The Essential Elements of Value-Based Care

Maximizing the Azara Ecosystem for Success

PRESENTED BY:

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USER CONFERENCE APR 30–MAY 2 | BOSTON, MA

Today’s Presenters

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Today’s Agenda

VBC PRIMER

THE ESSENTIAL ELEMENTS OF VBC

WRAP-UP & QUESTIONS

What is a VBC Model?

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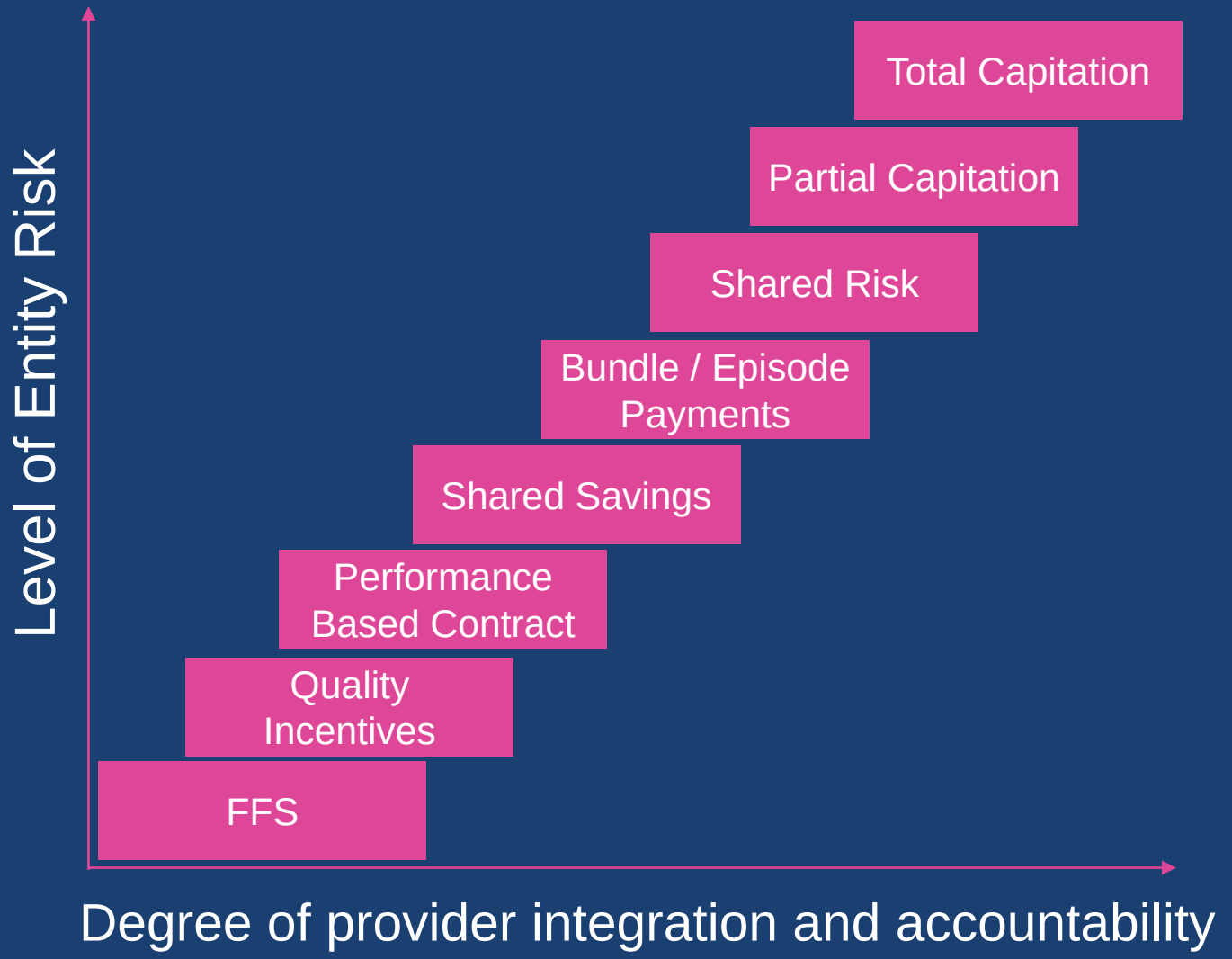

What is changing with VBC models?

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CMS Goal

100% Medicare
50% Medicaid

In VBC models by 2030

Health Equity

Will be a core component of all CMS VBC models

Health Equity will have a meaningful impact on revenue

SDOH Integration

Closed loop social referrals

Work will be compensated in new VBC models

Market Survey Results

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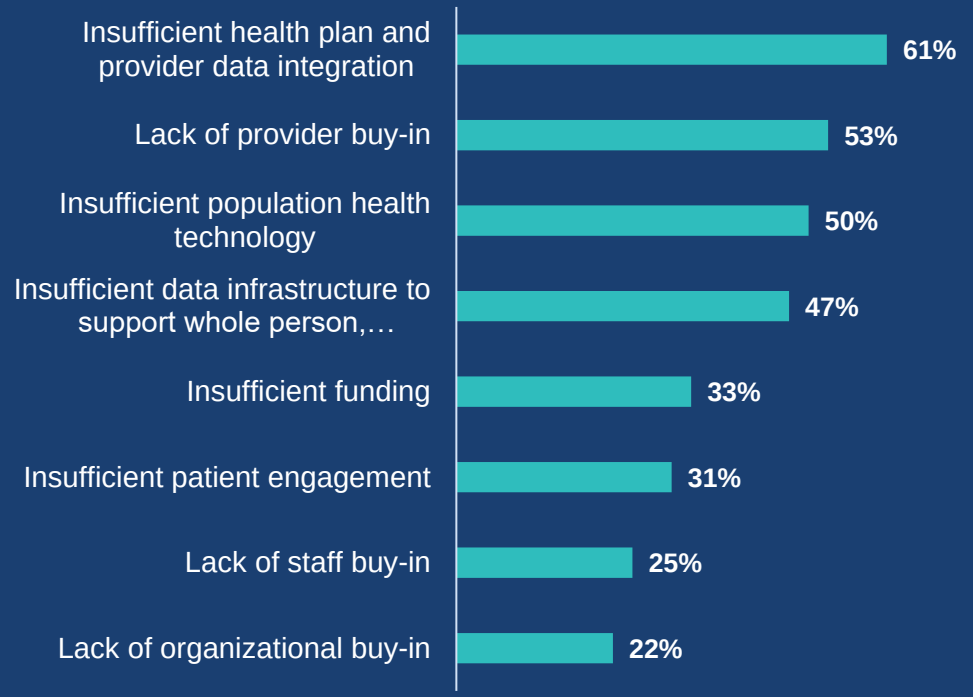
What obstacles has your organization experienced in successfully implementing value-based care initiatives?

*Others mentioned: “Physicians hate it, don't see value”

What causes your organization to experience these obstacles in successfully implementing value-based care initiatives?



*Others mentioned: “Patient compliance”

Essential Elements of VBC

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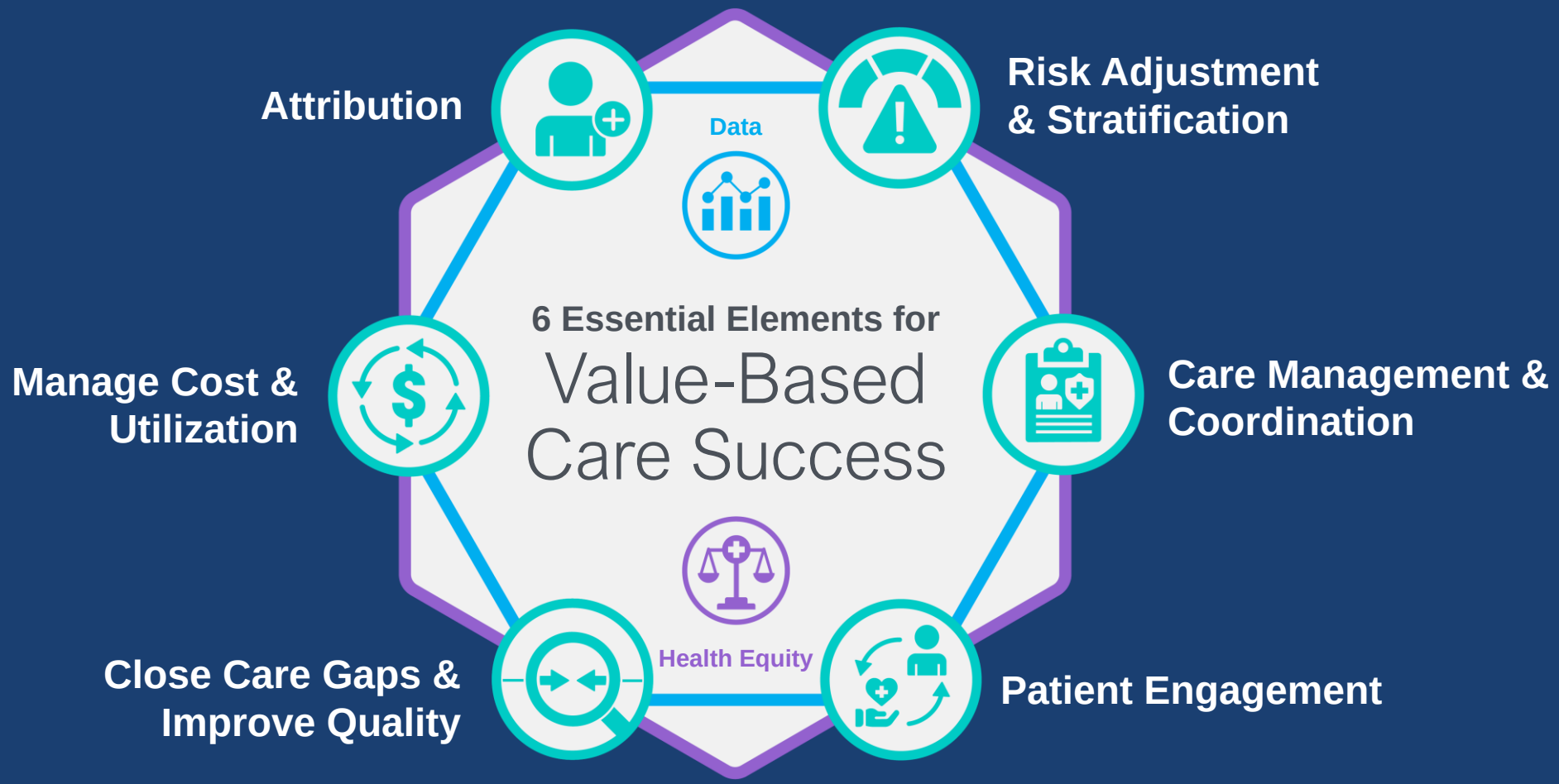

Azara Ecosystem

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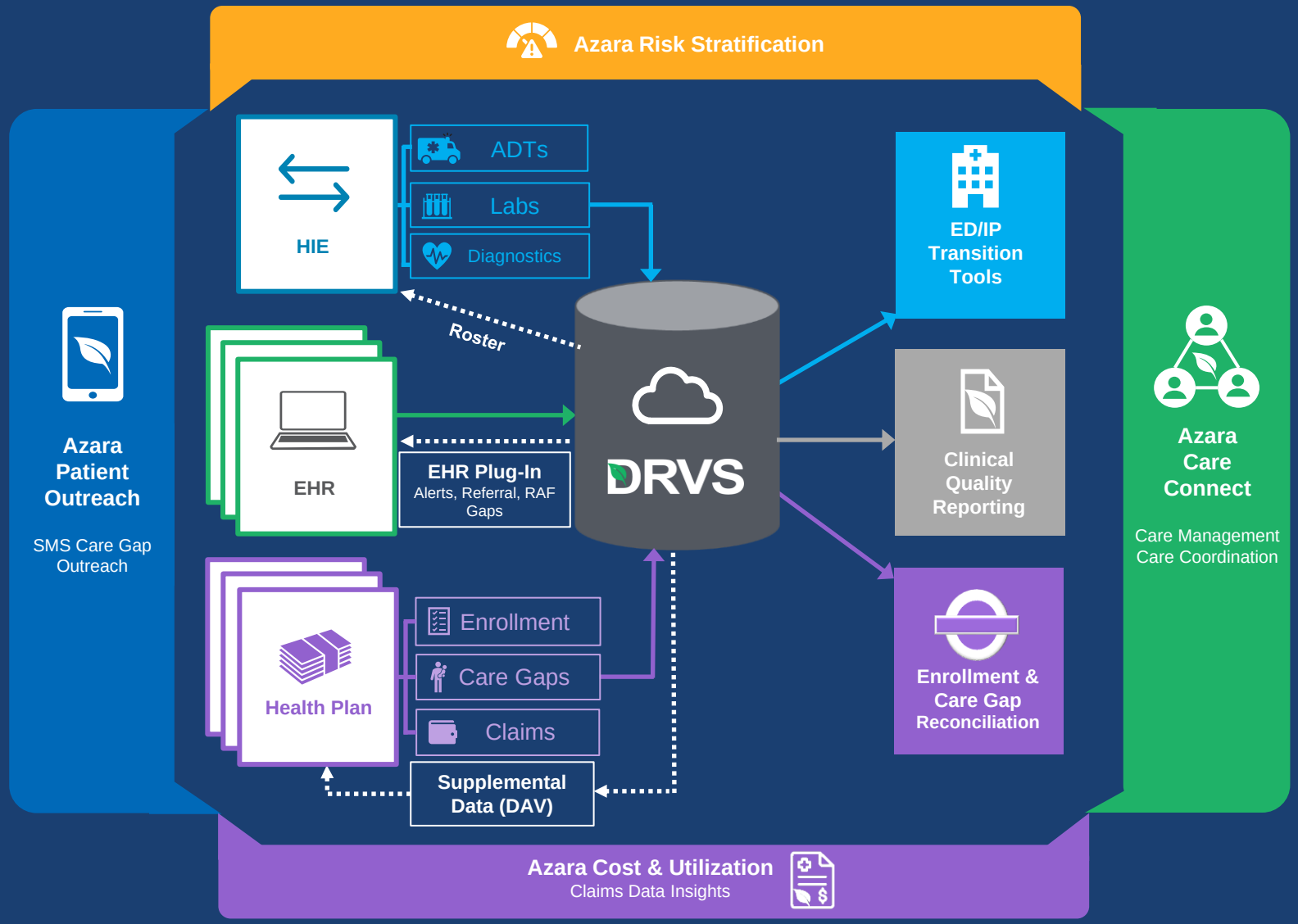
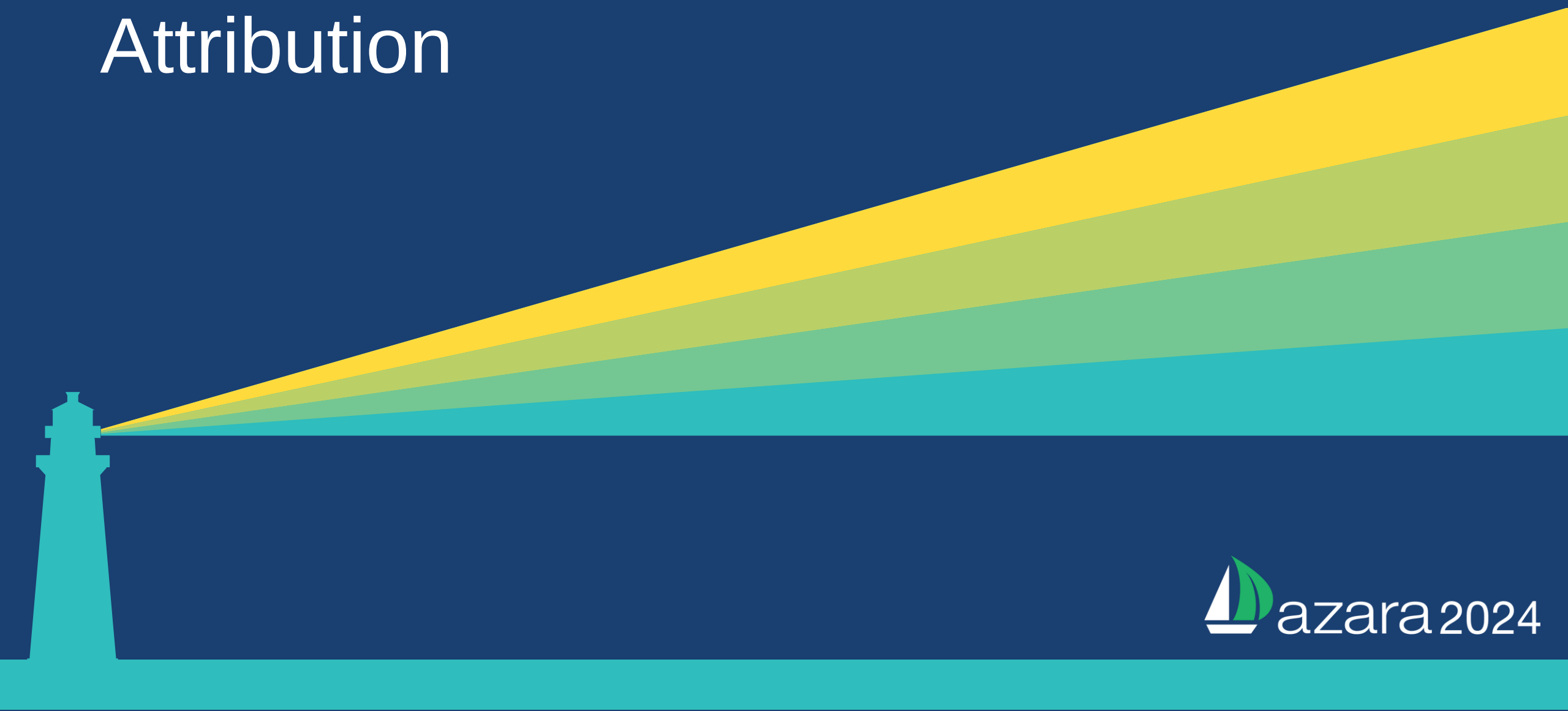


