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

Optimizing Analytics

Data Smart Strategies in Value Based Care

Today’s Speakers

Kara Gee RDH, BS
Associate Director, Clinical Transformation
Azara Healthcare

Stephanie Clouser
Director of Data and Analytics
Kentucky Primary Care Association

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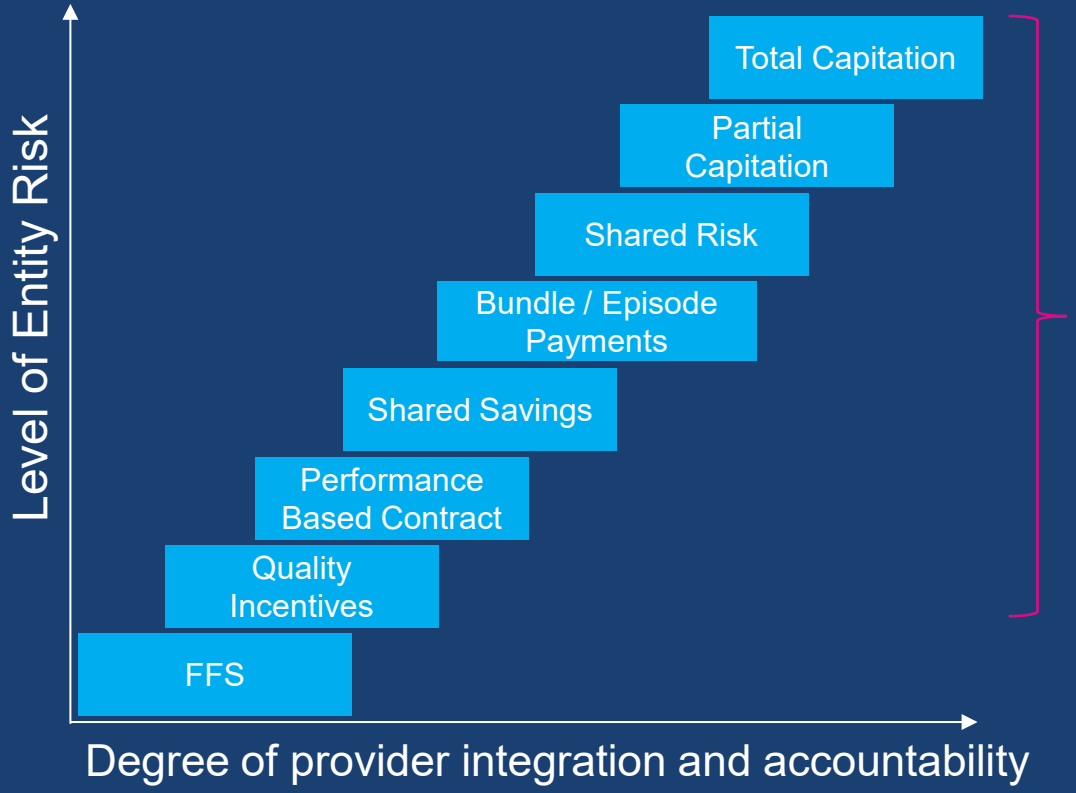
Value-Based Care Model

What is a VBC Model?



Azara defines value-based care (VBC) as any model or contract that provides the ability to earn additional revenue over an above the fee schedule or is at risk of losing revenue via two sided models or full capitation.

What is changing with VBC models?

CMS Goal

100% Medicare
50% Medicaid

In VBC models by 2030

Health Equity

Will be a core component of all CMS VBC models

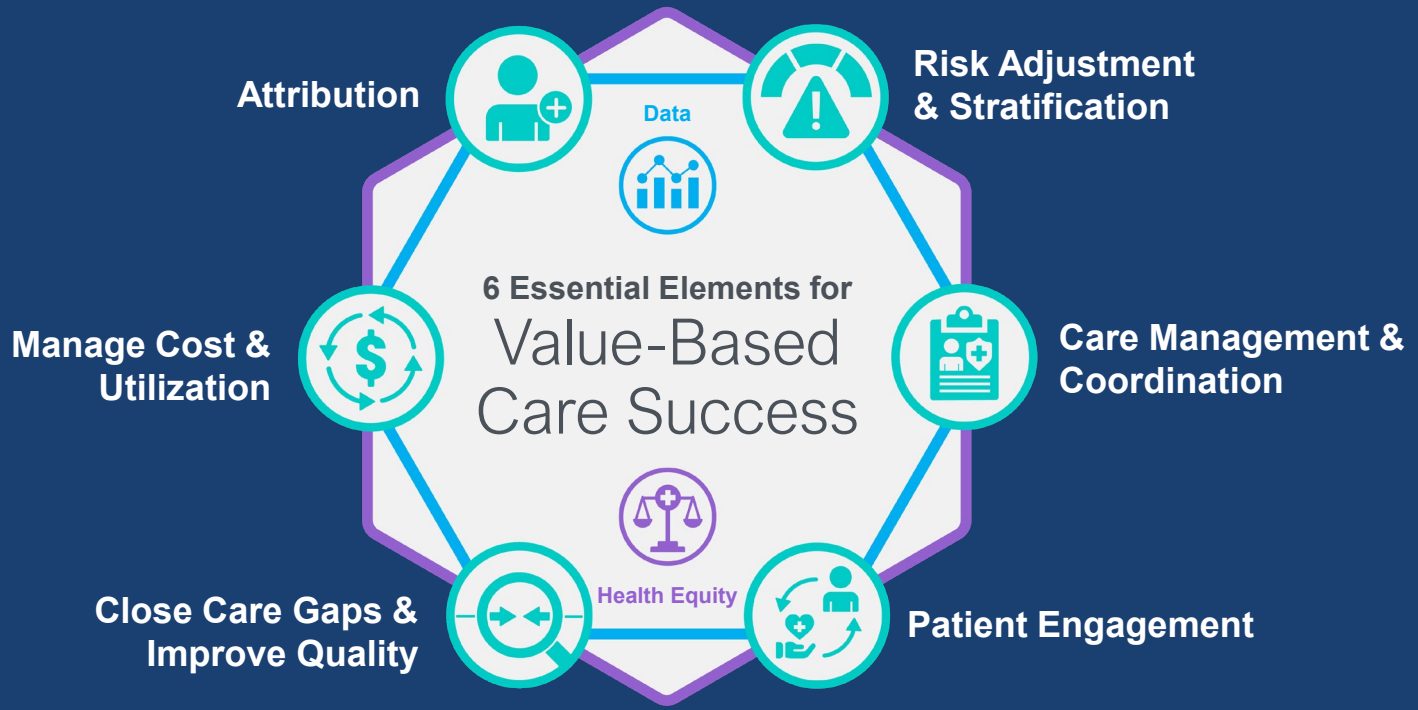
Health Equity will have a meaningful impact on revenue

SDOH Integration

Closed loop social referrals

Work will be compensated in new VBC models

Essential Elements of VBC



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

Attribution

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.
Reduced Costs	By proactively managing patient care, providers can identify and address potential health issues before they become more serious and expensive. Reduce unnecessary hospital admissions and lower overall healthcare costs.

