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Educational Webinar Series

WEBINAR 4 OF 4 · ZYNIX 2026 VALUE-BASED CARE SERIES

The 2027 Value-Based Care Automation Playbook

What to automate first, how to prove ROI, and when to scale

Thursday, November 5, 2026

JC **Jay Chowdappa, MD**
Physician & ACO Executive

GC **Gautam Chowdary**
CTO, Zynix AI

PI **Pooja Ika**
CEO, eternalHealth

MM **Mike McCabe**
Healthcare Executive

TODAY'S PANEL

Four lenses on what to automate in 2027

JC

Jay Chowdappa, MD

President & CEO, NHS

Physician and ACO executive

LENS

ACO and physician operations

PI

+ PANELIST

Pooja Ika

CEO, eternalHealth

Medicare Advantage plan in Massachusetts and Arizona

LENS

Health plan and member experience

GC

Gautam Chowdary

CTO, Zynix AI

Healthcare AI, data and interoperability

LENS

Execution, data and governance

MM

MODERATOR + PANELIST

Mike McCabe

CEO, Onadvisors LLC

Health plans, Medicaid managed care, PCAs and FQHCs

LENS

Medicaid and community health

WHERE WE HAVE BEEN

Three webinars built the case. Today: the playbook

MARCH

01

Automation with accountability

Can we scale engagement safely?

MAY

02

A real-world ACO use case

Can one workflow close the loop?

SEPTEMBER

03

The AI operating layer

What makes it repeatable?

TODAY · NOVEMBER 5

04

The 2027 automation playbook

What first? What ROI? When to scale?

Today's goal: a prioritized 90-day plan, not a longer AI wish list

Today's 60 minutes

0:00	**Welcome and panel**		Host, Mike	3 min
0:03	**The 2027 reality: automation today**		Jay	7 min
0:10	**What to automate first**	POLL 1	Jay, with Pooja and Mike	10 min
0:20	**How to execute safely**	POLL 2	Gautam	12 min
0:32	**How to prove ROI and when to scale**		Gautam, Jay	13 min
0:45	**Moderated panel and your questions**		Mike, with Pooja, Jay, Gautam	15 min

01

The 2027 reality

Why **next year is about completed care**, not mere insights



Jay Chowdappa, MD

Jay Chowdappa, MD JC

2027 raises the bar on completed care

ACOs/MSOs

Savings still hinge on quality & cost

REACH ends 2026

Medicare Advantage

Stars and risk-adjustment scrutiny keep gap closure in focus

LEAD model

10-year ACO model after REACH, built to include CHCs and rural practices

Starts Jan 1, 2027

ACCESS Model

Outcome-aligned payments for chronic care; new tracks April 2027

Live since Jul 2026

Insight is abundant. Completed care and capacity are scarce.

2027 brings new rails, and new guardrails, for automation

NEW RAILS
Making automation easier to connect

JAN 1, 2027 — Payer APIs for prior authorization and provider data access go live (CMS-0057-F)

2026–2031 — WISeR tests AI-assisted prior authorization in Original Medicare in six states

700+ — organizations pledged to CMS's Health Tech Ecosystem, including conversational AI

NEW GUARDRAILS
Keeping automation accountable

TCPA — Healthcare coordination calls benefit from established consent pathways and limited exemptions. Consent and opt-out rules apply (FCC, 2024)

STATE LAWS — AI interactions may require patient disclosure, with requirements varying by state and clinical context.

SECTION 1557 — Identify and reduce bias risk in clinical decision-support tools (HHS, 2025)

in 2027, automation has to be connected and accountable.

Sources: CMS-0057-F; CMS WISeR model page; CMS Health Tech Ecosystem (Apr 2026); FCC declaratory ruling (Feb 2024); Cal. AB 3030; Tex. HB 149; 45 CFR 92.210. Policy context, not legal advice.

AI use is widespread. Automated follow-through is not.

