California Quality Improvement, Health Education and Wellness Program Description 2026

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I. Health Plan and Membership

Health Net of California, Inc. and Health Net Community Solutions, Inc. (Health Net) are subsidiaries of Centene Corporation. Centene Corporate is a publicly traded company with health care operations throughout the United States.

As a statewide managed care company, Health Net's Quality Improvement (QI), Health Education (HEd), and Wellness Program encompasses multiple lines of businesses. Health Net is a full-service plan that offers the following individual, family, and group plans:

Health Net of California (HNCA):

- Group HMO/POS
- Group PPO
- Ambetter HMO
- Ambetter PPO
- Wellcare by Health Net HMO (H0562)
- Wellcare by Health Net HMO Chronic Special Needs Plans (C-SNP) (H0562)
- Medi-Cal Managed Care Dental Plans (Los Angeles and Sacramento)

Health Net Community Solutions (HNCS):

- Medi-Cal (Medicaid state health plan (SHP) with Geographic Managed Care (GMC) and Two-Plan contracts including Seniors and Persons with Disabilities (SPD)
- Wellcare by Health Net HMO Dual Special Needs Plan (D-SNP) (H3561)

II. Purpose and Goals

A. Mission

Transform the health of communities we serve, one person at a time.

B. Purpose:

Quality Improvement Purpose

The QI Program establishes standards for both the quality and safety of clinical care and service, as well as monitors and evaluates the adequacy and appropriateness of health care and administrative services on a continuous and systematic basis. The QI Program also supports the identification and pursuit of opportunities to improve health outcomes and member and provider satisfaction.

Health Education Purpose

The Health Education (HEd) System provides accessible no cost health education programs, services and resources based on the community health, cultural, and linguistic needs of the Health Net's SHP members and contractually-required program scope.

Wellness Purpose

The Wellness Department delivers programs for Commercial, Marketplace, and Medicare members in various settings, with a focus on both prevention and condition management to enhance members' quality of life.

C. Goals:

Quality Improvement's Goals:

- Support Health Net's strategic business plan to promote safe, high-quality care and services while maintaining full compliance with regulations or standards established by federal and state regulatory and accreditation agencies.
- Objectively and systematically monitor and evaluate services provided to Health Net members to ensure conformity to professionally recognized standards of practice and codes of ethics.
- Provide an integrative structure that links knowledge and processes together throughout the organization to assess and improve the quality and safety of clinical care with quality service provided to members.
- Develop and implement an annual quality improvement work plan and continually evaluate the effectiveness of plan activities at improving and maintaining performance of target measures and act, as needed, to improve performance.
- Support a partnership among members, practitioners, providers, regulators and purchasers to provide effective health management, health education, disease prevention and management, and facilitate appropriate use of health care resources and services.
- Design, implement and measure organization-wide programs that improve member, practitioner and provider satisfaction with Health Net's clinical delivery system. These programs are population-based, ongoing, clinical assessments and are evaluated to determine the effectiveness of clinical practice guidelines, preventive health guidelines, and care management programs.
- Monitor and improve Health Net's performance in promoting quality of service to improve member and provider satisfaction through the use of satisfaction surveys, focused studies, and analysis of data (e.g., administrative, primary care, high-volume specialists and specialty services, and mental health and substance use disorder services).
- Promote systems and business operations that provide and protect the confidentiality, privacy and security of member, practitioner and provider information while ensuring the integrity of data collection and reporting systems. This is done in accordance with state and federal requirements and accreditation guidelines.
- Anticipate, understand and respond to customer needs, be customer-driven and dedicated to a standard of excellence in all customer relationships.
- Provide a means by which members may seek resolution of perceived failure by practitioners and providers or Health Net personnel to provide appropriate services, access to care, or quality of care. Identify, review and investigate potential quality of care issues and take corrective action, when appropriate.
- Ensure the development of strategies and processes designed to improve health equity and mitigate health disparities.

Health Education's Goals:

- To provide culturally and linguistically appropriate health education programs and resources at no cost to
    - Support members and the community to achieve optimal physical and mental health.
    - Promote health equity.
    - Improve Health Net's quality performance.
    - Enhance member satisfaction.
    - To engage communities, stakeholders and partners by providing high quality health education programs and resources and retention.

Wellness Goals:

- Promote member health and prevent injury and disease through the provision of health promotion programs developed in accordance with preventive health guidelines based on scientific evidence and practitioner involvement.
- Empower members to manage their own health and actively participate in their health care through member risk assessments, health screenings and trainings in health decision-making.
- Promote optimal quality of life and health status among members with identified risk factors or chronic medical conditions through the provision of patient education and self-management programs.
- Reduce member risk for chronic conditions through the delivery of a diabetes risk reduction program.
- Offer personalized and clinically-proven tools to assist members to reduce stigma and improve mental health.
- Encourage continuous innovation and quality improvement in member health promotion, patient education and disease self-management programs.
- Promote member retention and satisfaction across product lines through the promotion of value-added resources and programs available to the member.

III. Scope

A. Overview of the QIHEd Program

The QI, HEd, and Wellness Program includes the development and implementation of standards for clinical care and service, the measurement of compliance to the standards, and implementation of actions to improve performance, health education and wellness programs, services, and resources. The scope of these activities considers the enrolled populations' (including delegated enrollees) demographics and health risk characteristics, as well as current national, state and regional public health goals. Health Net's Population Health Management (PHM) strategy provides a unifying framework to support the QI, HEd, and Wellness Programs in delivering a whole-person approach to caring for members.

Health Education interventions are based on community health and cultural and linguistic needs to encourage members to practice positive health and lifestyle behaviors, to use appropriate preventive care and primary health and dental care services, and to follow self-care regimen and treatment therapies. Health Education Services include individual, group or community-level education and are supported by trained health educators and public health professionals to encourage immediate positive knowledge gain and healthy behavioral intentions. Health education programs include individual, community or population-based initiatives designed to encourage

long-term behavioral changes for positive health outcomes. Provision of health education resources includes culturally and linguistically appropriate brochures, flyers, posters, newsletters, presentations, website articles, and social media resources. The framework uses risk stratification data compiled from a variety of data sources to help teams target the right members with the right resources to address member health and social drivers of health (SDoH) needs at all stages of life.

The QI, HEd, and Wellness Program impacts the following:

- **Health Net Members** in all demographic groups and in all service areas for which Health Net is licensed.
- **CalViva Health and Community Health Plan of Imperial Valley Members** in all demographic groups and in service areas for which Health Net is delegated.
- **Network Providers** including practitioners, facilities, hospitals, ancillary providers, and any other contracted or subcontracted provider types.
- **Aspects of Care** including level of care, health promotion, wellness, chronic conditions management, care management, continuity of care, appropriateness, timeliness, and clinical effectiveness of care and services covered by Health Net.
- **Health Disparities** by supporting activities and initiatives that improve the delivery of health care services, patient outcomes, and reduce health inequities.
- **Health Education** by providing accessible no cost health education programs, services and resources based on the community health, cultural and linguistic needs of Health Net's SNP members and contractually required program scope and by monitoring the quality and accessibility of health promotion and education resources made available to Health Net's SHP members by Health Net's subcontracting Health and Dental Plans, Participating Provider Groups (PPG), and Primary Care Physicians (PCPs).
- **Wellness programs** to inform members about, and encourage, appropriate use of the wellness services; identify and target age appropriate, at-risk members with specific education programs and measure the effectiveness of these programs; implement interventions through a diversity of delivery settings, and provide education through a variety of communication vehicles and vendors, in order to most effectively serve members; and integrate member health education functions into the activities of other Health Net departments, where appropriate, to further the mutual attainment of health care and quality improvement goals, and to support member satisfaction, retention and growth.
- **Communication** to meet the cultural and linguistic needs of all members.
- **Behavioral Health Aspects of Care** integration by monitoring and evaluating the care and service provided to improve behavioral health care in coordination with other medical conditions.
- **Practitioner/Provider Performance** relating to professional licensing, accessibility and availability of care, quality and safety of care and service, including practitioner and office associate behavior, medical record keeping practices, environmental safety and health, and health promotion.
- **Services Covered by Health Net** including preventive care, primary care, specialty care, telehealth, ancillary care, emergency services, behavioral health services, diagnostic services, pharmaceutical services, skilled nursing care, home health care, Long Term Services and Supports (LTSS): long term care (LTC), Community Based Adult Services (CBAS); CalAIM benefits and community supports, that meets the special, cultural and linguistic, complex, social or chronic needs of all members.
- **Internal Administrative Processes** which are related to service and quality of care, including customer services, enrollment services, provider relations, practitioner and provider qualifications and selection, confidential handling of

medical records and information, care management services, utilization review activities, preventive services, health education, information services and quality improvement.

B. Preventive Screening Guidelines

Health Net adopts nationally recognized preventive health guidelines for health maintenance, improvement and early detection of illness and disease for children and adults. The guidelines are reviewed, updated, and adopted on an annual basis or more frequently when new scientific evidence or national standards are published prior to the scheduled review date. Medical directors with various medical specialties are involved in the adoption of the guidelines. New Medi-Cal members receive the Preventive Health Screening guidelines in the new member welcome packet and new providers receive this information with orientation materials within 10 days of becoming authorized to see Health Net members. The guidelines inform members of health screening and immunization schedules for all ages. These are available in all 12 threshold languages. Printed guidelines are available to all members and network providers on the member and provider portals and by calling the Health Education Department. Updates, when applicable, are distributed to all practitioners via Provider Updates.

Preventive services relevant to Health Net's membership are monitored through the National Committee for Quality Assurance's (NCQA) Healthcare Effectiveness Data Information Set (HEDIS®) and other programs as specified in the QI, HEd, and Wellness Work Plan. In collaboration with physicians and providers, Health Net encourages members to utilize health promotion and preventive care services.

C. Clinical Practice Guidelines

Health Net adopts and disseminates evidenced-based clinical practice guidelines that are relevant to its membership for the provision of preventive and non-preventive health care services, acute and chronic medical services, and behavioral health services. These clinical practice guidelines assist practitioners, providers and members to make decisions about appropriate health care for specific clinical circumstances, to improve health care, and to reduce unnecessary variations in care.

In conjunction with Centene's Clinical Policy Committee, Health Net adopts guidelines from recognized organizations that develop or disseminate evidenced-based clinical practice guidelines. These include professional medical associations, voluntary and other health organizations such as the National Institutes of Health (NIH) and the U.S. Preventive Services Task Force (USPSTF). Input from specialists is obtained as necessary and clinical practice guidelines are reviewed and approved by Health Net's Medical Advisory Council. The guidelines are updated and revised at least every two years or more frequently when new scientific evidence or national standards are published.

Guidelines are evaluated for consistency with Health Net's benefits, utilization management criteria, and member education materials. They are communicated to providers through provider updates and are available to providers on the Health Net websites, and to members upon request. Health Net monitors adherence to guideline recommendations and program outcomes using HEDIS measures.

D. New Technologies

Health Net has a formal process for recognizing and evaluating advances in new medical technologies, behavioral health procedures, pharmaceuticals, devices, and new

applications of existing technologies to ensure members have equitable access to safe and effective care and for inclusion in applicable benefit packages.

The Change Healthcare InterQual® criteria, the HAYES Technology Directory and other evidence-based resources are used as primary sources. This includes:

- Nationally recognized drug compendia resources such as American Hospital Formulary Service-Drug Information (AHFS DI®), Facts & Comparisons®, Clinical Pharmacology®, DRUGDEX®, Lexi-Drugs®, and the National Comprehensive Cancer Network® (NCCN®) Guidelines.
- Medical association publications, government-funded, or independent entities that assess and report on clinical care decisions and technology, including Agency for Healthcare Research and Quality (AHRQ), Hayes Technology Assessment, Up-To-Date, Cochrane Reviews, and National Institute for Health and Care Excellence (NICE).

In addition to Health Net's primary sources, Centene's Corporate Clinical Policy Department and Clinical Policy Committee in conjunction with Health Net of California's Medical Advisory Council are responsible for the evaluation of new technology that may be sought by members. A critical appraisal of the current published medical literature from peer-reviewed publications is undertaken to assist in the evaluation of medical technology.

E. Population Health Management

Annually, Health Net evaluates the needs of its enrolled population and uses that information to assess whether current programs need modification to better address the needs of its membership. Health Net examines data through population risk stratification using a predictive modeling tool that utilizes data from various sources including medical and behavioral claims/encounters, social needs data, pharmacy claims, laboratory results, health appraisal results, electronic health records, data from health plan Utilization Management (UM) and/or Care Management (CM) programs, and advanced data sources such as all-payer claims databases or regional health information. The data are used for:

- Evaluation of the characteristics and needs of the member population including an analysis of the impact of relevant social drivers of health.
- Evaluation of health status and risks by using utilization data broken out into at least the following cohorts based on the enrolled product lines: birth to age 18, age 19 to 64, and ages 65 and over.
- Evaluation of the needs of child members with Special Health Care Needs (CSHCN)
- Evaluation of the needs of members with disabilities.
- Evaluation of the needs of member with severe and persistent mental illness.

Data are reported separately by product lines to facilitate an understanding of similarities and differences in health needs and status. When the data analysis is complete, it is used to determine if changes are required to population health management programs or resources. In addition, there is an evaluation of the extent to which PHM programs facilitate access and connection to community resources that address member needs outside the scope of the health benefit plan. Modifications to program design and resources are made based on these findings.

The Risk Stratification, Segmentation, Tiering (RSST) methodology identifies significant changes in members' health status or level of care. In this way, members are monitored to ensure appropriate re-stratification and connection to Chronic Disease Management, Care Management, Enhanced Care Management (ECM), Complex Care Management (CCM), Community Supports (CS) and other programs. Outcomes data is stratified by race, ethnicity, language, and age on a plan-level including ER/inpatient (IP) utilization, ambulatory and preventative visits within a twelve-month period, enrollment into CCM, and transitions for high-risk members having connection with their assigned Care Manager.

The PHM operations team is a cross-unit team composed of talent from multiple departments and is led by a core team of a Medical Director, Pharmacist, and a Chief Health Equity Officer. The team is accountable to Health Net's Health Care Delivery Steering and QI Committees.

Basic Population Health Management

The Basic Population Health Management (BPHM) services support the ongoing, seasonal, episodic, and occasional needs of our members across all lines of business to ensure appropriate care. Using a multi-pronged, non-delegated, empanelment approach to BPHM, we directly facilitate connections to primary care. New Medi-Cal Member welcome packets are sent to ask members to schedule their initial health appointments (IHA), and conduct new member outreach to facilitate appointment scheduling, and survey members to ensure they are satisfied with their assigned providers. Primary care providers (PCPs) are also notified of new member enrollment within 10 days of assignment to facilitate PCPs seeing their patients within 120 days of assignment. Members who do not select a PCP within 30-days of enrollment are auto-assigned a PCP within 40-days of enrollment (at the time of enrollment for Medicare and within 40 days of enrollment for Medi-Cal). Full-benefit dual-eligible Members are not required to select a Medi-Cal PCP.

The Plan proactively outreaches to members without a PCP visit in the past year to assist in arranging appointments, transportation, or interpreters, if needed. Hard-to-reach members, including those with unstable housing or no phone, are assigned to the Plan's MemberConnections® Field Team for in-person outreach. The MemberConnections Representatives (MCR) also assist with PCP selection or change. Members are informed that they can select a variety of providers in lieu of a PCP (e.g., Nurse Practitioner, Certified Nurse Midwife, Physician Assistant).

Chronic Conditions Management

Health Net offers an integrated care management program to Commercial, Marketplace, Medicare, and Medicaid members that address members' physical, behavioral, and psychosocial needs. Care managers support members to increase their awareness of self-care strategies and empower participants to manage their chronic conditions. This program includes a population-based identification process, risk stratification, interventions based on clinical need, patient self-management, disease education, and process and outcome measurement. Multi-disciplinary teams are involved in the development of these efforts. Referrals to care management programs are multichannel and come through provider and member self-referrals. Members enrolled in the care management program with chronic conditions are included in the integrated care model.

Centene's Population Health Management Office conducts chronic conditions management for members with designated diagnoses. The program includes member stratification, disease education, and promotion of self-management principles. Members requiring additional support are referred to Care Management.

Complex Health Needs/Care Management

Health Net is committed to serving members with complex medical or behavioral health needs through coordinating services and assisting them in accessing needed resources.

Health Net provides care management for Medi-Cal including seniors and persons with disabilities, Medicare including Special Needs Plans, Commercial, and Exchange/Marketplace. Health Net partners with vendors for select employer group accounts. Medical groups also provide care management as indicated in their delegation agreements. The goal of Care Management is to support members in achieving optimum health, functional capability, and quality of life through improved management of their disease or condition, and access to available resources.

Members in Complex Care Management have typically experienced a critical event or have a complex diagnosis that may be compounded by social drivers of health requiring oversight and coordination of care with practitioners, providers and/or community and social service agencies. Members are identified using Health Net data sources and may also be referred into the program via multiple avenues, such as:

- Health information
- Internal program
- Discharge planning referral
- Utilization management referral
- Member or caregiver self-referral
- Practitioner referral, and
- Ancillary providers (e.g., home health, physical therapy, occupational therapy).

