3840 Kilroy Airport Way
Long Beach, CA 90806

February 18, 2026

«Provider_Name»
«Contact_Title»
«Address_Line_1» «Address_Line_2»
«City», «State» «Zip_Code»

Subject: **Notification of July 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 July 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 July 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

3.7: Community Health Worker

Added language describing providers' responsibility to confirm compliance with APL requirements and to submit documentation of required CHW training completion.

Added the following sentences explaining the Community Health Worker (CHW) risk agreement and provider reimbursement:
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.

Added the following bullet points to list of activities a hospital must complete for services rendered in an emergency department (ED) or hospital:

- 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

Added language and a table to explain the diagnosis codes that doula providers should use.

Updated, in boldface and strikethrough type, the following sentence to reflect removing the option that doulas no longer have to submit a claim:

Doula providers have ~~four~~ **three** options for submitting claims.

Deleted "Doula Transaction Log Process" language for submitting claims as this process has been retired.

Updated language and ***added*** an outline with instructions on how to complete the Doula Visit Detail Log which logs doula visit data.

3.9: Annual Cognitive Health Assessment

Deleted the following bullet point from list of steps that providers must complete in order to bill and receive reimbursement for annual cognitive health assessments, as it is no longer a requirement, per AB 116:

- ~~Complete the DHCS Dementia Care Aware cognitive health assessment training prior to performing the assessments.~~

Section 6: Grievances, Appeals, and Disputes

6.4: Provider Disputes – Claims Processing

6.4.4: First Level Dispute

Updated section which details the First Level Dispute process for providers disputing decisions.

6.4.5: Second Level Dispute –Los Angeles (L.A.) County Only

Deleted and replaced the following section which details the Second Level Dispute process for Los Angeles County providers:

After completing the first level dispute process, for L.A. County Medi-Cal only, the provider may submit a second level dispute with L.A Care using the contact information below:

L.A. Care Health Plan
1055 West 7th Street 10th Floor
Los Angeles, CA 90017
866-522-2736

6.4.6: Second Level Dispute - All Other Counties

Deleted and replaced the following section which details the Second Level Dispute process for providers outside of Los Angeles County:

After completing a first level dispute, the provider may submit a second level dispute with Blue Shield Promise. The second level dispute must be submitted in accordance with the required information for a provider dispute. Blue Shield Promise will, within 45 working days of receipt, review the second level dispute and respond in writing, stating the pertinent facts and explaining the reason(s) for the determination.

6.4.7 Unjust or Unfair Payment Practice Escalations

Added new section which describes the process to handle unjust and unfair payment practices.

Section 7: Utilization Management

Changed "Primary Care Physician" to "Primary Care Provider" throughout this entire section.

7.1: Utilization Management Program

7.1.4: Medical Services Committee Structure and Membership

Deleted the following bullet point in list of reports that are reviewed by the UM Committee and the Board of Directors:

- ~~Total number of referrals by specialty~~

7.1.5: UM Review Process for Appropriateness of Care

Updated language and table listing the Blue Shield Promise approved guidelines or sources that may be utilized for issuing approvals, denials, or modifications.

7.1.6: Review Criteria

Updated, in boldface and strikethrough type, the following sentence explaining that the UM Department now uses the MCG 29th edition:

The UM Department uses nationally recognized evidenced based review criteria, i.e., MCG **29**~~27~~th Edition, the American College of Obstetrics and Gynecology, the American Academy of Pediatrics, the United States Preventative Services Task Force Standards, Comprehensive Perinatal Service Program Guidelines, and Title 22. A review of criterion is updated on an ongoing basis.

7.1.7: Medical Policy

Added this sub-section, which details how the Blue Shield Promise Medical Policy Committee reviews technologies for medical and behavioral health indications that are new or emerging.

7.4: Primary Care Physician Scope of Care

7.4.4: California Regulatory Required Programs

Deleted the following sentence in paragraph discussing CHDP provider responsibility to participate in the California VFC Program:

~~. All CHDP providers are required to participate in the VFC program in California and be in good standing.~~

7.5: Authorization and Review Process

7.5.1: Authorization Time Frames

Deleted and replaced the following language detailing processing timelines for inpatient and outpatient referral requests:

Emergency Post-Stabilization Service Request: Within 30 minutes of request received.

