azara
USER CONFERENCE
APR 29–MAY 1
BOSTON, MA
2025

Data-Driven Strategies for Managing MSSP

Establishing the Foundation

Today's Presenters

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Montana Primary Care Association

Carrie Taylor
Director, Clinical Transformation
Azara Healthcare

Agenda

Montana Health Plus
Network MSSP Journey

Azara Ecosystem
Optimizing MSSP Performance with DRVS

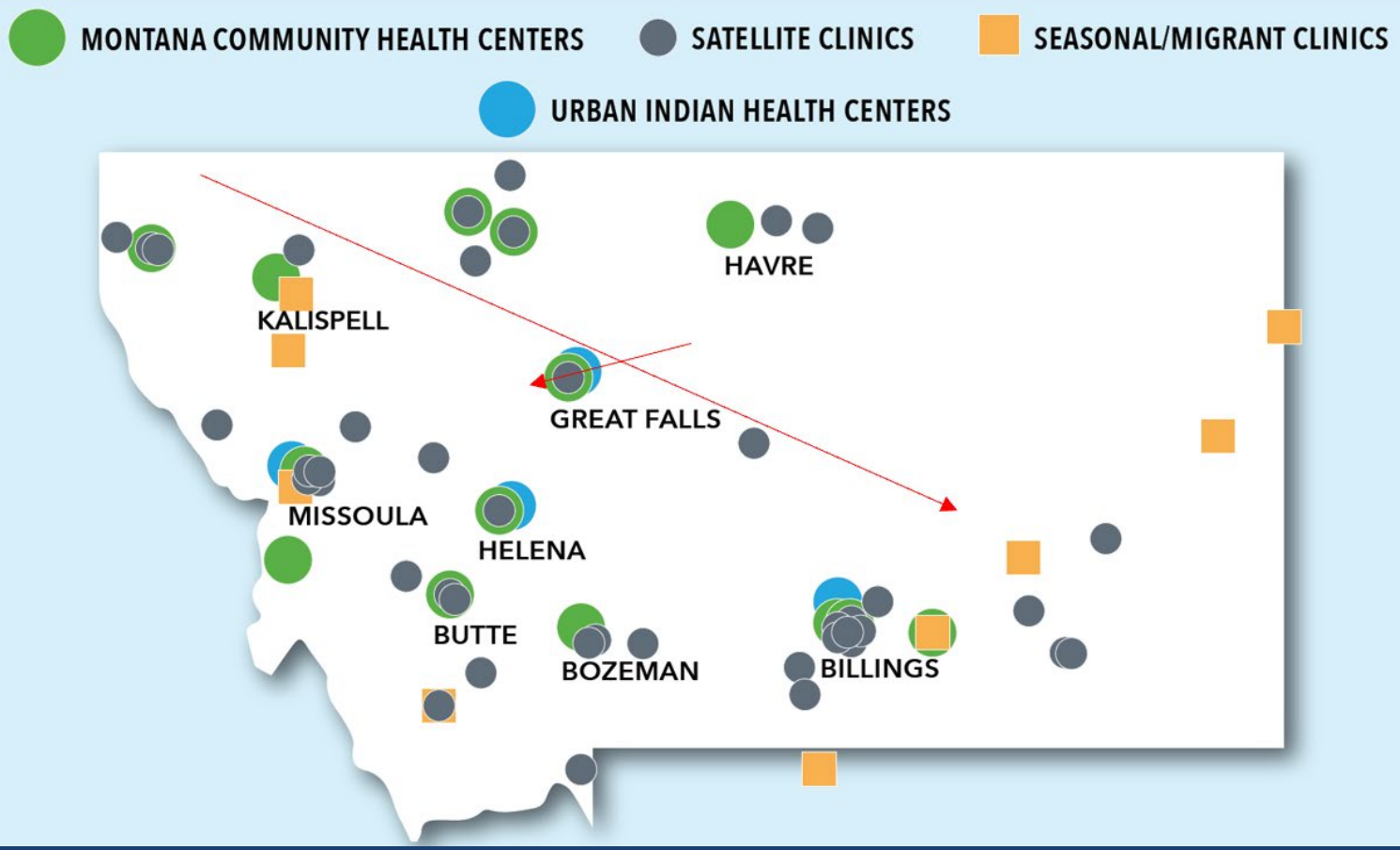
Product Update
Risk Adjustment (RAF)

Wrap Up & Q&A

Montana Health Plus

Network Journey to Using DRVS to Manage MSSP

MONTANA COMMUNITY HEALTH CENTERS



History of Value-Based Care in Montana FQHCs

Priority goal was and remains one network contract with Medicaid.

Experience with Value-Based Care started with the Medicaid Health Improvement Program.

Evolved into a PCMH Program with Medicaid, an FQHC specific version of CPC+.

Partnership with Medicaid

2010:

MT Health Improvement Program

2017:

PCMH/CPC+

2025:

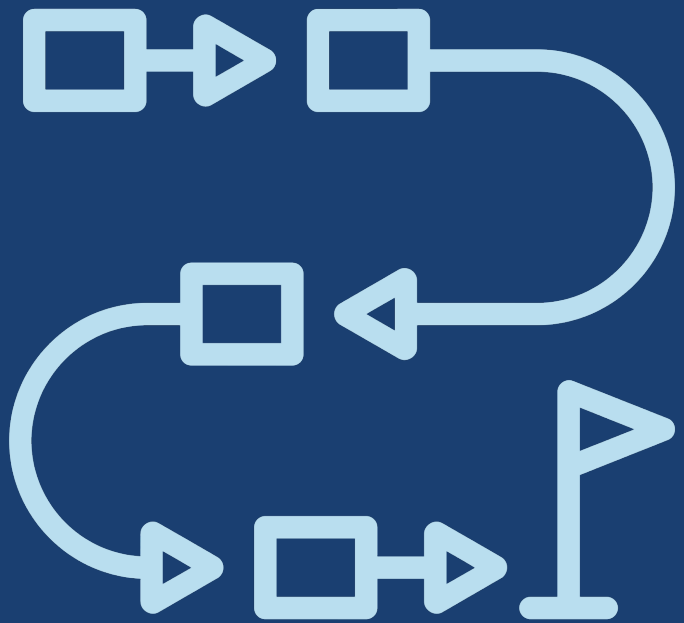
Developing New Primary Care Model

MPCA Strategic Priorities

- Getting more and better value-based contracts
- Maximizing performance under existing contracts
- Making good financial decisions that prepare us for the future and reward good performance
- Enhancing the influence of Montana Health Plus

How Do We Achieve Success?

