2024 QUALITY PROGRAM EVALUATION

Medi-Cal San Diego

EXECUTIVE SUMMARY

Blue Shield of California's 2024 Quality Improvement (QI) program supports our quality vision and strategy, driving us toward achieving our long-term goals. The detailed objectives and activities are outlined in the 2024 Quality Work Plan. Key goals and objectives are listed below.

The 2024 Quality Program Evaluation reviews and assesses Blue Shield Promise Health Plan's QI Program for Medi-Cal San Diego. This evaluation forms the basis for ongoing quality improvement activities in the 2025 Quality Work Plan and aligns with the 2025 Quality Program Description.

Goals and Objectives for the 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
- Year over year improvement on MCAS measures
- Achieved Health Equity Accreditation for Medi-Cal Line of Business
- Leadership commitment and involvement in the Quality Program

2024 Barriers:

- Incomplete and inaccurate data continues to impact the integrity of reports and causes discrepancies in the analysis for member and provider initiatives.
- Limited access to accurate member information and lack of real-time data and lag time in reporting impact interventions that require outreach.
- Lack of pediatric Medi-Cal providers in SD impacted access and availability.

2025 Opportunities 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.

- Exploring opportunities to collaborate with Quality Improvement and contracted vendors who can conduct Initial Health Assessments visits via telehealth, office hours, and in-home visits.

- Strengthen the incentive program and reward providers that value high-quality performance.

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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 operates under geographic managed care (GMC) model in San Diego County. The Plan holds a direct contract with the Federally Qualified Health Centers (FQHCs). Quality improvement and performance measurement activities are directly overseen by the Department of Health Care Services (DHCS) through its contracted external quality review organization (EQRO).

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 and service, member safety, as well as organizational services provided to members, while identifying opportunities for enhancement in existing programs and new program developments.

POPULATION

Blue Shield Promise served 190,584 Medi-Cal members in San Diego County in 2024.

OVERALL EFFECTIVENESS OF THE PROGRAM

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 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, credentialing, delegation oversight, 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 and meets quarterly with off cycle 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 the provision 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, and customer care. Minutes are approved and maintained for each meeting.

2024 Goals and Objectives for the Quality Program

Goal: Deliver an exceptional quality program across the company
Objectives:

- Maintain NCQA Health Plan Accreditation for all Medi-Cal products.
- Obtain NCQA Health Equity Accreditation for Medi-Cal by 2025.
- Meet or exceed minimum performance levels in all DHCS Managed Care Accountability Set measures for all Medi-Cal service areas.

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

- Improve physical and mental health outcomes.
- Ensure mechanisms are in place to identify and address patient safety issues and foster strong relationships with providers to improve safety within practices and clinics.
- Ensure that mechanisms are in place to monitor and address timely access and

availability of services, including for those members with complex or special needs.

- Ensure that mechanisms are in place to monitor and address the reduction of 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:

- Ensure accessible health care by maintaining an adequate, qualified provider network through regular assessments of the availability of preventive and primary care, and high-volume and high-impact providers.
- 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.
- Ensure that timely, medically necessary, and appropriate care and services meeting professionally recognized standards of practice are available to members with varying needs and complex conditions, including the race, ethnicity, and language needs of our membership.
- 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/or 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 language needs and preferences of the membership.

2024 Outcomes and Accomplishments

1. Maintained NCQA accreditation status for Medi-Cal line of business
2. Achieved Health Equity accreditation for Medi-Cal line of business
3. Blue Shield Promise conducted all QMC meetings quarterly as scheduled, with active participation from a mixture of internal and external practitioners with diverse specialties.
4. Blue Shield Promise preserved the quality committee structure throughout 2024, incorporating network provider participation, including pharmacy and behavioral health in various subcommittees, with external membership to the organization.
5. Year-over-year improvement in 14 of 18 measures, as a result of the following quality improvement initiatives: (see pages 17-19)
    - Enhancement of Performance Monitoring Tool used to leverage outreach efforts and compare provider performances.
    - Revamping of Incentive Program to provider groups that completed care gaps during 4th quarter.
    - Enhancement of the Health Navigator Program to improve efficiency and outcomes.
    - Increase in the number of members screened during Well Child and Mobile Mammography Community Clinic Days in 2024.

- Strengthen relationships with low performing providers for better performance.
- Initiation of several initiatives to effectively socialize and advance the DHCS Bold Goals to integrate health equity into cross-functional areas.
- Completion of the disparities report supporting NCQA Health Equity Accreditation.
- Proactive review of medical records with open gaps in care for key childhood measures to identify true non-compliant providers and target interventions.
- Utilization of San Diego County behavioral health claims files as supplemental data to enhance care coordination and ensure integrity of BH records.

6. The well-child clinic days supported by Quality Health Partners and conducted at various community-based organizations all around the County led to >200% increase in screenings compared to 2023.
7. Mobile Mammography Days held at various locations resulted in over 250% increase in members that completed screening compared to 2023.
8. Data improvements were made by Clinical Data Analytics team to enhance and support supplemental data submission.
9. The credentialing department continues to meet all credentialing timeframes and compliance with regulatory guidelines.
10. The annual updates to the Preventive Health Guidelines were completed before the deadline and within budget.
11. Significant increase of members that made appointments with the aid of IHA Coordinator due to a substantial increase in membership in January and February.
12. High completion rates of at least one screening for Early and Preventive Services, Diagnosis and Treatment (EPSDT) were noted on children <1 yr and between 1-2 years old. Overall improvement was noted for age group < 21 years old in 2024.
13. Average speed of answer and abandonment rates met the goals despite the increase in calls received by Customer Care.
14. All delegated entities met the reporting timeframes, and no entity was placed on the high-risk monitoring by the Delegation Oversight Committee. All audits were conducted timely.
15. BS Promise San Diego met access and availability standards for all PCP types and Family/General Practice.
16. Access and availability for adult psychiatry and the non-physician mental health outpatient services showed improvements in 2024, as well as pediatric psychiatry. Goals for geographic distribution and member ratios were met.
17. Net Promoter Score for Medi-Cal from the 2024 Clinician Satisfaction Survey was 45. The overall NPS for Blue Shield was 17.
18. Integrated Healthcare Association revamped the Align. Measure. Perform. (AMP) incentive program design methodology, with focus on making Clinical Quality performance the basis for providers to earn incentives in the AMP Program.
19. Integrated CLAS and Health Equity into our Quality Program Description and QI Work Plan.

20. The ratio of providers speaking the threshold languages met the thresholds for member to provider spoken languages.

2024 Quality Program Barriers

1. Incomplete and Inaccurate data that impacted the integrity of the report.
2. Inaccurate patient information contributed to the failed outreach attempts to members.
3. Except for dermatology and ophthalmology, the threshold for geographic distribution of specialty care providers, including high volume and high impact specialists did not meet the established thresholds. Internal medicine providers are directly employed with large health systems and their lack of participation in the Medi-Cal LOB significantly impacts the availability of providers that are willing to contract with the plan.
4. Access to urgent care, routine care, follow-up of routine care, including ER access instructions for medical showed improvements in 2024, however, results did not meet BSP's established goals.

Goals, Objectives and Opportunities for the 2025 Quality Program:

1. Meet or exceeding the 50th percentile for all MCAS measures.
2. Continue to build existing member and provider intervention strategies
3. Launch new targeted interventions to address barriers to care and improve performance on low performing HEDIS measures
4. Identify root causes of health inequities in terms of access and availability of care for Medi-Cal members and work to mitigate health inequity barriers.
5. Continue to expand partnership with other departments to achieve quality goals.
6. Collaborate with Data & Analytics to assess other data sources to identify potential eligible members for outreach, including the Continuity of Care Document (CCD) data.

In 2025, we will continue to expand partnership with other departments to reach quality goals. Below is a list of existing enhanced and new initiatives in key areas:

A. Member Engagement and Community Partnerships
   - Refining member segmentation criteria for outreach
   - Focusing on converting telehealth well child visits to in-person visits in existing successful programs
   - Developing and deploying targeted member communications with health equity lens
   - Identifying members in population health management programs to reinforce care gap messages and improve reporting of outcomes

- Targeting outreach to promote health education classes (e.g., diabetes, asthma)
- Adding mobile mammograms and well child clinics in target areas
- Collaborating with marketing to deploy Health reminder/education messages via email and Relay network (testing) (new initiative)
- Acquiring member contact information from health information exchanges (new initiative)
- Implementing program with vendor that uses phlebotomists with medical assistant & community health worker training to close care gaps and address SDOH (new initiative)
- Engaging targeted diabetic members in enrolling in health education programs or Wellvolution program or Medically Tailored Meals (MTM) programs (new initiative)
- Partnering with new CBOs focused on birthing people and infants/children in targeted subpopulations (new initiative)
- Conducting member focus groups to tailor interventions (new initiative)

B. **Provider Engagement**

- Providing on-site learning sessions with offices, reviewing patient workflow processes to enhance gap closure and data capture opportunities
- Restructuring provider incentive program to better align with new requirements
- Delivering and discussing focused lists to providers for targeted measure strategy
- Promoting Violet Health for health equity
- Promoting COZEVA to providers to use as point of care tool and to submit data (new initiative)
- Promoting Asthma Management Program (new initiative)
- Partnering with dental providers for topical fluoride applications (new initiative)
- Partnering with community health workers at provider groups for members who are historically not closing care gaps to address SDOH and find members (new initiative)
- Partnering with school-based clinics to close care gaps (new initiative)
- Implementing additional health equity projects with providers (new initiative)
- Promoting new self-collection HPV testing for cervical cancer screening (new initiative)

C. **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 state and county data to ensure data completeness and accuracy

- Implementing single sign-on capability with HealthMine (member incentive program) in Blue Shield member portal (new initiative)
- Using COZEVA for additional data acquisition, chart review/abstraction automation (new initiative)
- Expanding Epic Payer Platform for more Medi-Cal providers (new initiative)
- Leveraging additional analytics to identify pregnant members earlier for timely outreach (new initiative)
- Leveraging CCD data from HIEs to identify additional members who were in ED for BH or SUD (new initiative)
- Leveraging Decision Point Opus Tool to identify members to target for specific interventions (incorporating health equity) (new initiative)

D. Other Opportunities:
1. Increasing provider availability by collaborating with IPA and Medical Groups on provider recruitment and outreaching to providers to directly contract with the plan.
2. Improving Medi-Cal practitioner access and availability of primary care practitioners (PCP), behavioral healthcare, and specialty care practitioners (SCP).
3. Increasing provider engagement through in-services and provider meetings.
4. Involving the members in the coordination of their care among the providers involved.
5. Educating the Member Outreach team to be sensitive to the needs of the members.
6. Improving clinical outcomes through Population Management Program
7. Increasing awareness for EPSDT assessment through the creation of e-course training for the providers in SD.
8. Improving clinical health outcomes by focusing on social determinants of health through Population Health Management strategies.
9. Promoting increased communication and coordination between PCPs and specialists, between PCPs and BH practitioners, and promoting the use of telehealth services.

QUALITY OF CLINICAL CARE

Medi-Cal HEDIS (MCAS) Results

The table below displays Blue Shield Promise's performance in San Diego County on measures from the Managed Care Accountability Set (MCAS) selected by the California Department of Healthcare Services (DHCS). A subset of MCAS measures is 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:

Measure Name	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	**83.41**	78.10	**84.62**	77.37
Prenatal-Postpartum: Rate—Prenatal	X	TBD	TBD	84.55	**84.28**	84.23	**85.77**	85.40
Child and Adolescent Well Care Visits	X	TBD	TBD	51.81	**53.12**	48.07	45.42	48.93
Child Immunization Status-- Combo 10	X	TBD	TBD	27.49	**33.09**	30.90	**43.05**	34.79
Immunizations for Adolescents – Combination 2	X	TBD	TBD	34.30	**42.82**	34.31	34.79	35.04
Well-Child Visits in the First 30 Months of Life (First 15 Months)	X	TBD	TBD	60.38	53.55	58.38	44.48	55.72
Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)	X	TBD	TBD	69.43	**67.02**	66.76	**66.15**	65.83
Developmental Screening in the First Three Years of Life[1]	X	TBD	TBD	35.70	**49.45**	34.70	47.43	NA
Topical Fluoride in Children[1]	X	TBD	TBD	19.00	17.65	19.30	NA	NA
Lead Screening in Children	X	TBD	TBD	63.84	**64.23**	62.79	**65.47**	63.99
Breast Cancer Screening: Rate	X	TBD	TBD	52.68	**56.12**	52.60	**54.41**	50.95
Cervical Cancer Screening	X	TBD	TBD	57.18	56.34	57.11	53.41	57.64
Chlamydia Screening: Rate—total	X	TBD	TBD	55.95	**66.00**	56.04	**62.89**	55.32
Asthma Medication Ratio		TBD	TBD	66.24	**67.05**	65.61	**70.45**	69.18

Measure Name	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
Controlling High Blood Pressure	X	TBD	TBD	64.48	**69.25**	61.31	**70.00**	59.85
Glycemic Status Assessment for Patients With Diabetes (>9%)[2]	X	TBD	TBD	33.33	**31.63**	37.96	**38.52**	39.90
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (Total)	X	TBD	TBD	36.18	30.82	36.34	**33.55**	21.24
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (Total)	X	TBD	TBD	53.82	25.24	54.87	44.42	54.51
Postpartum Depression Screening and Follow Up – Depression	X	TBD	TBD	1.30	**10.02**	0.10	1.31	NA
Postpartum Depression Screening and Follow Up – Follow Up on Positive Screen	X	TBD	TBD	61.70	**NA**	63.40	NA	NA
Prenatal Depression Screening and Follow Up– Depression	X	TBD	TBD	5.62	**16.78**	0.23	1.39	NA
Prenatal Depression Screening and Follow Up – Follow Up on Positive Screen	X	TBD	TBD	50.98	**74.29**	54.84	NA	NA
Prenatal Immunization Status (Combination)	X	TBD	TBD	20.85	**36.56**	19.49	**38.33**	19.93

Measure Name	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
Adult's Access to Preventative/ Ambulatory Health Services	X	TBD	TBD	74.88	62.29	72.91	62.07	76.50
Colorectal Cancer Screening	X	TBD	TBD	38.07	36.08	NA	33.59	NA
Antidepressant Meds: Rate--Acute	X	TBD	TBD	62.43	**89.72**	60.79	**68.68**	60.44
Antidepressant Meds: Rate—Continuation	X	TBD	TBD	44.25	**79.68**	43.28	**58.56**	42.96
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications	X	TBD	TBD	81.42	**86.99**	79.05	**83.33**	79.36
Follow-Up After ED Visit for Substance Use - 7 days	X	TBD	TBD	24.00	20.62	24.51	**20.72**	13.39
Follow-Up After Emergency Department Visit for Mental Illness – 7 days	X	TBD	TBD	38.62	14.05	40.59	30.27	40.38
Follow-Up for Children w/ ADHD Meds: Continuation and Maintenance	X	TBD	TBD	53.90	50.62	54.40	NA	51.78
Follow-Up for Children w/ ADHD Meds: Initiation	X	TBD	TBD	45.72	**48.57**	44.21	**45.92**	39.78
Metabolic Monitoring for Children and Adolescents on Antipsychotics	X	TBD	TBD	35.59	33.71	34.38	**42.67**	34.30
Pharmacotherapy for Opioid Use Disorder	X	TBD	TBD	25.28	**49.11**	28.49	**32.23**	28.50

Measure Name	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
Plan All-Cause Readmissions	X	TBD	TBD	0.9619	1.0177	0.9853	0.9352	0.9960
Depression Remission or Response for Adolescents and Adults – Depression	X	TBD	TBD	4.17	**7.02**	NA	NA	NA
Depression Remission or Response for Adolescents and Adults – Depression Response	X	TBD	TBD	7.89	**14.62**	NA	NA	NA
Depression Remission or Response for Adolescents and Adults – Follow Up PHQ-9	X	TBD	TBD	26.68	59.**65**	NA	NA	NA
Depression Screening and Follow-Up for Adolescents and Adults - Screening	X	TBD	TBD	1.03	**9.91%**	NA	NA	NA
Depression Screening and Follow-Up for Adolescents and Adults – Follow Up on Positive Screen	X	TBD	TBD	70.91	**77.07**	NA	0.50	NA

[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 San Diego, there are 18 Managed Care Accountability Set (MCAS) measures that are held to the minimum performance level (MPL) set at the 50th percentile. Fourteen MCAS measures met or exceeded the 50th percentile according to NCQA's Quality Compass Percentile Ranking, improving from 13 measures that met the 50th percentile in 2023. Measures that met or exceeded the 50th percentile in 2024 are listed below:

a) Prenatal and Postpartum Care – Postpartum care
b) Child and Adolescent Well-Care Visits
c) Childhood Immunization Status – Combination 10 Immunizations
d) Developmental Screening in the First Three Years of Life
e) Immunizations for Adolescents – Combination 2 Immunizations
f) Well-Child Visits in the First 30 months- First 15 months of life - 6 or more Well-Child Visits
g) Well-Child Visits in the first 30 months - 15-30 months of life - 2+ Well-Child Visits
h) Lead Screening in Children
i) Breast Cancer Screening
j) Chlamydia Screening in Women – (Total)
k) Prenatal and Postpartum Care – Postpartum care
l) Prenatal and Postpartum Care – Timeliness of Prenatal Care
m) Lead Screening in Children
n) Breast Cancer Screening
o) Controlling Blood Pressure
p) Glycemic Status Assessment for Patients with Diabetes (>9%)
q) Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days

Accomplishments:

1. Enhancements to Performance Monitoring Tool: 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 Program: 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 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 bi-monthly huddles with the health navigators and team to discuss progress and address issues. Additionally, even though some IPAs had new leadership in 2024, improved communication and a focus on relationship building with IPAs contributed to better program outcomes and improved rates in San Diego.

