EXL

Health Equity Discussion

Driving health equity as a Payer

Address health equity drivers like food, housing, education, transportation and access to care that impact the total cost of care and health outcomes

Whole person health approach to closing care gaps and improving quality outcomes for underserved populations to be at par with overall population

Reduce disparities driven by in policies, claims processing rules, benefit design and health plan operations

Promote culturally and linguistically appropriate services through care management, CBO and provider partnerships

EXL framework to support and accelerate health equity

County Health for County Level Data

EASI for Zip Level Data

Trusted Partners for Individual Level Data

Data Enrichment

SDoH Data combined with Healthcare data for **Comprehensive Member 360 view**

Care Management: Identification & Stratification based on Social Risk

Quality Improvement: Focused Interventions to reduce disparities

Plan design & Policies

Equity Levers

CMS Compliance and Reporting

Tailored Care Pathways based on Social and Clinical Determinants

CBO integration to match with community resources as per need

Leveraging power of data

Direct Data Sources

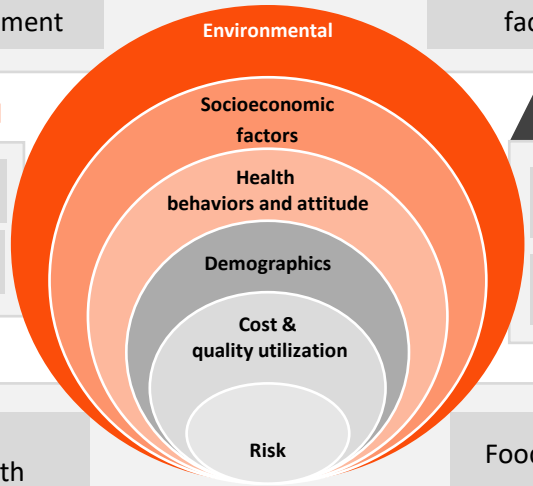
- EMR - Coded SDOH data elements like ICD-10 Z codes, SNOMED, CPT, LOINC, HCPCS Codes
- **Claims** - Coded SDOH data elements like ICD-10 Z codes, SNOMED, CPT, LOINC, HCPCS Codes
- **Surveys** - Data Collected from Surveys, HRAs, CMS/state data bases
- **Health Plan Enrollment data**

Indirect Data - County Health — County level

- Health outcomes
- Health factors
- Clinical care
- Social and economic environment
- Social and economic factors
- Physical environment
- Health behaviors
- Demographics

Indirect Data - EASI — ZIP level

- Demographic info
- Retail sales
- Consumer price index
- Quality of life
- NAICS business count
- Life stages



Indirect Data - Consumer data — Individual level

- Individual / Family
- Demographics – Race, Ethnicity
- Credit data
- Insurance scores
- Auto - Vehicles owned
- Health data
- Lifestyle
- Psychographics

Community Network Integration

- Behavioral Health
- Education
- Family & Youth
- Food, goods, health, housing
- Social & Financial support
- Transportation

Combine with healthcare data for comprehensive member 360 view

Identify & address Top social barriers

Include SDoH risk

Improve health equity

Quality Measurement, Analytics and Reporting to Improve Health Outcomes & Compliance

- EXL's Approach
  - Capture health equity data
  - Measure performance
  - Drive actions through analytics insights
- CMS upcoming quality initiatives
  - HEDIS Measures with Stratification by Race & Ethnicity
  - Race/Ethnicity Diversity of Membership (RDM)
  - Health Equity Index
  - CMS-HCC Stratification
- CMS Goal
  - Measurement Year 2022 – 5 measures
  - Measurement Year 2023 > 10 measures
  - Measurement Year 2023 > 15 measures(with direct data)

