3840 Kilroy Airport Way
Long Beach, CA 90806

October 17, 2025

Subject: **Notification of January 2026 updates to the *Blue Shield Promise Health Plan Medi-Cal Provider Manual***

Dear Provider:

Blue Shield Promise is revising the *Blue Shield Promise Health Plan Medi-Cal Provider Manual* (Manual). The changes in each provider manual section listed below are effective January 1, 2026.

On that date, you can search and download the revised manual on the Blue Shield Promise Provider website at www.blueshieldca.com/en/bsp/providers, in the *Provider manuals* section under *policies & guidelines*.

You may also request a PDF version of the revised *Blue Shield Promise Health Plan Medi-Cal Provider Manual* be emailed to you, once it is published, by emailing providermanuals@blueshieldca.com.

The *Blue Shield Promise Health Plan Medi-Cal Provider Manual* is included by reference in the agreement between Blue Shield of California Promise Health Plan (Blue Shield Promise) and those Medi-Cal providers contracted with Blue Shield Promise. If a conflict arises between the *Blue Shield Promise Health Plan Medi-Cal Provider Manual* and the agreement held by the provider and Blue Shield Promise, the agreement prevails.

If you have any questions regarding this notice or about the revisions that will be published in the January 2026 version of this Manual, please contact Blue Shield Promise Provider Customer Services at (800) 468-9935 [TTY 711] 6 a.m. to 6:30 p.m., Monday through Friday.

Sincerely,

Kimberli Robinson
Vice President, Network Operations

Section 3: Benefit Plans and Programs

3.2: Basic Population Health Management (BPHM)

3.2.8: Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) / Medi-Cal for Kids & Teens / PHM for Children

Added, in accordance with an upcoming APL for Private Duty Nursing (PDN), the following bullet point in list of services that providers ensure are provided to all members under age 21:

- Care Management services for children receiving Private Duty Nursing (PDN) services.

3.3: Managed Long-Term Services and Supports (MLTSS)

3.3.2: Long-Term Care (LTC)

3.3.2.6: Skilled Nursing Facility Workforce and Quality Incentive Program (SNF WQIP)

Updated the date of service year, from 2026 to 2025, for which (SNF WQIP) payments are made, in accordance with APL 25-002.

3.6: Enhanced Care Management

Updated, in boldface and strike-through type and according to DHCS's most recent policy guide list of ECM Populations of Focus, the following bullet point "populations of focus":

January 2022

- Individuals Transitioning from Incarceration (~~(post release services for~~ some Whole-Person Care (WPC) counties~~)~~)
- ~~Adults with Intellectual or Developmental Disabilities (I/DD)~~[1]
- ~~Pregnant or Postpartum Adults~~[2]

July 2023

- Adults without Dependent Children/Youth Living with Them Experiencing Homelessness
- Children and Youth Populations of Focus:
  - Children and Youth Involved in Child Welfare ~~of Children and Youth with I/DD~~
    ~~Pregnant or Postpartum Youth~~

January 2024

- ~~Pregnant and Postpartum Individuals (Adults & Youth) At Risk for Adverse Perinatal Outcomes~~**Birth Equity Population of Focus**

3.8: Doula Services

Added the following paragraph explaining the doula recommendation requirement:

Doula services are considered a preventive benefit and require a written recommendation from a physician and or other licensed practitioner of the healing arts. To increase access to services, DHCS Medical Director, Karen Mark, MD, issued a standing recommendation for the initial set of doula services for any Medi-Cal member who is pregnant or was pregnant within the past year.

Updated, in boldface and strike-through type, the following paragraph explaining the number of visits allowed for members:

All visits are limited to one per day, per member. ~~Only one doula can bill for a visit provided to the same member on the same day, excluding labor and delivery.~~ **More than one doula may provide services during a member's pregnancy and postpartum period. However, the total number of visits that a member may receive are per pregnancy and not per doula.**

Added the following language explaining place of service restrictions for doula services:

Doula services can be provided virtually or in person with locations in any setting including, but not limited to

- Homes
    - a doula may assist with home births provided by a licensed provider.
- office visits
- hospitals or
- alternative birth centers

Doula services provided virtually must be billed consistently with DHCS telehealth policy as outlined in the Medicine:Telehealth section of the Medi-Cal Provider Manual. This includes billing with modifier 93 for synchronous audio-only or modifier 95 for synchronous video.