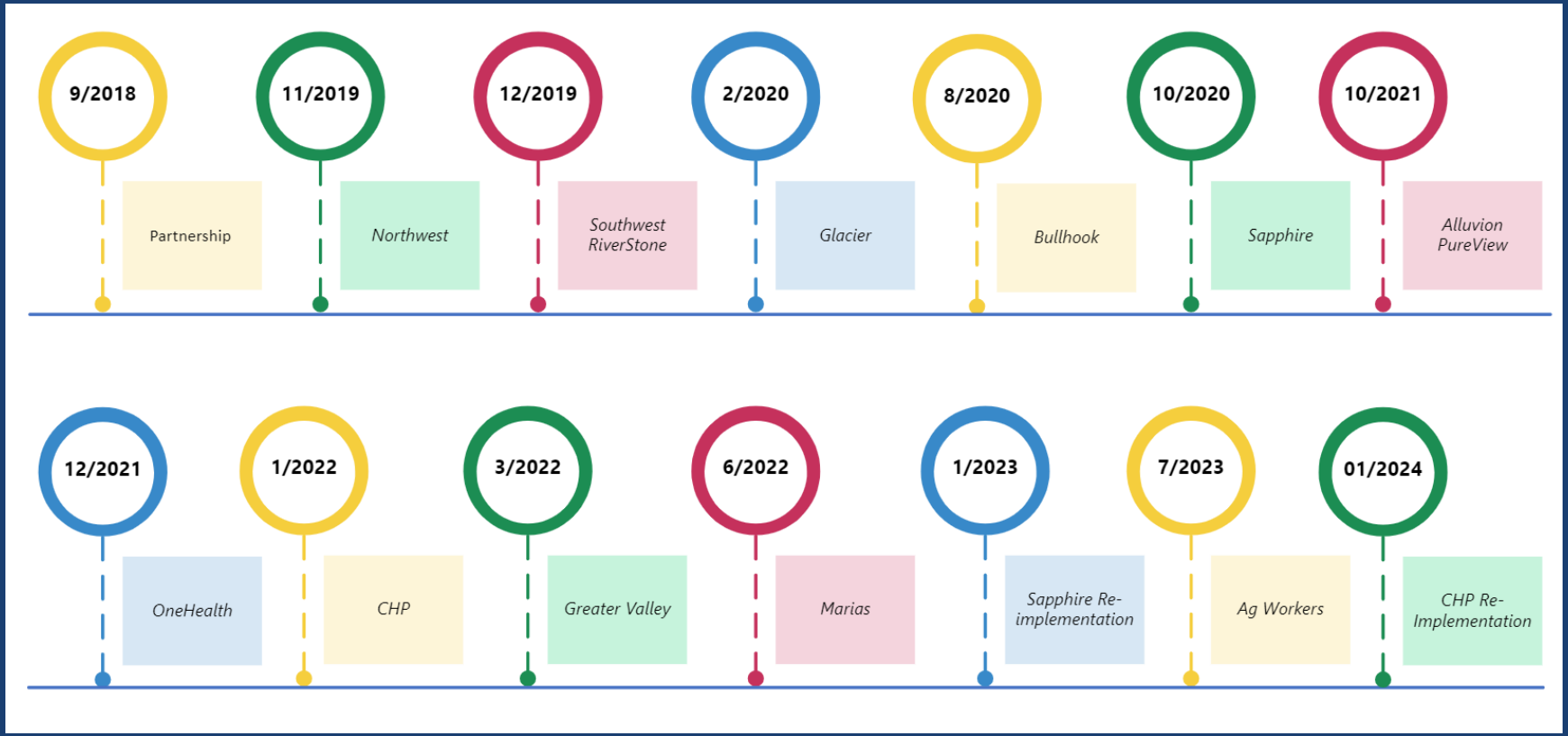
Data Strategy



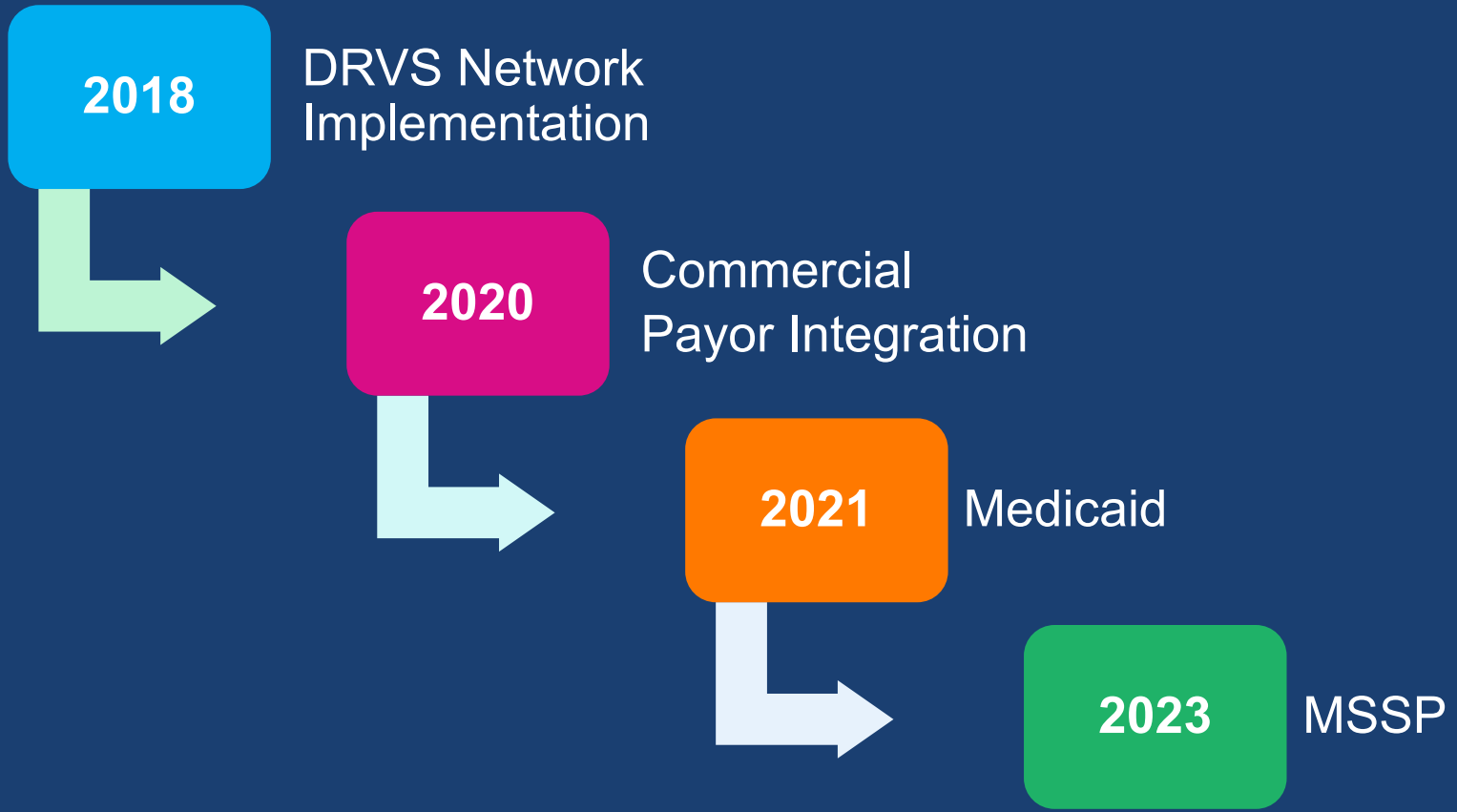
2018: DRVS pilot with Partnership Health Center.

Unanimous board decision to adopt and implement DRVS at every health center in the network.

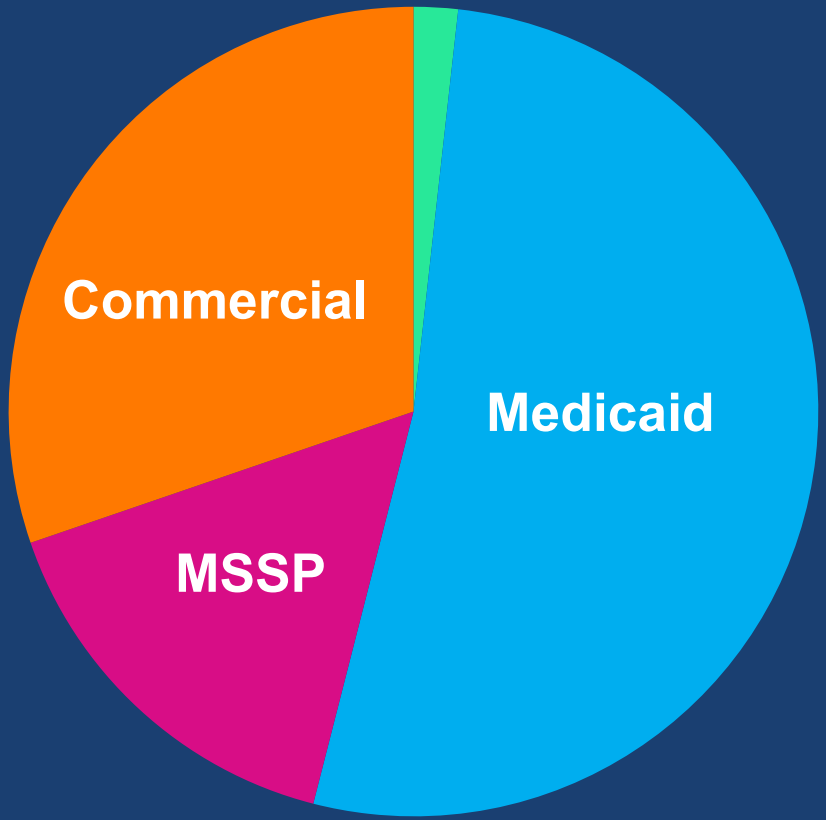
Montana Azara DRVS Implementation Timeline



Network Rollout



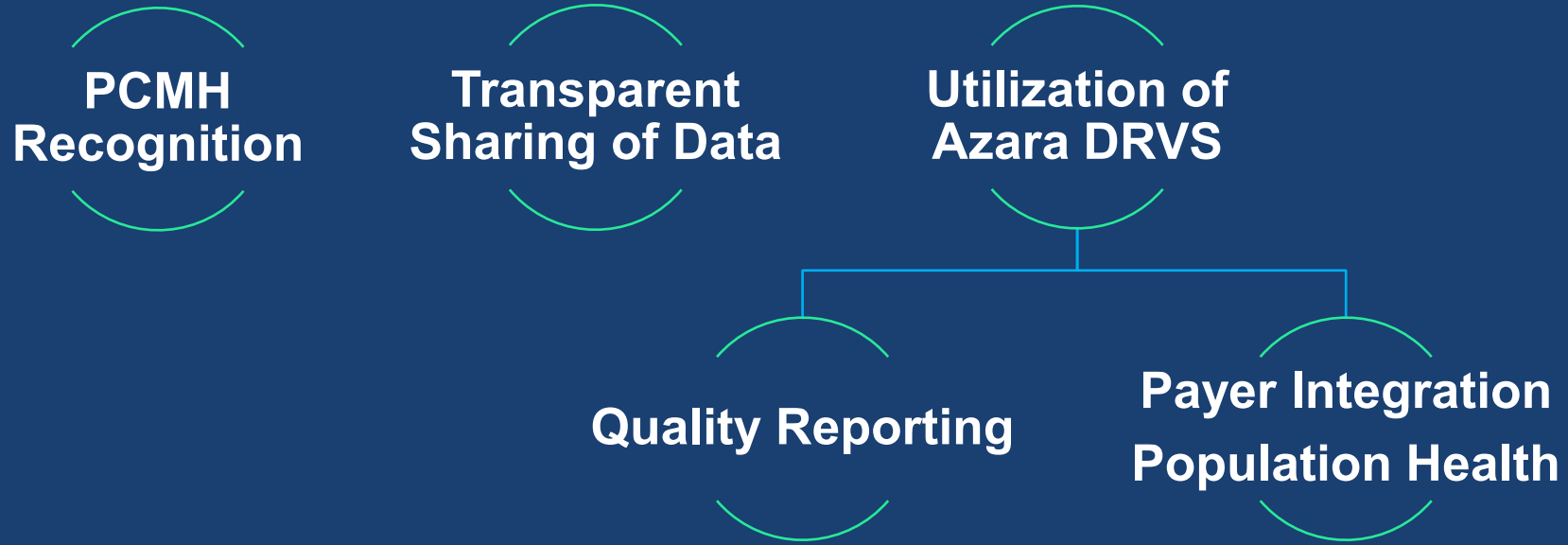
Member Distribution



Medicare Shared Savings Program

- 1st participation year 2023
- CMS goal: 2030 all Medicare members are aligned with an ACO
- Primary care is key – FQHC led ACO
- Revenue stream for health center
- Experience in payment models

Inside Our Care Delivery Model



Turning Strategy into Action

Network Focus & DRVS

Care Gaps

Risk Adjustment Factors (RAF) Gaps

HCC

Member Reports

Risk Stratification

MSSP Quality Reporting

All centers in ACO are connected to DRVS.

Utilized DRVS for completing web interface for 2023/2024 MSSP quality reporting.

2024 – QRDAIII quality report submission.

Azara Ecosystem

Optimizing MSSP Performance with DRVS

How DRVS Supports Our Work

PVP/CMP

Raf Gaps Per Patient Measure

RAF Gaps Medicare Report

Custom MSSP Dashboard

Other Tools Used

- Member Report
- Rising Risk Measure
- Newly Assigned Member Measure
- Transition of Care – ED/IP Dashboard and Report
- Care Reconciliation Report
- Medicare Annual Well Visit Member Based Measure
- Azara Patient Outreach (APO) Medicare AWV without appointment campaign

Managing RAF Gaps in VBC

Understand RAF Scores

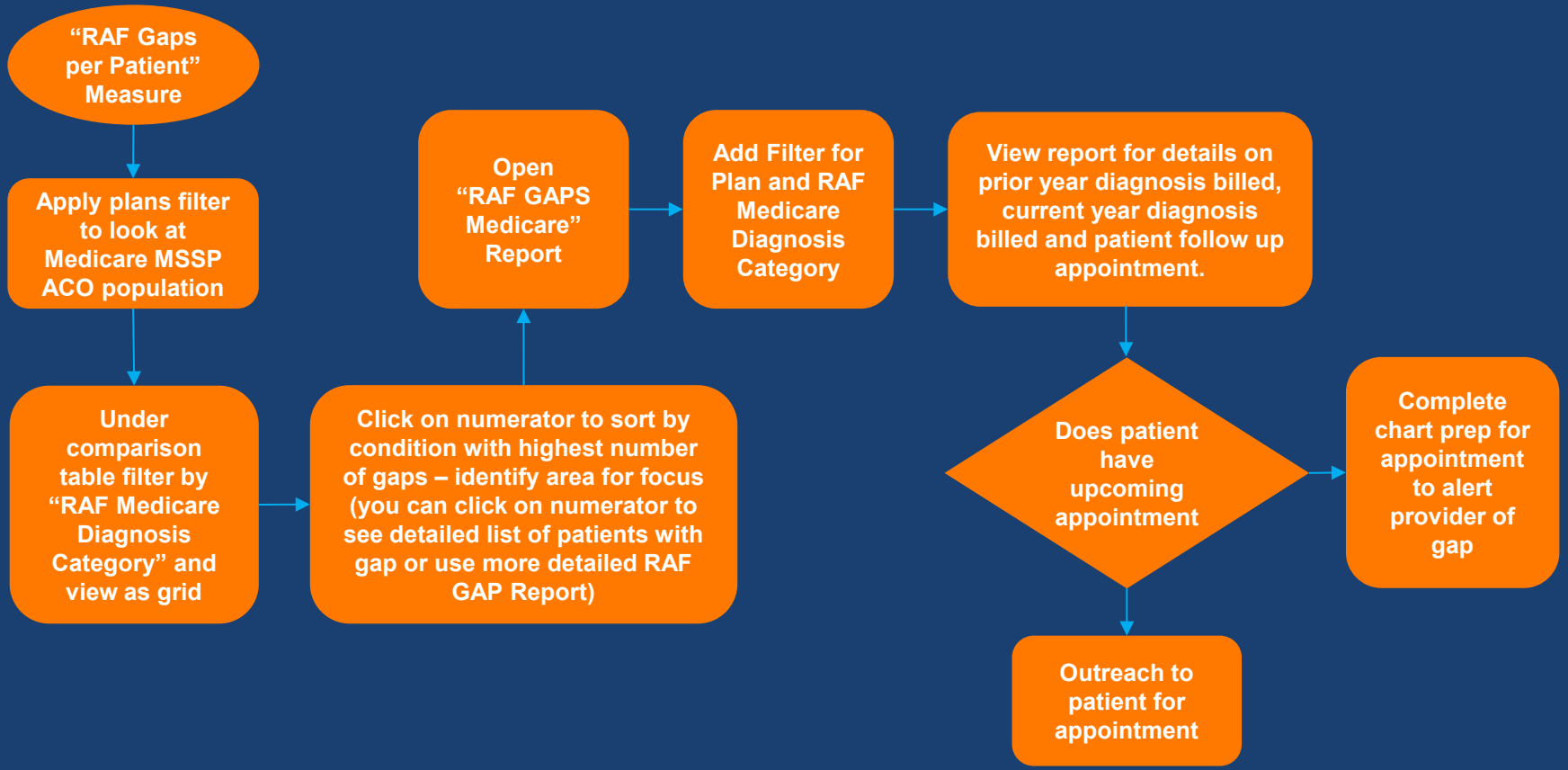
Identify RAF Gaps

Improve Documentation and Coding

Enhance patient engagement

Collaborate across teams

RAF Workflow



RAF on The PVP & CMP

2:16 AM Wednesday, April 16, 2025 Demo data

Barcelo, Andrea
MRN: 1100994
DOB: 7/19/1996 (28)

