Logan, CEO and founder of the consumer growth and engagement firm Pelorus HX, won the 2024 gold medal award for customer experience (CX) leader across all industries, conferred by Awards International, an organizer of international business awards programs.

The award recognized Logan's work while leading customer experience at Providence, a health system based in Renton, Wash. Logan believes that healthcare's biggest failing is its inability to see human beings at the receiving end of transactions. Instead, health systems see treatments, diagnostics, bills and/or perhaps physicians, but not individuals. How right he is.

Ultimately, I chose to use "customer" in my book's title, believing that the true customers in healthcare are the organizations — notably governments and self-insured employers — that select and pay for healthcare insurance products. Empowering these "customers" to improve their healthcare purchasing has transformative power.

NOW THE REAL GAME BEGINS

What a difference five years makes! Entering 2025, rising consumerism is becoming an irresistible force. Several factors contribute to this phenomenon, including:

- Mandated pricing transparency
- More "skin in the game" for consumers due to increasing out-of-pocket payments
- More numerous and better apps for assessing potential providers
- New types of consumer-friendly service providers

The social media vitriol following the murder of UnitedHealthcare's CEO Brian Thompson evidenced the enormous public anger and frustration with healthcare companies. In concert, press coverage has become more pointed and negative. A recent "bill of the month" article illustrates consumers' increased focus on fair payment for services received. [4]

After receiving an estimate of $7,203 with an out-of-pocket cost of $2,381 for a routine colonoscopy from Northwestern Medicine in Chicago, healthcare consultant Tom Contos agreed to go ahead with the procedure. The final bill was $19,206, with an out-of-pocket bill for $4,047. When pressed, Northwestern explained that the higher actual bill resulted from the removal of two polyps found during Contos' colonoscopy.

Incensed, Contos filed and lost appeals with Northwestern and his insurance company Aetna. Post-appeal, Northwestern asserted that the charges were accurate and non-negotiable. Failure to pay would require them to send the account to a collection agency. Contos then fired his primary care physician and left the Northwestern network. On leaving, Contos told Northwestern "I'm not paying [the additional charges], and I don't care if you send me to collections."

Bad customer reviews spread like wildfire. When he was the CEO of Merrill Lynch in the late 1990s and early 2000s, Dave Komansky frequently reminded his employees (of which I was one) that happy customers tell one person about their positive experience while unhappy customers tell 20 people about their bad experience. Tom Contos went ever farther. He contacted Kaiser Family Foundation Health News about his bad customer billing experience.

WHAT HEALTHCARE CONSUMERS SHOULD EXPECT

Most healthcare services, like colonoscopies, are commodities. According to Turquoise Health, a San Diego-based pricing transparency company, Northwestern's insured colonoscopy price was more than double the median for Chicago hospitals. Expecting premium pricing for routine services is a recipe for losing legions of informed, commercially insured consumers like Contos.

Moreover, two-thirds of patient touchpoints are nonclinical. Failing to delight customers at any stage in their healthcare journeys can trigger negative reviews, consumer dissatisfaction and market-share declines. Astute health system leaders understand this.

Under Terry Shaw's leadership, AdventHealth has been repositioning to embrace consumerism and whole-person health. Through its strategic plan ("Becoming AdventHealth 2030"), the health system has funded an independent primary care division with $250 million and granted autonomy to its primary care physicians to do what's best for their patients.

AdventHealth's highly rated health app is on its fifth iteration. It has millions of users. At enormous cost, Shaw replaced the communications systems at all Advent facilities within its seven-state geography to eliminate "phantom" appointments. As Shaw emphasizes, "Going forward, provider offices will open up their schedules to accommodate the consumer."

In 2022, Peter McCanna created a new vision statement for Baylor Scott & White Health that signaled a hard strategic pivot to embrace consumerism.

