From: DMHC Licensing eFiling

To: Candee_Bolyog@glic.com; mbhatia@accessinc.net; scastro@acngroup.com; dan.rhodes@ah.org; AndersonMV@aetna.com; andersonmv@aetna.com; lyle.honig@aidshealth.org; MLevin@alamedaalliance.org; MLevin@alamedaalliance.org; dmaroney@ahcusa.com; RobertW@ashn.com; dlagarzamd@gmail.com; dmccash@humana.com; matthew.morgan@aspirehealthplan.org; jfung@familycarecard.com; matthew@avantehealth.com; joel.criste@canopyhealth.com; terry.german@wellpoint.com; terry.german@wellpoint.com; jmoser@btmg.com; sjcasey@caldental.net; christy.k.bosse@healthnet.com; kathleen.lynaugh@blueshieldca.com; JLui@care1st.com; JLui@care1st.com; Tam.Rossini@caremore.com; ahsu@centralhealthplan.com; awarre@chgsd.com; cdobry@CCHPHMO.COM; tlee@tinkinlee.com; lorna.villacarlos-mora@cigna.com; lorna.villacarlos-mora@cigna.com; william.jameson@cigna.com; JLorge@communitymedical.org; awarre@chgsd.com; cecile_currier@concern-eap.com; stan.andrakowicz@smilebrands.com; ptanquary@hsd.co.contra-costa.ca.us; ptanquary@hsd.co.contra-costa.ca.us; TBrigham@dhs.lacounty.gov; Dee.Pupa@ventura.org; rsekaran@healthcarepartners.com; smithc@interdent.com; mhankinson@delta.org; Irma.Kato@uhc.com; mfenton@dentalhealthservices.com; LMitchel@sheppardmullin.com; Phillip.Bisesi@wellcare.com; bweir@empathia.com; slawrence@envisionrx.com; LKeeley@opticare.net; JSwartz@EPICLP.com; lisenhar@luxotticaretail.com; jkemper@firstdentalhealth.com; robert.patton@firstsightvision.net; mwright@maciasconsulting.com; mbcorrado@calvivahealth.org; mmyers@gemcarehealthplan.com; scanyon@gsmhp.com; terry.german@wellpoint.com; peggy.wagner@rfl.com; douglas.a.schur@healthnet.com; douglas.a.schur@healthnet.com; ashin@hpsj.com; teresa.jordan@healthspring.com; jkurian@hdmg.net; marcuss@holmangroup.com; jgluzman@magellanhealth.com; dmccash@humana.com; mayer-r@iehp.org; ccollins@wilkefleury.com; mayer-r@iehp.org; rbolding@ivhp.com; wnippe@ndbltd.com; deborah.espinal@kp.org; Carl.Breining@khs-net.com; Carl.Breining@khs-net.com; deborah.espinal@kp.org; sgoby@lacare.org; gvieth@lhp-ca.com; drn@libertydentalplan.com; Ahaydel@lacare.org; jgluzman@magellanhealth.com; candee_bolyog@glic.com; Larry.X.Tallman@healthnet.com; gmarch@marchvisioncare.com; JA91913@gmail.com; DMHCCorrespondence@mesvision.com; Mohit.Ghose@molinahealthcare.com; Mohit.Ghose@molinahealthcare.com; kgoldstein@mhealth.com; ekunz@onlok.org; troady@caloptima.org; maya@hioscar.com; Egibboney@partnershiphp.org; Brian.Douglas@pihhealth.org; twong@premiereyecare.net; CParkins@mwe.com; lhutchins@nammcal.com; LMitchel@sheppardmullin.com; smitha.dante@providence.org; cmcelroy@metlife.com; nmaruyama@sfhp.org; nmaruyama@sfhp.org; ashin@hpsj.com; ian.johansson@hpsm.org; ian.johansson@hpsm.org; rhudson@cencalhealth.org; ctomcala@scfhp.com; georgette.cook@vhp.sccgov.org; ctomcala@scfhp.com; dcarlson@ccah-alliance.org; abrag@satellitehealth.com; nmonk@scanhealthplan.com; Pantovic.Linda@scrippshealth.org; DThompson2@memorialcare.org; melissa.cook@sharp.com; sarah.doyle@caremark.com; christina.suggett@simnsa.com; sptacnik@affinitymd.com; LachanG@sutterhealth.org; JRStJohn@swbf.net; jennifer.d.thompson@optumhealth.com; Fred.Cook@assurant.com; elizabeth.hays@uhc.com; laurie.laspina@ucci.com; Elizabeth.Hays@uhc.com; melissa_k_stout-penn@UHC.com; jeffdavis@universalcare.com; sheree.marzka@beaconhealthoptions.com; jameskeu@yahoo.com; stu@visionplanofamerica.com; stuart@vsp.com; nick.shashati@sterlingvisioncare.com; jgrant@healthadvocate.com; Phillip.Bisesi@wellcare.com; scorbin@westerndental.com; r.downing@westernhealth.com; r.downing@westernhealth.com

