Quality Improvement Annual Evaluation 2024

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Section 1: Summary of Overall Effectiveness of QI Program

Health Net annually assesses the overall effectiveness of its Quality Improvement (QI) Program at improving network-wide clinical and service practices. In 2024, Health Net retained its National Committee for Quality Assurance (NCQA) Health Plan Accreditation (HPA). The "Accredited" status applied to the following lines of business: Commercial HMO/POS; Commercial PPO; Marketplace (Exchange) HMO/HSP; Marketplace (Exchange) PPO; Medicare HMO; and Medi-Cal HMO. Health Equity Accreditation (HEA) and HEA Plus was also renewed for Commercial HMO/POS; Commercial PPO; Marketplace (Exchange) HMO; Marketplace (Exchange) PPO; Medicare HMO; and Medi-Cal HMO. The 2024 Health Plan Ratings (HPRs) for Commercial HMO/POS, Medi-Cal and Medicare HMO was 3.5 stars. For Commercial PPO/EPO, the HPR was 3 stars.

Health Net continually strives to incorporate a culture of quality across the organization and conducts operations to improve member service and satisfaction. This philosophy also extends across the provider network to improve provider quality outcomes, as evidenced by the plan's Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) rates. The QI Department is a centralized team specialized in knowledge of each population across lines of business (LOBs) and collaborates with a dedicated analytics team.

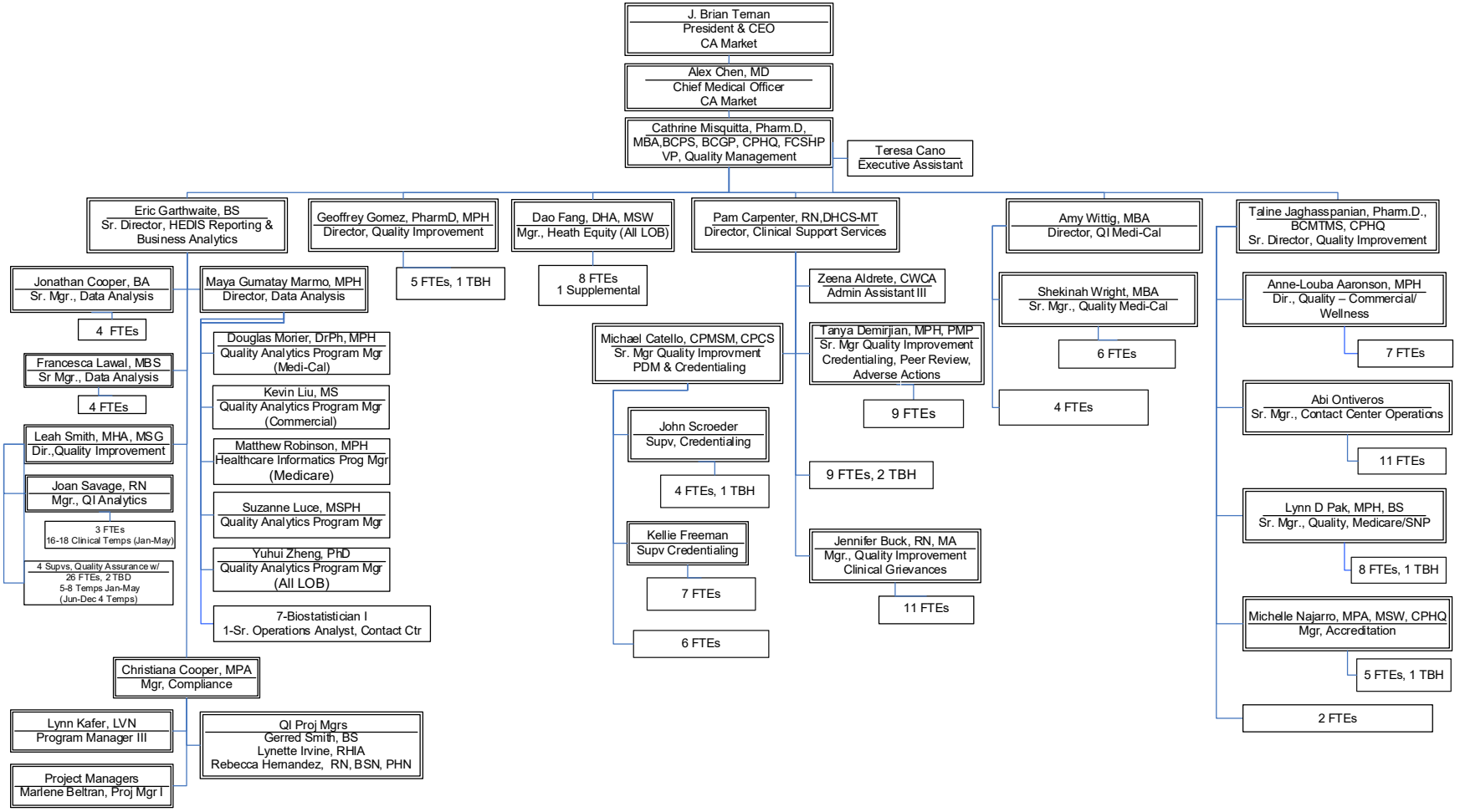
The Health Equity team provides oversight, implementation, and operational support to the Health Equity strategy. The Health Equity team supports departments throughout the organization and managed five core areas: Language Services, Health Literacy, Cultural Competency, Health Equity and Disparities, and Social Needs and Social Risks. Health Net has adopted the Culturally and Linguistically Appropriate Services (CLAS) Standards. The CLAS standards represent 15 different standards that served as the foundation for the development of the Health Equity team's strategic plans. To ensure that Health Net was continually striving to be responsive to our membership, Health Net conducted data analysis and designed and implemented services to meet the needs of members. Internally, Health Net surveyed new employees to determine staff diversity in cultural and linguistics and supported and trained bilingual associates. In 2024, Health Net completed health care bilingual certification for 315 staff members. Externally, Health Net conducted a biennial Geo Access report, which used member zip code data and correlated it with member language preference. This data was further overlaid with provider network language capabilities and a gap analysis was conducted to target network expansion. The Health Net Human Resources Department and the Diversity and Inclusion team was responsible for the overall coordination to ensure a diverse leadership and workforce.

Health Net disparity projects included a Los Angeles County Neighborhood Initiative Project to improve pediatric HEDIS measures and reduce health disparities; Improving HbA1c Management in Latino members in Los Angeles; Colorectal Cancer Screening Project for Commercial and Medicare; Improving Glycemic Status Assessment for Patients with Diabetes for Commercial; and Improving Well Child Visits through a Neighborhood Networks project targeting the African American population in Los Angeles County.

Adequacy of QI Program Resources

In 2024, Health Net's Quality Management Department, led by a Vice President, remained a centralized, interdisciplinary team working to support members in a coordinated manner, resulting in focused efforts to improve HEDIS and CAHPS performance across product lines. Participating Provider Groups (PPGs) could access HEDIS report cards and performance reports (Cozeva analytics provider platform), highlighting their performance on key measures compared to national benchmarks, as well as care gap reports including member and practitioner-level information for PPGs to determine actionable approaches to close care gaps. Five departments comprised Quality Management, each with a separate leadership structure: 1) Quality Improvement, for Commercial and Medicare, including Wellness; Quality Improvement for behavioral health, hospital quality and patient safety; Quality Improvement for Medi-Cal, including Health Education; 2) Credentialing/Clinical Quality of Care/Potential Quality Issues/Facility Site Review; 3) Program Accreditation and CAHPS, 4) Health Equity, and 5) HEDIS. The Quality Improvement Analytics team supported data needs across all Quality Management teams and departments.

Chart 1.2. Quality Management Department Staff



Quality Improvement Department

Four Directors led the Quality Improvement Department: A Senior Director of QI for the Commercial and Medicare teams; a QI Director for behavioral health; a Commercial/Exchange Director for the QI and Health Education/Wellness teams; and a Medi-Cal Director for the QI and Health Education/Wellness teams. All four Directors led management teams with a focus on each of the lines of business.

The Director leading the Commercial/Exchange QI and Wellness efforts had a team that consisted of three Senior Health Education Specialists; three Program Manager IIs; and one Health Educator. The Director collaborated with Program Manager IIIs along with cross-functional staff to develop robust initiatives to meet regulatory and purchaser requirements for Commercial and Marketplace products, and the Health Education/Wellness program. Initiatives were developed to meet the requirements of large purchasers, including adhering to the Covered California quality requirements and improving Quality Rating System (QRS) ratings; the Covered California Quality Transformation Initiative (QTI); implementing a QI Program (QIP) for a large employer-group; and meeting for the new CalPERS Quality Alignment Measure Set (QAMS) and performance guarantees for other purchasers.

Under the direction of the Medi-Cal QI Director, the Medi-Cal QI team consisted of a Senior QI Manager, two Program Manager IIIs, two Program Manager IIs, one Project Manager II, one Senior Quality Improvement Specialist, one Senior Health Education Specialist, two Quality Improvement Specialist IIs, and one Quality Improvement Specialist I. The Director and Senior QI Manager collaborated with team members and cross-functional partners to implement a comprehensive and streamlined approach to meeting compliance with the Department of Health Care Services (DHCS), NCQA, and Centers for Medicare & Medicaid Services (CMS).

Under the leadership of the Senior Director of QI for Commercial and Medicare teams, the team consisted of a Senior QI Manager, three Program Manager IIIs, one Program Manager II, two Senior Quality Improvement Specialist, and two Quality Improvement Specialists. The Senior Quality Improvement Manager collaborated with Program Managers and cross-functional partners to develop a comprehensive and coordinated approach to meeting compliance to Centers for Medicare & Medicaid Services (CMS), NCQA, and Department of Health Care Services (DHCS) regulatory requirements and improving Star ratings quality performance for the Medicare Advantage Plans, inclusive of Special Needs Plans (SNPs).

The QI Director leading and overseeing behavioral health, hospital quality and patient safety had a team that consisted of two Program Manager IIIs; two Senior Quality Improvement Specialists; one Quality Improvement Specialist II; and one Quality Specialist. Initiatives were developed to ensure behavioral health, hospital quality and patient safety requirements were met for Commercial, Marketplace and Medi-Cal products.

The Program Manager IIIs drove long term strategy for their topical areas to address health education and quality outcomes improvement. To continue efficiency across the

QI teams, PODs were maintained and are responsible for leading each program and measure strategy across all lines of business. A new Health Education pod was added in Q1 2024 for monitoring and oversight of all Health Education/Wellness programs.

Program Accreditation Team
The QI Sr. Director led the Program Accreditation team. The Program Accreditation team included a Manager of Accreditation, two Compliance Specialists, and a Compliance Analyst. This department managed the QI committees and sub-committees, led activities to ensure ongoing organization-wide compliance with requirements of accrediting bodies for the California Market, including the Health Plan Accreditation (HPA), Health Equity Accreditation (HEA), Health Equity Accreditation Plus (HEA Plus), and external and internal audit readiness. At year end, in review of staff resources and support, the Quality department transitioned Quality EDGE to the Program Accreditation team. As a result, a Compliance Analyst and Compliance Specialist were promoted to Project Manager II positions, a Quality Improvement Specialist I was added to the team, and a Quality Program Specialist transferred from the Quality Medi-Cal team.

CAHPS Team
The QI Sr. Director led the CAHPS team that included two Program Manager IIIs who oversaw t overall member experience. The team led improvement strategies including root cause analysis of member pain points, CAHPS survey exposure and training, mock CAHPS survey implementation, and improvement initiatives in partnership with operations and provider-facing teams.

Health Equity Team
The Health Equity team was unique in its cross-functional support structure. The Health Equity team had representation throughout the State and was staffed by a Vice President of Quality Management, a Manager of Health Equity, one Program Manager III, five Senior Health Equity Specialists, two Health Equity Specialists, and one supplemental staff position. Staff covered all services related to the California Market. Health Net has a strong governance structure to oversee and provide support to cultural and linguistic/health equity services. The Health Equity team has a breadth of knowledge as it relates to the integration of cultural and linguistic services within the health plan and across operational areas of cultural competency, health literacy, language assistance services, addressing health disparities and compliance. The Health Equity team analyzed, designed, and implemented strategies to support the reduction of health disparities and facilitated the Health Equity workgroups, which were responsible for developing and implementing an action plan to reduce health disparities in targeted HEDIS measures.

Credentialing/Clinical Quality of Care/Potential Quality Issues/Facility Site Review Department

Credentialing/Clinical Quality of Care/Potential Quality Issues/Facility Site review was led by a Director of Clinical Services and included two QI Senior Managers for Credentialing, Peer Review and Adverse Actions and a QI Manager of Clinical Grievance.

The Facility Site Review (FSR) team collaborated with other Medi-Cal Managed Care plans throughout the state to maintain and refine a standardized system-wide process for conducting reviews of primary care physician facility sites, along with Medical Record

Review (MRR) and Physical Accessibility Review Surveys (PARS). This process minimized duplication and supported consolidation of FSR surveys. The process incorporated evaluation criteria and standards in compliance with DHCS contractual requirements and was applicable to all Medi-Cal Managed Care plans. The FSR department also conducted provider education, provider outreach, and other QI activities. The Director provided regular updates of FSR/MRR/PARS activity via reports to the Health Net Community Solutions (HNCS) QIHE Committee twice a year. These evaluation reports identified overarching areas of noncompliance by sections and selected elements, reported at the county level with year-over-year (YOY) comparison. This detailed analysis allowed for monitoring and identification of improvement opportunities. The FSR department collaborated with the Regional Medical Directors and Credentialing, Provider Network, Clinical Grievances, Health Education, Cultural & Linguistic Services, and Provider Relations departments to implement process improvements.

HEDIS Department

A Senior Director of HEDIS Reporting and Business Analytics led the HEDIS department. There was one Director,two Senior Managers, two Managers, one Program Manager, three Medical Record Project Managers, three Supervisors, and three HEDIS Quality Improvement Project Managers, along with Medical Record Abstractors, Analysts and Customer Service Representatives that comprised the team. The HEDIS team was responsible for HEDIS measurement and reporting annual rates and outward-facing provider and member outreach to support supplemental data, EHR Improvements, and care gap closure.

The HEDIS team also had a QI Director of Data Analysis. The Director oversaw the Analytics team within the department and was responsible for ensuring the production of detailed reporting and analytics for all lines of business. The QI Research and Analysis (QIRA) team reported to the Director and was responsible for providing data and analytical support for QI projects. Additional staff were hired in 2024 resulting in a total of eight analysts (six Biostatistician I, one Biostatistician II, and one Sr. Contacts Center Operations Analyst) on the QIRA team. Additionally, there were three Quality Analytics Program Managers (QAPMs), focused solely on Medicare, Commercial, and Medi-Cal lines of business (LOBs), respectively, and two additional QAPMs who handled all LOBs. All five QAPMs reported directly to the QI Director of Data Analysis.

For a detailed description of each Quality Management department and function, refer to the 2024 HNCA Quality Improvement Program Description.

QI Committee Structure

Two Health Net committees successfully supported Health Net's QI Program in 2024: the Health Net of California Quality Improvement/Health Equity Committee (HNCA QIHEC) for Commercial/Marketplace, and the Health Net Community Solutions Quality Improvement/Health Equity Committee (HNCS QIHEC) for Medi-Cal. In 2024, Medicare member oversight transitioned to the National Medicare Quality Improvement & Utilization Management Committee (QIUMC). The CA Medicare product lines (including Dual Eligible) reported to the Centene and CA Board of Directors. Health Equity served as a key function of the HNCS QIHEC in an effort to prioritize efforts towards health disparities, social risks, social

determinants of health (SDoH), and community needs. Health Equity was added as a key function of the HNCA QIHEC for 2024. Lastly, in 2024 oversight of behavioral health reporting transitioned to the HNCA QIHEC and HNCS QIHEC.

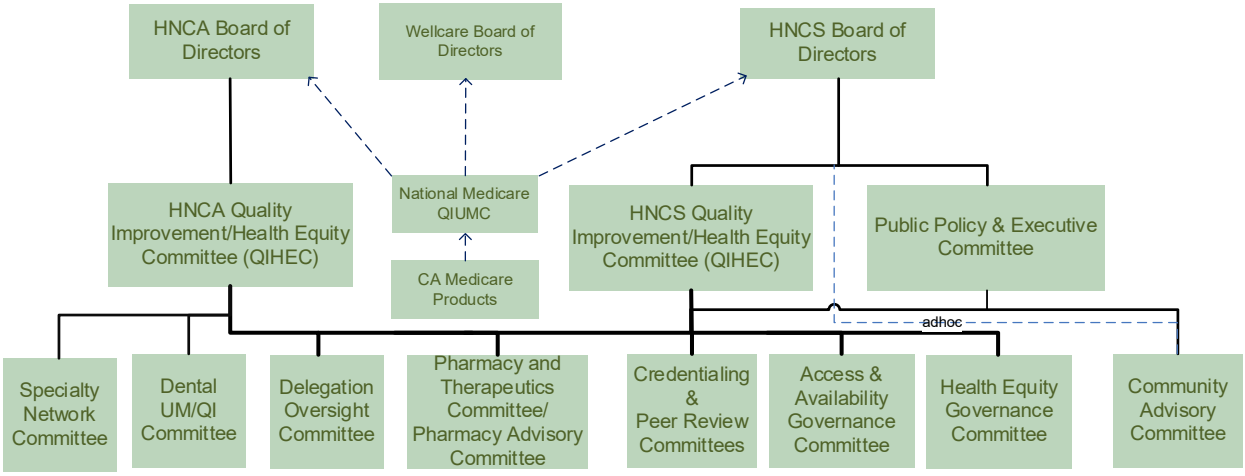
These committees oversaw the QI Program, provided feedback, decision support, and recommendations for the QI Program throughout the year. These committees received regular reports of program key findings and initiatives. Additionally, the Quality Governance Committee was chaired by the Sr. Director of Quality Improvement. The key objectives of the Governance Committee are to establish a company-wide vision and strategy for HEDIS and CAHPS improvement; inform stakeholders of performance; collaborate with operational leaders on needed improvements; communicate any compliance concerns and risks; and discuss best practices for interventions.

Health Net subcommittees also successfully supported Health Net's QI Program, as demonstrated in the organizational chart (Refer to Chart 1.2). Please refer to the 2024 Quality Improvement Program Description for more information on the sub-committees.

In 2024, the Health Net Pharmacy and Therapeutics (P&T) Committee transitioned to a national P&T Committee and the Pharmacy Advisory Committee (PAC) was established to address additional support needed for the California market.

The Access and Availability Governance Committee was changed in 2024 to the Network Access & Availability Governance (NAAG) Committee. The Committee provided strategic direction, guidance, and oversight of key Access and Availability functions. Committee meetings are held quarterly, and metrics reviewed include network adequacy, timely access, access grievances and access improvement initiatives.

Chart 1.2. Health Net Quality Improvement/Health Equity Committee Organizational Chart



Note: The Dental UM/QI Committee only reports up to the HNCA Board of Directors (BOD).

Practitioner Participation and Leadership Involvement in the QI Program

The committee structures for HNCA QIHEC and HNCS QIHEC ensured that external and internal physicians with various specialties participated in the planning, design, implementation, and review of the QI Program. Five external physicians participated in the HNCA QIHEC and eight in the HNCS QIHEC. Additionally, two external physicians were participants of the Credentialling and Peer Review Committee. External physician specialties included pediatrics, behavioral health, internal and family medicine, and emergency medicine. Additional participants included representatives from Centene Pharmacy Services, Behavioral Health, Credentialing, Health Equity, Peer Review, Provider Network Management, Appeal and Grievances, Customer Service Operations, Medicare Population Health & Clinical Operations Shared Services, and Population Health & Clinical Operations (PHCO) including Utilization Management, Case Management, and Medical Directors. A Health Net Medical Director chaired both committees and invited external practitioners to participate. Practitioner-involvement in 2024 included: reviewing and approving the 2023 QI Work Plan Evaluation, 2024 QI Work Plan and Annual Evaluation. Practitioners also discussed opportunities for improvement based on Reporting Year (RY) 2024 HEDIS results, Health Outcomes Survey (HOS) results, and CAHPS performance.

Section 2: Goals and Quality Indicators by Line of Business

The Quality Improvement 2024 Work Plan included eight categories pertaining to each line of business. To determine Health Net's success in achieving specified goals, the plan calculated the number and percentage of activities completed and objectives met per category (***Tables 2.1 and 2.2***) and outlined RY 2024 performance by line of business against the goals in the Appendix.

Table 2.1. Activities Completed by LOB. *Refer to 2024 QI Year End Work Plan Evaluation Section III: Quality Improvement Tracking System (QITS) year-end activities.*

SECTION	ACTIVITIES COMPLETED			TOTAL
	Commercial	Marketplace	Medi-Cal	
I. BEHAVIORAL HEALTH	4/5 80%	5/5 100%	4/5 80%	**13/15** **86.67%**
II. CHRONIC CONDITIONS	20/23 86.96%	21/23 91.30%	34/38 89.47%	**75/84** **89.29%**
III. HOSPITAL QUALITY	19/19 100%	17/17 100%	14/14 100%	**50/50** **100%**
*IV. MEMBER ENGAGEMENT & EXPERIENCE**	N/A	N/A	3/3 100%	**3/3** **100%**
V. PEDIATRIC/PERINATAL/DENTAL	33/34 97.06%	27/28 96.43%	58/62 93.55%	**118/124** **95.16%**
VI. PHARMACY & RELATED MEASURES	12/12 100%	2/2 100%	15/15 100%	**29/29** **100%**
VII. PREVENTIVE HEALTH	11/13 84.62%	9/10 90%	24/27 88.89%	**44/50** **92%**
*VIII. PROVIDER COMMUNICATION/ ENGAGEMENT**	9/11 81.82%	8/10 80%	13/15 86.67%	**30/36** **83.33%**
TOTAL	**108/117** **92.31%**	**89/95** **93.68%**	**165/179** **92.18%**	**362/391** **92.58%**

* CAHPS Member Experience-provider level activities are included under the Provider Communication/Engagement Section.