Attribution



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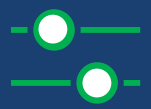
Attribution

Attribution is the process that payers use to assign patients to a provider who is accountable for the quality, patient experience, and total cost of care.

Key Challenges:

Difficulty obtaining attribution rosters

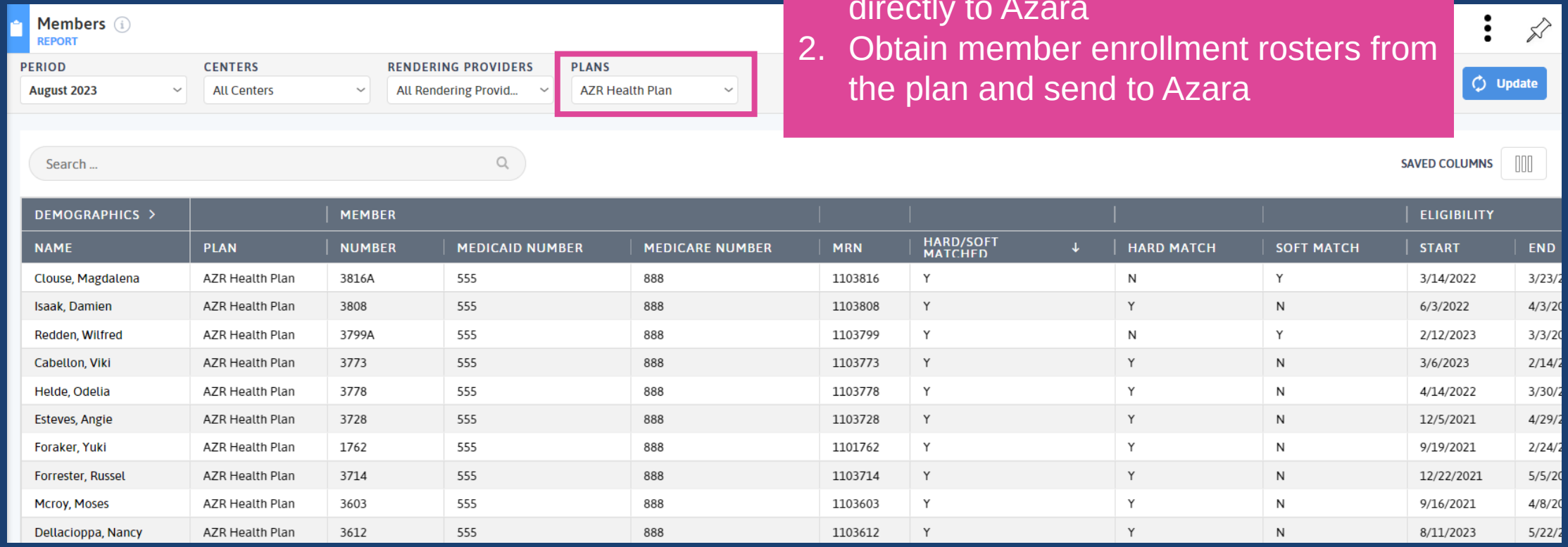


Payer attribution methods are different

Reconciling payer rosters with active patients is time consuming and burdensome

Health Plan Members

1. Plan sends member enrollment rosters directly to Azara
2. Obtain member enrollment rosters from the plan and send to Azara



DEMOGRAPHICS		MEMBER							ELIGIBILITY	
NAME	PLAN	NUMBER	MEDICAID NUMBER	MEDICARE NUMBER	MRN	HARD/SOFT MATCHED	HARD MATCH	SOFT MATCH	START	END
Clouse, Magdalena	AZR Health Plan	3816A	555	888	1103816	Y	N	Y	3/14/2022	3/23/2
Isaak, Damien	AZR Health Plan	3808	555	888	1103808	Y	Y	N	6/3/2022	4/3/20
Redden, Wilfred	AZR Health Plan	3799A	555	888	1103799	Y	N	Y	2/12/2023	3/3/20
Cabellon, Viki	AZR Health Plan	3773	555	888	1103773	Y	Y	N	3/6/2023	2/14/2
Helde, Odelia	AZR Health Plan	3778	555	888	1103778	Y	Y	N	4/14/2022	3/30/2
Esteves, Angie	AZR Health Plan	3728	555	888	1103728	Y	Y	N	12/5/2021	4/29/2
Foraker, Yuki	AZR Health Plan	1762	555	888	1101762	Y	Y	N	9/19/2021	2/24/2
Forrester, Russel	AZR Health Plan	3714	555	888	1103714	Y	Y	N	12/22/2021	5/5/20
Mcroy, Moses	AZR Health Plan	3603	555	888	1103603	Y	Y	N	9/16/2021	4/8/20
Dellacioppa, Nancy	AZR Health Plan	3612	555	888	1103612	Y	Y	N	8/11/2023	5/22/2

Core DRVS

Enrollment

Attributed Members & Patients

Core DRVS

Enrollment

Attributed Members, Not Patients

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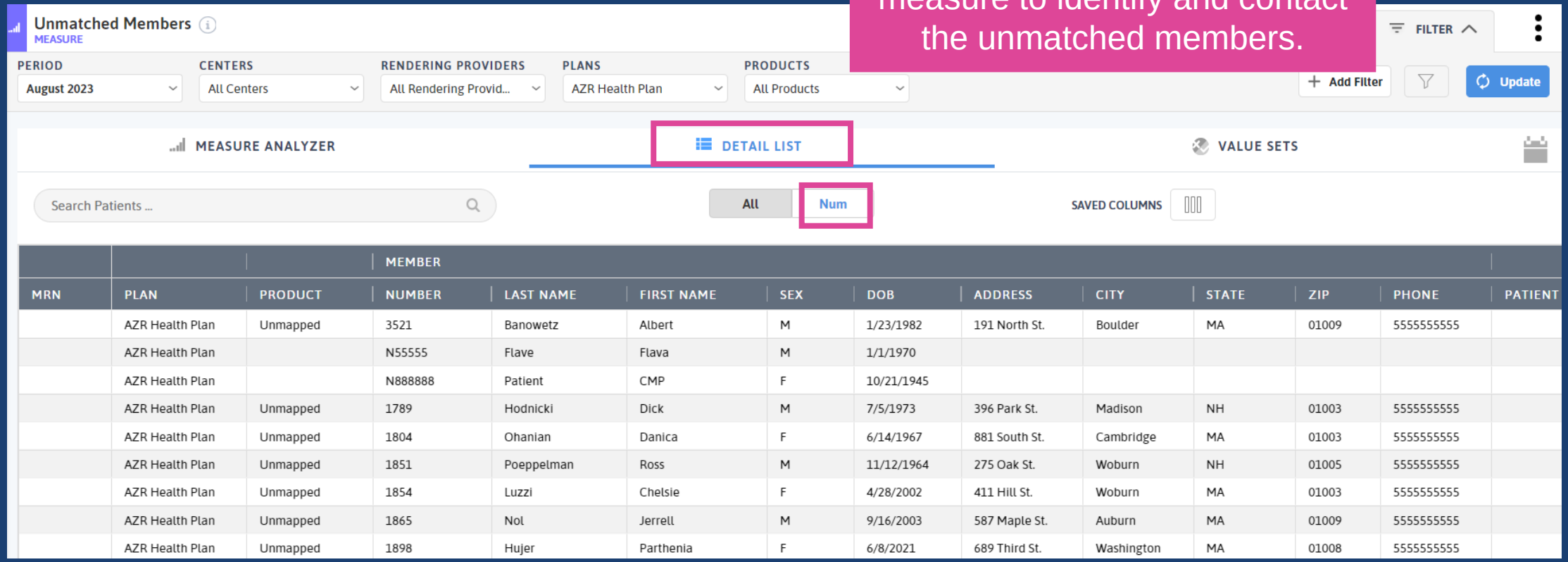
Use the Unmatched Member measure to identify and contact the unmatched members.



			MEMBER										
MRN	PLAN	PRODUCT	NUMBER	LAST NAME	FIRST NAME	SEX	DOB	ADDRESS	CITY	STATE	ZIP	PHONE	PATIENT
	AZR Health Plan	Unmapped	3521	Banowetz	Albert	M	1/23/1982	191 North St.	Boulder	MA	01009	5555555555	
	AZR Health Plan		N55555	Flave	Flava	M	1/1/1970						
	AZR Health Plan		N888888	Patient	CMP	F	10/21/1945						
	AZR Health Plan	Unmapped	1789	Hodnicki	Dick	M	7/5/1973	396 Park St.	Madison	NH	01003	5555555555	
	AZR Health Plan	Unmapped	1804	Ohanian	Danica	F	6/14/1967	881 South St.	Cambridge	MA	01003	5555555555	
	AZR Health Plan	Unmapped	1851	Poeppelman	Ross	M	11/12/1964	275 Oak St.	Woburn	NH	01005	5555555555	
	AZR Health Plan	Unmapped	1854	Luzzi	Chelsie	F	4/28/2002	411 Hill St.	Woburn	MA	01003	5555555555	
	AZR Health Plan	Unmapped	1865	Nol	Jerrell	M	9/16/2003	587 Maple St.	Auburn	MA	01009	5555555555	
	AZR Health Plan	Unmapped	1898	Hujer	Parthenia	F	6/8/2021	689 Third St.	Washington	MA	01008	5555555555	

Core DRVS

Enrollment

APO Campaigns

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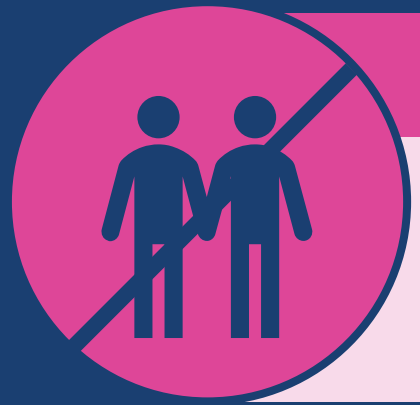
Members without a visit

Automated text messaging to patients attributed to your organization by the plan but have not had a visit in a certain timeframe (variable) to engage in making an appointment.

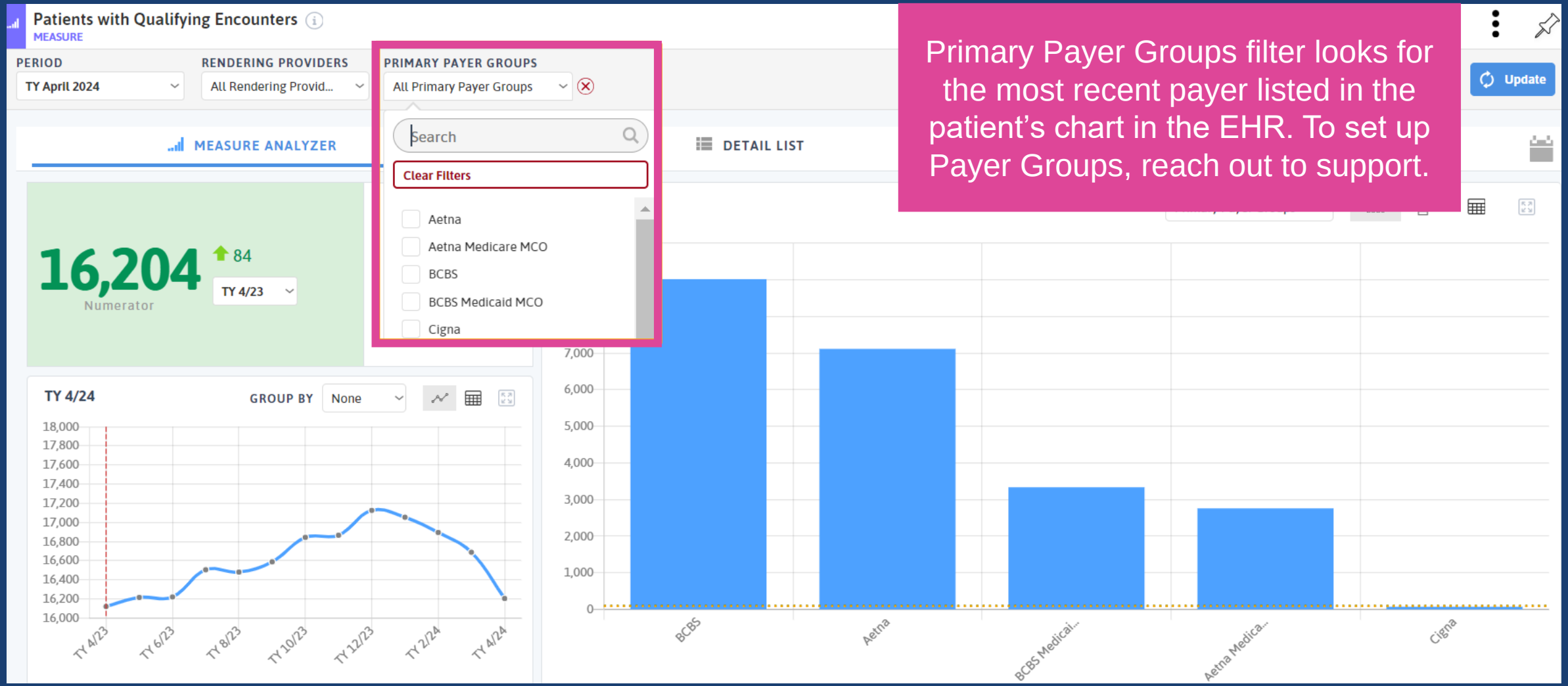


Unmatched members

Engage members attributed to your organization by the plan that your organization has never seen through automated text messaging.

