2025 Cultural and Linguistic Program Evaluation

Medi-Cal- Los Angeles County

August 2025

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Introduction

Blue Shield of California Promise Health Plan, inclusive of Medicaid products in Los Angeles and San Diego Counties, will be referred to as Blue Shield Promise for the remainder of this report. Blue Shield Promise is dedicated to advancing health equity, improving quality, and eliminating health care disparities and inequities across our member populations. To support this goal, Blue Shield Promise at least annually evaluates ongoing and completed culturally and linguistically appropriate services. This report will work in conjunction with the Blue Shield Promise Cultural and Linguistic Assessment and Disparities reports to improve the quality of our services for members.

Blue Shield Promise adheres to the Department of Health Care Services mandates, national culturally and linguistically appropriate services guidance from Health and Human Services (HHS), and accreditation standards from the National Committee for Quality Assurance (NCQA), collectively known as cultural and linguistic requirements. These fundamental requirements are used to develop policies and procedures, member and provider assessments, a retrospective evaluation of the overall Cultural and Linguistic Program, and strategic decisions for intervention. To further promote diversity, equity, and inclusion, Blue Shield Promise uses the NCQA Health Equity Accreditation framework to drive continuous improvement in health equity. Blue Shield Promise requires contracted delegates, vendors, independent physician associations, preferred provider groups, practitioners, ancillary providers, pharmacies, and hospitals (collectively, "Plan Administrators") to participate in and comply with Cultural and Linguistic Program policies and procedures.

Blue Shield Promise's Cultural and Linguistic team and Health Equity team monitor and evaluate Blue Shield's culturally and linguistically appropriate services. This report undergoes review and approval by two key committees: The Community Advisory Committee (CAC) and the Health Equity Oversight Committee (HEOC).

- The Community Advisory Committee is comprised of current Blue Shield Promise members and local community groups who provide feedback and support the identification and prioritization of opportunities for improvement.
- The Health Equity Oversight Committee is responsible for monitoring and approving this report, ensuing adherence to equity standards.

Evaluation Methodology

A comprehensive evaluation is in place to ensure Blue Shield Promise is compliant with all cultural and linguistic requirements, including those from our regulators and NCQA. Blue Shield Promise has set goals for each key component and uses these goals to evaluate culturally and linguistically appropriate activities provided by Blue Shield Promise, delegates and vendors, and contracted providers. Blue Shield Promise uses a comprehensive approach to collect and analyze data from members, providers, and staff. This data is utilized to evaluate both completed and ongoing cultural and linguistically appropriate activities. Evaluation is done on an ongoing basis and includes year-over-year trends. The methodology includes the following key components:

This report uses calendar years 2023, 2024, and 2025 data. The year-over-year formula is: ((Most recent value – Previous value) / Previous value) × 100. Green totals indicate increases or, for grievances, positive decreases. Red shows decreases or, for grievances, negative increases. Black means no change, and a dash indicates either an infinite increase or both years being zero.

Member Population

1) Conducting regular assessment of the population to understand the cultural and linguistic needs of the community and to adjust network adequacy.

Member Population Goals	
Member Self-Reported Race and Ethnicity	Achieve 80% self-reported race and ethnicity.
Self-Reported Language	Achieve 75% in self-reported language data.
Self-Reported Gender Identity	Reach 20% self-reported gender identity by 2028.
Self-Reported Sexual Orientation	Reach 20% self-reported sexual orientation by 2028.

Blue Shield Promise conducts annual assessments of its member population to identify and address the evolving cultural and linguistic needs of members. This process involves the collection and analysis of both quantitative and qualitative data, with a particular emphasis on self-reported demographic and language preference information provided by members.

A cornerstone of the population assessment methodology is the proactive gathering of self-reported data during member enrollment and ongoing member interactions. Members are encouraged to voluntarily report race, ethnicity, primary language, and preferred written and spoken language through multiple touchpoints, including enrollment forms, Customer Service interactions, and targeted outreach efforts. To support quality improvement and compliance, Blue Shield Promise has established measurable goals for the collection of self-reported demographic and language data.

Feedback from the population assessment is used to inform provider network development, staff training, and the design of culturally and linguistically appropriate interventions. By integrating self-reported data into ongoing evaluation cycles, Blue Shield Promise ensures that services remain responsive to the needs and preferences of its diverse member population.

Contracted Providers

2) Collaborating with contracted providers to ensure they meet the cultural and linguistic needs of the population.

Contracted Provider Goals	
Provider Languages	1 PCP (Family Medicine (General Medicine and Family Practice)), Internal Medicine, and Pediatrics) speaking a threshold language to 1,200 members speaking a threshold language.
	1 Specialist speaking a threshold language to 1,200 members speaking a threshold language
Provider Office Staff Languages	8% of provider office staff speak at least one threshold language.
Provider Race and Ethnicity	1 American Indian/Alaska Native practitioner to 600 American Indian/Alaska Native members.
	1 Asian practitioner to 700 Asian members.

	1 Black/African American practitioner to 900 Black/African American members.
	1 Hispanic/Latino practitioner to 3,400 Hispanic/Latino members.
	1 Middle Eastern/North African practitioner to 700 Middle Eastern/North African members.
	1 Native Hawaiian/Pacific Islander practitioner to 900 Native Hawaiian/Pacific Islander members.
	1 white practitioner to 700 white members.
	1 other race practitioner to 700 other race members.
Provider Training and Resources	100% providers complete the Advancing Health Equity training by 12/31/25 and at recredentialing thereafter.
Blue Shield is using the Ethnic / Cultural and Language Needs Standard to access if goal is met for PCP's. PCPs are defined as (Family Medicine (General Medicine and Family Practice), Internal Medicine, and Pediatrics). We are using the strictest standard for PCP's. For Specialties we are using the High-Volume Specialty Standard and applying ethnic/cultural and language standard for PCP.	

Blue Shield utilizes a systematic evaluation methodology to ensure that culturally and linguistically appropriate services are accessible for its diverse member population. The organization establishes quantifiable goals for key provider metrics, such as the ratio of practitioners who speak threshold languages to members requiring those languages and the representation of practitioners matching the racial, ethnic, and linguistic backgrounds of the populations served. For example, Blue Shield tracks the availability of primary care practitioners and specialists who can communicate in a threshold language, aiming for a standard of one provider for every 1,200 members needing language support. Additionally, the presence of provider office staff who speak at least one threshold language is monitored, with a target set at 8% representation.

To assess progress, Blue Shield collects and analyzes demographic and language data from both members and providers, comparing these figures to established benchmarks. Disparities in practitioner representation, for groups such as American Indian/Alaska Native, Asian, Black/African American, Hispanic/Latino, Middle Eastern/North African, and Native Hawaiian/Pacific Islander members, are identified by monitoring provider-to-member ratios.

Provider Training and Resources

Provider training materials help providers build cultural and linguistic skills through instruction on communication, language barriers, cultural respect, and patient-centered care.

Language Assistance Services and Nondiscrimination

3) Providing language assistance services to ensure effective communication and adhering to nondiscrimination policies.

Language Assistance Services and Nondiscrimination Goals	
Member Cultural and Linguistic Grievances	Blue Shield has no threshold for cultural and linguistic grievances and will review all culturally and linguistically related grievances.
Member Experience	Achieve a 20% response rate for interpreter satisfaction survey.
	Achieve a 95% satisfaction rate for face-to-face interpreter services.
Bilingual Services	100% of bilingual staff who interact with members are assessed for their bilingual skills
Preferred Languages	Achieve 100% availability of interpreter requests for all languages.
Written Translation Requests	Meet 100% of written translation requests for all threshold languages.

Blue Shield Promise conducts comprehensive surveys and analyzes member grievance data to assess the effectiveness of language services provided. This data is benchmarked against established goals, and when goals are not achieved, a thorough barriers analysis is conducted to identify areas for improvement and develop targeted interventions. The methodologies for these surveys and member grievances are outlined below.

Member Cultural and Linguistic Grievances

Blue Shield Promise does not establish a grievance threshold for cultural and linguistic related grievances as we believe each grievance should be examined to obtain the highest level of understanding of members' needs and preferences. For this report, we will examine grievances related to members' experience with internal and external services.

Member Experience

Blue Shield Promise conducts surveys among members who have used over-the-phone or face-to-face interpreter services, including American Sign Language, to evaluate their satisfaction with these services. The purpose is to assess members' experiences with language support during health care interactions. Interpreter services are provided by our vendor, Language Line Solutions (Language Line). A printed survey with a self-addressed stamped envelope is mailed to members who used interpreter services at least once in the previous year, using the same language and interpretation method they utilized (i.e., telephone or in-person). These surveys were distributed during the first quarter. The surveys were translated into Arabic, Armenian, Chinese, Farsi, Khmer (Cambodian), Korean, Russian, Spanish, Tagalog, Thai, and Vietnamese.

A small incentive (notebook) was provided to all members who returned their completed survey and provided us with their contact information. In addition, members were entered into a drawing for an additional incentive (duffle bag) item at the conclusion of the survey period.

Interpreter Satisfaction Surveys	Face to Face	Over the Phone
Total outreach	1,979	3,023
Response rate	4.5%	6.3%
Questions How satisfied are you with the interpreter services you received? Did the interpreter arrive on time? (for face-to-face interpreter appointments) Were you connected with an interpreter within one minute? (for over-the-phone interpreter appointments) Would you use an interpreter at your next doctor's appointment?		

Blue Shield Promise has established a goal to raise the response rate for both surveys to 20%. Furthermore, the organization is committed to attaining a 95% satisfaction rate for face-to-face interpreter services. Member feedback is essential in assessing whether modifications or improvements are necessary to the current contract or procedures for accessing interpreter services.

Language Assistance Services
Blue Shield Promise collects, stores, and retrieves members' preferred spoken and written language to ensure members receive the highest level of care and services available to support their healthcare journey. This data is stored in Blue Shield Promise membership systems and is securely maintained and accessed by approved personnel in compliance with their job duties. Member preferred language information is collected via a variety of pathways including member enrollment files, direct member collection from the member portal, and upon their request to update when speaking with Blue Shield Promise.
Additionally, Blue Shield Promise notifies individuals in languages spoken by one percent of the population or two-hundred eligible individuals, whichever is less, of the availability of no cost interpretation and translation services. Interpretation services are offered in 240+ languages and translation of member informing materials are provided in the threshold languages other than English spoken by five percent of the population or a thousand eligible individual, whichever is less.

Blue Shield Promise's goal is to timely provide all members, prospective members, and members of the public with effective and respectful care in a manner compatible with their cultural health beliefs and practices and in their preferred language at all points of contact. Blue Shield Promise requires staff or contracted vendors who provide interpretation or translation services to demonstrate proficiency in health care terminology and concepts relevant to health care delivery in English and the target language. To examine the quality of language services we will analyze member linguistic grievances to determine member satisfaction level with the language services being offered.

Blue Shield Promise Staff

4) Training and supporting staff to deliver culturally and linguistically appropriate services.

Blue Shield Promise Staff Goals	
Staff Training: Advancing Health Equity	Aim to have 100% of required employees complete training annually.
Staff Training: Improving the Healthcare Experience of the Transgender, Gender Diverse or Intersex Community	Aim to have 100% of required employees complete the training every two years.
Staff Experience: Culturally and Linguistically Appropriate Services	Achieve 80% overall satisfaction based on staff experience surveys conducted annually.

Staff Training

Blue Shield provides an evidence-based health equity learning program and transgender, gender diverse and intersex (TGI) cultural competency training to all staff. In 2025, all staff with verbal or written contact with members were required to complete trainings titled Advancing Health Equity and Improving the Healthcare Experience for the Transgender, Gender Diverse or Intersex Community. The goal is for 100% of assigned staff to complete the trainings.

Identified member-facing departments include:

- Appeals and Grievances
- Enrollment and Retention
- Community Resource Center
- Communication Governance
- Customer Service
- Quality
- Health Education and Cultural and Linguistic
- Utilization Management
- Population Health Management (Case Management Children's Health Services, Social Services and Behavioral Health Case Management)

Staff Experience: Culturally and Linguistically Appropriate Services

The Blue Shield and Blue Shield Promise Employee Experience Survey, Staff Experience Using Language Services, was conducted via the Blue Shield internal Qualtrics platform from May 2025 to June 2025. The survey included fifteen (15) questions regarding Blue Shield and Blue Shield Promise staff experiences with language services offered by both internal bilingual employees and external vendors. The Clinical Quality Department facilitated this survey, distributing it through people leaders who manage member-facing staff. The product types/line of businesses included in this survey but not limited to:

- Blue Shield Promise
- Blue Shield of California
- Covered California/Exchange
- Commercial
- Medicare

Employees who received the survey were asked to provide feedback on their language service utilization.

Survey Timeframe: May 12, 2025, to June 6, 2025.

Survey Target Audience: Member-facing employees who may have used language services. The following departments were chosen to participate:

- Utilization Management
- Customer Care
- Appeals & Grievances
- Medical Care Solutions
- Broker Relations
- Claims
- Health Education and Cultural and Linguistic
- Population Health Management (Case Management Children's Health Services, Social Services and Behavioral Health Case Management)

Participation Rate: 189 member-facing employees completed the survey.

Compliance Monitoring

5) Regularly monitoring compliance of established goals to ensure continuous improvement.

Compliance Monitoring Goal	
Barriers and Process Improvement	100% of identified barriers related to culturally and linguistically appropriate services will be tracked.

Blue Shield Promise's evaluation methodology for culturally and linguistically appropriate services is built around systematic and measurable processes. The organization aligns all assessment activities with clearly defined goals. Progress is tracked by establishing annual and long-term benchmarks, identifying measurable indicators, and setting specific timelines for data collection and review.

Compliance is ensured by regularly monitoring adherence by tracking 100% of identified barriers related to culturally and linguistically appropriate services to identify areas for improvement and provide detailed compliance reports. This comprehensive approach allows Blue Shield Promise to evaluate the effectiveness of culturally and linguistically appropriate activities across all components, including those delivered by Blue Shield, its delegates, vendors, and contracted providers, ensuring ongoing progress and accountability.

Member Population

Member Population Goals	
Member Self-Reported Race and Ethnicity	Achieve 80% self-reported race and ethnicity.
Self-Reported Language	Achieve 75% in self-reported language data.
Self-Reported Gender Identity	Achieve 20% self-reported gender identity by 2028.
Self-Reported Sexual Orientation	Achieve 20% self-reported sexual orientation by 2028.

Blue Shield Promise strongly supports the collection of culture, race, ethnicity, language, sexual orientation, and gender identity data, recognizing that the best source of this data is the member. Blue Shield Promise collects member data using various internal methods, including but not limited to the enrollment application, online member portal, and Business Information Systems, such as those used at points of contact with Customer Service.

Blue Shield conducts an annual assessment of its member population, comparing the current year's data to that of the previous year. This evaluation includes comprehensive demographic information including race, ethnicity, language, sexual orientation, and gender identity for members. The data referenced was current as of August 2024 and August 2025.

Member Population			
	2024	2025	Year-over-Year
Los Angeles County	374,377	379,104	1.26%
Data Source: Tableau Member Race/Ethnicity Self-Reported Data (80 Percent) Report			

Blue Shield Member Population Evaluation
The year-over-year evaluation of the member population reveals a slight increase in population. In Los Angeles County, the population experienced a 1.26% increase growing from 374,377 members in 2024 to 379,104 members in 2025.

Self-Reported Race and Ethnicity

Blue Shield Promise achieved an 80% completion rate for self-reported race and ethnicity data in 2024 and 2025. Blue Shield Promise is committed to activities that will help us sustain this achievement. This commitment highlights the importance of gathering accurate and comprehensive demographic information to better understand and serve the diverse needs of the member population.

Self-Reported Race and Ethnicity

Race & Ethnicity	Los Angeles		
	2024	2025	Year-over-year (%)
American Indian or Alaska Native	387	160	-58.66
Asian	20,333	6,626	-67.41
Black or African American	31,499	9,706	-69.19
Hispanic or Latino	251,042	301,830	20.23
Middle Eastern or North African	3	13	333.33
Native Hawaiian or Other Pacific Islander	3,493	1,264	-63.81
Some other race	6,583	23,972	264.15
White	30,339	12,890	-57.51
Total Provided	343,679	356,461	3.72
Unknown	13,747	91	-99.34
Choose not to disclose (decline)	34	55	61.76
No response	16,917	22,497	32.98
Total Membership	374,377	379,104	1.26%
Data source: Tableau Member Race/Ethnicity Self-Reported Data (80 Percent) Report			

Race & Ethnicity	Los Angeles		
	2024	2025	Year-over-year (%)
American Indian or Alaska Native	0.10%	0.04%	-60.00

Race & Ethnicity	Los Angeles		
	2024	2025	Year-over-year (%)
Asian	5.43%	1.75%	-67.77
Black or African American	8.41%	2.56%	-69.56
Hispanic or Latino	67.06%	79.62%	18.73
Middle Eastern or North African	0.08%	0.34%	325.00
Native Hawaiian or Other Pacific Islander	0.93%	0.33%	-64.52
Some other race	1.76%	6.32%	259.09
White	8.10%	3.40%	-58.02
Total Provided	91.80%	94.03%	2.43
Unknown	3.67%	0.02%	-99.46
Choose not to disclose (decline)	0.01%	0.01%	-
No response	4.52%	0.01%	-99.78%
Total Membership	100%	100%	

Data source: Tableau Member Race/Ethnicity Self-Reported Data (80 Percent) Report

Self-reported race and ethnicity goal evaluation

Blue Shield Promise continues to surpass the 80% goal of member self-reported race and ethnicity with 93.59% of members reporting their race and ethnicity in 2025. There was a 10.98% increase from 477,999 in 2024 to 530,479 in 2025 in the number of members who self-reported their race and ethnicity. Los Angeles County saw a 3.72% increase in self-reported race and ethnicity.

Additionally, the year-over-year analysis reveals notable shifts in demographic representation. There were significant decreases in several race and ethnicity categories. American Indian or Alaska Native membership decreased by 56.10%, Asian by 68.08%, Black or African American by 66.89%, Native Hawaiian or Other Pacific Islander by 59.31% and white by 59.15%. Groups that experienced an increase were Hispanic or Latino growing by 37.03% and Middle Eastern or North African dramatically growing by 1087.50%. However, the absolute value for this group remained small at 95. The "Some Other Race" category grew considerably by 164.7%. Meanwhile, the "Choose Not to Disclose" category increased by 28.57%% and "Unknown" decreased 28.57%. The "No Response" category saw a significant decrease of 99.54%, indicating a substantial improvement in response rates.

The percentage breakdown further illustrates these trends. Hispanic or Latino members rose from 56.77% to 76.88% of the self-reporting population, marking a 35.42% increase. Middle Eastern or North African members, in both counties, significantly increased from 0.14% to 1.68% representing a 1100% increase. All other groups experienced a significant drop, which aligns to the self-reported count decreases.

These data trends highlight both the progress made in encouraging self-reporting among members and the evolving demographic landscape within the population. The significant increases in certain groups, alongside the notable reduction in non-responses, reflect ongoing efforts to better understand and serve the diverse needs of the community. These insights will continue to guide strategies for equity and inclusion.

Preferred and Threshold Languages

Blue Shield collects, stores, and retrieves members preferred spoken and written language to facilitate access to appropriate services and support their healthcare journey. This data is securely maintained within the Blue Shield enrollment systems, such as Facets and Radiant One, and is accessed only by authorized personnel in accordance with their job responsibilities.

Member language preferences are gathered through various channels, including enrollment forms, the member portal, and interactions with customer service representatives. Blue Shield also ensures that members and providers

are informed about the availability of a no-cost interpreter and translation services, along with clear guidance on how to access these services.

Assessment data is used to determine all preferred languages spoken by one percent of the population or 200 eligible members, whichever is less, up to a maximum of 15 languages. All languages spoken by 5% of the population or by 1,000 people, whichever is less, are identified as threshold languages.

Languages	Los Angeles Count Preferred and Threshold Languages					
	2024 Spoken	2025 Spoken	Year-Over-year (%)	2024 Written	2025 Written	Year-over-year (%)
Arabic	618	633	2.43%	613	630	2.77%
Armenian	2,469	3,380	36.90%	2,456	3,369	37.17%
Cantonese	1,529	2,225	45.52%	NA	NA	NA
Chinese simplified	NA	NA	NA	2,233	2,956	32.38%
Chinese traditional	NA	NA	NA	2,259	2,268	0.40%
English	199,826	201,591	0.88%	200,012	201,842	0.91%
Farsi	779	1,009	29.53%	769	1,003	30.43%
Khmer (Cambodian)	517	467	-9.67%	513	463	-9.75%
Korean	1,071	1,087	1.49%	1,065	1,086	1.97%
Mandarin	3,470	3,154	-9.11%	NA	NA	NA
Russian	2,480	2,666	7.50%	2,474	2,661	7.56%
Spanish	156,396	160,767	2.79%	156,312	160,704	2.81%
Tagalog	603	572	-5.14%	580	557	-3.97%

Thai	263	283	7.60%	261	281	7.66%
Vietnamese	2,144	2,261	5.46%	2,134	2,251	5.48%
No data available	7	0	-	9	4	-55.56
Total Membership	374,377	379,104	1.26%	374,377	379,104	1.26%

Tableau Member Preferred Spoken and Written Language Report
Yellow indicates a threshold language, languages preferred by at least 1,000 members.

Languages	Los Angeles Percent Preferred and Threshold Languages					
	2024 Spoken	2025 Spoken	Year-over-year (%)	2024 Written	2025 Written	Year-over-year (%)
Arabic	0.17%	0.17%	0.00	0.17%	0.17%	0.00
Armenian	0.67%	0.89%	32.84	0.66%	0.89%	34.85
Cantonese	0.41%	0.59%	43.90	NA	NA	NA
Chinese simplified	NA	NA	NA	0.60%	0.78%	30.00
Chinese traditional	NA	NA	NA	0.61%	0.60%	-1.64
English	53.91%	53.18%	-1.35	53.96%	53.24%	-1.33
Farsi	0.21%	0.27%	28.57	0.21%	0.26%	23.81
Khmer (Cambodian)	0.14%	0.12%	-14.29	0.14%	0.12%	-14.29
Korean	0.29%	0.29%	0.00	0.29%	0.29%	0.00
Mandarin	0.94%	0.83%	-11.70	NA	NA	NA
Russian	0.67%	0.70%	4.48	0.67%	0.70%	4.48
Spanish	42.19%	42.41%	0.52	42.17%	42.39%	0.52
Tagalog	0.16%	0.15%	-6.25	0.16%	0.15%	-6.25

Thai	0.07%	0.07%	0.00	0.07%	0.07%	0.00
Vietnamese	0.58%	0.60%	3.45	0.58%	0.59%	1.72
Total Membership	100%	100%	0	100%	100%	0

Tableau Member Preferred Spoken and Written Language Report
Yellow indicates a threshold language, languages preferred by at least 1,000 members or by at least 5% of the population.

Preferred and threshold language evaluation

Blue Shield Promise surpasses the goal of having 75% self-reported data. As noted in the preceding language data tables, the preferred spoken languages include English, Spanish, Arabic, Armenian (LA County only), Cantonese (LA County only), Farsi, Khmer (LA County only), Korean, Mandarin, Russian, Spanish, Tagalog, Thai (LA County only) and Vietnamese. English and Spanish continue to be the predominant language preference for spoken and written languages in both counties. There was a slight decrease in English spoken and written selections and a small increase in Spanish selection in both counties. Noteworthy year-over-year observations include a significant increase in several of the other languages.

In Los Angeles County, both spoken and written preference for Armenian increased by 32.84% and 34.85%, respectively. Cantonese experienced a dramatic 43.90% increase in spoken language selection, while written Chinese Simplified saw an increase of 30.00%. Farsi increased by 28.57% in spoken language selection and surpassed the threshold language minimum with 1,009 members selecting this language. Russian experienced a modest increase of over 4% in both spoken and written. Conversely, some languages including written Traditional Chinese, spoken Mandarin and Tagalog, experienced a decrease in selection while Khmer (Cambodian) decreased by over 14% in both spoken and written.

In summary, language preference trends across Los Angeles County reveal both the enduring strength of English and Spanish and the growing significance of other languages within the member population. While English and Spanish remain firmly established as the predominant and threshold languages, notable rises in languages such as Armenian, Cantonese, Farsi, and Chinese spoken and written languages underscore the region's increasing linguistic

diversity. These trends highlight the need for ongoing attention to evolving language needs, ensuring accessible and culturally responsive communication for all members as populations shift and diversify.

Gender Identity and Sexual Orientation

Sex Assigned at Birth

Sex Assigned at Birth	Los Angeles		
	2024	2025	Year-over-year (%)
Sex Assigned at Birth: Male	168,058	172,309	2.53
Sex Assigned at Birth: Female	206,332	206,787	0.22
Sex Assigned at Birth: Unknown	1	1	0
Choose not to disclose (Decline)	3	0	-100.00
No Response	0	0	-
Total Self-Reported	374,391	379,097	1.26
Total Who Responded	374,394	379,097	1.26
Total Membership	374,394	379,097	1.26

Data source: Tableau Member Sex Assigned at Birth Report

Sex Assigned at Birth	Los Angeles		
	2024	2025	Year-over-year (%)
Sex Assigned at Birth: Male	44.89%	45.45%	1.25
Sex Assigned at Birth: Female	55.11%	54.55%	-1.02
Sex Assigned at Birth: Unknown	0.00%	0.00%	-
Choose not to disclose (Decline)	0.00%	0.00%	-
No Response	0.00%	0.00%	-
Total Self-Reported	100.00%	100.00%	0
Total Who Responded	100.00%	100.00%	0

Data source: Tableau Member Sex Assigned at Birth Report

Gender Identity

Gender Identity	Los Angeles		
	2024	2025	Year-over-year (%)
Male	1,082	1,386	28.10
Female	1,819	2,277	25.18
Non-Binary	29	42	44.83
Transgender Male	12	18	50.00
Transgender Female	13	18	38.46
Genderqueer	6	7	16.67
Other	1	1	0.00
Choose not to disclose (Decline)	0	0	-
No Response	371,426	375,341	1.05
Total Self-Reported	2,962	3,749	26.57
Total Who Responded	2,962	3,749	26.57
Total Membership	374,394	379,104	1.26

Data source: Tableau Member Gender Identity Report

Gender Identity	Los Angeles		
	2024	2025	Year-over-year (%)
Male	0.29%	0.37%	27.59
Female	0.49%	0.60%	22.45
Non-Binary	0.01%	0.01%	0.00
Transgender Male	0.00%	0.00%	0
Transgender Female	0.00%	0.00%	-

Genderqueer	0.00%	0.00%	-
Other	0.00%	0.00%	-
Choose not to disclose (Decline)	0.00%	0.00%	-
No Response	99.21%	99.01%	-0.20
Total Self-Reported	0.79%	0.99%	25.32
Data source: Tableau Member Gender Identity Report			

Pronouns

Pronouns	Los Angeles		
	2024	2025	Year-over-year (%)
He/Him	268	493	83.96
She/Her	465	804	72.90
They/Them	38	59	55.26
Other	4	17	325.00
Chose not to disclose (Decline)	44	70	59.09
No Response	373,601	377,702	1.10
Total Self-Reported	752	1,336	77.66
Total Who Responded	793	1,402	76.80
Total Membership	374,394	379,104	1.26
Data source: Tableau Member Pronouns Report			

Pronouns	Los Angeles		
	2024	2025	Year-over-year (%)
He/Him	0.07%	0.13%	85.71
She/Her	0.12%	0.21%	75.00
They/Them	0.01%	0.02%	100.00

Other	0.00%	0.00%	-
Chose not to disclose (Decline)	0.01%	0.02%	100.00
No Response	99.79%	99.63%	-0.16
Total Self-Reported	0.20%	0.35%	75.00
Total Who Responded	0.21%	0.37%	76.19
Data source: Tableau Member Pronouns Report			

Sexual Orientation

Sexual Orientation	Los Angeles		
	2024	2025	Year-over-year (%)
Lesbian	16	15	-6.25
Gay	42	53	26.19
Homosexual (Gay + Lesbian)	58	68	17.24
Heterosexual	531	843	58.76
Bisexual	43	53	23.26
Queer	29	33	13.79
Other	49	56	14.29
Don't Know	22	27	22.73
Choose not to Disclose (Decline)	106	159	50.00
Total Self-Reported	732	1080	47.54
Total Membership	374,394	379,104	1.26
Data source: Tableau Member Sexual Orientation Report			

Sexual Orientation	Los Angeles		
	2024	2025	Year-over-year (%)
Lesbian	0.00%	0.00%	-
Gay	0.01%	0.01%	0

Homosexual (Gay + Lesbian)	0.02%	0.02%	0
Heterosexual	0.14%	0.22%	57.14
Bisexual	0.01%	0.01%	0
Queer	0.01%	0.01%	0
Other	0.01%	0.01%	0
Don't Know	0.01%	0.01%	0
Total Self-Reported	0.20%	0.28%	40%
Choose not to Disclose (Decline)	0.03%	0.04%	33.33
Data source: Tableau Member Sexual Orientation Report			

Self-reported gender identity and sexual orientation and evaluation

The percentage of members who self-reported their gender identity and sexual orientation improved by 28.24% and 44.44%, respectively, although self-reporting of gender identity and sexual orientation remains very low. Although 100% of members reported their sex assigned at birth, only 1% reported their gender identity and less than 1% reported their pronouns and sexual orientation. A notable improvement also occurred in the number of members who self-reported their pronouns resulting in a 69.01% (from 1,510 to 2,552) surge in 2025.

In 2025, our total membership is almost evenly split between sexes, with 46.53% reporting being assigned male at birth and 53.47% reporting being assigned female at birth. Of those reporting their gender identity, the majority (6,012) self-identified with traditional gender categories. However, there were notable increases from 2024 in the number of members who self-identified as non-binary (90), a 34.55% increase, transgender male (38), a 35.71% increase, transgender female (44), a 7.32% increase, and genderqueer (5) a 6.25% increase. Of the members who reported their pronouns, the "she/her" selection increased by 68.37%, the "he/him" increased by 70.17% while the "they/them" selection increased by 24.27%. Sexual orientation self-reporting revealed a 50.09% increase in the members who identified as heterosexual, a 33.94% increase in the number of members who identified as bisexual and a 25.74% increase in members who identified as gay. There was a small decrease of 7.69% in the members who identified as lesbian.

The data reveals both encouraging progress and persistent challenges in capturing the diverse identities and experiences of our membership. While self-reporting rates for gender identity, sexual orientation and pronouns have shown increases, overall disclosure remains low, highlighting a continued need for trust-building and outreach. The growing representation of non-binary, transgender, and genderqueer identities, alongside notable changes in pronoun reporting, illustrates evolving member openness and the importance of inclusive data practices. As the demographic profile of our membership becomes more nuanced, we are better equipped to address disparities, tailor services, and foster a more welcoming environment for all members. Continued efforts are necessary to further support self-identification and achieve 20% self-reporting of gender identity and sexual orientation.

Practitioner Network Cultural Responsiveness

Contracted Provider Goals	
Provider Languages	1 PCP (Family Medicine (General Medicine and Family Practice)), Internal Medicine, and Pediatrics) speaking a threshold language to 1,200 members speaking a threshold language.
	1 Specialist speaking a threshold language to 1,200 members speaking a threshold language
Provider Office Staff Languages	8% of provider office staff speak at least one threshold language.
Provider Race and Ethnicity	1 American Indian/Alaska Native practitioner to 600 American Indian/Alaska Native members.
	1 Asian practitioner to 700 Asian members.
	1 Black/African American practitioner to 900 Black/African American members.
	1 Hispanic/Latino practitioner to 3,400 Hispanic/Latino members.
	1 Middle Eastern/North African practitioner to 700 Middle Eastern/North African members.

	1 Native Hawaiian/Pacific Islander practitioner to 900 Native Hawaiian/Pacific Islander members.
	1 white practitioner to 700 white members.
	1 other race practitioner to 700 other race members.
Provider Training and Resources	100% providers complete the Advancing Health Equity training by 12/31/25 and at recredentialing thereafter.
Blue Shield is using the Ethnic / Cultural and Language Needs Standard to access if goal is met for PCP's. PCPs are defined as (Family Medicine (General Medicine and Family Practice), Internal Medicine, and Pediatrics). We are using the strictest standard for PCP's. For Specialties we are using the High-Volume Specialty Standard and applying ethnic/cultural and language standard for PCP.	

Practitioner Race and Ethnicity

Blue Shield Promise assesses member demographics against in-network providers to ensure members' cultural, ethnic, racial and linguistic needs are met, and identify improvement areas. Providers can voluntarily share their race and ethnicity data, and Blue Shield encourages this self-reporting, as it is not mandatory in California. Blue Shield Promise's searchable provider directory allows members to filter search results by the provider's gender, race, and spoken languages. The search results display the information available for each provider profile.

Improved data collection methods will promote prosperous and robust data in the future, which will help Blue Shield Promise better assess the needs of member-to-provider population. In alignment with the updated March 2024 OMB Statistical Policy Directive (SPD) Number 15 regulation, Blue Shield Promise added the race option, Middle Eastern/North African in both the member and provider portal. The tables below demonstrate the current race and ethnicity data for Blue Shield members and providers.

Race and Ethnicities for Providers

Race & Ethnicity	Los Angeles		
	2024	2025	Year-over-year (%)
American Indian or Alaska Native	0	5	-
Asian	223	291	30.49

Black or African American	100	153	53.00
Hispanic or Latino	216	280	29.63
Middle Eastern or North African	0	0	-
Native Hawaiian or Other Pacific Islander	4	4	0
Some other race	72	77	6.94
White	413	555	34.38

Data source: Tableau Member Race/Ethnicity Self-Reported Data (80 Percent) Report

Comparison of Member to Practitioner Race and Ethnicity (self-reported)

Race and Ethnicity	Los Angeles County							
	Count			Percent			Ratio	
	2024	2025	Y-o-Y (%)	2024	2025	Y-o-Y (%)	2024	2025
Member: Hispanic or Latino	251,042	301,830	20.23	67.06%	79.62%	18.73	1:1,163	1:1,079
Provider: Hispanic or Latino	216	280	29.63	0.88%	0.86%	-2.27		
Member: Black or African American	31,499	9,706	-69.19	8.41%	2.56%	-69.56	1:316	1:64
Provider: Black or African American	100	153	53.00	0.41%	0.47%	14.63		
Member: Native Hawaiian or Other Pacific Islander	3,493	1,264	-63.81	0.93%	0.33%	-64.52	1:874	1:317

Race and Ethnicity	Los Angeles County							
	Count			Percent			Ratio	
	2024	2025	Y-o-Y (%)	2024	2025	Y-o-Y (%)	2024	2025
Provider: Native Hawaiian or Other Pacific Islander	4	4	0	0.02%	0.01%	-50.00		
Member: white	30,339	12,890	-57.51	8.10%	3.40%	-58.02	1:74	1:39
Provider: white	413	555	34.38	1.68%	1.71%	1.79		
Member: Asian	20,333	6,626	-67.41	5.43%	1.75%	-67.77	1:92	1:32
Provider: Asian	223	291	30.49	0.91%	0.90%	-1.10		
Member: American Indian or Alaska Native	387	160	-58.66	0.10%	0.04%	-60.00	-	1:56
Provider: American Indian or Alaska Native	0	5	-	0.00%	0.02%	-		
Members: Middle Eastern or North African	3	13	333.33	0.08%	0.34%	325.00	-	-
Provider: Middle Eastern or North African	0	0	-	0.00%	0.00%	-		
Member: Some other race	6,583	23,972	264.15	1.76%	6.32%	259.09	1:92	1:485
Provider: Some other race	72	77	6.94	0.29%	0.24%	-17.24		

Race and Ethnicity	Los Angeles County							
	Count			Percent			Ratio	
	2024	2025	Y-o-Y (%)	2024	2025	Y-o-Y (%)	2024	2025
Member: Sum of all self-reported	343,679	356,461	3.72	91.80%	94.03%	2.43		
Provider: Sum of all self-reported	812	1,085	33.62	3.31%	3.35%	1.21		
Member: Unknown	13,747	91	-99.34	3.67%	0.02%	-99.46		
Provider: Unknown	548	525	-4.20	2.24%	1.62%	-27.68		
Member: Choose not to disclose "Decline"	34	55	61.76	0.01%	0.01%	0.00		
Provider: Choose not to disclose "Decline"	0	0	-	0.00%	0.00%	-		
Member: Who did NOT RESPOND "No Response"	16,917	22,497	32.98	4.52%	5.93%	31.19		
Provider: Who did NOT RESPOND "No Response"	22,938	30,507	33.00	93.57%	94.17%	0.64		
Member: Sum of "Unknown" and "Decline"	13,781	146	-98.94	3.68%	0.04%	-98.91		
Provider: Sum of "Unknown" and "Decline"	548	525	-4.20	2.24%	1.62%	-27.68		
Total Membership	374,377	379,104	1.26	66.84%	66.89%	0.07		

Race and Ethnicity	Los Angeles County							
	Count			Percent			Ratio	
	2024	2025	Y-o-Y (%)	2024	2025	Y-o-Y (%)	2024	2025
Total Providers	24,514	32,397	32.16	74.23%	77.61%	4.55		
Data source: Tableau Member to Provider Combined Race/Ethnicity Report								

Race and ethnicities for providers evaluation

The data highlights the representation of providers by race and ethnicity based on self-reported data. Los Angeles County experienced notable increases in the number of self-reported providers across most racial and ethnic groups from 2024 to 2025. However, self-reporting remains low with only 6% of practitioners reporting a race and ethnicity. This year there were five practitioners in Los Angeles County who self-reported their race as American Indian or Alaska Native in comparison to zero practitioners in 2024. Another notable increase occurred in the number of providers who self-reported their race and ethnicity as Black or African American, with both counties experiencing about 50% increase. The total number of Asian practitioners increased by 28.29%, from 251 to 322. Hispanic or Latino practitioners increased by 29.62%, from 260 to 337. The number of white practitioners also increased by 36.78%, from 522 to 714. The number of Native Hawaiian or Other Pacific Islander practitioners increased by 25.00%, from 4 to 5. In 2025, the overall majority of practitioners (714) self-reported their race and ethnicity as white.

Most of the member-to-practitioner ratios are significantly better than our stated goals and have significantly improved year-over-year. For example, compared to the goal of 1:700, Asian practitioners have a ratio 1:32 in Los Angeles County, a decrease from 1:92 in 2024. Los Angeles County American Indian and Alaska Native practitioners have a 1:56 ratio surpassing the goal of 1:600. In contrast, the highest member to practitioner ratio is seen for the Hispanic or Latino population at 1:1,079 in LA County. This ratio increased from 1:1,163. Although the ratio meets the set goal of 1:3,400, these findings may underscore persistent gaps in certain populations. Further, ratios for Middle Eastern or North African (in both counties) did not meet the goal of 1:700.

Low rates of self-reporting among practitioners complicate efforts to accurately evaluate diversity and address potential gaps. This limited data may mask additional disparities or improvements within the provider network. The overall trends point to areas of progress, such as Black or African American representation, but also highlight pressing needs, especially in building a more representative network for Hispanic or Latino members. The year-over-year evaluation thus emphasizes both the importance and the urgency of continued improvements in data collection, transparency, and diversity initiatives to serve California's increasingly diverse population.

Practitioner and Office Staff Languages

This comprehensive evaluation will provide insights into the linguistic capabilities of practitioners and their office staff, highlighting areas for improvement where necessary. It will allow Blue Shield Promise to determine if there is a need to expand our provider network offerings to members to increase the quality of services offered.

To accurately assess whether the language services meet members' preferences and requirements, Blue Shield assessed members preferred spoken and written languages. This assessment covered languages spoken by at least 1% of the population or 200 eligible individuals, whichever is less. Threshold languages were also identified, these are defined by any language other than English spoken by 5% of the population or by 1,000 individuals, whichever is less.

Furthermore, Blue Shield analyzed the network by specialty type to ensure providers are meeting the needs and preferences of Blue Shield members to determine if network improvements can be made. The following specialties were assessed by threshold languages: pediatrics, family practice, cardiology, gastroenterology, and obstetrics/gynecology (OB/GYN).

Comparison of Member Preferred and Threshold Languages to Practitioner Languages

Language		Los Angeles			
		Count	%	Ratio	1:1200 Goal Met
English	Member	201,597	53.23%	1:19	Yes
	Provider	11,020	34.90%		
Spanish	Member	160,775	42.45%	1:21	Yes

	Provider	7,876	24.94%		
Mandarin	Member	3,154	0.83%	1:4	Yes
	Provider	1,053	3.33%		
Russian	Member	2,665	0.70%	1:7	Yes
	Provider	474	1.50%		
Vietnamese	Member	2,261	0.60%	1:5	Yes
	Provider	610	1.93%		
Armenian	Member	3,381	0.89%	1:6	Yes
	Provider	652	2.06%		
Tagalog	Member	Not a threshold language			
	Provider				
Farsi	Member	1,009	0.27%	1:2	Yes
	Provider	911	2.89%		
Cantonese	Member	2,225	0.59%	1:24	Yes
	Provider	98	0.31%		
Korean	Member	1,087	0.29%	1:3	Yes
	Provider	596	1.89%		
Data source: Practitioner to Member Spoken Language Threshold with Ratio Report					

2024 Comparison of Member Preferred and Threshold Languages to Practitioner Languages

Language	Los Angeles				Did we meet the standard of 1:1,200 (1 PCP:1,200 members)	
	Count		Percent		Ratio	Goal met
	Member	Provider	Member	Provider		
English	199,826	8,815	54.20%	37.11%	1:24	Yes
Spanish	156,396	6,022	42.42%	25.35%	1:27	Yes
Mandarin	3,470	867	0.94%	3.65%	1:5	Yes
Russian	2,480	363	0.67%	1.53%	1:8	Yes
Vietnamese	2,144	529	0.58%	2.23%	1:5	Yes
Armenian	2,469	539	0.67%	2.27%	1:6	Yes
Tagalog	NA	NA	NA	NA	NA	Yes
Korean	1,071	507	0.29%	2.13%	1:3	Yes
Cantonese	1,529	202	0.41%	0.85%	1:9	Yes
Total	370,653	24,351	100.00%	100.00%	1:16	Yes

Comparison of member preferred and threshold languages to practitioner languages evaluation

A comparative analysis of member and provider language data from 2024 to 2025 reveals important trends in both practitioner coverage and preferred language comparison. English remains the most common preferred language among members, comprising 53.23% in Los Angeles, with provider ratios well within the 1:1,200 goal. Spanish follows as the second most common language, with 42.45% members in Los Angeles, also meeting provider ratio goals in both regions. In 2025, Farsi reach the numeric value for a threshold language in Los Angeles County, with 1,009 members (0.27%) selecting it as their preferred language. The provider ratio is strong at 1.2. Other threshold languages, including Mandarin (Los Angeles County) and Russian (Los Angeles County) experienced a decrease in their provider ratio. The only ratio that experienced an increase was Cantonese in Los Angeles County. The ratio significantly rose from 1:9 to 1:24, highlighting an opportunity to strengthen our provider network to better serve members.

Specialty Provider to Member Language Ratio

2025 Specialty Provider to Member Language Ratio							
Language		Provider to Member Ratio Pediatric (Pediatric Members <18)	Provider to Member Ratio Family Practice	Provider to Member Ratio Internal Medicine	Provider to Member Ratio Cardiology	Provider to Member Ratio Gastroenterology	Provider to Member Ratio OB/GYN
Los Angeles	English	1:68	1:242	1:149	1:881	1:3,151	1:462
	Spanish	1:74	1:238	1:241	1:1,547	1:4,232	1:517
	Russian	1:22	1:77	1:45	1:382	1:889	1:178
	Mandarin	1:12	1:37	1:18	1:132	1:288	1:73
	Vietnamese	1:7	1:34	1:28	1:324	1:566	1:81
	Armenian	1:18	1:60	1:46	1:308	1:846	1:188
	Farsi	1:2	1:20	1:9	1:45	1:93	1:29
	Korean	1:3	1:35	1:17	1:73	1:363	1:45
	Cantonese	1:117	1:248	1:279	1:2,226	NA	1:117
Data source: Tableau Practitioner Specialty to Member Spoken Language Ratio Report							

2024 Specialty Provider to Member Language Ratio- Los Angeles County							
	Language	Provider to Member Ratio Pediatric (Pediatric Members <18)	Provider to Member Ratio Family Practice	Provider to Member Ratio Internal Medicine	Provider to Member Ratio Cardiology	Provider to Member Ratio Gastroenterology	Provider to Member Ratio OB/GYN
Los Angeles	English	1:81	1:280	1:165	1:1,632	1:3,065	1:534

2024 Specialty Provider to Member Language Ratio- Los Angeles County							
	Language	Provider to Member Ratio Pediatric (Pediatric Members <18)	Provider to Member Ratio Family Practice	Provider to Member Ratio Internal Medicine	Provider to Member Ratio Cardiology	Provider to Member Ratio Gastroenterology	Provider to Member Ratio OB/GYN
	Spanish	1:75	1:227	1:208	1:1,855	1:2,919	1:475
	Mandarin	1:11	1:39	1:21	1:439	1:293	1:76
	Russian	1:24	1:84	1:36	1:416	1:832	1:166
	Vietnamese	1:8	1:30	1:27	1:430	1:430	1:77
	Armenian	1:14	1:52	1:35	1:357	1:624	1:146
	Tagalog	1:1	1:9	1:8	1:301	1:301	1:32
	Cantonese	1:11	1:40	1:33	1:484	1:1,451	1:76
	Korean	1:3	1:35	1:16	1:155	1:361	1:42
	Grand Total	1:109	1:371	1:248	1:2,226	1:3,560	1:760
Data source: Tableau Practitioner Specialty to Member Spoken Language Ratio Report							

Examining the provider-to-member language ratios reveals notable differences in linguistic accessibility across specialties. In 2025, the previously identified gaps for language thresholds in Los Angeles County remained unchanged for the following specialties: cardiology (Spanish) and gastroenterology (English, Spanish, and Cantonese). However, for cardiology (English), the provider-to-patient ratio improved, decreasing from 1:1,632 to 1:881, meeting the threshold and for Spanish, the ratio improved (1:1,855 to 1:1,547), although not enough to meet our threshold goal. In contrast, gastroenterology ratios rose, notably for Spanish, which increased from 1:2,919 to 1:4,232 and Cantonese, due to the absence of provider language support for this language. A new gap was identified for the ratio for Cantonese cardiology increasing to 1:2,226.

Some specialties like pediatrics, in Los Angeles County, have much favorable ratios for Vietnamese (1:7), Farsi (1:2) and Korean (1:3) indicating strong language support for these populations.

Ongoing assessment of provider-to-member language ratios highlights both progress and persistent challenges in meeting linguistic accessibility standards across specialties and counties. Continued focus on addressing identified gaps will be essential to ensure equitable language services for all members, supporting improved care and patient satisfaction in the years ahead.

Language Services Available Through Practices

Practice Language	Los Angeles	
	Count	%
Spanish	2,010	93.66%
Mandarin	684	31.87%
Vietnamese	630	29.36%
Korean	563	26.23%
English	529	24.65%
Russian	553	25.77%
Tagalog	432	20.13%
Cantonese	467	21.76%
Farsi	418	19.48%
Armenian	373	17.38%
Chinese	288	13.42%
Arabic	226	10.53%
Khmer	29	1.35%
French	214	9.97%
Hindi	202	9.41%
Yue Chinese	180	8.39%
Urdu	93	4.33%

Practice Language	Los Angeles	
	Count	%
Persian	108	5.03%
Portuguese	58	2.70%
Japanese	69	3.22%
German	65	3.03%
Hebrew	83	3.87%
Punjabi	66	3.08%
Thai	75	3.49%
Gujarati	55	2.56%
Italian	47	2.19%
Turkish	49	2.28%
Modern Greek	31	1.44%
Telugu	33	1.54%
Sign Language	22	1.03%
Greek	22	1.03%
Lithuanian	13	0.61%
Taiwanese	35	1.63%
Polish	19	0.89%
Romanian	23	1.07%
Burmese	26	1.21%
Bengali	23	1.07%
Kannada	16	0.75%
Latin	10	0.47%
Filipino	23	1.07%
Lao	9	0.42%
Tamil	17	0.79%
Marathi	9	0.42%

Practice Language	Los Angeles	
	Count	%
Swedish	11	0.51%
Kashmiri	15	0.70%
Nepali	15	0.70%
Ukrainian	11	0.51%
Latvian	4	0.19%
Pashto	4	0.19%
Danish	6	0.28%
Hungarian	5	0.23%
Chinese (Family)	9	0.42%
Hmong	6	0.28%
Faroese	8	0.37%
Ilocano	2	0.09%
Indonesian	7	0.33%
Kurdish	0	0.00%
Malay	6	0.28%
Bulgarian	2	0.09%
Estonian	1	0.05%
Fataleka	5	0.23%
Malayalam	3	0.14%
Samoan	5	0.23%
Dutch	4	0.19%
Sindhi	4	0.19%
Wu Chinese	4	0.19%
Chamorro	3	0.14%
Egyptian	1	0.05%
Norwegian		

Practice Language	Los Angeles	
	Count	%
Sinhala	3	0.14%
Somali		
Bosnian	2	0.09%
Chaldean Neo-Aramaic	1	0.05%
Croatian	2	0.09%
Czech	2	0.09%
Hindustani	2	0.09%
Ibo	2	0.09%
Macedonian	2	0.09%
Shanghainese	2	0.09%
Swahili	0	0.00%
Achinese	1	0.05%
Afrikaans	1	0.05%
Amharic	1	0.05%
Cambodian	1	0.05%
Flemish	1	0.05%
Hakka	1	0.05%
Iloko	1	0.05%
Mien	1	0.05%
Min Nan Chinese	1	0.05%
Serbian	1	0.05%
Serbo-Croatian	1	0.05%
Tigrinya	0	0.00%
Tongan	1	0.05%
Yiddish	1	0.05%
Assyrian	0	0.00%

Practice Language	Los Angeles	
	Count	%
Cebuano	0	0.00%
Fukienese	0	0.00%
Hausa	0	0.00%
Navajo	0	0.00%
South Indian	0	0.00%
Toishanese	0	0.00%
Yoruba	0	0.00%
Total	2,146	100.00%

Data source: Tableau Language Services Available Through the Practice Report

Red font indicates county threshold language.

Languages	Los Angeles		
	2024	2025	Year-over-Year (%)
Arabic	200	226	13.00
Armenian	358	373	4.19
Cantonese	448	467	4.24
English	314	529	68.47
Farsi	416	418	0.48
Khmer (Cambodian)	29	29	-
Korean	529	563	6.43
Mandarin	633	684	8.06
Russian	536	553	3.17
Spanish	1,909	2,010	5.29
Tagalog	407	432	6.14

Thai	77	75	-2.60
Vietnamese	576	630	9.38
Data Source: Tableau report Language Services Available Through the Practice			

Languages	Los Angeles 2024	2025	Year-over-Year (%)
Arabic	9.90%	10.53%	6.36
Armenian	17.72%	17.38%	-1.92
Cantonese	22.18%	21.76%	-1.89
English	15.54%	24.65%	58.62
Farsi	20.59%	19.48%	-5.39
Khmer (Cambodian)	1.44%	1.35%	-6.25
Korean	26.19%	26.23%	0.15
Mandarin	31.34%	31.87%	1.69
Russian	26.53%	25.77%	-2.86
Spanish	94.50%	93.66%	-0.89
Tagalog	20.15%	20.13%	-0.10
Thai	3.81%	3.49%	-8.40
Vietnamese	28.51%	29.36%	2.98
Data Source: Tableau report Language Services Available Through the Practice			

Language services available through practices evaluation

Year-over-year evaluations of network office staff language capabilities indicate that both counties consistently surpass the 8% target for threshold languages. While Thai and Khmer are preferred languages in Los Angeles County, they are not designated threshold languages and did not reach the 8% benchmark. Spanish remains the

most prevalent, with 93.66% of offices in Los Angeles County reporting Spanish-speaking staff in 2025. Mandarin, Vietnamese, and Korean also significantly exceed the 8% threshold.

Notably, the prevalence of English as a reported spoken language is lower than anticipated, with only 24.65% in Los Angeles County reporting English-speaking staff. However, there was a notable 54.18% overall increase in offices reporting English capability in 2025. This lower count may be attributed to providers who, while reporting other languages, may inadvertently omit English. This issue was previously identified in our 2024 assessment and addressed in our workplan, potentially contributing to the recent increases.

Several languages showed modest year-over-year growth. In Los Angeles County, Arabic increased by 6.36% and Vietnamese by 2.98%. Conversely, Farsi, Thai, Khmer (Cambodian), and Russian saw decreases of 5.39%, 8.40%, 6.25%, and 2.86%, respectively.

The network continues to provide comprehensive language service availability, meeting or exceeding requirements for all threshold languages. Continued attention is warranted for Thai and Khmer (Cambodian), though they will not be included in the formal improvement plan as they are not classified as threshold languages. Ongoing monitoring will be maintained for these languages.

Provider Training and Resources

Blue Shield Promise is committed to ensuring that all members have access to quality health care and recognizes the importance of ensuring the provider network is equipped with tools needed to increase cultural awareness and provide culturally appropriate care for members. This information is available on the provider website and on the provider portal. Many of these training courses focus on health equity and cultural awareness and qualify for Continuing Medical Education (CME) credit. We included traffic information from 2022 and current data (when available) for insights in the table below.

Blue Shield Promise has transitioned from monitoring the number of providers who have completed general health equity and cultural awareness trainings to tracking completion of the new Advancing Health Equity training, as

required by the Department of Health Care Services. This training covers topics such as implicit bias, culturally and linguistically appropriate practices, diversity, equity and inclusion, gender-affirming care, among others. The goal is for all providers to complete the training by 12/31/2025 and at each subsequent recredentialing.

Course Title and Link	Description	Traffic	# of providers who received CME
Reducing Inequalities in cesarean delivery: From awareness to action- webinar held 4/22/25 Recorded webinar (51 min) Presentation (PDF, 5 MB) (CME available)	Dr. Kelly O. Elmore, a board-certified OB/GYN, advances understanding of the disparities in cesarean deliveries, their health impacts, and strategies for improvement. *(new training as 2025)*	53 attendees; 27 views	8 as of 9/25/25. Enduring CME available until 5/13/26
Care for Transgender/Nonbinary Patients held 10/18/23 Presentation (PDF, 4 MB) (CME available)	Barry K. Eisenberg, M.D. and Ilana Sherer, M.D., FAAP from the Palo Alto Medical Foundation/Sutter Health discuss and answer questions about what we can do to help improve healthcare experiences of transgender and nonbinary youth, adolescents, and adults.	179 attendees; 241 views	61

Course Title and Link	Description	Traffic	# of providers who received CME
Addressing Cardiac Care Disparities for Better Patient Outcomes Recorded webinar (51 min) Presentation (PDF, 7 MB) (CME available)	Dr. Columbus Batiste, chief of cardiology at Kaiser Permanente Riverside and Moreno Valley Medical Centers addresses key health disparities in cardiac care and how to reduce their occurrence.	17 attendees; 107 views	19
Racism in America Recorded webinar (54 min) Presentation (PDF, 683 KB) (CME available)	Dr. Tina Sacks, Assistant Professor at UC Berkeley School of Social Welfare, and Dr. Lily Lamboy discuss the latest research in health inequities, share insights from patient grievances and identify ways to avoid them.	86 attendees; 60 views	55
What your Lesbian, Gay, Bisexual, Transgender, and Questioning patients would like you to know Presentation (PDF, 1.3 MB)	This webinar covers practical guidelines and considerations for providing inclusive health care to your LGBT/Q patients. Topics include creating a welcoming	2363	933 (not all were BSC providers)

Course Title and Link	Description	Traffic	# of providers who received CME
(CME available)	environment for LGBT/Q patients, using nonjudgmental questions, and using language preferred by LGBT/Q patients.		
Implicit Bias in Healthcare and What You Can Do About It	eLearning: This interactive module is a quick way for clinicians and office staff to recognize and mitigate implicit bias.	94 views as of 9/2022. Updated number not available	n/a
Addressing low health literacy - Improve patient outcomes without adding time Recorded webinar (59 min) Presentation (PDF, 885 KB)	Dr. Cliff Coleman, MD, MPH, a national expert in health literacy, presents communication best practices designed to improve patients' understanding while not adding time to healthcare professionals' busy workloads.	131	85
Improving health literacy with plain Language Health literacy eLearning	This 10-minute interactive module provides the information and tools you need to use	Not available	n/a

Course Title and Link	Description	Traffic	# of providers who received CME
	plain language as part of good health literacy practice.		
Physician's practical guide to culturally competent care A Physician's Practical Guide to Culturally Competent Care	Product of the Department of Health and Human Services Office of Minority Health (OHS), this training is a free online educational program that will equip you with the knowledge, skills and awareness to best serve the healthcare needs of patients regardless of their cultural or linguistic background.	Not available	n/a

Providers seeking to enhance their cultural and linguistic awareness and understanding will find a wealth of resources conveniently outlined within the Blue Shield Promise provider website. The information found on the website summarizes key cultural and linguistic requirements, but also guides practitioners toward valuable self-assessment tools, educational courses, and practical toolkits designed to meet the requirements of the Blue Shield Promise Cultural and Linguistic Program. From continuing education opportunities and downloadable forms to multilingual support and guidelines for gender-inclusive care, the provider website serves as a comprehensive reference helping providers deliver equitable, culturally responsive healthcare to diverse patient populations.

Resource	Description	Website/Link
Educational Resources		
Blue Shield Provider Connection Learning resources	No cost courses covering topics ranging from bias to social determinants of health.	www.blueshieldca.com/en/provider/news-education/learning-resources Providers log in to access additional courses.
A Physician's Practical Guide to Culturally Competent Care	This course provides the knowledge and skills to serve patients of all cultural and linguistic backgrounds.	https://thinkculturalhealth.hhs.gov/education/physicians
U.S. Dept. of Health and Human Services, Office of Minority Health	Minority health resources.	www.minorityhealth.hhs.gov
Forms		
Blue Shield Multilingual Resources	Website in multiple languages, nondiscrimination notice and notice of language availability.	https://www.blueshieldca.com/en/bsp
2025 Cultural Awareness and Linguistic Resources	Compilation of resources, including links to training modules and information on how to access language assistance services.	https://www.blueshieldca.com/content/dam/bsca/en/promise/docs/BSC-Promise-Cultural-and-Linguistics-Resources.pdf
Downloadable Grievance Form	Grievance form in multiple languages	Medi-Cal appeals and grievance process | Blue Shield of CA Promise Health Plan
Member Forms	Notice of availability of language assistance services	https://www.blueshieldca.com/en/bsp/about-blue-shield-promise-health-plan/nondiscrimination-and-language-assistance-notice

Confidential Communications Request Forms	Multilingual request forms for confidential information	https://www.blueshieldca.com/en/bsp/about-blue-shield-promise-health-plan/confidential-communications

Provider training and resources evaluation

Blue Shield Promise supports cultural and linguistic awareness within its provider network through diverse educational resources, including training modules on transgender care, health disparities, implicit bias, and health literacy—many of which offer Continuing Medical Education credits. These easily accessible courses help providers stay current and foster equitable, inclusive care.

The provider network also has access to downloadable forms and links to national platforms, with resources available in multiple languages to reduce barriers and support effective care for all members. These efforts build a knowledgeable and culturally sensitive network, enhancing patient experiences.

In 2025, all contracted providers are required to complete training on advancing health equity. The training covers a variety of topics, including implicit bias, culturally and linguistically appropriate practices, diversity, equity, and inclusion, gender-affirming care, and more. The training rolled out to 21,343 providers in March 2025. Providers were directed to the provider portal to complete the training. As of August 31, 2025, 10% of providers have completed the training. The Health Equity team continues to drive the efforts to increase provider completion of the training through communication with contracted medical groups, at Joint Operations Meetings, and providers.

Language Assistance Services and Nondiscrimination

Language Assistance Services and Nondiscrimination Goals	
Member Cultural and Linguistic Grievances	Blue Shield has no threshold for cultural and linguistic grievances and will review all culturally and linguistically related grievances.
Member Experience	Achieve a 20% response rate for interpreter satisfaction survey.

	Achieve a 95% satisfaction rate for face-to-face interpreter services.
Bilingual Services	100% of bilingual staff who interact with members are assessed for their bilingual skills
Preferred Languages	Achieve 100% availability of interpreter requests for all languages.
Written Translation Requests	Meet 100% of written translation requests for all threshold languages.

Blue Shield Promise conducts comprehensive surveys and analyzes member grievance data to assess the effectiveness of language services provided. This data is benchmarked against established goals, and when goals are not achieved, a thorough barriers analysis is conducted to identify areas for improvement and develop targeted interventions.

Member Experience

Cultural and Linguistic Grievances

Blue Shield Promise does not establish a grievance threshold for cultural and linguistic related grievances as we believe each grievance should be examined to obtain the highest level of understanding of members' needs and preferences. For this report, we will examine grievances related to members' experience with internal and external services.

Member Grievances- Los Angeles County

Grievances	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Year over year (%)
Linguistic	9	9	15	15	17	5	7	14	6	11	-33.85
Cultural	19	18	21	21	36	36	0	3	0	0	-66.09

Member grievances evaluation

Blue Shield Promise is committed to delivering the highest quality of services to our members. As such, analyzing member grievances is one of the pathways that is used to determine if our internal services are meeting members' needs and preferences.

Blue Shield Promise had a total of 159 linguistically related grievances in 2023 through Q1 2024 and a total of 192 culturally related grievances. In comparison, in 2024 through Q2 2025, there were a total of 87 grievances related to linguistic concerns and 62 related to cultural concerns.

A review of these grievances indicates ongoing challenges encountered by members, particularly concerning language services. Key issues include unfulfilled face-to-face interpreter appointments, limited availability of American Sign Language (ASL) interpreters, providers not utilizing telephonic interpretation when a language barrier is identified or when an in-person face-to-face interpreter appointment is cancelled, member assumptions that the provider will arrange face-to-face interpretation, and difficulties locating providers who speak member's preferred language. The majority of cultural grievances involve reports of perceived discrimination or unprofessional behavior by providers or their staff. These findings underscore persistent and significant barriers to language access and effective communication.

We continue to enhance provider and member education regarding the availability of interpreter services through targeted communications and by offering educational resources on our website. Additionally, we have solicited input from our Community Advisory Committee on how to inform members about these services and will explore the feasibility of implementing their recommendations.

Member Experience of Language Assistance Services During Healthcare and Health Plan Encounters

Blue Shield Promise conducted a survey to evaluate member satisfaction with interpreter services. The survey was administered from December 2024 to February 2025 and targeted 5,002 members who had utilized over-the-phone or face-to-face interpreters, including American Sign Language (ASL), within the previous year. It was translated into Arabic, Armenian, Chinese, Farsi, Khmer (Cambodian), Korean, Russian, Spanish, Tagalog, Thai, and Vietnamese.

Members received the survey in the language and interpretation method corresponding to their service usage, along with a self-addressed, stamped envelope for return. The survey data was processed and analyzed by Blue Shield Promise staff.

Interpreter Services Satisfaction Survey

2024 survey (RY 2023)	Face to Face	Over the Phone
Total outreach	1,979	3,023
Response rate	4.6% (92)	6.3% (191)
How satisfied are you with the interpreter services you received?	94% reported being either satisfied or very satisfied	96% reported being either satisfied or very satisfied with their interpreter service.
Did the interpreter arrive on time?	91% reported that their interpreter was on time	
Were you connected with an interpreter within one minute?		84% were connected within one minute
Would you use an interpreter at your next doctor's appointment?	92% would use an interpreter in the future	96% would use an interpreter in the future

2023 survey (RY 2022)	Face to Face	Over the Phone
Total outreach	868	1,833
Response rate	10% (87)	3.4% (63)
How satisfied are you with the interpreter services you received?	93% reported being either satisfied or very satisfied	95% reported being either satisfied or very satisfied with their interpreter service.
Did the interpreter arrive on time?	92% reported that their interpreter was on time	
Would you use an interpreter at your next doctor's appointment?	93% would use an interpreter in the future	87% would use an interpreter in the future

According to 2024 survey data, 94% satisfaction rate for face-to-face interpreters and 96% satisfaction rate for over-the-phone interpreter services. A minority indicated neutral or dissatisfied responses. For face-to-face interpreters, 91% stated that the interpreter arrived on time, while 84% of those who used over-the-phone interpreters noted a connection within one minute. It is unclear whether members are considering connection time from their initial call or from the intake of their interpretation request. Overall, 92% of members expressed willingness to use face-to-face interpreters in future appointments, and 96% of telephonic interpreter service users would consider using these services again

Although there was a slight increase from 2024 satisfaction levels, the goal was not met for face-to-face interpreter services at 94%. However, the satisfaction rate for over-the-phone interpreter services surpassed the 95% satisfaction goal.

To achieve a targeted combined survey response rate of 20%, Blue Shield Promise introduced an incentive for the 2024 surveys. Members who completed the survey and provided contact information received a small notebook and were entered into a raffle to win one of several duffle bags. However, despite offering this incentive, the overall response rate for 2024 was 5.6%, closely aligning with the 2023 rate of 5.5%. Enhancing survey participation remains a key area for improvement. Accordingly, Blue Shield Promise is evaluating new strategies to increase engagement, including implementing a digital survey delivery system through email and the online survey platform, Qualtrics, as well as transitioning the survey cadence from annually to quarterly.

On an ongoing basis, the Cultural and Linguistic department works collaboratively with the Appeals and Grievance (A&G) department and our contracted vendor to address any grievances related to dissatisfaction with interpreter services. Our objective is to thoroughly understand all concerns regarding member dissatisfaction and evaluate whether adjustments are needed with our vendor and protocols for accessing these services.

Utilization of Language Assistance Services

Blue Shield Promise aims to provide all members with effective and respectful care in a manner compatible with their cultural health beliefs and practices and in their preferred language at all points of contact. Blue Shield Promise notifies members of the availability of no cost interpretation and translation services. Interpretation services are offered in 240+ languages and translation of member informing materials and health education materials are provided in DHCS county-specific threshold languages, which encompass the threshold languages spoken by five percent of the population or a thousand eligible individuals, whichever is less.

Bilingual Services

Blue Shield Promise may employ staff with direct member contact who are bilingual and demonstrate proficiency in the non-English language by satisfying those standards and criteria created to evaluate bilingual skills competency.

An example of our Bilingual Fluency Assessment is listed below:

- The employee must achieve a level 4 score to be promoted to and skilled as a bilingual employee.
- If the employee achieves a level 3 score and wants to still be considered, the user that requested the test for the employee can request a *double-blind review* (a second expert will analyze the test to determine if the score should be confirmed or pushed to level nine).
- If the employee scores under level 4, they must wait 90 days before retaking the test which will be offered again at their manager's discretion.
- If the employee disconnects the call at any point, they can call back into it within 3 minutes to resume.
- Test MUST be completed within 15 days of requesting one.

Only those employees who meet the minimum proficiency standards can assist members with limited English proficiency.

Blue Shield Promise recognizes that bilingual employees can improve the member's experience and is actively recruiting employees proficient in languages other than English. If a bilingual employee is not available, the Blue Shield Promise representative will connect a three-way call with Language Line for an over-the-phone interpreter. Blue Shield Promise currently does not have a method for capturing the total number of members that use our bilingual employee services.

Each of these employees underwent an assessment prior to being allowed to speak with members in another language beyond English to ensure competency. Blue Shield utilizes The Language Line Academy to assess and certify our employees. Agent competencies are recertified every three years.

Bilingual Staff Assessment

Blue Shield Promise Department	# of Staff Assessed	
	2023	2024
Appeals & Grievances	3	0
Behavioral Health	4	Data not available
Community Engagement	11	Data not available
Health Education and Cultural & Linguistic	5	1
Case Management/Disease Management (Complex Case Management)	4	8
Customer Service	12	21
Pharmacy	3	Data not available
Clinical Quality	10	Data not available
Workforce Management	1	Data not available
Special Investigations Unit	3	Data not available

Blue Shield Promise Department	# of Staff Assessed	
	2023	2024
Social Services	0	Data not available
Claims	0	Data not available
Utilization Management	1	Data not available
Total Number of Bilingual Employees	57	30
Source: Bilingual Assessment Report 2021 to date		

Blue Shield Bilingual Services Evaluation

The bilingual skill assessment data for 2025 is incomplete. Available information indicates that 30 staff members underwent evaluation of their bilingual abilities. Departments participating in the assessment included Health Education and Cultural and Linguistic Services, Case Management, and Customer Service, with Customer Service accounting for 21 agents assessed.

This lack of comprehensive data highlights an area for improvement. Currently, department leaders coordinate directly with the assessment vendor to schedule bilingual staff assessments. While this approach streamlines scheduling, it poses challenges in maintaining accurate and current records within a centralized database.

Interpreter Services

A key component to assessing whether members have access to services in their preferred language is examining the utilization of interpreter services by members and providers. Members are informed, at least annually, about the availability of language services, including interpreter services, and how to access these services. Providers are also notified about the availability of these services on an annual basis.

Blue Shield Promise's interpretation vendor, Language Line Solutions (Language Line), provides over-the-phone and onsite interpretation in more than 240 languages, including American Sign Language (ASL), through qualified

interpreters. Interpreter service utilization by members and providers is reviewed to help ensure that members have access to preferred services. At a minimum, annual notifications about available interpreter services are sent to members and providers.

The following tables show data on the use of interpreter services by members and providers. While the data distinguishes between member and provider requests, some overlap may occur if providers contact the Customer Service team instead of their dedicated line to request over-the-phone interpretation.