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 fundamental 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

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 Adjustment & Stratification

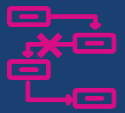
Key Outcomes:

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 preventive measures to maximize 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

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

Care Management & Coordination

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

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

Patient Engagement

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 & QI

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

Close Care Gaps & Improve Quality

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

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

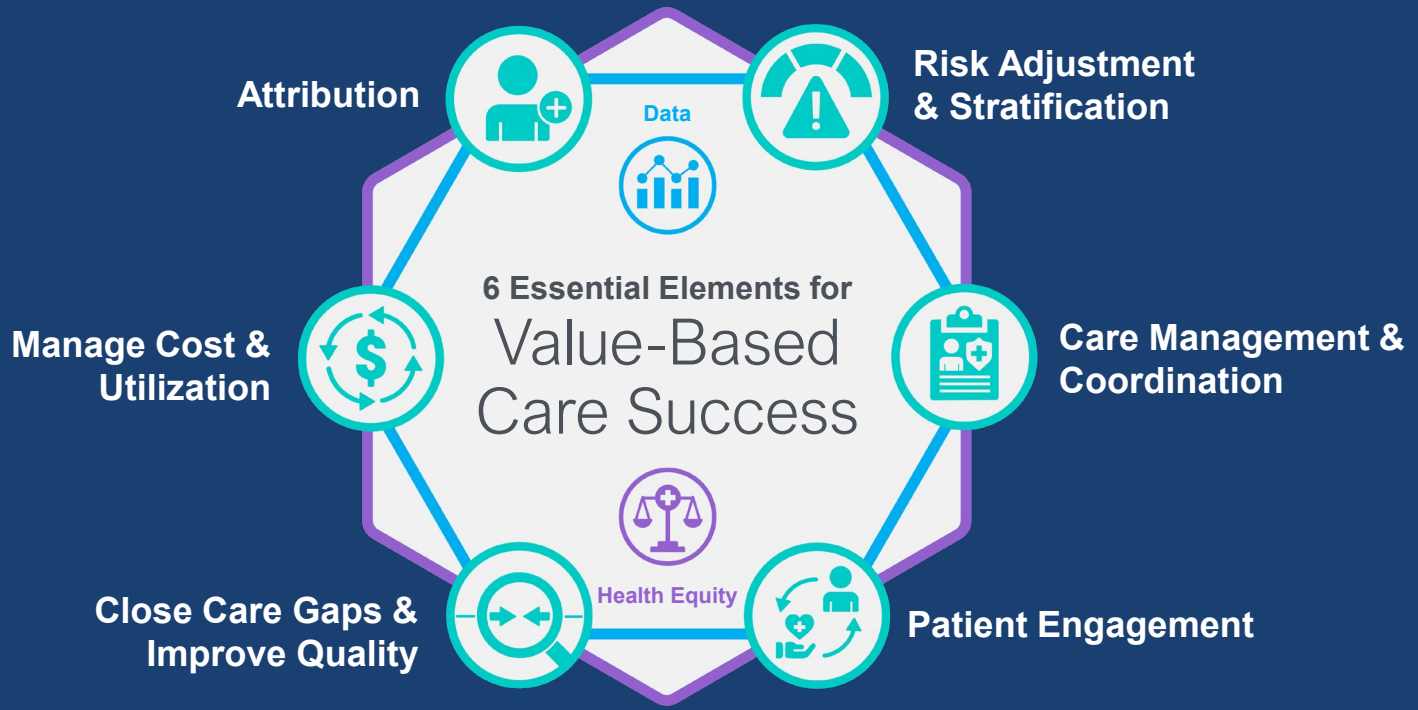
Effectively manage hospital utilization

Manage Cost and Utilization

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.

Essential Elements of VBC



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Optimizing Analytics for Smarter Population Health in Value-Based Care

Who we are, what we do, and how we do it

Kentucky Integrated Care

KIC KENTUCKY INTEGRATED CARE

Kentucky Integrated Care (KIC)

New LLC formed by KPCA and Participant Members in 2023 with first active contracts in 2024.

Legacy IPA formed as messenger model in 2010/2011 under the KPCA as Medicaid managed care entered KY. Transitioned to a CIN in 2019 still under the KPCA.

83 participants including FQHCs and RHCs with more than **3,000 credentialed practitioners.**

More than 20 EHRs in use.

More than **one million** unique Kentuckians seen annually by participants **(20-25% of KY's population).**

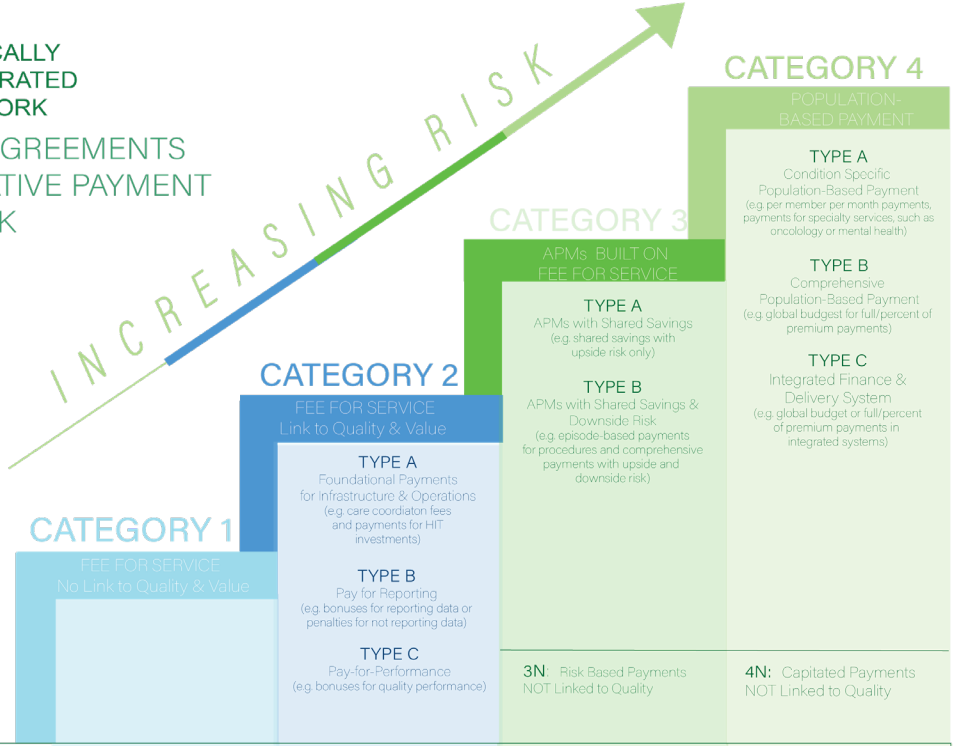
Approximately **350K patients in value-based agreements.**

Holds the base FFS contracts for the majority of our agreements (all the Medicaid contracts).

KIC KENTUCKY INTEGRATED CARE

KPC CLINICALLY INTEGRATED NETWORK

2024 CONTRACTS & AGREEMENTS WITHIN THE ALTERNATIVE PAYMENT MODELS FRAMEWORK



KPC CIN 2024 Contracts/ Value Based Agreements by Line of Business:				
MEDICAID:	Aetna Anthem Humana Passport United Healthcare WellCare	Humana Passport	Aetna Anthem NRSS Anthem PQIP United HealthCare WellCare	
MEDICARE ADVANTAGE:	Passport Wellcare	Anthem ESN*	Anthem Uplift* Wellcare	*Does not have an associated KPCA CIN Category 1 Base Contract
COMMERCIAL:	Caresource QHP Passport QHP WellcareQHP		Anthem EPHC*	
OTHER:	Solstice			

KIC KENTUCKY INTEGRATED CARE

CONTENT SOURCE of APM FRAMEWORK: The Health Care Payment Learning & Action Network (LAN); 2017 APM Framework Refresh

KIC Environmental Scan

5 statewide Medicaid MCOs

- One dominant plan
- Second plan with dominant regional market share
- Medicaid implemented common value-based program for all MCOs with 2% of premium withheld

One dominant traditional commercial health plan and self-insured TPA

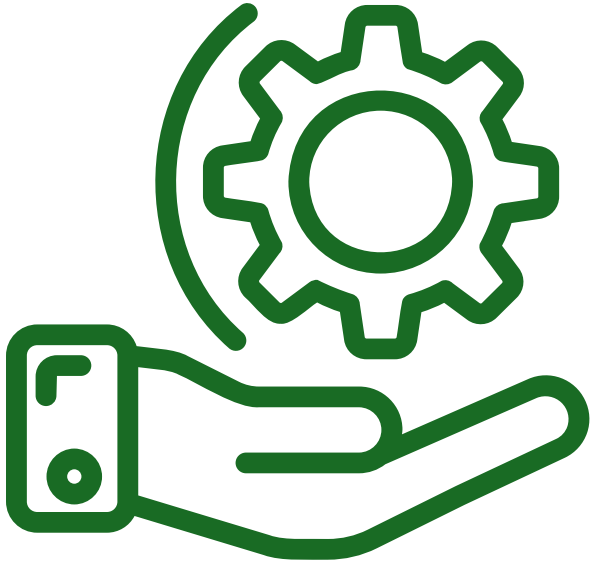
Approximately 1M patients covered by Medicare or a Medicare “product”

- Roughly 50/50 FFS vs MA/ACO
- Small ACO penetrance to date

KIC KENTUCKY INTEGRATED CARE

KIC Services

- Contracting
- Data aggregation
- Payer relations
- Provider relations
- Credentialing
- Compliance training and oversight
- Other training and technical assistance



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KIC Fiscal Considerations

Monthly PMPM network access/care management fees from payers (Annualized ~$10M).

