KERN HEALTH SYSTEMS

QUALITY IMPROVEMENT-UTILIZATION MANAGEMENT (QI-UM) COMMITTEE MEETING

Thursday, November 30, 2023
at
7:00 a.m.

2900 Buck Owens Blvd.
Bakersfield, CA 93308
4th Floor Kern River Room

For more information, call (661) 664-5000

AGENDA

Quality Improvement (QI) / Utilization Management (UM) Committee Meeting

Kern Health Systems
2900 Buck Owens Boulevard
Bakersfield, California 93308
1ST Floor Board Room

Thursday, November 30, 2023

7:00 A.M.

All agenda item supporting documentation is available for public review at Kern Health Systems in the Administration Department, 2900 Buck Owens Blvd, Bakersfield, CA 93308 during regular business hours, 8:00 a.m.–5:00 p.m., Monday through Friday, following the posting of the agenda. Any supporting documentation that relates to an agenda item for an open session of any regular meeting that is distributed after the agenda is posted and prior to the meeting will also be available for review at the same location.

COMMITTEE MEMBERS: Jennifer Ansolabehere, PHN; Satya Arya, MD; Debra Cox; Danielle C Colayco, PharmD; Todd Jeffries; Allen Kennedy; Michael Komin, MD; Philipp Melendez, MD; Chan Park, MD; Martha Tasinga, MD, CMO

CONSENT AGENDA/OPPORTUNITY FOR PUBLIC COMMENT: ALL ITEMS LISTED WITH A "CA" ARE CONSIDERED TO BE ROUTINE AND NON-CONTROVERSIAL BY KERN HEALTH SYSTEMS STAFF. THE "CA" REPRESENTS THE CONSENT AGENDA. CONSENT ITEMS WILL BE CONSIDERED FIRST AND MAY BE APPROVED BY ONE MOTION IF NO COMMITTEE MEMBER OR AUDIENCE WISHES TO COMMENT OR ASK QUESTIONS. IF COMMENT OR DISCUSSION IS DESIRED BY ANYONE, THE ITEM WILL BE REMOVED FROM THE CONSENT AGENDA AND WILL BE CONSIDERED IN LISTED SEQUENCE WITH AN OPPORTUNITY FOR ANY MEMBER OF THE PUBLIC TO ADDRESS THE COMMITTEE MEMBERS CONCERNING THE ITEM BEFORE ACTION IS TAKEN.

STAFF RECOMMENDATION SHOWN IN CAPS

PUBLIC PRESENTATIONS

1) This portion of the meeting is reserved for persons to address the Committee Members on any matter not on this agenda but under the jurisdiction of the Committee Members. Committee Members may respond briefly to statements made or questions posed. They may ask a question for clarification, make a referral to staff for factual information or request staff to report back to the Committee Members at a later meeting. Also, the Committee Members may take action to direct the staff to place a matter of business on a future agenda.
SPEAKERS ARE LIMITED TO TWO MINUTES. PLEASE STATE AND SPELL YOUR NAME BEFORE MAKING YOUR PRESENTATION. THANK YOU!

COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

2) On their own initiative, Committee Members may make an announcement or a report on their own activities. They may ask a question for clarification, make a referral to staff or take action to have staff place a matter of business on a future agenda (Gov. Code Sec. 54954.2[a])

CA-3) QI-UM Committee Q3 2023 Summary of Proceedings– APPROVE

CA-4) Physician Advisory Committee (PAC) Q3 2023 Summary of Proceedings – APPROVE

CA-5) Public Policy – Community Advisory Committee (PP-CAC) Q3 2023 Summary of Proceedings – APPROVE

CA-6) Drug Utilization Review (DUR) Committee Q3 2023 Summary of Proceedings - APPROVE

CA-7) Pharmacy TAR Log Statistics Q3 2023 – RECEIVE AND FILE

CA-8) Kaiser Reports **(PROPRIETARY AND CONFIDENTIAL)**

- KFHC APL Grievance Report Q3 2023 – RECEIVE AND FILE
- KFHC Volumes Report for Q3 2023 – RECEIVE AND FILE
- Kaiser Reports will be available upon request.

9) Credentialing Statistics Q3 2023 – APPROVE

10) Board Approved New & Existing Contracts Report – APPROVE

11) Credentialing & Recredentialing Summary Report – APPROVE

12) Network Review Q3 2023 – APPROVE

13) Enhanced Case Management Program Report Q3 2023 – APPROVE

14) Health Education Activity Report Q3 2023 – APPROVE

15) Grievance Operational Board Update Q3 2023 – APPROVE

16) Grievance Summary Reports Q3 2023 – APPROVE

17) Quality Improvement Program Reporting Q3 2023 – APPROVE

18) Utilization Management Program Reporting Q2 2023 – APPROVE

19) Population Health Management (PHM) Reporting Q3 2023 - APPROVE

ADJOURN MEETING TO THURSDAY, MARCH 21, 2024 @ 7:00 A.M.

AMERICANS WITH DISABILITIES ACT
(Government Code Section 54953.2)

The meeting facilities at Kern Health Systems are accessible to persons with disabilities. Disabled individuals who need special assistance to attend or participate in a meeting of the Board of Directors may request assistance at the Kern Health Systems office, 2900 Buck Owens Blvd. Bakersfield, California or by calling (661) 664-5000. Every effort will be made to reasonably accommodate individuals with disabilities by making meeting material available in alternative formats. Requests for assistance should be made five (5) working days in advance of a meeting whenever possible.

SUMMARY

QUALITY IMPROVEMENT (QI) / UTILIZATION MANAGEMENT (UM) COMMITTEE

KERN HEALTH SYSTEMS
2900 Buck Owens Blvd.
Bakersfield, California 93308

Thursday, September 21, 2023

COMMITTEE RECONVENED

Members: Ansolabehere, Arya, Cox, Colayco, Jeffries, Kennedy, Komin, Melendez, Park, Tasinga (Miller alternate)
ROLL CALL: 6 Present; 4 Absent – Ansolabehere, Cox, Jeffries, Park

MEETING CALLED TO ORDER AT 7:08 A.M. BY DR. TASINGA, MD, KHS CHIEF MEDICAL OFFICER

NOTE: The vote is displayed in bold below each item. For example, Ansolabehere-Arya denotes Member Ansolabehere made the motion and Member Arya seconded the motion.

CONSENT AGENDA/OPPORTUNITY FOR PUBLIC COMMENT: ALL ITEMS LISTED WITH A "CA" WERE CONSIDERED TO BE ROUTINE AND APPROVED BY ONE MOTION.

COMMITTEE ACTION SHOWN IN CAPS

PUBLIC PRESENTATIONS

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COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

2) On their own initiative, Committee Members may make an announcement or a report on their own activities. They may ask a question for clarification, make a referral to staff or take action to have staff place a matter of business on a future agenda (Gov. Code Sec. 54954.2[a]) **NO ONE HEARD.**

CA-3) QI-UM Committee Q2 2023 Summary of Proceedings – APPROVED
Arya-Melendez: 6 Ayes; 4 Absent – Ansolabehere, Cox, Jeffries, Park

CA-4) Physician Advisory Committee (PAC) Q2 2023 Summary of Proceedings – APPROVED
Arya-Melendez: 6 Ayes; 4 Absent – Ansolabehere, Cox, Jeffries, Park

CA-5) Public Policy – Community Advisory Committee (PP-CAC) Q2 2023 Summary of Proceedings – APPROVED
Arya-Melendez: 6 Ayes; 4 Absent – Ansolabehere, Cox, Jeffries, Park

CA-6) Drug Utilization Review (DUR) Committee Q2 2023 Summary of Proceedings – APPROVED
Arya-Melendez: 6 Ayes; 4 Absent – Ansolabehere, Cox, Jeffries, Park

CA-7) Pharmacy TAR Log Statistics Q2 2022 – RECEIVED AND FILED
Arya-Melendez: 6 Ayes; 4 Absent – Ansolabehere, Cox, Jeffries, Park

8) Quality Improvement Program Reporting Q2 2023 – APPROVED
Arya-Melendez: 6 Ayes; 4 Absent – Ansolabehere, Cox, Jeffries, Park

- QI Reporting for Q2
- Policy 20.50-I Medi-cal Managed Care Quality and Performance Improvement Program Requirements

KAILEY COLLIER, QUALITY IMPROVEMENT MANAGER, PRESENTED THE QUALITY IMPROVEMENT DEPARTMENT REPORT FOR 2ND QUARTER 2023. KAILEY PRESENTED A SUMMARY OF KEY ACTIVITIES AND OUTCOMES AS FOLLOWS:

- GRIEVANCE AND QUALITY-OF-CARE (QOC) CLASSIFICATIONS: THE CURRENT RATE OF GRIEVANCES PER 1K MEMBERS IS 7.90 AND THE RATE OF GRIEVANCES CLASSIFIED AS QOC IS 1.50 PER 1K MEMBERS. THERE WAS A SLIGHT DECREASE IN BOTH THE RATE OF GRIEVANCES AND THOSE CLASSIFIED AS QOC FROM Q1 TO Q2 OF 2023. NO SIGNIFICANT TRENDS IDENTIFIED.

- POTENTIAL QUALITY OF CARE (PQI) NOTIFICATIONS: THE RATE OF PQIS IDENTIFIED AS LEVEL 1, POTENTIAL HARM TO THE MEMBER, HAS

INCREASED SINCE THE BEGINNING OF THIS YEAR. THIS IS MOST LIKELY DUE TO 2 FACTORS:

ADDITION OF CLINICAL REVIEW FOR QOC ISSUES FOR GRIEVANCES RESULTING IN MORE PQI REFERRALS

A CHANGE IN THE GRIEVANCE QOC SCREENING PROCESS REDUCING THE VOLUME OF LEVEL 0, NO QOC ISSUE, AS REFERRAL TO THE PQI PROCESS.

IN SUMMARY, THERE WERE NO SIGNIFICANT TRENDS HAVE BEEN IDENTIFIED AT THIS TIME OUTSIDE OF THE ABOVE NOTED AREAS.

- FACILITY SITE REVIEWS (FSR) AND MEDICAL RECORD REVIEW (MRR): THE VOLUME OF SITE AND MEDICAL RECORD REVIEWS FOR THE 2ND QUARTER IS INCREASING COMPARED TO PREVIOUS QUARTERS DUE TO COMPLETION OF THE BACKLOG THAT HAD EVOLVED FROM THE PANDEMIC. REGARDING THE INITIAL HEALTH APPOINTMENTS: DURING THE 2ND QUARTER, A TOTAL OF 40 MEDICAL RECORDS WERE REVIEWED FOR INCLUSION OF AN INITIAL HEALTH APPOINTMENT. 10 OF 11 (91%) PEDIATRIC FILES WERE COMPLIANT AND ALL 29 (100%) ADULT FILES WERE COMPLIANT. EDUCATION WAS PROVIDED TO THOSE PROVIDERS WITH NON-COMPLIANT FILES. ADDITIONALLY, THE INITIAL HEALTH ASSESSMENT CHANGED TO AN INITIAL HEALTH APPOINTMENT EFFECTIVE JANUARY 1, 2023. THE PRIMARY CHANGE REMOVES THE SPECIFIC REQUIREMENT FOR COMPLETION OF THE STAYING HEALTHY ASSESSMENT TO MORE GENERAL SCREENING AND ASSESSMENT AREAS THAT MUST BE INCLUDED WITH FOLLOW UP OF AREAS THAT NEED TO BE ADDRESSED.

- QUALITY IMPROVEMENT PROJECTS: PERFORMANCE IMPROVEMENT PROJECTS ARE FOCUSING ON HEALTH EQUITY, SPECIFIC TO W30 MEASURE, 0-15 MONTHS AFRICAN AMERICAN POPULATION. ALSO, MCAS IMPROVEMENTS IN OUR PERFORMANCE IS CONTINUING WITH COLLABORATION WITH ECM TEAM AND DISCUSSING MCAS RESULTS AND SOLUTIONS WITH OUR ECM SITES ON SOLUTIONS TO IMPROVE MEASURES.

- GRIEVANCES AND QUALITY-OF-CARE (QOC) CLASSIFICATIONS: FOR Q2 2023, WE CLOSED A TOTAL OF 2943 GRIEVANCES OF WHICH 560 (19.03%) WERE CLASSIFIED AS QUALITY-OF-CARE (QOC) GRIEVANCES. THERE WAS NO SIGNIFICANT CHANGE IDENTIFIED IN VOLUME COMPARED TO PREVIOUS QUARTER AND WILL CONTINUE TO MONITOR FOR ANY TRENDS.

- POTENTIAL QUALITY ISSUE (PQI) NOTIFICATIONS: COMPARED TO PREVIOUS QUARTER THE NOTIFICATIONS DECREASED BY ABOUT 25%. THE PQI VOLUME HAS BEEN INCONSISTENT QUARTER OVER PREVIOUS QUARTER AND THERE WERE NO ISSUES IDENTIFIED AND WILL CONTINUE TO MONITOR FOR ANY TRENDS. ADDITIONALLY, THE FIFTY 30-DAY READMISSION

REVIEWS CONDUCTED EACH QUARTER WERE COMPLETED TIMELY FOR THE Q2 2023. THERE WERE NO TRENDS IDENTIFIED OVER TIME. PQI TREND BY PROVIDER REVEALED THERE WAS ONE PROVIDER WITH LEVEL 3 IDENTIFIED. THIS PROVIDER HAD HIGHEST RATIO OF PQI/1000 VISIT, OF WHICH THE MAJORITY OF PQIS IDENTIFIED WERE CLOSED AS LEVEL 0S-NO QUALITY-OF CARE ISSUES, HOWEVER, THERE WERE NO TRENDS IDENTIFIED AND WILL CONTINUE TO MONITOR THE DATA.

9) Utilization Management Program Reporting Q2 2023 – APPROVED
Arya-Melendez: 6 Ayes; 4 Absent – Ansolabehere, Cox, Jeffries, Park

Policy 3.02-P Major Organ Transplant
Policy 3.10-P Alcohol and Substance Abuse Treatment
Policy 3.14-P Mental Health Services
Policy 3.22-P Referral and Authorization Process
Policy 3.23-P Appeals Regarding Authorizations
Policy 3.24-I Pregnancy Maternity Care
Policy 3.24-P Pregnancy Maternity Care
Policy 3.31-P Emergency Services
Policy 3.87-P Access and Availability of Services LTC Members
Policy 3.91-P Long Term Care Services Program
Policy 3.92-P LTC Leave of Absence
Policy 3.95-P LTC Bed Hold
Policy 3.96-P LTC Continuity of Care

MISTY DOMINGUEZ WENT OVER ALL OF THE ABOVE POLICIES WITH THE COMMITTEE. THESE POLICIES WERE ALL MODIFIED TO BE IN ALIGNMENT WITH THE DHCS 2024 CONTRACT.

CA-10) Kaiser Reports (PROPRIETARY AND CONFIDENTIAL)
Arya-Melendez: 6 Ayes; 4 Absent – Ansolabehere, Cox, Jeffries, Park

- KFHC APL Grievance Report Q2 2023 – RECEIVED AND FILED
- KFHC Volumes Report for Q2 2023 – RECEIVED AND FILED
- Kaiser Reports will be available upon Request.

11) Population Health Management (PHM) Reporting Q2 2023 – APPROVED
Arya-Melendez: 6 Ayes; 4 Absent – Ansolabehere, Cox, Jeffries, Park

DANIELLE COLAYCO ASKED IF THE TRAUMA INFORMED CARE TRAINING WOULD BE AVAILABLE TO PROVIDERS IN ADDITION TO KHS STAFF? MICHELLE ANSWERED THAT SHE WOULD FORWARD THE INFORMATION TO HER ONCE SHE VERIFIED IF IT WAS POSSIBLE TO INCLUDE PROVIDERS.

12) Grievance Operational Board Update Q2 2023 – APPROVED
Arya-Melendez: 6 Ayes; 4 Absent – Ansolabehere, Cox, Jeffries, Park

13) Grievance Summary Reports Q2 2023 – APPROVED
Arya-Melendez: 6 Ayes; 4 Absent – Ansolabehere, Cox, Jeffries, Park

14) Credentialing Statistics Q2 2023 – APPROVED
Arya-Melendez: 6 Ayes; 4 Absent – Ansolabehere, Cox, Jeffries, Park

YOLANDA HERRERA, KHS CREDENTIALING MANAGER, PRESENTED THE PROVIDER NETWORK MANAGEMENT CREDENTIALING STATISTICS FOR 2ND QUARTER 2023 HIGHLIGHTING THE FOLLOWING RESULTS:

- DURING THE MONITORING/REPORTING PERIOD APRIL 1, 2023 THROUGH JUNE 30, 2023 THERE WERE A TOTAL OF 133 INITIALLY CREDENTIALED PROVIDERS AND 193 RECREDENTIALED PROVIDERS.
- 18 NEW CONTRACT VENDORS WERE APPROVED IN THE FOLLOWING AREAS: ABA, PHARMACY, COMMUNITY SUPPORT SERVICES, DME, SPECIALIST, LABORATORY, SNF & TRANSPORTATION
- THE PHYSICIAN ADVISORY COMMITTEE APPROVED ALL CREDENTIALING AND RECREDENTIALING FILES AS PRESENTED WITH NO DENIED APPLICATIONS DURING THIS TIME PERIOD.

CA-15) Board Approved New & Existing Contracts Report – RECEIVED AND FILED
Melendez-Arya: 6 Ayes; 4 Absent – Ansolabehere, Cox, Jeffries, Park

CA-16) Credentialing & Recredentialing Summary Report – RECEIVED AND FILED
Melendez-Arya: 6 Ayes; 4 Absent – Ansolabehere, Cox, Jeffries, Park

CA-17) Network Review for Q2 2023 – RECEIVED AND FILED
Melendez-Arya: 6 Ayes; 4 Absent – Ansolabehere, Cox, Jeffries, Park

JAMES WINFREY, KHS PROVIDER NETWORK MANAGER, PRESENTED THE PROVIDER NETWORK – NETWORK REVIEW REPORT 2ND QUARTER 2023 HIGHLIGHTING THE FOLLOWING RESULTS:

- AFTER HOURS CALLS: DURING Q2 2023 131 PROVIDER OFFICES WERE CONTACTED. OF THOSE OFFICES, 130 WERE COMPLIANT WITH THE EMERGENCY ACCESS STANDARDS AND 130 WERE COMPLIANT WITH THE URGENT CARE ACCESS STANDARDS. OUTREACH AND EDUCATION CONDUCTED VIA LETTER HAVE BEEN SUCCESSFUL.

- PROVIDER ACCESSIBILITY MONITORING SURVEY: THE AVERAGE WAIT TIME FOR AN URGENT PRIMARY CARE APPOINTMENT WAS 22.2 HOURS. THE AVERAGE WAIT TIME FOR A NON-URGENT PRIMARY CARE

APPOINTMENT WAS 1.9 DAYS. BASED ON THESE RESULTS, THE PLAN WAS DETERMINED TO BE COMPLIANT IN BOTH THE URGENT AND NON-URGENT TIME STANDARDS FOR PRIMARY CARE APPOINTMENTS IN Q2 2023. THE AVERAGE WAIT TIME FOR AN URGENT SPECIALIST APPOINTMENT WAS 63.5 HOURS. THE AVERAGE WAIT TIME FOR A NONURGENT SPECIALIST APPOINTMENT WAS 9.6 DAYS. BASED ON THESE RESULTS, THE PLAN WAS DETERMINED TO BE COMPLIANT IN BOTH THE URGENT AND NON-URGENT TIME STANDARDS FOR SPECIALIST APPOINTMENTS IN Q2 2023; THE RESULTS OF THE SURVEY CONFIRMED THE PLAN AND ALL PROVIDERS WERE IN COMPLIANCE WITH THE HOURS OF OPERATION AND APPOINTMENT OFFERED STANDARD.

- ACCESS GRIEVANCE REVIEWS: THERE WERE EIGHTY (80) ACCESS-RELATED GRIEVANCES IN Q4 2022. IN THIRTY-SEVEN (37) OF THE CASES IN Q4 2022, NO ISSUES WERE IDENTIFIED AND WERE CLOSED IN FAVOR OF THE PLAN. THE REMAINING FORTY-THREE (43) CASES IN Q4 2022 WERE CLOSED IN FAVOR OF THE ENROLLEE; THE KHS GRIEVANCE DEPARTMENT SENT LETTERS TO THE PROVIDERS INVOLVED IN THESE CASES, NOTIFYING THEM OF THE OUTCOME. THE FORTY-THREE (43) GRIEVANCES IN Q4 2022 THAT WERE CLOSED IN FAVOR OF THE ENROLLEE WERE FORWARDED TO THE PLAN'S PROVIDER NETWORK MANAGEMENT DEPARTMENT. THE PLAN REVIEWS GRIEVANCES ACROSS A FOUR-QUARTER ROLLING REVIEW PERIOD. TRENDS THAT ARE IDENTIFIED ARE REVIEWED WITH THE PROVIDER RELATIONS MANAGER ON A CASE-BY-CASE BASIS TO DEVELOP A TARGET-BASED STRATEGY TO ADDRESS. DURING Q4 2022, THE PLAN DID NOT IDENTIFY ANY TRENDS.

- GEOGRAPHIC ACCESSIBILITY & NETWORK CERTIFICATION: THE PLAN COMPLETED THE ACCESSIBILITY ANALYSIS OF THE ANNUAL NETWORK CERTIFICATION REPORTING DURING Q1 2023. THE PLAN SUBMITTED 51 AAS REQUESTS WHICH WAS IN LINE WITH THE PRIOR ANNUAL NETWORK CERTIFICATION AAS REQUESTS (44). IN Q2 2023, THE DHCS COMPLETED ITS REVIEW OF THE PLAN'S AAS REQUESTS. THE DHCS DENIED 14 OF THE PLAN'S AAS REQUESTS AND RETURNED TO THE PLAN FOR REVISION. THE PLAN REVISED THE 14 AAS REQUESTS AND SUBMITTED THEM TO THE DHCS. AS OF Q2 2023, THE REVISED AAS REQUESTS WERE STILL BEING REVIEWED BY THE DHCS. FOR NETWORK ADEQUACY, KHS UTILIZED SPH ANALYTICS, AN NCQA CERTIFIED SURVEY VENDOR, TO CONDUCT THE SURVEY FOR 2022. SPH'S METHODOLOGY INVOLVED TWO WAVES OF MAIL AND INTERNET, WITH A THIRD WAVE OF PHONE FOLLOW UP TO ADMINISTER THE SURVEY. BASED ON THE RESULTS OF 2022 SURVEY, KHS CALCULATED A NETWORK-WIDE FTE PERCENTAGE OF 58.19% FOR PRIMARY CARE PROVIDERS AND 47.11% FOR PHYSICIANS.

