The California Landscape
HN and CH&W

- **Medi-Cal (includes CH&W)**: 1,920,000 Members
- **Dual Eligible**: 9,900 Members
- **Medicare**: 172,000 Members
- **Commercial**: 642,000 Members

Health Plan

- **Fee For Service Providers**
- **Capitated Medical Groups**

Claims

Claims/Encounters
Integrated Approach

Total Solution Integration
- Physical Health
- Behavioral Health
- Pharmacy Services
- Ancillary Services
Diabetes and Coronary Artery Disease Prevalence

- Over 80% of all Diabetes-related coronary event spend is attributed to members with both Hypertension and/or Coronary Artery Disease.

- 183,000 members with DM with history of CAD and hypertension. The cardiovascular spend is about half of the total spend. Out of this population, 40% of the membership is not on the cardio-protective bundle.
SHAPE Description and Model

Target population
Region: California

All Health Net lines of business including Commercial, Exchanges, Medicare, Medi-Cal, and Cal MediConnect and related products.

All diabetic members over the age of 55 with both Hypertension and/or Coronary artery disease.

Systematic implementation in all patients with:
- Diabetes (age ≥55yo) AND
- Cardiovascular disease (high risk and/or prior heart attack or stroke)
- And/or hypertension

To ensure that these patients are on the cardio-protective bundle which is a daily dose of:
- Aspirin 75-235 mg
- Lovastatin 40mg
- Lisinopril 20 mg

To ensure compliance with medication with healthcare coaches:
- Healthcare coaches comprising diabetes educators, nutritionists, dieticians, etc.
- Engagement by healthcare coaches either on site at provider’s office or telephonic
- Frequency of engaging is determined by coach as per the acuity and risk.
SHAPE: Goals

**Short-Term Goals**
- Partner with providers and provider groups.
- Share best practices for care.
- Introduce the cardio-protective medication bundle to members and monitor their compliance and adherence.
- To educate members about their medication regimen and wellness.
- Share resources available to support education for providers as well as members.

**Long-Term Goals**
- Decrease and prevent cardiovascular events in this targeted high risk population.
- Educate these members with Coronary Artery Disease and Diabetes over the age of 55 about their medication regimen and wellness.
- Achieve the quadruple aim of improved population health, improved member experience, lowered costs, and improved provider experience.
SHAPE: Supporting Activities

Data analytics support
- Member list with DM, CAD and HTN
- Medication history for these high risk members
- Baseline utilization trends
- Number of cardiovascular events in these members

Additional Support
- HN Clinical Program Managers

Clinician Mentors
- HN Regional Medical Directors

MyStrength
- Member online engagement tool on motivation, weight loss, wellness, exercise

Quality Improvement
- Member/Provider interventions to close care gaps and improve related HEDIS® rates.

Case Management
- Conductor of clinical experience, provides tailored program per acuity

Disease Management
- Optum Commercial and Medicare; Omada online coaching program

Medication Adherence
- Pharmacy initiatives and electronic pill box

HN Clinical Pharmacy
- Telephonic member/provider communications to optimize therapy and improve outcomes

Envolve Pharmacy Solutions
- Medi-Cal OnDemand Program
SHAPE: Results to Date

Utilization rates around cardiovascular events decreased

Patient engagement increased

Increased cardio-protective medication bundle adherence rate
  • By 43% for those members with diabetes that were not receiving the suggested cardio-protective medication bundle at the start of the SHAPE program.

PMPM cost decreased with costs savings
  • Medicare LOB reduced by 60%.
  • MediCal LOB reduced by 27%.
  • Commercial LOB reduced by 17%.
# RY2019 Performance
## Progress to the 75th and 90th Percentile Benchmarks*

<table>
<thead>
<tr>
<th>Measure</th>
<th>Sub-Measure</th>
<th>Type</th>
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</table>

* Commercial, Marketplace, and Medi-Cal compared to 2019 Quality Compass® Benchmarks. Medicare compared to available 2018 Quality Compass Benchmarks®.