- Percentage retained for network operations
- Remainder disbursed to the participants based on attribution by contract for a range of uses to facilitate value-based care delivery

Earned savings distributed to participants based on annually approved distribution methodology by the BOM.

Total premium to payers for attributed membership >$3B.

Current earning potential **$30M-$50M.**

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KIC Challenges and Considerations

Culture change and **getting comfortable with being part of a larger group**

- Population health tool implementation
- Fragmented payer market/Medicaid expansion retraction
- Health care delivery “disruptors”
- Third party risk/value-based aggregators, enablers
- Regulatory environment
  - UDS vs. HEDIS vs. CMS vs. State
  - State Medicaid program, when is next RFP, new legislation/regulations, etc.
  - Federal, MA change
  - SCOTUS- Chevron decision impacts?

KIC KENTUCKY INTEGRATED CARE

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Azara Implementation

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Technology Investments

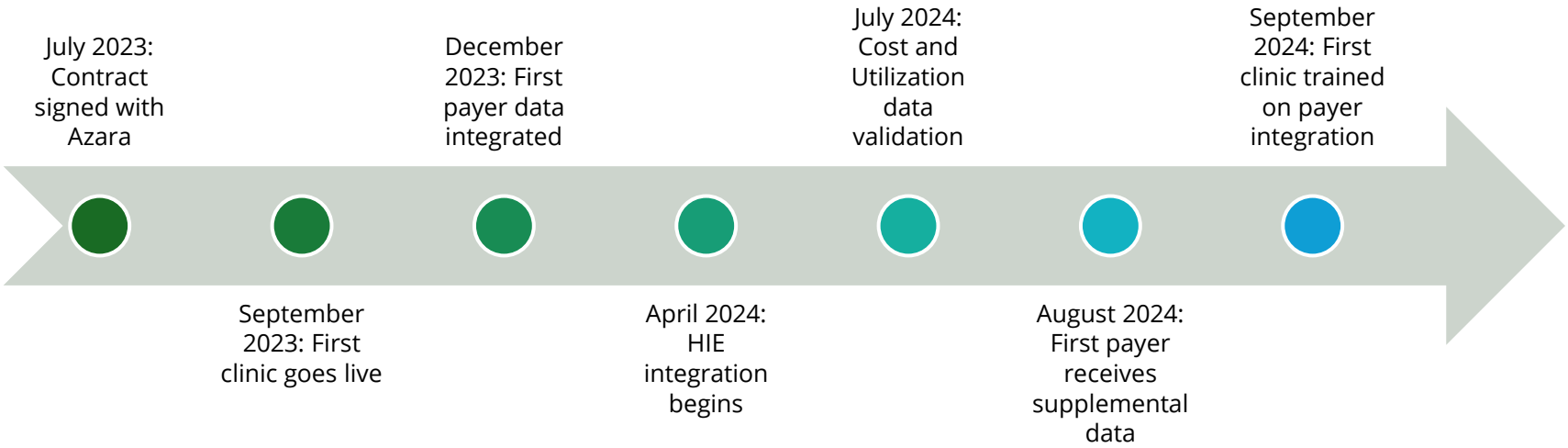
Dismantling of previous population health tool

Implementation of Azara

- Clinic EHR
- Payer data integration
- Kentucky Health Information Exchange (KHIE)
- Azara Cost and Utilization
- Network risk algorithm
- Database extract

KIC KENTUCKY INTEGRATED CARE

KIC's Azara Implementation Journey



KIC KENTUCKY INTEGRATED CARE

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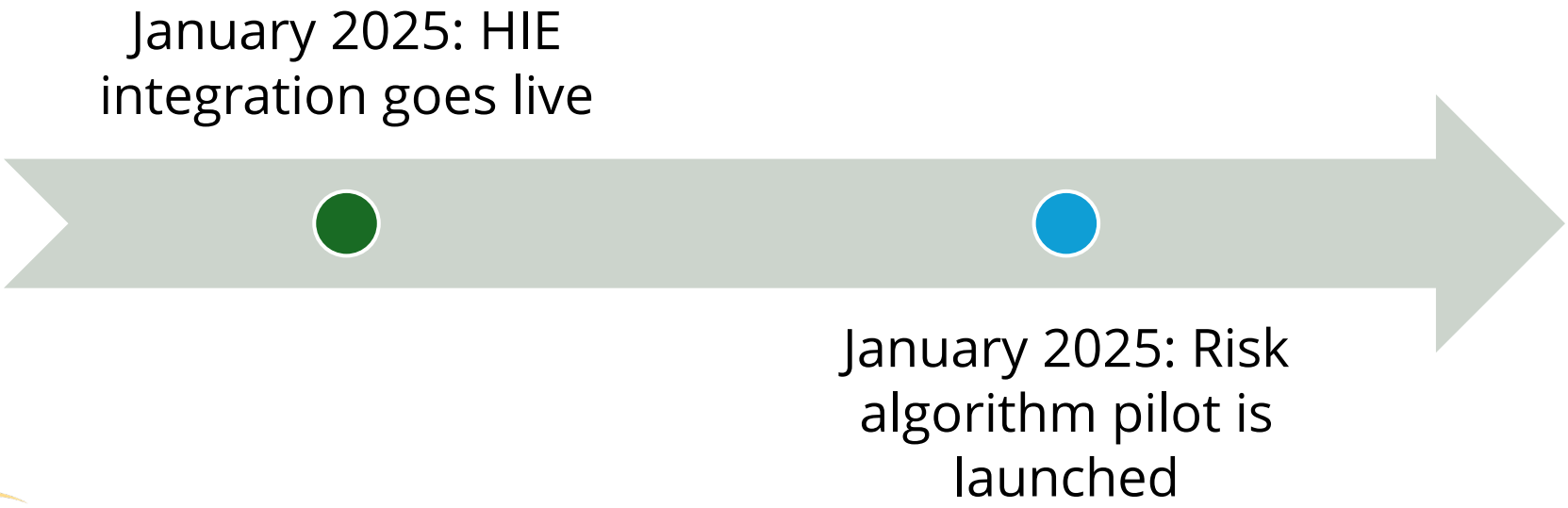

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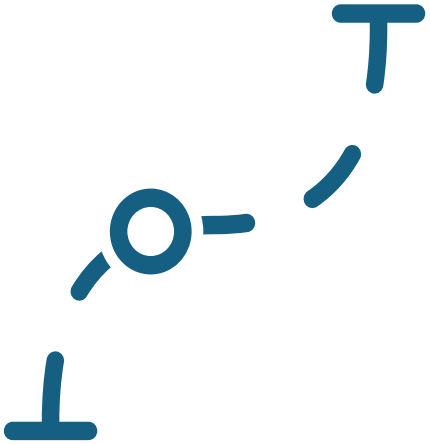
Current State



