3840 Kilroy Airport Way
Long Beach, CA 90806

August 14, 2026

«Provider_Name»
ATTN: «Contact_Title»
«Address_Line_1» «Address_Line_2»
«City», «State» «ZIP_Code»

Subject: Notification of January 2027 updates to the *Blue Shield Promise Health Plan Medi-Cal Provider Manual*

Dear Provider,

Blue Shield of California Promise Health Plan (Blue Shield Promise) is revising the *Blue Shield Promise Health Plan Medi-Cal Provider 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 the Blue Shield Promise Provider website at.blueshieldca.com/promise. Select *Providers*, then *Policies, guidelines, standards and forms.* Scroll down to find the link to the *Provider manuals* section.

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 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 2027 version of the *Manual*, please contact Blue Shield Promise Provider Services at (800) 468-9935 [TTY 711] 6 a.m. to 6:30 p.m. PT, Monday through Friday.

Sincerely,

Kimberli Robinson
Vice President, Network Operations

Section 3: Benefit Plans and Programs

3.2: Basic Population Health Management (BPHM)

Added, per NCQA PHM 3 and APL 26-005, the following language detailing providers' duties to perform BPHM services:

For members in Complex Care Management (CCM), providers are responsible for performing BPHM services to meet the specific needs of each member and for implementing the care management plan in collaboration with Blue Shield Promise Care Managers. Blue Shield Promise 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, IPA, or 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. A copy of Blue Shield Promise Complex Care Management (CCM) policy can be found at Clinical policies and procedures | Blue Shield of CA Promise Health Plan | Blue Shield of CA Promise Health Plan

3.2.7: Programs to Address Maternal Health Outcomes

Updated, in boldface type, the following sentence describing providers' duties to meet requirements for perinatal/postpartum individuals:

Blue Shield Promise is required to meet all requirements for perinatal and postpartum individuals, including covering provision of all medically necessary services for perinatal and postpartum birthing people, implementing and administrating a comprehensive risk assessment tool that is comparable to the American College of Obstetricians and Gynecologists (ACOG) and standards per Title 22 C.C.R. Section 51348, **at an early prenatal visit, one each trimester, and at the postpartum visit**, developing individualized care plans to include obstetrical, nutrition, psychosocial, and health education interventions, and providing appropriate follow-ups…

Updated, per APL 26-005, significant language within this Section 3.2.7, describing the Maternal Mental Health Program, introducing the Doula Services Program and providing bullet points listing the methods by which providers support the member through the pregnancy.

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

Updated, in boldface and strikethrough type, the following bullets in list of items that providers ensure will be provided to all members under age 21 (and their families, as appropriate):

- Preventive health visits, including age-specific screenings, assessments, and services, at intervals consistent with the American Academy of Pediatrics (AAP) Bright Futures periodicity schedule, and immunizations specified by **AAP, California Department of Public Health (CDPH), and** the Advisory Committee on Immunization Practices (ACIP) childhood immunization schedule.
- Care Management services for children receiving Private Duty Nursing (PDN) services. **All PDN services need to be submitted for prior authorization.**

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)

Changed all APL 25-002 references to the superseding APL 26-006, per APL 26-006 and throughout this section.

Updated, per APL 26-006 and in boldface type, the following sentence describing how payments are made by MCPs to facilities:

SNF WQIP payments will be issued with a detailed cover letter describing the payments, ~~what~~ **which plan year to which they apply,** ~~they apply to~~, whom to contact with any questions, and how to file a grievance.

3.7: Community Health Worker

Updated in strikethrough type, the removal of the following sentence describing how CHW services billed will be reimbursed:

~~. If supervising providers seek reimbursement at 100% of the Medi-Cal fee schedule, they are required to enter into a standalone CHW agreement with Blue Shield Promise. Otherwise,~~ CHW services billed will be reimbursed according to the capitated or negotiated contract rate.

