COPE HEALTH SOLUTIONS

Thought Leadership, Visionary Transformation

Montefiore DOING MORE℠

Population Health 360

A COMPREHENSIVE LOOK

ARC SUPPORTING MATERIALS

01 ARC Summary

Analytics for Risk Contracting (ARC) Suite

To successfully thrive in a pluralistic payment environment, organizations need to understand how to optimize their contracts from a holistic, system-wide point of view. This starts by looking at not just EHR data but also at claims data. Looking at claims data enables a provider to understand the total cost of care and services their members are using both in and out of their own network of providers and facilities. This data can be put to work to identify network gaps and clinical redesign opportunities and to transparently incentivize based on provider impact on total cost and quality of care.

Population Health Expertise Supported by Robust Analytics through the ARC Suite

COPE Health Solutions helps providers and health plans succeed in payment reform and delivery system transformation. Coupled with our population health expertise, our **Analytics for Risk Contracting (ARC) Suite** provides a powerful array of analytic and reporting tools designed to achieve optimal value and performance for organizations currently in or planning to move to risk-based arrangements. Leveraging our extensive, hands-on expertise in helping IPAs, ACOs and health systems achieve successful outcomes in risk contracts, our team
of managed care experts draw insights from the analytic outputs that are tailored to each organization's unique circumstances to interpret the data and recommend initiatives to help improve total cost and quality.

OUR APPROACH

We run our proprietary actuarial forecasting methodology to predict the cascading impact of interventions with a detailed budget and pro forma.

DATA INPUTS

- Medical, behavioral health, and pharmacy claims file combined with provider roster and attributes member file
- Total and risk adjusted utilization in Medicaid, Medicare, and commercial payors
- Avoidable utilization by care setting
- Total cost of care and member utilization across all lines of business (LOB) and by product categories
- Performance according to standard quality metrics
- Medicaid, Medicare and commercial payor data aggregation

PROCESS

- Target and prioritize opportunities to reduce unnecessary medical spend and identify appropriate opportunities based on data analytics outputs
- Evaluate the potential return on investment from identified opportunities
- Assess impact of return on investment on targets and the overall profit and loss
- Operationalize strategic interventions informed by return on investment impact

KEY OUTPUTS

- Strategies and workflow redesign to optimize care models
- Financial incentive and bonus funds flow tools for contracting
- Budget and forecasting model and operational dashboards to continuously evaluate impact

SUCCEEDING IN RISK BASED ARRANGEMENTS

The Analytics for Risk Contracting (ARC) Suite of tools, supported by our expert consulting services, is peerless in its capabilities to identify opportunities for improving revenue, quality, and clinical efficiency.

QUALITY MANAGEMENT

Effectively manage total cost of care through evidence-based medical practices

- Primary care provider (PCP) and specialist co-management
- Chronic condition management

REVENUE OPTIMIZATION

Increase premium revenue through membership growth, service expansion and appropriate documentation

- MCO quality incentive programs
- Membership enrollment reconciliation

UTILIZATION MANAGEMENT

Optimize appropriate utilization through improved care coordination

- Reduce duplication and improve clinical efficiency and effectiveness
- Improve patient and provider satisfaction

THE ARC SUITE'S UNIQUE SOLUTIONS

Physician Benchmarking

Our provider benchmarking methodology compares providers against their own peer network rather than relying on regional or national benchmarks. By using a provider's own data to benchmark the network, our clients are able to set realistic performance targets.

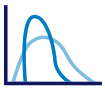
"Stitched" Claims

Our "stitching" methodology allows us to see total medical expenditures by specialty service categories. This is unique because it "stitches" all of the expenditures related to a service so it can be viewed as an episode of treatment - many other tools do not consider all related expenditure categories as part of the specialty service.

SNF Assessment Tool

We evaluate SNFs by benchmarking them against both peers and best practices across multiple domains: quality, staffing model, readmission rate, etc. The outputs of the analysis support network and care management strategies such as where to appropriately move volume, how to address service gaps, and how to better manage transitions from SNF to home care.

Quality Measure Overlap Tool



Our Quality Measure Overlap Tool allows us to identify a provider's overlap of similar quality measures across the numerous quality incentive programs such as HEDIS, ACO and health plan-specific programs. This enables us to prioritize the quality measures with the highest incentive opportunities and identify the most impactful interventions that will maximize quality revenue.

"Cascading Impact" of Interventions Methodology

This proprietary methodology predicts impacts to medical expenditure categories when initiatives are implemented. When an expenditure category is expected to go down, there may be other expenditure categories that go up. Our proprietary methodology predicts the impact of initiatives on medical expenditure categories.

Physician Compensation "Strawman"

This is a helpful recruitment tool for health systems or networks moving toward full-risk (sub-capitated) payment arrangements for in-network practices. Our Physician Compensation "Strawman" tool accurately shows a side-by-side comparison of fee-for-service business with a sub-capitated arrangement shown at the physician or practice level.

Provider Incentive and Funds Flow Toolset

Our funds flow toolset helps you properly incentivize providers to embrace and exhibit desired behaviors. This toolset allows organizations to adjust the size of the incentive (by provider type, by risk pool, by LOB, etc.) and to simulate the impact of successful initiatives on practice/provider revenue.

"Using its years of population health management experience and ARC, Montefiore's Care Management company found opportunities to reduce single-day admissions, admissions for end stage renal disease, improve in-network referral, and reduce overall cost of specialty care."

Stephen Rosenthal, *Senior Vice President, Population Health Management, Montefiore Health System and President of CMO, Montefiore Care Management*

ABOUT COPE HEALTH SOLUTIONS

COPE Health Solutions helps providers and payors thrive in the emerging pluralistic payment environment, allowing them to achieve visionary, organizationally relevant results. The firm has expertise in all aspects of population health, strategy, delivery system development, payment systems reform, workforce development, and value-enabling services, including peerless analytics and performance improvement.

ARC is a subsidiary of COPE Health Solutions, formed through an LLC between COPE Health Solutions, Montefiore Health System, Adventist Health, and Dr. Richard Merkin, owner of Heritage Provider Network Inc. Montefiore Health System and Adventist Health have been strategic partners with COPE Health Solutions in developing and using the cloud-native ARC tool.

COPE Health Solutions is a national leader in helping health care organizations succeed amid complexity and uncertainty

Learn more about how COPE Health Solutions can help your organization identify, prioritize and implement actionable initiatives to advance delivery system restructuring and payment systems reform effort, please visit us copehealthsolutions.com or call us at (213) 259-0245.

02 ARC Illustrated Guides

ARC

managing total cost of care through
clinical redesign

Identifying opportunities to manage total cost of care through effective specialty care co-management between PCP and Specialist.

LEARNING OBJECTIVES:

- Identify service lines with opportunities to positively impact total cost of care
- Use data-driven techniques to identify providers for specialty care redesign initiative
- Explore tools in ARC for on-going performance management

ARC: Clinical Use Case

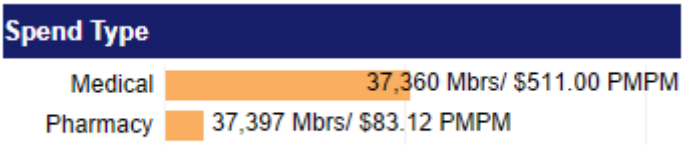
The ARC Suite is designed to help clients identify clear and actionable initiatives that improve performance and manage the total cost of care. Initiatives focus on achieving shared savings or generating margin for medical services ultimately demonstrating short and long-term profitability of transitioning from fee-for-service business to risk-bearing payment arrangements.

Data from all payors under which an IPA or ACO is at risk is collected, validated and transformed by payor and Line of Business (LOB). Resulting analysis is normalized for the underlying claims data across all payors and LOBs to generate:

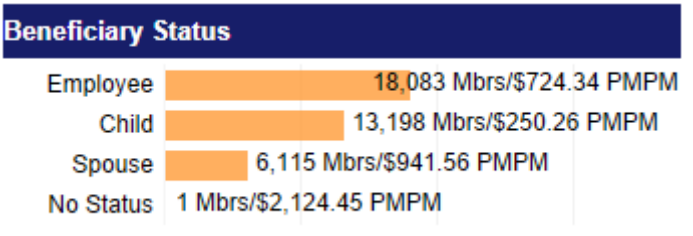
1. Risk contract baseline financial performance in P&L format, against benchmark performance, using high performing providers in the same network in order to set realistic goals for improvement in medical loss ratio and quality scores
2. Detailed visual analytics reports to explore opportunities using drill-down functionality
3. Cascading impacts of opportunities on associated medical expenditure categories using our actuarial waterfall methodology
4. A comprehensive 3-year roll-up budget to demonstrate the financial impact of successful interventions on practice revenue using a customizable funds flow model
5. A "Strawman" tool for primary care and other providers to calculate payment model scenarios and compare revenues side-by-side
6. A consolidated financial profile of a risk contract in baseline and projected and benchmark scenarios

Population Overview

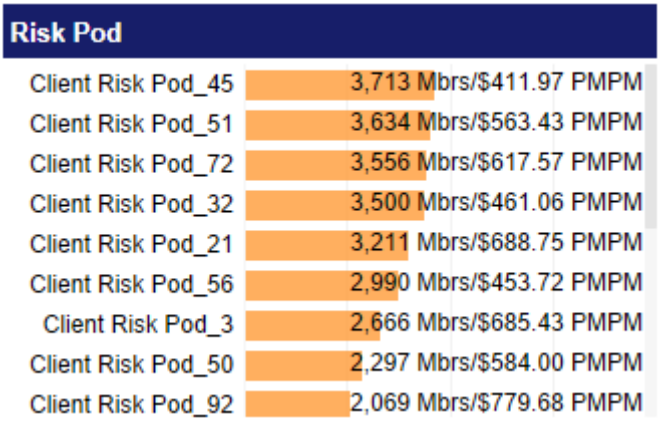
The Population Overview provides a summary of key parameters within the attributed member population, and allows the user to filter the data set to multiple member demographic categories. Within this view, each category displays the member count and the spending Per Member Per Month (PMPM). It can also serve as the main source for population and network filters. Filters are a powerful feature of ARC – by choosing an attribute to filter on (e.g. Spend Type), ARC will automatically apply the filter to all available attributes (e.g. Risk Pod, Beneficiary Status, Total Spend by Member etc.). This provides the user with the full picture for the chosen subset.



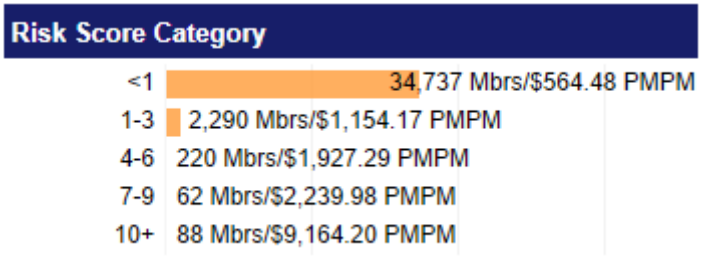
Spend Type: Eligible members and their costs are available by the Medical and Pharmacy spend type. This view allows the user to combine the cost across these two major spend categories



Beneficiary Status: Allows users to also see spend across the major Beneficiary Status categories: Employee, Spouse and Child, in employer-sponsored benefits.

