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Annual Provider Network Submission Instruction Manual

Measurement Year 2017

Annual Provider Network Submission Instruction Manual

Contents

Introduction

Health care service plans that are subject to timely access reporting requirements are expected to report all plan-contracted providers within each reported provider network, as well as the enrollees that each network services. (*See* Rule 1300.67.2.2, subd. (a)(1) & (2).) The timely access regulation in California Code of Regulations, title 28, section 1300.67.2.2(g)(2)(G)(ii) requires the health plan report a "complete list" of the plan's contracted physicians, hospitals, and other contracted providers. The Department reviews the types, location, and numbers of providers and enrollees reported by each health plan network. The Department provides a set of Report Forms in Excel format for Plans to submit the Provider Roster[1] data for each Measurement Year. Health plans are expected to use the following Network Report Forms to submit the Provider Roster data:

- Annual Provider Network Report Form- PCP
- Annual Provider Network Report Form- Specialists
- Annual Provider Network Report Form- Mental Health
- Annual Provider Network Report Form- Other Contracted Providers
- Annual Provider Network Report Form- Hospitals and Clinics
- Annual Provider Network Report Form- Enrollment and Service Area
- Timely Access and Network Adequacy Grievance Report Form

In addition to completing the network Report Forms, health plans are required to complete the Profile tab in the timely access web portal. The Profile tab allows health plans to describe each of the provider networks utilized by the plan, including a description of the associated lines-of-business, service area, and plan-to-plan arrangements for each network. The Profile tab also allows health plans to "crosswalk" health plan terminology to the Department's preferred terminology. The crosswalk section allows plans to align its terminology for a variety of fields, including county name, line-of-business, provider group, hospital, type of licensure, type of service, and specialty.

The crosswalk terminology for specialty, type of licensure, and type of service also reflects the types of providers the Department may review when evaluating the network for adequacy. Please examine these common provider types before submitting the Provider Roster for each reporting network, to ensure that the health plan has not inadvertently omitted, or failed to crosswalk, a common provider type in the Provider Roster submission. The provider types listed in the crosswalk section of the Profile tab represent common provider types only, and are not intended to be an exclusive list of all provider types available throughout the State or a limitation on the types of providers health plans should include in their networks.

[1] Throughout this Instruction Manual, "Provider Roster" shall refer to the annual network data submitted pursuant to Rule 1300.67.2.2(g)(2)(G) ("G" Data).

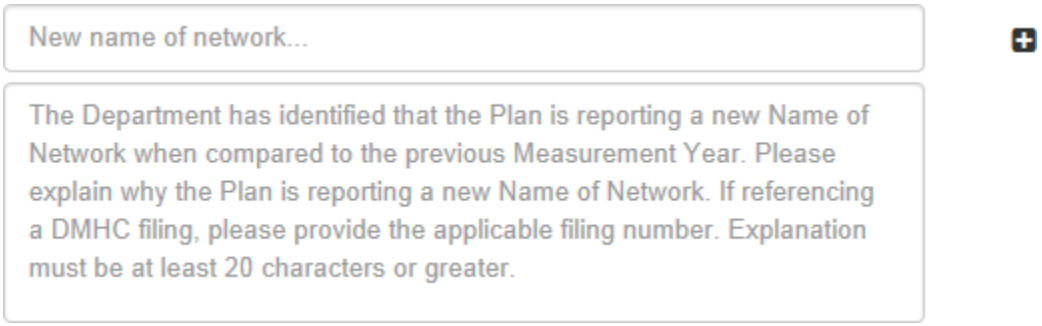
This Instruction Manual sets forth directions for how to submit health plan information confirming the status of the plan's provider network and enrollment for each unique health plan provider network, in order to comply with the format approved by the Department of Managed Health Care (the "Department"), pursuant to Health and Safety Code § 1367.035 and California Code of Regulations, title 28, section 1300.67.2.2(g)(2)(G). The instructions that follow address how to report health plan data for various network arrangements, how to set-up the Profile tab in the web portal, how to complete the network Report Forms, and how to submit those Report Forms via the timely access web portal. The Instruction Manual also addresses questions that have been raised by plans and other stakeholders regarding how to report annual provider network data.

New for Measurement Year 2017

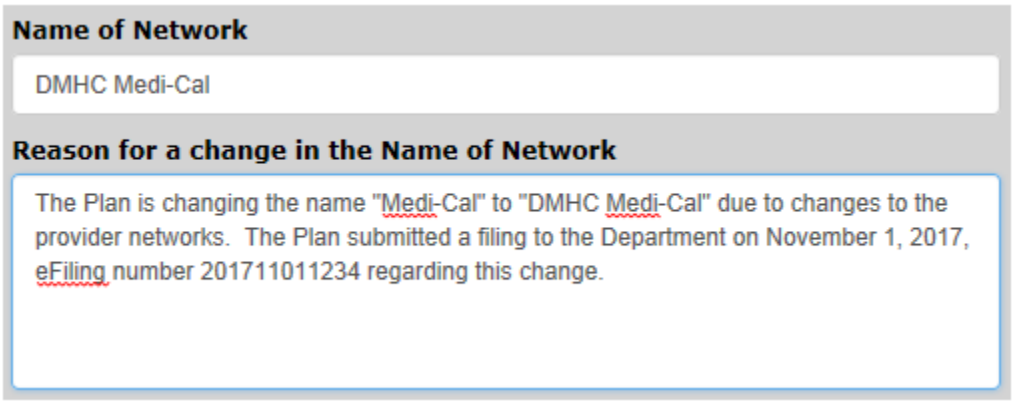
The DMHC has made a few notable changes to the Annual Provider Network Report Forms and the process for submitting health Plan data. The items below identify the major changes for Measurement Year 2017. See the Profile Tab Instructions and Populating Report Forms (Excel Templates) sections of this Instruction Manual for specific directions regarding how to submit data for these new fields and processes.

A. Name of Network Change Verification
   - Plans are required to provide a reason/verification for adding a new Name of Network or changing a previous Name of Network from the subsequent measurement year.

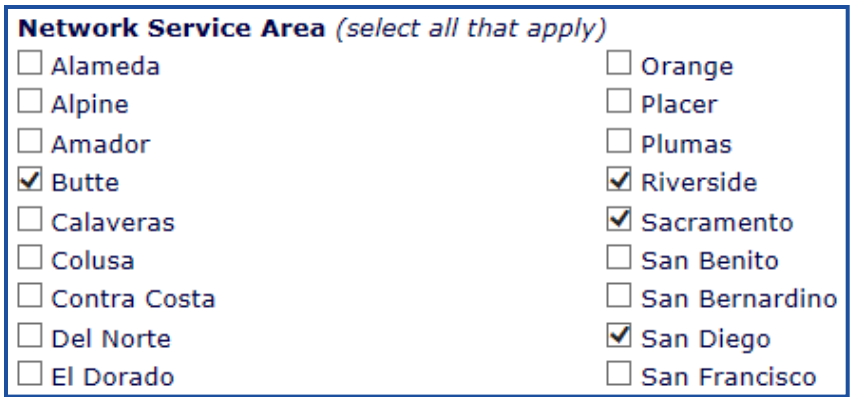
     Adding a new Name of Network:



     Changing an existing Name of Network:

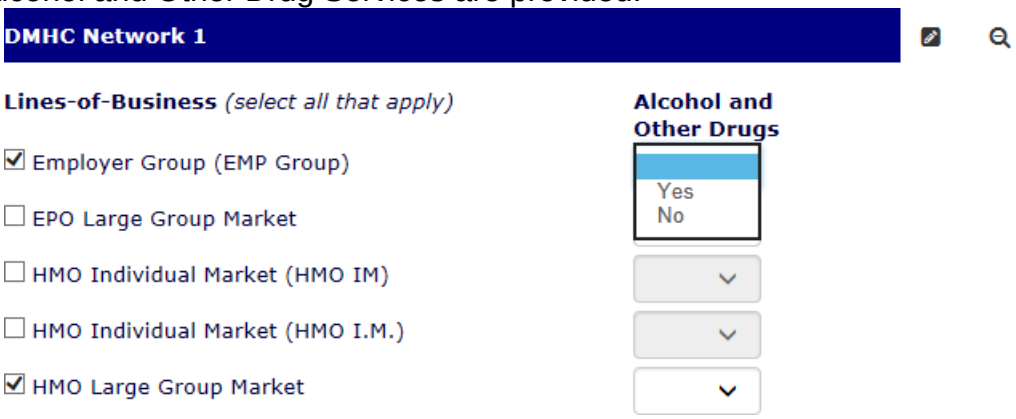


B. Name of Network Service Area County checklist
   - Plans will have to identify each full or partial county that is within the service area for the Name of Network being reported.



C. Alcohol and Other Drug Services Verification

- Plans with lines of businesses that are not required to cover alcohol and other drug services (i.e. large group products) will have to identify whether Alcohol and Other Drug Services are provided.



D. Specialty and License/Certificate Crosswalk Table Updates

- In the Clinic Service Type crosswalk table, the Department has split the "Freestanding – Primary and/or Specialty" clinic type into two separate clinic types: "Freestanding – Specialty" and "Freestanding – Primary."
- In the Mental Health Professional Specialty Type crosswalk table, the Department has replaced the term "Substance Use Disorder" with "Alcohol and Other Drugs".
- In the Mental Health Professional Licensure Type crosswalk table, the Department has replaced the term "Substance Abuse Professional – All Levels" with "Alcohol and Other Drug Counselor."
- In the Mental Health Facility Service Type crosswalk table, the Department has replaced the term "Substance Abuse" with "Alcohol and Other Drug".
- In the Specialist Specialty table, the Department has added "Addiction Medicine" and "Addiction Psychiatry".

E. Provider Groups/IPA Crosswalk Table Updates

- The Provider Groups/IPA Crosswalk table has been updated to reflect new and or reactivated provider groups, provider group name changes, and the removal of provider groups. The full list of these changes can be found in the 'Resources' tab in the timely access web portal.

F. Provider Network Report Form Template Changes
    - The Department has renamed the column "Hospital" to "Facility" in the PCP and Specialist Report Forms.
    - The Department has added the "Facility" and "Facility NPI" columns into the Other Contracted Provider Report Forms.
    - The Department has renamed the column "Hospital NPI" to "Facility NPI" in the PCP and Specialist Report Forms
    - The Department has added "Is the provider listed in the directory? (Y/R/O/S/N)" to all provider Report Forms.

G. Enrollment and Service Area Report Form Template Changes
    - If a plan is in a plan-to-plan arrangement, the primary plan is responsible for reporting its own enrollment that has been delegated to subcontracting health plans. The primary plan will identify the subcontracted plan, and the number of enrollees who have been delegated to that subcontracted plan, in the primary plan's own Enrollment and Service Area Report Form.
    - The subcontracting plan is still expected to submit an Enrollment and Service Area Report Form under the "Other Plan Network" tab in the web portal to demonstrate the portion of its service area that is incorporated under the plan-to-plan arrangement. In the "Number of Enrollees" column, the subcontracting plan should report a zero for every row in that column when reporting for a primary plan. All primary plan enrollees who are delegated to the subcontracting plan will be reported by the primary plan.
    - County and ZIP Code Validation
        - ZIP Codes and Counties listed in the Enrollment and Service Area Report Form will be validated against the USPS list of ZIP Codes and Counties in California. The complete USPS list of ZIP Codes and Counties in California can be found in the "Resources" Tab of the timely access web portal. Please verify to ensure that the ZIP Code and County combination you are reporting is listed. If not, it will not pass the front end validation.
        - Counties that have been identified as inside the service area in the Plan's Profile will also be validated against the service area reported on the Enrollment and Service Area Report Form. If a Plan lists a county as being inside the service area in the Enrollment and Service Area Report Form and that county was not indicated in the Plan's profile, the Report Form will not pass validation.

H. Plan-to-Plan Agreement to release Network Report Form Summaries

- The web portal has been revised to allow subcontracting plans to release their Network Report Form summaries to the primary plan(s) with which they have contracted.

I. Changes to the Definition of “Tertiary Care” within the Hospitals and Clinics Report Form
   - The Hospitals and Clinics Report Form has been revised in response to feedback concerning the “Tertiary Care” field within this Report Form. Please see the Report form for definitions of “Tertiary Care” and “Basic hospital services.”
     - The Plan will enter "Y" if the network is contracted with the reported hospital to provide only tertiary care services, and the network does not have a contract with the hospital to provide basic hospital services to the entire enrollee population.
     - The Plan will enter "N" if the network is contracted with the hospital to provide only basic hospital services to the entire enrollee population consistent with normal utilization and the hospital is not contracted to provide tertiary care services.
     - If the Plan is contracted with a hospital to provide both basic hospital services and tertiary services for the identified Network, the Plan will enter a “B” in this field.

Profile Tab Instructions

As part of the annual timely access submission process,[2] all plans must complete the Profile Tab available on the timely access web portal. This tab provides the DMHC with a high-level overview of each plan's network arrangements, and allows each plan to crosswalk their naming conventions to the Department's terminology in one centralized place for use with all submitted Annual Provider Network Report Forms. The Profile Tab also eliminates duplication of certain data across multiple Timely Access Report Forms and Annual Provider Network Review Report Forms.

The Profile Tab is organized by **Name of Network**. Each named network should refer to a unique combination of providers that has been reviewed and approved by the DMHC for use with one or more product lines. If there is any variation in the providers who participate in a network, that variation should be reported as a separate Name of Network. If Plans wish to add or change the name of an existing Name of Network from the previous measurement year, the Plan will be asked to provide the eFile number verifying the change, or any other information describing the reason for the change.

Also included in the Profile Tab are crosswalk tables to allow the Plan to connect its own Report Form terminology to the terminology used by the Department. This provides the Department with a clear framework for understanding the Plan's network data submissions. Completing the crosswalk tables will decrease the likelihood of the Plan receiving data error reports and requests for re-submission from the Department.

The information provided in the Profile will be used to validate information provided by the Plan in each of its Timely Access Report Forms and Annual Provider Network Review Report Forms. **Failure to fill out the Profile completely and accurately will cause the Plan's submission to fail validation, requiring the Plan to correct and resubmit its report(s).**

The Profile Tab is divided into eight separate categories:

- Health Plan Lines-of-Business
- Name of Network
- County Crosswalk
- Specialty Crosswalk
- Language Crosswalk
- Hospital Crosswalk
- Provider Groups/IPA Crosswalk
- Type of License and Certificate Crosswalk

[2] Throughout this Instruction Manual, the "timely access submission process" will refer to the annual submission of both Timely Access Compliance data ("A-F" Data) and Provider Roster data ("G" Data).

The sections below provide specific, step-by-step instructions for how to complete each of the eight categories contained within the Profile Tab.

Health Plan Lines-of-Business

In this section of the Profile Tab, health plans must describe which specific health care lines of business it will be reporting in its annual timely access submission. To complete this section, the health plan must identify all lines-of-business as follows:

1. Locate the appropriate product type as provided by the Department in the column titled: “DMHC Line-of-Business.”

2. Check the box next to all lines-of-business that are included in the Plan's submission. If you do not check the box next to a line-of-business, you will be unable to link it to any network or submit a report referring to that line-of-business.

3. Enter the Plan’s name for each checked line-of-business next to the DMHC identifier by first clicking the edit icon ( ), then typing the Plan’s line-of-business/product name in the resulting text box in the column titled “Crosswalk Code/Name.” If the Plan uses the same name to identify a line-of-business/product as appears in the column “DMHC Line-of-Business,” the Plan does not need to populate the “Crosswalk Code/Name” category for that line-of-business/product.

4. Once you have entered the Crosswalk/Code Name for a line-of-business, click the save icon ( ). YOU MUST CLICK SAVE - the Plan’s entry will not be recorded if the Plan does not click the save icon.

5. If the Plan has multiple lines-of-business of the same type (e.g. multiple “HMO Large Group Market” lines-of-business), click the add icon ( ). A new row will appear beneath the original row with the phrase “Additional Lookup” appearing beneath the DMHC Line-of-Business. Once this row appears, check the checkbox and enter the Plan’s name for the additional line-of-business following steps 2 and 3 above. Be sure to click the save icon ( ) after adding this entry.

6. If you wish to further edit or modify an existing entry, click the edit icon ( ), make the appropriate changes, then click the save icon ( ) to record your changes.

7. If you wish to delete an entry, click the delete icon ( ).

Name of Network

In this section of the Profile Tab, health plans must describe which specific networks it will be reporting in its annual timely access submission. A name of network represents a unique arrangement of providers previously approved by the Department for a specific service area that the Plan utilizes to provide care to enrollees in one or more lines-of-business. This section of the Profile allows the Department to understand which lines-of-business utilize which networks submitted by the Plan. Please identify the name of each unique network included in the Plan's timely access submission and the lines-of-business that utilize the network as follows:

1. Enter the name of the network in the text box and click the add icon ( ). The network name will appear on the webpage in a blue box followed by three icons:

2. Click the details icon ( ) next to the name of network. Four subsections will appear: "Lines-of-Business,", "Network Service Area," "Network Report Forms," and "Network Arrangements." Complete all four subsections as follows:

    a. **Lines-of-Business**: The list of all lines-of-business entered by the Plan in the previous section will appear beneath the Name of Network. Place a check mark next to all lines-of-business that use this Name of Network. If you do not see a Plan line-of-business, please ensure it has been entered under the "Lines-of-Business" section above and that it has been saved and has a check mark. Once you have finished identifying all lines-of-business that use this Name of Network, your entry will automatically be saved.

    If the Plan selects an IHSS, Large Group, or Employer product as the line-of-business for any of the Plan's networks, the Plan must identify whether the Plan covers Alcohol and Other Drugs services for those lines-of-business. If Alcohol and Other Drugs services, including chemical dependency treatment and counseling services, are covered in the Evidence of Coverage *for one or more groups* within the identified line-of-business associated with this Name of Network, please select "Yes" from the drop-down list for the corresponding line-of-business. If not, please select "No." If the "Alcohol and Other Drugs" drop-down list is grayed out, the Plan does not need to specify whether Alcohol and Other Drugs services are covered for that line-of-business.

b. **Network Service Area:** Place a check mark next to all counties in the Plan's approved service area for the identified Name of Network. If the approved service area for the identified Name of Network includes only part of a county, please select that county. Do not select counties which are part of the Plan's service area for a different Plan network, but are not part of the approved service area for the identified Name of Network.

c. **Network Report Forms**: Place a check mark next to all Report Forms that will include providers or enrollment associated with this Name of Network. Ensure that you have supplied an Enrollment and Service Area Report Form for every Name of Network submitted by the Plan. A missing Enrollment Report Form for a Name of Network will cause your submission to fail validation. Your check marks will be automatically saved.

d. **Network Arrangements**: Describe how providers are contracted with this Name of Network by identifying whether your network providers are directly contracted with the Plan ("Direct Network"), provided by a specialized mental health plan ("Plan-to-Plan for Mental Health Services"), and/or provided by another full service health plan ("Plan-to-Plan with another Full Service Plan"). If the Name of Network you are reporting is subcontracted by another health plan for use of those providers in the other plan's network, please select "Plan-to-Plan for use in Another Plan's Network."

   You may select more than one plan arrangement to reflect all arrangements that apply to this Name of Network. For example, if the Plan directly contracts for its PCP, Specialist, Hospital and Ancillary network but subcontracts with a mental health plan for mental health providers and facilities, you may select both "Direct Network" and "Plan-to-Plan for Mental Health Services." Please see Reporting Health Plan Network Arrangements below for instructions on how to complete the network Report Forms where the Plan engages in plan-to-plan arrangements. Once you have finished identifying network arrangements for this Name of Network, your entry will be automatically saved.

   For Reporting Plan-to-Plan Arrangements: If this Name of Network is in a plan-to-plan arrangement, please use the drop-down box under each subheading to identify all other health plans. If the Plan is in a plan-to-plan arrangement with more than one plan, click the save icon ( ) to add another health plan name.

3. If you wish to further edit or modify the name the Plan entered for the network, click the edit icon ( ), make the appropriate changes, then

click the save icon ( ) to record your changes. If the Plan reports a new Name of Network or changes the name of an existing Name of Network from the previous measurement year, the Plan will be required to provide an explanation with the eFile number verifying the add or change, or any other information describing the reason for the add or change. Be sure to click the save icon ( ) after providing an explanation for the name change or network addition.

4. If you wish to further edit or modify the lines-of-business, network service area, network Report Forms, or network arrangements associated with the Name of Network, click the details icon ( ) and make the appropriate changes. All changes will be saved automatically.

5. If you wish to delete an entry, click the delete icon ( ).

County Crosswalk

In this section of the Profile Tab, health plans must use the County Crosswalk table to link the Plan's terminology for county names to the Department's terminology. For example, if the Plan utilizes the term "LA" in its data to indicate a county that the Department refers to as "Los Angeles," the Plan will enter "LA" in the "Crosswalk Code/Name" column adjacent to the term "Los Angeles" in the "DMHC County" column.

The Plan's provider network, enrollment, and service area data will be validated against the County crosswalk table. The Plan must either use the Department's preferred terminology or appropriately crosswalk its own terminology to the Department's preferred terminology in order to avoid certain validation errors. For more information about the validation process for county information, see the Validation Tool section below.

Please crosswalk the Plan's terminology to the Department's terminology as follows:

1. For each county included in the Plan's network submission, locate the corresponding county name as provided by the DMHC in the column entitled: "DMHC County." If the Plan would like to report a county outside of California and the county is not listed in the County Crosswalk table, please crosswalk the county to "Other" in the County Crosswalk table. Refer to the Annual Provider Network Report Form – Enrollment and Service Area section for specific instructions on how to report out-of-state counties.

2. Insert the Plan's terminology for that county in the box next to the DMHC identifier by first clicking the edit icon ( ), then typing the Plan's county

name in the resulting text box in the column titled “Crosswalk Code/Name.” If the Plan uses the same name to identify a county as appears in the column “DMHC County,” leave the “Crosswalk Code/Name” column blank. The Plan is prohibited from populating the “Crosswalk Code/Name” with the same terminology as the DMHC’s preferred term.

3. Once finished entering each Crosswalk Code/Name, click the save icon ( ). YOU MUST CLICK SAVE - the Plan’s entry will not be recorded if the Plan does not click the save icon.

4. If the Plan uses more than one term in its Report Forms to refer to the same DMHC-listed county, click the add icon ( ) for that county. A new row will appear beneath the original row with the phrase “Additional Lookup” appearing beneath the DMHC County name. Once this row appears, follow steps 2 and 3 above to enter the additional Plan name for the county. Be sure to click the save icon ( ) after adding this entry.

5. If you wish to further edit or modify an existing entry, click the edit icon ( ), make the appropriate changes, then click the save icon ( ) to record your changes.

6. If you wish to delete an entry, click the delete icon ( ).

Specialty Crosswalk

In this section of the Profile Tab, health plans must use the Specialty tables to link the Plan’s terminology for provider specialty types to the Department’s terminology. For example, if the Plan utilizes the term “Family Practitioner” in its data to indicate what the Department refers to as a “Family Practice” physician, the Plan will enter “Family Practitioner” in the “Crosswalk Code/Name” column adjacent to the term “Family Practice” in the “DMHC PCP Specialty Type” column.

Please note, the “Specialist” Specialty Type Crosswalk table is based on selected American Board of Medical Specialties (ABMS) specialty certification types. The Specialist Report Form is reserved for physician providers. The Plan should report or crosswalk the physician’s specialty consistent with the specialty designations recognized by the American Board of Medical Specialties (ABMS). (See Cal.Code Regs § 1300.67.2.2(g)(2)(G)2.) The Plan should further indicate whether the provider is board-certified or board-eligible for the designated specialty in the “Board Certified or Eligible (Y/N)” field within the Specialist Report Form. If the provider is not a physician, please do not report or crosswalk the provider to the listed specialist physician type. NPs or PAs can be reported within

the Extender Tab of the PCP Report Form, or within the Other Contracted Providers Report Form. If the provider's specialty does not appear on the "Specialist" Specialty Crosswalk table, please crosswalk the specialty type to "Other." "NA" is not an acceptable value.

Please crosswalk the Plan's terminology to the Department's terminology as follows:

1. For each provider specialty included in the Plan's network submission, locate the corresponding specialty type as provided by the DMHC in the column titled: "DMHC Specialty Type." There is a separate table for mapping PCP Specialty Types, Specialist Specialty Types, Mental Health Professional Specialty Types, and Other Contracted Provider Category Types.

2. Insert the Plan's name for that specialty type in the box next to the DMHC identifier by first clicking the edit icon ( ), then typing the Plan's specialty terminology in the resulting text box in the column titled "Crosswalk Code/Name." If the Plan uses the same name to identify a specialty type as appears in the column "DMHC Specialty Type," leave the "Crosswalk Code/Name" column blank. The Plan is prohibited from populating the "Crosswalk Code/Name" with the same terminology as the DMHC's preferred term for that specialty type.

3. Once finished entering each Crosswalk Code/Name, click the save icon ( ). YOU MUST CLICK SAVE - the Plan's entry will not be recorded if the Plan does not click the save icon.

4. If the Plan uses more than one term in its Report Forms to refer to the same DMHC specialty type, click the add icon ( ) for that specialty type. A new row will appear beneath the original row with the phrase "Additional Lookup" appearing beneath the DMHC specialty name. Once this row appears, follow steps 2 and 3 above to enter the additional term for the DMHC specialty name. Be sure to click the save icon ( ) after adding this entry.

5. If you wish to further edit or modify an existing entry, click the edit icon ( ), make the appropriate changes, then click the save icon ( ) to record your changes.

6. If you wish to delete an entry, click the delete icon ( ).

Language Crosswalk

In this section of the Profile Tab, health plans must use the Language Table to link the Plan's terminology for language names to the Department's terminology. For example, if the Plan utilizes the term "ASL" in its data to indicate a language that the Department refers to as "American Sign Language," the Plan will enter "ASL" in the "Crosswalk Code/Name" column adjacent to the term "American Sign Language" in the "DMHC Language" column. Please crosswalk the Plan's terminology to the Department's terminology as follows:

1. For each language included in the Plan's network submission, locate the corresponding language name as provided by the DMHC in the column titled: "DMHC Language."

2. Insert the Plan's terminology for that language in the box next to the DMHC identifier by first clicking the edit icon ( ), then typing the Plan's language name in the resulting text box in the column titled "Crosswalk Code/Name." If the Plan uses the same name to identify a language as appears in the column "DMHC Language," leave the "Crosswalk Code/Name" column blank. The Plan is prohibited from populating the "Crosswalk Code/Name" with the same terminology as the DMHC's preferred term for that language.

3. Once finished, click the save icon ( ). YOU MUST CLICK SAVE - the Plan's entry will not be recorded if the Plan does not click the save icon.

4. If the Plan uses more than one term in its Report Forms to refer to the same DMHC-listed language, click the add icon ( ). A new row will appear beneath the original row with the phrase "Additional Lookup" appearing beneath the DMHC language name. Once this row appears, follow steps 2 and 3 above to enter the additional Plan name for the language. Be sure to click the save icon ( ) after adding this entry.

5. If you wish to further edit or modify an existing entry, click the edit icon ( ), make the appropriate changes, then click the save icon ( ) to record your changes.

6. If you wish to delete an entry, click the delete icon ( ).

Hospital Crosswalk

In this section of the Profile Tab, health plans must use the Hospital table to link the Plan's terminology for hospital names to the Department's terminology. For example, if the Plan utilizes the term "UCD Med Ctr" in its data to indicate a

hospital that the Department refers to as “University of California Davis Medical Center,” the Plan will enter “UCD Med Ctr” in the “Crosswalk Code/Name” column adjacent to the term “University of California Davis Medical Center” in the “DMHC Hospital” column.

The Department’s list of hospital names is derived from the Office for Statewide Health Planning and Development (“OSHPD”) list of all licensed hospital facilities. If it is unclear which health plan hospital correlates to the Department’s preferred hospital names, please refer to the OSHPD ID number included in the crosswalk table to further clarify the specific hospital to which the Department is referring.

Please crosswalk the Plan’s terminology to the Department’s terminology as follows:

1. For each hospital included in the Plan’s network submission, locate the corresponding hospital name as provided by the DMHC in the column titled: “DMHC Hospital.”

2. Insert the Plan’s terminology for that hospital in the box next to the DMHC identifier by first clicking the edit icon ( ), then typing the Plan’s hospital name in the resulting text box in the column titled “Crosswalk Code/Name.” If the Plan uses the same name to identify a hospital as appears in the column “DMHC Hospital,” leave the “Crosswalk Code/Name” column blank. The Plan is prohibited from populating the “Crosswalk Code/Name” with the same terminology as the DMHC’s preferred term for that hospital.

