blue california
Promise Health Plan

2025
QUALITY PROGRAM DESCRIPTION
Medi-Cal

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Blue Shield Promise Health Plan's Mission, Values, and Strategy

Blue Shield of California Promise Health Plan (Blue Shield Promise) is guided by our mission and values, which encourage innovation and enables us to be a catalyst for constructive and transformational change. Blue Shield Promise's Quality Program is committed to promoting continuous and coordinated care in a patient-centered environment that recognizes the positive relationship between health education, a culture of wellness, and an emphasis on prevention and affordable healthcare.

Blue Shield Promise is a licensee of the Blue Cross Blue Shield Association and is an affiliate of Blue Shield of California. Blue Shield Promise holds Health Plan Accreditation and Health Equity Accreditation from the National Committee for Quality Assurance (NCQA) for its Medicaid product line.

Mission

Blue Shield Promise's mission is to ensure all Californians have access to high-quality health care at an affordable price.

Values

Blue Shield Promise's core values guide us in our interactions, how we innovate, and how we shape the customer experience. These values – "Human", "Honest", and "Courageous" embody the evolution of our values, connect us to who we are today, and bring us closer to our customers as a true partner in health.

Human

- We connect with and respect everyone we interact with inside and outside of the company like they are family and friends.
- We strive to be our authentic selves, listening and communicating effectively, and showing empathy towards others by walking in their shoes.
- We are part of a high-performing team and adopt a learning mindset, keeping our members at the center of everything we do to create a personal, high-quality experience.

Honest

- We hold ourselves to the highest ethical and integrity standards.
- We build trust by doing what we say we are going to do and by acknowledging and correcting where we fall short.
- We are open and transparent, getting sustainable results the right way, and help others make better, more informed decisions.

Courageous

- We are industry leaders, thinking creatively and critically, and constantly innovating to transform health care.
- We stand up for what we believe in and are committed to the hard work necessary to achieve our ambitious goals.

- We continuously learn by stepping out of our comfort zones to conquer our fears, lead change, and challenge the status quo.

Strategy

Blue Shield Promise will create a healthcare system that is worthy of our family and friends and sustainably affordable by:

- Creating a personal, high-quality experience
- Serving more people
- Being financially responsible
- Being a great place to do meaningful work
- Standing for what's right

Covered Population and Counties Served

Medi-Cal

In San Diego County, Blue Shield Promise is directly contracted with the Department of Health Care Services (DHCS) and provides healthcare and services to San Diego Medi-Cal members.

In Los Angeles (LA) County, L.A. Care Health Plan is the plan administrator directly contracted with the DHCS for Los Angeles Medi-Cal. Blue Shield Promise is a plan partner with L.A. Care Health Plan and provides health care and services for assigned LA Medi-Cal members.

Quality Program Scope

Blue Shield Promise's Quality Program is comprehensive and designed to systematically and continuously monitor, evaluate, and improve the quality-of-care and/or services delivered to Blue Shield Promise members and providers. Quality improvement activities are conducted in all areas and dimensions of clinical and non-clinical member care and service.

Performance improvement projects and activities are selected and conducted using methodologies and practices that conform to respected health services research entities, as well as standards and best practices established by regulatory and accrediting bodies.

The scope of the Quality Program is to monitor and identify opportunities for improvement of care and services to both our members and providers. This is accomplished by monitoring and evaluating data, and by leading or supporting the identification, investigation, implementation, and evaluation of corrective actions that continuously improve and measure the quality of clinical and administrative services. A formal evaluation of the Quality Program is performed annually. Specific elements of the Quality Program include Effective/Efficient, Equitable, Patient Centered, Provider Supported, and Safe and Timely. Topics in these domains include, but are not limited to (details available in the Quality Work Plan):

- Quality Improvement Initiatives
- Continuity, Coordination, and Transitions of Care
- Population Health Management
- Care Management
- Wellness Initiatives and Preventive Care
- Delegation Oversight of Credentialing Entities; Utilization Management and Claims Processing Entities
- Pharmacy Initiatives to Improve Safety and Avoid Harm
- Individual and Organizational Provider Credentialing
- Potential Quality Issues
- Medical Record Documentation Review
- Member Experience and Satisfaction Initiatives
- Cultural & Linguistic Services
- Appeals and Grievances Analysis
- Health Equity
- Access & Availability of Services
- Cost Data Transparency
- Customer Call Center
- Utilization Management Timeliness
- Provider Collaborations
- Provider Incentives
- Value-Based Programs
- Provider Group Engagement

The Quality Program covers:

- All Blue Shield Promise members.
- All types of covered services; including, but not limited to preventive, primary, specialty, emergency, inpatient, behavioral health (including parity), ancillary care, and long-term services and supports (LTSS).
- All professional and institutional care in all settings including provider offices, hospitals, skilled nursing facilities, outpatient facilities, emergency facilities, ancillary providers, pathology and laboratory facilities, urgent care, home health, and telehealth.
- All directly contracted providers and all delegated or subcontracted providers.

Blue Shield Promise's Quality Program provides a formal structure to monitor the quality of care and services provided to members and to act on identified opportunities for improvement. Blue Shield Promise ensures, through monitoring, that the provision and utilization of services meets professionally recognized standards of practice.

Blue Shield Promise adheres to standards, guidelines, and requirements of the National Committee for Quality Assurance (NCQA), Department of Managed Health Care (DMHC), Department of Health Care Services (DHCS), Centers for Medicare and Medicaid Services (CMS), Knox-Keene Act provisions, federal and state government agencies, and agreed upon requirements from other payers, such as L.A. Care. Quality standards and requirements may vary by product line.

Quality Program Goals and Objectives

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

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

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

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

2025 Quality Program Goals

Goal: Deliver an exceptional Quality Program across the company
Objectives:

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

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

- Improve physical and mental health outcomes.
- Implement mechanisms to identify and address patient safety issues and establish

strong relationships with providers to enhance safety within practices and clinics.

- Implement mechanisms to monitor and address timely access to services, especially for members with complex or special needs.
- Monitor, identify and address health disparities in clinical areas.
- Ensure that mechanisms are in place to facilitate and improve continuity, coordination, and transitions of care.
- Ensure there is a separation between medical and financial decision making.
- Ensure members have access to all medically necessary covered services regardless of race, color, national origin, creed, ancestry, religion, language, age, gender/gender identity, marital status, sexual orientation, health status, or disability.
- Ensure quality improvement program goals align with the goals and priorities of the Department of Healthcare Services (DHCS).
- Utilize a system or process to maintain and improve quality-of-care in Medicaid-based services for Dual-eligible members.
- Monitor, evaluate and take action to improve the quality-of-care delivered to Seniors and People with Disabilities (SPD).
- Address all aspects of care; including behavioral health, non-emergency medical transportation, and Long-term Services and Supports (LTSS).
- Ensure adequate clinical resources are in place to administer the Quality Program; including a full-time Chief Medical Officer/Director whose responsibility is direct involvement in the implementation of the Quality Improvement activities in accordance with Title 22 CCR Section 53857.

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

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

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

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

Quality Program Governing Body

The Blue Shield Board of Directors is ultimately responsible for the Quality Program. The Board provides oversight on performance against the quality goals, including ensuring compliance and regulatory requirements are met. The Board has delegated oversight of quality activities to the Board Quality Improvement Committee.

Board Quality Improvement Committee

The Board Quality Improvement Committee (BQIC) is a standing committee of the Blue Shield Board of Directors. The BQIC has been delegated as the governing body to provide high-level strategic direction for company-wide quality initiatives (including applicable affiliates). The Board of Directors appoints members of the BQIC. A Physician Board member chairs the committee. The committee is responsible for the approval of Blue Shield Promise's quality program description, work plan and evaluation, and for monitoring performance toward quality and health equity program goals. Members of the executive management team, including the Blue Shield Promise Chief Medical Officer (CMO), participate and are accountable to BQIC. BQIC has delegated oversight of operational functions related to quality improvement activities to the Quality Oversight Committee and holds the ultimate oversight/approval authority for all Health Equity related programs and activities.

Quality Committee Structure

Blue Shield Promise maintains a robust quality committee structure to ensure accountability of oversight and performance of all aspects of clinical care and quality. The Quality Committee structure includes participation from network providers that provide health care services to Seniors and Persons with Disabilities and chronic conditions. The Quality Committee organizational chart is included as Appendix B. Committee membership and responsibilities are included in Appendix C.

Committee members are appointed on an annual basis or as vacancies arise and are staggered to protect the continuity of the committee's functions. Representatives of the Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), and L.A. Care may attend upon request. Standing or ad hoc work groups or task forces are established for quality activities that need broad interdepartmental collaboration, or to address a specific topic to be developed or monitored over a period of time.

Quality Oversight Committee

The Quality Oversight Committee (QOC) is comprised of cross-functional stakeholders and is delegated by the Board Quality Improvement Committee (BQIC) with the oversight, strategic direction, prioritization, and coordination of all quality improvement activities for Blue Shield of California health plans across all product lines, including Blue Shield Promise Medi-Cal. The committee is comprised of a voting membership of internal stakeholders and a representative group of network providers who have an interest in ensuring the advancement of quality outcomes. While the QOC is responsible for the approval of general quality related policies, each subcommittee is delegated the responsibility of approving policies related to the functions of that committee. The QOC is responsible for monitoring performance toward Quality Program goals and requesting corrective action, if necessary. The committee is chaired by the Chief Medical Officer (CMO) or designee, meets at least quarterly and reports to the BQIC.

Standing and/or ad hoc work groups or task forces are created for quality activities that need broad interdepartmental collaboration, or for activities that need development or monitoring over a period of time or to address a specific topic.