- Services rendered via text, email, chat, or modalities other than audio-visual or audio-only are not reimbursable.
- All doula services provided via telehealth must meet federal requirements for privacy, including the Health Insurance Portability and Accountability Act.

Updated, in boldface and strike-through type, the following language explaining how doulas use the Doula Transaction Log to collect and record transaction information:

Blue Shield Promise will only accept Doula Transaction Logs from individual doulas and doula groups and who have an active **Single Case Letter of A~~a~~greement (LOA)** with the plan.

If you are an individual doula and do not have an active **LOA** agreement with Blue Shield Promise, but your group does, we cannot accept Doula Transaction Log from you directly. Please submit a transaction log through your doula group.

Added the following language explaining the plan's responsibility to periodically monitor doula documentation:

Blue Shield Promise will periodically monitor and audit doula documentation regarding the dates, times, and duration of services provided to members.

Section 7: Utilization Management

7.1: Utilization Management Program

7.1.3: Organization of Health Care Delivery Services

Added language discussing the process for handling non-emergent care.

Removed language referring to Appendix 14 and Stance Health Solutions (formerly Western Drug Medical Supply), as Stance's services are no longer used and Appendix 14, which contains information about Stance, was removed from this provider manual.

7.2: Complex Case Management Program

7.2.1: The Role of the Case Manager

Updated, in boldface type, the following sentence explaining the Case Manager's responsibility to develop a plan of care:

Once accepted into the Case Management Program **and member consent is obtained**, the Case Manager will develop a plan of care…

Added, in accordance with Cal. Code Regs. Tit. 22, § 53891 - specified in section 53889(j)(2)(I), several bullet points explaining plan or member requests for disenrollment from case management services due to irreconcilable breakdown in relationship, or for any other "good cause" reasons.

7.3 Transitional Care Services (TCS)

7.3.3 Oversight and Monitoring

Updated, in boldface type, the following sentence about providing TCS services:

Blue Shield Promise is accountable for providing all **known and identified** TCS **services** in collaboration and partnership with discharging facilities, including ensuring hospitals provide discharge planning as required by federal and state requirements.

7.4: Primary Care Physician Scope of Care

7.4.3: Child Health and Disability Prevention Program (CHDP)

Updated language discussing providers' responsibilities to provide an Initial Health Appointment (IHA) for all members under the age of 21, which consists of a comprehensive health history and physical examination.

7.6: Emergency Services and Admission Review

7.6.1: Emergency Services

Deleted and replaced, in accordance with AB 1316, the paragraph defining an emergency psychiatric condition.

7.9: Carve-Out Benefits, Public Health, Linked Services, and Special Benefit Information

7.9.1: California Children's Services (CCS)

7.9.1.4 CCS Care Management

Updated, in boldface and strike-through type, the following sentence explaining the responsibility for CCS case management:

~~The~~ Blue Shield Promise ~~CCS Program~~ will be responsible for **needed** case management of all identified CCS-eligible members and authorized medically necessary care. When a member meets criteria for the CCS Program, the member/member's family or designee is contacted telephonically **or via mail** by a Blue Shield Promise employee to discuss their condition and enroll them in the ~~CCS~~ **Children's** Care Management Program. The CCS Program will be responsible for case management of all identified CCS-eligible members and authorizes medically necessary care.

7.9.1.5 CCS Age Out and Transition of Care Coordination Program

Updated, in boldface and strike-through type, the following paragraph discussing the program that assists CCS-eligible members nearing the age of 21 or who are transitioning out of CCS:

~~CCS~~ **Blue Shield Promise** Case Managers are available to assist the family in identifying appropriate options available to the member, such as specialty services, specialty hospitals, medications, durable medical equipment, etc. For unmet social needs, members/member's families may be referred to a PHP Social Worker for assistance. ~~60 days prior to the member's 21st birthday, members/member's families or their designee will receive a call from the Blue Shield Promise Case Manager to ensure the care planning is in process or completed.~~ If ~~the~~ assistance is needed, the Blue Shield Promise Case Manager will assist in locating an appropriate specialist as well as addressing any other needs.

7.9.2: Regional Centers

7.9.2.1: EIES DDS Provider Training

Added new sub-section, discussing the Regional Center program eligibility requirements, identification of potentially eligible children and how to refer to the Regional Center.

7.9.2.2: Provider Communications

Added new sub-section, discussing the responsibility to ensure that the provider network is aware of members eligible for or receiving services through the DDS program.

