



October 16, 2026

Subject: Notification of January 2027 updates to the *Blue Shield of California HMO IPA/Medical Group Procedures Manual*

Dear Provider:

Blue Shield of California (Blue Shield) is revising the *HMO IPA/Medical Group Procedures Manual* ("Manual"). The changes in each *Manual* section listed below are effective January 1, 2027.

On that date, you may search and download the revised *Manual* on Provider Connection at www.blueshieldca.com/provider in the *Provider Manuals* section under *Guidelines & resources*.

You may also request a PDF version of the revised *HMO IPA/Medical Group Procedures Manual* to be emailed to you once it is published by emailing providermanuals@blueshieldca.com.

The *HMO IPA/Medical Group Procedures Manual* is included by reference in the agreement between Blue Shield of California and those IPAs and medical groups contracted with Blue Shield. If a conflict arises between the *HMO IPA/Medical Group Procedures Manual* and the agreement held by the IPA or medical group and Blue Shield, the agreement prevails.

If you have any questions regarding this notice or about the revisions to be published in the January 2027 version of this *Manual*, please contact your Blue Shield Provider Relations Representative.

Sincerely,

A handwritten signature in black ink that reads "Kimberli Robinson".

Kimberli Robinson
Vice President, Network Operations

blueshieldca.com

Section 2.4 Blue Shield Added Advantage POS (Point-of-Service) Plan

Introduction

Added the following language: Claims for providers that are not within Blue Shield's provider network for mental health and substance use disorder services will process with Out-of-PPO Network benefits.

Section 2.5 Ancillary Benefits

Benefit Descriptions – Additional Infertility Benefits

Deleted and replaced with the following: All covered services under the infertility rider are the financial responsibility of and are reimbursed by Blue Shield. Prior authorization requirements, if applicable, are determined in accordance with the Blue Shield Prior Authorization List. Prior authorization, if required, is the responsibility of the delegated entity.

Section 2.6 Exclusions and Limitations

Updated the General Benefit Exclusions and Limitations to align with Evidence of Coverage (EOC) language.

Added a Prescription Drug Benefit Exclusions section to comply with Assembly Bill 118 (AB 118).

Section 2.8: Benefits and Benefit Programs

Care Management

Deleted the following language:

The care team prepares members in advance for hospital stays, including guided imagery recordings, to assist members in preparing for surgery or dealing with other health issues.

Deleted the following from list of services offered through the care management programs:

- Biometric home monitoring (for some members with diabetes, coronary artery disease, COPD, and heart failure)
- Cognitive behavioral therapy modules

Added the following new section and a corresponding flow chart to comply with a 2026 NCQA PHM 3B requirement:

Provider Coordination

The PCP or IPA/medical group is responsible for coordinating basic care management services to meet the specific needs of each member and for implementing the care management plan under the oversight of Blue Shield. Blue Shield oversees the coordination of care among providers, tracks member progress, updates care plans as needed, and facilitates communication with other providers to promote continuity of care. The PCP or IPA/medical group must maintain thorough documentation that captures the delivery of care, progress toward member goals, and the interventions used to address identified care needs.

Additional Care Management Program Descriptions

Deleted the Home-Based Complex Care program from the list of Care Management programs as this program is no longer offered to members.

Pharmaceutical Benefits - Office Administered Medications

Deleted language about the Drop Ship Program as Blue Shield is pausing expansion of program to HMO providers.

Section 4.1: Network Administration

Practitioner Credentialing

Updated the following items in the list of Blue Shield's HMO credentialing criteria that IPA/medical groups or direct-contracted practitioners must meet:

#4 – *Added*: If the physician utilizes the hospitalist program, the physician is required to provide a letter of the coverage arrangement to the Blue Shield Credentialing Department.

#5 – *Updated* liability insurance requirements as follows: \$1 million per occurrence and \$2 million aggregate for optometrists and audiologists; or \$1 million per occurrence and \$1 million aggregate for behavioral analysts.

