Is a Provider Sponsored Health Plan Right for You?

Ten Steps to a Provider-Sponsored Health Plan

March 20, 2014
Objectives

• Identify contributing factors leading to a shift in value based care
• Understand the spectrum of risk
• Understand the structure of a Provider Sponsored Health Plan
## Agenda

<table>
<thead>
<tr>
<th>Item</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opening Remarks and Background</td>
<td></td>
</tr>
<tr>
<td>Contributing factors creating the need for Value-Based Care</td>
<td>10 min</td>
</tr>
<tr>
<td>Spectrum of Risk</td>
<td>5 min</td>
</tr>
<tr>
<td>Provider Sponsored Health Plan Structure</td>
<td>40 min</td>
</tr>
<tr>
<td>Questions and Answers</td>
<td>5 min</td>
</tr>
</tbody>
</table>
Per Capita Healthcare Spending Must Come Down

CBO Estimated Government Outlays and Revenues (% of GDP)
By 2020, PPO costs for a family of 4 are projected to account for ~45% of household income.

Family of Four – Total PPO Cost Versus Median Family Income

<table>
<thead>
<tr>
<th>Year</th>
<th>PPO Cost</th>
<th>Family Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>$9,000</td>
<td>$63,000</td>
</tr>
<tr>
<td>2006</td>
<td>$13,000</td>
<td>$73,000</td>
</tr>
<tr>
<td>2011</td>
<td>$19,000</td>
<td>$75,000</td>
</tr>
<tr>
<td>2020 Tended</td>
<td>$41,000</td>
<td>$90,000</td>
</tr>
<tr>
<td>2020 3% Growth</td>
<td>$41,000</td>
<td>$96,000</td>
</tr>
<tr>
<td>2020 4% Growth</td>
<td>$41,000</td>
<td>$105,000</td>
</tr>
</tbody>
</table>

% of Income

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<tr>
<th></th>
<th>15%</th>
<th>18%</th>
<th>26%</th>
<th>45%</th>
<th>42%</th>
<th>38%</th>
</tr>
</thead>
</table>

Sources: PPO cost 2002-2011, Milliman; median family income 2002-2011, Census Bureau
Notes: 2011 family income is an estimate for Federal FY12; total PPO cost = employer contribution, employee payroll deduction, and employee out-of-pocket co-pays/deductibles. Numbers rounded to nearest hundred.
“Doing Nothing” Does Not Mean that Nothing Will Change

- Rate pressure
  - Rate freezes
  - Changes in payment methodology
  - Pricing transparency
  - Lower complexity care
- Utilization pressure
  - Shift towards outpatient and observation
  - Reduced ER visits
- Market pressure
  - Shifting referrals to competitor
  - Shift to lower cost diagnostic options
- High % of charges contracts are no guarantees of revenue

What’s a Win?

<table>
<thead>
<tr>
<th>Status Quo</th>
<th>Risk Arrangement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Utilization</td>
<td>↓</td>
</tr>
<tr>
<td>Rates</td>
<td>↓</td>
</tr>
<tr>
<td>Market Share</td>
<td>↓</td>
</tr>
</tbody>
</table>

Status Quo Risk Arrangement

<table>
<thead>
<tr>
<th>Operating Margin</th>
<th>Time</th>
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</thead>
<tbody>
<tr>
<td>-15%</td>
<td></td>
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</tbody>
</table>

Risk Arrangement

<table>
<thead>
<tr>
<th>Operating Margin</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>+2%</td>
<td></td>
</tr>
</tbody>
</table>
## What We Are Seeing in the Market

### Trends

**Clinically Integrated Networks**
- Major momentum in many/most markets
- Drivers different by market “type”
- Some cross-system collaborations
- Some IPA/Physician lead models, but mostly hospital / system supported

**ACO’s and Full Risk contracts**
- Commercial and Medicare ~50/50
- Latest Batch of MSSP about to be released to applicants
- Data reporting/sharing often still problematic
- Seeing selected expansion of full-risk contracts – some provider inspired
- Medicaid risk contracts in some states