3. Once finished, click the save icon ( ). YOU MUST CLICK SAVE - the Plan’s entry will not be recorded if the Plan does not click the save icon.

4. If the Plan uses more than one term in its Report Forms to refer to the same DMHC-listed hospital, click the add icon ( ). A new row will appear beneath the original row with the phrase “Additional Lookup” appearing beneath the DMHC hospital name. Once this row appears, follow steps 2 and 3 above to enter the additional Plan name for the hospital. Be sure to click the save icon ( ) after adding this entry.

5. If you wish to further edit or modify an existing entry, click the edit icon ( ), make the appropriate changes, then click the save icon ( ) to record your changes.

6. If you wish to delete an entry, click the delete icon ( ).

Provider Group/IPA Crosswalk

In this section of the Profile Tab, health plans must use the Provider Group/IPA table to link the Plan's terminology for provider group and IPA names to the Department's terminology. For example, if the Plan utilizes the term "Hill Phys MG" in its data to indicate a provider group that the Department refers to as "Hill Physicians Medical Group," the Plan will enter "Hill Phys MG" in the "Crosswalk Code/Name" column adjacent to the term "Hill Physicians Medical Group" in the "DMHC Provider Group/IPA" column. If the Plan is unable to identify which of its provider groups match to the Department's terminology, please see the Secretary of State identifier included in the table to obtain further information.

If the Plan contracts with providers who do not belong to a provider group or IPA, identify those providers as "Individually Contracted Provider" on the appropriate Report Form. If the Plan uses different terminology for "Individually Contracted Provider" the Plan may link this terminology to the Department's terminology in the Provider Group/IPA Crosswalk table. The term "Individually Contracted Provider" is available at the END of the alphabetical list of Provider Groups and IPAs. Enter the Plan's terminology for this provider type in the adjacent field, as detailed in the instructions below.

Please crosswalk the Plan's terminology to the Department's terminology as follows:

1. For each provider group and IPA included in the Plan's network submission, locate the corresponding provider group or IPA name as provided by the DMHC in the column titled: "DMHC Provider Group/IPA."

2. Insert the Plan's terminology for that provider group or IPA in the box next to the DMHC identifier by first clicking the edit icon (), then typing the Plan's provider group or IPA name in the resulting text box in the column titled "Crosswalk Code/Name." If the Plan uses the same name to identify a provider group or IPA as appears in the column "DMHC Provider Group/IPA," leave the "Crosswalk Code/Name" column blank. The Plan is prohibited from populating the "Crosswalk Code/Name" with the same terminology as the DMHC's preferred term for that provider group or IPA.

3. Once finished, click the save icon (). YOU MUST CLICK SAVE - the Plan's entry will not be recorded if the Plan does not click the save icon.

4. If the Plan uses more than one term in its Report Forms to refer to the same DMHC-listed provider group or IPA, click the add icon (). A new row will appear beneath the original row with the phrase "Additional Lookup" appearing beneath the DMHC Provider Group/IPA name. Once this row appears, follow steps 2 and 3 above to enter the additional Plan

name for the provider group or IPA. Be sure to click the save icon ( ) after adding this entry.

5. If you wish to further edit or modify an existing entry, click the edit icon ( ), make the appropriate changes, then click the save icon ( ) to record your changes.

6. If you wish to delete an entry, click the delete icon ( ).

Type of License and Certificate Crosswalk

In this section of the Profile Tab, health plans must use the table below to link the Plan's terminology for provider license and service types to the Department's terminology. For example, if the Plan utilizes the term "M.D." in its data to indicate what the Department refers to as "MD," the Plan will enter "M.D." in the "Crosswalk Code/Name" column adjacent to the term "MD" in the appropriate DMHC Licensure or Service column.

The Department has provided seven license- and service-type crosswalks for plans to populate: "PCP Extender Type," "PCP Licensure Type," "Specialist Licensure Type," "Hospital Service Type," "Clinic Service Type," "Mental Health Professional Licensure Type," and "Mental Health Facility Service Type." Please crosswalk the Plan's terminology to the Department's terminology as follows:

1. For each provider license or service type included in the Plan's network submission, locate the corresponding license or service type as provided by the DMHC in the column containing the DMHC license or service type (e.g. "DMHC PCP Licensure Type"). There is a separate table for mapping PCP, PCP Extender, Specialist, Hospital, Clinic, Mental Health Professional, and Mental Health Facility license or service types.

2. Insert the Plan's name for that license or service type in the box next to the DMHC identifier by first clicking the edit icon ( ), then typing the Plan's license or service type terminology in the resulting text box in the column entitled "Crosswalk Code/Name." If the Plan uses the same name to identify a licensure type as appears in the DMHC license or service type column, leave the "Crosswalk Code/Name" column blank. The Plan is prohibited from populating the "Crosswalk Code/Name" with the same terminology as the DMHC's preferred term for that license or service type.
3. Once finished, click the save icon ( ). YOU MUST CLICK SAVE - the Plan's entry will not be recorded if the Plan does not click the save icon.

4. If the Plan uses more than one term in its Report Forms to refer to the same DMHC license or service type, click the add icon ( ). A new row

will appear beneath the original row with the phrase “Additional Lookup” appearing beneath the DMHC license or service name. Once this row appears, follow steps 2 and 3 above to enter the additional term for the DMHC license or service name. Be sure to click the save icon ( ) after adding this entry.

5. If you wish to further edit or modify an existing entry, click the edit icon ( ), make the appropriate changes, then click the save icon ( ) to record your changes.

6. If you wish to delete an entry, click the delete icon ( ).

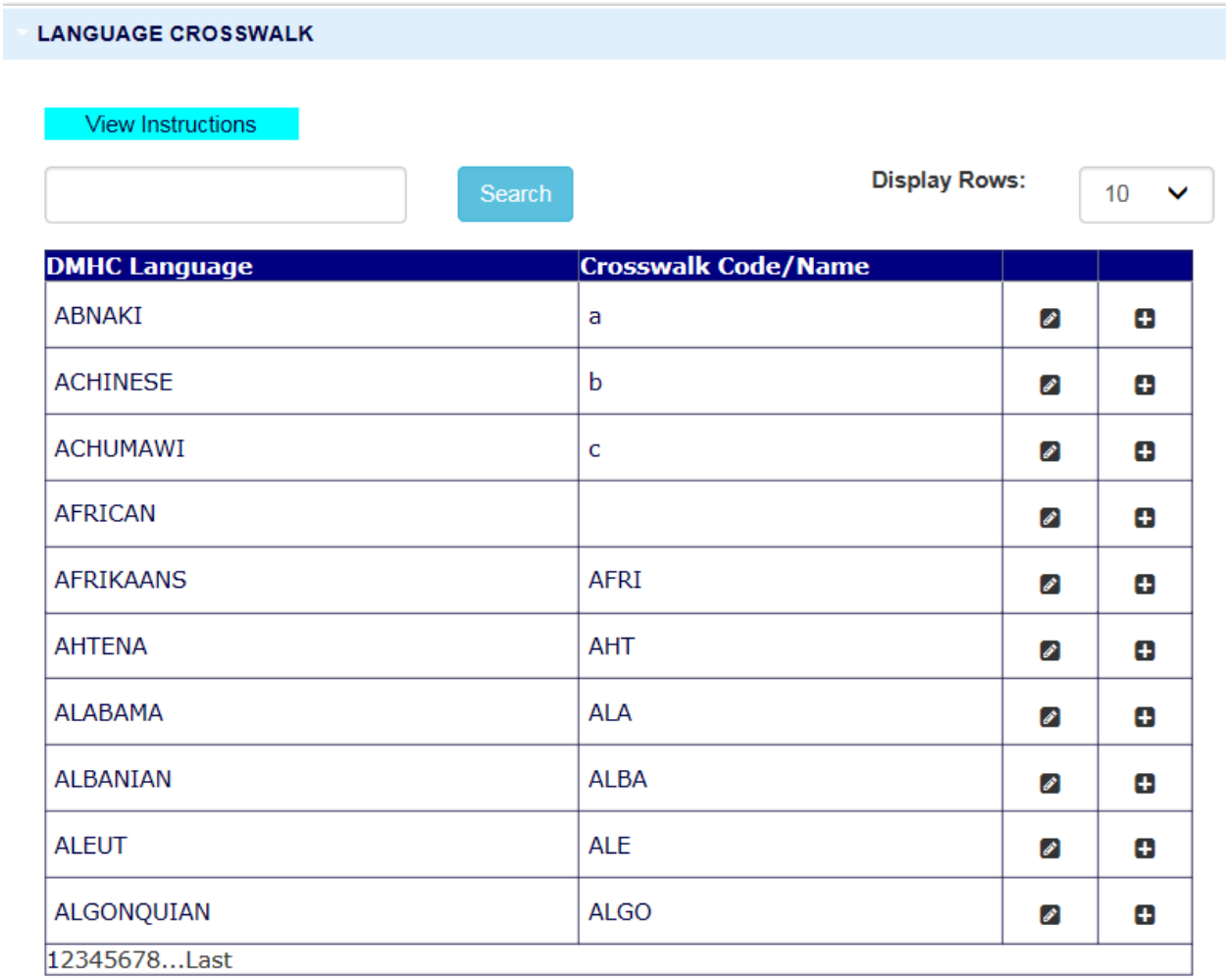
Frequently Asked Questions Regarding the Profile Tab

1. **When do I have to complete the Crosswalks described in the Profile tab?**

   If your Plan uses terminology that is identical to the Department’s terminology contained within the crosswalk sections of the Profile tab, your Plan does not need to complete the Crosswalk tables. If your Plan utilizes any variation on the DMHC’s preferred terminology described in the crosswalk sections, you must complete the “Crosswalk Code/Name” column for the Plan so that the Department can identify what Plan terminology equates to the Department’s preferred terminology. If the Plan does not complete the Crosswalk tables and utilizes terminology that varies in any way from the Department’s terminology, the Department will be unable to properly credit the Plan’s network as containing the value being measured in that field. This may result in the Plan’s network appearing to be missing certain types of providers or provider locations. For MY 2017, reporting health plans will be able to update their Profile in the Timely Access Web Portal, **beginning January 1, 2018.**

2. **If the language the Plan uses is not listed on the “Profile” tab, can I add it to the tables on the Look-up Code worksheet?**

   No. Additional languages cannot be added to the Language Crosswalk table in the Profile tab. The Plan is limited to the list of languages provided in the Crosswalk table. If the Provider speaks a language not listed in the Look-Up code, do not report that language.



DMHC Language	Crosswalk Code/Name		
ABNAKI	a		
ACHINESE	b		
ACHUMAWI	c		
AFRICAN			
AFRIKAANS	AFRI		
AHTENA	AHT		
ALABAMA	ALA		
ALBANIAN	ALBA		
ALEUT	ALE		
ALGONQUIAN	ALGO		
12345678...Last			

3. If the specialty the Plan uses is not listed on the Specialty Crosswalk table, can I add it?

Yes. If a provider practices a specialty that is not listed in the Specialty Crosswalk table within the Profile tab, then the Plan must select "Other" under the "DMHC Specialist Specialty Type" column and enter in the new specialty type under the "Crosswalk Code/Name" column. If the plan has multiple specialty types that are not listed in the "DMHC Specialist Specialty Type" column, the plan may click the "+" button on the "Other" row to add another "Other" specialty type. **Do not** enter a provider type as an "Other" specialty if that specialty is already listed elsewhere in the Department's "DMHC Specialist Specialty Type" column.

Example:

- ***Correct*:**

• **SPECIALIST SPECIALTY TYPE**

Search

Display Rows: 10

DMHC Specialist Specialty Type	Crosswalk Code/Name		
SURGERY - PLASTIC Additional Lookup: 2	PLASTIC SURGERY		
SURGERY - THORACIC	THORACIC SURGERY		
SURGERY - VASCULAR	GEN VASCULAR SURGERY		
UROLOGY			
OTHER	Emergency Medicine		
OTHER Additional Lookup: 2	Critical Care		
First...23456789			

- ***Incorrect*:**

• **SPECIALIST SPECIALTY TYPE**

Search

Display Rows: 10

DMHC Specialist Specialty Type	Crosswalk Code/Name		
SURGERY - PLASTIC Additional Lookup: 2	PLASTIC SURGERY		
SURGERY - THORACIC	THORACIC SURGERY		
SURGERY - VASCULAR	GEN VASCULAR SURGERY		
UROLOGY			
OTHER	General Surgery		
OTHER Additional Lookup: 2	Vascular Surgery		
First...23456789			

Please note: in previous Measurement Years, the Department requested that plans identify any “other” specialty types within the Annual Provider Network Report Forms themselves, under the column “Specialty/Subspecialty (Other).” For Measurement Year 2017, the Department has eliminated this column and is now asking plans to identify all “other” specialty types within the Specialty Crosswalk table.

If the Plan includes multiple specialty types in its Report Forms that map to the same specialty term as identified by the DMHC in the Specialty Crosswalk table, the Plan may make multiple entries in the Crosswalk table in order to map Plan terminology to the established DMHC terminology. Please see the following example:

- **SPECIALIST SPECIALTY TYPE**

Search | Display Rows: 10

DMHC Specialist Specialty Type	Crosswalk Code/Name		
ALLERGY/IMMUNOLOGY	ALLERGY		
ALLERGY/IMMUNOLOGY Additional Lookup: 2	IMMUNOLOGY		
ANESTHESIOLOGY			
CARDIOVASCULAR DISEASE			
CARDIOVASCULAR DISEASE Additional Lookup: 2			
DERMATOLOGY			
DERMATOLOGY Additional Lookup: 2			
DIAGNOSTIC RADIOLOGY			
ENDOCRINOLOGY			
ENDOCRINOLOGY Additional Lookup: 2			
12345678...Last			

Please note: For any provider listed with a specialty of "Other," the Department will presume that the provider does not have one of the specific specialty types identified in the Specialty Crosswalk list. The Department relies on the terminology set forth in the "DMHC Specialist Specialty Type" column for conducting its review of network adequacy. If a Plan has not utilized the Department's established terminology or crosswalked the Plan's own terminology to the Department's established terminology, the Department will assume that the provider type is not available in the network. Please be sure to report provider specialty types as instructed and to crosswalk all relevant provider types to the DMHC's established terminology so that the Plan is appropriately attributed those provider types in its network.

Reporting Health Plan Network Arrangements

Health plans provide services to enrollees via a variety of different network arrangements, including plan-to-plan arrangements, network leases, and direct contracting. The scenarios described below encompass the range of network arrangements relied upon by most health plans and provide specific instructions for how to report and submit data for each. Please find and follow the one or more scenarios that are relevant to your health plan's network reporting in order to successfully report this data to the Department. If your health plan has a network arrangement that is not reflected in the scenarios described below, please contact the Department for further guidance.

Plan-to-Plan Arrangements

In the past, health plans have not consistently reported plan-to-plan arrangements in a way that clearly defines which lines-of-business have access to subcontracting health plan networks. In order to make it clear exactly which providers are available to each line-of-business, the health plans must take the steps outlined below when reporting plan-to-plan arrangements. For the purposes of clarity, the Department utilizes the term "subcontracting plan" to refer to a Knox-Keene licensed specialized or full-service plan that has entered into a contract with a Knox-Keene licensed full-service plan (referred to as "primary plan") such that the subcontracting plan's network is available to enrollees in the primary plan and the primary plan has delegated the subcontracting plan to arrange services for some or all of its enrollees.

By taking the following steps, health plans can reduce confusion created by plan-to-plan arrangements and ensure that their Provider Roster submissions include the full array of providers available to enrollees:

- **Distinct Name of Network.** When the subcontracting plan is reporting the network of providers that are being made available to a primary plan through a plan-to-plan arrangement, the subcontracting plan should create a distinct Name of Network in the Profile Tab to describe the network providers that are specific to that plan-to-plan arrangement. If the same network of providers is available to multiple plans, the subcontracting plan may create one Name of Network and indicate in the Profile Tab which primary plans have access to that network.
- **Subcontracting Plan Does Not Report Enrollees from the Primary Plan.** When the subcontracting plan is reporting the service area of the network made available to enrollees specific to the plan-to-plan arrangement, the subcontracting plan should not report the primary plan's enrollees that have been delegated to the subcontracting plan. The subcontracting plan should only report the inside service area zip codes for each network used in its plan-to-plan arrangement. The primary plan is

required to report all of its enrollees, including those delegated to the subcontracting plan.

- **Identify Lines-of-Business Accessing Subcontracting Plan.** When the primary plan is setting up a Name of Network in the Profile tab, and the network contains a plan-to-plan arrangement, it must ensure that all lines-of-business associated with that particular network name are utilizing the plan-to-plan arrangement. If not all lines-of-business have access to the providers made available through the plan-to-plan arrangement, the primary plan should create a separate Name of Network for those lines-of-business that do not reflect a plan-to- plan arrangement.

Further instructions for reporting plan-to-plan relationships are described under Scenarios 4 and 5 below.

Health Plan Reporting Scenarios

If the Plan utilizes multiple contracting methods for different provider types in the same network, please follow the instructions below for each scenario that applies to the Name of Network being reported. The Plan will also be required to identify the different contracting methodologies used for each Name of Network when completing the Profile Tab in the web portal.

Identify which scenarios apply to your plan's contracted provider network for each Name of Network that your plan is reporting. Read the instructions for the applicable scenarios for information on how to appropriately fill out the spreadsheets for your plan.

Scenario 1: Health Plan's Network is Directly Contracted

The Name of Network I am reporting has a directly contracted provider network for delivering care. This means that my health plan contracts directly with some or all providers who participate in the Name of Network being reported, either on a capitated or fee-for-service basis. These direct contracts include contracts with medical groups or IPA's (groups of doctors), hospitals, and/or direct contracts with individual providers.

Instruction: If Scenario 1 describes your health plan, your health plan must report all directly-contracted providers for this Name of Network on the appropriate Department Report Forms (PCPs, Specialist, Mental Health, Hospitals, etc.). If the health plan's Network is comprised of some directly contracted providers (e.g. hospitals and physicians) and some providers obtained via a Plan-to-Plan arrangement (e.g. mental health providers, dentists), then the health plan should only report the directly contracted providers in this fashion and see the other Scenarios described below to determine how to submit the other providers in this Network. Please ensure that this network arrangement is identified as "Direct Network" in the "Network Arrangements" section of the Name of Network set-up under the Profile Tab in the web portal.

See the *Populating Report Forms (Excel Templates)* section below for specific instructions regarding how to report each individual provider.

Scenario 2: Health Plan's network includes Plan-to-Plan contracts with KKA licensed health plans not subject to timely access reporting

The Name of Network I am reporting includes providers obtained through one or more Plan-to-Plan contracts between my full-service health plan and a subcontracted KKA restricted licensed plan, specialized KKA licensed health plans (e.g. dental, vision, chiropractic, and acupuncture plans), or any other KKA licensed health plan that is not subject to timely access reporting requirements pursuant to Rule 1300.67.2.2, subd. (a).

Instruction: If Scenario 2 describes your health plan, your health plan must report all providers available in your health plan's network via the subcontracting plan for this Network on the appropriate Department Report Forms (PCPs, Specialist, Mental Health, Hospitals, etc.). The subcontracting plans in this scenario are not required to submit their own provider network for the purposes of annual network review, therefore, it is the responsibility of the full-service primary plan to report the providers made available to the network via the subcontracting plans. When reporting providers made available to your health plan's network via a contract with a subcontracting plan in this scenario, your health plan must also complete the column within the spreadsheet labeled, "Health Plan ID for Plan-to-Plan Contract." For any provider in the plan network that is contracted through this arrangement, your health plan will place the KKA license number for the subcontracting plan (i.e. 933 xxxx) in this column. To look up the KKA license number for another health plan, please go to the following link on the Department's public webpage: http://wpso.dmhc.ca.gov/hpsearch/viewLicensedHealthPlan.aspx

Additional Scenario: "**BUT** what if my health plan contracts with the same provider on a direct contract basis (or through a medical group) and the same doctor is contracted by the restricted licensee? Where or how does my health plan report this

provider?"

Instruction: For reporting purposes, simply **list the provider twice** (or three or four times). The first instance will indicate the provider is part of the health plan's direct network and the plan will leave the "Health Plan ID for Plan-to-Plan Contract" column blank to indicate it is a direct provider. In the second instance, please enter the subcontracting plan's KKA license number in the "Health Plan ID for Plan-to-Plan Contract" column.

When completing the "Network Arrangements" section of the Name of Network set-up under the Profile Tab in the web portal, identify this arrangement as "Direct Network." "Plan-to-Plan" arrangements should only be identified in the Network Arrangements section of the Profile tab if the Network has plan-to-plan arrangements with KKA-licensed health plans that are subject to timely access reporting requirements.

See the *Populating Report Forms (Excel Templates)* section below for specific instructions regarding how to report each individual provider.

Scenario 3: Health Plan reporting its own direct network for mental health professionals

The Name of Network I am reporting has a directly contracted mental health provider network with mental health professionals and facilities. This means that my health plan contracts directly with some or all mental health providers who participate in the Name of Network being reported, either on a capitated or fee-for-service basis. These direct contracts include contracts with medical groups or IPA's (groups of doctors), mental health facilities, and/or direct contracts with individual providers.

Instruction: If Scenario 3 describes your health plan, your health plan will follow the instructions listed in Scenario 1 by completing the provided Report Forms for mental health networks and submitting it to the Department.

See the *Populating Report Forms (Excel Templates)* section below for specific instructions regarding how to report each individual provider.

Scenario 4: Health Plan contracts with another KKA mental health specialized plan to administer mental health services

The Name of Network I am reporting includes providers obtained through one or more health plan contracts with a KKA-licensed specialized plan ("subcontracting mental health plan") to provide mental health services to my health plan's enrollees. The KKA-licensed specialized plans are subject to timely access

reporting. My health plan has information regarding the counties in which my health plan contracts with this/these plans in order to ensure all portions of my health plan's service area have appropriate access to mental health providers.

Instruction: If Scenario 4 describes your health plan, and your health plan is a **full service health plan**, please do the following:

1. Indicate the subcontracting mental health plan with which your health plan contracts for each unique Name of Network by checking the box for "Plan-to- Plan for Mental Health Services" in the "Network Arrangements" section of the Name of Network set-up under the Profile Tab in the web portal. When setting up your health plan's Network Arrangement for that Name of Network, be sure to click on the magnifying glass beside the "Plan-to-Plan for Mental Health Services" to identify the subcontracting mental health plan with which your health plan has contracted. See the Profile Tab Instructions above for further information regarding how to describe your health plan's networks.
2. Confirm that all lines-of-business associated with the Name of Network have access to the subcontracting mental health plan. If not, create a separate Name of Network for those lines-of-business that do not utilize this plan-to-plan arrangement.
3. Communicate with the subcontracting mental health plan to ensure it reports the mental health network utilized by your health plan in the "Other Plan Network" tab of the web portal.
4. When completing the Annual Provider Network Report Forms:
    a. **For Provider Report Forms: *Do not*** include providers obtained via the plan-to-plan contract in the PCP, PCP Extenders, Specialist, Hospital and Clinics, Mental Health Professionals, or Other Contracted Providers Network Report Forms.
    b. **For Enrollment and Service Area Report Form: *Do*** identify the subcontracting mental health plan in the "Health Plan ID of Subcontracting Health Plan" field in the Enrollment and Service Area Network Report Form and indicate the number of your health plan's enrollees who are delegated to the subcontracting mental health plan by County and ZIP Code. Make sure that the Enrollment and Service Area Network Report Form accurately reflects the primary plan's service area.

Instruction: If Scenario 4 describes your health plan, and your plan is a **subcontracting specialized mental health plan**, please do the following:

1. Complete the applicable Network Report Forms representing your plan's contracted providers that are available to the full-service health plan ("primary plan") with which your plan is contracted. When completing the Report Forms, leave the "Health Plan ID for Plan-to-Plan Contract" columns blank, indicating the providers are contracted with your plan.
2. Complete a separate Enrollment and Service Area Report Form for every primary plan from which your subcontracting mental health plan receives

enrollment and label the Report Forms appropriately so that the primary plan is identified. Complete all fields except the “Number of Plan Enrollees” field such that the Report Form accurately reflects the portion of your subcontracting mental health plan’s service area that is contracted with the primary plan. Please do not report enrollees that have been delegated to your subcontracting mental health plan from the primary plan. Instead, enter “0” in the “Number of Enrollees” column for every row.

3. Create a Name of Network in the Profile tab that is specific to the plan-to-plan arrangement. Indicate the primary plan that utilizes this Name of Network by checking the box for “Plan-to-Plan for Use in Another Plan's Network” in the “Network Arrangements” section of the Name of Network set-up under the Profile Tab in the web portal. When setting up your subcontracting mental health plan’s Network Arrangement for that Name of Network, be sure to click on the magnifying glass beside the “Plan-to-Plan for Use in Another Plan's Network” to indicate the primary plan with which your subcontracting mental health plan has contracted. This will populate the choices of health plans that appear in the “Other Plan Network” tab. See the Profile Tab Instructions above for further information regarding how to describe your health plan’s networks.
4. Click on the “Other Plan Network” tab in the Timely Access web portal and use the drop-down menu to select the primary plan with which your subcontracting mental health plan is contracted. Upload the appropriate Report Forms that reflect the provider network and service area that are available to the selected primary plan. Ensure that each Report Form includes all providers that are available to the primary plan for which your subcontracting mental health plan is reporting.
5. If your subcontracting mental health plan makes a separate arrangement of unique providers available to different primary plans, please be sure to report each unique arrangement of providers as a separate Name of Network and associate that Name of Network with the appropriate primary plan in the “Other Plan Network” tab.

Additional Scenario: “**BUT** what if there is ‘duplicate’ data because the same provider is included in the network for our direct contracted network and every health plan with whom we contract?”

Instruction: Submit all requested data for your plan’s own direct contracted network and the network utilized by a primary plan. These networks should be identified by their own unique Name of Network and reported on separate Report Forms so that the Department can easily identify which providers are associated with the primary plan and which are associated with your own plan’s lines-of-business. Additionally, the Report Forms for the primary plan are uploaded in the “Other Plan Network” section and are therefore submitted separately from the Report Forms for your own networks. Reporting the data for the primary plan networks separately from your own networks ensures that the Department can capture the differences in the individual plan networks.

Please also ensure that the network arrangements described above are reflected in the "Network Arrangements" section of the Name of Network set-up under the Profile Tab in the web portal.

See the *Populating Report Forms (Excel Templates)* section below for specific instructions regarding how to report each individual provider.

Please note: The primary plans and subcontracting mental health plans should each only report the providers with whom they are directly contracted on either a fee-for-service or capitated basis. Primary plans **should not** include mental health providers in the plan's Report Forms that are available to the plan only as a result of a plan-to-plan arrangement with a KKA-licensed subcontracting mental health plan that is subject to timely access reporting. All mental health providers made available to the primary plan's network as a result of a plan-to-plan contract must be reported by the subcontracting mental health plan and identified as being a part of the full-service plan's network via the "Profile" and "Other Plan Network" tabs in the web portal.

Scenario 5: Health Plan contracts with another full service health plan

The Name of Network I am reporting includes providers obtained through one or more subcontracts with another KKA-licensed full service health plan ("subcontracting plan") in order to provide services to enrollees. The KKA-full service plans are subject to timely access reporting. For example, my health plan is in the Medi-Cal arena, but we partner with another plan to provide Medi-Cal benefits through the Department of Health Care Services (the "DHCS") in certain counties.

Instruction: If Scenario 5 describes your health plan, and your health plan is the full-service health plan ("primary plan"), meaning it is the **health plan that holds the contract with the enrollee** (or DHCS if in the Medi-Cal arena), please do the following:

1. Indicate the subcontracting plan with which your health plan contracts for each unique Name of Network by checking the box for "Plan-to-Plan with Another Full Service Health Plan" in the "Network Arrangements" section of the Name of Network set-up under the Profile Tab in the web portal. When setting up your health plan's Network Arrangement for that Name of Network, be sure to click on the magnifying glass beside the "Plan-to-Plan with Another Full Service Health Plan" to identify the subcontracting mental health plan with which your health plan has contracted. See the Profile Tab Instructions above for further information regarding how to describe your health plan's networks.
2. Confirm that all lines-of-business associated with that Name of Network have access to the subcontracting plan. If not, create a separate Name of

Network for those lines-of-business that do not include a plan-to-plan arrangement.