✓ Measure reached the 75th percentile
✓✓ Measure at or above the 90th percentile
## Opportunities for Improvement

**Line of Business/Product Comparison to the 75<sup>th</sup> Percentile* for Pertinent HEDIS RY2019 Measures**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Sub-Measure</th>
<th>Type</th>
<th>Commercial</th>
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</table>

*Commercial, Marketplace, and Medi-Cal compared to 2019 Quality Compass® benchmarks. Medicare compared to available 2018 Quality Compass® benchmarks.

- ✓ Measure needs to reach the 75<sup>th</sup> percentile
- ✓ Measure missed the 75<sup>th</sup> percentile by 1% or less
Potential HEDIS® Measures Impacted

- Comprehensive Diabetes Care
- Persistence of Beta-Blocker Treatment After a Heart Attack
- Statin Therapy for Patients with Diabetes
- Statin Therapy for Patients with Cardiovascular Disease
- Controlling Blood Pressure
- Annual Monitoring for Patients on Persistent Medications
Quality Improvement and Initiative Spotlights
Quality Improvement Outreach/Strategy

Health Net

Member Outreach:
- Multimodal communications: mail, interactive voice recordings (IVRs), text messaging, online newsletters, letters and/or emails
- Live Calls by clinical pharmacists trained in Motivational Interviewing
- Incentive Programs
- In-home visits
- Health education classes coordinated with clinics
- Case Management and Disease Management

Provider and Provider Groups Outreach:
- Provider educational resources including webinars
- Care gap lists and HEDIS® report cards
- Provider Relations and Practice Transformation site visits
- PPG Joint Operation Meetings
USMM Self-Administered A1c and Microalbumin Test Kit Mailing

4,239 English-speaking members and 714 Spanish-speaking members with A1c and/or nephropathy screening care gaps received:

- Initial letter mailed with Self-Administered Test Kit,
- Follow-up letter after 2 weeks, if member has not mailed their sample to US Medical Management (USMM), and/or
- Final reminder via automated call, if needed

USMM’s self-administered testing kits for diabetics include the following:

- The items needed to provide a blood and/or urine sample
- Instructions on how to complete the screening
- A postage paid envelope to mail sample to USMM
Medi-Cal and CH&W

One Stop Clinic Program

Extended clinics hours (outside of regular business hours) supported by the health plan to address multiple care gaps and health needs for targeted populations facing access barriers to care.

- Target gaps in care (HEDIS)
- Offer Ancillary Services
- Provide Member Incentives
- Distribute Health Education Materials

The health plan offers and coordinates ancillary services onsite through collaboration with vendors, including MedXM for diabetic measures:

- A1c Testing
- Retinal Eye Exams
- Nephropathy Testing
HEDIS 2019 Member Incentive Program

Members are mailed an incentive form with a pre-paid return envelope.
- Member is eligible for an incentive award when the applicable provider visit is completed.
- Members mail or fax completed incentive forms to Health Net to receive their gift card.

The 2019 Member Incentive Program impacts multiple adult and child HEDIS measures including:

Diabetes Care
*Incentive available for 3 CDC sub-measures
- A1c Testing
- Retinal Eye Exams
- Nephropathy Testing

The HEDIS Team follows up with outreach calls in select counties to offer:
- Reminders to complete health screenings
- Health education to address barriers
- Support with scheduling a health appointment
- Information on incentives
- Transportation services via Logisticare
- Case Management support
- Reminders about mental health screenings

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- Case Management support
- Reminders about mental health screenings
Privileged & Confidential

Medicare

- Developed for all HN lines of business
- Provider Toolkit and Quick Reference Guide
- HEDIS Documentation and Best Practices
- HEDIS Measure Tip Sheets (includes CDC and CBP)

Provider Toolkits and HEDIS documents are available by request or for download on the Health Net Provider Portal.
Large Employer-Group QI Pilot Project

Education outreach for a select population of Commercial and Medicare members from a large employer-group with one or more chronic conditions: diabetes and/or hypertension and/or cardiovascular disease.