18) Health Education Activity Report Q2 2023 – APPROVED
Arya-Melendez: 6 Ayes; 4 Absent – Ansolabehere, Cox, Jeffries, Park

ISABEL SILVA SHARED THAT KHS' HEALTH EDUCATION DEPARTMENT IS EXPANDING INTO A BROADER ROLE AS THE WELLNESS AND PREVENTION DEPARTMENT TO MORE CLOSELY ALIGN WITH THE WELLNESS AND PREVENTIVE CARE REQUIREMENTS TO KEEP MEMBERS HEALTHY UNDER CALAIM. HEALTH LITERACY, EVIDENCE-BASED PRACTICES, CULTURALLY SENSITIVE CARE, LINGUISTICALLY APPROPRIATE SERVICES AND

CONTINUOUS MONITORING AND EVALUATION WILL SERVE AS THE DEPARTMENT'S FOUNDATIONAL PRINCIPLES UNDER THE LEADERSHIP OF THE SENIOR DIRECTOR OF WELLNESS AND PREVENTION, ISABEL SILVA.

19) Enhanced Case Management Program Report Q2 2023 – APPROVED
Melendez-Kennedy: 6 Ayes; 4 Absent – Ansolabehere, Cox, Jeffries, Park

ECM WENT LIVE WITH THE FOLLOWING SITES ON 09/01:

- EA FAMILY SERVICES
- CSV - DELANO
- PREMIER - MCFARLAND

ECM IS GOING LIVE WITH THE FOLLOWING POFS AS OF JANUARY 2023:

BIRTH EQUITY POF: ADULT AND YOUTH WHO ARE PREGNANT OR POSTPARTUM (FOR A PERIOD OF 12 MONTHS) THAT ARE SUBJECT TO RACIAL AND ETHNIC DISPARITIES AS DEFINED BY CDPH (CALIFORNIA DEPARTMENT OF PUBLIC HEALTH) DATA ON MATERNAL MORBIDITY AND MORTALITY. CURRENTLY, CDPH HAS IDENTIFIED THE BLACK, AMERICAN INDIAN, ALASKA NATIVE, AND PACIFIC ISLANDER POPULATIONS BUT THIS IS SUBJECT TO CHANGE BASED OFF OF CDPH DATA.

JUSTICE-INVOLVED POF: KERN HEALTH SYSTEMS CURRENTLY ACCEPTS ADULTS/YOUTH TRANSITIONING OUT OF INCARCERATION INTO ECM. AS OF JANUARY 2024, UNDER THE 1115 DEMONSTRATION WAIVER, ALL CALIFORNIA CORRECTIONAL INSTITUTIONS CAN BEGIN PARTICIPATING IN PRE-RELEASE OR IN-REACH SERVICES FOR ALL INCARCERATED POPULATIONS WITHIN 90 DAYS OF RELEASE.

IPP BASELINE DATA FOR JANUARY - JUNE 2023 SUBMITTED TO THE DHCS AS OF 09/01/23. EFFORTS TO CONTINUALLY IMPROVE OUTLINED BY ECM

ECM TRANSITIONING 3 SITES FROM DISTRIBUTIVE MODEL TO FULL SITE BY 11/01/23. CASE MANAGEMENT GOALS, DATA EXCHANGE STRATEGY OUTLINED

QUARTER 2 CLINICAL AUDITS RESULTS NEAR COMPLETION AND WILL BE SHARED ACCORDINGLY.

MEETING ADJOURNED AT 8:46 A.M. TO THURSDAY, NOVEMBER 30, 2023 @ 7:00 A.M

SUMMARY

PHYSICIAN ADVISORY COMMITTEE MEETING

KERN HEALTH SYSTEMS
2900 Buck Owens Blvd.
Bakersfield, California 93308

Wednesday, August 2, 2023
7:00 A.M.

COMMITTEE RECONVENED

Members: Aggarwal, Amin, Gevorgyan, Hair, Lascano, Parmar, Patel, Tasinga
ROLL CALL: 4 Present; 4 Absent – Aggarwal, Gevorgyan, Hair, Patel

Meeting called to order at 7:12 A.M. by Dr. Tasinga, MD, CMO

NOTE: The vote is displayed in bold below each item. For example, Amin-Parmar denotes Member Amin made the motion and Member Parmar seconded the motion.

CONSENT AGENDA/OPPORTUNITY FOR PUBLIC COMMENT: ALL ITEMS LISTED WITH A "CA" WERE CONSIDERED TO BE ROUTINE AND APPROVED BY ONE MOTION.

COMMITTEE ACTION SHOWN IN CAPS

PUBLIC PRESENTATIONS

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SPEAKERS ARE LIMITED TO TWO MINUTES. PLEASE STATE AND SPELL YOUR NAME BEFORE MAKING YOUR PRESENTATION. THANK YOU!
NO ONE HEARD.

COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

2) On their own initiative, Committee members may make an announcement or a report on their own activities. They may ask a question for clarification, make a referral to staff or take action to have staff place a matter of business on a future agenda (Gov. Code Sec. 54954.2[a]) **NO ONE HEARD.**

ADJOURN TO CLOSED SESSION – **N/A**

CLOSED SESSION

3) Closed Session regarding peer review of a provider (Welfare and Institutions Code Section 14087.38(o)) –

DUE TO A LACK OF QUORUM, OF VOTING MEMBERS, THE INITIAL AND RECREDENTIALING REPORTS COULD NOT BE APPROVED.

THE CREDENTIAL FILES MEETING CLEAN FILE REVIEW FOR INITIAL APPLICATIONS AND RECREDENTIALING WERE APPROVED BY DR. TASINGA AND WILL BE FORWARDED TO THE NEXT BOARD OF DIRECTORS.

THE CREDENTIAL FILES REQUIRING COMPREHENSIVE REVIEW WERE PENDED UNTIL THE NEXT SCHEDULED MEETING IN ORDER FOR DISCUSSION AND VOTE.

COMMITTEE TO RECONVENE TO OPEN SESSION – **N/A**

CA-4) Minutes for KHS Physician Advisory Committee meeting on June 7, 2023 – APPROVE – **N/A**

DUE TO LACK OF QUORUM, THE NEXT MEETING WIL BE HELD WEDNESDAY, SEPTEMBER 6, 2023 @ 7:00 A.M

AMERICANS WITH DISABILITIES ACT
(Government Code Section 54953.2)

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SUMMARY

PHYSICIAN ADVISORY COMMITTEE MEETING

KERN HEALTH SYSTEMS
2900 Buck Owens Blvd.
Bakersfield, California 93308

Wednesday, September 6, 2023
7:00 A.M.

COMMITTEE RECONVENED

Members: Aggarwal, Amin, Gevorgyan, Hair, Lascano, Parmar, Patel, Tasinga
ROLL CALL: 6 Present; 2 Absent – Gevorgyan, Parmar

Meeting called to order at 7:04 A.M. by Dr. Tasinga, MD, CMO

NOTE: The vote is displayed in bold below each item. For example, Amin-Parmar denotes Member Amin made the motion and Member Parmar seconded the motion.

CONSENT AGENDA/OPPORTUNITY FOR PUBLIC COMMENT: ALL ITEMS LISTED WITH A "CA" WERE CONSIDERED TO BE ROUTINE AND APPROVED BY ONE MOTION.

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SPEAKERS ARE LIMITED TO TWO MINUTES. PLEASE STATE AND SPELL YOUR NAME BEFORE MAKING YOUR PRESENTATION. THANK YOU!
NO ONE HEARD

COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

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- YOLANDA HERRERA INTRODUCED YESENIA SANCHEZ, CREDENTIALING COORDINATOR, WHO IS RESPONSIBLE FOR THE PRIMARY SOURCE VERIFICATION PROCESS FOR ALL INITIAL APPLICATIONS AND WILL ATTEND PAC MEETINGS AS NEEDED TO FOR COVERAGE AND OTHER PRESENTATIONS FROM CREDENTIALING.

- COMMITTEE STRUCTURE/PAC MEETINGS 2024: DR. TASINGA INFORMED THE MEMBERS AND PRESENTED A REVISED COMMITTEE STRUCTURE FOR THE CLINICAL AND PEER REVIEW COMMITTEE FOR KHS. BEGINNING IN 2024, AFTER REVIEW WITH LEGAL COUNSEL, IT WAS DETERMINED THAT THE CLINICAL AND PEER REVIEW COMMITTEES, INCLUDED THE PHYSICIAN ADVISORY COMMITTEE, WERE NOT CONSIDERED LEGISLATIVE BODIES AND THEREFORE THE MEETINGS OF SUCH COMMITTEES ARE NOT SUBJECT TO THE BROWN ACT. KHS WILL CONTINUE CURRENT STRUCTURE UNDER BROWN ACT FOR THE REMAINDER OF 2023 REQUIRING “IN-PERSON” MEETINGS; HOWEVER, BEGINNING IN JANUARY 2024, MEETINGS WILL NO LONGER BE REQUIRED TO BE IN-PERSON AND BASED ON NCQA REQUIREMENTS THERE WILL BE AN OPTION TO ATTEND BOTH IN-PERSON AS WELL AS VIRTUAL/REMOTE. FURTHER, MINUTES WILL BE RECORDED, WITH APPROVAL OF THE ATTENDEES, FOR THE PURPOSES OF TRANSCRIBING THE PROCEEDINGS OF THE MEETING IN A MANNER ACCEPTABLE TO NCQA. THE KHS QI-HE COMMITTEE ORGANIZATIONAL CHART FOR 2024 WILL BE SENT TO THE PAC MEMBERS FOR REVIEW AND NOMINATIONS OF ANY PARTICIPATING PROVIDERS WHO MAY BE INTERESTED IN PARTICIPATING IN ONE OF THESE COMMITTEES.

ADJOURNED TO CLOSED SESSION @ 7:06 A.M.

CLOSED SESSION

3) Closed Session regarding peer review of a provider (Welfare and Institutions Code Section 14087.38(o)) – BY A VOTE OF 6-0, THE COMMITTEE APPROVED PROVIDERS RECOMMENDED FOR INITIAL CREDENTIALING AND RECREDENTIALING. (AMIN-HAIR)

CREDENTIALING REPORT
MENTAL HEALTH PRE-APPROVALS FROM 8/30/2023:
IN COMPLIANCE WITH SENATE BILL 2581, DR. TASINGA, KHS CMO, APPROVED THE MENTAL/BEHAVIORAL HEALTH PROVIDERS AS LISTED ON THE 9/6/2023

CREDENTIALING REPORT, ALL MEETING CLEAN FILE CRITERIA, IN COMPLIANCE WITH THE 60-DAY TURNAROUND REQUIREMENTS. PROVIDERS WERE ACCEPTED AS PRESENTED.

INITIAL CREDENTIALING
THERE WERE NO COMPREHENSIVE REVIEWS PRESENTED FOR REVIEW. INITIAL APPLICANTS MEETING CLEAN FILE REVIEW WERE ACCEPTED AS PRESENTED.

RECREDENTIALING
COMPREHENSIVE REVIEWS WERE CONDUCTED FOR RECREDENTIALING APPLICATIONS LISTED BELOW FOR REVIEW OF ADDITIONAL ADVERSE INFORMATION AND/OR INFORMATION RELATED TO MALPRACTICE CASE(S) THAT RESULTED IN SETTLEMENT OR JUDGMENT MADE ON BEHALF OF THE PRACTITIONER WITHIN THE PREVIOUS THREE YEARS:

MEMBER GRIEVANCES: ALL PROVIDERS WITH SIGNIFICANT MEMBER & QUALITY GRIEVANCES WERE REVIEWED WITH NO QUALITY OF SERVICE OR CARE ISSUES REPORTED AS SIGNIFICANT TRENDS OR CONCERN REQUIRING FURTHER REVIEW BY THIS COMMITTEE.

PRV009406 - REVIEWED CLINICAL PRIVILEGE RESTRICTION FORM ADVENTIST HEALTH TEHACHAPI FOR WHICH THE PROVIDER INDICATED VOLUNTARY RESIGNATION. IN ADDITION, PROVIDER EXPLANATION WAS REVIEWED REGARDING VOLUNTARY ACCEPTANCE OF A BEHAVIORAL/PROFESSIONAL CONDUCT AGREEMENT AT ANTELOPE VALLEY MEDICAL CENTER. PROVIDER HAS ACCEPTED THIS AGREEMENT AND IS IN COMPLIANCE. PROVIDER EXPLANATION REVIEWED AND RECOMMEND APPROVAL OF CONTINUED NETWORK PARTICIPATION WITH CONTINUED MONTHLY MONITORING AND FAILURE TO MAINTAIN REMAINING HOSPITAL PRIVILEGES MAY RESULT IN TERMINATION OF NETWORK PARTICIPATION WITH KHS.
DELEGATION OF CREDENTIALING ACTIVITIES

2023 - 1ST & 2ND QUARTER REPORTS: YOLANDA HERRERA REPORTED THE DELEGATION OF CREDENTIALING ACTIVITIES AS FOLLOWS:

•1ST QUARTER REPORTS FOR 2023 INDICATE STABLE NETWORKS FOR THE DELEGATED ENTITIES WITH NO SIGNIFICANT DECREASE IN PROVIDERS, ALSO, THERE WERE NO SIGNIFICANT CHANGES IN THEIR CREDENTIALING PROGRAM, POLICIES/PROCEDURES OR PROVIDER NETWORK WAS REPORTED.

•2ND QUARTER REPORTS FOR 2023 INDICATE STABLE NETWORKS FOR THE DELEGATED ENTITIES WITH NO SIGNIFICANT DECREASE IN PROVIDERS, ALSO, THERE WERE NO SIGNIFICANT CHANGES IN THEIR CREDENTIALING PROGRAM, POLICIES/PROCEDURES OR PROVIDER NETWORK WAS REPORTED.

COMMITTEE RECONVENED TO OPEN SESSION @ 7:16 A.M.

CA-4) Minutes for KHS Physician Advisory Committee meeting on June 7, 2023 – APPROVED
Hair-Patel: All Ayes

CA-5) Minutes for KHS Physician Advisory Committee meeting on August 2, 2023 – APPROVED
Hair-Patel: All Ayes

6) Review Policy 20.50-I Medi-Cal Managed Care Quality and Performance Improvement Program Requirements – **HELD UNTIL NEXT MEETING**

MEETING ADJOURNED AT 8:09 A.M. TO WEDNESDAY, OCTOBER 4, 2023 @ 7:00 A.M

AMERICANS WITH DISABILITIES ACT
(Government Code Section 54953.2)

The meeting facilities at Kern Health Systems are accessible to persons with disabilities. Disabled individuals who need special assistance to attend or participate in a meeting of the KHS Finance Committee may request assistance at the Kern Health Systems office, 9700 Stockdale Highway, Bakersfield, California or by calling (661) 664-5000. Every effort will be made to reasonably accommodate individuals with disabilities by making meeting material available in alternative formats. Requests for assistance should be made five (5) working days in advance of a meeting whenever possible.

SUMMARY

PUBLIC POLICY/COMMUNITY ADVISORY COMMITTEE

KERN HEALTH SYSTEMS
2900 Buck Owens Boulevard
Bakersfield, California 93308
1st Floor Board Room

Tuesday, September 26, 2023

COMMITTEE RECONVENED

Members: Janet Hefner, Jennifer Wood, Jasmine Ochoa, Mark McAlister, Cecilia Hernandez-Colin, Beatriz Basulto, Tammy Torres, Yadira Ramirez, Michelle Bravo, Alex Garcia, Quon Louey, Kaelsun Singh Tyiska, Rukiyah Polk

ROLL CALL: 10 Present; 3 Absent – Jasmine Ochoa, Michelle Bravo, Alex Garcia

Meeting called to order by Louie Iturriria, Senior Director of Marketing and Member Engagement, at 11:03 AM.

NOTE: The vote is displayed in bold below each item. For example, Hefner-Wood denotes Member Hefner made the motion and Member Wood seconds the motion.

CONSENT AGENDA/OPPORTUNITY FOR PUBLIC COMMENT: ALL ITEMS LISTED WITH A "CA" WERE CONSIDERED TO BE ROUTINE AND APPROVED BY ONE MOTION.

COMMITTEE ACTION SHOWN IN CAPS

PUBLIC PRESENTATIONS

1) This portion of the meeting is reserved for persons to address the Committee on any matter not on this agenda but under the jurisdiction of the Committee. Committee members may respond briefly to statements made or questions posed. They may ask a question for clarification; make a referral to staff for factual information or request staff to report back to the Committee at a later meeting. Also, the Committee may take action to direct the staff to place a matter of business on a future agenda.
   SPEAKERS ARE LIMITED TO TWO MINUTES. PLEASE STATE AND SPELL YOUR NAME BEFORE MAKING YOUR PRESENTATION. THANK YOU!
   NO ONE HEARD.

COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

2) On their own initiative, Committee members may make an announcement or a report on their own activities. They may ask a question for clarification, make a referral to staff or take action to have staff place a matter of business on a future agenda (Gov. Code Sec. 54954.2[a]) **NO ONE HEARD.**

CA-3) Minutes for Public Policy/Community Advisory Committee meeting on June 27, 2023 -
APPROVED
McAlister-Wood: 10 Ayes; 3 Absent – Ochoa, Bravo, Garcia

CA-4) Report on September 2023 Medi-Cal Membership Enrollment - RECEIVED AND FILED
McAlister-Wood: 10 Ayes; 3 Absent – Ochoa, Bravo, Garcia

CA-5) Report on Health Education for Q2 2023 -
RECEIVED AND FILED
McAlister-Wood: 10 Ayes; 3 Absent – Ochoa, Bravo, Garcia

CA-6) Report on Marketing Medi-Cal Redetermination -
RECEIVED AND FILED
McAlister-Wood: 10 Ayes; 3 Absent – Ochoa, Bravo, Garcia

7) Report on Member Services – Grievance Operational Report and Grievance Summary for Q2 2023 -
APPROVED
Hefner-Hernandez Colin: 10 Ayes; 3 Absent – Ochoa, Bravo, Garcia

MS. WOOD INQUIRED ABOUT PRESENTING MORE DATA IN THE FUTURE REGARDING PATIENT ACCESS GRIEVANCES, AS TO BETTER UNDERSTAND THE REASON FOR THE INCREASE.

IN RESPONSE TO THIS, AT THE NEXT MEETING, MS. CARRILLO WILL BE PROVIDING A BREAK DOWN OF OUR ACCESS GRIEVANCES FOR Q2 AND Q3 BY WALK-IN VISITS, VS. SCHEDULED APPOINTMENTS, AVAILABILITY ACCESS GRIEVANCES, AND SHE WILL ALSO INCLUDE TELEPHONE ACCESS GRIEVANCES.

MR. LOUEY INQUIRED ABOUT THE TRACKING OF POSITIVE COMMENTS FROM MEMBERS AND ALSO PROVIDERS. THIS WAS ALSO MENTIONED IN THE LAST MEETING FROM MR. LOUEY AND MR. SINGH-TYISKA.

IN RESPONSE TO THIS, MEMBER SERVICES WILL REPORT ON THE NUMBER OF COMPLIMENTS RECEIVED DURING THE 3RD QUARTER AT THE NEXT MEETING. WE ARE ABLE TO TRACK COMPLIMENTS THROUGH QNXT (OUR CORE INFORMATION SYSTEM). MR. SCOTT ALSO ADDED THAT WE WILL INCLUDE RESULTS FROM OUR QUESTIONAIRE AFTER CAL SURVEYS.

8) Health Equity – Community Advisory Committee 2024 Changes - APPROVED
Louey-Hernandez Colin: 10 Ayes; 3 Absent – Ochoa, Bravo, Garcia

MS. SLAYTON-WOOD INQUIRED ABOUT THE RATIONALE FOR INCLUDING LEA'S AS PART OF THE NEW CAC RESTRUCTURE.

IN RESPONSE TO THIS, MS. SILVA SHARED THAT DHCS EXPECTS MCPS TO EXECUTE MOU'S WITH LEA'S IN 2025 AND WILL RELEASE A DRAFT TEMPLATE IN 2024. DHCS' INTENTION BEHIND THESE MOU'S IS TO SUPPORT LOCAL ENGAGEMENT AND CARE COORDINATION BETWEEN MCP'S AND LEA'S AS PART OF A WHOLE CHILD MODEL OF CARE SINCE LEA'S HAVE A CAPTIVE AUDIENCE OF STUDENTS AND FAMILIES. THE STUDENT BEHAVIORAL HEALTH INCENTIVE PROGRAM (SBHIP) EFFORTS THAT ARE CURRENTLY BEING IMPLEMENTED IS DHCS' ATTEMPT TO INITIATE LOCAL PARTNERSHIPS BETWEEN MCP'S AND LEA'S TO INCREASE STUDENT ACCESS TO BEHAVIORAL HEALTH SERVICES.