3. Communicate with the subcontracting plan to ensure it reports the provider network utilized by your health plan in the "Other Plan Network" tab of the web portal.
4. When completing the Annual Provider Network Report Forms:
    a. **For Provider Report Forms: *Do not*** include providers obtained via the plan-to-plan contract in the PCP, PCP Extenders, Specialist, Hospital and Clinics, Mental Health Professionals, or Other Contracted Providers Network Report Forms.
    b. **For Enrollment and Service Area Report Form: *Do*** identify the subcontracting plan in the "Health Plan ID of Subcontracting Health Plan" field in the Enrollment and Service Area Network Report Form and indicate the number of your health plan's enrollees who are delegated to the subcontracting plan by County and ZIP Code. Make sure that the Enrollment and Service Area Network Report Form accurately reflects the primary plan's service area.

Additional Scenario: "**BUT** what if my health plan contracts with the same provider on a direct contract basis (or through a medical group) and the same doctor is contracted by the subcontracted health plan? Where or how does my health plan report this provider?"

Instruction: For reporting purposes, the primary plan should report the provider as part of the plan's direct network. The subcontracting plan will be responsible for reporting all providers made available to your plan as a result of the plan-to-plan arrangement.

Additional Instruction: If Scenario 5 describes your health plan, and you are the **subcontracting plan** (i.e. you receive enrollees from the other KKA-licensed plan but do not hold the contract with the enrollee), your plan will be responsible for reporting this network information **separate** from your other submitted network information. Your health plan must:

1. Complete the applicable provider Network Report Forms representing your plan's contracted providers that are available to the full-service health plan ("primary plan") with which your plan is contracted. When completing the Report Forms, leave the "Health Plan ID for Plan-to-Plan Contract" columns blank, indicating the providers are contracted with your plan.
2. Complete a separate Enrollment and Service Area Report Form for every primary plan from which your plan receives enrollment and label the Report Forms appropriately so that the primary plan is identified. Complete all fields except the "Number of Plan Enrollees" field such that the Report Form accurately reflects the portion of your subcontracting mental health plan's service area that is contracted with the primary plan. Please do not report enrollees that have been delegated to your

subcontracting plan from the primary plan. Instead, enter “0” in the “Number of Enrollees” column for every row.

3. Create a Name of Network in the Profile tab that is specific to the plan-to-plan arrangement. Indicate the primary plan that utilizes this Name of Network by checking the box for “Plan-to-Plan for Use in Another Plan's Network” in the “Network Arrangements” section of the Name of Network set-up under the Profile Tab in the web portal. When setting up your subcontracting plan’s Network Arrangement for that Name of Network, be sure to click on the magnifying glass beside the “Plan-to-Plan for Use in Another Plan's Network” to indicate the primary plan with which your subcontracting plan has contracted. This will populate the choices of health plans that appear in the “Other Plan Network” tab. See the Profile Tab Instructions above for further information regarding how to describe your health plan’s networks.
4. Click on the “Other Plan Network” tab in the Timely Access web portal and use the drop-down menu to select the primary plan with which your subcontracting plan is contracted. Upload the appropriate Report Forms that reflect the provider network and service area that are available to the selected primary plan. Ensure that each Report Form includes all providers that are available to the primary plan for which your subcontracting plan is reporting.
5. If your subcontracting plan makes a separate arrangement of unique providers available to different primary plans, please be sure to report each unique arrangement of providers as a separate Name of Network and associate that Name of Network with the appropriate primary plan in the “Other Plan Network” tab.

Additional Scenario: “**BUT** what if there is ‘duplicate’ data because the same provider is included in the network for our direct contracted network and every health plan with whom we contract?”

Instruction: Submit all requested data for your plan’s own direct contracted network and the network utilized by a primary plan. These networks should be identified by their own unique Name of Network and reported on separate Report Forms so that the Department can easily identify which providers are associated with the primary plan and which are associated with your own plan’s lines-of-business. Additionally, the Report Forms for the primary plan are uploaded in the “Other Plan Network” section and are therefore submitted separately from the Report Forms for your own networks. Reporting the data for the primary plan networks separately from your own networks ensures that the Department can capture the differences in the individual plan networks.

Please also ensure that the network arrangements described above are reflected in the “Network Arrangements” section of the Name of Network set-up under the Profile Tab in the web portal.

See the *Populating Report Forms (Excel Templates)* section below for specific instructions regarding how to report each individual provider.

Please note: the primary and subcontracting full-service health plans should each only report the providers with whom they are directly contracted on either a fee-for-service or capitated basis. Primary plans **should not** include providers in the plan's Report Forms that are available to the plan only as a result of a plan-to-plan contract with a KKA- licensed subcontracting plan that is subject to timely access reporting. All providers made available to the primary plan's network as a result of a plan-to-plan contract must be reported by the subcontracting plan and identified as being a part of the primary plan's network via the "Profile" and "Other Plan Network" tabs in the web portal.

Scenario 6: Health Plan's network includes Plan-to-Plan contracts with non-KKA- licensed health insurance plans

The Name of Network I am reporting includes providers obtained through one or more Plan-to-Plan contracts between my health plan and a full-service or specialized health insurance plan that is not licensed by the Department of Managed Health Care.

Instruction: If Scenario 6 describes your health plan, your health plan must report all providers available in your health plan's network via the subcontracted non-KKA-licensed health insurance plan for this Name of Network on the appropriate Department Report Forms (PCPs, Specialist, Mental Health, Hospitals, etc.).

Additional Scenario: "**BUT** what if my health plan contracts with the same provider on a direct contract basis (or through a medical group) and the same doctor is contracted by the non-KKA-licensed health insurance plan? Where or how does my health plan report this provider?"

Instruction: For reporting purposes, assuming all other provider information is the same (e.g. medical group, address, hospital admitting privileges), simply **list the provider once**.

When completing the "Network Arrangements" section of the Name of Network set-up under the Profile Tab in the web portal, identify this arrangement as "Direct Network." "Plan-to-Plan" arrangements should only be identified in the Network Arrangements section of the Profile tab if the Network has plan-to-plan arrangements with KKA-licensed health plans that are subject to timely access reporting requirements.

See the *Populating Report Forms (Excel Templates)* section below for specific instructions regarding how to report each individual provider.

Populating Report Forms (Excel Templates)

The Department's Annual Provider Network Report Forms ("Report Forms") are published annually on the DMHC public website by November 1 of every year. They are available for download from the Department's website at: http://www.dmhc.ca.gov/LicensingReporting/SubmitHealthPlanFilings/AnnualProviderNetworkReporting.aspx. The health plan is expected to report all plan-contracted providers within each reported provider network, as well as the service area covered by the network and the number of enrollees that each network services.

The data submitted within the Report Forms, in combination with the information provided for each network in the Profile tab of the web portal, comprises the body of information upon which the Department will conduct its annual network review. It is imperative that the Report Forms are completed accurately and include all of the required information so that the health plan's network can be properly reviewed by the Department.

The crosswalk section of the health plan's Profile tab sets forth a list of common provider types. This list reflects the types of providers the Department may review for when evaluating the network for adequacy. Please review these common provider types before submitting the Report Forms for each reporting network, to ensure that the health plan has not inadvertently omitted, or failed to crosswalk a common provider type in the Provider Roster submission. The provider types listed in the crosswalk section of the Profile tab represent common provider types only, and are not intended to be an exclusive list of all provider types are necessary for delivering basic health care services. For more information about how to view and complete the Department's crosswalks, see Profile Tab Instructions above.

The Department provides Report Forms in Excel format for Plans to submit the Provider Roster data for each Measurement Year. Each Report Form contains instructions for how to populate the fields. Those instructions are repeated below for reference. Additionally, the Department has received various questions regarding populating the Report Forms. The sections below provide the instructions for how to populate each Report Form and provide responses to Frequently Asked Questions raised regarding each form:

- Annual Provider Network Report Form – PCP and PCP Extenders
- Annual Provider Network Report Form – Specialists
- Annual Provider Network Report Form – Mental Health
- Annual Provider Network Report Form – Other Contracted Providers
- Annual Provider Network Report Form – Hospitals and Clinics
- Annual Provider Network Report Form – Enrollment and Service Area

Health plans do not need to submit all of the Report Forms provided on the DMHC website. Only the Report Forms that are applicable to the Plan's network should be completed, uploaded, and submitted to the Department. Every Plan must submit an Enrollment and Service Area Network Report Form. Please be sure your plan has included enrollment information for every Name of Network identified in the Profile Tab when it submits its Enrollment and Service Area Network Report Form.

The Report Forms posted on the Department's website are the *only allowable* format for submitting the provider network data required in Rule 1300.67.2.2, subd. (g)(2)(G). Some plans may have Excel 2003 or other versions with limited rows, in which case, please submit as many worksheets as necessary to report all health plan network information. To ensure clarity, please "name" your various spreadsheets and add numbers, for example: PCPs, PCPs2, PCPs3. The Department will accept any naming convention, and the plan is invited to explain the naming convention it has taken in the narrative explanation portion of the filing, if such explanation is warranted. Instructions for how to enter provider data into the Annual Provider Network Report Forms are included as a tab within each Report Form workbook and are repeated below.

Website Access and Report Submission

Once the health plan has completed populating the Department's Annual Provider Network Report Forms in accordance with the directions described above and on the "Instructions" tab of each Report Form, the health plan must submit the Report Forms to the Department via the health plan web portal available at the following URL: https://wpso.dmhc.ca.gov/secure/auth/default.aspx. In order to submit health plan Annual Provider Network Report Forms, please follow these steps:

1. Log into the portal,
2. Select "E-filing,"
3. Click on "Online Forms,"
4. Select "Timely Access" in the Form Type pull down menu, and select the appropriate Reporting Period from the next pull down menu, then click "Create,"
5. Click on the blue tab labeled "Profile" and follow the instructions for each category identified in the gray bars under the Profile tab to enter information about your Name of Network, Lines of Business, and health plan terminology.
6. Click on the blue tab labeled "Provider Network" and upload each of the Plan's Annual Provider Network Report Forms.
7. If you are a subcontracting plan reporting a network utilized by a primary plan, click on the blue tab labeled "Other Plan Network" and upload the Annual Provider Network Report Forms relevant to the network utilized by the primary plan.

Frequently Asked Questions – Website Access and Report Submission

1. **If I have a Quality Improvement Fee Plan ("QIF Plan"), do I have to file twice?**

   It depends. Only Plans with counterpart QIF Plans will see the QIF checkbox option at the top of the web form. This checkbox is selected only if the Primary Plan and the QIF Plan have identical networks. The Plan will login and submit its Annual Network Report Forms for one Plan ID and then login again under the counterpart Plan ID to select the QIF checkbox indicating that the report has been filed by reference. If the primary Plan and QIF have different networks, then each should file its own separate Annual Network Report Forms reflecting so.

2. **Do I have to submit all of the Report Forms provided?**

   No. Only the Report Forms that are applicable to the Plan's network should be completed, uploaded, and submitted to the Department. Every Plan must submit an Enrollment and Service Area Network Report Form. Please be sure your plan has included enrollment information for every Name of Network identified in the Profile Tab when it submits its Enrollment and Service Area Network Report Form. If the Plan completing this Report Form serves as a subcontracting plan in a plan-to-plan arrangement ("Subcontracting Plan") such that the Plan provides services to individuals who are enrolled in another plan ("Primary Plan"), please complete a separate Network Report Form reflecting the service area only for the Primary Plan that is serviced through the Reporting Plan. The Subcontracting Plan should not report the Primary Plan's enrollees.

3. **Can I upload Excel spreadsheets previously distributed by the Department or my own spreadsheet with the same information?**

   No. Because specific programming has been embedded into the finalized Report Forms for validation purposes, the Plan **must** save, complete, and upload the finalized Department Excel spreadsheets only available at the Department's public website: http://www.dmhc.ca.gov/LicensingReporting/SubmitHealthPlanFilings/AnnualProviderNetworkReporting.aspx

4. **Where do I get login/password access to the Department web portal or eFile application?**

   Each licensed health plan has an identified Administrative Contact who is able to assign login/password access to the Department web portal or

additional access to the eFile application. If you do not know who your health plan's Administrative Contact is, please contact the DMHC's Office of Plan Licensing at LicensingeFiling@dmhc.ca.gov for that information.

5. **Why won't the system accept my submission after adding my Plan's information to the sample Report Forms provided?**

   Sample Report Forms will not be accepted as a valid report submission. **The sample Report Forms are for viewing purposes only.** Only the finalized Department Excel spreadsheets available at the Department's public website will be accepted.

6. **It is taking a really long time for my Report Form to upload and/or validate. Is this normal?**

   Yes. Due to the amount of data contained in the spreadsheets and, depending on the bandwidth or internet speed of each Plan's internet connection, a Report Form upload may take upwards of up to one minute or more.

   The normal waiting time for the validation process should be within 5-10 minutes. The TAR Portal will identify the wait time to validate the Plan's files once files are submitted. If multiple users request the data validation at the same time, the waiting time for the validation process may be longer. If you don't receive an email notification for the validation result within an hour, feel free to contact Caily Langston at Caily.Langston@dmhc.ca.gov for assistance.

7. **The system won't let me upload my Report Form due to its size. How do I submit?**

   Due to the programming embedded into the Annual Provider Network Report Forms for the validation functionality, plus the data input by the Plans, a single completed Report Form may become fairly large and even exceed the 25MB limit. The Plan may divide its information and upload multiple Report Forms for each reporting category. If the Plan submits multiple Report Forms for one provider type, please name the files to clearly identify that all files relate to the same provider type (e.g. "Report Form PCP1," "Report Form PCP2," "Report Form PCP3," etc.).

   You may verify the file size by checking the file properties. Make sure the actual size of the file is under 25,000,000 bytes (25 MB).

8. **Does the portal accept .XLSX files? Are both .XLSX and .XLS file types compatible with the portal?**

Yes. The system will accept the ".xlsx" file extension. The Report Form provided by the Department is in ".xls" file extension (Excel 2003), but you may save the file as ".xlsx" format (Excel 2007/Excel 2010) and upload to the system.

9. **Are there any entities that have a Plan ID but are not subject to their own reporting?**

   Yes, there are Plans that are not subject to the timely access reporting requirements. Only KKA-licensed full-service and behavioral health plans are subject to timely access reporting. Restricted licensees, non-mental health specialized plans, or non-KKA-licensed health insurers are not required to submit timely access reports. Please see the Reporting Health Plan Network Arrangements section for more information regarding how to report providers made available to the reporting plan via a plan-to-plan arrangement with an entity that is not subject to timely access reporting.

10. **Do Medicare Advantage plans need to submit data for MY 2017?**

    Health plans may, but are not currently required to, submit Annual Network Review data for networks serving exclusively Medicare Advantage enrollees. A plan is required to submit network data for Measurement Year 2017 if the network associated with a Medicare line-of-business also serves lines-of-businesses other than Medicare Advantage, and these lines-of-business are subject to timely access reporting requirements.

11. **Do Cal-MediConnect plans need to submit data for MY 2017?**

    Health plans may, but are not currently required to, submit Annual Network Review data for networks serving exclusively Cal-MediConnect enrollees. A plan is required to submit network data for Measurement Year 2017 if the network associated with a Cal-MediConnect line-of-business also serves lines-of-businesses other than Cal-MediConnect, and these lines-of-business are subject to timely access reporting requirements.

Validation Tool

Annual Provider Network Report Forms are subject to validation at the time of submission. If one or more Report Form does not pass validation, it cannot be submitted to the Department. Report Forms are validated to ensure the following criteria are met:

- All data included in the Report Form meet the character limitations and requirements described in the Instructions (e.g. number and type of characters);

- Report Forms do not include any deactivated California license numbers or NPI numbers;
- Report Forms use DMHC preferred terminology or are appropriately crosswalked on the Profile Tab:
    - Note: If a Plan has crosswalked any of its terminology to the DMHC preferred terminology and uploads a Report Form that includes the Plan's crosswalked term at least once, the Plan will not be able to remove or change that term in the Crosswalk table until the Plan removes the Report Form that contains the Plan's crosswalked term. Once the Report Form containing the term is removed, the Plan may then make changes to that specific term in the Crosswalk table;
- Networks identified in the Profile Tab appear in the Report Forms;
- Counties identified as part of the approved service area on the Profile Tab appear in the Enrollment and Service Area Report Form;
- Counties reported to be in the state of California on any Report Form are in the DMHC preferred format or have been crosswalked to the DMHC preferred terminology;
- Counties reported in the Enrollment and Service Area Report Form are associated with ZIP codes that are confirmed to be within that county according to the USPS ZIP Code/County reference list;
- The same ZIP code is not entered in both the "Plan's Approved Service Area Zip Code" field and in the "Outside Service Area Zip Code" field in one row; and
- Plans have completed the "Alcohol and Other Drugs" question in the Profile Tab for any Name of Networks that include Large Group, IHSS, or Employer Group lines-of-business.

After a Plan has uploaded the Report Form for a particular provider type (e.g. PCP, Specialist, Hospital, etc.), the "Validate Reports" button must be selected in order for the system to check the Plan's uploaded data against the Plan's profile. It will scan the report and verify that the Report Form(s) uploaded meets the criteria as defined on the instruction tab of the specific spreadsheet and will ensure that information provided in the Report Form is consistent with the information provided in the Plan's Profile Tab. Once the validation process is complete, the plan will receive an email notification regarding the validation result. All Report Forms must be validated they can be successfully submitted to the Department and satisfy the timely access reporting requirement.

The Department makes the Validation Tool available in the timely access web portal in advance of the Provider Roster submission deadline so that plans may test their Report Forms to ensure they pass validation before attempting to submit the final timely access report. Health plans are encouraged to run samples of their data through the tool as frequently as necessary to ensure that all data meets specifications and will be accepted at the time the timely access submission is due.

Frequently Asked Questions – Validation Tool

1. **What is the "Validate Report(s)" button?**

   All Report Forms must be validated before the Annual Provider Network Report Forms will be successfully submitted to the Department.

   After a Plan has uploaded the Report Form for a particular network category (e.g. PCP, Specialist, Hospital, etc.), the "Validate Reports" button must be selected. The system will validate your uploaded data in a background process. It will scan the report and verify that the Report Form(s) uploaded for a particular category meets the criteria as defined on the instruction tab of the specific spreadsheet (e.g. required fields populated appropriately, valid data lengths, all four record types included for each physician or specialist, etc.) and will ensure that information provided in the Annual Provider Network Report Form is consistent with the information provided in the Plan's Profile Tab. Once the validation process is complete, you will receive an email notification regarding the validation result.

2. **My Report Form won't validate and I got an error report. How do I fix it?**

   If the validate function detects errors, the error report generated is very specific as to which tab and row number the error is located and then details the specific error for that field. Please see the instruction tab of the spreadsheet or the Plan's Profile Tab to verify the information and data length or format of the required/requested information for that field.

   To fix an identified error, please do the following:

   i. Access the original Excel file on your own network and make the corrections to the original spreadsheet.
   ii. Select the **Remove** link to delete the previously uploaded Report Form from the web portal/eFile application.
   iii. Upload the newly corrected Report Form to the web portal.
   iv. Select "Validate Reports."

   Please remember that once you fix an error in a report, you must re-submit the complete report, not just the data that was corrected. The new file will replace the previously-submitted document.

3. **I am getting the "data length is invalid" validation error, but the data looks correct to me in the Report Form. What could be the problem?**

   There are probably some extra spaces within the data. The system will count spaces as part of the data length, so please remove leading and trailing spaces from the data.

4. **Why can't I open the validation error report?**

   The validation error report will be generated in an Excel 2007 format. If you do not have Excel 2007 or later version, you can download the Microsoft Excel Viewer from this link (https://www.microsoft.com/en-us/download/details.aspx?id=10) to open the error report. Notice that if you are using Excel 2003 with Microsoft Office Compatibility Pack to open the error report, you may not be able to see the full report.

5. **Will my Report Form validate if I include a P.O. Box address for a contracted provider?**

   P.O. Box addresses are not allowed to be reported as provider addresses in the PCP, Specialists, Hospitals & Clinics, Other Contracted Providers, and Mental Health Professionals Network Report Forms. Any Network Report Form containing a P.O. Box address will not pass validation and will not be accepted as part of the Plan's annual network submission. Only the physical address in which an enrollee can obtain services may be reported as a provider address in the PCP, Specialists, Hospitals & Clinics, Other Contracted Providers, and Mental Health Professionals Network Report Forms.

   P.O. Box addresses ("P.O. Box ####") associated with a provider or a facility are not to be confused with P.O. Box-only zip codes that are permissible to report in the Enrollment and Service Area Network Report Form. The Department takes into consideration any zip code reported in the "Plan's Approved Service Area Zip Code" field in the Enrollment and Service Area Network Report Form when identifying a network's service area for the purpose of network adequacy review. If the Plan reports P.O. Box-only zip codes in the Enrollment and Service Area template, those zip codes are considered in be in the Plan's service area. The Department evaluates these types of zip codes similarly to the standard zip codes that surround it.

6. **How will the forms be validated on the front end against the ZIP County list the Department publishes?**

   The Enrollment and Service Area Report Form will be validated against the United States Postal Service (USPS) ZIP code/county list that the Department will provide within the "Resources" Tab of the Timely Access web portal. A network's ZIP code and county combinations reported within California must match the USPS list of ZIP code and county combinations shared with the Plan on the web portal. If the Plan reports enrollment outside of California for a particular network, the Plan must first properly crosswalk the out-of-state county if the county is not already listed in the County Crosswalk table.

With respect to validation on the Report Forms for providers and facilities (PCP, Specialist, Mental Health, etc.), when a health plan reports a provider with a California address, the address will not pass validation if the county listed is not a county within California.

7. How should the Plan report a provider who does not practice within its service area?

The Plan should report the entire network of contracted providers and locations for each reporting network, regardless of whether the contracted provider location is inside or outside of the network's service area. The Department derives the network's service area from the data reported on the "Enrollment and Service Area Report Form" for the network.

Annual Provider Network Report Form – PCP and PCP Extenders

The PCP and PCP Extenders Report Form is the only accepted reporting format for a health plan to report its contracted network of Primary Care Physicians ("PCPs") and PCP Extenders for the purposes of timely access reporting. The health plan's submission must reflect the Plan's contracted network of Primary Care Physicians ("PCPs") and PCP Extenders as of December 31st of the Measurement Year.

To begin populating data, enter all of the required/requested information on the spreadsheet included in the Report Form workbook. Enter an additional row for any variation in at least one of the fields, such as additional addresses, specialties, etc. All fields must be completed for each row; information in fields that do not change must be repeated in the row representing the variation. In some cases, the DMHC requires plans to use specific terminology or crosswalk the Plan's own terminology to the Department's preferred terms. These fields are identified within the Instructions below. The Plan may crosswalk its terminology utilizing the "Crosswalk" links within the Timely Access Reporting Web Portal under the Profile tab. See the Profile Tab Instructions above for more information.

Be sure to report all PCPs and PCP extenders in the Plan's contracted network. See the provider types listed by the DMHC in the "PCP Specialty Type" table found under the "Specialty Crosswalk" link in the Profile tab for guidance as to what provider types should be reported on this form. The provider type must be crosswalked to the Department's preferred terms, as described in the instructions below.

Instructions – PCP and PCP Extenders Annual Provider Network Report Form

PCPs Tab		
REQUIRED FIELD	***INSTRUCTIONS*** *Enter data in each field as described below. If a certain field is not applicable, please enter "NA" unless such an entry is identified as not acceptable in the instructions. Please do not leave any required fields blank unless the instruction states a blank field is acceptable.*	***Data Type (Length)***
Last Name	Last name of the provider. "NA" is not an acceptable value.	Text (1 to 50 characters)
First Name	First name of the provider. "NA" is not an acceptable value.	Text (1 to 50 characters)
NPI	The unique National Provider Identification (NPI) number assigned to the provider. The Plan must report both the provider's NPI and license number. Do not include deactivated NPIs. "NA" is not an acceptable value.	Number (10 digits)
CA License	California License number. Please format MD licenses with the following format: "A", "G" or "C" followed by sequence of digits with no spaces or leading zeros. Please format DO licenses with the following format: "20" followed by "A", "G" or "C" followed by sequence of digits with no spaces or leading zeros. All other CA Licenses should not have any spaces or leading zeros. Do not include deactivated CA Licenses. The Plan must report both the provider's NPI and license number. "NA" is not an acceptable value unless a license number is entered in the "Non CA License" field.	Text (4 to 15 characters)

Non CA License	License number where license was issued outside of the state of California. Do not include deactivated Licenses. May leave blank if not applicable.	Text (0 to 30 characters)
Non CA License State	State in which non-California license was issued. May leave blank if not applicable.	Text (0 to 30 characters)
Type of Licensure	The type of license held by the physician. *(Please make sure the Type of Licensure is referenced on the "Type of License and Service Crosswalk" tables found in the Profile tab in the Timely Access Reporting Web Portal.)* "NA" is not an acceptable value.	Text (1 to 100 characters)
Health Plan ID for Plan-to-Plan Contract	The Plan ID of another Plan with which the Reporting Plan contracts ("Subcontracting Plan"). Complete this field if the Reporting Plan does not directly contract with the provider but instead includes this provider in the network through a contract with a Subcontracted Health Plan that is not subject to Timely Access reporting. Health plans that may be reported in this field include subcontracted restricted Knox-Keene licensees, specialized Knox-Keene licensed health plans (e.g. dental, vision, chiropractic, and acupuncture plans), and any other Knox-Keene licensed health plans that are not subject to timely access reporting requirements pursuant to Rule 1300.67.2.2, subd. (a). ***Do not complete this field if a Subcontracted Health Plan is subject to timely access reporting requirements***. The Subcontracted Health Plan must separately submit its contracted providers on behalf of the Reporting Plan via the "Other Plan Network" tab in the Timely Access Reporting Web Portal. Do not put the Reporting Plan's own Health Plan ID in this field. All Knox-Keene licensed health plans' ID numbers can be found on the Department's public website: http://wpso.dmhc.ca.gov/hpsearch/viewLicensedHealthPlan.aspx. See the *MY 2017 Annual Provider Network Submission Instruction Manual* for more information. May leave blank if the provider is not accessed through a Plan-to-Plan contract.	Text (0 or 8 characters)
Current Number of Enrollees Assigned to Provider	Enter the total number of patients assigned to the provider in this Name of Network as of December 31, 2017. This number is the sum of all patients enrolled in the Name of Network and assigned to this provider across all provider locations. If this provider is listed more than once, please repeat this number for every row associated with this provider for the identified Name of Network. If this provider participates in one or more networks where patients are not assigned, please distribute patients equally across all providers participating in the Name of Network within each county within the service area. See the Department's *MY 2017 Annual Provider Network Submission Instruction Manual* for further direction as to how to populate this field for those network types.	Number (1 to 6 digits)
Name of Network	The name used by the Plan to describe the network in which the provider participates. Each named network should refer to a unique combination of providers that has been reviewed and approved by the DMHC for use with one or more lines-of-business. If the network is utilized for a Covered California line-of-business, please use the Network ID number assigned by Covered California. *(Please make sure the Name of Network is referenced on the "Name of Network" table in the Profile tab in the Timely Access Reporting Web Portal.)* "NA" is not an acceptable value.	Text (1 to 100 characters)
Network Tier ID	If the network is a tiered network, enter "1" for the providers participating in the tier with the lowest cost share for enrollees; enter "2" for the providers participating in the tier with the next-lowest cost share for enrollees. Continue to number tiers accordingly, with the higher tier number correlating to higher cost-share for the enrollee. May leave blank if not applicable.	Number (0 to 2 digits)
Clinic Name	The name of the clinic at which the provider offers services either part- or full-time, if applicable. If the provider practices at a clinic, enter the Clinic Name only in the row where the Plan is reporting the address that correlates to the clinic location. If the provider practices at other, non-clinic locations, leave this field blank in the rows where the Plan is reporting those locations. Clinic name should match the clinic name included on the "Clinics" worksheet on the Hospital and Clinics Annual Provider Network Report Form template. May leave blank if not applicable.	Text (0 to 100 characters)