Sex at Birth: M
GI: Male
SO: Don't know

DIAGNOSES (10)

ASCVD	Asthma
CAD/No MI	Cancer
HCV	HIV
IVD	

RISK FACTORS (5)

ANTICOAG	Chronic Opioid Tx
SMI	TOB

SDOH (9)

CHILDCARE	EDU
LANGUAGE	MED/CARE
SAFETY	TRANSPORT-NONMED

RAF GAPS DIAGNOSIS CATEGORIES (2)

Diabetes	Pulmonary

Team-based huddles

Coordination of care

Identify RAF gaps

RAF Gaps (2)

DIAGNOSIS CATEGORY	CONTEXT	BILLED CY	UNBILLED CY	ACTIONS TO CONSIDER
Diabetes	Dx Not Billed		CHG: E11.9 (05/04/24)	Add to Chg Next Visit
Pulmonary	Dx Not Billed		EHR: J45.30 (05/04/24)	Add to Chg Next Visit

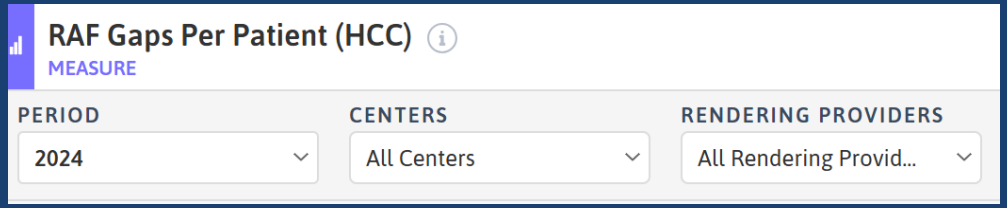
Total RAF Risk Score

MAX TOTAL SCORE	GAP SCORE	ACTUAL SCORE
0.809	0.809	0

DRVS RAF GAPS

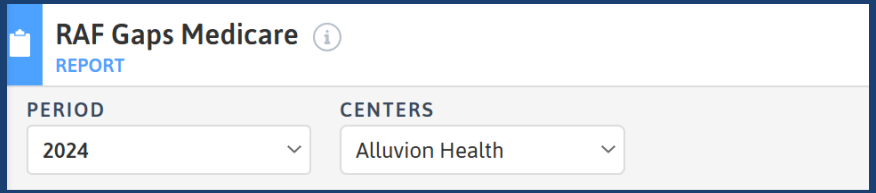
RAF Gaps Per Patient (HHC) Measure

Allows for sorting and analytics to identify focus.

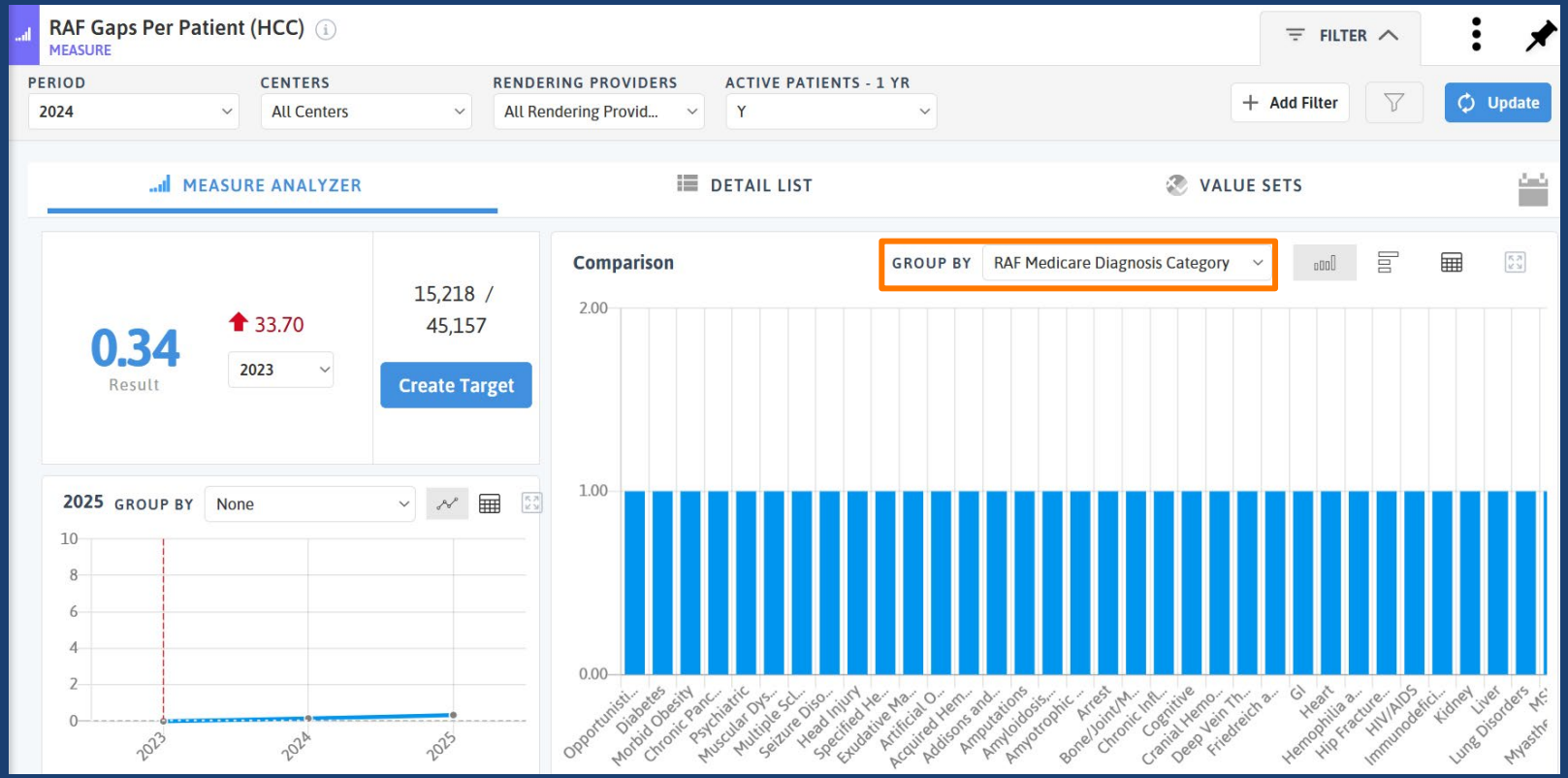


RAF GAPS Medicare Report

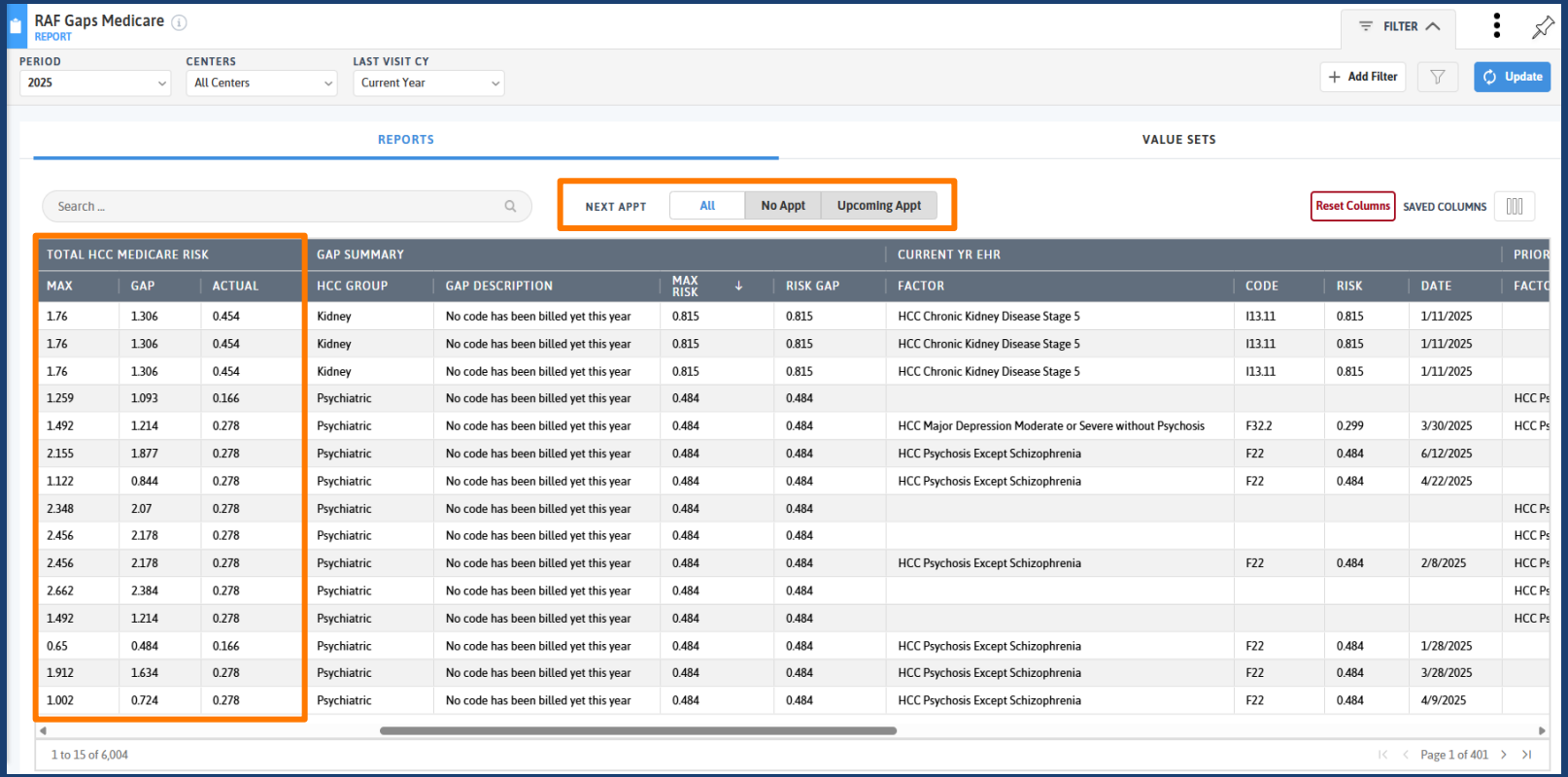
Detailed list to identify gaps, prioritize, and drive outreach.



