waymark

Preventing costly acute care for your Medicaid members

Proven predictive technology and community-based care

Problem

Nearly 40% of acute care in Medicaid is avoidable

3x

higher than Medicare & commercial insurance

$50B

in unnecessary annual spending

Why it happens:

- Unmet social needs
- Gaps in primary care access and care coordination
- Behavioral health needs

Traditional care management programs miss these patients until they're already in crisis at the hospital/ER

Patel S.Y., Baum A., & Basu S. (2024). Geographic variations and facility determinants of acute care utilization and spending for ACSCs. American Journal of Managed Care, 30(11), e329–e336.

waymark

Waymark is a **AI-enabled Healthcare provider** with automated care and escalation to community-based human teams.

Our Approach

Waymark offers an AI-powered, human in the loop, solution that sharply reduces Medicaid care delivery costs

Patient Targeting

waymark
Signal™

Identify impactable rising-risk patients early

- Proactively identifies rising-risk patients before they become high-cost
- Continuously assess full population

Automated Concierge

waymark
COMPASS

Deliver effective, enduring interventions at scale

- Automated patient engagement
- Resolves routine clinical needs and connects members to social services and navigates benefits

Human Escalation

waymark
CareTeams

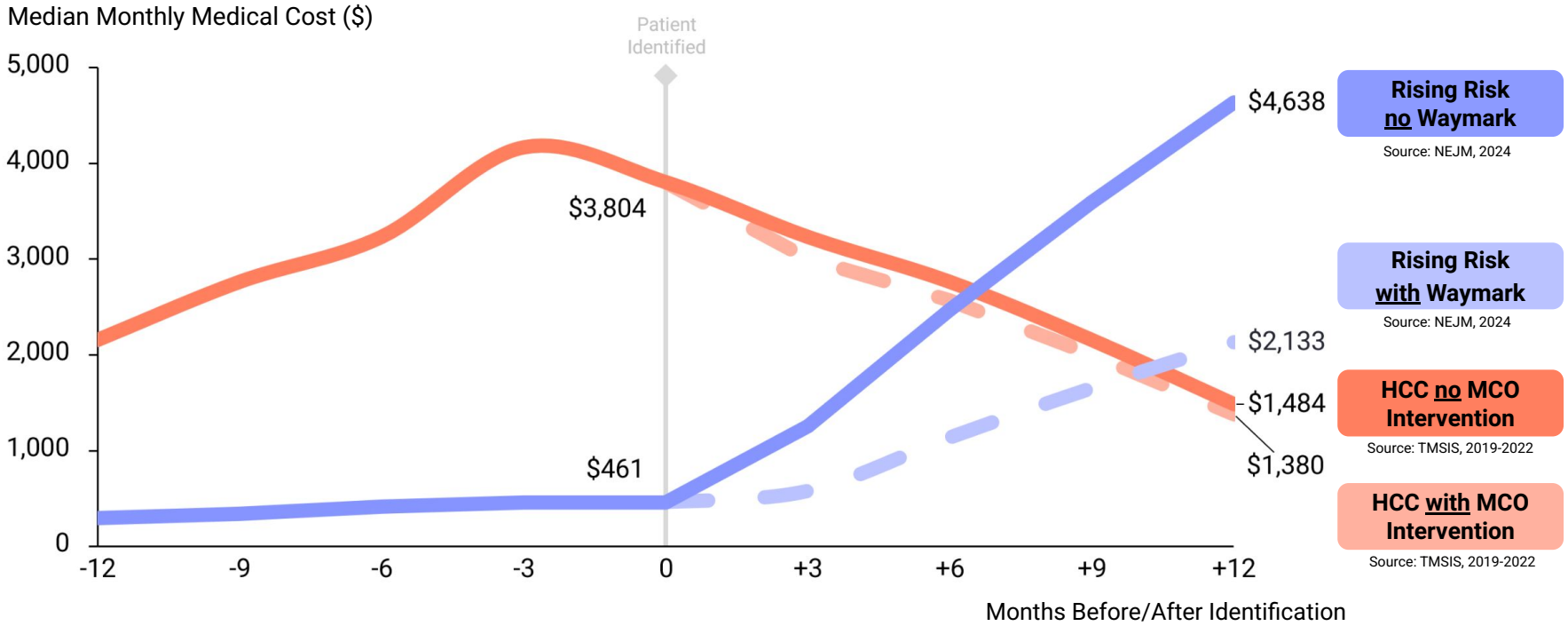
Seamlessly escalate to physician-led teams

- Complex cases routed to physician-led care teams
- Ensuring patient safety beyond what AI can handle alone

Patel, S. et al. Prediction of non emergent acute care utilization and cost among patients receiving Medicaid. Nature Scientific Reports; 14(1):824 (2024).