Table 2.2 Objectives Met by LOB. *Refer to the 2024 QI Year End Work Plan Evaluation.*

SECTION	OBJECTIVES MET			TOTAL
	Commercial	Marketplace	Medi-Cal	
I. BEHAVIORAL HEALTH	4/5 80%	5/5 100%	4/5 80%	**13/15** **86.67%**
II. CHRONIC CONDITIONS	3/4 75%	4/4 100%	9/10 90%	**16/18** **88.89%**
III. HOSPITAL QUALITY	11/13 84.62%	11/13 84.62%	11/13 84.62%	**33/39** **84.62%**
*IV. MEMBER ENGAGEMENT & EXPERIENCE**	N/A	N/A	1/1 100%	**1/1** **100%**

V. PEDIATRIC/PERINATAL/DENTAL	12/20 60%	12/16 75%	15/50 30%	**39/86** **45.35%**
VI. PHARMACY & RELATED MEASURES	2/12 16.67%	0/6 0%	2/5 40%	**4/23** **17.39%**
VII. PREVENTIVE HEALTH	5/10 50%	9/10 90%	13/20 65%	**27/40** **67.5%**
*VIII. PROVIDER COMMUNICATION/ ENGAGEMENT**	6/13 46.15%	9/13 69.23%	5/10 50%	**20/36** **55.56%**
TOTAL	**47/88** **53.41%**	**55/80** **68.75%**	**56/119** **47.06%**	**158/287** **55.05%**

* CAHPS Member Experience-provider level objectives are included under the Provider Communication/Engagement Section.

As shown in **Table 2.1**, 92.58% of the total 2024 activities across all lines of business were completed as planned, compared to 87.05% in 2023. In 2023, the Quality Improvement department shifted its focus to provider engagement combined with direct care gap closure, thereby eliminating or reducing lower impact activities. As a result, this had an impact on the completion rates, which rebounded in 2024 as a result of the strategy being more well-established. Additionally, Health Net met 55.05% of the total year objectives across all lines of business (**Table 2.2)**, increasing from 44.71% in 2023, which demonstrates that the strategy shift that occurred is having an overall positive impact both on overall process goals and outcome goals.

Performance Goals for All Health Net Lines of Business

Table 2.3 provides the performance goals across all Health Net lines of business. Quality goals varied by line of business and according to regulatory and accreditation standards which can change annually. These goals were the overall percentiles/Star ratings that Health Net sought to achieve. In contrast, the objectives provided in **Table 2.2** were tied to how much of the goals were accomplished within the year, which could include meeting directional improvement (e.g., improved performance year-over-year, shown in **Chart 2.3**).

Table 2.3. Performance Goals

LOB	*Standard*	*Goal*
Medicare	CMS Star rating system from 1-5 Stars	4-5 Stars
	HEDIS	75th Percentile
	CAHPS	Year-over-year (YOY) improvement, targeting rates to support 4 Star Performance
Commercial	Office of the Patient Advocate (OPA) from 1-5 Stars*	4-5 Stars
	CAHPS	YOY improvement, targeting 25th percentile
	HEDIS/CAHPS	75th Percentile
Marketplace	QRS from 1-5 Stars*	4-5 Stars {66th percentile for Quality Transformation Initiative (QTI)}
	HEDIS	75th Percentile
	CAHPS	YOY improvement, targeting rates to support 3 Star Summary Indicator (QRS)

Medi-Cal	DHCS Managed Care Accountability Set (MCAS) Measures	50th Percentile
	HEDIS (Plan level accreditation)	75th Percentile
	CAHPS	YOY improvement, targeting 25th percentile

*Star ratings available at the composite and not individual measure level.

The health plan Medicare performance rates were based on meeting the Stars and/or the 75th percentile goals. Commercial and Marketplace performances were tied to meeting the 75th percentile for all measures, translating to at least 4 stars (or the 66th percentile for the QTI measures). For Medi-Cal performance, rates must exceed the 50th percentile for MCAS measures as set by DHCS, or the 75th percentile for all other measures. The Appendix details measure-level progress toward goals.

CAHPS goals were based on contribution to the Quality Rating Programs. The goal for Medicare CAHPS was contribution to a 4-star overall rating. The goal for Commercial/ Marketplace and Medi-Cal was year-over-year improvement with the ultimate goal of the 25th percentile.

Table 2.4. Performance Goals for Provider Surveys

Survey Type	*Plan Goals*
Provider Appointment Availability Survey (PAAS)	70% Percentage rate or YOY directional improvement
PAAS Behavioral Health	70% Percentage rate or YOY directional improvement
Provider Satisfaction Survey (PSS)	YOY improvement
PSS (Behavioral Health)	YOY improvement
Provider After-Hours Availability Survey (PAHAS)	90% Percentage rate or YOY directional improvement
Telephone Access Survey	80% Percentage rate or YOY directional improvement

The performance goals for provider surveys were based on internal goals as shown in **Table 2.4**.

*Refer to the Appendix, **Tables A-2 and A-3**, for the summary of goal attainment by category for RY 2024.*

As the tables demonstrate, there is progress needed to reach the goals set for each line of business as seen in the objectives outcomes (**Table 2.2**).

Goals Met by Health Net Lines of Business

Medicare

For CMS Star Rating Year (RY) 2025, Health Net obtained an overall 3-Star Rating for Medicare contracts H0562 and H7360 and a 2.5-Star Rating for the H3561 contract. The lack of reward factor, coupled with increased cut points and decreased CAHPS scores, significantly influenced these outcomes.

CAHPS measures were 4-weight measures. The Quality Department was dedicated to improving CAHPS and plan administration measures through various initiatives including, but not limited to, root cause analysis of member pain points, including appeals, grievances, call drivers, Complaints Tracking Modules (CTMs), and management of the CAHPS Action Plan, utilized to build initiatives and identify areas of opportunity with Health Net's business partners. In addition to the analysis of the regulatory CAHPS survey, the team implemented and analyzed mock CAHPS survey results with an emphasis on Provider Group performance. Mock CAHPS survey scorecards were shared with provider groups.

Measures that achieved a 4-Star or 5-Star for 2 or more contracts included:
Diabetes Care - Eye Exam, Reducing the Risk of Falling, Plan All-Cause Readmissions, Members Choosing to Leave the Plan (Part C and Part D), Plan Makes Timely Decisions about Appeals, Call-Center – Foreign Language Interpreter and TTY Availability (Part C and Part D), Drug Plan Quality Improvement, Medication Adherence for Diabetes Medication, and Medication Therapy Management Program Completion Rate for Comprehensive Medication Review. Among the eleven measures, two are triple-weighted; five are quadruple-weighted measures, and one is a quintuple-weighted measure.

Measures requiring additional effort with a 3-Star or less for one or more contracts were:
Breast Cancer Screening, Colorectal Cancer Screening, Annual Flu Vaccine, Monitoring Physical Activity, Special Needs Plan (SNP) Care Management, Care for Older Adults-Medication Review and Pain Assessment, Osteoporosis Management in Women who had a Fracture, Diabetes Care – Blood Sugar Controlled, Controlling Blood Pressure, Improving Bladder Control, Medication Reconciliation Post-Discharge, Statin Therapy for Patients with Cardiovascular Disease, Transitions of Care, Follow-up after Emergency Department Visit for People with Multiple Chronic Conditions, Getting Needed Care, Getting Appointments and Care Quickly, Customer Service, Rating of Health Care Quality, Rating of Health Plan, Care Coordination, Complaints about the Health Plan, Health Plan Quality Improvement, Reviewing Appeals Decisions, Complaints about the Drug Plan, Rating of Drug Plan, Getting Needed Prescription Drugs, Medication Adherence for Hypertension, Medication Adherence for Cholesterol, and Statin Use in Persons with Diabetes. Among the thirty measures, four are triple-weighted measures, eleven were quadruple-weighted measures, and one was a quintuple-weighted measure.

The H0562 Chronic Condition Special Needs Plan (C-SNP) and H3561 D-SNP Models of Care were submitted for renewal in 2024 and received passing scores of 96.2% and 98.8% respectively. In addition, the Model of Care narrative for H3561 D-SNP was redlined to reflect the latest care coordination state requirements as outlined in the CalAIM DSNP Policy Guide. The updated D-SNP MOC was submitted to CMS via off-cycle review and received approval.

<u>Commercial/Marketplace</u>
On the 2024 NCQA Health Plan Ratings, Health Net Commercial HMO/POS has an overall 3.5 Star rating, with 4 Stars on Prevention and Equity, 3 Stars on Treatment, and 2 Stars on Patient Experience. Commercial PPO has an overall 3.5 Star rating (up from 3 Stars in 2023), with 3 Stars on Prevention and Equity, 3 Stars on Treatment (up from 2.5 Stars), and 1.5 Stars on Patient Experience. Kaiser (Northern and Southern California) – both integrated plans – were the only Commercial plans to score 4.5 Stars.

For the HMO 2024-2025 Office of the Patient Advocate (OPA) Report Card, Health Net's score remained at 3 out of 5 Stars on the *Quality of Medical Care* summary composite. Kaiser in Northern and Southern California were the only plans rated Excellent (5 Stars), while Sharp Health Plan was the only HMO plan rated Very Good (4 Stars). Health Net was one of seven (out of 10) HMO plans rated Good (3 Stars). On the *Patients Rate Their Experience* composite, Health Net HMO is one of six plans rated Fair (2 Stars), showing no change for Health Net. Again, this year none of the 10 HMO health plans scored Excellent, and Sharp Health Plan remains the only plan to score Good (3 Stars).

Health Net HMO attained 4 Stars in the Diabetes Care and Preventive Screening domains and attained 5 stars (1 of 2 plans) for Maternity care.

Targeted clinical areas, defined as those falling below 4 Stars, are Appropriate Use of Tests, Treatments and Procedures (3 Stars); Asthma and Lung Disease Care (3 Stars, up from 2 Stars); Heart Care (3 Stars), Behavioral and Mental Health Care (3 Stars, up from 2 Stars); and Treating Children (3 Stars). For the member experience domains, all three areas remained below the 4 Star goal: Getting Care Easily (1 Star); Satisfaction with Plan Services (2 Stars); and Satisfaction with Plan Doctors (3 Stars, up from 2 Stars).

On the PPO 2024-2025 (MY 2023) OPA Report Card, Health Net received 2 Stars (Fair, down from 3 Stars) on *Quality of Medical Care*. Of the six California PPO plans, three were rated as Good, and two as Fair (2 Stars). On the *Patients Rate Overall Experience* composite, Health Net PPO remained at 1 Star. Four plans scored 1 Star, one plan scored 3 stars, and one was unrated.

Within the *Quality of Medical Care* domain, Health Net PPO attained the 4 Star goal on the Maternity care clinical composite. All other composites were at 3 Stars or below, including Appropriate Use of Tests, Treatments and Procedures (3 Stars, up from 2 Stars); Diabetes Care (3 Stars); Heart Care (3 Stars, up from 2 Stars); Behavioral and Mental Health Care (2 Stars); Preventive Screenings (3 Stars); and Treating Children (2 Stars, down from 3 Stars).
Within the *Patients Rate Overall Experience* domain, Health Net PPO was rated 1 Star for Getting Care Easily and Satisfaction with Plan Services; and 2 Stars on Satisfaction with Plan Doctors.

The MY2023/RY2024 Behavioral Health ECHO Survey showed a slight decrease in Quality of Care concerns across Commercial and Marketplace; however, the general trend is that the most impactful member pain points are Access issues, Billing/Financial issues, and Customer Service issues. And there continues to be a strong focus on BH member outcomes (i.e., clinical improvement) and the ECHO results demonstrate this, as reflected by the percentage of favorable responses to the "perceived improvement" survey questions.

Overall, Health Net performed stronger on clinical care, while patient experience continues to remain an opportunity for improvement across the board.

The Covered California QRS is the Star rating system for Exchange products and included both HEDIS and CAHPS measures based on Measurement Year (MY) 2023 results. The quality ratings were on a scale of 1 to 5. These composite score ratings served as a resource for Californians as they shop for health coverage on the Marketplace.

Health Net Ambetter HMO's *Overall* summary rating for 2025 (based on MY 2023 data) remained at 3 Stars (out of 5 Stars) and was one of eight HMO plans with a 3 Star rating. Kaiser Permanente was the only plan to score 5 Stars on the summary rating. Health Net Ambetter HMO remained at 3 Stars for *Getting the Right Care* and increased from 2 to 3 Stars for *Plan Services for Members*. Due to the small CAHPS sample size, Health Net did not have enough data to receive a Star rating for *Members' Care Experience.*

Health Net Ambetter PPO's *Overall* summary rating remained at 3 Stars. *Getting the Right Care* and *Plan Services for Members* also remained at 3 Stars. The *Members' Care Experience* was not reported due to the small CAHPS sample size.

The Health Net QI team participated in Covered California Plan Management Advisory Group Meetings and continued to implement activities to meet contractual requirements to address Nulliparous, Term, Singleton, Vertex (NTSV) C-Section rates, Hospital-Acquired Conditions, and overall hospital quality. Health Net continued to be actively involved in key California collaboratives to ensure care delivery met the Quadruple Aim goals of improved population health, better patient experience, decreased costs, and improved provider satisfaction. Involvement in such collaboratives remained beneficial in supporting QI requirements and sustaining improvements for the Marketplace membership. In 2024, Health Net continued spearheading a multi-plan collaborative with L.A. Care, Molina, Blue Shield of California and Anthem, to raise performance at specific lower performing hospitals in Los Angeles County.

Collaborative participation included:

- California Quality Collaborative (CQC), with Cathi Misquitta on the Steering Committee;
- The Leapfrog Group, with Barbara Wentworth, Program Manager III, appointed to a Co-Chair position on the Partners Advisory Committee beginning in December 2018, was extended to a seventh year for 2025; and
- Integrated Healthcare Association (IHA) Align. Measure. Perform. (AMP) Program.

<u>Medi-Cal</u>

For RY 2024, HNCS achieved 29% of MCAS measures above the Minimum Performance Level (MPL).

To exceed the MPL, HNCS carried out numerous targeted programs to close care gaps, including support for member incentives through Quality EDGE (Evaluating Data to Generate Excellence) funding, One Stop Clinics, and mobile mammography events. The team continued to prioritize interventions along the strategic tracks noted in **Chart 2.1**. Critical interventions that addressed data and targeted analysis, member supportive and direct care services, provider engagement and compliance, all worked cohesively to support goal achievement.

In addition, the team collaborated with the Medical Affairs and Provider Engagement Teams to continue to implement Quality EDGE (See **Chart 2.2**). Quality EDGE was a systematic 5 step change management process that integrated quality improvement tools, focused measure sets and provider engagement strategic assessments to drive providers to rapid improvements in HEDIS outcomes. The Mission of Quality EDGE was to outperform all market competitors on

quality metrics by providing unparalleled consultative services, innovative programs and actionable reports while improving health equity. The Vision: We are the partner of choice, collaborating internally and with our providers to deliver the highest quality of care in the most vulnerable population. The team collaborated to identify the following goals for 2024:

1. Meet 60% of original (MY 2023) 12 MCAS measures that are held to the MPL over 50th percentile
2. 25% of new MCAS measures that are held to the MPL and have benchmarks over the 50th percentile.
3. Complete and deploy action plans for priority providers (specific targets in development).
4. Continually measure, evaluate, and improve processes to ensure efficacy of Quality EDGE and full engagement among the staff.
5. Improve results for “voice of the provider” (specific target in development).

CAHPS

The following CAHPS measures met their goal of achieving the 2024 Quality Compass Benchmark 25th percentile.

Rating Measures

- Rating of Health Care Quality
- Rating of Specialist
- Rating of Health Plan (Met the 50th percentile)

Composite Measures

- Getting Care Quickly
- How Well Doctors Communicate

ECHO Survey

- The MY2023/RY2024 Behavioral Health ECHO Survey showed a decrease in the total number of and PTMPY exempt grievances across the HNCS line of business; however, the most impactful member pain points amongst formal grievances are Attitude and Service issues, Access issues, and Quality of Care issues. And there continues to be a strong focus on BH member outcomes (clinical improvement) and the ECHO results demonstrate this, as reflected by the percentage of favorable responses to the “perceived improvement” survey questions.

Chart 2.1 2024 Quality Management Strategic Tracks

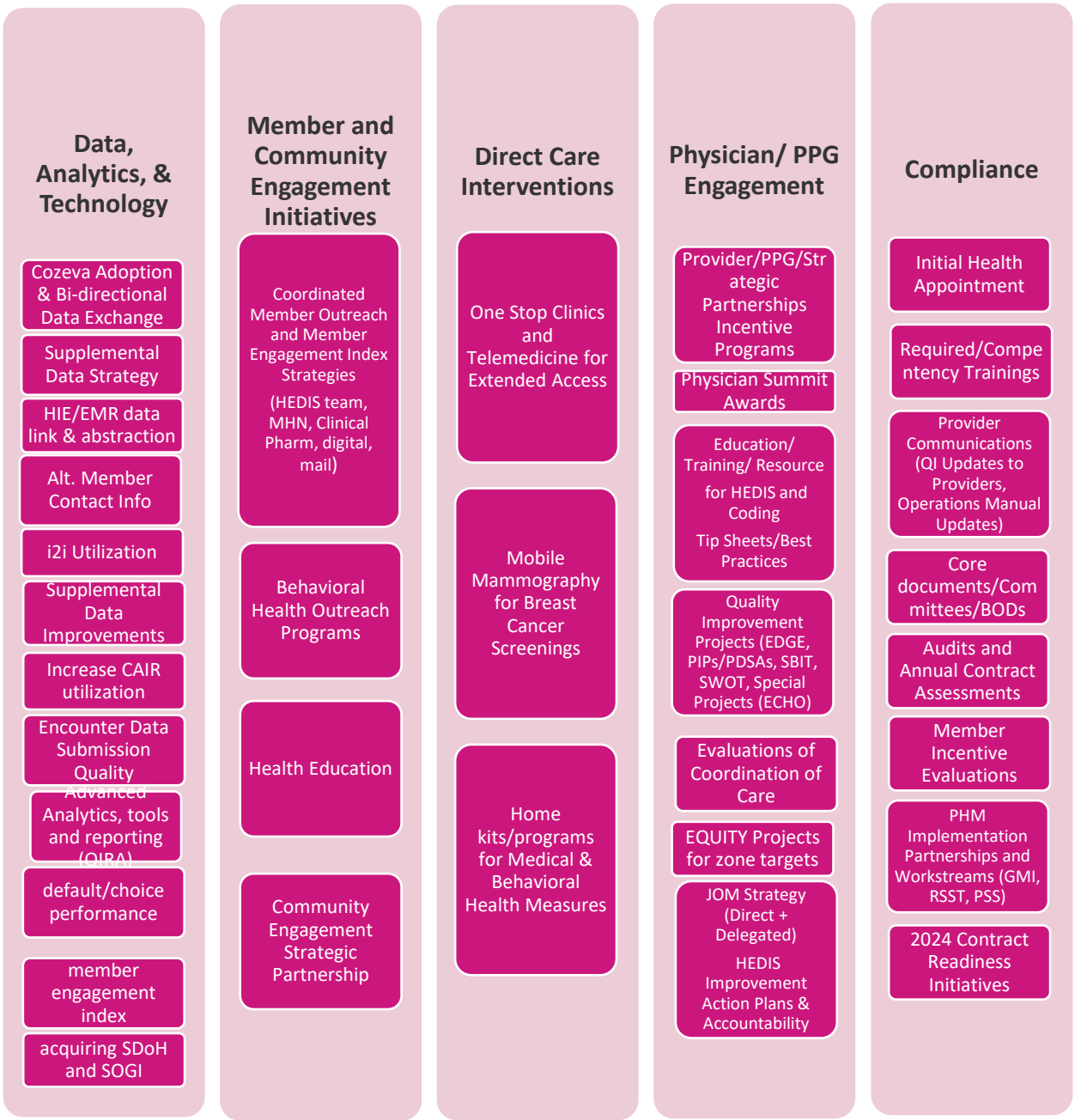
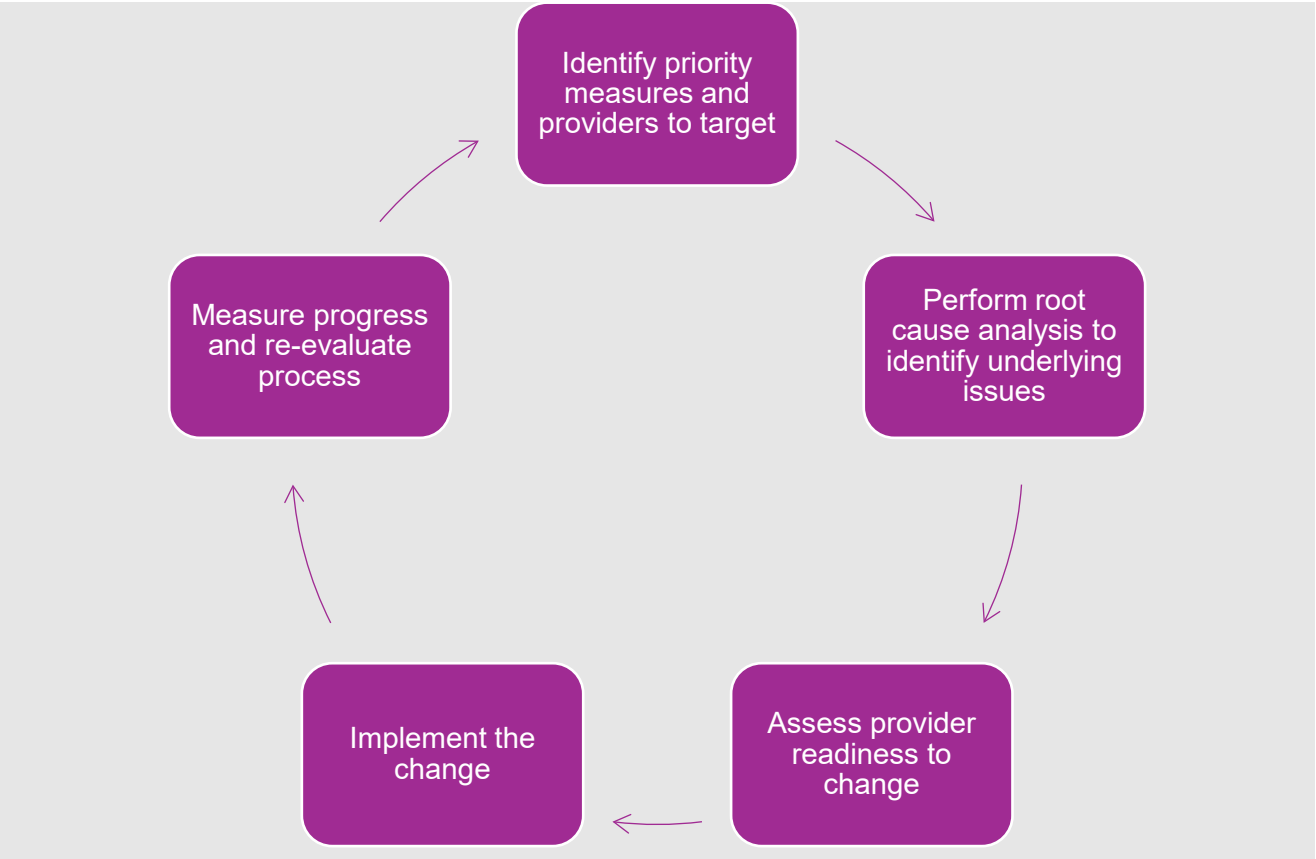