RAF Gaps Per Patient Measure



RAF Gaps Medicare Report



CY Filter on RAF Gaps

New Default Filter on RAF Reports and Measures

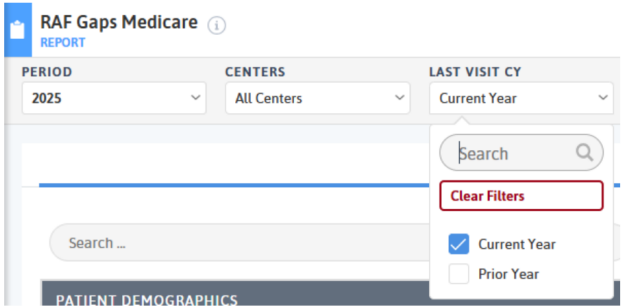
ANNOUNCEMENT

Last Visit CY Filter on RAF Gaps in DRVS

A new default filter **Last Visit CY** (where CY means current year) has been added to each RAF Gap report and measure.

This filter will allow you to see all patient RAF Gaps at the start of each calendar year, by filtering to "**Last Visit CY = Prior Year**".
Filtering like this will show you all patients whose last visit was in the Prior calendar year, aka showing you RAF Gaps for all of your patients who were seen last year.

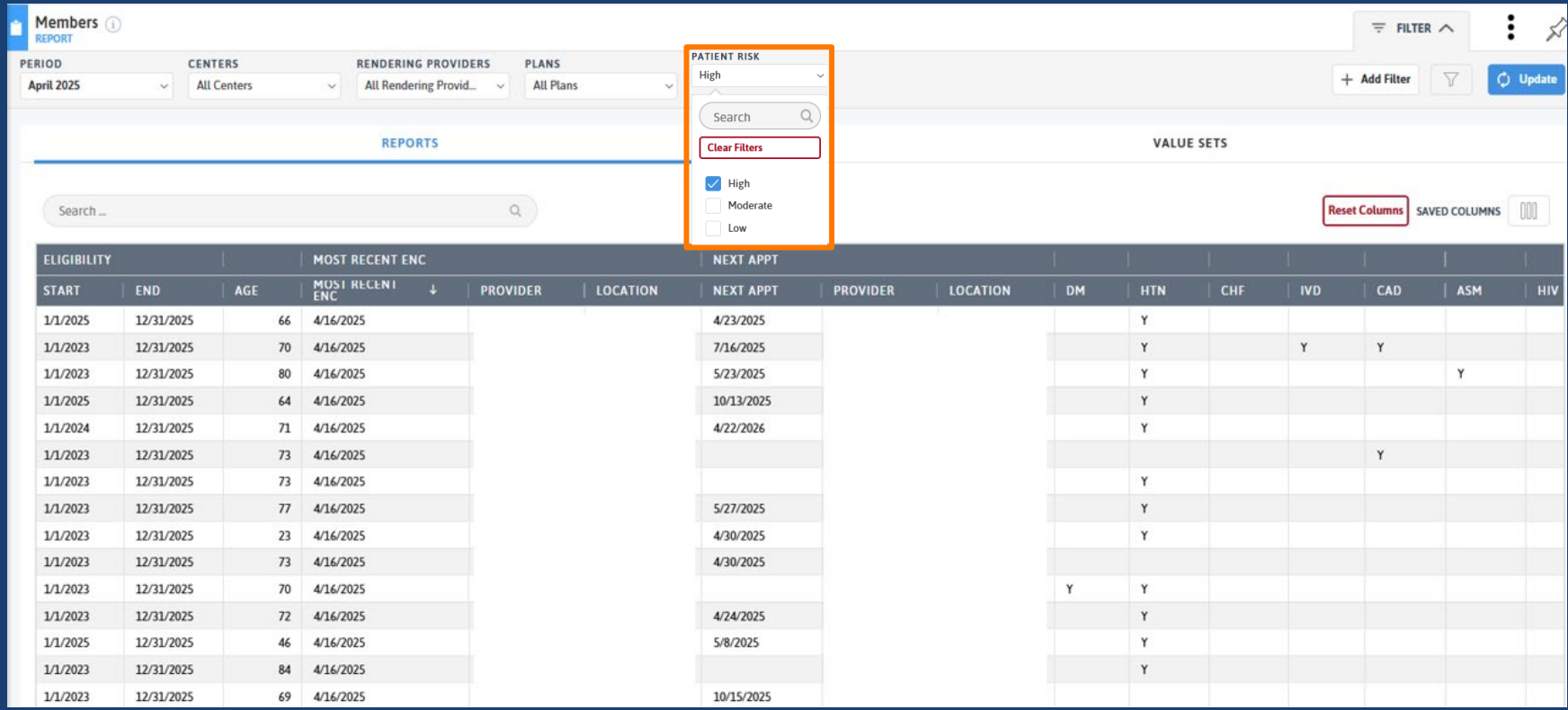
You can also choose to filter by "**Last Visit CY = Current Year**".
This will scope to your patients who have been seen in this calendar year only.
One use case for this is to help identify patients who have been seen this year but *still* have open RAF Gaps.
Gather those opportunities for RAF Gap closure by filtering to patients who have upcoming appointments where you know you can focus on closing those gaps.



This filter is a default filter on all RAF Gap reporting objects (measures and reports).

CREATED BY: Azara **PUBLISHED ON:** 03/06/2025

Members Report



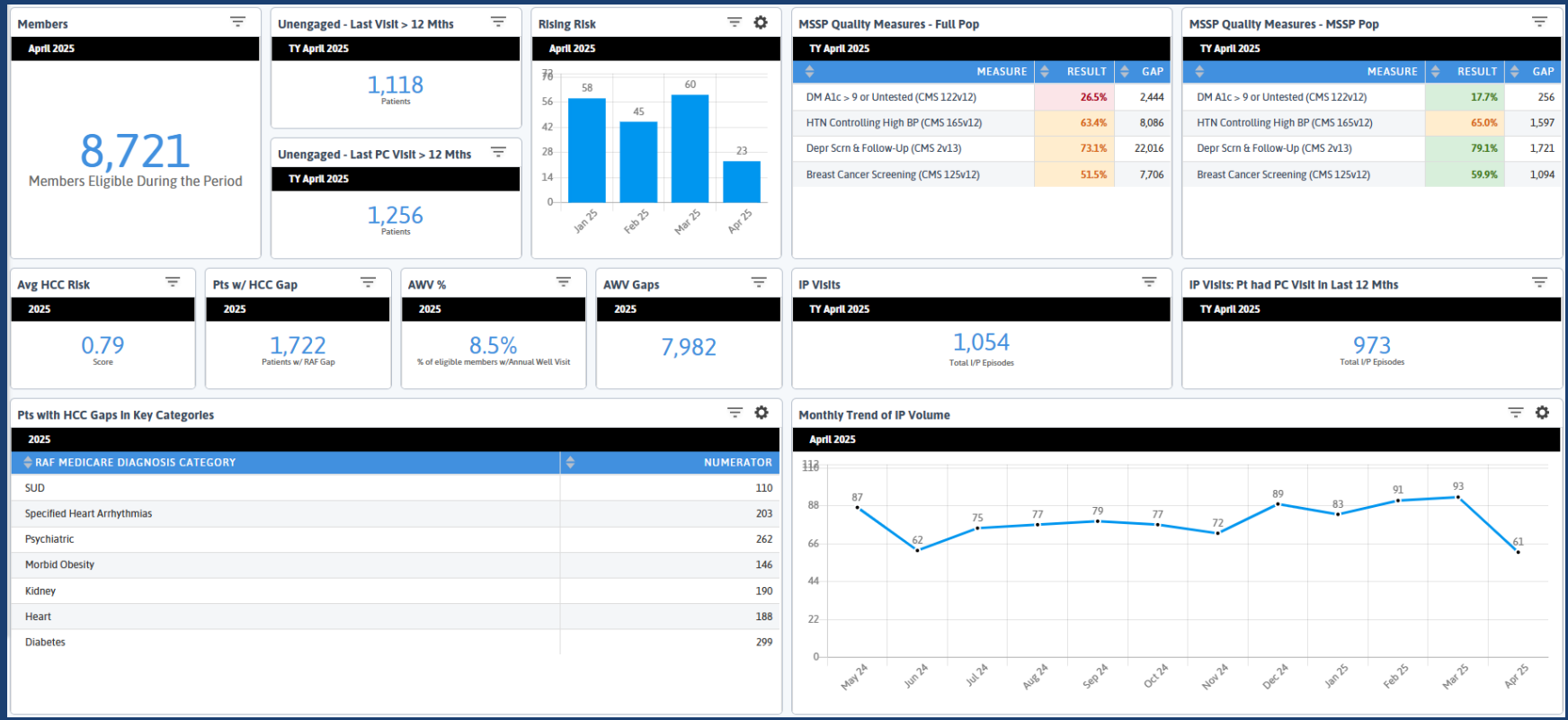
ELIGIBILITY			MOST RECENT ENC			NEXT APPT								
START	END	AGE	MOST RECENT ENC	PROVIDER	LOCATION	NEXT APPT	PROVIDER	LOCATION	DM	HTN	CHF	IVD	CAD	ASM	HIV
1/1/2025	12/31/2025	66	4/16/2025			4/23/2025				Y					
1/1/2023	12/31/2025	70	4/16/2025			7/16/2025				Y		Y	Y		
1/1/2023	12/31/2025	80	4/16/2025			5/23/2025				Y				Y	
1/1/2025	12/31/2025	64	4/16/2025			10/13/2025				Y					
1/1/2024	12/31/2025	71	4/16/2025			4/22/2026				Y					
1/1/2023	12/31/2025	73	4/16/2025										Y		
1/1/2023	12/31/2025	73	4/16/2025							Y					
1/1/2023	12/31/2025	77	4/16/2025			5/27/2025				Y					
1/1/2023	12/31/2025	23	4/16/2025			4/30/2025				Y					
1/1/2023	12/31/2025	73	4/16/2025			4/30/2025									
1/1/2023	12/31/2025	70	4/16/2025						Y	Y					
1/1/2023	12/31/2025	72	4/16/2025			4/24/2025				Y					
1/1/2025	12/31/2025	46	4/16/2025			5/8/2025				Y					
1/1/2023	12/31/2025	84	4/16/2025							Y					
1/1/2023	12/31/2025	69	4/16/2025			10/15/2025									

Understanding Attribution

Member Report offers data necessary for a comprehensive understanding of the members attributed to your organization.

- Eligibility Dates
- Plan Usual Provider
- Patient Risk
- Last and Next Appointment
- Chronic Conditions
- IP/ED Visits

Custom MSSP Dashboard



Custom Dashboard Breakdown

Member Report

Members Report is a tool that can be used to analyze the members attributed to the CHC.

Unengaged Members

Members who have not been seen in over 12 months and unengaged members who have not been seen in over 12 months by primary care at HC.

Rising Risk

Patients with a risk level calculated in the previous month period as low or moderate, with a high risk in the current period.

MSSP Quality Measures

Targeted quality measures looking at the entire patient population vs. the MSSP population.

Average HCC Risk Score

Calculates the average HCC by applying the HCC Medicare Risk algorithm to all patients with a qualifying encounter.

Patients with HCC Gap

Number of patients with HCC GAPS.

Annual Wellness Visits (AWV)

Pulls data from the Annual Wellness Visit Member-Based Report.

