The Guide to Success in Value-based Care

Using Innovaccer's Value-based Care Levers

innovaccer

Contents

Executive Summary

Value-based care (VBC) is not new in healthcare. It has been a decade since the launch of the Affordable Care Act (ACA) in 2010. However, healthcare organizations continue to face complex challenges in delivering appropriate care to their patients in a value-based world. Unable to identify the exact domains upon which they need to direct their efforts, their attention is focused on improving every parameter of VBC delivery to their patients. However, every healthcare organization is different, they have distinct needs, and the populations they serve are not the same, so their areas of focus are also likely to differ significantly.

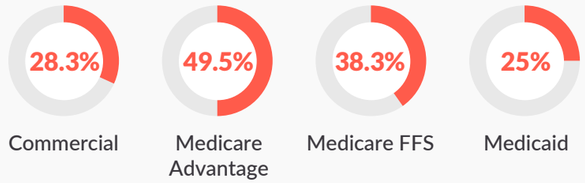
This VBC success guide is a review of a focused approach to succeeding in a value-based care ecosystem. Innovaccer has conceptualized 15 value levers that identify the priority areas for a healthcare organization to pursue to achieve success in its journey towards value-based care. These levers address six primary dimensions for managing overall healthcare costs: cost and utilization, network, contract, quality, risk, and attribution mix.

A Look Into the Concept of Value-based Care for the 2020s

Value-based care is a popular topic in healthcare. Nearly every organization is moving toward the concept of delivering care in a way that optimizes population health but minimizes overall costs.

According to a report by the Health Care Payment Learning and Action Network (HCP-LAN), approximately 34% of all healthcare payments made in 2017 were tied to an Alternative Payment Model (APM) with shared savings, shared risk, bundled payments, or population-based payments.[1]

In 2017, 34% of U.S. health care payments, representing approximately 226.3 million Americans and 77% of the covered population, flowed through categories 3 & 4 models. In each market, categories 3 & 4 payments accounted for:



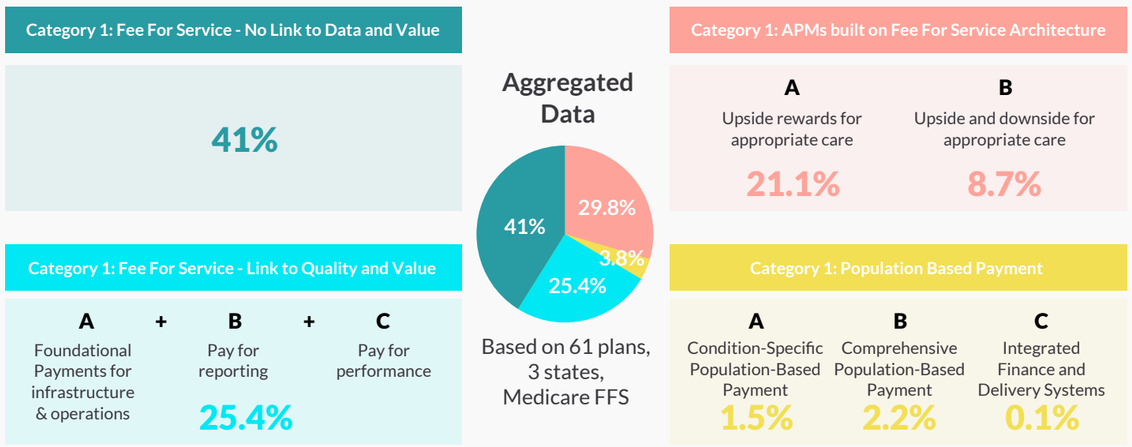
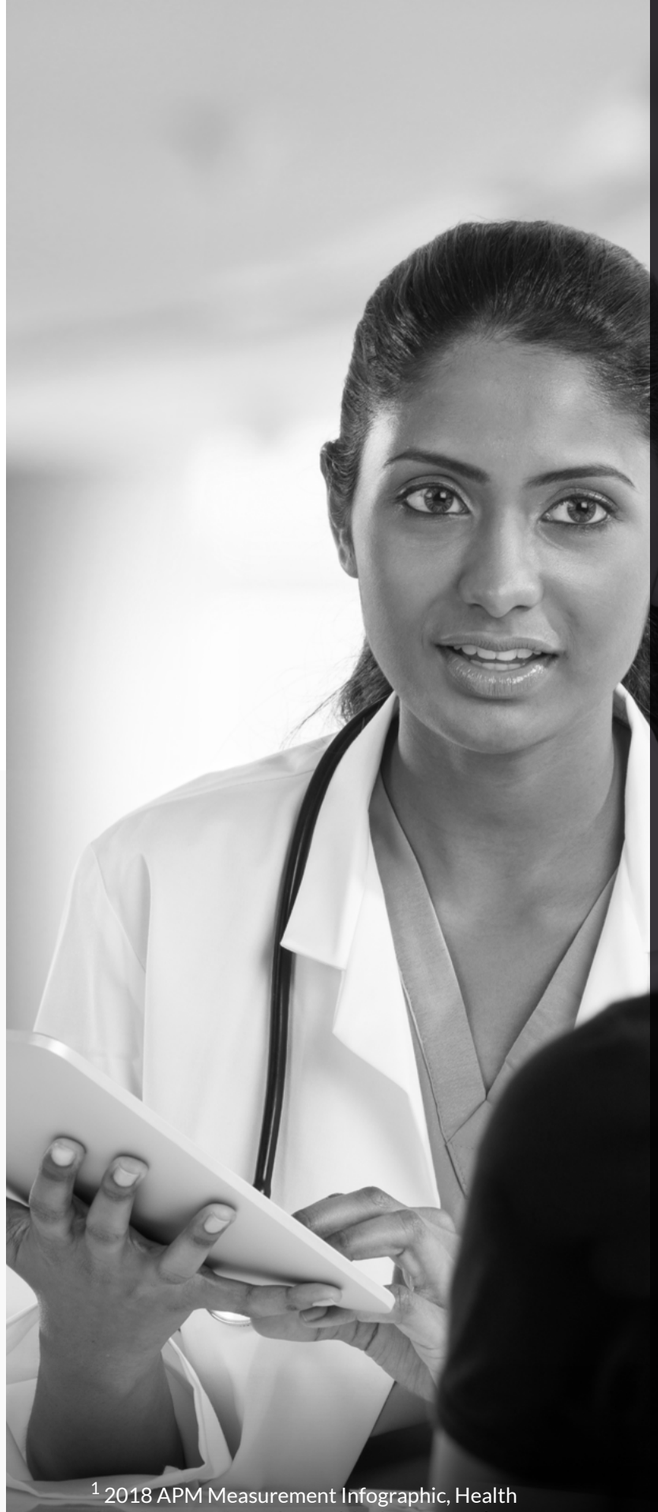


Fig. 1: Alternative Payment Model (APM) Measurement Effort Report by the Health Care Payment Learning and Action Network (HCP-LAN)



[1] 2018 APM Measurement Infographic, Health Care Payment Learning and Action Network: https://hcp-lan.org/2018-apm-measurement/2018-infographic/

What is U.S. Healthcare Lacking?