When Peter McCanna became CEO of Dallas-based Baylor Scott & White Health (BSW) in January 2022, he authored a new vision statement titled "Empowering You to Live Well." Accompanying the new vision statement was a hard strategic pivot to embrace consumerism. Essentially, BSW is transferring agency to consumers for managing their health. That requires giving consumers better tools for meeting their health and healthcare needs.

The MyBSWHealth app is the primary vehicle leading this charge. McCanna wants the app to become the industry's "finest customer engagement platform." Achieving this goal has required human design engineers, journey mappers and other nontraditional health system professionals to imagine, improve and enliven their customers' digital experiences. The early results have been impressive. The app has over 3 million users, including over 760,000 new customers to the BSW network.

A SIGN OF THINGS TO COME

Platforming and consumerism are coming to healthcare. Both Shaw and McCanna agree that the futures of their health systems rely on delivering value and a great experience to end-users. This is not a radical vision. Rather, it embodies a very American, "the-customer-is-always-right" approach to business development and execution.

For health system executives clinging to volume-driven business practices, it's time to open your eyes and embrace the coming wave in healthcare consumerism. Change is hard. Not changing, however, will be catastrophic. There is salvation in value.

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OLIVES NO JUICE: A CASE STUDY IN TODAY'S REVENUE CYCLE DYSTOPIA

Vendor pronouncements that AI technologies can transform the healthcare revenue cycle are commonplace and overblown. While both health systems and suppliers want to believe that AI can be their savior, there are limits to how it can improve payment mechanics between commercial health insurers and providers. No revenue cycle company flew closer to the sun than Olive AI. That company's dramatic rise and steep fall constitute a cautionary tale for both buyers and sellers of revenue cycle management (RCM) services.

DROWNED AI AMBITIONS

On Oct. 31, 2023, Olive AI announced it was ceasing operations. The news stunned the healthcare industry. Bold and fast-growing, Olive embodied the potential of AI-driven process automation to rewire healthcare's friction-filled revenue cycle operations. Founded in 2012, Olive had raised over $900 million in funding from many of the United States' most prominent venture firms, including Base 10 Partners, Sequoia Capital, General Catalyst and Tiger Global.

Olive AI was a digital juggernaut. It was the darling of the health tech industry and the pride of Columbus, Ohio. According to a July 2021 press release, Olive's enterprise software operated in "more than 900 hospitals in 40 states, including 20 of the top 100 U.S. health systems."a At that time, Olive had 1,400 employees and carried a $4 billion valuation.

Olive benefited from the market's over-exuberance during 2020-21, when easy money flowed into digital tech companies, inflating their valuations. In many ways, Olive's demise is the timeworn saga of a company paying the ultimate price for believing its own hype. In self-promoting "go save health care" bus ads, Olive mightily overpromised and vastly under-delivered.b As the market tightened and clients abandoned its platform, the company bled to death.

In a larger sense, however, the rise and fall of Olive AI is inextricably woven into the inscrutable, perverse and illogical character of healthcare's billing and payment mechanisms. The marketplace wanted to believe that technology could bring coherence, transparency and efficiency to the industry's convoluted revenue cycle mechanics. That dream along with Olive AI died an ignominious death.

HOT-POTATO PAYMENT

Healthcare providers confront a two-pronged challenge when seeking payment for their services. Governmental payers reimburse less than commercial payers. According to a RAND study of 2022 hospital pricing data, commercial payers on average paid 254% of traditional Medicare rates for equivalent service provisions.c On the plus side, governmental payers process payments faster through pre-determined reimbursement formulas.

By contrast, providers and commercial health insurers engage in intense zero-sum battles to determine payment amounts and timing. The mechanics for submitting appropriate claims are both complex and constantly changing. Payment delays and denials result. Commercial insurers generally have the upper hand in negotiating disputes because they control funding flows. As these hot-potato exchanges unfold, patient experience is usually an afterthought.