Cc: Jogani, Mahavir@DMHC; Pheng, Nancy@DMHC

Subject: SB 137 Annual Reporting

Date: Tuesday, November 01, 2016 4:51:00 PM

Attachments: Provider Directory Checklist - Annual Filing.pdf
Exhibit J-15 - Provider Directory Worksheet.xlsx
Exhibit II-6 - Annual Delayed Payment Report.xlsx

Dear Plan Representatives,

This message is being sent to all health plans regarding the annual reporting required by Section 1367.27, as enacted by Senate Bill 137 (2015). Please find attached the Department's Section 1367.27 Annual Filing Checklist, Exhibit J-15 Provider Directory Worksheet, and Exhibit II-6 Annual Delayed Payment Report. Please note these materials will also be available on the Department's eFiling web portal. Additionally, please note these materials will be revised prior to 2018 as necessary to ensure compliance with uniform provider directory standards developed by the Department pursuant to Section 1367.27(k). Should you have any questions regarding this message, please contact your plan's assigned licensing counsel or Mahavir Jogani, Attorney, Office of Plan Licensing, at 916-445-4565 or Mahavir.Jogani@dmhc.ca.gov.

Thank you,

Mahavir G. Jogani
Attorney
California Department of Managed Health Care

Office of Plan Licensing
980 9th Street, Suite 500
Sacramento, CA 95814
Phone: (916) 445-4565
Email: Mahavir.Jogani@dmhc.ca.gov

DEPARTMENT OF Managed Health Care

CHECKLIST FOR HEALTH CARE SERVICE PLANS
SECTION 1367.27 ANNUAL FILING (PROVIDER DIRECTORIES)

This checklist is not intended to be all-inclusive or to replace a health care service plan's obligation to comply with all requirements of the Knox-Keene Health Care Service Act of 1975, as amended.[1] *The Department of Managed Health Care ("Department") provides this checklist to assist health care service plans when preparing and submitting the filing. The Department may request additional information during its review of the filing.*

This checklist is intended to assist a health care service plan in satisfying the annual filing requirements under Section 1367.27. All health care service plans should submit the following compliance information to the Department as a **Report/Other** filing through the Department's eFiling web portal no later than **July 1st** of each year. Please use the subject field "Section 1367.27 Annual Compliance [YEAR]." The filing should, at a minimum, include the following:

Exhibit E-1, Summary of eFiling Information: Provide a brief description of the filing and Exhibits included in the filing, including the measures the Plan has established to ensure compliance with Section 1367.27. Within Exhibit E-1, please include the following information:

- ❑ The website URL for the Plan's online provider directory or directories;
- ❑ The website URL for each provider directory or directories which the Plan links or directs enrollees and consumers to in order to view contracting providers that deliver health care services to the Plan's enrollees, if any;
- ❑ The name of the Plan's vendor(s), if any, the Plan utilizes for Section 1367.27 compliance (e.g. provider outreach or verification), providing the eFiling number where the agreement was previously approved by the Department.[2] If the Plan does not currently utilize a vendor, please indicate so.
- ❑ Indicate whether the Plan has delayed payment to any providers as described in Section 1367.27(p) during the prior year. If yes, submit Exhibit II-6, Annual Delayed Payment Report, as outlined below.

