601 12th Street
Oakland, CA 94607

April 22, 2026

«Provider»
«Title»
«Address1» «Address2»
«City», «State» «Zip»

Subject: Notification of July 2026 updates to the Blue Shield *HMO IPA/Medical Group Procedures Manual*

Dear Provider:

Blue Shield is revising the *HMO IPA/Medical Group Procedures Manual* (Manual). The changes in each provider manual section listed below are effective July 1, 2026.

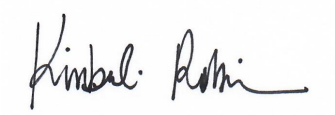
On that date, you can search and download the revised manual on Provider Connection at www.blueshieldca.com/provider in the *Provider Manuals* section under *Guidelines & resources*.

You may also request a PDF version of the revised *HMO IPA/Medical Group Procedures Manual* 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 (Blue Shield) 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 July 2026 version of this Manual, please contact your Blue Shield Provider Relations Coordinator.

Sincerely,



Kimberli Robinson
Vice President, Network Operations

Section 1.1 Introduction

Provider Audits

Updated the following language:

The provider shall permit the inspection, audit, and duplication of records, including downloading to a secure drive when necessary. All member records required to complete an audit or inspection shall be provided upon request.

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

Claims Submission - Submit Self-Referred Claims Electronically

Updated electronic submission instructions for self-referral claims.

Claims Submission - Submit Self-Referred Paper Claims

Updated the following language:

When submitting claims for a Blue Shield POS member who has self-referred, enter SELF REFERRAL in Block 17a (Name).

Section 2.5 Ancillary Benefits

Changed American Specialty Health Group, Inc. to American Specialty Health Plans.

Section 2.8: Benefits and Benefit Programs

Wellness and Prevention Programs - LifeReferrals 24/7℠

Added a registration option for the LifeReferrals program at www.lifereferrals.com.

Wellness and Prevention Programs - Preventive Health Guidelines

Added the California Department of Public Health as one of the Preventive Health Guideline sources per APL 25-015: AB 144.

Pharmaceutical Benefits

Changed section name from **Drug Formulary** to **Outpatient Prescription Drugs**.

Added language to align with the Blue Shield *Evidence of Coverage* (EOC) and ***updated*** links to pharmacy authorization pages on the Provider Portal.

Section 4.1: Network Administration

Contracting Requirements for Administrative Services Agreements

Added language: All agreements must include NCQA's CII requirements by 7/1/2027.

Continuity of Care for Members by Non-Contracted Providers

Removed strikethrough language: A member ~~whose provider is not part of an IPA/medical group~~ can request continuity of care services by completing Blue Shield's Request for Continuity of Care Services form...

Cultural and Linguistic Program Overview

Added Arabic to Covered Ca/HMO threshold languages.

Section 4.1: Network Administration *(cont'd.)*

Cultural and Linguistic Program Overview *(cont'd.)*

Removed Medicare plan type H2819-002, 003 and Medicare plan type H4937-001,002 from the Blue Shield Threshold Languages chart.

Added language for clarity: Blue Shield does not delegate language assistance services unless specifically stated in a delegation agreement. Providers may be authorized to issue certain utilization management and claims documents under relevant regulations.

Section 4.2: Member Rights and Responsibilities

Member Rights and Responsibilities

Deleted and ***replaced*** commercial rights and responsibilities language to comply with AB 118 – Compliance with Standardized Evidence of Coverage/Disclosure Form.

Section 4.3: Capitation

Capitation

Added the following language about Medicare Advantage capitation payments:

Capitation for members enrolled in a Blue Shield Medicare Advantage Benefits Program shall be paid on or before the later of: (i) the twentieth (20th) day of the month, or (ii) five (5) business days following the date Blue Shield receives the CMS capitation payment for such members.

Added the following new section:

Capitation Payment Bank Account Updates

For all new or existing bank account updates pertaining to capitation payments, please refer to the requirements listed in Appendix 3.

Section 4.4: Claims Administration

Electronic Claims Processing

Added language: There may be charges associated with electronic claims processing.

