CycleUP

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Solving the Capacity Puzzle

Why getting more done takes more than adding people. from Jeff Nieman, CEO

Jeff Nieman, *CEO*

For years, the capacity question in healthcare RCM was pretty straightforward.

If the workload increased, you hired more people. And if that still wasn't enough, you paid those people more overtime to close the gap.

Today, that model is becoming increasingly difficult to sustain. There simply aren't enough trained RCM professionals to bring on every time the work starts piling up. And it is piling up. AI-powered denials are seeing to that.

The RCM game itself hasn't changed much. Hospital business offices still need to work accounts, resolve denials, connect with patients, and ultimately collect what the hospital is owed. What has changed is the number of pieces on the board.

Healthcare organizations can now use generative AI tools, agentic AI, traditional automation, RCM professionals with different levels of experience, and outside partners to get the RCM work done. That gives decision-makers more options than ever to build the capacity they need.

It also gives them a lot more to figure out.

At Meduit, we've long believed that the best RCM results come from finding the right balance of AI and human expertise. I still believe that. But even that formula is getting more complicated.

That's because not all AI is the same anymore. The AI we've grown accustomed to can analyze data, recognize patterns, summarize, and assist with high-volume tasks. Agentic AI goes even further by taking action and moving work through multiple steps without needing a person at every juncture.

Headcount alone won't tell you much about the true capacity of a business office.

What matters is how much work gets done, how well, and whether the model can adjust...

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Solving the Capacity Puzzle: Why getting more done takes more than adding people.

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The human side has its own levels, too. Not every account requires expert insight or oversight, but many do, which means a modern business office must offer a full range of knowledge and judgment.

The capacity question is changing before our eyes from "How many people do we need to get everything done?" to "What combination of resources will get everything done most effectively?"

A cohesive business office has to bring all those pieces together. Technology, people, process, and compliance all have a role, with the mix changing with demand. Creating this model may mean building internally, working with outside partners, or a combination of the two.

Headcount alone won't tell you much about the true capacity of a business office. What matters is how much work gets done, how well, and whether the model can adjust when the work changes.

There are more pieces on the board now. The next challenge for RCM leaders is figuring out how they fit together.

That idea runs through this edition of *Cycle Up*, beginning with an article about a Meduit platform that helps match RCM work with the people and technology best equipped to handle it.

Enjoy *Cycle Up!*

Sincerely,
Jeff Nieman
CEO

Key Meduit **RCM Factoid**

Did You Know?

Meduit earned 9 awards for its marketing efforts from the Hermes, Aster, and Healthcare Advertising Awards, including a Platinum Hermes for Cycle Up.

Not bad for a magazine about revenue cycle management.

Putting the Right Work in the Right Hands

How Benchmark helps put RCM resources where they matter most.

Every revenue cycle account needs to be worked. But that doesn't mean every account should be worked the same way.

Some accounts are straightforward. Others take more time and require more familiarity with a specific insurance payer and what it takes to overturn a denied claim. The challenge for healthcare leaders is figuring out where people, technology, and time can make the biggest collective difference.

That's the thinking behind Benchmark, Meduit's proprietary AI-enabled workflow platform. Benchmark helps Meduit's RCM professionals organize and prioritize RCM work, directing accounts toward the people and technology best equipped to move them forward. For clients, that means faster account resolution and more Meduit resources directed to the work with the greatest potential to drive cash.

At the heart of Benchmark is a simple idea: two accounts with the same balance can have very different potential outcomes, and therefore, they warrant a different allocation of resources.

Benchmark uses historical data to analyze and predict the outcome of each account. From there, teams can prioritize accounts so they spend more time where their effort can have the biggest impact. It's the textbook definition of working smarter.

That doesn't mean lower-value accounts get ignored. Everything still has to be worked, but it's okay, and even prudent, to vary the level of intensity according to the prospective payoff.

The same principle applies to the people doing the RCM work.

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Putting the Right Work in the Right Hands

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Some accounts don't need a person with years of RCM experience. Others definitely do. Benchmark helps Meduit get the right account to the right person at the right time. This gives experienced team members more freedom to solve complex problems instead of spending their day on work that either technology or less experienced employees can handle.

Someone with 15 years of revenue cycle experience brings far more value to a difficult denial or complicated payer issue than to routine data entry or another task that can be automated.

Benchmark is also bringing more intelligence into an area where it's desperately needed: denials.

The platform uses agentic AI to identify why a claim was denied and provide specific information to help Meduit determine the right next steps. Employees spend less time on the phone and researching online for the information they need.