7.9.2.3: EIES DDS Care Management

Added new sub-section, discussing the responsibility to offer care coordination/care management for all identified EIES DDS eligible members.

7.9.4: Comprehensive Perinatal Services Program (CPSP)

Updated numerous cells in the chart with the recommended intervals for routine tests for individual patients during pregnancy.

7.9.14: Tuberculosis

Updated, in boldface type, the following paragraph discussing providers' responsibility, in accordance with AB 2133, to provide Tuberculosis (TB) screening:

Primary Care Physicians **(PCPs)** are responsible for screening for TB, identifying active cases, notifying the Local Health Department (LHD), assessing the need for Directly Observed Therapy (DOT), and referring cases for DOT to the LHD TB Control Officer. **Assembly Bill (AB) 2132, effective January 1, 2025, requires all PCPs to evaluate adult patients for TB and offer a TB screening test if risk factors are identified.**

All K-12 students entering a new school district in Los Angeles County must be screened and cleared for TB.

7.9.24: Community Supports

Updated, in accordance with CalAIM (Medi-Cal Transformation) – Transitional Rent, numerous bullet points in list of Community Supports offered to eligible Medi-Cal members in Los Angeles and San Diego Counties.

Added, in accordance with CalAIM (Medi-Cal Transformation) – Transitional Rent, a chart with DHCS Community Support HCPCS codes.

7.10: Delegated UM Reporting Requirements (IPA/Medical Groups Only)

Removed the "Maternity/Deliveries Admission (MDAR) Report – Maternity and Delivery cases" from the list of reports due.

Section 9: Quality Improvement

9.1: Quality Improvement Program

Added the following paragraph discussing the plan's accreditation:

Accreditation

Blue Shield Promise has received The National Committee for Quality Assurance (NCQA) Health Plan and Health Equity accreditation. The NCQA accreditation survey evaluates a health plan's organizational structure, operational processes, clinical quality, and patient satisfaction every three years.

9.1.3: Quality Improvement Process

Updated bullet points with information about the new Potential Quality Issue (PQI) Referral Form, used by providers to report Potential Quality Issues.

Updated, in boldface type, the following language explaining providers' responsibility to participate in quality studies:

...All network providers are required to participate in the quality studies process. This includes providing medical records upon request and at no cost to Blue Shield Promise (including network providers using an outside medical record vendor), **within 2 weeks of the request** in the requested time frames for the purposes of performance reporting and audits for the Healthcare Effectiveness Data and Information Set (HEDIS), Managed Care Accountability Set (MCAS), **Potential Quality Issues (PQI)**, and DHCS' validation of Encounter Data.

9.5: Initial Health Appointment (IHA)

Updated, in boldface type, the following bullet points and numbers in a list of documentation items that an IHA should include:

2. **Identification of Risks**
3. Social History
    - **Housing instability**
5. **Health Education**

Added "Adverse Childhood Experiences Screening (ACEs)" as a bullet point in list of items that Health Assessments for members under 21 years of age must include, in accordance with the AAP/Bright Futures Periodicity Schedule.

Added the following bullet points to list of items that the IHA Health Appointments for Asymptomatic members 21 years of age and older must include, at a minimum:

- Depression and suicide risk screening for older adults (65 years and older).
- Screening for anxiety for adults 64 years and younger, including pregnant and postpartum women.
- Adverse Childhood Experiences Screening (ACEs).
- Annual cognitive health assessment using at least one cognitive assessment tool for adults 65 years and older.

9.13: Credentialing Program

Updated, in accordance with APL 24-011, the following paragraph discussing providers' minimum credentialing requirements, in boldface type:

Purpose

To ensure that all network practitioners/providers meet the minimum credentials requirements set forth by Blue Shield Promise and the regulatory agencies including, but not limited to, the NCQA, DHCS, DMHC, CMS, L.A. Care, other regulatory agencies and credentialing mental health parity regulations for participation in the network. At least every three (3) years, the practitioners/providers are required to undergo recredentialing to ensure that they are in compliance with these standards, **except for Intermediate Care Facility/Developmentally Disabled (ICF/DD) facilities, which require recredentialing every two (2) years.**

9.13.1: Credentials Process for Directly Contracted Physicians

Updated, in boldface type, the following sentence explaining the credentialing standards for providers:

Blue Shield Promise has adopted **use of either** the California Participating Physician Application (CPPA) ~~and~~ **or** the Council for Affordable Quality Healthcare (CAQH) applications.

