



2025 Quality Program Evaluation

Medi-Cal Los Angeles



EXECUTIVE SUMMARY

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

Blue Shield Promise's Quality Program goals and objectives support the vision and strategy that drive us toward achieving our long-term goals. The 2025 Quality Program Evaluation for Medi-Cal Los Angeles evaluates the detailed goals, objectives and activities for the year as delineated in the Quality Work Plan. Overarching goals and objectives are listed below.

The 2025 Quality Program Evaluation documents the annual review of the Quality Program and serves as the foundation for the ongoing Quality Improvement (QI) activities described in the 2026 Quality Program Description.

Goals & Objectives of the 2025 Quality Program:

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

2025 Outcomes and Accomplishments:

- Maintained NCQA Accreditation status for Medi-Cal.
- Projected to meet Measurement Year 2025 performance goals on DHCS Managed Care Accountability Set (MCAS) measures held to the 50th percentile Minimum Performance Level (MPL).
- New approaches and expansions to provider and member engagement yielded improvement in MCAS measure and Initial Health Appointment (IHA) outcomes.
- Meaningful improvements in data accuracy and system advancements allowed deeper quantitative analysis to assess member needs.

2025 Overall Barriers:

- Persistent gaps in timely clinical data and member information continue to constrain Quality and Health Equity initiatives.
- Limited access to accurate member information impact interventions that require outreach.

- Customer service saw slight performance declines towards year-end, including call abandonment and calls answered within 30 seconds, though member experience with health plan as evaluated through CAHPS improved slightly year over year.

2025 Opportunities and Outlook:

- Continue Quality data improvement initiatives and system enhancements to elevate strategic planning and execution for Quality and Health Equity initiatives.
- Improve accuracy of new enrollee data in support of interventions and initiatives that require member outreach.
- Continue exploration of Quality performance support through vendor, provider and community based organization partnerships.
- Continue to gather qualitative data through member focus groups as a mechanism to enhance the efficacy of Health Equity initiatives.
- Initiated a QI/Health Equity study on Emergency Department utilization to identify drivers of avoidable ED use and inform targeted interventions to improve equitable access to primary and preventive care (see Appendix: QI/HE Study – Emergency Department Utilization).

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OVERVIEW

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

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

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

Blue Shield Promise does not delegate any Quality Improvement (QI) or Health Equity (HE) functions as they relate to medical and behavioral services. All responsibilities related to the development, implementation, monitoring, and reporting of quality and health equity activities are maintained internally to ensure alignment with regulatory requirements and organizational standards.

Population

Blue Shield Promise served approximately 367,718 Medi-Cal members in Los Angeles County in 2025.

OVERALL EFFECTIVENESS OF THE PROGRAM

2025 Outcomes and Accomplishments

A. Quality of Clinical Care

- In 2025, Blue Shield Promise also continued to enhance tools that give visibility of quality performance at the provider level. These reports are refreshed monthly and contain summary performance information, monthly trends, year-over-year

comparisons, and a blind comparison to other contracted provider groups in the county for each measure. (p. 16)

- Blue Shield Promise increased the total amount of well child and mammography clinic days from 26 in 2024 to 72 in 2025. In 2025 our vendor expanded their mobile mammography capabilities, allowing for additional mammogram clinic days. (p. 16)
- In 2025, outreach efforts increased significantly by 48%, with over 127,000 members targeted, an increase of more than 41,000 from 2024 (86,000 members). More than 50,000 care gaps were closed in 2025, more than double the 24,000 closed in 2024, representing a 108% increase. (p. 32)
- In 2025, we developed and launched 9, member, incentive health equity mailers and emails for Well Child and Adolescent Visits. These mailers and emails were sent to 43k members. (p. 33)
- Conducted annual Primary Source Validation (PSV) on existing supplemental data submissions to validate the integrity of the data and resolve issues that would disqualify the data from official Measurement Year (MY) 2025 reporting. (p. 41)

B. Safety of Clinical Care

- The Credentialing Department continues to meet all credentialing timeframes, is compliant with regulatory guidelines, and reduced turnaround time from 60+ days to under 30 days for initial credentialing. (p. 53)
- A new leadership team for Clinical Quality Review (CQR) was established near the end of Q1 2025, with continued refinement as the year progressed. These dedicated CQR positions have resulted in increased stability for the team and provided an increased focus on improving current processes with particular emphasis on quality and efficiency. (p. 54)
- There was a notable increase in timely Initial Health Assessment (IHA) outreach because of coordinated efforts between the IHA coordinators and [REDACTED], with 99% of calls completed within the desired timeframe in Fiscal Year (FY) 2025, compared to 71% in FY 2024. (p. 58)
- There was a total of 156 completed Facility Site Review (FSR) and Medical Record Review (MRR) audits with an FSR average of 94% and an MRR average of 90%. The 2025 average shows an increase in performance over 2024. (p. 64)

C. Quality of Service

- Customer Service team met the goals for average speed of answer and abandonment rate in 2025. (p. 79)
- In 2025, the Delegation Oversight teams conducted 100% of annual delegate audits timely, ensuring those delegated entities that fell below the thresholds were put on a corrective action plan (CAP) and followed to closure. (p. 82)
- In 2025 all delegated entities met 90% - 100% timely reporting. (p. 83)

D. Member Experience

- Adult CAHPS rating of Health Plan increased from 80.9% (2024) to 81.9% (2025), exceeded the NCQA benchmark of 77.7%, and resulted in the goal being met. (p. 87)
- All goals were met for both Appeals and Complaints for Medi-Cal Los Angeles (p. 98)
- In 2025, Blue Shield Promise continued to conduct “Member Check-in,” where 6 full-time call representatives’ outreach to Medi-Cal members to assist with access to plan benefits, providing information, assisting with appointments, understanding and resolving specialty referrals, etc. (p. 100)
- Blue Shield Promise continues to enhance the “Find a Doctor” tool allowing members to easily find providers based on the member preferences. This technology continues to be enhanced to ensure member useability and accessibility. (p. 100)

E. Provider Engagement and Experience

- In MY 2024, our HEDIS goal was met in Los Angeles County (measures hitting the 50th percentile and year-over-year improvement). Notably, 8 measures were at or above the 75th percentile – each of which were included in the Promise Quality Performance Incentive Program. (p. 106)
- Overall, the HEDIS MCAS Minimum Performance Level measures have improved over the last few measurement years (the majority at or above the 50th percentile) as it relates to Provider Incentive Programs. (p. 108)
- In 2024, the IHA program captured 36,058 IHA closures, 22,331 (62%) were timely, and have seen great year-over-year improvement in IHA volume and timely closures as it relates to Provider Incentive Programs. (p. 111)

Barriers and Opportunities for the 2025 Quality Program

- Comparison of Promise internal HEDIS rates generated by our certified HEDIS software vendor (Inovalon) to L.A. Care HEDIS rates revealed differences in number of members in denominators for multiple measures. Accurate member eligibility for the measure is important to identify members with gaps in care and Blue Shield continues to work with L.A. Care to reconcile the differences.
- Analysis of multiple HEDIS measures for data reconciliation purposes reinforced the need for clinic-level data for robust analysis of gaps in care. Blue Shield Promise continues to progress in this area and now has clinic-level data for some IPAs.
- The HEDIS outreach team experienced challenges as a significant number (an estimated 30%) of members had incorrect phone numbers.
- Enhancing the accuracy of new enrollment data to prevent incomplete or incorrect member contact information from impeding all member outreach efforts.
- Smaller labs that Blue Shield Promise is contracted with do not have the capability to submit electronic files with the lab results, or have data-sharing agreements, which contribute to HEDIS compliance.
- Clinical Quality Review (CQR) experienced delays related to processes that can slow processes down for clinical oversight and CQR investigations.

- Customer Service experienced increased call abandonment rates, a decline in the percentage of calls answered within 30 seconds, and overall performance deterioration toward the end of 2025.

2025 Program Objectives and Goals

The Blue Shield Promise 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 10 of 18 DHCS Managed Care Accountability Set 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 that quality improvement program goals align with the goals and priorities of the Department of Healthcare Services (DHCS).
- Utilize a system or process to maintain and improve quality-of-care in Medicaid-based services for Dual-eligible members.
- Monitor, evaluate and take action to improve the quality of care delivered to Seniors and People with Disabilities (SPD).
- Address all aspects of care; including behavioral health, non-emergency medical transportation, and Long-term Services and Supports (LTSS).
- Ensure adequate clinical resources are in place to administer the Quality Program; including a full-time Chief Medical Officer/Director whose responsibility is direct involvement in the implementation of the Quality Improvement activities in accordance with Title 22 CCR Section 53857.

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

Objectives:

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

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

Objectives:

- Assess and meet the standards for the cultural and linguistic needs of our members.
- Ensure languages spoken by at least 1% of our membership or 200 individuals, whichever is less, are identified and reviewed against the languages spoken by our provider network with the goal of addressing disparities.

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

Assessment of Quality Program Resources and Committee Structure

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

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

Blue Shield Promise maintained the quality committee structure throughout 2025, including network provider participation in a variety of subcommittees. The Quality Oversight Committee (QOC) is charged with the oversight, strategic direction, prioritization, and coordination of the quality program across all product lines. The QOC reports to the Board Quality Improvement Committee (BQIC) and is chaired by the Senior Vice President and Chief Health Officer. The QOC continued with a quarterly cadence and with ad-hoc meetings as needed.

Quality Improvement Program and Structure

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

recommends corrective action, and informs educational opportunities for providers to improve health outcomes.

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

QUALITY OF CLINICAL CARE

Medi-Cal HEDIS Results

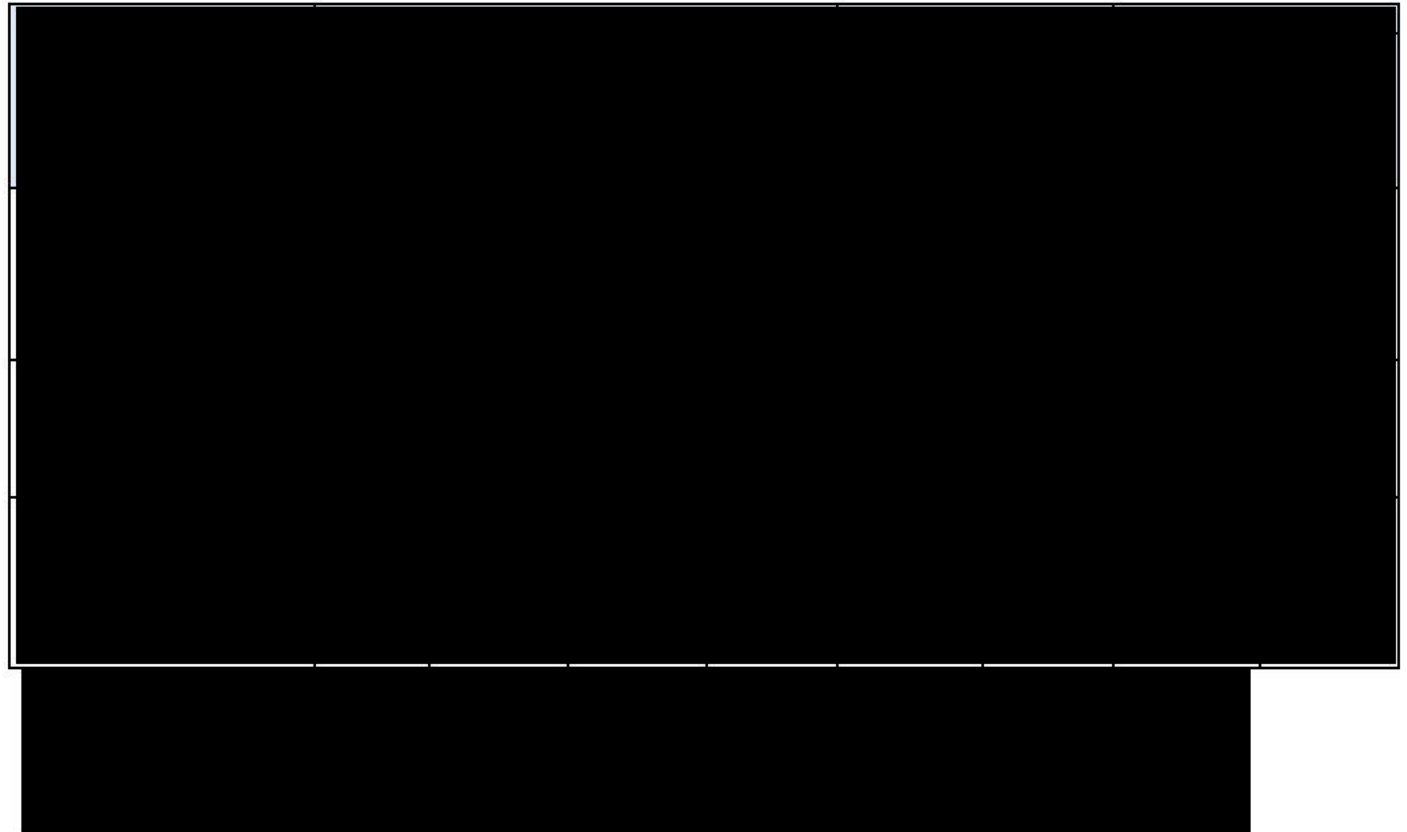
The table below displays Blue Shield Promise's performance in Los Angeles County on measures from the Managed Care Accountability Set (MCAS) selected by the California Department of Healthcare Services (DHCS). A subset of MCAS measures are held to a Minimum Performance Level (MPL). The MPL is the 50th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

For Measurement Year (MY) 2025/Reporting Year (RY) 2026, Blue Shield Promise's goal is to meet or exceed the 50th percentile for MCAS measures held to the MPL. We are also continuing to focus on NCQA star rating improvement over time. Blue Shield Promise's current and past performance rates are in the table displayed below. Bold rates indicate the 50th percentile has been met.

Below are the results (pending) of MY 2025 MCAS rates and QC percentiles. MY 2024 and MY 2023 performance are included for reference:

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Quantitative Analysis

For Los Angeles, there are 18 Managed Care Accountability Set (MCAS) measures that are held to the minimum performance level (MPL) set at the 50th percentile. Ten MCAS measures are predicted to meet or exceed the NQCA Quality Compass 50th percentile. Measures that are predicted to meet or exceed the 50th percentile in 2025 are listed below:

Note: Final rates for Measurement Year 2025 are expected to be released around June 2026. The measures listed below are predicted to meet or exceed the 50th percentile in 2025.

- a) Childhood Immunization Status – Combination 10
- b) Developmental Screening in the First Three Years of Life
- c) Immunizations for Adolescents – Combination 2 Immunizations
- d) Topical Fluoride in Children
- e) Breast Cancer Screening
- f) Cervical Cancer Screening
- g) Chlamydia Screening in Women
- h) Prenatal and Postpartum Care – Postpartum Care
- i) Prenatal and Postpartum Care – Timeliness of Prenatal Care
- j) Glycemic Status Assessment for Patients with Diabetes <9%

Accomplishments and Trends in Performance

1. **Enhancements to Performance Monitoring Tools:** In 2025, we continued to enhance various tools that were leveraged for targeting outreach efforts and for comparing provider group performance for prioritization of measures and groups to focus efforts. For instance, we incorporated graphs that plot out a provider group's overall performance based on size, improvement, and the number of measures on pace to reach the minimum performance level administratively. This feature allows the provider group to see how their performance compares to their peers throughout the measurement year. We also continued to enhance tools that give us visibility of quality performance at the provider level. These reports are refreshed monthly and contain summary performance information, monthly trends, year-over-year comparisons, and a blind comparison to other contracted provider groups in the county for each measure. In addition, we continued to enhance our [REDACTED] dashboards that contain heat maps displaying the zip codes and areas with open care gaps for each measure, provider performance and race/ethnicity information. We used these tools to target certain areas of Los Angeles County to launch various types of interventions, targeting specific populations. We continue to receive positive feedback from our provider groups regarding these tools.
2. **Revamping of Provider Incentive Programs:** We continued our Quarter 2, Quarter 3, and Quarter 4 care gap closure incentive programs, making slight changes to correlate to our 2025 needs and objectives. These incentive programs reward our provider groups financially for care gap closures within the specified timeframe and per quarter. Compliant gap closures can be achieved through claims, encounters, or supplemental data.
3. **Well Child and Mobile Mammography Community Clinic Days:** We increased the total amount of well child and mammography clinic days from 26 in 2024 to 72 in 2025. In 2025 our vendor expanded their mobile mammography capabilities, allowing for additional mammogram clinic days. We also continued providing point of care incentives at events, and improved giveaways, which were positively received by members. We also created themes for our well child clinics to create a fun, family-friendly environment, and included toys as giveaways for the kids. Lastly, we started hosting clinics on certain federal holidays, when schools were closed, to further enhance member engagement at clinic events.
4. **Strengthened Provider Engagement:** In 2025, more time was dedicated to developing relationships with our lower performing provider groups that have a significant impact on our overall performance at the county level. We identified these provider groups utilizing our Providing Ranking tool. We met monthly, sometimes more than once, with the provider group's Quality leadership team with the aim of gaining access to the provider's office for tailored improvement training.
5. **Cross-functional Workgroups:** Successfully initiated and led cross-functional workgroups to effectively socialize and advance the DHCS Bold Goals. The Clinical

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

6. **Focus Groups.** Launched 12 health equity focused member focus groups with Medi-Cal consumers to examine the factors and barriers in adhering to preventive care during the pregnancy journey and early childhood. In partnership with the Market Research internal team, the Clinical Quality department obtained member feedback to inform quality strategy, health equity interventions, and program design. Due to the focus groups, we have modified some member incentives related to pediatric incentives, tailored mailings, and shared findings with leadership and cross-functional teams.

Qualitative Analysis

Many factors influence HEDIS performance. One of the biggest impacts to HEDIS scores is data completeness and accuracy. How data is captured, reported, and communicated across platforms and between entities is a vital component to a successful Quality program. Other major barriers and mitigation plans included in the table below:

PLAN BARRIER		
Barrier	Cause	Reason/Effect/Mitigation Plan
Data Reconciliation with L.A. Care (Regulator)	Multiple data sources and ingestion issues	Comparison of Promise internal HEDIS rates generated by our certified HEDIS software vendor to L.A. Care HEDIS rates revealed differences in number of members in denominators for multiple measures. The Blue Shield Promise Clinical Quality Analytics department investigated possible causes of differing rates. Blue Shield Promise started an ongoing communication with L.A. Care providing examples of our discrepancies to L.A. Care's HEDIS team to investigate the root cause. Accurate member eligibility for the measure is important to identify members with gaps in care, and we

		continue to work with L.A. Care to reconcile the differences. Mitigation Plan: Quality data analysts from LA Care and Blue Shield Promise formed a workgroup to meet on a monthly cadence, or ad-hoc, as the need arises, to develop and enact a member level reconciliation process throughout the measurement year.
Lack of clinic-level data for member care gap analysis	Promise does not have data at the clinic level in Los Angeles County	To aid providers more effectively in outreach to members with gaps in care, Blue Shield Promise requires data at the clinic level for Los Angeles County. Currently, Blue Shield Promise distributes reports on member gaps in care at the Independent Physician Association (IPA) level. Analysis of multiple measures for data reconciliation purposes mentioned above reinforced the need for clinic-level data for robust analysis of gaps in care. We are progressing in this area and now have clinic-level data for some IPAs. Mitigation Plan: The Quality department has developed a tool that makes it possible to manually produce scorecards and member gap lists at various levels: by provider, by groups of individual providers, or by address.
Inaccurate member contact information	Members do not update changes to their contact information with the State	Difficulty outreaching to members to schedule appointments, with an estimated 30% of phone numbers incorrect. Mitigation Plan:

		Partner with providers to identify additional contact information or newly updated contact information.
PROVIDER/GROUP BARRIERS		
Barrier	Cause	Reason/Effect
Data Submission	Labs	Smaller labs that Blue Shield Promise is contracted with do not have the capability to submit electronic files with the lab results. No data sharing agreements with smaller labs to receive lab results. Independent Physician Association (IPAs) and Physician Provider Group (PPGs) submit claims and encounter data to the health plan but very few of them submit lab results to Blue Shield Promise. Identifying member information in the lab data is sometimes challenging. Labs can use different patient identifiers and are not consistently entering the data in the correct field. In addition, payer codes are sometimes not maintained so the labs are not sending all data. Mitigation Plan: We are currently working with all contracted labs to collect complete data on labs rendered for members. We have also gained access to certain lab vendors' portals to search for missing lab results.
Medical Record Review	Incomplete provider documentation	Some of the measures are missing all components and/or full record of previous tests and/or complete results. Mitigation Plan:

		Continue to work with providers to educate them on documentation requirements for HEDIS measures.
Continuity and Coordination of Care	Lack of coordination between PCPs and specialty providers	Primary Care Providers (PCPs) do not always get reports back from Specialists and ancillary care providers after referrals. Reports from labs and radiology centers are not always received by the PCPs. During the medical record review process, there was evidence that a lab was ordered but there was no result in the record despite encounter data showing that the lab was completed as ordered. Increased coordination and communication are needed between departments and teams that interact regularly with providers and/or plans to help support and/or drive efficient issue resolution. Lack of coordination of care between primary care providers and dental homes. Mitigation Plan: We are currently working with all contracted labs to ensure that data is complete with lab results after labs are rendered. Additionally, we are working with dental homes and primary care providers to coordinate primary care and dental care information, specifically around the area of topical fluoride.
MEMBER BARRIERS		

Barrier	Cause	Reason/Effect
Service gap	Social Determinants of Health Family and financial obligations	Decreased parent/member participation due to socio-economic and cultural factors. Meeting basic daily needs often takes precedence over a routine/preventive visit. Visits to Out of Network Providers for convenience. Cultural beliefs. Transportation: limited and/or difficulty navigating the system and scheduling. Geographic: Distance to receive services and availability of appointment times/clinic hours. Language and communication: Some members do not have reliable access to phone or TDD/TTY services. Education: varying levels of knowledge/understanding. Behavioral co-morbidities Housing instability. Members are unwilling to complete a well women exam with providers they are unfamiliar with. Mitigation Plan: We have implemented many interventions to help mitigate these barriers to care. Some of these interventions include, but are not limited to transportation resources, interpretation services, additional access points to seek

		care, member incentives, and conducted focus groups to identify additional solutions, conducted outreach to provide education.
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2025 Quality Improvement Interventions

Quality Improvement and Health Equity Study: Emergency Department Utilization

Blue Shield Promise initiated a Quality Improvement and Health Equity (QI/HE) study to further evaluate patterns of Emergency Department (ED) utilization among Medi-Cal members (see Appendix: QI/HE Study – Emergency Department Utilization). This study builds on prior findings that identified gaps in preventive and ambulatory care engagement, with over 40% of members not utilizing recommended preventive services and disparities observed across key demographic groups.

The purpose of this study is to assess ED utilization in relation to access to Primary Care Providers (PCPs) and behavioral health services, and to identify drivers of potentially avoidable ED visits. The analysis focuses on understanding disparities in utilization and barriers to accessing appropriate levels of care, including primary care, urgent care, and outpatient services.

Preliminary findings and existing evidence indicate that ED utilization is influenced by multiple factors, including limited access to primary care, appointment availability, transportation barriers, language access, and social determinants of health. The study emphasizes the importance of evaluating these structural and systemic drivers to inform targeted interventions and avoid misclassification of utilization patterns.

The study includes a retrospective analysis of utilization patterns over a one-year period, examining ED visit rates, high-frequency utilization, and differences in ED versus PCP engagement. Stratified analyses will assess variation across race/ethnicity, language, age, gender, disability status, and geography to identify populations with disproportionate utilization.

Findings from this study will inform the development of targeted interventions aimed at improving access to primary and preventive care, strengthening care coordination, and reducing avoidable ED utilization. This work aligns with Blue Shield Promise’s broader Quality Program goals to improve access, enhance member outcomes, and advance health equity.

The table below displays 2025 interventions and the barriers the intervention addresses. Additional QI member and provider engagement initiatives are discussed in more detail in the next section.

Intervention Description	Barrier Addressed
Quality Provider Engagement: In 2025, our tiering system for Medi-Cal providers was continued which allows us to further stratify our provider interventions. Providers were tiered based on their membership size and quality performance. Provider group quality management and provider office staff were educated on HEDIS, improved quality of care strategies, care gaps within their membership, and coding education. The Quality Interventions team also worked with providers and provider office staff to address barriers and opportunities to create specific, targeted interventions to improve their care outcomes.	Data Gap Medical Record Review Access to Records Gaps in encounter data submission Access to Care Improper documentation and Coding
Clinical Action Registry (CAR) reports were shared with provider groups monthly. The CAR reports contain provider group performance on various HEDIS and quality metrics along with member level detail on measure compliance. The member-level reports also allowed provider groups to identify if there were data discrepancies (due to coding, file transfers, or documentation), to work with us to identify the cause, and to prevent the issues going forward. The Quality Interventions team worked with provider groups to collect supplemental data throughout the year to ensure that all the services rendered are captured.	Providers are not aware of their performance Engaging Physician Provider Group (PPGs)/ Independent Physician's Association (IPAs) and PCPs to improve quality.
Individual Plan Partner joint operation meetings (JOM) with LA Care began in April of 2024 and continued through 2025. These meetings aided in aligning targeted actions on specific intervention and data needs.	Streamlining quality interventions and improving the integrity of our data exchanges with our plan partner to encourage a stronger collaborative spirit and sharing of best practices.
Blue Shield Promise participates in the Maternal and Child Health Workgroup led by plan partner L.A. Care, attends webinars held by L.A. Care for provider education, and participates in work groups for co-branded Plan Partner collateral development.	Provider education and communication regarding HEDIS measures, service provision, available incentives, and mandates

Intervention Description	Barrier Addressed
Blue Shield Promise participates in a workgroup focused on improving rates for the HEDIS measure, Well-Child Visits for the First 30 months of life. This workgroup is led by plan partner L.A. Care, who developed reports to identify the number of visits each infant had to date. This improvement allowed provider groups to prioritize outreach based on members closest to reaching compliance.	Provider education and communication regarding HEDIS measure requirements.
Supplemental Data Exchange: Increased the number of providers, groups, and/or Management Services Organizations (MSOs) providing clinical reports in the Blue Shield Promise layout to ensure correct identification of all Blue Shield Promise members and reporting of clinical data not otherwise reported or possibly lost in regular encounter files and/or claims. This provided better opportunities for: 1. Closing data gaps related to members and services 2. More appropriate outreach to members 3. Greater cooperation with groups on planning and actions	Gaps in encounter data submission
In 2025, we continued our collaboration with the Blue Shield Promise Community and Provider Engagement (CAPE) department to incorporate our gap closure outreach with their community-building endeavors. The CAPE team dedicated staff to outreach households with care gaps that were already part of their community building outreach efforts. Households nearest to their Community Resource Centers were prioritized. In 2025, one additional Community Resource Center was opened in a new location.	Care Gaps: member outreach to improve rates and quality of care Community Education: educating members on the resources available in their community

QI Initiatives – Member and Provider Outreach Campaigns

In 2025, the Clinical Quality department initiated both new and ongoing outreach campaigns. The following sections present a detailed overview of each initiative, including key outcomes, accomplishments, challenges encountered, and strategies for further improvement in 2026.

A. Mobile Mammography Unit

Blue Shield Promise reviewed data that indicated there were unmet healthcare needs related to breast cancer screening. Use of mobile mammography units engages women in screening for breast health to support cancer prevention services.

Methodology

Using a mobile mammography unit provides accessible breast health services to Blue Shield Promise members by reducing traditional barriers to access (i.e., transportation, time constraints, distrust of health care system) and for Provider Groups to improve Breast Cancer Screening rates identified within the HEDIS Domains of Care. It also offers visibility, accessibility, informal settings, familiar environments, and connections for members. The anticipated outcomes are: (1) For women to use a mobile mammography unit as an option for their primary source of medical care for breast cancer screening (2) Initiate preventive care (3) Enable member self-efficacy and (4) Advancing population health.