With multiple efforts being made with a focus on establishing value-based care as the new reality of U.S. healthcare delivery, many organizations are still facing complications while attempting to achieve better outcomes in clinical and financial operations. Common challenges include:

- Lack of true insights into their healthcare network and a poor understanding of the key areas for improvement
- Efforts are distributed to every aspect of care delivery, leading to a lack of focus on specific drivers for an organization
- Failure to gain insights into the factors causing the most loss related to clinical and financial operations
- Lack of a standard strategy to direct the focus on and address the most important areas of potential savings and improvement

How is Innovaccer Revolutionizing Value-based Care?

To assist healthcare organizations in identifying the most-effective parameters for their networks, Innovaccer has conceptualized 15 value levers that identify the top areas of focus for a healthcare organization to achieve success in its journey towards value-based care. These levers address six main dimensions relating to the management of overall healthcare costs: cost and utilization, network, contract, quality, risk, and attribution mix.

Innovaccer's Approach to Assessing the Gaps to Success in an Organization's Value-based Care Journey

Innovaccer adopts a three-phased structured approach to working with customers that drills down to the most significant factors impacting the organization's clinical and financial growth. First, in the Activation Phase, we review and understand the customer's existing efforts, successes, and how the organization prioritizes each value lever, narrowing the 15 levers down to a select few. Second, in conjunction with the customer, we enter into the Diagnostic Phase to identify the most critical levers. This is achieved by conducting a value-sizing exercise to further understand the opportunities for improvement in these top levers.

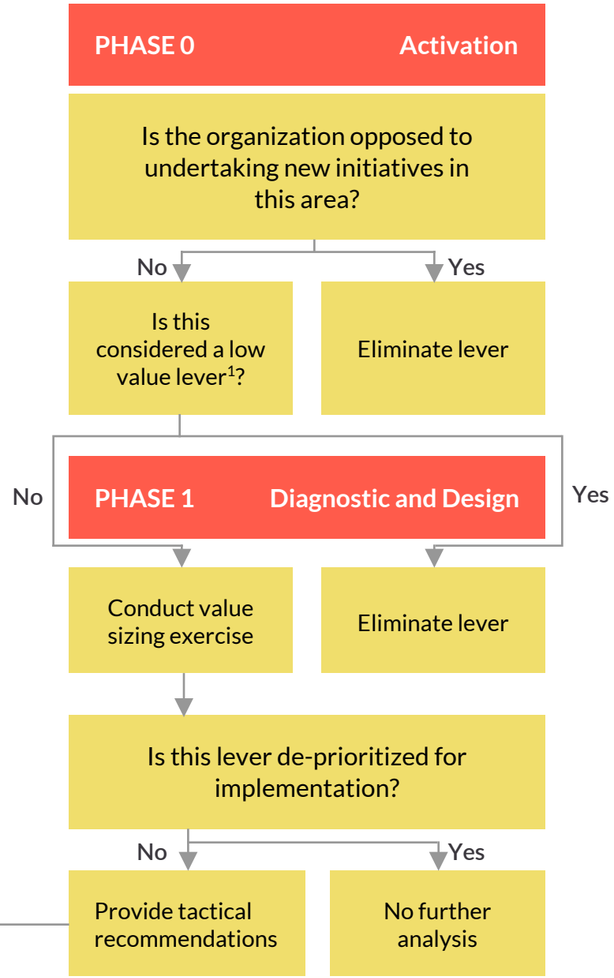


Fig. 2: Innovaccer's approach to value-based levers narrow down the enterprise focus to the top 4 levers using a structured elimination process to maximize ROI

[1]Decision point to be determined based on external research or past network analysis

Following that step, the remaining critical levers are shortlisted by comparing the relative cost of altering them against the potential long-term financial impact and strategic priority. This is plotted against the two dimensions of return and investment, with consideration given to the organization's current operations and limitations.

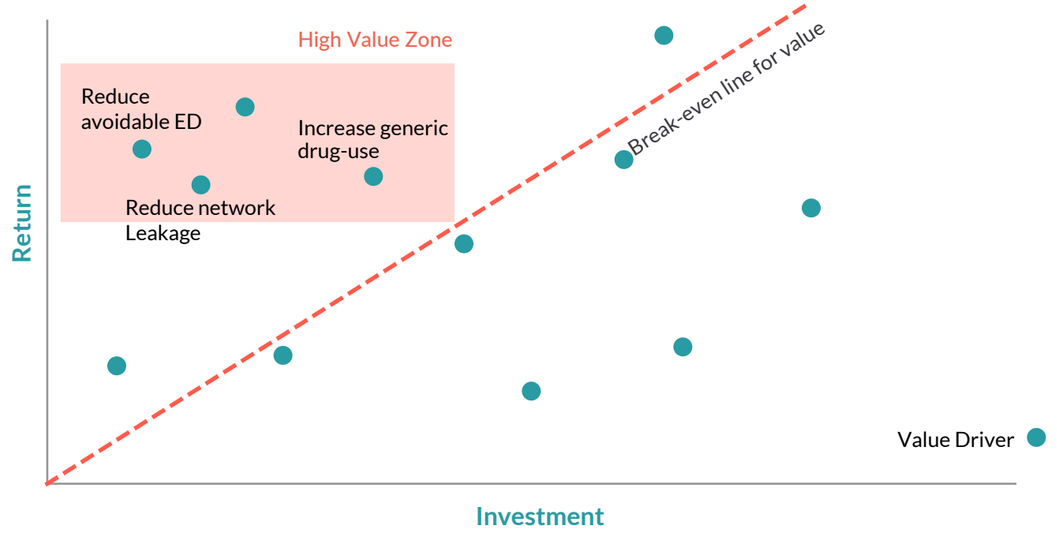


Fig. 3: Example of how a leading ACO identified its most important value-based levers

The Optimization Cycle to Assist Healthcare Organizations Win at Value-based Contracting

Innovaccer's value-based lever approach initially assists organizations in identifying the underperforming levers based on the outcomes they have been achieving. This enables them to develop focussed strategies for improvement. Innovaccer partners with these organizations to empower them throughout a 4-stage cycle.

