MOLINA® HEALTHCARE *of California*

2025 Quality Improvement Program Evaluation

Table of Contents

Background and Overview: Quality Improvement and Health Equity Transformation Program Description and Evaluation

Molina Healthcare of CA implements a formal process to monitor and evaluate the quality, appropriateness, efficiency, safety, and effectiveness of care and service systematically and objectively. Molina uses a multidimensional approach to focus on opportunities for improving processes and health outcomes and satisfaction of health plan members and network practitioners. Molina's Quality Improvement Program promotes the accountability of all employees and network practitioners to be responsible for the quality of care and services provided to our members.

Molina's Quality Improvement Program is comprised of the following:

- Quality Improvement and Health Equity Transformation Program Description: The Quality Improvement and Health Equity Transformation Program Description guides the formal processes for evaluating and improving the quality and appropriateness of health care services and the health status of the populations we serve. The Quality Improvement and Health Equity Transformation Program Description describes the quality activities undertaken by Molina to promote and achieve excellence in all areas through continuous improvement.
- Quality Improvement and Health Equity Transformation Program Work Plan: The Quality Improvement and Health Equity Transformation Program Work Plan documents and monitors quality improvement activities throughout Molina for the upcoming year. The work plan includes goals and objectives based on the strengths and opportunities for improvement as identified in the previous year's Quality Improvement and Health Equity Transformation Program evaluations and in the analysis of quality measures. Quality leadership updates the work plan as needed throughout the year to assess the progress of initiatives and to re-evaluate timeliness of initiatives undertaken.
- Quality Improvement and Health Equity Transformation Program Evaluation: The annual Quality Improvement and Health Equity Transformation Program Evaluation is an evaluation of quality improvement activities within the previous year. The evaluation provides a mechanism for determining the extent to which the activities documented in the work plan have contributed to improvements in the quality of care and services provided to Molina members. Through a structured review of clinical, service, and operational initiatives and trends, the program evaluation highlights Quality Improvement and Health Equity Transformation Program accomplishments and overall effectiveness of Molina's Quality Improvement and Health Equity Transformation Program as to identify barriers and opportunities for improvement.

The Quality Improvement and Health Equity Transformation Program activities outlined within this Evaluation document follow a structured format including a description of the activity, quantitative analysis and trending of measures, evaluation of effectiveness, barrier analysis and identified opportunities for improvement. The Quality Improvement and Health Equity Program Evaluation provides a review of the applicable activities contained in the Quality Improvement and Health Equity Program Work Plan that support the goals established in the Quality Improvement and Health Equity

Transformation Program Description.

Measurement, improvement, and accountability are three central key concepts that drive Molina's Quality Improvement and Health Equity Transformation Program. Molina drives continuous improvement by using innovative tools for measurement, evaluation, tracking and trending and receiving and incorporating vital feedback from our members/authorized caregivers, practitioners, facilities, community organizations, and other stakeholders. Molina uses strategies to meet key Program goals, which include, but are not limited to:

- Making sure that health plan members receive accessible, appropriate, cost-effective, and high-quality health care and services (including physical, behavioral, and oral health as applicable) throughout the care continuum.
- Emphasizing the delivery of personalized care so that the doctor or practitioner can maintain their pivotal role of managing the unique needs of Molina members.
- Creating and implementing processes and programs that respond to and address the culturally and linguistically diverse needs of our members.
- Helping individuals navigate the health care system by reducing barriers and supporting them to reach their optimal health.

Through this evaluation summary, Molina monitors key strategies and activities implemented in 2025. Overall, activities planned in 2025 were completed. Activities not completed will be considered for continuation in 2026. Opportunities for improvement were identified; interventions were implemented. Throughout each area, Molina implemented interventions that met the needs of the culturally and ethnically diverse membership.

Quality Improvement and Health Equity Transformation Program Effectiveness

To evaluate the effectiveness of the Quality Improvement and Health Equity Transformation Program, key Quality Improvement and Health Equity Transformation Program components need review. Molina reviews the program to ensure there are adequate resources (e.g., staffing and data and information support). Molina also evaluates committee structure, practitioner participation, and leadership involvement in the Quality Improvement and Health Equity Transformation Program. Evaluating Quality Improvement and Health Equity Transformation Program components helps ensure that the program is effective. Molina also conducted ongoing program activity monitoring through 2025 to ensure the Quality Improvement and Health Equity Transformation Program is designed to achieve improvements for Molina health plan members and practitioners.

Adequacy of QI Program Resources

During 2025, Molina Healthcare of CA evaluated adequacy of resources on an ongoing basis. As quality activities continued to expand in 20225, quality leadership continues to review allocated resources on an ongoing basis. Overall, the staffing and resources dedicated to quality continue to be adequate. Additional staff were brought on in 2025 to support increasing membership and support Quality initiatives for all lines of business.

Molina also evaluated data, information, resources, and software needed along with staffing, to ensure that Molina has an adequate health information system in place to collect, analyze and integrate the data necessary to implement the Quality Improvement and Health Equity Transformation Program. Molina continues to evaluate the systems, processes, and data in place to support the Quality Improvement and Health Equity Transformation Program going forward into 2026. As additional quality improvement activities continue to be implemented, Molina will continue to monitor the status of data and information support to ensure that Molina's Quality Improvement and Health Equity Transformation Program is effective.

At the end of 2025, Molina determined there were adequate staffing and resources in place for 2025, including data systems and staffing, to meet 2025 program goals. As membership increases and programs expand, quality and health plan leadership will continue to evaluate staffing and resource levels to ensure Molina can successfully complete the work. Molina has determined that current quality staffing is sufficient to support current quality improvement and health equity transformation activities and includes well-trained Quality Improvement and Health Equity Transformation Program leadership.

QIHET Committee and Subcommittee Structure

The Molina Healthcare of CA quality committee structure includes multiple subcommittees that report to the Quality Improvement and Health Equity Transformation Committee. The Committee meets every quarter and is facilitated by the Chief Medical Officer and AVP of Quality.

Molina continues to implement an effective committee structure to support the Quality Improvement and Health Equity Transformation Program. The Quality Improvement and Health Equity Transformation Committee oversees the overall direction and strategy for the Quality Improvement and Health Equity Transformation Program. During 2025, this committee also included ongoing participation and input from Molina network practitioners. Key health plan leadership from Healthcare Services and/or Network and/or Plan President and/or Community Engagement and/or appeals and grievances and/or Contact Center – attended all four committee meetings. The two (2) chairs facilitated all four (4) meetings to ensure there was participation from other key health plan leadership and network practitioners.

Practitioner Participation in the QIHET Program

Molina's partnership with network practitioners facilitated an environment where key practitioner input was received about Molina's Quality Improvement and Health Equity Transformation Program and initiatives through multiple avenues. Practitioners actively participated in Molina's Quality Improvement and Health Equity Transformation Committee, the Pharmacy and Therapeutics Committee and the Professional Review Committee. Primary Care Physicians were invited to and participated in Molina's Quality Improvement and Health Equity Transformation Committee in 2025, including pediatric physicians, gastroenterology and internal medicine. In addition to their responsibilities to the QIHETC, Molina's Chief Medical Officer also co-chaired and participated the Molina Healthcare Services Committee, the national Pharmacy and Therapeutics Committee and the national Professional Review Committee

External and internal practitioner involvement continued to be high, and attendance was consistent for practitioners. Additional feedback from practitioners was received through focused meetings and sought through written materials. After evaluating practitioner participation, Molina believes there are adequate practitioners involved in and consulted with, to meet the objectives of the Quality Improvement and Health Equity Transformation Program. To further solidify committee participation, Molina will look to include more practitioners with primary care, pediatrics, behavioral health, and additional specialty experience to ensure our in network, participating practitioners are representative of our population and the members our plan serves.

Leadership Involvement in the QIHET Program

Molina's leadership team fully supports and leads Molina's overall Quality Improvement and Health Equity Transformation Program. This was demonstrated through active participation of health plan leadership on the Quality Improvement and Health Equity Transformation Committee, the Healthcare Services Committee, the Delegation Oversight Committee, the Pharmacy and Therapeutics Committee, and the Professional Review Committee. Molina's leadership also participates in the National Quality Improvement and Health Equity Transformation Committee. Molina's leadership evaluates the need for changes to the overall Quality Improvement and Health Equity Transformation Program structure throughout the year. Molina's leadership involvement was adequate in 2025 as leaders regularly attended and actively participated in Quality Improvement and Health Equity Transformation

Committee meetings. In fact, during 2025, two (2) committee chairs – the AVP, Quality attended three (3) out of four (4) quarterly meetings and the Chief Medical Officer attended three (3) out of four (4) quarterly meetings.

Quality Measure Review

Medicaid

Introduction: Molina Healthcare of California conducts an annual evaluation of quality performance measures to assess the effectiveness, accessibility, and outcomes of care delivered to its Medicaid members. The MY2024 Quality Performance Measurement Report presents results across multiple clinical and service domains, comparing current-year performance to prior years and established national benchmarks to identify trends, strengths, and areas requiring improvement.

Purpose: The purpose of the Quality Performance Measurement Report is to evaluate Molina Healthcare of California's Medicaid HEDIS® performance for MY2024 against National Committee for Quality Assurance (NCQA) Quality Compass benchmarks, with an overall goal of achieving or exceeding the 67th percentile, identify where results improved or declined compared with MY2023 and highlight priority areas for quality improvement and targeted interventions that support regulatory and accreditation requirements.

Key Findings:

- Overall performance improved, with 56 of 70 reported Medicaid measures increasing from MY2023 to MY2024.
- 21 measures met or exceeded the 67th percentile benchmark, while the majority remained below goal, indicating ongoing improvement opportunities.
- Strong performance was observed in diabetes care, medication adherence, statin therapy, kidney health evaluation, and several behavioral health medication management measures.
- Prevention and screening measures showed mixed results, with improvements in chlamydia screening, pediatric weight assessment, and dental evaluations, but continued declines in cervical cancer screening and immunization measures.
- Behavioral health follow-up measures, including follow-up after hospitalization and high-intensity substance use treatment, remained among the lowest-performing measures, often at or below the 5th percentile.
- Cardiac rehabilitation measures consistently performed well below benchmark across all phases, representing one of the most significant gaps.
- Well-child visits, particularly visits within the first 15 months of life, continued to fall within the lowest performance thresholds despite modest improvement.

Opportunities and Interventions: Opportunities exist to strengthen care coordination, preventive service utilization, and timely follow-up after acute events. Targeted interventions should focus on improving post-discharge follow-up for behavioral health and substance use disorders, increasing engagement in cardiac rehabilitation, and enhancing access to preventive and ambulatory services. Continued provider engagement, member outreach, telehealth utilization, medication management support, and incentive-based strategies offer meaningful pathways to improve performance in persistently low-scoring areas

Overall Summary: The MY2024 Medicaid quality performance results demonstrate measurable progress across many clinical domains, reflecting the impact of ongoing quality improvement efforts. Despite these gains, several high-impact measures remain below benchmark, particularly in behavioral health follow-up, cardiac rehabilitation, immunizations, and early childhood preventive care. Sustained focus on targeted, data-driven interventions will be critical to closing performance gaps and advancing overall quality outcomes for Molina Healthcare of California's Medicaid population.

Marketplace

Introduction: Molina Healthcare of California conducts an annual evaluation of quality performance measures to assess the effectiveness, accessibility, and outcomes of care delivered to its Marketplace members. The MY2024 Quality Performance Measurement Report evaluates performance across multiple clinical quality domains using HEDIS and non-HEDIS measures to assess the effectiveness, accessibility, and appropriateness of care delivered to Marketplace members. Performance trends are compared across measurement years and benchmarked against CMS Marketplace Quality Rating System percentile.

Purpose: The purpose of the Quality Performance Measurement Report is to evaluate Molina Healthcare of California's Marketplace HEDIS® performance for MY2024, identify where results improved or declined compared with MY2023, identify areas of strength and underperformance, and assess progress toward achieving the established quality goal of meeting or exceeding the 75th percentile benchmark. The findings are intended to inform quality improvement planning by highlighting priority areas, guide targeted interventions, and support regulatory and accreditation requirements.

Key Findings:

- Overall performance improved, with 27 of 38 Marketplace measures showing increased rates from MY2023 to MY2024.
- Seven measures met or exceeded the 75th percentile benchmark, while the majority of measures remained below the target goal.
- Strong performance was observed in select areas, including Chlamydia Screening in Women, Immunizations for Adolescents (HPV), Kidney Health Evaluation for Patients with Diabetes, Depression Screening and Follow-Up measures, Initiation of Substance Use Disorder Treatment, and Plan All-Cause Readmissions.
- Several measures fell at or below the 5th percentile, indicating significant opportunities for improvement, including Breast Cancer Screening, Asthma Medication Ratio, Appropriate Treatment for Upper Respiratory Infection, Follow-Up After Hospitalization for Mental Illness (7-day), and Well-Child Visits in the First 15 Months of Life.
- Preventive care and screening measures generally demonstrated positive year-over-year improvement, though many did not reach benchmark goals.

- Persistent low performance was noted in respiratory care, behavioral health follow-up after hospitalization, appropriateness of antibiotic use, and pediatric well-care measures.

Opportunities and Interventions: The results highlight opportunities to strengthen preventive care, chronic disease management, behavioral health follow-up, and pediatric care engagement. Expanding provider engagement strategies, enhancing member outreach and education, and increasing use of in-home, telehealth, and digital condition management tools may help address performance gaps. Focused interventions targeting measures at or below the lowest percentile thresholds, particularly those without current interventions, represent a critical opportunity to improve outcomes and advance overall quality performance.

Overall Summary: Molina Healthcare of California's MY2024 Marketplace quality performance reflects meaningful improvement across many measures, demonstrating progress toward quality goals. However, most measures did not achieve the 75th percentile benchmark, and several critical clinical areas remain significantly underperforming. Continued emphasis on targeted, data-driven interventions and sustained quality improvement efforts will be essential to close performance gaps, enhance member outcomes, and improve overall Marketplace quality ratings.

Medicare

Introduction: Molina Healthcare of California completes an annual evaluation of Medicare performance measurement results to understand how well members are receiving recommended care across key clinical areas. The 2025 Quality Performance Measurement Report (based on MY2024 data) summarizes measure rates, compares them with prior-year performance, and assesses achievement against national benchmarks.

Purpose: The purpose of the Quality Performance Measurement Report is to evaluate Molina Healthcare of California's Medicare HEDIS® performance for MY2024, identify where results improved or declined compared with MY2023, determine which measures met the organization's benchmark goal (75th percentile), and highlight priority areas for quality improvement and targeted interventions.

Key Findings:

- Overall performance: 21 of 59 Medicare rates increased from MY2023 to MY2024.
- Benchmark attainment: 12 of 59 rates met the 75th percentile goal; 47 did not meet the goal.
- Measures reported at <5th percentile (priority improvement needs) included: CWP, PCE (bronchodilator/systemic corticosteroid), CRE (initiation/engagement/achievement), SPD statin adherence 80%, OMW, FUM (7- and 30-day), FUA (30-day), FUI (7- and 30-day), FUH (7- and 30-day), FMC, TRC medication reconciliation post-discharge, TRC patient engagement after inpatient discharge, and AAP.

- Prevention & Screening: Adult immunizations declined notably (influenza, pneumococcal 66+, Td/Tdap). Cancer screening results were relatively stable year-to-year but remained below the 75th percentile goal.
- Respiratory: All three respiratory measures declined from MY2023 to MY2024 and none met the 75th percentile goal; no current interventions were in place for this category.
- Cardiovascular: SPC statin received and SPC statin adherence 80% met/exceeded the 75th percentile goal; CRE measures remained at 0%, and other measures (e.g., CBP, PBH) did not meet goal.
- Diabetes: Some improvement occurred in glycemic control and blood pressure control; however, eye exams and kidney health evaluation declined, and both diabetes statin measures declined, with adherence flagged as a key low-performing area.
- Musculoskeletal: Both osteoporosis-related measures declined, with OMW at 0% in MY2024.
- Behavioral Health: Two measures met/exceeded goal (AMM acute phase; POD total), while several follow-up measures after ED visit/high-intensity care/hospitalization dropped sharply (including some at 0%).
- Care Coordination: Several TRC measures improved but none met the 75th percentile goal; key gaps included medication reconciliation post-discharge, patient engagement after inpatient discharge, and follow-up after ED visit for multiple high-risk chronic conditions.
- Appropriateness of Use: Seven measures met/exceeded the 75th percentile goal (including AAB, DDE falls/total, DAE, LBP, UOP, HDO), indicating relative strength in avoidance of low-value care and medication safety, though some subareas remained below target.
- Access/Availability: IET initiation met/exceeded the 75th percentile goal with substantial improvement; AAP remained low and IET engagement did not meet goal.
- Utilization: PCR (65+) increased (worse performance because it is an inverse measure) and did not meet the 75th percentile goal.

Opportunities and Interventions: Opportunities center on measures with the largest gaps to the 75th percentile goal, particularly adult immunizations, respiratory care, cardiac rehabilitation, diabetes monitoring (eye and kidney evaluation) and statin adherence, osteoporosis care after fracture, behavioral health and substance use follow-up after ED/inpatient events, and care transition activities such as medication reconciliation and timely patient engagement. Interventions already in use include member outreach (calls/texts/emails), home kits, in-home visits, incentives and digital programs in select domains, eye exam programming, and rewards. Additional high-yield interventions identified in the report for several categories include provider engagement meetings, focused provider/member education, and expanded outreach workflows to close care gaps and improve follow-up/transition processes.

Overall Summary: The MY2024 Medicare performance showed selective gains but broad underperformance against the 75th percentile benchmark goal, with only 12 of 59 rates meeting target. Strengths were concentrated in specific medication and appropriateness measures and select

behavioral health and substance use treatment measures, while significant deficits persisted in immunizations, respiratory care, cardiac rehabilitation, osteoporosis management, care coordination, and behavioral health follow-up. Prioritizing targeted, measurable interventions—especially those aimed at follow-up after acute events, preventive immunizations, and care transition processes—represents the clearest path to improving outcomes and closing benchmark gaps.

Annual Accomplishments

Molina's evaluation of the adequacy of Quality Improvement and Health equity Transformation Program resources, Quality Improvement and Health Equity Transformation Committee structure, practitioner participation, and leadership involvement determined that the current Quality Improvement and Health Equity Transformation Program structure was and be effective going into 2026. Molina does not recommend changes to the Quality Improvement and Health Equity Transformation Program structure currently. Ongoing monitoring will continue during 2026 to determine if changes are needed, based on membership, network practitioner, and other organizational changes.

Additionally, Molina integrated and communicated quality improvement and health equity transformation goals through structured work plans. Molina monitors current activities and reviews reports to identify opportunities for needed changes and improvements. These activities, in addition to ongoing improvement projects and quality improvement interventions form the basis of Molina's work plan. Molina also added more specificity to the program evaluation to evaluate its effectiveness, summarize performance improvement project activities, and describe program accomplishments.

Some program changes/modifications, however, were still recommended for 2026. These changes and modifications include the following:

1. Place more focus on CAHPS improvement activities,
2. Continue to use electronic interfaces and strategies to deliver messages to providers and members,
3. Continue expanded focus on quality and health equity integration,
4. Continue to enhance quality and network meetings with practitioners to jointly advance quality goals, and
5. Further integrate community engagement, clinical, quality and network participation in quality activities to improve health care and services for health plan members.

Molina's commitment to quality is strong and shared across all levels of the health plan. Beyond making sure that committee structures and participation still work effectively. Currently, there is no need to restructure the Quality Program for 2026. Molina will continue to pursue our goals to achieve overall quality excellence through ongoing monitoring, continuous quality improvement, and program modifications.

Potential Quality of Care

Introduction: Molina Healthcare of California conducts an annual evaluation of Potential Quality of Care (PQOC). The analysis evaluates all PQOC cases accepted and closed from Q1 through Q4 2025 and provides an overview of case severity, incident categories, locations of incidents, and provider monitoring outcomes to help evaluate trends and improve member safety and quality of care.

Purpose: Molina Healthcare of California analyzes PQOC case activity for calendar year 2025, to identify patterns or areas of potential risk, assess provider performance, and identify opportunities for quality improvement and system-level interventions.

Key Findings

- **Total PQOC Activity**:
  - 623 cases were accepted and 574 cases were closed across all MHCA lines of business.
- **Lines of Business With Highest Case Volume**:
  - MHCA–Medicaid reported the largest number of accepted cases (477).
- **Severity Levels**:
  - The majority of cases were classified as **Level 1 (no quality-of-care issue)** at 55%.
  - Level 2 (adverse occurrence handled appropriately) accounted for 42%.
  - Levels 3 and 4 combined represented approximately 3%.
- **Incident Categories**:
  - **Treatment-related issues** made up the overwhelming majority of accepted cases (over 600), significantly higher than all other categories.
  - Other categories—such as safety/trauma, procedures/surgery, and medication errors—represented small proportions.
- **Incident Locations**:
  - **Provider offices** represented the highest incident location counts.
  - Hospitals, emergency departments, skilled nursing facilities, and member homes contributed smaller portions.
- **Provider Ongoing Monitoring**:
  - Providers with three or more Level 2, 3, or 4 complaints in a six-month period were flagged for review.
  - Two providers met monitoring criteria in both Q1–Q2 and Q3–Q4 reporting periods.

Opportunities and Interventions: Findings suggest continued opportunities to enhance provider education, improve communication, and reinforce adherence to clinical standards—especially in high-volume treatment-related cases. Additional interventions may include targeted provider outreach, focused audits, improvement plans for trends identified through monitoring, and collaboration with clinical leadership to address systemic issues in care delivery environments.

Overall Summary: Across 2025, Molina Healthcare of California demonstrated strong oversight of quality-of-care concerns through comprehensive case review and structured provider monitoring

processes. Most PQOC cases reflect low-severity concerns, though treatment-related incidents and office-based care settings remain key focus areas for quality improvement. Ongoing monitoring of provider performance and targeted interventions will continue to support MHCA's mission to ensure safe, effective, and patient-centered care.

Population Assessment

Introduction: Molina Healthcare of California conducts an annual Population Assessment to evaluate the characteristics and needs of its member population across Medicaid, Marketplace, and Medicare lines of business. The assessment integrates demographic, clinical, utilization, and social determinants of health data to support population health management planning and ensure resources and programs align with member needs across diverse populations.

Purpose: The assessment examines population characteristics, health needs, and social risk factors to inform population health management strategies, support care coordination, and guide targeted interventions aimed at improving health outcomes, access to care, and equity across Molina Healthcare of California's membership.

Key Findings:

- Total membership in 2025 was 1,234,782 members, reflecting a 3.9% decrease from the prior year. Medicaid accounted for 86.0% of total membership, Marketplace 5.5%, and Medicare 8.5%.
- Medicaid and Medicare membership declined year over year, while Marketplace membership increased by 17.8%.
- Housing and financial insecurity were prevalent across all lines of business, with the highest concentrations identified among Medicaid members and in Los Angeles and San Diego counties.
- Among Medicaid members, 47.7% were identified with high or very high housing insecurity, and 58.3% with high or very high financial insecurity.
- Children and adolescents (ages 2–19) represented 331,872 Medicaid members and 4,098 Marketplace members in 2025, with most identified as healthy or having stable minor chronic conditions.
- Members with disabilities enrolled in ABD products totaled 172,526, representing 14.0% of total membership, with chronic conditions, mental disorders, and SPMI as the most prevalent condition categories.
- Members with serious mental illness or serious emotional disturbance totaled 57,930, with 85.4% enrolled in Medicaid and year-over-year increases observed across all lines of business.
- Disparities were identified among specific racial and ethnic subpopulations, including higher prevalence of chronic conditions among Asian Medicaid members and higher prevalence of mental disorders among American Indian/Alaskan Native Medicaid members.

Opportunities and Interventions: The assessment identified opportunities to strengthen and expand existing population health management programs addressing social determinants of health, maternal and child health, behavioral health, chronic condition management, and transitions of care. Current interventions include integrated care management, mobile and community-based outreach, member engagement platforms, alternative access points to care, and partnerships with community-based organizations. Opportunities include expanding geographic reach, improving data integration and reporting, increasing member engagement and contact accuracy, enhancing provider collaboration, and scaling programs that address housing instability, financial insecurity, maternal health disparities, and care continuity following hospital discharge.

Overall Summary: The 2025 Population Assessment demonstrates that Molina Healthcare of California serves a large, diverse population with complex medical, behavioral, and social needs across all lines of business. The findings reinforce the importance of ongoing data-driven analysis and targeted population health strategies to address identified risks, disparities, and gaps in care. Existing programs provide a foundation to support member needs, while continued refinement and expansion of interventions will be necessary to promote equitable access, improve health outcomes, and ensure appropriate resource alignment for California members.

Measurement of Effectiveness of Population Health Management programs

Introduction: Molina Healthcare of California conducted an annual evaluation of its Population Health Management (PHM) Strategy to assess program impact across Medicaid and Marketplace populations. The evaluation uses a comprehensive, systematic methodology to measure key performance indicators tied to prevention and health education, management of emerging risk, patient safety across settings, and support for members with multiple chronic conditions, with health and wellness activities spanning annual health exams, well-child/adolescent care, and prenatal/postpartum care.

Purpose: The assessment examines the effectiveness of Molina Healthcare of California's Population Health Management strategy and associated programs in improving health outcomes, care coordination, and member experience for Medicaid and Marketplace populations. Standardized clinical, utilization, and member experience measures are used to identify performance trends, evaluate the impact of interventions, and support data-driven decision-making and continuous quality improvement.

Key Findings:

Medicaid

- Prenatal and Postpartum Care (PPC): Timeliness of Prenatal Care increased to 85.64% and met the internal improvement goal, but did not meet the national benchmark.
- PPC Postpartum Care increased to 85.64%, met the internal improvement goal, and met the national benchmark.

- Follow-Up After Hospitalization for Mental Illness (FUH) 7 Days showed substantial improvement and met the internal improvement goal, but did not meet the national benchmark.
- Plan All-Cause Readmission (PCR) Observed-to-Expected ratio (ages 18–64) did not meet the internal improvement goal, although performance met the national benchmark threshold.
- Case Management Member Feedback: Level II and Level III surveys met performance goals across all questions; response-rate challenges were primarily related to outdated member contact information.
- Complaints and Grievances: Complaints were primarily related to care coordination and communication, including missed return calls and dissatisfaction with treatment plans.

Marketplace

- Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care met the internal improvement goal but did not meet the national benchmark.
- PPC Postpartum Care met the internal improvement goal but did not meet the national benchmark.
- Follow-Up After Hospitalization for Mental Illness (FUH) 7 Days demonstrated limited improvement and did not meet internal goals or national benchmarks.
- Plan All-Cause Readmission (PCR) Observed-to-Expected ratio (ages 18–64) did not meet the internal improvement goal, though national benchmark performance was achieved.
- Case Management Member Feedback: Level II and Level III surveys consistently met performance goals, with several measures sustaining 100% satisfaction.
- Complaints and Grievances: Complaint volume remained low, with themes primarily related to care coordination and treatment plan preferences.

Opportunities and Interventions: Across both lines of business, high-priority opportunities centered on strengthening member engagement, addressing socioeconomic barriers, improving communication and care coordination, and expanding access to care. Planned or ongoing interventions included provider education and targeted member outreach, partnerships with community organizations and social service agencies for transportation/financial/resource support, improvements to information sharing and transitions of care via electronic health records and standardized protocols, and access expansion through recruiting providers, telehealth, extended hours, and partnerships with vendors. For behavioral health follow-up, interventions emphasized collaboration with community mental health centers, integrated care models, educational campaigns and outreach, and multi-channel appointment reminders. For readmissions, plans focused on discharge planning, medication reconciliation and adherence supports, follow-up scheduling, and addressing social determinants through community partnerships. Survey response rate improvement efforts included adding alternate contact numbers and offering text/email survey options for members who opt in.

Overall Summary: The 2025 PHM Strategy evaluation demonstrated multiple areas of improvement and strong member-reported experience outcomes, particularly in case management satisfaction across Medicaid and Marketplace. Clinical measures for prenatal and postpartum care generally met internal improvement goals, though several results did not reach national benchmark percentiles, and behavioral health follow-up remained below benchmarks despite improvement in some segments. Utilization performance for readmissions did not meet internal improvement goals in either line of business, reinforcing the need for enhanced transitions of care, follow-up access, medication management, and targeted supports addressing social determinants. The organization identified and prioritized high-impact interventions intended to sustain gains, close benchmark gaps, and improve continuity and outcomes in the coming year.

Culturally and Linguistically Appropriate Services Program

Introduction: Molina Healthcare of California conducts an ongoing assessment of members' cultural, ethnic, racial, and linguistic needs and preferences to identify and address barriers to care. The analysis leverages member demographics, community data, provider information, language service utilization, clinical performance, and member experience to understand where disparities may exist and to guide culturally and linguistically responsive programs that support equitable access and outcomes across Medicaid, Marketplace, and Medicare lines of business.

Purpose: The purpose of the CLAS Analysis is to evaluate Molina Healthcare of California's CLAS activities and effectiveness over the measurement year, including delegated functions, and to present results in measurable terms. The evaluation is intended to identify cultural and linguistic barriers, analyze where performance falls short of goals through root cause/barrier analysis, incorporate community input, and prioritize quality improvement opportunities that reduce disparities and improve delivery of culturally and linguistically appropriate services for diverse member populations.

Key Findings:

- Molina Healthcare of California serves a highly diverse membership across all lines of business, with substantial Hispanic or Latino representation and notable variation in racial composition compared to statewide population benchmarks. Medicaid membership exceeds one million members, with Marketplace and Medicare representing smaller but diverse populations.
- Threshold languages identified for translation include Spanish as the most prevalent non-English language, followed by several additional languages meeting established population thresholds, such as Tagalog, Chinese, Vietnamese, Korean, Armenian, and Arabic.
- Network language capacity goals are met for Medicaid and Medicare for languages spoken by at least one percent of members; however, for Marketplace, the primary care provider–to–member ratio goal is not met for Mandarin Chinese.
- Interpretation services are widely utilized across organizational departments, with the highest utilization observed in Member Services, Care Connections, and Healthcare Services outreach functions, indicating ongoing demand for language assistance.

- Average interpreter connect time generally meets performance expectations, though certain languages, including Armenian and Laotian, do not consistently meet the established connect-time benchmark.
- Member experience with language services shows mixed year-over-year results. Medicaid adult members reported improvements in best-possible experience measures, while child results were mixed. Marketplace members reported decreased access to interpreters in clinical settings but improved access to translated and alternative-format materials.
- Staff feedback identified recurring challenges with interpreter quality and technical issues, but positive feedback outweighed reported concerns, suggesting overall staff satisfaction remains favorable.
- Provider demographic data completeness remains limited, with most provider race and ethnicity reported as unknown. The analysis identifies limited access to Native Hawaiian or Pacific Islander providers and low completion rates for cultural competency training among providers.
- Stratified quality and experience analyses identified potential disparities across select racial and language subpopulations based on established variance thresholds and denominator criteria.
- Social risk factors, particularly housing and food insecurity, remain prevalent among members across multiple measures, though Medicaid data reflects year-over-year decreases in overall housing insecurity severity.
- Targeted outreach initiatives focused on unengaged members demonstrated that the vast majority of targeted individuals belonged to racial and ethnic minority groups and experienced barriers related to language, transportation, scheduling, and navigation of care.
- A strategic transition to a new over-the-phone interpretation services model was implemented to improve operational efficiency, compliance oversight, access to interpreters, and overall member and provider experience.
- Overall findings indicate that CLAS program resources and infrastructure are sufficient, while also highlighting opportunities for continued improvement in data collection, staff training, and language service performance.

Opportunities and Interventions: The analysis identified opportunities to enhance culturally and linguistically appropriate services through improved provider language capacity in identified gap areas, enhanced interpreter service performance for select languages, and strengthened collection and reporting of health equity and provider demographic data. Interventions underway include culturally tailored community-based outreach, multilingual educational materials, expanded appointment availability, transportation support, and culturally responsive care coordination through trusted community partnerships. Operational enhancements to interpretation services further support equitable access and compliance as demand for language assistance continues to grow.

Overall Summary: The 2025 California CLAS Analysis demonstrates that Molina Healthcare of California maintains a strong foundation to support culturally and linguistically appropriate services across its diverse membership. While the overall program structure and resources are sufficient, the findings

underscore the importance of continued focus on reducing disparities through targeted interventions, improved data quality, expanded provider cultural competency efforts, and ongoing evaluation of language access services. These efforts collectively support Molina's commitment to advancing health equity and improving access to high-quality care for all members.

Member Experience

Introduction: The MY2024 California Member Experience Report presents a comprehensive review of member experience across Medicaid, Marketplace (QHP), Medicare, and Long-Term Services and Supports (LTSS) lines of business. The report examines trends in access to care, provider communication, care coordination, case management, cultural and linguistic services, and customer service using CAHPS® survey results and supplemental member experience measures collected between 2023 and 2025.

Purpose: The evaluation examines member-reported experiences with healthcare services in California to identify areas of strength, emerging trends, and opportunities for improvement across product lines. The findings are intended to inform quality improvement efforts and support ongoing initiatives to enhance access, service quality, and overall member experience.

Key Findings:

- Provider communication consistently performed well across Medicaid Child, Medicaid Adult, and Marketplace populations, with scores remaining high throughout the measurement period.
- Care coordination improved in several programs, with Child Medicaid exceeding benchmark performance in 2025 and strong results observed in case management programs across all lines of business.
- Case Management (Levels II, III, and LTSS) demonstrated exceptionally high satisfaction in 2025, frequently ranging from 97% to 100%, despite declining survey response rates.
- Interpreter access improved notably for both Child and Adult Medicaid populations in 2025, with Adult Medicaid meeting or exceeding established goals for interpreter availability and satisfaction.
- Call center performance met or exceeded service level, speed of answer, and abandonment rate goals across Medicaid, Marketplace, and Medicare, with Medicare showing the strongest performance.
- Timely access to care remained below benchmarks across Medicaid and Marketplace populations, particularly for getting needed care and obtaining appointments quickly.
- Behavioral health access and satisfaction showed modest improvement but continued to fall slightly below established goals for both Child and Adult Medicaid members.
- Medicare CAHPS and Star Ratings continued to reflect challenges, particularly related to access to care, customer service, and prescription drug experience.
- Survey response rates fluctuated across product lines and generally remained below internal and national benchmarks, indicating ongoing challenges with member engagement.

Opportunities and Interventions: Opportunities focus on improving timely access to care, strengthening behavioral health availability, and enhancing member engagement. Targeted interventions include expanding provider networks, optimizing scheduling workflows, increasing telehealth utilization, strengthening care navigation and referral processes, and improving outreach strategies to increase survey participation. Continued investment in language services, customer service operations, and case management programs is also warranted to sustain strong performance in these areas.

Overall Summary: Overall, the MY2024 California Member Experience results demonstrate meaningful strengths in provider communication, case management, cultural and linguistic services, and customer service performance. At the same time, persistent challenges related to timely access to care, behavioral health services, Medicare member experience, and survey engagement remain. Addressing these gaps while sustaining high-performing areas will be essential to further improving member experience and advancing equitable, high-quality care across all California lines of business.

Provider Experience

Introduction: The 2025 Provider Satisfaction Survey presents feedback from healthcare providers contracted with Molina Healthcare of California, including both Direct and IPA provider networks. The survey evaluates provider experiences across multiple operational domains, such as utilization management, access to care, administrative support, interpreter services, and overall satisfaction, and compares 2025 results with prior years and industry benchmarks.

Purpose: The survey is intended to assess provider perceptions of Molina Healthcare of California's performance across key service and operational areas, identify trends over time, and highlight areas of strength and opportunity that may influence provider experience and engagement.

Key Findings:

- Overall provider satisfaction declined in 2025 for both Direct and IPA providers, with a more pronounced decrease among Direct providers.
- Direct provider overall satisfaction decreased to 60.1% in 2025, falling below prior-year performance and industry benchmarks.
- IPA provider overall satisfaction declined modestly to 69.0% in 2025 and remained closer to benchmark levels than Direct providers.
- Comparative ratings show declining perceptions among Direct providers and improving, though still below-benchmark, perceptions among IPA providers.
- Survey response rates decreased substantially in 2025, particularly among IPA providers and specialists.
- Utilization and Quality Management scores declined or remained below benchmarks across both provider groups, with Direct providers reporting lower satisfaction.

- Accessibility measures for Direct providers declined in 2025, especially for specialty care, referrals, and diagnostic services, while IPA providers reported more stable access.
- Satisfaction with interpreter services was moderate across both networks, with concerns noted regarding interpreter training and competency.
- Provider telephone access standards met or exceeded established performance goals across all lines of business in 2025.
- IPA providers demonstrated higher willingness to recommend the health plan compared to Direct providers.

Opportunities and Interventions: The findings indicate opportunities to improve provider experience through administrative simplification, enhanced utilization management processes, improved care coordination, and strengthened provider support services. Targeted efforts to streamline authorization workflows, improve access to care managers, enhance provider communication, and strengthen interpreter training and coordination may help address key drivers of dissatisfaction. Increasing provider engagement and improving survey participation are also important to ensure representative feedback and inform future improvement efforts.

Overall Summary: The 2025 Provider Satisfaction Survey shows that provider experience with Molina Healthcare of California varies by provider network, with IPA providers reporting more stable satisfaction than Direct providers. While operational strengths are evident in areas such as telephone access standards, overall satisfaction and several core service domains declined in 2025 and remain below industry benchmarks. Addressing utilization management, access to care, administrative processes, and provider engagement represents a meaningful opportunity to strengthen provider relationships and improve Molina's competitive position within the California market.

Improvement Project and Activity Review

During 2025, Molina continued to focus on improving quality and health equity through focused performance improvement projects and quality improvement interventions to address member needs.

Medicaid

PIP #1: Improving the Percentage of Provider Notifications for Members with SUD/SMH Diagnoses Following or Within 7 Days of Emergency Department (ED) Visit
Multi-year topic focused on supporting DHCS's efforts to improve statewide performance on the Follow-Up After Emergency Department Visit for Mental Illness – 30 Day Follow Up – Total and Follow-up After Emergency Department Visit for Substance Use – 30-Day Follow-Up-Total behavioral health MCAS measures in relation to the DHCS' Bold Goals.

By December 31, 2025, Molina aimed to achieve 85% provider notification rate for members with SUD/SMH diagnoses who require a follow up appointment within 7 days of an Emergency Department visit.

- *The study population includes Molina Medi-Cal members ages 13 years and older who had emergency (ED) visits with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, and Molina Medi-Cal members ages 6 years of age and older who had emergency (ED) visits with a principal diagnosis of mental illness or intentional self-harm (SMH).*

In 2025 interventions were developed to target and address causes/barriers identified through the use of quality improvement process and tools.

- *The improvement Topic for this PIP was "Improve the Percentage of Provider Notifications for Members with SUD/SMH Diagnoses Following or Within 7 Days of Emergency Department (ED) Visit". The systems targeted for improvement included timely and accurate data received from the treating ED as well as the process for converting this data to a user-friendly format to facilitate provider notifications.*

Intervention Title: Convert raw ED data using an automated process to create a refined and filterable report user-friendly format report.

Intervention Description: This intervention tests the process of converting raw ED data received from the treating EDs using an automated process to create a refined and filterable user-friendly format report. Raw ED data contains a large amount of data that is not relevant for the case managers assessment process and provider notification. This data may include several diagnosis codes that denote the member's past medical and/or behavioral health history but are not directly relevant to the current ED visit. The user-friendly format provides only the pertinent data from the ED visit, which expedites case manager assessment. Intervention 1 in 2024 tested a manual report creation process. This was determined to be unsustainable, so the intervention was adapted to an automated process in 2025.

Barrier Addressed: Raw ED data not converted.

Lessons Learned:
Molina learned that the development of an automated process of converting raw ED data received from the treating EDs to create a refined and filterable user-friendly format report facilitated more timely and reliable delivery of this information to the staff responsible for coordinating provider notifications. The automated process eliminated the challenge of not having staff available and accountable to create reports manually.

Challenges Encountered:
Before implementation of this intervention, several weeks of testing and refinement were required to achieve the final version of the automated report.

How Challenges were resolved:
Testing and refinement continued until all involved were satisfied that the automated refined and filterable user-friendly format report was ready for implementation.

Demonstrated Success:
The automated refined and filterable user-friendly format report process intervention was found to be reliable and added value to the goal of increasing provider notification.

Intervention Status:
The automated refined and filterable user-friendly format report process intervention was found to be reliable, added value to the goal of increasing provider notification, and was therefore adopted.

PIP #2: Well-Child Visits in the First 30 Months of Life: W30-2 Measure Rate Among Black/African American Population
Multi-year topic focused on supporting DHCS's efforts to reduce the disparity among the Black/African American population for the Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6) measure.
By December 31, 2025, Molina will use multi-faceted approaches to increase the percentage of members who identify as African America/Black and are ages 15-30 months who receive a well-child visit during the measurement year, from 40.48% to 65.83% (2022 50th Percentile Goal).

- *The study population includes Molina Medi-Cal members that identify as Black/African American 15-30 months of age during reporting year. The members identify their self-identification during their enrollment application process. This race/ethnicity data is transferred from DHCS's 834 form and electronic medical record supplemental data files, which is then electronically transmitted to Molina Healthcare of CA.*

In 2025 interventions were developed to target and address causes/barriers identified through the use of quality improvement process and tools.

- The improvement topic for this PIP was "Well-Child Visits in the First 30 Months of Life: W30-2 Measure Rate Among Black/African American Population".

Intervention Title: In-home well child visits for African American/Black Ethnicity/Unknown Ethnicity members ages 15-30 months.

Intervention Description: This intervention is designed to increase the number of well-child visits completed by members ages 15-30 months of African American/Black Ethnicity/Unknown Ethnicity during the measurement year. The Molina member outreach team has discovered that parents/guardians report that they are unable to keep appointments during regular provider office hours due to competing priorities such as work or school hours. In-home visits offer

the family a more flexible option for well-child care visits.

Barrier Addressed: Lack of flexible appointment availability to accommodate evening and/or week-end timeframes due to parent/guardian overlapping work hours with office availability.

Lessons Learned:

- *Beginning this intervention late in 2024 resulted in a limited number of members in the 2024 measurement year who had not yet turned 30 months of age by November/December 2024.*
- *Development of this intervention required more time than expected as in-home vendors were initially reluctant to discuss including children this young in their home visit program. Reasons for this reluctance including concern that in-home visits would take care away from assigned pediatric PCPs, and that these visits may negatively impact vaccination schedules.*

Challenges Encountered:

- Difficulty completing outreach to parents/guardians of eligible members to offer in-home well child visits due to a high number of W30 members that did not have an affiliated parent/guardian listed in their demographic data.
- In-home vendors' initial refusal due to concerns that these members were too young, in-home visits could take care away from assigned pediatric PCPs, and the potential impact on existing vaccination schedules resulted in requiring additional time to build that process out.
- Vendors' difficulty with designing protocols for completing in-home visits for toddlers.

How Challenges were resolved:

- Molina persisted in discussions with vendors to overcome concerns raised and facilitate development of protocols and elements required for the in-home well child visits for children ages 15-30 months.
- Molina outreach team conducted demographic data research to identify the parents/guardians of eligible members.
- Member outreach team continued to offer parents/guardians in office visits with their assigned PCPs and offered the option of in-home visits if the parents/guardians shared barriers to in office visits (competing priorities, work schedules conflicting with available PCP office appointment times).

Demonstrated success:

- *Once vendor agreements were in place and in-home visits began, Molina saw a slow but incrementally increased number of monthly in-home visits.*
- *In-home visits facilitated an increase in well child visits completed for January – June 2025.*

Intervention status:

There has been a slow but incremental increase in the number of monthly in-home visits noted during the initial testing period of November 2024 to June 2025. In-home visits facilitated an increase in the total number of well child visits completed for January –June 2025. Additional testing of this intervention will be required to verify sustainability of improvement. Therefore, continued evaluation of this intervention will be conducted.

Medicare

Improvement Projects – Background:

Medicare Advantage Organizations (MAOs) are mandated by CMS to conduct improvement projects. MAOs are required to conduct one Chronic Care Improvement Program (CCIP) per contract, over a three-year project cycle. Medicare Advantage Organizations (MAOs) are mandated by CMS to conduct improvement projects. MAOs are required to conduct one Chronic Care Improvement Program (CCIP) per contract, over a three-year project cycle.

LOB	Program	Topic	Measure	Target	MY2023	MY2024	MY2025*	Goal Met? Y/N
Medicare	CCIP H5810	Improving Medication Adherence	Hypertension Medication Adherence	89.0%	86.6%	86.7%	88.9%	N
	CCIP H3038	Improving health outcomes for members with diabetes	GSD < 8%†	75.0%	N/A	72.5%	61.1%	N

Target: CCIP Goal – CMS Medicare 4-Star Rating

*MY2025 Data Sources: 2025 Adherence Data Tracking Jan-Nov (Dec); HEDIS Rate Tracker, Refresh Date 01/23/2025. MY25 rates are preliminary, as final rates are not yet available.

†GSD <8%: GSD <8% replaced HBD A1c in MY24. MY23 rates are unavailable

Analysis:

Based on preliminary data, H5810 CCIP measure performance improved by 2.2 percentage points from the previous year. Preliminary MY25 GSD <8% performance rates decreased from MY24. Molina will continue targeted improvement efforts to strengthen health outcomes and enhance measure performance.

Barriers	Interventions	Next Steps
• IT and reporting issues • Communication gaps between Members, Providers, and Molina teams	• Implement member-centric coaching model, care coordination, and care management • In-home kits	• Maintain key CCIP interventions, incentives and member education efforts. • Strengthen communication to close performance gaps.

• Pharmacies refusing to fill 90-day prescriptions • SDOH barriers (i.e., transportation, financial) • Education and health literacy; difficulty implementing diet	• Promote 90-day fills and increased use of mail-order or delivery pharmacy options • Conduct outreach campaigns and educate members on wellness, and health promotion activities • Enhance provider engagement and communication	• Continue enhancements to internal collaboration across teams. • Ensure alignment of data solutions to drive optimal performance outcomes

Central Health Plan

Improvement Projects – Background:

Medicare Advantage Organizations (MAOs) are mandated by CMS to conduct improvement projects. MAOs are required to conduct one Chronic Care Improvement Program (CCIP) per contract, over a three-year project cycle.

LOB	Program	Topic	Measure	Target	MY2023	MY2024	MY2025*	Goal Met? Y/N
Medicare	CCIP MAPD	Improving Medication Adherence	Hypertension Medication Adherence	89.0%	86.6%	86.7%	88.9%	N
	CCIP D-SNP		Diabetes Medication Adherence	79.5%	N/A	75.6%	56.6%	N
	CCIP C-SNP	Improving health outcomes for members with diabetes	GSD < 8%†	75.0%	N/A	73.9%	61.1%	N

Target: CCIP Goal – CMS Medicare 4-Star Rating

*MY2025 Data Sources: 2025 Adherence Data Tracking Jan-Nov (Dec); HEDIS Rate Tracker, Refresh Date 01/23/2025. MY25 rates are preliminary, as final rates are not yet available.

†GSD <8%: GSD <8% replaced HBD A1c in MY24. MY23 rates are unavailable.

Analysis:

Based on preliminary data, CCIP MAPD measure performance improved by 2.2 percentage points from the previous year. Preliminary rates for both GSD < 8% CCIPs decreased from the previous year. MY25 was the last year for the MAPD plan, and this CCIP will be formally closed upon validation of final MY25 data in CY26. Molina will continue targeted improvement efforts to strengthen health outcomes and enhance measure performance.

Barriers	Interventions	Next Steps

• IT and reporting issues • Communication gaps between Members, Providers, and Molina teams • Pharmacies refusing to fill 90-day prescriptions • SDOH barriers (i.e., transportation, financial) • Education and health literacy; difficulty implementing diet	• Implement member-centric coaching model, care coordination, and care management • In-home kits • Promote 90-day fills and increased use of mail-order or delivery pharmacy options • Conduct outreach campaigns and educate members on wellness, and health promotion activities • Enhance provider engagement and communication	• Maintain key CCIP interventions, incentives and member education efforts. • Strengthen communication to close performance gaps. • Continue enhancements to internal collaboration across teams. • Ensure alignment of data solutions to drive optimal performance outcomes

Network Availability

Introduction: Molina Healthcare of California conducted its 2025 Network Adequacy assessment to evaluate the availability and geographic distribution of practitioners across Primary Care, Specialty Care, and Behavioral Health services. The assessment includes trend analysis using data from 2023 through 2025 and examines performance across Medicaid, Marketplace, and Medicare lines of business. Practitioner-to-member ratios and geographic access standards were reviewed to determine whether members have timely and reasonable access to covered services.

Purpose: The assessment evaluates whether Molina Healthcare of California maintains an adequate provider network by analyzing practitioner-to-member ratios and geographic access to care across key provider types and lines of business. The analysis is intended to identify strengths in provider capacity, detect geographic access gaps, and inform targeted network interventions where standards are not met.

Key Findings:

- Practitioner-to-member ratios for Primary Care exceeded established standards across Medicaid, Marketplace, and Medicare from 2023 through 2025.
- Despite strong provider supply, geographic distribution standards for Primary Care were not met in many urban and rural areas across all lines of business in 2025.
- High-volume and high-impact specialties (OB/GYN and Hematology/Oncology) consistently met ratio standards across all programs.
- Geographic access for specialty care fell below standards in urban areas for Medicaid, Marketplace, and Medicare in 2025, despite adequate rural access.
- Behavioral Health ratios generally met standards across all lines of business, with psychology demonstrating strong supply throughout the review period.

- Urban geographic access gaps for psychology were identified across Medicaid, Marketplace, and Medicare in 2025.
- Medicaid psychiatry ratios improved in 2025 compared to prior years, meeting standards after previously falling below thresholds.
- Across service categories, geographic distribution—not provider supply—remains the primary barrier to member access.

Opportunities and Interventions: The assessment identifies opportunities to improve access through targeted recruitment and contracting in counties that did not meet geographic standards, expansion of partnerships with Federally Qualified Health Centers and rural health clinics, and increased use of telehealth and mobile clinics. Additional interventions include improving provider directory accuracy, strengthening collaboration with hospitals and health systems, offering recruitment and retention incentives, and prioritizing network expansion in underserved urban and rural areas. These strategies are designed to address distribution gaps while maintaining strong provider capacity

Overall Summary: The 2025 Network Adequacy assessment demonstrates that Molina Healthcare of California maintains strong practitioner-to-member ratios across Primary Care, Specialty Care, and Behavioral Health services for all lines of business. However, consistent geographic access gaps—particularly in urban areas and select rural counties—continue to limit timely access to care. These challenges have persisted across multiple years, indicating that provider distribution remains a systemic issue. The report outlines prioritized, ongoing interventions focused on targeted recruitment, enhanced contracting strategies, telehealth expansion, and data validation efforts to improve geographic access and ensure equitable care for members statewide.

Network Accessibility

Introduction: Molina Healthcare of California conducts an annual assessment of network accessibility for its Medicaid and Marketplace lines of business. The analysis evaluates the availability and timeliness of primary care, specialty care, and behavioral health services in accordance with State, contractual, and NCQA standards. This assessment ensures that members receive timely, appropriate care and that provider networks have adequate geographic distribution, appointment availability, and after-hours responsiveness.

Purpose: Molina Healthcare of California measured provider compliance with accessibility standards, identify barriers impacting timely care, and evaluate opportunities for improvement. The evaluation enables Molina Healthcare of California to monitor provider performance, address deficits, and reinforce the plan's commitment to ensuring members have dependable access to medical and behavioral health services.

Key Findings:

- **Primary Care**

        - Routine, urgent, and preventive appointment standards were consistently met across most categories.
        - Significant gaps identified in **after-hours availability** and **return call after-hours**, with compliance far below the 90% goal in all years.
        - Staffing limitations, lack of provider awareness, and high patient volume drive non-compliance.
    - **Behavioral Health**
        - High compliance for urgent care, preventive visits, and routine follow-up for both prescribers and non-prescribers.
        - **After-hours availability and return call after-hours** standards were not met.
        - Provider awareness and staffing limitations negatively affect responsiveness.
    - **High-Impact Specialists (Hematology/Oncology)**
        - Routine and urgent appointment availability generally met or exceeded standards.
        - After-hours access and return call after-hours performance significantly below expectations.
        - Recruitment challenges and limited practitioner availability impact access.
    - **High-Volume Specialists (OB/GYN)**
        - Did **not** meet compliance goals in **any** surveyed accessibility category in 2025.
        - Declines noted across routine care, urgent care, prenatal appointments, and return-call timeliness.
        - High patient volume and challenges offering alternative appointments persist.
    - **Member Complaints & Appeals**
        - **Medicaid:** Access complaints did not meet goals; access appeals and BH complaints met 2025 targets.
        - **Marketplace:** Access complaints and appeals did not meet 2025 goals; BH complaints and appeals met targets.
        - Persistent member concerns relate to appointment availability, referral delays, inability to reach providers, and inconsistent communication.

Opportunities and Interventions: Molina Healthcare of California has identified several improvement avenues focused on strengthening provider performance and member access. Planned interventions include:

- Enhanced **provider education** on accessibility standards through mailings, newsletters, and in-person sessions.
- **Recruitment and retention** initiatives to expand network capacity, especially in high-volume and high-impact specialties.
- **Corrective action and re-survey processes** for providers failing to meet standards.
- Increased emphasis on **after-hours solutions**, including nurse triage and clearer provider instructions.
- Continuous monitoring of access-related complaints to identify issues early and implement corrective strategies mid-cycle.

Overall Summary: Overall, Molina Healthcare of California demonstrated strong compliance in many routine and urgent care appointment standards across primary care, behavioral health, and high-impact specialties. However, significant shortcomings remain—particularly in after-hours access, return-call responsiveness, and accessibility among high-volume specialty providers. Member complaints reinforce these gaps, highlighting persistent challenges with availability, timeliness, and communication. Continued focus on provider education, network expansion, operational improvements, and targeted interventions will be critical to improving accessibility and ensuring members receive timely, high-quality care.

Continuity and Coordination of Care

Introduction: Continuity and coordination of care are critical to ensuring members experience seamless transitions across medical, behavioral health, and care settings. Effective coordination helps reduce fragmented care, avoid duplicative services, and support patient safety, particularly for members with complex or chronic conditions. Molina Healthcare of California monitors these aspects of care to assess performance, identify gaps, and support ongoing quality improvement activities across the delivery system.

Purpose: Molina Healthcare of California evaluates continuity and coordination of care performance for Measurement Year 2024 across Medicaid and Exchange lines of business using HEDIS Health Plan Ratings and QRS measures. The evaluation reviews performance against established goals and benchmarks to identify measures performing below expectations and to guide focused improvement actions and ongoing monitoring activities.

Key Findings:

- Medicaid overall performance: Ten required continuity and coordination measures were reported, with a measure rating average of 2.6.
- Medicaid measures meeting performance goals (HPR > 1):
- Eye Exam for Patients with Diabetes (Score 3)
- Prenatal and Postpartum Care – Prenatal (Score 3)
- Prenatal and Postpartum Care – Postpartum (Score 4)
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Score 2)
- Follow-Up After Emergency Department Visit for Mental Illness, 7 Days (Score 2)
- Follow-Up After Emergency Department Visit for Substance Use, 7 Days (Score 3)
- Initiation and Engagement of Substance Use Disorder Treatment – Engagement (Score 3)
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotics (Score 4)
- Medicaid measures not meeting performance goals:
- Follow-Up After Hospitalization for Mental Illness, 7 Days (Score 1)
- Follow-Up After High Intensity Care for Substance Use Disorder, 7 Days (Score 1)
- Exchange performance compared to the 75th percentile benchmark:

- Measures not meeting the benchmark included Prenatal and Postpartum Care (Prenatal and Postpartum rates), Coordination of Care (QHP survey), Follow-Up After Hospitalization for Mental Illness (7-day and 30-day), and Initiation and Engagement of Substance Use Disorder Treatment – Engagement.
- Measures meeting the benchmark included Depression Screening and Follow-Up for Adolescents and Adults (Screening) and Initiation of Substance Use Disorder Treatment.

Opportunities and Interventions: Medicaid: Follow-Up After Hospitalization for Mental Illness (7-day) and Follow-Up After High Intensity Care for Substance Use Disorder (7-day) were identified as priority opportunities due to lower performance scores. Interventions include automated notifications to providers following member discharge to support timely follow-up care, along with enhanced ADT functionality and daily monitoring. An additional intervention enables case managers to complete follow-up visits directly with members when appropriate, supported by ongoing tracking and bi-annual program evaluation.

Marketplace: Prenatal and Postpartum Care – Postpartum was selected for focused improvement. A national call campaign targeting Marketplace postpartum members not compliant with the measure is planned, beginning in December 2025 and continuing quarterly in 2026. Performance will be monitored through regular compliance reviews and outreach tracking.

Overall Summary: During MY2024, Molina Healthcare of California demonstrated generally strong Medicaid performance across continuity and coordination of care measures, with most measures meeting established performance goals and targeted improvement plans implemented for identified gaps. Exchange results indicated multiple measures below the 75th percentile benchmark, leading to focused intervention efforts, particularly for postpartum care. Ongoing monitoring and structured improvement activities support continued progress in care coordination and member outcomes across both lines of business.

Appendix

Appendix 1, Quality Performance Measurement Report

Appendix 2, Potential Quality of Care

Appendix 3, Population Assessment

Appendix 4, Measurement of Effectiveness of Population Health Management programs

Appendix 5, Culturally and Linguistically Appropriate Services Program

Appendix 6, Member Experience

Appendix 7, Provider Satisfaction

Appendix 8, Network Availability

Appendix 9, Network Accessibility

Appendix 10, Continuity and Coordination of Care

Appendix 1

Molina Healthcare of California

2025 Quality Performance Measurement Report

Molina Healthcare of California's 2025 (MY2024) Quality Performance Measurement Results and Analysis Report includes reported rates for quality measures across all Lines of Business and product lines, as appropriate. The results included in this report are designed to assess the quality of care that our members receive in key clinical areas. The report is divided into the following sections:

Report Background and Purpose

This report is an annual evaluation of performance measurement results for Molina Healthcare of California. This report summarizes the results for performance measures that are reported for the plan for the following lines of business.

Line of Business	Measures Reported
Medicaid	HEDIS measures reported to meet NCQA Health Plan Ratings/Accreditation and state regulatory requirements.

Methodology

Molina Healthcare collects and reports HEDIS measures uses an NCQA certified software vendor to collect HEDIS® data. Measures are collected and reported using either: 1) an administrative collection method, using claims, encounters, pharmacy, laboratory, and supplemental data (as appropriate); 2) a hybrid methodology, using a combination of administrative and medical record review data to search for additional data to meet numerator compliance; and 3) medical record review data, which only includes data from the medical records. Random samples are systematically drawn for hybrid review. In addition, Molina Healthcare reports non-HEDIS performance measures to meet regulatory requirements as needed.

The tables in this report display the annual performance results for all lines of business and products, as appropriate. The tables show prior year rates, current year rates and the difference between the two years' rates. Besides numeric rates, NA, NR, NB, and NQ rates were also reported. The key below describes these reporting values:

Reporting Value	Description
NA	The organization reported a small denominator (i.e. less than 30 members in the denominator)

NR	The organization chose not to report the measure.
NB	The organization does not offer the required benefits.
NQ	The organization is not required to report the measure.

The tables include the current NCQA Medicaid Quality Compass percentiles for the 5th, 10th, 25th, 33rd, 50th, 67th, 75th, 90th and 95th percentiles. Current rates are compared to the benchmarks to determine if goals are met. Quantitative analyses are completed for each table.

Benchmarks and Goals

Line of Business	Benchmarks	Goals
Medicaid	For HEDIS measures, benchmarks are taken from the Quality Compass HEDIS Means, Percentiles and Ratios.	The overall goal is to meet or achieve the 67th percentile/ 4 Star Health Plan Rating. If the goal is achieved, the goal is to reach the next percentile/Star.

Performance Measurement Results and Analysis for the Medicaid Population

Data Source: Molina Healthcare of California Medicaid HEDIS© Measures Rates – IDSS #11141

Goal: The goal is to meet or achieve the 67th percentile Quality Compass benchmark

“MY2022” is data collected from January-December 2022; “MY2023” is data collected from January-December 2023; “MY2024” is data collected from January-December 2024.

Executive Summary

Molina Healthcare of California evaluates performance measurement rates for its Medicaid population. Goals were set at the 66.67th percentile as identified by the National Committee for Quality Assurance in its Medicaid Health Plan Ratings for MY2024. Overall, fifty-six (56) out of the seventy (70) reported rates for Medicaid increased from MY2023 to MY2024. Out of these rates, twenty-one (21) met the 66.67th percentile and forty-nine (49) did not meet the 66.67th percentile goals. The following rates were reported within or less than the 5th percentile threshold, indicating the need for improvement: Appropriate Testing for Pharyngitis (CWP) -Total, Cardiac Rehabilitation (CRE) - Achievement (Total), Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) - 7 days (Total), Follow-Up After Hospitalization for Mental Illness (FUH) - 30 days (Total), Follow-Up After Hospitalization for Mental Illness (FUH) - 7 days (Total), Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) – Total, Adults' Access to Preventive/Ambulatory Health Services (AAP) – Total, Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) – Total, and Well-Child Visits in the First 30 Months of Life (W30) - (First 15 Months).

Prevention and Screening

In this category, ten of the sixteen reported measures increased performance in MY2024. Chlamydia Screening in Women (CHL) Total, Oral Evaluation, Dental Services (OED) – Total, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) - BMI percentile (Total), Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) - Counseling for Nutrition (Total), and Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) - Counseling for Physical Activity (Total) met or exceeded the 67th percentile Quality Compass goal. Adult Immunization Status (AIS-E) - Influenza (Total), Adult Immunization Status (AIS-E) - Pneumococcal (66+), and Adult Immunization Status (AIS-E) - Td/Tdap (Total) did not report a rate in MY2022, and no data was reported. Oral Evaluation, Dental Services (OED) - Total did not report a rate in MY2022 or MY2023 and no data was reported for comparison.

Trends: Chlamydia Screening in Women (CHL) Total, Lead Screening in Children (LSC) -Total, and Weight Assessment & Counseling (BMI, Nutrition, Physical Activity) showed consistent improvement over a 3-year period with most measures exceeding the 67th percentile Quality Compass goal. Lead Screening in Children (LSC) -Total has improved in performance but fell within the 25th percentile threshold, indicating area of improvement. Cervical Cancer Screening continues to decline in screening rate over a 3-year period. Childhood Immunization Status (CIS) - Combo 10 has remained below the 67th percentile Quality Compass benchmark over a 3-year period, with a slight recovery (1.70) in MY2024.

Areas of Concern: Most immunization measures (Adult & Adolescent) continue to fall below the 67th percentile Quality Compass goal over a 3-year period. Cervical Cancer Screening (CCS) declined (-1.94) in performance and is in the 10th percentile threshold, indicating an area of improvement.

Current Interventions: Provider engagement meetings and cervical and breast cancer screening member calls/texts/emails campaign.

Respiratory

In this category, all four of the reported measures increased performance in MY2024. Pharmacotherapy Management of COPD Exacerbation (PCE) – Bronchodilator and Pharmacotherapy Management of COPD Exacerbation (PCE) -Systemic Corticosteroid both met or exceeded the 67th percentile Quality Compass goal. Appropriate Testing for Pharyngitis (CWP) -Total fell below or within the 5th percentile threshold, indicating an area of improvement.

Trends: Pharmacotherapy Management of COPD Exacerbation (PCE) – Bronchodilator and Pharmacotherapy Management of COPD Exacerbation (PCE) -Systemic had a strong recovery in MY2024 after having a decrease in performance in MY2023.

Areas of Concern: Asthma Medication Ratio (AMR) -Total also recovered in MY2024 after having a decrease in performance in MY2023, however; this measure still fell within the 50th percentile Quality Compass goal, indicating an area of improvement. Appropriate Testing for Pharyngitis (CWP) -Total continues to remain in the 5th percentile threshold over a 3-year period, indicating an area of improvement.

Current Interventions: Provider engagement meetings, member calls/texts/emails campaign, and member medication management.

Cardiovascular

In this category, six of the eight reported measures increased performance in MY2024. Persistence of Beta-Blocker Treatment After a Heart Attack (PBH) and Statin Therapy for Patients With Cardiovascular Disease (SPC) - Statin Adherence 80% (Total) met or exceeded the 67th percentile Quality Compass goal, with an increase in +9.76 and +26.11, respectively. Cardiac Rehabilitation (CRE) - Initiation (Total), Cardiac Rehabilitation (CRE) - Engagement1 (Total), Cardiac Rehabilitation (CRE) - Engagement2 (Total), and Cardiac Rehabilitation (CRE) - Achievement (Total) fell within the 10th percentile Quality Compass goal in MY2024 and over a 3-year period, indicating an area of improvement.

Trends: Statin Therapy for Patients With Cardiovascular Disease (SPC) - Received Statin Therapy (Total), Statin Therapy for Patients With Cardiovascular Disease (SPC) - Statin Adherence 80% (Total), and Persistence of Beta-Blocker Treatment After a Heart Attack (PBH) have increased in performance over a 3-year period, indicating an upward trend.

Areas of Concern: All Cardiac Rehabilitation measures fell below or within the 10th percentile threshold in MY2024 and over a 3-year period, indicating the largest area of improvement for this category. Controlling High Blood Pressure (CBP) had a slight decline in MY2024 and fell within the 33rd percentile Quality Compass goal.

Current Interventions: Member in home/telehealth visits and member medication management.

Diabetes

In this category, five of the seven reported measures increased performance in MY2024. Kidney Health Evaluation for Patients With Diabetes (KED) – Total, Statin Therapy for Patients With Diabetes (SPD) - Received Statin Therapy, and Statin Therapy for Patients With Diabetes (SPD) - Statin Adherence 80% met or exceeded the 67th percentile Quality Compass goal. Glycemic Status Assessment for Patients With Diabetes (GSD) - Glycemic Status >9.0% is an inverse measure and a lower rate would indicate better performance.

Trends: Kidney Health Evaluation for Patients With Diabetes (KED) – Total, Statin Therapy for Patients With Diabetes (SPD) - Received Statin Therapy, and Statin Therapy for Patients With Diabetes (SPD) - Statin Adherence 80% made gradual improvement over a 3-year period, all three measures now exceed the 67th percentile Quality Compass goal. Eye Exam for Patients With Diabetes (EED) has also made gradual improvement over a 3-year period but still fell in the 50th percentile threshold.

Areas of Concern: Glycemic Status Assessment for Patients With Diabetes (GSD) - Glycemic Status <8.0% declined in performance from MY2022 to MY2023 and reported no change from MY2023 to MY2024, indicating an area of improvement. Inverse measure, Glycemic Status Assessment for Patients With Diabetes (GSD) - Glycemic Status >9.0% had a slight improvement in performance but fell in the 33rd percentile in MY2024, indicating an area of improvement.

Current Interventions: Member in home/telehealth visits.

Behavioral Health

In this category, seventeen of the eighteen reported measures increased performance in MY2024. Antidepressant Medication Management (AMM) - Effective Acute Phase Treatment, Antidepressant Medication Management (AMM) - Effective Continuation Phase Treatment, Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E) - Blood Glucose and Cholesterol Testing (Total), Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD), Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD), and Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA) met or exceeded the 67th percentile Quality Compass goal. Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) - 7 days (Total), Follow-Up After Hospitalization for Mental Illness (FUH) - 30 days (Total), and Follow-Up After Hospitalization for Mental Illness (FUH) - 7 days (Total) fell within or less than the 5th percentile threshold, indicating an area of improvement.

Trends: Strong improvements in Antidepressant Medication Management (AMM) - Effective Acute Phase Treatment, Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC), Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) over a 3-year period.

Areas of Concern: All 7- and 30-day follow-up (FUH and FUM being critically low) visit measures have remained under benchmark over a 3-year period, indicating the largest area of improvement in this category. Follow-Up Care for Children Prescribed ADHD Medication (ADD-E) - Initiation Phase and Follow-Up Care for Children Prescribed ADHD Medication (ADD-E) - Continuation and

Maintenance Phase have also remained under benchmark over a 3-year period, falling in the 25th and 10th percentile Quality Compass goal, respectively.

Current Interventions: provider engagement meetings, provider follow-up and resources, and member in home/telehealth visits.

Appropriateness of Use

In this category, four of the seven reported measures increased in performance in MY2024. None of the reported measures met or exceeded the 67th percentile Quality Compass goal. Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) - Total fell within or less than the 5th percentile threshold, indicating an area of improvement. Risk of Continued Opioid Use (COU) - ≥15 Days (Total), Risk of Continued Opioid Use (COU) - ≥31 Days (Total), Use of Opioids From Multiple Providers - Multiple Prescribers and Multiple Pharmacies (UOP), and Use of Opioids at High Dosage (HDO) are all inverse measures and a lower rate would indicate better performance.

Trends: Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) - Total and all opioid use measures decreased in performance over a 3-year period, indicating the largest areas of improvement.

Areas of Concern: All opioid use measures decreased in performance over a 3-year period, indicating the largest areas of improvement. Use of Imaging Studies for Low Back Pain (LBP) – Total also showed a slight decline in performance, falling in the 33rd percentile Quality Compass goal.

Current Interventions: The appropriateness of use category does not currently have interventions in place. Suggested interventions includes member education on medication adherence, provider education on documentation and coding, prescription monitoring programs and provider alerts for opioid prescribing patterns.

Access and Availability of Care

In this category, all six of the reported measures increased in performance in MY2024. Initiation and Engagement of Substance Use Disorder Treatment (IET) - Initiation of SUD Treatment - Total (Total) and Prenatal and Postpartum Care (PPC) - Postpartum Care met or exceeded the 67th percentile Quality Compass goal. Adults' Access to Preventive/Ambulatory Health Services (AAP) – Total and Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) – Total fell within or less than the 5th percentile threshold, indicating an area of improvement.

Trends: Prenatal and Postpartum Care (PPC) - Postpartum Care had significant improvement (+3.64) over a 3-year period and fell into the 75th percentile Quality Compass goal. Initiation and Engagement of Substance Use Disorder Treatment (IET) - Initiation of SUD Treatment - Total (Total) also had a significant improvement over a 3-year period and fell into the 75th percentile Quality Compass goal.

Areas of Concern: Adults' Access to Preventive/Ambulatory Health Services (AAP) – Total and Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) – Total continue to remain in the 5th percentile threshold over a 3-year period,

indicating the largest area of improvement. Initiation and Engagement of Substance Use Disorder Treatment (IET) - Engagement of SUD Treatment - Total (Total) has shown a slight improvement but remains below benchmark, this measure fell within the 25th percentile threshold in MY2024.

Current Interventions: Provider engagement meetings, member in home/telehealth visits, and member call/text/email campaign.

Utilization

In this category, all four of the reported measures increased in performance in MY2024. Plan All-Cause Readmissions (PCR) - Age 18-64 years met or exceeded the 67th percentile Quality Compass goal. Plan All-Cause Readmissions (PCR) - Age 18-64 years is an inverse measure, and a lower rate would indicate better performance.

Trends: All three well-child visit measures made positive movement over a 3-year period but remain below the 67th percentile Quality Compass goal.

Areas of Concern: All three well-child measures fell below the 67th percentile Quality Compass goal, indicating areas of improvement. Well-Child Visits in the First 30 Months of Life (W30) - (First 15 Months) continues to fall within the 5th percentile and is the largest area of improvement in this category.

Current Interventions: Member incentive/gift card, member emails/calls, and provider engagement meetings.

MOLINA HEALTHCARE

Effectiveness of Care: Prevention and Screening

HEDIS Measure	MY2022 Rates	MY2023 Rates	MY2024 Rates	MY2023 to MY2024 Comparison	MY2022 to MY2024 Comparison	5th Percentile	10th Percentile	25th Percentile	33rd Percentile	50th Percentile	67th Percentile	75th Percentile	90th Percentile	95th Percentile	Goal Met (Y/N)
Adult Immunization Status (AIS-E) - Influenza (Total)	-	15.69	14.15	-1.54	N/A	7.57	8.73	11.86	13.56	15.88	18.61	20.20	26.60	33.39	N
Adult Immunization Status (AIS-E) - Pneumococcal (66+)	-	51.32	53.58	2.26	N/A	18.42	28.84	40.69	43.72	51.81	58.40	62.93	71.90	78.71	N
Adult Immunization Status (AIS-E) - Td/Tdap (Total)	-	43.65	45.62	1.97	N/A	19.94	26.23	34.89	36.85	43.45	50.60	53.82	61.22	68.51	N
Breast Cancer Screening (BCS-E)	51.72	51.75	53.40	1.65	1.68	42.02	45.09	50.53	52.22	55.87	58.93	61.43	66.31	70.59	N
Cervical Cancer Screening (CCS)	51.09	50.36	48.42	-1.94	-2.67	37.93	45.50	51.82	53.53	58.15	61.52	64.06	68.16	71.29	N
Childhood Immunization Status (CIS) - Combo 10	33.33	26.28	27.98	1.70	-5.35	15.82	17.76	22.14	23.84	27.80	30.41	33.41	39.89	44.12	N
Chlamydia Screening in Women (CHL) Total	61.48	65.28	66.90	1.62	5.42	37.21	41.71	48.48	51.22	56.30	62.81	65.47	70.67	75.12	Y
Immunizations for Adolescents (IMA) - Combination 2	32.91	34.31	34.31	0.00	1.40	23.26	27.25	31.29	33.43	36.48	40.39	43.55	52.31	55.47	N
Immunizations for Adolescents (IMA) - HPV	34.66	35.28	35.28	0.00	0.62	24.29	28.71	32.05	34.29	37.47	41.85	44.77	53.28	56.25	N
Immunizations for Adolescents (IMA) - Meningococcal	73.22	70.32	68.13	-2.19	-5.09	60.34	68.37	76.64	78.59	82.48	85.89	87.59	90.51	91.97	N
Immunizations for Adolescents (IMA) - Tdap	84.55	84.43	84.67	0.24	0.12	69.10	77.43	82.24	83.61	86.37	88.32	89.27	92.70	93.92	N
Lead Screening in Children (LSC) -Total	57.91	58.39	64.96	6.57	7.05	34.91	39.66	61.31	64.66	69.96	74.62	76.34	82.86	85.40	N

Oral Evaluation, Dental Services (OED) - Total	-	-	100.00	N/A	N/A	0.03	19.59	33.01	37.84	45.16	49.54	51.30	55.03	58.89	Y
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) - BMI percentile (Total)	82.97	87.35	88.81	1.46	5.84	55.07	65.21	78.10	80.54	84.18	87.69	89.29	91.97	93.45	Y
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) - Counseling for Nutrition (Total)	74.94	81.27	85.16	3.89	10.22	37.46	55.72	66.42	69.34	73.46	77.70	81.39	85.64	87.20	Y
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) - Counseling for Physical Activity (Total)	74.45	79.81	83.94	4.13	9.49	35.28	49.64	61.31	64.94	69.66	75.91	78.80	83.70	86.11	Y

Analysis:

In this category, ten of the sixteen reported measures increased performance in MY2024. Chlamydia Screening in Women (CHL) Total, Oral Evaluation, Dental Services (OED) – Total, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) - BMI percentile (Total), Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) - Counseling for Nutrition (Total), and Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) - Counseling for Physical Activity (Total) met or exceeded the 67th percentile Quality Compass goal. Adult Immunization Status (AIS-E) - Influenza (Total), Adult Immunization Status (AIS-E) - Pneumococcal (66+), and Adult Immunization Status (AIS-E) - Td/Tdap (Total) did not report a rate in MY2022, and no data was reported. Oral Evaluation, Dental Services (OED) - Total did not report a rate in MY2022 or MY2023 and no data was reported for comparison.

Effectiveness of Care: Respiratory

HEDIS Measure	MY2022 Rates	MY2023 Rates	MY2024 Rates	MY2023 to MY2024 Comparison	MY2022 to MY2024 Comparison	5th Percentile	10th Percentile	25th Percentile	33rd Percentile	50th Percentile	67th Percentile	75th Percentile	90th Percentile	95th Percentile	Goal Met (Y/N)
Asthma Medication Ratio (AMR) -Total	61.84	58.68	67.13	8.45	5.29	48.72	52.00	57.63	59.38	63.66	68.13	70.39	76.25	80.74	N
Appropriate Testing for Pharyngitis (CWP) - Total	35.00	43.19	50.78	7.59	15.78	62.25	66.21	75.50	79.61	83.74	87.31	88.64	91.30	93.18	N
Pharmacotherapy Management of COPD Exacerbation (PCE) - Bronchodilator	86.07	82.90	88.24	5.34	2.17	62.04	70.88	78.94	81.23	84.42	86.25	87.50	91.01	92.50	Y
Pharmacotherapy Management of COPD Exacerbation (PCE) - Systemic Corticosteroid	65.61	60.29	75.76	15.47	10.15	48.02	55.52	63.16	66.29	70.93	74.92	76.68	81.76	85.75	Y

Analysis:

In this category, all four of the reported measures increased performance in MY2024. Pharmacotherapy Management of COPD Exacerbation (PCE) – Bronchodilator and Pharmacotherapy Management of COPD Exacerbation (PCE) -Systemic Corticosteroid both met or exceeded the 67th percentile Quality Compass goal. Appropriate Testing for Pharyngitis (CWP) -Total fell below or within the 5th percentile threshold, indicating an area of improvement.

MOLINA HEALTHCARE

Effectiveness of Care: Cardiovascular

HEDIS Measure	MY2022 Rates	MY2023 Rates	MY2024 Rates	MY2023 to MY2024 Comparison	MY2022 to MY2024 Comparison	5th Percentile	10th Percentile	25th Percentile	33rd Percentile	50th Percentile	67th Percentile	75th Percentile	90th Percentile	95th Percentile	Goal Met (Y/N)
Cardiac Rehabilitation (CRE) - Initiation (Total)	0.08	0.19	0.20	0.01	0.12	0.00	0.00	0.99	1.67	2.89	4.24	5.62	12.79	18.87	N
Cardiac Rehabilitation (CRE) - Engagement1 (Total)	0.51	0.19	0.40	0.21	-0.11	0.00	0.28	1.75	2.46	4.28	5.86	7.04	11.62	15.63	N
Cardiac Rehabilitation (CRE) - Engagement2 (Total)	0.68	0.19	0.20	0.01	-0.48	0.00	0.15	1.36	2.35	3.57	5.21	5.99	8.63	11.48	N
Cardiac Rehabilitation (CRE) - Achievement (Total)	0.34	0.19	0.00	-0.19	-0.34	0.00	0.00	0.18	0.57	1.42	2.32	2.78	3.86	4.87	N
Controlling High Blood Pressure (CBP)	58.64	67.88	65.21	-2.67	6.57	51.58	56.93	63.75	65.21	67.88	70.35	71.34	75.43	76.94	N
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	80.39	53.13	62.89	9.76	-17.50	43.18	44.12	51.28	53.66	56.71	61.22	62.93	68.52	71.20	Y
Statin Therapy for Patients With Cardiovascular Disease (SPC) - Received Statin Therapy (Total)	55.46	79.69	81.57	1.88	26.11	65.37	69.48	78.63	79.83	81.56	82.94	84.02	86.40	88.13	N
Statin Therapy for Patients With Cardiovascular Disease (SPC) - Statin Adherence 80% (Total)	83.88	70.23	82.58	12.35	-1.30	56.16	61.58	66.55	68.28	72.10	75.45	76.91	82.65	86.37	Y

Analysis:

In this category, six of the eight reported measures increased performance in MY2024. Persistence of Beta-Blocker Treatment After a Heart Attack (PBH) and Statin Therapy for Patients With Cardiovascular Disease (SPC) - Statin Adherence 80% (Total) met or exceeded the 67th percentile Quality Compass goal, with an increase in +9.76 and +26.11, respectively. Cardiac Rehabilitation (CRE) -

Initiation (Total), Cardiac Rehabilitation (CRE) - Engagement1 (Total), Cardiac Rehabilitation (CRE) - Engagement2 (Total), and Cardiac Rehabilitation (CRE) - Achievement (Total) fell within the 10th percentile Quality Compass goal in MY2024 and over a 3-year period, indicating an area of improvement.

Effectiveness of Care: Diabetes

HEDIS Measure	MY2022 Rates	MY2023 Rates	MY2024 Rates	MY2023 to MY2024 Comparison	MY2022 to MY2024 Comparison	5th Percentile	10th Percentile	25th Percentile	33rd Percentile	50th Percentile	67th Percentile	75th Percentile	90th Percentile	95th Percentile	Goal Met (Y/N)
Blood Pressure Control for Patients With Diabetes (BPD)	63.26	67.88	69.59	1.71	6.33	52.78	60.34	67.40	69.34	71.53	74.21	75.43	78.83	80.60	N
Eye Exam for Patients With Diabetes (EED)	53.04	54.01	59.12	5.11	6.08	37.96	42.09	50.12	52.55	56.39	60.83	62.53	68.61	72.02	N
Glycemic Status Assessment for Patients With Diabetes (GSD) - Glycemic Status <8.0%	56.45	55.23	55.23	0.00	-1.22	44.75	49.30	55.23	57.41	60.58	63.04	64.69	67.40	69.10	N
Glycemic Status Assessment for Patients With Diabetes (GSD) - Glycemic Status >9.0%	36.74	36.25	34.31	-1.94	-2.43	49.80	43.07	35.77	33.58	30.41	27.98	26.52	23.60	21.11	N
Kidney Health Evaluation for Patients With Diabetes (KED) - Total	48.18	49.91	53.33	3.42	5.15	27.97	30.61	36.87	38.74	42.13	46.17	48.71	54.15	57.24	Y
Statin Therapy for Patients With Diabetes (SPD) - Received Statin Therapy	69.49	68.26	71.70	3.44	2.21	50.85	56.26	63.09	64.27	66.99	69.01	70.22	73.76	76.27	Y
Statin Therapy for Patients With Diabetes (SPD) - Statin Adherence 80%	82.00	66.41	76.29	9.88	-5.71	53.47	57.38	64.13	65.75	68.98	72.29	74.49	80.89	83.79	Y

Analysis:

In this category, five of the seven reported measures increased performance in MY2024. Kidney Health Evaluation for Patients With Diabetes (KED) – Total, Statin Therapy for Patients With Diabetes (SPD) - Received Statin Therapy, and Statin Therapy for Patients With Diabetes (SPD) - Statin Adherence 80% met or exceeded the 67th percentile Quality Compass goal. Glycemic Status Assessment for Patients With Diabetes (GSD) - Glycemic Status >9.0% is an inverse measure and a lower rate would indicate better performance.

Effectiveness of Care: Behavioral Health

HEDIS Measure	MY2022 Rates	MY2023 Rates	MY2024 Rates	MY2023 to MY2024 Comparison	MY2022 to MY2024 Comparison	5th Percentile	10th Percentile	25th Percentile	33rd Percentile	50th Percentile	67th Percentile	75th Percentile	90th Percentile	95th Percentile	Goal Met (Y/N)
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E) - Initiation Phase	39.97	40.00	41.79	1.79	1.82	31.33	33.65	40.91	43.68	46.58	49.56	50.90	57.29	60.65	N
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E) - Continuation and Maintenance Phase	46.58	44.44	46.98	2.54	0.40	33.64	39.95	48.78	51.20	55.07	58.69	60.64	65.18	69.23	N
Antidepressant Medication Management (AMM) - Effective Acute Phase Treatment	64.94	62.28	69.60	7.32	4.66	46.76	51.57	58.21	60.87	64.36	66.99	69.38	76.65	80.24	Y
Antidepressant Medication Management (AMM) - Effective Continuation Phase Treatment	49.97	43.60	53.60	10.00	3.63	29.77	34.20	40.73	42.61	46.55	49.88	52.25	60.51	66.36	Y
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E) - Blood Glucose and Cholesterol Testing (Total)	40.79	42.63	44.51	1.88	3.72	24.24	26.70	30.56	33.26	37.93	41.52	44.03	55.96	64.82	Y

Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)	72.93	76.47	77.50	1.03	4.57	62.50	66.90	72.60	76.47	80.00	82.76	85.48	89.19	91.30	N
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	73.94	70.93	76.49	5.56	2.55	59.09	63.47	68.74	71.11	73.84	76.49	78.05	81.95	83.54	Y
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	80.53	86.42	84.93	-1.49	4.40	75.05	77.16	79.97	81.03	82.83	84.36	85.09	87.47	89.30	Y
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	70.09	61.75	73.55	11.80	3.46	43.54	49.57	59.49	62.98	66.73	69.67	71.64	77.21	79.92	Y
Follow-Up After Emergency Department Visit for Mental Illness (FUM) - 30 days (Total)	39.39	29.64	50.47	20.83	11.08	37.16	41.94	50.47	53.01	57.13	62.41	64.91	74.67	79.80	N
Follow-Up After Emergency Department Visit for Mental Illness (FUM) - 7 days (Total)	28.36	17.07	36.01	18.94	7.65	21.22	26.32	33.28	36.34	41.52	46.71	50.88	62.06	68.29	N
Follow-Up After Emergency Department Visit for Substance Use (FUA) - 30 days (Total)	28.76	32.49	41.91	9.42	13.15	22.75	25.19	30.17	33.33	39.10	43.24	45.80	53.27	56.54	N
Follow-Up After Emergency Department Visit for Substance Use (FUA) - 7 days (Total)	17.85	19.99	28.22	8.23	10.37	13.84	15.49	19.56	21.62	26.89	30.53	32.60	39.38	41.16	N
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) - 30 days (Total)	35.21	28.89	35.65	6.76	0.44	31.46	34.73	43.30	47.26	56.20	62.24	65.61	72.10	75.07	N
Follow-Up After High-Intensity Care for Substance Use	16.67	8.08	15.43	7.35	-1.24	15.71	18.61	24.44	28.46	33.88	40.55	44.68	53.73	56.29	N

Disorder (FUI) - 7 days (Total)															
Follow-Up After Hospitalization for Mental Illness (FUH) - 30 days (Total)	32.24	16.79	41.00	24.21	8.76	39.66	47.03	54.81	57.38	62.08	67.40	70.59	75.65	80.11	N
Follow-Up After Hospitalization for Mental Illness (FUH) - 7 days (Total)	16.94	3.82	20.00	16.18	3.06	20.54	26.07	32.39	35.29	40.00	45.08	48.65	57.76	63.35	N
Pharmacotherapy for Opioid Use Disorder (POD) -Total	21.51	10.48	16.21	5.73	-5.30	11.70	14.52	18.34	20.92	26.86	30.43	32.69	36.44	39.16	N

Analysis:

In this category, seventeen of the eighteen reported measures increased performance in MY2024. Antidepressant Medication Management (AMM) - Effective Acute Phase Treatment, Antidepressant Medication Management (AMM) - Effective Continuation Phase Treatment, Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E) - Blood Glucose and Cholesterol Testing (Total), Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD), Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD), and Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA) met or exceeded the 67th percentile Quality Compass goal. Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) - 7 days (Total), Follow-Up After Hospitalization for Mental Illness (FUH) - 30 days (Total), and Follow-Up After Hospitalization for Mental Illness (FUH) - 7 days (Total) fell within or less than the 5th percentile threshold, indicating an area of improvement.

MOLINA HEALTHCARE

Effectiveness of Care: Appropriateness of Use

HEDIS Measure	MY2022 Rates	MY2023 Rates	MY2024 Rates	MY2023 to MY2024 Comparison	MY2022 to MY2024 Comparison	5th Percentile	10th Percentile	25th Percentile	33rd Percentile	50th Percentile	67th Percentile	75th Percentile	90th Percentile	95th Percentile	Goal Met (Y/N)
Appropriate Treatment for Upper Respiratory Infection (URI) -Total	93.09	89.16	87.69	-1.47	-5.40	76.20	80.81	86.15	86.98	88.80	91.08	92.13	93.88	94.87	N
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) - Total	54.12	53.76	47.99	-5.77	-6.13	45.42	48.00	54.25	56.37	61.53	65.97	68.22	75.42	80.92	N
Risk of Continued Opioid Use (COU) - ≥15 Days (Total)	4.90	5.21	6.42	1.21	1.52	13.28	11.10	8.35	7.42	6.34	4.94	4.23	2.66	1.90	N
Risk of Continued Opioid Use (COU) - ≥31 Days (Total)	2.74	2.65	2.88	0.23	0.14	8.62	7.05	4.88	4.48	3.47	2.87	2.51	1.25	0.83	N
Use of Imaging Studies for Low Back Pain (LBP) - Total	73.36	70.42	69.42	-1.00	-3.94	62.37	63.66	66.13	67.69	70.19	73.20	74.04	78.08	80.64	N
Use of Opioids From Multiple Providers - Multiple Prescribers and Multiple Pharmacies (UOP)	0.17	0.78	2.53	1.75	2.36	5.01	3.81	2.44	2.00	1.54	1.09	0.87	0.53	0.43	N
Use of Opioids at High Dosage (HDO)	2.09	1.75	2.30	0.55	0.21	20.00	11.41	7.52	6.00	4.23	1.86	1.29	0.59	0.00	N

Analysis:

In this category, four of the seven reported measures increased in performance in MY2024. None of the reported measures met or exceeded the 67th percentile Quality Compass goal. Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) - Total fell within or less than the 5th percentile threshold, indicating an area of improvement. Risk of Continued Opioid Use (COU) - ≥15 Days (Total), Risk of Continued Opioid Use (COU) - ≥31 Days (Total), Use of Opioids From Multiple Providers - Multiple Prescribers and

Multiple Pharmacies (UOP), and Use of Opioids at High Dosage (HDO) are all inverse measures and a lower rate would indicate better performance.

Effectiveness of Care: Access/Availability of Care

HEDIS Measure	MY2022 Rates	MY2023 Rates	MY2024 Rates	MY2023 to MY2024 Comparison	MY2022 to MY2024 Comparison	5th Percentile	10th Percentile	25th Percentile	33rd Percentile	50th Percentile	67th Percentile	75th Percentile	90th Percentile	95th Percentile	Goal Met (Y/N)
Adults' Access to Preventive/Ambulatory Health Services (AAP) - Total	60.42	57.81	60.85	3.04	0.43	62.45	66.22	72.14	74.75	78.05	82.10	83.34	86.38	94.28	N
Initiation and Engagement of Substance Use Disorder Treatment (IET) - Initiation of SUD Treatment - Total (Total)	48.76	48.7	53.37	4.67	4.61	34.06	37.27	40.82	42.26	45.71	49.03	50.97	56.68	59.44	Y
Initiation and Engagement of Substance Use Disorder Treatment (IET) - Engagement of SUD Treatment - Total (Total)	8.46	7.13	11.32	4.19	2.86	5.66	7.33	10.14	11.35	14.80	17.80	19.51	27.95	31.00	N
Prenatal and Postpartum Care (PPC) - Timeliness of Prenatal Care	84.18	82.48	85.64	3.16	1.46	71.29	76.16	82.97	84.40	86.37	88.56	89.78	91.97	93.72	N
Prenatal and Postpartum Care (PPC) - Postpartum Care	82.00	79.56	85.64	6.08	3.64	66.91	72.26	78.10	79.73	82.48	83.94	85.15	88.32	90.41	Y
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) - Total	29.46	27.17	48.03	20.86	18.57	62.45	66.22	72.14	74.75	78.05	82.10	83.34	86.38	94.28	N

Analysis:

In this category, all six of the reported measures increased in performance in MY2024. Initiation and Engagement of Substance Use Disorder Treatment (IET) - Initiation of SUD Treatment - Total (Total) and Prenatal and Postpartum Care (PPC) - Postpartum Care met or exceeded the 67th percentile Quality Compass goal. Adults' Access to Preventive/Ambulatory Health Services (AAP) – Total and Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) – Total fell within or less than the 5th percentile threshold, indicating an area of improvement.

Effectiveness of Care: Utilization

HEDIS Measure	MY2022 Rates	MY2023 Rates	MY2024 Rates	MY2023 to MY2024 Comparison	MY2022 to MY2024 Comparison	5th Percentile	10th Percentile	25th Percentile	33rd Percentile	50th Percentile	67th Percentile	75th Percentile	90th Percentile	95th Percentile	Goal Met (Y/N)
Child and Adolescent Well-Care Visits (WCV) - Total	42.69	44.55	50.44	5.89	7.75	40.48	44.96	49.68	51.48	55.41	58.37	61.47	67.63	71.40	N
Well-Child Visits in the First 30 Months of Life (W30) - (First 15 Months)	35.79	32.38	40.95	8.57	5.16	44.76	49.46	58.04	60.39	63.38	66.35	67.49	71.71	76.58	N
Well-Child Visits in the First 30 Months of Life (W30) - (15 Months-30 Months)	59.42	61.24	62.47	1.23	3.05	60.51	64.14	68.38	70.06	72.32	75.87	77.50	82.12	85.88	N
Plan All-Cause Readmissions (PCR) - Age 18-64 years	86.88	89.48	100.00	10.52	13.12	146.94	139.71	128.31	121.55	114.62	106.96	104.41	95.98	91.77	Y

Analysis:

In this category, all four of the reported measures increased in performance in MY2024. Plan All-Cause Readmissions (PCR) - Age 18-64 years met or exceeded the 67th percentile Quality Compass goal. Plan All-Cause Readmissions (PCR) - Age 18-64 years is an inverse measure, and a lower rate would indicate better performance.

Molina Healthcare of California

2025 Quality Performance Measurement Report

Molina Healthcare of California's 2025 (MY2024) Quality Performance Measurement Results and Analysis Report includes reported rates for quality measures across all Lines of Business and product lines, as appropriate. The results included in this report are designed to assess the quality of care that our members receive in key clinical areas. The report is divided into the following sections:

Report Background and Purpose

This report is an annual evaluation of performance measurement results for Molina Healthcare of California. This report summarizes the results for performance measures that are reported for the plan for the following lines of business.

Line of Business	Measures Reported
Medicare	HEDIS measures reported to meet CMS Health Plan Rating requirements.

Methodology

Molina Healthcare collects and reports HEDIS measures uses an NCQA certified software vendor to collect HEDIS® data. Measures are collected and reported using either: 1) an administrative collection method, using claims, encounters, pharmacy, laboratory, and supplemental data (as appropriate); 2) a hybrid methodology, using a combination of administrative and medical record review data to search for additional data to meet numerator compliance; and 3) medical record review data, which only includes data from the medical records. Random samples are systematically drawn for hybrid review. In addition, Molina Healthcare reports non-HEDIS performance measures to meet regulatory requirements as needed.

The tables in this report display the annual performance results for all lines of business and products, as appropriate. The tables show prior year rates, current year rates and the difference between the two years' rates. Besides numeric rates, NA, NR, NB, and NQ rates were also reported. The key below describes these reporting values:

Reporting Value	Description
NA	The organization reported a small denominator (i.e. less than 30 members in the denominator)
NR	The organization chose not to report the measure.

NB	The organization does not offer the required benefits.
NQ	The organization is not required to report the measure.

The tables include the current Medicare Quality Compass percentiles for the 5th,10th, 25th, 33rd, 50th, 75th, 90th and 95th percentiles. Current rates are compared to the benchmarks to determine if goals are met. Quantitative analyses are completed for each table.

Benchmarks and Goals

Line of Business	Benchmarks	Goals
Medicare	For HEDIS measures, benchmarks are taken from the Quality Compass HEDIS Means, Percentiles and Ratios.	The overall goal is to meet or achieve the 75th percentile. If achieved, the goal is to reach the next percentile.

Performance Measurement Results and Analysis for the Medicare Population

Data Source: Molina Healthcare of California Medicare HEDIS© Measures Rates – IDSS #8711

Goal: The goal is to meet or achieve the 75th percentile Quality Compass benchmark

“MY2022” is data collected from January-December 2022; “MY2023” is data collected from January-December 2023; “MY2024” is data collected from January-December 2024.

Executive Summary

Molina Healthcare of California evaluates performance measurement rates for its Medicare population. Goals were set at the 75th percentile as identified by the National Committee for Quality Assurance in its Medicare Health Plan Ratings for MY2024. Twenty-one (21) out of the fifty-nine (59) rates for Medicare increased from MY2023 to MY2024. Out of these rates, twelve (12) met the 75th percentile and forty-seven (47) did not meet the 75th percentile goals. The following rates were reported at less than the 5th percentile, indicating the need for improvement: Appropriate Testing for Pharyngitis (CWP) -Total, Pharmacotherapy Management of COPD Exacerbation (PCE) – Bronchodilator, Pharmacotherapy Management of COPD Exacerbation (PCE) -Systemic Corticosteroid, Cardiac Rehabilitation (CRE) - Initiation (Total), Cardiac Rehabilitation (CRE) - Engagement1 (Total), Cardiac Rehabilitation (CRE) - Engagement2 (Total), Cardiac Rehabilitation (CRE) - Achievement (Total), Statin Therapy for Patients With Diabetes (SPD) - Statin Adherence 80%, Osteoporosis Management in Women Who Had a Fracture (OMW), Follow-Up After Emergency Department Visit for Mental Illness (FUM) - 30 days (Total), Follow-Up After Emergency Department Visit for Mental Illness (FUM) - 7 days (Total), Follow-Up After Emergency Department Visit for Substance Use (FUA) - 30 days (Total), Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) - 30 days (Total), Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) - 7 days (Total), Follow-Up After Hospitalization for Mental Illness (FUH) - 30 days (Total), Follow-Up After Hospitalization for Mental Illness (FUH) - 7 days (Total), Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC) -Total, Transitions of Care (TRC) - Medication Reconciliation Post-Discharge (Total), Transitions of Care (TRC) - Patient Engagement After Inpatient Discharge (Total), and Adults' Access to Preventive/Ambulatory Health Services (AAP) – Total.

Prevention and Screening

In this category, one of the five reported measures increased performance in MY2024. None of the measures met or exceeded the 75th percentile goal.

Trends: Overall, this category had significant declines in adult immunization rates, including influenza (–11.75), pneumococcal 66+ (–34.29), and Td/Tdap (–29.24) from MY2023 to MY2024. Cancer screening measures remain relatively stable year-to-year, with a slight increase (+1.11) in Breast Cancer Screening and a small decrease (–0.95) in Colorectal Cancer Screening. Despite this stability, both screenings continue to fall short of the 75th percentile goal. No measures in this category met the 75th percentile goal, and immunizations represent the most notable area for focused improvement.

Areas of Concern: Adult Immunization Status (AIS-E) - Pneumococcal (66+) and Breast Cancer Screening (BCS-E) fell within the 10th percentile threshold. Adult Immunization Status (AIS-E) - Influenza (Total) and Colorectal Cancer Screening (COL-E) -Total fell within the 25th percentile threshold. Adult Immunization Status (AIS-E) - Td/Tdap (Total) fell within the 33rd percentile threshold.

Current Interventions: Member home kits and member calls/text/emails.

Respiratory

In this category, none of the three reported measures increased performance in MY2024. None of the measures met or exceeded the 75th percentile goal.

Trends: Overall, in this category the measures experienced declines in performance from MY2023 to MY2024, with the largest decreases seen in the Pharmacotherapy Management of COPD Exacerbation measures. While the CWP measure shows improvement over a 3-year period, performance for all measures remains below national benchmarks. None of the respiratory measures met the 75th percentile goal, indicating continued opportunity for targeted interventions and provider engagement to improve respiratory care outcomes.

Areas of Concern: Appropriate Testing for Pharyngitis (CWP) -Total, Pharmacotherapy Management of COPD Exacerbation (PCE) – Bronchodilator, and Pharmacotherapy Management of COPD Exacerbation (PCE) -Systemic Corticosteroid below or within the 5th percentile threshold.

Current Interventions: This category does not have current interventions in place. Suggested interventions include provider engagement meetings, provider/member education, and member call/text/email.

Cardiovascular

In this category, four of the eight reported measures increased performance in MY2024. Statin Therapy for Patients With Cardiovascular Disease (SPC) - Received Statin Therapy (Total)and Statin Therapy for Patients With Cardiovascular Disease (SPC) - Statin Adherence 80% (Total) met or exceeded the 75th percentile goal.

Trends: Overall, this category had mixed performance with significant challenges. All Cardiac Rehabilitation (CRE) measures remain extremely low (0% in MY2024), indicating persistent gaps in both initiation, engagement, and achievement. CBP improved slightly (+0.94) from MY2023 to MY2024 but still did not meet the 75th percentile goal. PBH experienced a major decline, dropping to 0% in MY2024. In contrast, both Statin Therapy (SPC) measures—Statin Received and Statin Adherence—demonstrated strong performance and were the only cardiovascular measures to meet or exceed the 75th percentile goal. Overall, the category reflects limited improvement, with only statin-related measures achieving benchmark targets.

Areas of Concern: Cardiac Rehabilitation (CRE) - Initiation (Total), Cardiac Rehabilitation (CRE) - Engagement1 (Total), Cardiac Rehabilitation (CRE) - Engagement2 (Total), and Cardiac Rehabilitation (CRE) - Achievement (Total) fell below or within the 5th percentile threshold, indicating an area of improvement. Controlling High Blood Pressure (CBP) and Persistence of Beta-Blocker Treatment After a Heart Attack (PBH) fell within the 33rd percentile threshold.

Current Interventions: Member incentives, member digital conditioning management application, member calls/texts/emails, and member in-home visits.

Diabetes

In this category, two of the seven reported measures increased performance in MY2024. None of the measures met or exceeded the 75th percentile goal. Glycemic Status Assessment for Patients With Diabetes (GSD) - Glycemic Status >9.0% is an inverse measure and a lower rate indicates better performance.

Trends: Overall, glycemic control improved year over year (A1c <8.0% increased; inverse measure: A1c >9.0% decreased), and blood pressure control among members with diabetes rose again. However, screening/monitoring performance regressed: eye exams declined (-9.38), and kidney health evaluation slipped (-4.21) versus MY2023. Both SPD measures also declined in MY2024.

Areas of Concern: Statin Therapy for Patients With Diabetes (SPD) - Statin Adherence 80% fell below or within the 5th percentile threshold, indicating an area of improvement. Eye Exam for Patients With Diabetes (EED) and Statin Therapy for Patients With Diabetes (SPD) - Received Statin Therapy fell within the 10th percentile threshold. Blood Pressure Control for Patients With Diabetes (BPD) and Kidney Health Evaluation for Patients With Diabetes (KED) – Total fell within the 33rd percentile threshold. Glycemic Status Assessment for Patients With Diabetes (GSD) - Glycemic Status <8.0% and Glycemic Status Assessment for Patients With Diabetes (GSD) - Glycemic Status >9.0% fell with the 50th percentile threshold.

Current Interventions: Member calls/texts/emails, member home kits, member in-home visits, eye exam program, and member rewards program.

Musculoskeletal Conditions

In this category, both reported measures decreased performance in MY2024. None of the measures met or exceeded the 75th percentile goal.

Trends: OMW and OSW decreased in performance from MY2023 to MY2024.

Areas of Concern: Osteoporosis Management in Women Who Had a Fracture (OMW) fell below or within the 5th percentile threshold, indicating an area of improvement. Osteoporosis Screening in Older Women (OSW) fell within the 10th percentile threshold.

Current Interventions: Member calls/texts/emails and member in-home visits.

Behavioral Health

In this category, four of the twelve reported measures increased performance in MY2024. Antidepressant Medication Management (AMM) - Effective Acute Phase Treatment and Pharmacotherapy for Opioid Use Disorder (POD) -Total met or exceeded the 75th percentile goal.

Trends: Overall, this category had mixed performance-four measures improved year-over-year, eight declined; only two measures met the 75th percentile goal. Key improvements: SAA increased from 68.36% to 83.33% but below the 75th percentile goal. AMM – Effective Acute Phase Treatment rose from 72.56% to 88.89% and met the goal. AMM – Effective Continuation Phase Treatment rose from 55.81% to 72.22% but fell below the 75th percentile goal. POD improved from 66.67% to 100.00% and met goal. Significant declines: FUM – Follow-up After ED Visit for Mental Illness fell to 0.00% for both 7-day and 30-day. FUI – Follow-up After High-Intensity Care dropped to 0.00% for 7-day and 30-day. FUH declined (7-day: 15.38%→7.69%; 30-day: 33.97%→23.08%) from MY2023 to MY2024. FUA declined (7-day: 30.69%→25.00%; 30-day: 42.57%→25.00%) from MY2023 to MY2024.