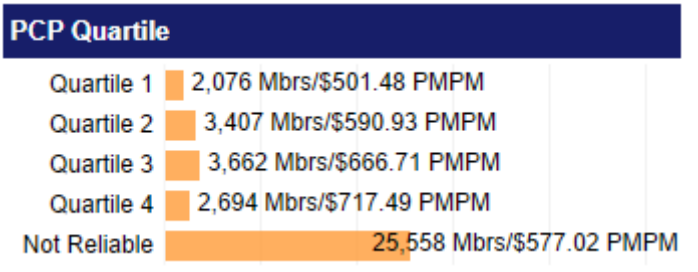


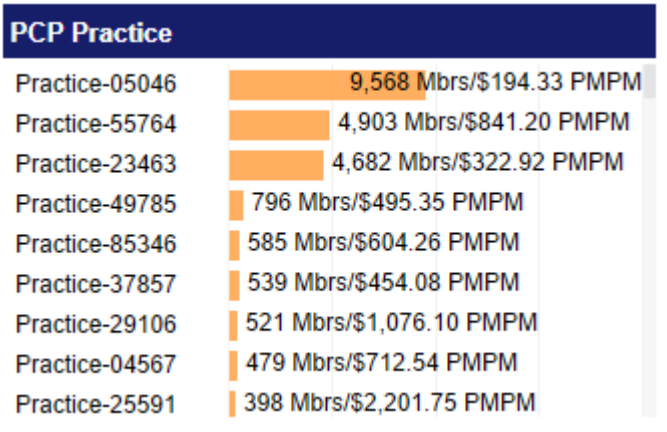
On any given engagement, ARC will work with clients to define Risk Pods, a collection of members, practices, facilities or even by geographies, where defining the subset is crucial for total cost of care management. For example, utilization patterns are often centered around facilities or practices. By defining Risk Pods, ARC allows users to capture the nuances of member utilization patterns, whether driven by geographical needs or other local market drivers. Doing so, not only allows users to apply greater context to their data analysis, but also supports the design of targeted clinical initiatives and subsequently helps track improvements by pod.

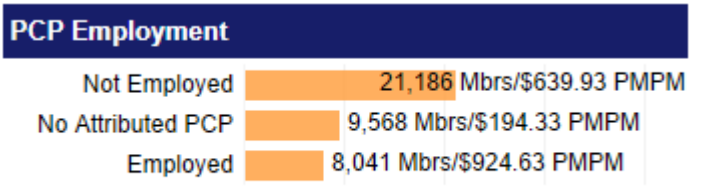


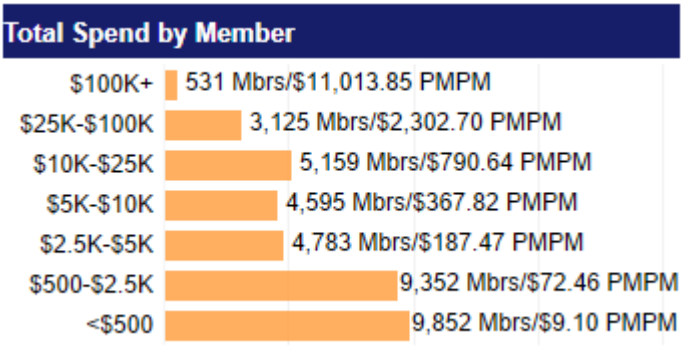
The Risk Score Category breaks down the distribution of Risk Scores and the associated costs for the selected population. Risk scoring is critical cross-cutting element throughout the ARC Suite. Whether provided with member files (e.g. MSSP) or calculated in ARC using the CMS-HCC model (Medicare) or the HHS-HCC model (Commercial or Medicaid) the member risk score serves to both stratify the populations and adjust performance measures and panels.

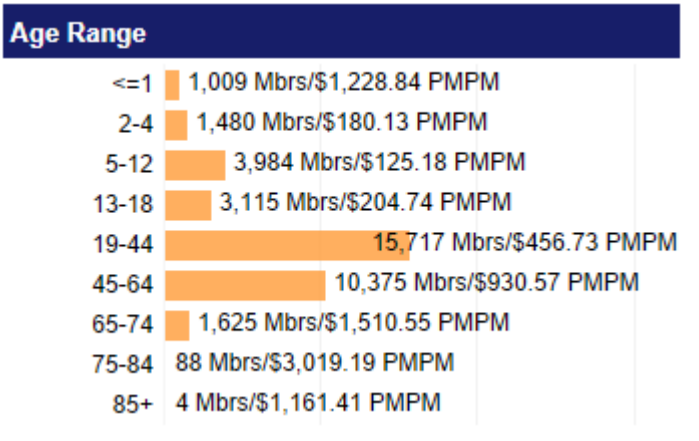
Member PCPs serve as a foundational component of the ARC Suite. Whether chosen upon enrollment, assigned by the payor, or attributed through ARC, PCPs serve as the basis for performance benchmarking. PCPs are ranked by the risk-adjusted admissions/1000 for their attributed panel. They are shown in their PCP performance quartile here, with high performers grouped in Quartile 1 and lowest performing PCPs in Quartile 4









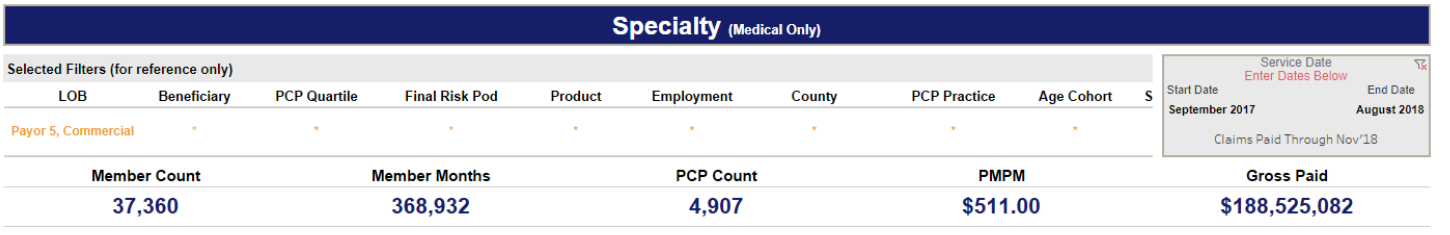


Total Spend by Member: Total Spend By Member breaks down the Gross Paid by spend range for a Member. This view allows the user to quickly filter information by a spend range to help analyze opportunities presented by Members with high spend.

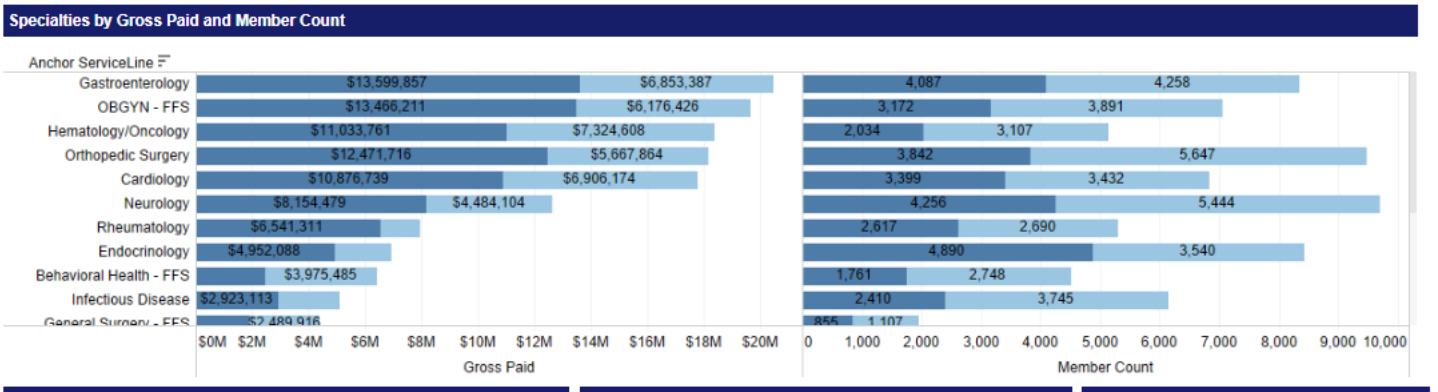
Age Range: ARC provides a breakdown by Age Range as part of the standard overview. This allows for quick identification of members who may be eligible for age specific programs.

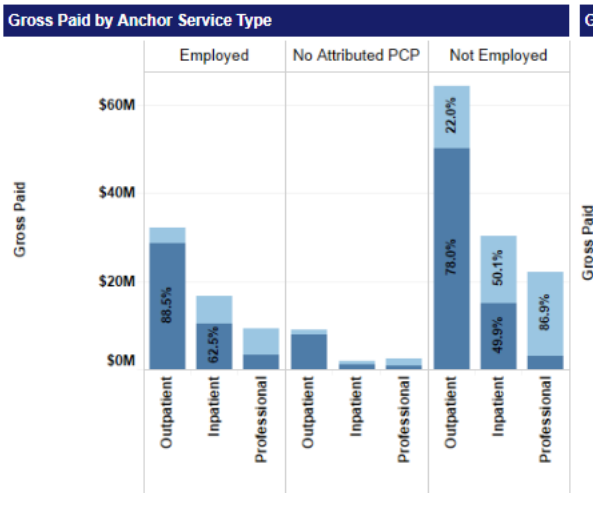
ARC: Clinical Use Case

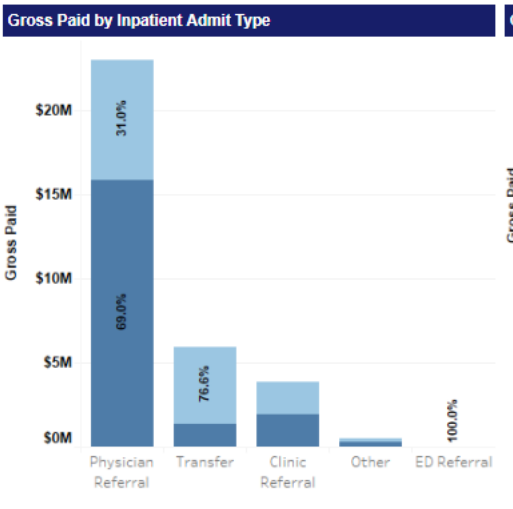
The ARC Specialty view utilizes a stitched claim methodology to create episodes of care, where associated and overlapping claims are anchored to the highest billed claim and service line by the primary diagnosis. As an example, any claims associated with an institutional claim but billed separately (individual claim lines) are stitched to the anchor and its associated service line, allowing the end user to understand the total impact of utilization patterns. Clients can choose to drill into one or more specific service lines to identify trends and opportunities for improved utilization of attributed members, and potential provider practice patterns or barriers for optimal care delivery.

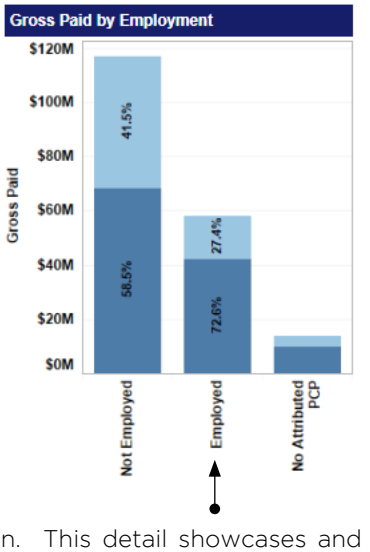


1. Filters can be applied to identify out migration by isolating claims paid to out of network providers. Clients configure and customize the view to represent their network to include owned and/or directly contracted network as well as the payor network.



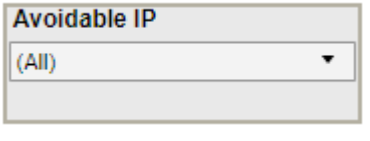


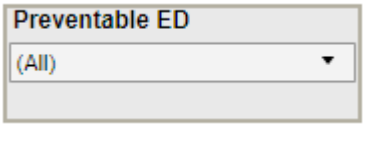


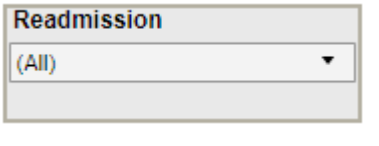


2. These graphs allow the client to view attributed member claim type by PCP affiliation. This detail showcases and compares member utilization patterns by employed group of physicians versus their voluntary/contracted counterparts to implement the right solution.

