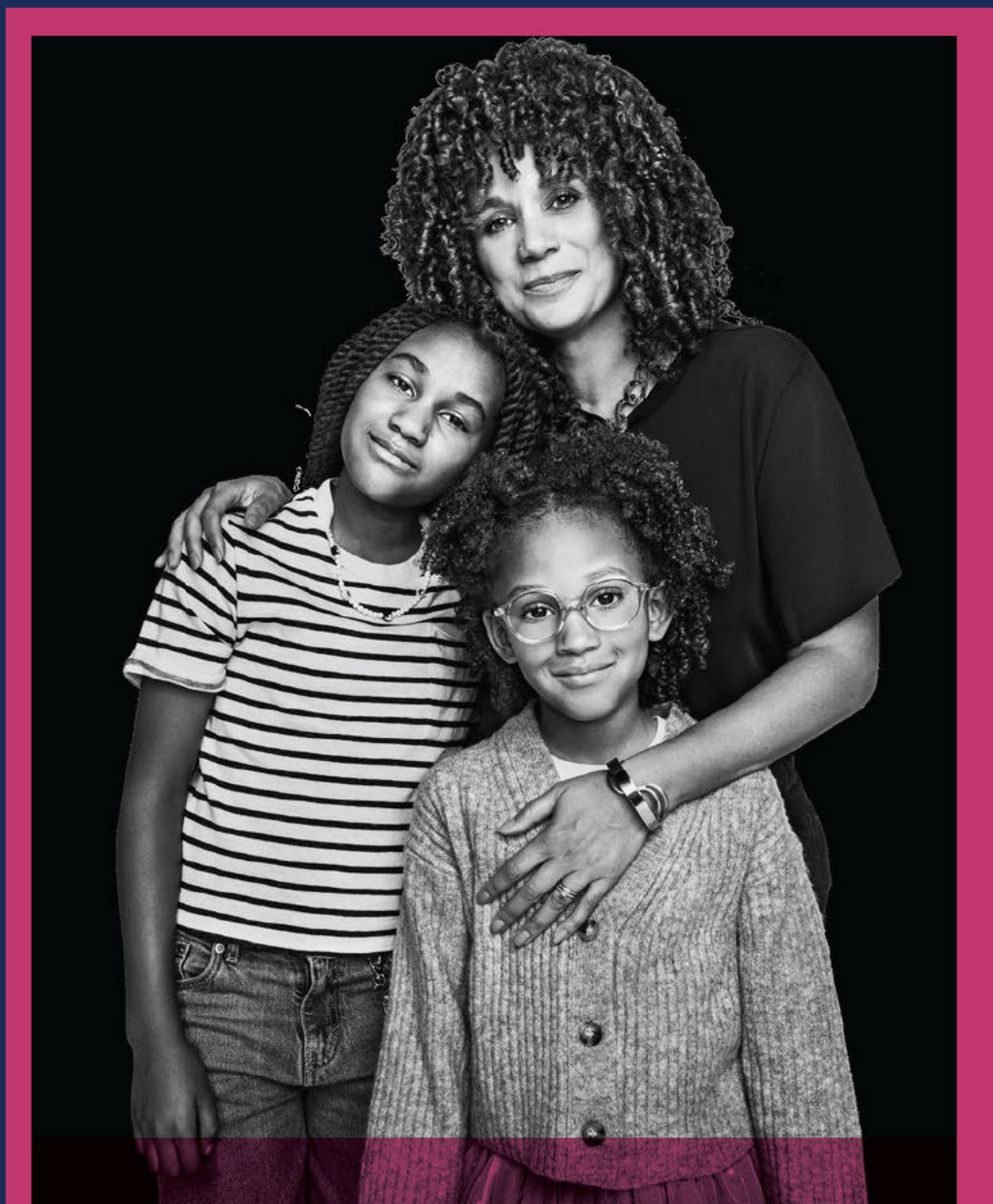




2025 Quality Program Evaluation

Medi-Cal San Diego



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 San Diego 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).

Table of Contents

OVERVIEW.....	6
Population.....	6
OVERALL EFFECTIVENESS OF THE PROGRAM	6
2025 Outcomes and Accomplishments.....	6
Barriers and Opportunities for the 2025 Quality Program.....	8
2025 Program Objectives and Goals	9
Assessment of Quality Program Resources and Committee Structure	11
Quality Improvement Program and Structure.....	11
QUALITY OF CLINICAL CARE	12
Medi-Cal HEDIS Results	12
2025 Quality Improvement Interventions	23
QI Initiatives – Member and Provider Outreach Campaigns.....	25
External Quality Review.....	39
Data Improvement	45
Manifest MedEx.....	48
Blue Shield Promise Pharmacy Services and Pharmacy Member Safety	49
Seniors and Persons with Disabilities Programs	53
SAFETY OF CLINICAL CARE	58
Credentialing.....	58
Potential Quality of Care Issues.....	60
Initial Health Appointment	64
Facility Site Review and Patient Safety / Physical Accessibility Review Survey.....	69
Physical Accessibility Review Survey	71
Comprehensive Perinatal Services Program	75
Early and Periodic Screening, Diagnostic and Treatment Program.....	77
QUALITY OF SERVICE	84
Customer Service	84
Delegation Oversight: UM/Claims/Credentialing.....	86
MEMBER EXPERIENCE	89
Member Satisfaction – CAHPS.....	89
Appeals and Grievances.....	98
Promise Health Plan Preventive Health Guidelines.....	106
Member and Family Engagement	107
PROVIDER ENGAGEMENT / PERFORMANCE / EXPERIENCE	111
Promise Quality Performance Incentive Program San Diego	111
Care Gap Provider Incentive Programs.....	113

Initial Health Appointment	116
Align. Measure. Perform. Medi-Cal Program.....	118
Discontinued Programs	119
Provider Experience - Clinician Satisfaction Survey	121
APPENDIX.....	131
A. 2025 Blue Shield Promise Annual Culturally and Linguistically Appropriate Services Program and Evaluation.....	131
B. 2025 Blue Shield Promise Health Disparities Report – Medi-Cal.....	131
C. 2025 Annual Network Summary Report – NCQA NET 1-3 Report	131
D. Quality Improvement and Health Equity Study: Utilization of Emergency Department Visits, Over- and Under-Utilization	131
E. Blue Shield of California Promise Health Plan Medi-Cal Population Health Management	131

OVERVIEW

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

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

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

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 184,012 Medi-Cal members in San Diego County in 2025.

OVERALL EFFECTIVENESS OF THE PROGRAM

2025 Outcomes and Accomplishments

A. Quality of Clinical Care

- Blue Shield Promise 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. (p. 16)

- In 2025, we continued to enhance the Health Navigator Program to not only enhance its efficiency and outcomes but also include additional health equity activities. (p. 17)
- Successfully completed disparities report supporting NCQA Health Equity Accreditation. (p. 17)
- Timely publication of the annual HEDIS Toolkit which communicates the NCQA measure specification for key measures for each LOB. (p. 46)
- 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 MY 2025 HEDIS reporting. (p. 46)
- Partnered with Operations Samahan to develop processes to successfully extract depression screening data from E-Clinical Works (ECW) for inclusion in HEDIS reporting. (p. 46)

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. 58)
- Aligned credentialing process between Blue Shield Classic and Promise Health Plan for one unified credentialing verification process and decision date. (p. 58)
- The Potential Quality of Care Issues (PQI) Team met the turnaround time goal in 2025 with a performance at 96.5%. (p. 60)
- Achieved a PQI case average turnaround time of 145 days, beating the goal of ≤ 180 days and had 0 referrals to the Credentialing Committee. (p. 60)
- Well-child visit completion rates, pediatric immunization rates, care management engagement, California Children's Services (CCS) enrollment, and Department of Developmental Services (DDS) referrals all showed measurable increases from 2024 to 2025, reflecting successful outreach and enhanced coordination efforts. (p. 80)

C. Quality of Service

- Customer Care Department met both their service level and abandonment rate goals and had no findings to be reported in 2025. (p. 85)
- In 2025 the Delegation Oversight team conducted 100% timely annual audits ensuring those delegated entities that fell below the thresholds were put on CAPS and followed to closure. (p. 89)
- All delegated entities are monitored through timely reporting. In 2025, all delegated entities met 100% timely reporting. (p. 89)

D. Member Experience

- Adult CAHPS rating of the Health Plan increased from 80.9% (2024) to 81.9% (2025), exceeded the NCQA benchmark of 77.7%, and resulted in meeting the goal. (p. 93)

- In 2025, Blue Shield Promise continued to conduct “Member Check-in,” where six full-time call representatives’ outreached Medi-Cal members to assist with access to plan benefits, provide information, assist with appointments, understanding and resolving specialty referrals, etc. (p. 105)
- Blue Shield Promise executed two annual newsletters containing important health information and resources in all ten threshold languages, addressing member access to care and transportation concerns. (p. 105)
- 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. (p. 106)

E. Provider Engagement and Experience

- In MY 2024, our HEDIS goal was met in San Diego County (measures hitting the 50th percentile and year-over-year improvement). Specifically, 15 of 18 measures met the 50th percentile and there was year-over-year improvement in 15 measures. (p. 111)
- Notably, 5 measures were at or above the 75th percentile – each of which were included in the PQPI Program. (p. 111)
- In San Diego, 13 measures were incentivized in at least one of the Care Gap Programs: 11 of 13 measures (85%) hit the 50th percentile. (p. 114)
- In 2024, the Initial Health Assessment (IHA) program captured 15,665 IHA closures, and 9,078 (58%) were timely. We have seen great year-over-year improvement in IHA volume and timely closures. (p. 116)
- Loyalty and satisfaction with Blue Shield Promise remained high in 2025 with over three out of five clinicians providing positive ratings. (p. 122)
- Satisfaction with the Plan’s Language Assistance Program continues to show high steady satisfaction rates for Measurement Year 2025, which continues from the previous Measurement Years. (p. 128)

Barriers and Opportunities for the 2025 Quality Program

- Inaccurate member contact information causing difficulty outreaching members to schedule appointments, with an estimated 30% of phone numbers being incorrect.
- Smaller labs that Blue Shield Promise is contracted with do not have the capability to submit electronic files and have no data sharing agreements to receive lab results.
- All independent radiology facilities in San Diego are experiencing a technician shortage, greatly impacting mammogram appointment availability.
- San Diego county has been experiencing a lack of pediatric providers since COVID, greatly impacting appointment availability.
- In 2025, we had a slight decrease in members screened during mobile mammography clinic days compared to 2024. The decrease of members screened can be attributed to increased member no shows because of fear of the U.S. Immigration and Customs Enforcement (ICE) in 2025.
- The Credentialing Department identified the need for a control process to obtain DMHC

approval for hospital terminations resulting from facility recredentialing issues.

- The Clinical Quality Review Team experienced delays related to processes which included intake performed by customer service sometimes missing key information and delays in receiving information from Appeals and Grievances Department.
- During MY 2025, the Children's Services Team faced several key challenges including resource gaps, such as limited staffing and constrained operational budgets, which occasionally hampered the ability to expand outreach and deliver timely services.
- The passage of AB 144 and resulting second update and approval cycle impacted the timeline for Preventive Health Guidelines (PHG) updates and necessitated expedited work from multiple teams.

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 14 of 18 DHCS Managed Care Accountability Set measures for San Diego.

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.

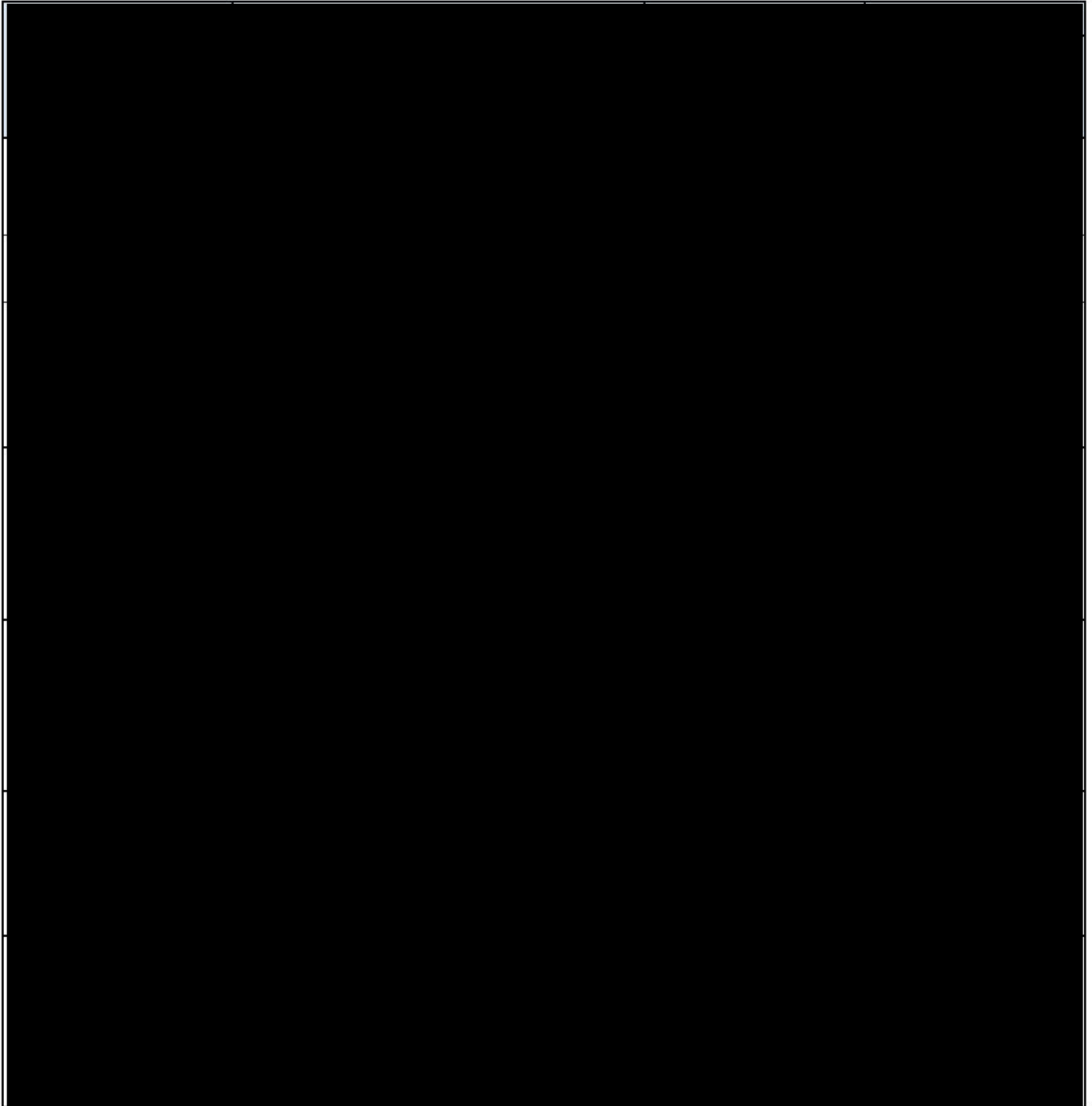
QUALITY OF CLINICAL CARE

Medi-Cal HEDIS Results

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

For Measurement Year (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. MY2024 and MY2023 performance are included for reference:



Quantitative Analysis

For San Diego, there are 18 Managed Care Accountability Set (MCAS) measures that are held to the minimum performance level (MPL) set at the 50th percentile. Fourteen MCAS measures

are predicted to meet or exceed the NCQA 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) Child and Adolescent Well-Care Visits
- b) Childhood Immunization Status – Combination 10 Immunizations
- c) Developmental Screening in the First Three Years of Life
- d) Immunizations for Adolescents – Combination 2 Immunizations
- e) Lead Screening in Children
- f) Breast Cancer Screening
- g) Cervical Cancer Screening
- h) Chlamydia Screening in Women – (Total)
- i) Prenatal and Postpartum Care – Postpartum Care
- j) Prenatal and Postpartum Care – Timeliness of Prenatal Care
- k) Asthma Medical Ratio
- l) Controlling Blood Pressure
- m) Glycemic Status Assessment for Patients with Diabetes (>9%)
- n) Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days

Accomplishments and Trends in Performance

1. **Enhancements to Performance Monitoring Tool:** 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 San Diego County to launch various types of interventions, targeting specific populations. We continue to receive positive feedback from our provider groups regarding these tools.
2. **Revamping of Provider Incentive Program:** 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 the provider groups financially for care gap closures within the specified timeframe per quarter. Compliant

gap closures can be achieved through claims, encounters, or supplemental data.