Areas of Concern: Follow-Up After Emergency Department Visit for Mental Illness (FUM) - 30 days (Total), Follow-Up After Emergency Department Visit for Mental Illness (FUM) - 7 days (Total), Follow-Up After Emergency Department Visit for Substance Use (FUA) - 30 days (Total), Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) - 30 days (Total), Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) - 7 days (Total), Follow-Up After Hospitalization for Mental Illness (FUH) - 30 days (Total), and Follow-Up After Hospitalization for Mental Illness (FUH) - 7 days (Total) fell below or within the 5th percentile threshold, indicating an area of improvement. Follow-Up After Emergency Department Visit for Substance Use (FUA) - 7 days (Total) fell within the 33rd percentile threshold. Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA) fell within the 50th percentile threshold. Antidepressant Medication Management (AMM) - Effective Continuation Phase Treatment fell within the 67th percentile threshold.

Current Interventions: This category does not have current interventions in place. Suggested interventions include provider engagement meetings, provider/member education, and member call/text/email.

Care Coordination

In this category, four of the six reported measures increased performance in MY2024. None of the measures met or exceeded the 75th percentile goal.

Trends: Overall, this category had improvement in most TRC measures but none of those measures met the 75th percentile goal. FMC had a significant decline (-6.41) over a 3-year period.

Areas of Concern: Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC) -Total, Transitions of Care (TRC) - Medication Reconciliation Post-Discharge (Total), and Transitions of Care (TRC) - Patient Engagement After Inpatient Discharge (Total) fell below or within the 5th percentile threshold, indicating an area of improvement. Transitions of Care (TRC)

- Notification of Inpatient Admission (Total) fell within the 10th percentile threshold. Transitions of Care (TRC) - Receipt of Discharge Information (Total) fell within the 25th percentile threshold. Advance Care Planning (ACP) fell within the 67th percentile threshold.

Current Interventions: This category does not have current interventions in place. Suggested interventions include provider engagement meetings, provider/member education, and member call/text/email.

Appropriateness of Use

In this category, four of the twelve reported measures increased performance in MY2024. Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) – Total, Potentially Harmful Drug-Disease Interactions in Older Adults (DDE) – Falls, Potentially Harmful Drug-Disease Interactions in Older Adults (DDE) -Total, Use of High-Risk Medications in Older Adults (DAE) – Total, Use of Imaging Studies for Low Back Pain (LBP) – Total, Use of Opioids From Multiple Providers - Multiple Prescribers and Multiple Pharmacies (UOP), and Use of Opioids at High Dosage (HDO) met or exceeded the 75th percentile goal. Potentially Harmful Drug-Disease Interactions in Older Adults (DDE) – Falls, Potentially Harmful Drug-Disease Interactions in Older Adults (DDE) – Dementia, Potentially Harmful Drug-Disease Interactions in Older Adults (DDE) - Chronic Kidney Disease, Potentially Harmful Drug-Disease Interactions in Older Adults (DDE) -Total , Risk of Continued Opioid Use (COU) - ≥15 Days (Total), Risk of Continued Opioid Use (COU) - ≥31 Days (Total), Use of High-Risk Medications in Older Adults (DAE) – Total, Use of Opioids From Multiple Providers - Multiple Prescribers and Multiple Pharmacies (UOP), and Use of Opioids at High Dosage (HDO) are inverse measures and a lower rate would indicate better performance.

Trends: Overall, this category had mixed performance with several measures decreasing performance in MY2024, and seven measures meeting the 75th percentile goal. These trends suggest opportunities to for targeted interventions such as improved clinical decision support, addressing medication safety, a reduction unnecessary antibiotic and imaging use, and enhanced care coordination and follow-up.

Areas of Concern: Potentially Harmful Drug-Disease Interactions in Older Adults (DDE) – Dementia fell within the 10th percentile threshold. Potentially Harmful Drug-Disease Interactions in Older Adults (DDE) - Chronic Kidney Disease fell within the 33rd percentile threshold. Appropriate Treatment for Upper Respiratory Infection (URI) -Total fell within the 50th percentile threshold. Risk of Continued Opioid Use (COU) - ≥15 Days (Total) and Risk of Continued Opioid Use (COU) - ≥31 Days (Total) fell within the 67th percentile threshold.

Current Interventions: This category does not have current interventions in place. Suggested interventions include provider engagement meetings, provider/member education, and member call/text/email.

Access and Availability of Care

In this category, one of the three reported measures increased in performance in MY2024. Initiation and Engagement of Substance Use Disorder Treatment (IET) - Initiation of SUD Treatment - Total (Total) met or exceeded the 75th percentile goal.

Trends: Overall, despite only one measure improving, it was a substantial improvement, and it was the sole measure meeting the desired benchmark. There were limited improvement and ongoing challenges in maintaining engagement in SUD treatment and maintaining high preventive/ambulatory access levels.

Areas of Concern: Adults' Access to Preventive/Ambulatory Health Services (AAP) - Total fell within the 5th percentile threshold, indicating an area of improvement. Initiation and Engagement of Substance Use Disorder Treatment (IET) - Engagement of SUD Treatment - Total (Total) the 50th percentile threshold.

Current Interventions: This category does not have current interventions in place. Suggested interventions include provider engagement meetings, provider/member education, and member call/text/email.

Utilization

In this category, Plan All-Cause Readmissions (PCR) - Age 65+ years was the only reported measure. This measure increased performance in MY2024 and did not meet or exceed the 75th percentile goal. PCR - Age 65+ years is an inverse measure, and a lower rate would indicate better performance.

Trends: PCR- Age 65+ years increased (77.82% → 92.15%) from MY2023 to MY2024. Since this is an inverse measure, an increase is a negative trend in performance.

Areas of Concern: Plan All-Cause Readmissions (PCR) - Age 65+ years fell above the 50th percentile in MY2024.

Current Interventions: This category does not have current interventions in place. Suggested interventions include provider engagement meetings, provider/member education, and member call/text/email.

Effectiveness of Care: Prevention and Screening

HEDIS Measure	MY2022 Rates	MY2023 Rates	MY2024 Rates	MY2023 to MY2024 Comparison	MY2022 to MY2024 Comparison	5th Percentile	10th Percentile	25th Percentile	33rd Percentile	50th Percentile	67th Percentile	75th Percentile	90th Percentile	95th Percentile	Goal Met (Y/N)
Adult Immunization Status (AIS-E) - Influenza (Total)	-	39.06	27.31	-11.75	N/A	9.09	14.32	24.55	30.17	39.28	47.93	52.39	66.14	73.48	N
Adult Immunization Status (AIS-E) - Pneumococcal (66+)	25.06	57.30	23.01	-34.29	-2.05	7.71	13.07	30.14	38.72	54.33	64.52	70.17	80.53	84.83	N
Adult Immunization Status (AIS-E) - Td/Tdap (Total)	-	46.73	17.49	-29.24	N/A	2.89	4.46	11.28	16.71	28.03	38.60	44.31	57.19	68.45	N
Breast Cancer Screening (BCS-E)	65.42	63.75	64.86	1.11	-0.56	53.62	58.48	65.80	69.02	72.67	77.13	79.14	83.60	85.97	N
Colorectal Cancer Screening (COL-E) - Total	63.42	63.68	62.73	-0.95	-0.69	41.38	51.19	61.86	64.82	69.66	74.24	76.97	81.80	84.03	N

Analysis:

In this category, one of the five reported measures increased performance in MY2024. None of the measures met or exceeded the 75th percentile goal.

Effectiveness of Care: Respiratory

HEDIS Measure	MY2022 Rates	MY2023 Rates	MY2024 Rates	MY2023 to MY2024 Comparison	MY2022 to MY2024 Comparison	5th Percentile	10th Percentile	25th Percentile	33rd Percentile	50th Percentile	67th Percentile	75th Percentile	90th Percentile	95th Percentile	Goal Met (Y/N)
Appropriate Testing for Pharyngitis (CWP) - Total	5.71	25.32	23.47	-1.85	17.76	18.78	27.15	42.55	51.00	60.58	67.27	70.83	78.09	81.63	N
Pharmacotherapy Management of COPD Exacerbation (PCE) - Bronchodilator	78.85	89.93	60.00	-29.93	-18.85	73.82	75.93	81.22	82.50	85.59	87.56	88.82	91.37	93.28	N
Pharmacotherapy Management of COPD Exacerbation (PCE) - Systemic Corticosteroid	50.00	73.51	50.00	-23.51	0.00	58.60	64.21	68.72	71.05	74.47	77.78	78.88	82.98	85.71	N

Analysis:

In this category, none of the three reported measures increased performance in MY2024. None of the measures met or exceeded the 75th percentile goal.

Effectiveness of Care: Cardiovascular

HEDIS Measure	MY2022 Rates	MY2023 Rates	MY2024 Rates	MY2023 to MY2024 Comparison	MY2022 to MY2024 Comparison	5th Percentile	10th Percentile	25th Percentile	33rd Percentile	50th Percentile	67th Percentile	75th Percentile	90th Percentile	95th Percentile	Goal Met (Y/N)
Cardiac Rehabilitation (CRE) - Initiation (Total)	0.00	1.64	0.00	-1.64	0.00	0.00	0.00	1.22	2.07	3.32	5.61	7.20	13.51	26.67	N
Cardiac Rehabilitation (CRE) - Engagement1 (Total)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.41	2.50	5.69	9.28	11.23	17.95	29.23	N
Cardiac Rehabilitation (CRE) - Engagement2 (Total)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.85	3.28	5.55	8.55	10.76	16.87	22.16	N
Cardiac Rehabilitation (CRE) - Achievement (Total)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.79	2.06	3.85	5.00	9.68	12.50	N
Controlling High Blood Pressure (CBP)	59.61	75.18	76.12	0.94	16.51	64.48	68.85	73.24	74.94	77.78	80.56	82.48	87.21	89.54	N
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	87.50	54.50	0.00	-54.50	-87.50	55.57	59.41	64.41	66.67	70.32	75.00	77.42	85.17	87.49	N
Statin Therapy for Patients With Cardiovascular Disease (SPC) - Received Statin Therapy (Total)	81.38	84.14	96.00	11.86	14.62	71.17	74.05	77.26	78.57	80.65	82.58	83.55	86.91	88.10	Y
Statin Therapy for Patients With Cardiovascular Disease (SPC) - Statin Adherence 80% (Total)	79.66	80.13	91.67	11.54	12.01	73.33	76.19	80.73	81.90	84.49	86.49	87.66	91.91	93.33	Y

Analysis:

In this category, four of the eight reported measures increased performance in MY2024. Statin Therapy for Patients With Cardiovascular Disease (SPC) - Received Statin Therapy (Total)and Statin Therapy for Patients With Cardiovascular Disease (SPC) - Statin Adherence 80% (Total) met or exceeded the 75th percentile goal.

Effectiveness of Care: Diabetes

HEDIS Measure	MY2022 Rates	MY2023 Rates	MY2024 Rates	MY2023 to MY2024 Comparison	MY2022 to MY2024 Comparison	5th Percentile	10th Percentile	25th Percentile	33rd Percentile	50th Percentile	67th Percentile	75th Percentile	90th Percentile	95th Percentile	Goal Met (Y/N)
Blood Pressure Control for Patients With Diabetes (BPD)	64.72	69.10	74.62	5.52	9.90	53.33	63.77	71.05	73.21	75.91	78.61	80.78	86.37	91.34	N
Eye Exam for Patients With Diabetes (EED)	75.18	76.89	67.51	-9.38	-7.67	55.56	61.80	69.10	72.26	77.12	80.79	83.21	86.62	89.04	N
Glycemic Status Assessment for Patients With Diabetes (GSD) - Glycemic Status <8.0%	61.07	68.86	75.63	6.77	14.56	47.12	61.63	69.10	71.58	74.94	77.86	79.05	82.48	83.87	N
Glycemic Status Assessment for Patients With Diabetes (GSD) - Glycemic Status >9.0%	29.44	22.63	16.70	-5.93	-12.74	45.80	29.20	21.17	18.73	15.50	12.50	11.19	8.70	7.14	N
Kidney Health Evaluation for Patients With Diabetes (KED) - Total	54.85	63.30	59.09	-4.21	4.24	32.90	41.52	52.30	55.47	59.95	66.98	70.33	79.06	83.20	N
Statin Therapy for Patients With Diabetes (SPD) - Received Statin Therapy	80.94	80.11	77.10	-3.01	-3.84	71.17	74.05	77.26	78.57	80.65	82.58	83.55	86.91	88.10	N
Statin Therapy for Patients With Diabetes (SPD) - Statin Adherence 80%	77.47	80.21	70.31	-9.90	-7.16	73.33	76.19	80.73	81.90	84.49	86.49	87.66	91.91	93.33	N

Analysis:

In this category, two of the seven reported measures increased performance in MY2024. None of the measures met or exceeded the 75th percentile goal. Glycemic Status Assessment for Patients With Diabetes (GSD) - Glycemic Status >9.0% is an inverse measure and a lower rate indicates better performance.

Effectiveness of Care: Musculoskeletal Conditions

HEDIS Measure	MY2022 Rates	MY2023 Rates	MY2024 Rates	MY2023 to MY2024 Comparison	MY2022 to MY2024 Comparison	5th Percentile	10th Percentile	25th Percentile	33rd Percentile	50th Percentile	67th Percentile	75th Percentile	90th Percentile	95th Percentile	Goal Met (Y/N)
Osteoporosis Management in Women Who Had a Fracture (OMW)	9.09	21.74	0.00	-21.74	-9.09	21.28	23.91	32.74	36.41	45.64	53.85	58.06	73.50	80.34	N
Osteoporosis Screening in Older Women (OSW)	45.91	47.59	39.47	-8.12	-6.44	30.98	36.76	44.08	47.47	53.05	59.26	62.81	69.97	73.60	N

Analysis:

In this category, both reported measures decreased performance in MY2024. None of the measures met or exceeded the 75th percentile goal.

Effectiveness of Care: Behavioral Health

HEDIS Measure	MY2022 Rates	MY2023 Rates	MY2024 Rates	MY2023 to MY2024 Comparison	MY2022 to MY2024 Comparison	5th Percentile	10th Percentile	25th Percentile	33rd Percentile	50th Percentile	67th Percentile	75th Percentile	90th Percentile	95th Percentile	Goal Met (Y/N)
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	82.86	68.36	83.33	14.97	0.47	68.06	71.36	75.47	77.03	80.76	83.58	85.37	90.00	91.93	N
Antidepressant Medication Management (AMM) - Effective Acute Phase Treatment	72.37	72.56	88.89	16.33	16.52	72.24	73.51	77.29	78.92	82.18	84.91	86.11	88.89	90.53	Y
Antidepressant Medication Management (AMM) - Effective Continuation Phase Treatment	44.74	55.81	72.22	16.41	27.48	53.86	56.88	60.96	62.88	66.14	70.79	72.56	76.55	79.66	N
Follow-Up After Emergency Department Visit for Mental Illness (FUM) - 30 days (Total)	37.04	40.95	0.00	-40.95	-37.04	30.21	32.31	39.57	42.86	48.81	57.78	61.63	73.63	76.67	N
Follow-Up After Emergency Department Visit for Mental Illness (FUM) - 7 days (Total)	29.63	25.71	0.00	-25.71	-29.63	14.94	17.82	23.68	26.67	30.77	40.13	44.44	58.42	63.86	N
Follow-Up After Emergency Department Visit for Substance Use (FUA) - 30 days (Total)	52.17	42.57	25.00	-17.57	-27.17	22.90	25.65	33.33	35.00	40.00	44.74	47.79	55.73	61.80	N
Follow-Up After Emergency Department Visit for Substance Use (FUA) - 7 days (Total)	26.09	30.69	25.00	-5.69	-1.09	10.51	13.92	19.49	21.21	25.10	29.35	31.07	37.71	45.69	N

Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) - 30 days (Total)	50.00	28.89	0.00	-28.89	-50.00	22.50	24.53	30.56	33.33	38.53	45.09	49.00	59.64	68.21	N
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) - 7 days (Total)	50.00	13.33	0.00	-13.33	-50.00	8.00	10.81	13.51	15.58	20.51	23.91	26.19	37.74	43.93	N
Follow-Up After Hospitalization for Mental Illness (FUH) - 30 days (Total)	24.14	33.97	23.08	-10.89	-1.06	20.00	28.85	39.13	43.10	49.65	58.38	62.38	74.58	78.26	N
Follow-Up After Hospitalization for Mental Illness (FUH) - 7 days (Total)	13.79	15.38	7.69	-7.69	-6.10	10.00	13.92	21.65	23.80	27.08	36.40	40.00	53.73	60.00	N
Pharmacotherapy for Opioid Use Disorder (POD) -Total	11.11	66.67	100.00	33.33	88.89	16.46	20.41	27.50	29.86	32.74	36.36	38.83	44.55	50.65	Y

Analysis:

In this category, four of the twelve reported measures increased performance in MY2024. Antidepressant Medication Management (AMM) - Effective Acute Phase Treatment and Pharmacotherapy for Opioid Use Disorder (POD) -Total met or exceeded the 75th percentile goal.

Effectiveness of Care: Care Coordination

HEDIS Measure	MY2022 Rates	MY2023 Rates	MY2024 Rates	MY2023 to MY2024 Comparison	MY2022 to MY2024 Comparison	5th Percentile	10th Percentile	25th Percentile	33rd Percentile	50th Percentile	67th Percentile	75th Percentile	90th Percentile	95th Percentile	Goal Met (Y/N)
Advance Care Planning (ACP)	66.78	65.18	66.47	1.29	-0.31	11.23	18.19	32.60	37.24	47.47	59.89	67.98	95.52	99.36	N
Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC) -Total	50.00	48.07	43.59	-4.48	-6.41	43.59	48.17	53.52	55.33	58.65	64.25	67.64	79.02	85.11	N
Transitions of Care (TRC) - Medication Reconciliation Post-Discharge (Total)	32.85	39.90	45.99	6.09	13.14	35.75	47.93	63.91	68.87	77.70	84.18	88.08	93.64	96.11	N
Transitions of Care (TRC) - Notification of Inpatient Admission (Total)	2.19	6.57	22.63	16.06	20.44	2.60	10.46	27.13	35.77	48.43	63.64	72.50	86.62	91.48	N
Transitions of Care (TRC) - Patient Engagement After Inpatient Discharge (Total)	73.24	72.99	64.96	-8.03	-8.28	75.00	78.23	83.21	84.91	87.83	90.27	91.97	94.58	96.35	N
Transitions of Care (TRC) - Receipt of Discharge Information (Total)	2.68	4.62	19.71	15.09	17.03	2.83	6.25	14.36	20.68	31.20	42.51	49.94	64.47	74.19	N

Analysis:

In this category, four of the six reported measures increased performance in MY2024. None of the measures met or exceeded the 75th percentile goal.

Effectiveness of Care: Appropriateness of Use

HEDIS Measure	MY2022 Rates	MY2023 Rates	MY2024 Rates	MY2023 to MY2024 Comparison	MY2022 to MY2024 Comparison	5th Percentile	10th Percentile	25th Percentile	33rd Percentile	50th Percentile	67th Percentile	75th Percentile	90th Percentile	95th Percentile	Goal Met (Y/N)
Appropriate Treatment for Upper Respiratory Infection (URI) -Total	88.64	71.81	67.81	-4.00	-20.83	43.51	48.73	57.33	61.22	67.10	71.82	75.54	83.97	88.11	N
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) - Total	52.38	40.30	42.31	2.01	-10.07	20.37	21.95	26.56	28.17	32.11	35.85	39.42	50.00	56.10	Y
Potentially Harmful Drug-Disease Interactions in Older Adults (DDE) - Falls	29.85	30.94	20.00	-10.94	-9.85	52.08	49.11	45.38	42.62	38.96	36.29	34.57	31.67	29.57	Y
Potentially Harmful Drug-Disease Interactions in Older Adults (DDE) - Dementia	48.15	34.67	50.00	15.33	1.85	54.35	50.00	43.90	42.01	38.73	35.55	33.40	28.71	25.12	N
Potentially Harmful Drug-Disease Interactions in Older Adults (DDE) - Chronic Kidney Disease	22.58	13.24	12.50	-0.74	-10.08	20.34	17.92	13.16	11.54	9.14	7.65	6.64	4.27	2.70	N
Potentially Harmful Drug-Disease Interactions in Older Adults (DDE) -Total	32.79	27.70	28.57	0.87	-4.22	44.93	41.78	37.43	36.04	32.97	30.54	29.26	25.44	23.19	Y
Risk of Continued Opioid Use (COU) - ≥15 Days (Total)	14.10	12.28	11.63	-0.65	-2.47	38.71	23.48	16.19	15.16	13.09	11.58	10.74	8.87	7.25	N
Risk of Continued Opioid Use (COU) - ≥31 Days (Total)	7.26	8.15	6.98	-1.17	-0.28	19.15	12.91	9.60	8.78	7.42	6.62	5.99	4.45	3.74	N

Use of High-Risk Medications in Older Adults (DAE) – Total	14.48	10.74	6.81	-3.93	-7.67	32.35	27.40	22.18	20.00	16.56	14.17	13.44	10.46	9.28	Y
Use of Imaging Studies for Low Back Pain (LBP) - Total	54.05	71.43	87.50	16.07	33.45	60.71	63.46	67.25	68.79	71.86	74.51	75.68	80.43	82.74	Y
Use of Opioids From Multiple Providers - Multiple Prescribers and Multiple Pharmacies (UOP)	1.14	1.18	0.00	-1.18	-1.14	2.33	1.64	1.01	0.79	0.52	0.28	0.18	0.00	0.00	Y
Use of Opioids at High Dosage (HDO)	2.31	2.74	0.00	-2.74	-2.31	11.02	9.38	6.35	5.34	3.69	2.66	2.13	1.06	0.74	Y

Analysis:

In this category, four of the twelve reported measures increased performance in MY2024. Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) – Total, Potentially Harmful Drug-Disease Interactions in Older Adults (DDE) – Falls, Potentially Harmful Drug-Disease Interactions in Older Adults (DDE) -Total, Use of High-Risk Medications in Older Adults (DAE) – Total, Use of Imaging Studies for Low Back Pain (LBP) – Total, Use of Opioids From Multiple Providers - Multiple Prescribers and Multiple Pharmacies (UOP), and Use of Opioids at High Dosage (HDO) met or exceeded the 75th percentile goal. Potentially Harmful Drug-Disease Interactions in Older Adults (DDE) – Falls, Potentially Harmful Drug-Disease Interactions in Older Adults (DDE) – Dementia, Potentially Harmful Drug-Disease Interactions in Older Adults (DDE) - Chronic Kidney Disease, Potentially Harmful Drug-Disease Interactions in Older Adults (DDE) -Total , Risk of Continued Opioid Use (COU) - ≥15 Days (Total), Risk of Continued Opioid Use (COU) - ≥31 Days (Total), Use of High-Risk Medications in Older Adults (DAE) – Total, Use of Opioids From Multiple Providers - Multiple Prescribers and Multiple Pharmacies (UOP), and Use of Opioids at High Dosage (HDO) are inverse measures and a lower rate would indicate better performance.

Effectiveness of Care: Access/Availability of Care

HEDIS Measure	MY2022 Rates	MY2023 Rates	MY2024 Rates	MY2023 to MY2024 Comparison	MY2022 to MY2024 Comparison	5th Percentile	10th Percentile	25th Percentile	33rd Percentile	50th Percentile	67th Percentile	75th Percentile	90th Percentile	95th Percentile	Goal Met (Y/N)
Adults' Access to Preventive/Ambulatory Health Services (AAP) - Total	92.12	88.48	87.28	-1.20	-4.84	88.31	90.74	93.47	94.25	95.70	96.92	97.45	99.58	100.00	N
Initiation and Engagement of Substance Use Disorder Treatment (IET) - Initiation of SUD Treatment - Total (Total)	24.37	56.18	82.35	26.17	57.98	9.64	16.52	26.17	30.76	36.37	41.67	45.13	53.60	58.49	Y
Initiation and Engagement of Substance Use Disorder Treatment (IET) - Engagement of SUD Treatment - Total (Total)	1.68	6.77	5.88	-0.89	4.20	0.47	1.00	2.44	3.16	4.71	6.59	7.90	10.54	13.64	N

Analysis:

In this category, one of the three reported measures increased in performance in MY2024. Initiation and Engagement of Substance Use Disorder Treatment (IET) - Initiation of SUD Treatment - Total (Total) met or exceeded the 75th percentile goal.

Effectiveness of Care: Utilization

HEDIS Measure	MY2022 Rates	MY2023 Rates	MY2024 Rates	MY2023 to MY2024 Comparison	MY2022 to MY2024 Comparison	5th Percentile	10th Percentile	25th Percentile	33rd Percentile	50th Percentile	67th Percentile	75th Percentile	90th Percentile	95th Percentile	Goal Met (Y/N)
Plan All-Cause Readmissions (PCR) - Age 65+ years	110.12	77.82	92.15	14.33	-17.97	115.98	107.55	99.37	95.89	89.52	79.71	74.59	65.69	61.80	N

Analysis:

In this category, Plan All-Cause Readmissions (PCR) - Age 65+ years was the only reported measure. This measure increased performance in MY2024 and did not meet or exceed the 75th percentile goal. PCR - Age 65+ years is an inverse measure, and a lower rate would indicate better performance.

Molina Healthcare of California

2025 Quality Performance Measurement Report

Molina Healthcare of California's 2025 (MY2024) Quality Performance Measurement Results and Analysis Report includes reported rates for quality measures across all Lines of Business and product lines, as appropriate. The results included in this report are designed to assess the quality of care that our members receive in key clinical areas. The report is divided into the following sections:

Report Background and Purpose

This report is an annual evaluation of performance measurement results for Molina Healthcare of California. This report summarizes the results for performance measures that are reported for the plan for the following lines of business.

Line of Business	Measures Reported
Marketplace	HEDIS measures reported to meet the CMS Quality Rating System requirements.

Methodology

Molina Healthcare collects and reports HEDIS measures uses an NCQA certified software vendor to collect HEDIS® data. Measures are collected and reported using either: 1) an administrative collection method, using claims, encounters, pharmacy, laboratory, and supplemental data (as appropriate); 2) a hybrid methodology, using a combination of administrative and medical record review data to search for additional data to meet numerator compliance; and 3) medical record review data, which only includes data from the medical records. Random samples are systematically drawn for hybrid review. In addition, Molina Healthcare reports non-HEDIS performance measures to meet regulatory requirements as needed.

The tables in this report display the annual performance results for all lines of business and products, as appropriate. The tables show prior year rates, current year rates and the difference between the two years' rates. Besides numeric rates, NA, NR, NB, and NQ rates were also reported. The key below describes these reporting values:

Reporting Value	Description
NA	The organization reported a small denominator (i.e. less than 30 members in the denominator)

NR	The organization chose not to report the measure.
NB	The organization does not offer the required benefits.
NQ	The organization is not required to report the measure.

The tables include the current Marketplace Quality Ratings System percentiles 5th, 10th, 25th, 50th, 67th, 75th, 90th and 95th. Current rates are compared to the benchmarks to determine if goals are met. Quantitative analyses are completed for each table.

Benchmarks and Goals

Line of Business	Benchmarks	Goals
Marketplace	For HEDIS measures, benchmarks are taken from the CMS Marketplace Quality Ratings System percentiles.	The overall goal is to meet or achieve the 75th percentile. If the goal is achieved, the goal is to reach the next percentile.

Performance Measurement Results and Analysis for the Marketplace Population

Data Source: Molina Healthcare of California Marketplace HEDIS© Measures Rates – IDSS #12003

Goal: The goal is to meet or achieve the 75th percentile Quality Compass benchmark

“MY2022” is data collected from January-December 2022; “MY2023” is data collected from January-December 2023; “MY2024” is data collected from January-December 2024.

Executive Summary

Molina Healthcare of California evaluates performance measurement rates for its Marketplace population. Goals were set at the 75th percentile as identified by the National Committee for Quality Assurance in its Marketplace Health Plan Ratings for MY2024. Twenty-seven (27) out of the thirty-eight (38) rates for Marketplace increased from MY2023 to MY2024. Out of these rates, seven (7) met the 75th percentile and thirty-one (31) did not meet the 75th percentile goals. The following rates were reported at less than the 5th percentile, indicating the need for improvement: Breast Cancer Screening (BCS-E), Asthma Medication Ratio (AMR) -Total, Appropriate Treatment for Upper Respiratory Infection (URI) -Total, and Well-Child Visits in the First 30 Months of Life (W30) - (First 15 Months).

Prevention and Screening

In this category, thirteen of the sixteen reported measures increased performance in MY2024. Chlamydia Screening in Women (CHL) Total and Immunizations for Adolescents (IMA) - HPV met or exceeded the 75th percentile goal. Breast Cancer Screening (BCS-E) fell below or within the 5th percentile threshold, indicating an area of improvement. Adult Immunization Status (AIS-E) - Influenza (Total), Adult Immunization Status (AIS-E) - Pneumococcal (66+), Adult Immunization Status (AIS-E) - Td/Tdap (Total), and Oral Evaluation, Dental Services (OED) – Total did not report a rate in MY2022, and no data was reported.

Trends: Breast Cancer Screening (BCS-E), Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL-E) -Total, Childhood Immunization Status (CIS) - Combo 10, and all WCC measures improved in performance from MY2023 to MY2024 but still fell below the 75th percentile goal. Chlamydia Screening in Women (CHL) Total and Immunizations for Adolescents (IMA) – HPV improved each measurement year and met the 75th percentile goal in MY2024. All AIS-E measures remain low in performance over a 3-year period. Adolescent immunizations (Meningococcal and Tdap) and OED continue to performance persistently low over a 3-year period.

Areas of Concern: Breast Cancer Screening (BCS-E) fell below or within the 5th percentile threshold, indicating an area of improvement. Immunizations for Adolescents (IMA) – Meningococcal and Oral Evaluation, Dental Services (OED) – Total fell within the 10th percentile threshold. Cervical Cancer Screening (CCS), Childhood Immunization Status (CIS) - Combo 10, and Colorectal Cancer Screening (COL-E) -Total fell within the 33rd percentile threshold. Adult Immunization Status (AIS-E) - Influenza (Total), Adult Immunization Status (AIS-E) - Pneumococcal (66+), Adult Immunization Status (AIS-E) - Td/Tdap (Total), Immunizations for Adolescents (IMA) - Combination 2, Immunizations for Adolescents (IMA) – Tdap, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) - BMI percentile (Total), Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) - Counseling for Nutrition (Total), and Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) - Counseling for Physical Activity (Total) fell within the 50th percentile threshold.

Current Interventions: Member call/text/email, member incentives, and member home lab kit program.

Respiratory

In this category, Asthma Medication Ratio (AMR) -Total was the only measure reported. This measure did not increase performance in MY2024 and did not meet or exceed the 75th percentile goal.

Trends: AMR significantly declined (76.67→63.50) in performance from MY2023 to MY2024.

Areas of Concern: AMR fell within the 5th percentile threshold, indicating an area of improvement.

Current Interventions: This category does not have current interventions in place. Suggested interventions includes provider engagement meetings and provider/member education.

Cardiovascular

In this category, Controlling High Blood Pressure (CBP) was the only reported measure. This measure increased performance in MY2024 but did not meet or exceed the 75th percentile goal.

Trends: This measure improved (+19.95) significantly over a 3-year period but still fell below the 75th percentile goal.

Areas of Concern: CBP fell within the 50th percentile threshold, indicating an area of improvement.

Current Interventions: Member in-home/telehealth visits and member digital condition management application.

Diabetes

In this category, two of the three reported measures increased performance in MY2024. Kidney Health Evaluation for Patients With Diabetes (KED) – Total met the 75th percentile goal. Glycemic Status Assessment for Patients With Diabetes (GSD) - Glycemic Status >9.0% is an inverse measure and a lower rate indicates better performance.

Trends: All the reported measures increased performance over a 3-year period and are positively trending towards the 75th percentile goal. KED met the 75th percentile goal in MY2024.

Areas of Concern: Eye Exam for Patients With Diabetes (EED) and Glycemic Status Assessment for Patients With Diabetes (GSD) - Glycemic Status >9.0%fell within the 67th percentile threshold.

Current Interventions: Home lab kit program and member digital condition management application.

Behavioral Health

In this category, three of the six reported measures increased performance in MY2024. Depression Screening and Follow-Up for Adolescents and Adults (DSF-E) - Depression Screening (Total) and Depression Screening and Follow-Up for Adolescents and Adults (DSF-E) - Follow-Up on Positive Screen (Total) met the 75th percentile goal. Follow-Up After Hospitalization for Mental Illness (FUH) - 7 days (Total) fell below or within the 5th percentile goal, indicating an area of improvement.

Trends: MY2024 was the first time both DSF-E measures were reported. Antidepressant Medication Management (AMM) - Effective Acute Phase Treatment increased in performance each measurement year but remained below the 75th percentile goal. Both FUH measures continue to performance very low over a 3-year period.

Areas of Concern: Follow-Up After Hospitalization for Mental Illness (FUH) - 7 days (Total) fell below or within the 5th percentile goal, indicating an area of improvement. Antidepressant Medication Management (AMM) - Effective Continuation Phase Treatment and Follow-Up After Hospitalization for Mental Illness (FUH) - 30 days (Total) fell within the 10th percentile threshold. Antidepressant Medication Management (AMM) - Effective Acute Phase Treatment fell within the 25th percentile threshold.

Current Interventions: This category does not have current inventions in place. Suggested interventions includes provider engagement meetings, member text/email/calls, and member/provider education.

Appropriateness of Use

In this category, one of the three reported measures increased performance in MY2024. None of the reported measures met the 75th percentile goal.

Trends: URI had a significant decline (-20.49) in performance over a 3-year period. Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) - Total had a significant decline (-11.98) in performance from MY2023 to MY2024.

Areas of Concern: Appropriate Treatment for Upper Respiratory Infection (URI) -Total fell below or within the 5th percentile threshold. Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) – Total fell within the 25th percentile threshold. Use of Imaging Studies for Low Back Pain (LBP) – Total fell within the 33rd percentile threshold.

Current Interventions: This category does not have current interventions in place. Suggested interventions includes member incentives/gift card, provider and member education, and member call/text/email.

Access and Availability of Care

In this category, three of the four reported measures increased in performance in MY2024. Initiation and Engagement of Substance Use Disorder Treatment (IET) - Initiation of SUD Treatment - Total (Total) met or exceeded the 75th percentile goal.

Trends: IET–Initiation increased performance over a 3-year period and met the 75th percentile goal in MY2024. PPC Postpartum has shown a positive trend in performance over a 3-year period but remained below the 75th percentile goal each measurement year.

Areas of Concern: Initiation and Engagement of Substance Use Disorder Treatment (IET) - Engagement of SUD Treatment - Total (Total) fell within the 10th percentile threshold. Prenatal and Postpartum Care (PPC) - Timeliness of Prenatal Care fell within the 33rd percentile threshold. Prenatal and Postpartum Care (PPC) - Postpartum Care within the 50th percentile threshold.

Current Interventions: Member in-home/telehealth visits.

Utilization

In this category, all four reported measures increased performance in MY2024. Plan All-Cause Readmissions (PCR) - Age 18-64 years met the 75th percentile goal. Plan All-Cause Readmissions (PCR) - Age 18-64 years is an inverse measure, and a lower rate would indicate better performance.

Trends: Child and Adolescent Well-Care Visits (WCV) – Total, Well-Child Visits in the First 30 Months of Life (W30) - (First 15 Months), and Well-Child Visits in the First 30 Months of Life (W30) - (15 Months-30 Months) increased performance from MY2023 to MY2024. Plan All-Cause Readmissions (PCR) - Age 18-64 years met the 75th percentile goal in MY2024 but there was a significant upward (+24.42) trend from MY2023 to MY2024; this is an inverse measure, and a lower rate is better.

Areas of Concern: Well-Child Visits in the First 30 Months of Life (W30) - (First 15 Months) fell below or within the 5th percentile threshold, indicating an area of improvement. Well-Child Visits in the First 30 Months of Life (W30) - (15 Months-30 Months) fell within the 25th percentile threshold. Child and Adolescent Well-Care Visits (WCV) – Total fell within the 33rd percentile threshold.

Current Interventions: Member in-home/telehealth visits

Effectiveness of Care: Prevention and Screening

HEDIS Measure	MY2022 Rates	MY2023 Rates	MY2024 Rates	MY2023 to MY2024 Comparison	MY2022 to MY2024 Comparison	5th Percentile	10th Percentile	25th Percentile	33rd Percentile	50th Percentile	67th Percentile	75th Percentile	90th Percentile	95th Percentile	Goal Met (Y/N)
Adult Immunization Status (AIS-E) - Influenza (Total)	-	20.52	20.01	-0.51	N/A	3.00	4.50	8.80	11.00	17.70	22.40	24.30	31.30	35.30	N
Adult Immunization Status (AIS-E) - Pneumococcal (66+)	-	34.16	40.60	6.44	N/A	2.40	10.20	23.00	27.80	37.40	47.60	52.50	65.60	70.60	N
Adult Immunization Status (AIS-E) - Td/Tdap (Total)	-	30.01	37.63	7.62	N/A	6.80	9.60	16.40	20.80	34.30	41.40	47.50	60.40	67.30	N
Breast Cancer Screening (BCS-E)	55.95	58.12	63.02	4.90	7.07	55.79	60.36	66.47	68.23	73.07	75.49	76.77	80.65	83.16	N
Cervical Cancer Screening (CCS)	46.72	47.20	51.58	4.38	4.86	25.30	30.90	39.17	43.44	52.48	61.86	65.03	73.39	76.72	N
Childhood Immunization Status (CIS) - Combo 10	34.38	16.28	30.43	14.15	-3.95	15.38	17.11	27.27	30.43	35.38	42.94	46.88	56.82	58.11	N
Chlamydia Screening in Women (CHL) Total	53.30	55.61	64.29	8.68	10.99	31.75	34.21	40.53	43.62	48.07	53.23	56.04	65.08	71.79	Y
Colorectal Cancer Screening (COL-E) - Total	32.54	37.29	51.50	14.21	18.96	29.10	34.00	42.50	44.90	54.10	58.30	60.80	66.60	71.60	N
Immunizations for Adolescents (IMA) - Combination 2	19.74	28.89	31.03	2.14	11.29	13.51	17.12	21.74	24.55	28.38	33.01	36.86	48.62	51.64	N
Immunizations for Adolescents (IMA) - HPV	21.05	30.00	32.76	2.76	11.71	0.00	6.30	15.80	19.70	25.00	28.60	32.70	43.90	50.00	Y
Immunizations for Adolescents (IMA) - Meningococcal	63.16	66.67	56.90	-9.77	-6.26	21.40	38.40	57.90	64.70	73.10	79.00	80.90	89.50	100.00	N
Immunizations for Adolescents (IMA) - Tdap	82.89	83.33	79.31	-4.02	-3.58	25.00	42.90	66.10	70.20	79.30	83.30	86.40	93.30	100.00	N

Oral Evaluation, Dental Services (OED) - Total	-	0.94	2.11	1.17	N/A	0.00	0.45	4.15	7.95	17.27	22.41	24.19	31.77	40.48	N
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) - BMI percentile (Total)	72.99	74.94	80.54	5.60	7.55	45.00	56.70	68.00	72.70	78.60	82.20	84.30	89.40	92.80	N
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) - Counseling for Nutrition (Total)	75.91	72.02	74.94	2.92	-0.97	35.80	45.50	58.50	62.00	69.30	74.40	77.20	84.60	87.20	N
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) - Counseling for Physical Activity (Total)	75.43	68.86	73.72	4.86	-1.71	33.30	41.60	55.00	58.50	66.20	71.70	74.80	81.90	85.50	N

Analysis:

In this category, thirteen of the sixteen reported measures increased performance in MY2024. Chlamydia Screening in Women (CHL) Total and I Immunizations for Adolescents (IMA) - HPV met or exceeded the 75th percentile goal. Breast Cancer Screening (BCS-E) fell below or within the 5th percentile threshold, indicating an area of improvement. Adult Immunization Status (AIS-E) - Influenza (Total), Adult Immunization Status (AIS-E) - Pneumococcal (66+), Adult Immunization Status (AIS-E) - Td/Tdap (Total), and Oral Evaluation, Dental Services (OED) – Total did not report a rate in MY2022, and no data was reported.

Effectiveness of Care: Respiratory

HEDIS Measure	MY2022 Rates	MY2023 Rates	MY2024 Rates	MY2023 to MY2024 Comparison	MY2022 to MY2024 Comparison	5th Percentile	10th Percentile	25th Percentile	33rd Percentile	50th Percentile	67th Percentile	75th Percentile	90th Percentile	95th Percentile	Goal Met (Y/N)
Asthma Medication Ratio (AMR) -Total	76.61	76.67	63.50	-13.17	-13.11	59.66	63.64	69.66	73.33	77.78	81.82	84.65	88.79	92.98	N

Analysis:

In this category, Asthma Medication Ratio (AMR) -Total was the only measure reported. This measure did not increase performance in MY2024 and did not meet or exceed the 75th percentile goal.

Effectiveness of Care: Cardiovascular

HEDIS Measure	MY2022 Rates	MY2023 Rates	MY2024 Rates	MY2023 to MY2024 Comparison	MY2022 to MY2024 Comparison	5th Percentile	10th Percentile	25th Percentile	33rd Percentile	50th Percentile	67th Percentile	75th Percentile	90th Percentile	95th Percentile	Goal Met (Y/N)
Controlling High Blood Pressure (CBP)	51.34	66.91	71.29	4.38	19.95	53.29	58.15	63.26	65.21	68.88	72.02	73.97	78.69	81.27	N

Analysis:

In this category, Controlling High Blood Pressure (CBP) was the only reported measure. This measure increased performance in MY2024 but did not meet or exceed the 75th percentile goal.

Effectiveness of Care: Diabetes

HEDIS Measure	MY2022 Rates	MY2023 Rates	MY2024 Rates	MY2023 to MY2024 Comparison	MY2022 to MY2024 Comparison	5th Percentile	10th Percentile	25th Percentile	33rd Percentile	50th Percentile	67th Percentile	75th Percentile	90th Percentile	95th Percentile	Goal Met (Y/N)
Eye Exam for Patients With Diabetes (EED)	45.01	43.31	53.28	9.97	8.27	22.09	27.01	33.09	36.50	43.80	50.36	53.33	63.69	69.53	N
Glycemic Status Assessment for Patients With Diabetes (GSD) - Glycemic Status >9.0%	-	32.36	26.03	-6.33	N/A	47.43	39.07	32.12	29.80	26.52	22.14	19.71	16.42	14.98	N
Kidney Health Evaluation for Patients With Diabetes (KED) - Total	56.07	59.66	60.61	0.95	4.54	32.17	35.78	43.01	46.35	52.28	56.64	58.43	65.11	71.75	Y

Analysis:

In this category, two of the three reported measures increased performance in MY2024. Kidney Health Evaluation for Patients With Diabetes (KED) – Total met the 75th percentile goal. Glycemic Status Assessment for Patients With Diabetes (GSD) - Glycemic Status >9.0% is an inverse measure and a lower rate indicates better performance.

Effectiveness of Care: Behavioral Health

HEDIS Measure	MY2022 Rates	MY2023 Rates	MY2024 Rates	MY2023 to MY2024 Comparison	MY2022 to MY2024 Comparison	5th Percentile	10th Percentile	25th Percentile	33rd Percentile	50th Percentile	67th Percentile	75th Percentile	90th Percentile	95th Percentile	Goal Met (Y/N)
Antidepressant Medication Management (AMM) - Effective Acute Phase Treatment	62.93	68.93	70.89	1.96	7.96	60.00	64.90	70.70	72.20	77.20	81.30	82.80	87.20	89.70	N
Antidepressant Medication Management (AMM) - Effective Continuation Phase Treatment	44.12	51.70	49.11	-2.59	4.99	42.90	47.40	54.50	56.70	60.80	64.60	67.20	72.10	76.30	N
Follow-Up After Hospitalization for Mental Illness (FUH) - 30 days (Total)	27.27	24.14	28.89	4.75	1.62	18.20	24.70	37.70	44.60	56.30	66.70	71.80	83.30	88.90	N
Follow-Up After Hospitalization for Mental Illness (FUH) - 7 days (Total)	13.64	10.34	11.11	0.77	-2.53	6.80	12.10	21.30	23.80	34.40	44.20	50.00	64.10	75.00	N
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E) - Depression Screening (Total)	-	-	20.47	N/A	N/A	0.00	0.00	0.00	0.30	1.40	4.10	9.30	20.10	28.00	Y
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E) - Follow-Up on Positive Screen (Total)	-	-	85.22	N/A	N/A	25.80	36.70	61.70	67.70	75.00	81.30	84.90	98.70	100.00	Y

Analysis:

In this category, three of the six reported measures increased performance in MY2024. Depression Screening and Follow-Up for Adolescents and Adults (DSF-E) - Depression Screening (Total) and Depression Screening and Follow-Up for Adolescents and Adults

(DSF-E) - Follow-Up on Positive Screen (Total) met the 75th percentile goal. Follow-Up After Hospitalization for Mental Illness (FUH) - 7 days (Total) fell below or within the 5th percentile goal, indicating an area of improvement.

Effectiveness of Care: Appropriateness of Use

HEDIS Measure	MY2022 Rates	MY2023 Rates	MY2024 Rates	MY2023 to MY2024 Comparison	MY2022 to MY2024 Comparison	5th Percentile	10th Percentile	25th Percentile	33rd Percentile	50th Percentile	67th Percentile	75th Percentile	90th Percentile	95th Percentile	Goal Met (Y/N)
Appropriate Treatment for Upper Respiratory Infection (URI) -Total	93.83	84.97	73.34	-11.63	-20.49	68.51	70.52	73.72	76.92	80.78	83.33	85.12	89.58	92.00	N
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) - Total	44.71	55.21	43.23	-11.98	-1.48	33.57	36.14	42.14	43.73	47.84	53.13	54.88	63.18	69.70	N
Use of Imaging Studies for Low Back Pain (LBP) - Total	73.67	67.60	70.60	3.00	-3.07	62.55	64.26	68.29	69.87	71.93	74.03	75.53	80.51	82.35	N

Analysis:

In this category, one of the three reported measures increased performance in MY2024. None of the reported measures met the 75th percentile goal.

Effectiveness of Care: Access/Availability of Care

HEDIS Measure	MY2022 Rates	MY2023 Rates	MY2024 Rates	MY2023 to MY2024 Comparison	MY2022 to MY2024 Comparison	5th Percentile	10th Percentile	25th Percentile	33rd Percentile	50th Percentile	67th Percentile	75th Percentile	90th Percentile	95th Percentile	Goal Met (Y/N)
Initiation and Engagement of Substance Use Disorder Treatment (IET) - Initiation of SUD Treatment - Total (Total)	39.14	45.49	52.83	7.34	13.69	23.40	27.30	33.30	35.40	39.80	44.00	46.10	52.40	56.20	Y
Initiation and Engagement of Substance Use Disorder Treatment (IET) - Engagement of SUD Treatment - Total (Total)	4.67	9.21	8.10	-1.11	3.43	3.00	5.40	8.90	10.00	12.10	14.10	15.90	21.00	24.20	N
Prenatal and Postpartum Care (PPC) - Timeliness of Prenatal Care	78.63	71.25	78.92	7.67	0.29	60.69	65.28	70.63	75.83	80.40	87.30	89.51	95.77	97.00	N
Prenatal and Postpartum Care (PPC) - Postpartum Care	79.77	79.58	81.86	2.28	2.09	61.29	65.08	72.34	75.00	80.77	87.45	88.89	94.25	95.93	N

Analysis:

In this category, three of the four reported measures increased in performance in MY2024. Initiation and Engagement of Substance Use Disorder Treatment (IET) - Initiation of SUD Treatment - Total (Total) met or exceeded the 75th percentile goal.

Effectiveness of Care: Utilization

HEDIS Measure	MY2022 Rates	MY2023 Rates	MY2024 Rates	MY2023 to MY2024 Comparison	MY2022 to MY2024 Comparison	5th Percentile	10th Percentile	25th Percentile	33rd Percentile	50th Percentile	67th Percentile	75th Percentile	90th Percentile	95th Percentile	Goal Met (Y/N)
Child and Adolescent Well-Care Visits (WCV) - Total	47.18	41.62	46.04	4.42	-1.14	22.95	28.70	39.63	42.82	49.85	55.50	58.56	70.07	73.78	N
Well-Child Visits in the First 30 Months of Life (W30) - (First 15 Months)	51.72	32.35	53.85	21.50	2.13	45.50	54.80	64.70	68.60	75.00	81.30	85.20	100.00	100.00	N
Well-Child Visits in the First 30 Months of Life (W30) - (15 Months-30 Months)	76.47	70.73	75.76	5.03	-0.71	53.80	66.70	74.70	76.90	83.00	87.50	90.50	100.00	100.00	N
Plan All-Cause Readmissions (PCR) - Age 18-64 years	71.28	77.40	101.82	24.42	30.54	188.3	169.94	149.79	141.63	132.67	120.17	114.93	100.01	93.46	Y

Analysis:

In this category, all four reported measures increased performance in MY2024. Plan All-Cause Readmissions (PCR) - Age 18-64 years met the 75th percentile goal. Plan All-Cause Readmissions (PCR) - Age 18-64 years is an inverse measure, and a lower rate would indicate better performance.

Appendix 2

Potential Quality of Care 2025 Annual Report Q1 2025 – Q4 2025

Molina Healthcare of California

January 2026

Presented by: Quality Program Management and Performance

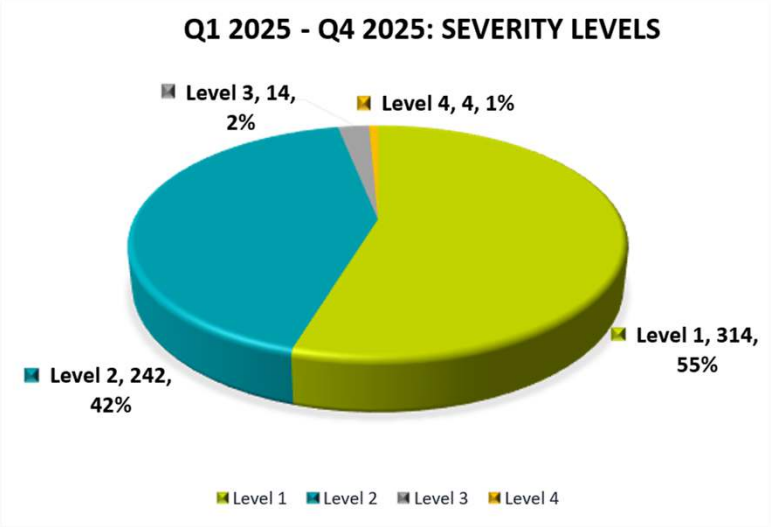
MOLINA HEALTHCARE

Potential Quality of Care Cases - Molina Healthcare of California: Q1 2025 - Q4 2025

Potential Quality of Care Cases
by **Line of Business**

Line of Business	Total Cases Accepted	Total Cases Closed
MHCA-Medicaid	477	446
Medicare - MAPD	54	45
Medicare - DSNP	47	42
MHCA-Marketplace	29	26
MHCA-DSNP	14	13
MHCA-CHP-MAPD	1	1
MHCA-MMO	1	1
MHCA - Medicare	0	0
MHCA - LTSS	0	0
MHCA – Medicare MMOP	0	0
Total	623	574

Potential Quality of Care case activity for referrals **accepted** and **closed** during **Q1 2025-Q4 2025**.

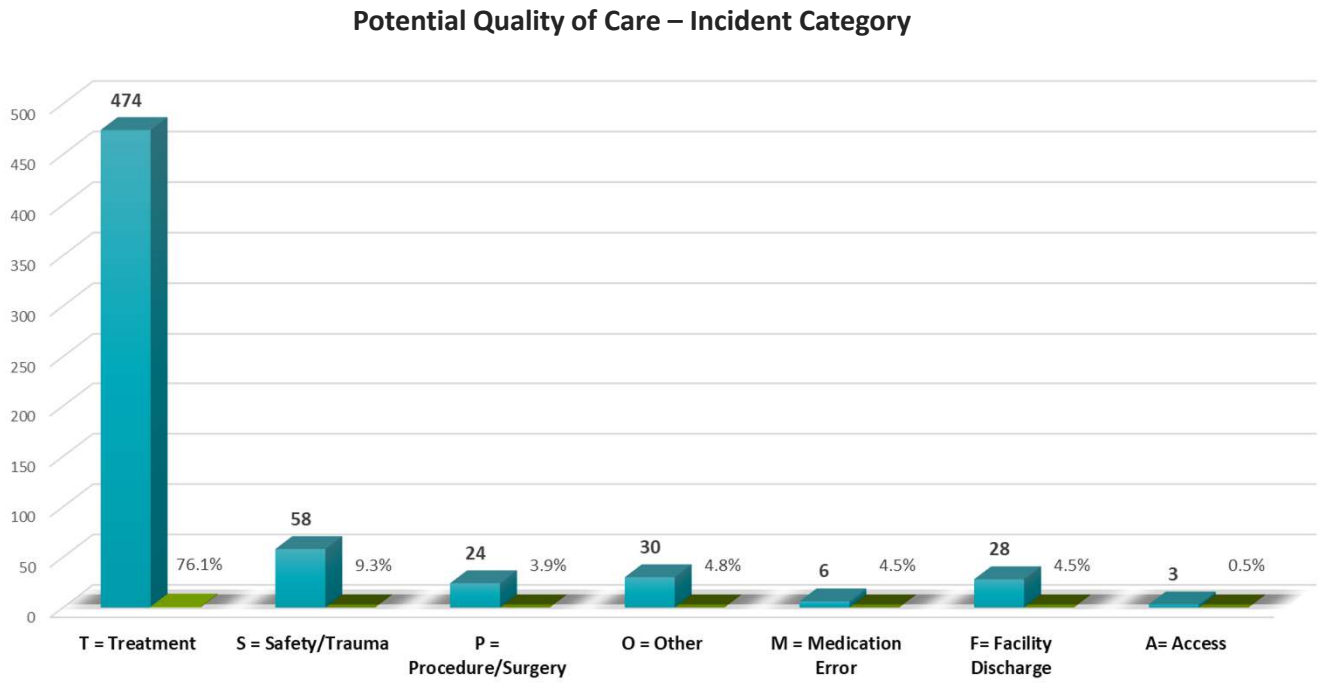


A Severity Level (1-4)* is assigned to each case upon completion of the investigation.

*** Severity Levels: Level 1 – No quality-of-care issue; Level 2 – Adverse occurrence, handled appropriately by provider; Level 3 – Moderate deviation from standard of care; Level 4 – Significant deviation from standard of care.**

MOLINA HEALTHCARE

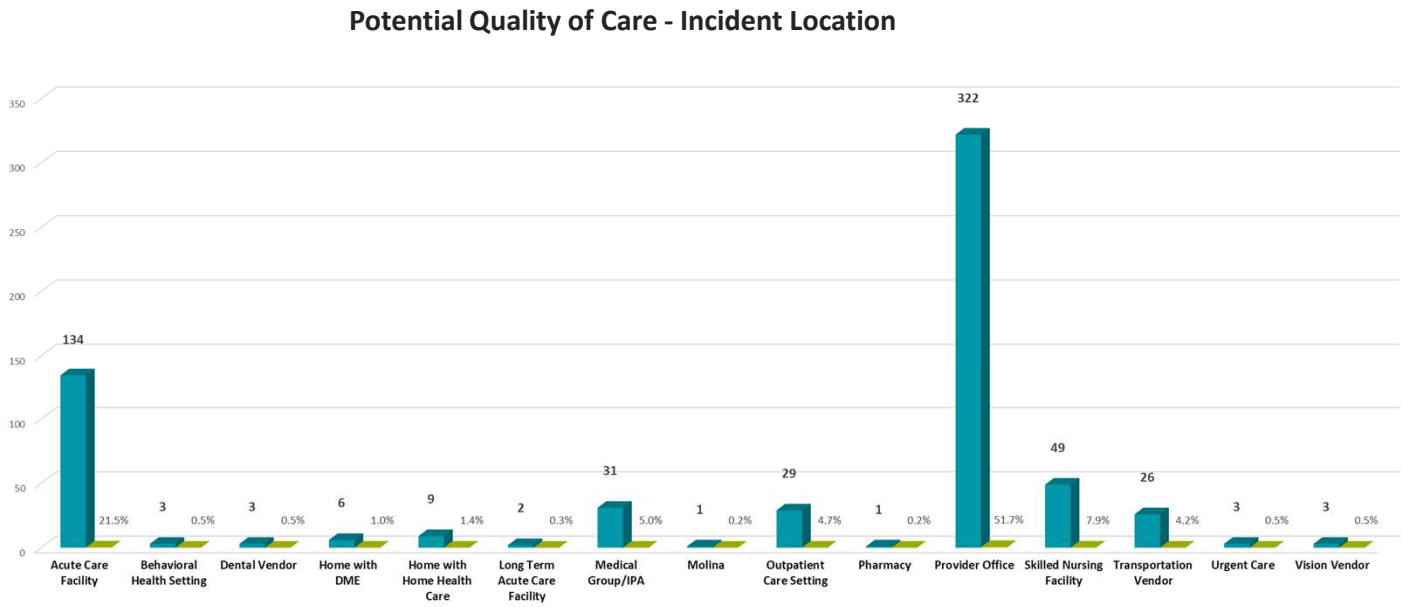
Potential Quality of Care Cases - Molina Healthcare of California: Q1 2025 - Q4 2025



The table captures the PQOC **categories** with related percentage of total cases that were accepted between Q1-Q4 2025.

MOLINA HEALTHCARE

Potential Quality of Care Cases - Molina Healthcare of California: Q1 2025 - Q4 2025



PQOC's are categorized by **location** with related percentage of total cases accepted between Q1-Q4 2025.

MOLINA HEALTHCARE

Potential Quality of Care Cases - Molina Healthcare of California: Q1 2025 - Q4 2025

Provider Ongoing Monitoring of Member Complaints

- Provider trends are measured on a semi-annual basis following quarters two and four of the calendar year. The threshold is defined as three or more complaints leveled at 2, 3, or 4 within the six-month, semi-annual timeframe. Providers who meet the threshold are referred to PRC for review.
- There were **two** providers that met the ongoing monitoring criteria during Q1-Q2 2025 (January 1 - June 30, 2025) and **two** providers who met the ongoing monitoring criteria during Q3-Q4 2025 (July 1 - December 31, 2025) reporting period.

Q1 2025 - Q2 2025			
Providers Referred to PRC	Level 2	Level 3	Level 4
Provider 1	4	0	0
Provider 2	3	0	0

Q3 2025 - Q4 2025			
Providers Referred to PRC	Level 2	Level 3	Level 4
Provider 1	8	1	1
Provider 2	3	0	0

MOLINA HEALTHCARE

Appendix 3

2025 Population Assessment: California

March 2026

Introduction

Molina Healthcare of California (Molina) aims for full integration of physical health, behavioral health, long-term services and supports (LTSS), and social support services to eliminate care fragmentation and provide a single, individualized care plan for our members. To determine the necessary structure and resources for our programs, Molina performs an annual Population Assessment to assess the appropriateness of resources and processes used to address member needs.

Annually, Molina identifies and assesses the following areas in the Population Assessment:

- Population characteristics and social determinants of health (SDOH);
- Needs of children and adolescent members (ages 2-19);
- Needs of individuals with disabilities;
- Serious mental illness (SMI) or serious emotional disturbance (SED);
- Needs of relevant subpopulations.

The Population Assessment informs updates to Molina's Population Health Management (PHM) activities and resources, including community-based resources, to address health care disparities and member needs.

Methodology

Molina's Population Assessment is completed using integrated data from multiple systems that include, but are not limited to, enrollment records, medical and behavioral health records, and encounter data. This review of data assists Molina in identifying and addressing the needs of our member population and guiding our Population Health Management (PHM) strategies and initiatives. The Population Assessment includes an evaluation of membership, member service and community needs, as well as demographic factors such as race, ethnicity, preferred language, and an evaluation of the prevalence of conditions specific to the populations we serve.

Additionally, Molina uses this data to identify at-risk members who may benefit from care management through an analysis of this integrated data. The data includes, but is not limited to, claims and encounter data, health assessments, clinical data, discharge and referral data, government and predictive modeling data, community and demographic data, and member and caregiver input.

Demographic Analysis: Summary

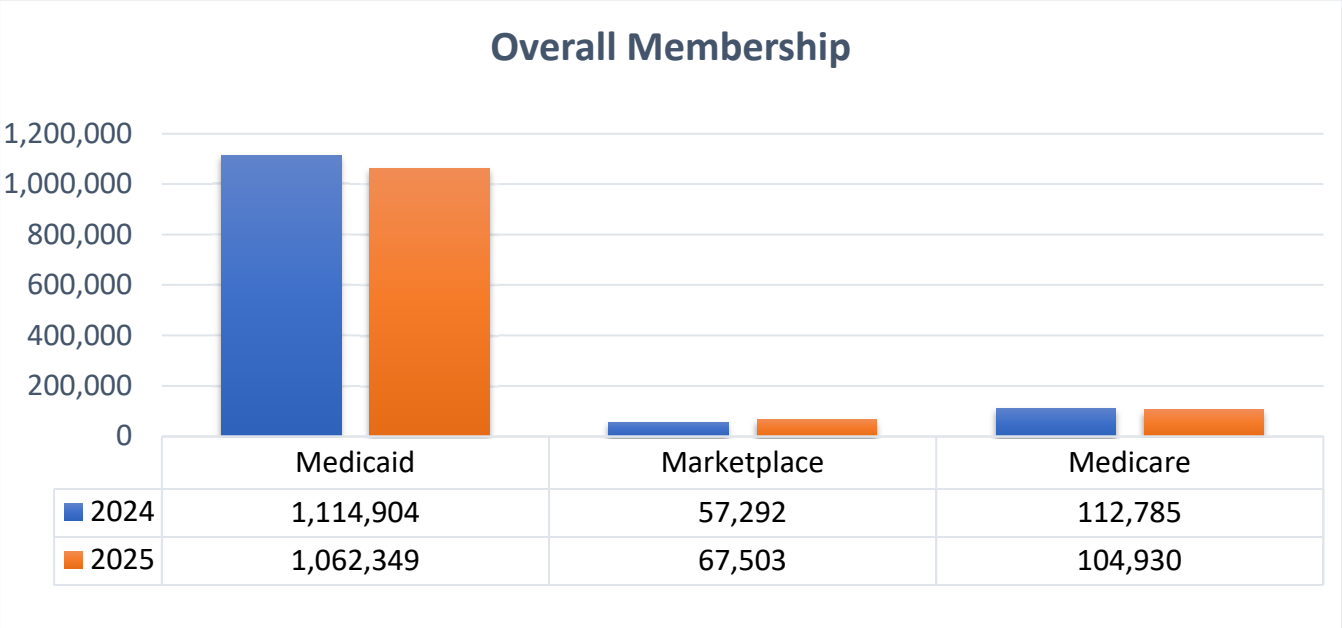
In 2025, Molina Healthcare of California (Molina) membership consisted of the following lines of business: Medicaid, Marketplace, and Medicare.

Demographic Analysis: Molina Overall Membership

In 2025, Molina had a total membership of 1,234,782 members, representing a 3.9% decrease compared to the total membership from the prior year (1,284,981). Most of Molina's members (86.0%) are in the Medicaid line of business, totaling 1,062,349 members, which is a 4.7% decrease compared to the prior year (1,114,904).

Marketplace members comprise 5.5% of the plan's total membership, totaling 67,503 members, which is a 17.8% increase compared to the prior year (57,292). Medicare members make up 8.5% of the plan's membership, totaling 104,930 members, which is a 7.0% decrease compared to the prior year (112,785).

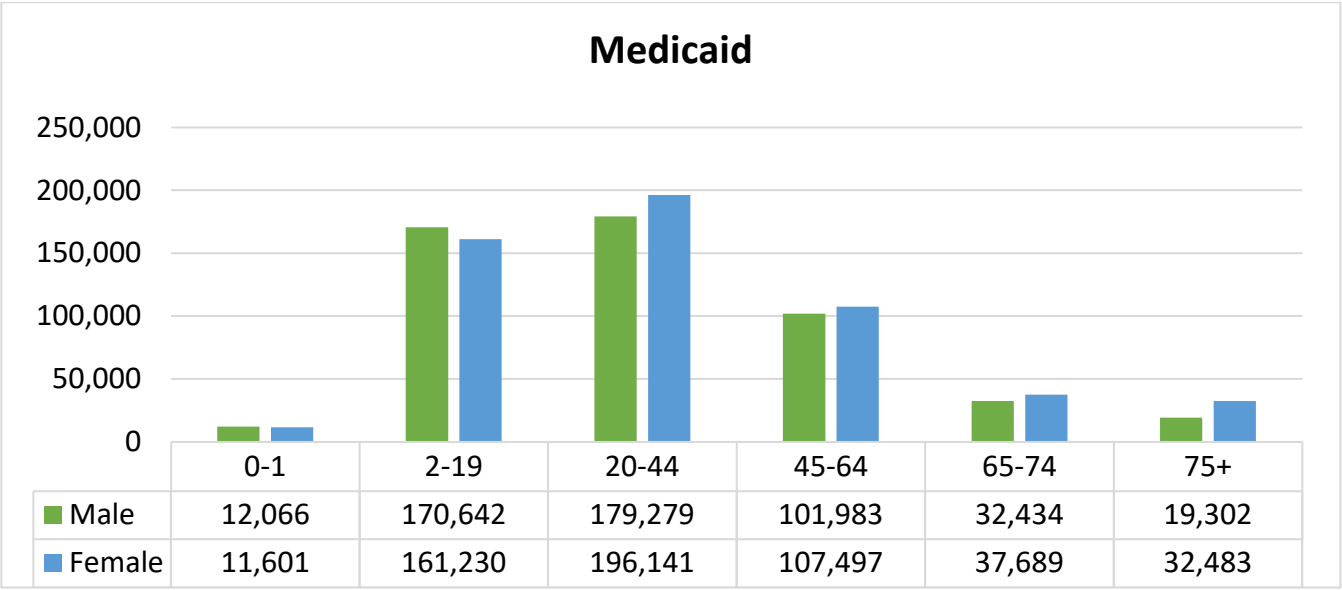
This analysis highlights the shifts in membership distribution across different lines of business, emphasizing changes in enrollment patterns among Molina's Medicaid, Marketplace, and Medicare plans over the past year.



	Medicaid	Marketplace	Medicare
2024	1,114,904	57,292	112,785
2025	1,062,349	67,503	104,930

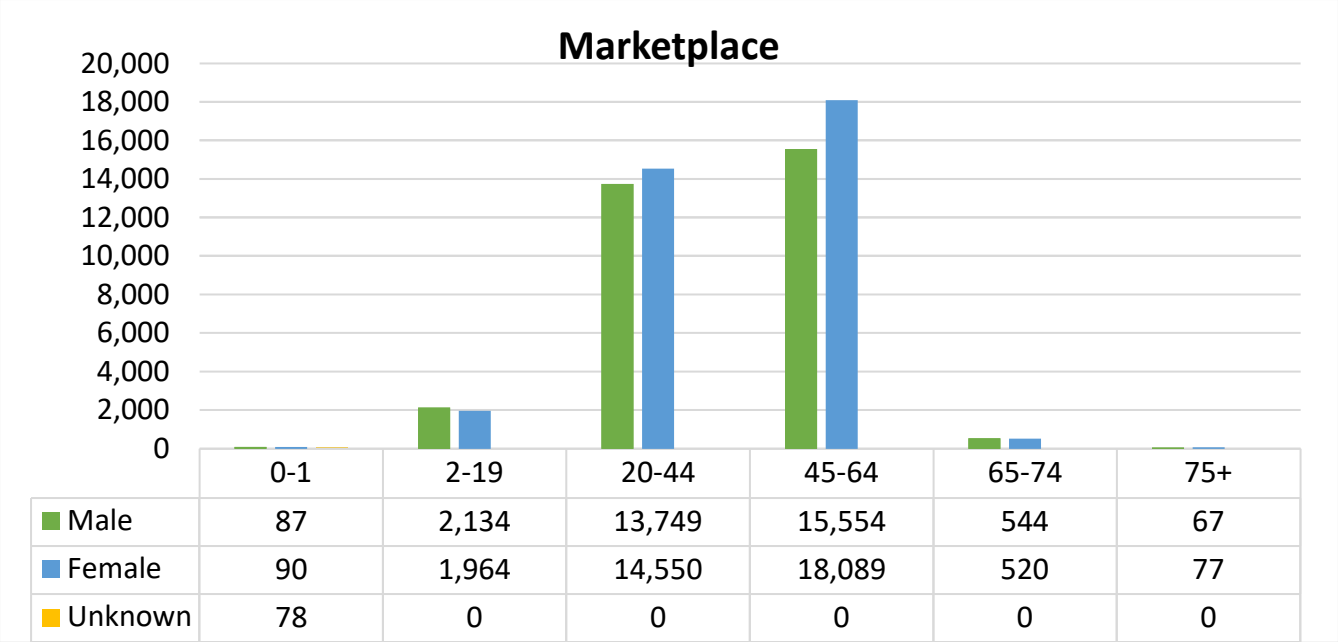
Demographic Analysis: Molina Member Gender and Age

Molina of California's Medicaid member composition is 52.8% female and 47.2% male. Members aged 20-44 years and older represent 35.3% of the membership, which consists of 52.3% female and 47.8% male members. All ages groups except for 0-1 and 2-19 have a higher proportion of females to males.



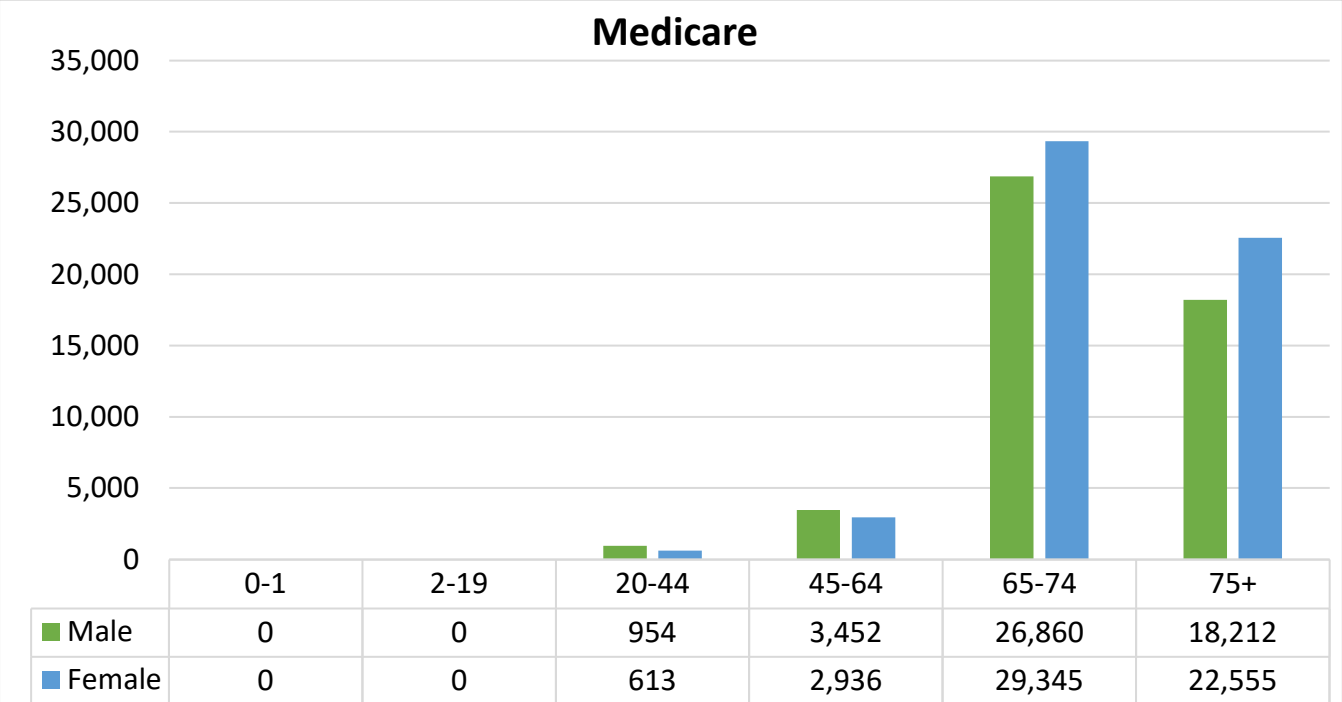
	0-1	2-19	20-44	45-64	65-74	75+
Male	12,066	170,642	179,279	101,983	32,434	19,302
Female	11,601	161,230	196,141	107,497	37,689	32,483

Molina's Marketplace member composition is 52.3% female, 47.6% male, and 0.1% unknown. Members 45-64 years of age represent 49.8% of the population, with a gender composition of 53.8% female and 46.2% male. All age groups, except for 2-19 and 65-74 have a higher proportion of females to males.



	0-1	2-19	20-44	45-64	65-74	75+
Male	87	2,134	13,749	15,554	544	67
Female	90	1,964	14,550	18,089	520	77
Unknown	78	0	0	0	0	0

Molina's Medicare population is generally older, with 92.4% of members being 65+ years of age. The Medicare membership has a larger proportion of female members, comprising 52.8%, compared to male members, who make up 47.2%. Members 65-74 years of age represent 53.6% of the membership. All age groups, 20-44 and 45-64 have a higher proportion of females compared to males.



	0-1	2-19	20-44	45-64	65-74	75+
Male	0	0	954	3,452	26,860	18,212
Female	0	0	613	2,936	29,345	22,555

This demographic analysis highlights the age and gender composition within Molina's various lines of business, underscoring differences in member characteristics across Medicaid, Marketplace, and Medicare plans.

Social Determinants of Health (SDOH)

Molina assesses the characteristics and needs of its member population to ensure the appropriate structure and resources are in place for its Population Health Management (PHM) program. This assessment focuses on key social determinants of health: housing and financial insecurity. By evaluating these determinants, Molina identifies the specific factors influencing member health and well-being, continually guiding the development of tailored strategies and interventions that address identified needs and improve care delivery. Key findings include:

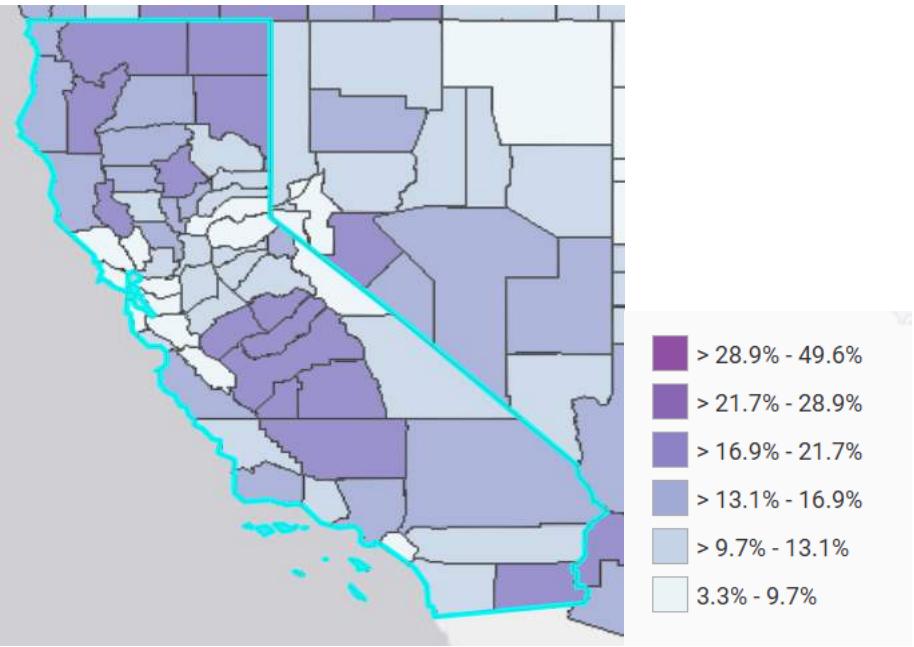
Housing Insecurity: In 2025, Molina members experiencing housing insecurity were identified in California using Optum's Impact Pro SDOH: Housing Insecurity identifier, which predicts members' likelihood to experience housing insecurity. In California's Medicaid population, 12.0% of members were identified as having very high housing insecurity and 35.7% with high housing insecurity. Of the Medicaid members, Los Angeles county had the highest number of members experiencing housing insecurity, with 53.5% identified with very high or high housing insecurity.

In the Marketplace population, 5.8% of members were identified as having very high housing insecurity and 33.0% with high housing insecurity. San Diego county had the highest number of Marketplace members experiencing housing insecurity, with 58.8% identified with very high or high housing insecurity.

In the Medicare population, 8.2% of members were identified with very high housing insecurity and 28.1% with high housing insecurity. Following the Marketplace lines of business, San Diego county also had the highest number of Medicare members experiencing housing insecurity, with 31.7% identified with very high or high housing insecurity.

Financial Insecurity: According to the Census Bureau, poverty is determined by comparing household income levels to established poverty thresholds, with households earning at or below 100% of these thresholds considered "in poverty."

California's counties with the highest poverty rate from the U.S. Census Bureau are Trinity (20.8%), Modoc (20.1%), Butte (19.9%), Kern (19.0%), Merced (18.6%), Madera (18.0%), Fresno (17.7%), Lake (17.6%), Kings (17.5%), Tulare (17.5%), Imperial (17.3%), Mariposa (17.3%), Lassen (17.1%), and Siskiyou (17.1%).



In 2025, Molina members experiencing financial insecurity were identified in California using Optum's Impact Pro SDOH: Financial Insecurity identified, which predicts members' likelihood to experience overwhelming stress of making ends meet, affecting one's health.

In California's Medicaid population, 36.3% of members were identified as having very high financial insecurity and 22% with high financial insecurity. Of the Medicaid members, Los Angeles county had the highest number of members experiencing financial insecurity, with 65.1% identified with very high or high financial insecurity.

In the Marketplace population, 27.0% of members were identified as having very high financial insecurity and 30.3% with high financial insecurity. Of the Marketplace members, San Diego county had the highest number of Marketplace members experiencing financial insecurity, with 79.3% identified with very high or high financial insecurity.

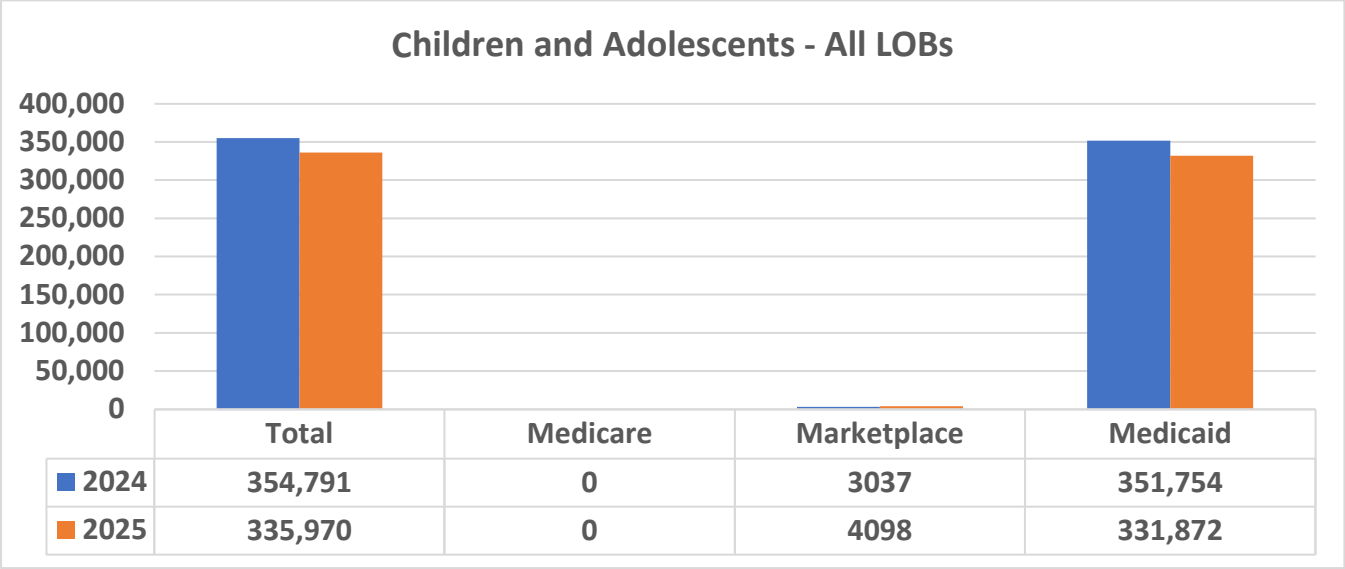
In the Medicare population, 13.1% of members were identified with very high financial insecurity and 22.2% with high financial insecurity. Of the Medicare members, San Diego county had the highest number of Medicare members experiencing financial insecurity, with 31.3% identified with very high or high financial insecurity.

Needs of Children and Adolescents (Ages 2-19)

Molina annually assesses the needs of its children and adolescent members aged 2–19 years as part of its comprehensive approach to Population Health Management. Key findings include:

Demographic Analysis, Children and Adolescents (Ages 2-19): Membership

The demographic analysis of children and adolescents (ages 2-19) within Molina's membership shows that in 2025, 331,872 children or adolescents were enrolled in the Medicaid line of business, 4,098 were enrolled in the Marketplace line of business, and zero were enrolled in the Medicare line of business. In contrast, in 2024, there were 351,754 children and adolescent members enrolled in the Medicaid line of business, and 3,037 children and adolescents enrolled in the Marketplace line of business.

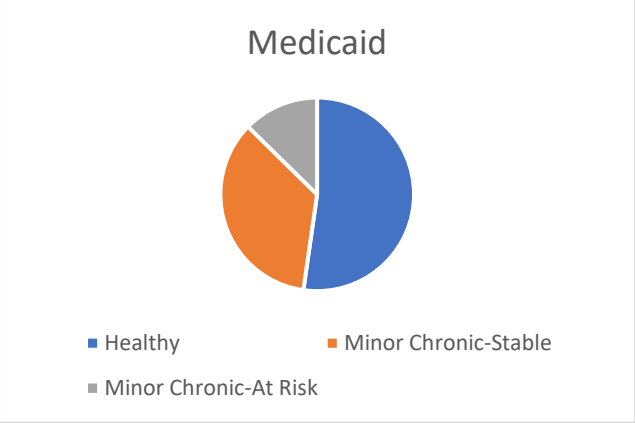


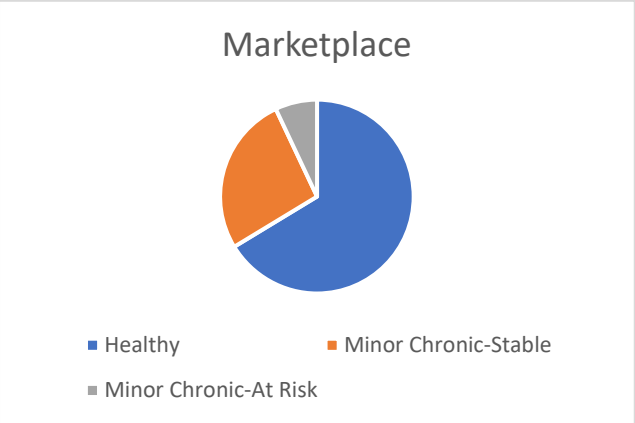
	Total	Medicare	Marketplace	Medicaid
2024	354,791	0	3037	351,754
2025	335,970	0	4098	331,872

Needs of Children and Adolescents (Ages 2-19): Top Three Population Health Categories

The analysis of the top three population health categories for children and adolescents (ages 2-19) within Molina's Medicaid membership revealed that in 2025, 37.9% of children or adolescents were identified by Optum's Impact Pro as "Healthy" (no chronic conditions or IP/ED use in the last 12 months or no clinically important gaps in care), 25.4% were identified as "Minor Chronic – Stable" (one or more chronic conditions of limited severity and/or comorbidities) and 9.2% were identified as "Minor Chronic – At Risk."

The analysis of the top three population health categories for children and adolescents (ages 2-19) within Molina's Marketplace membership revealed that in 2025, 45.5% of children or adolescents were identified by Optum's Impact Pro as "Healthy" (no chronic conditions or IP/ED use in the last 12 months or no clinically important gaps in care), 18.3% were identified as "Minor Chronic – Stable" (one or more chronic conditions of limited severity and/or comorbidities) and 4.8% were identified as "Minor Chronic – At Risk."





Needs of Children and Adolescents (Ages 2-19): Top Three Primary Risk Categories

The analysis of the top three primary risk categories for children and adolescents (ages 2-19) within Molina's membership were identified by Optum's Impact Pro. This predictive modeling tool defines Primary Risk Category as the risk marker category associated with the highest percentage of total predicted costs for a member based on Care Management models.

For the Medicaid population, 4.6% of children or adolescents had a primary risk category of infectious disease, 3.9% had a primary risk category of obesity, and 3.0% had a primary risk category of autism/developmental disorders in 2025.

For the Marketplace population, 4.3% had a primary risk category of infectious disease, 2.5% had a primary risk category of acute respiratory, and 2.4% had a primary risk category of obesity.

Needs of Members with Disabilities

Molina evaluates the needs of members with disabilities, focusing on those with acute needs for care coordination. Key findings include:

Demographic Analysis, Members with Disabilities: ABD

In 2025, Molina had a total of 172,526 members enrolled in Aged, Blind, and Disabled (ABD) products, representing 14.0% of the total membership and 16.2% of the Medicaid membership.

Age Distribution: The age distribution of members with disabilities indicates that the largest group is those aged 65-74, accounting for 38.9% of the total membership (67,043 members). Other age groups include 75+ at 30.0% (51,730 members), 45-64 at 16.1% (27,841 members), 20-44 at 9.8% (16,938 members), 2-19 at 5.1% (8,873 members), and 0-1 at 0.06% (99 members).

Gender Distribution: Among the members with disabilities, 52.6% are female and 47.4% are male, highlighting a slightly higher representation of females within this group.

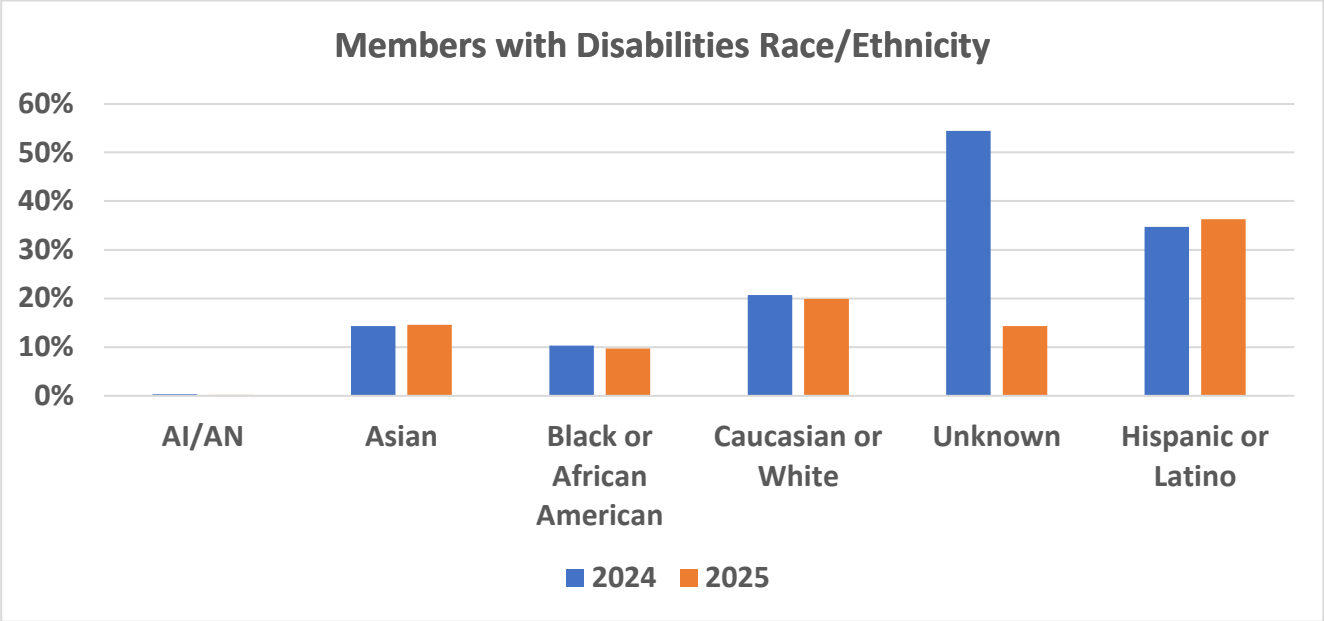
Race/Ethnicity Distribution: The racial and ethnic composition shows that 19.9% of the members are Caucasian/White, followed by 14.6% as Asian, and 9.7% as Black or African American. Over 14% of the population have “unknown” reported as their race/ethnicity. Over 36% of the ABD population reports being Hispanic or Latino.

Year Over Year Demographic Trends, Members with Disabilities: Race and Ethnicity

The year-over-year analysis of Molina membership trends for individuals with disabilities enrolled in ABD Products shows an increase. In 2024, the total membership increased by 56.2% compared to the previous year, changing from 102,642 members in 2023 to 160,336 members in 2024, indicating an increase of 57,694 members.

The racial and ethnic distribution of members with disabilities remained consistent between 2024 and 2025, except for the “unknown” category. In 2024, most members’ race was listed as Unknown, making up 54.4%, but this decreased dramatically to 14.3% in 2025. Caucasian or White members represented 20.7% in 2024 and decreased to 19.9%. Asian members represented 14.3% in 2024 and increased slightly to 14.6% in 2025. Hispanic or Latino members represented 34.7% in 2024 and increased to 36.32% in 2025.

This demographic trend highlights a significant increase in membership for individuals with disabilities over the past year, with the racial and ethnic composition showing minor shifts. The data underscores the continued predominance of Caucasian/White and Asian members within this population group.

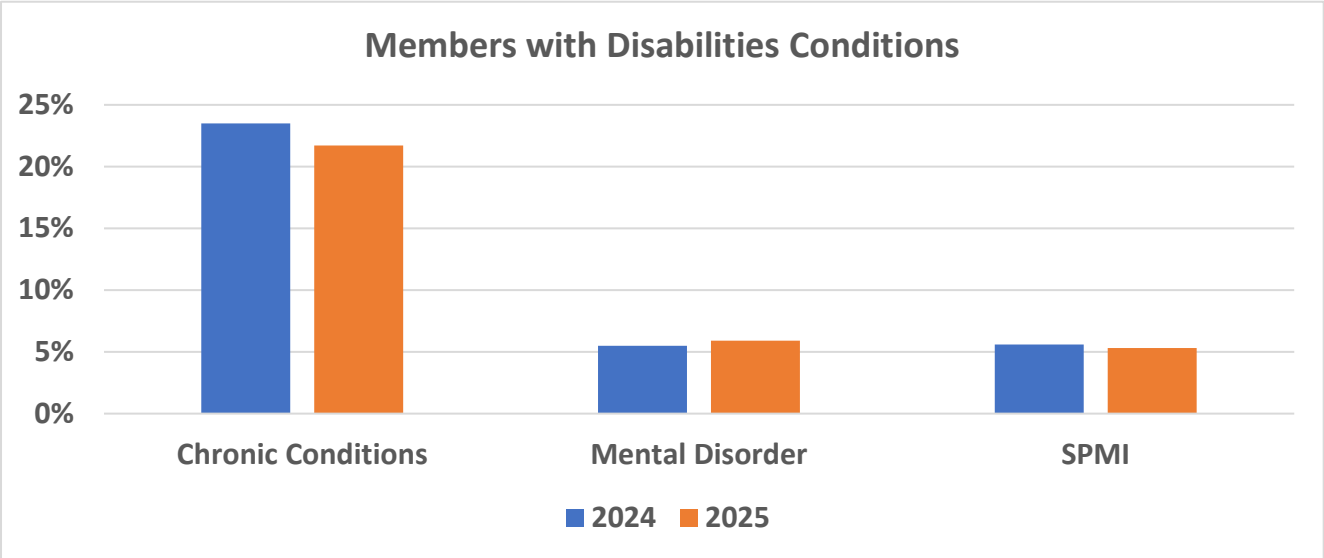


Condition Category-Specific Analysis, Members with Disabilities

In 2025, the top three condition category counts among Molina members with disabilities were Chronic Conditions (including Asthma, COPD, HTN, Diabetes, Heart Failure, and Cancer), followed by SPMI and Mental Disorder.

- Chronic Conditions: Member Count = 56,637 (21.7%)
- Mental Disorder: Member Count = 15,487 (5.9%)
- SPMI: Member Count = 13,970 (5.3%)

In 2024, the top three condition category counts among Molina members with disabilities included Chronic Condition (23.6%), Mental Disorder (5.6%), and SPMI (5.6%). This year-over-year comparison highlights trends in health conditions affecting individuals with disabilities.



Needs of Members with Serious Mental Illness (SMI) or Serious Emotional Disturbances (SED)

Molina annually assesses the needs of its members with Serious Mental Illness (SMI) or Serious Emotional Disturbances (SED) as part of its comprehensive approach to Population Health Management. Key findings include:

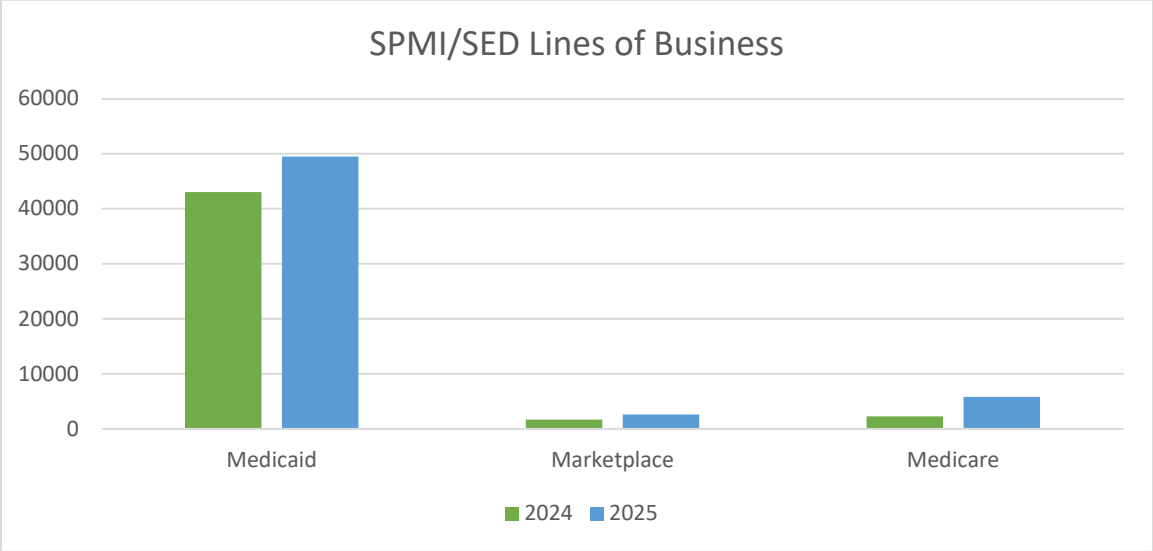
Demographic Analysis, with Serious Mental Illness (SMI) or Serious Emotional Disturbances (SED)

In 2025, Molina had a total of 57,930 members with serious mental illness (SMI) or serious emotional disturbances (SED) enrolled across the Medicaid, Marketplace, and Medicare lines of business. The distribution of members with SMI or SED by line of business is as follows:

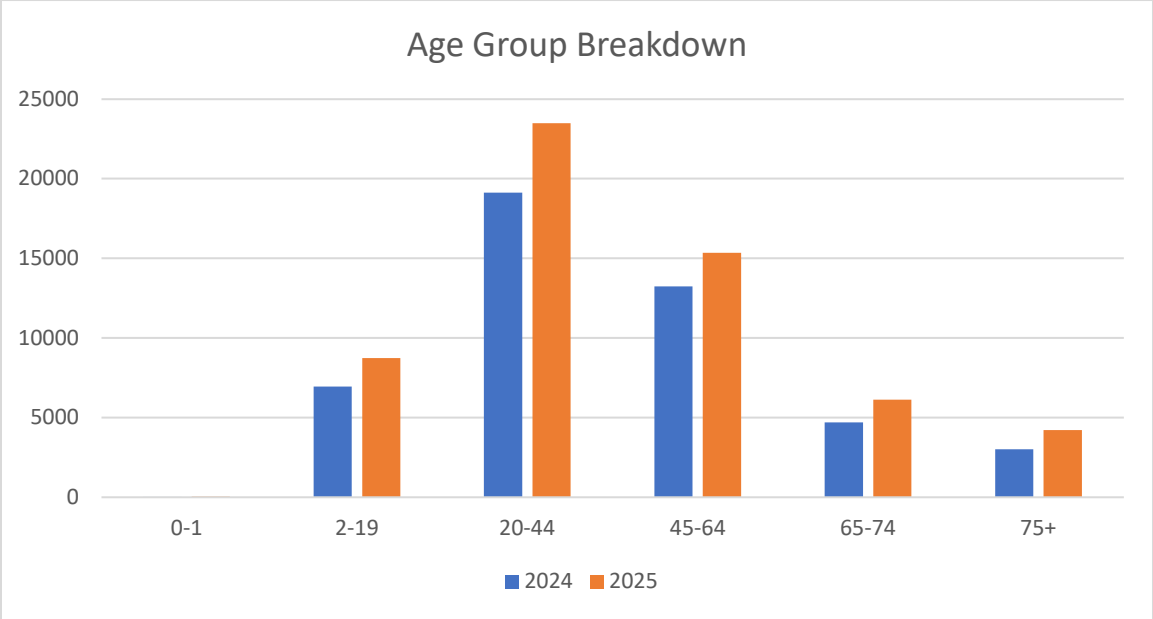
- Medicaid: 49,486 members
- Marketplace: 2,623 members
- Medicare: 5,821 members

The analysis of Molina's membership with SMI or SED shows that most of these members are enrolled in the Medicaid line of business, accounting for 85.4% of the total.

Year-over-year changes indicate that the number of Medicaid members with SMI or SED has increased by 6,468 members compared to the previous year. The number of Marketplace members with SMI or SED increased by 923, and the number of Medicare members increased by 3,557.



The largest age group among all members with SMI or SED is those aged 20-44, highlighting a significant concentration of individuals within this age range. This demographic trend emphasizes the varying distribution of SMI or SED prevalence across different lines of business and age groups within Molina's membership.

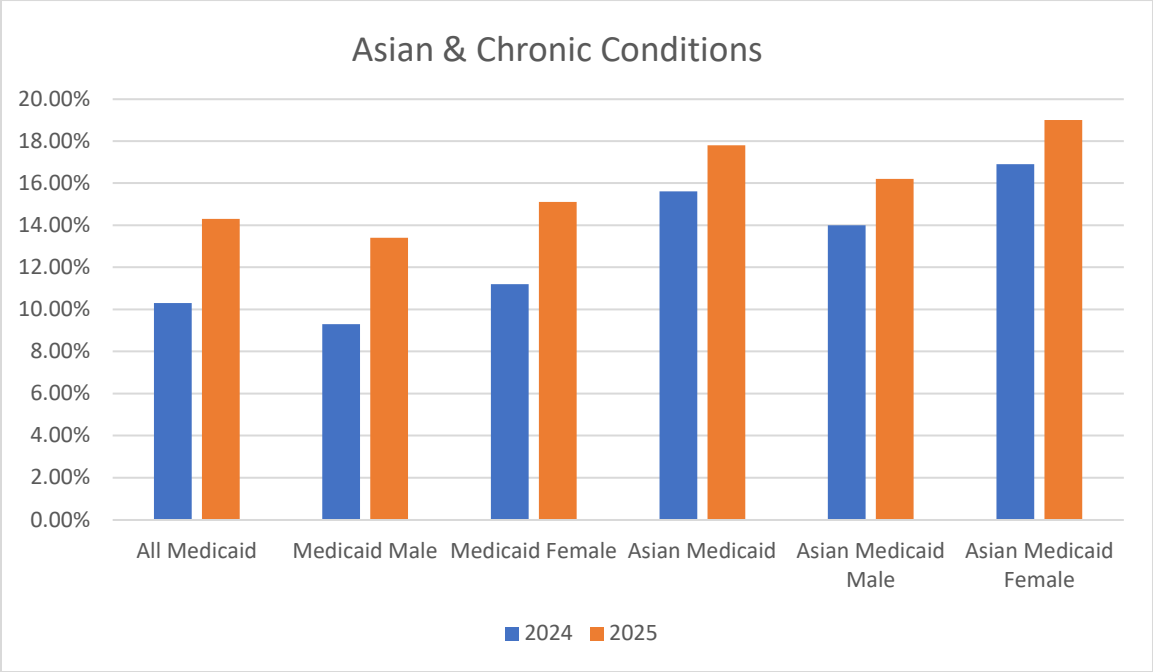


Needs of Relevant Member Subpopulations

Molina members are diverse with varying needs addressed through our population health programs. Specifically, many of our Molina Medicaid members struggle with chronic conditions and mental disorders. These identified Molina Medicaid members may also have additional unique needs based on their Race, Ethnicity, and Language. To determine relevant subpopulations, Molina utilized the 'Chronic Condition Dashboard,' which provides a stratified analysis of condition metrics, including chronic conditions and mental disorders within the member population. The assessment examined OMB racial/ethnic categories and identified groups with a higher prevalence of chronic conditions or mental disorders compared to the overall Molina membership. These findings were used to define subpopulations for targeted interventions.

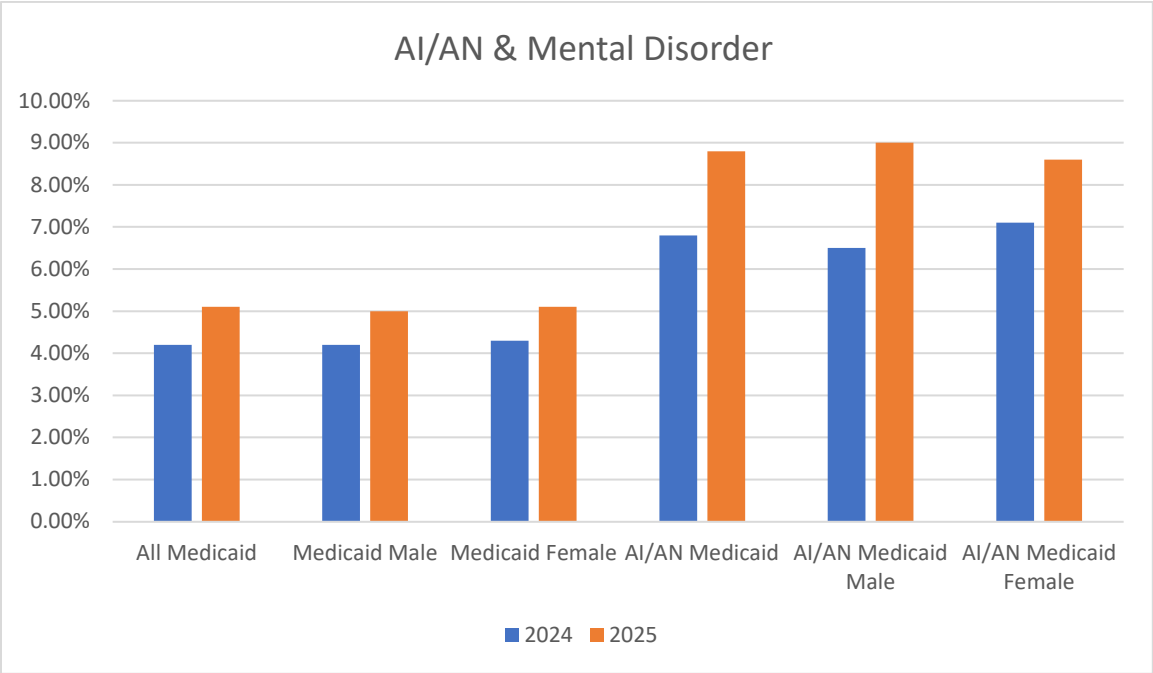
Member Race and Ethnicity Analysis: Asian Population

Compared to the overall California Medicaid population, Medicaid members identified with a chronic condition (including Asthma, COPD, HTN, Diabetes, Heart Failure, and Cancer) have a larger proportion of Asian individuals, with 17.8% members compared to 14.3% overall. The disparity is even larger when comparing the percentage of Medicaid female members to Medicaid Asian females identified with a chronic condition, with a 25.8% increase between non-Asian females and Asian females. This data is consistent with the information for the past two years.



Member Race and Ethnicity Analysis: American Indian/Alaskan Native Population

Compared to the overall California Medicaid population, Molina's Medicaid members identified with a mental disorder have a larger proportion of American Indian/Alaskan Native (AI/AN) individuals, with 8.8% members compared to 5.1% overall. The disparity is even larger when comparing the percentage of Medicaid male members to Medicaid AI/AN males identified with a mental disorder, with a 80% increase between non-AI/AN females and AI/AN males. This data is consistent with the information for the past two years.