Members undergo a comprehensive assessment, which is used to develop a care plan that meets their specific complex care needs. Care plans focus on the member's prioritized needs including monitoring the patient's understanding and adherence to the plan of care, identification and removal of barriers to care, achievement of short- and long-term goals, and restoration of the highest functional level that is possible for the patient.

The SNP Model of Care is a plan for delivering coordinated care and care management to our special needs members. SNP members that are classified as moderate or high priority are automatically referred into our care management program. Members that enroll in our care management program receive outreaches and interventions based on member need and will have an assigned care manager to serve as a primary point of contact during the episode of care.

F. Behavioral Health Services

Behavioral health services are provided to Health Net members including carved-in services for Medi-Cal. Health Net contracts with psychiatrists as well as non-MD behavioral health specialists. The medical directors and clinical and operational associates provide specialized guidance for behavioral health issues at all applicable Health Net committees. The Behavioral Health Medical Director attends the HNCA and HNCS Quality Improvement/Health Equity Committees (QIHEC).

Health Net takes a collaborative approach to educate providers and members on the importance of:

- Coordination of care and exchange of information between medical and behavioral health providers.
- Diagnosis, treatment, and referrals of behavioral health disorders including substance use disorders (SUD).
- Appropriate uses of psychopharmacologic medications and treatment adherence.
- Managing coexisting conditions and behavioral health preventive programs.

The following supportive sources are used to identify new initiatives or opportunities to enhance existing interventions:

- Member surveys to assess satisfaction with and access to behavioral health services.
- Provider surveys to assess satisfaction with the timeliness and usefulness of information and action from the plan, along with their experience with coordination of care.
- Network availability and adequacy of behavioral health practitioners and providers.
- Member quality of care and service complaints investigation.
- Evaluation of existing behavioral health QI initiatives.
- Behavioral health HEDIS measures.
- Care Management depression screening.

G. Operations and Service

Health Net evaluates the adequacy, effectiveness, and timeliness of internal operations against established standards to identify strengths and opportunities to improve member, practitioner, and provider satisfaction. Standards are based on regulatory and accrediting bodies.

Health Net monitors access to services and availability of the practitioner and provider network, member grievance and appeals, member satisfaction surveys, practitioners and provider satisfaction surveys, marketing material accuracy and provider feedback through Provider Engagement, Data Strategy & Insight, and Provider Network Management departments.

Quality improvement activities focused on service and internal operations require collaboration across departments through the QI, HEd, and Wellness Program. Activities involve associates from Population Health and Clinical Operations, Pharmacy, Health Equity, Appeals and Grievances, Customer Contact Center, Credentialing, Provider Network Management, Provider Engagement, Data Strategy & Insight, Claims, Compliance, Privacy, and Program Accreditation Departments.

H. Health Plan Performance

Health Net is an NCQA accredited managed care organization. Health Net conducts ongoing monitoring of each health plan's performance by participating in annual HEDIS measurement, member and provider satisfaction assessments, monitoring of appeals and grievances, and evaluating the accessibility and availability of medical services across all lines of business.

Health Net maintains a broad range of key performance and operational metrics to monitor clinical and service quality in Appeals and Grievances, Customer Service, Population Health and Clinical Operations which includes Utilization Management, Care Management, Concurrent Review, and the Medical Review Unit. The Health Net QI Department also monitors key performance metrics for Pharmacy.

Health Net monitors HEDIS rates, CMS Star Ratings and Quality Rating System (QRS) ratings, Quality Transformation Initiative (QTI) & 25-2-2 Policy of Covered California, Medicare HOS (Health Outcomes Survey), DMHC Health Equity and Quality measure performance, hospital quality metrics, access and availability standards, quality of care incidents, and CAHPS/Experience of Care and Health Outcomes (ECHO)/Outpatient Mental Health (OPMH) Survey results to assess practitioner and provider adherence to best practices and prioritize health plan outreach activities and campaigns. Health Net emphasizes the importance of technology/Electronic Health Records (EHRs) enabling providers to track and remind patients about regular health screenings. Multiple activities may be in place for each product line to improve outcomes, promote safety, increase screening and improve performance metrics. Examples are included in the following list (refer to the QI, HEd, and Wellness Annual Work Plan section for more details):

- Practitioner and provider outreach to improve exchange of quality performance data.
- Member outreach to close care gaps.
- Provider outreach to share quality performance ratings.
- Development of tools to assist practitioners and providers to improve performance.
- Hospital quality monitoring for hospital acquired conditions.

I. Credentialing and Recredentialing

Health Net is an NCQA accredited managed care organization. Health Net has established policies and standards to ensure the selection and retention of qualified practitioners and providers. Policies have also been developed for oversight of those organizations delegated to manage the credentialing of practitioners.

Recredentialing is initiated and completed within 36 months of the previous committee decision and incorporates a three year look back review of peer review and member activity that assists the Credentialing Committee in making an informed decision.

Ongoing monitoring occurs after the practitioner's initial inclusion to our network begins and occurs monthly, to ensure our plan can take immediate action to protect our members and maintain compliance with all regulatory agencies. We take action within 30 calendar days of the released report:

- Member complaints and quality of care service tracking and trending.
- Medicare/Medicaid sanctions.

- Federal Department report.
- Medicare opt-out.
- OI/LEIE: The Office of Inspector General list of excluded entities/listing of excluded Medicare and Medicaid providers.
- Medicare (CMS) Preclusion Listing.
- State Medical Board disciplinary action reports.
- Medi-Cal Suspended and Ineligible list (SIPL).
- Restricted Provider Database (RPD).
- Ongoing office monitoring.

Any delegates with continued compliance issues are reported to the Delegation Oversight Committee. The Delegation Oversight Committee is a subcommittee of HNCA and HNCS QIHECs. The Appeals and Grievances Department works with the Credentialing and the Peer Review teams to report on potential and substantiated quality of care issues. All practitioners and providers undergo a quality process of credentialing prior to finalizing contractual agreements and are recredentialed every three years. All practitioners and providers are monitored monthly for Medicare/Medicaid sanctions, license sanctions, limitations and expirations, quality of care and service incidents, and any other adverse actions. Trended issues and high severity-leveled cases are reported to the Peer Review Committee for review and determination.

J. Continuity and Coordination of Care

Ensuring that the care members receive is seamless and integrated is a major focus for Health Net. These activities can be divided into the following main areas:

- Across medical care settings that include (but are not limited to) outpatient, inpatient, residential, ambulatory, CBAS centers, and other types of locations where care may be provided.
- Transition between practitioners when practitioners leave the network or changes their health care setting.
- Continuity and coordination between medical care and behavioral health care.
- Referral and coordination with Medi-Cal carved out service providers.

Health Net identifies opportunities for improvement in continuity and coordination of care through various methodologies, including but not limited to:

- Member satisfaction surveys
- Appeals and Grievances data analysis
- Practitioner/provider satisfaction surveys
- HEDIS measures, and
- Medical record review.

For all members with identified complex health needs, Health Net supports their continuity and coordination of care through an integrated healthcare model that provides the level of care management the member needs based on acuity or behavioral health conditions.

The nurse advice line also addresses member triage needs 24 hours a day, seven days a week for all lines of business. Provider groups also support members through their coordination of care programs.

Mechanisms are implemented to monitor and facilitate continuity and coordination of care for members. These activities include, but are not limited to:

- Care Management
- Pharmacy programs
- Utilization Management
- Member Services functions
- Communication and data exchange that is appropriate and compliant with state and federal privacy and security regulations, and
- Information will be posted on the Plan website for advising providers, contractors, members, and the public how they can obtain information about the UM processes and guidelines used to authorize, modify, or deny health care services under the benefits provided by Health Net.

K. Delegation

In some instances, Health Net delegates utilization management, credentialing, complex care management, the operational components of claims processing and payment to designated practitioners, provider groups, contracted vendors or ancillary organizations. Comprehensive delegation policies and processes have been established to address oversight of these entities. Annually, delegated organizations must demonstrate the willingness, capability, proficiency and experience to manage the delegated responsibilities. Health Net will institute corrective action and/or may revoke delegation when it determines the delegate is unable or unwilling to carry out the delegated responsibilities. Delegates that are certified or NCQA accredited are not required to undergo an annual on-site review for elements included in the accreditation; however, Health Net will conduct reviews for all other elements not included in the NCQA accreditation.

Health Net conducts a structured pre-delegation evaluation to include analysis of program documents, audit of related files, and review of any organization being considered for delegation. The evaluation results are compiled, and a written summary of findings and recommendations are presented to the Delegation Oversight Committee for final determination. Audits are also performed annually for every delegate to determine the continuation of the delegated relationship. Health Net also retains the right to perform more frequent audits at the direction of the Delegation Oversight Committee in order to bring the entity into full compliance.

L. Safety

Health Net is committed to an ongoing collaboration with network providers, facilities and external accrediting agencies to build a safer health system. Current member or patient safety initiatives include:

- Featuring online quality tools to help members make informed decisions about where to receive quality care and services, such as The Leapfrog Group, CMS's Care Compare and Cal Hospital Compare. These tools allow members to easily compare hospitals across key areas of quality including patient safety, patient experience, maternal health, and overall performance. Cal Hospital Compare also produces Honor Rolls to identify high-performing hospitals for maternity care; patient safety; and opioid care. The Leapfrog Group features their Hospital Safety Grade. Health Net collaborates with Leapfrog and Cal Hospital Compare to address hospital quality, understand trends and performance details to guide strategy and messaging, and to identify and engage low performing hospitals on priority metrics.

- Access to nationally-endorsed quality comparison information from the Office of the Patient Advocate (OPA), now referred to as the California Health Care Quality Report Cards, to enrollees via the online portal. These report cards were developed with significant input from Integrated Healthcare Association (IHA) and its partner health plans (Health Net included) and are based on sound actuarial principles. The California Health Care Quality Report Cards rank quality and patient experience for Commercial HMO and PPO plans in California as well as quality, member experience and total health care costs for commercial and Medicare medical groups.
- Responses to quality of care issues for which an investigation of complaints is conducted, and action taken where applicable. Analyses of overall and individual trends are conducted.
- Monitoring of reportable hospital events and investigation of quality of care issues as appropriate.
- Providing educational information to members and practitioners on safe health practices.
- Credentialing and recredentialing to ensure only qualified practitioners and organizations provide care to members.
- Practitioner office site reviews in accordance with established criteria to ensure environments are safe, clean and accessible for members.
- Clinical practice guidelines distributed to network providers; Health Net evaluates and makes decisions on utilization management, member education, coverage of services, and other areas to be consistent with Health Net's clinical guidelines.
- Careful review of member complaints and member satisfaction surveys related to member safety to ensure action is taken when applicable.
- Care Management conducts activities to ensure that continuity and coordination of care are provided for high-risk members.
- Pharmaceutical information available for practitioners about member-specific topics and new medications. The Pharmacy Department also conducts utilization reviews and develops quality initiatives related to prescription drugs and best practices.
- Prescription drug information is available on the member portal of the Health Net website about generic and brand names, warnings, side effects, precautions, drug-drug interactions, overdose information and what to do if a dose is missed.
- Improvement initiatives that promote safety, such as the patient safety QI program which includes hospital-acquired condition monitoring, working to reduce hospital-acquired infections and improve sepsis care, promoting the Leapfrog Hospital Safety Grade and participation in Leapfrog surveys, reducing unnecessary C-sections, and promoting Cal Hospital Compare's Honor Rolls.
- Member guidance to drive awareness about hospital quality issues and the tools that can support informed decision-making, with particular focus on patient safety and maternal health.
- Participating in collaborative efforts to improve care with organizations such as The Leapfrog Group, the California Maternal Quality Care Collaborative (CMQCC), Cal Hospital Compare, California Quality Collaborative (CQC), the Health Services Advisory Group (HSAG), a hospital quality collaboration with other health plans, HICE (Health Industry Collaboration Effort); CAHP (California Association of Health Plans), Department of Managed Health Care (DMHC) and/or Department of Health Care Services (DHCS) Quality Collaborative meetings with other health plans, Public Health for All Californians Together (PHACT) Coalition, Integrated Healthcare Association (IHA), collaborations with several Local Health Jurisdictions (LHJs) and other Managed Care Plans (MCP) as a part of CalAIM, the Child Health Equity Collaborative organized by the

Institute for Health Improvement (IHI) with DHCS and all other California MCPs, and a recently-launched, multi-plan Affinity Group led by DHCS focused on infant well-child visits.

M. Health Equity and Cultural and Linguistic Needs

Health Net utilizes the Cultural and Linguistic Appropriate Services (CLAS) Standards, developed by the Office of Minority Health, as a guide for provision of culturally and linguistically appropriate services. CLAS Standards assure that services comply with the Office of Civil Rights Guidelines for culturally and linguistically appropriate access to health care services (Title VI of the Civil Rights Act). Health Net's objective is to promote effective communication with limited English proficient members by assuring access to culturally appropriate materials, print translations of member informing materials, telephonic and in-person interpreter services, and through culturally responsive Health Net associates and health care practitioners and providers.

At least every two years, Health Net completes an analysis of the cultural and linguistic needs of the membership. Data sources may include the following:

- Membership demographic data
- Call center data
- Appeals and grievance information, and
- Geo Access analysis of provider network language capabilities.

These data sources are used to analyze members' cultural and linguistic needs when developing communications to promote quality and health promotion activities and meet contractual obligations established by regulatory and accrediting bodies.

Health Net is aware of the diverse culture of California and is fully compliant with the contract requirements related to California's Department of Health Care Services (DHCS) regulatory agency Medi-Cal Managed Care Division (MMCD) Policy Letters, DMHC, and Department of Insurance (DOI) regulations for language assistance services and federal rules that require the provision of language assistance services. Additionally, we ensure processes to meet contractual and regulatory cultural and linguistic requirements identified by Centers for Medicare and Medicaid Services (CMS), Covered California, and other regulatory and oversight entities.

At least annually, Health Net informs members, practitioners and providers of the availability of the Language Assistance Program (LAP), which offers language assistance services at no cost to members, including how to access the services and their rights to file grievances, in compliance with legal, contractual, regulatory agency, and oversight agency guidelines. Semi-annually, the LAP is monitored; this report includes trend analysis of grievances, and summary of language preference for all product lines. Health Net quality committees approve the appropriate quality benchmarks, review language preference results, and make recommendations for incorporating language preference into QI, and health education programs, follow-up actions or corrective action plans as needed. This process is managed by the Health Equity team.

A Geo Access assessment is conducted using member zip code data and correlated with member language preference every two years. The language capabilities of the practitioner and provider network are compared to the language needs of Health Net members by line of business. The availability of linguistic services by contracted providers for limited English proficient members is analyzed and recommendations are

made to further enhance the promotion of available language services in support of members, practitioner and provider network. Contracted practitioners and providers are informed of the cultural and linguistic services available via Provider Updates and the provider operations manuals. Culturally informative materials, trainings, and in-services are provided to network practitioners and internal department associates periodically. The Health Net Cultural Competency Training Program addresses the delivery of services in a culturally competent manner to all members, including prohibiting discrimination based on national origin, race, color, ancestry, ethnic group identification, sex, sexual orientation, marital status, gender, gender identity, age, physical disability, mental disability, religion, language, medical condition, or genetic information.

Health Net held the National Committee for Quality Assurance (NCQA) Multicultural Health Care Distinction (MHC) from 2011 to 2023. NCQA's MHC offered distinction to organizations that engaged in efforts to improve culturally and linguistically appropriate services and reduce health care disparities. In 2022, NCQA transitioned MHC to Health Outcomes Accreditation (HOA), with an additional option for Community-Focused Care Accreditation (CFCA) (formerly Health Equity and Health Equity Plus Accreditation). Health Net was invited to participate in the NCQA CFCA pilot and was awarded CFCA in September 2022. Health Net renewed HOA and CFCA in September 2024. Health Net is the only health plan in the nation to earn the NCQA CFCA across all lines of business. The CFCA standards help provide a roadmap to improve and refine initiatives focused on providing high quality health care and connecting social and community support services to the communities we serve.

Health Net implements strategies to support the reduction of health disparities in clinical areas. Health Net facilitates health equity workgroups that are responsible for developing and implementing an action plan to reduce targeted health disparities. The health disparity reduction initiatives are aligned with requirements from NCQA HOA and CFCA Plus, Exchange requirements, DMHC Health Equity and Quality priorities, and Health Net internal directive to address health disparities. Disparity reduction actions are implemented through a model that integrates Health Net departments across Quality Improvement, Provider Engagement, Health Equity, Health Education, Wellness, regional clinical teams, and Public Programs. The model utilizes a multidimensional approach to improving quality and delivery of care inclusive of community outreach, member and provider interventions as well as system level initiatives. The following highlights the core components of the disparity reduction model:

- Planning inclusive of data analysis (spatial and descriptive), data validation, key informant interviews, literature reviews, development of community and internal advisory groups, and budget development.
- Implementation of actions targeting three core levels: 1) Member/Community where partnerships are formed to identify existing initiatives and leverage support of community feedback to design and implement interventions; 2) Provider interventions targeting high-volume, low-performing groups and practitioners who have disparate outcomes; and 3) Internal programs to improve disparities in identification, engagement and outcomes in Care Management and chronic conditions management.
- Evaluation and improvement of health disparity efforts is conducted using process and initiative level evaluation.