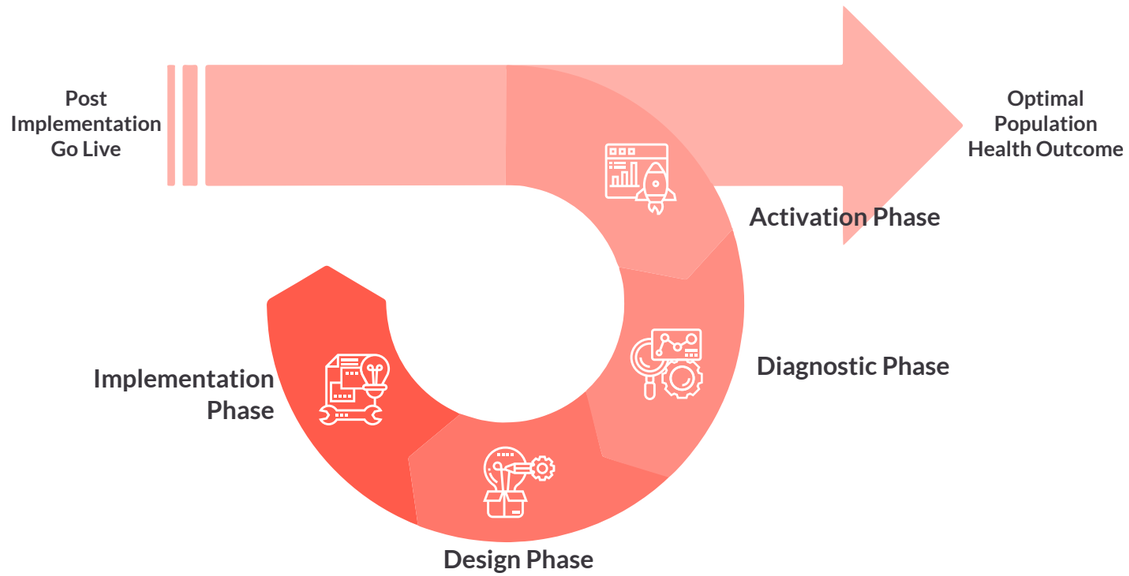


Fig. 4: Optimization cycle operates on 4 iterative steps to win at VBC contracts

The phases involved in this cycle include:

1. Activation Phase

In the activation phase, we enable the healthcare organization to identify their lowest-performing levers with a holistic, data-driven strategy. The organization undergoes an analysis of outcomes, previous performance, and its growth curve. The areas needing the most attention to enhance their clinical and financial growth are identified.

2. Diagnostic Phase

We conduct a thorough analysis of the root causes of the underperforming levers in this phase. Based on the insights obtained in the previous phase, we conduct a data-driven analysis of the factors responsible for low-performance areas related to the levers of concern. After identifying their roles, the underlying factors are prioritized based on their relative impact.

3. Design Phase

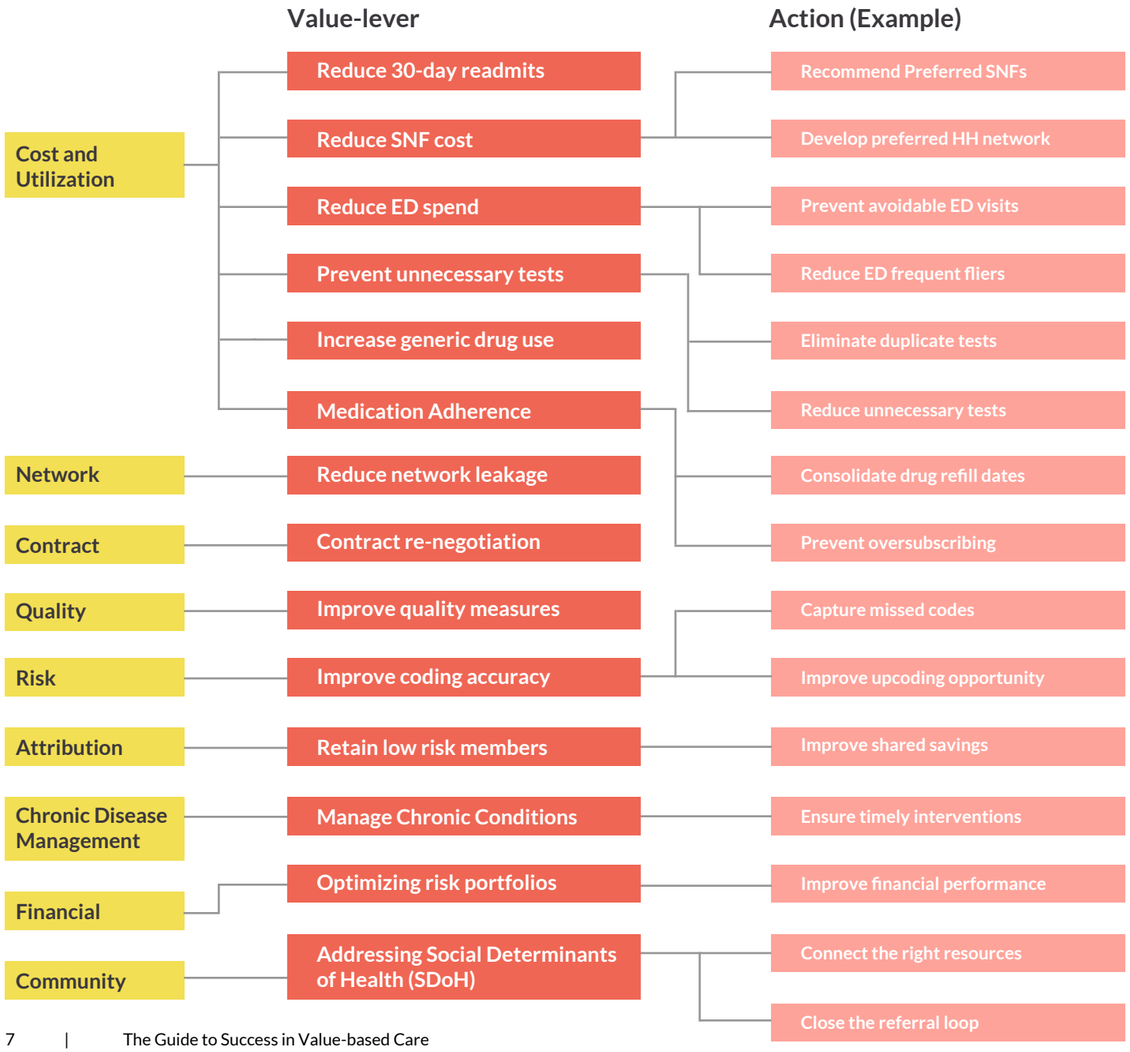
After the diagnostic phase, the low-performing levers have been identified, as well as the factors involved, and the organization has categorized them based on priority. With these insights in place, we can work together to devise multiple best-in-class processes and strategies to enhance their overall performance.