Removed, in strikethrough type, the following 2 sentences explaining how CHW services will be reimbursed and how CHW claims and billing will be processed:

~~CHW services are considered plan risk, indicating that Blue Shield Promise will provide reimbursement for all CHW services, provided a standalone CHW agreement is established.~~

~~. If supervising providers seek reimbursement at 100% of the Medi-Cal fee schedule, they are required to enter into a standalone CHW agreement with Blue Shield Promise. Otherwise, CHW services billed will be reimbursed according to the capitated or negotiated contract rate.~~

Removed the following language regarding the activities a provider must do for emergency services:

~~For services rendered in an emergency department (ED) or hospital, the hospital must:~~

- ~~Submit claims with revenue code 0942 (education/training) and the CHW CPT codes. Submit the claim on a UB04 form.~~
- ~~Ensure that the CHW modifier and Place of Service codes are included~~
- ~~Ensure that the Place of Service is ED or Hospital.~~

3.8: Doula Services

Deleted and replaced the following link for the Maternity Program:

https://www.blueshieldca.com/content/dam/bsca/en/promise/docs/Maternity-care-management-form.pdf.

Updated significant language under "How to submit 'Doula Visit Detail Log," providing numbered instructions for completing and submitting the Doula Visit Detail Log.

Updated the following link to the Blue Shield Promise Case Management program and Maternity Care Management Referral form:

https://www.blueshieldca.com/content/dam/bsca/en/promise/docs/Population-Health-Management-Referral-Form.pdf

3.11: Non-Specialty Mental Health Services (Medi-Cal Managed Care)

Updated, per APL 25-010, language, under the "County Behavioral Health Transition of Care Tool" topic, describing the steps the provider should take completing the Transition of Care Tool.

Added, per APL 26-002, the paragraph, under the "Trauma Screening" topic, describing the use of the Trauma Screening Tool to determine whether the member meets the "high-risk" threshold.

Added, per AB 133, the following language describing requirements for providers using the Authorization to Share Confidential Medi-Cal Information (ASCMI) form to share data:

When it is necessary to share member data, providers are required to obtain the member's consent by using the Authorization to Share Confidential Medi-Cal Information (ASCMI) form. This form serves as a formal "consent to share information" document and must be used to collect authorization for the disclosure of protected health information (PHI). The form can be found here: Authorization to Share Confidential Member Information (ASCMI) Form: AB 133.

Section 5: Enrollment

5.1: Eligibility

Updated, in boldface and strikethrough type, this Section 5.1, which describes the member eligibility requirements:

Eligible members must reside within the Blue Shield Promise approved service area and meet the requirements for Medi-Cal benefits. **Eligibility is not determined by Blue Shield but is reported via the DHCS (San Diego) or L.A. Care (Los Angeles) electronic eligibility file.** As eligibility may change at any time, providers are required to verify member eligibility at time of service. ~~Eligibility may change at any time, so providers are reminded to check member eligibility at the time of each visit.~~

5.9: Identification Cards

Updated, in boldface and strikethrough type, the following bullet in list of materials with which providers will furnish each new member within the first seven (7) calendar days of enrollment:

Blue Shield Promise will furnish each new member with materials within the first seven (7) calendar days of enrollment, including:

- A Member Identification Card ~~with~~ **that provides instructions and coverage information for emergency care.** ~~the 24-hour emergency numbers for their PCP~~

5.12: Transportation

Updated, in boldface and strikethrough type, the following sentence explaining how meals and lodging are covered:

Reasonably necessary expenses for meals and lodging for members receiving medically necessary covered services may be covered in addition to NEMT or NMT. Prior authorization or utilization management review ~~may~~ **will** apply.

Section 6: Grievances, Appeals, and Disputes

6.1: Member Grievances

Updated link for members to file a grievance to www.blueshieldca.com/en/bsp/medi-cal-members/your-medi-cal-program.

6.4: Provider Disputes – Claims Processing

6.4.1: Provider Questions, Concerns and Disputes

Updated the correct link for all provider payment-related issues to www.blueshieldca.com/en/bsp/providers/policies-guidelines-standards-forms/disputes.