Member Over the Phone Interpreter Requests

Language	Count of Calls			% of Languages		
	2023	2024	Year-over-Year (%)	2023	2024	Year-over-Year (%)
Spanish	49,584	43,211	-12.85	67%	71.8%	7.16
Mandarin (Chinese)	6,146	3,523	-42.68	8.3%	5.9%	-28.92
Russian	3,225	2,865	-11.16	4.0%	4.8%	20.00
Vietnamese	2,219	1,923	-13.34	3.0%	3.2%	6.67
Haitian creole	1,081	991	-8.33	1.5%	1.6%	6.67
Farsi	934	938	0.43	1.3%	1.6%	23.08
Armenian	1,316	1,137	-13.60	1.8%	1.9%	5.56
Arabic	1,421	1,050	-26.11	2.0%	1.7%	-15.00
Korean	1,837	894	-51.33	2.5%	1.5%	-40.00
Cantonese (Chinese)	1,154	726	-37.09	1.6%	1.2%	-25.00
Tagalog	1,278	802	-37.25	1.7%	1.3%	-23.53
Khmer	565	493	-12.74	<1.0%	<1.0 %	-
Dari	656	198	-69.82	<1.0%	<1.0 %	-
Thai	276	192	-30.43	<1.0%	<1.0 %	-

Language	Count of Calls			% of Languages		
	2023	2024	Year-over-Year (%)	2023	2024	Year-over-Year (%)
Japanese	123	131	6.50	<1.0%	<1.0 %	-
Pashto	311	153	-50.80	<1.0%	<1.0 %	-
Turkish	105	91	-13.33	<1.0%	<1.0 %	-
Ukrainian	130	86	-33.85	<1.0%	<1.0 %	-
Portuguese	122	101	-17.21	<1.0%	<1.0 %	-
Punjabi	81	77	-4.94	<1.0%	<1.0 %	-
French	-	61	-	-	<1.0 %	-
Amharic	75	52	-30.67	<1.0%	<1.0 %	-
Laotian	203	89	-56.16	<1.0%	<1.0 %	-
Hindi	81	53	-34.57	<1.0%	<1.0 %	-
Bengali	71	54	-23.94	<1.0%	<1.0 %	-
Somali	97	30	-69.07	<1.0%	<1.0 %	-
Burmese	63	16	-74.60	<1.0%	<1.0 %	-
Swahili	55	37	-32.73	<1.0%	<1.0 %	-
Other languages (<50 calls)	476	353	-25.84	<1.0%	<1.0%	-
Total Calls	73,685	60,197	-18.30	100%	100%	-
Data Source: Language Line Services Usage Summary Report (2024)						

Interpreter services evaluation

In 2024, there was a total of 60,197 requests for over-the-phone interpreter service, which was a 18.30% decrease from 2023. The top five requested languages for telephonic interpreter services were Spanish at 71.8%, Mandarin at 5.9%, Russian at 4.8 %, Vietnamese at 3.2%, and Haitian Creole at 1.6%. Spanish and Russian experienced small

declines of 12.85% and 11.16%, respectively. Mandarin saw a more significant decline (-42.68%) although it remained as the second most requested language, comprising almost 6% of the requests in 2024. Farsi saw a small increase of 0.43% and made up almost 2% of the requests in 2024. We will continue to monitor the number of requests to determine if we need to adjust our member and provider engagement strategies to ensure all are aware of these services.

Provider Requests

Language	Count of Calls			% of Languages		
	2023	2024	Year-over-Year (%)	2023	2024	Year-over-Year (%)
Spanish	660	15,950	2316.67	66.13%	72.3%	9.33
Haitian Creole	2	1,173	58550.00	0.20%	5.3%	2550.00
Dari	9	539	5888.89	0.90%	2.4%	166.67
Mandarin	184	499	171.20	18.44%	2.3%	-87.53
Russian	21	468	2128.57	2.10%	2.1%	0.00
Arabic	4	495	12275.00	0.40%	2.2%	450.00
Vietnamese	10	531	5210.00	1.00%	2.4%	140.00
Pashto	16	302	1787.50	1.60%	1.4%	-12.50
Tagalog	4	471	11675.00	0.40%	2.1%	425.00
Farsi	9	237	2533.33	0.90%	1.1%	22.22
Korean	22	230	945.45	2.20%	1.0%	-54.55
Cantonese	9	191	2022.22	0.90%	0.9%	0.00
Portuguese	2	88	4300.00	0.20%	0.4%	100.00
Thai	3	132	4300.00	0.30%	0.6%	100.00
Khmer	3	89	2866.67	0.30%	0.4%	33.33

Language	Count of Calls			% of Languages		
	2023	2024	Year-over-Year (%)	2023	2024	Year-over-Year (%)
Ukrainian	1	56	5500.00	0.10%	0.3%	200.00
Armenian	2	89	4350.00	0.20%	0.4%	100.00
Laotian	1	67	6600.00	0.10%	0.3%	200.00
Turkish	0	45	-	-	0.2%	-
French	2	33	1550.00	0.20%	0.1%	-50.00
Swahili	0	43	-	-	0.2%	-
Sudanese Arabic	0	28	-	-	0.1%	-
Somali	3	47	1466.67	0.30%	0.2%	-33.33
Tigrigna	0	33	-	-	0.1%	-
Amharic	8	33	312.50	0.80%	0.1%	-87.50
Punjabi	7	22	214.29	0.70%	0.1%	-85.71
Uzbek	0	10	-	-	0.0%	-
Burmese	1	27	2600.00	0.10%	0.1%	-
Karen	0	17	-	-	0.1%	-
Igbo	0	7	-	-	0.0%	-
Kinyarwanda	0	10	-	-	0.0%	-
Bengali	1	13	1200.00	0.10%	0.1%	-
Hebrew	0	10	-	-	0.0%	-
Japanese	5	8	60.00	0.50%	0.0%	-
Hindi	3	7	133.33	0.30%	0.0%	-
Hmong	1	3	200.00	0.01%	0.0%	-
Sorani	0	3	-	-	0.0%	-
Bulgarian	0	6	-	-	0.0%	-

Language	Count of Calls			% of Languages		
	2023	2024	Year-over-Year (%)	2023	2024	Year-over-Year (%)
Albanian	0	3	-	-	0.0%	-
Akateko	0	1	-	-	0.0%	-
Portuguese Brazilian	0	5	-	-	0.0%	-
Gujarati	0	6	-	-	0.0%	-
Fulani	0	1	-	-	0.0%	-
Italian	0	4	-	-	0.0%	-
Chaldean	0	2	-	-	0.0%	-
Samoan	0	4	-	-	0.0%	-
Polish	0	3	-	-	0.0%	-
Urdu	0	3	-	-	0.0%	-
Romanian	0	2	-	-	0.0%	-
Telugu	0	1	-	-	0.0%	-
Wolof	0	2	-	-	0.0%	-
Bahdini	0	1	-	-	0.0%	-
Marshallese	0	1	-	-	0.0%	-
Assyrian	0	1	-	-	0.0%	-
Chuukese	0	1	-	-	0.0%	-
Ilocano	0	1	-	-	0.0%	-
Krio	0	1	-	-	0.0%	-
Bosnian	0	1	-	-	0.0%	-
Karenni	0	1	-	-	0.0%	-
Lingala	0	1	-	-	0.0%	-

Language	Count of Calls			% of Languages		
	2023	2024	Year-over-Year (%)	2023	2024	Year-over-Year (%)
Czech	0	1	-	-	0.0%	-
Danish	2	0	-	0.20%	-	-
Dutch	1	0	-	0.10%	-	-
Finnish	1	0	-	0.10%	-	-
Yiddish	1	0	-	0.10%	-	-
Total Calls	998	22,059	2110.32	100%	100.00%	-
Data Source: Language Line Services Usage Summary Report (2024)						

Interpreter services evaluation

In 2024, provider requests for interpreter services rose sharply to 22,059 from 998 in 2023. Spanish continued as the leading requested language (72.3% of requests, up 9.33%), while Haitian Creole saw the largest increase, rising from 2 to 1,173 requests and becoming the second most requested language. Arabic and Tagalog requests also surged significantly, seeing increases of 12,275% and 11,675%, respectively. Additionally, the range of languages requested nearly doubled from 31 to 61.

The substantial increase in interpreter service requests in 2024 highlights both the growing diversity of the member population and Blue Shield Promise's commitment to meeting evolving linguistic needs. By expanding language support to a broader range of languages, Blue Shield Promise continues to uphold its promise of providing culturally and linguistically appropriate services to all members. We remain steadfast in our goal to deliver timely and effective language assistance, ensuring every member receives the support they need to fully access their health care benefits.

Translation Services

Blue Shield Promise translates materials deemed vital, that provide essential information to members about access and usage of Blue Shield Promise's health coverage benefits and services. Blue Shield Promise identifies vital documents (Standards and Non-Standard) using criteria defined in language assistance mandates. Additionally, Blue Shield translates health education materials. It is the responsibility of Blue Shield Promise to provide culturally and linguistically appropriate documents and materials to members in the threshold languages. Translated documents are required to meet the same standards as the English version. Members are informed of the availability of language services immediately upon enrollment, reminders on our website, annual member communications and with each mailing. Blue Shield Promise's written translation of materials and alternative formats are supported by our vendor ISI Language Solutions (ISI).

Translation of materials essential for members to access, participate in, or understand health plan benefits or covered health care services are available at no cost to members in threshold languages. Members can additionally request translations of materials in another format, such as Braille or in larger print. Blue Shield Promise written translation of materials is supported by our vendor ISI Language Solutions (ISI). The data listed below show an annual accumulative total of all written requests and if the written translation was completed in a timely manner. The goal for Blue Shield Promise is to meet 100% of written translation requests for all threshold languages.

The translation vendor is unable to produce a report by lines of business, therefore the data listed below show an annual accumulative total of all translation requests, and if the written translation was completed in a timely manner. Timely means in a manner appropriate for the situation in which language assistance is needed, not to exceed twenty-one (21) days of the request, unless otherwise mandated.

Written Translation Fulfillment

Language	Number of Documents			% of Documents Requested Completed		
	2023	2024	Year-over-Year (%)	2023	2024	Year-over-Year (%)
English	0	3,875	-	100%	100%	-

Language	Number of Documents			% of Documents Requested Completed		
	2023	2024	Year-over-Year (%)	2023	2024	Year-over-Year (%)
Spanish	1,342	3,585	167.14	100%	100%	-
Tagalog	141	903	540.43	100%	100%	-
Armenian	123	720	485.37	100%	100%	-
Russian	216	690	219.44	100%	100%	-
Vietnamese	173	662	282.66	100%	100%	-
Farsi	146	647	343.15	100%	100%	-
Chinese (Traditional)	158	611	286.71	100%	100%	-
Chinese (Simplified)	70	559	698.57	100%	100%	-
Arabic	170	545	220.59	100%	100%	-
Korean	119	351	194.96	100%	100%	-
Khmer (Cambodian)	100	228	128.00	100%	100%	-
Portuguese	0	11	-	-	100%	-
Japanese	0	7	-	-	100%	-
Ukrainian	0	7	-	-	100%	-
Hebrew	0	4	-	-	100%	-
Thai	0	4	-	-	100%	-
Chuukese (Trukese)	0	3	-	-	100%	-
Punjabi	0	2	-	-	100%	-
French (France)	0	2	-	-	100%	-
Haitian Creole (Haitian)	1	2	100.00	100%	100%	-
Iu Mien	0	2	-	-	100%	-

Language	Number of Documents			% of Documents Requested Completed		
	2023	2024	Year-over-Year (%)	2023	2024	Year-over-Year (%)
Hindi	0	2	-	-	100%	-
Hmong	0	2	-	-	100%	-
Bengali	0	2	-	-	100%	-
Lao (Laotian)	0	1	-	-	100%	-
Grand Total	2,759	13,427	386.66	100%	100%	-

Data source: ISI Translation Report (2024)

Translation services evaluation

From January 2024 through December 2024 there was a total of 13,427 requests for written translation services including alternative formats and 100% of those requests for translation were completed and returned to the relevant members. Blue Shield Promise has met its membership needs and preferences for this service. To better understand the data and our members' language service requests, we analyzed the number of requests per language type. The results show the top five requested written translation requests were English (in alternative format), Spanish, Tagalog, Armenian and Russian.

The year-over-year comparison of translated document language counts and completion percentages across languages reveals a marked increase in the number of documents translated. This trend is apparent in every language category, with an overall 386.66% increase in translation between 2023 and 2024.

Chinese Simplified saw a substantial increase in translated documents, increasing from 70 in 2023 to 559 in 2024. This represents a nearly 700% increase. Similarly, Spanish and Armenian saw notable increases of 540.43% and 485.37%, respectively. Important to note is that the English category represents the requests for alternative formats in English, which were not captured in the 2023 data. The completion rates for the document requests remained at 100% for both years across all languages, demonstrating a high level of efficiency in handling these requests.

This growth may indicate enhanced awareness among our members regarding the availability of translation services, as well as improved training of our internal staff concerning regulatory requirements and availability of translation services.

Blue Shield Promise Staff

Staff Training

Blue Shield Promise redesigned the cultural and linguistic training program into Advancing Health Equity in 2024. Guided by the Chief Health Equity Officers from Blue Shield of California and Blue Shield of California Promise Health Plan, thirty staff members across the organization collaborated to develop the Advancing Health Equity course. The course addresses implicit bias, culturally and linguistically appropriate practices, diversity, equity, inclusion, gender-affirming care, and other key topics. The course assignments commenced on March 3, 2025, with a completion deadline set for April 11, 2025.

Additionally, in compliance with state legislation, Blue Shield and Blue Shield Promise collaborated with an organization that serves the transgender, gender diverse, or intersex (TGI) community to create an evidence-based cultural competency training for staff on providing trans-inclusive care. The training, titled "Improving the Health Care Experience for the Transgender, Gender Diverse or Intersex Community," was assigned to Promise staff who have verbal or written contact with members. These staff were required to complete the TGI training starting April 16, 2025, with a completion deadline of June 30, 2025.

Assignment for both courses included:

- Appeals and Grievances
- Enrollment and Retention
- Community Resource Center
- Communication Governance
- Customer Service
- Quality
- Health Education and Cultural and Linguistic

- Utilization Management
- Population Health Management (Case Management Children's Health Services, Social Services and Behavioral Health Case Management)

Staff training evaluation

In 2025, 99% and 100% of the required staff completed the Advancing Health Equity and the TGI training, respectively. Efforts are underway to improve the efficiency of the training assignments for the next roll out of the trainings which will occur annually for the Advancing Health Equity and every two years for the TGI training.

Staff Experience with Language Assistance Services

Annually, Blue Shield of California and Blue Shield of California Promise Health Plan (Blue Shield) conduct an Employee Experience Survey to evaluate our vendor's language services to our members and the satisfaction our employees have with these vital services. Blue Sheild Promise revised the survey questions from 2024, to ask more targeted questions on interpreter and translation services. A year-over-year analysis was conducted, where questions were aligned.

Area for Improvement and Key Questions	2024	2025	Year over Year
Increase employee survey participation by 10%	304	189	-37.83%
Do you know how to access interpreter services?	56.90%	97.35%	71.09%
Do you know how to submit a request for a face-to-face interpreter, including ASL?	53.10%	30.69%	-42.20%
Do you know how to request a translation for written materials into a non-English language alternative format?	56.10%	86.76%	54.65%
Do you know how to access qualified bilingual staff if you need help communicating with a non-English speaking member?	55.60%	-	-

Question	Response				
1. Are you a Blue Shield or Blue Shield Promise (BSP) member facing employee?	Blue Shield: 86 Blue Shield Promise: 103				
2. Please indicate your department.	• Appeals & Grievances: 55 • Case Management: 42 • Community Resource Centers: 12 • Growth/Enrollment and Retention: 12 • Health Education: 1 • Medical Care Solutions: 16 • Medi-Cal Population Health Management (Case Management Children's Health Services, Social Services and Behavioral Health Case Management): 38 • Utilization Management: 5				
3. On a scale from 1 to 5, where 1 is the hardest and 5 is the easiest, how would you rate your experience with our over-the-phone interpreter service vendor?	1	2	3	4	5
	4	5	42	57	81
4. How long did you have to wait on hold for interpreter?	Less than one minute	One to two minutes	Two minutes to five minutes	More than five minutes	
	89	59	32	9	
5. How easy was it to get a hold of an over-the-phone interpreter in the language you requested?	Easy	Somewhat easy	Not easy	Very difficult	
	115	66	7	1	

Question	Response				
6. Did the over-the-phone interpreter assist you and the member as needed?	Yes: 178			No: 11	
7. Are you comfortable using the interpreter service line?	Yes: 184			No: 5	
8. Do you know how to submit a request for a face-to-face interpreter, including American Sign Language?	Yes: 58			No: 131	
9. On a scale from 1 to 5, where 1 is the hardest and 5 is the easiest, how would you rate your experience with our face-to-face interpreter service vendor?	1	2	3	4	5
	25	9	81	35	39
10. In the last 6 months, have you requested written materials in other languages besides English?	Yes: 68			No: 121	
11. Do you know which languages other than English Blue Shield offers written materials in?	Yes: 63			No: 5	
12. Do you know that Blue Shield offers alternative formats (e.g., audio, Braille,	Yes: 56			No: 12	

Question	Response				
large print, etc.) for translation?					
13. Do you know how to request a translation of written materials into another language or alternative format?	Yes: 59			No: 9	
14. If you requested a translation, how long did the translation take?	1-7 days	8-14 days	15-21 days	22-30 days	NA
	27	19	4	1	17
15. Were you satisfied with the translation process?	Yes: 78%			No: 22%	

Staff experience evaluation

In 2025, the survey was completed by 189 member-facing employees, a notable decrease from 304 participants in 2024. Despite the reduction in responses, the data provides a comprehensive view across departments, with significant representation from Appeals & Grievances, Case Management, and Medi-Cal Population Health Management. The participation was higher among Blue Shield Promise employees, indicating stronger engagement or awareness amongst Blue Shield Promise employees, compared to Blue Shield of California.

The survey reveals mixed experiences with interpreter services. Quantitatively, 81 respondents rated their experience with over-the-phone interpreter service at the highest level (5 out of 5), with the majority (115) finding it easy to obtain an interpreter in their requested language. Wait times have increased slightly: in 2025, 89 reported waiting less than a minute, while 59 waited 1-2 minutes, and some (9) waited more than five minutes. Although most staff (178) felt that the interpreter assisted effectively.

For face-to-face interpreters, 61% of staff found the experience to be poor to neutral, and few employees are comfortable requesting face-to-face interpreters; only 58 knew how, while 131 did not. A significant number of employees are also uncertain of how to request an ASL interpreter. In 2024, 127 of 304 employees were unsure how to request written translations, although this improved in 2025. Most translation requests were completed within 1-14 days, but satisfaction is mixed (78% satisfied, 22% dissatisfied). Only 1.3% found it easy to obtain non-English materials in 2024, dropping from 86% in 2022, suggesting more complicated procedures or communication issues.

Compliance Monitoring

Goals, Results, and Year Over Year

Category	Goal	Results	Results YoY
Member Population Goals			
Member Self-Reported Race and Ethnicity	Achieve 80% self-reported race and ethnicity.	Met	No change
Member Self-Reported Gender Identity	Achieve 20% self-report gender identity data capture by 2028.	Not met	No change
Member Self-Reported Sexual Orientation	Achieve 20% sexual orientation and data capture by 2028.	Not met	Increase
Contracted Provider Goals			
Provider race and ethnicity	1 American Indian/Alaska Native practitioner to 600 American Indian/Alaska Native members.	Met	No change
	1 Asian practitioner to 700 Asian members.	Met	No change

Category	Goal	Results	Results YoY
	1 Black/African American practitioner to 900 Black/African American members.	Met	No change
	1 Hispanic/Latino practitioner to 3,400 Hispanic/Latino members.	Met	No change
	1 Middle Eastern/North African practitioner to 700 Middle Eastern/North African members.	Not met	No change
	1 Native Hawaiian/Pacific Islander practitioner to 900 Native Hawaiian/Pacific Islander members.	Met	No change
	1 white practitioner to 700 white members.	Met	No change
	1 other race practitioner to 700 other race members.	Met in Los Angeles County	No change
Provider Languages	1 PCP (Family Medicine (General Medicine and Family Practice)), Internal Medicine, and Pediatrics) speaking a threshold language to 1,200 members speaking a threshold language.	Met	No change
	1 Specialist speaking a threshold language to 1,200 members speaking a threshold language	Not met	No change

Category	Goal	Results	Results YoY
Provider Office Staff Languages	8% of provider office staff speak at least one threshold language.	Met	No change
Provider Trainings and Resources	100% providers complete the Advancing Health Equity training by 12/31/25 and at recredentialing thereafter.	Not met	Baseline
Language Assistance Services and Nondiscrimination			
Member Cultural and Linguistic Grievances	Blue Shield Promise has no threshold for grievances related to cultural and linguistic grievances. Blue Shield Promise reviews all cultural and linguistic related grievances.	NA	NA
Member Experience	Achieve a 20% response rate for interpreter satisfaction survey.	Not met	No change
	Achieve a 95% satisfaction rate for face-to-face interpreter services.	Not met	No change
Preferred Languages	Fulfill 100% of interpreter requests for all languages.	Met	No change
Written Translation Requests	Fulfill 100% of written translation requests for all threshold languages.	Met	No change
Blue Shield Promise Staff Goals			
Staff Training: Advancing Health Equity	Aim to have 100% of required employees complete training annually.	Met	Baseline

Category	Goal	Results	Results YoY
Staff Training: Improving the Healthcare Experience of the Transgender, Gender Diverse or Intersex Community	Aim to have 100% of required employees complete the training every two years.	Met	Baseline
Staff Experience: Culturally and Linguistically Appropriate Services	Achieve 80% overall satisfaction based on staff experience surveys conducted annually.	Met	No change
Compliance Monitoring			
Barriers and Process Improvement	100% of identified barriers related to culturally and linguistically appropriate services will be tracked.	Met	No change

2025 Barrier Analysis

Listed below are the identified

Priority Item	Category	Barriers
1	**Provider Race and Ethnicity – Middle Eastern and North African:** Blue Shield Promise does not meet the goal of having 1 Middle Eastern and North African practitioner for every 700 Middle Eastern and North African members, in either county.	Administrative Facing: Blue Shield Promise believes the root cause of this insufficient data is that race and ethnicity are optional for providers to share. In addition, a lack of standard nationwide or statewide provider demographic registry poses an administrative burden and challenges to securing and maintaining the information

		needed to ensure appropriate network and workforce recruitment strategies.
2	**Provider Languages – Specialist:** Blue Shield does not meet the 1:1200 ratio for the following specialty types in Los Angeles County: • Cardiology- Spanish • Gastroenterology- English, Spanish, Cantonese	Administrative Facing: Lack of English-speaking gastroenterology and cardiology specialty providers continues to reflect in the data. Potential root cause is that these specialty providers are not populating the language field with English and believing the system will auto default to English. Lack of Spanish, Tagalog, Vietnamese, and Cantonese speaking specialty providers may be due to under reporting of provider languages and a network need to increase specialty providers that speak these languages
3	**Member Cultural and Linguistic Grievances** Blue Shield Promise does not currently maintain a formal target for member grievances; however, all grievances and identified gaps within the broader cultural and linguistic program are subject to thorough review and assessment.	Member and Administrative Facing: Lack of member and provider awareness regarding the process of requesting face-to-face interpreter services and the availability of on-demand over-the-phone interpreters when a language barrier is identified during health care encounters. We believe the potential root cause is members and providers are not recalling the pre-planning timeline requirements to request a face-to-face interpreter or that over-the-phone interpreter services are available at any time, which is affecting the member and providers healthcare visit. Additionally, despite high member satisfaction scores, as noted by the annual interpreter satisfaction member survey, member grievances related to face-to-face grievances persist. A root cause of this discordance may be that members may

		not recall their dissatisfaction with face-to-face interpreter services when they receive the annual survey. Administrative Facing: Lack of standardized processes for the efficient identification of categories and subcategories of cultural and linguistic related grievances which make it challenging to identify trends and address identified issues.
4	**Member Self-reported Gender Identification:** Blue Shield Promise has not achieved 20% self-report gender identity data capture.	Administrative and Systemic: Blue Shield Promise's goal of 20% may be ambitious, especially when considered against the realities of the current environment. Individuals may choose not to self-report their gender identity due to concerns about privacy, fear of disclosure, or a lack of trust in how their information will be used. Such hesitancy is further compounded by uncertainty about data protections and the potential for stigma or discrimination. These factors, in addition to privacy concerns, present significant challenges to accurate and comprehensive demographic data collection.
5	**Member Self-reported Sexual Orientation:** Blue Shield Promise has not achieved 20% self-report sexual orientation data capture.	Administrative and Systemic: Blue Shield Promise's goal of 20% may be ambitious, especially when considered against the realities of the current environment. Individuals may choose not to self-report their sexual orientation due to concerns about privacy, fear of disclosure, or a lack of trust in how their information will be

		used. Such hesitancy is further compounded by uncertainty about data protections and the potential for stigma or discrimination. These factors, in addition to privacy concerns, present significant challenges to accurate and comprehensive demographic data collection.
6	**Utilization of Language Assistance Services- Bilingual Services** Blue Shield Promise does not have a centralized system to track the number of employees who have been assessed for their bilingual skills.	Administrative Facing Lack of a centralized tracking system for bilingual employee skills assessment/certification makes it difficult to maintain current assessment data for the organization. The root cause may be that each department leader is responsible for scheduling bilingual assessments for their employees directly with the assessment vendor and the information is maintained within the department.
7	**Member Experience with Interpreter Services During Healthcare Encounters and Health Plan Encounters** Blue Shield Promise has not achieved a 20% response rate for the interpreter member satisfaction surveys	Administrative Facing Blue Shield Promise sends satisfaction surveys annually, which can lead to low response rates because members may not remember their interpreter services experience or may be reluctant to provide feedback after a long period of time. Many may also avoid the inconvenience of mailing the survey.

Barrier analysis evaluation

The barrier analysis highlights challenges impacting Blue Shield Promise's ability to provide equitable care, such as continued gaps in member and provider demographic data, inefficiency in the identification of cultural and linguistic grievances, and barriers in tracking provider trainings and employee bilingual skills assessments

Addressing these barriers is critical for Blue Shield Promise to achieve its mission of equitable care. By prioritizing ongoing evaluation, targeted interventions, and improved data collection, the organization can continue to close gaps in language access and cultural competency. This commitment will help pave the way for a more inclusive healthcare environment, where every member receives the support and services they need to thrive.

Community Committee Feedback and Evaluation

At Community Advisory Committee meetings, members shared various recommendations regarding the collection and use of self-identification data, with a focus on gender identity and sexual orientation, race and ethnicity, and language. Members discussed the significance of building trust to support participation and identified concerns about data privacy, perceptions of the healthcare system, and the current U.S. context as possible factors influencing self-identification processes. They also highlighted the relevance of transparency in the use of demographic information and needed assurance for protection of their information. We will continue to engage with the committee to keep them abreast of our interventions and solicit feedback.

Process Improvement Plan

The Health Equity Oversight Committee is responsible for overseeing all process improvement plans. These committees will designate accountable leads and facilitate cross-functional collaboration to ensure that workplans are executed on schedule and objectives are met.

2024 Process Improvement Plan

2024 Opportunities Item #1:

- Increase the number of Spanish speaking cardiologist in Los Angeles County and Spanish speaking gastroenterologists in Los Angeles County. Increasing the number of specialty providers that speak these

languages will ensure our members' network preferences are met and potentially will result in higher overall satisfaction.

- Examine our internal process of how we collect and display English speaking cardiologist and gastroenterologists in Los Angeles County to ensure our network language data is accurate.

Intervention:

Administrative Facing: Cross-department workgroup to be formed to review all provider network language data that did not meet goal, examine current outreach activities, determine best practices approach to increase the network in these areas, and develop a timeline. Additionally, this team will examine our internal process for collecting and displaying English and develop an action plan based on their findings.

Responsible: Health Equity, Provider Network

Informed: Health Equity Oversight Committee

Targeted Implementation date: Q3 2025

2025 Status and Impact: Completed. A modification in logic was necessary to resolve this deficiency, affecting the data processes related to network analytics as well as the presentation of information in Blue Shield's provider directory. Our primary objective will be to evaluate the outcomes associated with these changes. Specifically, in 2025, Blue Shield enhanced its systems by setting English as the default language (in place of 'unknown'), thereby improving clarity for members searching for providers online. This adjustment is expected to better meet members' cultural needs and preferences through improved accuracy and system functionality. The Information Technology team has recently finalized the programming update, and the revised data will be incorporated in the forthcoming reporting cycle.

2024 Opportunities Item #2 and #3: Increase member and provider awareness of:

1. How to request an interpreter and the pre-planning timeline requirements to book this service.
2. How to request written materials be translated into the members preferred written languages.

These two improvements will support our members overall satisfaction.

Interventions:

Member Facing

1. Ask members of the Community Review Committee to share their feedback on the best method of communication with them on language assistance resources.

2. Develop and disseminate a member notification on how to access language assistance services, including interpreter and translation information.

3. Develop and disseminate a provider letter and online provider announcement notification including cultural awareness and linguistic resources, language assistance services, including interpreter and translations and Cultural Competency training.

Administrative-Facing:

4. Setup a working session meeting to review grievance results and the current Customer Service process for asking and confirming the members preferred written language to receive material in. Based on findings an action plan will be developed and implemented.

Responsible: Health Equity, Quality, Customer Service, Provider Relations

Informed: Health Equity Oversight Committee

Targeted Implementation date: 1. September 2024; 2. September 2024; 3. October 2024; 4. Q4 2024

2025 Status:

1. Completed. Blue Shield Promise presented at the September 2024 Community Advisory Committee to gather input from members on various preferences on receiving health plan communications. Members shared they would strongly recommend to continue correspondence on programs/services provided by Blue Shield Promise.
2. Completed. Member newsletter article went out in Q4 2024 on availability of translation services and interpreter services. The article expanded on the timeframes for scheduling face-to-face interpreters, including ASL.
3. Completed. In 2025, there were two provider notifications regarding Blue Shield Promise language assistance services available to all providers. The annual mailing contains information on for providers on how to access interpreter services and language assistance information that is available to be used for their offices. Additionally, we shared information about the available provider training for them and office staff.
4. Discontinued- The majority of grievances are related to issues with interpreter services and not translation of materials and our focus will be on improving experience and access to interpreter services.

2024 Opportunities Item #4: Increase data capture for member and providers' race, ethnicity, and language information to allow for accurate network analysis and comparison to support member needs and preferences and increase data capture of member

Interventions

Member Facing

1. Partner with Violet (Vendor) and leverage their Health Equity provider training and other resources to encourage providers to self-identity race, ethnicity, language data.
2. Send reminders to all providers about the importance of updating their provider profile, which includes, but not limited to race, ethnicity, and spoken languages including office staff.
3. Send out reminders to all members regarding the privacy and protections of their race, ethnicity, and language, sexual orientation, and gender identity data and share the process for how to update their profiles.

Responsible: Health Transformation, Network Analytics, Health Equity, Provider Communication/Network Compliance

Informed: Health Equity Oversight Committee, Community Advisory Committee

Targeted Implementation date: 1. Q1 2025; 2. Q3 2024; 3. Q3 2024

2025 Status:

1. The pilot program was discontinued as it yielded little provider engagement. As of May 2025, a total of 90 providers were onboarded of the targeted 5000 providers. Very little commitment was demonstrated; therefore it was recommended to no longer proceed with this intervention.
2. Completed.
3. Completed. In 2025, Blue Shield Promise sent out written communication to all its Medi-Cal members to remind members on the importance of maintaining their information up-to-date. Members were reminded to leverage the member portal to self-identify race/ethnicity, preferred spoken and written languages, sexual orientation and ways that members can receive health plan communications. In 2025, while it did not achieve its goal of meeting the 20% goal of self-identified sexual orientation and gender identity, there was a slight increase in rates of self-identification. This modest improvement may be due to said reminders. In addition, this communication also includes reminders on the organization's importance of guarding personal and sensitive information which may have resonated with members' appeal to self-identify.

2024 Opportunities Item #5: Improve web system ability to count the number of providers that take trainings by year instead of an accumulative total. This shift would support the Plans ability trend data and see yearly training participation rates.

Intervention:

Administrative-Facing:

Establish meeting with IT/web team to examine system abilities to shift from accumulative to a year rate of providers who take CLAS training. The result of this meeting will include timeline for implementing the change.

Responsible: Quality, Health Equity, IT/Web

Informed: Health Equity Oversight Committee

Targeted Implementation date: Q1 2025

2025 Status: Discontinued. As part of the Department of Health Care Services requirement for all managed care plans and subcontractors are required to complete Diversity, Equity and Inclusion training as part of the Medi-Cal contract. This would require Blue Shield Promise to monitor providers completion of this training. A 100% completion is required. To date, we are at a 10% completion.

2025 Process Improvement Plan

2025 Opportunity #1: Improve Middle Eastern and North African provider capacity (Barrier #1)

Administrative facing intervention: Blue Shield Promise is forming a cross departmental workgroup to examine provider data to determine the precise root cause and develop an action plan to ensure Middle Eastern and North African providers are adequately represented in the Blue Shield Promise network. Responsible: Provider Relations; Network Analytics; Provider Contracting

Informed: Access to Care Committee; Health Equity Oversight Committee

Targeted implementation date: Q3 2025

Targeted completion date: To be determined

2025 Status: Not started

2025 Opportunity #2: Increase cardiologist and gastroenterologist capacity in Los Angeles County:

- **In Los Angeles County increase the number of Spanish-speaking cardiologist and English, Spanish and Cantonese gastroenterologist**

(Barrier #2)

Administrative facing intervention: Cross-department workgroup to be formed to review all provider network language data that did not meet goal, examine current outreach activities, determine best practices approach to increase the network in these areas, and develop a timeline.

Responsible: Provider Relations; Network Analytics; Provider Contracting

Informed: Access to Care Committee; Health Equity Oversight Committee

Targeted implementation date: Behind schedule for implementation date

Targeted completion date: Q1 2026

2025 Status: Initial conversations have occurred with Provider Network. Meetings with a formal workgroup will be scheduled.

2025 Opportunity #3: Decrease grievances related to face-to-face interpreters. (Barrier#3 and #7)

Administrative facing intervention: A cross-department workgroup will be formed to review existing process of categorizing grievances and identify ways to streamline the reporting process to internal teams. This will allow for better tracking and review of grievance

Member facing:
1. Explore the feasibility of a stand-along member flyer or short video on the availability of language services.
2. Transition interpreter satisfaction member survey from annual to quarterly.

Responsible:
Administrative: Cultural and Linguistic, Appeals and Grievance, Health Equity
Member Facing: 1, 2: Cultural and Linguistic

Informed:
Administrative and Member facing: Health Equity Oversight Committee and Community Advisory Committee

Targeted implementation date:
Administrative Facing: in-progress
Member Facing: 1. Q1 2026; 2. Q2 2026

Targeted completion date:
Administrative Facing: TBD
Member Facing: 1. Q1 2026; 2: ongoing

2025 Status:
Administrative Facing: in-progress
Member Facing: 1. Not started; 2: not started

2025 Opportunity #4: Improve member self-reported gender identification and sexual orientation (Barrier#4 and #5)

Administrative facing intervention: Explore opportunities for Customer Service to collect self-reported demographics from members when they call Blue Shield Promise.

Responsible: Health Equity; Customer Service

Informed: Health Equity Oversight Committee Community Advisory Committee

Targeted implementation date: Q2 2025

Targeted completion date: Q1 2027

2025 Status: In-progress. Blue Shield Promise will develop processes for member-facing staff, incorporating the feedback received from the Community Advisory Committee, to collect demographics without stigmatizing individuals who do not identify, or those who do.

2025 Opportunity #5: Increase tracking and reporting capabilities of staff bilingual assessments (Barrier #6)

Administrative facing intervention: Review current process with bilingual skills assessment vendor (Language Line) to explore the possibility of a reporting dashboard. Develop centralized tracking process whereby leaders of member-facing departments track bilingual assessments on a quarterly basis.

Responsible: Cultural and Linguistic and all internal departments that have their employees assessed for their bilingual skills, including Customer Services, Population Health Management (Care Management, Children's Services, Social Services), Community Engagement and Member Retention, Appeals & Grievances

Informed: Health Equity Oversight Committee Community Advisory Committee

Targeted implementation date: Q4 2025

Targeted completion date: Q2 2026

2025 Status: Not started

Compliance Monitoring

Looking ahead, it is imperative for the Cultural and Linguistic program to address bottlenecks in interventions by reinforcing compliance frameworks and streamlining governance processes. Increased collaboration and transparent communication between business owners and the Cultural and Linguistic Program, or appropriate oversight committee, should be prioritized to facilitate progress. Sustained attention to these areas will be vital to achieving the program's objectives and advancing health equity outcomes in the coming year.

Contribution

Employee Name	Title	Department	Section
Rosa Hernández	Sr. Manager	Health Education and Cultural & Linguistic	Primary author
Danielle Browning	Principal Program Manager	Health Equity, Cultural & Linguistic Program	Contributing author
Som Florendo	Program Manager	Clinical Operations Oversight	Staff Experience
Marilyn Milano	Principal Program Manager	Clinical Operations Oversight	Member and practitioner data

2025 Cultural and Linguistic Program Evaluation

Medi-Cal- San Diego County

August 2025

Production Date: August 2025

Table of Contents

Introduction

Blue Shield of California Promise Health Plan, inclusive of Medicaid products in Los Angeles and San Diego Counties, will be referred to as Blue Shield Promise for the remainder of this report. Blue Shield Promise is dedicated to advancing health equity, improving quality, and eliminating health care disparities and inequities across our member populations. To support this goal, Blue Shield Promise at least annually evaluates ongoing and completed culturally and linguistically appropriate services. This report will work in conjunction with the Blue Shield Promise Cultural and Linguistic Assessment and Disparities reports to improve the quality of our services for members.

Blue Shield Promise adheres to the Department of Health Care Services mandates, national culturally and linguistically appropriate services guidance from Health and Human Services (HHS), and accreditation standards from the National Committee for Quality Assurance (NCQA), collectively known as cultural and linguistic requirements. These fundamental requirements are used to develop policies and procedures, member and provider assessments, a retrospective evaluation of the overall Cultural and Linguistic Program, and strategic decisions for intervention. To further promote diversity, equity, and inclusion, Blue Shield Promise uses the NCQA Health Equity Accreditation framework to drive continuous improvement in health equity. Blue Shield Promise requires contracted delegates, vendors, independent physician associations, preferred provider groups, practitioners, ancillary providers, pharmacies, and hospitals (collectively, "Plan Administrators") to participate in and comply with Cultural and Linguistic Program policies and procedures.

Blue Shield Promise's Cultural and Linguistic team and Health Equity team monitor and evaluate Blue Shield's culturally and linguistically appropriate services. This report undergoes review and approval by two key committees: The Community Advisory Committee (CAC) and the Health Equity Oversight Committee (HEOC).

- The Community Advisory Committee is comprised of current Blue Shield Promise members and local community groups who provide feedback and support the identification and prioritization of opportunities for improvement.
- The Health Equity Oversight Committee is responsible for monitoring and approving this report, ensuing adherence to equity standards.

Evaluation Methodology

A comprehensive evaluation is in place to ensure Blue Shield Promise is compliant with all cultural and linguistic requirements, including those from our regulators and NCQA. Blue Shield Promise has set goals for each key

component and uses these goals to evaluate culturally and linguistically appropriate activities provided by Blue Shield Promise, delegates and vendors, and contracted providers. Blue Shield Promise uses a comprehensive approach to collect and analyze data from members, providers, and staff. This data is utilized to evaluate both completed and ongoing cultural and linguistically appropriate activities. Evaluation is done on an ongoing basis and includes year-over-year trends. The methodology includes the following key components:

This report uses calendar years 2023, 2024, and 2025 data. The year-over-year formula is: ((Most recent value – Previous value) / Previous value) × 100. Green totals indicate increases or, for grievances, positive decreases. Red shows decreases or, for grievances, negative increases. Black means no change, and a dash indicates either an infinite increase or both years being zero.

Member Population

1) Conducting regular assessment of the population to understand the cultural and linguistic needs of the community and to adjust network adequacy.

Member Population Goals	
Member Self-Reported Race and Ethnicity	Achieve 80% self-reported race and ethnicity.
Self-Reported Language	Achieve 75% in self-reported language data.
Self-Reported Gender Identity	Reach 20% self-reported gender identity by 2028.
Self-Reported Sexual Orientation	Reach 20% self-reported sexual orientation by 2028.

Blue Shield Promise conducts annual assessments of its member population to identify and address the evolving cultural and linguistic needs of members. This process involves the collection and analysis of both quantitative and qualitative data, with a particular emphasis on self-reported demographic and language preference information provided by members.

A cornerstone of the population assessment methodology is the proactive gathering of self-reported data during member enrollment and ongoing member interactions. Members are encouraged to voluntarily report race, ethnicity, primary language, and preferred written and spoken language through multiple touchpoints, including enrollment forms, Customer Service interactions, and targeted outreach efforts. To support quality improvement and

compliance, Blue Shield Promise has established measurable goals for the collection of self-reported demographic and language data.

Feedback from the population assessment is used to inform provider network development, staff training, and the design of culturally and linguistically appropriate interventions. By integrating self-reported data into ongoing evaluation cycles, Blue Shield Promise ensures that services remain responsive to the needs and preferences of its diverse member population.

Contracted Providers

2) Collaborating with contracted providers to ensure they meet the cultural and linguistic needs of the population.

Contracted Provider Goals	
Provider Languages	1 PCP (Family Medicine (General Medicine and Family Practice)), Internal Medicine, and Pediatrics) speaking a threshold language to 1,200 members speaking a threshold language.
	1 Specialist speaking a threshold language to 1,200 members speaking a threshold language
Provider Office Staff Languages	8% of provider office staff speak at least one threshold language.
Provider Race and Ethnicity	1 American Indian/Alaska Native practitioner to 600 American Indian/Alaska Native members.
	1 Asian practitioner to 700 Asian members.
	1 Black/African American practitioner to 900 Black/African American members.
	1 Hispanic/Latino practitioner to 3,400 Hispanic/Latino members.
	1 Middle Eastern/North African practitioner to 700 Middle Eastern/North African members.
	1 Native Hawaiian/Pacific Islander practitioner to 900 Native Hawaiian/Pacific Islander members.

	1 white practitioner to 700 white members.
	1 other race practitioner to 700 other race members.
Provider Training and Resources	100% providers complete the Advancing Health Equity training by 12/31/25 and at recredentialing thereafter.
Blue Shield is using the Ethnic / Cultural and Language Needs Standard to access if goal is met for PCP's. PCPs are defined as (Family Medicine (General Medicine and Family Practice), Internal Medicine, and Pediatrics). We are using the strictest standard for PCP's. For Specialties we are using the High-Volume Specialty Standard and applying ethnic/cultural and language standard for PCP.	

Blue Shield utilizes a systematic evaluation methodology to ensure that culturally and linguistically appropriate services are accessible for its diverse member population. The organization establishes quantifiable goals for key provider metrics, such as the ratio of practitioners who speak threshold languages to members requiring those languages and the representation of practitioners matching the racial, ethnic, and linguistic backgrounds of the populations served. For example, Blue Shield tracks the availability of primary care practitioners and specialists who can communicate in a threshold language, aiming for a standard of one provider for every 1,200 members needing language support. Additionally, the presence of provider office staff who speak at least one threshold language is monitored, with a target set at 8% representation.

To assess progress, Blue Shield collects and analyzes demographic and language data from both members and providers, comparing these figures to established benchmarks. Disparities in practitioner representation, for groups such as American Indian/Alaska Native, Asian, Black/African American, Hispanic/Latino, Middle Eastern/North African, and Native Hawaiian/Pacific Islander members, are identified by monitoring provider-to-member ratios.

Provider Training and Resources
Provider training materials help providers build cultural and linguistic skills through instruction on communication, language barriers, cultural respect, and patient-centered care.

Language Assistance Services and Nondiscrimination

3) Providing language assistance services to ensure effective communication and adhering to nondiscrimination policies.

Language Assistance Services and Nondiscrimination Goals

Member Cultural and Linguistic Grievances	Blue Shield has no threshold for cultural and linguistic grievances and will review all culturally and linguistically related grievances.
Member Experience	Achieve a 20% response rate for interpreter satisfaction survey.
	Achieve a 95% satisfaction rate for face-to-face interpreter services.
Bilingual Services	100% of bilingual staff who interact with members are assessed for their bilingual skills
Preferred Languages	Achieve 100% availability of interpreter requests for all languages.
Written Translation Requests	Meet 100% of written translation requests for all threshold languages.

Blue Shield Promise conducts comprehensive surveys and analyzes member grievance data to assess the effectiveness of language services provided. This data is benchmarked against established goals, and when goals are not achieved, a thorough barriers analysis is conducted to identify areas for improvement and develop targeted interventions. The methodologies for these surveys and member grievances are outlined below.

Member Cultural and Linguistic Grievances
Blue Shield Promise does not establish a grievance threshold for cultural and linguistic related grievances as we believe each grievance should be examined to obtain the highest level of understanding of members' needs and preferences. For this report, we will examine grievances related to members' experience with internal and external services.

Member Experience
Blue Shield Promise conducts surveys among members who have used over-the-phone or face-to-face interpreter services, including American Sign Language, to evaluate their satisfaction with these services. The purpose is to assess members' experiences with language support during health care interactions. Interpreter services are provided by our vendor, Language Line Solutions (Language Line). A printed survey with a self-addressed stamped envelope is mailed to members who used interpreter services at least once in the previous year, using the same language and interpretation method they utilized (i.e., telephone or in-person). These surveys were distributed during

the first quarter. The surveys were translated into Arabic, Armenian, Chinese, Farsi, Khmer (Cambodian), Korean, Russian, Spanish, Tagalog, Thai, and Vietnamese.

A small incentive (notebook) was provided to all members who returned their completed survey and provided us with their contact information. In addition, members were entered into a drawing for an additional incentive (duffle bag) item at the conclusion of the survey period.

Interpreter Satisfaction Surveys	Face to Face	Over the Phone
Total outreach	1,979	3,023
Response rate	4.5%	6.3%
Questions How satisfied are you with the interpreter services you received? Did the interpreter arrive on time? (for face-to-face interpreter appointments) Were you connected with an interpreter within one minute? (for over-the-phone interpreter appointments) Would you use an interpreter at your next doctor's appointment?		

Blue Shield Promise has established a goal to raise the response rate for both surveys to 20%. Furthermore, the organization is committed to attaining a 95% satisfaction rate for face-to-face interpreter services. Member feedback is essential in assessing whether modifications or improvements are necessary to the current contract or procedures for accessing interpreter services.

Language Assistance Services

Blue Shield Promise collects, stores, and retrieves members' preferred spoken and written language to ensure members receive the highest level of care and services available to support their healthcare journey. This data is stored in Blue Shield Promise membership systems and is securely maintained and accessed by approved personnel in compliance with their job duties. Member preferred language information is collected via a variety of pathways including member enrollment files, direct member collection from the member portal, and upon their request to update when speaking with Blue Shield Promise.

Additionally, Blue Shield Promise notifies individuals in languages spoken by one percent of the population or two-hundred eligible individuals, whichever is less, of the availability of no cost interpretation and translation services. Interpretation services are offered in 240+ languages and translation of member informing materials are provided in

the threshold languages other than English spoken by five percent of the population or a thousand eligible individual, whichever is less.

Blue Shield Promise's goal is to timely provide all members, prospective members, and members of the public with effective and respectful care in a manner compatible with their cultural health beliefs and practices and in their preferred language at all points of contact. Blue Shield Promise requires staff or contracted vendors who provide interpretation or translation services to demonstrate proficiency in health care terminology and concepts relevant to health care delivery in English and the target language. To examine the quality of language services we will analyze member linguistic grievances to determine member satisfaction level with the language services being offered.

Blue Shield Promise Staff

4) Training and supporting staff to deliver culturally and linguistically appropriate services.

Blue Shield Promise Staff Goals	
Staff Training: Advancing Health Equity	Aim to have 100% of required employees complete training annually.
Staff Training: Improving the Healthcare Experience of the Transgender, Gender Diverse or Intersex Community	Aim to have 100% of required employees complete the training every two years.
Staff Experience: Culturally and Linguistically Appropriate Services	Achieve 80% overall satisfaction based on staff experience surveys conducted annually.

Staff Training

Blue Shield provides an evidence-based health equity learning program and transgender, gender diverse and intersex (TGI) cultural competency training to all staff. In 2025, all staff with verbal or written contact with members were required to complete trainings titled Advancing Health Equity and Improving the Healthcare Experience for the Transgender, Gender Diverse or Intersex Community. The goal is for 100% of assigned staff to complete the trainings.

Identified member-facing departments include:

- Appeals and Grievances
- Enrollment and Retention
- Community Resource Center

- Communication Governance
- Customer Service
- Quality
- Health Education and Cultural and Linguistic
- Utilization Management
- Population Health Management (Case Management Children's Health Services, Social Services and Behavioral Health Case Management)

Staff Experience: Culturally and Linguistically Appropriate Services
The Blue Shield and Blue Shield Promise Employee Experience Survey, Staff Experience Using Language Services, was conducted via the Blue Shield internal Qualtrics platform from May 2025 to June 2025. The survey included fifteen (15) questions regarding Blue Shield and Blue Shield Promise staff experiences with language services offered by both internal bilingual employees and external vendors. The Clinical Quality Department facilitated this survey, distributing it through people leaders who manage member-facing staff. The product types/line of businesses included in this survey but not limited to:

- Blue Shield Promise
- Blue Shield of California
- Covered California/Exchange
- Commercial
- Medicare

Employees who received the survey were asked to provide feedback on their language service utilization.

Survey Timeframe: May 12, 2025, to June 6, 2025.

Survey Target Audience: Member-facing employees who may have used language services. The following departments were chosen to participate:

- Utilization Management
- Customer Care
- Appeals & Grievances

- Medical Care Solutions
- Broker Relations
- Claims
- Health Education and Cultural and Linguistic
- Population Health Management (Case Management Children's Health Services, Social Services and Behavioral Health Case Management)

Participation Rate: 189 member-facing employees completed the survey.

Compliance Monitoring

5) Regularly monitoring compliance of established goals to ensure continuous improvement.

Compliance Monitoring Goal	
Barriers and Process Improvement	100% of identified barriers related to culturally and linguistically appropriate services will be tracked.

Blue Shield Promise's evaluation methodology for culturally and linguistically appropriate services is built around systematic and measurable processes. The organization aligns all assessment activities with clearly defined goals. Progress is tracked by establishing annual and long-term benchmarks, identifying measurable indicators, and setting specific timelines for data collection and review.

Compliance is ensured by regularly monitoring adherence by tracking 100% of identified barriers related to culturally and linguistically appropriate services to identify areas for improvement and provide detailed compliance reports. This comprehensive approach allows Blue Shield Promise to evaluate the effectiveness of culturally and linguistically appropriate activities across all components, including those delivered by Blue Shield, its delegates, vendors, and contracted providers, ensuring ongoing progress and accountability.

Member Population

Member Population Goals	
Member Self-Reported Race and Ethnicity	Achieve 80% self-reported race and ethnicity.

Self-Reported Language	Achieve 75% in self-reported language data.
Self-Reported Gender Identity	Achieve 20% self-reported gender identity by 2028.
Self-Reported Sexual Orientation	Achieve 20% self-reported sexual orientation by 2028.

Blue Shield Promise strongly supports the collection of culture, race, ethnicity, language, sexual orientation, and gender identity data, recognizing that the best source of this data is the member. Blue Shield Promise collects member data using various internal methods, including but not limited to the enrollment application, online member portal, and Business Information Systems, such as those used at points of contact with Customer Service.

Blue Shield conducts an annual assessment of its member population, comparing the current year's data to that of the previous year. This evaluation includes comprehensive demographic information including race, ethnicity, language, sexual orientation, and gender identity for members. The data referenced was current as of August 2024 and August 2025.

Member Population			
	2024	2025	Year-over-Year
San Diego County	185,753	187,695	1.05%
Data Source: Tableau Member Race/Ethnicity Self-Reported Data (80 Percent) Report			

Blue Shield Member Population Evaluation
The year-over-year evaluation of the member population reveals a slight increase in population. In San Diego County membership grew by 1.05% increasing from 185,753 to 187,695. Overall, our member population increased by 1.19%.

Self-Reported Race and Ethnicity

Blue Shield Promise achieved an 80% completion rate for self-reported race and ethnicity data in 2024 and 2025. Blue Shield Promise is committed to activities that will help us sustain this achievement. This commitment highlights the importance of gathering accurate and comprehensive demographic information to better understand and serve the diverse needs of the member population.

Self-Reported Race and Ethnicity

Race & Ethnicity	San Diego		
	2024	2025	Year-over-year (%)
American Indian or Alaska Native	490	225	-54.08
Asian	11,028	3,383	-69.32
Black or African American	9,310	3,807	-59.11
Hispanic or Latino	66,966	133,930	100.00
Middle Eastern or North African	5	82	1540.00
Native Hawaiian or Other Pacific Islander	1,734	863	-50.23
Some other race	10	17,671	176,610.00
White	35,624	14,057	-60.54
Total Provided	134,320	174,018	29.55
Unknown	44,037	7,375	-83.25
Choose not to disclose (decline)	36	35	-2.78
No response	7,360	6,267	-14.85
Total Membership	185,753	187,695	1.05%

Data source: Tableau Member Race/Ethnicity Self-Reported Data (80 Percent) Report

Race & Ethnicity	San Diego		
	2024	2025	Year-over-year (%)
American Indian or Alaska Native	0.26%	0.12%	-53.85
Asian	5.94%	1.80%	-69.70

Race & Ethnicity	San Diego		
	2024	2025	Year-over-year (%)
Black or African American	5.01%	2.03%	-59.48
Hispanic or Latino	36.05%	71.36%	97.95
Middle Eastern or North African	0.27%	4.37%	1518.52
Native Hawaiian or Other Pacific Islander	0.93%	0.46%	-50.54
Some other race	4.93%	9.41%	90.87
White	19.18%	7.49%	-60.95
Total Provided	72.31%	92.71%	28.21
Unknown	23.71%	3.93%	-83.42
Choose not to disclose (decline)	0.02%	0.02%	-
No response	3.96%	0.02%	-99.49%
Total Membership	100%	100%	

Data source: Tableau Member Race/Ethnicity Self-Reported Data (80 Percent) Report

Self-reported race and ethnicity goal evaluation

Blue Shield Promise continues to surpass the 80% goal of member self-reported race and ethnicity with 93.59% of members reporting their race and ethnicity in 2025. There was a 10.98% increase from 477,999 in 2024 to 530,479 in 2025 in the number of members who self-reported their race and ethnicity. San Diego County experienced the greatest increase at 29.55% in self-reported race and ethnicity.

Additionally, the year-over-year analysis reveals notable shifts in demographic representation. There were significant decreases in several race and ethnicity categories. American Indian or Alaska Native membership decreased by 56.10%, Asian by 68.08%, Black or African American by 66.89%, Native Hawaiian or Other Pacific

Islander by 59.31% and white by 59.15%. Groups that experienced an increase were Hispanic or Latino growing by 37.03% and Middle Eastern or North African dramatically growing by 1087.50%. However, the absolute value for this group remained small at 95. The “Some Other Race” category grew considerably by 164.7%. Meanwhile, the “Choose Not to Disclose” category increased by 28.57%% and “Unknown” decreased 28.57%. The "No Response" category saw a significant decrease of 99.54%, indicating a substantial improvement in response rates.

The percentage breakdown further illustrates these trends. Hispanic or Latino members rose from 56.77% to 76.88% of the self-reporting population, marking a 35.42% increase, with San Diego County membership experiencing the greatest increase at 97.95%. Middle Eastern or North African members, in both counties, significantly increased from 0.14% to 1.68% representing a 1100% increase. All other groups experienced a significant drop, which aligns to the self-reported count decreases.

These data trends highlight both the progress made in encouraging self-reporting among members and the evolving demographic landscape within the population. The significant increases in certain groups, alongside the notable reduction in non-responses, reflect ongoing efforts to better understand and serve the diverse needs of the community. These insights will continue to guide strategies for equity and inclusion.

Preferred and Threshold Languages

Blue Shield collects, stores, and retrieves members preferred spoken and written language to facilitate access to appropriate services and support their healthcare journey. This data is securely maintained within the Blue Shield enrollment systems, such as Facets and Radiant One, and is accessed only by authorized personnel in accordance with their job responsibilities.

Member language preferences are gathered through various channels, including enrollment forms, the member portal, and interactions with customer service representatives. Blue Shield also ensures that members and providers are informed about the availability of a no-cost interpreter and translation services, along with clear guidance on how to access these services.

Assessment data is used to determine all preferred languages spoken by one percent of the population or 200 eligible members, whichever is less, up to a maximum of 15 languages. All languages spoken by 5% of the population or by 1,000 people, whichever is less, are identified as threshold languages.

Languages	San Diego Count Preferred and Threshold Languages					
	2024 Spoken	2025 Spoken	Year-Over-year (%)	2024 Written	2025 Written	Year-over-year (%)
Arabic	803	833	3.74	798	829	3.88
Chinese simplified	NA	NA	NA	453	498	9.93
Chinese traditional	NA	NA	NA	178	226	26.97
English	141,165	141,559	0.28	141,348	141,804	0.32
Farsi	484	604	24.79	477	595	24.74
Korean	309	338	9.39	308	335	8.77
Mandarin	552	600	8.70	NA	NA	NA
Russian	1,171	1,198	2.31	1,151	1,185	2.95%
Spanish	37,361	39,557	5.88	37,323	39,522	5.89
Tagalog	1,405	1,390	-1.07	1,342	1,333	-0.67
Vietnamese	1,267	1,264	-0.24	1,259	1,260	0.08
No data available	3	0	-	6	0	-
Total Membership	374,377	379,104	1.26	374,377	379,104	1.26

Tableau Member Preferred Spoken and Written Language Report
Yellow indicates a threshold language, languages preferred by at least 1,000 members.

Languages	San Diego Percent Preferred and Threshold Languages					
	2024 Spoken	2025 Spoken	Year-Over-year (0%)	2024 Written	2025 Written	Year-over-year (0%)
Arabic	0.43%	0.44%	2.33	0.43%	0.44%	2.33
Chinese simplified	NA	NA	NA	0.25%	0.27%	8.00
Chinese traditional	NA	NA	NA	0.10%	0.12%	20.00
English	76.37%	75.42%	-1.24	76.47%	75.55%	-1.20
Farsi	0.26%	0.32%	23.08	0.26%	0.32%	23.08
Korean	0.17%	0.18%	5.88	0.17%	0.18%	5.88
Mandarin	0.30%	0.32%	6.67	NA	NA	NA
Russian	0.63%	0.64%	1.59	0.62%	0.63%	1.61
Spanish	20.21%	21.08%	4.30	20.19%	21.06%	4.31
Tagalog	0.76%	0.74%	-2.63	0.73%	0.71%	-2.74
Vietnamese	0.69%	0.67%	-2.90	0.68%	0.67%	-1.47
Total Membership	100%	100%	0	100%	100%	0

Tableau Member Preferred Spoken and Written Language Report
Yellow indicates a threshold language, language preferred by at least 1,000 members or by at least 5% of the population.

Preferred and threshold language evaluation

Blue Shield Promise surpasses the goal of having 75% self-reported data. As noted in the preceding language data tables, the preferred spoken languages include English, Spanish, Arabic, Armenian (LA County only), Cantonese (LA County only), Farsi, Khmer (LA County only), Korean, Mandarin, Russian, Spanish, Tagalog, Thai (LA County only) and Vietnamese. English and Spanish continue to be the predominant language preference for spoken and written languages in both counties. There was a slight decrease in English spoken and written selections and a small

increase in Spanish selection in both counties. Noteworthy year-over-year observations include a significant increase in several of the other languages.

In San Diego County, the languages which saw a significant increase include Farsi, which experienced a 23.08% increase in both spoken and written selection, written Chinese Traditional with a 20% increase and written Chinese Simplified with an 8% increase. Tagalog and Vietnamese both saw a slight decrease in selection in both spoken and written.

In summary, language preference trends across San Diego County reveal both the enduring strength of English and Spanish and the growing significance of other languages within the member population. While English and Spanish remain firmly established as the predominant and threshold languages, notable rises in languages such as Armenian, Cantonese, Farsi, and Chinese spoken and written languages underscore the region's increasing linguistic diversity. These trends highlight the need for ongoing attention to evolving language needs, ensuring accessible and culturally responsive communication for all members as populations shift and diversify.

Gender Identity and Sexual Orientation

Sex Assigned at Birth

Sex Assigned at Birth	San Diego		
	2024	2025	Year-over-year (%)
Sex Assigned at Birth: Male	90,045	91,422	1.53
Sex Assigned at Birth: Female	95,712	96,273	0.59
Sex Assigned at Birth: Unknown	1	0	-100.00
Choose not to disclose (Decline)	8	0	-100.00
No Response	0	0	-
Total Self-Reported	185,758	187,695	1.04
Total Who Responded	185,766	187,695	1.04

Total Membership	185,766	187,695	1.04
Data source: Tableau Member Sex Assigned at Birth Report			

Sex Assigned at Birth	San Diego		
	2024	2025	Year-over-year (%)
Sex Assigned at Birth: Male	48.47%	48.71%	0.50
Sex Assigned at Birth: Female	51.52%	51.29%	-0.45
Sex Assigned at Birth: Unknown	0.00%	0.00%	-
Choose not to disclose (Decline)	0.00%	0.00%	-
No Response	0.00%	0.00%	-
Total Self-Reported	100.00%	100.00%	0
Total Who Responded	100.00%	100.00%	0
Data source: Tableau Member Sex Assigned at Birth Report			

Gender Identity

Gender Identity	San Diego		
	2024	2025	Year-over-year (%)
Male	725	1,045	44.14
Female	950	1,304	37.26
Non-Binary	38	48	26.32
Transgender Male	16	20	25.00
Transgender Female	28	26	-7.14
Genderqueer	10	10	0.00
Other	5	4	-20.00
Choose not to disclose (Decline)	0	0	-
No Response	183,987	185,224	0.67
Total Self-Reported	1,772	2,457	38.66
Total Who Responded	1,772	2,457	38.66
Total Membership	185,766	187,695	1.04
Data source: Tableau Member Gender Identity Report			

Gender Identity	San Diego		
	2024	2025	Year-over-year (%)
Male	0.39%	0.56%	43.59
Female	0.51%	0.69%	35.29
Non-Binary	0.02%	0.03%	50.00
Transgender Male	0.01%	0.01%	0.00
Transgender Female	0.02%	0.01%	-50.00
Genderqueer	0.01%	0.01%	0.00
Other	0.00%	0.00%	-
Choose not to disclose (Decline)	0.00%	0.00%	-
No Response	99.04%	98.68%	-0.36
Total Self-Reported	0.95%	1.31%	37.89
Data source: Tableau Member Gender Identity Report			

Pronouns

Pronouns	San Diego		
	2024	2025	Year-over-year (%)
He/Him	332	528	59.04
She/Her	398	649	63.07
They/Them	65	69	6.15
Other	12	18	50.00
Chose not to disclose (Decline)	36	53	47.22
No Response	184,975	186,428	0.79
Total Self-Reported	758	1,216	60.42
Total Who Responded	791	1,267	60.18
Total Membership	185,766	187,695	1.04
Data source: Tableau Member Pronouns Report			

Pronouns	San Diego		
	2024	2025	Year-over-year (%)

He/Him	0.18%	0.28%	55.56
She/Her	0.21%	0.35%	66.67
They/Them	0.03%	0.04%	33.33
Other	0.01%	0.01%	0.00
Chose not to disclose (Decline)	0.02%	0.03%	50.00
No Response	99.57%	99.32%	-0.25
Total Self-Reported	0.41%	0.65%	58.54
Total Who Responded	0.43%	0.68%	58.14
Data source: Tableau Member Pronouns Report			

Sexual Orientation

Sexual Orientation	San Diego		
	2024	2025	Year-over-year (%)
Lesbian	23	21	-8.70
Gay	59	74	25.42
Homosexual (Gay + Lesbian)	82	95	15.85
Heterosexual	555	787	41.80
Bisexual	66	93	40.91
Queer	33	28	-15.15
Other	49	44	-10.20
Don't Know	25	23	-8.00
Choose not to Disclose (Decline)	58	82	41.38
Total Self-Reported	810	1070	32.10
Total Membership	185,766	187,695	1.04
Data source: Tableau Member Sexual Orientation Report			

Sexual Orientation	San Diego		
	2024	2025	Year-over-year (%)
Lesbian	0.01%	0.01%	0
Gay	0.03%	0.04%	33.33

Homosexual (Gay + Lesbian)	0.04%	0.05%	25.00
Heterosexual	0.30%	0.42%	40.00
Bisexual	0.04%	0.05%	25.00
Queer	0.02%	0.01%	-50.00
Other	0.03%	0.02%	-33.33
Don't Know	0.01%	0.01%	0
Total Self-Reported	0.44%	0.56%	27.27%
Choose not to Disclose (Decline)	0.03%	0.04%	33.33
Data source: Tableau Member Sexual Orientation Report			

Self-reported gender identity and sexual orientation and evaluation

The percentage of members who self-reported their gender identity and sexual orientation improved by 28.24% and 44.44%, respectively, although self-reporting of gender identity and sexual orientation remains very low. Although 100% of members reported their sex assigned at birth, only 1% reported their gender identity and less than 1% reported their pronouns and sexual orientation. A notable improvement also occurred in the number of members who self-reported their pronouns resulting in a 69.01% (from 1,510 to 2,552) surge in 2025.

In 2025, our total membership is almost evenly split between sexes, with 46.53% reporting being assigned male at birth and 53.47% reporting being assigned female at birth. Of those reporting their gender identity, the majority (6,012) self-identified with traditional gender categories. However, there were notable increases from 2024 in the number of members who self-identified as non-binary (90), a 34.55% increase, transgender male (38), a 35.71% increase, transgender female (44), a 7.32% increase, and genderqueer (5) a 6.25% increase. Of the members who reported their pronouns, the "she/her" selection increased by 68.37%, the "he/him" increased by 70.17% while the "they/them" selection increased by 24.27%. Sexual orientation self-reporting revealed a 50.09% increase in the members who identified as heterosexual, a 33.94% increase in the number of members who identified as bisexual and a 25.74% increase in members who identified as gay. There was a small decrease of 7.69% in the members who identified as lesbian.

The data reveals both encouraging progress and persistent challenges in capturing the diverse identities and experiences of our membership. While self-reporting rates for gender identity, sexual orientation and pronouns have shown increases, overall disclosure remains low, highlighting a continued need for trust-building and outreach. The

growing representation of non-binary, transgender, and genderqueer identities, alongside notable changes in pronoun reporting, illustrates evolving member openness and the importance of inclusive data practices. As the demographic profile of our membership becomes more nuanced, we are better equipped to address disparities, tailor services, and foster a more welcoming environment for all members. Continued efforts are necessary to further support self-identification and achieve 20% self-reporting of gender identity and sexual orientation.

Practitioner Network Cultural Responsiveness

Contracted Provider Goals	
Provider Languages	1 PCP (Family Medicine (General Medicine and Family Practice)), Internal Medicine, and Pediatrics) speaking a threshold language to 1,200 members speaking a threshold language.
	1 Specialist speaking a threshold language to 1,200 members speaking a threshold language
Provider Office Staff Languages	8% of provider office staff speak at least one threshold language.
Provider Race and Ethnicity	1 American Indian/Alaska Native practitioner to 600 American Indian/Alaska Native members.
	1 Asian practitioner to 700 Asian members.
	1 Black/African American practitioner to 900 Black/African American members.
	1 Hispanic/Latino practitioner to 3,400 Hispanic/Latino members.
	1 Middle Eastern/North African practitioner to 700 Middle Eastern/North African members.
	1 Native Hawaiian/Pacific Islander practitioner to 900 Native Hawaiian/Pacific Islander members.
	1 white practitioner to 700 white members.
	1 other race practitioner to 700 other race members.
Provider Training and Resources	100% providers complete the Advancing Health Equity training by 12/31/25 and at recredentialing thereafter.

Blue Shield is using the Ethnic / Cultural and Language Needs Standard to access if goal is met for PCP's. PCPs are defined as (Family Medicine (General Medicine and Family Practice), Internal Medicine, and Pediatrics). We are using the strictest standard for PCP's. For Specialties we are using the High-Volume Specialty Standard and applying ethnic/cultural and language standard for PCP.

Practitioner Race and Ethnicity

Blue Shield Promise assesses member demographics against in-network providers to ensure members' cultural, ethnic, racial and linguistic needs are met, and identify improvement areas. Providers can voluntarily share their race and ethnicity data, and Blue Shield encourages this self-reporting, as it is not mandatory in California. Blue Shield Promise's searchable provider directory allows members to filter search results by the provider's gender, race, and spoken languages. The search results display the information available for each provider profile.

Improved data collection methods will promote prosperous and robust data in the future, which will help Blue Shield Promise better assess the needs of member-to-provider population. In alignment with the updated March 2024 OMB Statistical Policy Directive (SPD) Number 15 regulation, Blue Shield Promise added the race option, Middle Eastern/North African in both the member and provider portal. The tables below demonstrate the current race and ethnicity data for Blue Shield members and providers.