1. ADA Diabetes Forecast Magazine Bi-Monthly 2019 Mailing

2. Custom “Let’s Be Well” Toolkit Special Mailing
   Included:
   - Recipe Booklet
   - Precise Portions Control Plate
   - Portion Control Wheel
   - Water Bottle
   - AHA Managing High BP Guide
   - Stress Reliever
   - Resistance Exercise Bands
   - Foot Cream with Aloe Vera

3. Custom AHA Blood Pressure Guide, Cover Letter and Stress Reliever Special Mailing
American Heart Association (AHA) Recognition Programs

Target: BP™
- National initiative between the AHA and American Medical Association (AMA).
- Participants commit to improve high blood pressure and reduce the number of heart attacks and strokes each year across all of its lines of business.

Check. Change. Control. Cholesterol™
- New national AHA initiative.
- Educates and empowers patients through tools to promote awareness, detection, and management of high cholesterol.
- Participants commit to assess Atherosclerotic Cardiovascular Disease (ASCVD) risk, and implement ASCVD risk calculations into clinical workflows.
Take Charge of Your Health

- This online program helps participants with chronic medical conditions better manage their well-being through adherence and personal wellness strategies.
- Complements the traditional approach of nurse-based disease management by offering a self-paced portal-based program that does not require the intervention of a telephonic coach or Disease Management nurse.

Offered for diabetes and hypertension, with upcoming modules on heart failure, asthma, and COPD.

Available for Medicare and Commercial members.
Omada: Prediabetes Digital Therapy

**Purpose:** Online self-management prediabetes program for populations at risk of diabetes and cardiovascular disease

**Program Benefits:**

- Reduces the risk of type 2 diabetes and heart disease
- Prevention program to help pre-diabetics lose weight and reduce risk
- 16-Week Online Program (Foundation), 17+ Weeks (Graduates)
- Weekly lessons, weigh-ins, food/activity trackers,
- Dedicated health coach for support and motivation
- Best-in-class and clinically supported
Wellness Webinar Series

Each Wellness Webinar is offered on the 3rd Wednesday of each month.

- The program offers members with a variety of health education topics via webinar format hosted by guest speakers and health educators.
- In 2018, 1,754 members attended Wellness Webinars!

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<tr>
<th>2019 Wellness Webinar Schedule</th>
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<tr>
<td>January: Staying Well, Well, Well with Health Net</td>
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<tr>
<td>February: Making a Great Plate</td>
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<tr>
<td>March: Healthy Challenges: Ready, Set, Goals!</td>
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<tr>
<td>April: Acupressure: The Healing Power of Self-Care</td>
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<tr>
<td>May: Return to the Outdoors: The Healing Power of Nature</td>
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<tr>
<td>June: The Power of Prevention</td>
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<td>July: Healthy Skin Tips from the Expert</td>
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<tr>
<td>August: From Couch to 5K</td>
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<tr>
<td>September: Pain Management Alternatives</td>
</tr>
<tr>
<td>October: Weathering the Winter</td>
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<tr>
<td>November: Don’t Sugar Coat It: The Impact of Sugar on Your Health</td>
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<tr>
<td>December: Healthy Holidays</td>
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</table>

Our free wellness webinars help employees live a healthier lifestyle.
Technology: Diabetes OnDemand Program

Targets high-risk testing adults with diabetes in the Medi-Cal population.

- Cellular-enabled glucometer provides real-time biometric data to program care managers.
- Care gaps or poor control trigger outbound telephonic disease management coaching.
- Analyzes each member’s testing patterns to automatically replenish testing supplies via mail.
- Implemented Q4 2019.

On.Demand Lifecycle

Identification & Enrollment

Real-Time Readings

Strip Refills As Needed

01

02

03

04

05

Welcome Kit Received

Appropriate Interventions
SHAPE Disparity Reduction Project

Overall Goal

To increase adherence of the recommended cardio-protective medication bundle among Chinese-speaking members in San Gabriel Valley, Los Angeles County.