Population Health Management Activities to Address Member Needs

Molina's Integrated Care Management program incorporates condition specific coaching and motivational interviewing to address physical health, behavioral health needs and other social support services to eliminate fragmentation of care. This integration is achieved by implementing a member-directed and individualized plan of care that is shared amongst all providers active in a member's care. These targeted interventions consider the member's age, linguistic, and education needs and preferences. The interventions are also aimed at assisting members with navigating care, understanding treatment options, potential interventions, assisting members with self-management and avoiding adverse health outcomes.

Molina conducts extensive research of current literature to identify the factors that increase the likelihood of hospitalization, costly medical expenses, or poor health outcomes for members. Based on the information, Molina updates the criteria for its care management programs as needed. To ensure that programs and resources are sufficient to address identified needs, Molina's Program Descriptions and Work Plan evaluations are reviewed during National committees with representation from applicable stakeholders.

Population Health Management Programs, Activities, and Community Resources Review

Molina regularly evaluates the adequacy of our programs/activities addressing member needs, such as care coordination, health management, and culturally appropriate services. Molina also actively connects its members to relevant community resources and promotes community programs that align with their needs. This integration of community resources demonstrates Molina's commitment to actively and appropriately responding to the needs of its members. By aligning these resources with the specific needs identified during the Population Assessments, Molina ensures that its members receive the most relevant support and services. The strategic connection between community resources and member needs allows Molina to address various SDOH needs, enhancing overall well-being and access to care. This review identifies gaps and ensures that services meet the diverse health needs of California's members effectively.

Program and Activity	Barrier/Need being Addressed by Program	Populations of Focus (members with specific diagnoses, SPMI, Children between 2 and 19, members with disabilities, all ages/groups)	Opportunity for Improvement (gaps or needs being addressed)	Date Initiated
Molina on the Move: RV, Drop Trailer and One Stop Help Centers- community efforts. Partnerships with	Access to care Community support/resources SDOH	All members	-Opportunity: continue to expand the Molina One-Stop events and bringing preventive services to	Q1 2023- ongoing

shelters, transitional housing, and street outreach teams.	Member Satisfaction		members by taking our model and mirroring with partnered CBOs. -Expand mobile to include mobile mammography -Opportunity to leverage school sites	
WeConnect: A contingency management, reward-based app to support recovery from SUD and various BH conditions. WeConnect offers Peer Recovery Support Specialists and Online Support Meetings. WeConnect is a first level support platform for members experiencing substance use disorders. Since substance use disorder carries cultural stigma, these apps provide private support without shame or judgement including access to peer support specialists. They are inclusive programs serving diverse backgrounds. There is customized support tailored to diverse backgrounds and lived experiences and language access is available. These vendors fit into our health equity plan by helping members	Requires a provider referral indicating that it is part of the member's treatment. Provider cannot be someone who works at Molina and can be anyone on the member's care team. It requires us to engage with providers, for providers to conduct the screening, and then to refer members to WeConnect. Molina members are often referred by primary care to county treatment which is not disclosed to the plan as treatment information is protected under 42 CFR Part II. Molina seeks innovative ways to improve overall mental wellbeing and health for this at-risk population.	Members with specific diagnosis (Substance Use Disorder) Serious and Persistent Mental Illness- Medicaid	Opportunity: Work with vendor to have more boots on the ground outreach to providers and in community settings. Train CHW providers on this application with an LA County focus.	Ongoing

reach their optimal health, regardless of where they are. *PCR: (plan all-cause readmission) WeConnect members had 25 qualified HEDIS events of a member discharge from a hospital stay with 0 re-admits within 30-ays.				
Same Sky Health: Member engagement/texting vendor focusing on closing SDOH gaps in order to empower members to complete AWV. SDOH: Members are either referred to Case Management or the Molina Help Finder tool for support Once SDOH need is addressed members are prompted to complete AWV.	Under DHCS (CA Medicaid regulator) PHM strategy, all members must be assessed, and risk stratified. Vendor is assisting complete SDOH screeners for members in populations with high SVI. Increase annual wellness visits	Black women of childbearing age- Medicaid Members with no AWV in zip codes with high concentration of LGBTQIA community Members in zip codes with high SVI	Barriers in ingesting vendor files Barriers in vendor reporting Opportunities to expand membership High unable to contact or inaccurate Member contact information rate, resulting in low contact rates.	2019- ongoing

Reach Out: Mamas y Bebes (Molina CARES Accord). Grant used to fund parenting classes for expecting and new moms, class curriculum includes both parenting tips as well as how to recognize and address postpartum behavioral health issues such as postpartum depression and postpartum anxiety.	Low prenatal, postpartum and well child rates in the Hispanic/Latino population in Inland Empire	Maternal and early Childhood health	Opportunity to expand funding to other communities of focus and regions Opportunity: increase referrals both internally and externally	7/19/2021- ongoing (Grant funding was from 7/19/21- July 2023, however we continue to partner with Reach Out and refer members into their various programs.)
Member Advisory Committee (now called the Community Advisory Committee): MHC has added a mental wellness segment to each meeting. Techniques include get moving, positive affirmations, dance, breathing techniques, music.	Mental health and wellness Stress relief Member satisfaction	All ages/groups	N/A (already expanded to every county. 3rd year of program)	Q1 2022- ongoing
Healthcare in Action: Mobile unit/Street team.	Engaging our homeless population in preventive care Member location Annual wellness visits, routine preventive care SDOH/community resources	Serious and Persistent Mental Illness- Medicaid Members experiencing homelessness	Opportunity to expand to other counties/lines of business Molina provided funding and we signed a PCP contract with them. Only for Medi-Cal and in Los Angeles and San Diego because that is where HIA has teams available.	Ongoing

	Goal: members will only be temporarily assigned to HIA before transitioning back to traditional care setting			
Blood Lead Program: outreach/CM for elevated levels	Collaboration with the local county and public health dept. Identify children with elevated blood lead levels. Conduct outreach, education, and care plans. Coordination of care.	Child members with specific diagnosis	Data gaps. BLL not getting reported to parent/guardians We have continued to partner with the local county public health depts to leverage their BL trainings programs to highlight the important within our communities. Trainings are given both internally and to our provider partners and their staff.	
Doula Program: Building Doula network and offering provider incentives for joining the network. For members, we are connecting members to service, educating on doula services, and educating CBOs on doula services and how to refer to increase utilization. We are sending a provider partner a roster of black identifying perinatal	Poor birth outcomes Low prenatal/postpartum rates	All perinatal members	Expansion of doula network with a higher need in larger counties. Doulas have difficulty following Health Plan billing guidance. As a result we have launched Technical Assistance workshops for doulas to do hands on training with them for billing.	Q1 2024 and ongoing

members for the doula benefit.			Continue to monitor claims for billing issues.	
"Digital Health Maternal Engagement PlaAorm with Doula Support Services"	Poor birth outcomes Low prenatal/postpartum rates	Member with specific diagnosis Pregnant and postpartum members, disparities	To improve maternal birth outcomes, particularly Black maternal outcomes, Mae combines a digital health engagement platform with local in-person doula support, maternal health support and resources and education.	Medicaid launched: December 2025 and ongoing Marketplace launched: April 2025 and ongoing
Ouma **Generic name to use for public "Remote maternal/fetal medicine network of Care"**	Poor birth outcomes Low prenatal/postpartum rates Pre and postpartum members with SUD	Member with specific diagnosis Pregnant and postpartum members, disparities , members in rural areas (vast geography)	Comprehensive maternity benefit program giving members on-demand 24/7/365 access to care coordination and advocacy with telehealth access to maternal-fetal medicine OBGYN specialists, seasoned with perinatal navigators, lactations consultants and behavioral health specialists.	Launched May 2024 and ongoing
Transition of Care	Lack of knowledge by members about how to appropriately maintain care after transition. Lack of communication across settings of care to determine actions.	All ages/groups SPMI – with BH transition of care programs	Program needs additional resources for expansion. The MHI team would be able to speak to SPMI for Marketplace and Medicare. Specifically, you can	1/2024 - Current

		Children between 2 and 19 Members with Disabilities	reach out to Letarsha Pittman Children between 2-19 – we expanded the team for Transitions of Care so that we could outreach to all children who discharged from a hospital. We also worked on Admission Discharge and Transfer contract with Health Information Exchanges so that we could get data on when members were admitted, discharged, or transferred for timely transitions of care with the members. This was a requirement for our Medi-Cal population. We utilized ToC coaches and Case Managers to reach out to members within 3 business days of notification of the discharge. They provided care coordination and assessed the member for any further needs. For members with disabilities, same principle was applied. For more complex cases, a Complex	

			Case Manager was assigned. In instances where a member was already engaged in CM, CCM, or ECM, the member gets assigned to the same case manager for continuity.	
Health Management	Lack of knowledge by members on how to manage chronic conditions and key preventive health issues	All ages/groups for depression, COPD, heart disease, smoking cessation, diabetes,	Program outreach was increased in 2025 and we will continue to work on increasing enrollment.	1/2024 - Current
Care Management	Addressing key needs of members during specific periods of time	All ages/groups based on specific conditions or situations	Program needs to have increased participation	1/2024 - Current
Models of Care	Need consistent approach to improve health care of members with specific conditions	SPMI, BH, Substance Abuse, ESRD		1/2024 - Current
Community Baby Showers	In an effort to ensure that our pregnant members understand all the benefits that they are eligible for and connect them to available free resource, we conducted community baby showers in 2024 and into 2025	All perinatal people in the community.	This was for both Marketplace and Medi-Cal LOB Goal was to connect the members to a doula. In December, 2025 we started to see a decline in attendance due to the political environment. We will continue to monitor and provide other methods for people to attend these baby showers.	Ongoing

Alternative Access Points to Care: Bringing services to Members to meet them where they're at.	Members that cannot accommodate a traditional office visit appointment due to work schedules, childcare, etc. Care Connections: sees members in their homes for: prenatal, Postpartum, Well child, BH follow ups, diabetes and hypertension management, blood lead testing, fluoride application Ouma: remote maternal fetal medicine provider group Mae: doula network with maternal health platform/app Sprinter Health: in home labs for diabetes, hypertension, fluoride application DocGo: in-home visits and at our Molina One Step Centers and partnered CBOs: well child, diabetes, hypertension, child immunizations, fluoride application, colorectal cancer kits Let's Get Checked and Cologuard: testing kits mailed to members' homes for colorectal cancer screening and diabetes labs	All members with a gap in preventive care	Opportunity to ensure that after an "alternative" appointment, members are connected back to their assigned PCP.	Has been expanding since Care Connections started doing Postpartum Moms visits in CA in 2014

Member Incentives: encourages members to complete their preventive care Incentives vary across line of business. Vendors vary across line of business. Measures incentivized vary across LOB.	Member Satisfaction Gaps in Care Completion	Members with specific HEDIS gaps in care	High unable to contact or inaccurate Member contact information rate, resulting in low contact rates and low incentive fulfillment rates	2019-ongoing
Achieving Equity in Primary Care (grant program) Grant funding offered to select Provider practices.	Funds are to be used to bring more services into primary care so that members do not need multiple visits to complete their preventive care. For example: funding point of care testing, pap smears in the PCP office, weekend/after hour services, community health workers, mammogram events	Highly engaged network Provider practices	Continue to expand to cover more of the network	Q4 2021- ongoing

Summary

The diverse needs and characteristics of Molina's membership emphasize the need for continued analysis and targeted, data-driven interventions. Molina is committed to refining its approach, leveraging insights to enhance care strategies and address the evolving needs of our members. Our goal is to improve health outcomes, promote equitable access to care, and ensure that each member receives the necessary support and resources to achieve their best health. Our current programs are designed to meet the needs of our members.

Molina Healthcare of California's (Molina) annual Population Assessment assists Molina in stratifying its entire population and the development of appropriate targeted interventions to address the needs of each of the subsets. Molina will review the analysis to identify additional needs of our members, including any potential opportunities to improve our existing programs.

Next steps:

- Molina will continue to collect data on and assess member characteristics and needs and adjust resources provided to members as needed.
- Molina will continue to implement population health management initiatives and provide needed resources to staff and providers.
- Molina will continue to revamp and produce new cultural competency training resources for staff and providers. This summary highlights the diverse needs and characteristics of Molina's membership, guiding the development of targeted interventions and tailored care strategies to effectively serve its members.

The diverse needs and characteristics of Molina's membership emphasize the need for continued analysis and targeted, data-driven interventions. Molina is committed to refining its approach, leveraging insights to enhance care strategies and address the evolving needs of our members. Our goal is to improve health outcomes, promote equitable access to care, and ensure that each member receives the necessary support and resources to achieve their best health.

Appendix 4

2025 Measuring Effectiveness of the Population Health Strategy

Molina Healthcare of California

Introduction

Molina Healthcare's Population Health Management (PHM) Strategy evaluation is a critical component in assessing the effectiveness and impact of its PHM programs. This evaluation employs a comprehensive and systematic methodology designed to measure key performance indicators relevant to the target Medicaid and Marketplace populations served by Molina Healthcare of California.

In 2025, Molina Healthcare of California implemented a series of PHM programs and initiatives aimed at enhancing member health outcomes through targeted interventions. These programs concentrated on several key areas, including prevention and health education, managing members with emerging risks, ensuring patient safety across multiple settings, and supporting members with multiple chronic conditions. Health and wellness activities were central to these efforts, addressing crucial topics such as annual health exams, well-child and adolescent care, and prenatal and postpartum care.

Purpose

The primary goal of Molina Healthcare of California's Population Health Management (PHM) Strategy evaluation is to assess the effectiveness of its PHM programs and overall strategy. This evaluation is conducted using a robust methodology that focuses on key measures pertinent to the target population served by Molina Healthcare of California.

As part of this evaluation, Molina Healthcare of California consistently monitors a minimum of four measures annually, encompassing clinical, utilization, and experience metrics. The evaluation employs a valid and reliable methodology to ensure the accuracy and credibility of the results, utilizing rigorous and standardized approaches to data collection, analysis, and interpretation.

The measures selected for evaluation are closely aligned with the strategic goals outlined in the PHM Strategy, reflecting the impact and success of specific focus areas, activities, and programs. Insights gathered from this process contribute to continuous improvement efforts, enabling Molina Healthcare of California to refine and optimize its PHM programs and strategy over time. The aim is to achieve positive outcomes for the population served, translating the PHM strategy into improved health, enhanced care coordination, and a positive member experience. Through this systematic evaluation, Molina Healthcare of California aims to demonstrate accountability, inform decision-making, and drive ongoing enhancements in its Population Health Management approach.

MEDICAID

Measure One, Medicaid Clinical: Prenatal and Postpartum (PPC) Timeliness of Prenatal Care and Prenatal and Postpartum (PPC) Postpartum Care

Rationale: The Prenatal and Postpartum (PPC) measure represents the percentage of live births on or between October 8th of the year prior to the measurement year and October 7th of the measurement year. This measure assesses:

- Timeliness of Prenatal Care: The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment.
- Postpartum Care: The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.

Access to timely and adequate prenatal and postpartum care is vital to the health and well-being of mothers and their infants. These visits help identify and address potential risks early, improving maternal outcomes and reducing complications during pregnancy, delivery, and the postpartum period. Prenatal care during the first trimester allows for the detection of various conditions, while postpartum care supports recovery, addresses mental health needs, and helps manage chronic conditions.

Data Source: The Healthcare Effectiveness Data and Information Set (HEDIS©) Rates

Time Period: HEDIS© Calendar Year (CY) 2025 Rates, HEDIS© Measurement Year (MY) 2024 Data

Denominator: The number of Medicaid members who had live births between October 8th of the year prior to the measurement year and October 7th of the measurement year

Numerator: The number of Medicaid members who received a prenatal/postpartum care visit during the required time period

Goal: Increase by two percentage points compared to the prior year (CY2024/MY2023)

Comparative Benchmark: Achieve the 67th national percentile using Quality Compass

Measure	CY2025 (MY2024)	CY2024 (MY2023)	CY2023 (MY2022)	CY2025 Goal (+2) Met?	CY2025 Comparative Benchmark	Comparative Benchmark Met?
Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care	85.64%	82.48%	84.18%	Yes	88.56%	No
Prenatal and Postpartum Care (PPC) – Postpartum Care	85.64%	79.56%	82.00%	Yes	83.94%	Yes

Quantitative Analysis*:* The PPC Timeliness of Prenatal Care rate among Medicaid members for MY2024 was 85.64% compared to the MY2023 rate of 82.48% which was an increase of 3.16 percentage points. This rate increase met the Molina goal of a two-percentage point increase from the previous year and overall, the rate increased by 1.46 percentage points from MY2022 to MY2024; however, the MY2024 rate of 85.64% did not meet the national HEDIS benchmark Medicaid 67th percentile goal.

The PPC Postpartum Care rate among Medicaid members for MY2024 was 85.64% compared to the MY2023 rate of 79.56% which was an increase of 6.08 percentage points. This rate increase met the Molina goal of a two-percentage point increase from the previous year and overall, the rate increased by 3.64 percentage points from MY2022 to MY2024; furthermore, the MY2024 rate of 85.64% met the national HEDIS benchmark Medicaid 67th percentile goal.

Qualitative Analysis: The PPC measures play a vital role in assessing the quality of prenatal and postpartum care provided to members. Postpartum visits are essential for monitoring the physical and emotional well-being of mothers, addressing any complications, providing guidance on breastfeeding, contraception, and infant care, and identifying postpartum depression or other health issues.

Limited availability of healthcare providers, particularly in underserved areas, can pose challenges in ensuring timely prenatal and postpartum care. Insufficient availability of OB/Gyn practitioners or other prenatal care practitioners, as well as long wait times for appointments can hinder access to prenatal and postpartum services. Some members may face challenges in accessing healthcare services due to numerous factors such as transportation issues, lack of awareness, or competing demands. Inadequate communication and care coordination among healthcare providers can lead to fragmented care during the postpartum period.

Looking forward, Molina is committed to prioritizing improvement in the PPC measure compared to the previous year. Addressing potential barriers will be crucial in achieving this goal. These barriers include factors such as low member engagement, socioeconomic challenges, inadequate communication and care coordination, and provider shortages.

Measure Two, Medicaid Clinical: Follow-Up After Hospitalization for Mental Illness (FUH) 7 Days

Rationale: The Follow-Up After Hospitalization for Mental Illness (FUH) 7 Days measure tracks the percentage of discharges for members aged 6 years and older who were hospitalized for a principal diagnosis of mental illness, or any diagnosis of intentional self-harm, and had a mental health follow-up service within 7 days after discharge.

Timely follow-up care ensures continuity of care, reduces the risk of readmission or adverse events, and promotes recovery by connecting members with appropriate post-discharge services. This measure

emphasizes the importance of timely interventions to address ongoing mental health needs and improve overall outcomes for members.

Data Source: The Healthcare Effectiveness Data and Information Set (HEDIS©) Rates

Time Period: HEDIS© Calendar Year (CY) 2025 Rates, HEDIS© Measurement Year (MY) 2024 Data

Denominator: The number of Medicaid members discharged after being hospitalized for a principal diagnosis of mental illness or any diagnosis of intentional self-harm

Numerator: The number of Medicaid members who had a follow-up service for mental health within seven days of discharge for a principal diagnosis of mental illness or any diagnosis of intentional self-harm

Goal: Increase by two percentage points as compared to the prior year (CY2024/MY2023)

Comparative Benchmark: Achieve the 67th national percentile using Quality Compass

Measure	CY2025 (MY2024)	CY2024 (MY2023)	CY2023 (MY2022)	CY2025 Goal (+2) Met?	CY2025 Comparative Benchmark	Comparative Benchmark Met?
Follow-Up After Hospitalization for Mental Illness (FUH) - 7 Days (18-64 years)	20.69%	4.03%	17.46%	Yes	37.62%	No
Follow-Up After Hospitalization for Mental Illness (FUH) - 7 Days (Total)	20.00%	3.82%	16.94%	Yes	42.86%	No

Quantitative Analysis: The Follow-Up After Hospitalization for Mental Illness (FUH) 7-Days Total rate among Medicaid members aged18-64 years MY2024 rate was 20.69% compared to the MY2023 rate of 4.03% which was an increase of 16.66 percentage points. This rate increase met the Molina goal of a two-percentage point increase from the previous year and overall, the rate increased by 3.23 percentage points; however, the MY2024 rate of 20.69% did not meet the national HEDIS benchmark Medicaid 67th percentile goal.

The total rate for MY2024 was 20.00% compared to the MY2023 rate of 3.82% which was an increase of 16.18 percentage points. This rate increase met the Molina goal of a two-percentage point increase from the previous year and overall, the rate increased by 3.06 percentage points; however, the MY2024 rate of 20.00% did not meet the national HEDIS benchmark Medicaid 67th percentile goal.

Qualitative Analysis: Inadequate coordination and communication among healthcare providers can lead to fragmented care transitions, making it difficult to ensure timely and seamless follow-up visits. This includes poor care handoffs, insufficient information sharing, and inadequate care coordination between hospital staff, mental health providers, and primary care providers, which can contribute to missed or delayed follow-up visits. A shortage of mental health providers and limited availability of appointments can make it challenging for members to secure timely follow-up visits after hospitalization. The scarcity of mental health resources can result in delayed or missed appointments, hindering the achievement of the desired follow-up rates.

Looking forward, Molina is committed to prioritizing improvement in the FUH measure compared to the previous year. To achieve this goal, it is important to acknowledge the barriers that providers may encounter which may hinder reaching this goal. These barriers include limited access to mental health providers, fragmented care coordination, and stigma with mental illness.

Measure Three, Medicaid Utilization: Plan All-Cause Readmission (PCR) Observed-to-Expected Ratio (Ages 18-64)

Rationale: The Plan All-Cause Readmission (PCR) Observed-to-Expected Ratio (Ages 18-64) measures unplanned acute readmissions for any diagnosis among members discharged from acute inpatient and observation stays within 30 days.

This measure serves as an indicator of care quality by assessing how effectively healthcare systems manage care transitions and post-discharge support. Unplanned acute readmissions pose risks to members and often result from gaps in care, such as poor communication, inadequate discharge instructions, or insufficient follow-up. Proactively addressing these challenges promotes system-wide improvements in care coordination, patient engagement, and chronic care management.

Data Source: The Healthcare Effectiveness Data and Information Set (HEDIS©) Rates

Time Period: HEDIS© Calendar Year (CY) 2025 Rates, HEDIS© Measurement Year (MY) 2024 Data

Denominator: The number of Medicaid members aged 18-64 discharged from acute inpatient or observation stays

Numerator: The number of Medicaid members aged 18 to 64 who had an unplanned readmission for any diagnosis within 30 days after discharge from a prior acute inpatient and observation stay

Goal: Reduce unplanned acute inpatient and observation stays readmissions by two percentage points compared to the prior year (CY2024/MY2023)

Comparative Benchmark: Achieve the 67th national percentile using Quality Compass

Note: *PCR is an inverse measure, meaning that improved care will result in a* ***lower*** *rate as quality increases*

Measure	CY2025 (MY2024)	CY2024 (MY2023)	CY2023 (MY2022)	CY2025 Goal (-2) Met?	CY2025 Comparative Benchmark	Comparative Benchmark Met?
Plan All-Cause Readmission (PCR) – O/E (18-64)	101.55%	89.48%	86.88%	No	≤106.96%	Yes

Quantitative Analysis: The Plan All-Cause Readmissions Observed-to-Expected Ratio rate for Medicaid members aged 18-64 for MY2024 was 101.55% compared to the MY2023 rate of 89.48% which was an increase of 12.07 percentage points. The PCR is an inverse measure and a decrease in rates signifies better performance. This rate increase did not meet the Molina goal of a two-percentage point decrease from the previous year and overall, the rate has increased by 14.67 percentage points from MY2022 to MY2024; however, the MY2024 rate of 101.55% met the national HEDIS benchmark Medicaid 67th percentile goal.

Qualitative Analysis: Inadequate access to timely follow-up care, including outpatient visits with primary care providers, specialists, or therapists, can hinder appropriate monitoring and management of patients' conditions after hospital discharge. This can result from factors such as long wait times, limited availability of providers, or lack of transportation. Poor coordination during the transition from the hospital to home or another healthcare facility can lead to gaps in care and increase the risk of readmission. Lack of clear communication, incomplete discharge instructions, and confusion regarding medication management can all contribute to readmissions.

Looking forward, Molina is committed to prioritizing improvement in the PCR measure compared to the previous year. This commitment necessitates a focused effort to identify and address barriers that impact the PCR measure results and care coordination efforts. Key barriers that require attention include inadequate transitions of care, limited access to follow-up care, medication management, and socioeconomic factors.

Measure Four, Medicaid Member Feedback: Case Management Program, Level II

Rationale: The Case Management program is designed to enhance members' health status and reduce the burden of disease through education and care coordination. Case Managers working with Level II members assess their needs, escalating them to higher levels of care or transitioning them to Health Management as appropriate based on their progress. This measure is relevant to the PHM program as it focuses on managing members with emerging risks.

Risk Stratification: Risk stratification is the process of categorizing member populations into different levels of risk using utilization data, lab results, medications, health risk assessment results, and other relevant information.

Programmatic Risk Level Criteria Defined, Level II (any of the following):

- Level II focuses on returning members to their optimal well-being at the lowest level of care.
- This population is highly manageable with a good chance to self-manage their care.
- Two (2) or more admissions in the past six (6) months related to the same diagnosis.
- Three (3) to four (4) co-morbid conditions (including mental health conditions) AND an inability to provide self-care OR lacking a support system.
- Three (3) to five (5) emergency department (ED) visits within six (6) months.
- Resides in an institution such as a state psychiatric hospital or nursing home or is at risk of entering one.
- Not established with needed providers or shows resistance to receiving treatment, including behavioral health, medication regimens, wound care, etc.
- Needs assistance with three (3) or fewer ADLs/IADLs AND lacks adequate caregiver support.
- Members stepping down from Level III with progressing clinical stability and/or improved social support.

Methodology: A satisfaction survey is administered telephonically to Molina Healthcare of California members using a standardized survey tool. The survey targets members who are enrolled in the Case Management program and have received services for a minimum of 60 days, with a complexity level of II. A statistically valid random sample was drawn based on a 95% confidence interval and a 5% margin of error. The annual survey is conducted telephonically by National Quality staff and consists of eight questions. Data results were calculated by categorizing and summing the responses: Yes, No, and I Don't Know for the Yes/No questions, and by grouping and summing the responses on the Likert scale (1-7 and 8-10) questions.

Data Source: Clinical Care Advance (CCA) / Case Management Survey

Time Period: January 1st, 2025 to December 31st, 2025

Denominator: The number of Medicaid members whom the survey was administered, enrolled for at least 60 days, and with a complexity of Level II. Three attempts were made for each member at intervals to increase the probability of a completed survey.

Numerator: The number of Medicaid members who responded "completely satisfied" on questions 1-8 for all completed surveys

Goal: The survey results' goal was set at 80% favorable responses, defined as a 'Yes' response to Yes/No questions or an '8, 9 or 10' response to the Likert scale questions

Measure	CY2025	CY2024	CY2023	CY2025 Goal (80%) Met?
1. Did your case manager help you understand and adhere to the care your doctor recommended?	100%	98.6%	96.2%	Yes
2. Did your case manager help you find services and information you needed for your care?	100%	98.6%	93.1%	Yes
3. Did your case manager listen to your concerns?	100%	100.0%	99.2%	Yes
4. Did your case manager help you with your problems?	100%	98.6%	96.2%	Yes
5. Did your case manager treat you with respect?	100%	100.0%	100.0%	Yes
6. On a scale of 1-10, where 10 is very satisfied and 1 is not at all satisfied, how would you rate your overall experience with your case manager?	97.8%	94.6%	91.6%	Yes
7. On a scale of 1-10, where 10 is very satisfied and 1 is not at all satisfied, how would you rate your overall experience with the case management program?	97.8%	91.9%	87.8%	Yes
8. On a scale of 1-10, where 10 is very satisfied and 1 is not at all satisfied, how would you rate your experience with the case management program in helping you achieve your health goals?	97.8%	91.9%	87.0%	Yes

Quantitative Analysis: Of the 91 members in the Molina Healthcare of California sample for 2025, 46 members responded to the survey, resulting in a response rate of 50.5%. The survey, which contained eight questions, was administered telephonically to Molina Healthcare of California's Medicaid members using a standardized survey tool. Survey attempts are often unsuccessful due to incorrect member contact information, such as outdated primary phone numbers. The 2025 Level II Case Management Survey results show that the Medicaid line of business met the 80% goal for all eight responses.

When comparing CY2025 and CY2024 surveys, member satisfaction increased in 6 out of 8 areas, remained the same in 2 areas, and decreased in 0 areas. The largest increase in member satisfaction was by 5.9 percentage points, when members were asked, "How would you rate your experience with the

case management program in helping you achieve your health goals" and "How would you rate your overall experience with Molina's case management program."

Qualitative Analysis: Molina Healthcare of California conducted a survey of member satisfaction with Case Management services from January 2025 through December 2025 for members enrolled in Level II Case Management. The survey results for 2025 show a high level of satisfaction across all measures, with all goals being met and five out of eight questions scoring 100%, indicating that the case management program is performing exceptionally well.

Effectiveness of Interventions: The interventions implemented aimed to address key barriers such as unreliable member phone numbers and unreturned phone calls, leading to low survey response rates. These interventions included adding alternate phone numbers in the data pull as well as texting and emailing surveys to members who opted into these communication channels.

The data for 2025 showed an increase in satisfaction across six (6) of the eight (8) measures, with five (5) measures scoring 100%. This outcome suggests the interventions may be effective and should continue going forward as successful strategies to improve member response rates and satisfaction in future surveys.

Measure Five, Medicaid Member Feedback: Case Management Program, Level III

Rationale: The Complex Case Management (CCM) program involves a comprehensive assessment of the member's condition, determining the availability of benefits and resources, and developing and implementing an individualized case management plan. This plan includes performance goals, monitoring, and follow-up. Members identified as eligible for complex case management are referred to the appropriate Case Manager within five calendar days. This measure is relevant to the PHM program as it focuses on managing members with multiple chronic conditions.

Risk Stratification: Risk stratification is the process of categorizing member populations into different levels of risk using utilization data, lab results, medications, health risk assessment results, and other relevant information.

Programmatic Risk Level Criteria Defined, Level III (any of the following):

- Level III - Member self-reports "poor" health status.
- High-risk chronic illness with clinical instability, demonstrated by three (3) to four (4) admissions within six (6) months related to: Cardiovascular artery disease (CAD), congestive heart failure (CHF), COPD, end-stage renal disease (ESRD), asthma, diabetes, sickle cell anemia, HIV/AIDS, cancer, or behavioral health issues related to SPMI (schizophrenia/schizoaffective disorder, major depressive disorder), Multiple Sclerosis, Cerebral Palsy, and/or developmental disabilities or delays.

- More than four (4) co-morbid conditions, including mental health conditions, AND an inability to provide self-care or lacking a support system.
- High-risk maternity cases.
- Member requires assistance with four (4) or more ADLs/IADLs AND lacks adequate caregiver support.
- Deterioration of mental and/or physical condition requiring an increase in utilization of resources.
- High risk for re-hospitalization or institutionalization.
- Actual claims expenditures of $100,000 or greater annually.

Methodology: A satisfaction survey is administered telephonically to Molina Healthcare of California members using a standardized survey tool. The survey targets members who are enrolled in the Case Management program and have received services for a minimum of 60 days at a Level III complexity. A statistically valid random sample is drawn based on a 95% confidence interval and a 5% margin of error. The annual survey is conducted by National Quality staff and consists of eight questions. Data results are calculated by categorizing and summing the responses: Yes, No, and I Don't Know for Yes/No questions, and by grouping and summing the responses on the Likert scale (1-7 and 8-10) questions.

Data Source: Clinical Care Advance (CCA) / Case Management Survey

Time Period: January 1st, 2025 to December 31st, 2025

Denominator: The number of Medicaid members whom the survey was administered, enrolled for at least 60 days, and have a complexity of Level III. Three attempts were made for each member at intervals to increase the probability of a completed survey

Numerator: The number of Medicaid members who responded "completely satisfied" on questions 1-8 for all completed surveys

Goal: The survey results' goal was set at 80% favorable responses, which is defined as a 'Yes' response to Yes/No questions or an '8, 9 or 10' response to the Likert scale questions

Measure	CY2025	CY2024	CY2023	CY2025 Goal (80%) Met?
1. Did your case manager help you understand and adhere to the care your doctor recommended?	100%	97.0%	97.8%	Yes
2. Did your case manager help you find services and information you needed for your care?	100%	97.0%	95.7%	Yes
3. Did your case manager listen to your concerns?	100%	97.0%	100.0%	Yes

4. Did your case manager help you with your problems?	100%	97.0%	100.0%	Yes
5. Did your case manager treat you with respect?	100%	97.0%	100.0%	Yes
6. On a scale of 1-10, where 10 is very satisfied and 1 is not at all satisfied, how would you rate your overall experience with your case manager?	100%	97.0%	97.8%	Yes
7. On a scale of 1-10, where 10 is very satisfied and 1 is not at all satisfied, how would you rate your overall experience with the case management program?	100%	93.9%	91.3%	Yes
8. On a scale of 1-10, where 10 is very satisfied and 1 is not at all satisfied, how would you rate your experience with the case management program in helping you achieve your health goals?	100%	97.0%	84.8%	Yes

Quantitative Analysis: Of the 67 members in the Molina Healthcare of California sample for 2025, 26 members responded to the survey, resulting in a response rate of 38.8%. The survey, which contained eight questions, was administered telephonically to Molina Healthcare of California's Medicaid members using a standardized survey tool. Survey attempts are often unsuccessful due to incorrect member contact information, such as outdated primary phone numbers. The 2025 Complex (Level III) Case Management Survey results show that the Medicaid line of business met the 80% goal for all eight responses.

When comparing CY2025 and CY2024 surveys, member satisfaction increased in 8 out of 8 areas, remained the same in 0 areas, and decreased in 0 areas. The largest increase in member satisfaction was by 6.1 percentage points, when members were asked, "How would you rate your overall experience with Molina's case management program." A 3.0 percentage point increase was observed in all other questions.

Qualitative Analysis: Molina Healthcare of California conducted a survey of member satisfaction with Case Management services from January 2025 through December 2025 for members enrolled in Level III Case Management. The survey results for 2025 show a high level of satisfaction across all measures, with all goals being met and call questions scoring 100%, indicating that the case management program is performing exceptionally well.

Effectiveness of Interventions: The interventions implemented aimed to address key barriers such as unreliable member phone numbers and unreturned phone calls, leading to low survey response rates. These interventions included adding alternate phone numbers in the data pull as well as texting and emailing surveys to members who opted into these communication channels.

The data for 2025 showed an increase in satisfaction across all eight (8) measures, with all measures scoring 100%. This outcome suggests the interventions may be effective and should continue going forward as successful strategies to improve member response rates and satisfaction in future surveys.

Measure Six, Medicaid Member Feedback: Complaints and Grievances

Medicaid CM Category	CM Sub-Category	CY 2025
Case Manager	Care Coordination	234
	Didn't Return Call	90
	Dislike CM Treatment Plan	98
	Other	33
CM Face to Face No Show	Null	3
		Total Annual # of Complaints: 458

Quantitative Analysis: During the period of 1/1/25 through 12/31/25, a total of 458 Medicaid complaints were recorded, with the majority (234) falling under the "Case Manager" category, specifically related to "Care Coordination." Communication issues were also noted, with 90 complaints about calls not being returned. There were 98 complaints about dissatisfaction with case manager treatment plans, and 33 complaints were categorized as "Other." Three complaints were recorded for "CM Face to Face No Show."

Qualitative Analysis: The Medicaid complaints data indicates that there are some areas for improvement, particularly in care coordination and communication. Further drilldown on reasons for “Other” can improve member satisfaction for future interactions and planning. Addressing these specific areas can enhance an already well-functioning system, leading to even higher levels of patient satisfaction and effective care delivery.

MARKETPLACE

Measure One, Marketplace Clinical: Prenatal and Postpartum (PPC) Timeliness of Prenatal Care and Prenatal and Postpartum (PPC) Postpartum Care

Rationale: The Prenatal and Postpartum (PPC) measure represents the percentage of live births on or between October 8th of the year prior to the measurement year and October 7th of the measurement year. This measure assesses:

- Timeliness of Prenatal Care: The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment.
- Postpartum Care: The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.

Access to timely and adequate prenatal and postpartum care is vital to the health and well-being of mothers and their infants. These visits help identify and address potential risks early, improving maternal outcomes and reducing complications during pregnancy, delivery, and the postpartum period. Prenatal care during the first trimester allows for the detection of various conditions, while postpartum care supports recovery, addresses mental health needs, and helps manage chronic conditions.

Data Source: The Healthcare Effectiveness Data and Information Set (HEDIS©) Rates

Time Period: HEDIS© Calendar Year (CY) 2025 Rates, HEDIS© Measurement Year (MY) 2024 Data

Denominator: The number of Marketplace members who had live births between October 8th of the year prior to the measurement year and October 7th of the measurement year

Numerator: The number of Marketplace members who received a prenatal/postpartum care visit during the required time period.

Goal: Increase by two percentage points compared to the prior year (CY2024/MY2023).

Comparative Benchmark: Achieve the 75th national percentile using Quality Compass.

Measure	CY2025 (MY2024)	CY2024 (MY2023)	CY2023 (MY2022)	CY2025 Goal (+2) Met?	CY2025 Comparative Benchmark	Comparative Benchmark Met?
Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care	78.92%	71.25%	78.63%	Yes	89.51%	No
Prenatal and Postpartum Care (PPC) – Postpartum Care	81.86%	79.58%	79.77%	Yes	88.89%	No

Quantitative Analysis*:* The PPC Timeliness of Prenatal Care rate among Marketplace members for MY2024 was 78.92% compared to the MY2023 rate of 71.25%, which was an increase of 7.67 percentage points. This rate increase met the Molina goal of a two-percentage point increase from the previous year and overall, the rate increased by 0.29 percentage points from MY2022 to MY2024; however, the MY2024 rate of 78.92% did not meet the national HEDIS benchmark Marketplace 75th percentile goal.

The PPC Postpartum Care rate among Marketplace members for MY2024 was 81.86% compared to the MY2023 rate of 79.58% which was an increase of 2.28 percentage points. This rate increase met the Molina goal of a two-percentage point increase from the previous year and overall, the rate increased by 2.09 percentage points from MY2022 to MY2024; however, the MY2024 rate of 81.86% did not meet the national HEDIS benchmark Marketplace 75th percentile goal.

Qualitative Analysis: The PPC measures play a vital role in assessing the quality of prenatal and postpartum care provided to members. Postpartum visits are essential for monitoring the physical and emotional well-being of mothers, addressing any complications, providing guidance on breastfeeding, contraception, and infant care, and identifying postpartum depression or other health issues.

Limited availability of healthcare providers, particularly in underserved areas, can pose challenges in ensuring timely prenatal and postpartum care. Insufficient availability of OB/Gyn practitioners or other prenatal care practitioners, as well as long wait times for appointments can hinder access to prenatal and postpartum services. Some members may face challenges in accessing healthcare services due to numerous factors such as transportation issues, lack of awareness, or competing demands. Inadequate communication and care coordination among healthcare providers can lead to fragmented care during the postpartum period.

Looking forward, Molina is committed to prioritizing improvement in the PPC measure compared to the previous year. Addressing potential barriers will be crucial in achieving this goal. These barriers include factors such as low member engagement, socioeconomic challenges, inadequate communication and care coordination, and provider shortages.

Measure Two, Marketplace Clinical: Follow-Up After Hospitalization for Mental Illness (FUH) 7 Days

Rationale: The Follow-Up After Hospitalization for Mental Illness (FUH) 7 Days measure tracks the percentage of discharges for members aged 6 years and older who were hospitalized for a principal diagnosis of mental illness, or any diagnosis of intentional self-harm, and had a mental health follow-up service within 7 days after discharge.

Timely follow-up care ensures continuity of care, reduces the risk of readmission or adverse events, and promotes recovery by connecting members with appropriate post-discharge services. This measure

emphasizes the importance of timely interventions to address ongoing mental health needs and improve overall outcomes for members.

Data Source: The Healthcare Effectiveness Data and Information Set (HEDIS©) Rates

Time Period: HEDIS© Calendar Year (CY) 2025 Rates, HEDIS© Measurement Year (MY) 2024 Data

Denominator: The number of Medicaid members discharged after being hospitalized for a principal diagnosis of mental illness or any diagnosis of intentional self-harm

Numerator: The number of Medicaid members who had a follow-up service for mental health within seven days of discharge for a principal diagnosis of mental illness or any diagnosis of intentional self-harm.

Goal: Increase by two percentage points as compared to the prior year (CY2024/MY2023)

Comparative Benchmark: Achieve the 75th national percentile using Quality Compass

Measure	CY2025 (MY2024)	CY2024 (MY2023)	CY2023 (MY2022)	CY2025 Goal (+2) Met?	CY2025 Comparative Benchmark	Comparative Benchmark Met?
Follow-Up After Hospitalization for Mental Illness (FUH) - 7 Days (18-64 years)	11.36%	7.14%	13.64%	Yes	50.00%	No
Follow-Up After Hospitalization for Mental Illness (FUH) - 7 Days (Total)	11.11%	10.34%	13.64%	No	50.00%	No

Quantitative Analysis: The Follow-Up After Hospitalization for Mental Illness (FUH) 7-Days Total rate for Marketplace members aged 18-64 years for MY2024 was 11.36% compared to the MY2023 rate of 7.14% which was an increase of 4.22 percentage points. This rate increase met the Molina goal of a two-percentage point increase from the previous year but overall, the rate decreased by 2.28 percentage points from MY2022 to MY2024; furthermore, the MY2024 rate of 11.36% did not meet the national HEDIS benchmark Marketplace 75th percentile goal.

The total rate for MY2024 was 11.11% compared to the MY2023 rate of 10.34% which was an increase of 0.77 percentage points. This rate increase did not meet the Molina goal of a two-percentage point increase from the previous year and overall, the rate decreased by 2.53 percentage points from MY2022

to MY2024; furthermore, the MY2024 rate of 11.11% did not meet the national HEDIS benchmark Marketplace 75th percentile goal.

Qualitative Analysis: Inadequate coordination and communication among healthcare providers can lead to fragmented care transitions, making it difficult to ensure timely and seamless follow-up visits. This includes poor care handoffs, insufficient information sharing, and inadequate care coordination between hospital staff, mental health providers, and primary care providers, which can contribute to missed or delayed follow-up visits. A shortage of mental health providers and limited availability of appointments can make it challenging for members to secure timely follow-up visits after hospitalization. The scarcity of mental health resources can result in delayed or missed appointments, hindering the achievement of the desired follow-up rates.

Looking forward, Molina is committed to prioritizing improvement in the FUH measure compared to the previous year. To achieve this goal, it is important to acknowledge the barriers that providers may encounter which may hinder reaching this goal. These barriers include limited access to mental health providers, fragmented care coordination, and stigma with mental illness.

Effectiveness of Interventions: The interventions implemented aimed to address key barriers such as access to care, issues with communication and coordination of care, and compliance with follow-up care. These interventions included increasing collaboration with community mental health centers, implementing electronic health records and standardized protocols for information sharing, creating educational campaigns and outreach programs to address awareness on the importance of mental health care, and sending appointment reminders through multiple channels.

The data for 2025 shows mixed results. While the MY2024 rates for 18-64 years of age and total both increased when compared to MY2023, only the 18-64 years of age rate increased by more than two percentage points from MY2023, and neither rate met the national benchmark percentile, indicating that the interventions may not be effective at increasing FUH rates and additional interventions should be considered to impact this measure going forward.

Measure Three, Marketplace Utilization: Plan All-Cause Readmission (PCR) Observed-to-Expected Ratio (Ages 18-64)

Rationale: The Plan All-Cause Readmission (PCR) Observed-to-Expected Ratio (Ages 18-64) measures unplanned acute readmissions for any diagnosis among members discharged from acute inpatient and observation stays within 30 days.

This measure serves as an indicator of care quality by assessing how effectively healthcare systems manage care transitions and post-discharge support. Unplanned acute readmissions pose risks to members and often result from gaps in care, such as poor communication, inadequate discharge

instructions, or insufficient follow-up. Proactively addressing these challenges promotes system-wide improvements in care coordination, patient engagement, and chronic care management.

Data Source: The Healthcare Effectiveness Data and Information Set (HEDIS©) Rates

Time Period: HEDIS© Calendar Year (CY) 2025 Rates, HEDIS© Measurement Year (MY) 2024 Data

Denominator: The number of Marketplace members aged 18-64 discharged from acute inpatient or observation stays

Numerator: The number of Marketplace members aged 18 to 64 who had an unplanned readmission for any diagnosis within 30 days after discharge from a prior acute inpatient and observation stays

Goal: Reduce unplanned acute readmissions by two percentage points compared to the prior year (CY2024/MY2023)

Comparative Benchmark: Achieve the 75th national percentile using Quality Compass

Note: *PCR is an inverse measure, meaning that improved care will result in a* ***lower*** *rate as quality increases.*

Measure	CY2025 (MY2024)	CY2024 (MY2023)	CY2023 (MY2022)	CY2025 Goal (-2) Met?	CY2025 Comparative Benchmark	Comparative Benchmark Met?
Plan All-Cause Readmission (PCR) – O/E (18-64)	101.81%	77.40%	71.28%	No	≤114.93%	Yes

Quantitative Analysis: The Plan All-Cause Readmissions Observed-to-Expected Ratio rate for Marketplace members aged 18-64 for MY2024 was 101.81% compared to the MY2023 rate of 77.40% which was an increase of 24.41 percentage points. The PCR is an inverse measure and a decrease in rates signifies better performance. This rate increase did not meet the Molina goal of a two-percentage point decrease from the previous year but overall, the rate increased by 30.53 percentage points from MY2022 to MY2024; however, the MY2024 rate of 101.81% exceeded the national HEDIS benchmark Marketplace 75th percentile goal.

Qualitative Analysis: Inadequate access to timely follow-up care, including outpatient visits with primary care providers, specialists, or therapists, can hinder appropriate monitoring and management of patients' conditions after hospital discharge. This can result from factors such as long wait times, limited availability of providers, or lack of transportation. Poor coordination during the transition from the hospital to home or another healthcare facility can lead to gaps in care and increase the risk of

readmission. Lack of clear communication, incomplete discharge instructions, and confusion regarding medication management can all contribute to readmissions.

Looking forward, Molina is committed to prioritizing improvement in the PCR measure compared to the previous year. This commitment necessitates a focused effort to identify and address barriers that impact the PCR measure results and care coordination efforts. Key barriers that require attention include inadequate transitions of care, limited access to follow-up care, medication management, and socioeconomic factors.

Measure Four, Marketplace Member Feedback: Case Management Program, Level II

Rationale: The Case Management program is designed to enhance members' health status and reduce the burden of disease through education and care coordination. Case Managers working with Level II members assess their needs, escalating them to higher levels of care or transitioning them to Health Management as appropriate based on their progress. This measure is relevant to the PHM program as it focuses on managing members with emerging risks.

Risk Stratification: Risk stratification is the process of categorizing member populations into different levels of risk using utilization data, lab results, medications, health risk assessment results, and other relevant information.

Programmatic Risk Level Criteria Defined, Level II (any of the following):

- Level II focuses on returning members to their optimal well-being at the lowest level of care.
- This population is highly manageable with a good chance to self-manage their care.
- Two (2) or more admissions in the past six (6) months related to the same diagnosis.
- Three (3) to four (4) co-morbid conditions (including mental health conditions) AND an inability to provide self-care OR lacking a support system.
- Three (3) to five (5) emergency department (ED) visits within six (6) months.
- Resides in an institution such as a state psychiatric hospital or nursing home or is at risk of entering one.
- Not established with needed providers or shows resistance to receiving treatment, including behavioral health, medication regimens, wound care, etc.
- Needs assistance with three (3) or fewer ADLs/IADLs AND lacks adequate caregiver support.
- Members stepping down from Level III with progressing clinical stability and/or improved social support.

Methodology: A satisfaction survey is administered telephonically to Molina Healthcare of California members using a standardized survey tool. The survey targets members who are enrolled in the Case Management program and have received services for a minimum of 60 days, with a complexity level of II. A statistically valid random sample was drawn based on a 95% confidence interval and a 5% margin of

error. The annual survey is conducted telephonically by National Quality staff and consists of eight questions. Data results were calculated by categorizing and summing the responses: Yes, No, and I Don't Know for the Yes/No questions, and by grouping and summing the responses on the Likert scale (1-7 and 8-10) questions.

Data Source: Clinical Care Advance (CCA) / Case Management Survey

Time Period: January 1st, 2025 to December 31st, 2025

Denominator: The number of Marketplace members whom the survey was administered, enrolled for at least 60 days, and with a complexity of Level II. Three attempts were made for each member at intervals to increase the probability of a completed survey.

Numerator: The number of Marketplace members who responded "completely satisfied" on questions 1-8 for all completed surveys

Goal: The survey results' goal was set at 80% favorable responses, defined as a 'Yes' response to Yes/No questions or an '8, 9 or 10' response to the Likert scale questions

Measure	CY2025	CY2024	CY2023	CY2025 Goal (80%) Met?
1. Did your case manager help you understand and adhere to the care your doctor recommended?	100%	100%	100%	Yes
2. Did your case manager help you find services and information you needed for your care?	100%	100%	100%	Yes
3. Did your case manager listen to your concerns?	100%	100%	100%	Yes
4. Did your case manager help you with your problems?	100%	100%	100%	Yes
5. Did your case manager treat you with respect?	100%	100%	100%	Yes
6. On a scale of 1-10, where 10 is very satisfied and 1 is not at all satisfied, how would you rate your overall experience with your case manager?	100%	100%	100%	Yes
7. On a scale of 1-10, where 10 is very satisfied and 1 is not at all satisfied, how would you rate your overall experience with the case management program?	100%	100%	100%	Yes

8. On a scale of 1-10, where 10 is very satisfied and 1 is not at all satisfied, how would you rate your experience with the case management program in helping you achieve your health goals?	100%	100%	100%	Yes

Quantitative Analysis: Of the 17 members in the Molina Healthcare of California sample for 2025, 13 members responded to the survey, resulting in a response rate of 76.5%. The survey, which contained eight questions, was administered telephonically to Molina Healthcare of California's Marketplace members using a standardized survey tool. Survey attempts are often unsuccessful due to incorrect member contact information, such as outdated primary phone numbers. The 2025 Level II Case Management Survey results show that the Marketplace line of business met the 80% goal for all eight responses.

When comparing CY2025 and CY2024 surveys, member satisfaction increased in 0 out of 8 areas, remained the same in 8 areas, and decreased in 0 areas. All questions scored 100% for the past three years.

Qualitative Analysis: Molina Healthcare of California conducted a survey of member satisfaction with Case Management services from January 2025 through December 2025 for members enrolled in Level II Case Management. The survey results for 2025 show a high level of satisfaction across all measures, with all goals being met and all questions scoring 100%, indicating that the case management program is performing exceptionally well.

Measure Five, Marketplace Member Feedback: Case Management Program, Level III

Rationale: The Complex Case Management (CCM) program involves a comprehensive assessment of the member's condition, determining the availability of benefits and resources, and developing and implementing an individualized case management plan. This plan includes performance goals, monitoring, and follow-up. Members identified as eligible for complex case management are referred to the appropriate Case Manager within five calendar days. This measure is relevant to the PHM program as it focuses on managing members with multiple chronic conditions.

Risk Stratification: Risk stratification is the process of categorizing member populations into different levels of risk using utilization data, lab results, medications, health risk assessment results, and other relevant information.

Programmatic Risk Level Criteria Defined, Level III (any of the following):

- Level III - Member self-reports "poor" health status.

- High-risk chronic illness with clinical instability, demonstrated by three (3) to four (4) admissions within six (6) months related to: Cardiovascular artery disease (CAD), congestive heart failure (CHF), COPD, end-stage renal disease (ESRD), asthma, diabetes, sickle cell anemia, HIV/AIDS, cancer, or behavioral health issues related to SPMI (schizophrenia/schizoaffective disorder, major depressive disorder), Multiple Sclerosis, Cerebral Palsy, and/or developmental disabilities or delays.
- More than four (4) co-morbid conditions, including mental health conditions, AND an inability to provide self-care or lacking a support system.
- High-risk maternity cases.
- Member requires assistance with four (4) or more ADLs/IADLs AND lacks adequate caregiver support.
- Deterioration of mental and/or physical condition requiring an increase in utilization of resources.
- High risk for re-hospitalization or institutionalization.
- Actual claims expenditures of $100,000 or greater annually.

Methodology: A satisfaction survey is administered telephonically to Molina Healthcare of California members using a standardized survey tool. The survey targets members who are enrolled in the Case Management program and have received services for a minimum of 60 days at a Level III complexity. A statistically valid random sample is drawn based on a 95% confidence interval and a 5% margin of error. The annual survey is conducted by National Quality staff and consists of eight questions. Data results are calculated by categorizing and summing the responses: Yes, No, and I Don't Know for Yes/No questions, and by grouping and summing the responses on the Likert scale (1-7 and 8-10) questions.

Data Source: Clinical Care Advance (CCA) / Case Management Survey

Time Period: January 1st, 2025 to December 31st, 2025

Denominator: The number of Marketplace members whom the survey was administered, enrolled for at least 60 days, and have a complexity of Level III. Three attempts were made for each member at intervals to increase the probability of a completed survey.

Numerator: The number of Marketplace members who responded "completely satisfied" on questions 1-8 for all completed surveys

Goal: The survey results' goal was set at 80% favorable responses, which is defined as a 'Yes' response to Yes/No questions or an '8, 9 or 10' response to the Likert scale questions

Measure	CY2025	CY2024	CY2023	CY2025 Goal (80%) Met?
1. Did your case manager help you understand and adhere to the care your doctor recommended?	100.0%	100.0%	100.0%	Yes

2. Did your case manager help you find services and information you needed for your care?	100.0%	100.0%	100.0%	Yes
3. Did your case manager listen to your concerns?	100.0%	100.0%	100.0%	Yes
4. Did your case manager help you with your problems?	100.0%	100.0%	100.0%	Yes
5. Did your case manager treat you with respect?	100.0%	100.0%	100.0%	Yes
6. On a scale of 1-10, where 10 is very satisfied and 1 is not at all satisfied, how would you rate your overall experience with your case manager?	100.0%	96.2%	100.0%	Yes
7. On a scale of 1-10, where 10 is very satisfied and 1 is not at all satisfied, how would you rate your overall experience with the case management program?	100.0%	84.6%	100.0%	Yes
8. On a scale of 1-10, where 10 is very satisfied and 1 is not at all satisfied, how would you rate your experience with the case management program in helping you achieve your health goals?	100.0%	84.6%	100.0%	Yes

Quantitative Analysis: Of the 66 members in the Molina Healthcare of California sample for 2025, 33 members responded to the survey, resulting in a response rate of 50.0%. The survey, which contained eight questions, was administered telephonically to Molina Healthcare of California's Marketplace members using a standardized survey tool. Survey attempts are often unsuccessful due to incorrect member contact information, such as outdated primary phone numbers. The 2025 Complex Case Management Survey results show that the Marketplace line of business met the 80% goal for all eight responses.

When comparing CY2025 and CY2024 surveys, member satisfaction increased in 3 out of 8 areas, remained the same in 5 areas, and decreased in 0 areas. The largest increase in member satisfaction was by 15.4 percentage points, when members were asked, "How would you rate your overall experience with Molina's case management program," and when members were asked, "How would you rate your experience with the case management program in helping you achieve your health goals."

Qualitative Analysis: Molina Healthcare of California conducted a survey of member satisfaction with Case Management services from January 2025 through December 2025 for members enrolled in Level III

Case Management. The survey results for 2025 show a high level of satisfaction across all measures, with all goals being met and all questions scoring 100%, indicating that the case management program is performing exceptionally well.

Effectiveness of Interventions: The interventions implemented aimed to address key barriers such as unreliable member phone numbers and unreturned phone calls, leading to low survey response rates. These interventions included adding alternate phone numbers in the data pull as well as texting and emailing surveys to members who opted into these communication channels.

The data for 2025 showed an increase in satisfaction across three (3) of the eight (8) measures, with all measures scoring 100%. This outcome suggests the interventions may be effective and should continue going forward as successful strategies to improve member response rates and satisfaction in future surveys.

Measure Six, Marketplace Member Feedback: Complaints and Grievances

Marketplace Complaint Category	CM Sub-Category	CY 2025
Case Manager	Care Coordination	5
	Didn't Return Call	2
	Dislike CM Treatment Plan	4
	Other	0
CM Face to Face No Show	NULL	0
		Total Annual # of Complaints: 12

Quantitative Analysis: During the period of 1/1/25 to 12/31/25, a total of 12 complaints recorded, with the majority (5) falling under the “Case Manager” category, specifically related to “Care Coordination.” A communication issue was also noted, with 2 complaints about calls not being returned. There were also four complaints about members disliking the CM treatment plan.

Qualitative Analysis: The Marketplace complaint data reveals a low level of complaints. This suggests a high level of satisfaction among recipients or effective resolution of issues before they escalated to formal complaints. The low number of complaints related to treatment plans indicates that this area is being managed well, with effective communication and personalized care strategies. Additionally, the absence of complaints in the "Other" category points to efficient handling of various administrative and individual concerns. Overall, the data implies that Marketplace services are performing well, and maintaining these high standards can help sustain recipient satisfaction.

OVERALL SUMMARY

Medicaid Overall Summary: Molina Healthcare of California systematically monitors the effectiveness of its Population Management strategy on an annual basis to enable the Plan to develop and implement actions to increase member's satisfaction and evaluate the effectiveness of interventions. In reviewing the results of 2025, several areas of success were noted. Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care and Prenatal and Postpartum Care (PPC) – Postpartum Care, Follow-up After Hospitalization for Mental Illness (FUH, Member Feedback Case Management Program Level II, and Member Feedback Case Management Program Level III all met goal. In contrast, Plan All-Cause Readmission (PCR) – O/E (18-64), did not meet the goal of increasing by at least two percentage points compared to the previous year. Work will continue to identify roadblocks and enhance results during the next year.

Marketplace Overall Summary: In evaluating the Marketplace product's Population Management strategy showed areas that successfully met their goals include, Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care, Postpartum Care (PPC) – Postpartum Care, Member Feedback Case Management Program Level II, and Member Feedback Case Management Program Level III. However, there are areas that did not meet the goal such as, Follow-Up After Hospitalization for Mental Illness (FUH) - 30 Days (Total), and Plan All-Cause Readmission (PCR) – O/E (18-64). Ongoing analysis will focus on addressing gaps to enhance overall program effectiveness and member satisfaction. This will ensure comprehensive care continuity and reduce the likelihood of adverse health outcomes.

OPPORTUNITIES AND INTERVENTIONS

2025 Opportunities for Improvement and Planned Interventions

The following opportunities have been identified and were prioritized as high (H), medium (M), or Low (L) based upon the level of impact to members. Molina Healthcare of California will act on all high priorities first.

Measure	Priority	Opportunities for Improvement	Actions Taken or Planned	Date of Action
Measure One, Medicaid Clinical: Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care and PPC Postpartum Care	High	1. Enhance Member engagement 2. Address socioeconomic factors 3. Improve communication and care coordination 4. Expand access to care	1. Provider education to pregnant members about postpartum care. 1. Member education materials, personalized counseling sessions, and outreach programs 2. Increased provider collaboration with community organizations and social service agencies to connect them with financial assistance programs, transportation services, and community resources to mitigate financial constraints and improve access to care. 3. Implement electronic health records, standardized protocols for information sharing, and care transition processes. 4. Recruiting additional providers, implementing telehealth services, extending clinic hours, and establishing partnerships with healthcare facilities in underserved areas. 4. Partner with vendors like Mae and OUMA to expand access to prenatal and postpartum care.	Q1 2025 and ongoing

Measure	Priority	Opportunities for Improvement	Actions Taken or Planned	Date of Action
Measure One, Marketplace Clinical: Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care and PPC Postpartum Care	High	1. Enhance Member engagement 2. Address socioeconomic factors 3. Improve communication and care coordination 4. Expand access to care	1. Provider education to pregnant members about postpartum care. 1. Member education materials, personalized counseling sessions, and outreach programs 2. Increased provider collaboration with community organizations and social service agencies to connect them with financial assistance programs, transportation services, and community resources to mitigate financial constraints and improve access to care. 3. Implement electronic health records, standardized protocols for information sharing, and care transition processes. 4. Recruiting additional providers, implementing telehealth services, extending clinic hours, and establishing partnerships with healthcare facilities in underserved areas. 4. Partner with vendors like OUMA to expand access to prenatal and postpartum care.	Q1 2025 and ongoing

Measure	Priority	Opportunities for Improvement	Actions Taken or Planned	Date of Action
Measure Two, Medicaid Clinical: Follow-Up After Hospitalization for Mental Illness (FUH) 7 Days		1. Expand access to care 2. Improve communication and care coordination 3. Educate on importance of mental health care 4. Increase compliance with follow-up appointments	1. Increase collaborations with community mental health centers, telehealth services, and the integration of mental health services within primary care settings to help expand access to timely follow-up care. 2. Implement electronic health records, standardized protocols for information sharing, and care transition processes 3. Create educational campaigns, support groups and community outreach programs to raise awareness about the importance of mental health care. 4. Appointment reminders through various channels (e.g. phone calls, text messages), and the integration of support services such as care navigators or peer support programs.	Q1 2025 and ongoing

Measure	Priority	Opportunities for Improvement	Actions Taken or Planned	Date of Action
Measure Two, Marketplace Clinical: Follow-Up After Hospitalization for Mental Illness (FUH) 7 Days	High	1. Expand access to care 2. Improve communication and care coordination 3. Educate on importance of mental health care 4. Increase compliance with follow-up appointments	1. Increase collaborations with community mental health centers, telehealth services, and the integration of mental health services within primary care settings to help expand access to timely follow-up care. 2. Implement electronic health records, standardized protocols for information sharing, and care transition processes 3. Create educational campaigns, support groups and community outreach programs to raise awareness about the importance of mental health care. 4. Appointment reminders through various channels (e.g. phone calls, text messages), and the integration of support services such as care navigators or peer support programs.	Q1 2025 and ongoing
Measure Three, Medicaid Utilization: Plan All-Cause Readmission (PCR) O/E (18-64)	High	1. Enhance care coordination communication 2. Improve access to timely follow-up care 3. Improve medication adherence and management 4. Address social determinants of health	1. Develop comprehensive discharge plan to include detailed instructions, medication reconciliation and schedule follow-up appointments. 2. Collaborate with community resources to provide free or low-cost healthcare services, particularly for patients without insurance or limited financial means 3. Provider education about medications, including potential side effects and proper administration 3. Provide information about medication assistance programs 4. Collaborate with community organizations.	Q1 2025 and ongoing

Measure	Priority	Opportunities for Improvement	Actions Taken or Planned	Date of Action
Measure Three, Marketplace Utilization: Plan All-Cause Readmission (PCR) O/E (18-64)	High	1. Enhance care coordination communication 2. Improve access to timely follow-up care 3. Improve medication adherence and management 4. Address social determinants of health	1. Develop comprehensive discharge plan to include detailed instructions, medication reconciliation and schedule follow-up appointments. 2. Collaborate with community resources to provide free or low-cost healthcare services, particularly for patients without insurance or limited financial means 3. Provider education about medications, including potential side effects and proper administration 3. Provide information about medication assistance programs 4. Collaborate with community organizations.	Q1 2025 and ongoing
Measure Four, Medicaid Member Feedback: Case Management Program, Level II	High	1. Improve survey response rate	1. Include members' alternate phone numbers in the data pull 2. Implement measures to text and email surveys to members who have opted into these communications	Q1 2025 and ongoing
Measure Four, Marketplace Member Feedback: Case Management Program, Level II	High	1. Improve survey response rate	1. Include members' alternate phone numbers in the data pull 2. Implement measures to text and email surveys to members who have opted into these communications	Q1 2025 and ongoing
Measure Five, Medicaid Member Feedback: Case Management Program, Level III	High	1. Improve survey response rate	1. Include members' alternate phone numbers in the data pull 2. Implement measures to text and email surveys to members who have opted into these communications	Q1 2025 and ongoing

Measure	Priority	Opportunities for Improvement	Actions Taken or Planned	Date of Action
Measure Five, Marketplace Member Feedback: Case Management Program, Level III	High	1. Improve survey response rate	1. Include members' alternate phone numbers in the data pull 2. Implement measures to text and email surveys to members who have opted into these communications	Q1 2025 and ongoing

Appendix 5

2025 Culturally and Linguistically Appropriate Services Analysis:

California

Created: March 2026

Updated: April 2026

For internal use only.

California CLAS Analysis – Purpose

Molina Healthcare of **California** (Molina) assesses the cultural, ethnic, racial and linguistic needs and preferences of its members on an ongoing basis. Information gathered during regular monitoring and annual network assessment is used to identify and address cultural and/or linguistic barriers to care through the implementation of programs and interventions. Race, ethnicity and language data are used to assess the existence of disparities and to implement targeted efforts to improve the delivery of culturally and linguistically appropriate services (CLAS) and decrease health care disparities and inequities. The health plan works to ensure members who speak a language other than English, including American Sign Language (ASL), have equal access to quality health care through a culturally and linguistically responsive practitioner network, culturally competent staff, interpreter services, and translated written materials, including alternate formats.

Molina annually evaluates its performance on CLAS activities described in the program description and work plan, including all delegated functions. This evaluation provides an overview of completed and ongoing activities for CLAS. Presents the results of program initiatives in measurable terms. Analyzes the results on the plans performance efforts to reduce disparities and improve the provision of CLAS. Conducts a root cause/barrier analysis in areas where the plan falls short of goals. Includes community representatives in the analysis of results for review and feedback and evaluates the overall effectiveness of the CLAS program. Key outcomes are used to identify and prioritize quality improvement opportunities.

Molina's first CLAS objective is to assess the cultural, ethnic, racial, and linguistic needs of its members and assess the cultural responsiveness of the provider network. Activities to meet this objective include:

- Annually analyze member and demographic data to identify culturally and linguistically diverse populations, including unique needs and preferences.
- Annually assess demographic data of network practitioners.
- Analyze the capacity and responsiveness of the practitioner network to meet the social, linguistic and accessibility needs of members.
- Publish practitioner-level demographic data, including sex, race, ethnicity, language, and whether the provider has completed cultural competency training (as available) via the provider directory.
- Annually notify all network practitioners of the availability of language services.
- At least annually, distribute resource materials to providers, including education on cultural diversity, culturally and linguistically appropriate services and other health

For internal use only.

California CLAS Analysis – Purpose

equity topics via newsletters, on-site visits, Provider Orientation, the Provider Manual, the Provider Portal, and the website.

- Report the Race/Ethnicity Description of Membership (RDM) HEDIS® measure.
- Report the Language Description of Membership (LDM) HEDIS® measure.
- At least every three years, use census and/or community-level data to determine and report threshold languages for translation purposes.
- Identify specific cultural and linguistic disparities found within the plan's diverse populations.
- Analyze stratified HEDIS® results for potential cultural and linguistic disparities that prevent members from obtaining the recommended key chronic and preventive services.
- Analyze stratified responses of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and Qualified Health Plan (QHP®) experience surveys.

For internal use only.

California CLAS Analysis – Methodology

Molina recognizes the importance of diversity and conducts ongoing assessments to determine whether members' needs are met. The following data sources were used to conduct this year's analysis:

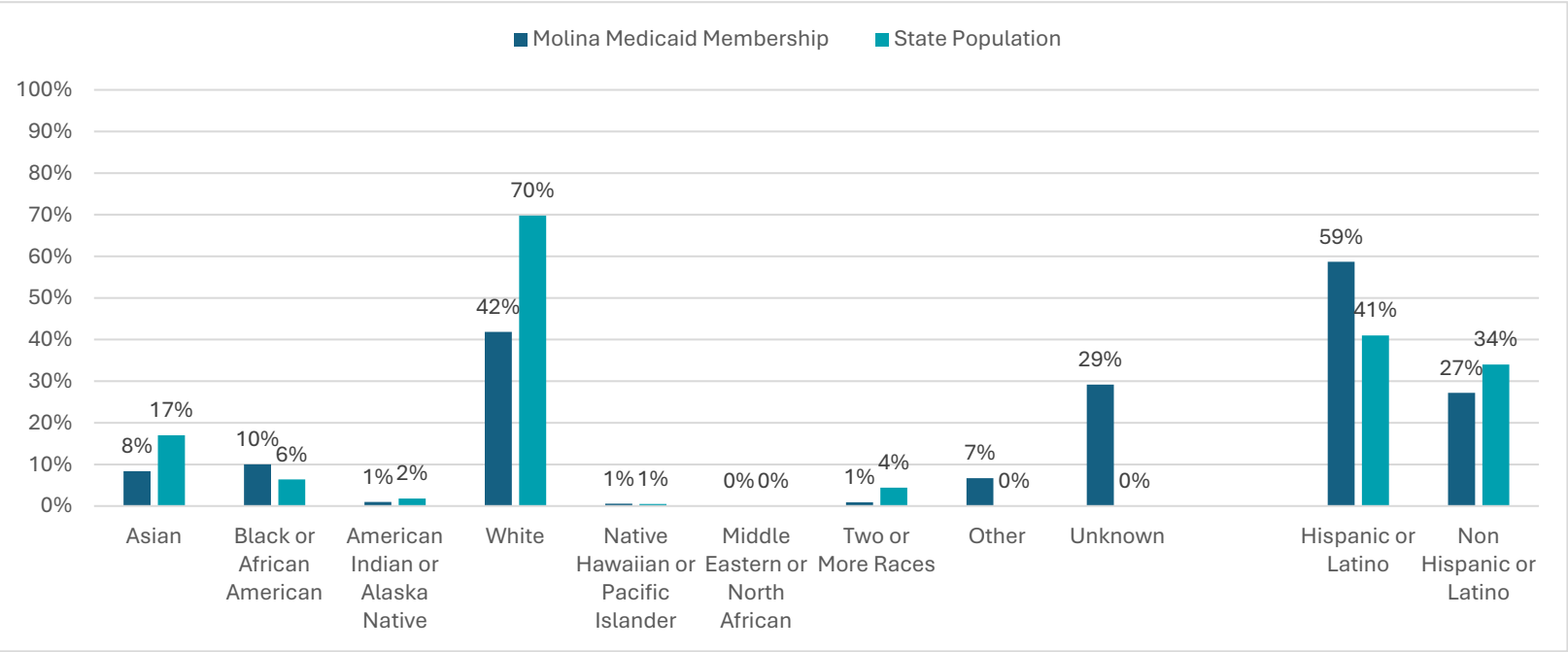
- Membership Data (all lines of business)– Information is collected through multiple data management systems, including enrollment/eligibility files, Salesforce, Clinical Care Advance, Health Information Exchange, Supplemental Data Sources, Member Month Table, and QNXT. Data retrieved is used to assess the diversity of member populations that Molina serves.
- Census Data – Data from the U.S. Census Bureau American Community Survey (ACS) is used to assess a community's race, ethnicity and language profile.
- Practitioner Data (all lines of business)– Race, ethnicity and language information is collected at time of credentialing and stored into the CACTUS system. The data is uploaded to QNXT and extracted using a custom query. When QNXT data is limited and/or incomplete, race, ethnicity and language information is extracted from the Provider Satisfaction Survey.
- Health Plan Descriptive Information – Health Equity Dashboard, Member Insights Dashboard, and LDM/RDM HEDIS® measures are used to assess demographic data completeness.
- Clinical Performance – Using HEDIS® 2025 methodology, Molina evaluates the following measures, including but not limited to: Colorectal Cancer Screening (COL-E), Breast Cancer Screening (BCS-E), Controlling Blood Pressure (CBP), Glycemic Status Assessment for Patients with Diabetes (GSD), Follow-Up After Emergency Department Visits for Substance Use (FUA), Prenatal and Postpartum Care (PPC), Initiation and Engagement of Substance Use Disorder Treatment (IET), and Child and Adolescent Well Care Visits (WCV). Rates are stratified by race and ethnicity using the Office of Management and Budget (OMB) two-question format, sex assigned at birth (male/female) and language.
- Member Experience –2025 CAHPS® for Medicaid and Medicare and the QHP® experience survey for Marketplace. Responses were stratified by race and ethnicity.

For internal use only.

California CLAS Analysis – Ethnic and Racial Assessment – Medicaid

Race, ethnicity and language data are used to assess the existence of disparities and to implement focused efforts to improve the delivery of CLAS and decrease health care disparities.

Molina Healthcare of California's Medicaid membership consisted of 1,089,879 individuals. Compared to the overall state population, Molina's Medicaid member population has a **larger** proportion of Black or African American individuals (10% Molina members compared to 6% statewide), a **smaller** proportion of Asian individuals (8% Molina members compared to 17% statewide), and a **smaller** proportion of White individuals (42% Molina members compared to 70% statewide). Hispanic or Latino Medicaid members comprise 59% of the overall membership, which is a **larger** proportion compared to state overall (41%). **Census Bureau does not report 'Other' or 'Unknown' and will include 'Middle Eastern or North African' in the 2030 Census.*

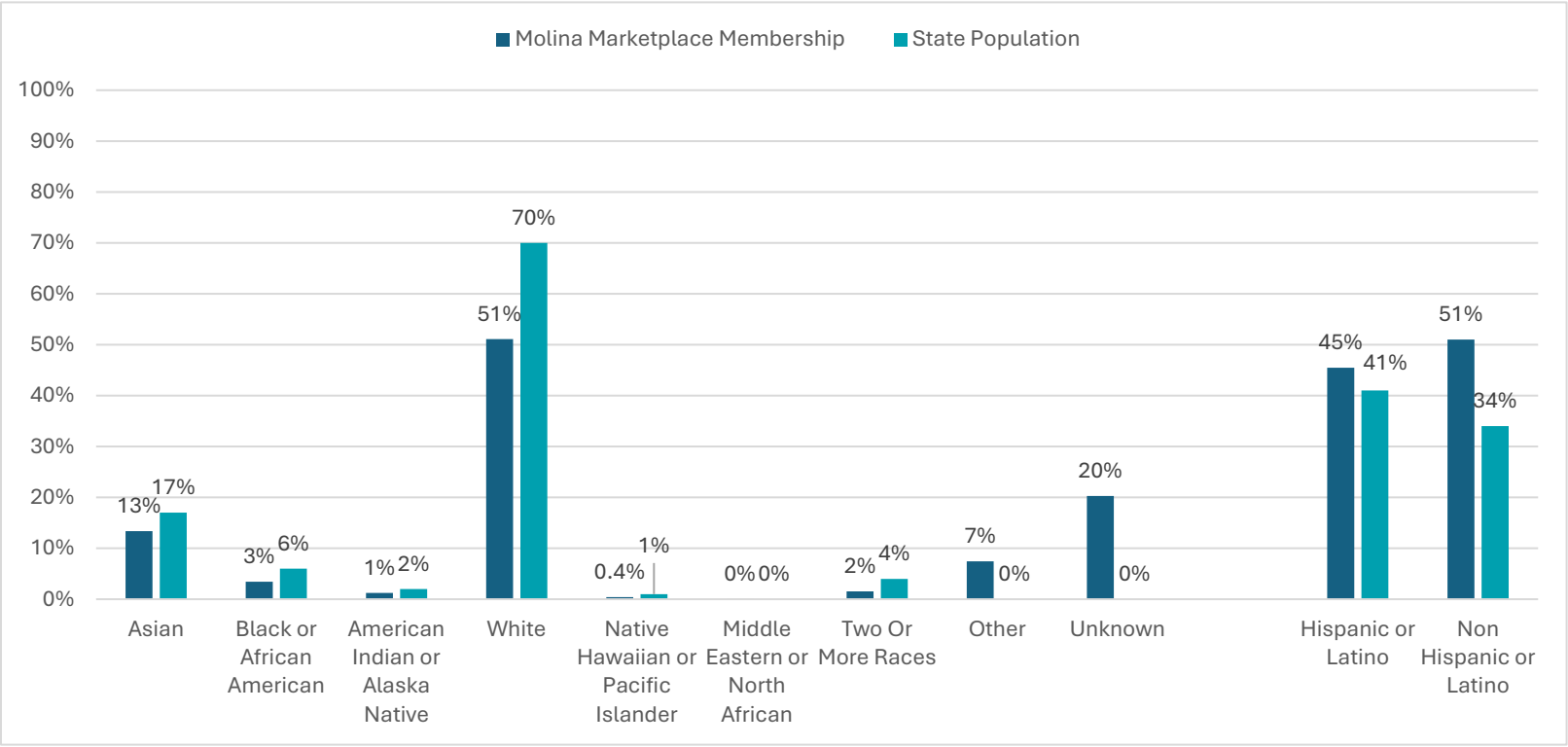


Member Insights Dashboard (Refresh Date: 02-11-2026); U.S. Census Bureau Population Estimates as of 07/01/2025

For internal use only.

California CLAS Analysis – Ethnic and Racial Assessment – Marketplace

Molina Healthcare of California's Marketplace membership consisted of 61,141 individuals. Compared to the overall state population, Molina's Marketplace member population has a **smaller** proportion of Black or African American individuals (3% Molina members compared to 6% statewide), a **larger** proportion of Native Hawaiian or Pacific Islander individuals (0.40% Molina members compared to 1% statewide), and a **smaller** proportion of White individuals (51% Molina members compared to 70% statewide). Hispanic or Latino Marketplace members comprised 45% of membership, which is a **larger** proportion compared to the state overall (41%). Not Hispanic or Latino Marketplace members comprised 51% of membership, which is a **larger** proportion compared to the state overall (34%). **Census Bureau does not report 'Other' or 'Unknown' and will include 'Middle Eastern or North African' in the 2030 Census.*

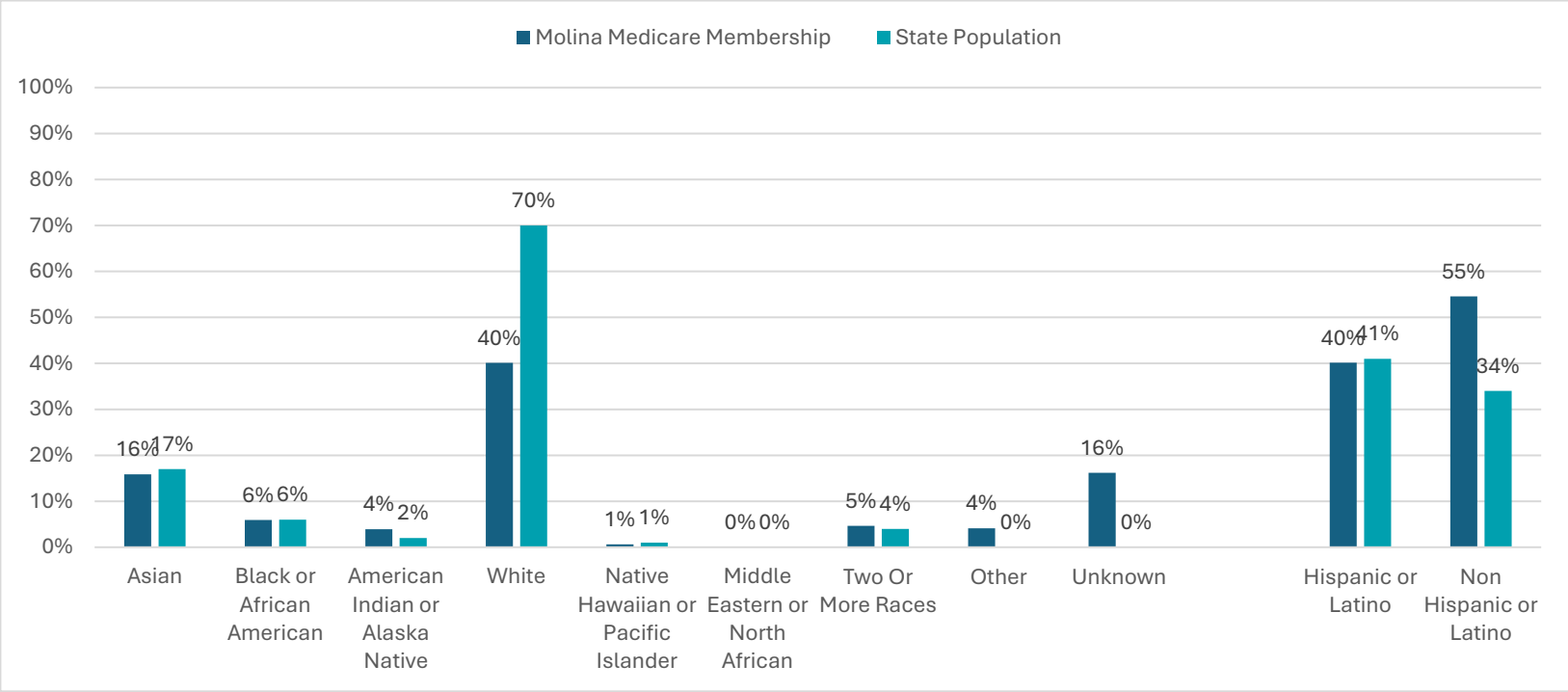


Member Insights Dashboard (Refresh Date: 02-11-2026); U.S. Census Bureau Population Estimates as of 07/01/2025

For internal use only.

California CLAS Analysis – Ethnic and Racial Assessment – Medicare

Molina Healthcare of California's Medicare membership consisted of 71,483 individuals. Compared to the overall state population, Molina's Medicare member population has an **equal** proportion of Black or African American individuals (6% Molina members compared to 6% statewide) and has a **smaller** proportion White individual (40% Molina members compared to 70% statewide). Hispanic or Latino Medicare members comprised 40% of membership, which is a **smaller** proportion compared to the state overall (41%). **Census Bureau does not report 'Other' or 'Unknown' and will include 'Middle Eastern or North African' in the 2030 Census.*



Member Insights Dashboard (02-11-2026); U.S. Census Bureau Population Estimates as of 07/01/2025

For internal use only.

California CLAS Analysis – Linguistic Preference Assessment

Molina uses census level data collected from The American Community Survey (ACS) to determine and report threshold languages for translation purposes. Threshold languages are all languages other than English spoken by 5% of the population or by 1,000 individuals, whichever is less. Molina maintains a list of all threshold languages and updates the list at least every 3 years.

Language	% of Speakers
Spanish	28%
Tagalog	2%
Chinese	2%
Vietnamese & other Austro-Asiatic Languages	1%
Korean	1%
Mandarin Chinese	1%
Yue Chinese	1%
Hindi	1%
Indian Persian	1%
Armenian	1%
Arabic	1%
Russian	0.5%
Punjabi	0.4%
Japanese	0.4%
Filipino	0.4%

U.S. Census Bureau ACS 2017-2021 Release Date: June 2025

For internal use only.

California CLAS Analysis – Linguistic Preference Assessment

Molina identified languages spoken by one percent of the population (or 200 eligible individuals), whichever is less, up to a maximum of 15 languages. In-depth analysis was conducted to analyze the capacity of the network to meet the language needs of members through the delivery of culturally appropriate and responsive health care services. **Goal: 1<2,000 PCP to Member Ratio.** **Ratios are rounded to the nearest whole number.*

Medicaid				
Language	**# of members who speak language**	**% of members who speak language**	**# of PCPs who speak language**	**Ratio**
English	677969	62.21%	17226	1:405
Spanish	345999	31.75%	5626	1:62
Arabic	14533	1.33%	619	1:24
Armenian	13694	1.26%	323	1:42
Vietnamese	9842	0.90%	589	1:17
Russian	9085	0.83%	323	1:28
Marketplace				
Language	**# of members who speak language**	**% of members who speak language**	**# of PCPs who speak language**	**Ratio**
English	37155	60.77%	14174	1:3
Spanish	19137	31.30%	4587	1:42
Mandarin Chinese	1381	2.26%	0	0:1381
Vietnamese	1035	1.69%	524	1:2
Russian	430	0.70%	282	1:2
Arabic	379	0.62%	554	1:1
Medicare				
Language	**# of members who speak language**	**% of members who speak language**	**# of PCPs who speak language**	**Ratio**
English	32138	44.96%	15993	1:2
Spanish	24960	34.92%	5511	1:5
Chinese	6329	8.85%	631	1:10
Korean	2079	2.91%	367	1:6
Vietnamese	1911	2.67%	690	1:3
Mandarin	991	1.39%	732	1:1
Tagalog	857	1.20%	750	1:1
Arabic	846	1.18%	602	1:1
Cantonese	417	0.58%	408	1:1

NOTE: Total may not equal 100% because only languages spoken by 1% of the population (or 200 eligible individuals) are reported with a maximum of 15 languages.

Member Insights Dashboard (02-11-2026); Provider QI Compliance Dashboard: 2025 Provider Data

For internal use only.

California CLAS Analysis – Linguistic County Analysis – Medicaid

In-depth analysis was conducted on Spanish-speaking primary care and Spanish-speaking specialty care physicians in the top five most populated counties with Molina members. This analysis is used to assess where there may be opportunities to expand its network to deliver culturally appropriate and responsive health care services. **Goal: <1:2,000 Provider to Member Ratio.** **Ratios are rounded to the nearest whole number.*

County	Members who speak Spanish (00-75+)	Members who speak Spanish (0-19)	Number of Spanish speaking Family/General practice	Ratio of Spanish speaking Family/General practice providers* to Spanish speaking members	Number of Spanish speaking Internal Medicine providers	Ratio of Spanish speaking Internal Medicine providers* to Spanish Speaking members	Number of Spanish speaking Pediatric providers	Ratio of Spanish Pediatric providers* to Spanish speaking members (0-19)
Los Angeles	194966	62891	1353	1:144	1049	1:186	743	1:85
San Diego	83653	34252	320	1:261	186	1:450	190	1:180
Riverside	30788	10575	205	1:148	143	1:215	113	1:94
San Bernadino	21434	6449	181	1:118	152	1:141	130	1:50
Sacramento	14078	5492	60	1:235	36	1:391	59	1:93

County	Members who speak Spanish (00-75+)	Number of Spanish speaking Cardiologists	Ratio of Spanish speaking Cardiologist* to Spanish speaking members	Number of Spanish speaking Nephrologists	Ratio of Spanish speaking Nephrologists* to Spanish speaking members	Number of Spanish speaking OB/GYN	Ratio of Spanish speaking OB/GYN* to Spanish speaking members	Number of Spanish speaking Psychiatrists	Ratio of Spanish speaking Psychiatrists* to Spanish speaking members
Los Angeles	194966	252	1:774	158	1:1234	391	1:499	44	1:4431
San Diego	83653	43	1:1945	41	1:2040	92	1:909	44	1:1901
Riverside	30788	35	1:880	34	1:906	79	1:340	12	1:2566
San Bernadino	21434	47	1:456	27	1:794	74	1:290	9	1:2382
Sacramento	14078	9	1:1564	2	1:7039	47	1:300	7	1:2011

Member Insights Dashboard (02-11-2026); Provider QI Compliance Dashboard: 2025 Provider Data

For internal use only.

Utah CLAS Analysis – Linguistic County Analysis – Marketplace

In-depth analysis was conducted on Spanish-speaking primary care and Spanish-speaking specialty care physicians in the top five most populated counties with Molina members. This analysis is used to assess where there may be opportunities to expand its network to deliver culturally appropriate and responsive health care services. **Goal: <1:2,000 Provider to Member Ratio.** **Ratios are rounded to the nearest whole number.*

County	Members who speak Spanish (00-75+)	Members who speak Spanish (0-19)	Number of Spanish speaking Family/General practice	Ratio of Spanish speaking Family/General practice providers* to Spanish speaking members	Number of Spanish speaking Internal Medicine providers	Ratio of Spanish speaking Internal Medicine providers* to Spanish Speaking members	Number of Spanish speaking Pediatric providers	Ratio of Spanish Pediatric providers* to Spanish speaking members (0-19)
San Diego	7727	483	342	1:23	191	1:40	153	1:3
Los Angeles	2370	33	1027	1:2	750	1:3	563	1:1
Riverside	2093	56	173	1:12	121	1:17	95	1:1
Imperial	4994	65	15	1:333	18	1:277	7	1:9
San Bernadino	1746	24	146	1:12	127	1:14	114	1:1

County	Members who speak Spanish (00-75+)	Number of Spanish speaking Cardiologists	Ratio of Spanish speaking Cardiologist* to Spanish speaking members	Number of Spanish speaking Nephrologists	Ratio of Spanish speaking Nephrologists* to Spanish speaking members	Number of Spanish speaking OB/GYN	Ratio of Spanish speaking OB/GYN* to Spanish speaking members	Number of Spanish speaking Psychiatrists	Ratio of Spanish speaking Psychiatrists* to Spanish speaking members
San Diego	7727	44	1:176	43	1:180	93	1:83	40	1:193
Los Angeles	2370	192	1:12	136	1:17	284	1:8	35	1:68
Riverside	2093	31	1:68	32	1:65	64	1:33	11	1:190
Imperial	4994	2	1:2497	3	1:1665	7	1:713	2	1:2497
San Bernadino	1746	44	1:40	27	1:65	60	1:29	9	1:194

Member Insights Dashboard (02-11-2026); Provider QI Compliance Dashboard: 2025 Provider Data

For internal use only.

California CLAS Analysis – Linguistic County Analysis – Medicare

In-depth analysis was conducted on Spanish-speaking primary care and Spanish-speaking specialty care physicians in the top five most populated counties with Molina members. This analysis is used to assess where there may be opportunities to expand its network to deliver culturally appropriate and responsive health care services. **Goal: <1:2,000 Provider to Member Ratio.** **Ratios are rounded to the nearest whole number.*

County	Members who speak Spanish (00-75+)	Members who speak Spanish (0-19)	Number of Spanish speaking Family/General practice	Ratio of Spanish speaking Family/General practice providers* to Spanish speaking members	Number of Spanish speaking Internal Medicine providers	Ratio of Spanish speaking Internal Medicine providers* to Spanish Speaking members	Number of Spanish speaking Pediatric providers	Ratio of Spanish Pediatric providers* to Spanish speaking members (0-19)
Los Angeles	5317	0	1207	1:4	928	1:6	609	609:0
San Diego	6895	0	340	1:20	186	1:37	134	134:0
Contra Costa	36	0	38	1:1	27	1:1	2	2:0
Riverside	2884	0	201	1:14	138	1:21	106	106:0
San Bernadino	2321	0	172	1:14	142	1:16	118	118:0

County	Members who speak Spanish (00-75+)	Number of Spanish speaking Cardiologists	Ratio of Spanish speaking Cardiologist* to Spanish speaking members	Number of Spanish speaking Nephrologists	Ratio of Spanish speaking Nephrologists* to Spanish speaking members	Number of Spanish speaking OB/GYN	Ratio of Spanish speaking OB/GYN* to Spanish speaking members	Number of Spanish speaking Psychiatrists	Ratio of Spanish speaking Psychiatrists* to Spanish speaking members
Los Angeles	5317	229	1:23	151	1:35	304	1:18	41	1:130
San Diego	6895	44	1:157	41	1:169	82	1:84	45	1:153
Contra Costa	36	5	1:7	6	1:6	12	1:3	0	0:36
Riverside	2884	35	1:82	35	1:82	68	1:42	12	1:240
San Bernadino	2321	46	1:50	27	1:86	66	1:35	10	1:232

Member Insights Dashboard (02-11-2026); Provider QI Compliance Dashboard: 2025 Provider Data

For internal use only.

California CLAS Analysis – Language Services: Interpretation Utilization

Molina offers interpretation services for any interaction a member is likely to have with the organization. An annual utilization assessment is conducted to evaluate access and adequacy of resources, as well as program structure.

To calculate utilization, Molina used call counts by department and divided it against the total number of members that speak a non-English language. The utilization indicator represents the percentage of individuals whose primary language is not English and who used interpretation services. Utilization rates can exceed 100% because the numerator represents total interpretation calls. Members may generate more than one call, resulting in utilization values greater than the size of the eligible population (non-English speakers).

Utilization Indicator = *Language Line Call Count / Total number of members that speak a non-English Language*.

Utilization is calculated using *only* the number of total members who self-reported speaking a non-English language (479,862).

Organization Department	2025 Call Count	2025 Utilization
(Call Center) Member Services	109526	23%
Care Connections (MMG)	83676	17%
Member Outreach (HCS)	49865	10%
Healthcare Services	33984	7%
Care Management	9532	2%
Pharmacy	6628	1%
Quality Improvement	4061	1%
Health Management	2166	0.5%
Utilization Management	1575	0.3%
Medicare	1554	0.3%
HealthPlan Services (HPS)	990	0.2%
High Risk OB (Health Management)	987	0.2%
Enrollment / Community Outreach	733	0.2%
Appeals & Grievances	663	0.1%
Convey	365	0.1%
Health Education	66	0.01%
Intake/Entitlement	27	0.01%
Care Management – HH	11	0.00%

For internal use only.

California CLAS Analysis – Language Services: Interpretation Connect Time

In-depth analysis was conducted on the average number of seconds it took to be connected to an interpreter. This analysis is used to identify opportunities for enhancing services provided to members who request interpretation while interacting with Molina's organizational departments. A connect time of 30 seconds or less is used as the performance benchmark for average connect time.

Number of seconds it took to be connected to an interpreter = Agent Connect Time + Interpreter Connect Time

Top 20 Languages (by volume)	2025 Avg. Connect Time (Seconds)	2025 Max Connect Time (Seconds)
Spanish	13.15896	757
Mandarin	13.27774	783
Arabic	14.37229	504
Vietnamese	12.66513	400
Cantonese	14.51019	694
Korean	19.79236	747
Russian	11.70346	524
Haitian Creole	9.769324	190
Chinese Mandarin	16.77754	920
Dari	13.11639	463
Tagalog	24.04167	556
Armenian	61.15304	1522
Pashto	13.34043	545
Chinese Cantonese	19.50019	640
Farsi	15.48371	612
Cambodian	15.7927	463
Ukrainian	20.60078	583
Punjabi	13.37968	147
Portuguese	12.58605	623
Laotian	38.5763	531

For internal use only.

California CLAS Analysis – Language Services: Interpretation Top Languages

Molina analyzes year-over-year top languages requested for interpretation services by line of business using external vendor reports. Data is used to determine if the top languages requested are consistent with the preferred languages reported by members.

LOB	Language	2025 Requests Percentage of Calls	Language	2024 Requests Percentage of Calls
Medicaid	Spanish	69%	Spanish	76%
	Arabic	5%	Arabic	4%
	Chinese Dialects	5%	Chinese Dialects	4%
	Haitian Creole	3%	Russian	3%
	Russian	3%	Haitian Creole	2%
	Vietnamese	2%	Armenian	2%
	Dari	2%	Vietnamese	2%
	Armenian	2%	Dari	1%
	Pashto	2%	Pashto	1%
	Farsi	1%	Farsi	1%
Marketplace	**Spanish**	**62%**	Spanish	73%
	Chinese Dialects	**10%**	Chinese Dialects	9%
	Vietnamese	**7%**	Vietnamese	5%
	Haitian Creole	**4%**	Russian	2%
	Arabic	**3%**	Arabic	2%
	Russian	**3%**	Haitian Creole	2%
	Korean	**1%**	Korean	1%
	Farsi	**1%**	Farsi	1%
	Punjabi	**1%**	Punjabi	1%
	Dari	**1%**	Tagalog	0.4%
Medicare	**Spanish**	**52%**	Spanish	66%
	Chinese Dialects	**23%**	Chinese Dialects	13%
	Vietnamese	**7%**	Vietnamese	6%
	Korean	**5%**	Korean	5%
	Arabic	**4%**	Arabic	2%
	Tagalog	**2%**	Cambodian	1%
	Cambodian	**1%**	Russian	1%
	Russian	**1%**	Tagalog	1%
	Farsi	**0.3%**	Portuguese	0.4%
	Portuguese	**0.3%**	Haitian Creole	0.4%

For internal use only.

California CLAS Analysis – Language Services: Translation

Molina develops materials in English, Spanish and other threshold languages, including alternate formats. Using external vendor reports, Molina analyzes translation project request data to determine if the top translated languages are consistent with the preferred languages reported by members.

Category	Language	2025 Requests (Percentage of Translation Projects)	Language	2024 Requests (Percentage of Translation Projects)
Molina Healthcare of California (All LOBS)	**Spanish**	**78%**	Spanish	48%
	Chinese	**6%**	Arabic	11%
	Arabic	**3%**	Vietnamese	9%
	Korean	**3%**	Tagalog	5%
	Vietnamese	**3%**	Russian	4%
	Tagalog	**1%**	Armenian	3%
	Russian	**1%**	Korean	3%
	Laotian	**1%**	Chinese	3%
	Armenian	**1%**	Hmong	3%
	Khmer	**0.40%**	Farsi	2%
Molina Corporate Enterprise	**Spanish**	**20%**	Spanish	66%
	Chinese	**10%**	Chinese	8%
	Arabic	**6%**	Arabic	6%
	Vietnamese	**5%**	Vietnamese	6%
	Korean	**4%**	Portuguese	2%
	Bengali	**4%**	Russian	2%
	Russian	**3%**	Korean	1%
	Urdu	**3%**	Tagalog	1%
	Haitian Creole	**2%**	Braille	1%
	Khmer	**2%**	Khmer	1%

For internal use only.

California CLAS Analysis – Language Services: Staff Satisfaction

Molina analyzes staff experience with language services for organization functions to consider its performance in all aspects of the CLAS program. Data is used to determine access and adequacy of resources, as well as program structure.

Issues By Language	Did Not Interpret Well	Difficult to Hear	Call Ended Unexpectedly	Distracted	Rude	Background Noise	No Knowledge of Industry Terminology	Side Conversations	Total Issues	Positive Feedback
Arabic	3	2	2	2	1				10	90
Bengali			1						1	
Chinese										26
Chinese – Cantonese	2		1	1	1		1	1	7	17
Chinese – Mandarin	1						1		1	33
Creole	2	4	3	1				2	12	29
Korean		1							1	6
Nepali			1	1		1		1	4	3
Other	5	4	5	2	1		1		18	135
Punjabi									0	3
Russian	2		1	2				1	5	35
Somali				1					1	4
Spanish	79	44	47	74	32	14	17	1	308	2028
Vietnamese	1								1	34

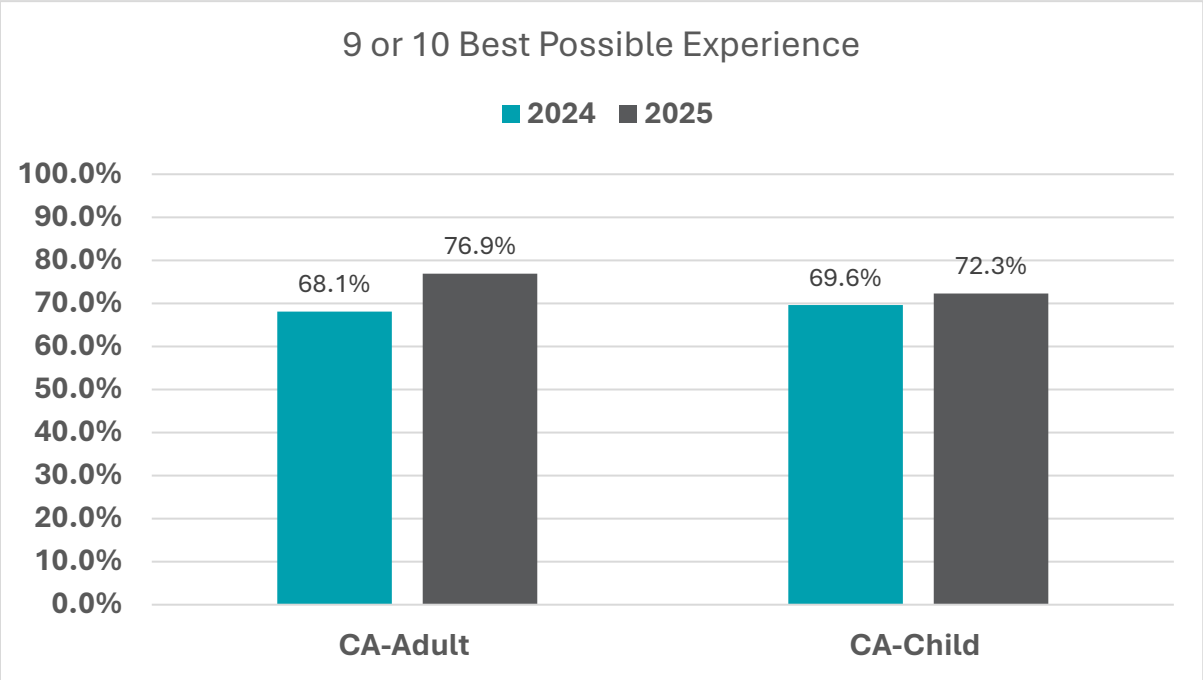
Positive Feedback:
“Very professional and fast with everything. If I’ve to contact someone for Vietnamese again, I’d love to speak with him again.”
“Very friendly and made sure that all information given was accurate before providing it to me.”
“Patient, Active Listening”
“Amazing job from interpreter”
“He was very helpful and very professional. Thank you!’
“He was very wonderful, kind and patient! Did as great job!’
“Very patient interpreter 10/10 really explained everything well”
“Good interpreting”
“Professional and courteous”

For internal use only.

California CLAS Analysis – Language Services: Member Satisfaction (Medicaid CAHPS® Survey)

The 2025 Medicaid CAHPS® Survey included two supplemental data questions to assess satisfaction with Molina's interpreter or language services when interacting with 1) a provider and 2) the health plan. Year-over-year data is used to analyze performance.

Question 1: In the last 6 months, if you utilized an interpreter or language services to help speak with your (or your child's) doctors or healthcare providers, how would you rate your experience?

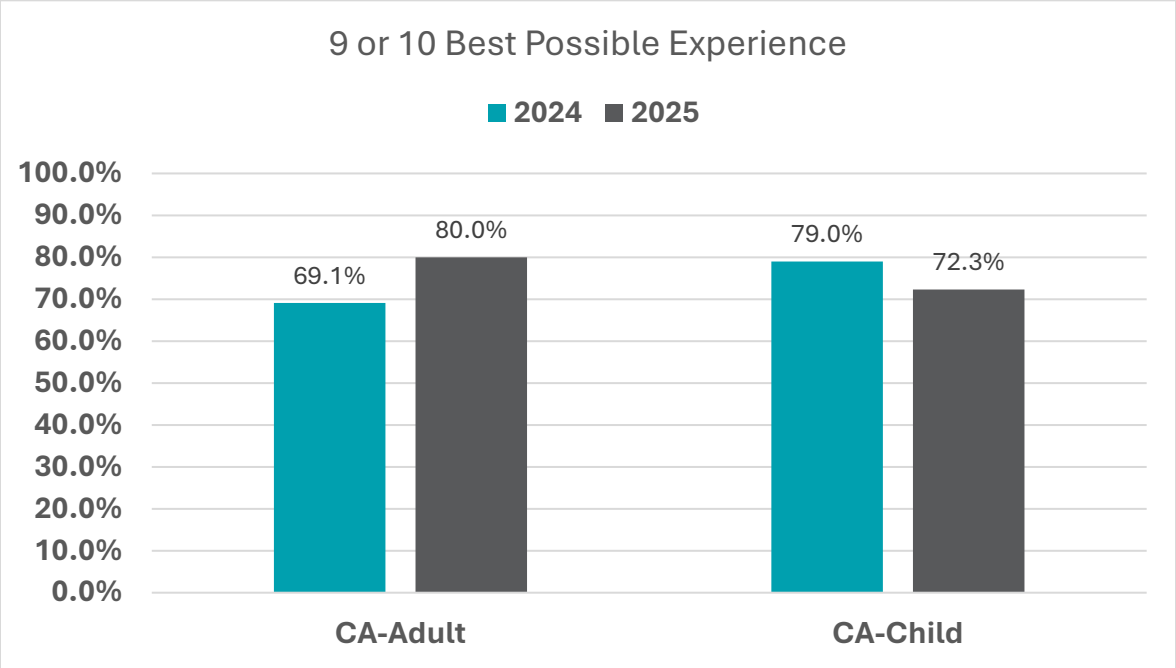


For internal use only.

California CLAS Analysis – Language Services: Member Satisfaction (Medicaid CAHPS® Survey)

The 2025 Medicaid CAHPS® Survey included two supplemental data questions to assess satisfaction with Molina's interpreter or language services when interacting with 1) a provider and 2) the health plan. Year-over-year data is used to analyze performance.