Race and Ethnicities for Providers

Race & Ethnicity	San Diego		
	2024	2025	Year-over-year (%)
American Indian or Alaska Native	0	3	-
Asian	48	52	8.33
Black or African American	22	39	77.27
Hispanic or Latino	61	77	26.23
Middle Eastern or North African	0	0	-
Native Hawaiian or Other Pacific Islander	0	2	0
Some other race	10	17	70.00
White	160	237	48.13

Data source: Tableau Member Race/Ethnicity Self-Reported Data (80 Percent) Report

Comparison of Member to Practitioner Race and Ethnicity (self-reported)

Race and Ethnicity	San Diego County							
	Count			Percent			Ratio	
	2024	2025	Y-o-Y (%)	2024	2025	Y-o-Y (%)	2024	2025
Member: Hispanic or Latino	66,966	133,930	100.00	36.05%	71.36%	97.95	1:1,099	1:1,740
Provider: Hispanic or Latino	61	77	26.23	0.43%	0.48%	11.63		
Member: Black or African American	9,310	3,807	-59.11	5.01%	2.03%	-59.48	1:424	1:99
Provider: Black or African American	22	39	77.27	0.15%	0.24%	60.00		
Member: Native Hawaiian or Other Pacific Islander	1,734	863	-50.23	0.93%	0.46%	-50.54	-	1:433
Provider: Native Hawaiian or Other Pacific Islander	0	2	-	0.00%	0.01%	-		
Member: white	35,624	14,057	-60.54	19.18%	7.49%	-60.95	1:224	1:60
Provider: white	160	237	48.13	1.12%	1.48%	32.14		
Member: Asian	11,028	3,383	-69.32	5.94%	1.80%	-69.70	1:231	1:66
Provider: Asian	48	52	8.33	0.34%	0.32%	-5.88		
Member: American Indian or Alaska Native	490	225	-54.08	0.26%	0.12%	-53.85	-	1:76
Provider: American Indian or Alaska Native	0	3	-	0.00%	0.02%	-		

Race and Ethnicity	San Diego County							
	Count			Percent			Ratio	
	2024	2025	Y-o-Y (%)	2024	2025	Y-o-Y (%)	2024	2025
Members: Middle Eastern or North African	5	82	1540.00	0.27%	4.37%	1518.52	-	-
Provider: Middle Eastern or North African	0	0	-	0.00%	0.00%	-		
Member: Some other race	9,163	17,671	92.85	4.93%	9.41%	90.87	1:917	1:1,040
Provider: Some other race	10	17	70.00	0.07%	0.11%	57.14		
Member: Sum of all self-reported	134,320	174,018	29.55	72.31%	92.71%	28.21		
Provider: Sum of all self-reported	240	350	45.83	1.68%	2.18%	29.76		
Member: Unknown	44,037	7,375	-83.25	23.71%	3.93%	-83.42		
Provider: Unknown	115	114	-0.87	0.81%	0.71%	-12.35		
Member: Choose not to disclose "Decline"	36	35	-2.78	0.02%	0.02%	0.00		
Provider: Choose not to disclose "Decline"	0	0	-	0.00%	0.00%	-		
Member: Who did NOT RESPOND "No Response"	7,360	6,267	-14.85	3.96%	3.34%	-15.66		

Race and Ethnicity	San Diego County							
	Count			Percent			Ratio	
	2024	2025	Y-o-Y (%)	2024	2025	Y-o-Y (%)	2024	2025
Provider: Who did NOT RESPOND "No Response"	13,843	15,486	11.87	97.08%	96.62%	-0.47		
Member: Sum of "Unknown" and "Decline"	13,781	7,410	-46.23	3.68%	3.95%	7.34		
Provider: Sum of "Unknown" and "Decline"	548	114	-79.20	2.24%	0.71%	-68.30		
Total Membership	374,377	187,695	-49.86	66.84%	33.11%	-50.46		
Total Providers	24,514	16,027	-34.62	74.23%	38.39%	-48.28		
Data source: Tableau Member to Provider Combined Race/Ethnicity Report								

Race and ethnicities for providers evaluation

The data highlights the representation of providers by race and ethnicity based on self-reported data. San Diego County experienced notable increases in the number of self-reported providers across most racial and ethnic groups from 2024 to 2025. However, self-reporting remains low with only 6% of practitioners reporting a race and ethnicity. This year there were four practitioners in San Diego County who self-reported as American Indian or Alaska Native, which was a marked increase from none in 2024. Another notable increase occurred in the number of providers who self-reported their race and ethnicity as Black or African American, with both counties experiencing about 50% increase. Additionally, in San Diego County, the number of practitioners who self-reported as some other race showed a marked increase of 70%, from 10 to 17. The total number of Asian practitioners increased by 28.29%, from 251 to 322. Hispanic or Latino practitioners increased by 29.62%, from 260 to 337. The number of white practitioners also increased by 36.78%, from 522 to 714. The number of Native Hawaiian or Other Pacific Islander practitioners increased by 25.00%, from 4 to 5. In 2025, the overall majority of practitioners (714) self-reported their race and ethnicity as white.

Most of the member-to-practitioner ratios are significantly better than our stated goals and have significantly improved year-over-year. In San Diego County, the current ratio is 1:66, which is drastic drop from 1:213 in 2024. Similarly, in San Diego the ratio is 1:76, surpassing the goal of 1:600. In contrast, the highest member to practitioner ratio is seen for the Hispanic or Latino population at 1:1,740 in San Diego County. These ratios increased from 1:1,163 and 1,099, respectively. Although these ratios meet the set goal of 1:3,400, these findings may underscore persistent gaps in certain populations. Further, ratios for Middle Eastern or North African (in both counties) and for some other race in San Diego County did not meet the goal of 1:700.

Low rates of self-reporting among practitioners complicate efforts to accurately evaluate diversity and address potential gaps. This limited data may mask additional disparities or improvements within the provider network. The overall trends point to areas of progress, such as Black or African American representation, but also highlight pressing needs, especially in building a more representative network for Hispanic or Latino members. The year-over-year evaluation thus emphasizes both the importance and the urgency of continued improvements in data collection, transparency, and diversity initiatives to serve California's increasingly diverse population.

Practitioner and Office Staff Languages

This comprehensive evaluation will provide insights into the linguistic capabilities of practitioners and their office staff, highlighting areas for improvement where necessary. It will allow Blue Shield Promise to determine if there is a need to expand our provider network offerings to members to increase the quality of services offered.

To accurately assess whether the language services meet members' preferences and requirements, Blue Shield assessed members preferred spoken and written languages. This assessment covered languages spoken by at least 1% of the population or 200 eligible individuals, whichever is less. Threshold languages were also identified, these are defined by any language other than English spoken by 5% of the population or by 1,000 individuals, whichever is less.

Furthermore, Blue Shield analyzed the network by specialty type to ensure providers are meeting the needs and preferences of Blue Shield members to determine if network improvements can be made. The following specialties were assessed by threshold languages: pediatrics, family practice, cardiology, gastroenterology, and obstetrics/gynecology (OB/GYN).

Comparison of Member Preferred and Threshold Languages to Practitioner Languages

Language		San Diego			
		Count	%	Ratio	1:1200 Goal Met
English	Member	141,559	75.55%	1:28	Yes
	Provider	5,155	32.91%		
Spanish	Member	39,558	21.11%	1:14	Yes
	Provider	2,959	18.89%		
Mandarin	Member	Not a threshold language			
	Provider				
Russian	Member	1,198	0.64%	1:12	Yes
	Provider	112	0.72%		
Vietnamese	Member	1,264	0.67%	1:7	Yes
	Provider	214	1.37%		
Armenian	Member	Not a threshold language			
	Provider				
Tagalog	Member	1,390	0.74%	1:7	Yes
	Provider	247	1.58%		
Farsi	Member	Not a threshold language			
	Provider				
Cantonese	Member	Not a threshold language			
	Provider				
Korean	Member	Not a threshold language			
	Provider				

Data source: Practitioner to Member Spoken Language Threshold with Ratio Report

2024 Comparison of Member Preferred and Threshold Languages to Practitioner Languages

Language	San Diego					Did we meet the standard of 1:1,200 (1 PCP:1,200 members)
	Count		Percent		Ratio	
	Member	Provider	Member	Provider		
English	141,165	4,875	76.84%	35.06%	1:30	Yes

Spanish	37,361	2,332	20.34%	16.77%	1:17	Yes
Mandarin	552	162	0.30%	1.17%	1:4	Yes
Russian	1,171	102	0.64%	0.73%	1:12	Yes
Vietnamese	1,267	157	0.69%	1.13%	1:9	Yes
Armenian	NA	NA	NA	NA	NA	Yes
Tagalog	1,405	193	0.76%	1.39%	1:8	Yes
Korean	NA	NA	NA	NA	NA	Yes
Cantonese	NA	NA	NA	NA	NA	Yes
Total	184,851	14,186	100.00%	100.00%	1:14	Yes

Comparison of member preferred and threshold languages to practitioner languages evaluation

A comparative analysis of member and provider language data from 2024 to 2025 reveals important trends in both practitioner coverage and preferred language comparison. English remains the most common preferred language among members, comprising 75.55% in San Diego, with provider ratios well within the 1:1,200 goal. Spanish follows as the second most common language 21.11% in San Diego, also meeting provider ratio goals in both regions. Other threshold languages, including Vietnamese and Tagalog experienced a decrease in their provider ratio.

Specialty Provider to Member Language Ratio

2025 Specialty Provider to Member Language Ratio							
Language		Provider to Member Ratio Pediatric (Pediatric Members <18)	Provider to Member Ratio Family Practice	Provider to Member Ratio Internal Medicine	Provider to Member Ratio Cardiology	Provider to Member Ratio Gastroenterology	Provider to Member Ratio OB/GYN
San Diego	English	1:67	1:448	1:275	1:1,707	1:3,933	1:694
	Spanish	1:47	1:131	1:160	1:880	1:2,199	1:319
	Russian	1:30	1:134	1:134	1:241	1:1,199	1:200
	Vietnamese	1:13	1:71	1:36	1:182	NA	1:126

	Tagalog	1:6	1:61	1:44	1:349	NA	1:348

Data source: Tableau Practitioner Specialty to Member Spoken Language Ratio Report

2024 Specialty Provider to Member Language Ratio- San Diego County							
	Language	Provider to Member Ratio Pediatric (Pediatric Members <18)	Provider to Member Ratio Family Practice	Provider to Member Ratio Internal Medicine	Provider to Member Ratio Cardiology	Provider to Member Ratio Gastroenterology	Provider to Member Ratio OB/GYN
San Diego	English	1:71	1:436	1:244	1:3,638	1:3,019	1:663
	Spanish	1:42	1:120	1:156	1:1,568	1:1,881	1:263
	Russian	1:40	1:108	1:70	1:1,178	1:1,178	1:196
	Vietnamese	1:20	1:68	1:39	1:634	NA	1:127
	Tagalog	1:8	1:65	1:45	1:1,417	NA	1:283
	Grand Total	1:80	1:379	1:260	1:3,313	1:3,501	1:697

Examining the provider-to-member language ratios reveals notable differences in linguistic accessibility across specialties. In San Diego, there was a shift in the previously identified gaps for language threshold with cardiology (Spanish and Tagalog) ratios meeting the 1:1,200 threshold. Support for these two languages significantly increased in 2025 with the ratio for Spanish-speaking cardiologist to Spanish-speaking members dropping to 1:880 and Tagalog 1:349. Conversely, the gaps continued in 2025 for gastroenterology (English and Spanish). Additional languages that did not meet the threshold goal for the gastroenterology specialty are Vietnamese and Tagalog. Neither of these languages have provider language support in the San Diego County network. It's also worth noting that the Russian gastroenterology ratio just met the goal at 1:1,199 increasing from 1:178 in 2024.

Ongoing assessment of provider-to-member language ratios highlights both progress and persistent challenges in meeting linguistic accessibility standards across specialties and counties. Continued focus on addressing identified gaps will be essential to ensure equitable language services for all members, supporting improved care and patient satisfaction in the years ahead.

Language Services Available Through Practices

Practice Language	San Diego	
	Count	%
Spanish	780	97.50%
Mandarin	234	29.25%
Vietnamese	285	35.63%
Korean	230	28.75%
English	220	27.50%
Russian	221	27.63%
Tagalog	233	29.13%
Cantonese	168	21.00%
Farsi	181	22.63%
Armenian	81	10.13%
Chinese	107	13.38%
Arabic	164	20.50%
Khmer	5	0.63%
French	109	13.63%
Hindi	87	10.88%
Yue Chinese	38	4.75%
Urdu	73	9.13%
Persian	14	1.75%
Portuguese	62	7.75%
Japanese	39	4.88%
German	33	4.13%
Hebrew	20	2.50%
Punjabi	27	3.38%
Thai	38	4.75%
Gujarati	19	2.38%
Italian	32	4.00%

Practice Language	San Diego	
	Count	%
Turkish	0	0.00%
Modern Greek	33	4.13%
Telugu	13	1.63%
Sign Language	27	3.38%
Greek	24	3.00%
Lithuanian	34	4.25%
Taiwanese	0	0.00%
Polish	21	2.63%
Romanian	7	0.88%
Burmese	0	0.00%
Bengali	3	0.38%
Kannada	8	1.00%
Latin	22	2.75%
Filipino	6	0.75%
Lao	18	2.25%
Tamil	5	0.63%
Marathi	9	1.13%
Swedish	9	1.13%
Kashmiri	0	0.00%
Nepali	0	0.00%
Ukrainian	6	0.75%
Latvian	11	1.38%
Pashto	11	1.38%
Danish	10	1.25%
Hungarian	5	0.63%
Chinese (Family)	0	0.00%
Hmong	5	0.63%
Faroese	3	0.38%

Practice Language	San Diego	
	Count	%
Ilocano	6	0.75%
Indonesian	1	0.13%
Kurdish	6	0.75%
Malay	0	0.00%
Bulgarian	5	0.63%
Estonian	5	0.63%
Fataleka	5	0.63%
Malayalam	2	0.25%
Samoan	0	0.00%
Dutch	0	0.00%
Sindhi	0	0.00%
Wu Chinese	0	0.00%
Chamorro	2	0.25%
Egyptian	2	0.25%
Norwegian	3	0.38%
Sinhala	0	0.00%
Somali	3	0.38%
Bosnian	0	0.00%
Chaldean Neo-Aramaic	2	0.25%
Croatian	0	0.00%
Czech	0	0.00%
Hindustani	0	0.00%
Ibo	0	0.00%
Macedonian	0	0.00%
Shanghainese	0	0.00%
Swahili	2	0.25%
Achinese	0	0.00%

Practice Language	San Diego	
	Count	%
Afrikaans	0	0.00%
Amharic	0	0.00%
Cambodian	0	0.00%
Flemish	0	0.00%
Hakka	0	0.00%
Iloko	0	0.00%
Mien	0	0.00%
Min Nan Chinese	0	0.00%
Serbian	0	0.00%
Serbo-Croatian	0	0.00%
Tigrinya	1	0.13%
Tongan	0	0.00%
Yiddish	0	0.00%
Assyrian	0	0.00%
Cebuano	0	0.00%
Fukienese	0	0.00%
Hausa	0	0.00%
Navajo	0	0.00%
South Indian	0	0.00%
Toishanese	0	0.00%
Yoruba	0	0.00%
Total	800	100.00%

Data source: Tableau Language Services Available Through the Practice Report

Red font indicates county threshold language.

Languages	San Diego		
	2024	2025	Year-over-Year (%)

Arabic	146	164	12.33
Armenian	65	81	24.62
Cantonese	147	168	14.29
English	137	220	60.58
Farsi	159	181	13.84
Khmer (Cambodian)	4	5	25.00
Korean	198	230	16.16
Mandarin	200	234	17.00
Russian	206	221	7.28
Spanish	713	780	9.40
Tagalog	195	233	19.49
Thai	37	38	2.70
Vietnamese	253	285	12.65
Data Source: Tableau report Language Services Available Through the Practice			

Languages	San Diego		
	2024	2025	Year-over-Year (%)
Arabic	19.92%	20.50%	2.91
Armenian	8.87%	10.13%	14.21
Cantonese	20.05%	21.00%	4.74
English	18.69%	27.50%	47.14
Farsi	21.69%	22.63%	4.33

Khmer (Cambodian)	0.55%	0.63%	14.55
Korean	27.01%	28.75%	6.44
Mandarin	27.29%	29.25%	7.18
Russian	28.10%	27.63%	-1.67
Spanish	97.27%	97.50%	0.24
Tagalog	26.60%	29.13%	9.51
Thai	5.05%	4.75%	-5.94
Vietnamese	34.52%	35.63%	3.22
Data Source: Tableau report Language Services Available Through the Practice			

Language services available through practices evaluation

Year-over-year evaluations of network office staff language capabilities indicate that both counties consistently surpass the 8% target for threshold languages. Spanish remains the most prevalent 97.50% in San Diego County reporting Spanish-speaking staff in 2025. Mandarin, Vietnamese, and Korean also significantly exceed the 8% threshold.

Notably, the prevalence of English as a reported spoken language is lower than anticipated, with only 27.50% in San Diego County reporting English-speaking staff. However, there was a notable 54.18% overall increase in offices reporting English capability in 2025. This lower count may be attributed to providers who, while reporting other languages, may inadvertently omit English. This issue was previously identified in our 2024 assessment and addressed in our workplan, potentially contributing to the recent increases.

Several languages showed modest year-over-year growth. In San Diego County, Arabic, Korean, and Mandarin rose by 3.59%, 2.55%, and 2.38%, respectively, while Farsi and Khmer experienced declines of 4.08% and 6.15%.

The network continues to provide comprehensive language service availability, meeting or exceeding requirements for all threshold languages. Continued attention is warranted for Thai and Khmer (Cambodian), though they will not

be included in the formal improvement plan as they are not classified as threshold languages. Ongoing monitoring will be maintained for these languages.

Provider Training and Resources

Blue Shield Promise is committed to ensuring that all members have access to quality health care and recognizes the importance of ensuring the provider network is equipped with tools needed to increase cultural awareness and provide culturally appropriate care for members. This information is available on the provider website and on the provider portal. Many of these training courses focus on health equity and cultural awareness and qualify for Continuing Medical Education (CME) credit. We included traffic information from 2022 and current data (when available) for insights in the table below.

Blue Shield Promise has transitioned from monitoring the number of providers who have completed general health equity and cultural awareness trainings to tracking completion of the new Advancing Health Equity training, as required by the Department of Health Care Services. This training covers topics such as implicit bias, culturally and linguistically appropriate practices, diversity, equity and inclusion, gender-affirming care, among others. The goal is for all providers to complete the training by 12/31/2025 and at each subsequent recredentialing.

Course Title and Link	Description	**Traffic**	**# of providers who received CME**
Reducing Inequalities in cesarean delivery: From awareness to action-webinar held 4/22/25 Recorded webinar (51 min) Presentation (PDF, 5 MB) (CME available)	Dr. Kelly O. Elmore, a board-certified OB/GYN, advances understanding of the disparities in cesarean deliveries, their health impacts, and strategies for improvement. *(new training as 2025)*	53 attendees; 27 views	8 as of 9/25/25. Enduring CME available until 5/13/26

Course Title and Link	Description	Traffic	# of providers who received CME
Care for Transgender/Nonbinary Patients held 10/18/23 Presentation (PDF, 4 MB) (CME available)	Barry K. Eisenberg, M.D. and Ilana Sherer, M.D., FAAP from the Palo Alto Medical Foundation/Sutter Health discuss and answer questions about what we can do to help improve healthcare experiences of transgender and nonbinary youth, adolescents, and adults.	179 attendees; 241 views	61
Addressing Cardiac Care Disparities for Better Patient Outcomes Recorded webinar (51 min) Presentation (PDF, 7 MB) (CME available)	Dr. Columbus Batiste, chief of cardiology at Kaiser Permanente Riverside and Moreno Valley Medical Centers addresses key health disparities in cardiac care and how to reduce their occurrence.	17 attendees; 107 views	19
Racism in America Recorded webinar (54 min) Presentation (PDF, 683 KB) (CME available)	Dr. Tina Sacks, Assistant Professor at UC Berkeley School of Social Welfare, and Dr. Lily Lamboy discuss the latest research in health inequities, share insights	86 attendees; 60 views	55

Course Title and Link	Description	Traffic	# of providers who received CME
	from patient grievances and identify ways to avoid them.		
What your Lesbian, Gay, Bisexual, Transgender, and Questioning patients would like you to know Presentation (PDF, 1.3 MB) (CME available)	This webinar covers practical guidelines and considerations for providing inclusive health care to your LGBT/Q patients. Topics include creating a welcoming environment for LGBT/Q patients, using nonjudgmental questions, and using language preferred by LGBT/Q patients.	2363	933 (not all were BSC providers)
Implicit Bias in Healthcare and What You Can Do About It	eLearning: This interactive module is a quick way for clinicians and office staff to recognize and mitigate implicit bias.	94 views as of 9/2022. Updated number not available	n/a
Addressing low health literacy - Improve patient outcomes without adding time Recorded webinar (59 min) Presentation (PDF, 885 KB)	Dr. Cliff Coleman, MD, MPH, a national expert in health literacy, presents communication best practices designed to improve patients' understanding while not	131	85

Course Title and Link	Description	Traffic	# of providers who received CME
	adding time to healthcare professionals' busy workloads.		
Improving health literacy with plain Language Health literacy eLearning	This 10-minute interactive module provides the information and tools you need to use plain language as part of good health literacy practice.	Not available	n/a
Physician's practical guide to culturally competent care A Physician's Practical Guide to Culturally Competent Care	Product of the Department of Health and Human Services Office of Minority Health (OHS), this training is a free online educational program that will equip you with the knowledge, skills and awareness to best serve the healthcare needs of patients regardless of their cultural or linguistic background.	Not available	n/a

Providers seeking to enhance their cultural and linguistic awareness and understanding will find a wealth of resources conveniently outlined within the Blue Shield Promise provider website. The information found on the website summarizes key cultural and linguistic requirements, but also guides practitioners toward valuable self-assessment tools, educational courses, and practical toolkits designed to meet the requirements of the Blue Shield

Promise Cultural and Linguistic Program. From continuing education opportunities and downloadable forms to multilingual support and guidelines for gender-inclusive care, the provider website serves as a comprehensive reference helping providers deliver equitable, culturally responsive healthcare to diverse patient populations.

Resource	Description	Website/Link
Educational Resources		
Blue Shield Provider Connection Learning resources	No cost courses covering topics ranging from bias to social determinants of health.	www.blueshieldca.com/en/provider/news-education/learning-resources Providers log in to access additional courses.
A Physician's Practical Guide to Culturally Competent Care	This course provides the knowledge and skills to serve patients of all cultural and linguistic backgrounds.	https://thinkculturalhealth.hhs.gov/education/physicians
U.S. Dept. of Health and Human Services, Office of Minority Health	Minority health resources.	www.minorityhealth.hhs.gov
Forms		
Blue Shield Multilingual Resources	Website in multiple languages, nondiscrimination notice and notice of language availability.	https://www.blueshieldca.com/en/bsp
2025 Cultural Awareness and Linguistic Resources	Compilation of resources, including links to training modules and information on how to access language assistance services.	https://www.blueshieldca.com/content/dam/bsca/en/promise/docs/BSC-Promise-Cultural-and-Linguistics-Resources.pdf
Downloadable Grievance Form	Grievance form in multiple languages	Medi-Cal appeals and grievance process | Blue Shield of CA Promise Health Plan
Member Forms	Notice of availability of language assistance services	https://www.blueshieldca.com/en/bsp/about-blue-shield-promise-

		health-plan/nondiscrimination-and-language-assistance-notice
Confidential Communications Request Forms	Multilingual request forms for confidential information	https://www.blueshieldca.com/en/bsp/about-blue-shield-promise-health-plan/confidential-communications

Provider training and resources evaluation

Blue Shield Promise supports cultural and linguistic awareness within its provider network through diverse educational resources, including training modules on transgender care, health disparities, implicit bias, and health literacy—many of which offer Continuing Medical Education credits. These easily accessible courses help providers stay current and foster equitable, inclusive care.

The provider network also has access to downloadable forms and links to national platforms, with resources available in multiple languages to reduce barriers and support effective care for all members. These efforts build a knowledgeable and culturally sensitive network, enhancing patient experiences.

In 2025, all contracted providers are required to complete training on advancing health equity. The training covers a variety of topics, including implicit bias, culturally and linguistically appropriate practices, diversity, equity, and inclusion, gender-affirming care, and more. The training rolled out to 21,343 providers in March 2025. Providers were directed to the provider portal to complete the training. As of August 31, 2025, 10% of providers have completed the training. The Health Equity team continues to drive the efforts to increase provider completion of the training through communication with contracted medical groups, at Joint Operations Meetings, and providers.

Language Assistance Services and Nondiscrimination

Language Assistance Services and Nondiscrimination Goals	
Member Cultural and Linguistic Grievances	Blue Shield has no threshold for cultural and linguistic grievances and will review all culturally and linguistically related grievances.
Member Experience	Achieve a 20% response rate for interpreter satisfaction survey.

	Achieve a 95% satisfaction rate for face-to-face interpreter services.
Bilingual Services	100% of bilingual staff who interact with members are assessed for their bilingual skills
Preferred Languages	Achieve 100% availability of interpreter requests for all languages.
Written Translation Requests	Meet 100% of written translation requests for all threshold languages.

Blue Shield Promise conducts comprehensive surveys and analyzes member grievance data to assess the effectiveness of language services provided. This data is benchmarked against established goals, and when goals are not achieved, a thorough barriers analysis is conducted to identify areas for improvement and develop targeted interventions.

Member Experience

Cultural and Linguistic Grievances

Blue Shield Promise does not establish a grievance threshold for cultural and linguistic related grievances as we believe each grievance should be examined to obtain the highest level of understanding of members' needs and preferences. For this report, we will examine grievances related to members' experience with internal and external services.

Member Grievances- San Diego County

Grievances	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Year over year (%)
Linguistic	13	16	28	16	21	1	10	10	8	15	-55.56
Cultural	7	9	16	15	30	20	0	1	2	0	-70.13

Member grievances evaluation

Blue Shield Promise is committed to delivering the highest quality of services to our members. As such, analyzing member grievances is one of the pathways that is used to determine if our internal services are meeting members' needs and preferences.

Blue Shield Promise had a total of 159 linguistically related grievances in 2023 through Q1 2024 and a total of 192 culturally related grievances. In comparison, in 2024 through Q2 2025, there were a total of 87 grievances related to linguistic concerns and 62 related to cultural concerns.

A review of these grievances indicates ongoing challenges encountered by members, particularly concerning language services. Key issues include unfulfilled face-to-face interpreter appointments, limited availability of American Sign Language (ASL) interpreters, providers not utilizing telephonic interpretation when a language barrier is identified or when an in-person face-to-face interpreter appointment is cancelled, member assumptions that the provider will arrange face-to-face interpretation, and difficulties locating providers who speak member's preferred language. The majority of cultural grievances involve reports of perceived discrimination or unprofessional behavior by providers or their staff. These findings underscore persistent and significant barriers to language access and effective communication.

We continue to enhance provider and member education regarding the availability of interpreter services through targeted communications and by offering educational resources on our website. Additionally, we have solicited input from our Community Advisory Committee on how to inform members about these services and will explore the feasibility of implementing their recommendations.

Member Experience of Language Assistance Services During Healthcare and Health Plan Encounters

Blue Shield Promise conducted a survey to evaluate member satisfaction with interpreter services. The survey was administered from December 2024 to February 2025 and targeted 5,002 members who had utilized over-the-phone or face-to-face interpreters, including American Sign Language (ASL), within the previous year. It was translated into Arabic, Armenian, Chinese, Farsi, Khmer (Cambodian), Korean, Russian, Spanish, Tagalog, Thai, and Vietnamese. Members received the survey in the language and interpretation method corresponding to their service usage, along with a self-addressed, stamped envelope for return. The survey data was processed and analyzed by Blue Shield Promise staff.

Interpreter Services Satisfaction Survey

2024 survey (RY 2023)	Face to Face	Over the Phone
Total outreach	1,979	3,023
Response rate	4.6% (92)	6.3% (191)
How satisfied are you with the interpreter services you received?	94% reported being either satisfied or very satisfied	96% reported being either satisfied or very satisfied with their interpreter service.
Did the interpreter arrive on time?	91% reported that their interpreter was on time	
Were you connected with an interpreter within one minute?		84% were connected within one minute
Would you use an interpreter at your next doctor's appointment?	92% would use an interpreter in the future	96% would use an interpreter in the future

2023 survey (RY 2022)	Face to Face	Over the Phone
Total outreach	868	1,833
Response rate	10% (87)	3.4% (63)
How satisfied are you with the interpreter services you received?	93% reported being either satisfied or very satisfied	95% reported being either satisfied or very satisfied with their interpreter service.
Did the interpreter arrive on time?	92% reported that their interpreter was on time	
Would you use an interpreter at your next doctor's appointment?	93% would use an interpreter in the future	87% would use an interpreter in the future

According to 2024 survey data, 94% satisfaction rate for face-to-face interpreters and 96% satisfaction rate for over-the-phone interpreter services. A minority indicated neutral or dissatisfied responses. For face-to-face interpreters, 91% stated that the interpreter arrived on time, while 84% of those who used over-the-phone interpreters noted a connection within one minute. It is unclear whether members are considering connection time from their initial call or from the intake of their interpretation request. Overall, 92% of members expressed willingness

to use face-to-face interpreters in future appointments, and 96% of telephonic interpreter service users would consider using these services again

Although there was a slight increase from 2024 satisfaction levels, the goal was not met for face-to-face interpreter services at 94%. However, the satisfaction rate for over-the-phone interpreter services surpassed the 95% satisfaction goal.

To achieve a targeted combined survey response rate of 20%, Blue Shield Promise introduced an incentive for the 2024 surveys. Members who completed the survey and provided contact information received a small notebook and were entered into a raffle to win one of several duffle bags. However, despite offering this incentive, the overall response rate for 2024 was 5.6%, closely aligning with the 2023 rate of 5.5%. Enhancing survey participation remains a key area for improvement. Accordingly, Blue Shield Promise is evaluating new strategies to increase engagement, including implementing a digital survey delivery system through email and the online survey platform, Qualtrics, as well as transitioning the survey cadence from annually to quarterly.

On an ongoing basis, the Cultural and Linguistic department works collaboratively with the Appeals and Grievance (A&G) department and our contracted vendor to address any grievances related to dissatisfaction with interpreter services. Our objective is to thoroughly understand all concerns regarding member dissatisfaction and evaluate whether adjustments are needed with our vendor and protocols for accessing these services.

Utilization of Language Assistance Services

Blue Shield Promise aims to provide all members with effective and respectful care in a manner compatible with their cultural health beliefs and practices and in their preferred language at all points of contact. Blue Shield Promise notifies members of the availability of no cost interpretation and translation services. Interpretation services are offered in 240+ languages and translation of member informing materials and health education materials are provided in DHCS county-specific threshold languages, which encompass the threshold languages spoken by five percent of the population or a thousand eligible individuals, whichever is less.

Bilingual Services

Blue Shield Promise may employ staff with direct member contact who are bilingual and demonstrate proficiency in the non-English language by satisfying those standards and criteria created to evaluate bilingual skills competency.

An example of our Bilingual Fluency Assessment is listed below:

- The employee must achieve a level 4 score to be promoted to and skilled as a bilingual employee.
- If the employee achieves a level 3 score and wants to still be considered, the user that requested the test for the employee can request a *double-blind review* (a second expert will analyze the test to determine if the score should be confirmed or pushed to level nine).
- If the employee scores under level 4, they must wait 90 days before retaking the test which will be offered again at their manager's discretion.
- If the employee disconnects the call at any point, they can call back into it within 3 minutes to resume.
- Test MUST be completed within 15 days of requesting one.

Only those employees who meet the minimum proficiency standards can assist members with limited English proficiency.

Blue Shield Promise recognizes that bilingual employees can improve the member's experience and is actively recruiting employees proficient in languages other than English. If a bilingual employee is not available, the Blue Shield Promise representative will connect a three-way call with Language Line for an over-the-phone interpreter. Blue Shield Promise currently does not have a method for capturing the total number of members that use our bilingual employee services.

Each of these employees underwent an assessment prior to being allowed to speak with members in another language beyond English to ensure competency. Blue Shield utilizes The Language Line Academy to assess and certify our employees. Agent competencies are recertified every three years.

Bilingual Staff Assessment

Blue Shield Promise Department	# of Staff Assessed	
	2023	2024
Appeals & Grievances	3	0

Blue Shield Promise Department	# of Staff Assessed	
	2023	2024
Behavioral Health	4	Data not available
Community Engagement	11	Data not available
Health Education and Cultural & Linguistic	5	1
Case Management/Disease Management (Complex Case Management)	4	8
Customer Service	12	21
Pharmacy	3	Data not available
Clinical Quality	10	Data not available
Workforce Management	1	Data not available
Special Investigations Unit	3	Data not available
Social Services	0	Data not available
Claims	0	Data not available
Utilization Management	1	Data not available
Total Number of Bilingual Employees	57	30
Source: B**ilingual** Assessment Report 2021 to date		

Blue Shield Bilingual Services Evaluation

The bilingual skill assessment data for 2025 is incomplete. Available information indicates that 30 staff members underwent evaluation of their bilingual abilities. Departments participating in the assessment included Health Education and Cultural and Linguistic Services, Case Management, and Customer Service, with Customer Service accounting for 21 agents assessed.

This lack of comprehensive data highlights an area for improvement. Currently, department leaders coordinate directly with the assessment vendor to schedule bilingual staff assessments. While this approach streamlines scheduling, it poses challenges in maintaining accurate and current records within a centralized database.

Interpreter Services

A key component to assessing whether members have access to services in their preferred language is examining the utilization of interpreter services by members and providers. Members are informed, at least annually, about the availability of language services, including interpreter services, and how to access these services. Providers are also notified about the availability of these services on an annual basis.

Blue Shield Promise's interpretation vendor, Language Line Solutions (Language Line), provides over-the-phone and onsite interpretation in more than 240 languages, including American Sign Language (ASL), through qualified interpreters. Interpreter service utilization by members and providers is reviewed to help ensure that members have access to preferred services. At a minimum, annual notifications about available interpreter services are sent to members and providers.

The following tables show data on the use of interpreter services by members and providers. While the data distinguishes between member and provider requests, some overlap may occur if providers contact the Customer Service team instead of their dedicated line to request over-the-phone interpretation.

Member Over the Phone Interpreter Requests

Language	Count of Calls			% of Languages		
	2023	2024	Year-over-Year (%)	2023	2024	Year-over-Year (%)
Spanish	49,584	43,211	-12.85	67%	71.8%	7.16
Mandarin (Chinese)	6,146	3,523	-42.68	8.3%	5.9%	-28.92
Russian	3,225	2,865	-11.16	4.0%	4.8%	20.00
Vietnamese	2,219	1,923	-13.34	3.0%	3.2%	6.67
Haitian creole	1,081	991	-8.33	1.5%	1.6%	6.67

Language	Count of Calls			% of Languages		
	2023	2024	Year-over-Year (%)	2023	2024	Year-over-Year (%)
Farsi	934	938	0.43	1.3%	1.6%	23.08
Armenian	1,316	1,137	-13.60	1.8%	1.9%	5.56
Arabic	1,421	1,050	-26.11	2.0%	1.7%	-15.00
Korean	1,837	894	-51.33	2.5%	1.5%	-40.00
Cantonese (Chinese)	1,154	726	-37.09	1.6%	1.2%	-25.00
Tagalog	1,278	802	-37.25	1.7%	1.3%	-23.53
Khmer	565	493	-12.74	<1.0%	<1.0 %	-
Dari	656	198	-69.82	<1.0%	<1.0 %	-
Thai	276	192	-30.43	<1.0%	<1.0 %	-
Japanese	123	131	6.50	<1.0%	<1.0 %	-
Pashto	311	153	-50.80	<1.0%	<1.0 %	-
Turkish	105	91	-13.33	<1.0%	<1.0 %	-
Ukrainian	130	86	-33.85	<1.0%	<1.0 %	-
Portuguese	122	101	-17.21	<1.0%	<1.0 %	-
Punjabi	81	77	-4.94	<1.0%	<1.0 %	-
French	-	61	-	-	<1.0 %	-
Amharic	75	52	-30.67	<1.0%	<1.0 %	-
Laotian	203	89	-56.16	<1.0%	<1.0 %	-
Hindi	81	53	-34.57	<1.0%	<1.0 %	-
Bengali	71	54	-23.94	<1.0%	<1.0 %	-
Somali	97	30	-69.07	<1.0%	<1.0 %	-
Burmese	63	16	-74.60	<1.0%	<1.0 %	-
Swahili	55	37	-32.73	<1.0%	<1.0 %	-
Other languages (<50 calls)	476	353	-25.84	<1.0%	<1.0%	-

Language	Count of Calls			% of Languages		
	2023	2024	Year-over-Year (%)	2023	2024	Year-over-Year (%)
Total Calls	73,685	60,197	-18.30	100%	100%	-
Data Source: Language Line Services Usage Summary Report (2024)						

Interpreter services evaluation

In 2024, there was a total of 60,197 requests for over-the-phone interpreter service, which was a 18.30% decrease from 2023. The top five requested languages for telephonic interpreter services were Spanish at 71.8%, Mandarin at 5.9%, Russian at 4.8 %, Vietnamese at 3.2%, and Haitian Creole at 1.6%. Spanish and Russian experienced small declines of 12.85% and 11.16%, respectively. Mandarin saw a more significant decline (-42.68%) although it remained as the second most requested language, comprising almost 6% of the requests in 2024. Farsi saw a small increase of 0.43% and made up almost 2% of the requests in 2024. We will continue to monitor the number of requests to determine if we need to adjust our member and provider engagement strategies to ensure all are aware of these services.

Provider Requests

Language	Count of Calls			% of Languages		
	2023	2024	Year-over-Year (%)	2023	2024	Year-over-Year (%)
Spanish	660	15,950	2316.67	66.13%	72.3%	9.33
Haitian Creole	2	1,173	58550.00	0.20%	5.3%	2550.00
Dari	9	539	5888.89	0.90%	2.4%	166.67
Mandarin	184	499	171.20	18.44%	2.3%	-87.53
Russian	21	468	2128.57	2.10%	2.1%	0.00

Language	Count of Calls			% of Languages		
	2023	2024	Year-over-Year (%)	2023	2024	Year-over-Year (%)
Arabic	4	495	12275.00	0.40%	2.2%	450.00
Vietnamese	10	531	5210.00	1.00%	2.4%	140.00
Pashto	16	302	1787.50	1.60%	1.4%	-12.50
Tagalog	4	471	11675.00	0.40%	2.1%	425.00
Farsi	9	237	2533.33	0.90%	1.1%	22.22
Korean	22	230	945.45	2.20%	1.0%	-54.55
Cantonese	9	191	2022.22	0.90%	0.9%	0.00
Portuguese	2	88	4300.00	0.20%	0.4%	100.00
Thai	3	132	4300.00	0.30%	0.6%	100.00
Khmer	3	89	2866.67	0.30%	0.4%	33.33
Ukrainian	1	56	5500.00	0.10%	0.3%	200.00
Armenian	2	89	4350.00	0.20%	0.4%	100.00
Laotian	1	67	6600.00	0.10%	0.3%	200.00
Turkish	0	45	-	-	0.2%	-
French	2	33	1550.00	0.20%	0.1%	-50.00
Swahili	0	43	-	-	0.2%	-
Sudanese Arabic	0	28	-	-	0.1%	-
Somali	3	47	1466.67	0.30%	0.2%	-33.33
Tigrigna	0	33	-	-	0.1%	-
Amharic	8	33	312.50	0.80%	0.1%	-87.50
Punjabi	7	22	214.29	0.70%	0.1%	-85.71
Uzbek	0	10	-	-	0.0%	-
Burmese	1	27	2600.00	0.10%	0.1%	-
Karen	0	17	-	-	0.1%	-
Igbo	0	7	-	-	0.0%	-

Language	Count of Calls			% of Languages		
	2023	2024	Year-over-Year (%)	2023	2024	Year-over-Year (%)
Kinyarwanda	0	10	-	-	0.0%	-
Bengali	1	13	1200.00	0.10%	0.1%	-
Hebrew	0	10	-	-	0.0%	-
Japanese	5	8	60.00	0.50%	0.0%	-
Hindi	3	7	133.33	0.30%	0.0%	-
Hmong	1	3	200.00	0.01%	0.0%	-
Sorani	0	3	-	-	0.0%	-
Bulgarian	0	6	-	-	0.0%	-
Albanian	0	3	-	-	0.0%	-
Akateko	0	1	-	-	0.0%	-
Portuguese Brazilian	0	5	-	-	0.0%	-
Gujarati	0	6	-	-	0.0%	-
Fulani	0	1	-	-	0.0%	-
Italian	0	4	-	-	0.0%	-
Chaldean	0	2	-	-	0.0%	-
Samoan	0	4	-	-	0.0%	-
Polish	0	3	-	-	0.0%	-
Urdu	0	3	-	-	0.0%	-
Romanian	0	2	-	-	0.0%	-
Telugu	0	1	-	-	0.0%	-
Wolof	0	2	-	-	0.0%	-
Bahdini	0	1	-	-	0.0%	-
Marshallese	0	1	-	-	0.0%	-
Assyrian	0	1	-	-	0.0%	-

Language	Count of Calls			% of Languages		
	2023	2024	Year-over-Year (%)	2023	2024	Year-over-Year (%)
Chuukese	0	1	-	-	0.0%	-
Ilocano	0	1	-	-	0.0%	-
Krio	0	1	-	-	0.0%	-
Bosnian	0	1	-	-	0.0%	-
Karenni	0	1	-	-	0.0%	-
Lingala	0	1	-	-	0.0%	-
Czech	0	1	-	-	0.0%	-
Danish	2	0	-	0.20%	-	-
Dutch	1	0	-	0.10%	-	-
Finnish	1	0	-	0.10%	-	-
Yiddish	1	0	-	0.10%	-	-
Total Calls	998	22,059	2110.32	100%	100.00%	-
Data Source: Language Line Services Usage Summary Report (2024)						

Interpreter services evaluation

In 2024, provider requests for interpreter services rose sharply to 22,059 from 998 in 2023. Spanish continued as the leading requested language (72.3% of requests, up 9.33%), while Haitian Creole saw the largest increase, rising from 2 to 1,173 requests and becoming the second most requested language. Arabic and Tagalog requests also surged significantly, seeing increases of 12,275% and 11,675%, respectively. Additionally, the range of languages requested nearly doubled from 31 to 61.

The substantial increase in interpreter service requests in 2024 highlights both the growing diversity of the member population and Blue Shield Promise's commitment to meeting evolving linguistic needs. By expanding language support to a broader range of languages, Blue Shield Promise continues to uphold its promise of providing culturally and linguistically appropriate services to all members. We remain steadfast in our goal to deliver timely and effective

language assistance, ensuring every member receives the support they need to fully access their health care benefits.

Translation Services

Blue Shield Promise translates materials deemed vital, that provide essential information to members about access and usage of Blue Shield Promise's health coverage benefits and services. Blue Shield Promise identifies vital documents (Standards and Non-Standard) using criteria defined in language assistance mandates. Additionally, Blue Shield translates health education materials. It is the responsibility of Blue Shield Promise to provide culturally and linguistically appropriate documents and materials to members in the threshold languages. Translated documents are required to meet the same standards as the English version. Members are informed of the availability of language services immediately upon enrollment, reminders on our website, annual member communications and with each mailing. Blue Shield Promise's written translation of materials and alternative formats are supported by our vendor ISI Language Solutions (ISI).

Translation of materials essential for members to access, participate in, or understand health plan benefits or covered health care services are available at no cost to members in threshold languages. Members can additionally request translations of materials in another format, such as Braille or in larger print. Blue Shield Promise written translation of materials is supported by our vendor ISI Language Solutions (ISI). The data listed below show an annual accumulative total of all written requests and if the written translation was completed in a timely manner. The goal for Blue Shield Promise is to meet 100% of written translation requests for all threshold languages.

The translation vendor is unable to produce a report by lines of business, therefore the data listed below show an annual accumulative total of all translation requests, and if the written translation was completed in a timely manner. Timely means in a manner appropriate for the situation in which language assistance is needed, not to exceed twenty-one (21) days of the request, unless otherwise mandated.

Written Translation Fulfillment

Language	Number of Documents			% of Documents Requested Completed		
	2023	2024	Year-over-Year (%)	2023	2024	Year-over-Year (%)
English	0	3,875	-	100%	100%	-

Language	Number of Documents			% of Documents Requested Completed		
	2023	2024	Year-over-Year (%)	2023	2024	Year-over-Year (%)
Spanish	1,342	3,585	167.14	100%	100%	-
Tagalog	141	903	540.43	100%	100%	-
Armenian	123	720	485.37	100%	100%	-
Russian	216	690	219.44	100%	100%	-
Vietnamese	173	662	282.66	100%	100%	-
Farsi	146	647	343.15	100%	100%	-
Chinese (Traditional)	158	611	286.71	100%	100%	-
Chinese (Simplified)	70	559	698.57	100%	100%	-
Arabic	170	545	220.59	100%	100%	-
Korean	119	351	194.96	100%	100%	-
Khmer (Cambodian)	100	228	128.00	100%	100%	-
Portuguese	0	11	-	-	100%	-
Japanese	0	7	-	-	100%	-
Ukrainian	0	7	-	-	100%	-
Hebrew	0	4	-	-	100%	-
Thai	0	4	-	-	100%	-
Chuukese (Trukese)	0	3	-	-	100%	-
Punjabi	0	2	-	-	100%	-
French (France)	0	2	-	-	100%	-
Haitian Creole (Haitian)	1	2	100.00	100%	100%	-
Iu Mien	0	2	-	-	100%	-
Hindi	0	2	-	-	100%	-
Hmong	0	2	-	-	100%	-

Language	Number of Documents			% of Documents Requested Completed		
	2023	2024	Year-over-Year (%)	2023	2024	Year-over-Year (%)
Bengali	0	2	-	-	100%	-
Lao (Laotian)	0	1	-	-	100%	-
Grand Total	2,759	13,427	386.66	100%	100%	-

Data source: ISI Translation Report (2024)

Translation services evaluation

From January 2024 through December 2024 there was a total of 13,427 requests for written translation services including alternative formats and 100% of those requests for translation were completed and returned to the relevant members. Blue Shield Promise has met its membership needs and preferences for this service. To better understand the data and our members' language service requests, we analyzed the number of requests per language type. The results show the top five requested written translation requests were English (in alternative format), Spanish, Tagalog, Armenian and Russian.

The year-over-year comparison of translated document language counts and completion percentages across languages reveals a marked increase in the number of documents translated. This trend is apparent in every language category, with an overall 386.66% increase in translation between 2023 and 2024.

Chinese Simplified saw a substantial increase in translated documents, increasing from 70 in 2023 to 559 in 2024. This represents a nearly 700% increase. Similarly, Spanish and Armenian saw notable increases of 540.43% and 485.37%, respectively. Important to note is that the English category represents the requests for alternative formats in English, which were not captured in the 2023 data. The completion rates for the document requests remained at 100% for both years across all languages, demonstrating a high level of efficiency in handling these requests.

This growth may indicate enhanced awareness among our members regarding the availability of translation services, as well as improved training of our internal staff concerning regulatory requirements and availability of translation services.

Blue Shield Promise Staff

Staff Training

Blue Shield Promise redesigned the cultural and linguistic training program into Advancing Health Equity in 2024. Guided by the Chief Health Equity Officers from Blue Shield of California and Blue Shield of California Promise Health Plan, thirty staff members across the organization collaborated to develop the Advancing Health Equity course. The course addresses implicit bias, culturally and linguistically appropriate practices, diversity, equity, inclusion, gender-affirming care, and other key topics. The course assignments commenced on March 3, 2025, with a completion deadline set for April 11, 2025.

Additionally, in compliance with state legislation, Blue Shield and Blue Shield Promise collaborated with an organization that serves the transgender, gender diverse, or intersex (TGI) community to create an evidence-based cultural competency training for staff on providing trans-inclusive care. The training, titled "Improving the Health Care Experience for the Transgender, Gender Diverse or Intersex Community," was assigned to Promise staff who have verbal or written contact with members. These staff were required to complete the TGI training starting April 16, 2025, with a completion deadline of June 30, 2025.

Assignment for both courses included:

- Appeals and Grievances
- Enrollment and Retention
- Community Resource Center
- Communication Governance
- Customer Service
- Quality
- Health Education and Cultural and Linguistic
- Utilization Management
- Population Health Management (Case Management Children's Health Services, Social Services and Behavioral Health Case Management)

Staff training evaluation

In 2025, 99% and 100% of the required staff completed the Advancing Health Equity and the TGI training, respectively. Efforts are underway to improve the efficiency of the training assignments for the next roll out of the trainings which will occur annually for the Advancing Health Equity and every two years for the TGI training.

Staff Experience with Language Assistance Services

Annually, Blue Shield of California and Blue Shield of California Promise Health Plan (Blue Shield) conduct an Employee Experience Survey to evaluate our vendor's language services to our members and the satisfaction our employees have with these vital services. Blue Sheild Promise revised the survey questions from 2024, to ask more targeted questions on interpreter and translation services. A year-over-year analysis was conducted, where questions were aligned.

Area for Improvement and Key Questions	2024	2025	Year over Year
Increase employee survey participation by 10%	304	189	-37.83%
Do you know how to access interpreter services?	56.90%	97.35%	71.09%
Do you know how to submit a request for a face-to-face interpreter, including ASL?	53.10%	30.69%	-42.20%
Do you know how to request a translation for written materials into a non-English language alternative format?	56.10%	86.76%	54.65%
Do you know how to access qualified bilingual staff if you need help communicating with a non-English speaking member?	55.60%	-	-

Question	Response
1. Are you a Blue Shield or Blue Shield Promise (BSP) member facing employee?	Blue Shield: 86 Blue Shield Promise: 103
2. Please indicate your department.	• Appeals & Grievances: 55 • Case Management: 42 • Community Resource Centers: 12 • Growth/Enrollment and Retention: 12

Question	Response				
	• Health Education: 1 • Medical Care Solutions: 16 • Medi-Cal Population Health Management (Case Management Children's Health Services, Social Services and Behavioral Health Case Management): 38 • Utilization Management: 5				
3. On a scale from 1 to 5, where 1 is the hardest and 5 is the easiest, how would you rate your experience with our over-the-phone interpreter service vendor?	1	2	3	4	5
	4	5	42	57	81
4. How long did you have to wait on hold for interpreter?	Less than one minute	One to two minutes	Two minutes to five minutes	More than five minutes	
	89	59	32	9	
5. How easy was it to get a hold of an over-the-phone interpreter in the language you requested?	Easy	Somewhat easy	Not easy	Very difficult	
	115	66	7	1	
6. Did the over-the-phone interpreter assist you and the member as needed?	Yes: 178		No: 11		
7. Are you comfortable using the interpreter service line?	Yes: 184		No: 5		
8. Do you know how to submit a request for a face-to-face interpreter, including American Sign Language?	Yes: 58		No: 131		
9. On a scale from 1 to 5, where 1 is the hardest and 5 is the easiest, how would you	1	2	3	4	5
	25	9	81	35	39

Question	Response				
rate your experience with our face-to-face interpreter service vendor?					
10. In the last 6 months, have you requested written materials in other languages besides English?	Yes: 68			No: 121	
11. Do you know which languages other than English Blue Shield offers written materials in?	Yes: 63			No: 5	
12. Do you know that Blue Shield offers alternative formats (e.g., audio, Braille, large print, etc.) for translation?	Yes: 56			No: 12	
13. Do you know how to request a translation of written materials into another language or alternative format?	Yes: 59			No: 9	
14. If you requested a translation, how long did the translation take?	1-7 days	8-14 days	15-21 days	22-30 days	NA
	27	19	4	1	17
15. Were you satisfied with the translation process?	Yes: 78%			No: 22%	

Staff experience evaluation

In 2025, the survey was completed by 189 member-facing employees, a notable decrease from 304 participants in 2024. Despite the reduction in responses, the data provides a comprehensive view across departments, with

significant representation from Appeals & Grievances, Case Management, and Medi-Cal Population Health Management. The participation was higher among Blue Shield Promise employees, indicating stronger engagement or awareness amongst Blue Shield Promise employees, compared to Blue Shield of California.

The survey reveals mixed experiences with interpreter services. Quantitatively, 81 respondents rated their experience with over-the-phone interpreter service at the highest level (5 out of 5), with the majority (115) finding it easy to obtain an interpreter in their requested language. Wait times have increased slightly: in 2025, 89 reported waiting less than a minute, while 59 waited 1-2 minutes, and some (9) waited more than five minutes. Although most staff (178) felt that the interpreter assisted effectively.

For face-to-face interpreters, 61% of staff found the experience to be poor to neutral, and few employees are comfortable requesting face-to-face interpreters; only 58 knew how, while 131 did not. A significant number of employees are also uncertain of how to request an ASL interpreter. In 2024, 127 of 304 employees were unsure how to request written translations, although this improved in 2025. Most translation requests were completed within 1-14 days, but satisfaction is mixed (78% satisfied, 22% dissatisfied). Only 1.3% found it easy to obtain non-English materials in 2024, dropping from 86% in 2022, suggesting more complicated procedures or communication issues.

Compliance Monitoring

Goals, Results, and Year Over Year

Category	Goal	Results	Results YoY
Member Population Goals			
Member Self-Reported Race and Ethnicity	Achieve 80% self-reported race and ethnicity.	Met	No change
Member Self-Reported Gender Identity	Achieve 20% self-report gender identity data capture by 2028.	Not met	No change
Member Self-Reported Sexual Orientation	Achieve 20% sexual orientation and data capture by 2028.	Not met	Increase

Category	Goal	Results	Results YoY
Contracted Provider Goals			
Provider race and ethnicity	1 American Indian/Alaska Native practitioner to 600 American Indian/Alaska Native members.	Met	No change
	1 Asian practitioner to 700 Asian members.	Met	No change
	1 Black/African American practitioner to 900 Black/African American members.	Met	No change
	1 Hispanic/Latino practitioner to 3,400 Hispanic/Latino members.	Met	No change
	1 Middle Eastern/North African practitioner to 700 Middle Eastern/North African members.	Not met	No change
	1 Native Hawaiian/Pacific Islander practitioner to 900 Native Hawaiian/Pacific Islander members.	Met	No change
	1 white practitioner to 700 white members.	Met	No change
	1 other race practitioner to 700 other race members.	Not met in San Diego County	No change
Provider Languages	1 PCP (Family Medicine (General Medicine and Family Practice)), Internal Medicine, and Pediatrics) speaking a threshold language to 1,200 members speaking a threshold language.	Met	No change

Category	Goal	Results	Results YoY
	1 Specialist speaking a threshold language to 1,200 members speaking a threshold language	Not met	No change
Provider Office Staff Languages	8% of provider office staff speak at least one threshold language.	Met	No change
Provider Trainings and Resources	100% providers complete the Advancing Health Equity training by 12/31/25 and at recredentialing thereafter.	Not met	Baseline
Language Assistance Services and Nondiscrimination			
Member Cultural and Linguistic Grievances	Blue Shield Promise has no threshold for grievances related to cultural and linguistic grievances. Blue Shield Promise reviews all cultural and linguistic related grievances.	NA	NA
Member Experience	Achieve a 20% response rate for interpreter satisfaction survey.	Not met	No change
	Achieve a 95% satisfaction rate for face-to-face interpreter services.	Not met	No change
Preferred Languages	Fulfill 100% of interpreter requests for all languages.	Met	No change
Written Translation Requests	Fulfill 100% of written translation requests for all threshold languages.	Met	No change
Blue Shield Promise Staff Goals			
Staff Training: Advancing Health Equity	Aim to have 100% of required employees complete training annually.	Met	Baseline

Category	Goal	Results	Results YoY
Staff Training: Improving the Healthcare Experience of the Transgender, Gender Diverse or Intersex Community	Aim to have 100% of required employees complete the training every two years.	Met	Baseline
Staff Experience: Culturally and Linguistically Appropriate Services	Achieve 80% overall satisfaction based on staff experience surveys conducted annually.	Met	No change
Compliance Monitoring			
Barriers and Process Improvement	100% of identified barriers related to culturally and linguistically appropriate services will be tracked.	Met	No change

2025 Barrier Analysis

Listed below are the identified

Priority Item	Category	Barriers
1	**Provider Race and Ethnicity – Middle Eastern and North African:** Blue Shield Promise does not meet the goal of having 1 Middle Eastern and North African practitioner for every 700 Middle Eastern and North African members, in either county.	Administrative Facing: Blue Shield Promise believes the root cause of this insufficient data is that race and ethnicity are optional for providers to share. In addition, a lack of standard nationwide or statewide provider demographic registry poses an administrative burden and challenges to securing and maintaining the information needed to ensure appropriate network and workforce recruitment strategies.

	Blue Shield Promise does not meet the goal of 1 other race practitioner for every 700 other race members in San Diego County.	
2	**Provider Languages – Specialist:** Blue Shield does not meet the 1:1200 ratio for the following specialty types in San Diego County: • Cardiology- English • Gastroenterology- English, Spanish, Vietnamese and Tagalog	Administrative Facing: Lack of English-speaking gastroenterology and cardiology specialty providers continues to reflect in the data. Potential root cause is that these specialty providers are not populating the language field with English and believing the system will auto default to English. Lack of Spanish, Tagalog, Vietnamese, and Cantonese speaking specialty providers may be due to under reporting of provider languages and a network need to increase specialty providers that speak these languages
3	**Member Cultural and Linguistic Grievances** Blue Shield Promise does not currently maintain a formal target for member grievances; however, all grievances and identified gaps within the broader cultural and linguistic program are subject to thorough review and assessment.	Member and Administrative Facing: Lack of member and provider awareness regarding the process of requesting face-to-face interpreter services and the availability of on-demand over-the-phone interpreters when a language barrier is identified during health care encounters. We believe the potential root cause is members and providers are not recalling the pre-planning timeline requirements to request a face-to-face interpreter or that over-the-phone interpreter services are available at any time, which is affecting the member and providers healthcare visit. Additionally, despite high member satisfaction scores, as noted by the annual interpreter satisfaction member survey, member grievances related to face-to-face grievances persist. A root cause of this discordance may be that members may

		not recall their dissatisfaction with face-to-face interpreter services when they receive the annual survey. Administrative Facing: Lack of standardized processes for the efficient identification of categories and subcategories of cultural and linguistic related grievances which make it challenging to identify trends and address identified issues.
4	**Member Self-reported Gender Identification:** Blue Shield Promise has not achieved 20% self-report gender identity data capture.	Administrative and Systemic: Blue Shield Promise's goal of 20% may be ambitious, especially when considered against the realities of the current environment. Individuals may choose not to self-report their gender identity due to concerns about privacy, fear of disclosure, or a lack of trust in how their information will be used. Such hesitancy is further compounded by uncertainty about data protections and the potential for stigma or discrimination. These factors, in addition to privacy concerns, present significant challenges to accurate and comprehensive demographic data collection.
5	**Member Self-reported Sexual Orientation:** Blue Shield Promise has not achieved 20% self-report sexual orientation data capture.	Administrative and Systemic: Blue Shield Promise's goal of 20% may be ambitious, especially when considered against the realities of the current environment. Individuals may choose not to self-report their sexual orientation due to concerns about privacy, fear of disclosure, or a lack of trust in how their information will be used. Such hesitancy is further compounded by uncertainty about data protections and the potential for stigma or discrimination. These factors, in addition to privacy concerns,

		present significant challenges to accurate and comprehensive demographic data collection.
6	**Utilization of Language Assistance Services- Bilingual Services** Blue Shield Promise does not have a centralized system to track the number of employees who have been assessed for their bilingual skills.	Administrative Facing Lack of a centralized tracking system for bilingual employee skills assessment/certification makes it difficult to maintain current assessment data for the organization. The root cause may be that each department leader is responsible for scheduling bilingual assessments for their employees directly with the assessment vendor and the information is maintained within the department.
7	**Member Experience with Interpreter Services During Healthcare Encounters and Health Plan Encounters** Blue Shield Promise has not achieved a 20% response rate for the interpreter member satisfaction surveys	Administrative Facing Blue Shield Promise sends satisfaction surveys annually, which can lead to low response rates because members may not remember their interpreter services experience or may be reluctant to provide feedback after a long period of time. Many may also avoid the inconvenience of mailing the survey.

Barrier analysis evaluation

The barrier analysis highlights challenges impacting Blue Shield Promise's ability to provide equitable care, such as continued gaps in member and provider demographic data, inefficiency in the identification of cultural and linguistic grievances, and barriers in tracking provider trainings and employee bilingual skills assessments

Addressing these barriers is critical for Blue Shield Promise to achieve its mission of equitable care. By prioritizing ongoing evaluation, targeted interventions, and improved data collection, the organization can continue to close gaps in language access and cultural competency. This commitment will help pave the way for a more inclusive healthcare environment, where every member receives the support and services they need to thrive.

Community Committee Feedback and Evaluation

At Community Advisory Committee meetings, members shared various recommendations regarding the collection and use of self-identification data, with a focus on gender identity and sexual orientation, race and ethnicity, and language. Members discussed the significance of building trust to support participation and identified concerns about data privacy, perceptions of the healthcare system, and the current U.S. context as possible factors influencing self-identification processes. They also highlighted the relevance of transparency in the use of demographic information and needed assurance for protection of their information. We will continue to engage with the committee to keep them abreast of our interventions and solicit feedback.

Process Improvement Plan

The Health Equity Oversight Committee is responsible for overseeing all process improvement plans. These committees will designate accountable leads and facilitate cross-functional collaboration to ensure that workplans are executed on schedule and objectives are met.

2024 Process Improvement Plan

2024 Opportunities Item #1:

- Increase the number of Spanish speaking cardiologist and Tagalog speaking gastroenterologists San Diego County. Increasing the number of specialty providers that speak these languages will ensure our members' network preferences are met and potentially will result in higher overall satisfaction.
- Examine our internal process of how we collect and display English speaking cardiologist and gastroenterologists to ensure our network language data is accurate.

Intervention:

Administrative Facing: Cross-department workgroup to be formed to review all provider network language data that did not meet goal, examine current outreach activities, determine best practices approach to increase the network in these areas, and develop a timeline. Additionally, this team will examine our internal process for collecting and displaying English and develop an action plan based on their findings.

Responsible: Health Equity, Provider Network

Informed: Health Equity Oversight Committee

Targeted Implementation date: Q3 2025

2025 Status and Impact: Completed. A modification in logic was necessary to resolve this deficiency, affecting the data processes related to network analytics as well as the presentation of information in Blue Shield's provider directory. Our primary objective will be to evaluate the outcomes associated with these changes. Specifically, in 2025, Blue Shield enhanced its systems by setting English as the default language (in place of 'unknown'), thereby improving clarity for members searching for providers online. This adjustment is expected to better meet members' cultural needs and preferences through improved accuracy and system functionality. The Information Technology team has recently finalized the programming update, and the revised data will be incorporated in the forthcoming reporting cycle.

2024 Opportunities Item #2 and #3: Increase member and provider awareness of:

1. **How to request an interpreter and the pre-planning timeline requirements to book this service.**
2. **How to request written materials be translated into the members preferred written languages.**

These two improvements will support our members overall satisfaction.

Interventions:

Member Facing

1. Ask members of the Community Review Committee to share their feedback on the best method of communication with them on language assistance resources.

2. Develop and disseminate a member notification on how to access language assistance services, including interpreter and translation information.

3. Develop and disseminate a provider letter and online provider announcement notification including cultural awareness and linguistic resources, language assistance services, including interpreter and translations and Cultural Competency training.

Administrative-Facing:
4. Setup a working session meeting to review grievance results and the current Customer Service process for asking and confirming the members preferred written language to receive material in. Based on findings an action plan will be developed and implemented.

Responsible: Health Equity, Quality, Customer Service, Provider Relations

Informed: Health Equity Oversight Committee

Targeted Implementation date: 1. September 2024; 2. September 2024; 3. October 2024; 4. Q4 2024

2025 Status:

1. Completed. Blue Shield Promise presented at the September 2024 Community Advisory Committee to gather input from members on various preferences on receiving health plan communications. Members shared they would strongly recommend to continue correspondence on programs/services provided by Blue Shield Promise.
2. Completed. Member newsletter article went out in Q4 2024 on availability of translation services and interpreter services. The article expanded on the timeframes for scheduling face-to-face interpreters, including ASL.
3. Completed. In 2025, there were two provider notifications regarding Blue Shield Promise language assistance services available to all providers. The annual mailing contains information on for providers on how to access interpreter services and language assistance information that is available to be used for their offices. Additionally, we shared information about the available provider training for them and office staff.
4. Discontinued- The majority of grievances are related to issues with interpreter services and not translation of materials and our focus will be on improving experience and access to interpreter services.

2024 Opportunities Item #4: Increase data capture for member and providers' race, ethnicity, and language information to allow for accurate network analysis and comparison to support member needs and preferences and increase data capture of member

Interventions

Member Facing

1. Partner with Violet (Vendor) and leverage their Health Equity provider training and other resources to encourage providers to self-identity race, ethnicity, language data.
2. Send reminders to all providers about the importance of updating their provider profile, which includes, but not limited to race, ethnicity, and spoken languages including office staff.
3. Send out reminders to all members regarding the privacy and protections of their race, ethnicity, and language, sexual orientation, and gender identity data and share the process for how to update their profiles.

Responsible: Health Transformation, Network Analytics, Health Equity, Provider Communication/Network Compliance

Informed: Health Equity Oversight Committee, Community Advisory Committee

Targeted Implementation date: 1. Q1 2025; 2. Q3 2024; 3. Q3 2024

2025 Status:

1. The pilot program was discontinued as it yielded little provider engagement. As of May 2025, a total of 90 providers were onboarded of the targeted 5000 providers. Very little commitment was demonstrated; therefore it was recommended to no longer proceed with this intervention.
2. Completed.
3. Completed. In 2025, Blue Shield Promise sent out written communication to all its Medi-Cal members to remind members on the importance of maintaining their information up-to-date. Members were reminded to leverage the member portal to self-identify race/ethnicity, preferred spoken and written languages, sexual orientation and ways that members can receive health plan communications. In 2025, while it did not achieve its goal of meeting the 20% goal of self-identified sexual orientation and gender identity, there was a slight

increase in rates of self-identification. This modest improvement may be due to said reminders. In addition, this communication also includes reminders on the organization's importance of guarding personal and sensitive information which may have resonated with members' appeal to self-identify.

2024 Opportunities Item #5: Improve web system ability to count the number of providers that take trainings by year instead of an accumulative total. This shift would support the Plans ability trend data and see yearly training participation rates.

Intervention:

Administrative-Facing:
Establish meeting with IT/web team to examine system abilities to shift from accumulative to a year rate of providers who take CLAS training. The result of this meeting will include timeline for implementing the change.

Responsible: Quality, Health Equity, IT/Web

Informed: Health Equity Oversight Committee

Targeted Implementation date: Q1 2025

2025 Status: Discontinued. As part of the Department of Health Care Services requirement for all managed care plans and subcontractors are required to complete Diversity, Equity and Inclusion training as part of the Medi-Cal contract. This would require Blue Shield Promise to monitor providers completion of this training. A 100% completion is required. To date, we are at a 10% completion.

2025 Process Improvement Plan

2025 Opportunity #1: Improve Middle Eastern and North African provider capacity (Barrier #1)

Administrative facing intervention: Blue Shield Promise is forming a cross departmental workgroup to examine provider data to determine the precise root cause and develop an action plan to ensure Middle Eastern and North African providers are adequately represented in the Blue Shield Promise network.
Responsible: Provider Relations; Network Analytics; Provider Contracting

Informed: Access to Care Committee; Health Equity Oversight Committee

Targeted implementation date: Q3 2025

Targeted completion date: To be determined

2025 Status: Not started

2025 Opportunity #2: Increase cardiologist and gastroenterologist capacity in San Diego County:

- **Increase the number of English-speaking cardiologist and Englis, Spanish, Vietnamese and Tagalog speaking gastroenterologist**

(Barrier #2)

Administrative facing intervention: Cross-department workgroup to be formed to review all provider network language data that did not meet goal, examine current outreach activities, determine best practices approach to increase the network in these areas, and develop a timeline.

Responsible: Provider Relations; Network Analytics; Provider Contracting

Informed: Access to Care Committee; Health Equity Oversight Committee

Targeted implementation date: Behind schedule for implementation date

Targeted completion date: Q1 2026

2025 Status: Initial conversations have occurred with Provider Network. Meetings with a formal workgroup will be scheduled.

2025 Opportunity #3: Decrease grievances related to face-to-face interpreters. (Barrier#3 and #7)

Administrative facing intervention: A cross-department workgroup will be formed to review existing process of categorizing grievances and identify ways to streamline the reporting process to internal teams. This will allow for better tracking and review of grievance

Member facing:
1. Explore the feasibility of a stand-along member flyer or short video on the availability of language services.
2. Transition interpreter satisfaction member survey from annual to quarterly.

Responsible:
Administrative: Cultural and Linguistic, Appeals and Grievance, Health Equity
Member Facing: 1, 2: Cultural and Linguistic

Informed:
Administrative and Member facing: Health Equity Oversight Committee and Community Advisory Committee

Targeted implementation date:
Administrative Facing: in-progress
Member Facing: 1. Q1 2026; 2. Q2 2026

Targeted completion date:
Administrative Facing: TBD
Member Facing: 1. Q1 2026; 2: ongoing

2025 Status:
Administrative Facing: in-progress
Member Facing: 1. Not started; 2: not started

2025 Opportunity #4: Improve member self-reported gender identification and sexual orientation (Barrier#4 and #5)

Administrative facing intervention: Explore opportunities for Customer Service to collect self-reported demographics from members when they call Blue Shield Promise.