Exhibit J-14, Provider Directory Policies & Procedures: File, as Exhibit(s) J-14, the Plan's current policies and procedures regarding the regular updating of the Plan's provider directory or directories as required by Section 1367.27(m).[2]

- ❑ The Exhibit J-14 should be a comprehensive document containing the Plan's provider directory policies and procedures which ensure compliance with Section 1367.27, and should at a minimum, address the following:
  - ✓ How all required provider information under Section 1367.27(h) and (i), as applicable, is accurately displayed in the Plan's provider directory or directories;

[1] California Health and Safety Code sections 1340 et seq. (the "Act"). References herein to "Section" are to sections of the Act. References to "Rule" refer to the regulations the Department promulgated at Title 28 of the California Code of Regulations.

[2] Please be advised that, in addition to providing the information required by this checklist, plans must continue to comply with all filing obligations and timeframes, including those described in Section 1352 and Rules 1300.52.

- ✓ The schedule for the regular updating of the Plan's provider directory or directories, including weekly, quarterly, and annual updates.
- ✓ How the Plan receives and verifies the accuracy of the information for each provider listed in the Plan's provider directory or directories, including how a provider can promptly verify or submit changes to their information using the Plan's online interface.
- ✓ The Plan's provider verification process, including the notification timing, content, and affirmative response requirements of Section 1367.27(l).
- ✓ The Plan's process for receiving and investigating reports of inaccurate directory information, including the methods for reporting required by Section 1367.27(m)(3).
- ✓ The Plan may, but is not required to, include diagrams or flowcharts which demonstrate compliance with Section 1367.27.

- ❑ If an Exhibit J-14 has been amended since last filed with the Department, please include both a redlined and clean version, with all changes denoted in accordance with Rule 1300.52.

- ❑ If an Exhibit J-14 has not been amended since last filed with the Department, please file a clean version of the Plan's policies and procedures.

Exhibit J-15, Provider Directory Worksheet:

- ❑ Populate and submit Exhibit J-15, available on the Department's eFiling web portal, to demonstrate compliance with Section 1367.27.

Exhibit II-6, Annual Delayed Payment Report:

- ❑ Populate and submit Exhibit II-6, available on the Department's eFiling web portal, for any provider capitation or claims payments delayed during the prior year pursuant to Section 1367.27(p). Please note this Exhibit will be automatically confidential, without any requirement that the Plan submit a Request for Confidential Treatment for this Exhibit.

- ❑ If the Plan has not delayed payment to any providers as described in Section 1367.27(p) during the prior year, this Exhibit is not required.

Please direct questions regarding this checklist to Mahavir Jogani, Attorney, Office of Plan Licensing, at Mahavir.Jogani@dmhc.ca.gov or (916) 445-4565.

Exhibit J-15: Provider Directory Worksheet

PROVIDE RESPONSES TO THE FOLLOWING TO AFFIRM COMPLIANCE WITH HEALTH AND SAFETY CODE SECTION 1367.27, AS ENACTED BY SENATE BILL 137 (2015):