For healthcare organizations, Benchmark adds another layer of automation and intelligence in a platform they don't have to manage themselves. Clients may never interact with Benchmark directly, but they benefit from the decisions it helps Meduit make about what work should happen first, where technology fits, and where experienced professionals are needed.

This is what resource optimization looks like in practice. Not just adding more, but getting more from what you already have and putting it where it can have the greatest impact.

We Want to Know What You Think

Have comments or questions regarding an article in this issue or a topic you'd like our editorial team to consider for an upcoming issue? Send us your thoughts at: contactus@meduitrcm.com.

And be sure to like and follow us on social media!

Small Claims Add Up Faster Than You Think

If you're sitting in a hospital business office, staring at a $700 denial and a $7,500 denial, it makes sense to tackle the larger one first, with the smaller one relegated to the "Later" pile. Only in most hospital business offices, where teams are chronically understaffed, "Later" usually never comes. And many of the smaller denials go untouched.

That would almost be okay if it were only the occasional $700 denial going ignored. But when it's $700 one day, $225 the next, and $185 after that, those denials add up.

AI gives payers the ability to deny claims at a volume that no lean business office can respond to. At least not without the same technology. Churning out denials at that rate can be relatively inexpensive for payers. It's a much different story for the hospital.

The AHA estimates hospitals spent $43 billion in 2025 trying to secure payments insurers already owed them. It estimates nearly $18 billion went toward overturning denials.

And the team doing that work? The same report found that in 2024, the average hospital had about 64 people on billing and administrative functions tied to payer requirements. That's roughly 6.5% of total staff.

So that's sixty-four people per hospital, trying to corral everything payers owe. Those odds aren't great.

Here's what makes the whole scenario sting even more for hospitals and health systems. That same AHA report points to a Health Affairs analysis of Medicare Advantage claims, which found that plans denied about 17% of initial submissions. The same study found that only 60% of those denials were ever resubmitted. Of the ones that were, two-thirds got paid.

So the denials that were addressed mostly got paid, but four out of ten never made it that far. In a lean business office, those are the sacrifices that have to be made.

...hospitals spent $43 BILLION in 2025
trying to secure payments insurers already owed them

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Small Claims Add Up Faster Than You Think

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It's All About Capacity

Most of the conversation about denials is around prevention. Of course, it's useful to have that information going forward, but it doesn't help with all the claims currently sitting in your "Later" pile. Those need someone working them yesterday.

Hiring more people seems like an obvious answer. Until you consider the shortage of experienced RCM professionals available, and how long the onboarding process is to get a new employee ready to take on denied claims. The backlog won't wait.

Which means the capacity has to come from somewhere other than hiring full-time employees. Keep in mind this isn't a temporary surge to withstand, either. AI-powered denials are the new normal, and the volume isn't going to recede. Hiring your way out of it means carrying a lot more fixed overhead, which most hospitals can't afford.

Plus, the same shortage of hours that impacts denial management also affects the rest of the back office's responsibilities. The longer A/R is allowed to age, the less likely it is to ever be collected. What business offices need is a way to handle heavier workloads without relying on hiring cycles.

That scenario entails experienced RCM people handling appeals and other judgment-intensive work, while AI handles the repetitive, high-volume work that lives on the rungs underneath. That combination lets hospitals get the best out of the staff they have and extend their office's ability to get more done.

Capacity shouldn't decide which claims get worked. Especially when the odds for reworked denials are favorable.

Whether a hospital builds its own AI-plus-expertise setup internally or brings in a partner with a ready-now solution is a separate question. But more capacity is out there. Hospitals and health systems just have to find their best way to integrate it. And fast.

Meduit's Comprehensive Business Office (CBO) combines experienced RCM professionals, proven processes, and AI-driven tools to add capacity across the business office, fortifying the team already in place rather than replacing it.

DOWNLOAD our CBO brochure to learn more

Year-Over-Year vs. Side-By-Side

Hospitals have plenty of ways to measure RCM performance. Year-over-year results and contracted benchmarks can tell leaders a lot about how something like an early out program is delivering. But one large health system had another way to measure performance.

For years, the health system has split its early out accounts between Meduit and another RCM partner, giving each agency its own share of work under similar conditions.

This setup gives hospital leadership a unique perspective. Instead of looking only at past outcomes, leaders can see how two different early out approaches work side-by-side.

In this particular instance, the numbers started to tell a consistent story. Every year, Meduit produced the stronger results.

Year-over-year performance tells you how your early out program is doing. A side-by-side comparison tells you how much better it could be doing. That's a big difference, as this health system found out.