- Moving from infrastructure-building phase to utility phase
- **53 member clinics onboarding or through implementation**
    - 13 have finished all phases of implementation (connection, data validation, training/adoption)
- All six payers have data (enrollment, claims, and care gap data) integrated
- Seeing first impact of supplemental data
- Dashboards, scorecards developed to advance value-based activities
- HIE integration live
- Piloting network Azara risk algorithm
- Clinics have implemented additional modules

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Supporting Value-based Care with Information

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Leveraging Data in Value-based Activities

Controlling our own data

- More timely feedback and insight
- More meaningful network analysis activities
- One-on-one practice support

Directing activity and resources

- Benchmarks and trends
- Supplemental data
- Contract negotiations
- Growth opportunities both inside and outside of VBA activities

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Data → Information

Name	Date modified	Type
Molina Raw Data	9/18/2024 1:25 PM	Microsoft Ex
UHC File All TIN Totals	9/10/2024 1:46 PM	Microsoft Ex
WellCare Clinic Totals	9/9/2024 5:18 PM	Microsoft Ex
WellCare	9/17/2024 3:12 PM	Microsoft Ex
WellCare	9/18/2024 11:36 AM	Microsoft Ex
September 2024 Membership Requests	9/18/2024 4:21 PM	R File
.Rhistory	9/18/2024 4:21 PM	RHISTORY Fi
Molina	9/18/2024 1:12 PM	Text Docum
UHG_KPCA_KY_Member_20240810	9/9/2024 1:49 PM	Text Docum

A	B	C	D	E	F	G	H	I
INDIVIDU/	INDIVIDU/	LAST-NAM	FIRST-NAI	MIDDLE-IN	SEX	DOB-CCYY	SSN	CASE-NUM

NAME	SEQ_VEND	VENDOR_I	SEQ_PROV	PCP_NPI	PCP_EFF_I	PCP_TER

SUBSCRIBER_ID|MEMB_First_Name|MEMB_Middle_Initial|MEMB_Las
|MEMB_GENDER|MEMB_ADDRESS_LINE_1|MEMB_ADDRESS_LINE_2|MEMB_
|MEMB_ZIP|MEMB_HOME_PHONE|MEMB_EMAIL|MEMB_MEDICAID_NO|MEMI
|MEMB_TERM_DATE|PCP_TAX_ID|PCP_NPI|PCP_NAME

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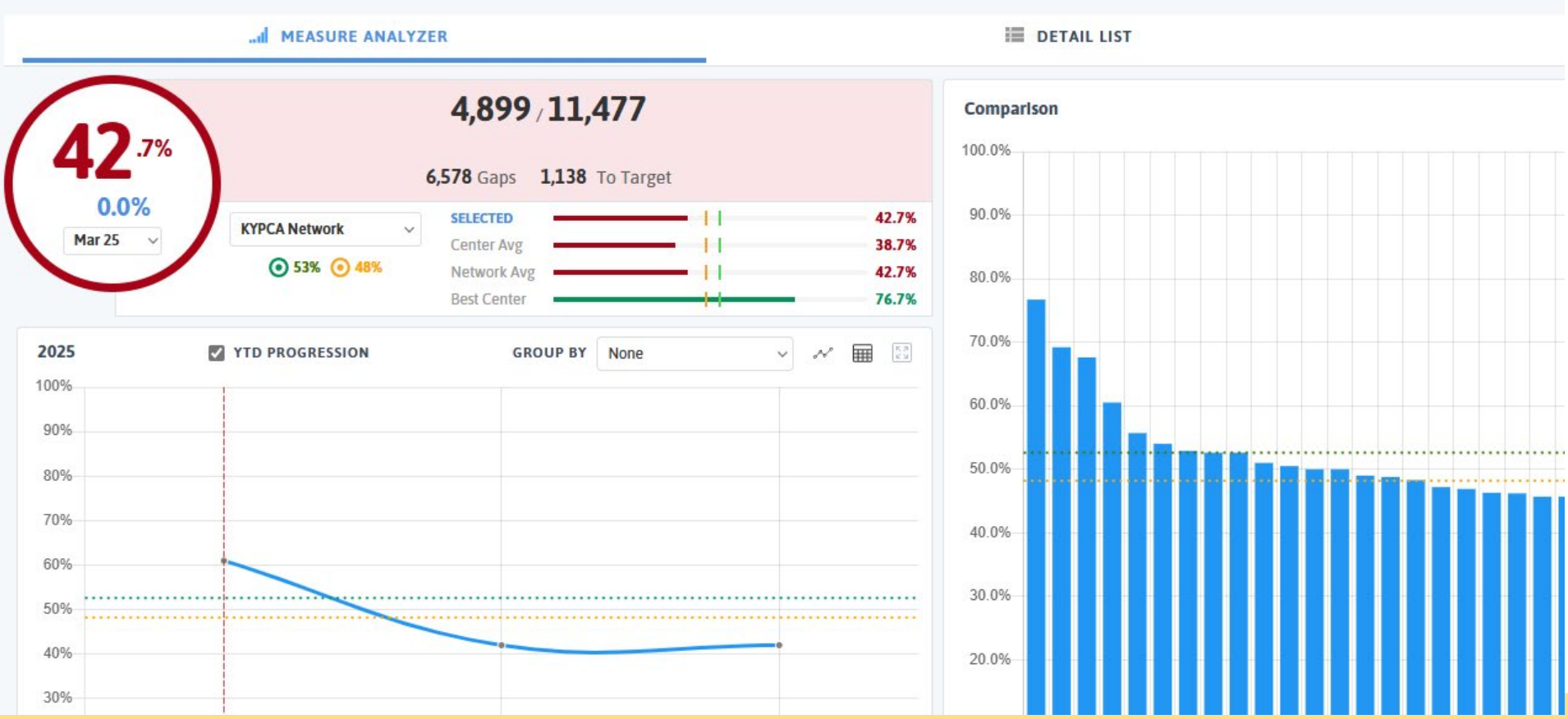
Baseline Data PY23.R | September 2024 Membership Requests.R | WellCare_Clinic_Totals2 | WellCare | Molina_Membership_Total | Molina_Raw_Data