	Knox-Keene Act Requirement	Plan Response (Yes, No, or N/A)	Plan's Explanation of Response (including references to Exhibits demonstrating compliance)
	General Requirements		
1	The Plan publishes and maintains a provider directory or directories for the specific network offered for each product using a consistent method of network and product naming, numbering, or other classification method that ensures the network(s) and plan product(s) in which a provider participates can be easily identified. *See* Section 1367.27(a) and (b).		
2	The Plan only lists currently contracted providers in its directory or directories and includes information on whether the provider is accepting new patients. *See* Section 1367.27(a).		
	Content Requirements		
3	Full service and specialized mental health care service plans must fill out the "§ 1367.27(h)" tab located within this Exhibit.		
4	All other specialized plans must fill out the "§ 1367.27(i)" tab located within this Exhibit.		
	Online Provider Directory		
5	An online provider directory or directories is available on the Plan's internet website. *See* Section 1367.27(c)(1).		[Please provide the website URL for the Plan's provider directory.]
6	The Plan's online directory or directories is available to the public, potential enrollees, enrollees, and providers without any restrictions or limitations. *See* Section 1367.27(c)(1).		
7	The Plan's online directory or directories is accessible through an identifiable link or tab and in a manner that is accessible and searchable by enrollees, potential enrollees, the public, and providers. *See* Section 1367.27(c)(2).		
	Printed Provider Directory		
8	A printed copy of the Plan's directory or directories can be requested by enrollees, potential enrollees, providers, and members of the public. *See* Section 1367.27(d)(1).		
9	A printed copy of the provider directory or directories can be requested via the Plan's toll-free telephone number, electronically, or in writing. *See* Section 1367.27(d)(1).		[Please provide: 1) the Plan's toll-free telephone number for requesting a printed directory; 2) the Plan's address to request a printed directory in writing; and 3) the Plan's contact for requesting a printed directory electronically.]
10	The Plan will mail a printed copy of the provider directory or directories to the requestor, postmarked no later than five (5) business days following the date of the request. *See* Section 1367.27(d)(1).		
11	The Plan's printed directory or directories contains the provider information required by Section 1367.27(h) and (i).		
	Provider Directory Updating		
12	The Plan updates the printed provider directory or directories at least quarterly. *See* Section 1367.27(d)(2).		
13	The Plan's online directory or directories is updated at least weekly, when informed of and upon confirmation that a contracting provider is no longer accepting new patients for a product, or an individual provider within a provider group is no longer accepting new patients. *See* Section 1367.27(e)(1)(A).		
14	The Plan's online directory or directories is updated at least weekly, when informed of and upon confirmation that a provider is no longer under contract for a particular plan product. *See* Section 1367.27(e)(1)(B).		
15	The Plan's online directory or directories is updated at least weekly, when informed of and upon confirmation that a provider's practice location or other information required under subdivision (h) or (i) has changed. *See* Section 1367.27(e)(1)(C).		
16	The Plan's online directory or directories is updated at least weekly, when informed of and upon confirmation that a change is necessary after completion of the Plan's investigation based on a complaint that a provider was not accepting new patients, was otherwise not available, or whose contact information was listed incorrectly. *See* Section 1367.27(e)(1)(D).		
17	The Plan's online directory or directories is updated at least weekly, when informed of and upon confirmation of a change in any other information that affects the content or accuracy of the provider directory or directories. *See* Section 1367.27(e)(1)(E).		
18	The Plan deletes provider(s) from the directory or directories upon confirmation that the provider has retired or otherwise ceased to practice. *See* Section 1367.27(e)(2)(A).		
19	The Plan deletes provider(s) from the directory or directories upon confirmation that the provider or provider group is no longer under contract with the Plan for any reason. *See* Section 1367.27(e)(2)(B).		

Exhibit J-15: Provider Directory Worksheet

PROVIDE RESPONSES TO THE FOLLOWING TO AFFIRM COMPLIANCE WITH HEALTH AND SAFETY CODE SECTION 1367.27, AS ENACTED BY SENATE BILL 137 (2015):