READ MORE about it in the case study

Spotlight on **Behind the Numbers**
with CFO Scott Warshaw

Scott Warshaw
Chief Financial Officer

In each edition of *Cycle Up*, we sit down with one of the leading voices on the Meduit team. In this issue, we caught up with Scott Warshaw, Meduit's *Chief Financial Officer*, about reimbursement pressure, the evolving role of AI, and why some of the most important RCM decisions transcend the spreadsheet. Enjoy the conversation.

Q. You've only been at Meduit a short time. What's stood out the most so far?

A: I'd say the breadth of RCM experience and expertise across the board has surpassed my expectations. Meduit has a deep bench of people with long-tenured backgrounds in the industry, and I think that leads to a level of attention to detail in the delivery of our services that's unique. And it translates into great outcomes for our clients.

Q: CFOs have a broad perspective across an entire organization. How does that view influence the decisions you make beyond the numbers themselves?

A: My role ultimately boils down to enabling the business to achieve its growth strategy. It's really about facilitating investment. How are we going to put money to work in different areas of the business, different end markets, and into the things that matter for our clients?

I'm fortunate to work with seasoned professionals across the business who are knowledgeable about the market and the services we provide. Together, we're able to make informed decisions as a team. The numbers may only tell part of the story. The strategic context around those numbers plays a meaningful role in decision-making.

Q: Hospitals are under more pressure than ever to do more with limited resources. From a CFO's perspective, how should healthcare leaders think about productivity and capacity today?

A: We all face capacity constraints in some regard. At the individual level, we only have so many hours in the day and so much energy to give. At an organizational level, there are limitations on capital and time.

Healthcare leaders can and should improve capacity by leveraging tools and technology. But productivity is really about how effectively organizations can put that limited capacity to work.

Meduit's model aligns our interests with those of the provider and seeks to deliver a patient experience that follows the golden rule, knowing each of us has been, and will be, a patient on the receiving end of care at some point in our lives. That's what helps these organizations become more productive. It's

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Spotlight on Behind the Numbers

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not necessarily serving more patients. It's getting paid fairly and in a timely manner for the services they're already providing.

Q: As AI becomes more capable, how does that change the way you think about investing in technology and people? How do you see the two working together in the future?

A: We are investors in AI to the extent that it enables our people. For example, when AI tools can transcribe calls so an agent doesn't have to type up call notes, the agent can listen more intently to what the patient is saying and move on to the next caller without delay.

We have thousands of employees enabled by these tools, so when we're hiring, we're looking for character first. That means attitude, work ethic, things of that nature, with specific technical skills second.

Healthcare is super personal. When I or somebody in my family has a serious health issue, I will undoubtedly choose to speak with a person who is compassionate and can empathize with the situation, and if they're supported by an AI tool, that's great.

There are certainly organizations out there that are trying to automate everything. And there are folks who think they should white-glove everything. I think Meduit takes a thoughtful approach to deliver the right experience for the situation, particularly when somebody is staring down a bill that they can't afford.

Q: What financial pressures facing hospitals and health systems concern you most right now?

A: I think it's reimbursement, which is a challenge with both first- and third-party payers. You have denied claims that aren't worked and unpaid insurance claims that lead to unexpected, hard-to-collect patient balances. We've only seen this play out more as prices rise, utilization rises, and there's more patient responsibility.

Being able to close that reimbursement gap is one of the top concerns facing hospitals and health systems today.

Q: What do you think will change the most about the way healthcare organizations think about revenue cycle performance and financial operations?

A: I think the growing trend of higher patient responsibility is here to stay. We've gone from a revenue cycle operation that was primarily a B2B collection process focused on government and commercial insurance to a consumer collections and financial engagement process.

That means focusing on clear, accurate patient statements, digital communications, and easy payment options that fit the person's needs.

For Meduit, it's about how efficiently we can identify, communicate, and collect on patient obligations while also delivering the best possible customer experience. That's something we've always seen as a priority, and I think it's only going to become more important for the clients we serve.