Emergency Care Request: Requires no prior authorization

Standard Request: Within seven 7 calendar days of the receipt received within the UM Department of the information reasonably necessary to make a determination.

7.5.6: Elective Admission Requests

Updated, in boldface and strikethrough type, the following paragraphs detailing the staff's assessment of the clinical appropriateness of care:

Site of Care Review: The UM clinical staff will review elective inpatient admission requests ~~for~~ **from a select list of recommended outpatient procedures to assess whether the inpatient setting is the most clinically appropriate site of care.**

If there is sufficient clinical information to determine that admission criteria are satisfied, the admission will be authorized. The Plan uses **review criteria for medical appropriateness as cited in Section 7.1.5. UM Review Process for Appropriateness of Care** ~~MCG Guidelines~~...

Section 9: Quality Improvement

9.1: Quality Improvement Program

Deleted and replaced the following paragraph discussing Blue Shield Promise's accreditation awards:

Blue Shield Promise has earned both Health Plan and Health Outcomes Accreditation (formerly Health Equity Accreditation) from The National Committee for Quality Assurance (NCQA), highlighting its commitment to excellence. Every three years, NCQA conducts a thorough assessment of health plans evaluating organizational leadership, operational effectiveness, clinical quality, and member satisfaction. This recognition reflects Blue Shield Promise's dedication to delivering high-quality, equitable care.

9.1.1: Program Structure Governing Body

Updated, in boldface and strikethrough type, the following sentence within the paragraph discussing Blue Shield Promise's delegation of its functions:

...At least quarterly, delegates are required to submit ~~performance~~ **regulatory** reports, which are reviewed for compliance...

9.1.3: Quality Improvement Process

Deleted and replaced the following language concerning the disclosure of HIV test results that provide identifying characteristics of a Medi-Cal member, to comply with California Assembly Bill 278:

In addition, per Section 120985 of the Health and Safety code, the results of an HIV test that identifies or provides identifying characteristics of a Medi-Cal member may be disclosed by a provider of health care without written authorization of the member/member's representative to the Medi-Cal managed care plan to which the member is assigned and to the external quality review organizations contracted by DHCS to conduct external quality reviews of Medi-Cal managed care plans to administer quality improvement programs.

9.2: Quality of Care Focused Studies

Deleted the following bullet point from list of sources for standards, norms, and guidelines pertaining to the measurement of quality of care:

- ~~Child Health and Disability Prevention (CHDP) program guidelines.~~

9.8: Access to Care

Added the following language describing how a provider can demonstrate compliance with the established primary care time-elapsed access standards:

Advanced Access

The primary care physician may demonstrate compliance with the established primary care time-elapsed access standards through the implementation of standards, policies, processes, or systems providing same day or next day appointments with primary care physicians or other qualified clinicians such as a nurse practitioner or physician assistant from the time an appointment is requested; and offers advanced scheduling of appointments for a later date if the member prefers not to accept the appointment offered within the same or next business day.

Section 10: Pharmacy and Medications

Deleted language about Prime, as it is irrelevant to the provider and pharmacy services that have historically been carved out of managed care health plans.

10.2: Specialty Pharmaceuticals

Added the following language discussing specialty drugs that will be "carved out:"

...In addition, starting on July 1, 2025 for LYFEGENIA, as approved by CMS, and on October 1, 2025 for CASGEVY, subject to CMS approval, these sickle cell disease (SCD) drugs will be carved out of managed care coverage for managed care plan (MCP) Members and not included in the Capitation Payment to MCPs...

Updated, in boldface type, the following list item describing the Pharmacy Department's actions after an authorization request is denied or modified:

6. If the prior authorization request is modified or denied, the Blue Shield Promise Pharmacy Department will notify the member and the physician in writing. **Letters of modification or denial will be mailed to the Blue Shield Promise member and a copy will be faxed to the provider.**

Section 11: Health Education

11.2: Scope of the Health Education Program

11.2.1: Member Education

Updated, in boldface and strikethrough type, the following paragraph describing health education programs provided by Blue Shield Promise:

…Additionally, Blue Shield Promise provides health education programs at various locations and virtually. Class topics include asthma, diabetes, hypertension, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), tobacco cessation, weight management for adults and children, healthy nutrition for families, mental health awareness and the ~~Healthier Living~~ **Chronic Disease Self-Management and Tomando Control de su Salud** Programs (chronic disease self-management), ~~developed by~~ **an SMRC Evidence-Based Self-Management Program originally developed at** Stanford University…

11.6: Program Resources

11.6.1: Health Education Staff

Updated NCQA name change from "Health Equity Standards" to "Health Outcomes Standards."