Health Net employees can be involved in Centene's national employee networks for veterans and/or military families, women, LGBTQ+ community, multicultural network, people with disabilities, and across life stages. The employee networks have community

engagement subcommittees that may indirectly impact health equity efforts and support employees in addressing health disparities within their communities.

Health Net is committed to supporting inclusive business practices, and cultural humility and eliminating health inequities and disparities by working to break down the barriers that prevent access to high-quality health care services. Through its HOA and CFCA programs and services, the organization is committed to finding solutions and providing appropriate resources and interventions to diverse individuals within its population and community. Finally, the organization is committed to CLAS and addressing social risks and needs by:

- Establishment of the Inclusive Business Practices Council
  - Composed of senior leaders from our business divisions, focuses on strategic accountability across inclusive core pillars.
  - Widespread distribution and presentation of the Inclusive Business Practices Council Annual Report, which reflects our commitment to inclusive business practices at Centene and demonstrates Centene's tangible steps to achieving a more inclusive workplace.
  - Ensuring policies and practices drive sustainable results throughout the enterprise.
  - Advocating for systemic change that embodies social justice, public policy, equity, and inclusion.
  - The council has taken action to focus on the following priorities:
    - Our People: We build trust with employees, members, and partners by promoting leadership, growth, and open communication, creating diverse perspectives that improve healthcare.
    - Our Business: By combining cultural awareness with operational excellence and inclusive practices, we remove barriers and align services with community needs, fostering trust and strong performance.
    - Our Communities: We address social and economic factors affecting health by empowering employees to create social impact, using data and partnerships to ensure fair access and stronger communities.
    - Local business unit Inclusive Business Practices Council development, and
    - Enterprise access to inclusive business practice resources.
- Embracing diversity without bias or discrimination.
- Supporting and strengthening equitable care through fair distribution in procedures, resources, systems, and mechanisms.
- Actively including, sharing, and engaging diverse individuals, groups, teams, partner organizations, and community members by providing on-going opportunities and pathways for participation in decision-making processes.
- Exhibiting respect for and value of diverse cultural health beliefs, behaviors, and needs of individuals and the community through responses and interactions when providing services to others.
- Partnership with Findhelp to support social needs assessment and community social risk identification.

The Health Equity department services in support of staff include Cultural Competency Training Program, in-services, and cultural awareness events. Cultural awareness in-services are provided upon hire to all Member Services staff. In addition, the Health Equity Department collaborates with internal departments such as Provider Engagement, Provider Network Administration, Health Education, and Quality Management to provide in-service of C&L/health equity services and/or Cultural Competency Training Program. As needed, Health Equity also provides in-services to

case managers to assist in building trust with patients who are recent immigrants. The goal of these in-services is to provide information to staff on cultural and linguistic requirements, non-discrimination requirements, the LAP, C&L and health equity resources and Health Net member diversity.

The Health Equity Department supports contracted providers in their efforts to provide culturally responsive care to members. The services offered to contracted providers are intended to:

- Encourage cultural responsiveness and awareness.
- Provide strategies that can easily be implemented into clinical practice.
- Foster improved communication and health outcomes for patients from diverse cultural and ethnic backgrounds, with limited English proficiency, disabilities, regardless of their gender, gender preference or gender identity.
- Foster non-discrimination based on national origin, race, color, ancestry, ethnic group identification, sex, sexual orientation, marital status, gender, gender identity, age, physical disability, mental disability, religion, language, medical condition, or genetic information.

Trainings for providers and their office staff are currently available for the following topics:

- Cultural Competency
- Dismantling Implicit Bias
- Gender Neutral Language
- Health Literacy
- Healthcare Barriers for Gender Diverse Populations
- Language Assistance Program
- Advancing Health Equity: Cultural Humility, Diversity and Equity in Healthcare
- Community Connect Program-Social Needs Support, and
- Gender Inclusive/Affirming Care.

N. Access and Availability

Health Net has established access to care standards for healthcare services in accordance with the regulatory and accrediting laws and regulations that are applicable to each line of business. These standards ensure Health Net's provider network has sufficient numbers and diversity to provide all members with appropriate access to and availability of practitioners, providers, health care services, and language assistance services. These standards also ensure Health Net members have appropriate access to medical services including primary care, specialty care, and behavioral care appointment access, after-hours access and instruction, urgent and emergent care, ancillary services access, and telephone customer service within a reasonable distance and time period. Health Net monitors effectiveness of this network to meet the needs and preferences of its membership, and to meet regulatory guidelines as they apply to each state and/or line of business through annual access and availability surveys. Health Net maintains detailed access and availability policies and procedures, which define and discuss the necessary elements for these systems across the continuum of care. Corrective actions are developed for identified performance issues per policy guidelines.

Health Net's standards, policies, and procedures are based on contractual, state and federal regulatory, and accreditation requirements. The processes and procedures designed to ensure that all medically necessary covered services are available and

accessible to all members regardless of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56, and that all covered services are provided in a culturally and linguistically appropriate manner. Description of the activities, including activities used by members that are seniors and persons with disabilities or persons with chronic conditions, and members who use Managed Medi-Cal Long-Term Supports and Services (MLTSS) in accordance with the standards set forth in 42 CFR 438.330(b)(5), designed to assure the provision of care management, coordination and continuity of care services. Such activities shall include, but are not limited to, those designed to assure availability and access to care, clinical services, and care management.

O. Member Experience (CAHPS)

Health Net continuously monitors member experience year-round by monitoring CAHPS survey results, mock CAHPS results, and monitoring member satisfaction including resolved member appeals and grievances, CMS complaint tracking modules (CTMs), and Call Center drivers. CAHPS survey results are integrated into Health Net's NCQA accreditation and various state and federal performance rating systems and reports including the following:

- Office of the Patient Advocate Report Cards, now referred to as the California Health Care Quality Report Cards
- CMS Medicare Star Ratings
- Exchange Quality Rating System (QRS)
- DHCS Medi-Cal Managed Care Quality Improvement Reports, and
- DMHC Health Equity and Quality reports.

Improvement efforts focus on educating CAHPS stakeholders and measure owners, offering focused provider webinars, partnering with operational teams to implement initiatives, deploying mock CAHPS results to be shared with Provider Groups, and participating in monthly Quality Governance Committee and Quality Focus Touchpoint meetings. CAHPS Program Managers meet with several business areas including Population Health and Clinical Operations, Customer Contact Center, Appeals and Grievances, Pharmacy, Provider Network Management, Provider Engagement (both provider and PPG facing teams), Delegation Oversight, Sales, and Marketing. Annually, Program Managers review data, documents, and reports to provide stakeholders with Integrated Member Satisfaction reports and CAHPS survey disparity reports, which are required for NCQA accreditation. These efforts aim to support and enhance member experience.

P. Provider Satisfaction

Provider satisfaction is assessed annually using valid survey methodology and a standardized comprehensive survey tool. The survey tool is designed to assess practitioner and provider satisfaction with the network, claims, quality, utilization management, cultural, linguistic, and disability access services and other administrative services. The Director of Provider Relations, in collaboration with other Health Net departments, is responsible for coordinating the provider satisfaction survey, aggregating and analyzing the findings, and reporting the results. Survey results are reviewed by the HNCA and HNCS QIHECs with specific recommendations for performance improvement interventions or actions.

Q. Health Education and Wellness Programs

Health Net provides an array of health and wellness services to Commercial and Marketplace members at the worksite and via the online secure Health Net member portal in the Wellness Center webpage.

Health Net's wellness programs integrate with our existing health improvement programs within quality improvement, pharmacy, and behavioral health to ensure that our members have the best program experience and highest possible engagement rates. Health Net Commercial and Marketplace members can access wellness tools and information on Health Net's member portal and the Sharecare platform. Members can also use the Sharecare portal to message professionals such as health coaches, participate in digital health coaching, view educational material, and learn more about programs for health coaching, tobacco cessation and participate in online challenges. The Sharecare portal is NCQA accredited.

Medicare members access health coaching and dietary counseling through Health Net Care Management and their provider, and Commercial members access these services through Sharecare's platform.

The Health Net Health Education System provides health education resources, materials, and services to Medi-Cal and Health Net Dental members. These services are based on community health, cultural, and linguistic needs to encourage members to practice positive health and lifestyle behaviors, to use appropriate preventive care and primary health care services, and to follow self-care regimens and treatment therapies. Health education services may include individual, group and community-level education, and are supported by trained health educators to encourage positive health and lifestyle behaviors.

Health Education and Wellness resources, services and materials vary by membership type but generally include:

- A RealAge Test from Sharecare that provides Commercial and Marketplace members with a personalized report of their behavioral and medical health risks and action plan. As part of this process, risks are stratified, eligibility for interventions is identified and individually tailored recommendations are generated based on the level of risk and readiness to change. Recommendations could include Wellness Health Coaching; online RealAge Programs; Eat Right Now (Mindful Eating Program); Craving to Quit (Tobacco Cessation), Unwinding by Sharecare, and/or articles and videos.
- RealAge Programs (Commercial/Marketplace) - The RealAge Program from Sharecare targets stress, sleep, nutrition, and activity - the four lifestyle areas of highest risk for mortality. The program guides members through goal setting in any or all of these categories, allowing members to choose actionable behavior changes based on their personal goals and preferences. The program allows users to track progress each day, sends helpful reminders to stay on track, and delivers personalized content recommendations in response to user-defined goals.
- Health Coaching (Commercial/Marketplace) - The telephonic coaching model is both an inbound and outbound outreach, appointment-based support that includes a designated coach. The length can vary depending on progress in changing behaviors and reducing risks. Once a participant is connected with a coach, the individual will work with that coach for ongoing engagement, and connect with their coach via telephone, SMS messaging, platform or email. If a

participant misses a coaching session and calls in, they can connect with an available coach. Members have access to unlimited inbound support for up to twelve months after program enrollment. Participants may also interact with the team through secure messaging features within the digital platform.
    - Sharecare's high-touch health coaching program is accredited by the National Committee for Quality Assurance (NCQA) in eight areas of health:
        - Healthy weight
        - Smoking/tobacco use
        - Encouraging physical activity
        - Healthy eating
        - Managing stress
        - At-risk drinking
        - Identifying depressive symptoms, and
        - Clinical preventive services.
- Lessons (Online Health Coaching for Commercial and Marketplace) - Lessons is the digital health coaching program from Sharecare. Lessons serve as a framework connecting high-touch coaching and a high-tech platform in delivering a personalized and engaging experience that supports members in achieving health goals. Each Lesson enables members to craft a multi-day personalized digital program that keeps them engaged and learning. Lessons consist of multiple programs related to stress, smoking cessation, as well as other lifestyle and disease management conditions. As coaches carry out the appropriate calls with members, they will understand each member's situation and, based on that, choose an appropriate Lesson for the member. Coaches assign and send a Lesson to the member, which will appear in the coaching hub within the platform. Topics include stress, healthy eating, exercise, tobacco, weight, and gaps in care.
- Unwinding by Sharecare (Commercial and Marketplace, and also available to other lines of business via the community offering) - The mindfulness program is designed to manage stress and build resilience in the workplace and at home, while also improving sleep, mental health and quality of life. Developed by psychiatrist and neuroscientist Dr. Jud Brewer, MD, PhD, and the Behavioral Health team at Sharecare, Unwinding offers on-demand stress reduction tools to help participants deal with stress throughout the day. Through the app, participants can improve sleep, access breathing exercises, follow guided meditations, watch high-end relaxation video content, attend live virtual events and more.
- Personal Health Profile (Commercial and Marketplace) – Tool that stores member's medical and prescription drug claims history if manually entered.
- Online Health Challenges (Commercial and Marketplace) – Health Net members have access to a variety of online health challenges. Stress, steps, and sleep are ongoing monthly challenges. Health Net members also have access to specific online health challenges designed to complement the monthly wellness webinars.
- Craving to Quit Tobacco Cessation (Commercial and Marketplace) – The Craving to Quit program from Sharecare covers most types of tobacco, lets participants talk with a personal coach for encouragement and support and offers a tailored plan to quit. The 21-day program teaches awareness of cravings and habits to help members stop, whether you smoke, vape, or dip. The App is Digital only. Telephonic coaching is offered through the Sharecare Health Coaching program. Craving to Quit uses evidence-based learning pathways to reduce or eliminate cravings at the source. Craving to Quit provides access to an online community, video modules, mindfulness exercises, and other tools.

- Eat Right Now Mindfulness Program (Commercial and Marketplace) – The Eat Right Now Program is an evidence-based program that combines neuroscience and mindfulness tools to help members identify eating triggers and ride out cravings to change their eating patterns for good. With help from videos and exercises, members will learn to listen to their body's hunger signals so they can differentiate between real hunger and emotional cravings. This progressive 28-day program lets members reshape how they eat in about 10 minutes a day. Through video, audio, and animated lessons, clinically validated exercises and on-demand tools, members will learn how to identify, work with, and eliminate their eating triggers.
- Eat Right Now Diabetes Prevention Program (DPP) and Weight Loss Track for Marketplace and select Commercial members – This is an innovative science-based virtual program from Sharecare that combines neuroscience and mindfulness tools with the CDC Diabetes Prevention Curriculum to help members identify eating triggers such as emotional and environmental triggers, address underlying anxiety, and ride out cravings to change their eating patterns for good. Participants receive daily video lessons, weekly classes by trained experts, smart scale, activity tracker, community support, and dedicated digital coach. The 22-week (up to twelve-month) program aims to help members lose a minimum of 5% of their body weight and significantly reduce the risk of developing Type 2 diabetes. For those that do not qualify for DPP but would benefit from a weight loss program, they can participate in the Weight Loss track. The Eat Right Now DPP program is available to Marketplace members along with an in-person option, and to select Commercial members (without an in-person option).
- Health Risk Assessment (Medicare C-SNP and D-SNP) – This is a survey tool that assesses a member's current health risk and identifies further assessment needs such as behavioral health, chronic conditions, disabilities, functional impairments, assistance in key activities of daily living, dementia, cognitive and mental status. The HRA should be completed within 90 days of enrollment and annually thereafter. Responses inform the Care Plan which is shared with the member's primary care provider to facilitate more efficient access to health and wellness services.
- An online content library containing educational materials, tools and resources for various topics, such as exercise, nutrition, stress reduction, substance use, tobacco, alcohol use, and weight control.
- Fluvention (all lines of business) - Health Net's multi-layered Fluvention campaign is designed to promote vaccinations as the key to flu prevention. Outreach modes include Interactive Voice Response (IVR), email; text messaging (Medicare only), public service announcements, and web resources. Health Net works to address these issues by utilizing enterprise-wide member and provider marketing and education as well as increasing access to facilities that provide flu vaccinations. The goal of these efforts is to decrease the spread of the flu by increasing the number of members that receive a timely annual flu vaccination and provide additional protection for members at high risk of developing severe illness. The campaign focuses on key program drivers by harnessing new technology platforms to drive all members toward vaccination, with a specific-focus on high-risk groups, including pregnant members and members aged six months to <5 years, 65+ years, and those with chronic conditions. In addition, Health Net utilizes leveraging the following additional strategies to increase flu vaccination uptake: social media campaigns, pop-up flu vaccination clinics, provider and provider-facing team training, health education resources, and community partnerships.