Outcomes through lens of health equity exposes disparity

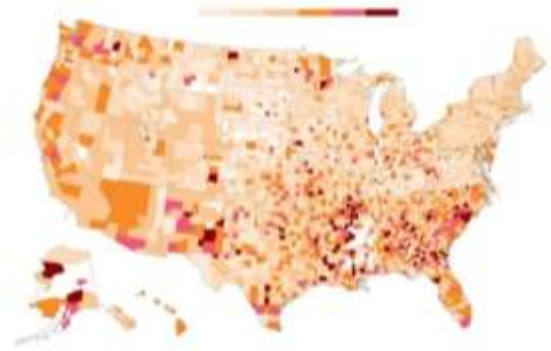
Quality Measure	Asian	African American	Hispanic	White
Gap Asthma Controller Medication	51.0%	53.2%	51.3%	52.7%
Gap Alzheimer Disease Provider 180 days visits	25.0%	16.5%	12.5%	7.5%
Gap Back Pain Provider 180 days visit	8.5%	5.5%	6.9%	6.5%
Gap Bipolar Provider 180 days visit	21.2%	28.4%	32.4%	17.8%
Gap CAD ACE 30 Days Medication	7.5%	12.7%	9.1%	10.7%
Gap CAD Beta Blocker 30 Day Medication	5.8%	10.0%	12.1%	8.0%
Gap CAD Lipid Medication	28.1%	36.3%	42.6%	37.4%
Gap CAD Lipid Rx 30 Days Medication	2.8%	9.0%	6.7%	6.1%
Gap Diabetes Eye Exam	42.9%	52.4%	49.2%	53.1%
Gap Diabetes HBA1c	6.5%	10.5%	6.8%	9.9%
Gap Mental Health Condition Tobacco Cessation 180 days	90.5%	77.8%	79.9%	84.4%
Gap Screening Breast Cancer 50-year female	30.4%	32.8%	35.7%	35.3%
Gap Substance Abuse Provider 180 days	28.9%	52.4%	38.0%	35.9%
Gap Schizophrenic Disorders Provider 180 days	50.0%	28.8%	42.9%	17.7%

EXL

SDoH combined with targeted modeling and analytics yields improved healthcare outcomes

SDoH can be used to target members where improvements to population health can be highly impactable and intervenable

SDOH RISK DISTRIBUTION BY COUNTY



SDOH Risk Factors	High Risk County Stats						
	Highest Risk County - State (Based on Prevalence)	Zip Code with High Prevalence	SDOH Risk Score of Zip	Total Zip member Count (Impacted Members)	Average Number of Open Care Gaps per Member	Highly Impactable Member Count in Zip	Highly Intervenable Member Count in Zip
Food Insecurity	Hamilton - OH	13353	3.2	423 (58%)	5	221	185
Access to care	Jackson - MO	63755	2.3	586 (52%)	6	385	234
Housing Instability	St Louis - MO	63024	2.5	674 (47%)	3	338	189
Sedentary Lifestyle	Litchfield - CT	6791	2.7	325 (41%)	3	402	278
Transportation difficulties	Hartford - CT	6022	2.1	789 (32%)	7	493	256
Education	New Haven - CT	6536	2.9	332 (39%)	9	213	102
Utility needs	Los Angeles - CA	90004	2.2	497 (43%)	4	335	156
Personal safety	Fairfield, CT	6852	2.8	328 (30%)	3	287	87
Economic Instability	Windham - CT	6260	2.4	221 (51%)	6	112	43
Social Isolation	Maricopa - AZ	85069	1.9	701 (27%)	7	513	201

TOP 5 HIGH SDOH RISK COUNTIES

Hamilton - OH, Jackson-MO, Maricopa-AZ, Churchill-NV, Tooele-UT

POPULATION WHOSE HEALTH OUTCOMES CAN BE POTENTIALLY IMPACTED BY SOCIAL DETERMINANTS

High ER Utilizers (>4 ER Visits)

ER Visits: 834 — 5% vs Benchmark

Member Count: 432 — 5% vs Benchmark

Top SDOH Risk Factors

Education	37%
Access to Care	32%
Economic Instability	25%

Chronic Comorbid Members

Member Count: 11K — 5% vs Benchmark

Top 3 Gaps	Member Count
Gap Asthma Provider 180 days	4322
Gap Diabetes Statin PDC 80 Percent	2912
CQM HTN ACE 80 PDC	1345

Top SDOH Risk Factor

Food Insecurity	41%
Economic Instability	33%
Education	23%

Members with Behavioral Health Conditions & Serious Mental Illness

Member Count: 4K — 5% vs Benchmark

Top 3 Gaps	
Gap Antidepressants 80 PDC	852
Gap Bipolar Provider 180 day	421
Gap ADHD Medications PDC 80	232

Top SDOH Risk Factor

Access to Care	30%
Economic Instability	25%
Transportation Barriers	15%

Please note the data and metrics in the reporting screens are derived from demo data and hence should not be interpreted to be representative of real-world data