4. Well Child and Mobile Mammography Community Clinic Days: We increased the total amount of well child and mammography clinic days from 13 in 2023 to 265 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.

8. Successfully completed disparities report supporting NCQA Health Equity Accreditation.

Qualitative Analysis

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**
Inaccurate member contact information	Members do not update changes to their contact information with the State	Difficulty outreaching 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 do not send all data.
Mammography – Limited Availability	Lack of technicians	All independent radiology facilities in San Diego are experiencing a technician shortage, greatly impacting mammogram appointment availability.
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.
Pediatric Appointment Availability	Lack of Pediatric Medi-Cal provider	San Diego county has been experiencing a lack of pediatric

		providers since COVID, greatly impacting appointment availability.
MEMBER BARRIERS		
Barrier	**Cause**	**Reason/Effect**
Service gap	Social Determinants of Health	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.
	Family and financial obligations	Cultural beliefs. Transportation: limited and/or difficulty navigating the system and scheduling. Geographic: Distance to receiving 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.

2024 Interventions

Intervention Description	Barrier Addressed
Quality Provider Engagement: In 2024, our tiering system for Medi-Cal providers was continued which allows us to further stratification of provider interventions. Providers were tiered based on their membership size and quality performance. Providers 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 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. The Quality Interventions team worked with provider groups to collect supplemental data throughout the year to ensure that all rendered services are captured.	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.
In 2024, Blue Shield Promise continued our provider incentive programs with a few modifications. 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)	Provider resources to help fund quality improvement efforts. Expanded areas of quality improvement focus

Intervention Description	Barrier Addressed
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 offered three care gap closure incentive programs in Quarter 2, Quarter 3, and a year-end program. Additionally, a chronic care incentive program was introduced for the Medi-Cal population in 2023 and continued 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 opportunities 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: Outreach to Medi-Cal members to educate and address gaps in care, provided scheduling assistance, addressed barriers to care, documented scheduled appointments, 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.

Intervention Description	Barrier Addressed
Continued Health Navigator Program: A dedicated Blue Shield Promise Health Navigator is placed at a specific clinic location 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
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
Continued and expanded Well Women and Mobile Mammography Days: Mobile clinic event days for members to receive breast and cervical cancer screenings.	Care Gaps: member outreach for increased member engagement to improve rates and quality of care. Access to 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 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.	Care Gaps: member outreach to improve rates and quality of care and member satisfaction.
Funded select provider groups to have physical gift cards in their offices. These providers opted to have an in-office gift card program for their members when they complete certain visit types to close care gaps.	Care Gaps: member outreach to improve rates and quality of care and member satisfaction.
Continuation of Well Child Community Clinic Days: In partnership with Quality Health Partners, Blue Shield Promise hosted community clinic days at various YMCA, Boys and Girls Club and MAAC locations in the county. At these clinic days, well child visits, lead screening, developmental screening and fluoride varnish applications are conducted for Promise members. 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 for increased member engagement to improve rates and quality of care Access to Care

Intervention Description	Barrier Addressed

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.	February 2024
Provider and Plan Quality Incentives (PPQI) Learning Sessions	Providing description and payouts of Value Incentive Program (VIP) provider incentive programs and Quarters 2, 3, and 4 care gap closure program, and new Promise Quality Performance Incentive (PQPI) program that replaced the VIP.	June 2024 October 2024
Supplemental Data Training	To gain a better understanding of supplemental data requirements of contracted provider groups.	October 2024

QI Initiatives – Member and Provider Outreach Campaigns

A. Mobile mammography

Blue Shield of California, Promise Health Plan, 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 an early breast cancer diagnosis have fewer complications and substantially higher rates of survival than those whose cancer is diagnosed late.

In 2024, there were 16 Mobile Mammography Days at various provider group locations, community-based organizations, and at Northgate locations. Events took place March – November 2024. In total, there were 621 members scheduled for a mobile mammogram, and 320 members screened. This was an increase of 251% in members scheduled and 267% increase in members screened compared to 2023.

Barriers

We experienced difficulty reaching members to schedule appointments due to wrong phone numbers, voicemail full, etc. For other event dates, although we scheduled enough appointments for the minimum required for the vendors, members canceled when appointment reminders were made or no showed during the scheduled event. We were also limited by the narrow availability of selected locations as we had to rely on securing space at community-based organizations. Unreliable transportation services presented a challenge in 2024, as it resulted in delayed arrivals and late pick-ups of members

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 YMCA, Boys and Girls Club and MAAC 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 community partner location, via telehealth, or in the comfort of their own home (i.e. an in-home visit).

Underserved communities with the highest need for well-child screenings were identified as target areas for our clinics. The events were held mostly on Saturdays 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 community organizations 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 community-based organizations (YMCA, Boys and Girls Club, and MAAC). Events took place January 2024 – December 2024. In total, there were 1,253 members scheduled for these events and 499 members completed their exams. This was a 204% increase in members completed compared to 2023.

By December 31, 2024, well-care visits (telehealth and in-person visits) were conducted for 3,889 members. There were 631 members who canceled or did not show up for their visit, accounting for 16% 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 of our selected locations.

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, 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, 155 members were identified for outreach from the ADT reports, and 32 members had booked appointments, yielding a 21% connection rate/appointment penetration rate. Among the 32 members who booked appointments, 23 members completed visits, demonstrating that 72% of members who booked visits, completed them. Given that Enhanced Care Management referrals were a key component of the telehealth visit, we identified that 20 ECM referrals were submitted between April – November 2024. In other words, among the 23 members who completed visits, approximately 87% (20/23) 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, 92 eligible members were eligible for outreach for San Diego. Among the 92 members, 20 booked an appointment, yielding a 22% connection rate/appointment penetration rate. Among the 20 members who booked appointments, 70% of members completed visits (14 out of 20). Lastly, among the 14 members who completed their visits, 6 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 (HIEs). 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 is placed at a specific clinic location (embedded) or at a provider group (non-embedded) to conduct outreach to members to support 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, where they can meet with members face-to-face, work directly with the 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 health navigator program launched in October of 2020 with a pilot FQHC in San Diego County. The program expanded late in 2021 to 10 health navigators, and in 2022 to 14 health navigators for provider groups. However, we removed 3 navigators in the last quarter of 2022

and 1 in 2023 due to poor performance. Data for the remaining 10 health navigators active in 2024 can be shown in the table below. Overall, across 10 health navigators, there were 24,545 members touched (i.e., reached a member or left a message with the member). There were 4,638 care gaps closed within these 11 provider groups for members that were included in the outreach.

Provider Group	Navigator Start Date	# of Members Touched in 2024	# of Care Gaps Closed
IHP – Vista Community Clinic	10/2020	5,387	894
Rady	4/2022	3,079	1,160
IHP – San Ysidro	10/2021	1,884	516
Prospect Vantage	3/2022	2,438	181
IHP – CHSI, SDAIHC, SDFC, IBCC	3/2022	2,212	378
FHCSD (3 navigators)	8/2022	6,285	637
IHP – TrueCare	3/2022	454	87
IHP – Neighborhood	9/2021	2,806	785
TOTAL		**24,545**	**4,638**

Barriers

Since the health navigator is employed by the FQHC, the MSO or IPA can have the health navigator focusing on other activities and aiding other departments instead of Blue Shield Promise members. For non-embedded health navigators, there were issues with not having direct access to the electronic medical records or to the scheduling system, which required a warm transfer to the clinic for scheduling, sometimes with long wait times.

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, conduct 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 32,000 San Diego members were targeted for outreach, with 543 appointments made and a total of 4,881 care gaps were closed.

Barriers

The HEDIS outreach team experienced challenges reaching members, as a significant number of members either had incorrect phone numbers, no phone numbers or did not answer the outreach calls (which consisted of 23% 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, 87,497 health care activities were targeted a total of 2,354 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	4,025	120	2.98%
Cervical Cancer Screening	27,266	284	1.04%
Immunizations for Adolescents	1,023	26	2.54%
HPV Vaccine (ages 9-12)	4,764	64	1.34%
Blood Lead Screening	680	15	2.21%
Annual Well Child Visit (ages 3-17)	31,659	1854	5.86%
Annual Well Visit (ages 18-21)	8,481	294	3.47%
Well-Child Visit 1 (0-15 Months)	608	14	2.30%
Well-Child Visit 2 (0-15 Months)	608	7	1.15%
Well-Child Visit 3 (0-15 Months)	608	6	0.99%
Well-Child Visit 4 (0-15 Months)	608	5	0.82%
Well-Child Visit 5 (0-15 Months)	608	3	0.49%
Well-Child Visit 6 (0-15 Months)	608	1	0.16%
Well-Child Visit 1 (15-30 Months)	688	9	1.31%
Well-Child Visit 2 (15-30 Months)	688	6	0.87%
Flu Shot (ages 6 months – 2 years)	4,575	23	0.50%
Total Health Care Activities	87,497	2,731	3.12%

[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 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 through 2024 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.

G. Embedded NP Program

This program aims to assist with the primary care physician shortage by offering the Mid-Level Practitioner Pilot Program to provider groups for preventative care services for 12 months. The program aims to improve the percentage of members who have completed services in the following Medi-Cal Managed Care Accountability Set (MCAS) measures:

Methodology

Mid-level practitioners were placed at FQHC locations in San Diego County that faced provider shortages since the COVID pandemic. These clinics needed provider bandwidth in the areas of pediatric care and well women care. Through placing additional provider staff, the other providers in the clinics could experience less burnout and more members could access timely care.

Quantitative and Qualitative Analysis

The program experienced some delays due to the overarching provider shortage in the county. It was difficult to hire the appropriate provider types. Additionally, not all providers were CHDP certified, which initially limited the types of visits they were able to complete. There were also concerns from the FQHC regarding the limited visit types for the mid-levels, which lead to a couple providers only working part-time on the program. The table below displays the provider groups included in the program and the number of scheduled and completed visits in 2024.

Provider Group	Start Date	Number of Scheduled Visits	Number of Actual (Completed) Visits
IHP – TrueCare	4/17/23	72	64
IHP – Neighborhood HealthCare	5/15/23 – NP 7/24/23 - PA	230	171
IHP – Vista Community Clinic	7/31/23	629	395

Barriers

This program experienced many barriers due to the staffing shortage in the county. In addition, some of the FQHC struggled with fitting these new providers into the workflow (limiting their schedule to only including Promise members). Due to the barriers and low impact of the program, Blue Shield Promise chose not to renew the program for 2025.

IHI Child Health Equity Collaborative

The purpose of the Institute for Healthcare Improvement (IHI) Child Health Equity Collaborative is to improve the completion of well-child visits (WCVs) for infants aged 0-30 months and adolescents aged 15-18 years old. The focus is on enhancing relationships with provider groups and community partners to ensure better and more accessible care for

target populations. Through this work with IHI and our partnering provider group we have made a commitment to health equity by focusing interventions on identifying populations impacted by inequity, understanding experiences and root causes around WCV gaps, and testing changes and building partnerships to improve equity. All of this is being done through a five-step intervention process over the course of one year. The five intervention areas include:

1. Equity & Transparent, Stratified, and Actionable Data
2. Understand Provider and Patient/Caregiver Experiences
3. Reliable & Equitable WCV Processes
4. Asset Mapping & Community Partnerships
5. Partnering for Effective Education & Communication

Throughout each of these intervention steps we have worked with IHI and our provider partner to identify areas of improvement for our target population. The population we identified is the Hispanic population of children ages 15-18 years and 19-21 years. We have worked through each step of the intervention process to make access to care more equitable for these members by addressing their underlying needs that were identified. This work is currently planned to continue through March of 2025, however there may be an extension for further interventions throughout 2025.

Performance Improvement Project (PIP)

The California Department of Health Care Services (DHCS) requires that full-scope Medi-Cal managed care health plans (MCPs) and population-specific plans (PSPs) conduct two PIPs per contract with DHCS. One of the 2023-2024 PIPs must target a health disparity as outlined in the Health Equity PIP Topic Proposal Form. The second topic must be related to an area in need of improvement (non-clinical). Blue Shield Promise selected the measures below for the 2023 – 2024 Performance Improvement Projects (PIPs):

a) Health Equity PIP: Well Child Visits in the First 30 Months of Life
b) Non-Clinical PIP: Improve the Percentage of Members Enrolled into Care Management, Complex Care Management (CCM), or Enhanced Care Management (ECM) Who Have Been Diagnosed With SMH/SUD Within 14 Days of Diagnoses

Health Equity PIP

Topic: Well Child Visits in the First 30 Months of Life - Well Child Visits in the first 15 months of life

Blue Shield Promise selected Well Child Visits in the First 30 Months of Life – Well Child Visits first 15 Months of life, as the 2023 – 2026 PIP Topic. For the narrowed focus, Blue Shield Promise has chosen to focus on the Hispanic population. Initially, the data showed that the largest equity gap was in the Black/African American populations. However, it was approved to focus on the Hispanic sub-population instead of the Black/African American sub-population for the 2023- 2024 PIP due to low volumes of the W30-6 Black/African American population. The PIP topic was approved by HSAG on January 4, 2024. Blue Shield Promise has completed its barrier analysis for this PIP and built targeted interventions for the target population.

During 2024 two interventions were implemented to target the focus population of the PIP. These interventions included (1) further leveraging our Health Navigators to conduct culturally relevant outreach to Hispanic members within the W30 population and (2) leveraging our Quality Health Partners relationship to ease access to care for this population.

1. Through the work with our Health Navigators, they were able to identify barriers for the Hispanic population and address these needs before scheduling a well child visit, while using the members preferred language of choice. These needs include working through transportation barriers, food insecurity and potential housing needs. Through this intervention, 118 members were successfully outreached and 43 of these members completed a W30 appointment (37.6%).

2. The intervention partnership with Quality Health Partners offered the target population alternative ways to complete a W30 appointment. This consisted of offering telehealth or in-home visits for members who were not able to complete a visit in-office due to various barriers. Members were thankful to have the option to complete an exam in a way that best fit their needs. During this intervention period 33 targeted members were successfully reached and 21 of these members completed a W30 telehealth appointment (63.64%).

Non-Clinical PIP

Topic: Improve the Percentage of Members Enrolled into Care Management, Complex Care Management (CCM), or Enhanced Care Management (ECM) Who Have Been Diagnosed With SMH/SUD Within 14 Days of Diagnoses

Blue Shield Promise has chosen to focus on members who have enrolled in a Care Management program who have been diagnosed with SMH/SUD within 14 days of diagnoses for the Non-Clinical PIP topic. This topic was chosen due to the complexities of these populations and the need for improvement in these areas. Blue Shield Promise completed its barrier analysis for this PIP and building its first targeted intervention. The second submission was completed and approved in November 2024. The second submission included our

baseline data results from calendar year 2023 and intervention results. Our baseline data showed that 2.14% of 1,309 members ages 6 and older who had an emergency department visit with a principal diagnosis of mental illness or substance use enrolled into CM, CCM, or ECM within 14 days of the ED visit during calendar year 2023.