With each step throughout this intricate payment journey, documentation errors can lead to payment adjustments, potentially slowing or negating payments. Commercial payers are not passive actors in this process. An analysis of 2023 claims in the ACA marketplace by the Kaiser Family Foundation found that qualified health plans denied 19% of in-network claims, with significant variation by insurer and state. Alabama's denial rate, for example, was 34%. [4]

Healthcare RCM is where the money is. That's why both payers and providers devote extraordinary resources to managing their RCM operations. Like the U.S. healthcare system it feeds, RCM is highly fragmented. It is populated by large numbers of competing point solutions offered by countless vendors. It is not unusual for health systems to have dozens of vendors offering component RCM "solutions." The aggregate activities of these RCM vendors often complicate rather than support efficient system management.

RCM Process: 11 Steps to Follow

To receive payment, providers must undertake and document the following activities through their RCM processes:

- **Scheduling.** Document demographics and insurance coverage
- **Pre-registration.** Validate all patient information, produce a cost estimate and receive prior authorization from payers for treatment
- **Registration.** Check in patients to receive treatments
- **Visit.** Conduct treatments and transcribe notes
- **Coding.** Review procedures and notes then input treatment codes
- **Chargemaster.** Align coding to billing parameters
- **Claim edits.** Document exceptions-based workflows
- **Bill holds.** Adjust for exceptions-based edits in the electronic health record
- **Claim submission.** Providers send claims to payers
- **Claim follow-up.** Address claim denials, unpaid claims, patient payment and secondary insurance
- **Cash posting.** Acknowledge receipt of payment for services provided

A $1 TRILLION INDUSTRY?

Activities related to healthcare billing and payment constitute a massive industry employing hundreds of thousands of healthcare professionals. According to a report issued by Grand View Research, the U.S. market in 2025 for outsourcing healthcare revenue cycle functions will be $189.6 billion. The report projects this market will grow 10.1% annually through 2030. [5]

That's just outsourced RCM activities. Grand View's analysis excludes in-house provider and payer RCM activities, which dwarf outsourced RCM.

Given healthcare's payment dynamics and complexity, it's difficult to pinpoint the exact level of healthcare's administrative expenses, including RCM. An October 2022 meta-analysis published in Health Affairs found healthcare's administrative expenditures ranged between 15% and 30% of total U.S. Healthcare expenditures. [6]

CMS projects that U.S. healthcare expenditure in 2025 will be about $5.3 trillion, representing 17.9% of the total U.S. economy. [7] Simple multiplication suggests that healthcare's administrative expenses in 2025 will range between $795 billion (15% of total) and $1.59 trillion (30% of total). Most estimates center around 25%.

The vast majority, perhaps greater than 80% of healthcare's administrative costs, relate to the RCM activities described above. With a 25% administrative cost allocation, that proportion suggests RCM is a $1 trillion business.

One trillion is a gargantuan number, almost beyond human comprehension. It would take 32,000 years to record a trillion seconds. A trillion dollars spent each year on processing medical claims is absurd. It represents a monstrous drag on the overall economy.

By comparison, Ibis World estimates that in 2025 U.S. automobile manufacturing revenues will be $384.5 billion, with an anemic 2.4% annual growth rate. [8] In today's America, processing medical claims is a far larger and more lucrative business than manufacturing cars and trucks.

OLIVE PLANTING

Olive's founder and CEO Sean Lane was right out of central casting. A decorated Air Force veteran with five combat tours, Lane earned his technology chops in military intelligence making massive data sets sensible, interoperable and usable. Given the magnitude and complexity of the RCM business, it's not surprising that investors got behind Lane. He had the right stuff.

Founded in 2012 as CrossChx, Lane's initial business model employed biometrics to facilitate patient check-ins. In 2017, CrossChx introduced an AI bot named Olive that completed menial administrative tasks. As the Olive bot gained traction with clients, Lane changed the company's name to Olive AI in 2018.