Project Update

- Analysis of SHAPE data by race, ethnicity, language and geography completed to identify targets for intervention.
- Literature review and Social Determinants of Health (SDoH) analysis completed for the selected population and geography.
- Infrastructure for sustaining disparity project established with internal workgroup and aligning efforts with existing external coalitions.
- Formative research with members and providers in process (key informant interviews and focus groups).

Next Steps

- Complete barrier analysis to help identify member and provider level interventions.
- Establish provider partnership to implement provider and member level interventions.
Health Net Contacts

Jean Shahdadpuri, MD, MBA
VP Medical Affairs

Jean.X.Shahdadpuri@healthnet.com
Thank you!
Appendix
# Quality Improvement Initiatives

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<tr>
<th>Measures</th>
<th>Description of 2019 QI Initiatives</th>
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<tr>
<td><strong>Multi-Measure Outreach</strong></td>
<td>▪ PPG member-level care gaps list and report cards ○○○○</td>
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<td>▪ Joint Operations Meeting with PPGs ○○</td>
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<td>▪ Provider educational webinars: topics include HEDIS, statin guidelines, etc. ○○○○</td>
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<td></td>
<td>▪ Live calls since Q3 2018 to close multiple care gaps (includes: CDC, CBP, MPM, and <em>New!</em> PBH) ○○○○</td>
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</table>
|                           | ▪ Participate in Right Care Initiative’s UBP to address preventing heart attacks, strokes, and diabetic complications ○○
|                           | ▪ *New!* Large Employer-Group Chronic Conditions QI Project, beginning 2019 ○○                  |
| **CDC**                   | ▪ *New!* American Diabetes Association (ADA) and AHA toolkit mailing to employer-group members in July 2019 ○○ |
|                           | ▪ *New!* Offered free registration to first 100 providers to ADA “Diabetes is Primary” and “Overcoming Therapeutic Inertia” Clinical Workshop in LA, Oct. 2019 ○○○○ |
|                           | ▪ ADA Diabetes Forecast Magazine Subscription with HN cover letter ○○○○                        |
|                           | ▪ Vendor A1c Test Kit mailing ○; *New!* A1c and Microalbumin Test Kit mailing ○○○              |
|                           | ▪ One Stop Clinic Program – extended clinic hours to address multiple care gaps (includes: eye exam, A1c test, and nephropathy testing) ○○|
|                           | ▪ Medi-Cal 2019 Incentive Program (includes: eye exam, A1c test, and nephropathy testing) ○○     |
|                           | ▪ In Q4, Pocket Guide to Diabetes Self-Management mailing ○                                    |
# Quality Improvement Initiatives