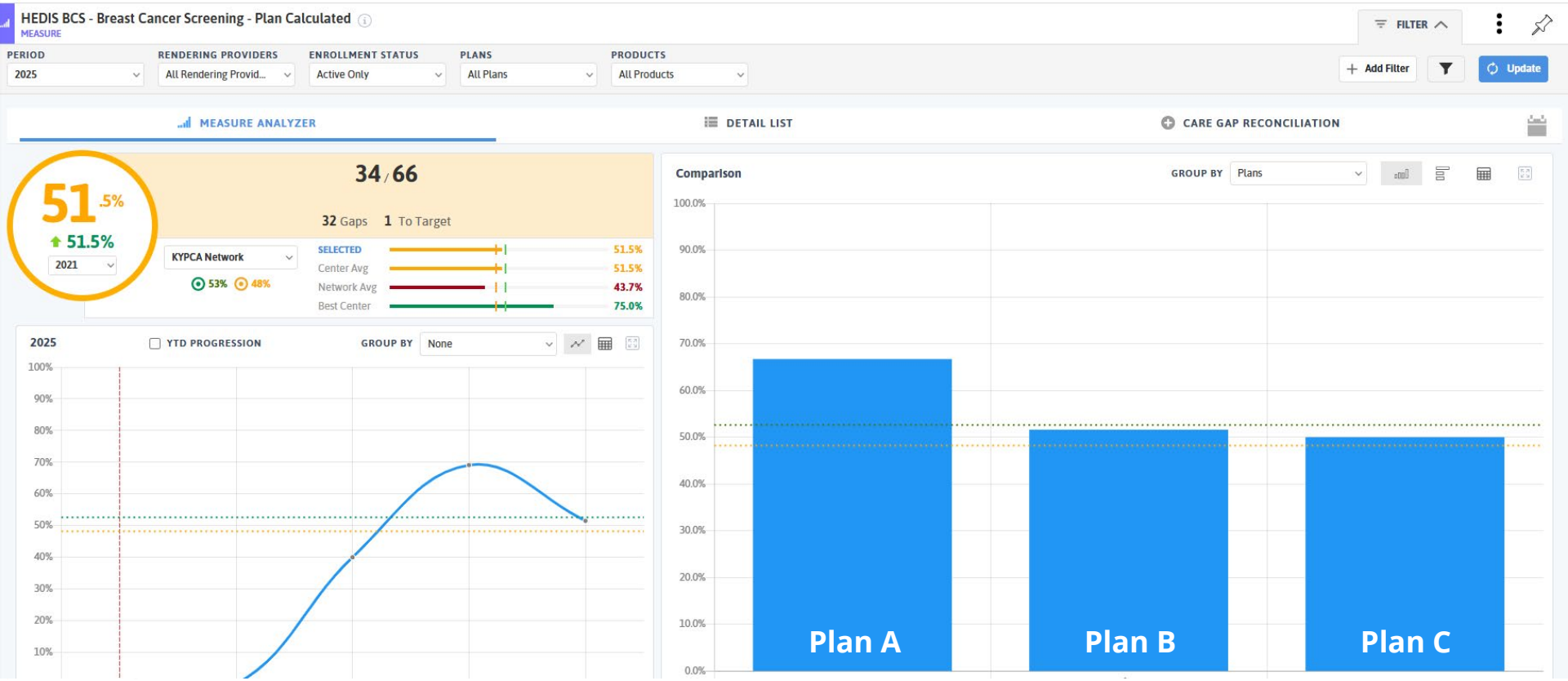
Source on Save | Run | Source

```r
setwd("Z:/Private/sclouser/Membership Reporting/9 September 2024 Membership Requests")

library(readr)
library(readxl)
library(dplyr)


### WELLCARE ###


wellcare <- read_csv("WellCare.csv", skip = 4)

wellCare_Total <- wellCare %>%
  group_by(VENDOR_NAME) %>% summarise("Number of Members" = length(SEQ_MEMB_ID))

wellCare_Clinic_Totals2 <- wellCare %>%
  group_by(LOB) %>% summarise("Number of Members" = length(SEQ_MEMB_ID))

wellCare_OldTINS <- wellCare %>%
  filter(IRS_TAX_ID %in% c(753105395, 352216071, 455399453, 611398630, 611362026, 203131989, 200885888, 611033691,
))

###Passport by Molina###

Molina <- read.fwf(
  file="Z:/Private/sclouser/Membership Reporting/2 February 2024 Membership Requests/Most Recent Clinic Attribution
  widths = c(20, 20, 30, 20, 1, 1, 8, 9, 15, 60, 60, 30, 2, 9, 8, 8, 12, 30, 80, 15, 254, 2, 2, 3, 2, 30, 30, 1, 1,
             1, 60, 60, 30, 2, 9, 30, 2, 15)
)
##Export file to add column headers##
write.csv(Molina,file="Molina Raw Data.csv",row.names=FALSE)

Molina_Raw_Data <- read_csv("Molina Raw Data.csv")

#library(dplyr)
Molina_Membership_Total <- Molina_Raw_Data %>%
  group_by(PCP_Provider_ID) %>% summarise("Number of Members" = length(`INDIVIDUAL-ID-NUMBER`))

##Remove Clinics no Longer in CIN##

Molina_Filtered <- Molina_Raw_Data %>%
  filter(!PCP_Provider_ID %in% c(753105395,352216071,455399453,611398630,611362026,203131989,200885888,611033691))


Molina_Filtered_Total <- Molina_Filtered %>%
  group_by(Molina_Filtered$`LINE-OF-BUSINESS`) %>% summarise("Number of Members" = length(`INDIVIDUAL-ID-NUMBER`))
```

Data → Information



Streamlined Management of Attributed Population



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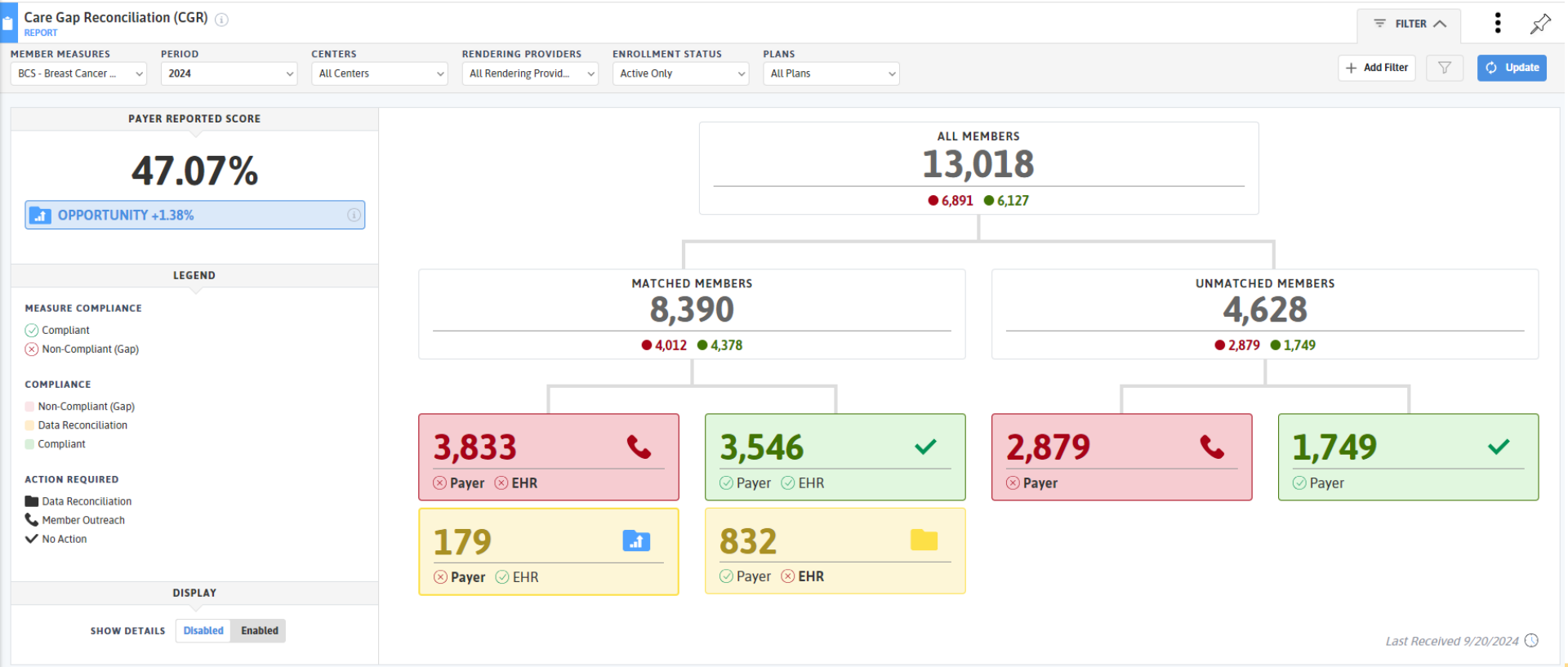

