ENSEMBLE

Protecting patient care through coverage disruption

A healthcare executive's playbook for the 2026–2028 planning cycle

WHAT'S INSIDE

An exploration of the macro forces driving coverage disruption and the financial impact measurable today

4 budgeting priorities for the 2026–2028 planning cycle to help protect operating margins

3 mitigation strategies to reduce coverage disruption risk and protect patient access to care

Executive summary

Healthcare leaders are entering a planning cycle where coverage instability will be a more predictable source of financial and access risk. As Medicaid eligibility checks become more frequent, work requirements add new documentation burdens, expired ACA subsidies add up and state financing flexibility tightens, more patients may experience temporary or permanent coverage gaps. For hospitals and health systems, those gaps can show up as eligibility denials, self-pay growth, higher uncompensated care, delayed reimbursement and more AR at risk.

Built on the frontline experience of Ensemble's payer strategy and patient experience teams serving 37 of the top health systems nationwide, this guide is designed to help healthcare executives prepare now, before coverage disruption becomes a larger operational and financial challenge. It translates the policy and payer-mix risk into practical planning priorities, front-end operating strategies and patient-support interventions that can help organizations identify coverage risk earlier, connect patients to assistance more quickly and reduce avoidable self-pay conversion.

What's inside

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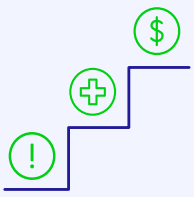
Hospitals don't need to choose between financial discipline and clinical service delivery. With the right approach, they can identify risk earlier, support patients more effectively and preserve the revenue needed to keep care accessible in the communities they serve.



The macro picture: What's driving the shift

Coverage disruption is building across the 2026–2028 planning cycle as Medicaid redeterminations become more frequent, work requirements add new documentation steps, ACA subsidy changes increase affordability pressure and states face tighter financing flexibility. For healthcare executives, the concern is the operational effect: more eligibility churn, more patients moving into self-pay status, higher uncompensated care, more eligibility-related denials and greater AR risk if front-end processes do not adapt.

5 structural changes reshaping reimbursement + payer mix

H.R. 1 — the budget reconciliation law signed into effect in 2025 — introduces structural changes that will materially affect reimbursement, payer mix and uncompensated care levels for every acute care provider in the country. These forces are the most consequential for financial planning.

$1.15 trillion in reduced federal healthcare spending over the next 10 years

10–17 million additional uninsured individuals due to tightened eligibility for government-sponsored programs and ACA subsidy reductions

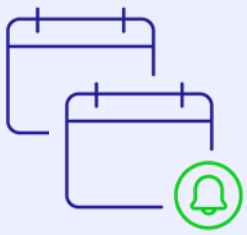
Semi-annual redeterminations mean Medicaid eligibility checks shift from annual to every six months, increasing churn and coverage instability

New limits on provider taxes and state-directed payments reduce states' ability to subsidize hospital reimbursement

New work requirements include 80 hours per month required for certain populations, with new verification and documentation rules

THE NEAR-TERM INFLECTION POINT

These forces are converging to create a measurable inflection point by December 31, 2026. After that date, payer-mix volatility will increase significantly, and the systems that have not already adapted their front-end operations will see preventable self-pay creation accelerate, carrying a high potential for severe cash degradation and unrecoverable write-offs.



Budget impact: Why traditional planning no longer works

For CFOs, the budget risk is the gap between historical run-rate assumptions and what will happen as coverage churn accelerates. Planning should pressure-test how changes in Medicaid volume, ACA coverage, self-pay conversion, eligibility denials, charity approvals and cash timing could affect net revenue, reserves and service-line performance.

PUTTING IT INTO CONTEXT

When a patient loses insurance coverage and converts to self-pay, collection rates typically fall to just 5%–20% of the amount owed.

For a $5,000 procedure, that means providers may collect only $250–$1,000, putting $4,000–$4,750 in revenue at risk per encounter.