Quantitative and Qualitative Analysis

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

In 2025, a total of 27 mobile mammography clinic days were held at various provider group locations, LA Care co-managed Community Resource Centers, and the Blue Shield Promise Information Resource Center. This is an increase from 17 mobile mammogram days held in 2024. Events took place January – December 2025. In total, there were 1,284 mammogram appointments scheduled, and 581 members screened. In 2024 there were 957 members scheduled and 364 members screened at mobile mammogram events. In 2025, we scheduled and screened significantly more members than in 2024.

Barriers

We encountered environmental and operational challenges that affected the results of the program. We had trouble reaching members to schedule appointments due to wrong phone numbers, being on a Do Not Call list, voicemail being full, and phone numbers being inactive. In addition, we had members state they did not want to leave their home because they were afraid of Immigration and Customs Enforcement (ICE). We also had issues with the changes to transportation services. Beginning in 2025, members were no longer able to receive same-day transportation to their appointment, which caused delays to members attending their appointment or same day cancellations due to no transportation. We were able to work with the department that manages the transportation benefits vendor for a solution, and this issue was resolved in Q2.

Plans for 2026

In 2026, we are offering mammogram clinics on weekends to better accommodate member parents who work during the weekdays or need childcare. In addition, we are ensuring that transportation for members is scheduled 24 hours in advance. We are also offering combined mammogram and well child clinics to identify and close gaps for any mothers who may need to complete their mammogram.

B. Well Child Clinic Days

Blue Shield Promise partnered with a vendor to conduct well child clinic days across the county. The vendor focused on well child visits, developmental screenings, lead testing and fluoride varnish applications for all children ages 0-21. These events were held at various Community Resource Center (CRC) locations across the county.

Methodology

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

With support from the members' PCP, members in need of their well-care visit were outreached telephonically and offered the opportunity to schedule their well-care visit on a selected date at a Blue Shield Promise Resource Center. Strategic locations were secured to provide well-care visits for members able to come in for their scheduled annual well-care visit. The events were held mostly on a Saturday to provide access for many families who were unable to access their PCP during regular office hours. In addition to the care the members received, these events provided the opportunity to educate the members on the importance of preventive care and to encourage follow-up visits with their PCP.

C. Mini Clinics

To address the decline in well-child visit (WCV) completions resulting from the discontinuation of telehealth services, mini clinics were implemented alongside our regular clinics. These mini clinics were designed to provide additional appointment opportunities for families. Each clinic was staffed by one provider, one medical assistant, and one Blue Shield Promise staff member. We implemented mini clinics across five community resource centers in Los Angeles County through Q3 and Q4 2025.

Quantitative and Qualitative Analysis

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

In 2025, there were 45 Well Child Clinic Days at various LA Care co-managed Community Resource Centers. This is an increase from 9 Well Child Clinic Days held in 2024. Events took place January 2025 – December 2025. In 2024 we held events for a shorter period, June – October. In total, there were 6,552 members scheduled for these events and 2,720 members completed their exams. In 2024 there were 1,494 members scheduled and 599 members screened at well child clinic days. In 2025, we scheduled and screened significantly more members than in 2024.

By December 31, 2025, 3,519 members received well-care visits through regular and mini clinics in the community. In the short time that mini clinics operated in 2025, 799 members received a well-care visit at our mini clinics, showcasing the success of mini clinics.

Barriers

Valid contact information remains the key barrier to keeping events like these from benefiting an even larger number of members. We also experienced a huge decline in scheduling and completion rates due to the political environment. Many members expressed concerns for their family and fear of leaving their home. We had families of members who stopped at CRC locations to make sure the clinic was legitimate and ICE was not in the area.

Plans for 2026

In 2026, we are fully integrating our mini clinic pilot and starting mini clinics earlier in the year. We have also increased the number of clinics within the county and have added clinics in the evening to accommodate kids who are in school and parents who work.

D. Asthma and Behavioral Health Outreach

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

Methodology:

To support timely follow-up care for members who had an emergency department (ED) visit for mental illness or substance use, daily Admit, Discharge, and Transfer (ADT) reports were used to identify members who have visited the emergency department (ED) due to substance use, drug overdose, mental illness, or intentional self-harm. In 2025, another data source, the Continuity of Care Document (CCD) reports, was included to identify eligible members. The ADT reports include the service level and primary diagnosis code and/or description for the member's visit. These identifying fields enabled Quality to identify ED visits with the primary diagnosis as mental illness, intentional self-harm, substance use, or unintentional drug overdose. Reports were generated to identify members with these specific diagnoses and provided to the vendor at least three times a week.

The vendor used the member list for outreach, including at least three phone call attempts, to book telehealth visits with members, ideally within 30 days of the ED visit. The vendor leveraged mid-level practitioners with behavioral health experience to conduct the telehealth visits, administer standardized screenings for substance use and mental illness, administer social needs screenings, and appropriately refer members for Enhanced Care Management (ECM) services. Following the visit, the vendor electronically shared information with the member's assigned PCP.

The vendor also employed telehealth visits to support members diagnosed with Asthma, who had an ED or acute inpatient stay for Asthma. Claims and Pharmacy data were employed to identify non-compliant members within the HEDIS Asthma Medication Ratio (AMR) eligible population who met criteria for Asthma Remediation Services, including an Asthma diagnosis (based on the HEDIS AMR technical specifications) and an ED visit or acute inpatient stay for Asthma. The Clinical Quality Analytics team generated the member list monthly. During the telehealth visit, the vendor discussed the importance of appropriately filling controller medications and appropriately informed and referred members for Asthma Remediation Services. Among members who accepted Asthma Remediation Services, the vendor completed the online Community Supports Referral form and submitted attestation letters to the Promise Community Supports team to initiate the remediation service process. In August 2025, the inclusion criteria were expanded to include members with AMR ratios between 0 to 0.49 and still eligible for asthma remediation services. In September 2025, the inclusion criteria were further expanded to include members diagnosed with Asthma but may not have had an ED visit or acute inpatient stay for asthma. The intent of these changes was to identify more non-compliant members to broadly support members who are prescribed these medications.

Quantitative and Qualitative Analysis

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

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

Given the primary objective was to achieve timely follow-up visits with members who had ED visits for mental illness and substance use, booking appointments was essential to the primary objective. Additionally, completing or attending the visit is the second main performance measure because completing the visit met numerator criteria for the two behavioral health HEDIS measures. The vendor performance reports showed that between January – December 2025, 398 members were identified for outreach from the ADT and CCD reports. This is a slight decrease from the 413 members who were identified in 2024. This is due to the technical challenges in receiving the ADT reports timely, and more systemic challenges in receiving complete ADT data from participating hospital facilities. Among the 398 members, 80 members had booked appointments, yielding a 20% connection rate. This connection rate was also lower than the 25% (105/413) connection rate in 2024. Among the 80 members with appointments booked 83% (66/80) completed their visits. This is higher than the 77% (81/105) completion rate from 2024. Given that visits with the vendor meet numerator criteria, it is critical that the completion rate remains high or shows directional improvement.

In 2025, performance was measured through the same indicators because booking and completing visits was essential to assessing and referring the member for Asthma Remediation Services. The telehealth visit provided the vendor with the information and feedback necessary to initiate the Asthma Remediation Referral process, including submitting the provider's attestation. In 2025, there were 650 eligible members identified for outreach in Los Angeles County, which is a large increase from the 146 eligible members identified in 2024. Twenty-two percent (144/650) of eligible members booked appointments, which is a lower connection rate/appointment penetration rate from 2024. In 2024, the connection rate was slightly higher at 24% (35/146). Among the 144 members who booked appointments, 70% of members completed visits (101 out of 144). The appointment completion rate at 70% in 2025 was lower than the 80% appointment completion rate (28/35) in 2024. However, given the large increase of members due to expanding the inclusion criteria, a much larger number of members booked and completed appointments. Because another internal team, the Population Health Management team, manages the Community Service for Asthma Remediation, we will continue to partner with this team to monitor the successful referrals and utilization of Asthma Remediation Services.

Barriers

For both programs, lack of valid phone numbers remains a key barrier to reaching members and booking appointments. Additionally, for timely follow-up care for members who had an ED visit for mental illness or substance use, there were internal data challenges that impacted the ADT reports. These challenges resulted in no ADT report distribution during some periods, or incomplete data in subsequent ADT reports. Ultimately, there was a large decrease in identifying potential eligible members. Additionally, the prior barrier identified where a large percentage of members identified with an ED visit from the ADT reports do not meet denominator criteria for the HEDIS measures, "Follow-Up After Emergency Department Visit for Mental Illness," or "Follow-Up After Emergency Department Visit for Substance Use," and

remained a challenge. A solution was implemented to incorporate CCD data and reports. However, the data challenges also impacted the distribution of the CCD reports.

Plans for 2026

We will explore piloting outreach to members who had an ED visit based on the ADT reports, but the primary diagnosis for the ED visit remains blank. This exploration is to address the discrepancy in the diagnosis, or lack thereof, in the ADT report and the member's final eligibility for the HEDIS measures, "Follow-Up After Emergency Department Visit for Mental Illness," or "Follow-Up After Emergency Department Visit for Substance Use." This pilot may help to identify members who initially have a blank diagnosis for the ED visit on the ADT reports and may have the ED visit related to substance use or mental illness based on the final claim.

To address the lack of valid phone numbers and declining appointment penetration rates, we will examine potential partnerships with the Social Services team to determine if there is an opportunity to leverage Community Health Workers for outreach and navigation services.

E. Health Navigator

For this program, a dedicated Blue Shield Promise Health Navigator (1 FTE) is placed at a specific clinic or IPA location to conduct outreach to members to support appointment scheduling, health education, identify missing compliant data and other Promise specific intervention implementation and oversight. Health navigators are located at IPAs and assist the IPA with improving compliance rates among Managed Care Accountability Set (MCAS) measures that are held to the minimum performance level (MPL) by the Department of Health Care Services (DHCS).

Methodology

The initiative's goal is to improve patient outcomes through member outreach and engagement and to reach the minimum performance level (MPL), or better, across the MCAS Measure Set.

Quantitative and Qualitative Analysis:

The program began as a pilot with an IPA in Los Angeles County during the fourth quarter of 2022. In 2023, Blue Shield Promise expanded its health navigator program to include more provider groups in Los Angeles. By 2025, there were eight health navigators working in the county, scheduling appointments for four different IPAs. These navigators help members understand the importance of wellness visits, explain the preventive measures offered by providers, and share information about telehealth options for certain types of appointments. Overall, across eight health navigators, there were 16,291 members touched (i.e., reached a member or left a message with the member). There were 619 care gaps closed within IPAs for members that were included in the outreach. The volume of care gaps closed is expected to

increase when data is finalized. On average, IPAs with at least one Health Navigator improved by 4.5% per focus measure.

Barriers

The LA health navigators began their roles mid-year because of the hiring and onboarding process, except for one IPA's navigator who started outreach earlier. This delayed initiation led to fewer members being reached during the initial months of 2025 which ultimately slowed progress toward outreach targets. Because the health navigator is employed by the FQHC, the MSO, or IPA, there is a risk of the employer allowing the Blue Shield Promise funded health navigator to focus on other activities and aiding other departments instead of Blue Shield Promise members. In 2025, there were clinical staffing shortages that led to decreased appointment availability at some locations. Health navigators continued to experience barriers in reaching members due to incorrect contact information. In addition, employee retention proved to be difficult in the health care industry.

Plans for 2026

In 2026, health navigator templates are being redesigned to reflect feedback from the end users and their leadership. Updates include streamlining format, identifying and removing duplicative member information, and delineating data according to roles and responsibilities. In 2026 a data integration tool will be implemented to enable health navigators to generate outreach lists and submit compliant records through the platform.

Communication is also being enhanced by including additional project managers whose work touches IPAs who receive health navigator support. Project artifacts, such as meeting agendas and summaries, will be created, shared, and approved in alignment with meeting schedules. In addition, to improve outcomes and maximize resources, Blue Shield Promise will increase oversight regarding targeted measures as priorities change throughout the year and use a data integration tool for additional data acquisition, chart review, and abstraction automation.

F. HEDIS Member Outreach

The Blue Shield Promise Medi-Cal member outreach team conducts outreach calls to Medi-Cal members with care gaps. The outreach campaign launched in January 2025 and continued through December 2025, with the outreach team performing daily call attempts.

Methodology

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

medical records for services that were previously rendered, and remind members of flu vaccinations if applicable.

Quantitative and Qualitative Analysis:

In 2025, outreach efforts increased significantly by 48%, with over 127,000 members targeted, an increase of more than 41,000 from 2024 (86,000 members). More than 50,000 care gaps were closed in 2025, more than double the 24,000 closed in 2024, representing a 108% increase. In addition, 1,836 appointments were scheduled directly by the team, an increase of 899 from the 937 scheduled in 2024. Together, these gains demonstrate a strong year-over-year improvement in outreach performance across Los Angeles County.

Barriers

The HEDIS outreach team experienced several challenges in reaching members, as a significant amount had incorrect or missing phone numbers, disconnected, or did not answer outreach calls, accounting for approximately 23% of the population for both counties. Limited appointment availability at provider offices also affected scheduling success. A major unforeseen barrier that occurred early in the year, fires in Altadena and Pacific Palisades, impacted 1,529 LA child members. In response, the HEDIS team conducted outreach to members in the affected zip codes to check on their safety and identify any immediate needs. An additional barrier involved members declining assistance due to community safety concerns related to ICE raids; fewer than 50 members across both counties specifically cited this reason.

Plans for 2026

Early outreach efforts were launched to promote 2026 well-child visits. During the first week January 2026, outreach lists with 31,653 members were created, with a focus on prioritizing well-child and immunization appointments within Los Angeles County.

G. Member Incentives

The Blue Shield Promise “My Wellness Rewards” Member Incentive Program is aimed to improve the quality of care for Promise members by incentivizing them to complete needed preventive care and screenings. The goals of this incentive program are to improve MCAS quality scores, motivate members to schedule appointments, complete target health care activities, and increase member satisfaction and health plan loyalty. Blue Shield Promise has contracted with a vendor to implement the incentive program. Target members can receive rewards for completing the following health care activities: Well Child Infant Visits, Well Child Annual Checkups, Cervical Cancer Screening, Breast Cancer Screening, A1c Testing (Q4 only), Blood Lead Screening, Immunizations for Adolescents, Flu Vaccine (ages 6 months – 2 years old), and HPV Vaccine (ages 9 to 12).

Methodology

The My Wellness Rewards Program is an omni-channel program (mail, email, digital site) that allows members to redeem their rewards. Members are first informed about the My Wellness Rewards Program and invited to register online for the program via mail. Once the member creates an account, they can view their available health actions and corresponding incentives for completing them. Once the member has completed their health action they can attest to the completed activity through their online portal and choose a reward to redeem. Throughout the year, members are sent mail and emails to encourage them to complete their health care activities and redeem their incentive by the end of the program on December 31, 2025.

In 2025, we launched the auto fulfillment incentive process with our incentive vendor. The auto fulfillment process allows us to bypass the need for member attestation and automatically redeem and mail incentives to members with identified gap closures from select outreach programs. QI member engagement programs that utilized auto fulfillment for completed care gaps were mini clinics and Postpartum and Prenatal incentive mailers.

Quantitative and Qualitative Analysis

The program was launched in April 2025 and ended December 31, 2025. Members have until February 28, 2026, to redeem gift cards for health care activities completed in 2025. In 2025, 237,927 health care activities were targeted, and a total of 3,104 incentives were distributed for completed activities.

The program's overall utilization declined from 1.54% in 2024 to 1.30% in 2025. This reduction is partly due to a rise in members receiving point-of-care incentives, which increased from 860 in 2024 to 1,572 in 2025. Members who received incentives at the point of care were not eligible to receive another incentive for the same service through the My Wellness Rewards program member portal.

Program improvements were made in 2025. Communications expanded in 2025, with 39 mailers and emails sent to date, representing an increase from 11 mailers and mails distributed in 2024. In 2025, we developed and launched 9 member incentive health equity mailers and emails for Well Child and Adolescent Visit members. These mailers and emails were sent to 43k members. 6,393 African American 3 to 21-year-old members noncompliant for this Well Child and Adolescent Visit HEDIS measure were included in the mail outreach.

Barriers

In 2025, we experienced several issues and barriers that affected the impact of this program. Some barriers include:

- Platform and Access Issues: instability of the member portal, members from auto fulfillment files missing incentive redemptions
- Member Experience: Poor roll out of launch of multifactor authentication resulting in

- challenges for members during login
- Communication and Transparency Barriers: Inconsistent communication on outages or program changes, delayed responses to issues and inquiries, and inadequate oversight of subcontractors

Plans for 2026

We are revising our list of incentivized measures and health-related actions for the 2026 program based on past performance and to better align with Quality priorities. In 2026, the Well Child Visit 0–15 Months and Well Child Visit 15–30 Months measures will be removed, as these measures have historically shown lower performance in the My Wellness Reward Program and measure performance has not benefitted from the incentive program. Additionally, the Immunizations for Adolescents member incentive will be discontinued to place greater emphasis on the HPV incentive. We are including a new incentive for colorectal cancer screening, as the Colorectal Cancer Screening measure is now included the 2026 Managed Care Accountability Set measures held to the 50th percentile threshold.

We are addressing current barriers in preparation for the 2026 program launch. Plans involve managing member mailings in-house to save money and enhance control. Internally, we are initiating the search for a new vendor to conduct our member incentive program in the future.

H. Postpartum Incentive Outreach Letter

The purpose of this program is to improve postpartum visit rates among Medi-Cal members who have recently given birth. The goal of this outreach is to improve Postpartum Care Visit and Prenatal Care Visit MCAS measure rate performance.

Methodology

Targeted members for outreach are identified from the monthly live birth report. Members with recent births are added to a list for the incentive mailer outreach. In the letter, members are provided with information about the importance of postpartum visits and they are notified that they can receive incentives for completed postpartum visits (7–84 days after delivery date) and for completed prenatal visits (prenatal visit in the first 12 weeks of pregnancy). Members can receive a gift card for reporting their prenatal and postpartum visits within the timeframe needed. To report the visit, members are instructed to call our HEDIS outreach team and report when the visits were completed, the location of the service, and confirm their mailing address for the incentive mailing to receive their gift cards within 4–6 weeks.

Quantitative and Qualitative Analysis

The 2025 program launched in January and completed in December. Postpartum mailers were sent to 2,546 members. A total of 509 incentives, 257 incentives for completed postpartum visits and 252 incentives for completed prenatal visits, were mailed to members

that reported completed visits within timeframe. A total of 189 incentives were distributed to members for completed care in 2024. More members reported completed visits and received incentives in 2025 compared to 2024.

Barriers

One of the primary challenges in the postpartum incentive outreach process is the accurate identification of new mothers for inclusion in the program. Data from live birth reports is used to determine which members should receive postpartum mailings; however, that data set only identifies a subset of postpartum members. This limitation affects the overall reach of the program, as not all mothers who need postpartum visits are receiving information and incentives related to these important appointments.

Additionally, there have been ongoing issues with timely incentive mailings from our incentive vendor. Delays in sending incentives have impacted the efficiency of the program and the member experience. Efforts are currently underway to address these challenges, and progress is being actively tracked throughout 2026 to ensure operational improvements.

Plans for 2026

We are currently in the process of obtaining approval for a revised outreach letter to be used in our 2026 postpartum incentive program. This updated letter is designed to provide more comprehensive information and resources tailored specifically for new mothers. Later in 2026, once launched, we plan to include information about the Promising Start Program. The Promising Start Program offers eligible members Amazon vouchers as well as essential postpartum and baby supplies when they complete both postpartum and newborn checkups. By incorporating these details directly into the outreach letter, members will have a better overview of their benefits and support options, making it easier for them to utilize the resources provided and complete needed care.

Advancing Health Equity

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

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

Blue Shield Promise's Quality team collaborates with the Health Equity team to use NCQA's

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

In 2025, we continued to observe inequities by race/ethnicity for poor diabetes control for members in Los Angeles County, quantified by the HEDIS measure “Glycemic Status Assessment for Patients with Diabetes >9.0% (GSD).” Across measurement years 2023 and 2024, the GSD rate among Hispanic/Latino members remained stagnant and did not meet the goal of the National Medicaid HMO 50th Percentile. The intervention strategy will remain focusing on reducing inequities for Hispanic/Latino members in Los Angeles County as they accounted for a large proportion of the denominator (when stratifying rates by ethnicity) and had the highest number of members demonstrating HbA1c Poor Control (>9.0%). We changed the intervention to focus on nutrition essential to diabetes management and piloted the promotion of the Community Support service Medically Tailored Meals/Medically Supportive Meals (MTM/MSM). The pilot included partnering with the HEDIS outreach team, to engage members diagnosed with diabetes and hypertension. Among members who consented to MTM/MSM, the HEDIS outreach team completed and facilitated the referral.

We also observed inequities by race/ethnicity for timely receipt of prenatal and postpartum care among Promise members in LA County, quantified by the HEDIS metric Prenatal and Postpartum Care. The target goal of the National Medicaid 50th percentile, or Minimum Performance Level (MPL), was not achieved when stratifying performance by race. Our intervention strategy will focus on reducing inequities for Black/African American members as these groups showed the highest number of preventive care visit gaps among Promise members. Additionally, the target goals among these groups were not achieved in both measurement years 2023 and 2024.

To understand member experiences and factors that contribute to inequities, and inform our interventions and strategies, we partnered with the Market Research team to design and implement a comprehensive series of focus groups across Los Angeles. These focus groups engaged a screened Medi-Cal consumer panel and were structured to address three priority areas: reproductive and maternity care, early childhood vaccinations, and health equity for Black/African American members. The focus groups explored barriers, communication preferences, cultural considerations, and reactions to existing and proposed quality interventions—such as care gap mailers, member incentive materials, and maternal/child health service concepts. Sessions were segmented by population (e.g., pregnancy planners, new mothers, caregivers of young children, Black/African American adults and families) to obtain actionable, community-specific insights. These focus groups directly supported the Department of Health Care Services (DHCS) Bold Goals by uncovering qualitative insights to refine interventions, shape member engagement strategies, and inform the Health Equity Disparities Report. The findings helped ensure that member voice—especially from communities experiencing inequities—guided program design and future QI initiatives.

In 2026, we will continue to leverage the qualitative insights from the focus groups to inform our interventions. To continue supporting Hispanic/Latino members demonstrating poor diabetes control, we will modify the 2025 pilot to increase the utilization of Medically Tailored Meals/Medically Supportive Meals (MTM/MSM). To improve timely prenatal and postpartum care among our Black/African American members, we will partner with the Maternal and Infant Health Equity team within the Office of the Chief Medical Officer to increase doula utilization and enrollment to maternity care management. Serving members across the life span, we will also continue supporting Black/African American and Native Hawaiian/Other Pacific Islander pediatric members to ensure they receive well-care visits. In 2026, we will be promoting well child clinic days to members within a radius of the clinic day location. Informed by the focus groups, the mailers will be culturally tailored to promote attendance. DHCS has observed inequities among these populations at the state level, encouraging managed care plans to advance health equity by addressing these state observed inequities.

2026 Goals and Outlook

Our performance goals in 2026 remain at meeting or exceeding the 50th percentile for all Managed Care Accountable Set (MCAS) measures. The MCAS measure set has expanded from 18 measures held to the 50th percentile in 2025 to 22 measures held to the 50th percentile in 2026. For the 2026 MCAS measure set, 2 high performing measures from 2025 were removed, 6 new measures were added, and 1 report-only measure was added. Overview of changes are included in the table below. New measures to the measure set are bolded:

2026 MCAS Changes	Domain	Measure
Measures Removed/Report only measure added	Reproductive Health and Cancer Prevention	Chlamydia Screening. High performing measure removed from measure set. Performed at the 90 th percentile in 2024.
	Chronic Disease Management	Asthma Medication Ratio removed (Follow Up After Acute Care Visit for Asthma measure will be a report-only measure and will not be held to MPL)
New MCAS measures for 2026	Behavioral Health Domain	Depression Screening for Adolescents and Adults
		Postpartum Depression Screening
		Postpartum Depression Follow-Up
		Prenatal Depression Screening

		Prenatal Depression Follow-Up
	Cancer Prevention	Colorectal Cancer Screening

Blue Shield Promise plans to continue to build on existing member and provider intervention strategies and launch new targeted interventions to address new measures, barriers to care, and improve poor performing measures in 2026. In 2026, we will continue to expand partnership with other departments to reach quality goals. See the tables below for a list of existing enhanced and new initiatives in key areas.

Enhanced Existing Work Across Key Areas	
Key Areas	Enhanced Initiatives
Member Engagement and Community Partnerships	Leverage existing teams to reinforce care gap messages and enroll members in programs to help close care gaps Additional well child clinic days and mobile mammograms – at all Community Resource Centers in LA Expand mini clinics throughout LA Continue to explore using community health workers supporting care gap closure with hard-to-reach members Add colorectal cancer screening to member incentives
Provider Engagement	Provide on-site quality learning sessions with offices, reviewing patient workflow processes to enhance gap closure & data capture opportunities Continue to refine provider incentive program to align with new requirements and for increased effectiveness Collaborate with Growth and Network teams to implement strategies to improve performance Additional in-office provider education
Technology, Data & Analytics	Offer supplemental data educational sessions with provider groups to ensure data submitted routinely and accurately Enhance tracking of state and county data to ensure data completeness and accuracy

	Gain direct EMR access for Medi-Cal QI team for additional provider groups Send admit, discharge, transfer data to additional provider groups
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New Initiatives Across Key Areas	
Key Areas	New Initiatives
Member Engagement and Community Partnerships	Promote new value-added benefit of diapers for new moms and babies (when available in Los Angeles county) Implement interventions with community-based organizations to advance health equity Conduct additional listening sessions with specific subpopulations to inform interventions Launch vendor intervention for lead and fluoride Execute contract with vendor for colorectal screening, A1c tests, and BP cuffs Contract with new member incentives vendor Collaborate with Marketing to include care gap closure messages for Relay Health (texting) Contract with vendor for immunizations
Provider Engagement	Promote a data integration tool for providers to use as point of care tool and to submit data Partner with school-based clinics to close care gaps Implement additional health equity projects with providers Provider learning modules on select HEDIS measures
Technology, Data & Analytics	Use a data integration tool for additional data acquisition, chart review/abstraction automation Leverage early prenatal identification project to identify pregnant members earlier for timely outreach

	Use predictive analytics tool to improve member targeting for specific interventions and for health equity Receive ADT feeds directly from select hospitals
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Data Improvement

Supplemental Data

Activity Description:

HEDIS improvement efforts, through supplemental, that are non-transactional data sources that capture care rendered to Blue Shield Promise Medi-Cal LA Care members. Supplemental data for this population includes lab results data from ancillary lab facilities (Quest, LabCorp, Heath Systems, smaller commercial labs), State Immunization Registry data, EHR data from provider organizations and data aggregators like [REDACTED], Blue Shield Promise strategic data initiatives including [REDACTED].

Goals:

1. Establish data channels for targeted data sources and work with stakeholders to set up, validate and include data in HEDIS reporting to close targeted HEDIS care gaps.
2. Work with internal and external stakeholders to resolve data issues impacting closure of HEDIS care gaps.
3. Provide tools to support stakeholders in submitting HEDIS Supplemental data.
4. Internal data validation and issue resolutions to validate the integrity and accuracy of the supplemental data to mitigate issues that would disqualify the from HEDIS reporting during HEDIS auditor validation.

Accomplishments:

1. **Provider Tools to support supplemental data submissions.**
 - i. Timely publication of the annual HEDIS Toolkit which communicates the NCQA measure specification for key measures for each LOB.
 - ii. Timely publication of the annual publication of the BSC HEDIS Supplemental data requirements document to capture key updates from NCQA pertaining to MY 2025, BSC data submission timelines, Primary Source Validation (PSV) requirements, data setup requirements, etc.
2. **Annual Stakeholder Training and monthly office hours.**
 - i. Provided training to CPMs providing general overview of HEDIS, Blue Shield data processes including HEDIS supplemental data.

- ii. Hosted live supplemental data training sessions with providers to help groups navigate the BSC supplemental data process.
- iii. Monthly office hours where stakeholders can ask questions pertaining to supplemental data submission processes.