	Knox-Keene Act Requirement	Plan Response (Yes, No, or N/A)	Plan's Explanation of Response (including references to Exhibits demonstrating compliance)
20	The Plan deletes provider(s) from the directory or directories upon confirmation that a contracting provider group has informed the Plan that a provider is no longer associated with the provider group and is no longer under contract with the Plan. *See* Section 1367.27(e)(1)(C).		
	Reports of Inaccuracy & Plan Investigation		
21	The Plan has a telephone number and dedicated email address to receive reports of a potential directory inaccuracy. *See* Section 1367.27(m)(3).		[Please provide the Plan's telephone number and dedicated email address for reporting potential inaccuracies.]
22	The Plan has an electronic form to receive reports of a potential directory inaccuracy. *See* Section 1367.27(m)(3).		[Please provide a hyperlink to the Plan's electronic form for reporting potential directory inaccuracies.]
23	The Plan promptly investigates each time it receives a report of a potential directory inaccuracy, taking no more than thirty (30) business days to verify the accuracy of the information or update the provider directory or directories. *See* Section 1367.27(o)(1) and (j)(3).		
24	The Plan's investigation includes contacting the affected provider within five business days. *See* Section 1367.27(o)(2).		
25	The Plan documents the receipt, investigation, and outcome of each reported potential directory inaccuracy in accordance with Section 1367.27(o)(2)(B).		
26	The Plan incorporates reports of potential directory inaccuracies received from enrollees into the Plan's grievance system. *See* Section 1368 and Rule 1300.68.		
27	The Plan makes changes to provider directory information required as a result of any investigation at the next required update, or the next scheduled update thereafter as applicable to the online directory. *See* Section 1367.27(o)(2)(C).		
	Provider Verification		
28	The Plan has processes to allow providers to promptly verify or submit changes to their directory information, including an online interface. *See* Section 1367.27 (m)(2).		
29	The Plan's online interface allows providers to submit verification or changes electronically and generates an acknowledgment of receipt. *See* Section 1367.27 (m)(2).		
30	The Plan annually reviews and updates the entire provider directory or directories for each product offered, including notification to each contracted provider. *See* Section 1367.27(l)(1).		
31	Individual providers not affiliated with a provider group described in Section 1367.27(h)(8)(A), (h)(8)(B), and (i) receive notification every six months. *See* Section 1367.27(l)(1)(A).		
32	The Plan's notification to providers satisfies the content requirements of Section 1367.27(l)(2).		
33	The Plan requires an affirmative response acknowledging the notification was received, except for general acute care hospitals. *See* Section 1367.27(l)(3).		
34	The Plan requires all notified providers to confirm their directory information is current and accurate or otherwise update their directory information. *See* Section 1367.27(l)(3).		
35	The Plan takes no more than fifteen (15) business days to verify the information of a notified provider who does not respond within thirty (30) business days. *See* Section 1367.27(l)(4).		
36	If the Plan cannot verify a provider's information, the Plan notifies the provider of pending directory removal ten (10) business days prior to removal. *See* Section 1367.27(l)(4).		
37	Non-responsive providers are removed from the Plan's directory or directories at the next required update, except for general acute care hospitals. *See* Section 1367.27(l)(4).		
	Disclosures		
38	The Plan's provider directory and website prominently displays the Plan's dedicated email address and telephone number to report a potential directory inaccuracy. *See* Section 1367.27(f).		
39	The Plan's online provider directory and website prominently displays the hyperlink to report a potential directory inaccuracy. *See* Section 1367.27(m)(3).		
40	The Plan's provider directory or directories includes a statement informing enrollees that they are entitled to language interpreter services at no cost, including information on how to obtain interpretation services. *See* Section 1367.27(g)(1).		

Exhibit J-15: Provider Directory Worksheet

PROVIDE RESPONSES TO THE FOLLOWING TO AFFIRM COMPLIANCE WITH HEALTH AND SAFETY CODE SECTION 1367.27, AS ENACTED BY SENATE BILL 137 (2015):

	Knox-Keene Act Requirement	Plan Response (Yes, No, or N/A)	Plan's Explanation of Response (including references to Exhibits demonstrating compliance)
41	The Plan's provider directory or directories includes a statement informing enrollees that they are entitled to full and equal access to covered services, including enrollees with disabilities as required under the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973. *See* Section 1367.27(g)(2).		
42	The Plan has removed any existing disclosures that are inconsistent with an enrollee's right to reasonably rely on the Plan's provider directory or directories. *See* Section 1367.27(q).		
43	The Plan has removed any existing disclosures that are inconsistent with the Plan's responsibility to ensure compliance with Section 1367.27, regardless of any delegated responsibilities. *See* Section 1367.27(n)(2).		
44	The Plan has removed any other existing disclosures that are inconsistent with the requirements of Section 1367.27.		
	Provider Obligations and Plan Oversight		
45	The Plan's provider contracts include a five business day notification requirement by providers when not accepting new patients. *See* Section 1367.27(j)(1).		
46	The Plan's provider contracts include a five (5) business day notification requirement by providers who were previously not accepting new patients, but are currently accepting new patients. *See* Section 1367.27(j)(1).		
47	The Plan requires all contracted providers who are not accepting new patients to direct an enrollee or potential enrollee seeking to become a new patient to both the Plan for additional assistance in finding a provider and to the Department to report any potential directory inaccuracy. *See* Section 1367.27(j)(2).		
48	The Plan specifically documented in a written contract any requirements of provider groups or other health care service plans to provide the Plan information necessary for compliance. *See* Section 1367.27(n).		

