Digital Health Revenue Models: A Customer Success Framework

Why How You Get Paid Changes Who You Serve, What You Measure, and How You Prove Value

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About This Framework

This framework maps the five most common revenue models in B2B2C digital health to the customer success strategies, stakeholders, value drivers, and KPIs that determine whether those models succeed or fail.

It's written for three audiences:

CS leaders operating in digital health who want a structured reference for how their company's revenue model should shape CS strategy, stakeholder management, and QBR execution.

CS leaders transitioning into digital health from traditional SaaS who need to understand what's different about this space and why their existing playbook won't translate directly.

Digital health founders and executives who want to ensure their CS function is built around the realities of their business model, not a generic SaaS template.

The framework covers five revenue models: **CPT Code / Remote Patient Monitoring Reimbursement**, **Per Member / Per Employee Per Month (PMPM/PEPM)**, **SaaS Platform Licensing**, **Value-Based / Outcomes-Based Contracts**, and **Hybrid Models**. For each model, it maps how the company gets paid, who the stakeholders are and what each one cares about, the KPIs that track whether value is being delivered, and how the buyer's upstream reimbursement environment shifts the entire value conversation.

Every model in this framework is based on companies I've worked with, accounts I've managed, or business models I've had to operationalize customer success around over almost 20 years in digital health. This isn't theoretical. It's what I've learned building CS programs from scratch at digital therapeutics companies, managing $6.2M enterprise portfolios across Fortune 500 clients, and driving member activation across Medicaid, commercial, and employer populations.

Revenue Model	Primary Stakeholder	Value Orientation	Engagement Gate Type	Lead KPI
CPT / RPM Reimbursement	Clinic Administrator / Practice Manager	Generating revenue (FFS); Reducing costs (capitated)	Patient device usage + provider billing compliance	Revenue per enrolled patient; avg. device days per patient
PMPM / PEPM	Health Plan Executive Sponsor or Employer HR/Benefits Leader	Reducing costs (cost avoidance, quality improvement)	Member/employee activation and sustained engagement	Member engagement rate; total cost of care per engaged member vs. control
SaaS Platform Licensing	Executive Sponsor (CMIO, VP Care Management)	Reducing costs (efficiency) or Generating revenue (enabling billable services)	Clinical workflow adoption and change management	User adoption rate (% licensed users active weekly); ROI vs. investment
Value-Based / Outcomes-Based	Health Plan CFO / Actuary	Reducing costs (proven, not assumed)	Enrollment volume sufficient for statistical significance + sustained engagement	Performance payment realization; clinical goal achievement rate

Revenue Model	Primary Stakeholder	Value Orientation	Engagement Gate Type	Lead KPI
Hybrid	Varies by dominant revenue stream	Often both simultaneously	Shifts as contract phases evolve	Depends on phase: activation metrics early, outcome/retention metrics later

Identifying Your Model

Most companies operate under one dominant model with elements of others. If you're not sure where your organization sits, these questions can help orient you:

How does your company get paid? If revenue flows from CPT billing codes, start with Model 1. If it's a flat per-member or per-employee fee, start with Model 2. If it's a platform subscription, start with Model 3. If any portion of revenue is contingent on hitting outcome targets, read Model 4 carefully regardless of your primary model.

Who must change behavior for value to materialize? If it's patients using a device or app, your Engagement Gate is an activation and adherence challenge. If it's clinicians adopting a workflow, your gate is a change management challenge. If it's both, you're operating in B2B2C territory and need to manage both gates simultaneously.

Is your buyer experiencing your program as generating revenue or reducing their costs? This single question changes which stakeholders hold budget authority, what metrics belong in your QBR, and how your champion sells the renewal internally. If you can't answer it for a specific account, that's the first conversation to have.

What's the shortest path between engagement and revenue impact? In RPM, the connection is monthly and direct. In PMPM, it's indirect until renewal. In VBC, it's contingent on a measurement period that may be 18-24 months away. The length of that path determines how much runway you have to course-correct and how early your warning systems need to fire.

Are different revenue streams within the same contract creating conflicting incentives? If so, you're operating a hybrid model and should read Model 5 for guidance on managing those trade-offs explicitly with the buyer.

To understand why this framework matters, it helps to know what's missing from the existing playbooks.

The Missing Framework

If you go looking for a book that explains how customer success actually works in digital health, you won't find one. There are excellent CS books that cover health scoring, churn metrics, and retention playbooks. There are digital health books that cover startup strategy, regulatory pathways, and business model archetypes. And there are healthcare finance books that explain how CMS sets rates, how value-based care restructures provider incentives, and how employer health plans flow dollars through the system.

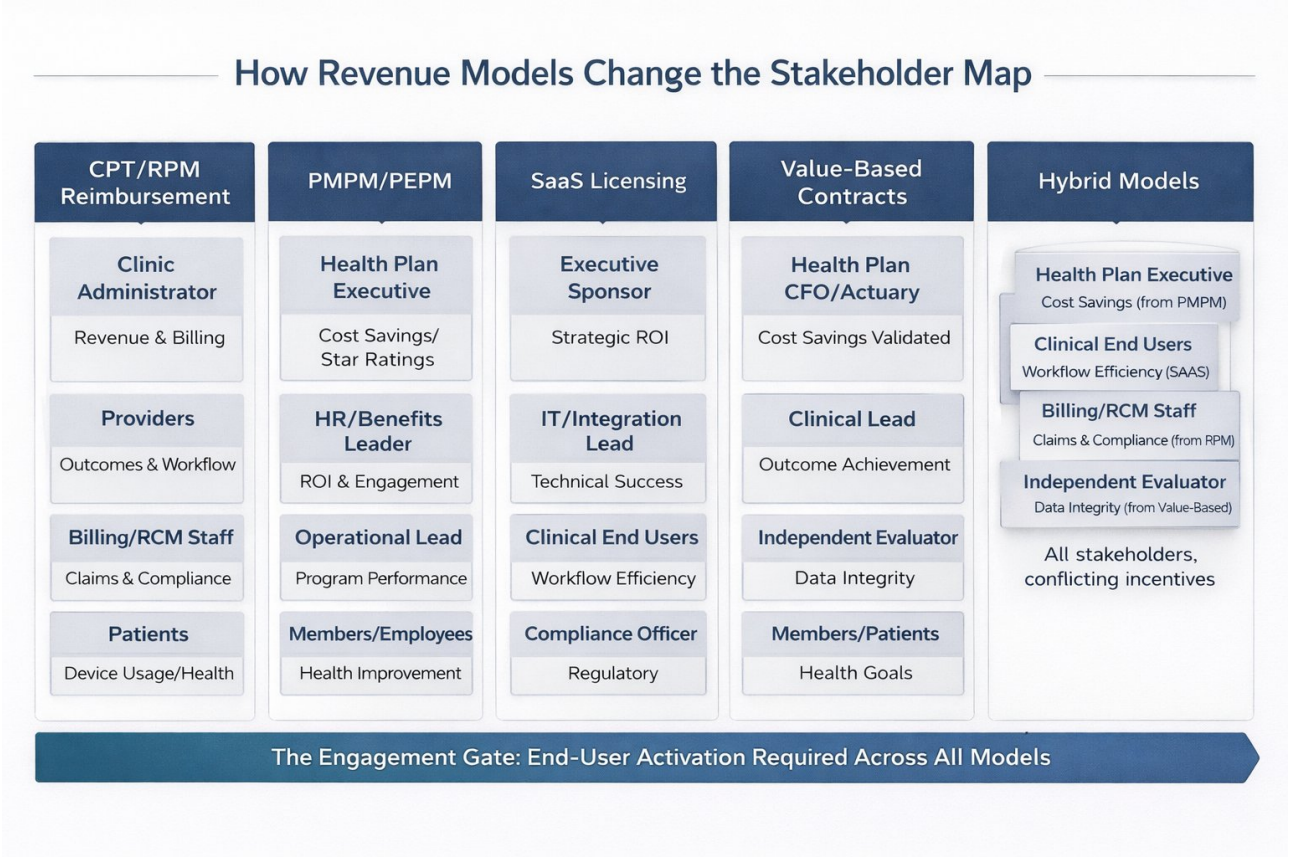
What's largely missing is anything that connects those layers together into a single operating model.