MEETING ADJOURNED BY LOUIE ITURRIRIA, SENIOR DIRECTOR OF MARKETING AND MEMBER ENGAGEMENT, AT 11:57 AM TO DECEMBER 12, 2023, AT 11:00 AM

COMMITTEE: ***DRUG UTILIZATION REVIEW (DUR) COMMITTEE***
DATE OF MEETING: ***SEPTEMBER 25, 2023***
CALL TO ORDER: ***6:34 P.M. BY MARTHA TASINGA, MD - CHAIR***

Members Present On-Site:	Martha Tasinga, MD – KHS Chief Medical Officer Dilbaugh Gehlawat, MD – Network Provider Kimberly Hoffmann, Pharm D. – BOD Member	James "Patrick" Person, RPh – Network Provider Sarabjeet Singh, MD - Network Provider, Cardiology Vasanthi Srinivas, MD – Network Provider, OB/GYN	Abdolreza Saadabadi, MD – Network Provider, Psychiatrist Bruce Wearda, RPh – KHS Director of Pharmacy
Members Virtual Remote:	None		
Members Excused=E Absent=A	Alison Bell, Pharm.D – Network Provider - E Sam Ratnayake, MD – Network Provider – A Joseph Tran, MD – Network Provider – A		
Staff Present:	John Miller, MD, KHS Medical Director Sukhpreet Sidhu, MD, KHS Medical Director Christina Kelly, KHS Pharmacy Admin Support Spvr Amy Daniel, KHS Executive Health Svcs Coordinator Michelle Curioso, KHS Director of PHM		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Public Comments	Martha Tasinga, MD, Committee Chair, asked for public comment. None were present.	*N/A*	*N/A*
Committee Comments	Martha Tasinga, MD, Committee Chair, asked for committee member announcements or reports.	*N/A*	*N/A*
Quorum	Attendance / Roll Call	Committee quorum requirement met.	*N/A*
CLOSED SESSION	N/A	*N/A*	*N/A*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
OLD BUSINESS	There was no old business to present	N/A	*N/A*
NEW BUSINESS **CA-3** **CA-4** **CA-5**	**Approval of Minutes** The Committee's Chairperson, Martha Tasinga MD, presented the meeting minutes for approval. Report of Plan Utilization Metrics – RECEIVED AND FILED Educational Articles – RECEIVED AND FILED	☑ **ACTION**: Ms. Hoffmann moved to approve minutes of June 26, 2023, seconded by Dr. Srinivas.	*09/25/23*
6 **7**	**NCQA Update** Dr. Tasinga explained the NCQA impacts to the plan, and modifications that may be needed. Due to Medi-cal new 2024 contracts being restructured many of the changes reflect NCQA requirements. There will be 8 new committees and they will all report to the QIHEC, instead of the Board beginning January 1, 2024. **DUR Update** Bruce introduced Dr. Saadabadi, Psychiatrist, as a new committee member to represent Mental Health. Bruce shared with the committee that at the State Global DUR Meeting, KHS was identified as a leader in MCAS Mental Health Measures. Dr. Saadabadi stated that in Kern County we treat our Mental Health Members, unlike other countries who are failing to do this. He stated this is probably why the stats showed higher numbers for Kern County. Dr. Hoffmann stated that the MCAS measures also applied to Hospital Administrations and follow-up. She and Dr. Tasinga shared with the committee about Kern Family's engagement with street medicine and DHCS Behavioral Health meeting that was held in August.	☑ **ACTION**: N/A	*09/25/23*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
8	Dr. Hoffmann also asked questions about MCAS Measures that pertain to Pregnancy. Dr. Gehlawat asked if we knew how many homeless members have Mental Health issues. **<u>Executive Order N-01-19 Medi-Cal Rx Update</u>** Bruce shared with the committee that there are new COVID vaccines coming out, specific for 2023. Obtaining the vaccines, and reimbursements will be different than they were in the past. Those details were presented to the committee.		
NEXT MEETING	Next meeting will be held Monday, November 20, 2023 at 6:30 pm	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned 7:38 pm. ***Respectfully submitted: Amy Daniel, KHS Executive Health Services Coordinator***	**N/A**	*N/A*

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____

Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____

Date Name

Quarter/Year of Audit - 2023	Minimun of 5% of TAR's were selected for Audit											
Month Audited	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Total TAR's for the month	56	73	75	63	49	31	33	36	29	35		
Turn Around Time Compliant	50%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
Notice of Action Compliant	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		
APPROVED TAR'S												
Timeliness - Reviewed & Returned in 1 busines day	1/2	3/3	2/2	3/3	3/3	1/1	0	1/1	1/1	2/2		
Date Stamped	2/2	3/3	2/2	3/3	3/3	1/1	0	1/1	1/1	2/2		
Fax copy attached	2/2	3/3	2/2	3/3	3/3	1/1	0	1/1	1/1	2/2		
Decision marked	2/2	3/3	2/2	3/3	3/3	1/1	0	1/1	1/1	2/2		
DENIED TAR'S												
Timeliness - Reviewed & Returned in 1 business day	0	0	0	0	0	0	0	0	0	0		
Initally Denied - Signed by Medical Dir and/or Pharm	0	0	0	0	0	0	0	0	0	0		
Letter sent within time frame	0	0	0	0	0	0	0	0	0	0		
Date Stamped	0	0	0	0	0	0	0	0	0	0		
Fax copy attached	0	0	0	0	0	0	0	0	0	0		
Decision marked	0	0	0	0	0	0	0	0	0	0		
Correct form letter, per current policies used	0	0	0	0	0	0	0	0	0	0		
NOA Commentary Met	0	0	0	0	0	0	0	0	0	0		
MODIFIED TAR'S												
Timeliness - Reviewed & Returned in 1 business day	0	0	0	0	0	0	0	0	0	0		
Date Stamped	0	0	0	0	0	0	0	0	0	0		
Fax copy attached	0	0	0	0	0	0	0	0	0	0		
Decision marked	0	0	0	0	0	0	0	0	0	0		
Correct form letter, per current policies used	0	0	0	0	0	0	0	0	0	0		
NOA Commentary Met	0	0	0	0	0	0	0	0	0	0		
DUPLICATE TAR'S												
Timeliness - Reviewd & Returned in 1 business day	0	0	0	1/1	0	0	0	0	0	0		
Date Stamped	0	0	0	1/1	0	0	0	0	0	0		
Fax copy attached	0	0	0	1/1	0	0	0	0	0	0		
CANCELLED *^#												
Returned to Provider to submit to MCRx	8	8	8	12	4	6	3	6	3	3		

* Total number of TAR's

^ Not required for monitoring

Per DHCS instruction, do not deny MCRx services

KERN HEALTH SYSTEMS

To: **KHS QI-UM Committee**

From: **Yolanda Herrera, CPMSM, CPCS**
Credentialing Manager

Date: **November 16, 2023**

Re: **3rd Quarter 2023 – PNM Credentialing Statistics**

Background

During the monitoring/reporting period July 1, 2023 through September 30, 2023 there were a total of 123 Initially Credentialed Providers and 110 Recredentialed Providers.

18 New Contracts were approved:

5 – ABA
1 - Acupuncture
1 – Anesthesiology Hosp-Based Group
2 – Community Support Services (ECM Services)
1 – Home Health
2 – Marriage/Family Therapy
1 - Primary Care
1 – Physical Therapy
1 – Speech Pathology Group
2 – Transportation
1 – Urgent Care

Discussion

- All credentialing and recredentialing files were approved as presented.
    - PCPs increased from 446 to 458 (As of Sept 2023 - Excluding out of area telehealth)
    - PCP additions included 12-Physicians and 16-NP/PA
    - PCP Terminations from the network included 19 (8-Physicians & 11-NP/PA)
    - Specialists increased from 2,624 to 2,721 (As of Sept 2023)
    - Specialists added to the network included 374
        - Includes non-licensed BH Technicians and Delegated Tertiary Specialists
    - Specialist terminations - 222
    - No significant trends identified for termed PCP or Specialist Providers
- All New Contracts were approved.

Fiscal Impact

N/A

Requested Action

- Informational Only

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PROVIDER NAME	LEGAL NAME/DBA/ADDRESS	SPECIALTY	CONTRACT STATUS	PROVIDER PRV	VENDOR PRV	PAC APPROVED - EFFECTIVE DATE
Ashkenazi, Julie BCBA	Holdsambeck & Associates inc dba: Achieve Behavior Change 1200 21st Street Ste. A Bakersfield CA	Qualified Autism Provider / Behavioral Analyst	Existing	PRV090332	PRV031922	Yes Eff 7/1/23
Gallegos, Alexandra BCBA	Bowcor Inc dba: Special Explorers *All Locations 401 19th Street Bakersfield CA	Qualified Autism Provider / Behavioral Analyst	Existing	PRV089246	ALL SITES	Yes Eff 7/1/23
Shores, Sheila BCBA	Holdsambeck & Associates inc dba: Achieve Behavior Change 1200 21st Street Ste. A Bakersfield CA	Qualified Autism Provider / Behavioral Analyst	Existing	PRV090333	PRV031922	Yes Eff 7/1/23
Soto, Jennifer BCBA	DV Therapy 1601 New Stine Rd Ste 195 Bakersfield CA	Qualified Autism Provider / Behavioral Analyst	Existing	PRV090334	PRV062569	Yes Eff 7/1/23
Vicenec, Kassandra BCBA	ACES 2020 LLC 1405 Commercial Way Ste. 120 Bakersfield CA	Qualified Autism Provider / Behavioral Analyst	Existing	PRV090335	PRV077047	Yes Eff 7/1/23
Weir, Sarah BCBA	Valley Achievement Center 1400 Stine Road *All Locations Bakersfield CA	Qualified Autism Provider / Behavioral Analyst	Existing	PRV090336	PRV014033	Yes Eff 7/1/23
Flores, Maribel LMFT	LLC MFH Heavenly Path Therapy - Maribel Flores Hartford 110 South Montclair Street Ste 205 Bakersfield CA	Marriage Family Therapy	New Contract	PRV077109	PRV077109	Yes Eff 8/1/23
Montiel, Alfredo BCBA	Ad Astra Behavior Analytic Services LP 6077 Coffee Road Ste 4 #1141 Bakersfield CA	Qualified Autism Provider / Behavioral Analyst	New Contract	PRV090717	PRV090716	Yes Eff 8/1/23
Munoz, Lizette, BCBA	Ad Astra Behavior Analytic Services LP 6077 Coffee Road Ste 4 #1141 Bakersfield CA	Qualified Autism Provider / Behavioral Analyst	New Contract	PRV090718	PRV090716	Yes Eff 8/1/23
Franco, Cristina BCBA	Cristina Franco dba: Avanza Behavior Solutions 7721 Gallup Drive Bakersfield CA	Qualified Autism Provider / Behavioral Analyst	New Contract	PRV057098	PRV090719	Yes Eff 8/1/23
Cameron, Cierra, LMFT	Ridgecrest Regional Hospital RHC 1111 N China Lake Blvd Ste. 190 Ridgecrest CA	Professional Counselor	Existing	PRV071515	PRV029495	Yes Eff 8/1/23
Dubon, Karen BCBA	Autism Behavior Services Inc 4900 California Ave Tower B, 2nd Flr Bakersfield CA	Qualified Autism Provider / Behavioral Analyst	Existing	PRV090605	PRV062872	Yes Eff 8/1/23
Espinal, Kiana BCBA	Adelante Behavioral Health ABA LLC 2005 Eye Street Ste. 8 Bakersfield CA	Qualified Autism Provider / Behavioral Analyst	Existing	PRV090614	PRV067923	Yes Eff 8/1/23
Guerra, Mallela BCBA	Bowcor Inc dba: Special Explorers *All Locations 401 19th Street Bakersfield CA	Qualified Autism Provider / Behavioral Analyst	Existing	PRV090624	ALL SITES	Yes Eff 8/1/23
Horvath, Angela LCSW	Reedley Community Hospital - Hanford 1025 N. Douty Street Hanford CA	Clinical Social Worker	Existing	PRV090627	PRV040784	Yes Eff 8/1/23
Hunter, Tessa BCBA	ACES 2020 LLC 1405 Commercial Way Ste. 120 Bakersfield CA	Qualified Autism Provider / Behavioral Analyst	Existing	PRV087860	PRV077047	Yes Eff 8/1/23

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Milbes, Noor BCBA	Autism Behavior Services Inc 4900 California Ave Tower B, 2nd Flr Bakersfield CA	Qualified Autism Provider / Behavioral Analyst	Existing	PRV090631	PRV062872	Yes Eff 8/1/23
Palma, Christian BCBA	California Spectrum Services 4865 Truxtun Avenue Bakersfield CA	Qualified Autism Provider / Behavioral Analyst	Existing	PRV090632	PRV031975	Yes Eff 8/1/23
Saini, Ruchika MD	Premier Valley Medical Group *All Loc 5401 White Lane Hanford CA Good Samaritan HC-Wasco RHC 1217 7th Street Wasco CA	Psychiatry	Existing	PRV000303	ALL SITES	Yes Eff 8/1/23
Urrutia, Jessica BCBA	ACES 2020 LLC 1405 Commercial Way Ste. 120 Bakersfield CA	Qualified Autism Provider / Behavioral Analyst	Existing	PRV090633	PRV077047	Yes Eff 8/1/23
Valdez, Adriana BCBA	ACES 2020 LLC 1405 Commercial Way Ste. 120 Bakersfield CA	Qualified Autism Provider / Behavioral Analyst	Existing	PRV089168	PRV077047	Yes Eff 8/1/23
White, Tennille BCBA	Bowcor Inc dba: Special Explorers *All Locations 401 19th Street Bakersfield CA	Qualified Autism Provider / Behavioral Analyst	Existing	PRV090634	ALL SITES	Yes Eff 8/1/23
Wyly, Lisa LCSW	Kern Valley Healthcare District 4300 Birch Street Lake Isabella CA	Clinical Social Worker	Existing	PRV066444	PRV046034	Yes Eff 8/1/23
Yasaei, Rama MD	Premier Valley Medical Group *All Loc 5401 White Lane Hanford CA Good Samaritan HC-Wasco RHC 1217 7th Street Wasco CA	Psychiatry	Existing	PRV083930	ALL SITES	Yes Eff 8/1/23
Expressable Speech-Language Pathology PC	Expressable Speech-Language Pathology PC 633 West Fifth Street, Office #2876B Los Angeles CA	Speech Pathology	New Contract	PRV091762	PRV091762	Yes Eff 9/1/23
Guardian Angel Home Care of Bakersfield LLC	Guardian Angel Home Care of Bakersfield LLC 5001 E Commerce Center Dr Ste 240 Bakersfield CA	Home Health	New Contract	PRV078293	PRV078293	Yes Eff 9/1/23
Amazona, Carlo MD	KC Wellness Center A Nurse Practitioner LED Corp. 331 S. H Street Bakersfield CA	PCP/Primary Care	New Contract	PRV000534	PRV076095	Yes Eff 9/1/23
Mejia, Norma NP-C	KC Wellness Center A Nurse Practitioner LED Corp. 331 S. H Street Bakersfield CA	PCP/Primary Care	New Contract	PRV029515	PRV076095	Yes Eff 9/1/23
Padilla Physical Therapy & Fitness Inc.	Padilla Physical Therapy & Fitness Inc. 1420 7th Street Wasco CA	Physical Therapy	New Contract	PRV091763	PRV091763	Yes Eff 9/1/23
RT Transportation	Domitilo Campos Espinoza dba: RT Transportation 3500 21st Street Bakersfield CA	Transportation	New Contract	PRV091764	PRV091764	Yes Eff 9/1/23

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Accelerated Urgent Care - Brimhall Road	Emergency Physicians Urgent Care Inc dba: Accelerated Urgent Care 9710 Brimhall Road Bakersfield CA	Urgent Care Clinic	Existing	PRV042028	PRV042028	**Yes** **Eff 9/1/23**
Accelerated Urgent Care - California Ave.	Emergency Physicians Urgent Care Inc dba: Accelerated Urgent Care 4040 California Avenue Bakersfield CA	Urgent Care Clinic	Existing	PRV081242	PRV081242	**Yes** **Eff 9/1/23**
Castellon, Chrystina MD	Bakersfield Hematology Oncology Grp Inc 9800 Brimhall Road Ste. 200 Bakersfield CA	Hematology / Oncology	Existing	PRV091773	PRV071514	**Yes** **Eff 9/1/23**
Casabay, Sheilanie NP-C	Baz Allergy, Asthma & Sinus Center Inc 7471 N. Fresno Street *All Locations Fresno CA	Allergy & Immunology	Existing	PRV091774	PRV080098 PRV080245 PRV041280	**Yes** **Eff 9/1/23**
Cheriyan, Anna MD	Clinica Sierra Vista 625 34th Street Ste. 100 & 200 Bakersfield CA	Family Practice	Existing	PRV057295	PRV057295	**Yes** **Eff 9/1/23**
Chetha, Amardeep MD	Clinica Sierra Vista 7800 Niles Street Bakersfield CA	General Practice	Existing	PRV089699	PRV057295	**Yes** **Eff 9/1/23**
Covenas Manrique, Cecilia MD	Clinica Sierra Vista 7800 Niles Street Bakersfield CA	General Practice	Existing	PRV089695	PRV000002	**Yes** **Eff 9/1/23**
D'Assumpcao, Carlos MD	Kern County Hospital Authority 1111 Columbus Street 9330 Stockdale Highway Ste. 400 Bakersfield CA	Infectious Disease	Existing	PRV048052	ALL SITES	**Yes** **Eff 9/1/23**
Day, Witney CRNA	Wafik Abdou MD Inc 4101 Empire Dr Ste 130 Bakersfield CA	Anesthesiology	Existing	PRV067213	PRV000435	**Yes** **Eff 9/1/23**
DeWitt, Hollie NP-C	Clinica Sierra Vista 301 Brundage Lane Bakersfield CA	Pediatrics	Existing	PRV089247	PRV00002	**Yes** **Eff 9/1/23**
Hlaing, Su MD	Clinica Sierra Vista 7800 Niles Street Bakersfield CA	General Practice	Existing	PRV089701	PRV000002	**Yes** **Eff 9/1/23**
Huynh, Vu-Quang MD	Adventist Health Delano Delano Prompt Care Clinic (Walk-In) 1201 Jefferson Street Delano CA 2300 7th Street Wasco CA (Walk-In)	General Practice	Existing	PRV009147	ALL SITES	**Yes** **Eff 9/1/23**
Idemudia, Funmilayo MD	Clinica Sierra Vista 7800 Niles Street Bakersfield CA	General Practice	Existing	PRV089694	PRV000002	**Yes** **Eff 9/1/23**
Imbert Matos, Licet MD	Clinica Sierra Vista 7800 Niles Street Bakersfield CA	General Practice	Existing	PRV089696	PRV000002	**Yes** **Eff 9/1/23**
Kaur, Sandeep NP-C	Comprehensive Care Clinic 2615 H Street Bakersfield CA	Internal Medicine	Existing	PRV083775	PRV000188	**Yes** **Eff 9/1/23**
Kim, Richard MD	Retina Institute of California 2323 16th St Ste. 400 Bakersfield CA	Ophthalmology	Existing	PRV089705	PRV000181	**Yes** **Eff 9/1/23**
Kitson, Michelle NP-C	Baz Allergy, Asthma & Sinus Center Inc 7471 N. Fresno Street *All Locations Fresno CA	Allergy & Immunology	Existing	PRV091777	ALL SITES	**Yes** **Eff 9/1/23**
LeSar, Benjamin MD	Kern Radiology Medical Group *All Locations 2301 Bahamas Dr. Bakersfield CA	Diagnostic Radiology	Existing	PRV084428	ALLSITES	**Yes** **Eff 9/1/23**
Martinez, Jennifer MD	Clinica Sierra Vista 2740 S Elm Ave Fresno CA	Pediatrics	Existing	PRV089520	PRV000002	**Yes** **Eff 9/1/23**
Martinez Lopez, Amelia MD	Clinica Sierra Vista 7800 Niles Street Bakersfield CA	General Practice	Existing	PRV089697	PRV000002	**Yes** **Eff 9/1/23**

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McAllister, Derek DO	Kern Radiology Medical Group *All Locations 2301 Bahamas Dr. Bakersfield CA	Diagnostic Radiology	Existing	PRV075982	ALL SITES	**Yes** **Eff 9/1/23**
Mu, Anandit DO	Clinica Sierra Vista 2740 S Elm Ave Fresno CA	Infectious Disease	Existing	PRV034631	PRV000002	**Yes** **Eff 9/1/23**
Nwigwe, Gloria NP-C	Adventist Health Community Center - Tehachapi 105 West E Street Tehachapi CA 2041 Belshaw Street Mojave CA 9350 N. Loop Blvd Cal City CA	Internal Medicine	Existing	PRV088083	ALL SITES	**Yes** **Eff 9/1/23**
Panithi, Ranjani MD	Clinica Sierra Vista 625 34th Street Ste. 100 & 200 Bakersfield CA	Pediatrics	Existing	PRV047412	PRV000002	**Yes** **Eff 9/1/23**
Patel, Ronakkumar MD	Omni Family Health 4161 Ming Ave Bakersfield CA	Endocrinology/ Metabolism	Existing	PRV065582	PRV000019	**Yes** **Eff 9/1/23**
Phelps, Heather NP-C	Emergency Physicians Urgent Care Inc dba: Accelerated Urgent Care 212 Coffee Road Ste. 100 *All Locations Bakersfield CA	Emergency Med / UC	Existing	PRV091744	ALL SITES	**Yes** **Eff 9/1/23**
Powell, Charles NP-C	Omni Family Health 1701 Stine Road Bakersfield CA	Family Practice	Existing	PRV089522	PRV000019	**Yes** **Eff 9/1/23**
Quang, Tony MD	LA Laser Center PC - California Ave 5600 California Avenue Ste. 101 & 103 Bakersfield CA	Radiation Oncology	Existing	PRV091790	PRV013922	**Yes** **Eff 9/1/23**
Rauf, Khalid MD	Clinica Sierra Vista 625 34th Street Ste. 100-200 Bakersfield 2740 S Elm Ave Fresno CA	Pulmonary Disease	Existing	PRV089208	PRV000002	**Yes** **Eff 9/1/23**
Roshan, Bakht MD	Clinica Sierra Vista 625 34th Street Ste. 100-200 Bakersfield 2740 S Elm Ave Fresno CA	Infectious Disease	Existing	PRV088708	PRV000002	**Yes** **Eff 9/1/23**
Sayle, Laura NP	Alan F. Dakak M Inc dba: Kern Pediatrics 3941 San Dimas Street Ste. 101 Bakersfield CA	Family Practice	Existing	PRV088720	PRV000342	**Yes** **Eff 9/1/23**
Sibanda, Belinda MD	Omni Family Health 4151 Mexicali Dr. Bakersfield CA 2811 H Street Bakersfield CA	Internal Medicine	Existing	PRV089702	PRV000019	**Yes** **Eff 9/1/23**
Sidhu, Erika NP-C	Baz Allergy, Asthma & Sinus Center Inc 7471 N. Fresno Street *All Locations Fresno CA	Allergy & Immunology	Existing	PRV091793	ALL SITES	**Yes** **Eff 9/1/23**
Sidhu, Kuljit NP-C	Clinica Sierra Vista 1015 Baker Street Ste 4 Bakersfield CA	Family Practice	Existing	PRV089248	PRV000002	**Yes** **Eff 9/1/23**
Smith, Kiara RD	Kern County Hospital Authority 1111 Columbus Street Bakersfield CA	Registered Dietician	Existing	PRV088719	ALL SITES	**Yes** **Eff 9/1/23**
Sohi, Dilraj NP-C	Emergency Physicians Urgent Care Inc dba: Accelerated Urgent Care 212 Coffee Road Ste. 100 *All Locations Bakersfield CA	Emergency Med / UC	Existing	PRV091795	ALL SITES	**Yes** **Eff 9/1/23**
Sung, Na Young MD	Clinica Sierra Vista 7800 Niles Street Bakersfield CA	General Practice	Existing	PRV089698	PRV000002	**Yes** **Eff 9/1/23**
Tirman, Phillip MD	Kern Radiology Medical Group *All Locations 2301 Bahamas Dr. Bakersfield CA	Diagnostic Radiology	Existing	PRV003553	ALL SITES	**Yes** **Eff 9/1/23**