<table>
<thead>
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</table>
| CBP                       | - Recipient of the American Heart Association’s (AHA) Target Blood Pressure Participation Award
  - *New!* American Heart Association (AHA) Managing BP Guide mailing
  - *New!* AHA mailing with education on hypertension and BP readings for employer-group
  - *New!* Member IVR to encourage members to monitor BP with their PCP and take medications, as prescribed                                                                                                                                  |
| Medication Adherence & MPM| - For Q4, mailing Annual Pocket Wellness Calendars covering multiple issues, such as medication adherence and cardiovascular health
  - *New!* Live Pharmacy calls to diabetic members with reminders of importance of statin therapies (SPD) – project tailored for employer-group                                                                                                                                 |
| SPD & SPC                 | - Provider educational outreach letters faxed to help support members on statin therapies (SPD)
  - *New!* Cover letter with ADA Diabetes Forecast magazine educating member on statin therapies
  - *New in Q4!* Pilot text-messaging campaign in development to educate diabetic and cardiac members on importance of medication compliance                                                                                                                                 |
| PBH                       | - Educational letter to members with recent beta-blocker prescription following heart attack                                                                                                                                                              |
Commercial and Exchange Rates and 3-Year Trends
<table>
<thead>
<tr>
<th>Measure</th>
<th>CA Commercial EPO/PPO</th>
<th>CA Commercial HMO/POS</th>
<th>CA Exchange EPO</th>
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<td>CBP Controlling High Blood Pressure</td>
<td>57.7%</td>
<td>64.2%</td>
<td>59.3%</td>
<td>62.8%</td>
<td>55.0%</td>
</tr>
<tr>
<td>CDC Blood Pressure Control (&lt;140/90 mm Hg)</td>
<td>60.8%</td>
<td>69.1%</td>
<td>60.3%</td>
<td>63.5%</td>
<td>54.7%</td>
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<tr>
<td>Eye Exam (Retinal) Performed</td>
<td>45.5%</td>
<td>57.0%</td>
<td>29.4%</td>
<td>49.2%</td>
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<tr>
<td>HbA1c Control (&lt;8.0%)</td>
<td>65.0%</td>
<td>65.8%</td>
<td>63.2%</td>
<td>58.4%</td>
<td>53.3%</td>
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<tr>
<td>HbA1c Poor Control (&gt;9.0%)</td>
<td>26.8%</td>
<td>19.6%</td>
<td>26.5%</td>
<td>26.8%</td>
<td>34.3%</td>
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<tr>
<td>Hemoglobin A1c (HbA1c) Testing</td>
<td>87.8%</td>
<td>93.2%</td>
<td>88.2%</td>
<td>89.5%</td>
<td>83.5%</td>
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<tr>
<td>Medical Attention for Nephropathy</td>
<td>89.1%</td>
<td>93.0%</td>
<td>91.2%</td>
<td>93.9%</td>
<td>87.8%</td>
</tr>
<tr>
<td>PBH Persistence of Beta-Blocker Treatment</td>
<td>70.0%</td>
<td>77.8%</td>
<td>66.7%</td>
<td>72.1%</td>
<td>80.0%</td>
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<tr>
<td>Heart Attack</td>
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<tr>
<td>SPC Received Statin Therapy_Total</td>
<td>81.7%</td>
<td>80.6%</td>
<td>66.7%</td>
<td>75.8%</td>
<td>73.3%</td>
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<tr>
<td>Statin Adherence 80%_Total</td>
<td>77.0%</td>
<td>74.4%</td>
<td>62.5%</td>
<td>71.6%</td>
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<tr>
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<td>61.7%</td>
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<td>60.3%</td>
</tr>
<tr>
<td>Statin Adherence 80%</td>
<td>71.2%</td>
<td>60.9%</td>
<td>76.0%</td>
<td>62.8%</td>
<td>53.7%</td>
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</table>

Measure above the 75th Quality Compass® National Benchmark for RY 2019
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Measure below the 75th Quality Compass® National Benchmark for RY 2019