Responsible: Health Equity; Customer Service

Informed: Health Equity Oversight Committee Community Advisory Committee

Targeted implementation date: Q2 2025

Targeted completion date: Q1 2027

2025 Status: In-progress. Blue Shield Promise will develop processes for member-facing staff, incorporating the feedback received from the Community Advisory Committee, to collect demographics without stigmatizing individuals who do not identify, or those who do.

2025 Opportunity #5: Increase tracking and reporting capabilities of staff bilingual assessments (Barrier #6)

Administrative facing intervention: Review current process with bilingual skills assessment vendor (Language Line) to explore the possibility of a reporting dashboard. Develop centralized tracking process whereby leaders of member-facing departments track bilingual assessments on a quarterly basis.

Responsible: Cultural and Linguistic and all internal departments that have their employees assessed for their bilingual skills, including Customer Services, Population Health Management (Care Management, Children's Services, Social Services), Community Engagement and Member Retention, Appeals & Grievances

Informed: Health Equity Oversight Committee Community Advisory Committee

Targeted implementation date: Q4 2025

Targeted completion date: Q2 2026

2025 Status: Not started

Compliance Monitoring

Looking ahead, it is imperative for the Cultural and Linguistic program to address bottlenecks in interventions by reinforcing compliance frameworks and streamlining governance processes. Increased collaboration and transparent communication between business owners and the Cultural and Linguistic Program, or appropriate oversight committee, should be prioritized to facilitate progress. Sustained attention to these areas will be vital to achieving the program's objectives and advancing health equity outcomes in the coming year.

Contribution

Employee Name	Title	Department	Section
Rosa Hernández	Sr. Manager	Health Education and Cultural & Linguistic	Primary author
Danielle Browning	Principal Program Manager	Health Equity, Cultural & Linguistic Program	Contributing author
Som Florendo	Program Manager	Clinical Operations Oversight	Staff Experience
Marilyn Milano	Principal Program Manager	Clinical Operations Oversight	Member and practitioner data

Medi-Cal Disparity Report for QI Evaluation

1. Activity Description

What to include: a blurb of what the activity is, its purpose, and if the activity is also tracked on the Quality Work Plan.

Blue Shield of California Promise Health Plan (known as Blue Shield Promise) is dedicated to identifying and addressing health care disparities with the aim of improving our services and advancing health equity of our members. To support this goal, Blue Shield Promise annually uses race, ethnicity, language, and gender data to assess and identify the existence of health disparities and develops and implements interventions to reduce those identified disparities to improve health of our members. The Disparities Report outlines the measures and processes used to identify and assess observed disparities and corresponding actions taken to mitigate identified health care disparities.

2. Goals

What to Include: Outline what the measurement year goal is and how it ties to EITHER or BOTH organizational objectives or regulatory requirements.

The 2025 measurement year goal was to identify, monitor, and reduce disparities in key Medi-Cal HEDIS and experience measures by:

- Stratifying performance data by demographic characteristics for "Controlling Blood Pressure (CBP)," "Glycemic Status Assessment for Patients with Diabetes 9.0% (GSD), formerly Hemoglobin A1c Control for Patients with Diabetes (HBD), "Prenatal and Postpartum Care (PPC), "Child and Adolescent Well Care Visits (WCV)," and the CAHPS question "Rating of Health Care (8,9,10)."
- Comparing findings, for applicable measures, to the Minimum Performance Level (MPL) as a benchmark, and reviewing trending data, to prioritize populations and measures for focused intervention.
- Aligning improvement efforts with organizational objectives related to health equity, regulatory compliance, and Medi-Cal quality performance.

This work supports regulatory requirements for health equity reporting and aligns with organizational priorities to improve outcomes for historically underserved Medi-Cal populations.

Medi-Cal Disparity Report for QI Evaluation

3. Accomplishments

What to Include: Highlight achievements from measurement year. Examples might include improved performance, completed audits, new projects launched, or completing corrective actions

During the measurement year, the following accomplishments were achieved:

- Completed a comprehensive health disparities analysis across multiple Medi-Cal HEDIS clinical and CAHPS experience measures. For the first time, we convened multiple internal stakeholders to review the analyses, collaboratively identify opportunities and actions to implement in 2025.
- Identified priority measures and member populations with persistent or emerging disparities to inform targeted quality improvement strategies, including HEDIS®: Glycemic Status Assessment for Patients with Diabetes >9% among Hispanic or Latino members, and HEDIS® Prenatal and Postpartum Care, among Black or African American members.
- Implemented the interventions, offering Medically Tailored Meals/Medically Supportive Meals (MTM/MSM) to members diagnosed with diabetes and demonstrating a glycemic index >9, and leveraging existing data tools to identify members earlier in their pregnancy journey.

Medi-Cal Disparity Report for QI Evaluation

4. Quantitative Analysis (if applicable)

What to Include: Showcase measurable data. It should track and trend with prior year to evaluate whether metrics demonstrated improvement, decline, or remained stable. Use graphs or tables when possible.

The data and tables below are from the Disparities report, including the stratified results for the aforementioned quality measures. Each of the measures are compared to the Department of Healthcare Services (DHCS) established Minimum Performance Level (MPL) because it is the quality standard that Managed Care Plans (MCPs) contracting with DHCS must meet or exceed.

Controlling Blood Pressure

In MY2024, the goal for Controlling High Blood Pressure (CBP) was the Department of Healthcare Services (DHCS) established Minimum Performance Level (MPL). The MPL is the quality standard that Managed Care Plans (MCPs) contracting with DHCS must meet or exceed. For this report, we have decided to use the MPL as the benchmark to compare our sub-population results. The MY2024 DHCS MPL was 64.48%.

"Some other Race" is an option members can select if they don't self-identify with the other race categories. "Two or More Races" is an option members can select if they identify with any combination of races, including "Some other Race".

"Asked But No Answer," is an option for members who decline to answer or provide a response. "Unknown" represents those members whom the organization did not obtain race information and did not receive a declined response.

Medi-Cal HEDIS® MY2023 and MY2024— Controlling High Blood Pressure (CBP) by Race, Los Angeles County:

Race	MY2023					MY2024				
	Numerator	Denominator	% Rate	Goal	Goal Met	Numerator	Denominator	% Rate	Goal	Goal Met
American Indian or Alaska Native	9	16	56.25%	61.31%	No	8	15	53.33%↓	64.48%	No
Asian	590	1,173	50.30%	61.31%	No	404	754	53.58%↑	64.48%	No
Black or African American	680	1,553	43.79%	61.31%	No	658	1,360	48.38%↑	64.48%	No
Native Hawaiian or Other Pacific Islander	223	437	51.03%	61.31%	No	438	821	53.35%↑	64.48%	No
Some Other Race	4,709	8,493	55.45%	61.31%	No	5,598	9,464	59.15%↑	64.48%	No
Two or More Races	1	3	33.33%	61.31%	No	4	6	66.67%↑	64.48%	Yes
Asked but No Answer	1	1	100%	61.31%	Yes	0	0	N/A	64.48%	N/A
Unknown Race	0	5	0.00%	61.31%	No	8	18	44.44%↑	64.48%	No
White	627	1,317	47.61%	61.31%	No	812	1,479	54.90%↑	64.48%	No

Medi-Cal Disparity Report for QI Evaluation

Total	**6,840**	**12,998**	**52.62%**	**61.31%**	**No**	**7,930**	**13,917**	**56.98%↑**	**64.48%**	**No**

N/A = Not applicable because there are no members in the numerator or denominator
↑↓ Trending data, reflecting an increase or decrease in performance, comparing MY2024 and MY2023

Medi-Cal HEDIS® MY2023 and MY2024— Controlling High Blood Pressure (CBP) by Ethnicity, Los Angeles County:

Ethnicity	MY2023					MY2024				
	Numerator	Denominator	% Rate	Goal	Goal Met	Numerator	Denominator	% Rate	Goal	Goal Met
Hispanic or Latino	2,248	4,016	55.98%	61.31%	No	5,385	9,234	58.32%↑	64.48%	No
Not Hispanic or Latino	1,763	3,739	47.15%	61.31%	No	2,475	4,539	54.53%↑	64.48%	No
Asked but no answer	1	2	50.00%	61.31%	No	1	1	100%↑	64.48%	Yes
Unknown ethnicity	2,828	5,241	53.96%	61.31%	No	69	143	48.25%↓	64.48%	No
Total	**6,840**	**12,998**	**52.62%**	**61.31%**	**No**	**7,930**	**13,917**	**56.98%↑**	**64.48%**	**No**

N/A = Not applicable because there are no members in the numerator or denominator

Glycemic Status Assessment for Patients with Diabetes >9.0% (GSD), formerly Hemoglobin A1c Control for Patients With Diabetes (HBD)

In MY2024, the goal was the Department of Healthcare Services (DHCS) established Minimum Performance Level (MPL). The MPL is the quality standard that Managed Care Plans (MCPs) contracting with DHCS are required to meet or exceed. For this report, we have decided to use the MPL as the benchmark to compare our sub-population results. The MY2024 DHCS MPL was 33.33%.

"Some other Race" is an option members can select if they don't self-identify with the other race categories. "Two or More Races" is an option members can select if they identify with any combination of races, including "Some other Race".

"Asked But No Answer," is an option for members who decline to answer or provide a response. "Unknown" represents those members whom the organization did not obtain race information and did not receive a declined response.

Medi-Cal HEDIS® MY2023 Hemoglobin A1c Control for Patients with Diabetes (HBD) - HbA1c poor control (>9.0%) and MY2024 — Glycemic Status Assessment for Patients with Diabetes >9.0% (GSD) by Race, Los Angeles County:

Race	MY2023					MY2024				
	Numerator	Denominator	% Rate	Goal	Goal Met	Numerator	Denominator	% Rate	Goal	Goal Met
American Indian or Alaska Native	6	18	33.33%	37.96%	Yes	6	15	40.00%↓	33.33%	No
Asian	254	934	27.19%	37.96%	Yes	131	577	22.70%↑	33.33%	Yes
Black or African American	562	1,186	47.39%	37.96%	No	470	1,015	46.31%↑	33.33%	No
Native Hawaiian or Other Pacific Islander	102	359	28.41%	37.96%	Yes	199	728	27.34%↑	33.33%	Yes
Some Other Race	4,248	10,542	40.30%	37.96%	No	4,799	12,395	38.72%↑	33.33%	No
Two or More Races	3	5	60.00%	37.96%	No	3	6	50.00%↑	33.33%	No
Asked but No Answer	1	2	50.00%	37.96%	No	1	2	50.00%	33.33%	No

Medi-Cal Disparity Report for QI Evaluation

Unknown Race	3	10	30.00%	37.96%	Yes	18	50	36.00%↓	33.33%	No
White	421	1,065	39.53%	37.96%	No	450	1,158	38.86%↑	33.33%	No
Total	**5,600**	**14,121**	**39.66%**	**37.96%**	**No**	**6,077**	**15,946**	**38.11%↑**	**33.33%**	**No**

N/A = Not applicable because there are no members in the numerator or denominator
↑↓ Trending data, reflecting an increase or decrease in performance, comparing MY2024 and MY2023

Medi-Cal HEDIS® MY2023 Hemoglobin A1c Control for Patients with Diabetes (HBD) - HbA1c poor control (>9.0%) and MY2024 — Glycemic Status Assessment for Patients with Diabetes >9.0% (GSD) by Ethnicity, Los Angeles County:

Ethnicity	MY2023					MY2024				
	Numerator	Denominator	% Rate	Goal	Goal Met	Numerator	Denominator	% Rate	Goal	Goal Met
Hispanic or Latino	1,952	5,048	38.67%	37.96%	No	4,524	11,676	38.75%↓	33.33%	No
Not Hispanic or Latino	1,069	2,873	37.21%	37.96%	Yes	1,510	4,136	26.53%↑	33.33%	Yes
Asked but no answer	0	3	0%	37.96%	Yes	1	2	0%	33.33%	Yes
Unknown ethnicity	2,579	6,197	41.62%	37.96%	No	42	132	50%↓	33.33%	No
Total	**5,600**	**14,121**	**39.66%**	**37.96%**	**No**	**6,077**	**15,946**	**38.11%↑**	**33.33%**	**No**

N/A = Not applicable because there are no members in the numerator or denominator
↑↓ Trending data, reflecting an increase or decrease in performance, comparing MY2024 and MY2023

Prenatal and Postpartum Care (PPC)

In MY2024, the goal for Prenatal and Postpartum (PPC) - Timeliness of Prenatal Care measure and Postpartum Care measure - was the Department of Healthcare Services (DHCS) established Minimum Performance Level (MPL). The MPL is the quality standard that Managed Care Plans (MCPs) contracting with DHCS are required to meet or exceed. For this report, we have decided to use the MPL as the benchmark to compare our sub-population results. The MY2024 DHCS MPL for Timeliness of Prenatal Care was 84.55% and for Postpartum Care was 80.23%.

"Some other Race" is an option members can select if they don't self-identify with the other race categories. "Two or More Races" is an option members can select if they identify with any combination of races, including "Some other Race".

"Asked But No Answer," is an option for members who decline to answer or provide a response. "Unknown" represents those members whom the organization did not obtain race information and did not receive a declined response.

Medi-Cal HEDIS® MY2023 and MY2024— Prenatal and Postpartum (PPC) – Timeliness of Prenatal Care by Race, Los Angeles County:

Race	MY2023					MY2024				
	Numerator	Denominator	% Rate	Goal	Goal Met	Numerator	Denominator	% Rate	Goal	Goal Met

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American Indian or Alaska Native	4	5	80.00%	84.23%	No	0	0	0.00%↓	N/A	N/A
Asian	56	85	65.88%	84.23%	No	41	57	71.93%↑	84.55%	No
Black or African American	280	401	69.83%	84.23%	No	186	261	71.26%↑	84.55%	No
Native Hawaiian or Other Pacific Islander	38	56	67.86%	84.23%	No	73	90	81.11%↑	84.55%	No
Some Other Race	2,168	2,828	76.66%	84.23%	No	2,391	2,835	84.34%↑	84.55%	No
Two Or More Races	0	1	0.00%	N/A	N/A	0	0	0.00%	N/A	N/A
Asked But No Answer	0	0	0.00%	N/A	N/A	2	2	100.00%↑	84.55%	Yes
Unknown Race	9	10	90.00%	84.23%	Yes	29	36	80.56%↓	84.55%	No
White	173	224	77.23%	84.23%	No	208	262	79.39%↑	84.55%	No
Total	**2,728**	**3,610**	**75.57%**	**84.23%**	**No**	**2,930**	**3,543**	**82.70%↑**	**84.55%**	**No**

N/A = Not applicable because there are no members in the numerator or denominator
↑↓ Trending data, reflecting an increase or decrease in performance, comparing MY2024 and MY2023

Medi-Cal HEDIS® MY2023 and MY2024— Prenatal and Postpartum (PPC) - Timeliness of Prenatal Care by Ethnicity, Los Angeles County

Ethnicity	MY2023					MY2024				
	Numerator	Denominator	% Rate	Goal	Goal Met	Numerator	Denominator	% Rate	Goal	Goal Met
Hispanic or Latino	1,292	977	76.16%	84.23%	No	1,929	2,289	84.27%↑	84.55%	No
Not Hispanic or Latino	548	390	70.71%	84.23%	No	979	1,221	80.18%↑	84.55%	No
Asked But No Answer	0	0	0.00%	N/A	N/A	0	0	0.00%	N/A	N/A
Unknown Ethnicity	1,770	1,361	76.89%	84.23%	No	22	33	66.67%↓	84.55%	No
Total	**3,610**	**2,728**	**75.75%**	**84.23%**	**No**	**2,930**	**3,543**	**82.70%↑**	**84.55%**	**No**

N/A = Not applicable because there are no members in the numerator or denominator
↑↓ Trending data, reflecting an increase or decrease in performance, comparing MY2024 and MY2023

Medi-Cal HEDIS® MY2023 and MY2024— Prenatal and Postpartum (PPC) – Postpartum Care by Race, Los Angeles County:

Race	MY2023					MY2024				
	Numerator	Denominator	% Rate	Goal	Goal Met	Numerator	Denominator	% Rate	Goal	Goal Met
American Indian or Alaska Native	1	5	20.00%	78.10%	No	0	0	0.00%↓	N/A	N/A
Asian	70	85	82.35%	78.10%	Yes	43	57	75.44%↓	80.23%	No
Black or African American	240	401	59.85%	78.10%	No	168	261	64.37%↑	80.23%	No
Native Hawaiian or Other Pacific Islander	46	56	82.14%	78.10%	Yes	69	90	76.67%↓	80.23%	No
Some Other Race	2,112	2,828	74.68%	78.10%	No	2,297	2,835	81.02%↑	80.23%	Yes

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Two Or More Races	1	1	100.00%	78.10%	Yes	0	0	0.00%↓	N/A	N/A
Asked But No Answer	0	0	0.00%	N/A	N/A	2	2	100.00%↑	80.23%	Yes
Unknown Race	6	10	60.00%	78.10%	No	28	36	77.78%↑	80.23%	No
White	156	224	69.64%	78.10%	No	188	262	71.76%↑	80.23%	No
Total	**2,632**	**3,610**	**72.91%**	**78.10%**	**No**	**2,795**	**3,543**	**78.89%↑**	**80.23%**	**No**

N/A = Not applicable because there are no members in the numerator or denominator

↑↓ Trending data, reflecting an increase or decrease in performance, comparing MY2024 and MY2023

Medi-Cal HEDIS® MY2023 and MY2024— Prenatal and Postpartum (PPC) - Postpartum Care by Ethnicity, Los Angeles County

Ethnicity	MY2023					MY2024				
	Numerator	Denominator	% Rate	Goal	Goal Met	Numerator	Denominator	% Rate	Goal	Goal Met
Hispanic or Latino	960	1,292	74.30%	78.10%	No	1,857	2,289	81.13%↑	80.23%	Yes
Not Hispanic or Latino	363	548	66.24%	78.10%	No	915	1,221	74.94%↑	80.23%	No
Asked But No Answer	0	0	0.00%	N/A	N/A	0	0	0.00%	N/A	N/A
Unknown Ethnicity	1,309	1,770	73.95%	78.10%	No	23	33	69.70%↓	80.23%	No
Total	**2,632**	**3,610**	**72.91%**	**78.10%**	**No**	**2,795**	**3,543**	**78.89%↑**	**80.23%**	**No**

N/A = Not applicable because there are no members in the numerator or denominator

↑↓ Trending data, reflecting an increase or decrease in performance, comparing MY2024 and MY2023

Child and Adolescent Well Care Visits (WCV)

Medi-Cal HEDIS® MY2023 and MY2024— Child and Adolescent Well Care Visits (WCV) by Race, Los Angeles County

Race	MY2023					MY2024				
	Numerator	Denominator	% Rate	Goal	Goal Met	Numerator	Denominator	% Rate	Goal	Goal Met
American Indian or Alaska Native	34	81	41.98%	48.07%	No	26	51	50.98%↑	51.81%	No
Asian	2,153	4,396	48.98%	48.07%	Yes	1,170	2,368	49.41%↑	51.81%	No
Black or African American	5,299	13,358	39.67%	48.07%	No	4,009	9,331	42.96%↑	51.81%	No
Native Hawaiian or Other Pacific Islander	1,222	2,585	47.27%	48.07%	No	1,831	3,624	50.52%↑	51.81%	No
Some Other Race	63,343	114,646	55.25%	48.07%	Yes	61,719	103,340	59.72%↑	51.81%	Yes
Two Or More Races	27	41	65.85%	48.07%	Yes	18	31	58.06%↓	51.81%	Yes
Asked But No Answer	5	7	71.43%	48.07%	Yes	4	10	40.00%↓	51.81%	No
Unknown Race	42	91	46.15%	48.07%	No	167	335	49.85%↑	51.81%	No
White	3,983	9,163	43.47%	48.07%	No	3,869	8,717	44.38%↑	51.81%	No
Total	**76,108**	**144,368**	**52.72%**	**48.07%**	**Yes**	**72,813**	**127,807**	**56.97%↑**	**51.81%**	**Yes**

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N/A = Not applicable because there are no members in the numerator or denominator
↑↓ Trending data, reflecting an increase or decrease in performance, comparing MY2024 and MY2023

Medi-Cal HEDIS® MY2023 and MY2024— Child and Adolescent Well Care Visits (WCV) by Ethnicity, Los Angeles County

Ethnicity	MY2023					MY2024				
	Numerator	Denominator	% Rate	Goal	Goal Met	Numerator	Denominator	% Rate	Goal	Goal Met
Hispanic or Latino	23,398	42,959	54.47%	48.07%	Yes	55,978	94,652	59.14%↑	51.81%	Yes
Not Hispanic or Latino	10,036	23,912	41.97%	48.07%	No	16,436	32,294	50.89%↑	51.81%	No
Asked But No Answer	2	5	40.00%	48.07%	No	0	2	0.00%↓	N/A	N/A
Unknown Ethnicity	42,672	77,492	55.07%	48.07%	Yes	399	859	46.45%↓	51.81%	No
Total	**76,108**	**144,368**	**52.72%**	**48.07%**	**Yes**	**72,813**	**127,807**	**56.97%↑**	**51.81%**	**Yes**

N/A = Not applicable because there are no members in the numerator or denominator
↑↓ Trending data, reflecting an increase or decrease in performance, comparing MY2024 and MY2023

CAHPS Measures from Press Ganey Analytics Stratified by Race and Ethnicity: Rating of Health Care (8+9+10)

Medi-Cal Overall Composite Scores – Los Angeles County Adult

CAHPS Measures	2021	2022	2023	2024	2024 Quality Compass Percentile*	Improvement Goal Met (Yes/No?)
Rating of Health Care (8+9+10)	70.4%	74.7%↑	67.2%↓	76.8%↑	33rd	Yes

*For RY2024, the benchmarks for Quality Compass for Rating of Healthcare were 10th:70.53%; 33rd:73.54%; 66th: 77.56%; 90th: 81.76%
↑↓ Trending data, reflecting an increase or decrease in performance, comparing MY2024 and MY2023

We also stratified the Child and Adolescent Well Care Visits (WCV) quality measure by language and gender.

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Medi-Cal HEDIS® MY2023 and MY2024—Child and Adolescent Well Care Visits (WCV) by Preferred Language: Los Angeles County

Language	MY2023					MY2024				
	Numerator	Denominator	% Rate	Goal	Goal Met	Numerator	Denominator	% Rate	Goal	Goal Met
Arabic	82	160	51.25%	48.07%	Yes	70	136	51.47%↓	51.81%	No
Armenian	222	418	53.11%	48.07%	Yes	258	419	53.22%↑	51.81%	Yes
Cambodian	2	4	50%	48.07%	Yes	5	8	62.50%↑	51.81%	Yes
Chinese	2	4	50%	48.07%	Yes	2	5	40.00%↓	51.81%	No
English	30,086	64,967	46.31%	48.07%	No	27,498	56,339	48.81%↑	51.81%	No
Farsi	1	2	50%	48.07%	Yes	2	2	100%↑	51.81%	Yes
Khmer	88	147	59.86%	48.07%	Yes	83	122	68.03%↑	51.81%	Yes
Korean	36	102	35.29%	48.07%	No	38	90	42.22%↑	51.81%	No
Other	79	139	56.83%	48.07%	Yes	80	141	56.74%↓	51.81%	Yes
Russian	109	255	42.75%	48.07%	No	246	424	58.02%↑	51.81%	Yes
Spanish	39,112	66,507	58.81%	48.07%	Yes	38,966	60,441	64.47%↑	51.81%	Yes
Tagalog	34	63	53.97%	48.07%	Yes	28	51	54.90%↑	51.81%	Yes
Unknown	6,020	11,463	52.52%	48.07%	Yes	5,288	9,194	57.52%↑	51.81%	Yes
Vietnamese	129	304	42.43%	48.07%	No	142	389	36.50%↓	51.81%	No
Total	**76,002**	**144,535**	**52.58%**	**48.07%**	**Yes**	**72,706**	**127,761**	**56.91%↑**	**51.81%**	**Yes**

Other represents languages outside of the respective county's threshold languages.

"Unknown" indicates members whose language was not provided or is unknown.

↑↓ **Trending data, reflecting an increase or decrease in performance, comparing MY2024 and MY2023**

Medi-Cal HEDIS® MY2023 Child and Adolescent Well Care Visits (WCV) by Gender, Los Angeles County

Gender	MY2023					MY2024				
	Numerator	Denominator	% Rate	Goal	Goal Met	Numerator	Denominator	% Rate	Goal	Goal Met
Female	38,003	70,941	53.57%	48.07%	Yes	36,206	62,734	57.71%↑	51.81%	Yes
Male	37,999	73,594	51.63%	48.07%	Yes	36,500	65,073	56.09%↑	51.81%	Yes
Unknown	0	0	N/A	N/A	N/A	0	0	N/A	51.81%	No
Total	**76,002**	**144,535**	**52.58%**	**48.07%**	**Yes**	**72,706**	**127,807**	**56.89%↑**	**51.81%**	**Yes**

↑↓ **Trending data, reflecting an increase or decrease in performance, comparing MY2024 and MY2023**

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5. Qualitative Analysis (if applicable)

What to Include: Provide insight from the team on why performance for the year is the way it is. This can include comparisons with prior year's write-up or highlight evolving trends over time.

Blue Shield Promise initially identified all performance areas that did not meet the goal and identified barriers to achieving the goal. The table below outlines, by county, and performance area, the quality measures that did not meet the goal. For numerous groups and stratifications, similar barriers remain from the prior year.

Performance Metrics That Did Not Meet Goal

Performance Area	Stratification	Barriers
Controlling High Blood Pressure	Race/Ethnicity – Black or African American, Native Hawaiian or Other Pacific Islander, White, Hispanic or Latino	• Behavioral factors such as diet, weight, and medication adherence and SDoH such as education, income, and neighborhood resources contribute to Black– White disparities in hypertension. Lower healthcare utilization compared to non-Hispanic White adults. Additionally, awareness of hypertension, treatment and control were lower in Hispanic adults compared to non-Hispanic white adults. (Colvin, Kalejaiye, Ogedegbe, Commodore-Mensah, 2022). • A larger proportion of Hispanic and Black adults lacked a personal health care provider compared the proportion White population that lacked a personal health care provider (Javed, Haisum Maqsood, Yahya, Amin, Acquah… & Nasir, 2022). • Implicit provider attitudes could also influence patient care. For example, health care professionals may have implicit feelings about medication use/adherence in certain racial/ethnic groups, which may affect quality of delivered care, including screening, prescribing, monitoring, etc. (Javed, Haisum Maqsood, Yahya, Amin, Acquah… & Nasir, 2022). • A 2023 qualitative study examining facilitators and barriers to hypertension management among Native Hawaiian or Alaskan Native populations highlighted barriers to hypertension management emphasized neighborhood level factors, such as historical loss of land and culture. This underlying issue influenced how Native Hawaiian perceived and experienced their neighborhood. Within the social environment, barriers included a lack of social cohesion and activities, influencing this populations motivation to be physically active, adopt a healthy diet, and lower stress (Ing, Park, Vegas, Haumea, Kaholokula). • Among Asian members, limited English proficiency may be a better to utilizing care even though insurance coverage is present. Additionally, diet may be another barrier as the article noted reduction in sodium intake is critical for East Asian countries including China, Korea, and Japan (Abrahamowicz, Ebinger, Whelton, Commodore-Mensah, & Yang, 2023).
Hemoglobin A1c Control for Patients with Diabetes (HBD) - HbA1c poor control (>9.0%)	Race/Ethnicity – Black or African American, White, Hispanic or Latino	• Among Hispanic/Latino members, a lack of knowledge is a barrier to successful diabetes self-management. Other studies had noted a lack of awareness of resources available (Ramal, Petersen, Ingram, & Champlin, 2012). • Among Black or African American, White, and Hispanic/Latino populations, a 2019 systematic review noted diet as a barrier to diabetes management. Difficulty in healthy cooking and cultural influence in dietary habits were also reported as barriers. Additionally, long working hours responding to the high cost of living was another barrier to diabetes management (Alloh, Hemingway, Turner-Wilson, 2019). • Among Black or African American populations, late diagnosis and lack of awareness were also barriers to proper diabetes management because lifestyle changes are key to successful diabetes management (Alloh, Hemingway, Turner-Wilson, 2019). • Competing demands in prioritizing bills over purchasing more expensive foods (Rendle, May, Uy, Tietbohl, Mangione, & Frosch, 2013). • Diabetes self-management is influenced by immediate and extended family (Ramal, Petersen, Ingram, & Champlin 2012).

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Performance Area	Stratification	Barriers
Timeliness of Prenatal Care	Race/Ethnicity – Asian, Black or African American, White, Hispanic or Latino	• A 2021 scoping review examined several articles aimed at capturing all the articles that depicted qualitative experiences of racial and ethnic minority patients who are low income with the worst perinatal outcomes. Minority was defined as black, Hispanic, Native American, or other racial or ethnic persons who self-identified as being a minority (Wishart, Cruz Alvarez, Ward, Danner, O'Brian). • The results from the journal article highlighted distrust in the healthcare system as a driver to not seeking or adhering to clinical care recommendations. Conversely, building a relationship with the clinician has been shown to increase a patient's willingness to follow clinical guidelines (Wishart, Cruz Alvarez, Ward, Danner, O'Brian, 2021). • Care coordination and communication styles are additional drivers to patient satisfaction and comfort with a patient's obstetric care ((Wishart, Cruz Alvarez, Ward, Danner, O'Brian, 2021).
Timeliness of Prenatal Care	Race/Ethnicity – Hispanic or Latino	
Postpartum Care	Race/Ethnicity - Black or African American, White	• A 2021 systematic review of the literature on postpartum attendance in marginalized populations in the United States noted barriers reported included transportation and unstable housing (Wouk, Morgan, Johnson, Tucker, Carlson, Berry, & Stuebe, 2021). The article defined people of color as under resourced groups, including Black and Indigenous mothers, Hispanic and Asian mothers. • The same systematic review reported that provider-level factors included being treated poorly during the intrapartum stay due to the race, ethnicity, language, culture, insurance status, or difference of opinion with the provider. Additionally, patients who had difficulty understanding their provider were also less likely to return for postpartum care (Wouk, Morgan, Johnson, Tucker, Carlson, Berry, & Stuebe, 2021). • Conversely, peer supporters, community health workers, and doulas who share culture and language with mothers could support increasing postpartum healthcare use and improve quality of care (Wouk, Morgan, Johnson, Tucker, Carlson, Berry, & Stuebe, 2021).
Child and Adolescent Well Care Visits	Race/Ethnicity - American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, White	• Qualitative interviews with Black/African American and Hispanic/Latinx caregivers and patients highlighted transportation, language, and scheduling as key barriers to well-child visits (Garg, Wilkie, LeBlanc, Lyu, Scornavacca, Fowler,...& Alper, 2022). • Among Native Hawaiian and Other Pacific Islanders, this group lacks a usual source of care when they are sick or need health advice. Additionally, immigration status may also impact this group's inclination to access government benefits (A Child Is a Child: Native Hawaiian and Pacific Islander Children's Health, 2024). • Transportation, language, and scheduling as key barriers to well-child visits (Garg, Wilkie, LeBlanc, Lyu, Scornavacca, Fowler,...& Alper, 2022). • Unique barriers for American Indian/Alaskan Native children include a long-standing mistrust of governmental agencies, discrimination in clinical settings, and the "cumulative burden of generations of unresolved traumas and racism" (Bell, Deen, Fuentes, Moore, & Committee on Native American Children Health, 2021).
Child and Adolescent Well Care Visits	Race/Ethnicity - American Indian or Alaska Native, Black or African American, Native Hawaiian or Other Pacific Islander, White	
Child and Adolescent Well Care Visits	Language – English, Korean, Vietnamese	• Due to cultural reasons for individuals who speak Russian there is a lack of awareness of what health insurance is and may experience challenges accessing care (Kostareva, Albright, Berens, Levin-Zamir, Aringazina, Lopatina,... & Sentell, 2020). • The same study noted immigrants may not be familiar with the significance of preventive services, noting limited language proficiency as a barrier. (Kostareva, Albright, Berens, Levin-Zamir, Aringazina, Lopatina,... & Sentell, 2020). • Among Vietnamese members, a barrier to visits is not having a usual place of care (A Look at Health in Orange a Look at Health in Orange County's Vietnamese Community County's Vietnamese Community, n.d). Another study noted this group was more likely to have had no contact with a health professional within the past 12 months than non-Hispanic White children (Yu, Huang, & Singh, 2010).

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Opportunities and barriers were identified using prior analyses by race/ethnicity, language, and gender, relevant literature, member feedback, and existing Blue Shield Promise programs. Opportunities were prioritized based on population size, condition prevalence, and potential impact. Blue Shield Promise will continue to monitor groups with small denominators or non-reportable populations.

Due to the high prevalence of diabetes among Hispanic or Latino members, the significant consequences of uncontrolled diabetes, and minimal improvement across recent measurement years, Glycemic Status Assessment for Patients with Diabetes (GSD) remains a priority opportunity. In Measurement Year 2024, more than 11,000 Hispanic or Latino members in Los Angeles County were diagnosed with diabetes, with nearly 40% demonstrating poor glycemic control (>9%), a pattern consistent over the past two years. Persistent barriers include limited knowledge of glycemic control, food insecurity, access to care, and insufficient social support. Improvement efforts will focus on expanding culturally tailored diabetes education and strengthening resources that address food insecurity.

Prenatal and Postpartum Care (PPC) was also selected as a priority based on population size, available resources, and the potential for long-term impact. While improvements were observed in Child and Adolescent Well Care Visits, disparities in PPC persist among Black and African American birthing people. Given the critical role of prenatal and postpartum care in maternal and infant health, Blue Shield Promise conducted focus groups with Black and African American birthing people in Los Angeles to better understand barriers. Findings highlighted challenges related to care logistics, access to resources (e.g., transportation and provider choice), and the need for sustained postpartum support. As a result, improvement efforts will focus on enhancing logistical support and maintaining consistent communication and assistance throughout the postpartum period.

6. Trends in Performance*

What to Include: Identify patterns found via quantitative/qualitative analysis over previous measurement year (steady improvement, recurring issues, etc.)

Measures tied to chronic disease management, such as glycemic control among those diagnosed with Diabetes continue to present an opportunity among Hispanic or Latino members. Diet and food insecurity remain persistent challenges for this group. Offering MTM/MSM to members can connect members to a registered dietician for nutritional counseling, along with home delivered meals to support a healthy diet.

Medi-Cal Disparity Report for QI Evaluation

7. Barriers and Mitigation Plans

What to Include: Challenges encountered for this measurement year (resource gaps, workflow inefficiencies, etc.) and what the mitigation plan is to overcome them.

Blue Shield Promise encountered two challenges to implementing the proposed interventions. First, in supporting members diagnosed with diabetes and hypertension, offering Medically Tailored Meals/Medically Supportive Meals required a resource to offer and complete the referral for the Community Support Service. The mitigation plan included partnering with an internal team to offer the meals and complete the referral process. Second, in supporting members earlier in their pregnancy journey, the challenge to leveraging existing data tools to identify members earlier in the pregnancy journey, was impacted by organization changes. The mitigation plan included partnering with the Population Health Management team to support the development of the early identification pregnancy tool. Through the mitigation plan, the first round of outreach to offer Medically Tailored Meals/Medically Supportive Meals was completed, and the early pregnancy identification tool will launch in Q1 2026.

8. Recommendations for the following year

What to Include: Outline suggested actions, adjustments, or even new initiatives for the following year. This section should also indicate whether current goals will remain or shift depending on this measurement year's results.

Recommendations for the following year include continuing implementation of the interventions outlined in the Disparities report, including a second iteration of the outreach to offer Medically Tailored Meals/Medically Supportive Meals. Additionally, Blue Shield Promise will reconvene the previous group to monitor the interventions, review the updated results and analyses in the following year, to identify if the prior disparities and inequities were addressed or need additional efforts.

Blue Shield of California and Blue Shield Promise Health Plan

2025 Annual Network Summary Report

NCQA NET 1-3
Effective Q4 2025
Final Version 04/2026
Amended 04/2026

Blue Shield of California
Access & Availability – 2025 Network Performance Summary

The Qualitative analysis was completed and provided by:

Network/Section	Title	Department
NET 1B&C BSC	Senior Manager	Provider Contracting
	Senior Provider Relationships Specialist	Provider Contracting
NET 2 A&C BSC (PPO only)	Senior Manager	Provider Contracting
NET 1B&C Promise	Program Manager	Provider Relations -Promise
NET 2 A&C Promise		
Behavior Health Contracting:		
NET 1D BH BSC	Program Manager	Behavioral Health Oversight
	Business Analyst	
NET 2B BH BSC		
NET 1D BH Promise	Program Manager	Quality Improvement - Promise
NET 2B BH Promise		
NET 3A BH Member Experience	Program Manager	Behavioral Health Strategies & Programs – QI
Member Experience, A&G,UM:		
NET 3A (A&G)	Senior Medical Informatics Analyst	Growth Servicing Analytics
NET 3A Member Experience	Program Manager	Member Experience
NET 3A Utilization Management/ OON Authorizations	Program Manager	Utilization Management

Blue Shield of California
Access & Availability – 2025 Network Performance Summary

I. Introduction:

California Physicians' Service, dba Blue Shield of California (BSC) and Blue Shield of California Promise Health Plan (BSP), collectively "Blue Shield," are nonprofit health plans dedicated to providing Californians with access to high-quality health care at an affordable price. BSC was founded in 1939 and serves the entire state of California. Blue Shield has over 7,500 employees and **Mike Stuart** is the **President and Chief Executive Officer.** Blue Shield is a not-for-profit mutual benefit corporation that has multiple affiliates that provide health, dental, vision, Medicaid, and Medicare health care service plans. With a national affiliation as an independent member of the BlueCross BlueShield Association, Blue Shield's Foundation funds nonprofit organizations that help strengthen the health safety net and address and prevent domestic violence.

Blue Shield of California Life & Health Insurance Company (Blue Shield Life) is a California corporation founded in 1954 and is licensed as a life and disability insurer. Blue Shield Life is a wholly owned subsidiary of BSC.

Blue Shield maintains open networks. Participating physicians and other health care professionals join the networks by accessing and completing the required documentation online or by calling the Plan directly. When network gaps are discovered, Blue Shield makes an effort to recruit sufficient numbers of providers to ensure the area's enrollees have access to medically necessary primary and acute care services and that specialty care remains reasonable. In the event these services are not within the established guidelines for distance and time, Blue Shield seeks alternate access to address any potentially identified network gaps.

Network Monitoring:

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

Blue Shield of California
Access & Availability – 2025 Network Performance Summary

Access to Care:

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

- Member experience, as measured through patient surveys addressing access to care and access-related grievances and appeals.
- Quality, relative to access to preventative care, such as vaccines and screenings affecting clinical outcomes, including incidence of communicable disease and cancer.
- Cost of Healthcare, relative to when members who cannot access primary or specialty care utilize the emergency department.

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

Access to Care Committee:

The Access to Care Committee is a cross-functional team responsible for execution of the BSC Policy and Procedure. This committee meets monthly and reports to the BSC Quality Management Committee. The committee oversees network adequacy, assuring that there is enough volume and type of providers, facilities, and ancillary care. The committee is tasked with improving access to care using the results of member and provider surveys, and other assessment tools.

Access and Availability Subcommittee:

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

Communication:

Blue Shield's Accessibility and Availability Standards and Guidelines are distributed annually to participating network providers and practitioners by way of operational manuals, online

practitioner and member web portals, written bulletins and update notices, policy, and procedure documents, and/or other recognized methods as appropriate. Standards are reviewed and/or revised annually or more frequently if/when necessary. Staff also communicate standards at routine audits, site visits, Joint Operating Meetings and in other settings. Members receive communication of these standards through Blue Shield's member materials.

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

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

- Medical and behavioral health services including appointments, emergency care, preventative services, i, after-hours care, and video visits.
- Cultural needs and preferences for members.

This report is reflective of the network access and availability using the provider network snapshot as of 01/15/25 (DMHC MY2025 TAR reporting) as this is the network in place for our members effective 1/2025. Any exceptions are notated. All assessments, actions and metrics are reflective of work done in 2025.

II. Availability of Practitioners (NET1):

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

Element A: Cultural Needs & Preferences

Description:

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Access & Availability – 2025 Network Performance Summary

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

Populations and Products in this analysis

- Commercial HMO/PPO
    - Covered California/Exchange
- Medicare (including dual and MedSupp plans)
- Medi-Cal (Los Angeles and San Diego Counties)

HMO (Commercial and Covered California/Exchange)	PPO (Commercial and Covered California / Exchange)	Medicare (including dual and MedSupp plans)	Medi-Cal (Los Angeles and San Diego Counties)
[redacted]	[redacted]	[redacted]	583,052

Element A -Cultural Needs and Preferences

Blue Shield of California
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Element B - Practitioners Providing Primary Care

Description:

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

Methodology:

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

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

Provider rosters used for access are internally produced and have an effective date as of 01/15/2025, apart from CDI PPO which has an effective date of 6/01/2025. All reports and access data are measured and audited using resulting 100-point testing through the Quest Analytics software, with the exception of IMAPD and GMAPD specialists which uses true membership in adherence with BSC's Access and Availability policy.

Blue Shield of California
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Element B - Practitioners Providing Primary Care

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

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

PCP Geographic Quantitative Analysis – Commercial Exchange Networks are included in PPO and HMO and Member to Provider ratio (all PCP tables)

MY2025/RY2025 Data Results

Blue Shield of California
Access & Availability – 2025 Network Performance Summary

Network	Specialty	Standard	Goal	MY2025 Results	Standard	Goal	MY2025 Results
Geographic Distribution of PCPs					**PCP to Member Ratio**		
Standard							
Access+ HMO	[redacted]	1 PCP w/n 15 miles or 30 minutes of each member	75%	[redacted]			
SaveNet HMO	[redacted]	1 PCP w/n 15 miles or 30 minutes of each member	75%	[redacted]			
Local Access+ HMO	[redacted]	1 PCP w/n 15 miles or 30 minutes of each member	75%	[redacted]	[redacted]	[redacted]	[redacted]
TRIO ACO HMO	[redacted]	1 PCP w/n 15 miles or 30 minutes of each member	75%	[redacted]			
CalPERS Access+ HMO/EPO	[redacted]	1 PCP w/n 15 miles or 30 minutes of each member	75%	[redacted]			
PPO DMHC	[redacted]	1 PCP w/n 15 miles or 30 minutes of each member	75%	[redacted]			
IFP ePPO	[redacted]	1 PCP w/n 15 miles or 30 minutes of each member	75%	[redacted]			
Tandem PPO	[redacted]	1 PCP w/n 15 miles or 30 minutes of each member	75%	[redacted]	[redacted]	[redacted]	[redacted]
CDI PPO	[redacted]	1 PCP w/n 15 miles or 30 minutes of each member	75%	[redacted]			

PCP Geographic Quantitative Analysis – Commercial Exchange Networks are included in PPO and HMO and Member to Provider ratio (all PCP tables)

MY2024/RY2024 Data Results:

Blue Shield of California
Access & Availability – 2025 Network Performance Summary

Network	Specialty	Standard	Goal	MY2024 Results	Standard	Goal	MY2024 Results
Geographic Distribution of PCPs					**PCP to Member Ratio**		
Standard							
Access+ HMO	[redacted]	1 PCP w/n 15 miles or 30 minutes of each member	75%	[redacted]			[redacted]
SaveNet HMO	[redacted]	1 PCP w/n 15 miles or 30 minutes of each member	75%	[redacted]			[redacted]
Local Access+ HMO	[redacted]	1 PCP w/n 15 miles or 30 minutes of each member	75%	[redacted]	[redacted]	[redacted]	[redacted]
TRIO ACO HMO	[redacted]	1 PCP w/n 15 miles or 30 minutes of each member	75%	[redacted]			[redacted]
CalPERS Access+ HMO/EPO	[redacted]	1 PCP w/n 15 miles or 30 minutes of each member	75%	[redacted]			[redacted]
PPO DMHC	[redacted]	1 PCP w/n 15 miles or 30 minutes of each member	75%	[redacted]			[redacted]
IFP ePPO	[redacted]	1 PCP w/n 15 miles or 30 minutes of each member	75%	[redacted]	[redacted]	[redacted]	[redacted]
Tandem PPO	[redacted]	1 PCP w/n 15 miles or 30 minutes of each member	75%	[redacted]			[redacted]
CDI PPO	[redacted]	1 PCP w/n 15 miles or 30 minutes of each member	75%	[redacted]			[redacted]

Blue Shield of California
Access & Availability – 2025 Network Performance Summary

PCP Geographic Quantitative Analysis - Medicare

MY2025/RY2025 Data Results:

Network	Specialty	Standard	Goal	MY2025 Results	Standard	MY2025 Results
Geographic Distribution of PCPs					**PCP to Member Ratio**	
Standard						
GMAPD HMO - Large Metro	[redacted]	1 PCP w/in 10 minutes or 5 miles of each beneficiary	75%	[redacted]	[redacted]	[redacted]
	[redacted]			[redacted]	[redacted]	[redacted]
GMAPD HMO - Metro	[redacted]	1 PCP w/in 15 minutes or 5 miles of each beneficiary	75%	[redacted]	[redacted]	[redacted]
	[redacted]			[redacted]	[redacted]	[redacted]
IMAPD HMO - Large Metro	[redacted]	1 PCP w/in 10 minutes or 5 miles of each beneficiary	75%	[redacted]	[redacted]	[redacted]
	[redacted]			[redacted]	[redacted]	[redacted]
IMAPD HMO - Metro	[redacted]	1 PCP w/in 15 minutes or 5 miles of each beneficiary	75%	[redacted]	[redacted]	[redacted]
	[redacted]			[redacted]	[redacted]	[redacted]
DSNP - Large Metro	[redacted]	1 PCP w/in 10 minutes or 5 miles of each beneficiary	75%	[redacted]	[redacted]	[redacted]
	[redacted]			[redacted]	[redacted]	[redacted]
DSNP - Metro	[redacted]	1 PCP w/in 15 minutes or 10 miles of each beneficiary	75%	[redacted]	[redacted]	[redacted]
	[redacted]			[redacted]	[redacted]	[redacted]

Blue Shield of California
Access & Availability – 2025 Network Performance Summary

Network	Specialty	Standard	Goal	MY2025 Results	Standard	MY2025 Results
Geographic Distribution of PCPs					**PCP to Member Ratio**	
Standard						
GMAPD PPO - Large Metro	[redacted]	1 PCP w/in 10 minutes or 5 miles of each beneficiary	75%	[redacted]	[redacted]	[redacted]
	[redacted]			[redacted]	[redacted]	[redacted]
GMAPD PPO - Metro	[redacted]	1 PCP w/in 15 minutes or 10 miles of each beneficiary	75%	[redacted]	[redacted]	[redacted]
	[redacted]			[redacted]	[redacted]	[redacted]
GMAPD PPO - Micro	[redacted]	1 PCP w/in 30 minutes or 20 miles of each beneficiary	75%	[redacted]	[redacted]	[redacted]
	[redacted]			[redacted]	[redacted]	[redacted]
GMAPD PPO - Rural	[redacted]	1 PCP w/in 40 minutes or 30 miles of each beneficiary	75%	[redacted]	[redacted]	[redacted]
	[redacted]			[redacted]	[redacted]	[redacted]
GMAPD PPO - CEAC	[redacted]	1 PCP w/in 70 minutes or 60 miles of each beneficiary	75%	[redacted]	[redacted]	[redacted]
	[redacted]			[redacted]	[redacted]	[redacted]
IMAPD PPO - Large Metro	[redacted]	1 PCP w/in 10 minutes or 5 miles of each beneficiary	75%	[redacted]	[redacted]	[redacted]
	[redacted]			[redacted]	[redacted]	[redacted]
IMAPD PPO - Metro	[redacted]	1 PCP w/in 10 minutes or 5 miles of each beneficiary	75%	[redacted]	[redacted]	[redacted]
	[redacted]			[redacted]	[redacted]	[redacted]

Blue Shield of California
Access & Availability – 2025 Network Performance Summary

PCP Geographic Quantitative Analysis - Medicare

MY2024/RY2024 Data Results:

Network	Specialty	Standard	Goal	MY2024 Results	Standard	MY2024 Results
Geographic Distribution of PCPs					**PCP to Member Ratio**	
Standard						
GMAPD HMO - Large Metro	[redacted]	1 PCP w/in 10 minutes or 5 miles of each beneficiary	75%	[redacted]	[redacted]	[redacted]
	[redacted]			[redacted]	[redacted]	[redacted]
GMAPD HMO - Metro	[redacted]	1 PCP w/in 15 minutes or 5 miles of each beneficiary	75%	[redacted]	[redacted]	[redacted]
	[redacted]			[redacted]	[redacted]	[redacted]
IMAPD HMO - Large Metro	[redacted]	1 PCP w/in 10 minutes or 5 miles of each beneficiary	75%	[redacted]	[redacted]	[redacted]
	[redacted]			[redacted]	[redacted]	[redacted]
IMAPD HMO - Metro	[redacted]	1 PCP w/in 15 minutes or 5 miles of each beneficiary	75%	[redacted]	[redacted]	[redacted]
	[redacted]			[redacted]	[redacted]	[redacted]
DSNP - Large Metro	[redacted]	1 PCP w/in 10 minutes or 5 miles of each beneficiary	75%	[redacted]	[redacted]	[redacted]
	[redacted]			[redacted]	[redacted]	[redacted]
DSNP - Metro	[redacted]	1 PCP w/in 15 minutes or 10 miles of each beneficiary	75%	[redacted]	[redacted]	[redacted]
	[redacted]			[redacted]	[redacted]	[redacted]

Blue Shield of California
Access & Availability – 2025 Network Performance Summary

Network	Specialty	Standard	Goal	MY2024 Results	Standard	MY2024 Results
Geographic Distribution of PCPs					**PCP to Member Ratio**	
Standard						
GMAPD PPO - Large Metro	[redacted]	1 PCP w/in 10 minutes or 5 miles of each beneficiary	75%	[redacted]	[redacted]	[redacted]
	[redacted]			[redacted]	[redacted]	[redacted]
GMAPD PPO - Metro	[redacted]	1 PCP w/in 15 minutes or 10 miles of each beneficiary	75%	[redacted]	[redacted]	[redacted]
	[redacted]			[redacted]	[redacted]	[redacted]
GMAPD PPO - Micro	[redacted]	1 PCP w/in 30 minutes or 20 miles of each beneficiary	75%	[redacted]	[redacted]	[redacted]
	[redacted]			[redacted]	[redacted]	[redacted]
GMAPD PPO - Rural	[redacted]	1 PCP w/in 40 minutes or 30 miles of each beneficiary	75%	[redacted]	[redacted]	[redacted]
	[redacted]			[redacted]	[redacted]	[redacted]
GMAPD PPO - CEAC	[redacted]	1 PCP w/in 70 minutes or 60 miles of each beneficiary	75%	[redacted]	[redacted]	[redacted]
	[redacted]			[redacted]	[redacted]	[redacted]
IMAPD PPO - Large Metro	[redacted]	1 PCP w/in 10 minutes or 5 miles of each beneficiary	75%	[redacted]	[redacted]	[redacted]
	[redacted]			[redacted]	[redacted]	[redacted]
IMAPD PPO - Metro	[redacted]	1 PCP w/in 10 minutes or 5 miles of each beneficiary	75%	[redacted]	[redacted]	[redacted]
	[redacted]			[redacted]	[redacted]	[redacted]

Blue Shield of California
Access & Availability – 2025 Network Performance Summary

PCP Geographic Quantitative Analysis – Promise Health Plan.

MY2025/RY2025 Data Results:

Network	Specialty	Standard	Goal	MY2025 Results	Standard	Goal	MY2025 Results
Geographic Distribution of PCPs					**PCP to Member Ratio**		
Standard							
LA Medi-Cal (Adult)	Family/General Practice	1 PCP w/n 10 miles or 30 min from any member or anticipated members home.	80%	98.7%	1:2000	100%	1 : 627
	Internal Medicine			97.5%			1 : 1083
SD Medi-Cal (Adult)	Family/General Practice	1 PCP w/n 10 miles or 30 min from any member or anticipated members home.	80%	100%	1:2000		1 : 2310
	Internal Medicine			90.2%			1 : 3789
LA Medi-Cal (Pediatric)	Family/General Practice	1 PCP w/n 10 miles or 30 min from any member or anticipated members home.	80%	98.7%	1:2000	100%	1 : 690
	Pediatrics			98.7%			1 : 1214
	Internal Medicine			96.3%			1 : 1947
SD Medi-Cal (Pediatric)	Family/General Practice	1 PCP w/n 10 miles or 30 min from any member or anticipated members home.	80%	100%	1:2000		1 : 2631
	Pediatrics			93.5%			1 : 1114
	Internal Medicine			89.6%			1 : 7286

PCP Geographic Quantitative Analysis – Promise Health Plan

MY2024/RY2024 Data Results:

Network	Specialty	Standard	Goal	MY2024 Results	Standard	Goal	MY2024 Results
Geographic Distribution of PCPs					**PCP to Member Ratio**		
Standard							
LA Medi-Cal (Adult)	All PCP	1 PCP w/n 10 miles or 30 min from any member or anticipated memebrs home.	100%	99.9%	1:2000	100%	1 : 131
	Family/General Practice		100%	99.5%			1 : 331
	Internal Medicine			99.4%			1 : 402
SD Medi-Cal (Adult)	All PCP	1 PCP w/n 10 miles or 30 min from any member or anticipated memebrs home.	100%	100.0%	1:2000		1 : 130
	Family/General Practice		100%	100.0%			1 : 392
	Internal Medicine			92.4%			1 : 431
LA Medi-Cal (Pediatric)	All PCP	1 PCP w/n 10 miles or 30 min from any member or anticipated memebrs home.	100%	99.9%	1:2000	100%	1 : 142
	Family/General Practice		100%	99.3%			1 : 357
	Pediatrics			98.9%			1 : 406
	Internal Medicine			99.1%			1 : 480
SD Medi-Cal (Pediatric)	All PCP	1 PCP w/n 10 miles or 30 min from any member or anticipated memebrs home.	100%	100.0%	1:2000		1 : 133
	Family/General Practice		100%	100.0%			1 : 398
	Pediatrics			99.4%			1 : 347
	Internal Medicine			91.8%			1 : 460

Blue Shield of California
Access & Availability – 2025 Network Performance Summary

Quantitative Analysis:

Blue Shield of California Classic networks:

- BSC met the standard of 1 PCP within 15 miles/30 minutes of each provider across all commercial product offerings in the Measurement year 2025. No action needed.
- BSC achieved all targets for Medicare lines of business in Measurement Year 2025. Notably, the GMAPD HMO network in the Metro area for Family/General Practice experienced a significant increase, rising from [redacted] in MY2024 to [redacted] in MY2025. The increase in the GMAPD HMO Metro area was achieved by proactively recruiting new providers to replace those retiring or leaving, and by expanding the network. This strategic, data-driven approach directly addressed the root causes of the previous year's deficiencies and resulted in a marked improvement in access for members. No further action is required.
- PCP-to-Member ratio goal for all Commercial and Medicare lines of business has been met.

Blue Shield of California Promise networks:

- Upon examination of the time and distance standards for BSP for Los Angeles County we met the goal of 80% for adult Family/General practice (98.7%), and Internal Medicine (97.5%). The goal of 80% was met for Pediatric Family/General (98.7%), Internal Medicine (96.3%) and Pediatrics (98.7%) When comparing these results to the prior year the threshold was updated from 100% in 2024 to 80% in 2025 to align with our Policy and Procedure. When reviewing PCP to member ratios for Los Angeles County we met the ratio of 1 member to 2,000 providers and performed positively compared to the previous year. In MY2025, Adult Family/General Practice decreased slightly from 99.5% in 2024 to 98.7%, and Adult Internal Medicine declined from 99.4% to 97.5%. Similarly, Pediatrics Family/General Practice dropped from 99.2% to 98.7%, Pediatrics Internal Medicine fell from 99.1% to 96.3% and Pediatrics specialty slightly dropped from 98.9% to 98.7%.
- In San Diego County, the goal of 80% was met for BSP Adult and Pediatric Family/General Practice, for Adult Internal Medicine (92.4%), Pediatric Internal Medicine (91.8%) and Pediatrics (93.5%). PCP to Member ratio goal in San Diego County was not met for both Adult and Pediatric for Family/General Practice and Internal Medicine in comparison to MY2024. In MY2025, Adult Internal Medicine decreased slightly from 92.4% in 2024 to 90.2%, and Pediatrics Internal Medicine declined from 91.8% to 89.6%. Family/General Practice remained steady at 100% for both 2024 and 2025. Pediatrics specialty decreased from 99.4% in MY2024 to 93.5% in MY2025.

Blue Shield of California
Access & Availability – 2025 Network Performance Summary

Qualitative Analysis

Blue Shield of California Classic networks:

- No action needed as goals were met for geographic distribution and practitioner to member ratio for all Commercial, Exchange, and Medicare lines of business.

Blue Shield of California Promise networks:

- San Diego County saw a significant decrease in practitioner to member ratio due to the termination of clinics and Independent Provider Associations (IPAs). These terminations impact the overall number of adult and pediatric providers available in the Promise network.
- In San Diego, physicians such as internal medicine providers are directly employed with large health systems and their lack of participation in the Medi-Cal line of business significantly impacts the availability of providers that are willing to contract directly with the plan.
- Specific access issues for Medi-Cal Pediatrics may contribute to many pediatricians are available only in center of excellence and may represent long travel distance; these specialty providers can be reached using free transportation services. In the event a contracted specialty provider is not available within time/distance standard, a single case of letter of agreement may be submitted ensuring access to an out-of-net network provider is available. In 2025, access challenges for Medi-Cal Pediatrics contributed to unmet member-to-provider ratios, largely due to specialists being concentrated in Centers of Excellence requiring long travel distances.

Opportunities/Interventions (apply to BSC and BSP both unless otherwise stated):

Opportunity for improvement	Interventions
BSC -No Network Adequacy issues; BSC to continue to ensure BSC has a robust network composition across all plans.	Continuing to increase the number of PCPs and Specialists. The results from RY2024 to RY2025 reflected these efforts and the IPA's ongoing recruitment and had adequate coverage.
BSP – There is an opportunity to increase PCP services in San Diego County which has proven to be an area with limited providers.	BSP's Contracting department initiates targeted outreach efforts to engage providers for direct contracting in San Diego County, with the goal of strengthening network adequacy and improving member access to care.

BSP - Increase provider availability by collaborating with our IPA and Medical Groups on provider recruitment and increasing access to PCP care services.	• Work with our subcontracted network to configure their contracted FQHCs as PCPs to expand primary care availability for members; members would no longer be limited to their previously assigned practitioner, but rather all PCP providers that practice out of the FQHC. • IPA/Medical Groups will be asked to provide their barriers, challenges, and mitigation plans. IPA and Medical Groups that continue to fail to meet threshold for Access to Care for PCP and Specialty services will be placed on a Corrective Action Plan. IPA and Medical Groups will be asked to document their mitigation plans, provide updates, and provide proof to demonstrate their interventions were completed.
BSP – There is an opportunity to increase providers wanting to participate in the Medi-Cal line of business through education of reimbursement models now available for Medi-Cal providers.	Educate IPA and direct network providers on the opportunities to increase their reimbursement through reimbursement models, such as Tri-Rates, FQHC Alternative Payment Methodology, and other incentive programs.

Element C - Practitioners Providing Specialty Care

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

Methodology:
High volume specialties are determined by selecting credentialed and contracted health professionals identified via claim activity for unique member occurrences in a 12-month

period (excluding primary care practitioners, hospital-based specialties, multi-specialty clinics, and laboratories). The top specialties are assessed for geographic availability and ratio assessment. All OB/GYNs are included in the availability monitoring activities. Behavioral Health practitioners are also included. The typical high-volume specialties are found in BSC's Addendum A of the Plan's Accessibility and Availability Policy and Procedures and BSP's Table I and are subject to change annually.

OB/GYNs are included in the availability of SCP monitoring activities for Commercial/Medicare members as Blue Shield of California does not distinguish between Obstetrics-Gynecology, Obstetrics, and Gynecology specialties.

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

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

All reports and access data are measured and audited using 100-point testing through the Quest Analytics software, with the exception of IMAPD and GMAPD specialists which use true membership in adherence with BSC's Access and Availability policy. All standards, ratios, and time and distance standards are referenced in this internal policy.

Element C - Practitioners Providing Specialty Care

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

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

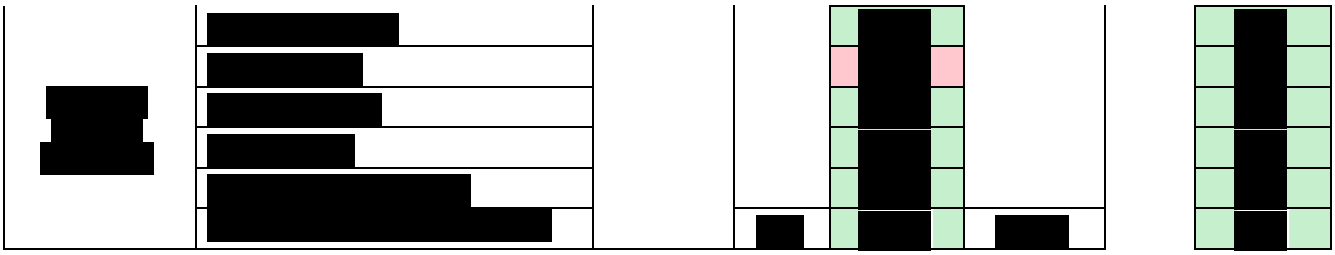
SCP Geographic Quantitative Analysis – Commercial
The following grid includes only those HIS/HVS which are included in the NET 2 analysis of appointment availability.

Blue Shield of California
Access & Availability – 2025 Network Performance Summary

MY2025/RY2025 Data Results

Network	Specialty	Standard	Goal	MY2025 Results	Standard	Goal	MY2025 Results
Geographic Distribution of Specialist (HVS & HIS)					Specialist to Member Ratio (HVS & HIS)		
Standard							
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Blue Shield of California
Access & Availability – 2025 Network Performance Summary



Network	Specialty	Standard	Goal	MY2025 Results	Standard	Goal	MY2025 Results
Geographic Distribution of Specialist (HVS & HIS)					Specialist to Member Ratio (HVS & HIS)		
Standard							
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
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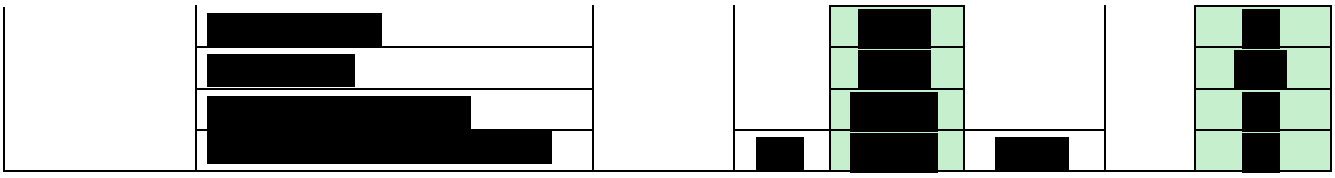
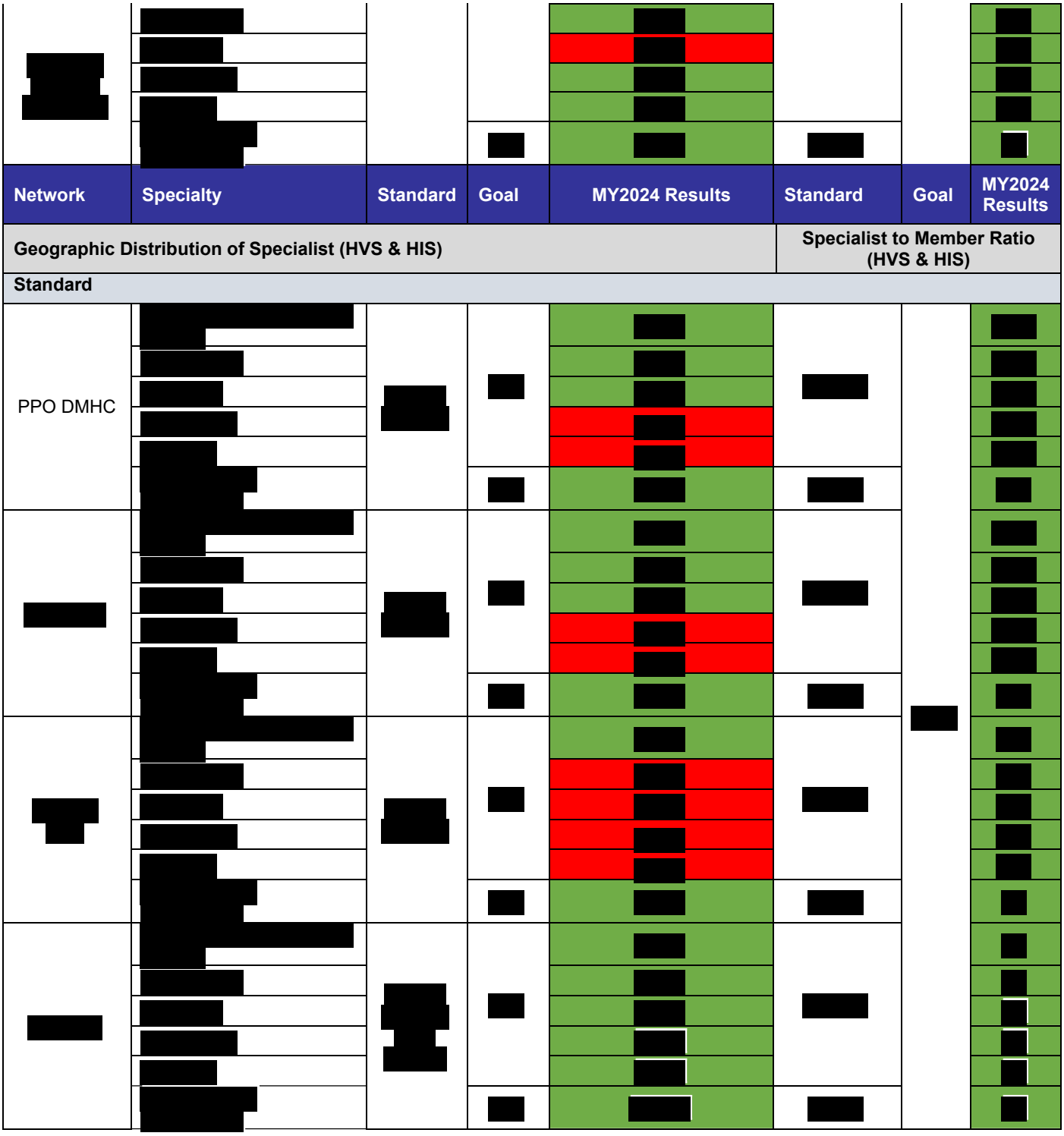
Blue Shield of California
Access & Availability – 2025 Network Performance Summary



MY2024/RY2024 Data Results

Network	Specialty	Standard	Goal	MY2024 Results	Standard	Goal	MY2024 Results
Geographic Distribution of Specialist (HVS & HIS)					Specialist to Member Ratio (HVS & HIS)		
Standard							

Blue Shield of California
Access & Availability – 2025 Network Performance Summary



Network	Specialty	Standard	Goal	MY2024 Results	Standard	Goal	MY2024 Results
Geographic Distribution of Specialist (HVS & HIS)					Specialist to Member Ratio (HVS & HIS)		
Standard							
PPO DMHC							

SCP Geographic Quantitative Analysis – Medicare

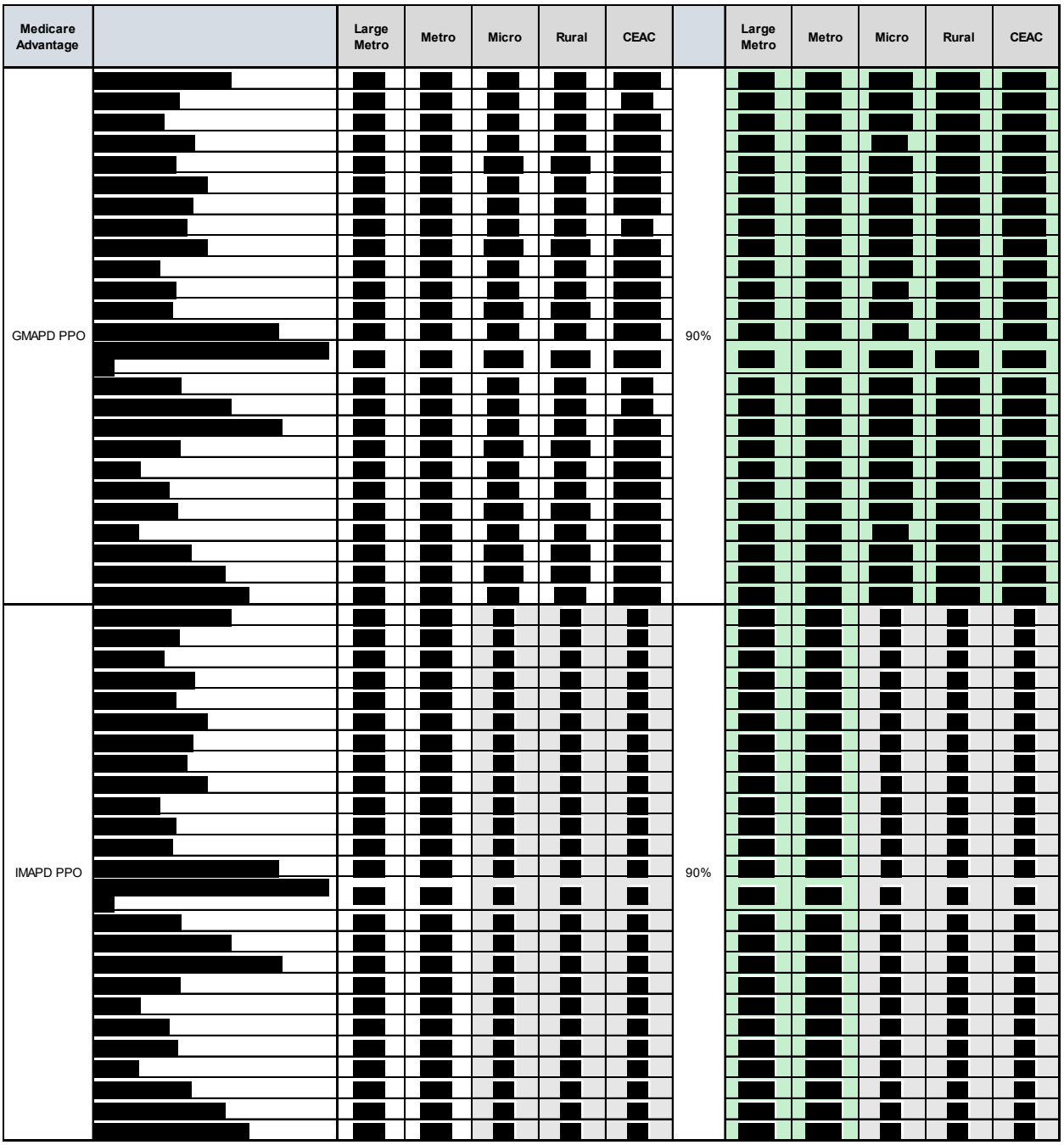
The following grid includes HIS/HVS specialties. The following specialties Oncology – Medical, Surgical and Oncology – Radiation/Radiation Oncology include Hematology specialty.