3. **Enhanced Health Navigator Program:** In 2025, we continued to enhance the Health Navigator Program to not only enhance its efficiency and outcomes but also include additional health equity activities. The new health equity enhancements included a health equity training for all navigators, which taught navigators how to use health equity strategies and provided useful tools for member engagement. In addition, a Health Navigator was also placed at a high volume FQHC to specifically focus on health equity interventions. We continued using prepopulated trackers, allowing the health navigators to streamline their work and focus on correct documentation of outreach attempts. We also continued to conduct regular bi-monthly huddles with the health navigators and team to discuss progress and address issues.
4. **Well Child and Mobile Mammography Community Clinic Days:** We increased the total amount of well child and mammography clinic days from 13 in 2024 to 34 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 added themed 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.
5. **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.
6. **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.
7. **NCQA Health Equity Accreditation.** Successfully completed disparities report supporting NCQA Health Equity Accreditation.
8. **Department of Managed Health Care Health Equity and Quality Measure Set (HEQMS) Monitoring and Action Plan.** Successfully submitted inaugural Department

of Managed Health Care Health Equity and Quality Measure Set (HEQMS) Corrective Action Plan for Measurement Year 2023.

9. **Community Design Sessions.** In collaboration with the Growth team, successfully planned and facilitated community design sessions in partnership with 10 community-based organizations, using structured learning and solution building discussions. These sessions directly informed the launch and expansion of navigations services, community listening sessions, targeted outreach and the scaling of regular and mini clinics days at trusted community locations, strengthening equitable access to preventive and maternal-child care services.
10. **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:
Inaccurate member contact information	Members do not update changes to their contact information with the State	Difficulty outreaching members to schedule appointments, with an estimated 30% of phone numbers being 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 do not send 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.
Mammography – Limited Availability	Lack of technicians	All independent radiology facilities in San Diego are experiencing a technician shortage, greatly impacting mammogram appointment availability. Mitigation Plan: Our clinic day vendor has obtained additional mobile mammogram capabilities which has allowed us to host additional mammogram clinic days. Additionally, mammogram facilities have opened same day appointments for mammogram appointments.
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 Provider (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.

Pediatric Appointment Availability	Lack of Pediatric Medi-Cal provider	San Diego county has been experiencing a lack of pediatric providers since COVID, greatly impacting appointment availability. Mitigation Plan: Additional clinic days are being hosted in San Diego county, in partnership with our providers and a vendor. This has allowed for additional access points, where members can seek pediatric well child appointments. Additionally, we have launched mini clinics, which take place during the week and evenings. These mini clinics are in partnership with well-known community-based organizations.
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 receiving services and availability of appointment times/clinic hours. Language and communication: Some members do not have reliable access to phone or TDD/TTY services.

		Education: varying levels of knowledge/understanding. Behavioral co-morbidities Housing instability. Members are unwilling to complete a well women exam with providers they are unfamiliar with. Mitigation Plan: We have implemented many interventions to help mitigate these barriers to care. These interventions include, but are not limited to transportation resources, interpretation services, additional access points to seek care, member incentives, conducted focus groups to identify additional solutions, conducted outreach to provide education, and launched the Promising Start program for new moms, which provide necessities needed for bringing a new baby home through the first year of line. In addition, to improve Social Drivers of Health (SDOH) data completeness and strengthen our ability to identify unmet member social needs, Blue Shield Promise is piloting a partnership with a large provider group in San Diego county. Through this initiative, the provider group will provide standardized SDOH screening data through a secure data-sharing and integration process, allowing Blue Shield Promise to reconcile gaps, enhance data accuracy, and better target follow up support and interventions for members experiencing social barriers.
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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 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 stratification of provider interventions. Providers were tiered based on their membership size and quality performance.	Data Gap Medical Record Review Access to Records Gaps in encounter data submission Access to Care

Intervention Description	Barrier Addressed
Providers were educated on HEDIS, improved quality of care strategies, care gaps within their membership, and coding education. The Quality Interventions team also worked with providers to address barriers and opportunities to create specific, targeted interventions to improve their care outcomes.	Improper documentation and Coding
Clinical Action Registry (CAR) reports were shared with provider groups monthly. The CAR reports contain provider group performance on various HEDIS and quality metrics along with member level detail on measure compliance. The member-level reports also allowed provider groups to identify if there were data discrepancies (due to coding, file transfers, documentation) and to work with us to identify the cause and to prevent the issues going forward. The Quality Interventions team worked with provider groups to collect supplemental data throughout the year to ensure that all rendered services are captured.	Providers are not aware of their performance. Engaging Physician Provider Group (PPGs)/ Independent Physician's Association (IPAs) and PCPs to improve quality.
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
Provided topical fluoride kits and training to providers: Fluoride kits and hands-on training were provided to providers and their staff who were ready to implement fluoride varnish for children into their workflow.	Care Gaps: member engagement and treatment
Funded select provider groups to have physical gift cards in their offices. These providers opted to have an in-office gift card program for their members when they complete certain visit types to close care gaps.	Care Gaps: member outreach to improve rates and quality of care and member satisfaction.
Participated in and chaired the San Diego Immunization Collation to improvement member education and advocacy for vaccines.	Care Gaps: member engagement and education

Intervention Description	Barrier Addressed
Founded the San Diego County Quality Improvement workgroup with all other Medi-Cal plans in San Diego, and co-chaired workgroup. This workgroup focuses on health outcomes of Medi-Cal members across the county. The focus of the workgroup for 2025-2026 is Topical Fluoride and Immunizations.	Gap Gaps: member engagement and education
Completed medical record reviews in provider EMRs to ensure that all rendered services were properly captured	Care Gaps: Data capture

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

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 Medi-Cal members by reducing traditional barriers to access (i.e., transportation, time constraints, distrust of health care system) and for the 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 an early breast cancer diagnosis have fewer complications and substantially higher rates of survival than those whose cancer is diagnosed late.

In 2025, there were 16 mobile mammography clinic days at various provider group locations, community-based organizations, and Northgate locations. Events took place February –

December 2025. This is an increase from 15 mobile mammogram days held in 2024. In total, there were 616 members scheduled for a mobile mammogram, and 299 members screened. In 2024 there were 601 members scheduled and 312 members screened at mobile mammogram events. In 2025, we had a slight increase in members scheduled and slight decrease in members screened compared to 2024. The decrease of members screened can be attributed to increased member no shows because of fear of ICE in 2025.

Barriers

We encountered environmental and operational challenges that affected the results of the program. We had members with fear of leaving their home due to the political environment (ICE raids). As a result, although we scheduled enough appointments for the minimum required for the vendors, members canceled during appointment reminder calls or no showed during the scheduled event. In addition, we experienced issues with availability of one of our vendors which caused us to cancel three clinic days. 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. This was most pronounced in the first quarter of 2025 when the new policy was implemented. We were able to work with the department that manages the transportation 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. We are also prioritizing holding the clinics at familiar Community Based Organizations to provide reassurance and safety to our members.

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 three different community-based organizations across the county. Additionally, we partnered with three new community-based organizations in 2025 to host well child events.

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 community partner location. Underserved communities with the highest need for well-child screenings were identified as target areas for our clinics. The events were held mostly on Saturdays to provide access for many families who were unable to access their 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 in San Diego County beginning in October 2025 at two locations with a community-based organization.

Quantitative and Qualitative Analysis

The Well Child Clinic Days allowed Blue Shield Promise to develop relationships with community organizations and reengage members in their healthcare, while also redirecting them back to their PCP.

In 2025, there were 18 Well Child Clinic Days at various community-based organizations. This is an increase from 9 Well Child Clinic Days held in 2024. Events took place March 2025 – December 2025. In total, there were 2,603 members scheduled for these events and 1,093 members completed their exams. In 2024 there were 1,253 members scheduled and 499 members screened at well child clinic days. In 2025, we scheduled and screened significantly more members than in 2024.

By December 31, 2025, 1,330 members received well-care visits through regular and mini clinics in the community. In the short time that mini clinics operated in 2025, 237 members received well-care visits 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.

Plans for 2026

In 2026, we are fully integrating our mini clinic pilot and starting mini clinics earlier in the year. We are also increasing the number of clinics within the county and will connect with additional community-based organizations to expand access to screenings and leveraging well-known, trusted locations within the communities.

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) were used to identify members who have visited the emergency department (ED) due to substance use, 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 and CCD 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 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 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 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 meets numerator criteria for the two behavioral health HEDIS measures. The vendor performance reports showed that between January – December 2025, 1,075 members were identified for outreach from the ADT and CCD reports. This is a large increase from the 155 members identified for outreach in 2024. In October 2025, quality piloted outreach to members who had an ED visit without a primary diagnosis, to address the barrier of incomplete data in the ADT and CCD reports. To mitigate the barrier of incomplete data to eligible FUA and FUM members for outreach, we piloted the vendor outreach to any member who had an ED visit and an appropriate discharge status. Out of the 1,075 members submitted for outreach, 181 members had booked appointments, yielding a 17% connection rate/appointment penetration rate. This connection rate is lower compared to the 21% (32/155) connection rate from 2024. 65% of the 181 members (118/181) who booked appointments completed them. This finding is critical because the visit meets numerator criteria. The 2025 completion rate of 65% is lower than the 2024 completion rate of 72% (23/32).

In 2025, performance was measured through the same indicators above 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 218 eligible members for outreach in

San Diego, which was an increase from 92 eligible members in 2024. Among the 218 members, 39 booked an appointment, yielding an 18% connection rate. The 18% connection rate in 2025 is lower than the 22% connection rate from 2024 (20/92). Among the 39 members who booked appointments, 74% of members completed visits, yielding a higher appointment completion rate in 2025 (in 2024, the completion rate was 70%, or 14 out of 20). Given that 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 impact 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," remained a challenge. The solution was implemented to incorporate CCD data and reports. However, the data challenges also had impact on the distribution of the CCD reports. Consequently, quality additionally began to pilot outreach to members who had ED visits based on the ADT reports, but the primary diagnosis for the ED visit was blank. While this yielded more members for outreach, the prior challenge of reaching members remained a barrier.

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 is placed at a specific clinic location (embedded) or at a provider group (non-embedded) to conduct outreach to

members to support appointment scheduling, health education, identify missing compliant data and other Promise specific intervention implementation and oversight. Embedded health navigators are located at a clinic site, where they can meet with members face-to-face, work directly with the clinic’s quality team and providers, and can influence clinic processes. Non-embedded health navigators are located at administrative offices or at IPAs.

Methodology

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

Quantitative and Qualitative Analysis

The health navigator program launched in October 2020 with a pilot FQHC in San Diego County. The program expanded late in 2021 to 10 health navigators. Data for the health navigators active in 2025 can be shown in the table below. Overall, across 10 health navigators, there were 45,877 members touched (i.e., reached a member or left a message with the member). There were 12,047 care gaps closed within these 11 provider groups for members that were included in the outreach. This is an increase from 2024 with 24,545 members touched and 4,638 gaps closed in 2024.

Barriers

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

Plans for 2026

In 2026 a data integration tool will be implemented to enable health navigators to generate outreach lists and submit compliant records through the platform. Additionally, health navigators will be able to offer members additional appointment scheduling options through mobile clinics.

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, conduct reminder calls for scheduled visits, review claims and encounters prior to the calls in case the member already had the service rendered recently, calls the provider offices to confirm that appointments were attended, collect relevant medical records for services that were previously rendered, and remind members of flu vaccinations if applicable.

Quantitative and Qualitative Analysis

In 2025, outreach efforts increased significantly by 11%, with over 38,000 members targeted, an increase of more than 4,000 from 2024 (34,000 members). More than 10,000 care gaps were closed, more than double the 4,800 closed in 2024, representing a 108% increase. In addition, 629 appointments were scheduled directly by the team, an increase of 86 from the 543 scheduled in 2024. Together, these gains demonstrate a strong year-over-year improvement in outreach performance across San Diego 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. An additional barrier involved members declining assistance due to community safety concerns related to ICE raids; fortunately, 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 of January 2026, outreach lists with over 11,000 members were created, with a focus on prioritizing well-child and immunization appointments within San Diego 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 and 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 online register for the program via mail. Once the member creates an account, they can view their available health actions and corresponding incentives for completing them. Once the member has completed their health action they can attest to the completed activity through their online portal and choose a reward to redeem. Throughout the year, members are sent mail and emails to encourage them to complete their health care activities and redeem their incentive until the end of the program on December 31, 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 Health Navigators and Postpartum and Prenatal incentive mailers

Quantitative and Qualitative Analysis

The program was launched in April 2025 and ended 12/31/2025. Members have until 2/28/2025 to redeem gift cards for health care activities completed in 2025. In 2025, 85,954 health care activities were targeted and a total of 4,001 incentives for completed activities were earned. The table below displays the program results per health care activity.

The program's overall utilization increased from 3.12% in 2024 to 4.65% in 2025. The program's utilization rate in 2025 would have been greater if not for the rise in point of care incentives during that year. Members receiving point of care incentives increased from 611 in 2024 to 1,853 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 41 mailers and emails sent to date, representing an increase from 11 mailers and emails 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 were sent to 29k members. 1,320 African American 3- 21-year-old members noncompliant for this Well Child and Adolescent Visit HEDIS measure were included in the mail outreach.

Barriers

Even though we utilization increased in 2025, we experienced several issues and barriers that affected the impact of this program. Some of them 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, 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

Target 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 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 sent 1,314 members. A total of 278 incentives, 133 incentives for completed postpartum visits

and 145 incentives for completed prenatal visits, were mailed to members that reported completed visits within timeframe. A total of 230 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 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. One of the key additions is information regarding the new 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.