3. Filters are also available to view potentially avoidable utilization patterns (30 Day All-Cause Readmissions, Avoidable Inpatient, Avoidable ED). In order to foster transparency, COPE Health Solutions utilizes publically available algorithms within this tool, however this can be customized for clients to reflect any other metrics that are used in other arenas



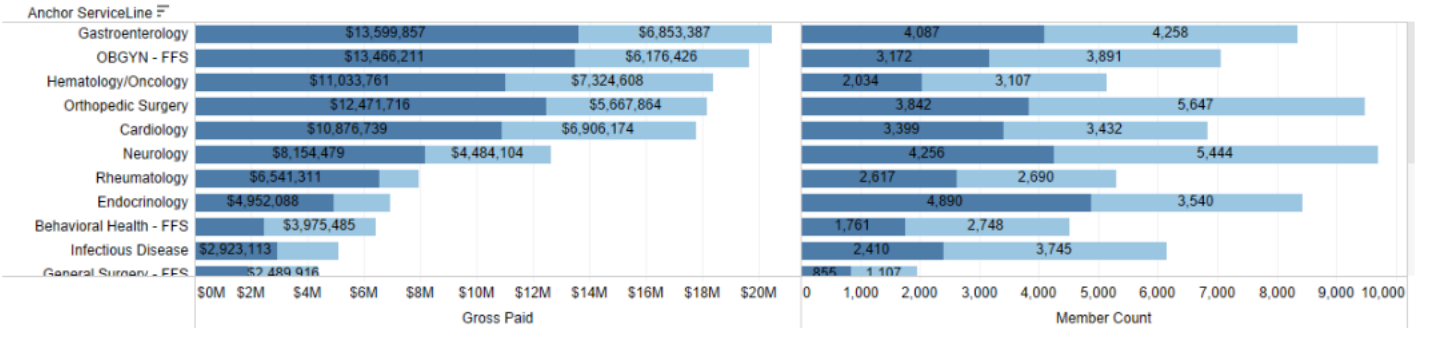




ARC: Clinical Use Case

1. In this example, we filter into Cardiology. Once filtered users can target PCP practices with an overall attribution driving the highest volumes or gross paid.

Specialties by Gross Paid and Member Count



Practice Member Attribution

Practice	Member Count	PMPM	Gross Paid
Practice-55764	4,898	$731.17	$38,003,477
Practice-05046	9,555	$161.88	$13,564,659
Practice-23463	4,681	$299.12	$13,295,977
Practice-25591	398	$2,015.47	$8,628,206
Practice-29106	519	$909.71	$5,107,102
Practice-49785	795	$437.70	$3,509,956
Practice-04567	479	$635.65	$3,302,846
Practice-85346	585	$485.56	$3,050,755

PCP Member Attribution

PCP Name	Member Count	PMPM	Gross Paid
Memb PCP-9521666..	70	$884.56	$681,994
Memb PCP-5126693..	56	$724.04	$444,562
Memb PCP-5534834..	17	$1,789.18	$320,263
Memb PCP-4396832..	41	$690.22	$311,978
Memb PCP-6544741..	11	$2,391.98	$294,213
Memb PCP-3475304..	7	$3,963.72	$293,315
Memb PCP-8923302..	26	$866.12	$236,450
Memb PCP-3595781..	8	$2,508.09	$230,744

Servicing Provider

Servicing Provider Name	Member Count	Gross Paid
Svr Provider_139016955051	370	$1,769,867
Svr Provider_321449089403	129	$1,460,539
Svr Provider_185623553252	7	$202,296
Svr Provider_106277600563	31	$115,228
Svr Provider_903770096759	10	$108,444
Svr Provider_951171364874	2	$102,833
Svr Provider_920335440109	1	$73,939
Svr Provider_636075024741	1	$70,336

2. Selecting a practice then allows the user to understand utilization by individual attributed PCP whose members may be consuming a disproportionate share of resources or most frequently seeking care outside of the network. In this example, ARC will further filter based on the user's selection of Practice 29106 in the Practice Member Attribution table. ARC will automatically filter **all** data to now reflect both Cardiology as well as Practice 29106 as filters. Users can sort the PCP Member Attribution table by Gross Paid, Member Count or PMPM to continue with their analysis.

3. When data is not masked, the servicing provider category allows clients understand where members are obtaining care by name: facilities, medical groups, diagnostic centers, etc. This is essential to clients wanting to understand where service gaps may exist within the network, or how improved connectivity of PCPs to in-network services may need to occur.

4. ARC also allows users to understand what conditions members were most often seeking care for - having applied Cardiology and Practice 29106 as filters, ARC correctly displays the appropriate member subset

Procedure Detail for Encounter: DRG for Inpatient; CCS (CPT) for all Others

Anchor Label	Member Count		Gross Paid	
	In Network	Out of Network	In Network	Out of Network
OTHER FACTORS INFLUENCING HEALTH S..	201	79	$252,105	$8,395
ESOPHAGITIS, GASTROENT & MISC DIGEST..	53	35	$197,803	$50,908
VAGINAL DELIVERY W/O COMPLICATING DI..	7	3	$157,925	$1,798
MEDICAL BACK PROBLEMS W/O MCC	52	43	$133,828	$20,107
RENAL FAILURE W CC	1	1	$129,986	$6,963
CARDIAC VALVE & OTH MAJ CARDIOTHORA..	1	1	$118,767	$2,976
FX, SPRN, STRN & DISL EXCEPT FEMUR, HI..	28	21	$118,491	$24,869
Diseases of the nervous system and sense orga..	138	66	$106,052	$32,853

Primary Servicing Condition; CCS Category for Primary Diagnosis Code

Anchor CCSLvl2Label	Member Count		Gross Paid	
	In Network	Out of Network	In Network	Out of Network
Diseases of the heart	67	32	$373,996	$80,426
Factors influencing health care	262	120	$284,964	$70,105
Non-traumatic joint disorders	80	57	$248,944	$21,471
Diseases of the urinary system	57	25	$241,237	$72,286
Complications mainly related to pregnancy	20	15	$209,064	$73,645
Hypertension	64	12	$161,884	$6,699
Spondylosis; intervertebral disc disorders; other ..	76	61	$145,967	$30,617
Respiratory infections	120	37	$142,616	$9,282

Drilling into Specialist Performance

This specialist attribution view is designed for service line leadership and operators to understand specialist performance based on utilization patterns of attributed members, and advise on opportunities to refine patient management in collaboration with the attributed PCP.

Specialist Performance

Summary

Unique Member Count	PMPM	Member Months	Gross Paid
386	$895.32	8,054	$7,210,879

Specialist Name	Service Line	Practice
(All)	Cardiology	(All)

Attributed Specialist NPI	Provider Name	Unique Member Count	Avg. Risk Score	Gross Paid	PMPM	Specialist IP Admit Rate	% OON Specialist Gross Paid	Specialist Avoidable IP Admit (PQI) Rate	Specialist OON IP Admit Rate	Specialist Readmission Rate	Specialist Single-Day Admit Rate	OON Specialist Risk Adjusted PMPM	Risk Adjusted PMPM
Specialist 2790163	Cardiologist 2790163	70	2.5	$633,991	$425.78	48.4	18.8%	16.7%	16.7%	16.7%	16.7%	$32.08	$170.66
Specialist 1628358	Cardiologist 1628358	29	0.9	$557,970	$888.49	76.4	46.4%	25.0%	75.0%	0.0%	0.0%	$453.69	$978.72
Specialist 1777336	Cardiologist 1777336	22	1.3	$797,199	$1,736.82	104.6	16.9%	0.0%	50.0%	50.0%	0.0%	$232.29	$1,373.93
Specialist 2581627	Cardiologist 2581627	22	0.9	$206,197	$426.91	24.8	87.6%	0.0%	100.0%	0.0%	0.0%	$436.19	$498.08
Specialist 2551907	Cardiologist 2551907	19	1.0	$494,262	$1,211.43	205.9	66.4%	0.0%	57.1%	28.6%	28.6%	$825.19	$1,243.45
Specialist 2268806	Cardiologist 2268806	17	1.6	$482,687	$1,517.88	150.9	8.2%	0.0%	0.0%	0.0%	0.0%	$77.23	$938.92
Specialist 2225422	Cardiologist 2225422	14	0.8	$138,445	$442.32	38.3	82.8%	0.0%	100.0%	0.0%	0.0%	$456.95	$551.99
Specialist 2671352	Cardiologist 2671352	13	0.9	$88,762	$327.54	88.6	27.9%	0.0%	0.0%	0.0%	50.0%	$103.44	$371.41
Specialist 1672854	Cardiologist 1672854	12	3.1	$65,454	$304.44	111.6	15.5%	0.0%	0.0%	0.0%	50.0%	$15.10	$97.22
Specialist 2000449	Cardiologist 2000449	12	0.6	$50,678	$191.96	90.9	25.0%	0.0%	0.0%	0.0%	0.0%	$73.96	$296.05
Specialist 2522141	Cardiologist 2522141	9	1.0	$382,906	$2,151.16	269.7	63.3%	0.0%	50.0%	25.0%	25.0%	$1,420.30	$2,242.69
Specialist 1778589	Cardiologist 1778589	7	0.9	$293,593	$1,823.56	149.1	44.3%	0.0%	50.0%	0.0%	0.0%	$889.31	$2,008.05
Specialist 2641462	Cardiologist 2641462	7	1.1	$48,000	$335.66	167.8	30.5%	50.0%	0.0%	50.0%	0.0%	$90.86	$298.37
Specialist 2045249	Cardiologist 2045249	6	0.9	$405,916	$3,075.12	181.8	31.1%	0.0%	0.0%	0.0%	0.0%	$1,056.83	$3,393.55
Specialist 2909701	Cardiologist 2909701	6	10.7	$574,560	$5,472.00	457.1	10.1%	50.0%	50.0%	25.0%	0.0%	$51.37	$510.96
Specialist 1672731	Cardiologist 1672731	5	6.1	$108,767	$1,222.10	134.8	5.5%	0.0%	0.0%	0.0%	0.0%	$11.07	$199.46
Specialist 2015480	Cardiologist 2015480	5	0.9	$35,517	$331.93	112.1	7.5%	0.0%	0.0%	0.0%	100.0%	$27.60	$370.15
Specialist 1687675	Cardiologist 1687675	4	0.8	$25,956	$324.45	0.0	33.1%	0.0%	0.0%	0.0%	0.0%	$126.50	$382.49
Specialist 1687711	Cardiologist 1687711	4	0.8	$16,908	$183.78	0.0	10.5%	0.0%	0.0%	0.0%	0.0%	$24.60	$235.22
Specialist 1687744	Cardiologist 1687744	4	0.8	$13,830	$150.33	0.0	11.2%	0.0%	0.0%	0.0%	0.0%	$19.86	$177.43
Specialist 1793370	Cardiologist 1793370	4	2.7	$9,903	$135.66	0.0	15.4%	0.0%	0.0%	0.0%	0.0%	$7.84	$50.75
Specialist 2313369	Cardiologist 2313369	4	0.9	$233,152	$2,534.26	260.9	37.3%	0.0%	50.0%	0.0%	50.0%	$1,002.71	$2,687.45
Specialist 2477258	Cardiologist 2477258	4	0.9	$26,655	$317.32	0.0	15.4%	0.0%	0.0%	0.0%	0.0%	$56.11	$364.84
Specialist 2551833	Cardiologist 2551833	4	0.8	$3,454	$44.86	0.0	59.4%	0.0%	0.0%	0.0%	0.0%	$34.48	$58.07
Specialist 2626384	Cardiologist 2626384	4	1.0	$33,807	$402.46	0.0	16.8%	0.0%	0.0%	0.0%	0.0%	$69.75	$414.48

Cardiology members are attributed to Cardiology providers utilizing an approach that begins with providers having had two or more E&M visits within the claim year. The specialist performance dashboard provides clients the ability to rank their specialists based on a combination of performance measures related to managing performance for that service line.

