KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	Provider Directory	**Policy #**	12.13-P
Policy Owner	Provider Relations	**Original Effective Date**	07/2008
Revision Effective Date	9/2024	**Approval Date**	02/10/2025
Line of Business	☒ Medi-Cal ☐ Medicare ☐ Corporate		

I. PURPOSE

Kern Health Systems (KHS) will develop and provide each member or family unit with a Provider Directory (directory).

II. POLICY

KHS will update the Medi-Cal Provider Directory on a quarterly basis[2]

KHS will cooperate with the Department of Health Care Services (DHCS) Enrollment program and shall provide to DHCS' enrollment contractor a list of network providers (provider directory), linguistic capabilities of the providers and other information deemed necessary by DHCS to assist Medi-Cal beneficiaries, and Potential Enrollees, in making an informed choice in health plans.[3]

The KHS directory will be developed, approved, produced, and distributed in accordance with the provisions outlined in the following statutory, regulatory, and contractual sources:

A. California Welfare and Institutions Code Section 14406(a)(3)
B. California Code of Regulations Title 22 §53895
C. DHCS Contract Exhibit A, Attachment 13, Provision 4 (D)(4) and Attachment 16, Provision 1
D. MMCD Policy Letter 00-02: Health Plan Provider Directory Policy, Guidelines, and Delivery Standards (April 13, 2000)
E. Health and Safety Code, Section 1367.27

III. DEFINITIONS

TERMS	DEFINITIONS
N/A	

IV. PROCEDURES

A. DEVELOPMENT

The directory is developed in accordance with the standards outlined in KHS Policy and Procedure #12.01-I: Member Materials including standards for reading level and translation.[4] Development of the Provider Directory is the responsibility of the Provider Relations and Marketing Departments.

The directory shall contain all applicable requirements outlined in 42 Code of Federal Regulations (CFR) 438.10(h), Health and Safety Code 1367.27, and most recent version of the Department of Managed Health Care's Uniform Provider Directory Standards.

B. APPROVAL

The directory is approved in accordance with the standards outlined in KHS Policy and Procedure #12.01-I: Member Materials.

A draft of the Medi-Cal directory is forwarded to the California Department of Health Care Services (DHCS) for review and approval.[5]

KHS will submit KHS Policy and Procedure #12.13-P Provider Directory to the California Department of Managed Health Care on an annual basis for departmental approval.

C. PRODUCTION

The directory is produced in accordance with the standards outlined in KHS Policy and Procedure #12.01-I: Member Materials.

D. DISTRIBUTION

The directory is distributed in accordance with the standards outlined in KHS Policy and Procedure #12.01-I: Member Materials. The Provider Directory is included in both the New Member Packet and Annual Member Packet.[6]
The Member Services Department provides a copy of the Provider Directory to any person within five (5) days of request.[7]

1. Distribution to Health Care Options
   Upon contact from the Health Care Options (HCO) Contractor, the Marketing Department arranges for shipment of the requested number of directories.[8]

KHS follows the Shipping and Packaging Specifications provided by MAXIMUS (see Attachment A).

E. TRACKING OF PROVIDER DATA

It is the responsibility of the Provider Relations Department to verify and update all practitioner specific information referenced above.

KHS uses a software product that allows for data entry and tracking of all provider information that is used for the development of the provider directory. At the time of initial entry of the data, all information is verified either by telephone or in writing.

KHS may, as it deems necessary, contract with an external vendor to conduct provider directory data validation.

On an annual basis KHS, via an external vendor, shall submit notification to all provider groups to confirm accuracy of all provider directory information (outlined in section A. Development); individual providers, not affiliated with a provider group shall receive notification at least once every six months. KHS requires an affirmative response from providers (excluding general acute care hospitals) acknowledging receipt of the notification and requires all notified providers to confirm their directory information is current and accurate, or otherwise update their directory information.