IHI Child Health Equity Collaborative

The purpose of the Institute for Healthcare Improvement (IHI) Child Health Equity Collaborative is to improve the completion of well-child visits (WCVs) for infants aged 0-30 months and adolescents aged 15-18 years old. The focus is on enhancing relationships with provider groups and community partners to ensure better and more accessible care for target populations. Through this work with IHI and our partnering provider group we have made a commitment to health equity by focusing interventions on identifying populations impacted by inequity, understanding experiences and root causes around WCV gaps, and testing changes and building partnerships to improve equity. All of this is being done through a five-step intervention process over the course of one year. The five intervention areas include:

1. Equity & Transparent, Stratified, and Actionable Data
2. Understand Provider and Patient/Caregiver Experiences

3. Reliable & Equitable WCV Processes
4. Asset Mapping & Community Partnerships
5. Partnering for Effective Education & Communication

Throughout each of these intervention steps we have worked with IHI and our provider partner to identify areas of improvement for our target population. The population we identified is the Hispanic population of members ages 15-18 years and 19-21 years. We have worked through each step of the intervention process to make access to care more equitable for these members by addressing their underlying needs that were identified.

This phase of the IHI Collaborative concluded in March 2025, and Phase Two launched in September 2025. Phase Two focuses on Well-Child Visits in the First 30 Months of Life (W30) for the Hispanic population. In December 2025, two clinics were identified to partner on the IHI work throughout 2026. The first intervention will focus on improving appointment access for well-child visits for children aged 0 to 30 months. Additional interventions addressing patient engagement and education will be incorporated throughout each intervention cycle. Phase Two is currently scheduled to continue through September 2026.

IHI Behavioral Health Collaborative

The Institute for Healthcare Improvement (IHI) is partnering with the CA Department of Health Care Services (DHCS) to strengthen partnerships between County Behavioral Health Plans (BHPs) and Managed Care Plans (MCPs), as well as other relevant partners to reduce behavioral health disparities and improve population health outcomes for Medi-Cal members, specifically improving the HEDIS measures, "Follow up after emergency department visit for mental illness (FUM) – 30 day" and "Follow-up after emergency department visit for substance abuse (FUA) – 30 day."

The goal of the collaborative is "by September 2026, participating behavioral health plans and managed care plans will report a 5% increase in 30-day follow-up after emergency department visits for mental illness (FUM) and a 5% increase in 30-day follow-up after emergency department visits for substance use (FUA)."

Through this work with IHI and our San Diego County Behavioral Health Plan, we aim to build processes that reduce the burden on members of navigating the fragmented behavioral health delivery system and ensure behavioral health services surrounding an emergency department visit are coordinated across systems, enabling Medi-Cal members to access appropriate, whole-person care. The collaborative structure for this learning collaborative includes:

1. Three two-day learning sessions for Behavioral Health Plan and Managed Care Plans (MCPs) to engage with faculty and develop peer-to-peer working relationships, share learning, and receive instructions.
2. Action Periods between learning sessions. The teams will complete intensive small-scale, iterative testing based on the needs of the community and relevant approaches and tools taught during Learning Sessions.

3. Quarterly coaching calls with expert faculty on the specific changes that teams are testing, what they are learning from their data, and whether they are making progress towards their aim.
4. Quantitative and qualitative measurement activities to support learning, inform real-time improvements, and provide insights that enable the spread of breakthrough improvements to other teams.

This phase of the collaborative started September 2025 and will conclude September 2026. At the end of 2025, we were in the development phase, conducting qualitative interviews with providers and members, and extracting insights from available quantitative data, stratified by different demographic variables. The next phase will include testing changes informed by the development period.

Performance Improvement Project (PIP)

The California Department of Health Care Services (DHCS) requires that full-scope Medi-Cal managed care health plans (MCPs) and population-specific plans (PSPs) conduct two PIPs per contract with DHCS. One of the 2023–2026 PIPs must target a health disparity as outlined in the Health Equity PIP Topic Proposal Form. The second topic must be related to an area in need of improvement (non-clinical). Blue Shield Promise selected the measures below for the 2023 – 2026 Performance Improvement Projects (PIPs):

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

Health Equity PIP

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

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

During 2025 three interventions were implemented to target the focus population of the PIP. These interventions included (1) further leveraging our Health Navigators to conduct culturally relevant outreach to Hispanic members within the W30 population and (2) leveraging our vendor relationship to ease access to care for this population and (3) conducting a Health

Equity training for one health navigator to provide them with additional Health Equity tools and strategies to improve outreach and engagement to the Hispanic population.

1. Through the work with our Health Navigators, they were able to identify barriers for the Hispanic population and address these needs before scheduling a well child visit, while using the members preferred language of choice. These needs include working through transportation barriers, food insecurity and potential housing needs. Through this intervention, 242 members were successfully outreached and 106 of these members completed a W30 appointment (43.8%).
2. The intervention partnership with the vendor offered the target population alternative ways to complete a W30 appointment. This consisted of hosting clinic days around the community in areas that have a high population of Hispanic members. During this intervention period 31 targeted members were successfully reached and 6 of these members became compliant with the W30 measure (28.57%).
3. The Blue Shield Promise Health Equity team (which specializes in health equity concepts and practices for the Medi-Cal population) conducted a Health Equity Training with one of the triaged member outreach specialists (health navigator). The training consisted of health equity principles and focused on Hispanic member engagement. After the training, the health navigator conducted outreach to Hispanic members (caregivers) 0-15 months of age who needed well child visits completed. The navigator will apply strategies and tools acquired during the training to strengthen outreach efforts and foster meaningful engagement within the Hispanic community. During the initial intervention period (2 months) the trained health navigator outreached 32 members within the target population and 11 of those members completed their appointment within the initial testing period (34.37%).

Non-Clinical PIP

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

Blue Shield Promise has chosen to focus on members who have enrolled in a Care Management program who have been diagnosed with SMH/SUD within 14 days of diagnoses for the Non-Clinical PIP topic. This topic was chosen due to the complexities of these populations and the need for improvement in these areas. Blue Shield Promise completed its barrier analysis for this PIP and building its first targeted intervention. The submission in November 2024 was approved. The 2025 submission in August was also approved. The baseline data showed that 2.14% of 1,309 members ages 6 and older who had an emergency department visit with a principal diagnosis of mental illness or substance use enrolled into CM, CCM, or ECM within 14 days of the ED visit during calendar year 2023. In the August 2025 submission, the Remeasurement 1 data showed that 5.72% of 1,434 members ages 6 and older who had an emergency department visit with a principal diagnosis of mental illness or substance use enrolled into CM, CCM, or ECM within 14 days of the ED visit during calendar

year 2024. The 5.72% performance rate from 2024 was a 3.58% increase from the 2.14% performance rate from 2023. The findings were also statistically significant.

The intervention in 2025 included continuing to leverage the vendor to contact members post-ED visit and referring members to ECM or CM. Quality identified eligible members from the Admit, Discharge, and Transfer (ADT). The vendor conducted telephonic outreach to facilitate follow-up visits or provides a telehealth visit. We modified this intervention by using the Continuity of Care Document (CCD) data as another source to identify members who had an ED visit for mental illness or substance use. Lastly, in October, we further modified the intervention by expanding outreach criteria to members who had an ED visit based on the ADT data, regardless if the ED visit was for substance use or mental illness.

In 2025, 0.59%, or 8/1,356 eligible members accepted ECM referrals. This is a drastic decline from 11%, or 64 of 534 eligible members, accepting ECM referrals in 2024. Separately, 178 out of 1,356 eligible members completed a visit with the vendor. Among the 178 members who completed a visit, 4.5% (4/178) accepted the ECM referral. This is also a significant decrease from the 60% (64/107) who completed visits with the vendor in 2024 and accepted the ECM referral.

In 2026, Quality will work with the vendor for an explanation for the drastic decline in acceptance of ECM referrals. Quality will continue to monitor the modified intervention. Quality will explore with subject matter experts (e.g., Population Health Management team) on how to increase appropriate ECM or CM referrals.

External Quality Review

The Center for Medicare and Medicaid Services (CMS) requires external quality review organizations (EQRO's) to report annually on how Medicaid managed care organizations address prior-year External Quality Review (EQR) recommendations. The Health Services Advisory Group, Inc. (HSAG), the EQRO for DHCS, completed the 2023-2024 Medi-Cal Managed Care Physical health External Quality Review Technical Report in April 2025. The document included plan-specific recommendations for Blue Shield Promise, requiring a response describing how the plan has addressed HSAG's recommendations from the 2023-2024 EQR technical report.

The recommendations from the 2023-2024 EQR technical report included conducting an analysis for quality measures that fell below the minimum performance levels (MPLs) in 2023, including Well-Child Visits, Topical Fluoride Application, Cervical Cancer Screening, and Follow-up after emergency department visits for mental illness and substance use. Part of the assessment included identifying contributing factors to performance and revising member- and provider-focused interventions based on the identified contributing factors.

Blue Shield Promise's response included a summary of drivers to performance, by measure, and included a description of the subsequent changes implemented. For well-child visits, a contributing factor was a shortage of pediatric providers – a challenge that has persisted since the COVID-19 pandemic. Blue Shield Promise addressed the issue through provider

partnerships, community clinic days, and telehealth options. Blue Shield Promise addressed topical fluoride performance through provider education on coding, training for primary care and dental providers, and distribution of fluoride kits, given that coding was a contributing factor to performance. Blue Shield Promise has addressed cervical cancer screening barriers through provider collaboration, member incentives, data-gap resolution, and education on in-office self-testing. To improve follow-up care for members with ED visits related to mental illness or substance use, Blue Shield Promise collaborated with Health Information Exchanges and county partners to support timely provider outreach within the 30-day follow-up window. Blue Shield Promise also worked with DHCS to address 2024 compliance review findings related to Availability of Services, Coordination and Continuity of Care, and Grievance and Appeal Systems by developing and implementing corrective action plans, submitting requested updates and documentation, and achieving DHCS closure of the CAPs on March 4, 2025. Blue Shield Promise submitted this response in August 2025 and is awaiting the next EQR technical report and recommendations.

Advancing Health Equity

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

- Identifying and mitigating social drivers of health (SDOH) to reduce health care inequities
- Employing the added Medi-Cal benefits that support prevention (e.g., doulas, community support, and Community Health Workers)
- Achieving & maintaining the National Committee for Quality Assurance (NCQA) Health Outcomes Accreditation
- Implementing 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 address inequities affecting the maternal and pediatric populations by gathering feedback directly from the Medi-Cal community through focus groups and strategic partnerships with community-based organizations. These collaborations, along with the leadership of the Growth team, enabled us to better identify and understand barriers to accessing preventive care throughout pregnancy and for children. Blue Shield Promise worked with 10 community-based organizations to facilitate structured learning and

collaborative co-design sessions over three days. These sessions combined shared learning with solution-focused discussions to pinpoint key barriers to care. The Growth team in partnership with Quality Improvement team played a pivotal role in leading the expansion of navigation services, implementing community-based listening sessions, enhancing targeted outreach, and scaling mini clinics and clinic days at trusted community locations. All ten participating community-based organizations (CBOs) have integrated training initiatives to enhance alignment with quality and health equity objectives. Nine CBOs have organized well-child events; three are engaging in platform-based outreach; three are providing navigation support services; four have facilitated community listening sessions; and one CBO has hosted mini-clinics. Insights from this process directly shaped Quality Improvement strategies to improve equitable access to preventive and maternal-child care services.

Additionally, 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 San Diego. 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 2025, we continued to observe inequities by race/ethnicity for poor diabetes control for members in San Diego 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 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 San Diego County, quantified by the HEDIS Prenatal and Postpartum Care measure. 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.

In 2024 and 2025, we acted on observed inequities for Child and Adolescent Well Care Visits (WCV) among Promise members in San Diego County. Our intervention strategy focused on reducing inequities for Black/African American and Asian members, as these groups showed the highest number of preventive care visit gaps among Promise members. Additionally, DHCS has historically observed inequities among these populations. We engaged our target populations by partnering with the vendor to improve access to well-child visits. This includes providing scheduling assistance, hosting clinic days, and administering a Social Drivers of Health (SDOH) assessment. Among Asian members, the improvement in performance between measurement year 2023 and 2024, and progress toward the 66.67th percentile national benchmark, resulted in the achievement of incentive dollars from DHCS' Quality Withhold and Incentive Program. Improvement with the selected racial and ethnic subgroups for WCV (i.e., for San Diego County is Black/African American and Asian members), resulted in points for incentive dollars earned. There remains an opportunity to achieve this level of improvement among Black/African American members.

Lastly, in 2025, we successfully completed and filed the Health Equity and Quality Measure Set (HEQMS) Corrective Action Plan with DMHC. In partnership with cross-functional teams, the barrier analyses and supporting documentation were packaged and submitted to DMHC. Findings from the HEQMS analysis identified disparities in preventive care and follow-up measures, particularly among racial and ethnic sub-populations, driven by gaps in access, data completeness and limitations, and care coordination. In response, Quality implemented targeted actions including enhanced data validation and stratification, expanded community-based outreach and navigation, strengthened provider engagement, and alignment of quality interventions to address identified inequities and improve equitable care delivery. As part of our 2026 efforts, we will monitor the CAP and performance for the next submission.

Plans for 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 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 state observed inequities. We will also continue to monitor the DMHC HEQMS CAP and performance for the next cycle.

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 2024 to 22 measures held to the 50th percentile in 2026. For the 2026 MCAS measure set, 2 measures from 2025 were removed, 6 new measures were added, and 1 report-only measure was added. Overview of changes is included in the table below. New measures to the measure set are in bold font:

2026 MCAS Measure Changes	Domain	Measure
Measures Removed/Report only measure added	Reproductive Health and Cancer Prevention	Chlamydia Screening. High performing measures removed from measure set. Performed at 75 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 enhance 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 – expansion to additional community-based organizations (CBOs) in SD Expand mini clinics throughout SD 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

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 Implement interventions with community-based organizations to advance health equity Conduct additional listening sessions with specific subpopulations to inform interventions Launch intervention with vendor 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

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 San Diego 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] and [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.

New supplemental data setups have been established in MY 2025

- i. BSC Strategic data project data channels.
 - a. [REDACTED] Solution: Successfully ingested [REDACTED] data for San Diego LOB 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.
 - a. Partnered with Operations Samahan to develop processes to successfully extract depression screening data from ECW for inclusion in HEDIS reporting.
 - b. San Diego County MCP file. Partnered with county of San Diego BH to capture HEDIS data from CareSmart EHR and successfully

- 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 cred

Quantitative Analysis

The Credentialing actions for 2025 are as follows:

Blue Shield Promise (San Diego)	2024	2025	Trends in Performance
Practitioner/Prov - Initial Cred files approved	544	1028	↑
Practitioner/Prov - Recred files approved	150	228	↑
Practitioner/Prov - Inactivation files	574*	51	↓
Practitioner/Prov - 805 Reports	0	1	↑
Healthcare Delivery Organizations (HDO) - Initial Cred files approved	51	60	↑
Healthcare Delivery Organizations (HDO) - Recred files approved	50	106	↑
Healthcare Delivery Organizations (HDO) - Inactivation files	215*	14	↓

*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.

Recommendations for 2026

The Credentialing Department goals for 2026 are as follows:

- Review AB 1041 and ensure alignment with 2027 credentialing 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 goal was achieved. TAT goal was met in 2025 at 96.5%.