**Provider-Sponsored Plans**
- Some marquis growth (Sutter, NSLIJ) and smaller players (CHOMP, Florida Hospital, solutions)
- ABCO says 1 in 5 systems to be payers by 2018

**Bundled Payments**
- Still limited in total application
- Still focused around cardio, ortho and birth episodes/procedures
- Illinois Bone and Joint - Leader

**PCMH**
- ~5000 accredited sites
- New growth has slowed
- Funding from commercial payers may be focused elsewhere

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**Growth of ACOs over time**

Source: Leavitt Partners Center for Accountable Care Intelligence, 2013

**ACOs by hospital referral region**

Source: Leavitt Partners Center for Accountable Care Intelligence, 2013. CHS Oppenheimer presentation 12/13.
8 Key Dimensions Determine Value-based Readiness

- **Market Intrinsic**
  - MSA Market Population
  - Population Density of MSA
  - MSA Payer Mix
  - Population Trends
  - MSA Utilization Rates

- **Value Prop**
  - Primary Care
  - Specialist
  - Hospital
  - Payer

- **Market Competitive**
  - Value-based Competitors
  - PCP Control
  - Market Share Differentiable Service Lines
  - MD Reimbursement
  - Payer Relations

- **Org Capacity**
  - MD-Hospital Collaboration
  - Financial Position and Strength
  - Claims-Based Performance Data
  - Cross-Continuum Services
  - Executive Alignment
  - Bandwidth

- **Physician Alignment**
  - Hospital – Private MD Relations
  - Economic Alignment
  - Clinical Alignment
  - Urgency for Change
  - P4P Experience

- **Collaboration Culture**
  - PCP – Specialty Relations
  - System-ness
  - Referral Management
  - Forums

- **Care Continuum**
  - Service Distribution
  - VNA & SNF
  - PCMH
  - Disease Mgt
  - Care Coordination
  - Pharmacy

- **Technology**
  - EMR
  - HIE
  - Analytics
  - Portal
  - Pop. Health
  - Patient Registry
  - Patient Attribution

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Contracting Strategy Needs to Address the Right Areas

Value-Based Model

Business Line
- Medicaid
- Medicare Direct
- Medicare Through Plans
- Commercial
- Employed Only
- Independents Only
- All Physicians

Providers
- P 4P
- Shared Savings
- Shared Risk With Corridors
- Shared Risk No Corridors
- Full Risk With Corridors
- Full Risk No Corridors
- Health Plan
Provider-Sponsored Health Plans Offer Greatest Value Opportunity

- Greater impact on Mission, more people insured
- Able to impact premiums
- Closer to the first dollar
- Control network development and usage
- Access to data
- Run health plan as you see fit
- Able to control provider rates
- Ability to Impact legislation/benefit design

Likely over 100 plans in operations today
Take a Step Back – Why Provider-Sponsored Plans?

Why Should Providers Play?

• **Waste**: 30-40% of all medical expense is waste.¹

• **Quality**: 50% of medical care is substandard.² Provider sponsored plans can be more efficient and effective.⁵

• **Preventative Disease**: 75% of total medical costs are for preventable conditions.³

• **Administrative Cost**: 31 cents out of every health care dollar goes to administrative cost, not medical care to people.⁴

History and What’s Different Now

Financial Imperatives:

• Continued Medicaid FFS deterioration

• Medicare FFS rates below Medicaid’s by 2020

• Employers less willing to accept cost shifting

• FFS penalizes high-value providers

• Already insuring employees

Prevalence and Performance

The Fit With Value-Based Care

Key Considerations for a Health Plan Fit

- Before an organization decides to create a health plan, certain qualitative considerations must be identified and discussed.

