Population Needs Assessment

2022

TABLE OF CONTENTS

POPULATION NEEDS ASSESSMENT OVERVIEW

Health Net's Population Needs Assessment (PNA) aims to identify the needs of members, review available programs and resources, and flag gaps in services. The health status of all members is considered, including Seniors and Persons with Disabilities (SPD), children and adults with special health care needs, members with Limited English Proficiency (LEP), and members from diverse cultural and ethnic backgrounds. Health Net's PNA development process was designed to meaningfully gather and synthesize data from primary sources to advise the development of action plans to improve member health outcomes and experiences. Analyses guide appropriate action plans, implemented by Health Education, Health Equity (formerly Cultural and Linguistic Services), and Quality Improvement departments. Health Net's seven Medi-Cal counties include Kern, Tulare, Los Angeles, Sacramento, San Diego, San Joaquin, Stanislaus.

Data Sources

Data sources used in developing Health Net's 2022 PNA reference the most recently available data from Measurement Years (MY) 2013-2021. They include:

- Access to care reports monitoring appointment availability.
- Claims and encounters highlighting health status and disease prevalence.
- Enrollment data detailing member demographics and profiles.
- Healthcare Effectiveness Data and Information Set (HEDIS®) noting performance on various pediatric and adult measures.
- Disparity analyses on multiple quality metrics using DHCS provided health disparities data coupled with additional internal data.
- Consumer Assessment of Healthcare Providers and Systems® (CAHPS) survey, and Health Information Form (HIF) survey responses are utilized to capture member experiences with the health plan, providers, and quality of care.

When compared to programs and interventions from Health Education, Health Equity, and Quality Improvement, all data sources help advise opportunities for improvement.

Key Findings

Membership Profile

As of December 2021, Health Net membership comprised of the following:

- **Total Membership:** 1,587,018 Medi-Cal members statewide (includes active and termed members).
    - Seniors and Persons with Disabilities (SPD) accounted for 17% of Health Net members.
- **Gender:** Females make up 53% of all members.
- **Age:** Nearly 48% of Health Net's membership were within the ages of 22-65, and about 42% were under the age of 22. Seniors aged 66 and above made up 10.2%.
- **Ethnicity:** Hispanics comprised the largest ethnic group, at 53.5%.
- **Language:** English was the preferred spoken language with 63.1% of the membership, followed by Spanish (27.6%) and Cantonese (1.4%).
- **Geography:** Los Angeles County maintained the largest proportion of members with nearly 68%, followed by Sacramento (8.33%), and Tulare (7.71%) counties.
- **Housing Status:** Poor housing conditions were experienced by an estimated 6.3% of all members, with Stanislaus (8%) and San Joaquin (7.7%) counties having the highest proportions at the county level.

Health Status and Disease Prevalence

- Claims and Encounter Data from January 1, 2021, to December 31, 2021:
    - Essential hypertension was once again the most submitted claims for all members, followed by diabetes mellitus without complication.
    - Claims specific to respiratory conditions (failure, insufficiency, or arrest) accounted for the highest percentage of costs.

    - Claims for blindness and vision defects are most common among children and adolescents ages 2-18, accounting for 9.57% of all claims.
    - For the same group, upper respiratory infections maintained its position for the highest percentage of costs at 4.5% in MY2021.
    - Mood and anxiety disorders represent the most reported behavioral health conditions for members.
    - Statewide, an estimated 16,930 members were flagged as smokers (MY2021). The largest proportion of nicotine dependent members changed from the age group 22-50 (43.63%) to 51-65 (50.1%).
- Self-reported Health Information Form (HIF) for MY2021:
    - Only 32% of respondents noted a provider visit within the past year, compared to 41% in MY2020.
    - High blood pressure was once again the most reported health condition at 29%.
    - Nearly 19% of members noted feeling "down, depressed, or hopeless at least several days during a 2-week period."
    - Thirty-two percent of members struggled to pay for basic needs (food, rent, bills and medicine).
    - Nearly 20% of responses made mention to at least some form of tobacco usage during the past year.

Health Disparities

Health Net prioritizes the reduction of health care disparities for the communities most impacted by inequalities and with the largest membership population – Los Angeles, Sacramento, and Tulare for this report. Disparity analyses were conducted using Health Net's MY2021 membership and HEDIS files, stratified by various demographic and socioeconomic characteristics. Health Net reviewed disparities specific to prevention and screening measures for these counties. Analysis was segmented by race/ethnicity and spoken language.

- In Los Angeles County:
    - Hispanics were above the 50th percentile (MPL) for Breast Cancer Screening (BCS), Chlamydia (CHL) but performed below the 50th for CCS and CIS-Combo 10.
    - Asian or Pacific Islanders and White members performed below the 50th percentile for all measures: Breast Cancer Screening (BSC), Cervical Cancer Screening (CCS), Chlamydia (CHL), Childhood Immunization Schedule (CIS) Combo 10, and Colorectal (COL).
- In Sacramento County:
    - Black and Hispanic members scored above the MPL for CHL, but below the MPL for BCS, CCS, and CIS-Combo 10.
    - American Indian/Alaskan Natives and Asian or Pacific Islanders exceeded the 50th percentile for CHL and CIS-Combo 10, while scoring below the 50th percentile for BCS and CCS.
    - White members scored below the 50th percentile for BCS, CCS, and CIS-Combo 10, but met the 50th percentile for CHL.
- In Tulare County:
    - Asian or Pacific Islanders and White members scored below the 50th percentile for BCS, CCS, and CIS-Combo 10.
    - Black members exceed the MPL for CCS and CHL but scored below for BCS and CIS-Combo 10.
- In Los Angeles, Sacramento, and San Diego Counties all race/ethnicities scored below the 50th percentile for PPC-postpartum and PPC-Prenatal measures.
- By spoken language:
    - Vietnamese speakers outperformed the other groups, with a scores above the MPL for BCS, CCS, and CIS-Combo 10.
    - Spanish speakers met the 50th percentile for CCS and exceeded it for BCS and CHL, while scoring below the 50th percentile for CIS-Combo 10.
    - Korean speakers scored below the 50th percentile for all measures.

- Statewide:
    - Statewide analysis on cardiovascular health and members flagged as potentially housing insecure found that these members performed much lower in all six measures (AMR, CBP, CDC-Eye exam, CDC-BP <140/90, HbA1c Test, and CDC-HbA1c <8) than those without housing insecurity.

Gap Analysis

Health Education Department

Areas for Opportunity for Health Education Department include:

- Increase access to behavioral health resources by promoting myStrength®, a comprehensive digital behavioral health platform that allows for learning on stress, depression, meditation, substance abuse, anxiety, COVID-19, and resources for LGBTQ+, to address the mental and behavioral health needs of members.
- Increase member participation in tobacco cessation program by implementing various member outreach strategies.
- Increase distribution of Heart Health resources (Healthy Heart Healthy Lives toolkit and Know Your Numbers brochure) to members identified with uncontrolled hypertension.

Quality Improvement Department

The Quality Department currently has the following active projects:

- Equity PIP for Breast Cancer Screening (BCS) targeting members 50-74 who identify as Russian by race/ethnicity and/or language.
- SWOT strategy for Asthma Medication Ratio (AMR) and Well Child Visit (WCV) in Kern County.
- Pediatrics PIP (Performance Improvement Plan) for Childhood Immunizations (CIS-10) for members 0-18 months of age in Los Angeles County.

Health Equity Department (formerly Cultural & Linguistics Department)

- The Language Assistance Program (LAP) complies with the language requirements and supports the goal of ensuring equal access to quality health care and services for all members. Health Equity Department will increase the utilization of a new Video Remote Interpreting (VRI) Services to support member language needs.

Action Plan

The Action Plan outlines existing or new programs prioritized by the Health Education, Health Equity, and Quality Improvement departments to address health disparities and improve health outcomes for members. The Health Education Department will continue to build momentum on connecting members with mental health resources, choosing to monitor, promote, and increase myStrength utilization, a comprehensive digital behavioral health platform that allows for learning on stress, depression, COVID-19, and much more. The Quality Improvement Department will continue implementing a health disparity project to improve breast cancer screenings (BCS) among Russian females ages 50-74 residing in Sacramento County. Health Equity will aim to reduce member language barriers and improve access to care through an on-demand Video Remote Interpreting (VRI) and Over the Phone Interpretation (OPI) service in-office pilot project.

Stakeholder Engagement

Health Net will continue to leverage the support of Community Advisory Committee (CAC) participants to receive input on PNA development and action plan implementation and share findings. One or more communication channels will be considered to inform Health Net providers of PNA highlights and recommendations. Examples include, health plan website posts, Provider Updates via email or fax, on-site visits at provider locations, and community provider lunch & learns, as appropriate.

DATA SOURCES

A variety of internal data sources are referenced in the development of the Population Needs Assessment (PNA). They offer insight to the membership profile, and guide the identification of member-based needs, care standards, potential disparities, and overall action plans. Primary data sources include claims and encounters, membership enrollment datasets, health program utilization, quality improvement projects, and member surveys.

Membership Data, December 2021

Health Net's membership profile included both active and termed members for that calendar year. This timeframe was selected to keep the membership analysis consistent with HEDIS and disparity analysis.

Healthcare Effectiveness Data and Information Set (HEDIS®), MY2020

HEDIS represents a set of performance measures selected by the Department of Health Care Services. They help the plan monitor and evaluate the quality and accessibility of care and services extended by Medi-Cal Managed Care Plans (MCPs). Health Net's performance is reported in the PNA on various pediatric, women's health, and chronic health measures. Low performing areas may be addressed through a Performance Improvement Project (PIP), Quality EDGE (Evaluating Data to Generate Excellence) projects, a Plan-Do-Study-Act (PDSAs) cycle, or a disparity analysis project, each aimed at enhancing and supporting member-based outcomes.

Claims and Encounter Data, MY2021

Multiple data sources are used to acquire claims and encounter data, pulling from corporate-wide data warehouses. These include medical, pharmacy and behavioral claims/encounters, and utilization management. These sources helped inform the following used in this assessment:

- Top health status and disease prevalence
- Top behavioral health diagnoses (claims and costs)
- High risk chronic health conditions
- Nicotine dependence
- Adverse Childhood Experience Screenings (ACEs)
- Coronavirus Disease (COVID-19) testing

Health Information Form, MY2021

The Health Information Form is a questionnaire that helps identify self-reported member needs and services. It is included in the new member welcome packet. Seniors and Persons with Disabilities (SPD) members receive telephonic outreach to assist form completion. Sections include Global Health, Behavioral Health (self-reported instances of depression, anxiety, and anti-psychotic medication) and Activities of Daily and Independent Living (stable housing and income for basic necessities).

Health Disparity Data, MY2019 and MY2021

Health disparity data flag gaps potential gaps in the delivery of quality care, performance on quality metrics, and barriers due to race/ethnicity, age, housing status, spoken language, Limited English proficiency, geography, and other broader Social Determinants of Health (SDoH) factors. Health Net's disparity analysis supplements the Department of Health Care Services (DHCS) MY2020 disparity data with updated internal findings to develop Health Net's disparity analysis. Data sources include:

- Department of Health Care Services (DHCS) health plan specific disparity data, MY2020.
- Health Net membership (Calendar Year 2021) and HEDIS data (MY2020), stratified by various demographic and socioeconomic characteristics.

Health Net Community Connect, MY2020

Health Net Community Connect is an online service that connects members to free or reduced cost social services in their communities. Website analytics, supported by Findhelp.org (formerly Aunt Bertha), help identify trends in emerging Social Determinants of Health by monitoring, tallying, and categorizing member searches. These findings helped Health Net assess the SDoH needs of members.

Timely Access Reports, MY2020-2021

Access to care standards monitor members' timely access for medical and behavioral health care within specific time-specific standards. Metrics include urgent and non-urgent appointments, after-hours availability, preventive visits/wellness checks, and access by provider type. Results inform rates of compliance, allowing for recommendations that improve appointment availability for members within timely timeframes. Data collection methodologies include:

- *Department of Managed Health Care Provider Appointment Availability Survey (PAAS), August-December 2021.* Health Net contracted with Sutherland Health Care Solutions to administer the survey as per outlined in the Department of Managed Health Care Provider Appointment Availability Survey Methodology.
- Through Sutherland Health Care Solutions, Health Net administered a separate PAAS to capture appointment access among a wider group of in-network, contracted specialists (random sample).
- Members can receive behavioral health services through the Managed Health Network (MHN)'s network of behavioral health care providers. The Psychiatry and Non-Physician Mental Health (NPMH) provider sample have their own performance standards specific to access.
- *Provider After-Hours Availability Survey (PAHAS), October-December 2021.* Sutherland Health Care Solutions administered this telephonic survey to determine providers' after-hours availability.

Consumer Assessment of Healthcare Providers and Systems (CAHPS), MY2020

Health Net's administered CAHPS survey seeks to measure health care consumers' experiences with the quality of care and customer service provided by their health plan. Findings from standardized questions help guide improvement strategies, aimed at meeting member expectations and preferences. Survey administration methodology included a mail and internet protocol, reaching adult members 18 years and older who had been continuously enrolled in the plan for at least five of the last six months in the measurement year.

Language Assistance Program (LAP), MY2013-2021

LAP offers a variety of language support services, such as culturally and linguistically appropriate material translations and interpreter support services for members, contracted providers, and staff. To identify gaps in services and opportunities for improvement, analyses considered language assistance service utilization and a GEO access comparison. The GEO access aimed to flag areas where members who identified as speaking a given language did not live within an appropriate time and distance parameter to a Primary Care Provider (PCP) or Specialist that can meet their preferred language needs.

Health Education Programs & Services Utilization, MY2020

Health Education resources promote positive lifestyle behaviors and encourage timely preventive care health services. Programs and services offer culturally and linguistically appropriate materials, covering a variety of health education topics.

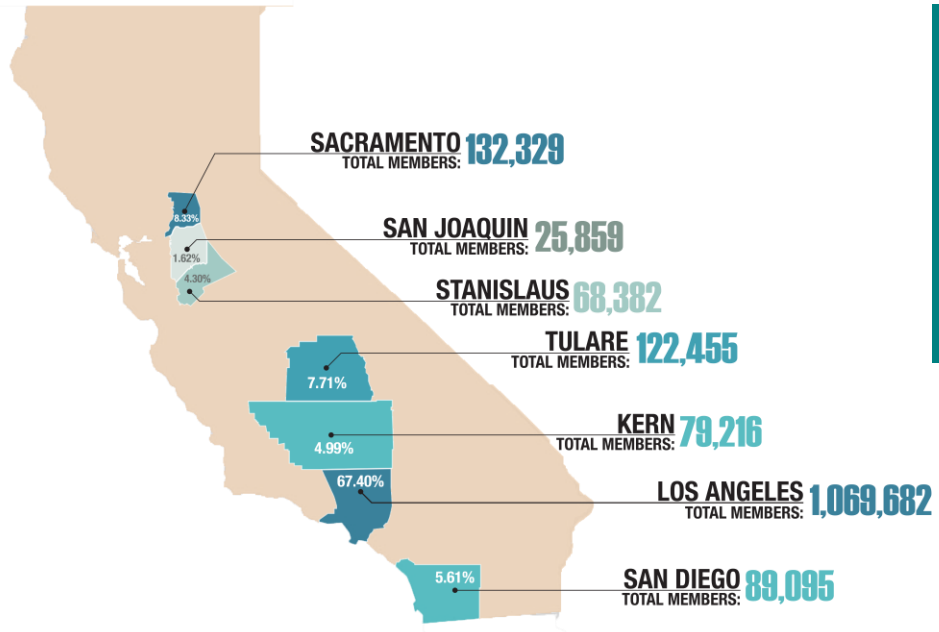
KEY DATA ASSESSMENT FINDINGS

Assessment findings highlight member health status and program gaps and help inform corresponding action plans. Data elements reviewed here include membership demographics, health status, disease prevalence, access to care performance, and various disparity analyses.

MEMBERSHIP/ GROUP PROFILE

The membership profile was developed using December 2021 data, which includes both active and termed members for the calendar year. Key demographic characteristics include geographic distribution, sex, race/ethnicity, age, Seniors and Persons with Disabilities (SPD), spoken language, Limited English Proficiency (LEP) counts, and housing insecurity. Please reference **Appendices A – C** for complete membership profile details by county.

Membership Distribution



Health Net had 1,587,018 Medi-Cal members across seven counties. Los Angeles has the largest proportion of the membership at nearly 68%. Each of the remaining counties have less than 9% of the membership

By Sex, December 2021

The sex distribution is nearly even in each county. In Los Angeles, females make up nearly 54% of county members, followed by 53.1% in Tulare County. Males make up between 46.3-49.5% of members in the remaining counties. Females account for a little over 53% of Health Net's total membership. See Table 1 for county specific data.

By Age, December 2021

Nearly 48% (47.4%) of the total Health Net Medi-Cal membership is between the ages of 22 and 65 years, followed by those 22 years and under at 42.4%. Members in the 66 and older age group make up the smallest proportion of members with 10.2% of the total membership.

Table 1: Health Net Membership Data - Age Groups by County, December 2020 & December 2021

	Kern	Los Angeles	Sacramento	San Diego	San Joaquin	Stanislaus	Tulare	2020	2021
Age Group	**79,216**	**1,069,682**	**132,329**	**89,095**	**25,859**	**68,382**	**122,455**	**1,571,750**	**1,587,018**
0-13 Years	22,770 (28.7%)	256,489 (24%)	37,519 (28.4%)	22,327 (25.1%)	7,096 (27.4%)	19,806 (29%)	41,172 (33.6%)	399,631 (25.4%)	407,179 (25.7%)
14-21 Years	14,015 (17.7%)	174,676 (16.3%)	21,033 (15.9%)	14,365 (16.1%)	4,339 (16.8%)	13,352 (19.5%)	22,900 (18.7%)	264,442 (16.8%)	264,680 (16.7%)
22-50 Years	29,160 (36.8%)	352,383 (32.9%)	49,904 (37.7%)	30,350 (34.1%)	10,296 (39.8%)	24,706 (36.1%)	41,363 (33.8%)	525,030 (33.4%)	538,162 (33.9%)
51-65 Years	10,452 (13.2%)	150,792 (14.1%)	17,886 (13.5%)	11,002 (12.3%)	3,347 (12.9%)	8,268 (12.1%)	13,144 (10.7%)	211,851 (13.5%)	214,891 (13.5%)
66+ Years	2,819 (3.6%)	135,342 (12.7%)	5,987 (4.5%)	11,051 (12.4%)	781 (3%)	2,250 (3.3%)	3,876 (3.2%)	170,796 (10.9%)	162,106 (10.2%)

By Race/Ethnicity, December 2021

Hispanics make up the largest group in six of seven counties (Table 2). In Sacramento County, White members have the highest proportion at 25.5%, and the second highest counts in the remaining six counties. Black member representation is third highest in Kern County at 7.3%. Asian or Pacific Islander membership is third highest in the other six counties. Overall, rates by race/ethnicity have remained consistent for Health Net since December 2018.

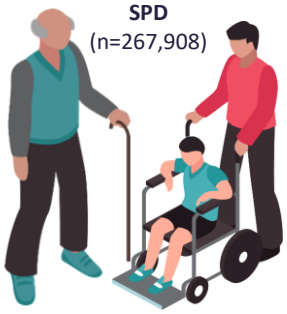
Table 2: Health Net Membership Data - Race/Ethnicity by County, December 2020 & December 2021

	Kern	Los Angeles	Sacramento	San Diego	San Joaquin	Stanislaus	Tulare	2020	2021
R/E	**79,216**	**1,069,682**	**132,329**	**89,095**	**25,859**	**68,382**	**122,455**	**1,571,750**	**1,587,018**
Hispanic	44,954 (56.7%)	605,557 (56.6%)	28,962 (21.9%)	32,997 (37%)	10,834 (41.9%)	35,537 (52%)	90,080 (73.6%)	841,471 (53.5%)	848,921 (53.5%)
White	17,938 (22.6%)	141,187 (13.2%)	33,711 (25.5%)	22,458 (25.2%)	5,221 (20.2%)	18,109 (26.5%)	15,569 (12.7%)	251,731 (16.0%)	254,193 (16%)
API	2,611 (3.3%)	130,230 (12.2%)	23,385 (17.7%)	8,776 (9.9%)	3,129 (12.1%)	3,793 (5.5%)	4,394 (3.6%)	177,541 (11.3%)	176,318 (11.1%)
Black	5,812 (7.3%)	102,759 (9.6%)	18,218 (13.8%)	4,980 (5.6%)	2,709 (10.5%)	2,457 (3.6%)	1,725 (1.4%)	137,292 (8.7%)	138,660 (8.7%)
*AI/AN**	220 (0.3%)	1168 (0.1%)	730 (0.6%)	310 (0.3%)	104 (0.4%)	159 (0.2%)	684 (0.6%)	3,383 (0.2%)	3,375 (0.2%)
Other	1,619 (2%)	17,927 (1.7%)	1,382 (1%)	1,305 (1.5%)	490 (1.9%)	2,015 (2.9%)	1,008 (0.8%)	28,281 (1.8%)	25,746 (1.6%)
Unknown	6,062 (7.7%)	70,854 (6.6%)	25,941 (19.6%)	18,269 (20.5%)	3,372 (13%)	6,312 (9.2%)	8,995 (7.3%)	132,051 (8.4%)	139,805 (8.8%)

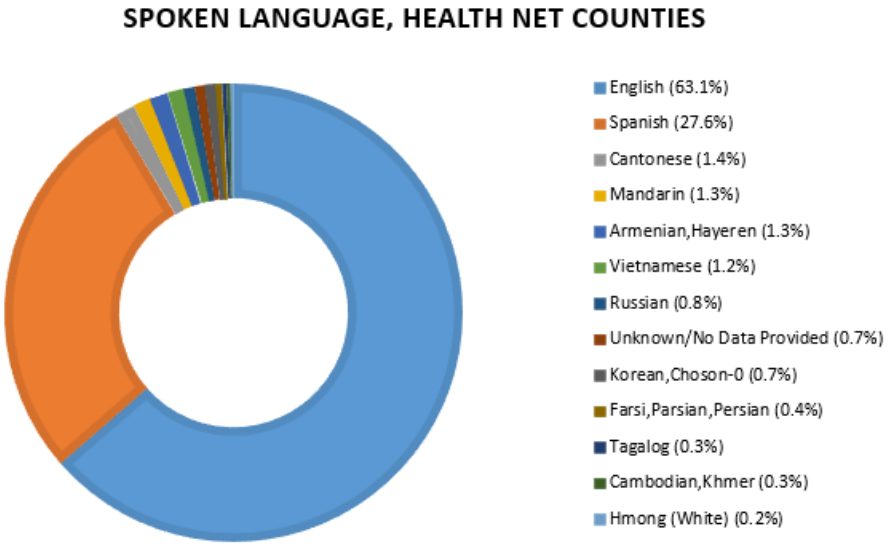
**American Indian/Alaskan Native*

By Seniors and Persons with Disabilities (SPD), December 2021

Seniors and Persons with Disabilities (SPD) make up nearly 17% of Health Net's Medi-Cal membership (n=267,908). The rate is highest in Los Angeles County with 19% of its membership, followed by San Diego (18.8%), Sacramento (13.1%) and Kern (11.7%) Counties. Stanislaus, Tulare, and San Joaquin Counties note counts under 11%.

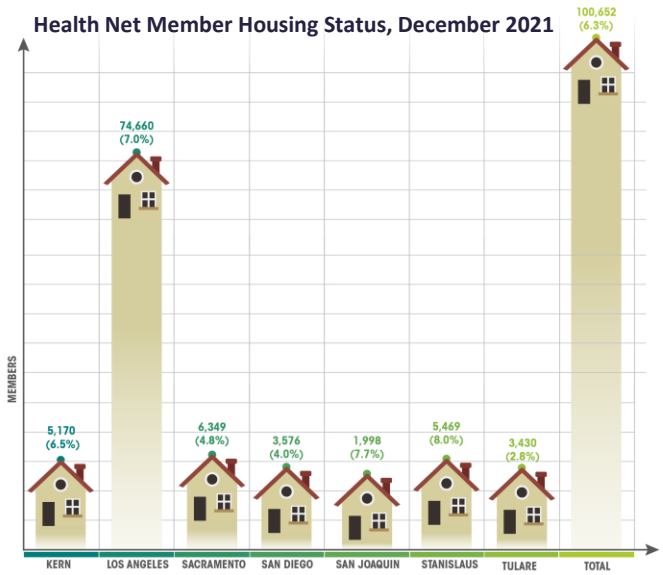


Health Net's Primary Spoken Language by All County, December 2021 (n=1,587,018)



By Housing Status, December 2021

Poor housing conditions correlate to multiple adverse health outcomes in both children and adults[1]. A total of 6.3% of Health Net members in all 7 counties do not have adequate housing or are likely experiencing homelessness[2]. At the county level, Stanislaus continue to have the highest rate of 8%, followed by San Joaquin with a 7.7%



[1] US Housing Insecurity and the Health of Very Youth Children: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3134514/; Accessed May 2022

[2] Members are categorized as likely to be housing insecure if they registered with the address of a shelter for people experiencing homelessness, place of worship, hospital, transitional housing, public office, or an address containing a keyword synonymous with "homelessness, "General Delivery", or "Friend's Couch". In addition, the condition of homelessness is currently recognized in the ICD-10 coding criteria, ICD-10-CM Code Z59.0.

Geographic Classification

Place of residence influences various aspects of health, particularly in access to care. Rural areas tend to have fewer physicians and health care resources, and often report higher incidences of premature death from the leading causes of death[3]. Among Health Net's membership, a large majority of Medi-Cal members live in an urban area[4] (73.4%), and an additional 8.4% in a suburban area. At the county level, over 90% of members in Los Angeles and Sacramento Counties live in either an urban or suburban area. A high proportion of members live in a rural geography in Kern (71.6%) and Tulare Counties (87.8%). Please see Appendix C for additional details.

