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SECTION 5: PROVIDER SERVICES

PROVIDER RIGHTS AND RESPONSIBILITIES

Provider Rights

Health Plan values its relationship with Providers and Providers have the right to know what they can expect from Health Plan. Providers' Rights include but are not limited to the following:

- **Communication with Members:** The right to freely communicate with Members about their treatment, including medication treatment options, regardless of benefit coverage limitations.
- **Review of Credentialing Information:** The right to review information Health Plan has obtained to evaluate the Provider's individual credentialing application, including attestation, credentialing verification (CV), and information obtained from any outside source (e.g., malpractice insurance carriers, State licensing boards), with the exception of references, recommendations, or other peer-review protected information. Health Plan is not required to reveal the source of information if the information is not obtained to meet Health Plan credentialing verification requirements or if disclosure is prohibited by law.
- **Correction of Credentialing Information:** The right to correct erroneous information when credentialing information obtained from other sources varies substantially from information submitted by the Provider. The correction of erroneous information submitted by another source is detailed in the Credentialing section of this Provider Manual.
- **Credentialing Updates:** The right to be informed of a Provider's credentialing application status upon request to Health Plan.
- **Staying Informed:** The right to receive information about Health Plan, including but not limited to available programs and services, its staff and their respective titles, operational requirements, and contractual relationships.
- **Coordination of Care:** The right to information on how Health Plan coordinates its interventions with treatment plans for individual Members.
- **Health Plan Support:** The right to receive support from HPSJ in making decisions interactively with Members regarding their health care.
- **Health Plan Contact Information:** The right to receive contact information for staff responsible for managing and communicating with the Provider's Members.
- **Health Plan Communications:** The right to expect and receive communication from Health Plan staff regarding complaints, issues, or concerns relating to Provider rights and responsibilities and their staff.
- **Grievance and Appeals**: The right to receive policies and procedures about the grievance and appeals process.
- **Telehealth**: All Providers furnishing applicable Covered Services via audio-only synchronous interactions must also offer those same services via video synchronous interactions as to preserve Member choice. To preserve a Member's right to access Covered Services in-person, a Provider furnishing services through video synchronous

interaction or audio-only synchronous interaction must offer those same services via in-person and or face-to-face contact. Providers must arrange for a referral to, and a facilitation of, in-person care that does not require a Member to independently contact a different Provider to arrange for that care.

Providers are also required to explain the following to Members:

- The Member's right to access Covered Services delivered via Telehealth in-person.
- That use of Telehealth is voluntary and that consent for the use of Telehealth can be withdrawn at any time by the Member without affecting their ability to access Medi-Cal Covered Services in the future.
- The availability of Non-Medical Transportation to in-person visits.
- The potential limitations or risks related to receiving Covered Services through Telehealth as compared to an in-person visit, if applicable.

PROVIDER DIRECTORY MAINTENANCE RESPONSIBILITY

In order to assure Members of timely and accurate information on the Providers available in the Health Plan network, it is important that Providers comply with Health Plan's policies regarding Provider Directory maintenance. Health Plan has a regulatory responsibility to publish an accurate Directory of all Providers. This Provider Directory will be maintained and updated in accordance with State and federal law, including but not limited to Section 1367.27 of the Health and Safety Code. Health Plan is required to have a current Provider Directory to reflect the following changes:

- Provider is no longer accepting new Members
- Provider was previously not accepting new Members but is now open to new Members
- Provider is no longer contracted with Health Plan (contract termination has occurred)
- Provider has moved to a different location
- Provider has added a location
- Provider has changed its office hours
- A change in languages spoken in the office
- As a result of an error identified through a Member complaint
- Any other information affecting the accuracy of the Provider Directory

Provider Demographic Information

This Directory will include, but not be limited to, the following demographic information for each Provider as required by Section 1367.27 (h) of the Health and Safety Code:

▪ Provider's Name	▪ National Provider Identification Number (NPI)
▪ Practice Address(s) and Site Name if applicable	▪ California License Type and Number
▪ Telephone Number during business hours	▪ Name of Affiliated Medical Group or Clinic and NPI, Address, Telephone Number
▪ Telephone Number after business hours	▪ Office Email Address if available
▪ Office Hours and Days Open	▪ Hospital admitting privileges at hospitals contracted with HPSJ, if any, for physicians and surgeons

▪ Whether the Provider is accepting new patients	▪ Cultural and Linguistics Capabilities - Interceptors available – languages or American Sign Languages (non-English language(s) spoken by the Provider or other medical professional or qualified interpreter, if any, on the Provider's staff)
▪ Type of Practitioner	▪ Board certification if any
▪ Area of Specialty	▪ Accessibility to accommodate Members with physical disabilities
▪ For ECM or Community Supports Indication of the Population of Focus the Provider serves, whether the Provider	▪ Identification of Network Providers or sites that are not available to all or new Members
▪ Enhanced Care Management Provider organization name, mailing address, contact information for new referrals and telephone and email, contact information for existing patients and telephone and email (if different than contact information for new referrals)	

In addition to the above, the Provider Directory will also include information regarding physical accessibility and office hours.

