2024 QUALITY PROGRAM EVALUATION

Medi-Cal Los Angeles

EXECUTIVE SUMMARY

Blue Shield of California's 2023 quality improvement (QI) program goals and objectives support the quality vision and quality strategy and drive us toward achieving our long-term goals. Detailed goals, objectives and activities for the year are delineated in the 2024 Quality Work Plan. Overarching goals and objectives are listed below.

The 2024 Quality Program Evaluation documents the annual review of the Blue Shield of California's (BSC) Quality Improvement Program for all product lines. This evaluation serves as the foundation for the ongoing Quality Improvement activities described in the 2024 Quality Work Plan and any needed changes to the 2025 Quality Program Description.

Goals & Objectives of 2024 Quality Program:

- Deliver an exceptional quality program across the company.
- Improve the quality, safety, and efficiency of health care services delivered.
- Improve members' experiences with services, care, and their own health outcomes.
- Ensure care and services are provided to members in a way that is equitable and includes services that are culturally and linguistically appropriate.

2024 Outcomes and Accomplishments:

- Maintained NCQA Accreditation status for Medi-Cal.
- Engaged a large provider group in Los Angeles to focus efforts on member preventive and care services.
- Exceeded all customer call center goals.

2024 Overall Barriers:

- Data challenges and data lags continue to impact data integrity and lead to discrepancies in analysis for member and provider initiatives.
- Limited access to accurate member information and lack of real-time data impacts interventions that require outreach.
- Provider availability to take new patients, provider list data accuracy, and reduction of in-person appointments.

2024Opportunities and Outlook:

- Improving accuracy of new enrollee data as incomplete or incorrect contact information hampers interventions and programs such as the Initial Health Assessments member outreach efforts.
- Explore opportunities to collaborate with Quality Improvement and contracted vendors who can conduct Initial Health Assessments visits via telehealth, office hours, and in-home visits.

Table of Contents

OVERVIEW

Blue Shield of California Promise Health Plan (Blue Shield Promise) is a managed care organization, wholly owned by Blue Shield of California, offering Medi-Cal in Los Angeles and San Diego. It is led by healthcare professionals with a "members first" philosophy and is committed to building a quality network of providers and partnering with community organizations for its members.

Blue Shield Promise in Los Angeles works in partnership with L.A. Care Health Plan, the Local Initiative for Los Angeles County. Blue Shield Promise in Los Angeles holds direct contracts with Independent Practice Associations (IPAs) and medical groups. Where quality improvement and performance measurement activities of the IPAs and medical groups are not delegated, Blue Shield Promise is directly overseen by L.A. Care Health Plan for these activities.

Blue Shield Promise Health Plan's Quality Improvement (QI) Program is designed to directly support the Plan's mission by monitoring and improving various aspects of clinical care, clinical service, and organizational services provided to members, while identifying opportunities for enhancements in existing programs and new program developments.

Population

Blue Shield Promise served approximately 393,650 Medi-Cal members in Los Angeles County in 2024.

OVERALL EFFECTIVENESS OF THE PROGRAM

2024 Outcomes and Accomplishments

A. Quality of Clinical Care

- Blue Shield Promise enhanced various tools that were leveraged for targeting outreach efforts and for comparing provider group performance for prioritization of measures and groups to focus efforts. (p. 19)
- In 2024, we further refined the Health Navigator Program to enhance its efficiency and outcomes. (p. 19)
- Blue Shield Promise increased the total amount of well child and mammography clinic days from 21 in 2023 to 26 in 2024 and made program enhancements in 2024. (p. 20)
- The Blue Shield Promise Medi-Cal member outreach team conducts outreach calls to Medi-Cal members with care gaps. In 2024, over 86,000 Los Angeles members were targeted for outreach, with over 24,000 care gaps closed. (p. 30)

- The Clinical Quality Analytics data team met with provider groups to address concerns related to HEDIS care gap closure via supplemental data streams. (p. 39)
- The Clinical Quality Analytics data team also worked with groups to eliminate redundant data in efforts to improve the quality of the supplemental data feeds. (p. 39)

B. Safety of Clinical Care

- The Credentialing Department continues to meet all credentialing timeframes and is compliant with regulatory guidelines. (p. 40)
- The Clinical Quality Review team managed case volumes and maintained compliance with turnaround times within intra-departmental control and workflows and inter-departmental shared processes and communication. (p. 43)
- Met internal compliance goal for Potential Quality Issues (PQIs) average turnaround time (TAT) 190.4 (TAT goal is ≤180 days). (p. 43)

C. Quality of Service

- Customer Service team met the goals for average speed of answer and abandonment rate. (p. 61)
- In 2024, the Delegation Oversight teams conducted 100% of annual delegate audits timely, ensuring those delegated entities that fell below the thresholds were put on a corrective action plan (CAP) and followed to closure. (p. 64)
- All delegated entities for UM, Credentialing and Claims achieved met the goal for timely reporting. (p. 64)

D. Member Experience

- There were no Access Appeals for Medi-Cal in 2024, Medi-Cal appeals rate is below 1.0 and met goal in 2024. (p. 76)
- There were no "Attitude and Service" Appeals for Medi-Cal in 2024, Medi-Cal appeals rate is below 1.0 and met goal in 2024. (p. 76)
- Blue Shield Promise conducted a Medicaid adult and child CAHPS surveys, in 2024, for NCQA accreditation, regulatory purposes, and quality improvement efforts. (p. 67 – 69)
    - Los Angeles Adult had 115 Spanish language completed surveys.
    - Los Angeles Child had 159 Spanish language completed surveys.
    - Access to care measures 'getting needed care' and 'getting care quickly' increased when compared to the previous year for adult CAHPS in LA.

E. Provider Engagement and Experience

- In February 2024, 19 out of 34 participating Blue Shield Promise Medi-Cal providers earned an incentive payout totaling $4.2M for Measurement Year 2023. (p. 83)
- The 2024 PCMH Program provided incentive payments totaling $2.4 M. (p. 85)
- The 2023 Chronic Care Program was paid in June 2024 and totaled $22,199. (p. 86)
- The overall provider survey results for Measurement Year (MY) 2024, for those clinicians who are satisfied, exceed those who are dissatisfied. (p. 88)

Barriers and Opportunities for the 2024 Quality Program

- Comparison of Promise internal HEDIS rates generated by our certified HEDIS software vendor (Inovalon) to L.A. Care HEDIS rates revealed differences in number of members in denominators for multiple measures. Accurate member eligibility for the measure is important to identify members with gaps in care and Blue Shield continues to work with L.A. Care to reconcile the differences.
- Analysis of multiple HEDIS measures for data reconciliation purposes reinforced the need for clinic-level data for robust analysis of gaps in care. We are progressing in this area and now have clinic-level data for some IPAs.
- The HEDIS outreach team experienced challenges as a significant number (an estimated 30%) of members had incorrect phone numbers.
- Enhancing the accuracy of new enrollment data to prevent incomplete or incorrect member contact information from impeding IHA member outreach efforts.
- Continue collaboration with the vendor, Quality Health Partners, to make outreach calls to members, offer telehealth visits, and organize "Clinic Days," which facilitate the completion of an IHA.
- Quality performance is a small component of the AMP program measurement.
- IHA releases results 11 months after close of measure year, which can be frustrating for provider partners to not see results in 'real time'.
- Reimbursement – Clinicians mentioned many times that Blue Shield reimburses poorly and has higher costs for benefit plan products. Several instances were mentioned to comparable health plans that reimburse higher rates. An opportunity exists to compare Blue Shield's reimbursement to other organizations by potentially using coordination of benefits data or external sources for comparison and potential correction.

2025 Program Objectives and Goals

Blue Shield Promise's Quality Program is dedicated to advancing healthcare and transforming the lives of its members through high quality and affordable member-centered care. Blue Shield Promise's quality strategy is to support and ensure accountability across the organization and our providers in personalized, evidence-based care resulting in improved outcomes and member experience.

Blue Shield Promise strives to be recognized as a quality leader in California and nationally by achieving outcomes dedicated to improving health care quality. Our long-term goals include:

- Maintain National Committee for Quality Assurance (NCQA) Health Plan Accreditation across all product lines and achieve a five-star NCQA Health Plan Rating in its Medi-Cal product line.
- Achieve the 75th percentile in all Department of Health Care Services (DHCS) Managed Care Accountability Set measures for Medi-Cal.
- Maintain NCQA Health Equity Accreditation for Medi-Cal.

Blue Shield Promise's Quality Program goals and objectives support the quality vision and strategy that drive us toward achieving our long-term goals. Detailed goals, objectives, and activities for the year are delineated in the Quality Work Plan. Overarching goals and objectives are listed below.

2025 Quality Program Goals

Goal: Deliver an exceptional Quality Program across the company

Objectives:

- Maintain NCQA Health Plan & Health Equity Accreditations for all Medi-Cal products.
- Meet or exceed minimum performance levels in 14 of 18 DHCS Managed Care Accountability Set measures for San Diego and 10 of 18 measures for Los Angeles.

Goal: Improve the quality, safety, and efficiency of health care services delivered

Objectives:

- Improve physical and mental health outcomes.
- Implement mechanisms to identify and address patient safety issues and establish strong relationships with providers to enhance safety within practices and clinics.
- Implement mechanisms to monitor and address timely access to services, especially for members with complex or special needs.
- Monitor, identify and address health disparities in clinical areas.
- Ensure that mechanisms are in place to facilitate and improve continuity, coordination, and transitions of care.
- Ensure there is a separation between medical and financial decision making.
- Ensure members have access to all medically necessary covered services regardless of race, color, national origin, creed, ancestry, religion, language, age, gender/gender identity, marital status, sexual orientation, health status, or disability.
- Ensure quality improvement program goals align with the goals and priorities of the Department of Healthcare Services (DHCS).
- Utilize a system or process to maintain and improve quality-of-care in Medicaid-based services for Dual-eligible members.
- Monitor, evaluate and take action to improve the quality-of-care delivered to Seniors and People with Disabilities (SPD).

- Address all aspects of care; including behavioral health, non-emergency medical transportation, and Long-term Services and Supports (LTSS).
- Ensure adequate clinical resources are in place to administer the Quality Program; including a full-time Chief Medical Officer/Director whose responsibility is direct involvement in the implementation of the Quality Improvement activities in accordance with Title 22 CCR Section 53857.

Goal: Improve members' experiences with services, care, and their own health outcomes

Objectives:

- Maintain a qualified provider network through regular assessments of preventive, primary care, and high-impact providers to ensure accessible health care. Facilitate culturally sensitive and linguistically appropriate services.
- Monitor, improve, and measure member and provider satisfaction with all aspects of the delivery system and network.
- Implement initiatives to improve member and provider experience and satisfaction.
- Ensure performance of delegated vendors and providers against Blue Shield Promise standards and requirements.
- Provide timely, necessary, and appropriate care that meets professional standards for members with diverse and complex needs, including considerations of race, ethnicity, and language.
- Ensure availability and access to care, clinical services, care coordination, and care management to vulnerable populations, including Dual-eligible Duals and Seniors and Persons with Disabilities (SPD).

Goal: Ensure care and services are provided to members in a way that is equitable and includes services that are culturally and linguistically appropriate

Objectives:

- Assess and meet the standards for the cultural and linguistic needs of our members.
- Ensure languages spoken by at least 1% of our membership or 200 individuals, whichever is less, are identified and reviewed against the languages spoken by our provider network with the goal of addressing disparities.
- Adhere to national Culturally and Linguistically Appropriate Services (CLAS) standards and NCQA Healthy Equity Accreditation Standards.
- Develop and maintain processes to obtain and utilize race, ethnicity, and language data in the development of services and programs.
- Assess and implement processes to obtain sexual orientation and gender identity (SOGI) data in the development of Health Equity services and programs while ensuring appropriate privacy protections are in place and training is given to member facing staff.
- Implement or improve programs and services that support the elimination of health care disparities in our membership.
- Ensure the provider network is sufficient to meet the cultural and linguistic needs and preferences of the membership.

Assessment of Quality Program Resources and Committee Structure

Blue Shield Promise (BSP) has a robust cohort of employees dedicated to quality improvement activities, with separate teams that are focused on Commercial, Medicare, and Medi-Cal outcomes. These teams all roll up under a leadership team that works in tandem to achieve our yearly quality goals, as and our longer-term goals, as defined in our annual Quality Program Description.

BSP's Clinical Quality department is comprised of teams specializing in accreditation, clinical quality improvement, clinical quality review, quality analytics and measurement, and quality assurance.

Blue Shield Promise Health Plan maintained the quality committee structure throughout 2024, including network provider participation in a variety of subcommittees. The Quality Oversight Committee (QOC) is charged with the oversight, strategic direction, prioritization, and coordination of the quality program across all product lines. The QOC reports to the Board Quality Improvement Committee (BQIC) and is chaired by the Senior Vice President and Chief Health Officer. The QOC continued with a quarterly cadence with ad-hoc meetings as needed.

Quality Improvement Program and Structure

The Blue Shield Promise Quality Management Committee (QMC) is charged with the development, oversight, guidance, and coordination of Blue Shield Promise quality activities. Comprised of a voting membership of network providers and internal stakeholders of the Quality Program. The QMC approves Medi-Cal specific policies and assures compliance with accrediting and regulatory quality activities from entities including DHCS, DMHC, CMS, NCQA, and L.A. Care. The QMC monitors provisions of care, identifies problems, recommends corrective action, and informs educational opportunities for providers to improve health outcomes.

Chaired by the Blue Shield of California Promise Health Plan Chief Medical Officer or physician designee, the Quality Management Committee reports to the Quality Oversight Committee and meets at least four times per year. All QMC meetings were conducted quarterly as scheduled, with active participation from a mixture of internal and external practitioners with diverse specialties, as well as behavioral health and pharmacy. Quorums were consistently met at each meeting. At least two network physicians are maintained during each meeting to meet the quorum. Standing agenda items include QI work plan updates, sub-committees' reports, appeals and grievances, customer care. Minutes are approved and maintained for each meeting.

QUALITY OF CLINICAL CARE

Medi-Cal HEDIS Results

The table below displays Blue Shield Promise's performance in Los Angeles County on measures from the Managed Care Accountability Set (MCAS) selected by the California Department of Healthcare Services (DHCS). A subset of MCAS measures are held to a Minimum Performance Level (MPL). The MPL is the 50th percentile of the National Committee for Quality Assurance (NCQA) Quality Compass (QC) for Medicaid.

For Measurement Year 2024/Reporting Year 2025, Blue Shield Promise's goal is to meet or exceed the 50th percentile for MCAS measures held to the MPL. We are also continuing to focus on NCQA star rating improvement over time. Blue Shield Promise's current and past performance rates are in the table displayed below. Bold rates indicate the 50th percentile has been met.

Below are the final results of MY 2024 MCAS rates and QC rankings. MY2023 and MY2022 performance are included for reference:

(**Note:** MY2024 HEDIS final rates forthcoming; data to be released and updated in June 2025)

Measure Description	MY2024				MY2023		MY2022	
	MY 2024 MCAS	*MY 2024 Final Rate	*MY 2024 Plan Rating QC Ranking	2023 QC 50th Percentile	MY 2023 Final Rate	2022 QC 50th Percentile	MY 2022 Final Rate	2021 QC 50th Percentile
Prenatal-Postpartum: Rate—Postpartum	X	TBD	TBD	80.23	74.42	78.10	70.45	77.37
Prenatal-Postpartum: Rate—Prenatal	X	TBD	TBD	84.55	**90.70**	84.23	**93.18**	85.40
Child and Adolescent Well Care Visits	X	TBD	TBD	51.81	**52.05**	48.07	46.48	48.93
Child Immunization Status – Combo 10	X	TBD	TBD	27.49	**33.85**	30.90	32.84	34.79
Immunizations for Adolescents – Combination 2	X	TBD	TBD	34.30	**39.75**	34.31	**38.10**	35.04
Well-Child Visits in the First 30 Months of Life (First 15 Months)	X	TBD	TBD	60.38	45.71	58.38	38.89	55.72
Well-Child Visits in the First 30 Months of Life	X	TBD	TBD	69.43	61.78	66.76	58.46	65.83

Measure Description	MY2024				MY2023		MY2022	
	MY 2024 MCAS	*MY 2024 Final Rate	*MY 2024 Plan Rating QC Ranking	2023 QC 50th Percentile	MY 2023 Final Rate	2022 QC 50th Percentile	MY 2022 Final Rate	2021 QC 50th Percentile
(15 Months-30 Months)								
Developmental Screening in the First Three Years of Life [1]	X	TBD	TBD	35.70	**37.52**	34.70	30.18	NA
Topical Fluoride in Children[1]	X	TBD	TBD	19.00	**22.83**	19.30	NA	NA
Lead Screening in Children	X	TBD	TBD	63.84	58.41	62.79	53.21	63.99
Breast Cancer Screening	X	TBD	TBD	52.68	**60.15**	52.60	**55.35**	50.95
Cervical Cancer Screening	X	TBD	TBD	57.18	56.27	57.11	**69.39**	57.64
Chlamydia Screening: Rate—total	X	TBD	TBD	55.95	**70.39**	56.04	**68.71**	55.32
Asthma Medication Ratio	X	TBD	TBD	66.24	58.79	65.61	58.85	69.18
Controlling High Blood Pressure	X	TBD	TBD	64.48	**68.29**	61.31	**65.91**	59.85
Glycemic Status Assessment for Patients With Diabetes (>9%)[2]	X	TBD	TBD	33.33	40.48	37.96	**35.56**	39.90
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (Total)	X	TBD	TBD	36.18	24.72	36.34	22.21	21.24
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (Total)	X	TBD	TBD	53.82	34.53	54.87	32.58	54.51
Postpartum Depression Screening and Follow Up – Depression Screening	X	TBD	TBD	1.30	**7.85**	0.10	0.93	NA
Postpartum Depression Screening and Follow Up –	X	TBD	TBD	61.70	**70.37**	63.40	40.00	NA

Measure Description	MY2024				MY2023		MY2022	
	MY 2024 MCAS	*MY 2024 Final Rate	*MY 2024 Plan Rating QC Ranking	2023 QC 50th Percentile	MY 2023 Final Rate	2022 QC 50th Percentile	MY 2022 Final Rate	2021 QC 50th Percentile
Follow Up on Positive Screen								
Prenatal Depression Screening and Follow Up– Depression Screening	X	TBD	TBD	5.62	**7.71**	0.23	1.00	NA
Prenatal Depression Screening and Follow Up – Follow Up on Positive Screen	X	TBD	TBD	50.98	50.00	54.84	16.67	NA
Prenatal Immunization Status (Combination)	X	TBD	TBD	20.85	18.51	19.49	17.43	19.93
Adult's Access to Preventative/ Ambulatory Health Services	X	TBD	TBD	74.88	61.30	72.91	60.03	76.50
Colorectal Cancer Screening	X	TBD	TBD	38.07	37.72	NA	34.05	NA
Antidepressant Meds: Rate--Acute Phase	X	TBD	TBD	62.43	**86.04**	60.79	**60.80**	60.44
Antidepressant Meds: Rate—Continuation	X	TBD	TBD	44.25	**75.13**	43.28	**42.59**	42.96
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications	X	TBD	TBD	81.42	**81.21**	79.05	**80.56**	79.36
Follow-Up After ED Visit for Substance Use - 7 days	X	TBD	TBD	24.00	14.81	24.51	13.29	13.39
Follow-Up After Emergency Department Visit for Mental Illness – 7 days	X	TBD	TBD	38.62	22.37	40.59	20.57	40.38
Follow-Up for Children w/ ADHD Meds: Continuation and Maintenance	X	TBD	TBD	53.90	52.09	54.40	**65.43**	51.78

Measure Description	MY2024				MY2023		MY2022	
	MY 2024 MCAS	*MY 2024 Final Rate	*MY 2024 Plan Rating QC Ranking	2023 QC 50th Percentile	MY 2023 Final Rate	2022 QC 50th Percentile	MY 2022 Final Rate	2021 QC 50th Percentile
Follow-Up for Children w/ ADHD Meds: Initiation	X	TBD	TBD	45.72	**54.93**	44.21	**52.48**	39.78
Metabolic Monitoring for Children and Adolescents on Antipsychotics	X	TBD	TBD	35.59	**48.26**	34.38	**49.44**	34.30
Pharmacotherapy for Opioid Use Disorder	X	TBD	TBD	25.28	**34.51**	28.49	13.46	28.50
Plan All-Cause Readmissions	X	TBD	TBD	0.9619	NA	0.9853	NA	0.9960
Depression Remission or Response for Adolescents and Adults – Depression Remission	X	TBD	TBD	4.17	**5.26**	NA	NA	NA
Depression Remission or Response for Adolescents and Adults – Depression Response	X	TBD	TBD	7.89	6.32	NA	NA	NA
Depression Remission or Response for Adolescents and Adults – Follow Up PHQ-9	X	TBD	TBD	26.68	22.11	NA	NA	NA
Depression Screening and Follow-Up for Adolescents and Adults - Screening	X	TBD	TBD	1.03	**5.35**	NA	NA	NA
Depression Screening and Follow-Up for Adolescents and Adults – Follow Up on Positive Screen	X	TBD	TBD	70.91	67.88	NA	38.10	NA

Source: L.A. Care HEDIS Rate Tracker, provided by L.A. Care. Due to continued data reconciliation work (see Barriers below), Blue Shield Promise uses rates L.A. Care reports to DHCS rather than internal Inovalon (vendor) rates.