6.4.3: Provider Disputes Policy and Procedure

Updated the link for providers to submit a dispute to www.blueshieldca.com/en/bsp/providers/policies-guidelines-standards-forms/disputes.

6.4.4: First Level Dispute

Updated item #4 with the correct link with information about the Provider Dispute Resolution process: www.blueshieldca.com/en/bsp/providers/policies-guidelines-standards-forms/disputes.

6.4.8 Provider Dispute Resolution (PDR) Training Office Hours

Added, per APL 26-XXX (PDR Mechanism), this Section 6.4.8, which describes the Plan's responsibility to offer recurring online Provider Dispute Resolution (PDR) Training Office Hours to support provider education and promote consistent understanding of PDR requirements and processes.

Section 7: Utilization Management

7.1: Utilization Management Program

7.1.5: UM Review Process for Appropriateness of Care

Updated several cells in the "Type Hierarchy" chart, which categorizes type of treatment and hierarchy of standards.

7.3 Transitional Care Services (TCS)

7.3.2.c: TCS for Birthing Population

Added this new Section 7.3.2.c, which contains information about High-intensity Transitional Care Services (TCS) for pregnant and postpartum members.

7.4: Primary Care Physician Scope of Care

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

Updated, in boldface type, the following bullet in list of screening and preventive services covered by Medi-Cal Kids & Teens:

- Advisory Committee on Immunization Practices (ACIP), **California Department of Public Health (CDPH), and American Academy of Pediatrics (AAP) as part of the Bright Futures periodicity schedule** recommended vaccines.

Updated, in boldface type, the following bullet in list of EPSDT/Medi-Cal Kids & Teens covered services:

- Home nursing/**Private Duty Nursing**

7.4.3: Child Health and Disability Prevention Program (CHDP)

Deleted the following language describing a "Periodicity Schedule:

The Initial Health Appointment (IHA) for all members under the age of 21 years consists of a comprehensive health history and physical examination and includes an age-appropriate health education behavioral assessments and screenings as recommended by the Bright Futures American Academy of Pediatrics (AAP) Recommendations for Preventive Pediatric Health Care, also known as the "Periodicity Schedule," ~~a schedule of screenings and assessments recommended at each well-child visit from infancy through adolescence.~~

7.4.4: California Regulatory Required Programs

Deleted and replaced the following paragraph explaining providers' responsibilities to conduct periodic health care assessments:

California state statutes and regulations impose specific responsibilities on doctors, nurse practitioners, and physician assistants doing periodic health care assessments on children between birth and 72 months. These providers must provide oral or written anticipatory guidance to a parent or guardian of the child, including, at a minimum, the information that a child can be harmed by exposure to lead, especially from deteriorating or disturbed lead-based paint and lead-contaminated dust and soil, and is particularly at risk of lead poisoning from the time the child begins to crawl to 72 months of age. The anticipatory guidance must be provided at each periodic health assessment, starting at birth until 72 months of age. California regulations require a blood lead test at 12 and 24 months, or between 24 months and 72 months when a child has not had a documented lead screening. These provider responsibilities apply to all physicians, nurse practitioners, and physician assistants, and are only a summary of the provider responsibilities.

Updated, in boldface and strikethrough type, the following bullets in list of occurrences that would render network providers to be not required to perform a blood lead screening test:

Network providers are not required to perform a blood lead screening test if either of the following applies:

a) In the professional judgment of the network provider, the risk of screening poses a greater risk to the child member's health than the risk of **not identifying** lead poisoning.
b) ~~If the~~**If the child's** ~~a~~ parent~~-guardian~~ or guardian ~~or other person with legal authority~~ **or the child is**~~f~~ **18, 19, or 20 years of age** ~~to withhold consent for the child~~ refuses to consent to the screening.

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

7.9.1: California Children's Services (CCS)

7.9.1.1 CCS Provider Training

Changed "CCS" Program to "Blue Shield Children's Services" Program within this Section.

