Smarter Levees, Safer Spend

Part 2 of 3 | Why do Value Leaks Persist Across the Levees?

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NO. 7 | August 14, 2025

Linking the Levees Avoids Boiling the Ocean

Key Learnings

- **Several driving forces continue to crack the "levees" that health plans use to control cost**. Most health plans have tools and processes for cost control which can often be upgraded or improved. But that is not where the larger challenge is today. The challenge is that their tools and processes don't work together. Legacy platforms, siloed teams, vendor lock-in, weak incentives, and a shortage of data and AI talent are among several drivers that keep the cost protective levees disconnected. Even great systems leak value when the levees aren't linked.
- **The winning health plans will not boil the ocean but navigate the storms by linking the levees.** The health plans that win in the short and long run will not only plug holes and weather the current storms by improving their tools and processes. They will start to link the levees. Instead of doing a ground-up full replacement of core tools and processes, they'll build lightweight data, application and even AI layers, combining old core with a new spectrum of vendor solutions. To tie people together, they'll create shared scorecards, dashboards and innovative contracts with providers. They'll start small, like connecting nurse triage to UM or remote monitoring to care plans and scale fast when the numbers prove out.

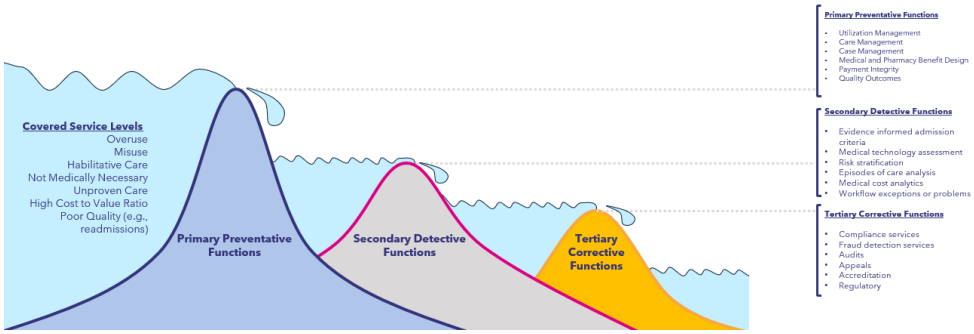
A Recap on the Cost of Value Leaks

Part 1 of this article series demonstrated that value leaks for health plans are real and costly. GLP-1 spend is climbing toward $100B a year, for instance. Improper Medicare payments still exceed $30B. A single nurse-triage link saved 80% to 90% of low-acuity ER visits. A connected heart-failure program could cost up to $7.5M. The takeaway was clear. When control points stay isolated, the cracks between the levees remain, dollars slip through, and member trust erodes.

Below is the diagram we had shared in part 1 of the article, showing how the service and financial leaks traverse the primary, secondary and tertiary functions or "levees".

LONG VIEW
THRIVE BY DESIGN

Functions that Constitute "Levees" Against Value Leaks



Why the "Cracks" Persist

The answer lies not in one obstacle, but in a set of long-standing *structural* blockers that reinforce each other over time. The result is a patchwork system, functional on the surface, fragile underneath. Below is a set of key drivers with examples and some possible ways to "navigate the storms".