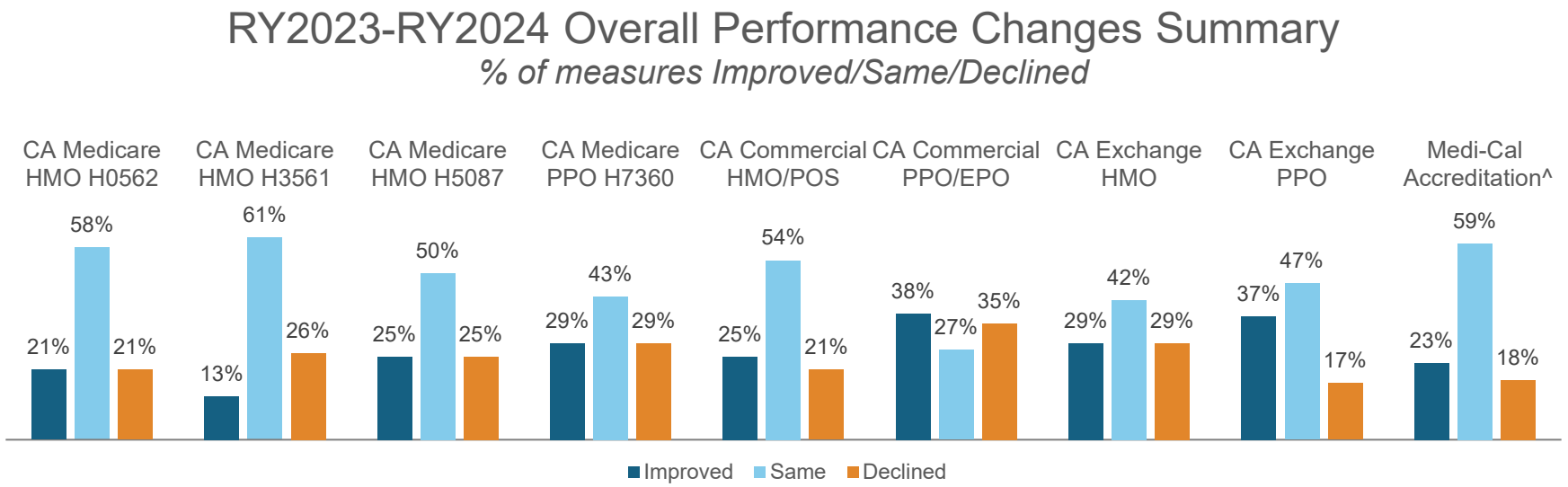
Chart 2.2 Quality EDGE 5 Step Process



Quality EDGE continued to provide funding and technical assistance for eligible tools and resources to help providers close targeted care gaps. In partnership with the Provider Engagement team, Health Net's provider network was approached with targeted HEDIS measures needing improvement and/or gap closure. The provider engagement piece was implemented in conjunction with QI-led direct care gap closure programs, along with Corporate-led support (for Medicare and Marketplace).

Chart 2.3. Year-over-Year Performance Change Summary – Overall Changes

Health Net based the year-over-year comparison on percentile improvement; highlighting the percent of total measures per product line that improved, remain unchanged, or declined from the prior reporting year. The percentile benchmarks referenced ranged from the 5th to the 90th percentiles.



^Medi-Cal Accreditation includes the following counties: Los Angeles, San Joaquin, Stanislaus, and Tulare

Notes:

- Medicare H-contracts should be viewed with caution due to the movement of D-SNP members between RY 2024 and RY 2023.
- Exchange HMO and PPO rates were compared against the National Quality Compass Commercial HMO and PPO benchmarks if there were no National Quality Compass Exchange benchmarks.

Barriers to achieving goals and objectives (across all LOBs).

Quality of Care Measures

- CA member roster file and attribution issues impacted provider group's utilization of RxEffect and engagement with members on medication adherence in October 2024.
- Low Cozeva adoption among provider offices with small panel sizes. May be considered too time intensive to request supplemental data files from offices with low panel sizes.
- Contractual delays with vendors leading to delay in program implementation. This also resulted in the inability to leverage Shared Services in-home vendors for direct care gap closure interventions for Marketplace.
- Staffing and resource shortages at PCP offices or specialty clinics (Radiology facilities).
- Member knowledge gap/awareness/education on existing or updated guidelines on services.
- Provider education & awareness:
  - Lack of recommendation on updated guidelines by providers.
  - Lack of provider awareness on coding pertinent to measure or overall updated recommendations.
  - Lack of expanded hours programs in collaboration with provider Clinics on multiple measures.
  - Lengthy internal compliance review process leading to delays in member outreach programs combined with contractual delays with vendors.
  - Lack of texting vendors for member outreach.
  - Lack of member awareness of periodicity schedule for pediatric measures: well-child visits, immunizations and screenings.

Chronic Conditions

- Delays in collateral approval for DSNP A1c kit bulk mailing by Corporate resulted in late launch in Q3.
- Delays in standing up vendors due to shifting contract priorities and DHCS requirements impacted availability of targeted outreaches to Medi-Cal members; other LOBs targeted outreaches delayed due to vendor realignment in 2024.
- BP monitor/cuff is covered benefit for IFP/Marketplace (Ambetter). For all other commercial members, blood pressure cuffs are not a covered benefit impacting the promotion of self-measured blood pressure monitoring (SMBP)
- Inability to identify reliable in-home vendor to conduct BMD screening.

Preventative Care

- Lack of staffing/resources served as barriers at radiology facilities
- Inability to identify reliable in-home vendor to conduct chlamydia screening (CHL) screening. Delays in standing up vendors due to shifting contract priorities and DHCS requirements impacted availability of targeted outreaches to Medi-Cal members for CHL.
- Lack of Provider knowledge regarding updated guidelines on CCS and CHL.
- Limited mobile mammography events scheduled for Medicare, Commercial, and Marketplace lines of business despite outreach efforts.
- Low member engagement via phone outreach by CBOs due to limited member knowledge about the Community Health Worker (CHW) benefit.

- Member knowledge and education on updated guidelines along with cultural barriers to service and topic.

Member Experience/CAHPS

- Impacts of the COVID-19 pandemic was still being seen with members' access to care:
  - Members' making up for delayed care.
  - High staff turnover rates making it hard for clinics.
  - Limited appointment availability.
  - Shortage of all behavioral health provider types.
  - Persistent stigma around behavioral health treatment.
  - Ongoing impacts of social drivers of health.
- Operational issues that impacted member experience/CAHPS:
  - Prior authorization delays for care.
  - PCP and specialist referral delays.
  - Delays in provider claims processing.
  - Member difficulty in navigating and understanding benefits

Patient Safety/Hospital

- The all-payer status of the measures places limitations on the ability of a single plan to influence performance. Other stakeholders are needed to collectively create the impetus for hospitals to address priority metrics, especially for low performers, and to provide QI guidance to hospitals on how to improve.
- Hospital staff discontinuity and turnover disrupts implementation of best practices and quality improvement initiatives. Includes turnover of Quality leadership, especially at poor performing hospitals.
- As seasoned nurses exit the field, training and support for new-graduate hires is needed to facilitate continuous, reliable implementation of QI protocols.
- Members may not be aware of the variation in quality among local, covered hospitals, or of the online tools available to help them make an informed choice for site of care.
- Especially among poor performers, hospital leadership may not prioritize quality performance and fail to invest in evidence-based systems.
- Slippage in maintaining appropriate standards of care for hospital-level maternity services have remained a concern since the pandemic and represent a barrier to improving C-section rates.

Pediatric Measures

- *Childhood Immunization Status – Combination 10*
  - Lack of parent understanding of the importance of immunizations.
  - The complicated and time-bound immunization schedule – immunizations completed out of timeframe.
  - Parent refusals for vaccines during office visits.
  - Lack of strong recommendations from providers for immunizations.
  - Missing one or both flu vaccines. Parent's viewing the flu vaccine as optional.
  - Missing Hep B vaccines from hospitals.
  - Members not completing the vaccine series after turning one year.

- *Developmental Screening in the First Three Years of Life* (DEV)
  - Incorrect modifiers used by providers billing for developmental screenings.
- *Immunizations for Adolescents – Combination 2* (IMA-2)
  - Missing HPV vaccines.
  - Parent vaccine hesitancy for the HPV vaccine.
  - Providers not starting HPV vaccine series at age 9.
- *Lead Screening in Children*
  - Providers not using approved DHCS CPT Code(s) for Anticipatory Guidance for Lead Blood Screening in Children.
  - Member engagement, due to invalid or outdated member contact data.
  - Member access to appointments with providers for well-child visits.
- *Oral Evaluation, Dental Services*
  - Access to pediatric dentists.
- *Topical Fluoride for Children*
  - Primary care providers not applying fluoride varnish in medical offices.
- *Well-Child Visits in the First 30 Months of Life - 0 to 15 Months* (W30-15)
  - Members did not understand the importance of infant well-care checkups, the periodicity schedule and what to expect in infant well-care checkups.
  - Lack of connection of pregnant members to pediatricians to get the parent established with the pediatrician so the parent knows when to bring in the newborn after discharge from the hospital.
  - Data gap of W30-6+ visits. Completed W30-6+ visits are not getting to the health plan primarily due to the lack of a link between the birthing parent and the newborn.
  - Lack of access to infant well-care visits. It could take weeks or months to get well-care appointments, putting the infant behind on visits according to periodicity schedule. Lack of dedicated provider time to well-care visits.
- *Well-Child Visits in the First 30 Months of Life - 15 to 30 Months* (W30-30)
  - Members did not complete infant well-care after babies turn one year.
  - Parents were not able to bring children to well-care appointments during regular business hours.
  - Lack of access to well-care visits. It could take weeks or months to get well-care appointments. Lack of dedicated provider time to well-care visits.
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents*
  - Access to well-care visit appointments.
  - Providers coding correctly using correct CPT II codes.
- *Child and Adolescent Well-Care Visits* (WCV):
  - Lack of provider outreach to members to complete WCV.
  - Lack of member engagement with child and adolescent well-care.
  - Parents were unable to bring children to well-care appointments during regular business hours.
  - Lack of access to well-care visits. It could take weeks or months to get well-care appointments. Lack of dedicated provider time to well-care visits.

Pharmacy Measures: AMR

- *Asthma Medication Ration (AMR):*
  - Lack of provider awareness around asthma remediation services and process to obtain Cal Aim services for Medi-Cal members.

Provider Access and Availability Surveys

- Specialists and Psychiatrists may not have sufficient tools and guidance to address timely access and improve member satisfaction.
- Specialists and Psychiatrists may not be maintaining sufficient office hours and not complying with timely access standards.
- Geographical constraints in more rural areas contribute to difficulty contracting with providers.
- An ongoing issue since post COVID-19 pandemic, is that providers are still facing several challenges such as administrative barriers in their practices making it difficult to adhere to meeting timely access standards.
- Specialists and Psychiatrists are unable to offer timely access to appointments due to high demand for appointments, especially specialty care that creates a supply demand issue.
- Provider Appointment Availability Survey administration process has revealed certain challenges with obtaining accurate responses from provider offices especially for capturing urgent appointment availability.
- DMHC survey methodology related nuances contribute to the inaccurate capture of true availability of appointments to members for several reasons:
  - Survey response captured is for a specific practitioner. Many provider offices offer an appointment with another provider in the office if the specific provider is unable to accommodate the appointment request.
  - For urgent care, several provider groups offer availability at urgent care centers, and this availability is not captured in the DMHC Provider Appointment Availability Survey.
- Nationwide shortages of Psychiatrists are recognized and documented by multiple organizations and agencies, including the Commonwealth Fund, the Association of American Medical Colleges, and the U.S. Government Accountability Office.

Behavioral Health

- Difficulty reaching Medi-Cal population by phone because of unreliable and highly variable contact information.
- Lack of education about behavioral health treatment and addressing the stigma of diagnosis.
- Lack of timely access to Admit, Discharge, and Transfer (ADT) data.
- Care gap closures of time-sensitive HEDIS measures were negatively impacted by persistent barrier in sharing information related to substance use admissions/hospitalizations without documented member consent, rendering ADT data unable to identify members with emergency department (ED) visit for substance use.
- ADT data may not include 100% of the eligible populations because of internal facility limitations on data sharing.
- Timeliness of referrals and follow-ups.

- Plan limitations and restrictions on data sharing with providers for substance use disorders impacts timeliness of follow up.
- Not all providers leverage Cozeva platform on a daily basis to prioritize behavioral health outreach and gap closures.
- Members in ADT reports may not ultimately end up in the eligible population because of the lack of a principle mental health or substance use diagnosis.

Coordination of Care/Member Engagement

- Delayed receipt of Care for Older Adults-Medication Review (COA-MR) Unable to Reach list from Corporate Clinical Pharmacy Services (CPS) team postponed launch of direct care gap closure in market.
- Limited support from CalAim, Population Health, Health Equity team (CPHE) clinical pharmacist to conduct Medication Reconciliation Post-Discharge (MRP) outreach in market.
- No actionable Admission, Discharge, and Transfer (ADT) report available yet for providers to work.
- The transition of the Medicare member rewards program to a point-based system, coupled with a delayed launch led to low member engagement.
- Low Cozeva adoption among provider offices with small panel sizes. May be considered too time intensive to request supplemental data files from offices with low panel sizes.
- Lack of visibility into impact of Shared Services initiatives that directly contribute to care.

Section 3: Overall Effectiveness of QI Work Plan Initiatives

3.1. Behavioral Health

RY 2024 (MY 2023) performance goals for the behavioral health (BH) outcomes were to improve continuity of care in behavioral health for all members by aligning activities with DHCS and DMHC goals in the following measures: Antidepressant Medication Management (AMM); Follow up after Hospitalization/ED Visit (FUH/FUA/FUM); and Depression Screening (DSF) across products lines in the CA Market.

- Commercial: Achieve directional improvement toward the National Quality Compass 50th percentile for the AMM, FUA, FUM and FUH measures. Program objectives included achieving improvement within the Commercial HMO and PPO product lines for AMM.

- Marketplace/Exchange: Increase BH rates included in the QRS Star Rating and meet the Quality Transformation Initiative (QTI) benchmark for the AMM, DSF and FUH measures. Program objectives included achieving improvement within the Marketplace HMO and PPO product lines for AMM, as well as directional improvement in the QRS for the Coordination of Care (COC) report.

- Medicare: Achieve directional improvement in FUM to exceed the SNP goal of 30-day follow up for members over 10% of target (FUM30 for H0562, H3561, and H5087).

- Medi-Cal: Achieve directional improvement or meet/exceed the Minimum Performance Level (MPL) for the Managed Care Accountability Set (MCAS) measures FUA and FUM. Program objectives included directional improvement in the number of reporting units that meet the 50th Percentile within the Medi-Cal product line for AMM, FUA, FUM, DSF-E and Depression Remission or Response for Adolescents and Adults (DRR-E).

Improve Behavioral Health (Mental Health and Substance Use) Outcomes

Overall, all behavioral health activities were on-track or completed based on the December Quality Improvement Tracking System (QITS). As summarized below, some initiatives were discontinued.

Similar to 2023, although Health Net saw directional improvement in several quality metrics, performance increases in quality compass benchmarks were exceeding the pace of Health Net's directional improvement. While actions may be addressing barriers, further barrier analysis is recommended to identify actions that may contribute to larger improvements, resulting in achieving the 50th Quality Compass benchmarks. Additionally, similar to 2023, opportunities remain in addressing timely and ongoing treatment for substance use and promoting behavioral health screenings and timely follow-up for members that screen positive for mental health needs (e.g., depression). This includes Legacy Managed Health Network (MHN) care managers (CMs) conducting member outreach calls to close gaps for members who visit the emergency department (ED) for a mental health or substance use issue. Assessments completed during those calls are counted as supplemental data gap closures. Also, leveraging digital applications like Teladoc and Sharecare to encourage members to participate in self-administered depression screenings. If members screen positive, Health Net CMs follow up with a member outreach call to assess further and refer for additional follow up as necessary. Almost all interventions and programs will continue in 2025, with modifications. Lastly, lessons learned from 2024 pertain to monitoring each outreach team’s capacity to support additional live calls. In 2022, the decision was made to discontinue AMM outreach calls across the CA Market to support FUA/FUM Medi-Cal performance. In addition, the AMM metric is being retired by NCQA. All quality measures except AMM will remain a priority in 2025 and the plan will need to continue to monitor priorities across the CA Market (note that AMM is still a priority for Commercial in 2025). For example, given the lack of directional improvement observed among the Medicare H-contracts, and the addition of the Health Outcome Survey question, Health Net will examine how to support Medicare performance. Ultimately, partnerships with clinical outreach teams will remain critical to supporting performance improvement as their teams can support outreach efforts across the CA Market for various measures.

There were persistent barriers impacting all substance use related metrics due to various interpretations of the 42 Code of Federal Regulations (CFR) Part 2 regulations. Those interpretations may have led to incomplete or no data sharing at all by ED facilities feeding data into the ADT reports because of their own internal policies regarding SUD data sharing. This then led to limitations in the ADT reports that the Legacy MHN CMs received. This meant that the CMs were not reaching 100% of the eligible denominator because the facilities were limiting their data sharing. Also, another persistent barrier to both FUM and FUA were that, in order to be included in the eligible denominator, the member must have had a principle mental health or substance use diagnosis, and a final diagnosis was difficult to determine from ADT reports. There were multiple diagnoses presenting in the ED and the final diagnosis may not be seen at all, or may not have been seen until after the 30 day gap closure window. A persistent barrier for

depression screening metrics was the lack of Logical Observation Identifiers Names and Codes (LOINC®) codes, which are required to ensure and track that an approved screening tool was used to assess depression. Provider education initiatives are ongoing to ensure providers send complete information to the Plan for successful depression screening gap closures.

Follow-Up Care for Children Prescribed ADHD Medication (ADD):

For RY 2024 on Follow-Up Care for Children Prescribed ADHD Medication (ADD):

- 50th percentile goal **not met** for Medicare HMO, Commercial HMO/PPO, Marketplace HMO, PPO or Medi-Cal

Reference Appendix, Table A-9.

Table 3.1a. ADD-Follow Up for Children Prescribed ADHD Medication (Continuation & Maintenance Phase) - All LOBs (MY 2021-MY 2023/RY 2022-RY 2024)

Line of Business	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023
CA Commercial HMO/POS	39.74%	47.86%	40.83%
CA Exchange HMO	N/A	N/A	50.00%
Medi-Cal Accreditation	34.84%	47.75%	41.10%

For the ADD Continuation and Maintenance phase of the ADD metric, Health Net did not achieve the Quality Compass National 50th percentile goal for all product lines.

Commercial PPO

For RY 2024, the plan saw improvement in both phases with a rate of 35.48% for ADD - Initiation Phase and a rate of 25.00% for ADD - Continuation & Maintenance Phase. Results for both phases did not achieve the performance goals of 36.25% and 44.80% respectively, however the ADD-Continuation & Maintenance Phase showed improvement over the prior year.

Commercial HMO/POS

For RY 2024, the rate of 37.74% for the ADD - Initiation Phase exceeded the goal of 35.95%, but the rate of 40.83% for the ADD - Continuation & Maintenance Phase did not meet the goal of 45.57%. However, both phases showed a very small decrease from RY 2023.

Marketplace HMO

Due to a small membership denominator (less than 30), rates for ADD – Initiation Phase and ADD – Continuation & Maintenance Phase were not reported for RY 2024.

Marketplace PPO

Due to a small membership denominator (less than 30), rates for ADD – Initiation Phase and ADD – Continuation & Maintenance Phase were not reported for RY 2024.

Medi-Cal

For RY 2024, the rate of 41.51% for ADD – Initiation Phase exceeded the goal of 39.78%, whereas the ADD – Continuation & Maintenance Phase rate of 41.10% fell below the goal of 51.78%. While RY 2024 performance did not meet the goal, both Initiation and Continuation & Maintenance performance rates showed directional improvement in comparison to RY 2023.

Follow-Up After Hospitalization for Mental Illness (FUH) for Discharges for Members 6 Years of Age and Older

For RY 2024 on Follow-Up After Hospitalization for Mental Illness (FUH) for Discharges for Members 6 Years of Age and Older:

- 50th percentile goal **met** for FUH7 and FUH30 for Commercial HMO
- 50th percentile goal **not met** for Commercial PPO, Marketplace HMO/PPO or Medi-Cal

Reference Appendix, Table A-9.

Table 3.1b. FUH30 - Follow Up Within 30 Days After Inpatient Psychiatric Episode (Admin)-Total-All LOBs (MY 2021-MY 2023/RY 2022-RY 2024)

Line of Business	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023
CA Commercial HMO/POS	72.95%	69.22%	76.09%
*CA Commercial PPO**	69.92%	64.42%	63.24%
*CA Exchange HMO***	66.83%	69.80%	70.00%
CA Exchange PPO	68.69%	61.47%	70.10%
Medi-Cal Accreditation	15.64%	37.33%	19.33%

*MY 2021 and 2022 rates listed applies to CA Commercial EPO/PPO. MY 2023 rate applies to CA Commercial PPO only. **MY 2021 and 2022 rates listed applies to CA Exchange HMO/HSP. MY 2023 rate applies to CA Exchange HMO only.

The goal was met for both FUH7 and FUH30 for the Commercial HMO lines of business. The National 50th percentile goal was not met for either FUH7 or FUH30 for Commercial HMO/PPO, Marketplace HMO/PPO or Medi-Cal.