*[1] Uses CMS National Median for Federal Fiscal Year 2023/Fiscal Year 2024 reporting published in September 2024/2023 for the two non-HEDIS measures

[2] MY2023 and MY2022 – using rates and percentiles for Hemoglobin A1c Control for Patients with Diabetes – HbA1c Poor Control (> 9%)

*MY 2024 data will be available in Q2 2025.

Quantitative Analysis:

For Los Angeles, there are 18 Managed Care Accountability Set (MCAS) measures that are held to the minimum performance level (MPL) set at the 50th percentile. Eleven MCAS measures met or exceeded the 50th percentile according to NCQA's Quality Compass Percentile Ranking, improving from 9 measures that met the 50th percentile in 2023. Measures that met or exceeded the 50th percentile in 2024 are listed below:

a) Child and Adolescent Well-Care Visits
b) Developmental Screening in the First Three Years of Life
c) Immunizations for Adolescents – Combination 2 Immunizations
d) Lead Screening in Children
e) Topical Fluoride in Children
f) Breast Cancer Screening
g) Cervical Cancer Screening
h) Chlamydia Screening in Women
i) Prenatal and Postpartum Care – Postpartum care
j) Prenatal and Postpartum Care – Timeliness of Prenatal Care
k) Controlling Blood Pressure

2024 L.A. Care Auto-Assigned Membership Incentive

In Los Angeles County, auto-assigned membership is awarded by L.A. Care based solely on the Plan Partner Incentive performance in a set of measures for Quality Improvement, Member Satisfaction, Utilization Management, and Encounters. Auto-assignment allocation is based on 1) our year-over-year improvement in the Plan Partner Incentive measures and 2) our performance on the measure set versus Anthem's. The methodology for auto-assignment is based on that of DHCS.

Of the auto-assigned membership available to L.A. Care, Promise Health Plan, and Anthem combined, L.A. Care always keeps 50% of the pool and the other 50% is divided between Promise and Anthem based on performance in the Plan Partner Incentive program.

For calendar year 2024, our auto-assignment allocation was based on our measurement year 2022 (MY2022) performance in the Plan Partner Incentive program. Promise Health Plan received 31% of the pool available, Anthem received 19%, and L.A. Care retained its 50%. This was a 7.5% increase from our 2021 allocation of 23.5%.

Qualitative Analysis: Barriers

Many factors influence HEDIS performance. One of the biggest impacts to HEDIS scores is data completeness and accuracy. How data is captured, reported, and communicated across platforms and between entities is a vital component to a successful Quality program.

Other major barriers include:

PLAN BARRIER		
Barrier	**Cause**	**Reason/Effect**
Data Reconciliation with L.A. Care (Regulator)	Multiple data sources and ingestion issues	Comparison of Promise internal HEDIS rates generated by our certified HEDIS software vendor (Inovalon) to L.A. Care HEDIS rates revealed differences in number of members in denominators for multiple measures. The Promise Clinical Quality Analytics department investigated possible causes of differing rates. Blue Shield Promise started an ongoing communication with L.A. Care providing examples of our discrepancies to L.A. Care's HEDIS team to investigate the root cause. Accurate member eligibility for the measure is important to identify members with gaps in care and we continue to work with L.A. Care to reconcile the differences.
Lack of clinic-level data for member care gap analysis	Promise does not have data at the clinic level in Los Angeles County	To aid providers more effectively in outreach to members with gaps in care, Blue Shield Promise requires data at the clinic level for Los Angeles County. Currently, Blue Shield Promise distributes reports on member gaps in care at the Independent Physician Association (IPA) level. Analysis of multiple measures for data reconciliation purposes mentioned above reinforced the need for clinic-level data for robust analysis of gaps in care. We are progressing in this area and now have clinic-level data for some IPAs.

Inaccurate member contact information	Members do not update changes to their contact information with the State	Difficulty outreaching to members to schedule appointments, with an estimated 30% of phone numbers incorrect.
PROVIDER/GROUP BARRIERS		
Barrier	**Cause**	**Reason/Effect**
Data Submission	Labs	Smaller labs that Blue Shield Promise is contracted with do not have the capability to submit electronic files with the lab results. No data sharing agreements with smaller labs to receive lab results. Independent Physician Association (IPAs) and Physician Provider Group (PPGs) submit claims and encounter data to the health plan but very few of them submit lab results to Blue Shield Promise. Identifying member information in the lab data is sometimes challenging. Labs can use different patient identifiers (e.g. CIN Number, MHC Number, SSN, etc.) and are not consistently entering the data in the correct field. In addition, payer codes are sometimes not maintained so the labs are not sending all data.
Medical Record Review	Incomplete provider documentation	Some of the measures are missing all components and/or full record of previous tests and/or complete results.
Continuity and Coordination of Care	Lack of coordination between PCPs and specialty providers	Primary Care Practitioners (PCPs) do not always get reports back from Specialists and ancillary care providers after referrals.

		Reports from labs and radiology centers are not always received by the PCPs. During the medical record review process, there was evidence that a lab was ordered but there was no result in the record despite encounter data showing that the lab was completed as ordered. Increased coordination and communication are needed between departments and teams that interact regularly with providers and/or plans to help support and/or drive efficient issue resolution. Lack of coordination of care between primary care providers and dental homes.
MEMBER BARRIERS		
Barrier	**Cause**	**Reason/Effect**
Service gap	Social Determinants of Health Family and financial obligations	Decreased parent/member participation due to socio-economic and cultural factors. Meeting basic daily needs often takes precedence over a routine/preventive visit. Transportation challenges and clinic locations impact access to care. Language and literacy barriers. Visits to Out of Network Providers for convenience. Cultural beliefs.

		Transportation: limited and/or difficulty navigating the system and scheduling. Geographic: Distance to receive services and availability of appointment times/clinic hours. Language and communication: Some members do not have reliable access to phone or TDD/TTY services. Education: varying levels of knowledge/understanding. Behavioral co-morbidities Housing instability. Members are unwilling to complete a well women exam with providers they are unfamiliar with.

Accomplishments

1. Enhancements to Performance Monitoring Tools: In 2024, we enhanced various tools that were leveraged for targeting outreach efforts and for comparing provider group performance for prioritization of measures and groups to focus efforts. For instance, we incorporated graphs that plot out a provider group's overall performance based on size, improvement, and the number of measures on pace to reach the minimum performance level administratively. This feature allows the provider group to see how their performance compares to their peers throughout the measurement year. We also developed a prototype that gives us new visibility of quality performance at the provider level. These reports are refreshed monthly and contain summary performance information, monthly trends, year-over-year comparisons, and a blind comparison to other contracted provider groups in the county for each measure. In addition, we continued to enhance our Tableau dashboards that contain heat maps displaying the zip codes and areas with open care gaps for each measure, provider performance and race/ethnicity information. We used these tools to target certain areas of Los Angeles County to launch various types of interventions, targeting specific populations. We continue to receive

positive feedback from our provider groups regarding these tools.

2. Revamping of Provider Incentive Programs: In addition to continuing our Quarter 2 and Quarter 3 care gap closure incentive programs, Blue Shield Promise launched a new quarterly provider incentive program in Quarter 4 of 2024. This new incentive program rewards financially rewards provider groups for every additional compliant care gap closure in Quarter 4 of each measurement year. Compliant gap closures can be achieved through claims, encounters, or supplemental data.

3. Enhanced Health Navigator Program: In 2024, we further refined the Health Navigator Program to enhance its efficiency and outcomes. We revised the program's management structure by appointing a single Promise Lead to oversee all Navigators. We introduced prepopulated trackers, allowing the health navigators to streamline their work and focus on correct documentation of outreach attempts. We continued to conduct regular monthly huddles with the health navigators and team to discuss progress and address issues. Additionally, improved communication and relationships with IPAs contributed to better program outcomes and improved rates in Los Angeles.

4. Well Child and Mobile Mammography Community Clinic Days: We increased the total amount of well child and mammography clinic days from 21 in 2023 to 26 in 2024. We made program changes in 2024. Additional enhancements included adding an additional vendor to increase capacity, providing point of care incentives at events, and improved giveaways (breast cancer awareness bracelets, notebooks, and roses. We also added themes to well child clinics to create a fun, family friendly environment, and included toys as giveaways for the kids. Lastly, we solidified the process to ensure that member PCPs were contacted for those with abnormal screenings to ensure follow up.

5. Prospective Medical Record Review: In 2024, the prospective medical record review project for key childhood measures began earlier than in 2023. The program was initiated to proactively retrieve medical records for members with open gaps in care for specific priority HEDIS measures, aiming to improve administrative rate performance. By starting the project earlier in 2024, more records were reviewed. With more reviewed records we were able to have a better picture of who was truly noncompliant to include in targeted interventions.

6. Strengthening relationships with low performing providers for better performance. In 2024, more time was dedicated to developing relationships with our lower performing provider groups that have a significant impact on our overall performance at the county level. We identified these provider groups utilizing our recently developed Providing Ranking tool. We met monthly, sometimes more than once, with the

provider group's Quality leadership team with the aim of gaining access to the provider's office for tailored improvement training.

7. Successfully initiated and led cross-functional workgroups to effectively socialize and advance the DHCS Bold Goals. Quality developed a workgroup for each Bold Goal or aligned an existing cross-functional workgroup to incorporate the Bold Goals. For each workgroup, either a cross-functional leader was identified as the owner, with a quality owner, or a teammate from Quality was designated as the workgroup owner. Through these workgroups, Quality is brought to forefront by routinely reviewing the quality metrics that align with the Bold Goals, coordinating interventions and programs, and planning new actions.

2024 Interventions

Intervention Description	Barrier Addressed
Quality Provider Engagement: In 2024, a tiering system was implemented with Medi-Cal providers which allowed further stratification of provider interventions. Providers were tiered based on their membership size and quality performance. Provider Group Quality management and provider office staff were educated on HEDIS, improved quality of care strategies, care gaps within their membership, and coding education. The Quality Interventions team also worked with providers and provider office staff to address barriers and opportunities to create specific, targeted interventions to improve their care outcomes.	Data Gap Medical Record Review Access to Records Gaps in encounter data submission Access to Care Improper documentation and Coding
Clinical Action Registry (CAR) reports were shared with provider groups monthly. The CAR reports contain provider group performance on various HEDIS and quality metrics along with member level detail on measure compliance. The member-level reports also allowed provider groups to identify if there were data discrepancies (due to coding, file transfers, documentation) and to work with us to identify the cause and to prevent the issues going forward.	Providers are not aware of their performance Engaging Physician Provider Group (PPGs)/ Independent Physician's Association (IPAs) and Primary Care Practitioner (PCPs) to improve quality.

Intervention Description	Barrier Addressed
The Quality Interventions team worked with provider groups to collect supplemental data throughout the year to ensure that all the services rendered are captured.	
Individual Plan Partner joint operation meetings (JOM) with LA Care began in April of 2024. These meetings aided in aligning targeted actions on specific intervention and data needs.	Streamlining quality interventions and improving the integrity of our data exchanges with our plan partner to encourage a stronger collaborative spirit and sharing of best practices.
Blue Shield Promise participates in the Maternal and Child Health Workgroup led by plan partner L.A. Care, attends webinars held by L.A. Care for provider education, participates in work groups for co-branded Plan Partner collateral development	Provider education and communication regarding HEDIS measures, service provision, available incentives, and mandates
Blue Shield Promise participates in a workgroup focused on improving rates for the Well-Child Visits HEDIS for the First 30 months of life measure. This workgroup is led by plan partner L.A. Care, who developed reports to identify the number of visits each infant had to date. This improvement allowed provider groups to prioritize outreach based on members closest to reaching compliance.	Provider education and communication regarding HEDIS measure requirements.
In 2024, Blue Shield Promise continued our provider incentive programs with a few modifications. Within our Promise Quality Performance Incentive (PQPI) program, the weight of the HEDIS domain increased by 5%, from 75% to 80%. We maintained a Medi-Cal specific multi-domain provider incentive program suited to focus on closure of care gaps, measure compliance and achieving Minimum Performance Level (MPLs). Programs include the Integrated Healthcare Association's (IHA) Align. Measure. Perform (AMP) program for Medi-Cal Managed Care, the Patient Centered Medical Home incentive program, and the Initial Health Assessment provider incentive program. There were also bonus opportunities for patient experience process assessments, submission of SDOH Z codes, and performance on the newer follow-up after emergency department visit for mental health and substance abuse measures. In addition, we continued two care	Provider resources to help fund quality improvement efforts Expanded areas of quality improvement focus

Intervention Description	Barrier Addressed
gap closure incentive programs in Quarter 2, Quarter 3; and a revised version of our Quarter 4 care gap closure program in Quarter 4 of 2024. Our chronic care incentive program continued for the Medi-Cal population in 2024. The Chronic Care Provider Incentive Program was offered to independent practice associations (IPAs) and medical groups (I.e. provider groups) to address the needs of our members with chronic conditions during office visits to improve the recapture rate of eligible chronic condition codes.	
Supplemental Data Exchange: Increased the number of providers, groups, and/or Management Services Organizations (MSOs) providing clinical reports in the Blue Shield Promise layout to ensure correct identification of all Blue Shield Promise members and reporting of clinical data not otherwise reported or possibly lost in regular encounter files and/or claims. This provided better opportunity for: 1. Closing data gaps related to members and services 2. More appropriate outreach to members 3. Greater cooperation with groups on planning and actions	Gaps in encounter data submission
Continued HEDIS member outreach calls: Outreached to Medi-Cal members to educate and address gaps in care, provided scheduling assistance, addressed barriers to care, documented scheduled appointments and placed reminder calls and rescheduled appointments if necessary. The outreach team received prioritized member lists based on measure and deadlines.	Care Gaps: member outreach to improve rates and quality of care
In 2024, we continued our collaboration with the Blue Shield Promise Community and Provider Engagement (CAPE) department to incorporate our gap closure outreach with their community-building endeavors. The CAPE team dedicated staff to outreach to households with care gaps that were already part of their community building outreach efforts. Households nearest to their Community Resource Centers were prioritized. In 2024, additional Community Resource Centers were opened in new locations.	Care Gaps: member outreach to improve rates and quality of care Community Education: educating members on the resources available in their community

Intervention Description	Barrier Addressed
Continuation of the Health Navigator Program: A dedicated Blue Shield Promise Health Navigator is placed at specific clinic locations to conduct outreach to members to support appointment scheduling, health education, identify missing compliant member data and other Promise specific intervention and oversight. In 2024, we assigned one Promise Lead to oversee all Health Navigators, streamlining the program's management.	Care Gaps: member outreach to improve rates and quality of care
Continued and expanded Mobile Mammography Days: Mobile clinic event days for members to receive breast cancer screenings.	Care Gaps: member outreach for increased member engagement to improve rates and quality of care. Access to Care
We also coordinated a Well Women Day Event to provide gift cards on site for women who had a cervical cancer screening and were referred for a mammography on the same day.	Care Gaps: member outreach for increased member engagement to improve rates and quality of care. Access to Care
Provided topical fluoride kids and training to providers: Fluoride kits and hands-on training were provided to providers and their staff who were ready to implement this new treatment for children into their workflow.	Gap Gaps: member engagement and treatment
Continuation of the Well Child Community Clinic Days in partnership with Quality Health Partners where members received well-care visits in the community. In 2024, we expanded these visits to be held at various Community Resources. These events also offered telehealth well-care visits for those unable to keep their scheduled appointments. Blue Shield Promise added the following list of services that were offered during these events: • Developmental screening in the first three years of life • Lead screening for children • And topical fluoride for children Additionally, Quality Health Partners was used to conduct well child visits via telehealth and in-home appointments which expanded access to care across the county for our childhood members.	Care Gaps: member outreach to improve rates and quality of care
Launched new member incentive program “My Wellness Rewards”. My Wellness Rewards member incentive program is an omni channel outreach program that informs and provides target	Care Gaps: member outreach to improve rates

Intervention Description	Barrier Addressed
members with digital and physical gift cards for completing select preventative care services. Blue Shield Promise also continued the mailed fulfillment incentive program which rewards members included in select interventions with physical gift cards for completed care.	and quality of care and member satisfaction.

Trainings conducted in 2024:

Name of the Training	Purpose	Date
Provider Engagement	To gain an understanding of how to engage providers around HEDIS and interventions to improve HEDIS rates and preventive care outcomes	Throughout 2024
HEDIS MRR Training	To learn about the HEDIS measures that are part of hybrid review and how to navigate within system to review and abstract charts.	Throughout 2024
Provider Office HEDIS Optimization Education	Tailored education for provider office staff (Office Managers, medical assistants, receptionists) on how to understand Quality and improve their Provider's HEDIS rates.	Quarter 4, 2024
Provider CAHPS Course	Promoted LA Care Training: Information for providers and office administrators on what CAHPS is and how they can improve patient experience. Topics include access, referrals, communications with patients, and care coordination.	September 2024
Provider and Plan Quality Incentives (PQPI) Learning Sessions	Providing description and payouts of all provider incentive programs: care gap closure programs for Quarters 2, and 3, Year End incentive program in Quarter 4 , and our Promise Quality Performance Incentive (PQPI) program..	June 2024 October 2024

QI Initiatives – Member and Provider Outreach Campaigns

A. Mobile Mammography Unit

Blue Shield Promise, evaluated data which supports unmet healthcare needs. A Mobile Mammography Unit engages women in screening for breast health to support cancer prevention services.

Methodology

Using a Mobile Mammography Unit provides accessible breast health services to Blue Shield of California Promise Health Plan Medi-Cal members by reducing traditional barriers to access (i.e. transportation, time constraints, distrust of health care system) and for Provider Groups to improve Breast Cancer Screening rates identified within the HEDIS Domains of Care. A Mobile Mammography Unit offers visibility, accessibility, informal settings, familiar environments, and connections for members. The anticipated outcomes are (1) For women to use a Mobile Mammography Unit as an option for their primary source of medical care for breast cancer screening (2) Women using Mobile Mammography Units for additional and/or annual visits (3) Initiate Preventive Care (4) Enable Member Self-Efficacy and (5) Advancing Population Health.

Quantitative and Qualitative Analysis

The Mobile Mammography Unit allowed Blue Shield Promise Health Plan to develop relationships with community organizations, assess and respond to unmet healthcare needs, connecting members to wider community resources and successfully build more healthcare capacity. Literature supports (cancer.org) patients with a breast cancer diagnosis early have fewer complications and substantially higher rates of survival than those whose cancer is diagnosed late.

In 2024, a total of 17 Mobile Mammography Days were held at various provider group locations, LA Care co-managed Community Resource Centers, and a Blue Shield resource center. Events took place February – December 2024. In total, there were 975 mammogram appointments scheduled, and 364 members screened. This was an increase of 153% in members scheduled and 108% increase in members screened compared to 2023.

Barriers

We had trouble reaching members to schedule appointments due to wrong phone numbers, being on a Do Not Call list, voicemail being full, and phone numbers being inactive, etc. In addition, on a couple of occasions, the mammogram unit overheated. In some instances, scheduled members canceled with short notice while others simply did not show up.

B. Well Child Clinic Days: Quality Health Partners

Blue Shield Promise partnered with Quality Health Partners (QHP) to conduct well child clinic days across the county. Quality Health Partners focused on well child visits, developmental screenings, lead testing and fluoride varnish applications for all children ages 0-21. These events were held at Blue Shield Resource Center locations across the county. Additionally, Quality Health Partners was able to offer telehealth and in-home appointments to members who were unable to make it to one of the events.

Methodology

For this program, children aged 0-21 years, that have not seen their PCP in more than 12 months were targeted. Blue Shield Promise partners with all contracted providers to gain support for the program and ensure that members are reengaged with their assigned PCP. During the well child visits, Quality Health Partners provided useful education to each member and provided their PCP contact information. In some cases, QHP supported members with scheduling follow up appointments with their assigned PCP.

With support from the members' Primary Care Provider, members in need of their well-care visit were outreached telephonically and offered the opportunity to schedule their well-care visit on a selected date at a Blue Shield Promise Resource Center, via telehealth, or in the comfort of their own home (i.e. an in-home visit).

Strategic locations were secured to provide well-care visits for members able to come in for their scheduled annual well-care visit. The events were held mostly on a Saturday to provide access for many families who were unable to access their Primary Care provider during regular office hours. For those unable to keep their appointments, the location was staffed with a nurse practitioner or physician assistant who was able to conduct a well-care visit via telehealth. In addition to the care the members received, these events provided the opportunity to educate the members on the importance of preventive care and to encourage follow-up visits with their primary care provider.

Quantitative and Qualitative Analysis

The Well Child Clinic Days allowed Blue Shield Promise to develop relationships with the LA Care co-managed Community Resource Centers and reengage members in their healthcare, while also redirecting them back to their PCP.