Note: **Geographic classification rates in MY2021 is based on population density by zip codes.**

HEALTH STATUS AND DISEASE PREVALENCE

Members' health status is based on various claims and encounter data metrics. Self-reported surveys help identify member needs, while state/county assessments allow for comparisons to larger community benchmarks. Health Net uses the most recently available data from the following sources to gauge levels of performance and opportunities for improvement.

Healthcare Effectiveness Data and Information Set (HEDIS)

The Department of Health Care Services (DHCS) requires that Medicaid Managed Care Plans perform at least as well as the National Medicaid 50th percentile. For each clinical measure that falls below that threshold, the health plan must implement a proactive and continuous Performance Improvement Project (PIP), a Plan-Do-Study-Act (PDSA) cycle, or a disparity analysis project focused on improving that selected measure. Using the most recently available data (MY2020), Health Net's HEDIS outcomes are categorized into three areas: *Pediatric Health (*Figure 1*), Women's Health* (Figure 2), *and Adult + Chronic Health* (Figure 3). Under Pediatric Health (Table 3), nine measures are captured for review. Tulare County had the most favorable outcomes, noting two measures under the 50th percentile. Kern County had all nine measures below the MPL. Across all counties, two measures were consistently below the 50th percentile: Well-Child Visits in the First 30 Months of Life – 0 to 15 Months (W30-15) and Child and Adolescent Well-Care Visits (WCV). Additional information can be found in Appendix D of this report.

The COVID-19 pandemic negatively impacted health care access. This was observed across many HEDIS metrics during MY2021, resulting in lower performance for some measures. Health Net anticipates DHCS will provide benchmark data in the near future across all Medi-Cal plans for further evaluation.

[3] National Center for Chronic Disease Prevention and Health Promotion: https://www.cdc.gov/chronicdisease/resources/publications/factsheets/rural-health.htm ; Accessed May 2022.
[4] Urban – Zip Codes containing a population of more than 3,000 people per square mile.

Figure 1: Pediatric Measures

- **APM:** Metabolic Monitoring for Children and Adolescents on Antipsychotics - Total
- **CIS-10:** Childhood Immunization Status – Combo 10
- **IMA-2:** Immunizations for Adolescents – Combo 2
- **WCC-BMI:** Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for BMI
- **WCC-N:** Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Nutrition
- **WCC-PA:** Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Physical Activity
- **WCV:** Child and Adolescent Well-Care Visits
- **W30-15:** Well-Child Visits in the First 30 Months of Life – 0 to 15 Months
- **W30-30:** Well-Child Visits in the First 30 Months of Life – 15 to 30 Months

Table 3: HEDIS - Pediatric Health Measures by Health Net Counties, MY2020

	Total Measures	*# below 50th Percentile*	*% below 50th Percentile*	*Measures below 50th Percentile*
Kern	9	9	100%	APM, CIS-10, IMA-2, WCC-BMI, WCC-N, WCC-PA, WCV, W30-15, W30-30
Los Angeles	9	5	56%	APM, CIS-10, W30-15, W30-30, WCV
Sacramento	9	3	33%	CIS-10, W30-15, WCV
San Diego	9	3	33%	IMA-2, W30-15, WCV
San Joaquin	9	7	78%	CIS-10, IMA-2, W30-15, W30-30, WCC-N, WCC-PA, WCV
Stanislaus	9	7	78%	CIS-10, IMA-2, W30-15, W30-30, WCC-N, WCC-PA, WCV
Tulare	9	2	22%	W30-15, WCV

>=80% of measures in category are below 50th Percentile

<=20% of measures in category are below 50th Percentile

Five measures are grouped under Women's Health (Figure 2). Tulare County continues to lead in outcomes across all counties with only one measure (BCS) below the 50th percentile benchmark. Table 4 on the following page shows that the remaining six counties had at least four of five measures below the MPL. Statewide, Breast Cancer Screening was consistently below the benchmark. Cervical Cancer Screening and Timeliness of Prenatal Care did not meet performance levels in six of the seven counties. Further information on HEDIS benchmarks can be found in Appendix D.

Figure 2: Women's Health Measures

- **BCS:** Breast Cancer Screening
- **CCS:** Cervical Cancer Screening
- **PPC- Prenatal:** Prenatal and Postpartum Care – Timeliness of Prenatal Care
- **PPC- Postpartum:** Prenatal and Postpartum Care – Postpartum Care
- **CHL:** Chlamydia Screening in Women

Table 4: HEDIS - Women's Health Measures, MY2020

	Total Measures	# below 50th Percentile	% below 50th Percentile	Measures below 50th Percentile
Kern	5	5	100%	BCS, CCS, CHL, PPC- Prenatal, PPC- Postpartum
Los Angeles	5	4	80%	BCS, CCS, PPC- Prenatal, PPC- Postpartum
Sacramento	5	4	80%	BCS, CCS, PPC- Prenatal, PPC- Postpartum
San Diego	5	5	100%	BCS, CCS, CHL, PPC- Prenatal, PPC- Postpartum
San Joaquin	5	5	100%	BCS, CCS, CHL, PPC- Prenatal, PPC- Postpartum
Stanislaus	5	4	80%	BCS, CCS, CHL, PPC- Prenatal
Tulare	5	1	20%	BCS

>=80% of measures in category are below 50th Percentile

<=20% of measures in category are below 50th Percentile

The Adult and Chronic Health group incorporates six measures (Figure 3). Table 5 below shows that San Diego County had the best performance, meeting benchmarks on five of six measures. San Joaquin and Tulare Counties missed the MPL on three measures. Comprehensive Diabetes Care – HbA1c Poor Control (>9%) and Antidepressant Medication Management – Effective Continuation Phase Treatment are the most recurring measures statewide below the 50th percentile, each populating in at least 6 counties.

Figure 3: Adult and Chronic Health Measures

- **AMM-A:** Antidepressant Medication Management – Effective Acute Phase Treatment
- **AMM-C:** Antidepressant Medication Management – Effective Continuation Phase Treatment
- **AMR:** Asthma Medication Ratio
- **CBP:** Controlling High Blood Pressure
- **CDC-H9:** Comprehensive Diabetes Care – HbA1c Poor Control (>9.0%)
- **SSD:** Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications

Table 5: HEDIS - Adult + Chronic Health (AH) Measures, MY2020

	Total Measures	# below 50th Percentile	% below 50th Percentile	Measures below 50th Percentile
Kern	6	5	83%	AMM-C, AMR, CBP, CDC-H9, SSD
Los Angeles	6	5	83%	AMM-A, AMM-C, AMR, CDC-H9, SSD
Sacramento	6	4	67%	AMM-A, AMM-C, CBP, CDC-H9
San Diego	6	1	17%	CDC-H9
San Joaquin	6	3	50%	AMM-C, CBP, CDC-H9
Stanislaus	6	5	83%	AMM-C, AMR, CBP, CDC-H9, SSD
Tulare	6	3	50%	AMM-A, AMM-C, SSD

>=80% of measures in category are below 50th Percentile

<=20% of measures in category are below 50th Percentile

Please reference **Appendix D** for a comprehensive overview of percentile ratings by measure.

High Risk Chronic Health Conditions

Health Net supports population health management (PHM) by identifying members considered high risk for chronic health conditions, enabling enrollment into disease management, case management and/or clinical pharmacy management programs. Members are considered high-risk when they fall within any of these categories:

High Risk Member Selection Criteria	
Outpatient Surgery (OPS)	3 or More OPS in last 12 Months
Emergency Room (ER) - 3 Months	2 or More ER Visit in last 3 Months
ER- 6 Months	3 or More ER Visit in last 6 Months
ER- 12 Months	5 or More ER Visit in last 12 Months
Inpatient Admit (Acute)	More Than 1 in last 12 Months
Ambulatory Care Sensitive Condition Admit	Any in last 12 Months
Catastrophic Admit	Any in last 12 Months
Population Health Category	_05b or Higher (New POP Health Category)
Chronic Conditions	Presence of 5 or More chronic conditions

In MY2021, Health Net identified 12,195 Health Net members within a high-risk category for asthma, chronic heart failure, and/or diabetes. Table 6 below lists counts by age and county for each condition. In 2021, Health Net members aged 66+ carry the most significant burden of high-risk conditions, with 6,120 or 50.18% of the entire high-risk population. The 22-50-year-old age group follows with 2,817 high-risk counts or 23.10% of the population's total. Overall, counts for all three chronic conditions combined are highest for ages 66+ in Los Angeles and San Diego Counties and 22-50 years in Kern, Sacramento, San Joaquin, Stanislaus, and Tulare Counties. Of all seven counties, Los Angeles County holds the largest proportion of high-risk members for these categories with 7,230 members.

Chronic heart failure (CHF) is highest among adults 66+ years across all counties accounting for 4,275 members or 78.7% of the total group with CHF. Los Angeles County accounts for nearly 77.7% of the entire high-risk CHF population from a county perspective. From an age and county perspective, drilling down further, members aged 66+ in Los Angeles County carry a disproportionate rate of high-risk individuals with CHF at 68.89% of the entire population. To give the perspective of this magnitude, the cohort with the following leading numbers comes from 51–65-year-old members in LA County at 388 individuals at 7.14%.

Out of the age classifications listed, members aged 66+ count for the largest segment of members with asthma, with 1,524 individuals or 32.30% of total members with asthma. Lastly, the county and age stratifications indicate that the most considerable burden of high-risk members with asthma occurs in the 66+ population in Los Angeles County; these individuals contribute to 1,324 counts or 28.06% of the total members with asthma overall.

Diabetes is more common among adults 22+ years but highest within the 22-50 age group at 49.98% (1,022) of the total population with diabetes. Los Angeles leads the bunch among counties, carrying 35.89% (734) of the high-risk population with diabetes; Sacramento follows LA at 16.67% (341) and Tulare at 16.58%. Considering that Tulare County comprises 7.71% of the total Health Net membership yet nearly 17% of the high-risk population with diabetes, this insight depicts a disparity that can come into focus for the health plan. From an age and county perspective, members aged 22-50 in Los Angeles County and Tulare carry a significant rate of high-risk members with diabetes at 13.84% and 10.51% of the entire population experiencing diabetes.

Table 6: Claims/Encounter Data – Chronic Conditions by Age (All Counties), MY2021

	Asthma	*Chronic Heart Failure*	*Diabetes*	*Total*
Kern	**381**	**198**	**221**	**800**
0-13 Years	48 (12.60%)	1 (0.51%)	-	49
14-21 Years	26 (6.832%)	1 (0.51%)	8 (3.62%)	35
22-50 Years	165 (43.31%)	42 (21.21%)	131 (59.28%)	338
51-65 Years	112 (29.40%)	95 (47.98%)	75 (33.94%)	282
66+ Years	30 (7.87%)	59 (29.80%)	7 (3.17%)	96
Los Angeles	**2,274**	**4,222**	**734**	**7,230**
0-13 Years	116 (5.10%)	2 (0.05%)	2 (0.27%)	120
14-21 Years	67 (2.95%)	2 (0.05%)	14 (1.91%)	83
22-50 Years	387 (17.02%)	88 (2.08%)	283 (38.56%)	758
51-65 Years	380 (16.71%)	388 (9.19%)	208 (28.34%)	976
66+ Years	1,324 (58.22%)	3,742 (88.63%)	227 (30.93%)	5,293
Sacramento	**660**	**245**	**341**	**1,246**
0-13 Years	67 (10.15%)	1 (0.41%)	5 (1.47%)	73
14-21 Years	54 (8.18%)	-	6 (1.76%)	60
22-50 Years	359 (54.39%)	39 (15.92%)	179 (52.49%)	577
51-65 Years	147 (22.27%)	128 (52.24%)	127 (37.24%)	402
66+ Years	33 (5%)	77 (31.43%)	24 (7.04%)	134
San Diego	**263**	**384**	**179**	**826**
0-13 Years	5 (1.90%)	-	-	5
14-21 Years	14 (5.32%)	-	5 (2.79%)	19
22-50 Years	94 (35.74%)	24 (6.25%)	80 (44.69%)	198
51-65 Years	75 (28.52%)	78 (20.31%)	51 (28.49%)	204
66+ Years	75 (28.52%)	282 (73.44%)	43 (24.02%)	400
San Joaquin	**89**	**44**	**57**	**190**
0-13 Years	7 (7.87%)	-	-	7
14-21 Years	11 (12.36%)	1 (2.27%)	3 (5.26%)	15
22-50 Years	51 (57.30%)	11 (25%)	29 (50.88%)	91
51-65 Years	19 (21.35%)	23 (52.27%)	24 (42.11%)	66
66+ Years	1 (1.12%)	9 (20.45%)	1 (1.75%)	11
Stanislaus	**295**	**114**	**174**	**583**
0-13 Years	43 (14.58%)	-	1 (0.57%)	44
14-21 Years	39 (13.22%)	-	10 (5.75%)	49
22-50 Years	139 (47.12%)	31 (27.19%)	105 (60.34%)	275
51-65 Years	54 (18.31%)	53 (46.49%)	52 (29.89%)	159
66+ Years	20 (6.78%)	30 (26.32%)	6 (3.45%)	56
Tulare	**756**	**225**	**339**	**1320**
0-13 Years	165 (21.83%)	1 (0.44%)	4 (1.18%)	170
14-21 Years	71 (9.39%)	1 (0.44%)	9 (2.65%)	81
22-50 Years	317 (41.93%)	48 (21.33%)	215 (53.42%)	580
51-65 Years	162 (21.43%)	99 (44%)	98 (28.91%)	359
66+ Years	41 (5.42%)	76 (33.78%)	13 (3.83%)	130
Total	**4,718 (38.69%)**	**5,432 (44.54%)**	**2,045 (16.77%)**	**12,195**

When viewed by race/ethnicity in Los Angeles County (Table 7), Whites (31.84%), Hispanics (25.11%), and Asian or Pacific Islanders (APIs; 19.09%) lead the counts among members with asthma. Black members follow with 365 (16.05%). White members account for 46.02% (1,943) of counts among members with CHF, followed by APIs at 19.33%. High-risk diabetes is most prevalent among Hispanics, with over half the count.

In Sacramento County, Black (31.82%) and White (26.21%) members have the highest asthma counts. As with Los Angeles, CHF is most common among White members (35.1%), followed by APIs (18.37%) and Blacks (17.55%). White and Hispanic members make up over 20% of all members with high-risk diabetes within Sacramento County.

Table 7: Claims/Encounter Data – Chronic Conditions by Race/Ethnicity (Los Angeles & Sacramento Counties), MY2021

	Asthma	*Chronic Heart Failure*	*Diabetes*	*Total*
Los Angeles	**2,274**	**4,222**	**734**	**7,230**
Alaskan Native or American Indian	5 (0.22%)	1 (0.02%)	2 (0.27%)	8
Asian or Pacific Islander	434 (19.09%)	816 (19.33%)	83 (11.31%)	1333
Black	365 (16.05%)	346 (8.20%)	91 (12.40%)	802
Hispanic	571 (25.11%)	810 (19.19%)	376 (51.23%)	1757
Other / Unknown	175 (7.69%)	306 (7.25%)	68 (9.26%)	549
White	724 (31.84%)	1,943 (46.02%)	114 (15.53%)	2781
Sacramento	**660**	**245**	**341**	**1,246**
Alaskan Native or American Indian	9 (1.36%)	4 (1.63%)	4 (1.17%)	17
Asian or Pacific Islander	46 (6.97%)	45 (18.37%)	47 (13.78%)	138
Black	210 (31.82%)	43 (17.55%)	55 (16.13%)	308
Hispanic	94 (14.24%)	30 (12.24%)	78 (22.87%)	202
Other / Unknown	128 (19.39%)	37 (15.1%)	57 (16.71%)	222
White	173 (26.21%)	86 (35.10%)	100 (29.33%)	359

Table 8 indicates that Hispanic and White members have the highest rates for all three chronic conditions in the other five counties (Tulare, Kern, Stanislaus, San Joaquin, and San Diego) combined at 46.28% and 28.66%. Similarly, to MY2020, Hispanic members have the highest counts in all five counties for diabetes. White members note the highest cases of CHF across the five counties at 358 (37.10%) and the highest counts for asthma in San Diego and Kern counties.

Out of the Race and Ethnicity classifications listed, Hispanic members count for the largest segment of members with asthma, with 846 individuals or 47.42% of total members with high-risk asthma. Lastly, the county and race/ethnicity stratifications indicate that the most considerable burden of high-risk members experiencing asthma occurs in the Hispanic population in Tulare County; these individuals contribute to 481 counts or 26.96% of the total overall members with asthma (Table 8).

Chronic heart failure (CHF) is highest among White members across all counties. White members account for 358 members or 37.10% of the CHF group, while Hispanic members trail slightly behind at 33.58%. From this five-county perspective, San Diego County accounts for nearly 40% of the entire high-risk CHF population. From a race/ethnicity and county perspective, drilling down further, White members in San Diego County carry a disproportionate rate of high-risk CHF individuals at 15.44% of the entire population.

Diabetes is most common among Hispanic members at 56.80% of the population with diabetes. Tulare leads among these counties, carrying 34.95% (339) of the high-risk population with diabetes; Kern follows Tulare at 22.78%, and San Diego at 18.45%. Considering that Tulare County comprises of 7.71% of the total Health Net

membership, nearly 35% of the high-risk population with diabetes, this insight depicts a disparity that can come into focus for the health plan. From a race/ethnicity county perspective, Hispanic members in Tulare and Kern Counties carry a significant rate of high-risk individuals with diabetes at 24.85% and 13.30%, respectively, of the entire population experiencing diabetes.

Black members make up the fourth-highest count for asthma across Kern, San Diego, San Joaquin, and Tulare Counties. In addition, APIs have the third-highest counts for chronic heart failure in four of five counties and the third-highest count for asthma in Stanislaus. Refer to Table 8 for further information.

Table 8: Claims/Encounter Data – Chronic Conditions by Race/Ethnicity (Tulare, San Diego, Kern, San Joaquin, & Stanislaus Counties), MY2021

	Asthma	***Chronic Heart Failure***	***Diabetes***	***Total***
Kern	**381**	**198**	**221**	**800**
Alaskan Native or American Indian	-	-	2 (0.9%)	2
Asian or Pacific Islander	5 (1.31%)	7 (3.54%)	2 (0.9%)	14
Black	57 (14.96%)	21 (10.61%)	23 (10.41%)	101
Hispanic	148 (38.85%)	73 (36.87%)	129 (58.37%)	350
Other / Unknown	51 (13.38%)	18 (9.1%)	13 (5.88%)	82
White	120 (31.50%)	79 (39.90%)	52 (23.53%)	251
San Diego	**263**	**384**	**179**	**826**
Alaskan Native or American Indian	3 (1.14%)	2 (0.52%)	-	5
Asian or Pacific Islander	32 (12.17%)	58 (15.10%)	17 (9.50%)	107
Black	27 (10.27%)	26 (6.77%)	13 (7.26%)	66
Hispanic	61 (23.19%)	96 (25%)	79 (44.13%)	236
Other / Unknown	58 (22.05%)	53 (13.8%)	31 (17.32%)	142
White	82 (31.18%)	149 (38.80%)	39 (21.79%)	270
San Joaquin	**89**	**44**	**57**	**190**
Alaskan Native or American Indian	-	-	-	0
Asian or Pacific Islander	6 (6.74%)	6 (13.64%)	4 (7.02%)	16
Black	15 (16.85%)	6 (13.64%)	11 (19.30%)	32
Hispanic	29 (32.58%)	9 (20.45%)	18 (31.58%)	56
Other / Unknown	13 (14.61%)	7 (15.91%)	7 (12.28%)	27
White	26 (29.21%)	16 (36.36%)	17 (29.82%)	59
Stanislaus	**295**	**114**	**174**	**583**
Alaskan Native or American Indian	2 (0.68%)	1 (0.88%)	1 (0.57%)	4
Asian or Pacific Islander	14 (4.75%)	13 (11.40%)	13 (7.47%)	40
Black	17 (5.76%)	10 (8.77%)	9 (5.17%)	36
Hispanic	127 (43.05%)	30 (26.32%)	84 (48.28%)	241
Other / Unknown	33 (11.19%)	8 (7.02%)	16 (9.2%)	57
White	102 (34.58%)	52 (45.61%)	51 (29.31%)	205
Tulare	**756**	**225**	**339**	**1,320**
Alaskan Native or American Indian	1 (0.13%)	4 (1.78%)	1 (0.3%)	6
Asian or Pacific Islander	23 (3.04%)	11 (4.89%)	13 (3.832%)	47
Black	19 (2.51%)	8 (3.56%)	9 (2.65%)	36
Hispanic	481 (63.62%)	116 (51.56%)	241 (71.09%)	838

Other / Unknown	70 (9.26%)	24 (10.66%)	18 (5.31%)	112
White	162 (21.43%)	62 (27.56%)	57 (16.81%)	281

Top Medical Diagnoses and Costs

The top 10 medical diagnoses and costs are produced using Health Net Measurement Year 2021 claims and encounter data. Recognizing year-over-year trends and patterns helps prioritize where intervention efforts should be focused. For all members, 9 of the top 10 claims in 2020 rolled over to 2021, with essential hypertension, both diabetes mellitus (with and without complications), and degenerative conditions of the spine being the top 4 claims in both years (Table 9). Hypertension is the most common diagnosis based on claims at nearly 11%. Respiratory conditions (failure, insufficiency, or arrest) account for the highest percentage of costs among all claims submitted (4.53%). All top 10 costs submitted in 2020 are also reflected in 2021 (Table 10).

Table 9: Claims/Encounter Data - Top 10 Claims, All Members, MY2019-2020

	% of Claims	
	2020	**2021**
Essential hypertension	9.47%	10.88%
Diabetes mellitus without complication	3.20%	3.30%
Spondylosis; intervertebral disc disorders; other back problems	3.30%	3.11%
Diabetes mellitus with complications	2.97%	3.07%
Blindness and vision defects	2.66%	2.98%
Other connective tissue disease	2.19%	2.24%
Abdominal pain	2.01%	2.11%
Other non-traumatic joint disorders	1.89%	2.07%
Other lower respiratory disease	2.35%	1.94%
Normal pregnancy and/or delivery	*N/A**	1.59%

**** Claim/diagnosis not captured as a top 10 item in 2020***

Table 10: Claims/Encounter Data - Top 10 Costs, All Members, MY2019-2020

	% of Costs	
	2020	**2021**
Respiratory failure; insufficiency; arrest	4.72%	4.53%
Essential hypertension	3.63%	3.97%
Septicemia (except in labor)	3.44%	3.72%
Diabetes mellitus with complications	2.49%	2.80%
Other nervous system disorders	2.59%	2.74%
Spondylosis; intervertebral disc disorders; other back problems	2.55%	2.68%
Chronic kidney disease	2.18%	1.98%
Chronic obstructive pulmonary disease and bronchiectasis	1.98%	1.97%
Diabetes mellitus without complication	1.68%	1.91%
Delirium, dementia, and amnestic and other cognitive disorders	1.84%	1.72%

Table 11 shows that claims for blindness and vision defects are most common among children and adolescents ages 2-18, accounting for 9.57% of all claims. Upper respiratory infections maintain its position for the highest percentage of costs in 2021, although with rate of 4.47%, it is slightly lower than the previous year (Table 12). COVID-related claims were categorized under “Viral Infection,” which was among one of the top 10 claims for members ages 2-18.

Table 11: Claims/Encounter Data -Top 10 Claims, Ages 2-18, MY2020-2021

	% of Claims	
	2020	2021
Blindness and vision defects	8.23%	9.57%
Other upper respiratory infections	7.11%	6.30%
Other nutritional; endocrine; and metabolic disorders	3.68%	4.45%
Other upper respiratory disease	3.79%	3.85%
Developmental disorders	2.40%	3.49%
Other skin disorders	*N/A**	3.35%
Abdominal pain	2.91%	3.29%
Administrative/social admission	2.69%	3.28%
Viral infection**	2.45%	2.22%
Disorders usually diagnosed in infancy, childhood, or adolescence	*N/A**	2.19%

**** Claim/diagnosis not captured as a top 10 item in 2021***
*****Viral infections include COVID-19 related claims***

Table 12: Claims/Encounter Data -Top 10 Costs, Ages 2-18, MY2020-2021

	% of Costs	
	2020	2021
Other upper respiratory infections	4.84%	4.47%
Other nutritional; endocrine; and metabolic disorders	3.92%	4.39%
Abdominal pain	3.45%	3.68%
Fracture of upper limb	3.03%	3.60%
Blindness and vision defects	2.86%	3.41%
Other skin disorders	2.62%	3.02%
Other upper respiratory disease	2.60%	2.77%
Appendicitis and other appendiceal conditions	2.96%	2.51%
Disorders usually diagnosed in infancy, childhood, or adolescence	*N/A**	2.44%
Administrative/social admission	*N/A**	2.26%

In adults aged 19 years or older, 90% of all claims mirrored from the previous year. Noted in Tables 13-14 below, essential hypertension represents nearly 12.5% of claims and second highest of costs. Respiratory conditions contribute to 4.85% of costs.