Legacy MHN Clinical Operations case managers (CMs) utilized daily discharge reports to continue phone outreach for all members discharged from an inpatient psychiatric stay in the Commercial HMO/POS line of business. From Q1-Q4, Legacy MHN achieved a 33% reach rate and engaged with 566 members out of an eligible population of 1701 members. Those who connected with an MHN Clinical Operations CM reflect eligible members in the UC contract who accepted referrals and also accepted at least one intervention (such as education, follow-up calls, MHN 24/7 phone number, myStrength, etc.) These live calls are approved as supplemental data source to identify compliant members who support evidence of FUH care gap closure.

Follow-Up After Emergency Department Visit for Mental Illness (FUM) for ED Visits for Members 6 Years of Age and Older and Follow-Up After Emergency Department Visit for Substance Use Disorder (FUA) for ED Visits for Members 6 Years of Age and Older

Legacy MHN Clinical Operations CMs continued to utilize custom ADT reports to continue with routine phone member outreach to members visiting the emergency department (ED) for a mental illness. In MY 2024, MHN achieved a 21.7% reach rate and engaged 1355 members out of an eligible population of 6233 members. MHN Clinical Operations CMs also continued to utilize custom ADT reports to continue with routine phone member outreach to members visiting the emergency department (ED) for substance abuse. From Q1-Q4, MHN achieved a 18.7% reach rate and engaged 1093 members out of an eligible population of 5831 members. Those who connected with a CM reflect eligible members across the CA market who accepted referrals and accepted at least one intervention (such as education, follow-up calls, MHN 24/7 phone number, myStrength, etc.).

For MY2024, results of the live calls were approved for supplemental data use to identify compliant members who support evidence of FUM/FUA care gap closure.

Depression Screening and Follow-Up for Adolescents and Adults (DSF-E):

For RY 2024 on Depression Screening and Follow-Up for Adolescents and Adults (DSF-E):

- Goal of directional improvement was **met** for Total Initial Depression screenings for Commercial HMO/POS, Commercial EPO/PPO, Marketplace HMO/HSP/PPO and Medi-Cal.
- Goal of directional improvement in Follow Up Screenings was **not met** for Commercial HMO/POS, Marketplace HMO or Medi-Cal.

Reference Appendix, Table A-9.

Table 3.1c. DSF - Total Depression Screening (Admin)-All LOBs (MY 2021-MY 2023/RY 2022-RY 2024

Line of Business	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023
CA Commercial HMO/POS	0.41%	0.42%	2.74%
*CA Commercial PPO**	0.04%	0.05%	0.59%
*CA Exchange HMO***	0.21%	0.25%	2.09%
CA Exchange PPO	0.04%	0.09%	0.48%
Medi-Cal Accreditation	0.46%	0.92%	8.27%

*MY 2021 and 2022 rates listed applies to CA Commercial EPO/PPO. MY 2023 rate applies to CA Commercial PPO only. **MY 2021 and 2022 rates listed applies to CA Exchange HMO/HSP. MY 2023 rate applies to CA Exchange HMO only.

Table 3.1d. DSF- Follow Up On Positive Depression Screening (Admin) – Total - All LOBs (MY 2021-MY 2023/RY 2022-RY 2024)

Line of Business	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023
CA Commercial HMO/POS	72.81%	67.32%	56.12%
*CA Exchange HMO**	79.01%	77.46%	67.42%
CA Exchange PPO	N/A	N/A	N/R
Medi-Cal Accreditation	86.32%	74.02%	69.25%

*MY 2021 and 2022 rates listed applies to CA Exchange HMO/HSP. MY 2023 rate applies to CA Exchange HMO only
N/R Not reportable due to small denominator size.

The plan continued using the PHQ9 screening tool on the Sharecare site and the myStrength app to screen and identify members with depression. If member screened positive on the Sharecare screening, a Plan CM would conduct additional member outreach to further assess for depressive symptoms, refer as needed, and use their assessment as supplemental data gap closures.

Commercial HMO/POS

For measuring the percent of myStrength participants that had a positive depression screening score on the PHQ9 (PHQ9 ≥ 10) in MY 2023, the rate of 56.00% did not meet the goal of directional improvement from the prior year.

Marketplace HMO

For measuring the percent of myStrength participants that had a positive depression screening score on the PHQ9 (PHQ9 ≥ 10) in MY 2023, the rate of 67.42% did meet the goal of directional improvement from the prior year.

Marketplace PPO

For measuring the percent of myStrength participants that had a positive depression screening score on the PHQ9 (PHQ9 ≥ 10), the rate of 40% did meet the goal of directional improvement over the prior measurement year. However, due to the small population size for Marketplace, with only 10 members in the denominator, larger rate swings were seen. With the small denominator, these rates were non-reportable.

Medi-Cal

For measuring the percent of myStrength participants that had a positive depression screening score on the PHQ9 (PHQ9 ≥ 10), the rate of 69.25% did meet the goal of directional improvement from the prior year.

3.2. Chronic Conditions/Chronic Disease

Controlling Blood Pressure (CBP):

For RY 2024 on Controlling Blood Pressure (CBP):

- 50th percentile goal unmet for Commercial HMO/POS and EPO/POS.
- 50th percentile goal unmet for Marketplace HMO and PPO.
- Medicare H0562 and H3561 did not meet goal of 4 Star.
- For Medi-Cal, Kings County met QC 75th goal and Tulare County met QC 50th goal.

Reference Appendix, Table A-4.

Table 3.2a Trends in Controlling Blood Pressure (CBP)
(MY 2021-MY 2023/RY 2022-RY 2024)

Line of Business	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023
CA Commercial HMO/POS	65.26%	62.50%	70.36%
*CA Commercial PPO**	56.08%	51.11%	61.80%
*CA Exchange HMO***	60.05%	61.01%	62.50%
CA Exchange PPO	53.28%	58.05%	61.10%
CA Medicare HMO H0562	67.78%	74.21%	76.16%
CA Medicare HMO H3561	76.40%	73.97%	76.40%
Medi-Cal Accreditation	56.51%	62.47%	65.46%

*MY 2021 and 2022 rates listed applies to CA Commercial EPO/PPO. MY 2023 rate applies to CA Commercial PPO only. **MY 2021 and 2022 rates listed applies to CA Exchange HMO/HSP. MY 2023 rate applies to CA Exchange HMO only.

Glycemic Status Assessment for Patients with Diabetes (GSD):

For RY 2024 on Glycemic Status Assessment for Patients with Diabetes (GSD):

- 50th percentile goal was unmet for Commercial HMO/POS and EPO/POS.
- 50th percentile goal was unmet for Marketplace HMO and PPO.
- Medicare H0562 and H3561 did not meet goal of 4 Star.
- For Medi-Cal, Kings County met QC 75th goal and Tulare County met QC 50th goal.

Reference Appendix, Table A-4.

Table 3.2b Trends in HbA1c Control for Patients with Diabetes (HBD)
(MY 2021-MY 2023/RY 2022-RY 2024)

Line of Business	HEDIS MY 2021*	HEDIS MY 2022	HEDIS MY 2023
CA Commercial HMO/POS	57.18%	64.96%	62.78%
*CA Commercial PPO***	63.75%	63.99%	67.64%
*CA Exchange HMO****	60.34%	59.85%	68.86%
CA Exchange PPO	54.50%	55.72%	60.34%
CA Medicare HMO H0562	73.21%	73.72%	74.45%
CA Medicare HMO H3561	68.75%	71.05%	70.07%

Medi-Cal Accreditation ****	42.34%	36.25%	36.10%

*2021 CDC-HbA1c Control Measure reflect HEDIS Measure Comprehensive Diabetes Care (CDC) and for MY 2022, the CDC measures were separated into three standalone measures: Hemoglobin A1c Control for Patients with Diabetes, Eye Exam for Patients with Diabetes, and Blood Pressure Control for Patients with Diabetes. **MY 2021 and 2022 rates listed applies to CA Commercial EPO/PPO. MY 2023 rate applies to CA Commercial PPO only. ***MY 2021 and 2022 rates listed applies to CA Exchange HMO/HSP. MY 2023 rate applies to CA Exchange HMO only. **** For Medi-Cal LOB HbA1c Poor Control (>9.0%). A lower rate indicates better performance for this indicator.

The measure previously known as "Hemoglobin A1c Control for Patients with Diabetes" (HBD) was revised and renamed to "Glycemic Status Assessment for Patients With Diabetes." The updated measure now includes a glucose management indicator (GMI) in addition to hemoglobin A1c, offering a more comprehensive view of diabetes management.

Eye Exam for Patients with Diabetes (EED):

For RY 2024 on Eye Exam for Patients with Diabetes (EED):

- 50th percentile goal met for Commercial HMO/POS and unmet for EPO/PPO.
- 50th percentile goal met for Marketplace HMO and PPO.
- Medicare H0562 met goal of 4 Star and H3561 had 3 Star.

Reference Appendix, Table A-4.

Table 3.2c Trends in Eye Exam for Patients with Diabetes (EED) (MY 2021-MY 2023/RY 2022-RY 2024)

Line of Business	HEDIS MY 2021*	HEDIS MY 2022	HEDIS MY 2023
CA Commercial HMO/POS	51.82%	60.58%	57.22%
*CA Commercial PPO***	38.44%	39.42%	45.26%
*CA Exchange HMO****	49.64%	49.15%	46.96%
CA Exchange PPO	34.31%	25.06%	32.36%
CA Medicare HMO H0562	77.55%	83.70%	79.32%
CA Medicare HMO H3561	79.95%	77.86%	76.64%
Medi-Cal Accreditation	50.85%	55.47%	55.61%

*2021 reflect HEDIS Measure Comprehensive Diabetes Care (CDC) and for MY 2022, the CDC measures were separated into three standalone measures: Hemoglobin A1c Control for Patients with Diabetes, Eye Exam for Patients with Diabetes, and Blood Pressure Control for Patients with Diabetes. **MY 2021 and 2022 rates listed applies to CA Commercial EPO/PPO. MY 2023 rate applies to CA Commercial PPO only. ***MY 2021 and 2022 rates listed applies to CA Exchange HMO/HSP. MY 2023 rate applies to CA Exchange HMO only.

Kidney Health Evaluation for Patients with Diabetes (KED):

For RY 2024 on Kidney Health Evaluation for Patients with Diabetes (KED):

- Medicare H0562 and H3561 exceeded goal earning 5 Star.
- Corporate bulk mailing of KED kits in 2024 coupled with targeted outreach to providers to encourage members to return kits impacted overall rate.

Reference Appendix, Table A-4.

Table 3.2d Trends in Kidney Health Evaluation for Patients with Diabetes (KED) - (MY 2021-MY 2023/RY 2022-RY 2024)

Line of Business	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023
CA Medicare HMO H0562	60.98%	63.96%	66.24%
CA Medicare HMO H3561	61.61%	63.76%	65.74%

3.3. Hospital Quality/Patient Safety

Reporting in 2024 showed that network hospital performance improved on nearly all high priority metrics from the previous year. The five priority hospital-acquired infection scores [standardized infection ratios, or SIRs, for CAUTI (catheter-associated urinary tract infection), CLABSI (central line-associated bloodstream infection), C.Diff (Clostridioides difficile infection), MRSA (methicillin-resistant Staphylococcus aureus), and SSI-Colon (surgical site infection following colon surgery)] all improved in the percentage of total network hospitals that reported an SIR of 1.0 or lower or maintained excellent performance (=>90%). Four of five reduced the percentage of hospitals reporting outlier SIRs of 2.0 or higher or maintained performance of <1% outliers, for all infections with the exception of SSI-Colon, which increased slightly by less than one percentage point (5.5% to 6.1%).

A range of initiatives were focused on driving these improvements. Poor performing hospitals were targeted with enhanced outreach about the status of the low-performing metrics at each of those facilities. All 33 hospitals identified as the poorest performers received mailings notifying them of that status and subsequent email or telephonic outreach to the hospital's Quality staff. Updates about the status of poor performing metrics at these hospitals and contextual details such as the quality improvement programs in place and barriers the hospital was working to overcome were obtained from 75% of those facilities. A subset of those hospitals (8 facilities) is included in a multi-health plan collaborative that Health Net spearheads among the 5 total participating health plans, to engage hospital leadership on priority metrics and to help identify and connect them with available QI tools and contacts to help them improve.

All hospitals in the network received guidance about our priority metrics and performance expectations, referrals to free quality improvement tools and resources that address these metrics, and contact information to relevant organizations and staff. Ongoing collaborative relationships with key organizations aligned across hospital quality objectives support this work, including The Leapfrog Group, Cal Hospital Compare and Cynosure Health, the Health Services Advisory Group, the California Maternal Quality Care Collaborative (CMQCC), and the California Health Care Foundation, in addition to other health plans. Internally, contracting staff are provided with Hospital Quality Scorecards that offer context on individual facilities' quality performance to inform that team's engagement and discussions with hospitals.

A priority metric that failed to improve according to 2024 reporting was Nulliparous, Term, Singleton, Vertex (NTSV) C-section rates across network hospitals. Reporting for MY 2023 reflected a drop-in hospital meeting the NTSV C-section rate target of <=23.6% to 48%, from 51.8% the previous year. While this trend is concerning, our network performance was superior to the statewide finding that just 42% of California hospitals offering maternity services met this

target. Health Net has placed concerted effort on this measure with initiatives ranging from close collaboration with CMQCC to promote their tools and programs to hospitals, particularly lower performers, and including this measure in all hospital quality programs, including multi-plan initiatives. Health Net has collaborated across organizations, including with other health plans, to support the use of doulas, and conducted monthly outreach to pregnant members to raise awareness about C-section overuse and steps families can take to help ensure a medically appropriate mode of delivery, including informed hospital choice for delivery.

New member-facing online resources were developed to raise awareness about differences in quality among hospitals and about the importance of accounting for quality performance when choosing a site for care. Members had access to step-by-step guidance about why, how and where to access free hospital quality tools to guide informed decision making.

3.4. Member Engagement and Experience

Continuity/Coordination of Care (Behavioral and Nonbehavioral)

In 2024, significant progress was made across key measures, reflecting strong collaboration and strategic initiatives. For Plan All Cause Readmissions (PCR), efforts successfully engaged low-performing PPGs with the collaboration of the assigned supervisory medical director (SMD), leading to the development of targeted strategies to address gaps. Six PPGs with high inpatient utilization trends were identified, and communications between the Supervisory Medical Directors (SMD), Clinical Program Manager (CPM), and PPGs were initiated to share and implement best practices. Quarterly blind comparison reports of high-cost providers were distributed, serving as a vital resource for Provider Engagement representatives in their provider engagements. Additionally, quarterly communications with SMDs and CPMs focused on identifying and addressing barriers within high-volume, low-performing PPGs. Plan All Cause Readmissions (PCR) paced to goal, demonstrating the effectiveness of these interventions.

For Transitions of Care (TRC), the goal of 90% PPG participation in provider outreach was exceeded through collaboration with the Quality Improvement Program Manager (QIPM) team. We achieved a milestone when a pharmacist under the Case Management team began conducting Medication Reconciliation Post-Discharge (MRP) calls on July 1, 2024 on a part-time basis, completing 31 MRPs by the end of the year. In Follow-Up After Emergency Department Visit for People with High-Risk Multiple Chronic Conditions (FMC) and PCR, the Provider Performance & Analytics team collaborated to flag measures with short turn-around times in ADT reports sent to PPGs, ensuring timely responses and action.

The Care for Older Adults - Medication Review (COA-MR) measure also saw substantial contributions, with our Clinical Pharmacist completing 3,215 medication reviews for members without a pharmacy claim on file. The HEDIS team, along with our QI team, worked diligently to upload these reviews to Cozeva, enabling care gap closure. Furthermore, Health Risk Assessment (HRA) UTR outreach was initiated with Community Health Worker (CHW), Partners in Care (PIC), empowering CHWs to conduct HRAs and upload results to Bloom's platform, which is Health Net's third-party vendor focused on gathering HRA information during enrollment. This helps directly address care gap closures.

For Initial Health Appointments (IHA), collaboration with the Provider Engagement team continued to identify and address low-performing providers. Additionally, a new partnership with Provider Engagement, Cozeva, and QI was initiated to align on more frequent data uploads, enabling Provider Engagement to view provider IHA rates and address barriers in a timely manner.

Collectively, these efforts demonstrate a commitment to improving quality outcomes, fostering collaboration, and implementing strategic solutions to address barriers and drive measurable improvements. The Quality Improvement department is looking to enhance outreach efforts in 2025 by leveraging Community Health Worker (CHW) organizations to engage hard-to-reach populations that Bloom Healthcare could not reach, ensuring more comprehensive member engagement and care coordination.

3.5. Pediatric/Dental/Children's Health Program

Improve Immunizations & Well-Child Visits Among the Pediatric Population

Childhood Immunization Status – Combo 10:

For RY 2024 on Childhood Immunization Status – Combo 10:

- 50th percentile goal **met** for Commercial HMO/POS and PPO
- 66th percentile goal **not met** for Commercial Exchange HMO and PPO
- 50th percentile goal **not met** for Medi-Cal Accreditation

Reference Appendix, Tables A-8.

In RY 2024, Commercial HMO/POS and PPO both met the 50th percentile goal for CIS-10, despite decreases in the rates from RY 2023. The Commercial HMO 50th percentile benchmark decreased 11.33 percentage points in MY 2023/RY 2024 from MY 2022/RY 2023. The Commercial Exchange product lines did not meet the 66th percentile and did not see directional improvement in CIS-10 rates. Medi-Cal Accreditation did not meet the 50th percentile benchmark, but did see directional improvement in RY 2024 compared to RY 2023.

2024 QI initiatives included live call concierge member outreach timed to the well-child visit and immunizations periodicity schedule (Exchange only), provider outreach with care gap lists (Exchange and Medi-Cal only), data reconciliation with providers and community-based approaches in Los Angeles to address disparities in CIS-10 rates (neighborhood initiative primarily targeting Medi-Cal community members). Provider call barriers include the inability to identify which vaccines need to be uploaded to Cozeva when providers submit the child's entire medical record. Quality Analytics Program Managers and the HEDIS Quality Improvement Project Managers identified an opportunity to create a list for each member who needs vaccines of the dates of administration of all doses of each vaccine, allowing the HEDIS Outreach Team to easily identify which vaccines need to be uploaded to Cozeva when providers submit the child's entire medical record. This "yellow immunization card" look alike project is in progress in 2025.

Another barrier to CIS-10 is the increase in parental refusals for vaccines, especially the flu vaccine. Missing flu vaccines are the primary reason that children are non-compliant for CIS-10. In 2025, QI plans to target flu vaccines to members and providers in outreaches.

Table 3.5a. Trends in Childhood Immunization Status – Combination 10 (CIS-10) Hybrid (MY 2021-MY 2023/RY 2022-RY 2024)

Line of Business	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023
CA Commercial HMO/POS	60.97%	62.53%	56.70%
*CA Commercial PPO**	54.33%	52.69%	51.75%
*CA Exchange HMO***	51.39%	46.15%	25.30%
CA Exchange PPO	41.86%	45.45%	42.11%
Medi-Cal Accreditation	31.87%	24.09%	28.71%

*MY 2021 and 2022 rates listed applies to CA Commercial EPO/PPO. MY 2023 rate applies to CA Commercial PPO only. **MY 2021 and 2022 rates listed applies to CA Exchange HMO/HSP. MY 2023 rate applies to CA Exchange HMO only.

Immunizations for Adolescents – Combination 2 (IMA-2):

For RY 2024 on Immunization for Adolescents – Combination 2:

- 50th percentile goal **met** for Commercial HMO/POS
- 50th percentile goal **not met** for Commercial PPO
- MY 2018 25th percentile QRS 25-2-2 benchmark **met** for Exchange HMO and PPO
- 50th Percentile goal **met** for Medi-Cal Accreditation

Reference Appendix, Tables A-8.

In RY 2024, Commercial HMO IMA-2 rates decreased compared to RY 2023. Commercial HMO still exceeded the 50th percentile benchmark, whereas Commercial PPO did not. Exchange HMO and PPO increased IMA-2 rates in MY 2023/RY 2024 compared to MY 2022/RY 2024 and exceeded the 25th percentile benchmark for QRS 25-2-2. The Medi-Cal Accreditation rate met the 50th percentile in RY 2024 and experienced a slight decrease from RY 2023.

2024 QI Initiatives for IMA-2 include: Family Unit HEDIS live calls; member newsletter articles on the importance of well-care visits for children and adolescents and immunizations; and sharing American Cancer Society Provider Resources on the HPV Vaccine. Missing one or both of the HPV vaccines is the primary reason for non-compliance for IMA-2. QI is exploring additional member outreaches specific to HPV in 2025. Provider outreach and education to start the HPV vaccine at nine years of age will continue

Table 3.5b. Trends in Immunizations for Adolescents – Combination 2 (IMA-2) Hybrid (MY 2021-MY 2023/RY 2022-RY 2024)

Line of Business	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023
CA Commercial HMO/POS	37.47%	41.85%	38.69%

*CA Commercial PPO**	25.55%	29.19%	24.91%
*CA Exchange HMO***	31.39%	29.56%	31.06%
CA Exchange PPO	25.71%	14.65%	21.69%
Medi-Cal Accreditation	35.04%	36.25%	35.77%

*MY 2021 and 2022 rates listed applies to CA Commercial EPO/PPO. MY 2023 rate applies to CA Commercial PPO only. **MY 2021 and 2022 rates listed applies to CA Exchange HMO/HSP. MY 2023 rate applies to CA Exchange HMO only.

Well-Child Visits in the First 15 Months (W30-15):

For RY 2024 on Well-Child Visits in the First 15 Months:

- 50th percentile goal **not met** for Commercial HMO/POS
- 50th percentile goal **not met** for Commercial PPO/EPO
- 50th percentile QRS benchmark **not met** for Exchange HMO or PPO
- 50th Percentile goal **not met** for Medi-Cal Accreditation

Reference Appendix, TableA.8.

In RY 2024, Commercial HMO and PPO did not meet the 50th percentile benchmark for W30-15. Commercial HMO did see directional improvement of 5.65 percentage points from RY 2023. Exchange HMO and PPO did not meet the 50th percentile benchmark and experienced declines in rates from RY 2023. Medi-Cal Accreditation did not meet the 50th percentile goal, but did show directional improvement of seven percentage points.