Most existing content treats stakeholder identification, value definition, revenue model mechanics, and metrics design as separate disciplines. There's excellent work across digital health commercialization, implementation science, value-based care operations, and healthcare SaaS strategy. But they rarely connect into a unified framework that a CS leader can use to map their company's revenue model to the specific stakeholders, value drivers, and KPIs that determine whether that model succeeds or fails. The entrepreneurship books treat the payment system as background context. The payment books stop at the provider level and never get to the vendor.

That means the people doing this work today, the CS leaders and account managers at digital health companies, are piecing it together on their own. They're combining frameworks from traditional SaaS with tribal knowledge about healthcare billing, layering in what they've learned from payer conversations and contract negotiations, and building something that works for their specific company without a shared model to reference.

This framework is an attempt to connect those disciplines into a single reference that practitioners can use. It starts with the five revenue models that digital health companies actually operate under, connects each one to the healthcare payment environment that makes it possible, and then shows why end-user engagement (what I call the Engagement Gate) is the prerequisite for value realization across all of them, regardless of which stakeholders you're serving or how your contracts are structured.

It's built from practitioner experience, not theory. Every model described here is one I've worked in, managed accounts around, or built CS programs to support. With that said, I've pressure-tested the framework with peers across the industry to make sure it holds beyond my own experience.



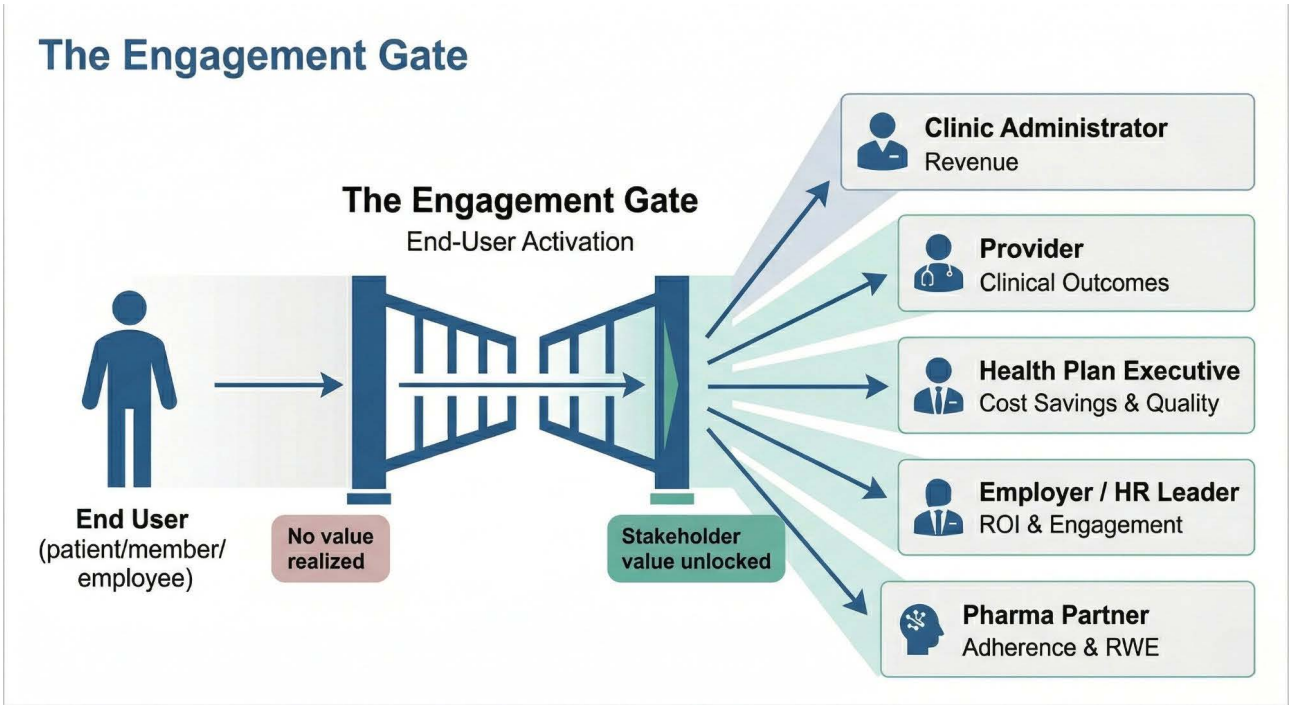
The Value Orientation: Generating Revenue or Reducing Costs

Before diving into how each revenue model works mechanically, it's worth naming the strategic orientation that sits underneath every value conversation in digital health: is this program generating revenue for the customer, or reducing their costs? Most CS leaders know the answer intuitively for their product. Where it gets missed is recognizing that the same product can shift between orientations depending on the buyer's payment environment, and that the shift changes everything downstream: which stakeholders hold budget authority, what metrics belong in your QBR, and how your champion sells the renewal internally.

An RPM program in a fee-for-service practice is generating new revenue the organization didn't have before. The same RPM program in a capitated Medicare Advantage plan is a cost-avoidance tool. The product is identical. The value story is completely different, and a CS leader who walks into both accounts with the same deck will lose credibility with one of them.

Each revenue model in this framework can sit on one or both sides of this line, depending on the buyer's payment environment and, in some cases, depending on which stakeholder you're addressing within the same account. The model-by-model sections that follow will call out where and why that shift happens. But the principle is worth naming up front: if you haven't identified whether this specific buyer experiences your program as generating revenue or reducing costs, you're building a value narrative on assumptions rather than on their financial reality.

The Engagement Gate: Why Nothing in This Framework Matters Without It



Every revenue model in digital health, no matter how well structured, depends on a single prerequisite: the end user has to actually use the product.

This sounds obvious. It isn't. In traditional SaaS, the end user is an employee who's been told to use the software. Their boss bought it, IT installed it, and there's an implicit expectation that they'll log in and do their job. Activation is a training problem, not an existential one.

In digital health, the end user is usually a patient or health plan member who never asked for your product in the first place. Their doctor mentioned it, or their health plan sent an email, or their employer added it to a benefits portal they rarely visit. There's no boss telling them to use it. There's no workflow requiring it. The decision to engage is entirely voluntary, and the default is to ignore it.

This is the Engagement Gate. It's the threshold that must be crossed before any stakeholder in the digital health ecosystem sees value. But it's important to recognize that the gate is not a single event. Crossing it requires two distinct phases: activation (getting the user to engage in the first place, typically a day 0-30 challenge) and adherence (keeping them engaged over time, a day 30-365 challenge). The CS plays for these two phases are entirely different. Activation is a marketing and behavioral design problem: personas, channel strategy, campaign development. Adherence is a clinical and product design problem: habit formation, value reinforcement, friction reduction. A patient who downloads an RPM app and uses the device for 30 days but quits at day 45 crossed the activation gate but failed the adherence gate. In models like VBC and RPM, where outcomes and sustained usage drive revenue, that distinction is the difference

between short-term billing success and long-term contract failure. The clinic administrator can't see CPT reimbursement revenue if patients aren't using the device. The health plan executive can't see cost savings if members aren't enrolling in the program. The employer can't see reduced absenteeism if employees never download the app. The pharma partner can't see adherence data if patients aren't using the companion tool. Every value driver mapped in this framework, for every stakeholder, traces back to whether someone at the end of the chain opened the app, used the device, or completed the enrollment.