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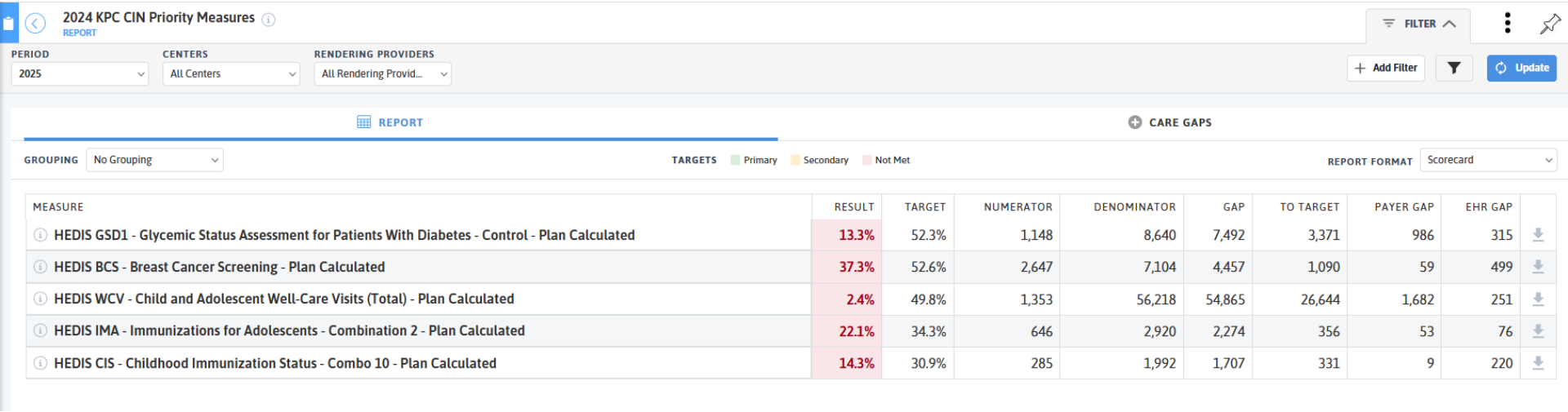

2024 KPC CIN Priority Measures
REPORT

FILTER

PERIOD: 2025
CENTERS: All Centers
RENDERING PROVIDERS: All Rendering Provid...

Add Filter | Update

REPORT | CARE GAPS

GROUPING: No Grouping
TARGETS: Primary, Secondary, Not Met
REPORT FORMAT: Scorecard

MEASURE	RESULT	TARGET	NUMERATOR	DENOMINATOR	GAP	TO TARGET	PAYER GAP	EHR GAP
HEDIS GSD1 - Glycemic Status Assessment for Patients With Diabetes - Control - Plan Calculated	13.3%	52.3%	1,148	8,640	7,492	3,371	986	315
HEDIS BCS - Breast Cancer Screening - Plan Calculated	37.3%	52.6%	2,647	7,104	4,457	1,090	59	499
HEDIS WCV - Child and Adolescent Well-Care Visits (Total) - Plan Calculated	2.4%	49.8%	1,353	56,218	54,865	26,644	1,682	251
HEDIS IMA - Immunizations for Adolescents - Combination 2 - Plan Calculated	22.1%	34.3%	646	2,920	2,274	356	53	76
HEDIS CIS - Childhood Immunization Status - Combo 10 - Plan Calculated	14.3%	30.9%	285	1,992	1,707	331	9	220

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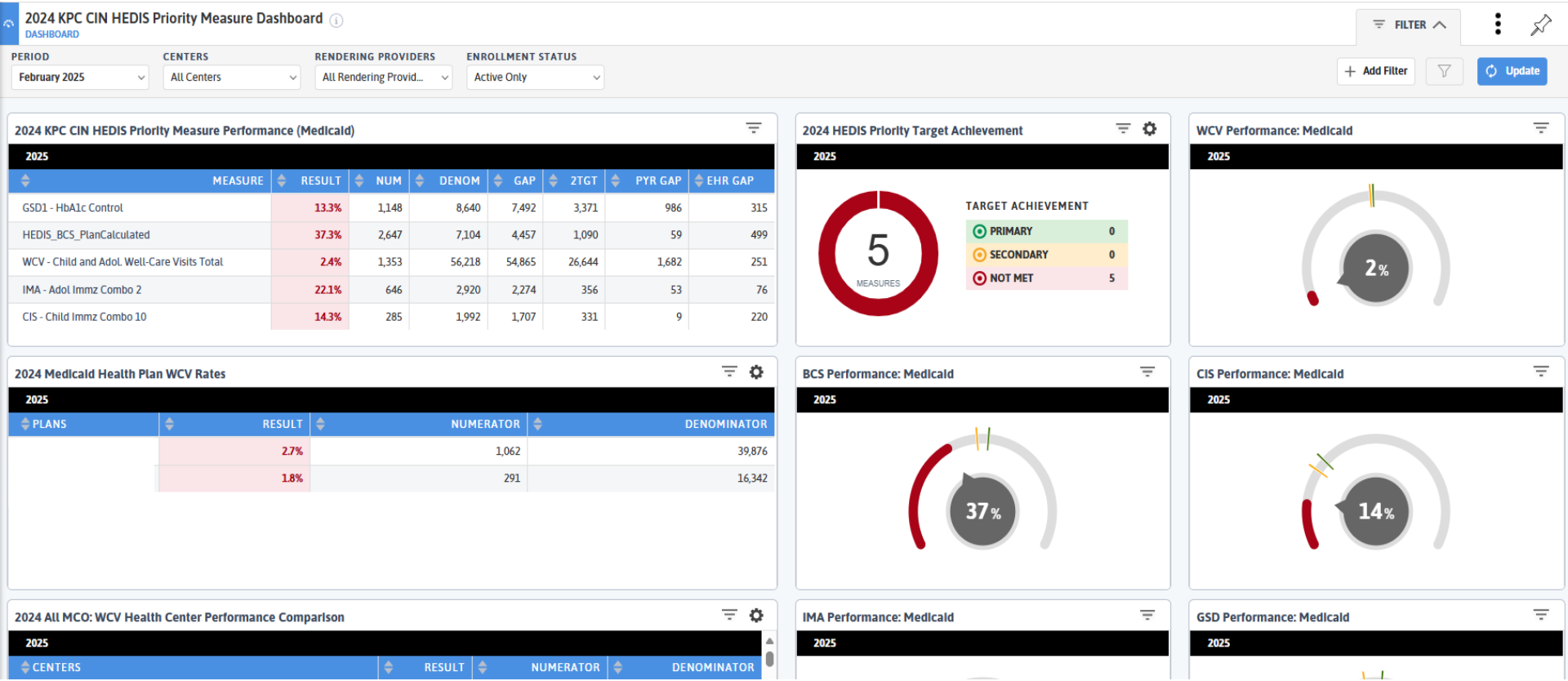
Data → Information