4. Implementation Phase

In the final phase, we develop operations to transform the relevant clinical, financial, and operational business workflows based on the strategies built in the design phase. Not only does this phase include the implementation of clinical and financial methods for enhancing outcomes, but it also includes contract management services.

Innovaccer's 15 Levers for Success at Value-based Care

Based on an analysis and thorough review of leading organizations and the factors affecting their performance, Innovaccer has identified 15 key levers driving the overall population health management strategy for an organization.



Our healthcare consulting experience has allowed us to analyze the 15 levers driving an organization's addressable population health opportunities. The 15 value levers are described in detail below.

1. Reducing 30-day Readmissions

Under the changing dynamics of healthcare delivery, where the shift towards a value-based model is the primary goal, reducing hospital readmissions is critical to performance measures. It's not just a matter of the high costs associated with repeated hospitalizations; hospital readmissions are a reflection of inefficient services and poor care coordination. Since it is the vulnerable and elderly patients that are most often readmitted, practices serving these populations will be the most impacted by Medicare penalties for low performance.

The 30-day readmission rate is a classic cost-containment lever that targets growing inpatient spend. Most readmission rates are in the high teens or greater (15–19%). Many Accountable Care Organizations (ACOs) strive to drive this towards a figure in the lower teens, with the lowest 2017 Medicare Shared Savings Program (MSSP) readmission rate hovering around 10%.

Features:

- This lever is typically controlled by implementing the Transitional Care Management (TCM) protocol via InCare, a smart, AI-assisted care management solution.
- TCM protocols assure that the care manager attempts to call the patient within 24–72 hours post-discharge with an appropriate individualized protocol.
- At a minimum, care managers address patient concerns, red flags, discharge instructions, new medications and orders, and medication reconciliation. A post-discharge follow-up visit is scheduled as needed.
- The patient is encouraged to keep communication with the care manager and provider a priority, decreasing the risk of potential readmission for factors that could have been prevented with good care coordination.

Fig. 5: Innovaccer's 15 value-based levers

2. Reducing SNF Costs

With skilled nursing facilities reimbursed on a per diem basis, the utilization reimbursements vary with metrics such as length of stay, charge amount per day, among others, in comparison to other healthcare organizations. An increase in the utilization of such parameters adds to the particular facility's revenue but poses a barrier to a healthcare network's efforts to deliver cost-effective care.

Common post-acute care settings include long-term acute care hospitals (LTACHs), inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs), and home health agency (HHA) services in the home. Due to the high average daily cost in the first three settings, most ACOs are primarily focused on moving SNF admits to lower intensity of care sites such as home care.

SNF costs generally average between $10–14K per admission compared to home health care at ~$3K. The latter assumes four hours per day at $21/hour for 25 days, plus other costs. Similarly, among SNFs, there is a wide cost variance that may lend to optimization opportunities.

Features:

There are two primary sources of value that can reduce overall SNF cost:

- Redirecting up to 15% of existing SNF admits to home care with an HHA
- Creating a preferred SNF network and increasing transfers to preferred facilities by 25%

3. Reducing ED Visits

Emergency departments (EDs) are the healthcare settings where patients are treated for acute life-threatening or severe health issues such as fatal injuries, accidents, and heart attacks. Given the critical conditions that are treated in an ED, the cost of visiting one can be exceptionally high. Lack of awareness, variable care quality, communication lags, and missing information can lead to unnecessary duplication of care that can lead to high costs.

We have leveraged the New York University ED algorithm to classify the types of ED visits into four buckets:

- **Non-emergent Visits:** An unnecessary ED visit that could have been avoided.
- **Emergent but Treatable through Primary Care Visits:** A visit that could have been seen in the office or handled at an urgent care center
- **ED Care Needed but Preventable/ Avoidable Visits:** A visit that could have been prevented if appropriate chronic disease management and care coordination were in place
- **Non-avoidable Visits:** An urgent visit that can only be treated in an ED.

Features:

Additional sources of value include:

- Care managers perform a series of post-ED discharge weekly calls lasting one month for high-ED utilizers or post inpatient discharge patients. The goals of these calls are to anticipate issues, educate, prepare, and "tuck in" the patient over the weekend, assuring meds are refilled, concerns are addressed, and direction is given in the event issues arise. Tuck-in protocols are a proactive approach to decrease ED visits by high utilizers.
- Care managers can facilitate patient education through a comprehensive patient engagement tool.

4. Managing Referral Patterns

Coordinating care among in-service and out-of-network providers can prove difficult and time-consuming. Preventing patient "leakage" out of their network requires data, analytics, and insight that can help health systems in three main areas: patient retention, network optimization, and network growth planning.