Leverage predictive & prescriptive analytics to deliver equitable health

Identify unmet social needs and tailor care interventions accordingly

SDOH Access to Care

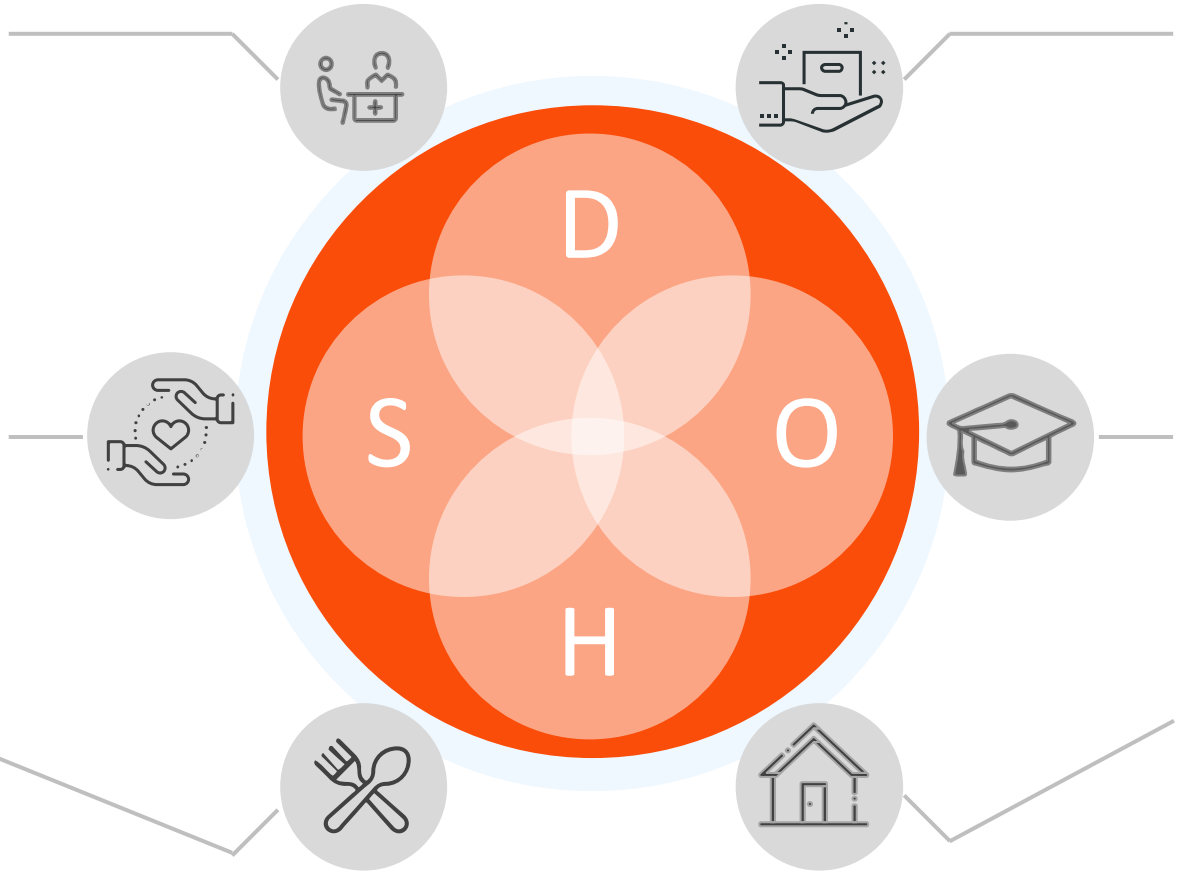
- This model provides a county-level access to care index, helps to identify PCP/hospital bed shortage buckets and recommends preferred healthcare setting

Intervenability

- Identify and stratify member who have better propensity to engage and manage their health and change behavior

SDOH Food Insecurity Index

- The model provides a food security index at household level. Help manage the food security to improve the patients' health outcomes



SDOH Clinical Risk

- Identify and stratify member cohorts most impacted by non-clinical systemic social barriers and work on unmet social needs that deter optimal patient treatment journey

SDOH Health Literacy

- This model based on Claims, Eligibility, SDOH data & 2003 (NAAL) Survey, provides a Health Literacy Score and recommends simple ways for low literacy level people to better understand health information

SDOH Housing Problem Index

- This model based on County Health Ranking & US Census, leverages predictors like income, housing value etc. and provides a housing problem index at zip-code level

EXL predictive models feeding into proactive care management

Medication Adherence Model

Identifies patients who have poor adherence to reduce risk of hospitalization/ adverse health outcomes

Wellbeing model

Creates a composite score for assessing well-being across 5 dimensions (e.g., social, emotional, financial, physical, etc.)

