3840 Kilroy Airport Way
Long Beach, CA 90806

July 25, 2025

Subject: **Notification of October 2025 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 October 1, 2025.

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 October 2025 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,

Aliza Arjoyan
Senior Vice President
Provider Partnerships and Network Management

Section 3: Benefit Plans and Programs

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

3.3.1: Community-Based Adult Services (CBAS)

3.3.1.1: Accessing CBAS

Added the following language explaining a provider's responsibility to submit a CBAS Treatment Authorization Request (TAR) Form when it is believed that a member needs CBAS:

A provider who believes a member needs CBAS should complete a CBAS Treatment Authorization Request (TAR) Form, and along with required documentation, submit it to Blue Shield Promise MLTSS/Long-Term Care Department for review, or fax it to (855) 699-9876 (Los Angeles County) or (619) 219-3308 San Diego County. For questions, please call Blue Shield Promise at (855) 622-2755. This TAR form(s) can be accessed on the Blue Shield Promise provider website in the Forms section.

3.3.2.1: Accessing LTC Services

Updated language to note that when submitting an authorization request for long-term care, the documents listed in this section are **required** to be submitted in order to request an initial approval.

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

Added, in accordance with APL 25-002, this new sub-section, detailing the SNF WQIP payments to SNFs who meet performance and quality requirements.

3.7: Community Health Worker

Updated, boldface type, the following paragraph discussing the responsibilities of a provider supervising a community health worker (CHW):

Supervising Provider Requirements and Qualifications

A supervising provider is an enrolled Medi-Cal provider employing or otherwise overseeing the CHW, with whom Blue Shield Promise contracts. The Supervising Provider ensures that CHWs meet the qualifications listed above, oversees CHWs and the services delivered to Blue Shield Promise members, **tracks and submits data required for reporting**, and submits claims for services provided by CHWs. The supervising provider must be a licensed provider, pharmacist, a hospital, including the emergency department, an outpatient clinic, a local health jurisdiction (LHJ), or a community-based organization (CBO).

Added, to the CPT/HPCS chart, HCPCS codes G0019 and G0022 to align with the updated Medi-Cal Provider Manual for the CHW, released by DHCS for April 2025.

Added billing criteria for newly added HCPCS codes G0019 and G0022 to align with updated Medi-Cal Provider Manual for the CHW, released by DHCS for April 2025.

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

Deleted and ***replaced*** the following section:

Non-Specialty Mental Health Services Access

Blue Shield Promise members may access Non-Specialty Mental Health Services (NSMHS) directly via our no wrong door policy. No prior authorization is required for evaluation or treatment of a mental health condition. PCPs, specialty providers, County Departments, Community Based Organizations, and case managers are welcome to refer members to the Blue Shield Promise network. The completed Medi-Cal Member Social Services and Mental Health Referral Form, which can be accessed on the Blue Shield Promise provider website at www.blueshieldca.com/en/bsp/providers in the *Forms* section, should be emailed to Blue Shield Promise at MediCalmentalhealth@blueshieldca.com, or faxed to (323) 889-2109 (Los Angeles County) or (619) 219-3320 (San Diego County). The Blue Shield Promise Social Services team is available Monday through Friday from 8 a.m. to 5 p.m. for NSMHS coordinated access to our network of NSMHS providers by phone at (877) 221-0208.

Added the following paragraph regarding a member that requires a higher level of care:

County Behavioral Health Transition of Care Tool

Blue Shield Promise understands the importance of coordinating care for our members. If a Medi-Cal member requires a higher level of care, refer to Section 7.9.8 Specialty Mental Health Services (Medi-Cal Managed Care) of this manual. All NSMHS providers are required to complete a Transition of Care Tool for Medi-Cal Mental Health Services.

Added the following paragraph regarding frequency limits for psychological testing and Neuropsychological testing:

Frequency Limits

DHCS has frequency limits for psychological testing and neuropsychological testing. NSMHS providers should refer to the guidance published by the DHCS at Non-Specialty Mental Health Services: Psychiatric and Psychological Services.