Table 13: Claims/Encounter Data -Top 10 Claims, Ages 19+ Years, MY2020-2021

	% of Claims	
	2020	2021
Essential hypertension	10.83%	12.45%
Diabetes mellitus without complication	3.63%	3.73%
Diabetes mellitus with complications	3.38%	3.50%
Spondylosis; intervertebral disc disorders; other back problems	3.65%	3.44%
Other connective tissue disease	2.30%	2.33%
Blindness and vision defects	1.93%	2.11%
Other non-traumatic joint disorders	1.92%	2.10%
Abdominal pain	1.90%	1.96%
Other lower respiratory disease	2.28%	1.89%
Normal pregnancy and/or delivery	*N/A**	1.77%

**** Claim/diagnosis not captured as a top 10 item in 2020***

Table 14: Claims/Encounter Data -Top 10 Costs, Ages 19+ Years, MY2020-2021

	% of Costs	
	2020	2021
Respiratory failure; insufficiency; arrest	5.04%	4.85%
Essential hypertension	3.90%	4.29%
Septicemia (except in labor)	4.35%	3.97%
Diabetes mellitus with complications	2.67%	3.01%
Other nervous system disorders	2.71%	2.87%
Spondylosis; intervertebral disc disorders; other back problems	2.69%	2.84%
Chronic kidney disease	2.34%	2.14%
Chronic obstructive pulmonary disease and bronchiectasis	2.12%	2.13%
Diabetes mellitus without complication	1.79%	2.04%
Delirium, dementia, and amnestic and other cognitive disorders	1.98%	1.86%

Among members with disabilities, all top 10 claims submitted in 2020 are also captured in 2021 (Table 15). Essential hypertension represents the highest proportion of claims and the third highest of costs (Table 16). Nine out of the top 10 costs in 2020 were mirrored in 2021, with respiratory failure at the top with 7.18% of costs.

Table 15: Claims/Encounter Data - Top 10 Claims, Members with Disabilities, MY2020-2021

	% of Claims	
	2020	**2021**
Essential hypertension	8.51%	11.13%
Diabetes mellitus with complications	3.85%	3.93%
Spondylosis; intervertebral disc disorders; other back problems	4.12%	3.78%
Diabetes mellitus without complication	3.40%	3.64%
Schizophrenia and other psychotic disorders	3.32%	3.52%
Chronic kidney disease	3.37%	3.03%
Other connective tissue disease	2.45%	2.39%
Other lower respiratory disease	2.62%	2.20%
Other nervous system disorders	2.07%	2.15%
Chronic obstructive pulmonary disease and bronchiectasis	2.05%	1.82%

**** Claim/diagnosis not captured as a top 10 item in 2021***

Table 16: Claims/Encounter Data - Top 10 Costs, Members with Disabilities, MY2020-2021

	% of Costs	
	2020	**2021**
Respiratory failure; insufficiency; arrest	7.46%	7.18%
Septicemia (except in labor)	5.59%	5.01%
Essential hypertension	2.97%	3.74%
Chronic kidney disease	3.62%	3.43%
Other nervous system disorders	3.05%	3.26%
Diabetes mellitus with complications	2.73%	3.10%
Spondylosis; intervertebral disc disorders; other back problems	2.92%	3.06%
Chronic obstructive pulmonary disease and bronchiectasis	2.88%	3.01%
Hypertension with complications and secondary hypertension	2.34%	2.31%
Schizophrenia and other psychotic disorders	*N/A**	1.86%

The top 10 behavioral health conditions are referenced in Table 17. Mood, Anxiety, Schizophrenia, and Autistic Disorders continue to make up the top four in 2021. See **Appendix E** for information on the number of counseling session per diagnosis.

Table 17: Claims/Encounter Data - Top 10 Behavioral Health Conditions for All Ages, MY2020-2021 (n= 55,073)

Behavioral Health	***2020***	***2021***
Mood Disorders	21,567	21,357
Anxiety Disorders	11,789	13,698
Schizophrenia and other Psychotic Disorders	6,647	5,642
Autistic Disorder	3,223	3,637
Adjustment Disorder with Mixed Anxiety & Depressed Mood	2,377	3,091
Post-Traumatic Stress Disorder (unspecified)	1,696	1,968
Sexual and Gender Identity Disorders	1,801	1,599
Substance Related and Addictive Disorders	1,496	1,496
Post-Traumatic Stress Disorder (chronic)	1,141	1,405
Adjustment Disorder Unspecified	N/A*	1,162
Total:	**54,516**	**55,073**

Adverse Childhood Experiences

Adverse Childhood Experiences (ACEs) are traumatic events experienced prior to age 18. This may include various types of abuse (physical, sexual, or emotional), substance use, mental health problems, or other problematic events witnessed or experienced in the household to name a few. Because of the link to various health problems throughout the lifespan, providers are encouraged to screen for ACEs in children, adolescents, and adults to assess and treat toxic stress to improve outcomes.

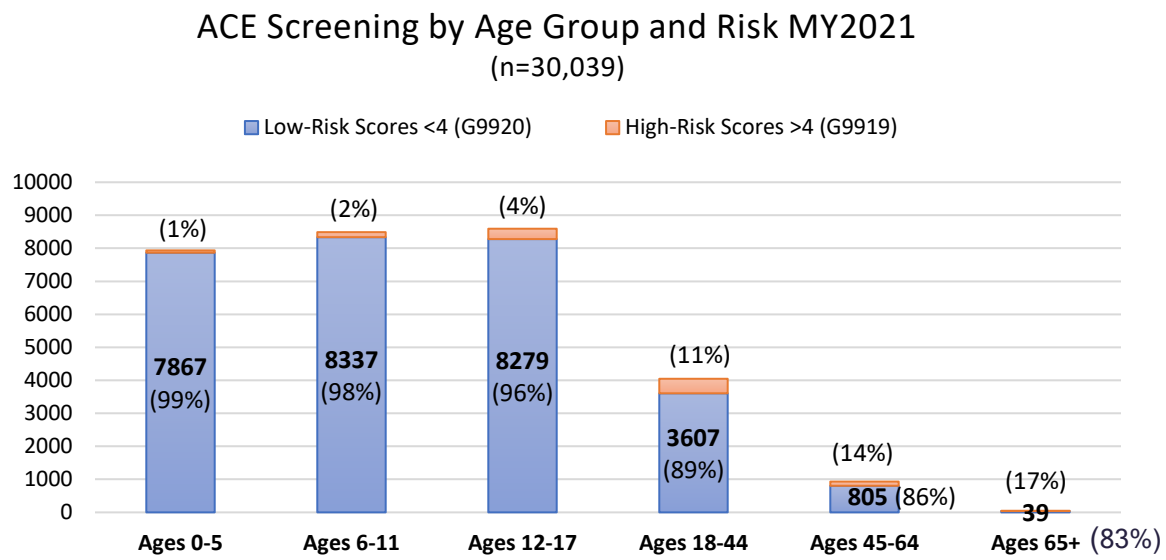
Health Net paid for a total of 30,066 ACE screenings in 2021 (per available claims as of 3/31/2022), representing 30,039 unique members. Of unique members, a majority (96.24%; n=28,911) had an ACEs score between 0-3, representing a lower risk score for toxic stress. The remaining 3.7% had an ACEs score of four or greater, indicating high risk for toxic stress. Los Angeles County had the highest number of screenings overall with 15,386, followed by Sacramento and Tulare Counties. Stanislaus County has the highest percentage of high-risk ACEs score at 10.23%.

Table 18: Claims/Encounter Data – Paid ACES Claims by County, MY2021

Counties	*Low-Risk <4*	*High-Risk >4*	*Total Members*
Kern	2,040 (97%)	65 (3%)	2,105
Los Angeles	14,911 (97%)	475 (3%)	15,386
Sacramento	5,443 (97%)	153 (3%)	5,596
San Diego	1,311 (90%)	146 (10%)	1,457
San Joaquin	92 (99%)	1 (1%)	93
Stanislaus	351 (90%)	40 (10%)	391
Tulare	4,786 (95%)	231 (5%)	5,017
Total	**28,911 (96%)**	**1,128 (4%)**	**30,039**

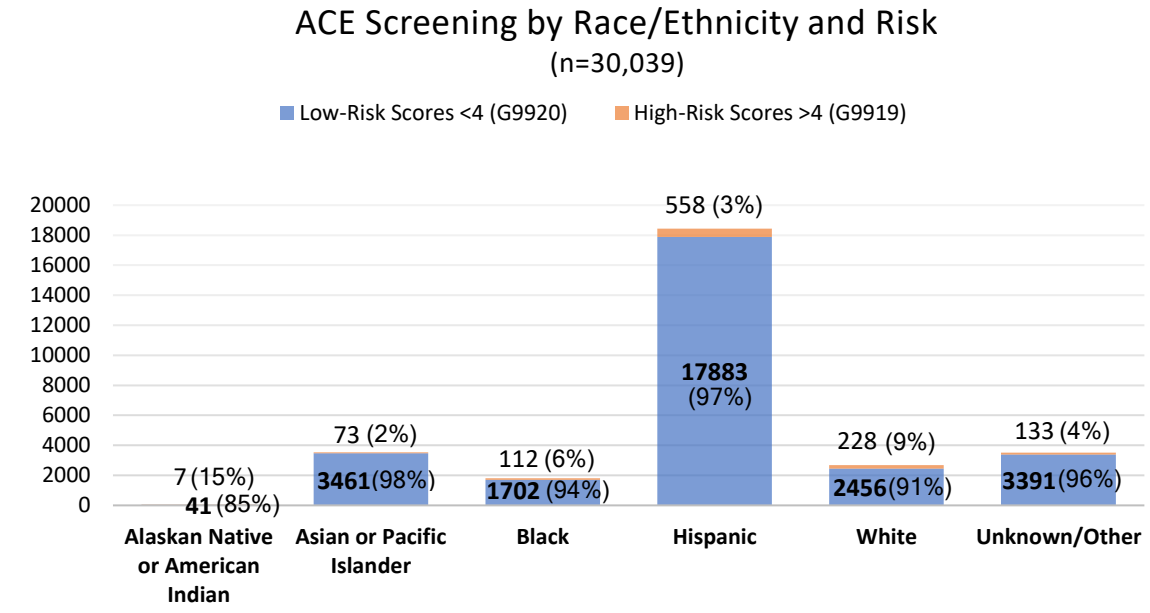
Females represent 52.76% of all unique ACE submissions (n= 15,862). Of these, 5% were flagged with a high-risk ACE score of 4 or more. Table 19. shows that children ages 12-17 account for the largest proportion of claims at 28.61%, and screenings overall for children and adolescents under the age 18 account for 83% of all claims submitted. Of all age groups, Health Net adults were more likely to exhibit high-risk ACE scores. An estimated 24.5% of screenings among the 18-44 and 45-64 age groups had a high-risk score.

Table 19: Claims/Encounter Data - ACEs Screenings by Age Group and Risk, MY2021



Hispanics account for the largest proportion of all screenings (61.37%). Asian or Pacific Islander members represent 12% of claims, followed by White members (9%). Alaskan Native or American Indian had 15% of their total screenings flagged as high risk, leading rates among all groups (Table 20). Though only 3% of Hispanics screened were considered high-risk, because they comprise 59.5% of all screened members, they represent a greater number of high-risk individuals than any other group.

Table 20: Claims/Encounter Data - ACEs Screenings by Ethnicity and Risk, MY2021



Coronavirus Disease 2019 (COVID-19)

Since December 2020, COVID-19 vaccinations have been approved for ages 5 years and older and have been widely distributed throughout the United States. Tables 21-22 below highlight the various indicators (Vaccination and Testing/Positivity Rates) used to monitor the COVID-19 infection and vaccination status in the Health Net membership population. Overall, 41.6% of Health Net's membership age 5 years and older remained unvaccinated while 53% of the same population completed their vaccination series not including boosters.

Out of all the age groups stratified, individuals 60 years and above typically exhibit the highest vaccination rates. Compliance within this age category remains a top priority as the severity of respiratory illness associated with the SARS-COV2 virus positively correlates with age. Vaccination rates for younger Health Net members fall behind those of their older counterparts due to different timelines in approvals and emergency use authorizations of the vaccines. The Food and Drug Administration (FDA) approved the use of the Pfizer-BioNTech COVID-19 Vaccine in children ages 12 to 15 on an emergency use basis on May 10, 2021, followed by the Advisory Committee and Immunization Practices (ACIP) recommendation and Centers for Disease Control and Prevention (CDC) approval the same week. The FDA issued an Emergency Use Authorization (EUA) for the Pfizer-BioNTech COVID-19 Vaccine for children ages 5 to 11 on October 29, 2021, followed by ACIP recommendation and CDC approval on November 2, 2021. Our data captures vaccination rates from January 1, 2021, to December 31, 2021. With the younger populations approvals coming in toward the end of the calendar year, naturally the vaccination rates for these age groups are lower when compared to populations who've had access to the vaccine for almost a year prior. As approvals are received and the Health Plan and state work to create new initiatives to increase access to vaccination, the vaccination rates for these younger populations are expected to rise.

When identifying for testing and positivity rates, middle-aged Health Net members exhibit lower positivity rates. Health Net's adolescent membership (12-21) carry a larger burden of the positivity rate. Out of all age groups stratified, individuals within the 70+ year old age range exhibited the highest infection rates overall.

Table 21: Vaccination Status, Test/Infection Rate by Age, MY2021

	Vaccine Status				Test/Infection Rate	
Age Group	**Unvaccinated**	**Vaccinated**	**Complete**	**Booster**	**Test Positive**	**COVID %**
05-11	73.8%	26.2%	21.4%	0.3%	8.5%	5.8%
12-16	39.6%	60.4%	54.9%	11.6%	12.3%	6.6%
17-21	35.3%	64.7%	59.1%	21.4%	12.3%	8.4%
22-34	42.7%	57.3%	51.9%	20.3%	8.2%	10.4%
35-49	39.5%	60.5%	55.4%	24.9%	8.8%	11.5%
50-59	30.2%	69.8%	64.6%	35.2%	9.6%	11.9%
60-64	26.7%	73.3%	68.1%	41.2%	8.7%	11.9%
65-69	23.3%	76.7%	71.3%	47.3%	9.5%	11.6%
70-74	21.6%	78.4%	72.5%	49.8%	8.9%	13.0%
75-79	20.9%	79.1%	73.4%	51.4%	9.0%	13.9%
80+	24.2%	75.8%	69.0%	46.5%	6.8%	16.8%
Overall	41.6%	58.4%	53.0%	22.6%	9.3%	9.8%

Amongst the identifiable Health Net membership, African American and White individuals represent the most considerable portions of the unvaccinated membership at 55.2% and 45.3%. American Indian and Alaskan native members exhibited the highest vaccination rates at 80.5%, Asians at 79.8%, and Native Hawaiian and Pacific Islanders at 69.6%. Among vaccination completions and booster doses following up a completion series, Asian members displayed the highest rates followed by those identifying as multi-racial.

Table 22: Vaccination Status, Test/Infection Rate by Race and Ethnicity, MY2021

	Vaccine Status				Test/Infection Rate	
Race/Ethnicity	**Unvaccinated**	**Vaccinated**	**Complete**	**Booster**	**Test Positive**	**COVID %**
African American	55.2%	44.8%	39.2%	14.5%	6.3%	8.8%
AI/AN	19.5%	80.5%	73.2%	25.9%	10.3%	10.8%
Asian	20.2%	79.8%	74.7%	44.3%	7.8%	6.2%
Hispanic or Latino	41.7%	58.3%	52.8%	19.7%	10.4%	10.6%
Multi Race	44.0%	56.0%	52.2%	31.3%	8.7%	7.1%
NH/PI	30.4%	69.6%	63.3%	22.3%	12.0%	10.8%
White	45.3%	54.7%	49.6%	21.8%	9.0%	10.4%
Unknown/Other	66.9%	33.1%	29.3%	15.4%	9.7%	8.3%
Overall	41.6%	58.4%	53.0%	22.6%	9.3%	9.8%

Health Information Form (HIF)

The Health Information Form is a questionnaire that helps identify self-reported member needs and services. It is included in the new member welcome packet. Seniors and Persons with Disabilities (SPD) members receive telephonic outreach to assist form completion. HIF questions are grouped into four themes: Global Health (perceived health rating, provider visit frequency, hospital and ED visits, flu shots); Physical Health (self-reported health conditions); Behavioral Health (self-reported instances of depression, anxiety, and anti-psychotic medication), and Activities of Daily and Independent Living (stable housing and ability to pay for basic necessities). Members are given an overall risk score based on responses. This helps connect high-risk members with case management resources where appropriate.

In MY2021, a total of 12,145 health information forms were completed, representing 11,803 unique members. Tables 23-24 note survey responses in additional detail from all completed forms (n=12,145). In comparison to the 2021 PNA, there was a 45% decrease in the amount of HIF forms completed by unique members for MY2020 (17,699) that may be attributed because of the COVID-19 pandemic.

Table 23: HIF – Global & Physical Health, MY2020-2021 (n= 12,145)

Global Health	*2020*	*2021*
Provider visit in past 12 months	41.40%	32.00%
Ever had transportation barriers to medical appointments	10.71%	10.03%
Hospital visits in the last 3 months		
3 or more times	1.49%	1.28%
2 times	1.58%	1.72%
1 time	5.94%	4.97%
Emergency Department visits in the last year		
3 or more times	5.08%	5.20%
2 times	4.90%	3.93%
1 time	9.94%	7.57%
Received flu shot in last 12 months	23.70%	16.90%
Trouble eating due to problems with mouth or teeth	14.63%	13.14%
Any physical activity during the week	36.10%	24.46%

Physical Health	***2020***	***2021***
Medical/health conditions		
High blood pressure	25.22%	29.07%
High cholesterol	19.11%	22.88%
Arthritis	17.97%	21.52%
Asthma	12.54%	13.50%
Diabetes, Type 2	10.84%	13.02%
Pre-Diabetes	5.79%	6.93%
Heart Disease	5.70%	5.24%
COPD/Emphysema	4.57%	4.42%
Developmental delay	3.63%	4.28%
Cancer	3.40%	4.23%

Table 24: HIF – Behavioral Health & Independent Living, MY2020-2021

Behavioral Health	***2020***	***2021***
Loneliness in the past 2 weeks		
Several days	13.29%	15.22%
More than half the days	3.77%	4.72%
Nearly every day	5.37%	6.97%
Little interest or pleasure in doing things in past 2 weeks		
Several days	7.01%	6.61%
More than half the days	2.57%	2.53%
Nearly every day	3.85%	4.23%
Feeling down, depressed or hopeless in past two weeks		
Several days	16.64%	18.57%
More than half the days	4.70%	6.67%
Nearly every day	6.44%	6.78%
Days felt lonely in past month (30 days)		
Less than 5 days	17.82%	19.74%
More than half the days (more than 15)	7.07%	9.17%
Most days (I always feel lonely)	4.99%	6.78%
Tobacco use during the past year		
Daily or almost daily	9.62%	12.53%
Weekly	1.60%	4.01%
Monthly	1.44%	1.77%
Once or twice	3.96%	1.42%
Behavioral health disorder diagnosis, such as anxiety, depression, bipolar or schizophrenia?	23.83%	28.86%
Anti-psychotic medication prescriptions within the past 90 days?	9.18%	10.79%
Independent Living	**2020**	**2021**
In the past two months, have you been living in stable housing that you own, rent or stay in as part of a household?	81.38%	84.25
Do you sometimes run out of money to pay for food, rent, bills, and medicine?	29.65%	32.39

Nicotine Dependence

The Health Information Form offered a glimpse into members self-reported tobacco use within a 12-month period. Noted in Table 24, nearly 20% of members reported at least some form of tobacco use during the past year, reflecting an increase of 3% from MY2020. Other sources, such as claims and pharmacy data, can provide additional data in identifying members with some form of nicotine dependence. Tables 25-26 below highlight dependence based on race/ethnicity, age group and county. A total of 16,930 members were flagged in MY2021, a 45.15% decrease from MY2020. The COVID-19 pandemic may have influenced this decrease.

- Statewide, the largest proportion of nicotine dependence members changed from age group 22-50 (43.63%) to 51-65 (50.1%).
- Seniors represent nearly 6% of the sample.
- Los Angeles alone accounts for 59.3% of all nicotine dependence members, with the distribution highest among the 22-50 and 51-65 age groups.
- Nicotine dependence in San Diego and Tulare Counties is highest among 22-50 years of age.

Table 25: Claims/Encounter Data - Nicotine Dependence by Age Group, MY2021

	2020	2021
Kern	**2,430**	**946**
0-13 Years	2 (0.08%)	0
14-21 Years	88 (3.62%)	7 (0.7%)
22-50 Years	1,290 (53.09%)	355 (37.5%)
51-65 Years	988 (40.66%)	563 (59.5%)
66+ Years	62 (2.55%)	21 (2.2%)
Los Angeles	**19,335**	**10,036**
0-13 Years	27 (0.14%)	1 (0%)
14-21 Years	525 (2.72%)	46 (0.5%)
22-50 Years	9,602 (49.66%)	4382 (43.7%)
51-65 Years	7,840 (40.55%)	4965 (49.5%)
66+ Years	1,341 (6.94%)	642 (6.4%)
Sacramento	**2,785**	**2,495**
0-13 Years	1 (0.04%)	0
14-21 Years	39 (1.40%)	20 (0.8%)
22-50 Years	1,338 (48.04%)	1018 (40.8%)
51-65 Years	1,272 (45.67%)	1321 (52.9%)
66+ Years	135 (4.85%)	136 (5.5%)
San Diego	**1,030**	**995**
0-13 Years	0	0
14-21 Years	78 (7.57%)	17 (1.7%)
22-50 Years	584 (56.70%)	457 (45.9%)
51-65 Years	321 (31.17%)	428 (43%)
66+ Years	47 (4.56%)	93 (9.3)
San Joaquin	**587**	**289**
0-13 Years	0	0
14-21 Years	9 (1.53%)	0
22-50 Years	306 (52.13%)	132 (45.7%)
51-65 Years	248 (42.25%)	155 (53.6%)
66+ Years	24 (4.09%)	2 (0.7%)
Stanislaus	**662**	**896**
0-13 Years	0	0
14-21 Years	9 (1.36%)	7 (0.8%)
22-50 Years	325 (49.09%)	392 (43.8%)
51-65 Years	303 (45.77%)	474 (52.9%)
66+ Years	25 (3.78%)	23 (2.6%)
Tulare	**4,042**	**1,273**
0-13 Years	6 (0.15%)	0
14-21 Years	197 (4.87%)	18 (1.4%)
22-50 Years	2,374 (58.73%)	651 (51.1%)
51-65 Years	1,317 (32.58%)	576 (45.2%)
66+ Years	148 (3.66%)	28 (2.2%)
Total	**30,871**	**16,930**

White members have the highest proportion of nicotine dependence in all seven counties. Among these, they surpass half of all nicotine dependence members in Kern, San Diego, San Joaquin, Stanislaus, and Tulare Counties. Hispanics have the second highest rates in Kern, San Diego, Stanislaus, and Tulare Counties. Black members have the second highest in Los Angeles County (23.7%), Sacramento County (21.5%) and third highest in all other counties. Asian or Pacific Islanders have higher concentrations for nicotine dependence in Los Angeles (8.3%), Sacramento (5.9%), and San Diego (5.5%) Counties.

Table 26: Claims/Encounter Data - Nicotine Dependence by Race/Ethnicity, MY2021

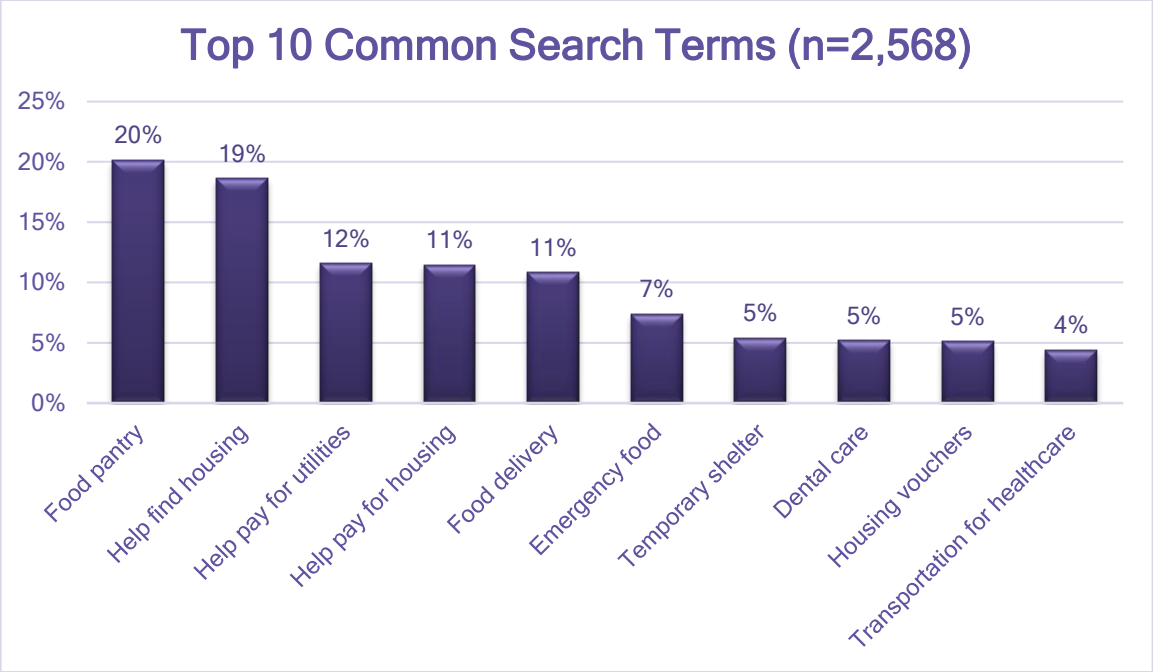
	2020	2021		2020	2021
Kern	**2,430**	**946**	**San Joaquin**	**587**	**289**
Alaskan Native or American Indian	16 (0.66%)	4 (0.4%)	*Alaskan Native or American Indian*	9 (1.53%)	0
Asian or Pacific Islander	35 (1.44%)	13 (1.4%)	*Asian or Pacific Islander*	34 (5.79%)	5 (1.7%)
Black	342 (14.07%)	118 (12.5%)	*Black*	75 (12.78%)	40 (13.8%)
Hispanic	666 (27.41%)	146 (15.4%)	*Hispanic*	140 (23.85%)	40 (13.8%)
Unknown / Other	131 (5.39%)	82 (8.7%)	*Unknown / Other*	61 (10.39%)	48 (16.6%)
White	1,240 (51.03%)	583 (61.6%)	*White*	268 (45.66%)	156 (54%)
Los Angeles	**19,335**	**10036**	**Stanislaus**	**662**	**896**
Alaskan Native or American Indian	55 (0.28%)	11 (0.1%)	*Alaskan Native or American Indian*	6 (0.91%)	2 (0.2%)
Asian or Pacific Islander	1915 (9.90%)	838 (8.3%)	*Asian or Pacific Islander*	33 (4.98%)	34 (3.8%)
Black	4,235 (21.90%)	2382 (23.7%)	*Black*	37 (5.59%)	37 (4.1%)
Hispanic	6,297 (32.57%)	2225 (22.2%)	*Hispanic*	167 (25.23%)	195 (21.8%)
Unknown / Other	1252 (6.48%)	1154 (11.5%)	*Unknown / Other*	51 (7.70%)	62 (6.9%)
White	5,581 (28.86%)	3426 (34.1%)	*White*	368 (55.59%)	566 (63.2%)
Sacramento	**2,785**	**2495**	**Tulare**	**4,042**	**1273**
Alaskan Native or American Indian	36 (1.29%)	42 (1.7%)	*Alaskan Native or American Indian*	27 (0.67%)	9 (0.7%)
Asian or Pacific Islander	199 (7.15%)	147 (5.9%)	*Asian or Pacific Islander*	83 (2.05%)	35 (2.7%)
Black	619 (22.23%)	536 (21.5%)	*Black*	127 (3.14%)	44 (3.5%)
Hispanic	275 (9.87%)	206 (8.3%)	*Hispanic*	1,721 (42.58%)	385 (30.2%)
Unknown / Other	629 (22.59%)	511 (20.5%)	*Unknown / Other*	584 (14.45%)	162 (12.7%)
White	1,027 (36.88%)	1053 (42.2%)	*White*	1,500 (37.11%)	638 (50.1%)
San Diego	**1,030**	**995**	**Total**	**30,871**	**16,930**
Alaskan Native or American Indian	3 (0.29%)	0			
Asian or Pacific Islander	58 (5.63%)	55 (5.5%)			
Black	102 (9.90%)	102 (10.3%)			
Hispanic	145 (14.08%)	132 (13.3%)			
Unknown / Other	318 (30.87%)	206 (20.7%)			
White	404 (39.22%)	500 (50.3%)			

Health Net Community Connect

Health Net Community Connect is an online service that connects members to free or reduced cost social services in their communities. Supported by Findhelp.org (formally Aunt Bertha), website analytics help identify trends in emerging Social Determinants of Health by monitoring, tallying, and categorizing member searches.