Core DRVS | Enrollment | APO

Primary Payer Group Filter



Primary Payer Groups filter looks for the most recent payer listed in the patient's chart in the EHR. To set up Payer Groups, reach out to support.

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Attribution

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Key Outcomes

Improved Care Coordination	Attribution and empanelment ensure each patient has a designated primary care provider (PCP) and care team. This fosters a strong patient-doctor relationship, leading to better communication, care continuity, and preventive care.
Improved Patient Outcomes	Stronger relationships between patients and their PCPs can lead to earlier diagnoses, better management of chronic conditions, and ultimately, improved health outcomes for patients.
Reduced Costs	By proactively managing patient care, providers can identify and address potential health issues before they become more serious and expensive. This can help reduce unnecessary hospital admissions and lower overall healthcare costs.

Risk Adjustment & Stratification

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Risk Adjustment & Stratification

Risk Adjustment	Code appropriate level of acuity
Risk Stratification	Appropriate allocation of resources + Identify & provide support for patients

HIGHER POPULATION RISK = ADDITIONAL REVENUE TO DELIVER APPROPRIATE CARE

UNDERSTANDING AND MANAGING RISK IS FUNDEMENTAL TO SUCCESS IN VBC CONTRACTS

Risk Adjustment

Risk Adjustment is the process by which payers ensure that providers are paid enough to appropriately care for all their patients.

Key Challenges:

Ensuring providers code for the appropriate level of acuity

Payers use a variety of risk adjustment models

Models do not include race, ethnicity or SDOH data

Alert Providers of RAF Gaps

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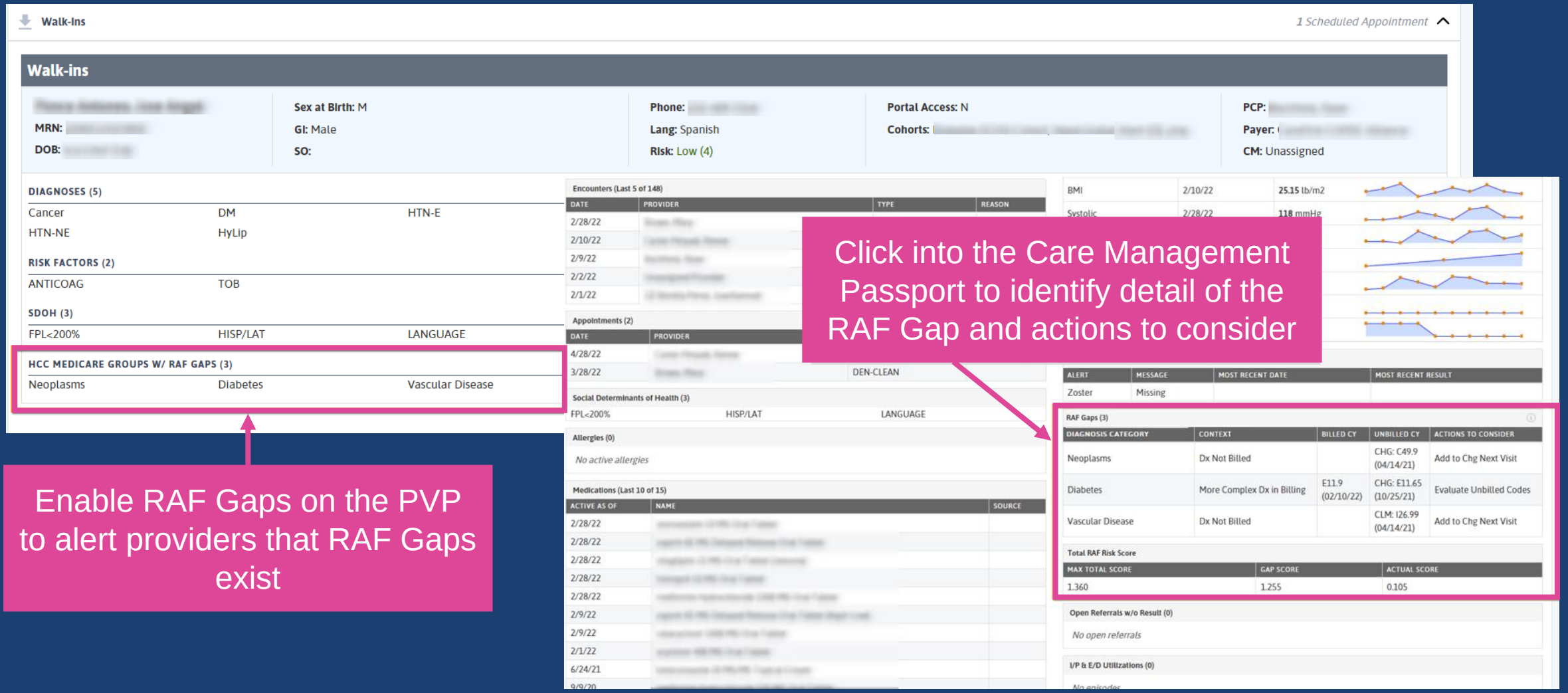

Click into the Care Management Passport to identify detail of the RAF Gap and actions to consider

Enable RAF Gaps on the PVP to alert providers that RAF Gaps exist

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RAF Gap Functionality in the EHR

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RAF Gaps (5)

Diagnosis Category	Context	Billed CY	Unbilled CY	Actions To Consider
Diabetes	More Complex Dx in EHR	E11.9 (7/6/2022)	EHR: E11.649 (6/14/2021)	Evaluate Unbilled Codes
Morbid Obesity	Dx Not Billed		EHR: E66.01 (5/25/2021)	Add to Chg Next Visit
Other Significant Endocrine and Metabolic Disorders	Dx Not Billed		CLM: E21.3 (5/6/2021)	Add to Chg Next Visit
Seizure Disorders and Convulsions	Dx Not Billed		CHG: R56.9 (5/25/2021)	Add to Chg Next Visit
Vascular Disease	More Complex Dx in Billing	I82.A13 (7/12/2022)	CHG: I26.99 (3/1/2021)	e Unbilled Codes

Total RAF Risk Score

Max Total Score	Gap Score	Actual Score
1.771	0.906	0.865

Azara must have claims integration to display diagnoses from claims

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EHR Plug-In

Where is the Opportunity?

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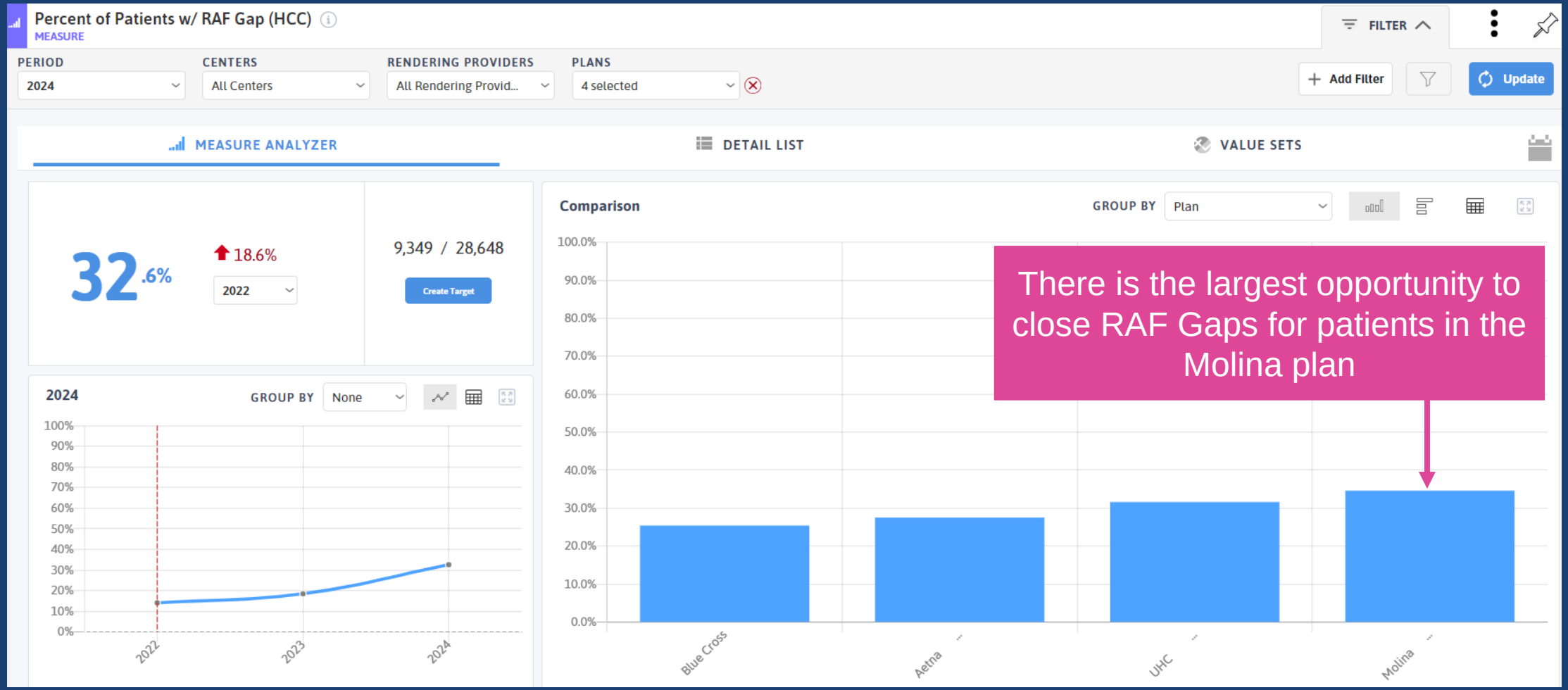

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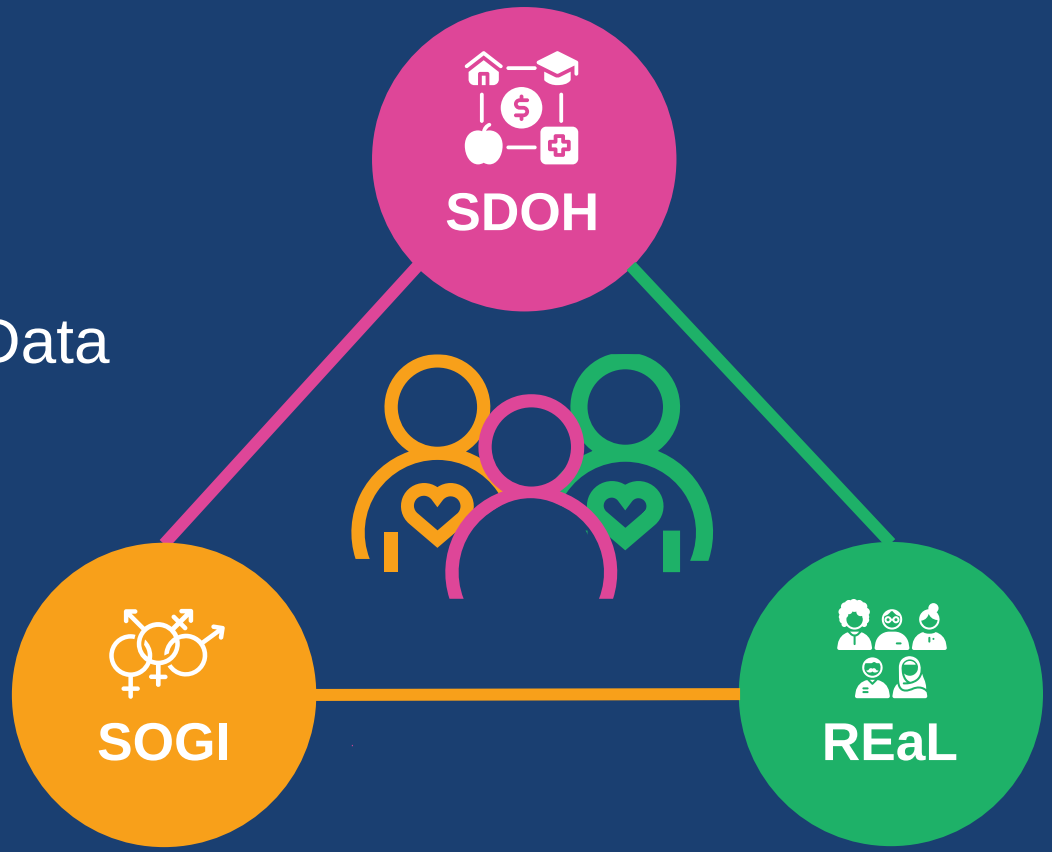
The Near Future…

SDOH: Social Drivers of Health Data

REaL: Race Ethnicity & Language Data

SOGI: Sexual Orientation & Gender Identity Data

SDOH + SOGI + REaL: Think of these three data types as a ‘bundle’ that will be used in various ways, most of the time intersecting but not always.



Risk Stratification

Risk Stratification is the process of classifying patients into groups based on their likelihood of developing certain health problems or experiencing negative health outcomes.

Key Challenges:

Comprehensive risk stratification requires multiple sources of data

Payer risk models use lagged claims data

Identifying the “right” patients to maximize limited resources

Risk Stratify the Population

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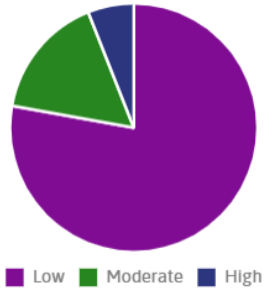
Risk Criteria Weighting

DIAGNOSES	PATIENT COUNT	PREVALENCE	% HIGH RISK	POINTS
Diabetes	66,385	13%	20%	2
Hypertension	148,818	29%	13%	2
Hyperlipidemia	138,087	27%	12%	1
ASCVD	26,076	5%	30%	1
CHF	10,443	2%	45%	3
CAD	17,715	3%	35%	2
Ischemic Stroke	4,772	1%	31%	1
Hemorrhagic Stroke	608	0%	25%	2
IVD	23,062	4%	31%	1
Afib	8,612	2%	31%	2
Persistent Asthma	17,654	3%	20%	2
COPD	27,575	5%	25%	2
Chronic NonMalignant Pain	54,224	10%	15%	1
Cirrhosis	2,332	0%	28%	2
CKD Stages 3&4	11,596	2%	23%	1
CKD Stage 5	495	0%	44%	2
ESRD	1,019	0%	40%	1

Risk Category Distribution



High Risk Patients

31,156

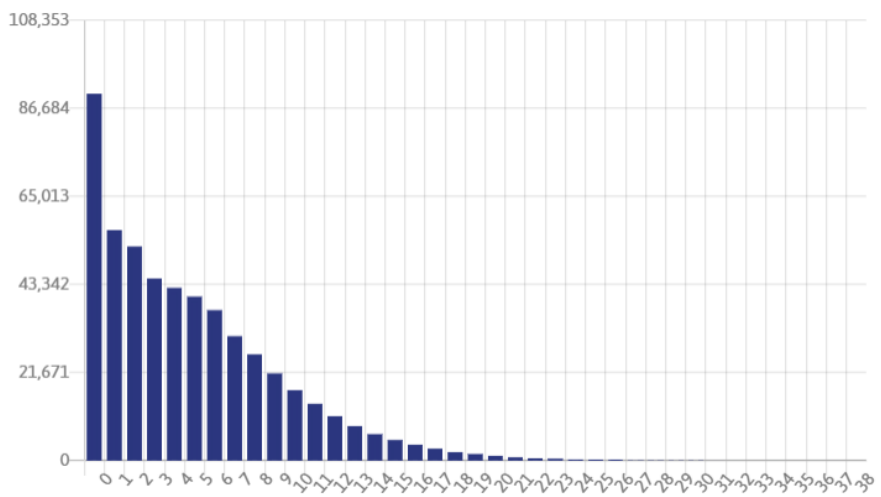
Pts w/ qualifying encounter

Total Patients

518,529

Pts w/ qualifying encounter

Risk Score Distribution



Risk Score Thresholds

Geriatric (65-149)

CATEGORY	# PATIENTS	PREVALENCE	THRESHO
High	4,521	6%	16.00
Moderate	12,880	17%	11.00
Low	56,594	76%	0

Adult (22-64)

CATEGORY	# PATIENTS	PREVALENCE	THRESHO
High	17,196	6%	14.00
Moderate	47,505	16%	9.00
Low	226,152	78%	0

Pediatric (0-21)

CATEGORY	# PATIENTS	PREVALENCE	THRESHO
High	9,439	6%	8.00
Moderate	23,449	15%	5.00
Low	120,792	79%	0

Rising Risk Patients

1,628

Pts w/ New High Risk Level

Core DRVS | Azara Risk

Many Ways to Use Azara Risk

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PVP & CMP

Registry

Dynamic Cohorts

Rising Risk Measure

Risk Filter

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Risk Adjustment & Stratification

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Key Outcomes

Increased Revenue	Risk adjustment identifies patients who qualify for additional reimbursement but haven't been coded correctly. By capturing these missed diagnoses and procedures, healthcare providers can recover lost revenue and improve their financial performance.
Targeted Interventions	Risk stratification allows you to identify individuals at higher risk for specific health problems, enabling focused interventions and preventative measures tailored to those most likely to benefit, maximizing the impact of population health programs.
Resource Optimization	Understanding risk across your population allows more efficient resource allocation. Focus can be given to high-risk, high-cost individuals who will benefit the most from high touch actions like care management.