In addition, the following related results were achieved:

- PQI case average turnaround time (TAT): 145 days (TAT goal is ≤ 180 days)
- CAP and Education Letters issued: 8 CAPs and 53 Education letters issued
- Referrals to Credentialing Committee: 0

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 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

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	183	274	312	209	978	92	21	42	46	201	35	38	29	19	121
Internal PQIs	15	14	10	7	46	9	9	5	2	25	8	11	8	16	43
Total Received	198	288	322	216	1024	101	30	47	48	226	43	49	37	35	164

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	98	68	99	176	441	139	84	25	69	317	13	11	19	14	43
C-1	71	62	95	140	368	30	22	37	23	112	16	19	13	24	50
C-2	7	3	0	1	11	2	0	1	1	4	3	1	0	3	4
C-3	0	0	1	0	1	0	0	1	0	1	1	0	0	0	0
Total Closed	176	133	195	317	821	171	106	64	93	434	33	31	32	41	137

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, and training of staff on new or revised requirements, 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

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

IHA Outreach Activities and Outcomes

Table 1: Initial Health Appointment (IHA) - Outreach Rates for FY 2023 through FY 2025 – SD County

Initial Health Appointment	FY25		FY24		FY23	
Total New Membership	40,035		79,238		29,557	
Initial Health Appointment Outreach	FY25	FY25%	FY24	FY24%	FY23	FY23%
Appt Scheduled/Will Schedule	2,957	7%	6,851	9%	2,204	7%
IHA Completed Prior to Outreach	2,919	7%	3,944	5%	1,963	7%
Ineligible/Termed/Disenrolled Prior to Outreach	4,745	12%	6,597	8%	1,368	5%
Unable to Reach/Left Message/Declined Outreach	20,845	52%	23,270	29%	21,441	73%
No Contact/Incorrect Contact Information Provided	8,569	21%	12,493	16%	1,336	4%
Total IHA Outreach	40,035	100%	53,155	67%	28,312	96%
Outreach Completed Untimely/ Outreach Not Completed	0	0	26,083	33%	1,245	4%

FY25 – Enrollment between Jul 2024 to Jun 2025

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

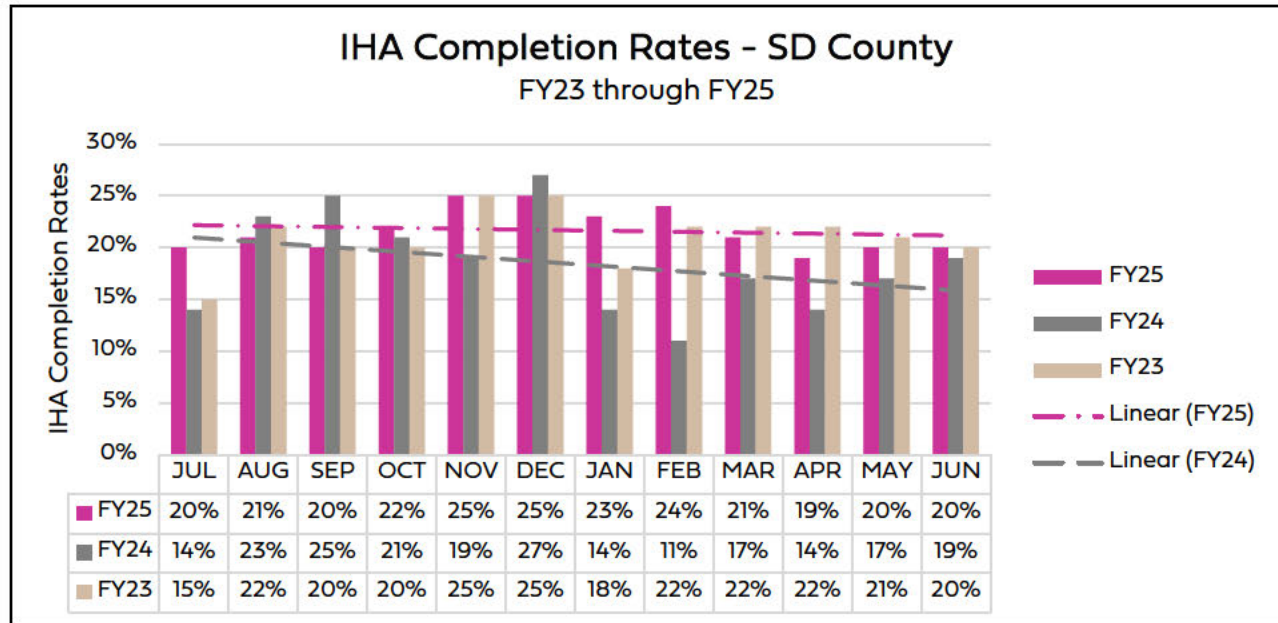
Our Blue Shield Promise Initial Health Appointment (IHA) outreach coordinators conducted phone outreach in accordance with our standard protocol and policy, calling newly enrolled members of all ages to encourage and/or provide-assistance in scheduling an IHA throughout Fiscal Year (FY) 2025.

Outreach Calls

During FY 2025, Blue Shield Promise IHA outreach coordinators and the vendor, [REDACTED] made a total of 40,035 outreach calls. This decrease in the number of calls made in FY 2025 is due to a substantial decrease in membership. 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.

The IHA outreach coordinators, with the assistance of [REDACTED], completed 100% of calls in FY 2025, a significant improvement from the 67% completion rate in FY 2024. Consistent with previous years (FY 2023 and FY 2024), the most frequent call outcome was "unable to reach/left message/declined outreach, which accounted for 52% of call results in FY 2025, up from 29% the previous year. Furthermore, FY 2025 saw a noticeable increase in members with no contact or incorrect contact information, rising from 16% in FY 2024 to 21% in FY 2025. Notably, 7% of members had already completed an IHA prior to outreach in FY 2025, compared to 5% in FY 2024.

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

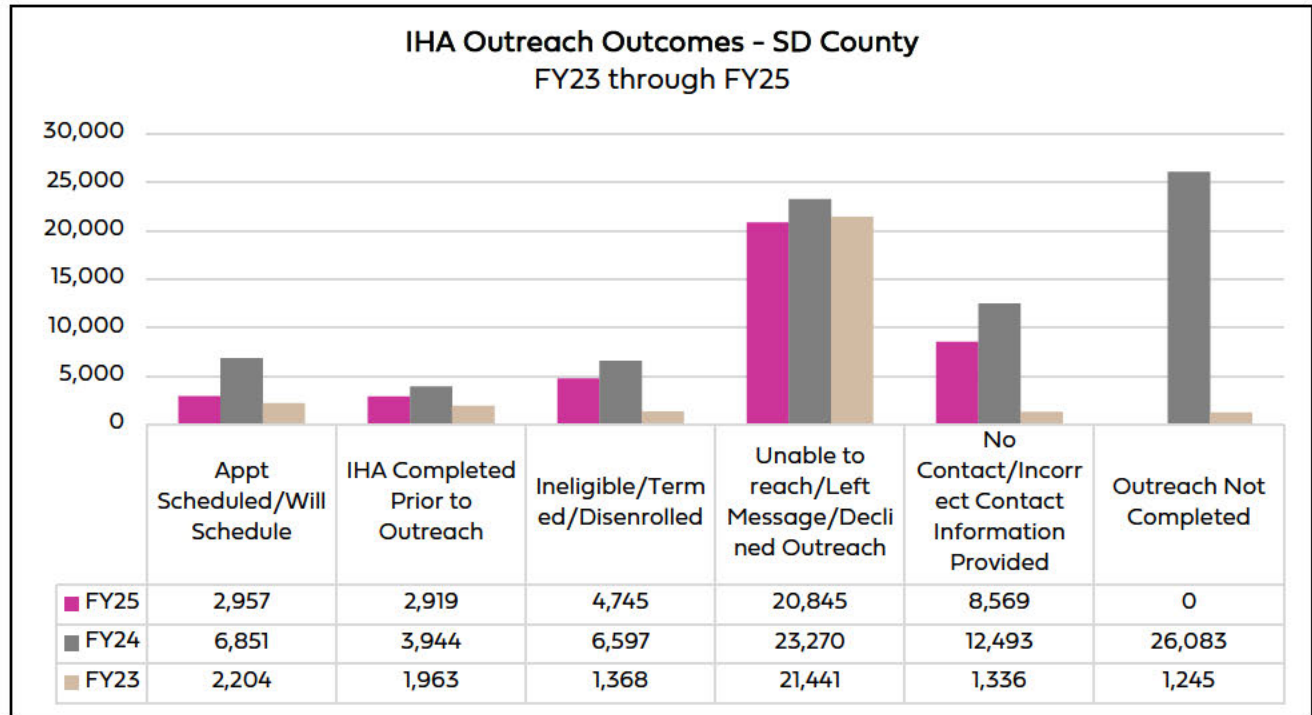


FY25 – Enrollment between Jul 2024 to Jun 2025

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

The IHA completion rates are assessed using data from the third and fourth quarters of the previous measurement year, along with the first and second quarters of the current measurement year, rather than following a typical calendar year. This methodology ensures a comprehensive and accurate collection of encounter data. The comparison between FY 2025 and FY 2024 IHA Completion Rates for San Diego County reveals that FY 2025 had higher completion rates than FY 2024 for nine out of twelve months. In FY 2025, the rates were higher by 1% to 6% than in FY 2024. The highest completion rate in FY 2025 was 25% in both November and December. The month of December had the highest completion rate for FY 2023, FY 2024, and FY 2025.

Table 3: Blue Shield Promise IHA Outreach Call Results from FY 2023 through FY 2025 – SD County



FY25 – Enrollment between Jul 2024 to Jun 2025

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

During FY 2025, Blue Shield Promise IHA outreach calls saw a significant reduction in overall call volume primarily due to a marked decline in membership.

The most common outcome for outreach efforts continued to be the “Unable to reach/left message/declined outreach” category, totaling 20,845 calls in FY 2025 compared to 23,270 in FY 2024. Notably, 100% of outreach calls in FY 2025 were completed timely.

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

IHA Medical Record Review	Audited CY25 (FY25 Enrollees)	Audited CY24 (FY24 Enrollees)	Audited CY23 (FY23 Enrollees)
Total Medical Records Audited	873	653	502
# Providers Audited	188	126	96
Average Score	96%	96%	96%

FY25 – Enrollment between Jul 2024 to Jun 2025

Table 4 Summary: IHA Medical Record Review- SD County

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

In CY 2025, medical record reviews were conducted on members enrolled in CY 2024. There was a significant increase in the number of audits conducted, with 188 providers audited in CY 2025 compared to 126 in CY 2024. Additionally, the volume of medical records reviewed increased substantially, from 653 in CY 2024 to 873 in CY 2025. Throughout CY 2025, the emphasis remained on auditing more Federally Qualified Health Centers (FQHCs) within San Diego County, which contributed to the overall rise in both medical records reviewed and providers audited. Despite these increases, the average audit score consistently remained high at 96% in both years.

Qualitative Analysis

The overall IHA completion rates in San Diego County showed a marked improvement in FY 2025 compared to FY 2024. This positive trend can be attributed in part to the proactive outreach efforts and telehealth appointments offerings provided by [REDACTED]. Notably, IHA completion rates surpassed those of the previous year in nine out of twelve months in FY 2025. The highest completion rates were observed in November and December, reaching 25% in these months. Consistently, December has emerged as the peak month for IHA completion in FY 2023, FY 2024, and FY 2025.

Trends in Performance

- Decrease in New Membership and Outreach Volume:

There was a notable decline in the number of newly enrolled members from FY 2024 to FY 2025, which led to a reduction in outreach calls made. The drop in membership was primarily due to the re-implementation of annual eligibility verification, member-initiated coverage termination, and relocation out of state.

- Improved Outreach Completion Rates:

FY 2025 saw a significant improvement, with outreach coordinators completing 100% of calls, compared to 67% in FY 2024 and 96% in FY 2023.

- Persistent Challenges in Member Contact:

The most frequent outcome for outreach remained “unable to reach/left message/declined outreach,” accounting for 52% of calls in FY 2025—an increase from 29% in FY 2024. There was also a rise in cases of “no contact/incorrect contact information,” jumping from 16% in

FY 2024 to 21% in FY 2025, suggesting ongoing issues with accurate member data.

- **Increase in Medical Record Audits:**

The number of providers audited, and medical records reviewed, increased substantially in CY 2025 compared to CY 2024. Despite the larger audit volume, the average score remained steady at a high 96%, indicating sustained quality in IHA documentation.

- **Impact of Proactive Outreach and Telehealth:**

The improvement in completion rates is attributed to proactive outreach and telehealth offerings, particularly through [REDACTED], facilitating easier access for members to schedule and complete their IHAs.

Opportunities for Improvement

1. Enhancing the accuracy of new enrollment data to prevent incomplete or incorrect contact information from impeding IHA member outreach efforts.
2. Continue collaboration with the vendor [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 QI and [REDACTED] to reach out to members and assist in scheduling telehealth appointments as part of an IHA.
4. Blue Shield Promise IHA team continued participating in Joint Operating Meetings with participating IPAs and FQHCs 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) 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 (BSP). 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 San Diego County

Compliance Metrics - Quantitative Analysis	CY25	CY24	CY23
Total Facility Site Reviews Due (Contracted and Pre-Contractual)	10	10	9
Total Facility Site Reviews Completed	10	10	9
Total Facility Site Reviews Completed on Time	10	10	5
Average Facility Site Review Score	96%	96%	88%
% Pass Rate ($\geq 80\%$ aggregate score)	100%	100%	88%
Total Medical Record Reviews Due (Contracted and Pre-Contractual)	11	12	5
Total Medical Record Reviews Completed	11	12	4
Total Medical Record Reviews Completed on Time	11	11	1
Average Medical Record Review Score	94%	91%	86%
% Pass Rate ($\geq 80\%$ aggregate score)	100%	92%	75%
Department Metrics (Regardless of Due Date) Facility Site Review & Medical Records Review	CY25	CY24	CY23
Total Facility Site Reviews Completed	11	11	14
Average Facility Site Review Score	96%	94%	90%
Total Medical Records Reviews Completed	11	14	11
Average Medical Record Review Score	95%	90%	88%
Total Primary Care Physician Sites removed from the network due to Non-Compliance with Facility Site Review Requirements	3	0	0

Qualitative Analysis

There was a total of 10 Medi-Cal FSR sites due in 2025. Of these, 10 FSRs were completed on time. There was a total of 11 Medi-Cal MRRs due in 2025. There were 11 MRRs completed on time. There was no change in volume of reviews due in 2025 compared to 2024. San Diego continues to participate in the collaborative process and in 2025 the network was evaluated for 2026 volume. This tri-annual process increases the number of assigned reviews going forward.

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.

Trends in the year-to-year MRR scores indicate that average scores are rising in compliance from prior years, perhaps due to the standards at the 3-year mark of implementation as of July 2022. Thus, our network has adapted and understood the standards and have implemented the standards into their practice.