When isolating by PCP Practice, this view also allows for leadership to understand specialist and PCP affinity (shared membership) in order to refine practice patterns and co-management of patients between PCPs and high preforming specialists.

For each service line, Key Performance Indicators (KPIs) are utilized to measure the outcomes for services provided under the specialist's purview.

Initiative Current State and Assumptions

Within the pre-populated financial models are individual tabs to model the impact of each initiative under consideration. The cumulative impact is then summarized and projected over a 3-year period. Based on an assessment of operational conditions, an analyst can populate the appropriate engagement and impact assumptions (in yellow) that drive the initiative return.

Utilization Assumptions

	Commercial
Eligible Member Count	37,397
Eligible Member Month	368,932
Selected Population	
Total Admissions	1,661
Total Avoidable Admission[1]	64
% Avoidable OON[1]	19.4%
Avoidable INN Admission[1]	52
Avoidable OON Admission[1]	12
Total Emergent & Urgent Admission[2]	664
% OON	39.5%
OON Emergent & Urgent Admission[2]	262
% Population Engaged By End of Projection Year	
Projection Year 1	40%
Projection Year 2	55%
Projection Year 3	70%
Utilization Reduction (% of admissions for selected population)	
Magnitude of Avoidable INN Impact	
Projection Year 1	15%
Projection Year 2	25%
Projection Year 3	35%
Magnitude of Avoidable OON Impact	
Projection Year 1	5%
Projection Year 2	10%
Projection Year 3	15%
Repatriation of OON admissions (% of emergent admissions)	
Magnitude of Impact	
Projection Year 1	20%
Projection Year 2	33%
Projection Year 3	40%

Implementation and Ongoing Costs

Cost Assumptions

Cost Assumption			
Initiative Implementation Cost	**Gross - for all LOB**		
UR Design	$ 51,938		
Implementation[3]	$ 80,324		
Other Implementation (IT, hardware, interfaces)	$ 100,000		
Subtotal	$ 232,261		
Initiative Operating Cost	**Medicaid**	**Medicare**	**Commercial**
MD[4][6]	$ -	$ -	$ 0.27
RN[5][6]	$ -	$ -	$ 0.21
Subtotal	$ -	$ -	$ 0.48

Upfront, one-time implementation costs as well as ongoing PMPM fees are used to model the expense component of the initiative.

Here, implementation costs are converted to PMPMs to be spread across lines of business based on the medical expense of each payor/LOB combination.

Initiative Impact - Contracting Entity

The direct impact of the initiative on the population is calculated to help support target setting for use in performance dashboards.

Initiative Impact - Contracting Entity

	Commercial
INN Admission[1]	1,339
OON Admission[1]	322
Utilization Reduction (% of all admissions)	
In Network	**Commercial**
Projection Year 1	0.22%
Projection Year 2	0.52%
Projection Year 3	0.97%
Out of Network	
Projection Year 1	0.00%
Projection Year 2	0.31%
Projection Year 3	0.31%
Population Engaged By End of Projection Year	
Projection Year 1	26
Projection Year 2	35
Projection Year 3	45
Utilization Reduction (total admissions)	
In-Network Reduction	
Projection Year 1	3
Projection Year 2	7
Projection Year 3	13
Out-Of-Network Reduction	
Projection Year 1	0
Projection Year 2	1
Projection Year 3	1
Repatriated OON Emergent Admissions	
Projection Year 1	21
Projection Year 2	48
Projection Year 3	73

Initiative Cumulative ROI and 3-year projection

The direct impact to utilization is passed through an actuarial waterfall to understand the impact of a reduction in a specific type of utilization on increases in other areas (e.g. reductions in short duration surgical admissions may result in increases in outpatient surgery and/or rehabilitation). The financial results of these direct and indirect impacts to utilization are summarized on an annual and cumulative basis to present the initiative ROI.

Financial Impact

	Commercial
Projection Year 1	
Total (INN + OON) MLR Saving	$ 75,950
MLR Savings From OON Repatriation	$ -
Total Initiative Cost	$ 303,338
Net Impact of Initiative	**$ (227,389)**
Projection Year 2	
Total (INN + OON) MLR Saving	$ 250,451
MLR Savings From OON Repatriation	$ -
Total Initiative Cost	$ 97,731
Net Impact of Initiative	**$ 152,720**
Projection Year 3	
Total (INN + OON) MLR Saving	$ 402,350
MLR Savings From OON Repatriation	$ -
Total Initiative Cost	$ 124,384
Net Impact of Initiative	**$ 277,966**
Cumulative Net Impact	
Total (INN + OON) MLR Saving	$ 728,750
MLR Savings From OON Repatriation	$ -
Total Initiative Cost	$ 525,453
Net Impact of Initiative	**$ 203,297**

ARC

strengthening your **contracting strategy**

A financial forecasting tool for risk contract revenue and expenditures

LEARNING OBJECTIVES:

- Perform a pre-contract assessment, including contract structure, network and deal points before arriving at a go / no-go decision
- Identify opportunities to improve contract performance and model resulting impact to facility financials
- Example best practices for provider incentive models to promote value-based care

Sizing the Opportunity

The ARC Suite is designed to help clients identify clear and actionable initiatives that improve performance and manage the total cost of care - thus achieving shared savings or generating margin for medical services and ultimately demonstrating short and long-term profitability of transitioning from fee-for-service business to risk-bearing payment arrangements.

To size the opportunity, we begin with assessing the Current State/Historical performance:

Data from all payors under which IPA or APACO is at risk, is collected, validated and transformed by payor and line of business (LOB). The resulting analysis is normalized for the underlying claims data across all payors and LOB to generate:

1. Risk contract's baseline financial performance in P&L format against benchmark performance (*using high performing providers in the same network*) in order to set realistic goals for improvement in medical loss ratio and quality scores
   - Output includes detailed visual analytics reports to explore opportunities using "drill down" functionality
2. Cascading impact of opportunities on medical expenditure categories using our proprietary "waterfall" methodology
3. A comprehensive 3-year roll-up budget to demonstrate the financial impact of successful interventions on practice revenue using a customized funds flow methodology
4. "Strawman" tool for primary care and other providers - the tool calculates payment model scenarios side-by-side
5. Consolidated financial profile of a risk contract in baseline, projected and benchmark scenarios

Current State vs. Benchmark

Revenue	Member Months	Member Count	Current State Expenditures PMPM	Benchmark Expenditures PMPM
$917,986,028	**1,616,655**	**203,248**	**$548.38**	**$493.19**

Line of Business	Projection Scenario	Network	Risk Pool
(All)	Benchmark	(All)	(All)

Current State				Benchmark				Opportunity	
Revenues		$917,986,028		Revenues		$917,986,028			
Expenditure	Risk Pool	Current State Gross Amount	Current State Expenditures PMPM	Expenditure	Risk Pool	Gross Amount Benchmark	Benchmark Expenditures PMPM	% Difference	Opportunity $
Claims Based	Institutional	$308,796,474	$191.01	Claims Based	Institutional	$243,866,161	$150.85	▲26.6%	($64.93M)
	Professional	$255,116,999	$157.81		Professional	$250,534,631	$154.97	▲1.8%	($4.58M)
	Other Ancillary	$272,143,001	$168.34		Other Ancillary	$257,666,836	$159.38	▲5.6%	($14.48M)
Non-Claims Based	IBNR	$41,548,676	$25.70	Non-Claims Based	IBNR	$36,312,468	$22.46	▲14.4%	($5.24M)
	MSO Expenses	$2,365,000	$1.46		MSO Expenses	$2,365,000	$1.46		$0.00M
	Other Expenses	$6,578,399	$4.07		Other Expenses	$6,578,399	$4.07		$0.00M
Net Profit		$31,437,480		Net Profit		$120,662,533		▲11.2%	($89.23M)

The Current State vs. Benchmark Comparison is a standardized financial view of risk contract revenue and expenditures for the population compared against the benchmark performance. The benchmark scenario can be calculated using one or multiple sets of variables of performance by panel (e.g. risk-adjusted admits/1,000). This view identifies potential improvement opportunities across by payor, line of business and risk pool.

In addition, expenses can be further broken out by service categories to identify service line specific opportunities:

Current State Expenditures			Benchmark Expenditures				Opportunity
Expenditure Detail	Current State Gross Amount	Current State Expenditures PMPM	Expenditure Detail	Gross Amount Benchmark	Benchmark Expenditures PMPM	% Difference	Opportunity $
Medical	$82,424,316	$50.98	Medical	$61,969,496	$38.33	▲33.0%	($20.45M)
Surgical	$73,242,399	$45.30	Surgical	$62,442,746	$38.62	▲17.3%	($10.80M)
Other	$54,147,362	$33.49	Other	$40,569,974	$25.10	▲33.5%	($13.58M)
NBD	$21,733,847	$13.44	NBD	$15,657,066	$9.68	▲38.8%	($6.08M)
ED	$15,777,423	$9.76	ED	$14,519,773	$8.98	▲8.7%	($1.26M)
SNF	$15,265,546	$9.44	SNF	$10,911,514	$6.75	▲39.9%	($4.35M)
Outpatient Surgery	$13,926,621	$8.61	Outpatient Surgery	$14,060,880	$8.70	▼-1.0%	$0.13M
Chemotherapy	$9,735,501	$6.02	Chemotherapy	$8,171,284	$5.05	▲19.1%	($1.56M)
NICU	$7,862,660	$5.67	NICU	$4,592,717	$3.31	▲71.2%	($3.27M)
MH/CD	$6,389,968	$3.95	MH/CD	$4,652,280	$2.88	▲37.4%	($1.74M)
Clinic Visits	$5,254,440	$3.25	Clinic Visits	$5,154,522	$3.19	▲1.9%	($0.10M)
Transplant	$3,036,392	$1.88	Transplant	$1,163,910	$0.72	▲160.9%	($1.87M)
Grand Total	**$308,796,474**	**$191.01**	Grand Total	**$243,866,161**	**$150.85**	▲26.6%	**($64.93M)**

Please note: Benchmark expenditure is an internal benchmark that is specific to the client. The benchmark represents what medical expenditure would look like if all primary care providers within a network are performing at an equally high level.

Initiative Current State and Assumptions

Within the pre-populated financial models are individual tabs to model the impact of each initiative under consideration. The cumulative impact is then summarized and projected over a 3-year period.