11.6.4: Departments in Collaboration with Health Education

Updated, in boldface and strikethrough type, the following sentence describing the cultural and linguistic standards that Blue Shield Promise follows:

…Blue Shield Promise adheres to NCQA ~~Multicultural Distinction~~**Health** ~~Equity~~ **Outcomes** Standards **(formerly Health Equity Standards)** and the National CLAS standards…

Section 12: Provider Services

12.1: Provider Manual Distribution

Updated language to reflect a change from quarterly to semiannual distribution.

12.7: Provider Network Changes

12.7.2: Termination Notification Requirements

Updated, in accordance with APL 25-002 and 25-016 and in boldface and strikethrough type, the following item number describing the threshold language requirements for member materials:

4. Member notices must be sent in the members' preferred language within the threshold language requirements for each county, in accordance with **APL 25-005**~~21-004~~. Blue Shield Promise will provide the IPA/medical groups with letter templates and enclosures, all translated in the threshold languages. Alternative format selection for members with

visual Impairments or other disabilities requiring provisions of written materials in alternative formats must also be available upon request, in accordance with **APL 25-016**~~22-002~~.

Section 14: Claims

14.1: Claim Submission

14.1.1: Payment Policy

Added this sub-section, which describes how to access Blue Shield Promise's adopted payment policies for Medi-Cal provider types.

14.6: Delegation Oversight Claims

Updated, in boldface and strikethrough type, the following language referring providers to Appendix 3: Delegation of Claims Processing Responsibilities and Appendix 8: Delegation Requirements for Claims and Newly Contracted Provider Training for delegation requirements:

Please see Appendi**ces**~~x~~ **3: Delegation of Claims Processing Responsibilities and** 8: Delegation Requirements for Claims and Newly Contracted Provider Training requirements for Blue Shield Promise's Delegated Entity/Specialty Health Plans.

Section 15: Financial

15.1: Financial Analysis

Updated, in boldface and strikethrough type, the following 2 bullet points in a list of grading criteria that must be included in DMHC filing submissions:

- **Claims** Incurred but Not Reported ~~Claims~~ (IBNR)
- **Claims Timeliness Percentage**

Updated, in boldface type, the following bullet point in a list of filing schedules that DMHC Filing Schedules should include:

- Schedule B – **Unsecured Affiliated** Receivables **(Normal Course of Business)**.

Added the following bullet point in a list of items that Annual Financial Statements should include:

- Supporting Documentation requested for the annual reviews.

Updated, in boldface and strikethrough type, the following paragraph discussing corrective action plans arising from failure to comply with Solvency Regulations:

Failure to comply with the Solvency Regulations, L.A. Care financial solvency contractual obligations, and submission of DMHC filing**,** ~~and~~ financial statements **and supporting documentation** timely to BSCPHP may require entities to submit a corrective action plan to correct any ~~financial solvency~~ deficiencies.

15.2: Capitation Payments

Updated throughout this entire sub-section explaining the capitation process and timelines.

15.3: Medical Loss Ratio Requirements for Subcontractors and Downstream Contractors

Updated, in boldface and strikethrough type, the following language discussing the due dates for the Annual Medi-Cal Medical Loss Ratio Annual reports:

The due dates for the Annual Medi-Cal Medical Loss Ratio Annual reports ~~will be~~ **are**

communicated by Blue Shield Promise upon receipt **of the request** from the Department of Health Care Services (DHCS).

All reports **and any requested supporting documentation** should be returned to ProviderSolvency@blueshieldca.com or as otherwise directed by Blue Shield Promise.