Address	Physical address of the provider's practice location, including street number and street name. Do not include number for suite, office, building, etc. If reporting more than one address, enter an additional row identifying each additional office, clinic, or medical group address. Data for all non-address fields must be repeated in each row. If the provider also serves as a telehealth provider, include only the physical locations at which the provider treats patients. "NA" is not an acceptable value.	Text (1 to 100 characters)
Address 2	Insert the number of the office, suite, building, or other location identifier. If this information is not applicable to the address, leave blank.	Text (0 to 50 characters)
City	City in which the practice address is located. "NA" is not an acceptable value.	Text (1 to 50 characters)
County	County in which the practice address is located. *(Please make sure the County is referenced on the "County Crosswalk" table in the Profile tab in the Timely Access Reporting Web Portal.)* "NA" is not an acceptable value.	Text (1 to 50 characters)
State	State in which the practice address is located. "NA" is not an acceptable value.	Text (2 to 30 characters)
Zip Code	Zip code in which the practice address is located. "NA" is not an acceptable value.	Text (5 or 10 characters)
Phone Number	If appointments are offered at this location, enter the phone number, separating the area code and first 3 digits with a "-" (e.g. 123-456-7890). May leave blank if not applicable.	Text (0 to 12 characters)
Telehealth (Y/N)	Enter "Y" if the provider delivers telehealth services, otherwise enter "N." Telehealth is defined as: "the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers." (Bus. and Prof Code section 2290.5). Please enter a "Y" in this column if the provider is contracted to provide and currently provides synchronous or asynchronous health care services from a "distant" site to enrollees while the enrollee is at a health care provider's "originating" site.	Text (1 to 2 characters)
Accepting New Patients (Y/N)	Enter "Y" to indicate the provider is accepting new patients at this location, enter "N" to indicate the provider is not accepting new patients at this location. If the provider is only accepting existing patients, past patients, or patients from a waitlist, please enter "N" in this field. If the Plan is uncertain as to whether a provider is accepting new patients, enter "N." See the *MY 2017 Annual Provider Network Submission Instruction Manual* for information regarding how to report this field in a PPO product or other product type in which patients are not assigned to a PCP. "NA" is not an acceptable value.	Text (1 character)
Specialty	Enter the provider's specialty. If the provider has more than one specialty, enter an additional row identifying each additional specialty. Data for all other fields must be repeated in each row. Only report providers that serve as a PCP for the identified Name of Network in this field. If a provider does not serve as a PCP for the identified Name of Network, the Plan should not report the provider as a PCP. If the provider only serves as a specialist for the identified Name of Network, the provider should be reported on the Specialist Annual Provider Network Report Form template. If the provider serves as both a PCP and a Specialist for the identified Name of Network (e.g. obstetrician/gynecologists), the provider should be reported on both the PCP Annual Provider Network Report Form template and the Specialist Annual Provider Network Report Form template. When reporting the Specialty, make sure the Specialty is referenced on the "PCP Specialty Type" table found under the "Specialty Crosswalk" link in the Profile tab in the Timely Access Reporting Web Portal. If the provider's specialty does not appear on the "Specialty Crosswalk" table, please crosswalk the specialty type to "Other." "NA" is not an acceptable value.	Text (1 to 100 characters)

Board Certified or Eligible (Y/N)	Enter "Y" if the provider is board-certified or board-eligible, otherwise enter "N".	Text (1-2 characters)
Provider Group/IPA	Name of the provider group and/or IPA affiliated with the contracted provider (if applicable). If the provider is associated with more than one provider group or IPA, enter an additional row identifying each additional provider group or IPA. Data for all other fields must be repeated in each row. If the provider is not affiliated with a provider group, please enter the value "Individually Contracted Provider" as set forth in the Profile tab in the Timely Access Reporting Web Portal. *(Please make sure the Provider Group is referenced on the "Provider Groups/IPA Crosswalk" table in the Profile tab in the Timely Access Reporting Web Portal.)*	Text (1 to 100 characters)
Facility	Enter the name of each hospital with which the provider holds privileges or the facility at which the provider primarily delivers services. Facility refers to a licensed hospital, ambulatory surgery center, laboratory, radiology or imaging center, other outpatient setting as described in Health and Safety Code § 1248.1, and any other facility contemplated under Health and Safety Code § 1371.9, subd. (f)(1). If the provider has admitting privileges at more than one hospital, enter an additional row identifying each additional hospital. If the provider uses a hospitalist or some other physician arrangement to admit patients to one or more hospitals, please enter the hospital name in this field. If the provider is facility-based and works primarily at one or more facility locations, list the facility in this field. Enter an additional row identifying each additional facility. When reporting more than one hospital or facility affiliation for the provider, data for all other fields must be repeated in each row. *(If entering a hospital name in this field, please make sure the Hospital is referenced on the "Hospitals Crosswalk" table in the Profile tab in the Timely Access Reporting Web Portal. If entering a clinic or other facility type that has been reported on another Network Report Form template, please enter the name of that facility exactly as it appears on the other Network Report Form.)*	Text (1 to 100 characters)
Facility NPI	Enter the NPI number corresponding to the facility or hospital identified in the "Facility" field.	Number (10 digits)
Is the Provider Listed in the Directory?	Identify whether or not, on December 31, 2017, the provider was listed in the Plan's online provider directory/directories maintained pursuant to section 1367.27, as follows: • Enter a "Y" if the provider was listed at the location indicated in the "Address" field and with the specialty type identified in the "Specialty/Subspecialty" field. • Enter an "R" if the provider and/or the associated location and specialty information described in the "Address" field and "Specialty/Subspecialty" field was removed from the directory pursuant to section 1367.27, subd. (l), resulting from failure to respond to plan notification seeking verification of directory information. • Enter an "O" if the provider and/or the associated location and specialty information described in the "Address" field and "Specialty/Subspecialty" field was omitted from the directory. "Omitted providers" refers to providers that are in the Plan's contracted network but are purposely left out of the provider directory. • Enter an "S" if the provider and/or the associated location and specialty information described in the "Address" field and/or "Specialty/Subspecialty" field was withheld from the directory pursuant to the DMHC's uniform provider directory standards and/or DMHC approval. • Enter an "N" if the provider was not listed in the directory at the location indicated in the "Address" field and with the specialty identified in the "Specialty/Subspecialty" field for any reason other than those listed above.	Text (1 to 2 characters)

REQUESTED FIELD	***INSTRUCTIONS*** *Enter data in each field as described below. If a certain field is not applicable, please enter "NA" unless such an entry is identified as not acceptable in the instructions. Requested fields may be left blank.*	***Data Type (Length)***

Provider Language 1	Language spoken by the provider. *(Please make sure the Provider Language 1 is referenced on the "Language Crosswalk" table in the Profile tab in the Timely Access Reporting Web Portal.)*	Text (0 to 50 characters)
Provider Language 2	Language spoken by the provider. *(Please make sure the Provider Language 2 is referenced on the "Language Crosswalk" table in the Profile tab in the Timely Access Reporting Web Portal.)*	Text (0 to 50 characters)
Provider Language 3	Language spoken by the provider. *(Please make sure the Provider Language 3 is referenced on the "Language Crosswalk" table in the Profile tab in the Timely Access Reporting Web Portal.)*	Text (0 to 50 characters)

PCP Extenders Tab		
REQUIRED FIELD	***INSTRUCTIONS*** *Enter data in each field as described below. If a certain field is not applicable, please enter "NA" unless such an entry is identified as not acceptable in the instructions. Please do not leave any required fields blank unless the instruction states a blank field is acceptable.*	***Data Type (Length)***
Last Name	Last name of the provider. "NA" is not an acceptable value.	Text (1 to 50 characters)
First Name	First name of the provider. "NA" is not an acceptable value.	Text (1 to 50 characters)
NPI	The unique National Provider Identification (NPI) number assigned to the provider. The Plan must report both the provider's NPI and license number. Do not include deactivated NPIs. "NA" is not an acceptable value.	Number (10 digits)
CA License	California License number. All CA Licenses should not have any spaces or leading zeros. Do not include deactivated CA Licenses. The Plan must report both the provider's NPI and license number. "NA" is not an acceptable value.	Text (4 to 15 characters)
Type of Licensure	The type of license held by the provider. *(Please make sure the Type of Licensure is referenced on the "Type of License and Service Crosswalk" table found in the Profile tab in the Timely Access Reporting Web Portal.)* "NA" is not an acceptable value.	Text (1 to 100 characters)
Health Plan ID for Plan-to-Plan Contract	The Plan ID of another Plan with which the Reporting Plan contracts ("Subcontracting Plan"). Complete this field if the Reporting Plan does not directly contract with the provider but instead includes this provider in the network through a contract with a Subcontracted Health Plan that is not subject to Timely Access reporting. Health plans that may be reported in this field include subcontracted restricted Knox-Keene licensees, specialized Knox-Keene licensed health plans (e.g. dental, vision, chiropractic, and acupuncture plans), and any other Knox-Keene licensed health plans that are not subject to timely access reporting requirements pursuant to Rule 1300.67.2.2, subd. (a). ***Do not complete this field if a Subcontracted Health Plan is subject to timely access reporting requirements***. The Subcontracted Health Plan must separately submit its contracted providers on behalf of the Reporting Plan via the "Other Plan Network" tab in the Timely Access Reporting Web Portal. Do not put the Reporting Plan's own Health Plan ID in this field. All Knox-Keene licensed health plans' ID numbers can be found on the Department's public website: http://wpso.dmhc.ca.gov/hpsearch/viewLicensedHealthPlan.aspx. See the *MY 2017 Annual Provider Network Submission Instruction Manual* for more information. May leave blank if the provider is not accessed through a Plan-to-Plan contract.	Text (0 or 8 characters)
Current Number of Enrollees Assigned to Provider	If the Plan assigns patients to the extender, enter the total number of patients assigned to the provider in this Name of Network as of December 31, 2017. This number is the sum of all patients enrolled in the Name of Network and assigned to this provider across all provider locations. If this provider is listed more than once, please repeat this number for every row associated with this provider for the identified Name of Network. May leave blank if Plan does not assign enrollees to the extender.	Number (0 to 6 digits)

Name of Network	The name used by the Plan to describe the network in which the provider participates. Each named network should refer to a unique combination of providers that has been reviewed and approved by the DMHC for use with one or more lines-of-business. If the network is utilized for a Covered California line-of-business, please use the Network ID number assigned by Covered California. *(Please make sure the Name of Network is referenced on the "Name of Network" table in the Profile tab in the Timely Access Reporting Web Portal.)* "NA" is not an acceptable value.	Text (1 to 100 characters)
Clinic Name	The name of the clinic at which the provider offers services either part- or full-time, if applicable. If the provider practices at a clinic, enter the Clinic Name only in the row where the Plan is reporting the address that correlates to the clinic location. If the provider practices at other, non-clinic locations, leave this field blank in the rows where the Plan is reporting those locations. Clinic name should match the clinic name included on the "Clinics" worksheet on the Hospital and Clinics Annual Provider Network Report Form template. May leave blank if not applicable.	Text (0 to 100 characters)
Address	Physical address of the provider's practice location, including street number and street name. Do not include number for suite, office, building, etc. If reporting more than one address, enter an additional row identifying each additional office, clinic, or medical group address. Data for all non-address fields must be repeated in each row. If the provider also serves as a telehealth provider, include only the physical locations at which the provider treats patients. "NA" is not an acceptable value.	Text (1 to 100 characters)
Address 2	Insert the number of the office, suite, building, or other location identifier. If this information is not applicable to the address, leave blank.	Text (0 to 50 characters)
City	City in which the practice address is located. "NA" is not an acceptable value.	Text (1 to 50 characters)
County	County in which the practice address is located. *(Please make sure the County is referenced on the "County Crosswalk" table in the Profile tab in the Timely Access Reporting Web Portal.)* "NA" is not an acceptable value.	Text (1 to 50 characters)
State	State in which the practice address is located. "NA" is not an acceptable value.	Text (2 to 30 characters)
Zip Code	Zip code in which the practice address is located. "NA" is not an acceptable value.	Text (5 or 10 characters)
Phone Number	If appointments are offered at this location, enter the phone number, separating the area code and first 3 digits with a "-" (e.g. 123-456-7890). May leave blank if not applicable.	Text (0 to 12 characters)
Telehealth (Y/N)	Enter "Y" if the provider delivers telehealth services, otherwise enter "N." Telehealth is defined as: "the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers." (Bus. and Prof Code section 2290.5). Please enter a "Y" in this column if the physician provides significant amounts of synchronous or asynchronous health care services from a "distant" site to enrollees while the enrollee is at a health care provider's "originating" site.	Text (1 to 2 characters)
Accepting New Patients (Y/N)	Enter "Y" to indicate the provider is accepting new patients at this location, enter "N" to indicate the provider is not accepting new patients at this location. If the provider is only accepting existing patients, past patients, or patients from a waitlist, please enter "N" in this category. See the *MY 2017 Annual Provider Network Submission Instruction Manual* document for information regarding how to report this field in a PPO product or other product type in which patients are not assigned to a PCP.	Text (1 to 2 characters)
NPI of Supervising PCP	National Provider Identification (NPI) number of the individual PCP that supervises the extender.	Number (10 digits)

Provider Group / IPA	Name of the provider group and/or IPA affiliated with the contracted provider (if applicable). If the provider is associated with more than one provider group or IPA, enter an additional row identifying each additional provider group or IPA. Data for all other fields must be repeated in each row. If the provider is not affiliated with a provider group, please enter the value "Individually Contracted Provider" as set forth in the Profile tab in the Timely Access Reporting Web Portal. *(Please make sure the Provider Group is referenced on the "Provider Groups/IPA Crosswalk" table in the Profile tab in the Timely Access Reporting Web Portal.)*	Text (1 to 100 characters)
Is the Provider Listed in the Directory?	Identify whether or not, on December 31, 2017, the provider was listed in the Plan's online provider directory/directories maintained pursuant to section 1367.27, as follows: • Enter a "Y" if the provider was listed at the location indicated in the "Address" field and with the specialty type identified in the "Specialty/Subspecialty" field. • Enter an "R" if the provider and/or the associated location and specialty information described in the "Address" field and "Specialty/Subspecialty" field were removed from the directory pursuant to section 1367.27, subd. (l), resulting from failure to respond to plan notification seeking verification of directory information. • Enter an "O" if the provider and/or the associated location and specialty information described in the "Address" field and "Specialty/Subspecialty" field were omitted from the directory. "Omitted providers" refers to providers that are in the Plan's contracted network but are purposely left out of the provider directory. • Enter an "S" if the provider and/or the associated location and specialty information described in the "Address" field and/or "Specialty/Subspecialty" field were withheld from the directory pursuant to the DMHC's uniform provider directory standards and/or DMHC approval. • Enter an "N" if the provider was not listed in the directory at the location indicated in the "Address" field and with the specialty identified in the "Specialty/Subspecialty" field for any reason other than those listed above.	Text (1 to 2 characters)

REQUESTED FIELD	***INSTRUCTIONS*** *Enter data in each field as described below. If a certain field is not applicable, please enter "NA" unless such an entry is identified as not acceptable in the instructions. Requested fields may be left blank.*	***Data Type (Length)***
Provider Language 1	Language spoken by the provider. *(Please make sure the Provider Language 1 is referenced on the "Language Crosswalk" table in the Profile tab in the Timely Access Reporting Web Portal.)*	Text (0 to 50 characters)
Provider Language 2	Language spoken by the provider. *(Please make sure the Provider Language 2 is referenced on the "Language Crosswalk" table in the Profile tab in the Timely Access Reporting Web Portal.)*	Text (0 to 50 characters)
Provider Language 3	Language spoken by the provider. *(Please make sure the Provider Language 3 is referenced on the "Language Crosswalk" table in the Profile tab in the Timely Access Reporting Web Portal.)*	Text (0 to 50 characters)

Frequently Asked Questions – PCP and PCP Extenders Annual Provider Network Report Form

1. How do I populate the "NPI" and "CA License" field in the PCP Report Form if my plan does not capture NPI or CA license information for some or all of its PCPs or PCP Extenders?

The DMHC recommends that the Plan utilize the Department of Consumer Affairs website (http://www.dca.ca.gov/) or the NPI database (https://npiregistry.cms.hhs.gov/) to identify the provider license or NPI number, respectively, of its providers.

DMHC has included two columns in the Report Forms that allow the Plan to identify providers who are licensed in a state other than California and to provide the out-of-state license number. Please only report a provider's out-of-state license number if they do not also have a California license number.

2. **Do I need to report Tax Identification Numbers ("TINS") or Social Security Numbers in the report?**

   No. The finalized network Report Forms for the March 31, 2018 submission do not request Plans to include TINs or SSNs and the Department specifically requests that Plans do not include any type of Personally Identifiable Information in the Report Forms beyond the information that is being requested. Prior to submission of the data, Plans will be asked to affirm that the submission does not contain any Personal Health Information or Personally Identifiable Information.

3. **My Plan offers a PPO product in which patients are not assigned to PCPs. How should I populate the "Current Number of Enrollees Assigned to Provider" field for these types of products?**

   For Measurement Year 2017 (due March 31, 2018), the methodology described below for reporting "Current Number of Patients Assigned" for PPO lines-of-business will be accepted by the DMHC. All calculations of patients assigned to providers should be conducted based on "County" and "Name of Network" reported in the Annual Provider Network Report Forms. Please note, if the Plan maintains more than one PPO network name (e.g. California Blue PPO Network, California Gold PPO Network, etc.), please separately calculate the number of patients assigned for each PPO network using the following methodology:

   i. Identify the total number of enrollees in that PPO network name residing in that county as of December 31, 2017.
   ii. Identify the total number of PCPs in that PPO network practicing in that county as of December 31, 2017.
   iii. Divide the number of enrollees (item 1) by the number of PCPs (item 2).
   iv. Place the resulting number in the column entitled "Current Number of Enrollees Assigned to Provider" for each PCP located within that county and contracted in the specific PPO product.

v. Repeat this value in the "Number of Patients Assigned" column for every entry related to the same provider when reporting this Name of Network.

For example, there are 2,000 enrollees in Los Angeles County and 50 PCPs associated with the Plan's "California Blue PPO" Name of Network. Divide the number of enrollees by the number of PCPs to get an average of 40 enrollees per PCP. On the PCP Annual Provider Network Report Form template, enter "40" in the column "Current Number of Patients Assigned" for every PCP listed on the template with the identified name of network "California Blue PPO" and the identified county of "Los Angeles."

Last Name	First Name	NPI	Current Number of Enrollees Assigned to Provider	Name of Network	Address	City	County	State	Zip Code	Provider Group/IPA
West	Robert	1234567899	40	California Blue PPO Network	123 Main Street	San Gabriel	Los Angeles	CA	91776	Facey Medical Group
West	Robert	1234567899	40	California Blue PPO Network	456 Van Owen Street	Burbank	Los Angeles	CA	91111	Facey Medical Group
West	Robert	1234567899	40	California Blue PPO Network	789 Orange Street	Valencia	Los Angeles	CA	92222	Facey Medical Group
West	Robert	1234567899	40	California Blue PPO Network	123 Main Street	San Gabriel	Los Angeles	CA	91776	Health Care Partners
West	Robert	1234567899	40	California Blue PPO Network	456 Van Owen Street	Burbank	Los Angeles	CA	91111	Health Care Partners
West	Robert	1234567899	40	California Blue PPO Network	789 Orange Street	Valencia	Los Angeles	CA	92222	Health Care Partners
West	Robert	1234567899	100	California Gold PPO Network	123 Main Street	San Gabriel	Los Angeles	CA	91776	Facey Medical Group
West	Robert	1234567899	100	California Gold PPO Network	456 Van Owen Street	Burbank	Los Angeles	CA	91111	Facey Medical Group
West	Robert	1234567899	100	California Gold PPO Network	789 Orange Street	Valencia	Los Angeles	CA	92222	Facey Medical Group
West	Robert	1234567899	100	California Gold PPO Network	123 Main Street	San Gabriel	Los Angeles	CA	91776	Health Care Partners
West	Robert	1234567899	100	California Gold PPO Network	456 Van Owen Street	Burbank	Los Angeles	CA	91111	Health Care Partners
West	Robert	1234567899	100	California Gold PPO Network	789 Orange Street	Valencia	Los Angeles	CA	92222	Health Care Partners

4. My Plan offers a PPO product in which patients are not assigned to PCPs. How should I populate the "Accepting New Patients" field for these types of products?

The Plan must complete the "Accepting New Patients" column for each PCP in the PPO network. If the PCP is continually accepting new referrals, the Plan may enter "Y" in this column. If the Plan maintains a contract with the physician under which the physician must accept all patients from this product line, the Plan may enter "Y" in this column. If the Plan does not have a contractual clause that requires the physician to accept all patients and the Plan does not have specific information as to whether or not the provider is accepting new patients, the Plan may enter "NA" in this field.

5. My Plan assigns patients to a delegated provider group and the group then assigns the patients to individual PCPs. How do I complete the "Current Number of Enrollees Assigned to Provider" tab?

If the Plan assigns to a delegated provider group, please first list all of the individual physicians available through that delegated group on the PCP Report Form. Second, clarify with the group whether they assign patients to a particular provider within the group. If the group or site assigns patients to specific individual PCPs, obtain that information from the group and list the number of patients assigned for each PCP on the Plan's provider list. If no assignment is made, i.e. a patient may see any PCP

within the group or site at any time and does not have a particular PCP identified on their membership card, the DMHC will accept the following methodology, calculated for each individual Name of Network:

i. Identify the total number of enrollees in the Name of Network assigned to the group. (Example: 2,000 enrollees in the California Gold HMO Network are assigned to Facey Medical Group.)
ii. Identify the total number of individual PCPs available to this Name of Network through the group. (Example: 8 PCPs are in Facey Medical Group and are available to the California Gold HMO Network).
iii. Divide the number of enrollees (item 1) by the number of PCPs (item 2). (Example: 2,000/8 = 250.)
iv. Place the resulting number in the column entitled "Current Number of Enrollees Assigned to Provider" for each individual PCP that is associated with that group and included in that Name of Network.

Please ensure that the numbers entered in this field are specific to the Name of Network being reported. For example, if the Plan contracts with the same medical group to participate in multiple networks, it must identify the number of patients from each Name of Network that are assigned to the providers and report only the number of patients assigned to that provider for the specific Name of Network being reported.

Example:

Last Name	First Name	NPI	Current Number of Enrollees Assigned to Provider	Name of Network	Address	City	County	State	Zip Code	Provider Group/IPA
West	Robert	1234567899	250	California Gold HMO Network	123 Main Street	San Gabriel	Los Angeles	CA	91776	Facey Medical Group
West	Robert	1234567899	250	California Gold HMO Network	456 Van Owen Street	Burbank	Los Angeles	CA	91111	Facey Medical Group
West	Robert	1234567899	250	California Gold HMO Network	789 Orange Street	Valencia	Los Angeles	CA	92222	Facey Medical Group
West	Robert	1234567899	500	California Gold HMO Network	123 Main Street	San Gabriel	Los Angeles	CA	91776	Heal h Care Partners
West	Robert	1234567899	500	California Gold HMO Network	456 Van Owen Street	Burbank	Los Angeles	CA	91111	Heal h Care Partners
West	Robert	1234567899	500	California Gold HMO Network	789 Orange Street	Valencia	Los Angeles	CA	92222	Heal h Care Partners
West	Robert	1234567899	200	California Blue HMO Network	123 Main Street	San Gabriel	Los Angeles	CA	91776	Facey Medical Group
West	Robert	1234567899	200	California Blue HMO Network	456 Van Owen Street	Burbank	Los Angeles	CA	91111	Facey Medical Group
West	Robert	1234567899	200	California Blue HMO Network	789 Orange Street	Valencia	Los Angeles	CA	92222	Facey Medical Group
West	Robert	1234567899	700	California Blue HMO Network	123 Main Street	San Gabriel	Los Angeles	CA	91776	Heal h Care Partners
West	Robert	1234567899	700	California Blue HMO Network	456 Van Owen Street	Burbank	Los Angeles	CA	91111	Heal h Care Partners
West	Robert	1234567899	700	California Blue HMO Network	789 Orange Street	Valencia	Los Angeles	CA	92222	Heal h Care Partners

6. My Plan utilizes a staff model arrangement where the Plan assigns enrollees to a particular group or site. How do I complete the "Current Number of Enrollees Assigned to Provider" tab?

In a staff model arrangement, where enrollees are assigned to a particular group or site, please first list all of the individual physicians available through that delegated group on the PCP Report Form. Second, clarify with the group whether they assign patients to a particular provider within the group. If the group or site assigns patients to specific individual PCPs, list the number of patients assigned for each PCP on the Plan's provider list. If no assignment is made, i.e. a patient may see any PCP within the group or site at any time and does not have a particular PCP identified on their membership card, then the DMHC will accept the following methodology:

i. Identify the total number of enrollees assigned to the group or site for the Name of Network being reported. (Example: 2,800 enrollees in the California Blue HMO Network are assigned to Health Care Partners.)
ii. Identify the total number of individual PCPs available through the group or site for the Name of Network being reported. (Example: 7 PCPs are in Health Care Partners and are available to California Blue HMO Network enrollees.)
iii. Divide the number of enrollees (item 1) by the number of PCPs (item 2). (Example: 2,800/4 = 700.)
iv. Place the resulting number in the column entitled "Current Number of Enrollees Assigned to Provider" for each individual PCP associated with that group or site.

Please ensure that the numbers entered in this field are specific to the Name of Network being reported. For example, if the Plan assigns to the same group or site for participation in multiple networks, it must identify the number of patients from each Name of Network that are assigned to the providers and report only the number of patients assigned to that provider for the specific Name of Network being reported.

Last Name	First Name	NPI	Current Number of Enrollees Assigned to Provider	Name of Network	Address	City	County	State	Zip Code	Provider Group/IPA
West	Robert	1234567899	250	California Gold HMO Network	123 Main Street	San Gabriel	Los Angeles	CA	91776	Facey Medical Group
West	Robert	1234567899	250	California Gold HMO Network	456 Van Owen Street	Burbank	Los Angeles	CA	91111	Facey Medical Group
West	Robert	1234567899	250	California Gold HMO Network	789 Orange Street	Valencia	Los Angeles	CA	92222	Facey Medical Group
West	Robert	1234567899	500	California Gold HMO Network	123 Main Street	San Gabriel	Los Angeles	CA	91776	Health Care Partners
West	Robert	1234567899	500	California Gold HMO Network	456 Van Owen Street	Burbank	Los Angeles	CA	91111	Health Care Partners
West	Robert	1234567899	500	California Gold HMO Network	789 Orange Street	Valencia	Los Angeles	CA	92222	Health Care Partners
West	Robert	1234567899	200	California Blue HMO Network	123 Main Street	San Gabriel	Los Angeles	CA	91776	Facey Medical Group
West	Robert	1234567899	200	California Blue HMO Network	456 Van Owen Street	Burbank	Los Angeles	CA	91111	Facey Medical Group
West	Robert	1234567899	200	California Blue HMO Network	789 Orange Street	Valencia	Los Angeles	CA	92222	Facey Medical Group
West	Robert	1234567899	700	California Blue HMO Network	123 Main Street	San Gabriel	Los Angeles	CA	91776	Health Care Partners
West	Robert	1234567899	700	California Blue HMO Network	456 Van Owen Street	Burbank	Los Angeles	CA	91111	Health Care Partners
West	Robert	1234567899	700	California Blue HMO Network	789 Orange Street	Valencia	Los Angeles	CA	92222	Health Care Partners

7. How do I report "Current Number of Enrollees Assigned to Provider" when the PCP has multiple addresses, specialties, or other data that will warrant multiple rows?

If the Plan must enter multiple rows for the same provider in one Name of Network, report the total number of enrollees assigned to the physician by Name of Network. If the physician has a different number of patients assigned at each location or by different medical groups within the same name of network, please add all number of patients assigned across locations and medical groups for the name of network being reported and place that number in all subsequent records for that physician within that name of network.