1. The notification shall include:
    a. The information KHS has in its directory or directories regarding the provider or provider group.
    b. A statement that the failure to respond to the notification may result in a delay of payment or reimbursement of a claim.
    c. Instructions on how the provider or provider group can update the information in the provider directory or directories using the online interface.

KHS, in conjunction with their contracted external vendor, will take no more than fifteen (15) business days to verify the information of a notified provider who does not respond in thirty (30) business days. If KHS cannot verify a provider's information, KHS will notify the provider of pending removal ten (10) business days prior to removal. the provider shall be removed from the provider directory at the next required update after the ten (10) business day notice period (excluding general acute care hospitals). A provider shall not be removed from the provider directory if response is received prior to the end of the 10 (ten) business day notice period.

KHS shall maintain a dedicated e-mail address and an electronic form to receive reports of potential directory inaccuracies and will generate an automated acknowledgment of receipt when submissions are received; additionally, reports of inaccuracies can be submitted via telephone, through KHS' member services department. The KHS website shall prominently display the dedicated e-mail address and member services phone number to report potential inaccuracies. Upon receipt of such report, KHS shall take no longer than five (5) business days to contact the affected provider and thirty (30) business days to verify the accuracy of the information. KHS will document the receipt, investigation, and outcome of each reported potential directory inaccuracy.

The documentation shall include the provider's name, location, and a description of the plan's investigation, the outcome of the investigation, and any changes or updates made to its provider directory. If changes to the provider directory are required as a result of KHS' investigation, the changes to the directory shall be made no later than the next scheduled update, or sooner if required by federal law or regulations.

KHS may delay reimbursement owed to a provider if the provider fails to respond to the KHS' attempts to verify the provider's information. KHS shall not delay payment unless it has attempted to verify the provider's information. KHS may seek to delay payment or reimbursement owed to a provider only after the ten (10) business day notice period outlined above in this section. For all delays in reimbursement initiated due to provider non-compliance with KHS provider data verification efforts as outlined above, KHS shall handle in line with Health and Safety Code 1367.27 (p).

Upon delay of payment or reimbursement under this policy, KHS shall document each instance a payment or reimbursement was delayed and report this information to the California Department of Managed Healthcare (DMHC). This information shall be submitted along with the policies and procedures required to be submitted annually to the department pursuant to section B. Approval.

1. DMHC Annual Provider Appointment Availability Survey

   On an annual basis, KHS will conduct an Annual Provider Appointment Availability Survey, as outlined in KHS Policy and Procedure 4.30-P Accessibility Standards. Upon completion of that year's survey, the Provider Network Management Department will investigate all providers found to be Ineligible as a result of the survey. Based on the results of the investigation, KHS will conduct provider education and/or update the Plan's provider database and directory as applicable. Investigation and database/directory updates will take place in line with the timeframes established above

F. ONLINE DIRECTORY

In addition to the printed directory, KHS will maintain a searchable online directory, accessible to the public without any restrictions or limitations, through the plan's internet website. The online directory will be updated on a weekly basis, capturing all applicable changes in provider information made during the prior week. The online directory will capture all practitioner specific information included in the printed directory, as outlined in section A. Development.

G. ACCESS TO CARE INFORMATION IN THE PROVIDER DIRECTORY

All provider directories published and maintained by KHS will include information regarding the standards for timely access to care (as outlined in KHS policy 4.30-P Accessibility Standards) in a section titled Timely Access to Care.

H. ASSESSMENT OF DIRECTORY ACCURACY

On an annual basis KHS will conduct an evaluation of its provider directory to monitor the accuracy of:

1. Office locations and phone numbers
2. Hospital affiliations
3. Accepting new patients' status
4. Awareness of office staff of provider's participation in the KHS network

KHS will develop and utilize a methodology and survey tool to collect information to appropriately assess provider directory accuracy. KHS will survey a statistically valid sample of individual provider directory listings.

Results of the survey will be reviewed by Provider Network Management (PNM) Management Team and be reported to the QI/UM report. The report will detail the methodology and survey tool utilized. The report will include a qualitative analysis examining the underlying reasons or causes driving the survey results. The report will identify potential opportunities to improve the accuracy of the information within the KHS provider directory and will outline an action plan to improve accuracy.

