NAACOS AI Innovation Spotlight

How ACOs Are Using Actuarial AI to Win in VBC

Tuesday, November 10, 2026 · 1:00 PM ET

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UNC HEALTH

TODAY'S SPEAKERS

UNC Health Alliance and Arbital Health



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AGENDA

What we'll cover in the next hour

1. **The state of ACOs today**
2. **UNC Health Alliance's story: the MSSP vs. LEAD decision**
3. **Day to day at UNC: how the team uses Arbital AI**
4. **Live Arbital AI Demo**
5. **Live Q&A**

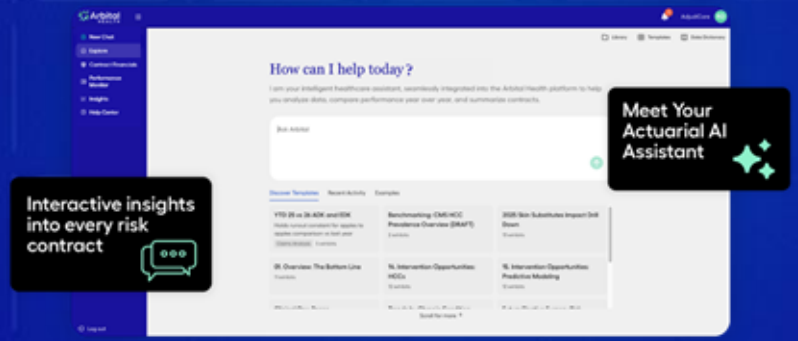
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Proactively Manage Risk with Arbital AI

The analysis behind a contract's results has usually meant weeks of manual work in disconnected spreadsheets. Arbital AI runs that analysis in minutes and ties every answer to your contract's financial terms.

See what's happening in every contract, why, and what bends the curve, while there's still time to act.



6.5M
patient lives managed on the platform

1,500
contract reconciliations completed

$25B
in medical spend managed

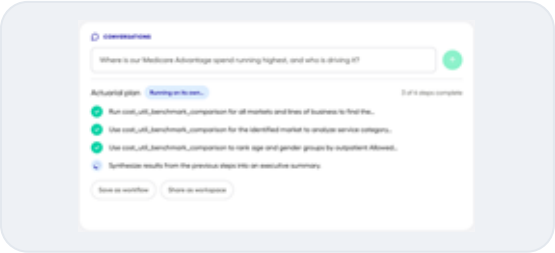
HOW ARBITAL AI WORKS

Actuarial answers in minutes, built by actuaries

Built and checked by credentialed actuaries, so every answer traces back to validated contract logic.

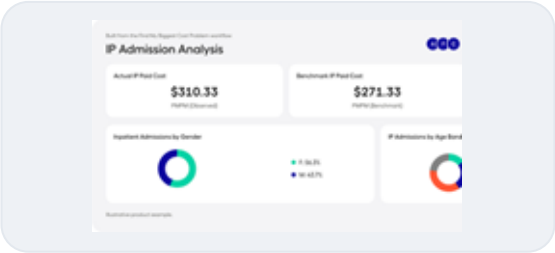
WHAT TEAMS USE IT FOR

- **Track contract performance**
- **Find cost drivers and opportunities**
- **Settle with one set of numbers**
- **Share reporting with partners and teams**



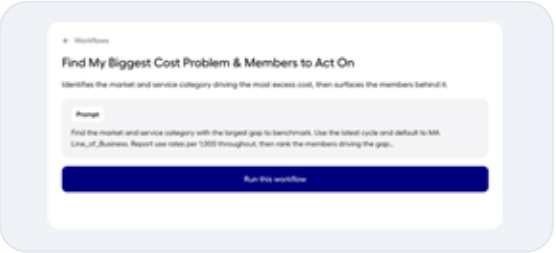
Conversations

Ask in plain English and get answers traced back to your contract data.



Workspaces

Keep findings in one shared view your team works from.



Workflows

Hand it a multi-step analysis, and it builds the plan and runs every step.

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THE IMPACT

Where Arbital shows up in your results

Every lever ties to a number your organization already tracks.

REVENUE	Close risk adjustment gaps before settlement.	Revenue protected
MEDICAL COST	See which members and providers drive cost, in time to act.	Lower medical cost
ADMIN COST	Stop rebuilding the same data and reports every cycle.	Lower cost to run
SETTLEMENT AND CASH	Know where each contract will land before the books close.	Fewer surprises

"Are we making or losing money on this contract?" Answered with numbers you can stand behind.