- **Mission**
  - Serving the local population
  - Working with community providers to deliver care and establish quality and value guidelines

- **Community Value**
  - Reinvestment at local level as opposed to national level
  - Administration and providers part of the community

- **Profit Motives**
  - Large payors have shareholders and dividends
  - Provider Plan profits are meant for local reinvestment of resources and infrastructure to deliver care

- **Brand Identification**
  - Built in brand recognition and co-branding opportunities from the Hospital Member

- **Payor Pitfalls**
  - Payor reaction to Provider Sponsored Plan
10 Steps to Provider-Sponsored Plans

1. Assessment / Business Case
2. New Organization Formation
3. Plan Design
4. Provider Network Recruitment and Relations
5. Medical Management
6. Operations and Staffing
7. Financial Planning and Reporting
8. Technology Systems
9. Regulatory Compliance
10. Health Plan Sales / Broker Relations / Community Relations
#1 Assessment and Business Case

- **Potential Network Size and Providers**
  - Total number of providers
  - Primary vs. Specialty mix
  - Post acute resources

- **Local Payor Reaction**
  - Payor willingness to continue to work with organization
  - Organization’s capability to work without payors

- **Market Position & Local Competition**
  - Current or potential competitive advantages
  - Market share and payor mix
  - Population and employment trends

- **Community Receptiveness**
  - Consumer and employer reaction
  - Communication capacity

- **Regulatory Environment**
  - Local legislation receptiveness (community health standards)
  - State legislation receptiveness (varies from state to state), including by business line

- **Costs and Financial Position**
  - Risk Based Capital
  - Bond rating
  - Reserves on hand (including IBNR)
#1 There are significant costs to starting a health plan

## Startup Costs

<table>
<thead>
<tr>
<th>Cost Category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation Costs</td>
<td>$500,000</td>
</tr>
<tr>
<td>Staff (comp, facility)</td>
<td>$4,500,000</td>
</tr>
<tr>
<td>Legal/Consulting</td>
<td>$1,000,000</td>
</tr>
<tr>
<td>Other</td>
<td>$500,000</td>
</tr>
<tr>
<td>Total</td>
<td><strong>$6,500,000</strong></td>
</tr>
<tr>
<td>Risk Based Capital</td>
<td>$15,300,000</td>
</tr>
<tr>
<td><strong>Total Initial Required Capital</strong></td>
<td><strong>$21,800,000</strong></td>
</tr>
</tbody>
</table>

## Ongoing Financials

<table>
<thead>
<tr>
<th>Cost Category</th>
<th>PMPM</th>
<th>Annual ¹</th>
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</thead>
<tbody>
<tr>
<td>Total Premium</td>
<td>$150.00</td>
<td>$180,000,000</td>
</tr>
<tr>
<td>Medical Costs</td>
<td>$132.08</td>
<td>$158,500,000</td>
</tr>
<tr>
<td>Operations</td>
<td>$4.17</td>
<td>$5,000,000</td>
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<tr>
<td>Admin/Medical Management</td>
<td>$8.50</td>
<td>$10,200,000</td>
</tr>
<tr>
<td>Premium Tax</td>
<td>$3.00</td>
<td>$3,600,000</td>
</tr>
<tr>
<td>Profit</td>
<td>$2.25</td>
<td>$2,700,000</td>
</tr>
<tr>
<td><strong>Payback period</strong></td>
<td></td>
<td>2.4 years</td>
</tr>
</tbody>
</table>

¹ Assumes 100,000 members
#2 New Organization Formation

- Mission / Vision
  - Local impact
  - Desired population and why
  - Provider, patient, and employer value propositions
  - Organizational identity and future state identity

- Legal Entity
  - Subsidiary
  - LLC
  - For Profit or Not For Profit
  - Taxable

- Line of Business
  - PPO
  - HMO
  - EPO

- Governance
  - Board Structure
  - Committee Structure
#3 Plan Design

- Desired patient behavior
- Business Lines
  - Commercial, Medicare, Medicaid
- Benefit Levels
  - Silver, Gold, Platinum
  - Essential health components of exchange plans
- Targeted Members
  - Specific employers, all employers, populations, governmental business
- Reinsurance / Stop Loss
  - Attachment Point
  - Percentage paid after Attachment Point
- Coverage Specifics
  - Administrative philosophy
  - Clinical coverage
  - Limits
#3 Things to consider when designing a health plan