7.9.1.2 Provider Communications

Changed "CCS Nurses" to "Blue Shield Children's Services" within this section

7.9.1.4 CCS Care Management

Updated, in boldface and strikethrough type, the following language explaining the responsibility for needed care coordination/case management:

The Blue Shield Promise CCS Program will be responsible for needed **care coordination/**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…

7.9.2.2: Provider Communications

Updated sentence to reflect that the Blue Shield Promise Children's Services Program, not ~~Nurses~~, is responsible for informing the member's PCP of the member's Regional Center eligibility.

7.9.3: Women, Infants, and Children Program (WIC)

Added the following paragraph, which explains the process for referral of a therapeutic formula:

In the event that therapeutic formula is medically necessary, a referral must be submitted to Medi-Cal Rx in accordance with the Treatment Authorization Request (TAR) process. If request is denied by Medi-Cal Rx, a WIC attestation form must be completed and submitted to WIC upon member referral.

7.9.4: Comprehensive Perinatal Services Program (CPSP)

Updated the "Time (Weeks Gestation) Assessment / Service" Table, which categorizes the time of gestation and accompanying standard treatments.

Added the following paragraph, regarding how providers may also utilize standards for a comprehensive risk assessment:

In addition to ACOG and CPSP standards, providers may also utilize standards for a comprehensive risk assessment from the American Academy of Family Physicians (AAFP), American College of Nurse Midwives (ACNM), and National Association of Certified Professional Midwives (NACPM).

Updated, in boldface and strikethrough type, the following paragraph, which describes the responsibility to ensure that our members get optimal perinatal care and the best possible pregnancy outcomes:

Blue Shield Promise needs your assistance to ensure that our members get optimal perinatal care and the best possible pregnancy outcomes. In addition, we must maintain compliance with the ~~the Department of Health Care Services (DHCS) Policy Letter (PL) 12-003 Obstetrical Care – Perinatal Services~~ Department of Health Care Services (DHCS) All Plan Letter (APL) 26-005 Maternity Services for Pregnant and Postpartum Medi-Cal Members.

7.9.8: Specialty Mental Health Services (Medi-Cal Managed Care)

Updated, per BH-001 NSMHS PP and in boldface and strikethrough type, the following paragraph, which describes the referral process when members need access to specialty mental health services:

The PCP may also refer to the Blue Shield Promise ~~Social Services~~ **Behavioral Health Care Management** team for screening to determine the most appropriate level of care **and coordinate member care services with the MHP to facilitate transitions or addition of services. Here is a link to the referral form:** https://www.blueshieldca.com/content/dam/bsca/en/promise/docs/Social-services-referral-form.pdf.

Added, per AB 133, the following paragraph explaining providers' duties when it is necessary to share member data:

When it is necessary to share member data, providers are required to obtain the member's consent by using the Authorization to Share Confidential Medi-Cal Information (ASCMI) form. This form serves as a formal "consent to share information" document and must be used to collect authorization for the disclosure of protected health information (PHI). Form can be found here: Authorization to Share Confidential Member Information (ASCMI) Form: AB 133.

7.9.9: Alcohol and Drug Treatment

Updated, per AB 133 and in boldface type, the following paragraph, explaining providers' duties When it is necessary to share member data:

Any member identified with possible alcohol or substance use disorders shall be referred to the County Alcohol and Drug Program in the county where the member resides for evaluation and treatment. **When it is necessary to share member data, providers are required to obtain the member's consent by using the Authorization to Share Confidential Medi-Cal Information (ASCMI) form. This form serves as a formal "consent to share information" document and must be used to collect authorization for the disclosure of protected health information (PHI). Form can be found here: Authorization to Share Confidential Member Information (ASCMI) Form: AB 133.**

7.9.17: Enteral Nutrition

Updated, per APL 25-013, this Section 7.9.17, which provides information about the coverage, utilization management and administration of enteral nutrition.

Section 9: Quality Improvement

9.1: Quality Improvement Program

9.1.3: Quality Improvement Process

Updated 2 bullets, under the "Quality of Care Reviews," topic, which describes a comprehensive review system to address potential quality of care issues.