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Varaprasathan, Gita MD	Kern Radiology Medical Group *All Locations 2301 Bahamas Dr. Bakersfield CA	Diagnostic Radiology	Existing	PRV002827	ALL SITES	**Yes** **Eff 9/1/23**
Villachica, Gabriel NP-C	Clinica Sierra Vista 425 Del Sol Parkway Delano CA	Family Practice	Existing	PRV043410	PRV000002	**Yes** **Eff 9/1/23**
Win, Htet Htet MD	Omni Family Health 4131 Ming Ave Bakersfield CA	Endocrinology/ Metabolism	Existing	PRV068750	PRV000019	**Yes** **Eff 9/1/23**
Wortman, William MD	Kern Radiology Medical Group *All Locations 2301 Bahamas Dr. Bakersfield CA	Diagnostic Radiology	Existing	PRV002731	ALL SITES	**Yes** **Eff 9/1/23**
Yomi, Timiiye MD	Clinica Sierra Vista 7800 Niles Street Bakersfield CA	General Practice	Existing	PRV089700	PRV000002	**Yes** **Eff 9/1/23**
Yoon, Jane MD	Ridgecrest Regional Hospital 1111 N China Lake Blvd Ste. 190 1041 N. China Lake Blvd Ridgecrest CA	Pediatrics	Existing	PRV082700	PRV029495 PRV000279 PRV054886	**Yes** **Eff 9/1/23**

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	PROVIDER NAME	LEGAL NAME/DBA/ADDRESS	SPECIALTY	CONTRACT STATUS	PROV PRV	VENDOR PRV	PAC APPROVED - EFFECTIVE DATE
1	Moten, Artisa LMFT	Awakened Consulting, Inc 728 21st St Bakersfield CA	Marriage/Family Therapy	New Contract	PRV082141	PRV082141	Yes Eff 9/1/23
2	Gray, Elaina BCBA	Positive Behavior Supports Corporation 3815 Ming Ave #352 Bakersfield CA	QASP / Behavioral Analyst	New Contract	PRV092349	PRV092347	Yes Eff 9/1/23
3	Moua, Piyaporn BCBA	Positive Behavior Supports Corporation 3815 Ming Ave #352 Bakersfield CA	QASP / Behavioral Analyst	New Contract	PRV092350	PRV092347	Yes Eff 9/1/23
4	Mutrie, Jimel BCBA	Positive Behavior Supports Corporation 3815 Ming Ave #352 Bakersfield CA	QASP / Behavioral Analyst	New Contract	PRV084248	PRV092347	Yes Eff 9/1/23
5	Rizo, Jonathan LEP	Jonathan Rizo dba: Rizo Psychological & Behavioral Health Serv 930 Truxtun Ave Ste 206 Bakersfield CA	QASP / Behavioral Analyst	New Contract	PRV092319	PRV092319	Yes Eff 9/1/23
6	Chavez, Kevin BCBA	California Psychcare Inc 624 Commerce Dr Unit E Palmdale CA	QASP / Behavioral Analyst	Existing	PRV092729	PRV011225	Yes Eff 9/1/23
7	Hurtado, Jerry BCBA	Prism Behavioral Solutions 4900 California Avenue Ste. 210B Bakersfield CA	QASP / Behavioral Analyst	Existing	PRV092730	PRV069746	Yes Eff 9/1/23
8	Kahlon, Angad MD	Kern County Hospital Authority 1700 Mt Vernon Ave Bakersfield CA	Psychiatry	Existing	PRV069771	ALL SITES	Yes Eff 9/1/23
9	Koecklin, Lia BCBA	California Psychcare Inc 624 Commerce Dr Unit E Palmdale CA	QASP / Behavioral Analyst	Existing	PRV092731	PRV011225	Yes Eff 9/1/23
10	Rodriguez, Jenny BCBA	Adelante Behavioral Health ABA LLC 2005 Eye Street Ste. 8 Bakersfield CA	QASP / Behavioral Analyst	Existing	PRV092732	PRV067923	Yes Eff 9/1/23
11	Sivia, Itwinder MD	Kern County Hospital Authority 1700 Mt Vernon Ave Bakersfield CA	Psychiatry	Existing	PRV077131	ALL SITES	Yes Eff 9/1/23
12	Trejo, Kimberly LCSW	Adventist Health Reedley 2141 High St Selma CA 93662	Clinical Social Worker	Existing	PRV092733	PRV077724	Yes Eff 9/1/23
13	Wyant, Billie LCSW	Adventist Health Reedley 1025 N Douty St. Hanford CA	Clinical Social Worker	Existing	PRV092735	PRV040784	Yes Eff 9/1/23
14	Bakersfield American Indian Health Project	Bakersfield American Indian Health Project 501 40th Street Bakersfield CA	Enhanced Care / Case Management	New Contract	PRV092023	PRV092023	Yes Eff 10/1/23

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	PROVIDER NAME	LEGAL NAME/DBA/ADDRESS	SPECIALTY	CONTRACT STATUS	PROV PRV	VENDOR PRV	PAC APPROVED - EFFECTIVE DATE
15	Cal City Urgent Care	Cal City Urgent Care INC. A California Professional Medical Corporation DBA: Cal City Urgent Care 8100 California City Blvd California City CA	Urgent Care Clinic	New Contract	PRV087138	PRV087138	Yes Eff 10/1/23
16	Kim, Paul MD	Cal City Urgent Care INC. A California Professional Medical Corporation DBA: Cal City Urgent Care 8100 California City Blvd California City CA	Preventive Medicine / UC	New Contract	PRV087137	PRV087138	Yes Eff 10/1/23
17	Environmental Alternatives	Environmental Alternatives DBA: EA Family Services 3201 F Street Bakersfield CA	Enhanced Care / Case Management	New Contract	PRV090574	PRV090574	Retro Approval 9/1/2023
18	Joy Service	Mijo Yoon DBA: Joy Service 2211 Brundage Ln Ste A Bakersfield CA	Transportation	New Contract	PRV092736	PRV092736	Yes Eff 10/1/23
19	Kurian, Leonard MD	Good Samaritan Wasco - RHC 1217 7th Street Wasco CA	OB/GYN	Existing	PRV039242	PRV068674	Yes Eff 10/1/23
20	Milyani, Wa'el MD	LA Laser Center PC - California Ave 5600 California Avenue Ste. 101 & 103 Bakersfield CA	Dermatopathology	Existing	PRV059909	PRV081021	Yes Eff 10/1/23
21	Abidali, Ali DO	Ridgecrest Regional Hospital 1041 N China Lake Blvd Ridgecrest CA	General Surgery	Existing	PRV091675	PRV054886 PRV000279	Yes Eff 10/1/23
22	Baek, Soo PA-C	Vanguard Medical Corporation 565 Kern Street Shafter CA	Family Practice	Existing	PRV092737	ALL SITES	Yes Eff 10/1/23
23	Bagri, Amri NP-C	1st Choice Urgent Care *All locations 6515 Panama Lane Ste 106 Bakersfield CA	Family Practice / UC	Existing	PRV086358	ALL SITES	Yes Eff 10/1/23
24	Barlas, Talal MD	Omni Family Health 6700 Niles Street Bakersfield CA 4151 Mexicali Dr Bakersfield CA	Internal Medicine	Existing	PRV091049	PRV000019	Yes Eff 10/1/23

KERN HEALTH SYSTEMS
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	PROVIDER NAME	LEGAL NAME/DBA/ADDRESS	SPECIALTY	CONTRACT STATUS	PROV PRV	VENDOR PRV	PAC APPROVED - EFFECTIVE DATE
25	Barroso-Perez, Arlenis MD	Clinica Sierra Vista 625 34th Street Ste 100 & 200 Bakersfield CA	Family Practice	Existing	PRV043991	PRV000002	Yes Eff 10/1/23
26	Bath, Kulwant MD	Kern County Hospital Authority 1111 Columbus Street Bakersfield CA	Nephrology	Existing	PRV092066	ALL SITES	Yes Eff 10/1/23
27	Bazargani, Soroush MD	Adventist Health Physicians Network 2701 Chester Ave Ste. 102 Bakersfield CA Kern County Hospital Authority 1111 Columbus Street Bakersfield CA	Urology	Existing	PRV089703	ALL SITES	Yes Eff 10/1/23
28	Carlton, Jacqueline PA-C	Omni Family Health 659 S. Central Valley Highway Shafter CA	Family Practice	Existing	PRV091052	PRV000019	Yes Eff 10/1/23
29	Corcoran, Susan CNM	Ridgecrest Regional Hospital 1011 N China Lake Blvd Ste. A Ridgecrest CA	Nurse Midwife	Existing	PRV091050	PRV038718 PRV029495	Yes Eff 10/1/23
30	Foulad, David MD	Comprehensive Blood & Cancer Center 6501 Truxtun Ave Bakersfield CA	Breast Onc Surgery	Existing	PRV091048	PRV013881	Yes Eff 10/1/23
31	Gordillo-Miller, Lauren NP-C	Kern County Public Health Department 1800 Mt Vernon Ave Bakersfield CA	General Practice (Mobile Unit)	Existing	PRV086911	PRV005731	Yes Eff 10/1/23
32	Guerrero, Whitney MD	Adventist Health Physicians Network 20211 W Valley Blvd Tehachapi CA	General Surgery	Existing	PRV092738	PRV064970	Yes Eff 10/1/23
33	Hernandez, Jonathan NP-C	Clinica Sierra Vista 625 34th Street Ste 100 & 200 Bakersfield CA 2740 S. Elm Avenue Fresno	General Practice	Existing	PRV043626	PRV000002	Yes Eff 10/1/23
34	Jorgensen, Aubrey NP-C	Coastal Kids, A Professional Med Corp 1215 34th Street Bakersfield CA	Pediatrics	Existing	PRV083547	PRV077048	Yes Eff 10/1/23
35	Kahlon, Jason MD	Kern County Hospital Authority 1111 Columbus Street Bakersfield CA	Internal Medicine / Hospitalist	Existing	PRV088717	ALL SITES	Yes Eff 10/1/23

KERN HEALTH SYSTEMS
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	PROVIDER NAME	LEGAL NAME/DBA/ADDRESS	SPECIALTY	CONTRACT STATUS	PROV PRV	VENDOR PRV	PAC APPROVED - EFFECTIVE DATE
36	Lee, Chih-Cheng MD	Adventist Health Tehachapi Valley 105 West E St Tehachapi CA Adventist Health Delano 1201 Jefferson St Delano CA	General Surgery	Existing	**PRV092739**	**ALL SITES**	**Yes Eff 10/1/23**
37	Liang, Carmin DO	Kern County Hospital Authority 1111 Columbus Street Bakersfield CA	Family Practice	Existing	**PRV089867**	**ALL SITES**	**Yes Eff 10/1/23**
38	Macias-Moreno, Isis MD	Omni Family Health 659 S. Central Valley Hwy Shafter CA 4131 Ming Ave Bakersfield CA	Family Practice	Existing	**PRV091053**	**PRV000019**	**Yes Eff 10/1/23**
39	Mee, Tracy NP-C	Clinica Sierra Vista 625 34th Street Ste 100 & 200 Bakersfield CA	OB/GYN	Existing	**PRV085612**	**PRV000002**	**Yes Eff 10/1/23**
40	Merino, Anthony PA-C	Universal Healthcare Services *All Primary Care Locations Universal Urgent Care *All Universal UC Locations	Internal Med / UC	Existing	**PRV048587**	**ALL SITES**	**Yes Eff 10/1/23**
41	Miller, Thomas PA-C	Comprehensive Medical Group 1230 Jefferson St Delano CA	Internal Medicine	Existing	**PRV001031**	**PRV000258**	**Yes Eff 10/1/23**
42	Mitchell, Hilary PA-C	Kern County Hospital Authority 1700 Mt Vernon Ave Bakersfield CA	General Surgery	Existing	**PRV092062**	**ALL SITES**	**Yes Eff 10/1/23**
43	Nhan, Jack PA-C	Kern County Hospital Authority 1700 Mt Vernon Ave Bakersfield CA	General Surgery	Existing	**PRV092061**	**ALL SITES**	**Yes Eff 10/1/23**
44	Peace, Nykia MD	Clinica Sierra Vista 2400 Wible Rd Ste 14 Bakersfield CA	Family Medicine	Existing	**PRV076760**	**PRV000002**	**Yes Eff 10/1/23**
45	Picking, Julie NP-C	Vanguard Medical Corporation 565 Kern Street Shafter CA	Family Practice	Existing	**PRV059213**	**ALL SITES**	**Yes Eff 10/1/23**
46	Powell, David MD	Clinica Sierra Vista 2400 Wible Rd Ste 14 Bakersfield CA	Family Practice	Existing	**PRV092740**	**PRV000002**	**Yes Eff 10/1/23**
47	Prompradit, Eli PA-C	ACE Eyecare 1721 Westwind Dr Ste B Bakersfield CA	Family Practice	Existing	**PRV092741**	**PRV041736**	**Yes Eff 10/1/23**
48	Rosado III, Jesus MD	Ridgecrest Regional Hospital 1041 N China Lake Blvd Ridgecrest CA	General Surgery	Existing	**PRV081966**	**PRV054886**	**Yes Eff 10/1/23**

KERN HEALTH SYSTEMS
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	PROVIDER NAME	LEGAL NAME/DBA/ADDRESS	SPECIALTY	CONTRACT STATUS	PROV PRV	VENDOR PRV	PAC APPROVED - EFFECTIVE DATE
49	Shang, Sherry OD	Clinica Sierra Vista 625 34th Street Ste 100 & 200 Bakersfield CA	Optometry	Existing	**PRV092742**	**PRV000002**	**Yes Eff 10/1/23**
50	Singh, Harnek MD	Clinica Sierra Vista 7800 Niles St Bakersfield CA	Family Practice	Existing	**PRV091046**	**PRV000002**	**Yes Eff 10/1/23**
52	Sukkar, Marah MD	Kern County Hospital Authority 1111 Columbus Street 9330 Stockdale Hwy Ste 400 Bakersfield CA	Internal Medicine	Existing	**PRV089704**	**ALL SITES**	**Yes Eff 10/1/23**
52	Sunalp, Murad MD	Golden State Eye Medical Group 6000 Physicians Blvd Ste D205 Bakersfield CA	Ophthalmology	Existing	**PRV002384**	**PRV000333**	**Yes Eff 10/1/23**
53	Tachiquin, Denise NP-C	Vanguard Medical Corporation 565 Kern Street Shafter CA	General Practice	Existing	**PRV091095**	**ALL SITES**	**Yes Eff 10/1/23**
54	Tangri, Rajiv DO	Stockdale Radiology Physicians Services 4000 Empire Dr Ste 100 Bakersfield CA	Diagnostic Radiology	Existing	**PRV049854**	**PRV000396**	**Yes Eff 10/1/23**

KERN HEALTH SYSTEMS
3rd Quarter 2023
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

Report Date: September 8, 2023

Department: Provider Network Management

Monitoring Period: July 1, 2023 through September 30, 2023

Population:

Providers	Credentialed	Recredentialed
MD's	50	48
DO's	5	3
AU's	0	0
DC's	0	6
AC's	0	0
PA's	7	12
NP's	21	11
CRNA's	1	1
DPM's	0	1
OD's	1	1
ND's	0	0
RD's	1	0
BCBA's	19	2
LM's	0	0
Mental Health	8	9
Ocularist	0	0
OT	0	0
Ancillary	10	16
CSS	0	0
TOTAL	**123**	**110**

Specialty	Providers Credentialed	Providers Recredentialed	Providers Sent to PAC	Providers Not Approved
Acupuncture	0	0	0	0
Addiction Medicine	0	0	0	0
Allergy & Immunology	3	0	3	0
Anesthesiology / CRNA	1	1	2	0
Audiology	0	0	0	0
Autism / Behavioral Analyst	19	2	21	0
Cardiology	0	4	4	0
Chiropractor	0	6	6	0
Colon & Rectal Surgery	0	0	0	0
Critical Care	0	0	0	0
Dermatology	2	1	3	0
Emergency Medicine	2	1	3	0
Endocrinology	2	3	5	0
Family Practice	18	16	34	0
Gastroenterology	0	1	1	0
General Practice	12	0	12	0

KERN HEALTH SYSTEMS
3rd Quarter 2023
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

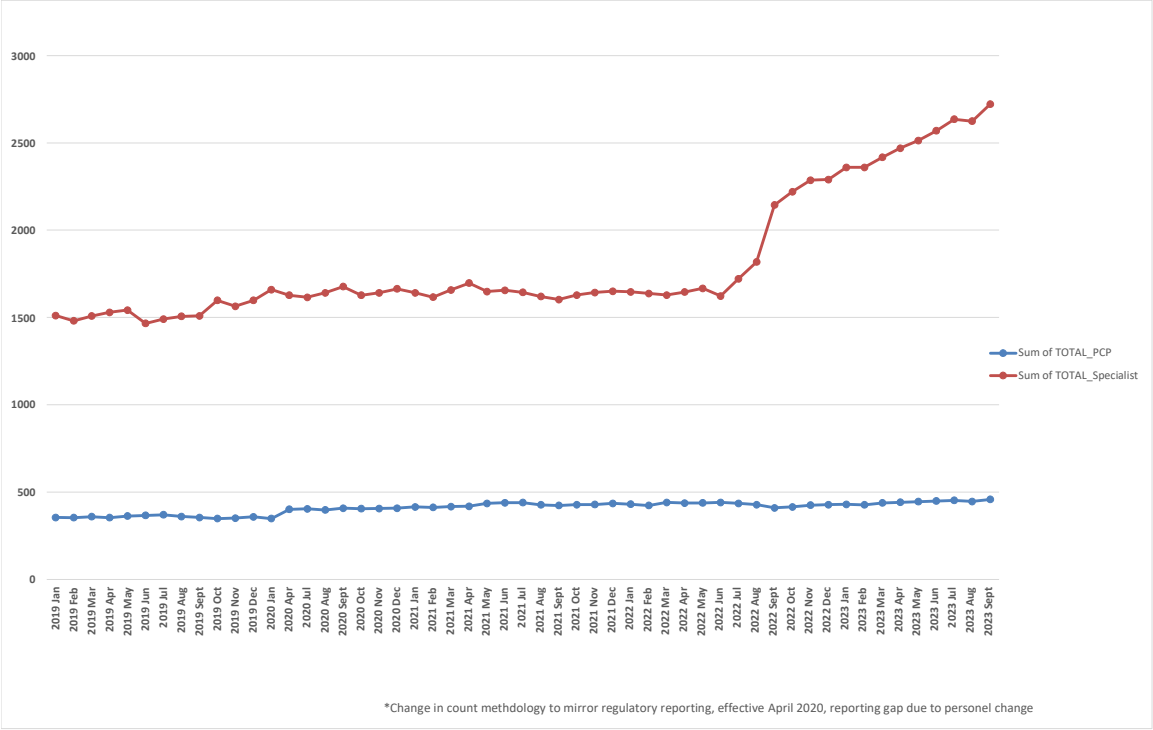
Specialty	Providers Credentialed	Providers Recredentialed	Providers Sent to PAC	Providers Not Approved
General Surgery	7	0	7	0
Genetics	0	0	0	0
Gynecology	0	0	0	0
Gynecology/Oncology	0	0	0	0
Hematology/Oncology	1	1	2	0
Hospitalist	1	0	1	0
Infectious Disease	3	0	3	0
Internal Medicine	8	19	27	0
Mental Health	8	9	17	0
MidWife (Certified)	1	0	1	0
MidWife (Licensed)	0	0	0	0
Naturopathic Medicine	0	0	0	0
Neonatology	0	0	0	0
Nephrology	1	1	2	0
Neurological Surgery	0	1	1	0
Neurology	0	2	2	0
Obstetrics & Gynecology	2	8	10	0
Ocularist	0	0	0	0
Occupational Therapy	0	0	0	0
Ophthalmology	2	1	3	0
Optometry	1	1	2	0
Orthopedic Surgery / Hand Surg	0	0	0	0
Otolaryngology	0	0	0	0
Pain Management	0	1	1	0
Pathology	0	1	1	0
Pediatrics	5	6	11	0
Physical Medicine & Rehab	0	0	0	0
Plastic Sugery	0	1	1	0
Podiatry	0	1	1	0
Preventive Medicine	1	0	1	0
Psychiatry	4	3	7	0
Pulmonary	1	1	2	0
Radiation Oncology	1	1	2	0
Radiology	6	2	8	0
Registered Dieticians	1	0	1	0
Rheumatology	0	0	0	0
Sleep Medicine	0	0	0	0
Thoracic Surgery	0	0	0	0
Urology	1	0	1	0
Vascular Medicine	0	0	0	0
Vascular Surgery	0	0	0	0
KHS Medical Directors	0	0	0	0
TOTAL	**114**	**95**	**209**	**0**

KERN HEALTH SYSTEMS
3rd Quarter 2023
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

ANCILLARY	Providers Credentialed	Providers Recredentialed	Providers Sent to PAC	Providers Not Approved
Ambulance	0	0	0	0
Cancer Center	0	0	0	0
Cardiac Sonography	0	0	0	0
Comm. Based Adult Services	0	0	0	0
Dialysis Center	0	1	1	0
DME	0	3	3	0
Hearing Aid Dispenser	0	0	0	0
Home Health	1	0	1	0
Home Infusion/Compounding	0	0	0	0
Hospice	0	1	1	0
Hospital / Tertiary Hospital	0	2	2	0
Laboratory	0	2	2	0
Lactation Consultant	0	0	0	0
MRI	0	0	0	0
Ocular Prosthetics	0	0	0	0
Pharmacy	0	4	4	0
Pharmacy/DME	0	0	0	0
Physical / Speech Therapy	2	0	2	0
Prosthetics & Orthotics	0	1	1	0
Radiology	0	0	0	0
Skilled Nursing	0	1	1	0
Sleep Lab	0	1	1	0
Surgery Center	0	0	0	0
Transportation	2	0	2	0
Urgent Care	3	0	3	0
Community Support Services	2	0	2	0
TOTAL	**10**	**16**	**26**	**0**

Defer = 0 **Denied = 0**

PCP/Specialist Summary



*Change in count methdology to mirror regulatory reporting, effective April 2020, reporting gap due to personel change

KERN HEALTH SYSTEMS

To: KHS QI-UM Committee

From: Provider Network Management Department

Date: 11/30/2023

Re: Provider Network Management - Network Review Q3, 2023

Background:
The Department of Managed Health Care (DMHC) and the Department of Health Care Services (DHCS) maintain accessibility, availability, and adequacy standards the Plan is required to meet. The Plan's standards and monitoring activities are outlined in policy and procedure 4.30-P accessibility standards. The Plan utilizes the Provider Network Management Network Review to monitor accessibility, availability, and adequacy standards.