Section 17: Culturally and Linguistically Appropriate Services (CLAS)

17.1: Blue Shield Promise Health Plan and Subcontractor's Responsibility in the Provision of CLAS

Updated, in boldface and strikethrough type, the following name change of the CLAS area that Blue Shield Promise Health Plan will be responsible for:

21. Maintaining a committee that oversees Health ~~Equity Accreditation~~**Outcomes Accreditation (formerly Health Equity Accreditation)** and CLAS oversight and approve related documentation. Blue Shield Promise members will serve as active committee members.

Appendices

Appendix 1: Delegation of Utilization Management Responsibilities

Updated numerous cells in the "Delegation of Utilization Management Responsibilities" Table which charts delegated UM activity, IPA/medical group responsibility, Blue Shield Promise responsibility, reporting frequency, performance evaluation and corrective action plans.

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 8: Delegation Requirements for Claims and Newly Contracted Provider Training

Definitions

Updated, in strikethrough type, the following sentence as part of the definition of a "Delegated Entity/Specialty Health Plan:"

…"Delegated Entity/Specialty Health Plan" describes any party (Medical Group, IPA, Restricted/Limited Knox Keene Plan etc., ~~or for example Vendor for Vision Care~~) who enters into a legal agreement by which an organization gives another entity the authority to perform certain functions on its behalf…

Audits and Audit Preparation

Updated this sub-section, which details the process for audits of claims and provider disputes, the requirement for the Delegated Entity/Specialty Health Plan to participate in submitting documents through the HICE Claims Operational Questionnaire Repository and the procedures for the annual audit for Newly Contracted Provider Training Material oversight.

Date Stamping

Updated, in boldface type, the following sentence about processing Electronic Data Interchange (EDI) claims:

This would also apply to Electronic Data Interchange (EDI) claims. **The delegated entities need to submit the 837 files specifically related to the claims sample selection that provides the raw data information for validation.**

Payment Accuracy

Updated, in accordance with DMHC APL 25-007/AB 3275, this entire sub-section with information regarding claims interest processing and accrual.

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

- Payment methodology via remit message code for both paper and EDI EOB/EOP/RA.

Updated paragraphs within the "Corrective Action (CAP)/Follow Up Audits" sub-section, which has information about the annual claims and PDR audit, non-compliant annual audit, follow-up audit, required reports submitted as oversight to ensure compliance, monitoring and remediation.

Claims Function and Support Oversight

Updated, in boldface type, the following bullet point in list of internal controls that Delegated Entity/Specialty Health Plans use to ensure claims processes are monitored for integrity and security:

Delegated Entity/Specialty Health Plan shall implement **internal** controls to ensure claims processes are monitored for integrity and security to protect claims from being altered by unauthorized personnel.

- **Delegated Entity/Specialty Health Plan shall not allow a conflict of interest that may affect the claims process end to end. e.g. separation of duties within the organization including but not limited to authority to approve or deny claims once it has been finalized.**

Newly Contracted Provider Training Oversight Audit

Updated, in boldface and strikethrough type, the following two bullet points in list of items that the New and Biennial training includes:

- ~~Diversity, equity, and inclusion training (sensitivity, diversity, communication skills, and cultural competency training) as specified in DHCS Medi-Cal Managed Care Boilerplate Contract Exhibit A, Attachment III, Subsection 5.2.11.C (Diversity, Equity, and Inclusion Training).~~
- **Biennial training is a DHCS requirement that is based upon your organization's contract effective date**

Updated large section of language with information about providers' requirement to provide evidence of having attended both Newly Contracted Provider and Biennial training. This section also discusses providers accessing training and attestation of training.

Updated, in boldface type, the following bullet points within a list of areas where if the Delegated Entity/Specialty Health Plan is found to be non-compliant, a CAP will be requested:

- **Biennial provider training was not timely or did not occur**
- Unable to provide evidence that a newly contracted provider was trained **or a biennial training provider training was completed**

Updated, in boldface type, the following sentence explaining the CAP process for non-compliance with the training requirement:

Note: Related to the Newly Contracted Provider Training **or Biennial Training** audit**s** no preliminary audit results will be provided. The auditor will provide the final overall audit results of met or not met.

Claims Delegate Reporting Instructions

Updated the Report Naming Convention, which details the naming convention for reports.

Appendix 12: Utilization Management Timeliness Standards

Changed timeline for a decision from 5 working days to 7 calendar days in multiple cells.

Appendix 13: HEDIS Guidelines

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