Drivers of the "Cracks"	Examples	Possible Ways to Navigate the Storm
Legacy systems and fragmented platforms Most plans still run multiple, aging core systems for claims, care, pharmacy, and UM. Replacing them is viewed as risky and costly, so a large percentage of IT spend stays in "keep-the-lights-on" mode.	Most health plans have been on a long-term "transformation" track to replace legacy systems, yet progress is slow. Even when a core claims platform is swapped, old rules are often copy-pasted, keeping convoluted logic alive in the new platform. 1. **74 percent** of insurers keep critical operations on legacy tech (Earnix, 2025). 2. **67 percent** of U.S. health plans say they are "actively modernizing" claims and care systems, showing the scale of the backlog (AHIP/Oliver Wyman survey, 2023).	Create a **modular "middle-layer" platform** that lets old cores coexist with new APIs, data sources and even AI solutions. Use a Strangler Fig-pattern migration: route high-value, low-risk transactions first, prove ROI, then retire legacy modules in waves. Fund from cross-functional savings, not the IT budget alone.
Care intervention models rely on lagged claims, not real-time data Claims-based risk scores rely on 30- to 90-day-old data, missing urgent changes and embedding bias.	A widely used cost-prediction algorithm sent **17 % fewer Black patients** to chronic-care programs because past spending (claims) was lower for these members, masking true clinical risk (Obermeyer et al. 2019). Plans that added same-day admit-discharge-transfer (ADT) alerts to their nurse triage saw **10 % fewer 30-day readmissions** in pilot groups. CMS issued the 2024 Interoperability Final Rule after finding plans struggle to use real-time data in UM decisions. With January 1, 2027 fast approaching for API's going live, many plans are beginning to connect claims analytics to UM processes.	Blend real-time ADT feeds and key EMR fields (vitals, labs) into the risk engine, run quarterly bias audits, and trigger same-day outreach when high-risk flags update.
EMR data not integrated into care management Clinical data often sit in provider EMRs, unseen by plan care teams, leaving blind spots in outreach and UM.	Care managers fly blind without the benefit of lab results and notes that never leave provider EHRs. Much of the nuances of medical necessity debates can "live in the margins" or such EHR notes, without which, timely and meaningful peer to peer discussions cannot occur, further	Fund a **provider data-exchange incentive**: create an innovative contract with a partner provider system and pay a bonus per member when ADT feeds and CCDs flow nightly. Use lightweight FHIR event subscriptions instead of full HIE builds.

LONG GAME HEALTH

Drivers of the "Cracks"	Examples	Possible Ways to Navigate the Storm
	exacerbating provider abrasion and delaying member services or approving unnecessary services. 1. **83 percent** of Medicaid MCOs want better clinical data sharing with providers (IMI survey, 2023). 2. **56 percent** cite low EHR adoption among behavioral-health providers as a barrier (IMI BH report, 2024).	
Education and training gaps in medical analytics Plans buy analytics tools but staff lack data science and advanced statistics skills to use them or trust their output.	Spotting "bendable" trends using data requires basic data analysis skills such as clustering, root cause analysis, differentiating between correlation and causation, understanding data bias etc. Most teams are trained in the usage of analytics tools but not advanced data methodologies. 1. **9 percent** of Medicaid plans hold SDoH data but lack even having analytic staff to use it (IMI, 2023). 2. AHIMA/NORC workforce study calls for urgent upskilling in health-data analytics (2023).	Launch an internal **Data-Literacy Academy**: short, role-based micro-credentials for nurses, analysts, and operators. Train basic usage of data, AI, data science, statistics etc. Pair each new analytics tool with mandatory "explain-the-model" sessions so staff trust outputs.
Shortage of workforce trained in AI / technology Payers compete with tech firms for talent; internal teams lack scale to deploy AI broadly.	1. **79 percent** of payers feel unprepared for scaled AI due to talent gaps (Black Book, 2025).	Build a **hybrid talent model**: core AI team in-house, plus fellowships with universities and outcome-based contracts with vendors. Cycle through AI vendors since most are still in the "proving ROI" phase. Unlike core platforms where plans have deep relationship with claims platform vendors, be prepared to have semi-deep relationships with many AI vendors and don't be afraid to cycle through them via short horizon contracts.
Misaligned incentives across UM, CM, network, actuarial Different departments chase conflicting KPIs, so integration stalls without shared goals.	UM nurses are judged on denials; network teams on provider satisfaction. This leads to teams often not working together. 1. COPE Health notes siloed KPIs turn UM into a "barrier," not a partner (2024 brief). 2. Advisory Board finds only **28 percent** of plans tie cross-department ROI to shared metrics (2023).	Create a **single "value scorecard"** that blends MLR, quality, and member-experience KPIs. Link 20 percent of executive comp across UM, CM, network, and finance to that shared score.
Long-term vendor lock-in contracts Multi-year deals with PBMs, core-admin, or PI vendors make it expensive to switch or add new data feeds.	Often long standing contracts and their time horizons dictate when a system or platform is enhanced, replaced or integrated. 1. Blue Shield of California broke a CVS Caremark PBM contract in 2023 to regain flexibility, targeting 10–15 percent drug-cost savings (FierceHealthcare). 2. **46 percent** of regional plans say contract terms limit IT flexibility (AArete survey, 2024).	Adopt **modular procurement**: smaller, 9-month contracts with data-ownership clauses and API standards. Use "plug-and-play" RFP scoring that rewards vendors for openness, not closed ecosystems.
Culture that values growth over integration Rapid expansion without infrastructure investment creates cracks that widen under volume.	Many plans, especially MA plans have grown rapidly simply chasing membership without the right economics and cash balance for delayed payments from proper risk adjustments. 1. Friday Health Plans collapsed in 2023 after 5× ACA growth outpaced ops and tech (S&P Global MI). 2. **65 percent** of health executives say growth initiatives still outrank integration projects (Deloitte, 2024).	Establish an **Integration Capital Fund**: earmark 15 percent of annual growth budget for tech-debt pay-down and data-link projects. Require the board to review integration KPIs alongside growth KPIs each quarter.

