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THE ECONOMICS OF NETWORK LEAKAGE

Why Preventing Leakage Starts Before a Patient Ever Leaves the Network

Executive Summary

Network leakage occurs when attributed patients receive care outside an ACO's preferred network, and the costs run deeper than any single revenue line. HCC conditions go undocumented, benchmark scores decline, quality gaps stay open, and preventable readmissions follow broken coordination chains, leaving the organization accountable for outcomes it can no longer see or influence.

Claims data confirms the problem six to eight weeks after care is delivered, by which point the encounter has already happened and the cost is largely locked in. Clinical data from EHR systems provides a near real-time signal, giving care teams the ability to act weeks before a claim is ever processed, which is how leakage gets prevented rather than just reported.

Primary care is where that signal originates and where the real leverage lies. Attribution, HCC documentation, quality performance, and proactive care management all flow from the primary care relationship, and when primary care is consistently delivered within the network, the downstream leakage problem shrinks. Organizations operating under any value-based care model, whether MSSP, ACO REACH, or the CMS LEAD Model, share the same fundamental requirement: they need to know which patients are at risk before a claim confirms it. Shared savings potential, attribution stability, and quality performance all depend on acting ahead of the data lag, not after it, which requires a platform that unifies clinical and claims data, surfaces at-risk patients in real time, and gives care teams the tools to act. That is what CareSpace® is built to do.

32.9%
of ACO spending flows outside the preferred network

66.7%
specialist referral leakage rate despite network design

6-8 Weeks
claims data lag: too late to prevent the encounter

$160M+
annual leakage exposure for a mid-size ACO with 200 providers

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The Information is there. The Problem is where ACOs look for it.

The challenge with leakage management is not information. It is timing. Claims data arrives six to eight weeks after care is delivered. By the time an ACO can confirm that a patient received care outside the network, the encounter has already happened, the episode has already started, and the cost is largely locked in.

For ACOs that rely on claims as their primary signal, this lag means they are always managing last quarter's problems. Clinical data from EHR systems does not carry that lag. From in-network primary care encounters alone, an ACO can identify in near real time:

- **Which attributed patients received a primary care visit this month**
- **Which patients are overdue for their Annual Wellness Visit**
- **Which high-risk patients have not had a recent follow-up encounter**
- **Which patients have open preventive care gaps for age-appropriate screenings**
- **Which patients have documented SDoH barriers that may limit engagement with in-network providers**

These are not retrospective indicators. They are current signals available weeks before a claim is filed. The ACOs that act on them are not reacting to leakage. They are preventing it.

The Leakage Problem Starts Earlier Than Most ACOs Realize

Most leakage conversations focus on specialty referrals, but the failure rarely begins there. It begins months earlier in primary care, when no one followed up on a missed appointment, identified a rising A1C, or checked whether a patient could afford their medication. Unmanaged conditions escalate, and patients in distress do not pause to check network status. Proactive primary care, including structured follow-ups, medication adherence checks, and preventive screenings, is the structural prevention mechanism for network leakage and, notably, one of the few ACO strategies that advances both fee-for-service revenue and value-based performance at the same time.

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The Full Cost of Leakage Goes Beyond Lost Revenue

Research estimates per-physician leakage losses between $821,000 and $971,000 annually. For a mid-size ACO with 200 providers, that exposure exceeds $160 million. But revenue is only part of what is at stake.

HCC benchmarks erode

out-of-network encounters leave chronic conditions undocumented, producing benchmarks that understate population complexity and make shared savings harder to achieve.

Quality gaps go unclosed:

one missed in-network visit means one lost year of preventive screenings, care gap closures, and HCC documentation for that patient.

Duplicate imaging accumulates

disconnected providers order the same imaging twice, and the ACO absorbs the cost with no utilization control.

Readmissions increase

when coordination breaks at discharge or after a specialist visit, preventable readmissions follow, and without visibility into the cause, improvement is not possible.

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Primary Care Is Where Leakage Begins, and Where It Can Be Stopped

The most consequential leakage often happens early in the care journey, in primary care and preventive services, well before a specialist referral or post-acute episode is ever triggered.