Section 5: Enrollment

5.8: Eligibility Verification

Updated language indicating that a self-service feature to check member eligibility is available to providers after they log into their account on Provider Connection.

Section 7: Utilization Management

7.1: Utilization Management Program

7.1.2: UM Reporting Requirements for IPA/Medical Groups

Deleted and ***replaced*** the following criterion for sending authorization logs to Blue Shield Promise:

Approval/denial data files: ("Authorization Logs") must be delivered in the IPA9 file layout via the Provider Connection Portal at www.blueshieldca.com/providerwebapp/authorization/IPAFileUpload. Providers must be registered on Provider Connection to view this page. If an IPA/medical group is currently submitting logs via IPA10 format, no changes are required.

7.1.3: Organization of Health Care Delivery Services

Updated all references to "Western Drug Medical Supply" to "Stance Health Solutions (formerly Western Drug Medical Supply)" in the Durable Medical Equipment Provider section.

7.1.5: UM Review Process for Appropriateness of Care

Changed all instances of MCG (Milliman Care Guidelines) 25th edition to MCG 27th edition.

7.4: Primary Care Physician Scope of Care

7.4.3 Child Health and Disability Prevention Program (CHDP)

Updated the following lists of tests that a CHDP physical examination should include per the AAP/Bright Futures Periodicity Schedule.

- Risk assessment screening for tuberculosis with tuberculin tests if risks are identified
- Risk assessment screening for anemia and Hepatitis B, with testing if warranted

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

7.9.4: Comprehensive Perinatal Services Program (CPSP)

Updated, in accordance with AB 1936, the following chart with recommended intervals for routine tests for pregnant patients, in strikethrough and bold-face type:

Time (Weeks Gestation)	Assessment / Service
Initial (as early as possible)	• ~~Maternal~~ **Assembly Bill 1936 (AB 1936) requires at least one maternal** mental health screening ~~completed at least once~~ during the pregnancy
Initial Postpartum: –within 3 weeks following delivery AND Follow-up Comprehensive visit no later than 12 weeks after birth	Physical exam to include: **14. AB 1936 requires** ~~Screening for~~ maternal mental health **screening to be conducted during the** ~~completed within the~~ first six (6) weeks of the postpartum period**, and additional postpartum screenings, if determined to be medical necessary and clinically appropriate.**

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

7.9.6: Sensitive Services

Deleted *and* ***replaced*** language under the heading **Outpatient Mental Health Care for Children** with the following:

Non-Specialty Mental Health Services for minors 12 years of age or older

Minors 12 years of age or older may consent to non-specialty outpatient Medi-Cal mental health treatment or counseling if, in the opinion of the attending professional person, the minor is mature enough to participate intelligently in the outpatient services. For more information please follow the guidance outlined in APL 24-019.

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

Added the following list of inpatient and specialty outpatient mental health services that are carved-out of the Blue Shield Promise Medi-Cal benefit agreement:

1. Mental health services (assessments, plan development, therapy, rehabilitation, and collateral)

2. Medication support services
3. Day treatment intensive services
4. Day rehabilitation services
5. Crisis intervention services
6. Crisis stabilization services
7. Targeted case management services
8. Therapeutic behavioral services
9. Adult residential treatment services
10. Crisis residential treatment services
11. Acute psychiatric inpatient hospital services
12. Psychiatric inpatient hospital professional services
13. Psychiatric health facility services

Section 9: Quality Improvement

9.1: Quality Improvement Program

9.1.1: Program Structure Governing Body

Updated, in strikethrough and boldface type, the following sentences explaining the process to delegate utilization management (UM), credentialing, and/or claims functions:

Delegation Oversight Committee (DOC)

…A pre-delegation assessment is conducted ~~within 12 months of~~**prior to** implementing a delegated relationship, to assess the entity's ability to perform the proposed delegated functions

9.5: Initial Health Appointment (IHA)

Updated, in compliance with APL 24-008 and in boldface type, the following bullet point in list of services that an IHA must include:

- Immunizations as recommended by ACIP and CDC schedules and reported to the California Immunization Registry (CAIR) within 14 **calendar** days of administration.