We target ‘rising risk’ patients, your future high cost claimants

Rising risk patients are those who are not high cost currently but will be within 6-12 months



Note: Data shown above is sourced from the TMSIS dataset for all Medicaid MCOs for 2019, 2021, and 2022 (excluding COVID year 2020) with a sample size of 49.4M Medicaid patients

1. Baum A, Batniji R, Ratcliffe H, DeGosztonyi M, Basu S. Supporting rising-risk Medicaid patients through early intervention. NEJM Catal Innov Care Deliv. 2024;5(11). doi:10.1056/CAT.24.0060
2. HCCs are defined as greater than $50k in allowed amount claims per person per year [standard actuarial definition] cumulative in any 12 month period for people with >3 months of eligibility
3. Meta-analytics population-weighted average reduction (https://pubmed.ncbi.nlm.nih.gov/36121357/, https://pubmed.ncbi.nlm.nih.gov/21993059/, https://pubmed.ncbi.nlm.nih.gov/32672916/, https://pubmed.ncbi.nlm.nih.gov/20860506)

We do this through the Waymark Signal™ Suite

Signal identifies which patients need support, who would benefit most, and what interventions to provide

Signal for Rising Risk

Rising risk targeting tool for multiple populations

80–90%
accuracy in predicting avoidable ER/IP visits

3X
higher accuracy than industry next-best algorithm

Built for Medicaid & Duals

nature SCIENTIFIC REPORTS

- **10x better prediction of care cost** than the standard CDPS model used by states and MCOs
- **Validated on data from 30.6 million patients** on Medicaid, the largest such sample size for a Medicaid-specific risk algorithm
- **Neutralized the Black-White prediction bias** in common cost-based risk models
- **Incorporates data from multiple sources** including individual and area-level SDOH, clinical history, demographics, and risk trajectory
- **Population-specific algorithms** for Medicaid, Duals, High-risk Maternity, and HEDIS

Patel, S. et al. Prediction of non emergent acute care utilization and cost among patients receiving Medicaid. Nature Scientific Reports; 14(1):824 (2024).

Compass then provides them a 24/7 AI-powered concierge

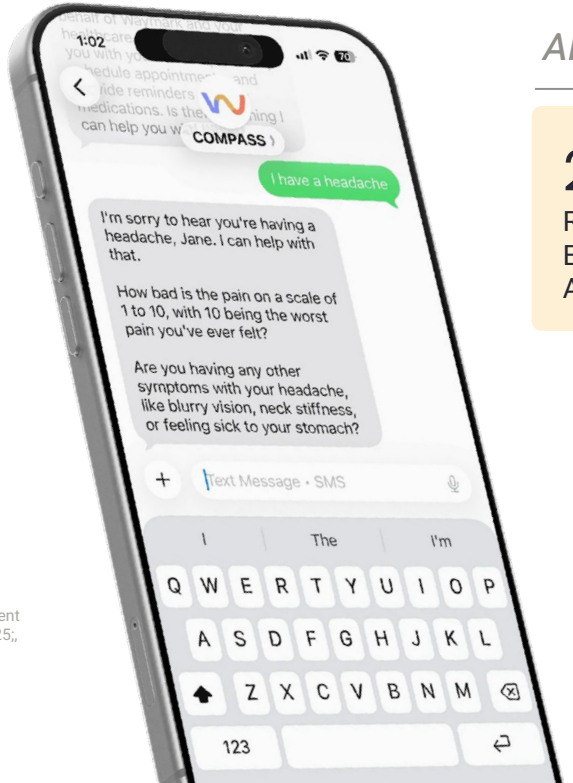
Giving members access to the care they need by adding PCP capacity to an already overburdened system

waymark

COMPASS

Clinically-validated AI-powered triage and navigation with active physician-in-the-loop oversight

- **Instant access** to SMS-based AI Care Navigation
- **Available 24/7** for patients
- **MD-validated** clinical guidance