Question 2: In the last six months, if you utilized an interpreter or language services to help coordinate appointments with your doctors or other healthcare providers, how would you rate your experience?

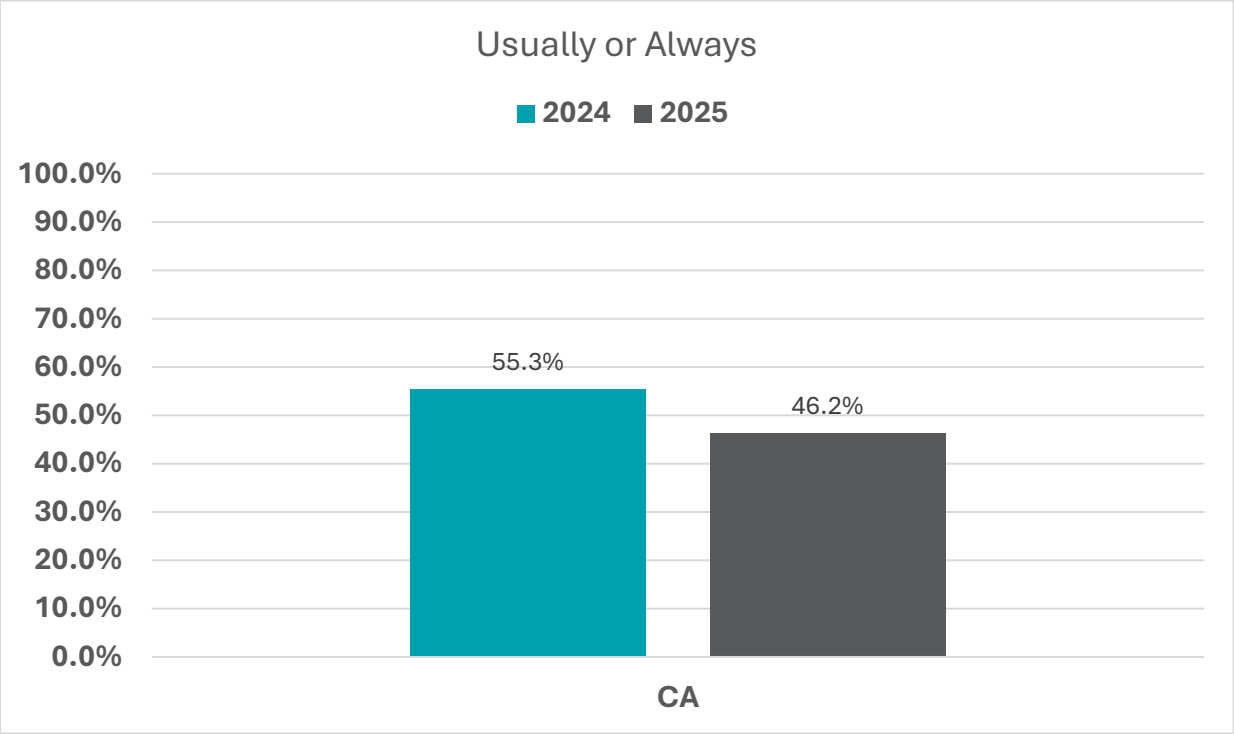


For internal use only.

California CLAS Analysis – Language Services: Member Satisfaction (QHP® Survey)

The 2025 QHP® Survey included three questions to assess satisfaction with Molina's interpreter or language services when interacting with 1) a provider and 2) the health plan. Year-over-year data is used to analyze performance.

Question 1: In the last 6 months, when you needed an interpreter at your doctor's office or clinic, how often did you get one? Include in-person, telephone, or video appointments.

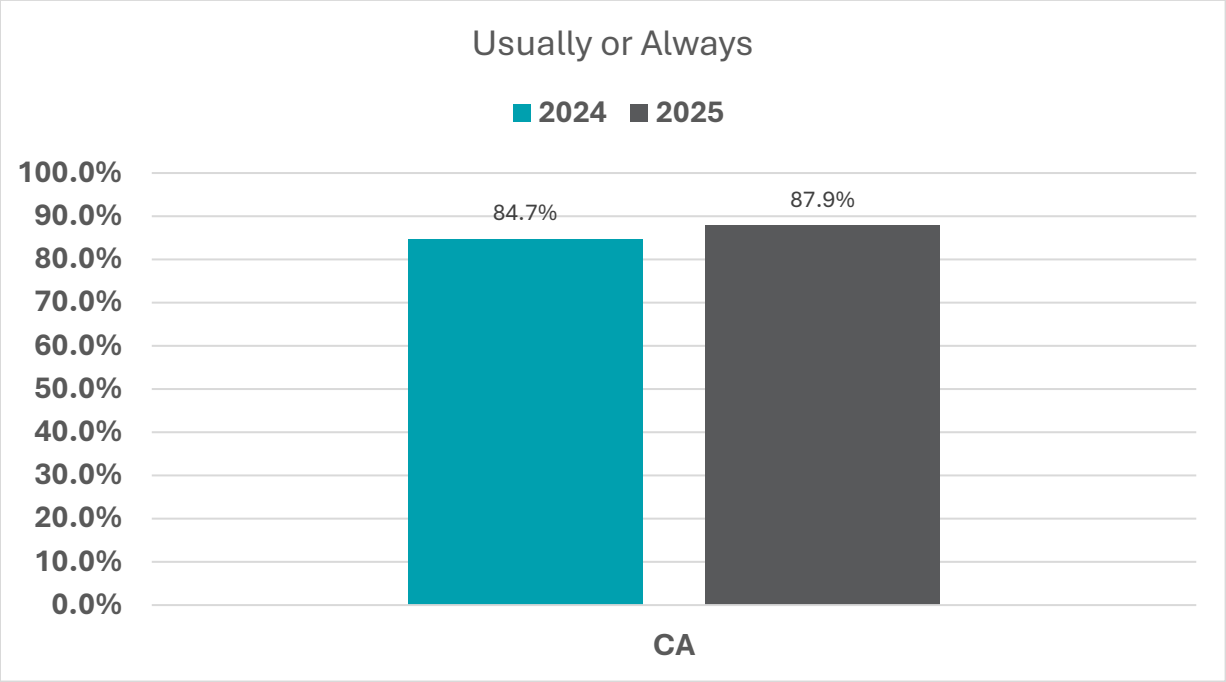


For internal use only.

California CLAS Analysis – Language Services: Member Satisfaction (QHP® Survey)

The 2025 QHP® Survey included three questions to assess satisfaction with Molina's interpreter or language services when interacting with 1) a provider and 2) the health plan. Year-over-year data is used to analyze performance.

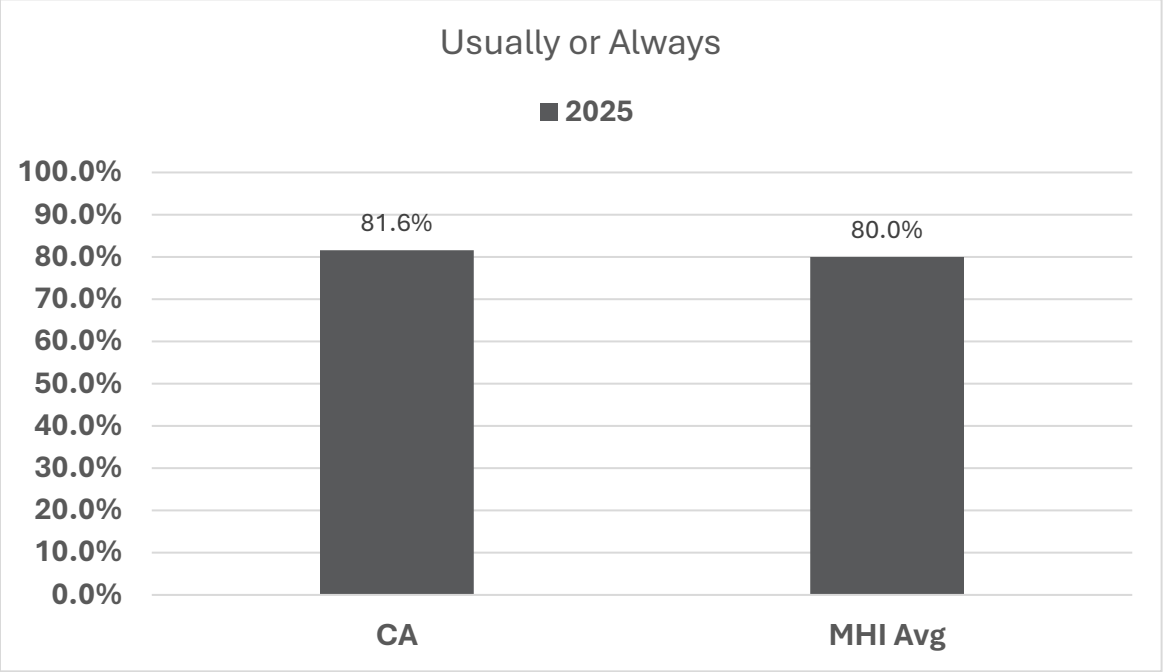
Question 2: In the last 6 months, how often were the health plan forms that you had to fill out available in the language you prefer?



California CLAS Analysis – Language Services: Member Satisfaction (QHP® Survey)

The 2025 QHP® Survey included three questions to assess satisfaction with Molina's interpreter or language services when interacting with 1) a provider and 2) the health plan. Year-over-year data is used to analyze performance.

Question 3: In the last 6 months, how often were the health plan forms that you had to fill out available in the format you needed, such as large print or braille?



California CLAS Analysis – Network Cultural Responsiveness

Molina assesses the demographic data and availability of its practitioners to ensure that Molina members have sufficient access and choice of providers.

Race	Medicaid Membership	Marketplace Membership	Medicare Membership	Network Providers	Sufficient Coverage of Providers?		
	Percent	Percent	Percent	Percent	Medicaid	Marketplace	Medicare
American Indian or Alaska Native	1%	1%	4%	0.80%	Yes	Yes	Yes
Asian	8%	13%	16%	26.60%	Yes	Yes	Yes
Black or African American	10%	3%	6%	2.40%	Yes	Yes	Yes
White	42%	51%	40%	21.80%	Yes	Yes	Yes
Native Hawaiian or Pacific Islander	1%	0%	1%	0.00%	No	NA	No
Mixed/Other	7%	7%	4%	48.40%	Yes	Yes	Yes
Ethnicity							
Hispanic or Latino	59%	45%	40%	17.50%	Yes	Yes	Yes

According to internal databases, the majority of providers race/ethnicity is unknown. To address lack of complete provider and ethnicity data, Molina added demographic questions to the Provider Satisfaction Survey in 2021. Based on the 2025 Provider Satisfaction Survey, majority of providers are Asian, White, and Mixed/Other.

For internal use only.

California CLAS Analysis – Network Cultural Responsiveness

Molina Healthcare expects its network providers to effectively provide services to people of all cultures, races, ethnic backgrounds, religions, members of the LGBTQIA+ community, individuals living in geographically diverse areas, older adults and persons with disabilities. Providers are expected to deliver services in a manner that recognizes values, affirms and respects the worth of individuals and protects and preserves dignity of each.

A 'culturally competent and responsive provider network' refers to a group of providers who are trained and committed to delivering health care and health care services that respect the diverse cultural backgrounds, lived experiences, and unique needs and preferences of their patients. Provider training and quality monitoring are crucial to fostering a culturally competent and responsive practitioner network and ensuring the delivery of high-quality health care services. Molina offers materials and resources on cultural competency and other health equity related topics to participating health care providers. Providers attest annually to the completion of cultural competency training and Molina tracks and reports providers who have indicated completing cultural competency training through the Provider Directory.

3% of Molina Healthcare of California providers have completed Cultural Competency training and are identified as responsive to the culturally and linguistically diverse needs of Molina members. (QNXT Provider Data as of 02/16/2026)

For internal use only.

California CLAS Analysis – Network Cultural Responsiveness

The following is not a complete list of potential disparities in any race, ethnicity, or language group. Subpopulations are analyzed for a potential disparity that is identified by having a ≥10% variance from the subpopulation with the highest quality score. The subpopulation must be greater than 30 members to be included in the disparity analysis.

When prioritizing potential disparities, factors beyond the quality gap of ≥10% should also be considered:

1. **Prevalence:** Determining how prevalent the condition is among the subpopulation.
2. **Disparities Quality Gap:** How large is the gap between the subpopulation with the lowest quality score and the subpopulation with the highest quality score for that measure?
3. **Impact:** The influence a condition, access/availability of care, or preventive screening has financially, publicly, and on the community at large that is being evaluated. (e.g. – affects large numbers, leading cause of morbidity/mortality, high resource use, severity of illness, and patient/societal consequences of poor quality).

Recommendations and criteria considerations from the National Quality Forum (NQF), Institute for Healthcare Improvement (IHI), and National Committee for Quality Assurance (NCQA), have been reviewed to help inform Molina's approach to identifying potential disparities to address.

NOTE:
Green: Indicates the subpopulation with the highest quality score.
Red: Indicates a potential disparity (identified by having a ≥10% variance from the subpopulation with the highest quality score).

Because hybrid rates reflect only a subsample of the eligible population, *administrative rates are used* to more accurately reflect disparities across subpopulations.

For internal use only.

California CLAS Analysis – Health Care Disparities Assessment (Medicaid)

Molina analyzes clinical performance and member experience measures by race, ethnicity, and language to determine if health care disparities exist among Molina members.

Colorectal Cancer Screening (COL-E)	Stratified HEDIS® Rate 2025			Stratified HEDIS® Rate 2024	Goal Rate 67th percentile
Race	Num	Den	Rate		
American Indian or Alaska Native	23	89	**25.84%**	18.22%	45.84%
Asian	7729	18866	**40.97%**	38.84%	45.84%
Black or African American	828	2939	**28.17%**	29.02%	45.84%
Native Hawaiian or Pacific Islander	31	157	**19.75%**	NA	45.84%
White	2967	9309	**31.87%**	36.83%	45.84%
Some Other Race	53	109	**48.62%**	NA	45.84%
Two Or More Races	40	89	**44.94%**	NA	45.84%
Asked But No Answer	3	7	**42.86%**	NA	45.84%
Unknown	9569	23372	**40.94%**	39.37%	45.84%
Ethnicity					
Hispanic or Latino	9234	22459	**41.11%**	40.13%	45.84%
Not Hispanic or Latino	5129	12716	**40.34%**	32.32%	45.84%
Asked But No Answer	NA	NA	**NA**	NA	45.84%
Unknown	6880	19762	**34.81%**	39.49%	45.84%
Language					
English	10728	32306	**33.21%**	32.01%	45.84%
Non-English	10509	22611	**46.48%**	45.88%	45.84%
Unknown	6	20	**30.00%**	28.57%*	45.84%

2025 IDSS Reported Rate: 38.67%

Race: Potential disparities found in the American Indian or Alaska Native, Black or African American, Native Hawaiian or Pacific Islander and White subpopulations.
Ethnicity: No potential disparities found.
Language: Potential disparity found in the English-speaking subpopulation.

*2024 HEDIS rates with less than 30 members in the denominator.

For internal use only.

California CLAS Analysis – Health Care Disparities Assessment (Marketplace)

Molina analyzes clinical performance and member experience measures by race, ethnicity, and language to determine if health care disparities exist among Molina members.

Colorectal Cancer Screening (COL-E)	Stratified HEDIS® Rate 2025			Stratified HEDIS® Rate 2024	Goal Rate 75th percentile
Race	Num	Den	Rate		
American Indian or Alaska Native	16	25	**64.00%**	NA	N/A
Asian	683	1333	**51.24%**	0.00%*	N/A
Black or African American	116	201	**57.71%**	NA	N/A
Native Hawaiian or Pacific Islander	17	32	**53.13%**	NA	N/A
White	1784	3703	**48.18%**	16.67%*	N/A
Some Other Race	764	1525	**50.10%**	NA	N/A
Two Or More Races	54	85	**63.53%**	NA	N/A
Asked But No Answer	0	1	**0.00%**	NA	N/A
Unknown	4095	7715	**53.08%**	34.41%	N/A
Ethnicity					
Hispanic or Latino	2441	4503	**54.21%**	16.67%*	N/A
Not Hispanic or Latino	3514	7020	**50.06%**	0.00%*	N/A
Asked But No Answer	NA	NA	**NA**	NA	N/A
Unknown	1574	3097	**50.82%**	34.41%	N/A
Language					
English	3778	7111	**53.13%**	41.03%	N/A
Non-English	3611	7207	**50.10%**	35.76%	N/A
Unknown	140	302	**46.36%**	26.57%	N/A

2025 IDSS Reported Rate: 51.50%

Race: Potential disparities found in the Asian, Native Hawaiian or Pacific Islander, White, Some Other Race and Unknown subpopulations.
Ethnicity: No potential disparities found.
Language: No potential disparities found.

*2024 HEDIS rates with less than 30 members in the denominator.

For internal use only.

California CLAS Analysis – Health Care Disparities Assessment (Medicare)

Molina analyzes clinical performance and member experience measures by race, ethnicity, and language to determine if health care disparities exist among Molina members.

Colorectal Cancer Screening (COL-E)	Stratified HEDIS® Rate 2025			Stratified HEDIS® Rate 2024	Goal Rate 75th percentile
Race	Num	Den	Rate		
American Indian or Alaska Native	6	10	**60.00%**	NA	76.97%
Asian	1156	1666	**69.39%**	100%*	76.97%
Black or African American	202	344	**58.72%**	80.00%*	76.97%
Native Hawaiian or Pacific Islander	6	8	**75.00%**	NA	76.97%
White	628	1000	**62.80%**	72.41%*	76.97%
Some Other Race	19	30	**63.33%**	NA	76.97%
Two Or More Races	28	40	**70.00%**	NA	76.97%
Asked But No Answer	15	21	**71.43%**	NA	76.97%
Unknown	1545	2301	**67.14%**	-	76.97%
Ethnicity					
Hispanic or Latino	1542	2076	**69.94%**	61.54%*	76.97%
Not Hispanic or Latino	715	1064	**67.20%**	0.00%	76.97%
Asked But No Answer	NA	NA	**NA**	NA	76.97%
Unknown	1437	2278	**63.08%**	58.07%	76.97%
Language					
English	1882	3040	**61.91%**	60.19%	76.97%
Non-English	1722	2379	**72.38%**	79.07%	76.97%
Unknown	2	2	**100%**	59.85%	76.97%

2025 IDSS Reported Rate: 66.52%

Race: Potential disparity found in the Black or African American subpopulation.
Ethnicity: No potential disparities found.
Language: Potential disparity found in the English-speaking subpopulation.

*2024 HEDIS rates with less than 30 members in the denominator.

For internal use only.

California CLAS Analysis – Health Care Disparities Assessment (Medicaid)

Molina analyzes clinical performance and member experience measures by race, ethnicity, and language to determine if health care disparities exist among Molina members.

Breast Cancer Screening (BCS-E)	Stratified HEDIS® Rate 2025			Goal Rate 67th percentile
Race	Num	Den	Rate	
American Indian or Alaska Native	13	35	**37.14%**	58.93%
Asian	3807	7152	**53.23%**	58.93%
Black or African American	400	876	**45.66%**	58.93%
Native Hawaiian or Pacific Islander	10	53	**18.87%**	58.93%
White	1161	2829	**41.04%**	58.93%
Some Other Race	17	27	**62.96%**	58.93%
Two or More Races	20	29	**68.97%**	58.93%
Asked But No Answer	3	4	**75.00%**	58.93%
Unknown	5364	9211	**58.23%**	58.93%
Ethnicity				
Hispanic or Latino	5371	9172	**58.56%**	58.93%
Not Hispanic or Latino	2417	4599	**52.55%**	58.93%
Asked But No Answer	NA	NA	**NA**	58.93%
Unknown	3007	6445	**46.66%**	58.93%
Language				
English	4550	10022	**45.40%**	58.93%
Non-English	6239	10185	**61.26%**	58.93%
Unknown	6	9	**66.67%**	58.93%

2025 IDSS Reported Rate: 53.40%

Race: Potential disparities found in the American Indian or Alaska Native, Black or African American, Native Hawaiian or Pacific Islander and White subpopulation.
Ethnicity: Potential disparity found in the Unknown subpopulation.
Language: Potential disparity found in the English-speaking subpopulation.

For internal use only.

California CLAS Analysis – Health Care Disparities Assessment (Marketplace)

Molina analyzes clinical performance and member experience measures by race, ethnicity, and language to determine if health care disparities exist among Molina members.

Breast Cancer Screening (BCS-E)	Stratified HEDIS® Rate 2025			Goal Rate 75th percentile
Race	Num	Den	Rate	
American Indian or Alaska Native	5	6	**83.33%**	76.77%
Asian	269	404	**66.58%**	76.77%
Black or African American	53	77	**68.83%**	76.77%
Native Hawaiian or Pacific Islander	7	8	**87.50%**	76.77%
White	621	1059	**58.64%**	76.77%
Some Other Race	276	460	**60.00%**	76.77%
Two or More Races	23	30	**76.67%**	76.77%
Asked But No Answer	NA	NA	**NA**	76.77%
Unknown	2713	3394	**64.02%**	76.77%
Ethnicity				
Hispanic or Latino	1031	1544	**66.77%**	76.77%
Not Hispanic or Latino	1380	2249	**61.36%**	76.77%
Asked But No Answer	NA	NA	**NA**	76.77%
Unknown	1016	1645	**61.76%**	76.77%
Language				
English	1608	2478	**64.89%**	76.77%
Non-English	1764	2866	**61.55%**	76.77%
Unknown	55	94	**58.51%**	76.77%

2025 IDSS Reported Rate: 63.02%

Race: Potential disparities found in the Asian, White, Some Other Race and Unknown subpopulations.
Ethnicity: No potential disparities found.
Language: No potential disparities found.

For internal use only.

California CLAS Analysis – Health Care Disparities Assessment (Medicare)

Molina analyzes clinical performance and member experience measures by race, ethnicity, and language to determine if health care disparities exist among Molina members.

Breast Cancer Screening (BCS-E)	Stratified HEDIS® Rate 2025			Goal Rate 75th percentile
Race	Num	Den	Rate	
American Indian or Alaska Native	3	5	**60.00%**	79.14%
Asian	434	643	**67.50%**	79.14%
Black or African American	97	137	**70.80%**	79.14%
Native Hawaiian or Pacific Islander	1	2	**50.00%**	79.14%
White	207	347	**59.65%**	79.14%
Some Other Race	9	16	**56.25%**	79.14%
Two or More Races	14	19	**73.68%**	79.14%
Asked But No Answer	7	8	**87.50%**	79.14%
Unknown	628	931	**67.45%**	79.14%
Ethnicity				
Hispanic or Latino	566	806	**70.22%**	79.14%
Not Hispanic or Latino	267	404	**66.09%**	79.14%
Asked But No Answer	NA	NA	**NA**	79.14%
Unknown	567	898	**63.14%**	79.14%
Language				
English	715	1162	**61.53%**	79.14%
Non-English	684	945	**72.38%**	79.14%
Unknown	1	1	**100%**	79.14%

2025 IDSS Reported Rate: 66.41%

Race: Potential disparity found in the White subpopulation.
Ethnicity: No potential disparities found.
Language: Potential disparity found in the English-speaking subpopulation.

For internal use only.

California CLAS Analysis – Health Care Disparities Assessment (Medicaid)

Molina analyzes clinical performance and member experience measures by race, ethnicity, and language to determine if health care disparities exist among Molina members.

Controlling Blood Pressure (CBP)	Stratified HEDIS® Rate 2025			Stratified HEDIS® Rate 2024	Goal Rate 67th percentile
Race	Num	Den	Rate		
American Indian or Alaska Native	21	46	**45.65%**	NA	70.35%
Asian	3848	6653	**57.84%**	52.17%	70.35%
Black or African American	506	1101	**45.96%**	64.71%*	70.35%
Native Hawaiian or Pacific Islander	21	44	**47.73%**	NA	70.35%
White	1368	2460	**55.61%**	75.76%	70.35%
Some Other Race	21	36	**58.33%**	NA	70.35%
Two Or More Races	14	21	**58.33%**	NA	70.35%
Asked But No Answer	3	4	**75.00%**	NA	70.35%
Unknown	5094	8380	**60.79%**	63.59%	70.35%
Ethnicity					
Hispanic or Latino	5008	8151	**61.44%**	79.39%	70.35%
Not Hispanic or Latino	2609	4503	**57.94%**	59.46%	70.35%
Asked But No Answer	NA	NA	**NA**	NA	70.35%
Unknown	3279	6097	**53.78%**	63.59%	70.35%
Language					
English	5619	10348	**54.30%**	71.62%	70.35%
Non-English	5276	8401	**62.80%**	76.56%	70.35%
Unknown	1	2	**50.00%**	NA	70.35%

2025 IDSS Reported Rate: 65.21%

Race: Potential disparities found in the American Indian or Alaska Native, Black or African American and Native Hawaiian or Pacific Islander subpopulations.
Ethnicity: No potential disparities found.
Language: No potential disparities found.

*2024 HEDIS rates with less than 30 members in the denominator.

For internal use only.

California CLAS Analysis – Health Care Disparities Assessment (Marketplace)

Molina analyzes clinical performance and member experience measures by race, ethnicity, and language to determine if health care disparities exist among Molina members.

Controlling Blood Pressure (CBP)	Stratified HEDIS® Rate 2025			Stratified HEDIS® Rate 2024	Goal Rate 75th percentile
Race	Num	Den	Rate		
American Indian or Alaska Native	10	13	**76.92%**	NA	73.97%
Asian	301	523	**57.55%**	NA	73.97%
Black or African American	79	130	**60.77%**	NA	73.97%
Native Hawaiian or Pacific Islander	11	16	**68.75%**	NA	73.97%
White	684	1290	**53.02%**	80.00%*	73.97%
Some Other Race	310	562	**55.16%**	NA	73.97%
Two Or More Races	21	36	**58.33%**	NA	73.97%
Asked But No Answer	0	2	**0.00%**	NA	73.97%
Unknown	1682	2936	**57.29%**	66.58%	73.97%
Ethnicity					
Hispanic or Latino	1123	1926	**58.31%**	88.89%	73.97%
Not Hispanic or Latino	1350	2477	**54.50%**	0.00%*	73.97%
Asked But No Answer	NA	NA	**NA**	NA	73.97%
Unknown	625	1105	**56.56%**	66.58%	73.97%
Language					
English	1587	2891	**54.89%**	70.16%	73.97%
Non-English	1470	2521	**58.31%**	69.92%	73.97%
Unknown	41	96	**42.71%**	62.20%	73.97%

2025 IDSS Reported Rate: 71.29%

Race: Potential disparities found in the Asian, White, Some Other Race, Two Or More Races and Unknown subpopulations.
Ethnicity: No potential disparities found.
Language: No potential disparities found.

*2024 HEDIS rates with less than 30 members in the denominator.

For internal use only.

California CLAS Analysis – Health Care Disparities Assessment (Medicare)

Molina analyzes clinical performance and member experience measures by race, ethnicity, and language to determine if health care disparities exist among Molina members.

Controlling Blood Pressure (CBP)	Stratified HEDIS® Rate 2025			Stratified HEDIS® Rate 2024	Goal Rate 75th percentile
Race	Num	Den	Rate		
American Indian or Alaska Native	8	14	**57.14%**	NA	82.48%
Asian	1594	2451	**65.03%**	60.00%*	82.48%
Black or African American	280	441	**63.49%**	100%*	82.48%
Native Hawaiian or Pacific Islander	8	13	**61.54%**	NA	82.48%
White	605	950	**63.68%**	75.00%*	82.48%
Some Other Race	27	45	**60.00%**	NA	82.48%
Two Or More Races	30	41	**73.17%**	NA	82.48%
Asked But No Answer	60	90	**66.67%**	NA	82.48%
Unknown	2040	3038	**67.15%**	75.52%	82.48%
Ethnicity					
Hispanic or Latino	2218	3284	**67.54%**	60.00%*	82.48%
Not Hispanic or Latino	936	1475	**63.46%**	76.47%*	82.48%
Asked But No Answer	NA	NA	**NA**	NA	82.48%
Unknown	1498	2324	**64.46%**	75.52%	82.48%
Language					
English	2013	3203	**62.85%**	67.21%	82.48%
Non-English	2639	3879	**68.03%**	70.77%	82.48%
Unknown	0	1	**0.00%**	77.89%	82.48%

2025 IDSS Reported Rate: 76.40%

Race: Potential disparity found in the Some Other Race subpopulation.
Ethnicity: No potential disparities found.
Language: No potential disparities found.

*2024 HEDIS rates with less than 30 members in the denominator.

For internal use only.

California CLAS Analysis – Health Care Disparities Assessment (Medicaid)

Molina analyzes clinical performance and member experience measures by race, ethnicity, and language to determine if health care disparities exist among Molina members.

Glycemic Status Assessment for Patients with Diabetes (GSD) <8.0%	Stratified HEDIS® Rate 2025			Stratified HEDIS® Rate 2024	Goal Rate 67th percentile
Race	Num	Den	Rate		
American Indian or Alaska Native	17	48	**35.42%**	36.71%	63.04%
Asian	3909	6980	**56.00%**	56.59%	63.04%
Black or African American	452	980	**46.12%**	44.04%	63.04%
Native Hawaiian or Pacific Islander	23	54	**42.59%**	NA	63.04%
White	1075	1933	**55.61%**	53.50%	63.04%
Some Other Race	23	36	**63.89%**	NA	63.04%
Two Or More Races	19	34	**55.88%**	NA	63.04%
Asked But No Answer	2	3	**66.67%**	NA	63.04%
Unknown	5860	10686	**54.84%**	50.65%	63.04%
Ethnicity					
Hispanic or Latino	5864	10844	**54.08%**	50.09%	63.04%
Not Hispanic or Latino	2608	4679	**55.74%**	51.28%	63.04%
Asked But No Answer	NA	NA	**NA**	NA	63.04%
Unknown	2908	5231	**55.59%**	53.79%	63.04%
Language					
English	5391	10450	**51.59%**	48.12%	63.04%
Non-English	5988	10300	**58.14%**	55.28%	63.04%
Unknown	1	4	**25.00%**	33.33%	63.04%

2025 IDSS Reported Rate: 55.23%

Race: Potential disparities found in the American Indian or Alaska Native, Black or African American and Native Hawaiian or Pacific Islander subpopulations.
Ethnicity: No potential disparities found.
Language: No potential disparities found.

*2024 HEDIS rates with less than 30 members in the denominator.

For internal use only.

California CLAS Analysis – Health Care Disparities Assessment (Medicare)

Molina analyzes clinical performance and member experience measures by race, ethnicity, and language to determine if health care disparities exist among Molina members.

Glycemic Status Assessment for Patients with Diabetes (GSD) <8.0%	Stratified HEDIS® Rate 2025			Stratified HEDIS® Rate 2024	Goal Rate 75th percentile
Race	Num	Den	Rate		
American Indian or Alaska Native	10	14	**71.43%**	NA	79.05%
Asian	995	1486	**66.96%**	NA	79.05%
Black or African American	185	273	**67.77%**	NA	79.05%
Native Hawaiian or Pacific Islander	2	6	**33.33%**	NA	79.05%
White	340	568	**59.86%**	NA	79.05%
Some Other Race	20	29	**68.97%**	NA	79.05%
Two Or More Races	19	31	**61.29%**	NA	79.05%
Asked But No Answer	36	71	**50.70%**	NA	79.05%
Unknown	1470	2303	**63.83%**	59.49%	79.05%
Ethnicity					
Hispanic or Latino	1533	2441	**62.80%**	NA	79.05%
Not Hispanic or Latino	576	872	**66.06%**	NA	79.05%
Asked But No Answer	NA	NA	**NA**	NA	79.05%
Unknown	968	1468	**65.94%**	59.49%	79.05%
Language					
English	1371	2136	**64.19%**	48.75%	79.05%
Non-English	1705	2644	**64.49%**	71.05%	79.05%
Unknown	1	1	**100%**	NA	79.05%

2025 IDSS Reported Rate: 72.75%

Race: Potential disparity found in the Asked But No Answer subpopulation.
Ethnicity: No potential disparities found.
Language: No potential disparities found.

*2024 HEDIS rates with less than 30 members in the denominator.

For internal use only.

California CLAS Analysis – Health Care Disparities Assessment (Medicaid)

Molina analyzes clinical performance and member experience measures by race, ethnicity, and language to determine if health care disparities exist among Molina members.

Glycemic Status Assessment for Patients with Diabetes (GSD) >9.0%	Stratified HEDIS® Rate 2025			Stratified HEDIS® Rate 2024	Goal Rate 67th percentile
Race	Num	Den	Rate		
American Indian or Alaska Native	28	48	**58.33%**	62.03%	27.98%
Asian	2427	6980	**35.42%**	4.25%	27.98%
Black or African American	465	980	**47.45%**	50.12%	27.98%
Native Hawaiian or Pacific Islander	25	54	**46.30%**	NA	27.98%
White	718	1933	**37.14%**	40.80%	27.98%
Some Other Race	8	36	**22.22%**	NA	27.98%
Two Or More Races	13	34	**38.24%**	NA	27.98%
Asked But No Answer	1	3	**33.33%**	NA	27.98%
Unknown	3766	10686	**35.24%**	39.43%	27.98%
Ethnicity					
Hispanic or Latino	3914	10844	**36.09%**	41.75%	27.98%
Not Hispanic or Latino	1670	4679	**35.69%**	41.99%	27.98%
Asked But No Answer	NA	NA	**NA**	NA	27.98%
Unknown	1912	5231	**36.55%**	39.07%	27.98%
Language					
English	4224	10450	**40.42%**	44.94%	27.98%
Non-English	3270	10300	**31.75%**	35.25%	27.98%
Unknown	2	4	**50.00%**	66.67%*	27.98%

2025 IDSS Reported Rate: 34.31%

Race: Potential disparities found in the American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Pacific Islander, Two Or More Races and Unknown subpopulations.
Ethnicity: No potential disparities found.
Language: Potential disparity found in the English-speaking subpopulation.

*2024 HEDIS rates with less than 30 members in the denominator.

For internal use only.

California CLAS Analysis – Health Care Disparities Assessment (Marketplace)

Molina analyzes clinical performance and member experience measures by race, ethnicity, and language to determine if health care disparities exist among Molina members.

Glycemic Status Assessment for Patients with Diabetes (GSD) >9.0%	Stratified HEDIS® Rate 2025			Goal Rate 75h percentile
Race	Num	Den	Rate	
American Indian or Alaska Native	4	10	**40.00%**	19.17%
Asian	132	513	**25.73%**	19.17%
Black or African American	31	89	**34.83%**	19.17%
Native Hawaiian or Pacific Islander	3	16	**18.75%**	19.17%
White	362	1001	**36.16%**	19.17%
Some Other Race	153	490	**31.22%**	19.17%
Two Or More Races	6	30	**20.00%**	19.17%
Asked But No Answer	NA	NA	**NA**	19.17%
Unknown	899	2714	**33.12%**	19.17%
Ethnicity				
Hispanic or Latino	608	1817	**33.46%**	19.17%
Not Hispanic or Latino	621	2011	**30.88%**	19.17%
Asked But No Answer	NA	NA	**NA**	19.17%
Unknown	361	1035	**34.88%**	19.17%
Language				
English	772	2355	**32.78%**	19.17%
Non-English	801	2418	**33.13%**	19.17%
Unknown	17	90	**18.89%**	19.17%

2025 IDSS Reported Rate: 26.03%

Race: Potential disparities found in the Black or African American, White, Some Other Race and Unknown subpopulations.
Ethnicity: No potential disparities found.
Language: Potential disparities found in the English-speaking and non-English speaking subpopulations.

*2024 HEDIS rates with less than 30 members in the denominator.

For internal use only.

California CLAS Analysis – Health Care Disparities Assessment (Medicare)

Molina analyzes clinical performance and member experience measures by race, ethnicity, and language to determine if health care disparities exist among Molina members.

Glycemic Status Assessment for Patients with Diabetes (GSD) >9.0%	Stratified HEDIS® Rate 2025			Stratified HEDIS® Rate 2024	Goal Rate 75th percentile
Race	Num	Den	Rate		
American Indian or Alaska Native	4	14	**28.57%**	NA	11.19%
Asian	345	1486	**23.22%**	NA	11.19%
Black or African American	32	71	**45.07%**	NA	11.19%
Native Hawaiian or Pacific Islander	4	6	**66.67%**	NA	11.19%
White	174	568	**30.36%**	NA	11.19%
Some Other Race	7	29	**21.14%**	NA	11.19%
Two Or More Races	10	31	**32.26%**	NA	11.19%
Asked But No Answer	32	71	**45.07%**	NA	11.19%
Unknown	598	2303	**25.97%**	27.85%	11.19%
Ethnicity					
Hispanic or Latino	1798	2441	**73.66%**	NA	11.19%
Not Hispanic or Latino	651	872	**74.66%**	NA	11.19%
Asked But No Answer	NA	NA	**NA**	NA	11.19%
Unknown	1088	1468	**74.11%**	27.85%	11.19%
Language					
English	575	2136	**26.92%**	36.59%	11.19%
Non-English	669	2644	**25.30%**	18.42%	11.19%
Unknown	NA	NA	**NA**	NA	11.19%

2025 IDSS Reported Rate: 18.25%

Race: Potential disparities found in the Black or African American and Asked But No Answer subpopulations.
Ethnicity: No potential disparities found.
Language: No potential disparities found.

*2024 HEDIS rates with less than 30 members in the denominator.

For internal use only.

California CLAS Analysis – Health Care Disparities Assessment (Medicaid)

Molina analyzes clinical performance and member experience measures by race, ethnicity, and language to determine if health care disparities exist among Molina members.

Follow-Up After Emergency Department Visits for Substance Use 30 Days (FUA)	Stratified HEDIS® Rate 2025			Goal Rate 67th percentile
Race	Num	Den	Rate	
American Indian or Alaska Native	1	4	**25.00%**	43.24%
Asian	609	1340	**45.44%**	43.24%
Black or African American	110	307	**35.83%**	43.24%
Native Hawaiian or Pacific Islander	15	33	**45.45%**	43.24%
White	412	891	**46.24%**	43.24%
Some Other Race	NA	NA	**NA**	43.24%
Two or More Races	3	6	**50.00%**	43.24%
Asked But No Answer	NA	NA	**NA**	43.24%
Unknown	475	972	**48.87%**	43.24%
Ethnicity				
Hispanic or Latino	548	1428	**38.38%**	43.24%
Not Hispanic or Latino	502	1096	**45.80%**	43.24%
Asked But No Answer	NA	NA	**NA**	43.24%
Unknown	575	1353	**42.50%**	43.24%
Language				
English	1479	3455	**42.81%**	43.24%
Non-English	146	422	**34.60%**	43.24%
Unknown	NA	NA	**NA**	43.24%

2025 IDSS Reported Rate: 41.94%

Race: Potential disparity found in the Black or African American subpopulation.
Ethnicity: No potential disparities found.
Language: No potential disparities found.

For internal use only.

California CLAS Analysis – Health Care Disparities Assessment (Medicare)

Molina analyzes clinical performance and member experience measures by race, ethnicity, and language to determine if health care disparities exist among Molina members.

Follow-Up After Emergency Department Visits for Substance Use 30 Days (FUA)	Stratified HEDIS® Rate 2025			Goal Rate 75th percentile
Race	Num	Den	Rate	
American Indian or Alaska Native	NA	NA	**NA**	47.79%
Asian	19	49	**38.78%**	47.79%
Black or African American	3	22	**13.64%**	47.79%
Native Hawaiian or Pacific Islander	0	1	**0.00%**	47.79%
White	8	20	**40.00%**	47.79%
Some Other Race	NA	NA	**NA**	47.79%
Two or More Races	NA	NA	**NA**	47.79%
Asked But No Answer	NA	NA	**NA**	47.79%
Unknown	13	31	**41.94%**	47.79%
Ethnicity				
Hispanic or Latino	9	26	**34.62%**	47.79%
Not Hispanic or Latino	18	45	**40.00%**	47.79%
Asked But No Answer	NA	NA	**NA**	47.79%
Unknown	16	52	**30.77%**	47.79%
Language				
English	35	102	**34.31%**	47.79%
Non-English	8	21	**38.10%**	47.79%
Unknown	NA	NA	**NA**	47.79%

2025 IDSS Reported Rate: 34.96%

Race: No potential disparities found.
Ethnicity: No potential disparities found.
Language: No disparity analysis conducted.

For internal use only.

California CLAS Analysis – Health Care Disparities Assessment (Medicaid)

Molina analyzes clinical performance and member experience measures by race, ethnicity, and language to determine if health care disparities exist among Molina members.

Follow-Up After Emergency Department Visits for Substance Use 7 Days (FUA)	Stratified HEDIS® Rate 2025			Goal Rate 67th percentile
Race	Num	Den	Rate	
American Indian or Alaska Native	1	4	**25.00%**	30.53%
Asian	608	1340	**45.37%**	30.53%
Black or African American	65	307	**21.17%**	30.53%
Native Hawaiian or Pacific Islander	9	33	**27.27%**	30.53%
White	313	891	**35.13%**	30.53%
Some Other Race	NA	NA	**NA**	30.53%
Two or More Races	1	6	**16.67%**	30.53%
Asked But No Answer	NA	NA	**NA**	30.53%
Unknown	318	972	**32.72%**	30.53%
Ethnicity				
Hispanic or Latino	368	1428	**25.77%**	30.53%
Not Hispanic or Latino	314	1096	**28.65%**	30.53%
Asked But No Answer	NA	NA	**NA**	30.53%
Unknown	412	1353	**30.45%**	30.53%
Language				
English	1002	3455	**29.00%**	30.53%
Non-English	92	422	**21.80%**	30.53%
Unknown	NA	NA	**NA**	30.53%

2025 IDSS Reported Rate: 28.22%

Race: Potential disparities found in the Black or African American, Native Hawaiian or Pacific Islander, White and Unknown subpopulation.
Ethnicity: No potential disparities found.
Language: No potential disparities found.

For internal use only.

California CLAS Analysis – Health Care Disparities Assessment (Medicare)

Molina analyzes clinical performance and member experience measures by race, ethnicity, and language to determine if health care disparities exist among Molina members.

Follow-Up After Emergency Department Visits for Substance Use 7 Days (FUA)	Stratified HEDIS® Rate 2025			Goal Rate 75th percentile
Race	Num	Den	Rate	
American Indian or Alaska Native	NA	NA	**NA**	31.07%
Asian	5	49	**10.20%**	31.07%
Black or African American	1	22	**4.55%**	31.07%
Native Hawaiian or Pacific Islander	0	1	**0.00%**	31.07%
White	2	20	**10.00%**	31.07%
Some Other Race	NA	NA	**NA**	31.07%
Two or More Races	NA	NA	**NA**	31.07%
Asked But No Answer	NA	NA	**NA**	31.07%
Unknown	10	31	**32.26%**	31.07%
Ethnicity				
Hispanic or Latino	7	26	**26.92%**	31.07%
Not Hispanic or Latino	6	45	**13.33%**	31.07%
Asked But No Answer	NA	NA	**NA**	31.07%
Unknown	5	52	**9.62%**	31.07%
Language				
English	14	102	**13.73%**	31.07%
Non-English	4	21	**19.05%**	31.07%
Unknown	NA	NA	**NA**	31.07%

2025 IDSS Reported Rate: 14.63%

Race: Potential disparity found in the Asian subpopulation.
Ethnicity: No potential disparities found.
Language: No disparity analysis conducted.

For internal use only.

California CLAS Analysis – Health Care Disparities Assessment (Medicaid)

Molina analyzes clinical performance and member experience measures by race, ethnicity, and language to determine if health care disparities exist among Molina members.

Timeliness of Prenatal Care (PPC)	Stratified HEDIS® Rate 2025			Stratified HEDIS® Rate 2024	Goal Rate 67th percentile
Race	Num	Den	Rate		
American Indian or Alaska Native	7	12	**58.33%**	NA	88.56%
Asian	1336	1608	**83.08%**	100%*	88.56%
Black or African American	214	274	**78.10%**	66.67%*	88.56%
Native Hawaiian or Pacific Islander	7	8	**87.50%**	NA	88.56%
White	320	411	**77.86%**	69.77%	88.56%
Some Other Race	12	13	**92.31%**	NA	88.56%
Two Or More Races	7	9	**77.78%**	NA	88.56%
Asked But No Answer	NA	NA	**NA**	NA	88.56%
Unknown	2128	2582	**82.42%**	84.07%	88.56%
Ethnicity					
Hispanic or Latino	2164	2663	**81.26%**	68.42%	88.56%
Not Hispanic or Latino	936	1107	**84.55%**	80.00%*	88.56%
Asked But No Answer	NA	NA	**NA**	NA	88.56%
Unknown	931	1147	**81.17%**	84.02%	88.56%
Language					
English	2538	3139	**80.85%**	75.00%	88.56%
Non-English	1493	1778	**83.97%**	66.67%*	88.56%
Unknown	NA	NA	**NA**	84.29%	88.56%

2025 IDSS Reported Rate: 85.64%

Race: No potential disparities found.
Ethnicity: No potential disparities found.
Language: No potential disparities found.

*2024 HEDIS rates with less than 30 members in the denominator.

For internal use only.

California CLAS Analysis – Health Care Disparities Assessment (Marketplace)

Molina analyzes clinical performance and member experience measures by race, ethnicity, and language to determine if health care disparities exist among Molina members.

Timeliness of Prenatal Care (PPC)	Stratified HEDIS® Rate 2025			Stratified HEDIS® Rate 2024	Goal Rate 67th percentile
Race	Num	Den	Rate		
American Indian or Alaska Native	1	1	**100%**	NA	89.51%
Asian	16	20	**80.00%**	NA	89.51%
Black or African American	1	5	**20.00%**	NA	89.51%
Native Hawaiian or Pacific Islander	0	1	**0.00%**	NA	89.51%
White	35	54	**64.81%**	0.00%	89.51%
Some Other Race	13	20	**65.00%**	NA	89.51%
Two Or More Races	1	1	**100%**	NA	89.51%
Asked But No Answer	NA	NA	**NA**	NA	89.51%
Unknown	75	106	**70.75%**	71.85%	89.51%
Ethnicity					
Hispanic or Latino	44	67	**65.67%**	0.00%*	89.51%
Not Hispanic or Latino	71	104	**68.27%**	NA	89.51%
Asked But No Answer	NA	NA	**NA**	NA	89.51%
Unknown	27	37	**72.97%**	71.85%	89.51%
Language					
English	115	162	**70.99%**	69.57%	89.51%
Non-English	21	38	**55.26%**	45.00%*	89.51%
Unknown	6	8	**75.00%**	74.71%	89.51%

2025 IDSS Reported Rate: 78.29%

Race: No potential disparities found.
Ethnicity: No potential disparities found.
Language: Potential disparity found in the non-English speaking subpopulation.

*2024 HEDIS rates with less than 30 members in the denominator.

For internal use only.

California CLAS Analysis – Health Care Disparities Assessment (Medicaid)

Molina analyzes clinical performance and member experience measures by race, ethnicity, and language to determine if health care disparities exist among Molina members.

Postpartum Care (PPC)	Stratified HEDIS® Rate 2025			Stratified HEDIS® Rate 2024	Goal Rate 67th percentile
Race	Num	Den	Rate		
American Indian or Alaska Native	7	12	**58.33%**	NA	83.94%
Asian	1317	1608	**81.90%**	100%*	83.94%
Black or African American	209	274	**76.28%**	100%*	83.94%
Native Hawaiian or Pacific Islander	7	8	**87.50%**	NA	83.94%
White	309	411	**75.18%**	67.44%	83.94%
Some Other Race	13	13	**100%**	NA	83.94%
Two Or More Races	7	9	**83.38%**	NA	83.94%
Asked But No Answer	NA	NA	**NA**	NA	83.94%
Unknown	2153	2582	**83.38%**	80.77%	83.94%
Ethnicity					
Hispanic or Latino	2182	2663	**81.94%**	65.79%	83.94%
Not Hispanic or Latino	909	1107	**82.11%**	90.00%*	83.94%
Asked But No Answer	NA	NA	**NA**	NA	83.94%
Unknown	931	1147	**81.17%**	80.72%	83.94%
Language					
English	2483	3139	**79.10%**	82.50%	83.94%
Non-English	1593	1778	**86.56%**	52.38%*	83.94%
Unknown	NA	NA	**NA**	80.86%	83.94%

2025 IDSS Reported Rate: 85.64%

Race: No potential disparities found.
Ethnicity: No potential disparities found.
Language: No potential disparities found.

*2024 HEDIS rates with less than 30 members in the denominator.

For internal use only.

California CLAS Analysis – Health Care Disparities Assessment (Marketplace)

Molina analyzes clinical performance and member experience measures by race, ethnicity, and language to determine if health care disparities exist among Molina members.

Postpartum Care (PPC)	Stratified HEDIS® Rate 2025			Stratified HEDIS® Rate 2024	Goal Rate 75th percentile
Race	Num	Den	Rate		
American Indian or Alaska Native	1	1	**100%**	NA	88.89%
Asian	13	20	**65.00%**	NA	88.89%
Black or African American	2	5	**40.00%**	NA	88.89%
Native Hawaiian or Pacific Islander	1	1	**100%**	NA	88.89%
White	41	54	**75.93%**	50.00%*	88.89%
Some Other Race	12	20	**60.00%**	NA	88.89%
Two Or More Races	1	1	**100%**	NA	88.89%
Asked But No Answer	NA	NA	**NA**	NA	88.89%
Unknown	70	106	**66.04%**	79.83%	88.89%
Ethnicity					
Hispanic or Latino	46	67	**68.66%**	50.00%*	88.89%
Not Hispanic or Latino	70	104	**67.31%**	NA	88.89%
Asked But No Answer	NA	NA	**NA**	NA	88.89%
Unknown	25	37	**67.57%**	79.83%	88.89%
Language					
English	105	162	**64.81%**	78.26%	88.89%
Non-English	31	38	**81.58%**	75.00%*	88.89%
Unknown	5	8	**62.50%**	80.46%	88.89%

2025 IDSS Reported Rate: 81.86%

Race: No potential disparities found.
Ethnicity: No potential disparities found.
Language: Potential disparity found in the English-speaking subpopulation.

*2024 HEDIS rates with less than 30 members in the denominator.

For internal use only.

California CLAS Analysis – Health Care Disparities Assessment (Medicaid)

Molina analyzes clinical performance and member experience measures by race, ethnicity, and language to determine if health care disparities exist among Molina members.

Initiation and Engagement of Substance Use Disorder Treatment (IET) *Composite Score*	Stratified HEDIS® Rate 2025			Goal Rate 67th percentile
Race	Num	Den	Rate	
American Indian or Alaska Native	16	34	**47.06%**	NA
Asian	1635	4282	**38.18%**	NA
Black or African American	351	996	**35.24%**	NA
Native Hawaiian or Pacific Islander	27	67	**40.30%**	NA
White	950	2485	**38.23%**	NA
Some Other Race	4	8	**50.00%**	NA
Two or More Races	10	28	**35.71%**	NA
Asked But No Answer	NA	NA	**NA**	NA
Unknown	1349	3817	**35.34%**	NA
Ethnicity				
Hispanic or Latino	1540	4283	**35.96%**	NA
Not Hispanic or Latino	1309	3452	**37.92%**	NA
Asked But No Answer	NA	NA	**NA**	NA
Unknown	1493	3982	**37.49%**	NA
Language				
English	3771	10171	**37.08%**	NA
Non-English	571	1546	**36.93%**	NA
Unknown	NA	NA	**NA**	NA

2025 IDSS Reported Rate: Initiation of SUD Treatment Total- 53.37%; Engagement of SUD Treatment Total- 11.32%

Race: Potential disparities found in the Black or African American, and Unknown subpopulations.
Ethnicity: No potential disparities found.
Language: No potential disparities found.

For internal use only.

California CLAS Analysis – Health Care Disparities Assessment (Marketplace)

Molina analyzes clinical performance and member experience measures by race, ethnicity, and language to determine if health care disparities exist among Molina members.

Initiation and Engagement of Substance Use Disorder Treatment (IET) *Composite Score*	Stratified HEDIS® Rate 2025			Goal Rate 75th percentile
Race	Num	Den	Rate	
American Indian or Alaska Native	1	3	**33.33%**	NA
Asian	11	30	**36.67%**	NA
Black or African American	13	26	**50.00%**	NA
Native Hawaiian or Pacific Islander	2	4	**50.00%**	NA
White	103	281	**36.65%**	NA
Some Other Race	21	54	**38.89%**	NA
Two or More Races	6	11	**54.55%**	NA
Asked But No Answer	NA	NA	**NA**	NA
Unknown	95	281	**33.81%**	NA
Ethnicity				
Hispanic or Latino	65	197	**32.99%**	NA
Not Hispanic or Latino	157	416	**37.74%**	NA
Asked But No Answer	NA	NA	**NA**	NA
Unknown	30	77	**38.96%**	NA
Language				
English	197	530	**37.17%**	NA
Non-English	55	158	**34.81%**	NA
Unknown	0	2	**0.00%**	NA

2025 IDSS Reported Rate: Initiation of SUD Treatment Total- 52.83; Engagement of SUD Treatment Total- 8.10%

Race: No potential disparities found.
Ethnicity: No potential disparities found.
Language: No potential disparities found.

For internal use only.

California CLAS Analysis – Health Care Disparities Assessment (Medicare)

Molina analyzes clinical performance and member experience measures by race, ethnicity, and language to determine if health care disparities exist among Molina members.

Initiation and Engagement of Substance Use Disorder Treatment (IET) *Composite Score*	Stratified HEDIS® Rate 2025			Goal Rate 67th percentile
Race	Num	Den	Rate	
American Indian or Alaska Native	NA	NA	**NA**	NA
Asian	132	318	**41.51%**	NA
Black or African American	43	116	**37.07%**	NA
Native Hawaiian or Pacific Islander	2	3	**66.67%**	NA
White	128	294	**43.54%**	NA
Some Other Race	3	8	**37.50%**	NA
Two or More Races	3	7	**42.86%**	NA
Asked But No Answer	18	36	**50.00%**	NA
Unknown	195	415	**46.99%**	NA
Ethnicity				
Hispanic or Latino	170	369	**46.07%**	NA
Not Hispanic or Latino	107	257	**41.63%**	NA
Asked But No Answer	NA	NA	**NA**	NA
Unknown	247	571	**43.26%**	NA
Language				
English	381	885	**43.05%**	NA
Non-English	143	312	**45.83%**	NA
Unknown	NA	NA	**NA**	NA

2025 IDSS Reported Rate: Initiation of SUD Treatment Total- 71.93%; Engagement of SUD Treatment Total- 8.65%

Race: Potential disparity found in the Black or African American subpopulation.
Ethnicity: No potential disparities found.
Language: No potential disparity found.

For internal use only.

California CLAS Analysis – Health Care Disparities Assessment (Medicaid)

Molina analyzes clinical performance and member experience measures by race, ethnicity, and language to determine if health care disparities exist among Molina members.

Child and Adolescent Well Care Visits (WCV)	Stratified HEDIS® Rate 2025			Stratified HEDIS® Rate 2024	Goal Rate 67th percentile
Race	Num	Den	Rate		
American Indian or Alaska Native	162	431	**37.59%**	32.96%	58.37%
Asian	19762	38288	**51.61%**	47.27%	58.37%
Black or African American	3121	8296	**37.62%**	33.87%	58.37%
Native Hawaiian or Pacific Islander	88	248	**35.48%**	NA	58.37%
White	5300	13473	**39.34%**	45.32%	58.37%
Some Other Race	30	64	**46.88%**	NA	58.37%
Two Or More Races	71	111	**63.96%**	NA	58.37%
Asked But No Answer	1	5	**20.00%**	NA	58.37%
Unknown	46140	87133	**52.95%**	44.79%	58.37%
Ethnicity					
Hispanic or Latino	44339	84027	**52.77%**	47.08%	58.37%
Not Hispanic or Latino	11931	24228	**49.24%**	37.12%	58.37%
Asked But No Answer	NA	NA	**NA**	NA	58.37%
Unknown	18405	39794	**46.25%**	45.02%	58.37%
Language					
English	127821	273795	**46.68%**	41.15%	58.37%
Non-English	96186	107310	**56.48%**	50.54%	58.37%
Unknown	18	42	**42.86%**	0.00%*	58.37%

2025 IDSS Reported Rate: 50.44%

Race: Potential disparities found in American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Pacific Islander, White, Some Other Race and Unknown subpopulations.
Ethnicity: No potential disparities found.
Language: No potential disparities found.

*2024 HEDIS rates with less than 30 members in the denominator.

For internal use only.

California CLAS Analysis – Health Care Disparities Assessment (Marketplace)

Molina analyzes clinical performance and member experience measures by race, ethnicity, and language to determine if health care disparities exist among Molina members.

Child and Adolescent Well Care Visits (WCV)	Stratified HEDIS® Rate 2025			Stratified HEDIS® Rate 2024	Goal Rate 67th percentile
Race	Num	Den	Rate		
American Indian or Alaska Native	0	2	**0.00%**	NA	58.56%
Asian	116	231	**50.22%**	36.36%	58.56%
Black or African American	8	21	**38.10%**	100%*	58.56%
Native Hawaiian or Pacific Islander	0	1	**0.00%**	NA	58.56%
White	118	273	**43.22%**	38.64%	58.56%
Some Other Race	60	113	**53.10%**	NA	58.56%
Two Or More Races	11	26	**42.31%**	NA	58.56%
Asked But No Answer	NA	NA	**NA**	NA	58.56%
Unknown	808	1768	**45.70%**	41.76%	58.56%
Ethnicity					
Hispanic or Latino	199	510	**39.02%**	36.71%	58.56%
Not Hispanic or Latino	596	1214	**49.09%**	47.62%*	58.56%
Asked But No Answer	NA	NA	**NA**	NA	58.56%
Unknown	326	711	**45.85%**	41.76%	58.56%
Language					
English	843	1818	**46.37%**	45.20%	58.56%
Non-English	264	579	**45.60%**	32.97%	58.56%
Unknown	14	38	**36.84%**	22.22%	58.56%

2025 IDSS Reported Rate: 46.04%

Race: Potential disparity found in the Two Or More Races subpopulation.
Ethnicity: Potential disparity found in the Hispanic or Latino subpopulation.
Language: No potential disparities found.

*2024 HEDIS rates with less than 30 members in the denominator.

For internal use only.

California CLAS Analysis – Language Diversity of Membership (LDM)

LDM Measure				
Spoken Preferred	2025 Reported Rate (Medicaid)	2024 Reported Rate (Medicaid)	2025 Reported Rate (Medicare)	2024 Reported Rate (Medicare)
English	65.94%	69.64%	52.79%	56.22%
Non-English	34.01%	29.40%	47.11%	43.74%
Declined	0.00%	0.00%	0.00%	0.00%
Unknown	0.05%	0.96%	0.11%	0.04%
Written Preferred				
English	65.94%	69.64%	52.79%	56.22%
Non-English	34.01%	29.40%	47.11%	43.74%
Declined	0.00%	0.00%	0.00%	0.00%
Unknown	0.05%	0.96%	0.11%	0.04%
Other Preferred				
English	65.94%	69.64%	52.79%	56.22%
Non-English	34.01%	29.40%	47.11%	43.74%
Declined	0.00%	0.00%	0.00%	0.00%
Unknown	0.05%	0.96%	0.11%	0.04%

For internal use only.

California CLAS Analysis – Race/Ethnicity Diversity of Membership (RDM)

RDM Measure				
Race	2025 Reported Rate (Medicaid)	2024 Reported Rate (Medicaid)	2025 Reported Rate (Medicare)	2024 Reported Rate (Medicare)
American Indian or Alaska Native	0.24%	0.29%	0.60%	0.17%
Asian	29.73%	5.18%	33.59%	9.40%
Black or African American	6.11%	7.17%	7.40%	7.68%
Native Hawaiian or Pacific Islander	0.23%	0.00%	0.23%	0.00%
White	12.45%	62.38%	15.74%	45.87%
Some Other Race	0.17%	0.00%	0.47%	0.00%
Two or More Races	0.19%	0.00%	0.63%	0.00%
Asked But No Answer	0.01%	0.00%	1.90%	0.00%
Unknown	50.88%	24.98%	39.42%	36.89%
Ethnicity				
Hispanic or Latino	48.38%	48.02%	42.29%	0.24%
Not Hispanic or Latino	21.21%	27.28%	21.52%	0.24%
Asked But No Answer	0.00%	0.00%	0.00%	0.00%
Unknown	30.41%	24.70%	36.19%	99.53%

For internal use only.

California CLAS Analysis – Health Care Disparities Assessment

Member Experience – Rating of Health Plan (9 or 10 – Best Heath Plan Possible) by Race, Ethnicity, and Sex Assigned at Birth.

Race	2025 CAHPS® Rate (Adult Medicaid)	2024 CAHPS® Rate (Adult Medicaid)	Adult Medicaid Goal (67th percentile)	2025 CAHPS® Rate (QHP)	2024 CAHPS® Rate (QHP)	QHP Goal (75th percentile)	2025 CAHPS® Rate (Medicare)	Medicare Goal (Base Group 4)
American Indian or Alaska Native	50.00%	25.00%	64.32%	50.00%	0.00%	NA	NA	87-88
Asian	60.90%	70.00%	64.32%	7.7%	0.00%	NA	36.80%	87-88
Black or African American	59.10%	50.00%	64.32%	20.00%	50.00%	NA	73.70%	87-88
Native Hawaiian or Pacific Islander	66.70%	50.00%	64.32%	0.00%	NA	NA	NA	87-88
White	60.80%	60.90%	64.32%	42.60%	30.10%	NA	66.70%	87-88
Other	67.60%	54.50%	64.32%	NA	NA	NA	NA	87-88
Ethnicity								
Hispanic or Latino	70.30%	68.30%	64.32%	60.50%	60.00%	NA	80.00%	87-88
Not Hispanic or Latino	52.90%	50.00%	64.32%	21.60%	27.60%	NA	55.30%	87-88
Sex Assigned at Birth								
Female	63.10%	63.80%	64.32%	48.80%	31.10%	NA	70.00%	87-88
Male	61.40%	53.60%	64.32%	43.10%	25.90%	NA	68.00%	87-88

Medicaid:
Race: Potential disparity found in the American Indian or Alaska Native subpopulation.
Ethnicity: Potential disparity found in the Not Hispanic or Latino subpopulation.

QHP:
Race: Potential disparity found in the Asian, Black or African American and Native Hawaiian or Pacific Islander subpopulation.
Ethnicity: Potential disparity found in the Not Hispanic or Latino subpopulation.

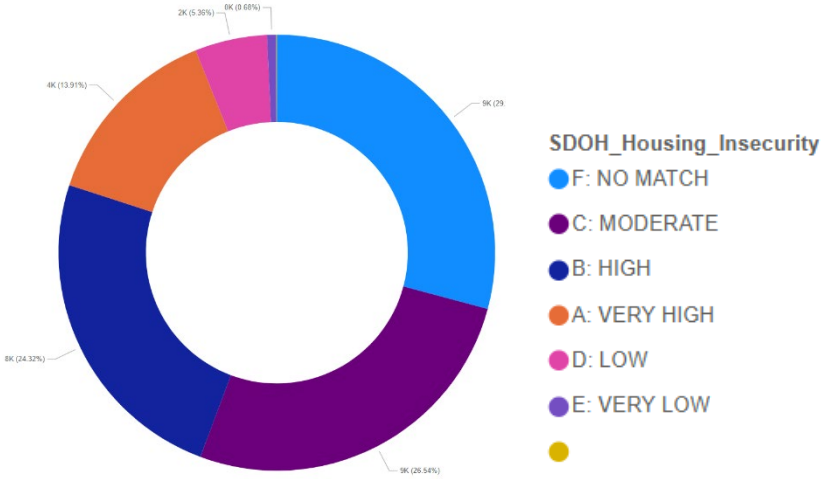
Medicare:
Race: Potential disparity found in the Asian subpopulation.
Ethnicity: Potential disparity found in the Not Hispanic or Latino subpopulation.

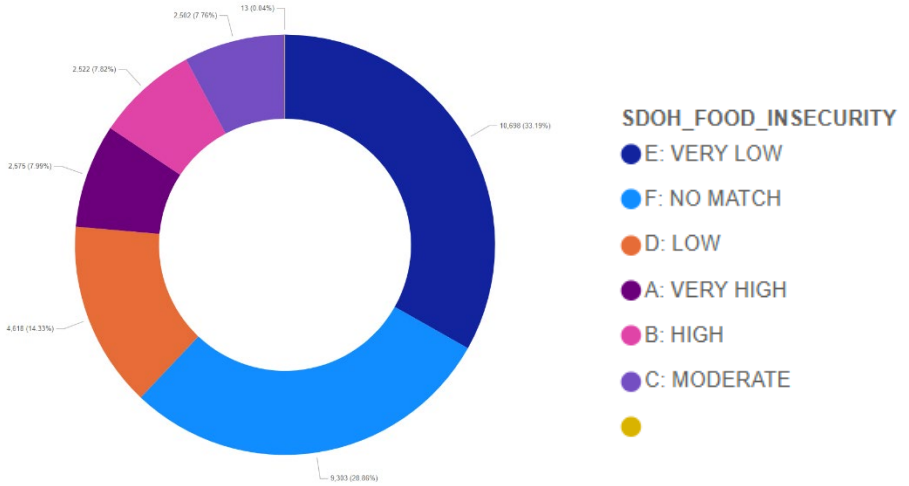
Medicare: H3038

For internal use only.

California CLAS Analysis – Social Risk/Social Needs (Medicaid)

Colorectal Cancer Screening (COLE): Eligible Member Population





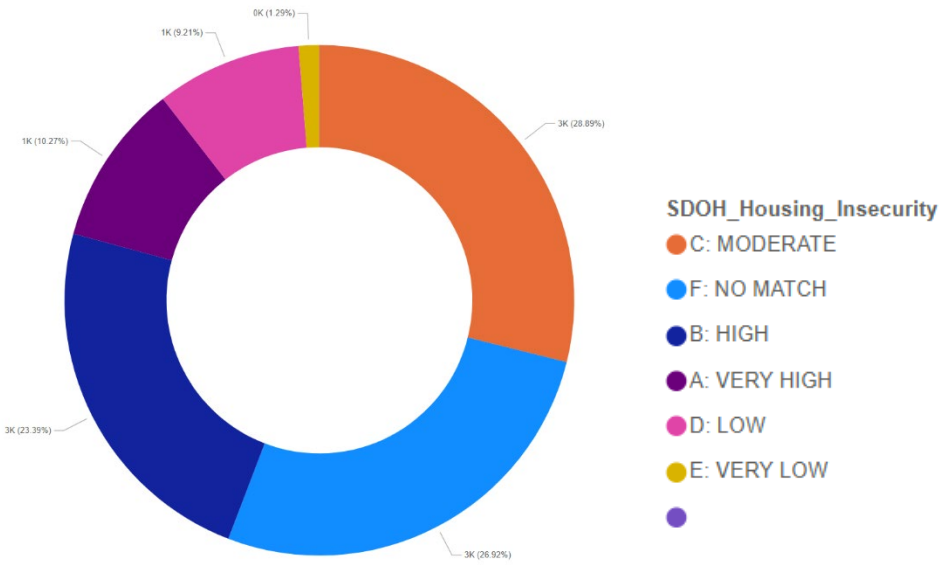
The Molina Healthcare Quality Performance Tool defines social determinants of health as “the economic and social conditions that influence individual and group differences in health status.” 24.32% of members report having high and 13.91% very high housing insecurity. 7.82% of members report having high and 7.99% very high food insecurity.

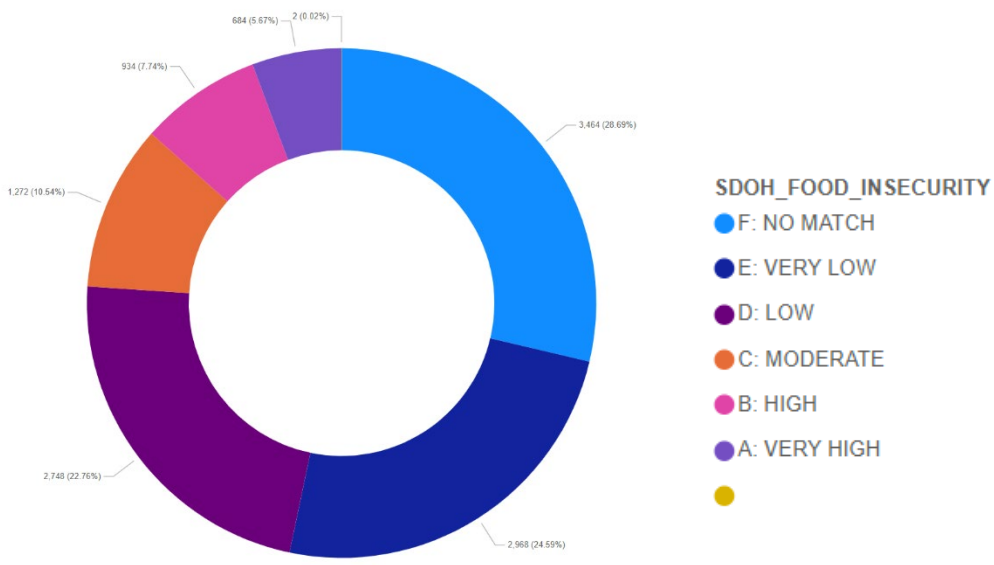
Health Equity Dashboard – SDOH Detail (MY2025, 03/04/2026)

For internal use only.

California CLAS Analysis – Social Risk/Social Needs (Marketplace)

Colorectal Cancer Screening (COLE): Eligible Member Population





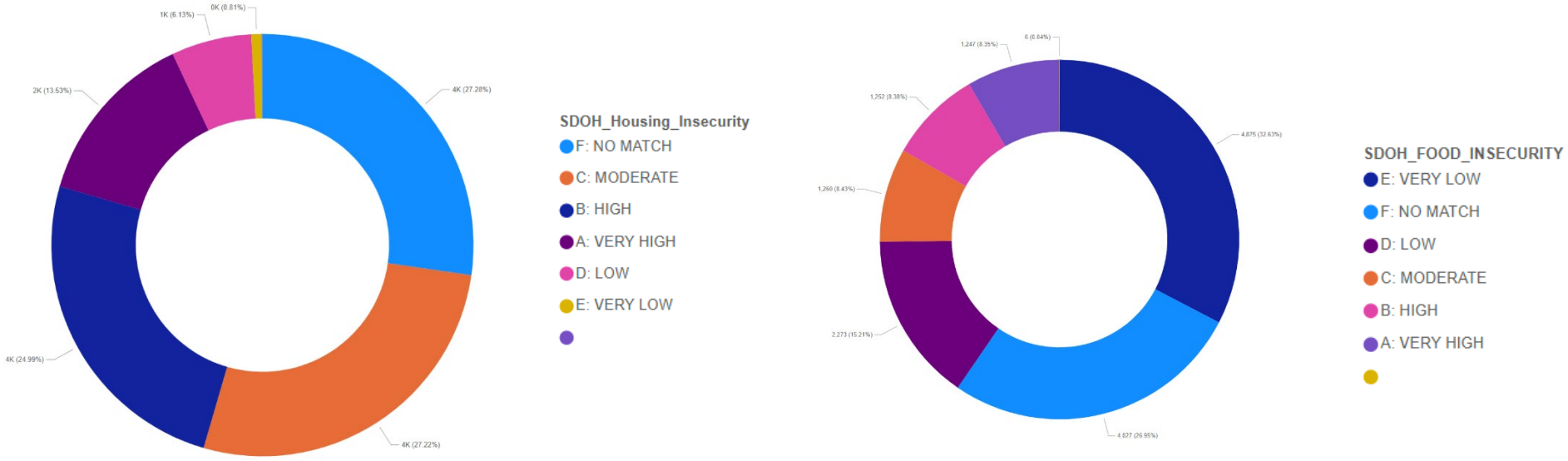
The Molina Healthcare Quality Performance Tool defines social determinants of health as “the economic and social conditions that influence individual and group differences in health status.” 23.39% of members report having high and 10.27% very high housing insecurity. 7.74% of members report having high and 5.67% very high food insecurity.

Health Equity Dashboard – SDOH Detail (MY2025, 03/04/2026)

For internal use only.

California CLAS Analysis – Social Risk/Social Needs (Medicaid)

Breast Cancer Screening (BCSE): Eligible Member Population



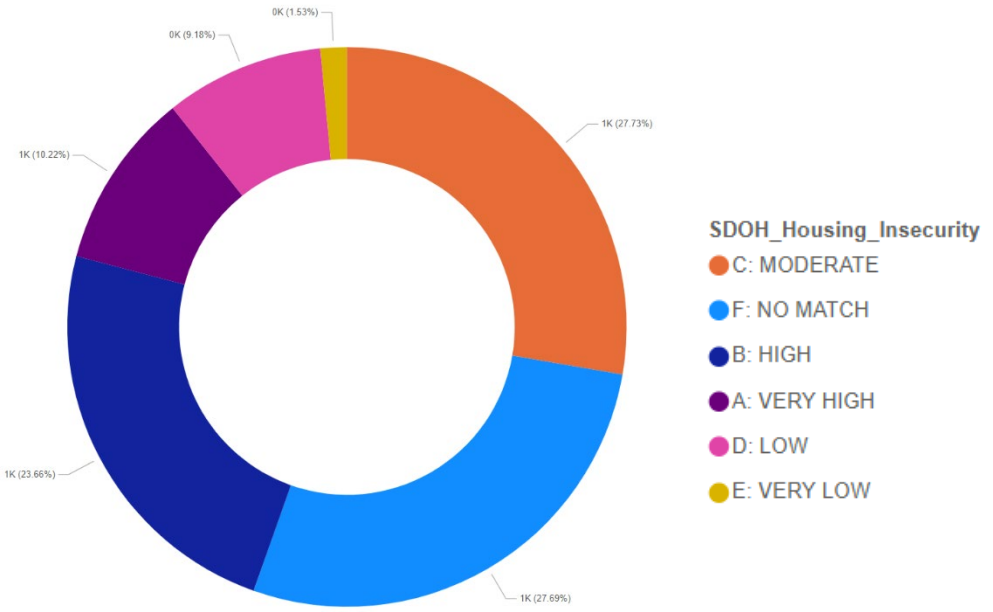
The Molina Healthcare Quality Performance Tool defines social determinants of health as “the economic and social conditions that influence individual and group differences in health status.” 24.99% of members report having high and 13.53% very high housing insecurity. 8.38% of members report having high and 8.35% very high food insecurity.

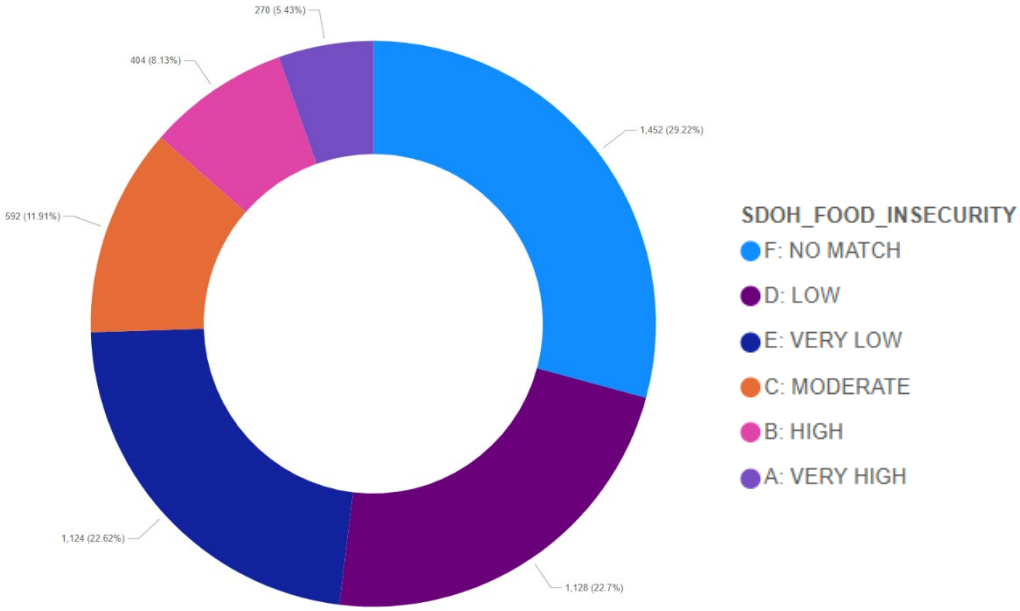
Health Equity Dashboard – SDOH Detail (MY2025, 03/04/2026)

For internal use only.

California CLAS Analysis – Social Risk/Social Needs (Marketplace)

Breast Cancer Screening (BCSE): Eligible Member Population





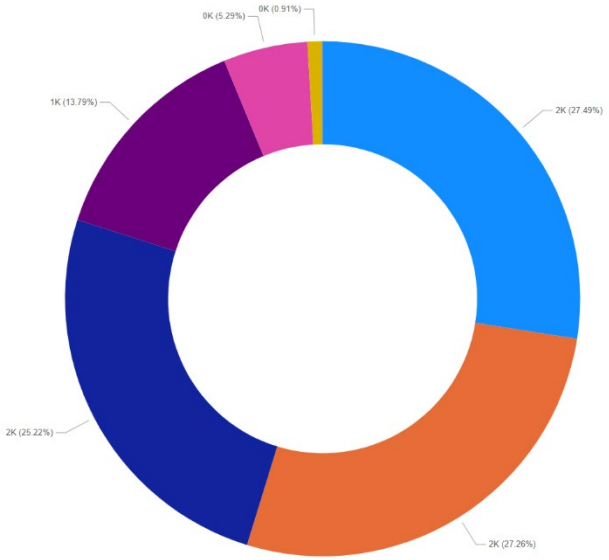
The Molina Healthcare Quality Performance Tool defines social determinants of health as “the economic and social conditions that influence individual and group differences in health status.” 23.66% of members report having high and 10.22% very high housing insecurity. 8.13% of members report having high and 5.43% very high food insecurity.

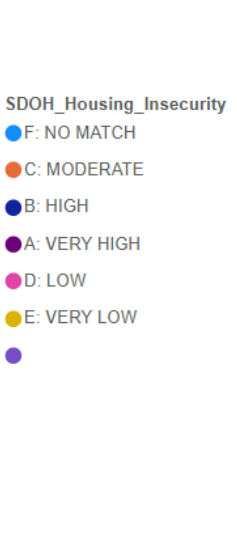
Health Equity Dashboard – SDOH Detail (MY2025, 03/04/2026)

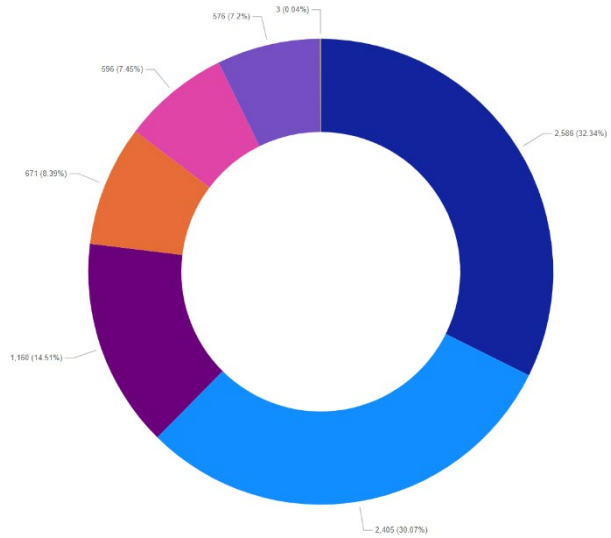
For internal use only.

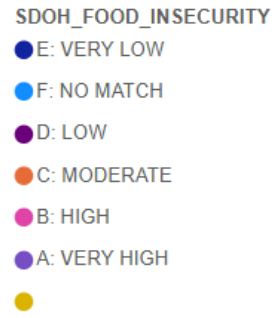
California CLAS Analysis – Social Risk/Social Needs (Medicaid)

Controlling Blood Pressure (CPB): Eligible Member Population









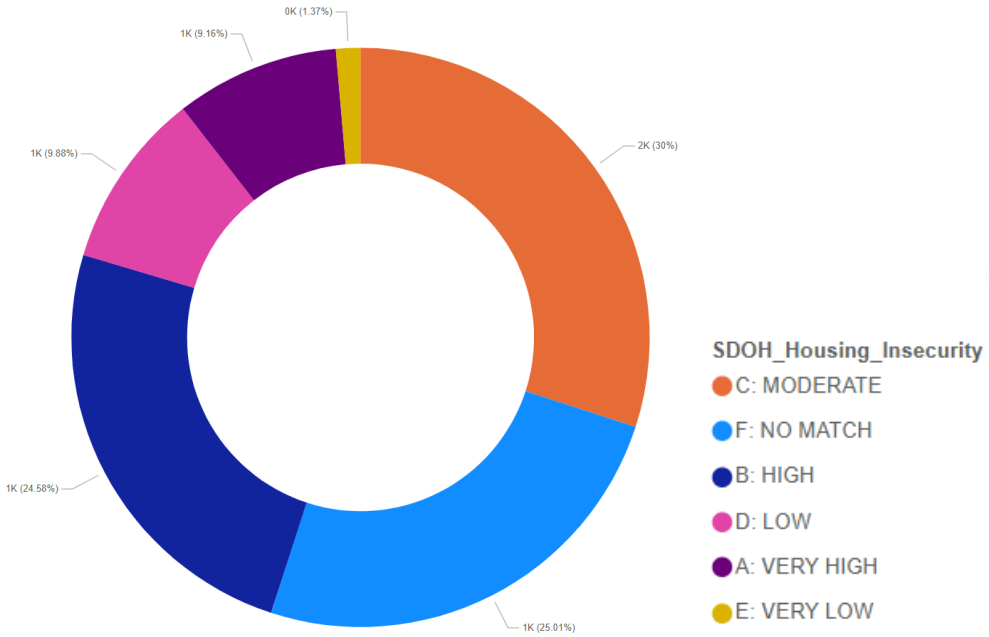
The Molina Healthcare Quality Performance Tool defines social determinants of health as “the economic and social conditions that influence individual and group differences in health status.” 25.22% of members report having high and 13.79% very high housing insecurity. 7.45% of members report having high and 7.20% very high food insecurity.

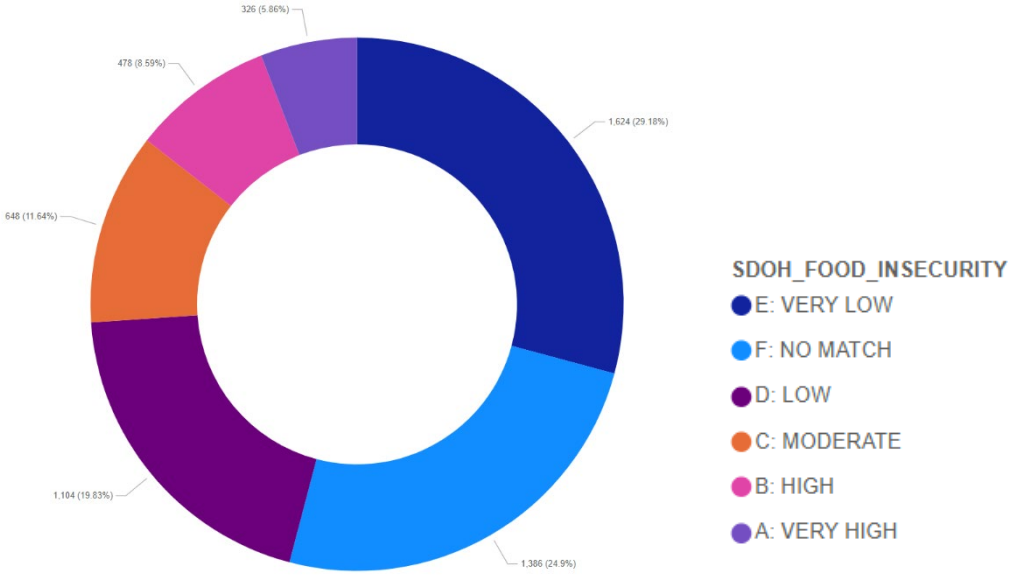
Health Equity Dashboard – SDOH Detail (MY2025, 03/04/2026)

For internal use only.

California CLAS Analysis – Social Risk/Social Needs (Marketplace)

Controlling Blood Pressure (CPB): Eligible Member Population





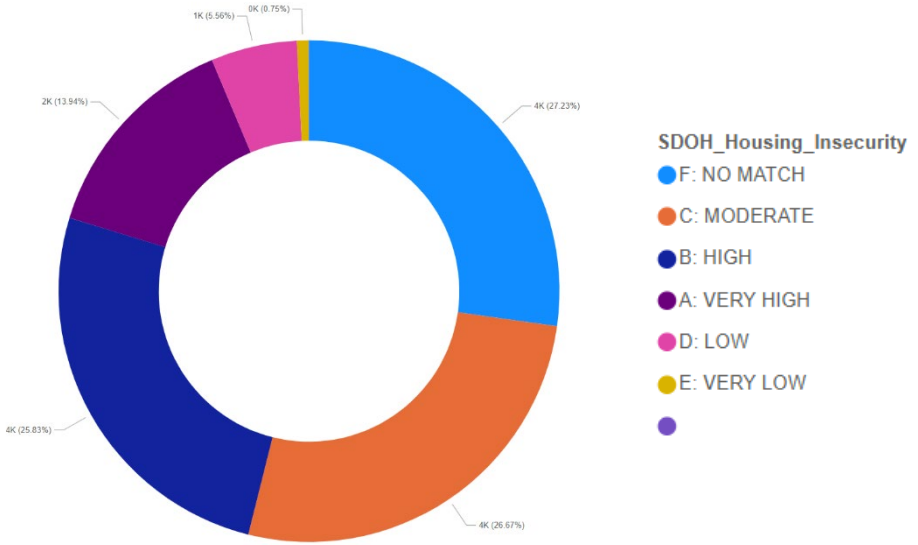
The Molina Healthcare Quality Performance Tool defines social determinants of health as “the economic and social conditions that influence individual and group differences in health status.” 24.58% of members report having high and 9.16% very high housing insecurity. 8.59% of members report having high and 5.86% very high food insecurity.

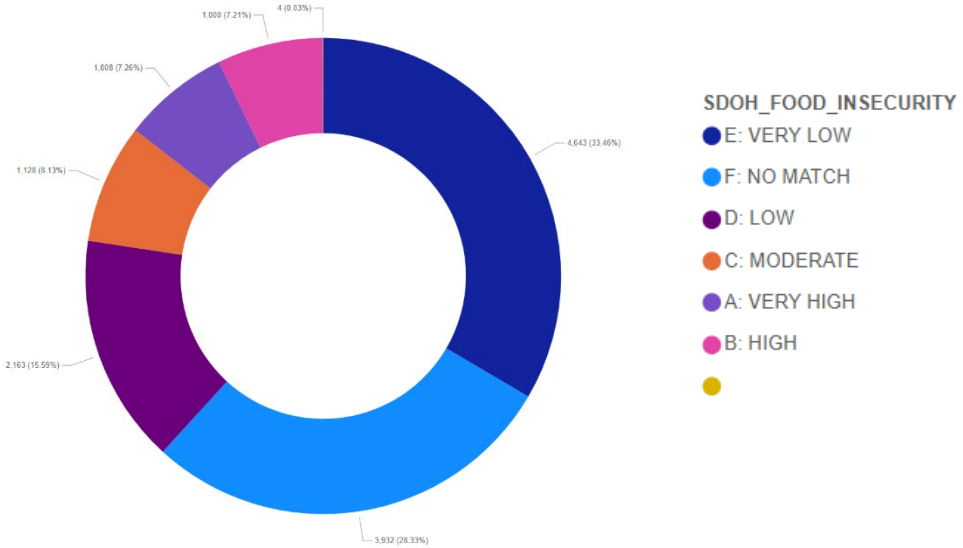
Health Equity Dashboard – SDOH Detail (MY2025, 03/04/2026)

For internal use only.

California CLAS Analysis – Social Risk/Social Needs (Medicaid)

Glycemic Status Assessment for Patients with Diabetes (Poor Control): Eligible Member Population





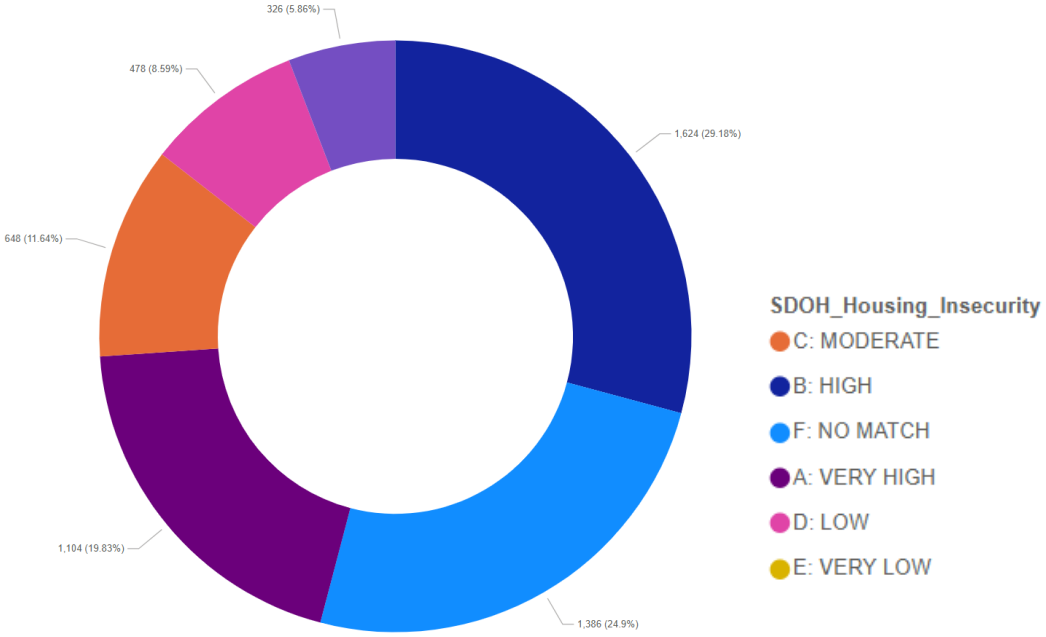
The Molina Healthcare Quality Performance Tool defines social determinants of health as “the economic and social conditions that influence individual and group differences in health status.” 25.83% of members report having high and 13.94% very high housing insecurity. 7.21% of members report having high and 7.26% very high food insecurity.

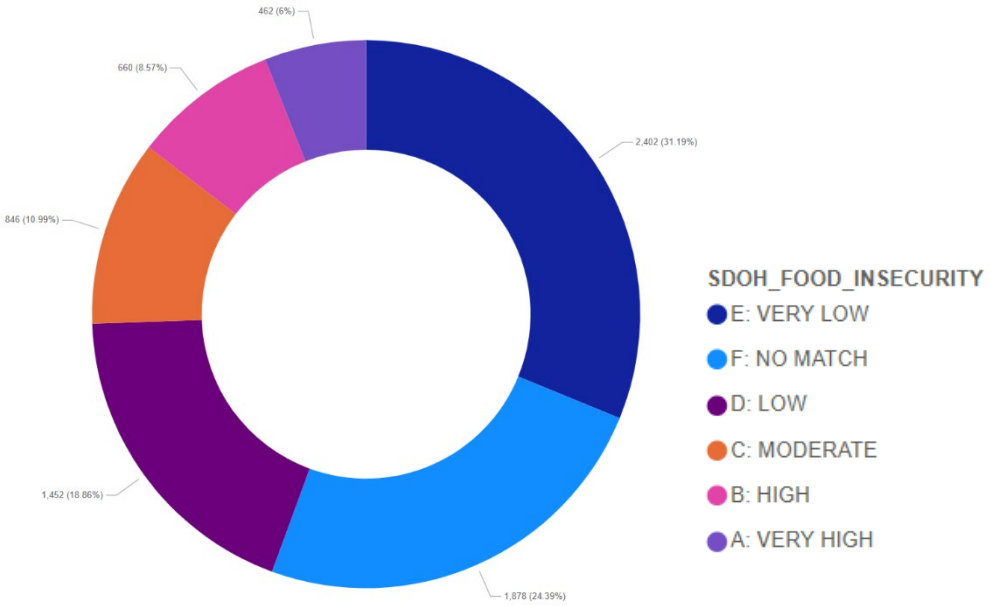
Health Equity Dashboard – SDOH Detail (MY2025, 03/04/2026)

For internal use only.

California CLAS Analysis – Social Risk/Social Needs (Marketplace)

Glycemic Status Assessment for Patients with Diabetes (Poor Control): Eligible Member Population





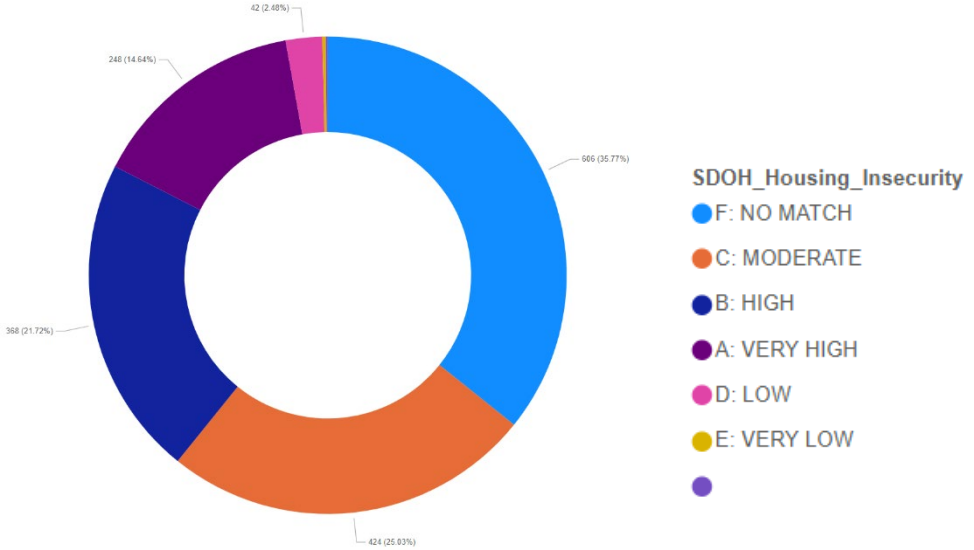
The Molina Healthcare Quality Performance Tool defines social determinants of health as “the economic and social conditions that influence individual and group differences in health status.” 25.83% of members report having high and 13.94% very high housing insecurity. 8.57% of members report having high and 6.00% very high food insecurity.

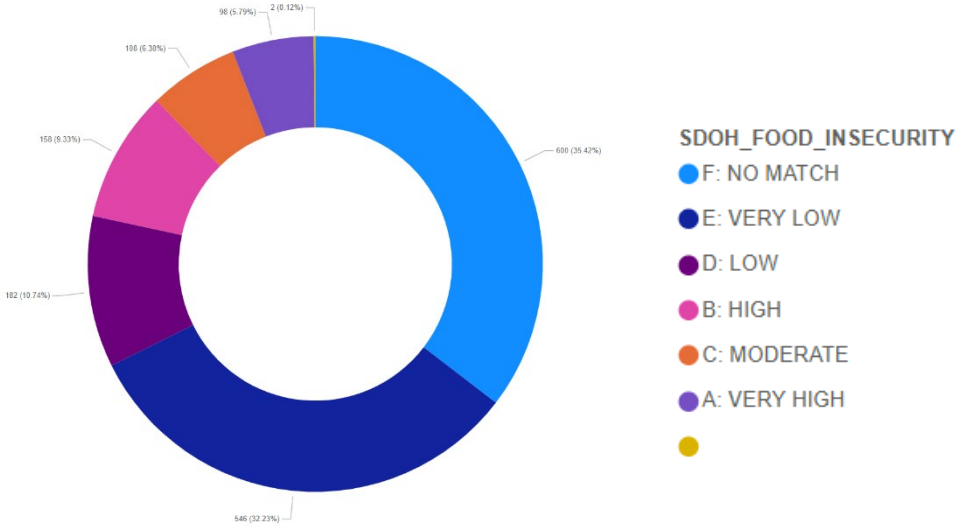
Health Equity Dashboard – SDOH Detail (MY2025, 03/04/2026)

For internal use only.

California CLAS Analysis – Social Risk/Social Needs (Medicaid)

Follow-Up After Emergency Department Visit for Substance Use 30 Days (FUA): Eligible Member Population





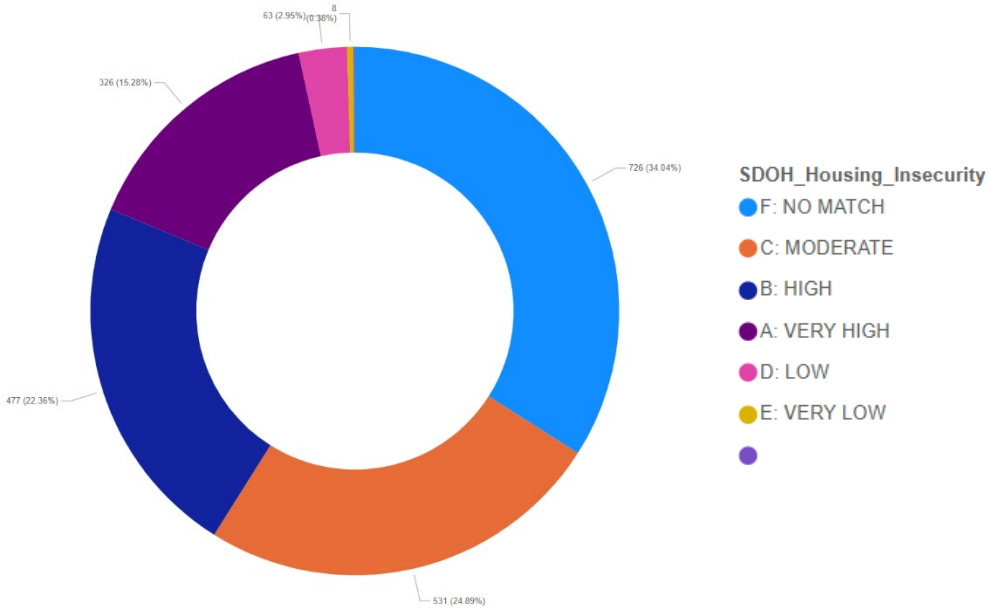
The Molina Healthcare Quality Performance Tool defines social determinants of health as “the economic and social conditions that influence individual and group differences in health status.” 21.72% of members report having high and 14.64% very high housing insecurity. 9.33% of members report having high and 5.79% very high food insecurity.

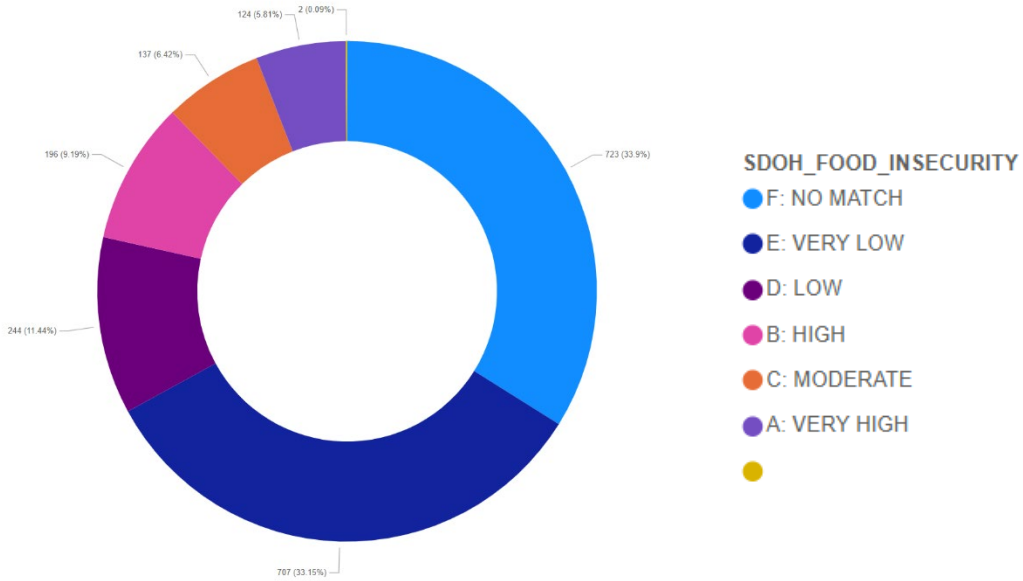
Health Equity Dashboard – SDOH Detail (MY2025, 03/04/2026)

For internal use only.

California CLAS Analysis – Social Risk/Social Needs (Medicaid)

Follow-Up After Emergency Department Visit for Substance Use 7 Days (FUA): Eligible Member Population



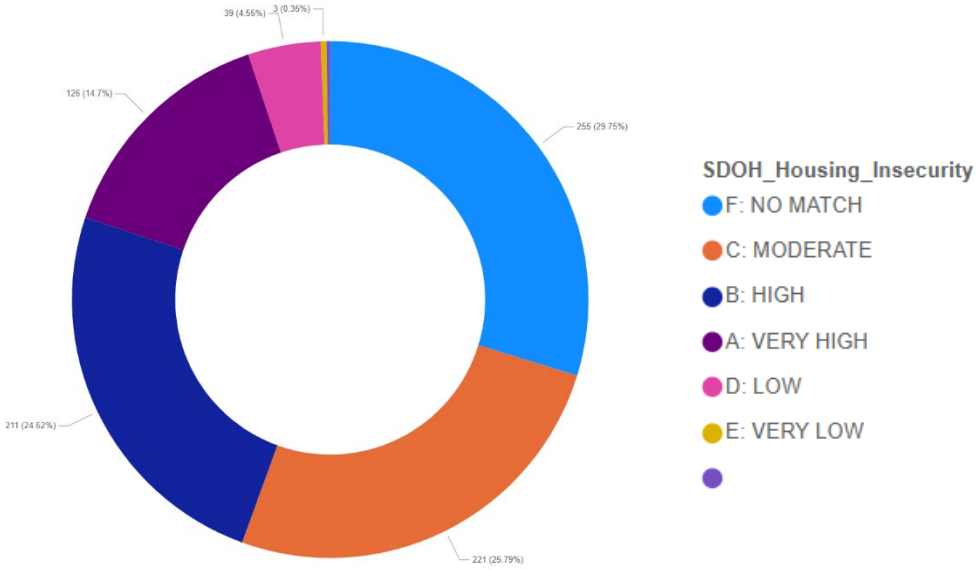


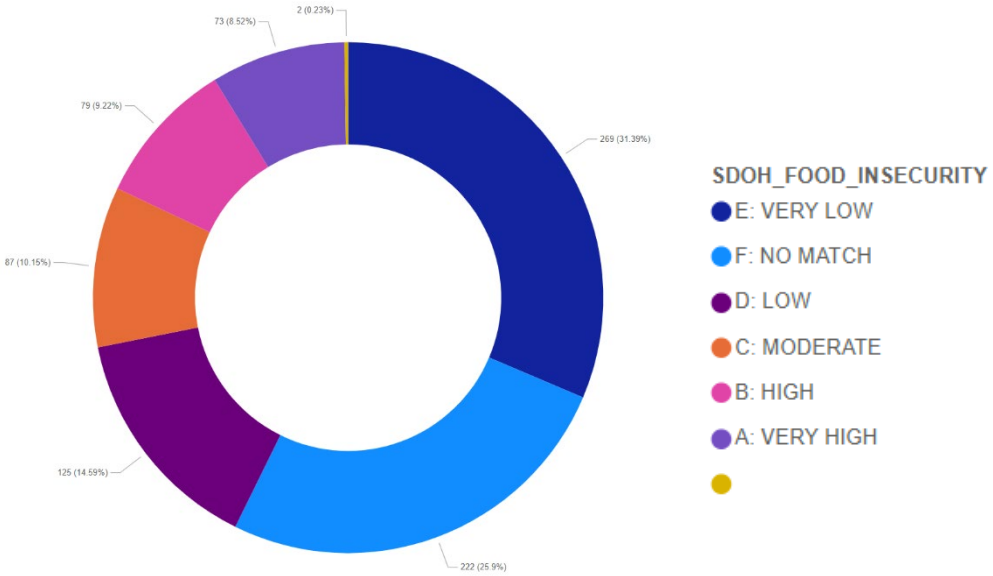
The Molina Healthcare Quality Performance Tool defines social determinants of health as “the economic and social conditions that influence individual and group differences in health status.” 22.36% of members report having high and 15.28% very high housing insecurity. 9.33% of members report having high and 5.79% very high food insecurity.

For internal use only.