3. Annual PSV

- i. Conduct annual PSV on existing supplemental data submissions to validate the integrity of the data and resolve issues that would disqualify the data from official MY 2025 reporting.

4. New supplemental data setups completed in 2025.

- i. Blue Shield Strategic data project data channels.
 - a. [REDACTED] Solution: Successfully ingested [REDACTED] data for LA Care Medi-Cal line of business, resulting in additional gaps closed for MY 2025.
 - b. EPP ETL enhancement to capture additional HEDIS measure data from EPP to close MY 2025 gaps.
- ii. Provider targeted supplement data feeds.
- iii. Clinical Quality Q4 push.
 - a. Development and distribution of LOB targeted supplemental data care gap reports to support Q4 efforts to close open care gaps.

Quantitative Analysis:

PSV and Data Setups 2025 LA Medi-Cal

PROJECT	TARGETED SOURCES	PASSED PSV	FAILED	WITHDRAWN
LOB TARGETED DATA SETUPS	4	0	0	4

MY 2025 vs. MY2024 HEDIS Supplemental data sources LA Medi-Cal

HEDIS MEASUREMENT YEAR	TOTAL SOURCE INCLUDED
HEDIS MY 2024	52
HEDIS MY 2025	52

[REDACTED]

Qualitative Analysis

[REDACTED]

Trends in Performance

[REDACTED]

Barriers and Mitigation Plans

Opportunities for 2026:

1. Risk of failing auditor PSV due to missing or incomplete PSV documentation.
 - a. Provider / stakeholder education on importance of maintaining the correct POS document which should be available upon request.
 - b. Peer reviews or QA of POS documentation uploaded to [REDACTED] UI.
2. Volume vs. Quality of supplemental data sources.
 - a. Stakeholders are focused on increasing volume of supplemental data, however that does not always result in improved rates. Emphasis should be on submissions that will close existing open care gaps.
 - b. Duplicated data sources which inflate the volume with little impact on gaps HEDIS gaps closed.
 - c. Provider / stakeholder education on importance aligning data feeds with open HEDIS care gaps as opposed to submitting data dumps.
 - d. Feedback reports to provider to show issues with data submissions such as submissions with irrelevant HEDIS data.
3. Cloud migration from On-Prem processes to streamline production processes and align with BSC corporate data processes.

Manifest MedEx

Blue Shield of California (BSC) continues to play an active role in supporting participation in health information exchange through Manifest MedEx (MX), a nonprofit that facilitates the secure exchange of claims and clinical records for providers and health plans to ensure patients are receiving safe, timely and high-quality care. Manifest MedEx's footprint now includes 50 million patient records across 19 health plans, 3 national laboratories and more than 3,400 healthcare organizations.

Accomplishments

Thus far, the Manifest MedEx (MX) project has accomplished the following:

- BSC is sharing medical, and pharmacy claims with Manifest MedEx for Commercial, Medicare and Medi-Cal
- Manifest MedEx has clinical data for approximately 63% of our members.
- Participating in State's Data Exchange Framework as of January 31, 2024.

Risks and Challenges

- The rate at which providers are adopting the system remains low, which results in an incomplete view of the patient's longitudinal health record. This issue is further compounded by the limited availability of resources and financial constraints, which pose significant barriers for smaller medical groups to participate in a Health Information Exchange (HIE).
- Blue Shield relies heavily on Manifest MedEx to provide complete, accurate, and timely clinical data for our members. However, this has proven to be a significant challenge. Despite these difficulties, Blue Shield remains committed to partnering with Manifest MedEx to address and close any data quality gaps.

2026 Outlook

- Continue to leverage Manifest MedEx data to support risk adjustment and Healthcare Effectiveness Data and Information Set (HEDIS).
- Explore enhancements with Manifest MedEx to support MediCal Enhanced Care Management.

Blue Shield Promise Pharmacy Services and Pharmacy Member Safety

Activity Description:

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 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 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.
 - 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.

These programs listed above are not specifically tracked on the Quality Work Plan.

Goal:

The goal for this program during MY 2025 is to meet the health plan's regulatory requirements to perform retrospectively, regular care management activities and act accordingly on issues of concern to the MCP in the measurement year as outlined in:

- U.S. federal law, Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (H.R. 6, Pub.L. 115-271), the SUPPORT Act
- Department of Health Care Services (DHCS) All Plan Letter (APL) 23-026 (Revised): Federal Drug Utilization Review Requirements Designed to Reduce Opioid Related Fraud, Misuse and Abuse
- DHCS APL 25-013: Medi-Cal Rx Pharmacy Benefits, And Cell and Gene Therapy Coverage

Accomplishments:

Blue Shield Promise completed all audits related to pharmacy services and pharmacy member safety with no corrective action needed. This year, the Clinical Pharmacy Operations Center (CPOC) team launched a Medi-Cal pharmacy program dashboard to be shared with the Medi-Cal Pharmacy Steering Committee and the Promise Chief Medical Officer on a quarterly basis.

The PRC program strengthened collaboration within the CPOC team by transitioning from optional weekly meetings to mandatory monthly meetings. These monthly sessions encourage team members to share member cases, collaborate on next steps, and provide peer feedback. The meetings also serve as an opportunity for continuing education on a range of opioid-related topics, equipping the team with knowledge and strategies to better support members to reduce their risk. The pharmacy team also increased collaboration by inviting Promise medical director(s) to participate and review Medi-Cal PRC cases at the Narcotic Safety Initiative Committee meetings.

Quantitative Analysis:

MY2025	Q1	Q2	Q3	Q4	Total
Patient Review & Coordination (PRC) Program					
Cases Reviewed	258	174	183	159	774
Cases Opened for Provider Outreach	5	8	5	4	22
Cases Closed	5	11	26	4	46
- Cases Closed (O2) Prescriber(s) Agreed to Manage/Coordinate Care	1	4	6	1	12
- Cases Closed (O3) Prescriber(s) Attested that the Medication Regimen is Appropriate	2	2	6	0	10
Behavioral Health Medications in Children (BHMC)					
Cases Reviewed	43	87	59	28	217
Cases Determined Clinically Appropriate	41	75	56	26	198
Medication Issues Addressed with Providers	2	12	3	2	19

MY2024	Q1	Q2	Q3	Q4	Total
Patient Review & Coordination (PRC) Program					
Cases Reviewed	269	227	214	243	953
Cases Opened for Provider Outreach	3	9	4	9	25
Cases Closed	3	6	8	11	28
- Cases Closed (O2) Prescriber(s) Agreed to Manage/Coordinate Care	2	1	2	1	6
- Cases Closed (O3) Prescriber(s) Attested that the Medication Regimen is Appropriate	1	0	0	1	2
Behavioral Health Medications in Children (BHMC)					
Cases Reviewed	171	109	167	105	552
Cases Determined Clinically Appropriate	170	107	166	104	547
Medication Issues Addressed with Providers	1	2	1	0	4

Qualitative Analysis:

In MY 2025, the overall volume of cases reviewed for both the PRC and BHMC programs decreased compared to MY 2024. This would be considered a steady improvement as a decrease in number of cases requiring pharmacy review means fewer potential issues. For the PRC program, this decrease in overall volume of cases reviewed is likely linked to overarching efforts across the nation to monitor safe use of opioid medications. For the BHMC program, this is likely due to an update in early 2025 to the automated report generation process to better filter our ineligible members.

For the Medi-Cal PRC program, closing the case O2 (prescriber agreeing to manage/coordinate care) or O3 (prescriber attestation that the medication regimen is appropriate) is considered successful provider outreach.

For the Medi-Cal PRC program, 48% of the cases closed in 2025 were due to the prescriber agreeing to manage/coordinate care or attestation that the medication regimen is medically appropriate. This is an increase from 2024 where 29% of the cases closed were due to the prescriber agreeing to manage/coordinate care or attested that the medication regimen is medically appropriate. This is because many of the cases closed in 2024 were closed due to membership termination, so there was an increased effort in 2025 to check membership eligibility while working cases.

Trends in Performance:

This is the first year evaluating pharmacy services, so trends in performance are not set. In MY 2025, the Pharmacy team continued to meet regulatory program requirements. The number of cases being actively worked as part of these programs remained steady with a slight decrease in 2025. The decrease in the number of cases worked in MY 2025 was due to diminished staffing resources in the second half of the year.

Barriers and Mitigation Plans:

Barrier	Mitigation Plan
Workflow Inefficiencies: Medi-Cal Rx pharmacy claims data lag due to pharmacy benefits being carved-out of health plan. Pharmacy team members must consult Medi-Cal Rx portal prior to outreach for the most updated pharmacy claims information.	Continue to run reports on a quarterly or monthly basis and investigate pharmacy claims data import process from Medi-Cal.
Workflow Inefficiencies: Medi-Cal Rx controls all prospective drug utilization review and safety edits.	Continue to conduct retrospective drug utilization review and share feedback with DHCS and Medi-Cal Rx.
Resource gaps: Limited human resources dedicated to Medi-Cal line of business	Ongoing annual assessment of resource allocation for Medi-Cal pharmacy programs.

Recommendations for the Following Year:

MY 2026 Goal(s):

Continue to meet regulatory requirements for Medi-Cal lines of business. There are no changes to the current goals anticipated.

Program adjustments for the following year:

- No change to program criteria for PRC or BHMC
- The Medi-Cal PRC program will continue to prioritize review of members with concurrent opioid-benzodiazepine to align with efforts in the Medicare line of business.

Seniors and Persons with Disabilities Programs

Blue Shield Promise's Health Risk Assessment (HRA) initiative exemplifies a comprehensive and member-centric approach in coordinating care for Seniors and Persons with Disabilities (SPD). The program utilizes structured telephonic outreach to engage members, offering a thorough health risk assessment, personalized care planning, and interprofessional care team meetings that foster ongoing collaboration and address both immediate and long-term health concerns. Continuous case management ensures that members receive timely health screenings and foundational health education, reinforcing their understanding of available resources and empowering them to make informed decisions about their well-being. Importantly, members retain autonomy throughout the process, with the opportunity to opt out at any stage, underscoring the program's commitment to respecting individual choice and promoting engagement on the member's terms.

The outreach process is methodical and member-focused: up to three telephonic attempts are made to reach each member, followed by a personalized letter containing the Clinical Services Coordinator's (CSC) contact information to facilitate further support. Blue Shield Promise's strategic implementation of the Auto Dialer elevates the quality and reliability of outreach efforts. Auto Dialer administers initial outreach, a rigorously designed tool that captures and analyzes demographic information, health behaviors, lifestyle factors, and existing health conditions. This data-driven approach enables predictive risk modeling, allowing for proactive identification of potential health challenges and tailored guidance to mitigate those risks. Engaged individuals are connected with CSCs to begin the HRA process. Upon completion of the HRA, whether conducted telephonically or via mailed forms, members are promptly contacted by a nurse to collaboratively develop an Individualized Care Plan and for any care coordination needs. This plan is the gateway to a suite of Population Health Management (PHM) services, including Social Services, Community Resources, Complex Case Management, and Health Education.

The streamlined process provides members with a single point of contact across multiple programs, reducing confusion and enhancing continuity of care. Members are furnished with the direct contact information of their assigned nurse, ensuring ready access to care coordination support whenever needed. Care plans are shared with the primary care physicians (PCPs) to foster collaborative approach to managing members' care.

This program demonstrates Blue Shield Promise's ongoing dedication to fostering holistic, evidence-based care that not only meets regulatory requirements but also prioritizes member empowerment, seamless service integration, and continuous quality improvement. Through strategic partnerships, robust outreach protocols, and a commitment to personalized support, the HRA initiative stands as a model of excellence in population health management and quality program evaluation.

Goals

30% completion of HRA for SPD population within 60 days of new enrollment.

PHM aims to initiate Health Risk Assessments (HRAs) for at least 90% of Seniors and Persons with Disabilities (SPD) members within 30 days of new enrollment and ensure completion within 60 days, aligning with regulatory requirements. Additionally, the program sets an internal target to increase the HRA completion rate to 20% for the SPD population.

Accomplishments

PHM's key accomplishments for the measurement year include streamlining the SPD HRA process to ensure alignment with regulatory requirements. Notably, the implementation of the Auto Dialer in December 2025 significantly enhanced outreach efforts, improving member engagement, and the efficiency of initial contact attempts. Additionally, ongoing enhancements to the Dashboard and Reporting for SPD HRA have strengthened the program's ability to monitor and track completion rates, supporting continuous quality improvement and more effective process oversight.

Quantitative Analysis

This quantitative analysis examines the performance of the Seniors and Persons with Disabilities (SPD) Health Risk Assessment (HRA) process for 2025, with a focus on evaluating completion rates, the impact of outreach strategies—including the introduction of the Auto Dialer—and measurable outcomes. The analysis also projects the anticipated effects of process enhancements planned for 2026, referencing pertinent data and metrics from the organizational dashboard and 2026 Care Management Reporting.

In 2025, the SPD HRA process experienced a plateau in completion rates, with year-over-year data indicating no significant increase despite sustained outreach efforts. Initial contact attempts were methodical, consisting of up to three telephonic calls per member, supplemented by personalized letters. The implementation of the Auto Dialer in December 2025 notably improved the consistency and efficiency of outreach, as reflected in increased rates of successful member contact during initial attempts. However, aggregate data from case management reporting shows that the overall HRA completion rate for the SPD population remained relatively stable, with only marginal improvement compared to the prior measurement year.

Measurable outcomes from 2025 underscore the challenges in advancing HRA completion rates. According to the dashboard metrics, the SPD population achieved a 30% HRA completion rate within the targeted 60-day window following new enrollment, meeting the organizational threshold but falling short of internal targets for year-over-year growth. The introduction of the Auto Dialer was associated with a 12% increase in successful initial contacts, as documented in Care Management Reporting. Despite this improvement in outreach efficiency, the conversion of contacted members to completed HRAs did not demonstrate a corresponding rise, indicating persistent barriers in member engagement and process navigation.

2026 Process Enhancements and Projected Impact

To address the observed plateau, the SPD HRA process for 2026 incorporates targeted engagement strategies, including expanded personalized follow-up and refined workflow protocols. These enhancements are designed to improve member responsiveness and streamline care coordination. Process alignment with evolving regulatory requirements is emphasized, with regular reviews and refresher training for staff. Real-time dashboard monitoring will enable leadership to track completion rates and outreach effectiveness, facilitating rapid adaptation to emerging trends. Based on predictive modeling from case management reporting and historical performance data, these interventions are projected to achieve at least a 5–10% increase in HRA completion rates within the critical 60-day window, with incremental improvements expected in subsequent quarters.

In summary, quantitative analysis of the SPD HRA process reveals a performance plateau in 2025, mitigated in part by enhanced outreach mechanisms such as the Auto Dialer. While measurable gains were observed in initial contact efficiency, overall completion rates remained steady. The 2026 process enhancements, supported by robust dashboard monitoring and data-driven adjustments, are anticipated to drive meaningful improvements in HRA completion rates, regulatory compliance, and overall program effectiveness.

Qualitative Analysis

Team insights suggest that the plateau in SPD HRA program performance during 2025 may have been influenced by significant organizational changes, including transitions in directors and managers. The introduction of new leadership in the fourth quarter of 2025, combined with enhancements to the SPD HRA process, positions PHM for anticipated improvements in 2026. The team is optimistic that these adjustments will drive higher completion rates and better regulatory compliance in the coming year, marking a positive shift from previous trends.

Trends in Performance

Quantitative and qualitative analyses of the previous measurement year indicate a clear trend of stagnation in the performance of the PHM SPD Health Risk Assessment (HRA) process. Despite the deployment of robust outreach strategies, including up to three telephonic contact attempts per member, personalized letters, and the introduction of the Auto Dialer in December 2025, the HRA completion rates for Seniors and Persons with Disabilities (SPD) remained steady, showing little to no significant improvement. Data from *Presentation 1.pptx* confirms that while the Auto Dialer contributed to a 12% increase in successful initial contacts, this did not translate into a corresponding rise in completed HRAs. The overall completion rate plateaued at 30% within the targeted 60-day window, meeting the organizational threshold but falling short of internal growth targets. These figures reveal persistent barriers in converting outreach into completed assessments, underscoring a need for process refinement.

Qualitatively, team insights point to organizational changes, most notably transitions in leadership and management roles, as a contributing factor to the plateau in SPD HRA performance. The absence of consistent direction and workflow clarity created challenges in process navigation and team alignment, further impeding progress. However, the introduction of new leadership in late 2025, combined with strategic enhancements to the SPD HRA process such as targeted tracking, monitoring reports, and ongoing development of dashboard tools, signals a positive shift for 2026. The leadership team's commitment to regular reviews, refresher training, and cross-departmental collaboration is expected to drive higher completion rates, improve regulatory compliance, and reverse the trend of stagnant performance in the coming year.

In summary, the trend in SPD HRA performance over the past year is characterized by a quantitative plateau and qualitatively attributed to organizational transitions. The outlook for 2026 is optimistic, with targeted interventions and infrastructure improvements poised to break the plateau and achieve meaningful progress.

Barriers and Mitigation Plans

Challenges encountered during 2025 measurement year included organizational changes, such as transitions in leadership and management roles, which contributed to a lack of consistent direction and impacted team alignment. Additionally, desk-level procedures were not consistently updated, resulting in workflow inefficiencies and confusion among staff. The complexity of the SPD HRA process itself further complicated efforts to achieve higher completion rates, as team members experienced difficulty navigating and executing the required steps. To mitigate these challenges, the newly established leadership team conducted a thorough review of the PHM SPD HRA end-to-end process, ensuring enhancements were made in alignment with current regulatory requirements. Guardrails have been implemented to facilitate efficient tracking and monitoring of HRA completion rates. A key element of the mitigation plan involves ongoing development and refinement of dashboard and reporting tools, enabling PHM leaders to closely monitor SPD HRA performance and rapidly respond to emerging trends or barriers.

Recommendations for 2026 and Beyond: Optimizing the SPD HRA Process

Drawing on the latest performance data from 2025 SPD HRA Data the following recommendations and improvement opportunities are proposed to enhance the effectiveness of the Seniors and Persons with Disabilities (SPD) Health Risk Assessment (HRA) process for 2026 and future years:

- **Expand Targeted Outreach Strategies:** Leverage successful engagement tools such as the Auto Dialer, which has already contributed to a 12% increase in initial member contacts, by integrating additional outreach channels like text messaging and streamlined HRA formats.
- **Shortening the HRA Questionnaire:** The SPD HRA process can be further optimized by shortening the HRA questionnaire from 46 questions to approximately 20 high-value questions. Reducing questionnaire length is expected to lower member burden, improve user experience, and increase overall completion rates, particularly among populations that may experience survey fatigue or access barriers.
- **Strengthen Data-Driven Process Adjustments:** Enhance dashboard and reporting capabilities to facilitate real-time monitoring of outreach effectiveness and completion rates. This will allow leadership to rapidly identify barriers, such as members lacking valid contact information and deploying targeted interventions, including additional mailings and vendor-managed outreach.
- **Increase Staff Training and Workflow Alignment:** Continue regular process reviews and refresher training for all staff, ensuring current protocols are consistently applied, and regulatory requirements are met. Address workflow inefficiencies identified in

2025 by updating desk-level procedures and clarifying roles, particularly in response to organizational transitions.

- **Foster Cross-Functional Collaboration and Feedback:** Promote open communication among clinical, administrative, and quality teams to share insights, overcome process bottlenecks, and spread best practices. Encourage a culture of continuous feedback by inviting team members to suggest improvements and report challenges encountered in member engagement.
- **Address Persistent Engagement Barriers:** Analyze reasons for the plateau in HRA completion rates—such as difficulty reaching high-risk members and conversion gaps between contact and completed assessments—and design interventions (e.g., more personalized follow-up, improved member education) to close these gaps.
- **Monitor and Adapt to Regulatory Changes:** Stay vigilant to evolving state and federal requirements, ensuring that process enhancements and reporting practices remain compliant and proactive.

By implementing these recommendations, the SPD HRA process will be more responsive, efficient, and capable of meeting both regulatory requirements and internal growth targets. Ongoing investment in technology, staff development, and cross-departmental collaboration will position the organization to overcome current barriers and deliver consistently high-quality care for SPD members in the coming years.

SAFETY OF CLINICAL CARE

Credentialing

Activity Description:

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

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

Accomplishments:

- The Credentialing Department continues to meet all credentialing timeframes and is compliant with regulatory guidelines.
- Align credentialing process between BSC and PHP for one unified credentialing verification process and decision date.
- Reduced turnaround time from 60+ days to under 30 days for initial credentialing

Quantitative Analysis:

The Credentialing actions for 2025 are as follows:

Blue Shield Promise (Los Angeles)	2024	2025	Trends in Performance
Practitioner/Prov - Initial Cred files approved	504	2213	↑
Practitioner/Prov - Recred files approved	243	396	↑
Practitioner/Prov - Inactivation files	574	65	↓
Practitioner/Prov - 805 Reports	0	1	↑
Healthcare Delivery Organizations (HDO) - Initial Cred files approved	168	177	↑
Healthcare Delivery Organizations (HDO) - Recred files approved	295	229	↓
Healthcare Delivery Organizations (HDO) - Inactivation files	215	63	↓

*2024 inactivations are not separated by county

Barriers and Mitigation Plans

- Consistent communication and bridging gaps between Credentialing, Provider Relations, and Network Management.
- Identification and timely notification to the Credentialing department of providers who are being terminated from delegated groups that require internal credentialing.
- Large influx in credentialing volume in 2025 attributed to insourcing of Magellan for Behavioral Health providers.

- Identified the need for a control process to obtain DMHC approval for hospital terminations resulting from facility recredentialing issues. Collaborated with network compliance to develop a procedure that ensures appropriate notification to network management regarding potential facility terminations.

2026 Recommendations:

The Credentialing Department goals for 2026 are as follows:

- Review AB 1041 and ensure alignment with 2027 cred requirements

Potential Quality of Care Issues

Description

Blue Shield of California Promise Health Plan has a robust program to review member clinical grievances and internally identified potential quality issues (PQIs). PQI cases, which are managed by the Clinical Quality Review (CQR) team, are investigated, reviewed, and assigned a severity level. Based on the findings confirmed by a licensed physician, further follow-up can include such actions and interventions as direct review by the Peer Review Committee (PRC), a corrective action plan (CAP) request, or an education letter outlining opportunities for improvement. Should a provider not satisfactorily respond to the finding of a confirmed quality problem, the PRC can make recommendations to the Credentialing Committee for evaluation of a provider's continued network participation. The PRC also reviews provider monitoring reports that may show care or service trends that could indicate an ongoing quality problem and takes appropriate action as indicated.

Goals

- PQI case average turnaround time (TAT) goal of ≤ 180 days at least 95% of the time
- Continue collaboration with the Appeals and Grievance Departments (AGD) to align and improve AGD and CQR front-end PQI processes and hand-offs for all lines of business.
 - Enhance processes that complete clinical oversight prior to cases being sent to Clinical Review Team for Improving production of cases and efficiency of reviews.
- Enhance platform which allows for additional efficiency and clarity in reporting of Potential Quality Issues across all lines of business.
- Enhance provider monitoring with analysis of aggregate PQI, complaint data and other findings from internal review to identify opportunities for improvement related to care or service trends.

- Develop workgroup that identifies detailed trends that can be worked through with inter-departmental teams to resolve issue trends and reduce incoming cases.

Accomplishments

TAT of 94.8% was achieved in 2025.

In addition, the following related results were achieved:

- PQI case average turnaround time (TAT): 141 days (TAT goal is ≤ 180 days)
- CAP and Education Letters issued: 15 CAPs and 150 Education Letters
- Referrals to Credentialing Committee: 5

A new leadership team for CQR was established near the end of Q1, with continued refinement as the year progressed. The leadership team now includes:

- A dedicated Senior Medical Director
- Senior Manager
- Manager
- 2 Clinical Auditor/Trainers
- Senior Operations Specialist

These dedicated CQR positions have resulted in increased stability for the team and provided an increased focus on improving current processes with particular emphasis on quality and efficiency.

Regular meetings with Appeals and Grievances Department (AGD) representatives have resulted in a better understanding of AGD processes and barriers. This increased collaboration is viewed as key in the effort to improve efficiency and ensure CQR can begin investigative processes as soon as possible.

Reporting requirements related to PQI processes were successfully transferred to the CQR auditor/trainer and Senior Operations Specialist. Opportunities to improve and enhance existing reports as well as develop meaningful new reports is an ongoing process. Improvements were made to reporting related to aggregating PQI and complaint data on the provider trending report. Provider monitoring was converted from semi-annual to quarterly to more efficiently analyze PQIs for trends and patterns requiring further intervention. Additional improvements to the report continue to be explored, based on suggestions made by the Peer Review Committee.

Training materials were updated and provided to internal and external department team members by CQR trainer/auditors during 2025. In addition to live training sessions, online training has also been developed and made available to BSC staff through the Shield Learns program. Annual training was provided to customer service and AGD staff to ensure appropriate understanding of what constitutes a potential quality of care case. Training on PQIs and CQR processes was also provided to external delegates in 2025. These trainings help ensure that cases received by the Clinical Quality Review team are correctly identified as having a quality-of-care issue or component.

Existing policies and procedures were reviewed and revised as indicated. New procedures were also developed to ensure CQR team members understand expected workflows and processes.

Quantitative Analysis

2025 Data for Medi-Cal Los Angeles

Cases Received	2023					2024					2025				
	Q1	Q2	Q3	Q4	2023 Total	Q1	Q2	Q3	Q4	2024 Total	Q1	Q2	Q3	Q4	2025 Total
Member Initiated PQIs	411	587	593	483	2074	173	38	109	104	424	90	79	66	43	278
Internal PQIs	14	29	36	27	106	19	16	13	11	59	32	30	9	35	106
Total Received	425	616	629	510	2180	192	54	122	115	483	122	109	75	78	384

Cases Closed	2023					2024					2025				
	Q1	Q2	Q3	Q4	2023 Total	Q1	Q2	Q3	Q4	2024 Total	Q1	Q2	Q3	Q4	2025 Total
C-0	197	177	220	354	948	252	213	39	175	679	41	28	36	38	90
C-1	107	112	186	302	707	96	55	52	61	264	42	40	45	57	131
C-2	7	7	5	4	23	2	1	6	6	15	5	5	5	3	11
C-3	0	0	0	0	0	0	0	0	0	0	0	2	0	1	2

Total Closed	311	296	411	660	1678	350	269	97	242	958	88	75	86	99	348
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Qualitative Analysis

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

Trends in Performance

The CQR team continued to exhibit strong levels of performance regarding TAT compliance goals and high levels of quality related to PQIs. Routine and focused audits helped identify areas of concern and actions were immediately taken in the form of coaching and re-training as needed.

Barriers and Mitigation Plans

Challenges experienced within CQR during 2025 include the following primary areas:

- **Staffing:** New leadership team members had to quickly learn CQR processes and address identified challenges. In addition to this learning curve, several clinical coordinators experienced personal challenges that resulted in some extended leaves of absence. Absences of key production positions can quickly result in a backlog of cases that impact clinical reviewer and medical director workloads. This challenge was addressed by cross training several team members and utilizing contingent workers as appropriate.
- **Delays related to processes in other departments:** Issues identified that can slow processes down for clinical oversight and CQR investigations include: (1) intake performed by customer service sometimes missing key information and (2) delays in receiving information from AGD. These issues continue to be addressed through ongoing collaboration with customer service and AGD leaders, as well as updated training made available to both departments to assist in appropriate identification of potential quality of care issues.
- **Providers who do not respond to requests for medical records, additional information, and/or corrective action plans:** Actions taken to address this issue during 2025 include working with Legal to update letters sent by CQR. Revised letters contain stronger language regarding contractual requirements and expectations. Instead of multiple

attempts to request information, the second letter is now clearly labeled as the second and final request. Initial steps were also taken to develop and implement an escalation process to Provider Relations when assistance is needed to obtain crucial information. A standard education letter was also developed to send to non-responders.