2019 75th National Benchmark
Medi-Cal Rates and 3-Year Trends
<table>
<thead>
<tr>
<th>Measure</th>
<th>CHW Region 1</th>
<th>CHW Region 2</th>
<th>CHW Region 3</th>
<th>Medi-Cal GMC Sacramento</th>
<th>Medi-Cal GMC San Diego</th>
<th>Medi-Cal Two Plan Kern</th>
<th>Medi-Cal Two Plan LA County</th>
<th>Medi-Cal Two Plan San Joaquin</th>
<th>Medi-Cal Two Plan Stanislaus</th>
<th>Medi-Cal Two Plan Tulare</th>
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</thead>
<tbody>
<tr>
<td><strong>CBP</strong> Controlling High Blood Pressure</td>
<td>62.0%</td>
<td>59.1%</td>
<td>73.2%</td>
<td>54.3%</td>
<td>64.2%</td>
<td>59.1%</td>
<td>61.8%</td>
<td>58.6%</td>
<td>63.5%</td>
<td>59.9%</td>
</tr>
<tr>
<td><strong>CDC</strong> Blood Pressure Control (&lt;140/90 mm Hg)</td>
<td>68.8%</td>
<td>67.6%</td>
<td>69.3%</td>
<td>58.9%</td>
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<td>62.5%</td>
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<td>64.0%</td>
<td>64.2%</td>
<td>66.9%</td>
</tr>
<tr>
<td><strong>CBP</strong> Eye Exam (Retinal) Performed</td>
<td>54.6%</td>
<td>52.8%</td>
<td>65.6%</td>
<td>55.5%</td>
<td>64.5%</td>
<td>53.5%</td>
<td>65.9%</td>
<td>58.9%</td>
<td>51.3%</td>
<td>65.5%</td>
</tr>
<tr>
<td><strong>CBP</strong> HbA1c Control (&lt;8.0%)</td>
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<td>52.1%</td>
<td>56.0%</td>
<td>51.1%</td>
<td>54.0%</td>
<td>50.4%</td>
<td>54.0%</td>
<td>45.7%</td>
<td>52.6%</td>
<td>52.8%</td>
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<tr>
<td><strong>CBP</strong> HbA1c Poor Control (&gt;9.0%)</td>
<td>37.3%</td>
<td>37.0%</td>
<td>34.2%</td>
<td>37.7%</td>
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<td>43.3%</td>
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<tr>
<td><strong>CBP</strong> Hemoglobin A1c (HbA1c) Testing</td>
<td>86.1%</td>
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<td>88.6%</td>
<td>87.4%</td>
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<td>81.8%</td>
<td>86.1%</td>
<td>93.2%</td>
</tr>
<tr>
<td><strong>CBP</strong> Medical Attention for Nephropathy</td>
<td>85.9%</td>
<td>88.1%</td>
<td>91.9%</td>
<td>91.7%</td>
<td>92.0%</td>
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<td>91.7%</td>
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<tr>
<td><strong>PBH</strong> Persistence of Beta-Blocker Treatment After a Heart Attack</td>
<td>71.9%</td>
<td>64.5%</td>
<td>88.2%</td>
<td>65.6%</td>
<td>69.2%</td>
<td>70.0%</td>
<td>72.5%</td>
<td>57.1%</td>
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<td>82.9%</td>
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<tr>
<td><strong>SPC</strong> Received Statin Therapy_Total</td>
<td>74.2%</td>
<td>76.3%</td>
<td>82.0%</td>
<td>73.9%</td>
<td>78.7%</td>
<td>72.0%</td>
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<td>79.5%</td>
<td>82.3%</td>
</tr>
<tr>
<td><strong>SPC</strong> Statin Adherence 80%_Total</td>
<td>59.4%</td>
<td>65.7%</td>
<td>65.8%</td>
<td>64.6%</td>
<td>68.0%</td>
<td>58.1%</td>
<td>71.9%</td>
<td>53.2%</td>
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<td>61.6%</td>
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<tr>
<td><strong>SPD</strong> Received Statin Therapy</td>
<td>57.0%</td>
<td>56.4%</td>
<td>60.1%</td>
<td>68.2%</td>
<td>66.2%</td>
<td>63.8%</td>
<td>69.2%</td>
<td>63.5%</td>
<td>63.9%</td>
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<td>64.8%</td>
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<td>59.0%</td>
<td>59.7%</td>
<td>52.1%</td>
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*Measure above the 75th Quality Compass® National Benchmark for RY 2019*
<table>
<thead>
<tr>
<th>Measure</th>
<th>Medi-Cal GMC Sacramento</th>
<th>Medi-Cal GMC San Diego</th>
<th>Medi-Cal Two Plan Kern</th>
<th>Medi-Cal Two Plan LA County</th>
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<th>Medi-Cal Two Plan Tulare</th>
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<tbody>
<tr>
<td>Blood Pressure Control (&lt;140/90 mm Hg)</td>
<td><img src="image" alt="Graph" /></td>
<td><img src="image" alt="Graph" /></td>
<td><img src="image" alt="Graph" /></td>
<td><img src="image" alt="Graph" /></td>
<td><img src="image" alt="Graph" /></td>
<td><img src="image" alt="Graph" /></td>
<td><img src="image" alt="Graph" /></td>
</tr>
<tr>
<td>Eye Exam (Retinal) Performed</td>
<td><img src="image" alt="Graph" /></td>
<td><img src="image" alt="Graph" /></td>
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<tr>
<td>HbA1c Poor Control (&gt;9.0%)</td>
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2019 75th National Benchmark