- Wellness Webinar Series (Commercial): Monthly health education topics provided to Commercial members and the community at no cost via webinars. Webinars are live and recorded. All registered participants receive a link to the recording. Past webinars are available on our website. Since 2024, Health Net provides an American Sign Language Interpreter during live webinars.
- Teladoc Mental Health (Digital Program) (all lines of business) – Members ages 13 years and older have access to an evidence-based, self-help resource to improve their mental health. This program is available online at www.teladochealth.com or via the Teladoc Health mobile app. It offers interactive, personalized modules that empower members to help manage their depression, anxiety, stress, substance use, pain, insomnia and many other mental health conditions. Members are referred into the program via Care Management or can self-refer into the program.
- Member discounts on health products and services (Commercial and Marketplace): Health Net members receive special rates to in-network gyms, in addition to savings on optical purchases and services, hearing aid products, a weight management program (Weight Watchers), acupuncture, massage and chiropractic care and other health and wellness products and services. These discounts are part of the Healthy Discount program and are promoted in member newsletters, collateral materials, the Health Net website, and microsites.
- Start Smart for Your Baby - Medi-Cal, Commercial and Exchange pregnant members are notified of educational resources at www.startsmartforyourbaby.com to help them achieve a successful pregnancy and healthy baby. High-risk pregnancies receive additional care management services from nurses.
- First Year of Life (FYOL) - This Medi-Cal program is available for children from birth to 15 months old. The purpose of the FYOL Program is to increase HEDIS rates for well-child visits and immunizations, reduce inappropriate emergency room visits, and provide parent or caregiver support. The program consists of Care Managers and Program Specialists with pediatric nursing and/or post-partum outreach experience. Telephonic outreach is completed at 2, 4, 6, 9, 12 & 15 months. Calls are completed two weeks prior to each scheduled well-child visit. Program staff will help with establishing pediatric care for the members. The plan staff also completes an age-appropriate assessment and education. This program is expected to expand to Commercial and Marketplace in 2026.
- Diabetes Prevention Program (Medi-Cal) - The Diabetes Prevention Program (DPP) is a twelve-month long program focused on helping Medi-Cal members lower their risk for diabetes through healthy lifestyle choices and weight loss. Eligible members include those ages 18 years and older and at risk of developing Type 2 diabetes.
- Health Education Literature (all lines of business) – The Health Education and Wellness Systems develop health education materials and also promote Krames on Demand which is available on the member portal. The goal of the literature is to provide members with information about general health or disease-related topics, explain risk levels relating to various health screenings and increase knowledge of how to maintain their own health.
- Community Health Fairs, Screening Events, and Onsite Wellness (all lines of business) - The Health Education and Wellness systems may support Community Engagement, employer groups, and provider groups to participate in health fairs and community events to promote health awareness to members and the community, conduct screenings including biometric screenings, provide flu vaccines, and promote health topics via tabletop displays.

- Healthy Living@Health Net (Health Net employees only): This program informs Health Net of California employees of available well-being opportunities and to increase awareness and engagement in well-being offerings for employees. Communication to employees is delivered by a Teams SharePoint site and volunteer well-being champions. A variety of well-being content including links to articles, educational materials, quarterly online health challenges, webinars, and other resources, are updated monthly to engage employees in aspects of well-being that include physical, emotional, spiritual, social, environmental, and financial well-being.
- Weight Management Resources (Medi-Cal) - Members have access to weight management resources through our Krames and Staywell Libraries. These resources can be found at Health Hub Weight Management.
- Kick It California (Medi-Cal) is a no cost, statewide tobacco cessation program that addresses smoking and vaping behaviors. Services include tailored one-on-one telephonic coaching in six languages (English, Spanish, Cantonese, Mandarin, Korean, and Vietnamese), a texting program in English or Spanish, a website chat function, and mobile apps on smoking and vaping. Telephonic coaching is available Monday-Friday, 7 am-9 pm, and Saturday, 9 am-5 pm (excluding holidays) by calling 1-800-300-8086. To learn more about available resources and medication options, members may call the toll-free number or visit www.kickitca.org.
- Community and Telephonic Health Education Classes - No-cost health education classes and webinars are offered to members and the community as needed. Classes are available in English and Spanish. Topics are determined by the community's needs.
    - Member Incentive Programs (Medi-Cal) - The Quality EDGE strategy was developed to strengthen provider and member engagement. Member engagement incentives are distributed at the point of care and are limited to open-access or one-stop clinic events. This approach ensures alignment with actions co-developed by providers and the Provider Engagement team, fostering collaboration and improving member experience.
- Health Education Resources (Medi-Cal) - Members or the parents of children and adolescent members may order health education materials on a wide range of topics, such as asthma, weight control, diabetes, immunizations, dental care, exercise and more. Some materials are available in twelve Medi-Cal threshold languages depending on the primary languages written or spoken by the member population of the identified geographic area (Arabic, Armenian, Chinese, Farsi, Hmong, Khmer, Korean, Russian, Spanish, Tagalog, and Vietnamese). Health education resources are provided to members and contracted providers for dissemination to their Medi-Cal and Health Net Dental members. Health Net produces health education resources for SHP members with a sixth grade or lower reading level and takes diverse cultural background into consideration in their development and translation. Resources are also available in alternative formats and threshold languages upon member request. The Health Equity Department reviews these resources for accuracy of translation, cultural content, and reading level. Moreover, Health Net evaluates member resources with the assistance of experts, Community Advisory Committees, focus groups, and/or individual and group interviews. Some PPGs may provide additional health education resources for members.
- Dental Education Resources (Medi-Cal) - Members can request Health Net's dental education resources by contacting the Customer Contact Center or requesting them through their doctor.

- Nurse Advice Line - Health Net members may speak to a nurse 24 hours a day, 7 days a week in the member's preferred language about any health-related concerns.
- Member Newsletter (all product lines) - *Whole You* Health Net News is mailed to head-of-household members annually to notify members of: NCQA, health equity, other regulatory articles; promotion of health education resources and wellness programs; and quality improvement interventions. It covers various health topics and the most up-to-date information on health education interventions.
- Health Education Programs and Services Flyer (Medi-Cal) - This flyer contains information on all health education interventions offered to members and information on how to access them.
- Adverse Childhood Experiences (ACEs) - Medi-Cal, Commercial, and Marketplace members and providers can participate in interventions and receive educational resources and support to address stressful or traumatic childhood experiences. Providers also have access to several trainings that will support their ACEs screening and support to members. Members can receive a screening for ACEs through their providers.

R. Telehealth Services

Health Net supports members' access to their care through telehealth programs by connecting them to licensed clinicians through leading and global providers of virtual care such as Teladoc Health and Hazel Health. Members can schedule general medical and behavioral health virtual visits with various pediatric and adult primary care providers. ConferMed of CA connects providers with California-licensed specialty care experts through secure, digital dialogues.

Members receiving services from Teladoc can access the mobile app to connect to providers anytime, anywhere by phone, video, or app. Remote consultations with doctors and mental health care professionals are provided via a secure HIPAA-compliant, videoconferencing and voice over internet protocol (VOIP) software. Medically trained, certified interpreters are available on-demand to limited English proficiency (LEP) membership across 27 high demand and threshold languages including Spanish and American Sign Language.

Hazel Health provides on-demand telehealth care at home and in schools and supports school nurses when a child has an urgent need. Via a computer, a child is connected to a health care professional for physical or mental health care. If a primary care physician's information is provided on the new patient questionnaire, Hazel will send follow-up records to the child's provider, improving the continuity of care. For kids needing behavioral health services, Hazel Heath can email or fax a referral form to Health Net. Health Net will refer members who require care management to the appropriate Health Net care management team for follow up. Hazel Health is currently available at approximately 180 participating schools with further expansion to more sites in the coming year.

ConferMed of CA provides an asynchronous, electronic consultation that offers PCPs rapid access to California-licensed specialty care experts through secure, digital dialogues. PCPs use eConsults at their discretion for non-urgent, non-procedural specialty care referrals. A digital referral, along with clinical information, images, lab results, and other content from the medical record, is sent directly to a specialist. In 70%–75% of cases, an eConsult will result in PCP management which helps prevent unnecessary/low value diagnostic testing and in-person appointments with specialists.

Most eConsults are reviewed by the specialist and responded to within 72-hours, which improves timely access for patients and removes potential geographic or language barriers that may occur during in person visits.

The goals of the telehealth program are to:

- Enhance member and provider experiences.
- Address critical provider shortages.
- Optimize care coordination.
- Reduce overall health care costs.
- Provide equal health care access to Limited English Proficiency members.
- Provide rapid and convenient access to urgent care after hours and when members assigned PCPs are not available.
- Reduce the incidence of unnecessary emergency room utilization.

S. MemberConnections® Program

MemberConnections is an educational and outreach Medi-Cal program, designed to help members navigate the health care system, promote preventive health practices, and connect them to health and community social services. MemberConnections representatives (MCRs) extend the reach of member engagement and care management efforts by making home visits and providing personalized service to members. MCRs are highly trained, specialized non-clinical members of our integrated care teams. MCRs serve as a liaison or intermediary link between the health plan, providers and members.

More specifically, MCRs:

- Conduct assessments to better understand members' needs such as the Health Risk Screening.
- Facilitate access to health services by scheduling medical appointments, helping members find doctors and specialists and checking the status of referral authorizations.
- Assist with removing barriers to health care by arranging transportation and language services through the health plan vendors.
- Connect members to care management to manage their chronic and/or complex health conditions.
- Address social needs by linking members to county and community resources.
- Help reduce health care costs by promoting preventive practices and educating members on how to use their benefits and appropriate utilization of health services.

T. Medical Records

Health Net requires its practitioners and providers to maintain current organized and detailed medical records. Records must be consistent with standard medical and professional practice and protected health information is handled in accordance with established policies and procedures to safeguard patient confidentiality.

Health Net's documentation standards address format, documentation, coordination of care and preventive care and includes but is not limited to the following areas: adult preventive care, pediatric preventive care and perinatal care. Standards are distributed on a regular basis and at the request of network providers.

Practitioners are required to have systems and procedures to provide consistent, confidential and comprehensive record keeping practices.

Health Net monitors both medical record keeping and medical record systems to assess the quality of medical record documentation and compliance with standards through PPG medical record audits. This occurs during the HEDIS process, DMHC and CMS surveys, and during routine DHCS audits.

Annually, the data is aggregated and analyzed to evaluate the effectiveness of interventions and identify opportunities for improvement. Actions are taken when compliance issues are identified. Appropriate interventions are implemented based on compliance rates established for each standard. Interventions may include sending Provider Updates, revising the provider operations manual, sending educational or reference materials to PPGs or practitioners, and creating medical record form templates.

U. Primary Care Provider Onsite Facility Review

Health Net is subject to the requirements in Statute 22, California Code of Regulations (CCR) for participation in Title 28, CCR, for Knox-Keene licensed health plans to conduct onsite reviews of PCP facility sites. Health Net ensures that the PCP sites are compliant with all applicable local, state, and federal standards. Each provider site, where applicable, must be licensed and accredited by the appropriate agencies and maintain compliance with all licensing standards. Prior to approval for use in providing primary care services to members, all contracted or subcontracted sites where primary health care services are provided are subject to initial onsite inspections, and periodic inspections thereafter, to evaluate the continuing capacity of the sites to support the delivery of quality health care services. These inspections include the following types of audits; facility site review, medical record review, physical accessibility review surveys, onsite grievance visits, PQI audits and Peer Review or Credentialing Committee document/audit requests.

The policy and procedures and the Facility Site Review (FSR) tool may be found in Health Net's policy CA.QI.26 *Primary Care Provider Onsite Facility Review*.

IV. Quality Improvement Program Structure

A. Governance

1. Board of Directors

The Health Net Boards of Directors are the governing bodies with ultimate authority, responsibility and oversight of the QI, Health Education, and Wellness Program, including review and approval of the annual QI, HEd, and Wellness Program Description, Work Plan and Evaluation. The Board of Directors have delegated the responsibility for overseeing the development and implementation of the QI, HEd, and Wellness Program and QI, HEd, and Wellness functions in the organization to the HNCA and HNCS QIHECs.

Functions:

- Establish strategic direction for the QI, HEd, and Wellness Program.

- Receive quarterly updates from Quality Management, and review reports from QI Committees, delineating actions taken and performance improvements at least annually.
- Ensure the QI, HEd, and Wellness Program and Work Plan are implemented effectively and result in improvements in care and service, and assess and recommend, as needed, resources to implement quality improvement activities.

B. QI Committee Structure

Health Net has established a committee structure to foster quality improvement discussions and activities from multi-disciplinary areas to ensure compliance with regulatory and accreditation requirements across all product lines. The structure of the Health Net committee promotes plan integration and provider network accountability for the identification, evaluation and measurement of key clinical and service activities.

The Quality Improvement Committee structure includes HNCA QIHEC, HNCS QIHEC, National Medicare QIUMC, and various sub-committees and workgroups. At least annually, committees review and approve the QI, HEd, and Wellness Program Description, Work Plan, Annual Work Plan Evaluation, and Annual Executive Summary. Subcommittees (usually quarterly), and workgroups meet regularly or are convened as needed. Quality committee and sub-committee minutes are recorded at each meeting. Minutes include topics and key discussion points, and planned actions and follow-up, if needed.

1. Health Net of CA Quality Improvement/Health Equity Committee

The Health Net of California Quality Improvement/Health Equity Committee has responsibility for oversight of the QI Program and is responsible for monitoring the quality and safety of care and services rendered to Health Net Commercial and Exchange members. The HNCA QIHEC is co-chaired by the VP Medical Director and the Chief Health Equity Officer (CHEO) and meets quarterly.

In 2024, Medicare member oversight transitioned to the National Medicare Quality Improvement & Utilization Management Committee (QIUMC). The CA Medicare product lines report up to the Centene and California Board of Directors.

The HNCA QIHEC structure ensures practitioners participate in the planning, design, implementation, and review of the QI Program. External network practitioners participate in HNCA QIHEC along with representatives from Quality Improvement Department, the Health Net of California (HNCA) Pharmacy Department, Network Management, Medical Affairs, Customer Service Operations, Credentialing, Peer Review, Appeals and Grievances, and Population Health & Clinical Operations (PHCO) which includes Utilization Management and Care Management.

QIHEC Functions:

- Review and approve the Annual QI, HEd and Wellness, Population Health Management, and Health Equity, Program Description, Work Plan and Evaluation.
- Report to the Board of Directors or Executive Management Team at least annually.

- Recommend and revise, or oversee policy changes, for effective QI and Wellness program operation and program achievement.
- Ensure external practitioners, who are representative of the specialties in the network, participate in the QI Program through planning, design, implementation or review.
- Maintain meeting minutes.
- Review behavioral health care initiatives and outcomes.
- Monitor activities and evaluate the results of QI activities, institute needed actions, and ensure follow up as appropriate.
- Analyze and evaluate the results of focused audits, studies, quality of care and safety issues and quality of service issues.
- Monitor for compliance and other quality improvement findings that identify trends and opportunities for improvement.
- Provide input and recommendations for corrective actions and monitor previously identified opportunities for improvement.
- Oversee state and federal regulatory QI Program requirements by reviewing reports on required QI activities.
- Provide support and guidance to health plan associates on quality improvement priorities and projects.
- Monitor data for opportunities to improve member and practitioner perception of satisfaction with quality of service.
- Address UM and QI activities which affect implementation and effectiveness of the QI Program and interventions.

2. Health Net Community Solutions QI/HE Committee

The HNCS QIHEC encompasses Health Net's Medi-Cal line of business. The committee is charged with monitoring the health equity activities, medical management, and quality of care and services rendered to members, including identifying and selecting opportunities for improvement, and monitoring and evaluating the effectiveness of interventions. The HNCS QIHEC is co-chaired by the VP Medical Director and the CHEO. The QIHEC meets quarterly. External practitioners participate in this committee along with representatives from Behavioral Health, Pharmacy Department, Dental Department, Network Management, Medical Affairs, Customer Service Operations, Credentialing, Peer Review, Appeals and Grievances, and Population Health & Clinical Operations (PHCO) which includes Utilization Management and Care Management.

The Quality Improvement and Oral Health Access Committee reports to the HNCS QIHEC and the HNCS Board of Directors.

HNCS QIHEC Functions:

- Review and approve the annual QI, and HEd, Population Health Management, UM, and Health Equity Program Descriptions, Work Plans, and Evaluations.
- Report to the Board of Directors or executive management team at least annually.
- Recommend and revise, or oversee policy changes, for effective QI and HEd program operation and program achievement.
- Ensure external providers and subcontractors, who are representative of the specialties in the network (i.e. behavioral health, SPD and members with chronic conditions), actively participate in the QI Program through planning, design, implementation or review.

- Maintain meeting minutes for submission to the BOD and DHCS upon request; and be made publicly available on a quarterly basis.
- Review behavioral health care initiatives and outcomes, including informing the Non-Specialty Mental Health Services (NSMHS) Member and PCP Outreach & Education Plan.
- Address activities and priorities related to the QI and Health Equity Transformation Program (QIHETP).
- Analyze and evaluate the results of QI and health equity activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys.
- Monitor activities and evaluate the results of QI and HEd activities, institute needed actions, and ensure follow up as appropriate.
- Analyze and evaluate the results of focused audits, studies, quality of care and safety issues and quality of service issues.
- Monitor for compliance and other quality improvement findings that identify trends and opportunities for improvement.
- Provide input and recommendations for corrective actions and monitor previously identified opportunities for improvement.
- Provide support and guidance to Plan associates on quality improvement priorities and projects.
- Monitor data for opportunities to improve member and practitioner perception of satisfaction with quality of service.
- Address UM, QI, HEd, and Health Equity activities which affect implementation and effectiveness of the QI Program and interventions.
- Review, approve, evaluate and make recommendations for physical accessibility of the practitioners and provider offices.

