LONG VIEW
THRIVE BY DESIGN

Smarter Levees, Safer Spend

Part 3 of 3 | Four Steps to Link the Levees

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Old Methods; Renewed Defense

Key Learnings

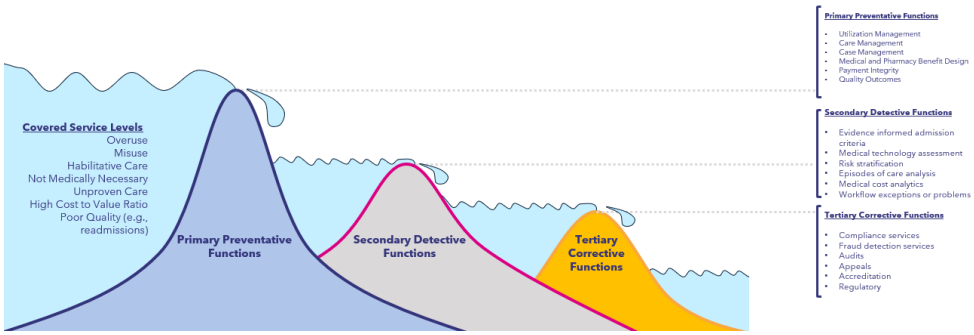
- **Health plans must quantify value leaks in a new way, by examining how preventative, detective and corrective functions work together as opposed to siloes.** Using a simple effort-versus-impact matrix (the HEAL matrix shown in this article) health plans can qualify and quantify where the Medical Loss Ratio (MLR) value today is leaking. Quick wins like pairing prior-auth data with pre-pay edits can save up to four percent of medical spend in weeks, not months.
- **Planning roadmaps is a tried-and-true method but shortening their time horizon helps organizations realize tangible value sooner.** A rolling 18- to 30-month roadmap keeps work focused and flexible. It lets health plans tackle high-value fixes now while revisiting goals as the market shifts. This cannot be a "one and done" discipline, rather one that iterates every 2-3 years.
- **Health plans have long been plagued by a myriad of vendors, solutions and platforms; it's time to deploy a Vendor/Value Management Office (VMO).** A VMO tracks every project against appropriately defined qualitative and quantitative goals shared across departments. Sharing such goals will "link the levees" across departments. VMO's do not imply net new FTE's, rather FTE levels should remain the same, but roles and responsibilities need to shift.
- **The greatest habit for health plans to break is to own the business value, not just the tech.** With the proliferation of technologies and now AI solutions, there is grave danger to throw technology alone at the problem. Health plans must resist this urge. Rather, health plans should create a cross-functional VMO and an up-skilled workforce with shared metric responsibilities to protect margin and lift member and provider experience.

A Summary of Prior Articles

Part 1 of this article series demonstrated that value leaks are real, sizeable and exist despite the individual preventative, detective and corrective functions. Part 2 described the various driving forces that contribute to continued siloes across the levees and why such value leaks persist. In this 3rd installation of the article, we will describe a path to remedy, a continuous method to fortify existing levees and link the various levees to protect against value leakages.

Below is the diagram we had shared in prior parts of the article, showing how the service and financial leaks traverse the primary, secondary and tertiary functions or "levees".

Functions that Constitute "Levees" Against Value Leaks



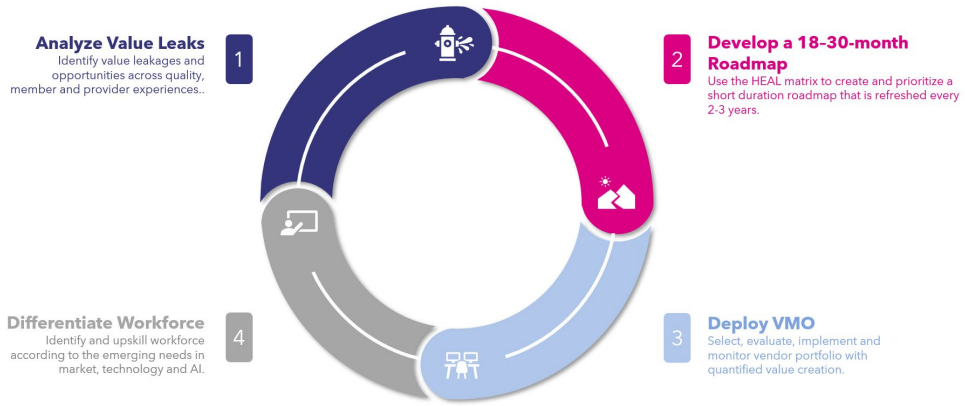
The Path Forward to "Link the Levees"

As we had discussed in part 2 of the article, the driving forces that cause the value leaks to be persistent and deep, systematic and challenging to navigate. Thus, the levees and the links among them cannot be reforged overnight but they must evolve over time. One of the common mistakes by health plans is to attempt to solve this problem with new technology, especially given the rapid evolution of AI and point solutions in the marketplace. Health plans must resist this temptation to throw technology or AI at this problem. Rather, health plans should create the right shared incentives among functional teams (shared KPI's like pre to post auth concordance rate), thoughtfully redesign the business process and update workforce skills, such as algorithmic analysis and systems thinking.