SDOH Health Equity Model Suite

Includes Food Insecurity index, Access to Care Model, Health Literacy, Housing Index & SDOH clinical risk to work on social barriers that deter optimal patient treatment journey

Intervenability

Identify and stratify member who have better propensity to engage and manage their health and change behavior

Surgery Probability

Predicts the probability of members having cardiac or musculoskeletal surgery in the next two years

Impactability model

Tells probability of reduction in avoidable IP, ER & readmissions associated with care gap closures

Behavioral Health Model

Predicts member's risk of getting behavioral health conditions

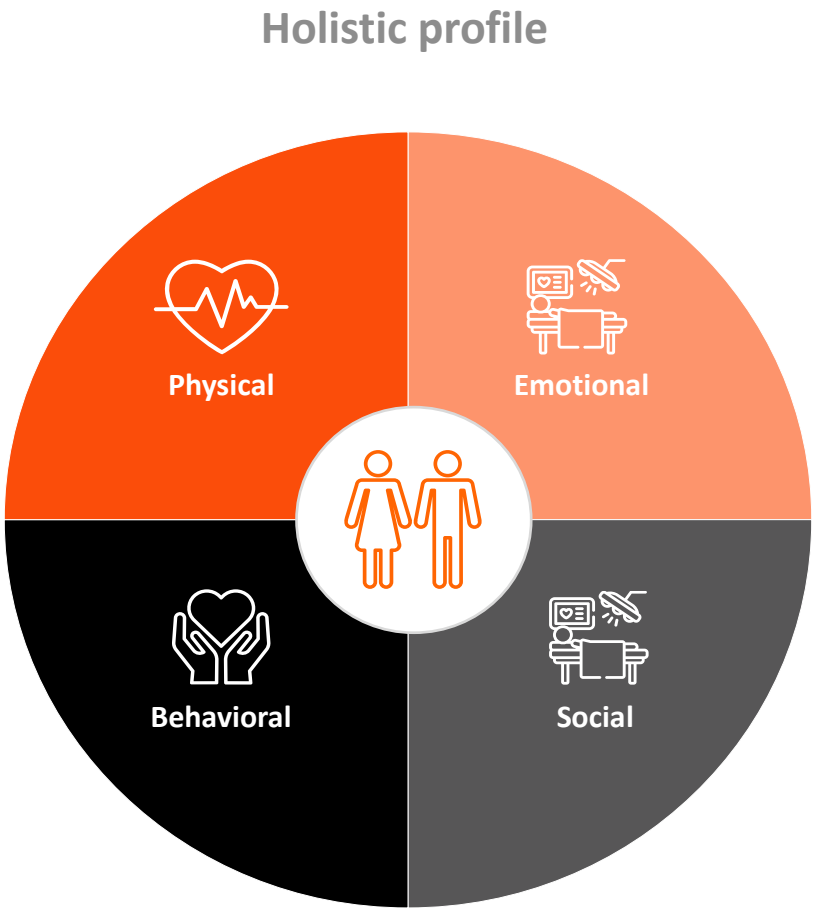
Risk models

Concurrent, Prospective & Emerging Risk Models predict risk scores in concurrent yr., following yr. & likelihood of becoming high-risk in next 24 months

Opioid Abuse Risk Model

Predicts member's risk to opioid abuse

Holistic member profile & targeted care management to drive health equity



- Precisely **identify** members at-risk for high utilization over the coming 24 to 36 months
- Determine **impactability** at individual member level, with prioritized gaps, recommended barriers & interventions
- **Intervene** with member based on known SDoH attributes and behaviors to reduce and mitigate future risk
- Drive member engagement through automation and **multi-channel communication**
- Enable personalized care and empower care teams through **single unified care plans** and shared decision making
- Create a **closed loop feedback approach** with continuous improvement including tracking trend of the population programs and the efficiency of engagement operations implemented

EXLVantage™- Data Analytics & Reporting – Modular Solution

DATA INTAKE AND AGGREGATION

ADT & HIE Data
EHR & Clinical Data
SDOH Data
Lab & Biometric Data
Rx Claims
Medical Claims
HRA and Survey Data
Provider Data
Enrollment Data
Activity Data
Program Participation
Consumer Data
Disability, Leave & WC Data
Call Center Data
CAHPS Data
Benefits
RPM & Device Data