Updated paragraph discussing the plan's methods and timelines for handling a Behavior Health/Mental Health/Substance Abuse practitioners'/providers' application.

9.13.2: Minimum Credentials Criteria

Updated, in strike-through and boldface type, the following paragraph explaining the process when providers fail to return their recredentialing applications:

A final follow-up **email notification** will be sent to practitioners/providers who have not returned their applications ~~after 90 days~~ from the initial mailing. **The Provider Information and Enrollment department and the** Contracting Department will be notified of the practitioners/providers who are non-responsive to the recredentialing requests and will follow their procedures for appropriate action, including administrative termination for non-compliance.

Updated, in strike-through and boldface type, the following paragraph informing about verifying credentialing primary sources:

The primary source verifications must be completed within 120 calendar days, **along with current and signed attestation confirming the correctness and completeness of the provider's application.** ~~and the provider's attestation must be signed and dated within 180 calendar days prior to the Credentialing Committee decision.~~

Deleted and replaced the following bullet point in list of methods to monitor the practitioner for license, DEA, and malpractice insurance expiration dates:

- DEA renewals are verified from the U.S. Drug Enforcement Administration or by an updated copy from the provider. In-scope practitioners who are required to have a DEA license but do not currently prescribe must submit documentation stating that they do not prescribe and provide the name of a covering physician who can prescribe on their behalf. If the practitioner states in writing they do not prescribe controlled substances and that, in their professional judgment, their patients do not require controlled substances, they are not required to have a DEA certificate. However, they must describe their process for handling instances when a patient requires a controlled substance.

Deleted and replaced the following item describing the ICF/DD recredentialing process:

C. Recredentialing is to occur every two (2) years through re-submission of an ICF/DD Attestation. If an ICF/DD facility has a change to any requirement attested to between the recredentialing years, an ICF/DD facility must report that change to their MCPs along with any required documentation, within 90-days of when the change occurred.

Added, in accordance with an LA Care Mandate, an outline itemizing the Federally Qualified Health Clinic (FQHC) credentialing requirements.

9.13.3: Specialty Credentialing Specifications

Updated, in strike-through and boldface type, the following sentence explaining supervision of a Non-Physician Medical Practitioners (NPMP):

NPMP requiring supervision must have a supervising practitioner agreement, **also known**~~s~~ **as a Collaboration Agreement**, completed, and signed by both the NPMP and ~~e~~the contracted supervising physician.

Updated, in accordance with Assembly Bill 890 (AB 890), the following language clarifying nurse practitioners' ability to practice:

Nurse Practitioners (NP)

Assembly Bill 890 (AB 890) grants nurse practitioners **the ability to** ~~full~~ practice **independently**, ~~authority~~ allowing them to work without physician supervision. To practice in an integrated setting, **103** NPs must hold national certification and carry liability insurance. If an NP is interested in solo practice, completion of a three (3) year transition to practice will be required ~~as well~~.

AB 890 allows **103** NPs to practice to the full extent of their education and training and allows direct access to health care for millions of Californians who now have coverage but often struggle to find healthcare providers…

9.13.4: Credentials Process for IPA/Medical Groups

Added the following bullet point in list of items an IPA/medical group must collect and review when it identifies occurrences of poor quality:

- Updating provider licenses upon expiration

Updated, in boldface type, the following outline number in list of items that a delegation agreement must have:

17. The delegation agreement must include the following:
    b. Describes the delegated activities and the responsibilities of the Delegate and the Sub-delegated entity. **Agreements implemented on or after 7/1/25 must include Credentialing Information Integrity requirements, including Staff Training.**
    - The Agreement should include the annual review of the delegate's policies and procedures and review of files, as applicable, and Credentialing Information Integrity (CII) annual audit**, annual training** and monitoring processes.

9.14: Quality Improvement and Health Equity Transformation Program

9.14.7: Network Provider Training

Updated, in accordance with APL 24-016, language describing the requirement for providers to complete Network Provider Training.

Added, in accordance with APL 24-016, the following sentence explaining the requirement to monitor discrimination grievances:

The APL 24-016 also requires that Blue Shield Promise monitor grievances related to discrimination, enforcing corrective action for individuals with a grievance concerning discrimination filed against them.

