

A FIELD GUIDE FOR FINANCE AND OPERATIONS LEADERS

The signal you already own

Every health system loses revenue to coding gaps, loses members to silent disengagement, misses growth it could have targeted, and absorbs emergency visits it could have prevented. **These look like four problems. They are four readings of one signal** — the behavior of the people you already serve.

01 Members slipping away

02 Growth you can't see

03 Revenue left uncoded

04 ED visits you could prevent

The money is in your **own filings**

You don't need a vendor to tell you the category exists. The public record already describes the gap — for both community health centers and hospitals — using data your organization files every year.

HRSA UDS · COMMUNITY HEALTH CENTERS

Risk & capitation

Your Uniform Data System report shows your panel by payer and program. What it does not show is the share of senior and dually-eligible encounters carrying an uncaptured risk-adjustment opportunity — revenue you are entitled to but never coded.

CMS COST REPORT · HOSPITALS

Medicare mix & margin

Your Medicare Cost Report carries net patient revenue, payer days, and discharges. The HCC and risk-adjustment gap is implied by those numbers — but the report never surfaces it as a recoverable figure.

KFF / MACPAC · MEDICAID MANAGED CARE

Churn costs more

Member turnover in Medicaid managed care runs high, and the asymmetry is unforgiving: losing a member and re-acquiring another costs a multiple of what it would have cost to keep the first one engaged.

THE PATTERN ACROSS ALL FOUR

Late, not absent

The information needed to act exists inside your organization. It simply arrives too late — after the gap is unbillable, after the member has gone, after the avoidable visit has happened.

Read it against your own organization

If you file **HRSA UDS**, you can already see your patient panel. If you file a **CMS Cost Report**, you can already see your payer mix and margin. What neither filing shows you is the percentage of that activity that is leaking value right now — and that percentage is exactly what this paper is about.

02 — THE COST IS REAL, AND MOSTLY INVISIBLE

One patient, four **different** losses

The loss is never labeled “loss.” It shows up as a routine encounter, a quiet no-show, a marketing dollar spent in the wrong zip code, an emergency visit that didn’t have to happen. Here is the same underlying behavior, surfacing as four separate departments’ problems.

CODING

The under-coded senior

A dually-eligible patient with two managed chronic conditions comes in for a routine visit. The documentation supports a higher risk-adjusted picture than what gets coded. The encounter closes clean, on time — and the capitation that should have followed never does.

Owned by: the coding team

RETENTION

The silently disengaging member

No complaint, no disenrollment call. Just a slowly lengthening gap between visits, a missed refill, an unreturned outreach. By the time a report flags the drop, the member has effectively already left — and the cost of replacing them has already begun.

Owned by: care coordination

GROWTH

The mistargeted acquisition spend

Outreach and marketing budget goes out the door aimed at a broad, generic population — when the highest-yield prospects look behaviorally like the members you already serve well. The spend works, just not nearly as hard as it could.

Owned by: enrollment & growth

UTILIZATION

The avoidable emergency visit

A patient whose behavior had been drifting — missed follow-ups, an unfilled prescription, a gap in contact — shows up in the ED for something that earlier outreach could have headed off. The visit is absorbed as cost, and the signal that would have predicted it was sitting in the same behavioral stream all along.

Owned by: population health & utilization

The patient is one person. You see four.

This is the core of it. A patient lives a single, continuous life. Your organization is built to experience that life as a set of disconnected operational signals, each routed to a different team running a different tool.

HOW THE PATIENT EXPERIENCES IT

One continuous stream of decisions.

Which appointments to keep. Which prescriptions to fill. When to show up at the ED. Whether to stay in your panel at all. To the patient it is one life, one relationship with your organization, made of choices that all come from the same place.

HOW YOUR SYSTEM EXPERIENCES IT

Four disconnected signals.

The same stream of behavior is split at the door and handed to four teams who never compare notes:

Coding sees a billing event.

Care coordination sees a retention metric.

Growth sees a market segment.

Population health sees an ED visit.

No one owns the behavior itself — only the four shadows it casts on four different reports.

Large, sophisticated systems paper over this with deep electronic-record investment and a senior clinical-informatics function whose full-time job is to stitch the signals back together. That is a real solution. It is also one that depends on bench strength and budget most organizations structurally do not have — which is precisely the divide the next section is about.