We target the following areas:

- **Inefficient Referrals:** Patients do not see a high-performing specialist (per cost and/or quality metrics).
- **Poor Provider Match:** The patient is not referred to an appropriate provider and does not receive care that meets their needs.
- **Unsuccessful Scheduling:** Referrals are never put on the calendar and are not followed up.
- **Appointment Non-adherence:** Patient no-shows and lack of awareness of referral details.
- **Lack of Awareness and Association with Medical Savings:** Providers do not realize 8% more in savings by under-capitalizing specialist tiering.
- **Inability to Establish Referral Lists:** Using priorities like network adequacy, proximity to patient zip code or PCP office, and the patient's insurance network to establish referrals.

5. Preventing Unecessary Tests

Patients are often recommended to undergo tests that are not relevant to their treatment, or a single test is repeated at multiple labs or health centers due to a lack of communication and interoperability.

To avoid this, there should be a centralized data repository updated in real-time for all patients. This way, examinations and diagnoses are tracked, and duplication of high-cost tests can be prevented.

Also, patient education is an important factor in facilitating proactive responses from patients during their care journey.

6. Increasing Generic Drug Use

Reducing medication spend plays a key role in minimizing healthcare expenditure.

In a few Innovaccer studies of Medicare Advantage plans, we found out that physicians have the power to reduce up to ~10% of pharmacy expenses by prescribing less costly alternative medication equivalents. Using Walter Kluwer's data, we realized that only 20–30% of the potential savings can be realized from branded drugs and the remainder from generic equivalents.

With a focus on this value lever, we can help organizations realize savings and better manage their population's medication usage.

7. Increasing Medication Adherence

Medication adherence refers to whether patients take their medications as prescribed (e.g., one pill twice daily) and whether they continue to take prescribed medication for the recommended duration.

Ensuring that patients use their medications correctly and stick to the prescribed care program is a challenge for many healthcare providers. Mostly, it's patients with chronic conditions on long-term medication regimens who fail to follow their care programs.

As it can lead to poorly managed conditions, a decreased quality of life, or even disability and death, medication non-adherence has severe consequences on a population's health. Additionally, it negatively impacts healthcare expenditures.

About $300 billion of preventable healthcare costs can be attributed to medication non-adherence. This represents up to 10% of total healthcare costs.

We target the following factors contributing to non-adherence:

Condition-related Factors

- Lack of symptoms
- Severity of symptoms
- Depression
- Psychotic disorders
- Cognitive decline or disorders

Patient-related Factors

- Visual, hearing, and cognitive impairment
- Insufficient knowledge and understanding of disease condition
- Unrealistic perceived risk and susceptibility to disease
- Lack of perceived benefits of treatment
- Poor motivation and lack of confidence
- Denial or lack of knowledge of the consequences of non-adherence
- Untreated alcohol or drug use disorder

Health Care System Factors

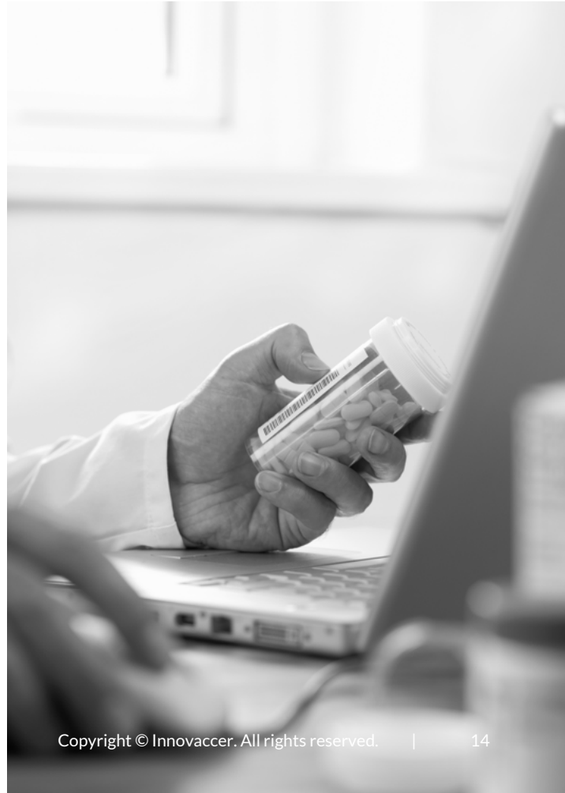
- Patient-provider relationship
- Long wait times
- Lack of care coordination and continuity
- Restricted formularies

Therapy-related Factors

- The complexity of the medication regimen
- Duration of therapy
- Frequent changes in the prescribed regimen
- Actual or perceived side effects

Social and Economic Factors:

- Limited language proficiency
- Low health literacy
- Unstable living conditions/ homelessness
- Lack of health insurance
- Medication cost
- Inadequate transportation or poor access



8. Reducing Network Leakage

Network leakage for ACOs occurs when its attributed patients are visiting practices or institutions not owned by or contracted with the ACO.

To provide integrated care across the continuum, healthcare organizations need to ensure that patients have maximum access to all levels of care services without going out of network. Most organizations lose about $200 to $500M per year due to network leakage, much of which is potentially avoidable.