Example: Robert West is contracted in two of the Plan's participating networks, has three locations and participates in two medical groups. For the California Gold HMO network, Dr. West has 100 patients assigned to him by Facey Medical Group and 150 patients assigned to him by Health Care Partners, for a total of 250 patients assigned to Dr. West in the California Gold HMO Network. For the California Blue HMO Network, Dr. West has 200 patients assigned to him by Facey Medical Group and 300 patients assigned to him by Health Care Partners, for a total of 500 patients assigned to Dr. West in the California Blue HMO Network. To enter data for Dr. West the relevant fields of the Plan's spreadsheet would look like this:

Last Name	First Name	NPI	Current Number of Enrollees Assigned to Provider	Name of Network	Address	City	County	State	Zip Code	Provider Group/IPA
West	Robert	1234567899	250	California Gold HMO Network	123 Main Street	San Gabriel	Los Angeles	CA	91776	Facey Medical Group
West	Robert	1234567899	250	California Gold HMO Network	456 Van Owen Street	Burbank	Los Angeles	CA	91111	Facey Medical Group
West	Robert	1234567899	250	California Gold HMO Network	789 Orange Street	Valencia	Los Angeles	CA	92222	Facey Medical Group
West	Robert	1234567899	250	California Gold HMO Network	123 Main Street	San Gabriel	Los Angeles	CA	91776	Health Care Partners
West	Robert	1234567899	250	California Gold HMO Network	456 Van Owen Street	Burbank	Los Angeles	CA	91111	Health Care Partners
West	Robert	1234567899	250	California Gold HMO Network	789 Orange Street	Valencia	Los Angeles	CA	92222	Health Care Partners
West	Robert	1234567899	500	California Blue HMO Network	123 Main Street	San Gabriel	Los Angeles	CA	91776	Facey Medical Group
West	Robert	1234567899	500	California Blue HMO Network	456 Van Owen Street	Burbank	Los Angeles	CA	91111	Facey Medical Group
West	Robert	1234567899	500	California Blue HMO Network	789 Orange Street	Valencia	Los Angeles	CA	92222	Facey Medical Group
West	Robert	1234567899	500	California Blue HMO Network	123 Main Street	San Gabriel	Los Angeles	CA	91776	Health Care Partners
West	Robert	1234567899	500	California Blue HMO Network	456 Van Owen Street	Burbank	Los Angeles	CA	91111	Health Care Partners
West	Robert	1234567899	500	California Blue HMO Network	789 Orange Street	Valencia	Los Angeles	CA	92222	Health Care Partners

8. My Plan delivers some primary care and specialty physician services via a contract with a Federally Qualified Health Center ("FQHC") which employs many individual physicians and has multiple clinic locations. How do I report this arrangement on the Report Forms?

List each individual physician that is available at the FQHC on separate rows within the Report Form. Identify the physician's association with the

FQHC in the “Provider Group/IPA” field and identify the specific FQHC site or location name within the “Clinic Name” field. If the physician is associated with more than one provider group, IPA, or FQHC, enter an additional row identifying each additional provider group, IPA, or FQHC. Data for all other fields must be repeated in each row. Please make sure the FQHC is referenced on the "Provider Groups/IPA Crosswalk" table in the Profile tab in the Timely Access Reporting web portal.

9. **My Plan contracts with medical groups who contract with their own hospitalist groups and my Plan does not track or maintain which groups use which hospitalists at each specific hospital. How do I complete the Facility and Facility NPI fields in the PCP Annual Provider Network Report Form?**

   Where the Plan’s physicians are contracted via a medical group and that medical group maintains a contract with a hospitalist group for admitting privileges, please report admitting privileges on the PCP Report Form as follows:

   - Where the Plan has confirmation from the medical group that all physicians within that group may utilize the hospitalist group to admit to specific hospitals, please identify all hospitals with which the hospitalist group maintains admitting privileges and enter each hospital name in the “Facility” column on the PCP Report Form for each physician associated with that medical group.

     Example: Dr. Jones, a specialist, is part of ABC Medical Group. ABC Medical Group has a contract with XYZ Hospitalist Group. XYZ Hospitalist group has hospitalists who can admit to Memorial Hospital and General Hospital. On the Specialist Report Form, enter Dr. Jones twice. On the first entry, list “General Hospital” in the “Facility” column. On the second entry, list “Memorial Hospital” in the “Facility” column.

   - Where the Plan has confirmed that some physicians within the medical group may utilize the hospitalist group to admit to specific hospitals, please identify all hospitals with which the hospitalist group maintains admitting privileges and enter each hospital name in the “Facility” column on the PCP Report Form for only those physicians identified by the medical group as being able to admit via a hospitalist.

10. **My Plan has multiple categories to describe whether a PCP is accepting new patients. How do I populate the “Accepting New Patients” column in the PCP Report Form?**

The purpose of the “Accepting New Patients” field is to identify if the provider accepts new patients versus accepting existing or past patients. The Plan would populate the field with an “N” if the provider does not accept any new patients even though the provider is able to accept appointments for existing or past patients. If the provider maintains a contract with the Plan for this Plan product under which the provider is required to accept all patients, please place a “Y” in this category. If the Plan does not know if the provider is accepting new patients, and the contract does not require the provider to take all patients, please enter “NA” in the “Accepting New Patients” column.

11. What is a Network Tier ID?

The Network Tier ID column only applies to those Plans that operate a tiered network. A tiered network is a product in which the Plan offers more than one “participating network” at different levels of cost- sharing. For example, in a tiered PPO network, an enrollee may access a Plan- defined group of participating providers (“Tier 1”) and pay only 20% of the cost, or they can choose to access a separate Plan-defined group of participating providers (“Tier 2”) and pay 40% of the cost, or they can choose to access a provider outside of the participating network and pay 60% of the cost. When completing the Annual Provider Network Report Forms, the Plan would identify the Tier 1 providers as a “1” in the “Network Tier ID” column, then it would identify the Tier 2 providers as a “2” in the “Network Tier ID” column. Please note: If the Plan also maintains an out-of-network benefit, the Plan should not submit the out-of-network providers on its Annual Provider Network Report Forms.

12. My Plan does not maintain the office number, suite number, building, or other location identifier for providers in a distinct field, therefore I cannot complete the “Address 2” column. Will this cause the data to be rejected?

The Address 2 field is an optional field for Plans that separate the number of the office, suite, building, or other location identifier in their own databases. The validation tool will accept this information in the “Address” or “Address 2” field. If the Plan does not separate out the office number, suite number, building, or other location identifier into a separate column, please leave the “Address 2” field blank.

13. For Provider Specialty, there is a validation error on “Obstetrics and Gynecology.” This is a valid value based on the pick list and provider type. I have tried multiple times to correct it but nothing is working. Is it OK to submit with the validation error?

You are receiving this error because the Plan attempted to enter the value "Obstetrics and Gynecology" in the Specialty column without first

crosswalking that terminology to the Department's preferred term ("Obstetrics/Gynecology"). Please map “Obstetrics and Gynecology” to the Department's preferred terminology in the Specialty crosswalk table in the Profile Tab to resolve this validation error.

14. **I have one or more contracted providers whose given first or last name is “Na,” but I cannot submit the Report Form because that value is not allowed in the first or last name fields.**

    Please add a period to the provider’s first name to read as “Na.” and the DMHC will remove the period on its end post-submission. Please note that entering “NA” for the purposes of indicating the first or last name is not available is not a valid entry in this field. The solution described in this example is only to be used in situations where a provider’s legitimate name happens to be “Na.”

15. **How do I distinguish between a clinic and a provider group in smaller practice arrangements? For example: Jane Doe MD and her two mid-level practitioners, all primary care providers, with members individually assigned to them are contracted with the plan under the group “Jane Doe Family Health Care Group.” Should the Plan list “Jane Doe Family Health Care Group” in the Clinic column on the PCP Report Form and identify “Jane Doe Family Health Care Group” on the Clinic Report Form as a “free standing – primary care” clinic types, or should “Jane Doe Family Health Care Group” be listed as a Medical Group/IPA?**

    In this scenario, the Plan must first determine if the provider is a clinic or just a stand-alone physician office that employs mid-levels. If this is a clinic, identify “Jane Doe Family Health Care Group” as the “Clinic Name” on the PCP Report Form and also separately identify it as a clinic on the Hospital and Clinic Report Form (as described in the example). If this is not a clinic, but instead a physician office that employs mid-levels, identify the name of the physician individually on the PCP tab under "First Name" and "Last Name," then identify the mid-levels on the "PCP Extenders" tab and associate those mid-levels with the PCP's NPI number in the column "Supervising PCP NPI."

    If “Jane Doe Family Health Care Group” holds a group contract with the Plan (i.e. it is a medical group or IPA that is contracted with the Plan as a group), separately identify Jane Doe and each of her midlevel providers on the PCP Report Form and PCP Extenders Report Form, respectively, and then report “Jane Doe Family Health Care Group” under the Medical Group / IPA column in each of those Report Forms.

16. **In my plan’s network we have providers who are licensed in Internal Medicine, but who have a specialty in some other specialty area, for**

example pulmonology, and they do not have an open panel, and are not practicing as a PCP. They are only practicing as a specialist. How are we to report these providers on the Provider Network Report Form templates? Are we to report them as specialist? Or are we to report them as PCPs?

If a provider is not contracted to deliver primary care services to plan enrollees, the plan should not report the provider as a PCP. If the provider only serves as a specialist for the identified Name of Network, the provider should be reported on the Specialist Report Form template. If the provider serves as both a PCP and a Specialist for the identified Name of Network, the provider should be reported on both the PCP and the Specialist Report Form templates.

17. **What definition is the Department using in MY 2017 to define telehealth providers?**

The Department uses the definition for telehealth set forth in Business and Professions Code Section 2290.5. (Please see the Instructions Tab in the PCP, Mental Health, Specialist and Other Contracted Provider Report Forms, in the field for “Telehealth” within these instructions).

The Business and Professions Code defines telehealth as "the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers."

18. **How should health plans report the address for providers, including telehealth providers?**

The plan should report the physical address of the practice location where the provider treats patients, including street number and street name. If the provider practices in more than one location, enter an additional row for each practice location, and repeat all other fields in each row. If the provider also serves as a telehealth provider, report only the physical locations at which the provider treats patients in person. "NA" is not an acceptable value for this field. If a provider does not have a physical location at which he or she treats patients in person, do not report the provider on the Report Form. The plan may instead submit a narrative explanation with the Annual Network Review submission that includes the provider’s information.

19. How should the Plan report a provider who does not practice within its service area?

The Plan should report the entire network of contracted providers and locations for each reporting network, regardless of whether the contracted provider location is inside or outside of the network's service area. The Department derives the network's service area from the data reported on the "Enrollment and Service Area Report Form" for the network.

Annual Provider Network Report Form – Specialists

The Specialists Report Form is the only accepted reporting format for a health plan to report its contracted network of specialist physicians for the purposes of timely access reporting. The health plan's submission must reflect the Plan's contracted network of specialist physicians as of December 31st of the Measurement Year.

To begin populating data, enter all of the required/requested information on the spreadsheet included in the Report Form workbook. Enter an additional row for any variation in one of the fields, such as additional addresses, specialties, etc. All fields must be completed for each row, information in fields that do not change must be repeated in the row representing the variation. In some cases, the DMHC requires plans to use specific terminology or crosswalk the Plan's own terminology to the Department's preferred terms. These fields are identified within the Instructions below. The Plan may crosswalk its terminology utilizing the "Crosswalk" links within the Timely Access Reporting Web Portal under the Profile tab. See the Profile Tab Instructions above for more information.

Be sure to report all specialists in the Plan's contracted network. See the provider types listed by the DMHC in the "Specialist Specialty Type" table found under the "Specialty Crosswalk" link in the Profile tab for guidance as to what provider types should be reported on this form. The provider type must be crosswalked to the Department's preferred terms, as described in the instructions below.

Instructions – Specialist Annual Provider Network Report Form

Specialists Tab		
REQUIRED FIELD	***INSTRUCTIONS*** *Enter data in each field as described below. If a certain field is not applicable, please enter "NA" unless such an entry is identified as not acceptable in the instructions. Please do not leave any required fields blank unless the instruction states a blank field is acceptable.*	***Data Type (Length)***
Last Name	Last name of the provider. "NA" is not an acceptable value.	Text (1 to 50 characters)
First Name	First name of the provider. "NA" is not an acceptable value.	Text (1 to 50 characters)
NPI	The unique National Provider Identification (NPI) number assigned to the provider. The Plan must report both the provider's NPI and license number. Do not include deactivated NPIs. "NA" is not an acceptable value.	Number (10 digits)
CA License	California License number. Please format MD licenses with the following format: "A", "G" or "C" followed by sequence of digits with no spaces or leading zeros. Please format DO licenses with the following format: "20" followed by "A", "G" or "C" followed by sequence of digits with no spaces or leading zeros. All other CA Licenses should not have any spaces or leading zeros. Do not include deactivated CA Licenses. The Plan must report both the provider's NPI and license number. "NA" is not an acceptable value unless a license number is entered in the "Non CA License" field.	Text (4 to 15 characters)
Non CA License	License number where license was issued outside of the state of California. Do not include deactivated Licenses. May leave blank if not applicable.	Text (0 to 30 characters)
Non CA License State	State in which non-California license was issued. May leave blank if not applicable.	Text (0 to 30 characters)

Type of Licensure	The type of license held by the physician. *(Please make sure the Type of Licensure is referenced on the "Type of License and Service Crosswalk" table found in the Profile tab in the Timely Access Reporting Web Portal.)* "NA" is not an acceptable value.	Text (1 to 100 characters)
Health Plan ID for Plan-to-Plan Contract	The Plan ID of another Plan with which the Reporting Plan contracts ("Subcontracting Plan"). Complete this field if the Reporting Plan does not directly contract with the provider but instead includes this provider in the network through a contract with a Subcontracted Health Plan that is not subject to Timely Access reporting. Health plans that may be reported in this field include subcontracted restricted Knox-Keene licensees, specialized Knox-Keene licensed health plans (e.g. dental, vision, chiropractic, and acupuncture plans), and any other Knox-Keene licensed health plans that are not subject to timely access reporting requirements pursuant to Rule 1300.67.2.2, subd. (a). ***Do not complete this field if a Subcontracted Health Plan is subject to timely access reporting requirements***. The Subcontracted Health Plan must separately submit its contracted providers on behalf of the Reporting Plan via the "Other Plan Network" tab in the Timely Access Reporting Web Portal. Do not put the Reporting Plan's own Health Plan ID in this field. All Knox-Keene licensed health plans' ID numbers can be found on the Department's public website: http://wpso.dmhc.ca.gov/hpsearch/viewLicensedHealthPlan.aspx. See the *MY 2017 Annual Provider Network Submission Instruction Manual* for more information. May leave blank if the provider is not accessed through a Plan-to-Plan contract.	Text (0 or 8 characters)
Name of Network	The name used by the Plan to describe the network in which the provider participates. Each named network should refer to a unique combination of providers that has been reviewed and approved by the DMHC for use with one or more lines-of-business. If the network is utilized for a Covered California line-of-business, please use the Network ID number assigned by Covered California. *(Please make sure the Name of Network is referenced on the "Name of Network" table in the Profile tab in the Timely Access Reporting Web Portal.)* "NA" is not an acceptable value.	Text (1 to 100 characters)
Network Tier ID	If the network is a tiered network, enter "1" for the providers participating in the tier with the lowest cost share for enrollees; enter "2" for the providers participating in the tier with the next-lowest cost share for enrollees. Continue to number tiers accordingly, with the higher tier number correlating to higher cost-share for the enrollee. May leave blank if not applicable.	Number (0 to 2 digits)
Clinic Name	The name of the clinic at which the provider offers services either part- or full-time, if applicable. If the provider practices at a clinic, enter the Clinic Name only in the row where the Plan is reporting the address that correlates to the clinic location. If the provider practices at other, non-clinic locations, leave this field blank in the rows where the Plan is reporting those locations. Clinic name should match the clinic name included on the "Clinics" worksheet on the Hospital and Clinics Annual Provider Network Report Form template. May leave blank if not applicable.	Text (0 to 100 characters)
Address	Physical address of the provider's practice location, including street number and street name. If reporting more than one address, enter an additional row identifying each additional office, clinic, or medical group address. Data for all non-address fields must be repeated in each row. If the provider also serves as a telehealth provider, include only the physical locations at which the provider treats patients. "NA" is not an acceptable value.	Text (1 to 100 characters)
Address 2	Insert the number of the office, suite, building, or other location identifier. If this information is not applicable to the address, leave blank.	Text (0 to 50 characters)
City	City in which the practice address is located. "NA" is not an acceptable value.	Text (1 to 50 characters)
County	County in which the practice address is located. (*Please make sure the County is referenced on the "County Crosswalk" table in the Profile tab in the Timely Access Reporting Web Portal.)* "NA" is not an acceptable value.	Text (1 to 50 characters)
State	State in which the practice address is located. "NA" is not an acceptable value.	Text (2 to 30 characters)

Zip Code	Zip code in which the practice address is located. "NA" is not an acceptable value.	Text (5 or 10 characters)
Phone Number	If appointments are offered at this location, enter the phone number, separating the area code and first 3 digits with a "-" (e.g. 123-456-7890). May leave blank if not applicable.	Text (0 to 12 characters)
Telehealth (Y/N)	Enter "Y" if the provider delivers telehealth services, otherwise enter "N." Telehealth is defined as: "the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers." (Bus. and Prof Code section 2290.5). Please enter a "Y" in this column if the provider is contracted to provide and currently provides synchronous or asynchronous health care services from a "distant" site to enrollees while the enrollee is at a health care provider's "originating" site.	Text (1 to 2 characters)
Accepting New Referrals (Y/N)	If Plan assigns patients or tracks referrals to this provider, enter "Y" to indicate the provider is accepting new patients or referrals at this location, enter "N" to indicate the provider is not accepting new patients or referrals at this location. If the provider is only accepting existing patients, past patients, or patients from a waitlist, please enter "N" in this field. If the Plan is uncertain as to whether a provider is accepting new patients, enter "N." See the *MY 2017 Annual Provider Network Submission Instruction Manual* for information regarding how to report this field when patients are not assigned to a specialist provider. "NA" is not an acceptable value.	Text (1 character)
Specialty / Subspecialty	Enter the provider's specialty. If the provider has more than one specialty, enter an additional row identifying each additional specialty. Data for all other fields must be repeated in each row. Only report providers that serve as the reported Specialty for the identified Name of Network. If the provider serves as both a PCP and a Specialist for the identified Name of Network (e.g., obstetrician/gynecologists), the provider should be reported on both the PCP Annual Provider Network Report Form template and the Specialist Annual Provider Network Report Form template. When reporting the Specialty/Subspecialty, make sure the Specialty is referenced on the "Specialist Specialty Type" table found under the "Specialty Crosswalk" link in the Profile tab in the Timely Access Reporting Web Portal. The Crosswalk table is based on selected American Board of Medical Specialties (ABMS) specialty certification types. The Plan should report providers according to the ABMS specialty type(s) that the provider holds. If the provider's specialty does not appear on the "Specialty Crosswalk" table, please crosswalk the specialty type to "Other." "NA" is not an acceptable value.	Text (1 to 100 characters)
Board Eligible or Certified (Y/N)	Enter "Y" if the provider is board-certified or board-eligible, otherwise enter "N".	Text (1 to 2 characters)
Provider Group/IPA	Name of the provider group and/or IPA affiliated with contracted provider (if applicable). If the provider is associated with more than one provider group or IPA, enter an additional row identifying each additional provider group or IPA. Data for all other fields must be repeated in each row. If the provider is not affiliated with a provider group, please enter the value "Individually Contracted Provider" as set forth in the Profile tab in the Timely Access Reporting Web Portal. *(Please make sure the Provider Group is referenced on the "Provider Groups/IPA Crosswalk" table in the Profile tab in the Timely Access Reporting Web Portal.)*	Text (1 to 100 characters)

Facility	Enter the name of each hospital with which the provider holds privileges or the facility at which the provider primarily delivers services. Facility refers to a licensed hospital, ambulatory surgery center, laboratory, radiology or imaging center, other outpatient setting as described in Health and Safety Code § 1248.1, and any other facility contemplated under Health and Safety Code § 1371.9, subd. (f)(1). If the provider has admitting privileges at more than one hospital, enter an additional row identifying each additional hospital. If the provider uses a hospitalist or some other physician arrangement to admit patients to one or more hospitals, please enter the hospital name in this field. If the provider is facility-based and works primarily at one or more facility locations, list the facility in this field. Enter an additional row identifying each additional facility. When reporting more than one hospital or facility affiliation for the provider, data for all other fields must be repeated in each row. (If entering a hospital name in this field, please make sure the Hospital is referenced on the "Hospitals Crosswalk" table in the Profile tab in the Timely Access Reporting Web Portal. If entering a clinic or other facility type that has been reported on another Network Report Form template, please enter the name of that facility exactly as it appears on the other Network Report Form.)	Text (1 to 100 characters)
Facility NPI	Enter the NPI number corresponding to the facility or hospital identified in the "Facility" field.	Number (10 digits)
Hospitalist (Y/N)	If the provider is able to admit to the hospital using a hospitalist or some other physician arrangement, enter "Y," if the provider holds the admitting privileges directly with the hospital, enter "N."	Text (1 to 2 characters)
Is the Provider Listed in the Directory?	Identify whether or not, on December 31, 2017, the provider was listed in the Plan's online provider directory/directories maintained pursuant to section 1367.27, as follows: • Enter a "Y" if the provider was listed at the location indicated in the "Address" field and with the specialty type identified in the "Specialty/Subspecialty" field. • Enter an "R" if the provider and/or the associated location and specialty information described in the "Address" field and "Specialty/Subspecialty" field were removed from the directory pursuant to section 1367.27, subd. (l), resulting from failure to respond to plan notification seeking verification of directory information. • Enter an "O" if the provider and/or the associated location and specialty information described in the "Address" field and "Specialty/Subspecialty" field were omitted from the directory. "Omitted providers" refers to providers that are in the Plan's contracted network but are purposely left out of the provider directory. • Enter an "S" if the provider and/or the associated location and specialty information described in the "Address" field and/or "Specialty/Subspecialty" field were withheld from the directory pursuant to the DMHC's uniform provider directory standards and/or DMHC approval. • Enter an "N" if the provider was not listed in the directory at the location indicated in the "Address" field and with the specialty identified in the "Specialty/Subspecialty" field for any reason other than those listed above.	Text (1 to 2 characters)

REQUESTED FIELD	***INSTRUCTIONS*** *Enter data in each field as described below. If a certain field is not applicable, please enter "NA" unless such an entry is identified as not acceptable in the instructions. Requested fields may be left blank.*	***Data Type (Length)***
Provider Language 1	Language spoken by the provider. *(Please make sure the Provider Language 1 is referenced on the "Language Crosswalk" table in the Profile tab in the Timely Access Reporting Web Portal.)*	Text (0 to 50 characters)
Provider Language 2	Language spoken by the provider. *(Please make sure the Provider Language 2 is referenced on the "Language Crosswalk" table in the Profile tab in the Timely Access Reporting Web Portal.)*	Text (0 to 50 characters)
Provider Language 3	Language spoken by the provider. *(Please make sure the Provider Language 3 is referenced on the "Language Crosswalk" table in the Profile tab in the Timely Access Reporting Web Portal.)*	Text (0 to 50 characters)

Frequently Asked Questions – Specialist Annual Provider Network Report Form

1. **How do I populate the "NPI" and "CA License" field in the Specialist Report Form if my plan does not capture NPI or CA license information for some or all of its specialists?**

   The DMHC recommends that the Plan utilize the Department of Consumer Affairs website (http://www.dca.ca.gov/) or the NPI database (https://npiregistry.cms.hhs.gov/) to identify the provider license or NPI number, respectively, of its providers.

   DMHC has included two columns in the Report Forms that allow the Plan to identify providers who are licensed in a state other than California and to provide the out-of-state license number. Please only report a provider's out-of-state license number if they do not also have a California license number.

2. **My Plan delivers some primary care and specialty physician services via a contract with a Federally Qualified Health Center ("FQHC") which employs many individual physicians and has multiple clinic locations. How do I report this arrangement on the Report Forms?**

   List each individual physician that is available at the FQHC on separate rows within the Report Form. Identify the physician's association with the FQHC in the "Provider Group/IPA" field and identify the specific FQHC site or location name within the "Clinic Name" field. If the physician is associated with more than one provider group, IPA, or FQHC, enter an additional row identifying each additional provider group, IPA, or FQHC. Data for all other fields must be repeated in each row. Please make sure the FQHC is referenced on the "Provider Groups/IPA Crosswalk" table in the Profile tab in the Timely Access Reporting web portal.

3. **My Plan contracts with medical groups who contract with their own hospitalist groups and my Plan does not track or maintain which groups use which hospitalists at each specific hospital. How do I complete the Facility, Facility NPI, and Hospitalist fields in the Specialist Annual Provider Network Report Form?**

   Where the Plan's physicians are contracted via a medical group and that medical group maintains a contract with a hospitalist group for admitting privileges, please report admitting privileges on the Specialist Annual Provider Network Report Form as follows:

- Where the Plan has confirmation from the medical group that all physicians within that group may utilize the hospitalist group to admit to specific hospitals, please identify all hospitals with which the hospitalist group maintains admitting privileges and enter each hospital name in the "Facility" column on the Specialist Report Form for each physician associated with that medical group. Enter a "Y" in the "Hospitalist (Y/N)" column in the Specialist Report Form.

  Example: Dr. Jones, a specialist, is part of ABC Medical Group. ABC Medical Group has a contract with XYZ Hospitalist Group. XYZ Hospitalist group has hospitalists who can admit to Memorial Hospital and General Hospital. On the Specialist Report Form, enter Dr. Jones twice. On the first entry, list "General Hospital" in the "Facility" column. On the second entry, list "Memorial Hospital" in the "Facility" column. For each of these entries, enter "Y" in the "Hospitalist" column.

- Where the Plan has confirmed that some physicians within the medical group may utilize the hospitalist group to admit to specific hospitals, please identify all hospitals with which the hospitalist group maintains admitting privileges and enter each hospital name in the "Facility" column on the Specialist Report Form for only those physicians identified by the medical group as being able to admit via a hospitalist.

4. My Plan has multiple categories to describe whether a physician is accepting new referrals. How do I populate the "Accepting New Referrals" column in the Specialist Report Form?

The purpose of the "Accepting New Referrals" field is to identify if the provider accepts new patients versus accepting existing or past patients. The Plan would populate the field with an "N" if the provider does not accept new patients even though the provider is accepts appointments for existing or past patients, or accepts patients from a waitlist. If the provider maintains a contract with the Plan for this Plan product under which the provider is required to accept all referrals, please place a "Y" in this category. If the Plan does not know if the provider is accepting new referrals, and the contract does not require the provider to take all patients and referrals, please enter "NA" in the "Accepting New Referrals" column.

5. What is a Network Tier ID?

The Network Tier ID column only applies to those Plans that operate a tiered network. A tiered network is a product in which the Plan offers more than one "participating network" at different levels of cost- sharing. For example, in a tiered PPO network, an enrollee may access a Plan- defined group of participating providers ("Tier 1") and pay only 20% of the cost, or they can choose to access a separate Plan-defined group of participating

providers (“Tier 2”) and pay 40% of the cost, or they can choose to access a provider outside of the participating network and pay 60% of the cost. When completing the Annual Provider Network Report Forms, the Plan would identify the Tier 1 providers as a “1” in the “Network Tier ID” column, then it would identify the Tier 2 providers as a “2” in the “Network Tier ID” column. Please note: If the Plan also maintains an out-of-network benefit, the Plan should not submit the out-of-network providers on its Annual Provider Network Report Forms.

6. **My Plan does not maintain the office number, suite number, building, or other location identifier for providers in a distinct field, therefore I cannot complete the “Address 2” column. Will this cause the data to be rejected?**

   The Address 2 field is an optional field for Plans that separate the number of the office, suite, building, or other location identifier in their own databases. The validation tool will accept this information in the “Address” or “Address 2” field. If the Plan does not separate out the office number, suite number, building, or other location identifier into a separate column, please leave the “Address 2” field blank.

7. **My mental health plan provides both non-physician mental health providers as well as psychiatrists. How do I report these provider types in the Annual Provider Network Report Forms?**

   All non-physician mental health providers are reported in the “Annual Provider Network Report Form – Mental Health.” All psychiatrists must be reported in the “Annual Provider Network Report Form – Specialists.” If your mental health plan offers both provider types, please submit both types of Annual Provider Network Report Forms.

8. **How does the Department define Medical Toxicology Specialists, as identified on the Department’s Specialty Crosswalk table?**

   Please refer to the American Board of Medical Specialties’ definition for Medical Toxicologists: “Medical Toxicologists are physicians who specialize in the prevention, evaluation, treatment and monitoring of injury and illness from exposures to drugs and chemicals, as well as biological and radiological agents. These specialists care for people in clinical, academic, governmental and public health settings, and provide poison control center leadership. Important areas of Medical Toxicology include acute drug poisoning; adverse drug events; drug abuse, addiction and withdrawal; chemicals and hazardous materials; terrorism preparedness; venomous bites and stings; and environmental and workplace exposures.”