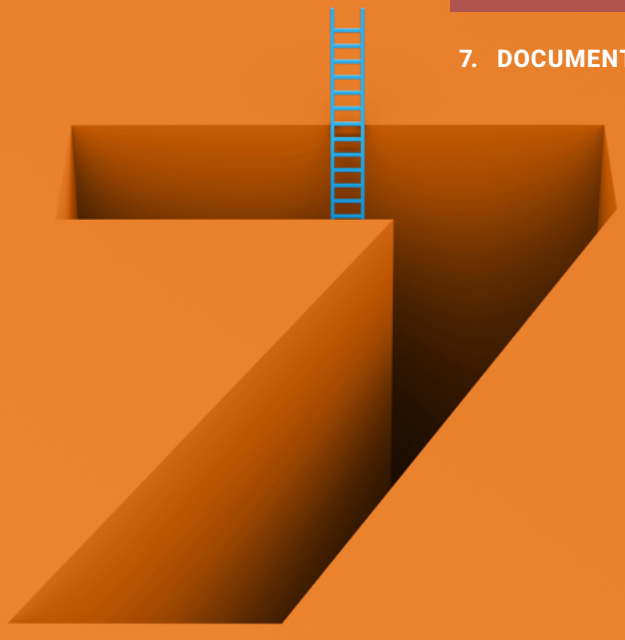
Compliance News Update:

Seven Compliance Risks in Medical Debt Collection

Medical debt collection sits at the intersection of consumer protection, healthcare stewardship, compliance governance, and data privacy. Organizations must consider not only whether their policies meet applicable requirements, but also how their procedures and day-to-day practices affect consumers, healthcare clients, and regulatory exposure.

Traditional risk scoring—Impact, or Severity, multiplied by Probability, or Likelihood—provides an essential starting point. When a finding reaches a medium risk level or above, the next step is to identify the specific behavior creating the exposure and the control needed to address it. A simple risk-to-control framework can help teams evaluate issues consistently, consider them from multiple perspectives, and move more quickly from identifying a concern to taking corrective action.

Risk Area	High-Risk Practice	Stronger Control
1. BALANCE ACCURACY	Assuming account balances are correct	Verify balances and supporting account data before proceeding
2. FEES AND INTEREST	Including improper fees or interest	Conduct state-specific fee and interest reviews and apply appropriate controls
3. PRIVACY	Oversharing account information	Limit disclosures and use respectful, privacy-conscious outreach
4. CONTACT FREQUENCY	Engaging in excessive outreach	Establish and monitor contact-cadence controls
5. ESCALATION & CONSUMER TREATMENT	Applying undue pressure or escalating unnecessarily	Use de-escalation, empathy, and clear escalation protocols
6. VENDOR GOVERNANCE	Adding unverified vendor options	Apply due diligence, defined standards, and ongoing oversight
7. DOCUMENTATION	Maintaining weak or incomplete records	Create complete, consistent, and defensible documentation



Compliance News Update: Seven Compliance Risks in Medical Debt Collection

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Used consistently, this framework can help organizations accomplish three important objectives:

1. **IDENTIFY:** Recognize common regulatory and compliance tripwires in medical debt collection and connect them to everyday operational practices.
2. **UNDERSTAND:** Define what strong medical debt collection practices look like beyond minimum requirements, including validation, dispute handling, communication, privacy, and documentation controls.
3. **APPLY:** Connect each identified risk to a practical, repeatable control that can reduce regulatory exposure, improve consumer outcomes, and strengthen relationships with healthcare clients.

The goal is not to make compliance risk assessment more complicated. It is to make it more actionable. When teams connect a specific high-risk practice to a clear operational control, they can move more quickly from identifying a problem to reducing it—and create a more consistent and defensible approach to medical debt collection.

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A Medicare Bad Debt Myth Worth Busting

Most hospitals file their annual cost report and move on, thinking all is well.

But usually, it isn't.

Medicare Bad Debt reimbursement is an area where hospitals and health systems consistently miss out on money they're owed. Usually, it's due to a misaligned S-10 field here, a gap created by staff turnover there, or regulations that changed close to the filing deadline.

All are things small enough to miss, but big enough to add up. Industry data pegs hospital underreporting at 6% – 7% every year. That could translate to six or seven figures of reimbursement that a hospital never sees.

MYTH: Most hospitals collect all the MBD reimbursement they're owed.

REALITY:
WE'VE FOUND MISSED REVENUE 100%
of the time we've done a lookback.

That 100% figure is real. Every time our Government Reimbursement Team runs a lookback, they find missed value. While recovery figures vary, there's always one constant: every client we've worked with thought they had filed appropriately. Which just goes to show that even the best RCM teams don't always have the tools or time to double-check everything.

That's what a lookback is for. There's no upfront cost. No fee if nothing is found (which has yet to happen). And when the money does come back, it can go where the hospital needs it most, including supporting an overloaded business office to make sure all future reimbursement is accounted for.

The good news for hospitals and health systems is that missed reimbursement isn't lost for good. The bad news is that it's just sitting there until someone goes and gets it.