9.5: Initial Health Appointment (IHA)

Changed DHCS All Plan Letter 22-030 to DHCS All Plan Letter 26-001, under the "Purpose."

Updated several bullets, throughout this Section, which describes the health services included in an Initial Health Appointment.

9.13: Credentialing Program

9.13.1: Credentials Process for Directly Contracted Physicians

Deleted and replaced the following paragraph regarding adopting a credentialing method:

Blue Shield Promise has adopted the Council for Affordable Quality Healthcare (CAQH) application as the preferred credentialing method, with the California Participating Physician Application (CPPA) accepted as an alternative.

Updated, in boldface and strikethrough type, the following number items in list of items the practitioner must provide in addition to completing an initial application:

2. A copy of a current and valid Drug Enforcement Administration (DEA) certificate~~ if applicable.~~ **If provider does not have a current DEA certificate, explanation or covering physician may be required, if applicable.**
6. ~~Medicare number~~ Medi-Cal number and NPI number.
7. ~~Physician Supervisory Agreement~~**Delegation of Services Agreement** (for Midlevel only, as applicable).
8. ~~A copy of the ECFMG certificate (if applicable).~~ **Proof of Medi-Cal enrollment.**

Updated, in boldface and strikethrough type, the following sentence explaining the notification time for credentialing decisions:

The Credentialing Committee's approval date is considered as the final credentialing approval date. Practitioners are notified of the credentialing decision within ~~thirty~~ ten (~~30~~10) ~~calendar~~ **business** days.

9.13.2: Minimum Credentials Criteria

Deleted and replaced the following Roman numerals with language regarding DEA documentation:

b. A copy of a valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate with a California address, if applicable.
    i. A practitioner whose DEA or CDS certificate is pending will be required to submit a written statement from the in-network prescribing practitioner attesting that they will write prescriptions on the practitioner's behalf during the period while the DEA or CDS certificate is pending. The statement must include covering physician name NPI, and their DEA number for the record.
    ii. 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.

Removed the following Roman numeral explaining Non-Physician Medical Practitioners (NPMP) requirements:

~~(iii) Board Certified Assistant Behavioral Analysts must be board-certified and must include a delegation of service agreement or supervising practitioner agreement completed and signed by a Behavior Analyst Certification Board (BACB) certified supervising physician~~

Updated extensive language, under the "Recredentialing" topic, describing the recredentialing process.

Updated, under the "Automatic Administrative Terminations" topic, extensive language which describes conditions resulting in a provider's automatic termination.

Deleted, replaced and updated extensive language and numerous bullets, under the "Health Delivery Organizations (HDO)" topic, describing the credentialing process for hospitals, home health agencies, skilled nursing facilities, ambulatory surgery centers, and Federally Qualified Health Centers (FQHC).

9.13.4: Credentials Process for IPA/Medical Groups

Added item c to the following list of methods that the Plan will use for the file review:

c. HICE File Methodology - 30 initial files and 30 recredentialed for MSO's 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. (Utilized for annual audits only).

Updated, in boldface type, the following item 10, which explains duty to develop Credentialing Information Integrity (CII) policies and procedures:

10. Delegated entities must develop and implement Credentialing Information Integrity (CII) policies and procedures, audits credentialing information for inappropriate documentation and updates and implement corrective actions that address identified integrity issues. (This requirement replaces NCQA's Credentialing System Controls requirements, **effective 7/1/2025**).

Updated, in boldface type, the following item numbers 11 and 15 in list of credentialing activities that will be monitored:

11. The Delegate is required to review all Blue Shield Promise practitioners/ providers sanction activities **monthly or** within the 30 calendar days of the report's release by the reporting entity and report the findings to Blue Shield Promise as Blue Shield Promise practitioners/providers are identified that require action to be taken.
15. The Delegate will be required to sign and abide by the credentialing delegation agreement **and this Blue Shield Promise Provider Manual**.