81%

of physicians use AI in their practice, up from 38% in 2023

AMA physician survey, 2026

84%

of health insurers **use AI or machine learning** in some capacity

NAIC survey of 93 insurers, 2025

22%

of healthcare organizations have put **domain-specific AI tools** into use

Menlo Ventures, 2025

3%

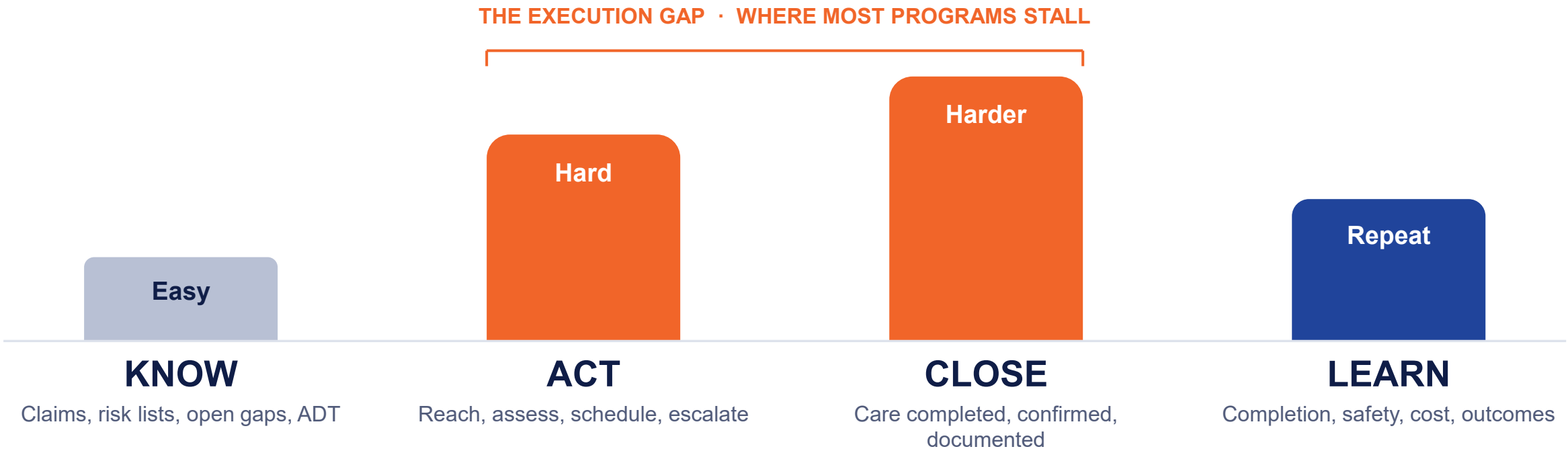
of provider organizations run **AI agents in live workflows;** 43% are still piloting

Microsoft and The Health Management Academy, 2026

The gap: it isn't insight. It's follow-through: reaching the patient, completing the care, closing the loop.

Jay Chowdappa, MD JC

Knowing is easy. Acting is hard. Closing is harder.



16% **of TCM-eligible Medicare discharges received TCM**
2018–19 data · HHS ASPE, 2023

36% **of traditional Medicare patients had an annual wellness visit**
2019 data · JAMA Health Forum, 2026

Start with the need : not the vendor

Six steps to decide what to automate, what to keep, and when to scale.

01 ASSESS

What do you already have? Where does care fall through?

02 PRIORITIZE

Score high-value gaps; apply the safety gate.

03 BUILD OR PARTNER

Use existing systems; buy or integrate only what is missing.

04 PILOT

Launch a controlled cohort with clinical oversight.

05 PROVE

Track completed care, cost, safety and outcomes.

06 SCALE

Expand, correct or stop using an evidence-based gate.