In 2024, there were 9 Well Child Clinic Days at various LA Care co-managed Community Resource Centers. Events took place June 2024 – October 2024. In total, there were 1,494 members scheduled for these events and 599 members completed their exams. This resulted in a 283% increase in members completed compared to 2023.

By December 31, 2024, well-care visits (telehealth and in-person visits) were conducted for 15,808 members. There were 1,776 members who canceled or did not show up for their visit, accounting for 11% of those scheduled.

Barriers

Valid contact information remains the key barrier to keeping events like these from benefiting an even larger number of members. We were also limited by the narrow availability to hold our events because we had to plan around Community Resource Centers scheduled programming. Unreliable transportation services presented a challenge in 2024, as it resulted in delayed arrivals and late pick-ups of members.

C. Asthma and Behavioral Health Outreach: Quality Health Partners

Blue Shield Promise partnered with Quality Health Partners (QHP) to support two additional key areas, including timely follow-up care for members who had an emergency department (ED) visit for mental illness or substance use, and Asthma Remediation Community Support Referrals for members diagnosed with Asthma, and had an ED visit and/or acute inpatient stay for Asthma. Among members who had an ED visit for mental illness or substance use, Quality Health Partners focused on completing follow-up visits within 30 days of the ED visit, including supporting appropriate referrals to Enhanced Care Management (ECM) services. Among members diagnosed with Asthma and had an ED visit and/or acute inpatient stay for Asthma, QHP offered and appropriately referred members for Asthma Remediation Services, to support physical modifications to the home environment and enable the individual to function in their home, ultimately aiming to prevent acute asthma episodes that could result in the need for emergency services or hospitalization.

Methodology:

To support timely follow-up care for members who had an emergency department (ED) visit for mental illness or substance use, daily Admit, Discharge, and Transfer (ADT) reports were used to identify members who have visited the emergency department (ED) due to substance use, drug overdose, mental illness, or intentional self-harm. The ADT reports include the service level and primary diagnosis code and/or description for the member's visit. These identifying fields enabled Quality to identify ED visits with the primary diagnosis as mental illness, intentional self-harm, substance use, or unintentional drug overdose. Reports were generated to identify members with these specific diagnoses and provided to Quality Health Partners at least three times a week.

Quality Health Partners used the member list for outreach, including at least three phone call attempts, to book telehealth visits with members, ideally within 30 days of the ED visit. Quality Health Partners leveraged mid-level practitioners with behavioral health experience to conduct the telehealth visits, administer standardized screenings for substance use and mental illness, administer social needs screenings, and appropriately refer members for

Enhanced Care Management (ECM) services. Following the visit, Quality Health Partners electronically shared information with the member's assigned Primary Care Provider.

Quality Health Partners also employed telehealth visits to support members diagnosed with Asthma, who had an ED or acute inpatient stay for Asthma. Claims and Pharmacy data were employed to identify non-compliant members within the HEDIS Asthma Medication Ratio (AMR) eligible population who met criteria for Asthma Remediation Services, including an Asthma diagnosis (based on the HEDIS AMR technical specifications) and an ED visit or acute inpatient stay for Asthma. The Clinical Quality Analytics team generated the member list monthly. During the telehealth visit, Quality Health Partners discussed the importance of appropriately filling controller medications and appropriately informed and referred members for Asthma Remediation Services. Among members who accepted Asthma Remediation Services, Quality Health Partners completed the online Community Supports Referral form and submitted attestation letters to the Promise Community Supports team to initiate the remediation service process.

Quantitative and Qualitative Analysis

For the Quality Health Partners outreach supporting timely follow-up care after an ED visit for mental illness or substance use conditions, performance was measured through the following indicators:

- Connection Rate/Appointment Penetration (percentage of visits booked among those outreached)
- Percentage of completed visits among booked visits

Given the primary objective was to achieve timely follow-up visits with members who had ED visits for mental illness and substance use, booking appointments was essential to the primary objective. Additionally, completing or attending the visit is the second main performance measure because completing the visit met numerator criteria for the two behavioral health HEDIS measures. Quality Health Partners performance reports showed that between April – November 2024, 413 members were identified for outreach from the ADT reports, and 105 members had booked appointments, yielding a 25% connection rate/appointment penetration rate. Among the 105 members who booked appointments, 81 members completed visits, demonstrating that 77% of members who booked visits completed them. Given that Enhanced Care Management Referrals were a key component of the telehealth visit, we identified that 48 ECM referrals were submitted between April – November 2024. In other words, among the 81 members who completed visits, approximately 59% (48/81) accepted an ECM referral. Because 2024 is the first year of this type of intervention, this year's results will serve as a baseline for subsequent year results.

In October 2024, Quality Health Partners began outreach and supported telehealth visits for members diagnosed with Asthma, who had an ED or acute inpatient stay for Asthma. Performance was measured through the same indicators because booking and completing visits was essential to assessing and referring the member for Asthma Remediation Services. The telehealth visit provided Quality Health Partners with the information and feedback

necessary to initiate the Asthma Remediation Referral process, including submitting the provider's attestation. From October – November, 146 eligible members were eligible for outreach for San Diego. Among the 146 members, 35 booked an appointment, yielding a 24% connection rate/appointment penetration rate. Among the 35 members who booked appointments, 80% of members completed visits (28 out of 35). Lastly, among the 28 members who completed their visits, 20 accepted the referral for Asthma Remediation Services, and Quality Health Partners submitted attestation letters for those members. Given this is a new type of intervention and Community Support, we will continue monitoring this intervention to establish baseline performance in 2025.

Barriers

For both programs, lack of valid phone numbers remains a key barrier to reaching members and booking appointments. One solution we are exploring in 2025 is the use of alternate contact information provided from the health information exchanges (HIE's). The HIE's may contain more updated contact information necessary to reach the member.

Another barrier specific to timely follow-up care for members who had an ED visit for mental illness or substance use is that a large percentage of members identified with an ED visit from the ADT reports do not meet denominator criteria for the HEDIS measures "Follow-Up After Emergency Department Visit for Mental Illness," or "Follow-Up After Emergency Department Visit for Substance Use." The outreach is intended to support these two quality metrics, however, identifying real-time data sources to outreach to eligible members remains a challenge. In 2025, we will be collaborating with Data & Analytics to assess other data sources to identify potential eligible members for outreach, including the Continuity of Care Document (CCD) data.

Quality will continue to implement, modify, and evaluate these two outreach programs in 2025.

D. Health Navigator

For this program, a dedicated Blue Shield Promise Health Navigator (1 FTE) is placed at a specific clinic or IPA location to conduct outreach to members to support with appointment scheduling, health education, identify missing compliant data and other Promise specific intervention implementation and oversight. Embedded health navigators are located at a clinic site, can meet with members face-to-face, works directly with clinic's quality team and providers, and can influence clinic processes. Non-embedded health navigators are located at administrative offices or at IPAs.

Methodology

The initiative goal is to improve member relationships and preventative care outcomes through member engagement by the Health Navigator. Health Navigators support clinic processes to address care gaps across the MCAS Measure Set.

Quantitative and Qualitative Analysis:

The program launched in Q4 2022 with a pilot IPA in Los Angeles County. Blue Shield Promise's health navigator program was expanded in 2023 to include additional provider groups in Los Angeles. In 2024, 8 health navigators were active in Los Angeles County scheduling appointments for 11 different IPAs and 4,373 gaps in care were closed. The navigators achieved this by educating members on the significance of wellness visits, detailing the preventive measures implemented by providers, and offering information about the telehealth options available for certain types of visits.

In Los Angeles County, our rates improved in all but two focused Quality measures. On average, IPAs with at least one Health Navigator improved by 4.5% per measure.

Measure	MY 2023 YTD (claims thru 12/10/2023)	MY 2024 YTD (claims thru 12/10/2024, final rates pending)
Asthma Medication Ratio (Total)	69.01%	54.9%
Breast Cancer Screening	60.79%	61.9%
Controlling High Blood Pressure	49.29%	53.9%
Cervical Cancer Screening	53.59%	52.5%
Chlamydia Screening in Women (Total)	68.93%	70.6%
Childhood Immunization Status - Combo 10	22.99%	23.6%
Developmental Screening in the First Three Years of Life	35.95%	46.5%
Follow-Up After Emergency Department Visit for Substance Use - 30 days (Total)	17.80%	22.3%
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (Total)	21.45%	32.2%
Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control	42.24%	39.3%
Immunizations for Adolescents - Combination 2	39.90%	42.1%
Lead Screening in Children	59.73%	63.8%

Prenatal and Postpartum Care - Timeliness of Prenatal Care	75.83%	83.5%
Prenatal and Postpartum Care - Postpartum Care	71.69%	78.0%
Topical Fluoride for Children - Dental or Oral Health Services	0.07%	11.9%
Well-Child Visits in the First 30 Months of Life (First 15 Months)	31.41%	42.8%
Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)	60.96%	69.2%
Child and Adolescent Well-Care Visits (Total)	45.10%	51.2%

Barriers

Because the heath navigator is employed by the FQHC, the MSO or IPA, there is a risk of the employer allowing the Blue Shield Promise funded health navigator to focus on other activities and aiding other departments instead of Blue Shield Promise members. In 2024, there were clinical staffing shortages that led to decreased appointment availability at some locations. Health navigators continued to experience barriers in reaching members due to faulty contact information. In addition, employee retention proved to be difficult in the health care industry.

E. HEDIS Member Outreach

The Blue Shield Promise Medi-Cal member outreach team conducts outreach calls to Medi-Cal members with care gaps. The team initiated calls in January 2024 and continued through December 2024.

Methodology

Members are offered scheduling assistance support and are educated about the importance of completing the visit. The HEDIS member outreach team assists members with transportation needs, conducts reminder calls for scheduled visits, review claims and encounters prior to the calls in case the member already had the service rendered recently, calls the provider offices to confirm that appointments were attended, collect relevant medical records for services that were previously rendered, and remind members of flu vaccinations if applicable.

Quantitative and Qualitative Analysis:

In 2024, over 86,000 Los Angeles members were targeted for outreach, with over 24,000 care gaps closed.

Barriers

The HEDIS outreach team experienced challenges reaching a member, as a significant number of members either had incorrect phone numbers, no phone numbers or did not answer the outreach calls (which consisted of 27% of members). In addition, limited appointment availability at provider offices impacted scheduling outcomes.

F. Member Incentives

The Blue Shield Promise My Wellness Rewards Member Incentive Program is aimed to improve the quality of care for Promise members by incentivizing them to complete needed preventive care and screenings. The goals of this incentive program are to improve MCAS quality scores, motivate members to schedule appointments and complete target health care activities, and increase member satisfaction and health plan loyalty. Blue Shield Promise has contracted with vendor, Healthmine, to implement the incentive program. Target members can receive rewards for completing the following health care activities: Well Child Infant Visits, Well Child Annual Checkups, Cervical Cancer Screening, Breast Cancer Screening, Blood Lead Screening, Immunizations for Adolescents, Flu Vaccine (ages 6 months – 2 years old), and HPV Vaccine (ages 9 to 12).

Methodology

The My Wellness Rewards Program is an omni-channel program (mail, email, digital site) that allows members to redeem their rewards. Members are first informed about the My Wellness Rewards Program and invited to online register for the program via mail. Once the member creates an account, they can view their available health actions and corresponding incentives for completing them. Once the member has completed their health action they can attest to the completed activity through their online portal and choose a reward to redeem. Throughout the year, members are sent mail and emails to encourage them to complete their health care activities and redeem their incentive until the end of the program on December 31, 2024.

Quantitative and Qualitative Analysis

The program was launched in April 2024 and ended 12/31/2024. Members have until 1/31/2025 to redeem gift cards for health care activities completed in 2024. In 2024, 258,266 health care activities were targeted a total of 3,981 incentives for completed activities earned. The table below displays the program results per health care activity.

Health Care Activity (HCA)	HCAs Eligible[1]	Incentives Earned	HCA Utilization
Breast Cancer Screening	8256	162	1.96%
Cervical Cancer Screening	52751	339	0.64%
Immunizations for Adolescents	5,107	96	1.88%
HPV Vaccine (ages 9-12)	19,941	283	1.42%
Blood Lead Screening	2,098	28	1.33%
Annual Well Child Visit (ages 3-17)	116,290	*2511*	2.16%
Annual Well Visit (ages 18-21)	29,060	*339*	1.17%
Well-Child Visit 1 (0-15 Months)	1,689	30	1.78%
Well-Child Visit 2 (0-15 Months)	1,689	23	1.36%
Well-Child Visit 3 (0-15 Months)	1,689	16	0.95%
Well-Child Visit 4 (0-15 Months)	1,689	14	0.83%
Well-Child Visit 5 (0-15 Months)	1,689	13	0.77%
Well-Child Visit 6 (0-15 Months)	1,689	10	0.59%
Well-Child Visit 1 (15-30 Months)	2,149	46	2.14%
Well-Child Visit 2 (15-30 Months)	2,149	27	1.26%
Flu Shot (ages 6 months – 2 years)	10,331	44	0.43%
Total Health Care Activities	**258,266**	**3,981**	**1.54%**

[1]Using noncompliant volume at start of program

*Data for 2024 activities as of 1/27/2025

Barriers

In 2024, we switched to a new incentive vendor and program, ending mail-in attestations for health activities and promoting online registrations for program participation. This shift to digital has caused a drop in incentive redemption, but we expect higher participation in 2025 as members adjust to the new program. Additionally, we faced operational issues with Healthmine, limiting the volume of completed member communications. We intended to send members continual communications throughout 2024 but ended up sending target members four mailers and one email in 2024. With these issues resolved, we are prepared to implement a comprehensive communication strategy for 2025. We continue to not include text messaging as a communication channel due to Telephone Consumer Protection Act (TCPA) concerns.

Advancing Health Equity

In accordance with regulatory and contractual requirements, including the Department of Healthcare Services (DHCS) requirement to integrate equity into various functional areas, the DHCS Bold Goals 50x2025 initiative, and Health Equity Accreditation requirements, the Promise Quality team is aligning its initiatives and investments by employing the following:

- Identifying and mitigating social drivers of health (SDOH) to reduce health care inequities
- Employing the added Medi-Cal benefits that support prevention (e.g., doulas, community support, and Community Health Workers)
- Achieving & maintaining National Committee for Quality Assurance (NCQA) Health Equity Accreditation
- Aligning with the California Department of Managed Health Care (DMHC) All Plan Letter 22-028 Health Equity and Quality Measure Set and Reporting Process

Blue Shield Promise's Quality collaborates with the Health Equity team to use NCQA's Health Equity Accreditation Standards to focus and guide health equity work for Blue Shield Promise members. In alignment with the Health Equity Standards, Blue Shield Promise annually collects data to identify inequities related to race, ethnicity, language, and gender. This framework also supports the DHCS Bold Goals 50x2025 initiative and new DMHC requirements.

In 2024, we observed inequities by race/ethnicity for poor diabetes control for members in Los Angeles County, additionally target goals for Los Angeles were not achieved. Our intervention strategy will focus on reducing inequities for Hispanic/Latino members in Los Angeles County as they accounted for a large proportion of the denominator (when stratifying rates by ethnicity) and had the highest number of members demonstrating HbA1c Poor Control (>9.0%). We collaborated with Health Education to add a Spanish-speaking Diabetes Management series at the Wilmington Community Resource Center in August 2024, targeting members demonstrating poor blood sugar control who live near the resource center, and utilizing a combination of approaches to encourage attendance. We will continue supporting this identified opportunity in 2025.

We also observed inequities by race/ethnicity for Child and Adolescent Well Care Visits (WCV) among Promise members in LA County. Target goals, which was the DHCS Minimum Performance level, were not achieved when stratifying performance by race. Our intervention strategy will focus on reducing inequities for Black/African American, Native Hawaiian/Pacific Islander, American Indian/Alaskan Native, and white members as these groups showed the highest number of preventive care visit gaps among Promise members. In 2024, and continuing in 2025, we will engage our target populations by partnering with Quality Health Partners to improve access to well-child visits. This includes providing scheduling assistance, hosting clinic days, and administering a social drivers of health (SDoH) assessment.

2025 Goals and Outlook

Our performance goals in 2025 remain at meeting or exceeding the 50th percentile for all MCAS measures. Blue Shield Promise plans to continue to build on existing member and provider intervention strategies and launch new targeted interventions to address barriers to care and improve poor performing measures in 2025. In 2025, we will continue to expand partnership with other departments to reach quality goals. See the tables below for a list of existing enhanced and new initiatives in key areas.

Enhanced Existing Work Across Key Areas	
Key Areas	**Enhanced Initiatives**
Member Engagement and Community Partnerships	Refine member segmentation criteria for outreach Focus on converting telehealth well child visits to in-person visits in existing successful programs Developing and deploying targeted member communications with health equity lens Identification of members in population health management programs to reinforce care gap messages and improve reporting of outcomes Targeted outreach to promote health education classes (e.g., diabetes, asthma) Additional mobile mammograms and well child clinics in target areas
Provider Engagement	Provide on-site learning sessions with offices, reviewing patient workflow processes to enhance gap closure and data capture opportunities Restructure provider incentive program to better align with new requirements Delivering and discussing focused lists to providers for targeted measure strategy
Technology, Data & Analytics	Supplemental data educational sessions with provider groups to ensure supplemental data submitted routinely and accurately for primary source verification HEDIS care gap data available in Care Connect and Shield Advisor for all outreach teams

	Tracking of state and county data to ensure data completeness and accuracy

New Initiatives Across Key Areas	
Key Areas	**New Initiatives**
Member Engagement and Community Partnerships	Collaborate with marketing to deploy health reminder/education messages via email and Relay network (texting) Acquire member contact information from health information exchanges Implement program with vendor that uses phlebotomists with medical assistant & community health worker training to close care gaps and address SDOH Engage targeted diabetic members in enrolling in health education programs or Wellvolution program or Medically Tailored Meals (MTM) programs Partner with new CBOs focused on birthing people and infants/children in targeted subpopulations Conduct member focus groups to tailor interventions
Provider Engagement	Promote COZEVA to providers to use as point of care tool and to submit data Promote Asthma Management Program Partner with dental providers for topical fluoride applications Partner with community health workers at provider groups for members who are historically not closing care gap to address SDOH and find members Partner with school-based clinics to close care gaps Implement additional health equity projects with providers

	Promotion of new self-collection HPV testing for cervical cancer screening
Technology, Data & Analytics	Implement single sign-on capability with HealthMine (member incentive program) in Blue Shield member portal Use COZEVA for additional data acquisition, chart review/abstraction automation Expand Epic Payer Platform for more Medi-Cal providers Leverage additional analytics to identify pregnant members earlier for timely outreach Leverage CCD data from HIEs to identify additional members who were in ED for BH or SUD Leverage Decision Point Opus Tool to identify members to target for specific interventions (incorporating health equity)

Data Improvement

Data Improvements - Supplemental Data – DHCS Los Angeles

For 2024, the Clinical Quality Analytics data team's efforts on supplemental data were focused on the areas below.

1. **Provider Tools to support supplemental data submissions**.
    i. Updated the HEDIS Toolkit which consolidates the NCQA specifications and requirements for key HEDIS measures across all lines of business (LOB) into a single document designed to support both clinical and data teams.
    ii. Updated BSC HEDIS Supplemental data requirements document to capture key updates from NCQA pertaining to MY2024, BSC data submission timelines, Primary Source Validation (PSV) requirements, data setup requirements, etc.

2. **Annual Stakeholder Training.**
    i. Provided training for CPMs to provide general overview of HEDIS, Blue Shield Promise data processes including HEDIS supplemental data.
    ii. Hosted a live supplemental data training session with providers to help groups navigate the BSC supplemental data process.

3. **Meetings and communication.**

i. Setup standing monthly meetings with Clinical Program Managers (CPMs) to address various topics regarding HEDIS care gap closure and supplemental data processes.
ii. Hosted monthly "Provider office hours" for external stakeholders addressing general HEDIS / supplemental data topics.

4. **Technical and Analytic Support.**
   i. Provided CPM and provider groups with analytical support on supplemental data related topics.
   ii. Met with provider groups to address concerns related to HEDIS care gap closure via supplemental data streams.
   iii. Worked with groups to eliminate redundant data in efforts to improve the quality of the supplemental data feeds.

5. **LA CARE Partnership.**
   i. Supported efforts towards MY2024 reporting including HEDIS documentation, and auditor validation for supplemental data.
   ii. Attended monthly meetings with LA CARE to discuss and address concerns relating to HEDIS.
   iii. Streamlined the submission of monthly HEDIS files to LA CARE for the proactive HEDIS runs.
   iv. Participated in QI JOM - Blue Shield Promise/LA Care meeting geared toward Quality data reconciliation.

6. **Strategic Data Setups.**
   i. Epic Payor Platform (EPP) – Ingestion of new provider organizations live on EPP in 2024 for HEDIS MY2024 reporting.
   ii. EPIC Clinical Analytics Document (CAnD) implementation allowing ingestion of HEDIS measure focused data from Care Gap data flows and historical events.

7. **Clinical Quality Q4 push.**
   i. Development and distribution of LOB targeted supplemental data care gap reports to support Q4 efforts to close open care gaps.

HEDIS MY2024 PSV and Data Setup Status Summary – MEDICAID LA

Supplemental data expansion in 2024 was driven by priority groups identified by line of business.