MY2025/RY2025 Data Results

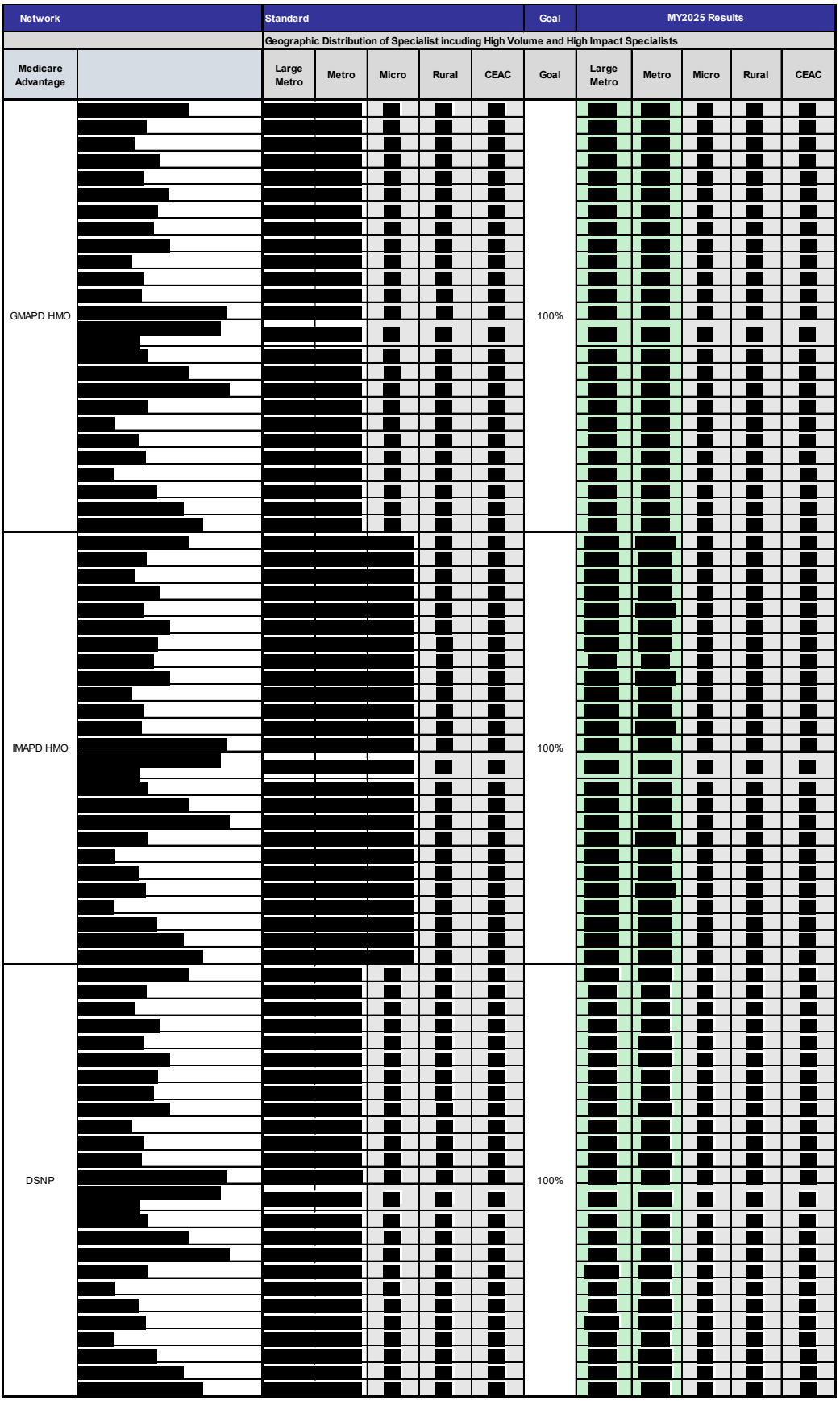
Blue Shield of California
Access & Availability – 2025 Network Performance Summary

Network	Specialty	Standard					Goal	MY2025 Results				
		Geographic Distribution of Specialist incuding High Volume and High Impact Specialists										
Medicare Advantage		Large Metro	Metro	Micro	Rural	CEAC		Large Metro	Metro	Micro	Rural	CEAC
GMAPD HMO							90%					
IMAPD HMO							90%					
DSNP							90%					

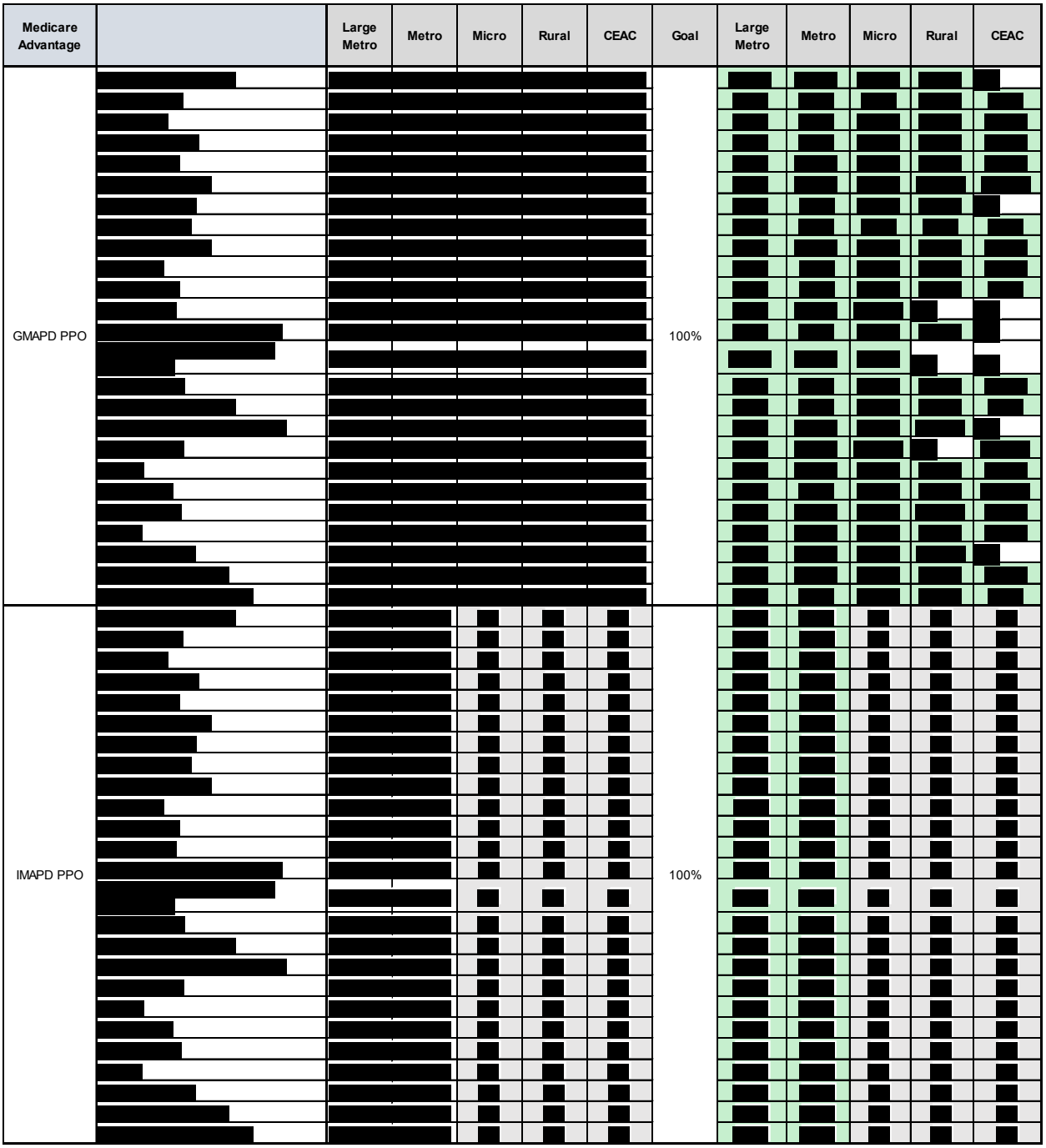
Blue Shield of California
Access & Availability – 2025 Network Performance Summary



Blue Shield of California
Access & Availability – 2025 Network Performance Summary



Blue Shield of California
Access & Availability – 2025 Network Performance Summary



SCP Geographic Quantitative Analysis – Medicare

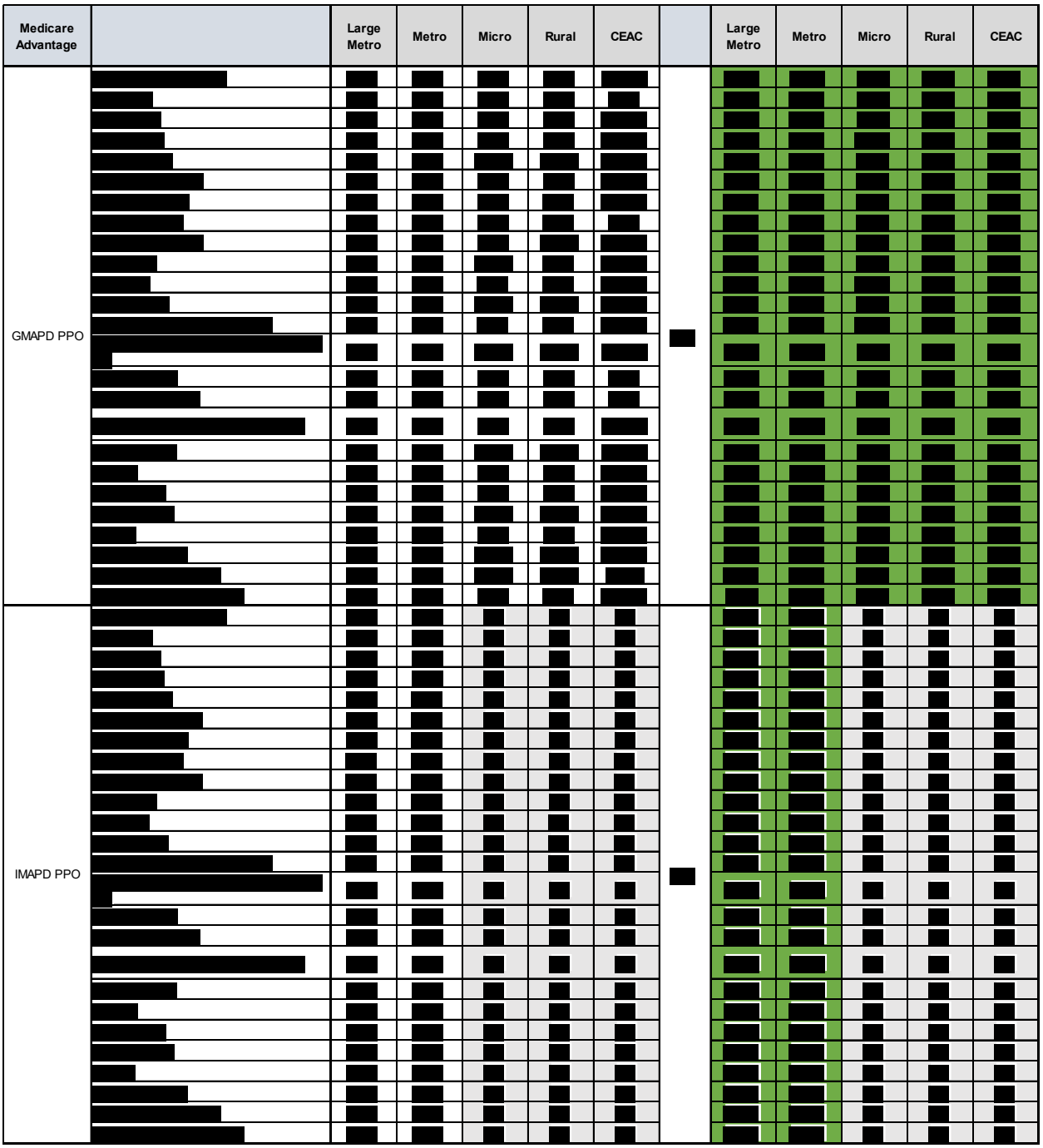
The following grid includes HIS/HVS specialties. The following specialties Oncology – Medical, Surgical and Oncology – Radiation/Radiation Oncology include Hematology specialty.

MY2024/RY2024 Data Results

Blue Shield of California
Access & Availability – 2025 Network Performance Summary

Network	Specialty	Standard					Goal	MY2024 Results				
		Geographic Distribution of Specialist incuding High Volume and High Impact Specialists										
Medicare Advantage		Large Metro	Metro	Micro	Rural	CEAC		Large Metro	Metro	Micro	Rural	CEAC
GMAPD HMO							90%					
IMAPD HMO							90%					
DSNP							90%					

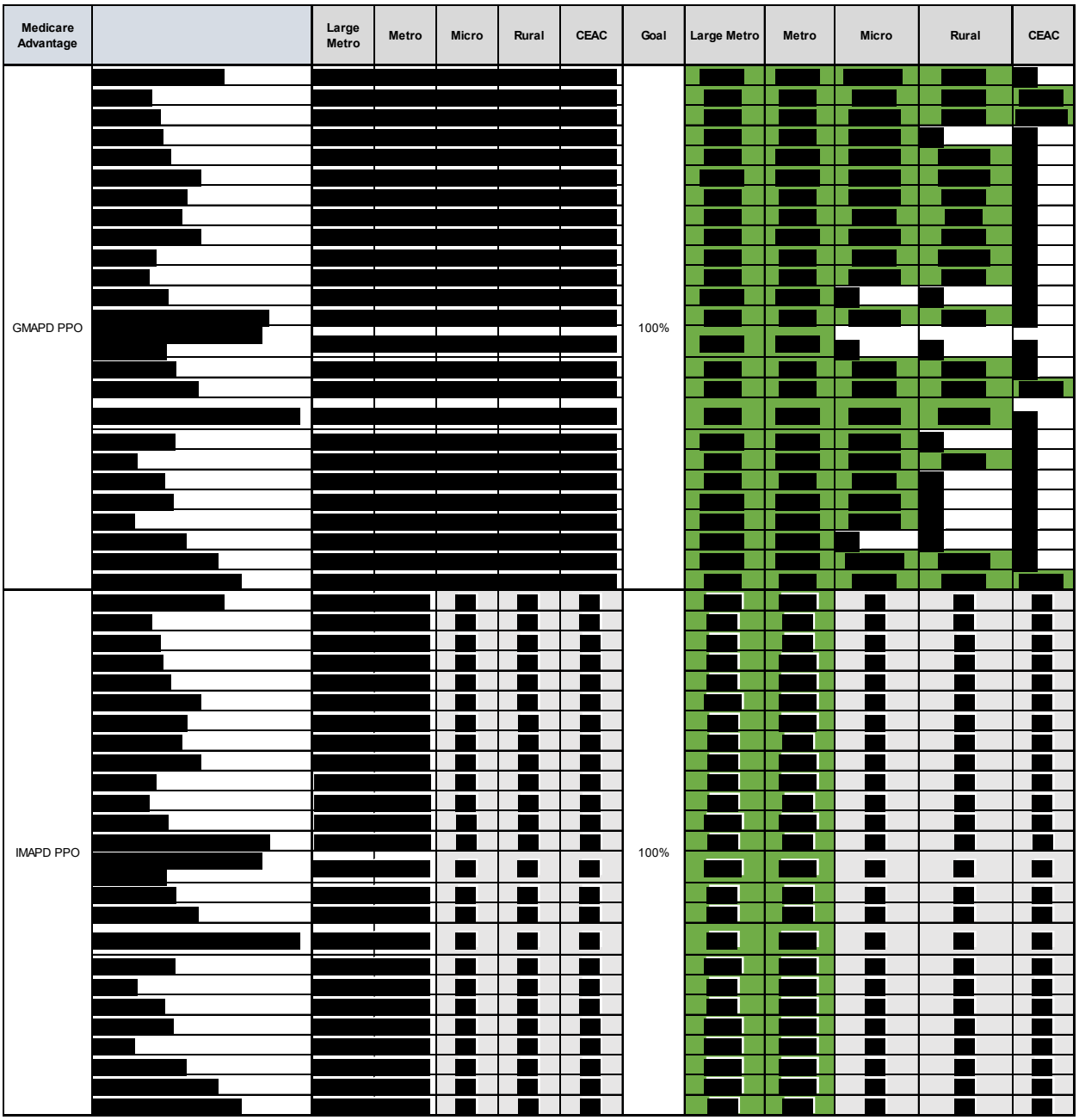
Blue Shield of California
Access & Availability – 2025 Network Performance Summary



Blue Shield of California
Access & Availability – 2025 Network Performance Summary

Network		Standard					Goal	MY2024 Results				
		Geographic Distribution of Specialist incuding High Volume and High Impact Specialists										
Medicare Advantage		Large Metro	Metro	Micro	Rural	CEAC	Goal	Large Metro	Metro	Micro	Rural	CEAC
GMAPD HMO							100%					
IMAPD HMO							100%					
DSNP							100%					

Blue Shield of California
Access & Availability – 2025 Network Performance Summary



Blue Shield of California
Access & Availability – 2025 Network Performance Summary

Geographic Distribution of Specialists, High Volume and High Impact Specialists: Quantitative Analysis
MY2025/RY2025

Network	Specialty	Standard	Goal	MY2025 Results	Standard	Goal	MY2025 Results
Geographic Distribution of Specialists, including High Volume and High Impact Specialists					**Specialist to Member Ratio**		
Standard							
LA Medi-Cal Adult	Cardiology/Intervention Cardiology (HI)	1 specialist (per spc type) within 15 miles or 30 min from members address or anticipated address	90%	96.7%	1:10000	90%	1:1554
	Dermatology (HV)			98.9%			1:3745
	Hematology (HV)			98.3%			1:1625
	Neurology (HI)			98.8%			1:2137
	Oncology (HV, HI)			98.3%			1:1157
	Orthopedic Surgery (HV)			98.4%			1:1771
	Obstretics and Gynecology (HV)			98.9%	1:5000		1:623
LA Medi-Cal Pediatric	Cardiology/Intervention Cardiology (HI)	1 specialist (per spc type) within 15 miles or 30 min from members address or anticipated address	90%	95.8%	1:10000	90%	1:1838
	Dermatology (HV)			98.9%			1:3745
	Hematology (HV)			98.3%			1:1725
	Neurology (HI)			98.8%			1:2412
	Oncology (HV, HI)			98.3%			1:1214
	Orthopedic Surgery (HV)			98.4%			1:1771
	Obstretics and Gynecology (HV)			98.9%	1:5000		1:638
SD Medi-Cal Adult	Cardiology/Intervention Cardiology (HI)	1 specialist (per spc type) within 15 miles or 30 min from members address or anticipated address	90%	89.9%	1:10000	90%	1:1334
	Dermatology (HV)			93.5%			1:1994
	Hematology (HV)			87.9%			1:2229
	Neurology (HI)			87.7%			1:1435
	Oncology (HV, HI)			87.9%			1:1894
	Orthopedic Surgery (HV)			88.6%			1:1515
	Obstretics and Gynecology (HV)			90.1%	1:5000		1:480
SD Medi-Cal Pediatric	Cardiology/Intervention Cardiology (HI)	1 specialist (per spc type) within 15 miles or 30 min from members address or anticipated address	90%	89.9%	1:10000	90%	1:1373
	Dermatology (HV)			93.5%			1:1994
	Hematology (HV)			87.4%			1:2398
	Neurology (HI)			87.7%			1:1446
	Oncology (HV, HI)			87.9%			1:1994
	Orthopedic Surgery (HV)			88.6%			1:1515
	Obstretics and Gynecology (HV)			90.1%	1:5000		1:482

Blue Shield of California
Access & Availability – 2025 Network Performance Summary

MY2024/RY2024 Data Results

Network	Specialty	Standard	Goal	MY2024 Results	Standard	Goal	MY2024 Results
Geographic Distribution of Specialists, including High Volume and High Impact Specialists					Specialist to Member Ratio		
Standard							
LA Medi-Cal Adult	Cardiology/Intervention Cardiology (HI)	1 specialist (per spc type) within 15 miles or 30 min from members address or anticipated address	90%	97.1%	1:10000	90%	1:1387
	Hematology (HV)			98.4%			1:1628
	Neurology (HI)			98.7%			1:1762
	Oncology (HV, HI)			98.4%			1:1092
	Orthopedic Surgery (HV)			61.7%			1:36478
	Obstretics and Gynecology (HV)			98.9%	1:5000		1:515
LA Medi-Cal Pediatric	Cardiology/Intervention Cardiology (HI)	1 specialist (per spc type) within 15 miles or 30 min from members address or anticipated address	90%	96.2%	1:10000	90%	1:1533
	Hematology (HV)			98.4%			1:1729
	Neurology (HI)			98.7%			1:1930
	Oncology (HV, HI)			98.4%			1:1147
	Orthopedic Surgery (HV)			61.7%			1:36478
	Obstretics and Gynecology (HV)			98.9%	1:5000		1:526
SD Medi-Cal Adult	Cardiology/Intervention Cardiology (HI)	1 specialist (per spc type) within 15 miles or 30 min from members address or anticipated address	90%	89.7%	1:10000	90%	1:1101
	Hematology (HV)			86.3%			1:1754
	Neurology (HI)			87.0%			1:1289
	Oncology (HV, HI)			86.3%			1:1493
	Orthopedic Surgery (HV)			N/A			N/A
	Obstretics and Gynecology (HV)			89.9%	1:5000		1:395
SD Medi-Cal Pediatric	Cardiology/Intervention Cardiology (HI)	1 specialist (per spc type) within 15 miles or 30 min from members address or anticipated address	90%	89.7%	1:10000	90%	1:1117
	Hematology (HV)			86.3%			1:1862
	Neurology (HI)			87.0%			1:1300
	Oncology (HV, HI)			86.3%			1:1571
	Orthopedic Surgery (HV)			N/A			N/A
	Obstretics and Gynecology (HV)			89.9%	1:5000		1:395

Blue Shield of California
Access & Availability – 2025 Network Performance Summary

Geographic Distribution of Specialists - Quantitative Analysis
MY2025/RY2025 Data Results

Network	Specialty	Standard	Goal	MY2025 Results	Standard	Goal	MY2025 Results
Geographic Distribution of Specialists, including High Volume and High Impact Specialists					**Specialist to Member Ratio**		
Standard							
LA Medi-Cal Adult	Cardiology/Intervention Cardiology (HI)	1 specialist (per spc type) within 15 miles or 30 min from members address or anticipated address	90%	96.7%	1:10000	90%	1:1554
	Dermatology (HV)			98.9%			1:3745
	Gastroenterology			96.9%			1:2712
	Ophthalmology			99.2%			1:1195
	Endocrinology			97.4%			1:4978
	ENT-Otolaryngology			97.4%			1:5314
	General Surgery			97.8%			1:1612
	Hematology (HV)			98.3%			1:1625
	HIV-AIDS Specialist / Infectious Disease			96.3%			1:4855
	Nephrology			98.3%			1:2137
	Neurology (HI)			98.8%			1:2137
	Oncology (HV, HI)			98.3%			1:1157
	Orthopedic Surgery (HV)			98.4%			1:1771
	Physical Medicine and Rehabilitation			98.5%			1:6242
	Pulmonology			95.4%			1:3171
	Obstretics and Gynecology (HV)			98.9%	1:5000		1:623
LA Medi-Cal Pediatric	Cardiology/Intervention Cardiology (HI)	1 specialist (per spc type) within 15 miles or 30 min from members address or anticipated address	90%	95.8%	1:10000	90%	1:1838
	Dermatology (HV)			98.9%			1:3745
	Gastroenterology			95.9%			1:3277
	Ophthalmology			98.7%			1:1244
	Endocrinology			97.4%			1:5462
	ENT-Otolaryngology			97.4%			1:5387
	General Surgery			97.8%			1:1710
	Hematology (HV)			98.3%			1:1725
	HIV-AIDS Specialist / Infectious Disease			96.2%			1:5041
	Nephrology			98.2%			1:2553
	Neurology (HI)			98.8%			1:2412
	Oncology (HV, HI)			98.3%			1:1214
	Orthopedic Surgery (HV)			98.4%			1:1740
	Physical Medicine and Rehabilitation			98.5%			1:7419
	Pulmonology			95.4%			1:3641
	Obstretics and Gynecology (HV)			98.9%	1:5000		1:638

Blue Shield of California
Access & Availability – 2025 Network Performance Summary

SD Medi-Cal Adult	Cardiology/Intervention Cardiology (HI)	1 specialist (per spc type) within 15 miles or 30 min from members address or anticipated address	90%	89.9%	1:10000	90%	1:1334
	Dermatology (HV)			93.5%			1:1994
	Gastroenterology			89.2%			1:2153
	Ophthalmology			92.0%			1:1169
	Endocrinology			87.1%			1:3444
	ENT-Otolaryngology			87.9%			1:3055
	General Surgery			86.6%			1:1662
	Hematology (HV)			87.9%			1:2229
	HIV-AIDS Specialist / Infectious Disease			92.5%			1:2960
	Nephrology			87.4%			1:2105
	Neurology (HI)			87.7%			1:1435
	Oncology (HV, HI)			87.9%			1:1894
	Orthopedic Surgery (HV)			88.6%			1:1515
	Physical Medicine and Rehabilitation			86.7%			1:5412
	Pulmonology			89.3%			1:1994
	Obstretics and Gynecology (HV)			90.1%	1:5000		1:480
SD Medi-Cal Pediatric	Cardiology/Intervention Cardiology (HI)	1 specialist (per spc type) within 15 miles or 30 min from members address or anticipated address	90%	89.9%	1:10000	90%	1:1373
	Dermatology (HV)			93.5%			1:1994
	Gastroenterology			89.2%			1:2153
	Ophthalmology			92.0%			1:1184
	Endocrinology			87.1%			1:3574
	ENT-Otolaryngology			87.9%			1:3105
	General Surgery			86.6%			1:1691
	Hematology (HV)			87.4%			1:2398
	HIV-AIDS Specialist / Infectious Disease			87.5%			1:3007
	Nephrology			87.4%			1:2153
	Neurology (HI)			87.7%			1:1446
	Oncology (HV, HI)			87.9%			1:1994
	Orthopedic Surgery (HV)			88.6%			1:1528
	Physical Medicine and Rehabilitation			86.7%			1:5412
	Pulmonology			89.3%			1:2105
	Obstretics and Gynecology (HV)			90.1%	1:5000		1:482

Blue Shield of California
Access & Availability – 2025 Network Performance Summary

MY2024/RY2024 Data Results

Network	Specialty	Standard	Goal	MY2024 Results	Standard	Goal	MY2024 Results
Geographic Distribution of Specialists, including High Volume and High Impact Specialists					**Specialist to Member Ratio**		
Standard							
LA Medi-Cal Adult	Cardiology/Intervention Cardiology (HI)	1 specialist (per spc type) within 15 miles or 30 min from members address or anticipated address	90%	97.1%	1:10000	90%	1:1387
	Dermatology			98.8%			1:3881
	Gastroenterology			95.9%			1:2184
	Ophthalmology			99.2%			1:1070
	Endocrinology			97.6%			1:4292
	ENT-Otolaryngology			97.4%			1:4099
	General Surgery			97.8%			1:1298
	Hematology (HV)			98.4%			1:1628
	HIV-AIDS Specialist / Infectious Disease			96.2%			1:3685
	Nephrology			98.2%			1:1983
	Neurology (HI)			98.7%			1:1762
	Oncology (HV, HI)			98.4%			1:1092
	Orthopedic Surgery (HV)			61.7%			1:36478
	Physical Medicine and Rehabilitation			98.6%			1:6289
	Pulmonology			95.1%			1:2482
	Obstretics and Gynecology (HV)			98.9%	1:5000		1:515
LA Medi-Cal Pediatric	Cardiology/Intervention Cardiology (HI)	1 specialist (per spc type) within 15 miles or 30 min from members address or anticipated address	90%	96.2%	1:10000	90%	1:1533
	Dermatology			98.8%			1:3922
	Gastroenterology			95.5%			1:2551
	Ophthalmology			98.6%			1:1095
	Endocrinology			97.5%			1:4617
	ENT-Otolaryngology			97.4%			1:4099
	General Surgery			97.8%			1:1382
	Hematology (HV)			98.4%			1:1729
	HIV-AIDS Specialist / Infectious Disease			95.6%			1:3881
	Nephrology			98.1%			1:2384
	Neurology (HI)			98.7%			1:1930
	Oncology (HV, HI)			98.4%			1:1147
	Orthopedic Surgery (HV)			61.7%			1:36478
	Physical Medicine and Rehabilitation			98.6%			1:6755
	Pulmonology			95.0%			1:2806
	Obstretics and Gynecology (HV)			98.9%	1:5000		1:526

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

<u>Quantitative Analysis: (apply to BSC and BSP both unless otherwise stated):</u>
Based on the Geographic Distribution of Specialist (HVS & HIS)

This analysis compares the Geographic Distribution of High-Volume and High-Impact Specialists performance between Measurement Year 2024/Reporting Year 2024 and Measurement Year 2025/Reporting Year 2025 across all networks. The comparison evaluates whether each network, specialty and Specialist to Member Ratio met the established goals.

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Blue Shield of California
Access & Availability – 2025 Network Performance Summary

- [redacted]

Medicare:

- [redacted]

Blue Shield of California
Access & Availability – 2025 Network Performance Summary

This analysis compares the Geographic Distribution of Specialists, including High-Volume and High-Impact Specialists, performance between Measurement Year 2024/Reporting Year 2024 and Measurement Year 2025/Reporting Year 2025 across Medi-Cal LA (Adult, Pediatric) and Medi-Cal SD (Adult, Pediatric). The comparison evaluates whether each network, specialty and Specialist to Member Ratio met the established goals.

- **LA Medi-Cal Adult** – All specialties met or exceeded the 90% goal in 2024, with results ranging from 95.1% to 99.2%. The only exception was Orthopedic Surgery which was at 61.7% in 2024 but dramatically improved to 98.4% in 2025. All other specialties maintained strong performance in 2025.
- **LA Medi-Cal Pediatric** – Similar to the Adult network, all specialties except Orthopedic Surgery met the 90% goal in 2024. Performance remained consistently strong in 2025 across all specialties that had previously met goals.
- **SD Medi-Cal Adult Network:** The San Diego Adult network faced substantial challenges in 2024 with multiple specialties falling below the 90% threshold. Cardiology/Intervention Cardiology achieved 89.7% and improved marginally to 89.9% in 2025, still 0.1 percentage points below goal. Hematology was at 86.3% in 2024 and improved to 87.9% in 2025, gaining 1.6 percentage points but remaining 2.1 points below target. Neurology achieved 87.0% in 2024 and improved to 87.7% in 2025. Oncology reached 86.3% in 2024 and improved to 87.9% in 2025. Obstetrics and Gynecology was at 89.9% in 2024 and improved to 90.1% in 2025, successfully crossing the threshold by 0.2 percentage points. Gastroenterology improved from 87.0% to 89.2%. Endocrinology rose from 86.3% to 87.1%, improving by 0.8 percentage points while remaining 2.9 points short. ENT-Otolaryngology increased from 86.9% to 87.9%. General Surgery remained essentially flat, moving from 86.3% to 86.6%. HIV-AIDS Specialist/Infectious Disease showed the strongest improvement, jumping from 87.3% to 92.5%, a gain of 5.2 percentage points and now exceeding the goal. Nephrology edged up from 87.3% to 87.4%. Physical Medicine and Rehabilitation increased from 86.3% to 86.7% but is still 3.3 points short. Pulmonology moved from 89.1% to 89.3% and Orthopedic Surgery, which was N/A in 2024, achieved 88.6% in 2025, still 1.4 points below goal.
- **SD Medi-Cal Pediatric Network:** This network mirrored the adult network's challenges. Cardiology/Intervention Cardiology was at 89.7% in 2024 and improved to 89.9% in 2025, Hematology achieved 86.3% in 2024 and improved to 87.4% in 2025. Neurology was at 87.0% in 2024 and improved to 87.7% in 2025, and Oncology reached 86.3% in 2024 and improved to 87.9% in 2025 Obstetrics and Gynecology improved from 89.9% to 90.1%, successfully meeting the goal. Gastroenterology improved from 87.0% to 89.2%, and Endocrinology increased from 86.3% to 87.1%, improving by 0.8 percentage points while remaining 2.9 points short. ENT-

Otolaryngology rose from 86.9% to 87.9%. General Surgery moved from 86.3% to 86.6%. HIV-AIDS Specialist/Infectious Disease showed minimal improvement from 87.3% to 87.5%. Nephrology edged from 87.3% to 87.4%. Physical Medicine and Rehabilitation increased from 86.3% to 86.7% and Pulmonology moved from 89.1% to 89.3%, improving by only 0.2 percentage points and staying 0.7 points below goal. Orthopedic Surgery, which was N/A in 2024, achieved 88.6% in 2025, still 1.4 points below goal.

The goal was met by the Specialist to Member Ratio metric across ALL networks in MY2025. No further action is required.

Qualitative Analysis:

- [redacted]
- Lack of Oncology and Hematology specialists throughout CA to contract with, compounded by budgetary constraints. Blue Shield contracts with health systems, such as CHLA, CHOC, Rady's for pediatric care, and UCLA, UCSF, UCSD, etc. for adult care to assist in filling in the gaps.
- In San Diego County, BSP's ability to expand its provider network is impacted by the presence of large medical groups, including Kaiser, Scripps and Sharp, which have elected not to enter into contractual agreements with the plan or its affiliated IPAs. This limits the pool of providers available for direct contracting and presents challenges in meeting network adequacy standards. To mitigate this constraint, BSP implements structured annual outreach initiatives aimed at identifying and engaging new provider groups for potential contracting opportunities, thereby supporting continued compliance with access and availability requirements.
- Access challenges in rural regions of Los Angeles and San Diego Counties have impacted our ability to meet timely care standards. In many cases, members elect to seek specialty services outside their residential area, often closer to their place of employment or at California Healthcare Centers of Excellence—resulting in utilization patterns that fall outside BSP-defined geographic access parameters.
- BSP continues to face recruitment challenges in both Los Angeles and San Diego Counties related to Medi-Cal provider participation. Compared to other payer networks, Medi-Cal presents unique barriers, including less competitive reimbursement structures and heightened compliance requirements for both patients and providers. These factors contribute to reduced provider engagement and limit network expansion efforts within the Medi-Cal program.

Blue Shield of California
Access & Availability – 2025 Network Performance Summary

Opportunities/Interventions (apply to BSC and BSP both unless otherwise stated):

Opportunity for improvement	Interventions
BSC – Strengthen specialist recruitment strategies by reviewing network composition and increasing efforts in rural and high-demand geographic areas to address patient access gaps.	BSC to partner with contracted IPA/Medical Groups on provider recruitment areas to ensure the plan meets specialty gaps in areas like neurology. BSC will coordinate with contracted IPA and Medical Groups to hold targeted specialist recruitment events (such as job fairs) in rural counties like Humboldt, Mariposa, and Tuolumne. In addition, BSC will implement a virtual medicine pilot program for specialties with persistent gaps and track recruitment progress monthly. Additional strategies include partnering with local medical schools and hosting virtual career fairs to attract specialists in high-demand areas.
BSP – Increase provider availability by collaborating with IPA and Medical Groups on provider recruitment and increasing access to PCP	Distribute access and availability report bi-annually. IPA/Medical Groups will be asked to provide their barriers, challenges, and mitigation plans. IPA and Medical Groups that continue to fail to meet threshold for Access to Care for Specialty services will be placed on a Corrective Action Plan. IPA and Medical Groups will be asked to document their mitigation plans, provide updates, and provide proof to demonstrate their interventions were completed.
BSP – Conduct our annual evaluation of specialty time and distance standards by zip code and specialty provider type to identify network gaps.	We will evaluate the demand and need of the specialty type and area and conduct outreach to providers that will close network deficiencies. We will also work with IPA and Medical Groups to identify providers in their network that participate in Non-Medi-Cal plans and discuss the providers' willingness to participate in Medi-Cal.

BSP – There is an opportunity to improve the quality of our provider network data to improve the accuracy of our provider network adequacy reports.	• Implemented an automated online provider network change submission process, which enables our subcontracted network to update their network quicker and improve our data accuracy used for network adequacy reporting. • Educate network on data tools to ensure quarterly validation via of data. Trainings are being held for network providers on new provider data processes, including the creation of a provider training guide. • As a result of APL 25-006, BSP implemented a data monitoring process to improve data quality by reviewing data distributed by DHCS, including the examination of data errors, which will improve provider participation and better reflect the efforts from the plan.

Element D - Practitioners Providing Behavioral Healthcare

Description:
BSC has established standards and monitoring mechanisms to ensure that its behavioral health network has a sufficient number of practitioners for its FEP PPO, self-funded, Medicare supplemental, and individual Medicare Advantage products which utilizes the direct contracted BSC Behavior Health providers. All fully insured Commercial product lines access behavior healthcare services through a Plan-to-Plan arrangement with Magellan and are therefore exempt for this report. All Promise Health Plan product lines are monitored and managed by BSP.

Methodology:
BSC performs an annual evaluation using the MY2025 Timely Access Reporting BSC Behavioral Health provider network, assessing geographical distribution and member to provider ratios for all behavioral healthcare practitioners to ensure set standards are met.

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

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

Element D - Practitioners Providing Behavioral Healthcare

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

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

Blue Shield of California Classic: Behavioral Health
MY2025/RY2025 Data Results:

Blue Shield of California
Access & Availability – 2025 Network Performance Summary

Network	Specialty	Standard	Goal	MY2025 Results	Standard	Goal	MY2025 Results
BSC Behavior Health							
DMHC PPO (MedSupp, ASO, FEP PPO(BSC only at risk for Professional for FEP))					1:10000	100%	
					1:10000	100%	
					1:10000	100%	
					1:10000	100%	
					1:10000	100%	
					1:10000	100%	
					1:10000	100%	
					1:10000	100%	
HPN					1:10000	100%	
					1:10000	100%	
					1:10000	100%	
					1:10000	100%	
					1:10000	100%	
					1:10000	100%	
					1:10000	100%	
					1:10000	100%	
Tandem					1:10000	100%	
					1:10000	100%	
					1:10000	100%	
					1:10000	100%	
					1:10000	100%	
					1:10000	100%	
					1:10000	100%	
					1:10000	100%	

Blue Shield of California
Access & Availability – 2025 Network Performance Summary

BSC Behavior Health - Medicare Advantage						
IMAPD HMO	[redacted]	[redacted]	90%	[redacted]	100%	[redacted]
DSNP	[redacted]	[redacted]	90%	[redacted]	100%	[redacted]
IMAPD PPO	[redacted]	[redacted]	[redacted]	[redacted]	100%	[redacted]

Blue Shield of California
Access & Availability – 2025 Network Performance Summary

Blue Shield of California Classic: Behavioral Health
MY2024/RY2024 Data Results:

Network	Specialty	Standard	Goal	MY2024 Results	Standard	Goal	MY2024 Results
BSC Behavior Health							
DMHC PPO (MedSupp, ASO, FEP PPO(BSC only at risk for Professional for FEP))	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	1:20000	100%	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	1:20000	100%	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	1:20000	100%	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	1:20000	100%	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	1:20000	100%	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	1:20000	100%	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
HPN	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	1:20000	100%	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	1:20000	100%	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	1:20000	100%	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	1:20000	100%	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	1:20000	100%	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	1:20000	100%	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
Tandem	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	1:20000	100%	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	1:20000	100%	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	1:20000	100%	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	1:20000	100%	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	1:20000	100%	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	1:20000	100%	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]

Blue Shield of California
Access & Availability – 2025 Network Performance Summary

[redacted]

Magellan Delegated Behavioral Health Network (Commercial HMO/PPO and Covered California/Exchange) – MY2025/RY2025 Results

Network	Specialty	Standard	Goal	MY2025 Results	Standard	Goal	MY2025 Results
Magellan Behavioral Health							
	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	1:10000	100%	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	1:10000	100%	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	1:10000	100%	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
Magellan Delegated Behavioral Health Network (Commercial HMO/PPO and Covered California/Exchange)	[redacted]	[redacted]	[redacted]	[redacted]	1:10000	100%	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	1:10000	100%	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	1:10000	100%	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	1:10000	100%	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]			[redacted]

In MY2025/RY2025, behavioral health services for applicable fully insured Commercial members (Commercial HMO/PPO and Covered California/Exchange, as applicable) were accessed through a plan-to-plan arrangement with Magellan. Because this delegated arrangement did not represent ≥70% of total applicable membership for the measurement year, the organization is including Magellan's network assessment results and related oversight activities to demonstrate how access standards were evaluated and supported for the delegated Commercial population. Effective 2026, the Magellan arrangement was terminated, and behavioral health services were transitioned to an insourced model.

Blue Shield of California
Access & Availability – 2025 Network Performance Summary

Blue Shield Promise Health Plan: Behavioral Health
Measurement Year 2025/Reporting Year 2025 Data Results:

Network	Type	Specialty	Standard	Goal	MY2025 Results	Standard	Goal	MY2025 Results	Standard	Goal	MY2025 Results	Standard	Goal	MY2025 Results
Geographic Distribution of Behavioral Health Practioners									**BH practitioner to Member Ratio**			**BH practitioners accepting new patients to Member Ratio**		
LA Medi-Cal	Non-Prescribers	Licensed Clinical Social Worker - Adult	1 within 30 miles from members address or anticipated address	75%	100%	1 within 60 min from members address or anticipated address	75%	100.0%	1:5500	90%	1:133	1:5500	75%	1:134
		Licensed Marriage and Family Therapist - Adult			100%			100.0%			1:102			1:104
		Licensed Professional Clinical Counselor - Adult			97.8%			100%			1:779			1:785
		Psychology - Adult			100%			100%			1:574			1:605
		Licensed Clinical Social Worker - Pediatric			100%			100%			1:243			1:246
		Licensed Marriage and Family Therapist - Pediatric			100%			100%			1:185			1:189
		Licensed Professional Clinical Counselor - Pediatric			97.8%			99.8%			1:1462			1:1484
		Psychology - Pediatric			100%			100%			1:860			1:908
	Prescribers	Addiction Medicine - Adult			91.4%			95.7%	1:10000		1:131077	1:10000		1:131077
		Addiction Medicine - Pediatric			91.4%			95.7%			1:393232			1:393232
		Psychiatric Mental Health Nurse Practitioner - Adult			N/A*			N/A*			N/A*			N/A*
		Psychiatric Mental Health Nurse Practitioner - Pediatric			N/A*			N/A*			N/A*			N/A*
		Psychiatry - Adult			100%			100%			1:1342			1:1440
		Psychiatry - Pediatric			100%			100%			1:1771			1:1891
SD Medi-Cal	Non-Prescribers	Licensed Clinical Social Worker - Adult	1 within 30 miles from members address or anticipated address	75%	96.3%	1 within 60 min from members address or anticipated address	75%	99.8%	1:5500	90%	1:803	1:5500	75%	1:885
		Licensed Marriage and Family Therapist - Adult			98.8%			100%			1:665			1:702
		Licensed Professional Clinical Counselor - Adult			95.6%			99.0%			1:8236			1:9472
		Psychology - Adult			96.5%			100%			1:776			1:857
		Licensed Clinical Social Worker - Pediatric			96.3%			99.8%			1:952			1:992
		Licensed Marriage and Family Therapist - Pediatric			98.8%			100%			1:723			1:761
		Licensed Professional Clinical Counselor - Pediatric			94.7%			98.8%			1:9970			1:10524
		Psychology - Pediatric			96.5%			99.9%			1:1041			1:1141
	Prescribers	Addiction Medicine - Adult			N/A*			N/A*	1:10000		N/A*	1:10000		N/A*
		Addiction Medicine - Pediatric			N/A*			N/A*			N/A*			N/A*
		Psychiatric Mental Health Nurse Practitioner - Adult			N/A*			N/A*			N/A*			N/A*
		Psychiatric Mental Health Nurse Practitioner - Pediatric			N/A*			N/A*			N/A*			N/A*
		Psychiatry - Adult			96.8%			100%			1:952			1:1030
		Psychiatry - Pediatric			96.5%			100%			1:1155			1:1230

N/A* - there were no Addiction Medicne providers in 2024 in San Diego

** - there were no Addiction Psychiatry specialty in 2024

*** - there were no Psychiatric Mental Health Nurse Practitioners in 2024

Blue Shield of California
Access & Availability – 2025 Network Performance Summary

Network	Specialty	Standard	Goal	MY2025 Results	Standard	Goal	MY2025 Results
MHSA Behavior Health - Standard					BH practitioner to Member Ratio		
DSNP	[redacted]	[redacted]	90%	[redacted]	[redacted]	100%	[redacted]

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

Network	Type	Specialty	Standard	Goal	MY2024 Results	Standard	Goal	MY2024 Results
Geographic Distribution of Behavioral Health Practioners						BH practitioner to Member Ratio		
LA Medi-Cal	Non-Prescribers	Licensed Clinical Social Worker - Adult	1 within 15 miles or 30 min from members address or anticipated address	90%	99.9%	1:10000	100%	1:217
		Licensed Marriage and Family Therapist - Adult			99.9%			1:156
		Licensed Professional Clinical Counselor - Adult			83.8%			1:1566
		Psychology - Adult			99.9%			1:738
		Licensed Clinical Social Worker - Pediatric			99.9%			1:714
		Licensed Marriage and Family Therapist - Pediatric			99.9%			1:487
		Licensed Professional Clinical Counselor - Pediatric			83.7%			1:7015
		Psychology - Pediatric			99.8%			1:1267
	Prescribers	Psychiatry - Adult			99.9%			1:1666
		Psychiatric Mental Health Nurse Practitioner - Adult			69.1%			1:26056
		Psychiatry - Pediatric			99.9%			1:2084
		Psychiatric Mental Health Nurse Practitioner - Pediatric			53.1%			1:36478
SD Medi-Cal	Non-Prescribers	Licensed Clinical Social Worker - Adult	1 within 15 miles or 30 min from members address or anticipated address	90%	92.4%	1:10000	100%	1:762
		Licensed Marriage and Family Therapist - Adult			99.9%			1:729
		Licensed Professional Clinical Counselor - Adult			91.8%			1:12567
		Psychology - Adult			93.5%			1:670
		Licensed Clinical Social Worker - Pediatric			92.4%			1:986
		Licensed Marriage and Family Therapist - Pediatric			99.5%			1:887
		Licensed Professional Clinical Counselor - Pediatric			90.7%			1:21543
		Psychology - Pediatric			93.5%			1:887
	Prescribers	Psychiatry - Adult			99.0%			1:725
		Psychiatric Mental Health Nurse Practitioner - Adult			82.4%			1:25134
		Psychiatry - Pediatric			99.0%			1:820
		Psychiatric Mental Health Nurse Practitioner - Pediatric			82.4%			1:25134

Network	Specialty	Standard	Goal	MY2024 Results	Standard	Goal	MY2024 Results
MHSA Behavior Health - Standard					BH practitioner to Member Ratio		
DSNP	[redacted]	[redacted]	90%	[redacted]	[redacted]	100%	[redacted]

<u>Quantitative Analysis:</u>

Blue Shield of California Classic networks:

In MY 2025, BSC added a new provider type to the analysis: Addiction Medicine practitioners.

Comparing MY2025 and MY2024, the following specialties met access goals in both years: Licensed Clinical Social Worker (Urban, Suburban, Rural), Licensed Marriage and Family Therapist (Urban, Suburban, Rural), Licensed Professional Clinical Counselor (Urban, Suburban), Psychology (Urban, Suburban, Rural), and Psychiatry (Urban, Suburban, Rural). All ratio goals for these specialties were also met, remaining well below the 1:20,000 threshold.

Blue Shield of California
Access & Availability – 2025 Network Performance Summary

FULL PPO Network:

- [redacted]

Ratio Goal Comparison (Goal: 1:20,000)

- [redacted]

HPN Network:

- [redacted]

Blue Shield of California
Access & Availability – 2025 Network Performance Summary

- [redacted]
- [redacted]

Ratio Goal Comparison:

- [redacted]

Tandem Network:

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

Ratio Goal Comparison:

- [redacted].

Blue Shield of California Medicare:

- [redacted].
- DNSP

- [redacted]

Magellan Delegated Behavioral Health Network (Commercial HMO/PPO and Covered California/Exchange):
Quantitative Analysis (MY2025/RY2025)

[redacted]

Ratio Analysis:

[redacted]

Summary:

Overall, the Magellan delegated network demonstrates strong performance for most behavioral health practitioner types, with the majority meeting both distance and ratio standards. The primary areas requiring attention are **Addictive Psychiatry** (distance and ratio gaps across all areas) and **LPCC** (rural distance gap and suburban/rural ratio gaps).
Blue Shield of California Promise Health Plan networks:

- LA Medi-Cal
    - In LA County the standard of a provider within 30 miles of our members was met for the Measurement year 2025. This measure does not have any comparison with 2024 as it was combined with time and distance in 2024.

- In LA County the standard of a provider within 60 minutes of our members was met for the Measurement year 2025. This measure does not have any comparison with 2024 as it was combined with time and distance in 2024.

- In LA County the standard of a BH practitioner to member ratio 1 per 5,500 for Non-Prescribers was met for the Measurement year 2025. The Prescriber provider type that did not meet the standard of a BH practitioner to member ratio 1 per 10,000 members was Addiction Medicine (AM) for adult and children. Addiction Medicine (AM) for adults did not meet the goal of 1 per 10,000 with a ratio of 1 per 131,077. AM for children did not meet the goal of 1 per 10,000 with a ratio of 1 per 393,232. It is worth noting that Blue Shield Promise is a Medi-Cal Managed Care Plan and that substance use disorder treatment is contractually carved out to the local Drug Medi-Cal Organized Delivery System. Therefore, Blue Shield Promise does not contract with these providers since it cannot use AM providers. No comparison for MY 2025 for the provider type AM since it was not measured in 2024.

- In LA County the standard of BH practitioners accepting new patients to member ratio 1 per 5,500 for Non-Prescribers was met for the Measurement year 2025. The Prescriber provider type that did not meet the standard of BH practitioners accepting new patients to member ratio 1 per 10,000 members was Addiction Medicine (AM) for adult and children. Accepting AM for adults did not meet the goal of 1 per 10,000 with a ratio of 1 per 131,077. Accepting AM for children did not meet the goal of 1 per 10,000 with a ratio of 1 per 393,232. It is worth noting that Blue Shield Promise is a Medi-Cal Managed Care Plan and that substance use disorder treatment is contractually carved out to the local Drug Medi-Cal Organized Delivery System. Therefore, Blue Shield Promise does not contract with these providers since it cannot use AM providers. There is no comparison for MY2025 as this was not measured in 2024

- SD Medi-Cal
  - In SD County the standard of a provider within 30 miles of our members was met for the Measurement year 2025. This measure does not have any comparison with 2024 as it was combined with time and distance in 2024. No action required.
  - In SD County the standard of a provider within 60 minutes of our members was met for the Measurement year 2025. This measure does not have any comparison with 2024 as it was combined with time and distance in 2024. No action required.
  - In SD County the standard for Non-Prescribers of a BH practitioner to member ratio 1 per 5,500 was mostly met for the Measurement year 2025. The provider type that did not meet the standard was Licensed Professional Clinical Counselors (LPCC) for adults and children. LPCC for adults did not meet the

standard of 1 per 5,500 with a current ratio of 1 per 8236. LPCC for children did not meet the goal of 1 per 5,500 with a current ratio of 9,970. No comparison for MY 2025 for the provider type LPCC since the standard was different in 2024.

- In SD County the standard of accepting new patients BH practitioner to member ratio 1 per 5,500 for Non-Prescribers was mostly met for the Measurement year 2025. The provider type that did not meet the standard was Licensed Professional Clinical Counselors (LPCC) for adults and children. Accepting LPCC for adults did not meet the goal of 1 per 5,500 with a current ratio of 1 per 94,72. Accepting LPCC for children did not meet the goal of 1 per 5,500 with a ratio of 1 per 10,524. No comparison for MY 2025 for the provider type LPCC since the ratio was not measured in 2024.

- DNSP
  - [redacted]

Qualitative Analysis:

Blue Shield of California Classic networks:
Barriers:

[redacted]

Blue Shield of California
Access & Availability – 2025 Network Performance Summary

Magellan Delegated Behavioral Health Network (Commercial HMO/PPO and Covered California/Exchange):

Blue Shield of California Promise Health Plan networks:
Blue Shield of California Promise Health Plan continues to enhance its behavioral health provider network to meet the needs of its diverse membership. The Licensed Professional Clinical Counselor (LPCC) credential has seen slower adoption compared to more established licenses such as LMFT and LCSW, though recent years have shown increased interest. To address geographic disparities, the contracting team actively monitors provider availability by ZIP code and targets outreach in underserved areas. The outskirts of San Diego and Los Angeles counties, in particular, have historically faced limited behavioral health access due to distance from urban centers. In response, Blue Shield has expanded telehealth services to ensure equitable access across all regions. Addiction Medicine (AM) providers are typically not part of a Medi-Cal Managed Care Plan, as these services are contractually carved out by the California Department of Health Care Services (DHCS) and delegated to the local Drug Medi-Cal Organized Delivery System (DMC-ODS). In both counties where Blue Shield Promise operates, access to these services through the DMC-ODS is robust and well-established with no significant number of calls and or grievances regarding these services.

<u>2025 Opportunities for Improvement and 2026 Interventions (BSC & BSP; Delegated Network Included Where Applicable)</u>

Opportunity for improvement	Interventions
BSC - Insufficient numbers of LPCCs in certain California zip codes	Targeted recruitment of LPCCs into BSC's Commercial network. List of impacted zip codes has been provided to the Behavioral Health Network Management team for recruitment.
BSC - Insufficient numbers of MHNPs in certain California zip codes	Targeted recruitment of MHNPs into BSC's Commercial network. List of impacted zip codes has been provided to the Behavioral Health Network Management team for recruitment.

Blue Shield of California
Access & Availability – 2025 Network Performance Summary

BSC - Insufficient numbers of Addiction Medicine Providers in certain California zip codes	Targeted recruitment of Psychiatrists specializing in Addiction Medicine into BSC's Commercial network. List of impacted zip codes has been provided to the Behavioral Health Network Management team for recruitment.
Magellan (delegated Commercial HMO/PPO and Covered CA/Exchange) – Improve availability of LPCC (rural distance and suburban ratio)	Targeted recruitment/contracting by Magellan for LPCC in impacted zip codes/geographies identified in the MY2025 assessment; results and remediation actions reviewed and tracked through vendor oversight for the delegated Commercial population. Effective 1/2026, the Magellan delegated arrangement was terminated and BH services were transitioned to an insourced model; recruitment/contracting and ongoing monitoring are now managed internally.
Magellan (delegated Commercial HMO/PPO and Covered California/Exchange) – Insufficient Addictive Psychiatry provider coverage across urban, suburban, and rural areas (new specialty measured in 2025; limited provider supply).	Targeted recruitment/contracting by Magellan for Addictive Psychiatry in impacted zip codes/geographies identified in the MY2025 assessment; results and remediation actions reviewed and tracked through vendor oversight for the delegated Commercial population. Effective 1/2026, the Magellan delegated arrangement was terminated and BH services were transitioned to an insourced model; recruitment/contracting and ongoing monitoring are now managed internally.
BSP – the BSP BH and Contracting team is committed to enhancing access across all provider types within its comprehensive care network. This includes Licensed Professional Clinical Counselors (LPCCs) serving both adult and pediatric populations.	The BSP Behavioral Health and Contracting team will initiate targeted contracting efforts to address gaps in LPCC provider availability across San Diego County. Specifically: • **Adult LPCC Providers**: Contracting will be pursued in the 48 ZIP codes

	identified as having deficiencies in adult LPCC coverage. • **Pediatric LPCC Providers**: Contracting will also be pursued in the 51 ZIP codes identified as having deficiencies in pediatric LPCC coverage. • **This goal will be ongoing**

III. Accessibility of Services (NET2):

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

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

Description:

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

Methodology:

Provider Appointment Availability Survey (PAAS):

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

BSC and BSP surveyed and reported a separate rate of compliance with the time elapsed standards for the networks in each county for each Provider Survey Type as required by the DMHC methodology. The BSC provider survey types surveyed in MY2025 were primary care providers, specialist providers (cardiologists, obstetricians/gynecologists, hematologists, neurologists, and oncologists), and behavioral health providers. Since not all high impact and high-volume specialists as defined by BSC were included in the survey, a comprehensive review of specialists is not possible for this section. These responses are limited to those high impact and high-volume specialty types that were surveyed. BSP provider survey types also included primary care providers, specialist providers, and behavioral health providers. The

Blue Shield of California
Access & Availability – 2025 Network Performance Summary

BSP specialist survey reviewed high volume and high impact specialty types (cardiology, oncology, neurology, hematology, dermatology and obstetrics/gynecology).

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

Provider ER and After-Hours Survey

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

The plans conduct a telephone survey of primary care physician and behavioral health provider offices to assess after-hours physician availability and access to appropriate emergency and urgent care information. The MY2025 survey was conducted by BSC's and BSP's vendor, using the Health Industry Collaboration Effort (HICE) database for and applying the National Committee for Quality Assurance (NCQA) "8/30" sampling methodology.

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

Blue Shield of California
Access & Availability – 2025 Network Performance Summary

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

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

Element A - Access to Primary Care

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

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

Element C - Access to Specialty Care

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

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

Blue Shield of California – Commercial/Exchange/Medicare

PCP

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

Type	Network	Goal	MY2024	MY2025	YOY Comparison
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Blue Shield of California
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	Medicare				

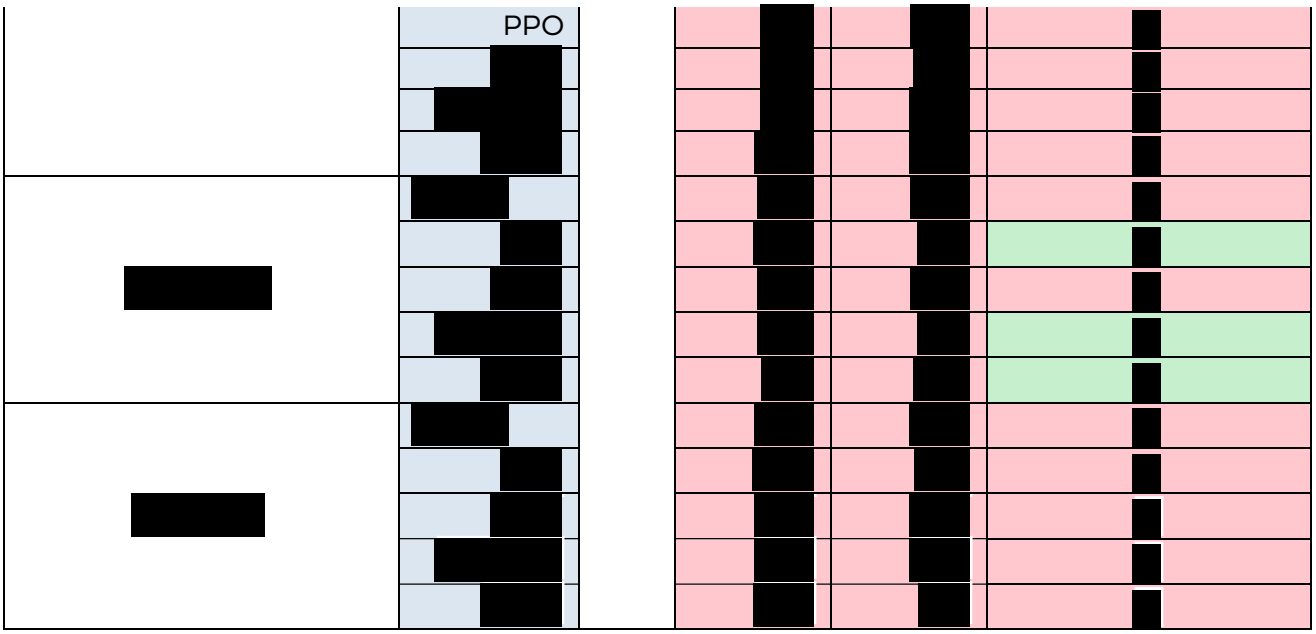
Type	Network	Goal	MY2024	MY2025	YOY Comparison
ER Access Instructions		100%			

SCP

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

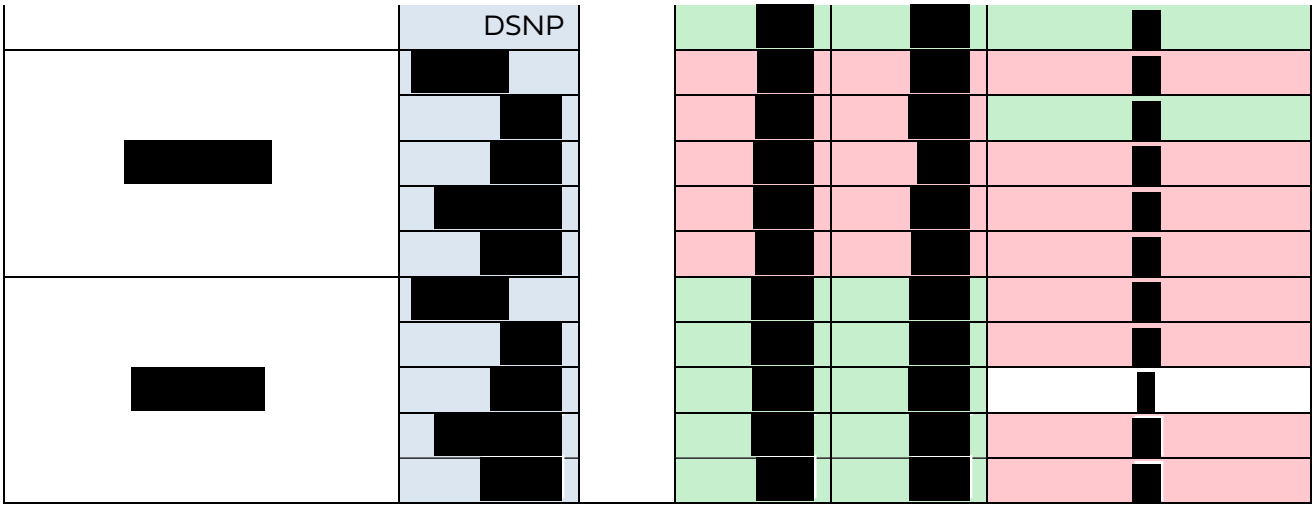
Urgent care					
Specialty	**Network**	**Goal**	**MY2024**	**MY2025**	**YOY Comparison**
HI and HV Specialties					
Cardiovascular disease	Overall	75%			

Blue Shield of California
Access & Availability – 2025 Network Performance Summary



Routine Care					
Specialty	Network	Goal	MY2024	MY2025	YOY Comparison
HI and HV Specialties					
Cardiovascular disease	Overall	75%			

Blue Shield of California
Access & Availability – 2025 Network Performance Summary



Blue Shield of California-/Medi-Cal

PCP

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

Type	Network	Goal	MY2024	MY2025	YOY Comparison
Urgent Care (hours)	Medi-Cal LA	75%	69%	68%	▼
	Medi-Cal SD		63%	77%	▲
Routine Care (days)	Medi-Cal LA		85%	87%	▲
	Medi-Cal SD		72%	91%	▲

Type	Network	Goal	MY2024	MY2025	YOY Comparison
ER Access Instructions	Medi-Cal LA	100%	92%	89%	▼
	Medi-Cal SD		91%	75%	▼
After hours availability	Medi-Cal LA		86%	78%	▼
	Medi-Cal SD		86%	62%	▼

SCP

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

Blue Shield of California
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Urgent care					
Specialty	Network	Goal	MY2024	MY2025	YOY Comparison
HI and HV Specialties					
Cardiology/Intervention Cardiology	Medi-Cal LA	75%	67%	71%	▲
	Medi-Cal SD		60%	66%	▲
Dermatology	Medi-Cal LA		61%	36%	▼
	Medi-Cal SD		55%	50%	▼
Oncology	Medi-Cal LA		74%	63%	▼
	Medi-Cal SD		38%	70%	▲
Hematology	Medi-Cal LA		82%	57%	▼
	Medi-Cal SD		82%	57%	▼
Neurology	Medi-Cal LA		60%	38%	▼
	Medi-Cal SD		32%	59%	▲
Obstetrics/Gynecology	Medi-Cal LA		67%	57%	▼
	Medi-Cal SD		*NA	19%	*NA

Routine Care					
Specialty	Network	Goal	MY2024	MY2025	YOY Comparison
HI and HV Specialties					
Cardiology/Intervention Cardiology	Medi-Cal LA	75%	78%	85%	▲
	Medi-Cal SD		57%	56%	▼
Dermatology	Medi-Cal LA		64%	50%	▼
	Medi-Cal SD		73%	60%	▼
Oncology	Medi-Cal LA		96%	85%	▼
	Medi-Cal SD		76%	80%	▲
Hematology	Medi-Cal LA		100%	91%	▼
	Medi-Cal SD		82%	71%	▼
Neurology	Medi-Cal LA		48%	42%	▼
	Medi-Cal SD		45%	41%	▼
Obstetrics/Gynecology	Medi-Cal LA		100%	81%	▼
	Medi-Cal SD		*NA	28%	*NA

* *Medi-Cal San Diego Obstetrics/Gynecology specialists were inadvertently omitted from the Provider Appointment Availability Survey Contact List and not surveyed for Measurement Year 2023. They were included and surveyed in Measurement Year 2024, and they will also be included and surveyed in Measurement Year 2025. Network Compliance has taken the following steps to ensure that Medi-Cal San Diego Obstetrics/Gynecology specialists are included in the future: Added the specialists to a secondary checklist to be conducted after the contact lists are generated, developed a new naming convention for files to ensure these contact lists display the contents accurately, worked with survey vendor -to add these specialists to the pre-survey validation process.*

Quantitative Analysis (NET 2 A and C congruent unless otherwise stated):
Blue Shield of California Classic networks:

Blue Shield of California
Access & Availability – 2025 Network Performance Summary

Urgent Care:

[redacted]

Routine Care:

[redacted]

ER Access Instructions and After-Hours Availability:

[redacted]

ER Access Instructions

- [redacted]

After Hours Availability:

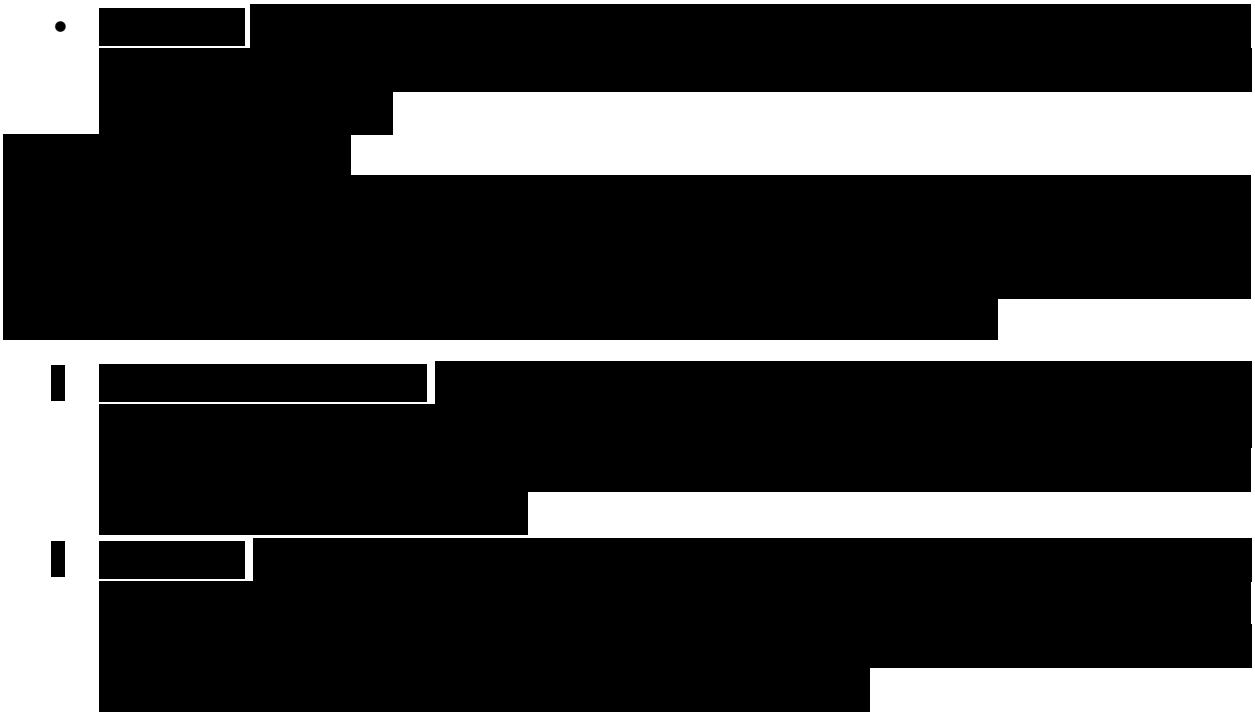
- [redacted]

Urgent Care Specialists:

[redacted]

- [redacted]

Blue Shield of California
Access & Availability – 2025 Network Performance Summary



Blue Shield of California Promise networks:

Urgent Care:

Blue Shield Promise met Urgent Care appointment availability in San Diego County with an improved rate of 77% increasing from 63% in MY2024. The goal was not met for Los Angeles County, decreasing from 69% in MY2024 to 68% in MY2025.