The following subcommittees report into QOC:

Behavioral Health Committee

The Behavioral Health Committee (BHC) is charged with development, oversight, guidance and coordination of the Behavioral Health program for Blue Shield and Blue Shield Promise, including but not limited to quality improvement, utilization management, and access to care activities. The committee monitors provisions of care, identifies problems, recommends corrective action, and guides the education of Behavioral Health Providers to improve behavioral health care outcomes and quality of services. The

committee is chaired by the Senior Director of Behavioral Health or other designee as approved by the Senior Vice President, Operations, meets quarterly, and reports to the QOC.

Credentialing Committee

The Credentialing Committee serves as a peer review committee comprised of Blue Shield Promise medical directors, network physicians, and quality leadership whose purpose is to determine if providers and facilities meet Blue Shield Promise's qualifications for participation.

The Credentialing Committee reviews cases referred by the Peer Review Committee and may take action against providers and/or facilities based on their investigation, review, and discussion. The Credentialing Committee is responsible for the annual review and approval of credentialing policies and procedures. The committee is chaired by a Blue Shield Promise Regional Medical Director or designee, meets monthly, and reports to the QOC.

Delegation Oversight Committee

The Delegation Oversight Committee (DOC) is an authoritative body responsible for making decisions on various delegated functions. These functions include claims processing, credentialing, utilization management, training for newly contracted providers, and the termination of specialists. Additionally, the DOC reviews compliance controls, Information Technology (IT) system controls, and financial solvency.

The DOC has the authority to approve new and continuing delegation arrangements, and changes in delegation status based on the oversight activities of the delegated organizations. It also approves delegation oversight policies and procedures and mandates corrective actions for delegates that fail to meet regulatory and/or Blue Shield Promise requirements as specified in delegation agreements. The committee is co-chaired by the Blue Shield Promise Regional Medical Director or their designee, meets monthly and reports to the QOC.

Specialty Compliance Committee

The Specialty Compliance Committee (SCC) is charged with the oversight of the vision and dental vendor processes to ensure they are effective and meet contractual obligations and service level agreements. The SCC will conduct regular reviews of the vendors' quality improvement work plan and barrier analysis to ensure continuous progress and address any obstacles faced by the vendors. The committee is chaired by the Vice President of Specialty or their designee, meets at least quarterly, and reports to the DOC.

Health Equity Oversight Committee

While the BQIC holds the ultimate authority for quality related activities, due to the need for detailed review and discussion of the subject matter, the Health Equity Oversight Committee (HEOC) has the designated responsibility for overseeing Health Equity activities for Blue Shield of California and Blue Shield Promise. The HEOC provides a summary of Health Equity related activities, findings, recommendations, and actions and is accountable for all Health Equity functions and responsibilities delegated to subcontractors, if any. The HEOC will continuously monitor, review, evaluate, and improve the quality of health equity of clinical care services, case management, coordination, and continuity of service provided to all members.

The HEOC is also responsible for oversight of Culturally and Linguistically Appropriate Services (CLAS) Program activities. The HEOC is responsible for the initial review, feedback, and approval of the annual written evaluation of the CLAS Program documents, including a description of the completed and ongoing CLAS activities, trending of measures to assess performance, and analysis of results of initiatives, including barrier analysis and possible root causes and opportunities for improvement. The HEOC reviews and approves the Blue Shield of California and Blue Shield Promise CLAS Program policies/procedures and monitors, evaluates, and takes effective actions to address any needed improvements in quality and health equity of care.

The committee ensures feedback is received and considered from Blue Shield's network providers that deliver health care services to members affected by health disparities from the Community Review Committee (CRC), the Promise Community Advisory Committee (CAC) and the Promise Provider Advisory Council (PAC).

The committee is chaired by the Chief Health Equity Officers or their designee, meets at least quarterly, and reports to BQIC via QOC.

Network/Access & Availability Committee

The Network/Access & Availability Committee is responsible for oversighting components of our network related to access and availability of practitioners, assessment of network adequacy, continued access to care, physician and hospital directory requirements, practitioner termination notice requirements, and assignment, review, and approval of the Annual Network Summary Reports. The committee is chaired by a Blue Shield Promise Regional Medical Director or designee, meets quarterly, and reports to QOC.

Pharmacy & Therapeutics Committee

The Pharmacy & Therapeutics (P&T) Committee is responsible for the oversight and approval of policies and procedures pertaining to formulary management, drug utilization, pharmacy-related quality improvement, and educational programs, pharmaceutical utilization management programs, and other drug issues related to patient care. The

Committee determines medication policies based on the medical evidence for comparative safety (both short-term and long-term implications), comparative efficacy and comparative cost when comparative safety and efficacy are equal. The committee is comprised of actively practicing network physicians and clinical pharmacists licensed in California. The committee is chaired by a Blue Shield Medical Director or designee, meets quarterly and reports to the QOC.

Quality Management Committee (Blue Shield Promise)

The Quality Management Committee (QMC) is charged with the development, oversight, guidance, and coordination of Blue Shield Promise quality activities. The voting membership is comprised 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 such as those required by the Department of Health Care Services (DHCS), Department of Managed Healthcare (DMHC), Center for Medicare & Medicaid Services (CMS), National Committee for Quality Assurance (NCQA), and L.A. Care. The QMC monitors provisions of care, identifies problems, recommends corrective action, and informs educational opportunities for providers to improve health outcomes. The committee is chaired by the Blue Shield of California Promise Health Plan Chief Medical Officer or designee, meets quarterly and reports to the QOC.

The following subcommittees report directly to QMC:

Peer Review Committee (Blue Shield Promise)

The Peer Review Committee (PRC) investigates, discusses, and acts on potential quality issues arising from member complaints and issues referred internally. Cases requiring investigation may involve components of care delivered by an individual provider or a health delivery organization such as a hospital, skilled nursing facility, medical group, independent physician association (IPA), or other types of organizations that deliver care to members. Upon review and discussion, the PRC may refer cases and recommend actions to the Credentialing Committee when quality-of-care concerns are identified that may represent ongoing detrimental impact to patient safety. The PRC is also responsible for approving peer review related policies. The committee is chaired by a Blue Shield Promise Medical Director or designee, meets monthly, and reports to the QMC.

Medical Services Committee

The Medical Services Committee (MSC) is charged with the development, oversight, guidance, and coordination of Utilization Management (UM) and Care Management (CM) activities as outlined in the UM Program and Population Health Management Program. Comprised of a voting membership of network providers and internal staff, the MSC is responsible for the review and approval of program documents and policies, and the monitoring of UM and CM activities and data. The committee is

chaired by the Chief Medical Officer or designee, meets at least three times per year, and reports to the QMC.

Medical Policy Committee (Blue Shield Promise)

The Medical Policy Committee (MPC) evaluates and sets medical policy for Blue Shield Promise to ensure consistency of the process and decision variables used to make determinations. The MPC reviews information from appropriate government regulatory bodies, published scientific evidence, evidence-based literature, and expert medical opinion; and gathers input from relevant specialists and professionals who have expertise in the technology. The MPC has the authority to approve related medical policies. The committee is chaired by a Blue Shield Promise Medical Director or designee, meets quarterly, and reports to the QMC.

Confidentiality of Committee Content

Committee members and participants, including network providers, consultants, and others, will maintain the standards of ethics and confidentiality regarding both patient information and proprietary information. Internal members adhere to the Blue Shield Promise Code of Conduct. Annually, voting and non-voting external members will sign a Confidentiality Statement that is kept on file by the business area responsible for facilitating the committee. This statement requires disclosure of potential conflict of interest concerns and/or attempts to exert undue influence of decision making to a Chief Medical Officer (CMO) or other appropriate Blue Shield Promise authority. Breach of confidentiality may result in disciplinary action, up to and including termination. Activities and minutes of the Quality Committees are for the sole and confidential use of Blue Shield Promise and are protected by State and Federal laws (1157 of the California Code of Evidence, Federal Information Act SB 889) and the Health Insurance Portability and Accountability Act (HIPAA).

Executive Leadership

President and Chief Executive Officer

The President & Chief Executive Officer (CEO) supports the Quality Program through oversight and ultimate supervision of individuals participating in quality programs and is responsible for the implementation of the Quality Program. The President & CEO also coordinates the allocation of resources and formal reports to the Board.

Executive Vice President, Chief Operating Officer

The Chief Operating Officer (COO) reports to the President and CEO and holds responsibility for Transformation and Customer Service, Corporate Development, Finance, Global Business Services, and Cost of Healthcare.

Executive Vice President, Strategy, Health Solutions and Innovation

The Executive Vice President (EVP), Strategy, Health Solutions, and Innovation reports to the

President and CEO, with the responsibility for the Health Solutions organization, which includes health care services, health care transformation and acceleration, network management and provider partnerships, strategy, and innovation.

Executive Vice President, Chief Growth Officer

The Executive Vice President (EVP) of Growth is part of the executive leadership team. This role is responsible for driving strategic initiatives to expand membership, optimize customer retention, and increase market share within the health insurance sector. This individual leads efforts across all lines of business to identify and capitalize on growth opportunities while ensuring alignment with regulatory requirements, organizational goals, and the mission to provide exceptional value and service to members.

President and Chief Executive Officer, Blue Shield Promise

The President and Chief Executive Officer (CEO) of Blue Shield Promise is responsible for providing strategic leadership by working with the Board and other management to establish long-range goals, strategies, plans, and policies. This role provides oversight of quality plans and outcomes, ensuring the plans developed improve quality performance and drive equitable outcomes. The President & CEO of Blue Shield Promise reports to the Executive Vice President, Chief Growth Officer.