The intervention included leveraging Quality Health Partners to contact members post-ED visit and referring members to ECM or CM. Quality identified eligible members from the Admit, Discharge, and Transfer (ADT). QHP conducted telephonic outreach to facilitate follow-up visits or provides a telehealth visit. Between April and November 2024, around 11%, or 64 of 534 eligible members, accepted ECM referrals. Separately, 107 members out of 534 eligible members completed a telehealth visit with QHP, so 64 out of 107, or 60% of members who completed visits accepted the ECM referral.

Quality continues with the first intervention and planning for the second intervention. For the second intervention, quality is exploring the addition of Continuity of Care Document (CCD) data to our current reports to quickly identify more members who have had ED visits for mental illness or substance use.

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 the 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 team 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 Child and Adolescent Well Care Visits (WCV) among Promise members in San Diego County. Target goals, which are set at 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.

<u>Data Improvements - Supplemental Data – DHCS San Diego</u>

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. **Strategic Data Setups.**
    i. Manifest MX NCQA DAV CCDA ingestion for DHCS population.
    ii. Epic Payor Platform (EPP) – Ingestion of EPP data for HEDIS MY2024 reporting for DHCS population where applicable.
    iii. San Diego County Behavioral Health data – Ingestion of county behavioral file to capture non-billable care geared towards FUI and FUM HEDIS measure improvement efforts.

6. **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 SD

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	20	20	0	0
NEW DATA SETUPS AND PSV	11	9	0	2
	31	**29**	**0**	**2**

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 Medicaid San Diego.
    a. NCQA DAV (Data Aggregator Validation)
    b. Cozeva Standard supplemental data
    c. Cozeva non-standard supplemental data

SAFETY OF CLINICAL CARE

Continuity and Coordination of Care

Blue Shield Promise San Diego annually collects data on exchange of information

regarding continuity and coordination of care a) between medical practitioners, b) between medical and behavioral healthcare practitioners, and c) across settings.

Starting MY 2025, BSP will monitor performance and act on one required continuity and coordination of care HEDIS Health Plan Ratings measure for which it received a rating of "1" or "0."

Medicaid measure list:

Medicaid Measures:
• Eye Exam for Patients With Diabetes (EED)
• Prenatal and Postpartum Care (PPC)— Prenatal Rate
• Prenatal and Postpartum Care (PPC)— Postpartum Rate
• Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)
• Follow-Up After Hospitalization for Mental Illness (FUH)—7 days—Total Rate
• Follow-Up After Emergency Department Visit for Mental Illness (FUM)—7 days—Total Rate
• Follow-Up After Emergency Department Visit for Substance Use (FUA)—7 days—Total Rate
• Initiation and Engagement of Substance Use Disorder Treatment (IET)—Engagement of SUD Treatment —Total Rate
• Follow-Up After High Intensity Care for Substance Use Disorder (FUI)—7 Days —Total Rate
• Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

An average rating of 3.0 or higher across all required measures. BSP will follow the following steps to calculate the 3.0 average.

- Obtain the most recent Health Plan Ratings scoresheet.
- Identify each measure's rating using the "Measure Rating Score Compared to Percentiles" column.
- Calculate the average by adding the ratings for all numerical scores and dividing by the number of measures.

BSP will develop an improvement plan in at least one required measure that scored 0 or 1 and will document all actions the organization plans to take to improve each measure's

rating. BSP's improvement plan will identify measures with a rating of "1" or "0" on the most recent Health Plan Ratings scoresheet.

Credentialing

Blue Shield of California Promise Health Plan 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.

Qualitative Analysis:
The credentialing department continues to meet all credentialing timeframes and is compliant with regulatory guidelines.

Quantitative Analysis:

The Credentialing Committee actions for 2024 are as follows:

Providers		HDOs	
Initial Creds approved	544	Initial Healthcare Delivery Organizations (HDO) approved	51
Re-creds approved	150	Re-cred Healthcare Delivery Organizations approved	50
Inactivation Providers*	574	Inactivation Healthcare Delivery Organizations*	215

*Inactivations are not separated by county

805 Report

There were no 805 reports received 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 – Medi-Cal SD – MY 2024

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

SD County

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	162	227	123	136	648	183	274	312	209	978	92	21	42	46	201
Internal PQIs	8	5	9	5	27	15	14	10	7	46	9	9	5	2	25
Total Received	170	232	132	141	675	198	288	322	216	1024	101	30	47	48	226

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	68	100	152	134	454	98	68	99	176	441	139	84	25	69	317
C-1	39	51	66	47	203	71	62	95	140	368	30	22	37	23	112

C-2	3	3	0	1	7	7	3	0	1	11	2	0	1	1	4
C-3	1	0	0	0	1	0	0	1	0	1	0	0	1	0	1
Total Closed	111	154	218	182	665	176	133	195	317	821	171	106	64	93	434

- PQI case average turnaround time (TAT): 189.5 days (TAT goal is ≤180 days)
- CAP and Education Letters issued: 46
- 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
- Clinical staff and medical directors were re-trained 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 issue, 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 efficiency 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 a workgroup that identifies detailed trends that can be worked through with inter-departmental teams to resolve issue trends and reduce incoming cases.

Preventive Health Guidelines

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:

a) Quality Improvement team ensures there are no discrepancies with any current interventions that are in place.
b) Mandates team ensures state and federal mandates are met.
c) Legal consult ensures compliance with regulations.
d) Medical Policy ensures alignment with medical policies in use for utilization management.
e) Health Education ensures readability and suitability for the Medi-Cal population,
f) Benefits Intent team ensures 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.
g) Digital Content team assists 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.

Clinical Access Programs

Initial Health Appointment (IHA)

Initial Health Appointments (IHA) are required within 120 days of the date of enrollment for all new 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) 2022 through FY 2024 – SD County

Initial Health Appointment	FY24		FY23		FY22	
Total New Membership	79,238		29,557		19,568	
Initial Health Appointment Outreach	**FY24**	**FY24 %**	**FY23**	**FY23%**	**FY22**	**FY22 %**
Appt Scheduled/Will Schedule	6,851	9%	2,204	7%	1,498	8%
IHA Completed Prior to Outreach	3,944	5%	1,963	7%	611	3%
Ineligible/Termed/Disenrolled	6,597	8%	1,368	5%	5,893	30%
Unable to Reach/Left Message/Declined Outreach	23,270	29%	21,441	73%	7,469	38%
No Contact/Incorrect Contact Information Provided	12,493	16%	1,336	4%	1,957	10%
Total IHA Outreach	**53,155**	**67%**	**28,312**	**96%**	**17,428**	**89%**
Outreach Completed Untimely/ Outreach Not Completed	26,083	33%	1,245	4%	2,140	11%

Table 1 Summary: Initial Health Appointment (IHA) Outreach Metrics for Fiscal Year (FY) 2024 – SD County

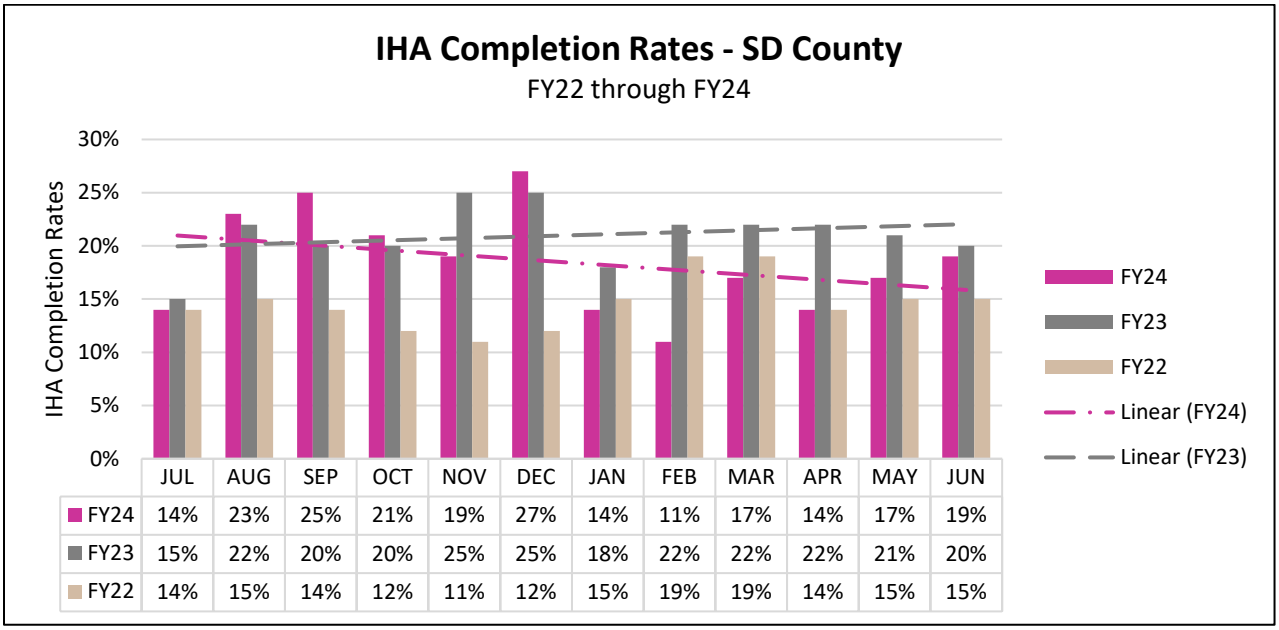
Our Blue Shield Promise IHA outreach coordinators conducted phone outreach in accordance with our standard protocol and policy, calling newly enrolled members of all ages to encourage and/or provide assistance in scheduling an IHA throughout FY24.

Outreach Calls

In Fiscal Year 2024, Blue Shield Promise IHA outreach coordinators and vendor, Quality Health Partners, made a total of 53,155 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 67% of calls in FY24, compared to 96% in FY23. The goal of 100% call completion was not met because of a significant rise in membership during the January and February CY24 enrollment months, a disruption in calls for two months, and a leadership decision to halt calls in June 2023 to comply with regulatory requirements and stay on schedule. 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 – SD County



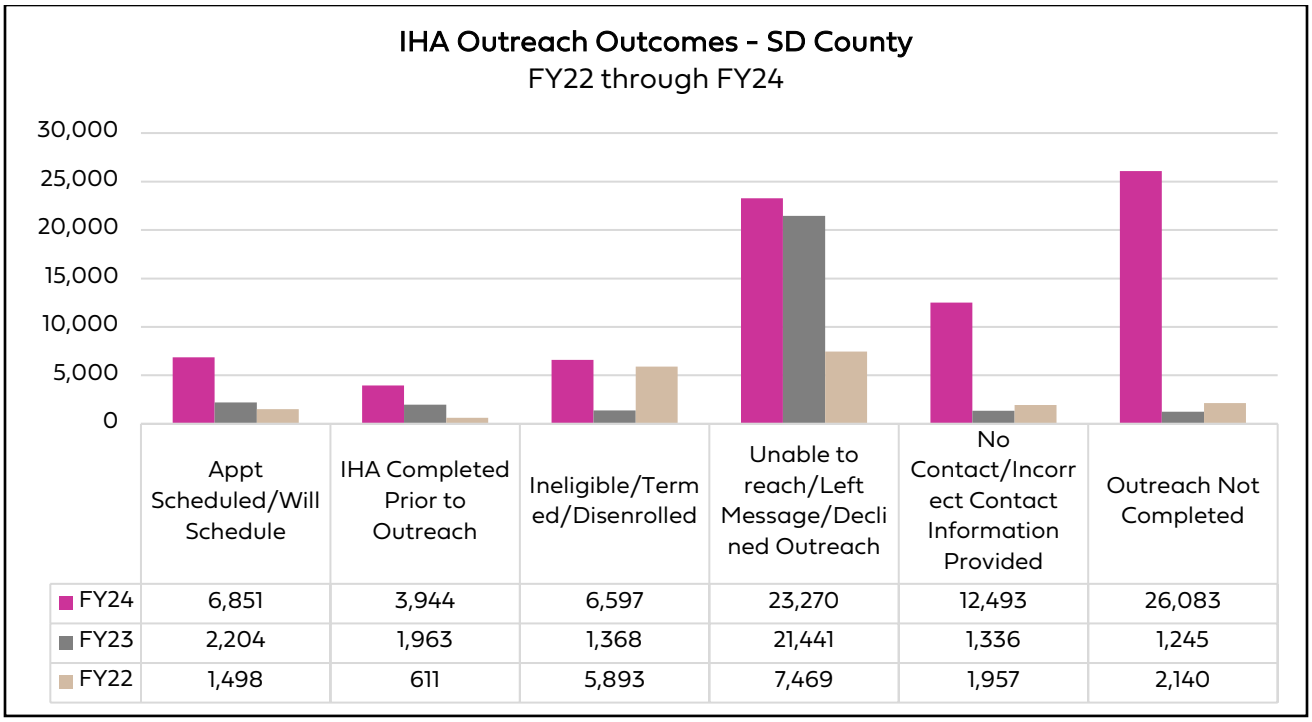
	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY24	14%	23%	25%	21%	19%	27%	14%	11%	17%	14%	17%	19%
FY23	15%	22%	20%	20%	25%	25%	18%	22%	22%	22%	21%	20%
FY22	14%	15%	14%	12%	11%	12%	15%	19%	19%	14%	15%	15%

FY24 – Enrollment between Jul 2023 to Jun 2024

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

The IHA completion rates are assessed using data from the third and fourth quarters of the previous measurement year, along with the first and second quarters of the current measurement year, rather than following a typical calendar year. This methodology ensures a comprehensive and accurate collection of encounter data. The comparison between FY24 and FY23 IHA Completion Rates for San Diego County reveals that FY23 had higher completion rates than FY24 for eight out of twelve months. Specifically, in FY24, the rates were only slightly higher in August and October (by 1%) and markedly higher in September (by 5%) compared to FY23. Notably, the highest completion rate across all three fiscal years was achieved in December 2024, with a 27% completion rate.

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



	Appt Scheduled/Will Schedule	IHA Completed Prior to Outreach	Ineligible/Termed/Disenrolled	Unable to reach/Left Message/Declined Outreach	No Contact/Incorrect Contact Information Provided	Outreach Not Completed
FY24	6,851	3,944	6,597	23,270	12,493	26,083
FY23	2,204	1,963	1,368	21,441	1,336	1,245
FY22	1,498	611	5,893	7,469	1,957	2,140

FY24– Enrollment between Jul 2023 to Jun 2024

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

Blue Shield Promise IHA outreach calls experienced a notable rise in overall call volume in FY24, attributed to a substantial increase in membership.

The call response types remained consistent between FY23 and FY24. For both years, the predominant outcome category was "Unable to reach/left message/declined outreach," with 21,441 calls in FY23 and 23,270 calls in FY24. Additionally, the percentage of members who scheduled an appointment with the help of a Blue Shield Promise IHA coordinator saw a significant rise in 2024, increasing from 2,204 in 2023 to 6,851 in 2024.

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

IHA Medical Record Review	Audited CY24 (CY23 Enrollees)	Audited CY23 (CY22 Enrollees)	Audited CY22 (CY21 Enrollees)
Total Medical Records Audited	653	502	205
# Providers Audited	126	96	36
Average Score	96%	96%	96%

Table 4 Summary: IHA Medical Record Review- SD County

Medi-Cal Managed Health Care Plans are responsible for ensuring the completion of the Initial Health Appointment (IHA) through comprehensive medical record reviews and 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 passing score set at 90%.

In CY23, IHA medical record reviews for members enrolled in 2022 resulted in an average score of 96%. This same score of 96% was maintained in CY24 for members enrolled in 2023. Notably, CY24 saw an increase in audits, with 126 providers audited compared to 96 providers in CY23. The focus in CY24 shifted towards auditing more Federally Qualified Health Centers (FQHCs) in San Diego County, thereby increasing the overall number of medical record reviews and providers audited.

Qualitative Analysis

1. Even with the support from Quality Health Partners, the overall IHA completion rates in San Diego County declined in FY24 compared to FY23. This decline is primarily attributed to a substantial increase in membership, which was a result of a Managed Care Plan (MCP) exiting the San Diego County managed care program.
2. IHA completion rates were higher in eight out of twelve months in FY23 than in FY24. Although the highest completion rate in FY24 was recorded at 27% in December, enrollment in FY24 was three times that of FY22 and more than double the membership of FY23.