Routine Care:

When it comes to providing timely routine care, Blue Shield Promise met compliance in Los Angeles County increasing from 85% to 87% and a sharp increase of 19% in San Diego County, from 72% to 91%.

ER Access and After-Hours Instructions:

ER Access Instructions proved to be a challenge for Blue Shield Promise as we did not meet goal in Los Angeles County (89%), a slight 3% decrease from MY2024(92%) nor in San Diego County (75%), a 16% decrease from MY2024(91%)

Blue Shield Promise failed to meet After hours availability in Los Angeles County (78%), an 8% decline from MY2024(86%) nor in San Diego County (62%) a 24% decline from MY2024(86%).

Urgent Care Specialists:

In Specialty Urgent Care, Blue Shield Promise (BSP) experienced mixed trends in meeting goals across Los Angeles and San Diego Counties for Cardiology/Intervention Cardiology, Dermatology, Oncology, Hematology, Neurology, and Obstetrics/Gynecology. Notably, Cardiology/Intervention Cardiology improved in both Los Angeles (from 67% in MY2024 to 71% in MY2025) and San Diego (from 60% to 66%), reflecting an upward trend. Oncology in

San Diego also showed significant improvement, rising from 38% to 70%. Neurology in San Diego increased from 32% to 59%.
Conversely, Dermatology declined in both Los Angeles (from 61% to 36%) and San Diego (from 55% to 50%). Oncology, Hematology, and Neurology in Los Angeles all saw decreases: Oncology dropped from 74% to 63%, Hematology from 82% to 57%, and Neurology from 60% to 38%. Obstetrics/Gynecology in Los Angeles declined from 67% to 57%.

Routine Care Specialists:
In Specialty Routine Care, Blue Shield Promise (BSP) demonstrated varied trends in meeting goals across Los Angeles and San Diego Counties for Cardiology/Intervention Cardiology, Dermatology, Oncology, Hematology, Neurology, and Obstetrics/Gynecology. Cardiology/Intervention Cardiology in Los Angeles showed an upward trend, increasing from 78% in MY2024 to 85% in MY2025. In contrast, San Diego saw a slight decline in Cardiology/Intervention Cardiology, dropping from 57% to 56%.
Dermatology declined in both regions: Los Angeles decreased from 64% to 50%, and San Diego from 73% to 60%. Oncology in Los Angeles also declined, from 96% to 85%, while San Diego improved from 76% to 80%. Hematology decreased in both Los Angeles (from 100% to 91%) and San Diego (from 82% to 71%).
Neurology showed a downward trend in both regions: Los Angeles dropped from 48% to 42%, and San Diego from 45% to 41%. Obstetrics/Gynecology in Los Angeles declined from 100% to 81%, while in San Diego, the rate was 28% in MY2025

Qualitative Analysis (NET 2 A and C congruent unless otherwise stated):
Upon examination of results and goals that did not meet goals the following barriers were identified:

Blue Shield of California Classic networks:

- ER Access Instructions and After-Hours Availability: Groups reported that guidelines for after-hours requirements, including emergency instructions, are unclear. While medical groups generally provide appropriate instructions, this is not consistently the case for individual physicians in private practice. Providers in these settings often share their personal phone numbers for immediate availability, which leads to non-compliance with established requirements.
- Groups reported challenges with recruiting specialists due to the high costs of living and provider shortages. These circumstances affect routine, urgent, and emergency care.
- Practices are also affected by constant turnover, and this is causing gaps in addressing routine care.

  - Groups identified that Physicians continue to leave their medical groups, i.e., retiring, moving out of the area, and/or switching to part-time hours.
  - Providers have encouraged virtual/telemedicine to help with scheduling appointments, but are struggling to keep up with the demand, and these appointments are not falling within the routine timeframes.
- After the pandemic, providers shifted to concierge/virtual visits but are now having challenges keeping up with the demand.

Blue Shield of California Promise networks:

- When it comes to Urgent Care compliance in Los Angeles County, we have seen numerous barriers such as Physicians in this geographic region have reporting an increase in the growing population needing healthcare, and increasingly complex medical cases. Delivering high-quality care amid rising demand and case complexity has become increasingly difficult. The administrative burden to meet requirements of multiple health plans also impacts the time spent on patient appointments. Our downstream networks are promoting best practices, including reserving time for urgent and same-day visits, accommodating walk-ins, and offering telehealth options to improve patient access and convenience.
- BSP has identified several factors contributing to suboptimal performance in the ER Instruction and After-Hours survey domains. A high volume of outbound survey calls has led to provider fatigue, resulting in incomplete responses or premature call terminations. This has adversely affected survey completion rates and overall performance metrics. Additionally, data integrity issues have been observed, including outdated or incorrect provider contact information, disconnected phone lines, and instances of non-response. These factors collectively hinder BSP's ability accurately reflect provider engagement
- The survey does not account for members being able to see alternate PCP providers located at the same office or clinic, which is provided to members as an alternative when their requested provider is not available.
- There is a lack of general practitioners and specialists in LA and SD County, which makes it challenging to recruit providers to participate in Medi-Cal.
- Requirements (trainings, such as DEI and New Provider Orientation) to participate in Medi-Cal, which makes it difficult to recruit providers into network. The focus for Medi-Cal providers has now shifted to administratively meeting regulatory requirements by plan partner instead of focusing on patient care- this is driving practitioners to not want to participate in Medi-Cal.

Blue Shield of California
Access & Availability – 2025 Network Performance Summary

2025 Opportunities for improvement and 2026 interventions (BSC):

Opportunity for improvement	Interventions
BSC - Encourage IPA/medical groups to continuously evaluate network composition and specialty panels, recruit providers as needed and proactively address gaps to meet service demands.	Continue regular follow-up with IPA/Medical Groups on network adequacy and ensure prompt gap closure by assessing PCP and specialty needs and initiating recruitment or contracting as required (e.g., Loma Linda and Memorial Care actively recruiting physicians and extenders to meet service demands)
BSC – Encourage IPA/Medical Groups to utilize telehealth services to help with urgent care	Some specialty physician offices offer telehealth services and same-day appointments with an alternate physician. For example: Cedars Sinai Medical Group released a new program for 24/7 on-demand care to include video visits; they also have assigned providers who take turns in responding to messages and include language about calling 911. Scripps also has Scripps Health Express where they provide appointments on the same day at 9 Scripps coastal Medical Center Locations.
BSC – Provide resources to IPA/medical groups continue to educate their physician offices on access to care standards/ERAH, PAAS.	IPA/Medical Groups to share information from the health plan on standards including appropriate after-hours messaging, setting expectations with patients around timely appointments, etc. throughout their UM meetings and their provider communications Also, Blue Shield of California conducted outreach to physician groups and independent practice associations (IPAs) that scored the lowest 25% of the survey. Survey findings were shared, and these groups identified barriers and explored opportunities for improvement. The health plan will continue to support contracted IPAs and medical groups by providing compliance education and sharing examples of both compliance and non-compliance as described in the Provider Manual

Blue Shield of California
Access & Availability – 2025 Network Performance Summary

BSC – Encourage IPA/Medical Groups to partner with their Urgent Care network on Urgent Care usages by providing better ways to provide access to care for members	These efforts will free up PCP and Specialty availability and provide patients with additional access to care. Example: Desert Valley Medical Group is planning a call ahead program in the future for ER services/triage.
BSP – There is an opportunity to improve the quality of our provider network data to improve the accuracy of our provider network and improve the outcomes of our appointment availability surveys and network adequacy reports.	• Implemented an automated online provider network change submission process, which enables our subcontracted network to update their network quicker and improve our data accuracy used for appointment availability surveys. • Educate network on data tools to ensure quarterly validation via of data. Trainings are being held for network providers on new provider data processes, including the creation of a provider training guide. • As a result of APL 25-006, BSP implemented a data monitoring process to improve data quality by reviewing data distributed by DHCS, including the examination of data errors, which will improve provider participation and better reflect the efforts from the plan.
BSP - There is an opportunity to improve our subcontracted networks' performance through ongoing access and availability monitoring processes, including education and corrective action plans when they fail to meet standards.	• Provider Network has incorporated a Corrective Action Plan (CAP) in our access availability monitoring process when subcontractors fail to meet goals. Subcontractors are asked to provide their mitigation plans every 30-60 days and remain on a CAP until they have provided all requested documentation to address their deficiencies. CAPs are also being incorporated into Access & Availability Subcommittee to increase visibility and input on provider interventions. • Improve our monitoring process of subcontracted network by enhancing reports to include year-over-year results; this enhancement will provide further insights into areas that require targeted improvement. • Execute Secret Shopper Program to monitor access improvements in our poorer performing medical practices. A sampling of these practices is drawn from the validated annual

	PAAS Raw Data Templates' results for the most-recent Measurement Year. On an annual basis, this outbound call survey is used to evaluate access-related data directly from a sample set of targeted provider groups/IPAs to determine whether appointment accessibility has improved and/or is improving over time.
BSP - There is an opportunity to increase providers wanting to participate in the Medi-Cal line of business through education of reimbursement models now available for Medi-Cal providers.	• Educate IPA and direct network providers on the opportunities to increase their reimbursement through reimbursement models, such as Tri-Rates, FQHC Alternative Payment Methodology, and other incentive programs. • LOAs are used on a case-by-case basis to ensure members receive care, however, providers fail to sign a contract; these providers are not included in surveys. We will monitor highly utilized out of network providers to target for contracting and explain the reimbursement opportunities of being a contracted provider.

Element B: Access to Behavioral Healthcare

Description:

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

Methodology:

Provider Appointment Availability Survey (PAAS)

Blue Shield of California Commercial and Promise Health Plans conducted the Provider Appointment Availability Survey using the Department of Managed Health Care (DMHC) methodology, through the our vendor. The methodology was developed by the DMHC pursuant to the Knox-Keene Health Care Service Plan Act of 1975. The PAAS methodology, published under authority granted in Section 1367.03, subd. (f)(3), is a regulation in accordance with Government Code section 11342.600. For measurement year 2025, all reporting health plans were required to adhere to the PAAS methodology when developing and reporting rates of compliance for timely access appointment standards, pursuant to Rule 1300.67.2.2, subd. (g).

BSC surveyed and reported a separate rate of compliance with the time elapsed standards for the networks in each county for each Provider Survey Type as required by the DMHC methodology. The provider survey types surveyed in MY2025 were primary care providers, specialist providers (cardiologists, hematologists, neurologists and oncologists), and behavioral health providers. Since not all high impact and high-volume specialists as defined by BSC were included in the survey, a comprehensive review of specialists is not possible for this section. These responses are limited to those high impact and high-volume specialty types that were surveyed.

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

Provider ER and After-Hours Survey

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

BSC conducts a telephone survey of primary care physician and behavioral health provider offices to assess after-hours physician availability and access to appropriate emergency and urgent care information. The MY2025 survey was conducted by BSC's vendor using the Health Industry Collaboration Effort (HICE) database for and applying the National Committee for Quality Assurance (NCQA) "8/30" sampling methodology.

Up to 30 completed primary care physician surveys are attempted per physician organization. A sample of 30 providers and up to 20 oversample providers were randomly selected per provider group per county. Oversample provided replacements when invalid telephone numbers or refusals were encountered. If the first 8 providers surveyed were in compliance (all elements/questions), then the review ceases, and the score provided is 100%. If any of the providers surveyed were out of compliance, the review continued for the remaining 22 providers with an overall score provided for all 30. The physician sample was

drawn from the Blue Shield of California provider rosters. Primary care and behavioral health providers were included in the ER/After-Hours Survey. Surveys are conducted telephonically after normal business hours between 6:00 p.m. and 8:00 a.m., except for groups that use a call center that operates 24/7 and requires member identification to access a healthcare professional. In those cases, their score was based on a description of their call protocol. Survey questions were tailored to whether an interviewer reached a live person, a recording, or an auto-attendant. If a phone tree or message offered an option to dial a different number to reach a physician directly, the survey vendor was instructed to end the call and record that the physician was available immediately, in order to minimize intrusion on the physician's time. Only completed interviews were used in the analysis of the data. If the response choice "don't know" or "refused" was selected for a question, those responses were not included in the analysis of that question.
Blue Shield of California's after-hours standard requires that a PCP or covering physician is available to members 24 hours a day, 7 days a week. Emergency instructions are required for both answering services or a machine and must include clear instructions for obtaining emergency care.

Follow up Routine Care
Follow up Routine Care appointments were determined using an analysis of Behavioral Health claims for 2025. Claims were narrowed to locations that service appointments including offices, treatment facilities, and urgent care centers. The first initial visit for 2025 was identified by CPT code and subsequent follow up care codes with the same primary diagnosis and practitioner were included in the count of follow up care. For non-physicians, follow up routine care was additionally assessed on the PAAS.

Element B - Access to Behavioral Healthcare
Using valid methodology, the organization annually collects and analyzes data to evaluate access to appointments for behavioral healthcare for:

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

Classic BH
Care for a non-life-threatening emergency:

Type	Network	Goal	MY2024	MY2025	YOY Comparison
		100%			

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Access & Availability – 2025 Network Performance Summary

Access to BH care:

Urgent Care within 48 hours					
Type	Network	Goal	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Access to BH care: Initial visit for Routine Care within 10 business days:

Routine Care within 10 days					
Type	Network	Goal	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Follow Up Routine Care:

The following tables review initial appointments that had a timely follow up appointment with the same provider/same primary diagnosis, as assessed through claims data. Some members may choose not to pursue a follow up appointment or may have a follow up appointment under a different primary diagnosis, which would not be captured in our data. Additionally, providers may have assessed and documented that there would be no clinical harm if the member had a follow-up appointment outside the 10 or 15 business day standard.

Follow up appointment					
Type	Network	Goal	MY2024	MY2025	YOY Comparison
Prescriber (within 15 business days)	Overall	75%	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]		[redacted]	[redacted]	[redacted]
	[redacted]		[redacted]	[redacted]	[redacted]
	[redacted]		[redacted]	[redacted]	[redacted]

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This table represents the average number of business days between initial and follow-up appointments captured in the table above.

Follow up appointment					
Type	Network	Goal	MY2024	MY2025	YOY Comparison
Prescriber	Overall	15			
[redacted]	[redacted]	[redacted]			

The table below shows rates of non-prescribers who report having timely follow-up appointments on the PAAS.

Access to BH care: Follow up Routine Care Appointment within 10 business days:

Follow up Routine Care Appointment within 10 days					
Type	Network	Goal	MY2024	MY2025	YOY Comparison
Non-prescriber	Overall	75%			
	[redacted]				

Behavioral Health – Medi-Cal

Care for a non-life-threatening emergency:

Type	Network	Goal	MY2024	MY2025	Change
ER access instructions: prescriber	Medi-Cal LA	100%	70%	71%	▲
	Medi-Cal SD		78%	89%	▲
ER access instructions: non-prescriber	Medi-Cal LA		89%	75%	▼
	Medi-Cal SD		93%	98%	▲
After-Hours Availability: Prescriber	Medi-Cal LA		52%	41%	▼
	Medi-Cal SD		59%	51%	▼
After-Hours Availability: Non-Prescriber	Medi-Cal LA		43%	48%	▲
	Medi-Cal SD		43%	48%	▲

Access for Urgent Care:

Urgent Care within 48 Hours					
Type	Network	Goal	MY2024	MY2025	YOY Comparison

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Prescriber	Medi-Cal LA	75%	84%	86%	▲
	Medi-Cal SD		84%	69%	▼
Non-prescriber	Medi-Cal LA		68%	80%	▲
	Medi-Cal SD		68%	74%	▲

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

Routine Care within 10 days					
Type	Network	Goal	MY2024	MY2025	YOY Comparison
Prescriber	Medi-Cal LA	75%	91%	100%	▲
	Medi-Cal SD		86%	100%	▲
Non-prescriber	Medi-Cal LA		73%	89%	▲
	Medi-Cal SD		68%	84%	▲

Access for Follow-up Routine Care:

Follow up appointment					
Type	Network	Goal	MY2024	MY2025	YOY Comparison
Prescriber (15 days)	Medi-Cal LA	75%	93%	100%	▲
	Medi-Cal SD		91%	100%	▲
Non-prescriber (10 Days)	Medi-Cal LA		58%	91%	▲
	Medi-Cal SD		54%	84%	▲

Quantitative Analysis:
Blue Shield of California Classic networks

[redacted]

Care for a non-life – threatening emergency:

[redacted]

- [redacted]

Access for Urgent Care:

[redacted]

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

[redacted]

Follow-up Routine Care:

[redacted]

Blue Shield of California
Access & Availability – 2025 Network Performance Summary

Blue Shield of California Promise networks:

Care for a non-life – threatening emergency:

Los Angeles County

- In measurement year 2025, the goal of achieving 100% among prescribers for ER access instructions was not met, as performance increased slightly from 70% in 2024 to 71% in 2025.
- For non-prescribers, performance declined from 89% in 2024 to 75% in 2025.
- After-Hours Availability for prescribers decreased from 52% to 41%, while non-prescribers improved from 43% to 48%, though both remain well below 100%.

San Diego County

- In measurement year 2025, the goal of achieving 100% among prescribers for ER access instructions was not met, but performance improved from 78% in 2024 to 89% in 2025.
- For non-prescribers, performance improved from 93% to 98%, approaching the goal of 100%.
- After-Hours Availability for prescribers declined from 59% to 51%, while non-prescribers improved from 43% to 48%.

Access for Urgent Care:

- In measurement year 2025, the goal of achieving 75% among both prescribers and non-prescribers in Los Angeles County was met, as the performance improved from 84% to 86% for prescribers and improved from 68% to 80% for non-prescribers.

- In measurement year 2025, the goal of achieving 75% among both prescribers and non-prescribers in San Diego County was not met, as the performance declined from 84% to 69% for prescribers and improved from 68% to 74% for non-prescribers.

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

- In measurement year 2025, the goal of achieving 75% among both prescribers and non-prescribers in Los Angeles County was met, as the performance improved from 91% to 100% for prescribers and improved from 73% to 89% for non-prescribers.
- In measurement year 2025, the goal of achieving 75% among both prescribers and non-prescribers in San Diego County was met, as the performance improved from 86% to 100% for prescribers and improved from 68% to 84% for non-prescribers.

Access for follow-up Routine Care:

- In measurement year 2025, the goal of achieving 75% among both prescribers and non-prescribers in Los Angeles County was met, as the performance improved from 93% to 100% for prescribers and improved from 58% to 91% for non-prescribers.
- In measurement year 2025, the goal of achieving 75% among both prescribers and non-prescribers in San Diego County was met, as the performance improved from 91% to 100% for prescribers and improved from 54% to 84% for non-prescribers.

Qualitative Analysis (Prescribers and non-Prescribers congruent unless otherwise stated):
Blue Shield of California Classic networks

- The ER and After-Hours survey does not assess members' actual experiences in accessing emergency care.
- BH demand outweighs the BH Network capacity.
- With efforts to increase BH Network capacity, there are many BH providers who are new to managed care.
- Lacking targeted and specific education to behavioral health providers about after-hours messaging requirements and appointment access standards.
- Follow up appointment methodology using claims data for prescribers is not fully reliable:
    - Member declined follow up appointment offered by the provider
    - Provider assessed and documented there would be no clinical harm if the member was offered a follow-up appointment longer than standard
    - The diagnosis changed from the initial appointment to the follow-up appointment
    - The member had his/her follow up appointment with a different provider in the group or office.

Blue Shield of California
Access & Availability – 2025 Network Performance Summary

Blue Shield of California Promise networks:

Care for a non-life – threatening emergency barriers:

- Members in both counties face challenges obtaining appropriate care for non-life-threatening emergencies in the ER, especially after-hours. While members are accessing ER services, inconsistent mental health provider coverage often results in delayed or inadequate behavioral health interventions. Reduced staffing and limited psychiatric resources during evenings and weekends further increase the risk of inappropriate discharge. These gaps in care create a disconnect between ER utilization and performance goals, as access does not guarantee timely or quality outcomes.

Access for Urgent Care barriers:

- Members in San Diego County experienced access barriers when accessing urgent BH service needs for both prescribers and non-prescribers. These barriers could include factors such as limited availability of urgent care facilities, insufficient staffing, or logistical challenges that hinder timely access to care.

2025 Opportunities for improvement and 2026 interventions (BSC and BSP, Prescribers and non-Prescribers congruent unless otherwise stated):

Opportunity for improvement	Interventions
BSC - The ER and After-Hours survey does not assess members' actual experiences in accessing emergency care: BSC needs to track what happens when members call into the BSC Call Center with urgent or emergent BH needs.	Blue Shield of California (BSC) is enhancing all aspects of our behavioral health (BH) operations effective January 1, 2026. One improvement underway is the implementation of a dedicated BH Call Center trained to identify members with potential urgent or emergent needs. These members will be transferred to a dedicated team staffed with licensed clinicians who will conduct triage and screening and will ensure the member is aided in getting to the appropriate provider type and level of care within timeliness standards. Further, member calls risk-rated as urgent, non-life-threatening emergent, or life-threatening emergent will be tracked within our Care Management systems and timeliness outcomes will be reported to relevant workgroups and/or committees for performance monitoring purposes.
BSC - Follow up appointment methodology using claims data for prescribers is not fully reliable: BSC needs to assess timeliness of	BSC will add questions about timeliness of follow-up-appointments, separately for prescribers and non-prescribers, to the 2026 BH Member Experience Survey.

prescriber follow-up-appointments in additional ways	
BSP – Access to ER services during normal work hours and after-hours: Behavioral Health access. BSP needs to track if mental health professionals are available during normal work hours and after hours.	Implement a comprehensive ER support enhancement initiative that ensures members presenting with mental health needs receive timely behavioral health care, especially during after-hours. The Behavioral Health Operations team will collaborate with ER facilities to identify and implement solutions such as Telehealth when in person provider is not available. Additionally, the team will develop and distribute clear protocols and informational materials to ER staff to streamline behavioral health triage and reduce delays in care. Internal departments will coordinate with the Access and Crisis Line to reinforce 24/7 availability and educate members on these resources through targeted outreach following ER visits. This activity will be completed by Q2 2026 ..
BSP- is working on improving all access to care, in particular Urgent behavioral health services for both prescribing and non-prescribing provider to enhance the availability and timeliness of urgent behavioral health services.	The BH team will work with the internal departments to develop a workflow to facilitate timely referrals. The team will work on creating a streamlined process to ensure that patients who need urgent behavioral health services are referred quickly and efficiently to the appropriate providers. The aim is to reduce delays in care and improve overall access to urgent behavioral health services. This activity will be completed by Q4 2025.

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Assessment of Network Adequacy (NET 3):

The organization provides members adequate network access for needed healthcare services.

Element A: Assessment of Member Experience Accessing the Network

Description:

On an annual basis, Blue Shield assesses and evaluates appeals, complaints & grievances, utilization data including requests for and utilization of OON benefits, and claims related to access to determine if there are any potential issues related to network adequacy.

Methodology:

Blue Shield evaluates appeals, complaints and grievances utilizing the quality of care, access, attitude and service, billing and financial issues, and quality of practitioner office site categorization. These results are then reviewed to determine appropriate resolution in the form of member and/or provider communication.

Blue Shield also conducts member surveys to determine members' experiences with the provider network regarding getting care in a timely manner, quality of providers, and quality of care by surveying its members using California and nationwide standard surveys including the, Consumer Assessment of Healthcare Providers and Systems (CAHPS), and Enrollee Experience Survey (EES).

On an annual basis, Blue Shield of California assesses and evaluates appeals, complaints & grievances, utilization data including requests for and utilization of OON benefits, and claims related to access to determine if any potential issues related to network adequacy.

BSC annually assesses member experience for its behavioral health or substance abuse services by leveraging a custom Behavioral Health Member Experience survey. Additional custom questions have been added to the survey to better understand the members needs specific to California unique healthcare environment and Applied Behavioral Health Assessment populations.

Grievances, Complaints, and Appeals

Blue Shield of California's grievances, appeals and complaints (GACs) are tracked in the Facets Appeal system. 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 on a regular basis to aggregate detailed information concerning all appeals. Coordinators are responsible for entering GACs into the system and assigning appropriate codes. Accuracy is audited on a regular basis.

Blue Shield aggregates and evaluates GACs for all lines of business. All GACs are included in reporting, i.e., sampling is not used. This report encompasses data for all PPO, HMO, QHP (identified as On Exchange), Medicare, and Medi-Cal products divided between Behavioral Health and non-Behavioral Health. The reporting period is January 1, 2024, through

Blue Shield of California
Access & Availability – 2025 Network Performance Summary

December 31, 2024. The sum of appeals was calculated and annualized to reflect average monthly rates per 1,000 members (ptmpm).

Quality of care (potential quality issues/quality of care)

- perception of inadequate or inappropriate care
- delay in care that impacts quality of care received.

Quality of practitioner office site (complaints)

- dirty office
- Parking is not acceptable

Access (appeals and complaints)

- perception of provider non availability or access
- delay in referral/authorization
- inconvenient access/location
- inconvenient hours of operation
- specialist coordination

Attitude & Service (complaints)

- A primary care physician/medical group will not provide a referral or service.
- primary care physician/medical group delay in processing referral or service
- health plan provided incorrect information.
- incorrect pcp assignment
- customer service complaints

Billing & Financial (appeals and complaints)

appeals

- claims denial: services are not a benefit, authorization not obtained.
- benefit coverage: copayment, coinsurance, deductible, allowed amount, coordination of benefits.
- pharmacy copayments/deductibles
- eligibility/enrollment; transfers, rate increases, reinstatements, effective dates
- denial/delay of referral to specialist
- denial of referral to out of network specialist
- denial/delay of referral to specialist – 2nd opinion
- denial/delay of referral or authorization
- denial/delay of referral or authorization – out of network
- preservice (prior) authorization denial
- Prior Pharmacy authorization denial

Complaints

- delay of payment
- rate increases

Element A – Assessment of Member Experience Accessing the Network

The organization annually identifies gaps in networks specific to geographic areas or types of practitioners or providers by:

1. Using analysis results related to member experience with network adequacy for nonbehavioral healthcare services from ME 7, Element C and Element D
2. Using analysis results related to member experience with network adequacy for behavioral healthcare services from ME 7, Element E
3. Compiling and analyzing nonbehavioral requests for and utilization of out-of-network services

4. Compiling and analyzing behavioral healthcare requests for and utilization of out-of-network services

BlueShield Medical (non-behavioral health) Appeals and Complaints

	Goal	PPO		HMO		OnXchange		Medicare		MediCal	
LOB		**Count**	**Rate**	**Count**	**Rate**	**Count**	**Rate**	**Count**	**Rate**	**Count**	**Rate**
Access complaints	≤ 1 per thousand members per month	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	3768	0.54
Access appeals		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	0	0.00
Total		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	3768	0.54

BlueShield Behavioral Health Appeals and Complaints

	Goal	PPO		HMO		OnXchange		Medicare		MediCal	
LOB		**Count**	**Rate**	**Count**	**Rate**	**Count**	**Rate**	**Count**	**Rate**	**Count**	**Rate**
Access complaints	≤ 1 per thousand members per month	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	6	0.00
Access appeals		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	0	0.00
Total		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	6	0.00

Quantitative Analysis:

- Medical
  - The appeals and complaints goal of 1 per 1000 members per month was met for all LOB.
  - Both PPO and HMO lines of business met the goal of ≤ 1 complaint per 1,000 members per month for behavioral health access.
  - QHP's made up less than 1% of total QHP network appeals in 2024. This very low total volume of 27 for the year was primarily driven by appeals related to Timely Access Specialists. Grievances were also primarily due to cases for Timely Access Specialists.
  - Medicare access complaints made up ~9 % of all Medicare complaints in 2024. The 628 cases were primarily driven by transportation issues. Some of the primary drivers of transportation issues covered anything from not receiving transportation and having limited transportation benefits.
  - Medi-Cal access complaints made up ~40% of all Medi-Cal complaints in 2024. The 3768 cases were primarily driven by specialists. Some of the primary drivers of specialists included delay in referrals and authorizations, appointment availability and scheduling issues, specialist coordination/continuity of care, and network adequacy/provider access.

All goals were met. No further action.

- Behavioral Health
    - The appeals and complaints goal of 1 per 1000 members per month was met for all LOB.
    - Behavioral access complaints were very low across all Classic and BSP networks. Continuous monitoring of this category will continue. No action is required.
    - No behavioral health access complaints or appeals were reported for PPO or HMO during the measurement year, indicating stable access performance.
    - All goals were met. No further action.

Member Experience Surveys

Blue Shield of California herein referred to as 'Blue Shield' is strongly committed to member experience. Blue Shield systematically works to integrate a multi-disciplinary approach for quality improvement activities, working to improve and develop member centered design strategies and partnering with members and practitioners to deliver quality member experience and care.

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

Blue Shield has established appropriate monitoring mechanisms to ensure that its members have appropriate access to care. For its Commercial HMO/POS, PPO, Qualified Health Plan HMO, Qualified Health Plan PPO, and Medicare populations this includes participation in the NCQA Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, the California Healthcare Performance Information System (CHPI) ICE ER/After-Hours Survey, and the Provider Appointment Availability Survey (PAAS). The survey is administered annually to members to measure their experiences with their health plan and affiliated providers. Blue Shield uses an NCQA and CMS certified survey vendor Press Ganey Associates LLC., ("Press Ganey") who administers the CAHPS Survey in accordance with the National Committee for Quality Assurance ("NCQA") and CMS' protocol and specifications.

HEDIS CAHPS - Adult Commercial HMO/POS & Adult Commercial PPO

Blue Shield of California utilized an NCQA and CMS certified vendor Press Ganey to conduct the Consumer Assessment and Healthcare Providers and Systems (CAHPS) 5.1 Health Plan

Survey. The CAHPS survey is a requirement of the National Committee for Quality Assurance (NCQA), for compliance with its accreditation requirements. Department of Healthcare Services (DHCS) and Department of Managed Health Care (DMHC) also require the administration of CAHPS for compliance purposes. The primary objective of the CAHPS member experience survey is to assess the members' clinical quality experience. The CAHPS survey assesses the member's experience in a qualitative manner and allows health plans to obtain information about the member's experiences with the health plan and healthcare services. The survey aims to measure the members' expectations and goals, determine the areas with the greatest effects on overall satisfaction, and identify areas of opportunity for improvement, to increase the quality of care that Blue Shield provides its members. Blue Shield conducts the survey for its Commercial HMO/POS, Commercial PPO, Medicaid Adult in Los Angeles County, Medicaid Adult in San Diego County, Medicaid Child in Los Angeles County, and Medicaid Child in San Diego County populations annually. County regions are determined by the state of California. The survey for measurement year (MY) 2024 was fielded February 25, 2025 – May 7, 2025 reporting year also known as (RY2025)

- Eligibility is determined according to NCQA program requirements for accreditation. Member eligibility criteria for measurement year 2024 include the following:
- For adult CAHPS: all members ages eighteen (18) years or older as of December 31st of the measurement year
- For Child CAHPS: all members under the age of eighteen (18) years as of December 31st of the measurement year
- Currently enrolled at the time the sample is drawn.
- Continuously enrolled for at least twelve (12) months of the reporting year with BSC commercial insurance coverage.
- No more than one (1) gap in enrollment of up to forty-five (45) days during the measurement year

The Press Ganey survey vendor conducted the survey on behalf of Blue Shield of California. Press Ganey, a certified NCQA survey vendor, utilized a mix-mode methodology to administer the CAHPS 5.1H survey according to program requirements. The methodology consisted of the following:

- Two-wave mailing with recurrent reminder post cards, with mail to web capabilities.
- Email survey reminders to Commercial HMO/POS and Commercial PPO members with valid emails.
- A minimum of three (3) to a maximum of six (6) telephone attempts are made to follow up with non-respondents via Computer Assisted Telephone Interviews (CATI).

The table below details the response rates:

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MY2024 Adult Commercial HEDIS CAHPS	Sampling	Response Rate	Mail Completed	Phone completed	Internet Completed	Total Completes	Year over Year Response Rate Delta
Commercial HMO/POS	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Commercial PPO	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Medicaid Adult LA	2302	9.9%	89	85	50	224	-0.5%
Medicaid Adult SD	2,309	9.4%	85	80	48	213	+0.2%
Medicaid Child LA	2,302	11%	56	127	67	250	+0.5%
Medicaid Child SD	2,302	8.3%	46	89	53	188	+0.2%

N/A indicates internet methodology is not applicable.

Medicare Advantage Prescription Drug Plan CAHPS – MAPD

Blue Shield of California utilizes Press Ganey as a Center of Medicare and Medicaid Service (CMS) certified vendor to conduct the Medicare Advantage Prescription Drug Plan (MAPD) CAHPS Survey. The survey aims to measure how well the plans meet the members' expectations, determine the areas with the greatest effects on overall satisfaction, and identify areas of opportunity for improvement. BSC conducts the MAPD CAHPS for Medicare Advantage and Medicare-Medicaid members. The survey was fielded February 26th, 2025 – May 31st, 2025.

- Blue Shield conforms to strict CMS sample selection and eligibility requirements. This ensures Blue Shield generates a sample population frame that is unbiased and accurate. When compiling the sample size Blue Shield follows the eligibility requirements as outlined by CMS:
- Medicare beneficiaries ages eighteen (18) years or older at the time the sample is drawn for the measurement year.
- Continuously enrolled for at least the last six (6) months of the reporting year with BSC Medicare health insurance product.
- Excludes beneficiaries that are institutionalized or deceased at the time of the sample draw.

Press Ganey survey vendor utilized a mix-mode methodology to administer the CAHPS MAPD survey. The methodology consisted of a two-wave mailing. A final attempt of up to five (5) telephone outreaches are made, with follow-up completed by Computer Assisted Telephone

Interviews (CATI) to non-responders. The survey fielding and methodology is done according to CMS guidelines by Press Ganey in four (4) waves consisting of the following:

- The survey vendor sends a prenotification post card letter.
- The survey vendor sends the first survey questionnaire.
- Second survey questionnaire sent by survey vendor.
- Survey vendor conducts telephone follow-up by Computer Assisted Telephone Interviews

BSC strategically oversamples to ensure appropriate response rate for the MAPD CAHPS survey for the Medicare population based on expected responses. By anticipating expected response rates for the sample size, BSC can produce reliable data that is statistically significant. In measurement year 2025, BSC oversampled the Medicare population. The table below details the response rates:

MY2024 Response Rate	Sample Size	Total Mail Completes	Total Phone Completes	Total Internet Completes	Total completes	MY2024 Response Rate	MY2024 Response Rate Delta
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

N/A indicates data is not available.

Qualified Health Plan Enrollee Experience Survey (QHP EES)

Blue Shield utilized Health and Human Services (HHS), and CMS certified vendor Press Ganey to conduct the Enrollee Experience Survey (ESS). The EES is a requirement by CMS for compliance with its Qualified Health Plan (QHP) Issuer requirements. The primary objective is to obtain information from the members about their experiences with health care for the Quality Reporting System (QRS). The survey aims to measure how well the plans meet the members' expectations, determine the areas with the greatest effects on overall satisfaction, and identify areas of opportunity for improvement, to increase the experience and quality of care that Blue Shield provides its members. BSC conducts the EES for its Covered California On-Exchange members. The survey was fielded February 19th, 2025 – May 2nd, 2025.

- Eligibility is determined according to CMS program requirements. Eligible member criteria include the following:
- Members enrolled in the Exchange or qualified health plan.
- Members ages eighteen (18) years or older as of December 31st of the measurement year
- Exclude enrollees who have requested to not be contacted (i.e., on a "Do Not Survey" list)

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Press Ganey survey vendor utilized a mix-mode methodology to administer the Enrollee Experience Survey. The methodology consisted of the following:

- Prenotification letter with Internet URL to complete the survey.
- 2-wave mail with recurrent reminder post cards
- Corresponding email to sampled enrollees with a valid email.
- Three (3) to six (6) telephone attempts are made to follow up by CATI to non-responders.

The table below details the response rates:

MY2024 EES QHP	Total Sample	Response Rate	Mail Completed	Phone completed	Internet Completed	Total Completes	Year over Year Response Rate Delta
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Member Experience Accessing the Network Survey - CAHPS Questions

The following table 1 demonstrates CAHPS performance across the commercial HMO, PPO, Medi-Cal, and Medicare product lines for 2022 through 2024 based on NCQA Accreditation rankings and thresholds. Scores use the Summary Rate or Top Box score (%Always/Usually for composites and % 8,9,10 for overall ratings)

Table 1. CAHPS Results and Goals by Composite: Line of Business

Getting Care Quickly Composite	MY2022	MY2023	MY2024	MY2024 Goal	Goal Met?
Commercial HMO/POS	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Commercial PPO	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Medicaid Adult LA	69.0%	77.3%	71.5%	80.4%	No
Medicaid Adult SD	72.2%	76.3%	82.3%	80.4%	Yes
Medicaid Child LA	79.9%	70.6%	79.0%	86.3%	No
Medicaid Child SD	72.9%	86.4%	78.3%	86.3%	No
Medicare H0504	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Medicare H4937	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Medicare H5928	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Medicare DSNP H2819	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

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Scores shown in Summary (% Always/Usually), Commercial goals represent Previous years NCQA Quality Compass average benchmark ** Medicare benchmark represents previous year CMS national average.

Getting Needed Care Composite	MY2022	MY2023	MY2024	MY2024 Goal	Goal Met?
Commercial HMO/POS	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Commercial PPO	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Medicaid Adult LA	73.0%	78.8%	76.6%	81.5%	No
Medicaid Adult SD	75.5%	77.7%	81.2%	81.5%	No
Medicaid Child LA	82.5%	71.0%	76.4%	83.3%	No
Medicaid Child SD	74.5%	78.9%	74.6%	83.3%	No
Medicare H0504	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Medicare H4937	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Medicare H5928	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Medicare DSNP H2819	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Scores shown in Summary (% Always/Usually), Commercial goals represent Previous years NCQA Quality Compass average benchmark ** Medicare benchmark represents previous year CMS national average.

Table 2. CAHPS Trends by Survey Question: Commercial HMO/POS

CAHPS Adult Commercial HMO/POS Survey Questions	MY2022	MY2023	MY2024	YOY Comparison
Getting Care Quickly (%always/usually)	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

▲Represents score has increased from last year ▼ Represents score has decreased from last year - No change
Scores shown in Summary (% Always/Usually)

Table 3. CAHPS Trends by Survey Question: Commercial PPO

CAHPS Adult Commercial PPO Survey Questions	MY2022	MY2023	MY2024	YOY comparison
Getting Care Quickly (%always/usually)	[redacted]	[redacted]	[redacted]	[redacted]

Q4. Getting care as soon as needed	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

▲Represents score has increased from last year▼ Represents score has decreased from last year - No change
Scores shown in Summary (% Always/Usually)

Table 4. CAHPS Trends by Survey Question: Medicaid Adult LA

CAHPS Adult Medicaid LA Survey Questions	MY2022	MY2023	MY2024	YOY comparison
Getting Care Quickly (%always/usually)	69.0%	77.3%	71.5%	-5.80%▼
Q4. Getting care as soon as needed	70.6%	86.1%	73.6%	-12.50%▼
Q6. Getting appointment as soon as needed	67.3%	68.6%	69.5%	0.90%▲
Getting Needed Care (%Always/Usually)	73.0%	78.8%	76.6%	-2.20%▼
Q9. Easy to get care believed necessary	78.3%	82.2%	85.7%	3.50%▲
Q20. Easy to get appointment with specialist	67.8%	75.3%	67.4%	-7.90%▼

▲Represents score has increased from last year▼ Represents score has decreased from last year - No change
Scores shown in Summary (% Always/Usually)

Table 5. CAHPS Trends by Survey Question: Medicaid Adult SD

CAHPS Adult Medicaid SD Survey Questions	MY2022	MY2023	MY2024	YOY comparison
Getting Care Quickly (%always/usually)	72.2%	76.3%	82.3%	6.00%▲
Q4. Getting care as soon as needed	72.7%	79.7%	88.7%	9.00%▲
Q6. Getting appointment as soon as needed	71.7%	72.9%	75.8%	2.90%▲

Getting Needed Care (%Always/Usually)	75.5%	77.7%	81.2%	3.50%▲
Q9. Easy to get care believed necessary	75.3%	81.5%	83.5%	2.00%▲
Q20. Easy to get appointment with specialist	75.7%	74.0%	79.0%	5.00%▲

▲Represents score has increased from last year▼ Represents score has decreased from last year - No change
Scores shown in Summary (% Always/Usually

Table 6. CAHPS Trends by Survey Question: Medicaid Child LA

CAHPS Child Medicaid LA Survey Questions	MY2022	MY2023	MY2024	YOY comparison
Getting Care Quickly (%always/usually)	79.9%	70.6%	79.0%	8.40%▲
Q4. Getting care as soon as needed	79.7%	72.9%	78.3%	5.40%▲
Q6. Getting appointment as soon as needed	80.1%	68.4%	79.7%	11.30%▲
Getting Needed Care (%Always/Usually)	82.5%	71.0%	76.4%	5.40%▲
Q9. Easy to get care believed necessary	84.5%	76.6%	79.9%	3.30%▲
Q20. Easy to get appointment with specialist	80.6%	65.5%	72.9%	7.40%▲

▲Represents score has increased from last year▼ Represents score has decreased from last year - No change
Scores shown in Summary (% Always/Usually)

Table 7. CAHPS Trends by Survey Question: Medicaid Child SD

CAHPS Child Medicaid SD Survey Questions	MY2022	MY2023	MY2024	YOY comparison
Getting Care Quickly (%always/usually)	72.9%	86.4%	78.3%	-8.10%▼
Q4. Getting care as soon as needed	74.6%	91.2%	76.7%	-14.50%▼
Q6. Getting appointment as soon as needed	71.2%	81.5%	79.8%	-1.70%▼
Getting Needed Care (%Always/Usually)	74.5%	78.9%	74.6%	-4.30%▼
Q9. Easy to get care believed necessary	84.0%	88.5%	81.8%	-6.70%▼

Q20. Easy to get appointment with specialist	65.1%	69.4%	67.4%	-2.00%▼

▲Represents score has increased from last year▼ Represents score has decreased from last year - No change
Scores shown in Summary (% Always/Usually)

Table 8. CAHPS Trends by Survey Question: Medicare H0504

(H0504) CAHPS Medicare Survey Questions	MY2022	MY2023	MY2024	YOY comparison
Getting Needed Care (%Always)	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

▲Represents score has increased from last year▼ Represents score has decreased from last year - No change
Scores shown in Summary (% Always/Usually)

Table 9. CAHPS Trends by Survey Question: Medicare H4937

(H4937) CAHPS Medicare Survey Questions	MY2022	MY2023	MY2024	YOY comparison
Getting Needed Care (%Always)	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Q8. Dr. seen within 15 minutes of appt. time	[redacted]	[redacted]	[redacted]	-

▲Represents score has increased from last year▼ Represents score has decreased from last year - No change
Scores shown in Summary (% Always/Usually)

Table 10. CAHPS Trends by Survey Question: Medicare H5928

(H5928) CAHPS Medicare Survey Questions	MY2022	MY2023	MY2024	YOY comparison
Getting Needed Care (%Always)	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

▲Represents score has increased from last year▼ Represents score has decreased from last year - No change
Scores shown in Summary (% Always/Usually)

Table 11. CAHPS Trends by Survey Question: Medicare H2819

(H2819) CAHPS Medicare Survey Questions	MY2024	YOY comparison
Getting Needed Care (%Always)	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

Q8. Dr. seen within 15 minutes of appt. time	[redacted]	[redacted]

▲Represents score has increased from last year▼ Represents score has decreased from last year - No change Scores shown in Summary (% Always/Usually). H2819 MY2024 is the first year being surveys and historical trend data is not available.

Member Experience Accessing the Network Survey - QHP Enrollee Experience Questions

The following table demonstrates Enrollee Experience performance across the QHP HMO and PPO product lines for 2020 through 2024. MY2024 goals are based on 2022 CMS national average thresholds. Scores use the Summary Rate or Top Box (%Always/Usually for composites and % 8,9,10 for overall ratings). The goal of the Enrollee Experience Survey is based on previous years CMS national average data.

Table 12. Enrollee Experience Survey Trends by Survey Question: QHP HMO and PPO

Access to Care	MY2022	MY2023	MY2024	MY2024 Goal	Goal Met?
QHP HMO	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

NA denotes that comparison is not available due to lack of data. Scores shown as summary rate (%Always+Usually) Measurement year goal is based on previous years CMS national data average.

Table 13. Enrollee Experience Survey Trends by Line of Business: QHP HMO

QHP HMO Enrollee Experience Survey Questions	MY2022	MY2023	MY2024	YOY comparison
Access to Care (%Always+Usually)	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

▲Represents score has increased or reportable from last year ▼ Represents score has decreased from last year - No change. NA-Data not available, NR- Non-reportable data due to small sample size. Scores shown in Summary (%Always+Usually)

Table 14. Enrollee Experience Survey Trends by Line of Business: QHP PPO

QHP PPO Enrollee Experience Survey Questions	MY2022	MY2023	MY2024	YOY comparison
Access to Care (%Always+Usually)	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

▲Represents score has increased or reportable from last year ▼ Represents score has decreased from last year - No change. NA-Data not available, NR- Non-reportable data due to small sample size. Scores shown in Summary (%Always+Usually)

Behavioral Health Overview

BSC delegates behavioral and mental health services to Managed Service Organizations such as Magellan Health Services. The majority of BSC members in Medicare, Commercial and On-Exchange members are delegated to Magellan, resulting in automatic credit.

BSC conducts its own Behavioral health survey using the Experience of Health Outcomes Survey (ECHO) as a foundation to assess members experience with Behavioral health services. The survey is conducted annually in Q3 of every year and the data is used internally for quality improvement purposes for its non-delegated members.

Behavioral Health (BH) Member Experience Survey:

The purpose of the BH survey is to assess the experience and overall satisfaction of members, 18 years of age or older, or parent/guardian of children under the age of eighteen, who have received behavioral health or substance abuse services in the past 12 months. BSC uses a robust behavioral health survey, using the Experience of Care and Health Outcomes (ECHO) survey as a foundation. BSC behavioral health survey includes supplemental questions which quantify the members' experience, members' health outcomes, network adequacy, health plan interactions, and ease of accessing behavioral health services. BSC developed a more robust survey for meaningful data collection and to measure key performance indicators, which can be used for quality improvement purposes. BSC contracted with Press Ganey, an NCQA certified survey vendor, to conduct a mail-only BH survey. BSC supplies Press Ganey with a membership file of all eligible members based on the 2024 claims data for non-delegated behavioral and mental health services. Press Ganey administers the modified 37

question behavioral health survey. A sample member was drawn from the eligible populations that submitted a claim in 2024. The survey asks members about:

- Getting Treatment Quickly
- How Well Clinicians Communicate
- Access to Treatment and Information
- Informed About Treatment Options
- Office Wait Times
- Informed about Medication Side Effects
- Network adequacy
- Provider referrals
- Care coordination
- Telemedicine and Telehealth services
- Prescription Medicine
- Using your Health Plan
- Health Outcomes

In 2023 the survey instrument was modified with supplemental questions to focus on collecting access to care feedback of members after Covid. Then in 2024 the survey instrument was modified to collect feedback from members encompassing on the entirely of the member experience and specific quality improvement efforts BSC is focusing on. However due to the changes in survey instruments, BSC is not able to collect longitudinal trend data year over year because the questions have changed.

Timeframe: Behavioral Health survey was fielded from October 16, 2024, to November 20, 2024.

Methodology: Press Ganey utilized a one-wave mail survey methodology to administer the custom behavioral health plan member experience and health outcome survey. BSC conducts a mail only survey to maintain members' confidence in confidentiality and privacy for this high-risk population.

Data Source: In 2024 behavioral health survey with supplemental and customized questions. In total the survey is two pages front and back, totaling thirty-seven questions.

Sampling Methodology: Majority of BSC members are delegated to Behavioral Health Managed Services Company's including Magellan. Except for a small portion of members and even smaller applied behavioral health members are not delegated to mental and behavioral health managed care services. BSC meticulously identified those members to ensure the voice of the member is heard. BSC survey population sample criteria consist of the following:

Members are not delegated to behavioral health management services.

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Members in Administrative Shared Organization (ASO), Shared Advantage, and Individual Medicare Advantage Prescription Drug plan (IMAPD) and Group Medicare Advantage Prescription Drug Plan (GMAPD), Adult Medi-Cal and Child Medi-Cal

- Members 18 years and older as of September 20th, 2024, at the time the sample file was extracted.
- Enrolled at the time sample is drawn.
- Members that have had at least one behavioral health and mental health services claim in 2024.
- Enrolled at the time sample is drawn.
- Press Ganey cleaned the sample file by removing members in the Do Not Contact Registry maintained by BSC, duplicate records based on the household address and phones, and invalid records. From the sample file of unique members, a random selection of records was extracted, See below table for response rate details.

Measurement Year (MY) Response Rate	Sample Size	Total Mail Completes	Response Rate
2024 Response Rate for *Commercia* [redacted]	[redacted]	[redacted]	[redacted]
2023 Response Rate for *Commercia* [redacted]	[redacted]	[redacted]	[redacted]
2024 Response Rate of *Adult and Child Medi-Cal*	5,348	155	3.1%
2023 Response Rate of *Adult and Child Medi-Cal*	7,934	159	2.1%

BH Survey Goal: BSC considers the data collect in 2024 as a baseline which will inform the goals for 2025.

The table and graphs below provide a Summary rate or Top Two Box that represents the most favorable response percentage(s) and is used best for comparison purposes. The Summary Rate is the sum of the proportion of respondents who selected the most favorable response options such as ("Usually" and "Always"; "Yes"; "2 days or less"; "10 days or less"; "None"; "4-5"; "Not a problem"; and "Excellent" and "Very Good") for the attribute questions.

Overall BH Survey Results: BSC

2024 Behavioral health survey	***Commercial***	***Medicare***	***Adult Medi-Cal***	***Child Medi-Cal***
Total respondent	[redacted]	[redacted]	*149*	*10*

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Likelihood to recommend provider (Q4) (% 5 or 4)	[redacted]	[redacted]	86.0%	83.3%
Overall ease of getting counseling or treatment needed (Q6) (% Very or Somewhat easy)	[redacted]	[redacted]	85.6%	83.3%
Q14. Got an appointment as soon as wanted (% Always or Usually)	[redacted]	[redacted]	82.6%	66.7%
Q19. Service locations are convenient ([redacted]	[redacted]	[redacted]	74.8%	33.3%
Q20. Can get urgent treatment as soon as needed (% Strongly agree or agree)	[redacted]	[redacted]	67.8%	33.3%
Q21. Happy with choice of providers in network (% Strongly agree or agree)	[redacted]	[redacted]	79.7%	66.7%
Q22. Healthcare costs are affordable (% Strongly agree or agree)	[redacted]	[redacted]	85.6%	100%

The Summary Rate is the sum of the proportion of respondents who selected the most favorable response options such as ("Usually" and "Always"; "Yes"; "2 days or less"; "10 days or less"; "None"; "4-5"; "Not a problem"; and "Excellent" and "Very Good") for the attribute questions. MY2022 BSC goals will be to improve 2% in summary rate score from the previous year. *Results are unreliable due to small denominator/completed surveys.

Product Line Summary Results

BSC segmented behavioral health survey data by product line and age. However, reporting of the data segmented by product line and age results in small response rates and unreliable results. This is due to two factors:

1) Significant portion of BSC populations is delegated to external behavioral health management services and,

2). Any remaining population member in applied behavioral health assessment networks within BSC are very small. The remaining small population results in extremely low response rates, which also impacts on the number of completed surveys.

This impacted on the Medi-Cal child population BH survey results with only six complete surveys, results are not reliable.

Low response rates and low completed survey numbers lead to BSC having Medi-Cal Child survey responses as non-reportable measures or unreliable data due to low completed surveys. Non-reportable measures and the low reliability of less than 30 completed surveys cannot be used for quality improvement purposes.

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Performance improvement measured by the member experience survey is difficult to improve, it is longitudinal, and not all measures can be selected for improvement at once. BSC has identified that member experience measure related to access to care continue to be an area of opportunity historically and identified by appeals and grievance data.

Enrollee Experience Quantitative Analysis

- Most LOBs did not meet their MY2024 goals for getting care quickly.
- Only Medicaid Adult SD and Medicare H4937 met or exceeded their goals for getting care quickly.
- Performance varied year-over-year, with some LOBs improving and others declining for getting care quickly.
- Gaps between results and goals were sometimes substantial, especially for Commercial PPO and Medicaid lines for getting care quickly.
- 20% (2 out of 10) met or exceeded their MY2024 goals for getting care quickly.
- Medicare H4937 exceeded its goal by +2.50 points for getting care quickly.
- Commercial PPO fell short of its goal by -11.00 points for getting care quickly.
- None of the lines of business met their MY2024 goal for getting needed care.
- The smallest gap to goal was for Medicaid Adult SD (–0.3 percentage points) for getting needed care.
- The largest gap was for Medicaid Child SD (–8.7 percentage points) for getting needed care.
- **(2022→2024):** Medicaid Adult SD (+5.7 points) for getting needed care.
- **(2022→2024):** Medicaid Child LA (–6.1 points) for getting needed care.
- Medicaid Child LA (–11.5 points from 2022 to 2023) for getting needed care.
- Most lines of business showed either flat or negative trends over the three years for getting needed care.
- Only Medicaid Adult SD and Medicaid Adult LA had notable net improvements from 2022 to 2024 for getting needed care.
- Several lines (e.g., Commercial HMO/POS, Medicare H0504, Medicare H5928) ended MY2024 very close to their 2022 starting point for getting needed care.

Behavioral Health Member Experience Quantitative Analysis

- [redacted] Only 66.7% of Child Medi-Cal members got an appointment as soon as they wanted.
- [redacted]

- [redacted]
- [redacted]

Results/Goals:

- Medi-Cal Adult San Diego met goal for "getting care quickly" composite for MY2024.
- [redacted].
- [redacted]
- BH does not have any goals because benchmarks are not available in 2024. Benchmarks are not available because 2024 survey is the baseline and longitudinal trending is not available due to the changes in the survey instrument from 2023 to 2024.

Qualitative Analysis:

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

Medical Barriers

in Addition to the national financial barriers mentioned above, licensed mental and behavioral healthcare professionals continues, impacting rural areas specifically. This shortage of licensed professionals impacts access to care for members across all lines of business seeking behavioral health services. These factors outside of healthcare, on both a national and state level, impact on the member experience and quality health outcomes. It is important to understand these factors impacting members so that BSC can continue to create a healthcare system worthy of our friends and family, which is sustainably affordable.

Opportunities/Interventions (apply to BSC and BSP both unless otherwise stated):

People

- **CAHPS Member Experience Team**: CAHPS member experience has been re-organized to ensure subject matter experience for member experience are line of business specific.

- **RX Advocates:** The Rx advocacy team is a dedicated team of Medicare pharmacy technicians who proactively engage members, and providers, to minimize the impact of common barriers often found within the pharmacy journey such as formulary changes and rejected claims.
- **Medi-Cal Member Check-In**: Six full-time call representatives' conduct year-round targeted outreach to members to see if there is any assistance needed to access their plan benefits, including but not limited to providing information, assisting with making appointments, understanding and resolving specialty referrals.

Process

- **MAPD Simulation CAHPS**: BSC administered a Medicare Advantage Prescription Drug Plan simulation CAHPS survey in Q4 2024. BSC surveyed ninety-five thousand (95,000) members with twenty thousand eight hundred eighty (20,880) surveys returned. This data is used to identify root causes, CAHPS drivers and individual members that need outreach. This information is disseminated throughout the organizations dedicated to outreach teams to conduct service recovery.
- **Provider Collaborative:** BSC is working with external consultants to create a provider focused collaborative which allows BSC to work with provider groups directly to improve the member experience. The collaborative led by the consultants focuses on quality improvement projects centered on member experience at the provider group, while the provider collaborative if focused on Medicare, we believe it will impact all members.
- **HEDIS Outreach Teams:** BSC Live Agent Outreach conduct calls throughout the year 2024 to Commercial and On-Exchange members. Live agents call close care gap members to remind members of the care needed to be done. Agents educate members on the importance of keeping up to date with care, as well as offer appointment scheduling assistance.
- **In 2024, HEDIS Medi-Cal Simulation survey**, this survey will allow BSC to simulate the HEDIS Medicaid CAHPS survey allowing BSP more insights into member level responses. Data collected from the survey will be used for quality improvement purposes. This program will launch in 2025.
- **Access to Care Health Education Mailer:** Blue Shield Promise Medi-Cal mails 2 rounds of Access to Care guides in Q2 and Q3 of 2024, helping members know when to use Teledoc, Nurse Advice, Urgent Care, and the Emergency Room in all 10 threshold languages. BSP continue to use the member engagement material at all events, Community Resource Centers, providers, etc. This program is working to address access to care barriers as identified by complaints data in 2024.
- **Member Newsletters:** Blue Shield Promise Medi-Cal executed 2 annual newsletters in Q2 and Q4 of 2024. The Medi-Cal member newsletters contained important health information and resources in all 10 threshold languages.

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Technology

- **AI/ML Predictive CAHPS Solution**: BSC partnered with an external vendor to develop. AI/ML solution which allows BSC to identify individual members CAHPS risk and how likely a member will rate low in specific CAHPS measures. This solution is used for targeted outreach to ensure meaningful materials are sent to members that will benefit from it the most.
- **Enhanced Member Experience Dashboard:** BSC in partnership with the survey vendor has an enhanced member experience dashboard which helps centralize all CAHPS related surveys into one platform. The democratization of data and easy user interface allows for greater self-service and allows the organization to share the data with a larger audience. This enables the organization to continue its efforts in creating a member experience culture which is member centric, and data driven.
- **Provider Data Exchange**: BSC, in partnership with the survey vendor, has started to work with Medicare provider groups to share CAHPS member experience data. This member experience data exchange allows provider groups to share results with BSC. Allowing BSC to cross reference provider level CAHPS data with health plan CAHPS data to identify root cause. This will allow BSC and the providers on the data exchange to identify resources to help improve the members' experience.
- **Virtual Blue**: All PPO plans / TRIO HMO Virtual Blue integrates primary, specialty, behavioral and mental health care, emphasizing quick, convenient access to high-quality care, often allowing members to schedule an appointment as early as the same day or the next day. Members who choose Virtual Blue have the option to see virtual or in-person providers, depending on their needs and preferences, with no referrals needed. This helped improve the access to care measures for many lines of business and improved the member experience.
- **Find A Doctor:** BSC Continues to improve the accuracy of finding a doctor tool. BSC created a user interface allowing providers to easily attest to the providers' information as it relates to address, new patient appointments, etc. This allows the provider directory to be more accurate and up to date, improving the members' experience when it comes to finding providers and services.
- **Care Navigator Dashboard**: In conjunction with care navigators, the call encounters are captured within a centralized dashboard. This dashboard allows for the capturing of data to identify root causes and proactively identify barriers for Medicare members, allowing BSC to resolve issues before they become a major issue.

Health Opportunities Program: Healthy Opportunities (via supplier) is a digital engagement solution that offers helpful tools, resources, and lifestyle support through personalized empowerment. Member engagement program that encourages members to complete care by offering rewards to members who self-attest in completing certain preventive care screenings. Target membership is Subset of Commercial and On-Exchange

Behavioral health (apply to BSC and BSP both unless otherwise stated):

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Qualitative Analysis

Opportunities and Interventions

Recognizing these barriers, BSC has developed robust strategies, and intervention plans to improve behavioral health (BH) services for our members. These interventions are centered around the member's BH experience and care. Our overall strategy to improve member experience is focused on three key areas: People, Process, and Technology.

People:

- BSC continues to integrate BH into the primary care setting to address the ongoing need and demand for psychiatrists, therapists, and counselors. This effort continues to be one of the ways BSC addresses and improves access to care for BH services. An example of this is BSC's Collaborative Care Model (CoCM), a systematic approach to BH integrated care that is centered around the patient and where primary care and BH providers collaborate effectively using shared care plans to address patient goals. BSC's goal is to expand across all provider groups to ensure every BSC member has access to CoCM, which provides a patient-centered, evidence based model to improve overall health.

- BSC continues to create a robust and diverse BH provider network for our members, which now includes telehealth providers. This continued growth effort will have a positive impact on both access to care and availability. Since 2023 it has achieved an 112% increase in BH providers in BSC network for commercial members. This work is on-going and expected to continue into 2025. These recruitment efforts are continuous and have a strong focus for BSC through 2025 and into 2026.

- In addition, BSC continues to focus on contracting BH providers who treat children and adolescents, as well as providers who specialize in treating eating disorders, Obsessive Compulsive Disorder (OCD), and other therapy types that may require specific treatment modalities. There are also ongoing recruitment efforts to contract with clinics that provide Medication-Assisted Treatment (MAT) for substance use disorders. This work is on-going and has a strong emphasis for 2025 and continues through 2026.

Process:

- BSC continues to support its network providers. Regular and consistent provider communications are sent to network providers educating them on the BH Access to care requirements for Urgent Care, Routine Care, ER Instruction and follow up care appointments.

Technology:

- In 2024, BSC continued to enhance Find-A-Doctor tool to ensure members ease of finding a provider within the health plan's network. The enhancement that occurred in

2023 include: Increased Provider Specialty Data (Areas of Special Interest) by more than double to enable future capabilities, Enabled Providers to update their specialty information directly on Provider Connect Portal, and Enabled Search by Provider Group - Allows member to find specialty BH vendors added to the network. This work impacts all lines of business. In 2025, we plan to enable appointment scheduling for over 10,000 mental health providers and continue to make improvements to our Find-a-Doctor tool to make it easier for our members to find providers and access care.

In 2024, BSC redesigned mental health landing pages for Commercial and Medicare members. The enhancements ensure members ease of finding and understanding information about the health plan and benefits. The enhancements that occurred in 2024 include: Redesign of Mental Health landing page to enable easier navigation for members digitally and developed resources for Customer Engagement teams to better support our members. In 2025, we will continue to add self-guided resources including a tool that provides BH resources based on a member's self-assessment accessed through our mental health landing page.

Element A - Out-of-Network Services

Blue Shield conducted an internal analysis of medical and behavioral health out-of-network requests and claims. Out-of-network authorizations are the total number of out-of-network referrals, reported by provider specialty type, received by the Utilization Management (UM) department in MY2024.
Claim counts reflect the number of out-of-network claim line items received in 2024 by specialty provider type. Claims billed/allowed indicated the percentage of out-of-network claims that were paid for a given specialty type.

MY2025/RY2025
Out-of-Network Service Referrals / Authorizations
Exchange products are captured in PPO and HMO networks

Table 1: Annual out-of-network authrization requests per 1,000 members

LOB	Total OON Requests	Total OON Requests/1000 Members	Approved OON Requests	Approved OON Requests/1000 Members	Denied OON Requests	Denied OON Requests/1000 Members	**Goal Met (<10 OON Requests/1000 Members**
[redacted]							
[redacted]							
Medi-Cal	40	0.07	40	0.07	0	0.00	**Yes**

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Table 2: Behavioral Health. Annual out-of-network authrization requests per 1,000 members

LOB	Total OON Requests	Total OON Requests/1000 Members	Approved OON Requests	Approved OON Requests/1000 Members	Denied OON Requests	Denied OON Requests/1000 Members	**Goal Met (<10 OON Requests/1000 Members**
[redacted]							
Medi-Cal	24	0.04	24	0.04	0	0	**Yes**

Table 3: Annual utilization of out-of-network services per 1000 members

LOB	Total Claims for OON Services	Total OON Claims/1000 Members	Percentage/Number of OON Claims Paid at In-Network Level	Percentage of OON Claims Paid at OON Levels	Percentage/ Number of OON Claims Denied	**Goal Met (<550 OON Claims/1000 Members)**
[redacted]						
Medi-Cal	63794	109.3	49% (30884)	50% (32108)	1% (792)	**Yes**

Table 4: Behavioral Health. Annual utilization of out-of-network services per 1000 members

LOB	Total Claims for OON Services	Total OON Claims/1000 Members	Percentage/Number of OON Claims Paid at In-Network Level	Percentage of OON Claims Paid at OON Levels	Percentage/ Number of OON Claims Denied	**Goal Met (<550 OON Claims/1000 Members)**
[redacted]						
Medi-Cal	1052	1.8	23% (243)	77% (809)	0%	**Yes**

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MY2024/RY2024
Out-of-Network Service Referrals / Authorizations
Exchange products are captured in PPO and HMO networks

Table 1: Annual out-of-network authrization requests per 1,000 members

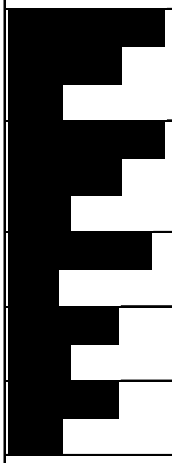
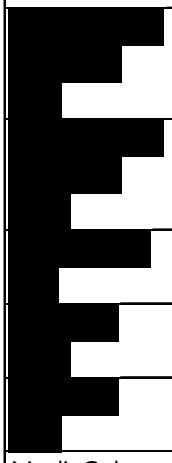
LOB	Total OON Requests	Total OON Requests/1000 Members	Approved OON Requests	Approved OON Requests/1000 Members	Denied OON Requests	Denied OON Requests/1000 Members	**Goal Met (<10 OON Requests/1000 Members**
							
Medi-Cal	100	0.19	100	0.19	0	0.00	**Yes**

Table 2: Behavioral Health. Annual out-of-network authrization requests per 1,000 members

LOB	Total OON Requests	Total OON Requests/1000 Members	Approved OON Requests	Approved OON Requests/1000 Members	Denied OON Requests	Denied OON Requests/1000 Members	**Goal Met (<10 OON Requests/1000 Members**
							
Medi-Cal	96	0.186	96	0.186	0	0	**Yes**

Blue Shield of California
Access & Availability – 2025 Network Performance Summary

Table 3: Annual utilization of out-of-network services per 1000 members

LOB	Total Claims for OON Services	Total OON Claims/1000 Members	Percentage/Number of OON Claims Paid at In-Network Level	Percentage of OON Claims Paid at OON Levels	Percentage/Number of OON Claims Denied	**Goal Met (<550 OON Claims/1000 Members)**
[redacted]						
Medi-Cal	66247	128.4	47% (30906)	53% (35341)	0% (0)	**Yes**

Table 4: Behavioral Health. Annual utilization of out-of-network services per 1000 members

LOB	Total Claims for OON Services	Total OON Claims/1000 Members	Percentage/Number of OON Claims Paid at In-Network Level	Percentage of OON Claims Paid at OON Levels	Percentage/Number of OON Claims Denied	**Goal Met (<550 OON Claims/1000 Members)**
[redacted]						
Medi-Cal	1155	2.2	23% (263)	77% (892)	0%	**Yes**

Quantitative Analysis: Reporting Year 2025 with Year-Over-Year Comparison to Reporting Year 2024.

Table 1: Annual Out-of-Network Authorization Requests per 1,000 Members

Authorization data were evaluated for out-of-network service requests. Requests were evaluated as approved or denied. All lines of business met the performance goal of less than 10 out-of-network requests per 1,000 members in both RY2024 and RY2025. This appears to demonstrate that authorization review processes are effectively identifying and redirecting out-of-network requests to qualified in-network providers and practitioners.

- [redacted]

[redacted]

- [redacted]
- [redacted]
- [redacted]
- **Medi-Cal** had 100 total OON requests (0.19 per 1,000 members) in RY2024, compared to 40 total OON requests (0.07 per 1,000 members) in RY2025. In RY2024, all 100 were approved and 0 were denied. In RY2025, all 40 were approved and 0 were denied.

