



Uncovering Hidden Healthcare Revenue

Reducing Revenue Leakage Through
Continuous Eligibility Integrity and
Insurance Discovery

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Turning Missed Coverage into Recovered Revenue

How health systems are identifying and recovering overlooked reimbursement through stronger eligibility integrity practices.

Executive Summary

Health systems continue to face mounting financial pressures driven by labor shortages, reimbursement volatility, increasing denial activity, and rising operational costs. While many organizations focus on new revenue opportunities or cost reduction strategies, a significant source of financial gain remains unaddressed within their existing operations. A meaningful portion of revenue loss is tied to incomplete or inaccurate insurance coverage identification, not volume or payer mix.

Patients are often classified as self-pay or uninsured when valid coverage exists. In other cases, primary, secondary, or tertiary payers are missed or recorded incorrectly. These gaps lead to preventable denials, delayed reimbursement, and avoidable write-offs. Over time, the cumulative effect creates unnecessary pressure on financial performance and revenue cycle teams.

Traditional eligibility processes do not fully address this challenge. Point-of-service checks rely on limited information and often fail to reflect changes in coverage, coordination of benefits complexities, or inconsistencies across systems. This leaves organizations with a persistent gap between the coverage recorded in their systems and the reimbursement they are entitled to receive.

This paper outlines a more comprehensive approach to eligibility integrity, including retrospective analysis of prior accounts, ongoing monitoring of account activity, and the ability to identify discrepancies before claims are final. When combined with disciplined execution, this approach ensures that newly discovered coverage is accurately applied and translated into reimbursement.

Organizations using this model have recovered substantial revenue that would otherwise remain uncollected, while improving claim accuracy, reducing avoidable denials, and easing the burden on internal staff. These gains are achieved within existing patient populations, without increasing volume or adding complexity.

Eligibility integrity reframes revenue optimization as a function of accuracy rather than expansion. By improving the accuracy and reliability of coverage data, health systems can strengthen financial performance and create a more stable revenue cycle.

The Problem: Revenue Loss Hidden in Plain Sight

Many health systems operate with a high percentage of accounts categorized as self-pay or uninsured at registration. In reality, this classification is often inaccurate.

Common drivers include:

- Incomplete insurance capture at intake
- Changes in coverage not reflected in patient records
- Secondary or tertiary coverage that is not identified
- Coordination of benefits issues that lead to denials

The financial impact is substantial. Daily charges tied to these accounts can reach into the millions, creating a growing pool of revenue that is either delayed or written off entirely.

A New Approach to Eligibility Integrity

Recovering this revenue requires more than traditional eligibility checks. It demands a continuous and systematic process that includes:

1. Historical Data Reconciliation

Reviewing prior accounts to identify missed coverage opportunities.

2. Ongoing Monitoring

Analyzing new admissions and accounts daily to identify coverage before billing.

3. Advanced Identification Logic

Using data-driven models to detect:

- Active primary, secondary, or tertiary coverage
- Discrepancies in existing payer information
- Accounts at risk for coordination of benefits denials

4. Operational Execution

Ensuring identified coverage is not just flagged, but acted upon through:

- Accurate loading into patient accounting systems
- Alignment with existing workflows
- Reduction of manual effort for internal teams



Case Example: Large Safety-Net Hospital

A large Midwestern safety-net hospital serving thousands of patients each day faced persistent challenges related to self-pay classifications and claim denials. The hospital processes more than 2,400 patient encounters daily and manages average gross daily charges exceeding \$5 million. Approximately 23% of accounts initially entered the revenue cycle as self-pay or uninsured, creating elevated financial risk and a substantial likelihood of missed reimbursement opportunities, despite internal concerns that coverage existed but was not being captured.