NEEDS ASSESSMENT: Existing tools • Staff capacity • Broken handoffs • Data access • Accountable owner

Jay Chowdappa, MD JC

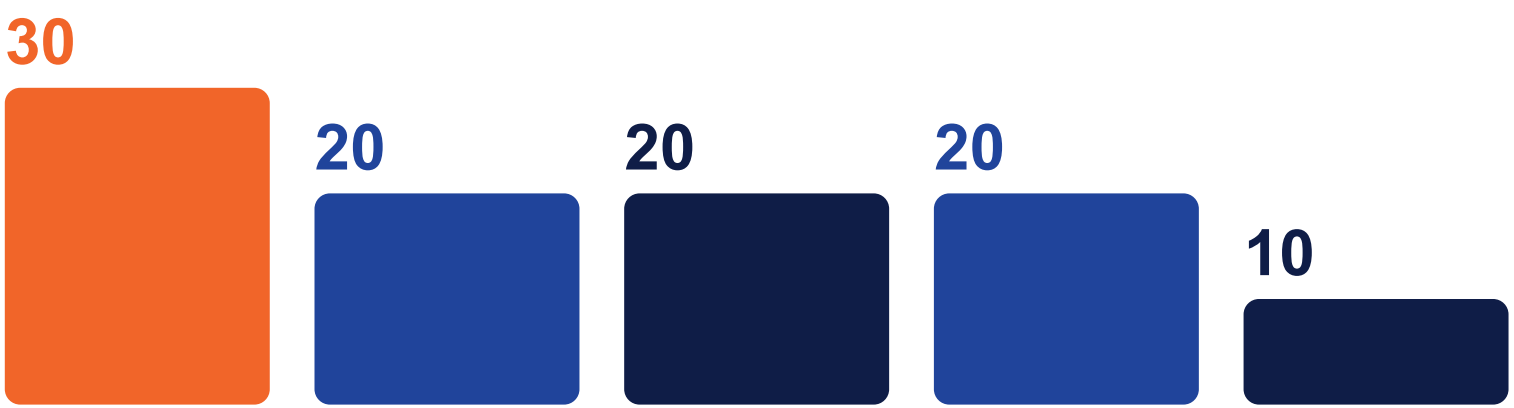
After the needs audit, score the opportunities

SAFETY CHECK (YES / NO)

All three must be yes before you score

- Red flags reach a clinician
- Consent and opt-out honored
- Each exception has an owner

PRIORITIZE · SCORE OUT OF 100



Value
How much clinical or financial value?

Volume
Enough patients to matter?

Readiness
Data and an owner in place today?

Measurable
Results visible in 90 days?

Adoption
Will staff and patients use it?

Highest score goes first. Weights are illustrative; tune them to your contracts and population.

Jay Chowdappa, MD JC

There is no universal first workflow

Health plan	ACO	Risk-bearing group	Care management team	Health center
Medicare Advantage, Medicaid	MSSP, LEAD	Full-risk groups, MSOs	Plan, ACO or health system	FQHCs, PCAs
OFTEN STARTS WITH	OFTEN STARTS WITH	OFTEN STARTS WITH	OFTEN STARTS WITH	OFTEN STARTS WITH
Medication adherence and refills	**Post-discharge and AWV outreach**	**HCC and pre-visit support**	**AI-embedded care management**	**Access, care-gap outreach, HRSN and CBO closed loop**
WHY	WHY	WHY	WHY	WHY
Adherence measures drive Star Ratings	**Total cost of care and quality move together**	**Complete documentation, confirmed by a clinician**	**Risk stratification route patients to check-ins and tasks**	**Thin staff; care gaps drive quality scores**

Any of these can go first.

Jay Chowdappa, MD JC

One workflow, three operating models

Post-discharge follow-up in a health plan, an ACO and a community health center network

	Health plan Medicare Advantage	ACO/MSO MSSP, REACH, LEAD	Health center network FQHCs, RHCs, PCAs
TRIGGER	Discharge notice or ADT	ADT alert from hospital or HIE	ADT feeds across many EHRs
WHO ACTS	Plan care managers with network PCPs	ACO/Practice care team (TCM)	Care coordinators and CHWs
DONE WHEN	Follow-up visit and med reconciliation	Contact in 2 business days, visit kept	Visit kept, barriers resolved
LEADERS WATCH	TRC measure, readmissions	TCM completion, total cost	Kept visits, staff hours

LIVE POLL 1 OF 2

What would you automate in 2027?



Pick the one you could launch and measure in 90 days.