#8 – *Added*: For those eligible practitioners who do not prescribe medications, a written statement is required to explain why the practitioner does not prescribe medication. The explanation must also include their process for situations where a patient might need a controlled substance. This statement will be included in the credentialing file.

Specialty Credentialing Specifications

Added the following new section to comply with Assembly Bill 1041 (AB 1041):

Healthcare Provider Credentials

Assembly Bill 1041 (AB 1041) requires the following procedures be put in place for healthcare providers, effective January 1, 2027:

- For healthcare providers, with the exception of mental health/substance use disorder specialists requesting credentialing:
 - Blue Shield utilizes the Council for Affordable Quality Healthcare (CAQH) provider portal as its primary source for credentialing applications. For applications submitted through CAQH, the application receipt date is established on the date the completed CAQH file is received and made available to Blue Shield for review.
 - Blue Shield shall notify the applicant within ten (10) business days to verify receipt and inform the applicant whether the CAQH application is sufficient for processing or if additional information is needed.

A determination shall be made regarding the credentials of a provider within 90 days after receiving a credentialing application that is sufficient for processing, including all required third-party verifications. The 90-day timeline shall apply only to the credentialing process and does not include contracting completion.
 - Provisional Approval: If the 90-day requirement is not met, the applicant's credentials will be provisionally approved for 120 days, unless all the following apply:
 - The applicant is subject to discipline by the licensing entity for that applicant.

- The applicant has one or more adverse action reports or one or more reports of malpractice payments filed with the National Practitioner Data Bank.
- The applicant has not been credentialed by Blue Shield in the past five years.
- The provider shall be notified of the credentialing decision within 10 calendar days of clean file approval.

To prevent processing delays, providers should register and maintain a current and active CAQH ProView profile.

Continuity of Care by a Terminated Provider

Added the following new language:

To ensure Blue Shield can meet applicable continuity of care regulatory requirements and effectively support members impacted by provider or medical group terminations, IPA/medical groups that have issued or received a termination notice must continue to submit their open authorization logs to Blue Shield in accordance with delegation requirements. Open authorization logs must also be submitted at least 30 days prior to the termination effective date. This allows the Clinical Operations Department sufficient time to identify impacted members with open authorizations who may be affected by the provider termination and to facilitate continuity of care review activities, where applicable.

Cultural and Linguistic Program Overview

Reorganized the section and *added* the following contact information:

- **Requesting Services:**
 - **Interpreter Services for Scheduled or On-Demand Needs:**
 - To request interpreter services for Blue Shield patients enrolled in a CalPERS plan, please call (833) 220-8014 and provide Client ID# 34091.
 - For all other Blue Shield patients, please call (833) 220-8015 and provide Client ID# 34094.
 - **For translation requests**, email the request form (see forms under the Health Equity Resources and Training section) to BSCProviders@biglanguage.com.
 - **For any additional support**, contact Blue Shield Provider Services at (800) 541-6652 between 6 a.m. and 6:30 p.m. PT, Monday through Friday.

Section 4.2: Member Rights and Responsibilities

Member Grievance Process

Updated the path to find the *Potential Quality Issue (PQI) Referral Form* to: Visit Blue Shield's Provider Connection website at www.blueshieldca.com/provider, click on *Guidelines and resources* at the top of the page, select *Patient Care Resources*, then *Provider and patient care programs*. Click *View our programs*, navigate to "Quality and patient safety," and click *Blue Shield Potential Quality Issue Reporting Form*.

Section 4.4: Claims Administration

Electronic Claims Processing

Deleted and replaced with the following language about clearinghouse fees: Providers are responsible for any fees charged by clearinghouses for electronic claim submissions.

Section 4.5: Provider Dispute Resolution

Provider Dispute Resolution - Unfair Billing and Payment Patterns

Under the sub-heading "How to submit a Provider Dispute" *added* language to clarify that this process applies to the mandatory first level of appeal.

Under the sub-heading "Final Provider Disputes," *added* language in boldface type as follows:

Unless the provider agreement requires two levels of appeals, the provider or capitated entities that disagree with Blue Shield's written determination may pursue the matter further by initiating a final provider dispute.