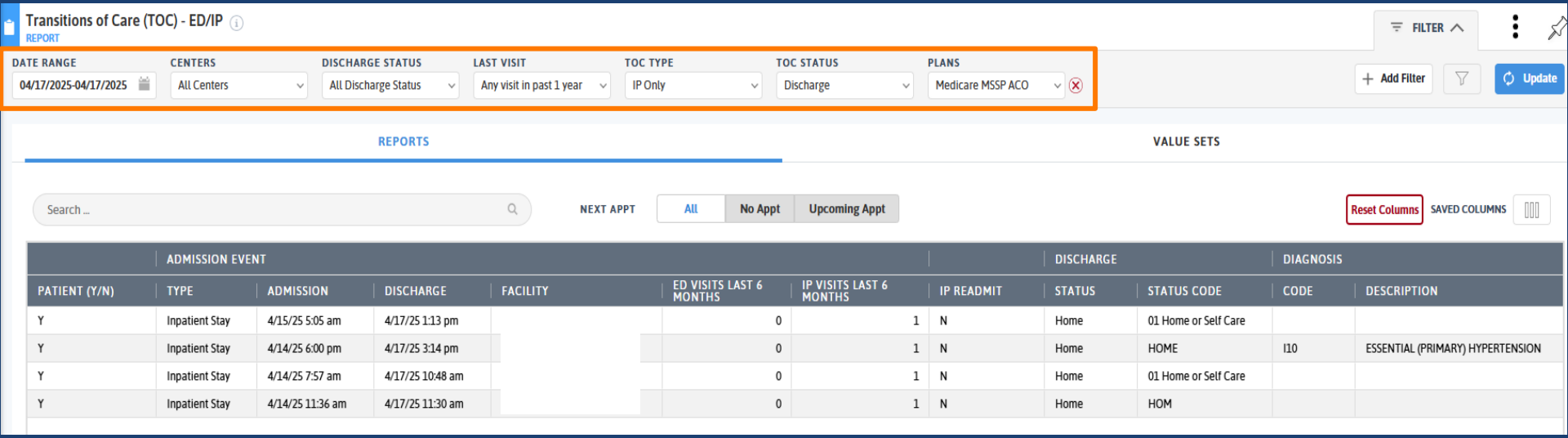
Patients with RAF Gap in Key Categories

Number of patients with RAF gaps in key Medicare categories.

Inpatient Visits

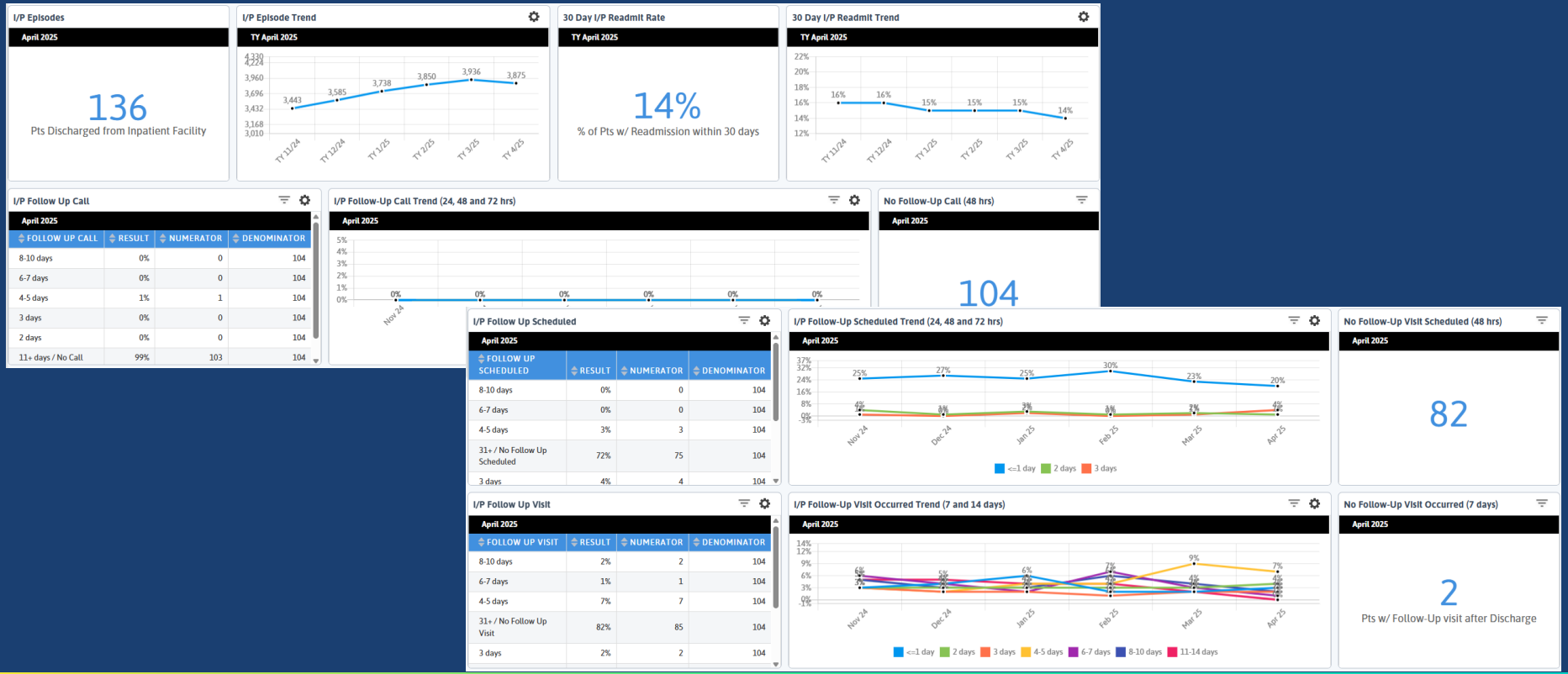
Patients with an inpatient visit in the last 12 months, had a PCP visit in the previous 12 months, with a monthly trend of IP visits.

Transitions of Care IP Report



	ADMISSION EVENT							DISCHARGE		DIAGNOSIS	
PATIENT (Y/N)	TYPE	ADMISSION	DISCHARGE	FACILITY	ED VISITS LAST 6 MONTHS	IP VISITS LAST 6 MONTHS	IP READMIT	STATUS	STATUS CODE	CODE	DESCRIPTION
Y	Inpatient Stay	4/15/25 5:05 am	4/17/25 1:13 pm		0	1	N	Home	01 Home or Self Care		
Y	Inpatient Stay	4/14/25 6:00 pm	4/17/25 3:14 pm		0	1	N	Home	HOME	I10	ESSENTIAL (PRIMARY) HYPERTENSION
Y	Inpatient Stay	4/14/25 7:57 am	4/17/25 10:48 am		0	1	N	Home	01 Home or Self Care		
Y	Inpatient Stay	4/14/25 11:36 am	4/17/25 11:30 am		0	1	N	Home	HOM		

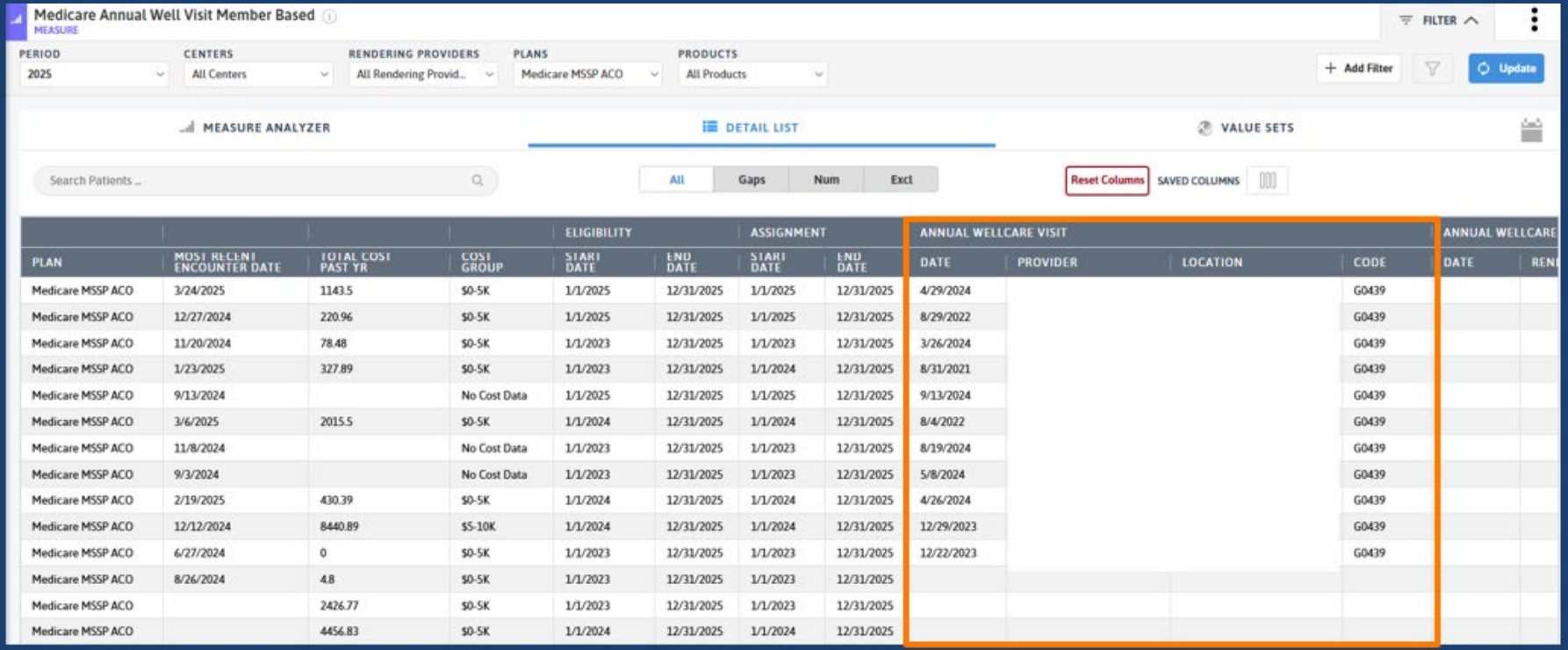
Transitions of Care (I/P) Dashboard



Benefits of Transitions of Care

- Interface with HIE or hospitals to get daily patient updates in DRVS.
- Run daily TOC Registry Reports for IP/ED admissions and discharges.
- Add IP/ED alerts to pre-visit planning reports (PVP).
- Improve follow-up by requesting discharge summaries and med recs.
- Monitor TOC processes with DRVS Dashboards and quality measures.
- Use Care Management Passport for detailed IP/ED history and outcomes.
- Track readmission rates to manage costs.
- Identify frequent utilizers for targeted care management.