PROJECT	# SOURCES	PASSED PSV	FAILED	UNABLE TO COMPLETE
ANNUAL PROACTIVE PSV	12	12	0	0
NEW DATA SETUPS AND PSV	4	3	0	1
	15	15	0	1

2025 Outlook:

Focus areas for 2025.

1. Publication of HEDIS Toolkit and Supplemental requirements documents.
2. Provide technical and analytical support to internal and external stakeholders on HEDIS supplemental data.
3. Digital Health Record (DHR) transition for HEDIS supplemental data.
4. COZEVA implementation and consumption of clinical quality data formats below into HEDIS reporting for provider groups aligned with LA CARE Medicaid population.
    a. NCQA DAV (Data Aggregator Validation)
    b. COZEVA Standard supplemental data
    c. COZEVA non-standard supplemental data

SAFETY OF CLINICAL CARE

Credentialing (LA County)

Blue Shield of California Promise Health Plan (Blue Shield Promise) maintains a well-defined Credentialing Program to evaluate and select qualified independent practitioners and organizational providers to provide care to our members. The process includes verifying qualifications, as required by NCQA and regulatory agencies, maintaining protocols to notify network practitioners of credentialing decisions, and monitoring for sanctions. The process for verifying practitioners includes verifying license, training, DEA, malpractice insurance and other quality requirements, as required. The process for verifying organizational providers, such as hospitals and ambulatory surgery centers, includes verifying the provider is in good standing with federal and state regulatory bodies and is accredited by an appropriate organization. The Credentialing Program includes recredentialing practitioners and organizational providers at least every 36 months. The Credentials Committee, which includes external practicing physicians,

oversees the Credentialing Program, and makes final decisions about credentialing and recredentialing practitioners and organizational providers.

The Credentialing Department continues to meet all credentialing timeframes and is compliant with regulatory guidelines. The Credentialing Committee actions for 2024 are as follows:

Providers		HDOs	
Initial Creds approved	504	Initial Healthcare Delivery Organizations (HDO) approved	168
Re-creds approved	243	Re-cred Healthcare Delivery Organizations approved	295
Inactivation Providers*	574	Inactivation Healthcare Delivery Organizations*	215

*Inactivations are not separated by county

805 Report

- There were no 805 reports made in 2024.

Barriers

- Consistent communication and bridging gaps between Credentialing, Provider Relations, Network Management and Provider Enrollment department creating workflow challenges for Provider Enrollment.
- Identification and timely notification to the Credentialing department of providers who are being terminated from delegated groups that require internal credentialing.
- Large influx in credentialing volume in 4th quarter attributed to Behavioral Health, Tricare and CalPERS.
- DHCS updated their policy which required Blue Shield's internal credentialing policies to be split between Blue Shield Commercial and Promise Medi-Cal to ensure regulatory compliance.
- Implementing a new process to route newly contracted Behavioral Health applications for credentialing via the CLMS portal to the vendor as they do not have access to CLMS.

2024 Trainings

Name of Training	Purpose	Attendees	Date
Credentialing Touch Base	To review workflow processes, provide support, answer questions and provide training when necessary.	Sagility and Internal Team	Twice a month
Internal Credentialing meeting	Review and train staff on the different aspects of credentialing providers and departmental processes	Internal Staff	Monthly
Provider Training Sessions 1 and 2 Materials	Data entry compliance training	Internal and Vendor Staff	2nd and 3rd Quarter
Facility Training Sessions 1 and 2 Materials	Credentialing System training	Internal and Vendor Staff	2nd and 3rd Quarter

2024 Outlook & Goals

The Credentialing Department goals for 2024 were as follows:

- Policies and Procedures remain in compliance with National Committee for Quality Assurance (NCQA), Centers for Medicare and Medicaid Services (CMS), Department of Health Care Services (DHCS), L.A. Care and Department Managed Health Care (DMHC).
- Continuation of aligning credentialing process between BSC and PHP for one unified credentialing verification process and decision date.
- Continue all quarterly reporting within the required timeframes.

Potential Quality of Care Issues

Description

Blue Shield of California Promise Health Plan has a robust program to review member clinical grievances and internally identified potential quality issues (PQIs). PQI cases, which are managed by the Clinical Quality Review (CQR) team, are investigated, reviewed, and assigned a severity level. Based on the findings confirmed by a licensed physician, further follow-up can include such actions and interventions as direct review by the Peer Review Committee (PRC), a corrective action plan (CAP) request, or an education letter outlining

opportunities for improvement. Should a provider not satisfactorily respond to the finding of a confirmed quality problem, the PRC can make recommendations to the Credentialing Committee for evaluation of a provider's continued network participation. The PRC also reviews provider monitoring reports that may show care or service trends that could indicate an ongoing quality problem and takes appropriate action as indicated.

Quantitative Analysis

2024 Data for Medi-Cal Los Angeles

Cases Received	2022					2023					2024				
	Q1	Q2	Q3	Q4	2022 Total	Q1	Q2	Q3	Q4	2023 Total	Q1	Q2	Q3	Q4	2024 Total
Member Initiated PQIs	333	496	275	264	1368	411	587	593	483	2074	173	38	109	104	424
Internal PQIs	7	10	17	12	46	14	29	36	27	106	19	16	13	11	59
Total Received	340	506	292	276	1414	425	616	629	510	2180	192	54	122	115	483

Cases Closed	2022					2023					2024				
	Q1	Q2	Q3	Q4	2022 Total	Q1	Q2	Q3	Q4	2023 Total	Q1	Q2	Q3	Q4	2024 Total
C-0	149	219	329	291	988	197	177	220	354	948	252	213	39	175	679
C-1	87	103	152	112	454	107	112	186	302	707	96	55	52	61	264
C-2	1	10	4	1	16	7	7	5	4	23	2	1	6	6	15
C-3	1	1	1	1	4	0	0	0	0	0	0	0	0	0	0
Total Closed	238	333	486	405	1462	311	296	411	660	1678	350	269	97	242	958

- PQI case average turnaround time (TAT): 190.4 (TAT goal is ≤180 days)
- CAP and Education Letters issued: 126
- Referrals to Credentialing Committee: 0

Qualitative Analysis

The CQR team managed case volumes and maintained compliance with turnaround times within intra-departmental control and workflows and inter-departmental shared processes and communication. In addition, identified quality and safety issues were addressed with individual practitioners, medical groups, independent physician associations (IPAs), and Blue Shield Promise internal departments as appropriate.

2024 Interventions

Clinical Quality Review Interventions for 2024 include:

- All closed member grievances were screened by and those with a PQI component were opened and reviewed by the CQR team
- Provider monitoring was conducted on a semi-annual basis to analyze PQIs for trends and patterns requiring further intervention
- Retraining clinical staff and medical directors to ensure appropriate understanding of what constitutes a potential quality of care case.
    - The updated understanding of what defines a quality of care case will decrease cases reviewed by the Clinical Quality Review team that do not have a true quality issues, or unsubstantiated quality issues.

2025 Outlook and Goals

Clinical Quality Review Outlook and Goals for 2025 include:

- Continue collaboration with the Appeals and Grievance Departments (AGD) to align and improve AGD and CQR front-end PQI processes and hand-offs for all lines of business.
    - Enhance processes that complete clinical oversight prior to cases being sent to Clinical Review Team for Improving production of cases and efficiency of reviews.
- Enhance platform which allows for additional efficiencies and clarity in reporting of Potential Quality Issues across all lines of business.
- Enhance provider monitoring with analysis of aggregate PQI, complaint data and other findings from internal review to identify opportunities for improvement related to care or service trends.
- Develop workgroup that identifies detailed trends that can be work through with inter-departmental teams to resolve issue trends and reduce incoming cases.

Initial Health Assessment (IHA)

An Initial Health Appointment (IHA) is required within 120 days from the date of enrollment for all new Medi-Cal members. Blue Shield Promise IHA outreach coordinators conducted phone outreach in accordance with our standard protocol and policy, calling newly enrolled

members of all ages to assist and/or provide a reminder to schedule an IHA within 120 days of enrollment.

IHA Outreach Activities and Outcomes

Table 1: Initial Health Appointment (IHA) Outreach Rates for Fiscal Year (FY) 22 through FY24 – LA County

Initial Health Appointment	FY24		FY23		FY22	
Total New Membership	105,373		67,647		33,589	
Initial Health Appointment Outreach Outcomes	**FY24**	**FY24%**	**FY23**	**FY23 %**	**FY22**	**FY22 %**
Appt Scheduled/Will Schedule	7,009	7%	2,118	3%	1,593	5%
IHA Completed Prior to Outreach	4,395	4%	2,199	3%	1,492	4%
Ineligible/Termed/Disenrolled Prior to Outreach	19,381	18%	15,484	23%	3,519	10%
Unable to reach/Left Message/Declined Outreach	23,889	23%	19,593	29%	12,932	39%
No Contact/Incorrect Contact Information Provided	19,876	19%	6,728	10%	4,450	13%
Total IHA Outreach	**74,550**	**71%**	**46,122**	**68%**	**23,986**	**71%**
Outreach Not Completed	30,823	29%	21,525	32%	9,603	29%

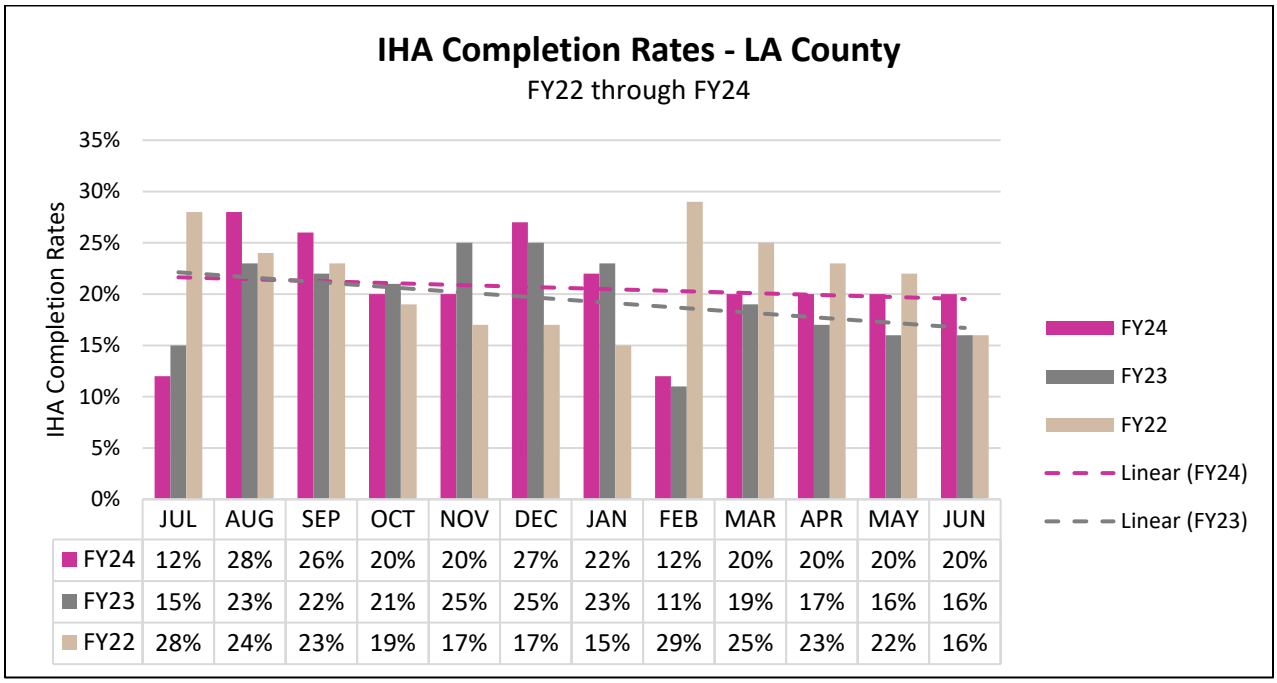
Table 1 Summary: Initial Health Appointment (IHA) Outreach Metrics for FY24 – LA County

Our Blue Shield Promise IHA outreach coordinators conducted phone outreach in accordance with our standard protocol and policy, calling newly enrolled members of all ages to encourage and/or provide assistance in scheduling an IHA throughout 2024.

Outreach Calls

In FY24, Blue Shield Promise IHA outreach coordinators and vendor, Quality Health Partners, made a total of 74,550 member calls. This number exceeded the calls made in FY23 due to a substantial increase in membership and contributions from Quality Health Partners. The IHA outreach coordinators completed 71% of calls in FY24, compared to 68% in FY23. The goal of 100% call completion was not met in the first half of 2024 because of a significant rise in membership during the January and February CY24 enrollment months resulting in a significant increase in outreach calls for the following 3-4 months and delays to beginning outreach calls for new members enrolled in the following months. Enrollment of new members and the number of outreach calls completed have tripled from FY22 to FY24.

Table 2: Monthly IHA Completion Rates from FY22 through FY24 – LA County



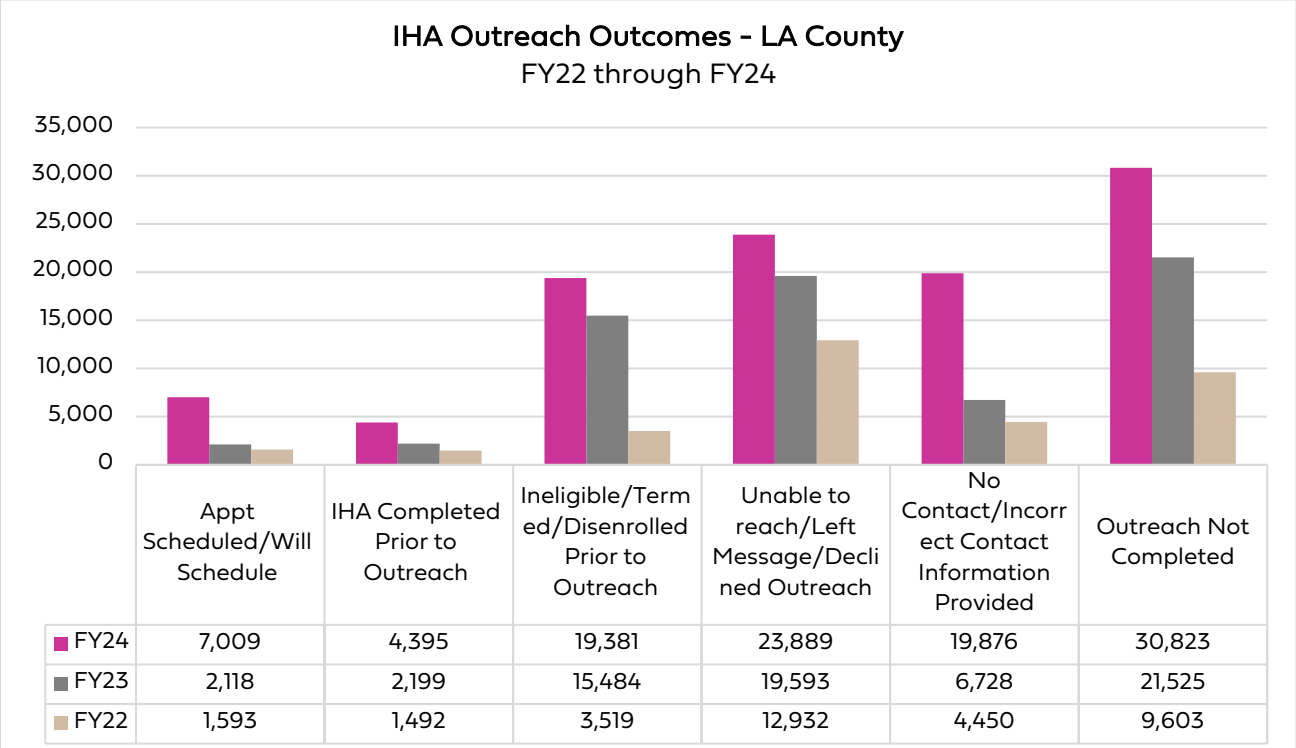
	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY24	12%	28%	26%	20%	20%	27%	22%	12%	20%	20%	20%	20%
FY23	15%	23%	22%	21%	25%	25%	23%	11%	19%	17%	16%	16%
FY22	28%	24%	23%	19%	17%	17%	15%	29%	25%	23%	22%	16%

FY24 – Enrollment between Jul 2023 to Jun 2024

Table 2 Summary: Monthly IHA Completion Rates from FY22 thru FY24 – LA County

IHA completion rates are evaluated using the third and fourth quarters of the previous measurement year, along with the first and second quarters of the current measurement year, rather than a typical calendar year. This approach allows for the measurement of complete and accurate encounter data. A comparison of IHA Completion Rates for Los Angeles County between FY24 and FY23 shows that FY24 had higher rates for eight out of twelve months. Specifically, the rates in FY24 were only slightly higher in December, February, and March (by 1 to 2%) and moderately higher in April (by 3%) compared to FY23. The most notable increases in FY24 were observed in September, May, and June, each with a 4% rise compared to FY23. The highest increase in completion rates from FY23 to FY24 occurred in August, with a 28% completion rate (a 5% increase).

Table 3: Blue Shield Promise IHA Outreach Call Results from FY22 through FY24- LA County



	Appt Scheduled/Will Schedule	IHA Completed Prior to Outreach	Ineligible/Termed/Disenrolled Prior to Outreach	Unable to reach/Left Message/Declined Outreach	No Contact/Incorrect Contact Information Provided	Outreach Not Completed
FY24	7,009	4,395	19,381	23,889	19,876	30,823
FY23	2,118	2,199	15,484	19,593	6,728	21,525
FY22	1,593	1,492	3,519	12,932	4,450	9,603

FY24– Enrollment between Jul 2023 to Jun 2024

Table 3 Summary: IHA Outreach Call Results from FY22 through FY24- LA County

Blue Shield Promise IHA outreach calls experienced a notable increase in total call volume in FY24, driven by a significant rise in membership. This surge in membership in the first quarter of CY24 led to a substantial increase in "outreach not completed" cases, which rose from 21,525 in 2023 to 30,823 in 2024. Despite receiving outreach assistance from Quality Health Partners, the IHA Outreach team was unable to complete calls to the increased volume of all new enrollees for several months in the first half of 2024. The number of members who were ineligible, terminated, or disenrolled before outreach saw a substantial increase, from 15,484 in 2023 to 19,381 in 2024. Due to the increased number of newly enrolled members, there was also a significant rise in the number of members who either received assistance in making appointments or committed to making them, as well as those who had already completed their IHA prior to outreach, in 2024 compared to 2023.

Table 4: IHA Medical Record Review from FY22 through FY24- LA County

IHA Medical Record Review	Audited CY24 (CY23 Enrollees)	Audited CY23 (CY22 Enrollees)	Audited CY22 (CY21 Enrollees)
Total Medical Records Audited	551	732	471
Providers Audited	101	177	89
Average Score	95%	95%	93%

Table 4 Summary: IHA Medical Record Review- LA County

Medi-Cal Managed Health Care Plans are responsible for ensuring the completion of the Initial Health Appointment (IHA) through comprehensive medical record review audits. These audits assess whether all required elements of the IHA visit, such as preventative services, immunizations, diagnostic lab testing, and blood lead level testing, have been completed. Requests for these medical records are sent to Primary Care Practitioner (PCP) offices and tracked for receipt, with a benchmark audit passing score set at 90%.

In CY23, IHA medical record review audits were conducted for members enrolled in 2022, achieving an average score of 95%. This same score of 95% was maintained in CY24 for members enrolled in 2023. However, in CY24, our focus shifted towards increasing audits on Federally Qualified Health Centers (FQHCs) in San Diego County, which led to a reduction in the number of audits conducted in Los Angeles County.

Qualitative Analysis

1. The contributions of Quality Health Partners, particularly through telehealth visits and Clinic Days, led to a slight increase in overall IHA completion rates in FY24 compared to FY23. The highest completion rate in FY24 was 28% in August, surpassing the highest rates of 25% seen in both November and December of FY23.
2. Blue Shield Promise IHA member outreach calls increased in FY24 due to a large increase in membership in January 2024 and February 2024.

Opportunities for Improvement

1. Enhancing the accuracy of new enrollment data to prevent incomplete or incorrect member contact information from impeding IHA member outreach efforts.
2. Continue collaboration with the vendor, Quality Health Partners, to make outreach calls to members, offer telehealth visits, and organize "Clinic Days," which facilitate the completion of an IHA.

Interventions

Targeted efforts continued in 2024 to increase the amount of Blue Shield Promise new members completing their IHA appointment within 120 days of enrollment and many of these efforts will continue in 2025.

1. The Blue Shield Promise IHA Provider Incentive Program remained in effect in 2024, incentivizing providers completing IHA visits within 120 days.
2. The Blue Shield Promise IHA Member Incentive Program was halted in mid-2024 because of budgetary limitations, but it is set to resume in the second quarter of CY25.
3. Maintain partnership with Quality department and vendor, Quality Health Partners, to reach out to members and assist in scheduling telehealth appointments as part of an IHA.
4. Blue Shield Promise IHA team to continue participating in Joint Operating Meetings with participating IPAs to discuss and address barriers in membership outreach.
5. Continue the escalation process to address non-compliance with requests for medical records and CAPs related to IHAs from providers.