Section 5.1: Utilization Management

Ambulance Services

Deleted and replaced with the following language regarding coordinating care with Blue Shield: The IPA/medical group must coordinate care with the Blue Shield Medical Care Solutions Department regardless of which party is financially at risk per the DOFR.

Medical Benefit Drugs

Deleted language about the Drop Ship Program as Blue Shield is pausing expansion of program to HMO providers.

Out-of-Plan Services

Changed section name to "Out-of-Network Services" and *updated* language in boldface type as follows: When providing an authorization for out-of-network services, the IPA/medical group must contact the Blue Shield Medical Care Solutions Department for a letter of agreement **(LOA) when the DOFR is Blue Shield risk. Fax LOA requests to (844) 807-8997, or to (844) 262-5611 for office, infusion, or home health-administered medications.**

Section 5.2: Quality Management Programs

Quality Management and Improvement

Added a new section "Healthcare Provider Responsibilities for Coordination of Care" that details how contracted providers are expected to work collaboratively with Blue Shield by:

- sharing information effectively
- managing care transitions
- addressing medical, behavioral, and social needs
- engaging members and caregivers in their care, and
- complying with quality and regulatory requirements to ensure coordinated, whole-person care.

Quality of Care Reviews

Added the following language to comply with an NCQA requirement:

Following review completion, quality findings may result in an education letter or a corrective action plan (CAP), depending on severity. If an education letter or CAP is issued because of a quality of care finding, the provider is expected to take appropriate actions to remediate the quality-of-care issue in accordance with the requirements set forth in education and/or the accepted CAP. Blue Shield will follow up with the provider to monitor the implementation of the corrective action to ensure that the appropriate actions have been taken to address the quality-of-care issue.

Delegation of Credentialing - Credentialing Oversight

Added the HICE 30/30 File Methodology as one of the techniques Blue Shield uses for file review which is: 30 initial files and 30 recredentialed for MSOs that manage five (5) or more medical groups that share the same policy, procedures and credentialing committee. The review will consist of files from each group for a combined audit result. This method is utilized for annual audits only.

Delegation of Credentialing - Required Submissions/Notifications of Credentialing Program Activity

Added language about where to submit reports: Semi-annual and/or quarterly reports must be submitted to the assigned auditor and/or the delegation oversight mailbox at bsc_cred.delegation@blueshieldca.com

Specialty Credentialing Specifications

Healthcare Provider Credentials

Assembly Bill 1041 (AB 1041) requires the following procedures to be put in place for healthcare providers, effective January 1, 2027 with Council for Affordable Quality Healthcare (CAQH) requirements effective January 1, 2028.

For healthcare providers, with the exception of mental health/substance use disorder specialists:

- Delegated entities that perform credentialing on behalf of the health plan must comply with applicable California requirements under AB 1041, including Health and Safety Code §§ 1374.198 and 1380.2. Beginning January 1, 2027, delegated entities must make a credentialing determination within 90 days of receiving a completed provider credentialing application, including all required third-party verifications. Within 10 business days of receipt by the credentialing department, the delegated entity must notify the applicant that the application was received and whether it is complete.
- If a provider is approved before the end of the 90-day timeline, the provider must be activated and notified of activation within 10 calendar days of approval. The 90-day timeframe applies only to the credentialing process and does not include completion of contracting activities. If the delegated entity does not meet the 90-day requirement, the provider's credentials must be provisionally approved for 120 days unless the applicant: is subject to discipline by the licensing entity for that applicant; is subject to one or more adverse action reports or one or more reports of malpractice payments filed with the National Practitioner Data Bank; and has not been credentialed by Blue Shield in the last five (5) years.
- Beginning January 1, 2028, delegated entities must subscribe to and use the most current CAQH credentialing form and comply with CAQH credentialing processes. Additional information may only be requested from providers to clarify or confirm information submitted through CAQH, including information not specifically disclosed on the application. Delegated entities must minimize requests for additional information, and providers must respond to such requests within 10 business days.
- Delegated entities must maintain policies, procedures, agreements, and oversight processes that demonstrate compliance with these requirements and must provide documentation to the health plan upon request.