Care Management & Coordination

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What's The Difference?

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	Care Management	Care Coordination
Resource Type	Licensed professional	Non-clinical unlicensed professional, often CHW
Resource Assignment	Follows patient for long term, typically 75 - 150 patients in total	Focused on specific gaps/tasks, does not follow patient
Resource Objective	Collaborate with care-team and patient to improve outcomes	Contact patient, screen for barriers, and connect to services
Patient Identification	High-risk patients, typically 5% of population	Any patient with care gaps or screening needs

Care Management & Coordination

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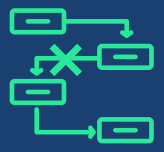
By proactively managing patient populations through care coordination and care management programs, healthcare providers can close care gaps, improve population health outcomes, and achieve success in value-based care models.

Key Challenges:



Ineffective processes for identification and placement of patient into the appropriate care program

Staffing shortages

Tools/technology does not align with workflows

Automate Identification of Patients

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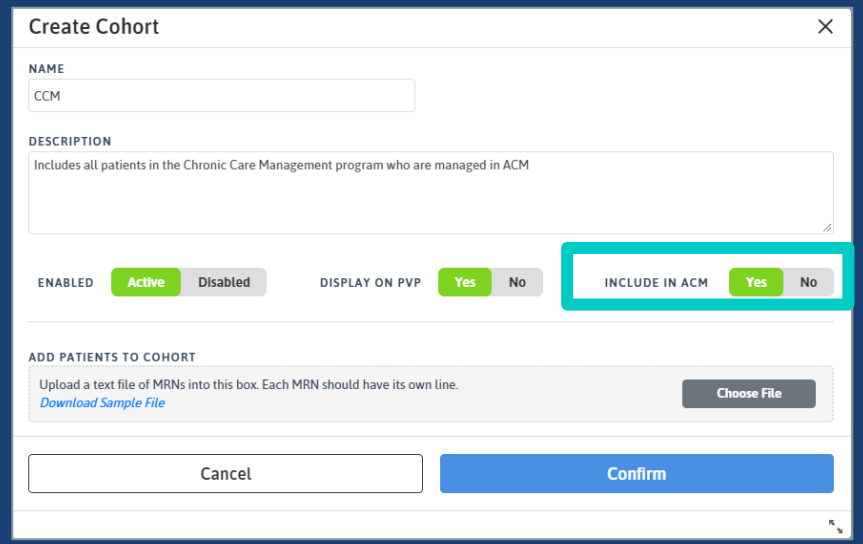
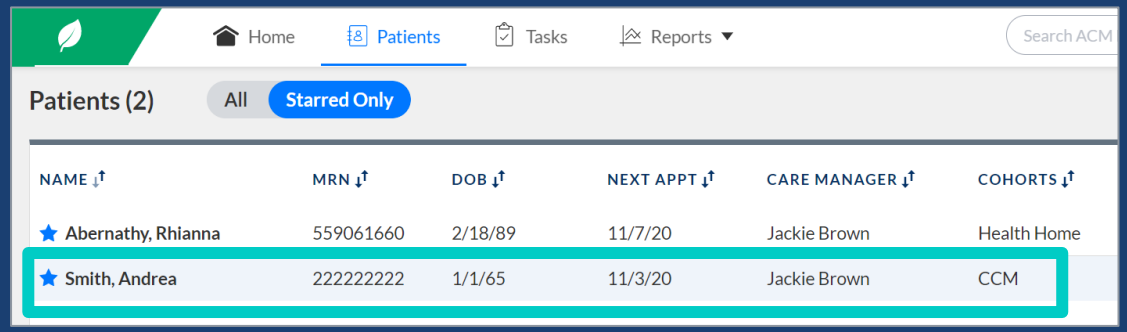
Care Management: Cohort is enabled in **DRVS**

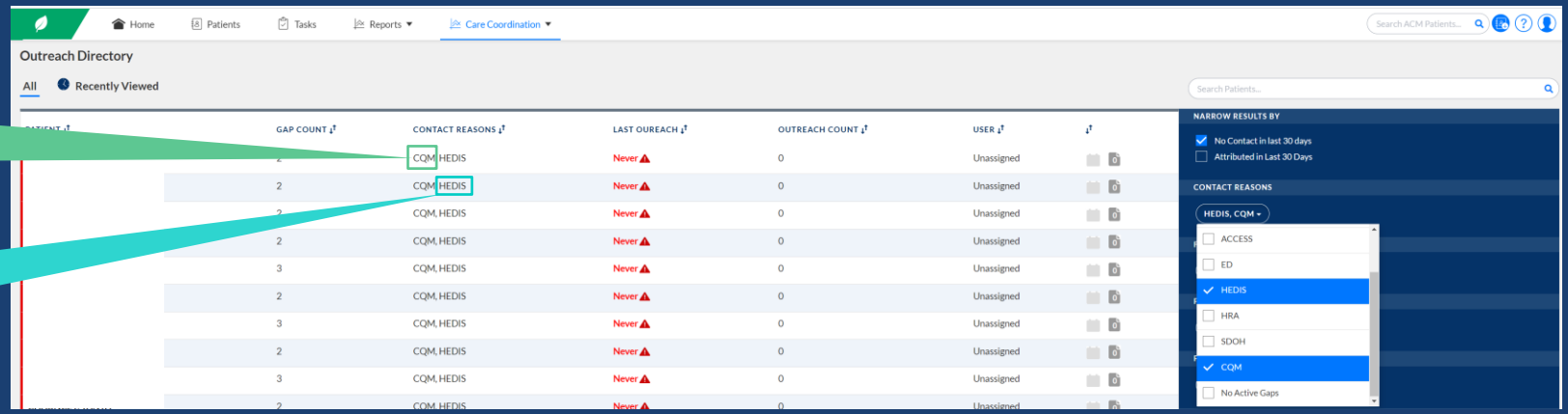




Care Connect: Gap lists are loaded from **CQM Gaps in DRVS** or from **payer care gap files**

CQM is from DRVS

HEDIS is from a payer



ACC

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Build Efficient Workflows

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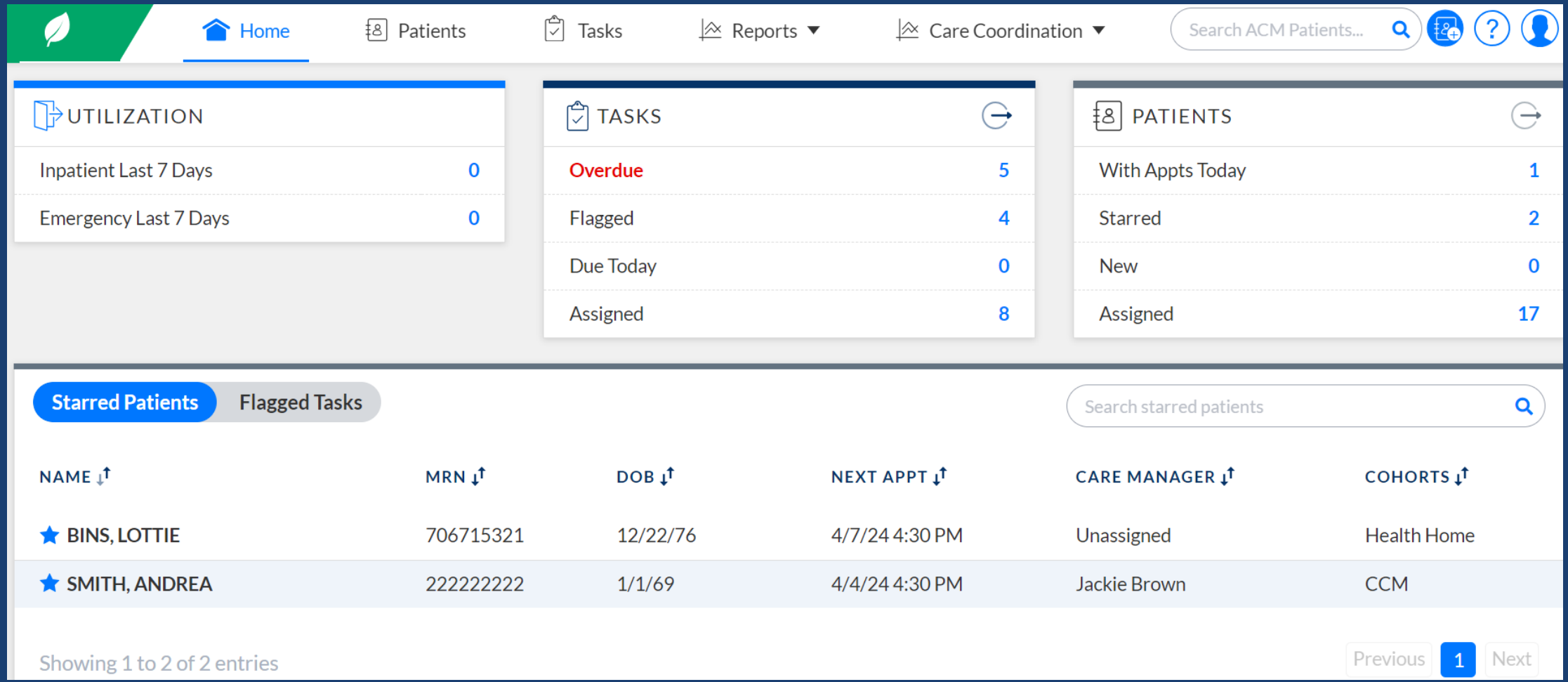

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Tools Designed for Care Managers

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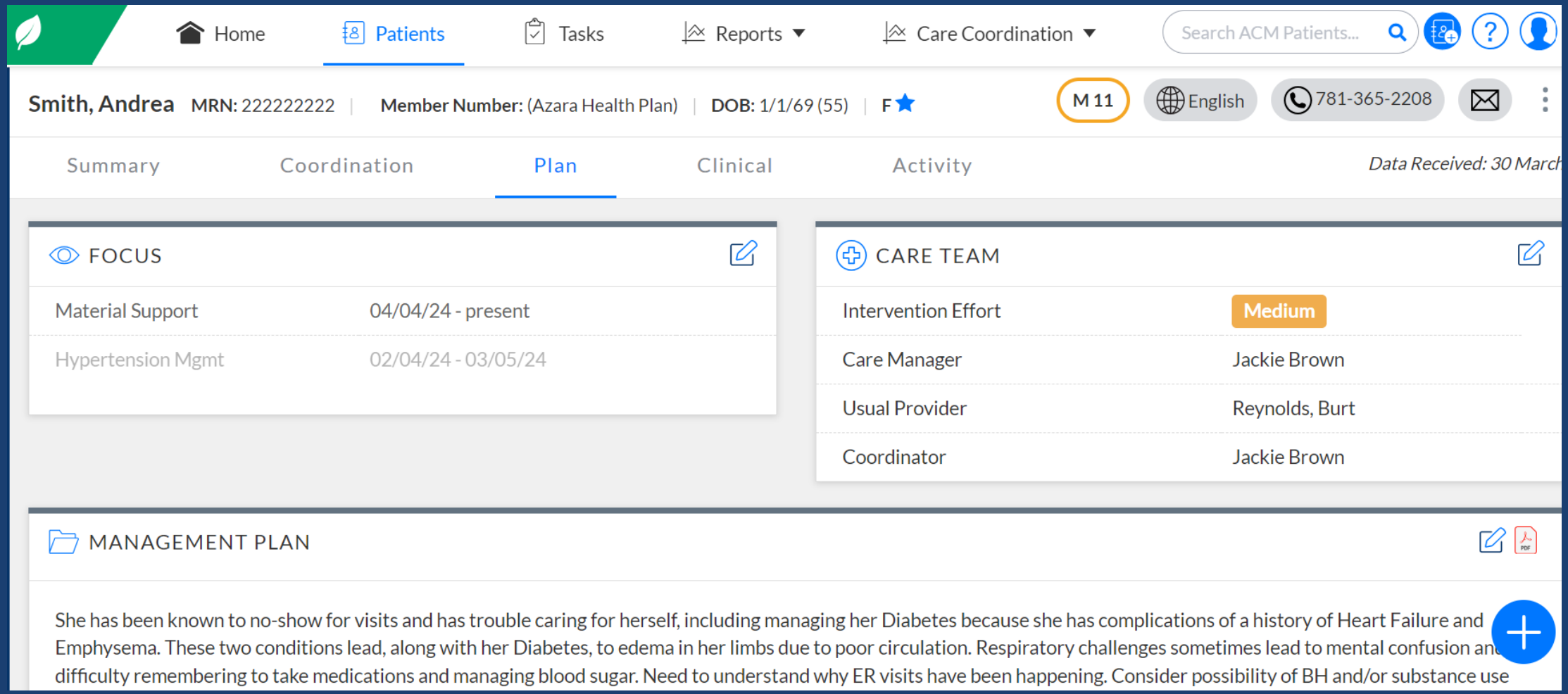

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Prioritize & Track Outreaches