Section 10: Pharmacy and Medications

10.1: Pharmaceutical Utilization Management

Deleted and replaced the following paragraph, describing the Pharmaceutical Utilization Management Program:

The Pharmaceutical Utilization Management Program applies to drugs billed through medical or institutional claims. The Blue Shield of California Pharmacy & Therapeutics Committee oversees and approves policies and procedures for drug utilization management, including medication policies for drugs covered under the medical benefit, to ensure appropriate use based on current medical evidence. To view the Healthcare Professional/Physician Administered Drug Requests (medical benefit drugs) form, go to Blue Shield Promise's Provider Portal at https://www.blueshieldca.com/en/bsp/providers/policies-guidelines-standards-forms/provider-forms and click on *Administrative authorization request forms.*

10.2: Specialty Pharmaceuticals

Updated, in boldface and strikethrough type, the following sentence explaining how the Pharmacy Department will conduct the prior authorization review:

The Blue Shield Promise Pharmacy Department will conduct the prior authorization review utilizing **the medication policies**~~ycriteria and guidelines~~ approved by the Blue Shield of California Pharmacy & Therapeutics Committee unless the health care provider has been delegated to perform the prior authorization review.

Deleted and replaced the following "*Note:*" sentence, detailing which drugs are "carved out":

...As of July 1, 2025, for LYFGENIA and October 1, 2025 for CASGEVY these drugs are carved out of managed care coverage for managed care plan (MCP) Members when used for the treatment of sickle cell disease (SCD) and are not included in the Capitation Payment to MCPs...

Updated, in boldface and strikethrough type, the following sentence explaining the standard used to conduct the prior authorization review:

The IPA/medical group will be expected to conduct the prior authorization review utilizing Blue Shield Promise **medication policies**~~criteria and guidelines~~ approved by the Blue Shield of California Pharmacy & Therapeutics Committee. Adherence to Blue Shield Promise's medical necessity, site of service and biosimilar first policies ~~is~~**are** required and will be subject to the delegation audit.

Section 11: Health Education

11.2: Scope of the Health Education Program

11.2.1: Member Education

Added the following sentence providing the website containing the schedule of health education classes:

A quarterly schedule of health education classes is available at bsca.com/health-education-classes.

Added "California Department of Public Health" to the list of organizations from which the Plan receives recommendations for Preventive Health Guidelines.

11.3: Member Education Contractual Requirements

11.3.1: Provider's Responsibility to Health Education

Updated, per APL 26-005 and in boldface and strikethrough type, the following language providing the website for educational materials and videos on breastfeeding:

Educational materials and videos on breastfeeding are available on our health education library at www.blueshieldca.com/healtheducationlibrary.

~~Additionally, providers should not distribute samples or materials with formula company logos on them to their patients, as per MMCD Policy Letter 98-10. Providers are encouraged to refer Medi-Cal patients to WIC services.~~

11.6: Program Resources (cont'd.)

11.6.3: Wellvolution

Updated, in boldface and strikethrough type, the following sentence describing the Chronic Condition Reversal Programs:

Chronic Condition Reversal Programs – Turn back the clock and reverse the course of chronic conditions like hyperlipidemia, ~~hypertension, type 2 diabetes~~**diabetes management and prevention** and more with the support from health coaches and a supportive member community…

Section 14: Claims

14.2: Claims Processing Overview

Updated the address to submit refunds for overpayment, as follows:

1. Address through December 31, 2026: Blue Shield of California Promise Health Plan, P.O. Box 241012, Lodi, CA 94241
2. Address effective on and after January 1, 2027: Blue Shield of California Promise Health Plan, P.O. Box 60512, City of Industry, CA 91716-0512

Section 15: Financial

15.1: Financial Analysis

Updated, in boldface and strikethrough type, the following 2 bullets in list of items that a DMHC submission should include:

- Confirmation **(includes additional details for annual submission)**
- Grading Criteria
    - Claims **and** Incurred but Not Reported (IBNR)

15.2: Capitation Payments

Updated the following 2 paragraphs, which provide a description and location of the Capitation Payment Bank Account Updates and Combined Eligibility and Capitation Report:

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 15.