To prevent processing delays, providers should register and maintain current and active CAQH Proview profile.

Service Accessibility Standards

Deleted and replaced grids in the following sections to comply with NCQA standards.

- Service Accessibility Standards for Commercial and Medicare
- Geographic Distribution
- Behavioral Health Geographic Access Standards
- Provider-to-Member Ratio

CMS Network Adequacy Requirements for Medicare Advantage Products

Added the following sub-section:

Medicare GeoAccess and Provider-to-Member Ratios (Behavioral Health and Non-Behavioral Health)

The availability of providers, as established by CMS, is measured by the number of required providers, travel distance, and travel time to providers. Blue Shield demonstrates that 90% of its provider network meets CMS time and distance standards and complies with the minimum number of providers for each CMS-designated specialty.

CMS Health Services Delivery (HSD) Reference File tables, available at www.cms.gov/medicare/health-drug-plans/medicare-advantage-application under *Downloads*, list the commonly reported provider and facility specialty types required by CMS. These specialty types are subject to annual CMS updates.

Section 6.1 Blue Shield Medicare Advantage Plan Program Overview

Added Placer and Sacramento counties to the Individual Blue Shield Medicare Advantage HMO Plan service areas.

Section 6.3 Blue Shield Medicare Advantage Plan Enrollment and Eligibility

Blue Shield Medicare Advantage Plan Eligibility Criteria

Removed language stating that individuals with End Stage Renal Disease (ESRD) were generally ineligible to enroll in a Blue Shield Medicare Advantage plan, except under limited circumstances. This update aligns with 42 CFR § 422.50, which now permits individuals with ESRD to enroll in a Medicare Advantage Special Needs Plan (SNP) if the plan elects to accept ESRD members.

Section 6.4 Blue Shield Medicare Advantage Plan Network Administration

IPA/Medical Group Responsibilities - Provider Requests to Transfer or Disenroll Blue Shield Medicare Advantage Plan Members

Updated the section name and references throughout the section to remove "or disenroll." This section only pertains to transferring a member to a different provider, not disenrolling a member from Blue Shield.

Health Risk Assessment (HRA)

Added language in boldface type as follows: For Dual Eligible Special Needs Plan (D-SNP) members, the HRA survey is mailed to the member and Blue Shield support staff follow up with telephonic outreach to the member to complete the HRA over the phone **at the time of enrollment and annually thereafter.**

IPA/Medical Group Responsibilities

Reorganized the section and moved existing subsections under the following new headings: Delegated Utilization Management Functions, Plan-Retained Administrative and Contractual Requirements, and Coordinate Expedited Initial Determinations.

IPA/Medical Group Responsibilities - Reporting End Stage Renal Disease Members

Removed language stating that individuals with End Stage Renal Disease (ESRD) were generally ineligible to enroll in a Blue Shield Medicare Advantage plan, except under limited circumstances. This update aligns with 42 CFR § 422.50, which now permits individuals with ESRD to enroll in a Medicare Advantage Special Needs Plan (SNP) if the plan elects to accept ESRD members.

Appendix 4-C 2027 Actuarial Cost Model

Deleted and replaced with 2027 cost models.

Appendix 5-A: Utilization Management Delegation Standards

Medicare Service Denial Letters

Removed the HICE website or the Blue Shield Provider Connection website as sources for Medicare Service Denial letters. Blue Shield denial letter templates may be obtained by contacting a Blue Shield Delegation Oversight Nurse.

Appendix 5-B: Credentialing/Recredentialing Delegation Standards

Section XIII. Healthcare Provider Credentials

Added new section. See Section 5.2 Healthcare Provider Credentials above for language.

Appendix 6-D: Blue Shield Medicare Advantage Plan Required Billing Elements

Updated the vendors used for CMS expedited reviews to: Commence Health or Acentra Health, depending upon the service area.