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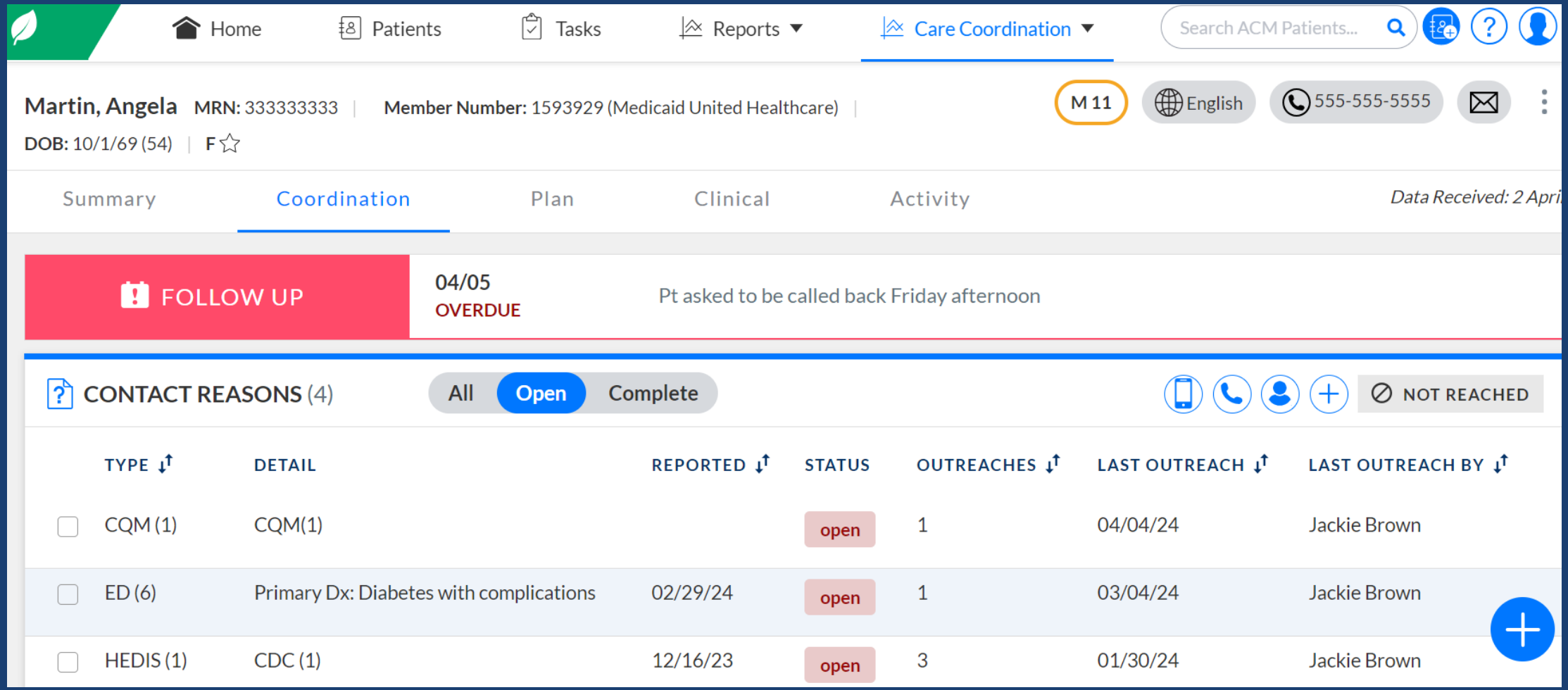

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Demonstrate Impact of CM Program

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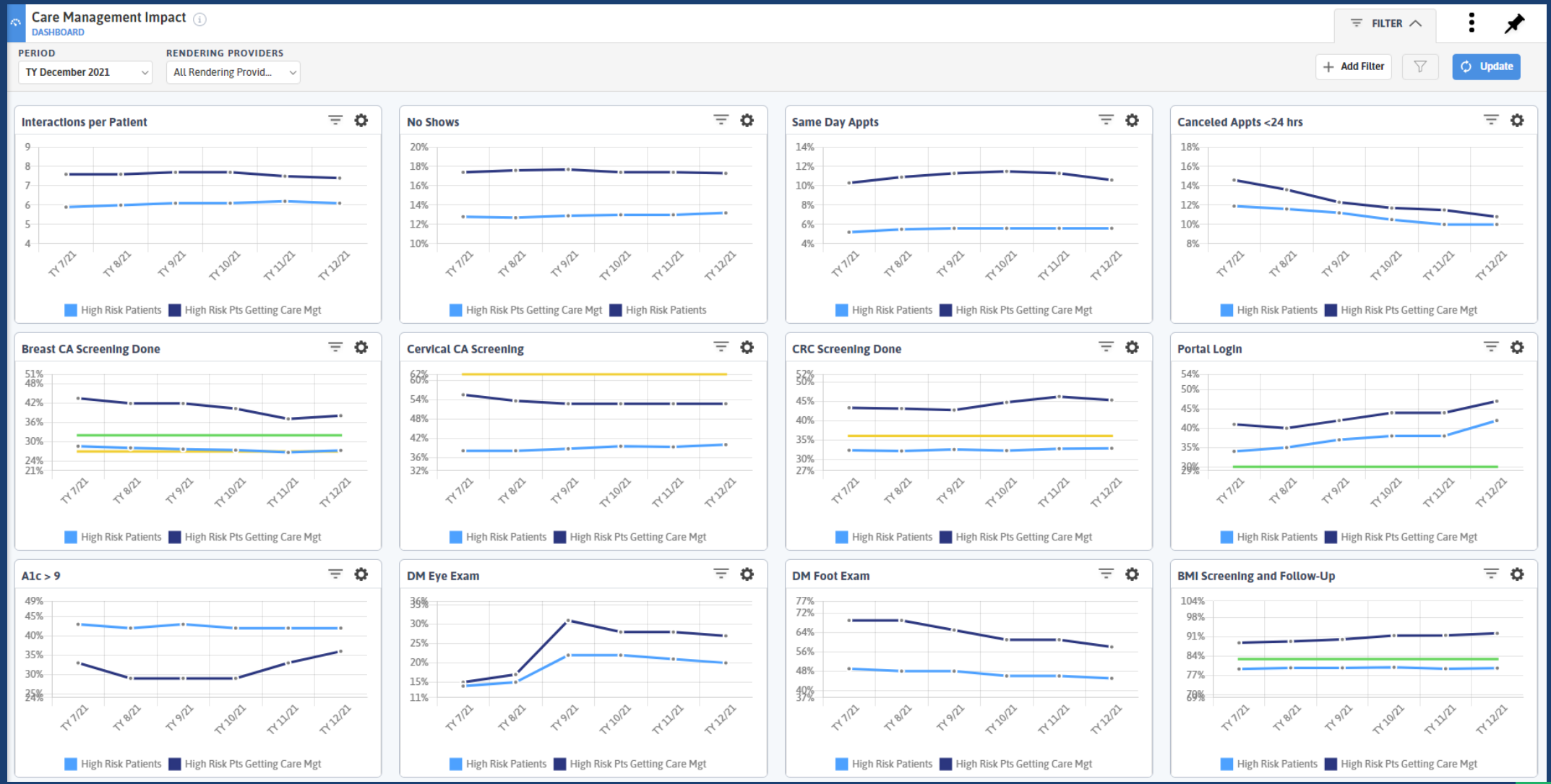

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Track Productivity

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# of Outreaches Performed

41

41 outreaches over 33 Patients

Unsuccessful Outreaches

19

46% of Outreaches

CONTACT REASON	# PATIENTS
Access	1
ACCESS	2
ED	2
HEDIS	7
HRA	3

Successful Outreaches

22

54% of Outreaches

CONTACT REASON	# PATIENTS
Access	1
ACCESS	3
ED	5
HEDIS	7
HRA	2

OUTREACH METHOD

In Person | Mailing | Phone | Research | Text

USER	TOTAL	SUCCESSFUL					UNSUCCESSFUL				
Jackie Brown	6	1	0	1	0	1	1	0	1	1	0
Ipsa Nirupa	7	1	1	1	0	1	1	0	1	1	0
Sianeh Bah	6	0	1	1	0	1	1	0	1	1	0
Ambaya Dinath	6	1	0	1	0	1	1	0	1	0	1
Braeden Orr	5	1	0	1	0	1	0	0	1	1	0
Hudson Lim	4	0	0	1	0	1	1	0	0	1	0
Andala Motala	3	0	0	1	0	0	0	0	1	1	0
Nora Misbahi	3	0	0	2	0	0	0	0	0	1	0
Cohen Braswell	1	0	0	1	0	0	0	0	0	0	0
	41	4	2	10	0	6	5	0	6	7	1

ACC | Core DRVS

Care Management & Coordination

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Key Outcomes

Utilization and Cost Reduction	By preventing avoidable hospital admissions, unnecessary procedures, and medication errors, care management and coordination can lead to significant cost savings for healthcare providers and payers.
Improved Quality Metrics	Effective care management and coordination can help providers achieve better performance on these metrics, resulting in positive financial rewards.
Increased Efficiency	Streamlined communication and care coordination can improve workflow, reduce administrative tasks for providers, and allow them to dedicate more time to direct patient care.

Patient Engagement

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Patient Engagement

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Patient Engagement fosters a collaborative partnership between patients and providers, empowering patients to take a proactive role in preventive care and early disease detection, ultimately leading to better health outcomes.

Key Challenges:

Outreach is time consuming and labor intensive

Using the right modality to reach the most patients

Health literacy barriers

Azara Patient Outreach | Campaigns

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- **Cancer Screening**
  - Breast
  - Cervical
  - Colorectal
  - Unreturned FIT Kits
- **Chronic Disease**
  - Diabetes A1c
  - Comprehensive Diabetes
  - Undiagnosed Hypertension
  - Hypertension Control
  - CKD Screening Patients w/ HTN
  - CKD Screening Patients w/ Diabetes
- **Pediatrics**
  - Childhood Immunizations
  - Well-Child Visits
  - Adolescent Immunizations
  - HPV Vaccination
- **Preventative Visits**
  - Patients Without Visits
  - Members Without Visits
  - Unmatched Patients
  - Transitions of Care
  - Seasonal Flu
  - Chlamydia Screening
- **COVID-19**
  - Immunization Availability
  - 2nd Dose Reminder
  - Booster Dose Reminder
- **Medicaid Eligibility**
  - Initial Redetermination
  - Follow-Up Redetermination
  - Redetermination Date Passed

APO | Core DRVS

Evaluate Engagement Programs

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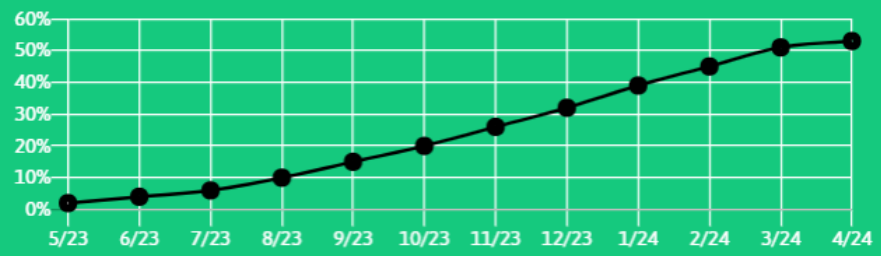
IMPACT

473
CARE GAPS CLOSED
▲ 18 Last Month

53%
CARE GAP CLOSURE RATE

ENROLLEES W/CARE GAP CLOSURES BY MONTH



EFFECTIVENESS

+46.6%
SINCE BASELINE
▲ 2.0% Last Month

HOW IS THIS CALCULATED?
Increase in % of patients who received a Diabetes A1c compared to the baseline

CAMPAIGN DETAILS

1,003
TOTAL ENROLLEES
TY April 2024

925
ENROLLEES MESSAGED
TY April 2024

Campaign Name	Diabetes A1c reminder without appointment
Start Date	Jan 2023 *15 months*
Duration	1 messages after 27 days
Success Criteria	Diabetes A1c

5,383
MESSAGES SENT
TY April 2024
▲ 225 Last Month

PATIENT ENGAGEMENT

892
PTS SUCCESSFULLY REACHED
TY April 2024
▲ 18 Last Month

59%
MADE APPT

50%
KEPT APPT

53%
CARE GAP CLOSED

APO | Core DRVS

Track Patient Engagement

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Core DRVS

Patient Engagement

azara 2024

Key Outcomes

Reduced Costs	Engaged patients are more likely to adopt healthy behaviors, such as exercising regularly, taking their medications, and improved self management skills, leading to better management of chronic conditions and reduced hospital / ED visits.
Improved Patient Satisfaction	Timely appointment reminders, preventive care reminders, and easy access to information can contribute to a more positive patient experience and higher satisfaction scores.
Increased Efficiency	Using analytics and dynamic cohorts coupled with automated texting, provider organizations can drive care gap closure across their patient population with limited staff involvement.

Close Care Gaps and Improve Quality

azara 2024

Close Care Gaps & Improve Quality

azara 2024

Closing care gaps and improving clinical quality measure performance is critical to unlock valuable financial incentives, achieve shared savings, and deliver improved health outcomes for patients.

Key Challenges:

Tracking performance across multiple plans and programs

Reconciling claims and clinical data

Lack of information at point of care

Closing Care Gaps | Ample Opportunities

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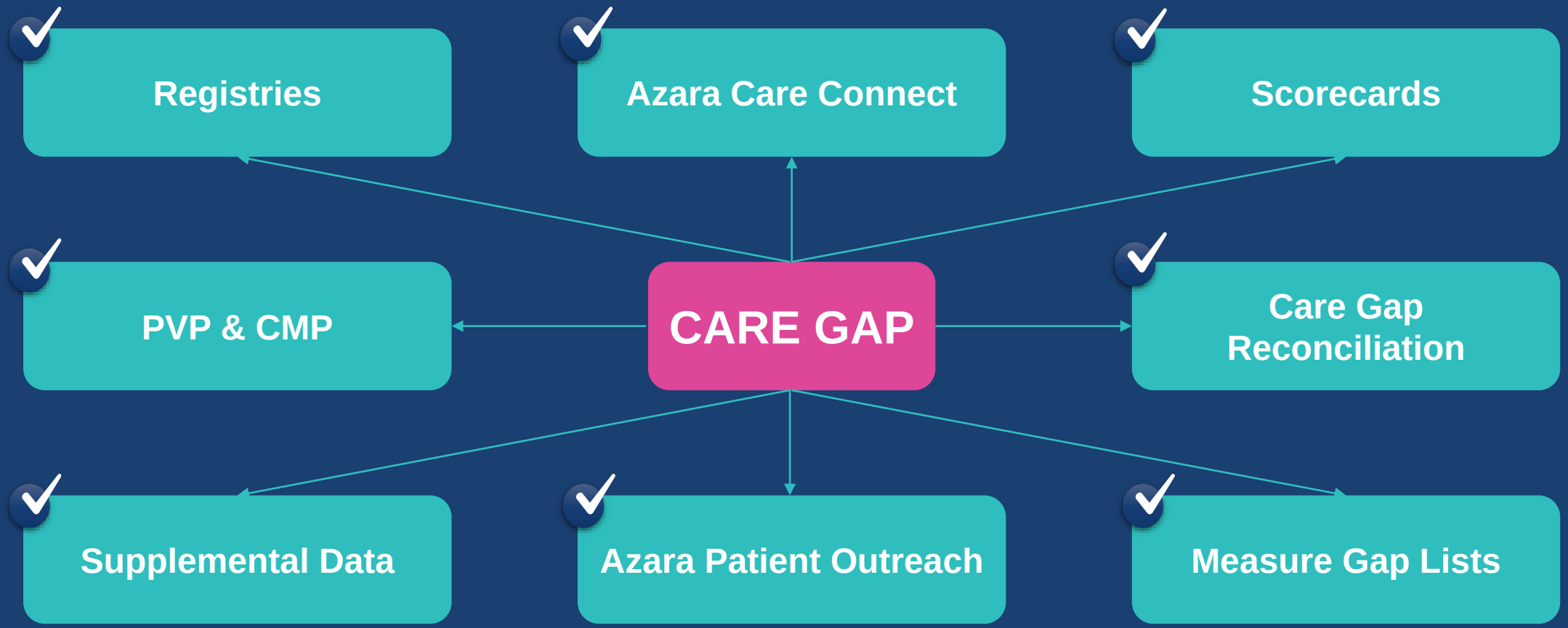