In a 2022 interview with TechCrunch Live, Lane explained how Olive strategically pivoted 27 times to refine its business model. [9] Olive AI was pivot 28. Part of Olive's appeal was Lane's expansive vision for the company. He drove Olive to create an internet for healthcare. He envisioned Olive as an enterprise-wide platform that could transform healthcare companies from "wing to wing."

Lane believed the industry's biggest failing was its need to use four million "human routers" to sequence care delivery. He preached that machine intelligence built on deep neural networks could annually "liberate 10 billion hours of wasted human effort."

OLIVE PITTING

By definition, Olive had to be big and scalable. It also had to engage multiple partners to eliminate friction among providers, payers and patients. Accordingly, Lane created a ventures arm to foster inorganic growth. He expanded service offerings to automate prior authorization decisions, manage the health of populations, offer disease-specific solutions and so much more.

The bigger and more diverse Olive became, the harder it became to execute Lane's vision. As operating losses grew, Olive began cutting staff.

A devastating Axios Pro report by Erin Brodwin in April 2022 found that Olive had generated only a fraction of the savings it promised. [10] Deeply embarrassed, disappointed customers didn't speak up even as Epic forced Olive to stop referencing its name in marketing materials and KLAS noted Olive's tendency to overstate its capabilities. In reality, Olive's vaunted AI capabilities often turned out to be 1990's-era screen-scraping technologies.

PRIDE COMES BEFORE THE FALL

Olive's hubris created the seeds of its destruction. Too many RCM companies sell the same AI vaporware as Olive did.

At the same time, there is an unhealthy reciprocity between healthcare companies and their RCM suppliers. Both are desperate to achieve efficiencies. Neither fully understands how healthcare's complex and convoluted payment mechanics complicate both human and technological challenges. Performance suffers as waste proliferates.

It doesn't have to be this way. The path from RCM dystopia to euphoria incorporates logical automation and consumerism. Olive provides a sober example of the consequences of the failure to understand that fundamental reality.

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REVENUE CYCLE EUPHORIA LOGICAL AUTOMATION AND CONSUMERISM

In April 1999, The Modern Library published its list of the top one hundred nonfiction books of the 20th century. Number one was "The Education of Henry Adams," an intellectual autobiography written in 1905 by the great grandson and grandson of John Adams and John Quincy Adams, the second and sixth presidents of the United States. [1]

What captivates me about Henry Adams' book is how he internalizes the rapid advances of science, technology and society during the second industrial revolution (late 1800s to early 1900s). Adams calls this period "the dynamo." Always referring to himself in the third person, Adams concludes that his classical education lacked the scientific and mathematical knowledge necessary to understand and contextualize the dynamo.

To compensate, Adams educated himself about mind-bending technologies such as X-rays, the internal combustion engine, electrification and radio waves among others. He relied on reading, experiences and relationships to guide his education.

I confronted a similar conundrum in healthcare. Nothing in my academic training or decades-long career prepared me for the massive scale, intricacy and malleability of the revenue cycle management (RCM) industry within U.S. healthcare. Like Henry Adams, I engaged in a self-education quest. As a nod to Adams' approach, here's my third-person account of what I have learned.

THE RCM EDUCATION OF DAVID W. JOHNSON

When David W. Johnson published "The Customer Revolution in Healthcare" in 2019, he believed he thoroughly understood U.S. healthcare's structure, power dynamics and operations. Perverse financial incentives had created an artificial, supply-driven economic model that optimized treatment volume, under-invested in preventive care, generated enormous waste and tolerated gaping disparities.

Since 2019, a series of fortuitous circumstances and relationships brought Johnson face-to-face with the roiling underbelly of U.S. healthcare, the hot-potato mechanics of who pays how much to whom for which services. Four actors feature prominently in Johnson's RCM "education."

Nephew Derek

Like his uncle, Derek Johnson attended Colgate University, served in the Peace Corps, earned a Master's degree in public policy and pursued a healthcare career. Deviating from his uncle's path, he chose to work in RCM.