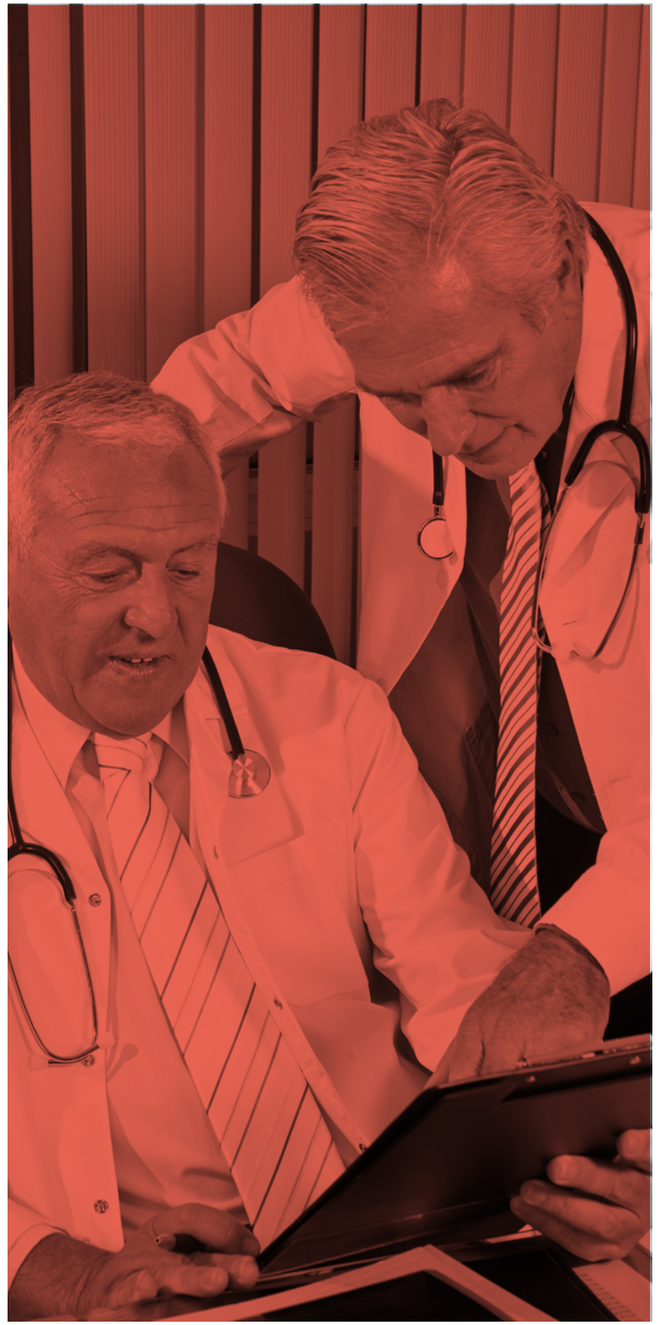
Common disadvantages of network leakage:

- Lost revenue to ACO-associated providers
- ACO does not have control overspending or the quality or efficiency of care provided outside the network
- Commercial contracts might also increase spending on certain patients or lead to ACOs paying out-of-network providers based on the type of contract

In the case of MSSP contracts, we have observed leakage ranging from 40–60%.

Typical sources of network leakage that we target through our strategy of real-time data integration and analysis include:

- Network PCPs referring to out-of-network specialists based on personal relationships (38%)
- Lack of provider understanding of the same/similar services within the network



9. Renegotiating Contracts

A critical but often overlooked aspect of VBC opportunities starts with contract negotiation, which includes setting realistic cost benchmarks and negotiating favorable contract terms.

This is a lever for which we provide significant hands-on consulting collaboration to support contract evaluation and management activities:

- **Diagnostic:** Review of existing contract terms/language and assessment of contracting opportunities.
- **Design:** Optimization of contract parameters.
- **Implementation:** Negotiation coaching, development of talking points, and preparation of fact-based evidence to support commercial payer discussions.

10. Improving Quality Measures

Quality measures assess care across the full continuum of healthcare delivery, from the level of individual physicians all the way to health insurance plans. Hundreds of quality measure variables are used for tracking quality performance in VBC arrangements.

The measures that we target in our strategy generally fall into four broad categories:

- **Structure:** Assesses the characteristics of a care setting, including facilities, personnel, supplies, and policies related to all aspects of care delivery.
- **Process:** Determines if the services provided to patients are consistent with and meet the standards for routine high-quality clinical care.
- **Outcome:** Evaluates utilization and patient health as a result of the care received, reviews hospitalizations, complications, and morbidity and mortality benchmarks.
- **Patient Experience:** Provides an outlet for patients to deliver feedback on their care experiences.

11. Improving Coding Accuracy

A risk score measures an individual beneficiary's relative risk. These scores are used to adjust payments for each beneficiary based on expected expenditures. Patient demographics and diagnosis data are required to calculate estimated risk using the various risk models defined by the Centers for Medicare & Medicaid (CMS).

Payers rely on clinical documentation and accurate coding to justify value-based reimbursement based on recorded patient risk.

We believe that proper documentation leads to improved patient-provider relationships within and outside of the healthcare system. We help in the accurate documentation of codes that drive increased efficiency, eventually leading to more effective patient care.

12. Retaining Low-Risk Members

This lever significantly affects performance and helps in retaining lower healthcare costs. We characterize it as monitoring members who are not high utilizers for network retention and optimization and endeavoring to create value by meeting their needs and improving their health outcomes.

13. Managing Chronic Conditions

Chronic care management services can be defined as tasks completed outside of traditional face-to-face office visits related to the care of a patient who has two or more significant chronic conditions. These tasks include proper medication management, communication with the patient or other physicians to coordinate care, devising care plans, and assisting physicians and care teams with round-the-clock services.

This lever focuses on managing chronically-ill patients with conditions such as diabetes, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), asthma, and hypertension among others. It caters to devising better care plans for these patients to ultimately help them adopt greater self-care.

14. Optimizing Risk Portfolios

Estimating risk scores for non-actuarial purposes such as disease management or cost containment on the provider side of healthcare is fairly new- primarily shadowing care management. For actuarial purposes, payers are interested in moderating the risk of an entire population. On the other hand, for non-actuarial purposes, an accurate patient-specific risk is required.

With the estimation of future risk scores, healthcare providers can gauge the likelihood of outcomes such as the number of hospital admissions, emergency department visits, and other factors.

Innovaccer has created a new risk scoring methodology which incorporates not only the historical claims data of the patients, but also the data from sources such as electronic health records, labs, pharmacy, and social determinants of health as its independent variables. By using advanced regression analysis, we have predicted the future cost of the patients with the coefficient of determination (R2) varying between 0.5 to 0.65. The coefficient of determination is a measure of the closeness of the predicted values to the actual values. In other words, it depicts the accuracy of the risk scoring model. This future cost estimated by our model can be used as a proxy for gauging the risk at an individual level.

15. Addressing Social Determinants of Health (SDoH)

The last lever focuses on the importance of incorporating social determinants of health (SDoH) data in the care processes. The Centers for Disease Control and Prevention (CDC) has defined an algorithm to estimate the Social Vulnerability Index (SVI) for every census tract in the U.S. However, this algorithm is based on a simple summation of the percentile ranks for all SDoHs, which results in an over-estimation of social vulnerability in cases of high positive correlation between multiple SDoHs.