Opportunities for Improvement

1. Enhancing the accuracy of new enrollment data to prevent incomplete or incorrect 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 QI and 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 and FQHCs 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) site to ensure and support the safe and effective provision of appropriate clinical services.

Residual effects of the global pandemic influence the volume of site reviews performed by Blue Shield Promise (BSP). Site reviews are conducted on a triannual basis, therefore, the volume of due site reviews in 2024 are correlated with those performed in 2021. There is a decline in due sites, likely from the effects of the executive order to cease all in-person site reviews due to the covid virus. In fact, the executive order to resume in-person reviews was not lifted until the summer of 2022. The total FSRs due for calendar year 2024 has increased slightly in FSRs and more than doubled for MRRs.

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

Compliance Metrics - Quantitative Analysis	CY24	CY23	CY22
Total **Facility Site Reviews** Due (Contracted and Pre-Contractual)	10	9	18
Total Facility Site Reviews Completed	10	9	9
Total Facility Site Reviews Completed on Time	10	5	2
Average Facility Site Review Score	96%	88%	88%
% Pass Rate (≥80% aggregate score)	100%	88%	89%
Total **Medical Record Reviews** Due (Contracted and Pre-Contractual)	12	5	15
Total Medical Record Reviews Completed	12	4	8
Total Medical Record Reviews Completed on Time	11	1	0

Average Medical Record Review Score	91%	86%	87%
% Pass Rate (≥80% aggregate score)	92%	75%	100%
Department Metrics (Regardless of Due Date) **Facility Site Review & Medical Records Review**	**CY24**	**CY23**	**CY22**
Total Facility Site Reviews Completed	11	14	9
Average Facility Site Review Score	94%	90%	89%
Total Medical Records Reviews Completed	14	11	8
Average Medical Record Review Score	90%	88%	87%
Total Primary Care Physician Sites removed from the network due to Non-Compliance with Facility Site Review Requirements	0	0	2

Qualitative Analysis

There was a total of 10 Medi-Cal FSR sites due in 2024. Of these, 10 FSRs were completed on time and a total of 11 were completed, regardless of due date. There was a total of 12 Medi-Cal MRRs due in 2024. There were 11 MRRs completed on time and a total of 14 completed regardless of due date.

Year to year comparisons of scoring in FSR appear to improve with the previous year in 2023. This may be related to the returned in-person, on-site nature of site reviews that BSP returned to after a period of hiatus due to the pandemic.

Trends in the year-to-year MRR scores indicate that average scores are rising in compliance from prior years, perhaps in part from implementing additional audit criteria in preventative measure sections.

FSR/MRR Criteria Trends

Quantitative analysis of FSR and MRR scoring trends will possibly continue in 2025 program analyses when volume of FSR and MRR audits are expected to resume predating the Public Health Emergency (PHE).

Physical Accessibility Review Survey (PARS)

Monitoring Access and Safety areas

Physical Accessibility Review Survey (PARS) audits assess access and safety of the physical location of PCP site locations and High-Volume Specialists (HVS). Data provided on the volume of PARS reviews is shared and will be expected to increase as site reviewers resume full in-person site reviews. Additional quantitative analysis is provided for sections of the FSR audit tool which monitors access and safety (see table 6).

Table 6: PARS Metrics SD County

San Diego County	CY24	CY23	CY22
PARS Completed	41	4	2
PARS Completed at Basic Level	18	1	0
PARS Completed at Limited Level	23	3	2

Table 7 - FSR Access/Safety Criteria SD 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.	10	0	0	10	100%
2) Pedestrian ramps have a level landing at the top and bottom of the ramp.	7	0	3	7	100%
3) Exit and exam room doorway openings allow for clear passage of a person in a wheelchair.	10	0	0	10	100%
4) Accessible passenger elevator or reasonable alternative for multi-level floor accommodation.	3	0	7	3	100%
5) Clear floor space for wheelchairs in the waiting area and exam room.	10	0	0	10	100%
6) Wheelchair accessible restroom facilities.	10	0	0	10	100%
7) Wheelchair accessible handwashing facilities or reasonable alternative.	10	0	0	10	100%
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.	10	0	0	10	100%
2) Restrooms are clean and contain appropriate sanitary supplies.	10	0	0	10	100%
C. Site environment is safe for all patients, visitors, and personnel.	Yes	No	NA	Total#	Compliance
1) Fire safety and prevention.	9	1	0	10	90%
2) Emergency non-medical procedures (e.g. site evacuation, workplace violence).	9	1	0	10	90%
3) Lighting is adequate in all areas to ensure safety.	10	0	0	10	100%
4) Exit doors and aisles are unobstructed and egress (escape) accessible.	10	0	0	10	100%
5) Exit doors are clearly marked with "Exit" signs.	10	0	0	10	100%

6) Clearly diagramed "Evacuation Routes" for emergencies are posted in a visible location at all elevators, stairs and exits.	10	0	0	10	100%
7) Electrical cords and outlets are in good working condition.	10	0	0	10	100%
8) Fire Fighting Equipment in accessible location	10	0	0	10	100%
9) An employee alarm system.	10	0	0	10	100%
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 plans to be carried out in case of medical emergency on site.	10	0	0	10	100%
2) Emergency equipment is stored together in an easily accessible location and is ready to be used.	10	0	0	10	100%
3) Emergency phone number contacts are posted, updated annually and as changes occur.	9	1	0	10	90%
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.	9	1	0	10	90%
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.	8	2	0	10	80%
6) Medication dosage chart for all medications included with emergency equipment (or other method for determining dosage) is kept with emergency medications.	4	6	0	10	40%
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.	9	1	0	10	90%
8) Replace/re-stock emergency medication, equipment and supplies immediately after use.	10	0	0	10	100%
E. Medical and lab equipment used for patient care is properly maintained.	Yes	No	NA	Total#	Compliance
1) Medical equipment is clean.	10	0	0	10	100%

2) Written documentation demonstrates the appropriate maintenance of all medical equipment according to equipment manufacturer's guidelines.	7	3	0	10	70%

Qualitative Analysis

Under the access and safety audit criteria category, individual criterion related to the storing of emergency medication dosage charts and maintaining medical equipment as per its manufacturer's guidelines are areas of improvement.

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 FSRs conducted, sites were only 40% 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. Study common reasons for deficiencies by working with Healthy Data System vendor to analyze both BSP and cross county FSR commonly found deficiencies to build targeted training and support.
2. Build on nurse's anecdotal findings so targeted education related to common low scoring and/or missed criteria in the access and safety section of the FSR audit tool are carried out.
3. Continue to iterate and provide best practice resources in the form of policies or example logs, etc. by which site staff can implement into practice for ongoing compliance and adherence to standards.
4. Bring trends to Healthy San Diego Facility Site Review Workgroup to leverage industry and local county best practices.

2025 Goals

1. Continue to provide technical and educational support to provider sites as it relates to low scoring audit criteria in both FSR and MRR audit tools.
2. Monitor effectiveness of program interventions through both qualitative and quantitative measures
3. Evaluate expanding the interim visit to include periodic corrective actions as part of monitoring assessments to improve provider's next periodic scores.

4. Continue to leverage technology in our internal and vendor databases to understand trends and establish baseline performance for groups over a period of time.

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 these 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 obstetrical 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. 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.

KEY FINDINGS AND INTERVENTIONS

Table 8: CPSP Medical Record Review for SD County

Medical Record Reviews	Audited CY24 (Deliveries CY23)	Audited CY23 (Deliveries CY22)	Audited CY22 (Deliveries CY21)
Total OB Providers Audited	6	9	3
Average Medical Record Review Score	91%	92%	94%
Total # of Records Audited	30	55	18
CPSP CAPs	**Audited CY24 (Deliveries CY23)**	**Audited CY23 (Deliveries CY22)**	**Audited CY22 (Deliveries CY21)**
Total OB Provided Audited	6	9	3
Total CAPs Issued	0	0	0

Table 8 Summary: CPSP Medical Record Review for SD County

The CPSP medical record review is conducted to ensure optimum perinatal care and pregnancy outcomes for BSC PHP 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 2023, CPSP medical record reviews were conducted for pregnant members with a successful delivery during 2022. The average score for medical records reviewed was 92%. The passing score is 80%.

Nine OB providers were audited in 2023, achieving an average score of 92%. The audit for 2024 is currently ongoing. So far, we have audited 36 OB providers, with an average score of 91%. It should be noted that in San Diego County, a "provider" includes Federally Qualified Health Centers (FQHCs). These centers have multiple providers who care for patients, and thus multiple providers' medical records are audited, although each FQHC is counted as a single provider.

Qualitative Analysis

1. In both 2023 and 2024 (with the 2024 audit still ongoing), all providers audited scored above the 80% passing threshold. Providers achieved a marginally higher average score in 2023 compared to 2024. Notably, no Corrective Action Plans (CAPs) were requested in either year.

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 completing of at least one (1) EPSDT visit with a primary care physician.

KEY FINDINGS AND INTERVENTIONS

Table 9: EPSDT Rates for 2024 – SD County

Annual EPSDT Participation Report Form CMS-416 Calendar Year: 2024 State MCP: California Promise Health Plan

County: SD									
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	67,213	1,523	6,435	9,727	12,617	15,223	13,158	8,530
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	652,988	5,594	62,080	98,090	128,027	153,663	132,118	73,416
3b. Average Period of Eligibility	Total	0.81	0.31	0.80	0.84	0.85	0.84	0.84	0.72
4. Expected Number of Screenings per Eligible	Total		2.14	2.01	0.84	0.85	0.84	0.84	0.72
5. Expected Number of Screenings	Total	64,973	3,263	12,933	8,174	10,669	12,805	11,010	6,118
6. Total Screens Received	Total	37,728	2,512	9,665	5,963	5,725	6,786	5,087	1,990
7. SCREENING RATIO	Total	0.58	0.77	0.75	0.73	0.54	0.53	0.46	0.33
8. Total Eligibles Who Should Receive at Least One Initial or Periodic Screen	Total	56,734	1,523	6,435	8,174	10,669	12,805	11,010	6,118
9. Total Eligibles Receiving at Least One Initial or Periodic Screen	Total	28,422	1,137	4,527	5,089	5,187	6,145	4,605	1,732
10. PARTICIPANT RATIO	Total	0.50	0.75	0.70	0.62	0.49	0.48	0.42	0.28

11. Total Eligibles Referred for Corrective Treatment	Total	4,905	261	984	720	752	1,026	916	246
14a. Total Number of Screening Blood Lead Tests	Total	3,248	3	2,049	1,014	155	17	8	2

Table 9 Summary – Metrics for 2024 – SD 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 2022, was 56,734 and yet the total number of San Diego County Blue Shield Promise members under the age of 21 that did receive at least one screening or periodic exam was only 28,422 (50%).

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 42% – 75% for ages 1-2, 3-5, 6-9, and 10-14, and 15-18. Children < 1 yr had the highest rate of screening or periodic exam at 75%. The lowest rate of 28% was in children ages 19-20.

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 2024, increasing from 44% in 2022 to 50% in 2024. The highest completion rate for all age ranges of children under the age of 21 were for <1 year and 1-2 year-olds who received at least one screening or periodic exam, with rates of 75% and 70%.%. The lowest completion rate for all age ranges of children under the age of 21 were for 19–20-year-olds. Twenty-eight percent (28%) of the members in this age range received at least one screening or periodic exam in 2024, compared to 14% in 2023.

2. In addition, the number of all Blue Shield Promise members under the age of 21 referred for corrective treatment remained low but showed that more than twice the number (and in some cases, over three times the number) of members received referrals in 2024 compared to 2023.

Opportunities for Improvement

1. The average rate of Blue Shield Promise members under 21 in San Diego County receiving at least one screening or periodic exam (EPSDT services) in 2024 was 50%.

%. While this marks an increase from the 44% rate in 2023, it still highlights the need for further 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 San Diego 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 San Diego County obtaining timely EPSDT services.

Interventions

Targeted efforts continued in 2023 to increase the amount of San Diego 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 San Diego 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 member engagement 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 2024, such as home visits, telehealth visits, other alternative settings that support obtaining preventive services.

QUALITY OF SERVICE

Customer Service: 2024 Telephone Access Study (Medi-Cal San Diego)

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

Calls Received	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
2023	7,162	7,179	7,402	6,200	6,777	6,112	6,327	7,286	6,294	7,008	6,522	6,455	80,724
2024	11,792	9,481	9,036	9,897	9,438	8,159	9,398	9,377	8,869	9,525	7,426	7,747	110,145
Abandoned Calls	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Total**
2023	24	32	35	34	46	54	51	52	30	31	28	25	442
2024	118	188	165	162	79	52	73	77	102	91	78	83	1268
Answered within 30 Seconds %	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Average**
2023	96%	91%	92%	91%	89%	87%	88%	87%	93%	94%	92%	92%	91%
2024	82%	78%	77%	79%	87%	93%	90%	88%	80%	87%	83%	85%	84%
Abandonment Rate %	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Average**
2023	0.3%	0.4%	0.5%	0.5%	0.7%	0.9%	0.8%	0.7%	0.5%	0.4%	0.4%	0.4%	1%
2024	1.0%	2.0%	1.8%	1.6%	0.8%	0.6%	0.8%	0.8%	1.2%	1.0%	1.1%	1.1%	1.1%

Reporting Quarter	Calls Received	Abandoned Calls	Average % of Answered Calls Within 30 Seconds	Average Abandonment Rate
1st Quarter	30,309	471	79%	1.6%
2nd Quarter	27,494	293	86%	1.0%
3rd Quarter	27,644	252	86%	0.9%
4th Quarter	24,698	252	85%	1.0%
Total/Average	**110,145**	**1,268**	**84%**	**1.1%**

Customer Care Department received a total of 110,145 calls in 2024. This showed an increase of 29,421 calls compared to the 80,724 received in 2023. There was an increase in abandoned calls with a total of 1,268 abandoned calls in 2024 compared to 442 in 2023. The annual rate of abandoned calls was 1.1%, which is below our goal of <5%, thus meeting our goal. The annual average rate of calls answered within 30 seconds in 2024 was 84%. The lowest performance was shown in the first quarter with an average of 79%.

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

Access to Care

Provider Network Summary Report

Accessibility and Availability (collectively referred to as Access) to care is fundamental to the Blue Shield mission, which is to provide care that is worthy of our family and friends and sustainably affordable. Access to care directly affects:

- Member experience, as measured through patient surveys addressing access to care and access-related grievances and appeals.
- Quality, relative to access to preventative care, such as vaccines and screenings affecting clinical outcomes, including incidence of communicable disease and cancer.

- Cost of Healthcare, relative to when members who cannot access primary or specialty care utilize the emergency department.

Blue Shield's accessibility and availability standards are established in compliance with the State of California Knox-Keene Act for Blue Shield of California enrollees and the California Insurance Code for Blue Shield of California Life & Health Insurance Company insureds, each of which requires that Blue Shield provides members with reasonable access to care. Blue Shield standards meet the availability guidelines set forth in state regulations for geographic proximity of health care providers. In addition, the standards are established in accordance with NCQA guidelines, the Centers for Medicare, and Medicaid Services ("CMS") regulations, and Department of Health Care Services ("DHCS") requirements. Blue Shield will continually evaluate and augment standards to reflect the changing environment of how health care services are provided.

Access and Availability Subcommittee:
The Access and Availability Subcommittee is a cross-functional team that is a sister committee to the Access to Care Workgroup. The subcommittee focuses on BSP lines of business and concerns unique to that part of the organization. The subcommittee meets on a quarterly basis as well as coordinating off-cycle monthly meetings with business owners leading active projects that report through the subcommittee.

Communication:
Blue Shield's Accessibility and Availability Standards and Guidelines are distributed annually to participating network providers and practitioners by way of operational manuals, online practitioner and member web portals, written bulletins and update notices, policy, and procedure documents, and/or other recognized methods as appropriate. Standards are reviewed and/or revised annually or more frequently if/when necessary. Staff also communicate standards at routine audits, site visits, and Joint Operating Meetings and in other settings. Members receive communication of these standards through Blue Shield's member materials.