Chief Medical Officer of Blue Shield Promise

The Chief Medical Officer (CMO) is a board-certified physician that holds an unrestricted license to practice medicine in the state of California pursuant to Section 2050 of the Business and Professional Code. The CMO serves as a resource in planning, educating, and evaluating clinical functions and supports the promotion of managed care systems. The CMO ensures the process by which all UM decisions for approvals, modifications, or denials are based in whole or in part on medical necessity, utilizing evidence-based guidelines and existence of coverage, and that the handling of requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to members, comply with regulatory requirements. The CMO chairs the Blue Shield Promise Quality Management Committee.

Responsibilities include, but are not limited to:

- Ensuring that medical decisions are rendered by qualified medical personnel, unhindered by fiscal or administrative management.
- Ensuring that the medical care provided meets the community standards for acceptable medical care.
- Ensuring that medical protocols and rules of conduct for plan medical personnel are followed.
- Contributing to the development and implementation of medical policy.
- Assuring compliance with the requirements of accrediting and regulatory agencies,

including but not limited to CMS, DHCS, DMHC, L.A. Care, and NCQA.

- Directing the implementation of the Quality Improvement process.
- Overseeing the formulation and modification of comprehensive policies and procedures that support the Quality Improvement operations.
- Reviewing Quality Improvement Program, Work Plan, Annual Evaluation, and Quarterly Reports.
- Assisting with the development, conduct, review, and analysis of Healthcare Effectiveness Data and Information Set (HEDIS) and quality improvement projects and studies.
- Participating in the analysis of quality improvement data.

Vice President, Quality

The Vice President (VP), Quality, reports to the Chief Medical Officer (CMO) and is responsible for providing consistent and innovative leadership to improve quality performance across all lines of business. This role is responsible for setting and driving the overall quality strategy and programs across the enterprise, ensuring that key functions are aligned with established goals and objectives to achieve desired quality outcomes. The VP designs, implements, and administers clinical quality improvement programs and initiatives. This position leads an enterprise-wide collaborative process to establish performance benchmarks that align with regulatory requirements and line-of-business goals. The VP is a voting member of the Quality Oversight Committee (QOC) and provides support to the Board Quality Improvement Committee (BQIC).

Senior Vice President, Health Solutions Operations

The Senior Vice President, Health Solutions Operations, reports to the Executive Vice President of Health Solution. This role is responsible for overseeing the operational strategy and performance of the Health Solutions business unit. Oversee the operational strategy and performance of the Health Solutions business unit. Lead operational performance enhancements, innovation, and build strategic partnerships to deliver impactful solutions within complex healthcare environments.

Key Quality Program Leaders

The Clinical Quality Department comprised of multidisciplinary staff/teams that address all aspects of the department operations and functions. See Appendix A for organizational charts.

All staff responsible for quality improvement studies and activities have bachelor's degrees and at least five years of health plan and/or health care experience. Upon hire, staff directly involved with Medi-Cal quality improvement studies complete HEDIS training, DHCS Medi-Cal 101 Training, and Provider Engagement Training. Staff are provided additional training specific to their respective roles, including trainings on L.A. Care, Provider Incentives, and value-based programs. For information on the qualifications of staff responsible for Medi-

Cal quality improvement studies and activities, see Appendix D.

Senior Director, Clinical Quality, Quality Improvement

The Senior Director of Clinical Quality, Quality Improvement, is responsible for the development and execution of the Medi-Cal clinical quality improvement strategy. The Senior Director of Quality Improvement reports to the Vice President of Clinical Quality, and as the designated plan Medi-Cal subject matter expert, works closely with the Chief Medical Officer and other cross-functional stakeholders. The Senior Director reports any areas of concern to the Vice President of Clinical Quality, the Chief Medical Officer, the Chief Compliance Officer, and/or appropriate committees. Responsibilities include:

- Developing and executing the quality improvement strategy for Medi-Cal San Diego and Los Angeles counties.
- Ensuring that Medi-Cal Quality Improvement Projects, Performance Improvement Projects (PIPs), Plan Do Study Acts (PDSAs), and Performance Improvement Plans are conducted and monitored appropriately.
- Monitoring and reporting to the Blue Shield Promise Quality Management Committee the status of quality improvement activities and initiatives in alignment with the quality program goals and DHCS requirements.
- Overseeing the formulation and modification of comprehensive policies and procedures that support quality improvement processes.
- Identifying compliance problems and formulating recommendations for corrective action.
- Serving as liaison with regulatory agencies for Medi-Cal performance improvement activities.

Director, Quality Improvement

Responsible for the strategy, development, and implementation of clinical quality improvement activities for Blue Shield Promise Medi-Cal, including oversight of DHCS and L.A. Care Performance Improvement Plans (PIPs), and Plan, Do, Study, Act (PDSA) projects.

Senior Manager, Quality Improvement, Medi-Cal

Responsible for the execution and oversight of clinical quality improvement activities for Medi-Cal San Diego.

Senior Manager, Quality Improvement, Medi-Cal

Responsible for the execution and oversight of clinical quality improvement activities for Medi-Cal Los Angeles.

Director, Medicare Star Program

Responsible for oversight and performance of the Medicare Star Program. Coordinates efforts with key stakeholders to develop strategy and implementation to achieve program

goals.

Senior Manager, Medicare Quality Programs
Responsible for member and provider engagement strategy to drive improvements in targeted Healthcare Effectiveness Data and Information Set (HEDIS) measures, collaborating with key stakeholders to identify barriers and opportunities for improvement, and implementing enhancements that align with goals/objectives.

Manager, Medicare Star Program
Responsible for the planning, design, and management of efforts aimed at improving Medicare Star performance. Collaborates with key stakeholders to identify gaps, barriers, and opportunities for improvements.

The following role(s) report to the Senior Vice President, Health Solutions Operations

Director, Clinical Quality Analytics
Responsible for Healthcare Effectiveness Data and Information Set (HEDIS) production, analytics, medical record review, and outreach. Oversees teams of analysts and health informaticists that facilitate data collection, analysis, extracts, and reporting of HEDIS data.

The following roles reporting to the Director, Clinical Quality Analytics:

Senior Manager, Clinical Quality Analytics
Responsible for HEDIS data operations, including annual HEDIS audit activities and data submission preparation, HEDIS engine vendor management, and summary and member level data extractions for downstream reporting, such as care gap reports for quality improvement activities. Responsible for regulatory HEDIS reporting to entities such as the Integrated Healthcare Association (IHA), Centers for Medicare and Medicaid Services (CMS), Covered California, and the Department of Health Care Services (DHCS). Oversees the HEDIS data operations, including compliance with HEDIS regulatory requirements and annual HEDIS submissions.

Senior Manager, Clinical Quality Analytics
Provides day-to-day direction and oversight of data analytics for the Quality Program. Responsible for the development and production of reporting, analytics, and consulting support across all lines of business for Clinical Quality initiatives. Responsible for monthly care gap reports, dashboards, member outreach reports, and initiatives, such as provider benchmarking, member engagement, behavioral health, population health, health solutions, health transformation, and digital marketing.

Director, Business Operations
Responsible for business planning and oversight for Clinical Quality. Provides administrative

support to BQIC.

Additional Quality Program Stakeholders

Additional stakeholders that provide input into the Quality program are multidisciplinary staff/teams that provide both clinical and non-clinical input.

Senior Director, Clinical Operations Oversight

Responsible for Blue Shield's operational oversight activities, including but not limited to NCQA Health Plan and Health Equity Accreditation activities, routine regulatory survey coordination, readiness and monitoring activities for commercial products, management of operational committee functions and governance. Responsible for development and implementation of the operational risk assessment program.

Chief Health Equity Officer

The Chief Health Equity Officer (CHEO) reports to the President and CEO, Blue Shield Promise, with the responsibility of leading cross-functional health equity work across the organization. The CHEO will work to identify and reduce health disparities and inequities. This role provides leadership in the design and implementation of strategies and programs to ensure health equity is prioritized and addressed. Additionally, the CHEO reports to the Executive Steering Committee when needed regarding health equity related activities.

Senior Medical Director, Behavioral Health

The Medical Director, Behavioral Health is a California licensed physician (M.D. or D.O.), board-certified in Psychiatry, whose duties include oversight of Behavioral Health clinical workgroups and the BH program operations and provides MH/SUD consultation and management of utilization management teams.

Medical Director(s), Behavioral Health

The Behavioral Health Medical Director(s) will report to the Senior Medical Director, Behavioral Health. This role will have core responsibilities in the areas of psychiatric inpatient concurrent review, pre- and post-service utilization review, and collaboration with Nurse Care Managers.

Senior Manager, Clinical Quality Review

A licensed clinical professional responsible for the day-to-day operations of the Clinical Quality Review (CQR) team. This position oversees the team that investigates deviations in the standard of care to address the practitioner component of potential quality issues (PQI).

Dental Director

A licensed dentist who serves as the professional dental quality resource and provides regulatory oversight either directly or through delegation to appropriate staff. Reviews clinical dental appeals for the Appeals and Grievance Department (AGD).

Medical Director, Utilization Management
A board-certified, licensed physician who reviews all potential quality issue (PQI) cases to investigate and identify any deviations in the standard of care.

Regional Medical Director
A board-certified, licensed physician who reviews Potential Quality Issues (PQI) cases. Chairs the Peer Review Committee (PRC) and attends the Credentialing Committee and the Quality Oversight Committee.

Medical Director, Line of Business
The Medical Director, Line of Business position is dedicated to supporting the promotion of growth and increased market share of Administrative Services Only (ASO) business. This includes strategic clinical and healthcare cost management guidance for the existing Blue Shield of California book of business. This position reports directly to the Senior Regional Medical Director and will be responsible for aligning goals with the Vice President (VP) of ASO Dedicated Operations. This position provides clinical direction to the sales team and sales processes and interacts directly with employers. This role will be at the center of driving strategy for how to reduce cost of care, while increasing engagement and improving the quality of care for our employer's members.