Section 4.5: Provider Dispute Resolution

Provider Dispute Resolution - Unfair Payment Patterns - Levels

Added and ***removed*** language in boldface type and strikethrough as follows:

CCR, Title 28, Section 1300.71.38 requires health plans to offer a provider dispute resolution process. State law **and the arbitration process** do not require ~~health plans to offer~~ **a provider to complete** two levels of dispute.

Provider Dispute Resolution - Unfair Billing and Payment Patterns - Arbitration

Removed "and final" from the following: If after participating in the initial ~~and final~~ levels of the Dispute Resolution Process....

Provider Disputes of Medicare Advantage Claims - Non-Contracted Providers

Per APL 25-17 Introduction of additional IMR Organization, ***removed*** references to Maximus Federal Services (the CMS-contracted IMR vendor) and ***added*** language: The provider may request an independent medical review, conducted by a CMS-contracted organization, to evaluate the dismissal decision within 60 calendar days.

Utilization Management Criteria and Guidelines

Updated section to align with SB 855 CDI regs.

Medical Necessity

Updated in boldface type below to align with SB 855 CDI regs:

Medically necessary treatment of a MH/SUD means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following: Not primarily for the economic benefit of the health care service plan/**disability insurer** and subscribers/**insureds** or for the convenience of the patient, treating physician, or other health care provider.

Medical Policy and Medication Policy

Added Radiation Oncology medical policies are accessible at www.evolent.com/blue-shield-of-california-policies.

Delegation of UM

Added the following to the list of UM activities that are delegated: UM Nonbehavioral Health Care, Behavioral HealthCare and Pharmacy Rates Reports evaluated annually.

Clinical Trials for Cancer or Life-Threatening Conditions

Added the following new section:

Delegation and Utilization Management Responsibilities

For Commercial members, participation in a clinical trial requires review by Blue Shield.

When a treating provider determines a member may benefit from participation in a clinical trial, the IPA or delegated medical group is responsible for:

- Referring the member for a consultation to evaluate clinical trial eligibility; and
- Reviewing and adjudicating standard of care services related to the evaluation, including but not limited to consults, pre-clinical trial laboratory testing, diagnostic imaging, biopsies, and other non-investigational services, in accordance with delegated utilization management authority.

Clinical trial participation and investigational services are not delegated. Requests for clinical trial participation must be submitted to Blue Shield for benefit determination. Blue Shield will review the request based on the member's EOC and applicable benefit provisions.

If the clinical trial is determined to be a covered benefit, Blue Shield will issue authorization for covered clinical trial services and coordinate approval with the provider and facility, including authorization duration and any required extensions.

Medical Benefit Drugs

Added language: Due to the complexity of these drugs, some medical benefit drugs require prior authorization to ensure medical necessity and place of administration. Additionally, medical benefit drugs may have step therapy requirements to use preferred agent including biosimilars before a non-preferred medication is approved for coverage.

Outpatient Prescription Drugs

Removed language on submitting prior authorization requests as Section 2.8 details that process.

Mental Health and Substance Use Disorder Services - Primary Care Physician Consultation Line

Removed the section. The consultation line is being retired due to inactivity from PCPs. Blue Shield will support PCPs and members with care management and referrals to Behavioral Health providers when needed.

Section 5.2: Quality Management Programs

Accreditation

Updated Blue Shield's accreditation status.

Medical Record Review - Access to Records

Added timeframe for medical records "of 2 weeks of the request, or within the timeframe outline in the request, at no cost to Blue Shield."

Added language: In addition to utilization management, quality improvement, and other administrative purposes, these parties shall have access to, and copies of, medical records (including digital charts and claims) within 45–60 days of request. Records are also required to support federal risk adjustment programs and related audits, including:

- Medicare Advantage (MA)...
- Affordable Care Act (ACA)...
- RADV Audits...

All records must be maintained for at least ten (10) years from the final date of the contract period, or from the completion of any audit, whichever is later. Provider agrees to provide all such records at no charge to Blue Shield upon request. If provider or a designated copy vendor invoices Blue Shield and Blue Shield pays the vendor to expedite the process, Blue Shield reserves the right to recover such fees from provider.