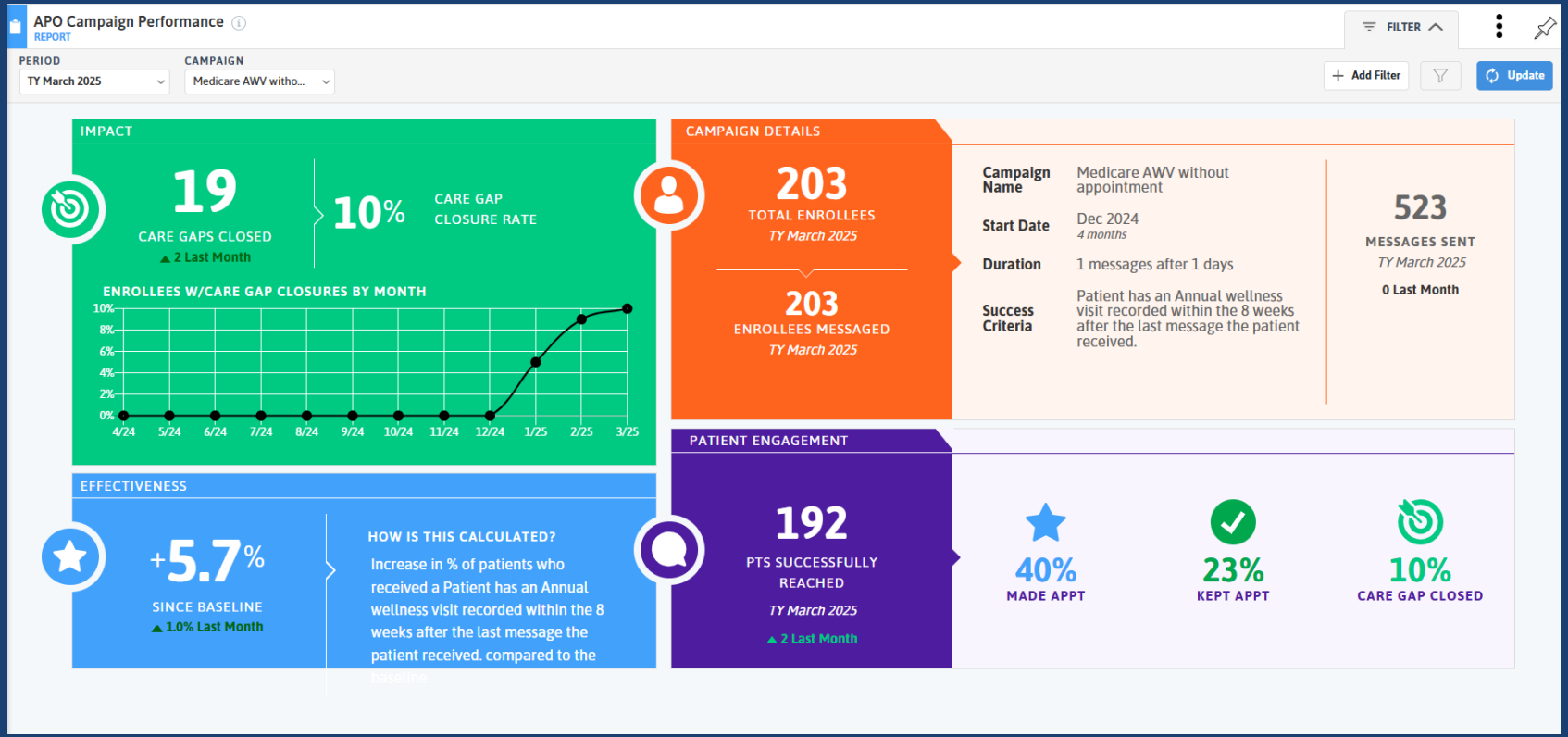
Medicare Annual Well Visit Member Based Measure



				ELIGIBILITY		ASSIGNMENT		ANNUAL WELLCARE VISIT				ANNUAL WELLCARE	
PLAN	MOST RECENT ENCOUNTER DATE	TOTAL COST PAST YR	COST GROUP	START DATE	END DATE	START DATE	END DATE	DATE	PROVIDER	LOCATION	CODE	DATE	REN
Medicare MSSP ACO	3/24/2025	1143.5	$0-5K	1/1/2025	12/31/2025	1/1/2025	12/31/2025	4/29/2024			G0439		
Medicare MSSP ACO	12/27/2024	220.96	$0-5K	1/1/2025	12/31/2025	1/1/2025	12/31/2025	8/29/2022			G0439		
Medicare MSSP ACO	11/20/2024	78.48	$0-5K	1/1/2023	12/31/2025	1/1/2023	12/31/2025	3/26/2024			G0439		
Medicare MSSP ACO	1/23/2025	327.89	$0-5K	1/1/2023	12/31/2025	1/1/2024	12/31/2025	8/31/2021			G0439		
Medicare MSSP ACO	9/13/2024		No Cost Data	1/1/2025	12/31/2025	1/1/2025	12/31/2025	9/13/2024			G0439		
Medicare MSSP ACO	3/6/2025	2015.5	$0-5K	1/1/2024	12/31/2025	1/1/2024	12/31/2025	8/4/2022			G0439		
Medicare MSSP ACO	11/8/2024		No Cost Data	1/1/2023	12/31/2025	1/1/2023	12/31/2025	8/19/2024			G0439		
Medicare MSSP ACO	9/3/2024		No Cost Data	1/1/2023	12/31/2025	1/1/2023	12/31/2025	5/8/2024			G0439		
Medicare MSSP ACO	2/19/2025	430.39	$0-5K	1/1/2024	12/31/2025	1/1/2024	12/31/2025	4/26/2024			G0439		
Medicare MSSP ACO	12/12/2024	8440.89	$5-10K	1/1/2024	12/31/2025	1/1/2024	12/31/2025	12/29/2023			G0439		
Medicare MSSP ACO	6/27/2024	0	$0-5K	1/1/2023	12/31/2025	1/1/2023	12/31/2025	12/22/2023			G0439		
Medicare MSSP ACO	8/26/2024	4.8	$0-5K	1/1/2023	12/31/2025	1/1/2023	12/31/2025						
Medicare MSSP ACO		2426.77	$0-5K	1/1/2023	12/31/2025	1/1/2023	12/31/2025						
Medicare MSSP ACO		4456.83	$0-5K	1/1/2024	12/31/2025	1/1/2024	12/31/2025						

Azara Patient Outreach (APO)

Medicare AWV without appointment campaign.



Recommended Report Cadence

- MHP providing tools and suggestion to centers on cadence for running reports.
- Education for centers on utilizing DRVS for VBC.

Value Based Care in DRVS:

The below is a list of Measures/Reports/Dashboards that are available in DRVS to support health centers work in value based care:

DRVS	Recommended Action	Frequency
Member Report	Utilize to view member attribution for each payer.	Monthly
Force Match Administration	All payers – review members who were not able to be automatically matched by DRVS	Monthly
Newly Assigned Members	The detailed list in this measure can be used to identify members to outreach to establish care with your practice	Monthly
GJA MSSP Dashboard	MSSP PRIORITY: 1. HCC Gaps – utilize report to outreach to members with GAPS 2. AWV –recall members due for AWV 3. Inpatient Visit – schedule patients for follow up. 4. Rising Risk – identify patients with increasing risk who may need care management or outreach 5. Unengaged – identify members who need outreach to schedule	Monthly
RAF Gaps Medicare	1. Filter to MSSP 2. Sort by patient to identify gaps for each patient. 3. ACTION – outreach to schedule or pre visit plan if patient has upcoming appointment.	Recommended weekly
PVP/CMP	Use at point of care to identify RAF gaps and pre-visit plan.	Daily
Transition of Care IP/ED Report	Identify IP/ED admissions to outreach after discharge and	Daily

Strategic Priorities

RAF Gaps – Recall Patients

- Reminder at start of year RAF scores reset.
- Need to recapture chronic conditions from year to year.

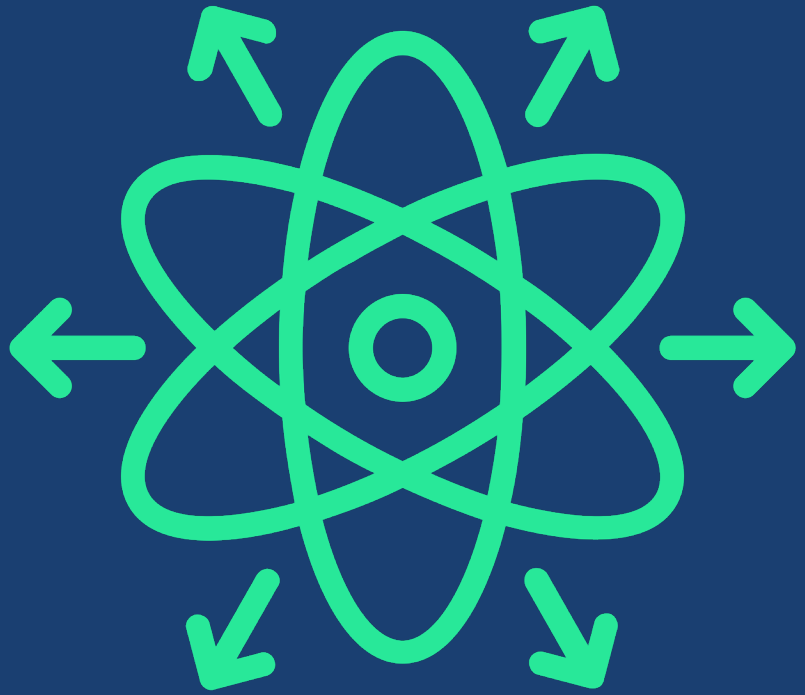
Code to Highest Specificity

- Identify codes that are not coded to the highest specificity.
- Use of DRVS CMP/RAF.

Medicare Wellness Visits

- Drill down by month when patient is due and recall.
- Focus on the start of the year on members who didn’t have a completed AWV in 2024.

Challenges



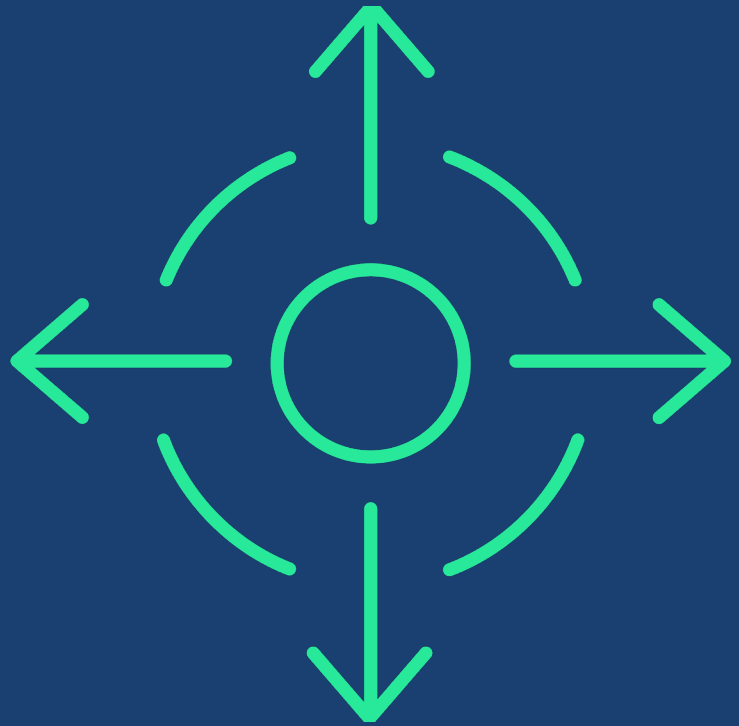
- Mapping of ICD-10 Codes between EHR and DRVS
- Coding education and EMR tool adoption
- Staff turnover at health center sites
- Repetition of education
- Priority fatigue

ACU

Next Frontier – Center-facing tool to manage attributed population.

Stratify patients by cost and risk and further modify and develop population health strategies utilizing ACU.

Develop strategies for how the network and centers work together to identify and care manage high-risk patients.



Celebrating Our Wins!