Choose one or more answers

- A Post-discharge and transitions of care
- B AWVs and preventive gaps
- C Medication adherence and refills
- D Chronic care management
- E After-hours and patient access

PANEL CHECK-IN

Does the poll match what you see?

PI

Pooja Ika

HEALTH PLAN LENS

Where would a Medicare Advantage plan start in 2027, and why?

MM

Mike McCabe

MEDICAID AND COMMUNITY HEALTH LENS

What changes for Medicaid plans, health centers and community-based organizations, where staff are thin and EHRs are fragmented?

03

How to execute safely

One loop, integration without waiting, and oversight by design

GC Gautam Chowdary, CTO, ZYNIX.AI

LIVE POLL 2 OF 2

What most often stops AI from scaling?



Choose the biggest barrier today, not the biggest long-term issue.

Choose one or more answers

- **A** EMR and data integration
- **B** Staff adoption and trust
- **C** Clinical governance and liability
- **D** Proving ROI

Gautam Chowdary GC

Define closure before the first outreach

01 Trigger
ADT, due list or open gap

02 Prioritize
Who first, and why

03 Reach
Voice, text or portal, in the patient's language

04 Assess
Protocol-driven questions

RED FLAG → CLINICIAN

05 Book or route
An owned next step, every time

06 Complete
Visit, lab or refill

YOUR CARE TEAM

07 Write back
Structured result in the record

08 Measure
Stage and outcome, every week

A risk score changes nothing until it becomes an owned action.

Gautam Chowdary GC

One implementation example: Zynix workflows

Build on what you own; add missing capability. Clinical decisions remain human.



LIVE: running with Zynix customers today. PILOT: early deployment, scope set per client. Depth varies by client, permissions and EMR access.

Gautam Chowdary GC

One discharge. Eight steps. Two distinct responsibilities.

Illustrative post-discharge follow-up. A red flag at step 4 goes straight to an RN or clinician.

1. TRIGGER
ADT discharge received

DATA SIGNAL

2. MATCH
Identify the patient and outreach rules

ZYNIX

3. REACH
AI voice or text initiates logistics outreach

ZYNIX

4. FLAG
Symptom / medication question routed to RN

ZYNIX → TEAM

5. ASSESS
Licensed staff complete clinical TCM contact

CLINICAL TEAM

6. BOOK
Follow-up appointment coordinated and reminded

ZYNIX + PRACTICE

7. VERIFY
Visit kept and clinician documentation confirmed

PRACTICE RECORD

8. MEASURE
Record outcome, review conversion weekly

SHARED SCORECARD

Success means the right clinical action happened and is documented : not simply that an AI call was completed.

Gautam Chowdary GC

Don't let the EMR backlog stall every workflow

DAY 1

Start with what you have

Claims, ADT, due lists and scheduling files

NEXT

Close the loop in the record

Structured write-back and exception routing

LATER

Go deeper where it pays

FHIR and APIs, prioritized by volume and ROI

DAY-1 NON-NEGOTIABLES

- **Patient identity matching**
- **Consent and contact preferences**
- **Reconciliation to the source record**
- **A named owner for every hand-off**

Zynix today: 30+ EMR types connected across hundreds of practices.

Gautam Chowdary GC

Human oversight is designed in, not disclaimed

TIER 1

Administrative

Scheduling, reminders and logistics

Automated, routinely audited

TIER 2

Structured clinical info

Check-ins, symptom and medication questions

Protocol + licensed escalation

TIER 3

Clinical decisions

Diagnosis, treatment and care plans

A clinician decides

More automation → More human judgment

Every tier: AI disclosure · consent and opt-out · audit trail · bias checks · escalation monitoring

Gautam Chowdary GC

From prediction to action: risk and waste

Actionable predictive risk CKM & CKD progression models: in validation* LIVE	**SCORE** Readmission, ED and admission risk	**ROUTE** Prioritized care-manager queue	**ACT** AI outreach plus a care-manager task	**MEASURE** Visit kept, care completed, outcome tracked
Waste Guardian Early warning for waste and abuse PILOT	**SCAN** Claims every month: DME, drugs, utilization	**FLAG** Unusual patterns, with the evidence attached	**REVIEW** A person investigates every flag	**ACT** Provider outreach, education or audit

Signals prioritize. People decide.