Internal analysis identified several recurring issues:

- Incomplete insurance discovery during registration
- Missed secondary payer opportunities
- Inaccurate demographic matching
- Delayed identification of Medicare or commercial coverage
- Recurring Medicaid coordination of benefits denials



Solving the Lost Revenue Challenge

To address these gaps, **eInsights** implemented a continuous eligibility integrity workflow designed to evaluate historic and newly discharged accounts. The solution incorporated:

- Retrospective analysis of prior discharge data
- Daily eligibility monitoring
- Automated payer discovery
- Demographic reconciliation
- Pre-bill insurance identification
- coverage loading support within the Cerner patient accounting environment

Using **eInsights** proprietary technology and services the initiative also:

- Corrected accounts inaccurately classified as self-pay
- Identified overlooked secondary insurance opportunities
- Uncovered coverage spanning more than 100 commercial and governmental payers
- Reconciled thousands of demographic inconsistencies affecting claims accuracy
- Identified a substantial volume of Medicaid accounts requiring re-certification review

Through a combination of automated eligibility analysis, demographic reconciliation, payer discovery workflows, and operational account remediation, the initiative produced measurable financial and operational improvements. Within the first 90 days of implementation, the organization identified coverage across nearly 9,000 previously unresolved self-pay accounts, generating approximately \$3.3 million in additional reimbursement.

Measurable Outcomes

Operationally, the engagement reduced manual research requirements and accelerated the correction of payer information before claim submission, helping prevent avoidable denials and downstream rebilling activity. Over a 23-month period, the organization realized more than \$40.5 million in recovered fee-for-service reimbursement tied directly to newly identified or corrected

insurance coverage. The engagement also reduced Medicaid coordination of benefits denials, improved billing accuracy prior to claim submission, and significantly decreased revenue leakage associated with incomplete registration data.

Financial Recovery

- Millions in additional reimbursement identified within the first quarter
- Significant recovery from accounts previously classified as self-pay
- Additional collections tied to corrected or expanded coverage information

Coverage Visibility

- Identification of coverage across a broad set of government and commercial payers
- Resolution of mismatched or incomplete patient records
- Flagging of large volumes of accounts requiring eligibility updates or recertification

Operational Impact

- Reduction in manual work required by revenue cycle teams
- More accurate claims at initial submission
- Decrease in avoidable denials tied to missing coverage

Long-Term Impact

As the eligibility integrity workflows matured and operational efficiencies improved, reimbursement performance continued to accelerate. By May 2025, the initiative had generated more than \$40.5 million in recovered reimbursement tied to corrected or newly identified insurance coverage.

The engagement demonstrated that continuous eligibility monitoring combined with operational workflow support can produce sustained financial improvement for hospitals serving high volumes of underinsured and self-pay patients.

Why This Model Works

This approach succeeds because it addresses both sides of the problem:

- **Data Accuracy**
Ensuring coverage information is complete and correct
- **Process Execution**
Making sure insights translate into action within existing systems

It is not enough to identify coverage. The real value comes from converting that discovery into billable claims and collected revenue.

Implications for Health Systems

For many health systems, eligibility integrity has traditionally been treated as a front-end registration task rather than an ongoing revenue cycle discipline. As reimbursement pressures increase and denial volumes continue to rise, organizations are reevaluating how coverage identification, payer accuracy, and coordination of benefits workflows affect long-term financial performance. The implications extend beyond reimbursement recovery. Stronger eligibility integrity processes can reduce avoidable denials, improve billing accuracy, decrease manual rework, and create more stable revenue cycle operations.

Organizations that adopt a structured eligibility integrity strategy can expect:

- Improved cash flow without increasing patient volume
- Reduced reliance on manual processes
- Stronger performance against denial benchmarks
- Better alignment between front-end and back-end revenue cycle functions

Most importantly, they gain visibility into revenue that already exists within their current patient base.

Conclusion

The case example demonstrates how continuous coverage discovery workflows can improve financial performance and operational efficiency within complex hospital environments. Through ongoing payer discovery, demographic reconciliation, and pre-bill coverage identification, the hospital reduced revenue leakage tied to self-pay misclassification, missed secondary coverage, and Medicaid coordination of benefits denials.

Over time, the initiative evolved beyond a traditional insurance discovery effort into an integrated operational process supporting reimbursement accuracy across the revenue cycle. More than \$40.5 million in reimbursement was ultimately recovered through corrected or newly identified coverage, while manual account research and downstream claim rework were significantly reduced.

The results illustrate the importance of combining technology-enabled eligibility analysis with experienced operational support. For hospitals managing large volumes of self-pay and underinsured accounts, continuous coverage discovery can provide measurable financial value while improving the accuracy and efficiency of reimbursement operations.