3. National Medicare Quality Improvement & Utilization Management Committee

All California Medicare products report up to the National Medicare QIUM Committee, the Centene National Board of Directors, and the local CA Board of Directors. The goal of this committee is to improve the quality of care and services provided to Centene's Medicare members. The committee:

- Provides a forum for the members of the committee to engage in review, coordination, and directions of the Plan's QI and UM Programs and activities that relate to key clinical and operations processes and outcomes of the organization.
- Provides input for and approvals of organization activities, ensuring that QI and UM measures and processes are working effectively throughout the organization.
- Monitoring, assessing, evaluating and analyzing progress towards goals represented on the National Medicare QI Work Plan.
- Ensuring appropriate follow-up action, as necessary, to complete planned program initiatives.
- Provides general direction and oversight for program functions, voicing recommendations for improvement, requesting corrective action and providing approval where necessary and appropriate.

4. Public Policy Committee

The HNCS Statewide Public Policy Committee (PPC) provides a bidirectional forum for Medi-Cal and dual eligible members, community-based organizations, contracted

clinics, and healthcare advocates to discuss and address the operational, policy and experience needs of the HNCS member. This form works to inform public policy and health equity decisions, recommend programming and interventions to address county and member specific needs. The PPC meets quarterly and provides regular reports to the Board of Directors based on recommendations from Health Net members and provider partners. The HNCS Board of Directors and HNCS QIHEC provide oversight of the HNCS public policy structure. This forum is also utilized to meet D-SNP State Medicaid Agency Contract (SMAC) Enrollee Advisory Committee (EAC) requirements.

5. QI Sub-Committees and Workgroups

The following subcommittees and workgroups provide ongoing updates to the HNCA QIHEC and/or HNCS QIHECs to ensure consistent decision-making, share information and provide a mechanism for escalating issues.

Network Access and Availability Governance Committee

The Network Access and Availability Governance (NAAG) Committee provides strategic direction, guidance and oversight to the Access and Availability Workgroup. Its goal and mission statement are to ensure members have access to comprehensive, quality care and services to obtain the right care at the right time. The committee will ensure sponsorship of planned initiatives and provide management of the execution of initiatives planned by the workgroup to proactively improve access, member experience and satisfaction across all lines of business and networks. Functions of the committee include:

- Provide strategic direction, guidance and oversight informed by data-driven evidence that ensures positive experience for members as they access their care with practitioners or interact with the health plan.
- Increase oversight of PPGs and direct network providers through monitoring, evaluation and communication of access and availability results.
- Sponsor approved initiatives to improve access and availability.
- Approve the Access and Availability Program Description and Work Plan.
- Provide feedback and approval on recommended key initiatives and actions.
- Recommend and approve policy decisions.
- Ensure follow-up, as appropriate.
- Report key findings and initiatives to commercial and Medi-Cal quality committees.

Specialty Network Committee

The Health Net Specialty Network Committee provides oversight of specialty programs for the Commercial and Medicare lines of business. The committee is responsible for monitoring and making recommendations for appropriate action regarding Health Net's performance center networks.

The committee membership involves associates across Health Net departments including Clinical Grievance & Appeals, Utilization Management, Medical Affairs, Provider Network Management, Quality Improvement, Health Care Services, Contracting, Centene National Transplant Health Solutions, and Care Management. The committee is chaired by a Health Net medical director, meets at least quarterly and reports to the HNCA QIHEC annually. Responsibilities include:

- Establish benchmarks and maintain evidence-based quality performance criteria such as volume and outcomes.
- Evaluate programs requesting to contract with Health Net.
- Coordinate with the Centene National Transplant Health Solutions program regarding Quality outcomes for contracted Transplant centers.
- Request no less than annually, data from Bariatric Performance Centers using Health Net's data collection tool.
- Review findings as documented through Specialty Network Committee assessments and determine appropriate actions based on these findings. Monitor corrective actions as appropriate.
- Monitor and ensure appropriate access and availability for specialized services.
- Oversee Health Net communication regarding the Health Net performance center networks.

Pharmacy and Therapeutics Committee

The Centene's Pharmacy and Therapeutics Committee (P&T) is a decision-making body that meets quarterly to develop and update the company's drug formulary or drug list. The P&T Committee's primary goal is to assure continuous member access to quality-driven, rational, affordable drug benefits. The committee's members provide oversight for the development, implementation and maintenance of a regional strategy to optimize pharmacotherapy that is cost-effective for members.

The Committee membership includes Pharmacy Services pharmacists and associates and practicing pharmacists and practitioners from the provider network. A Centene medical director chairs the P&T Committee. Responsibilities include:

- Review and approve policies that outline pharmaceutical restrictions, preferences, management procedures, delineation of recommended drug list exceptions, substitution/interchange, step-therapy protocols and adoption of pharmaceutical patient safety procedures.
- Review of pharmaceutical utilization and prescribing practice patterns.
- Review, revising and adoption of the formulary on an annual basis.
- Report to the HNCA and HNCS QIHECs at least quarterly.

Pharmacy Advisory Committee

The Health Net Pharmacy Advisory Committee (PAC) is responsible for oversight and communication about Health Net's pharmaceutical program. The quarterly Committee advises on medical and pharmacy drug benefit services to ensure they are managed effectively and efficiently, while ensuring quality care is provided to the health plan membership. Membership includes Health Net's Medical Directors or his/her designees, Centene Pharmacy Services California Pharmacy team, physicians and pharmacists, and other areas that may be impacted by pharmacy operations.
The Committee functions include:

- Reviews and approves Pharmacy Policy and Procedures specific to California pharmacy operations.
- Provides input to California specific Prior Authorization criteria and policies that guide exceptions and other utilization management processes, including drug utilization review, quantity limits, and therapeutic interchange.
- Review medical drugs authorization requirements and alignment with Pharmacy and Medical policies.

- Presents Health Plan Pharmacy Business Review and Quarterly Corporate DUR outcomes and/or clinical initiatives reporting.
- Review and approve DOFR drug categorizations.
- Reviews Corporate P&T Meeting minutes.
- Report on Annual Inter-rater Reliability (IRR) review results.
- Discuss other pharmacy-related issues specific to California i.e., regulatory, pharmacist compensation, etc.
- Discuss Pharmacy benefit options to remain competitive.
- Coordinate with various Health Net of California departments, including Health Care Services, Legal, Underwriting, Compliance, Finance, Program Accreditation and Provider Services Department to ensure legal and regulatory compliance.
- Report quarterly to the Health Net of California Quality Improvement Committee (HNCA QIHEC) as well as the Health Net Community Solutions (HNCS QHIEC) on drug therapy management opportunities that promote the quality of care and/or services provided to members.
- Review California pharmacy operational key performance indicators to identify drug trends (financially impactful) and/or improvement areas, design action plans to improve performance, measure performance improvement, and report results to appropriate committees.

Credentialing and Peer Review Committee

The Health Net Credentialing Committee (CC) oversees the credentialing and recredentialing process for non-delegated practitioners and providers. This process ensures that the networks of health care practitioners and providers providing professional services to Health Net members are trained, licensed, qualified and meet criteria for participation in accordance with regulatory requirements and accrediting entity standards. The committee reviews performance data and has final decision-making authority. The Credentialing Committee has representation from primary and specialty care participating practitioners, is chaired by a Health Net Medical Director and meets monthly. Ad-hoc meetings are scheduled on an as-needed basis.

The Peer Review Committee (PRC) is an independent review body established to achieve an effective mechanism for continuous review and evaluation of the quality of care and service delivered to enrollees. This includes monitoring whether the provision and utilization of services meets professional standards of practice and care, identifying quality of care problems, addressing deficiencies, deliberating corrective actions, and when necessary, initiating remedial actions with follow up monitoring. The goal of the PRC is to ensure enrolled members receive quality care and service from network practitioners, providers, medical groups, and sub-contractors. This is accomplished through the following:

- Collection, review and interpretation of data and provider feedback that can be used in evaluating performance.
- Sharing results of analyses with practitioners and providers in a systematic and routine process.
- Prescribing and/or requesting necessary action steps for remediation of identified problems.
- Rendering ongoing observations and evaluations of issues with recommendations for quality improvement.

The PRC is a multidisciplinary committee with representation from a range of practitioners. Clinical peer experts are invited to participate on an as-needed basis when the committee deems appropriate to the discussion of standards of care. The health plan's Chief Medical Officer or designee appoints the committee chairperson, who must be an internal Medical Director. The composition of voting PRC members includes internal Medical Directors as well as community physicians; all of whom are credentialed by the health plan and are either engaged in clinical practice or belong to a medical group as a Medical Director or Administrator. All are expected to use their independent clinical judgment in assessing the appropriateness of clinical care and recommendations for corrective actions, when warranted.

On a quarterly basis, the PRC will report to the designated quality committee all cases with impact on member care and/or services. Reports include but are not limited to access to care issues and adverse events.

If at any time PRC deliberations result in recommendation for termination, suspension or altered condition of participation, the recommendation will be presented to the Credentialing Committee for acceptance, enactment of appeal rights and regulatory reporting, when applicable.

Peer Review Committee members and guests must sign a confidentiality and conflict of interest statement at least annually. Peer review records and proceedings are confidential and protected under applicable state and federal regulatory requirements and health plan policies for system controls.

Delegation Oversight Committee

The Delegation Oversight Committee (DOC) is responsible for overseeing the formal process by which another entity is given the authority to perform functions on behalf of Health Net. The Delegation Oversight Committee (DOC) provides a forum for discussion of delegates performance and an opportunity to discuss significant risks with health plan leadership. The Delegation Oversight Committee meets at least once a quarter with additional meetings added as needed to meet the business requirements. Responsibilities include:

- Ensuring there is a delegation agreement between Health Net and the entity, which outlines responsibilities, activities, reporting, evaluation process, and remedies for deficiencies.
- Monitoring and evaluating a delegate's performance with regulatory and accreditation standards through ongoing monitoring and annual audits of the entities' processes.
- Taking action if oversight activities reveal deficiencies in the delegate's processes.
- Evaluating a delegate's performance prior to granting delegation.

Medical Advisory Council

Health Net's Medical Advisory Council (MAC), in conjunction with Centene's Corporate Clinical Policy Committee, is responsible for oversight of the formal process for the development and approval of medical policies, technology assessment, medical necessity criteria, and clinical practice guidelines. The MAC uses the principles of evidenced-based medicine to provide fair and impartial assessment of current medical and scientific literature of the effectiveness and appropriateness of procedures, devices, select drugs and biologicals. The MAC membership includes medical directors with a variety of specialties represented and

other ancillary department representatives including Population Health and Clinical Operations, and Pharmacy, input is sought from practitioner experts as necessary. The MAC is chaired by the Vice President, Medical Affairs and meets periodically throughout the year.

Quality Improvement and Oral Health Access Committee

The Quality Improvement and Oral Health Access Committee monitors utilization management and care coordination activities, and the quality of care and services rendered to Medi-Cal dental members. The committee identifies and selects opportunities for improvement and monitors interventions.

The Quality Improvement and Oral Health Access (QIOHA) Committee is chaired by the Dental Medical Director and meets at least quarterly, independently of the HNCS QIHEC. The findings and action of the QIOHA Committee's Quality Improvement Program are presented at the quarterly meetings of the HNCS QIHEC and the HNCS Board of Directors. Annually, the Dental Medical Director presents a written report on the status of dental QI activities. The HNCS QIHEC approves the overall dental Quality Improvement System Manual (QIS) and the annual dental QIS report and directs the operational dental QIS to be modified on an ongoing basis.

Community Advisory Committee

The purpose of the Community Advisory Committee (CAC) is to establish and maintain community linkages with member and families, community advocates, and Traditional and Safety-Net providers" (Title 22 CCR Section 53876(c)). The CAC will act as a primary information source for the gathering of community feedback and cultural and linguistic information to assist the Community Engagement and Health Equity Departments in their efforts to support the community's health care needs of its Limited English Proficient (LEP) population and underserved communities. In accordance with MMCD Policy Letter 99-001 and the DHCS 2024 contract requirements, the CAC's advisory functions specifically include, but are not limited to, providing input on the following:

- Culturally responsive service or program design
- Priorities for health education and community outreach program
- Member experience survey results
- Findings of health education and cultural, linguistic, and disability population needs assessment
- Plan marketing materials and campaigns
- Communication of needs for provider network development and assessment
- Community resources and information
- Population Health Management (PHM)
- Quality
- Health delivery systems reforms to improve health outcomes
- Carved out services
- Coordination of care
- Non-Specialty Mental Health Services Outreach and Education Plan
- Health Equity and Oral Health Equity, and
- Accessibility of services.

The CAC comprises key community Stakeholders reflective of the Medi-Cal population in the Plan's service area such as Medi-Cal consumers (including those from hard-to-reach populations and members with physical disabilities, and Limited English Proficient (LEP)) from diverse cultural and ethnic backgrounds, community

advocates, community-based organizations and traditional and safety-net providers. The Plan will modify the CAC membership as the beneficiary population changes, and in accordance with MMCD Policy Letter 99-001 and the DHCS 2024 contract requirements.

The CAC is facilitated by the Program Manager of Community Advisory Committees with support from the Health Equity Department. Detailed records of all CAC meetings, activities and recommendations for improvement activities are maintained and reviewed by staff at regular intervals, along with the Population Needs Assessment/update, and summary reports of compliance monitoring and evaluation activities. The CAC meeting minutes are publicly posted on Health Net's website.

Member Advisory Committee

The purpose of Health Net's Member Advisory Committee is to empower members to bring their voices to the table to ensure Health Net is actively driving interventions and solutions to build more equitable care. The committee advocates for Health Net members by ensuring that Health Net is responsive to their diverse health care needs.

Member Advisory Committee members provide knowledgeable feedback based on their experiences navigating the healthcare system and benefits. The Member Advisory Committee selection committee will ensure membership reflects the general population of the health plan, including adolescents and parents or caregivers, as appropriate, and be modified as the population changes to ensure population representation and engagement. The Member Advisory Committee selection committee will include representatives from diverse and hard to-reach populations, with a specific emphasis on populations that experience health disparities such as individuals with diverse racial and ethnic backgrounds, genders, gender identity, and sexual orientation and physical disabilities.

Duties of the Member Advisory Committee include:

- Ensure committee inclusion and involvement in developing and updating cultural and linguistic policy and procedure decisions including those related to Quality Improvement (QI), education, and operational and cultural competency issues affecting groups who speak a primary language other than English. The Member Advisory Committee may also advise as necessary on member or provider targeted services, programs, and trainings.
- Provide and make recommendations to the plan regarding the cultural appropriateness of communications, partnerships, and services.
- Provide sufficient resources for the Member Advisory Committee to support the required Member Advisory Committee activities outlined above, including supporting the Member Advisory Committee in engagement strategies such as consumer listening sessions, focus groups, and/or surveys.
- Provide input and advice, including, but not limited to, on the following:
    - Culturally appropriate services or program design
    - Priorities for health education and outreach programs
    - Member experience survey results
    - Communication of needs for network development and assessment
    - Population Health Management
    - Quality
    - Health delivery systems reforms to improve health outcomes
    - Carved-out services
    - Behavioral Health services

- Coordination of care
- Health Equity
- Accessibility of services

Internal Health Equity Governance Committee

The Internal Health Equity Governance Committee (IHEGC) covers all lines of business and addresses identified health disparities, social risks, social drivers of health (SDoH), community needs, and makes ongoing recommendations to improve individual and community outcomes. The Chief Health Equity Officer and Health Equity Director convene and lead the IHEGC, which includes cross-functional representation and participation from:

- Provider, member, and community-facing teams
- Quality Improvement, Health Equity, and Accreditation
- Public Policy, Government Affairs, Strategic Giving
- Medi-Cal Product Leadership and Regional Teams
- Medicare Product Leadership
- Commercial and Marketplace Product Leadership
- CalAIM and Systems of Care
- Population Health and Clinical Operations
- Operations
- Provider Engagement
- Human Resources
- Data and Analytics
- Marketing and Communications
- Medical Affairs

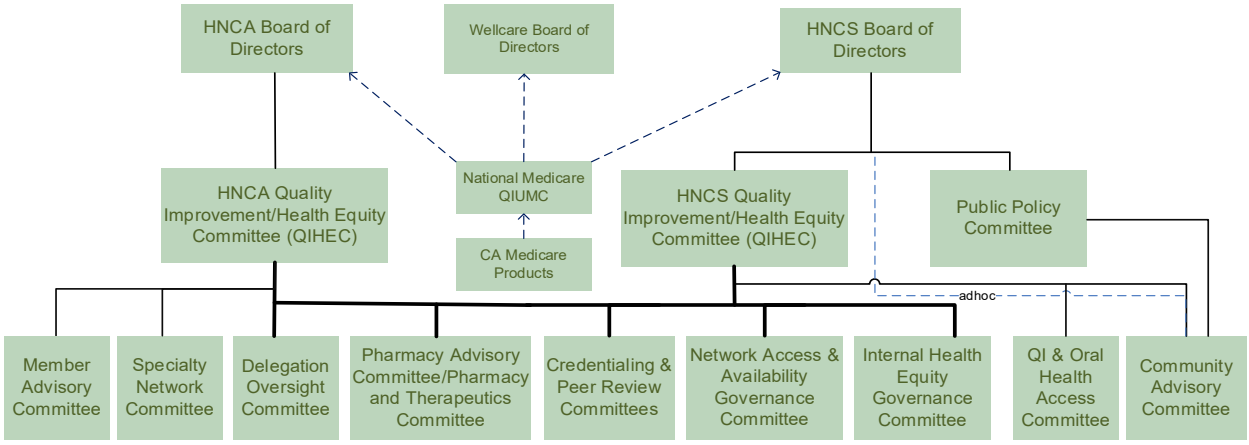
Key focus areas include:

- Driving connectedness across internal functional teams and external committees (Medicare-Medicaid Public Policy Committee, Medi-Cal Community Advisory Committees, Commercial Member Advisory Committees, QIHEC) to inform, address, and as appropriate approve community insights, gaps, or recommendations, to drive execution of long-term programming and maintain strategic health equity objectives.
- Supporting and strengthening equitable care via procedures, resources, systems, and mechanisms.
- Identifying priority areas of individual social needs and create responses and interventions accordingly.
- Selecting and engaging with social and community partners to improve health equity and access to available community resources.
- Implementing and evaluating community partnerships and sponsorships to enhance health and community resources and determine effectiveness.
- Monitoring health equity programs that aim to reduce health care inequities and disparities.
- Using SMART goals, reviewing, and providing feedback and input focusing on inclusion of adequate and appropriate health equity considerations in all new recommendations, benefits, and projects.
- Embedding a health equity lens and member voice into all operations. The leaders who participate in the IHEGC serve as health equity champions in other committees and governing bodies by giving voice to health equity considerations and approaches stemming from their shared knowledge and engagement on priorities advancing Health Net's health equity strategy.