California CLAS Analysis – Social Risk/Social Needs (Medicaid)

Prenatal and Postpartum Care, Timeliness of Prenatal Care (PPC): Eligible Member Population



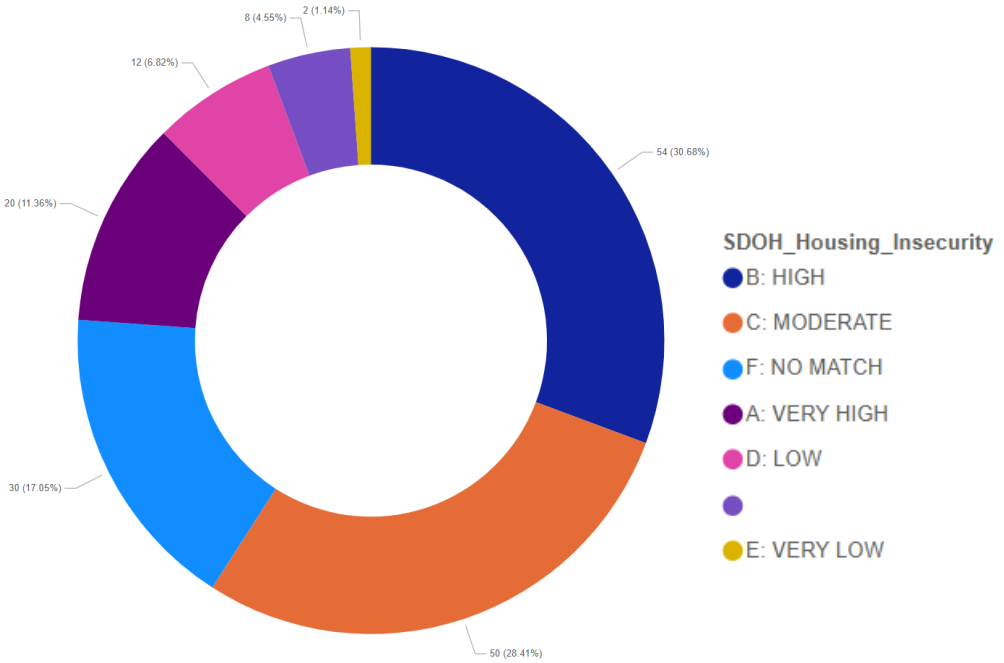


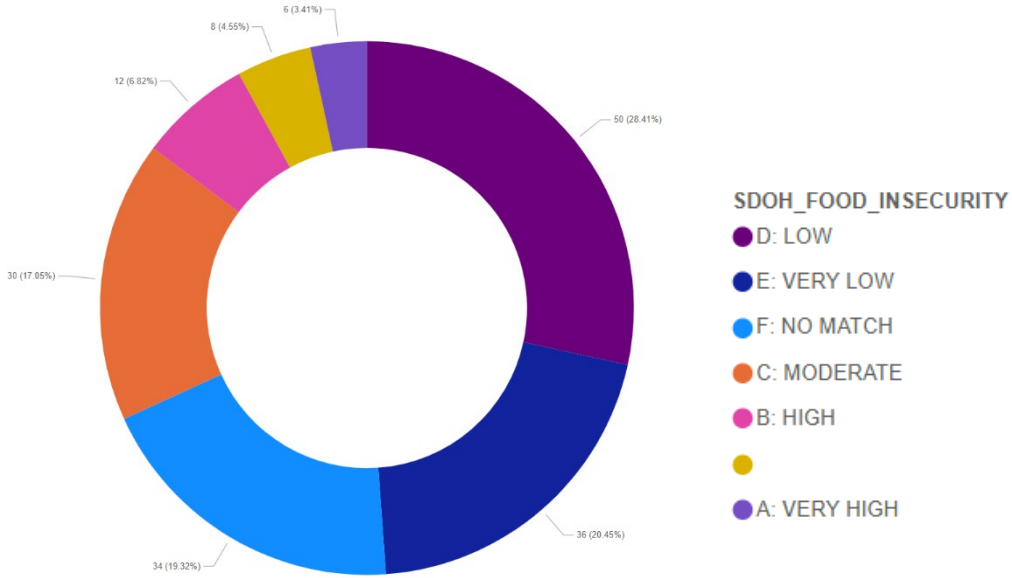
The Molina Healthcare Quality Performance Tool defines social determinants of health as “the economic and social conditions that influence individual and group differences in health status.” 24.62% of members report having high and 14.70% very high housing insecurity. 9.22% of members report having high and 8.52% very high food insecurity.

For internal use only.

California CLAS Analysis – Social Risk/Social Needs (Marketplace)

Prenatal and Postpartum Care, Timeliness of Prenatal Care (PPC): Eligible Member Population



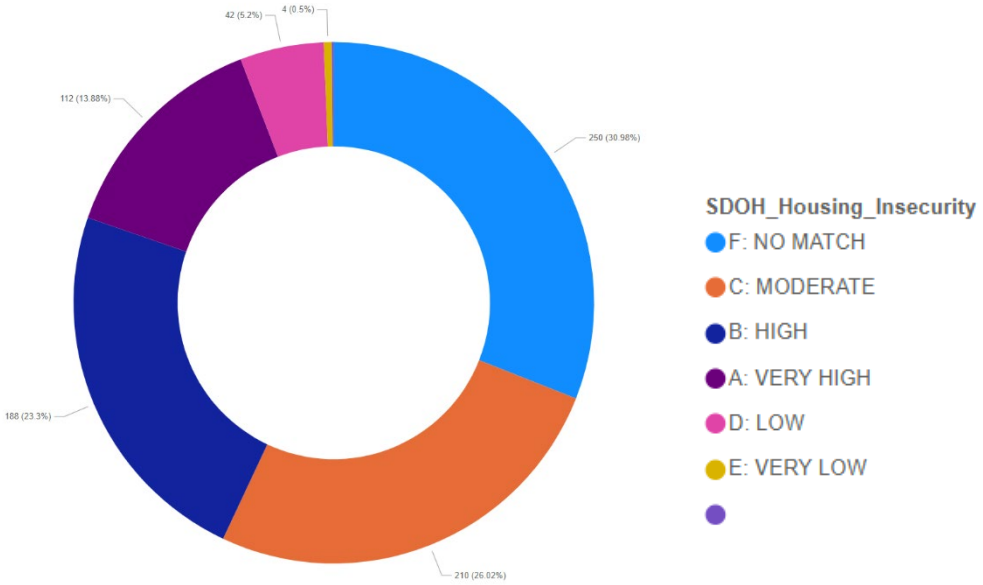


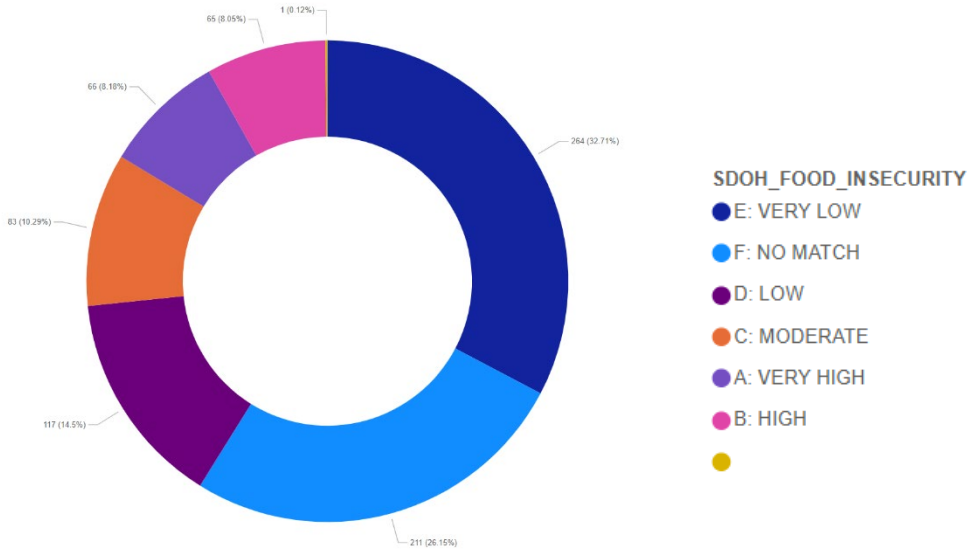
The Molina Healthcare Quality Performance Tool defines social determinants of health as “the economic and social conditions that influence individual and group differences in health status.” 30.68% of members report having high and 11.36% very high housing insecurity. 6.82% of members report having high and 3.41% very high food insecurity.

For internal use only.

California CLAS Analysis – Social Risk/Social Needs (Medicaid)

Prenatal and Postpartum Care, Postpartum Care (PPC): Eligible Member Population





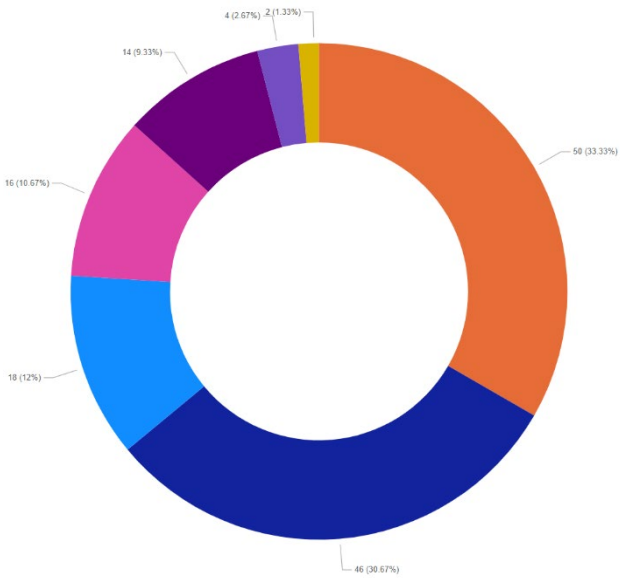
The Molina Healthcare Quality Performance Tool defines social determinants of health as “the economic and social conditions that influence individual and group differences in health status.” 23.30% of members report having high and 13.88% very high housing insecurity. 8.05% of members report having high and 8.18% very high food insecurity.

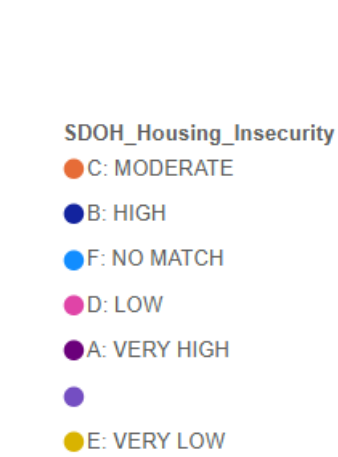
Health Equity Dashboard – SDOH Detail (MY2025, 03/04/2026)

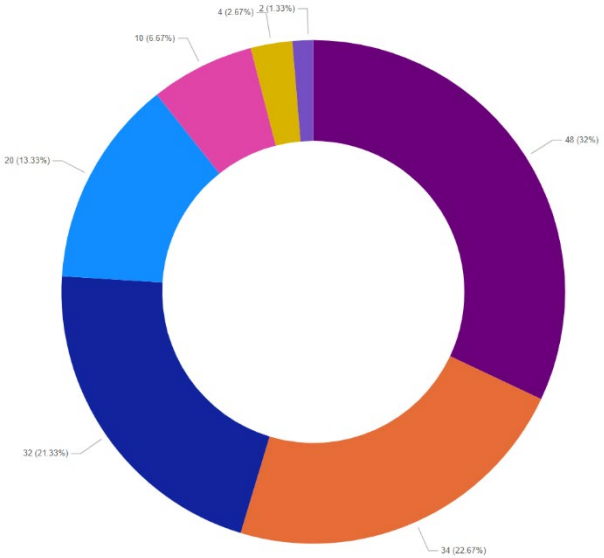
For internal use only.

California CLAS Analysis – Social Risk/Social Needs (Marketplace)

Prenatal and Postpartum Care, Postpartum Care (PPC): Eligible Member Population







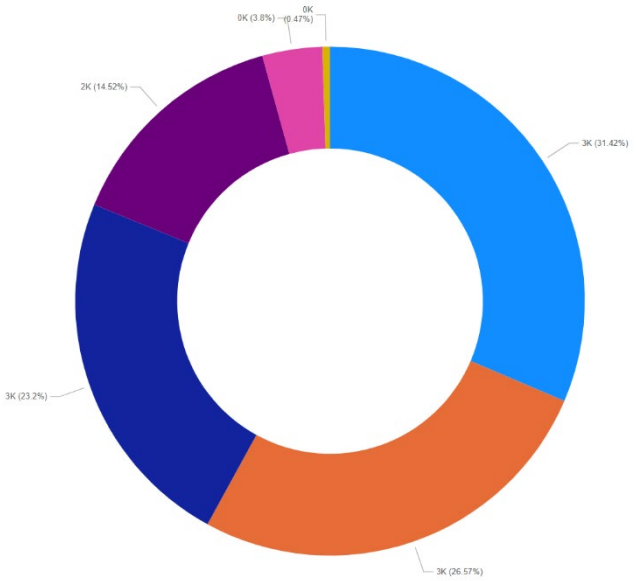
The Molina Healthcare Quality Performance Tool defines social determinants of health as “the economic and social conditions that influence individual and group differences in health status.” 30.67% of members report having high and 9.33% very high housing insecurity. 6.67% of members report having high and 1.33% very high food insecurity.

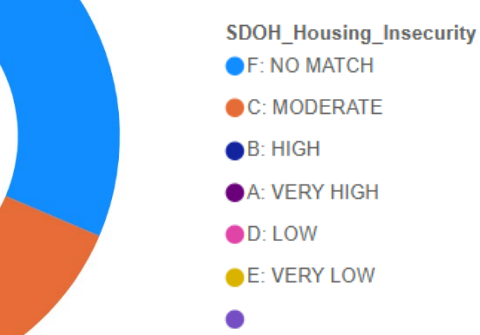
Health Equity Dashboard – SDOH Detail (MY2025, 03/04/2026)

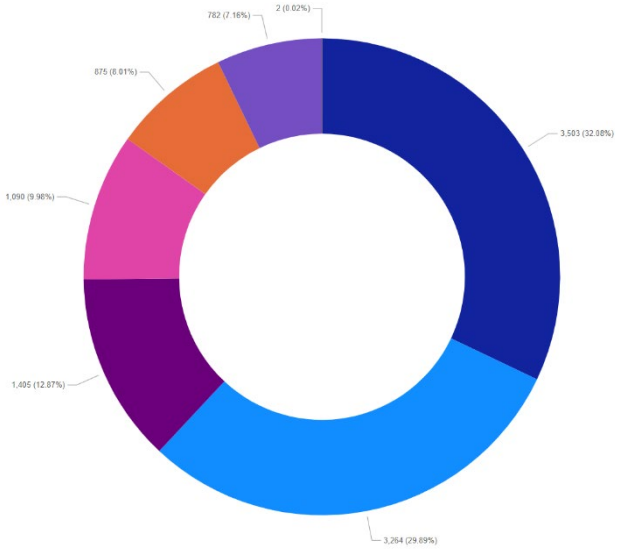
For internal use only.

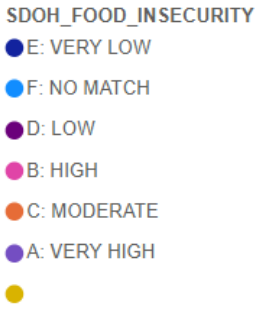
California CLAS Analysis – Social Risk/Social Needs (Medicaid)

Initiation and Engagement of Substance Use Disorder Treatment – Composite (IET): Eligible Member Population









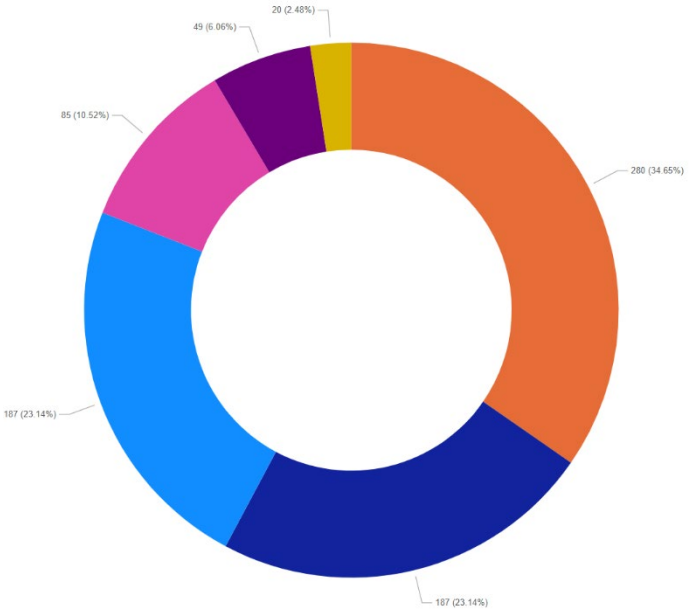
The Molina Healthcare Quality Performance Tool defines social determinants of health as “the economic and social conditions that influence individual and group differences in health status.” 23.20% of members report having high and 14.52% very high housing insecurity. 9.98% of members report having high and 7.16% very high food insecurity.

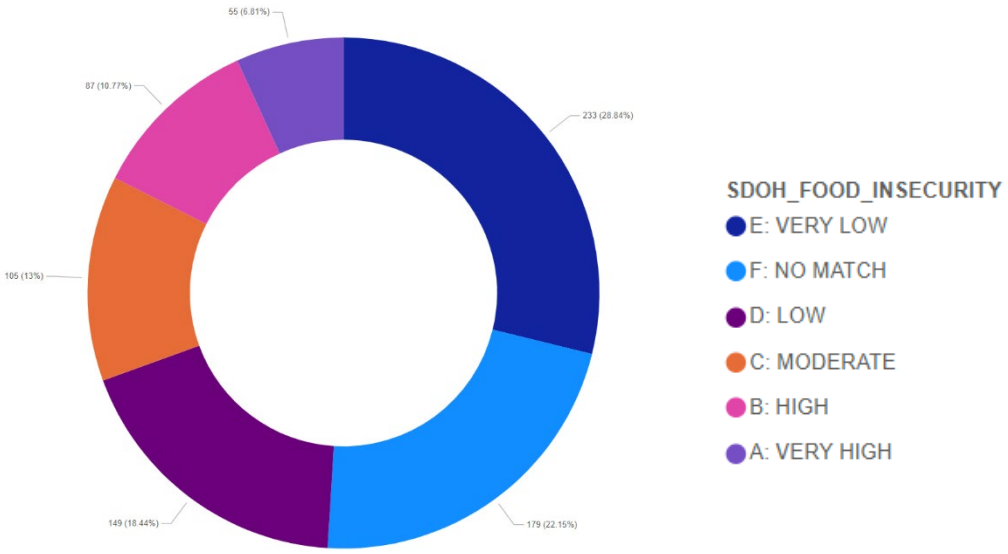
Health Equity Dashboard – SDOH Detail (MY2025, 03/04/2026)

For internal use only.

California CLAS Analysis – Social Risk/Social Needs (Marketplace)

Initiation and Engagement of Substance Use Disorder Treatment – Composite (IET): Eligible Member Population





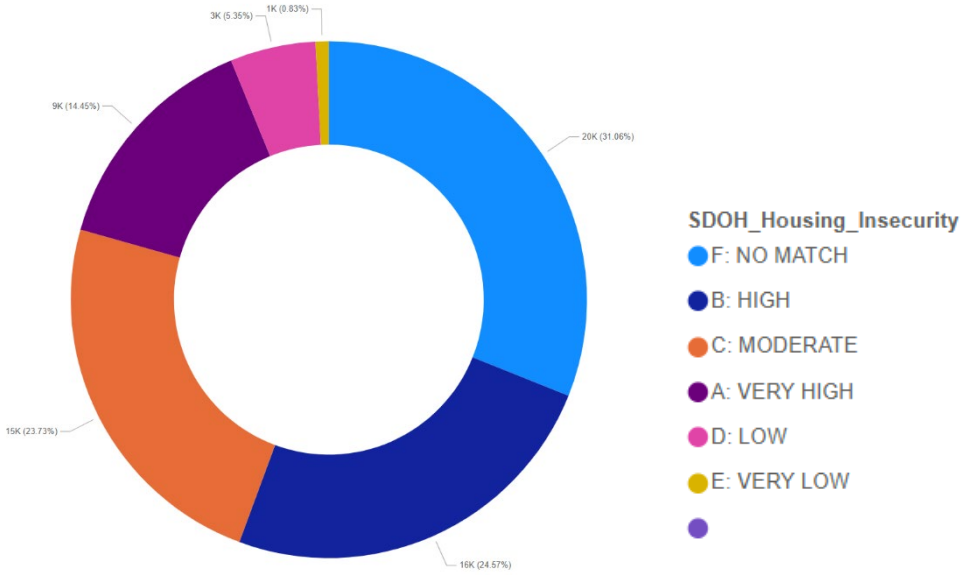
The Molina Healthcare Quality Performance Tool defines social determinants of health as “the economic and social conditions that influence individual and group differences in health status.” 23.14% of members report having high and 6.06% very high housing insecurity. 10.77% of members report having high and 6.81% very high food insecurity.

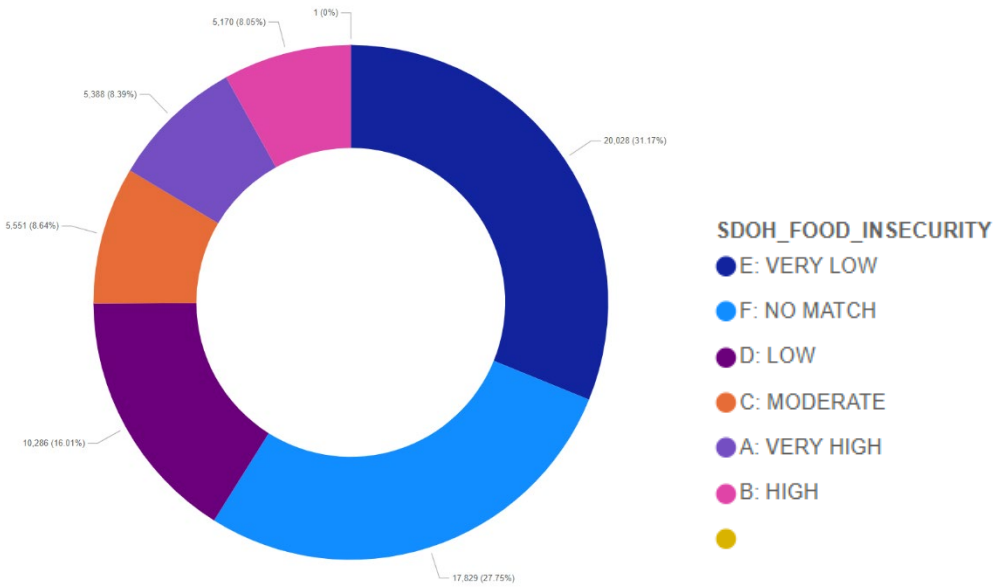
Health Equity Dashboard – SDOH Detail (MY2025, 03/04/2026)

For internal use only.

California CLAS Analysis – Social Risk/Social Needs (Medicaid)

Child and Adolescent Well-Care Visits (WCV): Eligible Member Population





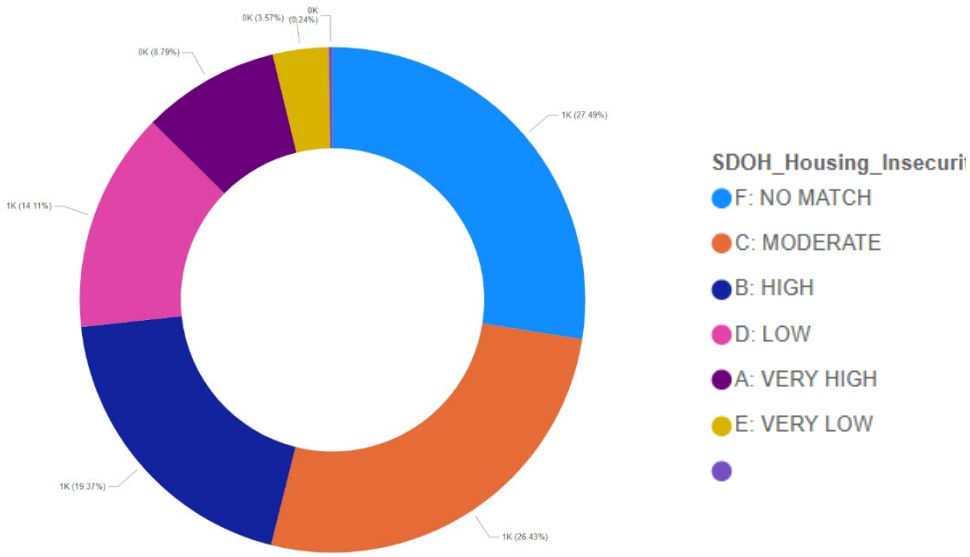
The Molina Healthcare Quality Performance Tool defines social determinants of health as “the economic and social conditions that influence individual and group differences in health status.” 24.57% of members report having high and 14.45% very high housing insecurity. 8.05% of members report having high and 8.39% very high food insecurity.

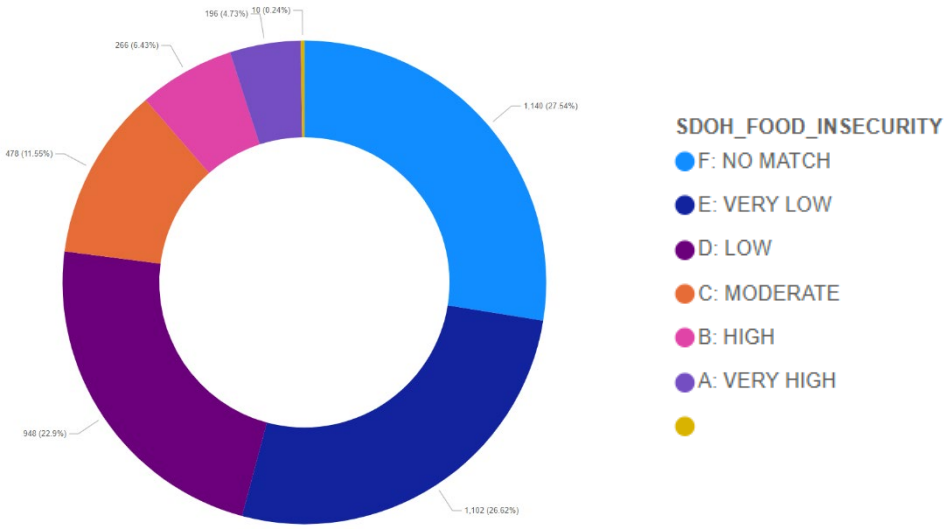
Health Equity Dashboard – SDOH Detail (MY2025, 03/04/2026)

For internal use only.

California CLAS Analysis – Social Risk/Social Needs (Marketplace)

Child and Adolescent Well-Care Visits (WCV): Eligible Member Population





The Molina Healthcare Quality Performance Tool defines social determinants of health as “the economic and social conditions that influence individual and group differences in health status.” 19.37% of members report having high and 8.79% very high housing insecurity. 6.43% of members report having high and 4.73% very high food insecurity.

Health Equity Dashboard – SDOH Detail (MY2025, 03/04/2026)

For internal use only.

California CLAS Analysis – Use of Data to Measure CLAS & Inequities

Opportunities and Prioritization – Health Care Inequities

Molina conducted a thorough analysis of member data, examining race, ethnicity, language needs, and engagement status, to identify populations facing significant barriers to care. This assessment revealed a substantial number of unengaged members, most of whom belong to racial and ethnic minority groups and require culturally and linguistically appropriate services to improve their access to health care.

Of the 1,255 members targeted through the Reach Out partnership, 1,203—over 95%—identified as members of racial and ethnic minority groups. These individuals were less likely to utilize their assigned Primary Care Providers (PCPs) and encountered various obstacles, including transportation challenges, language barriers, scheduling difficulties, and complexities in navigating health care services. Given the size of this group, the prevalence of access barriers, and the need for tailored interventions, Molina prioritized these members to address health care inequities in 2025.

To meet these needs, Molina implemented several culturally and linguistically appropriate strategies:

- Interpreter services were provided, including the availability of in-person interpreters to assist members with limited English proficiency. For Spanish-speaking and Hispanic members, Molina ensured at least two interpreters were present at events.
- Outreach materials were developed and distributed in all threshold languages, and targeted outreach efforts focused on non-English speaking members.
- Molina partnered with Reach Out, a community-based organization serving Yucca Valley, Jurupa Valley, and Upland, to deliver services in culturally familiar and trusted community settings. In addition to health care services, members could access resources such as diapers, formula, career coaching, and the community closet.
- Molina HEDIS Health Fair events were hosted in accessible locations, including community-based organization offices, to engage members directly within their communities.
- Transportation assistance was offered to reduce barriers related to cost and effort, making it easier for members to access care.
- Appointment availability was expanded, including after-hours and weekend options, to accommodate the diverse needs of members, such as those who work or have school-age children.
- Communication was enhanced through reminders and flexible scheduling. Reminder calls were adjusted from 72 to 48 hours, and members who wished to reschedule or cancel appointments were offered options such as later same-day appointments, in-home visits, or other event dates nearby.
- Case Managers and warm hand-offs were utilized to deliver culturally responsive care coordination and follow-up. For 2026, Molina aims to involve Community

For internal use only.

Health Workers (CHWs) to help close referral loops and ensure members access required and requested services.

These efforts collectively aim to provide equitable access to care by addressing cultural, linguistic, and social barriers. Molina's approach is designed to improve engagement and health outcomes among underserved populations, underscoring its commitment to identifying and prioritizing members who experience health care inequities and to delivering services that are culturally and linguistically appropriate for their needs.

Activities and Interventions

To address inequities among unengaged members from racial and ethnic minority populations, Molina implemented a series of culturally and linguistically appropriate outreach and engagement interventions in partnership with Reach Out. One of the primary interventions included the delivery of culturally tailored outreach and in-person community events, known as Molina HEDIS Health Fairs. These events were strategically held in trusted community locations, such as Reach Out offices, to reduce access barriers and increase engagement among underserved populations.

Culturally and Linguistically Appropriate Strategies

- Printed outreach materials were provided in all threshold languages, ensuring accessibility for non-English speaking members and those from racial and ethnic minority groups. Targeted outreach efforts were made to reach these populations effectively.
- Interpreter services were offered at all events to support members with limited English proficiency. When events targeted Hispanic and Spanish-speaking members, Molina increased the number of interpreters to two or more to meet the needs of attendees.
- Molina partnered with Reach Out, a community-based organization serving diverse populations. This partnership allowed services to be delivered in culturally familiar settings, where members could also access essential items such as diapers, clothes, and food to support their overall wellbeing.

Enhanced Outreach and Engagement Strategies

- Appointments were scheduled across all counties, with expanded availability including after-hours and weekend options. This approach accommodated members with varying schedules and responsibilities.
- Transportation assistance was provided to reduce access barriers and enable easier attendance at health events and appointments.
- Appointment reminders and follow-up outreach efforts were conducted to support continuity of care and promote member engagement.

These interventions directly addressed barriers related to language, transportation, and access. The strategies were specifically designed to improve engagement and reduce

For internal use only.

disparities in the utilization of preventive and chronic care services among underserved members.

Evaluation of Effectiveness

Molina, in collaboration with Reach Out, hosted 36 HEDIS Health Fair events to engage members from racial and ethnic minority populations. To evaluate the effectiveness of these culturally and linguistically appropriate interventions, Molina utilizes a comprehensive approach that includes member feedback surveys, process measures, and outcome data.

Health Equity Survey
As part of the ongoing partnership and event series, Molina developed a Health Equity Survey, which is scheduled for implementation in 2026. This survey is designed to assess member experiences, identify barriers to care, and measure the impact of interventions intended to increase engagement among underserved groups.
The Health Equity Survey collects detailed information on several key areas:

- Barriers to care, such as transportation, language access, cultural alignment with providers, cost, and scheduling challenges
- Drivers of engagement, including proximity, convenience, outreach efforts, and incentives
- Member-identified needs like transportation support, language services, health education, and care coordination
- Demographic information—race, ethnicity, and language spoken at home—to enable stratified analysis

Evaluation Metrics
Molina uses survey responses to evaluate both process and outcome measures, including:

- Member participation and engagement rates at health fair events
- Member-reported barriers before and after interventions
- Member satisfaction and perceived accessibility of services
- Identification of ongoing gaps in culturally and linguistically appropriate services

Survey results are analyzed by race, ethnicity, and language, enabling Molina to identify differences in experience and outcomes across populations. This stratified analysis helps determine whether interventions are effectively reducing disparities in access and engagement.

Application of Survey Findings
The findings from the Health Equity Survey are used to:

- Refine outreach strategies and enhance culturally and linguistically appropriate services
- Improve language access services and interpreter availability

For internal use only.

- Adjust event locations, scheduling, and transportation support based on member needs
- Strengthen partnerships with community-based organizations to better serve diverse populations

Qualitative Member Feedback
Overall, Molina has received positive qualitative feedback from members regarding their experience with the HEDIS Health Fair events. Members report improved access, engagement, and satisfaction with services tailored to their cultural and linguistic needs. Feedback collected through direct interactions and post-event outreach demonstrates that these interventions are effective in reducing barriers to care and improving the member experience.

For example, during a health fair at the Reach Out-Upland site on 07/23/2025, a father expressed appreciation for the rapid and effective support provided by Molina staff, describing his experience as “wonderful.” In another case, a mother returned to a Reach Out event multiple times to ensure her children were enrolled in a Medicaid incentive program, showing increased engagement and understanding of available benefits after receiving assistance in her preferred language.

Feedback from a Spanish-speaking member at a 07/11/2025 event highlighted the importance of language-accessible services. The member reported initial frustration with navigating insurance options: "I honestly was going to change insurance plans. It has been such a pain calling and being put on hold and eventually getting disconnected. I realized that all I needed was an insider to help me get things rolling. Thank you to the team for everyone's help and I'm so happy. I don’t want to change insurances anymore." After receiving culturally and linguistically appropriate support, he expressed satisfaction and decided to remain with Molina.

Identified Opportunities for Improvement
Evaluation efforts also revealed opportunities for improvement. High member volume at events led to longer wait times, prompting some members to reschedule for in-home visits. These findings are guiding adjustments to staffing, scheduling, and service delivery models to better meet member needs.

Continuous Quality Improvement
Through ongoing collection and analysis of member feedback, Molina evaluates the effectiveness of its interventions and continuously refines strategies to improve access, reduce barriers, and advance health equity for diverse populations.

HEDIS Measure Monitoring
In addition to survey and qualitative feedback, Molina monitors HEDIS measure performance (such as CBP, GSD, WCV, TFL, COL-E, EED, KED, and immunizations) to assess improvements in care utilization and outcomes within the targeted population. This

For internal use only.

multi-faceted evaluation enables Molina to identify successes and areas for improvement, supporting ongoing efforts to reduce health care inequities.

Opportunities and Prioritization – CLAS

Molina Healthcare of California identified a growing opportunity to strengthen Culturally and Linguistically Appropriate Services (CLAS) in response to increasing demand for language assistance among providers and members. Between January 2025 and June 2025, requests for interpretation services increased by 4.5 percent compared to the prior year, reflecting rising call volumes and greater reliance on language support to ensure equitable access to care. During this period, the average connect time using the current vendor, Globo interpretation services, was approximately 14.4 seconds. This upward trend highlighted the need for a more efficient, scalable, and reliable interpretation model that could meet member and provider needs without introducing operational delays or compliance risk.

Internal assessments and cross-functional reviews identified significant operational, financial, and compliance gaps within the existing Over-the-Phone Interpretation (OPI) model supported by the former vendor. The prior workflow required extensive manual intervention by Member Services staff, including call routing and eligibility verification, before providers and members could be connected to interpreters. This process increased call handling times, created administrative burden, and contributed to provider and member dissatisfaction, particularly as interpretation demand continued to grow. Manual eligibility checks also increased the likelihood of human error, introducing avoidable compliance and billing risks.

Activities and Interventions

As a result, Molina Healthcare of California prioritized transitioning OPI services to Hanna Interpreting Services to address these gaps and advance CLAS goals. The new model enables direct provider access to interpreters, supports real-time electronic eligibility verification, and improves enterprise-wide visibility into language service utilization. This transition strengthens compliance controls, improves operational efficiency, and enhances the experience for providers and members who rely on timely and accurate interpretation services. Ultimately, this strategic change positions Molina Healthcare of California to better meet growing language access needs and support equitable, culturally responsive care for its diverse member population. Implementation of the transition to Hanna Interpretating Services occurred in August 2025.

Evaluation of Effectiveness

Following the implementation of Hanna Interpreting Services in August 2025, Molina Healthcare of California evaluated the effectiveness of Over-the-Phone Interpretation services through utilization and performance metrics. From August 2025 through

For internal use only.

California CLAS Analysis – Use of Data to Measure CLAS & Inequities

December 2025, Hanna supported 71,435 interpretation requests across 74 languages. Service performance indicators demonstrated timely access and high satisfaction, with an average queue time of 11 seconds and an average call rating of 4.9. These results indicate improved responsiveness, broad language coverage, and a positive experience for providers and members requiring language assistance. Molina Healthcare of California will continue to monitor and evaluate interpretation services to ensure ongoing quality, accessibility, and alignment with CLAS standards.

For internal use only.

California CLAS Analysis – Analysis of Results & Barriers

CLAS Report	Analysis of Results	Root Cause/Barrier Analysis/Identified Opportunities
Linguistic Analysis	**Medicaid/Medicare:** The overall PCP to member ratio goal is met for all languages spoken by 1% of Molina's membership (or 200 eligible individuals). **Marketplace:** The overall PCP To member ratio goal is not met for all languages spoken by 1% of Molina's membership (or 200 eligible members). The ratio was not met for the following languages: Mandarin Chinese. Further analysis calculated Spanish speaking provider to Spanish speaking member ratios in the top five most populated counties in the state with Molina members. All counties and provider types met the ratio goal.	Shortage of providers who speak preferred languages by members in the service area. All providers have access to and utilize Molina's interpretation services to meet the language needs of Molina members. Molina Provider Contracting will continue to evaluate the areas served to determine the availability of providers who speak the preferred languages and will target any identified for contracting outreach.
Interpreter Services	Utilization of interpretation services indicates that members who speak non-English languages are engaging with the resources provided. Member Services, Care Connections (MMG), and Health Care Services Member Outreach report the highest levels of utilization. 2 of the top 20 languages requested for interpretation services (Armenian, and Laotian) did not meet the established connect-time performance benchmark. For all lines of business, top languages requested for interpretation were consistent with the non-English languages spoken by at least 1% of Molina's membership (or 200 eligible members).	Molina Healthcare will continue to collaborate with its interpretation services vendor to review languages that did not meet the connect time performance benchmark to identify potential barriers. The number of interpreters fluent may be limited. High call volumes and the demand for languages requested increase connect time.

For internal use only.

California CLAS Analysis – Analysis of Results & Barriers

Translation Services	Languages requested for member material translation were consistent with the non-English languages spoken by at least 1% of Molina's membership (or 200 eligible members).	
Staff Experience CLAS	Staff reported challenges with interpreter services, including poor interpretation quality, difficulty hearing the interpreter, calls ending unexpectedly, and instances where interpreters appeared distracted. Although some challenges were reported, the volume of issues was not significant enough to suggest that staff experience was declining or poor. The volume of positive feedback surpassed the total number of issues reported by Molina Healthcare staff. Overall Molina staff report positive experiences with the organization's interpretation services vendor.	All issues reported by Molina staff are submitted to the interpretation services vendor and evaluated. Molina will continue to meet with the vendor monthly to discuss any barriers Molina staff encounter.
Member Experience CLAS	**Medicaid:** California Adult CAHPS® results showed a year-over-year *increase* in the percentage of members who had the 'best possible experience' when utilizing an interpreter to help speak with a doctor/healthcare provider and to help coordinate appointments with their doctors/healthcare providers. California Child CAHPS® results showed a year-over-year *increase* in the percentage of members who had the 'best possible experience' when utilizing an interpreter to help speak with a doctor/healthcare provider and a year-over-year *decrease* in the proportion of members who had the 'best possible experience' when utilizing an interpreter to help coordinate appointments with their doctors/healthcare providers.	Molina Healthcare of California will further evaluate member experience with language services to identify root causes/barriers.

For internal use only.

California CLAS Analysis – Analysis of Results & Barriers

	QHP: California QHP® results showed a *decrease* year-over-year in the percentage of members who 'usually or always' received an interpreter at their doctor's office when they needed one. California QHP® results showed an *increase* year-over-year in the percentage of members who 'usually or always' received health plan forms they had to fill out in the language they preferred. California QHP® outperformed the Molina Healthcare average on the measure assessing the percentage of members who reported 'usually or always' receiving health plan forms in the format they needed (e.g. large print or braille).	
Network Cultural Responsiveness	Majority of Molina provider race/ethnicity data is unknown. Molina's efforts in 2025 to collect additional data via the provider satisfaction survey has been used in the analysis. Based on that data, there is a potential gap in culturally appropriate care. Members do not have significant access to Native Hawaiian or Pacific Islander providers. Three percent of California's provider network have attested to taking a cultural competency training. **Plan to address gaps:** Provide practitioners with cultural competency training and resources to support awareness of health beliefs and health-related behaviors among Molina's culturally diverse membership. Utilize available communication modalities to	Provider race and ethnicity data has not been captured comprehensively enough to support a full analysis. Because providers are not required to disclose race or ethnicity on credentialing applications, available data remains limited. In 2020, Molina introduced optional race and ethnicity questions in the Provider Satisfaction Survey, which provided a deeper analysis. Additional opportunities to gather provider race and ethnicity information include provider self-reported updates made through the provider online portal, the CAQH portal, or direct outreach to their provider services representative. Molina Quality will continue to evaluate the capacity of its network to meet the needs of members for culturally appropriate care as more data becomes available.

	promote and encourage the use of these resources. **Taking action:** Molina developed a provider cultural competency training, accompanied attestation link to monitor provider network completion, and a one-page resource guide that is accessible through the provider online portal. Awareness of these resources is promoted via the provider public facing website, and quarterly provider newsletter.	Molina Provider Contracting will evaluate the service area of network providers available for contracting.
Social Risk/Social Needs	**Medicaid:** In 2024, between 29.39% and 42.60% of eligible Medicaid members in selected HEDIS measures (CBP, PPC I, PPC II, HBD <8.0%, HBD >9.0%, WCV, COL-E) reported having 'high' and between 11.96% and 15.30% 'very high' housing insecurity. Molina Healthcare of California aims to reduce the percentage of members experiencing 'high' to 'very high' housing insecurity. This propensity indicates a greater likelihood of experiencing homelessness. In 2025, between 21.72% and 25.83% of eligible Medicaid members in selected HEDIS measures (COL-E, BCS-E, CBP, GSD >9.0%, FUA-30 day, FUA-7 day, PPC I, PPC II, IET, WCV) reported having 'high' and between 13.79% and 15.28% reported having 'very high' housing insecurity. Comparing 2024 to 2025, there was a year-over-year *decrease* in the proportion of eligible members in the selected HEDIS measures experiencing high and very high housing insecurity.	Members in California experience high cost of living (housing and food) that could potentially contribute to higher levels of housing and food insecurity. Economic instability and limited access to affordable housing. Ongoing monitoring to identify root causes is necessary to further assess.

	In 2024, between 12.40% and 21.16% of eligible Medicaid members in selected HEDIS measures (CBP, PPC I, PPC II, HBD <8.0%, HBD >9.0%, WCV, COL-E) reported having 'high' and between 2.21% and 4.72% 'very high' food insecurity. Molina Healthcare of California aims to reduce the percentage of members experiencing 'high' to 'very high' food insecurity. This propensity indicates that these members have a greater occurrence of food insecurity either because of financial reasons or lack of access to healthy food. In 2025, between 7.21% and 9.98% of eligible Medicaid members in selected HEDIS measures (COL-E, BCS-E, CBP, GSD >9.0%, FUA 30-day, FUA 7-day, PPC I, PPC II, IET, WCV) reported having 'high' food insecurity and between 5.79% and 8.52% reported having 'very high' food insecurity. Comparing 2024 to 2025, there was a year-over-year *decrease* in the proportion of eligible members in the selected HEDIS measures experiencing high food insecurity and a year-over-year *increase* in the proportion of eligible members experiencing very high food insecurity. **Marketplace:** In 2024, Molina Healthcare of California measured the relative contribution of housing insecurity among five SDOH factors. Eligible Marketplace members in selected HEDIS measures (CBP, PPC I, PPC II, HBD <8.0%, HBD	

	>9.0%, WCV, COL-E) had between 21% to 24% proportional contribution of housing insecurity among five SDOH factors. In 2025, Molina Healthcare of California measured the prevalence and severity of housing insecurity among Marketplace members. Between 19.37% and 30.68% of eligible members in selected HEDIS measures (COL-E, BCS-E, CBP, GSD >9.0%, FUA-30 day, FUA-7 day, PPC I, PPC II, IET, WCV) reported having 'high' and between 5.79% and 8.52% 'very high' housing insecurity. While 2024 to 2025 are not directly comparable, together they provide insight into the relative importance of addressing housing insecurity and the extent to which members experience severe housing-related social risk. Beginning in 2025, reporting high and very high housing insecurity established a baseline that will support more year-over-year comparisons that measure member-level severity in the Marketplace line of business. In 2024, Molina Healthcare of California measured the relative contribution of food insecurity among five SDOH factors. Eligible Marketplace members in selected HEDIS measures (CBP, PPC I, PPC II, HBD <8.0%, HBD >9.0%, WCV, COL-E) had a 20% proportional contribution of food insecurity among five SDOH factors. In 2025, Molina Healthcare of California measured the prevalence and severity of food insecurity among Marketplace members. Between 6.43% and 10.77% of eligible	

	members in selected HEDIS measures (COL-E, BCS-E, CBP, GSD >9.0%, FUA 30 day, FUA 7 day, PPC I, PPC II, IET, WCV) reported having 'high' and between 1.33% and 6.81% 'very high' housing insecurity. While 2024 to 2025 are not directly comparable, together they provide insight into the relative importance of addressing food insecurity and the extent to which members experience severe food-related social risk. Beginning in 2025, reporting high and very high food insecurity established a baseline that will support more year-over-year comparisons that measure member-level severity in the Marketplace line of business.	

For internal use only.

California CLAS Analysis – Evaluation of Effectiveness

Molina currently has activities and reporting in place for capturing and analyzing cultural and linguistic services, including members' unique needs and preferences. Furthermore, Molina is dedicated to identifying and improving cultural and linguistic barriers to care through the implementation of new programs, interventions and focused activities. Molina maintains a Cultural Competency and Health Equity Workgroup, which is comprised of representatives of all health plans and lines of business from various departments, such as Quality Improvement, Behavioral Health, Provider Services, Member Services, Healthcare Services and Human Resources. The Workgroup meets monthly to assess Health Equity and CLAS needs, such as training, employee communication, and improvement opportunities to advance equitable outcomes and improve access to quality care.

Based on the key findings and qualitative analysis in the 2025 CLAS Analysis and completed activities in 2025, **the overall CLAS program resources and structure is sufficient.** Although the effectiveness of Molina's strategies meets CLAS expectations, Molina identifies numerous areas as opportunities for improvement for the future. **These areas include the retrieval, storing and reporting of health equity data, sensitivity training for staff on historically marginalized populations and increasing the employee/member satisfaction with interpreter services.**

Recommendations and Next Steps:

This analysis will be presented to Molina's local and National Quality Improvement and Health Outcomes Committee for review and discussion. Analysis of results will also be shared with stakeholders such as members, providers, community representatives and partner organizations to gather feedback on needs relevant to the population served, in addition to program improvement opportunities and prioritization of identified needs.

For internal use only.

California CLAS Analysis – Report Changes from 2024 to 2025

1. Updated reporting out template.
2. Reported utilization of interpretation services by organizational function. Including a utilization indicator representing the percentage of individuals whose primary language is not English and who used interpretation services by organizational function.
3. Reported staff experience with language services.
4. Reported year-over-year CAHPS data analysis.
5. Conducted a disparity analysis on four additional HEDIS measures: Breast Cancer Screening (BCS-E), Follow-Up After Emergency Department Visits for Substance Use (FUA), Follow-Up After Hospitalization for Mental Illness (FUH), and Initiation and Engagement of Substance Use Disorder Treatment (IET).
6. Reported numerator and denominator count in stratified HEDIS rates.
7. Included the prioritization of health care inequities and opportunities to improve CLAS, reported interventions, and an evaluation of effectiveness.
8. Reported analysis of results for each CLAS activity or trending of measure, including a root cause/barrier analysis if the performance falls short of goals in table format.

For internal use only.

California CLAS Analysis – Detailed Methodology Internal Data

Final HEDIS Rates & Reporting Population

Medicaid: IDSS Submission 11141; Reporting Population: NCQA_308_11141_Medicaid

Marketplace: IDSS Submission 12003; Reporting Population: NCQA_308_12003_Marketplace

Medicare: IDSS Submission 16671; Reporting Population: NCQA_308_16671_Medicare_H3038

Member Insights Dashboard

Membership Identification: Active membership is identified using the QNXT database (source table: qnxt_enrollkeys).

Ethnicity/Race: Member ethnicity or race data is retrieved using a hierarchy of direct-data sources where the logic retrieves the *first positive* race or ethnicity value identified for a member to roll up to an OMB standardized category.

1. A positive value is identified as an ethnicity or race value that rolls up to an OMB category that excludes 'Unknown'.
2. Logic is in place to search for ethnicity or race values from the next source in the hierarchy if the first positive value rolls the member up to any of the following OMB categories: 'Asked but no answer', 'decline to answer' or 'some other race'.
    a. If there is not a more descriptive positive race or ethnicity value in another source, logic reverts to the first positive value of 'Asked but no answer'. 'Decline to answer' or 'some other race'.
3. If a single domain has more than one race value, the member is rolled up to the OMB category 'Two Or More Races'.

Domain Hierarchy:

Priority	Domain
1	834 Enrollment
2	Salesforce
3	CCA Assessment Data
4	HIE_ADT
5	HIE_CCD
6	HIE_ORU/VXU
7	SDS Files
8	QNXT

Member Language: Member spoken and written language data is retrieved using a hierarchy of direct data sources capturing any available positive language value.

For internal use only.

California CLAS Analysis – Detailed Methodology Internal Data

1. A positive spoken language value is identified as any language value that does not include 'Unknown'.
2. Logic is in place to exclude 'non-English' category if additional descriptive language values are available.
3. In the case that multiple domains have more than one positive non-English language spoken, written or primary/preferred language value, the first non-English language is retrieved and reported.
4. For sources that have only spoken and written language values, the values are stored in their respective spoken and written language columns. If value(s) are unknown, English is mapped.
5. For sources that have primary/preferred language and written language (but no spoken language), the written language value is stored in the respective column, and the primary language value is stored in the spoken language column. The same methodology is used when a primary language value and spoken language value (but no written language value) is available. The spoken language is stored in the respective column, and the primary language value is stored in the written language column. If value(s) are unknown, English is mapped.
6. For sources that only supply one language column (i.e. primary/preferred, etc.), the primary language is assigned to both the spoken language and written language column. If value is unknown, English is mapped.

Spoken language values are used to report out member language data in the 2025 CLAS Analysis.

Domain Hierarchy:

Priority	Domain
1	834 Enrollment
2	Salesforce
3	CCA Assessment Data
4	HIE_ADT
5	HIE_CCD
6	HIE_ORU/VXU
7	SDS Files
8	Enterprise_db
9	QNXT

Health Equity SDOH Detail Dashboard

Data is sourced from the SDOH indices within the iPro DataMart. These indices are propensity-based measures calculated by Optum (the iPro vendor) using an in-house predictive model. Model inputs are derived from third-party consumer data sources.

For internal use only.

California CLAS Analysis – Detailed Methodology Internal Data

Molina provides Optum with a monthly roster of Molina members, which Optum processes through its model and returns the resulting indices results to Molina.

QI Compliance Dashboard – Provider Data

Provider Identification: Providers are identified from the QNXT reporting database. All providers identified have an active affiliation and contract with Molina for a minimum of one day during the period the report covers.

Providers are classified using the following codes/descriptions:

Specialty Codes	Description
207RC0000X, 2080P0202X, 207RC0001X, 42, 312, 5, 151, CD, IC, ICE	Cardiologist
2080P0205X, 207RE0101X, 11, 156, EDM, REN, EN	Endocrinologist
207RN0300X, 2080P0210X, 21, 324, 154, NEP	Nephrologist
207VG0400X, 363LX0001X, 207VX0000X, 207VM0101X, 207V00000X, 16, 27, 26, 328, GO, OBG, GYN	OB/GYN
2080P0207X, 207RX0202X, 207VX0201X, 207RH0003X, 261QX0200X, 30	Oncologist
207QG0300X, 207QA0000X, 207Q00000X, 207QA0505X, 12, 207QS0010X, 316, FP, 1223G0001X, 208D00000X, 14, 318, IMG, GP	PCP – Family Medicine & General Practice
207RA0000X, 207R00000X, 207RG0100X, 207RG0300X, 19, 207RC0200X, 207RS0010X, 207RS0012X, 322, IM	PCP – Internal Medicine
2080A0000X, 208000000X, 363LP0200X, 345, 90, 2080P0201X, 364SP0200X, 40, PD, AA	PCP – Pediatric
52, 2080P0214X, 207RP1001X, 340, PUD	Pulmonologist
103TC1900X, 103TA0400X, 103TB0200X, 103T00000X, 103TC2200X, 103TC0700X, 103TA0700X, 103TH0004X, 103TS0200X, 103TF0200X, 103TR0400X, 103TP0016X, 103TM1800X, 103TH0100X, 103TE1100X, 82, 103TP2700X, 103TP2701X, 103TF0000X	Psychologist
2084P0800X, 48, 339, 192, 964, PSY , P, 163WP0808X, 363LP0808X, 364SP0808X	Psychiatrist

For internal use only.

Appendix 6

Executive Summary and Introduction

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) program, initiated in 1995 and developed by the Agency for Healthcare Research and Quality (AHRQ), serves as a vital tool in advancing our understanding of member experience within the healthcare system. This program is dedicated to enhancing the scientific comprehension of members' interactions with healthcare services.

CAHPS surveys are designed to investigate and disseminate strategies for improving the reliability and validity of survey results, reporting these results to various stakeholders, and, most importantly, leveraging this feedback to enhance members' experiences with healthcare. These surveys focus on crucial aspects of quality that consumers are best qualified to assess, including the communication skills of healthcare providers and the ease of access to healthcare services.

Member experience, as defined by CAHPS, encompasses the entirety of interactions members encounter within the healthcare system. This includes their interactions with health plans, as well as healthcare professionals such as doctors, nurses, and staff in hospitals, physician practices, and other healthcare facilities. It is essential to distinguish between "member satisfaction" and "member experience" since these terms, while often used interchangeably, carry distinct meanings. Member satisfaction reflects the overall contentment or approval of a member, whereas member experience delves deeper into the myriad of interactions members undergo throughout their healthcare journey.

Understanding and improving member experience is at the heart of CAHPS, as it plays a pivotal role in enhancing the quality of healthcare services and ensuring that healthcare systems are member-centered. CAHPS surveys are a valuable resource in this endeavor, providing valuable insights and data to healthcare providers and policymakers alike, facilitating evidence-based decisions, and ultimately contributing to a more member-centric healthcare landscape.

In California, as in many other states, CAHPS surveys play a crucial role in gathering feedback from healthcare consumers, including Medicaid beneficiaries and others, about their healthcare experiences. These surveys cover a wide range of topics that matter most to members, such as the communication skills of healthcare providers, the accessibility of healthcare services, and overall satisfaction with care.
Through the CAHPS survey in California, healthcare organizations and policymakers gain valuable insights into the strengths and areas for improvement within the state's healthcare system. This information is vital for ensuring that healthcare services in California are member-centered, efficient, and continuously evolving to meet the needs and expectations of its diverse population. In the following sections, we will delve deeper into the specific aspects of the CAHPS survey in California and its impact on healthcare quality and member experiences in the state.

Methodology

The CAHPS Health Plan Survey is a tool for collecting standardized information on enrollees' experiences with health plans and their services. It was designed to support consumers in assessing the performance of health plans and choosing the plans that best meet their needs. Health plans can also use the survey results to identify their strengths and weaknesses and target areas for improvement. Survey results can be used to:

- Support consumers in assessing the performance of health plans and choosing the plans that best meet their needs.
- Identify the strengths and weaknesses of health plans and target areas for improvement.

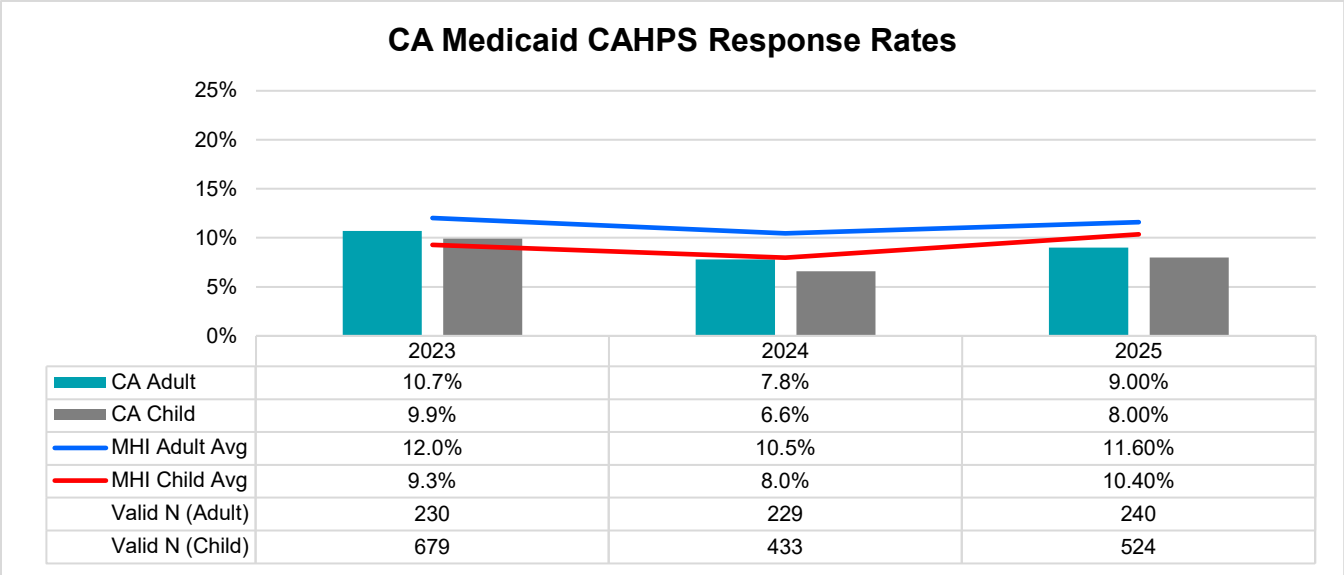
The Health Plan Survey includes standardized instruments and optional supplemental items that can be administered to adults and children enrolled in Medicaid and commercial health plans. The surveys for commercial and Medicaid plans are the same except for the time referent:

- The commercial questionnaire asks enrollees about their experience in the previous 12 months.
- The Medicaid questionnaire asks about experiences in the previous 6 months.

The Centers for Medicare & Medicaid Services (CMS) also administers a version of the CAHPS Health Plan Survey designed for Medicare beneficiaries

Survey Response Rates

Medicaid Response Rates



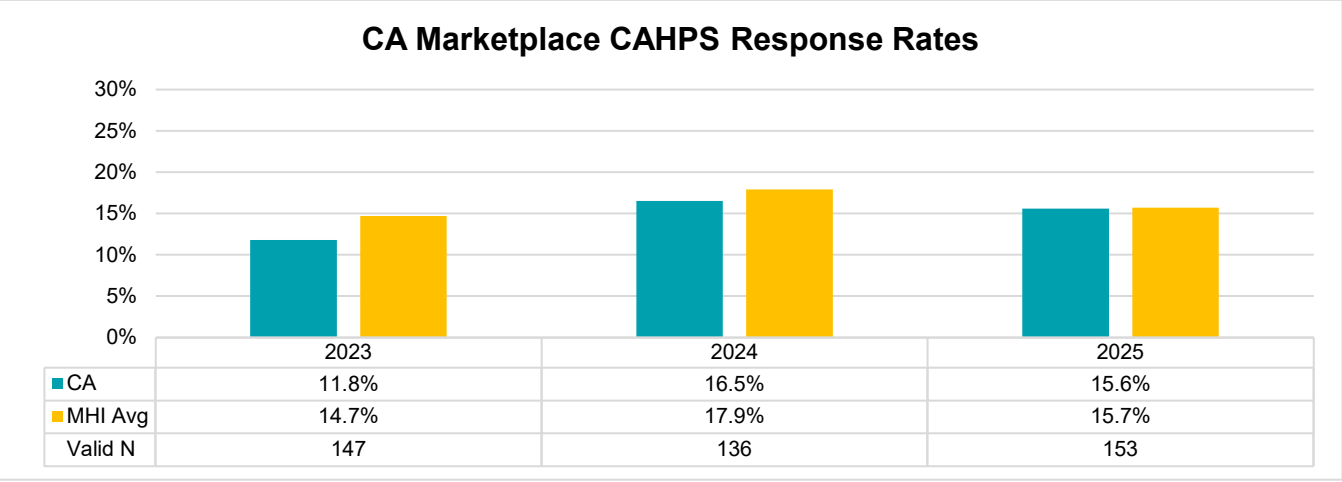
	2023	2024	2025
CA Adult	10.7%	7.8%	9.00%
CA Child	9.9%	6.6%	8.00%
MHI Adult Avg	12.0%	10.5%	11.60%
MHI Child Avg	9.3%	8.0%	10.40%
Valid N (Adult)	230	229	240
Valid N (Child)	679	433	524

The CA Medicaid CHAPS response rates show shifts across the three-year period, with a decline from 2023 to 2024 followed by a partial rebound in 2025 for both adult and child populations. The adult response rate decreased from 10.7% in 2023 to 7.8% in 2024, before improving to 9.0% in 2025. Similarly, the child response rate fell from 9.9% in 2023 to 6.6% in 2024, then increased to 8.0% in 2025. Although the 2025 recovery narrowed the gap, both adult and child response rates continue to trail the 2025 MHI Adult Average of 11.6% and the 2025 MHI Child Average of 10.4%.

The chart also shows that the valid N (sample size) declined between 2023 and 2024 for both populations—from 230 to 229 for adults and 679 to 433 for children—demonstrating reduced participation during that period. In 2025, valid N increased slightly for adults (240) and children (524), which likely contributed to the improved response rates but still reflects participation levels below those seen in 2023. The fluctuations across years point to ongoing challenges in member engagement, outreach consistency, and possible survey fatigue within the Medicaid population.

While the 2025 improvements are encouraging, the response rates remain below internal and external benchmarks, reinforcing the need for targeted strategies to stabilize and increase participation. Opportunities include enhancing member outreach methods, offering stronger or more appealing incentives for survey completion, expanding multi-channel communication (such as text, email, and member portals), and reinforcing member awareness about how their feedback contributes to program improvement. Increasing the accessibility and visibility of the survey—particularly for harder-to-reach populations—may help reverse the declining trend and support more robust participation in future cycles. Strengthening engagement efforts will not only increase response rates but also produce more comprehensive and representative insights into member experience.

Marketplace (QHP) Response Rates



	2023	2024	2025
CA	11.8%	16.5%	15.6%
MHI Avg	14.7%	17.9%	15.7%
Valid N	147	136	153

The CA Marketplace CAHPS response rates show continued improvement from 2023 through 2025, demonstrating strengthening member engagement with the survey over time. The response rate increased from 11.8% in 2023 to 16.5% in 2024, marking a substantial rise of 4.7 percentage points, and then remained strong at 15.6% in 2025. Although the 2025 rate reflects a slight decrease from 2024, it still represents a meaningful improvement compared to 2023 levels and indicates that outreach efforts are sustaining engagement more effectively than in prior years.

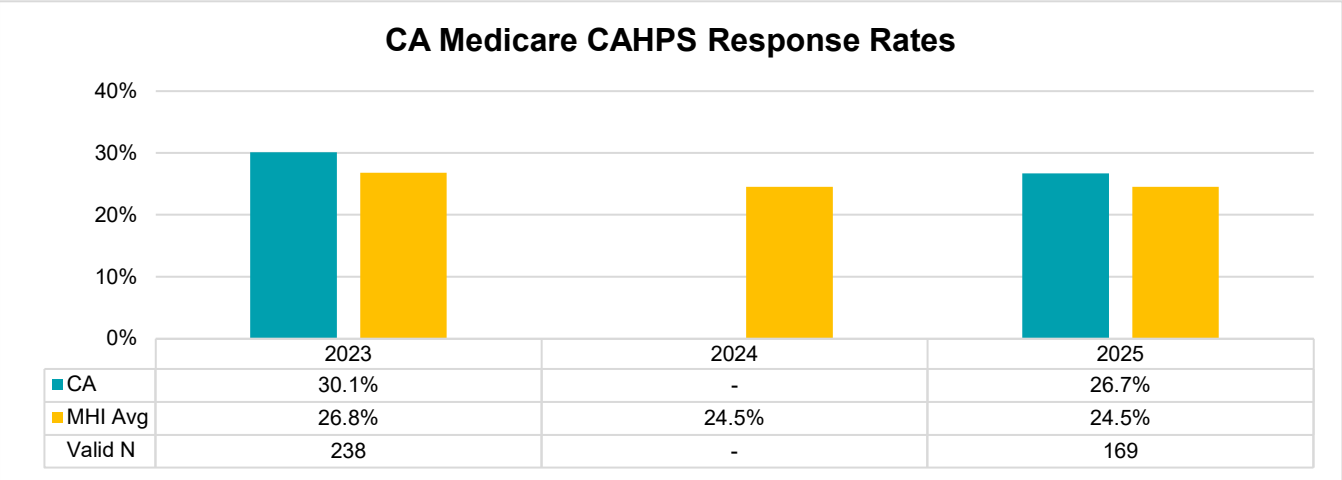
When compared with national benchmarks, California's 2025 response rate of 15.6% is almost aligned with the 2025 MHI Average of 15.7%, reflecting significant progress toward closing the gap observed in previous years. In 2024, California's response rate was just below the MHI Average of 17.9%, and in 2023 remained below the MHI Average of 14.7%. The narrowing difference by 2025 signals that California has improved its competitive standing relative to peer plans.

The valid sample size (N) also showed positive movement between 2024 and 2025, increasing from 136 to 153, which suggests enhanced survey reach and improved contact success with Marketplace members. This upward trend in valid N supports the overall improvement in response rate stability seen in 2025.

While the upward trajectory from 2023 to 2025 is encouraging, further opportunities remain to fully exceed national benchmarks and continue strengthening survey participation. Strategies to support future gains may include more personalized and timely outreach, multi-modal communication (text, email, portal messages), and expanded incentives to encourage member participation. Additionally, simplifying the survey experience and reinforcing the importance of member feedback may help sustain and elevate engagement in upcoming survey cycles.

Overall, the 2025 results demonstrate meaningful progress in Marketplace response rates, reflecting effective engagement strategies and improved survey visibility. Continued refinement of outreach and member communication efforts will be essential to further increase participation and surpass future MHI averages.

Medicare (MCAHPS) Response Rates



	2023	2024	2025
CA	30.1%	-	26.7%
MHI Avg	26.8%	24.5%	24.5%
Valid N	238	-	169

2024 Survey Not Conducted Due to Low Volume.

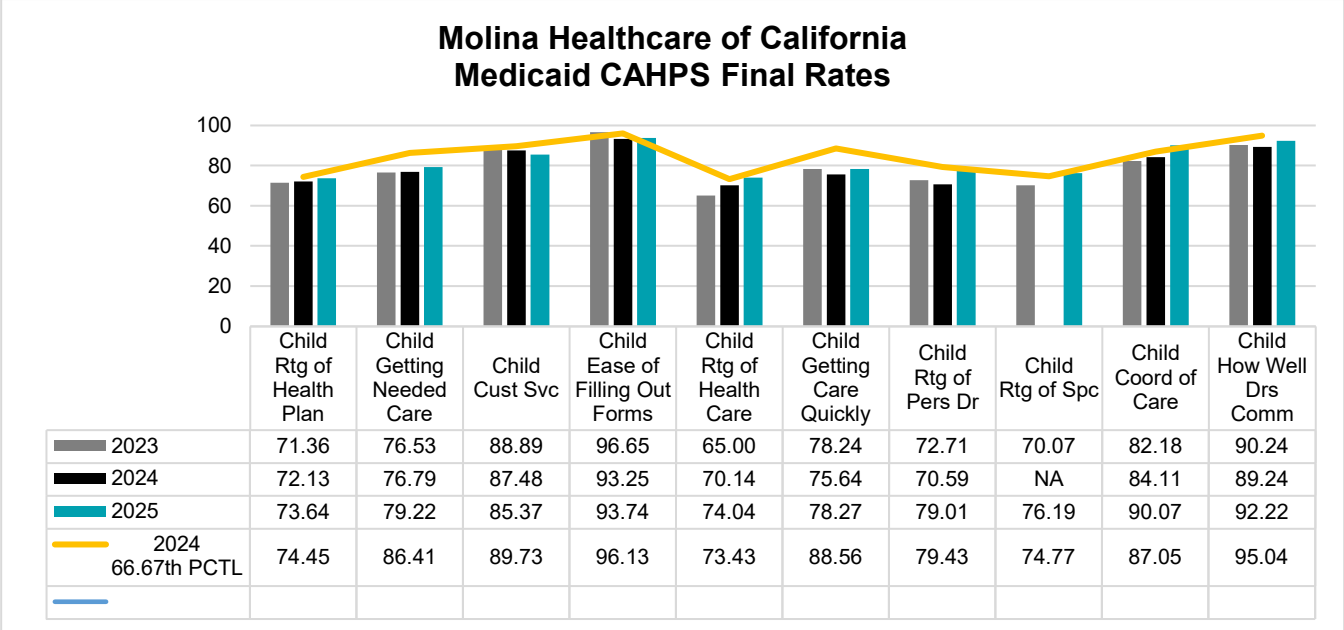
The CA Medicare CAHPS Response Rates chart shows notable shifts in member participation from 2023 through 2025, with a decline in 2024 followed by a partial recovery in 2025. In 2023, California achieved a response rate of 30.1%, outperforming the MHI Average of 26.8%. This strong engagement reflects effective outreach and survey visibility during that period. However, no response rate is reported for 2024, indicating that the survey did not generate a valid sample size that year. The absence of valid N, compared to 238 respondents in 2023, suggests a significant drop in survey participation or challenges in data collection.

In 2025, the response rate rebounded to 26.7%, closely aligning with the 2025 MHI Average of 24.5%. Although lower than the 2023 peak, the 2025 result—supported by a valid sample size of 169 respondents—demonstrates renewed member engagement and improvement over the lack of reportable data in 2024. This mirrors national participation patterns, as the MHI Average decreased from 26.8% in 2023 to 24.5% in both 2024 and 2025, indicating broader declines in Medicare CAHPS engagement.

Overall, the year-to-year variability underscores the importance of strengthening outreach and re-engagement strategies for Medicare members. To improve response rates in future cycles, Molina Healthcare should focus on targeted communication efforts, multi-channel reminders, clearer survey instructions, and the potential use of participation incentives. Reinforcing the value of CAHPS feedback—such as how survey input drives real improvements in plan benefits and member services—may also help motivate greater participation and stabilize response rates in subsequent years.

Survey Results

Child CAHPS Composites



	Child Rtg of Health Plan	Child Getting Needed Care	Child Cust Svc	Child Ease of Filling Out Forms	Child Rtg of Health Care	Child Getting Care Quickly	Child Rtg of Pers Dr	Child Rtg of Spc	Child Coord of Care	Child How Well Drs Comm
2023	71.36	76.53	88.89	96.65	65.00	78.24	72.71	70.07	82.18	90.24
2024	72.13	76.79	87.48	93.25	70.14	75.64	70.59	NA	84.11	89.24
2025	73.64	79.22	85.37	93.74	74.04	78.27	79.01	76.19	90.07	92.22
2024 66.67th PCTL	74.45	86.41	89.73	96.13	73.43	88.56	79.43	74.77	87.05	95.04

NQCA results used.
NA = Less than 100 respondents

The Molina Healthcare of California Medicaid CAHPS Final Rates from 2023–2025 reflect overall stability with several areas of improvement, as well as key metrics that continue to fall below the 66.67th percentile benchmark. The Child Rating of Health Plan increased steadily across all years, rising from 71.36 in 2023 to 72.13 in 2024, and reaching 73.64 in 2025. Although the metric continues to trend upward and is now closer to the benchmark of 74.45, it remains slightly below the target. A similar upward trajectory is seen in Child Getting Needed Care, which increased from 76.53 (2023) to 76.79 (2024) and 79.22 (2025). Despite this improvement, the measure remains below the benchmark of 86.41, signaling ongoing challenges with access-related issues for pediatric members.

Member experience measures demonstrate strong performance in certain areas. Child Customer Service rose from 88.99 in 2023 to 87.48 in 2024 and then improved slightly to 85.37 in 2025. While the metric remains below the percentile benchmark of 89.73, the consistent high scores indicate strong interactions with plan customer service representatives. Ease of Filling Out Forms remains one of the highest-performing measures across all three years, maintaining exceptionally strong scores of 96.65 (2023), 93.25 (2024), and 93.74 (2025). These values are well aligned with the high benchmark of 96.13, suggesting that the plan meets member expectations in administrative ease.

The Child Rating of Health Care shows notable improvement, rising from 65.00 in 2023 to 70.14 in 2024, and 74.04 in 2025, surpassing the benchmark of 73.43 by 2025. This demonstrates a positive upward shift in members' perceptions of overall health care quality.

However, Child Getting Care Quickly dropped from 78.24 (2023) to 75.64 (2024) but recovered slightly to 75.27 (2025)—remaining well below the benchmark of 88.56. These results highlight persistent access delays in scheduling or receiving timely care.

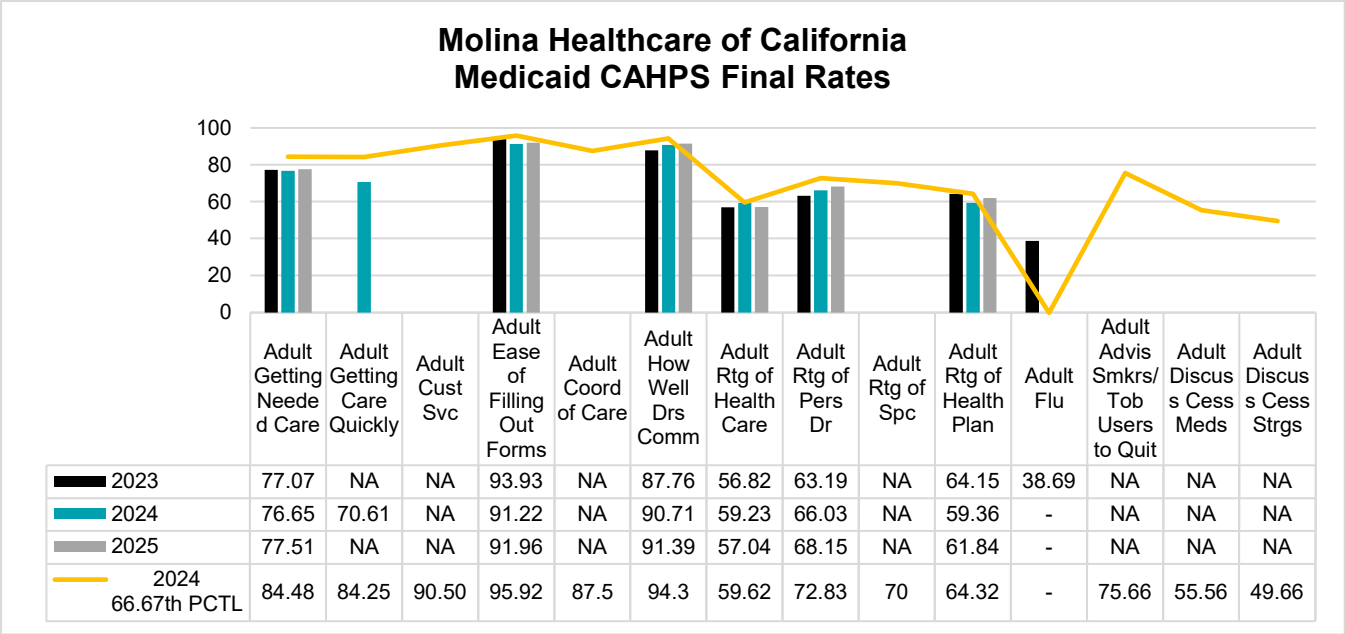
Ratings related to provider interactions reveal a mixed pattern. The Child Rating of Personal Doctor improved slightly from 72.71 (2023) to 70.59 (2024) and then to 79.01 (2025). By 2025, this measure aligns closely with the benchmark of 79.43, reflecting progress in provider-patient relationships. The Child Rating of Specialist, which lacked reportable data in 2024, increased to 76.19 in 2025, although still below the 74.77 benchmark, suggesting a need for more consistent access to or satisfaction with specialty care. Coordination of Care shows steady improvement—from 82.18 (2023) to 84.11 (2024) and 90.07 (2025), finally surpassing the benchmark of 87.05 in 2025. This indicates meaningful progress in ensuring continuity across providers and services.

The strongest-performing category across all years remains “How Well Doctors Communicate,” which scored 90.24 in 2024 and increased further to 92.22 in 2025. Although slightly below the benchmark of 95.04, the consistently high results indicate strong communication and rapport between members and their providers.

To close the remaining gaps and strengthen overall CAHPS performance, Molina Healthcare of California should prioritize a set of targeted improvement strategies. First, efforts to enhance access to timely care should continue, including expanding provider availability, optimizing appointment scheduling processes, and increasing the use of telehealth to reduce delays in securing needed care. Improving access to needed services also remains essential; this may involve reinforcing provider network adequacy, particularly for pediatric and specialty services—and offering more robust care navigation support so members can more easily locate providers who are accepting new patients. Sustaining high performance in provider communication is equally important; continued investments in provider training can help elevate communication scores closer to benchmark levels. In addition, addressing gaps related to specialist access and care coordination should remain a priority by improving referral pathways, ensuring timely follow-up, and enhancing communication between primary care and specialty providers. Finally, maintaining strong results in customer service and administrative processes will require ongoing staff coaching, performance monitoring, and continued efforts to simplify paperwork and minimize administrative burdens. Collectively, these strategies can help Molina Healthcare of California advance toward meeting or exceeding all benchmark goals and further elevate overall member experience.

Overall, the 2025 CAHPS results demonstrate meaningful improvement across several key measures, with Coordination of Care and Rating of Health Care now exceeding benchmarks. Continued focus on access, provider engagement, and specialty care availability will help Molina Healthcare of California meet or exceed all benchmark goals and further enhance member experience.

Adult CAHPS Composites



	Adult Getting Needed Care	Adult Getting Care Quickly	Adult Cust Svc	Adult Ease of Filling Out Forms	Adult Coord of Care	Adult How Well Drs Comm	Adult Rtg of Health Care	Adult Rtg of Pers Dr	Adult Rtg of Spc	Adult Rtg of Health Plan	Adult Flu	Adult Advis Smkrs/ Tob Users to Quit	Adult Discuss Cess Meds	Adult Discuss Cess Strgs
2023	77.07	NA	NA	93.93	NA	87.76	56.82	63.19	NA	64.15	38.69	NA	NA	NA
2024	76.65	70.61	NA	91.22	NA	90.71	59.23	66.03	NA	59.36	-	NA	NA	NA
2025	77.51	NA	NA	91.96	NA	91.39	57.04	68.15	NA	61.84	-	NA	NA	NA
2024 66.67th PCTL	84.48	84.25	90.50	95.92	87.5	94.3	59.62	72.83	70	64.32	-	75.66	55.56	49.66

NQCA results used.
NA = Less than 100 respondents

The Molina Healthcare of California Medicaid CAHPS Final Rates show generally stable performance across most adult experience measures from 2023 to 2025, with some areas demonstrating improvement and others continuing to fall below the 66.67th percentile benchmark. Adult Getting Needed Care remained steady, with results of 77.07 in 2023, 76.65 in 2024, and 77.51 in 2025, though still below the benchmark of 84.48. Adult Getting Care Quickly reported 70.61 in 2024 and NA in 2025, not quite reaching the benchmark of 84.25. Adult Customer Service is marked as NA for all years, indicating fewer than 100 respondents, making the measure not applicable for reporting.

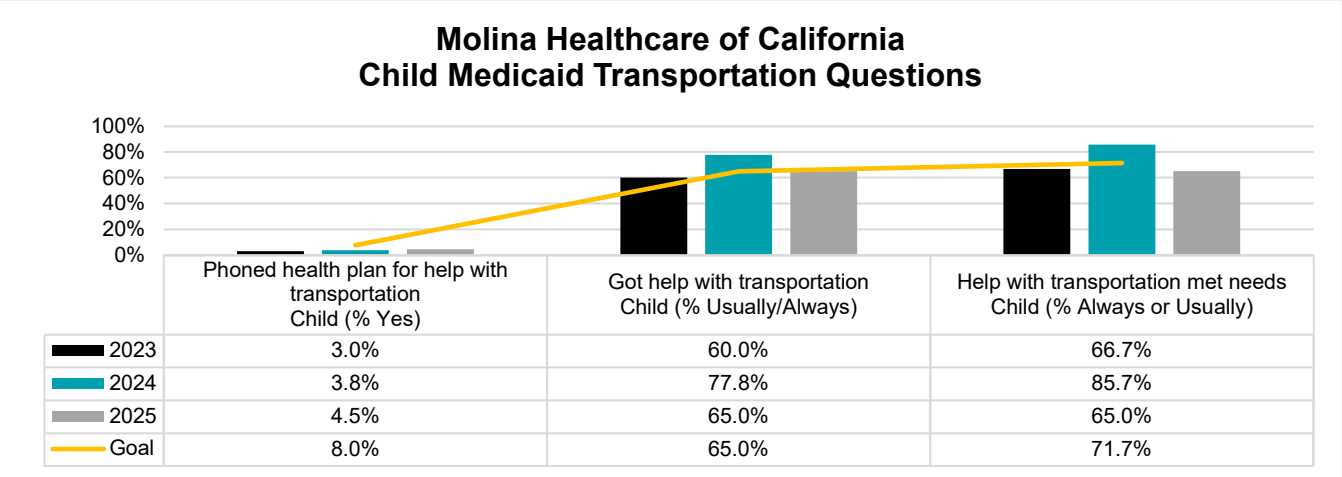
Administrative experience continues to be a strength. Adult Ease of Filling Out Forms scored 93.93 in 2023, 91.22 in 2024, and 91.96 in 2025, closely aligned with—not far below—the benchmark of 95.92. Coordination of Care performed well in 2024 at 90.71, exceeding the benchmark of 87.50, though the measure is NA for 2025 due to insufficient respondents. Communication with providers remains one of the strongest areas, with How Well Doctors Communicate improving from 87.76 in 2023 to 90.71 in 2024, and 91.39 in 2025, trending upward but still below the benchmark of 94.30.

Global rating measures show mixed performance. Rating of Health Care increased from 56.82 in 2023 to 59.23 in 2024, before dipping slightly to 57.04 in 2025, below the benchmark of 59.62. Rating of Personal Doctor improved each year, rising from 63.19 in 2023 to 66.03 in 2024 and 68.15 in 2025, approaching—but not yet reaching—the 72.83 benchmark. Rating of Specialist increased from 64.15 in 2023 to 59.36 in 2024 and then improved to 61.84 in 2025; however, the measure remains below the benchmark of 70.00. Rating of Health Plan demonstrated a gradual decline, decreasing from 64.15 in 2023 to 59.36 in 2024 and then slightly increased to 61.84 in 2025, nearing the benchmark of 64.32. Categories such as Adult

Flu and Adult Tobacco-Related Counseling Measures are labeled NA, indicating that fewer than 100 respondents participated, making results not applicable for reporting.

Overall, the results suggest areas of strength—particularly in communication with providers, administrative simplicity, and timely care improvements in 2025—while highlighting opportunities to further enhance access, care coordination, and specialty care experiences. Continued efforts to improve appointment availability, streamline authorization processes, and support stronger provider–member engagement will help drive additional improvement toward meeting the 66.67th percentile performance benchmarks across all CAHPS domains.

Child Supplemental Questions - Transportation



	Phoned health plan for help with transportation Child (% Yes)	Got help with transportation Child (% Usually/Always)	Help with transportation met needs Child (% Always or Usually)
2023	3.0%	60.0%	66.7%
2024	3.8%	77.8%	85.7%
2025	4.5%	65.0%	65.0%
Goal	8.0%	65.0%	71.7%

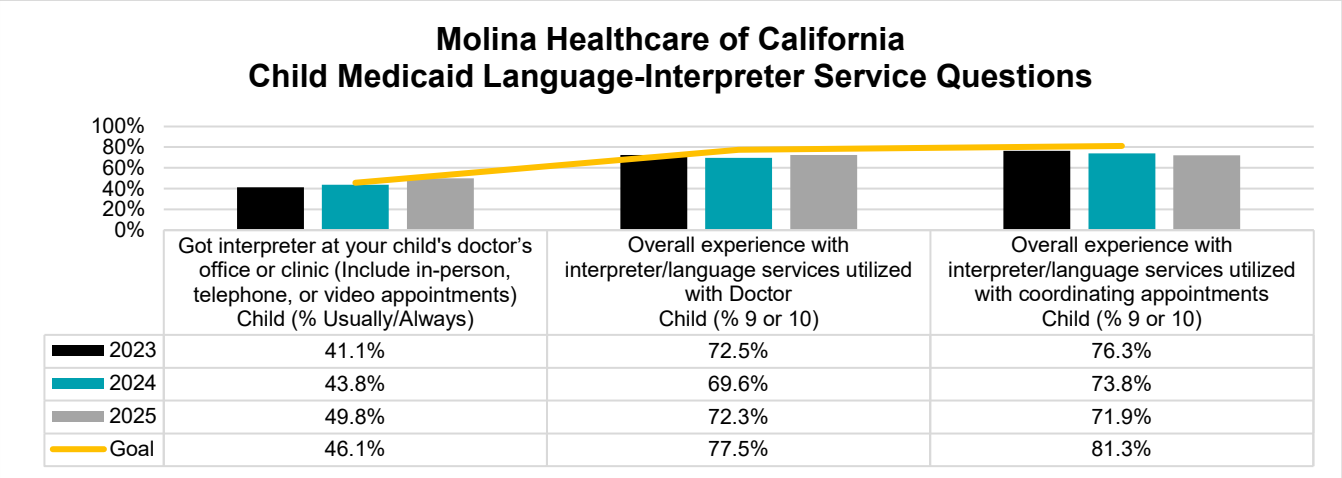
The Molina Healthcare of California Child Medicaid Transportation Questions reveal mixed results in access to transportation services. The percentage of respondents who phoned the health plan for help with transportation remained low at 3.0% in 2023, 3.8% in 2024, and 4.5% in 2025. While the 2025 figure shows a slight increase, it continues to fall well below the goal of 8.0%, suggesting that members may not be aware of transportation assistance options.

The percentage of members who received help with transportation rose from 60.0% in 2023 to 77.8% in 2024 but declined to 65.0% in 2025, meeting the goal but signaling a drop in performance compared to the prior year. Similarly, the percentage of respondents who reported that transportation met their needs increased from 66.7% in 2023 to 85.7% in 2024 but fell sharply to 65.0% in 2025, falling below the goal of 71.7%.

These results indicate that while significant progress was made in 2024, 2025 saw a regression in satisfaction and service delivery. To address these challenges, Molina Healthcare should focus on stabilizing transportation support by improving operational consistency, ensuring adequate resources, and reinforcing quality standards. Additionally, targeted communication campaigns to raise awareness of transportation benefits and

simplifying the request process remain critical to closing gaps in member engagement and satisfaction.

Child Supplemental Question-Interpreter Services



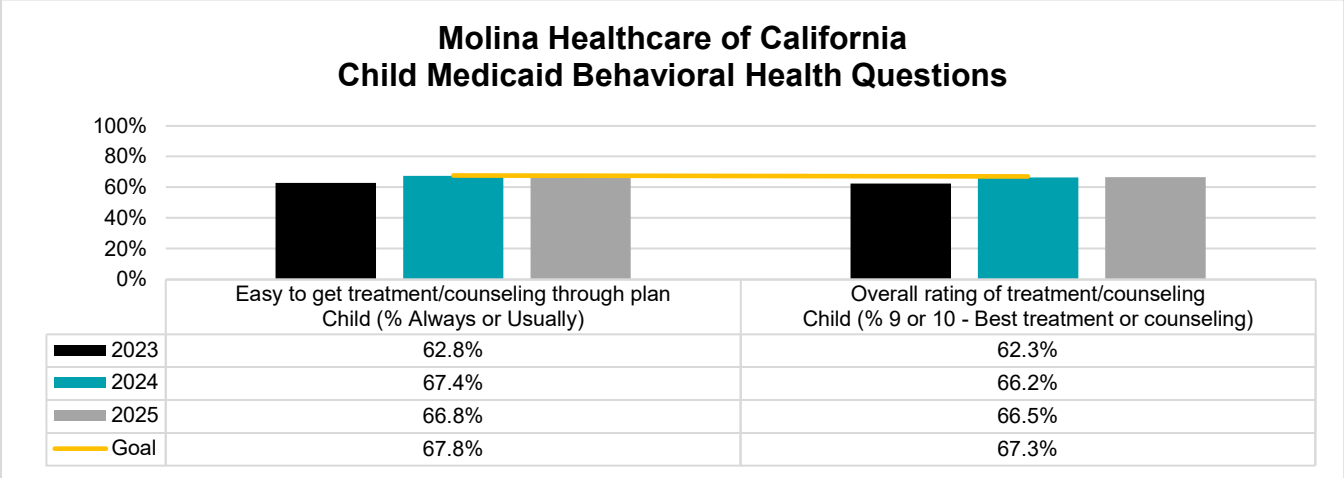
	Got interpreter at your child's doctor's office or clinic (Include in-person, telephone, or video appointments) Child (% Usually/Always)	Overall experience with interpreter/language services utilized with Doctor Child (% 9 or 10)	Overall experience with interpreter/language services utilized with coordinating appointments Child (% 9 or 10)
2023	41.1%	72.5%	76.3%
2024	43.8%	69.6%	73.8%
2025	49.8%	72.3%	71.9%
Goal	46.1%	77.5%	81.3%

The Molina Healthcare of California Child Medicaid Language-Interpreter Service Questions show mixed progress. The percentage of members who reported always or usually getting an interpreter at their child's doctor's office or clinic improved from 41.1% in 2023 to 43.8% in 2024 and reached 49.8% in 2025, surpassing the goal of 46.1%. This indicates notable progress in interpreter availability.

However, overall experience with interpreter or language services when utilized with a doctor declined from 72.5% in 2023 to 69.6% in 2024, then slightly recovered to 72.3% in 2025, remaining below the goal of 77.5%. Satisfaction with interpreter services for coordinating appointments decreased from 76.3% in 2023 to 73.8% in 2024 and further to 71.9% in 2025, falling short of the goal of 81.3%.

These findings suggest that while interpreter access improved significantly, overall satisfaction continues to lag. To address this, Molina Healthcare should focus on enhancing the quality and consistency of interpreter services, strengthening provider training, and improving coordination processes. Integrating interpreter request features into digital scheduling platforms and expanding real-time interpretation options could help improve member experience and close remaining gaps.

Child Supplemental Question - Behavioral Health

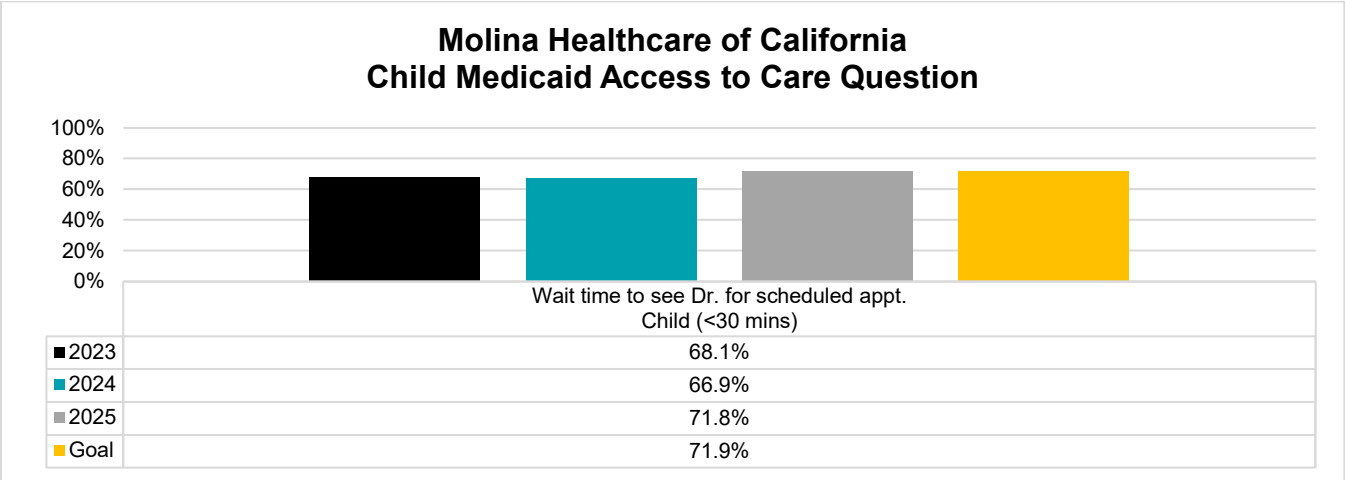


	Easy to get treatment/counseling through plan Child (% Always or Usually)	Overall rating of treatment/counseling Child (% 9 or 10 - Best treatment or counseling)
2023	62.8%	62.3%
2024	67.4%	66.2%
2025	66.8%	66.5%
Goal	67.8%	67.3%

The Molina Healthcare of California Child Medicaid Behavioral Health Questions data reflects moderate improvement in access to and satisfaction with behavioral health treatment, though the goal has not yet been fully met. The percentage of members who reported it was easy to get treatment or counseling through the health plan increased from 62.8% in 2023 to 67.4% in 2024 and 66.8% in 2025, remaining slightly below the goal of 67.8%**.** Similarly, the overall rating of treatment or counseling rose from 62.3% in 2023 to 66.2**%** in 2024 and 66.5% in 2025**,** just under the goal of 67.3%**.**

This upward trend suggests positive movement in improving behavioral health services, but further efforts are needed to enhance accessibility and perception of care quality. Potential interventions include expanding the provider network, reducing wait times for appointments, and increasing outreach efforts to educate members about available behavioral health resources. Additionally, telehealth solutions and care coordination improvements could help bridge remaining gaps, ensuring that children and families receive timely, high-quality behavioral health services that meet their needs.

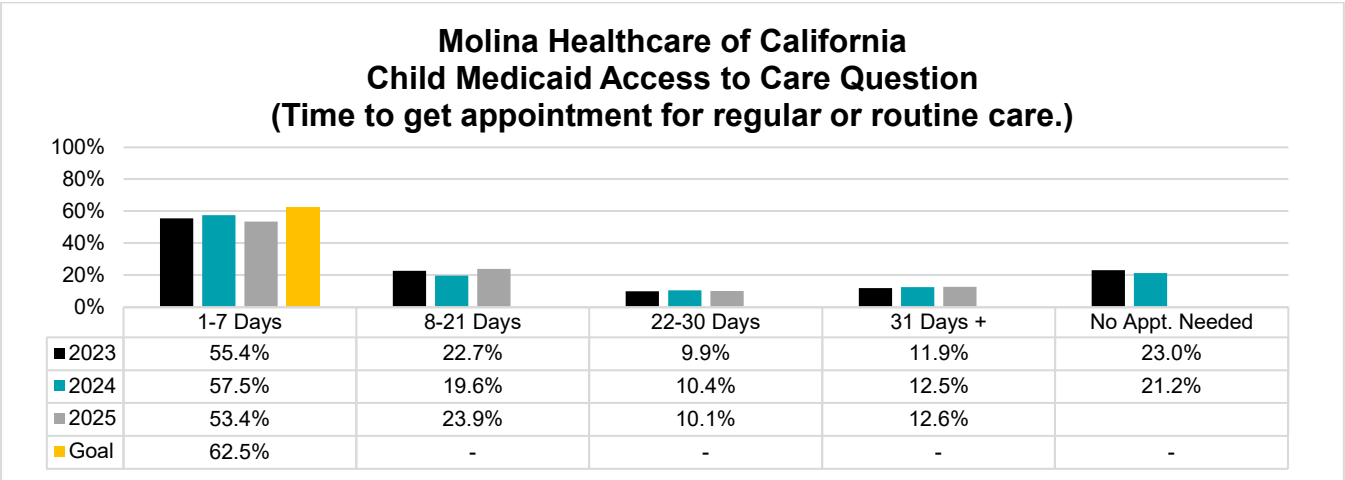
Child Supplemental Question - Access to Care



	Wait time to see Dr. for scheduled appt. Child (<30 mins)
2023	68.1%
2024	66.9%
2025	71.8%
Goal	71.9%

The data from Molina Healthcare of California regarding child Medicaid access to care shows relatively stable wait times for scheduled doctor appointments over the past three years. In 2023, 68.1% of respondents reported wait times of less than 30 minutes, which slightly declined to 66.9% in 2024 and improved to 71.8% in 2025 almost meeting the goal of 71.9%.

This upward movement in 2025 suggests that recent interventions may be having a positive impact, but continued efforts are needed to fully meet the goal. Strategies such as optimizing appointment scheduling, increasing provider availability, and implementing measures to reduce patient backlog will be essential in improving timely access to care and enhancing the overall member experience.



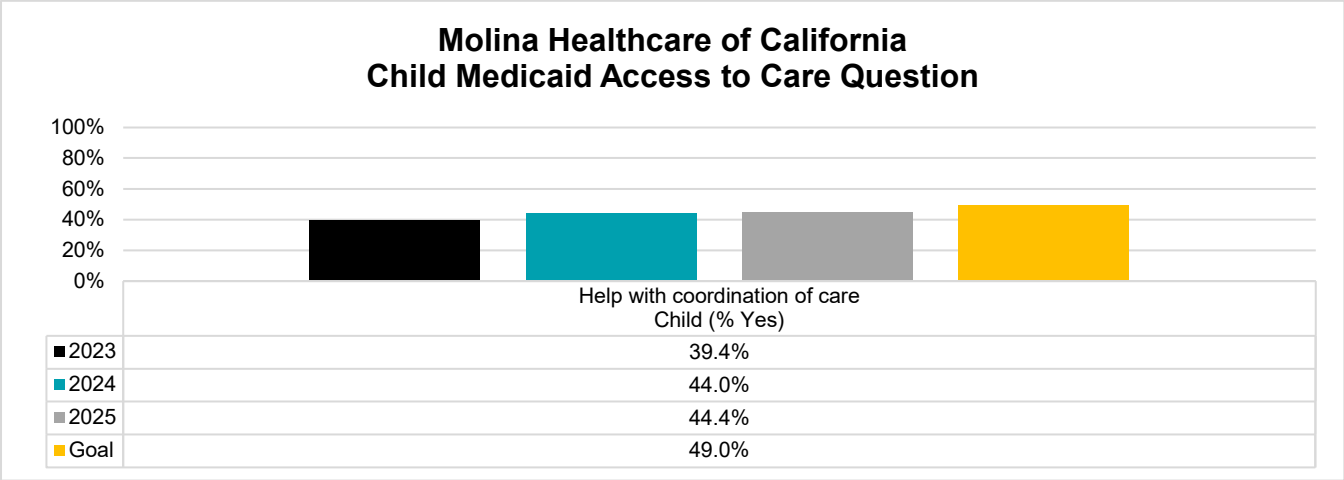
	1-7 Days	8-21 Days	22-30 Days	31 Days +	No Appt. Needed
2023	55.4%	22.7%	9.9%	11.9%	23.0%
2024	57.5%	19.6%	10.4%	12.5%	21.2%
2025	53.4%	23.9%	10.1%	12.6%	
Goal	62.5%	-	-	-	-

The Molina Healthcare of California Child Medicaid access to routine care results show a modest year-over-year improvement in timely access from 2023 to 2024, followed by a pullback in 2025. The share of respondents who obtained an appointment within 1–7 days rose from 55.4% in 2023 to 57.5% in 2024 but then declined to 53.4% in 2025—remaining below

the goal of 62.5% throughout the period. The 8–21 days category decreased from 22.7% (2023) to 19.6% (2024), then rose to 23.9% (2025), indicating some shifting from shortest to mid-range waits in 2025. Longer waits were relatively stable: 22–30 days hovered around ten percent (9.9% in 2023, 10.4% in 2024, 10.1% in 2025), while 31 days+ crept up slightly (11.9% → 12.5% → 12.6%). The share reporting “No appointment needed” dipped from 23.0% (2023) to 21.2% (2024), with no 2025 value displayed on the chart. Overall, access improved in 2024 but slipped in 2025, and performance across the three years remained short of the 1–7-day goal.

To close the gap to goal, prioritize (1) capacity and network adequacy in pediatrics and high-demand specialties; (2) scheduling optimization (open-access/short-slot templates, automated wait-list fill, and proactive outreach for reschedules); (3) convenience channels (telehealth, nurse advice, e-consults) to convert longer waits into earlier touchpoints; and (4) member navigation (text/email prompts, portal scheduling, ride support) to reduce deferrals and accelerate first available appointments. Continual monitoring of 1–7-day fill rates by clinic and time-of-day, coupled with rapid PDSA cycles, can help sustain gains and lift timely access above the 62.5% benchmark.

Child Supplemental Question - Coordination of Care

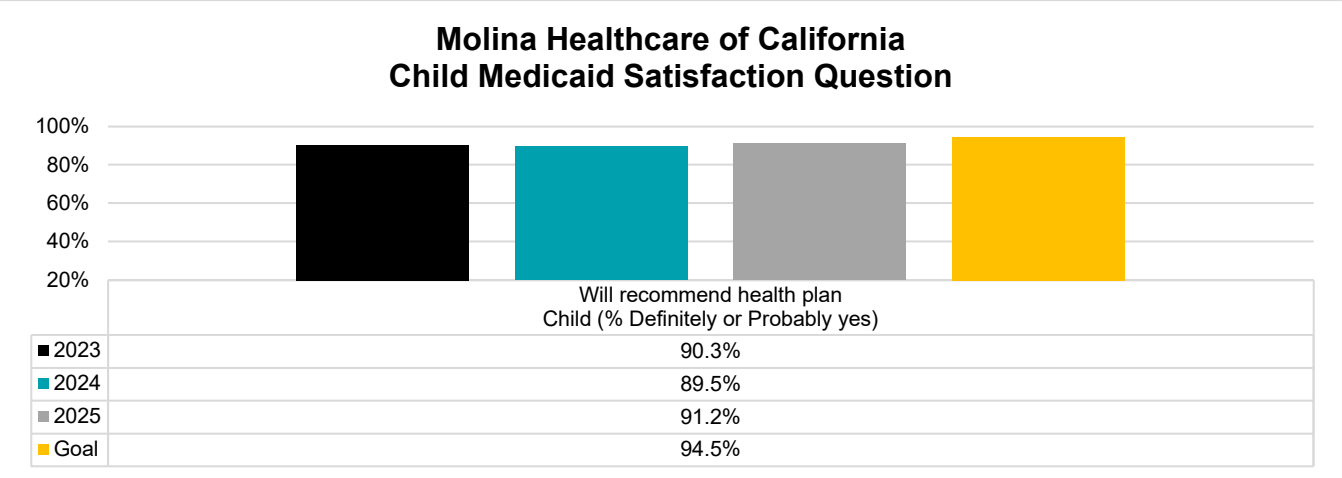


The data from Molina Healthcare of California on child Medicaid coordination of care shows a steady improvement in the percentage of respondents who reported receiving help with coordination. The percentage increased from 39.4% in 2023 to 44.0% in 2024 and reached 44.4% in 2025, almost meeting the established goal of 49.0%.

This consistent progress suggests that initiatives aimed at enhancing care coordination—such as improved case management, better communication between providers, and enhanced support for families navigating the healthcare system—are yielding results. To maintain and build upon this success, continued investment in care navigation services, proactive outreach,

and patient education on available resources will be essential in ensuring sustained improvements and equitable access to coordinated care.