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

Monitoring Access and Safety areas

Physical Accessibility Review Survey (PARS) audits assess access and safety of the physical location of PCP site locations and High-Volume Specialists (HVS). Data provided on the volume of PARS reviews is shared 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 San Diego County

San Diego County	CY25	CY24	CY23
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PARS Completed	11	41	4
PARS Completed at Basic Level	5	18	1
PARS Completed at Limited Level	3	23	3

Table 7 - FSR Access/Safety Criteria San Diego County 2025

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.	10	1	0	11	91%
2) Pedestrian ramps have a level landing at the top and bottom of the ramp.	10	0	1	10	100%
3) Exit and exam room doorway openings allow for clear passage of a person in a wheelchair.	11	0	0	11	100%
4) Accessible passenger elevator or reasonable alternative for multi-level floor accommodation.	2	1	8	3	67%
5) Clear floor space for wheelchairs in waiting area and exam room.	11	0	0	11	100%
6) Wheelchair accessible restroom facilities.	11	0	0	11	100%
7) Wheelchair accessible handwashing facilities or reasonable alternative.	11	0	0	11	100%
B. Site environment is maintained in a clean and sanitary condition.	Yes	No	NA	Total#	Compliance
1) All patient areas including floor/carpet, walls, and furniture are neat, clean, and well maintained.	11	0	0	11	100%
2) Restrooms are clean and contain appropriate sanitary supplies.	11	0	0	11	100%
C. Site environment is safe for all patients, visitors, and personnel.	Yes	No	NA	Total#	Compliance
1) Fire safety and prevention.	10	1	0	11	91%
2) Emergency non-medical procedures (e.g. site evacuation, workplace violence).	9	2	0	11	82%
3) Lighting is adequate in all areas to ensure safety.	11	0	0	11	100%
4) Exit doors and aisles are unobstructed and egress (escape) accessible.	11	0	0	11	100%
5) Exit doors are clearly marked with "Exit" signs.	11	0	0	11	100%
6) Clearly diagramed "Evacuation Routes" for emergencies are posted in a visible location at all elevators, stairs and exits.	11	0	0	11	100%
7) Electrical cords and outlets are in good working condition.	11	0	0	11	100%
8) Fire Fighting Equipment in accessible location	9	2	0	11	82%
9) An employee alarm system.	8	3	0	11	73%
D. Emergency health care services are available and accessible 24 hours a day, 7 days a week.	Yes	No	NA	Total#	Compliance

1) Personnel are trained in procedures/action plan to be carried out in case of medical emergency on site.	10	1	0	11	91%
2) Emergency equipment is stored together in easily accessible location and is ready to be used.	11	0	0	11	100%
3) Emergency phone number contacts are posted, updated annually and as changes occur.	10	1	0	11	91%
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.	10	1	0	11	91%
5) Emergency medicine for anaphylactic reaction management, opioid overdose, chest pain, asthma, and hypoglycemia. Epinephrine 1mg/ml (injectable) and Diphenhydramine (Benadryl) 25 mg (oral) or Diphenhydramine (Benadryl) 50 mg/ml (injectable), Naloxone, chewable Aspirin 81 mg, Nitroglycerine spray/tablet, bronchodilator medication (solution for nebulizer or metered dose inhaler), and glucose (any type of glucose containing at least 15 grams). Appropriate sizes of ESIP needles/syringes and alcohol wipes.	10	1	0	11	91%
6) Medication dosage chart for all medications included with emergency equipment (or other method for determining dosage) is kept with emergency medications.	10	1	0	11	91%
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.	11	0	0	11	100%
8) Replace/re-stock emergency medication, equipment and supplies immediately after use.	11	0	0	11	100%
E. Medical and lab equipment used for patient care is properly maintained.	Yes	No	NA	Total#	Compliance
1) Medical equipment is clean.	11	0	0	11	100%
2) Written documentation demonstrates the appropriate maintenance of all medical equipment according to equipment manufacturer's guidelines.	11	0	0	11	100%

Qualitative Analysis

Under the access and safety audit criteria category, individual criterion related to the Accessible passenger elevator at 67%, Emergency non-medical procedures at 83% firefighting equipment at 83%, An employee alarm system at 75% and Emergency non-medical procedures at 83%, are areas of improvement. Noting all these areas are revisions to the standards from July 2022. Relevance to the revisions is that 2025 was the first review of these offices since the revisions.

Showing Unit efforts and education from 2024 ensuring emergency medication dosage charts are stored with the physical emergency medications and kits are critical to preserving the life of members in the event of an emergency. The data demonstrates that of the FSRs conducted, sites were at 92% in 2025 up from 40% compliance in 2024. As a result, offices are better prepared to reduce risk for injury or death of members when appropriate emergency medications are properly dosed and administered.

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 Healthy San Diego Facility Site Review Workgroup 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.

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 these women have the necessary access to genetic screening and receive appropriate referrals. Comprehensive Perinatal Services Program (CPSP) integrates nutrition, psychosocial, and health education services with basic obstetrical services. This multidisciplinary approach to the delivery of prenatal care is based on the recognition that providing these services from conception through 12 weeks after delivery contributes significantly to improved pregnancy outcomes. The California Department of Public Health/Maternal Child and Adolescent Health (MCAH) Program oversees CPSP and the statewide system of perinatal care. Blue Shield of California Promise Health Plan (Blue Shield Promise) CPSP oversight and monitoring program tracks, monitors compliance and issues corrective actions to ensure initiation of prenatal care as soon as possible and to ensure the provision of comprehensive perinatal services per (DHCS) Policy Letter 12-003 and the CPSP standards contained in California Code of Regulations, Title 22, Section 51348.

KEY FINDINGS AND INTERVENTIONS

Table 8: CPSP Medical Record Review for San Diego County

Medical Record Reviews	Audited CY25	Audited CY24	Audited CY23
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	(Deliveries CY24)	(Deliveries CY23)	(Deliveries CY22)
Total OB Providers Audited	10	6	9
Average Medical Record Review Score	91%	91%	92%
Total # of Records Audited	37	30	55
CPSP CAPs	Audited CY25 (Deliveries CY24)	Audited CY24 (Deliveries CY23)	Audited CY23 (Deliveries CY22)
Total OB Provided Audited	10	6	9
Total CAPs Issued	1	0	0

Table 8 Summary: CPSP Medical Record Review for San Diego County

The CPSP medical record review is conducted to ensure optimum perinatal care and pregnancy outcomes for BSC PHP members and compliance with DHCS Policy Letter 12-003 and California Code of Regulations, Title 22, Section 51348. Requests for medical records are sent to obstetric offices and tracked for receipt. In 2025, CPSP medical record reviews were conducted for pregnant members with a successful delivery during CY 2024. The average score for medical records reviewed was 91%. The passing score is 80%.

Ten OB providers were audited in CY 2025, achieving an average score of 91%. Thirty-seven providers were audited, compared to 30 in 2024. It should be noted that in San Diego County, a "provider" includes Federally Qualified Health Centers (FQHCs). These centers have multiple providers who care for patients, and thus multiple providers' medical records are audited, although each FQHC is counted as a single provider.

Qualitative Analysis

1. In both 2024 and C2025, all providers audited scored above the 80% passing threshold. Providers achieved a marginally lower average score in 2025 and 2024 compared to C2023. There was one Corrective Action Plans (CAP) requested in 2025 and none in 2024.

Trends in Performance

- **Consistently High Audit Scores:**
The average medical record review scores remained consistently high across all three years, with scores of 92% in CY2023, and 91% in both CY2024 and CY2025. All providers audited during this period exceeded the 80% passing threshold.
- **Low Rate of Corrective Action Plans (CAPs):**

Over the three-year period, only one CAP was issued (in CY2025), with none issued in the preceding years.

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 Corrective Action Plans 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 Measurement Year (MY) 2026, 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 an upward trend 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 MY 2025, 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.
- **Implementing 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

Blue Shield of California Promise Health Plan maintains established telephone access standards and routinely monitors the 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 San Diego)

Calls Received	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
2025	9,065	8,733	9,279	9,402	8,964	9,061	10,271	9,227	9,979	10,561	8,736	9,463	112,741
2024	11,792	9,481	9,036	9,897	9,438	8,159	9,398	9,377	8,869	9,525	7,426	7,747	110,145
Abandoned Calls	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
2025	176	28	26	42	64	83	129	96	140	158	172	288	1,402
2024	118	188	165	162	79	52	73	77	102	91	78	83	1,268
Answered within 30 Seconds %	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Average
2025	81%	95%	96%	95%	91%	87%	85%	87%	84%	78%	68%	70%	85%
2024	82%	78%	77%	79%	87%	93%	90%	88%	80%	87%	83%	85%	84%
Abandonment Rate	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Average
2025	1.9%	0.3%	0.3%	0.5%	0.7%	0.9%	1.3%	1.0%	1.4%	1.5%	2.0%	3.0%	1.2%
2024	1.0%	2.0%	1.8%	1.6%	0.8%	0.6%	0.8%	0.8%	1.2%	1.0%	1.1%	1.1%	1.1%

Reporting Quarter	Calls Received	Abandoned Calls	Average % of Answered Calls Within 30 Seconds	Average Abandonment Rate
1 st Quarter	27,077	230	91%	0.8%
2 nd Quarter	27,427	189	91%	0.7%
3 rd Quarter	29,477	365	85%	1.2%
4 th Quarter	28,760	618	72%	2.1%
Total/Average	112,741	1,402	85%	1.2%

Trends In Performance

Overall call volume increased slightly in 2025 (112,741 vs. 110,145), with lower call volume in Q1 2025 and higher volume in Q4 2025. Abandoned calls increased year over year (1,402 vs. 1,268), with the most pronounced rise in Q4. Service level (% answered within 30 seconds) remained stable and slightly improved on average (85% vs. 84%); however, performance softened in Q4 2025. The average abandonment rate increased marginally (1.2% vs. 1.1%), driven primarily by late-year trends.

Qualitative Analysis

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

- Abandonment rate trended at 5% for the year.
- Average of 85% service level for the year.
- Customer Service received a total of 112,741 calls in 2025. This shows a 2% increase of 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 initial and the on-going assessment of performance results to ensure business goals and outcomes are achieved to further the delivery of quality health goals and outcomes for our members. The DOC reports to the Plan's Quality Oversight Committee (QOC)

Methodology

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

Deficiencies are addressed through mitigation between the Plan and delegated partners, which may result in the development of a correction action plan (CAP). CAPs are required when delegated partners fail to meet minimum thresholds as defined in the delegation oversight policies and procedures. Audits are also tracked to identify potential opportunities

for improvement across the network. Those delegates that pose a high risk to the Plan may be analyzed by a multidisciplinary sub-work group of the DOC and tracked through the DOC for company-wide transparency and intervention.

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

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

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

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

Credentialing/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
• Application Turn Around Time For BH/Substance Abuse Providers

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

2025 Goals

- 95% of applicable annual delegation oversight audits, including follow-up and/or focus audits to be completed in 2025.
- 95% of quarterly/semi-annual reporting to be received timely and reviewed within 30 days of receipt.
- 95% of completed audit results reported to the Delegation Oversight Committee.

The following metrics summarize 2025 activities for the Delegation Oversight Team

Function	Percentage of Timely Audits	Total Number of Pre-Del Audits	Percentage of Timely Reporting
Claims	100%	0	100%
Credentialing	100%	0	100%
UM	100%	0	100%

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.

Quantitative and Qualitative Analysis

In 2025 the Delegation Oversight team conducted 100% timely annual audits ensuring those delegated entities that fell below the thresholds were put on CAPS and followed to closure. Those delegated entities that pose a risk were put on a high- risk alert list in the DOC. In 2025, there was 1 delegate/MSO 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 100% timely reporting.

MEMBER EXPERIENCE

Member Satisfaction – CAHPS

2025 Promise Health Plan Medi-Cal San Diego, Adult and Child Quality Program Evaluation

Blue Shield of California Promise Health Plan (inclusive of Medicaid products in San Diego and LA Counties) for the remainder of this report will be referred to as Blue Shield Promise (BSP) 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. 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

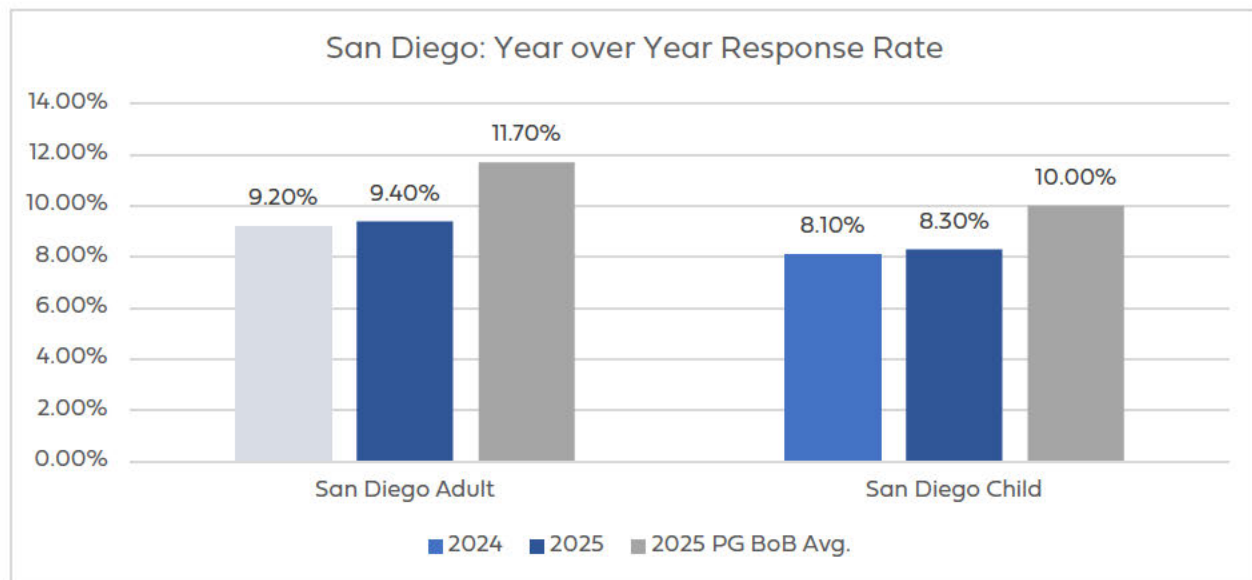
unbiased and accurate. When compiling the sample size, PHP follows the requirements as outlined by NCQA.

- 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:



San Diego LOB's	Sample Size	Grand Total Completes	Mail Completes	Telephone Completes	Internet Completes	Response Rate
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San Diego Adult	2,309	213	85	80	48	9.4%
San Diego Child	2,302	188	46	89	53	8.3%

- San Diego Adult had 57 Spanish language completed surveys.
- San Diego Child had 64 Spanish language completed surveys.

YoY Response Rate	2024	2025	2025 PG BoB Avg.
San Diego Adult	9.2%	9.4%	11.7%
San Diego Child	8.1%	8.3%	10.0%

- San Diego Adult response rate increased 0.2% from the previous year.
- San Diego Child response rate increased 0.2% from the previous year.