Other Committees and Workgroups:

Committees and work groups are convened at Health Net to address specific products or requirements and may not report directly to the Quality Improvement Committee. Current examples include the Quality Governance Committee (all LOBs), the HEDIS Data Committee, the quarterly Access & Availability Workgroup, and collaborative meetings. The CAHPS team attends Quality Governance Committee and Quality Focus Touchbase Meetings with the Medical Affairs and Provider Engagement Teams. These meetings address all CAHPS-related measures across lines of business including Medicare, Exchanges, Medi-Cal and Commercial. These forums review CAHPS implementation, CAHPS results, and are an opportunity to identify areas of improvement for CAHPS member experience survey results. The CAHPS team provides updates and analysis on Medicare call center metrics, Administrative Operational Star measures and PPG grievances. The meetings are cross-functional and include employees from multiple member-facing and provider-facing teams across the organization.

C. Health Net Quality Improvement/Health Equity Committee Organizational Chart



Note: The Quality Improvement and Oral Health Access Committee reports up to the HNCS Board of Directors.

V. QI, HEd, and Wellness Program Administration and Oversight

A. Key Associate Resources and Accountability

1. Health Net, LLC Chief Medical Officer (CMO)

This position has responsibility for the Quality and Medical Affairs Programs and must assure that the programs are compatible and interface appropriately with the provider network; oversee compliance with regulatory standards and reporting requirements; and achieve consistency in leading QI operations. This individual has direct authority over California's QI Program and staff, Medical Directors, and the Population Health program.

The Health Net LLC Chief Medical Officer (CMO) designates at least one medical director to provide clinical and administrative physician leadership to the QI Program, including:

- Oversight of the development, implementation and evaluation of QI projects and population-based care programs.

- Physician leadership for NCQA and regulatory agency surveys/audits.
- Representing Health Net as the physician QI liaison to external organizations, as needed.
- Chairing the Health Net quality committees.

2. Health Net Community Solutions Chief Medical Officer/Vice President, Medical Director, Medi-Cal

The Health Net Community Solutions Chief Medical Officer/VP Medical Director, Medi-Cal reports to the Health Net LLC CMO and is responsible for the development and implementation of strategies for access to care, improved quality outcomes, regulatory compliance and cost of care management. Reporting to the HNCS CMO/VP Medical Director are Supervisory (Regional) Medical Directors and the Dental Medical Directors. In this role, the HNCS CMO/VP Medical Director works closely with the Medical Affairs and Management teams, and cross-functional teams to create a culture of quality and accomplish the goals of the Quadruple Aim (Better Health, Better Care, Lower Cost, and Improved Provider Satisfaction).

3. Vice President, Medical Director, Commercial

The VP Medical Director for the commercial line of business reports to the Health Net LLC CMO. The VP Medical Director is responsible for supporting all medical aspects of the commercial line including promoting quality improvement efforts, identifying cost reduction opportunities, supporting the Account Management teams, and supporting the Sales team in growth endeavors. In this role, the VP Medical Director works closely with Medical Affairs, Population Health and Clinical Operations, Quality Improvement, and other cross-functional teams to promote a culture of quality and value and to advance the goals of the Quadruple Aim. Reporting to the VP Medical Director for the commercial line of business are a Clinical Program Manager and a Supervising Medical Director.

4. Vice President, Medical Affairs

The Vice President of Medical Affairs (VPMA) reports to the Health Net LLC CMO. The VPMA is responsible for clinical leadership and oversight of the following for all lines of business:

- Precertification, Concurrent, and Retrospective Review
- Appeals
- Grievances (both Quality of Care and Potential Quality Issues)
- Care Management, and
- Medical Policy.

The VPMA also serves as the Medical Affairs representative for the commercial and Medicare LOBs and reports to the Health Net of California Board of Directors. Reporting to the VPMA are the Director of Medical Policy, the Senior Medical Director of Medical Affairs (SMDMA), and all of the Central Medical Directors, either directly or indirectly (through the SMDMA).

5. Vice President of Quality Management

The VP of Quality Management reports directly to the Chief Medical Officer and is responsible for the overall direction and management of the QI, HEd, and Wellness Program and staff for all lines of business, including:

- Organization-wide QI, HEd, and Wellness Program, outcomes and compliance with regulatory and accreditation bodies and Market lead for the Medicare Star Program.
- Successful accreditation outcomes for all applicable regions and product lines.
- Overall HEDIS operations and performance.
- Credentialing, quality of care and peer review activities to ensure criteria for practitioner performance is measured and acted upon in a timely and consistent manner.
- Wellness, Health Education and Health Equity programs and services are developed and implemented for all members.

6. Behavioral Health Medical Director

The Behavioral Health Medical Director is involved with the behavioral health care aspects of the QI program and participates in the HNCA and HNCS QIHECs. To ensure that a close, coordinated approach to provision of behavioral health services and coordination of care with medical services is in place, the Medical Director is responsible for evaluating:

- Continuity and coordination care between behavioral and medical health
- Triage and referral processes, and
- Access and availability performances.

7. Supervisory (Regional) Medical Directors

The Medical Directors are licensed physicians responsible and accountable for assuring appropriate clinical relevance and focus of the Utilization Management, Care Management, Risk Adjustment, and QI Programs for all product lines. The Medical Directors interface with providers and individual practitioners and facilities to ensure the performance of the provider community meets established Health Net standards. The Medical Directors participate in HNCA and HNCS QIHECs and other QI activities.

8. Senior Director/Director of Quality Improvement

The Senior Director positions report to the VP of Quality Management. Three QI Directors report to the Senior Director of Quality Improvement. Responsibilities related to the QI, HEd, and Wellness Program include:

- Overall management of the QI, HEd, and Wellness Program, including behavioral health.
- Resolve barriers that prevent appropriate monitoring of quality of care and quality of services.
- Assure implementation of quality improvement and wellness activities.
- Review reports, identify issues, formulate policies and procedures and make recommendations to the QI committees.
- Provide consultation to Quality Management associates.
- Maintain NCQA accreditation and QI and HEd compliance.
- Direct and lead a cross-functional Health Net team, identifying and ensuring action is taken on priorities, leveraging relationships, and leading, to ensure appropriate and substantive interventions among leaders.

- Continuously assess the data and information available on performance measures, identify trends and risk areas, and then create a platform for change amongst the key Health Net stakeholders.
- Lead reporting and enterprise communication processes to share gaps and opportunities for improvement.
- Manage vendor relationships as necessary to support the processes to improve HEDIS, Stars, QRS, Quality Transformation Initiative, and DMHC Health Equity and Quality performance.
- Overall direction and management of the health education and wellness related programs including health disparities reduction efforts for all lines of business.
- Lead state-wide health education/promotion projects to operationalize regulatory requirements, establish best practices, design policies, establish standards, and ensure implementation and compliance.
- Review reports, identify issues, and make recommendations to the QI committees.
- Direct and oversee department-led interventions and programs that address CAHPS measures and identify and ensure action is taken on priorities.
- Manage wellness programs for Commercial and Medicare members, including:
    - Regularly inform members about, and encourage, appropriate use of the wellness services available to them through Health Net and/or their medical group or employer group.
    - Identify and target age appropriate, at-risk members with specific education programs and measure the effectiveness of these programs.
    - Integrate member health education functions into the activities of other Health Net departments, where appropriate, to further the mutual attainment of health care and quality improvement goals, and to support member satisfaction, retention and growth.
- To engage communities, stakeholders and partners by providing high quality health education programs and resources.
- Manage wellness programs for Commercial and Medicare members, including:
    - Regularly inform members about, and encourage, appropriate use of the wellness services available.
    - Identify and target members with appropriate wellness programs and measure the effectiveness of these programs.
    - Integrate member health education functions into the activities of other Health Net departments, where appropriate, to further the mutual attainment of health care and quality improvement goals, and to support member satisfaction, retention and growth.

9. Senior Director, Reporting and Business Analysis

The Senior Director of Reporting and Business Analysis reports to the VP of Quality Management and oversees a team of data analysts, project managers and support staff. Responsibilities related to the QI Program include:

- Direct management oversight for business process initiatives and optimize quality and efficiency in support of HEDIS objectives.
- Develop HEDIS organizational structure and resources allocation to assure the most efficient and successful HEDIS operation results.
- Build adequate resources within HEDIS Operations who are accountable for determining, operation and maintaining appropriate HEDIS reporting and operating systems.

- Serve as liaison and subject matter expert for the HEDIS business areas, providing assistance and direction for business processes to ensure timelines and desired business outcomes are realized.

10. Director of Quality Improvement Data Analysis

The Director of Data Analysis reports to the Sr. Director, Reporting and Business Analysis. Responsibilities related to the QI Program include:

- Assure identification of opportunities for quality improvement activities, related to achieving quality outcomes (e.g., Stars, clinical metrics, NCQA accreditation, member satisfaction).
- Review reports and guide the analytic approach across all lines of business and make recommendations to QI Committees.
- Assure implementation of quality improvement metrics and outcome measures.
- Ensure delivery of in-depth analysis to evaluate quality of care and service, member satisfaction and overall Health Net performance to identify opportunities for improvement.
- Continuously assess the data and information available on performance measures, identify trends and risk areas, and then create a platform for change amongst the key Health Net stakeholders.
- Lead reporting and enterprise communication processes to share gaps and opportunities for improvement.
- Ensure collaboration with HEDIS staff to identify areas of opportunity.
- Develop tools to track progress toward established goals and identify areas of opportunity.
- Provide feedback on quality outcomes and progress to Corporate and Market leadership.
- Identify data to be collected for QI initiatives, ensuring sound methodology and data collection for use in applicable outcome studies/evaluations.

11. Director of Clinical Services

The Director of Clinical Services reports to the VP of Quality Management. Responsibilities related to the QI Program include:

- Assure the Credentialing Department conducts credentialing/recredentialing activities in accordance with Health Net standards, state and federal regulatory requirements, and accrediting entity standards.
- Oversee Peer Review and Credentialing activities including the investigation of track and trend issues, identification of adverse action events, and presentation of quality issues to the Peer Review or Credentialing Committee.
- Oversee the Clinical Quality of Care (QOC)/Potential Quality Issues (PQI) Department is meeting state and federal compliance standards.
- Oversee facility site and medical record reviews activities, including and identifying deficiencies for PCPs meeting DHCS standards, corrective action plans, and physical accessibility review surveys for both primary care practitioners and high-volume specialty providers, including behavioral health and ancillary centers.

The Director of Clinical Services directs the clinical quality of care and the potential quality issues with guidance from the Senior Medical Director. Potential quality of care issues are reviewed by a Health Net Medical Director and based on findings,

are given a severity level, and as indicated, submitted to the Peer Review Committee (PRC) for appropriate resolution. Quarterly, an aggregate report of the number, severity, actions taken, adverse events and trends noted are reported to the HNCA and HNCS QIHECs.

The Credentialing Department is responsible for implementation of the credentialing program and the credentialing/recredentialing of health care practitioners and providers in accordance with Health Net standards for participation requirements, state and federal regulatory requirements, and accrediting entity standards. The department is also responsible for the credentialing adverse actions process, as well as peer review activities and committees.

12. Senior Director Vendor Partnerships

The Senior Director of Vendor Partnerships reports to the Vice President of Quality Management and oversees four key functions of the Clinical Vendor Management Team:

- Vendor Engagement, which includes researching and vetting vendors, managing RFPs, identifying service overlaps, and maintaining strategic corporate and market-level relationships
- Contract Set-Up and Maintenance, which manages SOWs, BAAs, legal review, security assessments, data-exchange setup, and invoice/payment workflows
- Program Implementation, which drives operational rollout through promotional strategy, member and provider communications, targeting and data pulls, meeting coordination, IT testing, and grievance management, and
- Contract Oversight, which ensures performance through JOC meetings, SLA and ROI monitoring, corrective action plans, cost tracking, issue resolution, and collaboration with Provider Engagement teams.

13. Quality Improvement Senior Managers/Managers

Health Net Quality Improvement Senior Managers/Managers report to the Senior Director or a Director of Quality Improvement. Managers oversee and manage the functions of the Quality Improvement Program and Health Education Systems, including HEDIS reporting, quality improvement and health education activities and other regulatory and compliance reporting. Responsibilities related to the QI Program include:

- Provide support to staff and facilitate daily quality improvement (QI) and health education functions through effective communication with departments and staff.
- Review and analyze reports, records, and directives for quality improvement and health education programs and services.
- Manage, oversee, and monitor all assigned quality improvement and health education programs, services, and initiatives.
- Confer with staff to obtain necessary data for planning work activities, including HEDIS reporting.
- Verify data submission compliance with government program requirements and ensure adherence with state, federal and certification requirements.
- Prepare and oversee reports and records on work activities for management.
- Evaluate and improve current procedures and practices and meet required standards.
- Manage delegate vendor oversight and corrective action plans as indicated.

- Monitor and analyze costs and assist with budget preparation.
- Communicate (or be a point person for) the respective product line goals and objectives.
- Support Programs, Owners, and Drivers (POD) results and productivity by communicating expectations and monitoring staff deliverables and participation.
- Provide manager oversight for respective PODs, including the development and implementation of strategies to drive performance improvement and promotion of programs.
- Maintain and address staffing and personnel needs.
- Oversee the completion of work plans, program descriptions, work plan evaluations, annual and semi-annual Member Incentive reports, and policies & procedures.
- Provide oversight and management of rating systems such as Medicare Stars, Commercial California Health Care Quality Report Cards (formerly Office of the Patient Advocate (OPA) report cards, Exchange Quality Rating System (QRS), Covered California Quality Transformation Initiative (QTI), Covered California 25-2-2 Policy, DMHC Health Equity and Quality, and Medi-Cal Managed Care Accountability Set (MCAS).

14. Health Equity Manager

The Health Equity Manager is responsible for the oversight, planning and coordination of cultural competency, health literacy, language assistance, social needs and risks, and health equity services and programs for all product lines for California. The Health Equity Manager also educates department leads on proposed and/or newly enacted legislation, oversees the delivery of culturally and linguistically appropriate services at all plan member points of contact, co-leads HOA and CFCA, and ensures that regulatory and accreditation requirements are met.

The following Health Equity Department's goals are implemented through four core competencies – language services, cultural competency, health literacy and health disparities reduction:

- Ensure language services meet regulatory requirements and achieve metric goals.
- Achieve appropriate reading grade level requirements and cultural appropriateness at market and product levels.
- Complete staff and provider trainings for required topics.
- Address health disparities through targeted cross-collaborative projects.
- Implement social needs assistance strategies with integrated approaches for mitigating social risks.

15. Health Education Lead

The Health Education Lead has a Master's degree in Public Health (MPH). The lead is responsible for the oversight, planning, coordination, and administration of health education programs and services statewide for SHP members, including the oversight of health and dental plans. The lead is also responsible for

- Overseeing the implementation and evaluation of the department's health education interventions and policies.

- Participating (or delegating participation) in community partnerships with local and state health departments.
- Budgeting and overseeing the department's operations.
- Maintaining compliance with government contracts including DHCS, CMS and DMHC for all contracted counties and service areas.
- Overseeing Health Education System (HES) staffing functions, implementing and evaluating health education interventions.

16. Quality Analytics Program Managers

Quality Analytics Program Managers are responsible for identifying, managing and tracking clinical, quality, correct coding, documentation and data submission projects that advance the objectives of Health Net's strategic goals.