Exhibit J-15 Provider Directory Worksheet

PROVIDE RESPONSES TO THE FOLLOWING TO AFFIRM COMPLIANCE WITH HEALTH AND SAFETY CODE SECTION 1367.27, AS ENACTED BY SENATE BILL 137 (2015):

	Provider Directory Requirements for Full Service and Specialized Mental Health Care Service Plans	Plan Response (Yes, No, or N/A)	Plan's Explanation of Response (including references to Exhibits demonstrating compliance)
	The Plan's provider directory or directories includes:		
1	The provider's name, practice location or locations, and contact information. *See* Section 1367.27(h)(1).		
2	Type of practitioner. *See* Section 1367.27(h)(2).		
3	National Provider Identifier number. *See* Section 1367.27(h)(3).		
4	California license number and type of license. *See* Section 1367.27(h)(4).		
5	The area of specialty, including board certification, if any. *See* Section 1367.27(h)(5).		
6	The provider's office email address, if available. *See* Section 1367.27(h)(6).		
7	The name of each affiliated provider group currently under contract with the plan through which the provider sees enrollees. *See* Section 1367.27(h)(7).		
8	As applicable, the Plan's provider directory or directories notes that authorization or referral may be required to access some providers. *See* Section 1367.27(h)(9).		
9	Non-English language, if any, spoken by a health care provider or other medical professional as well as non-English language spoken by a qualified medical interpreter on the provider's staff, if any. *See* Sections 1367.27(h)(10) and 1367.04.		
10	Identification of providers who no longer accept new patients for some or all of the plan's products. *See* Section 1367.27(h)(11).		
11	The network tier to which the provider is assigned, if the provider is not in the lowest tier, as applicable. Nothing in Section 1367.27 shall be construed to require the use of network tiers other than contract and noncontracting tiers. *See* Section 1367.27(h)(12).		
12	All other information necessary to conduct a search of the Plan's provider directory or directories pursuant to Section 1367.27(c)(2).		
	Is there a listing for each of the following providers that are under contract with the plan:		
13	For physicians and surgeons, the provider group, and admitting privileges, if any, at hospitals contracted with the plan. *See* Section 1367.27(h)(8)(A).		
14	Nurse practitioners, physicians assistants, psychologists, acupuncturists, optometrists, podiatrists, chiropractors, licensed clinical social workers, marriage and family therapists, professional clinical counselors, qualified autism service providers, as defined in Section 1374.73, nurse midwifes, and dentists. *See* Section 1367.27(h)(8)(B).		
15	Other provider types listed in the provider directory not referenced above, if any.		
16	For federally qualified health centers or primary care clinics, the name of the federally qualified health center or clinic. *See* Section 1367.27(h)(8)(C).		
17	For any provider described in Section 1367.27(h)(8)(A) and (B) who is employed by a federally qualified health center or primary care clinic, and to the extent their services may be accessed and are covered through the contract with the plan, the name of the provider, and name of the federally qualified health center or clinic. *See* Section 1367.27(h)(8)(D).		
18	Facilities, including, but not limited to, general acute care hospitals, skilled nursing facilities, urgent care clinics, ambulatory surgery centers, inpatient hospice, residential care facilities, and impatient rehabilitation facilities. *See* Section 1367.27(h)(8)(E).		
19	Pharmacies, clinical laboratories, imaging centers, and other facilities providing contracted health care services. *See* Section 1367.27(h)(8)(F).		