AI built for Medicaid

20.7% JMIR
Reduction in Acute Care Events linked to AI-guided decisions

>2.8M
member months of patient data used to train our AI

92x
Safer than the top performing LLM

100%
Emergency detection across 65 categories

Basu et al Clinical decision support for population health management: development and validation of integrated acuity and intervention prediction models, JAMIA, 2025;, ocaf225, https://doi.org/10.1093/jamia/ocaf225

Basu et al Reinforcement Learning to Prevent Acute Care Events Among Medicaid Populations: Mixed Methods Study. JMIR AI 2025;4:e74264. doi: 10.2196/74264

Basu, Sanjay and Patel, Sadiq and Batniji, Rajaie, Identification of Within-Person Receptivity Windows to Optimize Multidisciplinary Care Allocation: A Causal World Model Development and Validation Study. Available at SSRN: https://ssrn.com/abstract=6094003 or http://dx.doi.org/10.2139/ssrn.6094003

Our Approach

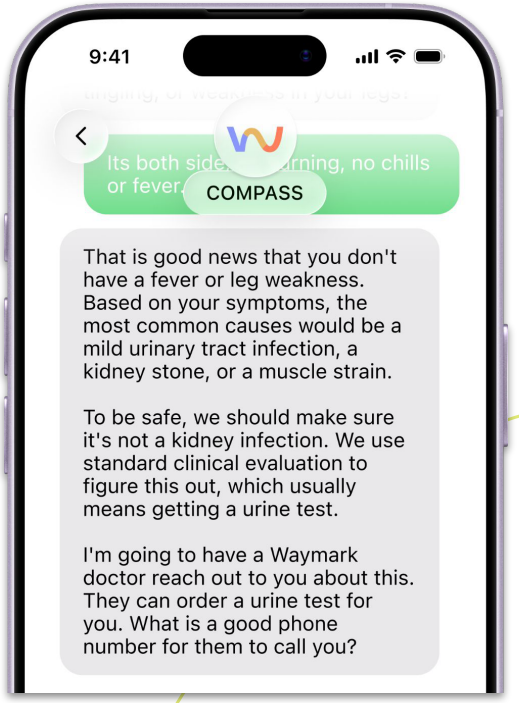
Compass AI completes outreach, triage, and escalation

Through text, Compass understands a members needs, connecting them to benefits, services, and guidance

Outreach

Triage

Clinical Escalation



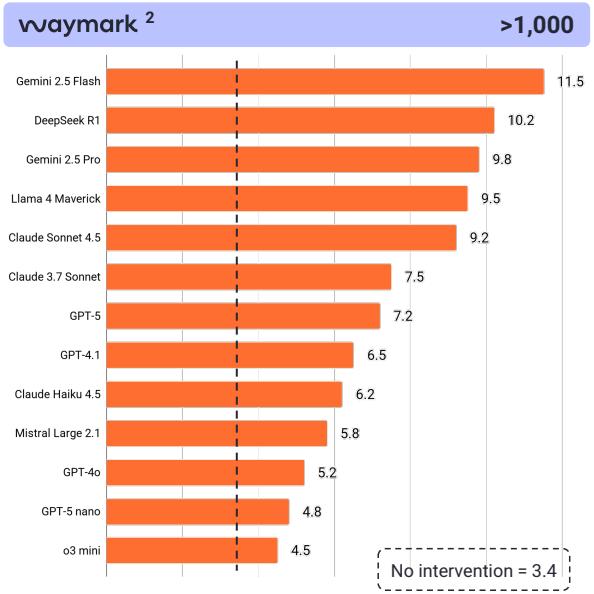
Our Approach

Waymark Compass is superior in detection and triage

Multi-framework triage and deterministic emergency detection for physician-in-the-loop escalations

System Type	Architecture	Sensitivity (True Positive)
waymark COMPASS	CQL + multi-framework ensemble safety checks + physician-in-the-loop	**83.0%** [1]
Non-LLM Approaches	Decision-theoretic controller (CQL)	72.7%
	Constellation architecture	68.5%
	Rule-based guardrails	60.0%
Classical ML Baselines	XGBoost + sentence embeddings	43.0%
	Logistic regression + TF-IDF	29.1%
Healthcare Safety Configuration (LLM Approaches)	DeepSeek-R1 (RAG)	32.7%
	GPT-5.1 (RAG)	40.0%