Facility Site Review FSR) and Patient Safety / Physical Accessibility Review Survey (PARS)

Evaluation of Overall Program Effectiveness

The site review process is part of the Managed Care Plan (MCP)'s quality improvement programs that focus on the capacity of each Primary Care Provider (PCP) office site to ensure and support the safe and effective provision of appropriate clinical services to Medi-Cal members.

Residual effects of the global pandemic continue to influence the volume of site reviews performed by Blue Shield Promise (BSP), Site reviews are conducted on a triannual basis, therefore, the volume of site reviews needing to be completed in 2024 are correlated with those performed in 2021. However, there was a significant decline in the amount of sites needing to have a site review as a result of the effects of the state of California Public Health Emergency executive order to cease all in-person site reviews due to the COVID-19 virus from 2020 - 2022. In fact, the executive order to resume in-person site reviews was not lifted until the summer of 2022. The total Facility Site Reviews (FSRs) due to be completed for calendar year 2024 declined to 45 FSRs and 47 Medical Record Reviews (MRRs).

Table 5: FSR Program Year-to-Year Metrics LA County

Compliance Metrics - Quantitative Analysis	CY24	CY23	CY22
Total **Facility Site Reviews** Due (Contracted and Pre-Contractual)	45	58	103
Total Facility Site Reviews Completed	45	45	83
Total Facility Site Reviews Completed on Time	42	17	4
Average Facility Site Review Score	93%	92%	89%
% Pass Rate (≥80% aggregate score)	100%	98%	95%

Total **Medical Record Reviews** Due (Contracted and Pre-Contractual)	47	51	76
Total Medical Record Reviews Completed	47	45	91
Total Medical Record Reviews Completed on Time	40	7	0
Average Medical Record Review Score	88%	87%	86%
% Pass Rate (≥80% aggregate score)	89%	93%	96%
Department Metrics (Regardless of Due Date) (Facility Site Review & Medical Records Review)	**CY24**	**CY23**	**CY22**
Total Facility Site Reviews Completed	49	113	83
Average Facility Site Review Score	93%	90%	89%
Total Medical Records Reviews Completed	51	133	91
Average Medical Record Review Score	88%	85%	86%
Total Primary Care Physician Sites removed from the network due to Non-Compliance with Facility Site Review Requirements	6	3	3

Qualitative Analysis

There was a total of 45 Medi-Cal FSR sites due in 2024. A total of 45 FSRs were completed regardless of due date. Many were completed on time due to the team's primary focus on backlog site reviews. There was a total of 47 Medi-Cal MRRs due in 2024. A total of 47 MRRs were completed. The was a total volume of 92 FSR and MRR audits completed.

Year to year comparisons of FSR audit scores continue to demonstrate improvement. This may be indicative of providers becoming more familiar with the state of California's requirements for the operation of a PCP office and having adequate time to achieve and maintain compliance with FSR program requirements in addition to the educational efforts of the FSR auditors with the PCP offices.

However, there is also a 50% increase in providers that were administratively terminated from the Blue Shield Promise network for FSR related non-compliance. Administrative terminations are the result of providers who continuously fail FSR and/or MRR audits three consecutive years in a row. The increase in providers who have been administratively terminated is reportedly due to the lasting impact of the pandemic on PCP financial stability, in addition to the lack of availability of qualified office staff to support the successful operation of a PCP office since the pandemic. Many PCPs retired or quit private practice because of the pandemic.

FSR/MRR Criteria Trends

Due to the impact of the cessation of all FSR and MRR audits during the Public Health Emergency from 2020 – 2022, the dramatic 50% increase in administrative terminations of PCP offices post pandemic, and the gradual resumption of FSR and MRR auditing from late 2022 – 2024, trending of FSR/MRR criteria has been difficult. Quantitative analysis of FSR and MRR criteria trends will continue to be monitored and analyzed in 2025

Physical Accessibility Review Survey (PARS)

Access and Safety areas monitored:

Physical Accessibility Review Survey (PARS) audits are a physical evaluation of a office site that provides care to Medi-Cal members who are seniors and/or persons with disabilities (SPDs). These service sites are Primary Care Provider (PCP) sites, Community Based Adult Services (CBAS) sites, High Volume Specialist (HVS) sites, or other Ancillary sites to ensure. The PARS onsite audit includes review of parking, exterior building, interior building, restrooms, exam rooms, and weight scales to establish if the facility has basic access or limited access for members with disabilities. (see Table 6 and 7) Additional quantitative analysis of office access and safety is also conducted during the FSR audit (see Table 7).

Table 6: PARS Metrics LA County

Los Angeles County	CY24	CY23	CY22
PARS Completed	49	63	67
PARS Completed at Basic Level	12	32	36
PARS Completed at Limited Level	37	31	59

Table 7: FSR Access/Safety Criteria LA County

Access/Safety					
A. Site is accessible and useable by individuals with physical disabilities. Sites must have the following safety accommodations for physically disabled persons:	Yes	No	NA	Total#	Compliance
1) Clearly marked (blue) curb or sign designating disabled-parking space near accessible primary entrance.	45	0	0	45	100%
2) Pedestrian ramps have a level landing at the top and bottom of the ramp.	25	1	19	26	96%
3) Exit and exam room doorway openings allow for clear passage of a person in a wheelchair.	45	0	0	45	100%
4) Accessible passenger elevator or reasonable alternative for multi-level floor accommodation.	9	0	36	9	100%
5) Clear floor space for wheelchair in waiting area and exam room.	44	1	0	45	98%
6) Wheelchair accessible restroom facilities.	43	2	0	45	96%
7) Wheelchair accessible handwashing facilities or reasonable alternative.	44	1	0	45	98%

B. Site environment is maintained in a clean and sanitary condition.	Yes	No	NA	Total#	Compliance
1) All patient areas including floor/carpet, walls, and furniture are neat, clean, and well maintained.	42	3	0	45	93%
2) Restrooms are clean and contain appropriate sanitary supplies.	44	1	0	45	98%
C. Site environment is safe for all patients, visitors, and personnel.	Yes	No	NA	Total#	Compliance
1) Fire safety and prevention.	44	1	0	45	98%
2) Emergency non-medical procedures (e.g. site evacuation, workplace violence).	40	5	0	45	89%
3) Lighting is adequate in all areas to ensure safety.	45	0	0	45	100%
4) Exit doors and aisles are unobstructed and egress (escape) accessible.	45	0	0	45	100%
5) Exit doors are clearly marked with "Exit" signs.	45	0	0	45	100%
6) Clearly diagramed "Evacuation Routes" for emergencies are posted in a visible location at all elevators, stairs and exits.	44	1	0	45	98%
7) Electrical cords and outlets are in good working condition.	44	1	0	45	98%
8) Fire Fighting Equipment in accessible location	44	1	0	45	98%
9) An employee alarm system.	39	3	3	42	93%
D. Emergency health care services are available and accessible 24 hours a day, 7 days a week.	Yes	No	NA	Total#	Compliance
1) Personnel are trained in procedures/action plan to be carried out in case of medical emergency on site.	45	0	0	45	100%
2) Emergency equipment is stored together in easily accessible location and is ready to be used.	44	1	0	45	98%
3) Emergency phone number contacts are posted, updated annually and as changes occur.	42	3	0	45	93%
Emergency medical equipment appropriate to practice/patient population is available on site:	Yes	No	NA	Total#	Compliance
4) Airway management: oxygen delivery system, nasal cannula or mask, bulb syringe and Ambu bag.	31	14	0	45	69%
5) Emergency medicine for anaphylactic reaction management, opioid overdose, chest pain, asthma, and hypoglycemia. Epinephrine 1mg/ml (injectable) and Diphenhydramine (Benadryl) 25 mg (oral) or Diphenhydramine (Benadryl) 50 mg/ml (injectable), Naloxone, chewable Aspirin 81 mg, Nitroglycerine spray/tablet, bronchodilator medication (solution for nebulizer or metered dose inhaler), and glucose (any type of glucose containing at least 15 grams). Appropriate sizes of ESIP needles/syringes and alcohol wipes.	39	6	0	45	87%
6) Medication dosage chart for all medications included with emergency equipment (or other method for determining dosage) is kept with emergency medications.	33	12	0	45	73%
There is a process in place on site to:	Yes	No	NA	Total#	Compliance
7) Document checking of emergency medication, equipment and supplies for expiration and operating status at least monthly.	39	6	0	45	87%

8) Replace/re-stock emergency medication, equipment and supplies immediately after use.	44	1	0	45	98%
E. Medical and lab equipment used for patient care is properly maintained.	Yes	No	NA	Total#	Compliance
1) Medical equipment is clean.	45	0	0	45	100%
2) Written documentation demonstrates the appropriate maintenance of all medical equipment according to equipment manufacturer's guidelines.	36	9	0	45	80%

Qualitative Analysis

To meet "Basic Access" requirements for the PARS audit, all (29) Critical Elements (CE) must be met. In 2024 25% of offices met the "Basic Access" requirements, compared to 51% in 2023 and 54% in 2022. While the decrease in the overall number of PARS audits in 2024 may account for some of the decrease in offices meeting "Basic Access" requirements, it is a concerning trend. There are several individual criterion that demonstrate the greatest opportunities for improvement and these individual criterion include: airway management: oxygen delivery system, nasal cannula or mask, bulb syringe and Ambu bag, medication dosage chart for all medications included with emergency equipment (or other method for determining dosage) is kept with emergency medications, Written documentation demonstrates the appropriate maintenance of all medical equipment according to equipment manufacturer's guidelines, all patient areas including floor/carpet, walls, and furniture are neat, clean, and well maintained, document checking of emergency medication, equipment and supplies for expiration and operating status at least monthly, emergency medicine for anaphylactic reaction management, opioid overdose, chest pain, asthma, and hypoglycemia.

More importantly, the critical element criteria regarding airway management which was again only 69% compliant in 2024 needs improvement. This compliance rate is comparably low to other access and safety criterion in the tool. Contributing factors to low scoring in this criterion continue to be the multifaceted nature of the audit question. To receive full credit for this criterion, a site must meet all requirements, or a deficiency is cited. There is no surprise that emergency medication and dosage charts are also low scoring as these emergency related supplies and medications often go hand in hand while assessing in the primary care setting.

Ensuring emergency medication dosage charts are stored with the physical emergency medications and kits are critical to preserving the life of members in the event of an emergency. The data demonstrates that of the audits conducted, sites were only 73% compliant with this requirement. Certified Reviewers and Master Trainers often find that clinics store dosage charts in separate locations than the portable kit of emergency devices

and medications. As such, they negate the purpose of having an emergency dosage chart for quick dosing reference. As a result, member lives can be at risk for injury or death if appropriate emergency medications are not properly dosed and administered.

Interventions

1. Provide facilities targeted education and technical support during both periodic and interim audits where critical element criteria like airway management are heavily scored
2. Encourage sites to be intentional when performing monthly documented expiration and/or operational checks of equipment so as to detect noncompliance early
3. Provide best practice resources in the form of policies by which site staff can implement into practice for ongoing compliance and adherence to standards

2025 Goals

1. Evaluate expanding the interim visit to include periodic corrective actions as part of monitoring assessments to improve provider's next periodic scores
2. Leverage technology in our internal and vendor databases to understand trends and establish baseline performance for groups over a period of time
3. Partner and collaborate with internal and external stakeholders to continuously improve outcomes and compliance with FSR tool and standards

Comprehensive Perinatal Services Program (CPSP)

Per the Department of Health Care Services (DHCS) Policy Letter 12-003, to ensure optimum perinatal care and pregnancy outcomes for Medi-Cal managed care beneficiaries, there are requirements for the Managed Care Plans (MCPs):

- MCPs must prioritize the prompt initiation of prenatal care and ensure the provision of comprehensive perinatal services.
- MCPs must ensure that providers have implemented a comprehensive risk assessment tool for all pregnant members that is comparable to American College of *Obstetricians and Gynecologists* (ACOG) and the Comprehensive Perinatal Services Program (CPSP) standards (California Code of Regulations, Title 22, Section 51348). A risk assessment must be completed at each trimester and postpartum visit.
- Individualized care plans must be developed to include obstetrical, nutritional, psychosocial, and health education interventions when indicated by identified risk factors.

- MCPs must ensure that nutrition, psychosocial, and health education services are provided by staff with demonstrated professional competence and that all prenatal care providers and non-physician medical practitioners are trained and educated on the standards and requirements of providing comprehensive perinatal services to Medi-Cal beneficiaries per ACOG standards.
- Plans must ensure that pregnant women at high risk of poor pregnancy outcomes are referred to appropriate specialists, including perinatologists.

Additionally, it is crucial to ensure that pregnant women have the necessary access to genetic screening and receive appropriate referrals. Comprehensive Perinatal Services Program (CPSP) integrates nutrition, psychosocial, and health education services with basic obstetric services. This multidisciplinary approach to the delivery of prenatal care is based on the recognition that providing these services from conception through 12 weeks after delivery contributes significantly to improved pregnancy outcomes.

The California Department of Public Health/Maternal Child and Adolescent Health (MCAH) Program oversees CPSP and the statewide system of perinatal care. The Blue Shield of California Promise Health Plan (Blue Shield Promise) CPSP oversight and monitoring program tracks, monitors compliance, and issues corrective actions to ensure initiation of prenatal care as soon as possible and to ensure the provision of comprehensive perinatal services per (DHCS) Policy Letter 12-003 and the CPSP standards contained in California Code of Regulations, Title 22, Section 51348, and to improve pregnancy outcomes

KEY FINDINGS AND INTERVENTIONS

Table 8: CPSP Medical Record Review for LA County

Medical Record Reviews	Audited CY24 (Deliveries CY23)	Audited CY23 (Deliveries CY22)	Audited CY22 (Deliveries CY21)
Total Providers Audited	13	30	43
Average Medical Record Review Score	89%	81%	88%
Total # of Records Audited	71	106	119
CPSP CAPs	**Audited CY24 (Deliveries CY23)**	**Audited CY23 (Deliveries CY22)**	**Audited CY22 (Deliveries CY21)**
Total Providers Audited	13	30	43
Total CPSP Medical Record Review CAPs Issued	1	8	4

Table 8 Summary: CPSP Medical Record Review for LA County

The CPSP medical record review is conducted to ensure optimum perinatal care and pregnancy outcomes for Blue Shield Promise members and compliance with DHCS Policy Letter 12-003 and California Code of Regulations, Title 22, Section 51348. Requests for medical records are sent to obstetric offices and tracked for receipt. In 2024, CPSP medical record reviews were conducted for pregnant members with a successful delivery during 2023. The average score for medical records reviewed was 89%. A passing score is 80%.

Thirteen OB providers were audited in 2024, with an average score of 89%. In 2023, thirty OB providers were audited, with an average score of 81%.

Qualitative Analysis

1. Fewer OB providers were audited in 2024 than in 2023. The average score was higher in 2024 than in 2023 (89% vs 81%). Only one Corrective Action Plan (CAP) was issued to OB providers scoring below standard in 2024, compared to eight issued in 2023.

Opportunities for Improvement

1. Continued Blue Shield Promise provider education to ensure optimum perinatal care and pregnancy outcomes for Medi-Cal managed care beneficiaries.
2. Include all Blue Shield Promise in-network obstetric providers in audits to ensure optimum perinatal care and pregnancy outcomes for Blue Shield Promise Medi-Cal managed care beneficiaries. Re-audit providers who do not meet the threshold audit score of 80% to evaluate effectiveness of Corrective Action Plans (CAP) and education.
3. Enhanced audit selection to increase accuracy of identifying members and providers.

Interventions

1. Create new job aids and training resources to enhance provider comprehension of CPSP and ACOG standards, bolster knowledge of our CPSP auditing and monitoring oversight program and improve adherence to medical record requests.
2. Educate providers through Corrective Action Plans and re-audit providers to assess their efficacy and ensure the highest standard of perinatal care and pregnancy outcomes for Blue Shield Promise Medi-Cal managed care beneficiaries.
3. Continue refining and enhancing the audit selection process to ensure accurate identification of OB providers and their members.
4. Maintain the escalation process started in 2023 to address non-compliance issues with medical record requests and CAPs.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a Medi-Cal benefit for individuals under the age of 21 years that provides a comprehensive array of prevention,

diagnostic and treatment services. The EPSDT benefit is designed to ensure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible. The goal is to ensure that individual children get the health care they need when they need it - the right care to the right child at the right time in the right setting. Blue Shield of California Promise Health Plan (Blue Shield Promise) strives to guarantee that all Blue Shield Promise Medi-Cal members who are under 21 years old receive EPSDT services in accordance with state and federal regulations and legislation. During 2024, Blue Shield Promise monitored Blue Shield Promise Medi-Cal members under the age of 21 years to determine if they received EPSDT services, evaluated the reports, and designed and implemented interventions to increase the number of members under the age of 21 years completion of at least one (1) EPSDT visit with a primary care physician.

KEY FINDINGS AND INTERVENTIONS

Table 9: EPSDT Rates for 2024 - LA County

Annual EPSDT Participation Report Form CMS-416 Calendar Year: 2024 State MCP: California Promise Health Plan County: LA									
Description	**Cat**	**Total**	**< 1**	**1-2**	**3-5**	**6-9**	**10-14**	**15-18**	**19-20**
1b. Total Individuals Eligible for EPSDT for 90 Continuous Days	Total	203,229	3,468	13,156	22,860	41,063	50,645	44,535	27,502
2a. State Periodicity Schedule			7	5	3	4	5	4	2
2b. Number of Years in Age Group			1	2	3	4	5	4	2
2c. Annualized State Periodicity Schedule			7	2.5	1	1	1	1	1
3a. Total Months of Eligibility	Total	2,021,220	11,997	122,843	229,196	421,612	527,956	464,996	242,620
3b. Average Period of Eligibility	Total	0.83	0.29	0.78	0.84	0.86	0.87	0.87	0.74
4. Expected Number of Screenings per Eligible	Total		2.02	1.95	0.84	0.86	0.87	0.87	0.74
5. Expected Number of Screenings	Total	189,789	6,998	25,592	19,100	35,134	43,996	38,750	20,218
6. Total Screens Received	Total	111,840	4,595	18,757	14,172	19,768	25,949	21,025	7,574
7. SCREENING RATIO	Total	0.59	0.66	0.73	0.74	0.56	0.59	0.54	0.37
8. Total Eligibles Who Should Receive at Least One Initial or Periodic Screen	Total	173,822	3,468	13,156	19,100	35,134	43,996	38,750	20,218
9. Total Eligibles Receiving at Least One Initial or Periodic Screen	Total	90,126	2,139	8,952	12,164	17,815	23,259	18,895	6,902
10. PARTICIPANT RATIO	Total	0.52	0.62	0.68	0.64	0.51	0.53	0.49	0.34

11. Total Eligibles Referred for Corrective Treatment	Total	17,663	395	1,909	2,106	3,261	4,508	4,036	1,448
14a. Total Number of Screening Blood Lead Tests	Total	2,422	5	1,462	726	156	45	28	0

Table 9 Summary – Metrics for 2024 – LA County

The total number of Blue Shield Promise Medi-Cal members under the age of 21 that should have received an EPSDT visit during the months of January – December 2024, was 173,822 and yet the total number of Los Angeles County Blue Shield Promise members under the age of 21 that did receive at least one screening or periodic exam was only 90,126 (52%).

Most age cohorts of children under the age of 21 years received similar amounts of at least one screening or periodic exam, with an overall range of 49% – 68% for ages <1, 1-2, 3-5, 6-9, 10-14, and 15-18. with a lower number of 19–20 year-old members (34%) receiving at least one screening or periodic exam (EPSDT services).

Qualitative Analysis

1. Overall completion rates of at least one screening or periodic exam (EPSDT services) for all Blue Shield Promise members under the age of 21 were higher in 2024than in 2023, increasing from 44% in 2023 to 52% in 2024. The highest completion rate for all age ranges of children under the age of 21 were for < 1-year olds and 1–2-year-olds who received at least one screening or periodic exam with rates of 68% and 64% respectively. The lowest completion rate for all age ranges of children under the age of 21 were for 19–20-year-olds. Thirty-four percent (34%) of the members in this age range received at least one screening or periodic exam in 2024, compared with 19% in 2023.
2. In addition, overall, the number of Blue Shield Promise members under 21 referred for corrective treatment was approximately the same in 2024 as it was in 2023. Notable exceptions were the increase in member referrals for the 15 –18-year- old age range, from 3,442 in 2023 to 4,036 in 2024 and for 19 – 20- year-olds, showing the largest increase, from 685 in 2023 to 1,448 in 2024.

Opportunities for Improvement

1. The average rate of Blue Shield Promise members under 21 in Los Angeles County receiving at least one screening or periodic exam (EPSDT services) in 2024 was 52%, which, although an increase from 19% in 2023, is indicative of a need for improvement.
2. Train Blue Shield Promise Member Services and outreach staff in behavioral interviewing techniques to increase effectiveness of education of members' families and caregivers regarding the importance of scheduling and obtaining EPSDT services.
3. Improving accuracy of Blue Shield Promise Member data as incomplete or incorrect contact information hampers Blue Shield Promise member outreach efforts.