What makes this gate so hard to open is well understood by anyone working in this space: users who didn't choose the product, zero tolerance for friction in the first experience, real access barriers across populations, trust that must be earned before engagement begins, and outreach that must respect boundaries around personal health information. These aren't theoretical challenges. They're the daily operating reality that makes digital health activation fundamentally different from SaaS onboarding, and they compound differently depending on the population being served.

This is what makes customer success in digital health fundamentally different from traditional SaaS, and why the function itself needs to be understood differently. In most SaaS companies, CS is a post-sale function: onboard the customer, drive adoption, manage renewals. In digital health, the CS function has to hold adoption, economics, clinical outcomes, and evidence together simultaneously. It's a commercialization discipline, not a post-sale discipline. The responsibilities described throughout this framework, from activation campaign design to billing workflow optimization to actuarial partnership on outcomes measurement, rarely sit cleanly in one traditional function. High-performing digital health companies either expand CS scope to include these capabilities or tightly integrate CS with clinical, product, analytics, and finance teams. The companies that try to run digital health CS with a traditional SaaS org chart will consistently underperform, not because their people lack talent, but because the structure doesn't match the complexity.

This is why end-user activation in digital health is not a CS problem in the traditional sense. It's a marketing and behavioral design problem that lives inside the CS function. It requires the same skills a marketer uses: personas, channel strategy, A/B testing, empathy mapping, and multichannel campaign development. But it must be executed within the CS framework, tied directly to client outcomes and contract performance.

One more nuance worth naming: while this section focuses on end-user engagement because that's the most common and most difficult gate in B2B2C digital health, the gating event shifts depending on the revenue model. In RPM, the gate is a combination of patient device usage and provider billing compliance. In SaaS licensing where the end user is a clinician or care manager, the gate is workflow adoption and change management, not patient behavior. In VBC, the gate includes enrollment volume sufficient to produce statistically meaningful outcomes. The Engagement Gate is the unifying concept, but the specific behavior that must change, and who must change it, varies by model. The model-by-model sections that follow will make these distinctions explicit.

Every model shares this same foundation. If the Engagement Gate isn't opened, nothing else in this framework works.

Revenue Model 1: CPT Code / Remote Patient Monitoring (RPM) Reimbursement

How It Works

Revenue is generated through CPT billing codes tied to remote patient monitoring services. Healthcare organizations enroll eligible patients, provide connected devices that transmit physiologic data, and bill payers for qualifying services. While RPM was originally designed around ongoing chronic disease management (diabetes, heart failure, COPD, hypertension), the current code structure also supports short-duration acute and transitional monitoring, including post-discharge monitoring to prevent hospital readmissions.

The current code structure, updated by CMS in 2026, provides two tiers of device supply and data transmission billing. CPT code 99445 covers 2 to 15 days of device data transmission in a 30-day period, while CPT code 99454 covers 16 to 30 days. Both codes are reimbursed at the same rate. For clinical staff management, CPT code 99470 covers 10 to 19 minutes of qualifying interaction per month, while CPT codes 99457 and 99458 cover 20-minute increments. Initial device setup and patient education are billed under 99453 as a one-time charge.

The 2026 CMS changes are worth noting because many practitioners learned RPM billing under the prior structure, which required a minimum of 16 days of device usage and 20 minutes of clinical interaction before any reimbursement was possible. The current structure eliminates that all-or-nothing threshold, allowing organizations to bill for shorter monitoring periods and briefer clinical interactions. This has meaningful implications for CS strategy, which are addressed throughout this section.

The digital health company's revenue may come from a platform license or per-patient fee charged to the healthcare organization, or through a revenue share on the CPT reimbursements the organization collects. In a revenue share model, the digital health company's revenue is directly tied to billing volume, making CS responsible not just for platform adoption but for maximizing patient enrollment, usage threshold compliance, and billing capture.

Why the Engagement Gate Matters Here

This is the model where end-user engagement has the most direct, immediate impact on revenue. Unlike every other model in this framework, the revenue impact isn't a lagging indicator you nervously review at a renewal meeting 12 months out. It's instantaneous. Every month, every patient either generates a billable event or doesn't, and the revenue either flows or it doesn't.

Because the 2026 code structure reimburses equally for 2-15 days and 16-30 days of device usage, the financial threshold for billing has dropped significantly. A patient who uses their device 5 days in a month now generates the same reimbursement as a patient who uses it 25 days. This means the short-term revenue signal and the clinical value signal have decoupled. Revenue can look healthy even when engagement is minimal.

This creates a trap that CS leaders must recognize. In RPM under the current structure, low-threshold billing can mask clinically insufficient engagement. The billing looks fine at 5 days of usage. But the clinical data generated from 5 days is far less actionable than 25 days. The clinical outcomes that justify program renewal, expansion, and advocacy require sustained, meaningful engagement, not just enough device usage to trigger a billing code.

The revenue pressure on CS therefore shifts from maximizing device days to protect billing to maximizing device days to protect clinical outcomes that justify renewal. If clinical staff don't document qualifying interactions, they cannot bill 99457, 99458, or the shorter-duration 99470. CS isn't just supporting revenue in this model. CS is the revenue engine. But the engine now runs on two fuels: billing compliance (which has gotten easier) and clinical outcome delivery (which hasn't).

Stakeholder Value Drivers and KPIs

Stakeholder	What They Care About	Value Drivers	KPIs
Clinic Administrators / Practice Managers	Revenue impact and financial return on program investment	CPT reimbursement flowing; claims processed and paid; revenue generated vs. collected; minimal claim denials	Revenue per enrolled patient; CPT claims submitted vs. paid; denial rate and denial aging; eligible patients enrolled (%)
Providers (MDs, PAs, NPs, Nurses)	Patient adherence, clinical outcomes, minimal workflow disruption	Improved patient outcomes; low workflow friction; visibility into patient adherence	Avg. time to clinical target; patient adherence rate (days active/30); provider login frequency; prescription/enrollment rate per provider
Billing / RCM Staff	Billing accuracy, clean claims, documentation compliance	Pre-built charge capture workflows; denial rate minimization; accurate documentation trail; correct code selection between short-duration and standard codes	First-pass claims acceptance rate; charge lag time (days between service and claim submission); days in A/R for RPM claims; code selection accuracy (99445 vs. 99454)
Patients / Members	Feeling better, simplified condition management, easy experience	Tangible health improvement; simple daily routine; responsive support	Device usage rate (days/month); patient-reported outcomes; 30/60/90-day retention rate; support ticket volume
CS Team (Internal)	Portfolio health, revenue protection, scalable operations	Proactive account visibility; early warning on at-risk accounts; engagement depth beyond billing thresholds	Customer health score; net revenue retention; time-to-value (onboarding to first claim); billable utilization rate; avg. device days per patient (not just billing eligibility rate)

A note on KPIs in digital health: In many cases, CS teams can't access the direct outcome data that proves value to stakeholders. Claims data lives with the payer. Clinical outcome trends live in the EHR. Cost savings calculations require actuarial analysis the vendor doesn't control. This means CS must build signal systems using proxy KPIs: metrics that are accessible to the CS team and correlate with the outcomes stakeholders care about. A drop in device usage days this month predicts lost billing revenue next month. A decline in provider login frequency predicts a drop in documented interactions, which predicts unbillable patients. The KPIs in the table above include both direct outcome metrics and the proxy signals CS teams can actually track day to day. The distinction matters because in digital health, the metrics you can see are often two steps removed from the result your stakeholder cares about.