DATA WAREHOUSE, QC & ENRICHMENT

Data acquisition

Data quality

Data integration

CONSUMER 360 VIEW

Holistic Member 360° View

KEY SOLUTION COMPONENTS IN FUNCTION

Member360⁰ View

Measure Library

Advanced Analytics

Data science

SDOH Enrichment

Benchmarks & Reporting

Adhoc Reporting & Data Discovery

Vendor Integration, Interoperability APIs

PREDICTIVE & PRESCRIPTIVE ANALYTICS & INSIGHTS

- Clinical & financial risk analytics & stratification
- Cost & Utilization metrics
- Gaps in care, HEDIS measures
- Impactability - gaps with potential savings, ED probability, IP probability score & readmission score
- Intervenability - propensity to engage, preferred communication channel, social barriers
- Outcome measurement and reporting
- Social Determinants of Health Risk by Barriers
- Behavioral Health, Medicare Adherence & Opioid Risk

REPORTING USE CASES

- Population Health Reporting
- Employer Group / Client Reporting
- Provider Network & VBC Reporting
- Pharmacy Reporting
- Outcomes & ROI Reporting
- Standard Cohort Analysis
- Action-Oriented Insights using Intelligent Automation & AI capabilities

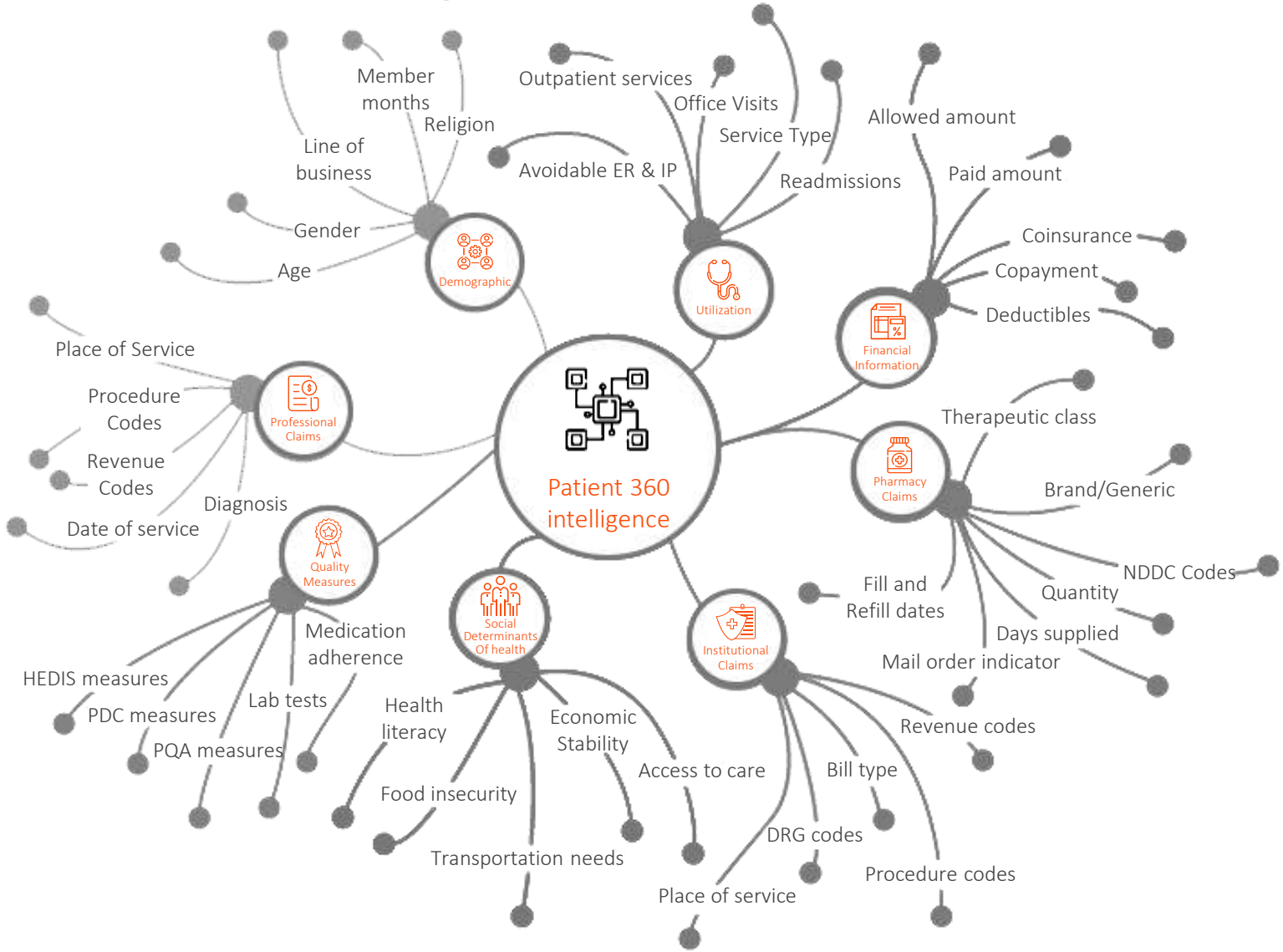
HITRUST CSF Certified

EXL

Proven longitudinal member 360 intelligence to drive outcomes

360°

Our solution offers a Comprehensive Data Strategy & Longitudinal 360° View so you can trust your data and save internal team effort.