The Appendix section shows an end-to-end example of linking the primary, secondary and tertiary levees. However, to achieve a true link, a methodical process must be followed, it cannot occur simply organically (otherwise it would have already been done). To properly and sustainably link the levees, we propose a 4-step, continuous, process. Running through these 4 steps continuously over time will evolve the right culture and skillset within health plans and thus circumvent the underlying drivers that have persisted the problems to date.

Below is a diagram to show the 4 steps, followed by a description of the steps.

Four Continuous Steps to "Link the Levees"



1. **Conduct a value leakage analysis**. Identify value leakage gaps and opportunities across cost, quality, provider and member experiences. Beyond conducting a qualitative

analysis, conduct a quantitative one to understand the size and impact of each leak in your organization. The relative size and difficulties associated with the leaks will help you sequence or prioritize which leaks to solve when.

For this step, using a sample matrix with example solutions from other health plans is useful. In Appendix A, we show such a simple matrix of effort versus impact (shown as the HEAL matrix below, HEAL stands for **H**igh-Value Quick Wins, **E**nterprise Builds, **A**djust and Automate, **L**eave for Later) to map your opportunities. The examples show how to "link the levees" across the various functions. The example solution and impacts below are simply examples, not an exhaustive list. Each health plan will have their own specific examples and must use the HEAL matrix accordingly.

2. **Develop an 18 to 30-month roadmap**. Using the HEAL matrix, create a short duration roadmap that is reimagined at least every 2-3 years due to changing market conditions. It is important that this roadmap be short duration. We intentionally create the upper end of this to be 30 months as opposed to 36 months or 3 years. Typical roadmap exercises are done over 3-5 years and much in the environment changes so years 4 and 5 often become "nice to have" or aspirational items with little grounding or practical significance. This is not to say that such nice to have and aspirational items are not important. At times such aspirational items indeed transform an organization. In our work, we have simply found that keeping the roadmap to 2–3-year cycle allows for short and mid-term value while keeping aspirational items revived through the iterations.

   For each initiative, ensure to define leading and lagging metrics to track results. Desired goals like reduced readmission rates, shorter discharge delays, or higher star ratings should be shared across teams rather than having siloed goals per team. Assign KPI's to be both owned by departments but also have KPI's that are shared across departments to start building the links among the various levees. Do not exclude departments such as corrective departments as they will have a broad perspective that ties long term strategy to tangible value leakages.

3. **Deploy a Vendor/Value Management Office (VMO)**. Unlike a traditional program or project office, this team's job is to track whether the various initiatives, solutions and vendor implementations are delivering actual gains, conduct root cause analysis and "re-balance" the entire portfolio of the HEAL matrix. Creating a VMO doesn't necessarily mean adding more FTE but does mean creating more focus across teams.

   Setting up the VMO comes with a great opportunistic potential of solving for a long standing "application proliferation" challenge. Health plans often have many software and solution platforms proliferated over time. Some often conduct an "application rationalization" effort to increase efficiency towards improving ALR. The VMO allows this to become a beneficial byproduct because evaluating initiatives often brings to light the various applications and solutions that may or may not be delivering the value they once did. Specifically, with the advent of Agentic AI, which allows for integrating workflows or solutions that previously remained siloed, there is an opportunity to consolidate applications over time by testing to see which application draws more user traffic organically.

4. **Differentiate yourself by building the right workforce**. Many teams within health plans will require upskilling and a talent makeover. Implementing initiatives such as the ones in the HEAL matrix, departments may experience a short period of success only to fall back to "muscle memory" of the organization which can keep the solution implemented but the process reverted to an earlier version which no longer yields benefits. An example of this is when health plans replace their UM platforms. With the new and upcoming regulations (e.g. CMS 0057-F) related to prior authorization, some health plans are seeking a new UM platform with better features. While the new platforms might have new features, old habits kick in and do not maximize the value to be extracted from new technologies and solution vendors. In our view, upskilling the workforce internally, rather than waiting to recruit the right talent from the market, helps build a new muscle memory. The upskilling should occur not only in technology

and emerging AI solutions, but also in regulations, process, business objectives and operating with a new set of metrics previously not co-owned by departments.

In summary, linking levees includes but is not limited to a technology transformation. It is a business model that must keep incentives, people and process as primary focal areas and technology as an enabler.

The Long View

Health plans that not only adapt once but develop a capability to sense the market and adapt time and again will become the long-standing plans in the market. Not only will such plans be able to manage risk and cost better but will create better member and provider experiences. Thus, they will not only survive short-term storms but also navigate and thrive in the long-term market.