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 San Diego Adult CAHPS: 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 San Diego Adult CAHPS 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	85.7%	86.2%	0.50%	↑	83.3%	Yes
Rating of Specialist	87.0%	85.3%	-1.70%	↓	82.5%	Yes
Getting needed care	77.7%	81.2%	3.50%	↑	81.5%	No
Getting care quickly	76.3%	82.3%	6.00%	↑	80.4%	Yes
Customer service	87.6%	86.7%	-0.90%	↓	89.1%	No
How well doctors communicate	91.4%	96.1%	4.70%	↑	93.0%	Yes
Coordination of Care	80.0%	77.9%	-2.10%	↓	85.6%	No
Ease of filling out forms.	95.6%	98.4%	2.80%	↑	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 San Diego Adult CAHPS 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 a goal met designation.
- Rating of Health Care increased slightly from 76.8% to 77.0% (+0.2 percentage points). Surpassed the NCQA average of 75.8%, and the goal was met.
- Rating of Personal Doctor improved from 85.7% to 86.2% (+0.5 percentage points). Remained above the NCQA benchmark of 83.3%, indicating goal met.
- Rating of Specialist declined from 87.0% to 85.3%, a -1.7 percentage point decrease. Despite the decline, performance remained above the NCQA average of 82.5%, and the goal was still met.
- Getting Needed Care increased from 77.7% to 81.2%, reflecting a +3.5 percentage point improvement. Fell 0.3 percentage points below the NCQA benchmark of 81.5%, resulting in goal not met.
- Getting Care Quickly improved substantially from 76.3% to 82.3%, a +6.0 percentage point increase. Exceeded the NCQA benchmark of 80.4%, indicating goal met.
- Customer Service decreased from 87.6% to 86.7%, a -0.9 percentage point change. Performance was 2.4 percentage points below the NCQA average of 89.1%, resulting in goal not met.
- How Well Doctors Communicate Increased notably from 91.4% to 96.1%, a +4.7 percentage point improvement. Exceeded the NCQA benchmark of 93.0%, indicating goal met.
- Coordination of Care declined from 80.0% to 77.9%, a -2.1 percentage point decrease. Remained 7.7 percentage points below the NCQA benchmark of 85.6%, and the goal was not met.
- Ease of Filling Out Forms increased from 95.6% to 98.4%, reflecting a +2.8 percentage point improvement. Exceeded the NCQA benchmark of 94.8%, and the goal was met.

Table 2 Medi-Cal CAHPS for San Diego 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 San Diego Child CAHPS Performance

Composites and Rating Questions	2024 Results	2025 Results	Delta	Trend	2024 NCQA Quality Compass average	Goal Met
Rating of health plan	89.5%	86.7%	-2.80%	↓	86.3%	Yes
Rating of health care	89.3%	85.1%	-4.20%	↓	86.9%	No

Rating of personal doctor	94.7%	88.6%	-6.10%	↓	89.7%	No
Rating of Specialist	85.2%	92.7%	7.50%	↑	87.2%	Yes
Getting needed care	78.9%	74.6%	-4.30%	↓	83.3%	No
Getting care quickly	86.4%	78.3%	-8.10%	↓	86.3%	No
Customer service	90.1%	90.8%	0.70%	↑	88.3%	Yes
How well doctors communicate	95.6%	91.2%	-4.40%	↓	93.8%	No
Coordination of Care	89.5%	82.2%	-7.30%	↓	83.5%	No
Ease of filling out forms.	93.1%	98.9%	5.80%	↑	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 San Diego Child CAHPS Quantitative Analysis (*See table 2.*)

- Rating of Health Plan decreased from 89.5% (2024) to 86.7% (2025), representing a -2.8 percentage point decline. Despite the decrease, performance remained well above the NCQA benchmark of 77.7%, and the goal was met.
- Rating of Health Care declined from 89.3% to 85.1%, a -4.2 percentage point decrease. Exceeded the NCQA benchmark of 75.8%, resulting in goal met despite year-over-year decline.
- Rating of Personal Doctor decreased from 94.7% to 88.6%, reflecting a -6.1 percentage point decline, the largest decrease among rating measures. Performance declined below NCQA benchmark of 89.7%, and the goal was not met.
- Rating of Specialist increased substantially from 85.2% to 92.7%, a +7.5-percentage point improvement. Exceeded the NCQA benchmark of 82.5%, and the goal was met, representing the strongest improvement among all child measures.
- Getting Needed Care declined from 78.9% to 74.6%, a -4.3 percentage point decrease. Fell 6.9 percentage points below the NCQA benchmark of 81.5%, resulting in goal not met.
- Getting Care Quickly decreased from 86.4% to 78.3%, representing a -8.1 percentage point decline, the largest decrease across all composites. Performance remained 2.1 percentage points below the NCQA benchmark of 80.4%, and the goal was not met.
- Customer Service increased slightly from 90.1% to 90.8%, reflecting a +0.7-percentage point improvement. This measure exceeded the NCQA benchmark of 89.1% and met goal.
- How Well Doctors Communicate declined from 95.6% to 91.2%, a -4.4 percentage point decrease. Fell 1.8 percentage points below the NCQA benchmark of 93.0%, resulting in goal not met.
- Coordination of Care decreased from 89.5% to 82.2%, a -7.3 percentage point decline. Performance was 3.4 percentage points below the NCQA benchmark

of 85.6%, and the goal was not met.

- Ease of Filling Out Forms improved markedly from 93.1% to 98.9%, a +5.8-percentage point increase. Exceeded the NCQA benchmark of 94.8%, and the goal was met, representing a 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

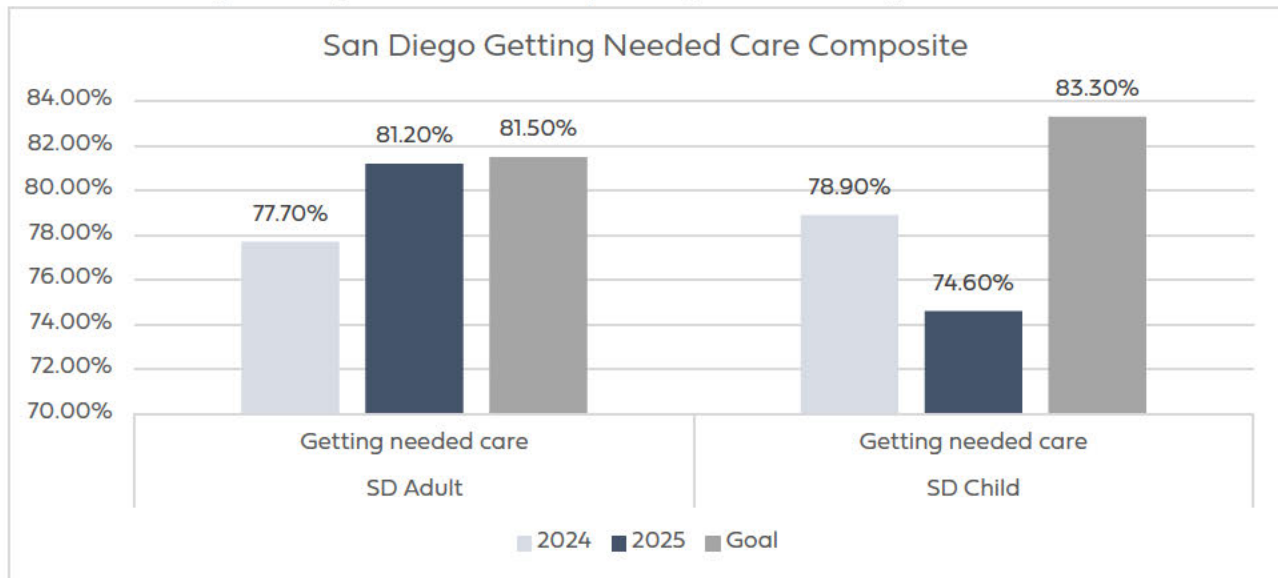
Rating of Health Plan		Rating of Health Care	
The below Composites have been identified as key drivers of Rating of Health Plan		The below Composites have been identified as key drivers of Rating of Health Care	
Getting needed care	Opportunity	Getting Care Quickly	Opportunity
Coordination of Care	Opportunity		

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. San Diego Getting Needed Care Composite Quantitative Analysis

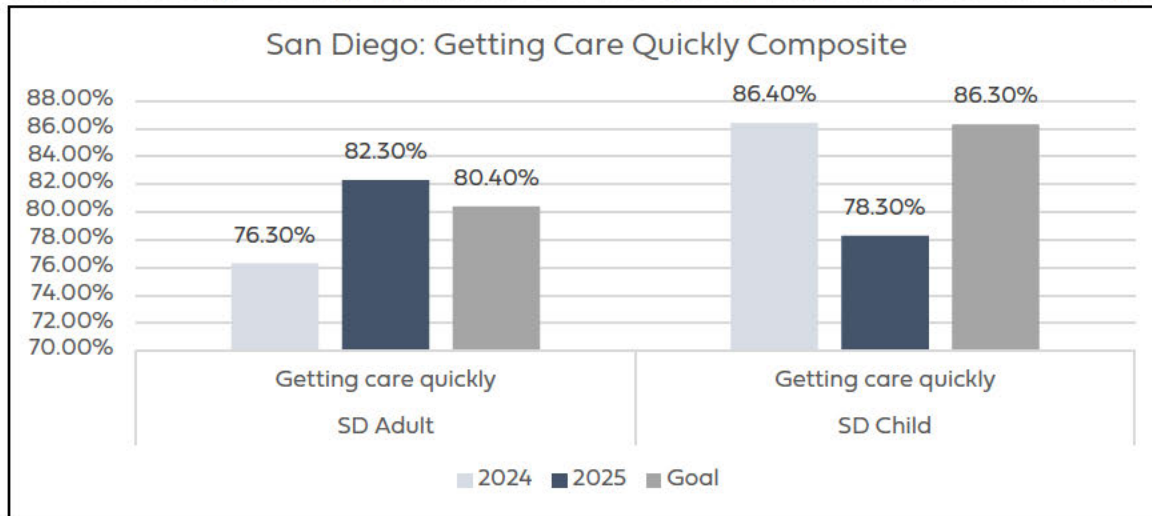


*Scores are shown in the summary rate that represents the most favorable response percentages.
% always+usually, % yes, and Ratings of % 8,9,10.*

- San Diego Adult increased from 77.7% (2024) to 81.2% (2025), reflecting a +2.2-percentage point improvement. Despite improvement, performance remained below the goal of 81.5%, and the measure did not meet goal.
- San Diego Child decreased from 78.9% (2024) to 74.6% (2025), representing a -8.7-percentage point decline. Performance remained below the goal of 83.3%, and the measure did not meet goal.
- Across all lines of business, question level getting specialist appointment as soon as needed continues to underperform and be an area of opportunity. Specialist appointment times and availability continue to impact the member's experience. Due to limited specialist providers, a national provider shortage and health care professional staffing shortages this area continues to be a pain point for members.

Getting Appointments and Care Quickly Composite Quantitative Analysis

Table 5. San Diego Getting Appointment and Care Quickly Composite Quantitative Analysis

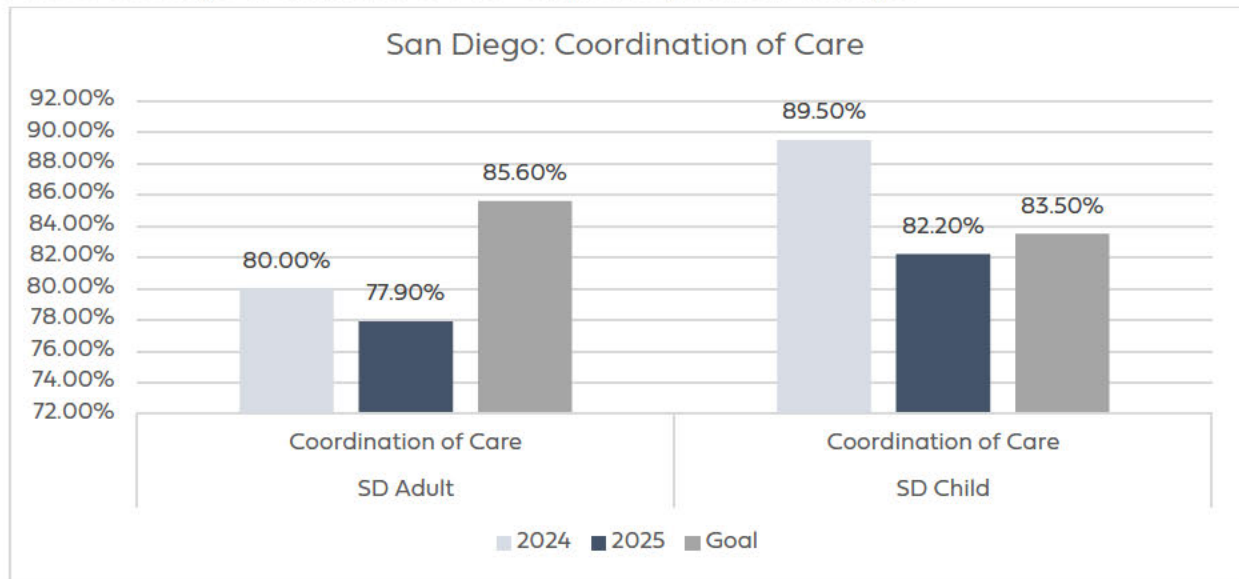


*Scores are shown in the summary rate that represents the most favorable response percentages.
% always+usually, % yes, and Ratings of % 8,9,10.*

- San Diego Adult (Getting Care Quickly) increased from 76.3% (2024) to 82.3% (2025), reflecting a +6.0-percentage point improvement. Exceeded the goal of 80.4% in 2025 (82.3% vs. 80.4%), indicating performance above target for the current year. Meaningful year-over-year improvement with 2025 performance meeting/exceeding the goal threshold displayed in the graph.
- San Diego Child (Getting Care Quickly) decreased from 86.4% (2024) to 78.3% (2025), representing a -8.1 percentage point decline. Did not meet the goal of 86.3% in 2025 (78.3% vs. 86.3%), indicating performance below target for the current year. Substantial decline year-over-year with a large gap to the goal shown in the graph (8.0 percentage points below goal in 2025: 78.3% vs. 86.3%).

Coordination of Care Composite Quantitative Analysis

Table 6. San Diego 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.

- San Diego Adult decreased from 80.0% (2024) to 77.9% (2025), reflecting a –2.1 percentage point decline. Performance remained 7.7 percentage points below the goal of 85.6%, and the measure did not meet goal.
- San Diego Child increased from 78.4% (2024) to 82.2% (2025), representing a +3.8-percentage point improvement. Despite improvement, performance remained 1.3 percentage points below the goal of 83.5%, resulting in goal not met for the current year.

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>	<u>Billing & Financial (appeals and complaints) appeals.</u>
• perception of inadequate or inappropriate care • delay in care that impacts the quality of care received.	• 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>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>complaints</u> • delay of payment • rate increases

Timeframe

This report encompasses data for all Blue Shield 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 San Diego

Table 7: Volume and Rate by Category for Medi-Cal San Diego

Appeals – Medical San Diego	2024			2025			Goal Met
PHP Medi-Cal SD	Count	Rate	%	Count	Rate	%	
Access	0	0.0	0%	-	-	0%	Yes
Attitude & Service	0	0.0	0%	-	-	0%	Yes
Billing & Financial	148	0.10	100%	245	0.11	100%	Yes
Quality of Care	0	0.0	0%	-	-	0%	Yes
Quality of Practitioner Office Site	0	0.0	0%	-	-	0%	Yes
PHP Medi-Cal SD Total	148	0.10	100%	245	0.11	100%	

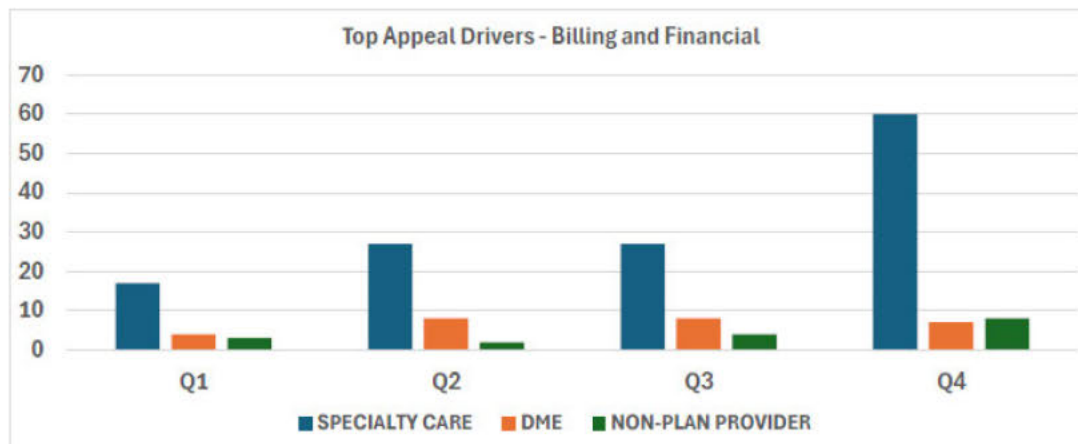
Medi-Cal San Diego Appeal – Access

- There were no Access appeals for Medi-Cal SD in 2025.