Blue Shield provides and arranges for the provision of covered health care services in a timely manner appropriate for the nature of each member's condition consistent with good professional practice. Blue Shield establishes and maintains provider networks, policies, procedures, and quality assurance monitoring systems and processes sufficient to ensure compliance with clinical appropriateness standards. Blue Shield, through the Accessibility and Availability Workgroup as well as within other forums, analyzes access to care information from various sources. Data is assessed at different levels including overall health plan, geographic area, product line, provider group and individual practitioner. Instances and patterns of non-compliance are identified and recommendations for corrective action are made by the work group.

Metrics:

Blue Shield measures and benchmarks accessibility and availability based on Federal, State, accreditation, and regulatory standards. Measurement allows for benchmarking, feedback to provider groups, and targeted improvement activities. Metrics cover timely accessibility and availability of:

- Medical and behavioral health services including appointments, emergency care, preventative services, inpatient, after-hours care, video visits and RN telephonic triage and screening.
- Dental, vision, chiropractic, and acupuncture services.
- Interpreter services.
- Authorizations for necessary care and service.
- Cultural needs and preferences for members.

This report is reflective of the network access and availability using the provider network snapshot as of 01/15/24 (DMHC MY2024 TAR reporting) as this is the network in place for our members effective 1/2024. Any exceptions are notated. All assessments, actions and metrics are reflective of work done in 2024.

I. Availability of Practitioners (NET1):

The organization maintains an adequate network of primary care practitioners (PCP), behavioral healthcare and specialty care practitioners (SCP) and monitors how effectively this network meets the needs and preferences of its membership.

Element A: Cultural Needs & Preferences

Description:

This section is the annual population assessment of cultural, ethnic, racial, and linguistic needs of members. The data reflected in this report covers Blue Shield's entire population across all lines of business. The analyzed data will assist in adjusting the availability of practitioners within the network as needed. This will allow the department to effectively address members' changing needs.

Populations and Products in this analysis

- Medi-Cal (Los Angeles and San Diego Counties)

Medi-Cal (Los Angeles and San Diego Counties)
516,043

Element A -Cultural Needs and Preferences

The organization:

1. Assesses the cultural, ethnic, racial, and linguistic needs of its members
2. Adjusts the availability of practitioners within its network, if necessary

Element B - Practitioners Providing Primary Care

Description:

Blue Shield has established standards and monitoring mechanisms to ensure that the network has enough PCPs to meet availability standards.

Methodology:

Blue Shield Promise Health Plan primary care practitioners (PCPs) are defined in the provider contract as a family practitioner, general practitioner, internist, or pediatrician who has been employed or contracted to provide primary care services to members and to be responsible for coordinating, referring, and managing the delivery of covered services to the member. A primary care practitioner shall include an obstetrician-gynecologist (OB/GYN) who is qualified and has agreed to serve as a PCP and may also include other specialists if approved in writing by BSC. An obstetrician-gynecologist (OB/GYN) type is included within the All-PCP data type.

Blue Shield assesses and ensures ongoing compliance with regulatory time and distance standards/guidelines for all components of the networks, i.e., professional, institutional, ancillary, etc. components, in several ways. Consistent with Blue Shield's practices for all products/networks, network adequacy is monitored quarterly through grievances and appeals data (access and availability complaints), monthly network tracking, quarterly network change analysis and ongoing recruitment efforts, and targeted regional analyses during the Transition and Disengagement process. In addition, Blue Shield requests capacity information from its participating medical groups biannually to ensure appropriate capacity is maintained for existing and potential new enrollment. Spatial analyses, using Quest Analytics software, are analyzed throughout the year, documented as part of Blue Shield's Quality Management processes, and reviewed by state and federal regulators during routine medical surveys and examinations as well as by accrediting organizations. Provider listings are also submitted to state regulators annually as part of Blue Shield's Timely Access compliance filing for the DMHC and Network Adequacy compliance filing for the Department of Insurance. Any network adequacy issues identified for members through Blue Shield's monitoring mechanisms are addressed to ensure ready and available access to medically necessary basic health care services.

Element B - Practitioners Providing Primary Care

To evaluate the availability of practitioners who provide primary care services, including general medicine or family practice, internal medicine and pediatrics, the organization:

1. Establishes measurable standards for the number of each type of practitioner providing primary care.
2. Establishes measurable standards for the geographic distribution of each type of practitioner providing primary care.
3. Annually analyzes performance against the standards for the number of each type of practitioner providing primary care.
4. Annually analyzes performance against the standards for the geographic distribution of each type of practitioner providing primary care.

PCP Geographic Quantitative Analysis – Promise Health Plan.

MY2024/RY2024 Data Results:

Network	Specialty	Standard	Goal	MY 2024 Results	Standard	Goal	MY 2024 Results
Geographic Distribution of Specialists, including High Volume and High Impact Specialists					Specialist to Member Ratio		
Standard							
SD Medi-Cal (Adult)	All PCP	1 PCP with 10 miles or 30 mins from any member or anticipated member home	100%	100%	1:2000	100%	1:130
	Family/Gen Practice			100%			1:392
	Internal Medicine		100%	92.4%			1:431
SD Medi-Cal (Pediatrics)	All PCP	1 PCP with 10 miles or 30 mins from any member or anticipated member home	100%	100%	1:2000	100%	1:133
	Family/Gen Practice		100%	100%			1:398
	Pediatrics			99.4%			1:347
	Internal Medicine			91.8%			1:460

Results/Goals:

BSP:

- In San Diego County for Medi-Cal (Adult), the goal of 100% was met for All PCP type, and Family/General Practice. However, the goal was not met for Adult Internal Medicine (92.4%). Comparing to previous year results, San Diego County Medi-Cal (Adult), the goal of 100% was met for All PCP and Family/general practice, the goal was not met for Internal Medicine (94%). The goal of 100% was met in San Diego Medi-Cal (Pediatric), for All PCP type, and Family/General practice. However, the goal was not met for Pediatrics (99.4%) and Internal Medicine (91.8%). Compared to the previous year, we had an improvement. In RY2023, the goal of 100% was not met for each SD Medi-Cal (Pediatric) category. PCP to Member ratios in San Diego County was met for all Adult and Pediatric categories.

Identified Barriers:

BSP:

- Contributing reasons why we believe these goals were not met in San Diego Counties come from the challenge of having lower participation in Medi-Cal compared to other payers due to reimbursement models, and patient and provider compliance requirements.
- In San Diego, physicians such as internal medicine providers are directly employed with large health systems and their lack of participating in the Medi-Cal line of business significantly impacts the availability of providers that are willing to contract directly with the plan.
- Specific access issues for Medi-Cal Pediatrics may be due to many pediatricians are available only in centers of excellence. This can cause long travel distance; these specialty providers can be reached using free transportation services. In the event a contracted specialty provider is not available within a time/distance standard, a single case of letter of agreement may be submitted ensuring access to an out of network provider is available.

2024 Opportunities for improvement and 2025 interventions (BSP):

Opportunity for improvement	Interventions	Responsible Party	Date to be implemented
BSP– Increase provider availability by collaborating with our IPA and Medical Groups on provider recruitment and increasing access to PCP care services.	Intervention #1 Monitor and report IPA and Medical Group performance; Results will be distributed on a minimum of a bi-annual basis. Intervention #2 Results will be distributed and will continue to be addressed with IPA/Medical Groups during the bi-annual JOMs. Intervention #3 IPA/Medical Groups will be asked to provide their barriers, challenges, and mitigation plans. IPA and Medical Groups that continue to fail to meet threshold for Access to Care for PCP and Specialty services will be placed on a Corrective Action Plan. IPA and Medical Groups will be asked to document their mitigation plans, provide updates, and	Sr. Manager, Provider Network Analytics & Provider Network	Q3 2024

	provide proof to demonstrate their interventions were completed.		
BSP – Improve PCP access in San Diego by outreaching to providers to contract with the plan directly.	Intervention #1 Develop reports to identify areas where PCP availability is not meeting time and distance thresholds. Intervention #2 Evaluate the demand and need of the specialty type and area and determine if we will pay the provider more than Medi-Cal rates to encourage participation in the Medi-Cal program.	Sr. Manager, Provider Network Analytics & Provider Network	Q3 2024

Element C - Practitioners Providing Specialty Care

Description:
Blue Shield has established standards and monitoring mechanisms to ensure that the network has enough SCPs to meet availability standards.

Methodology:
High volume specialties are determined by selecting credentialed and contracted health professionals identified via claim activity for unique member occurrences in a 12-month period (excluding primary care practitioners, hospital-based specialties, multi-specialty clinics, and laboratories). The top specialties are assessed for geographic availability and ratio assessment. All OB/GYNs are included in the availability monitoring activities. Behavioral Health practitioners are also included. The typical high-volume specialties are found in Addendum A of the Plan's Accessibility and Availability Policy and Procedures and are subject to change annually.

High impact specialties are determined by selecting the top specialties (excluding primary care practitioners and hospital-based specialties) that rank highest in-patient mortality and morbidity according to the Centers for Disease Control and Prevention. The typical HIS are found in Addendum A of the Plan's Accessibility and Availability Policy and Procedures and are subject to change annually. All high impact and high-volume specialties as defined by Blue Shield of California's Accessibility and Availability policy are included in this analysis. All Oncology are included in the availability of HIS monitoring activities for members.

An annual assessment of HVS & HIS geographical distribution and member to SCP ratio is performed to determine any network deficiencies. The analysis is based on DMHC TAR and CDI annual filings of provider rosters.

All reports and access data are measured and audited using 100-point testing through the Quest Analytics software.

Element C - Practitioners Providing Specialty Care

To evaluate the availability of specialists in its delivery system, the organization:

1. Defines the types of high-volume and high-impact specialists.
2. Establishes measurable standards for the number of each type of high-volume specialists.
3. Establishes measurable standards for the geographic distribution of each type of high-volume specialists.
4. Establishes measurable standards for the geographic distribution of each type of high-impact specialist.
5. Analyzes its performance against the established standards at least annually.

SCP Geographic Quantitative Analysis
MY2024/RY2024 Data Results

Network	Specialty	Standard	Goal	MY 2024 Results	Standard	Goal	MY 2024 Results
Geographic Distribution of Specialists, including High Volume and High Impact Specialists							Specialist to Member Ratio
Standard							
SD Medi-Cal Adult	Cardiology/Intervention Cardiology (HI)	1 specialist (per spc type) within 15 miles or 30 min from members address or anticipated address	90%	89.7%	1:10000	90%	1:1101
	Dermatology			93.4%			1:1795
	Gastroenterology			87.0%			1:1839
	Ophthalmology			91.9%			1:914
	Endocrinology			86.3%			1:2742
	ENT-Otolaryngology			86.9%			1:2600
	General Surgery			86.3%			1:1409
	Hematology (HV)			86.3%			1:1754
	HIV-AIDS Specialist / Infectious Disease			87.3%			1:2356
	Nephrology			87.3%			1:1657
	Neurology (HI)			87.0%			1:1289
	Oncology (HV, HI)			86.3%			1:1493
	Orthopedic Surgery			N/A			N/A
	Physical Medicine and Rehabilitation			86.3%			1:4309
	Pulmonology			89.1%			1:1604
	Obstretics and Gynecology (HV)			89.9%	1:5000		1:395
SD Medi-Cal Pediatric	Cardiology/Intervention Cardiology (HI)	1 specialist (per spc type) within 15 miles or 30 min from members address or anticipated address	90%	89.7%	1:10000	90%	1:1117
	Dermatology			93.4%			1:1795
	Gastroenterology			87.0%			1:1862
	Ophthalmology			91.9%			1:914
	Endocrinology			86.3%			1:2900
	ENT-Otolaryngology			86.9%			1:2600
	General Surgery			86.3%			1:1450
	Hematology (HV)			86.3%			1:1862
	HIV-AIDS Specialist / Infectious Disease			87.3%			1:2356
	Nephrology			87.3%			1:1694
	Neurology (HI)			87.0%			1:1300
	Oncology (HV, HI)			86.3%			1:1571
	Orthopedic Surgery			N/A			N/A
	Physical Medicine and Rehabilitation			86.3%			1:4435
	Pulmonology			89.1%			1:1676
	Obstretics and Gynecology (HV)			89.9%	1:5000		1:395

Network	Specialty	Standard	Goal	MY 2024 Results	Standard	Goal	MY 2024 Results
Geographic Distribution of Specialists, including High Volume and High Impact Specialists							Specialist to Member Ratio
Standard							
SD Medi-Cal (Adult)	Cardiology/Intervention Cardiology	1 specialist per SPC type within 15 miles or 30 mins from member's address or anticipated address	90%	89.7%	1:10000	90%	1:1101
	Hematology (HIV)			86.3%			1:1754
	Neurology (HI)			87.0%			1:1289
	Oncology (HI/HIV)			86.3%			1:1493
	Obstetrics and Gynecology (HIV)			89.9%	1:5000		1:395
SD Medi-Cal (Pediatrics)	Cardiology/Intervention Cardiology	1 specialist per SPC type within 15 miles or 30 mins from member's address or anticipated address	90%	89.7%	1:10000	90%	1:1117
	Hematology (HIV)			86.3%			1:1862
	Neurology (HI)			87.0%			1:1300
	Oncology (HI/HIV)			86.3%			1:1571
	Obstetrics and Gynecology			89.9%	1:5000		1:395

Results/Goals:

- In San Diego County, distribution of Adult and Pediatric Specialists met the 90% threshold of having 1 specialist within 15 miles or 30 mins from members address or anticipated address for Dermatology, and Ophthalmology, but did not meet the 90% threshold of having 1 specialist within 15 miles or 30 mins from members address or anticipated address for Cardiology/Cardiovascular Disease, Gastroenterology, Endocrinology, ENT, General Surgery, Hematology, HIV-AIDS Specialist/Infectious Disease, Nephrology, Neurology, Oncology, Orthopedic Medicine, and Physical Medicine, Pulmonology and OB/GYN.

Barriers:

BSP:

- It is a challenge in San Diego County to recruit providers to participate in Medi-Cal in comparison to other payers due to reimbursement models, and increased patient and provider compliance requirements.
- Due to the presence of large Medical Groups in San Diego, such as Scripps and Sharp Medical Groups, their lack of participation limits the available number of providers that can contract directly with the plan or other IPAs. We continue to look for contracting opportunities.
- Rural areas within San Diego County make it difficult for members to see providers within their area within the time standards; many members choose to travel out outside of the area for Specialty care that is closer to their place of work and to receive care from California Healthcare Centers of Excellence.

Opportunities/Interventions

- Blue Shield Promise can increase provider availability by collaborating with our IPA and Medical Groups on provider recruitment and increasing access to PCP and Specialty care services. Results will be distributed on a minimum of an annual basis. Results that will be distributed will continue to be addressed with IPA/Medical Groups during the bi-annual JOMs. IPA/Medical Groups will be asked to provide their barriers, challenges, and mitigation plans. IPA and Medical Groups that continue to fail to meet threshold for Access to Care for PCP and Specialty services will be placed on a Corrective Action Plan. IPA and Medical Groups will be asked to document their mitigation plans, provide updates, and provide proof to demonstrate their interventions were completed.
- In San Diego County, we will continue to outreach to providers to contract with the plan. We will evaluate the demand and need of the specialty type and area and determine if we will pay the provider more than Medi-Cal rates to encourage participation in the Medi-Cal program.

2024 Opportunities for improvement and 2025 interventions (BSP):

Opportunity for improvement	Interventions	Responsible Party	Date to be implemented
BSP– Increase provider availability by collaborating with IPA and Medical Groups on provider recruitment and increasing access to PCP	Distribute access and availability report bi-annually. IPA/Medical Groups will be asked to provide their barriers, challenges, and mitigation plans. IPA and Medical Groups that continue to fail to meet threshold for Access to Care for PCP and Specialty services will be placed on a Corrective Action Plan. IPA and Medical Groups will be asked to document their mitigation plans, provide updates, and provide proof to demonstrate their interventions were completed.	Provider Analytics and Provider Services	Q3 2024
BSP – Continue to outreach to providers to contract with the plan.	We will evaluate the demand and need of the specialty type and area and determine if we will pay the provider more than Medi-Cal rates to encourage participation in the Medi-Cal program.	Contracting & Provider Relations	Q2 2024

Element D - Practitioners Providing Behavioral Healthcare

Description:

All Promise Health Plan product lines are managed through a Plan-to-Plan arrangement with Beacon and are monitored by BSP.