Established a Strong PCMH Foundation

Achieved Full DRVS Adoption Across All Clinics

Cultivated Strategic Relationships

Embraced Repetition as a Strategy

Implemented Population Stratification for Targeted Interventions

Optimized Resource Utilization

Product Update

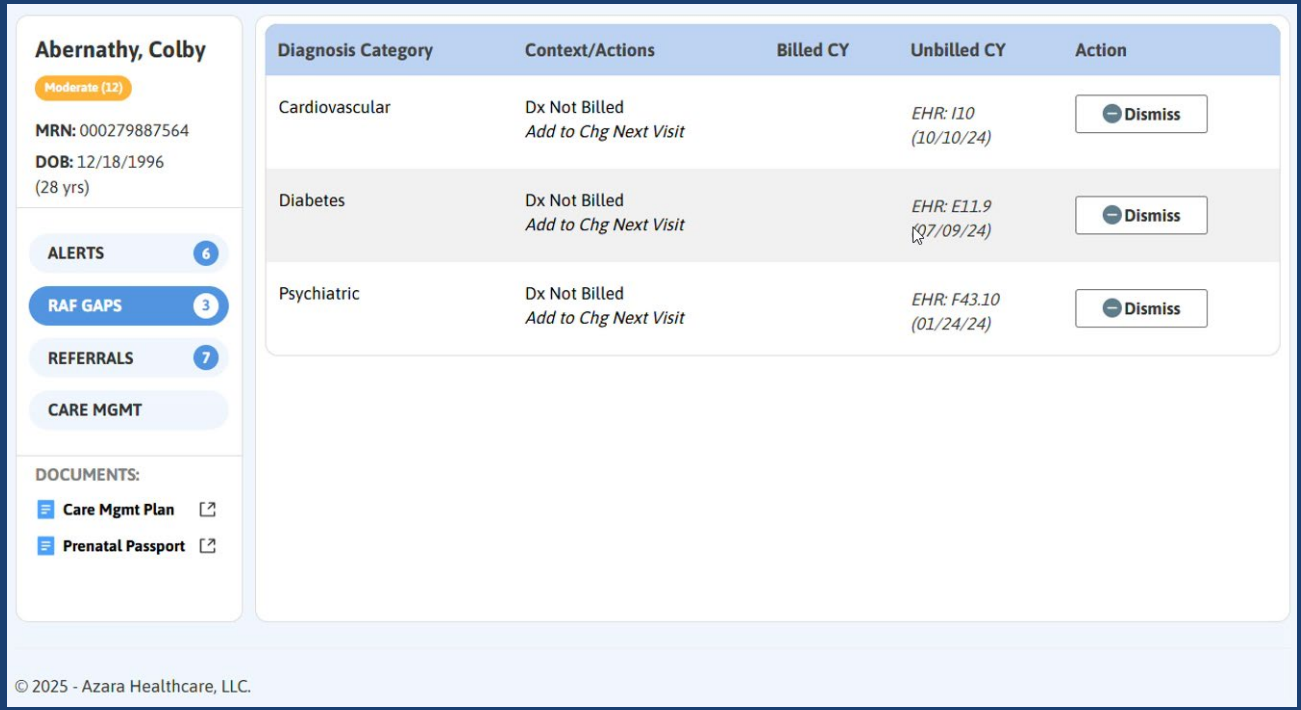
Risk Adjustment Factors (RAF)

Azara and HCC RAF

Where are we in our RAF Product Journey?

1. HCC RAF v28 Upgrade
2. Plug-In RAF Dismissals
3. New Measure
4. Coming soon… **More Plug-In RAF Actions**

NEW! Dismissing RAF Gaps in the EHR Plug-In

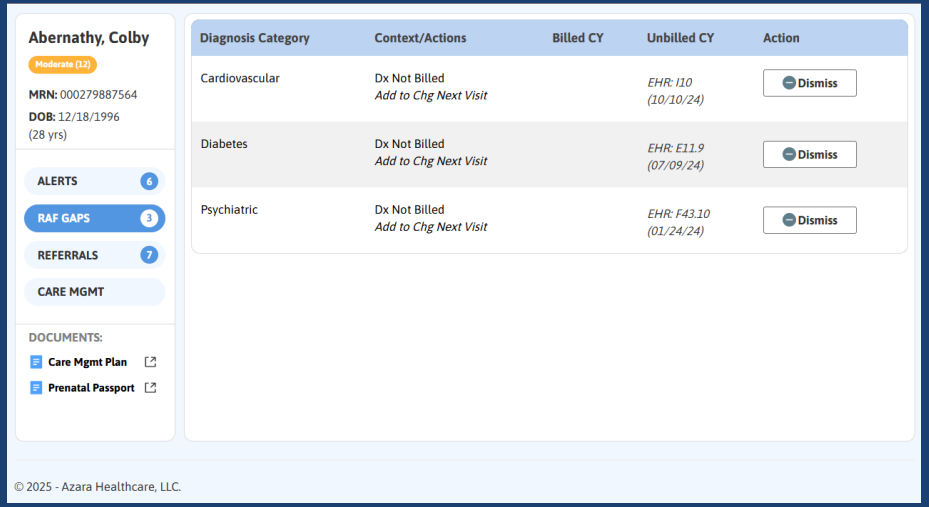


Available now for ALL centers who have the EHR Plug-in

How are RAF Gaps Closed?

A RAF gap is when a code has been billed in the past, but not the current year.

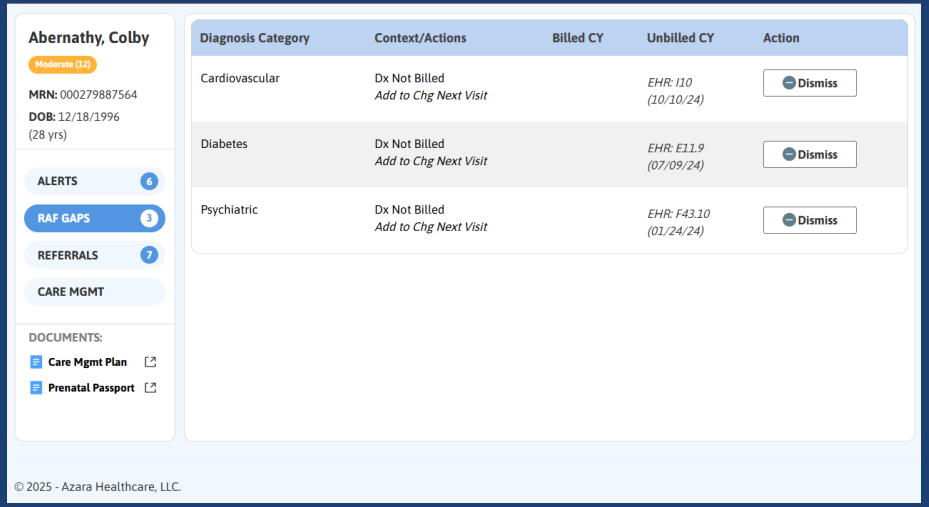
To **close** a RAF Gap, a diagnosis code must be documented that fits a patient's RAF Diagnosis Category from last years' billed diagnosis codes.



Where do “Dismissals” Come Into Play?

Currently, providers have no way to identify those RAF Gaps that no longer apply.

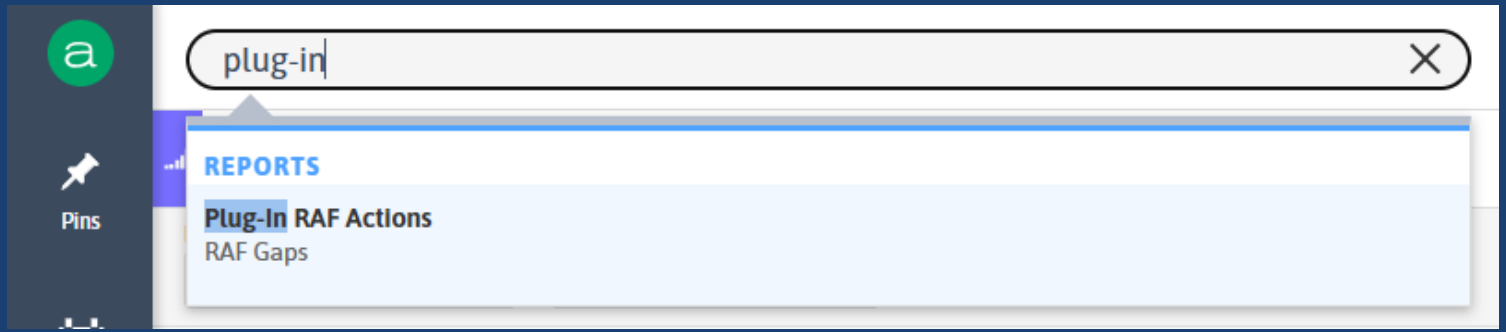
This means the gap stays open all year, adding to a center/organization’s RAF Gap Scores in DRVS and falsely inflating the number of *true* gaps that require action.



How do Dismissals Affect RAF and DRVS?

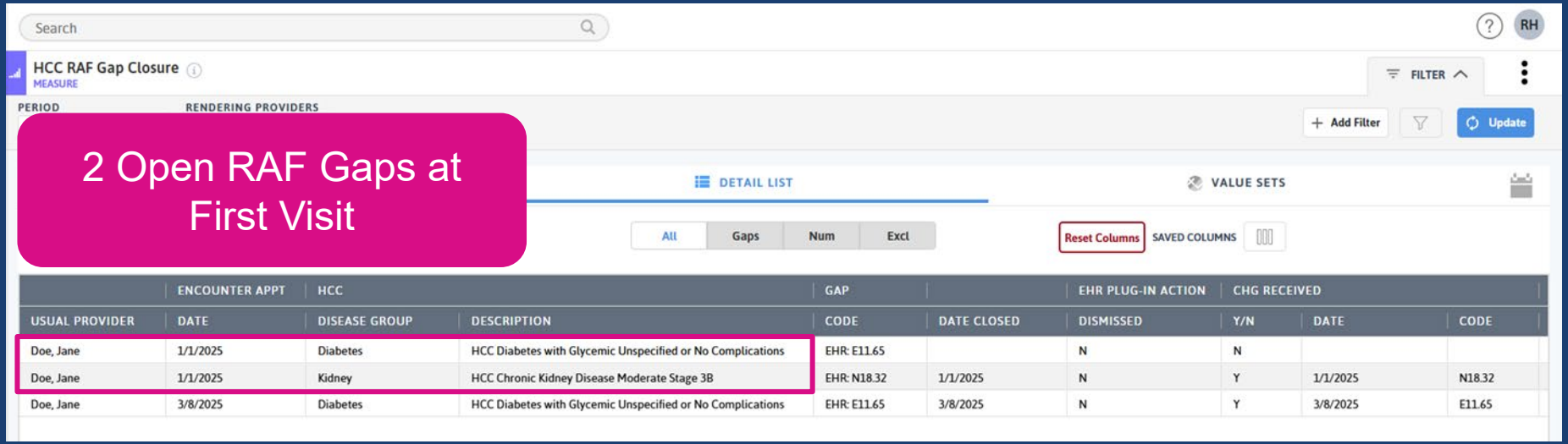
Dismissed RAF gaps flow downstream to DRVS in a few different ways…

1. Dismissed gaps are **excluded** from RAF Gap measure calculations
2. Dismissed gaps are **hidden** from the CMP RAF Gap table
3. The action of dismissing a gap is **logged in a new report**, Plug-In RAF Actions, available for those with the EHR Plug-In. This includes the user who took the action, when, and the reason why.



New Measure: HCC RAF Gap Closure

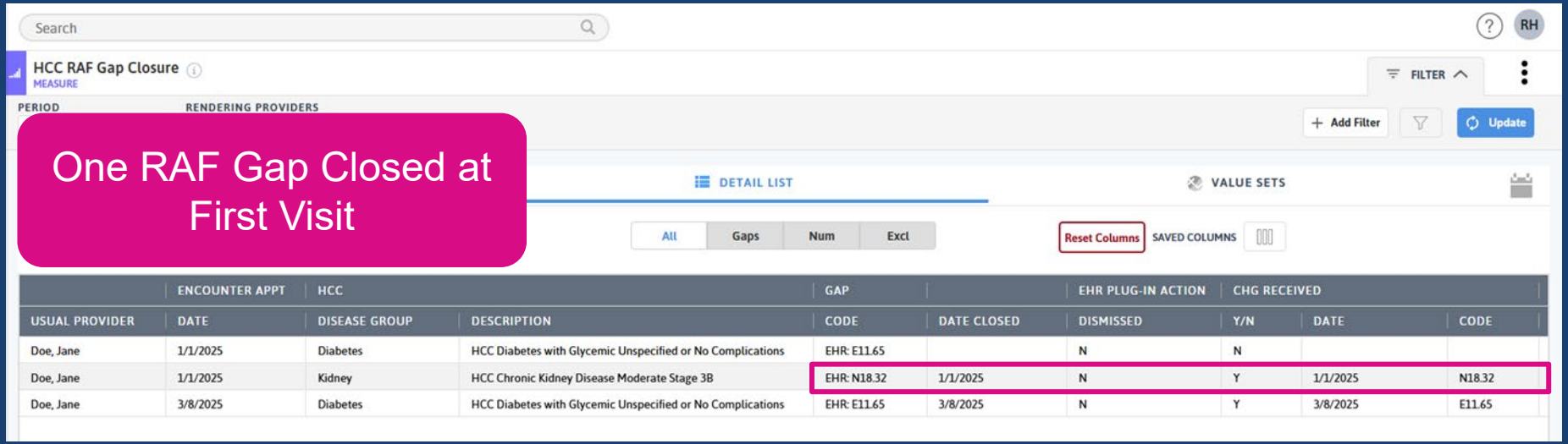
Review patients who had gaps at the time of their visit and whether the gap was closed at the point-of-care.