Table 2: Behavioral Health – Annual Out-of-Network Authorization Requests per 1,000 Members

Authorization data for behavioral health out-of-network services were evaluated. All lines of business met the performance goal of less than 10 OON requests per 1,000 members in both RY2024 and RY2025.

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- **Medi-Cal** had 96 total OON requests (0.186 per 1,000 members) in RY2024, compared to 24 total OON requests (0.04 per 1,000 members) in RY2025. In RY2024, all 96 were approved and 0 were denied. In RY2025, all 24 were approved and 0 were denied.

This year-over-year comparison demonstrates consistent performance across both reporting years, with all lines of business continuing to meet the established performance goals.

Table 3: Annual Utilization of Out-of-Network Services per 1,000 Members

Claims data were evaluated for actual use of out-of-network services. Claims were evaluated in three ways: paid at the in-network level, paid at the out-of-network level, or denied. All lines of business met the performance goal of less than 550 out-of-network claims per 1,000 members in both reporting years, MY2024/Ry2024 and MY2025/RY2025.

- **Medi-Cal** had 66,247 total OON claims (128.4 per 1,000 members) in RY2024, compared to 63,794 total OON claims (109.3 per 1,000 members) in RY2025. In RY2024, 47% (30,906) were paid at in-network level, 53% (35,341) at OON level, and 0% (0) denied. In RY2025, 49% (30,884) were paid at in-network level, 50% (32,108) at OON level, and 1% (792) denied.

Table 4: Behavioral Health – Annual Utilization of Out-of-Network Services per 1,000 Members

Claims data for behavioral health out-of-network services were evaluated. All lines of business met the performance goal of less than 550 OON claims per 1,000 members in both reporting years.

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- **Medi-Cal** had 1,155 total OON claims (2.2 per 1,000 members) in RY2024, compared to 1,052 total OON claims (1.8 per 1,000 members) in RY2025. In RY2024, 23% (263) were paid at in-network level, 77% (892) at OON level, and 0% denied. In RY2025, 23% (243) were paid at in-network level, 77% (809) at OON level, and 0% denied.

This comparison demonstrates consistent performance across both reporting years, with all lines of business meeting the established performance goals. The data appears to

demonstrate that authorization review processes are effectively identifying and redirecting out-of-network requests to qualified in-network providers and practitioners.

Barriers (apply to BSC and BSP both unless otherwise stated): None

Opportunities/Interventions: (apply to BSC and BSP both unless otherwise stated): None

Elements B and C: Opportunities to Improve Access to Nonbehavioral and Behavioral Healthcare Services

Description:
Opportunities and priorities were developed by the BSC Access to Care Workgroup, a cross functional group for comprehensive consideration of the member experience accessing networks and to ensure a multifaceted approach to solutions. Departments represented include Member Experience, Provider Partnership, Quality Assurance, Quality Improvement, Product, Blue Shield's targeted Medicare, Medi-Cal, Cal Medi-Connect, and D-SNP Health Plan, Healthcare and Community Health Transformation, Network Management, Medical Care Solutions, Enhanced Clinical Program, Network Compliance, Behavioral Health, and Pharmacy

Element B – Opportunities to Improve Access to Nonbehavioral Healthcare Services

The organization annually conducts improvement work for all lines of business: Medicare, Medicaid, On-Exchange and Commercial:

1. Prioritizes opportunities for improvement identified from analyses of availability (NET 1, Elements A, B, and C), accessibility (NET 2, Elements A and C), and member experience accessing the network (NET 3, Element A, factors 1 and 3)
2. Implements interventions on at least one opportunity, if applicable
3. Measures the effectiveness of interventions, if applicable

Element C – Opportunities to Improve Access to Nonbehavioral Healthcare Services

1. Prioritizes opportunities for improvement identified from analyses of availability (NET 1, Elements A and D), accessibility (NET 2, Element B), and member experience accessing the network (NET 3, Element A, factors 2 and 4)
2. Implements interventions on at least one opportunity, if applicable
3. Measures the effectiveness of interventions, if applicable

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Priority Action Plan (BSC)

For RY2025, the BSC priority action plan covers HMO, PPO, Exchange, and Medicare GMAPD and IMAPD networks. Barriers and opportunities are compiled from NET 1, NET 2, and NET 3 A and apply to all lines of business unless otherwise stated. (Note: Availability of Practitioners (NET1), Accessibility of Services (NET2). Assessment of Network Adequacy and Marketplace Network Transparency and Experience (NET 3), Element A: Assessment of Member Experience Accessing the Network (Net 3A).

1. Strengthen Network Composition & Provider Recruitment: Focus on rural recruitment & network composition, expanded telehealth specialty coverage
2. Improve Access Standards Compliance & Telehealth Utilization: Focus on solo/small practice; advance access & messaging tools for after hours, expand telehealth-only providers
3. Enhance Member Experience Through Data-Driven Outreach: Use Simulation CAHPS, continue improving FAD
4. Expand Behavioral Health Capacity & Reliability: Accelerate BH recruitment, launch the dedicated BH call center, improve grievance tracking

Commercial & Medicare Non-Behavioral Health		
Priorities	**Opportunities**	**Barriers**
Strengthen Network Composition & Provider Recruitment	• BSC to continue to ensure BSC has a robust network composition across all plans.	• Continuing to increase the number of PCPs and Specialists. The results from RY2024 to RY2025 reflected these efforts and the IPA's ongoing recruitment had adequate coverage
	• Strengthen specialist recruitment strategies by reviewing network composition and increasing efforts in rural and high-demand geographic areas to address patient access gaps. • BSC to partner with contracted IPA/Medical Groups on provider recruitment areas to ensure the plan meets specialty gaps in areas like neurology. BSC will coordinate with contracted IPA and	• CalPERS Access+ HMO Neurology specialty gaps - The counties of Humboldt, Mariposa, Nevada, Trinity, and Tuolumne are rural and geographically isolated, which creates notable challenges for attracting and retaining specialists, especially Neurologists. • Lack of Oncology and Hematology specialists throughout CA to contract with,

	Medical Groups to hold targeted specialist recruitment events (such as job fairs) in rural counties like Humboldt, Mariposa, and Tuolumne. In addition, BSC will implement a virtual medicine pilot program for specialties with persistent gaps and track recruitment progress monthly. Additional strategies include partnering with local medical schools and hosting virtual career fairs to attract specialists in high-demand areas.	compounded by budgetary constraints. Blue Shield contracts with health systems, such as CHLA, CHOC, Rady's for pediatric care, and UCLA, UCSF, UCSD, etc. for adult care to assist in filling in the gaps.
Improve Access Standards Compliance & Telehealth Utilization	• Encourage IPA/medical groups to continuously evaluate network composition and specialty panels, recruiting providers as needed, and proactively address gaps to meet service demands. Continue regular follow up with IPA/Medical Groups on network adequacy and ensure prompt gap closure by assessing PCP and specialty needs and initiating recruitment or contracting as required (e.g., Loma Linda and Memorial Care actively recruiting physicians and extenders to meet service demands). • Encourage IPA/Medical Groups to utilize telehealth services to help with urgent care. Some specialty physician offices offer telehealth services and same-day appointments with an alternate physician. For example: Cedars Sinai Medical Group released a new	• **ER Access Instructions and After-Hours Availability:** Groups reported that guidelines for after-hours requirements, including emergency instructions, are unclear. While medical groups generally provide appropriate instructions, this is not consistently the case for individual physicians in private practice. Providers in these settings often share their personal phone numbers for immediate availability, which leads to non-compliance with established requirements. • Groups reported challenges with recruiting specialists due to the high costs of living and provider shortages. These circumstances affect routine, urgent, and emergency care. • Practices are also affected by constant turnover, and this is causing gaps in addressing routine care. o Groups identified that Physicians continue to leave their medical

	program for 24/7 on-demand care to include video visits; they also have assigned providers who take turns in responding to messages and include language about calling 911. Scripps also has Scripps Health Express where they provide appointments on the same day at 9 Scripps coastal Medical Center Locations. • Provide resources to IPA/medical groups continue to educate their physician offices on access to care standards/ERAH, PAAS. IPA/Medical Groups to share information from the health plan on standards including appropriate after-hours messaging, setting expectations with patients around timely appointments, throughout their UM meetings and their provider communications. Also, Blue Shield of California conducted outreach to physician groups and independent practice associations (IPAs) that scored the lowest 25% of the survey. Survey findings were shared, and these groups identified barriers and explored opportunities for improvement. The health plan will continue to support contracted IPAs and medical groups by providing compliance education and sharing examples of both compliance and non-	groups, i.e., retiring, moving out of the area, and/or switching to part-time hours. ○ Providers have encouraged virtual/telemedicine to help with scheduling appointments, but are struggling to keep up with the demand, and these appointments are not falling within the routine timeframes. ▪ After the pandemic, providers shifted to concierge/virtual visits but are now having challenges keeping up with the demand.

	compliance as described in the Provider Manual. • Encourage IPA/Medical Groups to partner with their Urgent Care network on Urgent Care usages by providing better ways to provide access to care for members. These efforts will free up PCP and Specialty availability and provide patients with additional access to care. Example: Desert Valley Medical Group is planning a call ahead program in the future for ER services/triage.	
Enhance Member Experience Through Data-Driven Outreach	• **CAHPS Member Experience Team**: CAHPS member experience has been re-organized to ensure subject matter experience for member experience are line of business specific. • **RX Advocates:** The Rx advocacy team is a dedicated team of Medicare pharmacy technicians who proactively engage members, and providers, to minimize the impact of common barriers often found within the pharmacy journey such as formulary changes and rejected claims. **Process** • **MAPD Simulation CAHPS**: BSC administered a Medicare Advantage Prescription Drug Plan simulation CAHPS survey in Q4 2024. BSC surveyed ninety-five thousand (95,000) members with twenty	• In 2024, The cost of health care continues to be a barrier impacting the most vulnerable population: low income and fixed income populations. Evolving regulations continue to apply financial pressure on health plans to improve quality and reduce the cost of healthcare for members, increasing the administrative burden on providers. Nationally, the continued shortage of Primary Care and Specialists impact rural areas specifically. This shortage of licensed professionals impacts access to care for members across all lines of business. And continues to be a barrier for members.

	thousand eight hundred eighty (20,880) surveys returned. This data is used to identify root causes, CAHPS drivers and individual members that need outreach. This information is disseminated throughout the organizations dedicated to outreach teams to conduct service recovery. • **Provider Collaborative:** BSC is working with external consultants to create a provider focused collaborative which allows BSC to work with provider groups directly to improve the member experience. The collaborative lead by the consultants focuses on quality improvement projects centered on member experience at the provider group, while the provider collaborative if focused on Medicare, we believe it will impact all members. • **HEDIS Outreach Teams:** BSC Live Agent Outreach conduct calls throughout the year 2024 to Commercial and On-Exchange members. Live agents call close care gap members to remind members of the care needed to be done. Agents educate members on the importance of keeping up to date with care, as well as offer appointment scheduling assistance.	

	Technology • **AI/ML Predictive CAHPS Solution**: BSC partnered with an external vendor to develop.AI/ML solution which allows BSC to identify individual members CAHPS risk and how likely a member will rate low in specific CAHPS measures. This solution is used for targeted outreach to ensure meaningful materials are sent to members that will benefit from it the most. • **Enhanced Member Experience Dashboard:** BSC in partnership with the survey vendor has an enhanced member experience dashboard which helps centralize all CAHPS related surveys into one platform. The democratization of data and easy user interface allows for greater self-service and allows the organization to share the data with a larger audience. This enables the organization to continue its efforts in creating a member experience culture which is member centric, and data driven. • **Provider Data Exchange**: BSC, in partnership with the survey vendor, has started to work with Medicare provider groups to share CAHPS member experience data. This member experience data exchange allows provider groups to share results with BSC.	

	Allowing BSC to cross reference provider level CAHPS data with health plan CAHPS data to identify root cause. This will allow BSC and the providers on the data exchange to identify resources to help improve the members' experience. • **Find A Doctor:** BSC Continues to improve the accuracy of finding a doctor tool. BSC created a user interface allowing providers to easily attest to the providers' information as it relates to address, new patient appointments, etc. This allows the provider directory to be more accurate and up to date, improving the members' experience when it comes to finding providers and services. • **Care Navigator Dashboard**: In conjunction with care navigators, the call encounters are captured within a centralized dashboard. This dashboard allows for the capturing of data to identify root causes and proactively identify barriers for Medicare members, allowing BSC to resolve issues before they become a major issue. • **Health Opportunities Program:** Healthy Opportunities (via supplier) is a digital engagement solution that offers helpful tools, resources, and lifestyle support	

	through personalized empowerment. Member engagement program that encourages members to complete care by offering rewards to members who self-attest in completing certain preventive care screenings. Target membership is Subset of Commercial and On-Exchange.	

Commercial & Medicare Behavioral Health		
Priorities	**Opportunities**	**Barriers**
Expand Behavioral Health Capacity & Reliability	• Insufficient numbers of LPCCs in certain California zip codes. Targeted recruitment of LPCCs into BSC's Commercial network. List of impacted zip codes has been provided to the Behavioral Health Network Management team for recruitment. • Insufficient numbers of MHNPs in certain California zip codes. Targeted recruitment of MHNPs into BSC's Commercial network. List of impacted zip codes has been provided to the Behavioral Health Network Management team for recruitment. • Insufficient numbers of Addiction Medicine Providers in certain California zip codes. Targeted recruitment of Psychiatrists specializing in Addiction Medicine into BSC's Commercial network. List of impacted zip codes has been provided to the Behavioral	• There are some California zip codes in which BSC does not have sufficient numbers of Licensed Professional Clinical Counselors (LPCCs), Psychiatric Mental Health Nurse Practitioners (MHNPs) and Addiction Medicine providers contracted for our commercial networks. The Psychiatric Mental Health Nurse Practitioner (PMHNP) designation is relatively new, with only approximately 1,200 active providers statewide. Similarly, the Licensed Professional Clinical Counselor (LPCC) credential has seen slower adoption compared to more established licenses such as LMFT and LCSW, though recent years have shown increased interest. Finally, access remains challenging in

	Health Network Management team for recruitment.	rural and some suburban areas due to less provider penetration in those areas.
	• The ER and After-Hours survey does not assess members' actual experiences in accessing emergency care: BSC needs to track what happens when members call into the BSC Call Center with urgent or emergent BH needs. Blue Shield of California (BSC) is enhancing all aspects of our behavioral health (BH) operations effective January 1, 2026. One improvement underway is the implementation of a dedicated BH Call Center trained to identify members with potential urgent or emergent needs. These members will be transferred to a dedicated team staffed with licensed clinicians who will conduct triage and screening and will ensure the member is aided in getting to the appropriate provider type and level of care within timeliness standards. Further, member calls risk-rated as urgent, non-life-threatening emergent, or life-threatening emergent will be tracked within our Care Management systems and timeliness outcomes will be reported to relevant workgroups and/or committees for performance monitoring purposes. • Follow up appointment methodology using claims data	• The ER and After-Hours survey does not assess members' actual experiences in accessing emergency care. • BH demand outweighs the BH Network capacity. • With efforts to increase BH Network capacity, there are many BH providers who are new to managed care. • Lacking targeted and specific education to behavioral health providers about after-hours messaging requirements and appointment access standards. • Follow up appointment methodology using claims data for prescribers is not fully reliable: o Member declined follow up appointment offered by the provider o Provider assessed and documented there would be no clinical harm if the member was offered a follow-up appointment longer than standard o The diagnosis changed from the initial appointment to the follow-up appointment o The member had his/her follow up appointment with a different provider in the group or office.

	for prescribers is not fully reliable: BSC needs to assess timeliness of prescriber follow-up-appointments in additional ways. BSC will add questions about timeliness of follow-up-appointments, separately for prescribers and non-prescribers, to the 2026 BH Member Experience Survey.	
Expand Behavioral Health Capacity & Reliability	**Member Experience** **People:** • BSC continues to integrate BH into the primary care setting to address the ongoing need and demand for psychiatrists, therapists, and counselors. This effort continues to be one of the ways BSC addresses and improves access to care for BH services. An example of this is BSC's Collaborative Care Model (CoCM), a systematic approach to BH integrated care that is centered around the patient and where primary care and BH providers collaborate effectively using shared care plans to address patient goals. BSC's goal is to expand across all provider groups to ensure every BSC member has access to CoCM, which provides a patient-centered, evidence based model to improve overall health. • BSC continues to create a robust and diverse BH provider network for our members, which now includes telehealth	**Member Experience** • In Addition to the national financial barriers mentioned above, licensed mental and behavioral healthcare professionals continues, impacting rural areas specifically. This shortage of licensed professionals impacts access to care for members across all lines of business seeking behavioral health services. These factors outside of healthcare, on both a national and state level, impact on the member experience and quality health outcomes. It is important to understand these factors impacting members so that BSC can continue to create a healthcare system worthy of our friends and family, which is sustainably affordable.

	providers. This continued growth effort will have a positive impact on both access to care and availability. Since 2023 it has achieved an 112% increase in BH providers in BSC network for commercial members. This work is on-going and expected to continue into 2025. These recruitment efforts are continuous and have a strong focus for BSC through 2025 and into 2026. • In addition, BSC continues to focus on contracting BH providers who treat children and adolescents, as well as providers who specialize in treating eating disorders, Obsessive Compulsive Disorder (OCD), and other therapy types that may require specific treatment modalities. There are also ongoing recruitment efforts to contract with clinics that provide Medication-Assisted Treatment (MAT) for substance use disorders. This work is on-going and has a strong emphasis for 2025 and continues through 2026. **Process:** • BSC continues to support its network providers. Regular and consistent provider communications are sent to network providers educating them on the BH Access to care requirements for Urgent Care, Routine Care, ER Instruction	

	and follow up care appointments. **Technology:** • In 2024, BSC continued to enhance Find-A-Doctor tool to ensure members ease of finding a provider within the health plan's network. The enhancement that occurred in 2023 include: Increased Provider Specialty Data (Areas of Special Interest) by more than double to enable future capabilities, Enabled Providers to update their specialty information directly on Provider Connect Portal, and Enabled Search by Provider Group - Allows member to find specialty BH vendors added to the network. This work impacts all lines of business. In 2025, we plan to enable appointment scheduling for over 10,000 mental health providers and continue to make improvements to our Find-a-Doctor tool to make it easier for our members to find providers and access care. • **Virtual Blue**: All PPO plans / TRIO HMO Virtual Blue integrates primary, specialty, behavioral and mental health care, emphasizing quick, convenient access to high-quality care, often allowing members to schedule an appointment as early as the same day or the next day. Members who choose Virtual	

	Blue have the option to see virtual or in-person providers, depending on their needs and preferences, with no referrals needed. This helped improve the access to care measures for many lines of business and improved the member experience. • In 2024, BSC redesigned mental health landing pages for Commercial and Medicare members. The enhancements ensure members ease of finding and understanding information about the health plan and benefits. The enhancements that occurred in 2024 include: Redesign of Mental Health landing page to enable easier navigation for members digitally and developed resources for Customer Engagement teams to better support our members. In 2025, we will continue to add self-guided resources including a tool that provides BH resources based on a member's self-assessment accessed through our mental health landing page.	

Effectiveness of Past Interventions of RY 2024 Priority Action Plan (Classic)

For RY2024, the BSC priority action plan covers HMO, PPO, Exchange, and Medicare GMAPD and IMAPD networks. Barriers and opportunities are compiled from NET 1, NET 2, and NET 3 A and apply to all lines of business unless otherwise stated.

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1. Cross-Analysis of Data Sources: We will conduct a thorough cross-analysis of multiple data sources, including Member Experience, Grievance, utilization, quality, and PAAS results. This analysis will help us better understand the root causes of access to care challenges and develop targeted solutions.

Activities Undertaken

- BSC implemented an artificial intelligence/machine learning analytic tool to support cross-analysis of member experience data by identifying members at risk for low CAHPS ratings. This approach was effective in improving the targeting of member outreach during the year and remains an ongoing process, with continued refinement to further enhance identification of root causes and support improvements in access and member experience.

2. Continuous Improvement of Data Validity and Completeness: Our focus will be on continuously improving the validity and completeness of our data through enhanced communication and methodology refinement. This will ensure that our decisions are based on accurate and reliable information.

Activities Undertaken

- BSC continued to offer virtual health services across all lines of business through contracted providers, supplementing services available through medical groups. This strategy proved effective during the year and remains an ongoing effort to enhance access, data reliability, and informed network planning.

3. Dual Focus on Member and IPA/Medical Group Levels: We will adopt a dual focus approach, addressing network deficiencies at both the member level and the IPA/Medical Group level. This includes remediating any network deficiencies in line with the new DMHC methodology for assessing network adequacy for time, distance, and capacity standards.

Activities Undertaken

IPA/Medical Groups continue to reinforce education on access-to-care standards, including after-hours messaging and appointment timeliness, which has been effective during the year in supporting adherence at both the member and medical group levels. These efforts remain ongoing despite continued recruitment challenges related to provider availability and budgetary constraints

4. Target Critical Geographic Regions and Specialties: We will focus on targeting critical geographic regions and specialties to address areas with the most deficiencies. This targeted approach will help us allocate resources more effectively and improve access to care where it is needed the most.

Activities Undertaken

- BSC expanded the use of telehealth and virtual care services, including same-day and alternate physician visits offered by specialty offices, which was effective during the year in improving access in targeted geographic regions and specialties. This approach remains an ongoing effort, with continued enhancements to virtual care options.

5. Expansion of Key Primary Care Access Activities: We plan to expand key primary care access activities, including the Advanced Primary Care Model, Telehealth options, and the Virtual Blue Health Plan. These initiatives will provide more convenient and accessible care options for our members.

Activities Undertaken

- BSC supported 24/7 on-demand care models, including programs offered by Cedars-Sinai and Scripps Health Express, and expanded telehealth and virtual care utilization, including same-day and alternate physician visits. These efforts were effective during the year in improving urgent and routine access to care and remain ongoing as BSC continues to enhance expanded access models to address post-pandemic demand.

6. Emphasis on Behavioral Health: Recognizing the importance of behavioral health, we will emphasize it as a critical access issue. Behavioral health is a significant factor in overall healthcare access and addressing it will improve the well-being of our members.

Activities Undertaken

- BSC implemented strategies to integrate behavioral health services into the primary care setting, which proved effective during the year in helping offset demand for psychiatrists, therapists, and counselors. This work is ongoing, with continued efforts to further enhance integrated care models and strengthen access to behavioral health services over time.
- BSC continued recruitment and contracting efforts for psychiatrists and non-psychiatrist behavioral health providers, which were effective during the

year in improving access and availability. These efforts remain ongoing, with continued expansion of the network and an enhanced focus on cultural needs and provider diversity to further strengthen access for members.

7. Optimize Recruitment in Targeted Areas: To ensure we have adequate healthcare providers, we will optimize recruitment in targeted geographic areas. This includes replacing retired or termed providers and adding additional mid-level practitioners to meet the demand.

Activities Undertaken

- BSC worked with IPA/Medical Groups to replace retiring or departing physicians with new practitioners, which was effective during the year in maintaining provider capacity and meeting member demand in targeted areas. These recruitment efforts remain ongoing as BSC continues to strengthen network composition and address provider turnover to support sustained access to care.

8. Execute on Health Equity Goals: We are committed to executing specific health equity goals, such as improving access to preventative care for groups with lower screening rates. This will help reduce disparities and ensure all members receive the care they need.

Activities Undertaken

- BSC improved the accuracy of provider directory information by enabling providers to directly attest to and update their practice details through the Find-A-Doctor tool. This enhancement was effective during the year in supporting members' ability to locate appropriate providers and remains an ongoing effort, with continued improvements to search for functionality and usability to further advance health equity and access to care.

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Priority Action Plan (BSP)

For RY2025, the BSP priority action plan covers LA Medi-Cal, SD Medi-Cal networks. Barriers and opportunities are compiled from NET 1, NET 2, and NET 3 A:

- Identify root causes of health inequities in terms of access and availability of care for Medi-Cal members and work to mitigate health inequity barriers.
- Improve Medi-Cal practitioner access and availability of primary care practitioners (PCP), specialty care practitioners (SCP), and behavioral health (BH) practitioners.
- Improve Medi-Cal practitioner access and availability of PCP Urgent Care appointments during regular business hours for established Medi-Cal members/patients.

BSP Non-Behavioral Health		
Priorities	**Opportunities**	**Barriers**
Identify root causes of health inequities in terms of access and availability of care for Medi-Cal members and work to mitigate health inequity barriers.	• There is an opportunity to increase PCP services in San Diego County which has proven to be an area with limited providers. BSP's Contracting department initiates targeted outreach efforts to engage providers for direct contracting in San Diego County, with the goal of strengthening network adequacy and improving member access to care. • Increase provider availability by collaborating with our IPA and Medical Groups on provider recruitment and increasing access to PCP care services. Work with our subcontracted network to configure their contracted FQHCs as PCPs to expand primary care availability for members; members would no longer be limited to their	• San Diego County saw a significant decrease in practitioner to member ratio due to the termination of clinics and Independent Provider Associations (IPAs). These terminations impact the overall number of adult and pediatric providers available in the Promise network. • In San Diego, physicians such as internal medicine providers are directly employed with large health systems and their lack of participation in the Medi-Cal line of business significantly impacts the availability of providers that are willing to contract directly with the plan. • Specific access issues for Medi-Cal Pediatrics may contribute to many

	previously assigned practitioner, but rather all PCP providers that practice out of the FQHC. IPA/Medical Groups will be asked to provide their barriers, challenges, and mitigation plans. IPA and Medical Groups that continue to fail to meet threshold for Access to Care for PCP and Specialty services will be placed on a Corrective Action Plan. IPA and Medical Groups will be asked to document their mitigation plans, provide updates, and provide proof to demonstrate their interventions were completed. • There is an opportunity to increase providers wanting to participate in the Medi-Cal line of business through education of reimbursement models now available for Medi-Cal providers. Educate IPA and direct network providers on the opportunities to increase their reimbursement through reimbursement models, such as Tri-Rates, FQHC Alternative Payment Methodology, and other incentive programs.	pediatricians are available only in center of excellence and may represent long travel distance; these specialty providers can be reached using free transportation services. In the event a contracted specialty provider is not available within time/distance standard, a single case of letter of agreement may be submitted ensuring access to an out-of-net network provider is available. In 2025, access challenges for Medi-Cal Pediatrics contributed to unmet member-to-provider ratios, largely due to specialists being concentrated in Centers of Excellence requiring long travel distances.
	• Increase provider availability by collaborating with IPA and Medical Groups on provider recruitment and	• In San Diego County, BSP's ability to expand its provider network is impacted by the presence of large medical

	increasing access to PCP. Distribute access and availability report bi-annually. IPA/Medical Groups will be asked to provide their barriers, challenges, and mitigation plans. IPA and Medical Groups that continue to fail to meet threshold for Access to Care for Specialty services will be placed on a Corrective Action Plan. IPA and Medical Groups will be asked to document their mitigation plans, provide updates, and provide proof to demonstrate their interventions were completed. • Conduct our annual evaluation of specialty time and distance standards by zip code and specialty provider type to identify network gaps. We will evaluate the demand and need of the specialty type and area and conduct outreach to providers that will close network deficiencies. We will also work with IPA and Medical Groups to identify providers in their network that participate in Non-Medi-Cal plans and discuss the providers' willingness to participate in Medi-Cal.	groups, including Kaiser, Scripps and Sharp, which have elected not to enter into contractual agreements with the plan or its affiliated IPAs. This limits the pool of providers available for direct contracting and presents challenges in meeting network adequacy standards. To mitigate this constraint, BSP implements structured annual outreach initiatives aimed at identifying and engaging new provider groups for potential contracting opportunities, thereby supporting continued compliance with access and availability requirements. • BSP Access challenges in rural regions of Los Angeles and San Diego Counties have impacted our ability to meet timely care standards. In many cases, members elect to seek specialty services outside their residential area, often closer to their place of employment or at California Healthcare Centers of Excellence—resulting in utilization patterns that fall outside NCQA-defined geographic access parameters. • BSP continues to face recruitment challenges in both Los Angeles and San

		Diego Counties related to Medi-Cal provider participation. Compared to other payer networks, Medi-Cal presents unique barriers, including less competitive reimbursement structures and heightened compliance requirements for both patients and providers. These factors contribute to reduced provider engagement and limit network expansion efforts within the Medi-Cal program.
	Member Experience **People** • **Medi-Cal Member Check-In**: Six full-time call representatives' conduct year-round targeted outreach to members to see if there is any assistance needed to access their plan benefits, including but not limited to providing information, assisting with making appointments, understanding and resolving specialty referrals. **Process** • **In 2024, HEDIS Medi-Cal Simulation survey**, this survey will allow BSP to simulate the HEDIS Medicaid CAHPS survey allowing BSP more insights into member level responses. Data collected from the survey will be used for quality	**Member Experience** In 2024, The cost of health care continues to be a barrier impacting the most vulnerable population: low income and fixed income populations. Evolving regulations continue to apply financial pressure on health plans to improve quality and reduce the cost of healthcare for members, increasing the administrative burden on providers. Nationally, the continued shortage of Primary Care and Specialists impact rural areas specifically. This shortage of licensed professionals impacts access to care for members across all lines of business. And continues to be a barrier for members.

	improvement purposes. This program will launch in 2025. • **Access to Care Health Education Mailer:** Blue Shield Promise Medi-Cal mails 2 rounds of Access to Care guides in Q2 and Q3 of 2024, helping members know when to use Teledoc, Nurse Advice, Urgent Care, and the Emergency Room in all 10 threshold languages. BSP continue to use the member engagement material at all events, Community Resource Centers, providers, etc. This program is working to address access to care barriers as identified by complaints data in 2024. **Member Newsletters:** Blue Shield Promise Medi-Cal executed 2 annual newsletters in Q2 and Q4 of 2024. The Medi-Cal member newsletters contained important health information and resources in all 10 threshold languages	
Improve Medi-Cal practitioner access and availability of PCP Urgent Care appointments during regular business hours for established Medi-Cal members/patients.	• There is an opportunity to improve the quality of our provider network data to improve the accuracy of our provider network and improve the outcomes of our appointment availability surveys and network adequacy reports. o Implemented an automated online provider network change submission process, which enables our subcontracted	• When it comes to Urgent Care compliance in Los Angeles County, we have seen numerous barriers such as Physicians in this geographic region have reporting an increase in the growing population needing healthcare, and increasingly complex medical cases. Delivering high-quality

	network to update their network quicker and improve our data accuracy used for appointment availability surveys. o Educate network on data tools to ensure quarterly validation via of data. Trainings are being held for network providers on new provider data processes, including the creation of a provider training guide. o As a result of APL 25-006, BSP implemented a data monitoring process to improve data quality by reviewing data distributed by DHCS, including the examination of data errors, which will improve provider participation and better reflect the efforts from the plan. • There is an opportunity to improve our subcontracted networks' performance through ongoing access and availability monitoring processes, including education and corrective action plans when they fail to meet standards. o Provider Network has incorporated a Corrective Action Plan (CAP) in our access availability monitoring process when subcontractors fail to meet goals. Subcontractors are asked to provide their mitigation plans every 30-60 days and remain on a CAP until they have provided all	care amid rising demand and case complexity has become increasingly difficult. The administrative burden to meet requirements of multiple health plans also impacts the time spent on patient appointments. Our downstream networks are promoting best practices, including reserving time for urgent and same-day visits, accommodating walk-ins, and offering telehealth options to improve patient access and convenience. • BSP has identified several factors contributing to suboptimal performance in the ER Instruction and After-Hours survey domains. A high volume of outbound survey calls has led to provider fatigue, resulting in incomplete responses or premature call terminations. This has adversely affected survey completion rates and overall performance metrics. Additionally, data integrity issues have been observed, including outdated or

	requested documentation to address their deficiencies. CAPs are also being incorporated into Access & Availability Subcommittee to increase visibility and input on provider interventions. ○ Improve our monitoring process of subcontracted network by enhancing reports to include year-over-year results; this enhancement will provide further insights into areas that require targeted improvement. ○ Execute Secret Shopper Program to monitor access improvements in our poorer performing medical practices. A sampling of these practices is drawn from the validated annual PAAS Raw Data Templates' results for the most-recent Measurement Year. On an annual basis, this outbound call survey is used to evaluate access-related data directly from a sample set of targeted provider groups/IPAs to determine whether appointment accessibility has improved and/or is improving over time. • There is an opportunity to increase providers wanting to participate in the Medi-Cal line of business through education of reimbursement models now	incorrect provider contact information, disconnected phone lines, and instances of non-response. These factors collectively hinder BSP's ability accurately reflect provider engagement • The survey does not account for members being able to see alternate PCP providers located at the same office or clinic, which is provided to members as an alternative when their requested provider is not available. • There is a lack of general practitioners and specialists in LA and SD County, which makes it challenging to recruit providers to participate in Medi-Cal. • Requirements (trainings, such as DEI and New Provider Orientation) to participate in Medi-Cal, which makes it difficult to recruit providers into network. The focus for Medi-Cal providers has now shifted to administratively meeting regulatory requirements by plan partner instead of focusing on patient care- this is driving practitioners to not

	available for Medi-Cal providers. • Educate IPA and direct network providers on the opportunities to increase their reimbursement through reimbursement models, such as Tri-Rates, FQHC Alternative Payment Methodology, and other incentive programs. o LOAs are used on a case-by-case basis to ensure members receive care, however, providers fail to sign a contract; these providers are not included in surveys. We will monitor highly utilized out of network providers to target for contracting and explain the reimbursement opportunities of being a contracted provider.	want to participate in Medi-Cal

BSP Behavioral Health		
Priorities	**Opportunities**	**Barriers**
Improve Medi-Cal practitioner access and availability of primary care practitioners (PCP), specialty care practitioners (SCP), and behavioral health (BH) practitioners.	The BSP BH and Contracting team is committed to enhancing access across all provider types within its comprehensive care network. This includes Licensed Professional Clinical Counselors (LPCCs) serving both adult and pediatric populations. The BSP Behavioral Health and Contracting team will initiate	Blue Shield of California Promise Health Plan continues to enhance its behavioral health provider network to meet the needs of its diverse membership. The Licensed Professional Clinical Counselor (LPCC) credential has seen slower adoption compared to more established licenses such

	targeted contracting efforts to address gaps in LPCC provider availability across San Diego County. Specifically: • **Adult LPCC Providers**: Contracting will be pursued in the 48 ZIP codes identified as having deficiencies in adult LPCC coverage. • **Pediatric LPCC Providers**: Contracting will also be pursued in the 51 ZIP codes identified as having deficiencies in pediatric LPCC coverage. • **This goal will be ongoing**	as LMFT and LCSW, though recent years have shown increased interest. To address geographic disparities, the contracting team actively monitors provider availability by ZIP code and targets outreach in underserved areas. The outskirts of San Diego and Los Angeles counties, in particular, have historically faced limited behavioral health access due to distance from urban centers. In response, Blue Shield has expanded telehealth services to ensure equitable access across all regions. Addiction Medicine (AM) providers are typically not part of a Medi-Cal Managed Care Plan, as these services are contractually carved out by the California Department of Health Care Services (DHCS) and delegated to the local Drug Medi-Cal Organized Delivery System (DMC-ODS). In both counties where Blue Shield Promise operates, access to these services through the DMC-ODS is robust and well-established with no significant number of calls and or grievances regarding these services.
	• Access to ER services during normal work hours and after-hours: Behavioral Health access. BSP needs to	**Care for a non-life – threatening emergency barriers:**

	track if mental health professionals are available during normal work hours and after hours. Implement a comprehensive ER support enhancement initiative that ensures members presenting with mental health needs receive timely behavioral health care, especially during after-hours. The Behavioral Health Operations team will collaborate with ER facilities to identify and implement solutions such as Telehealth when in person provider is not available. Additionally, the team will develop and distribute clear protocols and informational materials to ER staff to streamline behavioral health triage and reduce delays in care. Internal departments will coordinate with the Access and Crisis Line to reinforce 24/7 availability and educate members on these resources through targeted outreach following ER visits. This activity will be completed by Q2 2026. • BSP- is working on improving all access to care, in particular Urgent behavioral health services for both prescribing and non- prescribing provider to enhance the availability and timeliness of urgent behavioral health services.	• Members in both counties face challenges obtaining appropriate care for non-life-threatening emergencies in the ER, especially after-hours. While members are accessing ER services, inconsistent mental health provider coverage often results in delayed or inadequate behavioral health interventions. Reduced staffing and limited psychiatric resources during evenings and weekends further increase the risk of inappropriate discharge. These gaps in care create a disconnect between ER utilization and performance goals, as access does not guarantee timely or quality outcomes. **Access for Urgent Care barriers:** • Members in San Diego County experienced access barriers when accessing urgent BH service needs for both prescribers and non-prescribers. These barriers could include factors such as limited availability of urgent care facilities, insufficient staffing, or logistical challenges that hinder timely access to care.

	The BH team will work with the internal departments to develop a workflow to facilitate timely referrals. The team will work on creating a streamlined process to ensure that patients who need urgent behavioral health services are referred quickly and efficiently to the appropriate providers. The aim is to reduce delays in care and improve overall access to urgent behavioral health services. This activity will be completed by Q4 2025.	

Effectiveness of Past Interventions of RY 2024 Priority Action Plan (Promise)

Key Actions to Address Priority Action Plan (BSP) for RY2024:

During 2025, BSP took the following actions to identify root causes of health inequities in terms of access and availability of care for Medi-Cal members and work to mitigate health inequity barriers:

ACTION #1: BSP Access and Availability Subcommittee reviewed 2024–2025-member grievance data involving access and availability of care issues encountered by our Medi-Cal members in San Diego and Los Angeles counties with a focus on identifying health inequities. The subcommittee identified 3 primary health inequity barriers contributing to Medi-Cal member difficulties in accessing health care services:

1. Limited PCP access and availability for Medi-Cal members in San Diego and Los Angeles counties.
2. Limited specialty care provider (SPC) access and availability for Medi-Cal members in San Diego and Los Angeles counties.
3. Transportation issues causing inability for Medi-Cal members in San Diego and Los Angeles counties from accessing health care services.

ACTION #2: BSP initiated the following actions to address the above identified health inequity issues contributing to Medi-Cal members in San Diego and Los Angeles counties having difficulty accessing health care services and transportation:

1. Targeted outbound calls to assist Medi-Cal members in San Diego and Los Angeles counties with PCP and Specialist appointment scheduling, new member appointments, follow up after ER visits, appointments to close gaps in care, and contacting each pregnant member to offer case management and appointment navigation assistance.
2. Grievance data involving access and availability of care issues encountered by our Medi-Cal members in San Diego and Los Angeles counties is calculated per one thousand members for each medical group to identify specific medical groups with patterns of access and availability issues. Medical groups exceeding >1.0 grievances per one thousand members are "non-compliant" with contract requirements and receive a Corrective Action Plan (CAP). In 2025, 1 (one) CAP was issued to a medical group in San Diego County for excessive access and availability issues. Medical groups receiving a CAP must submit an action plan to BSP for how they intend to improve the access and availability of PCPs and/or Specialists for our Medi-Cal members. Medical groups receiving a CAP are monitored for compliance with contract requirements. Repeated lack of compliance by medical groups may result in financial penalties and other actions including termination of their contract.
3. Grievances from Medi-Cal members in San Diego and Los Angeles counties indicate difficulties with scheduling transportation to obtain health care services thru BSP transportation vendor, Call the Car (CTC). BSP initiated monthly Joint Operational Committee meeting with CTC to discuss improving transportation services for our Medi-Cal members. In addition, BSP initiated member education on how to access Medi-Cal transportation benefits and the necessity to schedule transportation services at least 24 hours in advance to ensure the availability of transportation to health care services.

During 2025, BSP took the following actions to improve Medi-Cal practitioner access and availability of primary care practitioners (PCP), specialty care practitioners (SCP), and behavioral health (BH) practitioners.

ACTION #1: BSP Access and Availability Subcommittee reviewed 2024–2025-member grievance data involving access and availability issues with primary care practitioners (PCP) and specialty care practitioners (SCP) from our Medi-Cal members in San Diego and Los Angeles counties and relayed this data to BSP Network Contracting and Provider Relations departments during monthly meetings. BSP Network Contracting and Provider Relations meets with medical groups with patterns of grievances involving access and availability issues with PCPs and SCPs to strategize and plan improvement activities such as utilizing

medical group administrative staff as "health navigators" to assist BSP members in scheduling appointments with PCPs and SCPs, and providing provider education materials about Medi-Cal access and availability appointment standards for distribution to medical group administrative staff, PCPs and SCPs.

ACTION #2: BSP Access and Availability Subcommittee reviewed 2023–2025-member grievance data involving access and availability issues with behavioral health (BH) providers from our Medi-Cal members in San Diego and Los Angeles counties. Non-Specialty Mental Health Services (NSMHS) are the responsibility of BSP and not our medical groups. Due to the high volume of member grievances involving access and availability issues with outpatient NSMHS BH providers during the past year, BSP BH Network Contracting has been recruiting and adding all types of outpatient NSMHS BH providers to the BSP BH network in both San Diego and Los Angeles counties during 2025. The BSP BH Network Contracting team has significantly increased the number of contracted outpatient NSMHS BH providers by 27% in 2025 (adding 19 MDs, 67 PhDs, 1,705 Masters, and 274 ABA providers.)

During 2025, BSP took the following actions to improve Medi-Cal practitioner access and availability of PCP Urgent Care appointments during regular business hours for established Medi-Cal members/patients.

ACTION #1: BSPs online member provider directory (Find A Doctor) does not have the ability to list contracted Urgent Care Centers that are available in specific zip codes or searches. Medi-Cal member access to Urgent Care Centers would improve the access and availability of PCP Urgent Care appointments. In 2025, BSP began the planning, funding and systems improvements necessary to list contracted Urgent Care Centers that are available in Medi-Cal members specific zip codes or searches in Find A Doctor.

ACTION #2: BSP contracted provider data does not routinely include information about PCPs offering telehealth appointments which are known to improve the access and availability of PCP Urgent Care appointments. During 2025, BSP Provider Operations began gathering information from PCPs and medical groups that offer PCPs telehealth appointments and updating BSP contracted provider data to include this important information to improve Medi-Cal practitioner access and availability of PCP Urgent Care appointments during regular business hours.

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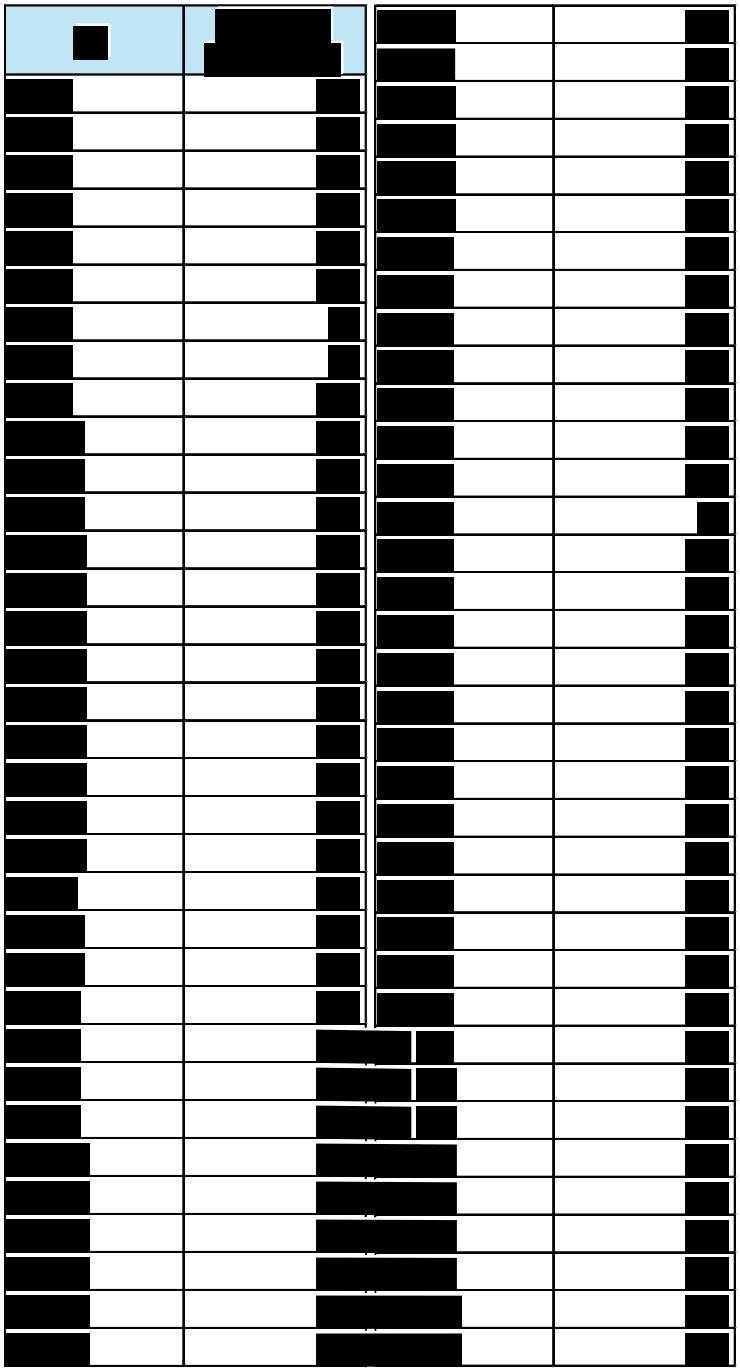
Supporting data

NET 2A

IPAs that do not meet BSC and BSP's standards are monitored on an ongoing basis. IPAs scoring below 25% are slated to or have received outreach regarding their scores to facilitate improvements.

Blue Shield Classic



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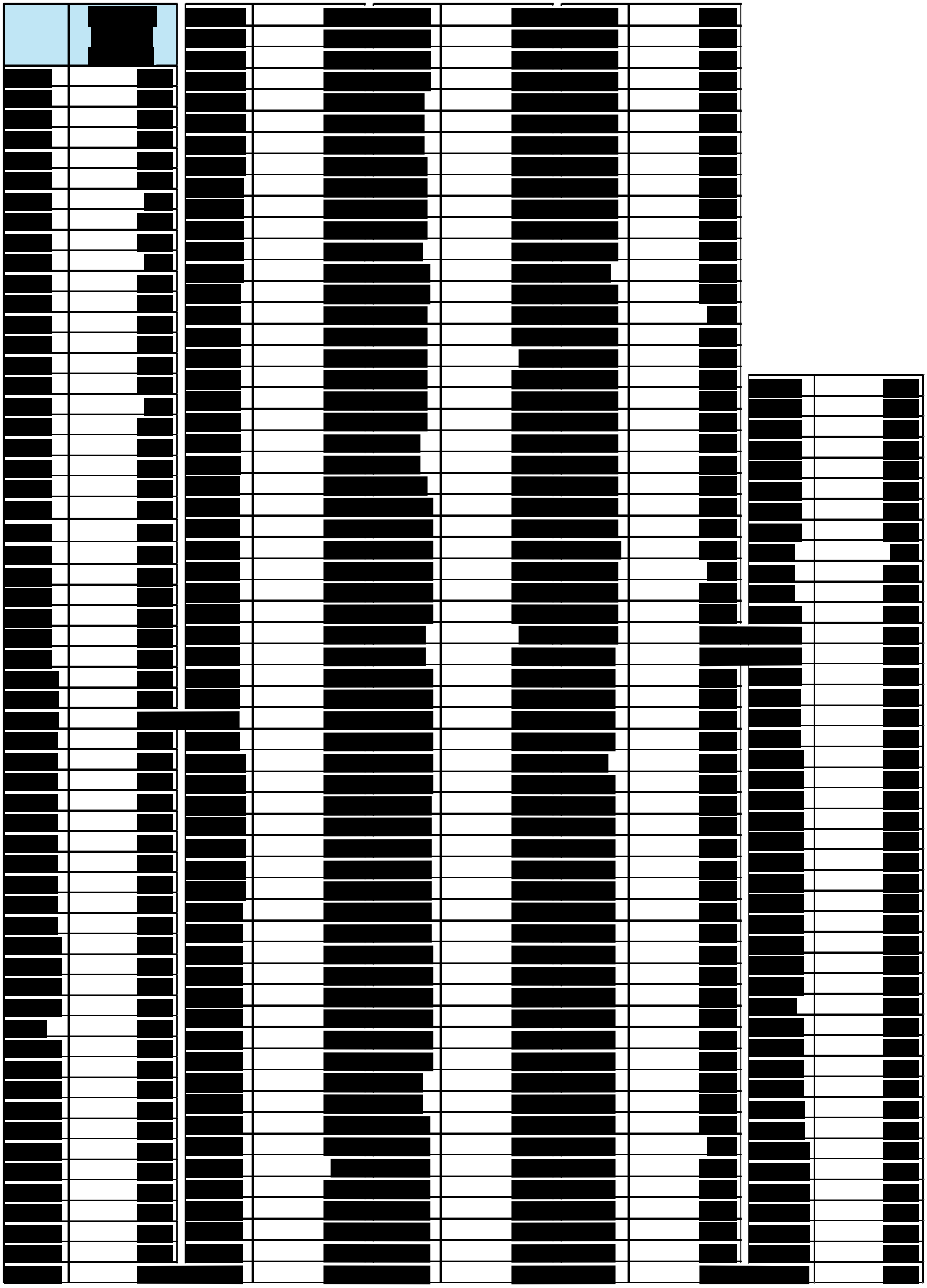

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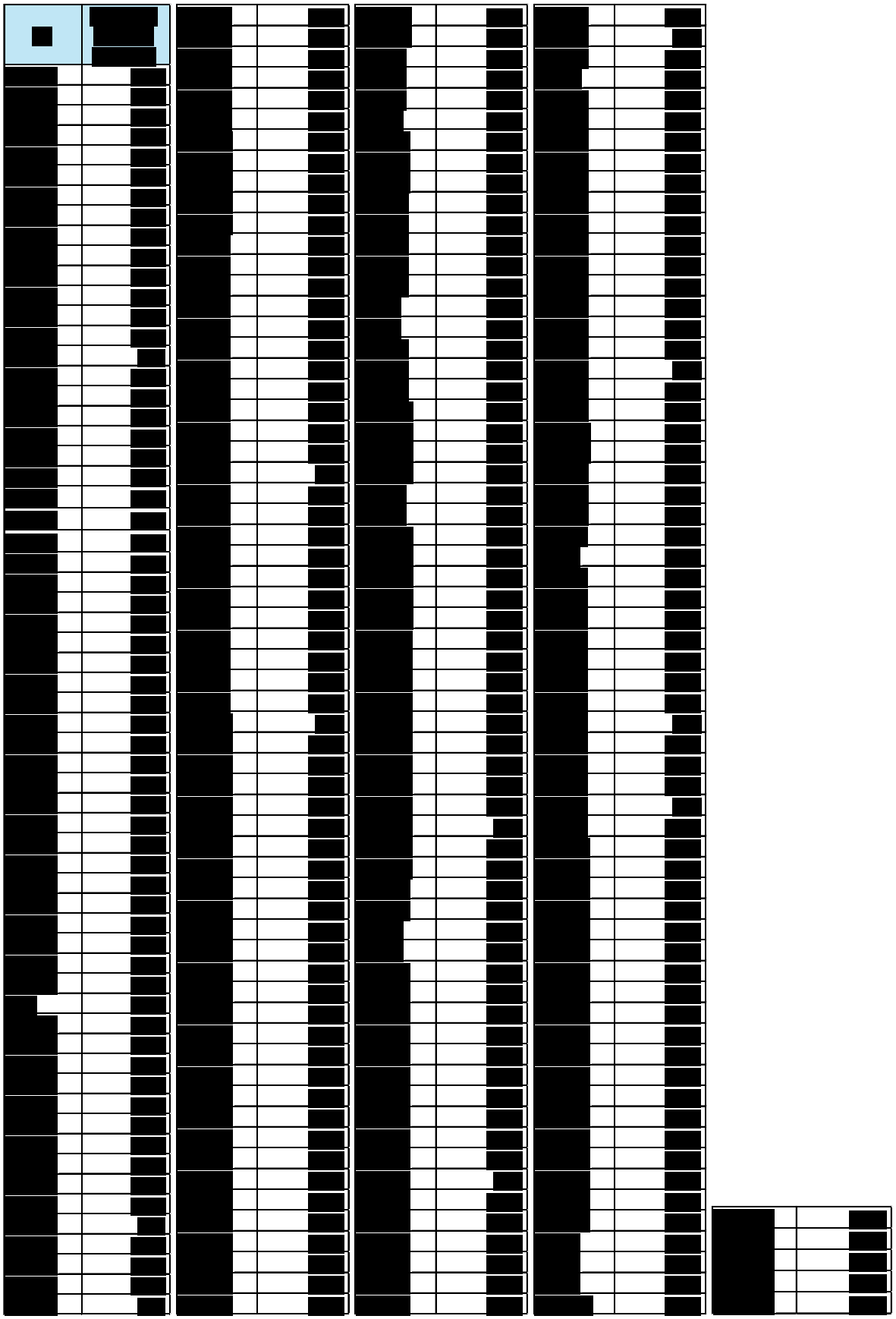

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Blue Shield Promise Health Plan

IPA	Emergency Response Compliant
IPA A342	42.9%
IPA A345	0.0%
IPA A584	13.6%
IPA A346	92.0%
IPA A354	88.2%
IPA A585	74.3%
IPA A357	92.6%
IPA A371	69.7%
IPA A377	96.0%
IPA A586	0.0%
IPA C387	92.2%
IPA C	91.9%
IPA C587	86.4%
IPA C588	50.0%
IPA C589	58.3%
IPA C396	96.7%
IPA C406	42.9%
IPA C407	86.7%
IPA D412	94.0%
IPA F431	70.6%
IPA F432	90.0%
IPA F435	97.4%
IPA G440	86.7%
IPA G444	96.3%
IPA H448	97.4%
IPA H450	61.5%
IPA H452	88.1%
IPA H454	92.0%
IPA H456	91.0%
IPA H458	60.0%
IPA H460	92.6%
IPA H590	96.1%
IPA I470	85.7%
IPA I591	83.3%
IPA K472	90.0%
IPA L476	0.0%
IPA M592	85.0%
IPA M484	92.9%
IPA N593	0.0%
IPA N494	86.7%
IPA O500	68.2%
IPA O501	88.3%
IPA P504	91.7%
IPA P594	70.0%
IPA P517	90.6%
IPA P524	96.3%
IPA P525	83.3%
IPA P529	85.7%
IPA P530	7.1%

IPA P532	9.1%
IPA P533	98.2%
IPA P536	76.0%
IPA P595	71.4%
IPA Q541	0.0%
IPA R544	89.5%
IPA S552	86.2%
IPA S596	95.0%
IPA S597	95.0%
IPA S598	98.1%
IPA S599	55.2%
IPA U567	95.0%
IPA U570	84.6%
IPA U574	86.2%
IPA U578	94.4%
IPA S53	96.7%
IPA W582	69.4%
IPA W583	55.2%
IPA W584	86.2%

	After Hours Response Compliance
IPA A343	87.5%
IPA A346	76.0%
IPA A350	87.5%
IPA A354	58.8%
IPA A377	79.6%
IPA B383	40.0%
IPA C387	77.0%
IPA C	79.7%
IPA A600	77.5%
IPA A601	85.7%
IPA C393	28.6%
IPA C396	78.1%
IPA C397	86.7%
IPA C406	44.4%
IPA C407	81.5%
IPA D412	78.7%
IPA E418	85.7%
IPA F430	16.7%
IPA F432	38.9%
IPA G440	56.6%
IPA G444	85.7%
IPA G446	23.5%
IPA H448	57.5%
IPA H452	76.3%
IPA H456	90.6%
IPA H458	0.0%
IPA H602	80.0%
IPA H462	58.8%
IPA I470	75.0%
IPA H603	86.4%
IPA K23	73.7%
IPA K471	83.3%
IPA L475	20.0%
IPA L476	0.0%
IPA K604	73.7%
IPA L605	85.7%
IPA M484	84.6%
IPA O500	26.7%
IPA N606	92.3%
IPA P504	78.3%
IPA O607	57.1%
IPA P517	91.8%
IPA P518	14.3%
IPA P524	85.7%
IPA P525	83.3%
IPA P526	0.0%
IPA P528	0.0%
IPA P529	54.2%
IPA P530	0.0%

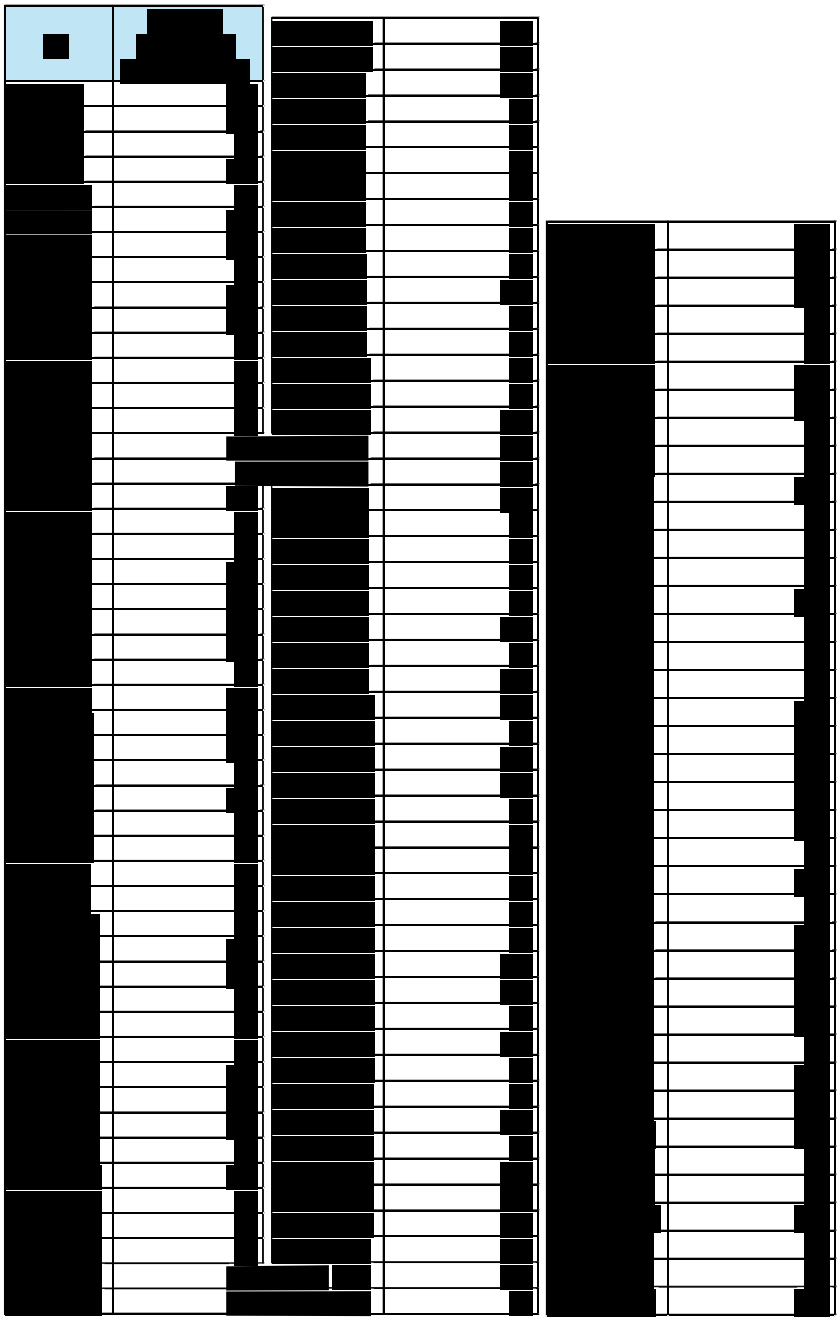
IPA P532	0.0%
IPA P533	87.7%
IPA P536	26.3%
IPA P608	0.0%
IPA Q541	0.0%
IPA S546	83.3%
IPA S609	85.7%
IPA S548	50.0%
IPA S552	85.2%
IPA T557	88.2%
IPA U567	94.7%
IPA U570	50.0%
IPA U574	85.2%
IPA U576	87.5%
IPA U578	82.4%
IPA S53	93.1%
IPA S53	78.1%
IPA W583	93.8%
IPA W584	80.8%

NET 2B

Blue Shield of California
Access & Availability – 2025 Network Performance Summary

Behavioral Health groups that do not meet BSC and BSP's standards are included in the table below. Direct contracted practitioners without a group affiliation are not included in the table below as they are a sample size of one.

Blue Shield Classic



Blue Shield Promise Health Plan

Blue Shield of California
Access & Availability – 2025 Network Performance Summary

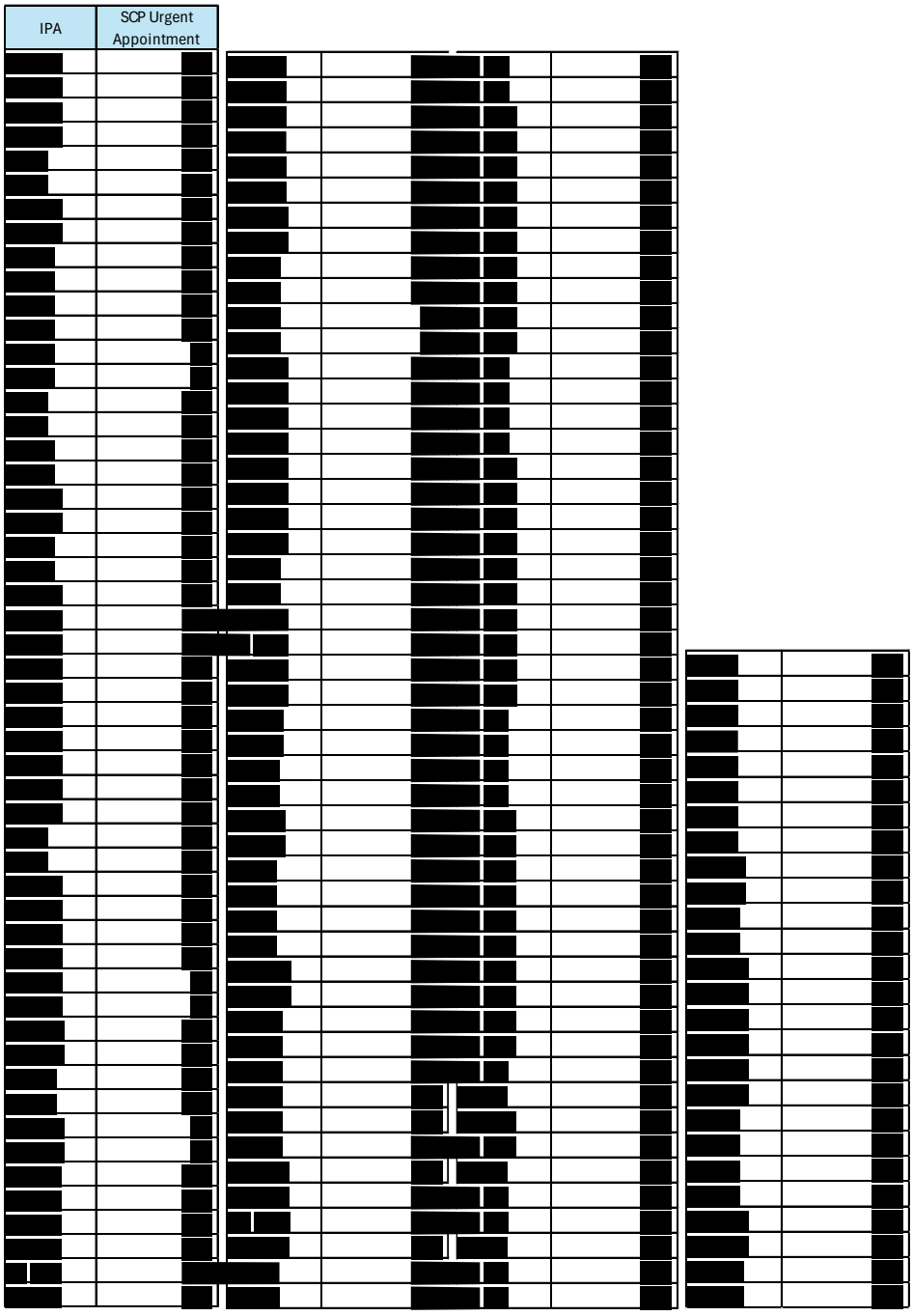
GROUP	BH Urgent Appointment (Prescriber)
GROUP A15	50%
GROUP A28	0%
GROUP B36	0%
GROUP C52	50%
GROUP C61	0%
GROUP C69	65%
GROUP D87	27%
GROUP F106	0%
GROUP F107	50%
GROUP F112	0%
GROUP F117	0%
GROUP F119	0%
GROUP H145	0%
GROUP H147	0%
GROUP I156	70%
GROUP I157	67%
GROUP I161	0%
GROUP J167	0%
GROUP L198	38%
GROUP M213	16%
GROUP M214	0%
GROUP M216	0%
GROUP M218	0%
GROUP M222	0%
GROUP M224	46%
GROUP M225	58%
GROUP M230	0%
GROUP N235	33%
GROUP N236	0%
GROUP O239	0%
GROUP O246	50%
GROUP P256	0%
GROUP P259	0%
GROUP P261	38%
GROUP R273	25%
GROUP R274	32%
GROUP S284	0%
GROUP S289	40%
GROUP S300	50%
GROUP S301	33%
GROUP S309	0%
GROUP T313	0%
GROUP T316	0%
GROUP T321	71%
GROUP T328	0%
GROUP T330	0%
GROUP U334	0%
GROUP W345	47%
GROUP G348	58%

NET 2C

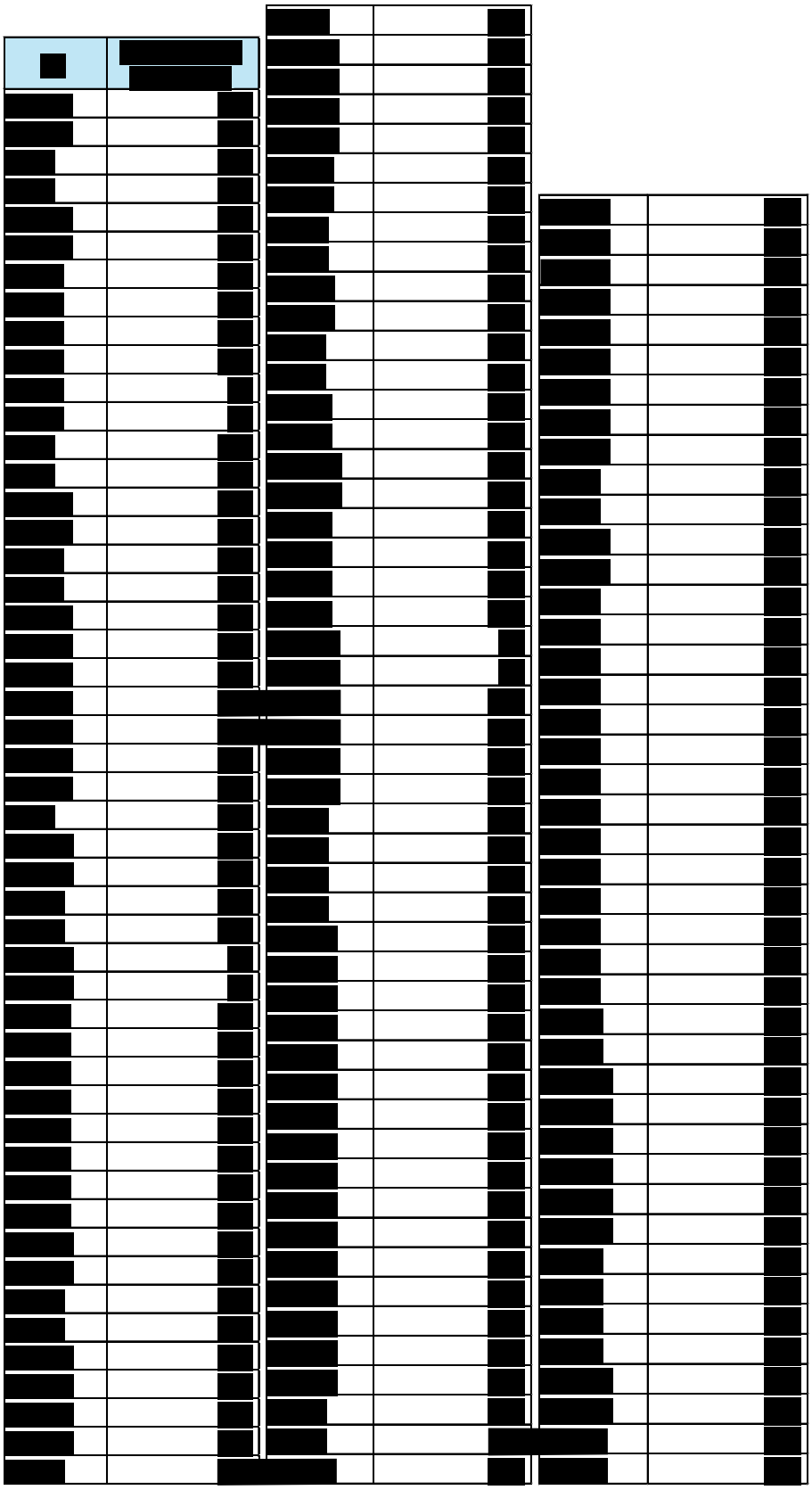
Blue Shield of California
Access & Availability – 2025 Network Performance Summary

IPAs that do not meet BSC and BSP's standards are monitored on an ongoing basis. IPAs scoring below 25% are slated to or have received outreach regarding their scores in an effort to facilitate improvements

Blue Shield Classic



Blue Shield of California
Access & Availability – 2025 Network Performance Summary



Blue Shield of California
Access & Availability – 2025 Network Performance Summary

Blue Shield Promise Health Plan

IPA	SCP Urgent Appointment
IPA A1	60%
IPA A614	55%
IPA A680	70%
IPA A681	70%
IPA A616	67%
IPA C11	65%
IPA E146	33%
IPA H644	60%
IPA H682	67%
IPA I683	0%
IPA I22	57%
IPA K684	0%
IPA P685	33%
IPA S686	67%
IPA S308	0%
IPA U65	50%

IPA	SCP Non - Urgent Appointment
IPA A614	60%
IPA A616	67%
IPA B107	71%
IPA C11	58%
IPA H644	50%
IPA H682	67%
IPA P685	67%
IPA P39	40%
IPA P39	40%
IPA U65	67%

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Quality Improvement and Health Equity Study: Utilization of Emergency Department Visits

Project Charter

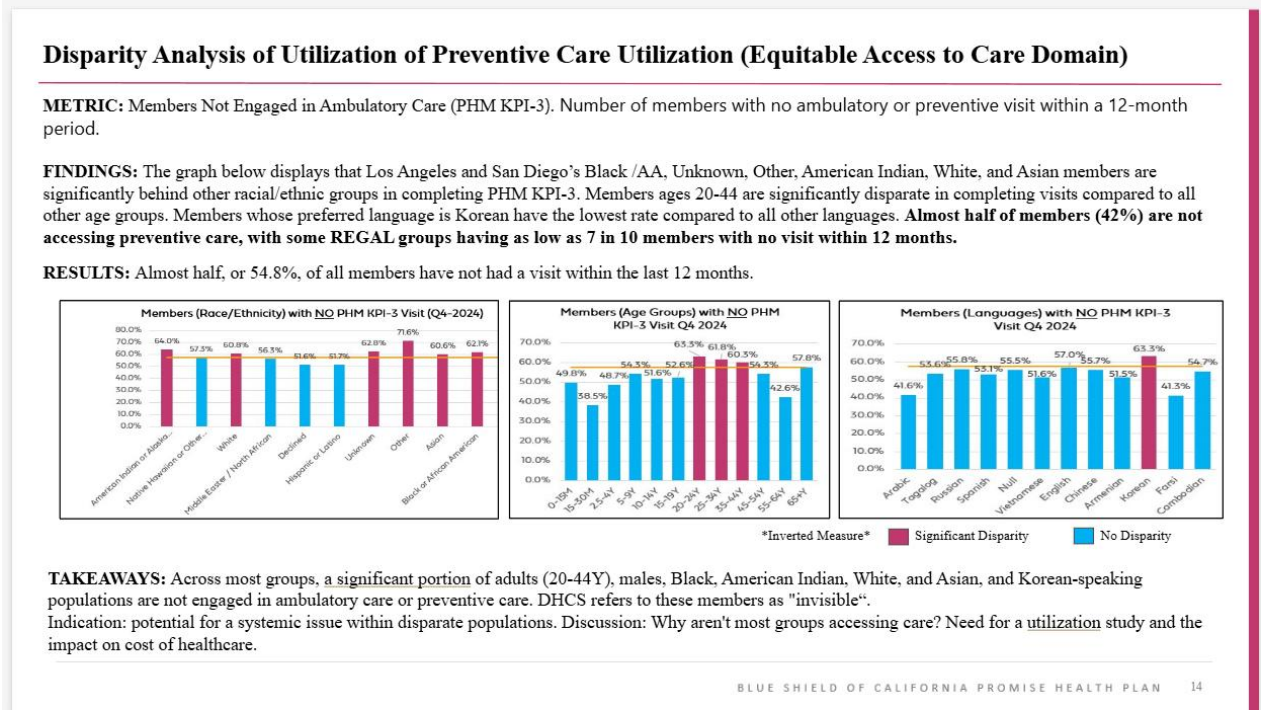
Understanding patterns of over- and under-utilization: An in-depth analysis of Emergency Department and Primary Care Provider utilization across the Medi-Cal member population

1 Project Details

Background: Limited PCP access is associated with higher rates of preventable hospitalizations, chronic disease complications, and poorer preventive service utilization. Access to PCP care is generally associated with better population health outcomes.

