LONG VIEW
THRIVE BY DESIGN

Smarter Levees, Safer Spend

Part 1 of 3 | How does Value Leak from Health Plans?

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Don't Just Raise Each Levee, Connect them

Key Learnings

- **The cost pressures for health plans are mounting, reaching "unprecedented" levels.** Health plans face an unprecedented level of pressure to manage both Medical and Administrative costs. GLP-1 drugs alone could drive over $100 billion in spend by 2030. Medicare paid out nearly $32 billion in improper claims last year. According to Georgetown University, at least 7.8 million will lose Medicaid and other coverage due to legislation. These aren't just statistics, they're storm signals for every health plan's financial defense.
- **It's not just each "levee" that needs fortification, it's the gaps among them that require remediation.** Most plans have strong functions like prior auth or payment integrity that serves as "levees" to protect against unnecessary services with adverse cost impacts. But when those functions don't work together, value leaks out. Siloed systems let avoidable costs slip through, even when each function works well on its own.
- **"Linking the levees," making the functions work together, is the key to preventing value leaks.** One regional plan saw 80–90% of unnecessary ED visits avoided by connecting nurse triage to UM. Another health plan cut heart failure readmissions by half through aligned remote monitoring and care management, saving $7.5 million for just 5,000 members.

Yes, We Are Now in Unprecedented Times

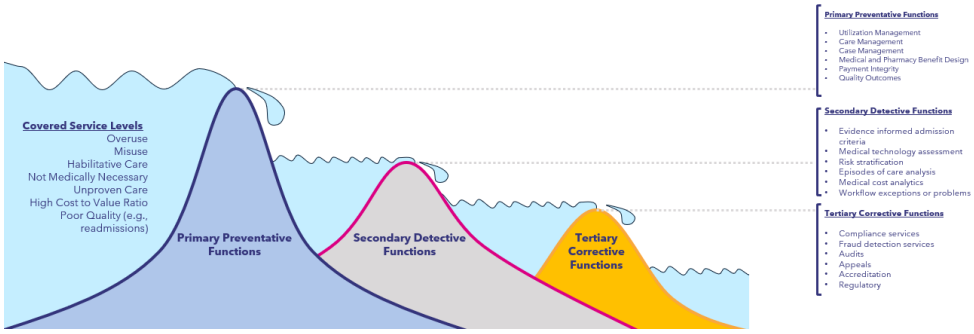
Health plans have long depended on a set of preventive functions (member or provider facing prior to fulfilling a covered service), detective functions (after a service has already been provided) and corrective functions (changing the process after a trend in service misuse is noticed). Collectively, these three types of functions work to manage risk and control cost as "levees" to protect its medical benefits budget. But these levees are under assault due to unprecedented changes in the healthcare landscape today, where value leakages are increasing.

Today, the cost pressures are coming faster and from numerous directions for both Medical and Administrative Loss Ratios (MLR and ALR). For example, GLP-1 drug costs are projected to exceed $100 billion a year, Medicare still pays more than $31 billion in improper claims annually, both of which increase MLR. As far as ALR is concerned, millions of members may lose coverage during Medicaid redeterminations, increasing ALR due to unavoidable fixed cost of operations (e.g., hardware, software infrastructure) being spread over fewer members. Additionally, CMS now requires FHIR-based data exchange for interoperability and shorter utilization-management turnaround times which are both costly and increase ALR.

The Levees that Protect Against Value Leaks

Plans seek to protect themselves from paying for services that chip away at their cost and quality through a layered approach including preventative (primary) functions where the plan aims to avoid services before they happen (e.g., deny services up front), evaluating the effectiveness of those decisions through detective (secondary) mechanisms (e.g., medical cost analytics), and conducting corrective services as a final step (e.g., fraud reviews). The detective and corrective functions require a more frequent and continuous integration with preventative functions due to the unprecedented nature of the cost environment today. The diagram and the table below show the various functions that constitute the levees.