2024 QI initiatives for W30-15 include: Referrals to Black Infant Health and Enhanced Care Management for the birth equity population of focus (Medi-Cal only); member outreach via live family unit calls; provider outreach and education and data reconciliation projects. Data gaps continue to be a barrier, especially for the first two well-child visits. Data reconciliation for those first two well-child visits with targeted providers for all lines of business will continue in 2025.

Table 3.5c. Trends in Well-Child Visits in the First 15 Months (W30-15) Admin (MY 2021 - MY 2023)

Line of Business	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023
CA Commercial HMO/POS	70.19%	70.69%	76.34%
*CA Commercial PPO**	68.15%	71.49%	62.56%
*CA Exchange HMO***	53.92%	48.28%	45.07%
CA Exchange PPO	55.77%	51.52%	36.73%
Medi-Cal Accreditation	45.06%	45.14%	52.15%

*MY 2021 and 2022 rates listed applies to CA Commercial EPO/PPO. MY 2023 rate applies to CA Commercial PPO only. **MY 2021 and 2022 rates listed applies to CA Exchange HMO/HSP. MY 2023 rate applies to CA Exchange HMO only.

Child and Adolescent Well Care Visits 3-21 (WCV)

For RY 2024 on Child and Adolescent Well-Care Visits 3-21:

- 50th percentile goal **not met** for Commercial HMO/POS
- 50th percentile goal **not met** for Commercial PPO/EPO
- 50th Percentile goal met for Medi-Cal Accreditation

Reference Appendix, Table A-8.

For RY 2024, Commercial HMO and PPO did not meet the 50th percentile benchmark for WCV, but both products demonstrated directional improvement compared to RY 2023. Medi-Cal Accreditation did not meet the 50th percentile benchmark but demonstrated directional improvement from RY 2023.

2024 QI initiatives to improve WCV include: member outreach via live Family Unit/Multigap calls, Proactive Outreach Manager (POM) automated phone messages, participation in community events, provider trainings, data reconciliation, and expanded access in targeted provider offices for well-care visits. Access to well-care appointments continues to be a barrier for WCV. QI will continue to support providers in expanding access beyond regular business hours to support well-care and preventive care in 2025.

Table 3.5d. Trends in Well Care Visits (WCV) Admin MY 2021 - MY 2023

Line of Business	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023
CA Commercial HMO/POS	53.84%	52.56%	54.58%
*CA Commercial PPO**	48.80%	44.79%	50.76%
*CA Exchange HMO***	40.24%	39.07%	43.50%
CA Exchange PPO	39.67%	38.08%	33.82%
Medi-Cal Accreditation	46.15%	44.04%	45.18%

*MY 2021 and 2022 rates listed applies to CA Commercial EPO/PPO. MY 2023 rate applies to CA Commercial PPO only. **MY 2021 and 2022 rates listed applies to CA Exchange HMO/HSP. MY 2023 rate applies to CA Exchange HMO only.

3.6. Perinatal Health/Reproductive Health

For RY 2024, Commercial HMO met the 66th percentile benchmark and was 0.26 percentage points shy of the 75th percentile for Timeliness of Prenatal Care (PPC-pre). Commercial PPO met the 75th for PPC-pre. Both Commercial HMO and PPO demonstrated directional improvement in PPC-pre in RY 2024 compared to RY 2023.

For RY 2024 Exchange, both Exchange HMO and PPO exceeded the QRS 25th percentile for PPC-pre. Exchange HMO exceeded the 75th percentile for PPC-pre and PPO exceeded the 50th percentile in RY 2024. Medi-Cal Accreditation exceeded the 50th percentile benchmark in RY 2024 and demonstrated directional improvement compared to RY 2023.

Table 3.6a. Trends in Prenatal and Postpartum Care – Timeliness of Prenatal Care (PPC-pre) Hybrid (MY 2021 - MY 2023)

Line of Business	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023
CA Commercial HMO/POS	92.35%	93.15%	93.71%
*CA Commercial PPO**	85.60%	84.40%	91.70%
*CA Exchange HMO***	85.20%	90.37%	92.38%
CA Exchange PPO	86.89%	86.45%	88.44%
Medi-Cal Accreditation	84.37%	86.74%	87.50%

*MY 2021 and 2022 rates listed applies to CA Commercial EPO/PPO. MY 2023 rate applies to CA Commercial PPO only. **MY 2021 and 2022 rates listed applies to CA Exchange HMO/HSP. MY 2023 rate applies to CA Exchange HMO only.

For RY 2024, Commercial HMO met the 66th percentile benchmark for postpartum care and was 0.26 percentage points shy of the 75th percentile for Postpartum Care (PPC-pst). Commercial PPO met the 50th percentile benchmark for PPC-pst. Both Commercial HMO and PPO demonstrated directional improvement in PPC-pst in RY 2024 compared to RY 2023.

For RY 2024 Exchange, both Exchange HMO and PPO exceeded the QRS 25th percentile for PPC-pst. Both Exchange HMO and PPO exceeded the 50th percentile in RY 2024 for PPC-pst. Medi-Cal Accreditation exceeded the 50th percentile benchmark for PPC-pst and demonstrated directional improvement compared to RY 2023.

Table 3.6b. Trends in Prenatal and Postpartum Care – Postpartum Care (PPC-pst) Hybrid (MY 2021 - MY 2023)

Line of Business	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023
CA Commercial HMO/POS	85.20%	90.41%	93.71%
*CA Commercial PPO**	82.00%	84.40%	84.72%
*CA Exchange HMO***	80.40%	81.85%	83.41%
CA Exchange PPO	72.82%	71.03%	86.71%
Medi-Cal Accreditation	79.86%	78.85%	82.64%

*MY 2021 and 2022 rates listed applies to CA Commercial EPO/PPO. MY 2023 rate applies to CA Commercial PPO only. **MY 2021 and 2022 rates listed applies to CA Exchange HMO/HSP. MY 2023 rate applies to CA Exchange HMO only.

2024 QI initiatives for Timeliness of Prenatal Care and Postpartum Care include: referrals to Centene's high risk case management program, *Start Smart for Your Baby;* Confirmation of Pregnancy Provider incentive (Medi-Cal only); Provider education; referrals to *Black Infant Health* (Medi-Cal only), and Enhanced Care Management for the birth equity population of focus (Medi-Cal only). The primary barrier for PPC is that the Provider Engagement teams do not have regular contact with OB/GYN specialty providers. QI may initiate a pilot project with Provider Engagement to outreach to targeted perinatal care providers in 2025.

3.7. Pharmacy and Related Measures

Improve Pharmacy Measures

In 2024, Commercial and Medi-Cal members who had an Asthma Medication Ratio (AMR) gap were outreached to by a pharmacist to address barriers to asthma medication adherence using motivational interviewing techniques and encouraged to discuss action plans with their providers. Members were encouraged to discuss with providers about changing medication to formoterol/Inhaled corticosteroid (ICS) combos that have shown to better control Asthma. Provider tip sheets for AMR were also updated to include this as a best practice.

Additionally, in 2024,the Pharmacy POD educated Medi-Cal providers on the CalAIM Asthma Remediation and Education Services for qualifying HN Medi-Cal members with asthma. Members referred to the services learned how to reduce asthma triggers in their home and received resources to help remove allergens and other indoor triggers. If members qualified, there were also provided with remediation tools such as air filters, dust mite control bedding, pest control, services outline in the CalAIM program.

Health Net will continue in 2025 to promote CalAIM Asthma Remediation services by partnering with providers and making the program available to qualifying members with asthma.

Improvements to Medicare medication adherence measures occurred through coordinated efforts targeting 22 priority PPGs using a designated Pharmacist team on adherence strategies and workflows. This will be expanding to additional groups in 2025. Pharmacy implemented extended day supply of adherence medications up to 100 days. Within the Part D report cards, SUPD member details and summaries were added for expanded line of sight to measure gaps. For SPC, provider calls were made by Pharmacist to educate/break down barriers around the measure and achieve compliance.

The Rx Effect predictive analytics application, already in place for Medicare, expanded to include Marketplace members. With this in place it provides more visibility to members that are at risk for non-adherence to the PDC measures.

Asthma Medication Ratio (AMR):

For RY 2024 on Asthma Medication Ratio (AMR):

- 50th percentile goal was **not met** for Commercial HMO/POS, PPO/EPO
- 50th percentile (QRS benchmark of 84.50%) goal was **not met** for Marketplace HMO and PPO
- Measure was not reported for Medicare H0562 and H3561

Table 3.7 Trends in Asthma Medication Ratio (AMR) (MY 2021 - MY 2023)

Line of Business	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023
CA Commercial HMO/POS	77.15%	76.57%	75.29%
*CA Commercial PPO**	79.11%	82.16%	74.60%
*CA Exchange HMO***	71.94%	70.68%	69.70%

CA Exchange PPO	69.77%	68.22%	68.55%
Medi-Cal Accreditation	59.22%	57.31%	57.56%

*MY 2021 and 2022 rates listed applies to CA Commercial EPO/PPO. MY 2023 rate applies to CA Commercial PPO only. **MY 2021 and 2022 rates listed applies to CA Exchange HMO/HSP. MY 2023 rate applies to CA Exchange HMO only.

3.8. Preventive Health/Cancer Prevention

In 2024, the preventive care measures focused strategies on member engagement, provider engagement, community access, and community based approaches. Members who were non-compliant for multiple cancer screenings and/or had multiple care gaps were outreached to complete their care. Medi-Cal members in San Joaquin and Stanislaus county and Medicare members were outreached via the live call concierge member outreach to schedule their appointments.

The Provider Engagement strategy focused on engaging with radiology facilities by providing education and also understanding their unique organizational barriers in providing care to members. The preventative care pod implemented multiple e-projects for breast cancer and colorectal cancer screening to communicate interventions and allow for appropriate follow-up and outreach by providers to members.

In order to address and reduce structural barriers to care and expand access, the preventive care pod enhanced the internal process for the mobile mammography program for closer partnership with both the vendor and provider clinics. Additionally, members who were non-compliant for colorectal cancer screening were sent in-home screening to complete their care through Cologuard or Fit-Kits.

In efforts to educate provider and provider facing teams on the most updated guidelines on cancer screening and reproductive health measures, provider education material such as tip sheets were updated with the latest best practices and coding practices. The QI Program Manager hosted multiple office hours and webinars to educate both provider facing teams and providers on the latest measure guidelines and interventions to improve care. The strategy also heavily focused on targeting high-volume low performing priority providers, as team members attended multiple meetings to discuss measure performance, strategies to improve performance, and opportunities for partnership and/or collaboration.

The microsite was updated with a health equity focus, guided by a literature review, to address racial and ethnic disparities in colorectal cancer screenings. As cancer screenings and reproductive health services may be a sensitive topic for members, the preventive care pod worked with community-based organizations on multiple cancer screening measures such as breast cancer screening and cervical cancer screening to provider culturally appropriate care to members through community health worker outreach and engagement.

For RY 2024, Commercial HMO/POS met the Quality Compass 50th percentile benchmark for Breast Cancer Screening and demonstrated directional improvement in BCS-E in RY 2024 compared to RY 2023.

For RY 2024 Exchange, Exchange HMO exceeded the QRS 25th percentile for BCS-E. Exchange HMO exceeded the 50th percentile for BCS-E and PPO performed below the 25th percentile in RY 2024. Medi-Cal Accreditation exceeded the 50th percentile benchmark in RY 2024 and demonstrated directional improvement compared to RY 2023.

For RY 2024, Medicare H0562 met the 4 STAR goal and H3561 met the 3 STAR goal but with directional improvement in RY 2024 in comparison to RY 2023.

Table 3.8a. Trends in Breast Cancer Screening (BCS) (MY 2021 - MY 2023)

Line of Business	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023
CA Commercial HMO/POS	72.87%	76.99%	76.79%
*CA Commercial PPO**	67.89%	70.27%	70.16%
*CA Exchange HMO***	65.22%	68.96%	71.3591%
CA Exchange PPO	48.96%	51.46%	53.11%
Medi-Cal Accreditation	49.60%	52.69%	53.96%
Medicare H0562	74.96%	77.2%	78.1%
Medicare H3561	70.47%	72.57%	71.54%

*MY 2021 and 2022 rates listed applies to CA Commercial EPO/PPO. MY 2023 rate applies to CA Commercial PPO only. **MY 2021 and 2022 rates listed applies to CA Exchange HMO/HSP. MY 2023 rate applies to CA Exchange HMO only.

Colorectal Cancer Screening (COL)

For RY 2024, Commercial HMO/POS performed below the Quality Compass 50th percentile benchmark for Colorectal Cancer Screening and demonstrated.

For RY 2024 Exchange HMO performed at the 25th percentile for COL-E and PPO performed below the 25th percentile in RY 2024.

For RY 2024, Medicare H0562 met the 4 STAR goal and H3561 met the 2 STAR goal but with directional improvement in RY 2024 in comparison to RY 2023 for COL-E.

Table 3.8b. Trends in Colorectal Cancer Screening (COL) (MY 2021 - MY 2023)

Line of Business	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023
CA Commercial HMO/POS	NA	Admin: 55.29% Hybrid: 58.15%	Admin: 58.96% Hybrid: 59.60%

*CA Commercial PPO**	NA	Admin: 47.82 Hybrid: 54.26%	Admin: 50.13% Hybrid: 53.55%
*CA Exchange HMO***	NA	Admin: 45.95% Hybrid: 53.04%	Admin: 56.4382% Hybrid: 59.7561%
CA Exchange PPO	NA	Admin: 28.08% Hybrid: 39.90%	Admin: 37.79% Hybrid: 44.77%
Medi-Cal Accreditation	NA	Admin: 32.29%	Admin: 34.86%
Medicare – H0562	Admin: 71.91% Hybrid: N/A	Admin: 71.21% Hybrid: 74.70%	Admin: 75.38% Hybrid: 77.62%
Medicare H3561	Admin: 66.94%	Admin: 65.40% Hybrid: 71.53%	Admin: 69.74% Hybrid: 71.53%

*MY 2022 rate listed applies to CA Commercial EPO/PPO. MY 2023 rate applies to CA Commercial PPO only. **MY 2022 rate listed applies to CA Exchange HMO/HSP. MY 2023 rate applies to CA Exchange HMO only.

Cervical Cancer Screening Ages 21-64 (CCS)

For RY 2024, Commercial HMO/POS performed below the Quality Compass 50th percentile benchmark for Cervical Cancer Screening and demonstrated directional improvement CCS-E in RY 2024 compared to RY 2023.

For RY 2024 Exchange, Exchange HMO exceeded the QRS 25th percentile for CCS-E. Exchange HMO exceeded the 50th percentile for ccs-E and PPO performed below the 25th percentile in RY 2024.

Medi-Cal Accreditation performed at the 25th percentile for RY 2024.

Table 3.8c. Trends in Cervical Cancer Screening (CCS) (MY 2021 - MY 2023)

Line of Business	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023
CA Commercial HMO/POS	Admin: 74.19% Hybrid: 75.70%	Admin: 73.56% Hybrid: 76.36%	Admin: 74.52% Hybrid: 74.75%
*CA Commercial PPO**	Admin: 69.63% Hybrid: 70.00%	Admin: 69.75% Hybrid: 74.71%	Admin: 70.49% Hybrid: 72.27%
*CA Exchange HMO***	Admin: 53.82% Hybrid: 57.32%	Admin: 60.53% Hybrid: 64.27%	Admin: 63.27% Hybrid: 63.68%
CA Exchange PPO	Admin: 40.58% Hybrid: 48.91%	Admin: 48.25% Hybrid: 57.18%	Admin: 47.23% Hybrid: 50.62%
Medi-Cal Accreditation	Admin: 51.75% Hybrid: 56.10%	Admin: 50.30% Hybrid: 58.52%	Admin: 49.63% Hybrid: 59.60%

*MY 2021 and 2022 rates listed applies to CA Commercial EPO/PPO. MY 2023 rate applies to CA Commercial PPO only. **MY 2021 and 2022 rates listed applies to CA Exchange HMO/HSP. MY 2023 rate applies to CA Exchange HMO only.

Chlamydia Cancer Screening in Women 16-24 (CHL):

For RY 2024, Commercial HMO/POS performed at the Quality Compass 50th percentile benchmark for Chlamydia Screening in Women.

For RY 2024 Exchange. Exchange HMO and PPO performed below the 25th percentile for CHL. Medi-Cal Accreditation performed at the 25th percentile for RY 2024.

Table 3.8d. Trends in Cervical Cancer Screening (CCS) (MY 2021 - MY 2023)

Line of Business	HEDIS MY 2021	HEDIS MY 2022	HEDIS MY 2023
CA Commercial HMO/POS	51.20%	51.26%	53.19%
*CA Commercial PPO**	44.06%	45.93%	46.40%
*CA Exchange HMO***	48.74%	47.58%	47.27%
CA Exchange PPO	45.51%	41.54%	41.58%
Medi-Cal Accreditation	66.77%	65.58%	68.58%

*MY 2021 and 2022 rates listed applies to CA Commercial EPO/PPO. MY 2023 rate applies to CA Commercial PPO only. **MY 2021 and 2022 rates listed applies to CA Exchange HMO/HSP. MY 2023 rate applies to CA Exchange HMO only.

3.9. Provider Engagement

CAHPS (Member Experience)

In 2024, there were several initiatives to improve CAHPS and address member pain points. Grievances, appeals, and regulatory complaints were frequently reviewed as CAHPS leading indicator metrics. A CAHPS Improvement Workgroup met monthly to drill down into CAHPS drivers and have cross-functional dialogue about issues, areas of opportunity, barriers, and improvement activities. The CAHPS Team was working more closely with provider-facing teams to better highlight CAHPS and brainstorm improvement opportunities with high volume provider groups.

The CAHPS Quality Improvement team had several initiatives in place to monitor member experience:

- Monthly review of grievances, appeals, and other sources of member pain point data (i.e. call drivers) (call drivers, disenrollment data) as CAHPS leading indicator metrics.
- Maintained a CAHPS Action Plan, which captured improvement initiatives with several stakeholder departments that impacted CAHPS/member experience. The CAHPS action plan was reviewed regularly with several key business areas.
- Monthly Quality Governance Meetings occurred to review CAHPS results, share updates, and brainstorm new initiatives and collaboration opportunities with several stakeholder departments and teams across the organization.
- Communicated final CAHPS results, year over year trends, and improvement opportunities with CAHPS liaisons and executive leadership.

CAHPS data were evaluated to identify trends in scores and used to compare performance to national benchmarks. Results were presented to internal workgroups to identify issues that may affect member experience scores and to examine possible causes of member complaints. The Quality Department in collaboration with the VP of Quality Management, VP of Provider Relations, Director of Provider Relations, Senior Manager of Provider Relations, QI Senior Director, the CAHPS Program Managers and the Manager of Quality Improvement Analytics took part in the barrier analysis and identified opportunities for improvement.

Commercial

CAHPS rates saw both increases and decreases in results. Overall rating measures decreased for HMO/POS and increased for PPO from the year prior. Both products saw mixed results across the composite measure with many of the PPO Product were non-reportable data due to small sample size (n<100). A key area of focus is around access, billing and referral delays to care, which is fueled by the product's nuanced benefit structure with delegated provider groups. This highlights the opportunity for the plan to strengthen partnerships with providers/groups to better monitor referral processes and prevent approval delays. Getting Needed Care, Getting Care Quickly measures and claims processing continues to be main pain point areas with members. Several CAHPS measures fell below the Quality Compass Average, indicating that Health Net is not keeping up with national performance. There continues to be an opportunity to monitor grievances and appeals around the Access to Care measures. Focus areas include reviewing appointment availability and provider/staff communication.

Qualitative Analysis:

1. There continues to be opportunities for improvement for Overall Rating CAHPS measures since all were below the Quality Compass Average in MY 2023 except Rating of Personal Doctor for PPO. All the rest of these Overall Rating measures are below or at the 25th percentile.
2. Overall Rating measures for the HMO product decreased compared to the previous year. In the PPO product, Overall Rating measures except Rating of Specialist increased compared to the previous year. Most notably, Coordination of Care (NR), which saw an increase year over year and met the Quality Compass (QC) Average for the Commercial PPO product. Many of the operational challenges have impacted member's rating of Rating of Health Plan and aspects of health care continued to be affected by the Covid-19. As seen with the declines in overall measures, these impacts from the Covid-19 pandemic and staffing shortages were likely to have a domino effect on care processes and member perception of care.
3. Commercial HMO/POS composite CAHPS results showed most decreases. There is room for improvement on the operational measures and the access measures including Customer Service, Claims Processing, Getting Needed Care, and Getting Care Quickly. Claims processing and referral delays have the biggest opportunity for improvement and are impacting other measures including Customer Service and some of the access measures. All the sub-measures in the composite measures are below the 25th percentile.
4. The Commercial PPO composite CAHPS results showed increase and decrease from the year prior. Customer Service and Coordination of Care had the largest increases year over year. This highlights the collaboration being done to provide the needed information to members from customer service and coordinating the members' care in a timely and proper manner.
5. For both the HMO/POS and the PPO products - grievance trends point to member dissatisfaction with referral processing, billing complaints and attitude and service. Although much work has been focused on improving claims processing, continued focus

needs to remain to improve internal processes. PPG partnerships should be leveraged to highlight opportunities to improve the referral process and prevent major approval delays. Informal grievances reveal member challenges attitude and service. Informal grievances are filed directly with the call center and the nature of grievances may differ than the formal grievances.

6. Most of the appeals received were tied to pharmacy and billing issues. Expedited appeals indicate some member challenges in obtaining their required prescription medications.