Numbers Needed to Harm (NNH) [3]

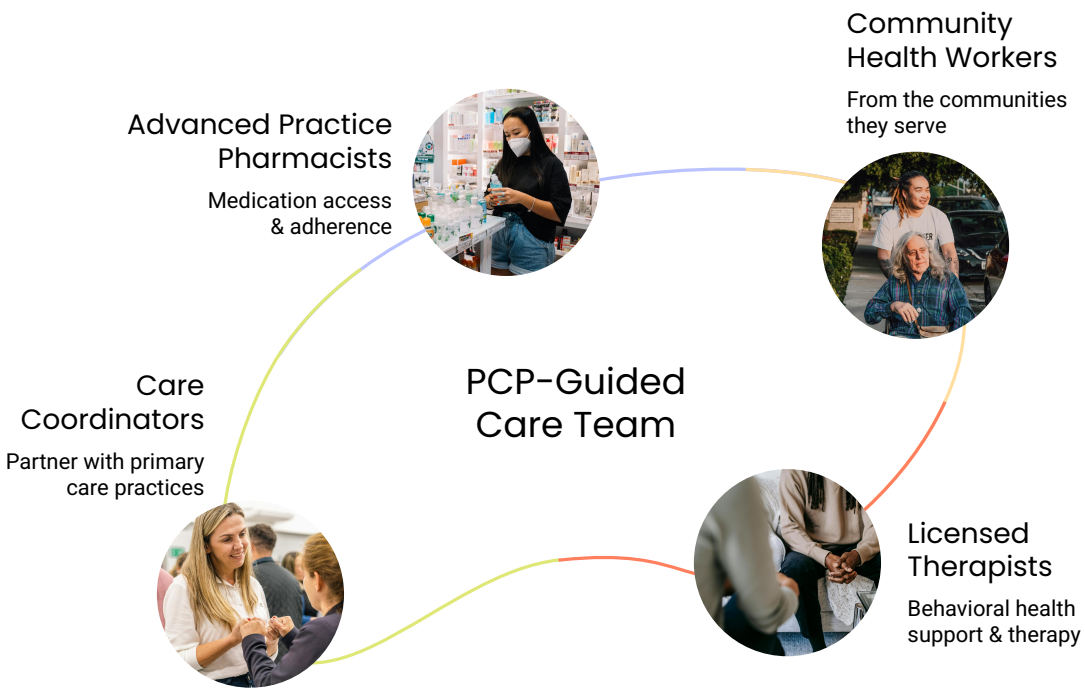


All clinical interventions reviewed by Waymark Physicians

1) Basu S, et al. Comparative evaluation of AI architectures for medical triage safety: a real-world validation study. JMIR AI. 24/02/2026:94081. DOI: 10.2196/94081
2) Waymark internal safety study aligned to traditional phase 1 safety study sample size of n=100; measures effect of reccomendation/escalation-type vs status quo
3)Wu D, Nateghi Haredasht F, Kumar Maharaj S, et al. First, Do NOHARM: Towards Clinically Safe Large Language Models. arXiv:2512.01241. 2025. mesures absolute action level performance on specialist-annotated cases.

Our Approach

For more complex patients, Waymark closes the loop with virtual community care teams ensuring higher clinical impact



Services

- **Accompaniment & Navigation**
  Access clinical and social care
- **Chronic Condition Support**
  Prevent complications and crises
- **Behavioral Health Therapy***
  Therapy and coordination
- **Social Services Coordination**
  Housing, food, transportation, etc.

Waymark model ensures impact through human judgement for complex patient cases when needed

Note: Under this arrangement, Licensed Therapy services would be billed FFS in addition to the PMPM fees that cover all over Waymark services
Patel, S. et al. Prediction of non emergent acute care utilization and cost among patients receiving Medicaid. Nature Scientific Reports; 14(1):824 (2024).