Discussion:
The Provider Network Management Network Review provides the overview and results for the Plan's After-Hours Survey, Provider Accessibility Monitoring Survey, Accessibility Grievance Review, Geographic Accessibility and DHCS Network Certification, Network Adequacy and Provider Counts, and the DHCS Quarterly Monitoring Report Template Review.

Fiscal Impact: N/A

Requested Action: Request to approve and file PNM Q3 2023 report.

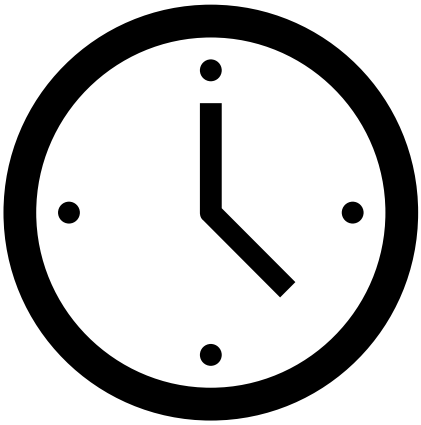
Provider Network Management
Network Review
Quarter 3, 2023

- **After-Hours Survey Report**
- **Provider Accessibility Monitoring Survey**
- **Access Grievance Review (Q1 2023 Review Period)**
- **Geographic Accessibility & DHCS Network Certification**
- **Network Adequacy & Provider Counts**
- **DHCS Quarterly Monitoring Report/Response Template (QMRT) (Q2 2023 Review Period)**

KERN HEALTH SYSTEMS

After-Hours Survey Report

Quarter 3, 2023



AFTER-HOURS CALLS

Q3, 2023

Introduction

As required by the Department of Managed Health Care (DMHC) Health & Safety Code 1348.8, Kern Health Systems (KHS) uses an after-hours caller program to assess compliance with access standards for Kern Family Health Care (KFHC) Members. KHS policy requires that:

1.) Provider's answering machine or answering service must instruct the member to call 911 if the purpose of the call is a medical emergency.

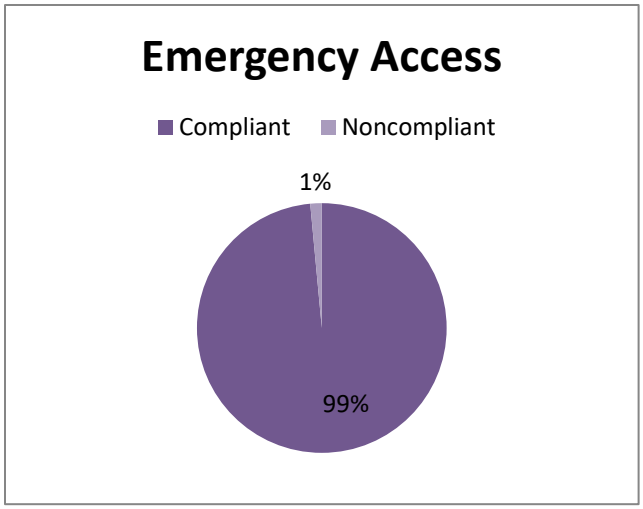
2.) For urgent matters, Provider's answering machine must provide an on-call number. If an answering service is used, the member must receive a call back from an on-call member of your office within 30 minutes of call.

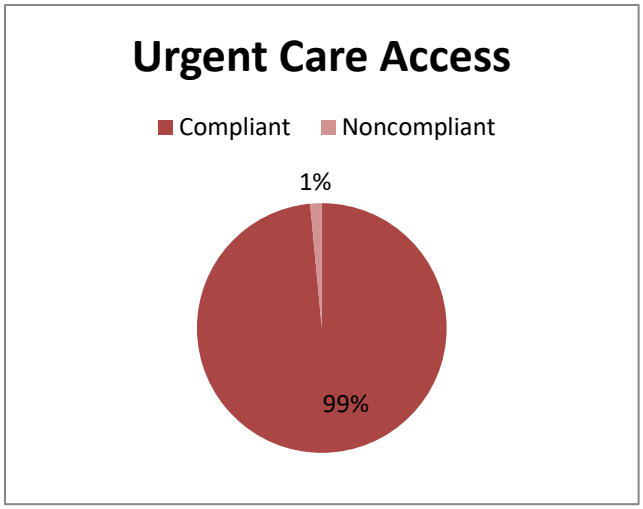
An initial survey is conducted by Health Dialog; the results are forwarded to the Plan's Provider Network Analyst Team who make additional follow up calls based on compliant/noncompliant data received from the survey vendor.

Providers who are found noncompliant with either/both standard(s) are notified via mailed letter and contacted by their Plan-assigned Provider Relations Representative. Providers who are found to be noncompliant for a second consecutive quarter are be notified by mailed letter and contacted by the Deputy Director of Provider Network or designee. Providers who are found noncompliant for a third consecutive quarter will be engaged via a Corrective Action Plan (CAP).

Results

During Q3 2023 135 provider offices were contacted. Of those offices, 133 were compliant with the Emergency Access Standards and 132 were compliant with the Urgent Care Access Standards.





AFTER-HOURS CALLS

Q3, 2023

Tracking, Trending, and Provider Outreach

The Plan utilizes the after-hours survey calls to monitor compliance at a network-wide level. The Plan was found compliant with Emergency Access and Urgent Access remaining in line with prior quarters, with percentages in Q3 2023 above 90%.

Compliance with after-hours standard	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023
Emergency Access	94%	95%	98%	100%	99%	99%
Urgent Care Access	81%	92%	97%	98%	99%	99%

The Plan reviews results of provider groups against prior quarters. The Plan conducts provider outreach as appropriate and maintains ongoing quarterly tracking/trending.

For Q3 2023, two offices were identified as noncompliant with both the emergency access and urgent access standards, and one office was identified as noncompliant with only the urgent access standard. The Plan's Provider Relations Representatives conducted targeted education and sent a letter notifying the provider groups of the survey results and Plan policy (template attached).

Upon review, the Plan has found that the outreach and education conducted via both letter and the Provider Relations Representatives/Provider Relations Supervisor/Deputy Director of Provider Network has seen success.

Provider Accessibility Monitoring Survey

Quarter 3, 2023

Provider Accessibility Monitoring Survey

Q3, 2023

Introduction

Kern Health Systems (KHS) conducts a provider accessibility monitoring survey to assess compliance with access standards for Kern Family Health Care (KFHC) Members.

In line with KHS Policy *4.30-P Accessibility Standards* and regulatory requirements, the quarterly provider accessibility monitoring survey reviews phone answering timeliness, appointment availability, provider office hours of operation, urgent and non-urgent call back times, phone answering timeliness, and in-office wait times at the network level.

The survey was conducted internally by KHS staff; the Plan's survey/compliance methodology is based on a survey/compliance methodology utilized by the Department of Health Care Services (DHCS) during their 2017 Medical Audit of the Plan.

A random sample of 15 primary care provider offices, 15 specialist offices, 5 non-physician mental health offices, 5 ancillary offices, and 5 OBGYN offices was contacted during Q3 2023 to monitor network compliance with the following accessibility metrics.

Appointment Availability Survey Results

Per KHS Policy, *4.30-P Accessibility Standards*, members must be offered appointments within the following timeframes:

Type of Appointment	Time Standard
Urgent care appointment for services that do not require prior authorization	Within 48 hours of a request
Non-urgent primary care appointment	Within 10 business days of a request
Urgent appointment for services that require prior authorization	Within 96 hours of a request
Non-urgent appointment with a specialist	Within 15 business days of a request
Non-urgent appointments with a non-physician mental health care provider	Must offer the appointment within 10 business days of request
Non-urgent appointment for ancillary services	Within 15 business days of a request
First prenatal OB/GYN visit	The lesser of 10 business days or within 2 weeks upon request

To monitor these standards, the randomly sampled providers were contacted via phone and asked for the next available appointment time for the applicable appointment type.

Of the primary care providers surveyed, the Plan compiled the wait time in hours to determine the average wait time for an urgent primary care appointment. The Plan compiled the wait time in days to determine the average wait time for a non-urgent primary care appointment. The average wait time for an urgent primary care appointment was **18.8 hours**. The average wait time for a non-urgent primary care appointment was **3.7 days**. **Based on these results, the Plan was determined to be compliant in both the urgent and non-urgent time standards for primary care appointments in Q3 2023.**

Of the specialist providers surveyed, the Plan compiled the wait time in hours to determine the average wait time for an urgent specialist appointment. The Plan compiled the wait time in days to determine the average wait time for a non-urgent specialist appointment. The average wait time for an urgent specialist appointment was **31.6 hours**. The average wait time for a non-urgent specialist appointment was **5 days**. **Based on these results, the Plan was determined to be compliant in both the urgent and non-urgent time standards for specialist appointments in Q3 2023.**

Of the non-physician mental health providers surveyed, the Plan compiled the wait time in days to determine the average wait time for an appointment with a non-physician mental health provider. The average wait time for a non-physician mental health provider appointment was **0.8 days**. **Based on these results, the Plan was determined to be compliant with the time standard for a mental health appointment in Q3 2023.**

Of the ancillary providers surveyed, the Plan compiled the wait time in days to determine the average wait time for an appointment with the ancillary provider. The Plan's average wait time for an ancillary appointment was **1.8 days**. **Based on these results, the Plan was determined to be compliant with the time standard for an ancillary appointment in Q3 2023.**

Of OB/GYN providers surveyed, the Plan compiled the wait time in days to determine the average wait time for a first prenatal appointment with an OB/GYN. The Plan's average wait time for a first prenatal appointment with an OB/GYN was **2.2 days**. **Based on these results, the Plan was determined to be compliant with the time standard for an OB/GYN first prenatal appointment in Q3 2023**

Tracking, Trending, and Provider Education based Appointment Availability
The Plan reviewed the appointment availability results of the Q3 2023 provider accessibility monitoring survey against the results of prior quarters. The Plan recognized a minor increase in wait time for Non-Urgent PCP appointments. The Plan recognized a minor decrease in wait time for Urgent PCP, Urgent Specialist, Non-Urgent Specialist, Non-Physician Mental Health, Ancillary, and OB/GYN appointments. The Plan does not consider these changes as a trend at this time as the results are in line with prior quarters.

Average urgent wait time in hours	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023
Primary Care	16.2	38.2	26.1	18.5	22.2	18.8
Specialist	67.0	76.6	44.9	113.7	63.5	31.6

Provider Accessibility Monitoring Survey

Q3, 2023

Average wait time in days	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023
Primary Care	6.5	4.3	2.8	3.5	1.9	3.6
Specialist	9.5	12.2	6.9	11.7	9.6	5
Non-Physician Mental Health	3.0	2.7	4.4	5.4	6.2	0.8
Ancillary	0.8	0	2	2.2	5.4	1.8
OB/GYN	4.6	4.0	6.2	6.6	4.2	2.2

The Plan reviews individual provider/group results against prior quarters. The Plan conducts provider outreach education as appropriate and maintains ongoing quarterly tracking/trending.

For all providers identified as newly noncompliant during Q3 2023, the Plan sent letters notifying the providers of the survey results and Plan policy (template attached).

Follow-up Survey Results

In Q3 2023, the Plan conducted a follow-up survey, resurveying all providers found to be previously noncompliant with appointment availability standards in Q2 2023. The previously noncompliant providers consisted of 2 primary care providers, 7 specialists and 1 non-physician mental health provider.

Based on the results of this follow-up survey, the Plan identified the 2 primary care providers, 4 of the specialists and the 1 non-physician mental health provider are now compliant. However, 3 specialists continue to be noncompliant. Of the 3 noncompliant specialists, 2 were noncompliant for a third consecutive quarter – Kern Medical Neurology and Kern Medical Ophthalmology. The Deputy Director of Provider Network and Provider Relations Supervisor have reached out directly to the noncompliant providers to discuss the results of the survey and the Plan's accessibility standards. Kern Medical Neurology reported that they have a provider returning from maternity leave in November, hired additional midlevel providers, and were looking to hire more additional midlevel providers. Kern Ophthalmology reported they had purchased a new medical device that helps diagnose patients allowing the providers to so more patients in shorter amounts of time. The Plan determined that neither provider would be put on a Corrective Action Plan at this time as both providers have put corrective measures into place. The Plan will not resurvey Kern Medical Neurology nor Kern Medical Ophthalmology in Q4 2023 as they are putting their corrective measures into place, and the Plan will wait until Q1 2024 to resurvey the providers. The Plan will continue to work with the providers and offer any assistance to facilitate them in becoming compliant.

Provider Accessibility Monitoring Survey

Q3, 2023

Hours Of Operation

Per KHS Policy, *4.30-P Accessibility Standards*, contracted providers must offer their KHS Medi-Cal members hours of operation that are no less than the hours of operation offered to non-Medi-Cal patients, or to Medi-Cal fee-for-service beneficiaries if the Network Provider serves only Medi-Cal beneficiaries.

To monitor this standard, the randomly sampled providers were contacted via phone and asked about their hours of operation and appointment time offered based on the health insurance of the patient.

The results of the survey confirmed the Plan and all providers were in compliance with the hours of operation and appointment offered standard.

Return Call Response Times

Per KHS Policy, *4.30-P Accessibility Standards*, providers must maintain a reasonable level of telephone accessibility to KHS members, and at minimum, the following response times are required:

Nature of Telephone Call	Response time
Urgent Medical	30 Minutes
Non-Urgent Medical	By close of following business day

To monitor these standards, the randomly sampled providers were contacted via phone and asked for the return time of a telephone call based on nature of the call.

The Plan compiled provider responses to calculate an average response time for an Urgent Medical call. The average response time for Urgent Medical calls was **10.2 hours** for Q3 2023. **Based on these results, the Plan was determined to be noncompliant with the response time standard for Urgent Medical Calls in Q3 2023.**

The Plan compiled provider responses to calculate an average response time for a Non-Urgent Medical call. The average response time for Non-Urgent Medical calls was **28.5** for Q3 2023. **Based on these results, the Plan was determined to be noncompliant with the response time standard for Non-Urgent Medical Calls in Q3 2023.**

Per KHS Policy, *3.15-I 24-Hour Telephone Triage Service*, Kern Health Systems has a contractual relationship with a third-party vendor to provide KHS membership with 24-hour advice and triage of member's telephone calls for medical and behavioral health issues.

Provider Accessibility Monitoring Survey

Q3, 2023

Phone Answering Timeliness Results

Per KHS Policy, *4.30-P Accessibility Standards*, providers must answer or design phone systems that answer phone calls within six rings.

To monitor this standard, the randomly sampled providers were contacted via phone and the count of telephone rings prior to answering the call were collected.

The Plan compiled collected data to calculate an average rings to answer. The average rings to answer was **2.1 rings**. **Based on these results, the Plan was determined to be compliant with the rings to answer standard in Q3 2023.**

	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023
Average rings to answer	1.9	2.9	2.4	1.4	1.8	2.1

In-office Wait Times

Per KHS Policy, *4.30-P Accessibility Standards,* providers must maintain in-office wait times within the following standards:

Service	Required Care	
	Urgent	Routine
Primary Care Services (including OB/GYN)	1 hour	1 hour
Specialty Care Services	1 hour	1 hour
Diagnostic Testing	1 hour	1 hour
Mental Health Services	1 hour	1 hour
Ancillary Providers	1 hour	1 hour

Providers are not held to the office waiting time standards for unscheduled, non-emergent, walk-in patients.

To monitor these standards, the randomly sampled providers were contacted via phone and asked for the current wait time for patients within their office.

The Plan compiled provider responses to calculate an average in-office wait time. The average in-office wait time was **14.5 minutes** for Q3 2023. **Based on these results, the Plan was determined to be compliant in-office wait time standard.**

All individual office results were compliant with the in-office wait time standard.

KERN HEALTH SYSTEMS

Access Grievance Review

Quarter 3, 2023

(Q1 2023 Review Period)

Provider Network Management

Access Grievance Review

Q3, 2023 (Q1 2023 Review Period)

KERN HEALTH SYSTEMS

Introduction and KHS Policy and Procedure

As outlined in KHS policy 5.01-P, *Member Grievance*, member grievances are documented, investigated, and resolved within thirty (30) calendar days by the KHS Member Services Department. On a quarterly basis, KHS' Provider Network Management Department reviews all access grievances from the previous quarter, in order to identify any potential access issues or trends within the Plan's network or amongst the Plan's contracted providers. The time standards for access to a primary care appointment, specialist appointment, in-office wait time, and provider telephone are outlined in KHS policy *4.30-P Accessibility Standards.*

Categorization

As of Q2 2020, the Member Service Department uses twenty-three DHCS recognized Grievance Types (or "dispositions") to categorize grievances. Grievances categorized as *Geographic Access*, *Provider Availability*, *Technology/Telephone*, or *Timely Access* are considered access grievances for the purposes of this review. The Plan reviews these grievance types against prior quarters, and the graphs utilized within this review only includes data that is in line with these grievance types.

Grievance Totals

There were **ninety-one (91)** access-related grievances in Q1 2023. In **fifty (50)** of the cases in Q1 2023, no issues were identified and were closed in favor of the Plan. The remaining **forty-one (41)** cases n Q1 2023 were closed in favor of the enrollee; the KHS Grievance Department sent letters to the providers involved in these cases, notifying them of the outcome.

The **forty-one (41)** grievances in Q1 2023 that were closed in favor of the enrollee were forwarded to the Plan's Provider Network Management Department. For each of these grievances, the members initial complaint, the provider's response, the Members Service Department's investigation, and the Grievance Committee's decision are reviewed by the Provider Network Management Department.

The access grievances found in favor of the enrollee for Q1 2023 categorized by the KHS Grievance Department as follows:

Timely Access	**17**
Provider Availability	**8**
Technology / Telephone	**16**

Access Grievance Review

Q3, 2023 (Q1 2023 Review Period)

Tracking and Trending

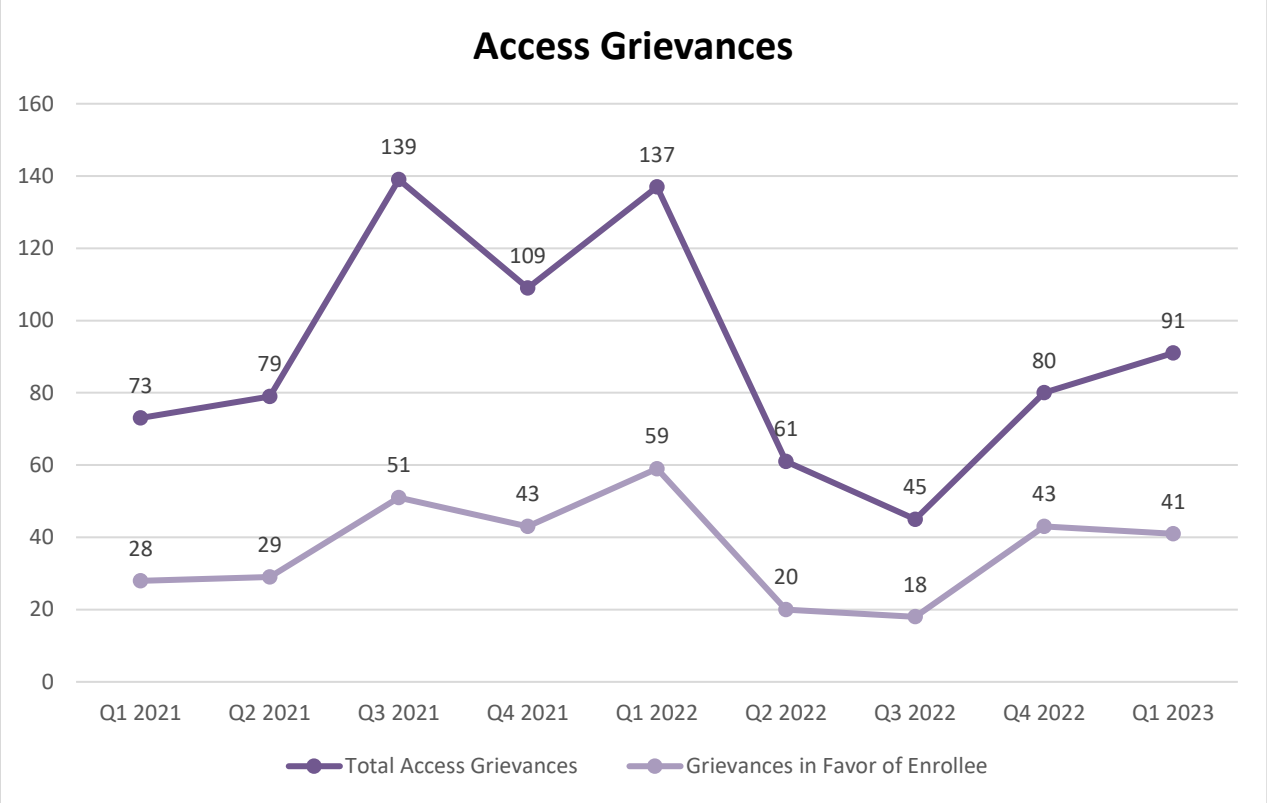
The Provider Network Management Department reviewed all access grievances found in favor of the enrollee received in Q1 2023 to identify any potential access issues or trends within the Plan's network or amongst the Plan's contracted providers. In addition to a review conducted against prior quarters, the Plan reviews Access Grievances against outcomes of other monitoring conducted as part of the quarterly *Provider Network Management, Network Review* (e.g. Appointment Availability Survey, DHCS' QMRT review, Network Adequacy).