Combined Eligibility and Capitation Report
The monthly Eligibility and Capitation report shows capitation details for all IPAs/capitated hospitals/medical groups and their assigned PCPs for specific reporting period. It includes the calculated payment amounts for all currently eligible capitated members. (The file layout for this report appears in Appendix 16.)

15.3: Medical Loss Ratio Requirements for Subcontractors and Downstream Contractors

Updated, with numerous edits, this Section 15.3 which explains the rules for sub-contractors, capitation and financial policies.

Section 17: Culturally and Linguistically Appropriate Services (CLAS)

17.3: Access to Free Interpretation Services

Updated, in boldface and strikethrough type, the following sentence explaining the process for bilingual staff not meeting the language proficiency standards:

...~~It is recommended that Bilingual~~ **bilingual** staff who **do not meet the minimum passing** score must ~~rate a 1=Novice or 2=Low Intermediate based on a scale of 1-5 on a language proficiency test~~ **use a telephonic or face-to-face interpreter for communicating with members**...

17.8: IPA/Medical Group Monitoring and Reporting Requirements

Changed October 31, 2025 to October 31, throughout this Section 17.8.

Appendices

Appendix 2: Delegation of Credentialing Responsibilities

Updated the "Delegation of Credentialing Responsibilities" Table with language concerning delegated credentialing activity, IPA/medical group responsibility, Blue Shield Promise responsibility, reporting frequency, performance evaluation and corrective action plans.

Appendix 3: Delegation of Claims Processing Responsibilities

Updated the "Delegation of Claims Processing Responsibilities" Table with language concerning delegated claims activity, IPA/medical group responsibility, Blue Shield Promise responsibility, reporting frequency, oversight of delegated claim's function and corrective action plans.

Appendix 6: List of Incidental Procedures for APG Payment Rate

Updated the "List of Incidental Procedures for APG Payment Rate" Table which categorizes CPT Codes and treatment descriptions.

Appendix 7: List of Office-Based Ambulatory Procedures for APG Payment Rate

Updated the "List of Office-Based Ambulatory Procedures for APG Payment Rate" Table which categorizes CPT Codes and treatment descriptions.

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

Audits and Audit Preparation

Updated, in boldface type, the sentence explaining entities' responsibilities to demonstrate their annual oversight and monitoring process:

For a Blue Shield Promise Contracted Delegated Entity that is a Limited/Restricted Knox Keene or Specialty Health Plan, that has contractually sub-delegated any functions, they must demonstrate their annual oversight and monitoring process **to assure compliance with regulatory requirements**...

Date Stamping

Updated the "Date Stamping" subsection, which explains the procedures for Delegated Entities/Specialty Health Plans to date stamp all paper claims.

Claims Delegate Reporting Instructions

Updated, in boldface and strikethrough type, the following sentence in the "Due Date" Column of the "Line of Business (LOB), Due Date and Report Location" Table:

Reports are submitted monthly. The reports are due by the 15th of the month following the end of the prior~~reported~~ month…

Appendix 11: 2027 Actuarial Cost Model

Updated years throughout this Appendix 11, which displays the 2027 Actuarial Cost Model Table.

Appendix 12: Utilization Management Timeliness Standards

Updated multiple cells in the "Utilization Management Timeliness Standards" Table, which categorizes the type of request, decision timeline and notification timelines.

Appendix 13: HEDIS Guidelines

Updated numerous cells in the "HEDIS Guidelines" table, which details treatments and methods used by HEDIS to measure treatment and criteria.

Appendix 15: Capitation Payment Bank Account Updates

Added this new Appendix 15, which details the process for when an IPA/medical group either adds or changes a bank or any of its banking information.

Appendix 16: Combined Eligibility and Capitation Report

Added this new Appendix 16, which contains a Table with the fields for the "Combined Eligibility" and "Capitation Report."