Our Impact

We engage 45%+ of the patients we target for our programs

We continuously monitor the total assigned population to catch rising risk as it happens

Rising Risk Patients

96%
Patient Satisfaction Score

100%
Targeted

Approach:

Continuous population monitoring enabling dynamic targeting

Advanced DS models predict patients most likely to benefit

45%
Engaged

Approach:

Multidisciplinary outreach guided by specific rising risk drivers

Automated outreach with tailored cadence, messaging, and timing

20%
Intervened

Approach:

Motivational interviewing to identify patient pain points

Care team goals and incentives to drive activation

Note: Waymark performance data as of 9/30/25 for currently eligible patients who have been eligible for 90+ days and rising risk targeted for 90+ days. % Targeted = patients targeted for outreach by Waymark, % Outreached = patients to whom we have attempted outreach % Engaged = Patients with whom we successfully made contact via outreach, % Intervened = Patients with whom we successfully made contact via outreach and who agree to receive one or more services from Waymark

Our Approach

How Signal, Compass, and our care teams work together

Maria's journey with Waymark

1

Signal identifies patient as rising-risk

Targeting algorithm detects patterns indicating future acute care use and triggers a message from **Compass AI**

2

Engage patient via Compass AI

Maria messages **Compass AI** about fatigue and thirst as well as lack of insulin

3

Escalation to virtual care team

CHW and pharmacist address her clinical and social needs, core drivers of hospital/ER use

4

Patient goal completed

Continuous access to **Compass AI** as patient's clinical status and social needs evolve

Maria, 54

- 3 ER visits in 2 months
- New diabetes diagnosis
- Housing instability

Through **Compass**, we discover she couldn't pick-up medications or store insulin

Virtual care team connects her to nearest pharmacy, transportation & housing resources

Maria has stable access to meds, housing, and is managing her diabetes. **0 ER visits since first engagement**

NEJM Catalyst

Waymark dramatically reduces avoidable hospital/ER visits

Peer-reviewed results show significant reductions versus a matched control group[1]

Outcome (N = 1,652)	**Relative Change in Event Rate vs. Control Group** *(all P<0.05)*
Outpatient Visits	▲ 16.2% *(59 More Events / 1000 Patients)*
All Acute Events	▼ 22.9% *(438 Fewer Events / 1000 Patients)*
Hospitalizations	▼ 39.4% *(149 Fewer Events / 1000 Patients)*
Emergency Visits	▼ 19.1% *(293 Fewer Events / 1000 Patients)*
Ambulatory Care Sensitive Acute Events	▼ 24.7% *(242 Fewer Events / 1000 Patients)*
Ambulatory Care Sensitive Hospitalizations	▼ 48.3% *(80 Fewer Events / 1000 Patients)*
Ambulatory Care Sensitive Emergency Visits	▼ 20.4% *(166 Fewer Events / 1000 Patients)*

$253 in total cost savings per intervened patient per month

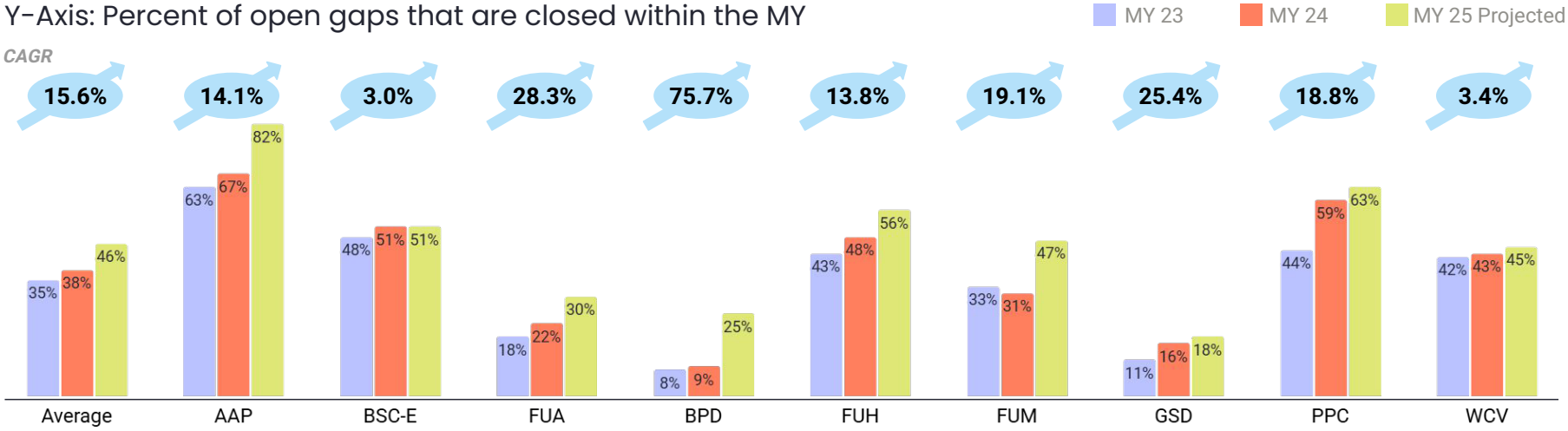
Note: "Ambulatory Care Sensitive" means an acute event that could have been avoided per NYU and AHRQ definitions