Provider Directory Audits

Health Plan will send a written notification to all contracted Providers at least once a year, and as frequent as every six (6) months, to verify the accuracy of the information on file. The following are key timelines and process points:

- Providers must respond to Health Plan within thirty (30) business days to confirm that the information is correct or provide changes needed to update the Directory.
- If no response is received from a Provider within the thirty (30) business days, Health Plan will send a second written notice.
- Provider must respond to Health Plan within fifteen (15) business days of the second notice to confirm the accuracy of the information or provide changes needed to update the Directory.

- If Health Plan does not receive a response from the Provider by the end of the 15 business days, and Health Plan cannot verify the Provider's information, Health Plan sends a third notice to give the Provider ten (10) business days prior notice of removal from the Provider Directory.

- Non-responsive Providers are removed from the Directory at the next required update.

- Failure to respond to the notices for Directory confirmation or changes may result in the delay of claims payment or Capitation Payments pursuant to HSC §1367.27. Please refer to the Provider Payment section in this manual for more information on payment delays.

PROVIDER COMMUNICATION

At Health Plan, we value our relationship with our Provider network and believe that prompt and effective communication is critical to ensure that you are receiving the information and support you need from us. Throughout the year, Health Plan is notified by regulators and accreditation agencies as to changes or clarifications that impact Members, billing, or other administrative processes. In order to keep you up to date, we have several communications strategies that we employ:

Provider Alerts

The primary method of communication is a *Provider Alert*. *Provider Alerts* are typically condensed documents providing valuable updates, information, and action requests. They are sent by fax and email to the contact information provided by the practice, and they are provided during meetings, visits, and programs. *Provider Alerts* often contain time sensitive information, so they should be a priority for review and response, if necessary. To ensure receipt of these important *Provider Alerts* on a timely basis, it is essential that Health Plan is provided with accurate and current practice information including contact information for receipt of these notices. Current, as well as past, *Provider Alerts* are also available on Doctor's Referral Express (DRE*)* and on the website, www.hpsj-mvhp.org.

Provider Alerts generally address the following types of issues:

- Changes to Health Plan policies, procedures, and processes
- Important regulatory or legislative changes
- Upcoming meetings or events beneficial to Providers to support Members
- Training opportunities and requirements
- Health Plan company announcements
- Health Plan initiatives requesting Provider input and/or feedback
- Changes in the Provider network that may impact the practice

- New programs and/or products in development where your input is requested
- New programs, products or Member benefits

Provider Webinars

Health Plan provides webinars to update Providers with important information. Providers will be notified in advance of upcoming webinars via *Provider Alerts*, through DRE, and through updates on the website, www.hpsj-mvhp.org.

Provider Newsletters

On a quarterly basis, Health Plan publishes a Provider newsletter called *PlanScan*. *PlanScan* is made available electronically to all Providers including contracted Facilities. Both current and back issues of *PlanScan* are available on the Health Plan website, www.hpsj-mvhp.org. This publication can be emailed to Providers by request.

Provider Feedback

In-Service Evaluation

Health Plan provides orientation sessions for new Providers as well as training on new policies, procedures, and regulations. These orientation sessions or "in-services" may be held either on location at the Provider office/clinic; through telephonic methods including webinar. In order to evaluate whether these in-services meet the needs of new Providers, Providers are asked to complete a one-page evaluation form and fax it back to Health Plan after each onsite training. To ensure that evaluations are not influenced by the presence of Health Plan staff, Providers are asked to complete and fax the evaluation form to Health Plan after the Provider Services Representative has left the training site. These forms can be faxed to (209) 462-5265.

Provider Satisfaction Surveys

Health Plan performs satisfaction surveys on an annual basis in order to gain perspective on the level of service provided to Providers and office staff and to determine the overall satisfaction of Health Plan from the Provider perspective. Providers are encouraged to complete these satisfaction surveys since the information gathered will be used to help improve services.

Focus Groups

Health Plan may conduct focus groups with Providers in order to gain feedback on how services can be enhanced. Providers invited to participate in a focus group will be contacted by Health Plan's Provider

Services Department. Providers that agree to participate in the focus group may be compensated

for their participation.

For more information or to provide feedback as to how Health Plan can enhance our service to Providers and improve satisfaction, please contact Health Plan at (209) 942-6320.