I. WEB-BASED DIRECTORY USABILITY ASSESSMENT

KHS will evaluate its web-based Provider Directory for usefulness and understanding to members and prospective members every three years. The assessment will evaluate the web-based provider directory's readability, intuitive content organization, ease of navigation, and availability in required threshold languages.

Every three years, prior to the start of the usability testing, the assessment tool will be reviewed by KHS' Member Engagement, Provider Network Management, and Cultural and Linguistic Departments. Appropriate KHS staff not involved in the development of the web-based physician directory will be designated to conduct usability test. Results of usability assessment will be shared with the Member Engagement, Marketing, Provider Network Management, and Cultural and Linguistic Departments and if needed, an action plan will be created based on any identified opportunities to improve the web-based provider directory usability.

J. TELEPHONE AVAILABILITY

Plan members can contact the Plan's Member Services Department to request a copy of the paper directory, or for assistance locating a provider on the Plan's online provider directory.

In addition to the printed and online provider directories, information from the Plan's Provider Directory will be made available over the phone via the Plan's Member Services Department. Members can contact the Plan's Member Services Department, and a Member Services Representative will assist in locating a provider and supplying the member with the provider's directory information.

K. REGULATORY SUBMISSIONS

On a bi-annual basis the Plan will submit a provider directory to its Managed Care Operations Division (MCOD) Contract manager for a bi-annual provider directory review. On a monthly basis, for months that fall outside of the bi-annual review submission, the Plan will submit a

monthly File and Use provider directory to its MCOD Contract manager. During each submission, the Plan will include an attestation that it is meeting Provider Directory Application Programming Interface (API) requirements as outlined in §8.0 Provider Directory API. The Plan will address any findings identified by the DHCS during provider directory reviews or annual medical audits within the DHCS specified timeframe.

L. PROVIDER DIRECTORY API

The Plan will maintain a Provider Directory Application Programming Interface (API) in line with KHS policy, 14.58-P, Interoperability and Patient Access. The Plan's Provider Directory API will include the following provider information:

1. Name of Provider or site, and any group affiliation
2. Name of medical group/foundation or independent physician association, if applicable
3. Type of practitioner
4. California License number and type of license if applicable
5. National Provider Identifier number
6. Street address(es)
7. Telephone number(s), including the telephone number to call after business hours.
8. Website URL for each service location or physician Provider, if applicable.
9. Specialty, as appropriate, including board certification or any other accreditation if available.
10. The provider's office email address, if available.
11. Whether the Provider is accepting new patients; and
12. Identification of Providers that are not available to all or new Members.

The Plan will update their Provider Directory API in accordance with 42 CFR section 438.10(h)(3) and Health and Safety Code section 1367.27.

M. DELEGATION

KHS shall ensure delegated entities comply with all provider directory requirements outlined in 42 CFR 438.10(h) and Health and Safety Code 1367.27. All applicable provider directory requirements shall be outlined in the Service Agreement entered into between the delegated entity and KHS.

V. ATTACHMENTS

Attachment A: Shipping and Packaging Specifications

VI. REFERENCES

Reference Type	Specific Reference
Other KHS Policies	12.01-I: Member Materials
Other KHS Policies	12.02-I: Translation of Written Member Materials
Other KHS Policies	12.14-I: Practitioner/Provider Listing

Other KHS Policies	2.71-P Facility Site Review and Medical Review
Regulatory	[2] MMCD Policy Letter 00-02
Regulatory	[3] DHS Contract A-16 (1)
Regulatory	[4] DHS Contract A-13 4(C)
Regulatory	[5] MMCD Policy Letter 00-02 (Provider Directory Changes)
Regulatory	[6] Required to be in NMP per W&I 14406(a)(3); Title 22 Section 53895 (a) and (b); and DHS Contract A-13 4(B); and MRMIB Contract A-II (F)(1) and (2).
Regulatory	[7] MRMIB Contract Exhibit A, II (F)(6)
Regulatory	[8] MMCD Policy Letter page 7