Marketplace

Overall Marketplace HMO and PPO saw a decrease in most of the rating measures in comparison to last year. However, HMO and PPO products saw an increase in most of the composite measures compared to MY 2022. There is still room for improvement seeing that all measures are still below the Press Ganey Book of Business (PG BOB) benchmarks average, a valuable tool for monitoring industry trends

Qualitative Analysis:

1. The main member pain point areas across all products continue to be around Attitude and Service, Billing and Financial Issues, and Access. The Marketplace membership tends to have certain expectations of what their plan terms and benefits offer. This highlights the need to better set expectations for members at both the health plan and provider office level.
2. There continues to be opportunities for improvement for all the Overall Ratings measures since all were below the QHP BOB average for both HMO and PPO.
3. The Access to Care, Care Coordination, Access to Information, and Plan Administration composite QHP measures have increased for the HMO product. For PPO product, Care Coordination, Access to Information, and Plan Administration composite QHP measures have increased from previous year. Although this highlights a great achievement, Health Net is still below the PG BOB average, underlining the need to still improve since our competitors are improving at a greater rate. Grievances show an opportunity for improved interaction with all member-facing teams, especially the Call Center and Provider Office Staff. Routine reminders and training opportunities will help keep member experience on the forefront of all member interactions. Claims issues were a driver of many member grievances and post-service appeals. Improved transparency and easy-to-find plan information are areas of opportunity. Having relevant topics posted online for members to easily access will help better inform members on common topics: member benefits, year over year benefit/cost changes. Marketplace members' enrollment and eligibility is also dependent in part on Covered California operations and information. There is room to improve the data shared between Covered California and the health plan.

Medi-Cal

CAHPS survey results for the HNCA Medi-Cal product, saw mixed results in 2024. There continues to be an opportunity to monitor grievances and appeals around the Access to Care measures. Possible focus areas include reviewing appointment availability, prior authorizations, transportation, and provider/staff communication.

Qualitative Analysis:

1. There continues to be opportunities for improvement for all of the Overall Rating CAHPS measures since all were below the QC Average in MY 2023. All four of these Overall Rating measures are below the 25th percentile. The Rating of Specialist continues to be

a low performer and it's important to analyze, investigate, and probe for weakness or QI opportunities among those measures or composites that are Key Drivers (or highly correlated) with rating of specialist. (e.g., How Well Doctors Communicate, Getting Care Quickly, Getting Needed Care, and Coordination of Care).

2. The Composite CAHPS survey measure results saw mixed results. The areas of focus should be around Access to Care since all these measures except Care Coordination were below the 25th 2023 Accreditation Percentile. These members already have unique barriers such as not prioritizing their health care (in comparison to the Commercial and Medicare populations) due to a high number of unique barriers and social determinants of health. The Customer Service measure improved from the prior year. It is important to continue to involve the Customer Service team in QI activities, seeking concrete customer-based input and improvements. The Customer Service team needs to be fully informed of updates/changes to processes and procedures.
3. Grievances and appeals show an opportunity for monitoring and improving the prior authorization and referral process. Trends in both grievances and appeals indicated that members are experiencing delays in both PCP and specialist care due to long turnaround times for prior authorizations and referrals to get approved. A recommended action includes regular monitoring of the Medi-Cal network – PCPs and specialists – to ensure members have a full provider network to choose from. The availability of appointments with a PCP continues to be a driver of grievances and there is discussion to incorporate a separate phone line to assist members with these appointments and the provider. There tends to be a higher lack of plan benefit knowledge for the Medi-Cal population. Members may not be aware of alternate means of securing appointments for their needed care. Members continue to have issues with their transportation vendor so there is an opportunity to work with the vendor to improve transportation services. Attitude and Service at the provider office and at the Call Center continue to be member pain points. The Exempt Grievances related to Attitude/Service which include but are not limited to Service by HN, Service by PCP, Service by PPG, Service by Pharmacy, Service by Specialist, and Service by Vendor. There should also be a focus on improving when a provider is incorrectly transferred or assigned. The Attitude and Service informal grievances are driven primarily by incorrect PCP assigned (Health Net error and Non-Health Plan error). Many members filed informal grievances for not receiving their member ID cards. Much of the Access informal grievances are caused by issues with the transportation vendor, Telephone access and Panel Disruption, as well as limited appointment availability at both the PCP and specialist level. There is an opportunity to improve members' billing and financial issues particularly with outpatient procedures. The largest issue in MY 2023 was Outpatient – Procedure appeals which decreased 10% from MY 2022. The other top issues included Diagnostic – MRI and DME - Other appeals. A barrier members face is unforeseen out of pocket costs to care usually due to billing errors. Finances are especially tight with this population so receiving any type of bill for care will upset the member and may deter them from seeking future care due to high costs. A recommended action is to implement routine customer service training to member-facing teams within the organization.

Medicare

CAHPS activities conducted in 2024 focused on supporting providers/PPG's, identifying member pain point areas, and collaborating with the Medical Affairs and Provider Engagement teams with the goal of improving member experience throughout the care journey. The CAHPS access to care measures and most rating measures continue to perform below 3 Stars.

The CAHPS Team partnered with the Corporate CAHPS Team and Press Ganey (the NCQA-approved CAHPS survey vendor) to administer the Regulatory CAHPS survey. Final results were shared with leadership, as well as cascaded out to all stakeholder departments within the organization. The CAHPS Team also conducted an off-cycle Mock CAHPS Survey to get a pulse on member experience throughout the year. The Mock CAHPS survey gave us the opportunity to capture results and tie them back to the members' PPG. Results from the Mock CAHPS Survey are a critical tool to shaping future CAHPS improvement initiatives that can be tailored to a specific PPG's strengths and weaknesses wit in member experience. The Medicare Quality team implemented a CA Center of Excellence Call Center in Q4 to address the nuances members face in the CA market. The goal is to reduce our member grievances. 2024 Medicare Grievances (Top Categories and Sub-Categories) Customer Service: Member unhappy with services- Vendor, Call Center Staff, provider practices, lack of caring/concern- Provider, Health Plan Staff, and Inappropriate Behavior.

1. Benefit Package:
   a. Wellcare Spendables, Health Plan, and OTC.
2. Access to Care:
   a. Network availability, Prior authorization delay, and Availability of appointment.
3. Other:
   a. Balance billing and ID Card.
4. Marketing:
   a. False/misleading information about Plan/Benefit, Sales misrepresentation, and Member materials.

For 2025 the CAHPS Team will continue to collaborate with stakeholder teams to improve operational processes, which will in turn have a positive impact on member experience. The priority CAHPS measures will continue to be related to access to care with a goal of reducing member appeals and grievances. To improve response rates for the regulatory CAHPS survey, the CAHPS team will need to work with other departments across the organization to prevent member abrasion. Results from the Mock CAHPS survey will also help drive improvement efforts at the plan level and with high volume, low performing PPGs.
Interventions planned for 2025 include:

- Improving inconsistencies of the provider network in the Provider Search Tool.
- Completing PPG Mock CAHPS Performance Reviews & Action Plan Development.
- Improving DSNP Member Experience w/Transportation by Building Handoff Process & enforcing vendor service level agreement (SLA) adherence.
- Classifying grievances more accurately on the Grievance Report.

<u>Provider Access, Availability, and Service and Satisfaction</u>

Commercial
Several statistically significant improvements in timely access results were observed in MY 2023 compared to MY 2022. Additionally, 8 out of 13 goals were met for the Commercial networks.

Marketplace
Several statistically significant improvements in timely access results were observed in MY 2023 compared to MY 2022. Additionally, 9 out of 13 goals were met for the Commercial Marketplace networks.

Medicare

The Medicare provider network results improved in several measures compared to MY 2022, however only 4 out of 12 goals were met.

Medi-Cal

Several statistically significant improvements in timely access results were observed in MY 2023 compared to MY 2022. Additionally, 8 out of 13 goals were met for the Commercial Marketplace networks.

Based on identified opportunities, the Access & Availability team identified actions for improvement in 2025. These activities are aimed at improving member satisfaction with receiving timely appointments and care with PCPs, Specialists and behavioral health care providers. The following are identified activities to drive improvements:

- Continue to conduct quarterly and annual analysis of PCP and Specialist open practices to identify the percentage of PCPs open to new members and the percentage of specialty care practitioners open to referrals.
- The Plan will continue to conduct a quarterly outreach to PPGs to obtain updated information on contracting with urgent care centers, reflected in the online directories.
- Plan will continue to leverage telehealth services via contracted providers (PCPs and Specialists) and third-party telehealth vendors to offer timely appointments to members.
- The plan will perform a review of Out-Of-Network (OON) requests for specialty care to assess members being referred out-of-network for services.
- Based on survey results, the Plan initiates Corrective Action Plans (CAPs).
- Conducts quarterly geo-access analysis to identify access issues in specific geographic areas and increase contracting efforts.
- Analyze grievances on a quarterly basis to identify providers with high volume of grievances and determine grievance reduction initiatives with providers.

Quality EDGE

Commercial/Marketplace

There was a total of 66 approved requests for Quality EDGE. The 2024 funding totaled $208,903. Approximately 74% of requests were for member and provider incentives to support gap closure for CBP, COL, HBD, CCS and CIS-10 measures.

Medi-Cal

There was a total of 405 approved requests for Medi-Cal. There were an additional 76 approved requests categorized under Medi-Cal Vaccine Response Program (VRP). Total funding equaled

$2,843,867. Almost 58% of requests were for member and provider incentives, 14% for mobile mammography, and six percent for one-stop clinics targeting pediatric measures.

3.10. Health Education and Wellness

In 2024, Health Education fulfilled a total of 115 order requests. There was a total of 600 articles requested resulting in the distribution of 75,284 pieces of printed health education materials that were distributed to provider offices. Additionally, the team reviewed their inventory of in-house materials which consisted of three pieces of materials due for their five-year review period in 2024 and determined them to be obsolete. The obsoleted materials were replaced with Krames resources which are categorized by DHCS as an approved company for written health education materials. Health Education also collaborated with Health Equity to conduct eight field testings to ensure all member facing materials are in line with DHCS standards. With regards to member incentives, Health Net had four member incentive programs in 2024 for Medi-Cal, one member incentive for Marketplace (via the Centene Corporate program), and one member incentive for select Commercial members.

The Health Education and Wellness teams also developed a PowerPoint presentation of digital health education resources to support patients. The presentation consisted of QR codes with links to reliable sources ranging from the Center for Disease Control and Prevention (CDC), World Health Organization (WHO), and American Heart Association (AHA). This resource covered a variety of health topics ranging from asthma to senior health. The deployment of this material was a collaborative effort among Health Education and Wellness, Quality Improvement and provider facing teams. The teams worked together to distribute this resource to providers who then shared pertinent resources with members. Collectively this resource was distributed to over 1,000 Medi-Cal Providers. The presentation of digital resources was also shared at the Plan's Community Advisory Committee for each of Health Net's counties. Other key accomplishments included, DHCS and DHMC approval to move forward with the transition of MyStrength to the Teladoc's Digital Mental Health Program; DHCS approval of a new Diabetes Prevention Program (DPP) vendor; and continuation of the partnership Every Woman Counts which offers health education classes for breast cancer and cervical cancer screenings.

Section 4: QI Reporting

4.1 Safety Monitoring of Potential Quality of Care Issues (PQIs)

A PQI is any suspected deviation from provider performance, clinical care, or outcome of care which requires further investigation to determine if an actual quality of care concern or opportunity for improvement exists. PQIs are identified by plan staff, providers, health care professionals, or vendors. PQI's are separate from member identified Quality of Care (QOC) concerns.

When a potential PQI is identified, a PQI Referral Form is completed (forms are available from department supervisors and are also available to our providers and vendors on the plan's Provider Portal). The PQI Referral form is faxed to the plan's Clinical Grievance Department,

where a case is systematically built and assigned to a Registered Nurse. The nurse will request the needed medical records and provide a clinical review and recommendation. Once the nurse's review is complete, it is forwarded to a Medical Director who will complete an independent review and level the case. All cases are assigned levels by the Medical Director from 0 to 4. All cases are tracked/trended with all cases leveled a 3 or 4 referred to the plan's Peer Review Committee.

As shown in Table 4.1, Health Net received and closed 87 PQIs in 2023. The cases were completed within the 90-day turnaround time. In 2024, Health Net received and closed 118 PQIs, an increase in cases from 2023. The increase in cases from 2023 to 2024 can be attributed to the addition of behavioral health PQIs beginning January 1, 2024. All cases were completed within the 90-day turnaround time. The following table shows the breakdown of leveling for cases.

- Level 0 – Investigation indicates no QOC issue has occurred.
- Level 1 – Investigation indicates that a particular case demonstrated no potential for serious adverse effects.
- Level 2 – Investigation indicates that a particular case demonstrated a minimal potential for serious adverse effects.
- Level 3 – Investigation indicates that a particular case has demonstrated a moderate potential for serious adverse effects.
- Level 4 – Investigation indicates that a particular case has demonstrated a significant potential for serious adverse effects.

Table 4.1 2023-2024 PQI Cases

PQI Level	2023	2024
Level 0	40	53
Level 1	1	5
Level 2	34	52
Level 3	2	6
Level 4	10	2
Total Cases	**87**	**118**

Chart 4.1 2023 PQI Leveling

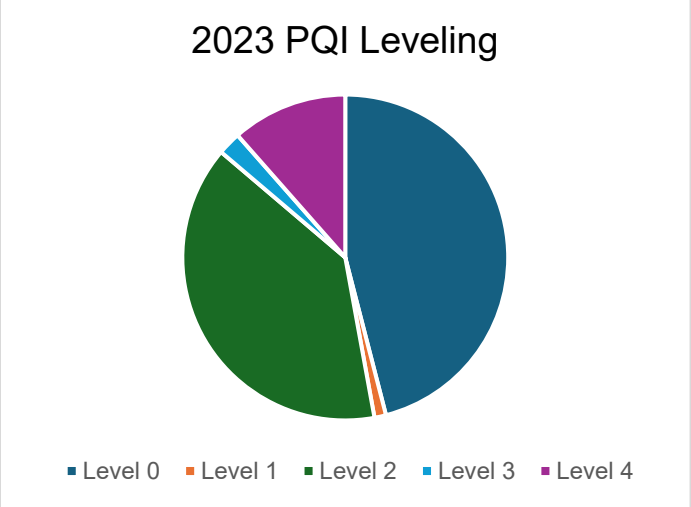
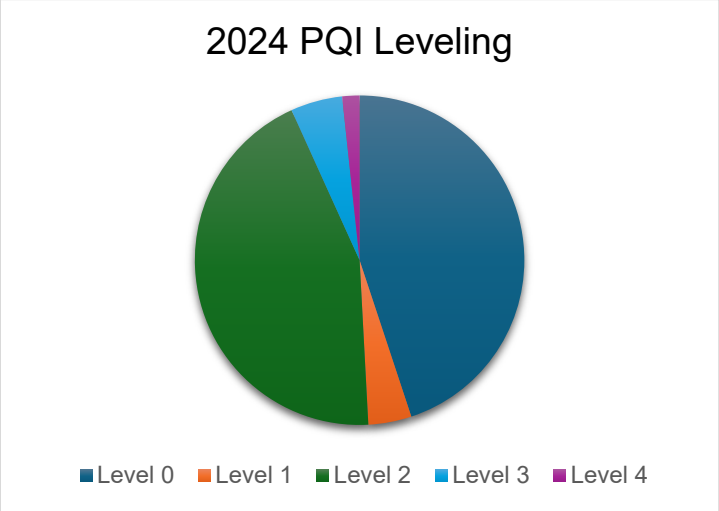


Chart 4.2 2024 PQI Leveling



4.2 Vendor/Delegation Oversight

Vendor Oversight

Health Net ensured delegated vendors supporting the plan were compliant with contractual and regulatory requirements. This was accomplished via ongoing monitoring and auditing.

2024 Delegated Vendor Auditing and Monitoring Activities

- Annual audits were conducted for Evolent (NIA), Centene Vision, Evicore, TurningPoint, ModivCare. Molina and ASH.
- Joint Oversight Committees (JOCs) were held quarterly in which performance metrics for all delegated vendor services was reviewed.
- Semi-annual scorecard evaluations of ModivCare were conducted which included reviews of PCS form process and appropriate transportation level of service was provided.
- Vendor Oversight Committee (VOC) monthly meetings were held to analyze transportation data and trends to identify opportunities to improve member satisfaction and compliance.

Delegated Vendor Auditing and Monitoring Summary

- Delegated Utilization Management (UM) – American Specialty Health (ASH), TurningPoint, Evolent (NIA) and Evicore were delegated for UM.
    - The Evicore annual audit resulted in no findings. The Evolent audit resulted in findings for use of outdated commercial letter templates. The ASH and TurningPoint annual audits have not been finalized.
- Delegated Credentialing – American Specialty Health (ASH) and Centene Vision were delegated for Credentialing.

    - The Centene Vision audit demonstrated compliance with no findings. The ASH audit has not been finalized. See below for transportation program.
- Delegated Specialty Services – The Centene Vision audit demonstrated compliance/no findings. The ASH annual audit has not been finalized.
- Transportation Program – The semiannual scorecard evaluations of ModivCare resulted in non-compliance with the PCS form process. ModivCare has an existing corrective action for this requirement and an active remediation plan. The annual audit has not been finalized. The health plan will be bringing the PCS form process in house in 2025.
- The audit of Molina has not yet been completed.

2025 Opportunities/Changes

For 2025, Health Net will continue to perform monitoring via scorecard evaluations, quarterly JOCs, monthly ModivCare VOCs and perform annual audits of delegated services. DentaQuest will replace Liberty Dental in 2025. The health plan will be bringing the PCS form process currently delegated to ModivCare in house in 2025.

Section 5: Summary of Key Accomplishments

2024 was a productive year for Health Net's Quality Improvement Program. The following is a brief summary of some the key QI interventions and accomplishments for this period.

Health Education and Wellness

- Digital QR code resource
    - Extensive library of branded and non-branded health sheets
    - Digital resources for providers to support patients
    - Easy-to-scan QR codes and clickable URL links for members/patients on several health topics
- Established Health Education/Wellness pod to oversee all regulatory and active purchaser requirements, and vendor management for all lines of business.
- DHCS/DMHC approval and successful preparation for the January 1, 2025 implementation of the Teladoc Mental Health Digital Program for all lines of business.
- Approval of the new Diabetes Prevention Program (DPP) vendor for Medi-Cal.
- Continued partnership with Every Woman Counts to provide education on breast cancer and cervical cancer screenings.
- Measure specific accomplishments
    - Diabetes health support page established for all lines of business.
    - Preventive Screening Guidelines updated for Medi-Cal line of business.
- Launched new Commercial wellness incentive. Amount increased to up to $100, with more member choice to earn rewards, for most groups that have opted into member rewards.
- Monthly Wellness Webinar series continued to have high attendance. In 2024, there was on average 440 individuals who registered for the webinars and 229 participants that attended. In December, began offering a sign language interpreter for the monthly wellness webinar series.

- Continued the Health Net employee wellness program Healthy Living@Health Net. There were 8 Well-being Champions who reached 318 team members with monthly well-being content. SharePoint site had 156 unique users with 5,408 site visits.

Quality Indicators and Ratings

- Health Net obtained an overall 3-Star Rating for Medicare contracts H0562 and H7360 and a 2-Star Rating for the H3561 contract for Star Rating Year 2025
- Met 25-2-2 Exclusion Policy requirements for Covered California, for both Ambetter HMO and PPO for MY 2023 (MY 2024 results are pending).
- Maintained 3 Star rating on the QRS Global score for both Ambetter HMO and PPO QRS Global Rating.

Regulatory/Accreditation Requirements and Submissions

- Maintained NCQA Health Plan Accreditation through 2025.
- Renewed Health Equity Accreditation through and HEA Plus through 2027.
- The H0562 DSNP and CSNP Models of Care were submitted for renewal in 2024 and received passing scores of 96.2% and 98.8% respectively.
- Submitted D-SNP Models of Care to DHCS accounting for the updated care coordination requirements outlined in the D-SNP Policy. Off-cycle MOC submissions submitted to CMS to reflect changes.
- Completed annual update submissions for our Medicare Chronic Care Improvement Programs to CMS for all applicable Medicare products.
- Documentation and reporting of the annual SNP and MMP MOC evaluations and progress towards goals.
- Submitted annual update for the Medi-Cal Clinical and Non-Clinical DHCS Performance Improvement Projects (PIP) to the Health Services Advisory Group (HSAG).
- In collaboration with DHCS and The Institute for Healthcare Improvement (IHI), Health Net launched its first Child Health Equity Collaborative project. IHI and DHCS have designed a 12-month Child Health Equity Collaborative that focuses on supporting Managed Care Plans to implement best practices in children's preventive services with their network providers and plan-based teams to provide effective whole-person pediatric care. Critical elements to achieve this goal include effective team-based care, automation and effective use of technology, including Electronic Health Records, population health management, and addressing social drivers of health.
- Successfully completed the DHCS Quality Monitoring Improvement Program (QMIP) with over 35 deliverables submitted to DHCS in 2024 detailing the improvement projects that were implemented in the domains of Children's Health, Cancer Prevention, Behavioral Health, and Reproductive Health.

Quality Improvement Initiatives

- Legacy MHN live member outreach calls were also used as a supplemental data source to support FUA (Follow-up After ED Visit for Alcohol and Other Drug Abuse Dependence) and FUM (Follow-Up after ED Visit for Mental Health) metrics for all Health Net Medi-Cal lines of business. In MY 2024 for FUA, 1,482 out of 7,783 members were engaged via phone, for an overall reach rate of 19% for the year; for FUM, we engaged 1,637 out of 7,596 members in the eligible population, for an overall reach rate of 21.6% for the year.

- Continued implementation of a large-scale Quality Improvement Project (QIP) around health equity for a large purchaser.
- Continued offering the MyHealthPays member incentive to align with QTI measures. Provided $100 per QTI screening for childhood immunizations, colorectal cancer screenings, blood pressure screening, and A1c screening (new in 2024) for a total of $422 maximum reward.
- Participated in panel discussions with the American Cancer Society's HPV Roundtable. Continued to share ACS resources with Provider Engagement to promote starting the HPV vaccine at nine years of age.
- Partnered with 3 provider groups – Regal, Bakersfield Medical Group and Astrana – to distribute customized BP kits to promote self-measured blood pressure monitoring (SMBP) with clinical support and follow-up to confirm receipt, appropriate use and proper BP capture. A total of 252 kits were distributed as follows: Regal -152, BFMG-40 and Astrana-60).
- Shared member lists from bulk, in-home kit campaigns with PPGs for active follow-up, encouraging kit returns and care compliance. Uploaded lists into Cozeva for providers to more easily access.
- Developed a desktop procedure and process flow in collaboration with the HEDIS team for data reconciliation with providers and tested the data reconciliation process with W30-6+, W30-2+ and WCV. Discovered that W30-2+ and WCV are data lag issues. Fifty-four percent (54%) of W30-6+ providers who opted-in showed a year over year improvement in their W30-6+ rates.
- Developed a partnership with Black Infant Health (BIH) in Sacramento, San Joaquin/Stanislaus, Los Angeles and City of Long Beach to refer Medi-Cal members to BIH.
- Outreached to providers to reconcile CIS-10 data and outreach to members to bring them in to close care gaps. Offered a provider incentive to Exchange providers who closed CIS-10 care gaps in Q4 2024.
- Conducted member outreach for pediatric measures:
    - Monthly POMs for WCV with an average 86% reach rate
    - Quarterly POMs for W30-15 and CIS-10 with an average 91% reach rate.
    - Family Unit/Multigap HEDIS outreach calls
        - Commercial/Exchange overall reach rate = 25.7%
        - Medi-Cal overall reach rate = 20.15%
    - Dental quarterly POMs started in Quarter 3 with a 78% reach rate.
    - Email campaigns for CIS-10/W30-15, WCV and WCC.
    - Newsletter articles on dental and HPV.
- Provider Engagement training on pediatric measures, best practices and action planning.
- Provider live call outreach to share gap lists and receive records of care received.
- Distributed 20 point of care Lead Care II Analyzers to Medi-Cal provider offices.
- Distributed digital health education resources to provider offices.
- Updated the Newborn Checklist with updated information about the Newborn Gateway for Medi-Cal enrollment.
- Received 117 Confirmation of Pregnancy Forms for timely prenatal care. Eighty-eight Confirmation of Pregnancy Forms were completed correctly.