A total of 14,933 searches were recorded among all Health Net counties with the top 10 common search terms being displayed in the table below. The most searches per county are in order as follows: Los Angeles, Sacramento, San Diego, Orange, Kern, Riverside, Tulare, San Bernardino, and Stanislaus. During 2021, there were 1,601 connections made, 726 referrals created, 10 close loop referrals and 38 total social needs assessments completed. These findings help Health Net assess the social needs and risks of members. Members can search for services by typing in search terms or by using a prebuilt search domain of 10 categories. Of the 14,933 searches, 2,568 were in the form of a category search. Food represents the highest search by category at 20% (n=513), followed by housing instability at 19% (n=487), and financial assistance for utilities 12% (n=308). Please see Table 32 on the following page for more details on search terms.

Table 32: Health Net Community Connect – Most Common Search Terms, MY2021



ACCESS TO CARE

Health Net established access to care standards to meet regulatory requirements. Ensuring adequate member access to health care is critical to delivering quality care and service. This section presents metrics from the Provider Appointment Availability Survey (PAAS), Provider After-Hours Availability Survey (PAHAS), and Consumer Assessment of Healthcare Providers and Systems (CAHPS).

DMHC Provider Appointment Availability Survey (PAAS)

The Department of Managed Health Care PAAS reviews patient access on various appointment scheduling metrics. Providers surveyed include Primary Care Providers (PCPs), Specialists, Ancillary Providers, behavioral health providers and psychiatry practice professionals. The DMHC PAAS survey was conducted via fax, email and telephone between August and December 2021.

Access to Primary Care Providers

Of 1,268 attempted surveys, a total of 822 responses were received from Primary Care Providers, resulting in a 64.8% response rate. Overall, PCPs met and exceeded the 80% performance goal of three of the five access measure standards among all seven Health Net counties. A statistically significant reduction was noted in 2021 for *Non-Urgent Appointment*, *Access to Preventive Care, Access to Physical Exams and Access to First Prenatal Appointment*. *Urgent Care Appointment* measure had an increase statistically significant.

Table 33: PAAS (DMHC + HN PCPs) - Access to Primary Care Providers, MY2020-2021

		Urgent Care Appointment within 48 hours of request (PCP)		*Non-Urgent Appointment within 10 business days of request (PCP)*		*Access to Preventive Health Check-Up/Well-Child Appointment within 10 business days of request (PCP)*		*Access to Physical Exams and Wellness Checks within 30 calendar days of request (PCP)*		*Access to First Prenatal Appointment within 10 business days of request (PCP)*	
		N (Rate %)									
County	**Performance Goal**	**2020**	**2021**	**2020**	**2021**	**2020**	**2021**	**2020**	**2021**	**2020**	**2021**
KERN	80%	106 (51)	118 (48)	108 (84)	121 (68)	67 (76)	86 (64)	63 (92)	✓ 87 (85)	24 (96)	✓ 27 (82)
LOS ANGELES	80%	977 (58)	1225 (69)	996 (94)	✓ 1257 (90)	591 (85)	✓ 1009 (84)	556 (95)	✓ 989 (94)	211 (94)	✓ 352 (85)
SACRAMENTO	80%	120 (56)	113 (61)	128 (96)	121 (67)	45 (87)	71 (68)	46 (98)	✓ 79 (80)	8 (87)	27 (63)
SAN DIEGO	80%	210 (73)	267 (65)	218 (98)	✓ 286 (85)	122 (91)	208 (76)	113 (95)	✓ 146 (90)	52 (98)	30 (77)
SAN JOAQUIN	80%	81 (42)	88 (49)	87 (87)	✓ 92 (85)	59 (81)	64 (69)	52 (100)	✓ 54 (94)	13 (100)	23 (65)
STANISLAUS	80%	93 (56)	86 (51)	94 (92)	91 (70)	52 (67)	60 (45)	50 (82)	57 (67)	9 (89)	21 (67)
TULARE	80%	116 (56)	102 (62)	117 (96)	✓ 105 (91)	74 (92)	✓ 68 (85)	65 (95)	✓ 61 (97)	45 (98)	✓ 28 (93)
Total	**80%**	**1,703 (58)**	**65%↑**	**1,748 (94)**	**85%↓**	**1,010 (84)**	**79%↓**	**945 (95)**	**91%↓**	**362 (95)**	**82%↓**

N: Total number respondents to the question
Rate: Percent of total number of respondents surveyed who met the access standard
↑↓ Statistically significant difference between MY 2021 PAAS vs MY 2020 PAAS (p<0.05)
✓ | *Rate above the performance goal*

At the county level, Los Angeles and Tulare Counties met performance goals on four of the five measure standards. Kern, San Diego, and San Joaquin Counties met two of the five performance goals.

Access to Specialists

Access to specialists make up the second component of the PAAS. A total of 1,727 specialists responded, accounting for a 62.5% response rate. The sample includes responses from the original DMHC PAAS, and an additional separate PAAS that incorporates a wider group of specialists. High-Impact specialists/oncology were also included but reported separately. They account for an additional 66 responses (66.7% response rate).

Table 34: PAAS - Access to Specialists, MY2020-2021

		PAAS (DMHC + HN Specialists)						*PAAS (High-Impact Specialists/Oncology)*			
		Urgent Care Appointment within 96 hours of request (Specialists)		*Non-Urgent Appointment within 15 business days of request (Specialists)*		*Access to First Prenatal Appointment within 10 business days of request (Specialists)*		*Urgent Care Appointment within 96 hours of request (Specialists)*		*Non-Urgent Appointment within 15 business days of request (Specialists)*	
		N (Rate %)									
County	**Performance Goal**	**2020**	**2021**	**2020**	**2021**	**2020**	**2021**	**2020**	**2021**	**2020**	**2021**
KERN	80%	77 (38)	90 (41)	79 (78)	95 (72)	8 (88)	12 (58)	3 (100)	1 (0)	3 (100)	✓ 1 (100)
LOS ANGELES	80%	994 (61)	1228 (45)	1,044 (86)	1299 (70)	88 (90)	✓ 90 (93)	70 (81)	44 (41)	73 (97)	✓ 45 (93)
SACRAMENTO	80%	142 (42)	157 (34)	177 (78)	179 (61)	3 (67)	10 (60)	5 (60)	✓ 5 (80)	5 (100)	✓ 6 (83)
SAN DIEGO	80%	274 (55)	307 (41)	292 (79)	344 (58)	6 (100)	15 (53)	15 (67)	4 (25)	17 (100)	✓ 6 (83)
SAN JOAQUIN	80%	103 (60)	102 (44)	106 (87)	103 (69)	6 (83)	9 (33)	5 (60)	1 (0)	5 (60)	✓ 1 (100)
STANISLAUS	80%	73 (59)	84 (46)	80 (80)	94 (55)	6 (33)	13 (39)	9 (68)	5 (20)	9 (68)	5 (20)
TULARE	80%	81 (51)	71 (31)	83 (78)	72 (78)	7 (86)	✓ 3 (100)	7 (100)	✓ 2 (100)	7 (100)	✓ 2 (100)
Total	**80%**	**1,744 (57)**	**43%↓**	**1,861 (84)**	**67%↓**	**124 (86)**	**76%↓**	**114 (78)**	**42%↓**	**119 (94)**	**86%**

N: Total number respondents to the question
Rate: Percent of total number of respondents surveyed who met the access standard
↑↓ Statistically significant difference between MY 2021 PAAS vs MY 2020 PAAS (p<0.05)
✓ | *Rate above the performance goal*

On average among Health Net counties, Specialists and OB/GYN providers surveyed met and exceeded the 80% performance goal in one of the five measures. Surveyed High-Impact Specialist surpassed the 80% performance goal for *Non-Urgent Appointment within 15 days* (86%). In comparison to 2020, four of the five measurements had a statistically significant reduction in 2021. At the county level, Tulare County met performance goal in three measures as displayed in Table 34.

Access to Psychiatrists & Non-Physician Mental Health (NPMH)

A total of 237 psychiatrists (85.6% response rate) and 744 non-physician mental health providers (83.3% response rate) completed the Provider Appointment Availability Survey. A statistically significant decrease was noted in 2021 for all four measures in comparison to 2020. Overall, Psychiatrists and NPMH providers did not meet the 90% performance goal for Health Net as a whole and only one county met one measure as shown in Table 35 below.

Table 35: PAAS - Access to Psychiatry, Non-Physician Mental Health (NPMH), MY2020-2021

		Urgent Care services within 96 hours of request (Psychiatrist)		***Non-Urgent Appointment within 15 business days of request (Psychiatrist)***		***Urgent Care services within 96 hours of request (NPMH)***		***Non-Urgent Appointment within 10 business days of request (NPMH)***	
		N (Rate %)							
County	Performance Goal	2020	2021	2020	2021	2020	2021	2020	2021
KERN	90%	2 (0)	7 (71)	2 (50)	7 (86)	24 (79)	42 (33)	24 (100)	44 (45)
LOS ANGELES	90%	72 (60)	70 (47)	75 (92)	76 (89)	136 (77)	134 (57)	167 (85)	173 (75)
SACRAMENTO	90%	20 (35)	30 (60)	20 (75)	33 (73)	75 (59)	91 (43)	86 (86)	106 (68)
SAN DIEGO	90%	45 (42)	44 (34)	48 (85)	48 (69)	124 (71)	125 (61)	133 (84)	142 (73)
SAN JOAQUIN	90%	4 (50)	5 (20)	4 (75)	5 (40)	29 (83)	31 (48)	29 (100)	32 (63)
STANISLAUS	90%	1 (100)	4 (75)	1 (100)	✓ 4 (100)	42 (62)	42 (52)	44 (89)	47 (60)
TULARE	90%	1 (0)	4 (25)	2 (50)	4 (50)	33 (46)	45 (60)	34 (88)	47 (68)
Total	**90%**	**145 (50)**	**46%↓**	**152 (86)**	**79%↓**	**463 (69)**	**53%↓**	**517 (87)**	**69%↓**

N: Total number respondents to the question
Rate: Percent of total number of respondents surveyed who met the access standard
N/A: No available responses
↑↓ Statistically significant difference between MY 2021 PAAS vs MY 2020 PAAS (p<0.05)
✓ *Rate above the performance goal*

Access to Ancillary Services

One hundred-twenty six of 128 surveys Ancillary responses were received, resulting in a 98.4% response rate. Response rates by ancillary type was 98.2% for mammography (107 out of 109), and 100% for physical therapy (19 out of 19).

Table 36: PAAS (DMHC) - Access to Ancillary, MY2020-2021

		Non-Urgent Services within 15 business days of request (Ancillary)	
		N (Rate %)	
County	**Performance Goal**	**2020**	**2021**
KERN	80%	13 (100)	✓ 21 (100)
LOS ANGELES	80%	62 (100)	✓ 65 (98)
SACRAMENTO	80%	9 (100)	✓ 11 (100)
SAN DIEGO	80%	18 (94)	✓ 19 (89)
SAN JOAQUIN	80%	4 (100)	✓ 4 (100)
STANISLAUS	80%	3 (100)	✓ 3 (100)
TULARE	80%	3 (100)	✓ 3(100)
Total	**80%**	**(112) 99**	**98%**

N: Total number respondents to the question
Rate: Percent of total number of respondents surveyed who met the access standard
↑↓ Statistically significant difference between MY 2021 PAAS vs MY 2020 PAAS (p<0.05)
✓ *Rate above the performance goal*

Ancillary Providers across all Health Net counties met and exceeded the 80% performance goal for "*Non-Urgent Services within 15 business days of requests*"

Provider After-Hours Availability Survey (PAHAS)

Health Net conducted the Provider After-Hours Availability Survey for Health Net contracted Medi-Cal providers in December 2021. A vendor, Sutherland Health Care Solutions implemented the survey telephonically. Health Net's PAHAS used two metrics to measure performance for access to after-hours care. A total of 1,912 completed calls (94% response rate) where included in the analysis. Overall, Health Net providers combined met the 90% goal for the measure *Appropriate After-Hours Emergency Instructions*. Both measures had statistically significant higher rates in 2021. At the county level, some counties did meet the goal as noted in Table 37.

Table 37: Provider After-Hours Survey Results, MY2020-2021

		Appropriate After-Hours Emergency Instructions		*Ability to contact on-call physician after-hours within 30 minutes*	
		N (Rate %)			
County	Performance Goal	2020	2021	2020	2021
KERN	90%	16 (100)	76 (86)	16 (75)	76 (24)
LOS ANGELES	90%	917 (92)	✓ 1150 (98)	917 (77)	1150 (86)
SACRAMENTO	90%	101 (83)	66 (85)	101 (59)	66 (74)
SAN DIEGO	90%	143 (94)	✓ 221 (95)	143 (70)	221 (81)
SAN JOAQUIN	90%	72 (96)	✓ 125 (95)	72 (63)	125 (42)
STANISLAUS	90%	144 (92)	✓ 163 (99)	144 (83)	163 (85)
TULARE	90%	165 (83)	✓ 111 (96)	165 (78)	111 (87)
Total	**90%**	**91%**	**96% ↑**	**75%**	**80%↑**

N: Total number respondents to the question

Rate: Percent of total number of respondents surveyed who met the access standard

↑↓ Statistically significant difference between MY 2021 PAAS vs MY 2020 PAAS (p<0.05)

✓ *Rate above the performance goal*

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Health Net members can rate their health care experience on a variety of measures via the CAHPS survey. The CAHPS survey is a standardized survey tool which collects member experiences with health plans and services. Health Net deployed the survey in February to a random sample of members. Survey findings highlight where the health plan is performing well, while also helping identify opportunities for improvement. A total of 481 surveys were received, accounting for a 10.7% response rate. All seven Health Net counties were represented in the survey.

Sample Size	English Completes	Spanish Completes	Mail Completes	Internet Completes	Total Completes
4,515	340	141	391	90	481

Several composite measures and rating metrics are used for HEDIS and health plan accreditation. Scores represent the proportion of members who rate Health Net favorably on a given measure. In reviewing data from 2020 to 2021, rates increased in three measures, decreased in nine measures, and stayed the same in one, as noted in Table 38.

Table 38: Composite Measures, CAHPS Survey Results 2020 – 2021

Type of Measures	2020	2021
Composite Measures		
Getting Care Quickly	*76%*	66% ↓
How Well Doctors Communicate	*92%*	85.5%↓
Getting Needed Care	*77%*	71%
Customer Service	*83%*	87%
Overall Rating Measures*		
Health Care	*52%*	47%
Personal Doctor	*63%*	61%
Specialist	*63%*	68%
Health Plan	*54%*	55%
HEDIS Measures		
Flu Vaccinations	*42%*	36%
Advising Smokers and Tobacco Users to Quit**	*71%*	66%
Discussing Cessation Medications**	*42%*	41%
Discussing Cessation Strategies**	*38%*	38%
Coordination of Care	*79%*	69%
Sample Size	*4,523*	4,515

Number of Completes	*369*	481
Response Rate	8%	11%

Legend: ↑/↓ Statistically higher/lower compared to prior year results.
* Reflects members who rated 9, 10 on the 0-10 scale (%9,10) to align with scores that are sent to NCQA for Health Plan Ratings.
** Measure is reported using a Rolling Average Methodology. The score shown is the reportable score for the corresponding year.

Quality Compass is NCQA's comprehensive national database of health plans' HEDIS and CAHPS results. The Quality Compass percentiles provide an indication of how health plans fared against last year's national average, with 100th being the highest possible. Table 39 below notes Health Net's rate comparison.

Table 39: CAHPS - Benchmarks, MY2020

Composite Scores	**2021 Rates**	**Comparison to 2020 Quality Compass® Benchmarks**
Getting Care Quickly	*66%*	Below 5th %tile
How Well Doctors Communicate	*86%*	Below 5th %tile
Getting Needed Care	*71%*	Below 5th %tile
Customer Service	*87%*	Below 25th %tile
Care Coordination	*69%*	Below 5th %tile
Overall Rating Scores**	***2021 Rates***	**Comparison to 2020 Quality Compass® Benchmarks**
Health Care	*47%*	Below 5th %tile
Personal Doctor	*61%*	Below 10th %tile
Specialist	*68%*	Below 50th %tile
Health Plan	*55%*	Below 20th %tile

** Reflects members who rated 9, 10 on the 0-10 scale (%9,10) to align with scores that are sent to NCQA for Health Plan Ratings.

Demographic information was captured in the CAHPS® Survey to help highlight disparities in care among respondents. When viewed by race (White, Black, or All Other), Black members reported favorable experiences ("9" or "10" rating out of a 0-10 scale) with their Health Plan more frequently when compared to other races. When viewed by ethnicity (Hispanic or Non-Hispanic), the proportion of members identifying as Hispanic noted favorable experiences more often across all Overall Rating measures ("9" or "10" rating out of a 0-10 scale). Of the respondents with a high school education or less, 62% gave Health Net an overall rating of 9 or 10. And of the respondents with some college education or more, 45% gave their health plan a rating of 9 or 10. Rating result details across measures by various demographic indicators can be found in Appendix F**.**

Although Health Net improved in the "Rating of Health Plan", "Rating of Specialist", and "Customer Service" CAHPS measures in 2020, results highlight areas of improvement that the plan needs to focus on, especially around the access to care-related measures. Continued efforts to improve all measures are needed in order to achieve the next percentile level of the Quality Compass scores, with added focus on those that did not meet the 25th percentile.

HEALTH DISPARITIES

Health Net has a long history of prioritizing the reduction of health care disparities for the communities most impacted by inequalities, collaborating with private and public partners statewide. Efforts aim to improve population health outcomes through culturally responsive interventions at the community, member, provider, and system levels.

For 2021, Health Net utilized a dynamic dashboard created in 2020 that supplemented DHCS Reporting Year 2021 health disparity data with additional internal figures. The dashboard allows for the stratification and comparison of HEDIS performance by variables, such as race/ethnicity, age, sex, geography, and housing status. This dashboard enables Health Net to impact overall HEDIS performance by identifying and targeting groups with compliance rates lower than their counterparts. The following tables reflect disparities identified

in Health Net's most populated regions: Los Angeles, Sacramento, and Tulare counties. Additional tables for Kern, San Diego, San Joaquin, and Stanislaus Counties can be found in Appendices G.

The orange shading in the tables indicate performance below the minimum performance level MPL. For all disparity data, colorectal cancer screening is not included in the performance percentiles, as there was no minimum performance level to use for that metric.

Racial/Ethnic Disparities

Racial and/or ethnic differences in the quality of care have been long-standing and significant contributors to disparities for certain population groups. Influencers include differences in place/geography, lack of access to adequate health coverage, communication difficulties between patient and provider, cultural barriers, provider stereotyping, and lack of access to providers.

Table 40: Health Disparity Data- Pattern by Race/Ethnicity in Los Angeles County for Preventive Measures, MY 2021

	HEDIS Measure(s)									
	BCS		CCS		CHL		CIS-Combo 10		COL	
	DEN	COMP RATE	DEN	COMP RATE	DEN	COMP RATE	DEN	COMP RATE	DEN	COMP RATE
AI/AN	75	45%	337	51%	14	64%	7	29%	154	29%
API	9506	57%	23091	54%	1325	57%	716	35%	17608	43%
Black	4417	47%	20224	50%	2330	77%	921	9%	10130	30%
Hispanic	22208	63%	93610	56%	18424	68%	7882	28%	41555	39%
Other	1167	48%	3987	52%	172	63%	4	25%	2580	31%
Unknown	2772	53%	12192	50%	786	64%	2227	23%	5874	31%
White	7440	50%	27164	49%	1588	55%	746	17%	16580	30%

Note: orange indicates the target group is performing below the 50th percentile.

In Los Angeles County (Table 40), Hispanics performed above the 50th percentile for BCS and CHL but performed below the MPL for CCS and CIS-Combo 10. American Indians/Alaskan Natives, Black, Other, and Unknown members exceeded the 50th percentile for CHL while scoring below the MPL for BCS, CCS, and CIS-Combo 10. Asian or Pacific Islanders and White members performed below the 50th percentile for all measures.

Table 41: Health Disparity Data-Pattern by Race/Ethnicity in Sacramento County for Preventive Measures, MY 2021

	HEDIS Measure(s)									
	BCS		CCS		CHL		CIS-Combo 10		COL	
	DEN	COMP RATE	DEN	COMP RATE	DEN	COMP RATE	DEN	COMP RATE	DEN	COMP RATE
AI/AN	31	29%	152	46%	9	78%	1	100%	79	16%
API	1511	57%	4887	56%	439	65%	223	46%	3012	32%
Black	578	49%	3238	53%	565	71%	205	16%	1349	26%
Hispanic	516	57%	3198	57%	991	68%	468	34%	1070	29%
Other	109	46%	244	43%	27	52%	1	0%	227	28%
Unknown	546	48%	3741	53%	409	60%	612	23%	1330	27%
White	1608	41%	6492	47%	542	58%	272	15%	3678	25%

Note: orange indicates the target group is performing below the 50th percentile.

In Sacramento County (Table 41), American Indian/Alaskan Natives and Asian or Pacific Islanders exceeded the 50th percentile for CHL and CIS-Combo 10, while scoring below the 50th percentile for BCS and CCS. Black, Hispanic, Unknown scored above the MPL for CHL, but below the MPL for BCS, CCS, and CIS-Combo 10. White members scored below the 50th percentile for BCS, CCS, and CIS-Combo 10, but met the 50th percentile for CHL. Members that identify as "Other" scored below the 50th percentile for all measures.

Table 42: Health Disparity Data- Pattern by Race/Ethnicity in Tulare County for Preventive Measures, MY 2021

	HEDIS Measure(s)									
	BCS		CCS		CHL		CIS-Combo 10		COL	
	DEN	COMP RATE	DEN	COMP RATE	DEN	COMP RATE	DEN	COMP RATE	DEN	COMP RATE
AI/AN	40	40%	152	55%	23	61%	11	0%	88	25%
API	228	58%	1251	60%	93	61%	23	43%	463	38%
Black	61	52%	308	62%	50	62%	22	18%	134	25%
Hispanic	2586	63%	14777	67%	3420	61%	1734	37%	5493	37%
Other	63	38%	154	49%	31	58%			113	40%
Unknown	210	52%	1398	59%	203	52%	511	36%	437	33%
White	954	49%	3812	56%	475	65%	178	28%	1949	30%

Note: orange indicates the target group is performing below the 50th percentile.

In Tulare County (Table 42), Hispanics outperformed other members and met the 50th percentile for CIS-Combo 10 and exceeded it for BCS, CCS, and CHL. Black members exceeded the MPL for CCS and CHL but scored below the 50th percentile for BCS and CIS-Combo 10. Except for CHL, which is above the 50th percentile, Asian or Pacific Islanders and White members scored below the MPL for BCS, CCS, and CIS-Combo 10. There is no data for members that identify as Other, but they scored at the MPL for CHL and below it for BCS and CCS. Members with Unknown race/ethnicity scored below the 50th percentile for all measures.