4 budgeting priorities
to protect operating margins, 2026–2028

PRIORITY 01

Build Medicaid risk modeling into budget assumptions

- [ ] **Build a baseline exposure model** by facility and service line that shows current Medicaid volume, Medicaid expansion volume, ACA Marketplace volume, self-pay conversion rate, Medicaid eligibility denial rate, charity approval rate, bad debt write-off rate and net revenue per encounter.
- [ ] **Run three payer mix scenarios for budget review:** conservative, expected and downside. For each scenario, quantify the movement from Medicaid or ACA coverage into self pay, the expected reimbursement loss, the change in uncompensated care and the reserve impact by quarter.
- [ ] **Tie assumptions to operational trigger points,** including renewal failure rates, state processing timelines, work-requirement documentation failures, pending eligibility inventory, uninsured growth in the primary service area and self-pay AR aging. Review these indicators monthly, not only during annual budget refreshes.

PRIORITY 02

Increase reserves for uncompensated care

- [ ] **Recalculate uncompensated care reserves using forward-looking coverage loss assumptions** rather than the prior-year run rate. The reserve model should distinguish between true self-pay, Medicaid-pending, charity-eligible, underinsured ACA Bronze plan patients and patients likely to regain coverage.
- [ ] **Create a monthly reserve variance dashboard** that compares projected versus actual self-pay gross charges, point-of-service collections, charity approvals, Medicaid-pending conversion, bad debt transfer, denial overturn rate and cash collections from retroactive coverage.

PRIORITY 03

Reassess service line exposure

- [ ] **Rank service lines by exposure, not just contribution margin.** Include Medicaid and ACA payer concentration, elective versus emergent mix, authorization dependency, average patient responsibility, no-show rate, denial rate, charity utilization and downstream specialty demand.

- [ ] **Use the analysis to guide decisions** on scheduling rules, financial clearance thresholds, discount policy, charity presumptive eligibility, service-line growth plans and where to prioritize coverage navigation resources.

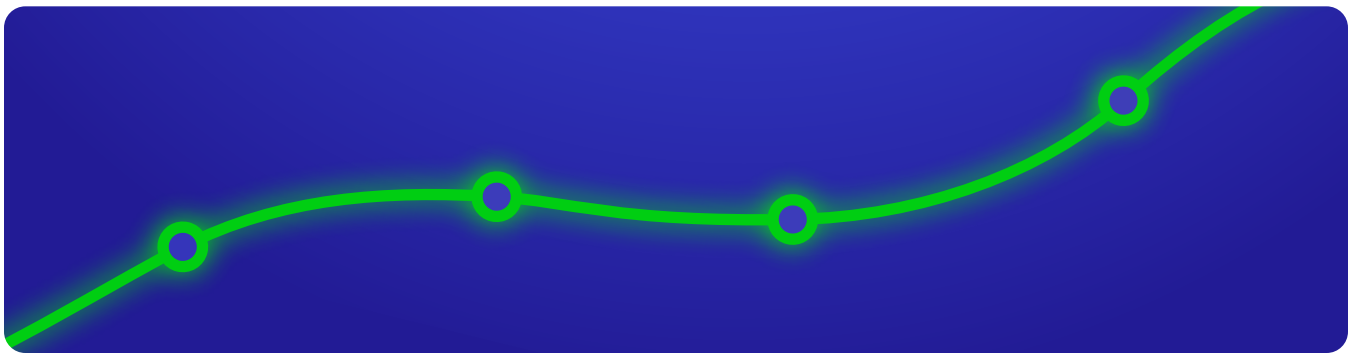
PRIORITY 04

Align workforce + access strategies

- [ ] **Translate payer-mix risk into operational capacity needs.** Quantify the number of additional eligibility checks, renewal touches, financial counseling encounters, Medicaid applications, charity screenings and payment plan conversations expected each month.

- [ ] **Focus resources where timely support can prevent avoidable coverage loss and financial distress for patients.** Prioritize work queues tied to Medicaid renewal windows, uninsured or underinsured scheduled services, repeat ED utilization, pending eligibility cases and patients who may qualify for charity care, financial counseling or coverage restoration.