4. Conduct PCP EPSDT training to educate PCPs about the importance and requirement for all Blue Shield Promise members under the age of 21 years to receive EPSDT services.
5. Blue Shield Promise Population Health Management (PHM) techniques focusing on the process of improving clinical health outcomes for our Blue Shield Promise members under the age of 21 in Los Angeles County, in addition to focusing on Social Determinants of Health Care (SDOH) and health equity may yield additional opportunities to intervene and increase the amount of Blue Shield Promise members under the age of 21 in Los Angeles County obtaining timely EPSDT services.

Interventions

Targeted efforts continued in 2023 to increase the amount of Los Angeles County Blue Shield Promise members under the age of 21 completing their EPSDT visits and many of these efforts continued in 2024.

1. Blue Shield Promise implemented an Initial Health Appointment (IHA) Provider Incentive Program in Los Angeles County in 2021. IHA appointments are also EPSDT preventive care appointments.
2. All providers who see members under the age of 21 are required per DHCS All Plan Letter 23-005 to complete EPSDT training at least every two years. Blue Shield Promise has created this course, distributed it via fax and/or email to providers who see members under the age of 21, and is tracking provider compliance.
3. Blue Shield Promise is partnering with our BSC Promise Customer Care team in outreach to new members, both through Welcome outreach calls and Welcome Letters, providing information about the importance of scheduling preventive care appointments.
4. This program was transitioned to the Population Health Management (PHM) team in the third quarter of 2024. The PHM team is exploring additional initiatives to increase EPSDT completion rates including EPSDT care coordination staffing, member communication campaigns using text messaging, enhanced member outreach activities, expansion of member incentives, increase in monetary value of member incentives, member provider partnerships by way of supporting care coordination resources, and technology solutions encouraging member use of telehealth services for EPSDT services.
5. Alternative care settings will be encouraged to increase EPSDT completion rates in 2025, such as home visits, telehealth visits, other alternative setting that support obtaining preventative services.

QUALITY OF SERVICE

Customer Service

2024 Telephone Access Study (Medi-Cal Los Angeles)

Blue Shield of California Promise Health Plan has telephone access standards in place and monitors member experience with telephone service, identifies and acts on areas of potential improvement. These standards include:

- Average speed of answer = within 30 seconds
- Percentage of calls abandoned before reaching Customer Care staff = 5 %

Methodology

Annually, the Customer Care Department collects and performs an analysis to measure its performance against its standards for access to Customer Care by telephone using the information from the member call log or telephone record.

Entries from January 1 – December 31, 2024, were generated and analyzed based on our goals.

Goals

- 80% of calls are answered within 30 seconds
- Abandonment rate is at 5% or below
- Maintain the average rate of speed of telephone response within 30 seconds by 80%
- Maintain the average abandoned calls at <5%

Findings and Quantitative Analysis (Medi-Cal Los Angeles):

Calls Received	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
2023	14,873	14,349	16,124	13,933	14,829	14,510	14,772	17,928	14,986	16,298	14,623	13,358	180,583
2024	17,681	18,470	18,302	19,220	19,248	16,366	19,140	19,679	18,433	20,640	16,513	16,148	219,840
Abandoned Calls	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Total**
2023	56	105	86	88	128	110	87	147	53	74	63	64	1061
2024	175	291	287	221	177	86	146	154	226	185	188	178	2314
Answered within 30 Seconds %	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Average**
2023	96%	91%	92%	91%	88%	87%	88%	87%	93%	94%	92%	93%	91%
2024	83%	79%	79%	81%	88%	93%	90%	88%	82%	87%	85%	84%	85%
Abandonment Rate %	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Average**
2023	0.4%	1%	1%	1%	1%	1%	1%	1%	0.4%	0.5%	0.4%	0.5%	0.6%
2024	1.0%	1.6%	1.6%	1.1%	0.9%	0.5%	0.8%	0.8%	1.2%	0.9%	1.1%	1.1%	1.0%

Reporting Quarter	Calls Received	Abandoned Calls	Average % of Answered Calls Within 30 Seconds	Average Abandonment Rate
1st Quarter	54,453	753	80%	1.4%
2nd Quarter	54,834	484	87%	0.9%
3rd Quarter	57,252	526	87%	0.9%
4th Quarter	53,301	551	85%	1.0%
Total/Average	**219,840**	**2,314**	**85%**	**1.0%**

Customer Care Department received a total of 219,840 calls in 2024. This showed an increase of 39,257 calls compared with the 180,583 calls received in 2023. There was an increase in abandoned calls with a total of 2,314 abandoned calls in 2024 compared to 1,061 received in 2023. The annual average rate of abandoned calls was 1.0%, which is below our goal of <5%, thus meeting our goal. The average rate of calls answered within 30 seconds in 2024 was 85%. The lowest performance was shown in the first quarter with an average of 80%.

Qualitative Analysis: Customer Care Department met the overall goal of answering 80% of calls within 30 seconds in 2024.

Delegation Oversight: UM/Claims/Credentialing

Blue Shield of California (BSC) and Blue Shield of California Promise Health Plan (BSCPHP), collectively the "Plan", gives external entities the authority to perform functions on its behalf. Although the Plan delegates the entity to perform the function, it maintains responsibility to ensure that the entity remains accountable and compliant with regulatory standards for the delegated core administrative and management functions. Compliance is monitored through pre-delegation audits, annual auditing, and ongoing monitoring.

Delegated core administrative and management functions may include, but are not limited to, credentialing, claims, and utilization management administration. The Delegation Oversight Committee (DOC) is responsible for overseeing the initial and on-going assessment of performance results to ensure business goals and outcomes are achieved to further the

delivery of quality health goals and outcomes for our members. The DOC reports to the Plan's Quality Oversight Committee (QOC).

Methodology

The Plan's Delegation Oversight Department is responsible for auditing (assessing), regulatory monitoring and oversight of delegated activities for our contracted delegated entities in alignment with regulatory, Plan and accreditation standards for all lines of business. The audit assesses/validates the capacity of Management Services Organizations (MSOs) and/or delegates to perform activities and delegated functions agreed upon by the Plan and contracted delegated entities. The annual review of delegated entities is performed using tools to evaluate the structure and processes of the delegates.

Deficiencies are addressed through mitigation between the Plan and delegated partners, which may result in the development of a correction action plan (CAP). CAPs are required when delegated partners fail to meet minimum thresholds as defined in the delegation oversight policies and procedures. Audits are also tracked to identify potential opportunities for improvement across the network. Those delegates that pose a high risk to the Plan may be analyzed by a multidisciplinary sub workgroup of the DOC and tracked through the DOC for company-wide transparency and intervention.

The audit tools are divided into sections to assess compliance with delegated function requirements. The sections include policy and procedure review to ensure a written process which meets standards/requirements and file review to evidence compliance with the standards/requirements. These two processes together ensure a holistic review of the delegated entities ability to perform the delegated functions.

The delegated entities policies and procedures must address, at a minimum, steps taken to perform the delegated function in accordance with regulations and standards, applicable turnaround time for processes, decision-making specifics, monitoring activities, and file processing protocols.

The following summarizes elements of file reviews conducted by the Plan:

Claims Annual/Quarterly/Monthly Oversight (Medi-Cal)
• Paid Contracted and Non-Contracted Providers including Emergency Room claims
• Family Planning/Sensitive Services – Non-Contracted providers excluding ER (please see enclosed list of family)
• Provider Dispute Resolution
• Adjustments – report showing payment adjustments to previously processed claims

• Contested/Provider Denials (contracted and non-contracted)
• Misdirected/Forwarded Claims
• Open inventory/Pend report to be provided on the day of the on-site audit
• Emergency Claims
• Medical Record Request Compliance

Credentialing Annual File Review

• Credentialing/Recredentialing Application and Attestation
• Licensure
• DEA
• Education/Training
• Board Certification
• Work History
• Malpractice Claims History
• State Sanctions, Restrictions on Licensure and Limitations on Scope of Practice
• Medicare and Medicaid Sanctions and Exclusions
• Malpractice Coverage
• Hospital Privileges
• Performance Monitoring (Recredentialing)
• Recredentialing Timeliness
• Medi-Cal Sanctions
• Medi-Cal Enrollment
• EPLS/SAM Verification
• Turn Around Time For Reviewing BH/Substance Abuse Providers (60 day completion)

Utilization Management Annual File Review

• Approvals
• Medical Necessity Denials
• Basic Case Management
• Standing Referrals
• Specialty Referrals
• Cancellation Authorizations
• Sterilization and Informed Consent

2024 Goals:

- 100% of applicable annual delegation oversight audits, including follow-up and/or focus audits to be completed in 2024.
- 100% of quarterly/semi-annual reporting to be received timely and reviewed within 30 days of receipt.
- 100% of completed audit results reported to the Delegation Oversight Committee.

The following metrics summarize 2024 activities for the Delegation Oversight Team.

Function	Percentage of Timely Audits	Total Number of Pre-De Audits	Percentage of Timely Reporting
Claims	100%	6	97%
Credentialing	100%	4	100%
UM	100%	4	100%

Quantitative and Qualitative Analysis

In 2024 the Delegation Oversight teams conducted 100% timely annual audits ensuring those delegated entities that fell below the thresholds were put on CAPS and followed to closure. Those delegated entities that pose a risk were put on a high- risk alert list in the DOC. In 2024, there were 3 delegates/MSOs put on the high-risk log for monitoring through the DOC and the results were as follows:

- Corrective actions were resolved with multi-disciplinary bi-weekly meetings between the Plan and the delegate and training from the Delegation Oversight team.
- Cross functional work with business partners to clarify responsibilities of the delegate.
- Contractual changes solicited a business decision to continue monitoring until the delegate closed ongoing opportunities.
- Termination of contract.

All delegated entities are monitored through timely reporting. Reporting timeframes vary by function and line of business however, at a minimum, delegated entities are required to report activities semi-annually. In 2024 all delegated entities met 90% -100% timely reporting. Those delegated entities that didn't meet timely submittal we given a 10- calendar day grace period due to various reasons, including but not limited to staff turnovers and system issues, that led to gaps in understanding, temporary inaccessibility of data, and following protocols. At the end of the grace period, all delegated entities were compliant.

2025 Outlook & Goals

In 2025, the Delegation Oversight Team will continue to work with our delegated entities collaborating and partnering to ensure compliance and quality. Also, to ensure our delegated

partners have the training and support needed to successfully perform the functions in which they are delegated.

Priorities include:

- Utilizing the Delegation Oversight Regulatory Management System (DORMS) a comprehensive database for tracking delegation activities; and
- Continued process improvements such as expansion of delegate training and automating notifications from contracting on changes in the delegation agreement; and
- Continued monitoring delegated entities overall compliance through annual oversight, development and tracking of CAPs, and report monitoring; and
- Conducting interrater reliability audits on the auditors to ensure consistency in auditing practices; and
- Collaborating with internal business partners to develop a holistic approach in working with our delegated partners; and
- Identifying and monitoring high risk delegates through the DOC.

MEMBER EXPERIENCE

Member Satisfaction – CAHPS

2023 Promise Health Plan Medi-Cal San Diego and Los Angeles; Adult and Child Quality Program Evaluation

Blue Shield of California Promise Health Plan (inclusive of Medicaid products in San Diego and LA Counties) for the remainder of this report will be referred to as Blue Shield Promise (BSP). BSP is an organization with a mission to transform the healthcare system to be worthy of our friends and family. BSP is strongly committed to member experience. BSP systematically works to integrate a multi-disciplinary approach with quality improvement activities for the member experience. BSP unceasingly works to improve and develop member-centered design strategies, partnering with members and practitioners to deliver quality member experience and care.

The member experience is an important indicator for measuring quality and is required by the Center of Medicare Medicaid Services (CMS), Department of Managed Healthcare Services (DMHC), and the National Committee for Quality Assurance (NCQA), for compliance with accreditation requirements. BSP's objective is to gain insight and obtain information from our members about their perceived experience and expectations related to the continuum of healthcare. The measurement of member experience determines the effects of overall member experience with quality and identifies areas of opportunities for quality improvement. BSP regards all members highly and acts with members' needs in mind.

BSP assesses member experience for its Medi-Cal San Diego (SD) and Los Angeles (LA) populations using various metrics which include the Consumer Assessment of Health Care Providers and Systems (CAHPS) Survey, Grievances, Appeals, and Complaints (GACs) data. The CAHPS survey is administered annually to members to measure their experiences with their health plans and affiliated providers. BSP uses an NCQA and CMS certified survey vendor Press Ganey, who administers the CAHPS Survey in accordance with NCQA and CMS protocol and specifications. BSP also collects and analyzes Grievances, Appeals, and Complaints data throughout the year. Both data sources are assessed and analyzed for this report.

A. MEMBER EXPERIENCE Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The CAHPS Survey is a requirement by the DHCS, NCQA, and CMS for compliance with its accreditation and regulatory requirements. The primary objective of the CAHPS survey is to obtain actionable, quantitative data from the members about their experiences with the continuum of health care. The survey aims to measure how well BSP, and contracted providers are meeting the members' expectations and goals, identify areas of opportunity for improvement, and to increase the quality of care that BSP provides its members. BSP utilizes an NCQA-certified vendor Press Ganey to conduct CAHPS survey for Medicaid child and adult populations.

Methodology: Press Ganey BSP survey vendor, utilized NCQA approved mix-mode methodology to administer the CAHPS Medicaid Child and Adult survey for the San Diego and Los Angeles County regions. County region is determined utilizing California's state-county mapping. Survey methodology consists of the following:

- First survey questionnaire is sent by the survey vendor.
- Reminder postcard is sent by survey vendor.
- Second survey questionnaire sent by survey vendor.
- Survey vendor conducts telephone follow-up by Computer Assisted Telephone Interviews from Press Ganey.

Time Frame: The survey is in the field February 20, 2024 – May 22, 2024, which represents reporting year (RY) 2024, using measurement year (MY) 2023 data.

Member Eligibility: BSP conforms to strict NCQA sample selection and eligibility requirements. This ensures PHP generates a sample population frame that is unbiased and accurate. When compiling the sample size PHP follows the requirements as outlined by NCQA.

- All child Medicaid members ages are 17 years or younger at the time the sample is drawn for the measurement year in specified County.

- All adult Medicaid members are ages 18 years or older at the time the sample is drawn for the measurement year in specified County.
- Continuously enrolled for no less than 6 months of the reporting year with BSP Medicaid health insurance coverage.
- Includes no more than one gap in enrollment of up to 45 days during the measurement year.

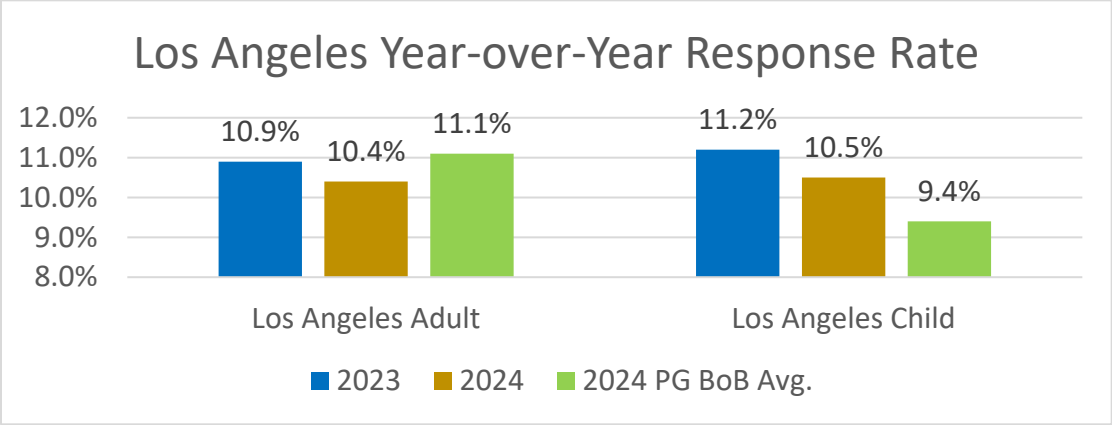
Overview: BSP in 2024 conducted a Medicaid adult and child CAHPS surveys for NCQA accreditation, regulatory purposes, and quality improvement efforts. BSP is committed to improving the member experience for all members and will continue to report Medicaid data.

Sample Size: BSP strategically oversamples to ensure an appropriate response rate for child and adult Medicaid CAHPS surveys. BSP oversamples according to expected responses for the Medicaid population. By anticipating expected response rates for the sample size, PHP can produce reliable data that is statistically significant. In 2024 BSP, oversampled for the Medicaid population.

BSP Sample Size for Medicaid CAHPS:

PHP Lines of Business	Sample Size	Grand Total Completes	Mail Completes	Telephone Completes	Internet Completes	Response Rate
Los Angeles Adult	2457	252	117	89	46	10.4%
Los Angeles Child	2459	257	80	109	68	10.5%

- Los Angeles Adult had 115 Spanish language completed surveys.
- Los Angeles Child had 159 Spanish language completed surveys.



YoY Response Rate	2023	2024	2024 PG BoB Avg.
Los Angeles Adult	10.9%	10.4%	11.1%

Los Angeles Child	11.2%	10.5%	9.4%

- Los Angeles Adult response rate decreased 0.5% from the previous year.
- Los Angeles Child response rate decreased 0.7% from the previous year.
- Response rates decreased slightly across all lines of business.

Goal: 2024 BSP goals will be compared to the NCQA quality compass Medicaid average from the previous year. This allows BSP to accurately track year-over-year growth, better understand areas of opportunity and set a realistic goal that BSP is targeting. Rates above average will indicate goal has been met, while rates below average will indicate goal not met.

Table 1. Medi-Cal CAHPS for Los Angeles Adult: 2023 and 2024 results are displayed for comparative performance year over year. The table also includes the new 2023 goal rate and indicator of met or not met when benchmarking against NCQA Quality Compass average from previous years.

Table 1.

Composites and Rating Questions	2023 Results	2024 Results	Delta	Trend	2023 NCQA Quality Compass average	Goal Met
Rating of health plan	80.1%	80.9%	0.80%	↑	77.7%	Yes
Rating of health care	67.2%	76.8%	9.60%	↑	74.6%	Yes
Rating of personal doctor	76.5%	81.7%	5.20%	↑	82.4%	No
Rating of Specialist	76.5%	81.0%	4.50%	↑	81.4%	No
Getting needed care	73.0%	78.8%	5.80%	↑	81.0%	No
Getting care quickly	69.0%	77.3%	8.30%	↑	80.4%	No
Customer service	87.5%	92.2%	4.70%	↑	89.2%	Yes
How well doctors communicate	86.7%	91.1%	4.40%	↑	92.5%	No
Coordination of Care	66.7%	79.1%	12.40%	↑	84.6%	No
Ease of filling out forms.	91.5%	92.5%	1.00%	↑	95.4%	No

Scores are shown in the summary rate that represents the most favorable response percentages.
% always+usually, % yes, and Ratings of % 8, 9, 10.
↓ ↑ *Indicates summary rate scores increased or decreased from the previous year.*
NA indicates not applicable to reporting.

Medi-Cal CAHPS for Los Angeles Adult Quantitative Analysis (*See table 3.)*

- 3 of 10 CAHPS composite measures met goal. Rating of health plan, rating of

health care, and customer service did meet goal.

- Access to care measures getting needed care and getting care quickly increased when compared to the previous year. Getting needed care increased 5.8% from the previous year but did not meet goal. Getting care quickly decreased of 8.3% from the previous year and did not meet goal.
- The rating of personal doctor increased 5.2% from the previous year and did not meet goal.
- Rating of specialist increased 4.5% from the previous year and did not meet goal.
- Care coordination had the largest increase in 2024. Care coordination decreased 12.4% from the previous year and did not meet goal.

Table 4 Medi-Cal CAHPS for Los Angeles Child: 2023 and 2024 results are displayed for comparative performance year over year. The table also includes new 2023 goal rate and indicator of met or not met when benchmarking against NCQA Quality Compass average from previous years.

Table 4.

Composites and Rating Questions	2023 Results	2024 Results	Delta	Trend	2023 NCQA Quality Compass average	Goal Met
Rating of health plan	87.1%	86.6%	-0.50%	↓	86.2%	Yes
Rating of health care	81.2%	81.5%	0.30%	↑	86.2%	No
Rating of personal doctor	86.7%	87.9%	1.20%	↑	89.3%	No
Rating of Specialist	79.8%	86.4%	6.60%	↑	85.6%	Yes
Getting needed care	82.5%	71.0%	-11.50%	↓	82.7%	No
Getting care quickly	79.9%	70.6%	-9.30%	↓	85.5%	No
Customer service	89.1%	88.1%	-1.00%	↓	87.6%	Yes
How well doctors communicate	92.1%	86.6%	-5.50%	↓	93.6%	No
Coordination of Care	83.5%	80.0%	-3.50%	↓	83.8%	No
Ease of filling out forms.	93.2%	89.9%	-3.30%	↓	95.8%	No

Scores are shown in the summary rate that represents the most favorable response percentages.

% always+usually, % yes, and Ratings of % 8, 9, 10.