Through frequent conversations and spreadsheet presentations, Johnson's nephew schooled his uncle in the mundane, day-to-day, labor-intensive approaches used to improve RCM outcomes. These interactions familiarized David Johnson with RCM's unique vernacular, including terms such as front-end, back-end, prior authorization, coding and denials.

In a telling example, a box checked in error on 15,000-plus patient accounts required manual correction. At five minutes per account, Derek Johnson's team spent over 1,250 hours fixing the problem. Delayed collection compounded total correction costs. David Johnson was to find that these types of clerical errors occur with alarming frequency.

hfma

In mid-2022, Johnson joined hfma's Board. RCM constitutes hfma's beating heart. The vast majority of its 135,000 members are RCM professionals. Hundreds of RCM companies exhibit at hfma conferences each year. As he acculturated at hfma, Johnson realized that healthcare RCM is as fragmented and convoluted as the system it funds.

Unlike commercial banking and other large industries, there are no comprehensive research reports on the RCM industry. Healthcare billing and collections operate underneath the market's radar. Johnson came to envision hfma as potentially the marketplace's most-trusted source for information on the RCM industry.

SparkChange Health

In early 2024, Johnson became the first external adviser to SparkChange, a Kansas City RCM automation company founded in 2019. Johnson learned that while most providers have digitized patient data, few have codified this data and even fewer have effective rules engines for automating claims processing. For these providers, RCM work queues become "over-routed" with too many human edits and breakage points.

Johnson engaged in weekly calls with SparkChange's CEO Sal LoPorto with the initial goal of clearly understanding the company's value proposition for clients. A breakthrough came when Johnson used the rudimentary triune brain model, which describes the three layers of the human brain, as a metaphor for RCM: [2]

> **The brain stem**, shared with reptiles, controls core bodily functions like breathing that keep creatures alive. Without the ability to issue bills and receive payment, providers would die.
>
> **The middle brain**, shared with mammals, controls motivations and emotions that drive behaviors necessary for survival (e.g., feeding, reproduction and parenting). For providers, highly developed and applied RCM behaviors enhance organizational vitality.
>
> **The neocortex**, unique to humans, enables speech, logic and other highest-order functions. For providers, using predictive analytics and other AI tools could optimize revenue collection, minimize friction and improve productivity.

Considering this metaphor, LoPorto emphasized that "middle brain" improvements generate the highest and most immediate financial returns. Indeed, pursuit of "neocortex" AI-driven improvements without having optimizing "middle-brain" operations is wasteful and counter-productive. With that, Johnson's learning took another step forward.

Jeff Logan

Logan is an award-winning customer experience leader, and founder of the consumer-friendly RCM company Pelorus. He has described his over-20-year career being "focused on growing businesses in a human-centric way."

Logan informed Johnson that two-thirds of health system touchpoints with consumers are non-clinical, related primarily to scheduling, billing and other administrative tasks. Consequently, improving end-users' non-clinical experience builds customer loyalty, increases revenue collection and enhances organizational performance. Kimberly Sullivan, SVP and chief revenue officer for Peace Health, emphasized consumerism's importance during an interview with Johnson:

> ***Ensuring patients and families have simple, secure digital tools to manage administrative tasks helps remove barriers to care, allowing them to focus on their health and healing. That's what gets him up in the morning.***

These relationships and experiences gave Johnson a firm grip on RCM dynamics. His understanding went from being superficial to granular.

I hope my third-person exposition conveys my deep appreciation for the RCM education I have received during the last several years. That education has made me keenly aware of the essential dilemma confronting RCM operations in U.S. healthcare.

RCM'S FUNDAMENTAL DILEMMA

In his book "No Problem," Alex Lowy describes three types of challenges: decisions, problems and dilemmas. Complexity and uncertainty increase as challenges move from decisions to problems to dilemmas. Lowy stresses the importance of understanding a challenge's type before seeking to address it.