Evaluate Care Gaps Across Programs

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Target Achievement - All

TARGET ACHIEVEMENT	
PRIMARY	2
SECONDARY	2
NOT MET	7

Capital Target Achievement

TARGET ACHIEVEMENT	
PRIMARY	2
SECONDARY	2
NOT MET	7

Capital High Deductible Target Achievement

TARGET ACHIEVEMENT	
PRIMARY	4
SECONDARY	0
NOT MET	7

Capital Medicare Advantage Target Achievement

TARGET ACHIEVEMENT	
PRIMARY	1
SECONDARY	3
NOT MET	7

Total - Capital High Deductible

MEASURE	RESULT	NUM	DENOM	EXCL	GAP	2TGT
Breast CA Screening Ages 50-74 (CMS125v11)	66.4%	459	691	31	232	94
Cervical Cancer Screening (CMS124v11)	11.7%	81	695	160	614	510
Colorectal Cancer Screening (CMS130v11)	67.9%	911	1,341	26	430	229
Appropriate Rx for Asthma	34.3%	12	35	0	23	15
HTN Controlling High BP (CMS165v11)	75.0%	628	837	35	209	84
Statin Therapy CVD (CMS347v6)	71.8%	405	564	33	159	75
Depression Screening & Follow-Up (CMS2v12)	22.8%	459	2,017	490	1,558	1,256
BMI Screen & Follow-Up 18+ (CMS69v11)	29.5%	229	776	7	547	
DM A1c > 9 or Untested (CMS122v11)	19.4%	67	346	9	67	0
Diabetes: Eye Exam (CMS 131v9)	43.4%	150	346	9	196	138
Childhood Immunization Status (CMS117v11)	38.5%	45	117	0	72	0

Capital

MEASURE	RESULT	NUM	DENOM	EXCL	GAP	2TGT
Breast CA Screening Ages 50-74 (CMS125v11)	68.5%	185	270	9	85	31
Cervical Cancer Screening (CMS124v11)	13.6%	49	360	96	311	257
Colorectal Cancer Screening (CMS130v11)	65.9%	368	558	8	190	107
Appropriate Rx for Asthma	29.4%	5	17	0	12	8
HTN Controlling High BP (CMS165v11)	77.3%	225	291	4	66	23
Statin Therapy CVD (CMS347v6)	73.9%	147	199	11	52	23
Depression Screening & Follow-Up (CMS2v12)	20.3%	158	777	187	619	503

Capital Medicare Advantage

MEASURE	RESULT	NUM	DENOM	EXCL	GAP	2TGT
Breast CA Screening Ages 50-74 (CMS125v11)	69.4%	77	111	8	34	12
Cervical Cancer Screening (CMS124v11)	0.0%	0	4	2	4	4
Colorectal Cancer Screening (CMS130v11)	73.6%	142	193	10	51	23
Appropriate Rx for Asthma	0.0%	0	0	0	0	0
HTN Controlling High BP (CMS165v11)	75.9%	126	166	13	40	16
Statin Therapy CVD (CMS347v6)	79.0%	79	100	9	21	6
Depression Screening & Follow-Up (CMS2v12)	11.4%	27	237	84	210	175

Core DRVS

Promote Health Equity

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GROUPING Races | TARGETS Primary Secondary Not Met | REPORT FORMAT CrossTab

RACES	COLORECTAL CANCER SCREENING (CMS 130V11)	BREAST CANCER SCREENING AGES 50-74 (CMS 125V11)	CHLAMYDIA SCREENING IN WOMEN (CMS 153V12)	DIABETES: EYE EXAM (CMS 131V9)
American Indian/Alaska Native	60.0%	100.0%	75.0%	98.8%
Asian Indian	72.7%	75.0%	66.7%	93.5%
Black/African American	77.3%	83.3%	80.0%	90.7%
Chinese	72.0%	66.7%	100.0%	97.1%
Filipino	82.6%	100.0%	78.6%	89.0%
Guamanian or Chamorro	68.2%	83.3%	81.8%	
Ignore	76.5%	80.0%	50.0%	
Japanese	57.1%	75.0%	85.7%	
Korean	65.4%	44.4%	75.0%	
More than One Race	63.3%	75.0%	80.0%	
Native Hawaiian	57.7%	80.0%	71.4%	94.7%
Other Pacific Islander	75.0%	80.0%	80.0%	91.7%
Samoan	73.7%	100.0%	85.7%	97.8%
Unmapped	63.6%	84.6%	76.9%	96.6%
Unreported/Choose Not to Disclose Race	71.4%	83.3%	75.0%	93.9%
White	70.0%	20.0%	90.9%	92.7%

Identify health disparities by using the CrossTab format on a Scorecard, grouped by races.

Reconcile Claims and Clinical Data

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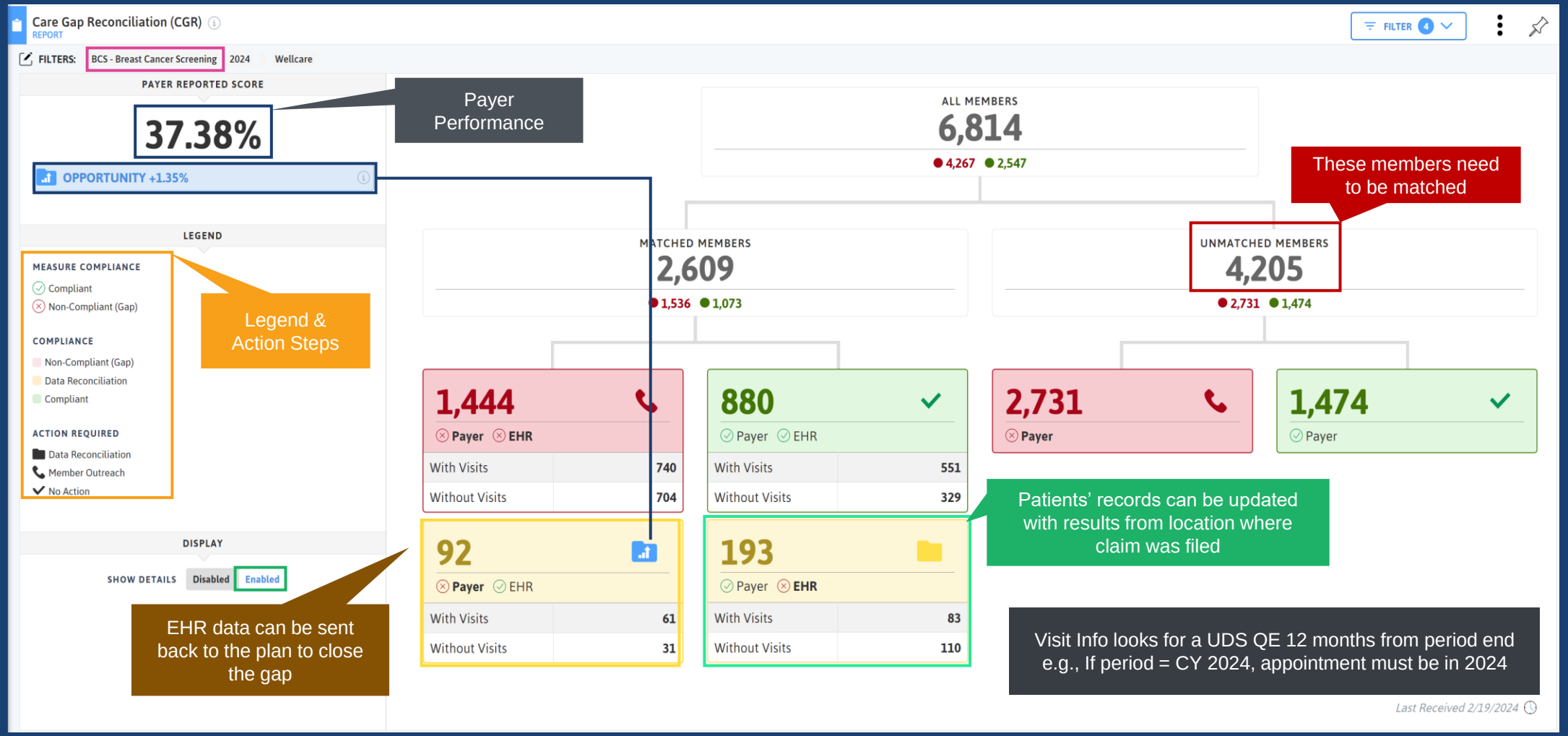

Enrollment | Care Gaps | Core DRVS

Targeted Outreach | Gap Lists

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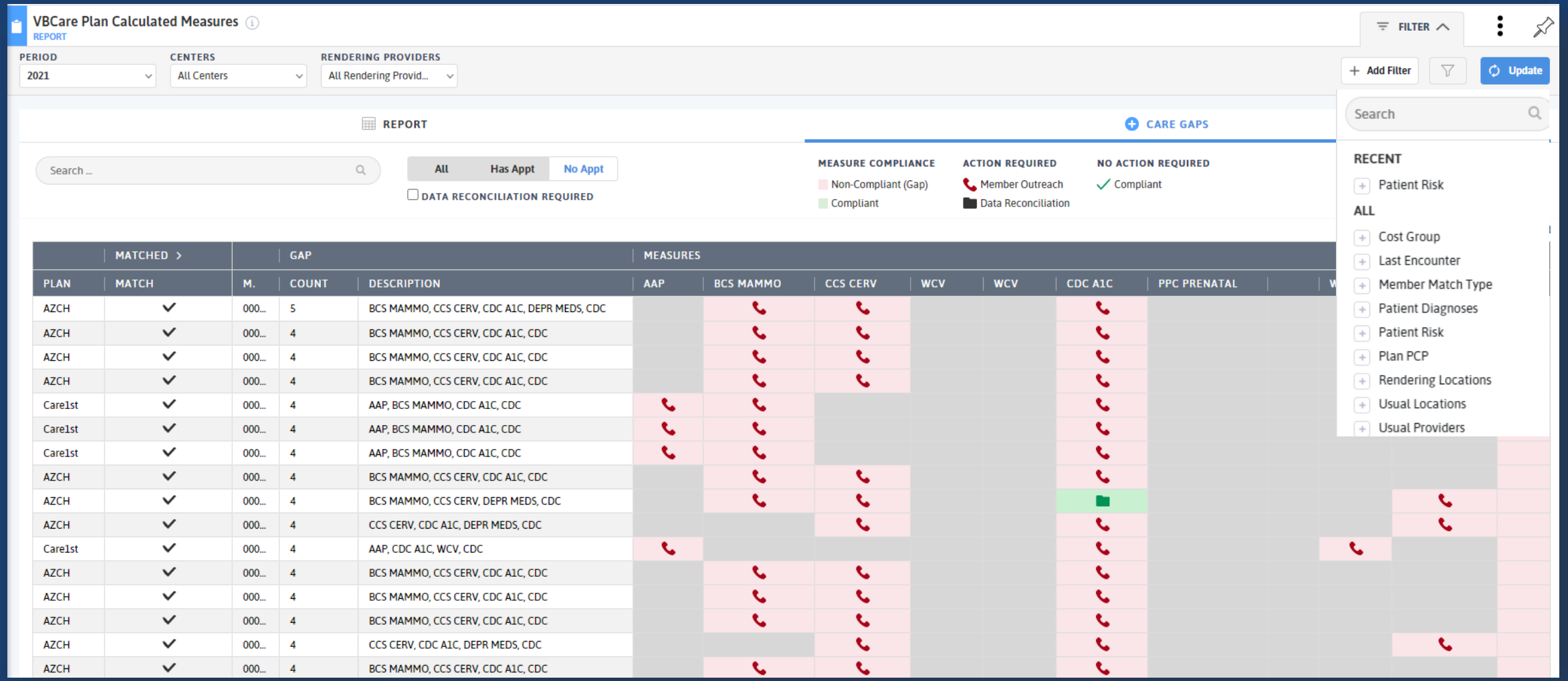

	MATCHED		GAP		MEASURES								
PLAN	MATCH	M.	COUNT	DESCRIPTION	AAP	BCS MAMMO	CCS CERV	WCV	WCV	CDC A1C	PPC PRENATAL		
AZCH	✓	000...	5	BCS MAMMO, CCS CERV, CDC A1C, DEPR MEDS, CDC		✆	✆			✆			
AZCH	✓	000...	4	BCS MAMMO, CCS CERV, CDC A1C, CDC		✆	✆			✆			
AZCH	✓	000...	4	BCS MAMMO, CCS CERV, CDC A1C, CDC		✆	✆			✆			
AZCH	✓	000...	4	BCS MAMMO, CCS CERV, CDC A1C, CDC		✆	✆			✆			
Care1st	✓	000...	4	AAP, BCS MAMMO, CDC A1C, CDC	✆	✆				✆			
Care1st	✓	000...	4	AAP, BCS MAMMO, CDC A1C, CDC	✆	✆				✆			
Care1st	✓	000...	4	AAP, BCS MAMMO, CDC A1C, CDC	✆	✆				✆			
AZCH	✓	000...	4	BCS MAMMO, CCS CERV, CDC A1C, CDC		✆	✆			✆			
AZCH	✓	000...	4	BCS MAMMO, CCS CERV, DEPR MEDS, CDC		✆	✆			■		✆	
AZCH	✓	000...	4	CCS CERV, CDC A1C, DEPR MEDS, CDC			✆			✆		✆	
Care1st	✓	000...	4	AAP, CDC A1C, WCV, CDC	✆					✆		✆	
AZCH	✓	000...	4	BCS MAMMO, CCS CERV, CDC A1C, CDC		✆	✆			✆			
AZCH	✓	000...	4	BCS MAMMO, CCS CERV, CDC A1C, CDC		✆	✆			✆			
AZCH	✓	000...	4	BCS MAMMO, CCS CERV, CDC A1C, CDC		✆	✆			✆			
AZCH	✓	000...	4	CCS CERV, CDC A1C, DEPR MEDS, CDC			✆			✆		✆	
AZCH	✓	000...	4	BCS MAMMO, CCS CERV, CDC A1C, CDC		✆	✆			✆			

Enrollment | Care Gaps | Core DRVS

Close Care Gaps & Improve Quality

azara 2024

Key Outcomes

Improved Patient Outcomes	By closing care gaps, healthcare providers can empower patients with preventive care, leading to earlier disease detection, improved chronic condition management, and ultimately, healthier patient populations.
Increased Revenue	Proactive care gap closure improves quality metrics for value-based programs, directly translating to financial rewards and ultimately better patient outcomes.
Increased Efficiency	Automating payer and clinical data reconciliation eliminates the burden of data gaps, freeing healthcare professionals to focus on identifying and addressing true clinical gaps in care.

Manage Cost & Utilization

azara 2024

Manage Cost & Utilization

azara 2024

Managing costs and utilization is a critical driver of value-based care success and can be a significant source of new revenue.