Specialty Care Profiling

Opportunity

- Specialty care profiling and alignment of high performing specialists with primary care to encourage implementation of best practices and strengthen referral pathways

Analytic Insights

- Cardiology out-of-network costs ($103 M)
- Pilot practice identified with high cardiology member attribution (6,173)

Intervention

- Implement community grand rounds and consensus care guidelines
- Develop co-management fellowship
- Implement phone and e-consult services

Pilot Practice Projected Impact	
Yr 1	• Net savings of $241,711 (1.3% reduction in overall cardiology spend) • Repatriation of 12 admissions
Yr 2	• Net savings of $908,270 (5% reduction in overall cardiology spend) • Repatriation of 28 admissions
Yr 3	• Net savings of $1.48 M (8% reduction in overall cardiology spend) • Repatriation of 40 admissions
Total	Cumulative net savings after 3 years of $2.64 M (14% reduction in overall cardiology spend)

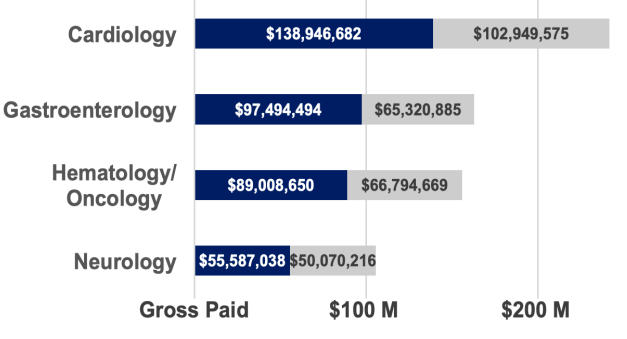
High-Level Opportunity

Cardiology Service Line Statistics:
- Patients – 89K
- PCPs – 1,016
- Average PMPM – $265
- Gross Paid – $242M

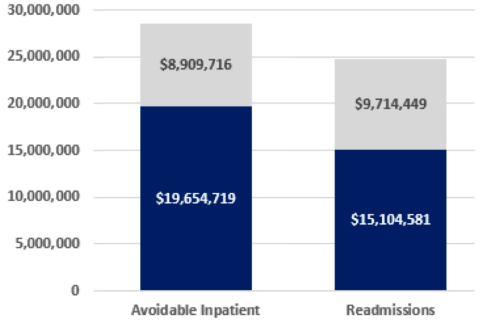
Potential Cardiology Opportunity:
- Avoidable IP – $28.5M
- OON – $103M

Key: In Network Out of Network

Specialties by Gross Paid and Member Count



Potential Avoidable Spend by Category



Strategic Opportunities Identified through ARC Suite

Opportunity Identified: Cardiology is top gross paid specialty with opportunities to reduce MLR and out-of-network leakage

ARC Suite Intervention:
- Utilize the ARC Suite to complete economic profiling of cardiologists to rank specialists
- Create actionable interventions to improve PCP utilization of top performing cardiologists and access
- Project ROI for at-risk entity and align providers through funds flow
- Regularly review performance

Please note: In this example, the Clinical Redesign team has identified opportunities in Cardiology and designed targeted initiatives accordingly.

Managing the Hospital Contribution Margin

As a result of reducing unnecessary utilization, the hospitals are likely to experience loss in revenue both from the risk contract as well as other sources such as GME/IME and DSH. The hospital financial view against benchmark helps organizations understand the impact to hospital contribution margin as a result of reduced unnecessary utilization from initiatives.

Current State Inpatient Admissions	Projected Inpatient Admissions	Change in Net Profit
9,606	7,784	$14,295,814

Payor	Line of Business	Projection Scenario
Payor 3	(All)	Benchmark

Current State			Projection Scenario			Difference	
						% Difference	Change in Net Profit
Revenue		$139,874,958	Revenue		$113,276,991	23.5%	$26,597,967
Expenses	Fixed Cost	($71,998,498)	Expenses	Fixed Cost	($71,998,498)	0.0%	$0
	Variable Cost	($64,494,243)		Variable Cost	($52,192,090)	23.6%	($12,302,153)
Net Profit		$3,382,217	Net Profit		($10,913,597)	-131.0%	$14,295,814

Notes:

- Reducing inpatient utilization and keeping inpatient utilization in-network is critical to curbing total cost of care.
- Going from FFS to value-based care, it is important to recognize the impact on inpatient hospitals paid through fee-for-service contracts
- Reduction in admissions adversely affects the hospital bottom line as it loses revenue for each admission that is rerouted
- During the transition from FFS to value-based care, hospitals may receive a portion of the surplus generated through savings in total cost of care from the risk-bearing entity
- Hospital's ability to partner with community providers and reduce hospital admissions will improve their margins

Financial Planning

The financial impact of one or more initiatives is aggregated to show the 3-year MLR

Current State				Projection Year 3				Opportunity	
Revenues			$917,986,028	Revenues			$917,986,028		
Expenditure	Risk Pool	Current State Gross Amount	Current State Expenditures PMPM	Expenditure	Risk Pool	Gross Amount Benchmark	Benchmark Expenditures PMPM	% Difference	Opportunity $
Claims Based	Institutional	$308,796,474	$191.01	Claims Based	Institutional	$301,278,513	$186.36	▲2.5%	($7.52M)
	Professional	$255,116,999	$157.81		Professional	$257,991,904	$159.58	▼-1.1%	$2.87M
	Other Ancillary	$272,143,001	$168.34		Other Ancillary	$270,305,874	$167.20	▲0.7%	($1.84M)
Non-Claims Based	IBNR	$41,548,676	$25.70	Non-Claims Based	IBNR	$41,185,935	$25.48	▲0.9%	($0.36M)
	MSO Expenses	$2,365,000	$1.46		MSO Expenses	$2,365,000	$1.46		$0.00M
	Other Expenses	$6,578,399	$4.07		Other Expenses	$6,578,399	$4.07		$0.00M
Net Profit			$31,437,480	Net Profit			$38,280,402	▲0.8%	($6.84M)

Notes:

- Financial projections for risk contracts are aggregated for all payors with the ability to view each payor, line of business and risk pod
- The ARC Suite models the percent change in PMPM and projected costs based on initiative design to implement and operate an initiative using a proprietary actuarial methodology which predicts impacts of reduced unnecessary utilization to medical expenditures by category

Budgeting and Funds Flow

This view is an example funds flow allocation model to distribute the generated surplus to providers as a result of initiative implementation for the impacted risk business.

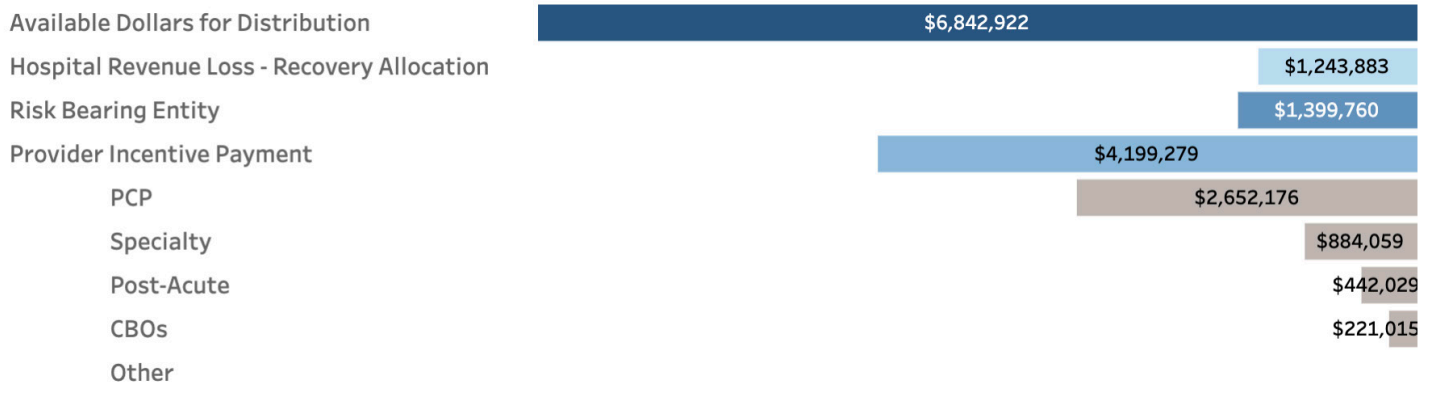
Member Months	Member Count	Gross Paid
1,616,655	203,248	$120,662,533

Payor: Payor 3

Projection Year: Year 3

	Baseline	Year 3
Net Profit/Loss	$31,437,480	$38,280,402
PMPM	$19.45	$23.68
Available Dollars for Distribution		$6,842,922

Contracting Entity



Notes:

- The ARC Suite calculates the total available surplus to distribute to providers due to cost savings or revenue generation as a result of initiative implementation. Users have the flexibility to inform the order of paying out incentive payments by provider type, ability to set caps and/or thresholds for allocation by line of business.
- In addition to hospitals and primary care providers, opportunities for bonuses for other community provider types (i.e. specialists, sub-acute, etc.) should be considered to improve level of alignment and overall outcomes

Funds Flow - Physician Strawman Model

The Physician Strawman is a forecasted schedule, generated for each provider, that includes projected revenue (fee-for-service or capitated) and potential incentive funds allocated per provider and per performance metric (assuming that the budgeted savings or additional in-network utilization are achieved)

Current State-members	PCP Incentive PMPM	Projected Financial Opportunity (Gross)
323	$29.23	113,309

Practice	Payor	Projection Scenario
Smith Family Practice	Payor 3	Benchmark

Contract Mockup

	Current State FFS Arrangement		Projection Scenario Capitation	% Difference	Gross Difference
FFS Revenue	$94,932	Capitated Revenue	$95,987	1.1%	$1,055
Eligible Bonus Funds	$0	Eligible Bonus Funds	$112,255	100.0%	$112,255
Maximum Eligible Funds	$94,932	Maximum Eligible Funds	$208,241	54.4%	$113,309

Grading Rubic

Metrics	Performance	Bonus Funds Earned
PMPM	56.0%	$6,286
Specialty PMPM	87.0%	$9,766
Risk Adjusted Inpatient/1000	100.0%	$11,225
Risk Adjusted ED/1000	75.4%	$8,462
Risk Adjusted Single Day Admits	67.0%	$7,521
Risk Adjusted Avoidable Admits/1000	54.0%	$6,062
Risk Adjusted ED Preventable/1000	45.0%	$5,051
% OON Total (ED+IP)	79.7%	$8,945
% OON ED Gross Paid	62.5%	$7,016
% OON Specialty Gross Paid	85.7%	$9,622
Total Bonus Earned		$79,957
Total Earned Revenue		$175,944

Notes:

- Strawman model encapsulates practice revenue by line of business, key practice metrics and performance incentive metrics and potential bonus/risk pool
- Uses client-specific quality and performance metrics based on the incentive strategy, budgeted bonus pool dollars available for physician incentives and provider-level performance data

Consolidated Financials

The consolidated financial statement displays the revenues and expenses for risk contracts by entity (contracting entity, and provider), year and by line of business.

Payor	Line of Business	Projection Scenario
Payor 3	(All)	Benchmark

		Current State			Benchmark			Difference	
		Contracting Entity	Provide	Total	Contracting Entity	Provider	Total	% Difference	Gross Difference
Revenues	Total	$917,986,028	$139,874,958	$1,057,860,986	$917,986,028	$113,276,991	$1,031,263,019	-2.6%	($26,597,967)
	Risk Pool Revenue	$917,986,028	$0	$917,986,028	$917,986,028	$0	$917,986,028	0.0%	$0
	Medical Services	$0	$139,874,958	$139,874,958	$0	$113,276,991	$113,276,991	-23.5%	($26,597,967)
Expenses	Total	$886,548,548	$136,492,741	$1,023,041,288	$797,323,495	$124,190,588	$921,514,083	-11.0%	($101,527,206)
	Claims Based	$836,056,473	$0	$836,056,473	$752,067,629	$0	$752,067,629	-11.2%	($83,988,844)
	Non-Claims Based	$50,492,074	$0	$50,492,074	$45,255,866	$0	$45,255,866	-11.6%	($5,236,208)
	Provider Medical Services	$0	$136,492,741	$136,492,741	$0	$124,190,588	$124,190,588	-9.9%	($12,302,153)
Net Profit				$34,819,698			$139,874,958		$105,055,260

ARC

analyzing **self-insured**

Managing total cost of care for the self-insured population

LEARNING OBJECTIVES:

- Aggregate members into geographical risk pods and identify the density of chronic conditions by risk pod
- Create targeted interventions and programs to engage members and reduce avoidable utilization
- Leverage population health findings to optimize benefit design
- Merge pharmacy and medical data together to optimize utilization and unit cost

ARC: Self-Insured Use Case

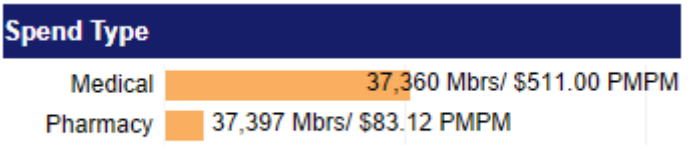
The ARC Suite is designed to help clients identify clear and actionable initiatives that improve performance and manage the total cost of care. Initiatives focus on achieving shared savings or generating margin for medical services ultimately demonstrating short and long-term profitability of transitioning from fee-for-service business to risk-bearing payment arrangements.