9. **For Provider Specialty, there is a validation error on “Obstetrics and Gynecology.” This is a valid value based on the pick list and provider type.**

I have tried multiple times to correct it but nothing is working. Is it OK to submit with the validation error?

You are receiving this error because the Plan attempted to enter the value "Obstetrics and Gynecology" in the Specialty column without first crosswalking that terminology to the Department's preferred term ("Obstetrics/Gynecology"). Please map “Obstetrics and Gynecology” to the Department's preferred terminology in the Specialty crosswalk table in the Profile Tab to resolve this validation error.

10. **I have one or more contracted providers whose given first or last name is “Na,” but I cannot submit the Report Form because that value is not allowed in the first or last name fields.**

    Please add a period to the provider’s first name to read as “Na.” and the DMHC will remove the period on its end post-submission. Please note that entering “NA” for the purposes of indicating the first or last name is not available is not a valid entry in this field. The solution described in this example is only to be used in situations where a provider’s legitimate name happens to be “Na.”

11. **In my plan’s network we have providers who are licensed in Internal Medicine, but who have a specialty in some other specialty area, for example pulmonology, and they do not have an open panel, and are not practicing as a PCP. They are only practicing as a specialist. How are we to report these providers on the Provider Network Report Form templates? Are we to report them as specialist? Or are we to report them as PCPs?**

    If a provider is not contracted to deliver primary care services to plan enrollees, the plan should not report the provider as a PCP. If the provider only serves as a specialist for the identified Name of Network, the provider should be reported on the Specialist Report Form template. If the provider serves as both a PCP and a Specialist for the identified Name of Network, the provider should be reported on both the PCP and the Specialist Report Form templates.

12. **What definition is the Department using in MY 2017 to define telehealth providers?**

    The Department uses the definition for telehealth set forth in Business and Professions Code Section 2290.5. (Please see the Instructions Tab in the PCP, Mental Health, Specialist and Other Contracted Provider Report Forms, in the field for “Telehealth” within these instructions).

    The Business and Professions Code defines telehealth as "the mode of delivering health care services and public health via information and

communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers."

13. How should health plans report the address for providers, including telehealth providers?

The plan should report the physical address of the practice location where the provider treats patients, including street number and street name. If the provider practices in more than one location, enter an additional row for each practice location, and repeat all other fields in each row. If the provider also serves as a telehealth provider, report only the physical locations at which the provider treats patients in person. "NA" is not an acceptable value for this field. If a provider does not have a physical location at which he or she treats patients in person, do not report the provider on the Report Form. The plan may instead submit a narrative explanation with the Annual Network Review submission that includes the provider's information.

14. How should the Plan report a provider who does not practice within its service area?

The Plan should report the entire network of contracted providers and locations for each reporting network, regardless of whether the contracted provider location is inside or outside of the network's service area. The Department derives the network's service area from the data reported on the "Enrollment and Service Area Report Form" for the network.

15. How should the plans report psychiatrists that are qualified autism providers?

A provider reported as a Qualified Autism Services Providers (QASP) must meet one or both definitions described in Health and Safety Code section 1374.73(c)(3). When a network- contracted QASP is a non-physician that meets the definition of Qualified Autism Services Provider, the provider must be reported on the Mental Health Report Form, and must be properly reported or crosswalked to Qualified Autism Services Provider on the "Mental Health Professional Specialty Type" Crosswalk table within the Plan's Profile Page. The certificate/licensure type must also be reported and/or crosswalked to the "Mental Health Professional Licensure Type" crosswalk table within the Profile Tab.

If the reported provider is a psychiatrist that meets the definition of a qualified autism services provider under the Act and treated patients during the measurement year as a QASP, please instead report this provider within the Specialists Report Form. Report this provider with the specialty type of “Psychiatry” on one row, and again on an additional row with a specialty type of “Qualified Autism Services Provider” crosswalked to “Other” in the Specialist Specialty Crosswalk table. Complete all other data fields for each row. If there are any other variations in the reporting fields for this provider, please complete as many additional rows as necessary.

Please note: In order for the Specialist Report Form to pass validation, the Plan cannot crosswalk to “Qualified Autism Services Provider” when reporting on the Specialist Report Form. The Plan must crosswalk a psychiatrist QASP to “Other” in the Specialist Specialty Crosswalk table to properly report the QASP specialty.

16. How should the Plan report or crosswalk a specialty type on the Specialist Report Form, and what types of providers can the Plan report?

The Specialist Report Form is reserved for physician providers. The Plan should report the physician’s specialty consistent with the specialty designations recognized by the American Board of Medical Specialties (ABMS). (See Cal.Code Regs § 1300.67.2.2(g)(2)(G)2.) The Plan should further indicate whether the provider is board-certified or board-eligible for the designated specialty in the “Board Certified or Eligible (Y/N)” field within the Specialist Report Form. If the physician’s specialty type does not appear on the "Specialist” Specialty Crosswalk table, please crosswalk the specialty type to “Other.” “NA" is not an acceptable value.

If the provider is not a physician, please do not report or crosswalk the provider to the listed specialist physician type. NPs or PAs can be reported within the Extender Tab of the PCP Report Form, or within the Other Contracted Providers Report Form.

Annual Provider Network Report Form – Mental Health

The Mental Health Report Form is the only accepted reporting format for a health plan to report its contracted network of Mental Health Professionals and Mental Health Facilities for the purposes of timely access reporting. The health plan's submission must reflect the Plan's contracted network of mental health professionals and facilities as of December 31st of the Measurement Year.

To begin populating data, enter all of the required/requested information on the spreadsheet included in the Report Form workbook. Enter an additional row for any variation in one of the fields, such as additional addresses, specialties, etc. All fields must be completed for each row, information in fields that do not change must be repeated in the row representing the variation. In some cases, the DMHC requires plans to use specific terminology or crosswalk the Plan's own terminology to the Department's preferred terms. These fields are identified within the Instructions below. The Plan may crosswalk its terminology utilizing the "Crosswalk" links within the Timely Access Reporting Web Portal under the Profile tab. See the Profile Tab Instructions above for more information.

Be sure to report all mental health professionals and facilities in the Plan's contracted network. See the provider types listed by the DMHC in the "Mental Health Professional Specialty Type" table found under the "Specialty Crosswalk" link and "Mental Health Professional Licensure Type" and "Mental Health Facility Service Type" tables found under the "Type of License and Service Crosswalk" link in the Profile tab for guidance as to what provider types should be reported on this form. The provider's type of licensure and specialty/area of expertise must be crosswalked to the Department's preferred terms.

Instructions – Mental Health Annual Provider Network Report Form

Mental Health Professionals Tab		
REQUIRED FIELD	***INSTRUCTIONS*** *Enter data in each field as described below. If a certain field is not applicable, please enter "NA" unless such an entry is identified as not acceptable in the instructions. Please do not leave any required fields blank unless the instruction states a blank field is acceptable.*	***Data Type (Length)***
Last Name	Last name of the provider. "NA" is not an acceptable value.	Text (1 to 50 characters)
First Name	First name of the provider. "NA" is not an acceptable value.	Text (1 to 50 characters)
NPI	The unique National Provider Identification (NPI) number assigned to the provider. Do not include deactivated NPIs.	Number (10 digits)
CA License / Certificate	California License or Certificate number. All CA Licenses should not have any spaces or leading zeros. Do not include deactivated CA Licenses. If the provider holds a certificate, enter the certificate number or identifier in this field. The Plan may enter "NA" in this field only if licensure or certification is not required under California law for the provider's specific area of practice.	Text (2 to 15 characters)
Non CA License / Certificate	License number or certificate identifier where license or certificate was issued outside of the state of California. May leave blank if not applicable.	Text (0 to 30 characters)

Non CA License / Certificate State	State in which non-California license or certificate was issued. May leave blank if not applicable.	Text (0 to 30 characters)
Type of Licensure/Certificate	The title of the license or certificate the provider holds. (*Please make sure the Type of Licensure is referenced on the "Mental Health Professional Licensure Type" table found under the "Type of License and Service Crosswalk" link in the Profile tab in the Timely Access Reporting Web Portal. If the provider's license/certificate type does not appear on the "Mental Health Professional Licensure Type" table, please follow the instructions within the Profile tab for entering an "Other" Licensure/Certificate type for this provider within the "Mental Health Professional Licensure Type" table.*) **Please do not list physicians, such as psychiatrists, on this spreadsheet**. Instead, please list them on the PCP or Specialist spreadsheet, as appropriate. If the provider has more than one license or certificate, add an additional row for each license or certificate. In some cases the provider may have a certificate that coincides with a "Specialty/Area of Expertise." In that case, please list the Type of License or Certificate in this field and the coordinating area of expertise in the "Specialty/Area of Expertise" field in the same row. For example, a provider who is accredited as a Certified Addiction Treatment Counselor will list *Alcohol and Other Drug Counselor* in the "Type of Licensure/Certificate" field and will list *Alcohol and Other Drugs* in the "Specialty/Area of Expertise" field in the same row.	Text (1 to 100 characters)
Health Plan ID for Plan-to-Plan Contract	The Plan ID of another Plan with which the Reporting Plan contracts ("Subcontracting Plan"). Complete this field if the Reporting Plan does not directly contract with the provider but instead includes this provider in the network through a contract with a Subcontracted Health Plan that is not subject to Timely Access reporting. Health plans that may be reported in this field include subcontracted restricted Knox-Keene licensees, specialized Knox-Keene licensed health plans (e.g. dental, vision, chiropractic, and acupuncture plans), and any other Knox-Keene licensed health plans that are not subject to timely access reporting requirements pursuant to Rule 1300.67.2.2, subd. (a). ***Do not complete this field if a Subcontracted Health Plan is subject to timely access reporting requirements***. The Subcontracted Health Plan must separately submit its contracted providers on behalf of the Reporting Plan via the "Other Plan Network" tab in the Timely Access Reporting Web Portal. Do not put the Reporting Plan's own Health Plan ID in this field. All Knox-Keene licensed health plans' ID numbers can be found on the Department's public website: http://wpso.dmhc.ca.gov/hpsearch/viewLicensedHealthPlan.aspx. See the *MY 2017 Annual Provider Network Submission Instruction Manual* for more information. May leave blank if the provider is not accessed through a Plan-to-Plan contract.	Text (0 or 8 characters)
Name of Network	The name used by the Plan to describe the network in which the provider participates. Each named network should refer to a unique combination of providers that has been reviewed and approved by the DMHC for use with one or more lines-of-business. If the network is utilized for a Covered California line-of-business, please use the Network ID number assigned by Covered California. (*Please make sure the Name of Network is referenced on the "Name of Network" table in the Profile tab in the Timely Access Report Web Portal.*) "NA" is not an acceptable value.	Text (1 to 100 characters)
Network Tier ID	If the network is a tiered network, enter "1" for the providers participating in the tier with the lowest cost share for enrollees; enter "2" for the providers participating in the tier with the next-lowest cost share for enrollees. Continue to number tiers accordingly, with the higher tier number correlating to higher cost-share for the enrollee. May leave blank if not applicable.	Number (0 to 2 digits)

Address	Physical address of the provider's practice location, including street number and street name. Do not include number for suite, office, building, etc. If reporting more than one address, enter an additional row identifying each additional office, clinic, or medical group address. Data for all non-address fields must be repeated in each row. If the provider also serves as a telehealth provider, include only the physical locations at which the provider treats patients. "NA" is not an acceptable value.	Text (1 to 100 characters)
Address 2	Insert the number of the office, suite, building, or other location identifier. If this information is not applicable to the address, leave blank.	Text (0 to 50 characters)
City	City in which the practice address is located. "NA" is not an acceptable value.	Text (1 to 50 characters)
County	County in which the practice address is located. (*Please make sure the County is referenced on the "County Crosswalk" table in the Profile tab in the Timely Access Reporting Web Portal.)* "NA" is not an acceptable value.	Text (1 to 50 characters)
State	State in which the practice address is located. "NA" is not an acceptable value.	Text (2 to 30 characters)
Zip Code	Zip code in which the practice address is located. "NA" is not an acceptable value.	Text (5 or 10 characters)
Phone Number	If appointments are offered at this location, enter the phone number, separating the area code and first 3 digits with a "-" (e.g. 123-456-7890). May leave blank if not applicable.	Text (12 characters)
Telehealth (Y/N)	Enter "Y" if the provider delivers telehealth services, otherwise enter "N." Telehealth is defined as: "the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers." (Bus. and Prof Code section 2290.5.) Please enter a "Y" in this column if the provider is contracted to provide and currently provides synchronous or asynchronous health care services from a "distant" site to enrollees while the enrollee is at a health care provider's "originating" site.	Text (1-2 characters)
Accepting New Referrals (Y/N)	Enter "Y" to indicate the provider is accepting new patients at this location, enter "N" to indicate the provider is not accepting new patients at this location. If the provider is only accepting existing patients, past patients, or patients from a waitlist, please enter "N" in this field. If the Plan is uncertain as to whether a provider is accepting new patients, enter "N." See the *MY 2017 Annual Provider Network Submission Instruction Manual* document for information regarding how to report this field in a PPO product or other product type in which patients are not assigned to a mental health provider. "NA" is not an acceptable value.	Text (1 character)

Specialty/Area of Expertise	Indicate the provider, professional or paraprofessional's specialty/area of expertise (adult, child/adolescent, etc.). *(Please make sure the Specialty is referenced on the "Mental Health Professional Specialty Type" table found under the "Specialty Crosswalk" link in the Profile tab in the Timely Access Reporting Web Portal. If the provider's specialty does not appear on the "Mental Health Professional Specialty Type" table, please follow the instructions within the Profile tab for entering an "Other" specialty type for this provider within the "Mental Health Professional Specialty Type" table.)* "NA" is not an acceptable value. In some cases the provider may have an area of expertise that coincides with a particular "Type of License/Certificate." In that case, please list the Area of Expertise in this field and the coordinating certificate in the "Type of Licensure/Certificate" field in the same row. For example, a provider who is accredited as a Certified Addiction Treatment Counselor will list *Alcohol and Other Drug Counselor* in the "Type of Licensure/Certificate" field and will list *Alcohol and Other Drugs* in the "Specialty/Area of Expertise" field in the same row. If the provider has multiple areas of expertise (e.g. child and Qualified Autism Services Professional), please add an additional row for each Specialty/Area of Expertise and repeat all other information.	Text (1 to 100 characters)
Provider Group / IPA	Name of the provider group and/or IPA affiliated with the contracted provider (if applicable). If the provider is associated with more than one provider group or IPA, enter an additional row identifying each additional provider group or IPA. Data for all other fields must be repeated in each row. If the provider is not affiliated with a provider group, please enter the value "Individually Contracted Provider" as set forth in the Profile tab in the Timely Access Reporting Web Portal. (Please make sure the Provider Group is referenced on the "Provider Groups/IPA Crosswalk" table in the Profile tab in the Timely Access Reporting Web Portal.)	Text (1 to 100 characters)
Is the Provider Listed in the Directory?	Identify whether or not, on December 31, 2017, the provider was listed in the Plan's online provider directory/directories maintained pursuant to section 1367.27, as follows: • Enter a "Y" if the provider was listed at the location indicated in the "Address" field and with the specialty type identified in the "Specialty/Subspecialty" field. • Enter an "R" if the provider and/or the associated location and specialty information described in the "Address" field and "Specialty/Subspecialty" field were removed from the directory pursuant to section 1367.27, subd. (l), resulting from failure to respond to plan notification seeking verification of directory information. • Enter an "O" if the provider and/or the associated location and specialty information described in the "Address" field and "Specialty/Subspecialty" field were omitted from the directory. "Omitted providers" refers to providers that are in the Plan's contracted network but are purposely left out of the provider directory. • Enter an "S" if the provider and/or the associated location and specialty information described in the "Address" field and/or "Specialty/Subspecialty" field were withheld from the directory pursuant to the DMHC's uniform provider directory standards and/or DMHC approval. • Enter an "N" if the provider was not listed in the directory at the location indicated in the "Address" field and with the specialty identified in the "Specialty/Subspecialty" field for any reason other than those listed above.	Text (1 to 2 characters)

REQUESTED FIELD	***INSTRUCTIONS*** *Enter data in each field as described below. If a certain field is not applicable, please enter "NA" unless such an entry is identified as not acceptable in the instructions. Requested fields may be left blank.*	***Data Type (Length)***

Provider Language 1	Language spoken by the provider. *(Please make sure the Provider Language 1 is referenced on the "Language Crosswalk" table in the Profile tab in the Timely Access Reporting Web Portal.)*	Text (0 to 50 characters)
Provider Language 2	Language spoken by the provider. *(Please make sure the Provider Language 2 is referenced on the "Language Crosswalk" table in the Profile tab in the Timely Access Reporting Web Portal.)*	Text (0 to 50 characters)
Provider Language 3	Language spoken by the provider. *(Please make sure the Provider Language 3 is referenced on the "Language Crosswalk" table in the Profile tab in the Timely Access Reporting Web Portal.)*	Text (0 to 50 characters)
E-mail Address	Business-facing email address used to communicate to the provider. If reporting more than one e-mail address, enter an additional row identifying each additional e-mail address. Data for all non-e-mail address fields must be repeated in each row.	Text (1 to 100 characters)

Mental Health Facilities Tab		
REQUIRED FIELD	***INSTRUCTIONS*** *Enter data in each field as described below. If a certain field is not applicable, please enter "NA" unless such an entry is identified as not acceptable in the instructions. Please do not leave any required fields blank unless the instruction states a blank field is acceptable.*	***Data Type (Length)***
Mental Health Facility Name	Legal Name of mental health facility. "NA" is not an acceptable value.	Text (1 to 100 characters)
DBA	"Doing-Business-As" name of facility. May leave blank if no DBA.	Text (0 to 100 characters)
Health Plan ID for Plan-to-Plan Contract	The Plan ID of another Plan with which the Reporting Plan contracts ("Subcontracting Plan"). Complete this field if the Reporting Plan does not directly contract with the provider but instead includes this provider in the network through a contract with a Subcontracted Health Plan that is not subject to Timely Access reporting. Health plans that may be reported in this field include subcontracted restricted Knox-Keene licensees, specialized Knox-Keene licensed health plans (e.g. dental, vision, chiropractic, and acupuncture plans), and any other Knox-Keene licensed health plans that are not subject to timely access reporting requirements pursuant to Rule 1300.67.2.2, subd. (a). ***Do not complete this field if a Subcontracted Health Plan is subject to timely access reporting requirements***. The Subcontracted Health Plan must separately submit its contracted providers on behalf of the Reporting Plan via the "Other Plan Network" tab in the Timely Access Reporting Web Portal. Do not put the Reporting Plan's own Health Plan ID in this field. All Knox-Keene licensed health plans' ID numbers can be found on the Department's public website: http://wpso.dmhc.ca.gov/hpsearch/viewLicensedHealthPlan.aspx. See the *MY 2017 Annual Provider Network Submission Instruction Manual* for more information. May leave blank if the provider is not accessed through a Plan-to-Plan contract.	Text (0 or 8 characters)
Address	Physical address of the facility, including street number and street name. Do not include number for suite, office, building, etc. If reporting more than one address, enter an additional row identifying each additional address. Data for all non-address fields must be repeated in each row. "NA" is not an acceptable value.	Text (1 to 100 characters)
Address 2	Insert the number of the office, suite, building, or other location identifier. If this information is not applicable to the address, leave blank.	Text (0 to 50 characters)
City	City in which the facility is located. "NA" is not an acceptable value.	Text (1 to 50 characters)
County	County in which the facility is located. (*Please make sure the County is referenced on the "County Crosswalk" table in the Profile tab in the Timely Access Reporting Web Portal.)* "NA" is not an acceptable value.	Text (1 to 50 characters)
State	State in which the facility is located. "NA" is not an acceptable value.	Text (2 to 30 characters)

Zip Code	Zip code in which the facility is located. "NA" is not an acceptable value.	Text (5 or 10 characters)
Phone Number	If appointments are offered at this location, enter the phone number, separating the area code and first 3 digits with a "-" (e.g. 123-456-7890). May leave blank if not applicable.	Text (0 to 12 characters)
NPI	The unique National Provider Identification (NPI) number assigned to the facility. Do not include deactivated NPIs. "NA" is not an acceptable value.	Number (10 digits)
CA License	CA License number of facility. All CA Licenses should not have any spaces or leading zeros. Do not include deactivated CA Licenses.	Text (1 to 30 characters)
Non CA License	License number where license was issued outside of the state of California. Do not include deactivated Licenses. May leave blank if not applicable.	Text (0 to 30 characters)
Non CA License State	State in which non-California license was issued. May leave blank if not applicable.	Text (0 to 30 characters)
Type of Service	Enter the type of service provided at the facility. (*Please make sure the Type of Service is referenced on the "Mental Health Facility Service Type" table found under the "Type of License and Service Crosswalk" link in the Profile tab in the Timely Access Reporting Web Portal. If the provider's service type does not appear on the "Mental Health Facility Service Type" table, please follow the instructions within the Profile tab for entering an "Other" service type for this provider within the "Mental Health Facility Service Type" table.*)	Text (1 to 100 characters)
Name of Network	The name used by the Plan to describe the network in which the provider participates. Each named network should refer to a unique combination of providers that has been reviewed and approved by the DMHC for use with one or more lines-of-business. If the network is utilized for a Covered California line-of-business, please use the Network ID number assigned by Covered California. *(Please make sure the Name of Network is referenced on the "Name of Network" table in the Profile tab in the Timely Access Reporting Web Portal.)* "NA" is not an acceptable value.	Text (1 to 100 characters)
Network Tier ID	If the network is a tiered network, enter "1" for the providers participating in the tier with the lowest cost share for enrollees; enter "2" for the providers participating in the tier with the next-lowest cost share for enrollees. Continue to number tiers accordingly, with the higher tier number correlating to higher cost-share for the enrollee. May leave blank if not applicable.	Number (0 to 2 digits)
Is the Provider Listed in the Directory?	Identify whether or not, on December 31, 2017, the provider was listed in the plan's online provider directory/directories maintained pursuant to section 1367.27, as follows: • Enter a "Y" if the provider was listed at the location indicated in the "Address" field and with the specialty type identified in the "Specialty/Subspecialty" field. • Enter an "R" if the provider and/or the associated location and specialty information described in the "Address" field and "Specialty/Subspecialty" field were removed from the directory pursuant to section 1367.27, subd. (l), resulting from failure to respond to plan notification seeking verification of directory information. • Enter an "O" if the provider and/or the associated location and specialty information described in the "Address" field and "Specialty/Subspecialty" field were omitted from the directory. "Omitted providers" refers to providers that are in the Plan's contracted network but are purposely left out of the provider directory. • Enter an "S" if the provider and/or the associated location and specialty information described in the "Address" field and/or "Specialty/Subspecialty" field were withheld from the directory pursuant to the DMHC's uniform provider directory standards and/or DMHC approval. • Enter an "N" if the provider was not listed in the directory at the location indicated in the "Address" field and with the specialty identified in the "Specialty/Subspecialty" field for any reason other than those listed above.	Text (1 to 2 characters)

REQUESTED FIELD	*INSTRUCTIONS* *Enter data in each field as described below. If a certain field is not applicable, please enter "NA" unless such an entry is identified as not acceptable in the instructions. Requested fields may be left blank.*	***Data Type (Length)***
E-mail Address	Business-facing email address used to communicate to the provider. If reporting more than one e-mail address, enter an additional row identifying each additional e-mail address. Data for all non-e-mail address fields must be repeated in each row.	Text (1 to 100 characters)

Frequently Asked Questions – Mental Health Annual Provider Network Report Form

1. **How do I populate the "NPI" and "CA License" field in the Mental Health Report Form if my plan does not capture NPI or CA license information for some or all of its mental health professionals and facilities, or if the network contains paraprofessionals who do not have these specific identifiers?**

   The DMHC recommends that the Plan utilize the Department of Consumer Affairs website (http://www.dca.ca.gov/), Office of Statewide Health Planning and Development website (http://www.oshpd.ca.gov/), or the NPI database (https://npiregistry.cms.hhs.gov/) to identify the provider license, mental health facility license or NPI number, respectively, of its providers.

   DMHC has included two columns in the Report Forms that allow the Plan to identify providers who are licensed in a state other than California and to provide the out-of-state license number. Please only report a provider's out-of-state license number if they do not also have a California license number.

   In the Mental Health Professionals tab, the health plan may list "NA" in the "NPI" column and "CA License/Certificate" column for mental health paraprofessionals who do not have an NPI or a CA License Number. The Department requires that the Plan list a certificate number in the "CA License/Certificate" column if one exists.

2. **My Plan has multiple categories to describe whether a provider is accepting new referrals. How do I populate the "Accepting New Referrals" column in the Mental Health Professionals Report Form?**

   The purpose of the "Accepting New Referrals" field is to identify if the provider accepts new patients versus accepting existing or past patients. The Plan would populate the field with an "N" if the provider does not accept any new patients even though the provider is able to accept appointments for existing or past patients. If the provider maintains a contract with the Plan for this Plan product under which the provider is required to accept all referrals, please place a "Y" in this category. If the Plan does not know if the provider is accepting new referrals, and the

contract does not require the provider to take all patients and referrals, please enter “NA” in the “Accepting New Referrals” column.

3. **What is a Network Tier ID?**

   The Network Tier ID column only applies to those Plans that operate a tiered network. A tiered network is a product in which the Plan offers more than one “participating network” at different levels of cost- sharing. For example, in a tiered PPO network, an enrollee may access a Plan- defined group of participating providers (“Tier 1”) and pay only 20% of the cost, or they can choose to access a separate Plan-defined group of participating providers (“Tier 2”) and pay 40% of the cost, or they can choose to access a provider outside of the participating network and pay 60% of the cost. When completing the Annual Provider Network Report Forms, the Plan would identify the Tier 1 providers as a “1” in the “Network Tier ID” column, then it would identify the Tier 2 providers as a “2” in the “Network Tier ID” column. Please note: If the Plan also maintains an out-of-network benefit, the Plan should not submit the out-of-network providers on its Annual Provider Network Report Forms.

4. **My Plan does not maintain the office number, suite number, building, or other location identifier for providers in a distinct field, therefore I cannot complete the “Address 2” column. Will this cause the data to be rejected?**

   The Address 2 field is an optional field for Plans that separate the number of the office, suite, building, or other location identifier in their own databases. The validation tool will accept this information in the “Address” or “Address 2” field. If the Plan does not separate out the office number, suite number, building, or other location identifier into a separate column, please leave the “Address 2” field blank.

5. **The mental health provider I am listing in the “Mental Health” template is a licensed marriage and family therapist and also a qualified autism services provider. How do I report this information?**

   If the provider is a licensed non-physician mental health provider, please indicate the area in which they hold a license or certificate in the “Type of Licensure/Certificate” column and then indicate what type of autism service provider they are in the “Specialty/Area of Expertise” column. If the provider maintains one license type but specializes in multiple areas of expertise, e.g. qualified autism services provider and alcohol and other drug, enter the provider twice, listing one area of expertise on one row and the other area of expertise on the second row. Please remember to complete the Department’s preferred terminology for “Type of Licensure/Certificate” and “Specialty/Area of Expertise” or complete a

Look Up Code on the Profile Tab in order to connect the Plan's terminology to the Department's terminology.

6. **My mental health plan provides both non-physician mental health providers as well as psychiatrists. How do I report these provider types in the Annual Provider Network Report Forms?**

   All non-physician mental health providers are reported in the "Annual Provider Network Report Form – Mental Health." All psychiatrists must be reported in the "Annual Provider Network Report Form – Specialists." If your mental health plan offers both provider types, please submit both types of Annual Provider Network Report Forms.

7. **I have one or more contracted providers whose given first or last name is "Na," but I cannot submit the Report Form because that value is not allowed in the first or last name fields.**

   Please add a period to the provider's first name to read as "Na." and the DMHC will remove the period on its end post-submission. Please note that entering "NA" for the purposes of indicating the first or last name is not available is not a valid entry in this field. The solution described in this example is only to be used in situations where a provider's legitimate name happens to be "Na."

8. **What definition is the Department using in MY 2017 to define telehealth providers?**

   The Department uses the definition for telehealth set forth in Business and Professions Code Section 2290.5. (Please see the Instructions Tab in the PCP, Mental Health, Specialist and Other Contracted Provider Report Forms, in the field for "Telehealth" within these instructions).

   The Business and Professions Code defines telehealth as "the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers."