04

Prove ROI, then scale

Measure completion, count every cost, and earn the right to expand

GC JC **Gautam Chowdary · Jay Chowdappa, MD**

Gautam Chowdary GC

Report completed care every week, not activity

WEEKLY

Eligible

Cohort and denominator fixed before launch

WEEKLY

Completed

Visit kept, screening done, refill filled

WEEKLY

Documented

Written back, with lag tracked in days

MONTHLY

Outcomes

Quality, utilization and staff hours

Safety and equity, every week: escalation time · complaints · opt-outs · results across populations

Jay Chowdappa, MD JC

Don't confuse activity with savings

VALUE YOU CAN VERIFY

- **Incremental completed care**
- **Quality measures closed**
- **Capacity redeployed**
  Only if staffing or throughput changes
- **Utilization change**
  Needs time and sound attribution

−

FULLY LOADED COST

- **Platform and implementation**
- **Integration and data operations**
- **Clinical oversight and escalations**
- **Training and change management**
- **Compliance and QA**

=

NET VALUE

Judged per completed workflow

Ask a vendor, (including us), for cost per completed workflow.

Jay Chowdappa, MD JC

What live programs have shown so far

OUTCOME

20%

increase in TCM follow-ups, from baseline

OUTCOME

22–25%

increase in AWVs completed, from baseline

SCALE

1M+

attributed lives on the platform

SCALE

30+

EMR types connected

Zynix customer programs. Increases are measured from baseline; results vary by population, staffing and appointment supply.

Jay Chowdappa, MD JC

Run the math: annual wellness visits

10,000
patients due an annual wellness visit

5,000
completed at baseline (50%)

7,000
completed with the AI Outreach program (70%)

+2,000
more completed visits (+20 %)

EACH ADDED VISIT IS WORTH MUCH MORE THAN THE VISIT FEE · WHAT PUBLISHED STUDIES FOUND

Quality gaps closed
Higher odds (1.5–2.4×) of preventive services after an AWV
Jiang et al., Prev Med 2018

Conditions documented
Higher MA risk scores with AWVs; clinician-confirmed conditions only
Zhang et al., JAMA Health Forum 2026

Earlier detection
Earlier Detection and more advance care planning
JAMA Netw Open 2024; JAGS 2026

Total cost of care
upto 5% lower RA cost comparatively in AWV patients
Health Affairs 2019; Am J Manag Care 2019

Measure locally: research sets expectations; your own baseline and a comparison group prove value.

Jay Chowdappa, MD JC

Run the math: post-discharge follow-up

1,000
Medicare discharges a year

500
followed up at baseline (50%)

700
followed up with the AI outreach program (70%)

+200
more patients followed up (+20 %)

THE READMISSION MATH, USING PUBLISHED AVERAGES

200
added follow-ups

×

15.4%
Medicare 30-day readmission rate[1]

×

22–32%
lower readmission risk with follow-up[2]

=

≈7–10
readmissions avoided

→

≈$120–180K
avoided hospital cost, at $18,100 each[3]

Also published: **TCM recipients had lower costs and mortality in days 31–60 after discharge (JAMA Intern Med 2018). High-risk care management in a Pioneer ACO was associated with 8% fewer hospitalizations and 6% lower spending (Health Affairs 2017); an untargeted program showed no effect (NEJM 2020).**

Measure locally: **research sets expectations; your own baseline and a comparison group prove value.**

Jay Chowdappa, MD JC

First 90 days: prove completion and safety

DAYS 0–30

Set up

- ✓ Audit assets; select 1–2 gaps
- ✓ Baseline + closure definition
- ✓ Name escalation owners
- ✓ Confirm data, consent, privacy

DAYS 31–60

Launch

- ✓ Start with controlled cohorts
- ✓ Review the scorecard weekly
- ✓ Audit escalations and transcripts
- ✓ Fix workflow defects fast