Table 43: Health Disparity Data-Pattern by Race/Ethnicity in Los Angeles, Sacramento, and San Diego Counties for Women's Preventive Measures, MY 2021

	HEDIS Measure(s)			
	PPC- Postpartum		PPC-Prenatal	
	DEN	COMP RATE	DEN	COMP RATE
AI/AN	15	47%	15	60%
API	677	68%	677	72%
Black	1031	51%	1031	68%
Hispanic	5570	66%	5570	74%
Other	109	45%	109	60%
Unknown	770	63%	770	76%
White	1070	64%	1070	73%

Note: orange indicates the target group is performing below the 50th percentile.

In Los Angeles, Sacramento, and San Diego Counties (Table 43), all race/ethnicities scored below the 50th percentile for PPC-postpartum and PPC-Prenatal measures.

Linguistics Disparities

To identify linguistic disparities, HEDIS compliance rates were compared across different spoken language groups. Table 44 demonstrates HEDIS performance for Armenian, Cantonese, English, Korean, Mandarin, Spanish and Vietnamese in Los Angeles County.

Table 44: Health Disparity Data- Pattern by Language in Los Angeles for Preventive Measures, MY 2021

	HEDIS Measure(s)									
	BCS		CCS		CHL		CIS-Combo 10		COL	
	DEN	COMP RATE	DEN	COMP RATE	DEN	COMP RATE	DEN	COMP RATE	DEN	COMP RATE
Armenian, Hayeren	1187	59%	2721	62%	55	44%	80	3%	2190	32%
Cantonese	1584	61%	3077	64%	168	54%	77	25%	2881	50%
English	22185	50%	123141	50%	13245	67%	8730	22%	48663	31%
Korean, Choson-0	706	46%	1246	51%	36	44%	10	30%	1207	38%
Mandarin	1523	52%	3112	59%	95	60%	141	36%	2805	45%
Spanish	16708	67%	39449	61%	10527	69%	3358	34%	29720	41%
Vietnamese	1362	70%	3004	65%	224	53%	49	41%	2567	51%

Note: orange indicates the target group is performing below the 50th percentile.

Spanish speakers met the 50th percentile for CCS and exceeded it for BCS and CHL, while scoring below the 50th percentile for CIS-Combo 10. Except for CHL, Vietnamese speakers scored above the MPL for BCS, CCS, and CIS-Combo 10. Armenian speakers met the MPL for BCS, scored above it for CCS, and scored below the MPL for CHL and CIS-Combo 10. Except for CHL and CIS-Combo 10, which were below the 50th percentile, Cantonese speakers exceeded the MPL for BCS and CCS. English and Mandarin speakers did not meet the 50th percentile for BCS, CCS, and CIS-Combo 10, but scored above the 50th percentile for CHL. Korean speakers scored below the 50th percentile for all measures.

Table 45: Health Disparity Data- Pattern by Language in Sacramento County for Preventive Measures, MY 2021

	HEDIS Measure(s)									
	BCS		CCS		CHL		CIS-Combo 10		COL	
	DEN	COMP RATE	DEN	COMP RATE	DEN	COMP RATE	DEN	COMP RATE	DEN	COMP RATE
Cantonese	202	66%	537	63%	52	73%	27	74%	412	35%
English	2962	46%	16092	50%	2038	64%	1298	24%	6960	25%
Hmong (White)	226	36%	625	49%	89	72%	42	36%	391	29%
Russian	389	37%	1191	53%	84	56%	59	0%	796	28%
Spanish	278	64%	1327	65%	561	70%	265	38%	558	32%
Vietnamese	363	74%	905	69%	57	60%	28	54%	712	40%

Note: orange indicates the target group is performing below the 50th percentile.

Cantonese, Spanish, and Vietnamese speaking members exceeded the MPL for all measures. English and Hmong speakers scored above the 50th percentile for CHL, but below the 50th percentile for BCS, CCS, and CIS-Combo 10. Russian speakers scored below the MPL for all measures.

Table 46: Health Disparity Data- Pattern by Language in Tulare County for Preventive Measures, MY 2021

	HEDIS Measure(s)									
	BCS		CCS		CHL		CIS-Combo 10		COL	
	DEN	COMP RATE	DEN	COMP RATE	DEN	COMP RATE	DEN	COMP RATE	DEN	COMP RATE
Arabic	10	60%	45	62%	3	67%	6	67%	21	38%
English	2150	50%	14453	60%	2476	63%	1741	33%	4503	31%
Laotian,Laothian,Pha Xa Loa	18	61%	25	60%	1	100%			29	59%
Spanish	1853	68%	7062	73%	1795	58%	726	44%	3888	39%
Unknown	56	55%	85	55%	1	0%			128	39%
Vietnamese	7	57%	19	68%					12	42%

Note: orange indicates the target group is performing below the 50th percentile

Arabic speakers scored above the 50th percentile for BCS, CCS, CHL, and CIS-Combo 10. Spanish speaking members met the MPL for CHL and exceeded the MPL for BCS, CCS, and CIS-Combo 10. There is no data on CIS-Combo 10 for Laotian speakers, however they exceeded the 50th percentile for BCS and CHL, while scoring below it for CCS. Except for CHL which exceeded the MPL, English speaking members scored below the MPL for BCS, CCS, and CIS-Combo 10. Vietnamese speaking members scored above the 50th percentile for CCS and below the MPL for BCS. There is no data available for CHL and CIS-Combo 10 for Vietnamese speaking members. Members that speak unknown languages scored below the MPL for BCS, CCS, and CHL. There is no data on CIS-Combo 10 for unknown language speaking members.

Disparities Based on Housing Status (Likely Homelessness)

Homelessness is an issue impacting California at large. Likely members experiencing homelessness more often experience poor health conditions and high rates of mental illness, substance or alcohol abuse, and mortality. Table 47 captures a statewide analysis of members flagged as potentially housing insecure (indicated in the "Yes" column) and compares those values to performance on cardiovascular measures. In all six measures, those who were housing insecure performed much lower than their counterparts. This may suggest barriers for accessing primary care.

Table 47: Health Disparity Data- Statewide Cardiovascular Measure Performance for Housing Insecure Members, MY 2021

	No		Yes	
HEDIS Measure(s)	DEN	COMP RATE	DEN	COMP RATE
AMR	18019	62%	1390	47%
CBP	59081	36%	3822	31%
CDC-BP <140/90	49415	37%	3906	29%
CDC-Eye exam	49415	53%	3906	36%
CDC-HBA1C Test	49415	82%	3906	70%
CDC-HbA1c <8	49415	44%	3906	30%

Table 48: Health Disparity Data- Statewide Women's Health Measure Performance for Housing Insecure Members, MY 2021

	No		Yes	
HEDIS Measure(s)	DEN	COMP RATE	DEN	COMP RATE
BCS	61592	57%	3258	30%
CCS	244240	55%	17834	37%
CHL	35713	64%	1851	72%
PPC-Postpartum	11814	68%	801	41%
PPC-Prenatal	11814	77%	801	58%

Statewide analysis of potentially housing insecure members was also compared against performance on women's health measures. Except for CHL, housing insecure members scored below their counterparts on the four other measures.

Table 49: Health Disparity Data- Pediatric Measure Performance for Housing Insecure Members in Los Angeles County, MY 2021

	No		Yes	
HEDIS Measure(s)	DEN	COMP RATE	DEN	COMP RATE
CIS-Combo 10	11905	26%	598	16%
W30	17314	58%	860	38%
WCV	328714	41%	10508	28%

In Los Angeles County, HEDIS performance for potentially housing insecure populations is assessed using pediatric measures (Table 49). The compliance rate is lower across all measures for the potentially unhoused group. The W30 and WCV measures do not have a color coding, as the MPL is not available for these measures to compare the members' compliance rates.

Cultural Competency Trainings

A culturally competent workforce and healthcare delivery system leads to positive health outcomes and fewer health disparities. As part of Health Net's commitment to improve health equity, the Health Equity department offers a variety of learning opportunities to support cultural and linguistically diverse patient care for providers including cultural humility, motivational interviewing, and implicit bias trainings. Additionally, Health Net offers provider and associate trainings on gender neutral language and healthcare barriers for gender diverse populations.

HEALTH EDUCATION, CULTURAL & LINGUISTIC, AND QUALITY IMPROVEMENT GAP ANALYSIS

The assessment findings help flag areas for improvement. The analysis below compares these gaps in member care to existing programs and services.

Health Education Department

Health Net's Health Education Department offers health education classes, health fairs, screenings, and community events on various topics statewide. Members and the community may participate at no cost. These services are extended through health educators, *promotoras* (community health workers), and community partners. The Health Education Department offers resources that are written in an appropriate cultural, linguistic, and reading level. Additionally, resources are available in threshold languages.
In MY2021, COVID-19 continued to present challenges in the way health education was offered to members and the community. In turn, the department looked to alternative means, reaching members through online platforms as well as in person presentations. Below are some identified areas for improvement and approaches to help address health education-related gaps identified in this Needs Assessment:

- To support deficient HEDIS measures, classes included topics on cervical cancer screening, diabetes, as well as, emergency preparedness, and nutrition and physical activity. Health Education conducted a total of 19 classes, reaching 268 participants through an in-person or virtual setting. Health Education will continue to explore various modalities for class offerings, such as calendared virtual classes or self-directed modules.
- Tobacco/nicotine dependence continues to be a high-risk behavior for our members. Statewide, the largest proportion of nicotine dependence members changed from age group 22-50 (43.63%) to 51-65 (50.1%). Los Angeles alone accounts for 59.3% of all nicotine dependence members, and San Diego and Tulare Counties is highest among 22-50 years of age. Health education will continue its effort to collaborate with *Kick It CA* to implement targeted telephonic outreach and offer a 2-week Nicotine

Replacement Therapy to eligible members – this proposal is currently under review with the Department of Health Care Services (DHCS) and will be implemented if approval is given.

- Mental and behavioral health is a recurring theme. Mood, anxiety, schizophrenia, and autistic disorders continue to make up the top four behavioral health conditions. Furthermore, Health Net observed a 2% increase in members who reported feeling loneliness in the past 2 weeks for several days during a 2-week period. Health education will continue to promote *myStrength*, a comprehensive digital behavioral health platform that allows for learning on stress, depression, meditation, substance abuse, anxiety, COVID-19, and resources for LGBTQ+. While member enrollment increased nearly 410% (n=680) between July 1, 2021 – May 17, 2022, the need for intervention continues in Counties where Nicotine Dependence is most prevalent.
- Hypertension, diabetes mellitus without complication, and spondylosis (degenerative conditions of the spine) were among the top 3 diagnoses among adult members aged 19+ years and older. Respiratory failure and hypertension were the highest of the top 10 conditions in terms of cost. Additionally, hypertension was the top medical/health self-reported condition by 29% of Health Information Form respondents. Moreover, hypertension and cholesterol are the top two conditions reported by members on the Health Information form. In 2021, Health Education rebranded heart health education resources with a new look. Using HEDIS data, Health Education identified 495 members with uncontrolled blood pressure to receive the *Healthy Heart Healthy Lives* toolkit and *Know Your Numbers* brochure. Health Education will continue to leverage these resources to targeted members with uncontrolled hypertension. To prevent the onset of type-2 diabetes, Health Net launched the Diabetes Prevention Program (DPP) in 2021. From May 2021- December 2021, 248 members enrolled in the all-mobile application program is administered by *Yes Health, Inc.* The digital health platform offers an in-the-moment, CDC approved, lifestyle and behavior change coaching to prevent chronic disease and promotes healthy habit adoption. Health Net will continue to promote this plan benefit to members and providers via member mailings, annual newsletter article, and provider webinar.

The Health Education Department will continue to partner with Quality Improvement and Health Equity Departments to conduct PDSAs and PIPs.

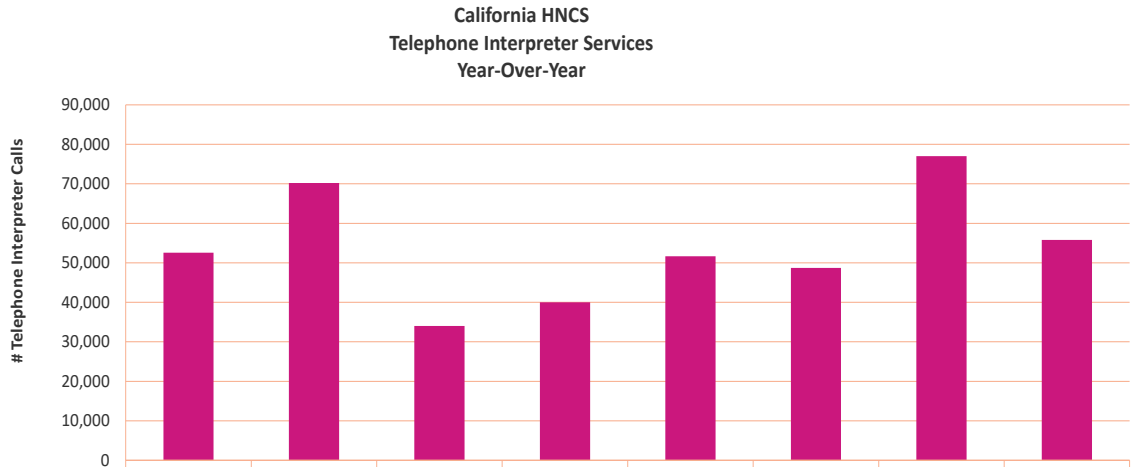
Health Equity Department (formerly Cultural and Linguistic Services)

The Language Assistance Program (LAP) is a statewide program that includes language support services. Language Assistance Services offer interpreter support for members, contracted providers, and staff to facilitate communication. Interpreter services include video remote interpreting, telephonic, and face-to-face interpretation. Translated materials are culturally and linguistically appropriate to support members' understanding of their health care benefits and services. Health Net provides professionally trained interpreters and actively discourages the use of family, friends, and minors as interpreters. Interpreter services are available to all providers and members 24 hours a day, seven days a week. LAP quality is monitored through the review of grievances, and quality surveys such as CAHPS.

To identify gaps in services and opportunities for improvement, analyses considered language assistance service utilization and a GEO access comparison. Tables 50-55 show the volume of language assistance services provided in MY2021.

An increased utilization rate observed correlates with the fluctuated experience as a result of the COVID-19 pandemic from 2020 to 2021. In 2021, doctors' offices resumed their normal operations, allowing more patients to visit doctors in person. This resulted in an increase for in-person requests (face-to-face and sign-language interpreting requests) while in 2020 office visits were limited and telemedicine-type approaches became the recommended practices. The increase in requests made in 2021 has steadily increased to almost match requests made the year prior to the pandemic (2019).

Table 50: Year-Over-Year Telephone Interpreter Requests 2014-2021



	2014	2015	2016	2017	2018	2019	2020	2021
Telephone Interpreter Calls	52,576	70,215	34,019	39,985	51,663	48,715	76,992	55,771

Table 51: Year-Over-Year Telephone Interpreter Requests – Percent Change

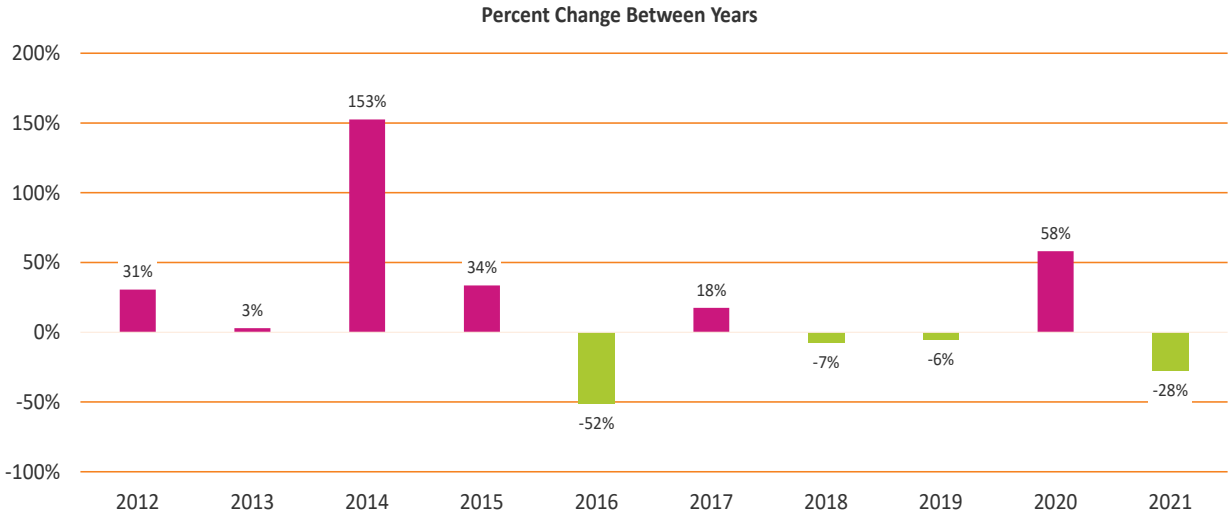


Table 52: Year-Over-Year Face-to-Face Interpreter Requests 2014-2021

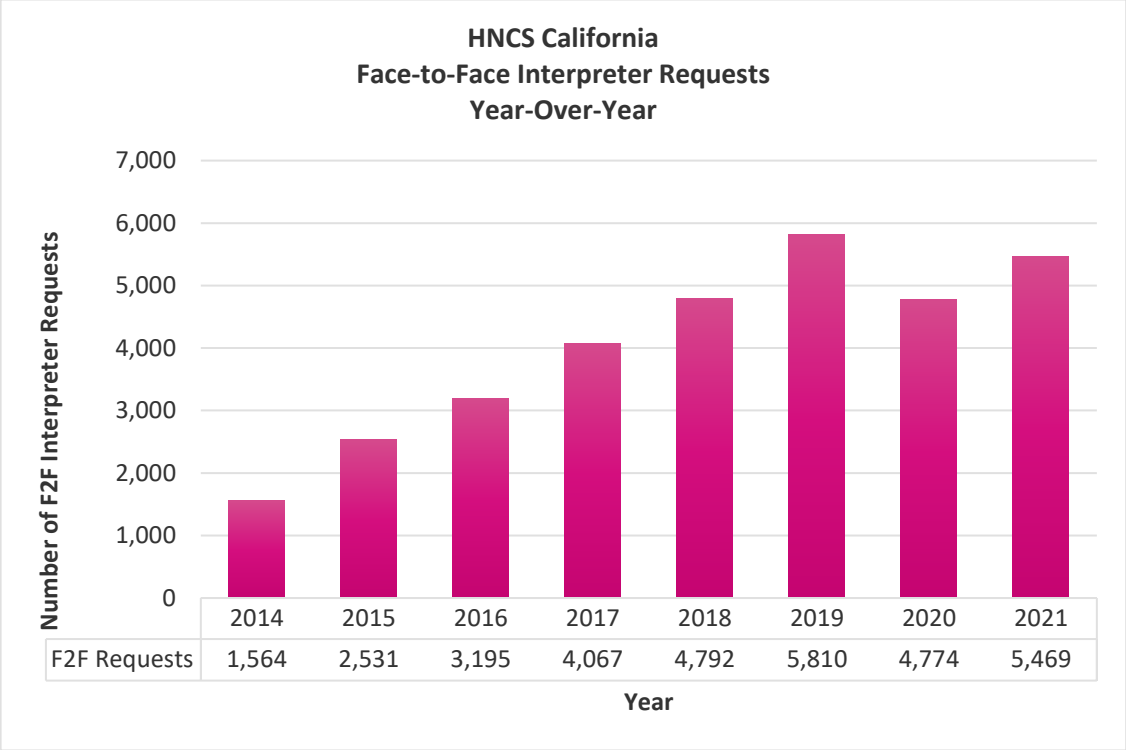
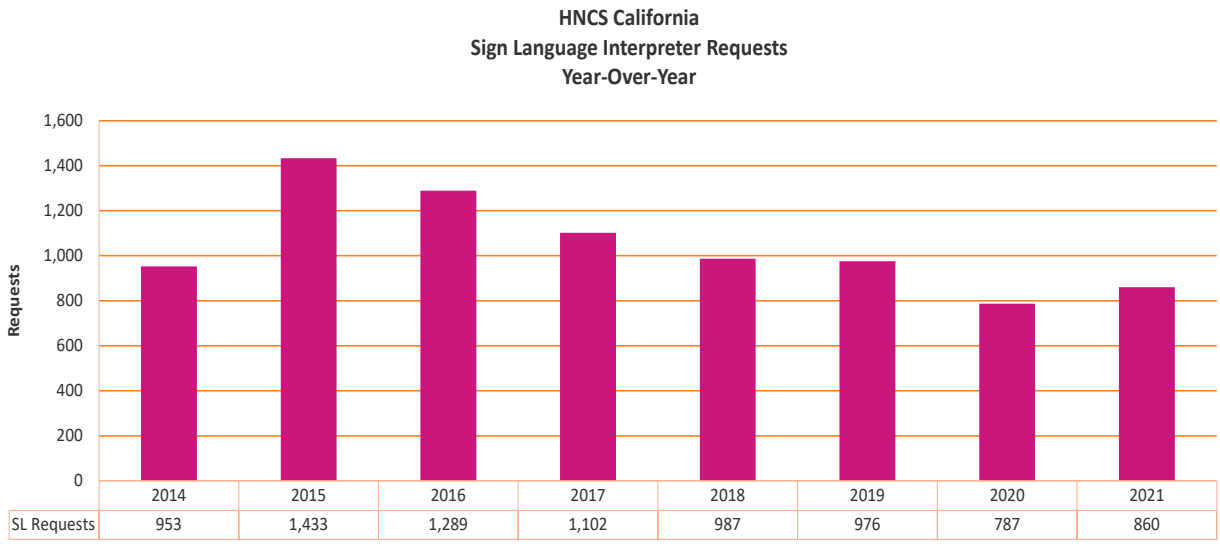


Table 53: Year-Over-Year Sign Language Interpreter Requests 2014-2022



With a workforce that lives in and mirrors our communities' diversity, Health Net also has in-house expertise with certified, bilingual staff. To reduce the amount of time associated with interpretation service transfers, qualified associates may serve as interpreters when member inquiries arise. Table 54 notes the total number of calls serviced through the Bilingual Call Center. In MY2021, Health Net staff assisted with 83,428 calls. This is a 63% increase over MY2020.

Table 54: Year-Over-Year Bilingual Call Center 2015-2021

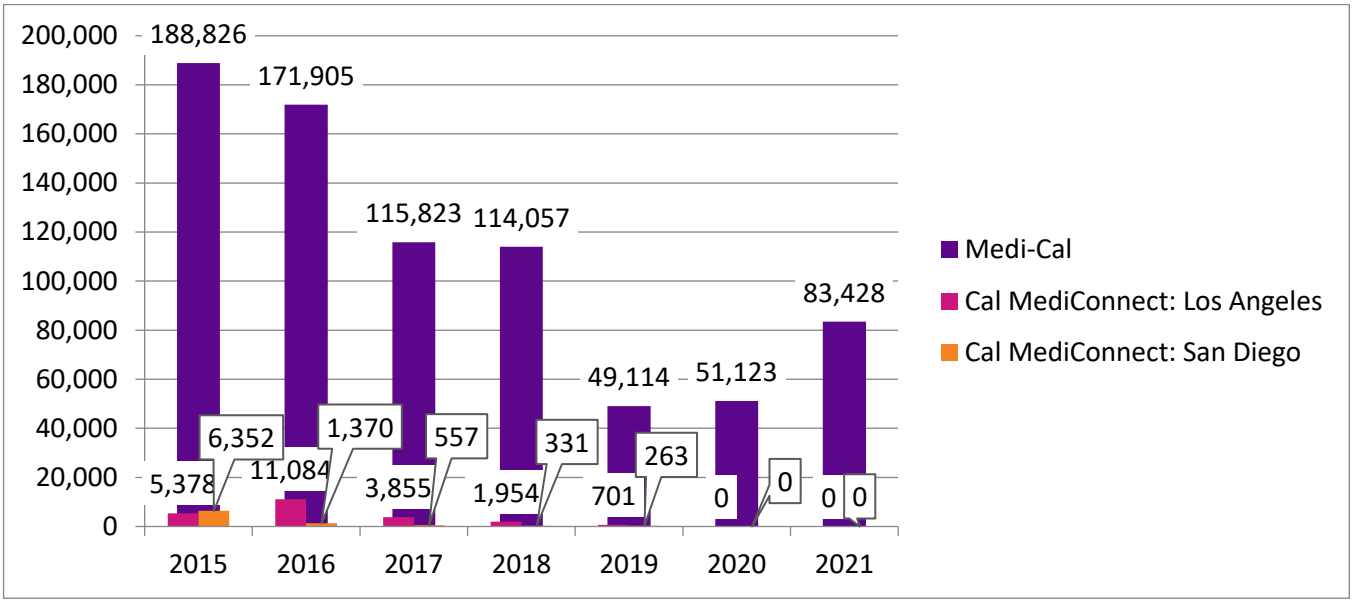
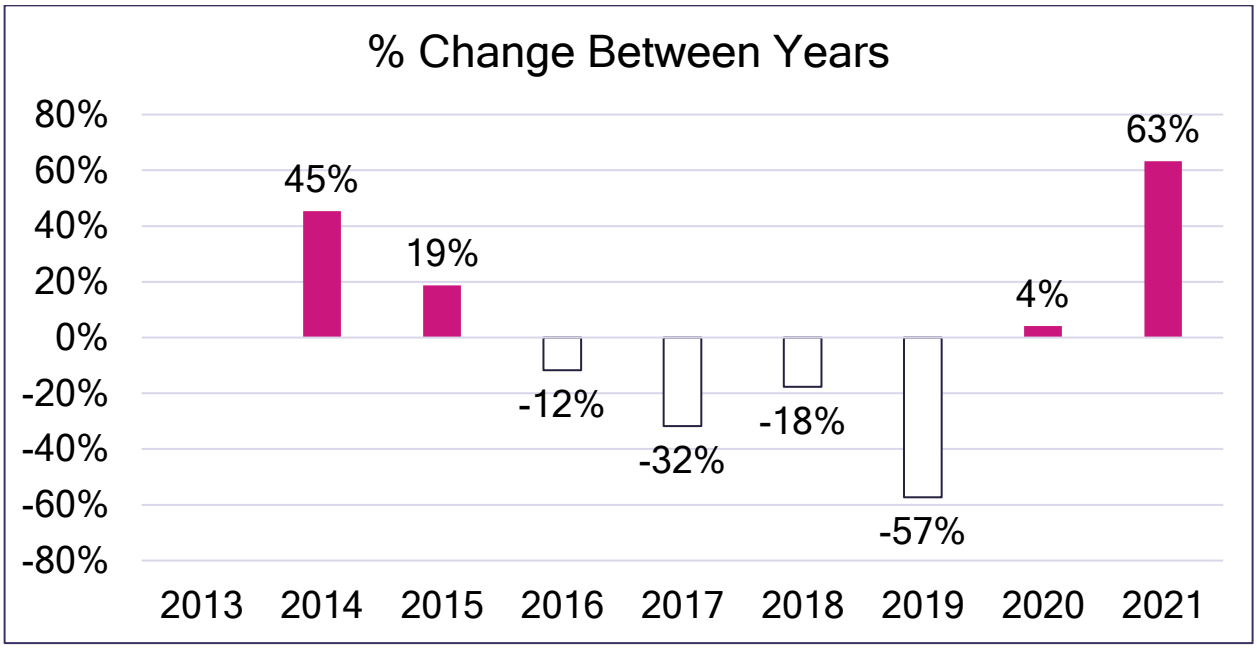


Table 55: Year-Over-Year Bilingual Call Center Percent Change 2013-2021



Quality Improvement

Quality Improvement (QI) program activities are selected based on their relevance to Health Net's membership, the ability to affect a significant portion of the population or the population at-risk, and their potential impact on high-volume, high-risk, or high-cost conditions or services. Morbidity, mortality, and vulnerable groups with special needs are considered in the selection process as well as race, ethnicity, and language disparities. For this section, MY2020 HEDIS data were used as the most recent.