Medi-Cal San Diego Appeal – Attitude and Service

- There were no Attitude and Services appeals for Medi-Cal SD in 2025.

Medi-Cal San Diego Appeal – Billing and Financial



- There were 245 Billing and Financial appeals in 2025. Billing & Financial appeals related to specialty care, non-plan providers, and DME were the top drivers in 2025.
- Blue Shield Promise Medi-Cal San Diego Billing and Financial Appeals rate was below 1.0 and met the goal in 2025.

Medi-Cal San Diego Appeal – Quality of Care

- There were no Quality-of-Care Appeals for Medi-Cal SD in 2025.

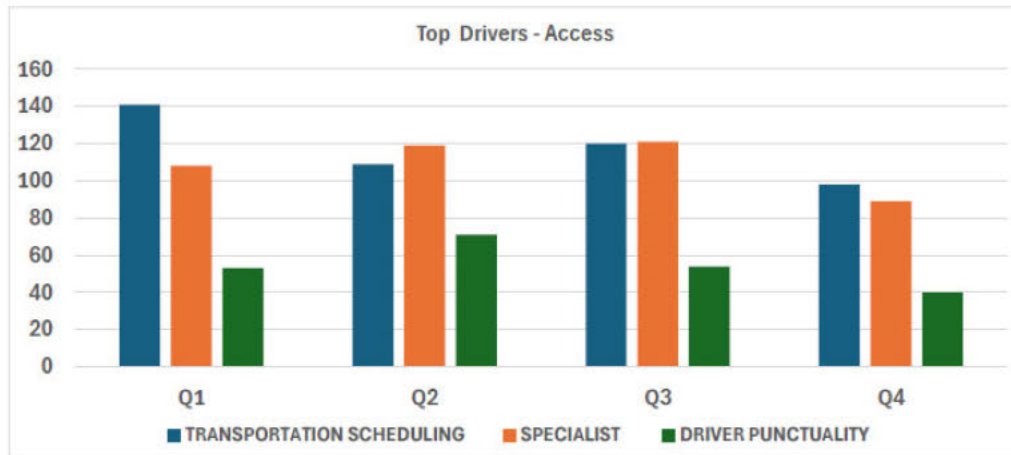
Medi-Cal San Diego Appeal – Quality Office Site

- There were no Quality Office Site Appeals for Medi-Cal SD in 2025.

Table 8: Volume and Rate by Category for Medi-Cal San Diego

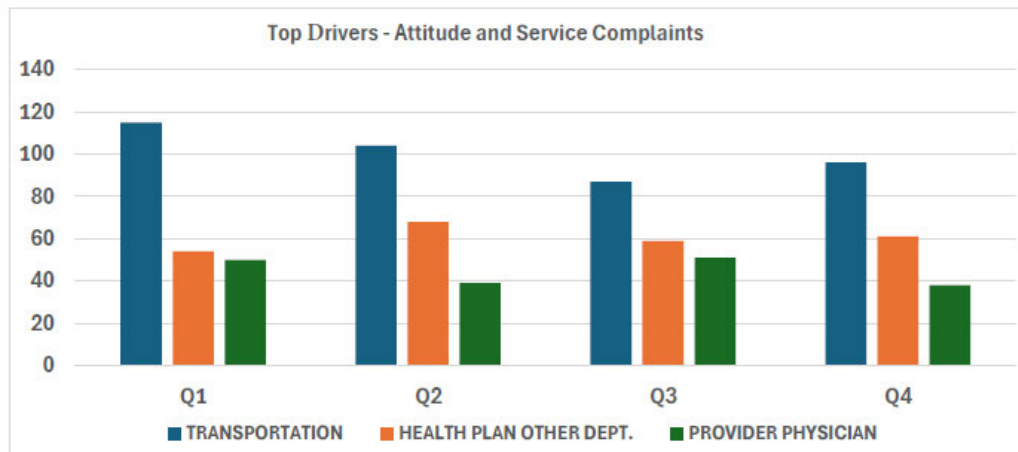
Complaints – Medical	2024			2025			Goal Met
	Count	Rate	%	Count	Rate	%	
PHP Medi-Cal SD							
Access	1395	1.0	37%	1,945	0.86	47%	Yes
Attitude & Service	1370	0.58	37%	1,251	0.55	31%	Yes
Billing & Financial	398	0.17	11%	465	0.20	11%	Yes
Quality of Care	567	0.25	15%	429	0.19	10%	Yes
Quality of Practitioner Office Site	4	0.0	0%	12	0.01	0%	Yes
PHP Medi-Cal SD Total	3734	2.00	100%	4102	1.81	100%	

Medi-Cal San Diego Complaint – Access



- Medi-Cal San Diego Access complaints related to specialist, transportation scheduling, and PCP were the top drivers in 2025. Access complaints made up 47% of total grievance filed.
- Medi-Cal SD access complaints did meet the goal in 2024.
- In 2025, Medi-Cal SD access complaints rate was below 1.0 and met goal.

Medi-Cal San Diego Complaint – Attitude & Service



- In 2025, Attitude and Services complaints related to transportation services, health plan, and providers were the top drivers. Attitude and Service complaints represent 31% of the total complaints filed in 2025.
- Medi-Cal SD Attitude and Services complaints rate was below 1.0 and met the goal in 2025.

Medi-Cal San Diego Complaint – Billing & Financial

- In 2025, Medi-Cal SD Billing & Financial complaints increased compared to the previous year. In 2025 Medi-Cal SD Billing & Financial complaints had a total record of 465 total records, which accounted for 11% in 2025.
- Medi-Cal SD Billing and Financial complaints rate was below 1.0 and did meet the goal in 2025.

Medi-Cal San Diego Complaint – Quality of Care

- In 2025, Medi-Cal SD Quality of Care complaints decreased compared to the previous year. In 2025 Medi-Cal SD quality of care complaints had a total record of 429 complaints, compared to the 567 complaints in 2024.
- This includes cases that were referred to the Potential Quality of Care team for review.
- Medi-Cal SD Quality of Care complaints rate was below 1.0 and did meet the goal in 2025.

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

- There were 12 Quality of Practitioner Office Site complaints in 2025. No further analysis was conducted due to not being enough volume in the recorded case.
- Medi-Cal SD Quality of Practitioner Office Site complaints rate was below 1.0 and met the goal in 2025.

Quantitative Analysis Appeals

2025 Top Appeals by Product

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

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

2025 Top complaints by Product

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

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

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 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 of 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

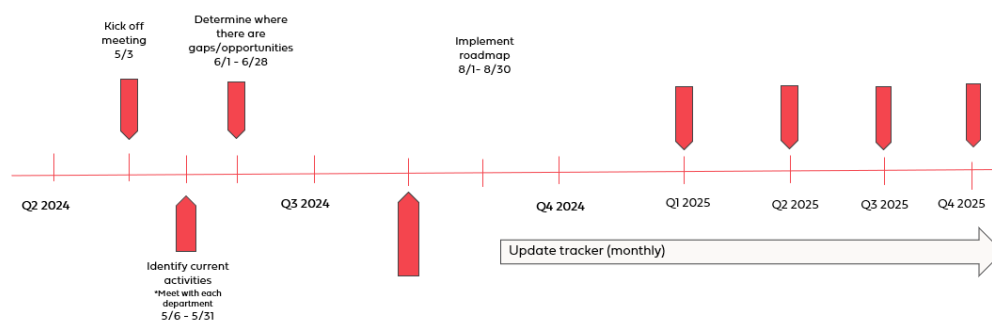
Introduction and Background

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.

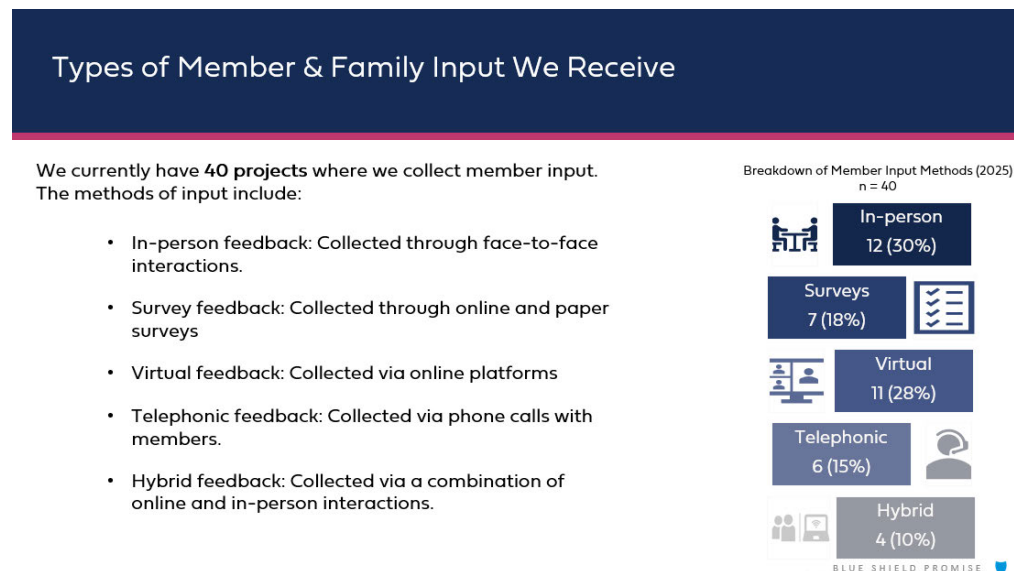


Figure 2. Types of Member & Family Engagement Input

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 San Diego

Activity Description

The Measurement Year (MY) 2024 Promise Quality Performance Incentive (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 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 San Diego County (measures hitting the 50th percentile and year-over-year improvement). Specifically, 15 of 18 measures met the 50th percentile and there was year-over-year improvement in 15 measures. Notably, 5 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 [REDACTED] more than MY 2023. Of note, the PQPI Program is influenced by membership, so an increase in payout does not necessarily indicate an increase in performance. For example, in MY 2023 there were

64,439 San Diego members included in the program compared to 108,560 in MY 2024.

Despite the nearly doubling of membership in San Diego, HEDIS performance detailed below highlights significant improvement or maintenance of stellar performance from MY 2023 to MY 2024. For example, 8 measures performed well above the 50th percentile, hitting impressive 66th or 75th percentile (e.g., CIS-10, DEV, IMA). However, there were a few HEDIS measures that did not perform as well year-over-year. For example, Asthma Medication Ratio in San Diego – dropping from 50th percentile performance in MY 2023 to 25th percentile in MY 2024.

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

SAN DIEGO MCAS MPL MEASURES INCLUDED IN PQPI PROGRAM	MY2023		MY2024		
	Final Rate	Percentile	Final Rate	YOY Trend	Percentile
Child and Adolescent Well-Care Visits ^A	53.12%	66 th	54.17%	↑	50 th
Childhood Immunization Status - Combination 10 Immunizations	33.09%	50 th	36.50%	↑	75 th
Developmental Screening in the First Three Years of Life ^A	49.45%	50 th	56.66%	↑	75 th
Immunizations for Adolescents - Combination 2 Immunizations	42.82%	75 th	41.36%	↓	66 th
Well-Child Visits in the First 30 months- First 15 months of life - 6 or more Well-Child Visits ^A	53.55%	25 th	61.40%	↑	50 th
Well-Child Visits in the first 30 months - 15-30 months of life - 2+ Well-Child Visits ^A	67.02%	50 th	71.58%	↑	50 th
Lead Screening in Children	64.23%	50 th	74.94%	↑	75 th
Topical Fluoride in Children ^A	17.65%	25 th	17.70%	↑	25 th
Breast Cancer Screening ^A	56.12%	66 th	58.93%	↑	66 th
Cervical Cancer Screening	56.34%	33 rd	58.77%	↑	50 th
Chlamydia Screening in Women – Total ^A	66.00%	75 th	68.81%	↑	75 th
Prenatal and Postpartum Care - Postpartum care	83.41%	75 th	84.17%	↑	75 th
Prenatal and Postpartum Care - Timeliness of prenatal care	84.28%	50 th	86.25%	↑	50 th
Asthma Medication Ratio ^A	67.05%	50 th	62.00%	↓	25 th
Controlling Blood Pressure	69.25%	75 th	66.95%	↓	50 th

Glycemic Status Assessment for Patients With Diabetes (>9%) [lower is better]	31.63%	75 th	30.56%	↑	66 th
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Regarding the Data Domain, it is notable that in San Diego County only 1 group met the threshold for point attainment for SDOH Z-Code submissions. For other Data Domain metrics, thresholds were not met 53.1% of the time – 17 missed threshold opportunities out of 32 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 (e.g., data attainment, modeling, report generation) 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 strategies, 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 among our Medi-Cal IPA provider network, 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 provided, given continued low performance on Data Domain components, including SDOH metrics.

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, 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 San Diego, 13 measures were incentivized in at least one of the Care Gap Programs: 11 of 13 measures (85%) hit the 50th percentile (highlighted in table below). 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 MY 2024.

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

Quantitative Analysis

The total payout for MY 2024 Care Gap Closure Programs in San Diego County was [REDACTED]. Of note, these programs are influenced by membership and measure changes, 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. Notable measures include Child and Adolescent Well-Care Visits, Cervical Cancer Screening, Controlling Blood Pressure, among others. This indicates a good return on investment and confirmation that the strategies deployed by the Clinical Quality and Medi-Cal teams are 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]	Y
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]	Y
Well Child Visits – First 30 Months of Life – 30 months	[REDACTED]	Y
Lead screening in children	[REDACTED]	Y
Follow-up after emergency department visit for substance use - total follow up within 30 days	[REDACTED]	Y
Follow-up after emergency department visit for mental illness - total follow up within 30 days	[REDACTED]	N
Asthma medication ratio	[REDACTED]	N
Breast Cancer Screening	[REDACTED]	Y
Glycemic Status Assessment for Patients with Diabetes (>9%)	[REDACTED]	Y
Controlling Blood Pressure	[REDACTED]	Y

Trends in Performance

Overall, HEDIS MCAS MPL measures are performing well (the majority at or above the 50th percentile), and have improved over the last few measurement years. There were only two measures that did not hit the 50th percentile in San Diego: Asthma Medication Ratio (which has since been removed from MCAS MPL) and Follow Up After ED Visit for Mental Illness. It is notable that these measures were only incentivized in one quarter and may have benefitted from inclusion in additional programs or other non-provider centered incentivization methods (e.g., member incentives).