Senior Medical Director, Utilization Management
The Utilization Management team ensures that Blue Shield is on the cutting edge of medical, medication, and payment policy to accelerate the emergence of a value-based health care system in California. This role oversees delivery and collaboration of clinical review activities.

Vice President, Medical Care Solutions
Leads the clinical and non-clinical staff in the implementation of care management and utilization management programs, care transitions, medical care programs, medical policy development and maintenance to all Blue Shield Promise members.

Vice President, Clinical Strategy and Programs
Administrative and functional responsibility in delivering and collaborating on all aspects of Clinical Programs and Strategies. This role oversees a portfolio that includes, at a minimum, lifestyle medicine, behavioral health, complex care management, prescription digital therapeutics, and oversight of delegated vendors.

Director, Clinical Quality
Responsible for operational oversight and direction for Medi-Cal mandated programs, including Facility Site Review, Initial Health Appointment Outreach and Monitoring, Case Findings, and Disability and Equality Program. The Director oversees the day-to-day

operations of clinical and non-clinical teams, responsible for ensuring organizational readiness and compliance with regulatory requirements.

Vice President, Customer Experience and Digital Transformation
Leads the strategic direction and execution of initiatives aimed at enhancing customer experience and driving digital transformation across the organization. This role will collaborate with various departments to ensure alignment with the company's mission, values, and strategic goals.

Senior Manager, Member Experience Improvement
Responsible for the strategy development and execution to assess and improve member satisfaction and experience with Blue Shield Health Plan Promise and member care. Charged with the cross-functional development of initiatives and interventions to improve indicators of patient satisfaction and experience, including the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.

Key Functional Areas and Responsible Departments

Quality is an enterprise-wide focus at Blue Shield Promise; many departments have a significant role and direct impact on the success of the Quality Program. Departments have policies and procedures that outline their requirements and operations. Some of the key departments and functions and responsibilities are described here.

Appeals and Grievances

The Appeals and Grievances Department (AGD) is responsible for evaluating and resolving member appeals and grievances. AGD works with other departments to investigate and resolve appeals and grievances, and in the analysis of data and identification of trends for improvements in operational processes and member experience.

Appeals and grievances are tracked and trended to identify opportunities for improvement and are reported to the Medical Services Committee, Quality Management Committee, Quality Oversight Committee, and Board Quality Improvement Committee as appropriate. Potential quality issues are forwarded to the Clinical Quality Review Department for further investigation.

Behavioral Health

Blue Shield Promise administers mental health and substance abuse benefits for Medi-Cal members with mild to moderate impairments resulting from a mental health condition including but not limited to:

- Individual/group mental health evaluation and treatment (psychotherapy)
- Psychological testing when clinically indicated to evaluate a mental health condition
- Psychiatric consultation for medication management

- Outpatient laboratory, supplies and supplements
- Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT)
- Drugs, provided in a primary care office setting excluding anti-psychotic drugs (which are covered by Medi-Cal FFS)
- Coordination of Care (Physical and/or Severe impairment of mental, emotional, or behavioral functioning), which include Interdisciplinary Care Team Meetings

Behavioral Health Treatment (BHT)

The following behavioral health treatment benefits for members have been integrated into Medi-Cal Managed Care:

- Inform members that Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program services are available for members under 21 years of age.
- Provide access to comprehensive screening and prevention services, at designated intervals or at other intervals indicated as medically necessary, in accordance with the most current Bright Futures periodicity schedule, including, but not limited to:
    - A health and developmental history
    - A comprehensive physical examination
    - Appropriate immunizations
    - Lab tests and lead toxicity screening
    - Screening services to identify developmental issues as early as possible.
- Provide access to medically necessary diagnostic and treatment services, including but not limited to, BHT services based upon a recommendation of a licensed physician, surgeon, or a licensed psychologist.
- Coordination of care for medical and behavioral health care with the primary care provider, regional center, California Children's Services (CCS), or other specialists.
- Care Coordination and case management for members receiving BHT services, including interdisciplinary care team meetings, if appropriate.

Clinical Access Programs

The Promise Clinical Access Programs Department is responsible for several programs in accordance with respective contractual and regulatory requirements, including outreach, oversight, and monitoring, as applicable.

Facility Site Review (FSR)

Prior to joining Blue Shield Promise's Medi-Cal provider network, prospective primary care providers are required to undergo an initial Facility Site Review (FSR) audit, achieve a passing score, and correct all deficiencies to ensure that each of the primary care providers have clean and safe offices and can provide quality primary care

services to our Medi-Cal members. Existing providers must complete an FSR audit at least every three years, and these FSR audits include facility and medical record reviews, and a Physical Accessibility Review Survey (PARS). High-volume providers that serve Medi-Cal members must have a PARS at least every three years. Focused site reviews, which may include facility, medical record, or PARS audits, are conducted in response to member complaints and grievances in accordance with CMS and Medi-Cal Managed Care Plan (MMCP) criteria, and applicable DHCS Medi-Cal Managed Care Division (MMCD) letters. FSR program data is reported quarterly to the Blue Shield Quality Management Committee (QMC).

Initial Health Appointment (IHA)

All Blue Shield Promise newly enrolled Medi-Cal members are required to have an Initial Health Appointment (IHA) with their primary care physician, within 120 days of enrollment. The IHA consists of a physical exam, review of systems, medical and social history, as well as the review of needed preventative services, including immunizations and blood lead testing. Blue Shield Promise conducts outreach to newly enrolled Medi-Cal members to encourage and assist in scheduling a timely IHA. IHA program data is reported quarterly to the QMC.

Comprehensive Perinatal Services Program (CPSP)

Blue Shield Promise ensures optimal, comprehensive, multidisciplinary pregnancy and postpartum services with oversight of obstetrics, risk assessment/ reassessments, health education, nutritional services, and psychosocial services in accordance with the most current standards or guidelines of the American College of Obstetrics and Gynecology (ACOG). The ACOG standards are the minimum measure of quality for perinatal services for all pregnant Medi-Cal members and ensure that all pregnant and post-partum patients are offered services that meet state CPSP standards. In addition, Blue Shield Promise has established mechanisms to refer pregnant and post-partum members to appropriate providers, and to track and monitor the quality of these services through quarterly medical record audits of Blue Shield Promise obstetric providers. CPSP program data is reported quarterly to the QMC.

Child Health and Disability Prevention Program (CHDP)

All Members under 21 years of age are to have access to and receive Child Health and Disability Prevention (CHDP) Program services in accordance with state and federal requirements for providing preventive services to children. The purpose of the CHDP program is to provide all members under 21 years of age complete health assessments for the early detection and prevention of disease and disability for low-income children and youth in accordance with state and federal requirements, to ensure the identification and referral of members for treatment, and to establish effective linkages, care coordination and non-duplication of services for members

who are already receiving services from local health department, Local Education Agencies (LEA) such as school districts, county offices of education, charter schools, community colleges, and university campuses, or community-based organizations.

The provision of CHDP services is accomplished through Blue Shield Promise providers and/or local health department and/or Local Education Agencies in accordance with L.A. Care's Memoranda of understanding. For more information on screening and diagnostic services for children, visit the CHDP website. All Members under 21 years of age are to receive an Initial Health Appointment within 120 days of enrollment. An Initial Health Appointment (IHA) consists of a comprehensive health history and physical examination and includes an age-appropriate health education behavioral assessment.

Early Prevention, Screening, Diagnosis, and Treatment (EPSDT)/Medi-Cal for Kids & Teens
The Early Prevention, Screening, Diagnosis, and Treatment (EPSDT) program has been renamed by DHCS in 2025 to "Medi-Cal for Kids & Teens." The Medi-Cal for Kids & Teens benefits and services include the provision of prevention, diagnostic and treatment services for infants, children, and youth under the age of 21. Medi-Cal for Kids & Teens services are key to ensuring that infants, children, and youth under the age of 21 receive age-appropriate preventive services, including screening for medical, dental, vision, hearing, and mental health, and for substance use disorders, as well as receiving developmental screenings and specialty services.

Clinical Quality Review

The Clinical Quality Review (CQR) Department conducts investigations of member complaints regarding potential quality issues (PQI). A PQI is a suspected deviation from expected performance or standards related to the quality-of-care or service rendered by a network provider, vendor, or IPA/medical group for all Blue Shield Promise members. A medical director provides clinical oversight and direction to the CQR process and reviews quality-of-care investigations. The CQR department refers significant quality findings to the Peer Review Committee (PRC) for discussion and action.

Each case is assigned a severity level upon review by the CQR nurse assigned to the case, medical director, and/or physician reviewer. Any severity level that indicates a potential quality issue may require education or an action plan to address the issue. PQI data is tracked and trended by the CQR team.

Compliance Department

The Compliance Department, the Chief Compliance Officer, and the Compliance Officers for Medi-Cal work with the Clinical Quality Department to ensure compliance with and enforcement of all regulatory and contractual requirements.

Credentialing

Blue Shield Promise maintains a credentialing program that follows regulatory and oversight requirements. Blue Shield Promise will credential, and re-credential all contracted independent providers and mid-level providers employed in contracted providers' offices who provide services to Blue Shield Promise members.

The credentialing of individual providers and organizational providers ensures our network providers are qualified to provide care to our members. Quality performance findings for individual providers such as those related to quality of service complaints and quality-of-care are considered in re-credentialing decisions.

Cultural and Linguistics

To satisfy the objective of serving a culturally and linguistically diverse population, the Cultural and Linguistics (C&L) Department oversees the review and coordination of member materials to ensure cultural and literacy appropriateness and to meet the translation needs of Blue Shield Promise's membership. The C&L and Health Education Departments leverage cultural needs and preference data to assess Blue Shield Promise's population.