Recommendations for 2026

- Continue collaboration with the Appeals and Grievance Department (AGD) and Customer Service to align and improve Customer Service, AGD and CQR front-end PQI processes and hand-offs for all lines of business. Continue to enhance processes for improving production of cases and efficiency of reviews.
- Enhance reporting capabilities to provide meaningful data and trends related to PQIs and CQR processes.
- Strengthen processes related to policy and procedure reviews, education, training of staff on new or revised requirements, and monitoring and oversight activities.
- Continue to develop a strong training program across various BSC departments to ensure potential quality of care issues are thoroughly documented, readily identified and sent to CQR in a timely manner.
- Continue to develop and implement processes related to providers who do not respond to requests for information. This will include finalizing and implementing process to escalate individual cases to Provider Relations for assistance. Additional components being explored include developing a routine report to make Provider Relations/Network Management aware of repeated non-responders and developing a new case severity level process that reflects no records and/or provider response received.

Initial Health Appointment

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

IHA Outreach Activities and Outcomes

Table 1: Initial Health Appointment (IHA) Outreach Rates for Fiscal Year (FY) 2023 through FY 2025 – LA County

Initial Health Appointment	FY 2025	FY 2024	FY 2023
Total New Membership	74,012	105,373	67,647

Initial Health Appointment Outreach Outcomes	FY25	FY25%	FY24	FY24%	FY23	FY23 %
Appt Scheduled/Will Schedule	6,453	9%	7,009	7%	2,118	3%
IHA Completed Prior to Outreach	5,439	7%	4,395	4%	2,199	3%
Ineligible/Termed/Disenrolled Prior to Outreach	9,888	13%	19,381	18%	15,484	23%
Unable to reach/Left Message/Declined Outreach	34,481	47%	23,889	23%	19,593	29%
No Contact/Incorrect Contact Information Provided	17,736	24%	19,876	19%	6,728	10%
Total IHA Outreach	73,997	99%	74,550	71%	46,122	68%
Outreach Completed Untimely/Outreach Not Completed	15	<1%	30,823	29%	21,525	32%

FY 2025 – Enrollment between July 2024 to June 2025

Table 1 Summary: Initial Health Appointment (IHA) Outreach Metrics for FY 2025 – LA County

Our Blue Shield Promise IHA outreach coordinators conducted phone outreach in accordance with our standard protocol and policy, calling newly enrolled members of all ages to encourage and/or provide assistance in scheduling an IHA throughout 2025.

Outreach Calls

During FY 2025, Blue Shield Promise IHA outreach coordinators and the vendor, [REDACTED] conducted a total of 73,997 outreach calls to members. This number is significantly less than in FY 2024, due to a decrease in enrollment. There was, however, a notable increase in timely IHA outreach because of coordinated efforts between the IHA coordinators and [REDACTED] with 99% of calls completed within the desired timeframe in FY 2025, compared to 71% in FY 2024. Although the objective of 100% call completion was not achieved, this was primarily due to a change in the referral process with [REDACTED] which resulted in 15 members not being appropriately referred back to the Blue Shield Promise IHA coordinators for outreach.

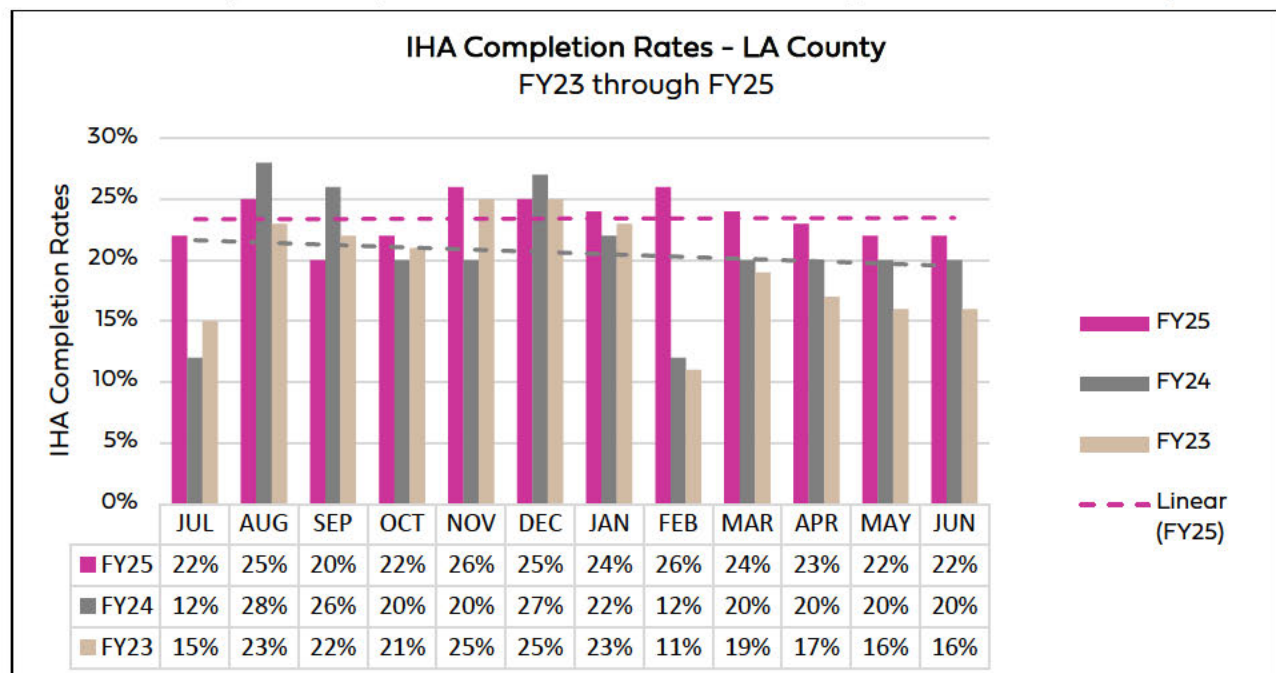
Enrollment of new members declined from FY 2024 to FY 2025 for various reasons within the Medi-Cal line of business. Contributing factors included the re-implementation of the Department of Health Care Services' annual redetermination eligibility verification process, member-initiated termination of coverage due to concerns about ICE, and members relocating out of state. Most members lost coverage for procedural reasons, such as failing

to return required forms on time or submitting forms with incomplete or inaccurate information.

In FY 2025, as in FY 2023 and FY 2024, “unable to reach/left message/declined outreach” accounted for the largest percentage of call outcomes. In FY 2025 there was an increase over FY 2023 and FY 2024 in the percentage of members who were assisted with scheduling appointments or had appointments scheduled already, increasing from 3% in FY 2023, 7% in FY 2024, to 9% in FY 2025.

There was also an increase in members who had completed an IHA prior to outreach, from 3% in FY 2023 to 4% in FY 2024 to 7% in FY 2025.

Table 2: Monthly IHA Completion Rates from FY 2023 through FY 2025 – LA County



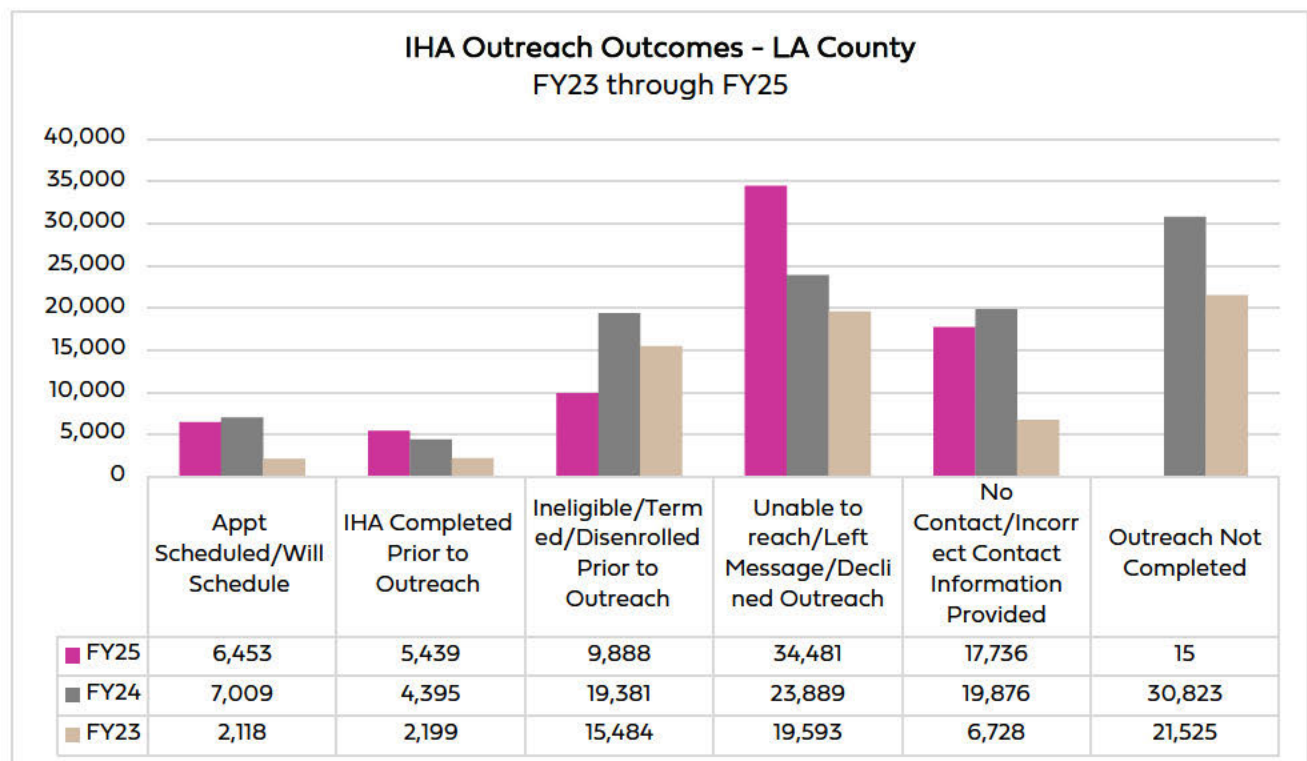
FY 2025 – Enrollment between Jul 2024 to Jun 2025

Table 2 Summary: Monthly IHA Completion Rates from FY 2023 thru FY 2025 – LA County

IHA completion rates are evaluated using the third and fourth quarters of the previous measurement year, along with the first and second quarters of the current measurement year, rather than a typical calendar year. This approach allows for the measurement of complete and accurate encounter data. A comparison of IHA Completion Rates for Los Angeles County between FY 2025 and FY 2024 shows that FY 2025 had higher rates for nine out of twelve months. The highest completion rate in FY 2025 was 26%, which occurred in November and February. The most notable increases in completion rates from FY 2024 to FY

2025 were observed in July and February, with a 10% rise in July and 14% rise in February in FY 2025.

Table 3: Blue Shield Promise IHA Outreach Call Results from FY 2023 through FY 2024- LA County



FY 2025– Enrollment between July 2024 to June 2025

Table 3 Summary: IHA Outreach Call Results from FY 2023 through FY 2025 - LA County

Blue Shield Promise IHA outreach calls experienced a notable decrease in total call volume in FY 2025 due to a decrease in membership. The outreach assistance from [REDACTED] contributed to a substantial increase in outreach completion in FY 2025. The number of members who had completed an IHA prior to outreach increased from 4,395 in FY 2024 to 5,439 in FY 2025. The number of ineligible/termed/disenrolled members prior to outreach decreased significantly from FY 2024 to FY 2025, from 19,381 to 9,888. The most frequently observed outreach outcome was in unable to reach/left message/declined outreach.

Table 4: IHA Medical Record Review from Calendar Year (CY) 2023 through CY 2025 - LA County

IHA Medical Record Review	Audited CY25	Audited CY24	Audited CY23
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	(FY25 Enrollees)	(FY24 Enrollees)	(FY23 Enrollees)
Total Medical Records Audited	1,130	551	732
Providers Audited	236	101	177
Average Score	95%	95%	95%

FY 2025 – Enrollment between July 2024 to June 2025

Table 4 Summary: IHA Medical Record Review- LA County

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

There was a significant increase in medical records audited, from 551 in Calendar Year (CY) 2024 to 1,130 in CY 2025. The number of providers audited increased from 101 in CY 2024 to 236 in CY 2025. The average audit score was 95% in each calendar year.

Qualitative Analysis

1. The contributions of [REDACTED] particularly through telehealth visits and Clinic Days, led to a slight increase in overall IHA completion rates in FY 2025 compared to FY 2024. The highest completion rate in FY 2025 was 26% in November and February. Completion rates in FY 2025 were greater than in FY 2024 in 9 out of 12 months.
2. Blue Shield Promise IHA member outreach calls decreased in FY 2025 due to a large decrease in membership, however there was a notable increase in timely outreach calls, in part due to the assistance of [REDACTED]

Trends in Performance

- Improved Timeliness and Outreach Completion:

There was a significant increase in the proportion of timely outreach calls. In FY 2025, 99% of outreach calls were completed within the desired timeframe, compared to 71% in FY 2024 and 68% in FY 2023. This improvement is attributed to the assistance of [REDACTED] despite a decrease in total call volume due to lower enrollment.

- Increase in Appointment Scheduling and Completion Rates:

The percentage of members who scheduled or were assisted in scheduling an IHA appointment increased steadily over the three-year period, rising from 3% in FY 2023 to 7% in FY 2024, and reaching 9% in FY 2025. Similarly, members who had already completed their IHA before outreach increased from 3% in FY 2023 to 4% in FY 2024, and to 7% in FY 2025.

- **Consistently High Audit Scores Despite Expanded Audits:**

The number of medical records and providers audited increased dramatically in CY 2025, yet the average audit score remained consistently high at 95% across CY 2023, CY 2024, and CY 2025.

- **Decrease in Ineligible or Disenrolled Members:**

The proportion of members deemed ineligible, termed, or disenrolled prior to outreach dropped substantially, from 23% in FY 2023 and 18% in FY 2024 to 13% in FY 2025.

- **Persistent Outreach Challenges:**

The largest proportion of outreach outcomes each year was “unable to reach/left message/declined outreach,” accounting for 47% in FY 2025, up from 23% in FY 2024 and 29% in FY 2023. Additionally, issues with incorrect or missing contact information persisted, comprising 24% in FY 2025, 19% in FY 2024, and 10% in FY 2023.

- **Impact of Membership Changes:**

A notable decline in total new membership occurred from FY 2024 (105,373) to FY 2025 (74,012), attributed to factors such as the re-implementation of annual eligibility verification, member relocations, and terminations due to procedural lapses. This decline influenced overall outreach volume.

Opportunities for Improvement

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

Interventions

Targeted efforts continued in 2025 to increase the amount of Blue Shield Promise new members completing their IHA appointment within 120 days of enrollment and many of these efforts will continue in 2026.

1. The Blue Shield Promise IHA Provider Incentive Program remained in effect in 2025, incentivizing providers to complete IHA visits within 120 days.

2. The Blue Shield Promise IHA Member Incentive Program was halted in mid-2024 because of budgetary limitations but resumed in the second quarter of CY 2025.
3. Maintained partnership with Quality department and vendor, [REDACTED] to reach out to members and assist in scheduling telehealth appointments as part of an IHA.
4. Blue Shield Promise IHA team to continue participating in Joint Operating Meetings with participating IPAs to discuss and address barriers in membership outreach.
5. Continued the escalation process to address non-compliance with requests for medical records and CAPs related to IHAs from providers.

Facility Site Review and Patient Safety / Physical Accessibility Review Survey

Evaluation of Overall Program Effectiveness

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

Residual effects of the global pandemic influence the volume of site reviews performed by Blue Shield Promise (Blue Shield Promise). Site reviews are conducted on a triannual basis, therefore, the volume of due site reviews in 2025 are correlated with those performed in 2022. The department resumed in-person reviews in the summer of 2022. The total Facility Site Reviews (FSR) due for calendar year 2025 has steadily increased as the backlog was resolved. The FSR unit has returned to pre-covid numbers as of the end of 2025.

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

Compliance Metrics - Quantitative Analysis	CY25	CY24	CY23
Total Facility Site Reviews Due (Contracted and Pre-Contractual)	75	45	58
Total Facility Site Reviews Completed	75	45	45
Total Facility Site Reviews Completed on Time	75	42	17
Average Facility Site Review Score	94%	93%	92%
% Pass Rate ($\geq 80\%$ aggregate score)	96%	100%	98%
Total Medical Record Reviews Due (Contracted and Pre-Contractual)	82	47	51
Total Medical Record Reviews Completed	81	47	45
Total Medical Record Reviews Completed on Time	81	40	7

Average Medical Record Review Score	90%	88%	87%
% Pass Rate ($\geq 80\%$ aggregate score)	90%	89%	93%
Department Metrics (Regardless of Due Date) (Facility Site Review & Medical Records Review)	CY25	CY24	CY23
Total Facility Site Reviews Completed	77	49	113
Average Facility Site Review Score	93%	93%	90%
Total Medical Records Reviews Completed	82	51	133
Average Medical Record Review Score	91%	88%	85%
Total Primary Care Physician Sites removed from the network due to Non-Compliance with Facility Site Review Requirements	3	6	3

Qualitative Analysis

There was a total of 75 Medi-Cal FSR sites due in 2025 of which 100% were completed within the stated due date. There was a total of 82 Medi-Cal Medical Record Reviews (MRR) due in 2025. A total of 81 MRRs were completed. There was a total of 156 completed FSR and MRR audits with an FSR average of 94% and an MRR average of 90%. The 2025 Average shows an increase in performance up from Year 2024.

Year-to-year comparisons of scoring in FSR appear to improve since 2024. This may be related to the continued technical and other support of our network regarding the DHCS standards and involvement in the JOM meetings, IHA reviews, general CAP closures for various Promise departments the Unit have participated in with the purpose of supporting and educating our delegated IPAs, MSOs and alike.

With the continuous provider education and technical support, there remains contracted providers who fail the FSR/MRR process 3 consecutive times. As such, these providers must be removed from the Blue Shield Promise network as an "administrative termination and all MCP's in the collaborative must also terminate the provider. All Members are reassigned to contracted network providers to provide the highest quality of care. The Termination process is shared with all MCP's and monitored by LA Care.

FSR/MRR Criteria Trends

Quantitative analysis of FSR and MRR scoring trends will possibly continue in 2026 program analyses. Standards are due to be revised by the 4th quarter of 2026 at which time, DHCS will allow time to educate and implement standard revisions into our network. Participating in

the county collaborative process supports alignment between the MCPs in educating the provider network.

Physical Accessibility Review Survey

Access and Safety areas monitored:

Physical Accessibility Review Survey (PARS) audits assess access and safety of the physical location of PCP site locations and High-Volume Specialists (HVS). Data provided on the volume of PARS reviews is shared with the Provider directory to support member decisions based on physical access needs. In addition, the PARS data is shared with each MCP in the collaborative further supporting our members and the collaborative process. Additional quantitative analysis is provided for sections of the FSR attachment C for PARS and FSR access and safety. (see table 6 and 7).

Table 6: PARS Metrics LA County

Los Angeles County	CY25	CY24	CY23
PARS Completed	155	49	63
PARS Completed at Basic Level	59	12	32
PARS Completed at Limited Level	96	37	31

Table 7: FSR Access/Safety Criteria LA County

Access/Safety	Yes	No	NA	Total	# Compliance
A. Site is accessible and useable by individuals with physical disabilities. Sites must have the following safety accommodations for physically disabled persons:					
1) Clearly marked (blue) curb or sign designating disabled-parking space near accessible primary entrance.	71	3	2	74	96%
2) Pedestrian ramps have a level landing at the top and bottom of the ramp.	46	0	30	46	100%
3) Exit and exam room doorway openings allow for clear passage of a person in a wheelchair.	75	0	1	75	100%
4) Accessible passenger elevator or reasonable alternative for multi-level floor accommodation.	27	0	49	27	100%
5) Clear floor space for wheelchairs in waiting area and exam room.	75	0	1	75	100%
6) Wheelchair accessible restroom facilities.	74	1	1	75	99%
7) Wheelchair accessible handwashing facilities or reasonable alternative.	74	1	1	75	99%

B. Site environment is maintained in a clean and sanitary condition.	Yes	No	NA	Total#	Compliance
1) All patient areas including floor/carpet, walls, and furniture are neat, clean, and well maintained.	69	6	1	75	92%
2) Restrooms are clean and contain appropriate sanitary supplies.	73	2	1	75	97%
C. Site environment is safe for all patients, visitors, and personnel.	Yes	No	NA	Total#	Compliance
1) Fire safety and prevention.	71	5	0	76	93%
2) Emergency non-medical procedures (e.g. site evacuation, workplace violence).	71	5	0	76	93%
3) Lighting is adequate in all areas to ensure safety.	76	0	0	76	100%
4) Exit doors and aisles are unobstructed and egress (escape) accessible.	75	0	1	75	100%
5) Exit doors are clearly marked with "Exit" signs.	73	2	1	75	97%
6) Clearly diagramed "Evacuation Routes" for emergencies are posted in a visible location at all elevators, stairs and exits.	69	6	1	75	92%
7) Electrical cords and outlets are in good working condition.	75	0	1	75	100%
8) Fire Fighting Equipment in accessible location	74	2	0	76	97%
9) An employee alarm system.	73	1	2	74	99%
D. Emergency health care services are available and accessible 24 hours a day, 7 days a week.	Yes	No	NA	Total#	Compliance
1) Personnel are trained in procedures/action plans to be carried out in case of medical emergency on site.	75	1	0	76	99%
2) Emergency equipment is stored together in easily accessible location and is ready to be used.	72	4	0	76	95%
3) Emergency phone number contacts are posted, updated annually and as changes occur.	72	4	0	76	95%
Emergency medical equipment appropriate to practice/patient population is available on site:	Yes	No	NA	Total#	Compliance
4) Airway management: oxygen delivery system, nasal cannula or mask, bulb syringe and Ambu bag.	66	10	0	76	87%
5) Emergency medicine for anaphylactic reaction management, opioid overdose, chest pain, asthma, and hypoglycemia. Epinephrine 1mg/ml (injectable) and	65	11	0	76	86%

Diphenhydramine (Benadryl) 25 mg (oral) or Diphenhydramine (Benadryl) 50 mg/ml (injectable), Naloxone, chewable Aspirin 81 mg, Nitroglycerine spray/tablet, bronchodilator medication (solution for nebulizer or metered dose inhaler), and glucose (any type of glucose containing at least 15 grams). Appropriate sizes of ESIP needles/syringes and alcohol wipes.					
6) Medication dosage chart for all medications included with emergency equipment (or other method for determining dosage) is kept with emergency medications.	56	20	0	76	74%
There is a process in place on site to:	Yes	No	NA	Total#	Compliance
7) Document checking of emergency medication, equipment and supplies for expiration and operating status at least monthly.	67	9	0	76	88%
8) Replace/re-stock emergency medication, equipment and supplies immediately after use.	74	2	0	76	97%
E. Medical and lab equipment used for patient care is properly maintained.	Yes	No	NA	Total#	Compliance
1) Medical equipment is clean.	76	0	0	76	100%
2) Written documentation demonstrates the appropriate maintenance of all medical equipment according to equipment manufacturer's guidelines.	64	12	0	76	84%

Qualitative Analysis

To meet "Basic Access" requirements for the PARS audit, all (29) Critical Elements (CE) must be met. In 2025 38% of offices met the "Basic Access" requirements, compared to 25% in 2024 and 51% in 2023. While the increase in the overall number of PARS audits in 2025 may account for some of the increase in offices meeting "Basic Access" requirements, it is a trend that the Basic and Limited numbers are typical, given the ages of the LA buildings and the exemptions allowed due to office building age.

Within the facility site review aspect of the department's duties, there are several individual criteria that demonstrate the greatest opportunities for improvement and these individual criteria include: Medication dosage chart for all medications included with emergency equipment (or other method for determining dosage) is kept with emergency medications at 74%. Written documentation demonstrates the appropriate maintenance of all medical equipment according to equipment manufacturer's guidelines at 84% airway management: oxygen delivery system, nasal cannula or mask, bulb syringe and Ambu bag at 86%.

Document checking of emergency medication, equipment and supplies for expiration and operating status at least monthly at 88%.

More importantly, the critical element criteria regarding airway management, which was only 69% compliant in 2024, is 87% in 2025 showing Unit efforts and education from 2024.

As a result, offices are better prepared to reduce risk for injury or death of members when appropriate Airway management is demonstrated.

Interventions

1. Evaluate common reasons for deficiencies, participate in a newly formed collaborative group studying the variances, reasoning for these variances and analyzing the review process by working with Healthy Data System vendor to analyze both Blue Shield Promise and cross county FSR commonly found deficiencies to build targeted training and support.
2. Nurse auditor education and participation of the FSR and MRR standards in a 5-day deep dive of each question, delving into the FAQ's authorized by DHCS and working through any discrepancies of the auditing process.
3. Continue to iterate and provide best practice, new resources provided to offices of assessment forms, policies or example logs, etc. by which site staff can implement into practice for ongoing compliance and adherence to standards.
4. Support staff have participated in an educational session and PPT presentation provided to call and or discuss and educate the newly implemented off-schedule updates to the standards prior to scheduling a review.
5. In January 2025, the Unit implemented Interim Medical Record reviews (MRR) on all sites with a failing section score at the 18-month mark of the original Periodic review.
6. Bring trends to Los Angeles County Collaborative to leverage industry and local county best practices.
7. Review of collaborative assignments and an increase of site assignments to BlueShield Promise allows more direct access to sites for on-site education.

2026 Goals

1. Continue to provide technical and educational support to provider sites as it relates to low scoring audit criteria in both FSR and MRR audit tools.
2. Monitor effectiveness of program interventions through both qualitative and quantitative measures.
3. Evaluate the Interim MRR process at the 18 months interim review to include corrective actions as part of the monitoring process to improve provider's next periodic scores.
4. Continue to leverage technology in our internal and vendor databases to understand trends and establish baseline performance for groups over a period of time.

Comprehensive Perinatal Services Program

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

- MCPs must prioritize the prompt initiation of prenatal care and ensure the provision of comprehensive perinatal services.
- MCPs must ensure that providers have implemented a comprehensive risk assessment tool for all pregnant members that is comparable to American College of *Obstetricians and Gynecologists* (ACOG) and the Comprehensive Perinatal Services Program (CPSP) standards (California Code of Regulations, Title 22, Section 51348). A risk assessment must be completed at each trimester and postpartum visit.
- Individualized care plans must be developed to include obstetrical, nutritional, psychosocial, and health education interventions when indicated by identified risk factors.
- MCPs must ensure that nutrition, psychosocial, and health education services are provided by staff with demonstrated professional competence, and that all prenatal care providers and non-physician medical practitioners are trained and educated on the standards and requirements of providing comprehensive perinatal services to Medi-Cal beneficiaries per ACOG standards.
- Plans must ensure that pregnant women at high risk of poor pregnancy outcomes are referred to appropriate specialists, including perinatologists.

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

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

KEY FINDINGS AND INTERVENTIONS

Table 8: CPSP Medical Record Review for LA County

Medical Record Reviews	Audited CY25 (Deliveries CY24)	Audited CY24 (Deliveries CY23)	Audited CY23 (Deliveries CY22)
Total Providers Audited	22	13	30
Average Medical Record Review Score	92%	89%	81%
Total # of Records Audited	101	71	106
CPSP CAPs	Audited CY25 (Deliveries CY24)	Audited CY24 (Deliveries CY23)	Audited CY23 (Deliveries CY22)
Total Providers Audited	22	13	30
Total CPSP Medical Record Review CAPs Issued	0	1	8

Table 8 Summary: CPSP Medical Record Review for LA County

The CPSP medical record review is conducted to ensure optimum perinatal care and pregnancy outcomes for Blue Shield Promise members and compliance with DHCS Policy Letter 12-003 and California Code of Regulations, Title 22, Section 51348. Requests for medical records are sent to obstetric offices and tracked for receipt. In 2025, CPSP medical record reviews were conducted for pregnant members with a successful delivery during 2024. The average score for medical records reviewed was 92%. The passing score is 80%.

Qualitative Analysis

1. Twenty-two OB providers were audited in 2025, with an average score of 92%. In 2024, thirteen OB providers were audited, with an average score of 89%.
2. The number of medical records audited increased from 71 in 2024 to 101 in 2025.
3. There were no Corrective Action Plans (CAPs) in 2025, compared to 1 in 2024 and 8 in 2023.

