



Policy and Procedure No: PR 13.10	Revision No: 10
Division: Care Management	
Department: Provider Relations	
Title: PHC-CA Provider Data Accuracy	
Effective Date: 7/1/2019	
Supersedes Policy No: PR 13.0, PR 13.1, PR 13.2, PR 13.3, PR 13.4, PR 13.5, PR 13.6, PR 13.7, PR 13.8, PR 13.9	
Reviewed/Revised by: Sandy Johansson	Review/Revision Date: 10/16/2025
Approving Committee: Member Provider Committee	Date: 12/15/2025
Executive Oversight Committee Date: 12/16/2025	

Purpose:

To describe PHC California’s (the Health Plan) compliance with California Health and Safety Code section 1367.27. This policy outlines the Health Plan’s review and monitoring processes ensuring the accuracy of the Health Plan’s provider directory data (both online and printed directory data) and the steps it takes when data errors are reported or discovered.

Policy:

1. The Health Plan produces and makes available an accurate provider directory in print and on its website. The Health Plan ensures the accuracy of information including, but not limited to:
 - a. The provider's name, practice location or locations, and contact information.
 - b. Type of practitioner
 - c. National Provider Identifier number
 - d. California license number and type of license
 - e. Provider name, address, phone number, office days and hours open for business
 - f. The provider's office email address, if available.
 - g. The area of specialty (taxonomy), including board certification, if any.
 - h. Population served
 - i. Subnetwork, if applicable
 - j. Provider group, if applicable
 - k. A listing for each of the following providers that are under contract with the Health Plan:
 - i. For physicians and surgeons, the provider group, and admitting privileges, if any, at hospitals contracted with the plan.
 - ii. Nurse practitioners, physician assistants, psychologists, acupuncturists, optometrists, podiatrists, chiropractors, licensed clinical social workers, marriage

and family therapists, professional clinical counselors, qualified autism service providers, as defined in [Section 1374.73](#), nurse midwives, and dentists.

- iii. For federally qualified health centers or primary care clinics, the name of the federally qualified health center or clinic.
 - iv. For any provider described in subparagraph (A) or (B) who is employed by a federally qualified health center or primary care clinic, and to the extent their services may be accessed and are covered through the contract with the Health Plan, the name of the provider, and the name of the federally qualified health center or clinic.
 - v. Facilities, including, but not limited to, general acute care hospitals, skilled nursing facilities, urgent care clinics, ambulatory surgery centers, inpatient hospice, residential care facilities, and inpatient rehabilitation facilities.
 - vi. Pharmacies, clinical laboratories, imaging centers, and other facilities providing contracted health care services.
- I. The provider directory or directories may note that authorization or referral may be required to access some providers.
 - m. Non-English language, if any, spoken by a health care provider or other medical professional as well as non-English language spoken by a qualified medical interpreter, in accordance with [Section 1367.04](#), if any, on the provider's staff.
 - n. Identification of providers who no longer accept new patients for some or all of the Health Plan's products.
 - o. The network tier to which the provider is assigned, if the provider is not in the lowest tier, as applicable. Nothing in this section shall be construed to require the use of network tiers other than contract and noncontracting tiers.
 - p. All other information necessary to conduct a search pursuant to paragraph (2) of subdivision (c).
2. The Health Plan provider directory includes the following for understandability and usefulness to existing and prospective Plan membership:
 - a. Content is easily understood at a sixth grade reading level.
 - b. Content is intuitive and well organized.
 - c. Content is easy to understand and navigate.
 - d. Directories are available in additional languages as deemed appropriate for Plan membership.
 3. The Health Plan designates a toll-free phone number and establishes a dedicated email address and online website form to receive reports of potential provider directory errors.