Child Supplemental Question - Satisfaction

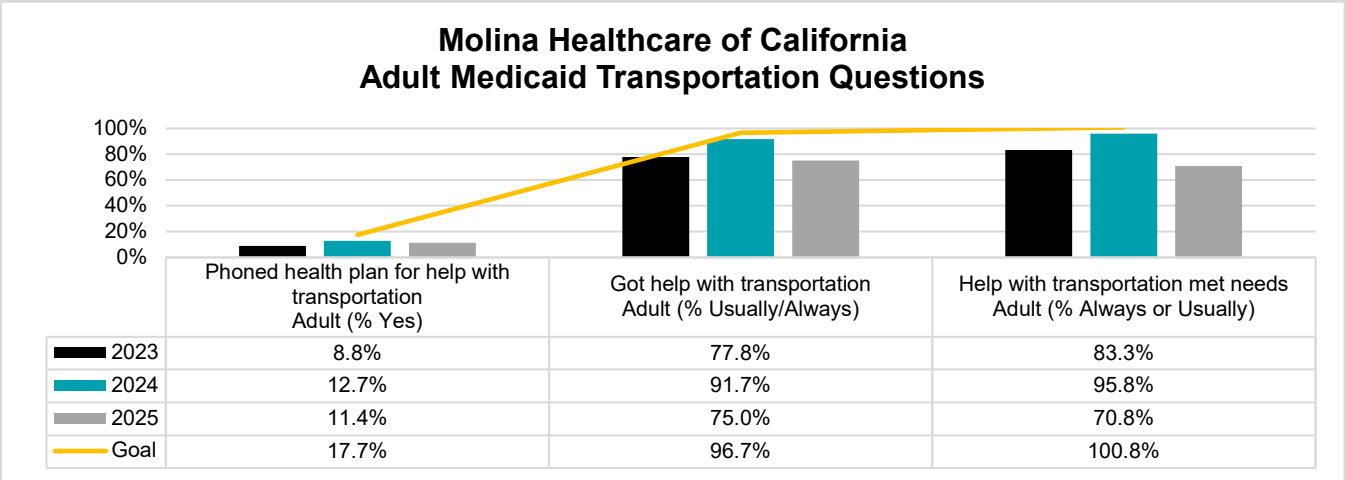


	Will recommend health plan Child (% Definitely or Probably yes)
2023	90.3%
2024	89.5%
2025	91.2%
Goal	94.5%

The data on Molina Healthcare of California's Child Medicaid satisfaction question indicates a slight downward trend followed by a recovery in 2025. In 2023, 90.3% of respondents indicated they would "definitely" or "probably" recommend the health plan, followed by a marginal decline to 89.5% in 2024, and then an increase to 91.2% in 2025. While this improvement is encouraging, the satisfaction rate still falls short of the goal of 94.5%.

Although the decline was reversed in 2025, the gap to the goal suggests that further improvements are needed to enhance member experiences and overall satisfaction. Addressing key factors such as access to care, customer service responsiveness, and provider quality could help drive satisfaction upward. Targeted interventions such as increased provider engagement, streamlining appointment scheduling, and expanding patient support programs may contribute to meeting and surpassing the satisfaction goal in the future.

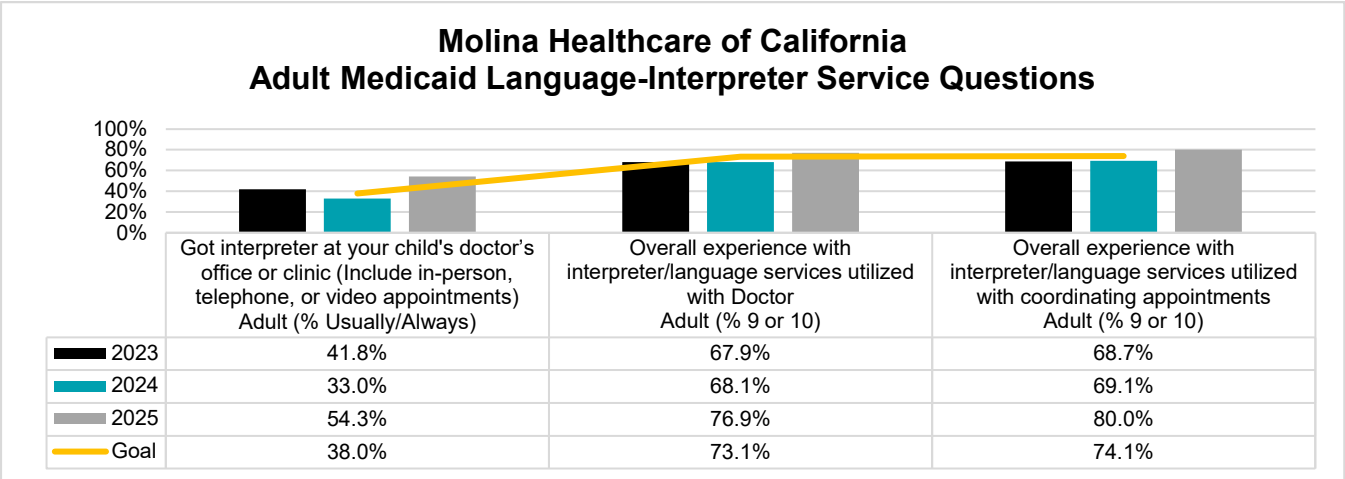
Adult Supplemental Questions - Transportation



	Phoned health plan for help with transportation Adult (% Yes)	Got help with transportation Adult (% Usually/Always)	Help with transportation met needs Adult (% Always or Usually)
2023	8.8%	77.8%	83.3%
2024	12.7%	91.7%	95.8%
2025	11.4%	75.0%	70.8%
Goal	17.7%	96.7%	100.8%

The data on Molina Healthcare of California's Adult Medicaid transportation services reflects notable changes in member experiences over the past three years. The percentage of adults who phoned the health plan for transportation assistance rose from 8.8% in 2023 to 12.7% in 2024, but slightly declined to 11.4% in 2025, remaining below the goal of 17.7%. The percentage of adults who received transportation help when needed improved significantly from 77.8% in 2023 to 91.7% in 2024, but then dropped to 75.0% in 2025, all below the goal of 96.7%. Similarly, the percentage of members who felt their transportation needs were met increased from 83.3% in 2023 to 95.8% in 2024, before falling to 70.8% in 2025, falling short of the goal of 100.8% . While 2024 marked a peak in performance, the decline in 2025 suggests challenges that require attention. Continued investment in transportation coordination, member outreach, and streamlined scheduling processes will be critical to reversing this trend and restoring high levels of access and satisfaction.

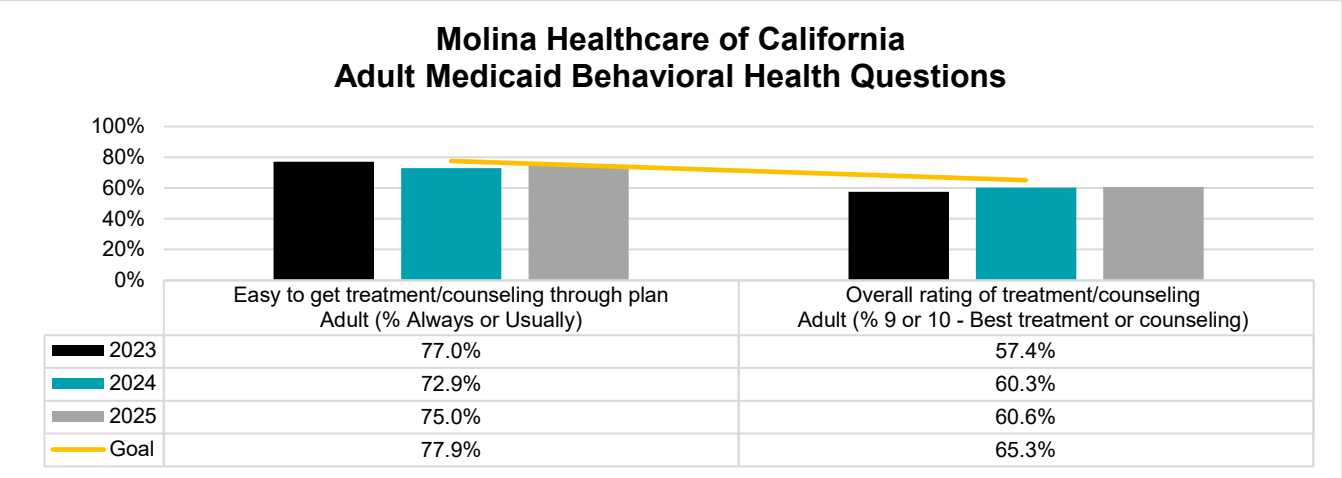
Adult Supplemental Question - Interpreter Services



	Got interpreter at your child's doctor's office or clinic (Include in-person, telephone, or video appointments) Adult (% Usually/Always)	Overall experience with interpreter/language services utilized with Doctor Adult (% 9 or 10)	Overall experience with interpreter/language services utilized with coordinating appointments Adult (% 9 or 10)
2023	41.8%	67.9%	68.7%
2024	33.0%	68.1%	69.1%
2025	54.3%	76.9%	80.0%
Goal	38.0%	73.1%	74.1%

The data on Molina Healthcare of California's Adult Medicaid Language-Interpreter Service Questions shows mixed results, with some improvements and ongoing challenges. The percentage of adults who received interpreter services at their doctor's office or clinic declined from 41.8% in 2023 to 33.0% in 2024 but rebounded significantly to 54.3% in 2025, surpassing the goal of 38.0%. Overall satisfaction with interpreter services used with doctors increased slightly from 67.9% in 2023 to 68.1% in 2024 and then rose to 76.9% in 2025, surpassing the target of 73.1%. Similarly, satisfaction with interpreter services for coordinating appointments improved from 68.7% in 2023 to 69.1% in 2024 and reached 80.0% in 2025, exceeding the goal of 74.1%. These trends indicate strong progress in 2025 after prior declines, suggesting that recent efforts to enhance interpreter access and quality have been effective. To sustain this momentum, continued investment in interpreter availability, streamlined scheduling processes, and member education about language support options will be essential.

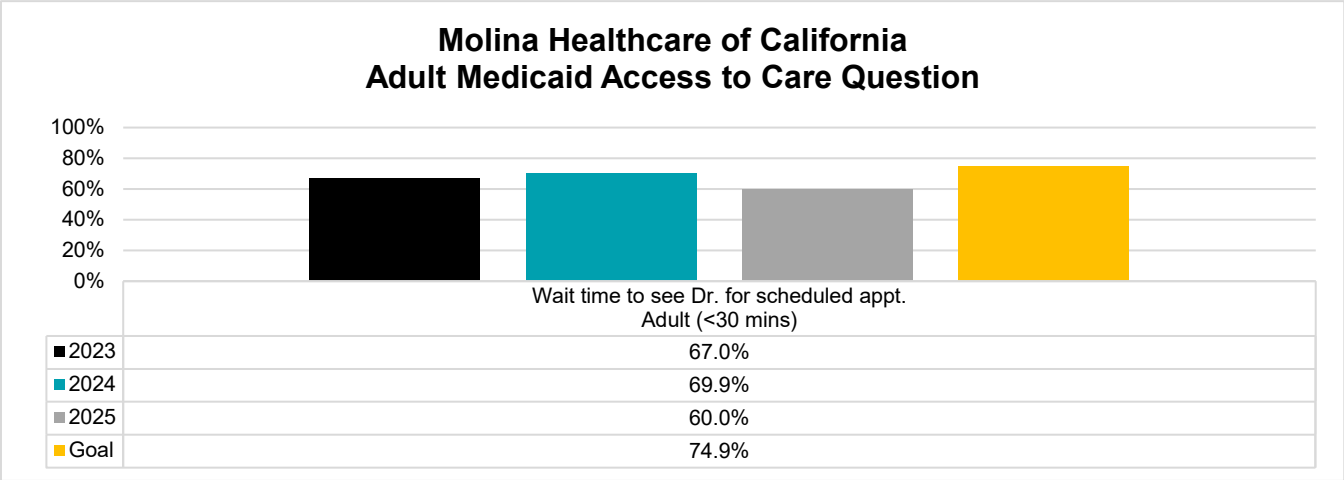
Adult Supplemental Question - Behavioral Health



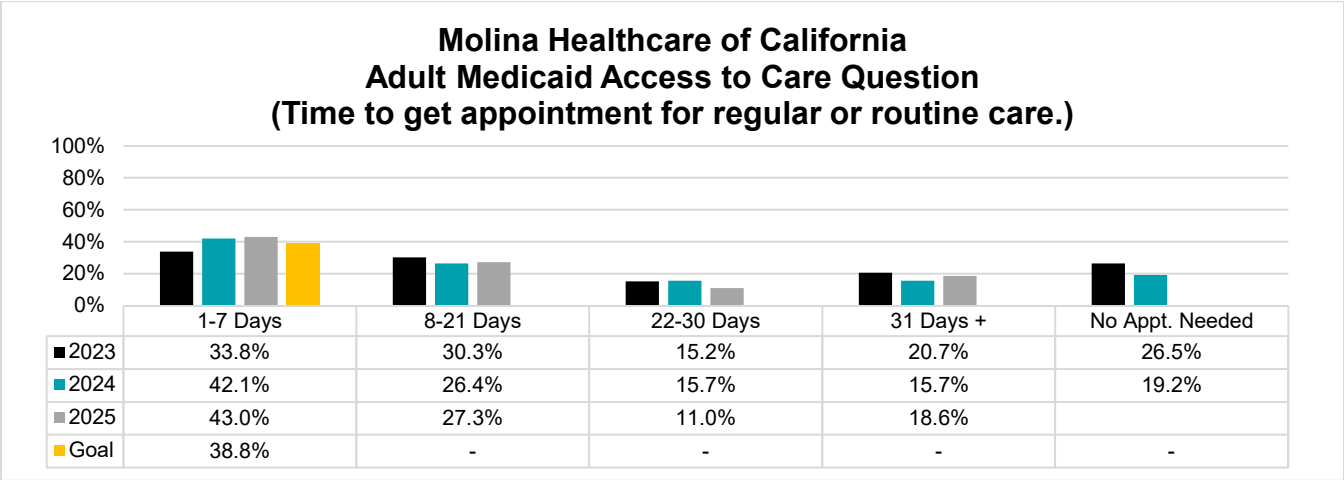
	Easy to get treatment/counseling through plan Adult (% Always or Usually)	Overall rating of treatment/counseling Adult (% 9 or 10 - Best treatment or counseling)
2023	77.0%	57.4%
2024	72.9%	60.3%
2025	75.0%	60.6%
Goal	77.9%	65.3%

The data on Molina Healthcare of California's Adult Medicaid Behavioral Health Questions shows mixed trends in patient experience. The percentage of adults who found it easy to get treatment or counseling through the plan decreased from 77.0% in 2023 to 72.9% in 2024 but improved slightly to 75.0% in 2025, though still below the goal of 77.9%. Meanwhile, the overall rating of treatment or counseling rose from 57.4% in 2023 to 60.3% in 2024 and reached 60.6% in 2025, continuing to approach the goal of 65.3%. These results suggest that while satisfaction with treatment quality is gradually improving, accessibility remains a challenge. To address these issues, Molina Healthcare should focus on expanding provider network capacity, reducing appointment wait times, and enhancing telehealth options for behavioral health services. Additionally, increasing member outreach and education about available mental health resources could help close the gap between need and utilization.

Adult Supplemental Question - Access to Care



	Wait time to see Dr. for scheduled appt. Adult (<30 mins)
2023	67.0%
2024	69.9%
2025	60.0%
Goal	74.9%



	1-7 Days	8-21 Days	22-30 Days	31 Days +	No Appt. Needed
2023	33.8%	30.3%	15.2%	20.7%	26.5%
2024	42.1%	26.4%	15.7%	15.7%	19.2%
2025	43.0%	27.3%	11.0%	18.6%	
Goal	38.8%	-	-	-	-

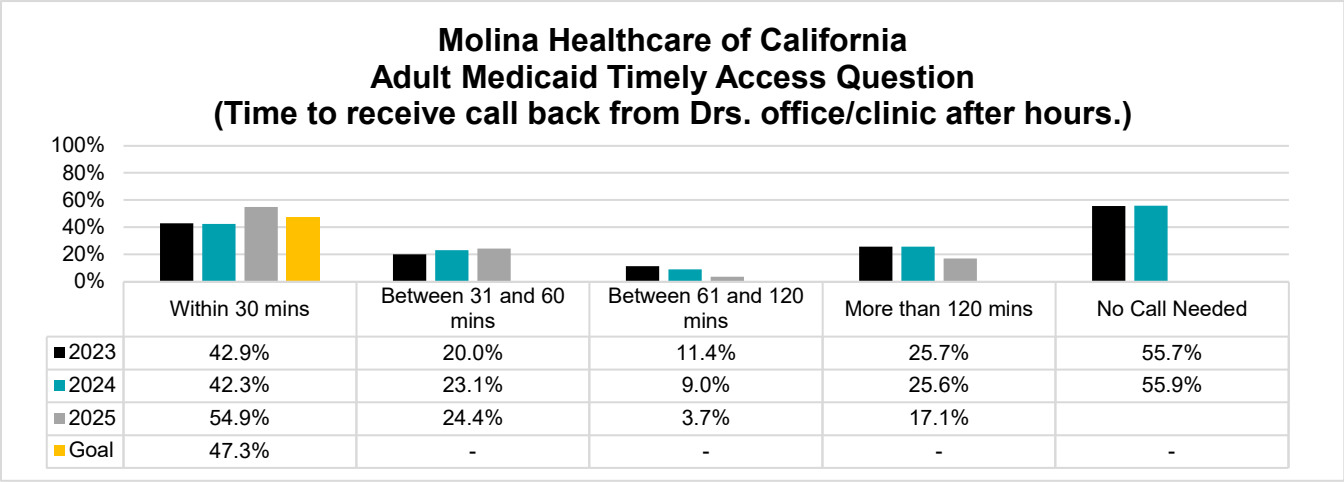
Molina Healthcare of California's Adult Medicaid Access to Care results show mixed performance across two access measures. For wait time to see a doctor for a scheduled appointment (<30 minutes), performance rose from 67.0% in 2023 to 69.9% in 2024, then declined to 60.0% in 2025, remaining below the goal of 74.9% across all three years. This pattern indicates that, despite improvement in 2024, members were less likely in 2025 to be seen within 30 minutes once at the clinic.

For time to get an appointment for regular or routine care, timely access improved and largely held gains. The share seen within 1–7 days increased from 33.8% (2023) to 42.1% (2024) and 43.0% (2025), exceeding the 38.8% goal in both 2024 and 2025. The 8–21 days category decreased from 30.3% (2023) to 26.4% (2024), then edged up to 27.3% (2025). Longer waits showed mixed but generally favorable movement: 22–30 days declined from 15.2% (2023) to 11.0% (2025), while 31 days+ fell from 20.7% (2023) to 15.7% (2024) before rising to 18.6% (2025). Members reporting "No appointment needed" decreased from 26.5% (2023) to 19.2% (2024); a 2025 value is not displayed on the chart. Overall, these trends suggest better

success obtaining appointments within a week, some shifting into mid-range waits in 2025, and ongoing opportunities to reduce the longest waits.

The plan made meaningful gains in getting appointments quickly, but in-clinic wait times worsened in 2025 and still lag the target. Continued efforts should focus on (1) increasing short-slot/same-day capacity and optimizing templates to preserve quick-access appointments; (2) load-balancing across high-demand clinics and expanding evening/virtual options to relieve bottlenecks; (3) proactive outreach and automated wait-list fills to move members from 8–21 days into 1–7 days; and (4) clinic-level huddles and flow management (arrival staggering, pre-visit readiness) to bring <30-minute wait performance back on track toward the 74.9% goal.

Adult Supplemental Question – Timely Access



	Within 30 mins	Between 31 and 60 mins	Between 61 and 120 mins	More than 120 mins	No Call Needed
2023	42.9%	20.0%	11.4%	25.7%	55.7%
2024	42.3%	23.1%	9.0%	25.6%	55.9%
2025	54.9%	24.4%	3.7%	17.1%	
Goal	47.3%	-	-	-	-

The analysis of Molina Healthcare of California's Adult Medicaid Timely Access results shows a period of slight decline followed by meaningful improvement in 2025. The percentage of members receiving a callback from their doctor's office or clinic within 30 minutes after hours decreased marginally from 42.9% in 2023 to 42.3% in 2024, remaining below the 47.3% goal. However, in 2025, performance improved significantly to 54.9%, surpassing the established goal and marking the strongest callback timeliness during the three-year period.

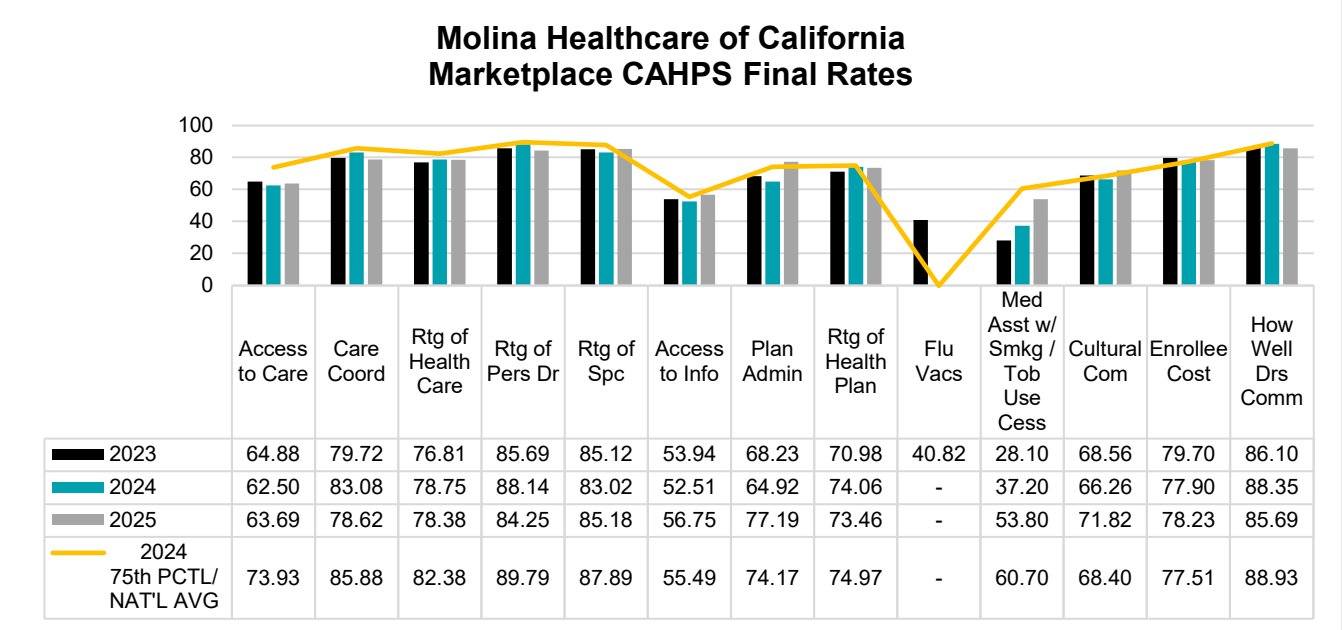
The proportion of members receiving callbacks between 31 and 60 minutes increased steadily from 20.0% in 2023 to 23.1% in 2024, and 24.4% in 2025, suggesting that many members continue to receive calls within a reasonable, though not ideal, timeframe. Meanwhile, the percentage waiting between 61 and 120 minutes declined across all years—from 11.4% in 2023 to 9.0% in 2024 and further to 3.7% in 2025—reflecting improvement in reducing mid-range delays. The share of members waiting more than 120 minutes was 25.7% in 2023, remained nearly unchanged in 2024 (25.6%), and then dropped to 17.1% in 2025, demonstrating meaningful progress in reducing extended after-hours wait times.

More than half of surveyed members reported that they did not need a callback, with values remaining consistent: 55.7% in 2023 and 55.9% in 2024 (the chart does not show a 2025 value). While this indicates that many members may not require after-hours support, the data

also highlight the importance of improving callback efficiency for those who do rely on this service.

Overall, although 2024 showed slight regression, 2025 marked a strong recovery, with the plan not only meeting but exceeding the callback-within-30-minutes goal and reducing longer wait times. Continued focus on after-hours staffing, triage efficiency, and communication workflows will be essential to sustain these gains and ensure timely access for members requiring urgent after-hours support.

Marketplace (QHP) CAHPS Composites



	Access to Care	Care Coord	Rtg of Health Care	Rtg of Pers Dr	Rtg of Spc	Access to Info	Plan Admin	Rtg of Health Plan	Flu Vacs	Med Asst w/ Smkg / Tob Use Cess	Cultural Com	Enrollee Cost	How Well Drs Comm
2023	64.88	79.72	76.81	85.69	85.12	53.94	68.23	70.98	40.82	28.10	68.56	79.70	86.10
2024	62.50	83.08	78.75	88.14	83.02	52.51	64.92	74.06	-	37.20	66.26	77.90	88.35
2025	63.69	78.62	78.38	84.25	85.18	56.75	77.19	73.46	-	53.80	71.82	78.23	85.69
2024 75th PCTL/ NAT'L AVG	73.93	85.88	82.38	89.79	87.89	55.49	74.17	74.97	-	60.70	68.40	77.51	88.93

Cultural Competence, Enrollee Cost and How Well Doctors Communicate use 2024 National Average as 2024 75th percentile.

The Molina Healthcare of California Marketplace CAHPS Final Rates show a mixed pattern from 2023 to 2025, with several encouraging gains in 2025 alongside persistent gaps to the 2024 75th percentile/national average benchmark. Access to Care slipped from 64.88 (2023) to 62.50 (2024) and 63.69 (2025), remaining below the 73.93 benchmark. Care Coordination held relatively steady—79.72 → 78.83 → 78.62—but stayed under the 85.88 benchmark. Global ratings had similar results: Rating of Health Plan showed some improvement from the 2023 rate of 70.98 to 74.06 in 2024 before slightly declining to 73.46 in 2025 falling below the benchmark of 74.97 while Rating of Health Care nudged to 78.38 (2025) though still shy of 82.38.

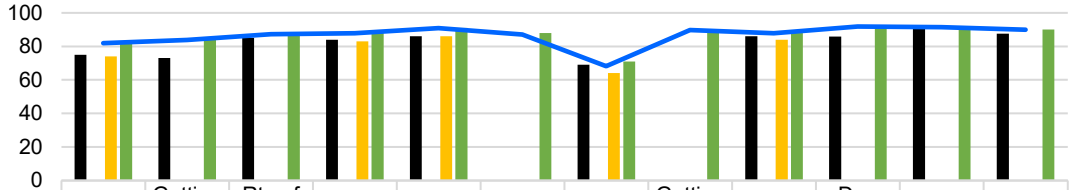
Provider-focused measures moved in different directions. Rating of Personal Doctor dipped to 84.25 (2025) after 88.14 (2024) and remains under 89.79, whereas Rating of Specialist improved to 85.18 (2025)—better than 2024's 83.02 but still below the 87.89 benchmark. How Well Doctors Communicate softened to 85.69 (2025) after 88.35 (2024), missing the 88.93 benchmark and signaling an opportunity to recapture recent gains.

Administrative and information measures show some of the clearest advances in 2025. Plan Administration rose sharply to 77.19 (2025), surpassing the 74.17 benchmark and reversing the decline seen in 2024. Access to Information increased to 56.75 (2025), exceeding the 55.49 benchmark and marking a two-year improvement from 2024's 52.51. Cultural Communication also strengthened to 71.82 (2025), moving above the 68.40 benchmark. Enrollee Cost remained solid at 78.23 (2025), above the 77.51 benchmark. Preventive/support measures continue to lag: Medical Assistance with Smoking/Tobacco Use Cessation improved versus 2023 but sits at 53.80 (2025), well below 60.70; Flu Vaccination shows data only in 2023 (40.82) with no 2024–2025 rates displayed, limiting trend assessment.

2025 brings notable wins in Plan Administration, Access to Information, Cultural Communication, Enrollee Cost, and Rating of Health Plan, which now meet or exceed national benchmarks. At the same time, Access to Care, Care Coordination, Rating of Personal Doctor, Rating of Specialist, Doctor Communication, and Tobacco Cessation Assistance remain below target. To close the remaining gaps, focus on appointment availability and navigation (to lift Access to Care), tighter handoffs and referral workflows (to improve Care Coordination and Specialist ratings), provider communication coaching and feedback loops (to restore Doctor Communication and Personal Doctor ratings), and a targeted preventive-care strategy that includes proactive cessation outreach and reinstated flu vaccination measurement.

Medicare (MCAHP) CAHPS Composites

Molina Healthcare of California
Medicare CAHPS Final Rates



	Getting Needed Care	Getting Appts/ Care Quickly	Rtg of Health Care Quality	Rtg of Health Plan	Cust Svc	Care Coord	Ann Flu Vac	Getting Needed Rx Drugs	Rtg of Drug Plan	Drs Who Comm Well	Rtg of Pers Dr	Rtg of Spc
2023 Base Group 4	75	73	85	84	86	NA	69	NA	86	85.8	91.1	87.5
2024 Base Group 4	-	-	-	-	-	-	-	-	-	-	-	-
2025 Base Group 4	74	-	-	83	86	-	64	-	84	-	-	-
Base Group 4	82	84	87	88	91	88	71	90	88	91.6	91.5	90.1
Book of Business	82.0	83.9	87.3	88.0	90.9	87.2	68.3	89.8	87.9	92.0	91.6	90.0

NA = Less than 100 respondents
2024 Survey Not Conducted Due to Low Volume.

The Molina Healthcare of California Medicare CAHPS Final Rates chart shows areas of relative stability and ongoing opportunities for improvement when compared with Base Group 4 and Book of Business benchmarks. Across the 2023–2025 reporting period, several measures remain below benchmark targets, particularly those related to access, preventive

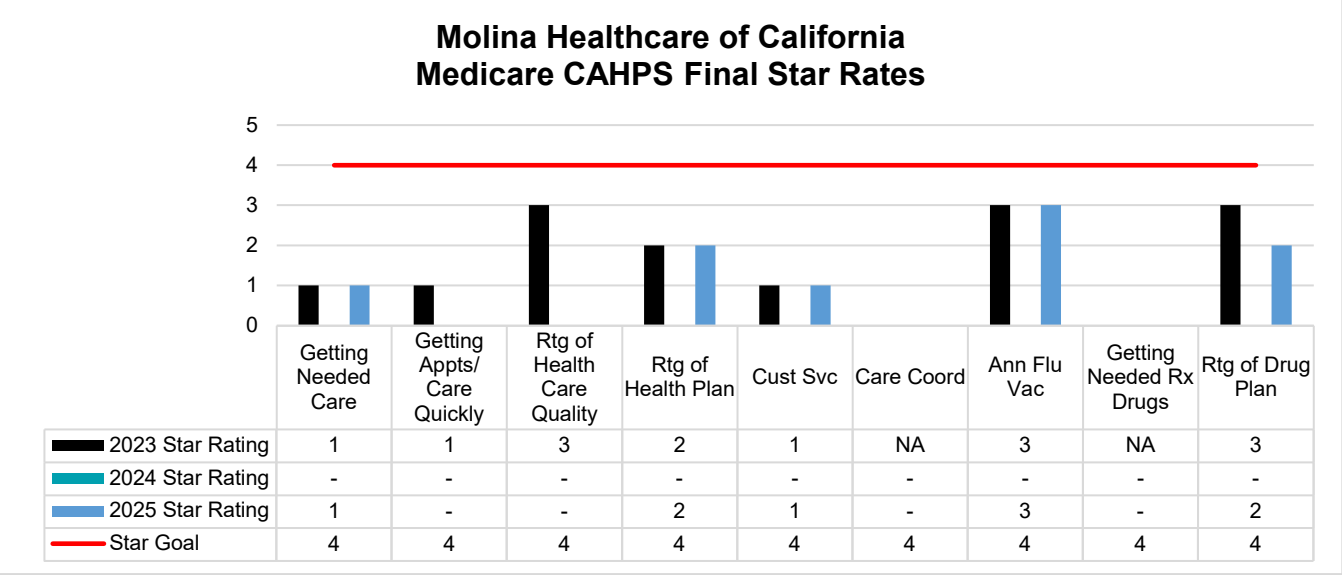
care, and prescription drug services, while provider-related ratings continue to demonstrate comparative strength.

Access to care metrics show limited progress. *Getting Needed Care* decreased slightly from 75 in 2023 to 74 in 2025, remaining below the Base Group 4 benchmark of 82. These results indicate that Medicare members still face challenges securing timely appointments and accessing needed services.

Measures related to overall care experience also indicate room for improvement. *Rating of Health Plan* showed minor fluctuation (84 in 2023 → 83 in 2025), remaining below the benchmark of 88, signaling ongoing concerns with overall plan satisfaction.

Preventive and pharmacy-related measures reflect notable gaps. *Annual Flu Vaccination* declined from 69 in 2023 to 64 in 2025, remaining below both Base Group 4 (71) and Book of Business (68.3) levels. Similarly, *Rating of Drug Plan* rose to 84, but remains below the Base Group 4 and Book of Business benchmarks of 88 and 87.9, respectively. These patterns highlight persistent issues related to medication access, affordability, and preventive health engagement.

Overall, while several measures demonstrate consistency or incremental improvement, persistent gaps remain in access to care, flu vaccination rates, prescription drug access, and global ratings. To close these gaps, Molina Healthcare should focus on enhancing appointment availability, improving member support for navigating care and pharmacy benefits, and strengthening preventive care outreach—particularly Medicare flu vaccination efforts. Continued investments in provider communication and care coordination are also recommended to ensure improvements in overall care experience and alignment with benchmark expectations.



	Getting Needed Care	Getting Appts/ Care Quickly	Rtg of Health Care Quality	Rtg of Health Plan	Cust Svc	Care Coord	Ann Flu Vac	Getting Needed Rx Drugs	Rtg of Drug Plan
2023 Star Rating	1	1	3	2	1	NA	3	NA	3
2024 Star Rating	-	-	-	-	-	-	-	-	-
2025 Star Rating	1	-	-	2	1	-	3	-	2
Star Goal	4	4	4	4	4	4	4	4	4

NA = Less than 100 respondents
2024 Survey Not Conducted Due to Low Volume.

The Medicare CAHPS Final Star Ratings for Molina Healthcare of California show ongoing challenges across multiple areas from 2023 to 2025. Although a few measures improved in 2025, most ratings remain far below the 4-star goal. Access measures continue to perform the worst—*Getting Needed Care* stayed at 1 star in both 2023 and 2025, and *Getting Appointments and Care Quickly* was also low, with only 1 star in 2023 and no rating in 2025 due to limited data. Global rating measures show mixed results: *Rating of Health Care Quality* held steady at 3 stars, while *Rating of Health Plan* dropped from 2 stars in 2023 to 1 star in 2025, suggesting declining member satisfaction. *Customer Service* remained at 1 star, indicating issues with responsiveness and support, and *Care Coordination* had no reportable ratings. Preventive care and pharmacy-related measures showed both progress and setbacks. *Annual Flu Vaccination* improved from 1 star in 2023 to 3 stars in 2025, though it still fell short of the 4-star benchmark. *Getting Needed Prescription Drugs* continued to lack a star rating due to insufficient data, while *Rating of Drug Plan* declined from 3 stars to 2 stars, signaling growing dissatisfaction with medication access and affordability. No star ratings were available for provider-related measures like doctor communication or specialist ratings, likely because of sample size limits—but other CAHPS results indicate these areas remain comparatively strong. Overall, the data shows that access, plan satisfaction, customer service, and prescription drug experience remain the most urgent areas for improvement.

Overall, the Medicare CAHPS Star Ratings show that several key areas continue to need significant improvement, especially in getting needed care, getting appointments quickly, overall plan satisfaction, customer service, and members' experiences with prescription drugs. To move closer to the 4-star goal, Molina Healthcare of California should focus on improving access to providers and reducing appointment wait times, streamlining scheduling processes to help members receive timely care, and strengthening customer service by improving responsiveness and follow-through. Increasing outreach efforts to boost flu vaccination rates and making prescription drug benefits easier to understand and more affordable—through clearer formulary education, better assistance program awareness, and stronger pharmacy network support—will also be essential. Together, these actions will address the major factors driving low star ratings and help improve overall member experience.

Member Experience with Case Management (Level II)

Survey Response Rates

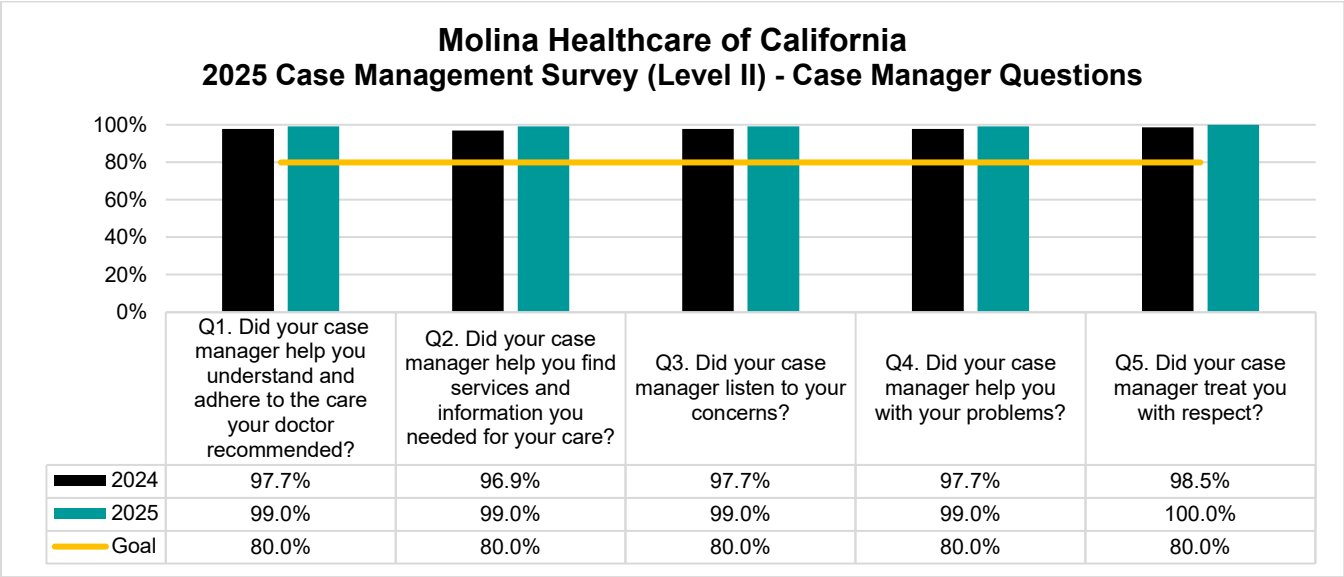
CA Case Management Survey Responses (Level II Case Manager)

		2024				2025			
		Total (Yes)	Medicaid (Yes)	Medicare (Yes)	Marketplace (Yes)	Total (Yes)	Medicaid (Yes)	Medicare (Yes)	Marketplace (Yes)
Q1	Did your case manager help you understand and adhere to the care your doctor recommended?	128	73	48	7	101	46	42	13
Q2	Did your case manager help you find services and information you needed for your care?	127	73	47	7	101	46	42	13
Q3	Did your case manager listen to your concerns?	128	74	47	7	101	46	42	13
Q4	Did your case manager help you with your problems?	128	73	48	7	101	46	42	13
Q5	Did your case manager treat you with respect?	129	74	48	7	102	46	42	13
Total Number of Respondents		**131**	**74**	**50**	**7**	**102**	**46**	**43**	**13**

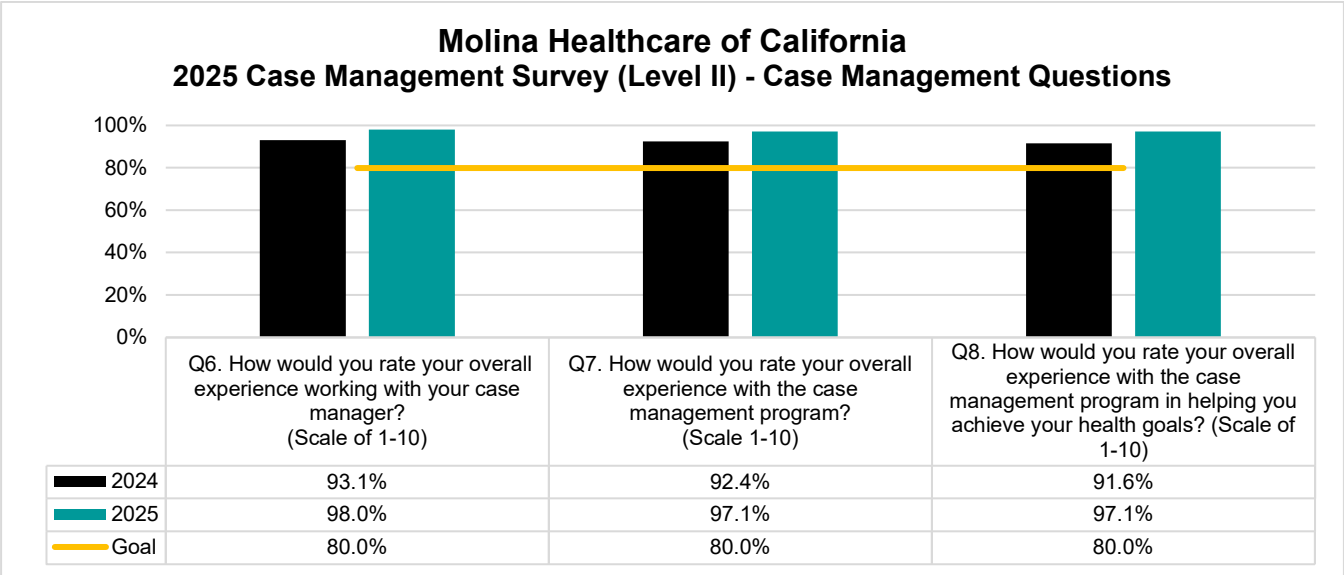
CA Case Management Survey Responses (Level II Case Management)

		2024				2025			
		Total (8-10)	Medicaid (8-10)	Medicare (8-10)	Marketplace (8-10)	Total (8-10)	Medicaid (8-10)	Medicare (8-10)	Marketplace (8-10)
Q6	How would you rate your overall experience working with your case manager? (Scale of 1-10)	122	70	45	7	100	45	42	13
Q7	How would you rate your overall experience with the case management program? (Scale 1-10)	121	68	46	7	99	45	41	13
Q8	How would you rate your overall experience with the case management program in helping you achieve your health goals? (Scale of 1-10)	120	68	45	7	99	45	41	13
Total Number of Respondents		**131**	**74**	**50**	**7**	**102**	**46**	**43**	**13**

Survey Results



	Q1. Did your case manager help you understand and adhere to the care your doctor recommended?	Q2. Did your case manager help you find services and information you needed for your care?	Q3. Did your case manager listen to your concerns?	Q4. Did your case manager help you with your problems?	Q5. Did your case manager treat you with respect?
2024	97.7%	96.9%	97.7%	97.7%	98.5%
2025	99.0%	99.0%	99.0%	99.0%	100.0%
Goal	80.0%	80.0%	80.0%	80.0%	80.0%



	Q6. How would you rate your overall experience working with your case manager? (Scale of 1-10)	Q7. How would you rate your overall experience with the case management program? (Scale 1-10)	Q8. How would you rate your overall experience with the case management program in helping you achieve your health goals? (Scale of 1-10)
2024	93.1%	92.4%	91.6%
2025	98.0%	97.1%	97.1%
Goal	80.0%	80.0%	80.0%

Analysis: Member Experience with Case Management (Level II)

When comparing the response rate between 2024 (38.1%) and 2025 (24.2%), Molina Healthcare of California experienced a decrease of 13.9 percentage points in member response rate. Out of the 344 members included in the 2024 survey, 131 members completed the survey, while 102 members completed the survey in 2025. Despite the decline in response rate, 2025 satisfaction scores remained exceptionally high, with all eight questions exceeding the 80% goal and demonstrating continued member confidence in Case Management services. In 2025, satisfaction ranged from 97.6% to 100%, representing an overall improvement from 2024 results (91.6%–98.5%). The strongest 2025 performance appeared in

Q1–Q5, where satisfaction scores reached 99.0% to 100%, reflecting consistently positive member interactions with case managers.

For Medicaid, the 2025 Case Management Survey results showed strong performance across all questions. Satisfaction scores remained high, ranging from 97.8% to 100%, and every item exceeded the 80% benchmark. Members continued to show strong confidence in their case managers' ability to help find needed services, listen to concerns, respond to problems, and treat members with respect. Notably, Q8, "How would you rate your experience with the case management program in helping you achieve your health goals?", maintained high performance at 97.8% in 2025, continuing the improvement trend observed in 2024.

The 2025 Medicare Case Management Survey demonstrated consistent satisfaction across all measures, with scores ranging from 95.3% to 100%, surpassing both the benchmark and several 2024 scores. In 2025, Medicare members expressed particularly high satisfaction with their case managers' communication and responsiveness (Q1–Q5), as well as their overall program experience. These improvements indicate that the enhancements made to case management services for Medicare members have been effective.

The 2025 Marketplace Case Management Survey also reflected strong performance. All eight questions exceeded the 80% goal, with satisfaction scores of 100% across the board. The Marketplace population reported particularly strong satisfaction in Q1–Q8, where results held at 100%, matching or exceeding 2024 levels. This consistency demonstrates ongoing success in delivering high-quality case management services to Marketplace members.

Barriers

- Barrier 1: Many members have disconnected or unreachable phone numbers, making outreach and survey engagement difficult.
- Barrier 2: Members frequently do not recall their Case Manager or participation in Case Management, reducing willingness to complete the survey.

Opportunities

- Opportunity 1: Implementing email-based Case Management Surveys may increase member accessibility and improve response rates.
- Opportunity 2: Including alternate phone numbers in survey outreach lists may help increase successful contact attempts and overall survey participation.

Member Experience with Complex Case Management (Level III)

Survey Response Rates

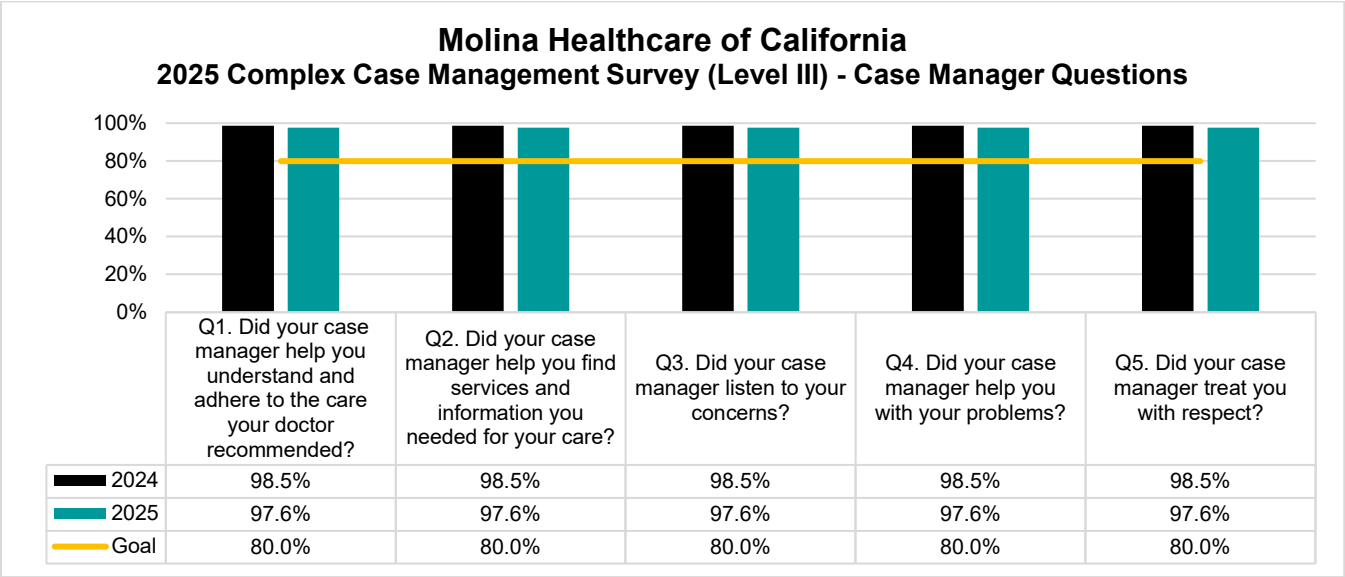
CA Complex Case Management Survey Responses (Level III Case Manager)

		2024				2025			
		Total (Yes)	Medicaid (Yes)	Medicare (Yes)	Marketplace (Yes)	Total (Yes)	Medicaid (Yes)	Medicare (Yes)	Marketplace (Yes)
Q1	Did your case manager help you understand and adhere to the care your doctor recommended?	67	32	9	26	80	26	21	33
Q2	Did your case manager help you find services and information you needed for your care?	67	32	9	26	80	26	21	33
Q3	Did your case manager listen to your concerns?	67	32	9	26	80	26	21	33
Q4	Did your case manager help you with your problems?	67	32	9	26	80	26	21	33
Q5	Did your case manager treat you with respect?	67	32	9	26	80	26	21	33
Total Number of Respondents		**68**	**33**	**9**	**26**	**82**	**26**	**23**	**33**

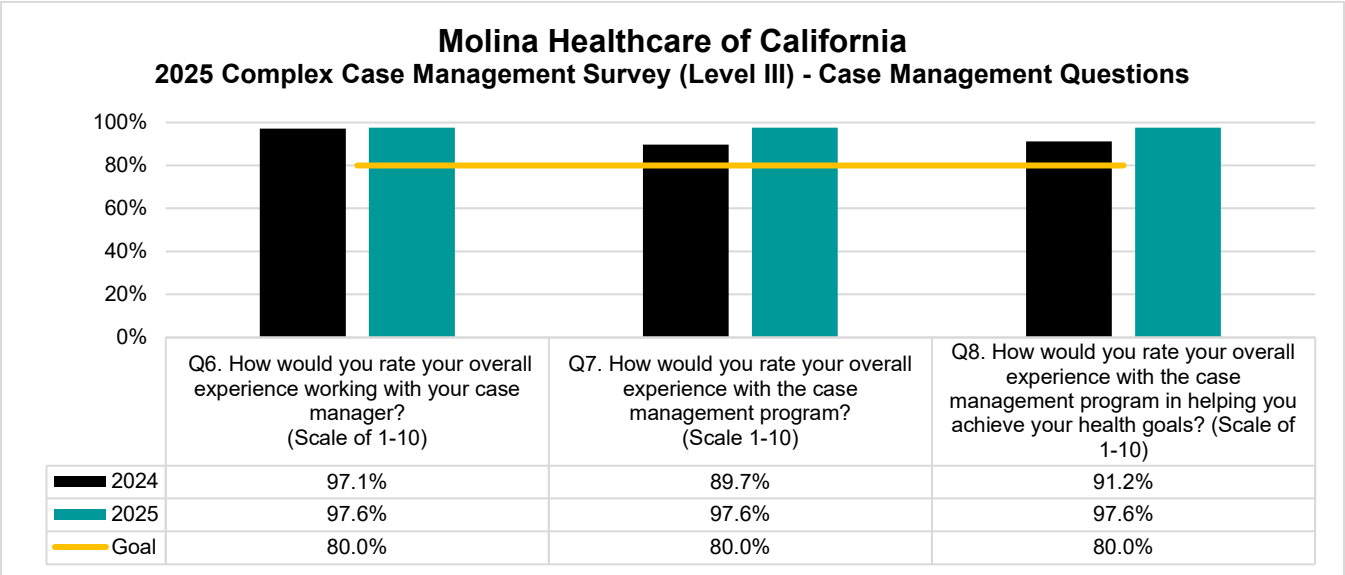
CA Complex Case Management Survey Responses (Level III Case Management)

		2024				2025			
		Total (8-10)	Medicaid (8-10)	Medicare (8-10)	Marketplace (8-10)	Total (8-10)	Medicaid (8-10)	Medicare (8-10)	Marketplace (8-10)
Q6	How would you rate your overall experience working with your case manager? (Scale of 1-10)	66	32	9	25	80	26	21	33
Q7	How would you rate your overall experience with the case management program? (Scale 1-10)	61	31	8	22	80	26	21	33
Q8	How would you rate your overall experience with the case management program in helping you achieve your health goals? (Scale of 1-10)	62	32	8	22	80	26	21	33
Total Number of Respondents		**68**	**33**	**9**	**26**	**82**	**26**	**23**	**33**

Survey Results



	Q1. Did your case manager help you understand and adhere to the care your doctor recommended?	Q2. Did your case manager help you find services and information you needed for your care?	Q3. Did your case manager listen to your concerns?	Q4. Did your case manager help you with your problems?	Q5. Did your case manager treat you with respect?
2024	98.5%	98.5%	98.5%	98.5%	98.5%
2025	97.6%	97.6%	97.6%	97.6%	97.6%
Goal	80.0%	80.0%	80.0%	80.0%	80.0%



	Q6. How would you rate your overall experience working with your case manager? (Scale of 1-10)	Q7. How would you rate your overall experience with the case management program? (Scale 1-10)	Q8. How would you rate your overall experience with the case management program in helping you achieve your health goals? (Scale of 1-10)
2024	97.1%	89.7%	91.2%
2025	97.6%	97.6%	97.6%
Goal	80.0%	80.0%	80.0%

Analysis: Member Experience with Complex Case Management (Level III)

When comparing the response rate between 2024 (43.6%) and 2025 (31.3%), Molina Healthcare of California experienced a decrease of 12.3 percentage points. Out of the 156 members included in the 2024 survey, 68 members completed the survey, while 82 members responded in 2025. Despite the lower response rate, 2025 results demonstrate exceptionally strong satisfaction, with all eight questions once again meeting the 80% goal and scoring between 97.6% and 100%, surpassing several of the 2024 levels. In 2024, satisfaction ranged from 89.7% to 98.5%, and 2025 continued this high performance, reinforcing that members

remain highly satisfied with their case managers and the support provided through the Complex Case Management Program. The greatest improvement in 2025 occurred in Q1–Q5, where satisfaction reached 100% for Marketplace and near-perfect scores for Medicaid and Medicare, demonstrating consistent excellence in case manager communication, respect, and responsiveness.

The 2025 Medicaid Complex Case Management Survey showed strong and stable satisfaction across all measures, scoring 100% and exceeding the 80% goal. Compared to 2024, Medicaid results held steady or increased in several areas, reflecting a positive trend. Satisfaction remained highest for Q1 (“Did your case manager help you understand and adhere to the care your doctor recommended?”) and Q5 (“Did your case manager treat you with respect?”), where Medicaid members rated their experience at 100% in 2025. Question 8, assessing members’ experience with support in achieving health goals, also demonstrated improvement in 2025, increasing to 100% from 97% in 2024.

The 2025 Medicare Complex Case Management Survey also performed strongly, with satisfaction scores between 91.3% and 100%. In 2024, Medicare scores ranged from 88.9% to 100%, so the 2025 results reflect a noticeable improvement across questions 7 and 8. Medicare members reported a slight decline in Q1–Q6 at 91.3%, although still above the goal of 80% satisfaction. Additionally, satisfaction related to overall experience with the program (Q7) increased slightly, demonstrating enhanced trust and value perceived in the case management services.

The 2025 Marketplace Complex Case Management Survey showed similar strength, with all eight questions meeting the 80% goal and achieving 100% satisfaction across all questions, replicating and even slightly improving the consistently strong performance observed in 2024. Marketplace members gave perfect scores in Q1–Q8 and maintained high ratings reinforcing that Marketplace case management support remains a top-performing area.

<u>Barriers</u>

- Barrier 1: Many members have disconnected or unreachable phone numbers, which limits outreach and successful survey completion.
- Barrier 2: Some members do not recall their Case Manager or their participation in the Complex Case Management Program, making them less likely to respond to survey questions.

<u>Opportunities</u>

- Opportunity 1: Expanding email-based distribution of Complex Case Management surveys may increase accessibility and improve response rates.
- Opportunity 2: Ensuring alternate phone numbers are included in outreach lists can improve contact success and lead to higher member participation in future surveys.

Long-Term Services & Supports (LTSS) Case Management (Level II)

Survey Response Rates

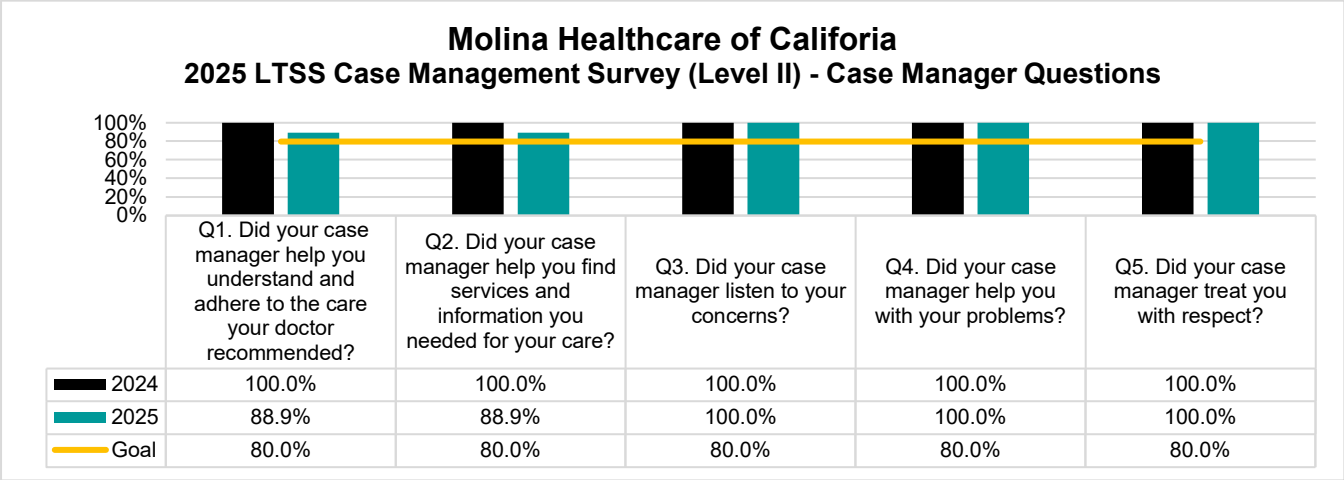
CA LTSS Case Management Survey Responses (Level II Case Manager)

		2024	2025
		LTSS (Yes)	LTSS (Yes)
Q1	Did your case manager help you understand and adhere to the care your doctor recommended?	91	8
Q2	Did your case manager help you find services and information you needed for your care?	91	8
Q3	Did your case manager listen to your concerns?	91	8
Q4	Did your case manager help you with your problems?	91	8
Q5	Did your case manager treat you with respect?	91	8
	Total Number of Respondents	**91**	**8**

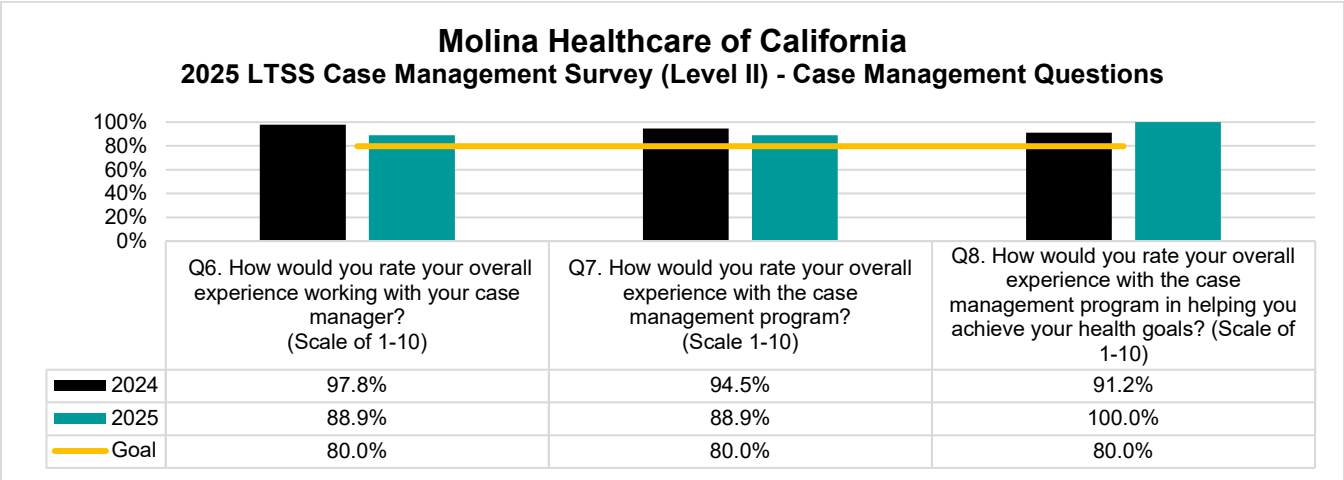
CA LTSS Case Management Survey Responses (Level II Case Management)

		2024	2025
		LTSS (8-10)	LTSS (8-10)
Q6	How would you rate your overall experience working with your case manager? (Scale of 1-10)	89	8
Q7	How would you rate your overall experience with the case management program? (Scale 1-10)	86	8
Q8	How would you rate your overall experience with the case management program in helping you achieve your health goals? (Scale of 1-10)	83	9
	Total Number of Respondents	**91**	**9**

Survey Results



	Q1. Did your case manager help you understand and adhere to the care your doctor recommended?	Q2. Did your case manager help you find services and information you needed for your care?	Q3. Did your case manager listen to your concerns?	Q4. Did your case manager help you with your problems?	Q5. Did your case manager treat you with respect?
2024	100.0%	100.0%	100.0%	100.0%	100.0%
2025	88.9%	88.9%	100.0%	100.0%	100.0%
Goal	80.0%	80.0%	80.0%	80.0%	80.0%



	Q6. How would you rate your overall experience working with your case manager? (Scale of 1-10)	Q7. How would you rate your overall experience with the case management program? (Scale 1-10)	Q8. How would you rate your overall experience with the case management program in helping you achieve your health goals? (Scale of 1-10)
2024	97.8%	94.5%	91.2%
2025	88.9%	88.9%	100.0%
Goal	80.0%	80.0%	80.0%

Analysis: Member Experience with LTSS Case Management (Level II)

When comparing the response rate between 2024 (39.6%) and 2025 (8.8%), Molina Healthcare of California experienced a notable decrease in member response rate by 30.8 percentage points. Out of the 230 members included in the 2024 survey, 91 members responded, while 8 members completed the survey in 2025. Despite the lower response rate in 2025, satisfaction levels remained strong. In 2024, member satisfaction scored between 91.2% and 100% across all eight questions, and all metrics exceeded the 80% goal. This demonstrates that LTSS members were highly satisfied with both the services provided by case managers and the overall Case Management Program. The greatest positive change in 2024 was for Q1: “Did your case manager help you understand and adhere to the care your doctor recommended?”, which reached 100% satisfaction, reflecting the strongest improvement compared to prior-year outcomes.

In 2025, satisfaction levels for LTSS members remained favorable despite the reduced sample size. All case manager experience questions (Q1–Q5) remained at 100% satisfaction, indicating continued excellence in communication, support, and respect delivered by case

managers. For the experience-of-care questions (Q6–Q8), satisfaction levels remained well above the 80% goal, with 88.9% for both working with the case manager (Q6) and overall program experience (Q7), and 100% satisfaction for members' experience with the program in helping them achieve their health goals (Q8). These results underscore ongoing member confidence in the LTSS Case Management Program.

Barriers

- Barrier 1: A large proportion of members have disconnected or unreachable phone numbers, making direct contact difficult.
- Barrier 2: Many members do not recall their Case Manager's name or their enrollment in Case Management, reducing willingness to participate in surveys.

Opportunities

- Opportunity 1: Implementing email survey distribution may increase accessibility and participation for members who cannot be reached by phone.
- Opportunity 2: Ensuring alternate phone numbers are included in survey outreach lists may improve contact success and overall response rates.

Long-Term Services & Supports (LTSS) Complex Case Management (Level III)

Survey Response Rates

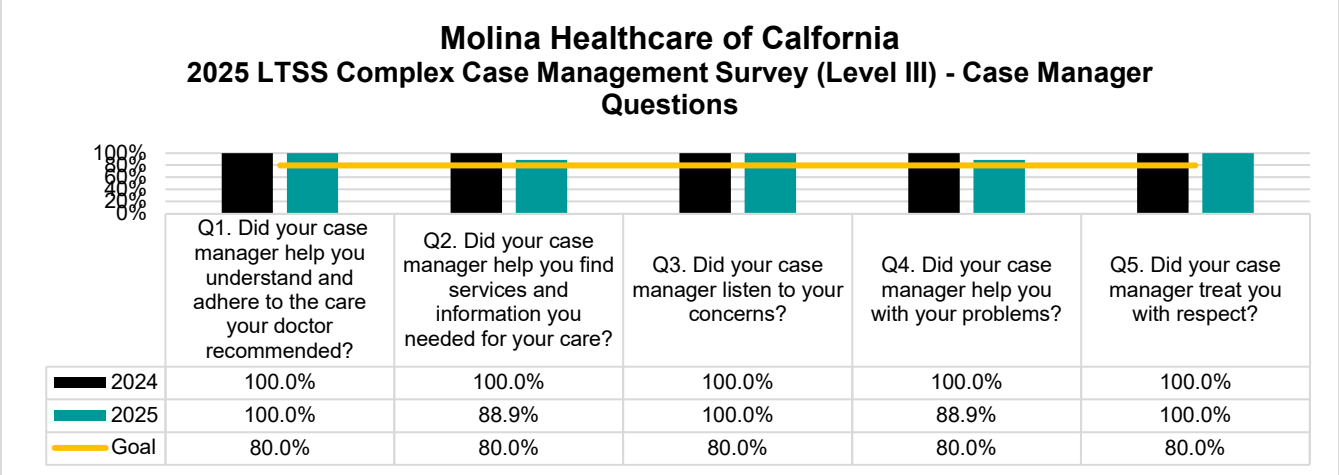
CA LTSS Complex Case Management Survey Responses (Level III Case Manager)

		2024	2025
		LTSS (Yes)	LTSS (Yes)
Q1	Did your case manager help you understand and adhere to the care your doctor recommended?	14	9
Q2	Did your case manager help you find services and information you needed for your care?	14	8
Q3	Did your case manager listen to your concerns?	14	9
Q4	Did your case manager help you with your problems?	14	8
Q5	Did your case manager treat you with respect?	14	9
Total Number of Respondents		**14**	**9**

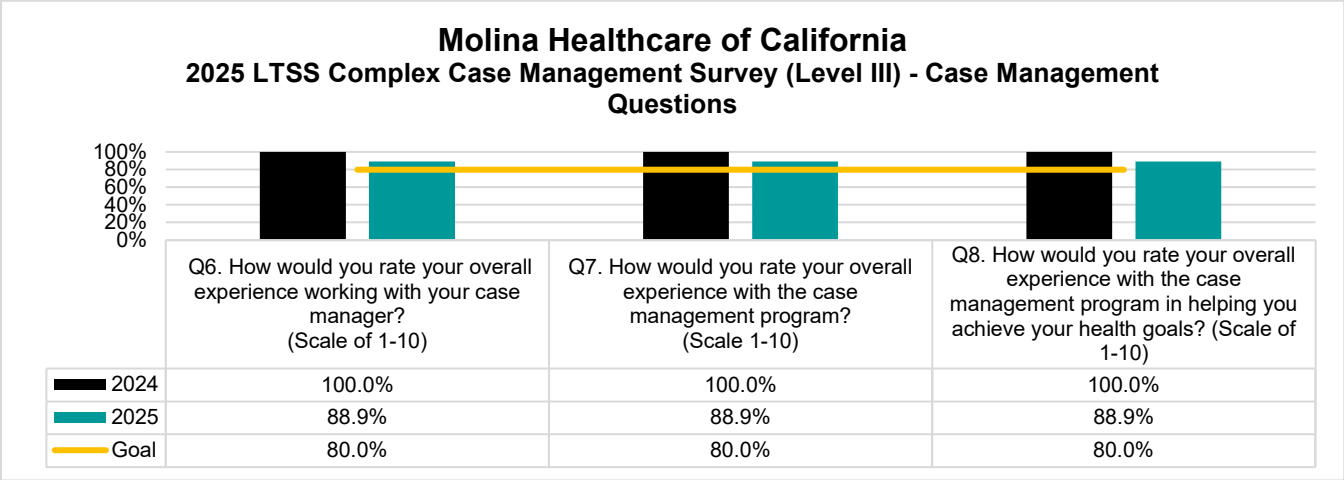
CA LTSS Complex Case Management Survey Responses (Level III Case Management)

		2024	2025
		LTSS (8-10)	LTSS (8-10)
Q6	How would you rate your overall experience working with your case manager? (Scale of 1-10)	14	8
Q7	How would you rate your overall experience with the case management program? (Scale 1-10)	14	8
Q8	How would you rate your overall experience with the case management program in helping you achieve your health goals? (Scale of 1-10)	14	8
Total Number of Respondents		**14**	**9**

Survey Results



	Q1. Did your case manager help you understand and adhere to the care your doctor recommended?	Q2. Did your case manager help you find services and information you needed for your care?	Q3. Did your case manager listen to your concerns?	Q4. Did your case manager help you with your problems?	Q5. Did your case manager treat you with respect?
2024	100.0%	100.0%	100.0%	100.0%	100.0%
2025	100.0%	88.9%	100.0%	88.9%	100.0%
Goal	80.0%	80.0%	80.0%	80.0%	80.0%



	Q6. How would you rate your overall experience working with your case manager? (Scale of 1-10)	Q7. How would you rate your overall experience with the case management program? (Scale 1-10)	Q8. How would you rate your overall experience with the case management program in helping you achieve your health goals? (Scale of 1-10)
2024	100.0%	100.0%	100.0%
2025	88.9%	88.9%	88.9%
Goal	80.0%	80.0%	80.0%

Analysis: Member Experience with LTSS Complex Case Management (Level III)

When comparing the response rate between 2024 (42.4%) and 2025 (27.3%), Molina Healthcare of California experienced a decrease of 15.1 percentage points in member response rate. Out of the 33 members included in the 2024 survey, 14 members responded, while 9 members completed the survey in 2025. Despite the decline in response rates, member satisfaction remained exceptionally high across both years. In 2024, LTSS Complex Case Management members reported 100% satisfaction across all eight questions, demonstrating unanimous agreement regarding the quality of services delivered by case managers and the effectiveness of the Complex Case Management Program.

In 2025, satisfaction levels continued to exceed performance expectations, with all five case manager questions (Q1–Q5) achieving 100% satisfaction, reflecting the continued strength of the program in communication, responsiveness, and respect. The remaining program experience questions (Q6–Q8) ranged from 88.9% to 100%, all above the 80% goal. Satisfaction with understanding and adhering to doctor-recommended care (Q1), as well as case manager listening (Q3) and respect (Q5), maintained perfect scores across both survey years. These results affirm that LTSS Complex Case Management services remain highly valued by participating members, even as response rates fluctuate.

<u>Barriers</u>

- Barrier 1: A substantial number of members have disconnected or unreachable phone numbers, limiting contact success rates and survey participation.
- Barrier 2: Many members do not recall their Case Manager or their enrollment in the Complex Case Management Program, reducing their willingness or ability to respond to survey questions.

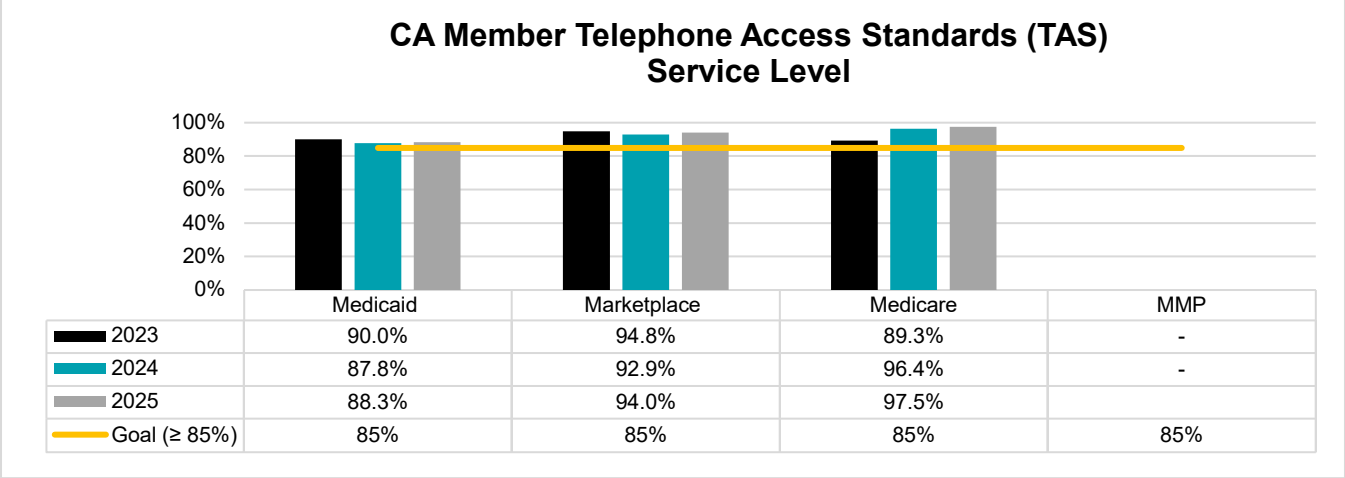
<u>Opportunities</u>

- Opportunity 1: Implementing email-based Complex Case Management Surveys may provide a more accessible communication channel and increase response rates.
- Opportunity 2: Ensuring that alternate and secondary phone numbers are included in outreach lists may improve contact success and enhance survey participation.

Telephone Access Standards

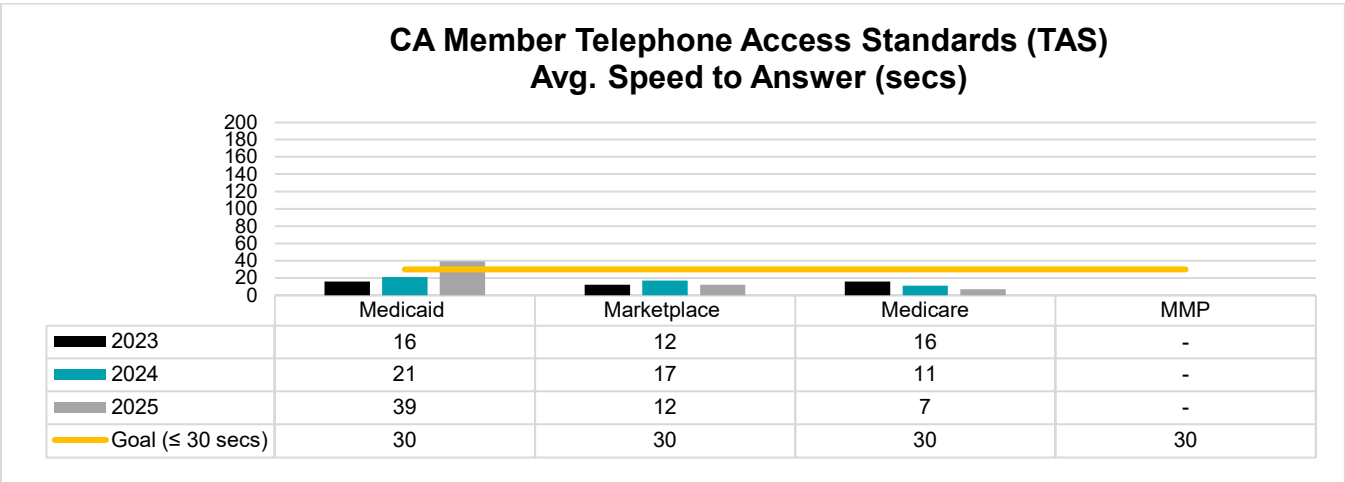
Average Speed of Answer / Abandonment Rate

Note: *Improvements are indicated by an increase in Service Level and a decrease in Avg. Speed to Answer and Abandonment Rate.*



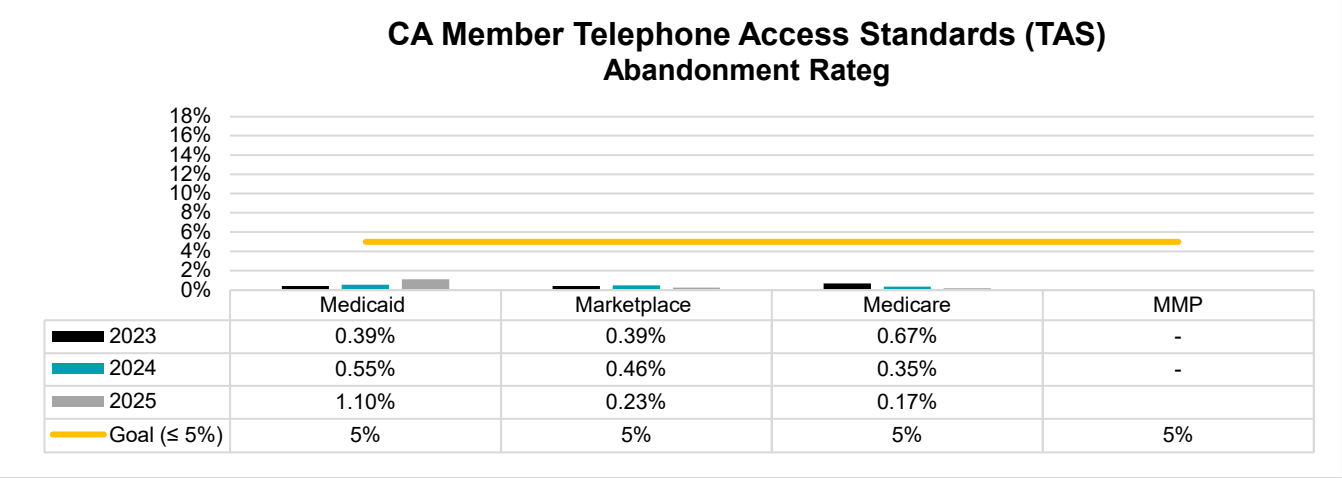
	Medicaid	Marketplace	Medicare	MMP
2023	90.0%	94.8%	89.3%	-
2024	87.8%	92.9%	96.4%	-
2025	88.3%	94.0%	97.5%	
Goal (≥ 85%)	85%	85%	85%	85%

Measurement period is January through December 2025.



	Medicaid	Marketplace	Medicare	MMP
2023	16	12	16	-
2024	21	17	11	-
2025	39	12	7	-
Goal (≤ 30 secs)	30	30	30	30

Measurement period is January through December 2025.



	Medicaid	Marketplace	Medicare	MMP
2023	0.39%	0.39%	0.67%	-
2024	0.55%	0.46%	0.35%	-
2025	1.10%	0.23%	0.17%	
Goal (≤ 5%)	5%	5%	5%	5%

Measurement period is January through December 2025.

Analysis

The CA Member Telephone Access Standards (TAS) results for Medicaid, Marketplace, and Medicare continue to demonstrate strong performance across all key indicators—Service Level, Average Speed to Answer, and Abandonment Rate—with most measures meeting or exceeding established goals. The updated 2023–2025 trend data show consistent strengths across programs as well as a few emerging areas that require proactive monitoring to maintain high access standards.

Service Level (Goal ≥ 85%)

All three programs maintained performance above the required 85% service level goal each year. Medicaid showed stable performance with minor variation, reporting 90.0% (2023), 87.8% (2024), and 88.3% (2025). Performance remained well above goal across all years. The Marketplace also consistently performed above target, with service levels of 94.8% (2023), 92.9% (2024), and 94.0% (2025). Medicare demonstrated the strongest upward trajectory, improving from 93.1% (2023) to 96.4% (2024) and 97.5% (2025), representing sustained excellence and notable improvement in member call accessibility.

Average Speed to Answer (Goal ≤ 30 seconds)

All programs met the ≤30-second goal each year with the exception of Medicaid in 2025 reporting 39 seconds, slightly above the goal of 30 seconds otherwise the programs show continued efficiency in call center responsiveness. Medicaid maintained fast response times despite slight variability—16 seconds (2023), 21 seconds (2024), and 39 seconds (2025). The Marketplace remained similarly efficient, with answer times of 12 seconds, 17 seconds, and 12 seconds, respectively, with all years still outperforming the 30-second benchmark. Medicare demonstrated the most improvement, decreasing from 16 seconds in 2023 to 7 seconds in 2025, ensuring members experience rapid access to support.

Abandonment Rate (Goal ≤ 5%)

Abandonment rates remained exceptionally low across all programs, well under the ≤5% goal. Medicaid maintained a very low rate at 0.39% (2023), 0.55% (2024), and 1.10% (2025). The Marketplace reported similarly low values—0.39%, 0.46%, and 0.23%, all within acceptable limits. Medicare showed the strongest improvement, decreasing from 0.67% (2023) to 0.35% (2024) and then dramatically to 0.17% (2025), indicating high call completion rates and effective call handling.

CA Member Telephone Access Standards for Medicaid, Marketplace, and Medicare reflect strong, consistent, and often improving performance across 2023–2025. All programs met or exceeded benchmarks for service level, response time, and abandonment rate. Medicare, in particular, demonstrated exceptional improvement across all metrics. While small increases in response times and abandonment rates emerged in certain areas, these remain well within acceptable standards and offer targeted opportunities for continued enhancement. Sustaining these high access standards will require a proactive focus on call-center optimization, demand forecasting, and digital service expansion to ensure members continue to receive timely, reliable support.

Conclusion

The MY2024 California Member Experience Report presents a comprehensive assessment of healthcare access, service quality, and overall satisfaction across Medicaid, Marketplace (QHP), Medicare, and LTSS programs. Findings from 2023–2025 demonstrate meaningful improvements in several high-impact areas—most notably provider communication, case management satisfaction, cultural competency, interpreter access, and call center performance—while also revealing persistent challenges in timely access to care, behavioral health service availability, and prescription drug affordability.

Across all product lines, provider communication remains one of the strongest drivers of positive member experience. Measures such as *How Well Doctors Communicate* consistently scored above 90% for Medicaid Child, Medicaid Adult, and QHP populations, and remained near benchmark levels for Medicare members. These consistently high results reflect strong clinical interactions and reinforce the importance of maintaining provider engagement, communication training, and culturally responsive care.

Care coordination shows encouraging improvement in multiple programs. Medicaid and QHP Care Coordination measures increased in 2025, with California Child Medicaid surpassing its benchmark and Adult Medicaid maintaining strong results in 2024 before partial data constraints in 2025. Case Management programs (Level II, Level III, and LTSS) continue to be among the highest-performing areas across all lines of business. In 2025, satisfaction in Case Management frequently reached 97–100%, demonstrating exceptional member confidence in care manager communication, respect, and problem-solving support.

The report also highlights notable gains in language services, particularly interpreter access. Medicaid Child and Adult interpreter measures improved substantially in 2025, with Adult Medicaid surpassing goals across all interpreter satisfaction measures. These results suggest that recent investments in interpreter availability and provider training are beginning to demonstrate measurable impact.

In addition, call center performance achieved consistently strong results across 2023–2025. All major lines of business met or exceeded Service Level, Average Speed to Answer, and Abandonment Rate goals, with Medicare showing the most significant improvement and maintaining the strongest performance across all call center metrics.

Despite these advancements, several persistent challenges remain:

- Timely access to care continues to fall below target across Medicaid and Marketplace plans. Measures such as *Getting Needed Care* and *Getting Appointments Quickly* consistently remained below benchmarks in 2025. Child and Adult Medicaid wait times for routine care and scheduled appointments show improvement in some areas but not yet at goal levels.
- Behavioral health access and satisfaction improved modestly from 2023 to 2025, but both Medicaid Child and Adult behavioral health measures remain just below their respective goals. Difficulty securing timely appointments remains a key barrier.
- Prescription drug access, particularly for Medicare, continues to be an area of underperformance. Measures such as *Getting Needed Prescription Drugs* and *Rating of Drug Plan* remained below Base Group 4 benchmarks in 2025 and contributed to lower Star Ratings.
- Member engagement and survey response rates remain inconsistent. While Medicaid and QHP response rates improved slightly in 2025 after declines in 2024, they remain below MHI national averages. Enhancing outreach, diversifying communication channels, and addressing contact challenges will be essential in future cycles.
- Transportation support, while showing strong improvements in 2024, demonstrated variability in 2025—particularly in Adult Medicaid. Continued focus on consistency, vendor reliability, and member awareness is needed.

To strengthen member experience and address unmet needs, Molina Healthcare of California should prioritize the following strategies:

1. Improve Access to Care and Reduce Wait Times
   Expand primary and specialty networks, optimize scheduling workflows, and increase telehealth availability to reduce delays and improve early access to both routine and behavioral health care.

2. Enhance Care Coordination and Integrated Navigation
   Strengthen referral pathways, expand care navigation programs, and deploy automated reminders for follow-up appointments, medication adherence, and referrals.
3. Boost Member Engagement and Survey Participation
   Utilize personalized outreach, culturally tailored messaging, and multi-channel engagement—including SMS, email, portal notifications, and digital incentives—to improve response rates and representativeness.
4. Advance Customer Service and Language Support
   Maintain high call center standards, improve Medicaid and QHP response times, and expand interpreter availability across clinics, telehealth, and member services.
5. Address Behavioral Health and Social Determinants of Health
   Increase access to behavioral health providers, reduce authorization barriers, expand transportation awareness campaigns, and continue to build culturally responsive care models.
6. Improve Prescription Drug Access and Affordability
   Strengthen pharmacy networks, simplify formulary navigation, and increase member education on low-cost alternatives and assistance programs.

Overall, the MY2024 California Member Experience results reflect significant strengths in provider communication, case management, customer service, and cultural/linguistic support. At the same time, consistent challenges in access to timely care, behavioral health, prescription drug availability, and member outreach highlight areas requiring targeted, system-level interventions. By strategically addressing these gaps and building on existing strengths, Molina Healthcare of California can continue to enhance member experience, elevate CAHPS outcomes, and advance equitable, high-quality care for all members statewide.

Appendix 7

I. Intro

The Provider Satisfaction Surveys (PSS) are an essential tool for obtaining input from healthcare professionals regarding their interactions with Molina, both in California and in other states. These surveys address many important issues to healthcare professionals, including provider relations, utilization and quality management, healthcare staff communication skills, and satisfaction with care.

Policymakers and healthcare organizations in California receive important information regarding the state's provider networks' strengths and opportunities for development through the PSS. This data is essential for making sure that California's healthcare system is effective, member-centered, and always changing to suit the demands of the state's diverse population. We shall go more deeply into the features of the PSS in the sections that follow.

II. Methodology

The Provider Satisfaction Survey (PSS) is performed annually as a tool to collect and analysis how well providers' expectations and needs are being met. Press Ganey, a NCQA Certified Survey Vendor, was selected to conduct the survey. A mixed wave of mail and internet with phone follow-up survey methodology was followed to administer the survey from September through December 2025.

The results are presented in Summary Rates, which show the percentage of respondents who rated the statement positively. Composite scores are calculated by averaging the Summary Rates of attributes within each section.

Positive response options:

- 'Yes'
- 'Well above average' or 'Somewhat above average'
- 'Completely satisfied' or 'Somewhat satisfied'
- Composite scores are calculated by taking the average Summary Rate of those attributes within each section.

Comparisons are made between the 2025 Summary Rates, prior years' rates, and the 2024 Press Ganey Aggregate Book of Business Benchmarks (BoB), which consists of 180 plans with a total of 27,031 respondents. This allows for an analysis of performance relative to industry benchmarks.

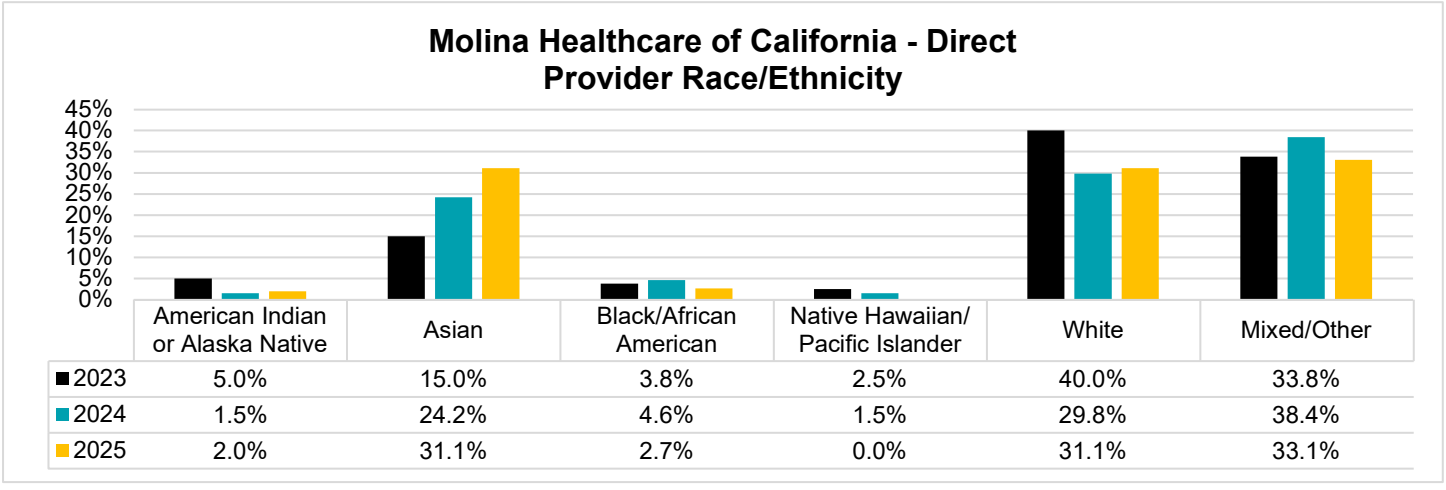
III. Data Sampling/Response Rates

	Year	PCP Responses	Specialist Responses	Behavioral Health Responses	Mail/Internet Responses	Phone Responses	Total Responses	Response Rate
Molina Healthcare of California – Direct	2024	49	186	3	115	123	238	15.9%
	2025	72	114	5	116	75	191	12.7%
	Var '2024-2025	23 response(s)	-72 response(s)	2 response(s)	1 response(s)	-48 response(s)	-47 response(s)	-3.2 percentage point(s)
	% change	47%	-39%	67%	1%	-39%	-20%	-20%
	MHI Avg.							
						Goal	**450**	**30%**

	Year	PCP Responses	Specialist Responses	Behavioral Health Responses	Mail/Internet Responses	Phone Responses	Total Responses	Response Rate
Molina Healthcare of California – IPA Providers	2024	92	314	5	222	189	411	17.5%
	2025	123	30	1	91	63	154	6.5%
	Var '2024-2025	31 response(s)	-284 response(s)	-4 response(s)	-131 response(s)	-126 response(s)	-257 response(s)	-11.0 percentage point(s)
	% change	34%	-90%	-80%	59%	-67%	-63%	-63%
	MHI Avg.							
						Goal	**450**	**30%**

The response data for Molina Healthcare of California – Direct and IPA Providers indicates a decline in overall survey participation from 2024 to 2025 across both provider groups, though the magnitude of change differs significantly between them. For Direct providers, total responses decreased from 238 in 2024 to 191 in 2025 (-47 responses, -19.7%), and the response rate declined from 15.9% to 12.7% (-3.2 percentage points). While PCP responses increased (+23, +46.9%) and Behavioral Health responses rose slightly (+2, +66.7%), participation from Specialists (-72, -38.7%) and Phone responses (-48, -39.0%) declined notably, contributing to the overall decrease. In contrast, IPA provider participation dropped substantially, with total responses falling from 411 to 154 (-257 responses, -62.5%) and the response rate declining from 17.5% to 6.5% (-11 percentage points). This decrease was largely driven by a sharp reduction in Specialist responses (-284, -90.4%), as well as declines in Mail/Internet (-131, -59.0%) and Phone responses (-126, -66.7%). Although PCP responses increased (+31, +33.7%), this gain was insufficient to offset declines across other provider types and response channels. Overall, both tables demonstrate reduced provider engagement with the survey in 2025, particularly among IPA specialists and traditional survey channels, suggesting a need for enhanced outreach, improved survey accessibility, and targeted engagement strategies to increase participation and move closer to the established response goals.

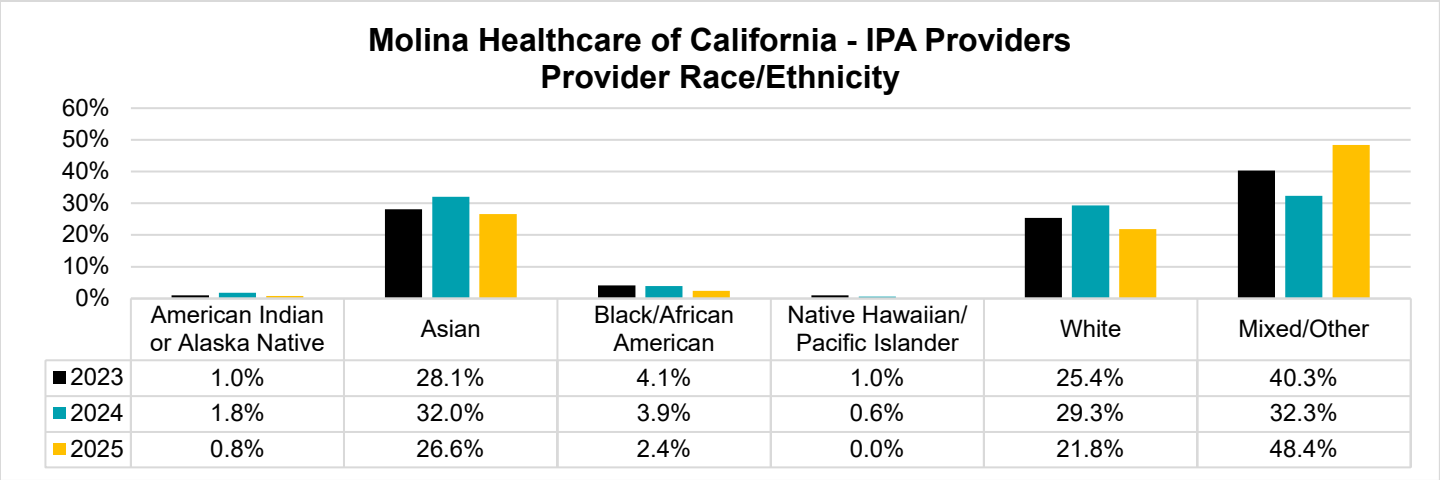
Provider Race / Ethnicity



	American Indian or Alaska Native	Asian	Black/African American	Native Hawaiian/ Pacific Islander	White	Mixed/Other
2023	5.0%	15.0%	3.8%	2.5%	40.0%	33.8%
2024	1.5%	24.2%	4.6%	1.5%	29.8%	38.4%
2025	2.0%	31.1%	2.7%	0.0%	31.1%	33.1%

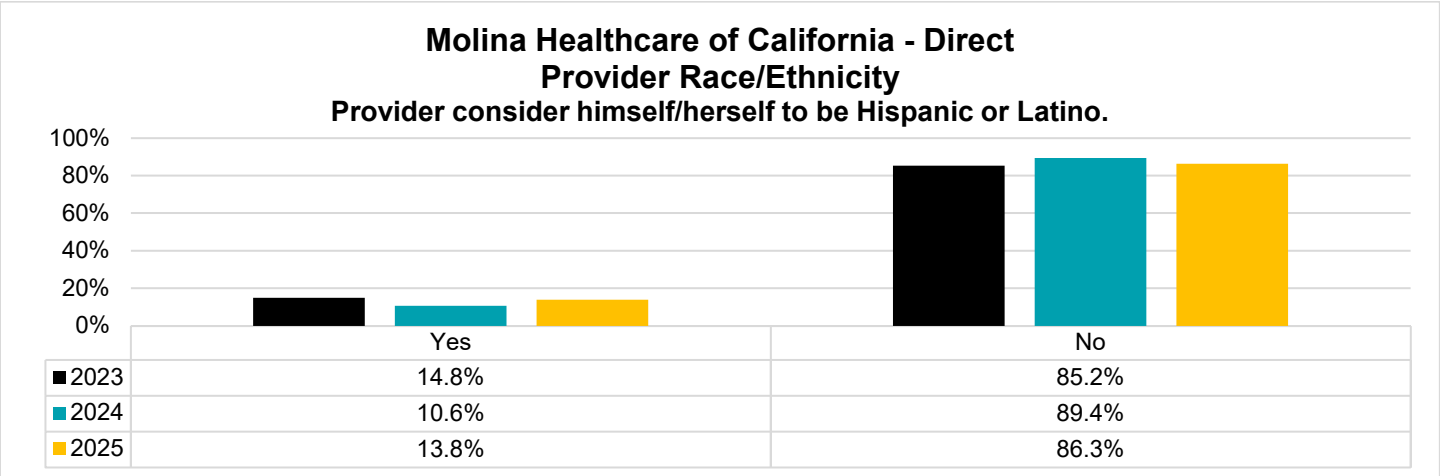
The provider race and ethnicity distribution for Molina Healthcare of California – Direct providers shows notable shifts in representation between 2023 and 2025, particularly among Asian, White, and Mixed/Other providers. Asian provider representation increased substantially, rising from 15.0% in 2023 to 24.2% in 2024 and 31.1% in 2025, representing the most significant growth among all groups. In contrast, the proportion of White providers declined from 40.0% in 2023 to 29.8% in 2024, before slightly increasing to 31.1% in 2025, indicating a decrease in majority representation over time.

Mixed/Other providers remained a significant portion of the network, increasing from 33.8% in 2023 to 38.4% in 2024, then moderating to 33.1% in 2025. Representation among Black/African American providers remained relatively small, fluctuating modestly from 3.8% in 2023 to 4.6% in 2024 and declining to 2.7% in 2025, while American Indian or Alaska Native providers decreased from 5.0% in 2023 to around 2.0% in 2025. Native Hawaiian/Pacific Islander representation remained minimal, declining to 0% in 2025. Overall, the data suggests increasing diversity within the provider network, driven primarily by growth in Asian providers and sustained representation in the Mixed/Other category, while several smaller minority groups remain underrepresented.



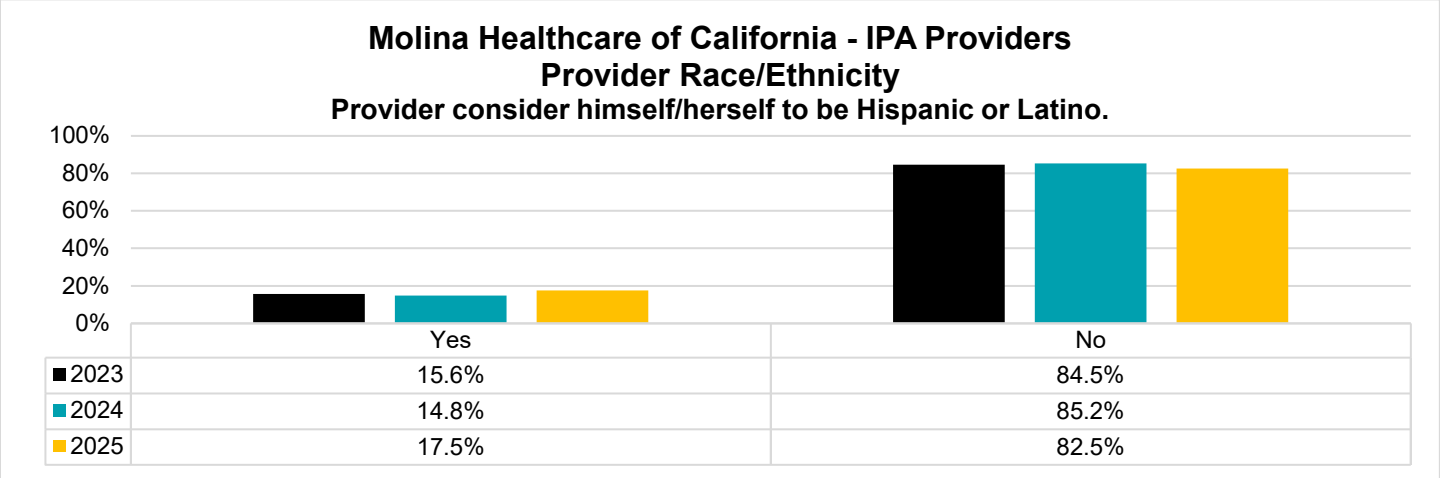
	American Indian or Alaska Native	Asian	Black/African American	Native Hawaiian/ Pacific Islander	White	Mixed/Other
2023	1.0%	28.1%	4.1%	1.0%	25.4%	40.3%
2024	1.8%	32.0%	3.9%	0.6%	29.3%	32.3%
2025	0.8%	26.6%	2.4%	0.0%	21.8%	48.4%

The provider race and ethnicity distribution for Molina Healthcare of California – IPA providers shows several shifts in representation between 2023 and 2025, particularly among Mixed/Other, Asian, and White providers. The Mixed/Other category represents the largest share of providers and increased significantly, rising from 40.3% in 2023 to 48.4% in 2025, despite a temporary decline in 2024 (32.3%). Asian providers remained the second largest group, increasing from 28.1% in 2023 to 32.0% in 2024, before declining to 26.6% in 2025. White provider representation fluctuated but trended downward overall, rising from 25.4% in 2023 to 29.3% in 2024, then declining to 21.8% in 2025. Representation among Black/African American providers remained relatively small, decreasing from 4.1% in 2023 to 2.4% in 2025, while American Indian or Alaska Native providers remained minimal, fluctuating between 0.8% and 1.8% across the three years. Native Hawaiian/Pacific Islander representation remained extremely limited, declining to 0% in 2025. Overall, the data indicates a diverse provider composition within the IPA network, with the largest growth occurring in the Mixed/Other category, while several smaller minority groups continue to have very limited representation.



	Yes	No
2023	14.8%	85.2%
2024	10.6%	89.4%
2025	13.8%	86.3%

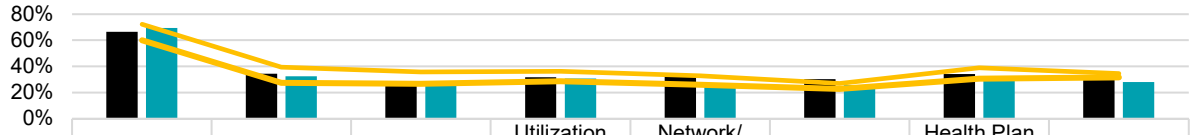
The data for Molina Healthcare of California – Direct providers identifying as Hispanic or Latino shows relatively stable but modest representation across the three-year period from 2023 to 2025. In 2023, 14.8% of providers identified as Hispanic or Latino, which declined to 10.6% in 2024, before increasing slightly to 13.8% in 2025. Correspondingly, the proportion of providers who did not identify as Hispanic or Latino increased from 85.2% in 2023 to 89.4% in 2024, then decreased to 86.3% in 2025. While the 2025 figure represents a partial recovery from the decline observed in 2024, the overall trend suggests that Hispanic/Latino representation within the Direct provider network remains relatively limited, especially considering California's diverse population. These findings highlight an opportunity for Molina Healthcare to continue strengthening provider recruitment and engagement strategies that support greater linguistic and cultural representation, which can enhance culturally competent care and improve access for Hispanic and Latino member populations.



The data for Molina Healthcare of California – IPA providers identifying as Hispanic or Latino indicates a slight upward trend in Hispanic/Latino representation from 2023 to 2025. In 2023, 15.6% of providers identified as Hispanic or Latino, which declined marginally to 14.8% in 2024, before increasing to 17.5% in 2025, representing the highest proportion across the three-year period. Correspondingly, the proportion of providers who did not identify as Hispanic or Latino decreased from 84.5% in 2023 to 82.5% in 2025. Although Hispanic/Latino providers remain a minority within the IPA network, the increase observed in 2025 suggests gradual improvement in representation. This trend may support efforts to enhance culturally and linguistically appropriate care for California's diverse member population, particularly in communities with higher Hispanic and Latino enrollment. However, the data also indicates continued opportunities for Molina Healthcare to further expand recruitment and engagement strategies that promote greater diversity and cultural alignment within the provider network.