Methodology:

Blue Shield's credentialed and contracted psychiatrists, physicians who specialize in addiction medicine, psychologists, and master's level therapists, which includes, but is not limited to, licensed clinical social workers (LCSW), licensed marriage and family therapists (LMFT),

licensed professional clinical counselors (LPCC), and psychiatric mental health nurse practitioners are high volume non-physician mental health practitioner types for this assessment.

Element D - Practitioners Providing Behavioral Healthcare

To evaluate the availability of high-volume behavioral healthcare practitioners in its delivery system, the organization:

1. Defines the types of high-volume behavioral healthcare practitioners.
2. Establishes measurable standards for the number of each type of high-volume behavioral healthcare practitioner.
3. Establishes measurable standards for the geographic distribution of each type of high-volume behavioral healthcare practitioner.
4. Analyzes performance against the standards annually.

Blue Shield Promise Health Plan: Behavioral Health
Measurement Year 2024/Reporting Year 2024 Data Results:

Network	Specialty	Standard	Goal	MY 2024 Results	Standard	Goal	MY 2024 Results
Geographic Distribution of Specialists, including High Volume and High Impact Specialists					Specialist to Member Ratio		
Standard							
SD Medi-Cal (Adult)	Non-physician mental health (NPMH) outpatient services - Adult	1 within 15 miles and 30 mins from member's address or anticipated address	90&	99.9%	1:10000	100%	1:298
	Non-physician mental health (NPMH) outpatient services - Pediatrics			99.9%			
	Psychiatry - Adult			99.9%	1:10000		1:725
	Psychiatry - Pediatrics			99.9%			

Results/Goals:

Blue Shield of California Promise Health Plan networks:

- SD Medi-Cal
    - Non-physician mental health (NPMH) outpatient services for adults showed improvement from 98.4% in 2023 to 99.9% in 2024. For pediatrics, there was a significant improvement from 94.7% in 2023 to 99.9% in 2024. Psychiatry for adults also showed significant improvement from 93.5% in 2023 to 99% in 2024. Lastly, psychiatry for pediatric showed the most significant improvement from 86.3% in 2023 to 99% in 2024. All goals were met for all categories for 2024.

Barriers (if applicable):

Blue Shield of California Promise Health Plan networks:

- All goals were met for 2024. There are no identified barriers currently.

Opportunities/Interventions:

Blue Shield of California Promise Health Plan networks:

- While all goals were met, BSP always strives to have the most robust network for our members. BSP will continue to seek network expansion for increased volume and diversity of providers after insourcing its Behavioral Health network in Q2 of 2024.

2024 Opportunities for improvement and 2025 interventions (BSP):

Opportunity for improvement	Interventions	Responsible Party	Date to be implemented
BSP - Create a robust and diverse provider network for our members after BH insourcing in 2023.	Recruit and contract with additional behavioral health providers in SD counties.	Provider Contracting	Ongoing

II. Accessibility of Services (NET2):

The organization provides and maintains appropriate access to primary care services, behavioral healthcare services, and specialty care services.

Elements A and C: Access to Primary Care, Access to Specialty Care, Access to Behavioral Healthcare

Description:

Blue Shield has established appropriate monitoring mechanisms to ensure that its members have appropriate access to care. This includes participation in HICE ER/After-Hours Survey, the Provider Appointment Availability Survey (PAAS), and internal reporting.

Methodology:

Provider Appointment Availability Survey (PAAS):

Blue Shield of California Promise Health Plan conducted the Provider Appointment Availability Survey using the Department of Managed Health Care (DMHC) methodology, through the vendor Sutherland Global. The methodology was developed by the DMHC pursuant to the Knox-Keene Health Care Service Plan Act of 1975. The PAAS methodology, published under authority granted in Section 1367.03, subd. (f)(3), is a regulation in accordance with Government Code section 11342.600. For measurement year 2024, all reporting health plans were required to adhere to the PAAS methodology when developing and reporting rates of compliance for timely access appointment standards, pursuant to Rule 1300.67.2.2, subd. (g).

BSP provider survey types included primary care providers, specialist providers, and behavioral health providers. The BSP specialist survey reviewed high volume and high impact

specialty types (cardiology, oncology, neurology, hematology, and obstetrics/gynecology). and gastroenterology).

The physician random sample was drawn from the BSP provider rosters using the Target Sample Size Chart in the DMHC methodology, which outlines the required survey sample size based on the number of providers in the Network/County. All remaining providers above the target sample size in the Network/County were used as oversample. Primary Care Providers that the health plan's Access and Availability Quality Assurance System verifies by confirming that appointments are scheduled consistent with the definition of advanced access in subsection (b)(1), in accordance with Rule 1300.67.2.2, subd. (d)(2)(E) were designated as advanced access. These providers did not need to furnish further appointment availability responses through PAAS. Ineligible providers and providers who refused to take the survey were replaced with oversample until the target survey sample size was reached and/or the oversample was depleted. If a provider declined to take the survey at the original point of contact an appointment was set up for a call back from the vendor or the provider was given a toll-free number to call-in and complete the survey. All surveys were required to be completed within 5 days of the initial contact, or they were recorded as a "soft refusal" and not included in the analysis.

Provider ER and After-Hours Survey

BSP participate in the Health Industry Collaboration Effort (HICE) annual Provider ER and After-Hours telephonic survey that surveys a sample of PCP's and BH providers to evaluate emergency instructions and after-hours access using the vendor Sutherland Global.

The plans conduct a telephone survey of primary care physician and behavioral health provider offices to assess after-hours physician availability and access to appropriate emergency and urgent care information. The MY2024 survey was conducted by BSP's vendor, Sutherland Global using the Health Industry Collaboration Effort (HICE) database for and applying the National Committee for Quality Assurance (NCQA) "8/30" sampling methodology.

Up to 30 completed primary care physician surveys are attempted per physician organization. A sample of 30 providers and up to 20 oversample providers were randomly selected per provider group per county. Oversample provided replacements when invalid telephone numbers or refusals were encountered. If the first 8 providers surveyed were in compliance (all elements/questions), then the review ceases, and the score provided is 100%. If any of the providers surveyed were out of compliance, the review continued for the remaining 22 providers with an overall score provided for all 30. The physician sample was drawn from the Blue Shield of California provider rosters. Primary care and behavioral health providers were included in the ER/After-Hours Survey. Surveys are conducted telephonically after normal business hours between 6:00 p.m. and 8:00 a.m., except for groups that use a call center that operates 24/7 and requires member identification to access a healthcare professional. In those cases, their score was based on a description of their call protocol.

Survey questions were tailored to whether an interviewer reached a live person, a recording, or an auto-attendant. If a phone tree or message offered an option to dial a different number to reach a physician directly, the survey vendor was instructed to end the call and record that the physician was available immediately, in order to minimize intrusion on the physician's time. Only completed interviews were used in the analysis of the data. If the response choice "don't know" or "refused" was selected for a question, those responses were not included in the analysis of that question.

Promise Health Plan's after-hours standard requires that a PCP or covering physician is available to members 24 hours a day, 7 days a week. Emergency instructions are required for both answering services or a machine and must include clear instructions for obtaining emergency care.

Element A - Access to Primary Care

Using valid methodology, the organization collects and performs an annual analysis of data to measure its performance against its standards for access to:

1. Regular and routine care appointments.
2. Urgent care appointments.
3. After-hours care.

Element C - Access to Specialty Care

Using valid methodology, the organization annually collects and analyzes data to evaluate access to appointments for:

1. High-volume specialty care.
2. High-impact specialty care.

Blue Shield of California- Medi-Cal

PCP

Urgent care standards are defined as within 48 hours for an appointment that does not require a prior authorization and within 96 hours for an appointment that does require prior authorization. All urgent PCP visits by definition do not require prior authorization. Routine care for a PCP is defined as 10 business days.

		Goal	MY2023	MY2024	YOY Comparison
Urgent Care (hours)		75%			
	Medi-Cal SD		51%	63%	▲
Routine Care (days)					
	Medi-Cal SD		74%	72%	▼

		Goal	MY2023	MY2024	YOY Comparison
ER access instructions	Overall	100%	93%	84%	▼
	Medi-Cal SD		80%	83%	▲
After hours availability	Overall		84%	48%	▼
	Medi-Cal SD		52%	49%	▼

SCP

Urgent care standards are defined as within 48 hours for an appointment that does not require a prior authorization and within 96 hours for an appointment that does require prior authorization. Routine care for an SCP is defined as 15 business days.

Urgent care					
Specialty	Network	Goal	MY2023	MY2024	YOY Comparison
HI and HV Specialties					
Cardiology/Intervention Cardiology		75%			
	Medi-Cal SD		44%	57%	▲
Oncology					
	Medi-Cal SD		40%	78%	▲
Hematology					
	Medi-Cal SD		52%	82%	▲
Neurology					
	Medi-Cal SD		36%	45%	▲
Obstetrics/Gynecology					
	Medi-Cal SD		29%	N/A	

Routine Care					
Specialty	Network	Goal	MY2023	MY2024	YOY Comparison
HI and HV Specialties					
Cardiology/Intervention Cardiology		75%			
	Medi-Cal SD		72%	57%	▼
Oncology					
	Medi-Cal SD		83%	51%	▼
Hematology					
	Medi-Cal SD		85%	82%	▼
Neurology					

	Medi-Cal SD		49%	32%	▼
Obstetrics/Gynecology					
	Medi-Cal SD		53%	N/A	N/A

Results/Goals (NET 2 A and C congruent unless otherwise stated):

Blue Shield of California Promise networks:

- Blue Shield Promise did not meet the 75% threshold for Urgent Care hours in San Diego County (63%), however, there was an improvement of 12% from the previous year. As a result, conversations were held with those IPA/Medical Groups not meeting the scores for the PAAS and PAS surveys to discuss their results, barriers, and opportunities to improve scores going forward. IPAs were also placed on a corrective action plan when they failed to meet thresholds for PAAS.
- Blue Shield Promise was very close to meeting the 75% threshold for Routine Care hours in San Diego County (72%), which was a decrease of 2% from the previous year. As a result, conversations were held with those IPA/Medical Groups not meeting the scores for the PAAS and PAS surveys to discuss their results, barriers, and opportunities to improve scores going forward. IPAs were also placed on a corrective action plan when they failed to meet thresholds for PAAS survey results.
- For PCP ER access instructions, Blue Shield Promise did not meet the 100% threshold, however, there was an increase in San Diego performance of 3%. As result, conversations are being held with those IPA/Medical Groups not meeting the scores for the ER/After Hours surveys to discuss their results, barriers, and opportunities to improve scores going forward. IPAs were also placed on a corrective action plan when they failed to meet thresholds for ERAH survey results.
- For PCP After hours availability Blue Shield Promise did not meet the 100% threshold and saw a significant decrease of 36% in comparison to the previous year. As result, conversations are being held with those IPA/Medical Groups not meeting the scores for the ER/After Hours surveys to discuss their results, barriers, and opportunities to improve scores going forward. IPAs were also placed on a corrective action plan when they failed to meet thresholds for ERAH survey results.
- For Specialty Routine Care, Blue Shield Promise did not meet the 75% threshold for Neurology but did see an improvement of 8% in Cardiology/Intervention Cardiology in San Diego County. As a result, conversations were held with those IPA/Medical Groups not meeting the scores for network adequacy to discuss their results, barriers, and opportunities to improve scores going forward. IPAs were also placed on a corrective action plan when they failed to meet time and distance standards.
- For Specialty Urgent Care, Blue Shield Promise did not meet the 75% threshold for Cardiology/Intervention Cardiology, Oncology, Neurology, and Obstetrics/Gynecology. As a result, conversations were held with those IPA/Medical

Groups not meeting the scores for network adequacy to discuss their results, barriers, and opportunities to improve scores going forward. IPAs were also placed on a corrective action plan when they failed to meet time and distance standards.

Barriers (NET 2 A and C congruent unless otherwise stated):

Blue Shield of California Promise networks:

- There are barriers to contracting with providers due to providers having exclusivity contracts with large medical groups and organizations- this limits Blue Shield Promise from being able to contract with providers directly to increase access and availability for specialty services.
- There is a lack of providers in general to contract with for specialty services, especially in rural areas. In addition to being limited providers, the providers that we do speak with do not want to contract with the Medi-Cal line of business due to lower reimbursement rates and the high level of regulatory requirements and oversight.
- Cross coverage is a barrier because it is not taken into consideration during the PAAS survey. Many large groups employ cross coverage staff models, so when a specific practitioner is not available, members can be directed to another practitioner in the same office for the same services, however the PAAS survey doesn't account for this.
- Rural areas within San Diego County make it difficult for members to see providers within their area within the time standards; many members choose to travel out outside of the area for PCP and Specialty care that is closer to their place of work and to receive care from California Healthcare Centers of Excellence.

Opportunities/Interventions (NET 2 A and C congruent unless otherwise stated):

Blue Shield of California Promise networks:

- Blue Shield Promise can increase provider availability by collaborating with our IPA and Medical Groups on provider recruitment and increasing access to PCP and Specialty care services. IPA/Medical Groups will be asked to provide their barriers, challenges, and mitigation plans. IPA and Medical Groups that continue to fail to meet threshold for Access to Care for PCP and Specialty services will be placed on a Corrective Action Plan. IPA and Medical Groups will be asked to document their mitigation plans, provide updates, and provide proof to demonstrate their interventions were completed.
- Increase provider availability by distributing reporting with IPAs on their PCP and Mid-Level assignments, encourage hiring of NPs and PAs to increase provider availability.

2024 Opportunities for improvement and 2025 interventions (BSC and BSP):

Opportunity for improvement	Interventions	Responsible Party	Date to be implemented

BSP – Increase provider availability by collaborating with IPA and Medical Groups on provider recruitment and increasing access to PCP and Specialty care services.	Distribute access and availability report bi-annually. IPA/Medical Groups will be asked to provide their barriers, challenges, and mitigation plans. IPA and Medical Groups that continue to fail to meet threshold for Access to Care for PCP and Specialty services will be placed on a Corrective Action Plan. IPA and Medical Groups will be asked to document their mitigation plans, provide updates, and provide proof to demonstrate their interventions were completed.	Provider Analytics and Provider Services	Q3, 2024
BSP - Increase provider availability by distributing reporting with IPAs on their PCP and Mid-Level assignments.	Monitor the IPAs network to ensure they meet the provider to member ratios by sharing reporting with IPAs on their PCP and Mid-Level assignments. Encourage the hiring of Mid-Level practitioners, NPs, PAs and midwives, to increase provider availability.	Provider Operation Analytics and Provider Services	Q3 2024

Element B: Access to Behavioral Healthcare

Description:

Blue Shield has established appropriate monitoring mechanisms to ensure that its members have appropriate access to behavioral healthcare. This includes participation in the HICE (Health Industry Collaboration Effort) ER/After-Hours Survey, the Provider Appointment Availability Survey (PAAS), and internal reporting.

Methodology:

Provider Appointment Availability Survey (PAAS)

Blue Shield of California Promise Health Plans conducted the Provider Appointment Availability Survey using the Department of Managed Health Care (DMHC) methodology, through the vendor Sutherland Global. The methodology was developed by the DMHC pursuant to the Knox-Keene Health Care Service Plan Act of 1975. The PAAS methodology, published under authority granted in Section 1367.03, subd. (f)(3), is a regulation in accordance with Government Code section 11342.600. For measurement year 2024, all reporting health plans were required to adhere to the PAAS methodology when developing and reporting

rates of compliance for timely access appointment standards, pursuant to Rule 1300.67.2.2, subd. (g).

BSC surveyed and reported a separate rate of compliance with the time elapsed standards for the networks in each county for each Provider Survey Type as required by the DMHC methodology. The provider survey types surveyed in MY2024 were primary care providers, specialist providers (cardiologists, hematologists, neurologists and oncologists), and behavioral health providers. Since not all high impact and high-volume specialists as defined by BSC were included in the survey, a comprehensive review of specialists is not possible for this section. These responses are limited to those high impact and high-volume specialty types that were surveyed.