9.7: Medical Records

9.7.3: Medical Record Review Categories

Updated, in boldface type, the following item in list of documentation criteria for medical record review:

F. All entries are signed, dated, and legible. **(All documentation must be in English, and Non -English proficient forms must have the English form available on site or in each record.)**

9.8: Access to Care

9.8.1: Monitoring Process

Added the following language to comply with APL 25-006 Timely Access Requirements:

DHCS Timely Access Requirements

As part of DHCS's network adequacy monitoring, DHCS reviews Blue Shield Promise's performance with timely access standards by administering a quarterly Timely Access Survey. The rate of compliance is assessed on a quarterly and annual basis during each Measurement Year and the annual results are posted publicly and included in the Annual Network Certification that is submitted to CMS in accordance with 42 CFR Section 438.207(d).

DHCS uses a third-party vendor to administer their quarterly Timely Access Survey. The Timely Access Survey uses Blue Shield Promise's Medi-Cal Managed Care 274 Provider Network file (274 Provider file) data and a statistical sampling methodology to identify provider locations for the practicing providers surveyed. The survey administrator contacts provider offices, Blue Shield Promise's Member Services lines, and nurse triage lines throughout the year to assess compliance standards. Provider offices are asked to confirm the next available appointments to collect appointment wait times, including accessibility through telehealth services. Provider offices are also asked to respond to questions related to knowledge of patients' rights to translation and interpretation services. Additionally, to validate Blue Shield Promise's 274 Provider file data, provider offices are asked to confirm information including but not limited to: each provider's telephone number, address, office hours, and whether the provider is accepting new patients.

Blue Shield Promise Member Services staff are asked to respond to questions related to translation, interpretation, and telehealth services. DHCS also verifies wait times for the Blue Shield Promise Member Services line and nurse triage line through their Timely Access Survey. DHCS provides the results to Blue Shield Promise each quarter and compiles the quarterly results into an annual result provided to Blue Shield Promise by the second quarter of the subsequent Measurement Year.

Added a Minimum Performance Level (MPL) chart to this section which lists timely access MPLs effective January 1, 2025 for the following categories: appointment wait times, MCP Member Services wait times, Provider knowledge of the interpretation services requirements, and 274 Provider file data quality.

9.14: Quality Improvement and Health Equity Transformation Program

9.14.3: Continuous Quality Improvement

Added a link to APL 23-001 at www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-001.pdf . This APL supersedes APL 21-006 for established standards for time or distance, timely access, and alternative access

9.14.7: Network Provider Training

Updated language to indicated that the mandated Network Provider DEI training program is outlined in APL 24-016 which can be accessed online at www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL%202024/APL24-016.pdf. Those required to complete the *Advancing Health Equity* course will receive an email notification with a link to register for and complete the course.

Section 10: Pharmacy and Medications

10.2: Specialty Pharmaceuticals

Updated, in boldface type, the following item in list of procedures for specialty

pharmaceuticals:

3. If additional information is needed to make a final determination, the **Blue Shield Promise** Pharmacy Department will send a request to the prescribing physician or the primary care physician. Pharmacy personnel will adhere to the HIPAA minimum necessary information requirements. **The Blue Shield Promise Pharmacy Department will also notify the patient that the request is pending additional information from the prescribing physician.**

Section 14: Claims

14.1: Claims Submission

Added a link to the Blue Shield Promise portal at www.blueshieldca.com/en/provider/claims/how-to-submit for instructions on how to submit paper claims via SimpliSend.

Section 15: Financial

15.3: Medical Loss Ratio Requirements for Subcontractors and Downstream Contractors

Updated, in boldface type, the following paragraph discussing financial reporting requirements:

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

Section 17: Culturally and Linguistically Appropriate Services (CLAS)

Added language describing the ability to receive language assistance interpreting services via the internet or video remote interpreting (VRI) services. VRI services must comply with federal quality standards.