- [ ] **Hold finance, access, clinical operations and revenue cycle accountable to a shared weekly operating review.** CFO-ready measures should include eligibility touch rate, coverage restored, clearance-before-service rate, deferral compliance, point-of-service collections, self-pay AR creation and net revenue preserved.



3 strategies to mitigate coverage disruption risk

The following strategies each target a distinct point of revenue leakage created by coverage disruption: the high-cost patient who is about to lose coverage, the non-emergent service that proceeds without financial clearance and repeated non-emergent ED encounters that drive the largest concentration of self-pay loss in most systems.

STRATEGY 01

Proactive coverage support for at-risk patients

Identify and support patients with scheduled high-cost services who are at risk of losing coverage because of a temporary gap they cannot resolve on their own.

- **Identify coverage risk before the encounter.** Use real-time eligibility checks, coverage discovery and analytics to flag patients with upcoming services who may be at risk of disenrollment, Medicaid redetermination failure, a past-due premium or another temporary coverage gap.
- **Reach patients early with clear next steps.** Deploy coordinated outreach through SMS, emails, portal messages, letters, front-desk scripting and phone support so patients understand the coverage issue, the documentation needed and the support available before they arrive for care.
- **Restore or preserve coverage wherever possible.** Support Medicaid re-enrollment, public benefits screening, financial assistance applications, charity care review, payment plan setup and coverage updates before the account converts to true self-pay or bad debt. Run Day 1, Day 30 and monthly scrubs across self pay, Medicaid-pending and bad debt inventory to find missed coverage, update accounts quickly and pursue retroactive coverage when state rules allow.
- **Evaluate premium support as a targeted patient-support option.** When a temporary premium payment could preserve coverage for a scheduled high-cost service, assess whether support is appropriate, compliant, clearly documented and lower than the avoidable financial harm to the patient and the expected uncompensated care exposure.

KPIs to track

- Patients retained in coverage
- Coverage restored
- Medicaid-pending conversion
- Charity approvals
- Financial assistance applications completed
- Self pay converted to coverage
- Retroactive coverage secured
- Patient outreach completion
- Uncompensated care

STRATEGY 02

Complete financial clearance before non-emergent care

Help patients understand their coverage, out-of-pocket responsibility and available support to resolve authorization, coverage or financial assistance needs before a non-emergent service.

- **Identify services that require clearance before the patient arrives.** Define which non-emergent services should be financially cleared in advance, with clinical leadership confirming what can be safely rescheduled and what must proceed based on medical need.
- **Start the conversation early and make the next step clear.** Use pre-service outreach to confirm coverage, explain authorization status, provide an accurate estimate, review financial assistance options and help the patient understand what action is needed before the scheduled service.
- **Resolve coverage and authorization issues before the date of service.** Verify eligibility, initiate or confirm authorization, coordinate with the physician office on missing orders or documentation, complete medical necessity checks and update the host system, so the patient is not asked to solve administrative gaps at registration.
- **Connect patients to the right financial path.** Screen for Medicaid eligibility, charity care, financial assistance, uninsured discounts, prompt-pay options and payment plans before service, so patients have time to make informed decisions without feeling pressured at the point of care.
- **Reschedule with support when clearance is incomplete.** If a non-emergent service cannot be cleared in time, help the patient reschedule rather than simply cancel the encounter. Provide clear documentation, next steps, contact information and follow-up timing so the patient can complete the needed coverage, authorization or assistance process.
- **Use exception-based workflows to prevent last-minute surprises.** Flag appointments with missing authorization, unresolved coverage, incomplete registration, medical necessity risk or high patient responsibility for second-level review several days before service, then escalate the cases that need immediate intervention.