A note on engagement depth vs. billing eligibility: Under the current code structure, it is tempting for CS teams to track "percentage of patients who met billing threshold" as a primary KPI. Because the threshold is now as low as 2 days, this metric will trend toward 100% without reflecting whether patients are actually engaging enough to produce meaningful clinical data. CS teams should track average device days per patient as the primary engagement metric, with billing eligibility rate as a secondary financial metric. The gap between the two tells you how much of your patient panel is generating revenue without generating clinical value, which is your leading indicator of renewal risk.

How the Buyer's Payment Environment Shifts the Value Story

At its core, the RPM model sits on the "generating revenue" side for most buyers: provider organizations are creating new reimbursement revenue they wouldn't have without the program. But that orientation flips entirely when the buyer operates under capitation.

The stakeholder table above assumes the most common RPM context: provider organizations billing Medicare. But the buyer's upstream reimbursement environment changes the value conversation significantly.

When the buyer operates under **fee-for-service Medicare,** the 2026 code changes make the financial case for RPM programs stronger and easier to demonstrate. The lower threshold means fewer patients fall into the "no revenue generated" category, which improves the program's overall financial return during ramp-up periods when engagement is still building. However, CS teams must resist the temptation to present billing volume as proof of program success. The QBR conversation should still center on clinical outcomes and engagement depth, with billing metrics as supporting evidence of financial sustainability.

When the buyer operates under **Medicare Advantage (capitated)**, RPM shifts from a revenue generator to a cost-avoidance tool. The MA plan receives fixed payments from CMS and is at risk for total cost of care. The QBR conversation moves from "how much revenue did we generate from CPT codes" to "how many ER visits and hospital readmissions did we prevent, and how is our quality performance affecting Star Ratings." Star Ratings matter because they directly affect CMS bonus payments, which means even under capitation, RPM has a revenue-generating component through quality measure improvement.

Hospital readmission reduction is one of the most financially compelling RPM use cases under capitation, and the 2026 code changes make it significantly more practical. CMS penalizes hospitals for excessive 30-day readmissions across conditions including heart failure, pneumonia, COPD, and hip/knee

replacement through the Hospital Readmissions Reduction Program. A patient discharged after a heart failure episode who is monitored via RPM for 7-10 days post-discharge can generate the same billing as a chronic patient monitored for 25 days, while also helping the organization avoid a readmission that could cost $15,000 or more and trigger CMS penalties. For CS teams, this means the value story for MA buyers should explicitly include readmission prevention as a quantifiable outcome, with tracked metrics like 30-day readmission rates for monitored versus unmonitored patients.

The 2026 code changes have a particularly significant strategic implication for MA buyers beyond readmission reduction. The lower monitoring threshold makes it financially viable to extend RPM into other acute and transitional care episodes: medication titration, temporary condition flare-ups, post-surgical recovery for procedures beyond the readmission penalty list. This expands the eligible patient population considerably. CS teams can now help MA buyers build a broader enrollment case: "which patients across chronic, acute, and transitional care would benefit from monitoring?" rather than limiting enrollment conversations to patients with ongoing chronic conditions. A broader monitored population strengthens the cost-avoidance case at renewal because more clinical interventions can be documented and attributed to the program.

When the buyer is part of an **ACO shared savings arrangement**, the primary success metric becomes total cost of care reduction for attributed patients. The ability to do targeted, short-duration monitoring around high-risk episodes (hospital discharge, medication changes) without committing to 30-day chronic monitoring creates a new lever for reducing total cost of care. Post-discharge readmission prevention is especially valuable here: readmissions are one of the largest drivers of total cost of care for attributed patients, and short-duration RPM monitoring during the critical 7-14 day post-discharge window directly targets the highest-cost events. CS can build a case for episodic RPM layered on top of chronic RPM, which wasn't financially viable under the prior threshold structure. CS must understand attribution rules and help target enrollment toward high-risk patients who represent the greatest cost-savings potential. QBRs require longer lookback periods (12-18 months) to demonstrate savings.

Real-World Example

At one digital therapeutics company operating entirely on a revenue share model, a large account had enrolled 200+ patients and showed strong early adoption. But revenue was running 40% below projections. The investigation revealed that patients were using the app consistently and the device data transmission codes were being billed successfully. The gap was in the provider interaction codes: clinicians were reviewing patient data and making clinical decisions, but they weren't documenting the qualifying interactions required to bill for management services. The billing department didn't realize those codes were available to them. After creating documentation templates, training providers on the revenue impact of their time, and working with the EHR administrator to add workflow shortcuts, revenue increased 65% within two months with the same patient panel. The clinic administrator became an active advocate, and the account expanded to additional locations.

Under the current code structure, this type of revenue leakage becomes both easier to prevent (because shorter interactions are now billable through 99470) and harder to detect (because the lower device threshold means billing looks healthier even when provider interaction codes are being missed). CS teams must monitor both device transmission billing and clinical management billing separately rather than treating "total RPM revenue" as a single metric.

The lesson: CS in RPM models isn't about software adoption metrics. It's about understanding billing requirements, identifying where revenue is being left on the table, and removing friction in the workflows that enable compliant billing. Under the 2026 code structure, it's also about recognizing that billing success alone no longer signals clinical success. The most dangerous accounts are the ones where billing looks healthy, engagement is shallow, and the clinical outcomes that justify renewal aren't materializing. When revenue metrics decouple from engagement and outcomes, the renewal is at risk long before anyone sees it coming.

Looking Ahead: The CMS ACCESS Model

CMS's ACCESS model (Advancing Chronic Care with Effective, Scalable Solutions), launching July 2026, signals where the payment landscape is heading. ACCESS introduces outcome-aligned payments for technology-enabled chronic care management, essentially combining RPM-style infrastructure with VBC-style payment logic. Organizations already running RPM programs are well positioned for ACCESS because the digital infrastructure and clinical workflows overlap significantly.

For CS leaders, ACCESS reinforces the framework's core argument: the same product and the same patient population can sit under fundamentally different payment structures, and the CS motion must adapt accordingly. An organization managing hypertensive patients through RPM today under fee-for-service billing codes may transition those same patients into ACCESS's outcome-aligned payments tomorrow. The stakeholders don't change. The engagement requirements don't change. But the value story, the measurement burden, and the financial risk profile shift dramatically.

ACCESS is too new to assess operationally, but it's worth watching as an early signal of how CMS intends to connect technology-enabled care delivery to outcomes-based payment at scale.

Revenue Model 2: Per Member / Per Employee Per Month (PMPM / PEPM)

How It Works

The digital health company charges a recurring flat fee per eligible member (health plan contracts) or per eligible employee (employer contracts), independent of actual platform usage or engagement. Revenue is predictable and tied to population size, not utilization.