Service Accessibility Standards for Commercial and Medicare

Updated standard for regular and routine care PCP to 30 business days of request for Medicare (previously stated within 30 calendar days).

Provider Availability Standards for Commercial Products - Geographic Distribution

Added "or 60 minutes" to High-Volume and High-Impact Specialists standards: One High-Volume Specialists of each type and one High-Impact Specialists of each type within 30 miles **or 60 minutes** of each member.

Provider Availability Standards for Commercial Products

Added the following new section:

Access to Care Standards for Commercial Products

Blue Shield requires participating IPA/medical groups to maintain adequate practice coverage to ensure timely access to care for members. When a needed specialty is not available within the IPA/medical group network, IPA/medical groups must refer members to an available and accessible Blue Shield provider, where possible, consistent with established patterns of practice and in alignment with the member's clinical needs. In circumstances where medically necessary covered

Access to Care Standards for Commercial Products *(cont'd.)*

services are not available within the IPA/medical group's contracted network, referrals to qualified specialists outside of the IPA/medical group's contracted network is required.

When a member requires primary or specialty services and those services are reasonably available, care is typically coordinated within the IPA/medical group's contracted network. If a required service is not reasonably accessible within the IPA/medical group's contracted network, the IPA/medical group may refer the member to a provider within Blue Shield's PPO network to support timely access to care. When services remain unavailable within both networks, an out-of-network referral may be considered to ensure the member receives the necessary covered services.

IPA/medical groups play an important role in supporting compliance with applicable regulatory access standards. However, access standards do not prohibit IPA/medical groups from accommodating a member's preference to wait for a later appointment from a specific participating provider or selecting another provider within a reasonable distance beyond the access standards.

If an IPA/medical group experiences challenges in providing primary or specialty care services in alignment with the access requirements described above in the Geographic Distribution table, the following options may assist in resolving these circumstances:

1. Contact Blue Shield Provider Customer Service via Live Chat after logging in at blueshieldca.com/provider or by telephone at (800) 541-6652, 6 a.m. to 6:30 p.m. PT, Monday through Friday, to explore arrangements for covered healthcare services through a Blue Shield PPO Network provider who agrees to see members with an HMO product and meets applicable driving time and distance standards; or
2. Consider authorizing access to an appropriate out-of-network provider who meets the driving time and distance requirements to ensure covered services remain available to the member.

When either option is pursued, the IPA/medical group would generally be responsible for the professional services provided under these circumstances.

Provider Availability Standards for Commercial Products - Provider-to-Member Ratio

Changed compliance target for PCPs from 100% to 80%.

Section 6.6 Blue Shield Medicare Advantage Plan Member Rights and Responsibilities

Member Rights and Responsibilities

Updated the Blue Shield Civil Rights Coordinator phone number to (800) 894-5487.

Member Complaint and Appeals Resolution - Blue Shield Medicare Advantage Plan Responsibility

Per APL 25-17 Introduction of additional IMR Organization, ***removed*** references to "Maximus Federal Services" (the CMS-contracted IMR vendor) and ***replaced*** with "a CMS-contracted independent medical review (IMR) organization."

Appendix 1-A Glossary

Updated definitions.

Appendix 3-A: Blue Shield Combined Eligibility/Capitation Report

Updated the report file layout.

Appendix 3-B: Blue Shield HMO Eligibility Adds and Terminations Report

Updated the report file layout.

Appendix 3-C: Banking Information for Capitation Payments

Created this new appendix to outline the criteria an IPA/medical group must use to complete a bank update for capitation payments.

Appendix 4-A: Claims, Compliance Program, IT System Security, and Oversight Monitoring

Key Terms and Definitions - Contested Claims (Commercial)

Added language:

Note: As defined by CCR Title 28, Section 1300.71(a)(9)- (12) DMHC clarification regarding the determination of financial responsibility between the Delegate and the Health Plan is not related to Medical Necessity per the below requirements.

(9) "***Health Maintenance Organization***" or "***HMO***" means a full service health care service plan that maintains a line of business that meets the criteria of Section 1373.10(b)(1)-(3).