In order to improve on the limitations of the CDC model, Innovaccer has developed proprietary algorithms to cater to social determinants. Innovaccer's approach uses 58 SDoH factors categorized into seven categories to analyze the social vulnerability index of regions across the nation drilled-down to the zip-code level.

How did Leading Healthcare Organizations Succeed in the Value-based Care Market?

Through our value-based care levers, Innovaccer has helped multiple leading healthcare organizations in achieving the best clinical and financial outcomes.

The concept adopts an operational mechanism to identify and capitalize on the value-based levers identified to track the progress.

What are OKRs?

OKR (Objectives & Key Results) is a goal setting & management methodology for businesses and organizations.

Who uses OKRs?

OKRs were invented at Intel and later made popular at Google. Today, numerous organizations use OKRs

intel amazon FACEBOOK Google Deloitte. Panasonic. Microsoft accenture High performance. Delivered.

Why use OKRs?

There are four main benefits of OKRs:

- **Alignment** – ensure everyone pushing in the same direction
- **Focus** – do the most important work
- **Transparency** – know what others are working on
- **Engagement** – own your results

Fig. 6: Operational Mechanism to Drive Focus

The Success Story of a Leading Midwest America-based Clinically Integrated Network (CIN)

A CIN in Midwest America adopted Innovaccer's value-based care levers approach to identify the key areas of focus. Prior to adopting the approach, the CIN was observing a loss of $26 million in shared savings. Later, the CIN partnered with Innovaccer to set up a data infrastructure to integrate their clinical and claims data. Once the data was integrated, they identified the domains that held the promise of better savings. Based on the insights obtained, the CIN focused on enhancing its Skilled Nursing Facilities (SNFs) and care management approach.

With a data-driven value-based lever approach, the organization was able to increase its shared savings from a loss of $26 million to a profit of $12 million in just 3 years.

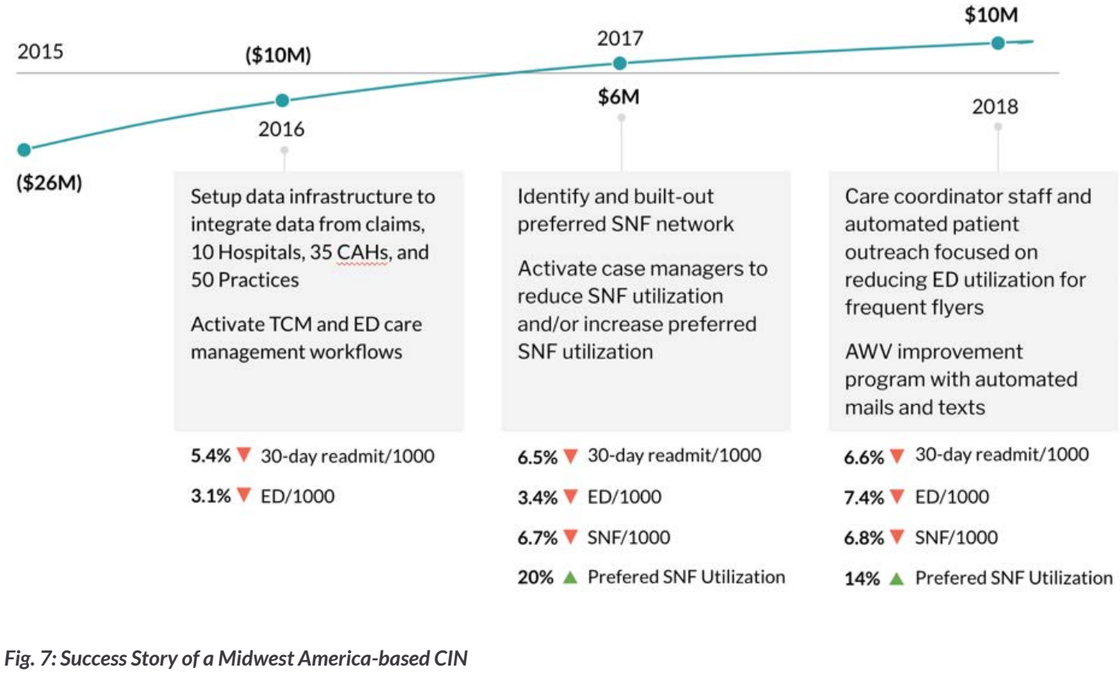


Fig. 7: Success Story of a Midwest America-based CIN

Success Story of a Leading Florida-based Accountable Care Organization (ACO)

A leading Florida-based ACO adopted a smart strategy toward improving the key factors affecting its overall value-based outcomes. Three critical performance levers were highlighted based on 2018 claims data with nine months of runout. The ACO completed the analysis on three of their most important parameters and identified a potential savings of up to $11 million in annual recurring medical expense by targeting four key initiatives described in the graph below:

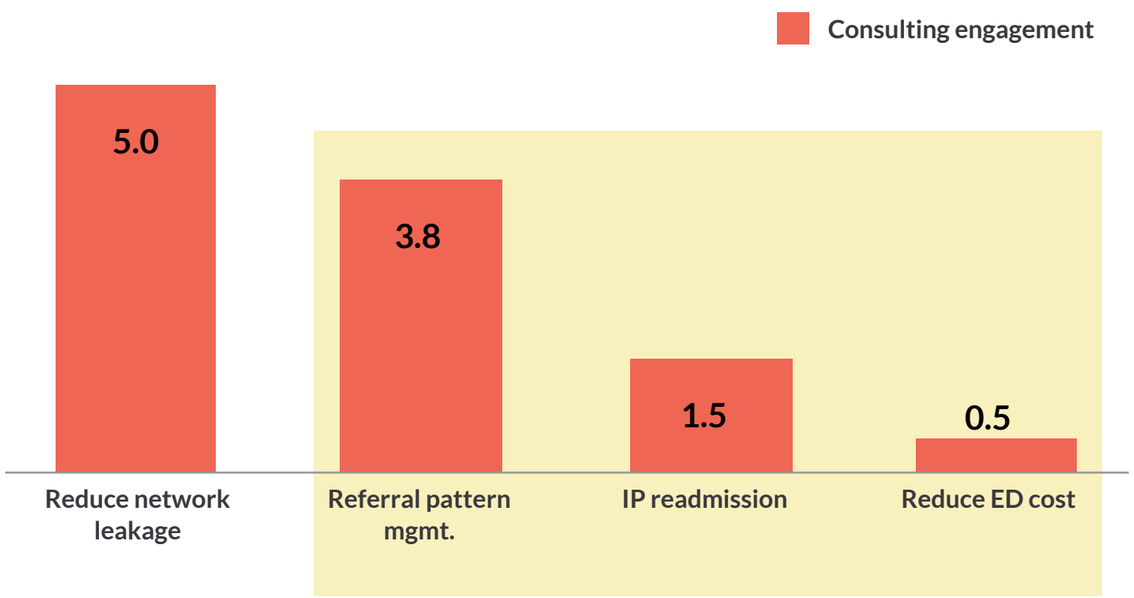


Fig. 8: Estimated savings opportunity per lever ($M)