<table>
<thead>
<tr>
<th>Benefit Plan Design</th>
<th>Rate Factors</th>
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<tbody>
<tr>
<td>• Benefit coverage amounts</td>
<td>• Plan maximums</td>
</tr>
<tr>
<td>• Current and historical rates</td>
<td>• Size of risk pool</td>
</tr>
<tr>
<td>• Exchange plan requirements</td>
<td>• Supplemental life rates (age banded or composite)</td>
</tr>
<tr>
<td></td>
<td>• Rate guarantee</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Claims Management</th>
<th>Census Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Medical Loss Ratio</td>
<td>• Age</td>
</tr>
<tr>
<td>• Waiver of premium claims and reserves</td>
<td>• Gender</td>
</tr>
<tr>
<td>• Plan expenses</td>
<td>• Employee classes (FT, PT, executive, physicians)</td>
</tr>
</tbody>
</table>

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#3 Exchange plans must have 10 components

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance abuse, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including vision and oral
#4 Provider Recruitment and Relations

**Tasks**

- Submit for Certificate of Authority to the Department of Insurance
- Assess and prioritize the Current Network
  - Employed, independent, contracted
- Gaps in the Network
  - Specialties, geographically, strategically
- Level of Interest from potential network participants
- Create Provider Value Propositions
- Create Contract Templates with Legal Assistance
- Hire Provider Relations Representatives
- Develop Credentialing Process
- Meet with Key Stakeholders
- Refine Value Propositions
- Obtain Provider Commitments
- Communicate, communicate, communicate

**Phase**

- **Initiation**
- **Implementation**
#4 Mapping the Network and Population
#4 Recruiting providers will be difficult if certain concerns cannot be addressed

- Reimbursement
- Product line
- Reasons for not choosing another product line
- Rules of the new organization
  - Provider Manual
- Incentives for quality, utilization, or cost containment
- Opportunities to be involved in the organization
  - Committees
  - Workgroups
- Authorization Rules
- Referral Rules
- Credentialing and application
#5 Medical Management

- Medical Director
- Licensure: Multi-state URO certifications and seeking URA accreditation. HEDIS certification. NCQA
- Utilization Management
  - UM Plan and medical management policies
  - Pre-Certification
  - Selection and application of Criteria Sets
  - Concurrent Review
  - Discharge Planning
  - UM Committee Participation
- Auto Approval Process
- Case Management and Disease Management Programs: Pediatric/Adult Asthma, Diabetes, COPD, CHF, High Risk Maternity, Obesity, Children with Special Needs, and Cancer
- Quality Improvement and Population Health Management: QI and HEDIS study coordination and member outreach
- Other: RNs are Certified Case Managers, formation of corporate Medical Management Clinical Oversight Committee
#6 Operations

Health Plan Operations

- Care Management
- Provider Customer Service
- Provider Relations
- Network Management & Contracting
- Human Resources
- Member Customer Experience
- Claims Processing
- Information Technology
#6 Draft Organizational Structure

- Considerations
  - Recruiting, onboarding and training
  - Other Executive members
  - Legal and Compliance

Use domain experts, not high performers
#6 Claims Management (Example of Department)

- Claim receipt via X-12 837 or Paper
  - Claims clearinghouse and OCR vendor
  - Claim submission web portal functionality
- Claim Processing
  - Workflow system of claims adjudication
  - Auto-adjudication and manual processing
  - Integration with client’s COB and subrogation vendors
- Audit Processing
  - Monthly review of 3% (example) of processors work; includes auto adjudicated claims
  - Audit types are customizable
  - Compliant with all external audit review agencies
- Check Run Processing
  - Pre-release review offered to clients (internal)
    - High Dollar review
  - Integration with client’s FWA vendors
  - Flexible as to frequency of check runs
  - Outsourced vendor for EOP production and x12 835s
- Filings
  - Reinsurance/ Third Party Liability
- Tracking and Trending
  - Auto-adjudication work group
  - Correspondence analysis
  - Communications work group