To better understand patterns of over- and under-utilization, an in-depth analysis of preventive and ambulatory care utilization was conducted across the Medi-Cal member population using data retrieved from Blue Shield Promise's Health Equity dashboard.

Findings revealed that a substantial proportion of members, over 40 percent, are not engaging in preventive care, with significant disparities observed across race, age, and language groups. These patterns highlight systemic access challenges and underscore the need for targeted, equity-focused interventions to improve engagement in routine care.



Disparity Analysis of Utilization of Preventive Care Utilization (Equitable Access to Care Domain)

METRIC: Members Not Engaged in Ambulatory Care (PHM KPI-3). Number of members with no ambulatory or preventive visit within a 12-month period.

FINDINGS: The graph below displays that Los Angeles and San Diego's Black /AA, Unknown, Other, American Indian, White, and Asian members are significantly behind other racial/ethnic groups in completing PHM KPI-3. Members ages 20-44 are significantly disparate in completing visits compared to all other age groups. Members whose preferred language is Korean have the lowest rate compared to all other languages. **Almost half of members (42%) are not accessing preventive care, with some REGAL groups having as low as 7 in 10 members with no visit within 12 months.**

RESULTS: Almost half, or 54.8%, of all members have not had a visit within the last 12 months.

TAKEAWAYS: Across most groups, a significant portion of adults (20-44Y), males, Black, American Indian, White, and Asian, and Korean-speaking populations are not engaged in ambulatory care or preventive care. DHCS refers to these members as "invisible".
Indication: potential for a systemic issue within disparate populations. Discussion: Why aren't most groups accessing care? Need for a utilization study and the impact on cost of healthcare.

BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN 14

Figure 1. Utilization of Preventive Care Analysis

In response, Promise formed a Utilization Management workgroup to discuss barriers, implications and design a strategy to address these findings. Research consistently shows that higher access to and continuity with a primary care provider (PCP) is associated with lower emergency department (ER) utilization. As a result, the workgroup called for a follow-up assessment to assess correlation between PCP visits and Emergency Department utilization.

Project Charter: Utilization of Emergency Department Visits

Quality Improvement Study Description: Promise HEO and UM teams will assess rates of ED utilization as correlated to access to Primary Care and Behavioral Health Services, including an analysis to understand root causes. The teams will prepare an analysis and design subsequent interventions to reduce avoidable ED visits. The purpose of this analysis is to identify disparities and inequities in emergency department utilization among Medi-Cal members for conditions that may have been appropriately treated in primary care, urgent care, telehealth, or outpatient settings. Assessment results will include:

- Identify populations with disproportionately high avoidable ED use
- Evaluate barriers to timely ambulatory care
- Examine social, geographic, demographic, and clinical drivers (ECM)
- Inform targeted interventions to improve equitable access to care

Project Lead: Team members responsible for oversight, implementation, and evaluation of the project include a multi-disciplinary team:

- Office of the CMO: Jennifer Nuovo, MD, Chief Medical Officer
- Health Equity Office: Valerie Martinez, Chief Health Equity Officer
- Utilization Management: Kathryn Gray, Melissa Williams
- Population Health Management: Jennifer Miyamoto Echeverria
- Case Management: Ysobel Smith
- Medical Informatics: Jason Barnhart
- Project Manager: Alexis Duke, Health Equity Office

Target Population: Medi-Cal members

Project Goals:

1) Project objectives
    a. Workgroup will finalize plan by 5/22/2026
    b. CMO will present to QIHEC by 6/30/2026
    c. Medical Informatics lead will obtain baseline data by 6/1/2026
    d. Identified Data Analyst will prepare analysis by 8/1/2026
    e. CHEO, UM leads, and CMO will draft report with findings 9/1/2026
    f. Workgroup to review findings by 10/1/2026
    g. Workgroup to identify at least 3 interventions to address priority findings by 11/12026
    h. CMO will present final report to QIHEC by 12/31/2026
    i. Report to identify interventions to launch 1/1/2027 with study parameters identified.

2 Data –

Hypothesis: Specific ED visits can be avoided by routing to a Primary Care Provider and/or Urgent Care. Avoidable ED utilization is influenced by:

- Access barriers

- Social determinants of health
- Provider availability
- Transportation limitations
- Health literacy
- Structural inequities
- Prior healthcare experiences

Avoidable visits can be routed to the PCP to maximize PCP care including optimal coordination of care for preventive care screening, behavioral health screening, efficient referral mechanisms, and establishing trust with an assigned provider.

Metrics to assess include:

1) Rates of ED visits
2) Type of visits with high utilization (pain management, dental, UTI)
3) Review list of visit type and identify potentially avoidable ED visits
4) Which member populations have the highest rates of avoidable ED visits?
5) Members utilizing ED more than PCP visits. This can lead to potential to reach out to these members specifically for education and coordination of care with PCP
6) Are there disparities by:
    a. Race/ethnicity
    b. Language
    c. Age
    d. Gender
    e. Disability status
    f. Geography
    g. Socioeconomic status
    h. Engaged in Case Management
7) "Access to PCP in last 12 months" rates per PHM metric in HEART Dashboard
8) Identify a rolling report of members utilizing the ED more than 3 times in a year for outreach by Care Management. (Current risk stratification tool may not identify these members as complex)

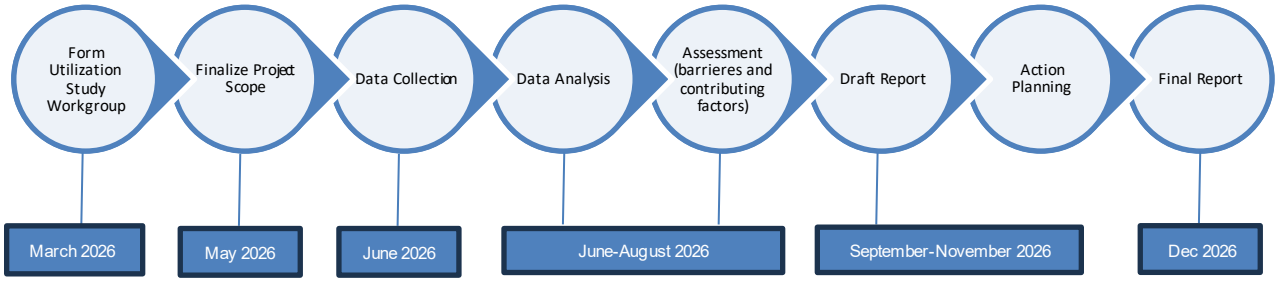
Measurement Period: 1 year look back. Confirm validity of report – note data sources.

3 Analysis - Review data for salient outcomes and assess the following considerations -

1. Are there access barriers contributing to disparities?
2. Anticipate why ED was chosen
    a. Difficulty accessing PCP
    b. Transportation barriers
    c. Language barriers
    d. Trust in healthcare system
    e. Prior discrimination experiences
    f. Appointment availability
    g. Referral barriers
    h. Care coordination issues
    i. Staffing limitations

3. Assess potential for variation in individual behaviors vs structural barriers
4. Avoid framing high ED use as "misuse" without understanding:
    a. Limited geographical access to provider
    b. Hours available
    c. Work schedule constraints
    d. Childcare barriers
    e. Historical inequities
    f. Culture
5. What factors are associated with increased avoidable ED utilization?
6. Create a table noting the potential barriers and current interventions offered. Identify gaps to observe potential interventions.

4 Timeline



Blue Shield of California Promise Health Plan
Medi-Cal

Population Health Management (PHM)
DHCS Exhibit A,
Attachment III, Section 4.3

Production Date: July 16, 2026

Revision Date:

Contents

Background

This addendum documents Blue Shield of California Promise Health Plan's (Blue Shield Promise) Population Health Management (PHM) activities and supports the Plan's Quality Improvement (QI) Program Evaluation. It is intended to demonstrate compliance with the requirements set forth in Exhibit A, Attachment III, Section 4.3, Population Health Management and Coordination of Care, of the Department of Health Care Service (DHCS) boilerplate contract. For each requirement, this addendum summarizes the Plan's current activities and cites the governing policies, program descriptions, deliverables, and committee records that evidence of compliance. Supporting documents referenced throughout are maintained by Blue Shield Promise and are available for review upon request.

Blue Shield of California's Program Purpose

Blue Shield of California Promise Health Plan (Blue Shield Promise) Population Health Management (PHM) Program is designed to ensure that all members have access to a comprehensive set of services based on their needs and preferences across the continuum of care, which leads to longer, healthier, and happier lives, improved outcomes, and health equity. Specifically, the PHM Program intends to:

- Build trust with and meaningfully engage members.
- Gather, share, and assess timely and accurate data to identify efficient and effective opportunities for intervention through processes such as data-driven risk stratification, predictive analytics, identification of gaps in care, and standardized assessment processes.
- Address upstream drivers of health through integration with public health and social services.
- Support all members in staying healthy.
- Provide care management services for members at higher risk of poor outcomes.
- Provide transitional care services (TCS) for members transferring from one setting or level of care to another.
- Reduce health disparities; and
- Identify and mitigate Social Drivers of Health (SDOH)

Blue Shield of California's Mission and Core Values

Blue Shield Promise's mission is to ensure all Californians have access to high-quality health care at an affordable price. Blue Shield Promise is guided by our mission and values, which encourage innovation and enable us to be a catalyst for constructive and transformational change.

As a nonprofit health plan, we are driven by our mission to create a healthcare system that is worthy of our family and friends and sustainably affordable, which aligns with our core values: Human, Honest and Courageous. We have deeply held foundational beliefs and values that have always guided us and the experiences we create – for our members, our partners, ourselves, and others. These values drive our interactions, and we strive to make those interactions meaningful.

Human

We connect with and respect everyone we interact with inside and outside the company like they're family and friends. We strive to be our authentic selves, listening and communicating effectively, and showing empathy towards others by walking in their shoes.

We also embody Personal and People Leadership behaviors: we are part of a high-performing team and adopt a learning mindset, keeping our members at the center of everything we do to create a personal, high-quality experience.

Honest

We hold ourselves to the highest ethical and integrity standards. We build trust by doing what we say we're going to do and by acknowledging and correcting where we fall short. Our Results Leadership behaviors are closely aligned here: we're open and transparent, getting sustainable results the right way and helping others make better, more informed decisions.

Courageous

We're industry leaders, thinking creatively and critically, and constantly innovating to transform health care. We stand up for what we believe in and are committed to the hard work necessary to achieve our ambitious goals. And we exhibit Thought Leadership when we're courageous: we continuously learn by stepping out of our comfort zones to conquer our fears, lead change, and challenge the status quo.

Population Health Management Program Strategy

Population Health Management Program (PHM) is a shift from evaluation of a single-disease state toward a whole-person focus. PHM combines wellness and care management (complex, disease, and transitional), with requirements that recognize the important role of data analytics for identifying population needs, targeting resources to the right individuals at the right time and evaluating the impact of the program strategy and goals.

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

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

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

The PHM Program is a multidisciplinary, continuum-based approach to the delivery of targeted interventions based on the application of evidence-based practice guidelines within a structured program. This is done by proactively identifying distinct populations with chronic or complex conditions that are considered high-risk. The Program establishes ongoing dialog and one-to-one communication with members to assist in setting goals, develop actionable care plans, and encourage members to make the right choices regarding lifestyle changes.

The PHM Program focuses on providing individualized interventions that:

- Are linguistically and culturally sensitive
- Serve as a vehicle to develop and reinforce the member-practitioner relationship
- Prescribe a comprehensive plan of care enhancing medical testing, self-monitoring and self-management of one's health

- Focus on empowering the member with the knowledge necessary to understand when his/her condition is worsening
- Continuously assesses the member's gaps in care; and
- Keep members healthy
- Mange members with emerging risk
- Focus on maintaining patient safety or outcomes across settings
- Manage multiple chronic illnesses

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

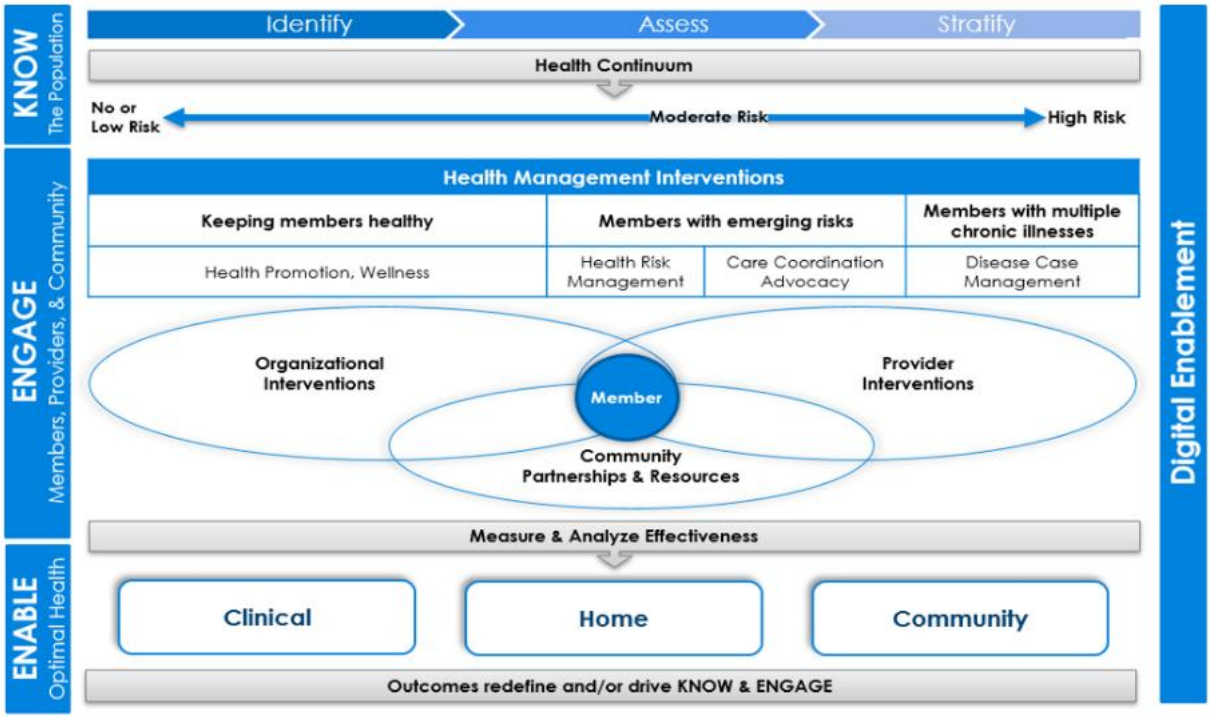
Blue Shield Promise's Population Health Management strategy also aims to align with DHCS' vision for the Population Needs Assessment process to encompass stronger engagement with Local Health Jurisdictions (LHJs) and community stakeholders. This engagement serves to foster a deeper understanding of the health and social needs of Promise members and the communities in which they live. As part of this process, Blue Shield Promise collaborates with other Managed Care Plans (MCPs) and LHJs in Los Angeles and San Diego Counties to meaningfully participate in the Community Health Assessments (CHAs)/and Community Health Improvement Plans (CHIPs) that are conducted by the LHJs to collectively drive toward shared SMART goals. These SMART goals are informed by and align with community priorities and DHCS Bold Goals. Subsequently, insights from the CHAs/CHIPs and collaborations with MHPs and LHJs inform PHM design and implementation, as depicted in the framework (Figure 1) below.

Blue Shield of California Promise Health Plan continuously works with local government agencies, community organizations, provider groups and other stakeholders to identify the needs of our members and the communities we serve. Since January 1, 2024, Blue Shield Promise has worked closely with the San Diego County Health and Human Services Agency, other Medi-Cal managed care plans, and community stakeholders to meaningfully contribute to San Diego County's Community Health Assessment (CHA) and Community Health Improvement Plans (CHIP), which serves as the Population Needs Assessment. Blue Shield Promise actively participates in various collaborative meetings and

provides resources to support strategies and action plans prioritized in the CHA/CHIP.

Additionally, Blue Shield Promise's PHM Steering Committee is a multidisciplinary committee with accountability for the implementation and performance of the PHM program. The group is sponsored by the Promise Chief Executive Office and Blue Shield Chief Medical Officer and includes the Promise Chief Medical Officer as well as senior leadership with direct accountability for PHM within CalAIM. The Committee meets regularly to monitor, evaluate, and direct overall compliance of the PHM Program. Medical Directors are closely involved with the design and implementation of PHM, including providing consultation on complex cases and transitions of care.

Figure 1. Population Health Management Framework (from DHCS PHM Policy Guide)



Programs or Services Offered to Members

Blue Shield Promise has a PHM program that is a multi-faceted approach to health and well-being. It includes:

- Identification, assessment and stratification of targeted populations and their health care needs.
- Development and implementation of programs and services that are tailored to improve the health and well-being of individuals in the different stratification levels.
- Interacting with members and providing intervention or resources.
- Coordination of community resources, programs, and providers
- Partnering with members to create an individualized care plan that is aligned to their goals
- Analyzing outcomes to target areas for improvement.

Blue Shield Promise aligns programs with delivery systems, including Accountable Care Organizations (ACO) and practitioners, to meet population heath goals. Members are identified for appropriate care management interventions and programs based on diagnosis, utilization patterns, and emerging risk. The Programs utilize medical and pharmacy claims, authorizations, as well as direct referrals in the identification process. Blue Shield Promise's sophisticated identification engine ensures members are placed in the optimal program for their condition and members are not enrolled in multiple programs simultaneously for the best member experience. All members who participate in Blue Shield Promise PHM programs are given the option to opt out. The Blue Shield Promise PHM Program offers the following services to our Medi-Cal members:

- Internal Referrals from departments including but not limited to: Appeals/Grievances, Member Services,
- Utilization Management
- Primary Care, Specialty Care, and other Providers/Practitioners
- IPA/Medical Group Care Management
- Member or caregiver self-referral
- Facility Discharge Planners
- Community Based Organizations (CBOs)
- Local Education Agencies (LEAs)
- Local Government Agencies (LGAs)

4.3 Population Health Management and Coordination of Care

4.3.1 Population Health Management Program Requirements

Blue Shield Promise demonstrates compliance with DHCS PHM program requirements through the development, implementation, and annual evaluation of a comprehensive PHM Strategy and PHM Program Description. The PHM Program is designed to ensure all members have access to wellness, prevention, care coordination, care management, transitional care, behavioral health, and social service interventions based on individual needs and preferences across the continuum of care. The program utilizes timely and accurate data, predictive analytics, risk stratification, population segmentation, gap-in-care identification, and standardized assessments to identify member needs and deliver targeted interventions that promote improved health outcomes and health equity.

The annual PHM Strategy serves as Blue Shield Promise's actionable roadmap for improving the health of its member population and communities. The strategy is informed by Population Needs Assessment (PNA) findings, including meaningful participation in Local Health Jurisdiction Community Health Assessments (CHA) and Community Health Improvement Plans (CHIP), as required by DHCS. Population-level data, health disparities, social drivers of health, community priorities, and DHCS Bold Goals are incorporated into the strategy to guide program priorities, interventions, and resource allocation. Blue Shield Promise collaborates with local health departments, community organizations, providers, and other stakeholders to ensure PHM activities align with identified population health needs and support equitable access to care and services.

Blue Shield Promise maintains an NCQA-aligned PHM framework that assesses member needs at both the individual and community level through integrated data sources, including claims, encounters, laboratory results, pharmacy data, electronic medical records, health risk assessments, demographic information, utilization patterns, and socioeconomic factors. Members are stratified and segmented using predictive modeling and risk assessment methodologies to ensure they are connected to appropriate interventions, ranging from wellness and prevention services for the general population to care management programs for members with emerging risks, multiple chronic conditions, complex care needs, behavioral health needs, and social service needs.

Program effectiveness is monitored through established goals, performance measures, outcome evaluations, and continuous quality improvement activities. Findings from annual population assessments are used to update PHM program structure, strategies, services, staffing, and resources to better meet member needs. Blue Shield Promise reports on PHM program operations, effectiveness, and outcomes through its annual NCQA PHM Program Description and evaluation processes, which assess care coordination, member engagement, health outcomes, health equity initiatives, and opportunities for improvement. This ongoing evaluation and refinement process supports compliance with DHCS PHM requirements, NCQA PHM standards, and CalAIM population health management objectives while advancing equitable health outcomes for all members.

4.3.2 Population Needs Assessment

Blue Shield Promise complies with the guidance set forth in the DHCS PNA and PHM Strategy requirements by actively participating in Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) processes conducted within its service areas and using the resulting population health findings to inform PHM strategy development, program design, and quality improvement activities. As required by DHCS guidance and APL 23-021, Blue Shield Promise collaborates with Local Health Departments (LHDs), community organizations, provider groups, and other stakeholders to identify population-level health and social needs, health disparities, gaps in services, and community priorities that impact the health of Medi-Cal members.

Since January 1, 2024, Blue Shield Promise has worked closely with the San Diego County Health and Human Services Agency, other Medi-Cal managed care plans, and community stakeholders to meaningfully contribute to San Diego County's Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) process, which serves as the Population Needs Assessment for the service area. Blue Shield Promise actively participates in collaborative meetings, planning activities, and community workgroups and provides resources to support strategies and action plans prioritized through the CHA/CHIP process. This collaboration supports the identification of community health priorities and ensures that population-level needs are incorporated into Blue Shield Promise's PHM planning and implementation activities.

Consistent with contractual requirements, Blue Shield Promise develops and submits an annual Population Health Management Strategy that demonstrates how the organization is responding to identified community needs and advancing DHCS population health priorities. The PHM Strategy is informed by findings from the Population Needs Assessment process, including CHA/CHIP priorities, population health data, identified health disparities, social drivers of health, and community stakeholder input. Information obtained through the PNA process is used to annually evaluate and update targeted member outreach and health education materials, cultural and linguistic strategies, quality improvement initiatives, wellness and prevention programs, and population health interventions to ensure services remain aligned with the evolving needs of the communities served.

Blue Shield Promise also shares CHA/CHIP findings with internal governance and advisory structures and incorporates the results into ongoing PHM oversight, program evaluation, and strategic planning efforts. Findings from the Population Needs Assessment and Community Health Improvement Planning process help guide PHM priorities related to health equity, care coordination, prevention, and community-based interventions designed to improve member outcomes across the continuum of care. The organization further uses population assessment findings to refine PHM programs, resource allocation, and targeted interventions to address identified gaps, improve access to services, and reduce disparities among the populations served.

In accordance with DHCS requirements, Blue Shield Promise makes Population Health Management publicly available and publishes information regarding its participation in the Population Needs Assessment process on its provider website. Population Health Management program information can be accessed at Blue Shield Promise Population Health Management. Community Health Assessments and Community Health Improvement Plans developed by San Diego County are publicly available through the Live Well San Diego Leadership Teams website, which serves as a key resource informing Blue Shield Promise's PNA and annual PHM Strategy development.

4.3.3 Data Integration and Exchange

Blue Shield Promise supports data integration and exchange activities necessary to identify member needs and coordinate care across the delivery system, as described in PHM-003 Risk Stratification, Segmentation and Tiering (RSST) Policy

and Procedure. Blue Shield Promise leverages DHCS Medi-Cal Connect as a foundational data source and integrates Risk Stratification, Segmentation, and Tiering (RSST) data within its Management Information System (MIS) and care management platforms to support member assessments, risk identification, care coordination, and population health interventions. The policy incorporates data from trusted partners and multiple health information sources to create a comprehensive view of member needs and characteristics, consistent with NCQA PHM standards and DHCS guidance.

Through its integrated data infrastructure, Blue Shield Promise enhances interoperability and data exchange capabilities by incorporating Medi-Cal Connect risk stratification data, predictive analytics, claims and utilization information, and care management data into workflows that support coordinated, whole-person care. The organization utilizes standardized risk stratification models and predictive tools to identify members who may benefit from wellness and prevention services, care management, transitional care services, and other PHM interventions. Integrated data is used to support care coordination across delivery systems, improve member engagement, inform assessments, and facilitate timely access to appropriate services.

In accordance with applicable federal and state requirements, Blue Shield Promise maintains processes to support reporting, data exchange, and compliance with DHCS Population Health Management requirements, NCQA standards, and interoperability expectations. The organization's data integration approach enables the secure exchange of information necessary to assess member needs, support population health management activities, facilitate care coordination, and meet regulatory reporting obligations. The PHM-003 Risk Stratification, Segmentation and Tiering (RSST) policy serves as the governing document for these activities and demonstrates Blue Shield Promise's commitment to data-driven population health management and interoperable care delivery.

4.3.4 Medi-Cal Connect (DHCS' PHM Service)

Blue Shield Promise utilizes Medi-Cal Connect Risk Stratification, Segmentation, and Tiering (RSST) functionality to identify member health risks, assess member needs, and support population health management activities. Members are stratified into standardized high, medium-rising, and low-risk tiers using DHCS-defined methodologies, which provide a foundation for identifying members who may benefit from additional screening, assessment, care coordination,

wellness and prevention services, Transitional Care Services, Enhanced Care Management, and other population health interventions. Risk stratification results are used to support a comprehensive understanding of member health needs, preferences, and service requirements and to facilitate timely and appropriate intervention.

RSST is utilized to inform and enable member screening and assessment activities, including the identification of members requiring additional evaluation and the prioritization of outreach for individuals at increased risk. High-risk members are assessed to better understand their clinical, behavioral, and social needs and to support engagement in appropriate care and support services. Risk information is incorporated into care management workflows to support individualized care planning, targeted interventions, and ongoing population health management activities.

Additionally, RSST risk tiers from Medi-Cal Connect is utilized to support member engagement and education efforts by facilitating targeted outreach, connecting members to appropriate programs and services, and enabling interventions that are aligned with individual risk levels and identified needs. This approach promotes coordinated, data-driven care and supports compliance with DHCS Population Health Management requirements.

The processes used to support Risk Stratification, Segmentation, and Tiering activities are documented in PHM-003: Risk Stratification, Segmentation and Tiering (RSST).

4.3.5 Population Risk Stratification and Segmentation, and Risk Tiering

Blue Shield Promise utilizes Risk Stratification, Segmentation, and Tiering (RSST) methodologies to identify and assess member-level risks, needs, and service requirements across the population. Through the use of Medi-Cal Connect RSST functionality, members are stratified into standardized high, medium-rising, and low-risk tiers based on comprehensive data sources and evidence-based methodologies that support identification of physical health, behavioral health, developmental, oral health, Long-Term Services and Supports (LTSS), social needs, and emerging health risks. Risk stratification activities are conducted upon enrollment, annually thereafter, upon significant changes in health status or level of care, and when new information or referrals indicate a potential change in member risk or needs. The resulting risk assessments are used to guide

member screening, needs assessments, care planning, and referral to appropriate services and interventions.

Blue Shield Promise utilizes PHM Service Risk Tier outputs and supplemental predictive analytics to connect members, including those with rising risk, to the appropriate level of service, including Basic Population Health Management, wellness and prevention programs, Transitional Care Services, Complex Care Management, Enhanced Care Management, and other care coordination programs. The organization also leverages additional data sources and predictive modeling methodologies to support a comprehensive understanding of member needs, promote meaningful member engagement, and proactively identify individuals who may benefit from targeted interventions.

Consistent with DHCS PHM guidance and NCQA Population Health Management standards, Blue Shield Promise continuously monitors and evaluates the effectiveness of its risk stratification methodologies through routine validation, performance monitoring, and ongoing review of utilization, outcomes, and member engagement data. These activities support continuous improvement, help mitigate potential bias in risk stratification processes, and ensure members are connected to services that are responsive to their evolving health and social needs. The processes governing these activities are documented in "PHM-003 Risk Stratification, Segmentation and Tiering (RSST)".

4.3.6 Screening and Assessments

Blue Shield Promise conducts timely member screening and assessment activities in accordance with DHCS guidance, NCQA Population Health Management standards, and applicable federal and state requirements. Newly enrolled members are contacted within 90 days of enrollment and are encouraged to complete a Health Information Form (HIF) to identify health and social needs. Blue Shield Promise makes a minimum of three outreach attempts using available communication methods to support completion of the screening process. Screening results are reviewed by Care Management staff and members with identified needs are referred for further assessment, care coordination, or care management interventions, as appropriate. Information obtained through screening and assessment activities may be shared with DHCS, managed care plans, or providers serving the member, upon request, to support care coordination and prevent duplication of services.

Blue Shield Promise utilizes multiple data sources, including Risk Stratification, Segmentation, and Tiering (RSST) results, claims, encounters, pharmacy information, hospital discharge data, electronic health records, referrals, and predictive analytics to identify members who may benefit from additional screening, assessment, care coordination, or case management services. Members identified through these processes receive comprehensive assessments that evaluate medical, behavioral health, social, functional, cultural, linguistic, and care coordination needs, as well as Social Determinants of Health (SDOH) and community resource needs. Assessment findings are used to develop individualized care plans and connect members to appropriate services and support.

Blue Shield Promise monitors compliance with screening and assessment requirements through ongoing oversight and reporting processes, including tracking outreach attempts, screening completion rates, assessment timeliness, member engagement, and care management referrals. Monthly, weekly, and annual monitoring activities are conducted to evaluate performance and support continuous quality improvement in screening, assessment, and care coordination processes. The processes governing these activities are documented in the following policies "PHMCM-006 New Enrollment Screening Policy", "PHM-008 Case Management and Care Coordination", and "PHM-003 Risk Stratification, Segmentation and Tiering (RSST)".

4.3.7 Care Management Programs

Blue Shield Promise maintains a comprehensive Population Health Management (PHM) delivery infrastructure designed to meet the needs of members across the continuum of care through person-centered, risk-based interventions and coordinated care management services. Blue Shield Promise provides Basic PHM services to all members and uses Risk Stratification, Segmentation, and Tiering (RSST), predictive analytics, claims data, referrals, and other clinical and social data sources to identify members who may require more intensive care management interventions. Members identified as high-risk, medium/rising-risk, or meeting Enhanced Care Management (ECM) Populations of Focus criteria are connected to the appropriate level of care management services based on the intensity of their health and social needs.

Blue Shield Promise operates both Enhanced Care Management (ECM) and Complex Care Management (CCM) programs to provide coordinated, whole-

person care for members with complex medical, behavioral health, developmental, social, and long-term services and supports (LTSS) needs. ECM provides comprehensive, community-based, interdisciplinary, and person-centered care management for the highest-risk members who meet DHCS Populations of Focus criteria, while CCM provides ongoing care coordination and care management services for high-risk and medium/rising-risk members with chronic, complex, episodic, or transitional care needs. Both programs integrate Basic PHM principles and are designed to improve health outcomes, increase functional capability, address Social Determinants of Health (SDOH), and ensure members receive services in the most appropriate setting.

Members enrolled in CCM or ECM are assigned a dedicated care manager and receive a comprehensive assessment that evaluates physical health, behavioral health, substance use disorder, developmental, oral health, LTSS, caregiver support, community resource, and SDOH needs. Assessment findings are used to develop an individualized electronic Care Management Plan (CMP) that includes member-centered goals, interventions, referrals, care coordination activities, monitoring, and follow-up. Care plans are reviewed and updated as members' needs change and are shared with treating providers, including primary care providers, to support coordinated care and prevent duplication of services. CCM is operated as an opt-out program, allowing eligible members the opportunity to participate or decline services.

Blue Shield Promise care managers are responsible for supporting members across physical health, behavioral health, community-based, and social service systems; facilitating referrals to Community Supports, Community Health Workers, LTSS providers, and other community resources; monitoring service completion; addressing care gaps; supporting treatment adherence; and ensuring members have access to medically necessary services and resources. Members under age 21 are provided care management services consistent with EPSDT requirements, and disease-specific programs, including asthma and diabetes management, are incorporated into the CCM approach as appropriate.

The processes governing care management infrastructure, care manager responsibilities, assessment and care planning activities, ECM operations, and care coordination requirements are documented in the following policies "PHM-008 Case Management and Care Coordination", "PHMSS-010 CalAIM Enhanced Care Management", "PHM-002 PHM Policy, and Promise Children's Services Program Nurse Care Coordination and Care Management Process".

4.3.8 Basic Population Health Management

Blue Shield Promise provides Basic Population Health Management (PHM) services to all members through a comprehensive, person-centered infrastructure that promotes access to primary care, preventive services, care coordination, health education, community resources, and wellness programs across the continuum of care. Members are connected to an ongoing source of care through an assigned Primary Care Provider (PCP), and care coordination processes are designed to ensure timely access to physical health, behavioral health, substance use disorder (SUD), oral health, developmental, long-term services and supports (LTSS), palliative care, and social services. Care coordination activities include referrals, navigation support, transition of care management, coordination with community resources, and communication among providers to support continuity of care and prevent duplication of services. The processes governing these activities are described in the following polices: "PHM-008 Case Management and Care Coordination", "PHM-009 Coordination of Care", and "PHM-002 PHM Policy".

Blue Shield Promise supports member access to needed services by utilizing risk stratification, care management, social services, and coordination of care processes to identify and address physical, behavioral, developmental, and social needs. Members receive assistance navigating health care delivery systems, scheduling appointments, accessing transportation resources, understanding treatment plans, and connecting to community-based programs, public benefits, Community Supports, and other social service resources that address Social Determinants of Health (SDOH). Care management and coordination processes include the development of individualized care plans, ongoing assessment of member needs, provider communication, and referrals to appropriate services and supports.

Blue Shield Promise delivers services in a culturally and linguistically competent manner and incorporates health equity principles into population health activities. Language assistance services, alternative communication formats, member education materials, and person-centered planning approaches are used to support member engagement and ensure services are responsive to diverse member needs and preferences. Care coordination processes also facilitate the sharing of information among

providers and partner organizations, while maintaining compliance with applicable privacy, confidentiality, and data-sharing requirements.

In support of wellness and prevention requirements, Blue Shield Promise maintains evidence-based wellness, prevention, and disease management programs that align with NCQA Population Health Management standards and DHCS population health objectives. As described in PHM Program Description and the Blue Shield Promise Member Handbook for San Diego County, wellness and prevention services include health risk assessments, health education resources, self-management tools, disease management programs, preventive screenings, maternal health programs, behavioral health resources, and access to digital wellness programs. These programs are designed to support members in managing chronic conditions, improving health outcomes, promoting preventive care utilization, and achieving individual wellness goals. Information from Population Needs Assessments (PNAs), Community Health Assessments (CHAs), Community Health Improvement Plans (CHIPs), and stakeholder engagement activities is used to inform the design and implementation of wellness and prevention strategies.

The policies and procedures governing Basic PHM, wellness and prevention services, care coordination, social services, and continuity of care are documented in PHM-002 PHM Policy, PHM-008 Case Management and Care Coordination, PHM-009 Coordination of Care, PHMSS-005 Social Services Department Delivery of Care, 2025 PHM Program Description, and BSP-2026 BSP-SD-EOC-508 (2).

4.3.9 Other Population Health Requirements for Children

Blue Shield Promise maintains a comprehensive children's health infrastructure to ensure members under the age of 21 receive all medically necessary preventive, diagnostic, treatment, care coordination, and case management services required under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. As outlined in Policy "PHM-007 EPSDT" and the "Children's Services Program Description", Blue Shield Promise ensures members have access to preventive screenings, developmental assessments, behavioral health services, dental, vision, hearing, specialty care, transportation, care management, and other medically necessary services to correct or ameliorate identified conditions. Blue Shield Promise coordinates care with primary care providers (PCPs), specialists, community partners, local education agencies, and

county programs to ensure services are delivered timely and in accordance with state and federal requirements.

For children and youth with special health care needs (CYSHCN), Blue Shield Promise maintains processes to identify, assess, and manage children with chronic physical, behavioral, developmental, or emotional conditions requiring services beyond those generally needed by children. Members identified with special health care needs receive comprehensive assessments, care coordination, and individualized treatment planning to facilitate timely access to pediatric specialists, subspecialists, ancillary services, transportation, durable medical equipment, and other medically necessary services. Blue Shield Promise coordinates care with California Children's Services (CCS), Regional Centers, Early Start Programs, Local Education Agencies, Women, Infants and Children (WIC), behavioral health providers, and other community-based programs to support whole-person, family-centered care and improve health outcomes for CYSHCN members. Monitoring activities include oversight of access, quality, health equity, member satisfaction, treatment plans, and care coordination processes. The processes governing these activities are documented in PHMCM-005 Children with Special Health Care Needs.

Blue Shield Promise also maintains systems to identify and refer children who may be eligible for Early Start and developmental disability services. Children with developmental delays, developmental risk factors, or conditions known to lead to developmental delays are identified through preventive screenings, assessments, provider referrals, utilization review activities, data analytics, and case management processes. Blue Shield Promise collaborates with Regional Centers and Early Start programs in determining medically necessary diagnostic, preventive, and treatment services and provides case management and care coordination to ensure children receive services identified in Individualized Family Service Plans (IFSPs), Individualized Education Plans (IEPs), and other care plans, with active participation from the member's PCP. Blue Shield Promise maintains Memorandums of Understanding (MOUs) and care coordination processes with CCS, Regional Centers, Early Start programs, Local Education Agencies, and other community partners to facilitate information sharing, referrals, continuity of care, and non-duplication of services.

4.3.10 Transitional Care Services

Blue Shield Promise maintains a comprehensive Transitional Care Services (TCS) program to support members transitioning between care settings, including hospitals, skilled nursing facilities, rehabilitation facilities, long-term care facilities, home, and community-based settings. Through risk stratification and care transition processes, members are identified as high-, medium-rising-, or low-risk and receive transitional care support appropriate to their level of need. High-risk members are assigned a dedicated care manager who serves as a single point of contact throughout the transition and is responsible for conducting outreach, coordinating services, facilitating communication among providers, completing assessments, supporting medication reconciliation, reviewing discharge plans, arranging follow-up care, and ensuring members are connected to appropriate services and supports. Members already enrolled in Complex Care Management (CCM) or Enhanced Care Management (ECM) continue to receive transition support through their assigned care manager.

Blue Shield Promise utilizes a multidisciplinary approach that includes Care Management, Utilization Management, physicians, social workers, pharmacists, behavioral health teams, discharge planners, and community partners to support safe and effective care transitions. The organization coordinates discharge planning activities, ensures timely processing of prior authorizations, facilitates referrals to ECM, CCM, Community Supports, In-Home Supportive Services (IHSS), and other Home and Community-Based Services (HCBS), and works with members, caregivers, providers, and facilities to identify the most appropriate post-discharge setting based on member needs, preferences, and goals. Members with behavioral health or substance use disorder needs receive coordinated transition support to promote continuity of care and access to treatment services.

For lower-risk members, Blue Shield Promise provides access to a dedicated Transitional Care Services team and support line to assist with discharge-related needs, appointment scheduling, referrals, transportation coordination, and connection to longer-term care management programs when appropriate. The Transitional Care Services team also conducts assessments to identify members who may benefit from ECM, CCM, Community Supports, Community Health Workers, or additional social services. Blue Shield Promise works closely with hospitals, skilled nursing facilities, discharge planners, and community partners to ensure continuity of care, prevent unnecessary delays in discharge, support

transitions to home and community settings, and verify that members safely reach their designated care setting with necessary services in place.

The processes governing discharge planning, care transitions, risk identification, care manager responsibilities, follow-up activities, medication reconciliation, community resource referrals, and transitional care oversight are documented in "PHMCM-001 Managing Care Transitions".

4.3.11 Targeted Case Management Services

Blue Shield Promise Health Plan maintains an integrated care management and coordination framework to ensure compliance with contractual requirements related to Targeted Case Management (TCM). Through established identification, referral, care coordination, and monitoring processes, the Plan identifies members who may benefit from TCM services, facilitates referrals to appropriate Local Governmental Agencies (LGAs) and community-based programs, and coordinates medically necessary services to support whole-person care. Eligible members are identified through risk stratification activities, utilization and clinical data reviews, provider referrals, community referrals, discharge planning, and member self-referrals to ensure timely access to appropriate care management services.

The Plan collaborates with LGAs and TCM providers to support continuity of care and ensure members receive coordinated, member-centered services. Through established communication channels, data-sharing processes, and designated liaison support, Blue Shield Promise exchanges information regarding member enrollment, care management assignments, and service needs to facilitate coordination across organizations. Care coordination activities include collaboration with TCM providers, primary care practitioners, specialists, behavioral health providers, and community-based organizations to address identified medical, behavioral, and social needs.

Blue Shield Promise remains responsible for coordinating medically necessary covered services identified through the member's care plan, including facilitating referrals, supporting prior authorization requirements, coordinating services delivered both within and outside the provider network, and ensuring timely access to appropriate care and resources. Care management and utilization management teams work collaboratively to monitor member needs, address barriers to care, and coordinate services across the continuum of care.

To prevent duplication of services, the Plan has implemented oversight and coordination processes that monitor member participation across TCM,

Enhanced Care Management (ECM), and other care management programs. Enrollment reviews, routine data reconciliation, communication between care managers, and coordination with LGAs are utilized to identify overlapping services and ensure members receive the most appropriate level of care management. When members are receiving services from multiple programs, care teams collaborate to clearly define roles and responsibilities, promote continuity of care, and prevent duplication of care management activities.

Blue Shield Promise designates staff responsible for TCM coordination and maintains established points of contact for collaboration with LGAs and county partners. These representatives facilitate information sharing, support communication between care teams, address operational issues, and ensure coordination activities are carried out in accordance with regulatory and contractual requirements. The Plan also supports communication with primary care providers and care managers to ensure they are informed of TCM involvement and can effectively participate in the member's care planning and service coordination activities.

For members under 21 years of age, Blue Shield Promise maintains processes to ensure timely access to medically necessary services and ongoing fulfillment of EPSDT obligations. Care coordination activities are designed to support comprehensive service delivery for children and youth, including those receiving or being considered for TCM services, while ensuring the Plan remains accountable for the provision and coordination of all medically necessary covered benefits.

Through these processes, Blue Shield Promise demonstrates compliance with contractual requirements related to TCM population identification, referral management, LGA collaboration, care coordination, prevention of duplicative services, designation of responsible coordination staff, provider communication, and oversight of services for children and youth eligible for EPSDT benefits.

4.3.12 Mental Health Services

Blue Shield Promise has adopted a "no wrong door" approach to reduce barriers and ensure timely access to mental health services for members. Consistent with this approach, the Plan does not require prior authorization for any Non-Specialty Mental Health Services (NSMHS), simplifying and expediting member access to care.

Delivery of mental health benefits between the Plan and the County Mental Health Plan is structured to ensure continuity of care while promoting

coordination and oversight. Given the bifurcation of behavioral health services between the Plan and the County, both entities have implemented standardized processes to prevent gaps in care and ensure appropriate placement within the system of care, including use of the DHCS Behavioral Health Screening Tool to guide referrals and the DHCS Transition of Care Tool to support safe, coordinated transitions. Memoranda of Understanding (MOUs) are executed between the Plan and the counties it serves, and an approved dispute resolution process is in place.

To strengthen system alignment, the local collaborative has established three workgroups: the Healthy San Diego Behavioral Health Operations Workgroup, the Healthy San Diego Behavioral Health Quality Workgroup, and the Behavioral Health Workgroup. Collectively, these workgroups enhance coordination, communication, and accountability across delivery systems.

The Behavioral Health Operations Workgroup operationalizes All Plan Letters (APLs) and Behavioral Health Information Notices (BHINs) within San Diego County, and developed MOU training materials for providers and members, translated into all county threshold languages to ensure equitable access.

The Behavioral Health Workgroup, chaired by a Behavioral Health representative from the Plan, focuses on broad community engagement including providers, members, and government stakeholders to disseminate information on operational decisions, communicate benefit changes, and increase awareness of available services, while fostering collaboration to ensure culturally appropriate and equitable behavioral health services.

The Behavioral Health Quality Workgroup, co-chaired by Blue Shield of California Promise Health Plan and the County of San Diego, aligns both entities on quality initiatives related to HEDIS, the Medi-Cal Accountability Set (MCAS), the Behavioral Health Accountability Set (BHAS), and behavioral health population health management strategies. The workgroup is currently prioritizing improved follow-up care for members presenting to the emergency department with mental health or substance use-related diagnoses, including strengthened coordination through Admission, Discharge, and Transfer (ADT) data exchange and timely access to follow-up services.

Internally, the Behavioral Health Team implements the NSMHS Member and Provider Outreach and Education Plan, encompassing stakeholder and tribal partner engagement, population needs assessments, a structured outreach and education strategy, and utilization analyses stratified by health equity factors.

The plan incorporates adherence to National CLAS Standards, stigma reduction initiatives, and multiple access points for members seeking care, and is informed by and shared with the Community Advisory Committees (CAC) and the Quality Improvement Health Equity Council (QIHEC).

4.3.13 Alcohol and Substance Use Disorder Treatment Services

Members age 11 and older receive annual alcohol and drug misuse screenings from their Primary Care Provider (PCP), with additional screenings provided when medically necessary. Members who screen positive for, or are suspected of having, alcohol use disorder (AUD) or substance use disorder (SUD) are referred to the County Drug Medi-Cal Organized Delivery System (DMC-ODS) program for further evaluation, medically necessary treatment, and medication-assisted treatment (MAT), such as buprenorphine, when appropriate. Where local treatment is unavailable, members are assisted in locating other available services, and PCPs are provided community resource and referral information, including Medi-Cal Fee-for-Service detox providers.

Alcohol and Substance Use Disorder Treatment Services are primarily administered through the County DMC-ODS carve-out. Blue Shield Promise nonetheless supports a "no wrong door" approach: members seeking these services through the Plan are assisted through established Behavioral Health screening processes, referral and linkage support to county-operated services, and transition-of-care coordination when appropriate. San Diego County provides monthly encounter-level data files for DMC-ODS services, giving the Plan visibility into county-funded SUD treatment utilization and coordination efforts.

4.3.14 California Children's Services

Coordination of care for members eligible for California Children's Services (CCS) is governed by a dedicated CCS policy that establishes clear requirements for referral, care coordination, case management, and transition planning for members under age 21 with CCS-eligible medical conditions. The policy requires that children identified with potentially eligible conditions be referred to the County CCS Program for evaluation while Blue Shield Promise remains responsible for providing all medically necessary covered services until CCS eligibility is determined. Once a member is enrolled in CCS, Blue Shield Promise must maintain coordination and exchange of clinical information

among the primary care provider, CCS specialty providers, and the County CCS Program, ensuring seamless delivery of services and joint case management. BSC policy further mandates ongoing coordination when members are found ineligible, when CCS denies a service authorization, and during transitions of care, including hospital discharges and movement between pediatric and adult systems of care. All members referred to or confirmed as CCS eligible are managed through Care Management, with Utilization Management and Case Management teams collaborating to support continuity of care and access to services.

Blue Shield Promise policy also defines extensive CCS Liaison responsibilities as a key mechanism for strengthening care coordination and resolving barriers to care. The CCS Liaison serves as a designated leader and point of contact for children and youth enrolled in CCS, supporting internal care managers, Enhanced Care Management providers, county child welfare staff, and other stakeholders. Responsibilities include resolving escalated access issues, providing technical assistance, facilitating referrals to CCS and other supportive programs, assisting with service navigation across behavioral health, Community Supports, Transitional Care Services, and other resources, and coordinating with county partners and other health plan liaisons. The CCS Liaison participates in quarterly meetings with local CCS programs, contributes to quality improvement initiatives, supports Memorandum of Understanding (MOU) requirements between the health plan and county CCS agencies, provides education and training to staff, and works to strengthen collaborative relationships that improve outcomes and continuity of care for CCS members. CCS Liaison activities were reported to BSC's QMC in Q1 of 2026

4.3.15 Services for Persons with Developmental Disabilities

Blue Shield Promise has established policies to coordinate care for members under age 21 who have developmental disabilities or who may qualify for Early Start Program services. Blue Shield Promise's Utilization Management team identifies members with developmental disabilities and refers them for comprehensive assessment and care management, while primary care providers remain responsible for delivering screening, preventive, medically necessary, and therapeutic covered services. The policy requires coordination

with Regional Centers, which provide case management and access to developmental, educational, and social services, and directs Blue Shield Promise to maintain a dedicated liaison to support members and families in accessing medical and non-specialty mental health services, resolve care concerns, and facilitate referrals for supportive services. For infants and toddlers with developmental delays, established risk conditions, or other qualifying indicators, Blue Shield Promise must identify potential Early Start candidates, refer them to local Early Start programs, collaborate with Regional Centers on diagnostic and treatment planning, and coordinate all medically covered services identified in the Individual Family Service Plan (IFSP).

Blue Shield Promise policy also defines extensive Regional Center Liaison responsibilities that support oversight and care coordination activities reported through organizational monitoring processes. The Regional Center Liaison serves as a central point of contact for members, providers, care managers, and community partners; assists with escalated access and service issues; supports referrals and navigation across Enhanced Care Management, Community Supports, Behavioral Health, Home and Community-Based Services, and other resources; and participates in quarterly meetings with Regional Centers to address care coordination, quality improvement activities, and systemic concerns. Monitoring requirements include maintaining DDS and Early Intervention/Early Start referral tracking reports, reviewing Regional Center enrollment data, documenting coordination activities through meeting minutes, and reporting trends through Utilization Management leadership and the Chief Medical Officer. These liaison coordination and monitoring activities are subject to ongoing review, with findings and program performance reported through established governance and quality oversight processes, including the Q1 2026 Quality Management Committee (QMC) meeting.

4.3.16 School-Based Services

Blue Shield Promise believes members should have access to care regardless of where they access it. In furtherance of this principle, BSP participated in the Student Behavioral Health Incentive Program (SBHIP), establishing the foundation for relationships with local schools in its service area. This work included an MOU with the San Diego County Office of Education, which served as the Third-Party Administrator for participating school districts, and laid the

groundwork for the Child and Youth Behavioral Health Initiative (CYBHI), under which the San Diego district was part of the first program cohort.

Medi-Cal managed care plans were originally directed to establish MOUs with Local Educational Agencies (LEAs) through individual school districts to support school-based behavioral health services. The program structure has since evolved to a centralized coordination model utilizing Carelon to facilitate care coordination and program administration. Under the current model, schools and LEAs contract directly with Carelon, and Carelon in turn contracts with Medi-Cal managed care plans, eliminating the operational need for individual LEA- or district-level MOUs between plans and schools. While DHCS has not yet released a finalized comprehensive MOU template for LEAs (a template is expected in 2027 per the DHCS website), Blue Shield Promise has executed an interim MOU with Carelon to support implementation and reimbursement of school-based behavioral health services under CYBHI. Plan staff have attended DHCS CYBHI meetings, participated in program launch activities, established an SFTP site for CYBHI, and are actively working with Carelon on process implementation.

Blue Shield Promise is highly supportive of school-based behavioral health services and the increased accessibility this initiative provides to school-age members through early intervention, integrated support, and expanded access to care in educational settings.

4.3.17 Dental

Primary Care Providers (PCPs) conduct primary care dental screenings and facilitate timely referrals to dental providers; dental services themselves are carved out of the Blue Shield Promise benefit agreement and delivered by contracted dental providers. PCPs inspect members' teeth and gums for signs of infection, abnormalities, malocclusion, gum inflammation, plaque, caries, or missing teeth, and instruct members with identified conditions to schedule a dental appointment. Blue Shield Promise maintains a current list of Medi-Cal dental providers and assists PCPs with the dental referral process.

As part of the Child Health and Disability Prevention (CHDP) health assessment, children not seen by a dentist within the prior six months are referred to a Medi-Cal dentist. Dental screening for adults occurs at minimum as part of periodic examinations recommended by the U.S. Preventive Services Task Force (USPSTF), in addition to other encounters. PCPs are encouraged to educate members on

the importance of dental care, make corrective and preventive referrals, and document all screenings and referrals in the member's medical record.

4.3.18 Direct Observed Therapy for Treatment of Tuberculosis

Blue Shield Promise meets the tuberculosis (TB) Directly Observed Therapy (DOT) requirement through a structured care management process that identifies members at risk for treatment resistance or noncompliance, conducts outreach and assessment, and coordinates referrals to the Local Health Department (LHD) when appropriate. The Care Management Clinical Process directs care managers to receive and review active TB referrals, assess adherence to treatment protocols, and evaluate members for risk factors including multidrug resistance, treatment failure or relapse, substance use disorders, mental health conditions, age-related vulnerabilities, unmet housing needs, language or cultural barriers, and histories of missed appointments. Members with compliance or resistance concerns are presented to the Interdisciplinary Care Team (ICT), where the Medical Director determines whether referral to the LHD for DOT is warranted. The process also includes member outreach, assessment of care coordination needs, enrollment into care management when appropriate, and ongoing monitoring until TB is no longer active or care management services are no longer needed.

Blue Shield Promise further operationalizes these requirements by requiring primary care physicians to screen for TB, identify active cases, notify the LHD, assess the need for DOT, and refer active or at-risk members to the LHD TB Control Officer for DOT. BSC policy identifies high-risk populations consistent with DHCS requirements and instructs Case Management to use pharmacy claims monitoring, identify members with adherence barriers or social determinants of health concerns, conduct outreach, and escalate cases through the ICT and Medical Director review process. Once a member is referred for DOT, BSC/PHP coordinates care with the PCP and LHD and ensures all medically necessary covered services continue during treatment. BSC's out-of-plan care management model, maintains procedures for joint case management, coordination of care, and Memoranda of Understanding (MOUs) with Local Health Departments for TB DOT services, ensuring timely referrals, collaborative

care planning, and continued access to medically necessary services for pediatric and adult members receiving TB-related services.

4.3.19 Women, Infants, and Children Supplemental Nutrition Program

Blue Shield Promise meets the Women, Infants, and Children (WIC) Supplemental Nutrition Program requirement through established referral, documentation, and care coordination processes that identify and connect eligible members with WIC services. Blue Shield Promise requires that pregnant, breastfeeding, and postpartum members, as well as parents or guardians of children under age five, be identified and referred to the local WIC agency when nutritional risk is identified. When assistance with referral is needed, the Population Health Management (PHM), Maternity Care Management, Children's Services, and Social Services teams coordinate the referral by forwarding all required information to the WIC agency, including member demographics, nutritional assessments, and current hemoglobin or hematocrit laboratory values. Staff are also required to document both the laboratory values and the referral in the member's medical record, notify the member of the referral using a patient-centered approach, and complete follow-up with the WIC agency to confirm eligibility determination and ongoing coordination of care. These processes are supported through formal WIC Memoranda of Understanding (MOUs) that establish referral pathways and collaborative care coordination with local WIC agencies.

Blue Shield Promise further supports compliance through its comprehensive birthing population care management program. The program is designed to identify pregnant and postpartum members early through multiple referral and data sources and provide person-centered care coordination throughout pregnancy and the 12-month postpartum period. Care managers coordinate services with community-based resources, including the Women, Infants, and Children (WIC) program, and conduct comprehensive assessments that evaluate medical, behavioral, and social needs. During these assessments, members experiencing food insecurity or nutritional concerns are referred to the WIC program and other supportive resources as appropriate. Through ongoing outreach, individualized care planning, coordination with providers and community organizations, and monitoring of member needs, BSC/PHP ensures

eligible members are connected to nutritional support services and receive coordinated care consistent with WIC referral requirements.

4.3.20 Home and Community-Based Services Programs

The Plan's Home and Community-Based Services (HCBS) program, administered by PHM Social Services, supports social work case management and safeguards member confidentiality and personal health information in connection with HCBS service delivery.

Blue Shield Promise complies with Home and Community-Based Services (HCBS) requirements through a structured PHM Social Services program that identifies members who may benefit from HCBS and coordinates referrals to the appropriate administering agencies and waiver programs. The HCBS policy establishes processes to assess members' functional, medical, and social needs, refer eligible members to programs such as the Home and Community-Based Alternatives (HCBA) Waiver, Assisted Living Waiver (ALW), Developmental Disabilities (DD) Waiver, HIV/AIDS Waiver, Multipurpose Senior Services Program (MSSP), and other long-term services and supports, while ensuring members remain enrolled with BSC/PHP and continue receiving all covered Medi-Cal benefits and services. The policy also requires ongoing collaboration and information exchange with third-party entities, including DHCS, Regional Centers, waiver agencies, and MSSP providers, supported by Memoranda of Understanding (MOUs) and dedicated staff who serve as points of contact for access, care coordination, and service integration. BSC/PHP further tracks members enrolled in HCBS programs, provides care coordination for medically necessary non-waiver services, and uses Community Supports services to bridge gaps and support members in remaining safely in community settings of their choice.

Blue Shield Promise's policy further supports compliance by outlining a comprehensive social work case management model that assesses psychosocial barriers, develops individualized care plans, and coordinates linkages to community-based resources and long-term services and supports such as IHSS, CBAS, MSSP, Community Supports, housing resources, transportation assistance, and caregiver services. Social Services staff conduct assessments, obtain member consent for referrals, facilitate warm handoffs to

community agencies, maintain ongoing communication with external providers and agencies, and collaborate with designated MOU liaisons, including LTSS, Regional Center, and IHSS liaisons, to resolve access and coordination issues. BSC policy also establishes strict confidentiality standards requiring all personal health information (PHI) to be protected and shared only as necessary for care coordination and continuity of care in accordance with applicable privacy requirements. Through ongoing care coordination, interdisciplinary collaboration, referral tracking, and secure exchange of member information, BSC/PHP ensures continuity of services and coordinated delivery of HCBS and related supportive services.

4.3.21 In-Home Supportive Services

Blue Shield Promise complies with the In-Home Supportive Services (IHSS) requirements through its established Home and Community-Based Services (HCBS) program, which includes formal processes for identifying, referring, tracking, and coordinating services for members who may be eligible for or are receiving IHSS. The policy requires BSC/PHP to maintain Memoranda of Understanding (MOUs) with county IHSS agencies that define each party's responsibilities and support coordinated service delivery. When members are identified as eligible for IHSS, BSC/PHP coordinates with county IHSS agencies to prevent duplication of services across IHSS, Enhanced Care Management (ECM), Community Supports, and other programs. The policy further requires the plan to track all members receiving IHSS, continue coordinating with county agencies until IHSS services are no longer needed, conduct outreach whenever DHCS identifies a member as receiving IHSS, reassess the member's risk tier when members are receiving, referred to, or approved for IHSS, and continue providing basic Population Health Management (PHM) and care coordination for all medically necessary services while the member receives IHSS.

Blue Shield Promise coordination model also incorporates Community Supports services to ensure members continue receiving needed assistance while avoiding service overlap. The HCBS policy specifies that Community Supports personal care and homemaker services may only be provided in defined circumstances, such as when approved IHSS hours are exhausted, during an IHSS application waiting period after referral, or when a member is not eligible

for IHSS and requires short-term support to prevent institutional placement. Through these controls, Blue Shield Promise ensures that Community Supports and IHSS services are coordinated rather than duplicated. In addition, the policy establishes ongoing collaboration with county IHSS agencies, continuous tracking of IHSS enrollment, referral follow-up, and care coordination activities that support members' ability to remain safely in their homes and community settings while continuing to receive all medically necessary covered services. IHSS Liaison activities were most recently reported to the QMC in Q2 2026.

4.3.22 Indian Health Care Providers

Blue Shield Promise maintains a dedicated Tribal Liaison for each Indian Health Care Provider (IHCP) in its service area, responsible for coordinating referrals and ensuring appropriate payment for services provided to eligible Indian Members, consistent with Exhibit A, Attachment III, Subsection 3.3.7. The May 2026 Tribal Liaison report highlights ongoing efforts to improve claim resolution, coordination, and compliance for IHCPs. The Tribal Liaison works closely with internal teams and claims experts to resolve contracted and non-contracted claim issues, shares insights to prevent recurring problems, and supports process improvements such as member assignment and care coordination. These combined efforts strengthen collaboration, improve service delivery, and enhance outcomes for IHCP partners and the members they serve.

4.3.23 Justice Involved Reentry Coordination

Blue Shield Promise complies with Justice-Involved Reentry Coordination requirements through a structured Enhanced Care Management (ECM) program that supports members transitioning from correctional facilities to the community. Blue Shield Promise maintains a designated Justice-Involved (JI) Liaison who serves as the primary point of contact for correctional facilities, pre-release care managers, and ECM providers, supports ECM provider assignment, provides information regarding Community Supports, transportation services, and plan benefits, and facilitates coordination throughout the reentry process.

The policy establishes processes for assigning ECM providers to serve as pre-release and/or post-release care managers, ensuring continuity through warm handoffs, sharing reentry care plans and member information, and coordinating transitions from incarceration to community-based care. Blue Shield Promise also

ensures members have access to medically necessary services upon release, including ECM, behavioral health services, Community Supports, Non-Emergency Medical Transportation (NEMT), and other care coordination services, while supporting referrals, appointment scheduling, transportation arrangements, and ongoing follow-up to promote successful community reintegration and continuity of care. Justice Involved (JI) Liaison activities were reported to the QMC in Q2 2026.

4.3.24 Managed Care Liaisons

Blue Shield Promise provides quarterly oversight reporting to the Quality Management Committee (QMC), including a comprehensive review of activities related to all Managed Care Liaison functions. These updates encompass coordination efforts, program performance, operational issues, and regulatory compliance activities associated with Regional Center (RC), Targeted Case Management (TCM), California Children's Services (CCS), In-Home Supportive Services (IHSS), Tribal, and Justice Involved liaison programs.

Through these quarterly QMC presentations, BSC maintains executive-level oversight of liaison activities, monitors interagency collaboration and care coordination outcomes, and ensures ongoing compliance with DHCS requirements related to designated Managed Care Liaisons and associated Memoranda of Understanding (MOUs).

Conclusion

Blue Shield of Promise Health Plan's PHM framework provides a comprehensive, integrated approach to meeting the requirements outlined in DHCS Boilerplate Contract Exhibit A, Attachment III, Section 4.3. Through established processes for population identification, risk stratification and segmentation, care management, coordination of care, Enhanced Care Management (ECM), Targeted Case Management (TCM) collaboration, community resource integration, and ongoing monitoring, the Plan systematically identifies member needs and connects members to the appropriate level of intervention and support.

The PHM program leverages a wide range of clinical, claims, encounter, utilization, screening, referral, and social risk information to identify members who may benefit from additional support and to ensure that services are

tailored to each member's medical, behavioral, functional, and social needs. Through multidisciplinary care coordination processes, Blue Shield Promise facilitates communication among providers, care managers, community-based organizations, and local governmental partners to promote timely access to medically necessary services, continuity of care, and improved health outcomes.

The Plan's documented policies and operational workflows support the coordination of services across the continuum of care, including transitions of care, complex care management, ECM, TCM, EPSDT, behavioral health services, long-term services and supports, and community-based resources. These processes are designed to ensure members receive person-centered, coordinated care while minimizing fragmentation, preventing duplication of services, and addressing both clinical and non-clinical factors that influence health and well-being.

In addition, Blue Shield Promise maintains oversight, monitoring, quality assurance, and performance improvement activities to evaluate program effectiveness, identify opportunities for improvement, and ensure ongoing compliance with state and federal requirements. Routine monitoring, case reviews, data analysis, interdepartmental collaboration, provider engagement, and regulatory reporting support continuous improvement and accountability across all PHM functions.

Collectively, the Plan's PHM infrastructure, policies, procedures, and operational practices demonstrate a mature and integrated population health management program that supports whole-person care and fulfills the intent and requirements of DHCS Exhibit A, Attachment III, Section 4.3. Through coordinated, data-driven, and member-centered processes, Blue Shield Promise ensures that members are identified, assessed, connected to appropriate services, and supported through ongoing care management and care coordination activities designed to improve health outcomes, reduce barriers to care, and promote equitable access to services.

References

10.02.01 PHP UM PP Directly Observed Therapy for Treatment of Tuberculosis
2024 PHP Children's Services Program Description
2025 DHCS PHM Strategy Deliverable (SD County)
2025 PHM Program Description
2026 BSP-SD-EOC-508 Blue Shield Promise Member Handbook
2026 PHP Social Services Program Description
2026 Q1 QMC Meeting Minutes (Regional Center Liaison Activities)
2026 Q1 QMC Meeting Notes
Blue Shield Promise Provider Manual – Provider Manual Dental
Blue Shield Promise Provider Manual – Provider Manual Mental Health
Care Management Clinical Process (2172)
Medi-Cal PHM TCM Workflow
PHM-002 PHM Policy (MPS)
PHM-003 Risk Stratification, Segmentation and Tiering (RSST)
PHM-007 EPSDT
PHM-008 Case Management and Care Coordination
PHM-009 Coordination of Care
PHM-011 WIC (Blue Shield Promise-to-WIC Agency Referrals, b.)
PHMCM-001 Managing Care Transitions
PHMCM-002 Complex Case Management Process
PHMCM-005 Children with Special Health Care Needs
PHMCM-006 New Enrollment Screening Policy
PHMCM-007 California Children's Services (CCS)
PHMCM-008 Early Start Program and Developmental Disability Services (OLS)
PHMCM-010 Care Management for the Birthing Population
PHMSS-001 Voluntary Inpatient Detoxification
PHMSS-003 HCBS
PHMSS-004 CalAIM Community Supports Services
PHMSS-005 Social Services Department Delivery of Care
PHMSS-010 CalAIM Enhanced Care Management
PHMSS-016 CalAIM ECM Justice Involved (JI) Initiative P&P
PHP BH BHT Program 10.26.01
Promise Children's Services Program Nurse Care Coordination and Care
Management Process
Q2 2026 QMC Binder
Referral to NSMHS and Referral to SMHS
TCM Joint Policies and Procedures – San Diego (draft, 4/30/2026)
Tribal Liaison QMC Slide