Key Challenges:

Extracting actionable insights from claims data

Track multiple plans and programs in one place

Effectively manage hospital utilization

Manage Multiple VBC Contracts

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Summary

Total Claims Paid	Member Months	PMPM	Avg RUB
$428.1m ▼ $76.5m	901.1k ▼ 132.6k	$475 ▼ $25	3 ▲ 2

Top Cost Members

70.1% of Cost
8.2% of Members

$300.1m
Total Cost Top Members

70.1% of total cost ($253.2m) is attributed to 8.2% of top cost members (population of **6,150 members**)

Plan and Line of Business Summary

Plan & LOB	Total Cost ↓	MMs	PMPM	Resource Utilization Band (U 0 1 2 3 4 5)	Quality (Primary / Secondary / Not Met)
Health Plan 2 - Commercial	$126,128,124	327,569	$385	4,494 / 14,332 / 6,235	5 / 1 / 2
Health Plan 1 - Commercial	$112,688,289	225,123	$500	2,428 / 7,294 / 3,206	1 / 4
Health Plan 2 - Medicare	$38,407,479	31,739	$1,210	1,480 / 3,157 / 1,048 / 803 / 1,065	1 / 5
Health Plan 3 - Medicare	$35,722,124	32,000	$1,116	502 / 775 / 1,234	2 / 6
Health Plan 3 - Medicaid	$32,116,280	71,848	$447	3,246 / 1,344 / 2,814 / 1,165	3 / 2
Health Plan 1 - Medicaid	$29,142,800	38,095	$765	2,400 / 1,002 / 2,001 / 4,225 / 1,900	1 / 1 / 3

ACU | Enrollment | Claims | Core DRVS

Contract Details

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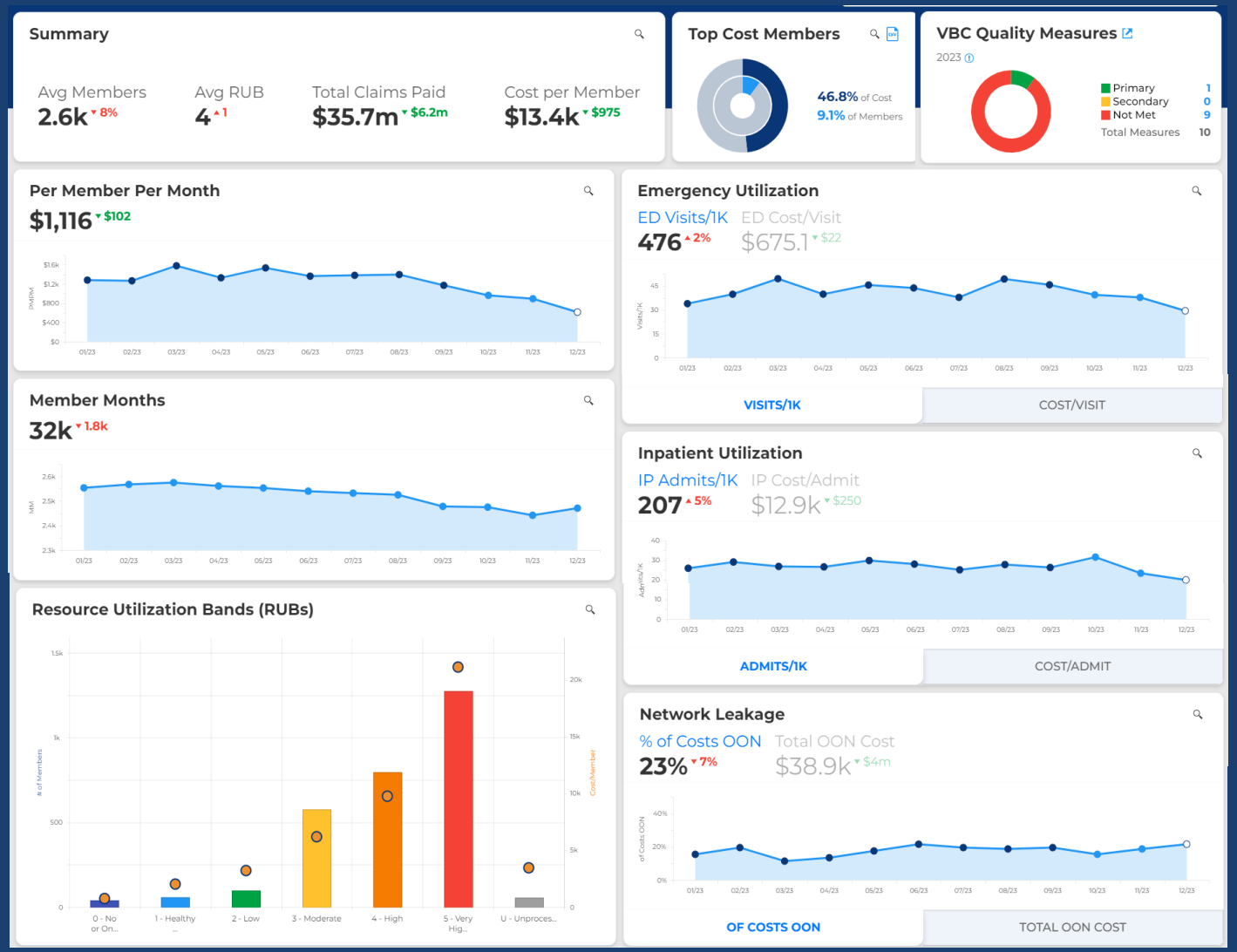

ACU | Enrollment | Claims | Core DRVS

Reduce Hospital Utilization

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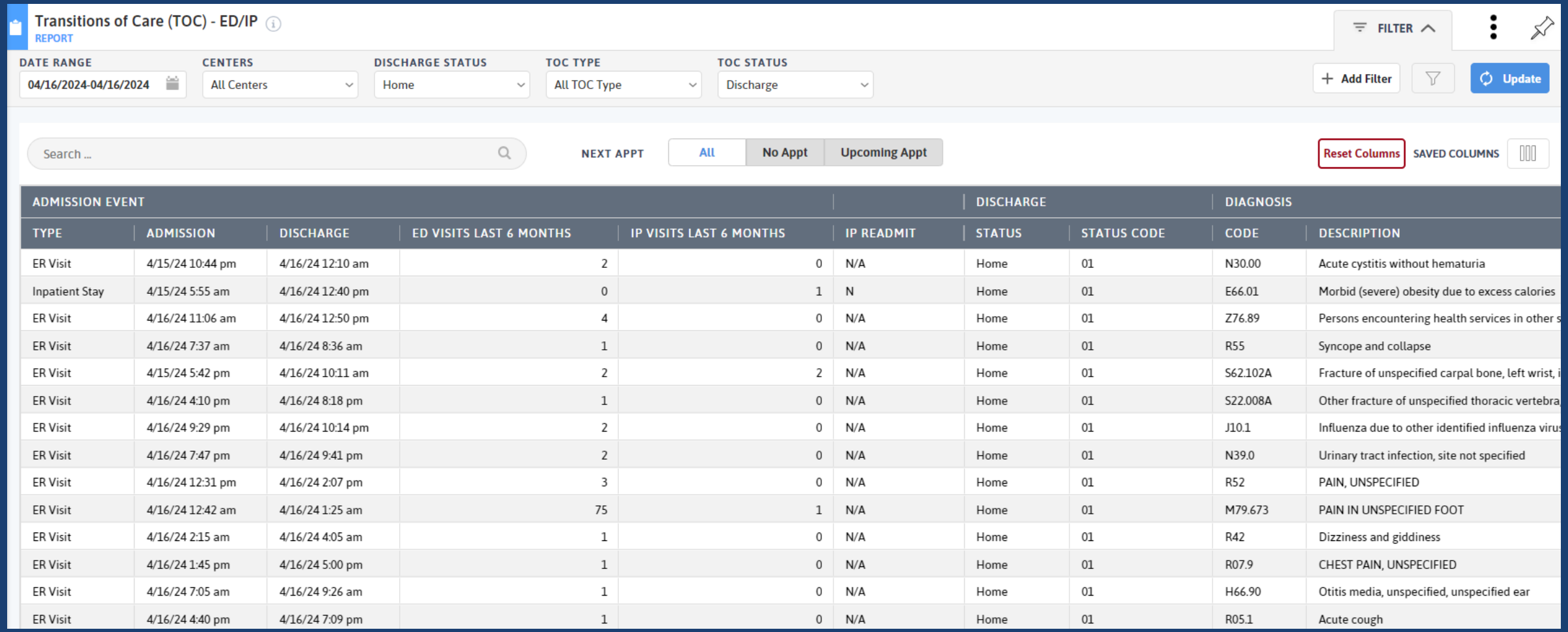

Transitions of Care (TOC) - ED/IP
REPORT

FILTER

DATE RANGE: 04/16/2024-04/16/2024
CENTERS: All Centers
DISCHARGE STATUS: Home
TOC TYPE: All TOC Type
TOC STATUS: Discharge

Add Filter | Update

Search ...

NEXT APPT: All | No Appt | Upcoming Appt

Reset Columns | SAVED COLUMNS

ADMISSION EVENT						DISCHARGE		DIAGNOSIS	
TYPE	ADMISSION	DISCHARGE	ED VISITS LAST 6 MONTHS	IP VISITS LAST 6 MONTHS	IP READMIT	STATUS	STATUS CODE	CODE	DESCRIPTION
ER Visit	4/15/24 10:44 pm	4/16/24 12:10 am	2	0	N/A	Home	01	N30.00	Acute cystitis without hematuria
Inpatient Stay	4/15/24 5:55 am	4/16/24 12:40 pm	0	1	N	Home	01	E66.01	Morbid (severe) obesity due to excess calories
ER Visit	4/16/24 11:06 am	4/16/24 12:50 pm	4	0	N/A	Home	01	Z76.89	Persons encountering health services in other s
ER Visit	4/16/24 7:37 am	4/16/24 8:36 am	1	0	N/A	Home	01	R55	Syncope and collapse
ER Visit	4/15/24 5:42 pm	4/16/24 10:11 am	2	2	N/A	Home	01	S62.102A	Fracture of unspecified carpal bone, left wrist, i
ER Visit	4/16/24 4:10 pm	4/16/24 8:18 pm	1	0	N/A	Home	01	S22.008A	Other fracture of unspecified thoracic vertebra
ER Visit	4/16/24 9:29 pm	4/16/24 10:14 pm	2	0	N/A	Home	01	J10.1	Influenza due to other identified influenza virus
ER Visit	4/16/24 7:47 pm	4/16/24 9:41 pm	2	0	N/A	Home	01	N39.0	Urinary tract infection, site not specified
ER Visit	4/16/24 12:31 pm	4/16/24 2:07 pm	3	0	N/A	Home	01	R52	PAIN, UNSPECIFIED
ER Visit	4/16/24 12:42 am	4/16/24 1:25 am	75	1	N/A	Home	01	M79.673	PAIN IN UNSPECIFIED FOOT
ER Visit	4/16/24 2:15 am	4/16/24 4:05 am	1	0	N/A	Home	01	R42	Dizziness and giddiness
ER Visit	4/16/24 1:45 pm	4/16/24 5:00 pm	1	0	N/A	Home	01	R07.9	CHEST PAIN, UNSPECIFIED
ER Visit	4/16/24 7:05 am	4/16/24 9:26 am	1	0	N/A	Home	01	H66.90	Otitis media, unspecified, unspecified ear
ER Visit	4/16/24 4:40 pm	4/16/24 7:09 pm	1	0	N/A	Home	01	R05.1	Acute cough

HIE/TOC | Core DRVS

Manage Cost and Utilization

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Key Outcomes

Reduced Costs	Proactively identify high-risk, high-cost patients and tailor care management programs to divert them from high-cost settings, achieving both cost reduction and improved health outcomes.
Enhanced Network Management	By analyzing utilization patterns, healthcare providers can pinpoint areas of leakage and identify gaps in their network, ultimately optimizing resource allocation and patient care.
Reduced Variation in Care	Identify providers deviating significantly from established care pathways for specific conditions.

Health Equity Embedded in DRVS

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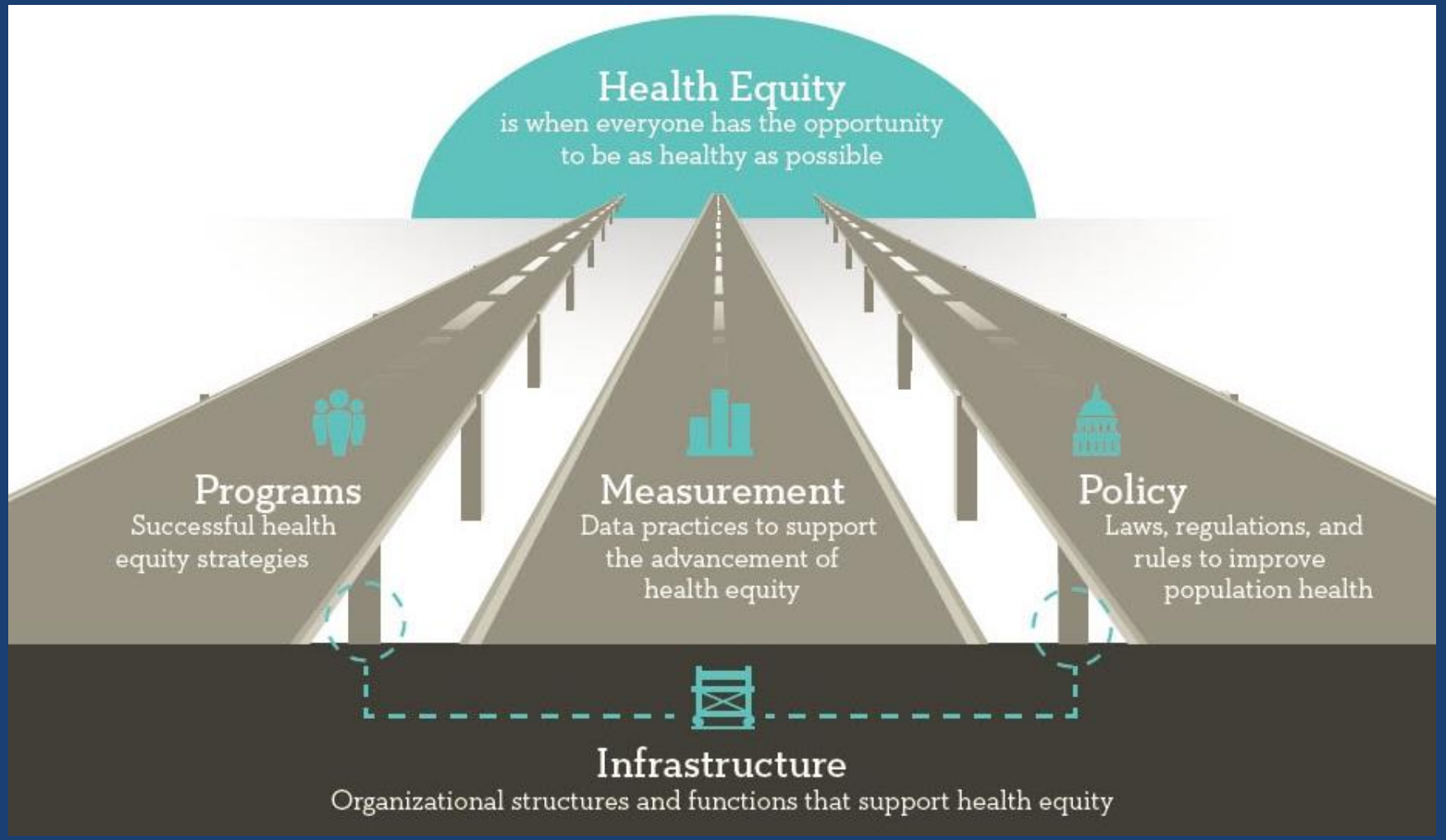