17.3: Access to Free Interpretation Services

Added the following language describing the requirement to provide free interpretation services:

To comply with the Americans with Disabilities Act, Blue Shield Promise and its subcontractors must ensure that all hard-of-hearing members with a speech disability will have access to free interpretation services whether through a video remote interpreting service, an on-site appearance, or through other methods that ensure communication, including assistive listening. Blue Shield Promise will make reasonable modifications to policies, practices, or procedures when such modifications are necessary to avoid discrimination based on disability.

Updated, in strikethrough and boldface type, the following language describing interpreter services:

1. Blue Shield Promise and its subcontractors must not require or suggest that **members with LEP**, hard-of-hearing, or deaf members provide their own interpreters, **pay for the cost of their own interpreter**, ~~or~~ use family members or friends as interpreters, **or rely on staff who are not qualified interpreters or qualified bilingual/multilingual staff**. The use of such persons may compromise the reliability of medical information and could result in a

breach of confidentiality or reluctance on the part of beneficiaries to reveal personal information critical to their situations. Minors should not interpret for adults. **An adult not qualified as an interpreter or minor child accompanying an LEP member may be used only in the following situations:**

- **As a temporary measure when there is an emergency involving an imminent threat to the safety or welfare of the members of the public and a qualified interpreter is not immediately available**
- **If the LEP member specifically requests that an accompanying adult interpret or facilitate communication. This request must be done in private with a qualified interpreter present and without an accompanying adult present. Additionally, the accompanying adult must agree to provide that assistance, the request and agreement are documented, and reliance on that accompanying adult for that assistance is appropriate under the circumstances.**

Bilingual/multilingual staff may be used to communicate directly with members with LEP only when they have demonstrated that they meet all of the qualifications of a qualified bilingual/multilingual interpreter.

17.3.2: Proficiency of Interpreters

Added a definition and required criteria for a Qualified Interpreter.

17.4: Cultural Competency and Health Equity Training

Added language detailing the commitment to implement and maintain the mandatory diversity, equity, and inclusion (DEI) training program and requirements set forth by APL 24-016. This language also discusses providers' requirement to complete this training.

17.5: Translation of Member-Informing and Health Education Materials

Updated language throughout this section, to comply with APL 25-005, describing the responsibility of Blue Shield Promise and the IPA/medical group to provide culturally and linguistically appropriate materials to members in the threshold languages and in alternative formats. This responsibility includes providing appropriate auxiliary aids and services for members with disabilities and companions with disabilities.

Appendices

Appendix 4: Access to Care Standards

Added a chart for the DHCS timely access survey, categorizing "Provider Type," Appointment Type" and "Timely Access Standard."

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

Removed all Compliance and IT Systems Security Integrity language from Appendix 8 and moved to Appendix 15.

Audits and Audit Preparation

Updated, in strikethrough and boldface type, the following paragraph detailing the requirement to provide the Delegated Entity/Specialty Health Plan with written audit results:

Blue Shield Promise will provide the Delegated Entity/Specialty Health Plan with written audit results within ~~10 business~~**30 calendar** days **from the scheduled audit date,** including an itemization of any deficiencies and whether or not the Delegated Entity/Specialty Health Plan

must prepare and submit a formal, written corrective action plan (to be on BSCPHP template provided by the auditor) to include root cause, remediation, and evidence of remediation within ~~10 business~~**30 calendar** days of receipt of audit results. If supporting documentation/evidence is not provided the CAP will be closed as non-compliant.

Payment Accuracy

Updated, in strikethrough and boldface type, the following paragraph explaining a Delegated Entity/Specialty Health Plan submission of response to corrective action plan:

Blue Shield Promise's corrective action plan requires a Delegated Entity/Specialty Health Plan to submit by the date indicated (~~10 business~~ **30 calendar** days) from audit result letter. Blue Shield Promise will review and provide a response to corrective action plan. If the CAP is not accepted, the Delegated Entity/Specialty Health Plan has ~~five (5)~~ **10** business days to submit a second CAP response. If the delegated entity remains non-compliant after two CAPs have been submitted and/or no response to CAP **has been submitted**, the delegated entity will be escalated to the Delegation Oversight Committee (DOC).