4. Whenever the Health Plan receives a report indicating that information listed in its provider directory or directories is inaccurate, the Health Plan must promptly investigate the reported inaccuracy and, no later than thirty (30) business days following receipt of the report, either verify the accuracy of the information or update the information in its provider directory or directories, as applicable. When investigating a report regarding its provider directory or directories, the Health Plan must, at a minimum, do the following:
 - a. Contact the affected provider no later than five (5) business days following receipt of the report.
 - b. Document the receipt and outcome of each report. The documentation must 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 or directories.
 - i. The Health Plan enters reports of potential directory inaccuracies received from enrollees into its grievance system.
 - c. If changes to the Health Plan's provider directory or directories are required as a result of the investigation, the changes to the online provider directory or directories must be made no later than the next scheduled weekly update, or the update immediately following that update, or sooner if required by federal law or regulations. For printed provider directories, the change shall be made no later than the next required update, or sooner if required by federal law or regulations.
 - d. See Provider Relations Policy and Procedure MC IT 8, PHC-CA Provider Directory Updates.
5. The Health Plan notifies the Department of Managed Healthcare (DMHC) via amendment filing and file a statement with the commissioner in instances where there has been a change in the Health Plan's network of ten percent (10%) or greater in accordance with California Health and Safety Code section 1367.27(r).
 - a. The Plan's Director of Provider Relations reviews percentage changes in the Plan's Medi-Cal network on a quarterly basis and in conjunction with the Plan's quarterly Geo Access review processes. Percentage calculation processes include calculating the total Medi-Cal network from the prior quarter against the current quarters Medi-Cal network total to substantiate percentage changes in the Plan's Medi-Cal network. This calculation process includes in-network providers identified as accepting new patient appointments only.
6. On an annual basis, the Health Plan shall ensure provider directory policies and procedures are submitted to DMHC pursuant to California Health and Safety Code 1367.27. The policies shall demonstrate how Provider directories are published and maintained by the Plan and include information regarding the standards for timely access to care, entitled "Timely Access to Care." The Health Plan policies must also demonstrate the process for updating the provider directory based on errors in the provider information identified while administering PAAS (See PHC-CA DMHC Timely Access to Care, Section B (2)).

- a. The Department provides the Provider Directory Checklist – Annual Filing as a reference tool for health care service plans when completing requirement annual filings. The Checklist is also available on the Department’s eFiling web portal.

7. Biannual Provider Directory Verification

- a. A plan shall take appropriate steps to ensure the accuracy of the information concerning each provider listed in the plan's provider directory or directories in accordance with this section, and shall, at least annually, review and update the entire provider directory or directories for each product offered. Each calendar year the plan shall notify all contracted providers as follows:
 - i. For individual providers who are not affiliated with a provider group and providers, the plan shall notify each provider at least once every six (6) months.
 - ii. The plan shall notify its contracted providers to ensure that all of the providers are contacted by the plan at least once annually.
 - iii. The notification shall include all of the following:
 - 1. The information the plan has in its directory or directories regarding the provider or provider group, including a list of networks and plan products that include the contracted provider or provider group.
 - 2. A statement that the failure to respond to the notification may result in a delay of payment or reimbursement of a claim pursuant.
 - 3. Instructions on how the provider or provider group can update the information in the provider directory or directories using the online interface developed.
 - iv. The plan shall require an affirmative response from the provider or provider group acknowledging that the notification was received. The provider or provider group shall confirm that the information in the provider directory or directories is current and accurate or update the information required to be in the directory or directories pursuant to this section, including whether or not the provider or provider group is accepting new patients for each plan product.
 - v. If the plan does not receive an affirmative response and confirmation from the provider that the information is current and accurate or, as an alternative, updates any information required to be in the directory or directories pursuant to this section, within thirty (30) business days, the plan shall take no more than fifteen (15) business days to verify whether the provider's information is correct or requires updates. The plan shall document the receipt and outcome of each attempt to verify the information. If the plan is unable to verify whether the provider's information is correct or requires updates, the plan shall notify the provider ten (10) business days in advance of removal that the provider will be removed from the provider directory or directories. The provider shall be removed from the provider directory or directories at the next required update of the provider directory or directories after the ten (10) business-day notice period. A

provider shall not be removed from the provider directory or directories if he or she responds before the end of the ten (10) business-day notice period.

Procedure:

1. The Director of Member Services or designee is responsible for receiving and documenting reports of provider directory errors through the Member Services call center, by email (published in the printed directory and offered through the Health Plan's website), or online form submission through the Plan's website. He or she enters enrollee and prospective enrollee reports of inaccurate provider information into the Member Services' call center records system.
2. The Director of Member Services or designee escalates reports of inaccurate provider data to the Director of Contracting and Provider Relations or designee. The Director of Contracting and Provider Relations or his or her designee documents the reported error and investigates the data error. Should the investigation reveal an error, he or she documents the corrected information and passes the correction or, in the case if a provider is no longer practicing, deletion instructions to the Director of Data Management who updates the provider record accordingly.
3. The Director of Data Management or designee is responsible to ensure that the updated provider data appears in the subsequent provider data export for the printed directory and data query for the online provider directory.
4. As described in PHC California Policy and Procedure IT 3.0 Provider Data Submissions for Managed Care, the Associate Director of Electronic Data Interchange (EDI) and Data Analytics or designee sends provider data to Lexis Nexis for validation of demographics, licensing, and sanction status, contact information, and practice locations on the first business day of each month.
5. The Marketing and Communications Materials Coordinator, under the direction of the Health Equity Officer and Director of Health Education, creates the provider directory using a DHCS-approved template document. He or she collaborates with the Information Technology (IT) and Data Management departments to pull the current provider report to populate the directory. The Director of Data Management ensures the Marketing and Communications Materials Coordinator receives a complete and current provider report.
6. The Marketing and Communications Materials Coordinator submits the directory to the Plan Administrator for review and approval prior to publishing it in print or posting it to the Health Plan's website.
7. The Health Plan Administrator is responsible for posting the required information regarding reporting directory errors on the Health Plan's website. He or she is responsible to ensure that the appropriate language regarding reporting provider and pharmacy directory errors appears in the footer of each page of the directory.
8. On an annual basis, the National Director of Contracting and Provider relations will file all necessary Provider Directory documents with DMHC via the eFiling web Portal.
9. On a biannual basis, the Health Plan will send a Provider notice in accordance with Health and Safety Code section 1367. 27(l) to validate Provider information to maintain its directory of PHC California providers.

a. The Health Plan's Project Manager or designee shall send a provider notice to all contracted providers requesting Providers to validate their data. The validations include the following:

i. Provider Notice:

1. Instructions to review and submit provider changes within thirty (30) business days.
2. Instructions on how the plan provider can update the information listed in the provider directory online.

ii. Attestation:

1. Receipt of network validation.
2. Confirm that the information in the provider directory or directories is current and accurate; or
3. Update the information required to be in the directory or directories

iii. Plan Provider Attestation Requirement:

1. The Health Plan requires an attestation from plan providers. If an attestation or an update is not received from the plan provider within thirty (30) business days, the Health Plan will:
 - a. Verify whether the information is correct or requires updates within fifteen (15) business days.
 - b. Document the receipt and outcome of each attempt to verify the information.
 - c. If unable to verify or update the information, the Health Plan will provide notification informing the provider that in ten (10) business days the provider will be removed from the provider directory.

iv. Removing a Health Plan Provider:

1. If no response to the provider notice(s) is received, after the required ten (10) business day notice period, the Health Plan provider shall:
 - a. Be removed from the provider directory by the next required update or
 - b. If the provider responds within the ten (10) business day notice period, the Health Plan provider will not be removed.

Definitions:

None.

Monitoring:

This policy is updated, as necessary, reviewed and approved annually by the Member Provider Committee (MPC).

The Compliance Department monitors the biannual Provider Directory data validation via Report Manager to ensure compliance with Health and Safety Code, Section 1367.27(l).

Reference(s):

1. Health and Safety Code, Section 1367.27.
2. Annual SB 1367.27 Provider Directory Bulletin, Practice Information Attestation Form
3. Managed Care Information Technology Policy and Procedure PHC-CA Interoperability and Patient Access Final Rule
4. Department of Managed Health Care (DMHC) All Plan Letter (APL) 23-015 (OPL), Supplemental Provider Directory Annual Filing Requirements, dated May 16, 2023.
5. Department of Managed Health Care (DMHC) All Plan letter (APL) 23-007 (OPL), Provider Directory Annual Filing Requirements, dated March 23, 2023.
6. [Department of Health Care Services \(DHCS\) All Plan Letter \(APL\) 22-026, Interoperability and Patient Access Final Rule, dated November 29, 2022.](#)
7. Managed Care Information Technology Policy and Procedure, PHC-CA Provider Data Submissions for Managed Care.
8. Provider Relations Policy and Procedure, PHC-CA DMHC Timely Access to Care.
9. Provider Relations Policy and Procedure MC IT 8, PHC-CA Provider Directory Updates.
10. DHCS OR Contract #22-20597, Exhibit A, Attachment III, Section 5.1.3. Member Information H.5
11. DHCS APL 25-006, Timely Access Requirements, published April 25, 2025

Regulatory Agency Approval(s):

<u>Date</u>	<u>Version</u>	<u>Regulatory Agency</u>	<u>Purpose</u>	<u>Response</u>
TBD	13.8	Department of Managed Health Care (DMHC)	DMHC Corrective Action Plan	TBD
8/15/2025	13.9	Department of Health Care Services (DHCS)	APL 25-006	Approved
	13.10	DMHC	Filing No. 20252156 (Provider Directory Annual Filing Requirements)	Pending