Data from all payors under which an IPA or ACO is at risk is collected, validated and transformed by payor and Line of Business (LOB). Resulting analysis is normalized for the underlying claims data across all payors and LOBs to generate:

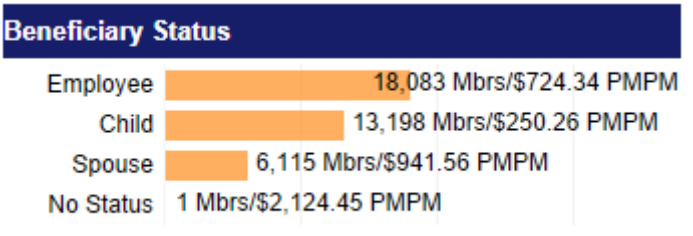
1. Risk contract baseline financial performance in P&L format, against benchmark performance, using high performing providers in the same network in order to set realistic goals for improvement in medical loss ratio and quality scores
2. Detailed visual analytics reports to explore opportunities using drill-down functionality
3. Cascading impacts of opportunities on associated medical expenditure categories using our actuarial waterfall methodology
4. A comprehensive 3-year roll-up budget to demonstrate the financial impact of successful interventions on practice revenue using a customizable funds flow model
5. A "Strawman" tool for primary care and other providers to calculate payment model scenarios and compare revenues side-by-side
6. A consolidated financial profile of a risk contract in baseline and projected and benchmark scenarios

Population Overview

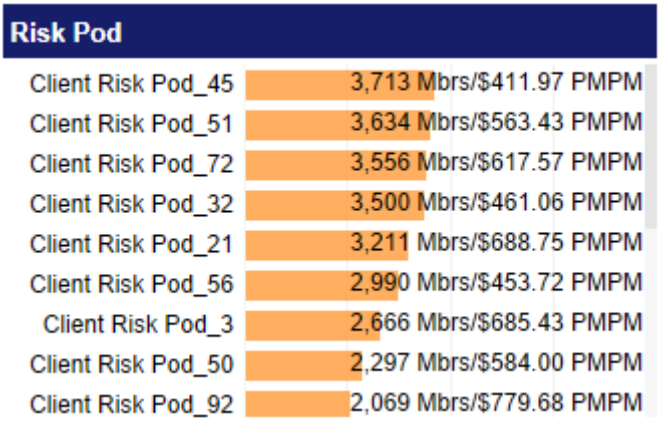
The Population Overview provides a summary of key parameters within the attributed member population, and allows the user to filter the data set to multiple member demographic categories. Within this view, each category displays the member count and the spending Per Member Per Month (PMPM). It can also serve as the main source for population and network filters. Filters are a powerful feature of ARC – by choosing an attribute to filter on (e.g. Spend Type), ARC will automatically apply the filter to all available attributes (e.g. Risk Pod, Beneficiary Status, Total Spend by Member etc.). This provides the user with the full picture for the chosen subset.



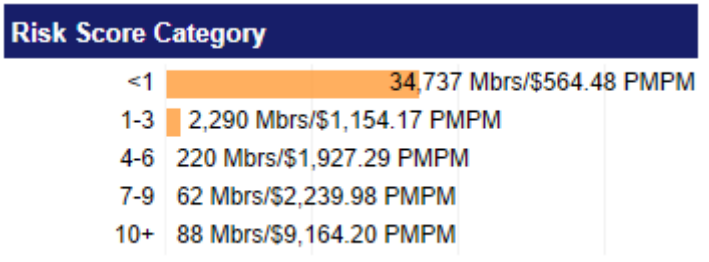
Spend Type: Eligible members and their costs are available by the Medical and Pharmacy spend type. This view allows the user to combine the cost across these two major spend categories



Beneficiary Status: Allows users to also see spend across the major Beneficiary Status categories: Employee, Spouse and Child.

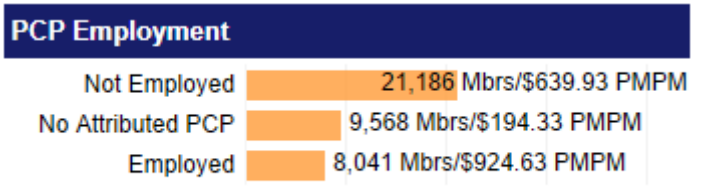


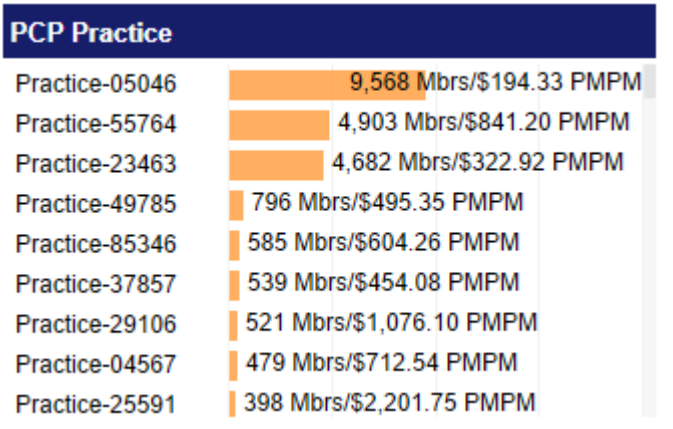
On any given ARC engagement, ARC will work with clients to define Risk Pods, a collection of members, practices, facilities or even by geographies, where defining the subset is crucial for total cost of care management. For example, utilization patterns are often centered around facilities or practices. By defining Risk Pods, ARC allows users to capture the nuances of member utilization patterns, whether driven by geographical needs or other local market drivers. Doing so, not only allows users to apply greater context to their data analysis, but also supports the design of targeted clinical initiatives and subsequently helps track improvements by pod.

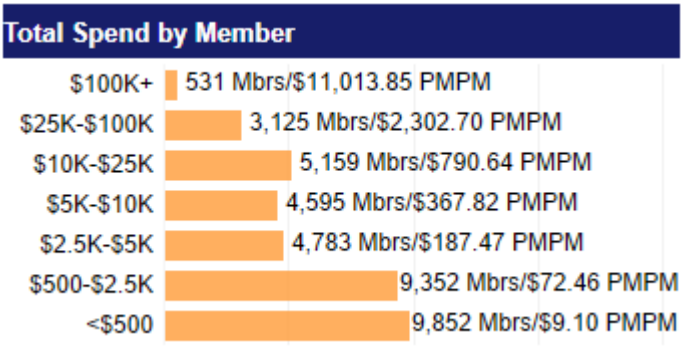


The Risk Score Category breaks down the distribution of Risk Scores and the associated costs for the selected population. Risk scoring is critical cross-cutting element throughout the ARC Suite. Whether provided with member files (e.g. MSSP) or calculated in ARC using the CMS-HCC model (Medicare) or the HHS-HCC model (Commercial or Medicaid) the member risk score serves to both stratify the populations and adjust performance measures and panels.

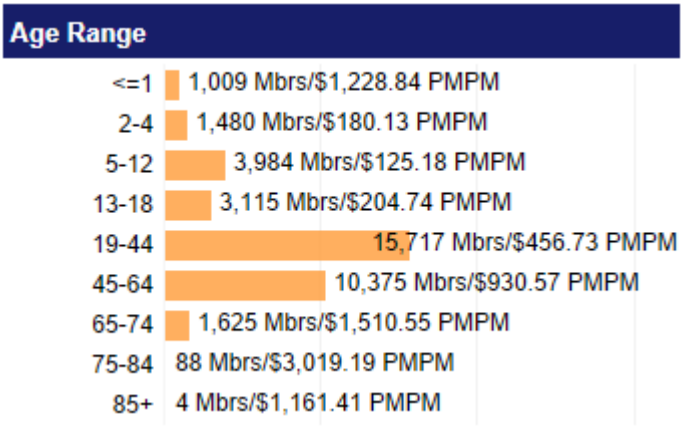
Member PCPs serve as a foundational component of the ARC Suite. Whether chosen upon enrollment, assigned by the payor, or attributed through ARC, PCPs serve as the basis for performance benchmarking. PCPs are ranked by the risk-adjusted admissions/1000 for their attributed panel.







Total Spend by Member: Total Spend By Member breaks down the Gross Paid by spend range for a Member. This view allows the user to quickly filter information by a spend range to help analyze opportunities presented by Members with high spend.



Age Range: ARC provides a breakdown by Age Range as part of the standard overview. This allows for quick identification of members who may be eligible for age specific programs.

ARC: Self-Insured Use Case

Identifying Cost Savings Opportunities for Medical Spend

In order to understand high impact drivers of total cost of care, we navigate to Inpatient and ED view to identify appropriate opportunities for reduction in medical spend. Here, users can quickly identify members with Preventable ED visits who are not attributed to a PCP:

Emergency Department (Medical Only)

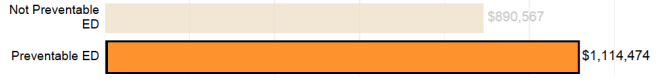
Selected Filters (for reference only)

LOB	Beneficiary	PCP Quartile	Final Risk Pod	Product	Employment	County	PCP Practice	Age Cohort	Sex
Payor 5, Commercial	*	Not Reliable	*	*	No Attributed PCP	*	Practice-05046	*	*

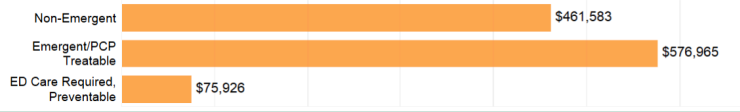
Preventable ED: (All)

ED Visits	% OON ED Gross Paid	ED Prev Gross Paid	% Preventable ED Gross Paid
492	14.8%	$1,114,474	100.0%

Preventable



ED Prev Category



PCP and Practice Member Attribution - ED Visits

PCP Practice...	Member Count	ED Visits	Gross Paid	% Preventable ED Gross Paid
Grand Total	3,217	3,994	$9,796,091	100.0%
Practice-55764	569	762	$2,024,576	100.0%
Non-Attributed PCP	430	492	$1,114,474	100.0%
Practice-23463	273	317	$654,335	100.0%
Practice-04567	60	83	$464,200	100.0%
Practice-29106	100	143	$341,862	100.0%
Practice-37857	122	166	$216,944	100.0%
Practice-49785	60	70	$182,944	100.0%

ED CCS Categories for CPTs

Anchor Label	Member Count	ED Visits	Gross Paid	% Preventable ED Gross Paid
Grand Total	430	492	$1,114,474	100.0%
ESOPHAGITIS, GASTROENT & MIS..	89	96	$309,541	100.0%
OTITIS MEDIA & URI W/O MCC	83	92	$95,807	100.0%
BRONCHITIS & ASTHMA W/O CC/M..	30	31	$48,848	100.0%
MEDICAL BACK PROBLEMS W/O M..	22	22	$40,765	100.0%
MINOR SKIN DISORDERS W/O MCC	21	22	$14,865	100.0%
HEADACHES W/O MCC	20	22	$64,950	100.0%
SIMPLE PNEUMONIA & PLEURISY ..	19	19	$59,745	100.0%
SIGNS & SYMPTOMS OF MUSCULO..	18	18	$27,072	100.0%
CHEST PAIN	17	17	$71,836	100.0%
KIDNEY & URINARY TRACT INFECT..	16	18	$58,354	100.0%
CELLULITIS W/O MCC	15	17	$15,554	100.0%
OTHER DISORDERS OF THE EYE ..	11	12	$7,908	100.0%
URINARY STONES W/O ESW LITHO..	9	9	$38,426	100.0%