04 — THE FOUR SYMPTOMS

What the split costs you

Each disconnected signal becomes its own chronic symptom — and each maps to value that was recoverable, if anyone had seen it in time.

01

Under-coded risk

Revenue you are entitled to, documented in the chart but never captured in the code — quietly forfeited, encounter after encounter.

02

Silently disengaging members

Attrition you find out about after it is irreversible, when retention was still cheap and still possible weeks earlier.

03

Mistargeted growth

Acquisition spend aimed at the wrong people, when the highest-yield prospects resemble members you already serve.

04

Avoidable ED utilization

Emergency visits that a timely intervention could have prevented — absorbed as cost after the fact, when the rising risk was visible in the behavior beforehand.

05 — WHY THE CURRENT MODEL KEEPS LOSING GROUND

The gap widens on its own

None of this is a failure of effort. The teams work hard inside the tools they have. The model itself is what keeps losing ground — for three compounding reasons.

01 You find out too late

Conventional reporting is a rear-view mirror. The coding gap is flagged after the claim window. The member is flagged as lapsed after they have gone. By the time the number lands on a dashboard, the moment to act on it has usually passed.

02 You pay four times for one signal

Four teams, four tools, four budgets — each chasing a different reading of the same underlying behavior, none of them aware of the others. The spend is real and recurring; the coordination is not.

03 The build-it-yourself path is closed to most

The organizations that genuinely solve this in-house are the ones with the deepest record-system investment and the largest informatics teams. For everyone else, “we’ll build it ourselves” is not a plan — it is a reason the gap stays open. The right move for most organizations is to buy the capability, not to fund a build they cannot staff.

Read the behavior **once**

Here is the shift. The same behavioral signal — read once, from data your organization already holds — surfaces a single patient across all four problems at the same time. Not four tools. One reading, four uses, entirely within your own organization.

THE UNIFIED BEHAVIORAL SIGNAL

One patient, surfaced four ways the moment their behavior shifts

RECOVERY 01 · RETENTION

A member worth keeping

The same signal flags the silent disengagement early — while re-engagement is still cheap and still works.

RECOVERY 02 · GROWTH

A lookalike worth pursuing

The behavioral profile of your best-served members sharpens acquisition targeting toward prospects who resemble them.

RECOVERY 03 · CODING

A coding gap worth recovering

The same patient surfaces as a documented-but-uncaptured risk-adjustment candidate before the claim window closes.

RECOVERY 04 · UTILIZATION

An ED visit worth preventing

Rising avoidable-utilization risk is flagged in time to intervene — the recovery a public-procurement RFQ is often written around.

Today you pay four teams to chase four versions of this signal, and none of them sees the other three. **The recovery is not a new data source. It is reading the signal you already own — once, and together.**

A number from data you already file

The natural question is “what is this worth for us, specifically?” — and you can get a defensible answer before any engagement, any contract, or any data leaving your building.

Your estimate comes from the public record

Using your organization’s own published filings — HRSA UDS for a community health center, the CMS Cost Report for a hospital — the four recoveries can be sized into a conservative Year-1 range, decomposed by stream, with every assumption stated. No proprietary access. No data sharing. Just the public record, read the way the four-recovery model reads it.

STEP 01

Start from your filing

Your published UDS or Cost Report supplies payer mix, panel, discharges, and margin.

STEP 02

Apply conservative rates

Each recovery stream is sized with deliberately conservative, fully disclosed realization assumptions.

STEP 03

See your range

You receive a Year-1 recoverable range for your specific organization — no engagement required to produce it.

This paper deliberately states method and ranges, not a figure for any one organization. The specific dollar estimate for your organization is produced individually, from your own filings, and shared with you directly.

THE NEXT STEP

Get your organization's estimate

Ask CentroidAI for a public-data RevCapture estimate for your organization. It takes nothing from you but your name — the rest comes from filings already in the public record.

YOUR CENTROIDAI CONTACT

Raj Subramanyam

CentroidAI • raj@centroid-ai.com

Request my estimate

FyndEm Clinical RevCapture is powered by CentroidAI. RevCapture is one capability within the broader **FyndEm Clinical** suite for predictive clinical and operational intelligence; we can introduce the rest when the timing is right for your organization.

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Public data referenced: HRSA Uniform Data System (UDS); CMS Medicare Cost Report (HCRIS); KFF and MACPAC Medicaid managed-care reporting. Figures in this paper are described as methodology and

ranges; organization-specific estimates are produced individually from public filings.