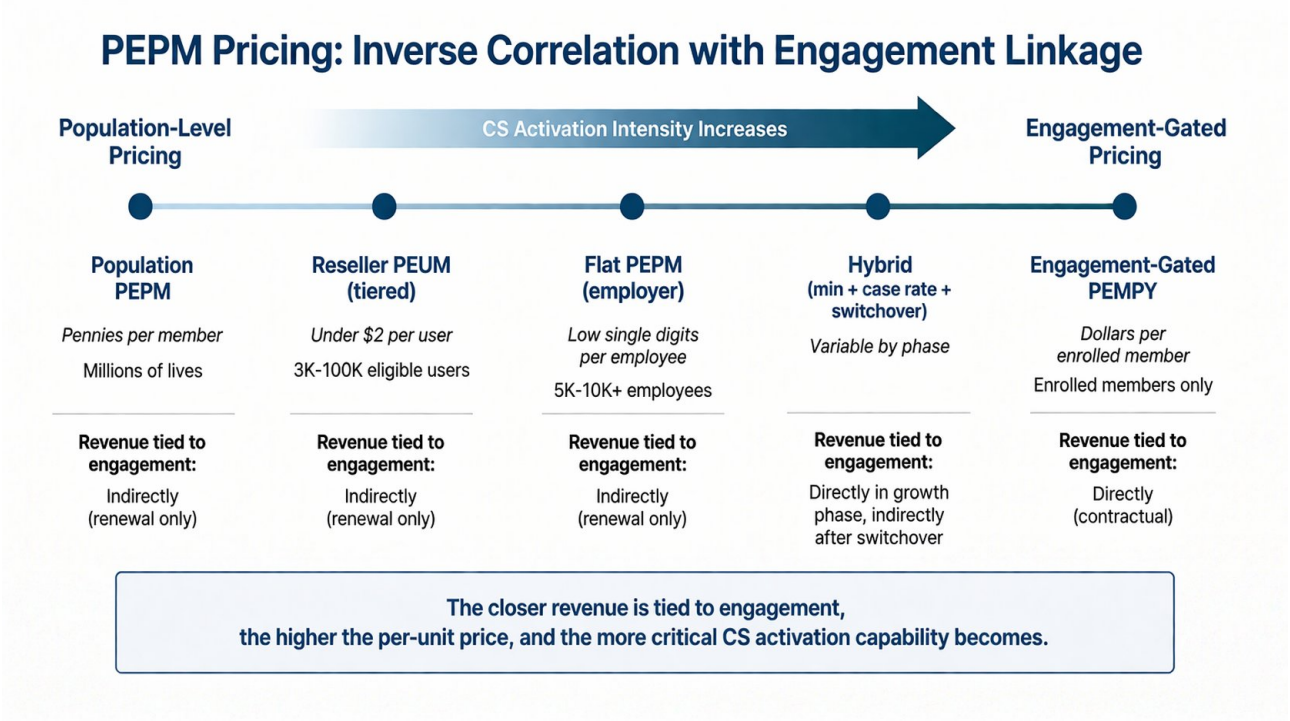
Contract structures vary significantly across the market. At the population level, a national payer might pay pennies per member per month across millions of covered lives. At the employer level, a self-insured company typically pays low single-digit dollars per eligible employee per month. The pricing correlates with population size: the larger the eligible pool, the lower the per-unit rate.

The Enrollment-Based Variant

Increasingly, buyers are pushing for contracts where they pay only for members who actually enroll or meet defined engagement thresholds, not the full eligible population. This variant fundamentally changes the CS operating model even though the external stakeholders and their value drivers remain largely the same.

Under traditional PMPM, the CS team allocates roughly 70% of resources toward retention and outcomes and 30% toward activation. Under enrollment-based pricing, that ratio inverts. Activation becomes the primary revenue driver because every member who doesn't enroll is revenue that never materializes. CS must build capabilities that look more like B2C growth marketing: multichannel outreach sequences, enrollment funnel optimization, incentive design, and A/B testing. This is the model where the marketing-inside-CS skillset becomes most critical.

The per-member price across these variants tells a revealing story. At the population-health end, where the vendor serves millions of lives at pennies per member, revenue floats independent of engagement until renewal. At the engagement-gated end, where the vendor is paid dollars per enrolled member, revenue is directly and contractually tied to user behavior. This spectrum is the financial expression of the Engagement Gate: the closer revenue is tied to engagement, the higher the per-unit price, and the more critical CS activation capability becomes.



Why the Engagement Gate Matters Here: The Guaranteed Revenue Trap

PMPM is the model most susceptible to CS complacency. Because the buyer pays regardless of whether members use the platform, there's a dangerous tendency to treat engagement as a nice-to-have rather than a must-have. The monthly invoice arrives on time. The revenue looks healthy. Everyone relaxes.

This is a trap. The revenue is guaranteed today, but the renewal is not. When the contract comes up for review 24 to 36 months later, the buyer's executive sponsor has to justify the spend to their CFO. If engagement is sitting at a fraction of the eligible population with no demonstrable outcomes, the program looks like an expensive line item that produced nothing. The contract doesn't renew, and the loss feels sudden even though the warning signs were visible for two years.

Stakeholder Value Drivers and KPIs

Stakeholder	What They Care About	Value Drivers	KPIs
Health Plan Executive Sponsor (VP Clinical Programs, CMO)	ROI demonstration, member outcomes, strategic differentiation	Cost avoidance for engaged members; quality measure improvement (HEDIS/Star Ratings); member retention; board-ready impact narrative	Total cost of care (TCOC) per engaged member vs. matched control; HEDIS measure lift; member retention rate (engaged vs. non-engaged); Star Ratings contribution
Health Plan Operational Lead (Director of Care Management)	Program performance, operational smoothness, internal credibility	Member engagement rate meeting targets; integration stability; internal stakeholder satisfaction	Member engagement rate (active users / eligible population); 30-day member retention; integration uptime; QBR executive sponsor attendance
Employer HR / Benefits Leader	ROI on benefits spend, employee engagement, reduced absenteeism	Demonstrable engagement rates; measurable health impact; competitive benefits positioning; minimal administrative burden	Employee enrollment rate; biometric improvement trends; healthcare cost trend vs. benchmark; absenteeism metrics; HR hours per month managing vendor
Members / Employees	Ease of access, personalized support, feeling healthier	Accessible low-friction experience; relevant content; tangible personal improvement; trust in privacy	Time to first engagement; session frequency; program completion rate; self-reported outcomes; NPS
CS Team (Internal)	Renewal readiness, activation performance, expansion signals	Strong engagement narrative for QBRs; scalable activation playbooks; proactive risk detection	Customer health score; NRR and GRR; time-to-value (contract to first activation wave); renewal forecast accuracy

How the Buyer's Payment Environment Shifts the Value Story

PMPM and PEPM contracts typically sit on the "reducing costs" side. The buyer is investing in a population health tool with the expectation that it will reduce downstream healthcare costs, improve quality metrics, or both. The value narrative is cost avoidance, not revenue generation, which means CS must build a savings story that often requires data the vendor doesn't directly control.

When the buyer is a **Medicare Advantage plan**, ROI scrutiny intensifies. MA plans receive capitated payments from CMS, so every dollar spent on a PMPM digital health program must be justified by cost savings or quality measure improvements that drive Star Ratings. The QBR conversation centers on total cost of care reduction for engaged members and HEDIS measure performance. CS must secure access to claims data (often with a 6-12 month lag) and build credible cost-savings analyses, which frequently requires partnering with the plan's actuarial team or an external evaluator.

When the buyer is a **Medicaid managed care plan**, the challenges shift dramatically. Member populations face real access barriers: lower digital literacy, limited device access, language barriers, and social determinants of health that affect every aspect of engagement. State-mandated quality measures drive the plan's priorities, and health equity metrics are increasingly required. Engagement benchmarks must be calibrated to the product type and the population being served. What looks like underperformance against

a generic industry benchmark may actually represent strong results given the barriers involved. CS teams that don't educate their buyers on this context risk having solid performance perceived as failure. Adaptation is essential: SMS-first engagement strategies, multi-language support, and partnerships with community-based organizations often outperform standard digital outreach with these populations.