Trends in Performance

- Improvement in Audit Scores:

Over the three-year period, there has been a consistent increase in the average medical record review scores among audited providers. The average score improved from 81% in CY 2023 (deliveries in CY 2022) to 89% in CY 2024 (deliveries in CY 2023), and to 92% in CY 2025 (deliveries in CY 2024).

- Reduction in Corrective Action Plans (CAPs):

The number of Corrective Action Plans issued has significantly decreased each year. Eight CAPs were issued in CY 2023, dropping to just one in CY 2024, and notably, no CAPs were required in CY 2025. This downward trend reflects improved provider adherence to CPSP requirements and the effectiveness of interventions such as targeted education and re-

auditing.

- Increase in Providers and Records Audited:

The total number of providers audited rose from 13 in CY 2024 to 22 in CY 2025, after auditing 30 providers in CY 2023. Similarly, the number of medical records reviewed increased from 71 in CY 2024 to 101 in CY 2025.

- Consistent Compliance Above Passing Threshold:

The average scores each year have remained well above the passing threshold of 80%, with marked improvement year after year.

Opportunities for Improvement

1. Continuing Blue Shield Promise provider education to ensure optimum perinatal care and pregnancy outcomes for Medi-Cal managed care beneficiaries.
2. Include all Blue Shield Promise in-network obstetric providers in audits to ensure optimum perinatal care and pregnancy outcomes for Blue Shield Promise Medi-Cal managed care beneficiaries. Re-audit providers who do not meet the threshold audit score of 80% to evaluate effectiveness of Corrective Action Plans (CAP) and education.
3. Enhance audit selection to increase accuracy of identifying members and providers.
4. Collaborate with Maternal, Infant, Child Health Equity team to track trends and identify areas for improvement and targeted education of providers.

Interventions

1. In 2025 we created new job aids and training resources to enhance provider comprehension of CPSP and ACOG standards, bolster knowledge of our CPSP auditing and monitoring oversight program and improve adherence to medical record requests.
2. Educated providers through CAPs and re-audited providers to assess their efficacy and ensure the highest standard of perinatal care and pregnancy outcomes for Blue Shield Promise Medi-Cal managed care beneficiaries.
3. Continued refining and enhancing the audit selection process to ensure accurate identification of OB providers and their members.
4. Maintained the escalation process started in 2023 to address non-compliance issues with medical record requests and CAPs.

Early and Periodic Screening, Diagnostic and Treatment Program

Blue Shield Promise administers the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program for eligible individuals under 21, aligning with state and federal regulations

and All Plan Letter (APL) 23-005. The program ensures comprehensive coverage and delivery of medically necessary services, including screening, vision, dental, hearing, and behavioral health treatments based on the American Academy of Pediatrics (AAP) Bright Futures Guidelines and Periodicity Schedule. These standards guide preventive care, screenings, and well-child visits, ensuring evidence-based, age-specific interventions.

The EPSDT program is integrated into Blue Shield Promise's Population Health Management (PHM) strategy, emphasizing early identification and intervention for health conditions through systematic risk assessment and care coordination. The program includes care coordination (CC) services for low-risk members and case management (CM) and Complex Case Management (CCM) services for high- and medium-risk members. Selection criteria and timely assessments (within 60 days of member agreement) ensure that those most in need receive targeted support. The program also includes structured communication with members' primary care providers (PCPs) and allows for member choice with an opt-out process.

Blue Shield Promise coordinates and covers all medically necessary EPSDT services, except those specifically carved out (e.g., California Children's Services [CCS], pharmacy, dental, specialty mental health, and substance use disorder services). For these carve-outs, the plan ensures non-medical and non-emergency medical transportation (NMT/NEMT) and maintains communication with carve-out programs to support continuous care. Members with CCS-eligible conditions are referred efficiently to local CCS offices, with Blue Shield Promise remaining responsible for ongoing EPSDT service provision and ensuring care continuity during and after transitions.

Quality Program Evaluation Focus

- **Regulatory Compliance:** Adherence to APL 23-005 and federal guidelines ensure program integrity and alignment with regulatory standards.
- **Evidence-Based Practice:** Utilization of AAP Bright Futures tools and periodicity schedules ensures preventive care is consistent with national best practices.
- **Comprehensive Case Management:** Early assessment, risk stratification, and ongoing communication with PCPs and carve-out programs to drive coordinated, member-centered care.
- **Continuous Improvement:** The program includes mechanisms for tracking member participation, opt-outs, and timely completion of assessments, supporting ongoing evaluation and quality improvement.
- **Access and Equity:** Coverage of all medically necessary services for eligible members, including transportation and coordination with external programs, addresses barriers to care and promote equitable health outcomes.

This quality evaluation demonstrates that Blue Shield Promise's EPSDT program is structured to meet regulatory requirements, deliver comprehensive, evidence-based care, and ensure seamless coordination across service areas, with ongoing evaluation mechanisms to drive improvement and address member needs.

Activity Description

The PHM Children's Services team is committed to achieving greater than 90% adherence to APL 23-005 and all applicable federal guidelines. This strict compliance ensures that the program maintains integrity and is fully aligned with regulatory standards. By meeting these requirements, the team guarantees that children and teens receive and have unfettered access to all medically necessary services, supporting the timely identification and effective treatment of health conditions. This activity is tracked on the Quality Work Plan to ensure ongoing oversight and accountability.

Goals

For the 2026 Measurement Year, the PHM Children's Services Team has established targeted goals tied directly to both organizational objectives and regulatory requirements. These goals include achieving a 5% year-over-year increase in well-child visits, a boost in immunization rates among pediatric members, and greater engagement in care management programs to ensure ongoing support for at-risk children. The team also aims to increase enrollment and service authorization request (SAR) approvals for the California Children Services (CCS) Program, expanding access to essential specialty services in line with state carve-out requirements. Additionally, efforts will focus on enhancing the identification and referral of members diagnosed with developmental disabilities to Regional Centers, thereby strengthening care coordination and connection to specialized support. Collectively, these initiatives advance Blue Shield Promise's mission to provide comprehensive, high-quality, and equitable care to children and adolescents, while upholding compliance with all relevant regulatory standards.

Accomplishments

2025 has yet been another great year for the PHM Children's Services Team. The team was not selected for audit this year, owing to outstanding performance and high scores achieved in both the LA Care and DHCS Annual Audits in 2024. Throughout 2025, the PHM Children's Services Team exceeded all its established goals, demonstrating significant improvements in well-child visits, immunization rates among pediatric members, and the successful closing of care gaps for EPSDT members. Notably, the team achieved its Health Equity objective by

boosting care management engagement within the Hispanic population, reflecting a strong commitment to equitable service delivery. Additionally, the PHM Children's Services Team reached monumental enrollment milestones in the California Children's Services (CCS) and Department of Developmental Services (DDS) Programs, expanding access to critical specialty and developmental services for eligible children and adolescents.

Quantitative Analysis

This section presents a quantitative evaluation of PHM Children's Services Team performance metrics for the 2025 measurement year, with comparative trends against 2024 benchmarks. The analysis utilizes data extracted from 2026 Care Management Reporting to highlight key improvements, areas of stability, and declines across critical indicators.

Metric	2024	2025	Change (%)
Well-Child Visit Completion Rate	75%	80%	+5%
Pediatric Immunization Rate	68%	73%	+5%
Care Management Engagement	45%	52%	+7%
CCS Enrollment	1,250	1,350	+8%
DDS Referrals	320	340	+6%

As illustrated in the table, all tracked metrics demonstrated measurable improvement in 2025 compared to 2024. Well-child visit completion rates increased by 5%, pediatric immunization rates rose by 5%, and care management engagement saw a notable 7% uptick. Enrollment in the California Children's Services (CCS) program and referrals to the Department of Developmental Services (DDS) both showed growth, reflecting the team's expanded outreach and enhanced coordination efforts.

2025 performance demonstrated upward trends for each key performance indicator:

- **Well-Child Visits:** Steady increase, signaling successful outreach and improved process workflows.
- **Immunization Rates:** Consistent upward trend, attributed to targeted interventions and education campaigns.
- **Care Management Engagement:** Marked growth, especially within high-risk populations, demonstrating effective case management strategies.

- **CCS Enrollment & DDS Referrals:** Both metrics reflect expanded access and timely identification of members for specialty services.

These quantitative outcomes confirm that the PHM Children’s Services Team not only met but exceeded organizational goals for 2025, with every major metric showing improvement over the prior year. The data supports a conclusion of positive momentum and effective program execution.

Qualitative Analysis

Team insights indicate that the positive performance observed in 2025 is the result of targeted strategies and operational improvements implemented throughout 2025. Compared to 2024, several key trends have emerged. First, the consistent growth in well-child visit completion and pediatric immunization rates can be attributed to enhanced outreach efforts and streamlined care coordination processes. The team prioritized member engagement by leveraging data-driven interventions and strengthening partnerships with community providers, which directly contributed to the 5% increase in both metrics over the prior year.

Additionally, the substantial increase in care management engagement, up 7% from 2024, reflects the effectiveness of newly adopted case management strategies, especially for high-risk pediatric populations. These strategies included proactive follow-up, personalized care plans, and expanded support resources for families. The steady rise in CCS enrollment and DDS referrals further underscores the impact of improved identification and referral mechanisms, ensuring that more children with complex needs are connected to specialty services in a timely manner.

Data from the reporting period also highlights ongoing operational enhancements, such as automation refinements within the CCS program and greater regulatory compliance, which have helped drive cost savings and process efficiencies. The team’s ability to adapt to evolving requirements, as seen in the implementation of new MOU mandates, has positioned the program for continued success. Overall, the upward trends across all major indicators this year not only surpassed last year’s results but also demonstrate the program’s growing capacity to deliver high-quality, accessible care to children and their families.

Trends in Performance

Patterns Identified via Quantitative and Qualitative Analysis

- **Steady Improvement Across Key Metrics:** Both quantitative data and qualitative insights reveal consistent upward trends throughout the previous measurement year. Well-child visit completion rates, pediatric immunization rates, care management engagement, CCS enrollment, and DDS referrals all showed measurable increases from 2024 to 2025, reflecting successful outreach and enhanced coordination efforts.
- **Effective Targeted Strategies:** The implementation of data-driven interventions strengthened partnerships with community providers and streamlined care coordination processes contributed to the improved performance observed in well-child visits and immunization rates.
- **Growth in High-Risk Population Engagement:** The team's newly adopted case management strategies, such as proactive follow-up and personalized care plans, led to a notable increase in engagement among high-risk pediatric members.
- **Operational Enhancements:** Automation refinements and improved regulatory compliance, particularly within the CCS program, drove process efficiencies and cost savings, supporting the program's overall success.
- **Expanded Access to Specialty Services:** Increased CCS enrollment and DDS referrals point to improved identification and referral mechanisms, ensuring more children with complex needs to receive timely specialized care.
- **Positive Momentum and Goal Achievement:** All major metrics not only surpassed previous year's results but also confirmed the team's capacity to deliver high-quality, accessible care, demonstrating effective program execution and ongoing positive momentum.

Barriers and Mitigation Plans

Challenges Encountered: During the 2025 Measurement Year, the Children's Services team faced several notable barriers. Key challenges included resource gaps, such as limited staffing and constrained operational budgets, which occasionally hampered the ability to expand outreach and deliver timely services. Workflow inefficiencies were also observed, particularly in the coordination of care across multiple programs and agencies, leading to delays in referrals and follow-up activities. Additionally, adapting to new regulatory requirements and evolving MOU mandates created additional administrative burdens, sometimes diverting focus from direct member engagement.

Mitigation Plans: To address these challenges, the team implemented several targeted solutions. Resource gaps were mitigated by prioritizing critical activities and reallocating existing staff to high-impact areas, while also advocating for increased funding and support. Workflow inefficiencies were tackled through process automation, streamlining referral and enrollment procedures, and enhancing interdepartmental communication channels. For

regulatory and administrative burdens, the team invested in training and technology upgrades to facilitate compliance and reduce manual workload. These mitigation efforts collectively strengthened program resilience and supported continued improvement in service delivery and outcomes.

Recommendations for the Following Year

Based on the performance trends and lessons learned during the 2025 Measurement Year, the following outline details recommended actions and strategic adjustments to further enhance the Children's Services Team's impact in 2026. These suggestions address persistent barriers, capitalize on recent successes, and align future goals with evolving needs.

- **Maintain and Refine Current Goals:** Given the measurable improvements across all key metrics in 2025, the existing goals for well-child visits, immunization rates, care management engagement, CCS enrollment, and DDS referrals should remain in place for 2026. However, targets may be modestly increased to drive continuous improvement and sustain positive momentum.
- **Expand Outreach and Engagement Strategies:** Building on the success of data-driven interventions, further expand outreach by incorporating additional community partnerships and leveraging digital engagement tools such as Auto Dialer. Target populations with historically lower engagement or access barriers, such as underserved neighborhoods or non-English speaking families.
- **Invest in Workforce Development:** Crosstrain team members to increase flexibility and resilience, especially during periods of high demand or staffing shortages.
- **Enhance Process Automation and Technology Integration:** Continue refining automation within referral and enrollment workflows, with a focus on reducing administrative burden and improving service timeliness. Explore opportunities to integrate new technology platforms that facilitate interdepartmental communication and real-time data sharing.
- **Strengthen Regulatory Compliance and Training:** Offer ongoing training and education to keep staff up to date with regulatory changes and MOU mandates. Develop standardized compliance checklists and digital resources to streamline administrative tasks and free up more time for direct member engagement.
- **Implement New Initiatives for High-Risk Populations:** Launch pilot programs focused on high-risk pediatric members, such as home-based care management or telehealth support. Evaluate outcomes and consider broader adoption if results demonstrate improved engagement and health outcomes.
- **Monitor, Evaluate, and Adjust Goals as Needed:** Establish quarterly review cycles to assess progress toward goals and make data-informed adjustments. If specific

metrics plateau or decline, re-examine strategies and adapt interventions to ensure ongoing improvement.

- **Foster a Culture of Continuous Improvement:** Encourage innovation and feedback from frontline staff, families, and community partners. Recognize and reward successful initiatives and share best practices across the organization.

In summary, the Children's Services Team should build on the solid foundation established in 2025 by maintaining ambitious yet achievable goals, implementing targeted new initiatives, and proactively addressing operational challenges. These recommendations will help drive further improvements in service delivery, member outcomes, and overall program effectiveness in 2026.

QUALITY OF SERVICE

Customer Service

2025 Telephone Access Study, Medi-Cal Los Angeles

Blue Shield of California Promise Health Plan maintains established telephone access standards and routinely monitors member experience with telephone services to identify opportunities for improvement and take corrective action as needed.

Methodology

Each year, the Customer Service Department collects and analyzes data to assess performance against established standards for telephone access to Customer Service. This analysis is based on information obtained from inbound call key performance indicators (KPIs) for the period of January 1 through December 31, 2025.

Customer Service Call Center Goals: DHCS Regulation

- 80% of incoming calls are answered within 30 seconds
- Abandonment rate not to exceed 5%

Findings and Quantitative Analysis (Medi-Cal Los Angeles)

Calls Received	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
2025	19,509	17,019	17,875	17,880	16,673	16,537	18,309	16,660	17,186	18,463	14,043	15,739	205,893
2024	17,681	18,470	18,302	19,220	19,248	16,366	19,140	19,679	18,433	20,640	16,513	16,148	219,840
Abandoned Calls	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
2025	352	56	37	81	92	151	246	199	250	288	284	479	2,515
2024	175	291	287	221	177	86	146	154	226	185	188	178	2,314
Answered within 30 Seconds %	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Average
2025	80%	94%	96%	94%	90%	86%	84%	86%	82%	77%	67%	70%	84%
2024	83%	79%	79%	81%	88%	93%	90%	88%	82%	87%	85%	84%	85%
Abandonment Rate	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Average
2025	1.8%	0.3%	0.2%	0.5%	0.6%	0.9%	1.3%	1.2%	1.5%	1.6%	2.0%	3.0%	1.2%
2024	1.0%	1.6%	1.6%	1.1%	0.9%	0.5%	0.8%	0.8%	1.2%	0.9%	1.1%	1.1%	1.0%

Reporting Quarter	Calls Received	Abandoned Calls	Average % of Answered Calls Within 30 Seconds	Average Abandonment Rate
1 st Quarter	54,403	445	90%	0.8%
2 nd Quarter	51,090	324	90%	0.7%
3 rd Quarter	52,155	695	84%	1.3%
4 th Quarter	48,245	1,051	71%	2.2%
Total/Average	205,893	2,515	84%	1.2%

Trends In Performance

Overall call volume decreased in 2025 compared to 2024 (205,893 vs. 213,840). However, abandoned calls increased year-over-year (2,515 vs. 2,314), resulting in a higher average abandonment rate (1.2% vs. 1.0%). Service level (percent answered within 30 seconds) remained relatively stable but decreased slightly in 2025 (84% vs. 85%). Performance was strongest in early-to-mid 2025 and declined in Q4, where abandonment and service-level deterioration were most pronounced.

Qualitative Analysis

Customer Care Department met both our service level and abandonment rate in 2025.

- The average abandonment rate trended at 5% for the year
- Service level year-to-date was 84%
- Customer Service received a total of 205,893 calls in 2025. This shows a 6% decrease in overall call volume compared to 2024.

- There were no findings to be reported in 2025.

2026 Outlook

The Customer Service Department will continue to implement process improvements to ensure all staff are informed of upcoming changes, including annual trainings and mandated requirements. Knowledge base articles will be reviewed and updated annually and shared with staff to communicate any changes, process updates, and/or regulatory requirements.

The Customer Service Department's goals will remain the same for 2026:

- 80% of calls answered within 30 seconds.
- Abandonment rate at 5% or below.

Delegation Oversight: UM/Claims/Credentialing

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

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

Methodology

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

Deficiencies are addressed through mitigation between the Plan and delegated partners, which may result in the development of a correction action plan (CAP). CAPs are required

when delegated partners fail to meet minimum thresholds as defined in the delegation oversight policies and procedures. Audits are also tracked to identify potential opportunities for improvement across the network. Those delegates that pose a high risk to the Plan may be analyzed by a multidisciplinary sub-work group of the DOC and tracked through the DOC for company-wide transparency and intervention.

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

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

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

Claims Annual/Quarterly/Monthly Oversight (Medi-Cal)
• Paid Contracted and Non-Contracted Providers including Emergency Room claims
• Family Planning/Sensitive Services – Non-Contracted providers excluding ER (please see enclosed list of family)
• Provider Dispute Resolution
• Adjustments – report showing payment adjustments to previously processed claims
• Contested/Provider Denials (contracted and non-contracted)
• Misdirected/Forwarded Claims
• Open inventory/Pend report to be provided on the day of the on-site audit
• Emergency Claims
• Medical Record Request Compliance

Credentialing/Recredentialing Annual File Review
• Credentialing/Recredentialing Application and Attestation, including Race, Ethnicity and Language (REL) and Non-Discrimination Statement regarding REL
• Licensure
• DEA
• Education/Training
• Board Certification
• Work History

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

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

2025 Goals:

- 100% of applicable annual delegation oversight audits, including follow-up and/or focus audits to be completed in 2025.
- 100% of quarterly/semi-annual reporting to be received timely and reviewed within 30 days of receipt.
- 100% of completed audit results reported to the Delegation Oversight Committee.

The following metrics summarize 2025 activities for the Delegation Oversight Team:

Function	Percentage of Timely Audits	Total Number of Pre-De Audits	Percentage of Timely Reporting
Claims	100%	11	97%
Credentialing	100%	10	100%
UM	100%	6	100%

Quantitative and Qualitative Analysis

In 2025 the Delegation Oversight teams conducted 100% timely annual audits ensuring those delegated entities that fell below the thresholds were put on CAPS and followed to closure. Those delegated entities that pose a risk were put on a high- risk alert list in the DOC. In 2025, there were 5 delegate/MSOs that were put on the high-risk log for monitoring through the DOC and the results were as follows:

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

All delegated entities are monitored through timely reporting. Reporting timeframes vary by function and line of business, however, at a minimum, delegated entities are required to report activities semi-annually. In 2025 all delegated entities met 90% - 100% timely reporting. Those delegated entities that didn't meet timely submittal were given a 10-calendar day grace period due to various reasons, including but not limited to staff turnovers and system issues, that led to gaps in understanding, temporary inaccessibility of data, and following protocols. At the end of the grace period, all delegated entities were compliant.

Trends in Performance

Our team has successfully maintained compliance with all timeliness regulatory requirements. We've observed trends in corrective actions related to UM letter template compliance and Claims audit readiness among our delegated entities. To address these issues, we conducted follow-up focused audits and provided targeted training sessions. These measures have been instrumental in ensuring that our delegated entities meet the required standards.

2026 Outlook & Strategic Direction

In 2026, the Delegation Oversight Team will continue to strengthen partnerships with delegated entities to promote operational compliance, service quality, and improved health outcomes for Plan members. The team will prioritize proactive engagement, timely intervention, and cross-functional collaboration to ensure delegates are well-equipped to meet regulatory, contractual, and accreditation standards. Emphasis will be placed on transparency, communication, and ongoing training to support consistent, high-quality performance across all delegated functions.

2026 Goals & Key Priorities

The Delegation Oversight Team will focus on the following priorities:

- **Maximize utilization of the Delegation Oversight Regulatory Management System (DORMS)** to streamline tracking of all delegation activities, support real-time monitoring, and centralize documentation for improved audit readiness.
- **Expand and enhance delegate training programs**, including updated training modules, standardized onboarding for new delegates, and targeted refresher training to address recurring trends or risk areas.
- **Automate notifications from Contracting** to ensure Delegation Oversight has immediate visibility into changes in delegation agreements, allowing for timely updates to oversight plans and audit scope.
- **Strengthen compliance monitoring** through comprehensive annual oversight, timely development and closure of Corrective Action Plans (CAPs), and consistent review of delegate reporting across all lines of business.
- **Conduct Inter-Rater Reliability (IRR) audits** on Delegation Oversight auditors to promote consistency, accuracy, and alignment with standards across all auditing practices.
- **Advance cross-functional collaboration** with internal partners—including Quality, Compliance, Contracting, Credentialing, and Claims—to create a unified and coordinated approach for overseeing delegated entities.

Refine risk-stratification processes to identify, monitor, and escalate high-risk delegates through the Delegation Oversight Committee (DOC), ensuring visibility, mitigation planning, and timely leadership intervention

MEMBER EXPERIENCE

Member Satisfaction – CAHPS

2025 Promise Health Plan Medi-Cal Los Angeles; Adult and Child Quality Program Evaluation

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

The Member Experience is an important indicator for measuring quality and is required by the Center of Medicare Medicaid Services (CMS), Department of Managed Healthcare Services (DMHC), and the National Committee for Quality Assurance (NCQA), for compliance

with accreditation requirements. Blue Shield Promise's objective is to gain insight and obtain information from our members, about their perceived experience and expectations related to the continuum of healthcare. The measurement of member experience determines the effects of overall member experience with quality and identifies areas of opportunities for quality improvement. Blue Shield Promise regards all members highly and acts with members' needs in mind.

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

A. Member Experience Consumer Assessment of Healthcare Providers and Systems (CAHPS)

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

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

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

Time Frame: The survey is in the field February 25, 2025 – May 7, 2025, which represents reporting year (RY) 2025, using measurement year (MY) 2024 data.

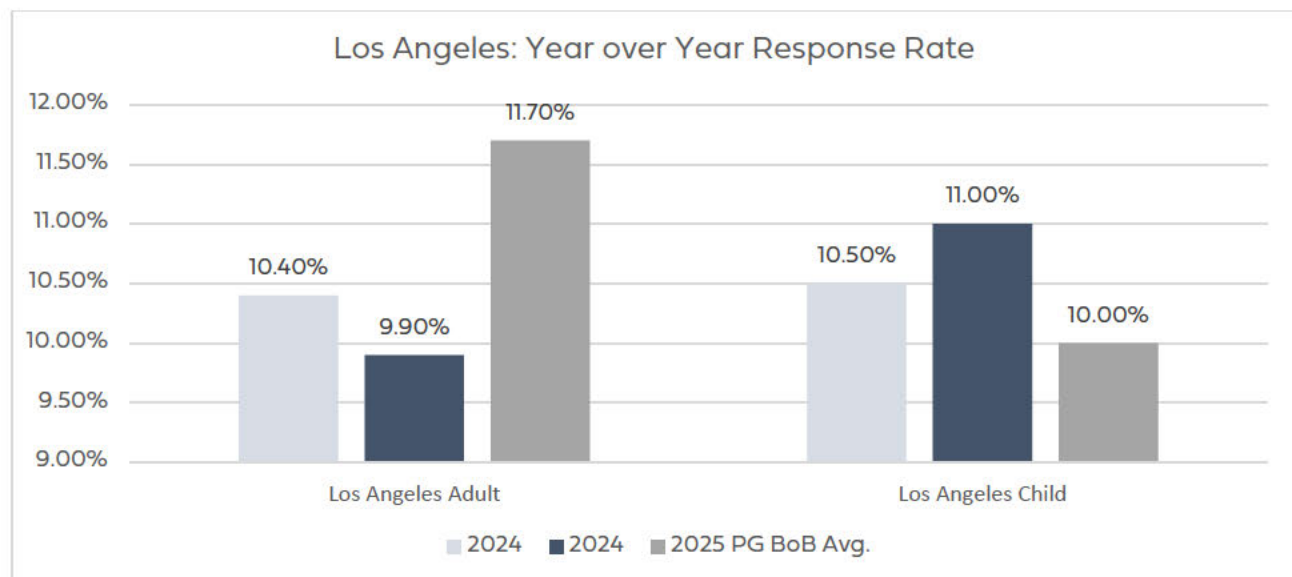
Member Eligibility: Blue Shield Promise conforms to strict NCQA sample selection and eligibility requirements. This ensures PHP generates a sample population frame that is unbiased and accurate. When compiling the sample size, PHP follows the requirements as outlined by NCQA.

- All child Medicaid members are ages 17 years or younger at the time the sample is drawn for the measurement year in specified County.
- All adult Medicaid members are ages 18 years or older at the time the sample is drawn for the measurement year in specified County.
- Continuously enrolled for no less than 6 months of the reporting year with Blue Shield Promise Medicaid health insurance coverage.
- Includes no more than one gap in enrollment of up to 45 days during the measurement year.

Overview: Blue Shield Promise in 2025 conducted a Medicaid adult and child CAHPS surveys for NCQA accreditation, regulatory purposes, and quality improvement efforts. Blue Shield Promise is committed to improving the member experience for all members and will continue to report Medicaid data.

Sample Size: Blue Shield Promise strategically oversamples to ensure an appropriate response rate for child and adult Medicaid CAHPS surveys. Blue Shield Promise oversamples according to expected responses for the Medicaid population. By anticipating expected response rates for the sample size, PHP can produce reliable data that is statistically significant. In 2025 Blue Shield Promise oversampled the Medicaid population.

Blue Shield Promise Sample Size for Medicaid CAHPS:



Los Angeles LOB's	Sample Size	Grand Total Completes	Mail Completes	Telephone Completes	Internet Completes	Response Rate
Los Angeles Adult	2,302	224	89	85	50	9.9%
Los Angeles Child	2,302	250	56	127	67	11.0%

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

YoY Response Rate	2024	2025	2025 PG BoB Avg.
Los Angeles Adult	10.4%	9.9%	11.7%
Los Angeles Child	10.5%	11.0%	10.0%

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

Goal: 2025 Blue Shield Promise goals will be compared to the NCQA quality compass Medicaid average from the previous year. This allows Blue Shield Promise to accurately track year-over-year growth, better understand areas of opportunity and set a realistic goal that Blue Shield Promise is targeting. Rates above average will indicate goal has been met, while rates below average will indicate goal not met.

Table 1. Medi-Cal CAHPS for Los Angeles Adult: 2024 and 2025 results are displayed for comparative performance year over year. The table also includes the new 2025 goal rate and indicator of met or not met when benchmarking against NCQA Quality Compass average from previous years.