Measure above the 75th Quality Compass® National Benchmark for RY 2019

Measure below the 75th Quality Compass® National Benchmark for RY 2019
<table>
<thead>
<tr>
<th></th>
<th>CBP</th>
<th>PBH</th>
<th>SPC</th>
<th>SPD</th>
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<tr>
<td><strong>Persisting</strong></td>
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<td><strong>High Blood</strong></td>
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<td>Pressure 2019</td>
<td>100%</td>
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<td><strong>Statin</strong> 2019</td>
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<td><strong>Adherence</strong> 2019</td>
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- **2019 75th National Benchmark**
- **Measure above the 75th Quality Compass® National Benchmark for RY 2019**
- **Measure below the 75th Quality Compass® National Benchmark for RY 2019**

**Providers:**
- Medi-Cal GMC Sacramento
- Medi-Cal GMC San Diego
- Medi-Cal Two Plan Kern
- Medi-Cal Two Plan LA County
- Medi-Cal Two Plan San Joaquin
- Medi-Cal Two Plan Stanislaus
- Medi-Cal Two Plan Tulare
Medicare Rates and 3-Year Trends
<table>
<thead>
<tr>
<th>Measure</th>
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<th>CA Medicare HMO H3561</th>
<th>CA Medicare-Medicaid HMO H3237</th>
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<td>CBP Controlling High Blood Pressure</td>
<td>68.9%</td>
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<td>65.2%</td>
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<tr>
<td>CDC Blood Pressure Control (&lt;140/90 mm Hg)</td>
<td>74.1%</td>
<td>73.3%</td>
<td>70.1%</td>
</tr>
<tr>
<td>Eye Exam (Retinal) Performed</td>
<td>82.4%</td>
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</tr>
<tr>
<td>HbA1c Control (&lt;8.0%)</td>
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<td>25.3%</td>
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<tr>
<td>Hemoglobin A1c (HbA1c) Testing</td>
<td>95.5%</td>
<td>95.1%</td>
<td>90.3%</td>
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<td>Medical Attention for Nephropathy</td>
<td>98.4%</td>
<td>97.4%</td>
<td>96.0%</td>
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<tr>
<td>PBH Persistence of Beta-Blocker Treatment</td>
<td>85.3%</td>
<td>96.7%</td>
<td>78.3%</td>
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<tr>
<td>After a Heart Attack</td>
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<tr>
<td>SPC Received Statin Therapy Total</td>
<td>75.6%</td>
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</tr>
<tr>
<td>Statin Adherence 80% Total</td>
<td>83.7%</td>
<td>80.1%</td>
<td>82.5%</td>
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<tr>
<td>SPD Received Statin Therapy</td>
<td>76.8%</td>
<td>78.1%</td>
<td>71.6%</td>
</tr>
<tr>
<td>Statin Adherence 80%</td>
<td>81.1%</td>
<td>79.9%</td>
<td>71.8%</td>
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Measure above the 75th Quality Compass®
National Benchmark for RY 2018
<table>
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<td>Controlling High Blood Pressure</td>
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<td>Persistence of Beta-Blocker Treatment After a Heart Attack</td>
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<td>Received Statin Therapy_Total</td>
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<tr>
<td>Statin Adherence 80%_Total</td>
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<tr>
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<tr>
<td>Statin Adherence 80%</td>
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- 2018 75th National Benchmark
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CA Medicare HMO H0562