VII. REVISION HISTORY

Action	Date	Brief Description of Updates	Author
Update	2025-05	Regulatory Updates - Submitted version 2024-09 to regulators, granted File & Use by DHCS for Post OR R.0101 and R.0162 on 4/1/2025. Policy filed with the DMHC (efiling 20251478); closure letter received on 4/21/2025.	Compliance
Revised	2024-09	The policy was revised to align with NCQA Standards, and Federal & State requirements. Necessary to complete KHS Usability Study. Changes include additions of Section I. WEB-BASED DIRECTORY USABILITY ASSESSMENT, which outlines when and how usability testing will be conducted and Section J: TELEPHONE AVAILABILITY, which explains how members can obtain a printed directory or information on a specific provider.	Provider Network Management
Revised	2024-02	[1]Section I updated by PNM per DMHC Comment Letter received on 2/9/2024, DMHC approval received on 2/27/2024, Filing No 20232298 – policy version was resubmitted for OR (R.0101, D.0350 and R.0162, D.0370) on 8/14/2024. Policy received approval on 9/13/2024 for DHCS 2024 post OR R.0101 and R.0162.	Provider Network Management
Revised	2023-12	Section E (2) updated by PNM per DMHC Comment Letter received on 11/30/2023.	Provider Network Management
Revised	2023-10	Policy updated per DMHC Comment Letter received on 9/19/2023 regarding 1367.27	Provider Network

		Annual Compliance for 2023.	Management
Revised	2023-07	Policy updated to include reference to Interoperability policy**.**	Provider Network Management
Revised	2023-02	Policy revised in line with DHCS APL 22-026, DHCS approval received on 3/23/2023.	Provider Network Management
Revised	2021-07	Policy revised to comply with Health and Safety Code 1367.27. Policy was changed to a public facing policy "P" and is no longer an internal version "I." Policy was approved by DMHC on 8/27/2021 filing no. 20211899.	Provider Network Management
Revised	2019-06	Revised to identify functions performed by the vendor and functions retained by the KHS. Policy approved by DMHC 7/17/2019 efiling #20191171.	Provider Network Management
Revised	2018-11	Policy revised to comply with Health and Safety Code 1367.27(m)(2). Policy reviewed and approved by the Department of Managed Health Care (DMHC) eFiling Number 20181285 completed 10/18/2018.	Provider Network Management
Revised	2016-07	Revised to comply with Senate Bill 137 and H&S 1367.27. Reference to Healthy Families removed.	Provider Network Management
Revised	2008-12	Revised per DHCS Work Plan Deliverable 16.A, 06/24/08.	Provider Network Management
Created	2006-01	Created during DHS Workplan process. Language regarding provider directories was removed from #40.01 – Practitioner/Provider Listings and Directories and placed into this new policy.	Provider Network Management

VIII. APPROVALS

Committees | Board (if applicable)	**Date Reviewed**	**Date Approved**
Choose an item.		

Regulatory Agencies (if applicable)	**Date Reviewed**	**Date Approved**
Department of Health Care Services (DHCS)	DMHC efiling, 20251478	4/21/2025
Department of Health Care Services (DHCS)	For D.0370, Updated OR R.0162	4/1/2025
Department of Health Care Services (DHCS)	For D.0350, Updated OR R.0101	4/1/2025

Department of Health Care Services (DHCS)	For D.0370, Updated OR R.0162 8/14/2024	9/13/2024
Department of Health Care Services (DHCS)	For D.0350, Updated OR R.0101 8/14/2024	9/13/2024
Department of Managed Health Care (DMHC)	10/2023 for 1367.27 Annual Compliance for 2023	2/27/2024
Department of Health Care Services (DHCS)	2024 Operational Readiness, R.0162	6/7/2023
Department of Health Care Services (DHCS)	12/2023 for DHCS APL 22-026	3/23/2023
Department of Health Care Services (DHCS)	2024 Operational Readiness, R.0101	1/23/2023
Department of Managed Health Care (DMHC)	7/2021 for Health and Safety Code 1367.27	8/27/2021
Department of Managed Health Care (DMHC)	6/2019 efiling #20191171	7/17/2019
Department of Managed Health Care (DMHC)	Health and Safety Code 1367.27(m)(2).	10/18/2018