MY2020 HEDIS gaps were reviewed in three categories. Under pediatric health, Kern and San Joaquin Counties noted the worst performance with at least 80% of measures below the minimum performance level. Well-Child Visits (0-15 months) and Child and Adolescent Well-Care Visits were consistently below MPL across all counties, and Childhood Immunization Status (CIS-10) rates were below the 50th percentile in five of seven

counties. In Los Angeles County, rates for Black members and Asian or Pacific Islanders were below MPL for CIS-10. In Sacramento County, Russian speakers scored below the 10th percentile for CIS-3.

Among the five measures under women's health, Breast Cancer Screening was consistently below the benchmark across all Health Net Counties. Cervical Cancer Screening and Timeliness of Prenatal Care measures did not meet performance levels in six of the seven counties. San Diego, Kern, and San Joaquin Counties missed the MPL on all measures. In Los Angeles County, White members, Blacks, and American Indians/Alaskan Natives missed performance levels on Breast Cancer and Cervical Cancer Screenings. In Sacramento County, Russian speakers scored below the 10th percentile for Breast Cancer Screenings.

Comprehensive Diabetes Care – HbA1c Poor Control (>9%) and Antidepressant Medication Management – Effective Continuation Phase Treatment are the most recurring adult and chronic health measures statewide below the 50th percentile, each populating in at least 6 counties. San Diego, Los Angeles, and Tulare counties each had five of six measures below the MPL.

Intervention selections may involve Health Net departments and collaborations with network providers and community entities (including public health). Activities aimed at supporting HEDIS rates statewide (below the 50th percentile) may take the form of a Performance Improvement Project (PIP), Plan-Do-Study-Act cycle (PDSA), or a disparity analysis. Table 57 below lists the latest projects aimed at improving HEDIS rates and outcomes. The Los Angeles Pediatrics PIP and Sacramento Equity PIP are in congruence with flagged needs. The MY2020 Los Angeles outcome for CIS-10 is at the 25th percentile. Moreover, Russian speakers in Sacramento County scored below the 10th percentile for Breast Cancer Screenings.

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

Table 57: HEDIS Activities, MY2020-2022

Type & Region	HEDIS Measures	Intervention Target	Goal	Outcome
2020-2021 **SWOT Strategy** Kern	Asthma Medication Ratio (AMR) and Well-Child Visit (WCV)	Kern Family Health Plan	Partner with Kern Family Health Care to identify common MCAS (Managed Care Accountability Set) measures, common disparities, and common providers by geographic locations in Kern County.	The Kern SWOT finished in May 2021. Health Net and Kern Family Health Care developed and implemented a provider survey to 5 of 7 high volume pediatric providers. QI learned Kern pediatric providers did not want to use telehealth for WCV. All providers wanted to see their children and adolescent members in their offices in-person. A data transmission issues was also noted during the SWOT discovery process. Health Net partnered with the Provider Group of the 7 shared high-volume pediatric providers and the Provider Group improved to meet the goal of encounters submitted withing 120 days of service.

2020-2022 **Pediatrics PIP** Los Angeles	Childhood Immunizations (CIS-10)	Members 0-18 months of age assigned to partner provider.	By December 31, 2022, increase the percentage of members (from baseline rate 7.57% to 11.89%) who complete the following Childhood Immunizations: three hepatitis B (HepB); two or three rotavirus (RV); and two influenza (flu) vaccines by their 18-month birthday.	Provider Partner deployed first part of the intervention: Telephonic outreach to members under 18 months of age who need to complete immunizations under CIS-10 measure. Dedicated office team member works on a daily process to identify members under 2 years of age who are missing targeted. vaccinations (HepB, Rotavirus and/or Flu), was hired by the partner provider. Trainings and additional member- and provider-facing materials were provided to support the office. Final results will be available 1st quarter of 2023.
2020-2022 **Equity PIP** Sacramento	Breast Cancer Screening (BCS)	Members 50-74 years of age, identified as Russian by Race/Ethnicity and/or Language	By 12/31/2022, use selected interventions to increase the percentage of breast cancer screenings among members 50-74 years of age, identified as Russian by Race/Ethnicity and/or Language, and assigned to Sacramento County, from a baseline rate of 38.46% to a goal rate of 50.13%.	Successfully established a partnership with a Provider Group in Sacramento who provides care coordination to the BCS non-compliant Russian speaking members. The Provider Group is reaching out to those members and scheduling their mammogram appointments. It is important to note the war between Russia and Ukraine has affected the membership cohort for this intervention. Final results will be available 1st quarter 2023.

Quality Improvement will continue to be proactive in addressing the preventive care needs of members, aimed at ensuring the highest quality of care.

ACTION PLAN 2022-2023

Based on assessment findings presented in the gap analysis, the following action plans outline three key objectives to address member needs. Health Education, Quality Improvement, and Health Equity departments will implement these proposed strategies and activities assuming no limitations and detrimental impacts resulting from the COVID-19 pandemic.

HEALTH EDUCATION DEPARTMENT

The current gap analysis found mental and behavioral health to be a recurring theme in MY2021. Mood and anxiety disorders, depression, and loneliness were themes identified. Health Education will look to continue building on current successes, continuing its 2021-2022 objective by supporting members' experience using the myStrength platform through June 30, 2023.

Table 58: Health Education Department Action Plan, 2022-2023

Objective 1: By June 30, 2023, Health Education Department will continue increasing annual utilization of the myStrength program by 20% from 165 to 198. (2019 baseline=65). **Data Source:** myStrength enrollment/outcome data, and program training records.
Strategies
1. Collaborate with Population Health Management to promote myStrength resources to members.
2. Promote myStrength app using the annual member newsletter and explore additional activities to promote myStrength/behavioral health resources (i.e., social media, provider communications, etc.) during Behavioral Health Awareness, and Suicide Prevention months.

QUALITY IMPROVEMENT DEPARTMENT

The age disparity analyses in Sacramento County found that Russian speaking women had statistically lower BCS rates when compared to younger women. Several Health Net counties were Russian speakers scored below the 10th percentile for Breast Cancer Screenings. Quality Improvement will continue the 2021-2022 intervention by collaborating with a high-volume provider in Sacramento to seek the maximum impact to improve screening rates among this group by December 31, 2022.

Table 59: Quality Improvement Department Action Plan-Disparity Performance Improvement Project, 2022-2023

Objective 2: By December 31, 2022, increase the percentage of breast cancer screenings among members 50-74 years of age, identified as Russian by Race/Ethnicity and/or Language, and assigned to Sacramento County, from a baseline rate of 32.37% to a goal rate of 42%. **Data Source:** SMART Aim Rolling 12-Month Measure Run Chart
Strategies
1. Conduct Family/community awareness campaigns, such as radio campaigns, with positive messaging about breast cancer and early detection saving lives in Russian
2. Identify breast cancer prevention education from providers and cancer resources translated into Russian. Identify and provide educational material to promote breast cancer screening in a culturally sensitive manner. Distribution of breast cancer educational materials will be provided by Health Net to providers to give to members' in-office.

HEALTH EQUITY DEPARTMENT

The 2022-2023 Health Equity action plan is to launch a pilot that provides on-demand VRI and telephonic service to combat this challenge by providing direct access, VRI equipment, IT support, and other support as needed to ensure providers can fully access the VRI services from the clinic. This objective is a new objective for 2022-2023. In comparison to last year's objective this one provides VRI equipment, IT support, and other supports.

Table 60: Health Equity Department Action Plan, 2022-2023

Objective 3: By June 30, 2023, the Health Equity Department will increase the utilization of on-demand VRI and Over the Phone Interpretation (OPI) service in-office from 0 to 700 to support member language needs. **Data Source:** Vendor Platform, VRI and OPI Utilization, Internal Tracking
Strategies
1. Providers with high interpreting utilization volume or have a high percentage of members/enrollees with limited English proficiency will be selected to participate in the on-demand VRI pilot. The Health Equity Department will be providing VRI equipment and IT support for providers.
2. Providers will be trained to use the equipment and VRI platform.

ACTION PLAN UPDATES 2021-2022

Based on 2021 Population Needs Assessment (PNA), Health Education, Quality Improvement, and Health Equity departments implemented the strategies and activities outlined below. Tables 61-63 provide progress made toward the 2021-2022 objectives and strategies.

HEALTH EDUCATION DEPARTMENT

During the 2021 PNA, the gap analysis findings highlighted a need to support mental and behavioral health, with efforts focused on expanding reach to underutilized resources. Mood and anxiety disorders, depression, and loneliness were recurring themes identified. Through the collaboration of multiple departments and entities, Health Education's 2021-2022 objective resulted in increased program enrollment statewide. This objective will continue in 2022-2023.

Table 61: Health Education Department Action Plan Update 2021-2022

Objective 1 By June 30, 2022, Health Education Department will continue to increase utilization of the myStrength program by 20% from 829 to 995 members. (2019 baseline=140).	**Progress Measure:** Measure objective used previous enrollment data (n=829), with goal to increase participation by 20% (n=166). Between July 1, 2021 – May 17, 2022, enrollment increased by nearly 410% (n=680). **Data source:** myStrength enrollment/outcome data, email outreach campaign reports, and program training records.
	Progress Toward Objective: Health Education successfully reached its objective, exceeding the goal by 410%. Increased social media presence and continued promotion to providers and community partners helped encourage member participation. This objective will be continuing in 2022-2023.
Strategies	
Strategy 1 Develop and implement email campaign to promote myStrength, educating members on topics such as depression, anxiety, mindfulness, and chronic pain (to name a few).	**Progress Discussion:** Launched an email campaign on 7/15/21 on health education program and services for Health Net members, including an overview of myStrength. The overview included information about the online program, which provides many tips and tools that can help members learn about stress, meditation, depression, long-term pain, and more. The campaign invited members to sign up by providing the myStrength link. Launched an email campaign on 9/1/21 to HN members regarding myStrength. The email campaign title was "Recharge, Refresh and Improve Your Mood." The campaign provided a brief summary about myStrength and invited members to sign up by including the myStrength link. Launched a total of seven Facebook and Twitter posts promoting myStrength and educating members on the importance of mental health and well-being. Posts were sent on: 7/7/21, 7/19/21, 7/27/21 with the following outcomes:

	• Post Engagement: 17,754 • Impressions: 975,767 • Reach: 465,513
Strategy 2 Develop and implement four trainings for providers, case management staff, public programs, and provider engagement staff on the availability and effectiveness of myStrength in supporting members' well-being.	**Progress Discussion**: Conducted a statewide training with six staff and providers in attendance on myStrength. Distributed Provider Update titled "Help Patients Manage Stress Response Resulting from Adverse Childhood Experiences" which promoted the myStrength program as a digital resource for ACEs screening which aligns with the Surgeon General's ACEs Roadmap. Presented myStrength to Opioid Workgroup/Population Health Management team to encourage promotion of myStrength as a resource to members during their outreach. Provider Operations Manual includes information and the myStrength link for providers to be able to refer members to visit the website. Provider Update, "Recognize and Address Mental Health Symptoms Early" talks about mental health awareness using providing tips to providers on helping their patients. The resource also includes myStrength information for providers to be able to refer members to visit the myStrength website.
Strategy 3 Continue working with myStrength to improve member enrollment documentation by Medicaid line of business. Medi-Cal participation may be underreported.	**Progress Discussion**: Monthly meetings with myStrength are in place to discuss engagement, reporting, promotion etc.

QUALITY IMPROVEMENT DEPARTMENT

During the 2021 PNA, the age disparity analyses in Sacramento County found that Russian speaking women had statistically lower BCS rates when compared to younger women. Furthermore, data flagged poor performance among women's health HEDIS measures with Sacramento County below the 50th percentile on all four measures. Quality Improvement aimed to support Breast Cancer Screening compliance rates through an approved Performance Improvement Project, collaborating with a high-volume provider in Sacramento. This objective will continue through December 2022, at which time this PIP project will phase out.

Table 62: Quality Improvement Department Action Plan Update, Disparity Performance Improvement Project 2021-2022

Objective 2 By December 31, 2022, to increase the percentage of breast cancer screenings (BCS) among members 50-74 years of age, identified as Russian by Race/Ethnicity and/or Language, and assigned to Sacramento County, from a baseline rate of 38.46% to a goal rate of 50.13%.	**Progress Measure:** We were informed by our provider partners that due to the COVID-19 pandemic and the Russian/Ukraine war, our member cohort for this improvement project has been greatly affected. As of November 2021, the current BCS rate was 32.37%. **Data source:** SMART Aim Rolling 12-Month Measure Run Chart.

	Progress Toward Objective: Established a partnership with a Provider Group in Sacramento who provides care coordination to the BCS non-compliant Russian speaking members. The Provider Group is reaching out to members in the project cohort and scheduling their mammogram appointments.
Strategies	
Strategy 1 Conduct Family/community awareness campaigns, such as radio campaigns, with positive messaging about breast cancer and early detection saving lives in Russian.	**Progress Discussion:** Health Net is sponsoring a local radio station session to spread breast cancer awareness, promote breast cancer screening, and provide breast cancer health education to the Slavic community in Sacramento County. A medical provider who speaks both Ukrainian and Russian will conduct a pre-recording session with the Executive Director of Slavic Assistance Center. This radio program is projected to broadcast at least twice a week until end of 2022.
Strategy 2 Identify breast cancer prevention education from providers and cancer resources translated into Russian. Identify and provide educational material to promote breast cancer screening in a culturally sensitive manner. Distribution of breast cancer educational materials will be provided by Health Net to providers to give to members' in-office.	**Progress Discussion**: Health Net prints and sends health education materials in Russian (as Russian is one of the threshold languages in Sacramento County) to our partner provider offices. Health Net continues to check in with partner providers to see if they need to restock/reorder any health education materials printed in Russian. We have provided culturally sensitive training to the outreach staff of a partner PPG before the member outreach began in November 2021.

HEALTH EQUITY DEPARTMENT

The Health Equity Department focused on expanding Language Assistance Program awareness, calling on Health Net staff to support Video Remote Interpreting (VRI) Services promotion and encourage program utilization. See Table 63 for 2021-2022 Action Plan updates.

Table 63: Health Equity Department Action Plan Update, 2021-2022

Objective 3 By June 30, 2022, Health Equity Department will increase the utilization of a new Video Remote Interpreting (VRI) Services from 0 to 75 appointments to support member language needs.	**Progress Measure:** Completed. 944 VRI requests were made from July 2021 – June 2022. **Data source:** Internal vendor tracker
	Progress Toward Objective: Due to the high utilization, we hope to extract best practices to successfully expand this service to engage more members. The Health Equity Department plans to launch a pilot with a new vendor to provide on-demand VRI and telephonic service to ensure this service continues to be readily available by providing direct access, VRI equipment, or support, as needed, to ensure providers can further access the VRI services from the clinic.

Strategies	
Strategy 1 Enhance language vendor network offering VRI services from two to five.	**Progress Discussion:** The Health Equity Department was successful in increasing vendor network to include more VRI services to members by increasing the number of vendors from two to five, with one additional vendor pending to be approved by DHCS.
Strategy 2 Educate 70% of Call Center staff on VRI services to support provider interpreter requests.	**Progress Discussion:** The Health Equity Department was successful in helping 80% of Call Center Staff complete the VRI service training. As part of the onboarding training and ongoing training, staff were informed of service.

STAKEHOLDER ENGAGEMENT

Health Net Community Advisory Committee (CAC) participants help serve as advisors to PNA development, and implementation of the PNA action plans. Approaches to developing the 2021 PNA were presented to CACs during Spring 2021. The design and plans for CACs was further expanded in early 2022 to local management by regional leads. Findings and recommendations of the 2022 PNA will be presented during the Fall 2022 meetings for further comment and input from participants.

Health Net will continue to employ multiple approaches to inform Health Net providers of PNA highlights and recommendations. Communication channels may include:

- **Provider Updates:** Provider Updates extend immediate information to Health Net's provider network, which include Physicians, Participating Physician Groups, Hospitals, and Ancillary Providers. Provider Updates are also available online through the provider portal.

- **Provider On-Site Outreach:** The Provider Engagement team conducts site visits regularly, allowing opportunities to discuss with providers PNA findings and recommendations.

- **Community Provider Lunch & Learns:** Lunch & Learn sessions bring together multiple providers in a community setting, planned regularly throughout the year. Hosted by Provider Engagement, these events provide important health plan program updates and information to support providers in better servicing their patients. PNA findings will be shared with those in attendance. Provider feedback about the PNA and/or proposed action plans will be considered for further enhancement.

- **Available Online:** For easy access to our members and community stakeholders, the 2022 PNA report will be available on the health plan's website.

APPENDICES

Appendix A: Health Net - Demographic Analysis by County, December 2021

	Kern		Los Angeles		Sacramento		San Diego		San Joaquin		Stanislaus		Tulare		Total	
	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%
Total Membership																
	79,216	4.99%	1,069,682	67.40%	132,329	8.33%	89,095	5.61%	25,859	1.62%	68,382	4.30%	122,455	7.71%	1,587,018	100.0%
Age Group																
0-13	22,770	28.70%	256,489	24%	37,519	28.40%	22,327	25.10%	7,096	27.40%	19,806	29%	41,172	33.60%	407,179	25.70%
14-21	14,015	17.70%	174,676	16.30%	21,033	15.90%	14,365	16.10%	4,339	16.80%	13,352	19.50%	22,900	18.70%	264,680	16.70%
22-50	29,160	36.80%	352,383	32.90%	49,904	37.70%	30,350	34.10%	10,296	39.80%	24,706	36.10%	41,363	33.80%	538,162	33.90%
51-65	10,452	13.20%	150,792	14.10%	17,886	13.50%	11,002	12.30%	3,347	12.90%	8,268	12.10%	13,144	10.70%	214,891	13.50%
>65	2,819	3.60%	135,342	12.70%	5,987	4.50%	11,051	12.40%	781	3%	2,250	3.30%	3,876	3.20%	162,106	10.20%
Sex																
F	40,350	50.9%	574,654	53.7%	67,871	51.3%	46,286	52%	13,050	50.5%	35,338	51.7%	65,072	53.1%	842,621	53.1%
M	38,866	49.1%	495,028	46.3%	64,458	48.7%	42,809	48%	12,809	49.5%	33,044	48.3%	57,383	46.9%	74,4397	46.9%
Race/Ethnicity																
AI/AN	220	0.3%	1,168	0.15	730	0.6%	310	0.3%	104	0.4%	159	0.2%	684	0.6%	3,375	0.2%
API	2,611	3.3%	130,230	12.2%	23,385	17.7%	8,776	9.9%	3,129	12.1%	3,793	5.5%	4,394	3.6%	176,318	11.1%
Black	5,812	7.3%	102,759	9.6%	18,218	13.8%	4,980	5.6%	2,709	10.5%	2,457	3.6%	1,725	1.4%	138,660	8.7%
Hispanic	44,954	56.7%	605,557	56.6%	28,962	1.9%	32,997	37%	10,834	41.9%	35,537	52%	90,080	73.6%	84,8921	53.5%
other	1,619	2%	17,927	1.7%	1,382	1%	1,305	1.5%	490	1.9%	2,015	2.9%	1,008	0.8%	25,746	1.6%
Unknown	6,062	7.7%	70,854	6.6%	25,941	19.6%	18,269	20.5%	3,372	13%	6,312	9.2%	8,995	7.3%	13,9805	8.8%
White	17,938	22.6%	141,187	13.2%	33,711	25.5%	22,458	25.2%	5,221	20.2%	18,109	26.5%	15,569	12.7%	254,193	16%
SPD (Seniors and persons with disabilities)																
	9,286	11.7%	203,735	19%	17,308	13.1%	16,730	18.8%	2,318	9%	7,177	10.5%	11,354	9.3%	267,908	16.9%

Appendix B: Health Net - Linguistic Analysis by County, December 2021

	Kern		Los Angeles		Sacramento		San Diego		San Joaquin		Stanislaus		Tulare		Total	
	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%
Total Membership																
	79,216	4.99%	1,069,682	67.40%	132,329	8.33%	89,095	5.61%	25,859	1.62%	68,382	4.30%	122,455	7.71%	1,587,018	100.0%
Spoken Language (member count >400)																
English	58,144	73.4%	636,282	59.5%	93,001	70.3%	66469	74.6%	21058	81.4%	51175	74.8%	74848	61.1%	1,000,977	63.1%
Spanish	20,175	25.5%	319,061	29.8%	15,843	12.0%	16981	19.1%	4370	16.9%	15563	22.8%	46144	37.7%	438,137	27.6%
Cantonese	13	0.0%	18,833	1.8%	2,589	2.0%	139	0.2%	30	0.1%	44	0.1%	35	0.0%	21,683	1.4%
Mandarin	9	0.0%	19,127	1.8%	481	0.4%	292	0.3%	16	0.1%	2	0.0%	30	0.0%	19,980	1.3%
Armenian/Hayeren	3	0.0%	19,605	1.8%	309	0.2%	10	0.0%	1	0.0%	4	0.0%	1	0.0%	19,933	1.3%
Vietnamese	56	0.1%	13,700	1.3%	3,375	2.6%	855	1.0%	83	0.3%	185	0.3%	86	0.1%	18,340	1.2%
Russian	10	0.0%	4,666	0.4%	7,287	5.5%	289	0.3%	6	0.0%	38	0.1%	2	0.0%	12,298	0.8%
Unknown	279	0.4%	8,131	0.8%	1,027	0.8%	1,138	1.3%	37	0.1%	427	0.6%	354	0.3%	11,393	0.7%
Korean/Choson-0	29	0.0%	11,395	1.1%	74	0.1%	226	0.3%	6	0.0%	1	0.0%	22	0.0%	11,753	0.7%
Declined To State	263	0.3%	5,444	0.5%	639	0.5%	244	0.3%	65	0.3%	257	0.4%	390	0.3%	7,302	0.5%
Farsi/Parsian/Persian	7	0.0%	4,021	0.4%	2,049	1.5%	418	0.5%	23	0.1%	148	0.2%	4	0.0%	6,670	0.4%
Tagalog	73	0.1%	2,881	0.3%	416	0.3%	1,151	1.3%	32	0.1%	19	0.0%	51	0.0%	4,623	0.3%
Cambodian/Khmer	21	0.0%	3,714	0.3%	105	0.1%	139	0.2%	53	0.2%	200	0.3%	9	0.0%	4,241	0.3%
Hmong (White)	0	0.0%	11	0.0%	3,360	2.5%	4	0.0%	20	0.1%	16	0.0%	56	0.0%	3,467	0.2%
Other	134	0.20%	2811	0.30%	1,774	1.30%	740	0.80%	28	0.1%	280	0.4%	322	0.3%	6,221	0.4%

*Other language: group all language with member count<400

Appendix C: Health Net - Demographic and SDoH Analysis by County, December 2021

	Kern		Los Angeles		Sacramento		San Diego		San Joaquin		Stanislaus		Tulare		Total	
	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%
Total Membership																
	79,216	4.99%	1,069,682	67.40%	132,329	8.33%	89,095	5.61%	25,859	1.62%	68,382	4.30%	122,455	7.71%	1,587,018	100.0%
Housing Insecure (likely homeless)																
	5,170	6.5%	74,660	7.0%	6,349	4.8%	3,576	4.0%	1,998	7.7%	5,469	8.0%	3,430	2.8%	100,652	6.3%
Urban Type*																
Urban	20,171	25.5%	937,749	87.7%	106,853	80.7%	3,2673	47.8%	55,563	62.4%	11,128	43.0%	916	0.7%	1,165,053	73.4%
Suburban	2,311	2.9%	64,562	6.0%	17,328	13.1%	9,151	13.4%	22,777	25.6%	3,223	12.5%	14,028	11.5%	133,380	8.4%
Rural	56,734	71.6%	67,364	6.3%	8,147	6.2%	26,557	38.8%	10,755	12.1%	11,508	44.5%	107,511	87.8%	288,576	18.2%
No Data Available			7	0	1	0	1	0							9	
HPI Quartiles*																
4	50,318	63.5%	514,783	48.1%	50,721	38.3%	21,011	23.6%	10,964	42.4%	37,960	55.5%	81,877	66.9%	767,634	48.4%
3	14,990	18.9%	317,096	29.6%	39,441	29.8%	26,219	29.4%	8,045	31.1%	19,886	29.1%	20,555	16.8%	446,232	28.1%
2	6,992	8.8%	151,840	14.2%	26,154	19.8%	23,789	26.7%	4,850	18.8%	8,423	12.3%	9,947	8.1%	231,995	14.6%
1	2,026	2.6%	65,615	6.1%	9,092	6.9%	13,631	15.3%	1,014	3.9%	171	0.3%	103	0.1%	91,652	5.8%
Blank	4,890	6.2%	20,348	1.9%	6,921	5.2%	4,445	5.0%	986	3.8%	1942	2.8%	9,973	8.1%	49,505	3.1%

HPI quartiles represents community health conditions. Compared to HPI quartile 1 or 2, members in quartiles 3 and 4 are living with poor community health conditions. Lower quartiles indicate better health.