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 (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 2024 Q2 Care Gap we offered \$25 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 ultimately to 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 15,665 IHA closures, 9,078 (58%) 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	2,693	2,558	1,547	1,497	783
% Timely	83%	68%	38%	41%	83%
MY24 Trend vs MY23 Trend	↑	↑	↓	↓	N/A
Untimely	543	1,230	2,533	2,121	160
Total	3,236	3,788	4,080	3,618	943
Overall MY24: 9,078 (Timely Closures) / 15,665 (Total Closures) = 58% Timely					

MY 2023 Timely vs. Untimely Closures by Quarter

	Q1	Q2	Q3	Q4	Remediation
Timely	817	1,049	776	784	N/A
% Timely	68%	64%	53%	50%	N/A
Untimely	379	582	702	784	N/A
Total	1,196	1,631	1,478	1,568	N/A
Overall MY23: 3,426 (Timely Closures) / 5,873 (Total Closures) = 58% Timely					

Trends in Performance

In 2024, the IHA program captured 15,665 IHA closures; of those closures 9,078 (58%) were timely. In 2023, the IHA Program captured 5,873 closures and 3,426 (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. Though we did not improve our timely closures, it is notable that we maintained performance despite there being such a large increase in membership.

One possible reason we did not see improvement from MY 2023 and MY 2024 is due to data issues. For example, looking at trends between MY 2023 and MY 2024, there is an increase in timely closures in Q1 and Q2, but not in Q3 or Q4. Based on the remediation results in 2024 (943 additional IHAs, 83% of which were timely), it is possible that some of the “missed” IHAs (due to lagging claims and encounters data) should have been placed in Q3 and Q4, falsely dragging down performance in those quarters.

In conclusion, we have seen consistent performance even with the increased volume of eligible members.

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 has shifted in MY26 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 MY26 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 MY 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 [REDACTED] (true earnings were [REDACTED]). incentive totals are calculated; however, payments are still pending final approval; payout scheduled to be issue no later than March 31st.

- San Diego: [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 MY2025, 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 MY2025 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 supported 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, only 1 IPA earned an incentive payment totaling less than [REDACTED]. Though we were hopeful after more time, training and familiarization that performance would increase. Unfortunately, the second year of the program showed continued poor performance,

ultimately leading us to discontinue the program: not a single IPA earned a payout in San Diego.

Quantitative Analysis

MY23	MY24
- Total payment: [REDACTED] - Number of IPAs paid: [REDACTED]	- Total payment: [REDACTED] - Number of IPAs paid: [REDACTED]

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 MY25. Further, due to new CMS rules and regulations, programs have shifted further in MY26 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

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].

- San Diego: [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%)

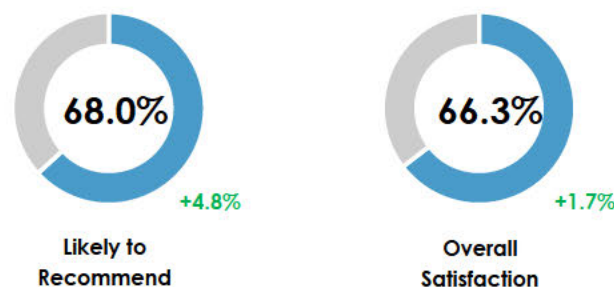
Net Promoter Score (NPS)

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%

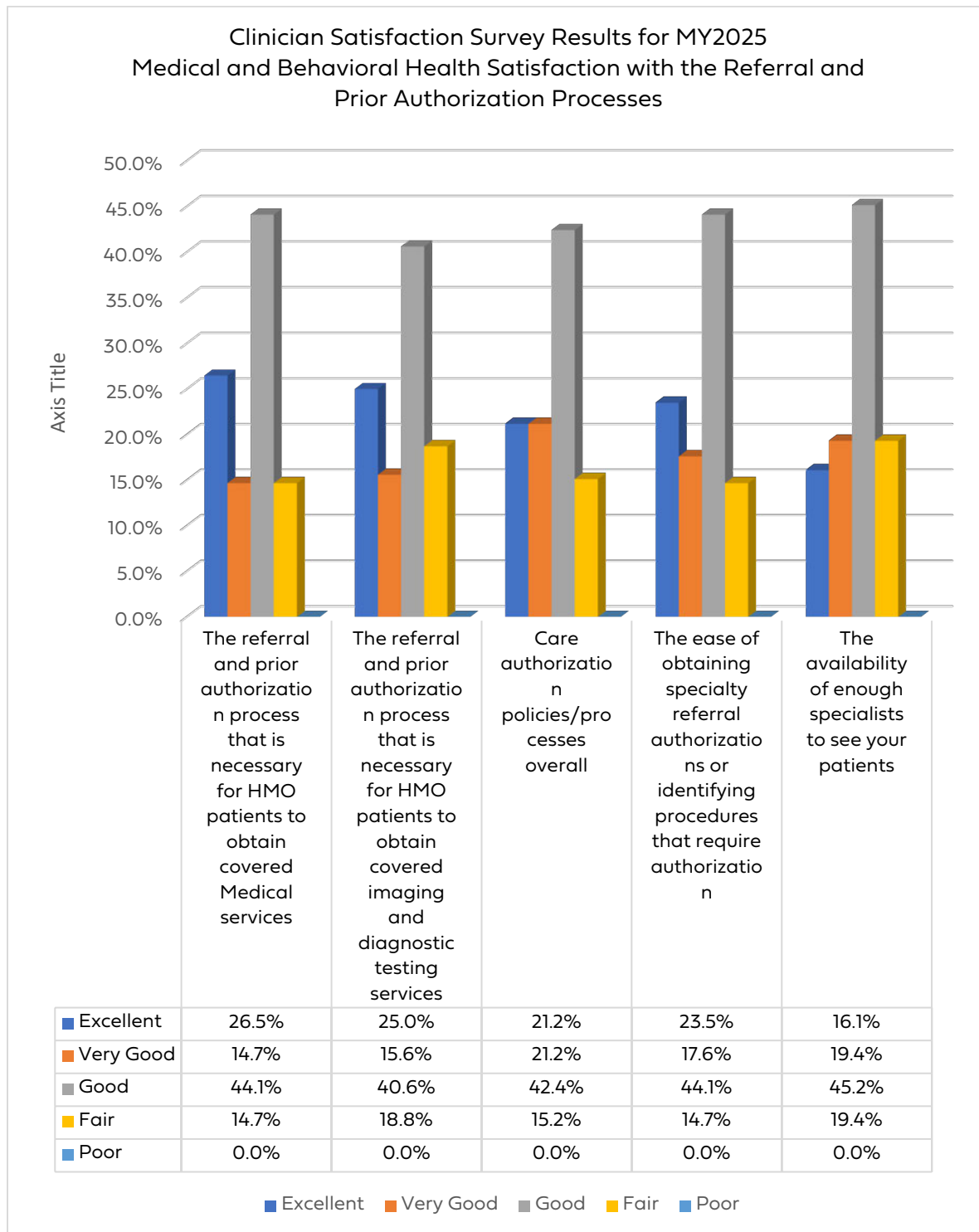
- **Routine and Urgent Care Appointments:** It takes an average of 5.4 days (5.7 in 2024) to schedule a routine appointment with an average of 14 minutes (14 minutes in 2024) of wait time in the office before the patient is seen. A significantly higher number of practices offer same/next day urgent appointments 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.

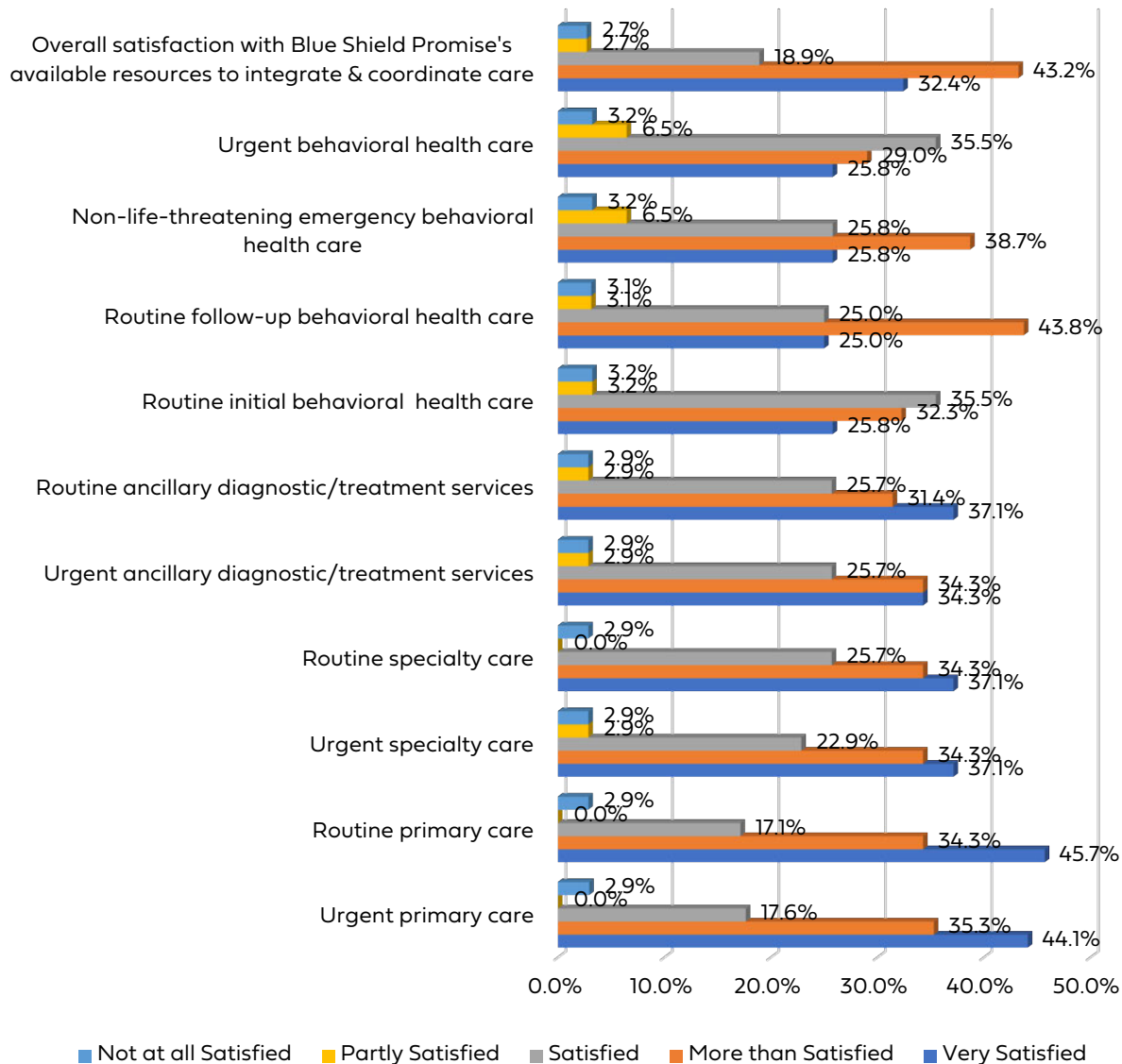
- **Telehealth:** Most respondents indicated they offer telehealth services like the previous two years. A significantly higher percentage of clinicians offer telehealth services using text messaging than in 2024, which increased 6.1%. Clinician satisfaction with all but one telehealth attribute (telephone 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.

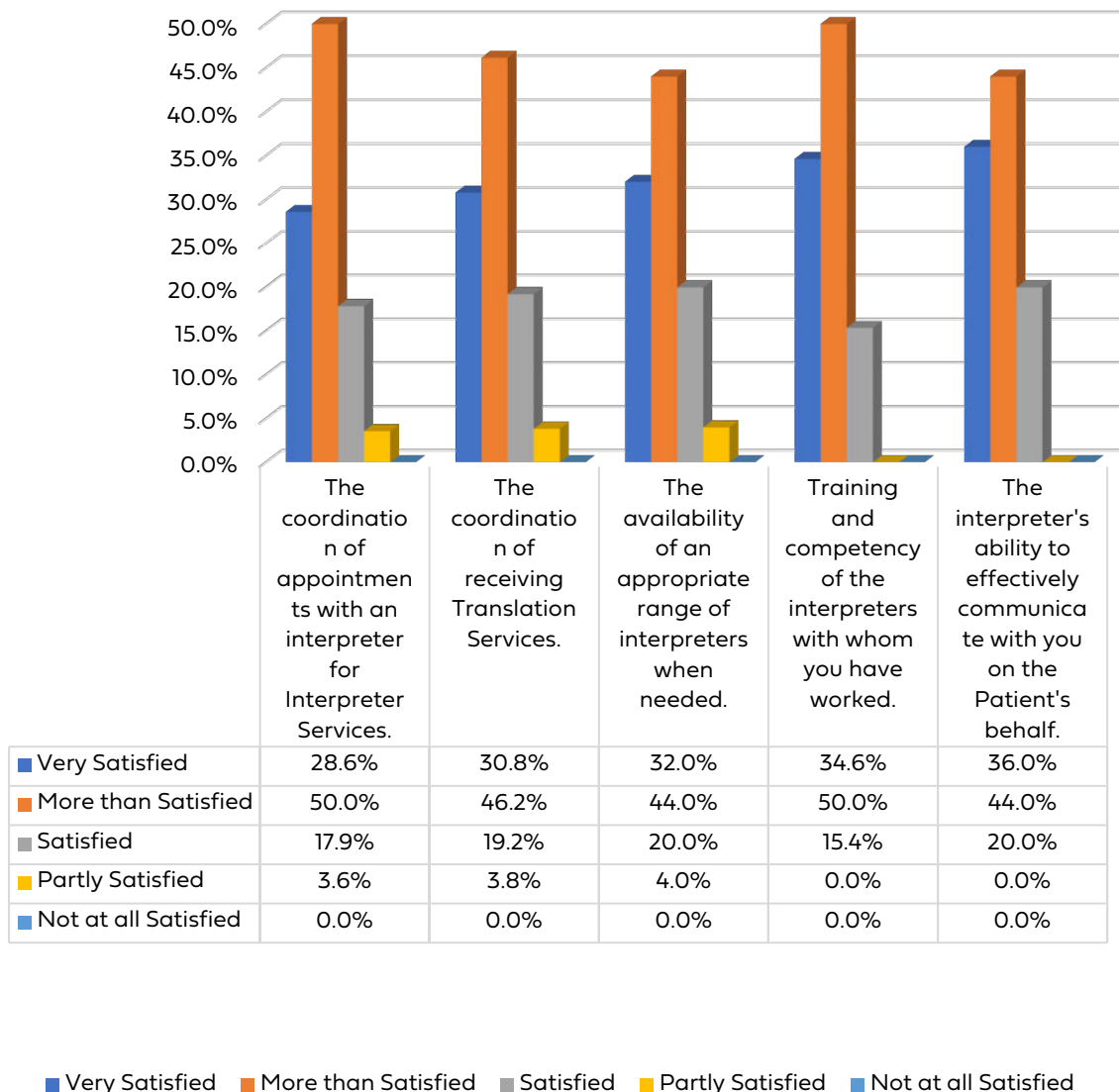
The clinician response percentages, for the current and previous MYs in which provider satisfaction with the Plan's Language Assistance Program have been assessed, are shown in the following table. The table summarizes the percentage of clinicians who stated they are satisfied with the Plan's Language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

<i>Questions: 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 Survey 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