When the buyer is a **self-insured employer**, the value conversation becomes a CFO conversation. Healthcare cost trend must improve measurably. Employee engagement must be visible enough that leadership perceives the benefit as worthwhile. And the HR team, which is typically lean, needs the vendor to minimize administrative burden. CS must speak financial language: ROI, cost trend, productivity gains, and competitive benefits positioning.

Real-World Example

At one enterprise behavioral health platform managing a portfolio of Fortune 500 employer clients, the CS team faced a common pattern: contracts were structured as flat PEPM, the invoices paid on time every month, and engagement hovered around 12-15% of eligible employees. The accounts looked healthy by revenue metrics. But when renewal conversations approached, the buyers consistently asked the same question: "What outcomes have we achieved?" The CS team had engagement data but no outcomes story.

The fix required two shifts. First, building a multichannel activation approach using personas, A/B-tested campaigns, and plug-and-play toolkits that empowered clients to drive their own engagement through manager communications, Slack channels, intranet placements, and targeted email sequences. This pushed activation rates significantly higher across the portfolio, with one client reaching 80%. Second, connecting that engagement to measurable outcomes that mattered to each buyer's specific context, whether that was reduced time-to-value, employee satisfaction scores, or utilization data that supported the benefits team's internal reporting.

The result was 100% net revenue retention and 95% client retention across a $6.2M book of business, because the renewal conversation shifted from "why are we paying for this?" to "how do we expand this to more populations?"

Revenue Model 3: SaaS Platform Licensing

How It Works

The digital health company sells software platform access on a subscription basis to healthcare organizations, health systems, or payers. This is the model closest to traditional B2B SaaS, but with healthcare-specific complexity layered on top. Contract structures include per-user licensing (per named clinician or care manager), entity-based licensing (flat annual fee for enterprise access), and module-based licensing (base platform plus add-on capabilities that enable land-and-expand over time).

Payment is typically annual or multi-year, with implementation and onboarding fees charged separately. Auto-renewal clauses are common. The revenue is predictable and recurring, but vulnerable to the same forces that drive SaaS churn anywhere: low adoption, competing priorities, and failure to demonstrate ROI. What makes healthcare different is the depth of implementation complexity and the number of stakeholders who must see value simultaneously.

Why the Engagement Gate Matters Here

In SaaS licensing, the "end user" is typically a clinician, care manager, or operational staff member rather than a patient. But the Engagement Gate still applies. If care managers don't adopt the platform as their primary workflow tool, the organization is paying for shelf-ware. If providers find the system adds friction rather than reducing it, they'll revert to spreadsheets and homegrown tools. And in B2B2C configurations where the platform has a patient-facing component, the patient engagement challenge from Models 1 and 2 layers on top of the clinical adoption challenge.

The unique difficulty in healthcare SaaS is that implementation timelines are significantly longer than traditional SaaS. EHR integration can take months. Compliance reviews add weeks. Clinical workflow configuration requires change management that most healthcare organizations struggle with. And the end users (clinicians) are the most time-constrained professionals in any industry. Every additional click, every separate login, every workflow disruption is a reason to stop using the platform.

Stakeholder Value Drivers and KPIs

Stakeholder	What They Care About	Value Drivers	KPIs
Executive Sponsor (CMIO, VP Population Health, VP Care Management)	Strategic ROI, organizational impact, internal credibility	Demonstrable impact on quality measures, cost per patient, or care manager productivity; platform adoption across licensed users; executive-ready impact narrative	ROI (quantified value vs. annual investment); user adoption rate (% of licensed users active weekly); feature utilization breadth; contract expansion
IT / Integration Lead	Technical success, security compliance, minimal ongoing burden	Seamless EHR integration; SSO authentication; HIPAA/HITRUST certification; minimal maintenance post-launch	EHR integration uptime; data sync accuracy; security audit pass rate; monthly IT maintenance hours
Clinical End Users (Care Managers, RNs, MDs)	Workflow efficiency, ease of use, time savings	Reduced administrative burden; intuitive interface; clinically relevant functionality	Daily/weekly active users; time saved per patient encounter; user satisfaction scores; training completion rate
Compliance / Privacy Officer	Regulatory compliance, risk mitigation, audit readiness	Complete BAA and audit trail; appropriate access controls; vendor security certifications current	Security incidents (target: zero); audit findings; access control review compliance
CS Team (Internal)	Logo retention, ARR growth, adoption health	Strong adoption across user base; multi-threaded stakeholder relationships; efficient onboarding	Logo retention rate; NRR; time to go-live; user adoption rate; expansion pipeline

How the Buyer's Payment Environment Shifts the Value Story

SaaS licensing can sit on either side depending on what the platform enables. A care management platform that improves operational efficiency is reducing costs through productivity gains. A platform that enables new billable services (CCM, TCM codes) is generating revenue the organization couldn't capture before. CS must identify which orientation applies to each account, because the ROI calculation and the stakeholders who control renewal authority are different in each case.

When the buyer is a **health system operating under MA capitation or ACO shared savings**, the platform must prove it reduces downstream healthcare costs, not just improves operational efficiency. Risk stratification capabilities, care gap closure tracking, and population health analytics become the features that drive renewal. The QBR conversation centers on total cost of care for managed patients and quality measure performance, not just platform usage metrics. Care manager productivity (patients managed per care manager with the platform vs. without) becomes a critical efficiency metric because it directly affects the organization's cost structure.

When the buyer is a **health system or provider organization operating fee-for-service**, the value conversation is more straightforward: does the platform help clinicians work more efficiently and does it support billable activities? If the platform enables care management billing (CCM, TCM codes), the ROI case includes revenue generated through the platform, not just cost savings. EHR integration depth matters enormously here because providers won't toggle between systems when they're already

documentation-heavy.

A Note on Pharma as Buyer

A distinct buyer context for SaaS platforms is pharmaceutical companies. When pharma is the buyer, the stakeholder map shifts entirely. Medical affairs, commercial/brand teams, market access, and R&D replace the health system stakeholders above. The digital health platform becomes a drug companion rather than a standalone care tool, and value is measured indirectly through drug adherence improvement, real-world evidence generation, and prescriber engagement rather than operational efficiency or cost reduction. This buyer context deserves deeper treatment than a single section can provide, but the core dynamics still apply: the Engagement Gate governs whether any of that indirect value materializes.

Real-World Example

The most common CS failure in healthcare SaaS is not a dramatic account loss. It's a slow erosion of adoption that becomes visible only at renewal. A platform launches successfully after a six-month implementation. Training sessions are completed. Early usage looks promising. But three months later, only 35% of licensed users are logging in weekly. Care managers have reverted to their old spreadsheets because the EHR integration requires them to copy and paste data between systems. The operational lead is satisfied because the few active users like the platform. But the executive sponsor hasn't been engaged in nine months and has no visibility into the platform's impact. When renewal approaches, procurement runs a cost-cutting exercise and the contract is reduced by 40%.

The root cause is almost always the same: insufficient EHR integration depth creating workflow friction, combined with CS over-investing in the operational relationship and under-investing in the executive sponsor relationship. The platform worked for the people who used it. But not enough people used it, and the person who controlled the budget didn't know the value it delivered.

The fix requires catching the erosion early enough to reverse it. CS teams should set adoption thresholds that trigger escalation, for example, if weekly active users drop below 50% of licensed seats by month three, that's not a usage dip, it's a structural problem that needs a different response than another training session. Separately, the executive sponsor needs a regular cadence that's distinct from the operational relationship, focused not on platform features but on the strategic metrics they care about: cost per patient, quality measure movement, care manager capacity. And the CS team needs to build a usage-to-value bridge that translates platform activity into the language the budget holder uses. "35% weekly active users" means nothing to a CFO. "Care managers using the platform are closing 40% more care gaps per week than those who aren't" gives them a reason to protect the contract.