Appendix A: The HEAL Matrix (Effort vs. Impact)

Impact/Effort	Low Effort	High Effort
High Impact	**High-Value Quick Wins**	**Enterprise Builds**
	1. **Prior Auth / UM➔ Pre- & Post-pay Claim-Integrity Rules**: Flow every PA approval (CPT, units, site) into the same rule set that edits pre-pay claims; auto-flag mismatches for denial or education. Impact: Cotiviti reports integrated editing lifts savings up to 4 % of medical spend and cuts recovery lag from > 90 days to < 5 days 2. **Nurse-First Triage Line ➔ Real-time UM Dashboards**: Stream call dispositions instantly; triage outcomes trigger SDoH follow-ups and feed chatbot rules. Impact: Conduit Health Partners shows 80–90 % ED avoidance and ≈ $88,750 potential savings per 100 calls when triage data flow into UM. 3. **Benefit Design (SmartShopper Rewards) ➔ Medical-Cost Analytics**: Feed price-variation dashboards to benefit teams each quarter; add or retire rewards based on real steerage gain. Impact: SmartShopper delivered $83 M plan-sponsor savings and $9.7 M member rewards in 2024, 3:1 ROI.	4. **Care Mgmt. / RPM Alerts ➔ Quality & Outcome Analytics**: Continuous vitals auto-enroll high-risk members; readmit results refine alert thresholds monthly. Impact: UMass Memorial's HF RPM cut 30-day readmissions 50 %, worth roughly $7.5 M for a 5 k-member panel. 5. **Pharmacy & Benefit Design ➔ Medical-Tech Assessment**: Use real-world outcome data to re-tier low-value genetic tests and adjust step-therapy rules each quarter. Impact: Demoting low-value genomic screens trimmed pharmacy trend 0.6 ppt in one regional plan year over year.
Low Impact	**Adjust and Automate**	**Leave for Later**
	6. **Case Mgmt. (Discharge Planning) ➔ Workflow-Exception Monitoring**: Exception engine flags DME or SNF placement delays; pushes tasks to CM staff same day. Impact: Studies show DME setup delays extend LOS; a 0.4-day reduction saves ≈ $1 800 per case when flagged early. 7. **Care Mgmt. ➔ Dynamic Risk-Strat Analytics**: Refresh risk tiers weekly; auto-adjust CM intensity instead of annual static tiers. Impact: UK NHS risk-stratification pilots cut unmet care needs 15 % by shifting resources to newly high-risk patients. 8. **UM Reviews ➔ Compliance Audits vs. InterQual / MCG**: Audit inpatient PA approvals against evidence criteria; coach nurses on high-variance cases. Impact: Provider coaching has lowered variance denials ≈ 22 % in MA appeal programs, speeding first-pass approvals.	9. **Provider EMR Data Capture ➔ Payment-Integrity Documentation Audits**: Pulling structured EMR notes into PI systems demands HL7/FHIR interfaces and provider consent; recoup rates rise only on a small subset of claims. Impact: CMS demo showed EMR-linked PI recovered an extra $3.2 M on $1.1 B in spend (≈0.3 %), well below quick-win thresholds.

Appendix B: A Projected Case Study

Humira-to-Biosimilar Shift Projected Case Study

The Humira-to-biosimilar conversion that follows shows all three levees working as one: compliance spots the rule change, formulary and prior auth tightens the front end, and payment integrity blocks any back-end claims. By having the teams "co-own" the outcomes, the health plan avoids costly upgrades to each "levee" but gains benefits by linking them. This example does not signify an actual case, but what a possible case might look like.

Levee	Role in the Story	Concrete Actions and Data
Tertiary (Corrective)	Compliance & Regulatory Follow-Up identifies a change	• January 2025: CMS publishes ASP update plus guidance urging plans to favor adalimumab biosimilars to cut Part D spend. • Plan's Compliance team flags the bulletin and opens a 30-day ticket with Pharmacy UM.

Primary (Preventive)	Pharmacy UM & Formulary set first gate	• Formulary Policy RX-TNF-001 updated:
		  ○ Tier 1: biosimilar NDCs; Tier 3: originator Humira.
		  ○ Step therapy: approve brand only after 12-week biosimilar trial or documented immune reaction.
		  ○ ePA portal auto-approves biosimilar fills under 30 minutes.
		• Providers notified via fax blast and EMR alert (CPT G1012).

Secondary (Detective)	Payment Integrity & Analytics watch back end	• Pre-pay edit cross-checks NDC list; denies Humira (00597-0001-02) claims lacking exception code. • Post-pay audit scheduled at 90 days for J0130 vs. J0135 discrepancies in physician-administered settings. • Pharmacy analytics dashboard tracks biosimilar penetration weekly.
Feedback Loop	Data moves both ways	• Audit finds 14% of Humira claims bypassed ePA via paper scripts. Findings sent to UM; portal updated to reject non-ePA scripts and require real-time override code.

How Linking the Controls (Levees) Can Pay Off in One Quarter

Metric	Before Integration (Q2 2025)	After Integration (Q3 2025)
Biosimilar share of adalimumab scripts	12 %	**68 %**
Anti-TNF drug spend per 1,000 members	$42 500	**$34 900** (-18 %)
Humira claims without approved override	287	**19**
Average ePA turnaround (biosimilar)	31 min	**27 min**

Net result: An 18 percent drop in category spend and near-elimination of unapproved Humira claims achieved with policy, data feeds, and aligned audit schedules, no new vendor fees.

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