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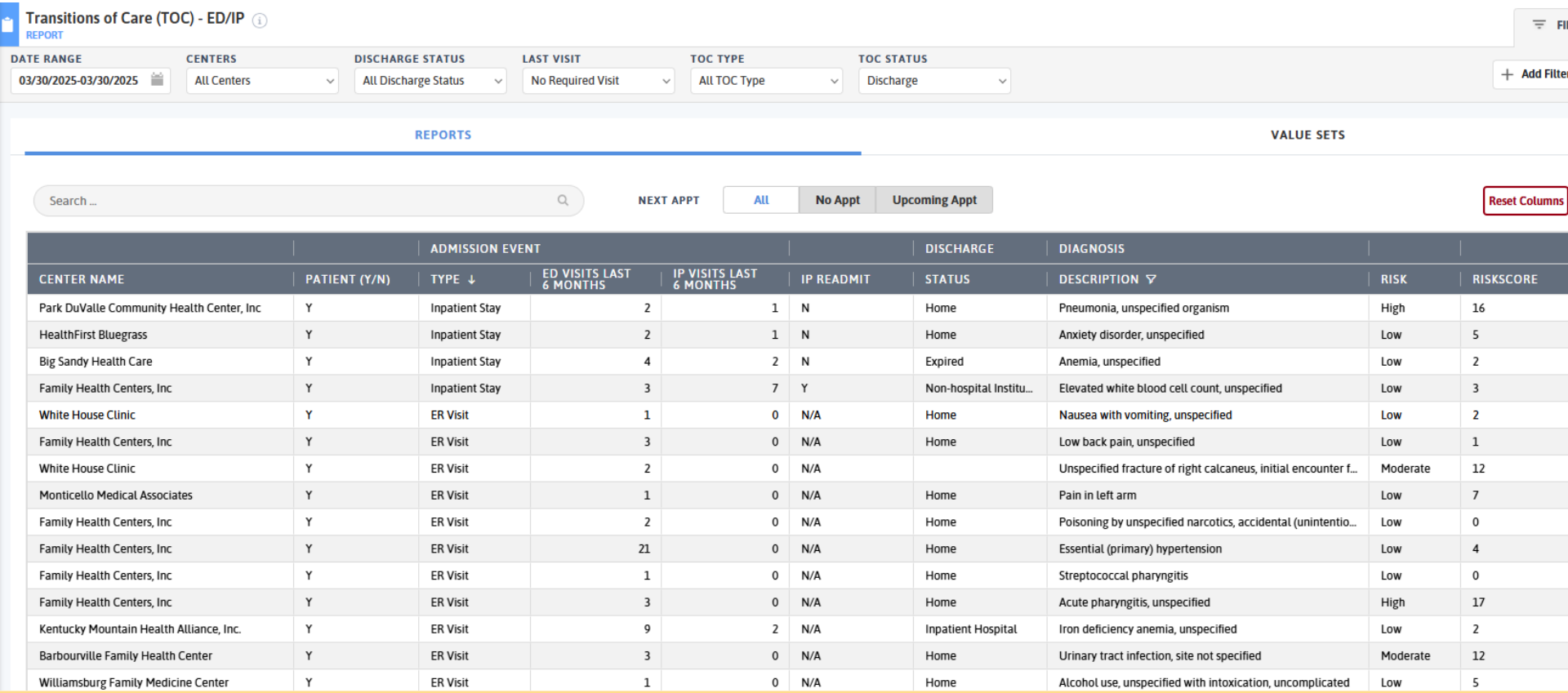
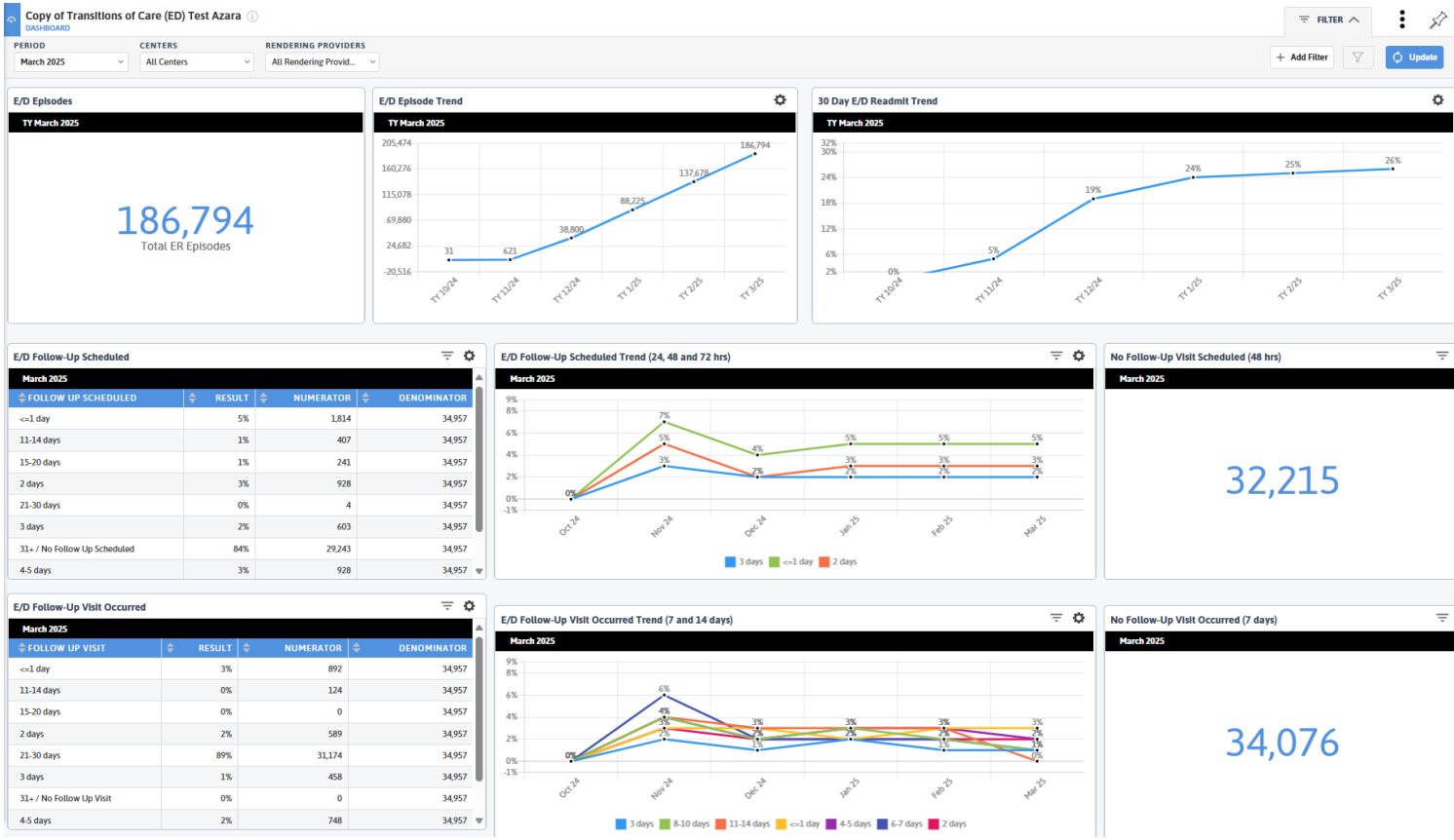


		ADMISSION EVENT				DISCHARGE	DIAGNOSIS		
CENTER NAME	PATIENT (Y/N)	TYPE ↓	ED VISITS LAST 6 MONTHS	IP VISITS LAST 6 MONTHS	IP READMIT	STATUS	DESCRIPTION ▽	RISK	RISKSCORE
Park DuValle Community Health Center, Inc	Y	Inpatient Stay	2	1	N	Home	Pneumonia, unspecified organism	High	16
HealthFirst Bluegrass	Y	Inpatient Stay	2	1	N	Home	Anxiety disorder, unspecified	Low	5
Big Sandy Health Care	Y	Inpatient Stay	4	2	N	Expired	Anemia, unspecified	Low	2
Family Health Centers, Inc	Y	Inpatient Stay	3	7	Y	Non-hospital Institu...	Elevated white blood cell count, unspecified	Low	3
White House Clinic	Y	ER Visit	1	0	N/A	Home	Nausea with vomiting, unspecified	Low	2
Family Health Centers, Inc	Y	ER Visit	3	0	N/A	Home	Low back pain, unspecified	Low	1
White House Clinic	Y	ER Visit	2	0	N/A		Unspecified fracture of right calcaneus, initial encounter f...	Moderate	12
Monticello Medical Associates	Y	ER Visit	1	0	N/A	Home	Pain in left arm	Low	7
Family Health Centers, Inc	Y	ER Visit	2	0	N/A	Home	Poisoning by unspecified narcotics, accidental (unintentio...	Low	0
Family Health Centers, Inc	Y	ER Visit	21	0	N/A	Home	Essential (primary) hypertension	Low	4
Family Health Centers, Inc	Y	ER Visit	1	0	N/A	Home	Streptococcal pharyngitis	Low	0
Family Health Centers, Inc	Y	ER Visit	3	0	N/A	Home	Acute pharyngitis, unspecified	High	17
Kentucky Mountain Health Alliance, Inc.	Y	ER Visit	9	2	N/A	Inpatient Hospital	Iron deficiency anemia, unspecified	Low	2
Barbourville Family Health Center	Y	ER Visit	3	0	N/A	Home	Urinary tract infection, site not specified	Moderate	12
Williamsburg Family Medicine Center	Y	ER Visit	1	0	N/A	Home	Alcohol use, unspecified with intoxication, uncomplicated	Low	5