Revenue Model 4: Value-Based / Outcomes-Based Contracts

How It Works

Revenue is tied partially or fully to achieving predefined clinical, engagement, or cost outcomes. The digital health company and the buyer (usually a health plan, ACO, or risk-bearing entity) agree on specific targets before the program launches. If the targets are met, the company earns the full contract value or a performance bonus. If targets are missed, revenue is reduced or the company absorbs financial risk.

Common structures include shared savings arrangements (vendor receives a percentage of cost savings achieved), outcomes-based performance tiers (base fee plus bonus tied to hitting clinical targets at bronze/silver/gold levels), pay-for-performance (payment mostly or entirely contingent on outcomes), and risk corridors where both upside and downside are shared within defined limits.

Contract terms are typically longer (3-5 years) because outcome measurement requires time: 12-18 months for clinical outcomes, 18-24 months for cost outcomes with claims runout. Performance payments are often not realized until well after the program has been operating, creating significant cash flow lag for the vendor.

Why the Engagement Gate Matters Here

This is the highest-stakes model in digital health, and it's where the Engagement Gate can be most devastating when it fails. Revenue is literally contingent on outcomes that CS influences: member enrollment, sustained engagement, clinical improvement, and cost reduction. If members don't enroll in sufficient numbers, the sample size may be too small to demonstrate statistically significant outcomes, even if the members who did participate got healthier. An $800K performance payment denied because 1,200 members enrolled out of 10,000 eligible isn't a CS failure in the traditional sense. It's a mathematical failure caused by insufficient activation.

This model also has no revenue floor in its purest forms. In RPM, even poor engagement produces some billable patients. In PMPM, the buyer pays regardless of engagement. In VBC, the performance payment can be zero. This creates existential pressure on CS teams and on the company's financial health if multiple VBC contracts underperform simultaneously.

What CS Must Become in This Model

Traditional CS skills (relationship management, QBRs, health scoring) are necessary but nowhere near sufficient. VBC demands that CS teams become what might be called outcome scientists: professionals who combine clinical program expertise, data analytics, health economics, and population health management into a single function. The CS leader must understand actuarial concepts like risk adjustment, be able to interpret claims data trends, and detect negative clinical trajectories months before the measurement period ends, because by that point it's too late to course-correct.

CS must also be deeply involved in the contracting phase, before the program launches. If sales commits to outcome targets without CS input (a common failure), the team inherits goals that may be clinically unrealistic. A contract that promises 70% of engaged members will achieve a specific clinical target when the national benchmark for that population is 35-40% sets CS up to deliver exceptional results and still "fail" contractually.

The risk adjustment trap is equally dangerous. Risk adjustment is the mechanism that accounts for changes in population health status over the measurement period. If a factory closes in the community and thousands of members lose secondary insurance and experience increased stress, the population becomes inherently sicker due to factors the digital health program didn't cause and can't control. Without proper risk adjustment, the vendor appears to have failed (costs went up) when they actually prevented costs from rising even further. The critical CS action happens during contract design, not during measurement: the risk adjustment methodology, the data sources, the baseline calculation approach, and the dispute resolution process must all be defined precisely before the ink is dry. A vague reference to "risk-adjusted outcomes" in a contract creates a dispute. A precisely defined methodology creates accountability for both sides. CS leaders who don't insist on this specificity during contracting are gambling millions of dollars on a handshake.

Stakeholder Value Drivers and KPIs

Stakeholder	What They Care About	Value Drivers	KPIs
Health Plan CFO / Actuary	Demonstrated cost savings, financial risk management, credible measurement	Total cost of care (TCOC) reduction validated by independent analysis; risk protection with capped downside; transparent methodology	TCOC trend vs. benchmark; gross savings generated; ROI (savings vs. program cost); shared savings payment validated
Health Plan Clinical Lead (CMO, VP Clinical Programs)	Clinical outcome achievement, quality measure improvement, member safety	Clinical targets met per contract; HEDIS/Star Rating improvement; evidence-based interventions; zero adverse events	Clinical goal achievement rate (% of engaged members meeting targets); HEDIS measure lift; Star Ratings contribution; adverse event rate
Independent Evaluator / Third-Party Validator	Methodological rigor, data integrity, objectivity	Access to complete data; pre-specified analysis plan; appropriate statistical methods; unbiased assessment	Measurement completion timeliness; data completeness; stakeholder acceptance of findings
Members / Patients	Health improvement, care coordination, accessible support	Noticeable health gains; coordinated care experience; responsive personalized support	Clinical outcome achievement; program completion rate; engagement consistency; NPS
CS Team (Internal)	Performance payment capture, outcome target achievement, contract renewal	Live visibility into contract performance; ability to course-correct before settlement; cross-functional alignment with clinical and data teams	Performance payment realization (% of at-risk revenue earned); outcome target achievement rate; member engagement rate; measurement readiness score

How the Buyer's Payment Environment Shifts the Value Story

Value-based contracts sit firmly on the "reducing costs" side, but with a critical distinction: the savings must be proven, not assumed. Unlike PMPM, where the buyer pays regardless and evaluates savings at renewal, VBC contracts make the revenue contingent on demonstrated cost reduction or outcome achievement. This means CS isn't just telling a savings story. CS is building the evidentiary case that the savings actually occurred.

When the buyer is a **Medicare Advantage plan**, cost savings alone aren't sufficient. MA plans expect both cost reduction and quality measure improvement because Star Ratings directly affect CMS bonus payments. CS must build long-term outcome sustainability rather than short-term wins, and should proactively propose performance metrics tied to Star Ratings measures. Measurement periods tend to be longer (18-24 months), and the buyer's appetite for risk-sharing is typically higher because they're already operating in a full-risk environment.

When the buyer is a **Medicaid managed care plan**, state-mandated quality measures are non-negotiable. Outcomes contracts are often tied to these exact measures, and social determinants of health increasingly factor into the metrics. Engagement expectations must be adjusted for the population, and cost savings may be harder to demonstrate given Medicaid's lower baseline costs. CS teams that focus outcomes contracts on quality and engagement metrics rather than cost savings often have more success in this context.

Real-World Example

One of the most common and preventable failures in VBC happens when the CS team operates transparently on engagement and clinical metrics but fails to monitor the data infrastructure underneath the outcomes measurement. In one scenario described across multiple industry practitioners, a health plan's data warehouse migration midway through a measurement period caused a significant gap in claims data completeness. The CS team, focused on member engagement and clinical outcomes, didn't detect the data issue until the measurement period ended and the independent evaluator couldn't validate the cost savings calculation. The performance payment went into dispute for months.

The fix is straightforward but requires a mindset shift: CS must treat data quality monitoring as a core operational responsibility, not an IT problem. Monthly checks on claims data completeness, eligibility file accuracy, and risk score trending should be part of the CS operating rhythm from day one of a VBC contract. The CS leader who catches a drop in claims data completeness early can force a fix that preserves the mathematical integrity of the final evaluation. The one who discovers it at the end of the measurement period has no recourse.

Revenue Model 5: Hybrid Models

How It Works

Most digital health companies don't operate under a single pure revenue model. In practice, contracts combine elements from two or more of the models above. A health plan contract might include a PMPM base fee plus an outcomes-based performance bonus. A health system deal might bundle a SaaS platform license with CPT reimbursement revenue sharing. An employer contract might start with an annual minimum fee, transition to per-case pricing as adoption grows, and eventually convert to a full PEPM structure once engagement crosses a defined threshold.

These combinations exist because both sides are managing risk. The buyer wants accountability for results without paying entirely for unproven outcomes. The vendor wants a revenue floor to cover operational costs while pursuing upside tied to performance. The hybrid structure is the negotiated middle ground.