The C&L Department ensures that both face-to-face and telephonic interaction is available to members in their preferred language. The C&L Department also educates internal departments on the requirements to provide vital documents in members' preferred languages. This department develops a Language Assistance Program Description and work plan that sets clear goals, policies, operational plans and management accountability and oversight and further define the enrollee assessment, provision of language assistance services, staff training requirements, and performance monitoring.

Blue Shield is committed to the principle that members receive care and services from all staff and providers that is effective, understandable, and respectful in a manner compatible with their cultural health beliefs and practices, and preferred languages. This includes an assessment of the linguistic needs of the Blue Shield population and provision of interpretation and translation services. The Language Assistance Program Description further defines the enrollee assessment, provision of language assistance services, staff training requirements and performance monitoring.

Customer Service

As a key touchpoint of a member's experience and interaction with Blue Shield Promise, the Customer Service Department reports operational performance to the Quality Management Committee such as average speed of answer and abandonment rates.

The Customer Service Department records all incoming calls with specific indicators for tracking, trending, and reporting.

Delegation Oversight

Blue Shield Promise may delegate various functions, including but not limited to claims, credentialing, financial solvency, and utilization management to entities such as groups, independent physician associations (IPAs), hospitals, and applicable vendors.

The Delegation Oversight (DO) team, under the purview of the Delegation Oversight Committee (DOC), is responsible for oversight of contracted delegated entities in collaboration with internal departments. This includes auditing, corrective action follow-up, and monitoring activities. Auditing tools are based on regulatory, industry, contractual, and Blue Shield Promise internal requirements.

Blue Shield Promise takes a leadership role in the development of strong partnerships with delegated entities to foster a collaborative relationship that ensures high-quality care and service for our members, and insight into external perspectives and industry trends. These efforts allow for training opportunities to maintain compliance with applicable Blue Shield Promise, state, federal, and other regulatory requirements.

Blue Shield Promise does not delegate clinical studies, clinical grievances, appeals, quality management/improvement functions, facility site/medical record reviews, access studies, the development of health education materials, or member/provider satisfaction surveys. Delegated IPAs and medical groups are expected to perform ongoing monitoring of internal quality improvement activities. Blue Shield Promise retains the right to revoke any delegated function if compliance with standards is not met.

Medical Care Solutions

The Medical Care Solutions (MCS) Department is responsible for the development, implementation, and ongoing monitoring of Blue Shield Promise's utilization management, care management, and clinical solutions programs. MCS has mechanisms in place to identify potential risk and quality-of-care issues through case management, transitions of care, utilization review, and/or referrals. These cases can be referred for active case management or care coordination of members with identified complex needs or chronic conditions.

MCS monitors and reports operational performance indicators to the Medical Services Committee and performs analyses such as over- and under-utilization.

Pharmacy Services

Pharmacy Services is responsible for pharmaceutical management programs, including utilization management and drug utilization review. Additionally, Pharmacy Services implements and maintains initiatives and processes to promote patient safety.

Provider Partnerships and Network Management

The Provider Partnerships and Network Management organization is comprised of provider network strategy, provider services, relations, contracting, analytics, delegation oversight, communications and education, and network compliance functions.

The Provider Partnerships and Network Management Department supports the Quality program through:

- Engaging Blue Shield Promise's providers in quality improvement activities.
- Facilitating provider education, communication, and hosting educational opportunities.
- Establishing and assessing accessibility and availability guidelines.
- Overseeing activities to ensure network compliance and reporting.
- Providing expertise in support of internal and external quality initiatives.

Quality Programmatic Components

Blue Shield Promise takes a cross-functional approach to achieve its Quality Program goals and objectives. The Clinical Quality Department partners with key stakeholders across the organization in the development and execution of activities to assure and improve in all domains of quality.

Community Participation in the Quality Program

Blue Shield Promise provides members or authorized representatives and providers opportunities to participate in quality management activities.

Public Policy Meetings

The Blue Shield Promise Public Policy Committee (PPC) is responsible for participating in establishing public policy pursuant to the Health Maintenance Organization Act of 1973 as defined in Section 1369 of the Act. The PPC's recommendations and actions taken from their input are reported to the governing board and recorded in the board's minutes.

Community Advisory Committee

The Community Advisory Committee (CAC) serves as a vital platform for gathering members, providers, and community insights on the Blue Shield Promise Medi-Cal program. The CAC includes eligible enrollees, community representatives/groups, Blue Shield staff, and network providers. With dedicated committees for Los Angeles County and San Diego County, the CAC actively seeks input on geographically, culturally, and linguistically appropriate services, addressing disparities, and meeting the diverse needs of Blue Shield Promise members. Emphasizing regional community health, the CAC focuses on optimizing member engagement, discussing new initiatives, and committing to reducing disparities. The committee regularly provides recommendations, conducts annual updates, and reviews policies to enhance quality and health equity. Actions influenced by CAC input in various

operational areas are reported to the Health Equity Oversight Committee (HEOC), and the Public Policy Committee (PPC).

At a minimum, the CAC membership includes individuals representing the racial/ethnic and linguistic groups that constitute at least 5 percent of eligible membership. The CAC is tasked with the review and recommendation of approval of the annual CLAS reporting & evaluation to the Health Equity Oversight Committee (HEOC), as well as associated documents, such as reports, policies, and procedures.

Provider Advisory Council

The purpose of the Blue Shield Promise Provider Advisory Council (PAC) is to develop partnerships with all constituent types that work with the plan to improve both provider and member satisfaction with the plan's provision of services. The specific purposes of the Council may also include capturing and resolving provider issues, seeking input on provider and member incentive programs, developing tactical engagement strategies, and identifying areas of improvement and new initiatives. The PAC shares information and data with the Quality Improvement Heath Equity Committee (QIHEC).

The PAC is comprised of Blue Shield Promise's Vice President of Medi-Cal Growth, Chief Medical Officer, and Senior Director of Community & Provider Engagement. Other members may include, but are not limited to, individuals representing the interests of:

- Ancillary providers
- Community-based organizations
- Behavioral/mental health providers
- Federally Qualified Health Centers
- Hospitals/Hospital Associations
- Long Term Services and Supports
- Pharmacies
- Physicians from primary and specialty care/Medical Associations
- Public Health Agencies

Local Health Department-Sponsored Quality Improvement Committee

In San Diego County, Blue Shield Promise staff participate in the Local Health Department-sponsored Quality Improvement Committee to collaborate on quality projects that change annually. For instance, in 2022 and 2023, the quality improvement projects included increasing the use of fluoride varnish and lead screening.

Provider Participation and Engagement

Participating providers are involved in the development and performance review of the quality program through participation in the Quality Management Committee. Additionally, network providers are active participants in the program through representation in the

Medical Services Committee, Credentials Committee, Pharmacy and Therapeutics Committees, and Peer Review Committee. A physician who is a member of the Board of Directors chairs the Board Quality Improvement Committee.

A clinician satisfaction survey is conducted annually to assess experience with Blue Shield Promise's plan processes and services to identify opportunities for improvement. The survey asks providers for feedback on topics such as Blue Shield Promise's services, the provision of language assistance to members, utilization management processes, and coordination of care.

Blue Shield Promise's administrative and clinical policies, clinical guidelines, and Quality Program information are available online and in the Provider Manual. Providers are sent an annual notice with key information and links to resources that are available online, such as clinical guidelines, medical record standards, the annual quality evaluation, and prior authorization procedures.

Blue Shield Promise provider agreements include provisions that require participation in, and adherence with Blue Shield Promise's quality improvement activities, and policies and procedures, including the provision of access to member medical records.

Continuity and Coordination of Care

Blue Shield Promise takes an active role in measuring and improving patient safety, member experience, and provider experience through improving continuity and coordination of care between providers, between care settings, and between medical and behavioral health providers. Through data collection and analysis, processes and initiatives are implemented to support our providers in delegated and non-delegated settings.

Health Equity Program

Blue Shield Promise is dedicated to promoting and advancing health equity, improving quality, and eliminating health disparities. To achieve this, Blue Shield Promise has developed a comprehensive framework to better understand the drivers of inequitable care. To further this goal, Blue Shield Promise collects data on member characteristics to better understand and assess member needs, preferences, and to measure health care disparities. In pursuit of greater health equity, Blue Shield Promise is focused on the following areas:

- Building a diverse staff by promoting diversity, equity, and inclusion.
- Collecting data on race/ethnicity, language, gender identity, and sexual orientation and ensuring appropriate privacy protections.
- Ensuring access and availability of language services that are culturally and linguistically appropriate.
- Increasing network cultural responsiveness.

- Reducing health care disparities.

These activities are tracked, monitored, and evaluated through the Quality Work Plan (see the section titled Quality Work Plan for details which contains specific, measurable, achievable goals/objectives organized by key departments/functional areas) and results will be reported in the annual CLAS Program evaluation.

Cultural and Linguistic Appropriate Services (CLAS) Program

Blue Shield Promise is committed to the principle that members receive care from all staff and providers that is effective, understandable, and respectful in a manner compatible with their cultural health beliefs and practices and preferred languages. The intent of Blue Shield's Cultural and Linguistic Appropriate Services (CLAS) Program is to further this goal by engaging a cross-functional team comprised of several internal business areas to ensure:

- Effective use of race and ethnicity data
- Access and availability of language services
- Practitioner network cultural responsiveness
- Efforts are in place to reduce health care disparities

This includes an assessment of the linguistic needs of the Blue Shield Promise population and provision of interpretation and translation services.