KPIs to track

- Days financially cleared before service
- Authorization secured before service
- Patients contacted before arrival
- Coverage or assistance applications initiated
- Estimates reviewed with patients
- Exceptions approved by clinical leadership
- Preventable self-pay creation
- Post-service patient billing escalations

STRATEGY 03

Proactively manage patients who rely on the ED for non-emergent needs

Identify patients who repeatedly turn to the emergency department for non-emergent issues because they do not have a reliable, coordinated path to primary care, behavioral health, financial assistance or other community-based support. The opportunity is to meet these patients in the moment, screen for coverage and financial support, understand what is driving repeat utilization and connect them to the most appropriate care path.

- **Screen in real time for coverage and assistance.** Conduct self-pay screening, presumptive Medicaid review, charity care eligibility and financial assistance screening during the visit when possible, rather than waiting until after discharge. Capture updated demographic, insurance and contact information so follow-up support can continue after the encounter.
- **Connect patients to the right next care setting.** For non-emergent visits, provide practical next steps such as scheduling or referral support for a primary care provider, clinic, urgent care, behavioral health service, pharmacy-based support or community resource. The hand-off should be warm, documented and specific enough that the patient knows where to go, when to go and what to bring.
- **Create high-utilizer support pathways.** Use rolling 6–12-month ED visit history, payer status, diagnosis patterns and presenting complaints to identify patients with repeated non-emergent use. For this cohort, build a documented intervention plan that may include case management, financial navigation, Medicaid or charity support, PCP connection, behavioral health referral and community resource coordination.
- **Equip registrars and financial navigators with clear scripts and escalation paths.** Expand existing processes so associates can explain coverage options, assistance programs and appropriate care alternatives with empathy and consistency. Provide escalation to clinical leadership, social work, case management or financial counseling when the patient's needs extend beyond registration.

KPIs to track

- ED visits per patient on a rolling 6–12-month basis
- Repeat visit rate for the high-utilizer cohort
- Self-pay ED volume
- Eligibility and charity screening completion
- Coverage conversion
- Financial counseling completion
- Behavioral health or community resource referral completion
- Top 5% ED utilizer cost concentration

Ensemble's approach to mitigate self-pay risk and protect access to care

Ensemble helps hospitals protect patient access and reduce avoidable self-pay risk through a proven operating model deployed across more than 200 hospitals nationwide. By combining front-end coverage intelligence, patient-centered financial assistance and disciplined AR management, Ensemble helps clients identify risk earlier, connect patients to the support they qualify for and preserve revenue that sustains care in their communities.

Prevent	Identify coverage gaps before or at the point of care through real-time eligibility checks, payer mix monitoring, targeted outreach and front-end financial clearance. The goal is to help fewer patients enter the system as self-pay when coverage or assistance may be available.
Convert	Use coverage discovery, Medicaid re-enrollment support, charity care screening, financial assistance and regular self-pay and bad debt scrubs to restore coverage or connect patients to the right financial path as quickly as possible.
Operate	Embed weekly intervention cycles, standardized processes, patient outreach scripts and monthly payer mix and AR-at-risk reporting into operating reviews so leaders can see exposure early, act consistently and track whether intervention is working.

> ""Healthcare is incredibly challenging right now. There are new regulations and shrinking margins. Having Ensemble in place already behind us has freed up bandwidth to focus on other priorities. The opportunity cost of trying to build the infrastructure and manage the teams ourselves would have been enormous."
>
> **CEO / President, July 2025, KLAS Research Interview**

Ensemble's results
protect margins + patient access

CLIENT RESULTS

$5M

additional revenue recovered in 12 months by converting accounts from self-pay status into eligible insurance coverage

3,400

self-pay accounts converted to insured coverage in 6 months, generating $6M in additional gross revenue

20%

increase in Medicaid conversion rate in 12 months

20%

increase in pre-service collections in 18 months

ENTERPRISE PERFORMANCE

47%+

of total patient cash collected at or prior to time of service (vs. 30% industry benchmark)

< 0.5%

eligibility-related denial target (vs. 1% industry benchmark)