How Attribution Works, and Why Primary Care Is Different

CMS attributes beneficiaries to ACOs based on the plurality of primary care services received, reassessed annually. When a patient consistently receives more primary care outside the ACO's network, CMS may reassign that patient at the next attribution cycle. Primary care leakage triggers a triple consequence that post-acute leakage does not carry:

Lost FFS revenue:
The visit itself goes to a competitor.

Lost quality and documentation control:
No opportunity to close care gaps, complete preventive screenings, or capture HCC codes.

Lost attribution:
If primary care consistently goes outside the network, CMS may stop attributing that patient to the ACO entirely.

Post-acute leakage carries higher dollar amounts per episode but does not carry this attribution risk. A patient whose skilled nursing care happens outside the network is still likely to be attributed to the primary care ACO. A patient whose primary care consistently goes elsewhere is not.

To track whether this risk is building, ACOs should be asking these questions every month:

- **Of the total attributed population, how many received a primary care encounter this month?**
- **Of those who did not, how many have open high-risk conditions or care gaps that make them likely to seek care elsewhere?**
- **Which patients identified as needing specialty care were referred in-network versus out-of-network?**
- **Which patients are trending toward higher cost based on current clinical data?**

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Where the Leakage Opportunity Lives in Primary Care

Annual Wellness Visits:
the foundation of attribution and the single best annual opportunity for risk documentation, care gap closure, and HCC capture. ACOs that push AWV completion above 60 percent consistently outperform on attribution retention and benchmark accuracy.

Preventive screenings:
mammograms, colonoscopies, diabetes monitoring. Services patients often seek wherever is most convenient, and a straightforward win to keep in-network.

Chronic disease follow-ups:
patients with multiple conditions who need regular touchpoints are the most likely to drift out of network when follow-up lapses.

Routine E&M encounters:
basic visits that cement the primary care relationship and protect attribution from eroding visit by visit.

Beyond Primary Care: Two Additional Levers to Reduce Leakage

1. Referral Patterns

79% of healthcare providers say in-network care coordination matters, yet 8 in 10 still refer patients out of network. The issue is not intent. Providers default to familiar specialists because changing behavior requires effort. When in-network specialist lists are embedded in EHR workflows and providers receive utilization scorecards showing their own referral patterns against peers, referral behavior shifts. The gap is infrastructure, not willingness.

2. Patient Education

Patients often seek out-of-network care simply because they do not know in-network alternatives exist. Consistent, clear communication at scheduling, check-in, discharge, and follow-up, highlighting in-network options and the cost and coordination benefits of staying in the network, is a low-effort, high-return intervention.

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How CareSpace® Supports Leakage Prevention

CareSpace® brings together EHR data, claims data, and social determinant of health (SDoH) data into a single view of every attributed patient. That unified longitudinal patient record is what makes proactive leakage prevention operationally feasible at scale, because care teams are working from a complete record rather than fragmented data or a claims file that arrives six to eight weeks after the fact.

The platform uses AI to surface the signals that matter before they become out-of-network encounters. CareSpace® identifies high-risk and high-cost patients using both clinical and claims data, stratifies them by the type of care they need, and gives care teams the ability to prioritize outreach before leakage happens rather than after claims confirm it. For patients who need ongoing monitoring, the platform supports remote patient monitoring workflows that maintain continuity of care within the network.

CareSpace® also drives AWV completion and preventive care workflows across the full attributed population, tracking age-appropriate screenings and flagging gaps before they become missed opportunities.

Rather than waiting for claims to confirm where patients received care, CareSpace® uses EHR data to build leading indicators of leakage risk. Care managers can see in near real time which patients have gaps in primary care engagement, which high-risk individuals have not been seen recently, and where early warning signs of out-of-network utilization are emerging. EHR-based risk signals in CareSpace® align with eventual claims outcomes at 80 to 90% accuracy, giving ACOs the ability to intervene weeks before leakage is confirmed, and well before the cost is locked in.

Conclusion

Network leakage is not a data problem. It is a timing problem. By the time claims confirm where patients went, the cost is already locked in and the opportunity to intervene has passed.

The organizations that close the performance gap are not waiting for that confirmation. They maintain strong primary care relationships, act on clinical signals before gaps compound, and build the infrastructure that makes proactive population management repeatable at scale.

Every value-based model demands it. CareSpace® makes it possible.

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