Source: cdc.gov

Essential Elements of VBC

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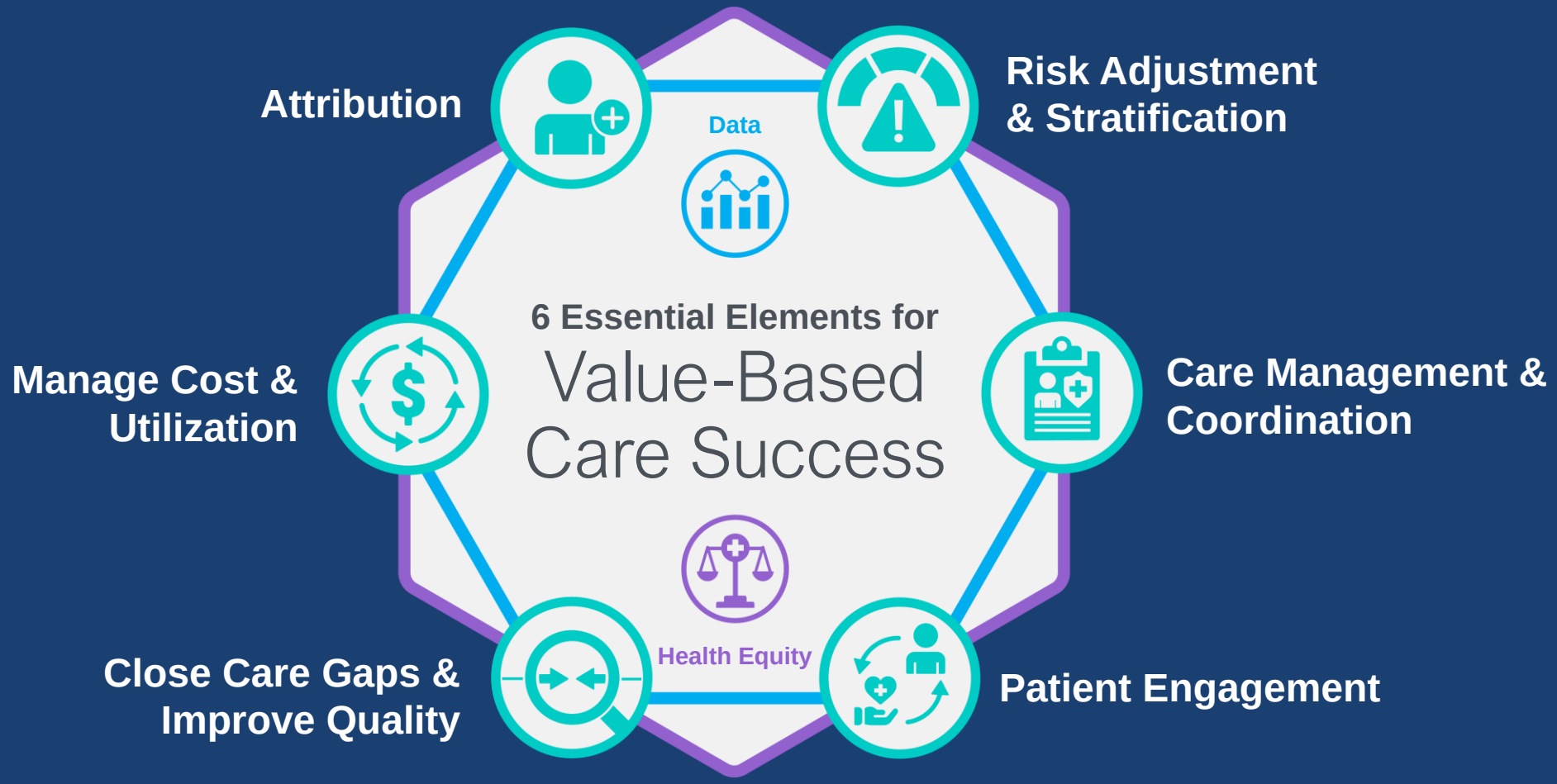

Additional Conference Sessions

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Azara Product	Session Name	Room
Thursday, May 2nd 10-11 am		
APO	Azara Patient Outreach: Raising the Sails of Cancer Screening	Otis
ACC	A Tale of Two Ships: Azara Care Connect to Support Value-Based Care	Marina III/IV
TOC	Navigating the Continuum: Enhancing Transitions of Care	Commonwealth C
Thursday, May 2nd 11:30-12:30 am		
ACU	Beyond Quality: How Azara Cost and Utilization Supports Value-Based Care Success	Commonwealth A/B

Questions?

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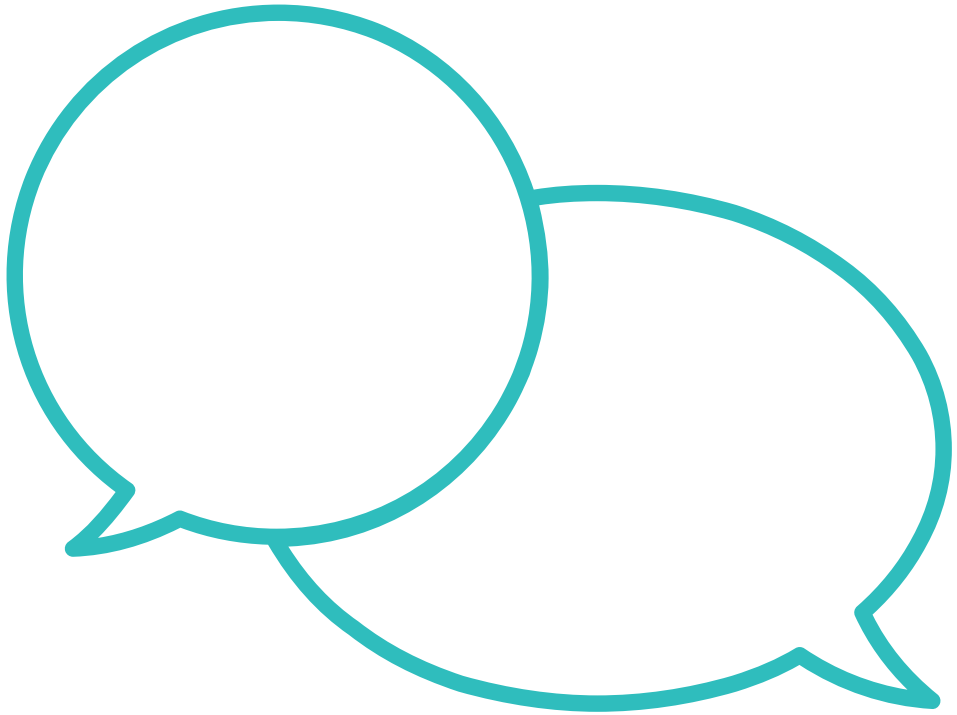


Azara healthcare

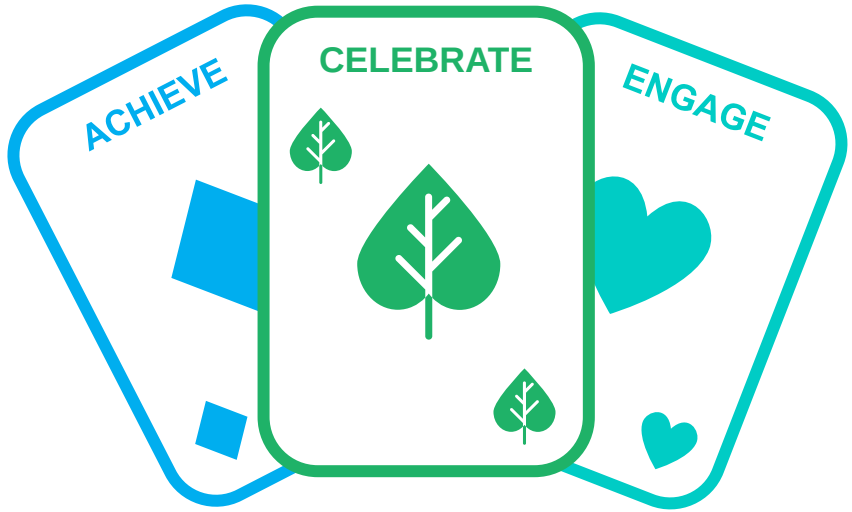
@AzaraDRVS

Achieve, Celebrate, Engage!

ACE'd it? Share your DRVS success story and become an Azara ACE!

Show your organization has used DRVS to **A**chieve measurable results, **C**elebrate improvement in patient health outcomes, and effectively **E**ngage care teams and/or patients. Stories should showcase how DRVS helped your organization overcome a challenge, the tools and solutions used to drive improvement and details of the successes that resulted from your initiatives. ACEs should be able to provide examples that quantify quality improvement, cost savings, operational efficiency or patient health improvement.

azara
ACE Program



Benefits:

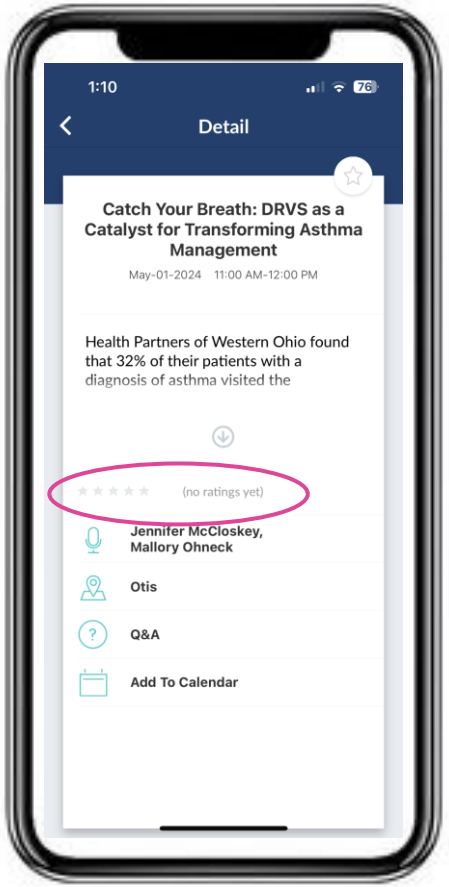
- Azara will help tell your story and provide a client-branded version for your use
- Potential to create a 2-4 minute video or hour-long Azara-hosted webinar
- Win Azara swag!

Submit your success story by completing the form at this link or scan our QR code:

See this year's ACE posters in the Ballroom Foyer!

We Want to Hear From You!

Click on the session from your agenda in the conference app.
Click the stars in the center of your screen to rate and provide feedback.



Quick and Easy

Provide brief feedback or ideas

Rate the session and the speaker(s)

Help us continue to improve

azara
USER CONFERENCE
2024

Thanks for attending!

MSSP Highlights

456
MSSP ACOs

597,231
Health care providers and organizations

10.9 million
Medicare Beneficiaries

67% of the ACOs are participating in two-sided risk

BIG reporting option changes coming in 2025
- MUST report using CQMs – Decisions To Make

New Health Equity (HE) components
- 2024 is the first year HE components have been included in MSSP
- New coding and payment for community health integration services
- Additional HE components/measures expected in coming years

MSSP – ACO Primary Care Flex

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One-time advanced shared savings payments of $250,000 are meant to help providers with the costs of forming an ACO

Monthly, prospective payments would replace Medicare fee-for-service pay for primary care

ACO PC Flex is embedded in the MSSP ACO model and is only available to Low Revenue MSSP ACOs

Program Start January 1, 2025	**Application Due Date** August 2024
Participation Voluntary	**Program Length** 5 years
Goal is to provide more primary care funding and flexibility, addressing traditional primary care underfunding	This is only available to Low Revenue ACOs with a goal to support and sustain independent primary care organizations.

ACO Reach Overview

132
Reach ACOs

131,772
Health care providers and organizations

2.1 million
Medicare Beneficiaries

More aggressive downside risk than MSSP

ACO Reach participants are required to submit a health equity plan and recruit beneficiaries from underserved communities

Health Equity Benchmark Adjustments can result in an additional $30 PBPM payment

Participating providers must collect certain SDOH and demographic data for all beneficiaries

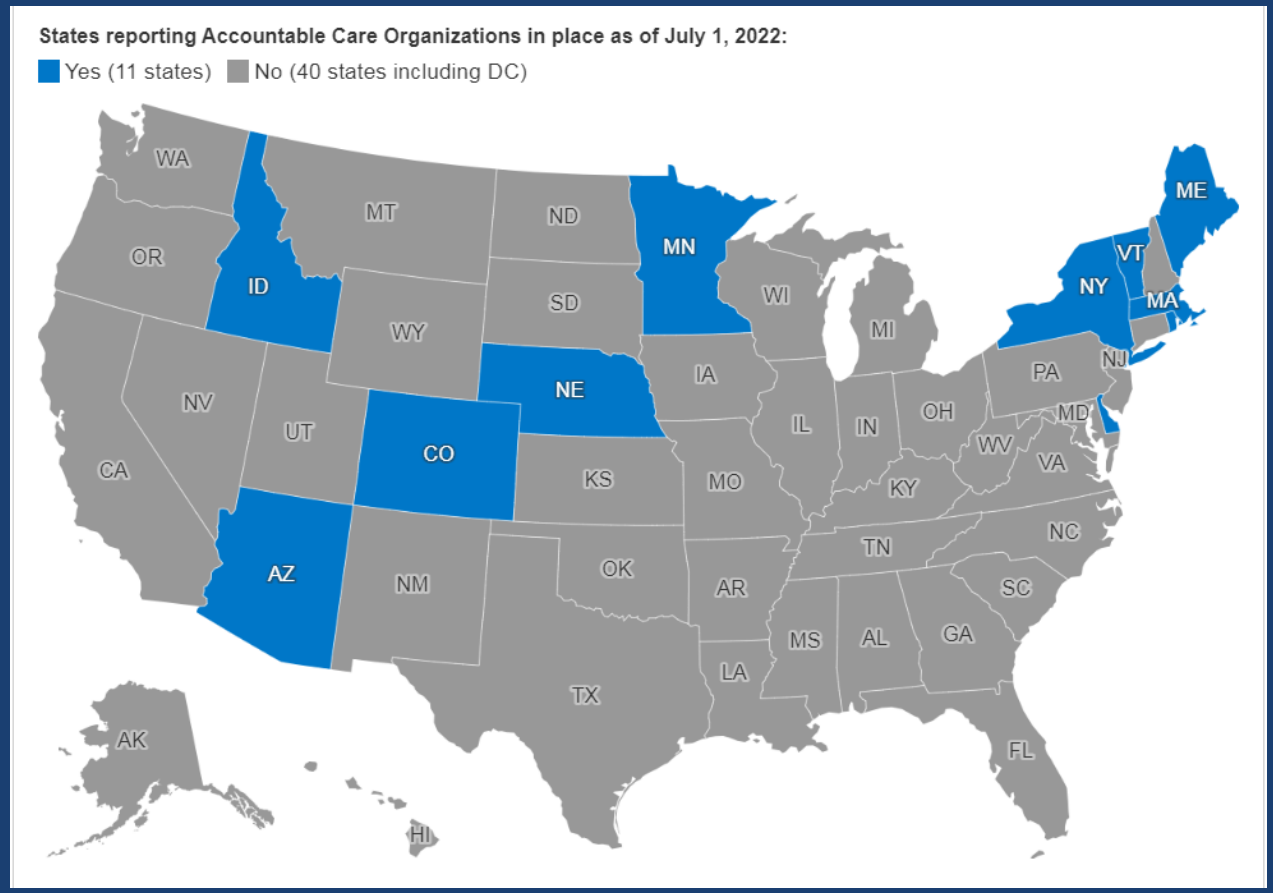
Medicaid ACOs

Unlike MSSP, state ACOs have had limited growth since 2015

2015	2016	2017	2018	2019	2022	2023
7	8	13	14	14	9	11

There is an important distinction between Medicaid ACOs and Medicaid Managed Care.

- ACOs are state sponsored and have state specific models
- Medicaid Managed Care may have various VBC programs that could include an ACO model, but it is specific to that Health Plan



Plus Delaware

https://www.kff.org/medicaid/issue-brief/mapping-medicaid-managed-care-models-delivery-system-and-payment-reform/

Attribution Methods

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Two components of attribution

Timing

- Retrospective: Most common in ACOs, attribution happens after a performance period based on claims data.
- Prospective: Attribution is done at the beginning of a period based on pre-existing patient-provider relationships.

Method

- Patient Choice: Patients select their primary care provider (PCP).
- Geography: Patients are attributed to providers based on location.
- Visit-Based: Patients are attributed to the provider they see most frequently.
- Clinical: Attribution is based on the provider assigned in the patient's electronic health record (EHR).
- Cost Derived: Attribution goes to the provider who delivers the most primary care services by cost.
- Event Derived: Attribution goes to the provider who delivers the most or most recent primary care services within a specific period.
- Functional: An algorithm determines the provider most involved in the patient's care.