9. **How should health plans report the address for providers, including telehealth providers?**

   The plan should report the physical address of the practice location where the provider treats patients, including street number and street name. If

the provider practices in more than one location, enter an additional row for each practice location, and repeat all other fields in each row. If the provider also serves as a telehealth provider, report only the physical locations at which the provider treats patients in person. "NA" is not an acceptable value for this field. If a provider does not have a physical location at which he or she treats patients in person, do not report the provider on the Report Form. The plan may instead submit a narrative explanation with the Annual Network Review submission that includes the provider's information.

10. How should the Plan report a provider who does not practice within its service area?

The Plan should report the entire network of contracted providers and locations for each reporting network, regardless of whether the contracted provider location is inside or outside of the network's service area. The Department derives the network's service area from the data reported on the "Enrollment and Service Area Report Form" for the network.

11. How should the plans report psychiatrists that are qualified autism providers?

A provider reported as a Qualified Autism Services Providers (QASP) must meet one or both definitions described in Health and Safety Code section 1374.73(c)(3). When a network- contracted QASP is a non-physician that meets the definition of Qualified Autism Services Provider, the provider must be reported on the Mental Health Report Form, and must be properly reported or crosswalked to Qualified Autism Services Provider on the "Mental Health Professional Specialty Type" Crosswalk table within the Plan's Profile Page. The certificate/licensure type must also be reported and/or crosswalked to the "Mental Health Professional Licensure Type" crosswalk table within the Profile Tab.

If the reported provider is a psychiatrist that meets the definition of a qualified autism services provider under the Act and treated patients during the measurement year as a QASP, please instead report this provider within the Specialists Report Form. Report this provider with the specialty type of "Psychiatry" on one row, and again on an additional row with a specialty type of "Qualified Autism Services Provider" crosswalked to "Other" in the Specialist Specialty Crosswalk table. Complete all other data fields for each row. If there are any other variations in the reporting fields for this provider, please complete as many additional rows as necessary.

Please note: In order for the Specialist Report Form to pass validation, the Plan cannot crosswalk to "Qualified Autism Services Provider" when

reporting on the Specialist Report Form. The Plan must crosswalk a psychiatrist QASP to “Other” in the Specialist Specialty Crosswalk table to properly report the QASP specialty.

12. Is it is acceptable not to include the QAS Paraprofessionals since they generally travel from their home to the location of the member and do not have address data?

Health plans are required to submit data for all contracted non-physician mental health providers on the Mental Health Report Form. The Mental Health Professional Crosswalk Table on the Plan’s Profile Page contains three distinct specialty types: Qualified Autism Services Provider, Qualified Autism Services Professional, and Qualified Autism Services Paraprofessional. The Plan should report and/or crosswalk contracted providers to these distinct provider types, in accordance with the definitions within the Knox Keene Act, Health and Safety Code section 1374.73. The certificate/licensure type must also be reported and/or crosswalked to the “Mental Health Professional Licensure Type” crosswalk table within the Profile Tab.

The Department expects that health plans will report the entire contracted network of mental health professionals. If a QAS Paraprofessional does not have a practice location due to frequent travel, please report the clinic, employer or provider group address for that provider type.

Annual Provider Network Report Form – Other Contracted Providers

The Other Contracted Providers Report Form is the only accepted reporting format for a health plan to report its contracted network of other contracted providers for the purposes of timely access reporting. The health plan's submission must reflect the Plan's network of other contracted providers as of December 31st of the Measurement Year. Provide the required and requested information for any contracted providers, such as physical therapists, pharmacies, imaging centers, laboratories, home health, etc., who deliver services on an outpatient basis and were not included in any other Annual Provider Network Report Forms.

To begin populating data, enter all of the required/requested information on the spreadsheet included in the Report Form workbook. Enter an additional row for any variation in one of the fields, such as, additional addresses, provider categories, etc. All fields must be completed for each row, information in fields that do not change must be repeated in the row representing the variation. In some cases, the DMHC requires plans to use specific terminology or crosswalk the Plan's own terminology to the Department's preferred terms. These fields are identified within the Instructions below. The Plan may crosswalk its terminology utilizing the "Crosswalk" links within the Timely Access Reporting Web Portal under the Profile tab. See the Profile Tab Instructions above for more information.

Be sure to report all other contracted providers in the Plan's contracted network. Report individual providers when the provider is available to provide outpatient services to enrollees through consultation or referral. See the provider types listed by the DMHC in the "Other Contracted Provider Type" table found under the "Specialty Crosswalk" link in the Profile tab for guidance as to what provider types should be reported on this form. The provider type must be crosswalked to the Department's preferred terms, as described in the instructions below.

Instructions – Other Contracted Provider Network Report Form

Other Contracted Providers Tab		
REQUIRED FIELD	***INSTRUCTIONS*** *Enter data in each field as described below. If a certain field is not applicable, please enter "NA" unless such an entry is identified as not acceptable in the instructions. Please do not leave any required fields blank unless the instruction states a blank field is acceptable.*	***Data Type (Length)***
Last Name	Last name of the individual provider. Enter "NA" if the provider is an entity, rather than an individual.	Text (1 to 50 characters)
First Name	First name of the individual provider. Enter "NA" if the provider is an entity, rather than an individual.	Text (1 to 50 characters)
Other Contracted Provider Entity Name	If the provider is an entity, rather than an individual, enter the entity name in this field. If the provider is an individual, enter "NA" in this field.	Text (1 to 100 characters)
DBA	"Doing Business As" name utilized by provider. May leave blank if not applicable.	Text (0 to 100 characters)
NPI	The unique National Provider Identification (NPI) number assigned to the provider. Do not include deactivated NPIs.	Number (10 digits)

CA License	California License number. All CA Licenses should not have any spaces or leading zeros. Do not include deactivated CA Licenses.	Text (1 to 30 characters)
Non CA License	License number where license was issued outside of the state of California. Do not include deactivated Licenses. May leave blank if not applicable.	Text (0 to 30 characters)
Non CA License State	State in which non-California license was issued. May leave blank if not applicable.	Text (0 to 30 characters)
Health Plan ID for Plan-to-Plan Contract	The Plan ID of another Plan with which the Reporting Plan contracts ("Subcontracting Plan"). Complete this field if the Reporting Plan does not directly contract with the provider but instead includes this provider in the network through a contract with a Subcontracted Health Plan that is not subject to Timely Access reporting. Health plans that may be reported in this field include subcontracted restricted Knox-Keene licensees, specialized Knox-Keene licensed health plans (e.g. dental, vision, chiropractic, and acupuncture plans), and any other Knox-Keene licensed health plans that are not subject to timely access reporting requirements pursuant to Rule 1300.67.2.2, subd. (a). ***Do not complete this field if a Subcontracted Health Plan is subject to timely access reporting requirements***. The Subcontracted Health Plan must separately submit its contracted providers on behalf of the Reporting Plan via the "Other Plan Network" tab in the Timely Access Reporting Web Portal. Do not put the Reporting Plan's own Health Plan ID in this field. All Knox-Keene licensed health plans' ID numbers can be found on the Department's public website: http://wpso.dmhc.ca.gov/hpsearch/viewLicensedHealthPlan.aspx. See the *MY 2017 Annual Provider Network Submission Instruction Manual* for more information. May leave blank if the provider is not accessed through a Plan-to-Plan contract.	Text (0 or 8 characters)
Address	Physical address of the provider's practice location, including street number and street name. Do not include number for suite, office, building, etc. If reporting more than one address, enter an additional row identifying each additional address. Data for all non-address fields must be repeated in each row. If the provider also serves as a telehealth provider, include only the physical locations at which the provider treats patients. "NA" is not an acceptable value.	Text (1 to 100 characters)
Address 2	Insert the number of the office, suite, building, or other location identifier. If this information is not applicable to the address, leave blank.	Text (0 to 50 characters)
City	City in which the practice address is located. "NA" is not an acceptable value.	Text (1 to 50 characters)
County	County in which the practice address is located. (*Please make sure the County is referenced on the "County Crosswalk" table in the Profile tab in the Timely Access Reporting Web Portal.)* "NA" is not an acceptable value.	Text (1 to 50 characters)
State	State in which the practice address is located. "NA" is not an acceptable value.	Text (2 to 30 characters)
Zip Code	Zip code in which the practice address is located. "NA" is not an acceptable value.	Text (5 or 10 characters)
Phone Number	If appointments are offered at this location, enter the phone number, separating the area code and first 3 digits with a "-" (e.g. 123-456-7890). May leave blank if not applicable.	Text (0 to 12 characters)
Telehealth (Y/N)	Enter "Y" if the identified other contracted provider delivers telehealth services, otherwise enter "N." Telehealth is defined as: "the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers." (Bus. and Prof Code section 2290.5). Please enter a "Y" in this column if the provider is contracted to provide and currently provides synchronous or asynchronous health care services from a "distant" site to enrollees while the enrollee is at a health care provider's "originating" site.	Text (1 to 2 characters)

Accepting New Referrals (Y/N)	If Plan assigns patients or tracks referrals to this provider, enter "Y" to indicate the provider is accepting new patients or referrals at this location, enter "N" to indicate the provider is not accepting new patients or referrals at this location. If the provider is only accepting existing patients, past patients, or patients from a waitlist, please enter "N" in this field. Provide this information for each address associated with the reported other contracted provider. May leave blank if Plan does not assign patients or track referrals to this provider.	Text (0 to 2 characters)
Name of Network	The name used by the Plan to describe the network in which the provider participates. Each named network should refer to a unique combination of providers that has been reviewed and approved by the DMHC for use with one or more lines-of-business. If the network is utilized for a Covered California line-of-business, please use the Network ID number assigned by Covered California. *(Please make sure the Name of Network is referenced on the "Name of Network" table in the Profile tab in the Timely Access Reporting Web Portal.)* "NA" is not an acceptable value.	Text (1 to 100 characters)
Network Tier ID	If the network is a tiered network, enter "1" for the providers participating in the tier with the lowest cost share for enrollees; enter "2" for the providers participating in the tier with the next-lowest cost share for enrollees. Continue to number tiers accordingly, with the higher tier number correlating to higher cost-share for the enrollee. May leave blank if not applicable.	Number (0 to 2 digits)
Contracted Provider Category	Identify the type of provider based on the categories provided in the "Other Contracted Provider Category Type" table found under the "Specialty Crosswalk" link available under the Profile tab in the Timely Access Reporting Web Portal. If the provider falls under more than one category, enter an additional row identifying each additional category. Data for all other fields must be repeated in each row. (*Please make sure the Contracted Provider Category is referenced on the "Other Contracted Provider Category Type" table found under the "Specialty Crosswalk" link in the Profile tab in the Timely Access Reporting Web Portal. If the provider's category type does not appear on the "Other Contracted Provider Category Type" table, please follow the instructions within the Profile tab for entering an "Other" provider type for this provider within the "Other Contracted Provider Category Type" table.*)	Text (1 to 100 characters)
Provider Group / IPA	Name of the provider group and/or IPA affiliated with the contracted provider (if applicable). If the provider is associated with more than one provider group or IPA, enter an additional row identifying each additional provider group or IPA. Data for all other fields must be repeated in each row. If the provider is not affiliated with a provider group, please enter the value "Individually Contracted Provider" as set forth in the Profile tab in the Timely Access Reporting Web Portal. *(Please make sure the Provider Group is referenced on the "Provider Groups/IPA Crosswalk" table in the Profile tab in the Timely Access Reporting Web Portal.)*	Text (1 to 100 characters)
Facility	If reporting an individual provider who primarily delivers services in a facility setting, enter the name of each facility at which the provider primarily delivers services. Facility refers to a licensed hospital, ambulatory surgery center, laboratory, radiology or imaging center, other outpatient setting as described in Health and Safety Code § 1248.1, and any other facility contemplated under Health and Safety Code § 1371.9, subd. (f)(1). If the provider works primarily at one or more facility locations, list the facility in this field. Enter an additional row identifying each additional facility. When reporting more than one facility affiliation for the provider, data for all other fields must be repeated in each row. *(If entering a hospital name in this field, please make sure the Hospital is referenced on the "Hospitals Crosswalk" table in the Profile tab in the Timely Access Reporting Web Portal. If entering a clinic or other facility type that has been separately reported on this or another Network Report Form template, please enter the name of that facility exactly as it appears on the other Network Report Form.)*	Text (1 to 100 characters)
Facility NPI	Enter the NPI number corresponding to the facility or hospital identified in the “Facility” field.	Number (10 digits)

Is the Provider Listed in the Directory?	Identify whether or not, on December 31, 2017, the provider was listed in the Plan's online provider directory/directories maintained pursuant to section 1367.27, as follows: • Enter a "Y" if the provider was listed at the location indicated in the "Address" field and with the specialty type identified in the "Specialty/Subspecialty" field. • Enter an "R" if the provider and/or the associated location and specialty information described in the "Address" field and "Specialty/Subspecialty" field were removed from the directory pursuant to section 1367.27, subd. (l), resulting from failure to respond to plan notification seeking verification of directory information. • Enter an "O" if the provider and/or the associated location and specialty information described in the "Address" field and "Specialty/Subspecialty" field were omitted from the directory. "Omitted providers" refers to providers that are in the Plan's contracted network but are purposely left out of the provider directory. • Enter an "S" if the provider and/or the associated location and specialty information described in the "Address" field and/or "Specialty/Subspecialty" field were withheld from the directory pursuant to the DMHC's uniform provider directory standards and/or DMHC approval. • Enter an "N" if the provider was not listed in the directory at the location indicated in the "Address" field and with the specialty identified in the "Specialty/Subspecialty" field for any reason other than those listed above.	Text (1 or 2 characters)

REQUESTED FIELD	***INSTRUCTIONS*** *Enter data in each field as described below. If a certain field is not applicable, please enter "NA" unless such an entry is identified as not acceptable in the instructions. Requested fields may be left blank.*	***Data Type (Length)***
Provider Language 1	Language spoken by the provider. *(Please make sure the Provider Language 1 is referenced on the "Language Crosswalk" table in the Profile tab in the Timely Access Reporting Web Portal.)*	Text (0 to 50 characters)
Provider Language 2	Language spoken by the provider. *(Please make sure the Provider Language 2 is referenced on the "Language Crosswalk" table in the Profile tab in the Timely Access Reporting Web Portal.)*	Text (0 to 50 characters)
Provider Language 3	Language spoken by the provider. *(Please make sure the Provider Language 3 is referenced on the "Language Crosswalk" table in the Profile tab in the Timely Access Reporting Web Portal.)*	Text (0 to 50 characters)

Frequently Asked Questions – Other Contracted Providers Annual Provider Network Report Form

1. What is a Network Tier ID?

The Network Tier ID column only applies to those Plans that operate a tiered network. A tiered network is a product in which the Plan offers more than one "participating network" at different levels of cost- sharing. For example, in a tiered PPO network, an enrollee may access a Plan- defined group of participating providers ("Tier 1") and pay only 20% of the cost, or they can choose to access a separate Plan-defined group of participating providers ("Tier 2") and pay 40% of the cost, or they can choose to access a provider outside of the participating network and pay 60% of the cost. When completing the Annual Provider Network Report Forms, the Plan would identify the Tier 1 providers as a "1" in the "Network Tier ID" column, then it would identify the Tier 2 providers as a "2" in the "Network Tier ID" column. Please note: If the Plan also maintains an out-of-network

benefit, the Plan should not submit the out-of-network providers on its Annual Provider Network Report Forms.

2. **My Plan does not maintain the office number, suite number, building, or other location identifier for providers in a distinct field, therefore I cannot complete the "Address 2" column. Will this cause the data to be rejected?**

   The Address 2 field is an optional field for Plans that separate the number of the office, suite, building, or other location identifier in their own databases. The validation tool will accept this information in the "Address" or "Address 2" field. If the Plan does not separate out the office number, suite number, building, or other location identifier into a separate column, please leave the "Address 2" field blank.

3. **I have one or more contracted providers whose given first or last name is "Na," but I cannot submit the Report Form because that value is not allowed in the first or last name fields.**

   Please add a period to the provider's first name to read as "Na." and the DMHC will remove the period on its end post-submission. Please note that entering "NA" for the purposes of indicating the first or last name is not available is not a valid entry in this field. The solution described in this example is only to be used in situations where a provider's legitimate name happens to be "Na."

4. **What definition is the Department using in MY 2017 to define telehealth providers?**

   The Department uses the definition for telehealth set forth in Business and Professions Code Section 2290.5. (Please see the Instructions Tab in the PCP, Mental Health, Specialist and Other Contracted Provider Report Forms, in the field for "Telehealth" within these instructions).

   The Business and Professions Code defines telehealth as "the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers."

5. **How should health plans report the address for providers, including telehealth providers?**

The plan should report the physical address of the practice location where the provider treats patients, including street number and street name. If the provider practices in more than one location, enter an additional row for each practice location, and repeat all other fields in each row. If the provider also serves as a telehealth provider, report only the physical locations at which the provider treats patients in person. "NA" is not an acceptable value for this field. If a provider does not have a physical location at which he or she treats patients in person, do not report the provider on the Report Form. The plan may instead submit a narrative explanation with the Annual Network Review submission that includes the provider's information.

6. **How should the Plan report a provider who does not practice within its service area?**

   The Plan should report the entire network of contracted providers and locations for each reporting network, regardless of whether the contracted provider location is inside or outside of the network's service area. The Department derives the network's service area from the data reported on the "Enrollment and Service Area Report Form" for the network.

7. **If Occupational Therapy, Physical Therapy, and Speech Therapy are available at Contracted Hospitals, should the Hospitals who provide these services also be listed on the Other Contracted Provider Template?**

   If Plan-contracted hospitals provide Occupational Therapy, Physical Therapy, and Speech Therapy services to the network's enrollees on an outpatient basis, the Plan should report the hospital in the Other Contracted Providers Report Form in addition to reporting the hospital in the Hospitals Report Form. A hospital that is reported on the Other Contracted Providers Report Form should identify and crosswalk the covered outpatient services in the "Contracted Provider Category" field (i.e. Physical Therapy, Speech Therapy, etc.). If the hospital only provides these contracted services on an inpatient basis, the Plan should report the hospital only in the Hospitals Report Form.

Annual Provider Network Report Form – Hospitals and Clinics

The Hospitals and Clinics Report Form is the only accepted reporting format for a health plan to report its contracted network of hospitals and clinics for the purposes of timely access reporting. The health plan's submission must reflect the Plan's contracted network of hospital and clinic facilities as of December 31st of the Measurement Year.

To begin populating data, enter all of the required/requested information on the spreadsheet included in this workbook. Enter an additional row for any variation in one of the fields, such as additional addresses, specialties, etc. All fields must be completed for each row, information in fields that do not change must be repeated in the row representing the variation. In some cases, the DMHC requires plans to use specific terminology or crosswalk the Plan's own terminology to the Department's preferred terms. These fields are identified within the Instructions below. The Plan may crosswalk its terminology utilizing the "Crosswalk" links within the Timely Access Reporting Web Portal under the Profile tab. See the Profile Tab Instructions above for more information.

Be sure to report all hospitals and clinics in the Plan's contracted network. See the provider types listed by the DMHC in the "Hospital Service Type" table and the "Clinic Service Type" table found under the "Type of License and Service Crosswalk" link in the Profile tab for guidance as to what provider types should be reported on this form. The provider type must be crosswalked to the Department's preferred terms.

Instructions – Hospital and Clinic Annual Provider Network Report Form

Hospitals Tab		
REQUIRED FIELD	***INSTRUCTIONS*** *Enter data in each field as described below. If a certain field is not applicable, please enter "NA" unless such an entry is identified as not acceptable in the instructions. Please do not leave any required fields blank unless the instruction states a blank field is acceptable.*	***Data Type (Length)***
Hospital Name	Legal name of the hospital facility utilized by the Plan. List the hospital name exactly as listed on the "Hospitals Crosswalk" table in the Plan's Profile tab in the Timely Access Reporting Web Portal. If the Plan does not use the terminology provided in the "Hospitals Crosswalk," or utilize the table to cross-reference plan terminology, the Plan will be asked to correct the data and re-submit. "NA" is not an acceptable value.	Text (1 to 100 characters)
DBA	"Doing-Business-As" name of facility. May leave blank if no DBA.	Text (0 to 100 characters)

Health Plan ID for Plan-to-Plan Contract	The Plan ID of another Plan with which the Reporting Plan contracts ("Subcontracting Plan"). Complete this field if the Reporting Plan does not directly contract with the provider but instead includes this provider in the network through a contract with a Subcontracted Health Plan that is not subject to Timely Access reporting. Health plans that may be reported in this field include subcontracted restricted Knox-Keene licensees, specialized Knox-Keene licensed health plans (e.g. dental, vision, chiropractic, and acupuncture plans), and any other Knox-Keene licensed health plans that are not subject to timely access reporting requirements pursuant to Rule 1300.67.2.2, subd. (a). ***Do not complete this field if a Subcontracted Health Plan is subject to timely access reporting requirements***. The Subcontracted Health Plan must separately submit its contracted providers on behalf of the Reporting Plan via the "Other Plan Network" tab in the Timely Access Reporting Web Portal. Do not put the Reporting Plan's own Health Plan ID in this field. All Knox-Keene licensed health plans' ID numbers can be found on the Department's public website: http://wpso.dmhc.ca.gov/hpsearch/viewLicensedHealthPlan.aspx. See the *MY 2017 Annual Provider Network Submission Instruction Manual* for more information. May leave blank if the provider is not accessed through a Plan-to-Plan contract.	Text (0 or 8 characters)
Address	Physical address of facility, including street number and street name. Data for all other fields must be repeated in each row. If reporting more than one address, enter an additional row identifying each additional address. Data for all non-address fields must be repeated in each row. "NA" is not an acceptable value.	Text (1 to 100 characters)
Address 2	Insert the number of the office, suite, building, or other location identifier. If this information is not applicable to the address, leave blank.	Text (0 to 50 characters)
City	City in which the facility is located. "NA" is not an acceptable value.	Text (1 to 50 characters)
County	County in which the facility is located. (*Please make sure the County is referenced on the "County Crosswalk" table in the Profile tab in the Timely Access Reporting Web Portal.)* "NA" is not an acceptable value.	Text (1 to 50 characters)
State	State in which the facility is located. "NA" is not an acceptable value.	Text (2 to 30 characters)
Zip Code	Zip code in which the facility is located. "NA" is not an acceptable value.	Text (5 or 10 characters)
Phone Number	Enter the phone number, separating the area code and first 3 digits with a "-" (e.g. 123-456-7890). May leave blank if not applicable.	Text (0 to 12 characters)
NPI	The unique National Provider Identification (NPI) number assigned to the facility. The Plan must report <u>both</u> the provider's NPI and license number. Do not include deactivated NPIs. "NA" is not an acceptable value.	Number (10 digits)
CA License	California License number of facility. All CA Licenses should not have any spaces or leading zeros. Do not include deactivated CA Licenses. The Plan must report <u>both</u> the provider's NPI and license number. "NA" is not an acceptable value unless a license number is entered in the "Non CA License" field.	Text (1 to 30 characters)
Non CA License	License number where license was issued outside of the state of California. Do not include deactivated Licenses. May leave blank if not applicable.	Text (0 to 30 characters)
Non CA License State	State in which non-California license was issued. May leave blank if not applicable.	Text (0 to 30 characters)
Type of Service	Enter the type of service provided at the facility. (*Please make sure the Type of Service is referenced on the "Hospital Service Type" table found under the "Type of License and Service Crosswalk" link in the Profile tab in the Timely Access Reporting Web Portal. If the provider's service type does not appear on the "Hospital Service Type" table, please follow the instructions within the Profile tab for entering an "Other" service type for this provider within the "Hospital Service Type" table.*) "NA" is not an acceptable value.	Text (1 to 100 characters)

Name of Network	The name used by the Plan to describe the network in which the provider participates. Each named network should refer to a unique combination of providers that has been reviewed and approved by the DMHC for use with one or more lines-of-business. If the network is utilized for a Covered California line-of-business, please use the Network ID number assigned by Covered California. *(Please make sure the Name of Network is referenced on the "Name of Network" table in the Profile tab in the Timely Access Reporting Web Portal.)* "NA" is not an acceptable value.	Text (1 to 100 characters)
Network Tier ID	If the network is a tiered network, enter "1" for the providers participating in the tier with the lowest cost share for enrollees; enter "2" for the providers participating in the tier with the next-lowest cost share for enrollees. Continue to number tiers accordingly, with the higher tier number correlating to higher cost-share for the enrollee. May leave blank if not applicable.	Number (0 to 2 digits)
Tertiary Care (Y/N)	Identify whether the hospital provides tertiary care services. Enter "Y" if the Plan is contracted with the hospital to only provide tertiary care services for the identified Network, and does not have a contract with the hospital to provide basic hospital services to the entire enrollee population. Enter "N" if the Plan is contracted with the hospital to provide only basic hospital services to the entire enrollee population consistent with normal utilization and the hospital does not provide tertiary care services. If the Plan is contracted with a hospital to provide both basic hospital services and tertiary services for the identified Network, the Plan should enter a "B" in this field. "Basic hospital services" refers to the services described in the definition of a general acute care hospital set forth in Health & Safety Code section 1250, subd. (a). A contract for tertiary care services is typically one which provides highly specialized or complex medical care performed by highly trained specialists and subspecialists often using advanced technology in state of the art facilities, including sophisticated intensive care facilities. See the *MY 2017 Annual Provider Network Submission Instruction Manual* document for more information regarding how to complete this field.	Text (1 to 2 characters)
Is the Provider Listed in the Directory?	Identify whether or not, on December 31, 2017, the provider was listed in the Plan's online provider directory/directories maintained pursuant to section 1367.27, as follows: • Enter a "Y" if the provider was listed at the location indicated in the "Address" field and with the specialty type identified in the "Specialty/Subspecialty" field. • Enter an "R" if the provider and/or the associated location and specialty information described in the "Address" field and "Specialty/Subspecialty" field were removed from the directory pursuant to section 1367.27, subd. (l), resulting from failure to respond to plan notification seeking verification of directory information. • Enter an "O" if the provider and/or the associated location and specialty information described in the "Address" field and "Specialty/Subspecialty" field were omitted from the directory. "Omitted providers" refers to providers that are in the Plan's contracted network but are purposely left out of the provider directory. • Enter an "S" if the provider and/or the associated location and specialty information described in the "Address" field and/or "Specialty/Subspecialty" field were withheld from the directory pursuant to the DMHC's uniform provider directory standards and/or DMHC approval. • Enter an "N" if the provider was not listed in the directory at the location indicated in the "Address" field and with the specialty identified in the "Specialty/Subspecialty" field for any reason other than those listed above.	Text (1 to 2 characters)

REQUESTED	***INSTRUCTIONS*** *Enter data in each field as described below. If a certain field is not applicable, please enter "NA" unless such an entry is identified as not acceptable in the instructions. Requested fields may be left blank.*	***Data Type (Length)***
Hospital System	Name of hospital system to which this facility belongs.	Text (0 to 100 characters)