Urban – Zip Codes containing a population of more than 3,000 people per square mile

Suburban – Zip codes containing a population between 1,000 – 3,000 people per square mile

Rural – Zip codes containing a population of less than 1,000 people per square mile

Appendix D: Health Net - HEDIS Performance by County, RY2021

RY2021 Final HEDIS Performance - All Measures by County

Admin & Chart Review Final Data

Product Name	HYBRID	Measure	Admin Data				Final Data					2020 National Benchmark			
			RY2020		RY2021		RY2020		RY2021						
			ADMIN DEN 202005	ADMIN RATE 202005	ADMIN DEN 202105	ADMIN RATE 202105	Final 2020 DEN	Final 2020 RATE	Final 2021 DEN	Final 2021 RATE	RY2021 Performance Status	NATL 25th	NATL 50th	NATL 75th	RY2020 Final Performance
KERN	N	Antidepressant Medication Management - Effective Acute Phase Treatment	534	50.56%	513	54.97%	534	50.56%	513	54.97%	50TH	50.38%	53.57%	58.93%	25TH
KERN	N	Antidepressant Medication Management - Effective Cont. Phase Treatment	534	34.64%	513	37.82%	534	34.64%	513	37.82%	25TH	34.23%	38.18%	43.10%	25TH
KERN	N	Asthma Medication Rati o	545	50.64%	520	52.88%	545	50.64%	520	52.88%	BELOW 25TH	57.59%	62.43%	68.13%	4 YEARS < 25TH
KERN	N	Metabolic Monitoring f or Children and Adolesc ents on Antipsychotics - Total	100	42.00%	78	33.33%	100	41.00%	78	33.33%	25TH	29.35%	35.43%	44.30%	75TH
KERN	N	Breast Cancer Screening	2813	53.25%	2886	47.96%	2813	53.25%	2886	47.96%	BELOW 25TH	52.85%	58.82%	64.06%	1 YEAR < 25TH
KERN	Y	Controlling High Blood P ressure	4039	29.14%	3922	19.99%	398	53.27%	411	49.64%	BELOW 25TH	54.01%	61.80%	67.64%	25TH
KERN	Y	Cervical Cancer Screeni ng	11838	50.76%	12499	49.94%	411	54.01%	409	50.61%	BELOW 25TH	55.23%	61.31%	67.40%	4 YEARS < 25TH
KERN	Y	Comprehensive Diabete s Care - HbA1c Poor Control (>9.0%)	2718	50.37%	2771	52.54%	411	36.25%	380	41.58%	25TH	45.96%	37.47%	32.85%	50TH
KERN	N	Chlamydia Screening in Women	1803	49.36%	1751	48.09%	1803	49.36%	1751	48.09%	BELOW 25TH	51.34%	58.44%	66.26%	1 YEAR < 25TH
KERN	Y	Childhood Immunizatio n Status - Combo 10	1100	25.82%	992	24.90%	411	26.03%	411	26.52%	BELOW 25TH	30.17%	37.47%	44.77%	4 YEARS < 25TH
KERN	Y	Immunizations for Adol escents - Combo 2	1512	35.19%	1504	33.11%	411	35.52%	411	32.85%	25TH	31.02%	36.86%	43.06%	50TH
KERN	Y	Prenatal and Postpartu m Care - Postpartum Care	735	63.54%	677	64.84%	411	67.64%	411	72.99%	25TH	71.30%	76.40%	80.89%	50TH
KERN	Y	Prenatal and Postpartu m Care - Timeliness of Prenatal Care	735	82.04%	677	74.00%	411	88.56%	411	82.73%	BELOW 25TH	84.18%	89.05%	92.94%	75TH

KERN	N	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	383	78.59%	447	73.60%	383	78.59%	447	73.60%	BELOW 25TH	78.65%	82.09%	84.78%	25TH
KERN	N	Well-Child Visits in the First 30 Months of Life - 0 to 15 Months	.	.	464	28.66%	411	50.12%	464	28.66%	BELOW 25TH	61.31%	67.88%	72.99%	-
KERN	N	Well-Child Visits in the First 30 Months of Life - 15 to 30 Months	.	.	990	51.01%	.	.	990	51.01%	BELOW 25TH	61.31%	67.88%	72.99%	-
KERN	Y	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for BMI	14418	31.22%	13204	52.32%	411	72.99%	411	71.05%	BELOW 25TH	71.29%	80.50%	87.23%	25TH
KERN	Y	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition	14418	16.59%	13204	18.02%	411	14.84%	411	50.85%	BELOW 25TH	63.02%	71.55%	80.05%	1 YEAR < 25TH
KERN	Y	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity	14418	8.25%	13204	17.52%	411	8.03%	411	48.42%	BELOW 25TH	57.42%	66.79%	76.28%	1 YEAR < 25TH
KERN	N	Child and Adolescent Well-Care Visits	.	.	26266	32.93%	.	.	26266	32.93%	BELOW 25TH	58.52%	65.94%	72.50%	-
LOS ANGELES	N	Antidepressant Medication Management - Effective Acute Phase Treatment	5686	51.72%	5528	52.97%	5685	51.72%	5528	52.97%	25TH	50.38%	53.57%	58.93%	25TH
LOS ANGELES	N	Antidepressant Medication Management - Effective Cont. Phase Treatment	5686	36.55%	5528	36.23%	5685	36.53%	5528	36.23%	25TH	34.23%	38.18%	43.10%	50TH
LOS ANGELES	N	Asthma Medication Ratio	8423	59.08%	8645	60.72%	8425	59.07%	8645	60.72%	25TH	57.59%	62.43%	68.13%	25TH
LOS ANGELES	N	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Total	599	51.42%	560	33.21%	599	51.42%	560	33.21%	25TH	29.35%	35.43%	44.30%	90TH
LOS ANGELES	N	Breast Cancer Screening	46828	62.13%	47534	57.29%	46829	62.13%	47534	57.29%	25TH	52.85%	58.82%	64.06%	50TH
LOS ANGELES	Y	Controlling High Blood Pressure	47905	37.21%	41195	33.70%	392	63.52%	411	61.80%	50TH	54.01%	61.80%	67.64%	50TH

LOS ANGELES	Y	Cervical Cancer Screening	170140	57.03%	180485	53.40%	411	59.61%	392	50.00%	BELOW 25TH	55.23%	61.31%	67.40%	25TH
LOS ANGELES	Y	Comprehensive Diabetes Care - HbA1c Poor Control (>9.0%)	35578	41.90%	36285	47.02%	409	34.23%	371	45.82%	25TH	45.96%	37.47%	32.85%	50TH
LOS ANGELES	N	Chlamydia Screening in Women	25267	68.86%	24641	67.52%	25268	68.86%	24641	67.52%	75TH	51.34%	58.44%	66.26%	75TH
LOS ANGELES	Y	Childhood Immunization Status - Combo 10	13386	22.79%	12503	25.28%	411	27.98%	411	33.82%	25TH	30.17%	37.47%	44.77%	25TH
LOS ANGELES	Y	Immunizations for Adolescents - Combo 2	19548	39.75%	19690	38.17%	411	41.36%	411	38.69%	50TH	31.02%	36.86%	43.06%	75TH
LOS ANGELES	Y	Prenatal and Postpartum Care - Postpartum Care	8143	61.70%	7677	63.10%	411	66.91%	411	73.72%	25TH	71.30%	76.40%	80.89%	50TH
LOS ANGELES	Y	Prenatal and Postpartum Care - Timeliness of Prenatal Care	8143	75.59%	7677	72.05%	411	86.13%	411	83.46%	BELOW 25TH	84.18%	89.05%	92.94%	50TH
LOS ANGELES	N	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	3061	85.76%	2957	81.84%	3061	85.76%	2957	81.84%	25TH	78.65%	82.09%	84.78%	75TH
LOS ANGELES	N	Well-Child Visits in the First 30 Months of Life - 0 to 15 Months	.	.	5797	40.40%	411	53.77%	5797	40.40%	BELOW 25TH	61.31%	67.88%	72.99%	-
LOS ANGELES	N	Well-Child Visits in the First 30 Months of Life - 15 to 30 Months	.	.	12377	64.77%	.	.	12377	64.77%	25TH	61.31%	67.88%	72.99%	-
LOS ANGELES	Y	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for BMI	187895	64.19%	168979	67.19%	411	87.10%	411	82.48%	50TH	71.29%	80.50%	87.23%	75TH
LOS ANGELES	Y	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition	187895	53.84%	168979	56.44%	411	55.23%	411	73.97%	50TH	63.02%	71.55%	80.05%	1 YEAR < 25TH
LOS ANGELES	Y	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity	187895	50.90%	168979	53.65%	411	52.31%	411	71.78%	50TH	57.42%	66.79%	76.28%	1 YEAR < 25TH
LOS ANGELES	N	Child and Adolescent Well-Care Visits	.	.	339222	40.60%	.	.	339222	40.60%	BELOW 25TH	58.52%	65.94%	72.50%	-

SACRAMENTO	N	Antidepressant Medication Management - Effective Acute Phase Treatment	928	52.26%	879	52.67%	929	52.21%	879	52.67%	25TH	50.38%	53.57%	58.93%	25TH
SACRAMENTO	N	Antidepressant Medication Management - Effective Cont. Phase Treatment	928	36.96%	879	37.20%	929	36.92%	879	37.20%	25TH	34.23%	38.18%	43.10%	50TH
SACRAMENTO	N	Asthma Medication Ratio	1211	62.10%	1239	63.28%	1211	62.10%	1239	63.28%	50TH	57.59%	62.43%	68.13%	25TH
SACRAMENTO	N	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Total	100	42.00%	111	39.64%	100	42.00%	111	39.64%	50TH	29.35%	35.43%	44.30%	75TH
SACRAMENTO	N	Breast Cancer Screening	4734	56.04%	4891	49.48%	4734	56.04%	4891	49.48%	BELOW 25TH	52.85%	58.82%	64.06%	25TH
SACRAMENTO	Y	Controlling High Blood Pressure	5897	34.14%	5442	37.30%	409	52.81%	411	49.15%	BELOW 25TH	54.01%	61.80%	67.64%	25TH
SACRAMENTO	Y	Cervical Cancer Screening	19640	54.38%	21942	52.42%	411	51.09%	411	58.15%	25TH	55.23%	61.31%	67.40%	4 YEARS < 25TH
SACRAMENTO	Y	Comprehensive Diabetes Care - HbA1c Poor Control (>9.0%)	3942	43.20%	4284	49.30%	411	36.50%	384	45.57%	25TH	45.96%	37.47%	32.85%	50TH
SACRAMENTO	N	Chlamydia Screening in Women	2688	68.97%	2983	65.07%	2688	68.97%	2983	65.07%	50TH	51.34%	58.44%	66.26%	75TH
SACRAMENTO	Y	Childhood Immunization Status - Combo 10	1813	25.26%	1782	26.88%	411	32.36%	411	34.06%	25TH	30.17%	37.47%	44.77%	25TH
SACRAMENTO	Y	Immunizations for Adolescents - Combo 2	2181	40.72%	2319	42.86%	411	41.61%	411	41.85%	50TH	31.02%	36.86%	43.06%	75TH
SACRAMENTO	Y	Prenatal and Postpartum Care - Postpartum Care	1166	70.33%	1280	69.45%	411	77.86%	411	72.51%	25TH	71.30%	76.40%	80.89%	90TH
SACRAMENTO	Y	Prenatal and Postpartum Care - Timeliness of Prenatal Care	1166	88.94%	1280	79.38%	411	91.48%	411	85.64%	25TH	84.18%	89.05%	92.94%	90TH
SACRAMENTO	N	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	506	88.14%	595	82.52%	506	88.14%	595	82.52%	50TH	78.65%	82.09%	84.78%	90TH
SACRAMENTO	N	Well-Child Visits in the First 30 Months of Life - 0 to 15 Months	.	.	1009	41.92%	411	53.04%	1009	41.92%	BELOW 25TH	61.31%	67.88%	72.99%	-
SACRAMENTO	N	Well-Child Visits in the First 30 Months of Life - 15 to 30 Months	.	.	1763	71.19%	.	.	1763	71.19%	50TH	61.31%	67.88%	72.99%	-
SACRAMENTO	Y	Weight Assessment and Counseling for Nutrition and Physical Activity f	22656	63.98%	22546	68.49%	411	86.86%	411	85.16%	50TH	71.29%	80.50%	87.23%	75TH

		or Children/Adolescents - Counseling for BMI													
SACRAMENTO	Y	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition	22656	64.51%	22546	66.32%	411	62.04%	411	85.40%	90TH	63.02%	71.55%	80.05%	25TH
SACRAMENTO	Y	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity	22656	59.61%	22546	62.43%	411	57.91%	411	81.75%	90TH	57.42%	66.79%	76.28%	25TH
SACRAMENTO	N	Child and Adolescent Well-Care Visits	.	.	41108	49.70%	.	.	41108	49.70%	BELOW 25TH	58.52%	65.94%	72.50%	-
SAN DIEGO	N	Antidepressant Medication Management - Effective Acute Phase Treatment	374	57.49%	392	57.65%	374	57.49%	392	57.65%	50TH	50.38%	53.57%	58.93%	75TH
SAN DIEGO	N	Antidepressant Medication Management - Effective Cont. Phase Treatment	374	41.71%	392	41.07%	374	41.71%	392	41.07%	50TH	34.23%	38.18%	43.10%	75TH
SAN DIEGO	N	Asthma Medication Ratio	466	68.45%	498	66.47%	466	68.45%	498	66.47%	50TH	57.59%	62.43%	68.13%	50TH
SAN DIEGO	N	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Total	94	36.17%	77	38.96%	94	36.17%	77	38.96%	50TH	29.35%	35.43%	44.30%	50TH
SAN DIEGO	N	Breast Cancer Screening	1714	55.25%	1764	49.83%	1714	55.08%	1764	49.83%	BELOW 25TH	52.85%	58.82%	64.06%	25TH
SAN DIEGO	Y	Controlling High Blood Pressure	1915	51.38%	1677	42.52%	380	66.84%	411	62.29%	50TH	54.01%	61.80%	67.64%	50TH
SAN DIEGO	Y	Cervical Cancer Screening	8093	46.92%	8955	43.84%	411	51.82%	411	50.12%	BELOW 25TH	55.23%	61.31%	67.40%	4 YEARS < 25TH
SAN DIEGO	Y	Comprehensive Diabetes Care - HbA1c Poor Control (>9.0%)	1221	41.03%	1298	47.84%	409	32.03%	366	41.80%	25TH	45.96%	37.47%	32.85%	75TH
SAN DIEGO	N	Chlamydia Screening in Women	1319	60.42%	1383	53.65%	1319	60.42%	1383	53.65%	25TH	51.34%	58.44%	66.26%	50TH
SAN DIEGO	Y	Childhood Immunization Status - Combo 10	891	32.88%	800	35.75%	411	38.93%	411	42.34%	50TH	30.17%	37.47%	44.77%	50TH
SAN DIEGO	Y	Immunizations for Adolescents - Combo 2	1560	35.13%	1522	32.06%	411	36.50%	411	33.82%	25TH	31.02%	36.86%	43.06%	50TH
SAN DIEGO	Y	Prenatal and Postpartum Care - Postpartum Care	284	66.20%	296	62.50%	276	75.72%	287	74.91%	25TH	71.30%	76.40%	80.89%	90TH

SAN DIEGO	Y	Prenatal and Postpartum Care - Timeliness of Prenatal Care	284	77.82%	296	75.68%	276	86.59%	287	83.28%	BELOW 25TH	84.18%	89.05%	92.94%	50TH
SAN DIEGO	N	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	300	91.67%	305	82.62%	300	91.67%	305	82.62%	50TH	78.65%	82.09%	84.78%	90TH
SAN DIEGO	N	Well-Child Visits in the First 30 Months of Life - 0 to 15 Months	.	.	271	41.33%	247	55.87%	271	41.33%	BELOW 25TH	61.31%	67.88%	72.99%	-
SAN DIEGO	N	Well-Child Visits in the First 30 Months of Life - 15 to 30 Months	.	.	749	69.16%	.	.	749	69.16%	50TH	61.31%	67.88%	72.99%	-
SAN DIEGO	Y	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for BMI	15047	62.55%	14045	61.86%	411	86.37%	411	85.16%	50TH	71.29%	80.50%	87.23%	75TH
SAN DIEGO	Y	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition	15047	64.57%	14045	62.03%	411	64.23%	411	74.21%	50TH	63.02%	71.55%	80.05%	25TH
SAN DIEGO	Y	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity	15047	61.57%	14045	60.14%	411	61.07%	411	73.72%	50TH	57.42%	66.79%	76.28%	25TH
SAN DIEGO	N	Child and Adolescent Well-Care Visits	.	.	24906	43.98%	.	.	24906	43.98%	BELOW 25TH	58.52%	65.94%	72.50%	-
SAN JOAQUIN	N	Antidepressant Medication Management - Effective Acute Phase Treatment	144	54.86%	153	53.59%	144	54.86%	153	53.59%	50TH	50.38%	53.57%	58.93%	50TH
SAN JOAQUIN	N	Antidepressant Medication Management - Effective Cont. Phase Treatment	144	38.19%	153	37.25%	144	38.19%	153	37.25%	25TH	34.23%	38.18%	43.10%	50TH
SAN JOAQUIN	N	Asthma Medication Ratio	124	61.29%	119	64.71%	124	61.29%	119	64.71%	50TH	57.59%	62.43%	68.13%	25TH
SAN JOAQUIN	N	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Total	16	31.25%	5	40.00%	16	31.25%	5	40.00%	50TH	29.35%	35.43%	44.30%	25TH

SAN JOAQUIN	N	Breast Cancer Screening	785	47.77%	804	41.17%	785	47.77%	804	41.17%	BELOW 25TH	52.85%	58.82%	64.06%	4 YEARS < 25TH
SAN JOAQUIN	Y	Controlling High Blood Pressure	1055	49.29%	940	38.19%	401	64.09%	411	55.72%	25TH	54.01%	61.80%	67.64%	50TH
SAN JOAQUIN	Y	Cervical Cancer Screening	3519	46.35%	3747	42.78%	411	49.39%	411	45.26%	BELOW 25TH	55.23%	61.31%	67.40%	4 YEARS < 25TH
SAN JOAQUIN	Y	Comprehensive Diabetes Care - HbA1c Poor Control (>9.0%)	695	42.88%	726	48.62%	411	38.20%	392	41.33%	25TH	45.96%	37.47%	32.85%	50TH
SAN JOAQUIN	N	Chlamydia Screening in Women	455	63.74%	445	55.51%	455	63.74%	445	55.51%	25TH	51.34%	58.44%	66.26%	50TH
SAN JOAQUIN	Y	Childhood Immunization Status - Combo 10	276	32.97%	267	32.21%	276	36.23%	267	35.21%	25TH	30.17%	37.47%	44.77%	50TH
SAN JOAQUIN	Y	Immunizations for Adolescents - Combo 2	375	30.93%	356	22.47%	374	31.28%	356	23.88%	BELOW 25TH	31.02%	36.86%	43.06%	25TH
SAN JOAQUIN	Y	Prenatal and Postpartum Care - Postpartum Care	184	63.04%	204	64.71%	178	67.98%	189	73.02%	25TH	71.30%	76.40%	80.89%	50TH
SAN JOAQUIN	Y	Prenatal and Postpartum Care - Timeliness of Prenatal Care	184	75.54%	204	74.51%	178	84.83%	189	84.13%	BELOW 25TH	84.18%	89.05%	92.94%	50TH
SAN JOAQUIN	N	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	60	90.00%	57	89.47%	60	90.00%	57	89.47%	90TH	78.65%	82.09%	84.78%	90TH
SAN JOAQUIN	N	Well-Child Visits in the First 30 Months of Life - 0 to 15 Months	.	.	131	29.77%	128	50.78%	131	29.77%	BELOW 25TH	61.31%	67.88%	72.99%	-
SAN JOAQUIN	N	Well-Child Visits in the First 30 Months of Life - 15 to 30 Months	.	.	251	56.97%	.	.	251	56.97%	BELOW 25TH	61.31%	67.88%	72.99%	-
SAN JOAQUIN	Y	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for BMI	3153	57.50%	2852	60.31%	411	85.89%	411	81.02%	50TH	71.29%	80.50%	87.23%	75TH
SAN JOAQUIN	Y	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition	3153	50.75%	2852	44.11%	411	49.88%	411	61.80%	BELOW 25TH	63.02%	71.55%	80.05%	1 YEAR < 25TH
SAN JOAQUIN	Y	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	3153	46.88%	2852	41.44%	411	45.74%	411	61.80%	25TH	57.42%	66.79%	76.28%	1 YEAR < 25TH

		- Counseling for Physical Activity													
SAN JOAQUIN	N	Child and Adolescent Well-Care Visits	.	.	6797	28.51%	.	.	6797	28.51%	BELOW 25TH	58.52%	65.94%	72.50%	-
STANISLAUS	N	Antidepressant Medication Management - Effective Acute Phase Treatment	630	52.38%	543	53.78%	630	52.38%	543	53.78%	50TH	50.38%	53.57%	58.93%	50TH
STANISLAUS	N	Antidepressant Medication Management - Effective Cont. Phase Treatment	630	32.38%	543	34.99%	630	32.38%	543	34.99%	25TH	34.23%	38.18%	43.10%	4 YEARS < 25TH
STANISLAUS	N	Asthma Medication Ratio	831	62.45%	774	62.40%	831	62.45%	774	62.40%	25TH	57.59%	62.43%	68.13%	25TH
STANISLAUS	N	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Total	74	47.30%	61	39.34%	74	47.30%	61	39.34%	50TH	29.35%	35.43%	44.30%	75TH
STANISLAUS	N	Breast Cancer Screening	2557	58.90%	2585	51.91%	2557	58.82%	2585	51.91%	BELOW 25TH	52.85%	58.82%	64.06%	50TH
STANISLAUS	Y	Controlling High Blood Pressure	3305	43.87%	2847	42.15%	384	60.68%	411	57.18%	25TH	54.01%	61.80%	67.64%	25TH
STANISLAUS	Y	Cervical Cancer Screening	11356	52.06%	11790	50.22%	411	54.26%	409	55.50%	25TH	55.23%	61.31%	67.40%	3 YEARS < 25TH
STANISLAUS	Y	Comprehensive Diabetes Care - HbA1c Poor Control (>9.0%)	2284	49.43%	2303	51.32%	411	37.71%	388	43.04%	25TH	45.96%	37.47%	32.85%	50TH
STANISLAUS	N	Chlamydia Screening in Women	1867	56.29%	1859	49.70%	1867	56.29%	1859	49.70%	BELOW 25TH	51.34%	58.44%	66.26%	25TH
STANISLAUS	Y	Childhood Immunization Status - Combo 10	983	24.31%	926	24.41%	411	27.98%	411	27.25%	BELOW 25TH	30.17%	37.47%	44.77%	25TH
STANISLAUS	Y	Immunizations for Adolescents - Combo 2	1646	28.43%	1731	32.99%	411	25.30%	411	34.31%	25TH	31.02%	36.86%	43.06%	1 YEAR < 25TH
STANISLAUS	Y	Prenatal and Postpartum Care - Postpartum Care	656	69.51%	667	66.57%	411	80.54%	411	79.08%	50TH	71.30%	76.40%	80.89%	90TH
STANISLAUS	Y	Prenatal and Postpartum Care - Timeliness of Prenatal Care	656	79.57%	667	79.01%	411	85.89%	411	88.08%	25TH	84.18%	89.05%	92.94%	50TH
STANISLAUS	N	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	274	82.48%	275	77.82%	274	82.48%	275	77.82%	BELOW 25TH	78.65%	82.09%	84.78%	50TH
STANISLAUS	N	Well-Child Visits in the First 30 Months of Life - 0 to 15 Months	.	.	507	39.45%	411	49.39%	507	39.45%	BELOW 25TH	61.31%	67.88%	72.99%	-