↓ ↑ *Indicates summary rate scores increased or decreased from the previous year.*

NA indicates not applicable to reporting.

Medi-Cal CAHPS for Los Angeles Child Quantitative Analysis (*See table 4.)*

- 3 of 10 CAHPS composite measures did meet 2023 goal. Rating of health plan,

rating of specialist, and customer service did meet goal.

- Rating of health care remained consistent from the previous year and did not meet goal.
- Getting needed care decreased 11.5% from the previous year and did not meet goal.
- Getting care quickly decreased 9.3% from the previous year and did not meet goal.
- Coordination of Care decreased 3.5% from the previous year and did not meet goal.

Areas of Opportunities and Barriers

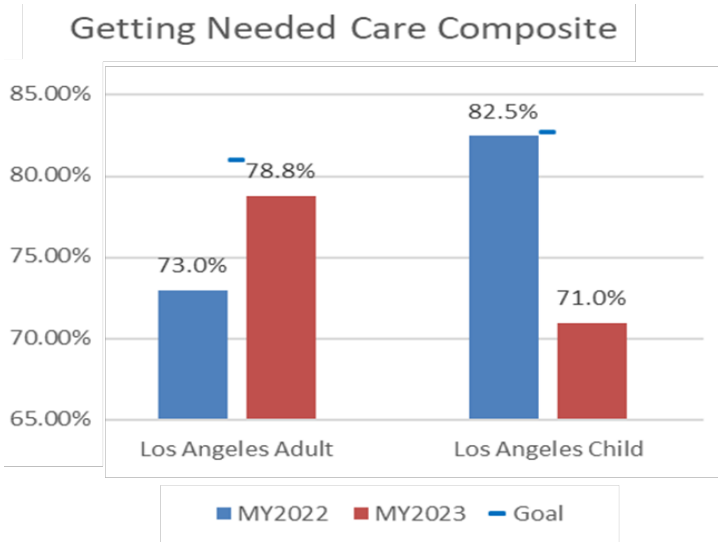
BSP conducted additional analysis of both Adult and Child Medi-Cal CAHPS to better understand the member's needs. BSP conducted an in-depth correlation analysis to understand drivers that will help improve the member experience. The table below indicates the top drivers that will improve the members' experience and increase rating questions. However, driver questions related to provider communication are not in scope for BSP.

Rating of Health Plan		Rating of Health Care	
The below Composites have been identified as key drivers of Rating of Health Plan		The below Composites have been identified as key drivers of Rating of Health Care	
Getting needed care	Opportunity	Ease of Filling Out Forms	Opportunity
Coordination of Care	Opportunity	Customer Service	Opportunity

BSP also conducts longitudinal assessments at both the composite and measurement levels. Year over year analysis helps BSP better understand trends and truly identify members' needs. By identifying areas of opportunities BSP can develop strategies and tactics to improve the member experience.

CAHPS Barriers and Opportunities Analysis

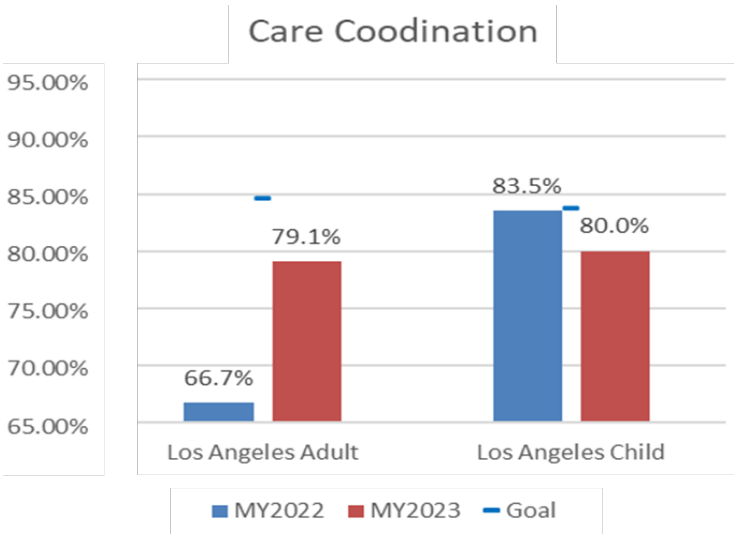
Getting Needed Care Composite Quantitative Analysis



Scores are shown in the summary rate that represents the most favorable response percentages.
% always+usually, % yes, and Ratings of % 8,9,10.

- Across all lines of business getting needed care did not meet goal.
- LA Adult "Getting Needed Care" composite increased 5.8% from the previous year.
- LA Child "Getting Needed Care" composite decreased 11.5% from the previous year.
- Across all lines of business, question level getting specialist appointment as soon as needed continues to underperform and be an area of opportunity. Specialist appointment times and availability continue to impact the member's experience. Due to limited specialist providers, a national provider shortage and health care professional staffing shortages this area continues to be a pain point for members.

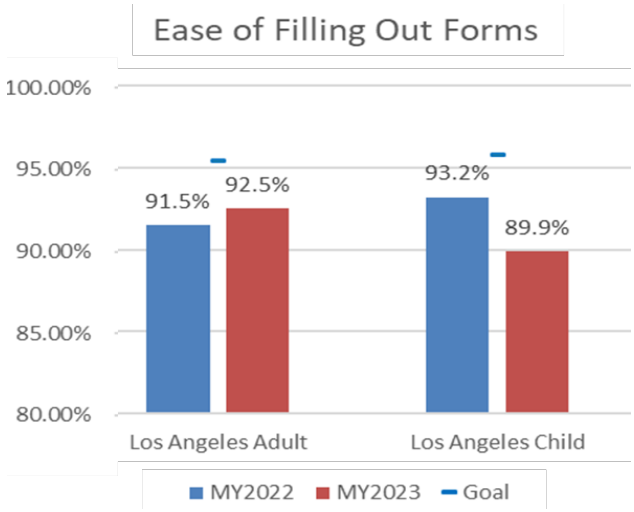
Coordination of Care Composite Quantitative Analysis



Scores are shown in the summary rate that represents the most favorable response percentages.
% always+usually, % yes, and Ratings of %8, 9, 10.

- LA Adult "Coordination of Care" increased 12.4% from the previous year.
- LA Child "Coordination of Care" decreased 3.5% from the previous year.
- For this measure "In the last 6 months, how often did your personal doctor seem informed and up to date about the care you got from these doctors or other health providers?" continues to be an area of opportunity for Los Angeles Adult and Child,. 3 of 4 lines of business did not meet the goal as indicated by the blue line.
- Member are indicating that Personal or primary care provider (PCP) are not up to date with specialist care. Coordination of Care continues to be an area of opportunity, with disparate Electronic Medical Records systems, Health Information Exchange and data sharing being different among providers and practices. This leads to PCP not being update to date with specialist appointments. Additionally, with staffing shortages continuing into 2024 resource constraints may also impact this measure.

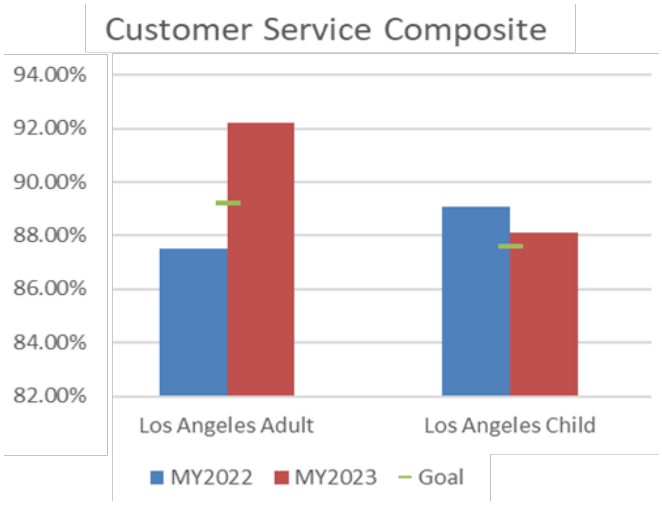
Ease of Filling Out Forms Composite Quantitative Analysis



Scores are shown in the summary rate that represents the most favorable response percentages.
% always+usually, % yes, and Ratings of % 8, 9, 10.

- LA Adult "Ease of Filling Out Forms" composite increased 1% from the previous year.
- LA Child "Ease of Filling Out Forms" composite decreased 3.3% from the previous year.
- "Ease of Filling Out Forms" is a single measure item measuring the members ease and ability to fill out forms. This measure is high-performing as indicated by the scores across each line of business. The goal for this measure is 95.8 for child and 95.4 for adults. This measure indicated that majority of members find it easy to fill out forms.

Customer Service Composite Quantitative Analysis



Scores are shown in the summary rate that represents the most favorable response percentages.
% always+usually, % yes, and Ratings of % 8, 9, 10.

- LA Adult "Customer Service" composite increased 4.7% from the previous year and did meet goal.
- LA Child "Customer Service" composite decreased slightly by 1% from the previous year and did meet goal.
- 3 of 4 lines of business experience an increase in performance when compared to the previous year.
- This composite measure continues to be an area of opportunity for BSP. As a critical member touch point for both the member and the plan this measure drives rating of health plan. This measure will continue to be an area of opportunity for BSP to improve the member experience.

Appeals and Grievances

Blue Shield of California Promise Health Plan also assesses grievances, appeals and complaints (GACs) on an annual basis. GAC's are tracked in the MedHok (MHK) system. Coordinators are responsible for entering GACs into the system and assigning appropriate codes. Coding accuracy is audited regularly. Detailed activity codes are assigned to each record describing the reason for filing an appeal, (i.e., claims denial, delay of referral/authorization, copay amount, etc.) Coding is reviewed and updated regularly to aggregate detailed information concerning all appeals and Complaints.

Categories of Appeals include:

Quality of care (potential quality issues/quality of care) • perception of inadequate or inappropriate care • delay in care that impacts the quality of care received. Quality of practitioner office site (complaints) • dirty office • parking not acceptable Access (appeals and complaints) • perception of provider non-availability or access • inconvenient access • inconvenient hours of operation • inconvenient location Attitude & Service (complaints) • primary care physician/medical group will not provide a referral or service. • primary care physician/medical group delay in processing referral or service • health plan provided incorrect information. • incorrect PCP assignment • customer service complaints	Billing & Financial (appeals and complaints) appeals. • claims denial: services are not a benefit, authorization not obtained. • benefit coverage: copayment, coinsurance, deductible, allowed amount, coordination of benefits. • pharmacy copayments/deductibles • eligibility/enrollment; transfers, rate increases, reinstatements, effective dates • denial/delay of referral to a specialist • denial of referral to out of network specialist • denial/delay of referral to a specialist – 2nd opinion • denial/delay of referral or authorization • denial/delay of referral or authorization – out of network • preservice (prior) authorization denial • pharmacy prior authorization denial complaints • delay of payment • rate increases

Timeframe

This report encompasses data for all BSP Promise Health Plan Medi-Cal products not related to Behavioral Health. The reporting period is January 1, 2024, through December 31, 2024.

Methodology

BSP aggregates and evaluates GACs for all lines of business. All GACs are included in reporting, i.e., sampling is not used. Methodology: The sum of appeals for every three months was calculated and annualized to reflect average monthly rates per 1,000 members (ptmpm). A threshold that defines an outlier was determined by using a cut-off of 1.0 standard deviations above the mean for each category separately over two quarters. Categories with too few cases (<100 for the year) are not identified due to too little data for an appropriate analysis.

Complaints & Appeals Goal: In 2024, the plan was observing the rate. The rate is PTMPM (per thousand members per month). This calculates the total number of appeals/complaints divided by the membership multiplied by a thousand and normalized by the number of months (12 for the year). The rate goal is determined by the plan as less than <1.0 overall.

Medi-Cal Appeals and Complaints Los Angeles

Table 1: Volume and Rate by Category for Medi-Cal Los Angeles

Appeals – Medi-Cal- Los Angeles	2023			2024			Goal
PHP Medi-Cal LA	Count	Rate	%	Count	Rate	%	Met
Access	0	0.00	0%	0	0	0%	Yes
Attitude & Service	0	0.00	0%	0	0	0%	Yes
Billing & Financial	221	0.05	100%	233	0.05	100%	Yes
Quality of Care	0	0.00	0%	0	0	0%	Yes
Quality of Practitioner Office Site	0	0.00	0%	0	0	0%	Yes
PHP Los Angeles Total	**221**	**0.05**	**100%**	**233**	**0.05**	**100%**	

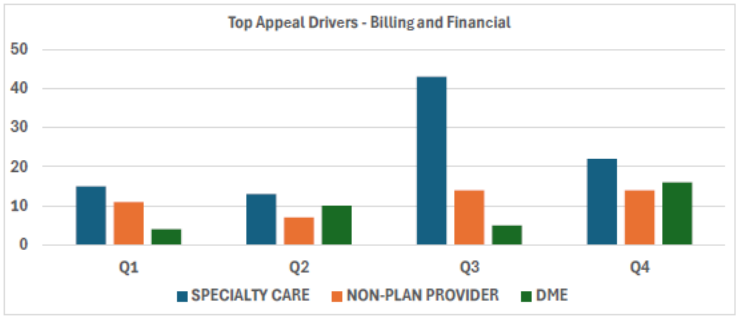
Medi-Cal Los Angeles Appeal – Access

- There were no Access Appeals for Medi-Cal in 2024, Medi-Cal appeals rate is below 1.0 and met goal in 2024.

Medi-Cal Los Angeles Appeal – Attitude and Service

- There were no Attitude and Services Appeals for Medi-Cal in 2023. There were no "Attitude and Service" Appeals for Medi-Cal in 2024, Medi-Cal appeals rate is below 1.0 and met goal in 2024.

Medi-Cal Los Angeles Appeal – Billing and Financial



- Medi-Cal LA Billing & Financial appeals related to specialty care, non-plan providers, and DME were the top drivers in 2024.
- Medi-Cal LA "Billing and Financial" appeals rate is below 1.0 and met goal in 2024.

Medi-Cal Los Angeles Appeal – Quality of Care

- There are no Quality-of-Care Appeals for Medi-Cal LA in 2024.
- Medi-Cal LA Appeals for quality care met goal in 2024 as the rate is below 1.0.

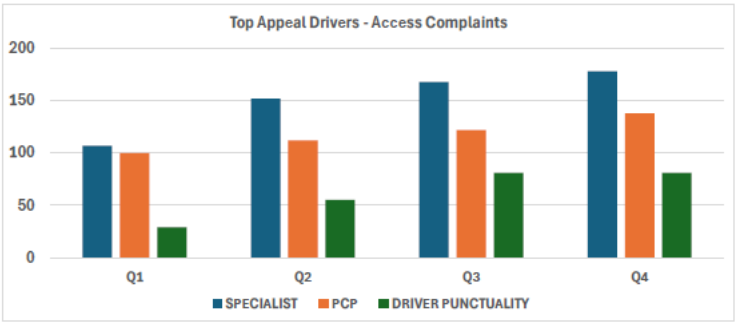
Medi-Cal Los Angeles Appeal – Quality Office Site

- There are no Quality Office Site Appeals for Medi-Cal LA in 2024. Appeals for Medi-Cal LA in 2024 rate is below 1.0 and met goal in 2024.

Table 2: Volume and Rate by Category

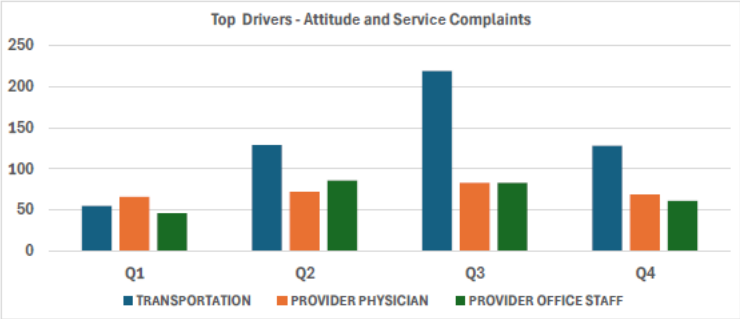
Complaints – Medical-Los Angeles	2023			2024			Goal
PHP Medi-Cal LA	Count	Rate	%	Count	Rate	%	Met
Access	1036	0.57	15%	2363	1.0	42%	No
Attitude & Service	2031	1.11	30%	1656	0.36	30%	Yes
Billing & Financial	1353	0.74	20%	522	0.11	9%	Yes
Quality of Care	2374	1.30	35%	1111	0.24	20%	Yes
Quality of Practitioner Office Site	0	0.00	0%	9	0.0	0%	Yes
PHP Los Angeles Total	**6794**	**3.72**	**100%**	**5691**	**1.23**	**100%**	

Medi-Cal Los Angeles Complaint – Access



- In 2024, Medi-Cal LA Access complaints related to specialist, primary care provider (PCP), and driver punctuality were the top drivers in 2024. Access complaints made up 42% of total grievance filed. This has increased from 2023 where access complaints made up 15% of total grievances filed.
- Medi-Cal LA complaint records for "Access" Increased by more than 27%, from 2023, from 1036 records to 2363 records in 2024.
- Medi-Cal LA Access complaints did not meet goal in 2024. Rate is above 1.0 and did not meet goal in 2024.

Medi-Cal Los Angeles Complaint – Attitude & Service



- In 2024, Attitude and Services complaints related to transportation services, providers, and provider office staff were the top drivers. Attitude and Service complaints represent 30% of the total complaints filed.
- For Medi-Cal LA, attitude and services complaints related to transportation services, providers, and provider office staff continue to be an area of opportunity.
- In 2024, Medi-Cal LA attitude and service complaints did meet the goal in 2024. Rate is below 1.0 and did meet the goal in 2024.

Medi-Cal Los Angeles Complaint – Billing & Financial

- Medi-Cal LA Billing & Financial complaints decreased in 2024. Billing and Financial in 2023 has 2,031 total records and decreased 375 records to 1,656 records in 2024.
- Medi-Cal LA "Billing and financial" complaints continue to account for 30% of total complaints filed in 2024.
- Medi-Cal LA "Billing and Financial" complaints did meet goal in 2024. Rate is below 1.0 and did meet goal in 2024.

Medi-Cal Los Angeles Complaint – Quality of Care

- Medi-Cal LA Quality-of-Care complaints related to inappropriate medical treatment and delay in authorized care were top drivers in 2023 and in 2024.
- Quality of Care complaints made up 20% of total grievance filed in 2024. This is a decrease from 35% in 2023.
- Medi-Cal LA Quality-of-care complaints decreased 2374 recorded complaints in 2023, to 1,111 recorded complaints in 2024, indicating a decrease in number of complaints from the previous year.
- Medi-Cal LA Quality-of-Care complaints did meet the goal in 2024. Rate is below1.0 and met goal in 2024.

Medi-Cal Los Angeles Complaint – Quality of Practitioner Office Site

- There were only nine (9) quality of practitioner office site complaints in 2024. The small number of cases was not enough to provide further analysis.

Quantitative Analysis Appeals

2024 Top Appeals

Appeals	Goals Met for Medi-Cal LA?
Access	Yes
Attitude & Service	Yes
Billing & Financial	Yes
Quality of Care	Yes
Quality of Practitioner Office Site	Yes

All goals were met for Medi-Cal appeals for LA County.

2024 Top Complaints

Complaints	Goals Met for Medi-Cal LA?
Access	No
Attitude & Service	Yes
Billing & Financial	Yes
Quality of Care	Yes
Quality of Practitioner Office Site	Yes

Most goals were not met. Further quantitative analysis was conducted. Access complaints for both Los Angeles did not meet goal and continue to be an area of opportunity for both Medi-Cal Los Angeles.

- Medi-Cal LA access complaints related to specialist, PCP, and driver punctuality were the top drivers in 2024. Access complaints made up 42% of total grievance filed.

Access complaints are areas of opportunity for both Medi-Cal LA. Along with appeals and complaints analysis, BSP also conducts a robust analysis of member experience surveys. Overlaying various sources of data, BSP has determined and identified barriers and areas of opportunity. Further assessment is provided below.

Overall Qualitative Analysis:

Overall, Barriers

Patients' perceptions and experiences are affected by how they judge the quality of the care they receive. If expectations are exceeded, they report higher quality, whereas, if the service is below their expectations, the quality is judged low. This perception of experience does not always correlate to quality, although research suggests higher member satisfaction as it relates to the members' overall health indicating a healthier member means better member experience.

Patient perception of the experience is driven by various direct and indirect factors. These factors include but are not limited to gender, race, ethnicity, socio-economic class, social determinants of health, geographical region, education, and provider relationships; however, it is also influenced by their relationship with the healthcare system, environment, cultural influences, access to services, distance to services, recovery, pain, and numerous other factors which impact their experience with healthcare. Their rating of satisfaction may not correlate to whether they received high quality of care or whether they had good clinical outcomes. Nonetheless, BSP continues to understand this dynamic relationship to better serve its members.

In 2024, The cost of health care continues to be a barrier impacting the most vulnerable population: low income and fixed income populations. Evolving regulations continue to apply financial pressure on health plans to improve quality and reduce the cost of healthcare for members increasing the administrative burden on providers. Nationally, the continued shortage of licensed healthcare professionals continues, impacting rural areas specifically (Association of American Medicare Colleges , 2024)[1]. This shortage in licensed professionals impact access to care for members across all lines of business. And continues to be a barrier for members.