Table 1. Medi-Cal CAHPS for Los Angeles Adult Performance

Composites and Rating Questions	2024 Results	2025 Results	Delta	Trend	2024 NCQA Quality Compass average	Goal Met
Rating of health plan	80.9%	81.9%	1.00%	↑	77.7%	Yes
Rating of health care	76.8%	77.0%	0.20%	↑	75.8%	Yes
Rating of personal doctor	81.7%	86.2%	4.50%	↑	83.3%	Yes
Rating of Specialist	81.0%	85.3%	4.30%	↑	82.5%	Yes
Getting needed care	78.8%	81.2%	2.40%	↑	81.5%	No
Getting care quickly	77.3%	82.3%	5.00%	↑	80.4%	Yes
Customer service	92.2%	86.7%	-5.50%	↓	89.1%	No
How well doctors communicate	91.1%	96.1%	5.00%	↑	93.0%	Yes
Coordination of Care	79.1%	77.9%	-1.20%	↓	85.6%	No
Ease of filling out forms.	92.5%	98.4%	5.90%	↑	94.8%	Yes

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

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

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

NA indicates not applicable to reporting.

Medi-Cal CAHPS for Los Angeles Adult Quantitative Analysis (*See table 1.*)

- Rating of Health Plan increased from 80.9% (2024) to 81.9% (2025), reflecting a +1.0 percentage point improvement. Exceeded the NCQA benchmark of 77.7%, resulting in goal met.
- Rating of Health Care increased slightly from 76.8% to 77.0% (+0.2 percentage points). Surpassed the NCQA benchmark of 75.8%, and the goal was met.
- Rating of Personal Doctor improved from 81.7% to 86.2%, representing a +4.5 percentage point increase. Despite improvement, performance remained 2.9 percentage points below the NCQA benchmark of 83.3%, resulting in goal not met per plan criteria.
- Rating of Specialist increased from 81.0% to 85.3%, a +4.3 percentage point improvement. Performance exceeded the prior year but remained below the NCQA benchmark of 82.5%, resulting in goal not met.
- Getting Needed Care increased from 78.8% to 81.2%, reflecting a +2.4 percentage point improvement. Fell 0.3 percentage points below the NCQA benchmark of 81.5%, resulting in goal not met.
- Getting Care Quickly improved from 77.3% to 82.3%, a +5.0 percentage point increase. Exceeded the NCQA benchmark of 80.4%, and the goal was met.
- Customer Service declined from 92.2% to 86.7%, representing a -5.5 percentage point decrease, the largest decline among Los Angeles Adult measures. Performance was 2.4 percentage points below the NCQA benchmark of 89.1%, resulting in goal not met.
- How Well Doctors Communicate increased from 91.1% to 96.1%, a +5.0 percentage point improvement. This measure met goal based on program standards relative to the NCQA benchmark of 93.0%.
- Coordination of Care decreased from 79.1% to 77.9%, reflecting a -1.2 percentage point decline. Performance remained 7.7 percentage points below the NCQA benchmark of 85.6%, resulting in goal not met.
- Ease of Filling Out Form increased from 92.5% to 98.4%, representing a +5.9 percentage point improvement. Exceeded the NCQA benchmark of 94.8%, and the goal was met, identifying this measure as high-performing.

Table 2 Medi-Cal CAHPS for Los Angeles Child: 2024 and 2025 results are displayed for comparative performance year over year. The table also includes the new 2025 goal rate and indicator of met or not met when benchmarking against NCQA Quality Compass average from previous years.

Table 2. Medi-Cal CAHPS for Los Angeles Child Performance

Composites and Rating Questions	2024 Results	2025 Results	Delta	Trend	2024 NCQA Quality Compass average	Goal Met
Rating of health plan	86.6%	86.7%	0.10%	↑	86.3%	Yes
Rating of health care	81.5%	85.1%	3.60%	↑	86.9%	No
Rating of personal doctor	87.9%	88.6%	0.70%	↑	89.7%	No
Rating of Specialist	86.4%	92.7%	6.30%	↑	87.2%	Yes
Getting needed care	71.0%	74.6%	3.60%	↑	83.3%	No
Getting care quickly	70.6%	78.3%	7.70%	↑	86.3%	No
Customer service	88.1%	90.8%	2.70%	↑	88.3%	Yes
How well doctors communicate	86.6%	92.1%	5.50%	↑	93.8%	No
Coordination of Care	80.0%	90.8%	10.80%	↑	83.5%	Yes
Ease of filling out forms.	89.9%	98.9%	9.00%	↑	94.9%	Yes

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

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

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

NA indicates not applicable to reporting.

Medi-Cal CAHPS for Los Angeles Child Quantitative Analysis (*See table 2.*)

- Rating of Health Plan increased marginally from 86.6% (2024) to 86.7% (2025), a +0.1 percentage point increase. Performance exceeded the NCQA benchmark of 86.3%, resulting in goal met.
- Rating of Health Care improved from 81.5% to 85.1%, reflecting a +3.6 percentage point increase. Despite improvement, performance remained 1.8 percentage points below the NCQA benchmark of 86.9%, resulting in goal not met.
- Rating of Personal Doctor increased from 87.9% to 88.6%, a +0.7 percentage point improvement. Performance remained 1.1 percentage points below the NCQA benchmark of 89.7%, and the goal was not met.
- Rating of Specialist increased substantially from 86.4% to 92.7%, representing a +6.3 percentage point improvement. Exceeded the NCQA benchmark of 87.2%, and the goal was met, identifying this as a high-performing measure.
- Getting Needed Care improved from 71.0% to 74.6%, reflecting a +3.6 percentage point increase. Performance remained 8.7 percentage points below the NCQA benchmark of 83.3%, resulting in goal not met.
- Getting Care Quickly increased from 70.6% to 78.3%, a +7.7 percentage point improvement, one of the largest gains across measures. Despite improvement, performance was 8.0 percentage points below the NCQA benchmark of 86.3%, and the goal was not met.
- Customer Service improved from 88.1% to 90.8%, reflecting a +2.7

percentage point increase. Exceeded the NCQA benchmark of 88.3%, resulting in goal met.

- How Well Doctors Communicate increased from 86.6% to 92.1%, a +5.5 percentage point improvement. Performance remained 1.7 percentage points below the NCQA benchmark of 93.8%, resulting in goal not met.
- Coordination of Care improved markedly from 80.0% to 90.8%, representing a +10.8 percentage point increase, the largest improvement among all Los Angeles Child measures. Exceeded the NCQA benchmark of 83.5%, and the goal was met.
- Ease of Filling Out Forms increased from 89.9% to 98.9%, reflecting a +9.0 percentage point improvement. Exceeded the NCQA benchmark of 94.9%, and the goal was met, identifying this as a consistently high-performing measure.

Areas of Opportunities and Barriers

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

Table 3. Areas of Opportunities and Barriers

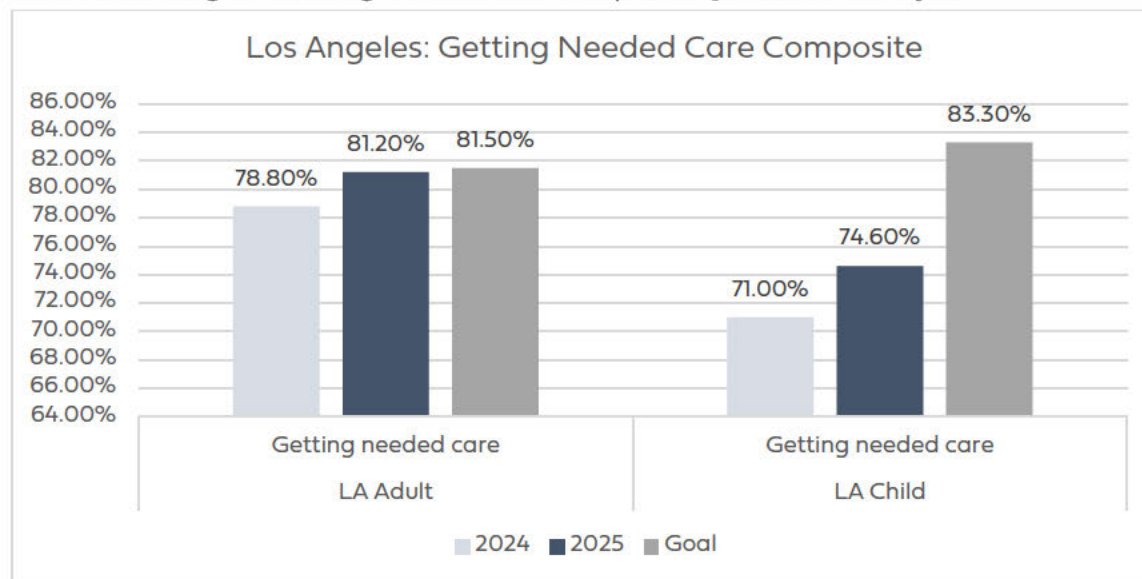
Rating of Health Plan		Rating of Health Care	
The below Composites have been identified as key drivers of Rating of Health Plan		The below Composites have been identified as key drivers of Rating of Health Care	
Getting needed care	Opportunity	Getting Care Quickly	Opportunity
Coordination of Care	Opportunity		

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

CAHPS Barriers and Opportunities Analysis

Getting Needed Care Composite Quantitative Analysis

Table 4. Los Angeles Getting Needed Care Composite Quantitative Analysis



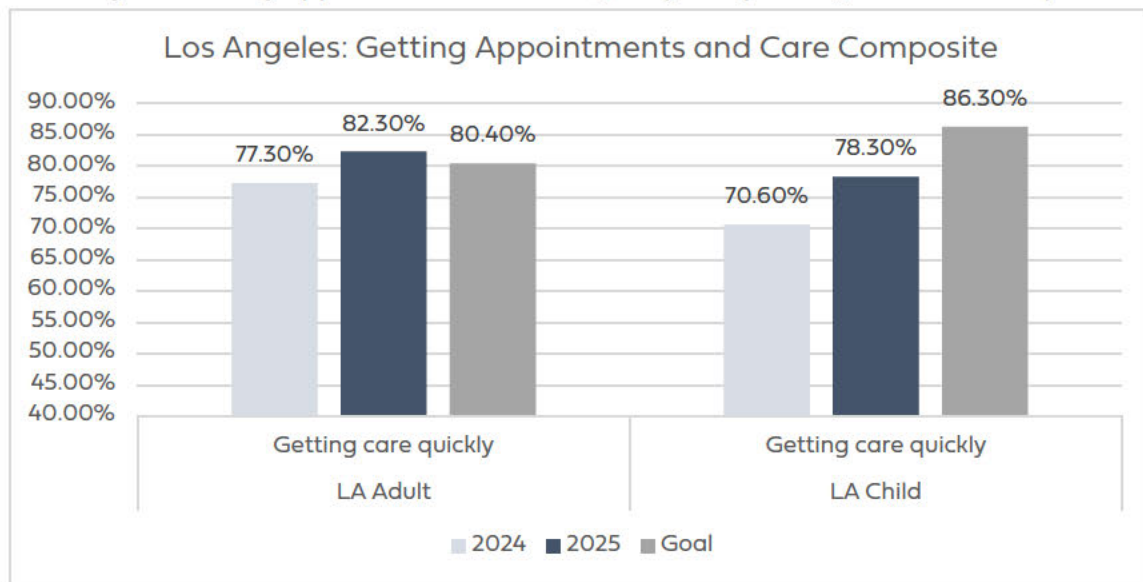
Scores are shown in the summary rate that represents the most favorable response percentages.

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

- Los Angeles Adult increased from 78.8% (2024) to 81.2% (2025), reflecting a +2.4 percentage point improvement year over year. Despite improvement, performance remained 0.3 percentage points below the goal of 81.5%, resulting in goal not met. The upward trend indicates progress, though the measure remains marginally below the target threshold.
- Los Angeles Child increased from 71.0% (2024) to 74.6% (2025), representing a +3.6 percentage point improvement. Performance remained 8.7 percentage points below the goal of 83.3%, and the measure did not meet goal. Although improvement was observed, the gap to goal remains substantial compared to the adult population.

Getting Appointments and Care Quickly Composite Quantitative Analysis

Table 5. Los Angeles Getting Appointment and Care Quickly Composite Quantitative Analysis

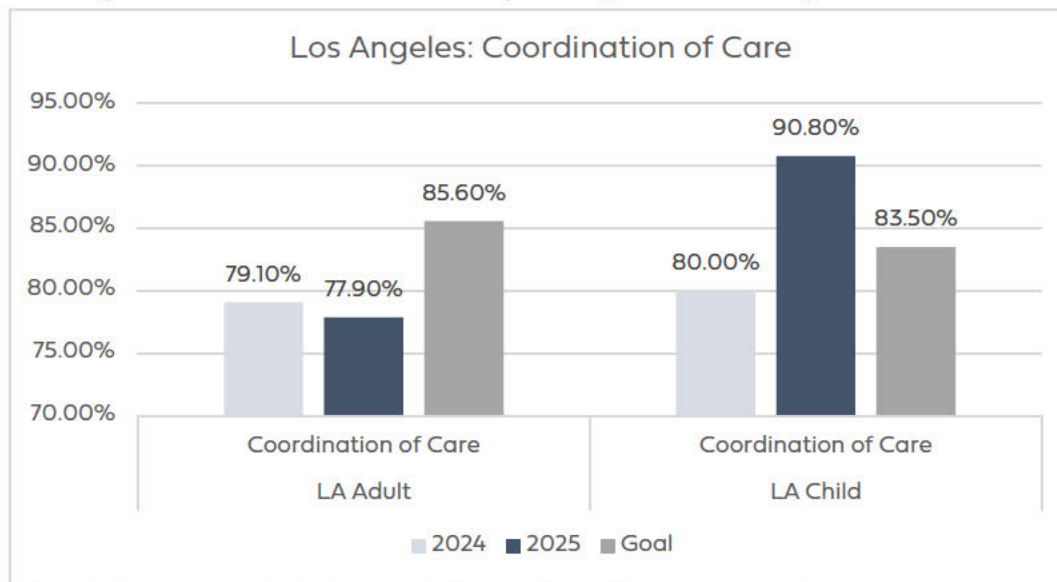


Scores are shown in the summary rate that represents the most favorable response percentages.
% always+usually, % yes, and Ratings of %8, 9, 10.

- Los Angeles Adult increased from 77.3% (2024) to 82.3% (2025), reflecting a +5.0 percentage point improvement year over year. Exceeded the goal of 80.4% in 2025 (82.3% vs. 80.4%), resulting in goal met. The upward trend demonstrates meaningful improvement in adult members' ability to obtain appointments and care quickly.
- Los Angeles Child increased from 70.6% (2024) to 78.3% (2025), representing a +7.7 percentage point improvement, the larger improvement between the two populations. Despite improvement, performance remained 8.0 percentage points below the goal of 86.3%, resulting in goal not met. Although progress was observed, the magnitude of the gap indicates persistent access challenges for the child population.

Coordination of Care Composite Quantitative Analysis

Table 6. Los Angeles Coordination of Care Composite Quantitative Analysis



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

- Los Angeles Adult decreased from 79.1% (2024) to 77.9% (2025), reflecting a -1.2 percentage point decline year over year. Performance remained 7.7 percentage points below the goal of 85.6%, resulting in goal not met. The downward trend indicates worsening member experience related to care coordination for the adult population.
- Los Angeles Child improved substantially from 80.0% (2024) to 90.8% (2025), representing a +10.8 percentage point increase, the largest improvement observed across Coordination of Care measures. Performance exceeded the goal of 83.5% by 7.3 percentage points, resulting in goal met. This improvement identifies Coordination of Care as a high-performing measure for the Los Angeles Child population in 2025.

Appeals and Grievances

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

Categories of Appeals include:

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

This report encompasses data for all Blue Shield Promise Promise Health Plan Medi-Cal products not related to Behavioral Health. The reporting period is January 1, 2025, through December 31, 2025.

Methodology

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

Complaints & Appeals Goal: In 2025, the plan observed the rate. The rate is PTMPM (per thousand members per month). This calculates the total number of appeals/complaints divided by the membership multiplied by a thousand and normalized by the number of

months (12 for the year). The rate goal is determined by the plan as less than <1.0 for each category in Appeals and Complaints.

Medi-Cal Appeals and Complaints Los Angeles

Table 7: Volume and Rate by Category for Medi-Cal Los Angeles

Appeals – Medi-Cal- Los Angeles	2024			2025			Goal Met
PHP Medi-Cal LA	Count	Rate	%	Count	Rate	%	
Access	0	0	0%	-	-	-	Yes
Attitude & Service	0	0	0%	-	-	-	Yes
Billing & Financial	233	0.05	100%	386	0.08	100%	Yes
Quality of Care	0	0	0%	-	-	-	Yes
Quality of Practitioner Office Site	0	0	0%	-	-	-	Yes
PHP Los Angeles Total	233	0.05	100%	386	0.08	100%	

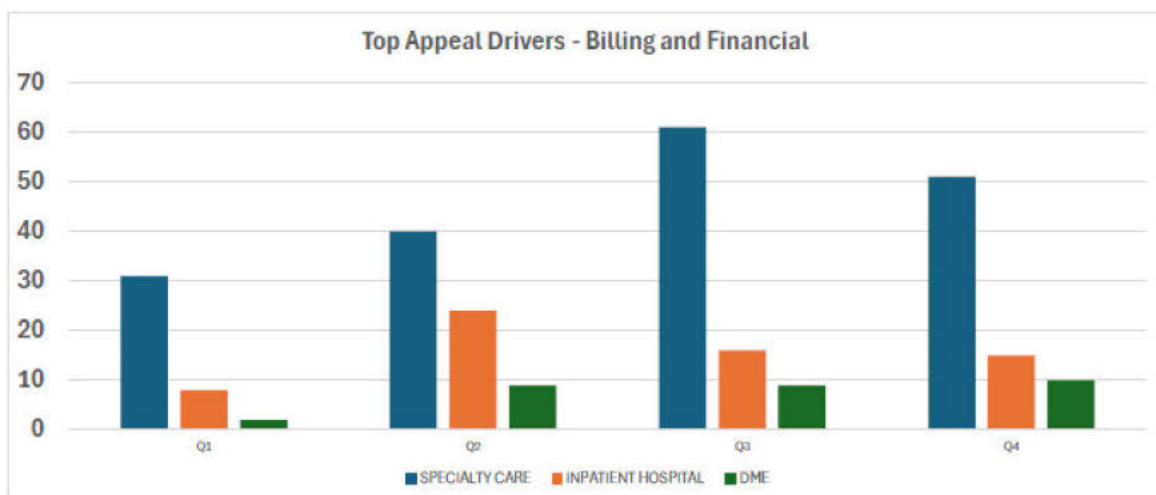
Medi-Cal Los Angeles Appeal – Access

- There were no Access Appeals for Medi-Cal in 2025, Medi-Cal appeals rate is below 1.0 and met goal in 2025.

Medi-Cal Los Angeles Appeal – Attitude and Service

- There were three hundred eighty-six (386) Attitude and Services Appeals for Medi-Cal in 2025. There were no specific pattern or trends in the data so no further analysis was conducted. Medi-Cal appeals rate is below 1.0 and met goal in 2025.

Medi-Cal Los Angeles Appeal – Billing and Financial



- Medi-Cal LA Financial appeals related to specialty care, inpatient hospital, and DME were the top drivers in 2025.

- Medi-Cal LA "Billing and Financial" appeals rate is below 1.0 and met goal in 2025.

Medi-Cal Los Angeles Appeal – Quality of Care

- There are no Quality-of-Care Appeals for Medi-Cal LA in 2025.
- Medi-Cal LA Appeals for quality care met goal in 2025 as the rate is below 1.0.

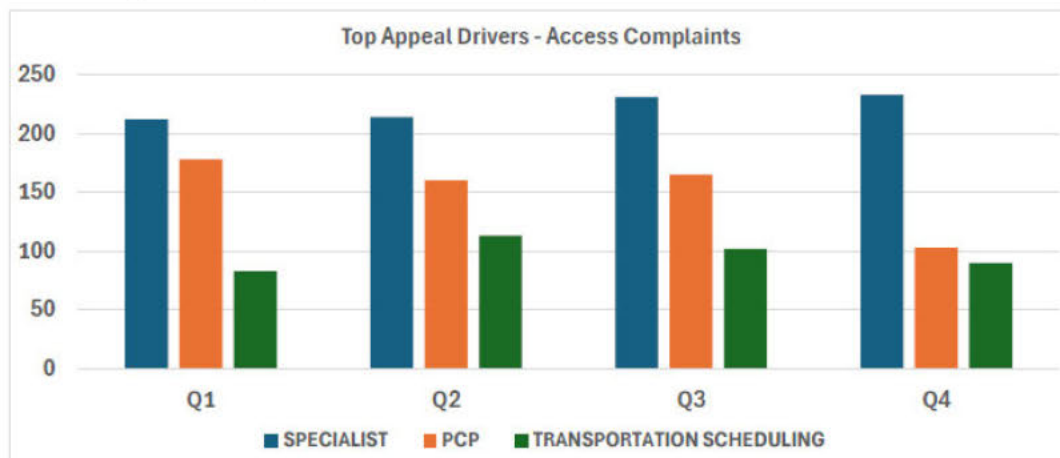
Medi-Cal Los Angeles Appeal – Quality Office Site

- There are no Quality Office Site Appeals for Medi-Cal LA in 2025. Appeals for Medi-Cal LA in 2025 rate is below 1.0 and met goal in 2025.

Table 8: Volume and Rate by Category

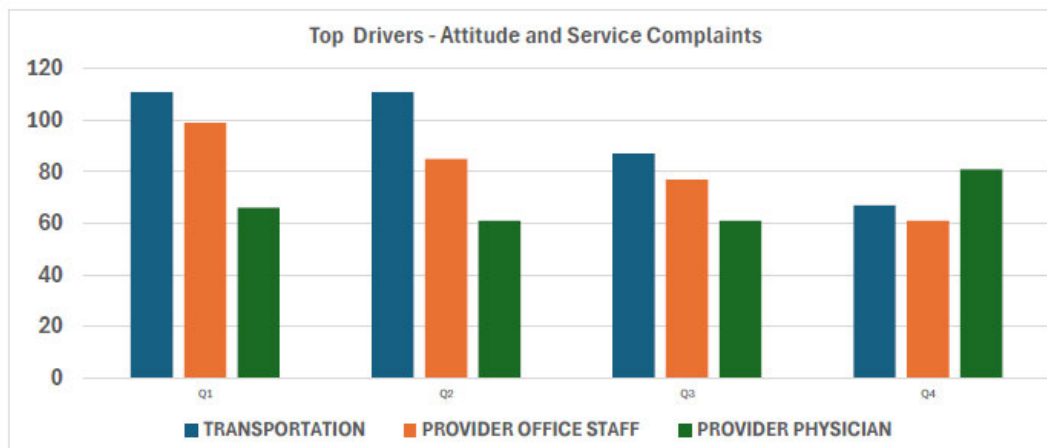
Complaints – Medical-Los Angeles	2024			2025			Goal Met
PHP Medi-Cal LA	Count	Rate	%	Count	Rate	%	
Access	2363	1.0	42%	3,067	0.67	52%	Yes
Attitude & Service	1656	0.36	30%	1,448	0.32	25%	Yes
Billing & Financial	522	0.11	9%	524	0.11	9%	Yes
Quality of Care	1111	0.24	20%	821	0.18	14%	Yes
Quality of Practitioner Office Site	9	0.0	0%	21	0.00	0%	Yes
PHP Los Angeles Total	5661	1.71	100%	5881	1.28	100%	

Medi-Cal Los Angeles Complaint – Access



- In 2025, Medi-Cal Access complaints related to specialists, PCP, and driver punctuality were the top drivers.
- In 2025, Access complaints made up 52% of total grievances filed. This has increased from 2024 where access complaints made up 42% of total grievances filed.
- Medi-Cal LA Access complaints rate is above 1.0 and did meet goal in 2025.

Medi-Cal Los Angeles Complaint – Attitude & Service



- Medi-Cal LA Attitude and Services complaints slightly decreased in 2025 compared to 2024. Attitude and Services in 2024 had 1,656 total records. In 2025, they decreased 208 records to 1,448 records.
- In 2025, Attitude and Services complaints related to transportation services, providers, and provider office staff were the top drivers. Attitude and Service complaints represent 25% of the total complaints filed in 2025.
- In 2025, the Medi-Cal LA attitude and service complaints rate was below 1.0 and did meet the goal.

Medi-Cal Los Angeles Complaint – Billing & Financial

- Medi-Cal LA Billing and Financial complaints slightly increased in 2025 compared to 2024. Billing and Financial in 2024 had 522 total records and increased 2 records to 524 records in 2025.
- Medi-Cal LA Billing and Financial complaints continue to account for 9% of total complaints filed in 2025.
- Medi-Cal LA Billing and Financial complaints rate was below 1.0 and did meet goal in 2025.

Medi-Cal Los Angeles Complaint – Quality of Care

- Medi-Cal LA had 821 Quality-of-Care complaints in 2025.
- Quality of Care complaints made up 14% of total grievance filed in 2025.
- Medi-Cal LA Quality-of-Care complaints rate was below 1.0 which met the goal in 2025.

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

- There were only 21 Quality of Practitioner Office Site complaints in 2025. The small number of cases was not enough to provide further analysis.

Quantitative Analysis Appeals

2025 Top Appeals by Product

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

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

2025 Top complaints by Product

Complaints – Goals	Medi-Cal LA
Access	Yes
Attitude & Service	Yes
Billing & Financial	Yes
Quality of Care	Yes
Quality of Practitioner Office Site	Yes

All goals were met for Medi-Cal complaints for LA.

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

Overall Qualitative Analysis

An integrated qualitative and quantitative review of CAHPS survey results, Appeals, and Complaints data identifies five consistent, system-level barriers impacting member experience across both San Diego and Los Angeles Medi-Cal populations. While select CAHPS measures demonstrate year-over-year improvement, the convergence of survey performance gaps, high-volume complaint categories, and concentrated-appearing drivers indicates that member challenges are primarily related to access, navigation, and operational execution, rather than clinical quality of care.

1. Difficulty Accessing Needed and Specialty Care

Across all three data sources, access to care—particularly specialty services—emerges as the most significant barrier. CAHPS results show that “Getting Needed Care” remains below benchmark for adult populations and declined for San Diego children. Complaints data

reinforces this finding, with Access complaints representing the largest share of grievances in both counties. Appeals further support this pattern, as specialty care services are a leading driver of Billing and Financial appeals. Collectively, these findings indicate persistent challenges with appointment availability, referral completion, and timely access to required services.

2. Transportation as a Structural Access Barrier

Transportation issues consistently appear as a critical impediment to care. Complaints data identifies transportation scheduling and driver punctuality as top drivers of Access and Attitude & Service complaints in both counties. While transportation is not directly measured in CAHPS, its impact is reflected in lower performance on access-related composites, including “Getting Needed Care” and “Getting Care Quickly.” Qualitatively, transportation functions as a prerequisite for access; when unreliable, it prevents members from benefiting from available provider services.

3. Care Coordination and Navigation Challenges

CAHPS results show that “Coordination of Care” did not meet benchmarks for adult members in both San Diego and Los Angeles, indicating difficulty navigating referrals, follow-ups, and care transitions. This theme aligns with complaint narratives related to access delays and service confusion and is reinforced by the driver analysis identifying care coordination as a key influencer of overall health plan ratings. The convergence of these findings suggests that members experience fragmentation across providers and services, is negatively affecting their perception of the care continuum.

4. Customer Service and Service Interaction Friction

Service-related barriers are evident across CAHPS and Complaints data. Adult CAHPS “Customer Service” scores declined and failed to meet benchmarks, while Attitude & Service complaints represent a substantial proportion of total grievances in both counties. Complaints cite interactions with health plan departments, provider offices, and transportation vendors as recurring issues. These findings indicate that inconsistent or unsatisfactory service encounters significantly shape the overall member experience, even when access or care is eventually achieved.