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Prioritizing resources for greatest impact

We go beyond basic risk stratification by identifying who is most impactable & what care should be delivered, in priority order

Track, trend and monitor current risk

Predict potential future risk for the **Chronic comorbid**

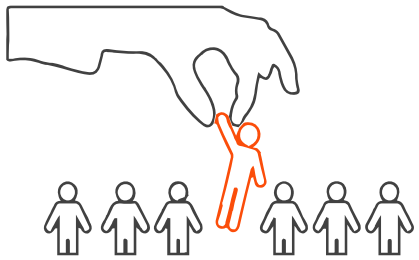
Identify opportunities for early engagement of **members who will become high risk in the future - "Emerging Risk"**

Prioritize member engagement based on potential for greatest impact on member costs and health outcomes

Identifying member with **higher propensity to engage** by leveraging the most effective communication channels and addressing **SDOH Barriers**

Care coordination & member engagement

Intervenable members



12%

25,000 Members

Transparency into top barriers impacting health outcomes paired with how to best engage

Member	Top conditions	Top Gaps	Top barriers			Interventions			Communication
			1st	2nd	3rd	1st	2nd	3rd	
1	Asthma diabetes depression bipolar	Office visit asthma controller HbA1c eye exam	No companion	Access to care	Economic status	Community resources	Telemedicine, transportation	Incentives (or points), high personal contact	Call, email,
2			Health literacy	Sedentary lifestyle	No companion	Education	10,000 steps	Community resources	Digital, Apps, email
3			Health literacy	Access to care	Sedentary lifestyle	Education	Telemedicine, transportation	Active lifestyle community resources	Apps, mail

Actionable clinical care gaps, SDoH barriers & mode of outreach for improved engagement

Member	Conditions		Top Clinical Gaps			Top SDOH Barriers			Interventions			Communications			
	1st	2nd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	4th
00001	Asthma	Diabetes	Asm Controller (PDC 75%)	Diabetes HBA1c	Diabetes Provider Visit	Access to Care	Health Literacy	Behavior Health	Telemedicine, Transportation	Education	Remote Monitoring, Community Resources	Call	Mail	Email	Digital/Apps
00002	CHF	Hyperlipidemia	HLP Provider	CHF Beta Blockers (PDC 80%)	HLP Statins (PDC 80%)	Access to Care	Health Literacy	Sedentary Lifestyle	Telemedicine, Transportation	Education	Incentives (or Points), High Personal Contact	Call	Mail	Email	Digital/Apps
00003	Diabetes	Hyperlipidemia	Diabetes HBA1c	Diabetes Provider Visit	HLP Provider Visit	No Companion	Health Literacy		Community Resources	Education		Call	Email	Digital/Apps	
00004	Hypertension	Hyperlipidemia	HTN Provider	HLP Provider	HTN Lipid	Access to Care	Behavior Health		Telemedicine, Transportation	Remote Monitoring, Community Resources		Call	Email	Digital/Apps	
00005	Hypertension		HTN Lipid	HTN Provider	HTN ACE (PDC 80%)	Access to Care	No Companion	Tobacco Risk	Telemedicine, Transportation	Community Resources	Tobacco Cessation Program	Call	Mail	Email	Digital/Apps
00006	Bipolar	Back Pain	Back Pain Provider	Bipolar Provider	Diabetes HBA1c	Economic Status	No Companion	Health Literacy	Incentives (or Points)	Community Resources	Education	Call	Email	Digital/Apps	
00007	Hypertension	Back Pain	HTN Lipid	Back Pain Provider	HTN Provider	Economic Status	Health Literacy	Tobacco Risk	Incentives (or Points)	Education	Tobacco Cessation Program	Call	Mail	Email	Digital/Apps
00008	Asthma	CAD	Asm Controller (PDC 75%)	CAD Provider	CAD Lipid Panel	Health Literacy			Education			Call	Mail	Email	Digital/Apps
00009	Hyperlipidemia	Diabetes	HLP Provider	HLP Statins (PDC 80%)	Diabetes HBA1c	Sedentary Lifestyle			Incentives (or Points), High Personal Contact			Call	Email	Digital/Apps	
00010	Diabetes	Hyperlipidemia	Diabetes Eye Exam	Diabetes Provider Visit	Antihyperlipidemics 30 Days	Economic Status	Health Literacy		Incentives (or Points)	Education		Call	Mail	Email	Digital/Apps
00011	Hyperlipidemia	Diabetes	HLP Provider	Diabetes HBA1c	Diabetes Provider Visit	Access to Care	Behavior Health		Telemedicine, Transportation	Remote Monitoring, Community Resources		Call	Mail	Email	Digital/Apps
00012	Diabetes	Asthma	Diabetes Eye Exam	Asm Controller (PDC 80%)	Diabetes	Health Literacy	Behavior Health	Tobacco Risk	Education	Remote Monitoring, Community Resources	Tobacco Cessation Program	Call	Mail	Email	Digital/Apps
00013	Hyperlipidemia	Back Pain	HLP Provider	Back Pain Provider	Antihyperlipidemics 30 Days	No Companion			Community Resources			Call	Mail	Email	Digital/Apps
00014	Asthma		Asm Controller (PDC 80%)	Asm Provider	Asm Rescue (PDC 80%)	Behavior Health	Access to Care	No Companion	Remote Monitoring, Community Resources	Telemedicine, Transportation	Community Resources	Call	Mail	Email	Digital/Apps
00015	Back Pain	Osteoarthritis	Back Pain Provider	Osteoarthritis Provider	Diabetes HBA1c	Transportation	Sedentary Lifestyle		Incentives (or Points), Telemedicine, Community Resources	Incentives (or Points), High Personal Contact		Call	Email	Digital/Apps	