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ACO TIN LEVEL ANALYSIS AND SIMULATION

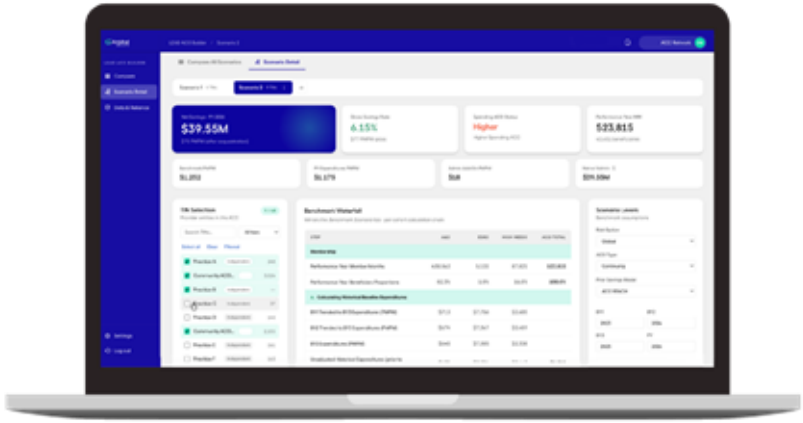
Arbital ATLAS

Know which providers belong in your LEAD ACO. Before you commit.

The Solution

Built for the complexity of LEAD, Arbital ATLAS gives ACOs a fast, clear view of how their TIN composition affects financial performance, **powered by national VRDC data and deep actuarial expertise.**

- → Know which TINs improve your benchmark before you commit to them.
- → Run every scenario in hours, not weeks. No manual spreadsheets.
- → Walk into the deadline with a clear, data-backed provider network strategy.



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Audience Poll

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Topic 1

The state of ACOs today

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Topic 2

UNC's story: the MSSP vs. LEAD decision

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Topic 3

Day to day at UNC: how the team uses Arbital AI

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OVERVIEW

Using Arbital AI

1. **How UNC Health Alliances uses Arbital AI**
2. **Who uses it**
3. **Leakage example**

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EXAMPLE USE CASES

UNC Health Alliance uses Arbital AI to conduct a variety of end-user initiated value-based care analytics across our portfolio

1. **Leakage Analysis**
   - Minimize leakage across contracts with different network arrangements (narrow vs. broad)
   - Percent of attributed patients receiving care out-of-network or revenue retention figures track referral behavior over time, by contract, practice, and provider

2. **Cost Insights**
   - Biggest opportunities in outpatient, inpatient, pharmacy
   - Identifying high-cost claimants
   - Comparing provider groups

1. **Benchmarking**
   - Set risk-adjusted benchmarks for segments in Commercial plan
   - Identify common and discrete drivers of cost and utilization at the entities with highest and lowest benchmarks, e.g. demographics, risk coding, disease type

1. **Risk adjustment and cost analysis for MSSP**
   - Two ACO, so want to track cost to make adjustment in MSSP contracts, since reporting is infrequent

ADOPTION SPANS EXECUTIVE LEADERSHIP AND FOUR CROSS-FUNCTIONAL TEAMS

Use of Arbital AI is being adopted across the UNC Health Alliance

9 roles | 4 teams

ENTERPRISE LEADERSHIP

Executive sponsorship connects operational, financial, and clinical adoption

Chief Financial & Administrative Officer

Executive Medical Director

PERFORMANCE

- Director of Performance Execution
- Finance & Strategy Analyst

FINANCE & STRATEGY

- Finance Manager
- Senior Healthcare Analytics Consultant

NETWORK

- Network Development Manager

DATA & ANALYTICS

- Manager of Business Intelligence & Data Analytics
- Health Economics focused Analysts

KEY TAKEAWAY **Arbital AI is not confined to one team or function; it supports decision-making across clinical, operational, financial, and analytical roles.**

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ARBITAL AI USE CASE

CIN leakage: Impacts & Opportunities

UNC Health Alliance

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Welcome

UNCHA / Arbital Health Cost-Focused Analytics





USE CASE OVERVIEW

Where was network leakage greatest in a large commercial contract by service, diagnosis, practice, and specialty?

Goal

To determine where better access, clearer referral pathways, and stronger care coordination could keep appropriate care inside the UNCHA CIN.

Contract & line of business

Commercial Product, inclusive of Narrow Network Product

Potential financial impact

$387M in cost incurred outside the CIN in 2025, 43% of allowed spend

ANALYSIS APPROACH

Six steps from total commercial leakage to practice-level retention opportunities.

1

Quantified overall plan leakage
Total commercial leaked allowed spend and the overall leakage rate.

2

Isolated physician services
Physician services as the largest actionable leakage category.

3

Used diagnosis groupers
Applied CCSR groupers to identify the key clinical drivers of leakage.

4

Estimated specialty-level opportunities
Prioritized high-dollar, high-rate specialties against leakage thresholds.

5

Examined high-cost leakage members
Reviewed top members to understand the clinical drivers behind their spend.

6

Compared attributed practices
Contrasted practice-level patterns to find referral retention opportunities.