IV. Composite Summary Rates

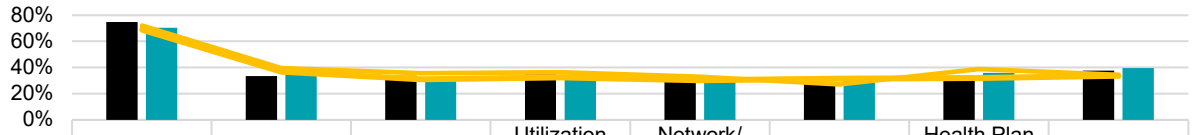
Molina Healthcare of California - Direct
Provider Satisfaction Survey Final Summary Rates



	Overall Satisfaction	Comparative Rating	Finance Issues	Utilization and Quality Management	Network/ Coordination of Care	Pharmacy	Health Plan Call Center Service Staff	Provider Relations
2023	66.3%	34.4%	28.4%	31.7%	33.3%	30.1%	34.2%	31.8%
2024	69.4%	32.3%	26.5%	30.6%	26.0%	25.6%	32.4%	28.0%
2025	60.1%	27.6%	26.7%	28.8%	26.0%	22.9%	30.7%	31.6%
2024 Press Ganey Book of Business	72.3%	39.5%	35.7%	36.3%	32.9%	27.2%	38.9%	34.5%

The Provider Satisfaction Survey results for Molina Healthcare of California – Direct providers show mixed performance between 2023 and 2025, with overall declines in several key satisfaction domains in 2025. Overall satisfaction increased slightly from 66.3% in 2023 to 69.4% in 2024, but declined to 60.1% in 2025, falling below both prior-year performance and the 2024 Press Ganey Book of Business benchmark of 72.3%. Similarly, the comparative rating decreased steadily from 34.4% in 2023 to 27.6% in 2025, indicating that providers viewed Molina less favorably relative to other contracted health plans. Most operational domains experienced modest declines or remained relatively stable, including Utilization and Quality Management (31.7% → 28.8%), Network/Coordination of Care (33.3% → 26.0%), and Pharmacy services (30.1% → 22.9%), suggesting potential concerns related to care coordination and pharmacy support. Health Plan Call Center Service Staff scores declined slightly from 34.2% to 30.7%, while Provider Relations remained relatively stable, increasing slightly from 31.8% in 2023 to 31.6% in 2025 after a dip in 2024. Overall, the findings indicate declining provider satisfaction across several operational areas in 2025, with most metrics remaining below industry benchmarks, highlighting opportunities for Molina to strengthen provider engagement, operational support, and care coordination processes within the Direct provider network.

Molina Healthcare of California - IPA Providers
Provider Satisfaction Survey Final Summary Rates

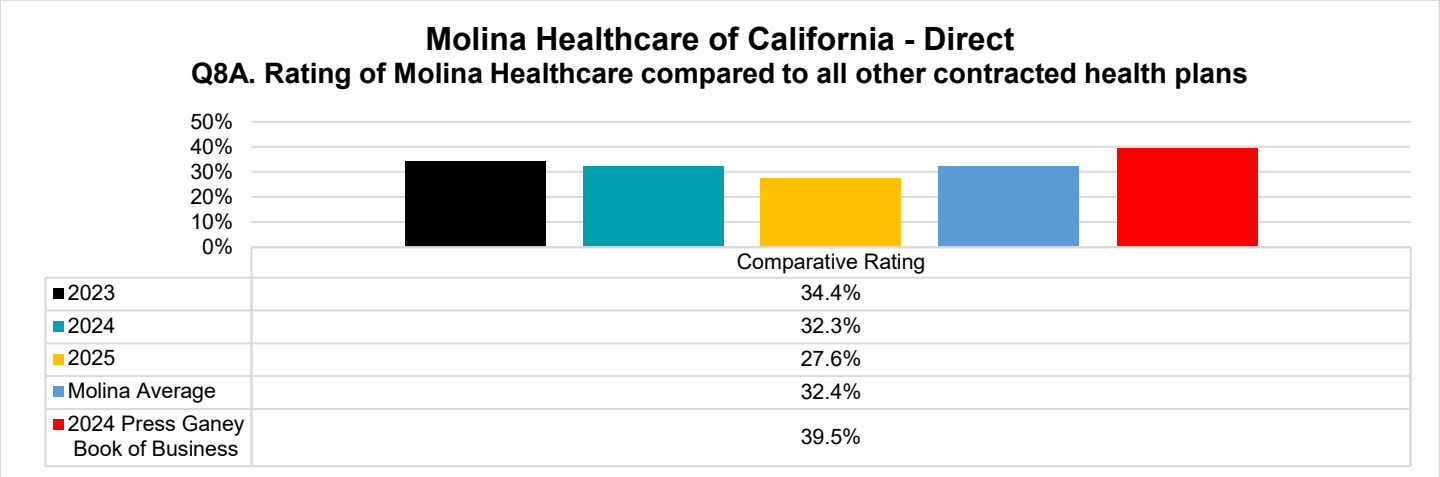


	Overall Satisfaction	Comparative Rating	Finance Issues	Utilization and Quality Management	Network/ Coordination of Care	Pharmacy	Health Plan Call Center Service Staff	Provider Relations
2023	74.7%	33.4%	33.7%	34.7%	30.3%	28.6%	33.4%	37.7%
2024	70.3%	35.0%	29.4%	32.7%	31.4%	30.4%	35.9%	39.5%
2025	69.0%	36.8%	31.1%	32.5%	30.3%	31.4%	32.0%	33.6%
2024 Press Ganey Book of Business	72.3%	39.5%	35.7%	36.3%	32.9%	27.2%	38.9%	34.5%

The Provider Satisfaction Survey results for Molina Healthcare of California – IPA providers indicate generally stable performance from 2023 to 2025 with modest fluctuations across several operational domains. Overall satisfaction declined slightly from 74.7% in 2023 to 70.3% in 2024 and 69.0% in 2025, though it remains relatively close to the 2024 Press Ganey Book of Business benchmark of 72.3%. In contrast, the comparative rating improved steadily from 33.4% in 2023 to 36.8% in 2025, suggesting providers perceive Molina somewhat more favorably relative to competing health plans

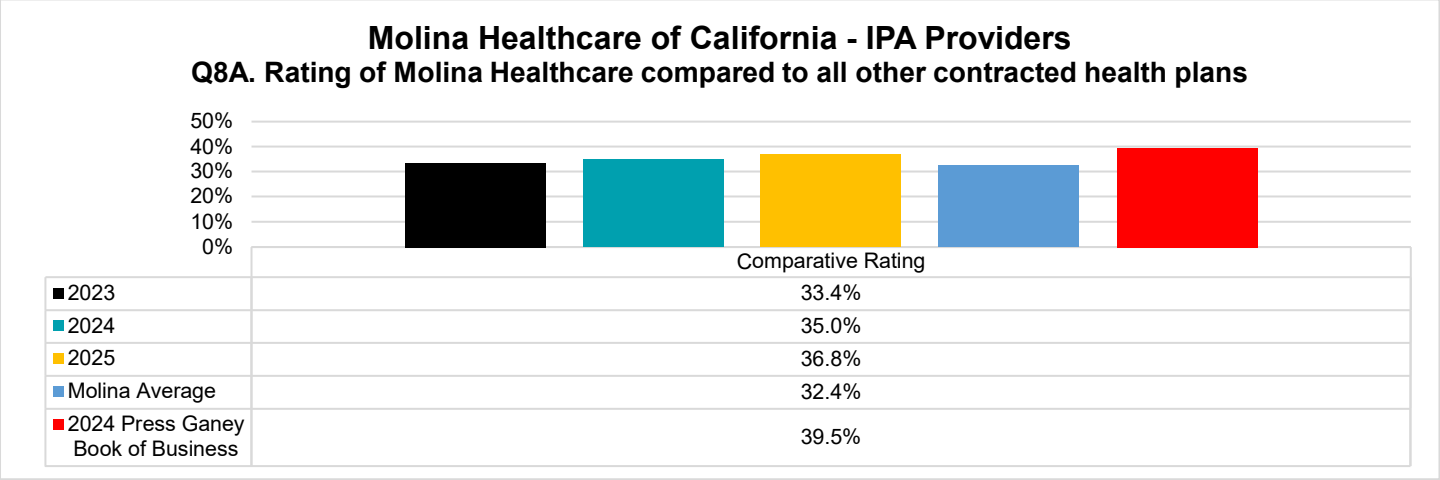
over time. Several operational areas showed moderate stability or incremental improvement, including Pharmacy services (28.6% → 31.4%) and Network/Coordination of Care, which remained consistent around 30–31% across all years. Finance Issues and Utilization and Quality Management scores declined slightly from 2023 but remained relatively stable through 2025, indicating ongoing opportunities to streamline administrative and authorization processes. Meanwhile, Provider Relations and Call Center Service Staff scores remained relatively strong compared to other domains, though both declined modestly in 2025 from their 2024 peaks. Overall, the results suggest that while IPA provider satisfaction remains relatively strong and stable, most measures remain below Press Ganey benchmarks, highlighting continued opportunities to enhance operational efficiency, communication, and provider support services.

V. Overall Satisfaction / Comparative Rating Summary Rates

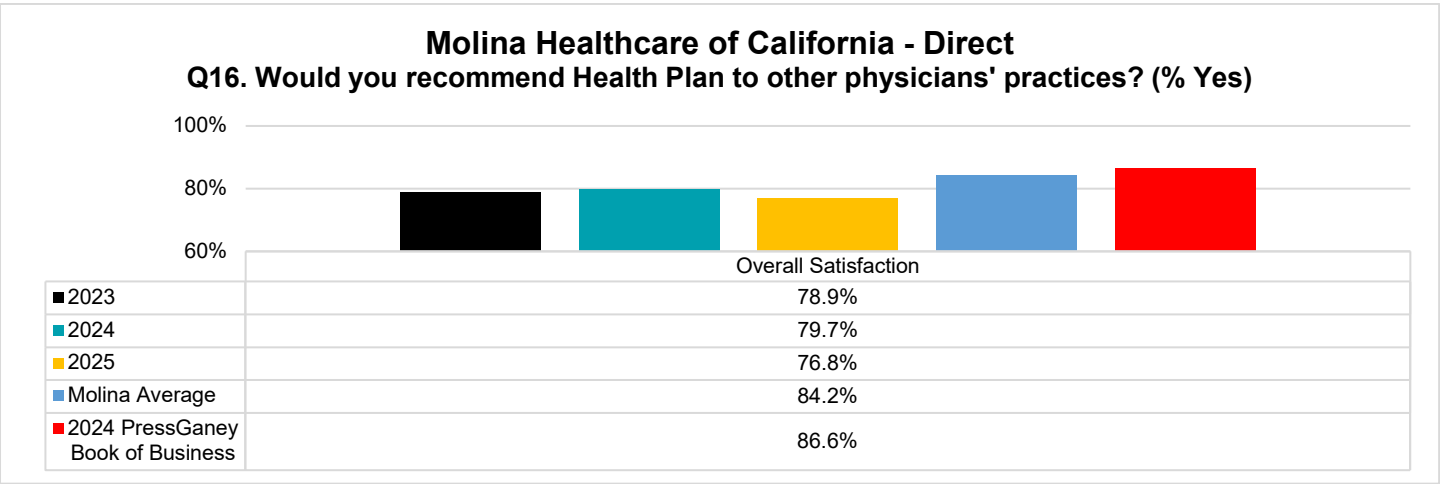


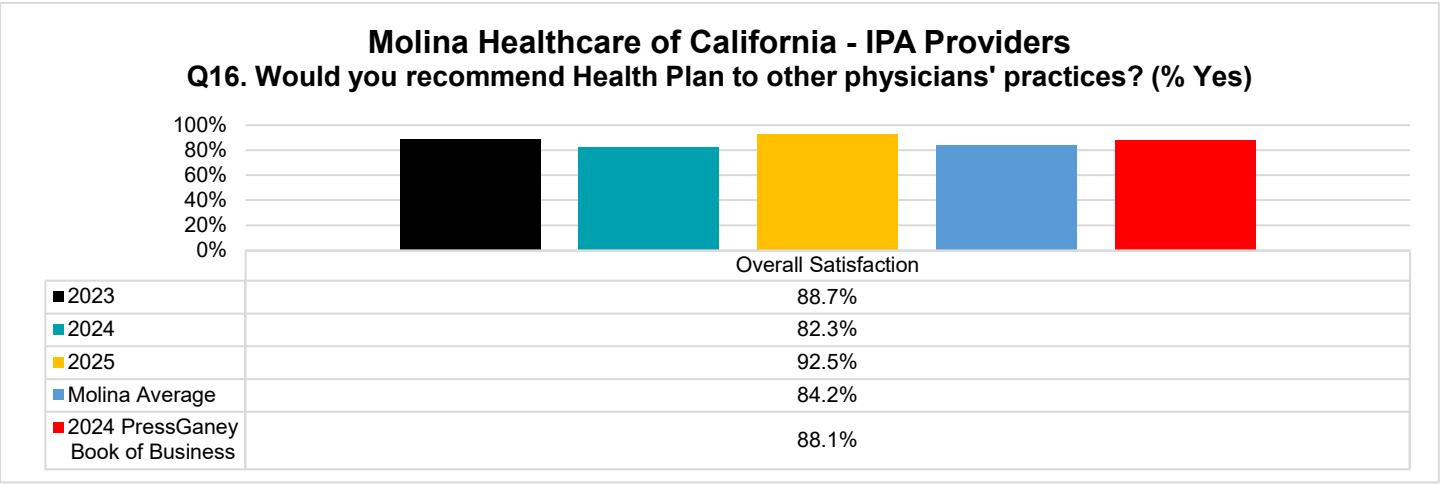
	Comparative Rating
2023	34.4%
2024	32.3%
2025	27.6%
Molina Average	32.4%
2024 Press Ganey Book of Business	39.5%

The comparative rating for Molina Healthcare of California – Direct providers shows a declining trend in how providers perceive Molina relative to other contracted health plans between 2023 and 2025. The comparative rating decreased from 34.4% in 2023 to 32.3% in 2024, and further declined to 27.6% in 2025, indicating that fewer providers rated Molina more favorably compared to competing health plans over time. The three-year Molina average of 32.4% also remains below the 2024 Press Ganey Book of Business benchmark of 39.5%, highlighting a gap between Molina's performance and industry standards. This downward trend suggests that providers within the Direct network may be experiencing ongoing challenges related to operational processes, administrative interactions, or support services that influence how they evaluate Molina relative to other plans. Overall, the results indicate an opportunity for Molina to strengthen provider engagement, improve operational efficiency, and enhance service support in order to improve its competitive perception among Direct network providers.



The comparative rating for Molina Healthcare of California – IPA providers shows a steady improvement in provider perceptions of Molina relative to other contracted health plans from 2023 to 2025. The comparative rating increased from 33.4% in 2023 to 35.0% in 2024, and further improved to 36.8% in 2025, indicating that a growing proportion of IPA providers rated Molina more favorably compared to competing health plans over time. Although this upward trend reflects positive momentum, the 2025 score remains slightly below the 2024 Press Ganey Book of Business benchmark of 39.5%, suggesting there is still a gap between Molina's performance and industry standards. The three-year Molina average of 32.4% further highlights this opportunity for improvement. Overall, the results suggest that while provider perceptions within the IPA network are improving, continued efforts to enhance operational processes, communication, and provider support services may help further strengthen Molina's competitive standing among contracted health plans.





The provider recommendation results (Q16) for Molina Healthcare of California show different trends between Direct and IPA provider networks from 2023 to 2025, highlighting variations in provider advocacy. Among Direct providers, the percentage of providers who would recommend the health plan remained relatively stable but declined slightly overall, moving from 78.9% in 2023 to 79.7% in 2024 and then decreasing to 76.8% in 2025. This score is below both the Molina average (84.2%) and the 2024 Press Ganey Book of Business benchmark (86.6%), suggesting that Direct providers demonstrate lower advocacy compared to broader benchmarks. In contrast, IPA providers show stronger and improving advocacy, increasing from 88.7% in 2023 to 92.5% in 2025, despite a temporary dip to 82.3% in 2024. The 2025 IPA score exceeds both the Molina average and the Press Ganey benchmark of 88.1%, indicating high levels of provider satisfaction and willingness to recommend the plan within the IPA network. Overall, the comparison suggests that IPA providers have stronger confidence in Molina and are more likely to recommend the health plan, while Direct provider advocacy remains positive but comparatively lower, highlighting an opportunity for Molina to strengthen engagement, operational support, and service experience within the Direct provider network.

Molina Healthcare of California - Direct
Please rate your overall satisfaction with . . .

	Molina Healthcare of California - Direct	Anthem Blue Cross Partnership Plan	Health Net Community Solutions, Inc.	Inland Empire Health Plan	L.A. Care Health Plan	Blue Shield of CA Promise Health Plan
2022	53.5%	64.0%	63.0%	58.0%	57.8%	60.4%
2023	66.3%	70.6%	65.9%	72.6%	59.3%	64.7%
2024	69.4%	75.0%	74.4%	74.2%	73.7%	76.5%
2025	60.1%	66.5%	66.7%	64.9%	69.0%	67.7%
Rank	6	4	3	5	1	2

Molina Healthcare of California - IPA Providers
Please rate your overall satisfaction with . . .

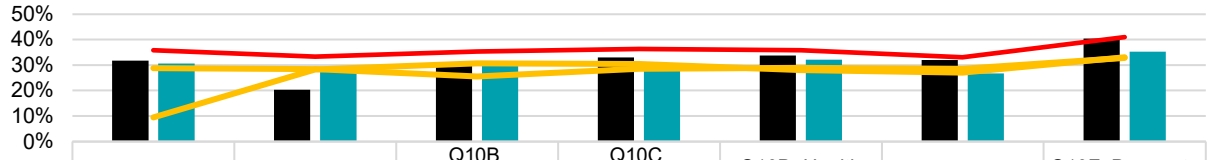
	Molina Healthcare of California - IPA Providers	Anthem Blue Cross Partnership Plan	Health Net Community Solutions, Inc.	Inland Empire Health Plan	L.A. Care Health Plan	Blue Shield of CA Promise Health Plan
2023	74.7%	81.9%	79.9%	79.5%	78.0%	82.3%
2024	70.3%	77.7%	73.8%	78.2%	72.1%	77.1%
2025	69.0%	76.6%	71.1%	72.0%	75.4%	76.4%
Rank	6	1	5	4	3	2

The overall satisfaction ratings comparing Molina Healthcare of California with other health plans reveal differences in performance between the Direct and IPA provider networks, as well as Molina's relative standing among competitors. Among Direct providers, Molina's satisfaction score increased from 53.5% in 2022 to 69.4% in 2024, but declined to 60.1% in 2025, placing Molina last (6th) among the six health plans evaluated. In contrast, other plans such as L.A. Care Health Plan (69.0%) and Blue Shield of California Promise Health Plan (67.7%) ranked higher in 2025, indicating stronger provider satisfaction within those networks. Among IPA providers, Molina also ranked 6th in 2025 with a satisfaction score of 69.0%, showing a gradual decline from 74.7% in 2023 to 70.3% in 2024. However, the gap between Molina and competitors appears narrower in the IPA network compared to

the Direct network. In both provider groups, competing plans such as Anthem Blue Cross Partnership Plan and Blue Shield of CA Promise Health Plan consistently demonstrate higher satisfaction scores, suggesting stronger provider experiences within those networks. Overall, the comparison indicates that Molina's provider satisfaction levels, while moderate, lag behind competing health plans across both Direct and IPA provider groups, highlighting opportunities to improve provider engagement, operational processes, and support services to enhance Molina's competitive standing among California health plans.

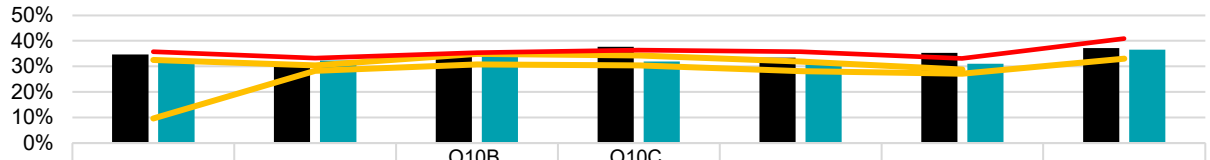
VI. Utilization & Quality Management Summary Rate

Molina Healthcare of California - Direct
Utilization and Quality Management Summary Rates



	Composite Summary Rate	Q10A. Access to knowledgeable UM staff	Q10B. Procedures for obtaining pre-certification/ referral/ authorization information	Q10C. Timeliness of obtaining pre-certification/ referral/ authorization information	Q10D. Health plan's facilitation/ support of appropriate clinical care for patients	Q10E. Access to Case/ Care Managers from this health plan	Q10F. Degree to which the plan covers and encourages preventive care and wellness
2023	31.7%	20.3%	31.0%	32.9%	33.7%	32.0%	40.3%
2024	30.6%	29.1%	30.9%	29.8%	32.1%	26.7%	35.2%
2025	28.8%	28.5%	25.6%	28.6%	28.9%	28.6%	32.9%
Molina Average	9.6%	28.3%	30.7%	30.4%	28.1%	27.1%	33.1%
2024 PressGaney Book of Business	35.8%	33.3%	35.4%	36.4%	35.8%	33.2%	41.0%

Molina Healthcare of California - IPA Providers
Utilization and Quality Management Summary Rates



	Composite Summary Rate	Q10A. Access to knowledgeable UM staff	Q10B. Procedures for obtaining pre-certification/ referral/ authorization information	Q10C. Timeliness of obtaining pre-certification/ referral/ authorization information	Q10D. Health plan's facilitation/ support of appropriate clinical care for patients	Q10E. Access to Case/ Care Managers from this health plan	Q10F. Degree to which the plan covers and encourages preventive care and wellness
2023	34.7%	30.3%	34.2%	37.6%	33.4%	35.3%	37.2%
2024	32.7%	32.3%	33.9%	31.9%	30.7%	31.0%	36.5%
2025	32.5%	30.4%	35.0%	34.3%	31.9%	28.8%	
Molina Average	9.6%	28.3%	30.7%	30.4%	28.1%	27.1%	33.1%
2024 PressGaney Book of Business	35.8%	33.3%	35.4%	36.4%	35.8%	33.2%	41.0%

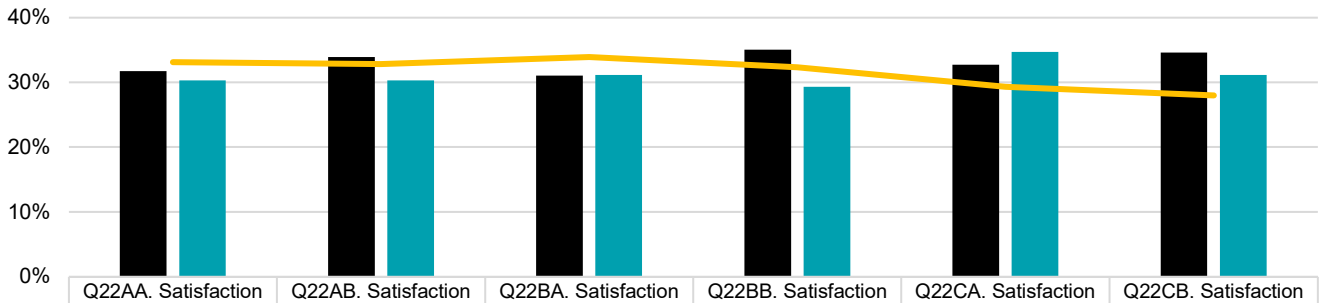
The Utilization and Quality Management (UQM) summary results for Molina Healthcare of California show generally similar performance patterns across the Direct and IPA provider networks, though IPA providers consistently report slightly higher satisfaction levels across most measures. Among Direct providers, the composite summary rate declined gradually from 31.7% in 2023 to 28.8% in 2025, reflecting modest decreases across several domains, including procedures for obtaining authorization information (31.0% to 25.6%), timeliness of authorization (32.9% to 28.6%), and health plan support

of appropriate clinical care (33.7% to 28.9%). Scores related to preventive care coverage and encouragement also declined from 40.3% in 2023 to 32.9% in 2025. In contrast, IPA providers demonstrate slightly stronger and more stable performance, with the composite score remaining relatively consistent from 34.7% in 2023 to 32.5% in 2025. IPA providers reported improvements in some areas, including authorization procedures (34.2% to 35.0%), though declines were observed in other domains such as access to care managers (35.3% to 28.8%) and preventive care support (37.2% to 36.5%). Across both networks, most measures remain below the 2024 Press Ganey Book of Business benchmarks, indicating continued opportunities to improve utilization management processes, communication regarding authorization requirements, and coordination of care. Overall, while IPA providers report slightly higher satisfaction with utilization and quality management functions, both provider groups highlight similar operational challenges, suggesting system-wide opportunities to streamline authorization processes, improve provider access to support resources, and strengthen care coordination.

VII. State Specific Questions

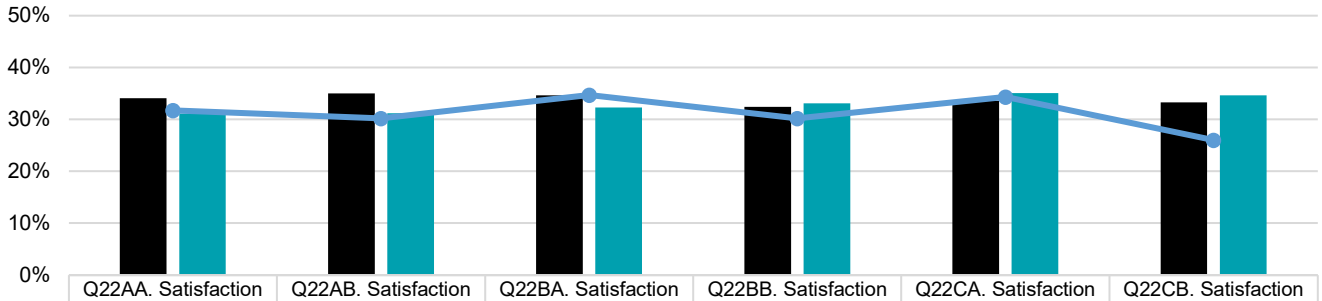
a. Satisfaction with Interpreters Summary Rates

Molina Healthcare of California - Direct Satisfaction with Interpreters Summary Rates



	Q22AA. Satisfaction with coordination of appointments with interpreter: Molina Healthcare	Q22AB. Satisfaction with coordination of appointments with interpreter: All other health plans	Q22BA. Satisfaction with availability of appropriate range of interpreters: Molina Healthcare	Q22BB. Satisfaction with availability of appropriate range of interpreters: All other health plans	Q22CA. Satisfaction with training and competency of available interpreters: Molina Healthcare	Q22CB. Satisfaction with training and competency of available interpreters: All other health plans
2023	31.7%	33.9%	31.0%	35.0%	32.7%	34.6%
2024	30.3%	30.3%	31.1%	29.3%	34.7%	31.1%
2025	33.1%	32.8%	33.9%	32.3%	29.3%	28.0%

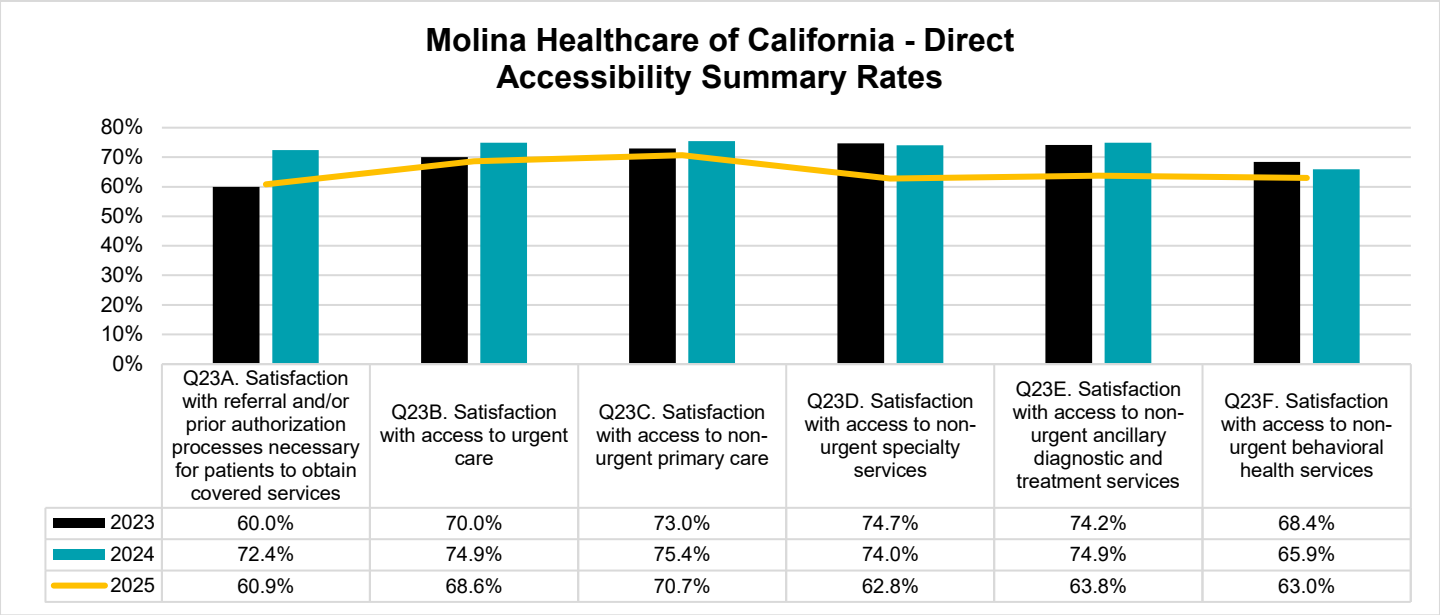
Molina Healthcare of California - IPA Providers Satisfaction with Interpreters Summary Rates



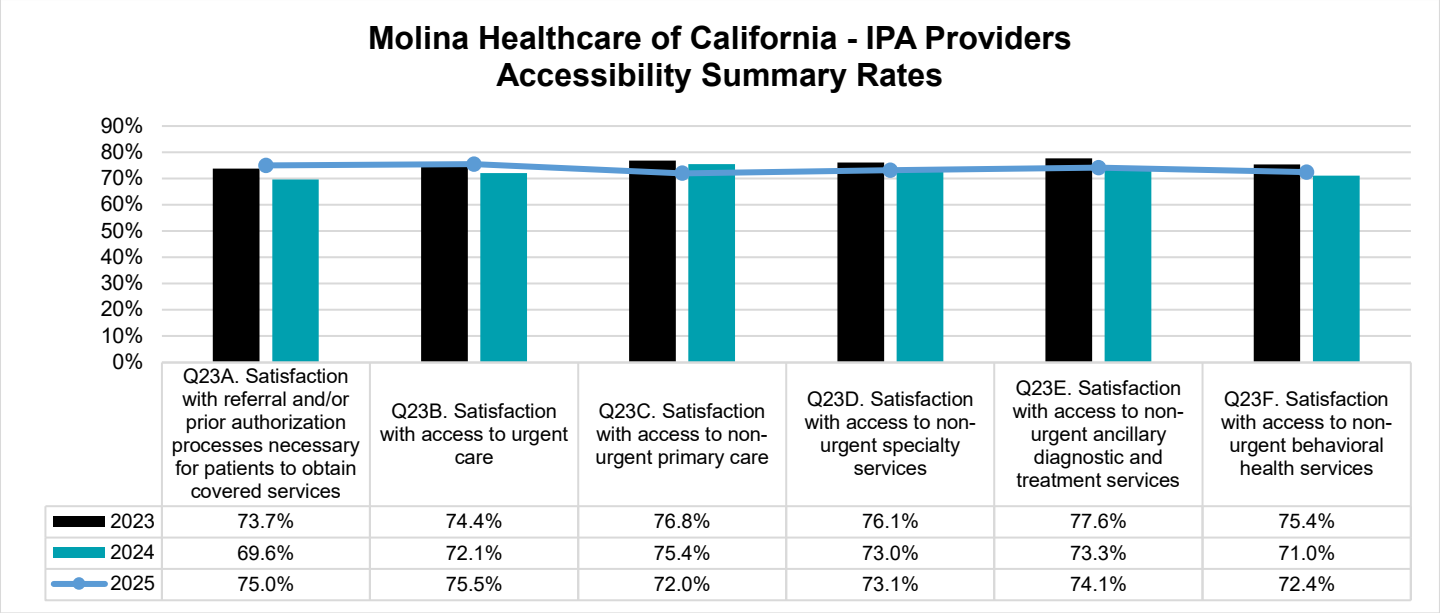
	Q22AA. Satisfaction with coordination of appointments with interpreter: Molina Healthcare	Q22AB. Satisfaction with coordination of appointments with interpreter: All other health plans	Q22BA. Satisfaction with availability of appropriate range of interpreters: Molina Healthcare	Q22BB. Satisfaction with availability of appropriate range of interpreters: All other health plans	Q22CA. Satisfaction with training and competency of available interpreters: Molina Healthcare	Q22CB. Satisfaction with training and competency of available interpreters: All other health plans
2023	34.1%	35.0%	34.6%	32.4%	33.6%	33.3%
2024	31.1%	31.2%	32.3%	33.1%	35.1%	34.6%
2025	32%	30.2%	34.7%	30.20%	34.3%	26.0%

The satisfaction with interpreter services results for Molina Healthcare of California show moderate and relatively stable provider perceptions across both Direct and IPA networks, with IPA providers generally reporting slightly higher satisfaction levels overall. Among Direct providers, satisfaction with interpreter-related services fluctuated modestly between 2023 and 2025. Coordination of appointments with interpreters for Molina increased slightly from 31.7% in 2023 to 33.1% in 2025, while satisfaction with the availability of an appropriate range of interpreters for Molina improved from 31.0% to 33.9% over the same period. However, satisfaction with training and competency of available interpreters declined, dropping from 32.7% in 2023 to 29.3% in 2025 for Molina and from 34.6% to 28.0% for other health plans, suggesting potential concerns related to interpreter training or provider expectations. In comparison, IPA providers consistently reported slightly higher satisfaction levels across most interpreter service domains, particularly regarding availability of interpreter range (34.7% in 2025) and training and competency of Molina interpreters (34.3%), though satisfaction with training for interpreters from other health plans declined more noticeably to 26.0% in 2025. Overall, both provider groups indicate relatively stable but moderate satisfaction with interpreter services, with IPA providers generally expressing more favorable perceptions. The results suggest opportunities for Molina Healthcare to strengthen interpreter training, competency assurance, and service coordination, which could further improve provider experience and support culturally and linguistically appropriate care for diverse patient populations.

b. Accessibility Summary Rates



	Q23A. Satisfaction with referral and/or prior authorization processes necessary for patients to obtain covered services	Q23B. Satisfaction with access to urgent care	Q23C. Satisfaction with access to non-urgent primary care	Q23D. Satisfaction with access to non-urgent specialty services	Q23E. Satisfaction with access to non-urgent ancillary diagnostic and treatment services	Q23F. Satisfaction with access to non-urgent behavioral health services
2023	60.0%	70.0%	73.0%	74.7%	74.2%	68.4%
2024	72.4%	74.9%	75.4%	74.0%	74.9%	65.9%
2025	60.9%	68.6%	70.7%	62.8%	63.8%	63.0%



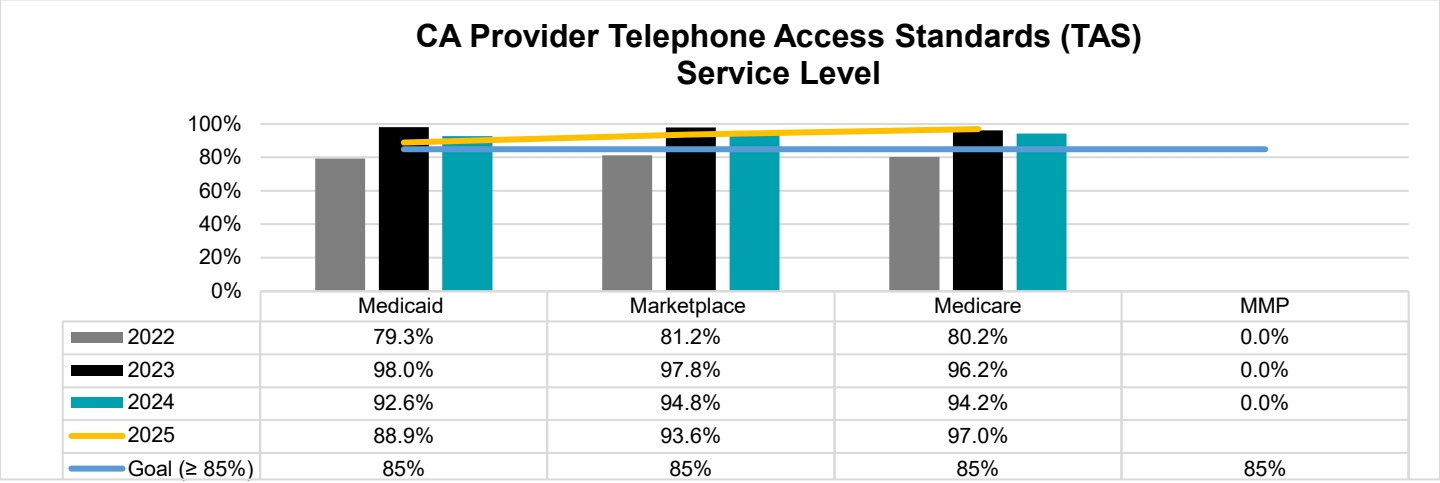
	Q23A. Satisfaction with referral and/or prior authorization processes necessary for patients to obtain covered services	Q23B. Satisfaction with access to urgent care	Q23C. Satisfaction with access to non-urgent primary care	Q23D. Satisfaction with access to non-urgent specialty services	Q23E. Satisfaction with access to non-urgent ancillary diagnostic and treatment services	Q23F. Satisfaction with access to non-urgent behavioral health services
2023	73.7%	74.4%	76.8%	76.1%	77.6%	75.4%
2024	69.6%	72.1%	75.4%	73.0%	73.3%	71.0%
2025	75.0%	75.5%	72.0%	73.1%	74.1%	72.4%

The Accessibility Summary Rates for Molina Healthcare of California reveal notable differences between Direct and IPA provider networks, with IPA providers consistently reporting higher satisfaction across all accessibility measures. Among Direct providers, satisfaction improved from 2023 to 2024 across most categories, including referral and prior authorization processes (60.0% to 72.4%), access to urgent care (70.0% to 74.9%), and access to non-urgent primary care (73.0% to 75.4%), but declined in 2025, falling to 60.9%, 68.6%, and 70.7% respectively. Similar declines were observed in access to non-urgent specialty services (74.7% to 62.8%) and diagnostic and treatment services (74.2% to 63.8%), suggesting worsening provider perceptions of accessibility within the Direct network in 2025. In contrast, IPA providers maintained relatively strong and stable accessibility scores, with most measures remaining in the low-to-mid 70% range across all three years. In 2025, IPA providers reported 75.0% satisfaction with referral and authorization processes, 75.5% with urgent care access, and 74.1% with access to diagnostic and treatment services, reflecting consistent performance and minimal fluctuation compared to the Direct network. Overall, the comparison suggests that IPA providers experience stronger and more stable access to care within the Molina network, while Direct providers reported more pronounced declines in accessibility measures in 2025, indicating opportunities for Molina Healthcare to improve referral processes, specialty access, and coordination of services within the Direct provider network.

VIII. Telephone Access Standards

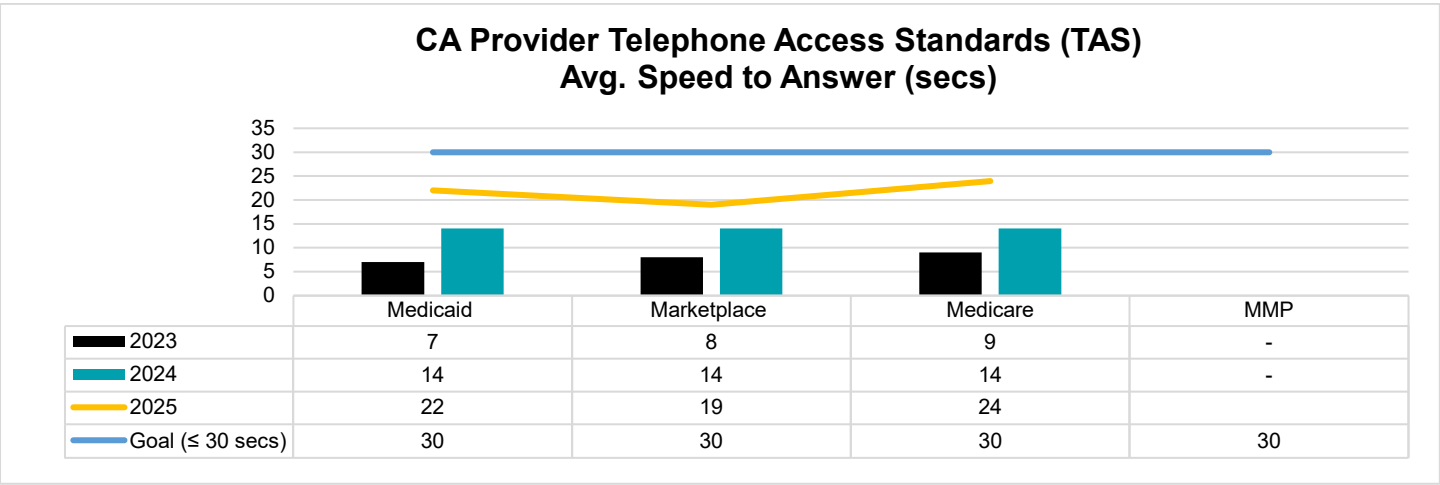
a. Service Level / Average Speed of Answer / Abandonment Rate

Note: *Improvements are indicated by an increase in Service Level and a decrease in Avg. Speed to Answer and Abandonment Rate.*



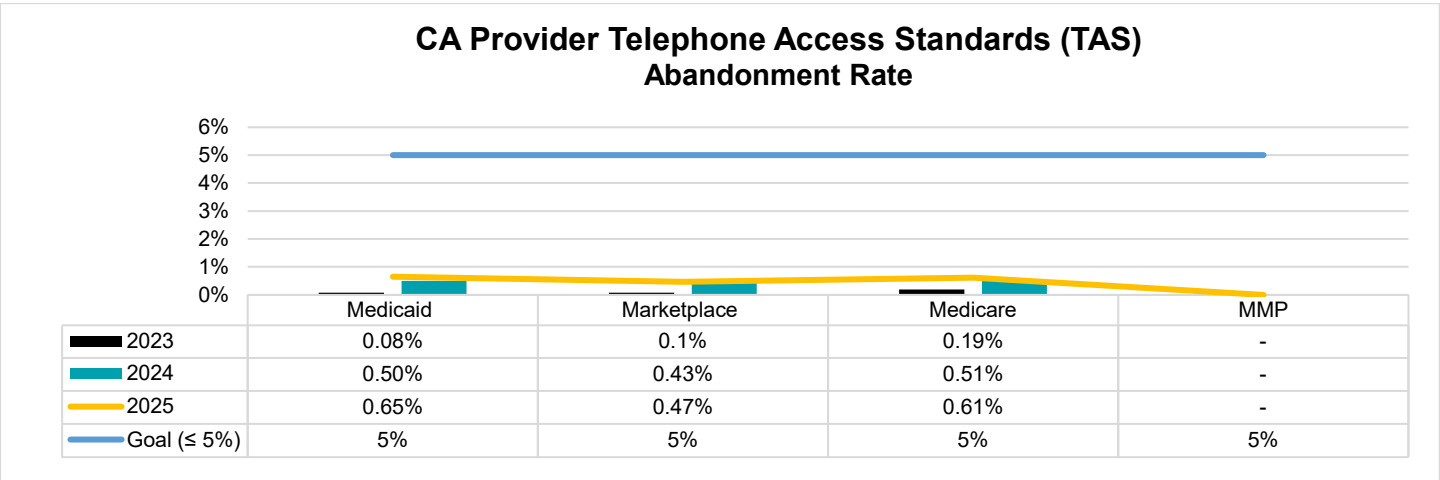
	Medicaid	Marketplace	Medicare	MMP
2022	79.3%	81.2%	80.2%	0.0%
2023	98.0%	97.8%	96.2%	0.0%
2024	92.6%	94.8%	94.2%	0.0%
2025	88.9%	93.6%	97.0%	
Goal (≥ 85%)	85%	85%	85%	85%

Measurement period is January through December 2025.



	Medicaid	Marketplace	Medicare	MMP
2023	7	8	9	-
2024	14	14	14	-
2025	22	19	24	
Goal (≤ 30 secs)	30	30	30	30

Measurement period is January through December 2025.



	Medicaid	Marketplace	Medicare	MMP
2023	0.08%	0.1%	0.19%	-
2024	0.50%	0.43%	0.51%	-
2025	0.65%	0.47%	0.61%	-
Goal (≤ 5%)	5%	5%	5%	5%

Measurement period is January through December 2025.

a. Analysis

The California Provider Telephone Access Standards (TAS) results demonstrate consistently strong call center performance across Medicaid, Marketplace, and Medicare lines, with all service metrics

meeting or exceeding established benchmarks, though some trends suggest increasing call demand over time. Service levels improved significantly from 2022 to 2023, rising from approximately 79–81% to above 96% across all lines, and while there were slight declines in 2024 and 2025, performance remained above the ≥85% goal, with 2025 service levels at 88.9% for Medicaid, 93.6% for Marketplace, and 97.0% for Medicare. In terms of average speed to answer, wait times increased gradually over the three-year period—from 7–9 seconds in 2023 to 14 seconds in 2024 and 19–24 seconds in 2025—but remained well below the ≤30-second performance target, indicating acceptable response times despite higher call volumes or operational pressures. Abandonment rates remained extremely low across all lines, ranging from 0.08% to 0.65% between 2023 and 2025, far outperforming the ≤5% benchmark and demonstrating strong call management and provider access support. Overall, the comparison across these metrics indicates that Molina Healthcare maintains high-performing provider telephone access services across its California lines of business, though the gradual increase in speed-to-answer times suggests an opportunity to monitor call volumes and staffing levels to sustain service quality as demand grows.

IX. Conclusion

The 2025 Provider Satisfaction Survey results indicate that provider experience with Molina Healthcare of California varies across provider groups and operational domains, with IPA providers generally reporting more stable satisfaction compared to Direct providers. While Molina continues to maintain strong operational performance in areas such as provider call center accessibility and telephone access standards, broader provider satisfaction measures remain below industry benchmarks and competing health plans. In particular, overall satisfaction among Direct providers declined to 60.1% in 2025, and Molina ranked 6th among six evaluated health plans, reflecting a decline from the gains observed in 2024. Similarly, the comparative rating among Direct providers decreased to 27.6%, further widening the gap between Molina and the Press Ganey Book of Business benchmark of 39.5%. IPA providers reported slightly stronger satisfaction levels, though overall satisfaction also declined modestly to 69.0% in 2025, indicating that while the IPA network performs better relative to Direct providers, opportunities for improvement remain across both provider networks.

Several operational domains emerged as key drivers influencing overall provider satisfaction. The most significant drivers include Utilization and Quality Management processes, network coordination and access to care, pharmacy support services, and provider administrative interactions. Declines in summary rates related to authorization procedures, timeliness of approvals, and access to care managers suggest that administrative complexity and care coordination challenges continue to impact provider perceptions of the health plan. Accessibility measures also indicate declining satisfaction among Direct providers in 2025, particularly related to specialty care access, referral processes, and diagnostic services, while IPA providers maintained relatively stable performance across these domains. Additionally, moderate satisfaction with interpreter services and declining perceptions of interpreter competency highlight opportunities to strengthen culturally and linguistically appropriate services for California's diverse member population. Despite these challenges, operational strengths remain evident in telephone access standards, where Molina exceeded regulatory performance thresholds for service level, speed to answer, and abandonment rates across all lines of business, demonstrating effective call center operations and provider support infrastructure.

X. Interventions/Key Drivers

Based on the findings, several key drivers of provider satisfaction have been identified that can inform targeted improvement strategies:

1. Utilization Management and Authorization Processes
Providers reported lower satisfaction with authorization procedures, timeliness of approvals, and

access to utilization management staff.
Recommended interventions:

- Implement streamlined prior authorization workflows and expand electronic authorization tools within provider portals.
- Increase transparency by providing real-time authorization status tracking and clearer clinical guidelines.
- Expand provider education and communication regarding authorization requirements and updates.

2. Care Coordination and Access to Case Management
Lower satisfaction scores related to access to care managers and coordination of care indicate opportunities to improve collaboration between providers and the health plan.
Recommended interventions:

- Expand care management outreach and improve provider access to care coordination teams.
- Implement dedicated provider escalation pathways for complex patient cases.
- Enhance communication between Molina care managers and provider offices through integrated digital platforms.

3. Provider Administrative Experience and Support Services
Administrative interactions—including provider relations, billing, and pharmacy support—continue to influence provider perceptions.
Recommended interventions:

- Enhance provider relations engagement through proactive outreach and regional provider forums.
- Improve provider portal functionality to simplify administrative tasks such as claims tracking, eligibility verification, and pharmacy benefit inquiries.
- Develop targeted training resources and quick reference guides to support provider offices.

4. Interpreter Services and Cultural Competency
Moderate satisfaction levels related to interpreter coordination and training highlight the importance of strengthening linguistic support services.
Recommended interventions:

- Expand interpreter vendor partnerships to increase availability and reduce scheduling delays.
- Implement standardized interpreter training and competency verification programs.
- Increase awareness among providers of available interpreter resources and scheduling processes.

5. Provider Engagement and Survey Participation
Survey response rates declined significantly in 2025, particularly among specialists and IPA providers, limiting provider representation in feedback data.
Recommended interventions:

- Increase provider outreach and engagement through targeted communication campaigns.

- Expand digital survey channels and mobile-friendly survey options to improve accessibility.
- Consider incentive strategies or simplified survey formats to encourage participation.

Overall Strategic Opportunity

Improving provider satisfaction will require a coordinated strategy that focuses on administrative simplification, enhanced care coordination, improved communication, and stronger provider engagement. While Molina demonstrates strong operational infrastructure in areas such as call center performance, targeted improvements in utilization management, provider support services, and access to care processes will be critical to strengthening provider relationships and improving Molina's competitive standing among California health plans. Continued monitoring of provider experience metrics, combined with proactive engagement and operational improvements, will support Molina's goal of delivering a provider-centered and high-performing healthcare network that ultimately improves member outcomes and access to quality care.

Appendix 8

2025 Assessment of Network Adequacy: Availability of Practitioners for California

Based on 2025 data with trend analysis from 2023-2024

February 26, 2026

Introduction

Molina Healthcare of California (Molina) conducts an annual availability assessment against established standards for numbers and geographic distribution for its Medicaid line of business to ensure it maintains an adequate network of practitioners who provide primary care services (Defined as: general and family practitioners, internal medicine, pediatrics); specialists (Defined as: Obstetrician/Gynecologists, Hematology/Oncology); and Behavioral Health practitioners (Defined as: Psychiatrists and Psychologists) per corporate Policy MHI-QUAL-021 "Availability of Health Care". Performance is evaluated based on the ratio of members to practitioners and the geographic distribution of providers. These standards are outlined in Molina's Network Adequacy Policies and Procedures which define the minimum requirements for the numeric and geographic distribution of Molina network composition. These Policies and Procedures are updated, reviewed, and approved as needed and minimally on an annual basis by the National Quality Improvement and Health Equity Transformation Committee (NQIHETC).

Methodology

Continuous monitoring provides the Health Plan with information to assess how effectively Molina meets established standards defined for each practitioner type. This report is compiled annually and evaluates the network for the number and geographic distribution of its practitioners using the following data sources:

QNXT: QNXT is the main repository for all records related to members, practitioners, claims, authorizations and call tracking. Membership data is generated at a given point in time using the member ID, physical address and zip code fields. Practitioner data is also pulled from QNXT at the same data point in time using the practitioner ID, practitioner type, practitioner specialty, practitioner name and physical location(s). For practitioners that are associated with multiple locations, all locations are considered in the analysis.

GeoAccess Report: The report that provides the number of practitioners, geographic location, and distance of members to available practitioners. The GeoAccess report includes all locations where members can receive care and calculates how many miles away each practitioner office is from the zip code of members' residences.

Practitioner to Member Ratios: Data generated in the GeoAccess report is used to determine the practitioner-to-member ratio. The numeric sufficiency of Internal Medicine, Family/General Practice, Pediatric, OB/GYN, Hematologists/Oncologists, Psychiatrists and Psychologists was determined by calculating the practitioners to members' ratio and then comparing this result to the standard.

Practitioner to Member Geographic Distribution: Measurement distance is determined by estimated driving distance in GeoAccess. GeoNetworks uses a proprietary algorithm for estimating distance between two locations. Each U.S. Zip Code has been assigned a classification that represents the average population density of both the individual Zip Code and the Zip Code that surround it within a three-mile radius. The classifications are:

- Urban - a Zip Code for which the population density is greater than 3,000 persons per square mile.
- Suburban - a ZIP Code for which the population density is between 1,000 and 3,000 persons per square mile.
- Rural - a ZIP Code for which the population density is less than 1,000 persons per square mile.

Practitioners providing Primary Care: Molina defines practitioners providing Primary Care as general and family medicine, internal medicine, and pediatric practitioners.

High-Volume and High-Impact Specialties: Molina defines high-volume participating specialist practitioners as those providing care in Obstetrics/Gynecology. High-impact specialists are defined as practitioners who treat specific conditions that have serious consequences for the member and require significant resources. Molina has identified Oncology/Hematology to be a high impact specialty for Molina members in accordance with Policy MHI-QUAL-021 "Availability of Health Care" and based on geo-access analyses. The minimum provider types were selected for this analysis to standardize data analysis and reporting across all Molina Medicaid and Marketplace Plans.

High-Volume Behavioral Health Practitioners: Molina defines high-volume practitioners providing Behavioral Healthcare as Psychiatrists and Psychologists in accordance with Policy MHI-QUAL-021 "Availability of Health Care" and based on geo-access analyses.

Measurement period: Data for this analysis was compiled in CY 2025 as an assessment of CY 2025.

Practitioners Providing Primary Care

Molina assessed the adequacy of its Primary Care network based on the needs of its member population to maintain the appropriate structure and resources are in place to ensure an appropriate ratio of Primary Care practitioners to members as well as an adequate geographic distribution of Primary Care practitioners. Details are summarized in the tables below by practitioner type. members

Ratio of Primary Care practitioners-to-members: Molina has established the following ratio of practitioner-to-members based on the following parameters:

- Number of practitioners: The number of unique primary care practitioners by practice type
- Number of members: All enrolled members at the time the data was analyzed
- Goal: Each primary care practitioner type will maintain a practitioner-to-member ratio goal of at least 1:2,000.

Table 1.1.1: Ratio of Primary Care practitioners to members (Medicaid)

Medicaid Primary Care Specialty	Number of Practitioners		Ratio		Goal	Goal Met?	
Calendar Year	Urban	Rural	Urban	Rural	1 provider per 2,000 members	Urban	Rural
Fam Med/Gen Prac							
2025	8,860	947	1:22	1:3	1:2,000	Yes	Yes
2024	17,803	10,735	1:62	2:1	1:2,000	Yes	Yes
2023	16,843	9,653	1:71	1:1	1:2,000	Yes	Yes
Internal Med							
2025	9,740	1,158	1:20	1:3	1:2,000	Yes	Yes
2024	21,180	13,099	1:52	2:1	1:2,000	Yes	Yes
2023	19,554	11,838	1:61	1:1	1:2,000	Yes	Yes
Pediatrics							
2025	4,248	282	1:52	1:1	1:2,000	Yes	Yes
2024	7,854	5,711	1:140	1:1	1:2,000	Yes	Yes
2023	7,533	5,324	1:158	1:2	1:2,000	Yes	Yes

*This table reflects 2025 data for all LOBs combined.

Table 1.1.2: Ratio of Primary Care practitioners to members (Marketplace)

Marketplace Primary Care Specialty	Number of Practitioners		Ratio		Goal	Goal Met?	
Calendar Year	Urban	Rural	Urban	Rural	1 provider per 2,000 members	Urban	Rural
Fam Med/Gen Prac							
2025	8,860	947	1:3	7:1	1:2,000	Yes	Yes
2024	11,358	10,068	1:6	7:1	1:2,000	Yes	Yes
2023	11,116	9,320	1:5	8:1	1:2,000	Yes	Yes
Internal Med							
2025	9,740	1,158	1:3	8:1	1:2,000	Yes	Yes
2024	13,887	12,453	1:5	9:1	1:2,000	Yes	Yes
2023	13,881	11,460	1:4	10:1	1:2,000	Yes	Yes
Pediatrics							
2025	4,248	282	1:9	1:4	1:2,000	Yes	Yes
2024	6,071	5,521	1:11	4:1	1:2,000	Yes	Yes
2023	6,007	5,227	1:9	5:1	1:2,000	Yes	Yes

*This table reflects 2025 data for all LOBs combined.

Table 1.1.3: Ratio of Primary Care practitioners to members (Medicare)

Medicare Primary Care Specialty	Number of Practitioners		Ratio		Goal	Goal Met?	
Calendar Year	Urban	Rural	Urban	Rural	1 provider per 2,000 members	Urban	Rural
Fam Med/Gen Prac							
2025	8,860	947	1:4	1:5	1:2,000	Yes	Yes
2024	11,385	10,146	1:9	3:1	1:2,000	Yes	Yes
2023	10,587	9,185	1:2	16:1	1:2,000	Yes	Yes
Internal Med							
2025	9,740	1,158	1:4	1:5	1:2,000	Yes	Yes
2024	13,906	12,524	1:7	3:1	1:2,000	Yes	Yes
2023	12,910	11,313	1:2	19:1	1:2,000	Yes	Yes

*This table reflects 2025 data for all LOBs combined.

Geographic distribution of Primary Care practitioners: Molina has established standards for the distribution of practitioner-to-members based on the following parameters:

- One (1) practitioner within
  - Twenty (20) miles in urban counties
  - Thirty (30) miles in rural counties
    - Goal: 90% of members have access to at least one (1) Primary Care practitioner within 20 miles for those residing in urban counties and 30 miles for those residing in rural counties

Table 1.2.1: Geographic distribution of Primary Care practitioners (Medicaid)

Medicaid Primary Care Specialty Calendar Year	Percentage of members with access to a practitioner within 20 miles (Urban)	Goal	Goal Met?	Percentage of members with access to a practitioner within 30 miles (Rural)	Goal	Goal Met?
Family Med/Gen Prac						
2025	57.02%	90%	No	66.54%	90%	No
2024	91.51%	90%	Yes	83.41%	90%	No
2023	97.47%	90%	Yes	86.63%	90%	No
Internal Med						
2025	56.63%	90%	No	66.42%	90%	No
2024	89.56%	90%	No	83.23%	90%	No
2023	96.80%	90%	Yes	86.04%	90%	No
Pediatrics						
2025	61.48%	90%	No	68.70%	90%	No
2024	90.92%	90%	Yes	85.94%	90%	No
2023	97.93%	90%	Yes	87.87%	90%	No

Table 1.2.2: Ratio of Primary Care practitioners to members (Marketplace)

Marketplace Primary Care Specialty Calendar Year	Percentage of members with access to a practitioner within 20 miles (Urban)	Goal	Goal Met?	Percentage of members with access to a practitioner within 30 miles (Rural)	Goal	Goal Met?
Family Med/Gen Prac						
2025	56.62%	90%	No	63.83%	90%	No
2024	75.36%	90%	No	69.00%	90%	No
2023	67.01%	90%	No	69.36%	90%	No
Internal Med						
2025	54.96%	90%	No	62.51%	90%	No
2024	75.71%	90%	No	69.24%	90%	No
2023	65.46%	90%	No	69.65%	90%	No
Pediatrics						
2025	59.25%	90%	No	62.33%	90%	No
2024	79.41%	90%	No	69.81%	90%	No
2023	68.95%	90%	No	70.31%	90%	No

Table 1.2.3: Geographic distribution of Primary Care practitioners (Medicare)

Medicare Primary Care Specialty Calendar Year	Percentage of members with access to a practitioner within 20 miles (Urban)	Goal	Goal Met?	Percentage of members with access to a practitioner within 30 miles (Rural)	Goal	Goal Met?
Family Med/Gen Prac						
2025	57.98%	90%	No	67.29%	90%	No
2024	80.66%	90%	No	87.55%	90%	No
2023	78.26%	90%	No	72.67%	90%	No
Internal Med						
2025	56.82%	90%	No	65.73%	90%	No
2024	78.00%	90%	No	85.54%	90%	No
2023	76.06%	90%	No	72.45%	90%	No

For Medicaid, Primary Care practitioner-to-member ratios remained well above the 1:2,000 standard across all specialties. In 2025, Family Medicine/General Practice ratios were 1:22 urban and 1:3 rural, while Internal Medicine reported 1:20 urban and 1:3 rural. Pediatrics also exceeded standards with 1:52 urban and 1:1 rural. These results confirm adequate provider capacity across the Medicaid network. However, geographic distribution results highlight persistent access gaps. While Family Medicine/General Practice and Pediatrics did not exceed the 90 percent standard in urban areas, rural access also fell short at 66.54 percent and 68.70 percent, respectively. Internal Medicine was below goal in both urban (56.63 percent) and rural (66.42 percent) areas. This indicates that, although supply is adequate, uneven provider distribution limits access for certain members.

Marketplace ratios were consistently strong and exceeded the 1:2,000 requirement across all specialties. In 2025, Family Medicine/General Practice reported ratios of 1:3 urban and 7:1 rural, Internal Medicine was 1:3 urban and 8:1 rural, and Pediatrics was 1:9 urban and 1:4 rural, all demonstrating more than adequate capacity. Despite this, geographic distribution analysis revealed significant challenges. Family Medicine/General Practice access in 2025 was 56.62 percent urban and 63.83 percent rural, well below the 90 percent standard. Internal Medicine results mirrored this pattern at 54.96 percent urban and 62.51 percent rural, and Pediatrics followed with 59.25 percent urban and 62.33 percent rural. These results indicate that Marketplace members face geographic barriers to accessing Primary Care despite ample provider supply.

Medicare ratios also confirmed adequate provider supply, with Family Medicine/General Practice at 1:4 urban and 1:5 rural and Internal Medicine at 1:4 urban and 1:5 rural in 2025. Ratios across both specialties consistently exceeded the required standard from 2023 through 2025. Geographic distribution, however, reflects persistent shortfalls. Family Medicine/General Practice reached 57.98 percent in urban areas and 67.29 percent in rural areas, below the 90 percent standard. Internal Medicine was further below, with 56.82 percent urban and 65.73 percent rural. These trends have remained consistent over the three-year period, signaling ongoing challenges in distributing Medicare Primary Care providers equitably across counties.

In summary, Molina's Primary Care practitioner-to-member ratios across Medicaid, Marketplace, and Medicare confirm that there is more than adequate supply to meet member demand. However, geographic distribution remains the critical barrier to access, for Medicaid, Marketplace and Medicare where both urban and rural measures fell well below the 90 percent standard. Targeted recruitment in underserved counties, expanded contracting with smaller practices, validation of provider location data, and increased use of telehealth will be necessary to address these deficiencies and ensure that members have timely, equitable access to Primary Care services across all lines of business.

Molina has executed a provider contracting strategy with an emphasis on Primary Care practitioners to create a robust network for the members we serve. The Health Plan conducts network adequacy analyses on a quarterly basis for ongoing monitoring, as well as an annual basis when there are changes to the network due to termed contracts. Those reports, and any accompanying findings or feedback, are discussed annually at the National Quality Improvement Committee. Action plans are developed, when necessary, to address any Primary Care network changes that could negatively impact member access to care. This continuous monitoring helps Molina remain apprised of the network's geographic makeup and implement any adjustments needed to maintain access. These results were reviewed, and root cause analyses were conducted during the Quality Improvement Committee meetings, serving as the conduit for improvement and scrutiny of the data. This meeting includes senior health plan leadership and ensures that goals are discussed and interventions specific to results are instituted.

Opportunities for Improvement

To help mitigate this issue, Molina Healthcare of California has discussed and prioritized the following action on the issues identified and discussed above:

Practitioner Type	Goal Not Met	Key Driver/s	Opportunities for Improvement
Family Medicine/ General Practice (Medicaid)	Geographic access fell below 90% Urban (57.02%) Rural (66.54%)	Urban counties not meeting goal: **Alameda, Napa, Monterey, Orange, and Madera** Rural counties not meeting goal: **Calaveras, Nevada, Tehama, Glenn, and Mariposa** Key drivers include provider shortages in rural Northern and Central California counties, clustering of contracted providers in large metro areas, limited participation of independent practices in Medicaid, and uneven distribution of family medicine/general practice providers. Population growth in counties like Alameda is also outpacing recruitment efforts.	Target recruitment and contracting in Alameda, Napa, Monterey, Orange, Madera, Calaveras, Nevada, Tehama, Glenn, and Mariposa counties. Expand partnerships with Federally Qualified Health Centers and rural health clinics to improve access. Expand telehealth and mobile clinic access to mitigate shortages in geographically dispersed rural areas. Collaborate with local hospitals and health systems in underserved counties to bolster pediatric coverage.
Internal Medicine (Medicaid)	Geographic access fell below 90% Urban (56.63%) Rural (66.42%)	Urban counties not meeting goal: **Monterey, Kern, Orange, Riverside, and Ventura** Rural counties not meeting goal: **Calaveras, Glenn, Nevada, Mariposa, and Tehama** Key drivers include shortages of internal medicine providers in smaller rural counties, clustering of providers in large metro areas, limited contracting with independent internal medicine practices, and uneven network expansion in growing counties such as Monterey and Orange.	Target recruitment and contracting of internal medicine providers in Monterey, Kern, Orange, Riverside, Ventura, Calaveras, Glenn, Nevada, Mariposa, and Tehama counties. Strengthen partnerships with local hospitals and health systems in underserved rural and mid-size counties. Expand contracting with Federally Qualified Health Centers and rural health clinics to increase access. Enhance tele-internal medicine services to address immediate shortages in rural and geographically dispersed areas.
Pediatrics (Medicaid)	Geographic access fell below 90% Urban (61.48%) Rural (68.70%)	Urban counties not meeting goal: **Santa Barbara, Santa Cruz, Kings, Kern, and San Diego** Rural counties not meeting goal: **Nevada, Glenn, Tehama, Mariposa, and Calaveras** Key drivers include shortages of pediatric practitioners in rural and agricultural regions (Nevada, Glenn, Tehama), concentration of providers in urban/suburban areas, limited Medicaid	Target recruitment and contracting in Santa Barbara, Santa Cruz, Kings, Kern, San Diego, Nevada, Glenn, Tehama, Mariposa, and Calaveras counties. Expand partnerships with Federally Qualified Health Centers and county clinics to strengthen pediatric access in rural regions. Expand tele-pediatrics and mobile pediatric clinics to improve access in geographically isolated areas.

		participation by independent pediatric practices in smaller counties (Santa Barbara, Santa Cruz, Kings), and growing pediatric population needs outpacing recruitment in high-growth counties.	Collaborate with local hospitals and health systems in underserved counties to bolster pediatric coverage.
Family Medicine / General Practice (Marketplace)	Geographic access fell below 90% Urban (56.62%) Rural (63.83%)	Urban counties not meeting goal: **Ventura, Orange, Kern, Imperial, and San Diego** Rural counties not meeting goal: **Mariposa, Contra Costa, and Butte** Key drivers include shortages of contracted family medicine providers in rural and agricultural regions, clustering of providers in urban cores, limited participation of independent practices in Marketplace networks, and rapid population growth in counties such as Imperial and Ventura outpacing provider recruitment.	Target recruitment and contracting of family medicine providers in Ventura, Orange, Kern, Imperial, San Diego, Mariposa, Contra Costa, and Butte counties. Strengthen partnerships with Federally Qualified Health Centers and rural health clinics in underserved areas. Offer recruitment and retention incentives (loan repayment, stipends, rural relocation support) for Marketplace family medicine providers. Expand telehealth and mobile clinic services to mitigate shortages in geographically dispersed counties. Collaborate with local health systems and physician groups to expand provider participation in Marketplace networks.
Internal Medicine (Marketplace)	Geographic access fell below 90% Urban (54.96%) Rural (62.51%)	Urban counties not meeting goal: **Sonoma, Napa, Santa Barbara, Merced, and Placer** Rural counties not meeting goal: **Mariposa, Contra Costa, and Butte** Key drivers include shortages of contracted internal medicine providers in rural and agricultural counties, uneven distribution of providers with clustering in large metro areas, limited Marketplace participation among independent practices, and population growth in counties such as Merced and Napa outpacing provider recruitment.	Target recruitment and contracting of internal medicine providers in Sonoma, Napa Santa Barbara, Merced, Placer, Mariposa, Contra Costa, and Butte counties. Strengthen partnerships with local hospitals and health systems in underserved counties to extend internal medicine coverage. Expand contracting with Federally Qualified Health Centers and rural health clinics to increase rural access. Implement rural recruitment/retention incentives (loan repayment, stipends, relocation support). Enhance tele-internal medicine services to address immediate access gaps in rural and geographically dispersed areas.
Pediatrics (Marketplace)	Geographic access fell below 90%	Urban counties not meeting goal: **Placer, Santa Barbara, Napa, Riverside, and San Diego**	Target recruitment and contracting of pediatric providers in Placer, Santa Barbara,

	Urban (59.25%) Rural (62.33%)	Rural counties not meeting goal: **Mariposa, Contra Costa, and Butte** Key drivers include shortages of pediatric providers in rural and border counties (Contra Costa, Butte), uneven geographic distribution with clustering in metro regions (San Diego, Santa Barbara), limited Marketplace participation by smaller independent pediatric practices, and growing pediatric population needs in suburban and agricultural counties (e.g., Riverside, Napa) outpacing recruitment.	Napa, Kern, San Diego, Mariposa, Contra Costa, and Butte counties. Develop partnerships with Federally Qualified Health Centers and county clinics to strengthen pediatric access in underserved rural and suburban counties. Expand tele-pediatrics and mobile pediatric clinics to improve access in geographically dispersed and border counties. Collaborate with local hospitals and health systems to expand pediatric capacity in high-growth regions.
Family Medicine / General Practice (Medicare)	Geographic access fell below 90% Urban (57.98%) Rural (67.29%)	Urban counties not meeting goal: **Sonoma, Napa, Santa Barbara, Imperial, and San Diego** Rural counties not meeting goal: **Tuolumne, Tehama, and Mariposa** Key drivers include shortages of family medicine providers in smaller rural and agricultural counties (Tehama, Mariposa), clustering of contracted providers in large metro regions, and limited Medicare participation among independent practices in semi-rural counties (Tuolumne). Napa and Sonoma face provider shortages exacerbated by high cost of living and provider outmigration.	Target recruitment and contracting of family medicine providers in Sonoma, Napa, Santa Barbara, Imperial, San Diego, Tuolumne, Tehama, and Mariposa counties. Expand partnerships with Federally Qualified Health Centers, rural health clinics, and local hospitals in underserved counties. Enhance telehealth and mobile clinic services to address provider shortages in geographically dispersed counties. Collaborate with physician groups and medical associations to expand Medicare-contracted provider networks in rural and semi-rural counties.
Internal Medicine (Medicare)	Geographic access fell below 90% Urban (56.82%) Rural (65.73%)	Urban counties not meeting goal: **Sonoma, Napa, Monterey, Riverside, and Santa Barbara** Rural counties not meeting goal: **Tuolumne, Calaveras, and Tehama** Key drivers include shortages of internal medicine providers in rural and agricultural counties (Calaveras, Tehama), concentration of providers in larger metro areas, limited Medicare participation by independent internal medicine practices, and provider recruitment challenges in semi-rural counties (Tuolumne) where cost of living and practice sustainability limit availability.	Target recruitment and contracting of internal medicine providers in Sonoma, Napa, Monterey, Riverside, Santa Barbara, Tuolumne, Calaveras, and Tehama counties. Strengthen partnerships with local hospitals and health systems in underserved counties. Expand contracting with Federally Qualified Health Centers and rural health clinics to increase rural access. Enhance tele-internal medicine services to improve access in geographically dispersed counties.

High-Volume & High-Impact Specialty Practitioners

Molina assessed the adequacy of its high-volume (i.e., Ob/Gyn) and high-impact (i.e., Hematology/Oncology) network practitioners based on the needs of its member population to ensure the appropriate structure and resources are in place to maintain an appropriate ratio of these specialty practitioners-to-members as well as an adequate geographic distribution of specialty practitioners. Details are summarized in the tables below by practitioner type.

Ratio of specialty care practitioners-to-members: Molina has established the following ratio of practitioner-to-members based on the following parameters:

- Number of practitioners: The number of unique specialty care practitioners by practice type
- Number of members: All enrolled members at the time the data was analyzed
- Goal: Each specialty care practitioner type will maintain a practitioner-to-member ratio of at least 1:2,000.

Tables 2.1.1: Ratio of High Volume & High Impact practitioners to members (Medicaid)

Medicaid High-Volume Specialty: OB/Gyn	Number of Practitioners		Ratio		Goal	Goal Met?	
Calendar Year	Urban	Rural	Urban	Rural	1 provider per 2,000 members	Urban	Rural
2025	3,297	2,563	1:66	1:1	1:2,000	Yes	Yes
2024	3,883	3,418	1:284	1:2	1:2,000	Yes	Yes
2023	3,542	3,022	1:336	1:3	1:2,000	Yes	Yes

Medicaid High-Impact Specialty: Hematology/Oncology	Number of Practitioners		Ratio		Goal	Goal Met?	
Calendar Year	Urban	Rural	Urban	Rural	1 provider per 2,000 members	Urban	Rural
2025	1,644	1,291	1:136	1:2	1:2,000	Yes	Yes
2024	2,032	1,819	1:542	1:4	1:2,000	Yes	Yes
2023	1,867	1,666	1:638	1:5	1:2,000	Yes	Yes

*This table reflects 2025 data for all LOBs combined.

Tables 2.1.2: Ratio of High Volume & High Impact practitioners to members (Marketplace)

Marketplace High-Volume Specialty: OB/Gyn	Number of Practitioners		Ratio		Goal	Goal Met?	
Calendar Year	Urban	Rural	Urban	Rural	1 provider per 2,000 members	Urban	Rural
2025	3,297	2,563	1:11	1:2	1:2,000	Yes	Yes
2024	3,592	3,213	1:18	2:1	1:2,000	Yes	Yes
2023	3,674	2,990	1:14	3:1	1:2,000	Yes	Yes

Marketplace High-Impact Specialty: Hematology/Oncology	Number of Practitioners		Ratio		Goal	Goal Met?	
Calendar Year	Urban	Rural	Urban	Rural	1 provider per 2,000 members	Urban	Rural
2025	1,644	1,291	1:22	1:1	1:2,000	Yes	Yes
2024	1,868	1,760	1:35	1:1	1:2,000	Yes	Yes
2023	1,865	1,659	1:28	1:1	1:2,000	Yes	Yes

*This table reflects 2025 data for all LOBs combined.

Tables 2.1.3: Ratio of High Volume & High Impact practitioners to members (Medicare)

Medicare High-Volume Specialty: OB/Gyn	Number of Practitioners		Ratio		Goal	Goal Met?	
Calendar Year	Urban	Rural	Urban	Rural	1 provider per 2,000 members	Urban	Rural
2025	3,297	2,563	1:13	1:2	1:2,000	Yes	Yes
2024	3,631	3,221	1:28	1:1	1:2,000	Yes	Yes
2023	3,363	2,964	1:6	5:1	1:2,000	Yes	Yes

Medicare High-Impact Specialty: Hematology/Oncology	Number of Practitioners		Ratio		Goal	Goal Met?	
Calendar Year	Urban	Rural	Urban	Rural	1 provider per 2,000 members	Urban	Rural
2025	1,644	1,291	1:25	1:1	1:2,000	Yes	Yes
2024	1,868	1,762	1:55	1:2	1:2,000	Yes	Yes
2023	1,768	1,659	1:12	3:1	1:2,000	Yes	Yes

*This table reflects 2025 data for all LOBs combined.

Geographic distribution of specialty care practitioners: Molina has established standards for the distribution of practitioner-to-members based on the following parameters:

- One (1) practitioner within
  - Thirty (30) miles in urban counties
  - Fifty (50) miles in rural counties
    - Goal: 80% of members have access to at least one (1) specialty care practitioner within 30 miles for those residing in urban counties and 50 miles for those residing in rural counties

Table 2.2.1: Geographic distribution of High Volume & High Impact practitioners (Medicaid)

Medicaid High-Volume Specialty: OB/Gyn	Percentage of members with access to a practitioner within 30 miles (Urban)	Goal	Goal Met?	Percentage of members with access to a practitioner within 50 miles (Rural)	Goal	Goal Met?
2025	74.52%	80%	No	100.00%	80%	Yes
2024	96.52%	80%	Yes	100.00%	80%	Yes
2023	97.83%	80%	Yes	100.00%	80%	Yes

Medicaid High-Impact Specialty: Hematology/Oncology	Percentage of members with access to a practitioner within 30 miles (Urban)	Goal	Goal Met?	Percentage of members with access to a practitioner within 50 miles (Rural)	Goal	Goal Met?
2025	75.12%	80%	No	100.00%	80%	Yes
2024	98.43%	80%	Yes	100.00%	80%	Yes
2023	99.63%	80%	Yes	100.00%	80%	Yes

Table 2.2.2: Geographic distribution of High Volume & High Impact practitioners (Marketplace)

Marketplace High-Volume Specialty: OB/Gyn	Percentage of members with access to a practitioner within 30 miles (Urban)	Goal	Goal Met?	Percentage of members with access to a practitioner within 50 miles (Rural)	Goal	Goal Met?
2025	71.59%	80%	No	100.00%	80%	Yes
2024	87.17%	80%	Yes	100.00%	80%	Yes
2023	77.03%	80%	No	100.00%	80%	Yes

Marketplace High-Impact Specialty: Hematology/Oncology	Percentage of members with access to a practitioner within 30 miles (Urban)	Goal	Goal Met?	Percentage of members with access to a practitioner within 50 miles (Rural)	Goal	Goal Met?
2025	75.25%	80%	No	100.00%	80%	Yes
2024	90.90%	80%	Yes	100.00%	80%	Yes
2023	77.03%	80%	No	100.00%	80%	Yes

Table 2.2.3: Geographic distribution of High Volume & High Impact practitioners (Medicare)

Medicare High-Volume Specialty: OB/Gyn	Percentage of members with access to a practitioner within 30 miles (Urban)	Goal	Goal Met?	Percentage of members with access to a practitioner within 50 miles (Rural)	Goal	Goal Met?
2025	72.85%	80%	No	100.00%	80%	Yes
2024	89.31%	80%	Yes	100.00%	80%	Yes
2023	90.51%	80%	Yes	100.00%	80%	Yes

Medicare High-Impact Specialty: Hematology/Oncology	Percentage of members with access to a practitioner within 30 miles (Urban)	Goal	Goal Met?	Percentage of members with access to a practitioner within 50 miles (Rural)	Goal	Goal Met?
2025	75.11%	80%	No	100.00%	80%	Yes
2024	86.35%	80%	Yes	100.00%	80%	Yes
2023	93.72%	80%	Yes	100.00%	80%	Yes

For Medicaid, ratios for high-volume and high-impact specialties consistently exceeded the 1:2,000 practitioner-to-member standard from 2023 through 2025. In 2025, OB/GYN reported ratios of 1:66 in urban areas and 1:1 in rural areas, and hematology/oncology reported 1:136 in urban areas and 1:2 in rural areas. These results confirm adequate supply across both specialties. Geographic distribution was unequally strong. OB/GYN access reached 74.52 percent in urban areas and 100 percent in rural areas, and hematology/oncology reached 75.12 percent urban and 100 percent rural. Both specialties did not meet the 80 percent goal within the last year, demonstrating inconsistent adequacy and instability in network access for Medicaid members.

Marketplace ratios remained far above the 1:2,000 standard across all three years. In 2025, OB/GYN achieved ratios of 1:11 urban and 1:2 rural, while hematology/oncology reported 1:22 urban and 1:1 rural. These ratios indicate a strong supply of high-volume and high-impact specialists within the Marketplace network. Geographic distribution, however, shows some variability over time. OB/GYN access exceeded the 80 percent threshold in 2024 (87.17 percent urban) but fell short in 2025 to 71.59 percent urban with 100 percent for rural access. Hematology/Oncology reflected the same trend, with 90.90 percent urban access in 2024 before declining to 75.25 percent in 2025, with rural access consistently at 100 percent. These results indicate that Marketplace specialty care networks are sufficient, though sustained efforts are needed to maintain consistent urban access above goal.

Medicare ratios also exceeded standards across all specialties. In 2025, OB/GYN reported ratios of 1:13 urban and 1:2 rural, while hematology/oncology achieved 1:25 urban and 1:1 rural. Both results demonstrate ample provider supply to meet members' needs. Geographic distribution results were generally strong but reflect small urban access gaps in prior years. OB/GYN access was 72.85 percent in urban areas and 100 percent in rural areas in 2025, below 90 and 80 percent standards. Hematology/oncology access did not achieve 75.11 percent urban and 100 percent rural in 2025, showing a declining shift in 2023 (93.72 percent). These results confirm that Medicare specialty networks are insufficient within some urban distribution, in which gaps remain.

Overall, Molina's high-volume and high-impact specialties demonstrate consistently adequate provider-to-member ratios across Medicaid, Marketplace, and Medicare. Geographic distribution goals were not met in most cases, with the notable deficiencies occurring in Medicaid, Marketplace and Medicare urban access in the current year. Observed variations between 2024 and 2025 in Medicaid, Marketplace, and Medicare OB/GYN and Hematology/Oncology suggest that current contracting and provider engagement strategies have not achieved their intended impact. Continued monitoring and recruitment in high-demand urban areas will ensure stable access and prevent reemergence of gaps.

Opportunities for Improvement

To help mitigate this issue, Molina Healthcare of California has discussed and prioritized the following action on the issues identified and discussed above:

Practitioner Type	Goal Not Met	Key Driver/s	Opportunities for Improvement
High-Volume OB/GYN (Medicaid)	Geographic access fell below 80% Urban (74.52%)	Urban counties not meeting goal: **Kern, Imperial, Napa, Sonoma, and Monterey** Key drivers of these issues include the geographic maldistribution of OB/Gyn providers, with a concentration in larger metropolitan areas, and limited Medicaid participation among small independent practices, which leave urban counties underserved. Additionally, geographic barriers and low provider density in urban regions contribute to reduced access.	Target provider recruitment and contracting in Kern, Imperial, Napa, Sonoma, and Monterey counties. Identify expiring/terminated contracts affecting the five counties; implement bridge contracting or LOAs. Enhanced OB reimbursement adders for prenatal/new OB intakes in target counties. Increase access to Mobile women's health rotations into underserved urban tracts.
High-Impact Hematology/ Oncology (Medicaid)	Geographic access fell below 80% Urban (75.12%)	Urban counties not meeting goal: **Monterey, Kern, Merced, Kings, and Ventura** Key drivers include shortages of Medicaid-contracted hematology/oncology providers and persistent access deficits across counties tied to clustering of providers within large hospital systems, limited Medicaid participation by small practices, and increased member demand in urban areas. Additionally, geographic barriers and low provider density in urban regions contribute to reduced access.	Target recruitment and contracting of internal medicine providers in Monterey, Kern, Merced, Kings, and Ventura counties. Promoting tele-oncology services can help extend access for members who live in areas with limited physical oncology coverage. Collaborating with major oncology centers and hospital systems can help expand the number of specialists available to Medicaid members. Streamline Medicaid credentialing to help accelerate onboarding for newly contracted hematology/oncology specialists.
High-Volume OB/GYN (Marketplace)	Geographic access fell below 80% Urban (71.59%)	Urban counties not meeting goal: **Santa Barbara, Ventura, San Diego, Imperial, and Kern** Key drivers of these issues include the geographic maldistribution of OB/Gyn providers, with a concentration in larger metropolitan areas, and limited Marketplace participation among small independent practices, which leave urban counties underserved. Additionally, geographic barriers and low provider density in urban regions contribute to reduced access.	Target recruitment and contracting of internal medicine providers in Santa Barbara, Ventura, San Diego, Imperial, and Kern counties. Strengthen Contracting and Network Adequacy by expanding Marketplace participation with system-employed OB/GYN practices, which often restrict Marketplace panels. Improve provider data accuracy and remove inactive/duplicate NPIs and update sites that moved, closed, or consolidated.

			Encourage OB/GYN practices to add evening/weekend clinic hours to increase appointment availability.
High-Impact Hematology/ Oncology (Marketplace)	Geographic access fell below 80% Urban (75.25%)	Urban counties not meeting goal: **Contra Costa, Monterey, Santa Barbara, Ventura, and Merced** Key drivers include shortages of Marketplace-contracted hematology/oncology providers and persistent access deficits across counties tied to clustering of providers within large hospital systems, limited Medicaid participation by small practices, and increased member demand in urban areas. Additionally, geographic barriers and low provider density in urban regions contribute to reduced access.	Target recruitment and contracting of internal medicine providers in Contra Costa, Monterey, Santa Barbara, Ventura, and Merced counties. Promoting tele-oncology services to help extend access for members who live in areas with limited physical oncology coverage. Working with practices to streamline referral processes can make it easier for Marketplace patients to enter oncology care. Removing inactive, duplicate, or relocated providers help reduce inaccuracies that impact adequacy calculations.
High-Volume OB/GYN (Medicare)	Geographic access fell below 80% Urban (72.85%)	Urban counties not meeting goal: **Imperial, Orange, Santa Barbara, Monterey, and Ventura** Key drivers of these issues include the geographic maldistribution of OB/Gyn providers, with a concentration in larger metropolitan areas, and limited Medicare participation among small independent practices, which leave urban counties underserved. Additionally, geographic barriers and low provider density in urban regions contribute to reduced access.	Target recruitment and contracting of internal medicine providers in Imperial, Orange, Santa Barbara, Monterey, and Ventura counties. Strengthen Contracting and Network Expansion by prioritizing contracting with independent OB/GYNs who may be more flexible about accepting Medicare Advantage members. Expand clinical capacity for Medicare beneficiaries by providing incentives for practices to offer extended hours to absorb increased demand. Strengthen Partnerships with FQHCs, Community Clinics, and Health Systems by working with hospital systems to broaden Medicare Advantage panel acceptance among employed OB/GYNs.
High-Impact Hematology/ Oncology (Medicare)	Geographic access fell below 80% Urban (75.11%)	Urban counties not meeting goal: **Imperial, Kern, San Diego, Ventura, and Santa Barbara** Key drivers include shortages of Marketplace-contracted hematology/oncology providers and persistent access deficits across counties tied to clustering of providers within large	Target recruitment and contracting of internal medicine providers in Imperial, Kern, San Diego, Ventura, and Santa Barbara counties. Develop contracting incentives that can encourage hematology oncology specialists to open or expand their Medicare panels.

		hospital systems, limited Medicare participation by small practices, and increased member demand in urban areas. Additionally, geographic barriers and low provider density in urban regions contribute to reduced access.	Conduct a full roster-to-directory reconciliation that can ensure that all active hematology/oncology providers are reflected accurately in adequacy files. Encouraging participating practices to increase appointment availability can help reduce bottlenecks in counties experiencing higher oncology demand.

Practitioners Providing Behavioral Healthcare

Molina assessed the adequacy of its Behavioral Healthcare network practitioners based on the needs of its member population to ensure the appropriate structure and resources are in place to maintain an appropriate ratio of these practitioners-to-members, as well as an adequate geographic distribution of practitioners. Molina identifies Psychiatrists and Psychologists as high-volume BH practitioners in accordance with California's state contractual requirements and based on geo-access analyses. Details are summarized in the tables below by practitioner type.

Ratio of Behavioral Healthcare practitioners-to-members: Molina has established the following ratio of practitioner-to-members based on the following parameters:

- Number of practitioners: The number of unique behavioral healthcare practitioners by practice type (i.e., Psychiatrists and Psychologists)
- Number of members: All enrolled members at the time the data was analyzed
- Goal: Each behavioral healthcare practitioner type will meet an established practitioner-to-member ratio of at least 1:2,000.

Table 3.1.1: Ratio of Behavioral Healthcare practitioners to members (Medicaid)

Medicaid Behavioral Health Specialty	Number of Practitioners		Ratio		Goal	Goal Met?	
Calendar Year	Urban	Rural	Urban	Rural	1 provider per 2,000 members	Urban	Rural
Psychiatry							
2025	41	33	1:5,794	1:53	1:2,000	Yes	Yes
2024	53	40	1:20,770	1:141	1:2,000	No	Yes
2023	34	33	1:33,269	1:94	1:2,000	No	Yes
Psychology							
2025	1,107	1,095	1:158	1:3	1:2,000	Yes	Yes
2024	2,739	2,345	1:402	1:3	1:2,000	Yes	Yes
2023	2,345	1,836	1:508	1:5	1:2,000	Yes	Yes

*This table reflects 2025 data for all LOBs combined.

Table 3.1.2 Ratio of Behavioral Healthcare practitioners to members (Marketplace)

Marketplace Behavioral Health Specialty	Number of Practitioners		Ratio		Goal	Goal Met?	
Calendar Year	Urban	Rural	Urban	Rural	1 provider per 2,000 members	Urban	Rural
Psychiatry							
2025	41	33	1:742	1:7	1:2,000	Yes	Yes
2024	42	38	1:1,432	1:8	1:2,000	Yes	Yes
2023	34	32	1:1,325	1:6	1:2,000	Yes	Yes
Psychology							
2025	1,107	1,095	1:38	1:1	1:2,000	Yes	Yes
2024	2,482	2,081	1:27	1:1	1:2,000	Yes	Yes
2023	2,132	1,745	1:25	2:1	1:2,000	Yes	Yes

*This table reflects 2025 data for all LOBs combined.

Table 3.1.3: Ratio of Behavioral Healthcare practitioners to members (Medicare)

Medicare Behavioral Health Specialty	Number of Practitioners		Ratio		Goal	Goal Met?	
Calendar Year	Urban	Rural	Urban	Rural	1 provider per 2,000 members	Urban	Rural
Psychiatry							
2025	41	33	1:661	1:22	1:2,000	Yes	Yes
2024	42	40	1:2,343	1:57	1:2,000	Yes	Yes
2023	34	33	1:567	1:4	1:2,000	Yes	Yes
Psychology							
2025	1,107	1,095	1:51	1:1	1:2,000	Yes	Yes
2024	2,472	2,074	1:42	1:2	1:2,000	Yes	Yes
2023	2,114	1,693	1:10	3:1	1:2,000	Yes	Yes

*This table reflects 2025 data for all LOBs combined.

Geographic distribution of Behavioral Healthcare practitioners: Molina has established standards for the distribution of practitioner-to-members based on the following parameters:

- One (1) Psychiatrists and Psychologists within
  - Thirty (30) miles in urban counties
  - Fifty (50) miles in rural counties
    - Goal: 80% of members have access to at least one (1) behavioral healthcare practitioner within 30 miles for those residing in urban counties and 50 miles for those residing in rural counties

Table 3.2.1 Geographic distribution of Behavioral Healthcare practitioners (Medicaid)

Medicaid Behavioral Health Specialty	Percentage of members with access to a practitioner within 30 miles (Urban)	Goal	Goal Met?	Percentage of members with access to a practitioner within 50 miles (Rural)	Goal	Goal Met?
Psychiatry						
2025	88.79%	80%	Yes	100.00%	80%	Yes
2024	100.00%	80%	Yes	100.00%	80%	Yes
2023	100.00%	80%	Yes	100.00%	80%	Yes
Psychology						
2025	74.79%	80%	No	100.00%	80%	Yes
2024	98.43%	80%	Yes	100.00%	80%	Yes
2023	99.70%	80%	Yes	100.00%	80%	Yes

Table 3.2.2: Geographic distribution of Behavioral Healthcare practitioners (Marketplace)

Marketplace Behavioral Health Specialty	Percentage of members with access to a practitioner within 30 miles (Urban)	Goal	Goal Met?	Percentage of members with access to a practitioner within 50 miles (Rural)	Goal	Goal Met?
Psychiatry						
2025	88.29%	80%	Yes	100.00%	80%	Yes
2024	90.48%	80%	Yes	100.00%	80%	Yes
2023	100.00%	80%	Yes	100.00%	80%	Yes
Psychology						
2025	77.11%	80%	No	100.00%	80%	Yes
2024	79.49%	80%	No	100.00%	80%	Yes
2023	72.70%	80%	No	100.00%	80%	Yes

Table 3.2.3 Geographic distribution of Behavioral Healthcare practitioners (Medicare)

Medicare Behavioral Health Specialty	Percentage of members with access to a practitioner within 30 miles (Urban)	Goal	Goal Met?	Percentage of members with access to a practitioner within 50 miles (Rural)	Goal	Goal Met?
Psychiatry						
2025	90.29%	80%	Yes	100.00%	80%	Yes
2024	95.24%	80%	Yes	100.00%	80%	Yes
2023	97.06%	80%	Yes	100.00%	80%	Yes
Psychology						
2025	75.97%	80%	No	100.00%	80%	Yes
2024	81.72%	80%	Yes	100.00%	80%	Yes
2023	80.84%	80%	Yes	100.00%	80%	Yes

The practitioner-to-member ratios for behavioral health services across Medicaid, Marketplace, and Medicare populations demonstrate overall strong performance, with a few exceptions that highlight opportunities for improvement.

Medicaid psychiatry ratios in urban areas did not meet the 1:2,000 goal across 2023–2024. However, in 2025, the ratio was 1:5,794 in urban areas, below the threshold, as well as rural areas exceeding standards with a ratio of 1:53. In 2024, results showed a ratio of 1:20,770 in urban areas and 1:141 in rural areas. These results indicate significant shortages of psychiatrists available to Medicaid members in urban regions. In contrast, psychology ratios exceeded standards in both urban and rural settings across all three years, with ratios ranging from 1:158 in urban areas in 2025 to 1:3 in rural areas. This reflects a sufficient supply of psychologists relative to membership.

Geographic distribution results further illustrate Molina's performance in ensuring member access to behavioral health providers. For Medicaid, access to both psychiatrists and psychologists within 30 miles (urban) and 50 miles (rural) did not meet the 80% standard across all three years. In 2025, members had access to a psychiatrist within the required distance in both urban and rural areas, however, 74.79% had access to a psychologist in urban areas, with 100% coverage in rural regions.

Marketplace psychiatry ratios were within goal across all years, with 2025 ratios of 1:742 in urban areas and 1:7 in rural areas, both well within the 1:2,000 standard. Psychology ratios also consistently met goals, with 2025 ratios of 1:38 in urban and 1:1 in rural areas, reflecting robust provider availability relative to membership. These results highlight the strength of Marketplace behavioral health networks across both specialties.

Geographic access results showed some variability. Psychiatry access consistently exceeded standards, with 2024 results at 88.29% for urban members and 100% for rural members. Psychology access was more mixed. In 2024, only 79.49% of urban members had access within 30 miles, falling short of the 80% benchmark. In addition, a decline was observed in 2025, with urban access descending to 77.11%, essentially not meeting the goal. Rural access remained at 100% across all years.

Medicare ratios similarly demonstrated strong performance. In 2025, psychiatry ratios were 1:661 in urban areas and 1:22 in rural areas. The ratio complied with the 1:2,000 standard, meeting the goal. Psychology ratios were very favorable, with 1:51 in urban areas and 1:1 in rural areas. Across 2023–2025, Medicare maintained adequate ratios, with no major gaps identified in behavioral health provider availability.

Geographic access for psychiatrists remained strong, with 90.29% of urban members and 100% of rural members meeting standards in 2025. Psychology access showed a downward trend over the three-year period. In 2023, only 80.84% of urban members had access within 30 miles, which was slightly above the 80% goal. By 2024, access improved to 81.72%, and in 2025, it fell to 75.97%, not passing the standard. Rural access remained consistently strong, with 100% of members meeting the 50-mile standard each year.

Overall, Molina's behavioral health practitioner ratios and geographic distribution results reflect a fluctuating network adequacy for psychology services and a solid improvement in psychiatry access in Medicaid, Marketplace, and Medicare. Strategies such as expanding psychology provider contracting, strengthening telepsychology services, and targeted recruitment in urban areas will be critical to improving access. The improvement in psychiatry access from 2023 to 2025 demonstrates that focused interventions can yield measurable results, providing a model for strengthening access in other lines of business where gaps persist.

Molina has executed a provider contracting strategy with an emphasis on Behavioral Health practitioners in order to create a robust network for the members we serve. The Health Plan conducts network adequacy analyses on a quarterly basis for ongoing monitoring, as well as an annual basis when there are changes to the network due to termed contracts. Those reports, and any accompanying findings or feedback, are discussed annually at the National Quality Improvement Committee. Action plans are developed, when necessary, to address any Primary Care network changes that could negatively impact member access to care. This continuous monitoring helps Molina remain apprised of the network's geographic makeup and implement any adjustments needed to maintain access. These results were reviewed, and root cause analyses were conducted during the Quality Improvement Committee meetings, serving as the conduit for improvement and scrutiny of the data. This meeting includes senior health plan leadership and ensures that goals are discussed and interventions specific to results are instituted.

Opportunities for Improvement

To help mitigate this issue, Molina Healthcare of California has discussed and prioritized the following action on the issues identified and discussed above:

Practitioner Type	Goal Not Met	Key Driver/s	Opportunities for Improvement
Psychology (Medicaid)	Geographic access fell below 80% Urban (74.79%)	Urban counties not meeting goal: **Sonoma, Marin, Yolo, Alameda, and Santa Cruz** Key drivers include limited psychiatrist participation in Medicaid networks, concentration of psychiatrists in larger metro hubs, and provider shortages in smaller counties. Additionally, geographic barriers and low provider density in urban regions contribute to reduced access.	Target provider recruitment and contracting in Sonoma, Marin, Yolo, Alameda, and Santa Cruz counties. Conduct full directory–roster reconciliation to ensure all active psychologists are accurately counted in access calculations. Support primary care clinics in integrating psychologists through collaborative care or collocated behavioral health models. Implement parallel processing of contracting and credentialing to shorten timeline to activation.
Psychology (Marketplace)	Geographic access fell below 80% Urban (77.11%)	Urban counties not meeting goal: **Monterey, Sonoma, Napa, Santa Cruz, and Imperial**	Target recruitment and contracting of internal medicine providers in Monterey, Sonoma, Napa, Santa Cruz, and Imperial counties.

		Key drivers include workforce shortages in urban counties, especially for Medicare participation among Psychology providers, and increased mental health needs post-pandemic and population growth may have outpaced provider availability. Additionally, geographic barriers and low provider density in urban regions contribute to reduced access.	Offer incentives, such as enhanced reimbursement or participation bonuses, to encourage psychologists to join or reopen Marketplace panels. Promote tele-psychology as a supplemental solution to expand access in counties with limited provider availability. Reduce administrative barriers by simplifying documentation requirements and offering hands-on support.
Psychology (Medicare)	Geographic access fell below 80% Urban (75.97%)	Urban counties not meeting goal: **Contra Costa, Alameda, Santa Clara, Santa Cruz, and Ventura** Key drivers include workforce shortages in urban counties, especially for Medicare participation among Psychology providers, and increased mental health needs post-pandemic and population growth may have outpaced provider availability. Additionally, geographic barriers and low provider density in urban regions contribute to reduced access.	Target recruitment and contracting of internal medicine providers in Contra Costa, Alameda, Santa Clara, Santa Cruz, and Ventura counties. Offer plan re-engagement in large multi-specialty and behavioral health groups to broaden network participation for Medicare Advantage members. Establish hybrid care options allowing initial assessments in person and follow-up appointments via telehealth. Provide targeted outreach to members in counties with low access rates to ensure they are connected to available services.

Summary

Across Medicaid, Marketplace, and Medicare lines of business, Molina's network adequacy analyses from 2023–2025 reveal consistent patterns: practitioner-to-member ratios largely exceed regulatory standards, but geographic distribution remains the primary barrier to true member access. Despite adequate or even abundant provider supply in most categories, members—particularly in urban areas for Medicare and Marketplace, and both urban and rural areas for Medicaid—face access limitations due to uneven provider location distribution. Year-over-year comparisons show stable capacity but fluctuating and often insufficient distribution, underscoring the need for targeted recruitment, data validation, and expanded telehealth solutions.

Primary Care ratios across all payor types consistently met and exceeded the 1:2,000 standard from 2023–2025. Medicaid, Marketplace, and Medicare each demonstrated strong practitioner capacity, with 2025 ratios showing exceptionally low member-to-provider counts—for example, Marketplace Family Medicine at 1:3 urban and 7:1 rural. However, year-over-year geographic distribution highlights persistent deficiencies. Urban access for Medicaid, Marketplace, and Medicare frequently fell well below the 90% standard, with 2025 measures such as Internal Medicine showing 56–57% urban access,

a trend consistent with previous years. Despite adequate ratios, counties with sparse provider presence continue to restrict access. The pattern has not meaningfully improved year over year, emphasizing that supply alone is insufficient without corrected distribution.

High-volume and high-impact specialties, including OB/GYN and Hematology/Oncology, demonstrated strong ratios across all programs in 2023–2025, far surpassing the required adequacy thresholds. Nonetheless, distribution patterns reveal instability. For Medicaid, urban access for OB/GYN and oncology remained below the 80% threshold across all measured years despite perfect rural access. Marketplace and Medicare showed similar volatility, with urban distribution dropping sharply from 2024 to 2025—for instance, Marketplace OB/GYN decreased from 87% in 2024 to 71% in 2025. Medicare oncology access also declined over the period, from 93% in 2023 to 75% in 2025. These fluctuations demonstrate that, although provider capacity is sufficient, urban distribution challenges persist year over year, requiring strengthened contracting strategies.

Behavioral health ratios show a mixed picture across Medicaid, Marketplace, and Medicare. Psychology provider ratios consistently exceeded standards from 2023–2025 across all lines of business, indicating a stable supply. Psychiatry ratios were more variable: Medicaid urban psychiatry ratios fell far below standards in 2023–2024 but improved substantially in 2025, while Marketplace and Medicare psychiatry ratios remained strong throughout. Geographic distribution data, however, highlight continued access issues. Medicaid and Marketplace psychology access in urban areas repeatedly fell below the 80% standard, with urban Marketplace psychology declining from 79% in 2024 to 77% in 2025. Medicare also experienced a downward trend in urban psychology access, dropping from 81% in 2024 to 75% in 2025. These year-over-year declines indicate growing distribution gaps despite maintaining strong practitioner ratios.

Across Primary Care, Specialty Care, and Behavioral Health, Molina maintains strong practitioner-to-member ratios year over year, demonstrating that overall provider supply is not the core issue. Instead, geographic distribution remains the systemic barrier to member access across all payor types and service categories. Urban access challenges are persistent and, in some cases, worsening—most notably in Marketplace and Medicare behavioral health and in specialty urban access across all lines of business. Rural access shows greater stability but is not uniformly adequate. Year-over-year patterns show that distribution gaps have remained consistent or widened, despite strong ratios. To address these disparities, Molina must continue targeted recruitment in underserved geographic zones, enhance contracting with smaller and independent practices, expand telehealth availability, and improve provider location validation to ensure that network adequacy translates into real, timely access for members.