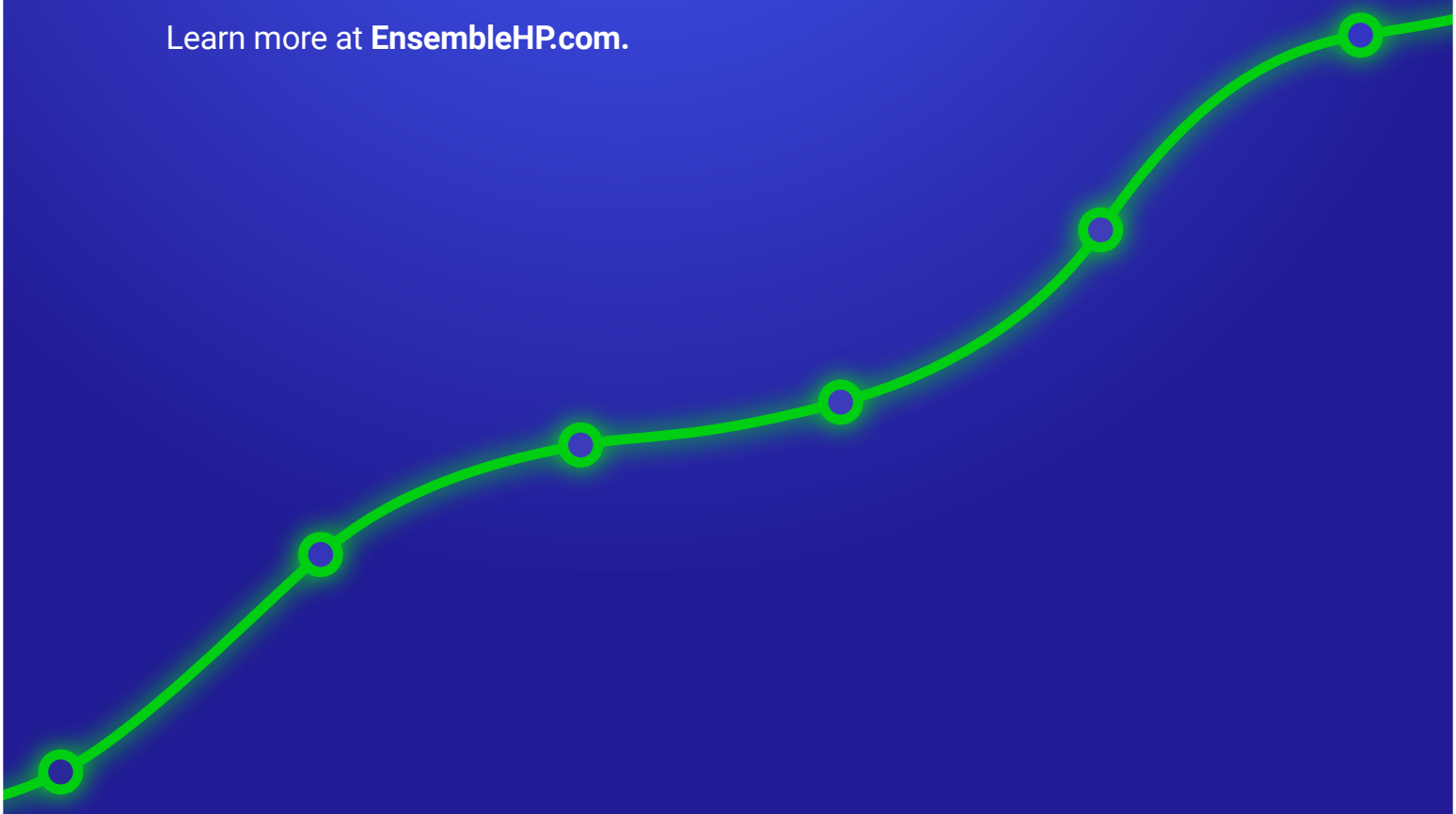
17%

improvement in patient experience KPIs

Ready to get started? We're ready to help.

Ensemble is the leading provider of integrated revenue cycle operations in healthcare, trusted by hundreds of hospitals nationwide to manage more than $55 billion in annual net patient revenue.

Learn more at **EnsembleHP.com.**



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