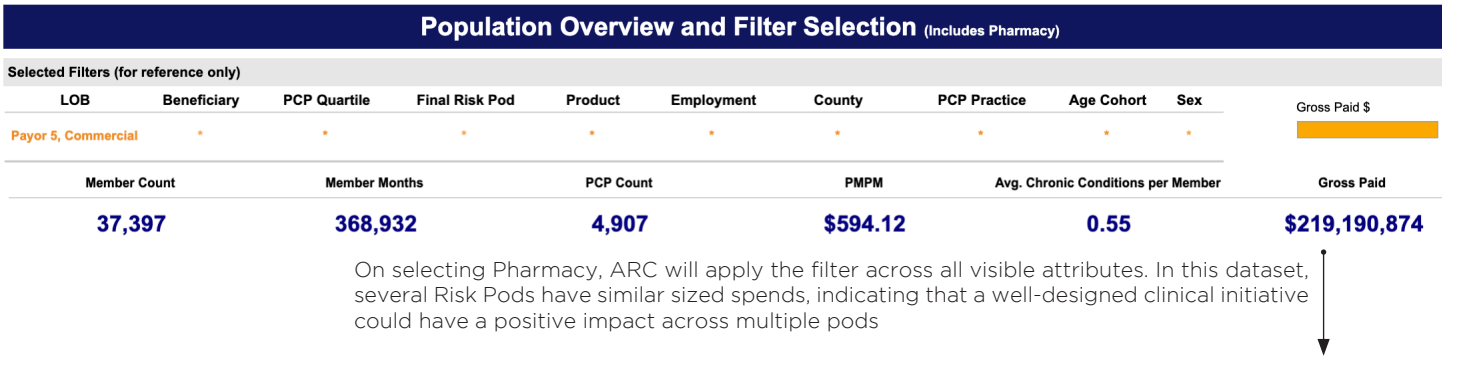
Member Detail

MemberID	Practice	Pcpnpi	Inpatient	Avoidable Admits (PQI)	Inpatient Admits OON	ED	ED Prev	ED Visits OON	Gross Paid
Member697520163431	Practice-05046	No Attributed PCP	0	0	0	1	1	0	$12,932
Member68910105858	Practice-05046	No Attributed PCP	0	0	0	1	1	0	$11,442
Member3788081786	Practice-05046	No Attributed PCP	0	0	0	2	1	0	$11,176
Member28504412599	Practice-05046	No Attributed PCP	0	0	0	1	1	0	$10,591
Member46525329568	Practice-05046	No Attributed PCP	0	0	0	1	1	0	$9,777
Member91353227216	Practice-05046	No Attributed PCP	0	0	0	1	1	0	$9,777
Member99735117126	Practice-05046	No Attributed PCP	0	0	0	1	1	0	$9,777
Member37091659321	Practice-05046	No Attributed PCP	0	0	0	1	1	0	$9,688
Member57150245202	Practice-05046	No Attributed PCP	0	0	0	1	1	0	$9,590
Member9229571943	Practice-05046	No Attributed PCP	0	0	0	3	1	0	$9,519
Member21454695352	Practice-05046	No Attributed PCP	0	0	0	1	1	0	$9,490
Member84550311062	Practice-05046	No Attributed PCP	0	0	0	1	1	0	$9,490
Member61284453548	Practice-05046	No Attributed PCP	0	0	0	2	1	0	$9,278
Member13776132375	Practice-05046	No Attributed PCP	0	0	0	1	1	0	$9,216
Member278474613628	Practice-05046	No Attributed PCP	0	0	0	2	1	0	$9,188

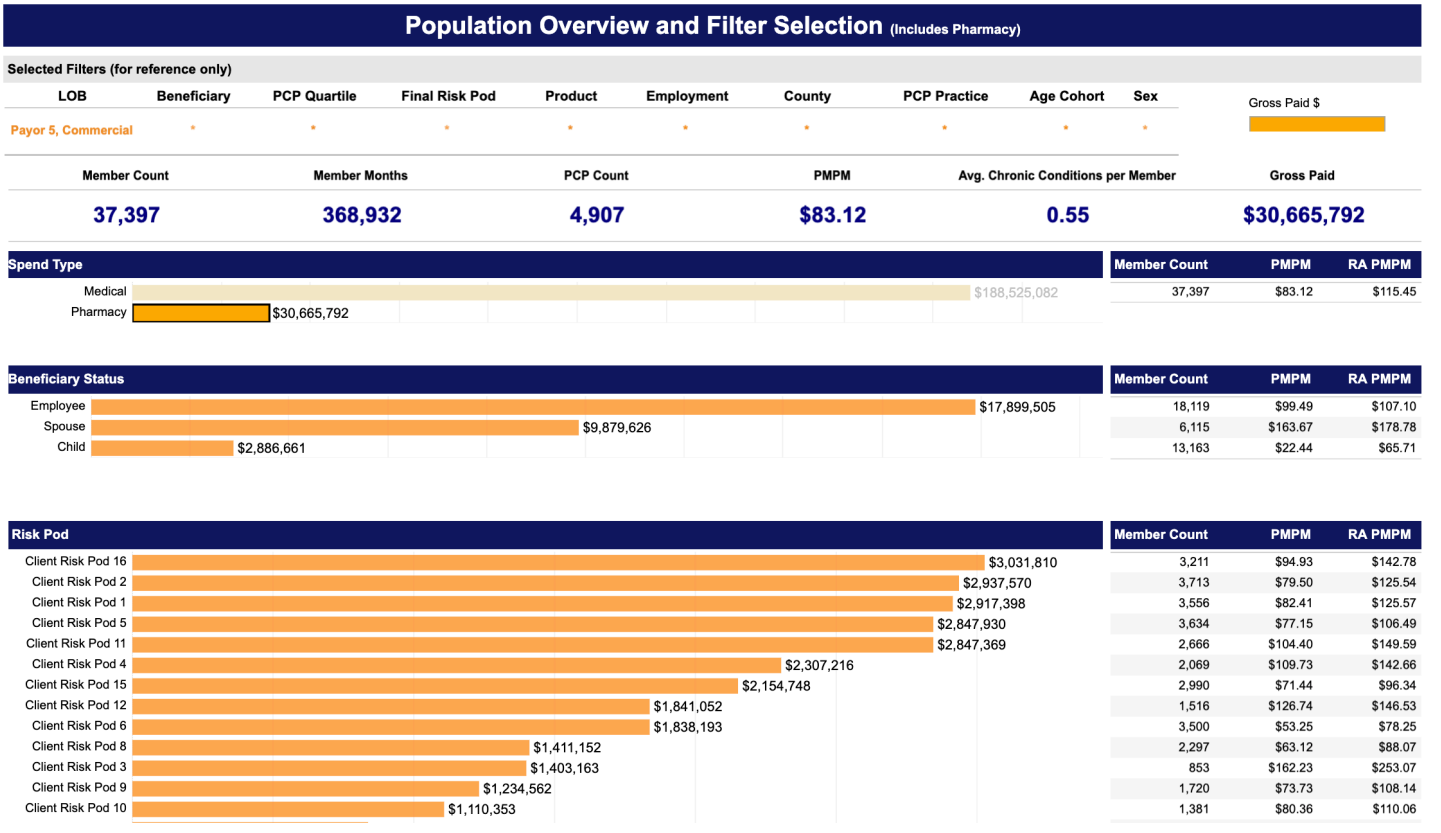
Sizing an Engagement Opportunity to reduce preventable ED visits

Identifying Cost Savings Opportunities for Pharmacy Spend

Additional opportunities can be realized by selecting a subpopulation to explore further cost savings. For example, in this sample dataset, Medical and Pharmacy spend is approximately $219M and $30M respectively. To uncover potential opportunities for improvement, the user starts by clicking on the bar graph titled "Pharmacy" in the Spend Type graph.



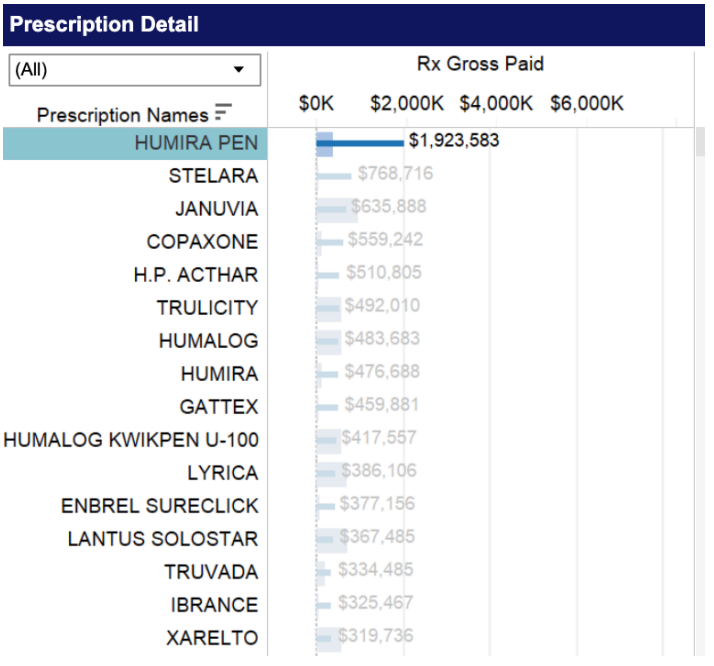
On selecting Pharmacy, ARC will apply the filter across all visible attributes. In this dataset, several Risk Pods have similar sized spends, indicating that a well-designed clinical initiative could have a positive impact across multiple pods