Build, Buy or Outsource
#6 Call Center (Example of Department)

- Location of center
- Language capabilities
  - Spanish
  - Foreign language line service
- Provider and Member Inbound Calls
- IVR Technology – Voice recognition software
- Customizable Automated Outbound Call Campaigns
- Member Outbound Calls
  - Education
  - Appointments
  - EPSDT (Medicaid)
- Quality Audits:
  - Monitoring of Customer Service Representatives
  - Member Satisfaction Survey
  - Provider Satisfaction Survey
#6 Key Performance Indicators

<table>
<thead>
<tr>
<th>Care Management</th>
<th>Claims</th>
<th>Customer Service</th>
<th>Finance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Turn-around Times</td>
<td>Turn-around Times</td>
<td>Average Speed of Answer</td>
<td>Membership &amp; Capitation Reconciliation</td>
</tr>
<tr>
<td>Call Stats</td>
<td>Inventory</td>
<td>Abandon Rate</td>
<td>State encounter warehouse to FSR reconciliation</td>
</tr>
<tr>
<td>Inter-rater reliability</td>
<td>Paid Correctly the First Time</td>
<td>First Call Resolution</td>
<td>Provider incentive development and management</td>
</tr>
<tr>
<td>Suite of Medical Performance</td>
<td>Paid with the first 20 days</td>
<td>Quality</td>
<td>EFT Providers</td>
</tr>
<tr>
<td>Days/1000</td>
<td>Auto Adjudication</td>
<td>Outreach Calls</td>
<td></td>
</tr>
<tr>
<td>ALOS</td>
<td>Financial Accuracy</td>
<td></td>
<td></td>
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<tr>
<td>Admits/1000</td>
<td>Refunds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Savings</td>
<td>Top Reasons:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider Profile</td>
<td>Correspondence</td>
<td></td>
<td></td>
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<tr>
<td>PCP</td>
<td>Recalcs</td>
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<td>Specialist</td>
<td>Refunds</td>
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<td>OB</td>
<td>837 Submitters</td>
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<tr>
<td>Overall</td>
<td>Reinsurance</td>
<td></td>
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<td>Portal Reports</td>
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#6 What makes sense to outsource?

<table>
<thead>
<tr>
<th>Function</th>
<th>Plan</th>
<th>Partner</th>
<th>FTE Estimates</th>
</tr>
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<tbody>
<tr>
<td>Customer Services</td>
<td>X</td>
<td>1:7,500 members</td>
<td></td>
</tr>
<tr>
<td>Invoice Management – Group/Broker</td>
<td>X</td>
<td>1:30,000 members</td>
<td></td>
</tr>
<tr>
<td>Utilization Management – moderate pre-cert program</td>
<td>X</td>
<td>1:5,000 members</td>
<td></td>
</tr>
<tr>
<td>Case &amp; Disease Management – Complex Case Mngt</td>
<td>X</td>
<td>1:3,500 members</td>
<td></td>
</tr>
<tr>
<td>Claims Management – adjudication, audit, recovery, mail</td>
<td>X</td>
<td>1:3,000 members</td>
<td></td>
</tr>
<tr>
<td>Eligibility Management</td>
<td>X</td>
<td>1:20,000 members</td>
<td></td>
</tr>
<tr>
<td>Data Integration – Trading partners</td>
<td>X</td>
<td>1:30,000 members</td>
<td></td>
</tr>
<tr>
<td>Finance and Accounting</td>
<td>X</td>
<td>1:20,000 members</td>
<td></td>
</tr>
<tr>
<td>Analytics and Reporting</td>
<td>X</td>
<td>1:30,000 members</td>
<td></td>
</tr>
<tr>
<td>Provider Relations and Network Management</td>
<td>X</td>
<td>1:800 provider groups</td>
<td></td>
</tr>
<tr>
<td>Compliance</td>
<td>X</td>
<td>1:30,000 members</td>
<td></td>
</tr>
<tr>
<td>Marketing</td>
<td>X</td>
<td>Depends on model</td>
<td></td>
</tr>
<tr>
<td>Community Relations</td>
<td>X</td>
<td>@ 1:25,000 members</td>
<td></td>
</tr>
<tr>
<td>Quality Management</td>
<td>X</td>
<td>1:20,000 members</td>
<td></td>
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Determining what to outsource is an art, not a science.
#7 Financial Planning and Reporting