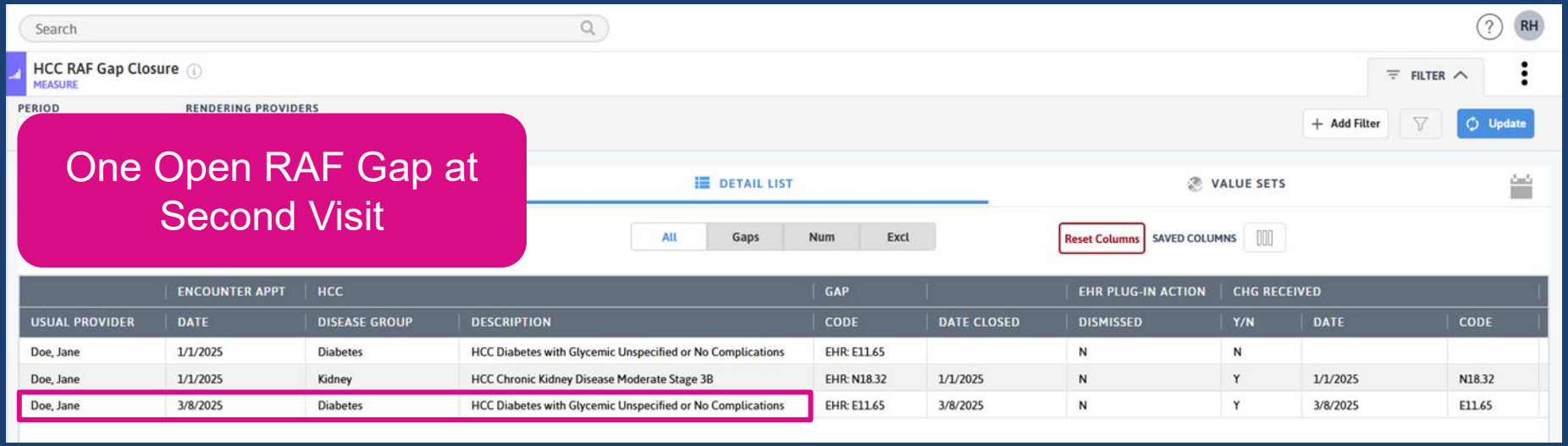
	ENCOUNTER APPT	HCC		GAP		EHR PLUG-IN ACTION	CHG RECEIVED		
USUAL PROVIDER	DATE	DISEASE GROUP	DESCRIPTION	CODE	DATE CLOSED	DISMISSED	Y/N	DATE	CODE
Doe, Jane	1/1/2025	Diabetes	HCC Diabetes with Glycemic Unspecified or No Complications	EHR: E11.65		N	N		
Doe, Jane	1/1/2025	Kidney	HCC Chronic Kidney Disease Moderate Stage 3B	EHR: N18.32	1/1/2025	N	Y	1/1/2025	N18.32
Doe, Jane	3/8/2025	Diabetes	HCC Diabetes with Glycemic Unspecified or No Complications	EHR: E11.65	3/8/2025	N	Y	3/8/2025	E11.65

New Measure: HCC RAF Gap Closure

Includes columns for encounter type, usual provider, rendering provider, and encounter location.



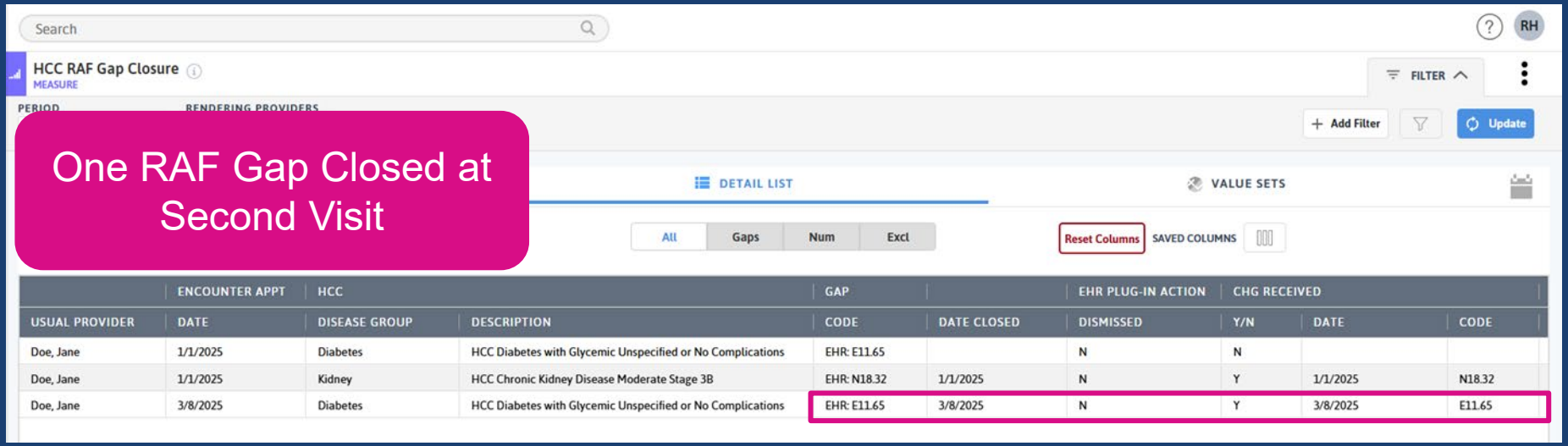
New Measure: HCC RAF Gap Closure



	ENCOUNTER APPT	HCC		GAP		EHR PLUG-IN ACTION	CHG RECEIVED		
USUAL PROVIDER	DATE	DISEASE GROUP	DESCRIPTION	CODE	DATE CLOSED	DISMISSED	Y/N	DATE	CODE
Doe, Jane	1/1/2025	Diabetes	HCC Diabetes with Glycemic Unspecified or No Complications	EHR: E11.65		N	N		
Doe, Jane	1/1/2025	Kidney	HCC Chronic Kidney Disease Moderate Stage 3B	EHR: N18.32	1/1/2025	N	Y	1/1/2025	N18.32
Doe, Jane	3/8/2025	Diabetes	HCC Diabetes with Glycemic Unspecified or No Complications	EHR: E11.65	3/8/2025	N	Y	3/8/2025	E11.65

New Measure: HCC RAF Gap Closure

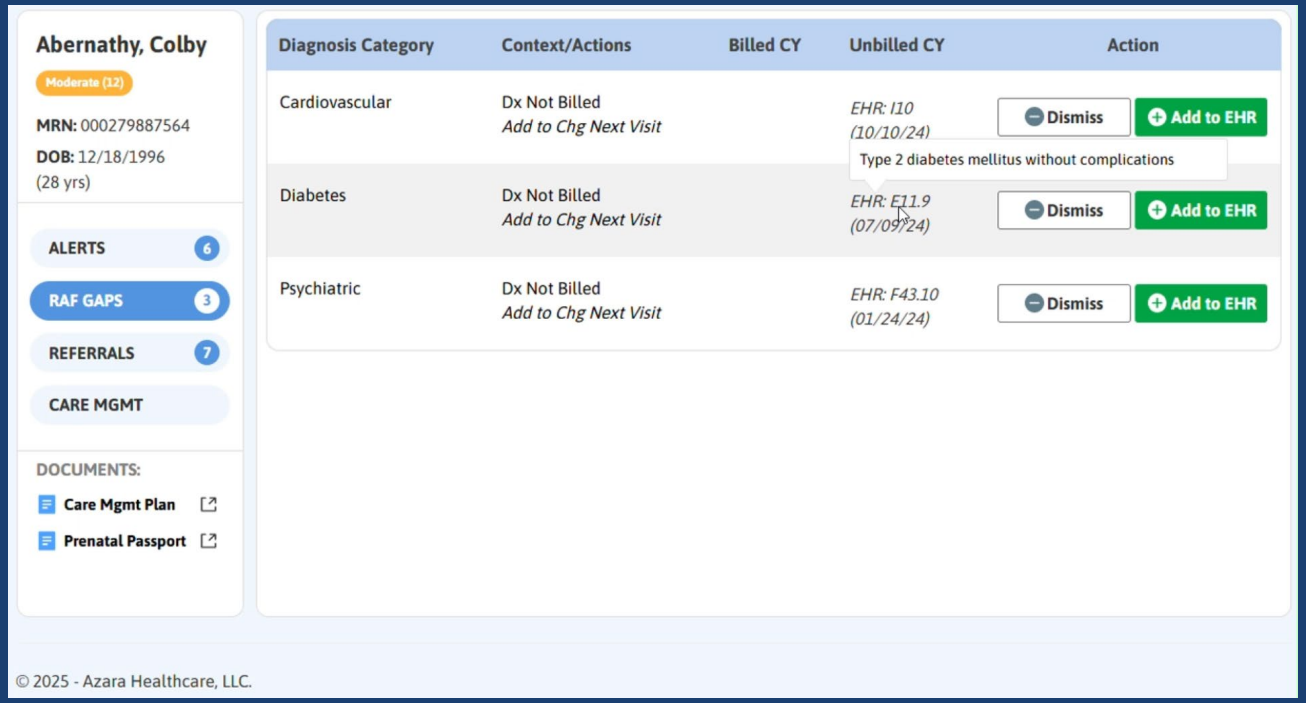
One RAF Gap Closed at Second Visit



	ENCOUNTER APPT	HCC		GAP		EHR PLUG-IN ACTION	CHG RECEIVED		
USUAL PROVIDER	DATE	DISEASE GROUP	DESCRIPTION	CODE	DATE CLOSED	DISMISSED	Y/N	DATE	CODE
Doe, Jane	1/1/2025	Diabetes	HCC Diabetes with Glycemic Unspecified or No Complications	EHR: E11.65		N	N		
Doe, Jane	1/1/2025	Kidney	HCC Chronic Kidney Disease Moderate Stage 3B	EHR: N18.32	1/1/2025	N	Y	1/1/2025	N18.32
Doe, Jane	3/8/2025	Diabetes	HCC Diabetes with Glycemic Unspecified or No Complications	EHR: E11.65	3/8/2025	N	Y	3/8/2025	E11.65

Coming Soon…

Add Dx Codes to your EHR from the Plug-In



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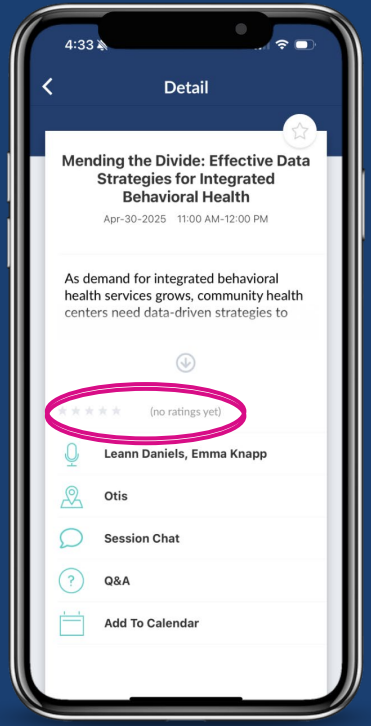

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Provide brief feedback or ideas

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