Taken together, CAHPS, Appeals, and Complaints data tell a consistent story: member experience challenges are driven by interconnected access and operational barriers, not isolated issues. Difficulty obtaining care, reaching appointments, navigating a fragmented system, interacting with service entities, and understanding fiscal responsibility collectively constrain the member experience. Addressing these five aligned barriers represents the greatest opportunity to improve overall member experience outcomes across Medi-Cal populations in San Diego and Los Angeles. Below are actions taken by Blue Shield Promise to

address these barriers broken out into people, process and technology which allow Blue Shield Promise to better address barriers based on defined activities.

People

- In 2025, Blue Shield Promise continues to conduct Member Check-in. Six full-time call representatives' outreaches Medi-Cal members to see if there is any assistance needed to access their plan benefits, including but not limited to providing information, assisting with making appointments, understanding, and resolving specialty referrals. This program was developed to address all four (4) barriers stated above.

Process

- Starting in Q2 2025, Blue Shield Promise continues to send Access to Care health education mailer highlighting the importance of routine care. Blue Shield Promise Mailed 40,000 health education mailers to Men ages 40+ who have not had a routine care appointment in more than 16 months. This program was developed to address all four (4) barriers above related to access to care and care coordination.
- Delivered in Q2 and Q4 of 2025, Blue Shield Promise continues to send member newsletters to prioritize health education. Blue Shield Promise executed two (2) annual newsletters containing important health information and resources in all ten (10) threshold languages. This program was developed to address access to care and transportation concerns.

Technology

- Blue Shield Promise continues to enhance the "Find a Doctor" tool allowing members to easily find providers based on the member preferences. This technology continues to be enhanced to ensure member useability and accessibility.

Blue Shield Promise continues to work towards improving member experience. Blue Shield Promise has a resolute clinical quality member experience team to help drive improvement efforts as measured by CAHPS surveys. Although improving our members' experience is an organizational goal and a mission for Blue Shield Promise, the dedicated team will ensure the member experience is at the forefront of every strategy and initiative that is developed.

Many areas of opportunities were identified throughout the report. Blue Shield Promise remains agile to ensure it can meet the members' needs and expectations. Strategy development is ongoing and will respond to areas of opportunity as they arise. Blue Shield Promise is conducting many multi-year initiatives that will continue into 2026, in addition to the ongoing mentions above. These include multiple methods to incorporate the member voice into strategy development and initiatives to improve the overall member experience.

Promise Health Plan Preventive Health Guidelines

Activity Description

At least annually, Blue Shield of California Promise Health Plan (BSCPHP) updates its Preventive Health Guidelines (PHGs) to ensure recommendations for appropriate preventive care and services are provided to members of various age groups. The PHGs are made available to members and providers online in both English and all threshold languages. The annual update and publication process is tracked on the Quality Work Plan.

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

Goals

BSCPHP is committed to quality initiatives that promote the improvement of health care outcomes by ensuring that care is based upon evidence-based clinical guidelines and scientific review. The goal of the annually updated PHGs is to ensure appropriate preventive care and services are recommended for members of various age groups, and to help providers and members make informed care decisions.

Accomplishments

In 2025, updates to the PHGs were reviewed by the following teams across the organization: The Quality Improvement team to ensure there are no discrepancies with any current interventions that are in place; the Mandates team to ensure state and federal mandates are met; Legal consult to ensure compliance with regulations; Medical Policy to ensure alignment with medical policies in use for utilization management; and with the Benefits Intent team to ensure alignment with their Preventive Health Benefit Policy, which differs from the PHGs in its intent. Although the PHGs primarily serve an educational purpose, the Benefit Policy leverages the same information to define which preventive care services are covered and must be provided at no cost to members. Various teams collaborate to assess whether the inclusion of specific guidelines should be operationally effective, ensuring compliance with new laws and regulations.

Due to the passage of California AB 144 in late September 2025, the PHGs required a second update and approval cycle (since immunization guidelines and sources were modified). The updates to the PHGs were successfully completed ahead of the deadline and within the allocated budget. The updated guidelines, available in both English and Spanish translations

were uploaded to the BSCPHP Provider Connection website, ensuring accessibility to both members and providers.

Qualitative Analysis

During the 2025 review cycle, the Preventive Health Guideline “endnotes” were found to be outdated and mis-ordered. They were updated and painstakingly re-ordered and double checked to ensure the notes corresponded to the appropriate section of the guidelines.

Trends in Performance

The 2025 update cycle was longer and more cumbersome than prior years, due to both the changing landscape of federal and state guidelines, and additional internal reviews and approvals needed.

Barriers and Mitigation Plans

The passage of AB 144 and resulting second update and approval cycle impacted the timeline for PHG updates and necessitated expedited work from multiple teams. Going forward, the mitigation plan is to monitor mandates and pending legislation in advance. Based on the timing of any new regulations/laws, the PHG updates may need to occur in two parts (i.e. multiple updates in a calendar year) to ensure compliance and timely publication of any changes. Additionally, it is recommended to begin the annual update cycle in *early* Q3 and plan for committee review in Q3 as well, allowing all Q4 for brand, copyediting, compliance reviews, translations and digital content updates.

Recommendations for 2026

The 2025 updates to the PHGs will continue to follow the same process as years prior, but the process and business ownership will transition from the Medical Care Programs team to the Clinical Strategy organization (under the Blue Shield of California Chief Medical Officer) for better alignment with clinical and quality oversight. To help ensure sufficient time for review and updates, the PHG business owner will monitor mandates and vaccine/preventive legislation to ensure ongoing compliance with federal and California-specific guidelines and regulations.

Member and Family Engagement

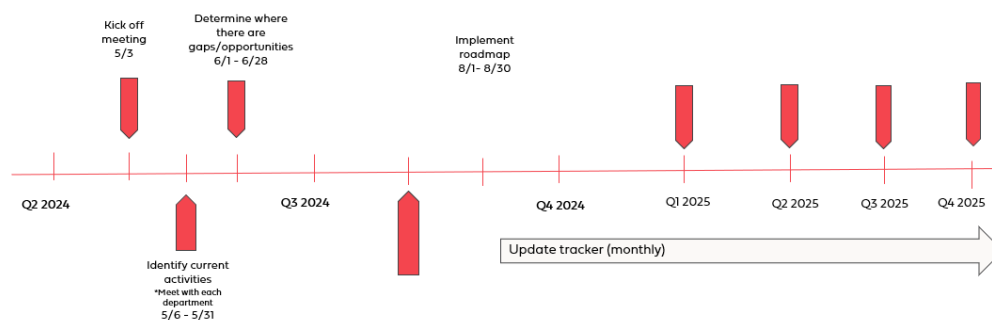
Introduction and Background

Blue Shield of California Promise Health Plan demonstrates its commitment to Member- and family-focused care through a structured, ongoing engagement strategy that involves Members, families, caregivers, and community partners as active contributors to the design, delivery, evaluation, and improvement of covered services.

Implementation

A structured implementation roadmap was established in 2024, progressing from assessment and gap identification to phased rollout. The Community Programs department operationalized the Member and Family Engagement policy through a defined engagement strategy, with ongoing program management supported by regular tracking, stakeholder engagement, and continuous improvement to align with organizational goals and member needs.

Implementation Roadmap



BLUE SHIELD PROMISE

Figure 1. Implementation Roadmap

Operational Model

Consistent with its Member and Family Engagement policy, Blue Shield Promise seeks input through multiple channels, including the Community Advisory Committee (CAC), Public Policy Committee (PPC), annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, monthly Net Promoter Score (NPS) surveys, Population Needs Assessment-related activities, focus groups, listening sessions, interviews, town halls, and community conversations conducted in partnership with trusted community-based organizations. This engagement approach is designed to ensure that Member and family perspectives are

incorporated into policies, programs, services, and organizational decision-making on an ongoing basis.

The following information was presented to the Quality Improvement and Health Equity Committee in September 2025.

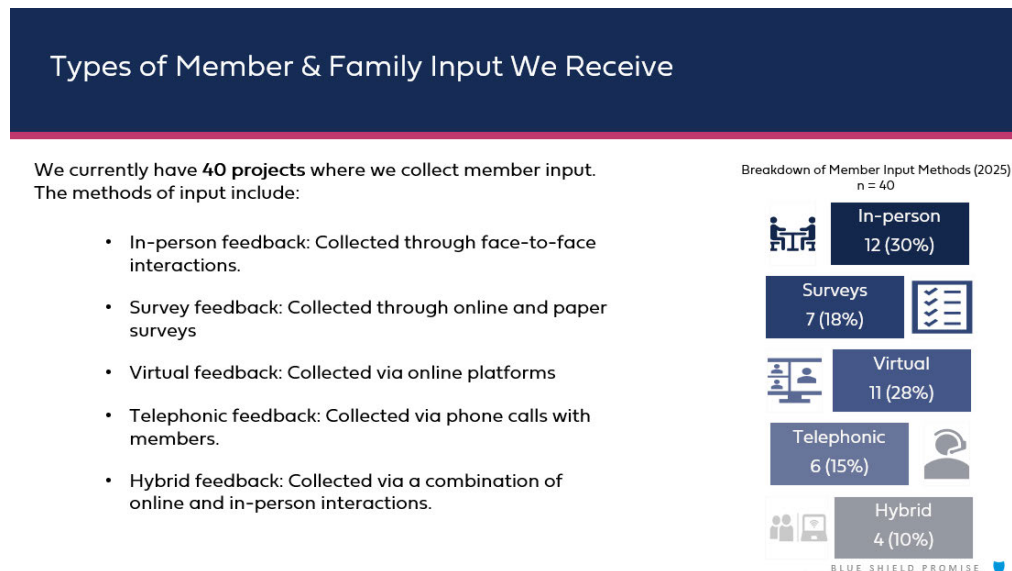


Figure 2. Types of Member & Family Engagement Input

Incorporating Member Feedback

Blue Shield Promise routinely reviews CAC findings and other Member feedback to identify barriers, preferences, and opportunities for improvement. As described in the policy, the CAC and PPC are standing committees that provide direct input on policies, programs, Member materials, service delivery, and organizational priorities. Committee members have weighed in on a wide range of topics, including the Marketing Plan, newsletter content, health plan information videos, member incentives, website updates, maternal health, appeals and grievances, and preventive screening initiatives. That input has informed tangible actions such as updates to welcome materials, improvements to Member ID cards, additional incentive options, and enhanced outreach support to help Members schedule appointments and navigate services. Blue Shield Promise also surveys committee participants and uses those results to assess whether engagement is meaningful and to identify additional topics of interest for future review.

Blue Shield Promise also gathers ongoing feedback through CAHPS and NPS surveys to monitor Member experience and identify trends requiring action. The plan receives approximately 300 NPS responses each month and has used this ongoing feedback to

reinforce continuous improvement efforts. In addition to standing committees and surveys, Blue Shield Promise conducts targeted listening sessions and focus groups to better understand the experiences of specific Member populations. Examples include listening sessions at the Metro LA Community Resource Center; quality focus groups with Medi-Cal members to identify barriers to well-child visits, vaccinations, and postpartum care; and the first ever community-driven quality co-design sessions with approximately 10 local community organizations focused on improving prenatal and postpartum care and promoting child wellness visits. Blue Shield Promise has also collaborated with the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) partners and local community organizations to identify emerging Member needs and support timely outreach, resource navigation, and community education during periods of disruption affecting food assistance access.

Implemented Initiatives

Blue Shield Promise also uses these findings to shape future interventions and monitor accountability for acting on Member and community input. Insights from committee discussions, surveys, focus groups, and listening sessions are used to tailor outreach materials, improve cultural and linguistic appropriateness, strengthen communication strategies, identify opportunities for provider education, and develop community-informed solutions to improve access and reduce disparities.

The following graphic illustrates three Member and Family Engagement initiatives implemented in 2025, detailing their objectives, key activities, and outcomes to show how member feedback is driving meaningful program enhancements.



Figure 3. Implemented Initiatives

Through this continuous feedback loop, Blue Shield Promise demonstrates not only that it engages Members and families as partners, but also that it uses the information gathered from these engagements to guide policy development, program refinement, and decision-making in a manner responsive to the needs of the communities it serves.

PROVIDER ENGAGEMENT / PERFORMANCE / EXPERIENCE

Promise Quality Performance Incentive Program

Activity Description

The MY 2024 PQPI Program utilized a streamlined approach to assess and reward performance for Healthcare Effectiveness Data and Information Set (HEDIS®) measures, Data metrics (Encounters and Social Determinants of Health (SDOH) Z-Codes) and Member Experience.

Goals

The goals of the measurement year (MY) 2024 PQPI Program are for the participating Independent Practice Associations (IPAs) and Medical Groups to reach key performance and/or improvement indicators on HEDIS, Data, and Member Experience domains. The higher the performance or greater the improvement from the previous measurement year, the higher the incentive payment. The measures in the HEDIS domain are in alignment with the Managed Care Accountability Sets (MCAS) Minimum Performance Level (MPL) measures, set forth by DHCS. DHCS' requirement is for IPAs and medical groups to hit the 50th percentile

on MCAS MPL measures; therefore, this program is directly aligned with DHCS' goals. Of note, HEDIS results are determined using each measure's complete HEDIS-eligible population. For MY 2024, 17 HEDIS metrics contribute to the overall HEDIS score and 4 HEDIS metrics were included as reporting only test measures.

Accomplishments

In MY 2024, our HEDIS goal was met in Los Angeles County (measures hitting the 50th percentile and year-over-year improvement). In Los Angeles, 11 of 18 measures met the 50th percentile and there was year-over-year improvement for 16 measures. Notably, 8 measures were at or above the 75th percentile – each of which were included in the PQPI Program.

Quantitative Analysis

The total payout for MY 2024 PQPI Program was [REDACTED] approximately the same as MY 2023. Of note, this program is influenced by membership, so an increase or decrease in payout does not necessarily indicate an increase or decrease in performance. For example, in MY 2023 there were 212,888 members included in the program compared to 267,421 in MY 2024.

Nevertheless, HEDIS performance detailed below highlights modest improvement or maintenance of stellar performance from MY 2023 to MY 2024. For example, there were 4 measures that maintained at or above the 50th percentile (e.g., WCV, CHL, DEV), and there were six that improved above the 50th percentile (e.g., IMA, CCS). However, there were a few HEDIS measures that did not perform as well year-over-year. For example CIS-10 measure fell from 50th percentile performance in MY 2023 to 25th percentile performance in MY 2024 in Los Angeles.

Please see the final rates for MCAS MPL HEDIS Measures that were incentivized within the PQPI Program - highlighted in yellow below you will see YOY trend analysis and the Year End Percentile.

LOS ANGELES MCAS MPL MEASURES INCLUDED IN PQPI PROGRAM	MY2023		MY2024		
	Final Rate	Year End Percentile	Final Rate	YOY Trend	Year End Percentile
Child and Adolescent Well-Care Visits ^A	52.05%	66 th	56.63%	↑	66 th
Childhood Immunization Status - Combination 10	33.85%	50 th	24.36%	↓	25 th
Developmental Screening in the First Three Years of Life ^{AA}	37.52%	50 th	46.99%	↑	50 th
Immunizations for Adolescents - Combination 2	39.75%	66 th	44.09%	↑	75 th
Well-Child Visits in the First 30 months- First 15 months of life - 6 or more Well-Child Visits ^A	45.71%	10 th	52.40%	↑	10 th
Well-Child Visits in the first 30 months - 15-30 months of life - 2+ Well-Child	61.78%	10 th	69.20%	↑	33 rd

Visits ^A					
Lead Screening in Children	58.41%	33 rd	64.54%	↑	50 th
Topical Fluoride in Children ^{*A}	22.83%	50 th	27.01%	↑	75 th
Breast Cancer Screening ^A	60.15%	75 th	62.59%	↑	75 th
Cervical Cancer Screening	56.27%	33 rd	75.81%	↑	95 th
Chlamydia Screening in Women – Total ^A	70.39%	90 th	72.08%	↑	90 th
Prenatal and Postpartum Care – Postpartum Care	74.42%	25 th	88.89%	↑	95 th
Prenatal and Postpartum Care – Timeliness of Prenatal Care	90.70%	75 th	97.78%	↑	95 th
Asthma Medication Ratio ^{*A}	58.79%	10 th	66.12%	↑	33 rd
Controlling Blood Pressure	68.29%	75 th	59.18%	↓	10 th
Glycemic Status Assessment for Patients With Diabetes (>9%) [lower is better]	40.48%	33 rd	29.63%	↑	75 th

Regarding the Data Domain, no groups met the threshold for point attainment for SDOH Z-Code submissions in Los Angeles. For other Data Domain metrics, in Los Angeles only about 1/3rd of possible points were earned (i.e., the thresholds were not met 64.8% of the time – 81 missed threshold opportunities out of 125 possible opportunities).

Trends in Performance

Overall, HEDIS MCAS MPL measures are performing well (the majority at or above the 50th percentile), and have only improved over the last few measurement years. This prolonged improvement and maintenance of performance is supported by PQPI focusing on including MCAS MPL measures in the program and assigning appropriate points and thresholds to certain measures that require more lift. SDOH Z-Code and Data metric performance has remained an area of struggle.

Barriers and Mitigation Plans

The PQPI Program remains a complicated program to run, given there are multiple Subject Matter Experts (SMEs) and data sources required to calculate performance. This program has many touch points from data, to modeling, to report generating and it can create workflow inefficiencies and opportunities for error. The PQPI Program is built every year based on prior year performance and current year modeling, so it is possible that some of the decisions that the Medi-Cal and PPQI team make regarding measures, measure points, thresholds, etc. may set the bar too low or too high for performance. Nevertheless, given the overall high performance of HEDIS in MY 2024 in our Medi-Cal IPA and Medical Group, evidence shows that our methods for determining point structure and thresholds are working. With a new

Senior Manager on the PPQI team, additional efforts will be made to create more robust evaluation processes looking at performance long-term, especially given changes to the 2026 program (see recommendations section below).

Recommendations

Given changes to guidelines published by CMS, the PQPI Program has changed significantly in MY 2026. Specifically, the program only includes HEDIS measures and there is no longer a Data or Member Experience component of the program. This is in alignment with recommendations the PPQI team would have recommended, given continued low performance on Data Domain components and lacking internal Member Experience data availability.

Care Gap Provider Incentive Programs

Activity Description

This program rewards provider organizations for gaps in care closed in a specified period, based on a tailored set of Healthcare Effectiveness Data and Information Set (HEDIS) measures. The measures were selected by assessing where Blue Shield Promise has seen the largest declines in preventive care throughout our Medi-Cal network. In 2024, the program operated during Q2 and Q3. We also administered a year-end care gap closure program where any data received by a specific date could count towards any date of service in the year.

Goals

Given measures are selected by assessing where Blue Shield Promise has seen largest declines in preventative care, and the goal of each Care Gap Incentive Program is to increase performance on struggling or lagging measures.

Accomplishments

Given the Care Gap Provider Incentive Programs are focused on HEDIS measures, it complements the PQPI Program (described above). Each iteration of the program allows us to reward care gap closure performance in a more real-time manner. In Los Angeles, 11 measures were incentivized; 5 of them (45% of selected measures) hit the 50th percentile. Further, many of the accomplishments listed in the PQPI section above apply here – the Care Gap Provider Incentive Programs and the PQPI Program work in tandem to push for excellent performance on MCAS MPL HEDIS Measures throughout the year.

Measures included in MY 2024 Care Gap Programs	Q2	Q3	Year End	Hit 50 th Percentile in MY24?
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Cervical Cancer Screening	X	X	X	Y
Childhood Immunization Status – Combo 10	X	X		N
Child and Adolescent Well-Care Visits	X	X	X	Y
Immunizations for Adolescents – Combo 2	X	X		Y
Well Child Visits – First 30 Months of Life – 15 months	X	X	X	N
Well Child Visits – First 30 Months of Life – 30 months	X	X	X	N
Lead screening in children	X			Y
Follow-up after emergency department visit for substance use - total follow up within 30 days	X			N
Follow-up after emergency department visit for mental illness - total follow up within 30 days	X			N
Asthma medication ratio		X		N
Glycemic Status Assessment for Patients with Diabetes (>9%)			X	Y

Quantitative Analysis

The total payout for MY 2024 Care Gap Closure Programs in Los Angeles was [REDACTED]. Of note, these programs are influenced by membership and measure changes between programs, so an increase or decrease in payout does not necessarily indicate an increase or decrease in performance.

However, in an analysis of amount of incentive dollars paid per incentivized measure specific to MY 2024, we notice an important trend: all measures where we paid [REDACTED] or more (highlighted in yellow below) hit the 50th percentile. Examples include CCS, and WCV. Though there were some missteps in performance (e.g., W30-2), overall, there is a good return on investment and confirmation that the strategies deployed by the Clinical Quality and Medical teams is working for the suite of Care Gap Closure Programs.

Measures included in MY24 Care Gap Programs	Total Paid Per Measure (Q2, Q3, Plus Year End)	Hit 50 th Percentile in MY24?
Cervical Cancer Screening	[REDACTED]	Y
Childhood Immunization Status – Combo 10	[REDACTED]	N
Child and Adolescent Well-Care Visits	[REDACTED]	Y
Immunizations for Adolescents – Combo 2	[REDACTED]	Y
Well Child Visits – First 30 Months of Life – 15 months	[REDACTED]	N
Well Child Visits – First 30 Months of Life – 30 months	[REDACTED]	N
Lead screening in children	[REDACTED]	Y
Follow-up after emergency department visit for substance use - total follow up within 30 days	[REDACTED]	N
Follow-up after emergency department visit for mental illness - total follow up within 30 days	[REDACTED]	N
Asthma medication ratio	[REDACTED]	N
Glycemic Status Assessment for Patients with Diabetes (>9%)	[REDACTED]	Y

Trends in Performance

Overall, HEDIS MCAS MPL measures have improved over the last few measurement years (the majority at or above the 50th percentile). Nevertheless, there are some key areas where Los Angeles performance could be improved – specifically around pediatric health (e.g., CIS-10, W30-1, W30-2) and behavioral health (FUA, FUM). These measures are historically difficult to achieve 50th percentile performance due to a variety of factors, including a large and diverse member pool who have unique needs.

Barriers and Mitigation Plans

Beginning in MY 2026, due to changes in CMS rules and regulations, we now must distribute the measures included in our Care Gap Closure Programs before the start of the measurement year. This means that we will no longer be able to assess real time trends in measure performance and build incentive programs around gaps in care. Instead, we must rely on historical trends and performance of these measures to build incentive programs. It is possible that performance may drop or change due to a regulatory-required change in strategy. This is something we are keeping an eye on and in close communication with our legal department and our external stakeholders (LA Care; DHCS) about options we may have, moving forward.

Recommendations

To prevent IPAs from waiting until later quarters to provide care or close gaps, our Care Gap Closure Incentive Programs have updated methodology that requires higher performance to meet minimum payment throughout the year. For example, in the 2024 Q2 Care Gap we offered \$10 for every compliant care gap closure demonstrated where performance rate was at the 10th - 24th percentile. In 2025, we offered the same amount of money, but for performance at the 25th - 49th percentile. We will continue to look at trends in performance throughout the year to tweak program methodology to ultimately incentivize closing care gaps early and efficiently for our members.

Initial Health Appointment

Activity Description

The Initial Health Appointment (IHA; formerly the Initial Health Assessment) program incentivizes our contracted provider networks for performing IHAs of new Medi-Cal enrollees to Promise Health Plan. The Department of Healthcare Services (DHCS) requires primary care providers to conduct an IHA for all new Medi-Cal members within 120 days of enrollment to Promise Health Plan. The IHA can be completed by a primary care physician (PCP), nurse practitioner (NP), obstetrician/gynecologist (OB/GYN), certified nurse midwife (CNM), or physician assistant (PA). The IHA Program pays \$75 for each timely IHA completed within 120 days. This program pays out quarterly in February, May, August, and November for the prior 3-month periods.

Goals

Our IHA provider incentive program rewards Blue Shield Promise network providers for ensuring that every member who requires an IHA receives the care they need within 120 days of enrollment with Promise Health Plan. Our goal is to ensure that our Medi-Cal members have timely access to their health care provider.

Accomplishments

In 2024, the IHA program captured 36,058 IHA closures and 22,331 (62%) were timely. We have seen great year-over-year improvement in IHA volume and timely closures.

Quantitative Analysis

MY 2024 Timely vs. Untimely Closures by Quarter

	Q1	Q2	Q3	Q4	Remediation
Timely	1,593	2,413	3,187	3,474	2,586
% Timely	64%	72%	55%	58%	95%
MY24 Trend vs MY23 Trend	↑	↑	↓	↑	N/A
Untimely	902	957	2,577	2,563	134
Total	2,495	3,370	5,764	6,037	2,720
Overall MY24: 13,253 (Timely Closures) / 20,386 (Total Closures) = 65% Timely					

MY 2023 Timely vs. Untimely Closures by Quarter

	Q1	Q2	Q3	Q4	Remediation
Timely	1,343	1,425	1,357	1,022	N/A
% Timely	57%	58%	62%	56%	N/A
Untimely	1,020	1,016	826	797	N/A
Total	2,363	2,441	2,183	1,819	N/A
Overall MY23: 5,147 (Timely Closures) / 8,806 (Total Closures) = 58% Timely					

Trends in Performance

In 2024, the IHA program captured 20,386 IHA closures, and 13,253 (65%) were timely. In 2023, the IHA Program captured 8,806 closures, and 5,147 (58%) were timely. It is important to note the large membership increase that occurred in 2024 – we had more than double the volume of members eligible for an IHA between MY 2023 and MY 2024. We can see a clear increase in year-over-year timely closures (58% in 2023 vs. 65% in 2024). Further, in 2024 compared to 2023, we saw increased performance in Q1, Q2 and Q4, but not in Q3. Notably, based on the remediation results in 2024 (2,720 additional IHAs, 95% of which were timely), it is possible to conclude that some of the “missed” IHAs (due to lagging claims and encounters data) likely should have been placed in Q3, falsely dragging down performance in those quarters. In conclusion, we have seen great year-over-year improvement in IHA volume and timely closures.

Barriers and Mitigation Plans

The IHA Program is vulnerable to lags in claims and encounters data, sometimes incorrectly capturing an IHA closure as timely / untimely when it was not. Our team continues to work closely with the IHA teams to understand in real-time what issues are being seen within the data through quarterly meetings and reporting.

Recommendations

Due to new CMS rules and regulations, this program shifted in MY 2026 to focus on incentivizing regular access to primary care doctors through approved pipelines (e.g., in office assessments and initial health appointments). This “combination” program, called the Primary Care Access Program, is being debuted in MY 2026 and will combine the IHA Program (with slight modifications – including a smaller dollar amount per closed timely IHA) and the IOA Program (previously run by the Risk Adjustment team). This will allow us to remain in compliance with CMS and still prioritize and reward timely access to primary care for our members.

Align. Measure. Perform. Medi-Cal Program

Blue Shield Promise has been in partnership with the Integrated Healthcare Association (IHA) since 2018 and is now launching the 8th year of its provider performance measurement program, Align. Measure. Perform (AMP), with the organization. The AMP programs continue to be a driving force of quality improvement, cost management and appropriate use of healthcare resources through standard measurement and annual incentive payouts for the Medi-Cal population.

For MY 2024, the IHA AMP program methodology included a standard set of Clinical Quality measures used for accountability purposes, public recognition, and public reporting.

In 2025, IHA implemented a redesign of the AMP programs incentive model to help align the California healthcare industry on shared goals for quality and equity. In collaboration with the IHA committees, as well as California public purchasers and regulators, IHA retired the Shared Savings and Attainment Pathways incentive design model and transitioned to a new incentive model that ties PO payments directly to quality performance. By incentivizing high performance on high-priority measures at the PO level, the redesigned AMP incentive model works to ensure that both POs and plans are focused on the same quality goals to help move California forward.

Starting with Measurement Year 2024, Blue Shield Promise Health Plan implemented a budget neutrality methodology to cap provider incentive payouts to not exceed [REDACTED] predetermined budget. MY 2024 incentive totals for Medi-Cal were [REDACTED] (true earnings were [REDACTED]). Incentive totals are calculated; however, payments are still pending final approval. The payout is scheduled to be issued no later than March 31st.