PROVIDER EDUCATION AND TRAINING

Health Plan provides training opportunities to Providers based on operational relevance and regulatory requirements. Some training topics include:

New Provider In-Service

Within ten (10) business days of a Provider becoming effective in the Health Plan network, a Provider Services Representative (PSR) will meet with Provider's designated office staff to provide a detailed orientation (i.e., in-service). This in-service includes, but is not limited to, the following:

- Overview of Health Plan
- Fraud Waste & Abuse State-mandated training information and Attestation
- Cultural Competency & Language State-mandated training information and Attestation
- Seniors and Persons with Disability (SPD) Awareness and Sensitivity Training and Attestation
- Health Insurance Portability and Accountability Act (HIPAA) State mandated training information and Attestation
- Diversity and Equity and Inclusion Training
- Early Periodic Screening, Diagnosis Testing (EPSDT) Training
- Review of information contained in the Provider Manual, including the Department of Health Care Services (DHCS) Timely Access standards and After-hour requirements Explanation of Doctors Referral Express (DRE)
- Assistance in setting up DRE access
- Guidance on electronic claims submission and online Authorization
- Guidance on coordinating preventive services (HEDIS) and standards, if applicable
- Members' Rights and Responsibilities, including Advanced Directives, including the Member Grievance and Appeals Process
- Provider Rights and Responsibilities, including the Provider Dispute Process
- Answers to any questions you may have regarding working with us

On-going Provider In-Services

Health Plan's Provider Services team conducts follow-up visits as necessary and in order to assess the Provider's experience working with Health Plan and to address any additional questions or concerns. Health Plan staff is also available to conduct follow-up trainings to review or address

any topic necessary to support Providers in performing their duties and functions. The goal is to ensure that working with Health Plan is a positive experience for Providers, their office staff and Members.

Valley Mountain Regional Center (VMRC)

There is training available through Valley Mountain Regional Center (VMRC), designed to assist Providers in identifying and managing Members with disabilities and behavioral health issues. VMRC serves children and adults with developmental disabilities in San Joaquin, Stanislaus, Amador, Calaveras and Tuolumne counties.

Other Training Opportunities

Health Plan also offers Providers and office staff the opportunity to attend trainings in either in-person setting during the day, as well as evening training on various operational and quality related topics. Topics could include, but not be limited to:

- Doctor's Referral Express (DRE) Refresher Training
- How to Successfully Pass a Facility Audit (FSR)
- How to Successfully Pass a Chart Audit
- Child Health and Disability Prevention (CHDP) and California Children's Services (CCS)
- Improving HEDIS performance
- Fluoride Varnish Treatment Training

DOCTORS REFERRAL EXPRESS (DRE)

One of the most beneficial resources to help in providing efficient service to Members is Doctors Referral Express (DRE). DRE is the HIPAA-compliant secure Provider portal that is available 24/7 to Providers. DRE also has a mobile application compatible with both iPhone and Android devices. This service is provided at no cost to the Provider and will assist in managing medical care for Members. Throughout this Provider Manual, there are references to DRE that indicate the use of this tool to accomplish several administrative tasks such as:

- Member eligibility verification
- Obtaining PCP Member rosters
- Sending emails to HPSJ departments
- Checking claims status
- Submitting Provider Dispute Resolution (PDR) and checking status
- Reviewing *Milliman Care Guidelines*
- Accessing HEDIS "Gap Reports"
- Accessing the Patient Benefit Dossier

- Obtaining/Status checking Authorization and referrals
- Obtaining Member coverage and benefits information
- Accessing Member utilization history
- Billing Code Finder (CPT, HCPCS)
- Provider Lookup Tool
- Accessing Forms and Data

Doctor's Referral Express (DRE) Portal Access

To receive access to Doctor's Referral Express (DRE), Providers and their authorized users must have an active contract with Health Plan. Each Provider office user (physician, medical assistant, office employee, biller, authorization clerk, etc.) is required to have their own unique access to DRE that is approved by the Provider office administration. Sharing log-in and password information is prohibited.

For security purposes, the user will be required to validate that an online account will be set up in their name and will be required to attest to the on-line Health Plan Confidentiality Statement. Upon receiving the application and completing the online attestation, each user will receive a confirmation e-mail from Health Plan providing them the resolution of the DRE access request. All fields must be completed in the online application before DRE Provider portal access will be activated. The Practice/Clinic NPI and Tax ID# will be required during the registration process.

Once the registration is completed, the user will be able to access DRE at the Health Plan website: www.hpsj-mvhp.org. A Provider Services Representative will contact all new Provider offices connecting to DRE to schedule training. To be compliant with Health Plan security standards, all DRE users will be required to validate their account on a quarterly basis. For questions regarding DRE access and training, please call the Provider Services department at (209) 942-6320.

DRE access can be obtained by linking to the Health Plan on-line web page www.hpsj.com/Providers.