KEY FINDINGS

Four findings: where leakage is real, where it is actionable, and where to be careful.

1 **Leakage is concentrated in physician services**

Takeaway: *Begin with physician services to help establish a broader containment strategy.*

2 **Behavioral health is the clearest scale-and-rate signal**

Takeaway: *Likely an access and network capacity issue: validate with clinical leaders before designing interventions.*

3 **UNC entities in rural geographies show a concentrated leakage signal**

Takeaway: *Partner with managed entities to identify access and network alignment barriers, develop targeted containment plans or enhanced Health Alliance Network Strategy.*

4 **The highest-cost, highest-leakage-rate diagnoses are concentrated in ongoing, complex specialty care rather than isolated acute services.**

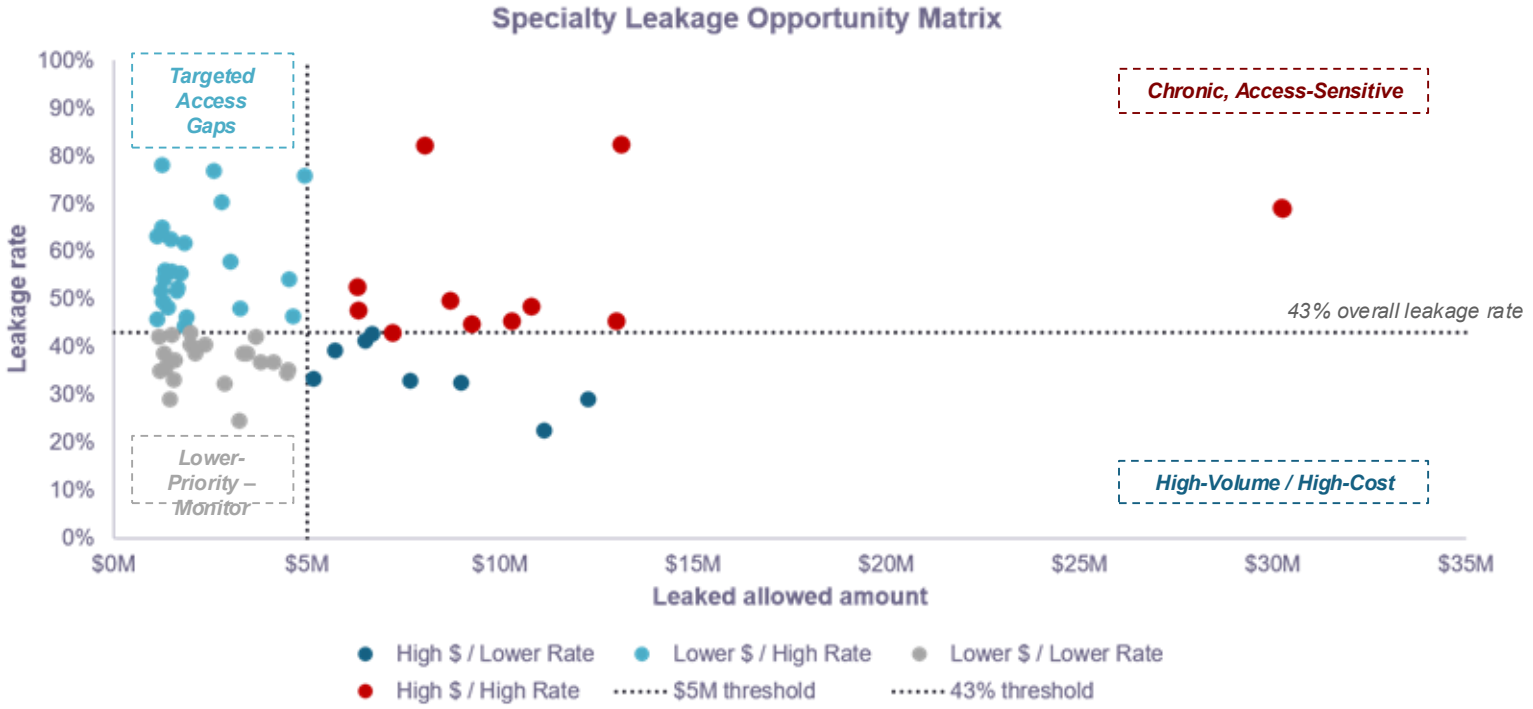
Takeaway: *This pattern points to access, capacity and referral pathways as likely cross-cutting drivers of leakage.*

Note: leakage should be evaluated alongside clinical context, access, and influenceability.

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LEAKAGE STORY: FROM TOTAL SPEND TO TARGET AREAS

Queried top 100 CCSR diagnosis categories by total leakage allowed amounts, matched to estimated specialty and graphed to see areas of containment opportunity.



