Timely Access Annual Provider Network Reporting Frequently Asked Questions

Measurement Year 2016

Timely Access Annual Provider Network Reporting Frequently Asked Questions

New for Measurement Year 2016

1. What has changed for reporting network data for Measurement Year 2016?

The DMHC has made a few notable changes to the Annual Provider Network Report Forms and the process for submitting health Plan data. The following identifies the major changes for Measurement Year 2016:

- Plans are required to report both NPI and CA License number for all providers. In prior years, the Department would accept blanks in one field if the other was populated. The Department will now require a value in both fields in order for the Plan's data to pass validation. Deactivated NPIs will not be accepted.
- Renamed the column "Inside Service Area Zip Code" to "Plan's Approved Service Area Zip Code" in the Enrollment form specifically for reporting the plan's service area.
- The Department has eliminated the "Specialty/Subspecialty (Other)" field. Please ensure that if the reported provider has any of the specialties identified in the Specialty Crosswalk list that the Plan has so specified within the Network Report Forms.
- The Department has eliminated the "Line-of-Business" field. Please ensure that all lines-of-businesses associated with a Name of Network in the Profile tab have access to the complete set of providers represented in the Name of Network within the Network Report Forms. If a particular line-of-business does not have access to the complete group of providers associated with the Name of Network, the Plan must create a separate Name of Network for that line-of-business and represent that relationship in the Profile tab. By associating a particular line-of-business with a specified Name of Network in the Profile tab, the plan is affirming that all providers listed in that Name of Network within the Annual Provider Network Report Forms are available to all enrollees in that particular line-of-business.
- The Department has changed the field entitled "Medical Group/IPA" to "Provider Group/IPA." This is to acknowledge that some groups contain more than just physicians (e.g. mental health provider groups). The Department has also developed a list of preferred DMHC names for mental health provider groups within the Provider Group/IPA Crosswalk in the Profile tab.
- Provider email address has been added as a requested field in the PCP, Specialist, and Mental Health Professionals template.

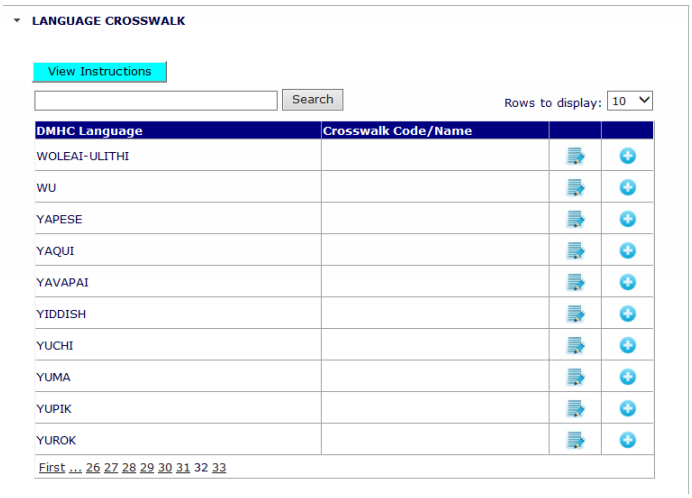
Populating Report Forms (Excel Templates)

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

If your Plan utilizes 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.

3. 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?

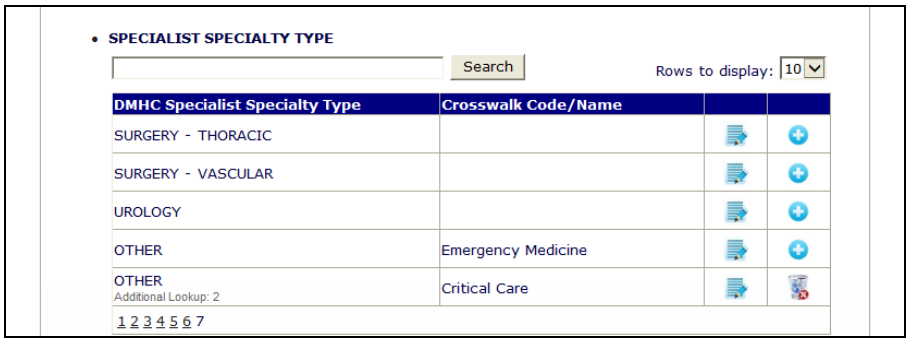
No. Additional languages cannot be added to the Language Crosswalk table in the Profile tab. The Plan is limited to the list of languages provided in the Crosswalk table. If the Provider speaks a language not listed in the Look-Up code, do not report that language.



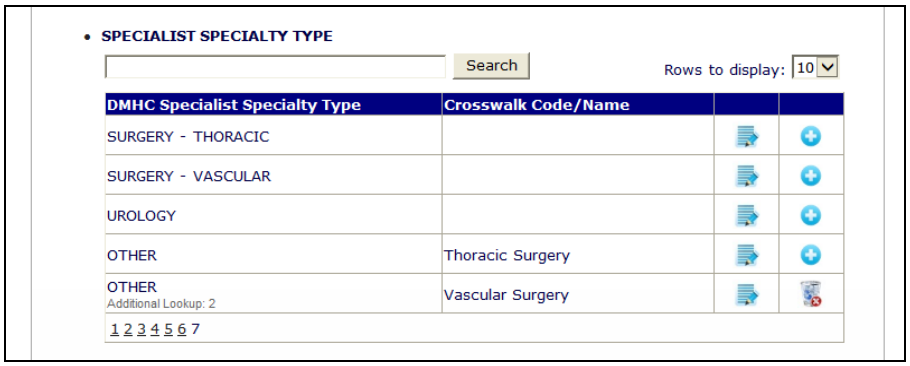
4. If the specialty the Plan uses is not listed on the Specialty Crosswalk table, can I add it?