1. Baum, A et al. Supporting Rising Risk Patients In Medicaid Through Technology-Enabled, Proactive Community-Based Early Intervention . NEJM Catalyst

Notes: Data through 1/04/2024. Number of ED visits or IP stays (including observation stays) is based on ADT feed data. Results were estimated using a propensity score-matched logistical difference-in-differences analysis, which controls for secular trends in utilization and time-invariant unmeasured confounding differences between the intervention (N = 1,652) and comparison (N = 21,631) groups, with additional control variables of age, sex, patients' baseline risk score and mean acute care utilization, and time period fixed effects. Avoidable hospitalizations defined by AHRQ PQIs, https://qualityindicators.ahrq.gov/measures/pqi_resources. Avoidable emergency visits defined by NYU Patch, Johnston KJ, Allen L, Melanson TA, Pitts SR. A "Patch" to the NYU Emergency Department Visit Algorithm. Health Serv Res 2017;52(4):1264–76. 10.1111/1475-6773.12638.

Waymark HEDIS Gap Closures Rates by Measure

Y-Axis: Percent of open gaps that are closed within the MY



15.6% average annual improvement in gap closure rates

Improvement Rate. Calculated as the 2023 - 2025P compound average growth rate (CAGR) for the average gap closure rate across the 9 HEDIS metrics listed above.

Y Axis: Percent of open gaps that were closed within the measurement year. Calculated using Waymark's blended MCO data combined with Waymark-calculated numerators and denominators for each gap. Exception: GSD excludes MCO gap data due to missingness that would otherwise artificially inflate improvement.

Inclusion criteria. Measures are included if all of the following are true: (1) The common contractual measures for live contracts in the first three years of operations as well as AAP and (2) The measure year is 2023, 2024, or 2025. Patients are included if all of the following are true: (1) The patient was assigned to Waymark for at least one month during the measure year and (2) The payer is one of two MCOs for which Waymark had live contracts with in 2023, 2024, and 2025.

Exclusion criteria. Patients or measures are excluded if any of the following apply: (1) Measure has a denominator < 20 in any year (2023, 2024, or 2025). This ensures the measure is sufficiently represented across all three years before trending or (2) Patients are from 2025 WCV and were assigned to the Waymark RCT Arm A or Arm B.

Our Approach

35+ peer-reviewed studies validate our tech and care model

Risk Prediction Publications

scientific reports	Prediction of Non-Emergent Acute Care Utilization and Cost (2024)	**90% accuracy** predicting future avoidable hospital/ER visits for Medicaid patients
npj | digital medicine	Predicting Quality Measure Completion Among 14M Patients Enrolled in Medicaid (2025)	**85% accuracy** predicting which patients need outreach to close HEDIS gaps
npj | digital public health	Early Detection of High-Risk Pregnancies Using Clinical and Social Data (2026)	**55-day earlier** advanced warning on high-risk pregnancies than EHR/claims data
HSR Health Services Research	Benefit- vs Risk-Based Prioritization on ED and Hospital Utilization (in press)	**49% reduction** in acute events versus traditional risk-based targeting

Care Model Publications

NEJM Catalyst	Supporting Rising-Risk Medicaid Patients Through Early Intervention (2024)	**48% reduction** in avoidable hospitalizations, **20% reduction** in avoidable ED visits
JMIR Publications Advancing Digital Health & Open Science	Reinforcement Learning to Prevent Acute Care Events Among Medicaid Populations (2025)	**20.7% relative reduction** in acute events; **NNT of 8** to prevent one acute event
NEJM Catalyst	An Artificial Intelligence Oracle for Proactive Population Health Quality Improvement (2026)	**45% reduction** in all-cause hospitalization, **30% reduction** in all-cause ED visits
JAMIA	Clinical Decision Support for Population Health Management (2026)	**NNT of 63** to prevent one acute care event