Chief Executive Leadership Approval *		
Title	**Signature**	**Date Approved**
Chief Executive Officer		
Chief Operating Officer		
Chief Compliance and Fraud Prevention Officer		
*Signatures are kept on file for reference but will not be on the published copy		

KERN HEALTH SYSTEMS

Policy and Procedure Review

KHS Policy & Procedure: 12.13-P Provider Directory

Last approved version: 12/6/2024

Reason for revision: The policy was revised to align with NCQA Standards, and Federal and State requirements.

Director Approval		
Title	**Signature**	**Date Approved**
Amisha Pannu Senior Director of Provider Network		
Nate Scott Senior Director of Member Services		
Louis Iturriria Senior Director of Marketing & Member Engagement		

Date posted to public drive: _____

Date posted to website ("P" policies only): _____

I. SHIPPING AND PACKAGING SPECIFICATIONS

1. Shipping and Packaging Specifications other than HCO requests.

   The Subcontractor will use the following specifications when packaging materials for shipment to a MAXIMUS designated site:

   a. Cartons are required for all material.
   b. All cartons within the shipment except the last carton must contain the same count.
   c. All cartons are to be labeled or marked with the content description, form number, county designated for use, quantity contained, and plan or client name.
      i. **If the request is for loose materials (other than provider directories), the individual units will be bundled in groups of no less than 100 ct.**
   d. All pallets within a shipment, except the last pallet, must contain the same number of cartons.
   e. All pallets are to be marked with their content(s), form number, and quantity contained on the pallet.
   f. A complete and succinct Bill of Lading must be provided that fully identifies the material contained within the shipment.
   g. Palletizing should consist of placing cartons four high on a standard size 48”x40” pallet (with four-way entry and conventional 2x4 lumber for the runners) and then wrapping the entire palletized load with plastic film.
   h. In the event shipments arrive at the MAXIMUS designated site with any of the following deficiencies, the shipment may be rejected and returned at Subcontractor's expense:
      1. Inadequate packaging, causing the product to be destroyed or severely damaged during the shipment process.
      2. Incorrect product delivered.
      3. Mixed product in the same carton.
      4. Mixed pallets of different product received.
      5. Deliveries made prior to MAXIMUS approval

2. Packaging and Palletizing

   a. All materials are always boxed.
   b. All products must be boxed before skidding.
   c. Individual box weight not to exceed 45 lbs.
   d. All pallets within a shipment must be identified by a “Pallet Flag”.
   e. A complete Bill of Lading will accompany each load.
   f. Only one item per pallet, no mixed loads.
   g. All pallets must include corner guards and stretch wrapped securely with a

pallet top on each load.

h. The loaded pallet height will not exceed 56" inclusive of the 4 ½ " of pallet platform height and top.
i. Total weight of loaded pallets not to exceed 1500 lbs.
j. The pallet size must be 48" x 40" with four (4) way stringer design and forklift opening side. Pallet must be durable enough to withstand multiple handling sessions.
k. All pallets must be in good condition for shipping.
l. This will apply to any new materials printed in the future.

3. Quantities delivered may vary by plus or minus five percent (5%) of amount specified on the Purchase Order.

II. SHIPPING

1. Deliveries

ALL JOBS WILL BE DELIVERED TO:
MAXIMUS Warehouse
879 F. Street, Ste. 140
West Sacramento, CA 95605
Receiving Hours: 8:30 am to 4:45 pm
No deliveries will be taken during lunch from 12-1pm
Don Niven, Warehouse Manager 916-669-4820