- Los Angeles: [REDACTED]

Barriers and Mitigation Plans

- With Quality performance now at the forefront of the AMP program incentive design, COHC budget adjustments will need to be revisited with hopes of securing more funding to ensure incentive payments for good quality performance are passed down to the provider organizations.
- Release of AMP results by IHA 11 months after close of measure year can be frustrating for provider partners to not see results in ‘real time.’
- Starting with MY 2025, high-priority clinical quality measures will continue to serve as the foundation for the incentive model. IHA will be engaging the Technical Payment Committee, Technical Measurement Committee and Program Governance Committees in 2026 to discuss “add-on” domains in the incentive design methodology for MY 2025 and future measurement years, focusing on developing mechanisms for race and ethnicity, health equity and reintroducing patient experience to the incentive design.

Recommendations

Blue Shield collaborated with IHA for 3 years to make quality more important in the AMP incentive design space. Now that quality is the main driver of incentives, securing COHC budgets that are more aligned with incentive design earnings.

Discontinued Programs

Chronic Care Provider Incentive Program

Activity Description

In 2023, Blue Shield debuted this provider incentive program to support the care of members with chronic conditions. The program supports our providers who address the needs of our members with chronic conditions through assessments (e.g., treatment planning, prescription of needed medications) during a member visit. A list of members with chronic conditions was provided to provider groups monthly. Providers were rewarded for the percentage of members with chronic conditions who were seen in both the baseline and measurement years via a year-over-year percentage calculation. The program paid out on a scale (\$0.01 up to \$5.00) for increasing the percentage of eligible members treated for a chronic condition, with a maximum potential earning of \$5.00 per member.

Goals

The goal of the Chronic Care Program was to increase regular and continued care (i.e., year-over-year) for our Medi-Cal members with documented chronic illnesses.

Accomplishments

Unfortunately, the Chronic Care Program does not boast of many accomplishments. It was clear in the first year that performance was poor (the 2023 Chronic Care Program was paid in June 2024 and totaled less than [REDACTED]). Though we were hopeful that after more time, training, and familiarization, performance would increase. Unfortunately, the second year of the program showed continued poor performance ultimately leading us to discontinue the program: only [REDACTED] was paid out across 5 IPAs and year-over-year percentage of unique members seen did not improve.

Quantitative Analysis

MY 2023	MY 2024
[REDACTED]	[REDACTED]
Number of IPAs paid: 6	Number of IPAs paid: 5

Trends in Performance

In the first year of the program, it was not deployed to provider groups until midway through the year; in the second year, providers complained that the methodology was too cumbersome and paid out too little for such a high-needs population, like Medi-Cal. As stated above, given the continued negative trend in performance, Blue Shield discontinued the program and shifted focus to other areas that address chronic care – including newly incentivizing “In Office Assessments” in MY 2026 through a new program (Primary Care Access Program).

Barriers and Mitigation Plans

New programs are not always successful. It takes significant time and effort to socialize and train our large network of Independent Practice Associations and their providers to new programming. Given the continued poor performance, and negative feedback we received from our provider network, the program was discontinued.

Recommendations

Given poor performance in this program, it was discontinued for MY 2025. Further, due to new CMS rules and regulations, programs have shifted further in MY 2026 to focus on incentivizing regular access to primary care doctors through approved pipelines (e.g., in office assessments and initial health appointments).

Patient Centered Medical Home (PCMH)

The Patient Centered Medical Home (PCMH) program is a model of care that puts patients at the forefront. PCMH is a certification that primary care practices can obtain by adhering

to key concepts, criteria, and competencies. The certifications are issued through the National Commission for Quality Assurance (NCQA) or the Joint Commission. PCMH helps build better relationships between patients and their clinical care teams. Primary care practices within the Blue Shield of California Promise Health Plan provider network who have obtained or maintained PCMH certification through NCQA or the Joint commission are considered for participation in the PCMH Program. For practices to qualify and receive an incentive payment, they must have achieved or maintained PCMH certification for at least one of their primary care practice locations and have a practice size of at least 100 Medi-Cal members within the six-month incentive period. In 2023, Blue Shield updated the payment methodology to include a [REDACTED] per member, averaged over the previous six-month period. The 2025 PCMH Program provided incentive payments in April and October 2024, totaling [REDACTED].

- Los Angeles: [REDACTED]

Effective October 31, 2025, Blue Shield of California Promise Health Plan retired the Patient Centered Medical Home (PCMH) provider incentive program, in alignment with updated federal regulations issued by the Centers for Medicare & Medicaid Services (CMS). CMS updated the Medicaid managed care regulations governing state-directed payments and value-based payment arrangements under 42 CFR 438.3(i)(3).

Provider Experience - Clinician Satisfaction Survey

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

Blue Shield Promise Compared to Other Health Plans

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

- The likelihood to recommend Blue Shield Promise to others stands at 68%. (+4.8%)
- Overall satisfaction with Blue Shield Promise stands at 66.3%. (+1.7%)
- 68.9% of clinicians have aligned interests and a sense of partnership with Blue Shield Promise. (+4.4%)

- 58.5% of clinicians say it is easier to work with Blue Shield Promise than other health plans. (-0.5%)
- 67.6% of clinicians believe they are treated fairly during contract negotiations with Blue Shield Promise. (+1.7%)

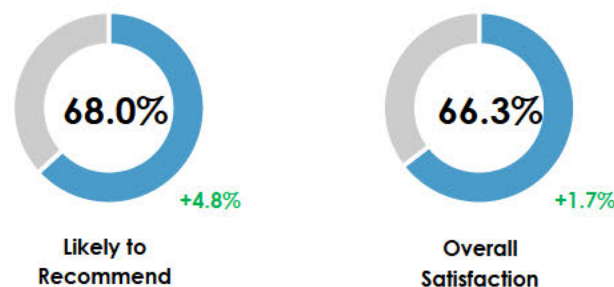
Net Promoter Score (NPS)

When clinicians were asked, “How likely are you to recommend Blue Shield Promise to others?” Blue Shield Promise’s 2025 NPS was 15. NPS is a scale that spans from -100 to +100. It is a 200-point spread that considers the willingness of clinicians to recommend Blue Shield Promise. Any score between 0 and 30 is considered good, and over 30 is exceptional, because that means more clinicians are promoting Blue Shield Promise than are critical. The top areas identified by the verbatims where Blue Shield Promise performs well are:

- Customer service: Some providers said representatives were pleasant, helpful, or easier to deal with than other Plans.
- Timely and accurate claim payments: A subset acknowledged improvements or generally dependable payment for straightforward claims.
- Provider portal usability: Some noted improvements or ease in finding eligibility information.
- Community health and innovation efforts: A small number highlighted Blue Shield Promise’s broader organizational initiatives (e.g., value-based care frameworks, population health programs).

Key Findings

Loyalty and satisfaction with Blue Shield Promise remained high in 2025 with over three out of five clinicians providing positive ratings.



Functions and Trends within Blue Shield Promise

- **Network Management:** According to the vendor’s book-of-business, scores for Blue Shield Promise compared to other health Plans concerning timeliness to answer questions

and/or resolve problems as well as the relevance and timeliness of communications of written materials, were significantly higher than the scores for MY 2024.

- Practice Experience with Blue Shield Promise:** Over half of Blue Shield Promise's surveyed clinicians rated Blue Shield Promise similar in 2025 and 2024 in the areas of:
 - (1) reimbursement rates being better than similar plans (53%, decrease of 2.9%),
 - (2) rarely experiencing reimbursement issues (66.9%, increase of 1.6%),
 - (3) being easier to work with - than similar Plans – (58.5%, decrease of 0.5%),
 - (4) practice is treated fairly during contract negotiations (67.6%, increase of 1.6%),
 - (5) aligned interests and sense of partnership (68.9%, increase of 4.4%), and
 - (6) the credentialing process compared to other health plans (57.8, decrease of 2.5%).

A significant number of clinicians indicated that patients with Blue Shield Promise were more satisfied with their coverage than other benefit plan products. Scores are highest among Primary Care Physicians and lowest among Behavioral Health Clinicians.
- Timely Access to Care:** Scores for each attribute of timely access to care are similar for 2024 and 2025. Satisfaction is significantly higher among Primary Care Physicians than Behavioral Health Clinicians and Specialists for all areas except for behavioral health care routine follow-up, urgent, and non-life-threatening emergency care.

Measurement Year 2025 Results and Previous Years

Questions	Percent Satisfied 2025	Percent Satisfied 2024	Percent Satisfied 2023	Percent Satisfied 2022	Percent Satisfied 2021	Percent Satisfied 2020
Satisfaction with Referral/Prior Authorization Process that is necessary for HMO patients to obtain covered services	85.3%	91.1%	91.8%	89.5%	92.2%	63.0%
Timely Access to Urgent Primary Care	97.1%	100%	98.9%	89.5%	100%	96.0%
Timely Access to Routine Primary Care	97.1%	100%	98.9%	96.5%	98.4%	98.0%
Timely Access to Urgent Specialty Care	94.3%	98.4%	99.0%	95.3%	95.4%	93.0%
Timely Access to Routine Specialty Care	97.1%	95.0%	98.0%	94.8%	98.9%	86.0%
Timely Access to Urgent Ancillary Diagnostic/Treatment Services	94.3%	93.0%	96.8%	85.0%	96.1%	96.0%
Timely Access to Routine Ancillary Diagnostic and Treatment Services	94.3%	91.9%	96.8%	93.3%	45.6%	96.0%
Timely Access to Routine Initial Behavioral Health Care	93.5%	96.6%	95.7%	90.8%	95.3%	78.0%
Timely Access to Routine Follow-up Behavioral Health Care	93.8%	94.8%	96.8%	90.8%	95.3%	81.0%
Timely Access to Non-life-threatening Emergency Behavioral Health Care	90.3%	98.2%	92.5%	91.0%	92.0%	79.0%
Timely Access to Urgent Behavioral Health Care	90.3%	93.0%	92.2%	89.3%	93.2%	81.0%

- Routine and Urgent Care Appointments:** It takes an average of 5.4 days (5.7 in 2024) to schedule a routine appointment with an average of 14 minutes (14 minutes in 2024) of wait

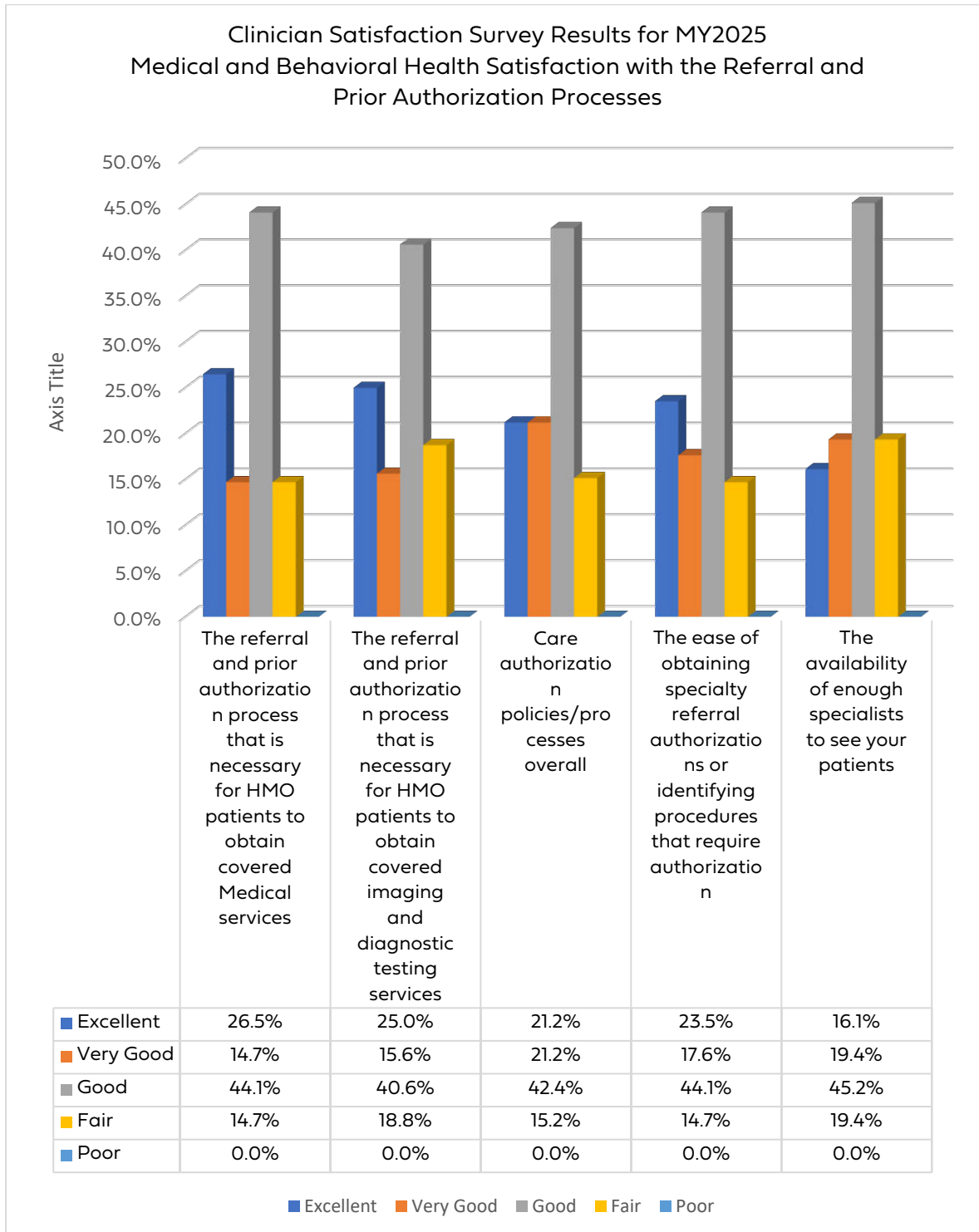
time in the office before the patient is seen. A significantly higher number of practices offer same/next day urgent appointments in 2025 (91.9%) compared to 2024 (82.7%). A significantly higher percentage of Primary Care Physicians offer same/next day urgent and routine appointments than Behavioral Health and Specialty Clinicians.

- Language Assistance Program:** All areas of the language assistance program remained relatively steady year after year with approximately 70% satisfied in each area, which is the same as 2024. The strongest area is the interpreter's ability to effectively communicate on the patient's behalf at 70.8% (2024 was 72.4%). Promise Health Plan had a high satisfaction rating (84.6%) with the training and competency of the interpreters. Significantly higher percentages of Primary Care and Specialist Physicians are satisfied with the interpreter's ability to effectively communicate on the patient's behalf and the training and competency of the interpreters they worked with than Behavioral Health Clinicians. A significantly higher percentage of Primary Care than Behavioral Health Clinicians are satisfied with the coordination of appointments with an interpreter for Interpreter Services and the availability of an appropriate range of interpreters when needed.
- Authorization Processes:** Satisfaction with all areas of the authorization process have remained steady over the past several years. There were no significant changes. Nearly half of clinicians reported that they are often or always able to refer patients to a specialist without having to wait for approval. Satisfaction with Blue Shield Promise remains significantly higher compared to the vendor's book-of-business. Primary Care Physicians provided higher scores (85.1%) than Behavioral Health Clinicians (65.5%) for the care authorization policies/processes overall.
- Outpatient Drugs:** Scores for the overall knowledge of Blue Shield Promise's clinical staff and the courtesy of Blue Shield Promise Pharmacy Call Center staff (2023 area of improvement) are higher for 2025 than the scores for 2024. Additionally, the scores are significantly higher than those for the vendor's book-of-business. Primary Care Physicians rated (1) the provider notifications that clearly state the reason for the requested drug not being approved for coverage and (2) the ease of outpatient drugs as the highest items of satisfaction with Blue Shield Promise.
- Behavioral Health:** Scores within the area of behavioral health have remained relatively steady since 2023. A significantly higher percentage of Primary Care than Specialty Physicians indicated that they were informed when the patient made an appointment with the mental health specialist, notified when a referred psychiatrist prescribed or

changed the dose of a psychoactive drug for a patient, and requested to coordinate or consult on the care of the mutual patient. This was an area requiring improvement in 2022.

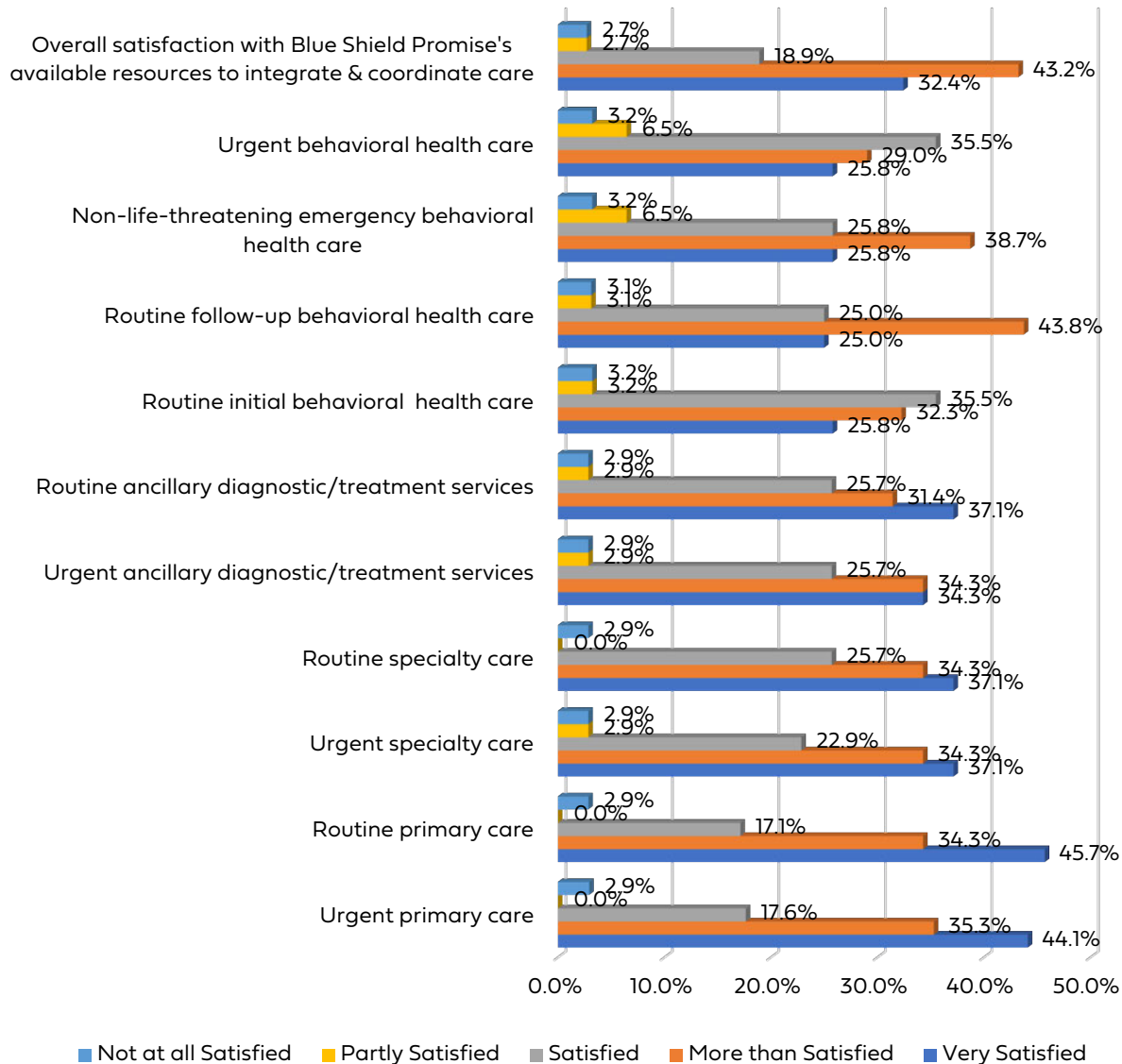
- **Coordination of Care:** Timeliness and helpfulness of consultant reports vary by area of medicine with lower ratings emerging for Mental Health Professionals and Psychiatrists and higher ratings for Cardiologists and Imaging Facilities, which is like previous surveys. Timeliness and helpfulness of facility discharge reports also vary by facility with lower ratings emerging for skilled nursing facilities and higher ratings for inpatient hospitals and emergency departments.
- **Telehealth:** Most respondents indicated they offer telehealth services like the previous two years. A significantly higher percentage of clinicians offer telehealth services using text messaging than in 2024, which increased 6.1%. Clinician satisfaction with all but one telehealth attribute (telephone visits) was similar to scores in 2024. Primary Care Physicians report the highest satisfaction with telehealth compared to Specialists and Behavioral Care clinicians.

The following graphs break out the MY 2025 clinician responses with the referral and prior authorization processes as well as timely access to various care and services. This graph represents clinician satisfaction with the Plan's Referral and Prior Authorization Processes for members.



The following graph demonstrates clinician satisfaction for timely access to various care and services for MY 2025.

Clinician Satisfaction Survey Results for MY2025 Medical and Behavioral Health Satisfaction with Timely Access to Various Care and Services



The MY 2025 Timely Access Report process requires health plans to include an assessment of their Language Assistance Program by surveying clinicians using the Clinician Satisfaction Survey. The Plan included questions in the Clinician Satisfaction Survey concerning access to interpreter services and translation services through the Plan's Language Assistance Program, as well as satisfaction with the available range of interpreters and their training and competency. The *Clinician Satisfaction Survey Tool* is included as an Exhibit with this submission. In addition, the methodology for the Clinician Satisfaction Survey is submitted as a policy and procedures with this Timely Access Compliance Report for MY 2025.

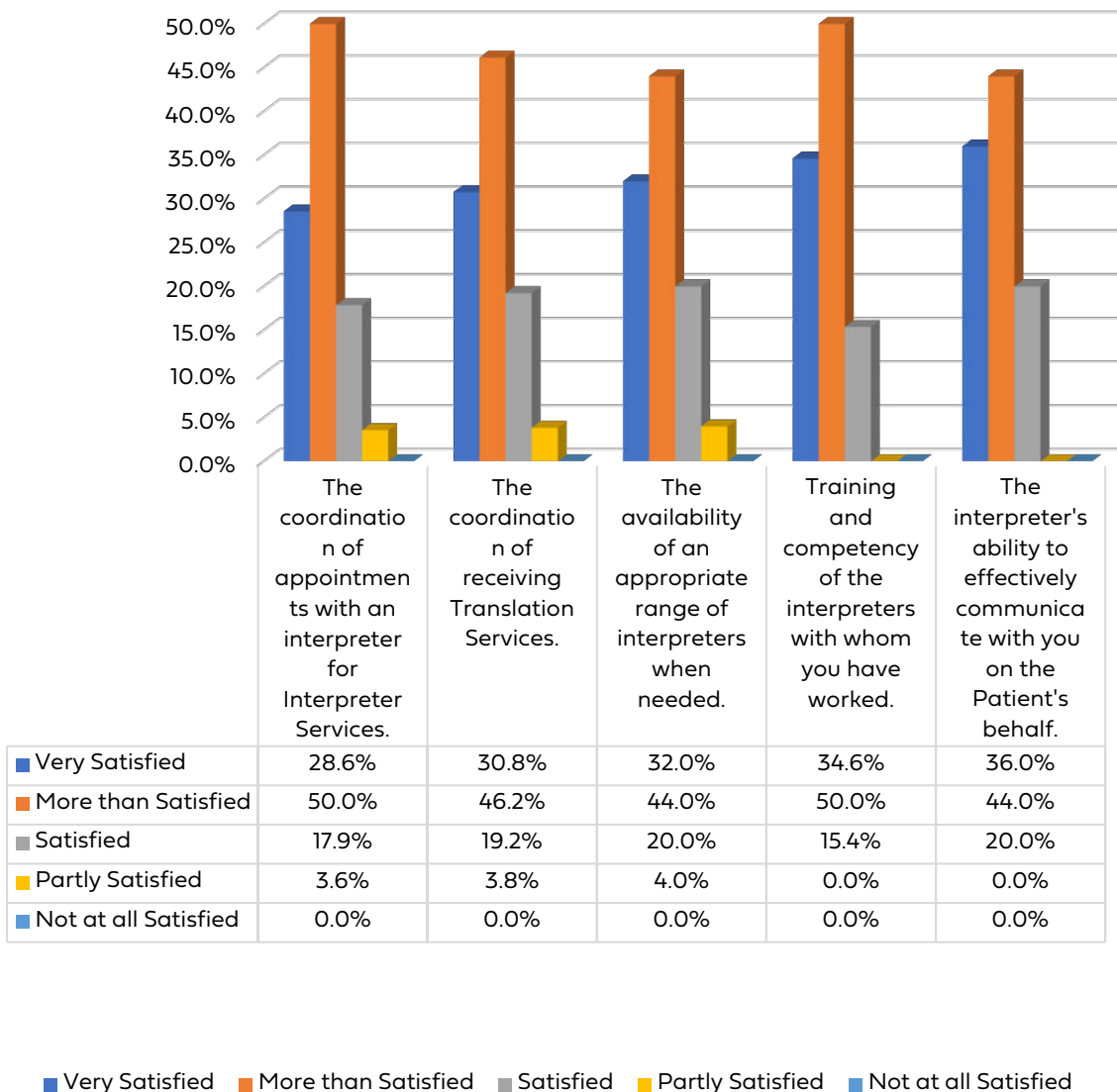
The clinician response percentages, for the current and previous MYs in which provider satisfaction with the Plan's Language Assistance Program have been assessed, are shown in the following table. The table summarizes the percentage of clinicians who stated they are satisfied with the Plan's Language Assistance Program.

<u>Questions:</u> <i>How satisfied are you with your patients' access to Blue Shield Promise's Language Assistance Program for:</i>	Percent Satisfied - by Measurement Year								
	2025	2024	2023	2022	2021	2020	2019	2018	2017
The coordination of appointments with an interpreter for interpreter services?	96%	96%	94%	100%	93%	96%	89%	87%	96%
Translation Services?	96%	96%	93%	100%	93%	96%	88%	87%	98%
The availability of an appropriate range of interpreters when needed?	96%	93%	93%	100%	94%	94%	86%	88%	N/A
Training and competency of interpreters with whom you have worked?	100%	98%	95%	100%	99%	95%	93%	88%	N/A
The interpreter's ability to effectively communicate with you on the patient's behalf?	100%	98%	96%	N/A	N/A	N/A	N/A	N/A	N/A

Satisfaction with the Plan's Language Assistance Program continues to show high steady satisfaction rates for MY 2025, which continues from the previous MYs. The strongest area for clinician satisfaction is the interpreter's ability to effectively communicate on the patient's behalf.

The reasons for the high rates of satisfaction remain twofold. First, more clinicians utilize the Plan's Language Assistance Program for interpretation and translation needs due to increases in telehealth usage. Secondly, the use of the Plan's Language Assistance Program continues to be emphasized as an available tool to communicate with patients resulting from infectious disease precautions and limitations placed on individuals accompanying family members as interpreters during clinician appointments. The following graph illustrates providers' satisfaction with the Plan's Language Assistance Program for MY 2025.

Clinician Satisfaction Survey Results for MY2025 Medical & Behavioral Health Satisfaction - When asked, "How satisfied are you with your patients' access to Blue Shield's Language Assistance Program for...?"



Next Steps

Blue Shield Promise knows that our clinicians' time is valuable. The information from the Clinician Satisfaction Survey provides valuable insight into where improvements were made from last year and where progress can be made in 2026. Blue Shield Promise reviews every response to the survey and continues to do everything possible to improve clinicians' experience with Blue Shield Promise. The responses to the annual Clinician Satisfaction

Surveys are important as the Plan initiates new programs and makes enhancements to existing programs. Our goal as a nonprofit health plan is to provide Californians with access to care that is worthy of our family and friends and sustainably affordable, and we are grateful for our clinicians' partnership.

APPENDIX

- A. 2025 Blue Shield Promise Annual Culturally and Linguistically Appropriate Services Program and Evaluation
- B. 2025 Blue Shield Promise Health Disparities Report – Medi-Cal
- C. 2025 Annual Network Summary Report – NCQA NET 1-3 Report
- D. Quality Improvement and Health Equity Study: Utilization of Emergency Department Visits, Over- and Under-Utilization
- E. Blue Shield of California Promise Health Plan Medi-Cal Population Health Management