Section 12: Provider Services

12.11: Provider Directory

Updated subsection with information about provider types included in the Provider Directory.

Section 14: Claims

14.2: Claims Processing Overview

Updated items D and E in the outline which explains the claims and interest process.

Section 15: Financial

15.3: Medical Loss Ratio Requirements for Subcontractors and Downstream Contractors

Updated, in boldface type, the following paragraph explaining payments and Medical Loss Ratio (MLR) reporting:

Commencing with the CY 2023 MLR Reporting year, and until modified by DHCS, applicable Subcontractors that receive $30,000,000 or more in Medi-Cal capitation annually, from **a single upstream entity, as** payment for services **provided** in a single county or rating region, for which they assume risk and are not directly providing will be subject to MLR Reporting, **remittance**, attestation and additional supporting documentation requirements.

Section 17: Culturally and Linguistically Appropriate Services (CLAS)

17.2: Identification of Members with Limited English Proficiency (LEP)

Added, in accordance with APL 25-005, added Russian as a threshold language.

17.3: Access to Free Interpretation Services

Added, in accordance with APL 25-005, language explaining the requirements and standards for using and providing a video remote interpreting (VRI) service.

17.4: Cultural Competency and Health Equity Training

Updated, in accordance with APL 24-016, language describing the requirement for providers to complete Cultural Competency and Health Equity Training. This language also explains the plan's responsibility to enforce and monitor corrective action plans for discrimination-based grievances.

Added, in accordance with APL 24-017, language describing the requirement to complete evidence-based cultural competency training about providing trans-inclusive health care.

17.7: Referrals to Culturally Appropriate Community Resources and Services

Updated, in accordance with internal process updates, language explaining providers' responsibility to refer and monitor members for culturally appropriate services and resources.

Appendices

Appendix 2: Delegation of Credentialing Responsibilities

Updated a chart for credentialing responsibilities, such as credentialing activity, IPA/medical group duties, plan responsibilities, performance evaluation and corrective action plans.

Appendix 8: Delegation Requirements for Claims and Newly Contracted Provider Training

Audits and Audit Preparation

Regulatory Audit

Updated, in boldface type, the following sentence about late document submissions:

Refusal to do so **and/or late submission** of documents will result in an escalation to Blue Shield Promise Contracting/Network Management.

Updated, in accordance with APL 25-007/AB3275, the following paragraph discussing the process when claims are not reimbursed, in strike-through and boldface type:

Paid and Denied Claims Timeliness: Verify that all claims are finalized within 30 calendar days at 90% and 99% at 90 calendar days (Title 19 Social Security Act 1902 (37~~)) and within 45 working days (CCR, Title 28, Section 1371.35 (a))~~ from the date of receipt of claim.

Beginning January 1, 2026, per APL 25-007/AB3275, if a complete claim is not reimbursed within 30 calendar days after receipt, interest accrues at a rate of 15 percent per year beginning with the first calendar day after the 30-calendar-day period. Additionally, Delegated Entities must continue to automatically include all accrued interest when making payment on a claim beyond the 30-calendar day requirement.

Claim processing begins when a claim is first delivered to the delegated payor's office. The number of days measured are ~~both~~ calendar ~~and working~~ days.

Payment Accuracy

Updated, in boldface type, the following number in list of items that payment accuracy includes:

(3) applying appropriate contract rates fee schedules **(including TRI Rate for Network/Contracted Providers)** as demonstrated by submitted documentation or shared via audit webinar

Updated, in accordance with APL 25-007/AB3275, paragraphs which explained the process for interest charging, interest accrual and penalties.

Updated, in accordance with APL 25-007/AB3275, paragraphs which explained the definition and process for contested claims.

Updated, in strike-through and boldface type, the following language about claim denial:

A Delegated Entity/Specialty Health Plan may deny a claim or portion thereof, by notifying the provider, in writing, that the claim is denied within ~~forty-five (45) working~~ **thirty (30) calendar** days after the date of receipt.

Added the following bullet point to list of information that Delegated Entities need to include in their EOP/RA:

- Delegated Entities need to include if the payment was for TRI Rate by using DHCS CARC

172.

Added, in accordance with APL 25-007/AB3275, the following letter to list of items that a provider dispute must include:

g. January 1, 2026, consistent with APL 25-007/AB 3275, interest and penalty, if applicable, are due on all claim payments that are not reimbursed within 30 calendar days after the date of receipt of a complete claim, including payments resulting from provider disputes.