CA Medicare HMO H3561

CA Medicare Medicaid HMO H3237
Thank you

&

?
Health Net
Diabetic Population Overview

Member Distribution

HNT California Diabetic Members

- High concentration of diabetic members in higher populated counties such as LA, San Diego, and Fresno
- Fewer members in Bay Area, more concentrated in Southern California and Sacramento area

Notes:
Spend and member figures based on all members with spend at each respective facility from July 1, 2015 to March 31, 2016 (9 Months)
Diabetes, Coronary Artery Disease, and Hypertension defined according to CMS guidelines
California Health & Wellness
Diabetic Population Overview

Member Distribution

CH&W Diabetic Members by County

- Majority of diabetic members over 55 come from Imperial County
- Higher population in Northern California than more populated areas
- Population distribution significantly differs from Health Net

Notes:
Spent and member figures based on all members with spend at each respective facility from July 1, 2015 to March 31, 2016 (9 Months)
Diabetes, Coronary Artery Disease, and Hypertension defined according to CMS guidelines
Centene Overview

**WHO WE ARE**

Centene provides access to high-quality healthcare, innovative programs and a wide range of health solutions that help families and individuals get well, stay well, and be well.

**PURPOSE**

Transforming the health of the community, one person at a time

**WHAT WE DO**

32 states with government-sponsored healthcare programs

Centene successfully provides high quality, whole health solutions for our diverse membership by recognizing the significance of the many different cultures our members represent and by forming partnerships in communities that bridge social, ethnic and economic gaps.

**BRAND PILLARS**

Focus on the Individual + Whole Health + Active Local Involvement

**Facts and Figures**

- 52,000 Employees
- #51 FORTUNE 500 (2019)
- #168 FORTUNE GLOBAL 500 LIST
- 15M Managed Care Members
- ~340 Product / Market Solutions
- 3 International Markets
- $73.6 – $74.2B Expected Revenue for 2019

11/8/2019
Right Care Initiative
Kaiser Permanente ALL/Phase

Kaiser Permanente’s medication bundle:
- **ALL:** Aspirin, Lisinopril (ACE-inhibitor), and Lipid lowering statin
- **PHASE:** Preventing Heart Attacks and Strokes Everyday (ALL protocol with beta blocker therapy and lifestyle emphasis added)

<table>
<thead>
<tr>
<th>Model of the Outcome Phase ALL</th>
<th>To ensure they are offered daily dose of:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systematic implementation in all patients with:</td>
<td>▪ Aspirin 75-235 mg</td>
</tr>
<tr>
<td>▪ Diabetes (age ≥ 55 y/o) or</td>
<td>▪ Lovastatin 40 mg</td>
</tr>
<tr>
<td>▪ Cardiovascular disease (prior heart attack or stroke)</td>
<td>▪ Lisinopril 20 mg</td>
</tr>
</tbody>
</table>

A Kaiser Permanente QI study tracked 170k individuals over 2 years. Compared to those with no medication bundle exposure:
- Of 47,268 “low exposure” individuals who used the medication bundle ≤1 year, 726 fewer heart attacks and strokes occurred (reduction in hospitalization for heart attack or stroke by 15 per 1,000 members).
- Among the 21,292 “high exposure” individuals who used the medication bundle 1-2 year, 545 fewer heart attacks and strokes occurred (reduction in hospitalization for heart attack or stroke by 26 per 1,000 members).
Introduction to the Cardio-Protective Bundle Pilot

Health Net is an active participant in the University of Best Practices’ Right Care Initiative which focuses on cardiovascular disease and diabetes with a focus on heart attack and stroke prevention.

Recommended best practices for those over the age of 55 with diabetes and at risk for and/or a history of heart disease with or without hypertension include a cardio-protective medication bundle of:

- Ace-Inhibitors
- Aspirin, and
- Statins

Health Net has initiatives and investments to improve population health - one of them being around diabetics and their cardiovascular health (UT# 22).
SHAPE Disparity Reduction Project

Best Overall Project Award Cohort 2019
The Disparities Leadership Program
Massachusetts General Hospital’s Disparities Solutions Center, Boston