The Board of Directors delegates the authority to review and approve the annual CLAS Program Evaluation and associated documents/reports to the Board Quality Improvement Committee (BQIC). BQIC delegates the review of CLAS related documentation to the Health Equity Oversight Committee (HEOC). HEOC reviews information from internal and external stakeholders including but not limited to data, reporting, and feedback from the CRC. The HEOC reports to the Quality Oversight Committee (QOC), which has day to day oversight of quality related activities and reports directly to BQIC.

Disability and Equality

Blue Shield Promise's approach to Disability and Equality ensures members with disabilities are included and considered in the organization's policy and program development and implementation. Blue Shield Promise collaborates cross-functionally and with the Chief Health Equity Office (CHEO) to design programs and interventions as needed with the goal of ensuring members with disabilities have equitable and timely access to care. Key areas of focus are:

- Physical, communication, and programmatic access
- Network adequacy
- Identifying and filling physical accessibility gaps in the provider network.

- Promoting preventative care by ensuring accessible medical equipment is available.
- Reducing appointment failure related to missed accessibility needs.
- Ensuring transportation services are dispatched correctly and timely.
- Emergency preparedness for members with disabilities and other critical health care needs.

Disability sensitivity training is conducted on at least an annual basis to bring awareness to the Blue Shield Promise member-facing departments, to equip teams with knowledge and resources to serve members with disabilities, and to integrate these competencies into the culture and established systems. Topics include:

- Appropriate terms and words used to describe and address persons with disabilities.
- Resources available to assist members with the selection of an accessible provider site.
- Internal resources and departments to collaborate and provide services, such as transportation, member materials in alternative formats and American Sign Language Interpreters.

Member Experience

Blue Shield Promise's strategic goals include improving overall member satisfaction and experience with our network providers, services, and products. Blue Shield Promise collects and analyzes data from a variety of sources to assess experience at all member touch points, including appeals and grievances, member survey results, and operational performance metrics.

Appeals and Grievances

Appeals and grievance data is routinely analyzed by the Appeals and Grievances Department to identify trends and opportunities for improvement. The results of the analysis with any actions taken are reported to the Quality Management Committee, Quality Oversight Committee, and Board Quality Improvement Committee.

Member Surveys

An important source of improving overall member satisfaction is through member surveys. Results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys are key indicators of member satisfaction and experience and directly impact health plan quality rating systems such as NCQA Health Plan Ratings. The CAHPS surveys are conducted annually in accordance with DHCS, NCQA, CMS, and other applicable regulatory requirements. Supplemental CAHPS projects may be conducted in addition to those required by regulatory entities to provide Blue Shield Promise deeper insight into member experience. CAHPS results, analysis, and improvement opportunities are presented to the Quality Management Committee and the Quality Oversight Committee.

Supplemental member surveys are conducted to satisfy regulatory, or accreditation needs, and/or to gain more insight and inform improvement initiatives, such as:

- Behavioral Health Experience of Care and Health Outcomes (ECHO) survey – assesses member experience with behavioral health care and services.
- Palliative Care Member Experience Survey – measures member experience within palliative care program to enhance services and offerings.
- Timely access to care and interpreter services survey as required by Department of Managed Health Care (DMHC) update to code § 1300.67.2.2. Timely Access to Non–Emergency Health Care Services and Annual Timely Access and Network Reporting Requirements. This survey measures the enrollees right to obtain timely access to care as measured by DMHC standards and obtains the experience of enrollees with limited English proficiency in obtaining interpreter services and translated materials in the enrollees preferred language.
- Simulation and mock surveys are modified CAHPS surveys conducted throughout the year to assess the member's experience. Data collected through these activities is used for quality improvement purposes; ensuring the Plan is monitoring and addressing the members needs proactively.

The improvement of member experience is driven by the Clinical Quality Member Experience Team through the facilitation of cross-functional workstreams and workgroups, with distinct focuses on specific opportunities. In addition to composite-specific quality improvement activities, initiatives that began in 2021 and continue in 2025 include:

- CAHPS Predictive Analytics Tool: Operationalized in 2025, the CAHPS Predictive Analytics tool has the capability to ingest and analyze various enterprise data member experience data sources to create member engagement segmentation to be used to drive decisions and prioritize initiatives.
- Table Talk: a virtual member community to gain insight directly from members.
- Provider Engagement: development and hosting of CAHPS training for providers.

To drive focused alignment across the enterprise, the Clinical Quality Member Experience team meets monthly with key internal stakeholders to drive strategy, goal setting, and improvement activities across all lines of business. The team provides regular reports to the Quality Oversight Committee.

Representatives from Clinical Quality also participate in member experience workgroups facilitated by the marketing and consumer organizations to ensure alignment with enterprise strategic goals in industry measurements such as Net Promoter Score and the Forrester Index.

Member Safety

As a key component to high-quality care, Blue Shield Promise's Quality Program has mechanisms in place to identify, address and/or mitigate member safety issues, and implements and monitors clinical and non-clinical activities to promote and improve member safety. The Quality Program incorporates data and information to prevent member harm across a variety of patient care settings and health plan processes.

Pharmacy

Pharmacy Services implements and maintains several activities and programs to improve drug safety and help our members manage their drugs, including:

- Opioid Management Strategies – to decrease inappropriate prescribing and use of narcotics for members with chronic, non-cancer pain. Efforts include:
    - Patient Review and Coordination (PRC) program, which includes the Drug Management Program (DMP), to help members safely use their opioid medications. Members at high risk for opioid-related adverse effects are identified and in coordination with the primary care provider, specialists, and other prescribers a plan is developed to reduce the risk for harm.
    - Enhanced medication policies and formulary management to prevent fraud and waste, implement safety edits for dose, quantity, and duration of use.
    - Prescriber education programs promoting prudent prescribing and proactive management of opioids.
    - Enhanced detection and management of fraud, waste, and abuse.
    - Engagement in local, state, and federal initiatives to address the opioid epidemic.
- Behavioral Health Medications in Children (BHMC)- a retrospective drug utilization review program that evaluates behavioral health medication prescription claims for children 18 years of age and under and enrolled in Medi-Cal, and that facilitates safe and appropriate use of those medications.

Provider and Facility Site Reviews

To assess patient safety in provider office and facility settings, the Facility Site Review (FSR) team has established site review criteria to identify and address safety issues. Criteria may include exits with clear egress, posted evacuation routes, medical and non-medical emergency protocols; provider and staff training on medical and non-medical emergency plans; location and storage of emergency equipment; maintenance and repair of medical equipment; cleanliness and condition of floors, furniture, and other physical site structures. Blue Shield Promise assists providers in developing best practices and office policies to address findings, as well as to meet regulatory and contractual requirements.

In addition, the Physical Accessibility Review Survey (PARS) is performed to evaluate the level of accessibility to critical provider types, such as primary care and high volume/high impact specialists. The PARS determines accessibility levels for general areas such as parking, exterior building, interior building, restroom, and exam room(s), as well as important

medical equipment, including a height adjustable exam table, accessible weight scales and specialized medical equipment such as, dialysis chairs and mammography equipment. The FSR department may perform these reviews when conducting on-site visits to investigate a safety issue. This information is used to provide offices with an accessibility level for people with disabilities and other health care needs. The accessibility levels are available in the Blue Shield Promise provider directory, giving members opportunities to select a provider with the needed accessibility level. Adequate accessibility to important care and services for members with a disability, mitigate potential safety issues at the physical site, as well as decrease appointment failure.

Network Accessibility and Availability

Blue Shield Promise is committed to ensuring that its members have access to primary care physicians, specialty care practitioners, ancillary providers, behavioral healthcare clinicians, urgent and emergency care, and after-hours telephone services. Blue Shield Promise has established appointment accessibility and spatial availability standards to ensure its networks have ample clinicians and specialty types, hospitals, and other healthcare institutions to effectively meet the needs and preferences of its members and future members.

The standards address:

- The ability to define provider types who serve as primary care physicians (Pediatrics, Family Medicine, Internal Medicine, etc.)
- Appointment accessibility for urgent and nonurgent services/procedures, including regular routine appointments, preventative care appointments, and initial care appointments
- After-hours and Emergency care
- Office wait times
- Triage and screening telephone services
- Provider-to-member ratios
- Time and distance standards relative to a member's home and a provider's location
- The establishment of high-volume and high-impact specialists and respective ratios
- The provision of transportation services for members
- A Language Assistance Program for interpreter services and translations

Blue Shield Promise conducts annual access-to-care surveys and studies using established standards and guidelines to evaluate regulatory and accreditation compliance and measure provider network performance.

Blue Shield Promise performs quarterly network assessments against established standards and guidelines to identify potential opportunities for improvement. Additionally, Blue Shield Promise completes accessibility and availability assessments for its behavioral health

network component.

Network Performance Programs

Blue Shield Promise plays a leading role in collaborating with providers, purchasers, external organizations, and other health plans to measure quality, efficiency, and costs to drive change in healthcare. Leveraging data improves healthcare quality and affordability and enables consumer transparency.