Exhibit J-15 Provider Directory Worksheet

PROVIDE RESPONSES TO THE FOLLOWING TO AFFIRM COMPLIANCE WITH HEALTH AND SAFETY CODE SECTION 1367.27, AS ENACTED BY SENATE BILL 137 (2015):

	Provider Directory Requirements for All Other Specialized Health Care Service Plans	Plan Response (Yes, No, or N/A)	Plan's Explanation of Response (including references to Exhibits demonstrating compliance)
	The Plan's provider directory or directories includes:		
1	The provider's name, practice location or locations, and contact information. *See* Section 1367.27(i)(1).		
2	Type of practitioner. *See* Section 1367.27(i)(2).		
3	National Provider Identifier number. *See* Section 1367.27(i)(3).		
4	California license number and type of license, if applicable. *See* Section 1367.27(i)(4).		
5	The area of specialty, including board of certification, or other accreditation, if any. *See* Section 1367.27(i)(5).		
6	The provider's office email address, if available. *See* Section 1367.27(i)(6).		
7	The name of each affiliated provider group or specialty plan practice group currently under contract with the plan through which the provider sees enrollees. *See* Section 1367.27(i)(7).		
8	The names of each allied health care professional to the extent there is a direct contract for those services covered through a contract with the plan. *See* Section 1367.27(i)(8).		
9	Non-English language, if any, spoken by a health care provider or other medical professional as well as non-English language spoken by a qualified medical interpreter on the provider's staff, if any. *See* Sections 1367.27(h)(10) and 1367.04.		
10	Identification of providers who no longer accept new patients for some or all of the plan's products. *See* Section 1367.27(i)(10).		
11	All other information necessary to conduct a search of the Plan's provider directory or directories pursuant to Section 1367.27(c)(2).		

Annual SB 137 delayed payment or reimbursement Report (Section 1327.27(p)(4))

SB-137 Health care coverage: provider directories, commencing July 1, 2016, requires a health care service plan, and a health insurer that contracts with providers for alternative rates of payment, to publish and maintain a provider directory or directories with information on contracting providers that deliver health care services to the plan's enrollees or the health insurer's insureds, and would require the plan or health insurer to make an online provider directory or directories available on the plan or health insurer's Internet Web site, as specified.

Section 1367.27 is added to the Health and Safety Code:
(a) Commencing July 1, 2016, a health care service plan shall publish and maintain a provider directory or directories with information on contracting providers that deliver health care services to the plan's enrollees, including those that accept new patients. A provider directory shall not list or include information on a provider that is not currently under contract with the plan.

(p) (1) Notwithstanding Sections 1371 and 1371.35, a plan may delay payment or reimbursement owed to a provider or provider group as specified in subparagraph (A) or (B), if the provider or provider group fails to respond to the plan's attempts to verify the provider's or provider group's information as required under subdivision (l). The plan shall not delay payment unless it has attempted to verify the provider's or provider group's information. As used in this subdivision, "verify" means to contact the provider or provider group in writing, electronically, and by telephone to confirm whether the provider's or provider group's information is correct or requires updates. A plan may seek to delay payment or reimbursement owed to a provider or provider group only after the 10-business day notice period described in paragraph (4) of subdivision (l) has lapsed.

(A) For a provider or provider group that receives compensation on a capitated or prepaid basis, the plan may delay no more than 50 percent of the next scheduled capitation payment for up to one calendar month.

(B) For any claims payment made to a provider or provider group, the plan may delay the claims payment for up to one calendar month beginning on the first day of the following month.

(2) A plan shall notify the provider or provider group 10 business days before it seeks to delay payment or reimbursement to a provider or provider group pursuant to this subdivision. If the plan delays a payment or reimbursement pursuant to this subdivision, the plan shall reimburse the full amount of any payment or reimbursement subject to delay to the provider or provider group according to either of the following timelines, as applicable:

(A) No later than three business days following the date on which the plan receives the information required to be submitted by the provider or provider group pursuant to subdivision (l).

(B) At the end of the one-calendar month delay described in subparagraph (A) or (B) of paragraph (1), as applicable, if the provider or provider group fails to provide the information required to be submitted to the plan pursuant to subdivision (l).

(3) A plan may terminate a contract for a pattern or repeated failure of the provider or provider group to alert the plan to a change in the information required to be in the directory or directories pursuant to this section.

(4) A plan that delays payment or reimbursement under this subdivision shall document each instance a payment or reimbursement was delayed and report this information to the department in a format described by the department pursuant to Section 1367.035. This information shall be submitted along with the policies and procedures required to be submitted annually to the department pursuant to paragraph (1) of subdivision (m).