Clinics Tab		
REQUIRED	***INSTRUCTIONS*** *Enter data in each field as described below. If a certain field is not applicable, please enter "NA" unless such an entry is identified as not acceptable in the instructions. Please do not leave any required fields blank unless the instruction states a blank field is acceptable.*	***Data Type (Length)***
Clinic Name	Legal name of clinic facility utilized by the Plan. "NA" is not an acceptable value.	Text (1 to 100 characters)
DBA	"Doing-Business-As" name of facility. May leave blank if no DBA.	Text (0 to 100 characters)
Health Plan ID for Plan-to-Plan Contract	The Plan ID of another Plan with which the Reporting Plan contracts ("Subcontracting Plan"). Complete this field if the Reporting Plan does not directly contract with the provider but instead includes this provider in the network through a contract with a Subcontracted Health Plan that is not subject to Timely Access reporting. Health plans that may be reported in this field include subcontracted restricted Knox-Keene licensees, specialized Knox-Keene licensed health plans (e.g. dental, vision, chiropractic, and acupuncture plans), and any other Knox-Keene licensed health plans that are not subject to timely access reporting requirements pursuant to Rule 1300.67.2.2, subd. (a). ***Do not complete this field if a Subcontracted Health Plan is subject to timely access reporting requirements***. The Subcontracted Health Plan must separately submit its contracted providers on behalf of the Reporting Plan via the "Other Plan Network" tab in the Timely Access Reporting Web Portal. Do not put the Reporting Plan's own Health Plan ID in this field. All Knox-Keene licensed health plans' ID numbers can be found on the Department's public website: http://wpso.dmhc.ca.gov/hpsearch/viewLicensedHealthPlan.aspx. See the *MY 2017 Annual Provider Network Submission Instruction Manual* for more information. May leave blank if the provider is not accessed through a Plan-to-Plan contract.	Text (0 or 8 characters)
Address	Physical address of facility, including street number and street name. Do not include number for suite, office, building, etc. If reporting more than one address, enter an additional row identifying each additional address. Data for all non-address fields must be repeated in each row. "NA" is not an acceptable value.	Text (1 to 100 characters)
Address 2	Insert the number of the office, suite, building, or other location identifier. If this information is not applicable to the address, leave blank.	Text (0 to 50 characters)
City	City in which the facility is located. "NA" is not an acceptable value.	Text (1 to 50 characters)
County	County in which the facility is located. (*Please make sure the County is referenced on the "County Crosswalk" table in the Profile tab in the Timely Access Reporting Web Portal.)* "NA" is not an acceptable value.	Text (1 to 50 characters)
State	State in which the facility is located. "NA" is not an acceptable value.	Text (2 to 30 characters)
Zip Code	Zip code in which the facility is located. "NA" is not an acceptable value.	Text (5 or 10 characters)
Phone Number	If appointments are offered at this location, enter the phone number, separating the area code and first 3 digits with a "-" (e.g. 123-456-7890). May leave blank if not applicable.	Text (0 to 12 characters)
NPI	The unique National Provider Identification (NPI) number assigned to the clinic. The Plan must report the provider's NPI. Do not include deactivated NPIs. If the clinic does not have an NPI, please list the NPI of the clinic's Medical Director. "NA" is not an acceptable value.	Number (10 digits)
CA License	California License number of facility. All CA Licenses should not have any spaces or leading zeros. Do not include deactivated CA Licenses.	Text (1 to 30 characters)
Non CA License	License number where license was issued outside of the state of California. Do not include deactivated Licenses. May leave blank if not applicable.	Text (0 to 30 characters)
Non CA License State	State in which non-California license was issued. May leave blank if not applicable.	Text (0 to 30 characters)

Type of Service	Enter the type of service provided at the facility. (*Please make sure the Type of Service is referenced on the "Clinic Service Type" table found under the "Type of License and Service Crosswalk" link in the Profile tab in the Timely Access Reporting Web Portal. If the provider's service type does not appear on the "Clinic Service Type" table, please follow the instructions within the Profile tab for entering an "Other" service type for this provider within the "Clinic Service Type" table.*)	Text (1 to 100 characters)
Name of Network	The name used by the Plan to describe the network in which the provider participates. Each named network should refer to a unique combination of providers that has been reviewed and approved by the DMHC for use with one or more lines-of-business. If the network is utilized for a Covered California line-of-business, please use the Network ID number assigned by Covered California. *(Please make sure the Name of Network is referenced on the "Name of Network" table in the Profile tab in the Timely Access Reporting Web Portal.)* "NA" is not an acceptable value.	Text (1 to 100 characters)
Network Tier ID	If the network is a tiered network, enter "1" for the providers participating in the tier with the lowest cost share for enrollees; enter "2" for the providers participating in the tier with the next-lowest cost share for enrollees. Continue to number tiers accordingly, with the higher tier number correlating to higher cost-share for the enrollee. May leave blank if not applicable.	Number (0 to 2 digits)
Accepting New Patients (Y/N)	If the clinic serves as a primary care provider, enter "Y" to indicate the clinic is accepting new patients or that the clinic serves “walk-in” patients at this location. Enter "N" to indicate clinic is not accepting new patients at this location. If the clinic serves as a primary care provider and is only accepting existing patients, past patients, or patients from a waitlist, please enter "N" in this field. Enter "NA" if the clinic does not serve as a primary care provider. See the *MY 2017 Annual Provider Network Submission Instruction Manual* for information regarding how to report this field when patients are not assigned to a clinic.	Text (1 to 2 characters)
Current Number of Enrollees Assigned to Provider	If the clinic serves as a primary care provider, enter the total number of patients assigned to the clinic in this Name of Network as of December 31, 2017. If this provider is listed more than once, please repeat this number for every row associated with this provider for the identified Name of Network. See the Department's *MY 2017 Annual Provider Network Submission Instruction Manual* for further direction as to how to populate this field for specific network types. May leave blank if not applicable.	Number (0 to 6 digits)
Is the Provider Listed in the Directory?	Identify whether or not, on December 31, 2017, the provider was listed in the Plan’s online provider directory/directories maintained pursuant to section 1367.27, as follows: • Enter a “Y” if the provider was listed at the location indicated in the “Address” field and with the specialty type identified in the “Specialty/Subspecialty” field. • Enter an “R” if the provider and/or the associated location and specialty information described in the “Address” field and “Specialty/Subspecialty” field were removed from the directory pursuant to section 1367.27, subd. (l), resulting from failure to respond to plan notification seeking verification of directory information. • Enter an “O” if the provider and/or the associated location and specialty information described in the “Address” field and “Specialty/Subspecialty” field were omitted from the directory. “Omitted providers” refers to providers that are in the Plan’s contracted network but are purposely left out of the provider directory. • Enter an “S” if the provider and/or the associated location and specialty information described in the “Address” field and/or “Specialty/Subspecialty” field were withheld from the directory pursuant to the DMHC’s uniform provider directory standards and/or DMHC approval. • Enter an “N” if the provider was not listed in the directory at the location indicated in the “Address” field and with the specialty identified in the “Specialty/Subspecialty” field for any reason other than those listed above.	Text (1 to 2 characters)

Frequently Asked Questions – Hospitals and Clinics Annual Provider Network Report Form

1. **How do I populate the "NPI" and "CA License" field in the Hospital and Clinics Report Form if my plan does not have that information or such identifiers do not exist for some contracted clinics?**

   The DMHC recommends that the Plan utilize the Department of Consumer Affairs website (http://www.dca.ca.gov/), Office of Statewide Health Planning and Development website (http://www.oshpd.ca.gov/), or the NPI database (https://npiregistry.cms.hhs.gov/) to identify the provider license, hospital license or NPI number, respectively, of its providers.

   DMHC has included two columns in the Report Forms that allow the Plan to identify providers who are licensed in a state other than California and to provide the out-of-state license number. Please only report a provider's out-of-state license number if they do not also have a California license number.

   All hospitals should have an NPI and license number. If a contracted clinic does not have an NPI, please list the NPI of the clinic's Medical Director in the "NPI" Column in the Hospital and Clinics Report Form on the Clinics tab. The Department requires the Plan to list a valid 10-digit NPI in the "NPI" column. The Plan may list "NA" in the "CA License" column and the "Non-CA License" column if the clinic does not have a CA/Non-CA License.

2. **Are the fields of "Accepting New Patients" and "Current Number of Enrollees Assigned to Provider" required for hospitals?**

   The fields "Accepting New Patients" and "Current Number of Enrollees Assigned to Provider" are not included on the Hospital Report Form and are therefore not required for hospitals; however, they are required fields on the Clinics tab of the Report Form.

3. **What hospital services qualify as "tertiary care" as required in the Hospital Report Form?**

   Typically, a tertiary care hospital is one which provides highly specialized, complex medical care performed by highly trained specialists and subspecialists often using advanced technology in state of the art facilities, including sophisticated intensive care facilities. Generally, these hospitals may be academic medical centers, or specialized children's hospitals in the case of the pediatric population. The hospital should be licensed or accredited, as applicable, to perform the treatment. Examples of such services might include complex cardiac procedures, complex

neurosurgery, organ transplant, treatment of severe burns, neonatology or other very complex treatments or procedures.

The Department does not have a standard list of services that it considers to be "tertiary" care; however, for the purposes of completing this field on the Hospital Report Form, plans should consider whether the hospital being reported is contracted to provide basic hospital services to the entire enrollee population consistent with normal utilization or whether the hospital is only contracted to deliver specific, specialized services to enrollees requiring that specific care. Complete the "Tertiary Care" field in the Hospital Report Form as follows:

- If the Plan is contracted with a hospital to only provide tertiary care, enter a "Y."
- If the Plan is contracted with the hospital to provide basic hospital services that do not include tertiary care services, enter an "N."
- If the Plan is contracted with the hospital to provide both basic hospital services and tertiary care services, enter a "B."

If the Plan does not know if the hospital provides tertiary care, the Plan may enter "NA" in this field.

4. What is a Network Tier ID?

The Network Tier ID column only applies to those Plans that operate a tiered network. A tiered network is a product in which the Plan offers more than one "participating network" at different levels of cost- sharing. For example, in a tiered PPO network, an enrollee may access a Plan- defined group of participating providers ("Tier 1") and pay only 20% of the cost, or they can choose to access a separate Plan-defined group of participating providers ("Tier 2") and pay 40% of the cost, or they can choose to access a provider outside of the participating network and pay 60% of the cost. When completing the Annual Provider Network Report Forms, the Plan would identify the Tier 1 providers as a "1" in the "Network Tier ID" column, then it would identify the Tier 2 providers as a "2" in the "Network Tier ID" column. Please note: If the Plan also maintains an out-of-network benefit, the Plan should not submit the out-of-network providers on its Annual Provider Network Report Forms.

5. My Plan does not maintain the office number, suite number, building, or other location identifier for providers in a distinct field, therefore I cannot complete the "Address 2" column. Will this cause the data to be rejected?

The Address 2 field is an optional field for Plans that separate the number of the office, suite, building, or other location identifier in their own databases. The validation tool will accept this information in the "Address"

or “Address 2” field. If the Plan does not separate out the office number, suite number, building, or other location identifier into a separate column, please leave the “Address 2” field blank.

6. **How do I distinguish between a clinic and a provider group in smaller practice arrangements? For example: Jane Doe MD and her two mid-level practitioners, all primary care providers, with members individually assigned to them are contracted with the plan under the group “Jane Doe Family Health Care Group.” Should the Plan list “Jane Doe Family Health Care Group” in the Clinic column on the PCP Report Form and identify “Jane Doe Family Health Care Group” on the Clinic Report Form as a “free standing – primary care” clinic types, or should “Jane Doe Family Health Care Group” be listed as a Medical Group/IPA?**

   In this scenario, the Plan must first determine if the provider is a clinic or just a stand-alone physician office that employs mid-levels. If this is a clinic, identify “Jane Doe Family Health Care Group” as the “Clinic Name” on the PCP Report Form and also separately identify it as a clinic on the Hospital and Clinic Report Form (as described in the example). If this is not a clinic, but instead a physician office that employs mid-levels, identify the name of the physician individually on the PCP tab under "First Name" and "Last Name," then identify the mid-levels on the "PCP Extenders" tab and associate those mid-levels with the PCP's NPI number in the column "Supervising PCP NPI."

   If “Jane Doe Family Health Care Group” holds a group contract with the Plan (i.e. it is a medical group or IPA that is contracted with the Plan as a group), separately identify Jane Doe and each of her midlevel providers on the PCP Report Form and PCP Extenders Report Form, respectively, and then report “Jane Doe Family Health Care Group” under the Medical Group / IPA column in each of those Report Forms.

7. **How should the Plan report a provider who does not practice within its service area?**

   The Plan should report the entire network of contracted providers and locations for each reporting network, regardless of whether the contracted provider location is inside or outside of the network’s service area. The Department derives the network’s service area from the data reported on the “Enrollment and Service Area Report Form” for the network.

8. **If Occupational Therapy, Physical Therapy, and Speech Therapy are available at Contracted Hospitals, should the Hospitals who provide these services also be listed on the Other Contracted Provider Template?**

If Plan-contracted hospitals provide Occupational Therapy, Physical Therapy, and Speech Therapy services to the network's enrollees on an outpatient basis, the Plan should report the hospital in the Other Contracted Providers Report Form in addition to reporting the hospital in the Hospitals Report Form. A hospital that is reported on the Other Contracted Providers Report Form should identify and crosswalk the covered outpatient services in the "Contracted Provider Category" field (i.e. Physical Therapy, Speech Therapy, etc.). If the hospital only provides these contracted services on an inpatient basis, the Plan should report the hospital only in the Hospitals Report Form.

Annual Provider Network Report Form – Enrollment and Service Area

The Enrollment and Service Area Report Form is the only accepted reporting format for a health plan to report its service area and enrollment associated with each reported Name of Network. The health plan's submission must reflect the Plan's enrollment and licensed service areas for all Names of Network as of December 31st of the Measurement Year. For each Name of Network, report by county, and then by Zip code, the number of enrollees in each line-of-business. Please note that each record should have at least one reported line-of-business. Please be sure to include every Zip code in the approved service area for each Name of Network, even if there are no enrollees currently residing in that Zip code. Please note that this template will be used to establish the Plan's service area for the purpose of evaluating geographic access for all current and potential enrollees.

Plan-to-Plan Arrangements: Before completing the Report Form, identify whether the reporting plan is a Primary Plan or a licensed Subcontracting Plan in a plan-to-plan contract. A Primary Plan is a licensed Knox-Keene health care service plan that holds a contract with a subscriber or enrollee to arrange for the provision of health care services in return for a prepaid or periodic charge. A Subcontracting Plan is a licensed Knox-Keene health care service plan or specialized health care service plan that is contracted with the Primary Plan to serve as a health plan on behalf of the Primary Plan for some or all of the Primary Plan's enrollees.

- Subcontracting Plan. If the Plan completing this Report Form serves as a Subcontracting Plan in a plan-to-plan arrangement, the Subcontracting Plan does not report the Primary Plan's enrollees on the Enrollment and Service Area Report Form. Instead, the Subcontracting Plan must use this Report Form to report the service area within which the Subcontracting Plan provides services to the Primary Plan network enrollees. To do this, please complete a separate Enrollment and Service Area Report Form on behalf of each Primary Plan with which the Subcontracting Plan contracts. When submitting an Enrollment and Service Area Report Form on behalf of a Primary Plan, the Subcontracting Plan must report all Zip code/county combinations that comprise the service area for all Primary Plan networks subject to the plan-to-plan contract. A Subcontracting Plan's Report Form completed on behalf of a Primary Plan should be submitted via the "Other Plan Network" tab in the Timely Access Reporting Web Portal. For more information, see the MY 2017 Annual Provider Network Submission Instruction Manual. If the Subcontracting Plan is also reporting as a Primary Plan for its own network(s), the Subcontracting Plan must report those networks on a separate Report Form and submit it via the "Provider Network" tab, in accordance with the regular submission process, in the Timely Access Reporting Web Portal.

- Primary Plan. If the Plan completing the Report Form serves as a Primary Plan in a plan-to-plan arrangement, the Primary Plan must report its complete licensed service area for each network and all enrollees for each network, regardless of

whether the Primary Plan is directly arranging services for the enrollees or if the Primary Plan has delegated the enrollees to a licensed Subcontracting Plan. When reporting enrollees delegated to a Subcontracting Plan, the Primary Plan must identify the Subcontracting Plan in the "Health Plan ID of Subcontracting Health Plan" field.

In some cases, the DMHC requires plans to use specific terminology or crosswalk the Plan's own terminology to the Department's preferred terms. These fields are identified within the Instructions below. The Plan may crosswalk its terminology utilizing the "Crosswalk" links within the Timely Access Reporting Web Portal under the Profile tab. Please see the Department's MY 2017 Annual Provider Network Submission Instruction Manual available at www.dmhc.ca.gov for further information regarding how to complete and submit these Reports Forms. See the Profile Tab Instructions above for more information.

Instructions – Enrollment and Service Area Annual Provider Network Report Form

Enrollment and Service Area Tab		
REQUIRED FIELD	***INSTRUCTIONS*** *Enter data in each field as described below. If a certain field is not applicable, please enter "NA" unless such an entry is identified as not acceptable in the instructions. Please do not leave any required fields blank unless the instruction states a blank field is acceptable.*	***Data Type (Length)***
Health Plan ID of Subcontracting Health Plan	The DMHC issued Plan ID # (933 xxxx) of the Subcontracting Health Plan with which the Primary Plan has a contract. (Leave blank if the Reporting Plan is the Subcontracting Health Plan.) This field is only to be populated where the Reporting Plan is a Primary Plan. It must reflect the Plan ID of another Plan with which the Reporting Plan contracts for the network identified in the "Name of Network" field. Do not put the Reporting Plan's own Health Plan ID in this field. All Knox-Keene Act licensed health plan ID numbers can be found on the Department's public website: http://wpso.dmhc.ca.gov/hpsearch/viewLicensedHealthPlan.aspx. See the *MY 2017 Annual Provider Network Submission Instruction Manual* for more information about populating this field.	Text (0 or 8 characters)
County	County in which the Plan enrollee resides or works. (*Please make sure the County is referenced on the "County Crosswalk" table in the Profile tab in the Timely Access Reporting Web Portal and is identified as a part of the service area in the "Name of Network" section of the Profile tab*.) "NA" is not an acceptable value.	Text (1 to 50 characters)
Plan's Approved Service Area Zip Code	Zip code in which the Plan enrollee resides or works, if Zip code is within the approved service area for the reported Name of Network. Report all Zip codes in each service area county that comprise the Plan's approved service area for each Name of Network. If no enrollees work or reside within a Zip code that is part of the reporting Network's approved service area county, enter the Zip code in this field and then enter a value of zero ("0") in the "Number of Enrollees" field described below. "NA" is not an acceptable value. If the Reporting Plan is a Subcontracting Plan, report all ZIP codes for which the Subcontracting Plan is contracted to arrange services on behalf of the Primary Plan Network.	Text (5 or 10 characters)
Outside Service Area Zip Code	Zip code in which the Plan enrollee resides or works, if Zip code is outside the approved service area for the reported Name of Network. May leave blank if not applicable.	Text (0 to 10 characters)

Line-of-Business	Line-of-business connected to the reported Name of Network for which the Plan is reporting enrollment and service area. Ensure the line-of-business is also connected to the reported Name of Network in the "Name of Network" table in the Profile tab in the Timely Access Reporting Web Portal. *(Please make sure the Plan's terminology for its lines-of-business is crosswalked to the Department's preferred terminology on the "Health Plan Lines-of-Business" table in the Profile tab in the Timely Access Reporting Web Portal.)*	Text (1 to 100 characters)
Name of Network	The name used by the Plan to describe the "Name of Network" on the PCP, Specialist, Hospital, Mental Health, and Other Contracted Providers spreadsheets. *(Please make sure the Name of Network is referenced on the "Name of Network" table in the Profile tab in the Timely Access Reporting Web Portal.)* "NA" is not an acceptable value.	Text (1 to 100 characters)
Benefit Design	Name of Benefit Design as marketed by the Plan.	Text (1 to 100 characters)
Number of Plan Enrollees	Number of Plan enrollees residing in the Zip code/county combination within each identified Name of Network and Line-of-Business. Enter "0" if Zip code is in the Plan's service area but no enrollees currently reside or work there. If the Reporting Plan is a Subcontracting Plan, enter a "0" in this field for all Zip code/county combinations for which the Subcontracting Plan is contracted to arrange services on behalf of the Primary Plan Network. The Primary Plan is responsible for reporting all enrollees, including those that the Primary Plan delegates to a Subcontracting Plan (see instruction for "Health Plan ID of Subcontracting Health Plan" field above). The Subcontracting Plan does not report the number of enrollees delegated to it by the Primary Plan. See the *MY 2017 Annual Provider Network Submission Instruction Manual* for more information about populating this field. "NA" is not an acceptable value.	Number (1 to 10 digits)

Frequently Asked Questions – Enrollment and Service Area Annual Provider Network Report Form

1. My Plan participates in a plan-to-plan arrangement. How do I report enrollment?

Every Plan subject to timely access reporting requirements must submit an Enrollment and Service Area Network Report Form. If the Plan completing this Report Form serves as a subcontracting plan in a plan-to-plan arrangement ("Subcontracting Plan") such that the Plan provides services to individuals who are enrolled in another plan ("Primary Plan"), please complete a separate Network Report Form reflecting the service area only for the Primary Plan that is serviced through the Subcontracting Plan and submit that Report Form under the "Other Plan Network" tab in the web portal. The Subcontracting Plan should not report the Primary Plan's enrollees that have been delegated to the subcontracting plan. The subcontracting plan should only report the inside service area zip codes for each network used in its plan-to-plan arrangement. The primary plan is required to report all of its enrollees, including those delegated to the subcontracting plan.

See the Reporting Health Plan Network Arrangements section above for more instruction related to reporting enrollment in a plan-to-plan arrangement.

2. Is the Department taking into consideration P.O. boxes when assessing service area?

The Department takes into consideration any zip code reported in the "Plan's Approved Service Area Zip Code" field in the Enrollment and Service Area Network Report Form when identifying a network's service area for the purpose of network adequacy review. If the Plan reports P.O. Box-only zip codes in the Enrollment and Service Area template, those zip codes are considered in be in the Plan's service area. The Department evaluates these types of zip codes similarly to the standard zip codes that surround it.

P.O. Box-only zip codes that are permissible to report in the Enrollment and Service Area Network Report Form are not to be confused with P.O. Box addresses ("P.O. Box ####") associated with a provider or a facility. P.O. Box addresses are not allowed to be reported as provider addresses in the PCP, Specialists, Hospitals & Clinics, Other Contracted Providers, and Mental Health Professionals Network Report Forms. Any Network Report Form containing a P.O. Box address will not pass validation and will not be accepted as part of the Plan's annual network submission. Only the physical address in which an enrollee can obtain services may be reported as a provider address in the PCP, Specialists, Hospitals & Clinics, Other Contracted Providers, and Mental Health Professionals Network Report Forms.

3. Some enrollees in my plan's network reside outside of the approved service area. How do I report these enrollees on the Enrollment and Service Area Report Form?

The Department has reviewed and approved all health plan networks to ensure that all potential enrollees have appropriate access to care within the defined service area. Therefore, all health plans should only be arranging care for enrollees who work or reside within the approved service area. The Department is aware of two situations that can arise in which a plan must report enrollees whose zip code falls outside of the service area:

i. Workplace Inside Service Area - Sometimes a plan may only track an enrollee's residential zip code but the enrollee has access to the service area because s/he works within the service area.
ii. Medi-Cal Eligibility File in Transition – For plans that maintain Medi-Cal networks, the plan will receive a file from the Department of Health Care Services identifying enrollees who have been auto-assigned to the plan or who will be moving into the plan's service area, but the enrollee's current address is not within the service area.

When completing the Enrollment Report Form, plans should report these enrollees, however, the plan should list the zip code for the enrollee under the column entitled "Outside Service Area Zip Code." If the Plan would like to report enrollees that reside in a county outside of California, please refer to question #4 below for specific instructions on how to report out-of-state counties.

The zip codes reported on the Enrollment Report Form are used to identify the plan's service area. The plan should ensure that all zip codes that are within the plan's service area are included on this Report Form under the column entitled "Plan's Approved Service Area Zip Code." If the plan did not have any enrollees residing within that zip code for the measurement year being reported, the plan should still include the zip code on its Report Form, but enter the number of enrollees as "0."

Plans must accurately report the zip code and county that is in the Plan's approved service area for every network. Please ensure the correct county is listed in the "County" column and the correct ZIP code is listed in the "Plan's Approved Service Area Zip Code" Column. If a zip code crosses multiple county lines, please report the same zip code and the county that resides outside of the service area on a separate line.

Example:

County	Plan's Approved Service Area Zip Code	Outside Service Area Zip Code	Line-of-Business	Name of Network
Kern		93243	Small Group	California Blue PPO Network
Los Angeles	93243		Small Group	California Blue PPO Network

4. **We are receiving errors on our Enrollment and Service Area template. We have members who are mapped to zip codes that are outside of the state of California, which is erroring out. How can we resolve this issue?**

   If the Plan would like to report enrollees that reside outside of California and the county is not listed in the County Crosswalk table in the Profile Tab in the timely access web portal, please crosswalk the county to "Other" in the County Crosswalk table.

   Examples:

   Reporting counties outside of California – Crosswalk the out-of-state county to "Other":

DMHC County	Crosswalk Code/Name		
KLAMATH (OR)			
LAKE (OR)			
OTHER	Houston		
12345678			

Reporting counties outside of California with the same name as a county inside of California – Crosswalk the county name and the state abbreviation to the term "Other." If you attempt to crosswalk only to the county name, the validation tool will identify this county as a California county and the Report Form will not pass validation:

DMHC County	Crosswalk Code/Name		
KLAMATH (OR)			
LAKE (OR)			
OTHER	BUTTE (SD)		
12345678			

5. **How will the forms be validated on the front end against the ZIP County list the Department publishes?**

   The Enrollment and Service Area Report Form will be validated against the United States Postal Service (USPS) ZIP code/county list that the Department will provide within the "Resources" Tab of the Timely Access web portal. Any reported service area ZIP code and county combinations located within California must match the USPS list of ZIP code and county combinations shared with the Plan on the web portal. If the network is reporting enrollment outside of California, the Plan must first properly crosswalk the out-of-state county if the county is not already listed in the County Crosswalk table.

   With respect to validation on the Report Forms for providers and facilities (PCP, Specialist, Mental Health, etc.), when a health plan reports a provider with a California address, the address will not pass validation if the county listed is not a county within California.

6. **How should I report ZIP codes in the Service Area and Enrollment form?**

   Within the Enrollment and Service Area Report Form, the Plan must report all ZIP code/counties that comprise each reported network's approved service area, and identify the total number of enrollees in each network who reside in the reported service area ZIP code/county. In some instances, the Plan may need to report enrollee ZIP code/counties that are

outside of the network's approved service area. The Enrollment and Service Area Report Form has two different ZIP code fields, so that the Plan's submission will differentiate between the ZIP code/counties that are reported as inside of the network's approved service area and those that are reported as outside of the approved service area.

Each ZIP code/county the plan reports must be reported either in the "Plan's Approved Service Area Zip Code" field or in the "Outside Service Area Zip Code" field. If the ZIP code/county is inside of the Plan's approved service area, it should be reported in the "Plan's Approved Service Area Zip Code" field. Any enrollment for this ZIP Code should be reported in the corresponding "Number of Plan Enrollees" field. If the network has enrollment outside of the Plan's approved service area, the Plan should report the ZIP code/county in the "Outside Service Area Zip Code" field, and enrollment number in the corresponding "Number of Plan Enrollees" field. If the Plan enters the same ZIP code in both the "Plan's Approved Service Area Zip Code" field and in the "Outside Service Area Zip Code" field in the same row, the Report Form will not pass validation. If the Plan reports a ZIP code/county in the "Plan's Approved Service Area Zip Code" field on one row and in the "Outside Service Area Zip Code" field on another row the Department will consider the ZIP code/county to be inside the network's approved service area when conducting its network analysis.

The Plan must also report all ZIP codes that are inside the network's approved service area, regardless of whether there was actual enrollment in the ZIP code as of December 31, 2017. If a ZIP code is inside the network's approved service area and the network does not have enrollment in the ZIP code, the Plan is required to report the ZIP code, and enter "0" in the "Number of Plan Enrollees" field. If the ZIP code is outside the network's approved service area and the network does not have enrollment in the ZIP code, the Plan is not required to report the ZIP code.

7. Do we need to do a separate Enrollment form for each network, or can we combine in one and differentiate using the Name of Network column?

If the reporting plan is reporting for itself, it may submit one Enrollment and Service Area Report Form to report enrollment and service area data for all of the reporting networks, as long as the Report Form does not exceed the row or file size limit. If the Enrollment and Service Area Report Form exceeds the row or file size limit, please submit as many additional Enrollment and Service Area Report Forms as needed to report all of the Plan's enrollment and service area data for each of the Plan's reported networks.

If the reporting plan is the subcontracting plan in a plan-to-plan arrangement, the reporting plan (subcontracting plan) must submit a separate Enrollment and Service Area Report Form for each primary plan for which the subcontracting plan is reporting data. When reporting on behalf of another plan, the Enrollment and Service Area Report Form should be submitted in the “Other Plan Network” tab within the web portal, separately for each primary plan with which the subcontracting plan has an arrangement. Please remember that when reporting on the Enrollment and Service Area Report Form on behalf of a primary plan, the subcontracting plan is only responsible for reporting the ZIP codes/counties that comprise the service area within which the subcontracting plan provides services to the primary plan enrollees. The subcontracting plan should report these ZIP codes/counties, and report “0” in the “Number of Plan Enrollees” field to avoid duplicate reporting with the primary plan. The primary plan is expected to report the number of enrollees in the reporting network. (Please refer to the Enrollment and Service Area Report Form Instructions Tab, and page 91 of the MY 2017 Annual Provider Network Submission Instruction Manual, for detailed instructions).