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:

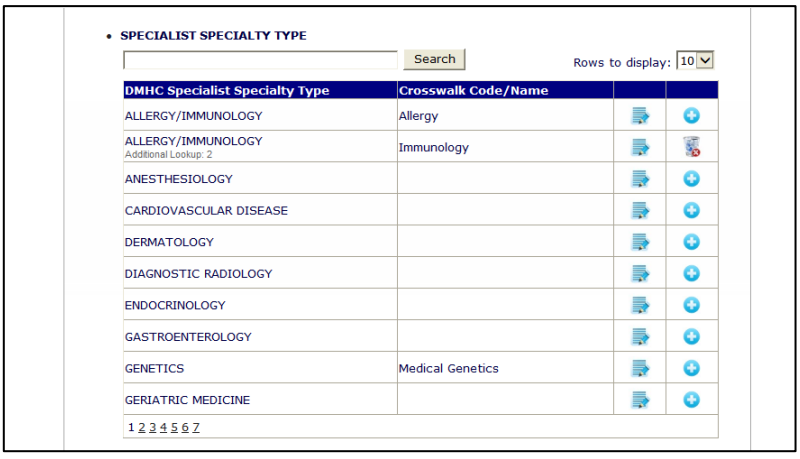


Incorrect:



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 2016, 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:



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.

5. 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, 2017 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.

6. 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 2016 (due March 31, 2017), 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:

1. Identify the total number of enrollees in that PPO network name residing in that county as of December 31, 2016.
2. Identify the total number of PCPs in that PPO network practicing in that county as of December 31, 2016.
3. Divide the number of enrollees (item 1) by the number of PCPs (item 2)
4. 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.
5. 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

The DMHC continues to research the best way to capture this data for PPO products and this methodology may change for Measurement Year 2017.

7. 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.

8. 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:

1. 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.)
2. 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).
3. Divide the number of enrollees (item 1) by the number of PCPs (item 2). (Example: 2,000/8 = 250.)
4. 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	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

9. 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:

1. 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.)
2. 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.)
3. Divide the number of enrollees (item 1) by the number of PCPs (item 2). (Example: 2,800/4 = 700.)
4. 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

10. 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

11. My Plan does not capture CA license for hospitals. How do I populate the Hospitals report template?

For all hospitals and for those other contracted providers who do have a California license but for whom the Plan does not maintain the license number in its database, 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://nppes.cms.hhs.gov/NPPESRegistry/NPIRegistryHome.do) to identify the provider license, hospital license or NPI number, respectively, of its providers.

DMHC has included two columns in the Report Templates 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.

12. 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 Spreadsheet; however, they are required fields on the Clinics Spreadsheet.

13. 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 Hospital, Hospital NPI, and Hospitalist fields in the PCP and Specialist Annual Provider Network Report templates?

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, Specialist, or Mental Health Annual Provider Network Report Form as follows:

1. 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 "Hospital" column on the PCP and Specialist Report Forms for each physician associated with that medical group. If reporting specialists, please also enter a "Y" in the Hospitalists 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 "Hospital" column. On the second entry, list "Memorial Hospital" in the "Hospital" column. For each of these entries, enter "Y" in the "Hospitalist" column.

2. 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 "Hospital" column on the PCP or Specialist Report Form for only those physicians identified by the medical group as being able to admit via a hospitalist.

14. My Plan has multiple categories to describe whether a PCP is accepting new patients. How do I populate the "Accepting New Patients/Referrals" columns in the PCP, Specialist and Mental Health templates?

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 or all referrals, please place a "Y" in this category. If the Plan does not know if the provider is accepting new patients or referrals, and the contract does not require the provider to take all patients and referrals, please enter "NA" in the "Accepting New Patients" column.

15. What hospital services qualify as "tertiary care" as required in the Hospitals template?

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 we consider to be "tertiary care." If the Plan considers a hospital to provide tertiary care, it may place a "Y" in the "Tertiary Care" column. If the Plan does not know if the hospital provides tertiary care, please enter "NA."

16. 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.

17. 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.

18. 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

substance abuse, 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.

19. 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.

20. Some enrollees in my plan's network reside outside of the approved service area. How do I report these enrollees on the Enrollment 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:

1. 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.

2. 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."

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."

Website Access and Report Submission

21. 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.

22. 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 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 Network Report Form. If your plan is in a plan-to-plan arrangement with another health plan, in which your plan arranges services for enrollees who hold a contract with the other "primary" plan, please report the enrollees your plan serves via the plan-to-plan arrangement on a separate Enrollment Network Report Form and submit that form under the "Other Plan Network" tab.

23. 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/TimelyAccessReport.aspx#.WHbLsU2QzuI

24. 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.

25. 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.

26. 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 1

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 Jeff Kral jkral@dmhc.ca.gov for assistance.

27. 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).

28. 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.

Validation Tool

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

The validate function was covered in the webinars conducted by the Department. 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.

30. 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:

1. Access the original Excel file on your own network and make the corrections to the original spreadsheet.
2. Select the **Remove** link to delete the previously uploaded report form from the web portal/eFile application.
3. Upload the newly corrected report form to the web portal.
4. 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.

33. 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.

34. 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.