(10) "***Reasonably relevant information***" means the minimum amount of itemized, accurate and material information generated by or in the possession of the provider related to the billed services that enables a claims adjudicator with appropriate training, experience, and competence in timely and accurate claims processing to determine the nature, cost, if applicable, and extent of the plan's or the plan's capitated provider's liability, if any, and to comply with any governmental information requirements.

(11) "***Information necessary to determine payer liability***" means the minimum amount of material information in the possession of third parties related to a provider's billed services that is required by a claims adjudicator or other individuals with appropriate training, experience, and competence in timely and accurate claims processing to determine the nature, cost, if applicable, and extent of the plan's or the plan's capitated provider's liability, if any, and to comply with any governmental information requirements.

(12) "***Plan***" for the purposes of this section means a licensed health care service plan and its contracted claims processing organization.

Measuring Timeliness and Accuracy - Interest Accuracy

Removed language in strikethrough type: To avoid a mandated ~~$10.00 per~~ claim penalty, the interest must be paid "automatically.

Removed language: For claims involving emergency services, the minim amount of interest due is the greater of either $15.00 for each 12-month period or 15 percent per annum calculated as described above.

Measuring Timeliness and Accuracy - Measuring Timeliness

Added and ***removed*** language in boldface and strikethrough type as follows: To fulfill the state regulations all denial notices must be mailed within ~~45 working~~ **30 calendar** days.

Best Practices and Claim Adjudication - Audits and Audit Preparation

Added language: Blue Shield utilizes the HICE Claims Operational Questionnaire and participates via the HICE Claims Operational Questionnaire Repository. The Delegated Entity/Specialty Health Plan is required to submit the questionnaire through this repository. Completion of the HICE Claims Operational Questionnaire is required and provides detailed information about your claims processing operations and internal controls.

Added language: The written CAP must be submitted on a Blue Shield template provided by the auditor.

Appendix 4-A: Claims, Compliance Program, IT System Security, and Oversight Monitoring *(cont'd.)*

Best Practices and Claim Adjudication - Date Stamping

Added language:

If an MSO managing multiple Delegated Entities receives a claim through one of their post office boxes and inadvertently loads the claim into the wrong Delegated Entity/Specialty Health Plan's claims system, the original received date of that claim needs to be used when the claim is entered into the correct Delegated Entity/Specialty Health Plan's claims system.

This would also apply to Electronic Data Interchange (EDI) claims. Delegated Entity/Specialty Health Plans must submit the 837 files associated with the selected claim sample to provide the raw data necessary for validation.

Appendix 5-A: Utilization Management Delegation Standards

Updated the term "entity" to "Delegated Entity/Specialty Health Plan."

Standards for Program Structure and Processes

Deleted and ***replaced*** the bullet point talking about results/reports of clinical data and UM statistics that are required to be documented in Delegated Entity/Specialty Health Plan's UM Committee meeting minutes:

- Review of UM results and performance reporting, including clinical and utilization data across all product lines. This includes Information Integrity findings, Non-Behavioral Health UM rates, Behavioral Health UM rates, and Pharmacy UM rates, which are used to monitor compliance with applicable regulatory and accreditation standards, identify trends, and support quality improvement efforts, including oversight of Delegated Entity/Specialty Health Plans.

Denial Standards - Service Denial Letter Format Components

Added the following to list of elements required in the Service Denial letter:

- If no Medicare National Coverage Determination (NCD) or Local Coverage Determination (LCD) applies, the denial notice must clearly identify the alternative evidenced based clinical guidelines used to assess medical necessity (e.g., MCG criteria, InterQual).

Appendix 5-B: Credentialing/Recredentialing Delegation Standards

Added "Delegation" to the title of the appendix.

Updated the terms "delegated entity" and "IPA/medical group" to "Delegated Entity/Specialty Health Plan."

Added the following new section:

Section XII. Credentials for Practitioners in Hospital Setting.

A. Physicians, nurse practitioners, and physician assistants who are credentialed to perform procedures in a hospital setting must have credentials to perform those same procedures at a Blue Shield Ambulatory Surgical Center (ASC).