Driving overall wellbeing

Member	Predicted Well-being Score	Predicted Well-being Category	Age	Gender	Risk Factor 1	Risk Factor 2	Risk Factor 3	Risk Factor 4	Risk Factor 5
A	2.53	Fair	40	F	**Emotional -** Anxiety	**Emotional -** Loss of Hope or Feel Sad Occasionally	**Physical -** Metabolic Syndrome	**Environmental -** Lack of Healthy Food	**Social -** Lack of Social Interaction
B	2.06	Poor	46	M	**Financial -** Financial Challenge	**Emotional -** Loss of Hope or Feel Sad Occasionally	**Psychological -** Body Image Management Concern	**Physical -** Obesity	**Physical -** Diabetes
C	3.70	Very Good	26	F	**Emotional -** Loss of Hope or Feel Sad Occasionally	**Psychological -** Body Image Management Concern	**Physical -** Metabolic Syndrome	**Social -** TV / Internet Addiction	**Social -** Lack of Social Interaction
D	4.18	Excellent	62	M	**Psychological -** Body Image Management Concern	**Physical -** Obesity	**Physical -** COPD	**Social -** Lack of Social Interaction	**Social -** Lack of Community Involvement
E	3.37	Good	35	M	**Emotional -** Loss of Hope or Feel Sad Occasionally	**Psychological -** Body Image Management Concern	**Physical -** Low Sleep Quality	**Physical -** Metabolic Syndrome	**Social -** TV / Internet Addiction

Act using Integrated Approach for Care Management

Client

Member data

Social and Clinical Profile

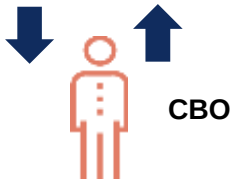
Member's 360º view of clinical and social risk is generated

SDoH Needs Screening

Members at elevated risk are screened to better understand their needs to tailor interventions

Matched with a CBO

Based on the SDoH factors the member is matched with the appropriate CBO



Monitor and Report

Outcomes measured

KPIs = Health Equity Compliance, Member Engagement, Cost & Utilization optimization

Case study

Population Health Analytics

Addressing Emerging Risk population with SDOH barriers to reduce clinical risk

To improve the quality of care while reducing costs through innovative engagement and prioritization programs, EXL partnered with a health plan to provide whole person care that addresses social and clinical gaps.