Functions that Constitute "Levees" Against Value Leaks



Value Leakage Protection (Service Leaks)	Primary Preventive Functions	Secondary Detective Functions	Tertiary Corrective Functions
• Overuse • Misuse • Habilitative Care • Not Medically Necessary • Unproven Care • High Cost to Value Ratio • Poor Quality (e.g., readmissions)	• Utilization Management (Prior Authorization, Site of Service Optimization etc.) • Care Management (Care Plan Development, Execution, Remote Patient Monitoring and Wearables, Wellness Screenings etc.) • Case Management (Acute and Episodic Management) • Medical and Pharmacy Benefit Design • Payment Integrity • Quality Outcomes	• Evidence informed admission criteria • Medical technology assessment • Risk stratification • Episodes of care analysis • Medical cost analytics • Workflow exceptions or problems	• Compliance services • Fraud detection services • Audits • Appeals • Accreditation • Regulatory

The Gaps are Already Showing

The potential gaps and associated tangible cost from poorly connected functions are no longer theoretical but continually on the rise.

For example, Conduit Health Partners reports that nurse-first triage can avert 80–90 percent of low-acuity emergency-department visits. Assuming 71% of ED visits are avoidable at an average cost of $1,250, a plan could avoid about $88,750 for every 100 triage calls. However, cutting 71% of the avoidable ED visits is much more complex and cannot be done via nurse-first triage alone. It requires a greater integration and "linking" of various functions. Many plans still contract with nurse triage vendors

to help members choose appropriate care settings. While nurses are effective for low-acuity cases, they cannot authoritatively direct the patients for mid or high-acuity cases as physicians would. ED misuse grows which is projected to worsen due to the loss of Medicaid and other coverage. The reforged triage solution will require more patient direction through a physician or APN who can use evidence based medical guidelines to direct the patient to the right setting that is medically necessary.

Also consider chronic disease management. Remote patient monitoring (RPM) for conditions like heart failure is growing, but programs are often run by providers, not payers. Payer care teams may only receive monthly reports, but no real-time information that can be integrated into preventative functions to keep a patient healthy and avoid an ED visit. As a result, opportunities for timely intervention go unmet, resulting in higher acuity inpatient visits.

The gaps are already showing and will continue to increase in size if left unchecked.

What does Plugging a "Crack" Look Like?

The core issue is not that the levees have poor functions, it is that the functions do not have meaningful integration. For example, emergency department overuse is often treated as a member behavior issue. But in an integrated model, real-time triage calls would feed directly into utilization dashboards. Frequent home-care referrals would be flagged by health systems for members with social needs follow-up. On-demand physicians (as in an "Uber" like fashion) in integration with the nurse triage line can direct patients more effectively. These integrative changes in the levees can improve patient and member satisfaction.

Similarly, chronic disease management works best when care is proactive. In a connected system, continuous data from remote monitors would automatically enroll high-risk members into care management programs via highly personalized patient engagement outreaches. Enrollment and engagement into such programs remain low and payor outreach on an immediate basis is limited, thus allowing value leakage. As an example of what is possible, UMass Memorial's program for heart failure achieved a 50 percent reduction in 30-day readmissions by conducting outreach calls after discharge. For a population of 5,000 members, that equates to roughly $7.5 million in avoided cost.

Positive results from fixings the leaks in the levees are possible, but the leaks continue to persist.

Part 2 of this series of articles will address the underlying drivers for why such cracks persist while part 3 will propose an approach to solving for the cracks in both the short and long term.

The Long View

The levees that protect against value leaks for health plans are cracking. But patching one leak at a time won't hold back the water. In the long run, health plans who both fortify each levee and link the levees together will command competitive value to its members and providers. In Part 2, we'll look at why the cracks in the levees have persisted for so long even with the best tools and good intentions. In Part 3, we'll show an approach to link the levees.

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Yes We are Now in Unprecedented Times

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