- Presented PPC performance data to 11 PPGs.
- Contracted with a provider to offer on-demand implicit bias and cultural humility training for 500 perinatal care and pediatric providers.
- D-SNP Community Health Worker initiative launched 10/7/24 for CBP and A1c - outreach capturing self-reported BP readings and completed A1c screenings with provider fax follow-up requesting medical records to count towards GSD care gap closure, and provider fax/faxback of compliant BP readings submitted as supplemental data for upload into Cozeva, with 13 CBP and 20 A1c faxes sent to providers.
- Launched targeted initiatives for Covered CA Quality Transformation Initiative (QTI), including:
    - Updated Direct Network Ambetter HMO/Ambetter PPO care gap incentive to pay out $100/care gap closed by colonoscopy annually to align with Cozeva (previously every 10 years for manual payments).
    - Mailed almost 7,000 care kits to all Ambetter members with an A1c, blood pressure, and/or medication adherence care gap.
    - Total of 1,214 providers identified for CBP low-volume provider outreach, with 100% calls attempted. Final reach rate was 51% (N=615), with providers committing to send data on 251 members (an additional 109 are pending appointments).
    - HEDIS team completed Power Automate outreach for Colorectal Cancer Screening to 430 providers.
    - Included in the following Corporate Marketplace programs: RxEffect and SureScripts to improve medication adherence rates; Radiology Incentive Program for breast cancer screening; Care Kits (expanded to include A1c in 2024).
- Expanded the Sharecare social needs screening (SNS) survey to include transportation and housing barriers (in addition to food insecurity which was launched in 2023), with referral to Find Help and Care Management for positive screens.
- Conducted educational training for the Provider Engagement (PE) team in collaboration with the HEDIS QIPM team to improve understanding and documentation of SNS-E requirements.
- Partnered with the HEDIS team to develop and refine documentation tools and best practices to support accurate capture of compliance codes for SNS-E.
- Initiated the SNS-E tip sheet draft to provide a quick reference guide for providers and internal teams, ensuring alignment with measure requirements.
- Launched the Medicare Partnership for Quality (P4Q) Program in Cozeva in May offering incentives to PCPs for closing care gaps (16 measures).
- Targeted 22 PPGs for monthly Pharmacy discussions and strategic planning to support Part D measures as well as streamlined Part D adherence only reports for select groups in Q4.
- Conducted OMW outreach to providers that yielded 83 supplemental hits toward care gap closure.
- HEDIS Multi-Gap Q4 Push Calls reached 20% of 3,936 attempted members (data through 12/30/24). Seventy members scheduled appointments with 48 members that will schedule.
- Osteoporosis Screening Radiology Incentive Program - engaging 83% of targeted provider groups and covering 91% of open MY24 OMW care gaps with upcoming due dates.

- Health Net pioneered in 2023 a Lead Blood Analyzer initiative for lead blood screening in children with funding for point of care (POC) Lead Care II lead blood analyzers including a one-year supply of test kits for Providers to perform POC lead blood testing in their offices. Year to date we have provided 21 analyzers to Providers. There has been an upward trend in overall compliance from Q1 to Q2 2024 of 5.14%.
- Enhanced the internal process for the Mobile Mammography program which led to closer engagement with the Provider Facing Teams to schedule mobile mammography events in an effort to expand access to Breast Cancer Screenings. As part of this enhancement, a POD member provided close monitoring and oversight, attended regular office hours with the PE/PEAE, shared target PPG lists, and also developed FAQ sheets to address common questions/issues pertinent to the program. This enhancement led to 69 Total Mobile Mammography Events (majority MCAL) and 1,066 mobile mammography screenings completed in 2024.
- Developed and implemented a data reconciliation e-campaign utilizing Power Automate. QI identified data gaps for W30-6+ and the HEDIS QIPM analyzed data that identified suspected data gaps for W30-2+ and WCV, specifically for 7–11-year-olds. The HEDIS QIPM set up the workflow in Power Automate, collected provider office contacts and email addresses, drafted the email content for the initial outreach, follow-up outreaches and the welcome email once providers opted-in to the process. The HEDIS QIPM team was able to track the providers who engaged in the data reconciliation process.
- Launched community partnerships with Black Infant Health (BIH) and Penny Lane, an Enhanced Care Management (ECM) provider to help support the Medi-Cal Clinical Performance Improvement Projects (PIP) with a focus on improving the W30-6+ measure for Health Net's Black/African American membership population.
- Updated over 20 HEDIS Tip Sheets and guides to support provider education on priority measures across lines-of-business.

Quality Improvement Department and Programs

- Continued Quality Governance Committee, chaired by the Senior Director of Quality Improvement.
- Approved and processed 663 Quality EDGE requests supporting providers and members with over $4,100,00 in funds across lines-of-business.
- In support of the Quality EDGE programs, the Quality Improvement Research and Analysis (QIRA) team developed a Priority Provider Profile built within a Power-BI dashboard that allows internal stakeholders the ability to segment priority HEDIS outcomes across individual practitioners and providers throughout the HEDIS measurement year, across all major lines of business and products. Year-over-year (YOY) and month-over-month (MOM) comparison allows teams to track performance and pacing towards the company's goals and established benchmarks.

Section 6: Annual QI Program Changes

Based on this evaluation, Health Net's Quality Management department effectively met safe clinical practice goals, had adequate resources, and a strong QI Committee structure, which

included productive practitioner participation and effective leadership. To ensure more alignment across all lines of business, Quality Management will continue as a centralized department, serving multiple business functions, and will continue to leverage Corporate Centene materials, activities, and reporting along with its internal processes. The pod approach continues to strengthen Health Net's standardized approach to quality improvement. In 2025, the Quality Improvement department will continue to focus on its strategy of provider engagement, direct care gap closure, and leveraging Corporate vendors and partners. There will be an emphasis on delivering more timely and user-friendly reports to providers to facilitate actionable care gap closure.

Section 7: Appendix

For 2025, the following measures are areas of focus, or opportunities for improvement based off of 2024 results, across all lines of business:

Table A-1. Opportunities for 2025 by Category

Adult Health Opportunities	Pediatric/Perinatal/Dental Health Opportunities
Chronic Care • Controlling Blood Pressure (CBP) ●●●● • HBD/GSD ●●●● • Management of Osteoporosis (OMW) ● • Eye Exam for Patients with Diabetes (EED) ● • Kidney Health Evaluation for Patients with Diabetes (KED) ●● • Health Outcomes Survey: Improving Physical Health (IMPH) ● • Health Outcomes Survey: Monitoring Physical Activity (MPA) ● • Health Outcomes Survey: Improving Bladder Control (MUI) ● • Health Outcomes Survey: Reducing Risk of Falls (RRF) ● **Preventive Care Opportunities** • Breast Cancer Screening (BCS) ●●●● • Cervical Cancer Screening (CCS) ●●● • Chlamydia Screening (CHL) ●●● • Colorectal Cancer Screening (COL) ●●●●	**Maternal Health** • Timeliness of Prenatal Care (PPC-Pre) ●●● • Postpartum Care (PPC-Post) ●●● **Child/Adolescent Health** • Children Under 2 Years Completing Immunizations (CIS-10) ●●● • Improve Immunization Status for Adolescents (IMA-2) ●● • Weight Assessment and Counseling (WCC) ●● • Developmental Screening in the First Three Years of Life (DEV) ● • Lead Screening in Children (LSC) ● • Well-Child Visits in the First 30 Months of Life (W30-2+/W30-6+) ●●● • Weight Assessment and counseling for Nutrition and Physical Activity for Children/Adolescents: BMI Percentile Documentation (WCC) ●● • Child and Adolescent Well-Care Visits for 3-18 Years of Age (WCV) ●● **Dental Health** • Topical Fluoride for Children (TFL-CH) ●● • Oral Evaluation, Dental Services (OED/OEV) ●
Behavioral Health Opportunities	**Care Coordination/Member Engagement Opportunities**

- Follow-Up After ED Visit for Substance Use – 7 Days (FUA) ●●
- Follow-Up After ED Visit for Substance Use – 30 Days (FUA) ●●
- Follow-Up After Hospitalization – 7 Days (FUH) ●●
- Follow-Up After Hospitalization – 30 Days (FUH) ●●
- Follow-Up After ED Visit for Mental Health – 7 Days (FUM) ●●●●
- Follow-Up After ED Visit for Mental Health – 30 Days (FUM) ●●●●
- Depression Remission & Response (DRR) ●
- Depression Screening & Follow Up (DSF) ●●●
- Initiation and Engagement in Alcohol and Other Drug Dependence Treatment (IET) ●
- Integrative Medicine for Mental Health (IMMH) ●
- AAP ●
- Care for Older Adults Functional Status Assessment (COA-FS) ●
- Care of Older Adults –Medication Review (COA-MR) ●
- Follow up After Emergency Dept Visit/Chronic Condition (FMC) ●
- Initial Health Assessment/Annual Wellness Visit (IHA/AWC) ●●●●
- Plan All-Cause Readmissions (PCR) ●●●
- Social Need Screening and Intervention (SNS-E) ●●
- Transitions of Care – Average (TRC-AVE) ●
- Transitions of Care - Medication Reconciliation Post Discharge (TRC-MRP) ●
- Transitions of Care - Patient Engagement (TRC-PE) ●

Overuse/Hospital Quality/Patient Safety Opportunities

Overuse:

- Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) ●●
- Appropriate Testing for Pharyngitis (CWP) ●●
- Low Back Pain (LBP) ●●
- Appropriate Treatment for Upper Respiratory Infection (URI) ●●

Member Experience – CAHPS Opportunities

- Adult Immunization Status - Flue (AISE) ●●●

Pharmacy and Related Measures

- Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO) ●
- Asthma Medication Ratio (AMR) ●●●
- Cardiovascular Magnetic Resonance (CMR) ●
- Concurrent Use of Opioids and Benzodiazepines (COB) ●●
- Use of Opioids at High Dosage (HDO) ●
- International Normalized Ratio Monitoring for Individuals on Warfarin (INR) ●
- Medication Adherence for Cholesterol (MAC/PDC-Statin) ●●●

Provider Surveys Opportunities

PAAS (Provider Appointment Availability Survey)

- Non-Urgent and Urgent Care Appointments for PCPS and Specialists (non-BH) ●●●
- Non-Urgent and Urgent Care Services with Specialists (BH and non-BH) ●●●

PAHAS (Provider After-Hours Availability Survey)

- Ability to contact on-call physician after-hours within 30 minutes ●●●

PSS (Provider Satisfaction Survey)

- All measures for non-behavioral health responders ●●●

• Medication Adherence for Diabetes Medications (MAD/PDC-Diabetes) ●●● • Medication Adherence for Hypertension MAH/PDC RAS ●●● • Persistence of Beta-Blocker Treatment After a Heart Attack (PBH) ● • Pharmacotherapy for Opioid Use Disorder (POD) ● • Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH) ● • Polypharmacy: Use of Multiple Central Nervous System (Poly-CNS) ● • Statin Therapy for Patients With Cardiovascular Disease (SPC) ●● • Statin Use in Persons with Diabetes (SUPD) ●●	

Medicare	●
Commercial	●
Marketplace	●
Medi-Cal	●

Table A-2. Summary of Outcomes by Category - Medicare, Commercial, Exchanges (RY 2024)

Category	*Medicare*		*Commercial*		*Marketplace*		*Total*	
	N	%	N	%	N	%	N	%
Adult Chronic Care	7/16	43.75%	6/18	33.33%	2/8	25%	**15/44**	**34.09%**
Adult Preventive Care and Utilization	5/10	50%	1/12	8.33%	0/12	0%	**6/34**	**17.65%**
Adult Survey (CAHPS)	0/7	0%	1/10	10%	0/8	0%	**1/25**	**4%**
Provider Surveys	3/12	25%	24/42	57.14%	8/13	61.54%	**35/67**	**52.24%**
Older Adults	6/13	46.15%	N/A	N/A	N/A	N/A	**6/15**	**40%**
Maternal and Child Care	N/A	N/A	1/20	5%	1/22	4.54%	**2/42**	**4.76%**
Behavioral Health	4/12	33.33%	0/16	0%	2/12	16.67%	**4/40**	**10%**
Total	**25/70**	**35.71%**	**33/118**	**27.97%**	**13/75**	**17.33%**	**69/267**	**25.84%**

Table A-3. Summary of Outcomes by Category - Medi-Cal (RY 2024)

Category	*Medi-Cal*	
	N	%
Adult Chronic Care	1/9	11.11%

Adult Preventive Care and Utilization	0/6	0%
Adult Member Survey (CAHPS)	2/5	40%
Provider Surveys	12/27	44.44%
Older Adults	N/A	N/A
Maternal and Child Care	0/13	0%
Behavioral Health	0/4	0%
Total	**15/64**	**23.44%**

Note: Quality of Care HEDIS metrics are based on Accreditation plan level rates.

Table A-4. Progress to RY 2024 Goals – Adult Chronic Care Outcomes (HEDIS)

	Medicare				*Commercial*				*Marketplace*						*Medi-Cal*	
MEASURE	**CA HMO**	**Goal Met**	**CA HMO H3561**	**Goal Met**	**CA HMO**	**Goal Met**	**CA PPO**	**Goal Met**	**CA EX HMO/ HSP**	**Goal Met**	**CA EX PPO**	**Goal Met**	**CA EX EPO**	**Goal Met**	**CA MCL**	**Goal Met**
Asthma Medication Ratio	67.35%	N/A	60.36%	N/A	75.29%		74.60%		69.70%		68.55%		N/R		57.56%	
COPD – Corticosteroid	66.99%		69.33%		73.24%		50.00%		N/R		N/R		N/R		61.82%	
COPD – Bronchodilator	78.97%		85.14%	✓	90.14%	✓	75.00%	✓	N/R		N/R		N/R		83.27%	
Beta Blocker after Heart Attack	52.5%		59.18%		60.42%		66.67%		N/R		N/R		N/R		50.23%	
Diabetes – Eye Exam	79.32%	✓	77.14%	✓	57.22%		45.26%		46.96%		32.36%		N/R		55.61%	
Diabetes – Kidney Monitoring	66.24%	✓	65.74%	✓	62.57%	✓	48.85%		60.01%	✓	46.80%	✓	N/R		51.47%	✓
Diabetes – Blood Sugar Control-A1c<8	74.45%		70.07%		63.46%		67.64%	✓	N/R		N/R		N/R		51.81%	
**Diabetes – Blood Sugar Control – A1c>9*	12.17%	✓	18.25%	✓	27.35%	✓	24.82%	✓	21.65%	N/A	29.68%	N/A	N/R		37.67%	
Controlled Blood Pressure	76.16%		76.40%		70.36%		61.80%		62.50%		61.10%		N/R		65.46%	

N/A *– Not Applicable*
NR *– Not reported due to small denominator*
**As of 2024, CMS QRS reporting A1c>9 (A1c poor control) replaced A1<8 as a new QRS measure.*
^Administrative rate only

Table A-5. Progress to RY 2024 Goals – Adult Preventive Care and Utilization Outcomes (HEDIS)

	Medicare				*Commercial*				*Marketplace*						*Medicaid*	
MEASURE	**CA HMO**	**Goal Met**	**CA HMO H3561**	**Goal Met**	**CA HMO**	**Goal Met**	**CA PPO**	**Goal Met**	**CA EX HMO/HSP**	**Goal Met**	**CA EX PPO**	**Goal Met**	**CA EX EPO**	**Goal Met**	**CA MCL**	**Goal Met**
Breast Cancer Screening-	78.09%	✓	71.54%		76.79%		70.16%		71.36%		53.11%		N/R		53.96%	
Colorectal Cancer Screening-	75.35%	✓	69.64%		58.96%		50.13%		56.44%		37.79%		N/R		34.85%	
Cervical Cancer Screening	N/A		N/A		74.52%		70.49%		63.27%		47.23%		N/R		49.62%	
Flu Vaccine	75%	✓	63%		35.42%		31.38%	✓	26.76%		20.97%		N/R		17.67%	
Low Back Pain	N/A		N/A		73.75%		74.33%		74.92%		75.34%		N/R		72.17%	
Avoid Antibiotics for Bronchitis	27.98%		30.85%		46.81%		44.44%		33.45%		32.72%		N/R		47.64%	
Prevent Readmission	10%	✓	10%	✓	**		**		**		**		N/R		N/A	

N/A *– Not Applicable*
NR *– Not reported due to small denominator*
***Observed to expected ratio*
^Administrative rate only

Table A-6. Progress to RY 2024 Goals – Adult Survey Outcomes (CAHPS)

	Medicare				Commercial				Marketplace				Medicaid	
MEASURE	CA HMO	Goal Met	CA HMO H3561	Goal Met	CA HMO	Goal Met	CA PPO	Goal Met	[1]CA EX HMO/ HSP	Goal Met	[1]CA EX PPO	Goal Met	CA MCL	Goal Met
Getting Needed Care	77%		72%		69.2%		68.3%		70.8%		61.4%		74.5%	
Getting Care Quickly	79%		NR		70.2%		80.2%		68.6%		57.0%		77.5%	✓
Care Coordination	84%		NR		81.4%	✓	78.9%		82.1%		75.2%		78.9%	
Rating of Health Care	84%		NR		49.8%		41.3%		79.0%		70.0%		54.7%	✓
Customer Service	87%		85%		78.2%		70.1%		N/A		N/A		85.9%	

Table A-7. Progress to RY 2023 Goals – Older Adult Outcomes (HEDIS)

	Medicare			
MEASURE	CA HMO	Goal Met	CA HMO H3561	Goal Met
Fall Risk Management	64%	✓	64%	✓
Urinary Incontinence Management	44%		NR	
Monitoring Physical Activity	55%	✓	44%	
Medication Reconciliation Post-Discharge	72.51%	✓	64.23%	
Management of Osteoporosis	50.39%		49.66%	

Older Adults – Assess Functional Status	54.46%	N/A	62.93%	N/A
Older Adults – Assess Pain	95%	✓	87%	
Older Adults – Medication Review	99%	✓	88%	

N/A *– Not Applicable*
NR *– Not reported due to small denominator*

Table A-8. Progress to RY 2024 Goals – Maternal and Child Health Outcomes (HEDIS)

	Commercial				*Marketplace*						*Medi-Cal*	
MEASURE	**CA HMO**	**Goal Met**	**CA PPO**	**Goal Met**	**CA EX HMO/ HSP**	**Goal Met**	**CA EX PPO**	**Goal Met**	**CA EX EPO**	**Goal Met**	**CA MCL**	**Goal Met**
Prenatal Care	93.71%		91.70%	✓	92.38%	✓	88.44%		N/R		87.50%	
Postpartum Care	93.71%		84.72%		83.41%		86.71%		N/R		82.64%	
Childhood Immunization Status – Combo 2	N/R		N/R		N/R		N/R		N/R		N/R	
Childhood Immunization Status – Combo 3	73.91%		53.71%		N/R		N/R		N/R		60.83	
Childhood Immunization Status – Combo 10	52.78%		39.30%		25.00%		42.11%		N/R		28.71	
Developmental Screening in the First 3 Years of Life (DEV)	N/A		N/A		N/A		N/A				32.88%	
Immunizations for Adolescents – Combo 2 (IMA-2)	38.74%		23.21%		31.06%		21.69%		NR		36.26%	
Lead Screening in Children (LSC)	N/A		N/A		N/A		N/A				53.53%	
Oral Evaluation, Dental Services (OED)	N/A		N/A		19.97%		33.36%				43.37%	

Topical Fluoride Application for Children	N/A		N/A		N/A		N/A				10.13%	
Weight Assessment and Counseling – BMI Percentile	78.16%		68.96%		75.77%	**	73.83%	**	N/R		86.96%	
Weight Assessment and Counseling – Counseling for Nutrition	72.95%		N/R		73.72%	**	64.20%	**	N/R		N/A	
Weight Assessment and Counseling – Counseling for Physical Activity	68.24%		N/R		70.66%	**	60.25%	**	N/R		N/A	
Well Child Visits in the First 30 Months of Life – 0–15 Months	76.34%		62.56%		45.07%		36.73%		N/R		52.15%	
Well Child Visits in the First 30 Months of Life – 15–30 Months	85.92%		77.52%		78.26%		66.67%		N/R		62.05%	
Child and Adolescent Well-Care Visits	54.58%		50.76%		43.50%		33.82%		N/R		45.18%	

N/A *– Not Applicable*
NR *– Not reported due to small denominator*
*** - Used the MY 2023 National Quality Compass Commercial 75th percentile as the benchmark. The WCC measures did not meet goal.*
^Administrative rate only

Table A-9. Progress to RY 2024 Goals – Behavioral Health Outcomes (HEDIS)

	Medicare				***Commercial***				***Marketplace***						***Medi-Cal***	
MEASURE	**CA HMO**	**Goal Met**	**CA HMO H3561**	**Goal Met**	**CA HMO**	**Goal Met**	**CA PPO**	**Goal Met**	**CA EX HMO/ HSP**	**Goal Met**	**CA EX PPO**	**Goal Met**	**CA EX EPO**	**Goal Met**	**CA MCL**	**Goal Met**
Antidepressant Management – Acute Phase	80.13%		77.77%		73.63%		71.03%		66.99%		67.96%		N/R		61.35%	
Antidepressant Management – Continuation Phase	61.00%		57.30%		56.91%		56.07%		50.61%		50.83%		N/R		41.15%	