Claims Delegate Reporting Instructions

Updated, in boldface type, the following chart that details instructions for claims delegate reporting:

Designated Principal Officer	
Who Can Sign:	Results for the quarter must be attested to **and** ~~/~~signed by a Designated Principal Officer **not a signature via snipping tool or typing name on document. A physical signature or computer-generated signature (must be DocuSign to include date and time) from the designated principal officer is mandatory**~~.~~ The person attesting to the accuracy and completeness of the report must be an executive of the organization, Vice President level of above.

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

Deleted and ***replaced*** Appendix 14, which details the capitation agreement with the durable medical equipment (DME) provider, which is now "Stance Health Solutions (formerly Western Drug Medical Supply)." Provider information was updated, following the DME provider merger and name change. The old table was replaced with a new table to include updates specific to inclusion of some items as both rental or purchase, under the capitation agreement.

Appendix 15: Delegation Requirements for Compliance Program and IT System Security Integrity

Removed Compliance and IT Systems Security Integrity language from Appendix 8 and created Appendix 15 therefrom. Appendix 15 details the process for conducting compliance oversight and monitoring of our contracted Delegated Entities, Specialty Health Plans, MSOs, and IPAs.

Delegation Oversight Compliance Program and IT Systems Security Monitoring and Review

Updated language detailing the requirement to provide the Delegated Entity/Specialty Health Plan/IPA/MSO with written results within **30** days. The timeframe was previously 10 business days.

Blue Shield Promise's Delegation Oversight team will provide the Delegated Entity/Specialty Health Plan/IPA/MSO with the written results from the monitoring within **30** business days

from the first date of the review. The results will include an itemization of all reviewed program elements that were met and not met (deficiencies).

Any deficiencies that were identified will require the Delegated Entity/Specialty Health Plan/IPA/MSO to provide a written corrective action plan (on the Blue Shield Promise CAP template provided by the auditor) and must include root cause and remediation plan, for each deficiency listed on the CAP template within **30** business days of receipt of audit results. If not, the CAP review will be closed as non-compliant, and the delegated entity/specialty health plan will be escalated to the Delegation Oversight Committee for being non-compliant.

While a Delegated Entity/Specialty Health Plan may contract with an MSO/IPA to manage certain functions on its behalf, the Delegated Entity/Specialty Health Plan that holds the contract with Blue Shield Promise is responsible for the performance and compliance of the MSO/IPA. This includes all deficiencies captured during these monitoring activities.

Specific to the IT Security Systems reviews, Blue Shield Promise may conduct a walk-through of the Delegated Entity's/Specialty Health Plan/IPA/MSO's operations to ensure the remediation was effective and compliant.

Compliance Program Monitoring and Annual Review

Updated the email address where requested documents from the Compliance Audit Evidence Grid must be submitted to: bscandphp_docpemonitoring@blueshieldca.com

Corrective Action Plan (CAP) Process (if applicable)

Deleted and ***replaced*** the following section:

A corrective action plan will be required for each compliance element found to be non-compliant.

The Delegated Entity/Specialty Health Plan/MSO/IPA will have **thirty (30) business days** to submit a CAP response. The remediation plan must include the following:

- The root cause of the deficiency
- A detailed remediation plan
- A target date for completion/implementation
- Responsible person(s) for implementation and ensuring continued compliance

If the CAP is not accepted, the Delegated Entity/Specialty Health Plan/MSO/IPA will have fifteen (15) business days to submit a second CAP response. After two (2) noncompliant CAP submissions and/or Delegation Oversight has not received a response to the CAP request, the delegated entity/Specialty Health Plan/MOS/IPA will be escalated to the Delegation Oversight Committee (DOC) for recommendations.

Note: No preliminary results will be provided. The final overall review results notice will either have a met or not met score.

A follow-up review will be conducted to ensure all agreed upon remediation plans have been implemented and are effective. The review may be conducted remotely, via on-site visits, scheduled meetings, and focal audits.