STANISLAUS	N	Well-Child Visits in the First 30 Months of Life - 15 to 30 Months	.	.	863	53.77%	.	.	863	53.77%	BELOW 25TH	61.31%	67.88%	72.99%	-
STANISLAUS	Y	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for BMI	14774	58.39%	12602	68.13%	411	82.97%	411	81.75%	50TH	71.29%	80.50%	87.23%	50TH
STANISLAUS	Y	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition	14774	45.17%	12602	34.70%	411	44.77%	411	63.99%	25TH	63.02%	71.55%	80.05%	1 YEAR < 25TH
STANISLAUS	Y	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity	14774	26.28%	12602	16.08%	411	26.52%	411	58.39%	25TH	57.42%	66.79%	76.28%	1 YEAR < 25TH
STANISLAUS	N	Child and Adolescent Well-Care Visits	.	.	26344	28.44%	.	.	26344	28.44%	BELOW 25TH	58.52%	65.94%	72.50%	-
TULARE	N	Antidepressant Medication Management - Effective Acute Phase Treatment	1077	43.18%	1102	47.91%	1077	43.18%	1102	47.91%	BELOW 25TH	50.38%	53.57%	58.93%	4 YEARS < 25TH
TULARE	N	Antidepressant Medication Management - Effective Cont. Phase Treatment	1077	27.48%	1102	31.76%	1077	27.48%	1102	31.76%	BELOW 25TH	34.23%	38.18%	43.10%	4 YEARS < 25TH
TULARE	N	Asthma Medication Ratio	1432	69.55%	1491	71.70%	1432	69.55%	1491	71.70%	75TH	57.59%	62.43%	68.13%	75TH
TULARE	N	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Total	149	42.28%	149	42.28%	149	41.61%	149	42.28%	50TH	29.35%	35.43%	44.30%	75TH
TULARE	N	Breast Cancer Screening	3813	56.70%	4139	58.32%	3813	56.70%	4139	58.32%	25TH	52.85%	58.82%	64.06%	25TH
TULARE	Y	Controlling High Blood Pressure	6995	47.71%	6699	51.19%	398	64.07%	411	63.50%	50TH	54.01%	61.80%	67.64%	50TH
TULARE	Y	Cervical Cancer Screening	20186	60.10%	21848	64.22%	411	65.45%	360	66.94%	50TH	55.23%	61.31%	67.40%	50TH
TULARE	Y	Comprehensive Diabetes Care - HbA1c Poor Control (>9.0%)	5020	57.55%	5425	37.36%	410	38.29%	384	37.24%	50TH	45.96%	37.47%	32.85%	50TH
TULARE	N	Chlamydia Screening in Women	4133	58.48%	4295	61.09%	4133	58.48%	4295	61.09%	50TH	51.34%	58.44%	66.26%	50TH
TULARE	Y	Childhood Immunization Status - Combo 10	2685	32.18%	2479	36.10%	411	40.88%	411	45.50%	75TH	30.17%	37.47%	44.77%	50TH

TULARE	Y	Immunizations for Adolescents - Combo 2	2712	41.78%	2930	39.56%	411	43.55%	411	44.28%	75TH	31.02%	36.86%	43.06%	75TH
TULARE	Y	Prenatal and Postpartum Care - Postpartum Care	1873	79.50%	1816	76.65%	411	88.08%	411	86.13%	90TH	71.30%	76.40%	80.89%	90TH
TULARE	Y	Prenatal and Postpartum Care - Timeliness of Prenatal Care	1873	90.34%	1816	89.81%	411	94.40%	411	92.46%	50TH	84.18%	89.05%	92.94%	90TH
TULARE	N	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	322	78.88%	326	78.83%	322	78.88%	326	78.83%	25TH	78.65%	82.09%	84.78%	25TH
TULARE	N	Well-Child Visits in the First 30 Months of Life - 0 to 15 Months	.	.	1343	52.64%	411	65.94%	1343	52.64%	BELOW 25TH	61.31%	67.88%	72.99%	-
TULARE	N	Well-Child Visits in the First 30 Months of Life - 15 to 30 Months	.	.	2453	70.53%	.	.	2453	70.53%	50TH	61.31%	67.88%	72.99%	-
TULARE	Y	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for BMI	34308	64.92%	33483	73.31%	411	87.59%	411	89.54%	75TH	71.29%	80.50%	87.23%	75TH
TULARE	Y	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition	34308	54.47%	33483	58.95%	411	51.82%	411	81.27%	75TH	63.02%	71.55%	80.05%	1 YEAR < 25TH
TULARE	Y	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity	34308	53.74%	33483	56.54%	411	50.12%	411	80.78%	75TH	57.42%	66.79%	76.28%	1 YEAR < 25TH
TULARE	N	Child and Adolescent Well-Care Visits	.	.	51718	43.89%	.	.	51718	43.89%	BELOW 25TH	58.52%	65.94%	72.50%	-

Appendix E: Claims/Encounter Data - Top 10 Behavioral Health Diagnosis, MY2021

Behavioral Health	Member Counts	Sessions	Member Counts	Sessions
	2020		2021	
Mood Disorders	21,567	194,538	21,357	215,091
Anxiety Disorders	11,789	87,110	13,698	136,070
Schizophrenia and other Psychotic Disorders	6,647	146,049	5,642	85,314
Autistic Disorder	3,223	513,686	3637	802,812
Adjustment Disorder with Mixed Anxiety & Depressed Mood	2,377	17,117	3,091	30,929
Post-Traumatic Stress Disorder (unspecified)	1,696	10,814	1,986	21,908
Sexual and Gender Identity Disorders	1,801	15,086	1,599	15,049
Substance Related and Addictive Disorders	1,496	16,505	1,496	11,215
Post-Traumatic Stress Disorder (chronic)	1,141	11,367	1,405	17,244
Adjustment Disorder Unspecified	N/A	N/A	1,162	9,669
Total:	**54,516**	**1,033,797**	**55,073**	**1,345,301**

Appendix F: CAHPS – Member Responses by Demographic Indicators, MY2020

Health Net - MCAL (Centene CA)

Demographic Segments

	Rating of Health Plan		Rating of Health Care		Health Status			Mental Health Status			Survey Type			Age			
	8-10 (G)	0-7 (H)	8-10 (I)	0-7 (J)	Excellent/ Very good (K)	Good (L)	Fair/Poor (M)	Excellent/ Very good (N)	Good (O)	Fair/Poor (P)	Mail (Q)	Phone (R)	Internet (S)	18-34 (T)	35-44 (U)	45-54 (V)	55+ (W)
Total respondents	*333*	*129*	*158*	*87*	*163*	*177*	*134*	*197*	*143*	*127*	*391*	*0^*	*90*	*118*	*50*	*89*	*212*
Rating Questions (% 9 or 10)																	
Q28. Rating of Health Plan	76.6% H	0.0%	75.5% J	17.9%	66.7% LM	48.2%	52.3%	66.0% OP	45.3%	51.2%	58.5% S	---	40.5%	55.9% U	34.7%	50.0%	62.3% U
Q8. Rating of Health Care	61.1% H	9.4%	73.4% J	0.0%	62.7% LM	41.2%	41.8%	66.3% OP	35.2%	36.0%	50.8% S	---	33.3%	41.3%	37.9%	34.0%	56.4% V
Q18. Rating of Personal Doctor	72.2% H	26.1%	76.8% J	21.3%	72.6% LM	57.8%	53.8%	75.0% OP	48.8%	56.2%	63.6% S	---	44.7%	54.2%	42.3%	53.7%	69.2% TV
Q22. Rating of Specialist	80.4% H	27.3%	79.7% J	38.1%	62.2%	73.5%	67.9%	75.4%	61.5%	65.1%	72.6%	---	35.3%	47.4%	56.3%	60.0%	78.7%
Rating Questions (% 8, 9 or 10)																	
Q28. Rating of Health Plan	100% H	0.0%	92.9% J	36.9%	80.8% LM	67.1%	68.9%	82.4% OP	63.5%	66.4%	73.8%	---	64.3%	76.6% U	55.1%	68.2%	76.5% U
Q8. Rating of Health Care	82.3% H	17.2%	100% J	0.0%	74.6%	61.9%	59.5%	74.7% O	54.9%	62.7%	68.0% S	---	50.0%	65.2%	55.2%	55.3%	70.1%
Q18. Rating of Personal Doctor	88.2% H	42.0%	92.0% J	47.5%	81.0%	75.2%	74.2%	87.0% OP	70.2%	71.9%	76.9%	---	74.5%	74.6%	53.8%	74.1%	82.5%
Q22. Rating of Specialist	96.3% H	48.5%	95.9% J	59.5%	89.2%	85.7%	83.0%	91.2%	82.1%	81.4%	87.9%	---	64.7%	78.9%	62.5%	80.0%	94.7%
Getting Needed Care (% A or U)	**83.8% H**	**40.8%**	**87.3% J**	**47.4%**	**77.8%**	**74.9%**	**64.6%**	**83.8% OP**	**69.2%**	**62.1%**	**71.7%**	**---**	**67.0%**	**65.2%**	**64.4%**	**70.1%**	**76.0%**
Q9. Getting care, tests, or treatment	87.4% H	41.5%	91.0% J	44.8%	86.2% M	76.5%	64.2%	88.3% OP	69.4%	65.8%	74.7%	---	72.9%	73.9%	62.1%	78.7%	78.0%
Q20. Getting specialist appointment	80.2% H	40.0%	83.5% J	50.0%	69.4%	73.2%	65.0%	79.3% P	68.9%	58.3%	68.6%	---	61.1%	56.5%	66.7%	61.5%	74.1%
Getting Care Quickly (% A or U)	**78.9% H**	**39.9%**	**84.0% J**	**43.9%**	**72.4%**	**58.9%**	**68.5%**	**75.9% O**	**58.9%**	**63.1%**	**66.5%**	**---**	**61.9%**	**60.6%**	**43.2%**	**67.8% U**	**73.3% U**
Q4. Getting urgent care	84.7% H	33.3%	88.9% J	35.7%	76.7%	57.1%	66.0%	77.8%	58.6%	63.0%	65.2%	---	65.2%	62.5%	36.4%	78.3%	70.4%
Q6. Getting routine care	73.2% H	46.4%	79.1% J	52.0%	68.1%	60.6%	71.1%	74.0% O	59.2%	63.1%	67.8%	---	58.5%	58.7%	50.0%	57.4%	76.2% TUV
Coordination of Care (Q17) (% A or U)	**77.2%**	**44.4%**	**82.4%**	**44.8%**	**77.4%**	**72.5%**	**58.3%**	**81.0% P**	**70.8%**	**56.4%**	**68.8%**	**---**	**73.3%**	**60.0%**	**64.3%**	**57.9%**	**76.9%**
Flu Vaccinations for Adults Ages 18-64 (Q31) (% Yes)	**40.1% H**	**26.3%**	**48.6% J**	**34.6%**	**37.6%**	**29.9%**	**43.4% L**	**35.6%**	**38.5%**	**35.2%**	**36.8%**	**---**	**33.3%**	**28.3%**	**34.7%**	**27.6%**	**45.9% TV**
Medical Assistance with Smoking and Tobacco Use Cessation (% A, U or S) *(Rolling average)*																	
Q33. Advising Smokers and Tobacco Users to Quit	75.7% H	52.3%	88.0% J	58.1%	55.9%	65.3%	78.4% K	61.9%	64.9%	75.6%	69.5%	---	47.1%	43.8%	66.7%	69.2%	70.8%
Q34. Discussing Cessation Medications	44.0%	34.1%	52.9%	35.5%	40.0%	36.7%	48.6%	39.5%	40.5%	43.9%	42.9%	---	27.8%	12.5%	40.0%	46.2%	45.5%
Q35. Discussing Cessation Strategies	41.7%	29.5%	45.8%	32.3%	45.5%	34.7%	36.1%	35.0%	40.5%	39.0%	38.5%	---	31.3%	12.5%	33.3%	50.0%	39.7%

% A = % Always, % U = % Usually, % S = % Sometimes. ^Indicates a base size smaller than 20. Interpret results with caution.

MY 2020 Medicaid Adult Survey - 52

Demographic Segments

	Rating of Health Plan		Rating of Health Care		Health Status			Mental Health Status			Survey Type			Age			
	8-10	0-7	8-10	0-7	Excellent/ Very good	Good	Fair/Poor	Excellent/ Very good	Good	Fair/Poor	Mail	Phone	Internet	18-34	35-44	45-54	55+
	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)	(P)	(Q)	(R)	(S)	(T)	(U)	(V)	(W)
Total respondents	*333*	*129*	*158*	*87*	*163*	*177*	*134*	*197*	*143*	*127*	*391*	*0^*	*90*	*118*	*50*	*89*	*212*
Customer Service (% A or U)	**94.0%** H	**62.7%**	**90.1%**	**81.4%**	**83.9%**	**87.6%**	**88.3%**	**88.0%**	**84.7%**	**89.0%**	**86.5%**	---	**88.8%**	**88.5%**	**75.0%**	**85.1%**	**90.2%**
Q24. Provided information or help	88.9% H	54.1%	85.9%	75.0%	77.3%	82.0%	82.4%	80.6%	75.5%	89.2%	79.4%	---	87.5%	87.1%	64.3%	76.7%	84.4%
Q25. Treated with courtesy and respect	99.1% H	71.4%	94.2%	87.9%	90.5%	93.2%	94.2%	95.5%	93.9%	88.9%	93.5%	---	90.0%	90.0%	85.7%	93.5%	95.9%
How Well Doctors Communicate (% A or U)	**89.7%** H	**72.1%**	**95.6%** J	**68.5%**	**90.5%**	**86.2%**	**80.1%**	**92.6%** P	**86.3%**	**78.6%**	**84.7%**	---	**90.2%**	**82.3%**	**75.0%**	**84.1%**	**88.2%**
Q12. Personal doctor explained things	88.7% H	71.7%	95.6% J	66.0%	87.9%	83.8%	80.3%	92.0% P	84.4%	76.1%	83.1%	---	89.3%	81.1%	64.7%	81.8%	88.1%
Q13. Personal doctor listened carefully	89.2% H	73.3%	95.5% J	67.3%	89.7%	84.6%	83.1%	91.9%	85.7%	80.6%	85.1%	---	89.3%	83.8%	76.5%	84.1%	88.0%
Q14. Personal doctor showed respect	92.5%	82.6%	97.3% J	77.4%	93.1%	92.5%	84.5%	94.7%	92.2%	85.1%	89.1%	---	96.4%	86.5%	88.2%	90.9%	90.8%
Q15. Personal doctor spent enough time	88.5% H	60.9%	93.8% J	63.5%	91.4% M	83.8%	72.5%	91.9% P	82.8%	72.7%	81.8%	---	85.7%	77.8%	70.6%	79.5%	86.1%
Other Measures																	
Q27. Ease of filling out forms (% A or U)	96.1% H	89.5%	94.6%	91.7%	95.3%	94.0%	93.6%	95.1%	93.9%	94.2%	94.0%	---	96.1%	93.5%	95.9%	93.9%	95.9%
Q7. Average number of visits to doctor's office or clinic	1.8	1.6	3.4	3.2	1.2	1.6	2.7 KL	1.4	1.4	2.7 NO	1.8	---	1.6	1.2	2.1	1.5	2.0 T
Q11. Average number of visits to personal doctor	2.2	1.6	3.0 J	2.1	1.4	2.1 K	2.6 K	1.9	1.8	2.5	2.2 S	---	1.3	1.6	1.8	2.0	2.2
Q21. Average number of specialists seen	1.7	1.8	1.8	1.9	1.5	1.6	1.9	1.6	1.8	1.8	1.6	---	1.9	1.0	1.6	1.9	1.8

% A = % Always, % U = % Usually, % S = % Sometimes. ^Indicates a base size smaller than 20. Interpret results with caution.

Demographic Segments

	Gender		Education		Race						Ethnicity	
	Male	Female	High school or less	Some college or more	White	Black or African-American	Asian	Native Hawaiian or Other Pacific Islander	American Indian or Alaska Native	Other	Hispanic	Not Hispanic
	(X)	(Y)	(Z)	(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)
Total respondents	*190*	*283*	*285*	*177*	*191*	*35*	*64*	*6^*	*7^*	*129*	*269*	*193*
Rating Questions (% 9 or 10)												
Q28. Rating of Health Plan	53.0%	56.4%	61.8% a	44.7%	53.5%	65.6%	50.0%	33.3%	57.1%	59.7%	61.5% i	47.0%
Q8. Rating of Health Care	44.3%	48.1%	51.5%	40.6%	47.3%	37.5%	43.5%	50.0%	50.0%	45.2%	55.9% i	39.3%
Q18. Rating of Personal Doctor	56.3%	63.1%	65.5%	54.4%	60.3%	66.7%	54.5%	66.7%	60.0%	59.3%	65.4%	55.2%
Q22. Rating of Specialist	58.0%	73.9%	74.7%	59.3%	69.4%	62.5%	69.2%	100%	100%	67.6%	72.9%	65.1%
Rating Questions (% 8, 9 or 10)												
Q28. Rating of Health Plan	68.5%	74.5%	77.8% a	64.1%	69.5%	75.0%	68.3%	50.0%	71.4%	79.8% b	76.5% i	66.5%
Q8. Rating of Health Care	60.8%	66.0%	67.6%	59.4%	65.5%	62.5%	60.9%	50.0%	50.0%	64.5%	70.1%	60.7%
Q18. Rating of Personal Doctor	75.7%	77.1%	77.0%	75.4%	75.6%	80.0%	75.8%	66.7%	60.0%	79.0%	79.6%	73.3%
Q22. Rating of Specialist	78.0%	89.8%	88.0%	83.1%	85.5%	75.0%	84.6%	100%	100%	88.2%	91.4%	82.5%
Getting Needed Care (% A or U)	**71.7%**	**72.1%**	**71.3%**	**72.4%**	**73.8%**	**75.0%**	**66.1%**	**100%**	**87.5%**	**69.9%**	**74.3%**	**70.2%**
Q9. Getting care, tests, or treatment	77.2%	74.2%	73.9%	76.0%	78.0%	62.5%	73.9%	100%	75.0%	71.4%	76.6%	73.8%
Q20. Getting specialist appointment	66.1%	69.9%	68.7%	68.8%	69.7%	87.5%	58.3%	100%	100%	68.3%	72.0%	66.7%
Getting Care Quickly (% A or U)	**62.7%**	**68.4%**	**63.1%**	**69.8%**	**70.5%** d	**62.6%**	**50.6%**	**87.5%**	**100%**	**64.8%**	**71.3%**	**60.8%**
Q4. Getting urgent care	63.4%	67.6%	63.3%	70.0%	66.0%	63.6%	54.5%	100%	100%	71.9%	74.5%	58.8%
Q6. Getting routine care	62.0%	69.2%	62.9%	69.5%	75.0% dg	61.5%	46.7%	75.0%	100%	57.7%	68.1%	62.7%
Coordination of Care (Q17) (% A or U)	**76.9%**	**64.2%**	**66.7%**	**72.3%**	**68.5%**	**33.3%**	**80.0%**	**NA**	**100%**	**64.5%**	**64.0%**	**72.2%**
Flu Vaccinations for Adults Ages 18-64 (Q31) (% Yes)	**29.9%**	**39.3%**	**35.9%**	**35.4%**	**34.8%**	**21.2%**	**51.9%** bcg	**40.0%**	**16.7%**	**26.8%**	**37.9%**	**32.2%**
Medical Assistance with Smoking and Tobacco Use Cessation (% A, U or S) *(Rolling average)*												
Q33. Advising Smokers and Tobacco Users to Quit	65.0%	66.1%	69.4%	61.2%	63.5%	73.7%	61.1%	100%	50.0%	65.4%	70.3%	63.8%
Q34. Discussing Cessation Medications	36.7%	41.7%	45.8%	32.0%	35.8%	57.9%	38.9%	0.0%	0.0%	46.2%	35.1%	43.2%
Q35. Discussing Cessation Strategies	40.0%	31.6%	42.3%	29.2%	28.8%	50.0%	33.3%	0.0%	0.0%	44.0%	43.2%	35.9%

% A = % Always, % U = % Usually, % S = % Sometimes. ^Indicates a base size smaller than 20. Interpret results with caution.

Appendix G: HEDIS – Health Disparity Analysis by Race/Ethnicity (Prevention and Screening Measures), MY2020

Table 1: Disparity Pattern by Race/Ethnicity for Medi-Cal Kern

	HEDIS Measure(s)									
	BCS		CCS		CHL		CIS-Combo 10		COL	
	DEN	COMP RATE	DEN	COMP RATE	DEN	COMP RATE	DEN	COMP RATE	DEN	COMP RATE
AI/AN	12	33%	56	39%	1	0%	1	0%	28	29%
API	149	56%	458	49%	42	33%	7	57%	290	35%
Black	201	51%	984	49%	159	57%	40	5%	506	29%
Hispanic	1246	57%	6307	55%	1113	49%	482	29%	2488	37%
Other	92	32%	214	53%	16	56%	1	0%	191	29%
Unknown	114	41%	560	45%	60	47%	364	24%	287	28%
White	1077	38%	3923	43%	360	44%	97	15%	2344	26%

Table 2: Disparity Pattern by Race/Ethnicity for Medi-Cal San Diego

	HEDIS Measure(s)									
	BCS		CCS		CHL		CIS-Combo 10		COL	
	DEN	COMP RATE	DEN	COMP RATE	DEN	COMP RATE	DEN	COMP RATE	DEN	COMP RATE
AI/AN	6	17%	37	43%	5	40%	3	0%	13	15%
API	258	53%	1079	43%	69	51%	31	32%	552	34%
Black	104	49%	488	38%	81	62%	20	45%	267	29%
Hispanic	485	53%	2601	48%	609	59%	362	42%	1012	37%
Other	43	63%	90	44%	21	33%	1	0%	108	31%
Unknown	286	52%	1993	43%	208	50%	236	31%	657	26%
White	587	45%	2668	42%	390	47%	147	29%	1385	30%

Table 3: Disparity Pattern by Race/Ethnicity for Medi-Cal San Joaquin

	HEDIS Measure(s)									
	BCS		CCS		CHL		CIS-Combo 10		COL	
	DEN	COMP RATE	DEN	COMP RATE	DEN	COMP RATE	DEN	COMP RATE	DEN	COMP RATE
AI/AN	7	29%	32	31%	1	100%			13	23%
API	158	42%	533	42%	35	46%	9	33%	323	27%
Black	64	28%	429	43%	45	62%	18	22%	202	19%
Hispanic	213	49%	1289	46%	228	56%	117	41%	507	25%
Other	23	43%	76	33%	3	33%			67	31%
Unknown	59	46%	309	46%	41	54%	104	27%	148	29%
White	281	37%	1081	39%	92	55%	19	16%	639	25%

Table 4: Disparity Pattern by Race/Ethnicity for Medi-Cal Stanislaus

	HEDIS Measure(s)									
	BCS		CCS		CHL		CIS-Combo 10		COL	
	DEN	COMP RATE	DEN	COMP RATE	DEN	COMP RATE	DEN	COMP RATE	DEN	COMP RATE
AI/AN	12	25%	38	45%	2	0%	3	33%	24	29%
API	271	52%	855	47%	76	53%	11	45%	554	28%
Black	84	39%	480	45%	57	67%	10	40%	219	24%
Hispanic	1023	62%	5537	58%	1139	50%	386	25%	2052	33%
Other	79	44%	188	48%	33	36%	1	0%	180	36%
Unknown	98	51%	494	44%	76	53%	413	24%	236	25%
White	1017	43%	4197	42%	475	46%	102	21%	2138	24%

Table 5: Disparity Pattern by Spoken Language for Medi-Cal Kern

	HEDIS Measure(s)									
	BCS		CCS		CHL		CIS-Combo 10		COL	
	DEN	COMP RATE	DEN	COMP RATE	DEN	COMP RATE	DEN	COMP RATE	DEN	COMP RATE
Arabic	7	57%	15	67%	1	0%	1	0%	12	42%
English	2014	43%	9913	47%	1263	49%	752	21%	4400	29%
Korean, Choson-0	5	60%	8	50%			1	100%	6	50%
Spanish	781	63%	2380	63%	476	46%	236	36%	1534	40%
Unknown	42	24%	64	28%	1	0%			113	23%
Vietnamese	8	38%	12	58%	1	100%			13	46%

Table 6: Disparity Pattern by Spoken Language for Medi-Cal San Diego

	HEDIS Measure(s)									
	BCS		CCS		CHL		CIS-Combo 10		COL	
	DEN	COMP RATE	DEN	COMP RATE	DEN	COMP RATE	DEN	COMP RATE	DEN	COMP RATE
Arabic	10	40%	30	37%	5	20%	2	100%	17	41%
English	1210	48%	7227	42%	1064	53%	628	33%	2844	30%
Spanish	354	55%	1283	52%	279	56%	153	50%	709	38%
Tagalog	30	57%	63	49%	2	50%	3	0%	53	49%
Unknown	49	37%	64	33%	1	0%			142	25%
Vietnamese	43	60%	96	56%	11	27%	3	0%	79	46%

Table 7: Disparity Pattern by Spoken Language for Medi-Cal San Joaquin

	HEDIS Measure(s)									
	BCS		CCS		CHL		CIS-Combo 10		COL	
	DEN	COMP RATE	DEN	COMP RATE	DEN	COMP RATE	DEN	COMP RATE	DEN	COMP RATE
Cambodian, Khmer	7	57%	13	69%	1	100%			13	46%
Cantonese	1	0%	8	75%					5	20%
English	663	38%	3294	41%	364	56%	204	26%	1607	24%
Spanish	111	56%	373	53%	77	52%	61	51%	229	31%
Unknown	1	100%	7	14%					9	0%
Vietnamese	6	50%	13	38%					6	33%

Table 8: Disparity Pattern by Spoken Language for Medi-Cal Stanislaus

	HEDIS Measure(s)									
	BCS		CCS		CHL		CIS-Combo 10		COL	
	DEN	COMP RATE	DEN	COMP RATE	DEN	COMP RATE	DEN	COMP RATE	DEN	COMP RATE
Cambodian, Khmer	50	50%	59	42%	1	100%			77	22%
English	1721	45%	9379	47%	1320	51%	742	23%	3765	25%
Laotian,Laothian,Pha Xa Loa	16	56%	25	36%					30	27%
Spanish	624	69%	1981	68%	524	46%	176	29%	1210	38%
Unknown	80	49%	111	36%	3	33%			160	24%
Vietnamese	34	65%	68	54%	1	100%			61	36%