Why the Engagement Gate Matters Here

Hybrid models create the most complex Engagement Gate challenge because different revenue streams within the same contract may pull CS priorities in opposite directions. The PMPM base fee incentivizes broad enrollment across the full eligible population to demonstrate reach and justify the per-member spend. But the shared savings component incentivizes targeting the highest-risk, highest-cost members because that's where the cost reduction materializes. CS can't fully optimize for both simultaneously, and pretending otherwise leads to mediocre performance on both.

Common Hybrid Structures

Hybrid Structure	What Makes CS Complex	CS Priority
PMPM base + outcomes-based performance bonus	Must drive engagement (PMPM renewal) AND outcomes (bonus capture) simultaneously. Engagement is measured monthly, outcomes annually with lag.	Secure base revenue through acceptable engagement. Build outcome measurement from day one. Report trajectory transparently.
SaaS platform license + CPT reimbursement	Must manage platform adoption (SaaS) AND billing workflow optimization (RPM) for different stakeholder groups within the same account.	Implementation success first. Then shift to billing enablement. Track both subscription health and reimbursement revenue.
PMPM + shared savings	Long feedback loops: PMPM revenue monthly, shared savings calculated 18-24 months later. Requires claims data access the vendor often doesn't control.	Treat PMPM as operating revenue and shared savings as upside. Build actuarial partnership early. Communicate utilization wins throughout measurement period.
Annual minimum + case rate + PEPM switchover	CS operating mode shifts as adoption grows: activation-critical early (every new user generates case rate revenue), then retention-critical after switchover (revenue becomes population-based).	Drive hard toward switchover threshold in Phase 1. Shift to sustained engagement and expansion post-switchover. Understand the financial reconciliation mechanics.

The Principle That Governs All Hybrid Models

Regardless of the specific combination, one principle applies: protect the base revenue first, then pursue the performance upside. The base fee (PMPM, SaaS license, annual minimum) is what keeps the lights on. The performance component (outcomes bonus, shared savings, case rate) is where margin and growth live. A CS team that chases the performance upside at the expense of basic engagement and stakeholder satisfaction risks losing the entire contract when the base comes up for renewal.

When Revenue Streams Conflict: The Trade-Off Conversation

Hybrid models are where the generating-revenue-or-reducing-costs distinction becomes most operationally complex, because different revenue streams within the same contract may sit on opposite sides. The SaaS license component might be justified by operational efficiency (reducing costs), while the CPT reimbursement share is justified by new revenue (generating revenue), and the outcomes bonus is justified by cost avoidance (reducing costs). CS must hold all three value stories simultaneously and know which one to lead with depending on which stakeholder is in the room.

The hardest moment in a hybrid contract is when the two revenue streams create genuinely conflicting incentives. This is not a problem to solve internally and hope the client doesn't notice. It's a conversation to have explicitly with the buyer.

The CS leader sits down with the buyer's executive team and presents the trade-off directly: "We have a strategic choice to make about where to focus resources this year. We can pursue broad enrollment targeting 35-40% of the eligible population. This maximizes engagement visibility and strengthens the base contract renewal case, but it dilutes the shared savings potential because healthier members don't generate cost savings. Or we can target enrollment toward the highest-risk 15% of the population. This

maximizes shared savings potential but produces a lower headline engagement rate. Which strategic outcome matters more to your organization right now?"

This transparency accomplishes three things. It aligns the buyer and vendor on strategy rather than letting misaligned expectations fester until renewal. It makes the buyer a co-owner of the trade-off rather than a judge of the outcome. And it demonstrates strategic thinking that positions CS as a partner rather than a vendor managing a contract.

Real-World Example

At one enterprise wellbeing platform, a Fortune 500 employer contract was structured with three phases: an annual minimum fee covering the first several thousand users, a per-case rate for users above that threshold, and a PEPM switchover once adoption crossed a defined trigger point. The total contract value was projected at nearly $2M if adoption targets were met.

This structure required the CS team to operate in three distinct modes over the contract lifecycle. In the early phase, every new activated user generated incremental revenue above the minimum floor. CS operated like a growth marketing team: running activation campaigns, building co-branded assets, deploying manager toolkits, and optimizing the enrollment funnel. Once adoption crossed the switchover threshold, the revenue model flipped to population-based pricing. CS priorities shifted from "activate more users" to "demonstrate enough value across the population to justify the per-employee spend at renewal." The same team that was running A/B-tested email campaigns six months earlier was now building executive ROI narratives for the buyer's CFO.

The lesson from hybrid models is that CS must understand the financial mechanics of the contract deeply enough to know when and how their operating priorities should shift. A team that runs the same playbook from month one through renewal will underperform at every stage.

How to Use This Framework

This framework is a **starting point, not a checklist**. Every digital health company has its own nuances based on product, market, and customer base. Here's how to put it into practice.

Identify your revenue model. Most companies operate under one primary model with elements of others. Start with the model that represents the majority of your revenue, then layer in the complexity from secondary models. If you're operating a hybrid, map each revenue stream separately and understand where they create conflicting incentives.

Map your actual stakeholders. The stakeholder categories in this framework are archetypes. In your accounts, identify the specific people who fill these roles. What are their names, their communication preferences, and their individual definitions of success? The framework tells you what a clinic administrator generally cares about. Your job is to learn what your clinic administrator specifically cares about.

Validate value drivers with your customers. Don't assume. During onboarding and early business reviews, explicitly ask each stakeholder what success looks like for them. The value drivers listed here should match, but the priority order will differ by account and by the buyer's upstream payment environment.

Understand your buyer's payment environment. This is the step most CS teams skip entirely. Start with the fundamental orientation: is your program generating revenue for this specific buyer, or reducing their costs? As the model-by-model sections show, the answer can change depending on the buyer's payment structure, and it determines which value story you tell. The same revenue model plays differently depending on whether your buyer operates under Medicare Advantage capitation, Medicaid managed care, commercial insurance, or ACO shared savings. Ask the question early. It changes everything about how you position value in every conversation that follows.

Build your QBR around the value map. Structure your business reviews so that every stakeholder in the room sees their value reflected. Show the administrator the financial impact. Show the clinical lead the outcomes data. Show the executive sponsor the strategic ROI. The QBR should be the moment where the entire value story comes together, not a recitation of platform usage metrics.

Know what counts as believable proof for each stakeholder. Not all evidence carries equal weight with every audience. An HR benefits leader may accept engagement trends and employee satisfaction data. An actuary will want matched cohort controls and claims-validated savings. A CMO will want clinical outcome data with appropriate statistical rigor. A CFO will want a number with a dollar sign in front of it. The QBR that presents the same type of evidence to all three will convince none of them. Calibrate the proof to the stakeholder, and when you don't have the evidence a specific stakeholder needs, name the gap honestly rather than stretching weaker data to fill it.

Remember the Engagement Gate. Before optimizing any of the above, make sure the end users are actually engaging with the product. Every stakeholder value chain in this framework traces back to whether someone at the end of the chain opened the app, used the device, or completed the enrollment. If that gate isn't open, nothing else matters.

About the Author

Joe Travers has spent almost 20 years in digital health and healthcare technology, with the last decade focused on building customer success functions in complex healthcare environments. He's managed enterprise portfolios across Fortune 500 clients including Amazon, Cigna, and Microsoft, achieving 100% net revenue retention and 95% client retention. His background combines digital marketing leadership at companies like Boston Scientific and EMD Millipore with deep operational CS experience across multiple healthcare revenue models, from CPT code reimbursement to value-based care contracts to employer wellness programs.

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