Data → Information



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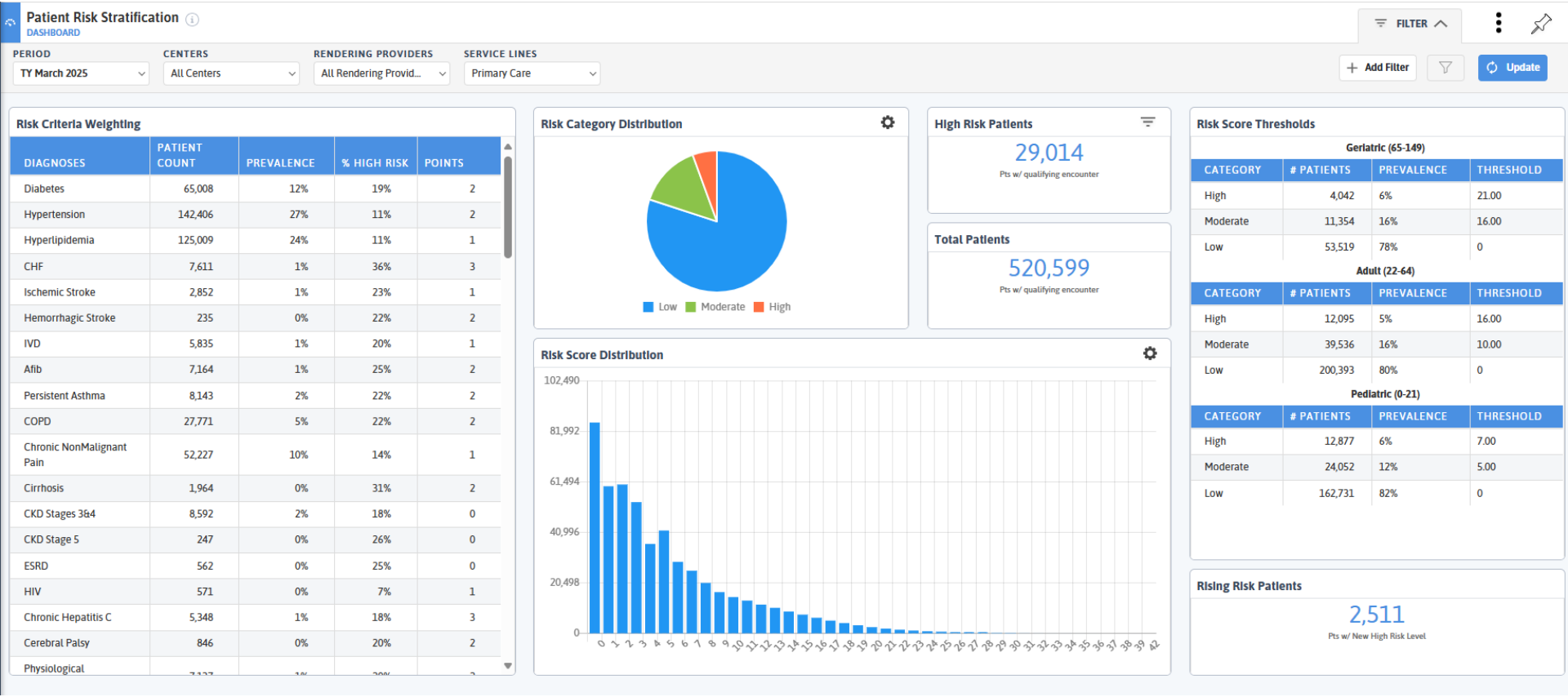


HIV Screening and Linkage to Care Dashboard

HIV Screening and Linkage to Care **Run on 3/13/2025 2:56:43 PM**

As part of the KPCA's ongoing efforts to meet the objectives of our HRSA grant, we are focusing on HIV screening as a key area of performance. To support this initiative, we have created this dashboard that highlights UDS HIV Screening and UDS Linkage to Care measures.

Some organizations will recieve a PDF of this dashboard in a monthly email subscription. Note that in the emailed PDF form, the dashboard displays network rates, but when accessed in DRVS the dashboard will display your individual clinic data. For a more detailed view of your data, click into any measure. If you have any questions or need additional support, please do not hesitate to reach out. Thank you for your continued dedication to improving patient care.

HIV Screening (CMS 349v6)

29.6%

% Pts screened for HIV

HIV Screening and Linkage to Care

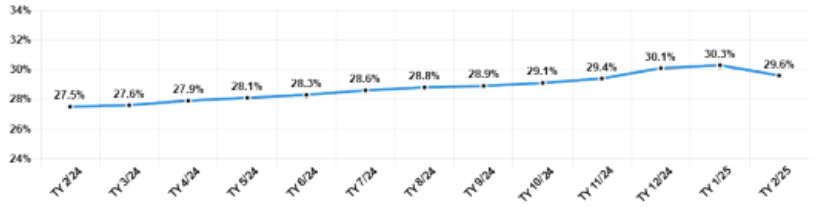
MEASURE	RESULT	NUM	DENOM	EXCL
HIV Screening (CMS 349v6)	29.6%	98,039	331,363	952
HIV Linkage to Care	37.2%	16	43	0

HIV Linkage to Care

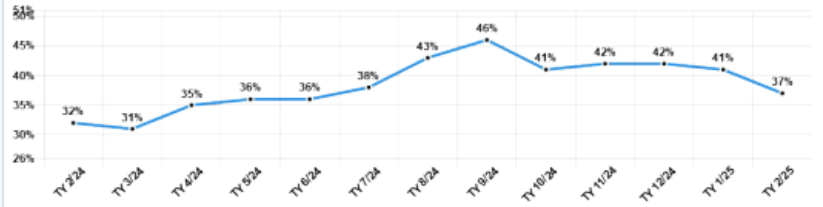
37%

% of New HIV Dx w/ Timely Follow-Up

HIV Screening (CMS 349v6) Trend Line



HIV Linkage to Care Trend Line



KIC KENTUCKY INTEGRATED CARE

Lessons Learned and Learning

Know your network

- **Transparency was key to building trust with members**
- **Managing expectations**

Network staff and providers are on this journey together

Don’t reinvent the wheel

Be your strongest advocate

Continual quality assurance is important to utility of the tool

Don’t let perfection be the enemy of progress

Data management is the responsibility of both the network and its members

Seeing early impact on performance and contract success

Value-based considerations are often different from UDS, other programs

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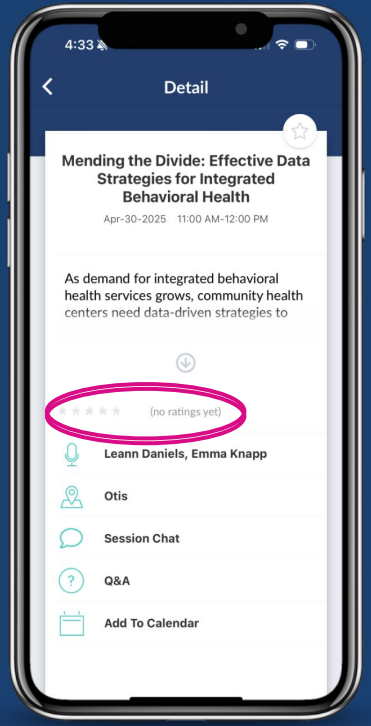
Questions?

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

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Help us continue to improve

Achieve, Celebrate, Engage!

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

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ACE Program

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.

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
- Potential to be featured at next year's Azara User Conference
- Win Azara swag!

Submit your success story by completing the form at this link.

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Thanks for attending!