(5) With respect to plans with Medi-Cal managed care contracts with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591) of the Welfare and Institutions Code, this subdivision shall be implemented only to the extent consistent with federal law and guidance.

Report A: Delayed payments for providers that receive compensation on a capitated or prepaid basis
For the Year Ended: _____

Section 1367.27 (p)(1)(A) provides for a provider or provider group that receives compensation on a capitated or prepaid basis, the plan may delay no more than 50 percent of the next scheduled capitation payment for up to one calendar month. If anytime during the year any payment or reimbursement was delayed, **document each instance a payment or reimbursement was delayed below.**

Provider Name (Physicians Medical Group or Independent Practice Association)	DBA (If applicable)	DMHC RBO# (If applicable)	NPI	Date **Written** Verification Attempted **(1)**	Date **Electronic** Verification Attempted **(1)**	Date **Telephone** Verification Attempted **(1)**	Date of 10-Day Notification for Delaying Payment **(2)**	Scheduled Payment Date **(3)**	Scheduled Amount **(4)**	Amount Paid	Amount Delayed	Percentage of amount delayed	Percentage of amount delayed in excess of 50%	Date Required Information **R**eceived **(5)**	Delayed Amount Payment Date	Days Delayed	Days Delayed in excess of 30 days	Reason for percentage of amount in excess of 50% and/or days delayed in excess of one month

Note:
(1) Date that the Plan attempted to verify the provider's or provider group's information per Section 1367.27(p)(1). Enter date in the applicable column for each attempt to contact the provider by each method. Section 1367.27(l)(4) requires the Plan to document the receipt and outcome of each attempt to verify the information. Such documentation is to be maintained for DMHC's examination.
(2) Date that the Plan notified the provider or provider group (10 business days before it seeks to delay payment or reimbursement to a provider or provider group per Section 1367.27(p)(2).)
(3) Scheduled Payment Date is payment date as required by the contract.
(4) Scheduled Amount due to provider per contract.
(5) The plan shall reimburse the full amount of any payment or reimbursement subject to delay to the provider or provider group according to either of the following timelines, as applicable: (A) No later than three business days following the date on which the plan receives the information required; or (B) At the end of the one-calendar month per Section 1367.27(p)(2).

Report B: Any claims payments made to a provider or provider group that are delayed due to Section 1367.27
For the Year Ended: ___________________________________

Section 1367.27 (p)(1)(B) For any claims payment made to a provider or provider group, the plan may delay the claims payment for up to one calendar month beginning on the first day of the following month.

If anytime during the year any payment or reimbursement was delayed, **document each instance a payment or reimbursement was delayed below.**

Claim #	Provider Name (Physicians Medical Group or Independent Practice Association)	DBA (If applicable)	DMHC RBO# (If applicable)	NPI	Date **Written** Verification Attempted **(1)**	Date **Electronic** Verification Attempted **(1)**	Date **Telephone** Verification Attempted **(1)**	Date of 10-Day Notification for Delaying Payment **(2)**	Total Adjudicated Amount	Date of Scheduled Payment	Amount Paid	Amount Delayed	Date Required Information **R**eceived	Delayed Amount Payment Date **(3)**	Days Delayed in excess of 3-business day or one-calendar month delay (4)	Reason for days delayed in excess of 30 days

Note:

(1) Date that the Plan attempted to verify the provider's or provider group's information per Section 1367.27(p)(1). Enter date in the applicable column for each attempt to contact the provider by each method.
Section 1367.27(l)(4) requires the Plan to document the receipt and outcome of each attempt to verify the information. Such documentation is to be maintained for DMHC's examination.

(2) Date that the Plan notified the provider or provider group (10 business days before it seeks to delay payment or reimbursement to a provider or provider group per Section 1367.27(p)(2).)

(3) The plan shall reimburse the full amount of any payment or reimbursement subject to delay to the provider or provider group according to either of the following timelines, as applicable: (A) No later than three business days following the date on which the plan receives the information required per Section 1367.27(p)(2)(A); or (B) At the end of the one-calendar month delay if provider fails to provide the information per Section 1367.27(p)(2)(B).

(4) Enter the number days delayed in excess of a) the three business days, or b) Count days from the first day of the following calendar month from the scheduled payment date.