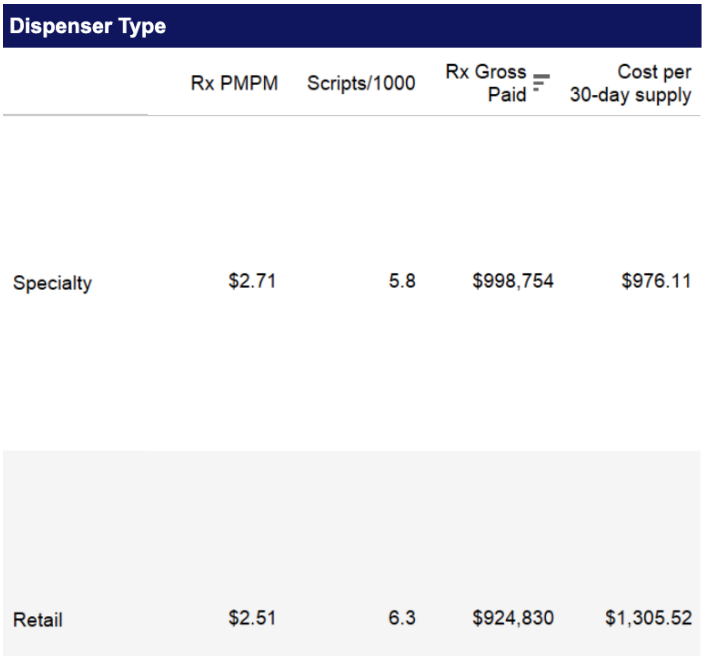


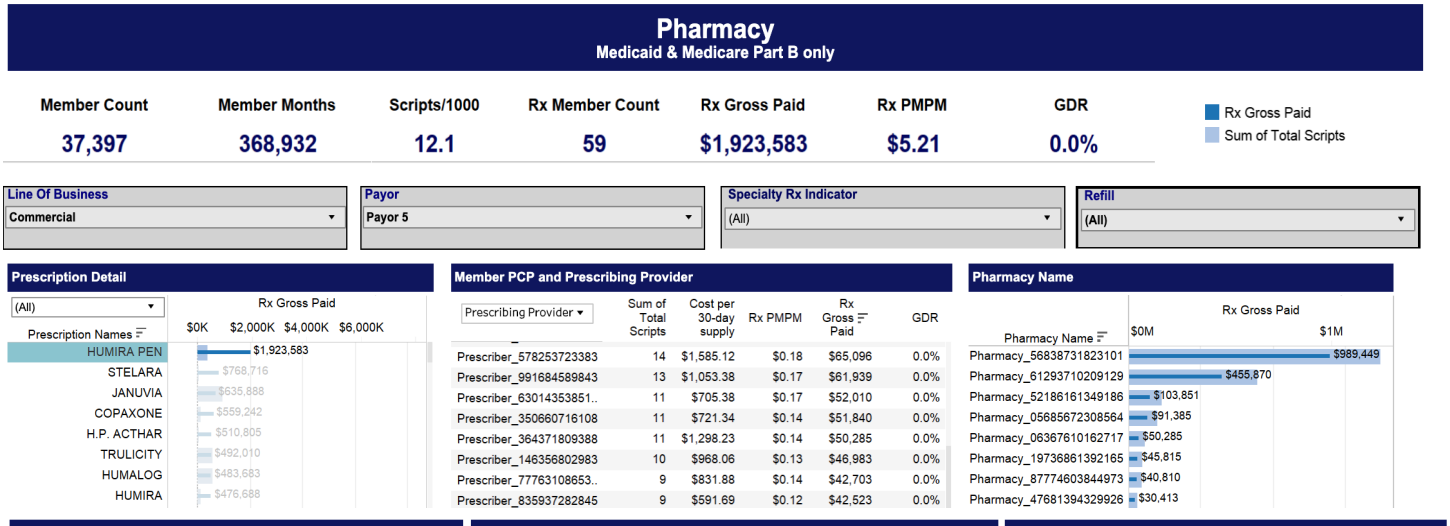
ARC: Self-Insured Use Case

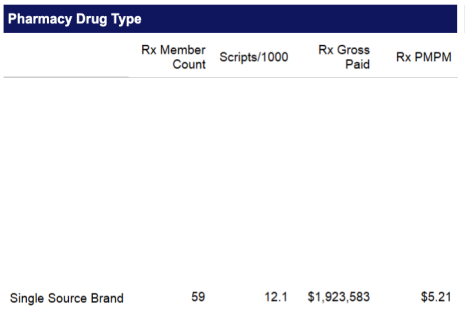
Drilling into Pharmacy

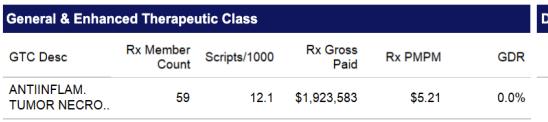
Users can further navigate into Pharmacy costs and analyze more granular patterns. In this example, ARC showcases prescription patterns and associated costs for this member population. The view help identify significant opportunities to reduce prescription costs by moving volume from Retail pharmacies towards client-owned Specialty Pharmacies for the same drug. This also improves client's revenue profile by reducing leakage to non-client owned Retail pharmacies.

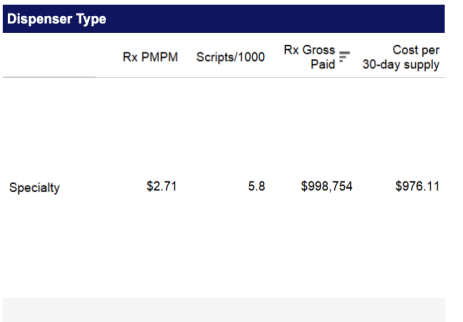












Additional opportunities can be examined by identifying prescribing providers with the highest dispensing rate out of retail pharmacies and work with them to redirect the pickup of the drugs from system-owned specialty pharmacies.

03 ARC In the Media

Healthcare Leaders Back Analytics Software That Overcomes Major Barrier to Value-Based Care

NEW YORK, NY—May 2, 2019 – COPE Health Solutions, Montefiore Health System, Adventist Health, and Heritage Provider Network Inc. have formed a joint venture to introduce an analytics software platform. Analytics for Risk Contracting (ARC) software enables healthcare providers to determine their actual care costs and understand the net financial effect of specific care improvement efforts, population health management and other quality and cost initiatives.

“Within two weeks of using ARC, we identified several large opportunities for improvement. We prioritized the most pressing ones and have begun the process to revise hospital contracts to generate annual savings going forward,” said John Beaman, Chief Business Officer for Adventist Health.

The ARC software suite overcomes the enormous challenge facing many providers in understanding their total cost of care and the expense breakdown for providing particular treatments or caring for specific patient groups. Health systems, physician groups and other healthcare providers often lack necessary operating information because under the fee-for-service system, payments have long been disconnected from costs.

“Not understanding the actual total cost of care, in detail, is a huge obstacle to moving U.S. healthcare to value-based care and risk-based payments,” said Yomi Ajao, the COPE Health Solutions senior vice president who led the development of the ARC software tool and will serve as president of the joint venture, Analytics for Risk Contracting, LLC. “The tremendous promise of value-based care won’t be realized unless providers can see their way forward to accepting more reimbursements tied to cost and quality goals. ARC solves this fundamental problem.”

More firepower

ARC uses proprietary algorithms for financial modeling that enable providers to understand and explore the net financial effect of various combinations of inputs, such as changes in specialty use, inpatient use, and physician incentives. Providers can see how they are performing against their care delivery and financial plans.

“Using its years of population health management experience and ARC, Montefiore’s Care Management company found opportunities to reduce single-day admissions, admissions for end stage renal disease, improve in-network referral, and reduce overall cost of specialty care,” said Stephen Rosenthal, President, Care Management Company, a subsidiary of Montefiore Health System.

Montefiore has been a pioneer in population health management and value based purchasing for more than two decades. Through its Care Management Organization, it administers comprehensive care to close to 500,000 Medicare and Medicaid beneficiaries, and members of commercial health plans.

“ARC software is a breakthrough for advancing value-based care. It gives physicians, health systems and other providers, the ability to transform their health plan contracting from volume to

value. We continue to see CMS' movement away from fee-for-service, most recently through the newly announced Direct Contracting Payment Models, and ARC can help medical groups, IPAs, ACOs and others considering these demonstrations," said Richard Merkin, MD, Founder and CEO of Heritage Provider Network, the nation's largest physician-founded, global risk-managed organization.

Going beyond other total cost of care tools, ARC software delivers precise information and detailed insight because of its analytical power and more comprehensive data sources. ARC:

- Aggregates data from numerous sources across the continuum of care and populations—claims, pharmaceutical, provider financials, and national, regional and network benchmarks.
- Identifies problems or variations within populations, service lines, clinicians or locations, such as avoidable utilization.
- Provides root causes and paths for navigating to solutions.

Working with ARC

Montefiore Health System and Adventist Health have been strategic partners with COPE Health Solutions, a population health management consulting firm, in developing and using the cloud-native ARC tool. They have teamed up with Heritage Provider Network to form a subsidiary of COPE Health Solutions to make the tool available as a software as a service platform. Clients also have the option of working with COPE Health Solutions to analyze data, develop insights, understand the financial consequences and plan and execute improvement efforts.

About COPE Health Solutions

COPE Health Solutions is a national health care business advisory firm and a leader in moving health care payers and providers to value-based payments and care models. It partners with clients to help them achieve visionary, market relevant health solutions. COPE Health Solutions' areas of expertise and focus include all aspects of strategy, population health management, value-based payment, data analytics, and workforce development for clients across the health care continuum, including hospitals, health systems, physician organizations, and health plans.

COPE Health Solutions' multidisciplinary team of health care experts provides clients with the experience, capabilities and tools needed to plan for, design, implement and support both the development and execution of strategy. The firm partners with clients through aligned mission and financial incentives to pursue performance excellence in a challenging and rapidly evolving health care environment. For more information, visit www.copehealthsolutions.com.

About Montefiore Health System

Montefiore Health System is one of New York's premier academic health systems and is a recognized leader in providing exceptional quality and personalized, accountable care to approximately three million people in communities across the Bronx, Westchester and the Hudson Valley. It is comprised of 11 hospitals, including the Children's Hospital at Montefiore, Burke Rehabilitation Hospital and close to 200 outpatient care sites. The advanced clinical and translational research at its' medical school, Albert Einstein College of Medicine, directly informs patient care and improves outcomes. From the Montefiore-Einstein Centers of Excellence in cancer, cardiology and vascular care, pediatrics, and transplantation, to its' preeminent school-based health program, Montefiore is a fully integrated healthcare delivery system providing coordinated, comprehensive care to patients and their families. For more information please visit www.montefiore.org. Follow us on Twitter and view us on Facebook and YouTube.

About Adventist Health
Adventist Health is a faith-based, nonprofit integrated health system serving more than 80 communities on the West Coast and Hawaii. Founded on Seventh-day Adventist heritage and values, Adventist Health provides care in hospitals, clinics, home care agencies, hospice agencies and joint-venture retirement centers in both rural and urban communities. Our compassionate and talented team of 37,000 includes associates, medical staff physicians, allied health professionals and volunteers driven in pursuit of one mission: living God's love by inspiring health, wholeness and hope. Together, we are transforming the American healthcare experience with an innovative, yet timeless, whole-person focus on physical, mental, spiritual and social healing.

About Heritage Provider Network
Heritage Provider Network, Inc. (HPN) is one of the most experienced physician organization leaders of accountable care and continuous value-based healthcare delivery improvements. Developing and managing coordinated, patient-doctor centric, integrated health care systems that offer some of the strongest solutions for the future of health, care and cost in the United States. HPN and its affiliates operate in New York, California, Arizona, Missouri and Colorado providing high quality, cost effective healthcare with over one million patient members and are dedicated to quality, affordable health care, and putting patients' wellness first. www.heritageprovidernetwork.com

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Analytics touted as solution for achieving value-based care

By **Greg Slabodkin**
Published **May 06 2019, 7:14am EDT**

More in **Value-based care, Healthcare analytics, Risk analysis, Healthcare costs, Quality of care, Population health, Health outcomes**

Three healthcare organizations and a consultancy have teamed to offer a platform designed to help providers better understand how they are performing against their care delivery and cost goals.

The Analytics for Risk Contracting (ARC) software, which leverages proprietary algorithms for financial modeling, is a joint venture between Adventist Health, COPE Health Solutions, Heritage Provider Network and Montefiore Health System.

"Not understanding the actual total cost of care, in detail, is a huge obstacle to moving U.S. healthcare to value-based care and risk-based payments," says Yomi Ajao, senior vice president of population health management consultancy COPE Health, who led the development of the ARC software and is president of the joint venture.

"The tremendous promise of value-based care won't be realized unless providers can see their way forward to accepting more reimbursements tied to cost and quality goals. ARC solves this fundamental problem," Ajao adds.

Adventist Health Systems headquarters

Also See: Multiple EHRs, lack of interoperability hamper Next Generation ACOs

According to the developers, the ARC software enables providers to calculate their actual care costs and gain insights into the net financial effects of specific care improvement efforts as well as population health management and other quality initiatives.

Specifically, the analytics tool aggregates data from numerous sources across the continuum of care and populations—such as claims, pharmaceutical, provider financials, and national, regional and network benchmarks—and identifies problems or variations within populations, service lines, clinicians or locations, such as avoidable utilization.

"Within two weeks of using ARC, we identified several large opportunities for improvement," says John Beaman, chief business officer at Adventist Health, a faith-based, nonprofit integrated healthcare system serving more than 80 communities on the West Coast and Hawaii. "We prioritized the most pressing ones and have begun the process to revise hospital contracts to generate annual savings going forward."

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Adventist and Montefiore, strategic partners with COPE in developing and using the cloud-native ARC tool, have teamed with Heritage Provider Network to form a subsidiary of COPE to make the tool available as a software-as-a-service platform.

"ARC software is a breakthrough for advancing value-based care," says Richard Merkin, MD, CEO of Heritage Provider Network, the country's largest physician-founded global risk-managed organization. "It gives physicians, health systems and other providers the ability to transform their health plan contracting from volume to value. We continue to see CMS' movement away from fee-for-service, most recently through the newly announced Direct Contracting Payment Models, and ARC can help medical groups, IPAs, ACOs and others considering these demonstrations."

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