Responsibilities include:

- Working across functional teams to develop performance trackers and tools as needed to meet national performance targets and drive quality improvement.
- Addressing the DHCS Corrective Action Plan (Medi-Cal), Medicare Star ratings, Exchange Quality Rating System (QRS) ratings, Covered California Quality Transformation Initiative (QTI) and 25-2-2 Policy, DMHC Health Equity and Quality measure set, and employer group performance guarantees (Commercial) by providing insight through statistical analysis of utilization and member data to identify opportunity areas that inform QI intervention.
- Facilitating the development of internal and external reports and the delivery of data as needed to support and monitor the action plans to accomplish the Quadruple Aim: 1) to improve member experience; 2) improve the quality of care; 3) to reduce health care costs; and 4) improve the provider experience.

17. Quality Improvement Analysts

The Quality Improvement Analysts reporting under the Director of QI Data Analysis conduct in-depth analysis to evaluate quality of care and service, member and provider satisfaction and overall Health Net performance to identify strategic opportunities for improvement.

Responsibilities include:

- Conduct deep dive strategic analyses to identify provider performance deficiencies and population vulnerabilities to target QI interventions.
- Review and assist in study design/methodology and provide data to be utilized for QI studies to meet regulatory requirements.
- Review and analyze the study findings and recommend corrective actions and next steps.
- Establish and implement programs and initiatives to meet NCQA and regulatory requirements.
- Continuously assess the data and information available on plan performance, to identify trends and risk areas.
- Provide support, guidance and collaboration with stakeholders in other Health Net Departments to ensure implementation, analysis and follow-up of activities.

- Develop tools to track progress toward established goals and identify areas of opportunity.

18. Quality Management Program Managers

The Quality Management Program Managers reporting to the Quality Improvement Directors/Sr. Manager are responsible for setting the tactical priorities for HEDIS performance improvement and managing projects across lines of business that advance the objectives of Health Net's strategic goals.

Responsibilities include:

- Serving as functional leaders across lines of business for targeted areas, including:
  - Child/adolescent health
  - Behavioral health
  - Maternal/perinatal health
  - Health Education promotion strategies
  - Chronic conditions strategy
  - Preventive health strategy
  - Care coordination and member engagement strategy
  - Pharmacy strategy support
  - Multi-gap/operations strategy support
  - CAHPS strategy, and
  - Provider engagement strategy.
- Setting tactical priorities based on data, provider partners, membership, and regulator purchaser priorities including Covered California Quality Transformation Initiatives, oversight of quality contractual requirements, and fostering statewide partnerships.
- Managing programs and evaluating effectiveness to achieve the targeted benchmarks and above.
- Assessing risks and monitoring performance of prior year's lower priority measures, elevating risk as needed, and setting as new tactical priority.
- Evaluating monthly HEDIS data, where applicable, to identify and/or track targeted population's progress.
- Supporting statewide program implementation and evaluation locally.

19. Quality Improvement Project Managers

Quality Improvement Project Managers implement statewide quality improvement Direct Care and Supportive Services initiatives and design associated studies to evaluate initiative effectiveness for all Health Net counties. They report to the Senior QI Manager, Manager of Program Accreditation, or QI Director.

Responsibilities include:

- Design and implement statewide programs that address member barriers and support care gap closures by providing direct care to members through innovative delivery methods.
- Develop strategies to effectively communicate with members through diverse methods and ensure all communication tools are accurate and relevant.
- Deploy methods to drive behavior change by encouraging members to seek care (i.e., member incentives, etc.).

- Design and implement evaluations to determine the most efficient and effective methods for HEDIS performance improvement.
- Tackle and monitor all statewide programs to report progress, address issues and adapt programs to meet target population needs.
- Scale up effective programs from Regional Teams, and deploy programs, trainings, and resources based on Regional Team's priorities.
- Provide project management support for major programs, including Medicare Stars, multi-gap call strategies, and other enterprise-wide initiatives, ensuring alignment with organizational goals and regulatory requirements.
- Collaborate cross-functionally with teams across Population Health, Clinical Operations, Pharmacy, Health Equity, Appeals and Grievances, Customer Contact Center, Credentialing, Provider Network Management, Provider Engagement, Data Strategy & Analytics, Claims, Compliance, Privacy, Program Accreditation, and Sales and Marketing to ensure successful implementation and outcomes.

20. Sr. Quality Improvement Specialists

Senior Quality Improvement Specialists implement quality improvement initiatives and studies for Health Net through multi-disciplinary workgroups designed to address clinical and service issues to meet all regulatory and accreditation requirements. They report to the QI Manager, QI Senior Managers or QI Directors.

Responsibilities include:

- Conduct the evaluation and review of the effectiveness of the QI Program and prepare documents for submission to the QI Committees, Executive Management Team, and the Board of Directors.
- Provide support, guidance and collaboration with Health Net departments to ensure implementation, analysis and follow-up of activities per the QI Work Plan.
- Review and/or revise policies and procedures on an annual basis, or as necessary.
- Identify data to be collected for selected studies and review format and methodology for appropriateness. Review and analyze the findings and recommend corrective actions and re-measurement as applicable.
- Establish and implement programs and initiatives to meet NCQA and regulatory body requirements.
- Development and implementation of member and provider interventions to improve HEDIS outcomes.
- Conduct deep dive analysis to identify provider group performance deficiencies and population vulnerabilities to target QI interventions.

21. Compliance Specialists

The Compliance Specialists report to the Manager of Accreditation and provide the following key deliverables and support to the overall QI Program:

- Support committee maintenance operations as needed.
- Monitor, report and execute necessary changes for programs and initiatives to meet NCQA and regulatory body requirements.
- Review and/or revise policies and procedures on an annual basis, or as necessary.

- Ensure all audit deliverables are prepared and maintained, including resolution of corrective action plans.

22. Manager of Program Accreditation

The Manager of Program Accreditation reports to the Senior Director of Quality Improvement. Responsibilities related to the QI Program include:

- Ensuring maintenance of Health Plan Accreditation, Health Outcomes and Community-Focused Care Accreditation, and maintain compliance with additional required NCQA accreditation programs.
- Coordination of the Quality Committees, including the Quality Improvement and Oral Health Access Committee, Specialty Network Committee, and CVH Workgroup.
- Ensure collaboration between Quality, Provider Engagement, and Medical Affairs to increase HEDIS rates.
- Review reports, identify issues, and make recommendations to the QI committees.
- Organize activities and provide consultation to Quality Management associates and other business units on areas related to accreditation.

23. Sr. Health Education Specialists/Health Educators/ Program Manager II

Health Education and Wellness staff hold Bachelor and Master degrees in health education, public health, health science, kinesiology, and nursing. They are responsible for the development, promotion, and implementation of member health communications, health education programs, worksite-based wellness programs, custom wellness programs, and community-based partnerships benefiting members. These programs and services reach all member households and client employer groups in large, mid-market and small business groups.

Health Education and Wellness staff are responsible for numerous projects and initiatives within the focus of member wellness, disease prevention, and member retention. Projects include, but are not limited to, managing and reporting on incentive programs, and diabetes prevention programs for specific lines of business. Staff oversee the revision of existing wellness programs, updating health education literature, and the design and development of new programs as needed. The staff is also responsible for the regulatory review and compliance of health education and wellness collateral and member communication related to Health Net's health education and wellness programs.

The Program Manager II (Training Specialist) is responsible for managing quality improvement initiatives, overseeing training programs, and supporting health education and wellness activities while ensuring compliance with regulatory requirements. This role leverages expertise in Quality Improvement, Health Education, and Wellness to develop and deliver training materials in collaboration with subject matter experts (SMEs), supporting both internal teams and external stakeholders. This role maintains training schedules, coordinates external training sessions, and assesses training effectiveness, providing recommendations to enhance programs. Regulatory responsibilities include leading SNP compliance by preparing and submitting reports such as the SNP Models of Care to CMS and DHCS. The Program Manager also monitors bariatric outcomes for Health Net surgeons and Bariatric Performance Centers, reporting quarterly findings, and

provides oversight of assigned wellness programs. By supporting the development of QI documentation, pulling QITS tracker data, and ensuring the timely completion of projects, the Program Manager II (Training Specialist) plays a critical role in advancing organizational quality improvement and training objectives.

The Program Manager II (QI Regulatory) is responsible for managing quality improvement initiatives while ensuring compliance with regulatory requirements. Regulatory responsibilities include leading DHCS Performance Improvement Projects (PIP), Plan-Do-Study-Act (PDSA), A-3 Lean Reports, Transformational PIPs, and Comprehensive Quality Improvement Projects. The Program Manger supports routine (monthly/quarterly) assessment of programs, including the development of evaluations plans, drafting criteria (in collaboration with the Program Manger III) to assess program effectiveness and prioritizing programs. The Program Manager also leads workgroups related to the regulatory deliverables with internal and external stakeholders and community partners. This is inclusive of the following coordination: Facilitation of meetings, agenda development, dissemination of action items, and monitoring and reporting progress. Program Managers also manage individual vendors to ensure compliance with the scope of work and timely, accurate invoice submissions. The Program Manager II (QI Regulatory) role is crucial to ensuring the organization meets the regulatory deliverables mandated by each governing body.

The Program Manager II (QI Non-Regulatory) is responsible for driving quality improvement programs and initiatives that enhance safety, cost efficiency, and clinical excellence. This role oversees planning and execution of QI programs and e-projects, ensuring alignment with strategic objectives through effective coordination of cross-functional teams and stakeholder engagement. Key responsibilities include gathering requirements, developing project plans, managing resources, and tracking engagement metrics to measure program effectiveness. The Program Manager (QI Non-Regulatory) also supports data reconciliation requests for vendor-related lead and disposition lists, supports data uploads to maintain accurate provider and quality data, and ensures thorough documentation of meetings, action items, and workflows. Additionally, the role identifies opportunities for process improvement, communicates program status, mitigates risks, and resolves issues throughout the project lifecycle, while ensuring all deliverables meet established quality standards.

24. Quality Improvement Specialists/Quality Program Strategist

The Quality Improvement Specialist and Quality Program Strategist roles support the implementation of quality improvement initiatives, regulatory compliance, and strategic program management across lines of business to enhance member outcomes and provider performance. They report to QI Managers. Responsibilities include:

- Implement and support quality improvement initiatives and programs across lines of business, ensuring alignment with organizational goals and regulatory requirements.
- Abstract, analyze, and manage data for quality reporting, decision-making, and trend analysis. Prepare ad-hoc and required reports to support project and program objectives.
- Track and coordinate projects to ensure timely execution, compliance, and alignment with specified objectives. Serve as the project liaison between teams to ensure efficient delivery of outcomes.

- Facilitate the development and maintenance of policies, procedures, and materials to align with best practices and regulatory requirements. Support audits and ensure corrective action plans for identified deficiencies are implemented promptly.
- Support the Quality Evaluating Data to Generate Excellence (EDGE) program through data entry, tracking reports, and assisting provider-facing teams with funding requests.
- Prepare quarterly and board-level committee slides, track updates for workplans and evaluations, and support other activities as needed.
- Prepare for audits, maintain accurate records, and coordinate team input for policies, procedures, and desktop updates to meet compliance standards.

B. Other Departments

1. Utilization Management

Utilization Management (UM) is responsible for directing and monitoring the use of health care services provided to members. The UM program involves pre-service, concurrent and post-service evaluation of the utilization of services provided to members and management of member appeals. The UM program requires cooperative participation of Health Net participating practitioners, delegates, hospitals and other providers to ensure a timely, effective and medically sound program. The program is structured to ensure that medical decisions are made by qualified health professionals, using written criteria based on sound clinical evidence, without undue influence of Health Net management or concerns for the plan's fiscal performance. See the UM Program Description for additional information.

2. Case/Care Management

Case/Care Management (CM) is responsible for the design, implementation and monitoring the effectiveness of the care management program and member outcomes. CM uses a systematic approach to identify and manage members who are currently accessing inpatient, ambulatory health care services, and may have compounding social drivers of health issues. Health Net's CM team partners with contracted practitioners, and member/family and/or caregivers to monitor, evaluate and facilitate continuity and coordination of care among its members, to improve care transitions and outcomes, and decrease readmission rates.

CM supports the integration of both physical and behavioral health services by ensuring that members who need behavioral health services are referred to the appropriate behavioral health provider to obtain medically necessary services. CM may refer these cases to a behavioral Care Manager who works in tandem with a physical health Care Manager on the member's care plan, as needed.

3. Clinical Vendor Management

Clinical Vendor Management team works in conjunction with Population Health and Clinical Operations for the monitoring and oversight of clinical performance metrics and operations for programs such as the Nurse Advice Line, Seniors and Persons with Disabilities health risk assessment (SPD HRA), in-app two-way communication program, telemedicine, surgery decision support program, behavior health services for members, and the specialty UM/prior authorization vendor for musculoskeletal and other select procedures.

4. Delegation Oversight

The Delegation Oversight Department is responsible for the development, implementation and monitoring of the delegation program for utilization management, credentialing, claims processing and payment, and complex care management for contracted Participating Provider Groups (PPGs) and strategic partners (delegated partners). Utilization Management/ Credentialing/ Claims Compliance Auditors perform regular evaluations of the delegated partners to assess the compliance with Health Net's delegation standards and requirements. Corrective action plans are requested from delegates demonstrating substandard performance. The purpose of the Delegation Oversight Committee (DOC) is to provide a forum for discussion of delegates performance and to address significant risks with health plan leadership.

5. Vendor Management Office (VMO)

The core responsibilities of the VMO are oversight, monitoring, and auditing of vendor delegates. Regular Joint Oversight Committees (JOCs) are led by the VMO in which performance metrics, member experience, complaints and grievances and the status of corrective actions are reviewed. Corrective actions are issued for non-compliance with service level requirements or for audit findings and are tracked through remediation.

6. Pharmacy Department

Centene's Pharmacy Services is responsible for managing the pharmaceutical benefits for all Health Net of California members.

The Pharmacy Department assists in the establishment and maintenance of the Health Net Formulary, and the education and communication of formulary and non-formulary issues throughout the Health Net provider and pharmacy network. In an effort to ensure the safe and appropriate prescribing of medications to the Health Net membership, the Pharmacy Department:

- Implements policies and procedures to ensure safety, quality and appropriate use and delivery of drug products and requests for pre-service, urgent and non-formulary drugs.
- Analyzes drug utilization patterns, pharmacy service indicators and cost-effectiveness to provide data sources for monitoring pharmaceutical care and services provided to members.
- Participates in multi-disciplinary integrated care management and quality improvement activities.
- Employs external practitioners, including pharmacists, in the development and annual update of pharmaceutical management procedures and guidelines.
- Evaluates and updates the drug formulary lists.
- Identifies, classifies and alerts appropriate individuals to potential drug-drug interactions.
- Notifies practitioners and members of Class 1 FDA drug withdrawals or other safety issues related to medication therapy.

7. Appeals and Grievances

The Appeals and Grievance Department is responsible for conducting full investigation and fair review of all member concerns and/or reconsideration requests. This includes reasonable efforts to gather all information needed to make accurate decisions and provide the member with a resolution in writing within applicable regulatory and contractual timeframes. If an appeal has been upheld by the plan, the members are provided with their next level of appeal rights and information regarding the appeal process which provides the member with an independent third-party review.

Appeals and grievances are monitored and trended to identify opportunities for improvements in service and quality of care. Regularly scheduled reports are presented to Health Net quality committees to ensure and allow the departments the ability to review, act and follow-up on service, quality events or trends that are significant at the practitioner, provider or plan level. Initiatives are put in place, as needed to address any identified deficiencies.

8. Customer Contact Center

The Customer Contact Center (CCC), organized by product line, is responsible for addressing telephone inquiries from members, practitioners and employer groups. Based on established criteria, the Customer Contact Center refers specific appeals and grievances and expedited requests to the Appeals and Grievances department for focused evaluation and follow-up for any quality of care or service issues.

Quarterly reports of trended member, practitioner and provider service-related issues are compiled and reviewed for action by the appropriate QI subcommittees. The analysis of these reports comprises one of the data sources utilized by the QI Department to directly identify and/or confirm opportunities for improvement.

9. Provider Network Management

Provider Network Management (PNM) initiates and directs work to recruit and expand hospital, practitioner and ancillary provider networks to serve Health Net members. PNM associates serve as liaisons with the practitioner and provider network for the resolution of contractual issues related to the terms and conditions and/or payment rate(s) for certain services.

10. Provider Engagement and Data Strategy & Insight

The Provider Engagement and Data Strategy & Insight departments at Health Net provides oversight and capabilities in support of improving and maintaining performance with providers and their membership across all lines of business. Collaboration between the departments involve the Provider Relations, Practice Transformation, Encounters, risk assessment forms (RAF), and Data Analytics and Solutions teams. The Provider Engagement and Data Strategy & Insight departments' success is dependent on both "internal" and "external" alignment to improve practitioner and provider performance and satisfaction.