The ACO projected a modest 5% improvement of the current $100 million out-of-network spends by reducing network leakage. It also projected $3 million and $0.8 million savings opportunities from the referral pattern management for MSSP and Allegiance, respectively, in certain disease-specific categories.

Based on an in-depth analysis, the following levers were identified and prioritized:

- **Referral Pattern Management:** The ACO performed an analysis of the top five disease-specific groupings, including orthopedics, sepsis, CHF, COPD, and ESRD. Based on the analysis, the ACO discovered close to $4 million of actionable savings by creating tiers of high-value specialist physicians, 75% of whom were associated with MSSP.
- **Reducing ED Spend:** The ACO observed around 5,000 avoidable ED visits, 94% of which were potentially redirectable to alternate service sites. Assuming 15%–40% of those were successfully redirected to primary care or urgent care, savings from ED spend could be in the $500K–$1.3 million range.
- **Reducing 30-day Readmits:** Patients who successfully completed TCM protocols saw an 8% lower readmission rate compared to the average number of patients discharged from the hospital, likely driven by the outperformance of a single care manager.

Innovaccer's FHIR-enabled Data Activation Platform Powers Innovation in Care Delivery

Innovaccer's FHIR-enabled Data Activation Platform was built to empower healthcare organizations to activate their healthcare data and perform multiple-level care operations with ease. With its 300+ automatic connectors to widely used healthcare data systems and applications, the platform enables rapid integration and generates actionable data for use at the point-of-care.

The FHIR-enabled Data Activation Platform reaches beyond the basic EHR clinical data to ensure that providers do not make decisions based on an incomplete view of the patient. The care team is provided with multidimensional insights into patients' living conditions and how other social and behavioral factors impact their overall health status.

The following solutions are built on Innovaccer's FHIR-enabled Data Activation Platform:

incare

A smart, AI-assisted care management solution, InCare has Patient-Centered Medical Home level care delivery hardcoded into the workflow. InCare streamlines the care management process, enabling systems to scale these programs at a lower cost and with higher quality.

ingraph

This a state-of-the-art analytics and reporting solution has more than 800 measures to track network performance and outcomes. It provides customizable measures and dashboards that are accessible across the network, along with automated reporting on quality measures.

innote

This smart, lightweight physician's digital assistant provides a critical system and population health insights derived from multiple data sources at the point of care. Using InNote, the recognition of care gaps, dropped codes, process measures, and referrals information can be shared with the clinician—without them having to leave the EHR experience.

inconnect

An automated analytics-driven patient engagement solution that scales patient outreach workflow, InConnect will bring patients closer to the care team.

inapi

From demographics to measures, to attributions, InAPI has a vast library of APIs to support any operation.

Conclusion

Value-based care is not guesswork. Here at Innovaccer, we have formulated a clear framework and developed processes to help healthcare organizations assess, design, activate, and implement proven solutions to navigate effectively and succeed in a value-based world. In the new normal of healthcare, value-based care is going to be on the frontlines of delivering the best care to patients. In order to ensure that healthcare organizations are on top of achieving clinical and financial excellence, they need a strategic plan to focus on high-yield areas and operationalize for impact. To become successful in VBC, it is imperative that organizations begin to tackle their most significant value levers with a systematic and laser-focused approach.

About the Authors

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Dr. David Nace is the Chief Medical Officer at Innovaccer where its category creating healthcare data activation platform is on a mission to organize healthcare information and make it accessible, useful, and actionable. Dr. Nace has over 25 years of executive management experience in large healthcare systems, payer health plans, and leading healthcare provider and health information technology organizations. With strong collaborative and cross-functional leadership skills, he previously served as SVP, CMO with United Health Group and VP, CMO with Aetna, and CMO at McKesson. Dr. Nace earned his medical degree from the University of Pittsburgh.

Kanav Hasija

Co-founder and Chief Customer Officer, Innovaccer, Inc.

Kanav Hasija is the Co-founder and Chief Customer Officer at Innovaccer, Inc. He has an engineering degree from the Indian Institute of Technology (IIT), Kharagpur, and Master in Patent Law from the University of New Hampshire School of Law. Over the years, he has gathered significant experience in the field of healthcare data analytics and entrepreneurial expertise, which has garnered him widespread international acclaim. He has received 'Franklin Pierce IP Scholar' for Academic and Research Efforts in the field of IP at Franklin Pierce Center for IP at UNH School of Law. He has received the 'Graduate Student Award' for providing exemplary leadership and global perspective by teaching, learning, or contributing productively to a global legal system at UHN School of Law. He has also received the inaugural Samsung-Stanford Patent Prize for publishing a paper on Patent Damages at Samsung Corporation, Stanford Law School.

About Innovaccer

Innovaccer, Inc. is a leading San Francisco-based healthcare technology company committed to making a powerful and enduring difference in the way care is delivered. The company leverages artificial intelligence and analytics to automate routine workflows and reduce manual overhead to facilitate more person-centered care. Its KLAS-recognized products have been deployed all over the U.S. across more than 1,000 locations, enabling more than 37,000 providers to transform care delivery and work collaboratively with payers. Innovaccer's FHIR-enabled Data Activation Platform has been successfully implemented with healthcare institutions, private health plans, and government organizations. By using the connected care framework, Innovaccer has unified records for more than 24 million members and generated more than $600M in savings.

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