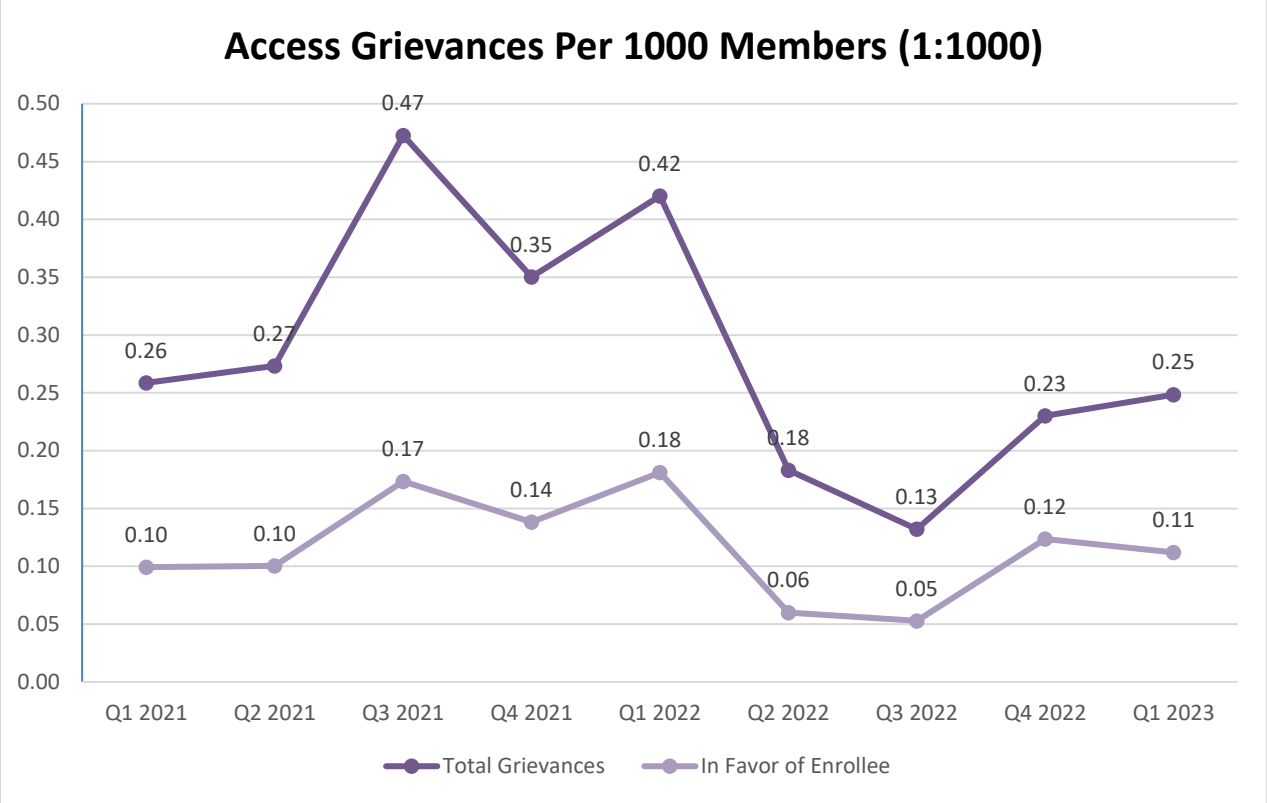
Upon review of Q1 2023 access grievances, the Plan identified the grievances increased from Q4 2022 to Q1 2023. The Plan's Access Grievances Per 1000 members for grievances found in favor of the enrollee decreased to 0.11 in Q1 2023 from 0.12 in Q4 2022. The increase in access grievances is due to a DHCS audit finding for Quality-of-Care grievances, which required new grievance processes to be put in place beginning August 1, 2022. One of the new processes required exempt grievances to be reviewed by the Quality Improvement department to ensure no Quality-of-Care grievances were missed. Because all exempt grievances were sent to the Quality Improvement department, more access grievances were identified. Moving forward, the Plan believes these increases will be the new normal count.

The Plan reviews grievances across a four-quarter rolling review period. Trends that are identified are reviewed with the Provider Relations Manager on a case-by-case basis to develop a target-based strategy to address. During Q1 2023, the Plan did not identify any trends. The Plan will continue to monitor access grievances for potential trends via the quarterly access grievance review.

Access Grievance Review

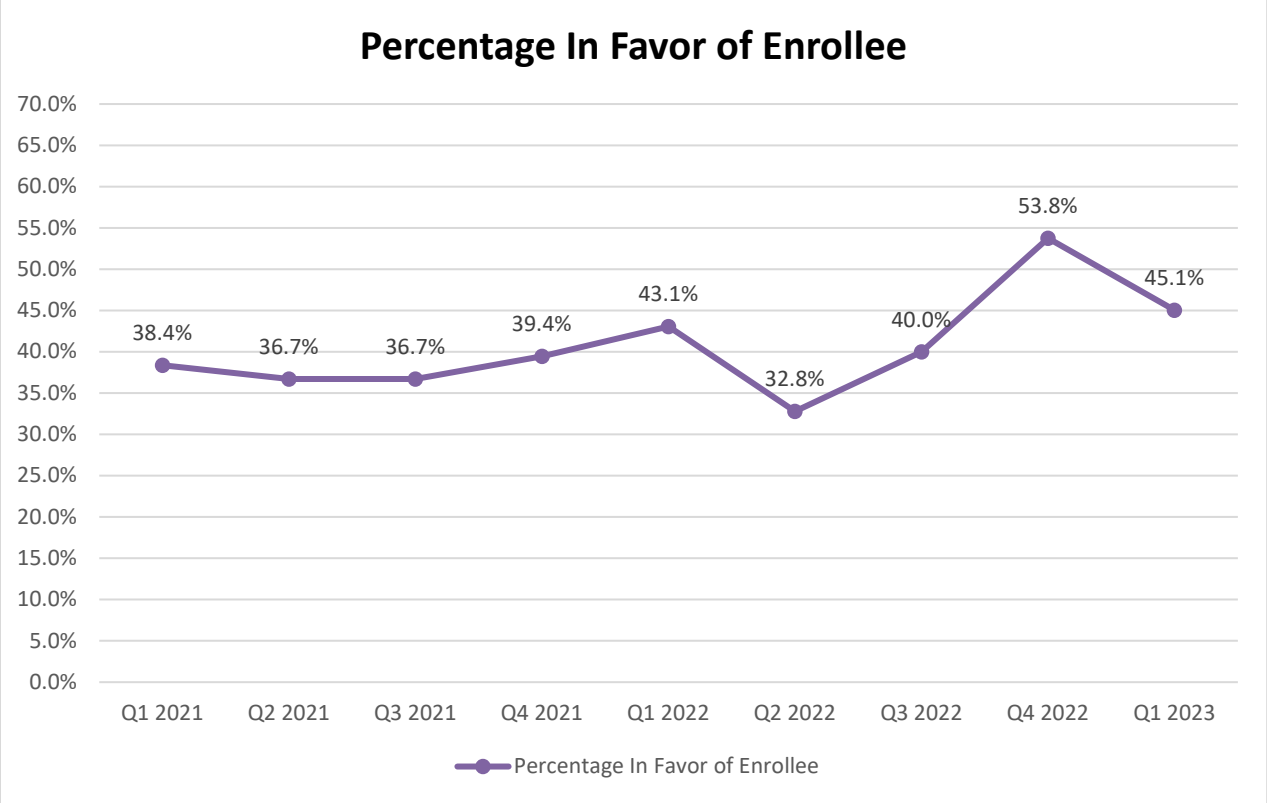
Q3, 2023 (Q1 2023 Review Period)

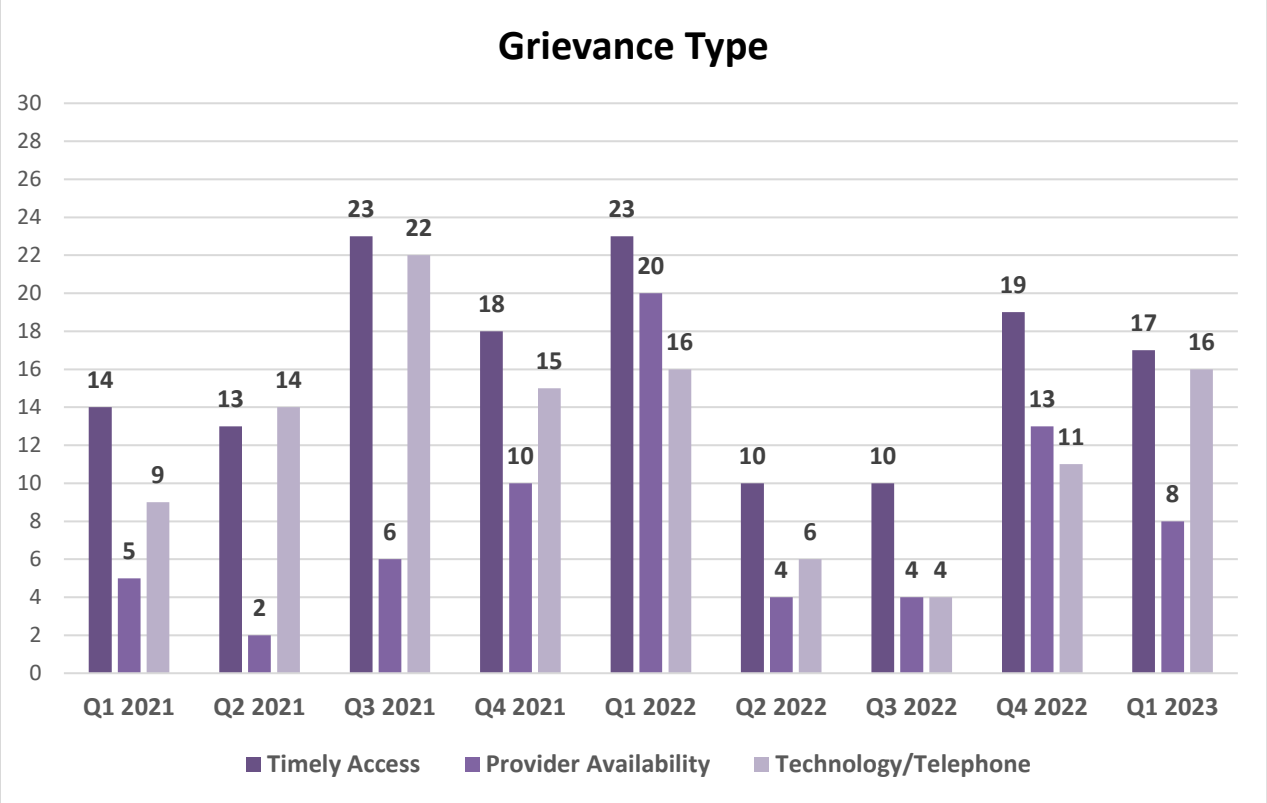




Access Grievance Review

Q3, 2023 (Q1 2023 Review Period)





Access Grievance Review

Q3, 2023 (Q1 2023 Review Period)

KERN HEALTH SYSTEMS

Exempt Grievances

On a quarterly basis, the Plan's Provider Network Management Department reviews all exempt grievances to identify potential trends amongst the provider network. For Q1 2023, there were a total of **1,924** exempt grievances.

Grievance Type	Q3 Count	Q3% of Total	Q4 Count	Q4% of Total	Q1 Count	Q1% of Total
Assault/Harassment	2	0.09%	0	0.00%	0	0.00%
Authorization	92	3.91%	31	1.71%	32	1.66%
Billing	24	1.02%	0	0.00%	0	0.00%
Case Management/Care Coordination	8	0.34%	4	0.22%	3	0.16%
Continuity of Care	38	1.62%	37	2.03%	6	0.31%
Denial of Payment Request	0	0.00%	0	0.00%	1	0.05%
Denial of Request to Dispute Financial Liability	0	0.00%	0	0.00%	2	0.10%
Eligibility	7	0.30%	1	0.06%	2	0.10%
Enrollment	5	0.21%	1	0.06%	46	2.39%
Injury	0	0.00%	1	0.06%	0	0.00%
Language Access	20	0.85%	13	0.77%	11	0.57%
Out-of-Network	0	0.00%	0	0.00%	4	0.21%
PHI/Confidentiality/HIPAA	2	0.09%	1	0.06%	0	0.00%
Plan Customer Service	1	0.04%	110	6.06%	167	8.68%
Physical Access	0	0.00%	4	0.22%	1	0.05%
Plan's Reduction/Suspension / Termination of Previously Authorized Service	0	0.00%	0	0.00%	3	0.16%
Provider/Staff Attitude	932	39.66%	662	36.47%	776	40.33%
Provider Availability	162	6.89%	114	6.28%	81	4.21%
Provider Direct Member Billing	0	0.00%	0	0.00%	5	0.26%
Referral	37	1.57%	7	0.39%	35	1.82%
Scheduling	79	3.36%	51	2.81%	47	2.44%
Technology/Telephone	170	7.23%	133	7.33%	152	7.90%
Timely Access	728	30.98%	621	34.21%	517	26.87%
Timely Response To Auth/Appeal Request	0	0.00%	0	0.00%	2	0.10%
Transportation (Driver Punctuality/Vehicle)	43	1.83%	3	0.17%	31	1.61%
Grand Total	**2350**		**1815**		**1924**	

In reviewing these totals against prior quarters, the Plan recognized exempt grievances increased from Q4 2022 to Q1 2023. The Plan identified an increase in the percentage of Plan Customer Service and Enrollment exempt grievances in Q1 2023. The Plan identified a decrease in the percentage of Timely Access exempt grievances in Q1 2023.

These changes are due to the new processes put in place requiring all exempt grievances being reviewed by the Quality Improvement department which led to changes in types of grievances. The Plan will continue to monitor exempt grievances for potential trends via the quarterly access grievance review.

Valid Values	The first three characters shall be the plan code, the rest of the characters will be a unique value for each record submitted (not just unique within this submission, but unique across time).
Edits	• First three characters must equal planCode • No duplicates with historical data

2.1.20 Grievance Received Date

File Layout Name	grievanceReceivedDate			
Data Format	Date			
Description	The date the plan received the grievance.			
Usage	**Grievances:**	**Required**	**Appeals:**	Not used
	COC:	Not used	**OON:**	Not used
Valid Values	CCYYMMDD			
Edits	• Must represent a date prior to the current month			

2.1.21 Grievance Type

File Layout Name	grievanceType			
Data Format	Array (May have multiple occurrences) X(36)			
Description	Define the type or types of grievance. Must have at least one value, but may have multiple values.			
Usage	**Grievances:**	**Required (one or more)**	**Appeals:**	Not used
	COC:	Not used	**OON:**	Not used
Valid Values	**Value**	**Definition**		
	Continuity Of Care	Grievance related to continuity of care review standard. Member's perception that their request for continuity of care is being rejected or not considered.		

	Geographic Access	Grievance related to geographic access to a state plan approved provider, pharmacy or hospital within the geographic requirements based on type of appointment and condition of member's health.
	Language Access	Grievance related to the inability to access or concerns with linguistic and interpreter services at the providers office.
	Out-of-Network	Grievance related to inability to obtain services from a non-contracted provider.
	Physical Access	Grievance related to the inability to physically access a provider or health plan due to office closure, not having wheelchair access, inadequate ramp, elevators, inadequate parking, or other requirements under the American with Disabilities Act.
	Provider Availability	Grievance related to the inability to see providers during normal hours of operation or concerns with the providers' hours of operation.
	Timely Access	Grievance related to timely access to a state plan approved provider within the timeframe requirements based on type of appointment and condition of member's health.
	Transportation	Grievance related to inability to access or concerns with transportation services.

	Discrimination	Grievance regarding alleged discrimination by the health plan, provider, or provider's staff based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental or physical disability, medical condition, genetic information, marital status, gender, gender identity, gender expression, or sexual orientation. May also include complaints where the member is treated differently after filing a grievance.
	Disability Discrimination	Grievance regarding alleged discrimination by the health plan, provider, or provider's staff based on disability. Include allegations of failure to provide auxiliary aids, or to make reasonable accommodations in policies and procedures, when necessary to ensure equal access for persons with disabilities.
	Fraud / Waste / Abuse	Grievance related to intentional or unintentional misuse of resources, fraudulent, non-compliant, dishonest or unethical conduct committed by a health network, plan, provider, vendor, consultant, and current or potential member.
	PHI / Confidentiality / HIPAA	Grievance related to the breach of Personal Health Information (PHI) or confidentiality. Privacy rules were not followed. For example, complaints regarding the provider inappropriately accessing, using or disclosing a member's PHI.

	Billing	Grievance related to bills received in error, premium and debt collection notices, reimbursement request, claim adjustment request or bills received after member was told issues were resolved. May include complaints regarding charges for non-covered services, benefits, or drugs not covered, etc.
	Authorization	Grievance related to the timeliness of an authorization or communication regarding the result (approval, denial or modification) of the authorization
	Eligibility	Grievance related to Medi-Cal plan member's eligibility or share of cost requirements.
	Enrollment	Grievance related to Medi-Cal plan enrollment information received, enrollment process, Medi-Cal plan member being disenrolled from plan, providers, or any of its health network, etc.
	Referral	Grievance related to the MCP's processing of referrals to covered services.
	Assault / Harassment	Grievance related to the physical, emotional, or sexual misconduct by a medical professional.
	Case Management / Care Coordination	Grievance related to case management or care coordination.
	Inappropriate Care	Grievance related to the overuse, underuse, or misuse of health care services.

	Member Informing Materials	Grievance regarding written materials provided in alternative formats or translation in threshold languages.
	Provider / Staff Attitude	Grievance related to inappropriate behavior, poor provider/staff attitude (includes non-clinical staff, etc.), rudeness, or mistreatment.
	Technology / Telephone	Grievance related to on-line scheduling systems, health plan system's connectivity, user friendliness, excessive waits, accessibility, via plan's website; or a member's inability to reach a provider or health plan's staff via phone or waiting on the phone too long.
Edits	• Must be in list of valid values • May have multiple values	

2.1.22 MER COC Disposition Date

File Layout Name	merCocDispositionDate			
Data Format	Date			
Description	The date on which The MER COC was determined either Met or Not Met			
Usage	**Grievances:**	Not used	**Appeals:**	Not used
	COC:	**Situational**	**OON:**	Not used
Valid Values	CCYYMMDD			
Edits	• Must be a valid date • Must be a past date • Must be present if cocType = MER Denial • Must be blank if cocType <> MER Denial			

KERN HEALTH SYSTEMS

Geographic Accessibility & DHCS Network Certification

Quarter 3, 2023

Geographic Accessibility & Network Certification

Q3, 2023

Geographic Accessibility

As required by the Department of Managed Health Care (DMHC) and the Department of Health Care Services (DHCS), Kern Health Systems (KHS) is required to maintain time and distance standards for certain provider types.

Per Section 1300.51 (d)(H) of the California Code of Regulations, KHS shall ensure, "all enrollees have a residence or workplace within **thirty (30) minutes or fifteen (15) miles** of a contracting or plan-operated **primary care provider**" as well as "**within thirty (30) minutes or fifteen (15) miles** of a contracting or plan-operated **hospital**". Further, per Section 1300.67.2.1(b), if "a plan's standards of accessibility […] are unreasonable restrictive […] the plan may propose alternative access standards of accessibility for that portion of its service area.

Per Exhibit A, Attachment 6 of the KHS contract with the DHCS, KHS, "shall maintain a network of **Primary Care Physicians** which are located **within thirty (30) minutes or ten (10) miles** of a member's residence unless [KHS] has a DHCS-approved alternative time and distance standard."

For all geographic areas in which the Plan does not currently meet the regulatory accessibility standard, The Plan monitors and maintains an alternative access standard that has been reviewed and approved by the DMHC and/or DHCS.

DHCS Annual Network Certification – 2022/2023

DHCS Network Adequacy Standards	
Primary Care (Adult and Pediatric)	10 miles or 30 minutes
Specialty Care (Adult and Pediatric)	45 miles or 75 minutes
OB/GYN Primary Care	10 miles or 30 minutes
OB/GYN Specialty Care	45 miles or 75 minutes
Hospitals	15 miles or 30 minutes
Non-Specialty Mental Health (Adult and Pediatric)	45 miles or 75 minutes

As a part of the Annual Network Certification requirement, outlined in APL 23-001, the Plan is required to submit geographic access analysis outlining compliance with the above-listed standards. For all zip codes in which the Plan was not compliant with an above-listed standard, the Plan is able to submit an alternative access standard (AAS) request.

The Plan completed the Accessibility Analysis of the Annual Network Certification (ANC) reporting during Q1 2023. The Plan submitted 51 AAS requests which was in line with the prior Annual Network Certification AAS requests (44). In Q2 2023, the DHCS completed its review of the Plan's AAS requests. The DHCS denied 14 of the Plan's AAS requests and returned to the Plan for revision. The Plan revised the 14 AAS requests and submitted them to the DHCS. As of Q3 2023, the revised AAS requests were still being reviewed by the DHCS.

In Q3 2023, the Plan was notified by the DHCS that they would be utilizing ArcGIS to map compliance with Time or Distance requirements with the 2023 ANC. The DHCS requested Plan feedback due to the "notable differences" from the ANC 2022. The Plan responded to the DHCS in Q4 2023.

KERN HEALTH SYSTEMS

Network Adequacy & Provider Counts

Quarter 3, 2023

Network Adequacy & Provider Counts

Q3, 2023

Introduction

Per CCR § 1300.67.2, Kern Health Systems (KHS) shall maintain, "at least one full-time equivalent physician to each one thousand two hundred (1,200) enrollees and […] approximately one full-time equivalent primary care physician for each two thousand (2,000) enrollees."

During Q3/Q4 2018, KHS, in conjunction with guidance from the Department of Managed Health Care (DMHC), developed and adopted an updated methodology for determining full-time equivalency for contracted providers. KHS memorialized this methodology in Policy 4.30-P *Accessibility Standards;* this policy was submitted to the DMHC and received approval on 12/14/2018.

