From: DMHC Licensing eFiling

Subject: DMHC Provider Directory filing and FAQs

Date: Friday, April 15, 2016 4:31:00 PM

Attachments: Provider Directories-Frequently Asked Questions.pdf

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Good afternoon,

This email is being sent to all health care service plans to provide additional clarification relating to provider directories and compliance with Health & Safety Code Section 1367.27, as enacted by Senate Bill 137 (Hernandez, 2015). Please note, the date by which a plan mustsubmit a “Section 1367.27 Compliance” filing has been extended, and should be submitted through the Department’s eFiling web portal no later than **May 6, 2016**. Additionally, pleasefind attached Provider Directories-Frequently Asked Questions provided as additional guidance for use in preparing the required compliance filing, noting that additional information may be requested by the Department within the course of reviewing a plan’s filing.

If you have any questions regarding this communication, please contact Mahavir Jogani, Attorney, Office of Plan Licensing, at (916) 445-4565 or Mahavir.Jogani@dmhc.ca.gov.

Thank you.

FREQUENTLY ASKED QUESTIONS

FOR HEALTH CARE SERVICE PLAN FILINGS RELATING TO PROVIDER DIRECTORIES

In preparation for health care service plan filings in relation to the provider directory requirements of Health & Safety Code Section[1] 1367.27, as enacted by Senate Bill 137 (Hernandez, 2015), the Department of Managed Health Care (the "Department" or "DMHC") offers the following Frequently Asked Questions ("FAQs") to accompany the information in the "Checklist and Worksheet" already distributed to healthcare service plans on March 16, 2016.

1. **What are the filing obligations of a Medicare Advantage or Medicare Advantage Part Dhealth care service plan?**

   A: If a Plan is solely limited to the Medicare Advantage market and has no other lines ofbusiness filed with the Department, that Plan would not be required to submit the provider directory compliance filing.

2. **If a printed copy of a Plan's provider directory or directories is requested, must the *entire***

   provider directory be provided?

   A: A Plan may limit requests for printed copies of its' provider directory or directories tothe geographic region in which the requester resides or works or intends to reside or work, consistent with Section 1367.27(d)(1).

3. **If Plan 1 subcontracts with Plan 2 to provide services to its enrollees, can Plan 1'sprovider directory link to or direct consumers to Plan 2's provider directory?**

   A: Yes, so long as Plan 2 is also a Knox-Keene licensee. Both Plans should ensure that their filings are consistent with one another, including complementary policies and procedures which address provider directory coordination and making any necessary revisions to existing plan-to-plan contracts. The same coordination would be required for both the online and printed versions of each Plan's provider directory or directories.

[1] Hereinafter referred to as "Section".

4. **Does SB 137 require plans to delay a providers' payment or reimbursement?**

   A: No, delayed payment or reimbursement is permissive, and Plans may choose whether toimplement these measures consistent with Section 1367.27(p) and other provisions of the Knox-Keene Act, including the Providers' Bill of Rights.

5. **Can a Plan delegate the annual or biannual provider outreach and verification processdescribed in Section 1367.27(l)?**

   A: Yes, delegation of the process described in Section 1367.27(l) can be delegated, subject to proper oversight by the Plan to ensure compliance. Any delegation of responsibilitiesmust be documented in written contract consistent with Sections 1367.27(l) and (n).

6. **What information should be listed in a plan's provider directory or directories for thefacilities listed in Sections 1367.27(h)(8)(E) and (F)?**

   A: For purposes of initial compliance, and subject to the Department's adoption of the uniform provider directory standards described in Section 1367.27(k), a Plan's providerdirectory or directories should, at a minimum, list the following facility information:

   - Name and type;
   - Location and contact information, including hours of operation;
   - National Provider Identifier number (at least one listing per location);
   - Affiliation(s) with a provider group, as defined by Section 1367.27(w);
   - Whether the facility is accepting new patients, unless the facility provides urgent oremergency health care services and is always accepting new patients; and
   - Network tier as described in Section 1367.27(h)(12), if applicable.

7. **Does a Plan have to treat all reports of inaccuracies or reports relating to its providerdirectory as grievances?**

   A: Not all reports relating to a Plan's provider directory or directories must be treated as agrievance, but enrollee reports of inaccuracies should be screened to identify whether the issue meets the definition of a grievance under Rule 1300.68 and should be handledas such. For example, if an enrollee claims to have reasonably relied on a Plan's provider directory and as a result suffered an adverse event, such as an unexpected bill for out-of-network services, this would constitute a grievance under Rule 1300.68. As such, Plans should clarify in their compliance filing their process for handling all reports received relating to provider directories.

8. **What changes are plans required to make to provider contracts?**

   A: Plans should ensure all provider contracts meet the requirements of Section 1367.27(j)(1). Plans should also ensure the requirements of Section 1367.27(n) are met,as applicable. A Plan may file template versions of provider agreements or amendments for review. Plans should specify in the Exhibit E-1 what contractual changes were made, how they were made, and when each agreement was or is anticipated to be finalized, and the Department will issue comments and/or seek affirmations as appropriate. Plans should also specify any changes made to provider manuals or policies.

9. **Are there any providers under contract with the plan that should not be listed in a plan'sprovider directory?**

   A: Section 1367.27 requires a Plan to publish and maintain a provider directory or directories with information on all contracting providers. A Plan should clearly indicatein Exhibit E-1 of the compliance filing if a provider is under contract with the Plan and is not listed in the Plan's provider directory or directories, providing the reasoning for not listing the provider. The Department will evaluate the Plan's justification for excluding the provider.

10. **Can the compliance obligations of a limited licensee or restricted licensee be clarified?**

    A: Plans with a limited or restricted Knox-Keene license should coordinate compliance with Section 1367.27 with each full-service plan they are contracted with. Plans shouldensure that their compliance filings are submitted consistent with one another, includingcomplementary policies and procedures which address provider directory coordination and making any necessary revisions to existing plan-to-plan contracts. Because full- service Plans are required to publish and maintain a provider directory or directories, but are in contract with the limited or restricted licensees, both the full-service and the limited or restricted Plans should additionally specify how provider information is communicated to ensure directory accuracy and timely updating.

11. **Can a Plan's provider directory or directories include disclaimers?**

    A: In addition to the disclosures required by Section 1367.27(g), a Plan's provider directory or directories may note that prior authorization or referral may be required toaccess certain providers. Information regarding how to obtain prior authorization or referral should be included in the provider directory. Furthermore, Plans may include information regarding the date of the most recent weekly or quarterly update. Taking into account the language and intent of Sections 1367.27(a) and (q), Plans should not have a disclaimer or similar language which in any way cautions against the ability to reasonably rely upon the Plan's provider directory or directories.

Please note that the above FAQs are not an exhaustive list of all inquiries pertaining to provider directory requirements received by the Department. Please direct further questions regarding compliance with Section 1367.27 to Mahavir Jogani, Attorney, Office of Plan Licensing, at Mahavir.Jogani@dmhc.ca.gov or (916) 445-4565.