Follow-Up After Hospitalization for Mental Illness – 7 days	30.77%	✓	23.61%		56.75%		47.06%		34.44%		39.18%		N/R		N/A	
Follow-Up After Hospitalization for Mental Illness – 30 days	50.77%	✓	40.00%		76.09%		63.24%		70.00%		70.10%		N/R		N/A	
Initiation of Substance Use Disorder Treatment	15.16%		39.26%	✓	28.87%		32.87%		32.17%		45.42%	✓*	N/R		N/A	
Engagement of Substance Use Disorder Treatment	1.46%		5.00%	✓	11.16%		15.73%		10.68%		18.98%	✓*	N/R		N/A	
Follow-Up for Children on ADHD Medication – Initiation	N/A		N/A		37.74%		35.48%		N/R		N/R		N/R		41.51%	
Follow-Up for Children on ADHD Medication – Continuation and Maintenance	N/A		N/A		40.83%		25.00%		N/R		N/R		N/R		41.10%	

N/A *– Not Applicable*
NR *– Not reported due to small denominator*
^Administrative rate only
**Given no Exchange benchmarks for Initiation/Engagement of Substance Use Disorder(IET), Commercial National Quality Compass benchmark was used as proxy.*

Table A-10. Medicare RY 2024 CAHPS Survey Summary

MEASURE	**CA Medicare H0562**				**CA Medicare H3561**				**WellCare H5087**			
	2023 Final		**2024 Final**		**2023 Final**		**2024 Final**		**2023 Final**		**2024 Final**	
	Score	**Star**	**Score**	**Star**	**Score**	**Star**	**Score**	**Star**	**Score**	**Star**	**Score**	**Star**
Annual Flu Vaccine	75	4	75	4	64	2	63	2	69	3	68	3
Getting Needed Care	76	2	77	2	76	2	72	1	71	1	74	1
Getting Care Quickly	75	2	79	1	72	2	N/A	N/A	N/A	N/A	N/A	N/A
Customer Service	87	1	87	2	87	1	85	1	N/A	N/A	N/A	N/A
Rating of Health Plan	85	2	85	2	82	1	79	1	84	2	85	2

Rating of Health Care Quality	85	2	84	2	81	1	N/A	N/A	N/A	N/A	N/A	N/A
Care Coordination	82	1	84	2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Rating of Drug Plan	85	3	86	3	85	2	82	1	84	2	87	3
Getting Needed Prescription Drugs	88	2	87	2	86	1	N/A	N/A	N/A	N/A	N/A	N/A

** Final scores are case-mix adjusted mean scores provided by CMS.*
*** Star ratings are final provided by CMS.*

2024 star higher than 2023 2024 star lower than 2023

Table A-11. Commercial HMO/POS RY 2024 CAHPS Survey Summary

	2023 Final		2024 Final	
Measure	**Rate**	**Percentile**	**Rate**	**Percentile**
Getting Needed Care	73.9%	<5th	69.2%	<5th
Getting Care Quickly	71.7%	<5th	70.2%	5th
How Well Doctors Communicate	89.6%	<5th	94.4%	25th
Customer Service	76.3%	<5th	78.2%	<5th
Claims Processing	79.6%	<5th	78.0%	<5th
Care Coordination	78.2%	10th	81.4%	25th
Rating of Health Care Quality	74.8%	25th	69.1%	10th
Rating of Personal Doctor	78.8%	5th	80.6%	10th
Rating of Specialist	80.6%	10th	79.3%	10th
Rating of Health Plan	64.2%	25th	65.5%	50th
Advising Smokers and Tobacco Users to Quit	73.3%	75th	72.0%	75th
Discussing Cessation Medications	46.7%	75th	33.3%	75th
Discussing Cessation Strategies	46.7%	75th	37.0%	75th

**2024 Percentile is based on final top box rate against 2024 National Quality Compass percentile cut points (non-PPO and PPO). All the 4 Overall Rating measures are rates of the top 8, 9, 10 categories.*
The QC HMO and PPO benchmark for the smoking measures was not reported/provided by NCQA due to low response rates across plans.

2024 percentile higher than 2023 2024 percentile lower than 2023

Table A-12. Commercial PPO RY 2024 CAHPS Survey Summary

	2023 Final		2024 Final	
Measure	Rate	Percentile	Rate	Percentile
Getting Needed Care	69.9%	<5th	68.3%	<5th
Getting Care Quickly	68.6%	<5th	80.2%	10th
How Well Doctors Communicate	94.3%	10th	92.1%	5th
Customer Service	70.6%	<5th	70.1%	75th
Claims Processing	67.2%	<5th	69.8%	<5th
Care Coordination	84.1%	50th	78.9%	10th
Rating of Health Care Quality	71.0%	10th	66.1%	10th
Rating of Personal Doctor	86.9%	50th	77.8%	5th
Rating of Specialist	78.0%	5th	78.3%	10th
Rating of Health Plan	56.1%	10th	49.0%	<5th
Advising Smokers and Tobacco Users to Quit	57.1%	75th	55.6%	75th
Discussing Cessation Medications	25.0%	75th	20.0%	75th
Discussing Cessation Strategies	12.5%	75th	10.0%	75th

**2024 Percentile is based on final top box rate against 2024 National Quality Compass percentile cut points (non-PPO and PPO). All the 4 Overall Rating measures are rates of the top 8, 9, 10 categories. The QC HMO and PPO benchmark for the smoking measures was not reported/provided by NCQA due to low response rates across plans.*

2024 percentile higher than 2023 2024 percentile lower than 2023

Table A-13. Exchanges HMO and PPO RY 2024 CAHPS Survey Summary

	Covered CA HMO				Covered CA Health Net PPO			
	2023 QHP Final		2024 QHP Final		2023 QHP Final		2024 QHP Final	
Measure	Score	Percentile	Score	Percentile	Score	Percentile	Score	Percentile
Access to Care	65.1%	10th	69.2%	25th	59.8%	<5th	59.7%	<5th
Getting Care Quickly	63.1%		68.6%	N/A	55.6%		57.0%	N/A
Getting Needed Care	62.9%		70.8%	N/A	62.5%		61.4%	N/A
Care Coordination	74.7%	<5th	82.1%	25th	73.7%	<5th	75.2%	<5th
Cultural Competence	58.7%		65.9%	N/A	56.2%		64.7%	N/A

Access to Information	53.1%	50th	65.9%	75th	51.5%	50th	64.7%	75th
Assistance Smoking and Tobacco Use Cessation	55.7%	75th	58.3%	75th	0.0%	75th	22.0%	75th
Rating of All Health Care	73.5%	5th	77.2%	10th	74.7%	5th	69.7%	<5th
Rating of Personal Doctor	82.2%	<5th	86.0%	10th	86.2%	10th	81.6%	<5th
Rating of Specialist	77.5%	<5th	83.7%	10th	87.5%	75th	81.5%	<5th
Rating of Health Plan	70.7%	50th	74.5%	75th	65.1%	10th	63.4%	5th
Plan Administration	63.2%	5th	67.9%	25th	55.8%	<5th	63.3%	5th

** 2024 and 2023 QHP final scores are case-mix adjusted scores (in normal font) and scaled mean scores (in italics).*
The 2024 percentile is based on the displayed score against the 2023 QHP Proof Sheet benchmark.
No 2023 benchmark for the measures Getting Care Quickly, Getting Needed Care, Cultural Competence, and Assistance Smoking and Tobacco Use Cessation.

2024 percentile higher than 2023 2024 percentile lower than 2023

Table A-14. Medi-Cal RY 2024 CAHPS Survey Summary

	2023 Final		2024 Final	
Measure	Rate	Percentile	Rate	Percentile
Getting Needed Care	75.3%	10th	74.5%	<5th
Getting Care Quickly	75.3%	10th	77.5%	25th
How Well Doctors Communicate	87.7%	<5th	92.2%	25th
Customer Service	88.1%	25th	85.9%	5th
Care Coordination	85.7%	50th	78.9%	<5th
Rating of Health Care Quality	67.9%	5th	74.6%	25th
Rating of Personal Doctor	78.0%	10th	80.8%	10th
Rating of Specialist	75.6%	10th	83.2%	25th
Rating of Health Plan	71.0%	5th	78.4%	50th
Advising Smokers and Tobacco Users to Quit	71.1%	25th	64.1%	5th
Discussing Cessation Medications	38.5%	<5th	36.9%	<5th
Discussing Cessation Strategies	28.2%	<5th	32.8%	<5th

*2024 Goals: Getting Needed Care Goal: 17.5th Percentile (76%), Rating of Health Plan Goal: 10th Percentile (71%). *2024 Percentile is based on 2024 National Quality Compass percentile cut points.*

2024 percentile higher than 2023 2024 percentile lower than 2023

Table A-15. Provider Appointment Availability Results – Commercial HMO/POS

				HMO/POS		
Access Measure	**Standard**	**Source**	**Performance Goal**	**2022 n (%)**	**2023 n (%)**	**Goal Met**
Access to Primary Care Physicians (PCPs)						
Urgent Care Appointment with PCP	Within 48 hours of request	PAAS	70%	8542 (50.4)	6281 (70.0) ↑	Yes
Non-Urgent Appointment with PCP	Within 10 business days of request		70%	8954 (74.9)	6590 (79.7) ↑	Yes
Access to Specialty Care Physicians (SCP)						
Urgent care services with Specialist	Within 96 hours of request	PAAS	70%	6144 (37.8)	5819 (59.1) ↑	No
Non-Urgent Appointment with Specialist	Within 15 business days of request		70%	6893 (54.6)	6639 (62.5) ↑	No
Access to Specialty Care Physicians (SCP) – High Volume (Obstetrics/Gynecology)						
Urgent care services with Specialist	Within 96 hours of request	PAAS	70%	551 (44.6)	213 (56.3)	No
Non-Urgent Appointment with Specialist	Within 15 business days of request		70%	593 (69.0)	224 (71.0)	Yes
Access to Specialty Care Physicians (SCP) – High Impact Specialists (Oncology)						
Urgent care services with Specialist	Within 96 hours of request	PAAS	70%	254 (47.2)	17 (64.7)	No
Non-Urgent Appointment with Specialist	Within 15 business days of request		70%	272 (78.7)	17 (88.2)	Yes
Access to Ancillary Providers - Physical Therapy, Mammogram						
Non-Urgent Ancillary *Services*	Within 15 business days of request	PAAS	70%	1246 (88.7)	1301 (92.9)	Yes
Access to Mental Health Providers – Psychiatrists, Non-Physician Mental Health						
Urgent Care services with Specialist (Psychiatrist)	Within 96 hours of request	PAAS	70%	2399 (38.3)	1918 (60.1) ↑	No
Non-Urgent Appointment with Specialist (Psychiatrist)	Within 15 business days of request		70%	2754 (68.7)	2244 (80.7) ↑	Yes

Urgent Care services with NPMH Provider	Within 96 hours of request		70%	4470 (58.1)	4322 (76.9) ↑	Yes
Non-Urgent Appointment with NPMH provider	With 10 business days of request		70%	5334 (79.1)	5260 (85.6) ↑	Yes

Table A-16. Provider Appointment Availability Results – Commercial Marketplace

			Commercial Marketplace			
Access Measure	**Standard**	**Source**	**Performance Goal**	**2022 n (%)**	**2023 n (%)**	**Goal Met**
Access to Primary Care Physicians (PCPs)						
Urgent Care Appointment with PCP	Within 48 hours of request	PAAS	70%	4780 (55.1)	2515 (74.4) ↑	Yes
Non-Urgent Appointment with PCP	Within 10 business days of request		70%	4949 (77.3)	2637 (83.7) ↑	Yes
Access to Specialty Care Physicians (SCP)						
Urgent care services with Specialist	Within 96 hours of request	PAAS	70%	3127 (44.8)	2567 (70.0) ↑	Yes
Non-Urgent Appointment with Specialist	Within 15 business days of request		70%	3445 (62.6)	2585 (70.0) ↑	Yes
Access to Specialty Care Physicians (SCP) – High Volume (Obstetrics/Gynecology)						
Urgent care services with Specialist	Within 96 hours of request	PAAS	70%	182 (42.3)	61 (47.5)	No
Non-Urgent Appointment with Specialist	Within 15 business days of request		70%	192 (69.3)	68 (69.1)	No
Access to Specialty Care Physicians (SCP) – High Impact Specialists (Oncology)						
Urgent care services with Specialist	Within 96 hours of request	PAAS	70%	83 (42.2)	11 (54.5)	No
Non-Urgent Appointment with Specialist	Within 15 business days of request		70%	90 (75.6)	15 (80.0)	Yes
Access to Ancillary Providers - Physical Therapy, Mammogram						
Non-Urgent Ancillary Services	Within 15 business days of request	PAAS	70%	1474 (92.6)	956 (97.1)	Yes

Access to Mental Health Providers – Psychiatrists, Non-Physician Mental Health						
Urgent Care services with Specialist (Psychiatrist)	Within 96 hours of request	PAAS	70%	2433 (41.3)	1276 (64.3) ↑	No
Non-Urgent Appointment with Specialist (Psychiatrist)	Within 15 business days of request		70%	2734 (68.0)	1440 (83.3) ↑	Yes
Urgent Care services with NPMH Provider	Within 96 hours of request		70%	4175 (57.9)	2913 (77.4) ↑	Yes
Non-Urgent Appointment with NPMH provider	With 10 business days of request		70%	4924 (81.1)	3385 (85.8) ↑	Yes

Table A-17. Provider Appointment Availability Results – Medicare

			Medicare			
Access Measure	**Standard**	**Source**	**Performance Goal**	**2022 n (%)**	**2023 n (%)**	**Goal Met**
Access to Primary Care Physicians (PCPs)						
Urgent Care Appointment with PCP	Within 48 hours of request	PAAS	70%	1666 (55.5%)	1080 (61.2%)	No
Non-Urgent Appointment with PCP	Within 10 business days of request		70%	1743 (79.5%)	1129 (78.2%)	Yes
Access to Specialty Care Physicians (SCP)						
Urgent care services with Specialist	Within 96 hours of request	PAAS	70%	2577 (42.3%)	735 (49.9%)	No
Non-Urgent Appointment with Specialist	Within 15 business days of request		70%	2763 (65.2%)	819 (68.9%)	No
Access to Specialty Care Physicians (SCP) – High Volume (Obstetrics/Gynecology)						
Urgent care services with Specialist	Within 96 hours of request	PAAS	70%	414 (40.3%)	193 (52.8%)	No
Non-Urgent Appointment with Specialist	Within 15 business days of request		70%	441 (68.5%)	197 (53.2%)	No
Access to Specialty Care Physicians (SCP) – High Impact Specialists (Oncology)						

Urgent care services with Specialist	Within 96 hours of request	PAAS	70%	198 (43.4%)	60 (58.3%)	No
Non-Urgent Appointment with Specialist	Within 15 business days of request		70%	208 (77.4%)	67 (80.6%)	Yes
Access to Mental Health Providers – Psychiatrists, Non-Physician Mental Health						
Urgent Care services with Specialist (Psychiatrist)	Within 96 hours of request	PAAS	70%	255 (37.0%)	697 (47.0%)	No
Non-Urgent Appointment with Specialist (Psychiatrist)	Within 15 business days of request		70%	283 (62.0%)	797 (69.0%)	No
Urgent Care services with NPMH Provider	Within 96 hours of request		70%	1248 (57.0%)	1124 (50.0%)	No
Non-Urgent Appointment with NPMH provider	With 10 business days of request		70%	1436 (79.0%)	1299 (82%)	Yes

Table A-18. Provider Appointment Availability Results – Medi-Cal

				Medi-Cal		
Access Measure	**Standard**	**Source**	**Performance Goal**	**2022 n (%)**	**2023 n (%)**	**Goal Met**
Access to Primary Care Physicians (PCPs)						
Urgent Care Appointment with PCP	Within 48 hours of request	PAAS	70%	2192 (56.3%)	1358 (78.4%) ↑	Yes
Non-Urgent Appointment with PCP	Within 10 business days of request		70%	2256 (81.3%)	1415 (86.2%) ↑	Yes
Access to Specialty Care Physicians (SCP)						
Urgent care services with Specialist	Within 96 hours of request	PAAS	70%	2480 (42.2%)	1382 (66.0%) ↑	No
Non-Urgent Appointment with Specialist	Within 15 business days of request		70%	2692 (62.3%)	1515 (68.3%) ↑	No
Access to Specialty Care Physicians (SCP) – High Volume (Obstetrics/Gynecology)						
Urgent care services with Specialist	Within 96 hours of request	PAAS	70%	91 (45.3%)	55 (63.6%)	No

Non-Urgent Appointment with Specialist	Within 15 business days of request		70%	153 (70.5%)	59 (84.7%)	Yes
Access to Specialty Care Physicians (SCP) – High Impact Specialists (Oncology)						
Urgent care services with Specialist	Within 96 hours of request	PAAS	70%	31 (41.9%)	4 (75.0%)	No
Non-Urgent Appointment with Specialist	Within 15 business days of request		70%	58 (74.0%)	4 (100.0%)	Yes
Access to Ancillary Providers - Physical Therapy, Mammogram						
Non-Urgent Ancillary Services	Within 15 business days of request	PAAS	70%	120 (89.2%)	244 (96.3%) ↑	Yes
Access to Mental Health Providers – Psychiatrists, Non-Physician Mental Health						
Urgent Care services with Specialist (Psychiatrist)	Within 96 hours of request	PAAS	70%	375 (36.9%)	245 (62.0%)↑	No
Non-Urgent Appointment with Specialist (Psychiatrist)	Within 15 business days of request		70%	404 (65.3%)	269 (82.5%)↑	Yes
Urgent Care services with NPMH Provider	Within 96 hours of request		70%	949 (61.6%)	820 (76.2%)↑	Yes
Non-Urgent Appointment with NPMH provider	With 10 business days of request		70%	1113 (83.2%)	945 (84.3%)↑	Yes

Table A-19. Provider Satisfaction Survey Results – Commercial HMO-POS

Access Measure	***Source***	***Commercial HMO-POS***	
		MY 2022 (%)	***MY 2023 (%)***
Referral and/or prior authorization process	Health Net Provider	72.8	81.7
Access to urgent care		82.6	79.7
Access to non-urgent primary care		80.4	80.1

Access Measure	Source	Commercial HMO-POS	
		MY 2022 (%)	MY 2023 (%)
Access to non-urgent specialty services	Satisfaction Survey	75.4	82.6
Access to non-urgent ancillary diagnostic & treatment services		79.3	84.1
Access to current and accurate provider directory data		70.1	77.7

Table A-20 Provider Satisfaction Survey Results – Medi-Cal

Access Measure	Source	Medi-Cal	
		MY 2022 N (%)	MY 2023 N (%)
Referral and/or prior authorization process	Health Net Provider Satisfaction Survey	80.7	80.0
Access to urgent care		84.4	82.2
Access to non-urgent primary care		86.9	83.4
Access to non-urgent specialty services		79.0	77.3
Access to non-urgent ancillary diagnostic & treatment services		80.6	78.9
Access to current and accurate provider directory data		76.8	74.4

Table A-21. Provider Satisfaction Survey Results (Behavioral Health) - Commercial

Network: CA Commercial (MHN Standalone, HMO, PPO, EPO)	*% Satisfied or Very Satisfied*	
Accessibility and Availability	***2022***	***2023***
Availability of interpreter services for members inquiring about BH services with you	97%	94%
Availability of interpreter services for patients during treatment/evaluation with you	97%	94%
Availability of MHN case management services to assist your patients	93%	91%
Ease of access to MHN's 24-hour clinical call center to support your patients	95%	96%
Ease of obtaining non-urgent ancillary diagnostics or treatment for your patients	92%	89%
MHN's ability to coordinate urgent hospital admissions for your patients	93%	92%

Table A-22. Provider Satisfaction Survey Results (Behavioral Health) – Medi-Cal

Timeliness Standards	*% Satisfied or Very Satisfied*	
	2022	**2023**
What is your perspective on or concern with the time standard for routine appointments with new patients?	59%	80%
What is your perspective on or concern with the time standard for routine follow-up appointments with a non-physician behavioral health provider?	N/A	85%
What is your perspective on or concern with the urgent time standard?	62%	59%
What is your perspective on or concern with the non-life-threatening emergent time standard?	62%	47%

Table A-23. Telephone Access Survey Results – Medi-Cal

Access Measure	*Standard*	*Goal*	*MY 2022 Rate (%)*	*MY 2023 Rate (%)*
Telephone Answer Time	Within 60 seconds	80%	100.0	100.0
Provider Call-back for non- urgent issues during normal business hours	Within one business day	80%	19.7	100.0

Table A-24. Provider After-Hours Availability Survey Results – Commercial HMO/POS

Access to After-Hours Care (PCP)	*Source*	*Standard*	*MY 2022 Rate (%)*	*MY 2023 Rate (%)*
Appropriate After-Hours Emergency Instructions	PAHAS	90%	92.7	93.9
*Ability to contact on-call physician after-hours within 30 minutes**		90%	79.0	77.3

***N** = number responded to question*
↑ ↓ Statistically significant difference between MY 2023 vs MY 2022, p<0.05

Table A-25. Provider After-Hours Availability Survey Results – Individual/Family Plan

Access to After-Hours Care (PCP)	*Source*	*Standard*	*MY 2022 Rate (%)*	*MY 2023 Rate (%)*
Appropriate After-Hours Emergency Instructions	PAHAS	90%	93.4	95.1
*Ability to contact on-call physician after-hours within 30 minutes**		90%	82.0	80.8

***N** = number responded to question*
↑ ↓ Statistically significant difference between MY 2023 vs MY 2022, p<0.05

Table A-26. Provider After-Hours Availability Survey Results –Medi-Cal

Access to After-Hours Care (PCP)	*Source*	*Performance Goal*	*MY 2022 N (%)*	*MY 2023 N (%)*
Appropriate After-Hours Emergency Instructions	PAHAS	90%	93.9	95.7
*Ability to contact on-call physician after-hours within 30 minutes**		90%	83.7	78.4