Key responsibilities of the Provider Engagement and Data Strategy & Insight departments include:

- Monitor and maintain and/or improved provider compliance (HEDIS, CAHPS, practitioner/provider satisfaction, UM metrics, RAF and encounter submissions) through provider outreach, training and education.
- Oversee and evaluate provider effectiveness.
- Assure business capabilities meet and support provider and member needs.
- Improve technical support, bi-directional data exchange, and communication channels or methodologies.
- Identify trends, issues, and opportunities to form and adopt best practices and meet or exceed performance targets.
- Engage and collaborate with targeted practitioners and providers through performance improvement projects.
- Collaborate with practitioners, providers and cross-functional departments to build and align incentives based on performance goals.

11. Program Accreditation

Program Accreditation (PA) supports and promotes activities to assess and monitor organization-wide ongoing compliance with requirements of accrediting bodies (NCQA). Responsibilities include managing the accreditation timelines, coordination and submission of documents and implementation of any identified actions based on survey outcomes. The PA team also manages collaboration between Quality, Provider Engagement, and Medical Affairs to increase HEDIS rates as it pertains to Quality EDGE efforts.

12. HEDIS Measurement and Reporting

The HEDIS Measurement and Reporting department is responsible for HEDIS, CAHPS, QHP, and Medicare HOS data collection and/or reporting. This unit ensures that the data and information systems used to produce HEDIS rates pass regulatory audits related to data system and medical record retrieval and review. The HEDIS Team comprises of compliance managers, data analysts, project and program managers, medical record abstractors and customer service representatives. They work on multiple projects throughout the year with internal and external stakeholders to improve and report on health plan HEDIS rates. The department partners with PPGs to identify data gaps, by providing coding and documentation education when necessary, and by ensuring that all forms of supplemental data, e.g., electronic medical records (EMR), lab data, state registries, alternative submission methods (ASM), Pay for Performance (P4P), and other ad hoc extracts are provided, procured, and captured in monthly reports. HEDIS works collaboratively with the QI team to identify areas of opportunity through a myriad of data analysis projects, monthly production of provider network care gap reports and member outreach and engagement.

13. Public Programs

The Public Programs department monitors and acts as a resource for the LTSS (CBAS, MSSP, IHSS, and LTC) services for Medi-Cal and dual eligible Medicare members. The department is engaged in the following activities:

- Support access to care initiatives through member outreach, coordination of care, and nursing home transitions.
- Early identification and referral to California Children's Services (CCS), and outreach to members aging out of program twelve months before their twenty-first birthday to avoid interruption in care.

- Referral/connection to carved out Medi-Cal benefits and providers.

14. Additional Resources

Additional resources available to the QI Program:

- Marketing/Sales
- Compliance
- Privacy
- Legal
- Medical Informatics
- Web Development
- Strategic Sourcing and Procurement
- Claims/Encounters
- Provider Communications
- Member Communications
- Corporate Shared Services departments
- Corporate Quality Department and services
- Corporate Population Health Management, and
- Corporate Accreditation department.

The **Management Information Systems (MIS)** supporting the QI Program allows key personnel the necessary access and ability to manage the data required to support the measurement aspects of the QI activities. Analytic resources within the QI Department are available to support Health Net efforts, including expertise from the Director of QI Research and Analytics, who holds a master's degree and has SAS and programming experience. Additional analytic and operational support is provided by regional and corporate departments such as Information Systems, Health Care Services, Pharmacy Operations, Medical Informatics, HEDIS Measurement and Reporting, Actuary, Finance, Strategic Planning, and Marketing. Computer systems used by Health Net to support Quality Management includes:

- **Centelligence™**, is a comprehensive family of integrated decision support and health care informatics solutions. The Centelligence platform integrates data from internal and external sources, producing actionable information: everything from care gap and wellness alerts to key performance indicator (KPI) dashboards, provider clinical profiling analyses, population level health risk stratifications, and over 12,000 unique operational and state compliance reports.
- **Centelligence Enterprise Data Warehouse (EDW)**, a hardware supporting both Insight and Foresight, EDW receives, integrates, and continually analyzes an enormous amount of transactional data, such as medical, behavioral, and pharmacy claims, lab test results, health assessments, service authorizations, and enrollee and provider information as required for QI Programs.
- **Statistical Analysis Software (SAS)**, an integrated software suite for advanced analytics, business intelligence, and data management. QI uses SAS to conduct predictive, barrier and statistical analysis.
- **R**, an open-source software environment for statistical computing and graphics. QI utilizes the R-Shiny package within R to build and display interactive dashboards.
- **Power BI**, a Microsoft product that transforms raw plan data from multiple sources into actionable insights through interactive dashboards, real-time analytics, and secure, collaborative sharing. It boosts efficiency by enabling

data-driven QI decision-making, streamlining data visualization, and offering, mobile accessibility for quick, informed actions driving QI programs.

- **MicroStrategy**, an enterprise business intelligence (BI) application software vendor. The MicroStrategy platform supports interactive dashboards, scorecards, highly formatted reports, ad hoc query, thresholds and alerts, and automated report distribution.
- **Inovalon's Converged Analytics**: A HEDIS-certified software system used to optimize quality measurement, reporting, and improvement initiatives. Converged Analytics is an NCQA-certified software; its primary use is for the purpose of building and tabulating HEDIS performance measures. Enables the Plan to integrate claims, member, provider, and supplemental data into a single repository, by applying a series of clinical rules and algorithms that automatically convert raw data into statistically meaningful information.
- **Cozeva®**, a value-based NCQA-certified care operating system with reporting and analytics functionality, offers up-to-date information on quality and risk measures to plan providers. Cozeva gives providers visibility to provider-level incentives, and supports supplemental data submissions, data integrations with EMRs, and biweekly data syncs to CAIR and various EHR systems. Provider groups have the ability to track and trend performance of their providers to better monitor, understand, and act on performance gaps through customizable dashboards.
- **Tableau**, a data visualization tool which connects easily to several data sources and allows for rapid insight by transforming data into dashboards and are also interactive. Quality uses this software for plotting data on maps and displaying outcomes through dashboarding.
- **Quest Analytics**, a software that allows geo-mapping to conduct analysis on provider and facility access and compliance for the Health Net membership.
- **Operational Data Warehouse (ODW)**, a hardware that supports Health Net's claims payment system called Automated Benefits System (ABS). Claims, encounters, member and provider information that are processed in ABS are stored in ODW. (Decommissioning and migration to Snowflake Cloud Platform started in 2023) AMISYS Advance, a claims processing engine with extensive capabilities for administration of multiple provider payment strategies. AMISYS Advance receives appropriate enrollee and provider data systematically; receives service authorization information in near real time from TruCare; and is integrated with our encounter production and submission software.
- **Snowflake Platform,** is the next generation of the Enterprise Data Warehouse built on top of the Snowflake platform. The platform allows the organization to unify, analyze, and share health plan data securely through a cloud-native platform. It consolidates data from disparate sources into a single, managed platform for data warehousing, data lakes, and artificial intelligence/machine learning (AI/ML), enabling advanced analytics, while providing built-in security, compliance, and auditing tools to monitor data quality and manage access.
- **TruCare**, an enrollee-centric health management platform for collaborative care coordination and management; and behavioral health, disabling condition, and utilization management. Integrated with Centelligence™ for access to supporting clinical data, TruCare allows Population Health and Clinical Operations staff to capture utilization, care and population-based chronic conditions data; proactively identify, stratify, and monitor high-risk enrollees; consistently determine appropriate levels of care through integration with InterQual Criteria and capture the impact of our programs and interventions.
- **OMNI**, the call center application with guided workflows and business process drivers that allow the business better flexibility and integration with internal data

systems and with changing environments. The OMNI application is used to research, record and share information between providers and members.
- **PRIME** is system application used by employees to handle complaints, grievances and appeals. PRIME includes business process management features that integrate with upstream applications, including Membership, Provider Authorizations and OMNI.

C. QI, HEd, and Wellness Program Activities

QI, HEd, and Wellness Program activities are selected based on their relevance to Health Net's membership, the ability to affect a significant portion of the population or the population at-risk and their potential impact on high-volume, high-risk or high-cost conditions or services. Morbidity, mortality and vulnerable groups with special needs are considered in the selection process as well as race, ethnicity, and language disparities.

Health Net fosters a multi-disciplinary approach to the quality improvement process and involves all functional areas with direct impact on quality and safety of care and service. Activities involve Health Net departments and collaborations with network providers, community entities including public health, quality improvement organization and behavioral health (see QI, HEd, and Wellness Work Plan for details of performance improvement goals, objectives, and activities). The QI Program uses PDSA cycles as one method for monitoring quality improvement activities.

1. Projects, Surveys and Audits

Issues/topics are selected based on identified opportunities for improvement through member and provider input, nationally and regionally identified or mandated projects, HEDIS, CAHPS/ECHO/OPMH Surveys, HOS measurement and participation in regional and national coalitions.

2. Incentive Programs

Health Net rewards targeted members for healthy behaviors and collaborates with providers to build performance-based incentive programs. Development and implementation of incentives are aligned with Health Net's market growth, provider partnership, and the Quadruple Aim strategies.

Member:

- Tailored member incentives offered to target Medi-Cal, Commercial, and Medicare populations to assist in closing care gaps for priority HEDIS measures including breast cancer screening, cervical cancer screening, diabetes management, well-child visits, and childhood immunizations.
- Participation in the Corporate member rewards or vendor programs for select Medicare and all Exchange populations to promote healthy behaviors and improvement in chronic and preventive care.
- Wellness Reward Program (for select Commercial members) – The Sharecare wellness reward structure in 2026 continues to offer flexibility for eligible members to earn rewards within the Sharecare wellness platform.

Provider:

- Pay for performance program for Commercial HMO providers based on HEDIS outcomes and member satisfaction.
- Tailored provider and PPG incentive programs for Medi-Cal providers for HEDIS outcomes and encounter submissions.
- Pay for Performance Program for Medicare providers as well as Quality Performance Program for Medicare PPG network to improve Medicare Stars.
- Ambetter from Health Net (HMO, PPO) incentives to close care gaps.

D. Provider Communications

Effective communication with network providers and subcontractors is crucial in advancing Health Net's quality improvement initiatives, studies, and fulfilling contractual obligations. Engagement with the Quality Improvement Health Education (QIHEd) Program is facilitated through various methods, including:

- Practitioner and provider office visits: Conducted by designated team members to ensure direct and personalized communication.
- Online training and educational webinars: These resources provide continuous learning opportunities and keep participants informed about the latest guidelines and best practices.
- Joint Operation Meetings (JOMs) and work groups: These collaborative forums foster active participation and dialogue, ensuring alignment with quality improvement goals.

This structured approach ensures that all participants are well-informed and actively contributing to Health Net's mission of enhancing health care quality and efficiency.

To keep health care providers informed about QIHEd and Wellness program activities, modifications and outcomes, as well as available quality resources and programs, several key methods are utilized. The resources described below can be accessed through the Provider Library at providerlibrary.healthnetcalifornia.com or on other provider resource pages available on the Health Net website at healthnet.com.

Available Resources:

- Provider Operations Manuals and Medi-Cal Operations Guides: Comprehensive manuals and guides outlining the operational policies and procedures necessary for providers to effectively deliver services.
- Provider Updates and Letters: Regular updates and communications sent to providers to keep them informed about important changes and developments.
- Provider Newsletters: Quarterly newsletters offering insights and updates about various health programs, initiatives, engagement in our communities, and best practices.
- Forms and Reference Documents: Essential forms and reference materials needed for administrative and operational purposes.
- Educational Materials and Resources: Resources aimed at enhancing provider knowledge and skills related to QIHEd and Wellness programs.

Communication Channels:

Provider updates, letters, and educational materials and resources are distributed via multiple channels including fax, mail and email. Additionally, these communications and materials are available in the Provider Library at providerlibrary.healthnetcalifornia.com under the "Updates and Letters" section, or on other provider resource pages on the Health Net provider website at healthnet.com.

E. Corrective Actions

Health Net takes timely and appropriate action to correct any significant or systemic problems identified through audits, internal reports, complaints, appeals, grievances, and delegation oversight activities.

F. Semi-Annual QI, Health Education and Wellness Systems Program Evaluation

Health Net reviews and evaluates quality improvement activities at least annually (semi-annual for Medi-Cal), to determine the overall effectiveness of the QI Program and progress towards influencing network-wide safe clinical practices.

It also addresses issues such as the adequacy of resources, committee and subcommittee structure, practitioner and provider participation, and leadership involvement.

The QI, HEd, and Wellness Program Evaluation is completed following the collection of the prior calendar year's HEDIS rates, CAHPS/ECHO/OPMH data, and HOS surveys as appropriate. These mechanisms are used to provide feedback to staff and providers regarding QI outcomes. The Evaluation includes:

- Description of completed and ongoing quality improvement activities for the year.
- Identifies the individual responsible for implementing activities.
- Timeframe for implementation.
- Trended data for clinical and service indicators.
- Assessment of barriers to achieving goals of the QI Program.
- Evaluation of the effectiveness of the QI Program compared to the progress or lack of progress in meeting goals and objectives in the QI, HEd, and Wellness Program Description and Work Plan.
- Determination if changes or restructure of the QI, HEd, and Wellness program for subsequent years is necessary.

The QI, HEd, and Wellness Program Evaluation is accompanied by an Annual Executive Summary which also determines the following:

- Overall effectiveness of the QI program;
- QI Committee and subcommittee structure; and
- Provider participation and leadership in the QI program.

These documents are submitted for review and approval to Health Net's quality committees and Health Net's Boards of Directors. The Program Evaluation is the basis for establishing the following year's Work Plan.

G. Annual QI, HEd, and Wellness Program Work Plan

The annual QI, HEd, and Wellness Work Plan builds on the recommendations and findings from the previous year's Program Evaluation and is updated at mid-year to reflect progress on quality improvement activities throughout the year. The Work Plan is submitted for review and approval to the Health Net QIHE Committees and Boards of Directors. The Work Plan documents the annual QI Program initiatives and delineates:

- Objectives, scope and population demographics.
- Improvement activities planned for the year covering quality and safety of clinical care, quality of service, and members' experience.
- Timeframes within which each activity is to be achieved and/or reported.
- Responsible department(s) and/or person(s) for each activity.
- Goals and benchmarks for each activity.
- Number of objectives met.
- Number of activities met.
- Planned monitoring of previously identified issues in prior years that require follow-up.
- Barriers identified when goals are not achieved.
- Follow-up action plan, including continuation status (close, continue, or continue with modifications).

The Work Plan allows integration of quality improvement reporting and activities from various Health Net departments and includes reporting requirements for both internal and external reporting. Each individual department retains the responsibility for the implementation and evaluation of their specific activities.

H. Standards of Practice

The standards used as criteria, measures, indicators, protocols, clinical practice guidelines or benchmarks in the QI Program, are based on professionally recognized standards. They are obtained from national and local medical professional associations and practice patterns, applicable medical literature, available medical knowledge, accreditation standards and state/federal requirements. These standards are:

- Used to evaluate quality and safety of care provided by network providers.
- Supported by reasonable scientific evidence and are approved by the Medical Advisory Council and reported to the quality committees.
- Incorporated into Health Net's clinical practice guidelines and reviewed at least every two years or when national guidelines, state or federal requirements change, and revised as appropriate.
- Communicated to practitioners, providers and appropriate Health Net associates in a systematic manner.

I. Privacy and Confidentiality of Information

The Health Net Privacy Officer is responsible for reviewing, approving and disseminating confidentiality policies and practices regarding the collection, appropriate and legitimate use, storage and disclosure of medical information in order to protect the privacy and confidentiality rights of members, employees, providers and the company. Health Net's contracts require that practitioners and providers maintain the confidentiality of member information and records. Information or copies of records may be released only to authorized individuals as permitted by state and federal law.

Prior to participation in the QI Program or its committees, participants are required to sign a confidentiality statement. All documents created as part of the QI Program are maintained in accordance with federal and state law.

Quality improvement activities are conducted and discussed under a code of confidentiality. Each Health Net department is responsible for safeguarding any confidential materials.

J. Conflict of Interest

No person(s) will be assigned or selected for a QI committee where a conflict of interest exists. Physician members will not review or participate in the review of their own care, referrals, or of other providers they are in direct competition with or are associated with through financial arrangements.

K. QI, HEd and Wellness Program Information Availability

Information about Health Net's QI, HEd, and Wellness Programs including program description, activities and progress toward goals is available upon request, to members, prospective members and providers. Health Net notifies members of the availability of information about the QI, HEd, and Wellness Programs through the member’s evidence of coverage and through the annual member newsletter highlighting Health Net’s QI, HEd, and Wellness Programs. Network providers and subcontractors are notified of the availability of information about the QI, HEd and Wellness Programs through committee meetings, JOMs, new practitioner/provider welcome letters, Provider Updates (including updates regarding Medi-Cal quality improvement findings and outcomes), and/or through the operations manuals available electronically in the Provider Library on Health Net’s online provider portal.