Deleted and replaced the following letter explaining the process for clean claims:

a. 90% of all clean claims from practitioners, who are individual or group practice or who practice in shared health facilities, within 30 calendar days of the date of receipt and 99% of all clean claims from practitioners within 90 calendar days from the date of receipt. (Title 42 Section 447.75).

Deleted and replaced the following paragraph discussing the responsibility to review and respond to a corrective action plan:

Blue Shield Promise's corrective action plan requires a Delegated Entity/Specialty Health Plan to submit by the date indicated (30 calendar days) from audit result letter. Blue Shield Promise will review and provide a response to corrective action plan. If the Delegated Entity/Specialty Health Plan remains non-compliant after two CAPs have been submitted and/or no response to CAP has been submitted, the Delegated Entity will be escalated to the Delegation Oversight Committee (DOC).

Claims Oversight Monitoring

Added this sub-section explaining controls ensuring that claims processes are monitored for integrity and security to protect claims from being altered by unauthorized personnel.

Claims Delegate Reporting Instructions

Reports

Changed "April 31st" to "April 30th," in the "Reports" charts.

Appendix 9: DHCS Community Supports Categories and Definitions

Updated entire Appendix 9 to reflect comprehensive definition changes as necessitated by the DHCS Community Supports Policy Guide Volumes 1 & 2 (including the addition of Transitional Rent).

Appendix 10: Community Supports Eligibility Criteria and Restrictions/Limitations Guide

Updated entire Appendix 10 to incorporate comprehensive updates to service definitions, criteria, restrictions/limitations, as necessitated by the DHCS Community Supports Policy Guides Volume 1 & 2 (including the additional of Transitional Rent).

Appendix 11: 2026 Actuarial Cost Model

Updated the years throughout Appendix 11, which discloses the projected utilization rate, unit cost, and per-member per-month (pmpm) information.

Appendix 14 (Removed): Durable Medical Equipment (DME) Supplies Included under Capitation

Removed Appendix 14 information about DME and capitation.

Appendix 15 (Renumbered to Appendix 14): Delegation Requirements for Compliance Program and IT System Security Integrity

Changed "Delegated Entity/Specialty Health Plan" to "entity," throughout this appendix.

Delegation Oversight Compliance Program and IT System Security Monitoring and Review

Removed paragraph explaining the responsibility to provide a corrective action plan (CAO) when deficiencies are identified.

Compliance Program Monitoring and Annual Review

Corrective Action Plan (CAP) Process (if applicable)

Deleted and replaced the following paragraph discussing the CAP process:

Any deficiencies that were identified will require the entities to provide a written corrective action plan (on the Blue Shield Promise CAP template provided by the auditor), for each deficiency listed on the CAP template within 30 business days of receipt of audit results. If not, the CAP review will be closed as non-compliant, and the entities will be escalated to the Delegation Oversight Committee for being non-compliant.

IT System Security Integrity Oversight and Monitoring

Updated section which discusses the process for Delegation Oversight performing an IT system security and integrity review to ensure policy and procedures regarding system changes are maintained.

Added the following bullet point in list of items that the Security Integrity Oversight and Monitoring assessment will encompass:

- Implemented controls to ensure internal processes are monitored for integrity of mechanisms and procedures to promote accountability and prevent fraud.

Corrective Action Plan (CAP) Process (if applicable)

Deleted and replaced the following bullet points discussing the CAP process:

- If deficiencies are identified, a Corrective Action Plan (CAP) is required.
- Submission of CAP response from entities must be within 30 calendar days of the audit result letter.
- If the CAP is not accepted, the entities will have fifteen (15) business days to submit a second CAP response. After two (2) noncompliant CAP submissions and/or Delegation Oversight has not received a response to the CAP request, the entities will be escalated to the Delegation Oversight Committee (DOC) for recommendations.
- If the entities cannot effectively remediate the deficiency within a determined timeline, a Risk Acceptance Form (RAF) will be required and must be completed and submitted monthly until the deficiency is fully remediated and validated by Blue Shield Promise Health.
- If the entities fail Risk Acceptance monitoring or remediation validation, then the entities will be escalated to the Delegation Oversight Committee.
- If the entities refuse to allow Blue Shield Promise to perform the IT System Integrity Review, then the entities will be referred to Network Management, Contracting and escalated to the Delegation Oversight Committee.