DAYS 61–90

Decide

- ✓ Reconcile completed care
- ✓ Total the fully loaded cost
- ✓ Review safety and equity
- ✓ Scale, fix or stop

Exit gate: verified completion + safe escalation + credible economics → scale, fix or stop

Jay Chowdappa, MD JC

Over the first 12 months: earn the right to scale

START ANYWHERE · ANY OF THESE CAN BE YOUR FIRST WORKFLOW

AI outreach PDV/AWV | Medication adherence | AI-embedded care management | HCC and pre-visit Review

= YOUR 90-DAY PLAN

MONTHS 0–3

Prove

Your first one or two workflows, a baseline and governance

MONTHS 3–6

Expand

Add the next workflow your score supports

MONTHS 6–9

Connect

Link workflows: shared queues, pre-visit context, write-back

MONTHS 9–12

Optimize

Unit economics, validated models, next-best actions

A go/no-go gate at every step. Scale on verified performance, not on AI features deployed.

THE PLAYBOOK ON ONE PAGE

Your 2027 automation decision

Apply the same six steps regardless of your organization or existing technology.

01 ASSESS

What do you already have? Where does care fall through?

02 PRIORITIZE

Score high-value gaps; apply the safety gate.

03 BUILD OR PARTNER

Use existing systems; buy or integrate only what is missing.

04 PILOT

Launch a controlled cohort with clinical oversight.

05 PROVE

Track completed care, cost, safety and outcomes.

06 SCALE

Expand, correct or stop using an evidence-based gate.

YOUR NEXT MOVE: **Choose one failing workflow; map the gap, measure closure, then make a 90-day go/no-go decision.**

MODERATED PANEL · 15 MINUTES

From playbook to practice:

Moderated by Mike McCabe, with Pooja Ika, Jay Chowdappa and Gautam Chowdary

MM

Mike McCabe

Healthcare Executive & Advisor

MODERATOR

PI

Pooja Ika

CEO, eternalHealth

HEALTH PLAN

JC

Jay Chowdappa, MD

ACO Executive; CEO, NHS

ACO

GC

Gautam Chowdary

CTO, Zynix AI

TECHNOLOGY

Send your questions now in the Questions panel

ROUND 1 OF 3 · ABOUT 3½ MIN

Proving value

“What evidence would make you renew or expand an automation program?

ANSWERING

PI **Pooja Ika**
Health plan

→

JC **Jay Chowdappa, MD**
ACO

Moderator: Mike McCabe

ROUND 2 OF 3 · ABOUT 3½ MIN

Earning trust

“What has to be true before AI talks to your members and patients?

ANSWERING

GC **Gautam Chowdary**
Controls

→

PI **Pooja Ika**
Member trust

Moderator: Mike McCabe

ROUND 3 OF 3 · ABOUT 2½ MIN · SKIP IF BEHIND

Sharing the work

> **Who should own outreach, escalation and closure: the plan, the ACO or the practice?**

ANSWERING

JC **Jay Chowdappa, MD** — ACO → PI **Pooja Ika** — Health plan → MM **Mike McCabe** — Health centers

Moderator: Mike McCabe

YOUR QUESTIONS

Ask the panel

Type your question in the Questions panel. Mike will route it to the right panelist.

- **Proving ROI before utilization data matures**
- **Day-1 data and integration**
- **Plan and provider roles**
- **Patient safety at scale**



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THANK YOU FOR JOINING OUR 2026 SERIES

Make 2027 the year of completed care

Assess the gap. Prove completed care. Scale responsibly.

Map one workflow with us in 30 minutes

calendly.com/jay-reeser-zynix/30min · jay.reeser@zynix.ai · zynix.ai

Thank you to Pooja Ika, Mike McCabe and VBC Exhibit Hall.

Q&A

Audience questions

Send yours in the **Questions panel**

JC Jay Chowdappa, MD

GC Gautam Chowdary

PI Pooja Ika

MM Mike McCabe

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NEXT STEP

Thank you

Scan to book a 30-minute call with our team

calendly.com/jay-reeser-zynix/30min

jay.reeser@zynix.ai · info@zynix.ai

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