- Financial analysis
  - GAAP
  - Statutory
- Cash-on-hand
- Risk Based Capital
- Reserves
- Incentives
- Reinsurance/stop loss
- Audits
- Ongoing reporting
  - Basic Analysis
  - Service Utilization
  - Claim Lag Reporting
  - IBNR – Incurred But Not Received
- Medical Loss Reporting
- Provider Profiling
#8 Technology and Systems

Technology and Systems

Claims Processing
- EDI
- EFT and 835
- Compliance

Customer Service
- Overall Experience
- Consumers
- Providers
- Telephonic system

Care Management
- Resources Available
- Resources to be hired
- Desired ratio
- Remote capabilities
- Patient criteria
- EHRs
- System interface

Data Warehouse
- Location
- Staffing
- SQL
- SAS

Portals
- Authorizations
- Provider queries
- Eligibility and claims
- Population Management

Build, Buy or Outsource
#9 Regulatory Compliance

- **State Considerations**
  - NAIC
  - Department of Insurance
  - Purchasers
  - Audits

- **Federal Considerations**
  - CMS
  - Reporting
  - Lack of clarity
  - Audits

- **Local Considerations**
  - Community
#10 Health Plan Sales, Broker Relations and Community Relations

- **Consumer Marketing**
  - Brochures
  - Commercials
  - Print
  - Billboard
  - Email

- **Employer Marketing**
  - Trade shows
  - Conventions
  - Fairs
  - Email
  - Industry journals and magazines

- **Exchange Network**
  - Federal.gov
  - State websites

- **Direct Sales**
  - Fairs
  - Churches
  - Events

- **Broker Network**
  - Commissioned agents
  - Employer groups
  - Consumer groups
#10 Medicaid Member Outreach and Education is highly regulated

**Goals:**
- Outreach to members/parents in order to relay information so they will understand the importance of preventative care
- Provide a link between members and their primary care physicians
- Help secure a “medical home” between members and their primary care physician
- Educate members/parents on transportation benefits if needed

**Outreach Population:**
- Eligible members who are new member’s or are due for a EPSDT exam

**Types of Services Provided:**
- Explanation of EPSDT benefits/positive effects
- Education to members/parents on preventative care
- Scheduling of EPSDT visit with primary care physician, assisting in creating a medical home
- Transportation services coordinated with client’s vendor
‘Health Plan’ Services and More

Eligibility/Capitation
- X12 834 eligibility data
- Reconciliation
- Premium receipt and validation

Care Management
- UM, CM/DM, Population Mngmnt
- Social Service, Outreach
- QI & Clinical Initiative Support
- Reports, analytics & certification support: HEDIS, etc
- Patient engagement; 24/7 RN Line

Medical Claims Management
- Claim Payment and EOB/EOP Production
- Coordination with SIU
- Fee Schedule Management

Customer Call Center
- Provider and Member Calls
- Member Outreach

Member Fulfillment
- ID Card Management
- Welcome Packet Fulfillment

Invoice Management
- Broker Commission Management
- Employer Group Invoicing

Financial and Actuarial
- Financial management and budgeting
- IBNR analysis and certification
- Risk sharing model development
- Financial Statistical Reporting
- Experience Rebate

Network Management
- Network development
- Negotiations
- Provider Credentialing
- Provider Relations

Reporting
- Operational
- OB 837
- Medical
- Analytical
Questions

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