These factors outside of healthcare, on both a national and state level, impact the member experience and quality health outcomes. It is important to understand these factors impacting members so that BSP can continue to create a healthcare system worthy of our friends and family, which is sustainably affordable.

People

- **CAHPS Member Experience Team**: BSP has been re-aligned CAHPS member experience teams within line of business functional areas. This re-alignment allows the

[1] GlobalData Plc. The Complexities of Physician Supply and Demand: Projections From 2021 to 2036. Washington, DC: AAMC; 2024.

CAHPS member experience team to work closer with the respective line of business units, creating efficiencies in workflow and resources.

- **Member Check-In**: Six full-time call representatives' conduct year-round targeted outreach to members to see if there is any assistance needed to access their plan benefits, including but not limited to providing information, assisting with making appointments, understanding, and resolving specialty referrals.

Process

- **In 2023, BSP launched a monthly mock CAHPS** survey for Medi-Cal members. The data collected is used to identify low performing providers. However, low response rates have been identified as areas of opportunity. The mock CAHPS programs are used with other supplemental data sources to help identify low performing provider groups. While the survey was utilized, many provider partners disagreed with the data. This resulted in unproductive partnership, so the program has been retired in 2024, and replaced with a HEDIS Medi-Cal Simulation CAHPS survey in 2024.
- **In 2024, HEDIS Medi-Cal Simulation survey**, this survey will allow BSP to simulate the HEDIS Medicaid CAHPS survey allowing BSP more insights into member level responses. Data collected from the survey will be used for quality improvement purposes. This program will launch in 2025.
- **Access to Care Health Education Mailer:** BSP mailed 2 rounds of Access to Care guides in Q2 and Q3 of 2024, helping members know when to use Teledoc, Nurse Advice, Urgent Care, and the Emergency Room in all 10 threshold languages. BSP continue to use the member engagement material at all events, Community Resource Centers, providers, etc. This program is working to address access to care barriers as identified by complaints data in 2024.
- **Member Newsletters:** BSP executed 2 annual newsletters in Q2 and Q4 of 2024. The member newsletters contained important health information and resources in all 10 threshold languages.

Technology

- **Artificial Intelligence/Machine Learning(AL/ML) Predictive CAHPS Solution**: BSP partnered with an external vendor to develop. AI/ML solution which allows the BSP identify individual members CAHPS risk and how likely a member will rate low in specific CAHPS measures. This solution is used for targeted outreach to ensure meaningful materials are sent to members that will benefit from it the most. This solution is expanding in 2025 to include provider report card to be used for provider engagement and member experience improvement work with contracted providers. The strategy for 2025 is to include partner providers to help drive member experience improvement at the provider group levels. This program is looking to improve member experience at the root cause.
- **Find A Doctor:** BSP Continues to improve the accuracy of Find a doctor tool. BSP created a user interface allowing provider to easily attest the providers information as it relates to address, new patient appointments, etc. This allows the provider directory

to be accurate and up to date improving the members experience when it comes to finding providers and services.

BSP continues to work towards improving member experience. BSP has a resolute clinical quality member experience team to help drive improvement efforts as measured by CAHPS surveys. Although improving the member experience is an organizational goal and a mission for BSP, the dedicated team will ensure the member experience is at the forefront of every strategy and initiative that is developed.
Many areas of opportunities were identified throughout the report. BSP remains agile to ensure it can meet the members' needs and expectations. Strategy development is ongoing and will respond to areas of opportunity as they arise. BSP is conducting many multi-year initiatives that will continue into the coming year, in addition to the ongoing mentions above. These include multiple methods to incorporate the member voice into strategy development and initiatives to improve the overall member experience.

Promise Health Plan Preventive Health Guidelines (PHG)

Summary:

At least annually, Blue Shield of California Promise Health Plan (Promise) updates its Preventive Health Guidelines (PHGs) to ensure recommendations for appropriate preventive care and services are provided to members of various age groups. The PHGs are made available to members and providers online in English, Spanish, Arabic, Armenian, Chinese, Farsi, Khmer (Cambodian), Korean, Russian, Tagalog, and Vietnamese.

The PHGs do not determine benefits or coverage for services but serve as an educational document meant to promote preventive health and education for Promise members.

Methodology:

In 2024, updates to the PHGs were reviewed by the following teams across the organization: The Quality Improvement team to ensure there are no discrepancies with any current interventions that are in place; the Mandates team to ensure state and federal mandates are met; Legal consult to ensure compliance with regulations; Medical Policy to ensure alignment with medical policies in use for utilization management; Health Education to ensure readability and suitability for the Medi-Cal population, and with the Benefits Intent team to ensure alignment with their Preventive Health Benefit Policy, which differs from the PHGs in its intent. While the PHGs are educational in nature, the Benefit Policy uses the same information to determine what preventive care services are available and what must be provided at no cost to the members. These teams determine whether the inclusion of certain guidelines should be effective operationally as mandated by new laws and regulations.

In addition, the Digital Content team assisted in uploading the PHGs to the Provider Connection and Health and Wellness websites for members and providers to access before the deadline.

Results:
The annual updates to the Preventive Health Guidelines were completed before the deadline and within budget. English and threshold languages translations were uploaded to the Promise Provider Connection website and the Promise Medi-Cal Health and Wellness website.

2024 Outlook:
The 2025 updates to the PHGs will continue to follow the same process as years prior.

PROVIDER ENGAGEMENT / PERFORMANCE / EXPERIENCE

Align. Measure. Perform (AMP)

Blue Shield of California Promise Health Plan has been in partnership with the Integrated Healthcare Association since 2018 and is now launching the eighth year of its provider performance measurement program, Align. Measure. Perform (AMP), with the organization. The AMP Medi-Cal Managed Care program helps improve care for vulnerable patient populations across California and strives to increase measure alignment across Medi-Cal plans.

For MY2023, IHA operated their standard AMP program methodology which includes a set of Clinical Quality measures used for accountability purposes, public recognition, and public reporting. Provider organizations are also assessed on Appropriate Resource Use (ARU) and cost. IHA upheld the shared savings pathway which allows providers to earn incentives in both shared savings and attainment pathways and holds providers accountable for year-over-year improvement. Starting with MY2022, IHA raised the minimum performance threshold of the Quality Gate from the 10th percentile to the 25th percentile, making Clinical Quality outcomes more meaningful in the incentive design.

This marks the sixth year that Blue Shield of California Promise Health Plan distributed an integrated payout for both AMP Commercial HMO and AMP Medi-Cal Managed Care programs. In February 2024, 19 out of 34 participating Blue Shield Promise Medi-Cal provider organizations earned an incentive payout totaling $4.2M for Measurement Year 2023.

Barriers:
- Quality performance is a small component of program measurement.

- IHA releases results 11 months after close of measure year, which can be frustrating for provider organizations to not see results in 'real time'.

2025 Outlook:
IHA has engaged the Technical Payment Committee, Technical Measurement Committee and Program Governance Committees in discussions and has decided to overhaul the AMP program incentive design methodology, starting with MY2024, with focus on making Clinical Quality performance the basis for providers to earn incentives in the AMP Program. The cost component of the program will now be a multiplier.

Promise Quality Performance Incentive (PQPI) Program

The PQPI Program utilizes a streamlined approach to assess and reward performance for Healthcare Effectiveness Data and Information Set (HEDIS®) measures, Encounters, and Social Determinants of Health (SDOH) Z-Codes.

The measures in the HEDIS domain are in alignment with the Managed Care Accountability Sets (MCAS) Minimum Performance Level (MPL) measures, set forth by DHCS. HEDIS results are determined using each measure's complete HEDIS-eligible population. HEDIS results are calculated using each measure's complete HEDIS-eligible population. For measurement year (MY) 2025, 17 HEDIS metrics contribute to the overall HEDIS score.

In MY 2024, the PQPI Program removed the Encounters domain and the SDOH Z-Code bonus opportunity. Instead, these metrics were combined into a "Data" Domain and is inclusive of both Encounters data and Z-Codes data. The Data domain for MY 2024 will measure the following:

1. Data Responsibility
2. Data Timeliness
3. Data Accuracy
4. Data Completeness
5. Z-Codes

The MY23 PQPI Program was paid out in December of 2024, totaling $8.5M. This was the second payment of the program.

Patient Centered Medical Home (PCMH)

The Patient Centered Medical Home (PCMH) program is a model of care that puts patients at the forefront. PCMH is a certification that primary care practices can obtain by adhering to key concepts, criteria, and competencies. The certifications are issued through the National Commission for Quality Assurance (NCQA) or the Joint Commission. PCMH helps build better relationships between patients and their clinical care teams. Primary care

practices within the Blue Shield of California Promise Health Plan provider network who have obtained or maintained PCMH certification through NCQA or the Joint commission are considered for participation in the PCMH Program. For practices to quality and receive an incentive payment, they must have achieved or maintained PCMH certification for at least one of their primary care practice locations and have a practice size of at least 100 Medi-Cal members within the six-month incentive period. In 2023, Blue Shield updated the payment methodology to include a $5.00 per member, averaged over the previous six-month period. The 2024 PCMH Program provided incentive payments in April and October, totaling $2.4M. The 2024 PCMH Program will be paid in April and October of 2024.

Care Gap Closure Incentive Program

This program rewards provider organizations for gaps in care closed in a specified period, based on a tailored set of Healthcare Effectiveness Data and Information Set (HEDIS) measures. The measures have been selected by assessing where Blue Shield Promise has seen the largest declines in preventive care throughout our Medi-Cal network.

In 2024, the program operated during Q2 and Q3. We also administered a year-end care gap closure program where any data received by a specific date could count towards any date of service in the year. The program payout totals for 2024 are pending.

Initial Health Appointment (IHA)

The Initial Health Appointment (IHA; formerly the Initial Health Assessment) program incentivizes our contracted provider networks for performing IHAs of new Medi-Cal enrollees to Promise Health Plan. Our IHA provider incentive program rewards Blue Shield Promise network providers for ensuring that every member who requires an IHA receives the care they need.

The Department of Healthcare Services (DHCS) requires primary care providers to conduct an IHA for all new Medi-Cal members within 120 days of enrollment to Promise Health Plan. The IHA can be completed by a primary care physician (PCP), nurse practitioner (NP), obstetrician/gynecologist (OB/GYN), certified nurse midwife (CNM), or physician assistant (PA). The 2023 IHA Program pays $75 for each timely IHA completed within 120 days.

The 2024 IHA Program is paid out quarterly in February, May, August, and November for the prior 3-month periods. The 2024 program payout total is pending.

Chronic Care Provider Incentive Program

In 2023, Blue Shield debuted a new provider incentive program in order to support the care of members with chronic conditions: Chronic Care Provider Incentive Program. The program supports our providers who address the needs of our members with chronic conditions through assessments (e.g., treatment planning, prescription of needed medications) during a member visit.

A list of members with chronic conditions is provided to provider groups monthly. Providers are rewarded for the percentage of members with chronic conditions who are seen in both the baseline and measurement years via a year-over-year percentage calculation. The program pays out on a scale ($0.01 up to $5.00) for increasing the percentage of eligible members treated for a chronic condition, with a maximum potential earning of $5.00 per member.

The 2023 Chronic Care Program was paid in June 2024 and totaled $22,199.

Provider Experience - Clinician Satisfaction Survey

The Clinician Satisfaction Survey (CSS) assesses our participating clinicians' satisfaction with Blue Shield in utilization management, authorizations and coordination of care, credentialing, translation and interpretation services, contracting, communications, reimbursement, access to care, telehealth, and other key areas. Primary care physicians, specialists, and behavioral health practitioners are sampled for the CSS using a statistically valid random sample methodology. The survey is administered using three modalities to maximize responses: U.S. mail, internet, and telephone. The survey is conducted by an independent firm, which is also responsible for following strict quality assurance guidelines, and the results are submitted to the California Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI).

Blue Shield compared to other health plans

Based on the survey vendor's aggregate book of business representing respondents from primary care, specialty care, and behavioral health areas of medicine, there are a few noteworthy findings for Blue Shield Promise:

- The likelihood to recommend Blue Shield Promise to others stands at 85.9%.
- Overall satisfaction with Blue Shield stands at 64.6%.
    - 65.5% of clinicians' practices align with Blue Shield's interests and partnerships.
    - 50.1% of clinicians are satisfied with Blue Shield's responsiveness and courtesy.

When asked what clinicians like about Blue Shield (inclusive of Blue Shield Promise), there were many compliments. Here are a few.

- *WORKING WITH A NON-PROFIT THAT IS MORE CONCERNED WITH PATIENT HEALTH THAN PROFITS*
- *WE ARE COMPLETELY SATISFIED WITH THE INSURANCE. WE DO NOT HAVE ANY PROBLEMS.*
- *NONE. WE ARE COMPLETELY SATISFIED WITH BLUE SHIELD HEALTH PLAN.*
- *I THINK YOU ARE VERY PROFESSIONAL AND DOING A GOOD JOB.*
- *BLUE SHIELD IS REALLY GOOD AND I DO NOT HAVE ANY ISSUES WITH THEM.*
- *ALLOWING ME TO PRACTICE WITH MINMAL INTERFERENCE.*
- *PAYING CLAIMS ON TIME AND HELPING SUPPORT OUR SMALL MEDICAL GROUP. THE HELP AFTER THE TWO THOUSAND EIGHTEEN FIRE THAT TOOK OUR TOWN.*

Net Promoter Score (NPS)

When clinicians were asked, "How likely are you to recommend Blue Shield to others?" Blue Shield's 2024 NPS was 17. NPS is a scale that spans from -100 to +100. It is a 200-point spread that considers the willingness of clinicians to recommend Blue Shield. Any score between 0 and 30 is considered good because that means more clinicians are promoting Blue Shield than are critical. The NPS by company, line of business, and clinician type are shown in the following table.

Line of Business	NPS	Clinician Type	NPS
Company Overall	17	Behavioral Health	-19
Blue Shield Promise	45	Primary Care Physicians	36
		Specialists	20

The top five areas identified by the verbatims where Blue Shield performs well are:

- Authorizations and Referrals
- Provider Portal
- Provider Services
- Claims
- Communications

Measurement Year (MY) Responses

The overall results for Measurement Year (MY) 2024, for those clinicians who are satisfied, exceed those who are dissatisfied. The clinician response percentages for Promise MY 2024 are shown in the table below, followed by a comparison of clinician satisfaction rates over the past several MYs. Response rates for clinicians who are satisfied are provided below.

Measurement Year 2024 Results and Previous Years (The below table shows results for Blue Shield Promise Health Plan only)

Questions	Percent Satisfied 2024	Percent Satisfied 2023	Percent Satisfied 2022	Percent Satisfied 2021	Percent Satisfied 2020
Satisfaction with Referral/Prior Authorization Process that is necessary for HMO patients to obtain covered services	91.1%	91.8%	89.5%	92.2%	63.0%
Timely Access to Urgent Primary Care	100%	98.9%	89.5%	100%	96.0%
Timely Access to Routine Primary Care	100%	98.9%	96.5%	98.4%	98.0%
Timely Access to Urgent Specialty Care	98.4%	99.0%	95.3%	95.4%	93.0%
Timely Access to Routine Specialty Care	95.0%	98.0%	94.8%	98.9%	86.0%
Timely Access to Urgent Ancillary Diagnostic/Treatment Services	93.0%	96.8%	85.0%	96.1%	96.0%
Timely Access to Routine Ancillary Diagnostic and Treatment Services	91.9%	96.8%	93.3%	45.6%	96.0%
Timely Access to Routine Initial Behavioral Health Care	96.6%	95.7%	90.8%	95.3%	78.0%
Timely Access to Routine Follow-up Behavioral Health Care	94.8%	96.8%	90.8%	95.3%	81.0%
Timely Access to Non-life-threatening Emergency Behavioral Health Care	98.2%	92.5%	91.0%	92.0%	79.0%
Timely Access to Urgent Behavioral Health Care	93.0%	92.2%	89.3%	93.2%	81.0%

Functions that are important to Clinicians

- **Network Management:** Clinicians rated Blue Shield similarly in 2024 and 2023, noting satisfaction with (1) responsiveness and courtesy and (2) timeliness in answering questions and/or resolving problems.
- **Practice Experience with Blue Shield:** Most clinicians rate Blue Shield favorably in the areas of practice experience during contract negotiations, aligned interests and sense of partnership, the credentialing process, ease of working with Blue Shield compared to other plans, reimbursement rates compared to similar plans, and patient satisfaction with their coverage compared to other plans. Scores are highest among Primary Care Physicians.

- **Timely Access to Care:** Scores for timely access to care experienced a slight decrease from 2023. This included routine and urgent primary care, routine and urgent ancillary diagnostic/treatment services, urgent specialty care, and resources to integrate and coordinate care. Satisfaction is highest among Primary Care Physicians.

Note: Blue Shield uses the state's annual Provider Appointment Availability Survey (PAAS) to assess accessibility followed by a proprietary Secret Shopper Evaluation (SSE) to better assess noncompliant clinicians. The SSE asks additional questions, such as whether an NP or PA is available and if Advanced Access is offered for same/next day appointments. For example, the PAAS indicated that 14% or PCPs and 39% of SCPs were noncompliant, however, the SSE reveled that of the 14% of PCP, 50% were compliant; and of the 39% of SCP, 29% were compliant.

- **Routine and Urgent Care Appointments:** It takes an average of 5.7 days to schedule a routine appointment, with an average wait time of 14 minutes in the office before the patient is seen. The wait time to be seen decreased from 2023 to 2024. A lower percentage of practices offered same/next-day urgent appointments (87.2%) in 2024 compared to previous years. An average of approximately 40% of urgent and routine appointments are available for same/next-day scheduling. Higher percentages of Primary Care and Specialty Physicians offer same/next-day urgent appointments than Behavioral Health Clinicians.
- **Language Assistance Program:** All areas of the language assistance program remained relatively steady year over year with approximately 70% satisfied in each area. The strongest area is the interpreter's ability to effectively communicate on the patient's behalf (72.4%).
- **Authorization Processes:** Satisfaction with all areas of the authorization process have remained steady over the past several years. There were no significant changes. Nearly half of clinicians reported that they are often or always able to refer patients to a specialist without having to wait for approval. The highest satisfaction ratings were from Primary Care and Specialty Physicians in all areas.
- **Outpatient Drugs:** There was a slight decrease in satisfaction from 2023 to 2024. Primary Care Physicians rated (1) the provider notifications that clearly state the reason for the requested drug not being approved for coverage and (2) the ease of outpatient drugs as the highest items of satisfaction with Blue Shield.
- **Behavioral Health:** Scores within the area of behavioral health remained relatively steady from previous years. This area tends to trend lower than other areas with under half of clinicians rating these attributes as excellent or very good. Satisfaction with behavioral health rated lower among Behavioral Health Physicians than Primary Care and Specialty Care Physicians.

- **Coordination of Care:** Timeliness and helpfulness of consultant reports varies by area of medicine with lower ratings emerging for mental health professionals and psychiatrists and the highest ratings for cardiologists and imaging facilities. Timeliness and helpfulness of facility discharge reports also varies by facility with lower ratings emerging for skilled nursing facilities and higher ratings for inpatient hospitals and emergency departments.
- **Telehealth:** A significantly higher percentage of respondents indicated they have been offering telehealth services since the COVID-19 pandemic, than the previous two years (24.3%). A higher percentage than in 2023 indicated that they do not currently offer it but are considering it (6.25%). Clinicians' satisfaction with the information provided to help implement telehealth services and administrative support of telehealth services remains relatively steady from year to year. Primary Care Physicians report the highest satisfaction with telehealth.

Opportunities

The CSS offers Blue Shield opportunities to improve clinicians' experience. Drawing from both the survey's responses and verbatims, these are the primary areas where improvements are requested from clinicians.

1. Reimbursement – Clinicians mentioned many times that Blue Shield reimburses poorly and has higher costs for benefit plan products. Several instances were mentioned to comparable health plans that reimburse higher rates. An opportunity exists to compare Blue Shield's reimbursement to other organizations by potentially using coordination of benefits data or external sources for comparison and potential correction.
2. Provider Services – use of off-shore personnel causes dissatisfaction. There are many complaints concerning the poor English skills at the provider service centers, and how these language barriers may be hindering patient care.
3. Provider Relations/RMDs – Many clinicians and group practices want Blue Shield to meet with them regularly. This is also an opportunity to share information with clinicians, which they strongly believe is needed from Blue Shield.
4. Brand recognition – The verbatims show that Blue Shield very often loses its identity to the larger Blue Plan in California. Many references, good and bad, were made to "Anthem," "Blue Cross," "Blue Cross Blue Shield," and "Profits and Stocks." Marketing efforts are needed to stress the "Shield" and nonprofit status instead of marketing as "Blue," which indirectly advertises for Blue Cross of California (dba Anthem Blue Cross).

APPENDIX

A. 2024 BSP Annual CLAS Program and Program Evaluation

B. BSP Medi-Cal Health Disparities Report 2024

C. Reporting Year 2024 NCQA NET 1-3 Report