Per KHS policy, 4.30-P *Accessibility Standards, §4.6 Full-time equivalent (FTE) Provider to Member Ratios,* "Full-time equivalency shall be determined via an annual survey of KHS' contracted providers to determine the percentage of time allocated to Plan's beneficiaries. The results of the survey will be used to calculate an average FTE percentage which will be applied to the Plan's network of providers when calculating the physician-to-enrollee compliance ratios. The methodology for the survey, results of the survey, and network capacity review of above ratios, will be reported annually to the KHS QI/UM Committee. Due to a maximum member assignment of 1,000 Mid-level providers serving in the Primary Care capacity will be counted as .5 of a PCP FTE, prior to percentage calculation."

Survey Methodology and Results

In 2020, KHS contracted with SPH Analytics to conduct our annual Provider Satisfaction Survey; as a part of that survey, responding providers were asked, "*What portion of your managed care volume is represented by Kern Health Systems?"* Outreach for the survey was placed to every contracted provider within the Plan's network. Responses received, and FTE calculations based on those responses, do not account for providers who refuse to participate in the survey. KHS used the responses collected from Primary Care Providers to calculate the FTE for Primary Care Providers, and used the responses collected from Primary Care Providers and Specialists to calculate the FTE for Physicians.

KHS utilized SPH Analytics, an NCQA certified survey vendor, to conduct the survey for 2022. SPH's methodology involved two waves of mail and Internet, with a third wave of phone follow up to administer the survey.

Based on the results of 2022 survey, KHS calculated a network-wide FTE percentage of **58.19% for Primary Care Providers** and **47.11% for Physicians.**

Network Adequacy & Provider Counts

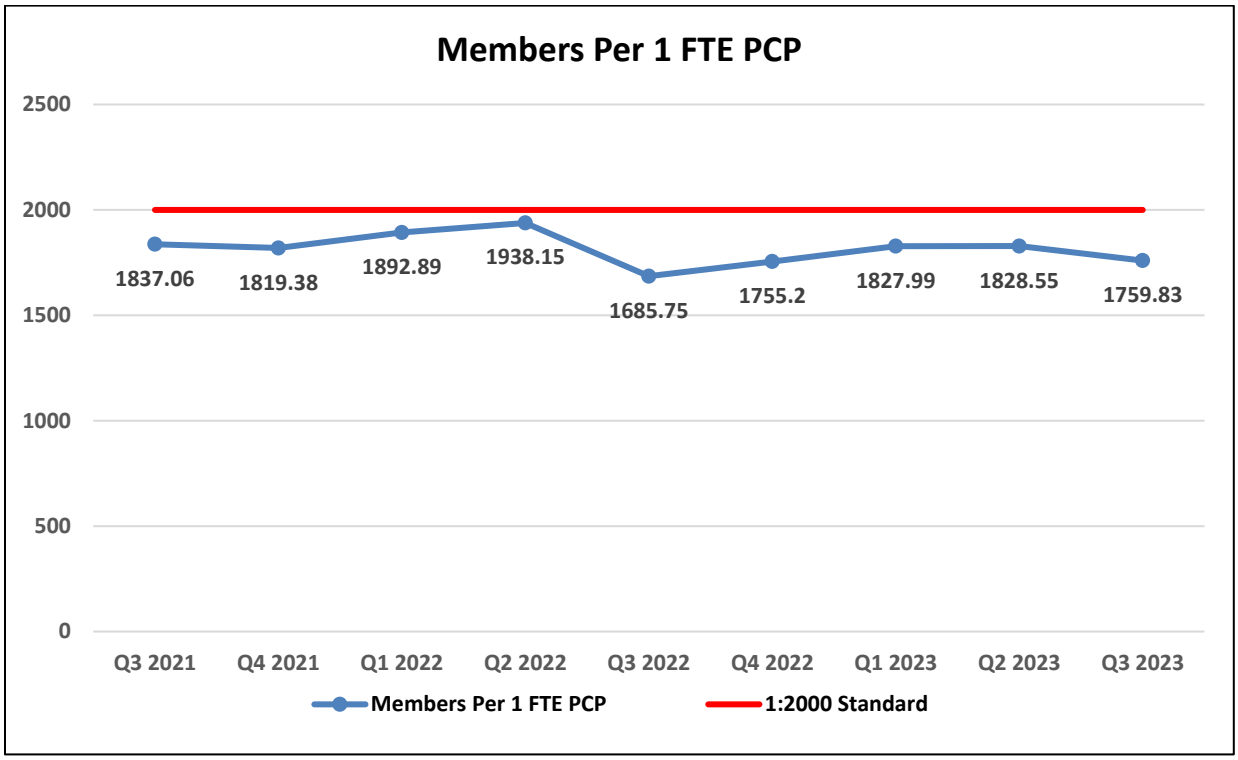
Q3, 2023

Full Time Equivalency Compliance Calculations

Of KHS' 366,073 membership at the close of Q3 2023, 15,835 were assigned and managed by Kaiser and did not access services through KHS' network of contracted providers; due to this, Kaiser managed membership is not considered when calculating FTE compliance.

As of the end of Q3 2023, the plan was contracted with 458 Primary Care Providers, a combination of 226 physicians and 232 mid-levels. Based on the FTE calculation process outlined above, with a 58.19% PCP FTE percentage, KHS maintains a total of **199.02 FTE PCPs**. With a membership enrollment of 350,238 utilizing KHS contracted PCPs, KHS currently maintains a ratio of **1 FTE PCP to every 1759.83 members**; KHS is compliant with state regulations and Plan policy.

PCP to Member Ratio

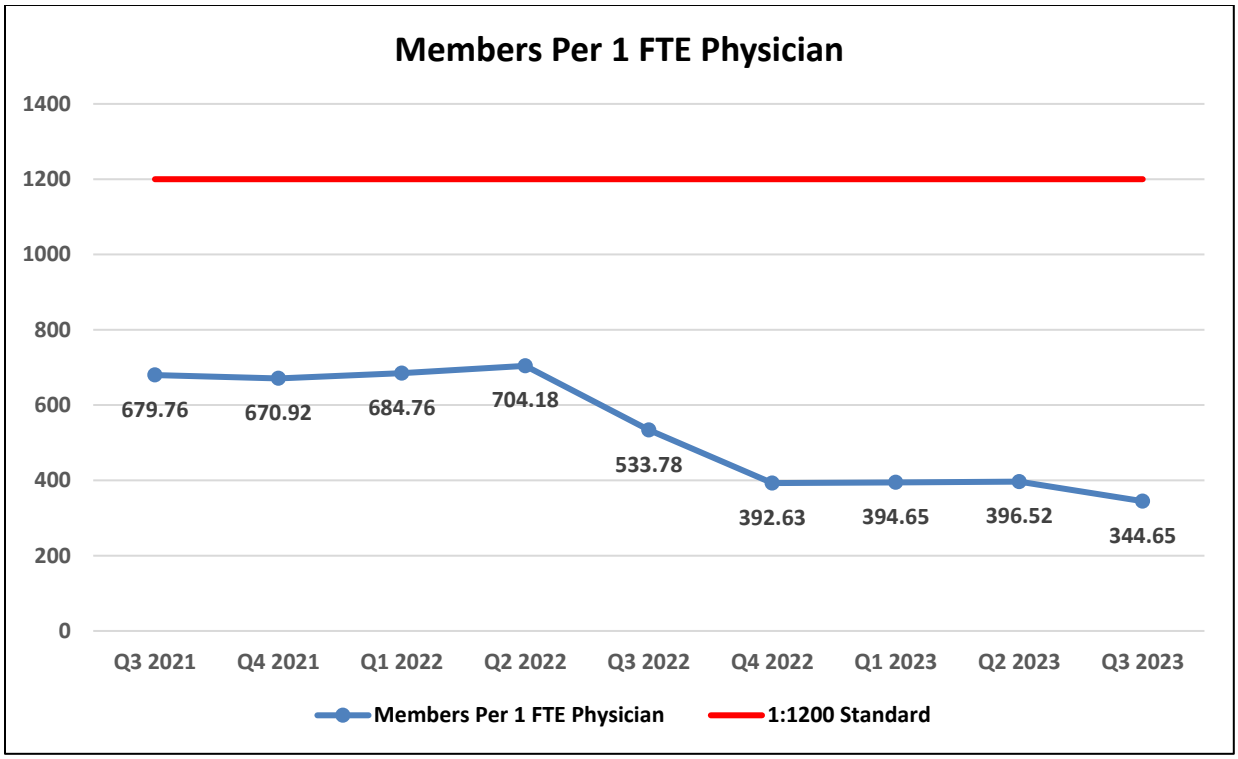


As of the end of Q3 2023, the plan was contracted with 2,157 Physicians. Based on the FTE calculation process outlined above, with a 47.11% Physician FTE percentage, KHS maintains a total of **1016.23 FTE Physicians**. With a total membership enrollment of 356,998 utilizing KHS contracted Physicians, KHS currently maintains a ratio of **1 FTE Physician to every 344.65 members**; KHS is compliant with state regulations and Plan policy.

Network Adequacy & Provider Counts

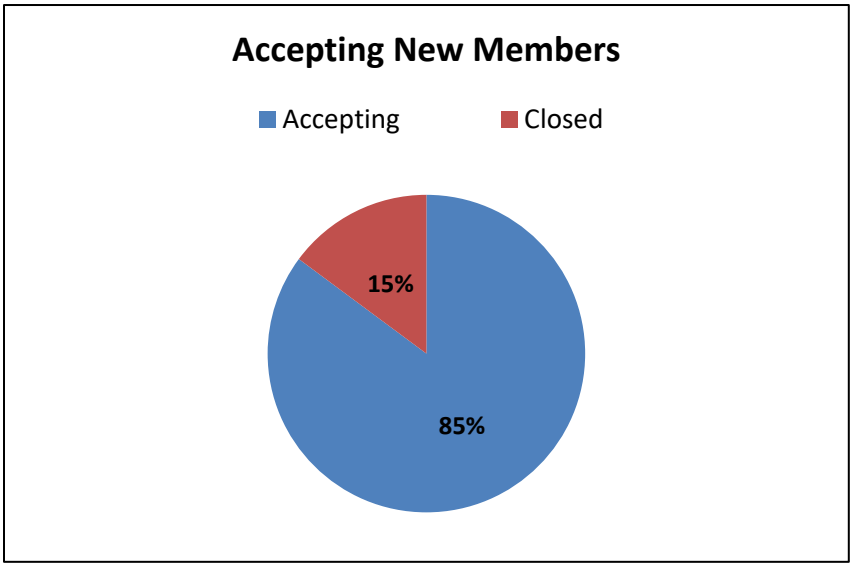
Q3, 2023

Physician to Member Ratio



Accepting New Members

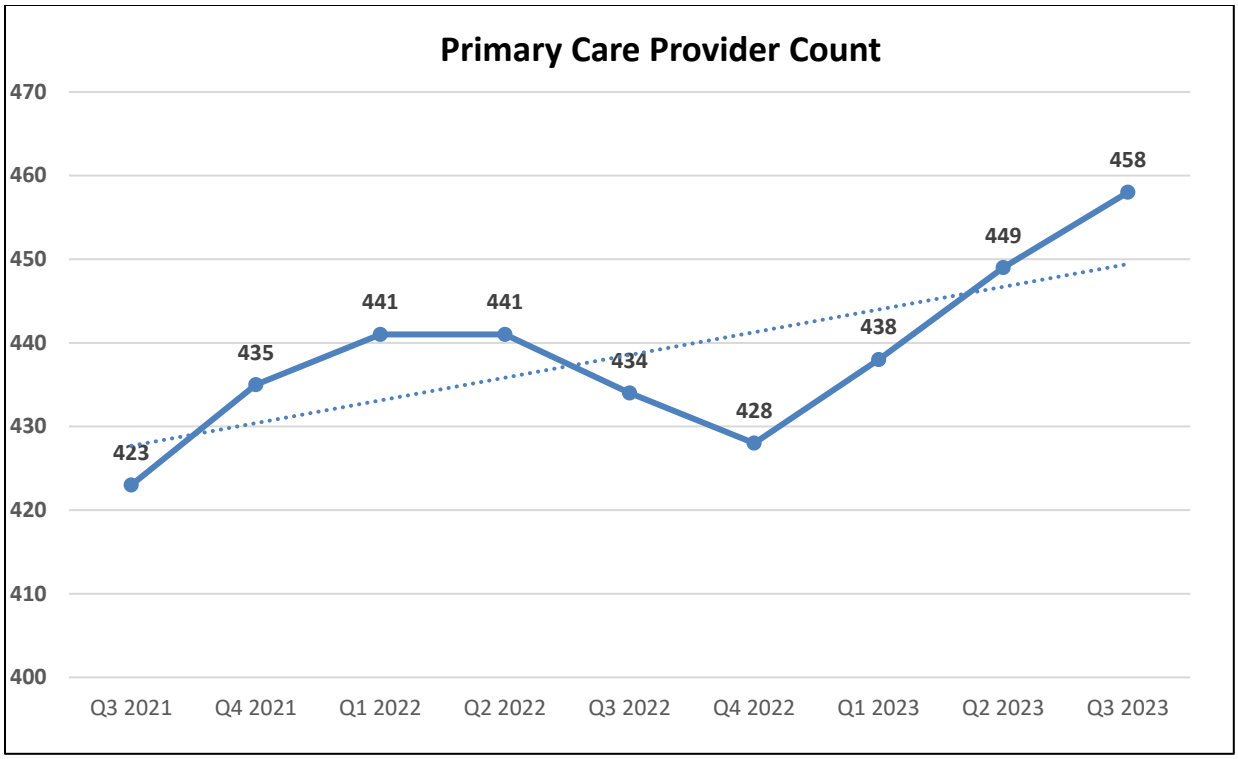
In addition to the Full Time Equivalency Compliance review conducted above, the Plan monitors adequacy of its Primary Care Network by reviewing the count/percentage of Primary Care Providers (PCP) who are accepting new members. **The Plan calculated that 85% of the network of Primary Care Providers is currently accepting new members at a minimum of one location**. The Plan will continue to monitor this percentage quarterly to ensure it maintains an adequate network of Primary Care Providers.

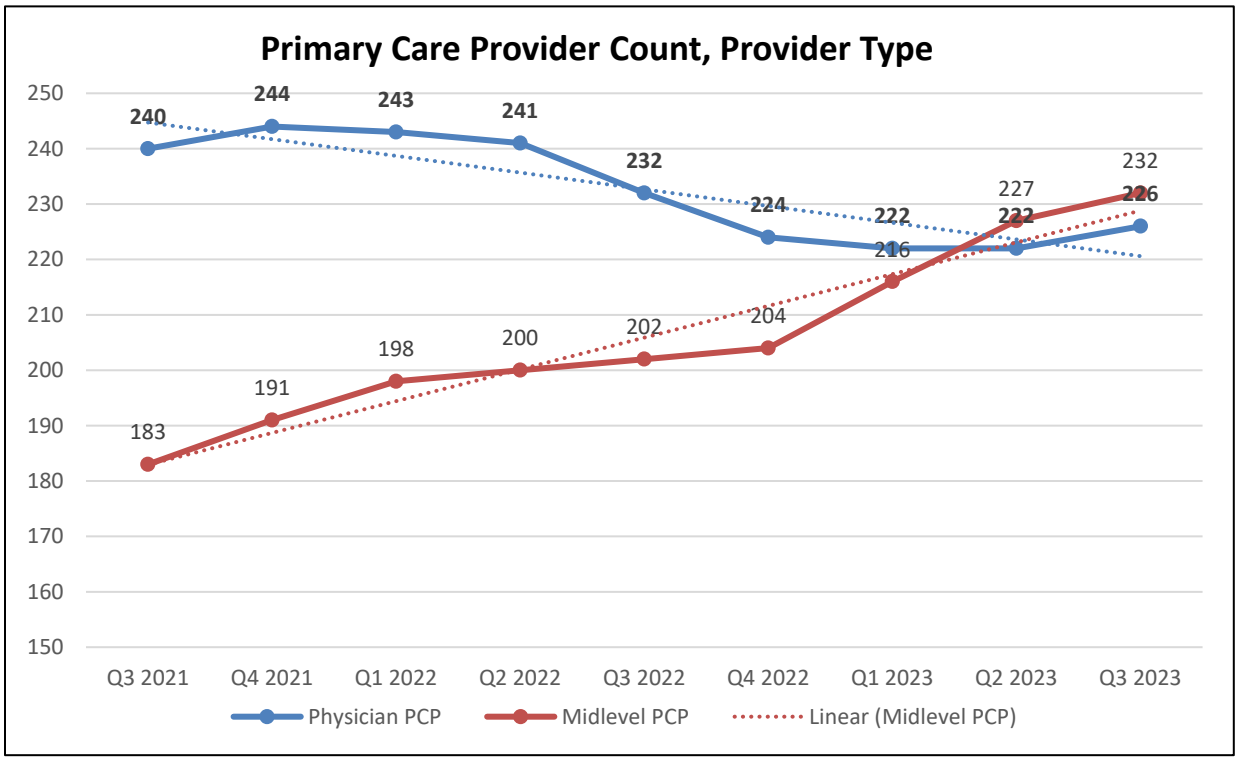


Network Adequacy & Provider Counts

Q3, 2023

Provider Counts – Primary Care Providers

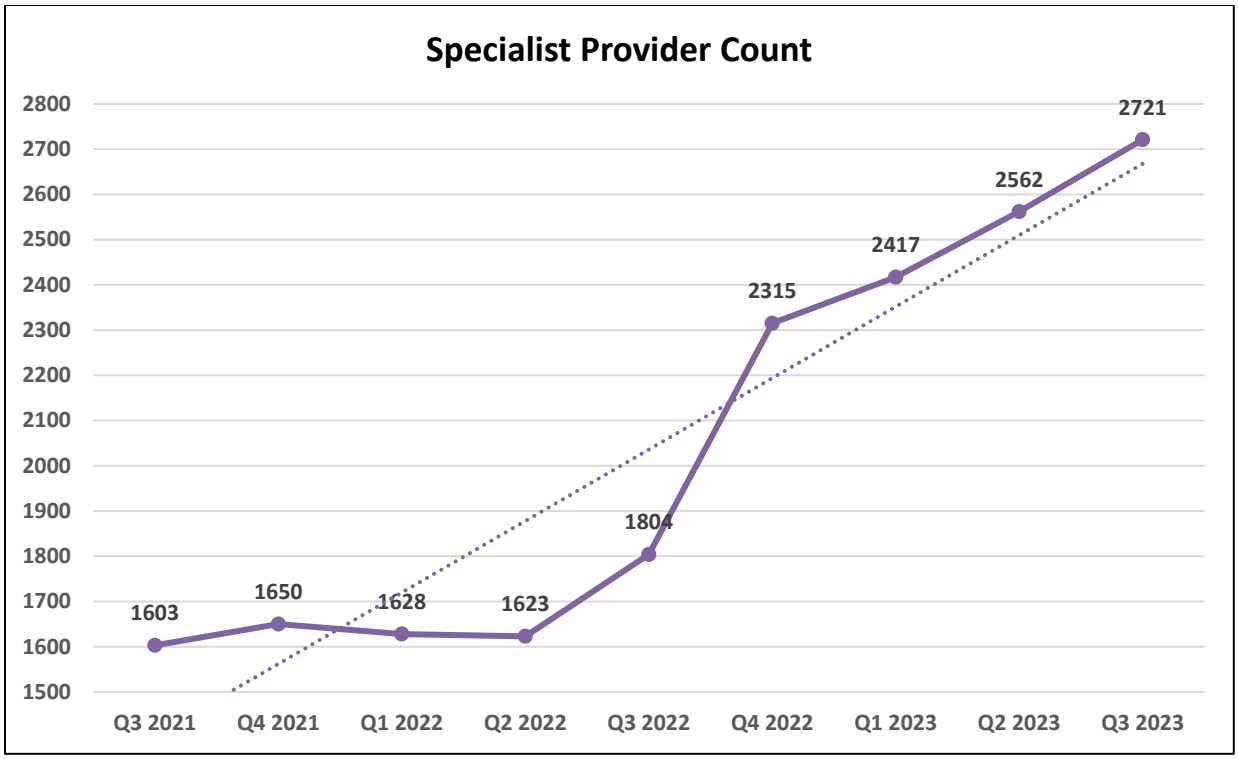




Network Adequacy & Provider Counts

Q3, 2023

Provider Counts – Specialist Providers



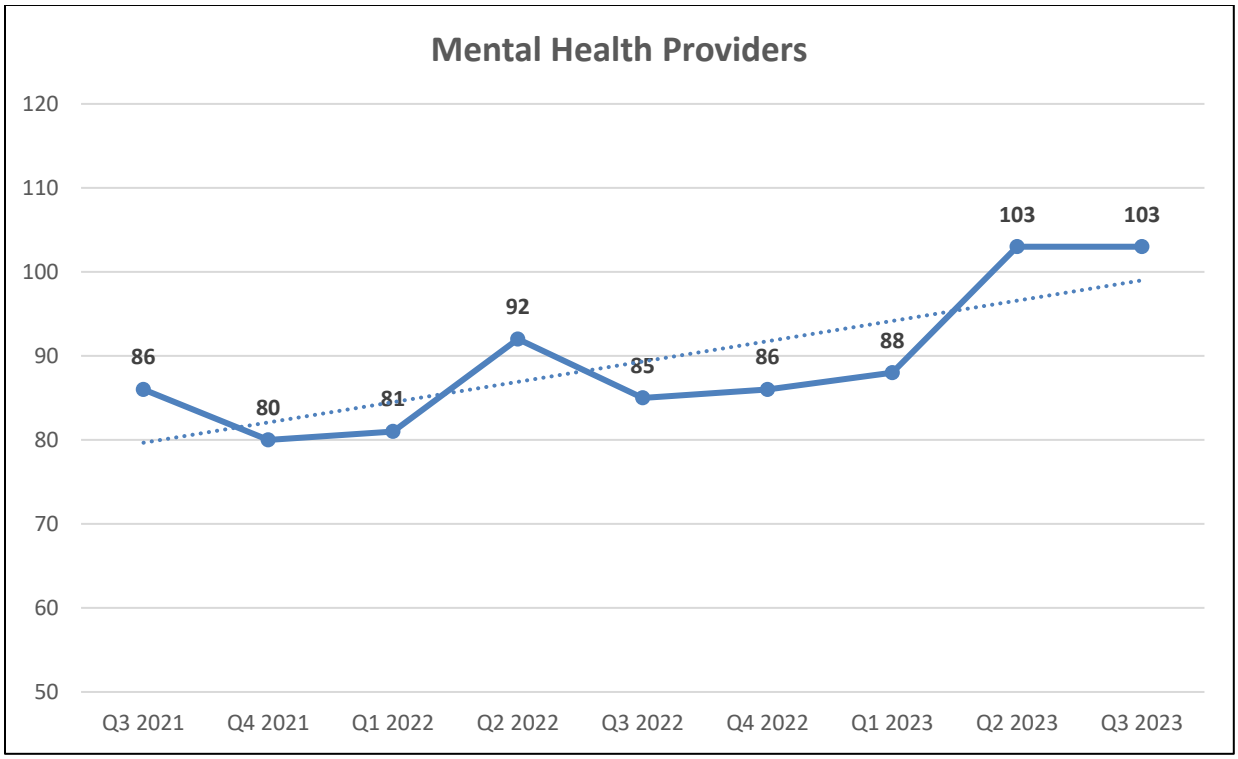
	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023
Cardiology	46	46	45	45	46	44	43	46	45
Dermatology	35	35	39	39	43	45	46	47	51
Endocrinology	23	24	25	25	26	26	27	25	28
Gastroenterology	21	24	24	26	31	33	33	35	34
General Surgery	59	62	65	60	63	64	63	62	59
Hematology	19	23	20	21	23	23	22	27	22
Infectious Disease	8	8	8	8	12	11	11	11	12
Nephrology	27	28	25	28	36	32	26	27	25
Neurology	25	25	22	26	29	29	33	33	31
Oncology	25	27	26	26	27	26	25	23	25
Ophthalmology	29	28	27	26	30	32	32	29	34
Orthopedic Surgery	21	22	23	26	29	32	32	32	32
Otolaryngology	9	9	9	9	13	14	14	12	15
Physical Med & Rehab	10	10	10	10	9	8	9	9	9
Psychiatry	48	53	54	53	57	65	67	64	68
Pulmonary Disease	17	20	20	20	21	21	21	20	28