Real Results

17x

Identification of emerging risk cohort with potential for 17 times cost increase in 3 years

10%

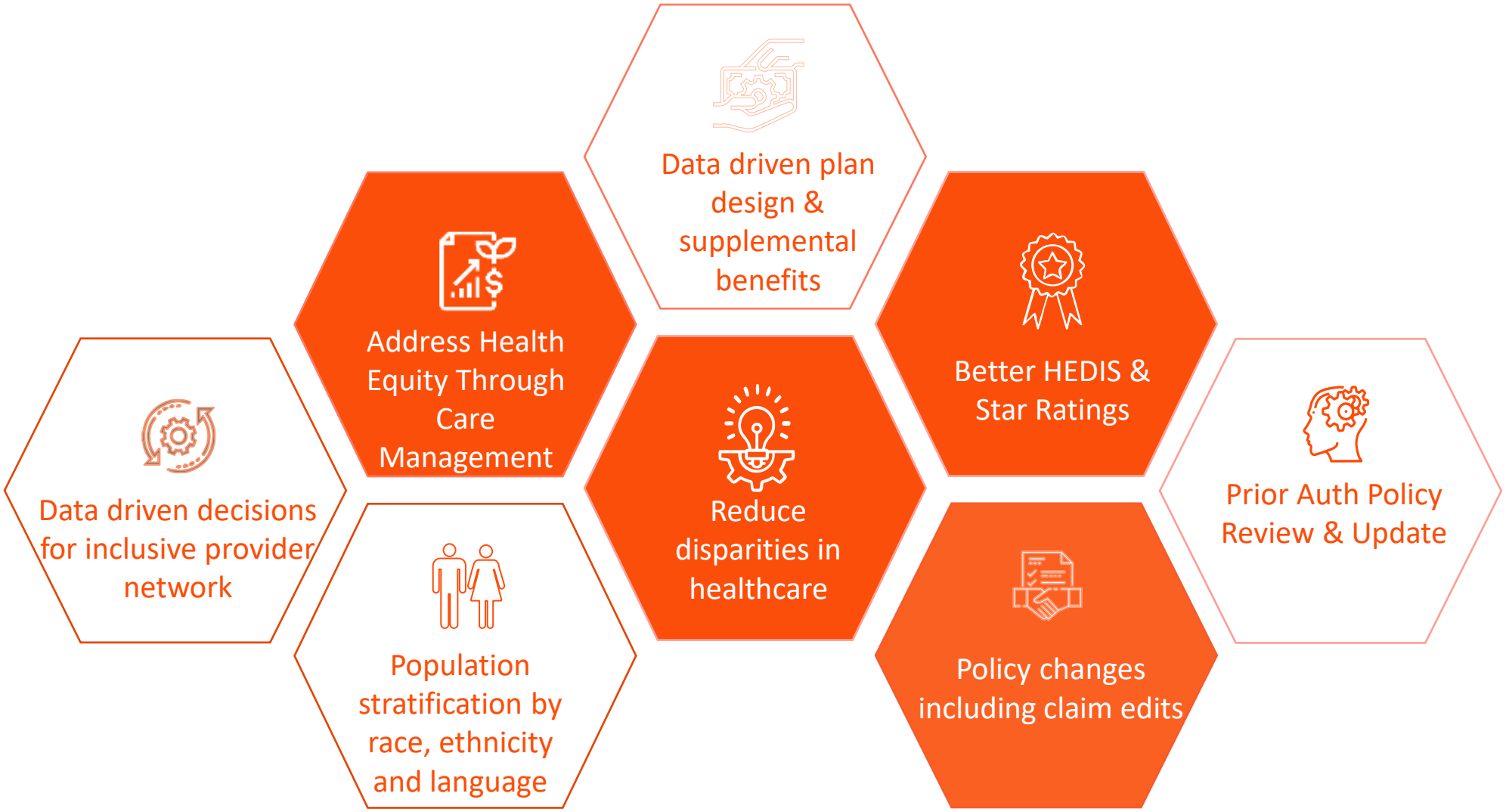
Increase in engagement rates and intervention completion through multi channel engagement and reduced operational cost

16%

Increase in gap closure rate for identified and stratified members

EXL

Value of engagement with EXL



Discussion

Thank you

EXL

CMS's Health Equity Initiative for Health Plans

CMS is committed to advancing equity in health and healthcare for all individuals and addressing inequities that exist in healthcare policies and programs that serve as barriers to equal opportunity. In MA and Part D, CMS is exploring ways to advance equity that include:

- Collecting more and improved data on beneficiaries' race, ethnicity and social determinants of health;
- Developing quality measures and methodological enhancements that better measure, and strengthen methods of addressing, health disparities;
- Driving value in the Medicare program to make sure that the Medicare dollar is spent effectively and efficiently on programmatic changes that will close health equity gaps.

Plans can meet this challenge by driving value in care delivery, developing qualitative and quantitative metrics to ensure accountability and transparency and equitable delivery of preventive and medical benefits, and taking other concrete steps to address disparities.

This includes not only offering supplemental benefits but making sure that these benefits address the most critical care gaps and barriers to care while complying with the requirements for supplemental benefits.