Opportunities for Improvement

We are actively improving the Geo Access reporting methodology through vendor collaboration to design and implement a custom solution. This model will enable precise capture and reporting of Geo Access data segmented by market and line of business, ensuring greater accuracy, consistency, and actionable insights for network adequacy analysis. To help mitigate this issue, Molina Healthcare of

California has discussed and prioritized the following action on the issues identified and discussed above:

Practitioner Type	Goal Not Met	Opportunities for Improvement	Actions	Date of Implementation or Planned Implementation
Family Medicine/ General Practice (Medicaid)	Geographic access fell below 90% Urban (57.02%) Rural (66.54%)	Urban counties not meeting goal: Alameda, Napa, Monterey, Orange, and Madera Rural counties not meeting goal: Calaveras, Nevada, Tehama, Glenn, and Mariposa Expand partnerships with Federally Qualified Health Centers and rural health clinics to improve access. Expand telehealth and mobile clinic access to mitigate shortages in geographically dispersed rural areas. Collaborate with local hospitals and health systems in underserved counties to bolster pediatric coverage.	Target recruitment and contracting in Alameda, Napa, Monterey, Orange, Madera, Calaveras, Nevada, Tehama, Glenn, and Mariposa counties. Establish targeted outreach campaigns in each county using local media, school districts, and community-based organizations to identify gaps in pediatric access. Deploy mobile pediatric clinics to reach geographically isolated communities on a recurring schedule. Develop formal access agreements that require clinics to reserve pediatric appointment slots for plan members.	11/1/2025 - Ongoing
Internal Medicine (Medicaid)	Geographic access fell below 90% Urban (56.63%) Rural (66.42%)	Urban counties not meeting goal: Monterey, Kern, Orange, Riverside, and Ventura Rural counties not meeting goal: Calaveras, Glenn, Nevada, Mariposa, and Tehama Strengthen partnerships with local hospitals and health systems in underserved rural and mid-size counties. Expand contracting with Federally Qualified Health Centers and rural health clinics to increase access. Enhance tele-internal medicine services to address immediate shortages in rural and geographically dispersed areas.	Target recruitment and contracting of internal medicine providers in Monterey, Kern, Orange, Riverside, Ventura, Calaveras, Glenn, Nevada, Mariposa, and Tehama counties. Establish county-specific MOUs with major systems (e.g., Dignity, Providence, Adventist, Kaiser, UCI, RUHS) to reserve same-day/next-day internal medicine slots for plan members. Execute expedited amendments with high-capacity FQHCs to add internal medicine panels with evening/weekend sessions. Create community access points (libraries, schools, county offices)	11/1/2025 - Ongoing

			with private rooms + Wi-Fi + MA support for vitals.	
Pediatrics (Medicaid)	Geographic access fell below 90% Urban (61.48%) Rural (68.70%)	Urban counties not meeting goal: Santa Barbara, Santa Cruz, Kings, Kern, and San Diego Rural counties not meeting goal: Nevada, Glenn, Tehama, Mariposa, and Calaveras Expand partnerships with Federally Qualified Health Centers and county clinics to strengthen pediatric access in rural regions. Expand tele-pediatrics and mobile pediatric clinics to improve access in geographically isolated areas. Collaborate with local hospitals and health systems in underserved counties to bolster pediatric coverage.	Target recruitment and contracting in Santa Barbara, Santa Cruz, Kings, Kern, San Diego, Nevada, Glenn, Tehama, Mariposa, and Calaveras counties. Establish access agreements with high-volume FQHCs to reserve pediatric appointment slots for plan members. Deploy pediatric consult tele-support to help clinics manage complex cases and reduce unnecessary referrals. Create bridge appointments for children discharged without an established PCP.	11/1/2025 - Ongoing
Family Medicine/ General Practice (Marketplace)	Geographic access fell below 90% Urban (56.62%) Rural (63.83%)	Urban counties not meeting goal: Ventura, Orange, Kern, Imperial, and San Diego Rural counties not meeting goal: Mariposa, Contra Costa, and Butte Strengthen partnerships with Federally Qualified Health Centers and rural health clinics in underserved areas. Offer recruitment and retention incentives (loan repayment, stipends, rural relocation support) for Marketplace family medicine providers. Expand telehealth and mobile clinic services to mitigate shortages in geographically dispersed counties. Collaborate with local health systems and physician groups to	Target recruitment and contracting of family medicine providers in Ventura, Orange, Kern, Imperial, San Diego, Mariposa, Contra Costa, and Butte counties. Execute access addenda with FQHCs/county clinics to reserve daily Marketplace family medicine slots (e.g., 10–15/day/site) with evening/weekend availability. Allocate Marketplace panels and urgent primary care access blocks and build shared staffing pools (locums/float APPs) to stabilize clinic shortages. Launch incentive suite for Marketplace family medicine providers by offering loan repayment supplements, signing/retention bonuses, rural/underserved stipends.	11/1/2025 - Ongoing

		expand provider participation in Marketplace networks.		
Internal Medicine (Marketplace)	Geographic access fell below 90% Urban (54.96%) Rural (62.51%)	Urban counties not meeting goal: Sonoma, Napa, Santa Barbara, Merced, and Placer Rural counties not meeting goal: Mariposa, Contra Costa, and Butte Strengthen partnerships with local hospitals and health systems in underserved counties to extend internal medicine coverage. Expand contracting with Federally Qualified Health Centers and rural health clinics to increase rural access. Implement rural recruitment/retention incentives (loan repayment, stipends, relocation support). Enhance tele-internal medicine services to address immediate access gaps in rural and geographically dispersed areas.	Target recruitment and contracting of internal medicine providers in Sonoma, Napa Santa Barbara, Merced, Placer, Mariposa, Contra Costa, and Butte counties. Reserve same/next-day internal medicine access blocks for plan members and deploy shared staffing pools (float NPs/MDs/locums) to backfill clinic shortages. Rapid onboarding of FQHCs/RHCs with expedited credentialing and temporary network exceptions (where allowed) to start services while files complete. Operate mobile internal medicine clinics on fixed routes (2–4 days/month) for preventive/urgent needs and chronic care check-ins; co-locate at critical access hospitals on high-traffic days.	11/1/2025 - Ongoing
Pediatrics (Marketplace)	Geographic access fell below 90% Urban (59.25%) Rural (62.33%)	Urban counties not meeting goal: Placer, Santa Barbara, Napa, Riverside, and San Diego Rural counties not meeting goal: Mariposa, Contra Costa, and Butte Develop partnerships with Federally Qualified Health Centers and county clinics to strengthen pediatric access in underserved rural and suburban counties. Expand tele-pediatrics and mobile pediatric clinics to improve access in geographically dispersed and border counties. Collaborate with local hospitals and health systems to expand	Target recruitment and contracting of pediatric providers in Placer, Santa Barbara, Napa, Kern, San Diego, Mariposa, Contra Costa, and Butte counties. Add access addenda that reserve pediatric slots and extend hours (evenings/weekends) and fund pediatric care coordinators to reduce no-shows and ensure follow-up. Enable eConsult + rapid referral for common pediatric conditions; standardize nurse triage protocols to convert calls into visits (virtual or in-person). Rapidly onboard FQHCs/RHCs/county clinics with expedited credentialing and,	11/1/2025 - Ongoing

		pediatric capacity in high-growth regions.	where permitted, temporary network exceptions to start care while files complete.	
Family Medicine/ General Practice (Medicare)	Geographic access fell below 90% Urban (57.98%) Rural (67.29%)	Urban counties not meeting goal: Sonoma, Napa, Santa Barbara, Imperial, and San Diego Rural counties not meeting goal: Tuolumne, Tehama, and Mariposa Expand partnerships with Federally Qualified Health Centers, rural health clinics, and local hospitals in underserved counties. Enhance telehealth and mobile clinic services to address provider shortages in geographically dispersed counties. Collaborate with physician groups and medical associations to expand Medicare-contracted provider networks in rural and semi-rural counties.	Target recruitment and contracting of family medicine providers in Sonoma, Napa, Santa Barbara, Imperial, San Diego, Tuolumne, Tehama, and Mariposa counties. Execute access addenda with high-volume FQHCs (reserve 10–20 family medicine/general practice slots/day/site, add evening/weekend sessions). Add mobile clinic days near schools/community hubs and after-hours tele-triage that converts to next-day in-person care. Create community telehealth access points (libraries, schools, county offices, family resource centers) with private rooms + MA/tele-presenters; distribute hotspots/tablets for connectivity gaps.	11/1/2025 - Ongoing
Internal Medicine (Medicare)	Geographic access fell below 90% Urban (56.82%) Rural (65.73%)	Urban counties not meeting goal: Sonoma, Napa, Monterey, Riverside, and Santa Barbara Rural counties not meeting goal: Tuolumne, Calaveras, and Tehama Strengthen partnerships with local hospitals and health systems in underserved counties. Expand contracting with Federally Qualified Health Centers and rural health clinics to increase rural access. Enhance tele-internal medicine services to improve access in geographically dispersed counties.	Target recruitment and contracting of internal medicine providers in Sonoma, Napa, Monterey, Riverside, Santa Barbara, Tuolumne, Calaveras, and Tehama counties. Collaborate with health systems to expand after-hours tele-IM triage that routes patients to next-day in-person Medicare appointments. Offer capacity grants for rural clinics (e.g., telehealth equipment, exam room upgrades, point-of-care testing capabilities) tied to access improvements. Implement evening/weekend tele-internal medicine services dedicated to Medicare members	11/1/2025 - Ongoing

			in rural and underserved semi-urban counties.	
High-Volume OB/GYN (Medicaid)	Geographic access fell below 80% Urban (74.52%)	Urban counties not meeting goal: Kern, Imperial, Napa, Sonoma, and Monterey Identify expiring/terminated contracts affecting the five counties; implement bridge contracting or LOAs. Enhanced OB reimbursement adders for prenatal/new OB intakes in target counties. Increase access to Mobile women's health rotations into underserved urban tracts.	Target provider recruitment and contracting in Kern, Imperial, Napa, Sonoma, and Monterey counties. Implement bridge contracts or Letters of Agreement (LOAs) to prevent service disruption while full contracting is finalized. Integrate mobile services with EMR systems so documentation, referrals, imaging orders, and follow-up coordination are seamless. Standardize same-week prenatal intake templates across contracted OB/GYN sites.	11/1/2025 - Ongoing
High-Impact Hematology/ Oncology (Medicaid)	Geographic access fell below 80% Urban (75.12%)	Urban counties not meeting goal: Monterey, Kern, Merced, Kings, and Ventura Promoting tele-oncology services can help extend access for members who live in areas with limited physical oncology coverage. Collaborating with major oncology centers and hospital systems can help expand the number of specialists available to Medicaid members. Streamline Medicaid credentialing to help accelerate onboarding for newly contracted hematology/oncology specialists.	Target recruitment and contracting of internal medicine providers in Monterey, Kern, Merced, Kings, and Ventura counties. Establish private tele-rooms with vitals and MA support at FQHCs, county clinics, and hospital outpatient departments. Deploy mobile outreach days focused on labs, port care, symptom checks, and nurse-led education linked to same-day tele-oncology visits to avoid ED use. Activate infusion center access agreements for Medicaid patients treated by community oncologists.	11/1/2025 - Ongoing
High-Volume OB/GYN (Marketplace)	Geographic access fell below 80% Urban (71.59%)	Urban counties not meeting goal: Santa Barbara, Ventura, San Diego, Imperial, and Kern Strengthen Contracting and Network Adequacy by expanding Marketplace participation with system-employed OB/GYN	Target recruitment and contracting of internal medicine providers in Santa Barbara, Ventura, San Diego, Imperial, and Kern counties. Convene executive-level meetings with regional systems/medical groups.	11/1/2025 - Ongoing

		practices, which often restrict Marketplace panels. Improve provider data accuracy and remove inactive/duplicate NPIs and update sites that moved, closed, or consolidated. Encourage OB/GYN practices to add evening/weekend clinic hours to increase appointment availability.	Add access clauses: appointment lag, same/next-day urgent GYN availability, and reserved Marketplace slots. Contract for evening (5–8 pm) and Saturday OB/GYN sessions at high-volume practices and FQHC partners.	
High-Impact Hematology/ Oncology (Marketplace)	Geographic access fell below 80% Urban (75.25%)	Urban counties not meeting goal: Contra Costa, Monterey, Santa Barbara, Ventura, and Merced Promoting tele-oncology services to help extend access for members who live in areas with limited physical oncology coverage. Working with practices to streamline referral processes can make it easier for Marketplace patients to enter oncology care. Removing inactive, duplicate, or relocated providers help reduce inaccuracies that impact adequacy calculations.	Target recruitment and contracting of internal medicine providers in Contra Costa, Monterey, Santa Barbara, Ventura, and Merced counties. Deploy tele-rooms (private space + vitals equipment + tele-presenter/MA) at FQHCs, county clinics, and system satellites in high-lag ZIPs across the five counties. Launch weekday evening (5–8 pm) and Saturday morning tele-oncology sessions dedicated to new consult triage, second opinions, toxicities, oral therapy management, and follow-ups. Implement a one-page standardized referral form (EMR-agnostic) with required fields.	11/1/2025 - Ongoing
High-Volume OB/GYN (Medicare)	Geographic access fell below 80% Urban (72.85%)	Urban counties not meeting goal: Imperial, Orange, Santa Barbara, Monterey, and Ventura Strengthen Contracting and Network Expansion by prioritizing contracting with independent OB/GYNs who may be more flexible about accepting Medicare Advantage members. Expand clinical capacity for Medicare beneficiaries by providing incentives for practices to offer extended hours to absorb increased demand.	Target recruitment and contracting of internal medicine providers in Imperial, Orange, Santa Barbara, Monterey, and Ventura counties. Provide enhanced reimbursement for new Medicare OB/GYN visits, well-woman exams, and preventive screenings. Prioritize recruitment of small and mid-sized practices, which often have fewer restrictions on Medicare Advantage participation	11/1/2025 - Ongoing

		Strengthen Partnerships with FQHCs, Community Clinics, and Health Systems by working with hospital systems to broaden Medicare Advantage panel acceptance among employed OB/GYNs.	compared to system-employed groups. Provide rate enhancements or extended-hours differential payments for practices.	
High-Impact Hematology/ Oncology (Medicare)	Geographic access fell below 80% Urban (75.11%)	Urban counties not meeting goal: Imperial, Kern, San Diego, Ventura, and Santa Barbara Develop contracting incentives that can encourage hematology oncology specialists to open or expand their Medicare panels. Conduct a full roster-to-directory reconciliation that can ensure that all active hematology/oncology providers are reflected accurately in adequacy files. Encouraging participating practices to increase appointment availability can help reduce bottlenecks in counties experiencing higher oncology demand.	Target recruitment and contracting of internal medicine providers in Imperial, Kern, San Diego, Ventura, and Santa Barbara counties. Provide targeted enhanced reimbursement for high-impact oncology services (new consults, infusion visits, treatment planning) to incentivize panel expansion. Build a fast-track Medicare contracting queue for oncology practices willing to take on new Medicare members. Reserve weekly consult blocks specifically for Medicare members in counties with long appointment lag.	11/1/2025 - Ongoing
Psychology (Medicaid)	Geographic access fell below 80% Urban (74.79%)	Urban counties not meeting goal: Sonoma, Marin, Yolo, Alameda, and Santa Cruz Conduct full directory–roster reconciliation to ensure all active psychologists are accurately counted in access calculations. Support primary care clinics in integrating psychologists through collaborative care or collocated behavioral health models. Implement parallel processing of contracting and credentialing to shorten timeline to activation.	Target provider recruitment and contracting in Sonoma, Marin, Yolo, Alameda, and Santa Cruz counties. Establish monthly attestation for large BH groups and 72-hour update requirements after any site change. Fund collaborative care (CoCM) or co-located BH pilots in FQHCs and high-volume PCP sites. Use LOAs/temporary network exceptions (as policy allows) to schedule while credentialing completes.	11/1/2025 - Ongoing
Psychology (Marketplace)	Geographic access fell below 80%	Urban counties not meeting goal: Monterey, Sonoma, Napa, Santa Cruz, and Imperial	Target recruitment and contracting of internal medicine providers in Monterey, Sonoma,	11/1/2025 - Ongoing

	Urban (77.11%)	Offer incentives, such as enhanced reimbursement or participation bonuses, to encourage psychologists to join or reopen Marketplace panels. Promote tele-psychology as a supplemental solution to expand access in counties with limited provider availability. Reduce administrative barriers by simplifying documentation requirements and offering hands-on support.	Napa, Santa Cruz, and Imperial counties. Offer enhanced reimbursement for new patient psychology visits, evidence-based therapy bundles (e.g., CBT), and extended hours differentials. Expand evening/weekend tele-psychology with CA-licensed clinicians; integrate with referral triage and self-scheduling links. Offer credentialing concierge, group trainings, and a self-service portal for directory updates.	
Psychology (Medicare)	Geographic access fell below 80% Urban (75.97%)	Urban counties not meeting goal: Contra Costa, Alameda, Santa Clara, Santa Cruz, and Ventura Offer plan re-engagement in large multi-specialty and behavioral health groups to broaden network participation for Medicare Advantage members. Establish hybrid care options allowing initial assessments in person and follow-up appointments via telehealth. Provide targeted outreach to members in counties with low access rates to ensure they are connected to available services.	Target recruitment and contracting of internal medicine providers in Contra Costa, Alameda, Santa Clara, Santa Cruz, and Ventura counties. Convene executive-level re-engagements with major multi-specialty and BH groups; negotiate Medicare Advantage participation. Standardize hybrid scheduling: first visit in-person (diagnostic assessment), subsequent sessions via tele for stable cases. Run multilingual outreach (SMS/IVR/email) guiding members to available psychology appointments, with self-schedule links and tele-options.	11/1/2025 - Ongoing

Conclusion

Molina Healthcare's analysis confirms that provider-to-member ratios across Primary Care, high-volume, high-impact, and behavioral health specialties are consistently adequate, demonstrating sufficient overall supply to meet member demand. However, geographic distribution continues to present challenges, particularly in Medicaid, Marketplace and Medicare Primary Care networks where both urban and rural access fall short of the 90 percent standard, and in Internal Medicine where urban and rural pediatrics access gaps persist despite strong ratios. Behavioral health networks demonstrate strong overall psychology capacity across all lines of business; however, persistent geographic access gaps in urban areas for Medicaid, Marketplace, and Medicare highlight the need for targeted recruitment and expanded telepsychology services to ensure equitable access.

The identified gaps reflect issues of provider distribution rather than overall supply, emphasizing the importance of refined contracting strategies, targeted recruitment in underserved regions, validation of provider location data, and expanded telehealth capacity. Molina has developed a set of prioritized interventions with specific timelines to address these deficiencies, ensuring sustainable improvements in access.

By maintaining strong ratios while implementing these focused strategies, Molina will continue to enhance equitable access, improve geographic distribution, and strengthen its ability to provide timely, high-quality care to all members across Medicaid, Marketplace, and Medicare.

Appendix 9

2025 Assessment of Network Adequacy: Accessibility of Services for California

November 19, 2025

Accessibility of Services Analysis: Medicaid

Introduction

Molina Healthcare of California (MHCA) conducts an annual accessibility assessment against established standards for numbers and geographic distribution for its Medicaid line of business to ensure it maintains an adequate network of practitioners who provide primary care services (i.e., General and Family Practitioners, Internal Medicine, Pediatrics); specialists (i.e., Obstetrician/Gynecologists, Hematology/Oncology); and Behavioral Health practitioners (i.e., Psychiatrists and Psychologists). Performance is evaluated based on State regulatory requirements as well as NCQA standards. This evaluation helps MHCA members seek appropriate care within established time limits.

Primary Care Practitioners (PCPs) serve as gatekeepers to manage the care of MHCA members. The PCP is responsible for ensuring members are up to date with their preventive care; coordinating and ordering health services; and connecting members to specialty care, as needed. Access standards are used as guidelines for PCP offices to triage patients to ensure appointment availability based on clinical needs and by member requests. MHCA must also have arrangements in place to manage after-hours care if an issue were to arise. Arrangements include implementing an answering service for after-hours calls or a voice mailbox that will page the on-call provider to return a member's call. MHCA informs PCPs of these requirements at the time of contracting and via routine updates to the Provider Manual. Members also receive information about getting care after-hours via various member materials, such as the Member Handbook.

Members may experience long waiting times and difficulty finding specialty practitioners with open panels. Delays in receiving medical care result in gaps in care, from diagnosis to treatment. Therefore, MHCA also assesses member access to specialty care practitioners to ensure members receive timely services that meet their needs. Evaluation of access to specialty practitioners includes access to both high-volume specialty and high-impact specialty care. These practitioners are identified based on claims volume relative to the characteristics of the member population. Additionally, MHCA strives to support our members in all aspects of care, including socio-emotional and behavioral health needs. Therefore, we also monitor accessibility of behavioral health practitioners that serve MHCA members.

The purpose of the analysis in this report is to evaluate the accessibility of primary care, specialty care, and behavioral healthcare as well as after-hours care in accordance with State regulatory and contractual requirements, and NCQA accreditation standards.

Data Source and Methodology

Continuous monitoring provides the Health Plan with information to assess effectively how MHCA meets established accessibility standards defined for each practitioner type. The provider appointment accessibility audit is conducted by Molina Healthcare Inc. Quality Program Management and Performance Department. MHCA gathers data using a telephonic survey during which our callers speak with a scheduler/front desk staff/office supervisor. A total of three attempts were made to contact the providers in each category. Participants were asked about appointment availability for various medical appointment types and assessed based upon MHCA's access standards. Providers who could not accommodate a specific appointment request were considered compliant if an alternative provider was available to accommodate the request within the specified time limit.

Additionally, after-hours access is also assessed. The following responses were considered as compliant for

after-hours access: calls answered by office staff and calls forwarded to voice messaging with instructions to call the ER; referral to provider on call; referral to Nurse Advice Line; referral to RN on call; and referral to answering service for a call back from a live person. Providers simply providing voicemail without instructions were considered non-compliant against the after-hours access standard.

Data Sampling

The survey population consisted of credentialed primary care (PCP), behavioral health (BH), high-impact (HI), and high-volume (HV) providers based on data obtained from MHCA. After duplicate providers and providers with fewer claims were removed, a statistically valid, random sample of providers was obtained using a sampling error of less than 5% at a 95% confidence level. The sample of providers receiving the survey included primary care, behavioral health, and specialty care (high-impact and high-volume). As part of MHCA's access standards, primary care providers were assessed on the availability of after-hours services. Providers are expected to provide emergency care instructions or access to care during office after-hours.

Identified Practitioners included in this evaluation/definition

Primary Care Practitioners: Molina defines Family Medicine and General Practice, Internal Medicine, and Pediatric providers as Primary Care practitioners.

High-Volume and High-Impact Specialties: Molina defines high-volume participating specialist practitioners as those providing Obstetrics/Gynecology care. High-impact specialists are defined as practitioners who treat specific conditions that have profound consequences for the member and require significant resources. California has identified Hematology/Oncology to be a high impact specialty for our Medicaid member population.

Behavioral Health Practitioners: Molina defines Psychiatrists and Psychologists as Behavioral Health Practitioners.

Measurement period

Data for this analysis was compiled between September 23rd to November 4th for Calendar Year (CY) 2025.

Access Standards

Standards/Goals for Primary and Specialty Care Providers

Medical Appointment Types	Standard
Routine Asymptomatic Care (PCP)	Within 10 business days
Routine Care (HI & HV)	Within 15 business days
Urgent Care No Prior Authorization (PCP, HI, & HV)	Within 48 hours
Urgent Care with Prior Authorization (PCP, HI, & HV)	Within 96 hours
Preventive/Routine Care (Adult) (PCP)	Within 20 business days
Return Call within Business Hours (PCP, HI, & HV)	Same Business Day
After-Hours Accessibility (PCP, HI, & HV)	24 hours a day/7 day a week
Return Call After-Hours (PCP, HI, & HV)	Within 30 minutes after member contacts organization
First Prenatal Care Visit (HV)	Within 2 weeks

Standards/Goals for Behavioral Health Providers

Behavioral Health Appointment Types	Standard
Urgent Care No Prior Authorization	Within 48 hours
Urgent Care with Prior Authorization	Within 96 hours
Routine Follow-Up (Prescriber)	Within 30 business days
Routine Follow-Up (Non-Prescriber)	Within 10 business days
Routine (Preventive) Care	Within 10 business days
Non-Life-threatening emergency	Within 6 hours
Return Call within Business Hours	Same Business Day
After-Hours Accessibility	24 hours a day/7 day a week
Return Call After-Hours	30 minutes after member contacts organization

All provider types must achieve 90% on access standards. Those not complying with the performance standards are notified of the findings and the need for corrective action to meet the appointment standard(s). Providers who are considered non-compliant against access standards are re-surveyed approximately six months after the initial audit has taken place.

Results

Primary Care Provider Accessibility of Services Results

Molina Healthcare of California assessed access to practitioners within its Primary Care network based on the needs of its member population to maintain the appropriate structure and resources according to established standards, during and after business hours. After removing duplicate providers and those with fewer claims during the measurement period, MHCA attempted to contact 63 Primary Care providers. The response rate was 63%. Details for appointment availability are summarized in the tables below by practitioner type.

Appointment Availability for Primary Care Providers

	PCP Asymptomatic Routine Care (Within 10 Business days)			PCP Urgent Care w/o PA (Within 48 hours)		
	2025 % Compliant	*2024 % Compliant*	*2023 % Compliant*	*2025 % Compliant*	*2024 % Compliant*	*2023 % Compliant*
Family & General Medicine	100%	100%	69%	100%	100%	44%
Internal Medicine	100%	83%	80%	100%	80%	50%
Pediatrics	100%	100%	57%	100%	100%	57%
Totals	**100%**	**98%**	**68%**	**100%**	**98%**	**50%**

	PCP Urgent Care w/ PA (Within 96 hours)			PCP Preventive/ Routine Care (Child) (Within 7 Business days)		
	2025 % Compliant	*2024 % Compliant*	*2023 % Compliant*	*2025 % Compliant*	*2024 % Compliant*	*2023 % Compliant*
Family & General Medicine	N/A	N/A	25%	83%	92%	31%
Internal Medicine	N/A	100%	100%	100%	100%	60%
Pediatrics	N/A	100%	N/A	100%	100%	43%
Totals	**N/A**	**100%**	**40%**	**96%**	**96%**	**40%**

	PCP Preventive/ Routine Care (Adult) (Within 20 Business days)			Return Calls During Business Day (Same Day)		
	2025 % Compliant	*2024 % Compliant*	*2023 % Compliant*	*2025 % Compliant*	*2024 % Compliant*	*2023 % Compliant*
Family & General Medicine	100%	100%	31%	86%	96%	N/A
Internal Medicine	100%	100%	40%	100%	67%	N/A
Pediatrics	100%	100%	43%	88%	100%	N/A
Totals	**100%**	**100%**	**36%**	**90%**	**94%**	**N/A**

Primary Care practitioners met and exceeded the 90% compliance goal and contractually required accessibility standards for Asymptomatic Routine Care, Urgent Care w/o Prior Authorization, and Preventive/Routine Care Adult were 100% compliant, there were no responses to Urgent Care w/Prior Authorization, preventive/Routine Care Child reached 96% and Return Call During the Business Day achieved 90% compliance.

The three year review shows Asymptomatic Routine Care increased two percentage points from 2025 to 2024 and increased 32 percentage points from 2025 to 2023. Urgent Care w/o Prior Authorization increased two percentage points from 2025 to 2024 and 50 percentage points from 2025 to 2023. Urgent Care w/Prior Authorization had no responses in 2025, and no comparison can be made. Preventive/Routine Care for Child reached 96% for 2025 and 2024 and increased 56 percentage points from 2025 to 2023. Preventive/Routine Care for Adults remained unchanged at 100% from 2025 to 2024 and increased 64 percentage points from 2025 to 2023. In addition to appointment accessibility, Molina evaluated the provider's responsiveness. Return Calls During the Business Day decreased four percentage points from 2025 to 2024 and this metric was not tracked in 2023. The above table summarizes MHCA's 2025 Primary Care appointment accessibility performance.

After-Hours Accessibility for Primary Care Providers

	After- Hours (24/7 coverage)			Return Call After Hours (Within 30 minutes)		
	2025 % Compliant	*2024 % Compliant*	*2023 % Compliant*	*2025 % Compliant*	*2024 % Compliant*	*2023 % Compliant*
Family & General Medicine	71%	100%	100%	0%	N/A	N/A
Internal Medicine	78%	67%	100%	0%	0%	N/A
Pediatrics	59%	100%	100%	0%	N/A	N/A
Totals	**68%**	**96%**	**100%**	**0%**	**0%**	**N/A**

Primary Care practitioners did not meet the 90% compliance goal and contractually required accessibility standards for After-Hours Availability (68%) and Return Call After-Hours (0%). The above table summarizes MHCA's 2025 Primary Care appointment after-hours performance.

After-Hours Availability decreased 28 percentage points from 2025 to 2024 and 32 percentage points from 2025 to 2023. Return Call After-Hours remained unchanged from 2025 to 2024 at 0% compliance and was not assessed in 2023.

Based on Molina's Primary Care appointment accessibility data, the Health Plan identified the following barriers to accessing care:

- Providers are not aware of the after-hour availability standards.

To mitigate these barriers the Health Plan will deploy a multi-pronged strategy to enhance provider accessibility, which includes distributing educational materials and conducting in person sessions to discuss standards and troubleshoot existing barriers. The effectiveness of these measures will be continuously assessed over the upcoming measurement period, ensuring that practitioners are well-supported in their efforts to achieve accessibility goals.

MHCA's analysis of access to primary care accessibility standards for its members shows steady compliance during the three year review period in primary care practitioners meeting the 90% compliance goal. This is in line with previous years' performance. After-Hours availability standards failed to meet the 90% compliance goal during the three year review period. This is in line with previous three years' performance. Results may be subject to variance in surveying methodology, including sampling criteria.

Behavioral Health Provider (prescribers and non-prescribers) Accessibility of Services Results

MHCA assessed the availability of Behavioral Health practitioners within its network based on the needs of its member population to maintain the appropriate structure and resources to ensure access to services according to established standards. After removing duplicate providers and those with fewer claims during the measurement period, MHCA attempted to contact 69 behavioral providers. The response rate was 32%. Details for appointment availability are summarized in the tables below by practitioner type.

Appointment Availability for Behavioral Health Providers

	Urgent Care w/o PA (Within 48 hours)			Urgent Care w/ PA (Within 96 hours)		
	2025 % Compliant	*2024 % Compliant*	*2023 % Compliant*	*2025 % Compliant*	*2024 % Compliant*	*2023 % Compliant*
Psychiatry	86%	100%	0%	100%	100%	100%
Psychology	100%	100%	0%	100%	100%	100%
Total	**95%**	**100%**	**0%**	**100%**	**100%**	**100%**

	Follow-up Routine Care (Within 30 business days Presc-Psychiatry) (Within 10 business days Non-Presc-Psychology)			BH Routine Care (Preventive) Appointment (Within 10 business days)		
	2025 % Compliant	*2024 % Compliant*	*2023 % Compliant*	*2025 % Compliant*	*2024 % Compliant*	*2023 % Compliant*
Psychiatry	100%	100%	100%	100%	100%	100%
Psychology	100%	100%	100%	100%	100%	100%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

	Non- Life Threatening Emergency (Within 6 hours)			Return Calls During Business Day (Same Day)		
	2025 % Compliant	*2024 % Compliant*	*2023 % Compliant*	*2025 % Compliant*	*2024 % Compliant*	*2023 % Compliant*
Psychiatry	89%	72%	100%	89%	100%	N/A
Psychology	100%	89%	100%	77%	100%	N/A
Total	**95%**	**81%**	**100%**	**82%**	**100%**	**27%**

The above tables summarize MHCA's 2025 appointment accessibility performance for the provider types in behavioral health. The Health Plan exceeded the goal of 90% compliance for Urgent Care w/o Prior Authorization and Non-Life-Threatening Emergency achieved 95%, Urgent Care w/Prior Authorization, Follow-Up Routine Care, and Routine Care (Preventive) achieved 100%. Return Call During the Business Day (82%) failed to meet the 90% compliance goal.

Urgent Care w/o Prior Authorization decreased five percentage points from 2025 to 2024 and increased 95 percentage points from 2025 to 2023.

Urgent Care w/Prior Authorization, Follow-Up Routine Care, and Routine Care (Preventive) all remained unchanged at 100% for 2025, 2024, and 2023.

Non-Life-Threatening Emergency increased 14 percentage points from 2025 to 2024 and decreased five percentage points from 2025 to 2023.

Return Call During the Business Day decreased 18 percentage points from 2025 to 2024 and increased 55 percentage points from 2025 to 2023.

Based on Molina's Behavioral Health appointment accessibility data, the Health Plan identified the following barriers to accessing care:

- The implementation of accessibility standards is hindered by a decrease in provider awareness of availability standards.

To mitigate these barriers the Health Plan will educate providers through mailings and in-person meetings. The goal is to review accessibility standards and resolve issues that prevent offices from meeting them. These efforts will be continuously tracked during the next measurement period to assess their effectiveness in helping practitioners improve their accessibility performance.

After-Hours Accessibility for Behavioral Health Providers

	After-Hours (24/7 coverage)			Return Call After-Hours (Within 30 minutes)		
	2025 % Compliant	*2024 % Compliant*	*2023 % Compliant*	*2025 % Compliant*	*2024 % Compliant*	*2023 % Compliant*
Psychiatry	44%	83%	100%	N/A	0%	N/A
Psychology	46%	84%	100%	13%	0%	N/A
Total	**45%**	**84%**	**100%**	**8%**	**0%**	**16%**

Behavioral Health practitioners did not meet the 90% compliance goal and contractually required accessibility standards for After-Hours Availability (45%) and Return Call After-Hours (8%). The above table summarizes MHCA's 2025 Behavioral Health appointment after-hours performance.

After-Hours Availability decreased 39 percentage points from 2025 to 2024 and 55 percentage points from 2025 to 2023. Return Call After-Hours increased eight percentage points from 2025 to 2024 and decreased eight percentage points from 2025 to 2023.

Based on Molina's Behavioral Health appointment accessibility data, the Health Plan identified the following barriers to accessing care:

- Providers are not aware of the after-hour availability standards.

To mitigate these barriers the Health Plan will deploy a multi-pronged strategy to enhance provider accessibility, which includes distributing educational materials and conducting in person sessions to discuss standards and troubleshoot existing barriers. The effectiveness of these measures will be continuously assessed over the upcoming measurement period, ensuring that practitioners are well-supported in their efforts to achieve accessibility goals.

MHCA's analysis of access to behavioral health accessibility standards for its members shows steady compliance during the three year review period in behavioral health practitioners meeting the 90% compliance goal. This is in line with previous years' performance. After-Hours availability standards failed to meet the 90% compliance goal and are in line with previous three years' performance. Results may be subject to variance in surveying methodology, including sampling criteria.

Specialty Care Provider Accessibility of Services Results

MHCA assessed access to high-impact and high-volume practitioners within its network based on the needs of its member population to maintain the appropriate structure and resources to ensure access to services according to the established standards. After removing duplicate providers and those with fewer claims during the measurement period, MHCA attempted to contact 58 high-impact and 47 high-volume providers. The response rate was 36% for high-impact providers and 57% for high-volume providers. Details for appointment availability are summarized in the tables below by practitioner type.

Appointment Availability for High-Impact Specialty Care Providers

	Routine Care (Within 15 business day)			Urgent Care w/o PA (Within 48 hours)		
	2025 % Compliant	*2024 % Compliant*	*2023 % Compliant*	*2025 % Compliant*	*2024 % Compliant*	*2023 % Compliant*
Hematology/Oncology	100%	100%	100%	91%	100%	100%
Total	**100%**	**100%**	**100%**	**91%**	**100%**	**100%**

	Urgent Care w/ PA (Within 96 hours)			Return Calls During Business Day (Same Day)		
	2025 % Compliant	*2024 % Compliant*	*2023 % Compliant*	*2025 % Compliant*	*2024 % Compliant*	*2023 % Compliant*
Hematology/Oncology	100%	N/A	100%	67%	100%	23%
Total	**100%**	**N/A**	**100%**	**67%**	**100%**	**23%**

The above tables summarize MHCA's 2025 appointment accessibility performance for the high-impact specialty provider, hematology/oncology, type. The Health Plan exceeded the goal of 90% for Routine Care and Urgent Care w/Prior Authorization as each achieved 100% and Urgent Care w/o Prior Authorization reached 91%.

Routine Care remained unchanged during the three year review achieving 100% each year.

Urgent Care w/o Prior Authorization decreased nine percent points from 2025 to 2024 and again in 2025 to 2023.

Urgent Care w/Prior Authorization was not assessed in 2024 so no comparison can be made and 2025 and 2023 both achieved 100%.

After-Hours Accessibility for High-Impact Providers

	After-Hours (24/7 coverage)			Return Call After-Hours (Within 30 minutes)		
	2025 % Compliant	*2024 % Compliant*	*2023 % Compliant*	*2025 % Compliant*	*2024 % Compliant*	*2023 % Compliant*
Hematology/Oncology	67%	95%	100%	0%	0%	0%
Total	**67%**	**95%**	**100%**	**0%**	**0%**	**0%**

High-Impact practitioners did not meet the 90% compliance goal and contractually required accessibility standards for After-Hours Availability (67%) and Return Call After-Hours (0%). The above table summarizes MHCA's 2025 High-Impact appointment after-hours performance.

After-Hours Availability decreased 28 percentage points from 2025 to 2024 and 33 percentage points from 2025 to 2023. Return Call After-Hours remained unchanged for 2025, 2024, 2023 at 0%.

Based on Molina's High-Impact appointment accessibility data, the Health Plan identified the following barriers to accessing care:

- Providers are not aware of the after-hour availability standards.

To mitigate these barriers the Health Plan will deploy a multi-pronged strategy to enhance provider accessibility, which includes distributing educational materials and conducting in person sessions to discuss standards and troubleshoot existing barriers. The effectiveness of these measures will be continuously assessed over the upcoming measurement period, ensuring that practitioners are well-supported in their efforts to achieve accessibility goals.

MHCA's analysis of access to High-Impact accessibility standards for its members shows steady compliance during the three year review period in High-Impact practitioners meeting the 90% compliance goal. This is in line with previous years' performance. After-Hours availability standards failed to meet the 90% compliance goal during the three year review period and are in line with previous three years' performance. Results may be subject to variance in surveying methodology, including sampling criteria.

Appointment Availability High-Volume Specialty Care Providers

	Routine Care (Within 15 business day)			Urgent Care w/o PA (Within 48 hours)		
	2025 % Compliant	*2024 % Compliant*	*2023 % Compliant*	*2025 % Compliant*	*2024 % Compliant*	*2023 % Compliant*
OB/GYN	85%	100%	97%	78%	100%	100%
Total	**85%**	**100%**	**97%**	**78%**	**100%**	**100%**

	Urgent Care w/ PA (Within 96 hours)			HV First Prenatal Care Visit Appointment (Within 2 weeks)		
	2025 % Compliant	*2024 % Compliant*	*2023 % Compliant*	*2025 % Compliant*	*2024 % Compliant*	*2023 % Compliant*
OB/GYN	88%	N/A	97%	83%	95%	97%
Total	**88%**	**N/A**	**97%**	**83%**	**95%**	**97%**

	Return Calls During Business Day (Same Day)		
	2025 % Compliant	*2024 % Compliant*	*2023 % Compliant*
OB/GYN	81%	100%	6%
Total	**81%**	**100%**	**6%**

The above tables summarize MHCA's 2025 appointment accessibility performance for the high-volume specialty provider, OB/GYN, type. The Health Plan failed to meet the goal of 90% compliance with all standards surveyed.

Routine Care achieved 85%, which is a decrease of 15 percentage points from 2025 to 2024 and 12 percentage points from 2025 to 2023.

Urgent Care w/o Prior Authorization reached 78%, which is a decrease of 22 percentage points from 2025 to 2024 and again from 2025 to 2023.
Urgent Care w/Prior Authorization achieved 88%, which is a decrease of nine percentage points from 2025 to 2023, and the standard was not assessed in 2024 so no comparison can be made.

First Prenatal Care Visit achieved 83%, which is an eight percentage point decrease from 2025 to 2024 and six percentage point decrease from 2025 to 2023.

Return Call During the Business Day reached 81%, which is a decrease of 19 percentage points from 2025 to

2024 and an increase of 75 percentage points from 2025 to 2023.

Based on Molina's Specialty Care appointment accessibility data, the Health Plan identified the following barriers to accessing care:

- Providers have an insufficient understanding of accessibility standard requirements.
- Alternative appointments can be difficult for specialty provider offices.

To mitigate these barriers the Health Plan will partner with providers by offering educational resources through mail and direct engagement. This communication will clarify accessibility standards and help resolve current barriers. The impact of these supportive measures will be continuously evaluated during the next measurement period to ensure providers can successfully meet their accessibility targets.

After-Hours Accessibility for High-Volume Providers

	After-Hours (24/7 coverage)			Return Call After-Hours (Within 30 minutes)		
	2025 % Compliant	*2024 % Compliant*	*2023 % Compliant*	*2025 % Compliant*	*2024 % Compliant*	*2023 % Compliant*
OB/GYN	63%	95%	100%	9%	0%	12%
Total	**63%**	**95%**	**100%**	**9%**	**0%**	**12%**

High-Volume practitioners did not meet the 90% compliance goal and contractually required accessibility standards for After-Hours Availability (63%) and Return Call After-Hours (9%). The above table summarizes MHCA's 2025 High-Impact appointment after-hours performance.

After-Hours Availability decreased 32 percentage points from 2025 to 2024 and 37 percentage points from 2025 to 2023. Return Call After-Hours increased nine percentage points from 2025 to 2024 and decreased three percentage points from 2025 to 2023.

Based on Molina's High-Impact appointment accessibility data, the Health Plan identified the following barriers to accessing care:

- Providers are not aware of the after-hour availability standards.

To mitigate these barriers the Health Plan will deploy a multi-pronged strategy to enhance provider accessibility, which includes distributing educational materials and conducting in person sessions to discuss standards and troubleshoot existing barriers. The effectiveness of these measures will be continuously assessed over the upcoming measurement period, ensuring that practitioners are well-supported in their efforts to achieve accessibility goals.

MHCA's analysis of access to High-Volume accessibility standards for its members shows a decline in compliance for 2025, which does not match the previous two years. After-Hours availability standards failed to meet the 90% compliance goal during the three year review period and are in line with previous three years' performance. Results may be subject to variance in surveying methodology, including sampling criteria.

Practitioner-Level Analysis

A practitioner-level analysis was performed on Primary Care, Behavioral Health, High-Impact Specialty, and High-Volume Specialty practitioners who did not meet the standards for routine care, urgent care with and without prior authorization, preventive/routine care (child), non-life-threatening emergency, return call during the business day, first prenatal care visit, after-hour accessibility, and return call after-hours.

Practitioner Type	Specialty	Appointment Type	Non-Compliant County (top 3)
	Family Medicine/General Practice	Preventive/Routine Care (Child) Appointment	San Bernardino
		Return Call within Business Hours	Riverside
			San Bernardino
		After-Hours Accessibility	Los Angeles
			San Bernardino
		Return Calls for After Hours	Los Angeles
			San Bernardino

	Internal Medicine	After-Hours Accessibility	San Diego
		Return Calls for After Hours	San Diego
	Pediatric	Return Call within Business Hours	Riverside
		After-Hours Accessibility	Los Angeles
			Riverside
			San Bernardino
		Return Calls for After Hours	Los Angeles
			Riverside
			San Bernardino
BH	Psychiatry	Urgent Care w/o Prior Authorization	San Diego
		Non-Life Threatening Emergency	Los Angeles
		After-Hours Accessibility	Los Angeles
			Riverside
			San Bernardino
		Return Calls for After Hours	Los Angeles
			Riverside
			San Bernardino
	Psychologist	After-Hours Accessibility	Los Angeles
			San Diego
		Return Calls for After Hours	Los Angeles
			San Diego
HI	Hematology/ Oncology	Return Calls During Business Hours	Los Angeles
			West Covina
			San Diego
		Urgent Care w/o Prior Authorization	Los Angeles
		After-Hours Accessibility	Los Angeles
			Alhambra
			San Gabriel
		Return Calls for After Hours	Los Angeles
			Alhambra
			San Gabriel
HV	Obstetrics & Gynecology	Routine Care Appointment	Los Angeles
			San Diego
		Urgent Care w/o Prior Authorization	Los Angeles
			San Diego
		Urgent Care w/ Prior Authorization	Los Angeles
		First Prenatal Care Visit Appointment	Los Angeles
			San Diego
		Return Calls During Business Hours	Los Angeles
			San Diego
		After-Hours Accessibility	Los Angeles
			San Diego

			Riverside
		Return Calls for After Hours	Los Angeles
			San Diego
			Riverside

The analysis for Primary Care Provider's found that family medicine/general practice practitioners were noncompliant with preventive/routine care (child), return call during the business day, after-hours availability, and return calls for after-hours in the counties of San Bernardino, Riverside, and Los Angeles. Internal Medicine practitioners were noncompliant with after-hours availability and return calls for after-hours in the county of San Diego. Pediatricians were noncompliant with return call during the business day, after-hours availability, and return calls for after-hours in the counties of Riverside, Los Angeles, and San Bernardino. Primary Care providers in urban areas often struggle to meet availability standards due to workforce shortages and high patient volume.

The Behavioral Health analysis saw Psychiatrists were noncompliant with urgent care w/o prior authorization, non-life-threatening emergency, after-hour accessibility, and return call for after-hours in the counties of San Diego, Los Angeles, Riverside, and San Bernardino. Psychologists were noncompliant with after-hour accessibility and return call for after-hours in the counties of Los Angeles and San Diego. The behavioral health sector's capacity to meet network adequacy standards is hindered by high patient volume, complex contracting processes, and challenges with physician recruitment even in urban counties like Los Angeles and San Diego.

High-Impact Specialty's analysis found Hematology/Oncology practitioners noncompliant with return call during the business day, urgent care w/o prior authorization, after-hour accessibility, and return call for after-hours in the counties of Los Angeles, West Covina, San Diego, Alhambra, and San Gabriel. Challenges like contracting issues and difficulty attracting practitioners, even to urban and suburban counties like those listed above, often cause high-impact practitioners to struggle to meet availability standards.

High-Volume Specialty's analysis saw OB/GYN's were noncompliant with routine care, urgent care with and without prior authorization, 1st prenatal care visit, return call during the business day, after-hour accessibility, and return call for after-hours in the counties of Los Angeles, San Diego, and Riverside. As with High-Impact Specialty providers, the high patient volume, contracting challenges, and attracting practitioners often leads to struggles meeting the availability standards.

During the Committee meeting, it was noted that primary care, behavioral health, high-impact specialty, and high-volume specialty practitioners struggle with access standards due to a lack of awareness of standards, adequate staffing to meet member needs, and high patient volume for these services. The key issues identified are insufficient awareness and inadequate internal processes to meet the members' access needs. Proposed solutions include recruiting additional doctors and ARNPs to increase available providers. After-hours accessibility could be addressed by implementing nurse triage systems for after-hours calls.

Supplemental Data: Medicaid - Access Complaints (Grievances) and Appeals

To supplement the analysis above, access complaints (grievances) and appeals were reviewed.

Molina Healthcare of California (Molina) has a thorough and consistent process for monitoring, evaluating, and addressing member complaints and appeals. The process is dictated by Molina's core policies and procedures: MHI-QUAL-23 Appeals and Grievances Quality Oversight Policy and Procedure. The purpose of this analysis is

to evaluate member complaints and appeals and identify opportunities for continuous quality improvement consistent with Molina's core policy.

Complaints (Grievances): Molina defines a complaint, also referred to as a grievance, as a member's expression of dissatisfaction about any matter, categorizing each based on a primary issue. Some complaints relate to multiple issues; however, due to system limitations and to control duplication, each member complaint is assigned to a single category. Therefore, this data reflects the number of complaints received from members but may understate the number of issues identified. Complaints are monitored monthly through the Plan-level Quality Improvement Committee (QIC) and analyzed on a quarterly basis.

Appeals: Molina defines an appeal as a formal member request for the Health Plan to reconsider a previous decision related to an adverse determination. Appeals are monitored monthly through the Plan-level Quality Improvement Committee (QIC) and analyzed on a quarterly basis.

Methodology and Data Sources: Continuous monitoring provides Molina with information to assess how effectively the Health Plan addresses member complaints (grievances) and appeals. For this analysis, Molina reviewed all medical and behavioral health-related complaints and appeals (i.e., no sampling occurred) for the Medicaid line of business. The measurement period was January 1, 2023, through June 30, 2025.

This report analyzes the following data:

- Member Complaint (Grievance): A member's expression of dissatisfaction about any matter.
- Member Appeal: A formal member request for the Health Plan to reconsider a previous decision related to an adverse determination.
- Access Category: Challenges involving the availability, timeliness, or adequacy of provider network services.

Quantitative Analysis: Medicaid Access complaints and appeals were distributed across categories as follows:

- Access Complaints were 4,232 (6.70 PTM) in CY 2023, 9,419 (8.46 PTM) in CY 2024, and 5,293 (4.79 PTM) in FY 2024-2025. The category did not meet the 2025 goal.
- Access Appeals were 439 (0.69 PTM) in CY 2023, 619 (0.56 PTM) in CY 2024, and 486 (0.44 PTM) in FY 2024-2025. The category met the 2025 goal.
- Access Behavioral Health Complaints were 240 (0.38 PTM) in CY 2023, 329 (0.30 PTM) in CY 2024, and 0 (0.00 PTM) in FY 2024-2025. The category met the 2025 goal.
- Access Behavioral Health Appeals were 9 (0.01 PTM) in CY 2023, 17 (0.02 PTM) in CY 2024, and 2 (0.00 PTM) in FY 2024-2025. The category met the 2025 goal.

Refer to the table below and Appendix A for a detailed breakdown by category.

Medicaid Access Complaints (Grievances) and Appeals
January 1, 2023, through June 30, 2025

Category	CY 2023		CY 2024		^ FY 2024-2025 (July 1, 2024 – June 30, 2025)		2025 Goal: FY 2024-2025 PTM < 2 PTM*
	Total	PTM	Total	PTM	Total	PTM	Goal Met: Yes/No
Access Complaints	4,232	6.70	9,419	8.46	5,293	4.79	**No**

Access Appeals	439	0.69	619	0.56	486	0.44	**Yes**
Access BH Complaints	240	0.38	329	0.30	0	0.00	**Yes**
Access BH Appeals	9	0.01	17	0.02	2	0.00	**Yes**
Total Membership	**631,738**		**1,113,469**		**1,105,301**		***PTM = Per Thousand Members***

Due to Molina's recent change from calendar year to fiscal year reporting, this analysis reflects a lookback period that includes a six-month overlap of data. This overlap does not affect the integrity of the analysis but may result in duplication within certain reporting periods.

Medicaid Access Complaints (Grievances) and Appeals - Breakdown by Provider Type FY 2024-2025		
Type	**Provider Type**	**Count**
Complaints	Behavioral Health	199
Complaints	Primary Care Provider	2327
Complaints	Specialist	1218
Total Cases (Complaints): 3,744*		

*Note: Complaints breakdown may not equal total complaints due to missing drill down data. Due to the way data is entered and categorized across agents, BH-related complaints are often categorized as non-BH but drilled down to the BH category; therefore, the data for overall complaints is not 1:1 with the drill down. *Qualitative Analysis*: A multi-disciplinary team consisting of Network and Quality leadership, who engage in implementing clinical programs and initiatives, participated in outcome discussions. These discussions focused on the results, barriers, areas of opportunity, and actions to take for improvement. A root cause analysis of the Medicaid complaints and appeals data indicated that remains a primary driver of complaints, specifically for PCPs and Specialists. This suggests that members may be encountering persistent barriers to timely appointments and service availability across the network for both primary and specialty care.

Potential contributing factors include:

- Limited contracted provider capacity in key counties resulting in appointment wait times beyond access standards.
- Prior authorization and referral processes contributing to access-related denials and delays.
- Inconsistent communication from provider offices regarding appointment availability and alternative options (e.g., telehealth, extended hours).]

To mitigate these potential barriers, Molina is evaluating actions such as reinforcing appointment accessibility standards during provider orientation, issuing periodic reminders in provider newsletters, expanding provider recruitment and contracting to strengthen access, increasing monitoring of access-related complaints and appeals with corrective action for practitioners not meeting standards, and reviewing opportunities to streamline prior authorization for commonly requested services. These mitigation activities will be monitored continuously throughout the next measurement period to allow for timely adjustments and mid-cycle corrective actions where needed.

Molina Healthcare of CA's Medicaid complaints and appeals data is reviewed by interdepartmental representatives from quality management, operations, provider relations, utilization management, and member services. Together, these stakeholders conduct root cause analysis; identify new barriers and opportunities for improvement; and guide the development and implementation of appropriate interventions to enhance performance. In FY 2024-2025, Molina met the goal for Medicaid Access Behavioral Health Complaints, Access Appeals and Access Behavioral Health Appeals. The goal was not met for Medicaid Access Complaints. Additional focus on these areas will continue through the intervention activities identified in the opportunities analysis.

Summary

MHCA met the accessibility goals for all appointment types in primary care, behavioral health, and high-impact practitioners but high-volume did not meet any of the standards accessed. MHCA after-hours goals for after-hours accessibility and return calls for after-hours were not met by primary care, behavioral health, or either specialty care. Molina Healthcare of California continues to need improvement in providing adequate care and access to all four provider types surveyed.

Opportunities for Improvement:

- MHCA will continue to evaluate opportunities to recruit and retain high-performing practitioners to the plan.
- MHCA will continue to provide education on appointment and accessibility standards.
- MHCA will continue to collaborate with the provider network on addressing and overcoming barriers to compliance.

Conclusion

Maintaining member access to a strong network is essential to ensure appropriate and timely access to practitioners for MHCA members. The Health Plan continually performs a comprehensive evaluation of the accessibility of the practitioner network and undertakes initiatives to ensure that members have access to quality health care and a variety of practitioners. Our analysis shows that MHCA must improve and increase network access for Primary Care, Behavioral Health, High-Impact, and High-Volume practitioners. The organization will continue to focus on recruiting and retaining providers in these four key areas.

Appendix A

Molina Healthcare of CA Medicaid Access Complaints (Grievances) and Appeals - Breakdown FY 2024-2025	
Type/Subcategory	**Count**

Behavioral Health Access Complaints	**199**
Appointment Availability	64
Cultural/Language/Comm Related	1
Distance Related	2
Eligibility	4
LOA w/Non PAR- Refusal	5
Other	12
PH: Unable to Reach/Lv Message	23
Provider Discharge	1
Provider Not Taking New Patients	1
Referral/Auth Delay	16
Unable to Locate	70
Primary Care Provider Access Complaints	**2,328**
Appointment Availability	797
Cultural/Language/Comm Related	24
Distance Related	34
Eligibility	244
LOA w/Non PAR- Refusal	15
Not Taking New Patients	49
Other	105
PCP Discharge	4
PH: Unable to Reach/Lv Message	148
Referral/Auth Delay	756
Unable to Locate	140
Wait Time	12
Specialist Access Complaints	**1,215**
Appointment Availability	271
Cultural/Language/Comm Related	8
Distance Related	56
Eligibility	87
LOA w/Non PAR- Refusal	18
Other	58
PH: Unable to Reach/Lv Message	47
Provider Discharge	1
Provider Not Taking New Patients	9
Referral/Auth Delay	515
Unable to Locate	141
Wait Time	4
Behavioral Health Access Appeals	**0**
N/A	0
Primary Care Provider Access Appeals	**0**
N/A	0
Specialist Access Appeals	**0**
N/A	0
Total Cases (Complaints and Appeals)	**3,742**

Accessibility of Services Analysis: Marketplace

Introduction

Molina Healthcare of California (MHCA) conducts an annual accessibility assessment against established standards for numbers and geographic distribution for its Marketplace line of business to ensure it maintains an adequate network of practitioners who provide primary care services (i.e., General and Family Practitioners, Internal Medicine, Pediatrics); specialists (i.e., Obstetrician/Gynecologists, Hematology/Oncology); and Behavioral Health practitioners (i.e., Psychiatrists and Psychologists). Performance is evaluated based on State regulatory requirements as well as NCQA standards. This evaluation helps MHCA members seek appropriate care within established time limits.

Primary Care Practitioners (PCPs) serve as gatekeepers to manage the care of MHCA members. The PCP is responsible for ensuring members are up to date with their preventive care; coordinating and ordering health services; and connecting members to specialty care, as needed. Access standards are used as guidelines for PCP offices to triage patients to ensure appointment availability based on clinical needs and by member requests. MHCA must also have arrangements in place to manage after-hours care if an issue were to arise. Arrangements include implementing an answering service for after-hours calls or a voice mailbox that will page the on-call provider to return a member's call. MHCA informs PCPs of these requirements at the time of contracting and via routine updates to the Provider Manual. Members also receive information about getting care after-hours via various member materials, such as the Member Handbook.

Members may experience long waiting times and difficulty finding specialty practitioners with open panels. Delays in receiving medical care result in gaps in care, from diagnosis to treatment. Therefore, MHCA also assesses member access to specialty care practitioners to ensure members receive timely services that meet their needs. Evaluation of access to specialty practitioners includes access to both high-volume specialty and high-impact specialty care. These practitioners are identified based on claims volume relative to the characteristics of the member population. Additionally, MHCA strives to support our members in all aspects of care, including socio-emotional and behavioral health needs. Therefore, we also monitor accessibility of behavioral health practitioners that serve MHCA members.

The purpose of the analysis in this report is to evaluate the accessibility of primary care, specialty care and behavioral healthcare as well as after-hours care in accordance with State regulatory and contractual requirements, and NCQA accreditation standards.

Data Source and Methodology

Continuous monitoring provides the Health Plan with information to assess effectively how MHCA meets established accessibility standards defined for each practitioner type. The provider appointment accessibility audit is conducted by Molina Healthcare Inc. Quality Program Management and Performance Department. MHCA gathers data using a telephonic survey during which our callers speak with a scheduler/front desk staff/office supervisor. A total of three attempts were made to contact the providers in each category. Participants were asked about appointment availability for various medical appointment types and assessed based upon MHCA's access standards. Providers who could not accommodate a specific appointment request were considered compliant if an alternative provider was available to accommodate the request within the specified time limit.

Additionally, after-hours access is also assessed. The following responses were considered as compliant for

after-hours access: calls answered by office staff and calls forwarded to voice messaging with instructions to call the ER; referral to provider on call; referral to Nurse Advice Line; referral to RN on call; and referral to answering service for a call back from a live person. Providers simply providing voicemail without instructions were considered non-compliant against the after-hours access standard.

Data Sampling

The survey population consisted of credentialed primary care (PCP), behavioral health (BH), high-impact (HI), and high-volume (HV) providers based on data obtained from MHCA. After duplicate providers and providers with fewer claims were removed, a statistically valid, random sample of providers was obtained using a sampling error of less than 5% at a 95% confidence level. The sample of providers receiving the survey included primary care, behavioral health, and specialty care (high-impact and high-volume). As part of MHCA's access standards, primary care providers were assessed on the availability of after-hours services. Providers are expected to provide emergency care instructions or access to care during office after-hours.

Identified Practitioners included in this evaluation/definition

Primary Care Practitioners: Molina defines Family Medicine and General Practice, Internal Medicine, and Pediatric providers as Primary Care practitioners.

High-Volume and High-Impact Specialties: Molina defines high-volume participating specialist practitioners as those providing Obstetrics/Gynecology care. High-impact specialists are defined as practitioners who treat specific conditions that have profound consequences for the member and require significant resources. California has identified Hematology/Oncology to be a high impact specialty for our Marketplace member population.

Behavioral Health Practitioners: Molina defines Psychiatrists and Psychologists as Behavioral Health Practitioners.

Measurement period

Data for this analysis was compiled between September 23rd to November 4th for Calendar Year (CY) 2025.

Access Standards

Standards/Goals for Primary and Specialty Care Providers

Medical Appointment Types	Standard
Routine Asymptomatic Care (PCP)	Within 10 Business Days
Routine Preventative Care (Adult) (PCP)	Within 20 Business Days
Routine Preventative Care (Child) (PCP)	Within 10 Business Days
Urgent Care No Prior Authorization (PCP, HI, HV)	Within 48 Hours
Urgent Care with Prior Authorization (PCP, HI, HV)	Within 96 Hours
Return Call within Business Hours (PCP, HI, HV)	Same Business Day
Routine Care (HI, HV)	Within 15 Business Days
After-Hours Accessibility (PCP, HI, HV)	24 Hours A Day/7 Day A Week
Return Call After-Hours (PCP, HI, HV)	Within 30 Minutes After Member Contacts Organization
First Prenatal Care Visit (HV)	Within 2 Weeks

Standards/Goals for Behavioral Health Providers

Behavioral Health Appointment Types	Standard
Urgent Care No Prior Authorization	Within 48 Hours
Urgent Care with Prior Authorization	Within 96 Hours
Routine Follow-Up (Prescriber)	Within 30 Business Days
Routine Follow-Up (Non-Prescriber)	Within 10 Business Days
Routine (Preventive) Care	Within 10 Business Days
Non-Life-Threatening Emergency	Within 6 Hours
Return Call Within Business Hours	Same Business Day
After-Hours Accessibility	24 Hours A Day/7 Day A Week
Return Call After-Hours	30 Minutes After Member Contacts Organization

All provider types must achieve 90% on access standards. Those not complying with the performance standards are notified of the findings and the need for corrective action to meet the appointment standard(s). Providers who are considered non-compliant against access standards are re-surveyed approximately six months after the initial audit has taken place.

Results

Primary Care Provider Accessibility of Services Results

Molina Healthcare of California assessed access to practitioners within its Primary Care network based on the needs of its member population to maintain the appropriate structure and resources according to established standards, during and after business hours. After removing duplicate providers and those with fewer claims during the measurement period, MHCA attempted to contact 47 Primary Care providers. The response rate was 70%. Details for appointment availability are summarized in the tables below by practitioner type.

Appointment Availability for Primary Care Providers

	PCP Asymptomatic Routine Care (Within 10 Business days)			PCP Urgent Care w/o PA (Within 48 hours)		
	2025 % Compliant	*2024 % Compliant*	*2023 % Compliant*	*2025 % Compliant*	*2024 % Compliant*	*2023 % Compliant*
Family & General Medicine	100%	100%	100%	100%	100%	33%
Internal Medicine	100%	100%	0%	100%	100%	0%
Pediatrics	100%	100%	0%	100%	100%	0%
Totals	100%	100%	60%	100%	100%	25%

	PCP Urgent Care w/ PA (Within 96 hours)			PCP Preventive/ Routine Care (Child) (Within 7 Business days)		
	2025 % Compliant	*2024 % Compliant*	*2023 % Compliant*	*2025 % Compliant*	*2024 % Compliant*	*2023 % Compliant*
Family & General Medicine	N/A	N/A	50%	83%	95%	100%
Internal Medicine	N/A	100%	NA	100%	100%	0%
Pediatrics	N/A	100%	0%	100%	100%	0%
Totals	N/A	100%	50%	96%	97%	60%

	PCP Preventive/ Routine Care (Adult) (Within 20 Business days)			Return Calls During Business Day (Same Day)		
	2025 % Compliant	*2024 % Compliant*	*2023 % Compliant*	*2025 % Compliant*	*2024 % Compliant*	*2023 % Compliant*
Family & General Medicine	100%	100%	67%	85%	100%	40%
Internal Medicine	100%	100%	0%	100%	100%	N/A
Pediatrics	100%	100%	0%	87%	100%	N/A
Totals	100%	100%	40%	88%	100%	40%

Primary Care practitioners met and exceeded the 90% compliance goal and contractually required accessibility standards for Asymptomatic Routine Care, Urgent Care w/o Prior Authorization, Preventive/Routine Care (Adult), and Preventative/Routine Care (Child). There were no participating primary care providers that required prior authorization for urgent care. Return calls during the business day was the only standard assessed that did not meet the 90% compliance goal (88%).

The three-year review shows Asymptomatic Routine Care increased 40 percentage points from 2023 (60%) to 2024 (100%) and maintained 100% compliance in 2025. Urgent care without prior authorization increased 75 percentage points from 2023 (25%) to 2024 (100%) and maintained 100% compliance in 2025. Compliance for urgent care with prior authorization increased 50 percentage points from 2023 (50%) to 2024 (100%). However, of the primary care providers and offices assessed in 2025, none required prior authorization for urgent care. Pediatric preventative/routine care increased 37 percentage points from 2023 (60%) to 2024 (97%) and decreased by 1 percentage point in 2025 (96%). Preventative/routine care for adults increased 60 percentage points from 2023 (40%) to 2024 (100%) and maintained 100% compliance in 2025. In addition to appointment accessibility, Molina evaluated the provider's responsiveness. Return calls during the business day increased 60 percentage points from 2023 (40%) to 2024 (100%) and decreased 12 percentage points in 2025 (88%), narrowly missing the 90% compliance goal. The above tables summarize MHCA's 2025 Primary Care appointment accessibility performance.

After-Hours Accessibility for Primary Care Providers

	After- Hours (24/7 coverage)			Return Call After Hours (Within 30 minutes)		
	2025 % Compliant	*2024 % Compliant*	*2023 % Compliant*	*2025 % Compliant*	*2024 % Compliant*	*2023 % Compliant*
Family & General Medicine	69%	100%	100%	0%	N/A	N/A
Internal Medicine	60%	80%	100%	0%	0%	N/A
Pediatrics	67%	100%	0%	0%	N/A	N/A
Totals	67%	97%	100%	0%	0%	0%

Primary Care practitioners did not meet the 90% compliance goal and contractually required accessibility standards for After-Hours Availability (67%) and Return Call After-Hours (0%). The above table summarizes MHCA's 2025 Primary Care appointment after-hours performance.

After-Hours Availability decreased 3 percentage points from 2023 (100%) to 2024 (97%) and decreased an additional 30 percentage points in 2025 (67%). Return Call After-Hours remained unchanged from 2023 to 2025 at 0% compliance.

Based on Molina's Primary Care appointment accessibility data, the Health Plan identified the following barriers to accessing care:

- Providers are not aware of the after-hour availability standards
- Providers may find it difficult to provide after-hours access
- Staffing limitations may prevent return calls during the required timeframe

To mitigate these barriers the Health Plan will deploy a multi-pronged strategy to enhance provider accessibility, which includes distributing educational materials and conducting in person sessions to discuss standards and troubleshoot existing barriers. The effectiveness of these measures will be continuously assessed over the upcoming measurement period, ensuring that practitioners are well-supported in their efforts to achieve accessibility goals.

Behavioral Health Provider (prescribers and non-prescribers) Accessibility of Services Results

MHCA assessed the availability of Behavioral Health practitioners within its network based on the needs of its member population to maintain the appropriate structure and resources to ensure access to services according to established standards. After removing duplicate providers and those with fewer claims during the measurement period, MHCA attempted to contact 57 behavioral providers. The response rate was 30%. Details for appointment availability are summarized in the tables below by practitioner type.

Appointment Availability for Behavioral Health Providers

	Urgent Care w/o PA (Within 48 hours)			Urgent Care w/ PA (Within 96 hours)		
	2025 % Compliant	*2024 % Compliant*	*2023 % Compliant*	*2025 % Compliant*	*2024 % Compliant*	*2023 % Compliant*
Psychiatry	86%	100%	N/A	N/A	100%	100%
Psychology	100%	100%	N/A	N/A	100%	100%
Total	**93%**	**100%**	**N/A**	**N/A**	**100%**	**100%**

	Follow-up Routine Care (Within 30 business days Presc-Psychiatry) (Within 10 business days Non-Presc-Psychology)			BH Routine Care (Preventive) Appointment (Within 10 business days)		
	2025 % Compliant	*2024 % Compliant*	*2023 % Compliant*	*2025 % Compliant*	*2024 % Compliant*	*2023 % Compliant*
Psychiatry	100%	100%	100%	100%	100%	100%
Psychology	100%	100%	100%	100%	100%	100%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

	Non- Life Threatening Emergency (Within 6 hours)			Return Calls During Business Day (Same Day)		
	2025 % Compliant	*2024 % Compliant*	*2023 % Compliant*	*2025 % Compliant*	*2024 % Compliant*	*2023 % Compliant*
Psychiatry	88%	80%	100%	88%	100%	N/A
Psychology	100%	100%	100%	78%	100%	N/A
Total	**94%**	**85%**	**100%**	**82%**	**100%**	**0%**

The above tables summarize MHCA's 2025 appointment accessibility performance for the provider types in behavioral health. The Health Plan exceeded the goal of 90% compliance for urgent care without prior authorization, follow-up routine care for psychiatrists, follow-up routine care for psychologists, routine preventative care, and non-life-threatening emergency care. There were no participating behavioral health providers that required prior authorization for urgent care needs. Return call during the business day (82%) failed to meet the 90% compliance goal.

Urgent care without prior authorization decreased seven percentage points from 2024 (100%) to 2025 (93%). Urgent care with prior authorization maintained 100% compliance in 2023 and 2024 and was not applicable in 2025. Follow-up routine care for psychiatrists (prescribers), follow-up routine care for psychologists (non-prescribers) and routine preventative care both achieved 100% compliance in 2023 and maintained full accessibility in 2024 and 2025. Non-life-threatening emergency (93%) increased 9 percentage points from 2024 (85%) and decreased 6 percentage points from 2023 (100%). Return calls during the business day earned 82% compliance in 2025, an 18 percentage point decrease from 2024 (100%) and an 82 percentage point increase from 2023 (0%).

Based on Molina's Behavioral Health appointment accessibility data, the Health Plan identified the following barriers to accessing care:

- Staffing limitations may prevent return calls during the required timeframe

To mitigate these barriers the Health Plan will educate providers through mailings and in-person meetings. The goal is to review accessibility standards and resolve issues that prevent offices from meeting them. These efforts will be continuously tracked during the next measurement period to assess their effectiveness in helping practitioners improve their accessibility performance.

After-Hours Accessibility for Behavioral Health Providers

	After-Hours (24/7 coverage)			Return Call After-Hours (Within 30 minutes)		
	2025 % Compliant	*2024 % Compliant*	*2023 % Compliant*	*2025 % Compliant*	*2024 % Compliant*	*2023 % Compliant*
Psychiatry	38%	100%	100%	N/A	N/A	N/A
Psychology	44%	67%	100%	29%	0%	N/A
Total	**41%**	**92%**	**100%**	**17%**	**0%**	**0%**

Behavioral Health practitioners did not meet the 90% compliance goal and contractually required accessibility standards for After-Hours Availability (41%) or Return Call After-Hours (17%). The above table summarizes MHCA's 2025 Behavioral Health appointment after-hours performance.

After-hours availability in 2025 (41%) decreased 51 percentage points from 2024 (92%) and 59 percentage points from 2023 (100%). Return call after-hours maintained 0% compliance in 2023 and 2024 and increased 17 percentage points in 2025 (17%).

Based on Molina's Behavioral Health appointment accessibility data, the Health Plan identified the following barriers to accessing care:

- Providers are not aware of the after-hour availability standards
- Staffing limitations may prevent return calls during the required timeframe

To mitigate these barriers the Health Plan will deploy a multi-pronged strategy to enhance provider accessibility, which includes distributing educational materials and conducting in person sessions to discuss standards and troubleshoot existing barriers. The effectiveness of these measures will be continuously assessed over the upcoming measurement period, ensuring that practitioners are well-supported in their efforts to achieve accessibility goals.

MHCA's analysis of access to behavioral health accessibility standards for its members shows steady compliance during the three-year review period in behavioral health practitioners meeting the 90% compliance goal. This is in line with previous years' performance. After-Hours availability standards failed to meet the 90% compliance goal and are in line with previous three years' performance. Results may be subject to variance in surveying methodology, including sampling criteria.

Specialty Care Provider Accessibility of Services Results

MHCA assessed access to high-impact and high-volume practitioners within its network based on the needs of its member population to maintain the appropriate structure and resources to ensure access to services according to the established standards. After removing duplicate providers and those with fewer claims during the measurement period, MHCA attempted to contact 50 high-impact and 36 high-volume providers. The response rate was 42% for high-impact providers and 64% for high-volume providers. Details for appointment availability are summarized in the tables below by practitioner type.

Appointment Availability for High-Impact Specialty Care Providers

	Routine Care (Within 15 business day)			Urgent Care w/o PA (Within 48 hours)		
	2025 % Compliant	*2024 % Compliant*	*2023 % Compliant*	*2025 % Compliant*	*2024 % Compliant*	*2023 % Compliant*
Hematology/ Oncology	100%	100%	100%	90%	100%	100%
Total	**100%**	**100%**	**100%**	**90%**	**100%**	**100%**

	Urgent Care w/ PA (Within 96 hours)			Return Calls During Business Day (Same Day)		
	2025 % Compliant	*2024 % Compliant*	*2023 % Compliant*	*2025 % Compliant*	*2024 % Compliant*	*2023 % Compliant*
Hematology/ Oncology	89%	N/A	100%	71%	100%	11%
Total	**89%**	**N/A**	**100%**	**71%**	**100%**	**11%**

The above tables summarize MHCA's 2025 appointment accessibility performance for the high-impact specialty providers, specifically hematologists and oncologists. The health plan exceeded the goal of 90% for routine care and urgent care without prior authorization. Urgent care with prior authorization and return calls during business day failed to meet the 90% compliance goal.

Routine care maintained 100% compliance across the three-year review period. Urgent care without prior authorization achieved 100% compliance in 2023 and 2024 and decreased 10 percentage points in 2025 (90%), however still met the 90% compliance goal. Urgent care with prior authorization surpassed the goal in 2023 (100%), was not applicable in 2024, and fell just shy of the goal in 2025 (89%), an 11 percentage point decrease across the three-year review period. Return calls during the business day earned 11% compliance in 2023, increased 89 percentage points in 2024 (100%), and decreased 29 percentage points in 2025 (71%).

Based on Molina's specialty care appointment accessibility data, the Health Plan identified the following barriers to accessing care:

- Staffing limitations may prevent urgent care and return calls during the required timeframe

After-Hours Accessibility for High-Impact Providers

	After-Hours (24/7 coverage)			Return Call After-Hours (Within 30 minutes)		
	2025 % Compliant	*2024 % Compliant*	*2023 % Compliant*	*2025 % Compliant*	*2024 % Compliant*	*2023 % Compliant*
Hematology/ Oncology	67%	92%	100%	0%	0%	0%
Total	**67%**	**92%**	**100%**	**0%**	**0%**	**0%**

High-Impact practitioners did not meet the 90% compliance goal and contractually required accessibility standards for after-hours availability (67%) and return call after-hours (0%). The above table summarizes MHCA's 2025 High-Impact appointment after-hours performance.

After-hours availability decreased 8 percentage points from 2023 (100%) to 2024 (92%) and decreased further in 2025 (67%) by 25 percentage points. Return call after-hours remained unchanged for 2025, 2024, 2023 at 0%.

Based on Molina's High-Impact appointment accessibility data, the Health Plan identified the following barriers to accessing care:

- Providers are not aware of the after-hour availability standards.
- Staffing limitations may prevent urgent care and return calls during the required timeframe

To mitigate these barriers the Health Plan will deploy a multi-pronged strategy to enhance provider accessibility, which includes distributing educational materials and conducting in person sessions to discuss standards and troubleshoot existing barriers. The effectiveness of these measures will be continuously assessed over the upcoming measurement period, ensuring that practitioners are well-supported in their efforts to achieve accessibility goals.

Appointment Availability High-Volume Specialty Care Providers

	Routine Care (Within 15 business day)			Urgent Care w/o PA (Within 48 hours)		
	2025 % Compliant	*2024 % Compliant*	*2023 % Compliant*	*2025 % Compliant*	*2024 % Compliant*	*2023 % Compliant*
OB/GYN	83%	100%	100%	77%	100%	100%
Total	**83%**	**100%**	**100%**	**77%**	**100%**	**100%**

	Urgent Care w/ PA (Within 96 hours)			HV First Prenatal Care Visit Appointment (Within 2 weeks)		
	2025 % Compliant	*2024 % Compliant*	*2023 % Compliant*	*2025 % Compliant*	*2024 % Compliant*	*2023 % Compliant*
OB/GYN	89%	N/A	100%	85%	86%	100%
Total	**89%**	**N/A**	**100%**	**85%**	**86%**	**100%**

	Return Calls During Business Day (Same Day)		
	2025 % Compliant	*2024 % Compliant*	*2023 % Compliant*
OB/GYN	83%	95%	97%
Total	**83%**	**95%**	**97%**

The above tables summarize MHCA's 2025 appointment accessibility performance for the high-volume specialty provider, OB/GYN, type. The Health Plan failed to meet the goal of 90% compliance with all standards surveyed.

Routine care maintained 100% compliance throughout 2023 and 2024 and experienced a 17 percentage point decrease in 2025 (83%), falling short of the 90% compliance goal. Similarly, urgent care without prior authorization maintained 100% compliance across 2023 and 2024 and decreased 23 percentage points in 2025 (77%). Urgent care without prior authorization earned 100% compliance in 2023, was not applicable to the survey in 2024, and decreased 11 percentage points in 2025 (89%). Similarly, first prenatal care appointment accessibility decreased 14 percentage points from 2023 (100%) to 2024 (86%) and decreased further by 1 percentage point from 2024 (86%) to 2025 (85%). Return-call during the business day has also shown steady decline across the three-year period; 2023 (97%), 2024 (95%), 2025 (83%).

Based on Molina's Specialty Care appointment accessibility data, the Health Plan identified the following barriers to accessing care:

- Providers have an insufficient understanding of accessibility standard requirements
- Alternative appointments can be difficult for specialty provider offices
- Staffing limitations may prevent access to care within the required timeframe

To mitigate these barriers the Health Plan will partner with providers by offering educational resources through mail and direct engagement. This communication will clarify accessibility standards and help resolve current barriers. The impact of these supportive measures will be continuously evaluated during the next measurement period to ensure providers can successfully meet their accessibility targets.

After-Hours Accessibility for High-Volume Providers

	After-Hours (24/7 coverage)			Return Call After-Hours (Within 30 minutes)		
	2025 % Compliant	*2024 % Compliant*	*2023 % Compliant*	*2025 % Compliant*	*2024 % Compliant*	*2023 % Compliant*
OB/GYN	81%	100%	6%	63%	95%	100%
Total	**81%**	**100%**	**6%**	**63%**	**95%**	**100%**

High-Volume practitioners did not meet the 90% compliance goal and contractually required accessibility standards for After-Hours Availability (81%) or Return Call After-Hours (63%). The above table summarizes MHCA's 2025 High-Impact appointment after-hours performance.

After-Hours Availability decreased 19 percentage points from 2024 (100%) to 2025 (81%) but shows a 75 percentage point increase from 2023 (6%) results. Return call after-hours earned 100% compliance in 2023, then decreased 5 percentage points in 2024 (95%), and decreased further by 32 percentage points in 2025 (63%).

Based on Molina's high-volume appointment accessibility data, the Health Plan identified the following barriers to accessing care:

- Providers are not aware of the after-hour availability standards
- Staffing limitations may prevent access to care within the required timeframe

To mitigate these barriers the Health Plan will deploy a multi-pronged strategy to enhance provider accessibility, which includes distributing educational materials and conducting in person sessions to discuss standards and troubleshoot existing barriers. The effectiveness of these measures will be continuously assessed over the upcoming measurement period, ensuring that practitioners are well-supported in their efforts to achieve accessibility goals.

MHCA's analysis of access to High-Volume accessibility standards for its members shows a decline in compliance for 2025, which is in line with the previous two years. After-Hours availability standards failed to meet the 2025 90% compliance goal, despite adequate accessibility in the previous two years. Results may be subject to variance in surveying methodology, including sampling criteria.

<u>Practitioner-Level Analysis</u>

A practitioner-level analysis was performed on Primary Care, Behavioral Health, High-Impact Specialty, and High-Volume Specialty practitioners who did not meet the standards for routine care, urgent care with and without prior authorization, preventive/routine care (child), non-life-threatening emergency, return call during the business day, first prenatal care visit, after-hour accessibility, and return call after-hours.

Practitioner Type	Specialty	Appointment Type	Non-Compliant County (top 3)
PCP	Family Medicine/General Practice	Preventive/Routine Care (Child) Appointment	San Bernardino
		Return Call within Business Hours	Riverside
			San Bernardino
		After-Hours Accessibility	Los Angeles
			San Bernardino
		Return Calls for After Hours	Los Angeles
			San Bernardino
	Internal Medicine	After-Hours Accessibility	San Diego
		Return Calls for After Hours	San Diego
	Pediatrics	Return Call within Business Hours	Riverside
			Los Angeles
		After-Hours Accessibility	San Diego
			Los Angeles
			Riverside
		Return Calls for After Hours	San Diego
			Los Angeles
			Riverside
BH	Psychiatry	Non-Life-threatening Emergency	Los Angeles
		Return Calls within Business Hours	San Diego
		After-Hours Accessibility	San Diego
			Los Angeles
			Riverside
		Return Calls for After Hours	San Diego
			Los Angeles
			Riverside
	Psychology	Return Calls within Business Hours	San Diego
		After-Hours Accessibility	San Diego
			Los Angeles
			Riverside
		Return Calls for After Hours	San Diego
			Los Angeles
			Riverside
HI	Hematology/ Oncology	Urgent Care / No Prior Authorization Required Appointment	Los Angeles
		Urgent Care / Prior Authorization Required Appointment	Los Angeles
		Return Calls within Business Hours	Los Angeles
			San Diego
		After-Hours Accessibility	Los Angeles
			San Diego
		Return Calls for After Hours	Los Angeles
			San Diego

HV	OB GYN	Routine Care Appointment	Los Angeles
			San Diego
		Urgent Care w/o Prior Authorization Appointment	San Diego
			Los Angeles
		Urgent Care w/ Prior Authorization Appointment	San Bernardino
		First Prenatal Care Visit Appointment	Los Angeles
			San Diego
		Return Calls During Business Hours	Los Angeles
			San Diego
		After-Hours Accessibility	Los Angeles
			San Diego
			Riverside
		Return Calls for After Hours	Los Angeles
			San Diego
			Riverside

The analysis for primary care providers found that family medicine/general practice practitioners were noncompliant with preventive/routine care (child), return call during the business day, after-hours availability, and return calls for after-hours in the counties of San Bernardino, Riverside, and Los Angeles. Internal Medicine practitioners were noncompliant with after-hours availability and return calls for after-hours in the county of San Diego. Pediatricians were noncompliant with return call during the business day, after-hours availability, and return calls for after-hours in the counties of Riverside, Los Angeles, and San Diego. Primary Care providers in urban areas often struggle to meet availability standards due to workforce shortages and high patient volume.

The behavioral health analysis saw psychiatrists were noncompliant with non-life-threatening emergency care, return call during the business day, after-hour accessibility, and return call for after-hours in the counties of San Diego, Los Angeles, and Riverside. Psychologists were noncompliant with return call during the business day, after-hour accessibility, and return call for after-hours in the counties of San Diego, Los Angeles, and Riverside. The behavioral health sector's capacity to meet network adequacy standards is hindered by high patient volume, complex contracting processes, and challenges with physician recruitment even in urban counties like Los Angeles and San Diego.

High-impact specialty's analysis found Hematology/Oncology practitioners noncompliant with return call during the business day, urgent care w/o prior authorization, urgent care with prior authorization, after-hour accessibility, and return call for after-hours in the counties of Los Angeles and San Diego. Challenges like contracting issues and difficulty attracting practitioners, even to urban and suburban counties like those listed above, often cause high-impact practitioners to struggle to meet availability standards.

High-volume specialty's analysis found OB/GYNs were noncompliant with routine care, urgent care with and without prior authorization, 1st prenatal care visit, return call during the business day, after-hour accessibility, and return call for after-hours in the counties of Los Angeles, San Diego, San Bernardino, and Riverside. As with high-impact specialty providers, the high patient volume, contracting challenges, and attracting practitioners often leads to struggles meeting the availability standards.

During the Committee meeting, it was noted that primary care, behavioral health, high-impact specialty, and high-volume specialty practitioners struggle with access standards due to a lack of awareness of standards, adequate staffing to meet member needs, and high patient volume for these services. The key issues identified are insufficient awareness and inadequate internal processes to meet the members' access needs. Proposed solutions include recruiting additional doctors and ARNPs to increase available providers. After-hours accessibility could be addressed by implementing nurse triage systems for after-hours calls.

Supplemental Data: Marketplace - Access Complaints (Grievances) and Appeals

To supplement the analysis above, access complaints (grievances) and appeals were reviewed. Molina Healthcare of CA (Molina) has a thorough and consistent process for monitoring, evaluating, and addressing member complaints and appeals. The process is dictated by Molina's core policies and procedures: MHI-QUAL-23 Appeals and Grievances Quality Oversight Policy and Procedure. The purpose of this analysis is to evaluate member complaints and appeals and identify opportunities for continuous quality improvement consistent with Molina's core policy.

Complaints (Grievances): Molina defines a complaint, also referred to as a grievance, as a member's expression of dissatisfaction about any matter, categorizing each based on a primary issue. Some complaints relate to multiple issues; however, due to system limitations and to control duplication, each member complaint is assigned to a single category. Therefore, this data reflects the number of complaints received from members but may understate the number of issues identified. Complaints are monitored monthly through the Plan-level Quality Improvement Committee (QIC) and analyzed on a quarterly basis.

Appeals: Molina defines an appeal as a formal member request for the Health Plan to reconsider a previous decision related to an adverse determination. Appeals are monitored monthly through the Plan-level Quality Improvement Committee (QIC) and analyzed on a quarterly basis.

Methodology and Data Sources: Continuous monitoring provides Molina with information to assess how effectively the Health Plan addresses member complaints (grievances) and appeals. For this analysis, Molina reviewed all medical and behavioral health-related complaints and appeals (i.e., no sampling occurred) for the Marketplace line of business. The measurement period was January 1, 2023, through June 30, 2025.

This report analyzes the following data:

- Member Complaint (Grievance): A member's expression of dissatisfaction about any matter.
- Member Appeal: A formal member request for the Health Plan to reconsider a previous decision related to an adverse determination.
- Access Category: Challenges involving the availability, timeliness, or adequacy of provider network services.

Quantitative Analysis: Marketplace Access complaints and appeals were distributed across categories as follows:

- Access Complaints were 801 (9.24 PTM) in CY 2023, 1,869 (32.44 PTM) in CY 2024, and 2,595 (36.76 PTM) in FY 2024-2025. The category did not meet the 2025 goal.
- Access Appeals were 167 (1.93 PTM) in CY 2023, 255 (4.43 PTM) in CY 2024, and 398 (5.64 PTM) in FY 2024-2025. The category did not meet the 2025 goal.

- Access Behavioral Health Complaints were 37 (0.43 PTM) in CY 2023, 65 (1.13 PTM) in CY 2024, and 0 (0 PTM) in FY 2024-2025. The category met the 2025 goal.
- Access Behavioral Health Appeals were 0 (0 PTM) in CY 2023, 3 (0.05 PTM) in CY 2024, and 3 (0.03 PTM) in FY 2024-2025. The category met the 2025goal.

Refer to the table below and Appendix A for a detailed breakdown by category.

Marketplace Access Complaints (Grievances) and Appeals January 1, 2023, through June 30, 2025							
Category	CY 2023		CY 2024		^ FY 2024-2025 (July 1, 2024 – June 30, 2025)		2025 Goal: FY 2024-2025 PTM < 2 PTM*
	Total	PTM	Total	PTM	Total	PTM	Goal Met: Yes/No
Access Complaints	801	9.24	1,869	32.44	2,595	36.76	No
Access Appeals	167	1.93	255	4.43	398	5.64	No
Access BH Complaints	37	0.43	65	1.13	0	0.00	Yes
Access BH Appeals	0	0.00	3	0.05	3	0.04	Yes
Total Membership	86,659		57,620		70,588		*PTM = Per Thousand Members

^ Due to Molina's recent change from calendar year to fiscal year reporting, this analysis reflects a lookback period that includes a six-month overlap of data. This overlap does not affect the integrity of the analysis but may result in duplication within certain reporting periods.

Marketplace Access Complaints (Grievances) and Appeals - Breakdown by Provider Type FY 2024-2025		
Type	Provider Type	Count
Complaints	Behavioral Health	95
Complaints	Primary Care Provider	880
Complaints	Specialist	461
Total Cases (Complaints): 1,436*		

*Note: Complaints breakdown may not equal total complaints due to missing drill down data. Due to the way data is entered and categorized across agents, BH-related complaints are often categorized as non-BH but drilled down to the BH category; therefore, the data for overall complaints is not 1:1 with the drill down.

Qualitative Analysis: A multi-disciplinary team consisting of Network and Quality leadership, who are involved in implementing clinical programs and initiatives, participated in outcome discussions. These discussions focused on the results, barriers, areas of opportunity, and actions to take for improvement. A root cause analysis of the Marketplace complaints and appeals data indicated that Access to PCPs and Specialists remains a primary driver of appeals. This suggests that members may be encountering persistent barriers to timely appointments and service availability across the network, including behavioral health.

Potential contributing factors include:

- Limited contracted provider capacity in key counties resulting in appointment wait times beyond access standards.
- Prior authorization and referral processes contributing to access-related denials and delays.

- Inconsistent communication from provider offices regarding appointment availability and alternative options (e.g., telehealth, extended hours).]

To mitigate these potential barriers, Molina is evaluating actions such as reinforcing appointment accessibility standards during provider orientation, issuing periodic reminders in provider newsletters, expanding provider recruitment and contracting to strengthen access, increasing monitoring of access-related complaints and appeals with corrective action for practitioners not meeting standards, and reviewing opportunities to streamline prior authorization for commonly requested services. These mitigation activities will be monitored continuously throughout the next measurement period to allow for timely adjustments and mid-cycle corrective actions where needed.

Molina Healthcare of CA's Marketplace complaints and appeals data is reviewed by interdepartmental representatives from quality management, operations, provider relations, utilization management, and member services. Together, these stakeholders conduct root cause analysis; identify new barriers and opportunities for improvement; and guide the development and implementation of appropriate interventions to enhance performance. In FY 2024-2025, Molina did not meet the goal for Marketplace Access Complaints, Access Behavioral Health Complaints. Additional focus on these areas will continue through the intervention activities identified in the opportunities analysis.

Summary

MHCA after-hours goals for after-hours accessibility, return calls during the business day, and return calls after-hours were not met by primary care, behavioral health, or either specialty care. Additionally, compliance and accessibility goals were not met for high-impact urgent care with prior authorization. Similarly, none of the assessed high-volume specialty care standards met the 90% compliance goal for 2025. Molina Healthcare of California continues to need improvement in providing adequate care and access to all four provider types surveyed.

Opportunities for Improvement:

- MHCA will continue to evaluate opportunities to recruit and retain high-performing practitioners to the plan
- MHCA will continue to provide education on appointment and accessibility standards
- MHCA will continue to collaborate with the provider network on addressing and overcoming barriers to compliance.

Conclusion

Maintaining member access to a strong network is essential to ensure appropriate and timely access to practitioners for MHCA members. The Health Plan continually performs a comprehensive evaluation of the accessibility of the practitioner network and undertakes initiatives to ensure that members have access to quality health care and a variety of practitioners. Our analysis shows that MHCA must improve and increase network access for Primary Care, Behavioral Health, High-Impact, and High-Volume practitioners. The organization will continue to focus on recruiting and retaining providers in these four key areas.

Appendix A

Molina Healthcare of CA Marketplace Access Complaints (Grievances) and Appeals - Breakdown FY 2024-2025	
Type/Subcategory	**Count**
Behavioral Health Access Complaints	**95**
Appointment Availability	22
Distance Related	3
Eligibility	3
LOA w/Non PAR- Refusal	4
Other	1
PH: Unable to Reach/Lv Message	1
Referral/Auth Delay	15
Unable to Locate	46
Primary Care Provider Access Complaints	**880**
Appointment Availability	259
Cultural/Language/Comm Related	7
Distance Related	18
Eligibility	127
LOA w/Non PAR- Refusal	11
Not Taking New Patients	27
Other	29
PCP Discharge	1
PH: Unable to Reach/Lv Message	28
Referral/Auth Delay	290
Unable to Locate	83
Specialist Access Complaints	**461**
Appointment Availability	87
Cultural/Language/Comm Related	1
Distance Related	24
Eligibility	50
LOA w/Non PAR- Refusal	8
Other	23
PH: Unable to Reach/Lv Message	11
Provider Not Taking New Patients	5
Referral/Auth Delay	174
Unable to Locate	75
Wait Time	3
Behavioral Health Access Appeals	**0**
N/A	0
Primary Care Provider Access Appeals	**0**
N/A	0
Specialist Access Appeals	**0**
N/A	0
Total Cases (Complaints and Appeals)	**1,436**

Appendix 10

2025 Continuity and Coordination of Care: Successes and Opportunities for Improvement for California

Report Date: March 6, 2026

Measurement Period: MY2024

How We Care for Our Members, an Introduction

Continuity and coordination of care are essential in healthcare, ensuring smooth transitions between medical practitioners, behavioral health specialists, and various care settings. These aspects become critical during changes in an individual's condition due to acute or chronic illnesses. Multiple studies highlight that gaps in communication and coordination can lead to errors, inconsistent care, duplicative care, and other issues that can arise with fractured care. Uncoordinated care and lack of care planning leading to significant patient safety risks, polypharmacy issues, and poor outcomes due to lack of planning and follow up. Due to multiple issues in the United States' health care system, individuals have difficulty navigating and connecting care with multiple providers. Often individuals experience both physical and behavioral health issues, complicating and increasing the number of practitioners involved in their care. The current healthcare system has multiple data lakes that store data, and do not effectively communicate across platforms, leading to individuals having multiple diagnostic tests repeated and results not being able to be shared across care settings and entities. efficient mechanisms for seamless information transfer and communication, resulting in challenges in maintaining continuous and coordinated care.

Monitoring and assessing aspects of continuity and coordination of care, and initiating actions as needed to optimize these factors, ensures seamless, continuous, and appropriate care for members. Molina Healthcare of California evaluates Medicaid performance using HEDIS HPR and QRS for the Exchange continuity and coordination measures, formulates improvement plans via workgroups and committees. These groups review all performance measures and focus on the measures that fall below the set threshold, receiving a rating of "1" or "0". The goal is to enhance outcomes for our members across the healthcare network, among medical practitioners, between medical and behavioral healthcare practitioners, and across various healthcare delivery settings.

Methodology

Medicaid

Utilizing the MY2024 HEDIS Technical Specifications, Medicaid rates are extracted from our HEDIS engine which evaluates data submitted by providers and practitioners for compliance in accordance with NCQA HEDIS Technical Specifications. These rates are collected and validated by our HEDIS Auditor, Advent, and submitted to NCQA annually. Although rates are monitored continuously throughout the year, an annual assessment takes place, followed by interventions based on continuous quality improvement activities. Both plan-level and enterprise-level assessments are conducted, employing tools such as Ishikawa Diagrams, discussions of the 5 Whys, and Failure Mode and Effects Analysis to develop hypotheses regarding key rate drivers, and interventions that will best serve our members.

Exchange

The Qualified Health Plan (QHP) insurer, Molina Healthcare of California collects and submits the annual QRS clinical measure and QHP Enrollee Experience Survey data outlined in the QRS Measure Technical Specifications from Centers for Medicare & Medicaid Services (CMS). Guidance is issued by CMS annually in the fall prior to the year of data submission. The data is obtained through the Health Insurance Exchange, aka the Health Insurance Marketplace based on the CMS requirements. Based on the ratings, interventions are determined by the plan and implemented to improve performance and quality of care.

Medicaid Results and Analysis

Molina Healthcare of California measured and calculated the required Medicaid HEDIS HPR rates for continuity and coordination of care measures during the reporting year 2025 for the measurement year 2024.

Table 1 listed below designates each measure required by product line, and the rating score compared to the percentile. If the rating score calculated exceeds the NCQA compliance goal of higher than "1" no improvement plan or action is required for Medicaid. A score of "0" or "1" requires an improvement plan along with actions for Medicaid.

Table 1: Medicaid

Rates and Comparative Analysis for California Medicaid

Medicaid HEDIS HPR Measure	Rate	Measure Rating Score Compared to Percentiles	Score of 1 or better?
1) Eye Exam for Patients with Diabetes (EED)	0.591	3	Yes
2) Prenatal and Postpartum Care (PPC)-Prenatal Rate	0.856	3	Yes
3) Prenatal and Postpartum Care (PPC)-Postpartum Rate	0.856	4	Yes
4) Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	0.48	2	Yes
5) Follow-Up After Hospitalization for Mental Illness, 7 Days Total Rate (FUH)	0.20	1	No
6) Follow-Up After Emergency Department Visit for Mental Illness, 7 Days Total Rate (FUM)	0.36	2	Yes
7) Follow-Up After Emergency Department Visit for Substance Use, 7 Days Total Rate (FUA)	0.282	3	Yes
8) Initiation and Engagement of Substance Use Disorder Treatment, Engagement of SUD Treatment Total Rate (IET)	0.113	3	Yes
9) Follow-Up After High Intensity Care for Substance Use Disorder, 7 Days Total Rate (FUI)	0.154	1	No
10) Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	0.849	4	Yes
Measure Rating Total		26/10	
Measure Rating Average		2.6	

Measures with NA (Small Denominator) or NB (No Benefit) audit designation is not included in calculation of the 3.0 average.
Measures with BR (Biased Rate), NR (Not Reported) or NQ (Not Required) audit designation, it is assigned a rating of 0 and included in the calculation of the 3.0 average. NCQA verifies the calculation at the time of survey.

Medicaid Monitoring Analysis

Molina Healthcare of California monitored its performance of each required Continuity and Coordination of Care measures for HEDIS Health Plan Ratings. This section provides a detailed discussion of the results for each measure for the Medicaid product line.

Eye Exam for Patients with Diabetes (EED) scored a "3." This score met the goal of a HPR >1 so an improvement plan and action are not needed.

Prenatal and Postpartum Care (PPC) – Prenatal Rate scored a "3." This score met the goal of a HPR >1 so an improvement plan and action are not needed.

Prenatal and Postpartum Care (PPC) – Postpartum Rate scored a "4." This score met the goal of a HPR >1 so an improvement plan and action are not needed.

Follow-up After Hospitalization for Mental Illness (FUH) – 7-day Rate scored a "1." This score did not meet the goal of a HPR >1 so an improvement plan and action may be needed.

Follow-up After Emergency Department Visit for Mental Illness (FUM) – 7-day Rate scored a "2." This score met the goal of a HPR >1 so an improvement plan and action are not needed.

Follow-up After Emergency Department Visit for Substance Use (FUA) – 7-day Rate scored a "3." This score met the goal of a HPR >1 so an improvement plan and action are not needed.

Follow-up After High Intensity Care for Substance Use Disorder (FUI) – 7-day Rate scored a "1." This score did not meet the goal of a HPR >1 so an improvement plan and action may be needed.

Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications (SSD) scored a "4". This score met the goal of a HPR >1 so an improvement plan and action are not needed.

Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) scored a "2." This score met the goal of a HPR >1 so an improvement plan and action are not needed.

Initiation and Engagement of Substance Use Disorder Treatment (IET) – Engagement of SUD Treatment scored a "3." This score met the goal of a HPR >1 so an improvement plan and action are not needed.

Based on the above analysis, Molina Healthcare of California has selected Follow-up After Hospitalization for Mental Illness (FUH) and Follow-up After High Intensity Care for Substance Use Disorder (FUI) for focused improvement plan and action.

Table 2 provides detailed information outlining the plan for improvement and actions that are being taken by measure. The table includes a description of each measure that requires an improvement plan and action to improve the measure's performance, description of the action plan and timeframe for implementation, each of the various responsible parties involved, how progress will be monitored and tracked, as well as frequency of monitoring and tracking progress.

Table 2: Medicaid Improvement Plans & Taking Action

HEDIS Measure	Action Plans	Date of each Action	Party Responsible for Improvement Plan Actions & Tasks	Monitoring & Tracking Progress including Frequency
Measure: *FUH/FUI*	**Action(s):** Automated notification to providers of members that have been discharged and require follow-up.	**March 2024 and ongoing**	***BH Access Lead –*** *establish the process of creating automated user-friendly reports for staff to review internally to prepare for staff telephonic or faxed provider notification.* ***PointClickCare –*** *responsible for ADT enhancements* ***Director HCS –*** *responsible for owning the relationship with PointClickCare* ***Case Management staff*** *- Tracking of provider notifications*	**Monitoring & Tracking Methods:** *Daily monitoring of the ADT system/data and full monitoring and evaluation of the program bi-annually* **Frequency:** *ongoing*
Measure: *FUH/FUI*	**Action(s):** When appropriate, have the Case Manager reach out to the member and complete the follow-up visit themselves	**September 2024 and ongoing**	***BH Access Lead –*** *creating materials, training Case management staff and providing case assignments to complete the follow-up visits* ***Case Management staff*** *– completing outreach/visit assignments*	**Monitoring & Tracking Methods:** *Daily monitoring of the ADT system/data and full monitoring and evaluation of the program bi-annually* **Frequency:** *ongoing*

Exchange Results and Analysis

Molina Healthcare of California measured and calculated the required Exchange QRS rates for continuity and coordination of care measures during the reporting year 2025 for the measurement year 2024.

Table 3 listed below designates each measure required by product line, and the rating score compared to the percentile. If the rating score calculated exceeds the NCQA compliance goal of higher than “1” no improvement plan

or action is required for a score of "0" or "1" requires an improvement plan along with actions for Exchange. For Exchange, the improvement plan must identify at least one measure for improvement regardless of its score (Table 4).

Table 3: Exchange

Rates and Comparative Analysis for Exchange

Exchange QRS Measure	Rate	Measure Rating Score Compared to 75th Percentile	Met Goal?
1) Prenatal and Postpartum Care (PPC)-Prenatal Rate	0.789	0.895	No
2) Prenatal and Postpartum Care (PPC)-Postpartum Rate	0.818	0.891	No
3) Depression screening and Follow-Up for Adolescents & Adults (DSF-E)	0.528	0.504	Yes
4) Coordination of Care	78.622	85.878	No
5) Follow-Up After Hospitalization for Mental Illness, 7 Days Total Rate (FUH)	0.111	0.50	No
6) Follow-Up After Hospitalization for Mental Illness, 30 Days (FUH)	0.289	0.718	No
7) Initiation and Engagement of Substance Use Disorder Treatment, Initiation of SUD Treatment Total Rate (IET)	0.528	0.461	Yes
8) Initiation and Engagement of Substance Use Disorder Treatment, Engagement of SUD Treatment (IET)	0.081	0.159	No

Exchange Monitoring Analysis

Molina Healthcare of California monitored its performance of each required Continuity and Coordination of Care measures for the exchange product line, comparing the ratings to the current exchange 75th percentile benchmark. This section provides a detailed discussion of the results for each measure for the Exchange product line.

Prenatal and Postpartum Care (PPC) – Prenatal Rate was 0.789. The 75th percentile benchmark was 0.895. The rate did not meet the benchmark goal, possibly indicating the need for improvement.

Prenatal and Postpartum Care (PPC) – Postpartum Rate was 0.818. The 75th percentile benchmark was 0.891. The rate did not meet the benchmark goal, possibly indicating the need for improvement.

Follow-up After Hospitalization for Mental Illness (FUH) – 7-day Rate was 0.111. The 75th percentile benchmark was 0.50. The rate did not meet the benchmark goal, possibly indicating the need for improvement.

Follow-up After Hospitalization for Mental Illness (FUH) – 30-day Rate was 0.289. The 75th percentile benchmark was 0.718. The rate did not meet the benchmark goal, possibly indicating the need for improvement.

Initiation and Engagement of Substance Use Disorder Treatment (IET) – Initiation of SUD Treatment rate was 0.582. The 75th percentile benchmark was 0.461. The rate met the benchmark goal, indicating improvement and action plan are not necessary.

Initiation and Engagement of Substance Use Disorder Treatment (IET) – Engagement of SUD Treatment was 0.081. The 75th percentile benchmark was 0.159. The rate did not meet the benchmark goal, possibly indicating the need for improvement.

Depression Screening and Follow-up for Adolescents and Adults (DSF-E) – Depression Screening Total was 0.528. The 75th percentile benchmark was 0.504. The rate met the benchmark goal, indicating improvement and action plan are not necessary.

Coordination of Care from the QHP survey was 78.622. The 75th percentile benchmark was 85.878. The rate did not meet the benchmark goal, possibly indicating the need for improvement.

Based on the above analysis, Molina Healthcare of California has selected the measure "Prenatal and Postpartum Care (PPC) - Postpartum" for focused improvement plan and action.

Table 4 provides detailed information outlining the plan for improvement and actions that are being taken. The table includes a description of each measure that requires an improvement plan and action to improve the measure's performance, description of the action plan and timeframe for implementation, each of the various responsible parties involved, how progress will be monitored and tracked, as well as frequency of monitoring and tracking progress.

Table 4: Exchange Improvement Plans & Taking Action

QRS Measure	Action Plans	Date of each Action	Party Responsible for Improvement Plan Actions & Tasks	Monitoring & Tracking Progress including Frequency
Measure: Prenatal & Postpartum Care (PPC) – Postpartum Rate	**Action(s):** National call campaign for all Marketplace postpartum members found not to be compliant with the PPC – postpartum rate measure. Goal is to achieve the QHP 75th percentile Quality Compass benchmark.	**Date(s):** December 2025 and then quarterly in 2026	**Responsible Parties:** Marketplace Quality Team: responsible for identifying member target list. MHI Member Engagement and Intervention (MEI) Team: responsible for pulling the member target lists, creating campaigns in Salesforce, and	**Monitoring & Tracking Methods:** Marketplace Quality team will monitor compliance with measure to generate quarterly member target list as well as overall quarterly program outcome tracking and reporting. MEI monitors and tracks project outreach completion on a weekly basis during the call campaign.

QRS Measure	Action Plans	Date of each Action	Party Responsible for Improvement Plan Actions & Tasks	Monitoring & Tracking Progress including Frequency
			reporting through BI dashboards. Outbound Contact Center: responsible for member outreach.	