The physician random sample was drawn from the BSC provider rosters using the Target Sample Size Chart in the DMHC methodology, which outlines the required survey sample size based on the number of providers in the Network/County. All remaining providers above the target sample size in the Network/County were used as oversample. Primary Care Providers that the health plan's Access and Availability Quality Assurance System verifies by confirming that appointments are scheduled consistent with the definition of advanced access in subsection (b)(1), in accordance with Rule 1300.67.2.2, subd. (d)(2)(E) were designated as advanced access. These providers did not need to furnish further appointment availability responses through PAAS. Ineligible providers and providers who refused to take the survey were replaced with oversample until the target survey sample size was reached and/or the oversample was depleted. If a provider declined to take the survey at the original point of contact an appointment was set up for a call back from the vendor or the provider was given a toll-free number to call-in and complete the survey. All surveys were required to be completed within 5 days of the initial contact, or they were recorded as a "soft-refusal" and not included in the analysis.

Provider ER and After-Hours Survey

BSC participates in the Health Industry Collaboration Effort (HICE) annual Provider ER and After-Hours telephonic survey that surveys a sample of PCP's and BH providers to evaluate emergency instructions and after-hours access using the vendor Sutherland Global.

BSC conducts a telephone survey of primary care physician and behavioral health provider offices to assess after-hours physician availability and access to appropriate emergency and urgent care information. The MY2023 survey was conducted by BSC's vendor, Sutherland Global using the Health Industry Collaboration Effort (HICE) database for and applying the National Committee for Quality Assurance (NCQA) "8/30" sampling methodology.

Up to 30 completed primary care physician surveys are attempted per physician organization. A sample of 30 providers and up to 20 oversample providers were randomly selected per provider group per county. Oversample provided replacements when invalid telephone numbers or refusals were encountered. If the first 8 providers surveyed were in

compliance (all elements/questions), then the review ceases, and the score provided is 100%. If any of the providers surveyed were out of compliance, the review continued for the remaining 22 providers with an overall score provided for all 30. The physician sample was drawn from the Blue Shield of California provider rosters. Primary care and behavioral health providers were included in the ER/After-Hours Survey. Surveys are conducted telephonically after normal business hours between 6:00 p.m. and 8:00 a.m., except for groups that use a call center that operates 24/7 and requires member identification to access a healthcare professional. In those cases, their score was based on a description of their call protocol. Survey questions were tailored to whether an interviewer reached a live person, a recording, or an auto-attendant. If a phone tree or message offered an option to dial a different number to reach a physician directly, the survey vendor was instructed to end the call and record that the physician was available immediately, in order to minimize intrusion on the physician's time. Only completed interviews were used in the analysis of the data. If the response choice "don't know" or "refused" was selected for a question, those responses were not included in the analysis of that question.

Blue Shield of California's after-hours standard requires that a PCP or covering physician is available to members 24 hours a day, 7 days a week. Emergency instructions are required for both answering services or a machine and must include clear instructions for obtaining emergency care.

Follow up Routine Care

Follow up Routine Care appointments were determined using an analysis of Behavioral Health claims for 2023. Claims were narrowed to locations that service appointments including offices, treatment facilities, and urgent care centers. The first initial visit for 2023 was identified by CPT code and subsequent follow up care codes with the same primary diagnosis and practitioner were included in the count of follow up care.

Element B - Access to Behavioral Healthcare

Using valid methodology, the organization annually collects and analyzes data to evaluate access to appointments for behavioral healthcare for:

1. Care for a non-life-threatening emergency within 6 hours.
2. Urgent care within 48 hours.
3. Initial visit for routine care within 10 business days.
4. Follow-up routine care.

<u>Behavioral Health – Medi-Cal</u>

Care for a non-life-threatening emergency:

		Goal	MY2023	MY2024	YOY Comparison
ER access instructions prescriber		100%			
	Medi-Cal SD		79%	83%	▲

ER access instructions non-prescriber					
	Medi-Cal SD		16%	49%	▲

Access for Urgent Care:

Urgent Care within 48 Hours					
		Goal	MY2023	MY2024	YOY Comparison
Prescriber		75%			
	Medi-Cal SD		42%	84%	▲
Non-prescriber					
	Medi-Cal SD		46%	68%	▲

Access for Routine Care: Initial visit for Routine Care within 10 business days:

Routine Care within 10 days					
		Goal	MY2023	MY2024	YOY Comparison
Prescriber		75%			
	Medi-Cal SD		78%	86%	▲
Non-prescriber					
	Medi-Cal SD		82%	68%	▼

Access for Follow-up Routine Care:

Follow up appointment					
		Goal	MY2023	MY2024	YOY Comparison
Prescriber (15 days)		75%			
	Medi-Cal SD		76%	91%	▲
Non-prescriber (10 Days)					
	Medi-Cal SD		75%	54%	▼

Results/Goals:

Blue Shield of California Promise Health Plan networks:

Medi-Cal San Diego (Medi-Cal SD):

- ER access instructions for prescribers showed a slight increase from 79% in 2023 to 83% in 2024. ER instructions for non-prescribers dramatically increase from 16% in

2023 to 49% in 2024. Although both goals were not met, ER access instructions for non-prescribers more than doubled in 2024.

- Access to urgent care for prescribers doubled from 42% in 2023 to 84% in 2024. Access to urgent care for non-prescribers increased from 46% in 2023 to 68% in 2024. ER instructions for non-prescribers dramatically increase from 15.5% in 2023 to 49% in 2024. Only prescriber groups met this goal in 2024.
- Access for routine care for prescribers increased from 78% in 2023 to 86% in 2024. Access for routine care for non-prescribers decreased from 82% in 2023 to 68% in 2024. Only prescriber groups met this goal in 2024.
- Access for follow-up routine care for prescribers increased from 76% in 2023 to 90% in 2024. Access for follow-up routine care for non-prescribers decreased from 75% in 2023 to 54% in 2024. Only prescriber groups met this goal in 2024.

Barriers (Prescribers and non-Prescribers congruent unless otherwise stated):

Blue Shield of California Promise Health Plan networks.

- Although this year's YOY comparison from 2023 has increased, provider outbound messaging to members for emergencies, urgent and routine appointments continue to lack completeness, which leads to goals not being met for 2024.
- The shortage of BH providers and providers' lack of availability to accept new members has affected routine and follow-up routine care rates.
- Existing BH providers who are providing care also lack availability due to members staying longer in treatment.
- There continues to be limited access to BH services for those members living in remote areas.

Opportunities/Interventions:

Blue Shield of California Promise Health Plan networks:

- Increase ER access instructions for both prescriber and non-prescriber groups.
- Increase urgent care access for non-prescriber groups.
- Increase access for follow-up routine care for non-prescriber groups.
- Create a robust and diverse provider network for our members, which includes telehealth providers.

2024 Opportunities for improvement and 2025 interventions (BSP):

Opportunity for improvement	Interventions	Responsible Party	Date to be implemented

BSP - Increase urgent care access for non-prescriber groups.	Provider education around urgent care access for members.	Provider Education team	All quarters throughout the year.
BSP - Increase access for follow-up routine care for non-prescriber groups.	Provider education around urgent care access for members.	Provider Education team	All quarters throughout the year.
BSP - Create a robust and diverse provider network for our members after BH insourcing in 2023, including telehealth provider network.	Recruit and contract with additional BH providers in SD counties.	Provider Contracting team	All quarters throughout the year.
	Utilize the targeted rate increase fee schedule to incentivize BH providers to join the network.	Provider Contracting team	All quarters throughout 2024.

Assessment of Network Adequacy (NET 3):
The organization provides members adequate network access for needed healthcare services.

Element A: Assessment of Member Experience Accessing the Network
Description:
On an annual basis, Blue Shield assesses and evaluates appeals, complaints & grievances, utilization data including requests for and utilization of OON benefits, and claims related to access to determine if there are any potential issues related to network adequacy.

Methodology:
Blue Shield evaluates appeals, complaints and grievances utilizing the quality of care, access, attitude and service, billing and financial issues, and quality of practitioner office site categorization. These results are then reviewed to determine appropriate resolution in the form of member and/or provider communication.
Blue Shield also conducts member surveys to determine members' experiences with the provider network regarding getting care in a timely manner, quality of providers, and quality of care by surveying its members using California and nationwide standard surveys including the Patient Assessment Survey (PAS), Consumer Assessment of Healthcare Providers and Systems (CAHPS), and Enrollee Experience Survey (EES).

On an annual basis, Blue Shield of California assesses and evaluates appeals, complaints & grievances, utilization data including requests for and utilization of OON benefits, and claims related to access to determine if any potential issues related to network adequacy.
BSC annually assesses member experience for its behavioral health or substance abuse services by leveraging a custom Behavioral Health Member Experience survey. Additional

custom questions have been added to the survey to better understand the members needs specific to California unique healthcare environment and Applied Behavioral Health Assessment populations.

Delegation Oversight: Utilization Management/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 initial and the 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-work group 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
• Provider Dispute Resolution
• Adjustments – report showing payment adjustments to previously processed claims
• Contested/Provider Denials (contracted & non-contracted)
• Misdirected/Forwarded Claims
• Open inventory/pend report to provide on the day of the on-site audit
• Emergency Claims
• Medical Records 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
• Application Turn Around Time For BH/Substance Abuse Providers

Utilization Management Annual File Review

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

2024 Goals:

- 95% of applicable annual delegation oversight audits, including follow-up and/or focus audits to be completed in 2024.
- 95% of quarterly/semi-annual reporting to be received timely and reviewed within 30 days of receipt.
- 95% 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-Del Audits	Percentage of Timely Reporting
Claims	100%	0	97%
Credentialing	100%	2	100%
UM	100%	0	100%

Quantitative and Qualitative Analysis:

In 2024 the Delegation Oversight team 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 no delegates put on the high-risk log for monitoring through the DOC.

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

A. CAHPS

2024 Member Satisfaction Report

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. 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) 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 County regions. The county region is determined to utilize California's state- county mapping. The survey methodology consists of the following:

- The 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 a specified County.
- All adult Medicaid members are 18 years or older at the time the sample is drawn for the measurement year in a 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.

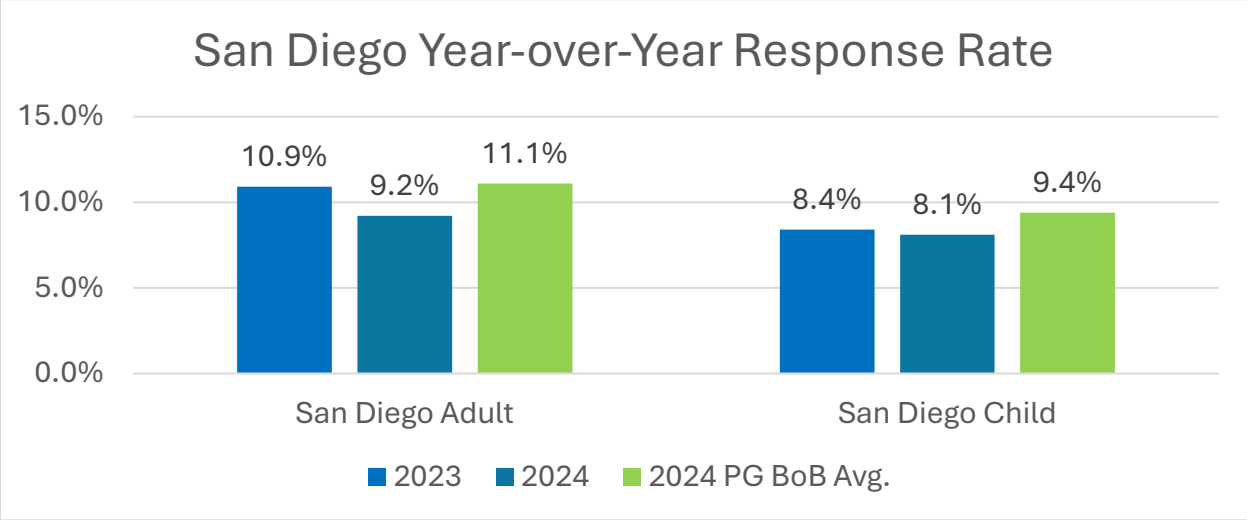
Overview: In 2024 BSP conducted a Medicaid adult and child CAHPS surveys for NCQA accreditation, regulatory purposes, and quality improvement efforts. BSP is committed to improving the member experience for all members and will continue to report Medicaid data.

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
San Diego Adult	2457	224	111	68	45	9.2%
San Diego Child	2459	197	62	74	61	8.1%

- San Diego Adult had 59 Spanish language completed surveys.
- San Diego Child had 87 Spanish language completed surveys.



YoY Response Rate	2023	2024	2024 PG BoB Avg.
San Diego Adult	10.9%	9.2%	11.1%
San Diego Child	8.4%	8.1%	9.4%

- San Diego Adult response rate decreased 1.7% from the previous year.
- San Diego Child response rate decreased 0.3% 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 San Diego Adult CAHPS: 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	73.8%	80.9%	7.10%	↑	77.7%	Yes
Rating of health care	70.6%	76.8%	6.20%	↑	74.6%	Yes
Rating of personal doctor	75.6%	85.7%	10.10%	↑	82.4%	Yes
Rating of Specialist	85.4%	87.0%	1.60%	↑	81.4%	Yes
Getting needed care	75.5%	77.7%	2.20%	↑	81.0%	No
Getting care quickly	72.2%	76.3%	4.10%	↑	80.4%	No
Customer service	89.5%	87.6%	-1.90%	↓	89.2%	No
How well doctors communicate	90.9%	91.4%	0.50%	↑	92.5%	No

Coordination of Care	82.1%	80.0%	-2.10%	↓	84.6%	No
Ease of filling out forms.	92.0%	95.6%	3.60%	↑	95.4%	Yes

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 San Diego Adult CAHPS Quantitative Analysis (*See table 1.)*

- 5 of 10 CAHPS composite measures met 2024 goals. Rating of health plan, rating of health care, rating of personal doctor, rating of specialist, and ease of filling out forms met goal.
- Access to care measures: getting needed care and getting care quickly did not met goal. Getting needed care increased 2.2% from the previous year but, was below goal. Getting care quickly increased 4.1% from the previous year, but did not meet foal.
- Care coordination decreased 2.1% when compared to the previous year and did not meet goal.

Table 2 Medi-Cal CAHPS for San Diego Child: 2023 and 2024 results are displayed for comparative performance year over year. 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 2.

Composites and Rating Questions	2023 Results	2024 Results	Delta	Trend	2023 NCQA Quality Compass average	Goal Met
Rating of health plan	86.7%	89.5%	2.80%	↑	86.2%	Yes
Rating of health care	88.9%	89.3%	0.40%	↑	86.2%	Yes
Rating of personal doctor	90.8%	94.7%	3.90%	↑	89.3%	Yes
Rating of Specialist	86.8%	85.2%	-1.60%	↓	85.6%	No
Getting needed care	74.5%	78.9%	4.40%	↑	82.7%	No
Getting care quickly	72.9%	86.4%	13.50%	↑	85.5%	Yes

Customer service	85.6%	90.1%	4.50%	↑	87.6%	Yes
How well doctors communicate	94.3%	95.6%	1.30%	↑	93.6%	Yes
Coordination of Care	85.7%	89.5%	3.80%	↑	83.8%	Yes
Ease of filling out forms.	96.8%	93.1%	-3.70%	↓	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 San Diego Child CAHPS Quantitative Analysis (*See table 2.)*

- 7 of 10 CAHPS composite measures did meet the 2023 goal. The composite measure rating of health plan, rating of health care, rating of personal doctor, getting care quickly, and customer service, how well doctors communicate, and care coordination did meet 2024 goal.
- The rating of specialist decreased 1.6% from the previous year and did not meet goal.
- Getting needed care increased 4.4% from the previous year but did not meet the goal of 82.7%. Getting needed care was 3.8% below the goal.
- Ease of filling out forms decreased 3.7% from the previous year and did not meet the 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.