Vertical threshold = $5M total leaked allowed amount Horizontal threshold = 43% overall narrow network leakage rate

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LEAKAGE STORY: KEY CLINICAL CONDITIONS REPRESENT THE GREATEST LEAKAGE

Break out the top 100 highest cost patients by leakage allowed amount into specialties to understand the clinical drivers behind their spend.

Clinical theme	Patients
Oncology/hematology	33
Cardiovascular	14
Endocrine/metabolic/nutritional	13
Neurologic/behavioral	12
Trauma/orthopedic	9
Infection/septicemia	5
Renal	4
Other clinical conditions	6

Null values excluded

11% of total leakage dollars come from these top 100 most expensive patients



Bottom line

Expensive leakage is overwhelmingly driven by complex specialty-intensive care, particularly oncology, metabolic/renal disease, and cardiovascular disease.

Next Step: Utilize patient address information to analyze geographic options for patients. Work with Medical Director to understand PCP utilization and/or ACG risk factors.

SPECIALTY LEAKAGE BY REGION

Specialty X clears the 70% leakage bar in every region – the rest of the mix shifts by geography.

How specialties were selected

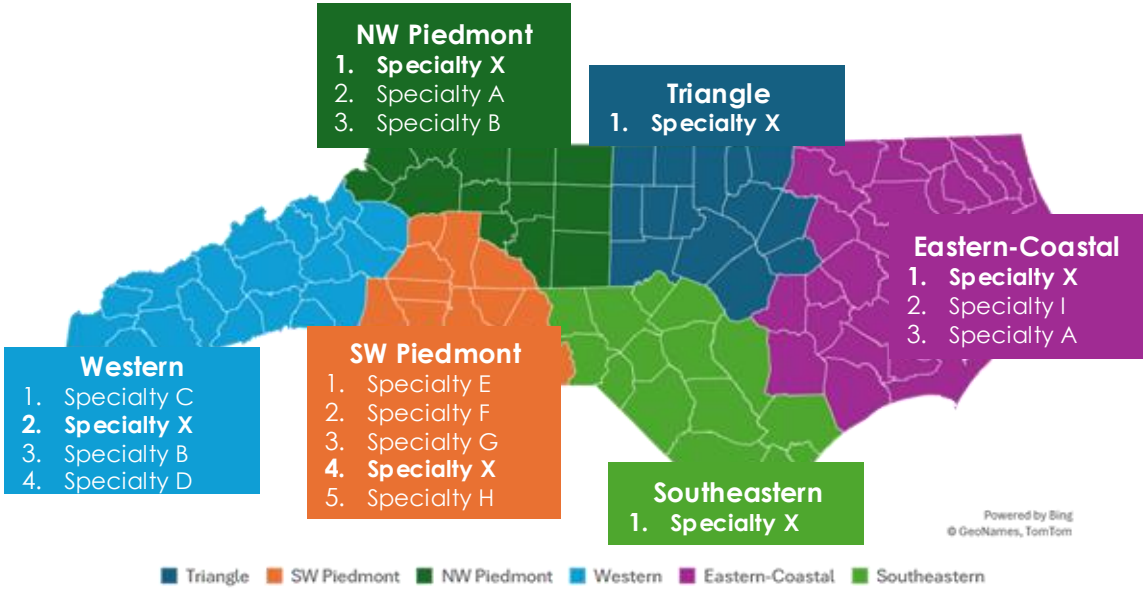
Top specialties by CCSR diagnosis, ranked on total leakage dollars against the 51.88% physician-services BP aggregate leakage benchmark

Threshold applied

Only specialties above a 70% leakage rate are shown; lower-rate specialties exist but were excluded to keep the focus actionable

Region proxy

Regions that apply to NC Managed Medicaid and NC Rural Organizations Orchestrating Transformation for Sustainability (ROOTS) Hubs used as the regional breakout



Next steps

- Analyze the regional variation to explore actionable items - access, capacity, or referral patterns.
- Test whether drug costs drive leakage in pharmacy-heavy specialties – Specialty A (NW Piedmont, Eastern-Coastal) and Specialty D (Western).

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FOLLOW-UP ITEMS

Five next steps, sequenced from immediate to deeper work.

Discussion	1	**Tag every finding for influenceability** Influenceable, capacity-constrained, or clinically appropriate.
Analysis & discussion	2	**Model recapture at 5% / 10% / 20%** Influenceable categories only. Pressure-test with SMEs.
Partnership & analysis	3	**Layer in Site of Service analysis** Understand other influencing factors not found in claims.
Analysis	4	**Map where leakage happens to understand "why"** Find where patients exit in the highest-leakage specialties.
Partner & assess	5	**Assess specialty X access with UNC HCS** Test whether the 85% rate reflects access or capacity limits.

Topic 4

Live Arbital AI Demo

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Live Q&A

Questions?

Schedule a meeting with us at ArbitalHealth.com/Schedule-A-Meeting