Decisions are straightforward. Solutions emerge from known options. Problems are more complex but always have solutions. Achieving desired outcomes requires research, opinion solicitation and barrier identification. Dilemmas have no solutions. Decision-makers navigate between competing forces to create incremental improvement.

RCM falls squarely into the dilemma category. As long as payers want to pay less and providers want to receive more, they will battle endlessly for relative advantage. Both payers and providers benefit from RCM's complexity and lack of transparency. Each blames the other for payment dysfunction and consumer dissatisfaction.

No matter how powerful, AI tools cannot eliminate this inherent payer-provider conflict. Provider wins are incremental and never sufficient. Progress occurs through consistent "middle-brain" improvements. In football vernacular, success is three yards and a cloud of dust, not hail-Mary touchdown passes. Unlike football, however, the RCM game never ends.

Case Examples of Effective, Incremental RCM Performance Improvement

Two case examples involving SparkChange and Jeff Logan provide insight into how we might escape from the U.S. healthcare systems' RCM dilemma. Neither is an eye-popping example of technological wizardry. Instead, each illustrates how logical automation and consumerism improve RCM performance despite the inherent payer-provider dilemma. This is the secret for RCM success.

1 Improving Flow Through Logical Automation

Centra Health is a large regional health system headquartered in Lynchburg, Virginia. Claims flowed like molasses through Centra's RCM platform. Laboring with limited visibility to patient data and lacking actionable reports, it took Centra's RCM team 20 days, on average, to submit claims to payers. Even more telling, Centra had not billed a patient for their portion of the bill in the previous 12 months.

Robert Boos, Centra Health's vice president of revenue cycle, was beyond frustrated. He abhorred the thought of outsourcing his RCM operations to a third-party vendor because the "take our mess for less" strategy rarely generated the promised payoff. Still, he desperately needed Centra's RCM operations to speed up claims processing and increase cash collections.

Boos engaged SparkChange to work with his team to improve Centra's RCM performance. Acknowledging the importance of making incremental improvements, Centra and SparkChange employed "middle-brain" data intelligence and visibility tools with automation to discover and exploit actionable insights.

Over time, Centra realized reductions in claims processing to five days and 70% declines in payer denials, while annual cash collections increased by $200 million. An ecstatic Bob Booze crowed that "SparkChange help us light up the room."

2 Improving Intelligence Through Consumerism

When Jeff Logan, founder of the RCM firm Pelorus was group vice president, patient and market experience, at Renton-Wash.-based Providence, his team would monitor consumer calls to solve problems and aggregate data for systemic improvement.

One day, dozens of calls came from Idaho patients unable to pay their bills. Their digital payment forms didn't have an "Idaho" box to check. This was an easy problem to solve. Customers and the health system were happy. Unrecognized, this glitch could have continued for months, frustrating consumers and reducing cash collections.

Neither of these examples are eye-popping examples of technological wizardry. Instead, they illustrate how logical automation and consumerism improve RCM performance despite the inherent payer-provider dilemma. This is the secret for RCM success.

RCM HAPPINESS IS A MODEST THING

Journalists routinely ignored tennis champion Stefan Edberg, preferring to interview more colorful players like Boris Becker and Andre Agassi. Not seeking the limelight, Edberg observed in 1993 that he preferred to "just go out and do the business and play tennis." He summed up his philosophy this way:[c]

> ***My parents … taught me early that happiness is often a modest thing. It has nothing to do with money or fame.***

Edberg's wisdom applies. In healthcare RCM, success is a modest thing, and happiness comes from incremental cash-flow improvement.

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His first book, **"Market vs. Medicine: America's Epic Fight for Better, Affordable Healthcare,"** *and his second book,* **"The Customer Revolution in Healthcare: Delivering Kinder, Smarter, Affordable Care for All"** *(McGraw-Hill 2019), are available* for purchase on www.4sighthealth.com. Get his new book with Paul Kusserow, The Coming Healthcare Revolution: 10 Forces that Will Cure America's Healthcare Crisis, now.