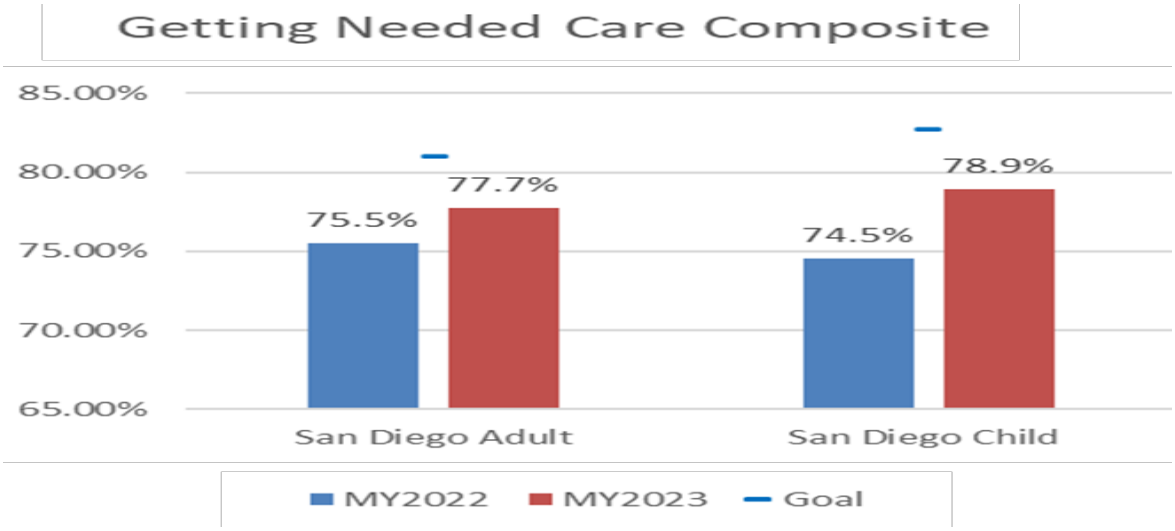
Rating of Health Plan		Rating of Health Care	
The below Composites have been identified as key drivers of Rating of Health Plan		The below Composites have been identified as key drivers of Rating of Health Care	
Getting needed care	Opportunity	Ease of Filling Out Forms	Opportunity
Coordination of Care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

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

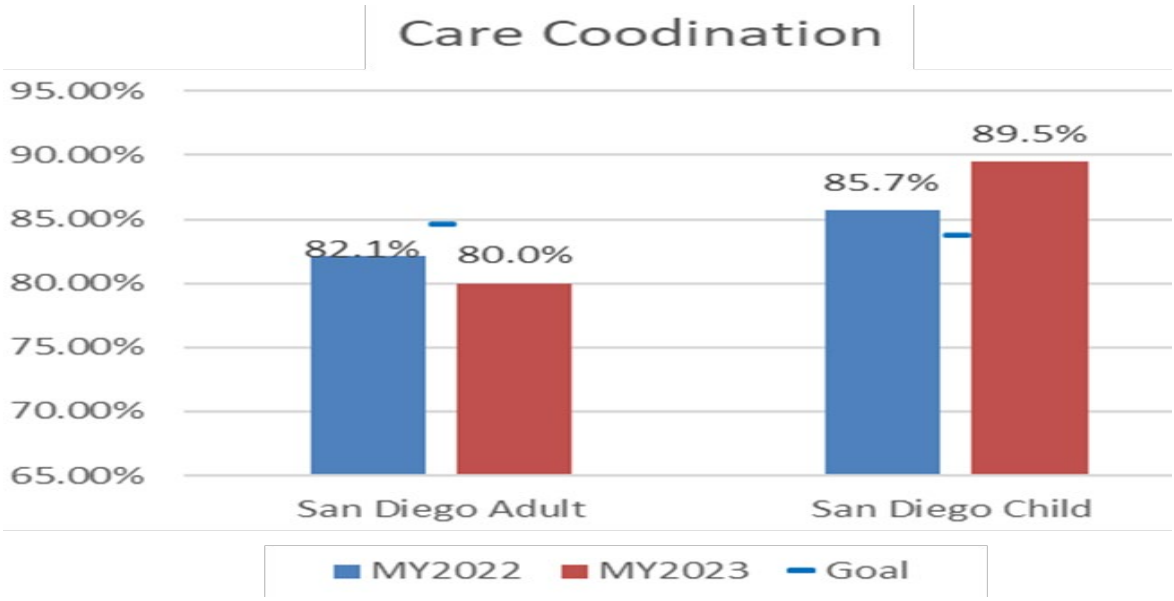


Scores are shown in the summary rate that represents the most favorable response percentages.

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

- Across all lines of business getting needed care did not meet the goal.
- SD Adult "Getting Needed Care" composite increased 2.2% from the previous year.
- SD Child "Getting Needed Care" composite increased 4.4% from the previous year.
- Across all lines of business, the 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.

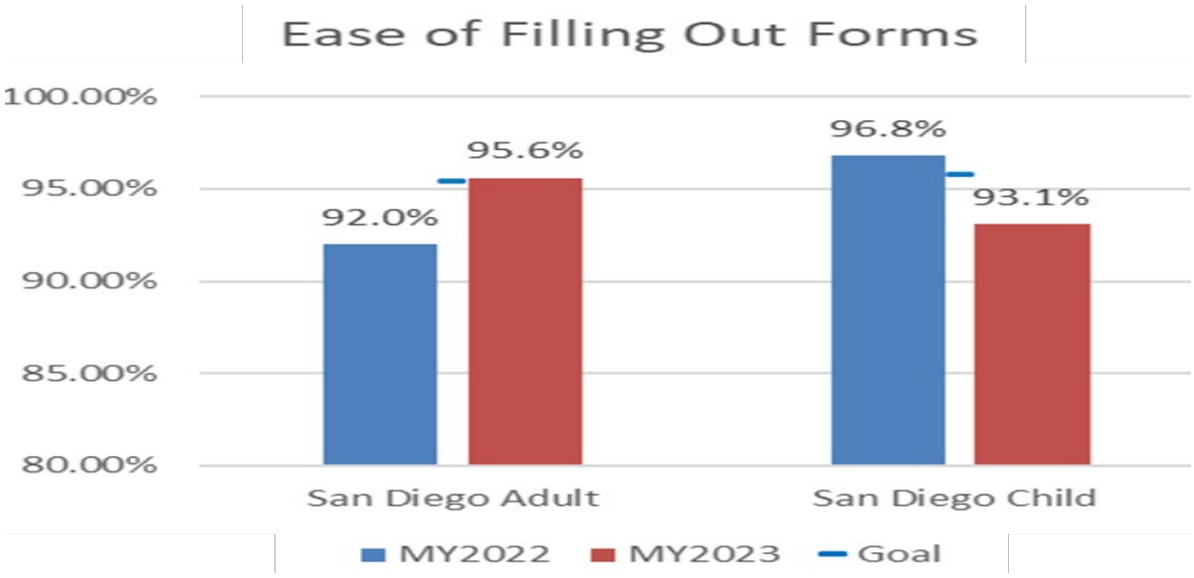
Coordination of Care Composite Quantitative Analysis



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

- SD Adult "Coordination of Care" decreased 2.1% from the previous year.
- SD Child "Coordination of Care" increased 3.8% 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 San Diego Adult. 3 of 4 lines of business did not meet the goal as indicated by the blue line. San Diego Child did meet goal in MY2023.
- 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.

B. 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 MHK. 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 San Diego

Table 3: Volume and Rate by Category for Medi-Cal San Diego

Appeals – Medical San Diego	2023			2024			Goal
PHP Medi-Cal SD	Count	Rate	%	Count	Rate	%	Met
Access	0	0.00	0%	0	0.0	0%	Yes
Attitude & Service	0	0.00	0%	0	0.0	0%	Yes
Billing & Financial	148	0.08	100%	241	0.10	100%	Yes
Quality of Care	0	0.00	0%	0	0.0	0%	Yes
Quality of Practitioner Office Site	0	0.00	0%	0	0.0	0%	Yes
PHP Medi-Cal SD Total	**148**	**0.08**	**100%**	**62**	**0.10**	**100%**	

Medi-Cal San Diego Appeal – Access

- There were no Access appeals for Medi-Cal SD in 2024.

Medi-Cal San Diego Appeal – Attitude and Service

- There were no Attitude and Services appeals for Medi-Cal SD in 2024.

Medi-Cal San Diego Appeal – Billing and Financial

- There were 241 Billing and Financial appeals, averaging less than 60 per quarter in 2024. Not enough data for trending. No further analysis was conducted.
- Blue Shield Promise Medi-Cal San Diego Billing and Financial Appeals met goal in 2024. Rate is below 1.0 and met goal in 2024.

Medi-Cal San Diego Appeal – Quality of Care

- There were no Quality-of-Care Appeals for Medi-Cal SD in 2024.

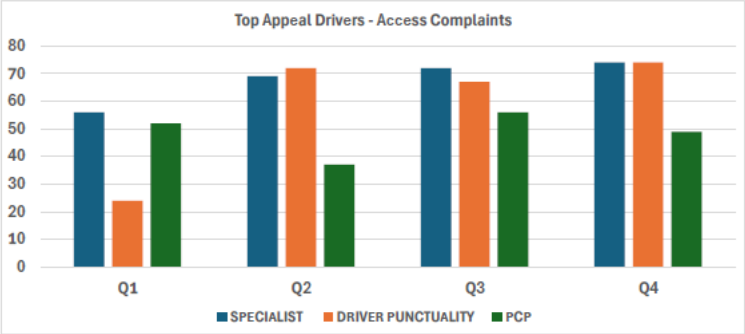
Medi-Cal San Diego Appeal – Quality Office Site

- There were no Quality Office Site Appeals for Medi-Cal SD in 2024.

Table 4: Volume and Rate by Category for Medi-Cal San Diego

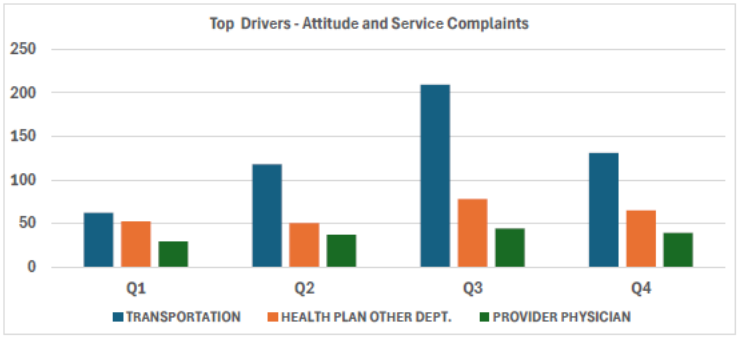
Complaints - Medical	2023			2024			Goal
PHP Medi-Cal SD	Count	Rate	%	Count	Rate	%	Met
Access	576	1.26	16%	1395	1.0	37%	No
Attitude & Service	1137	2.49	31%	1370	0.58	37%	Yes
Billing & Financial	797	1.75	22%	398	0.17	11%	Yes
Quality of Care	1101	2.41	30%	567	0.25	15%	Yes
Quality of Practitioner Office Site	0	0.00	0%	4	0.0	0%	Yes
PHP Medi-Cal SD Total	**3611**	**7.92**	**100%**	**3734**	**1.56**		

Medi-Cal San Diego Complaint – Access



- In 2024, access complaints related to specialists, driver punctuality, and PCP were the top drivers in 2024. Access complaints made up 37% of total grievance filed.
- In 2024, access complaints increased to 37% of total complaints and increase of 21% from 2023.
- In 2024, Medi-Cal SD access complaints did not meet the goal in 2024. Rate is above1.0 and did not meet goal in 2024.

Medi-Cal San Diego Complaint – Attitude & Service



- In 2024, Attitude and Services complaints related to transportation services, health plan, and providers were the top drivers. Attitude and service complaints represent 37% of the total complaints filed.
- In 2024, Medi-Cal SD Attitude & Service complaints remained steady compared to 2023. In 2023 there was a total record of 1137 Attitude & Service complaints, this number slightly increased to 1370 om 2024.
- Medi-Cal SD Attitude and Services complaints did meet the goal in 2024. Rate is below 1.0 and met the goal in 2024.

Medi-Cal San Diego Complaint – Billing & Financial

- In 2024, Medi-Cal SD Billing & Financial complaints decreased compared to the previous year. In 2023 Medi-Cal SD Billing & Financial complaints had a total record of 797, and in 2024 decreased to 398 total records.
- Medi-Cal SD Billing and Financial complaints did meet the goal in 202. Rate is below 1.0 and did meet the goal in 2024.

Medi-Cal San Diego Complaint – Quality of Care

- In 2024, Medi-Cal SD quality of care complaints decreased compared to the previous year. In 2023 Medi-Cal SD quality of care complaints had a total record of 1101, and in 2024 decreased to 567 total records.
- This includes cases referred to the Potential Quality of Care team for review.
- Medi-Cal SD Quality of Care complaints did not meet the goal in 2024. Rate is below 1.0 and did not meet the goal in 2024.

Medi-Cal San Diego Complaint – Quality of Practitioner Office Site

- There were 0 quality of practitioner office site complaint in 2024. No further analysis was conducted due to not being enough volume in the recorded

case.

- Medi-Cal SD Quality of Practitioner Office Site complaints met the goal in 2024. Rate is below 1.0 and met the goal in 2024.

Quantitative Analysis Appeals

2024 Top Appeals by Product

Appeals – Goals	Medi-Cal SD
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 SD.

2024 Top complaints by Product

Complaints – Goals	Medi-Cal SD
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 San Diego did not meet goal and continue to be an area of opportunity for Medi-Cal SD.

- Medi-Cal SD Access complaints related to specialist, driver punctuality, and PCP were the top drivers in 2024. Access complaints made up 37% of total grievance filed.

Access complaints are areas of opportunity for both Medi-Cal SD. 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 impacts 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 on 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.

[1] GlobalData Plc. The Complexities of Physician Supply and Demand:

Projections From 2021 to 2036. Washington, DC: AAMC; 2024.

People

- **CAHPS Member Experience Team**: BSP has been re-aligned as a CAHPS member experience team within line of business functional areas. This re-alignment allows the 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 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 BSC 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 Predictive CAHPS Solution**: BSP partnered with an external vendor to develop.
  AI/ML solution which allows the BSP to 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 to 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.

Citations:

1. GlobalData Plc. The Complexities of Physician Supply and Demand:

Projections From 2021 to 2036. Washington, DC: AAMC; 2024.

PROVIDER ENGAGEMENT / EXPERIENCE

Align. Measure. Perform. (AMP) Medi-Cal Managed Care Program.

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 the 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 for 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 – 2024 Clinician Satisfaction Survey

2024 Clinician Satisfaction Surveys Results

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:

- The likelihood to recommend Blue Shield to others stands at 63.2%.
  - 64.5% of clinicians have aligned interests and a sense of partnership with Blue Shield.
  - 59.0% of clinicians say it is easier to work with Blue Shield than other health plans.
  - 66.0% of clinicians believe they are treated fairly during contract negotiations with Blue Shield.
- 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, 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
		Primary Care Physicians	36
Blue Shield Promise	45	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 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

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	83.00%	85.0%	80.8%	88.2%	87.3%
Satisfaction with the Authorization Process that is necessary for your PPO patients to obtain covered services	80.40%	84.7%	80.6%	81.3%	86.9%
Overall Satisfaction with the Authorization Processes	82.30%	81.6%	79.7%	84.8%	87.1%
Timely Access to Urgent Primary Care	95.40%	98.4%	95.4%	97.8%	97.8%
Timely Access to Routine Primary Care	95.50%	98.8%	96.5%	98.5%	98.8%
Timely Access to Urgent Specialty Care	91.30%	95.2%	95.3%	94.9%	94.3%
Timely Access to Routine Specialty Care	91.70%	94.9%	94.8%	94.8%	95.5%
Timely Access to Urgent Ancillary Diagnostic/Treatment Services	93.20%	94.4%	93.0%	94.2%	96.4%
Timely Access to Routine Ancillary Diagnostic and Treatment Services	94.20%	95.2%	93.3%	93.9%	95.9%
Timely Access to Routine Initial Behavioral Health Care	88.00%	91.6%	90.8%	90.0%	91.2%
Timely Access to Routine Follow-up Behavioral Health Care	88.70%	91.9%	90.8%	89.5%	93.0%

Questions	Percent Satisfied 2024	Percent Satisfied 2023	Percent Satisfied 2022	Percent Satisfied 2021	Percent Satisfied 2020
Timely Access to Non-life-threatening Emergency Behavioral Health Care	89.80%	94.1%	91.0%	91.0%	92.0%
Timely Access to Urgent Behavioral Health Care	87.90%	92.3%	89.3%	91.0%	91.5%

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).