The Long View

In the long run, winning health plans are ones that will link every levee, not just raise individual ones. They will trade point solutions for shared data, share KPI's thoughtfully across teams and create shared accountability. They will make the operating model to be dynamic and flexible, one that can plug in modular solutions that can flex with new rules and new trends. Last, and not the least, they will invest in people as much as platforms, teaching nurses, actuaries, and analysts to pursue the same objectives: less waste, better care, lower trend.

Part 3 will show how to link the levees. We will map quick-win pilots, show how and why to create a two-three-year roadmap, and more to help close the cracks.

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References

Why the "Cracks" Still Persist

1. American Academy of Actuaries. Drivers of 2023 Health Insurance Premium Changes. Issue Brief. Washington, DC, June 2022.
2. American Health Information Management Association (AHIMA). Cottrell, Seth, et al. Health Information Workforce: Survey Results on Workforce Challenges and the Role of Emerging Technologies. Chicago, IL, October 2023.
3. AArete. Vendor Contract Optimization Survey: Regional Health Plans and IT Flexibility. Chicago, IL, April 2024.
4. Advisory Board Company. Aligning Incentives in Care Management Programs. Research brief. Washington, DC, 2023.
5. AHIP and Oliver Wyman. 2023 Health Plan Digital Transformation Survey. Washington, DC, September 2023.
6. Obermeyer, Ziad, et al. "Dissecting Racial Bias in an Algorithm Used to Manage the Health of Populations." Science 366, no. 6464 (October 25, 2019): 447-453. https://www.science.org/doi/10.1126/science.aax2342.
7. Office of the National Coordinator for Health IT. Improving Hospital Transitions and Care Coordination Using Event Notification. Washington, DC, 2022. https://www.healthit.gov/sites/default/files/onc-beacon-lg1-adt-alerts-for-toc-and-care-coord.pdf.
8. Black Book Research. "Payer IT Vendors Enter 'AI Gold Rush' as Health Plans Race to Build Infrastructure for Trusted Automation." Press release, May 22 2025.
9. Centers for Medicare & Medicaid Services (CMS). CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F) Fact Sheet. Baltimore, MD, January 17 2024.
10. COPE Health Solutions. Tirado, Shanah, and Yomi Ajao. "Designing Effective Organizational Care Management to Gain Control of the Total Cost of Care." COPE Health Solutions Insights (blog), 2024.
11. Deloitte. 2024 U.S. Health Care Outlook. Deloitte Insights. New York, NY, January 2024.
12. Diamond, Frank. "Blue Shield of California Ditches CVS Caremark as PBM, Unveils New Pharmacy Care Model." FierceHealthcare, August 17 2023.
13. Earnix. "Overcoming Legacy Technology: The Future of Insurance Innovation." Earnix Blog, February 20 2025.
14. Hammel, Tyler, and Kris E. Figuracion. "Friday Health Plans Collapse Caused by Rapid Growth, Unsustainable Pricing." S&P Global Market Intelligence, June 2023.
15. Institute for Medicaid Innovation. 2023 Annual Medicaid Health Plan Survey: Key Findings. Washington, DC, 2023.
16. Institute for Medicaid Innovation. 2024 Behavioral Health Integration Report. Washington, DC, 2024.