Blue Shield Promise program participation includes:

- Blue Distinction Centers
- California Regional Healthcare Cost & Quality Atlas
- California Hospital Assessment and Reporting Taskforce (CHART)
- California Quality Collaborative (CQC)
- Catalyst for Payment Reform (CPR)
- Purchaser Business Group on Health (PBGH)

Additionally, Blue Shield Promise utilizes meaningful measurement to incentivize provider performance through proprietary programs:

- Integrated Healthcare Association (IHA) Align. Measure. Perform (AMP)
    - Blue Shield Promise partners with IHA to incentivize participating Medi-Cal provider organizations on an annual basis on measures in quality, cost, and appropriate resource use.
- L.A. Care's Value Initiative for IPA Performance Program (VIIP)
    - L.A. Care's Value Initiative for IPA Performance and Pay for Performance (VIIP+P4P) program measures, reports, and provides financial rewards for provider group performance across multiple industry-standard metrics, including HEDIS, utilization, encounters, and member experience. Provider groups are rewarded for superior performance compared to peers and for year-over-year improvement. The goal of the program is to improve the quality-of-care for members of L.A. Care and of its plan partners. Blue Shield Promise collaborates with L.A. Care's VIIP+P4P Program to help IPAs identify opportunities for improvement.
- Promise Quality Performance Incentive (PQPI)
    - Blue Shield Promise Health Plan incentivizes participating Medi-Cal provider organizations in domains of HEDIS, utilization, encounter data, and member experience.
- Patient Centered Medical Home (PCMH)
    - Blue Shield Promise awards Medi-Cal primary care practices who have obtained PCMH certification through NCQA or The Joint Commission.
- Initial Health Appointment
    - Blue Shield Promise awards provider organizations for on-time completion of

Initial Health Appointment (IHAs) for new Medi-Cal members to our plan.

- Care Gap Closure Program
    - Blue Shield Promise awards provider organizations for closure of care gaps on select/priority Healthcare Effectiveness Data and Information Set (HEDIS) measures.

Blue Shield Promise promotes quality and efficiency in healthcare data for all California providers and participates in quality collaboratives such as California legislation, Blue Cross Blue Shield Association (BCBSA), Industry Collaborative Effort (ICE), and Multi-Stakeholder Collaboratives.

Population Health Management

Blue Shield Promise's Population Health Management (PHM) program is a comprehensive and cohesive plan of action that addresses the needs of our members across the continuum of care, including the community setting, through participation, engagement, and targeted interventions. It is structured to enhance quality of life and activities of daily living, improve self-management by the member/family, slow disease progression, and reduce health care service usage associated with avoidable complications, such as emergency room visits, hospitalizations, and readmissions.

Blue Shield Promise's PHM program addresses all covered individuals' health care needs by focusing on:

- Keeping members healthy
- Managing members with emerging risk
- Patient safety or outcomes across settings
- Managing multiple chronic illnesses

Each program aligned to an area of focus has its own program goals that are tracked independently; the highest priority goals are monitored as part of the overall population health management strategy. This strategy aims to achieve and track 2-4 high-priority goals for each level of risk stratification or area of focus and achieve improved physical, mental, and social health outcomes for Blue Shield Promise members and the communities in which they live.

PHM programs report in to and are overseen by the Quality Oversight Committee, including the review and approval of the annual population health assessment, program description, and annual evaluation. Additionally, PHM programs are discussed and reviewed at the Quality Improvement Health Equity Committee.

Palliative Care

Palliative care is specialized medical care for individuals with serious illnesses. It helps manage the problems and stress from a serious illness with the goal of improving quality of life for both the person with the serious illness and those who help care for them. It is provided by a team of doctors, nurses, social workers, and chaplains who work together with a person's primary doctor(s) to provide an extra layer of support. Palliative care is appropriate at any age and at any time for patients with a serious illness. It can be provided along with other medical treatment.

Palliative care helps keep people with serious illnesses at home, not in the emergency room or the hospital. Studies show that it reduces physical discomfort, improves quality of life, and makes living with a serious illness easier. Palliative care is a standard service that is offered to all eligible Blue Shield members in all 58 California counties. There is no additional cost to the member.

Preventive Health

Blue Shield Promise designs, implements, and promotes member-directed preventive health initiatives. Preventive health guidelines are reviewed and updated annually and are based on generally recognized scientific research and medical authority direction, including but not limited to the U.S. Preventive Services Task Force (USPSTF), the Centers for Disease Control (CDC) Immunization Schedules, the Advisory Committee on Immunization Practices (ACIP), The American Academy of Pediatrics (AAP) Bright Futures Periodicity Schedule, and with state and federal preventive benefit mandates. Guidelines are developed with provider input and appropriate clinical review, including collaboration with behavioral health providers if necessary. Those populations at highest risk are targeted for specific interventions which are monitored and evaluated for effectiveness.

Seniors and Persons with Disabilities (SPD) Programs

The program starts with telephonic outreach to members who are trained in member engagement who outreach to members and provide screening, basic health information and care coordination services. Three attempts are made to contact the member by phone and then a letter is sent with the Clinical Services Coordinator (CSCs) contact information. Blue Shield Promise is contracted with a vendor to provide outreach to the member population and hand off to the internal team for care planning, inter-disciplinary team meetings, and on-going care management.

Blue Shield Promise has partnered with MediKeeper, an NCQA-accredited vendor, to outreach to members and administer the Health Risk Assessments (HRA). The HRA is an instrument used to collect and analyze an individual's demographics, health-related behaviors, lifestyle, and health conditions and to compare the collected information with standardized data. Results are used to predict the risks of developing specific medical conditions and provide information to individuals about how to reduce risks.

Members receive a Health Risk Assessment (HRA) telephonically or mailed with a self-addressed, stamped envelope. Once complete, outreach from a nurse to develop an Individualized Care Plan which includes basic care coordination services. The program is the entryway for the members into the various PHM services, such as our Social Services, Community resources, complex case management, and Health Education. This provides the member with one contact across numerous programs, resources, and settings to minimize member abrasion and confusion. Members are given the name and direct phone number of the nurse for any care coordination question or need they may have in the future.

Quality Improvement Process

Blue Shield Promise uses a Continuous Quality Improvement (CQI) process to measure performance, conduct quantitative and qualitative analysis, and assess and identify barriers and opportunities for improvement. Interventions are implemented to improve performance and are remeasured to determine the effectiveness of the interventions.

Quality Program Description

The Quality Program Description may be amended to reflect changes in scope and identified needs resulting from new or revised regulatory and/or accreditation requirements or significant changes in membership, provider scope, scope of services or operations occurring during the year. The Quality Program Description is reviewed at least annually and is approved by the Quality Oversight Committee (QOC) and the Board Quality Improvement Committee (BQIC).

Quality Work Plan

The 2025 Quality Work Plan outlines key activities for the year, and includes any activities not completed during the previous year, unless identified in the Annual Evaluation as issues that are no longer relevant or feasible to pursue. It is reviewed, approved, and monitored regularly by the Quality Management Committee (QMC), QOC, and BQIC.

The Quality Work Plan is a fluid document that contains goals/targets on several topics including those related to Safety, Health Equity, Effective and Efficient Care, Patient Centered, Timeliness of Service and Care, and Provider-supported. It is revised, as needed, to meet changing priorities, regulatory requirements, and identified areas for improvement.

The scope of the annual work plan includes:

- Goal and objective description
- Planned activities
- Performance target or measurable goals
- Time frame for all yearly planned activities including initiation and completion
- The person(s) responsible for each activity
- Status updates

- Root cause and corrective action if an activity is at risk
- Monitoring of previously identified issues
- Reporting requirements and frequency

Ongoing Monitoring/Quarterly Reports

Ongoing monitoring is a key mechanism to evaluate the progress of quality activities, as outlined in the Work Plan, and are submitted to the Quality Management Committee, Quality Oversight Committee, and Board Quality Improvement Committee (BQIC) for review and approval at least quarterly. Reports are submitted to DHCS on a quarterly basis.

Annual Quality Program Evaluation

Blue Shield Promise's Quality Program is reviewed at least annually to assess the overall effectiveness of the program. Findings from the annual Quality Program Evaluation are considered at the time of the Quality Program revision.

The assessment of activities in the Quality Work Plan is conducted to evaluate the success of individual activities in meeting the specific goals and objectives of the Quality Program. The annual review of the Quality Program ensures that the overall program is comprehensive, meets current industry standards, and is effective in continuously improving the quality of health care and services delivered. Identified opportunities are addressed in the following year's program and work plan.

Annually a written report based on activities of the previous calendar year is generated and is then submitted to the QMC, QOC, and BQIC. The evaluation includes:

- A description of completed and on-going quality improvement activities that address quality and safety of clinical care and quality of service.
- Trending of clinical and service measures to assess performance in quality and safety of clinical care, and quality of service.
- Analysis of the overall effectiveness of the quality improvement program and of its progress toward influencing networkwide safe clinical practices.
- Recommendations for Quality Program revisions and needed quality improvement initiatives for the upcoming year.
- Activities that should be continued in the following year's Quality Work Plan.

An executive summary is presented to the QMC, QOC, and BQIC for review and action which may include acceptance, clarification, modification, and follow-up as appropriate. An informational summary of the annual evaluation is available to providers.

Corrective Action Plans

As a part of the ongoing monitoring of the Quality Work Plan, or as a result of the annual evaluation, business areas are expected to identify root causes and develop corrective

actions if activities are not tracking toward/did not meet the respective goal. Educational materials and resources may also be given to the provider to address quality-of-care concerns or other identified deficiencies.
The corrective action plans can be developed from issues arising from but not limited to:

- Member/Provider experience survey results
- Access to care surveys and audits
- Availability studies
- Potential or actual quality-of-care issues
- Quality-focused review studies, such as provider tracking and trending
- Results of HEDIS or other quality improvement initiatives or measures
- A requirement from a regulatory entity

Standards of Practice

Blue Shield Promise reviews and adopts standards of practice from professionally recognized sources in the development and implementation of criteria, policies and procedures, metrics, indicators, protocols, clinical practice guidelines, review standards, or benchmarks in its quality program. Sources include, but are not limited to:

- National and local medical professional associations
- Local professionally recognized practices
- Evidence-based medical literature
- State and federal requirements

Thresholds and targets derived from these standards and norms will be:

- Measurable
- Achievable
- Consistent with national/community standards
- Consistent with requirements of regulatory agencies and legal guidelines
- Valuable to the assessment of quality or the potential improvement of quality for our member population

Data Sources

Blue Shield Promise's Quality Program provides a formal structure to monitor the quality-of-care and services provided to members and to act on identified opportunities for improvement. Blue Shield Promise ensures through monitoring, that the provision and utilization of services meets professionally recognized standards of practice.

Quality improvement is a data-driven process. Blue Shield Promise uses a variety of data sources to monitor, analyze, and evaluate quality improvement goals and objectives.

Data sources include, but are not limited to:

- Healthcare Effectiveness Data and Information Set (HEDIS®)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®)
- Provider access and availability data, and satisfaction surveys
- Customer Service call data
- Pertinent medical records (minimum necessary)
- Appointment access surveys and geo-access data
- Encounter and claims data
- Member and provider complaint data
- Appeal information
- Laboratory Data
- Pharmacy data
- Case management/care coordination data
- Utilization reports and case review data
- Authorization and denial reporting
- Delegation oversight audits
- Statistical, epidemiological, and demographic member information
- Enrollment and disenrollment data
- Language and cultural data
- Race and Ethnicity data
- Sexual Orientation and Gender Identity data
- Vendor performance data including competency assessment results for language assistance
- Health Information Exchanges

Quality improvement medical records review and outreach team oversee data collection for hybrid HEDIS measures for Medi-Cal populations. The Clinical Quality Analytics team oversees supplemental data collection for administrative and hybrid HEDIS measures. The Clinical Quality Member Experience team oversees data collection for CAHPS measures. Results of key indicators and data sources, such as HEDIS and CAHPS results, are analyzed by multidisciplinary teams, and opportunities for improvement are targeted.

Quality Improvement Strategy

The Clinical Quality department develops and implements cross-functional quality strategies to drive improvement in the quality-of-care, service, and health outcomes.

Activities include:

- Provider Engagement
  - Provider practice assessments to review quality improvement activities and program structure, electronic medical record (EMR) information, operational risks,

barriers, opportunities for improvement, and current needs.
    - The development of a provider work plan to meet the unique needs identified throughout the assessment.
    - Quality Outreach Toolkit, including provider performance on HEDIS measures compared to peers, member care gap lists, measure tip sheets.
    - Review quality dashboards that incorporate measure performance, trends, and peer comparison.
    - Conducting joint operations meetings with IPAs and Medical Groups in delegated arrangements to emphasize the use of educational materials and tools.
    - The development and dissemination of clinical standards, administrative or clinical practice guidelines.
    - Provider Web Portal: central location that contains the reports and tools for participating providers.
    - Supporting Federally Qualified Health Centers (FQHCs) with health navigators to outreach members and close gaps in care.
    - Offering funding to primary care practices to purchase topical fluoride kits and use these kits during visits with members under the age of 21.
    - Expanding access through funding mid-level practitioners and/or holding clinic days after hours or on weekends.
- Member Engagement
    - Offering health promotion and education programs on the use of health plan benefits and services.
    - Increased access to care through mobile medical units and clinic days for preventive care in women and children.
    - Offering members physical or electronic gift cards for closing care gaps.
    - In-home care, such as in-home visits and the availability of blood pressure cuffs.
- Cross-functional Improvements
    - Ensuring the availability of member materials in threshold language.
    - Modifying internal processes to improve access and quality of services provided to members.
    - Modifying the provider network to improve accessibility.
    - Partnering with Community and Provider Engagement teams to hold clinic days in the community.

A key component of Blue Shield Promise's quality outcomes is the ability to ingest supplemental data from providers. Blue Shield Promise partners closely with IPAs, medical groups, and provider organizations to ensure supplemental data is submitted timely and accurately. Blue Shield Promise provides analytical support to troubleshoot issues, distributes toolkits and requirement documents, and offers training via webinar on Blue Shield Promise processes.

To ensure compliance with regulatory agencies (e.g., National Committee for Quality

Assurance, (NCQA)), providers must comply with Blue Shield Promise policies and procedures and allow the health plan to use their performance data (e.g., HEDIS, clinical performance data).

Dissemination of Information

Results of quality improvement activities are communicated to providers in the most appropriate manner, including but not limited to:

- Correspondence with a provider displaying individual results and a comparison to the provider's group or affiliation, or against the peers in the network.
- Correspondence with the IPA/PMGs showing results and comparisons to the network.
- Announcements and Informational communications, as needed.
- Online
- Provider Manual updates

Clinical Measurement Activities and Quality Performance Reporting

Blue Shield Promise Health Plan's Clinical Quality Department adheres to CMS quality and reporting requirements as specified under 42 CFR§ 422.152 and all DHCS standards in accordance with Title 22, CCR, Section 53860 (d) and Title 42, USC, Section 1396a(30)(C) for quality performance reporting. Blue Shield Promise cooperates and assists the External Quality Review Organization (EQRO) contracted with the DHCS in the review process.

Blue Shield Promise uses data collection and analysis to track clinical issues that are relevant to our population. At a minimum, Blue Shield Promise will adopt and establish quantitative measures to assess performance and identify and prioritize areas for improvement.

Medi-Cal Managed Care Accountability Set (MCAS) and Health Plan Effectiveness Data and Information Set (HEDIS®)

Blue Shield Promise aligns improvement efforts to improve Health Plan Effectiveness Data and Information Set (HEDIS) measures with the Medi-Cal Managed Care Accountability Set (MCAS). Improvement projects are conducted in accordance with DHCS standards. Blue Shield Promise cooperates and assists the External Quality Review Organization (EQRO) in the review of quality outcomes and timeliness of services provided.

Quality Improvement Projects, Performance Improvement Projects, and Plan, Do, Study, and Act (PDSA) Projects

Blue Shield Promise conducts and/or participates in quality improvement projects (QIPs) in conjunction with DHCS, DMHC, and/or CMS on statewide or targeted collaboratives. The quality improvement projects with regulatory agencies are selected based on options provided to the participants. Other quality improvement projects are based on clinical measurement rate performance and all those that score below minimum performance levels (50th percentile based on national percentiles) will be an improvement project the next

year.

All quality improvement projects leverage standardized guidelines on preventive care, such as the American Academy of Pediatrics (AAP), Advisory Committee on Immunizations Practices, American College of Obstetrics and Gynecology, U. S. Preventive Services Task Force, and other nationally recognized sources as appropriate.

Financial Incentives

Blue Shield Promise ensures the provision of appropriate care that is consistent with professionally recognized standards of practice. Care is not withheld or delayed for any reason including potential gain and or incentive to the plan, providers, or employees. Blue Shield Promise does not exert economic pressure to cause institutions to grant privileges to healthcare providers that would not otherwise be granted, nor pressure healthcare providers or institutions to render care beyond the scope of their training or experience. All treatment decisions are rendered by appropriate clinical staff, void of any influence or oversight by the Finance Department. The Medical Director's responsibility to supervise medical management of the Plan's benefits is not influenced in any way by the Finance Department.

Blue Shield Promise annually distributes a statement to all providers and employees who make utilization management decisions affirming that there are no financial incentives or gains for utilization management decision makers to delay or withhold appropriate care.

Information Systems and Data Governance

Blue Shield Promise uses an array of data sources for claims, encounters, and eligibility data. The Information Technology (IT) organization is responsible for processing data from these sources and maintaining system integrity and data quality. The Enterprise Data Governance program establishes data governance policies, ensuring overall data quality and integrity.

All membership and medical claims are processed through the FACETS system. This is the ultimate source for data in these domains for all lines of business. The data then flows from FACETS to the Book of Record, then to Business Information Systems (BIS), which is the reporting database that is used by analytic staff to generate regular and ad-hoc reporting to business units.

The Clinical Quality Analytics team leverages BIS to feed the HEDIS analytics engine and works with Information Technology to remediate any upstream issues related to data quality.

Confidentiality and Information Security

Information is one of Blue Shield Promise's most valuable and essential assets. Handling it properly is critical to our success and protecting it is the responsibility of all staff. All Blue

Shield Promise employees, contracting providers, and Plan business associates are required to maintain the confidentiality of member information, medical records, peer review, and quality improvement records. All information used for quality improvement activities will be maintained as confidential in accordance with state and federal laws and regulations. External providers that participate in an advisory capacity on our Credentials, Peer Review, or similar committees, are required to sign a confidentiality statement annually, which allows for candid and objective discussion necessary for effective quality improvement.

Compliance with information security policies is mandatory and critical to Blue Shield Promise's success. Blue Shield Promise maintains information security policies and procedures designed to secure Blue Shield Promise's information assets and ensure compliance with regulatory, contractual and accreditation requirements.

Conflict-of-Interest

Blue Shield Promise administers a business ethics code ("the Code") to ensure that actual and potential conflicts of interest are avoided by employees, a contingent workforce (leased workers, independent contractors, and consultants) and members of the Board of Directors. The Code delineates the Company's conflict-of-interest policy.

A Conflict-of-Interest Disclosure Statement is signed on an annual basis and at the time of hire/service for all employees and members of the Board of Directors. A Conflict-of-Interest Disclosure Statement is signed by any contingent workforce at the time of engagement. As actual and potential conflicts of interest arise during the year, employees, contingent workforce, and members of the Board of Directors disclose such new information to the Corporate Compliance and Ethics Department by submitting a Conflict-of-Interest Questionnaire, available at the Corporate Compliance and Ethics website.

Appendix A – Organizational Structure
Appendix B - Quality Committee Structure
Appendix C – Quality Committee Responsibilities *(available upon request)*
Appendix D – Medi-Cal QI Staff *(available upon request)*
Appendix E – Dual Special Needs Plan Model of Care QI Measures