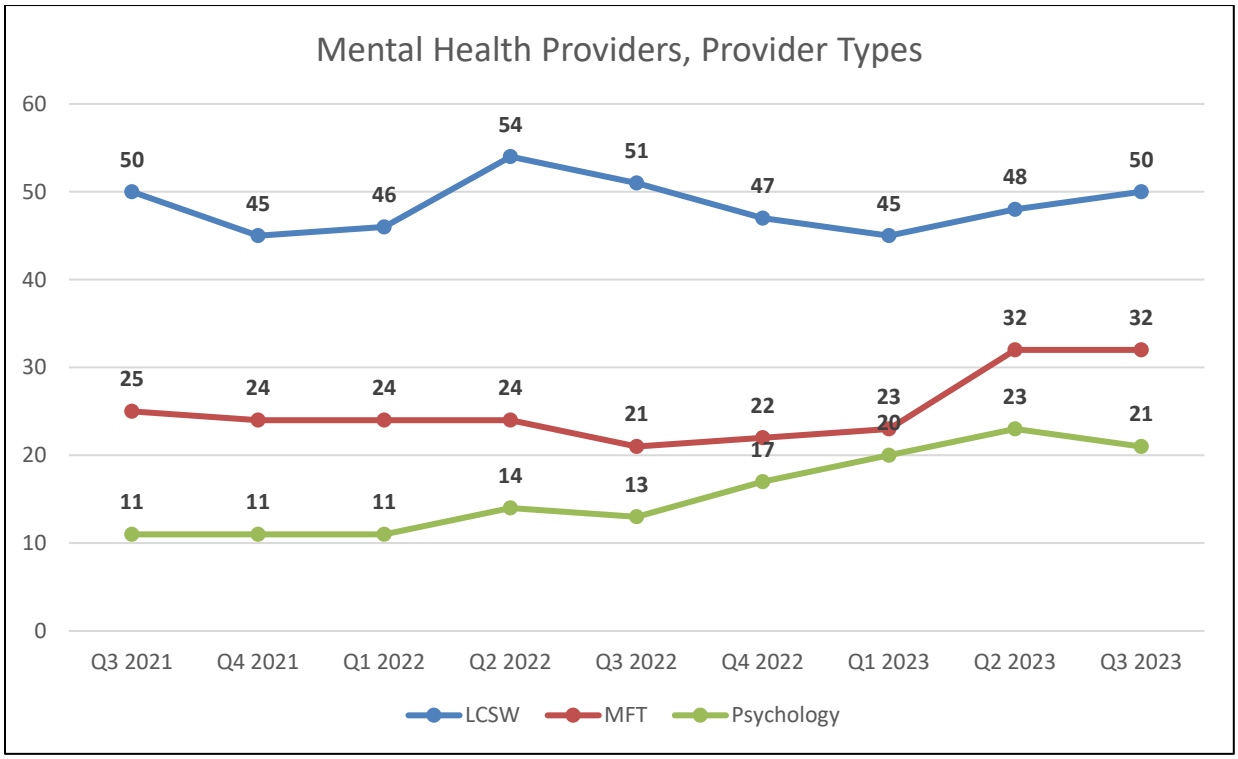
> 5% Increase		> 5% Decrease	
≤ 5% Increase		≤ 5% Decrease	

Network Adequacy & Provider Counts

Q3, 2023

Provider Counts – Mental Health (Psychology, LMFT, LCSW)





Network Adequacy & Provider Counts

Q3, 2023

Provider Counts – Facilities

	2019	2020	2021	2022	Current
Hospital	18	18	21	20	21
Surgery Center	17	19	19	19	19
Urgent Care	17	17	19	22	24

Provider Counts – Other Provider Types

	2019	2020	2021	2022	Current
Ambulance/Transport	13	17	16	15	16
Dialysis	16	18	19	19	19
Home Health	13	13	14	15	15
Hospice	11	13	16	18	18
Pharmacy	139	147	150	145	139
Physical Therapy	29	30	29	32	34

Tracking and Trending

The Plan utilizes the quarterly Network Adequacy and Provider Counts review to monitor fluctuations within the network. The Plan has reviewed the results of the Q3 2023 report and compared against prior quarters (outlined above) and identified that PCP and Mental Health provider counts remain consistent across the review period as illustrated in the graphs.

To mirror regulatory adequacy reviews and processes of other health plans, the Plan has modified its provider count methodology to include providers contracted with the Plan via tertiary providers. Due to this methodology change, the Plan's specialist count continues to see a large increase as illustrated in the above graph. These providers are not new to the Plan; however, they were not previously included in these counts.

Significant Network Change

As outlined in California Health and Safety Code, Section 1367.27, subdivision ®: *Whenever a plan determines (…) that there has been a 10 percent change in the network for a product in a region, the plan shall file an amendment to the plan application with the department.*

The Plan initiated the Significant Network Change filing on December 9, 2021 (Filing No. 20214807). The Plan received comment letters from the DMHC on January 10, 2022, March 9, 2022, May 10, 2022, July 8, 2022, August 31, 2022, October 31, 2022, December 21, 2022, February 13, 2023, April 11, 2023, June 9, 2023, and August 8, 2023. The Plan has responded to all letters within the 30-day timeframe. The Plan continues to work with the DMHC towards approval of this Significant Network Change filling.

DHCS Quarterly Monitoring Report/Response Template (QMRT)

Quarter 3, 2023

(Q2, 2023 QMRT)

Provider Network Management

Quarterly Monitoring Report/Response Template

Q3, 2023 (Q2, 2023 QMRT)

KERN HEALTH SYSTEMS

Introduction

Department of Health Care Services (DHCS) monitors and assesses specific compliance categories on a quarterly basis. Their review is provided to the Plan, and when potential areas of concern are identified, response is required via the Quarterly Monitoring Report/Response Template (QMRT). The Plan reviews all data received from the DHCS against internal access monitoring tools to identify any potential issues or trends within the Plan network.

On 7/05/2023 the Plan's Provider Network Management Department received Q2 2023 QMRT and accompanying reports from the DHCS and during Q3 2023 the Plan's Provider Network Management departments reviewed the following categories:

FTE Provider to Member Ratio

DHCS uses the Plan's 274 file submission to calculate and monitor FTE provider to member ratios. For Q3 2022 QMRT no response was requested from the Plan, and the DHCS review found the Plan to be in compliance with the standard:

Service Area and/or Reporting Unit	FTE PCP Per 2,000 members	FTE Physician Per 1,200 members
Kern	11	38

The Plan's standards and monitoring of FTE provider to member ratios are outlined in Plan policy and procedure *4.30-P Accessibility Standards*. While the Plan was unable to replicate the above ratios provided by the DHCS, the Plan's own quarterly monitor (*Network Adequacy and Provider Counts*, *Q2 2023*) also found the Plan to be in compliance with regulatory standards.

Timely Access

DHCS' External Quality Review Organization (EQRO) conducts a timely access survey of Plan providers to ensure compliance with provider availability and appointment wait time standards. For Q2 2023 QMRT the Plan was provided with timely access data reporting providers' ability to respond to the timely access survey and providers' ability to meet the next three (3) appointments within timely access standards.

The Plan was found not to be meeting **Measure 4** (providers with appointment times collected) and **Measure 5** (providers with appointment times within access standards). The Plan response to the findings pointed out that the Plan's results were in line with or higher than the Medi-Cal Statewide averages. For **Measure 4**, the Plan indicated that there may be issues with the survey methodology as front-office staff frequently forward survey questions to the office manager, who is more difficult to get in touch with or who may be not respond. In response to **Measure 4** and **Measure 5**, the Plan pointed to the Plan's standards and monitoring of timely access outlined in Plan policy and procedure *4.30-P Accessibility Standards*, and indicated the Plan's own quarterly monitoring (*Provider Accessibility Monitoring Survey*, *Q3 2023*) found the Plan to be in compliance with all regulatory standards.

Network Report

DHCS uses the Plan's 274 file to generate Network Report in an effort to improve network provider data quality and support compliance with Annual Network Certification and timely access survey. For Q2 2023 QMRT no response was requested from the Plan, and no Network Report data was provided to the Plan. The Plan's standards and monitoring of accessibility are outlined in the Plan's policy and procedure *4.30-P Accessibility Standards.*

Mandatory Provider Types

The Plan is required to contract with at least one of the following Mandatory Provider Types within its service area, where available: Freestanding Birthing Centers (FBC), Certified Nurse Midwife (CNM), Licensed Midwife (LM), and Indian Health Facilities (IHF). For Q2 2023 QMRT no response was requested from the Plan, and no Mandatory Provider Type data was provided to the Plan. The Plan maintains ongoing efforts to identify and contract will all provider types, including the above listed Mandatory Provider Types. This requirement is also reviewed by the Plan and DHCS as part of the Plan's Annual Network Certification. The Plan's most recent submission was found to be in compliance with regulatory requirements.

Physician Supervisor to Non-Physician Medical Practitioner Ratios

DHCS uses the Plan's 274 file submission to calculate and monitor Physician Supervisor to Non-Physician Medical Practitioner Ratios. For Q2 2023 QMRT no response was requested from the Plan, and the DHCS' review found the Plan to be in compliance with the standard:

Service Area(s) and/or Reporting Unit	Physician Supervisor Per Non-Physician Medical Practitioner Ratio
Kern	9

The Plan's standards for Physician Supervisor to Non-Physician Medical Practitioner ratios are outlined in Plan policy and procedure *4.04-P Non-Physician Medical Practitioners – Supervision by Physicians.*

Out-of-Network Requests

The Plan reports Out-of-Network (OON) requests to DHCS when a member is requesting to a see a provider or facility when a medically necessary service is not available in the Plan's network. The DHCS analyzes the data to identify potential areas of concern. Based on Q1 2023 data which was provided to the Plan in the Q2 2023 QMRT, the Plan identified Hospital, General Surgery, and Rural Health Center as the three provider types with the highest number of out-of-network requests. The Plan provided a response to the DHCS addressing these three provider types, including the Plan's strategy to reduce the number of requests, barriers/challenges to resolving the number of requests, and contracting/recruiting efforts.

Enhanced Care Management Quarter III QIC Report

Background:

ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high cost and/or high-need Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. Members who will be eligible for ECM are expected to be among the most vulnerable and highest-need Medi-Cal Managed Care Members. Members who stratify into the ECM program are broken up into the following DHCS defined Populations of Focus:

	ECM Populations of Focus	Adults	Children & Youth
1a	Individuals Experiencing Homelessness: *Adults without Dependent Children/Youth Living with Them Experiencing Homelessness*	✓	
1b	Individuals Experiencing Homelessness: *Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness*	✓	✓
2	Individuals At Risk for Avoidable Hospital or ED Utilization (*Formerly "High Utilizers"*)	✓	✓
3	Individuals with Serious Mental Health and/or SUD Needs	✓	✓
4	Individuals Transitioning from Incarceration	✓	✓
5	Adults Living in the Community and At Risk for LTC Institutionalization	✓	
6	Adult Nursing Facility Residents Transitioning to the Community	✓	
7	Children and Youth Enrolled in CCS or CCS WCM with Additional Needs Beyond the CCS Condition		✓
8	Children and Youth Involved in Child Welfare		✓
9	Birth Equity Population of Focus	✓	✓

Future Populations of Focus:

January 2024

- **Birth Equity PoF**: Adult and Youth who are pregnant or postpartum (for a period of 12 months) that are subject to racial and ethnic disparities as defined by CDPH (California Department of Public Health) data on maternal morbidity and mortality. Currently, CDPH has identified the Black, American Indian, Alaska Native, and Pacific Islander populations but this is subject to change based off CDPH data.

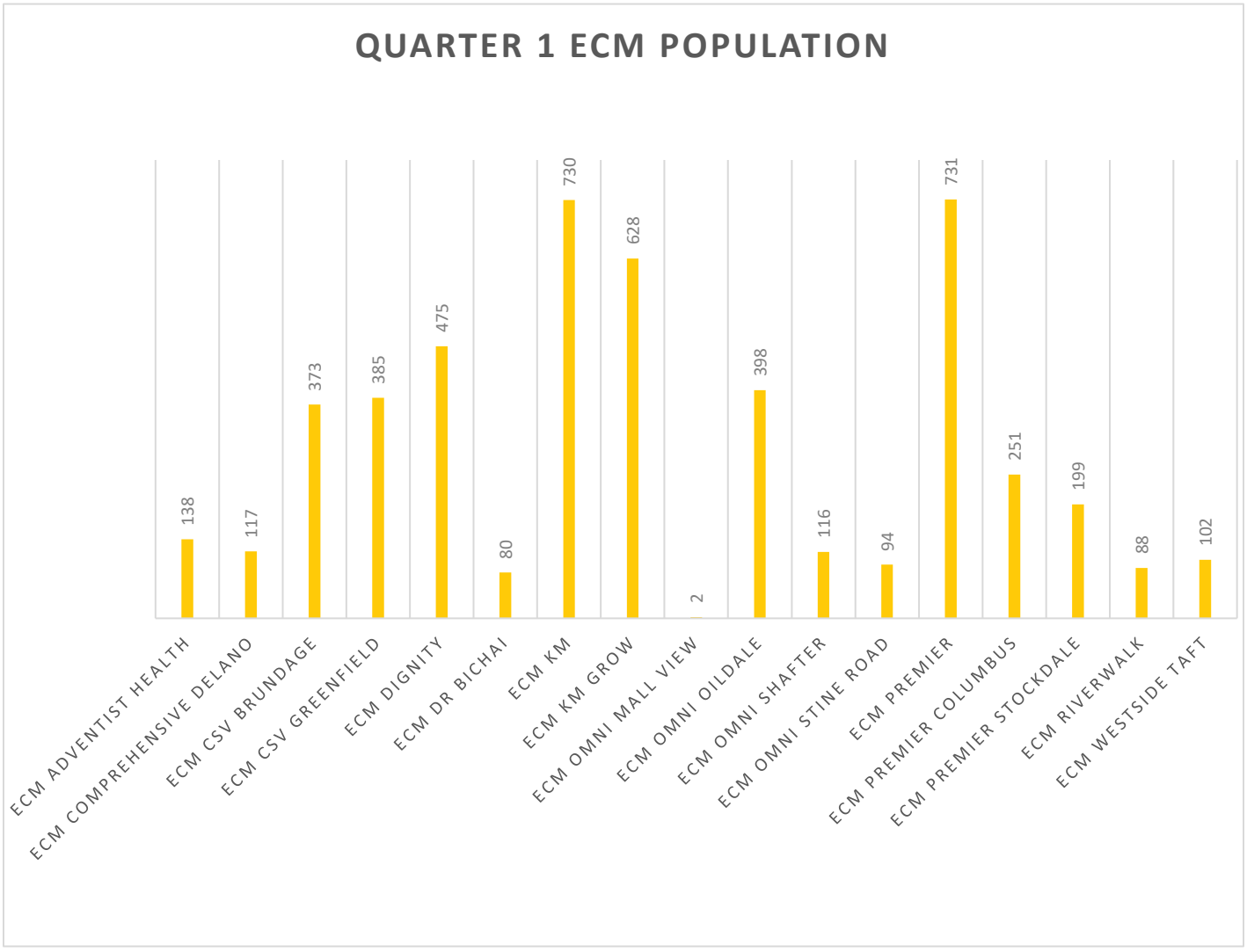
- **Justice-Involved PoF:** The ECM team continues to focus on the Justice-Involved Initiative, requiring extensive work and relationship/partnership-building with all correctional facilities throughout the county as the Justice-Involved Initiative goes live throughout the state, as early as 10/1/24 (once DHCS has approved the Readiness Assessment by Correctional Facilities), to be implemented (mandated by DHCS) no later than 9/1/26. The ECM team has worked diligently to contact our local correctional facilities and establish relationships with them in preparation for the Justice-Involved Initiative. We have met with local representatives of the Kern County Sheriff Department, Kern County Probation, and Kern Behavioral Health and Recovery Services, for the county adult and juvenile correctional facilities. We have also met with the CalAIM representative for the California Department of Corrections and Rehabilitation (CDC-R) for the state adult facilities located in our county. We have follow-up meetings with all of these teams in November. We have continued to work with all of our current ECM providers and other potential providers in an effort to build appropriate capacity for these Populations of Focus. The ECM team has also started to partner with Kaiser and Anthem representatives for the Justice-Involved Initiative to ensure 100% network overlap of all JI ECM providers amongst all three plans moving forward. Currently, KHS is aligned mostly with Anthem, only missing one contracted provider that they are still in outreach with. Kaiser has 8 projected providers that KHS is not contracted with. 1 of those is reportedly contracted, 2 of those are in contracting, and 5 are in outreach currently.

ECM Demographic Data

As of October 31st 2023, ECM had a total of 5,858 members currently enrolled in Enhanced Care Management services. These members are stratified into 25 ECM sites via geographic logic and are assigned into the above distinct populations of focus.

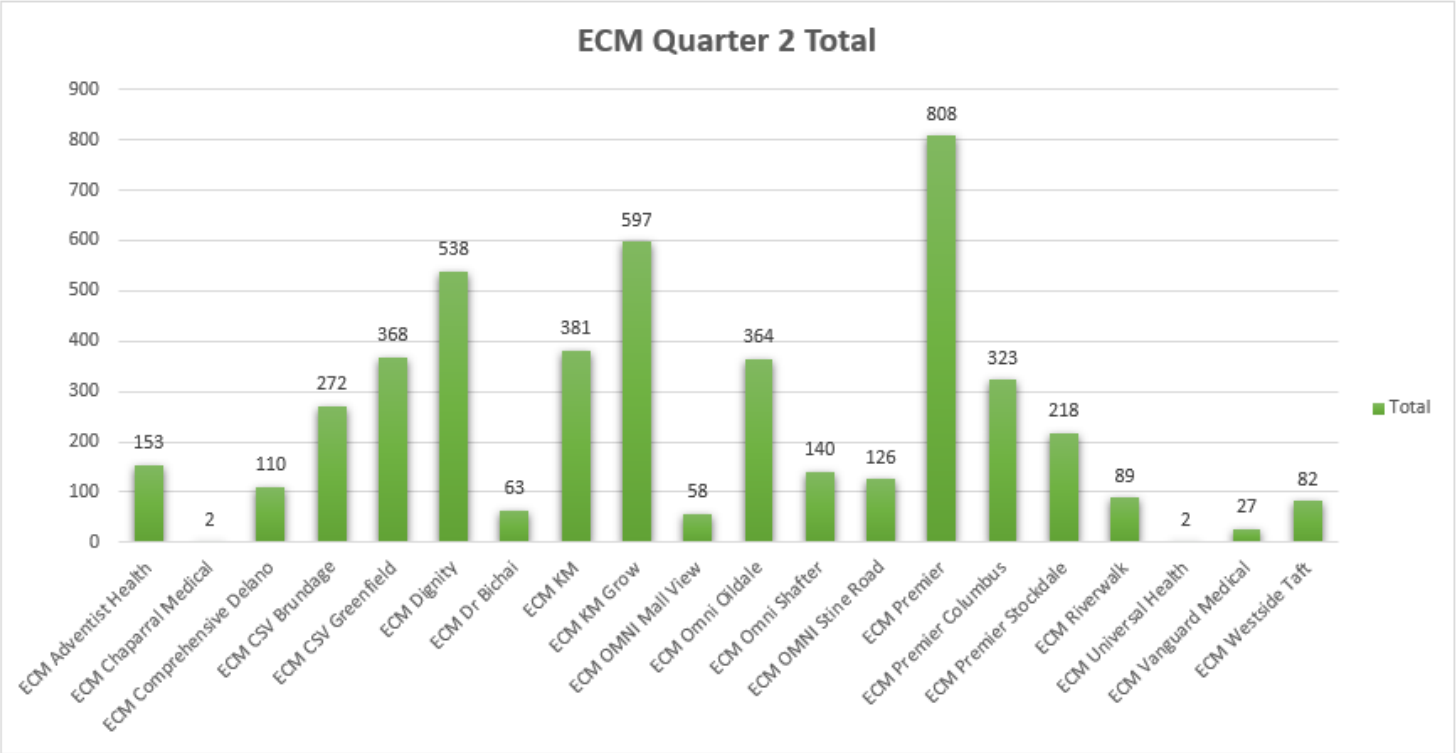
ECM Population amount by site Quarter 1 2023

Total Population: 4,097



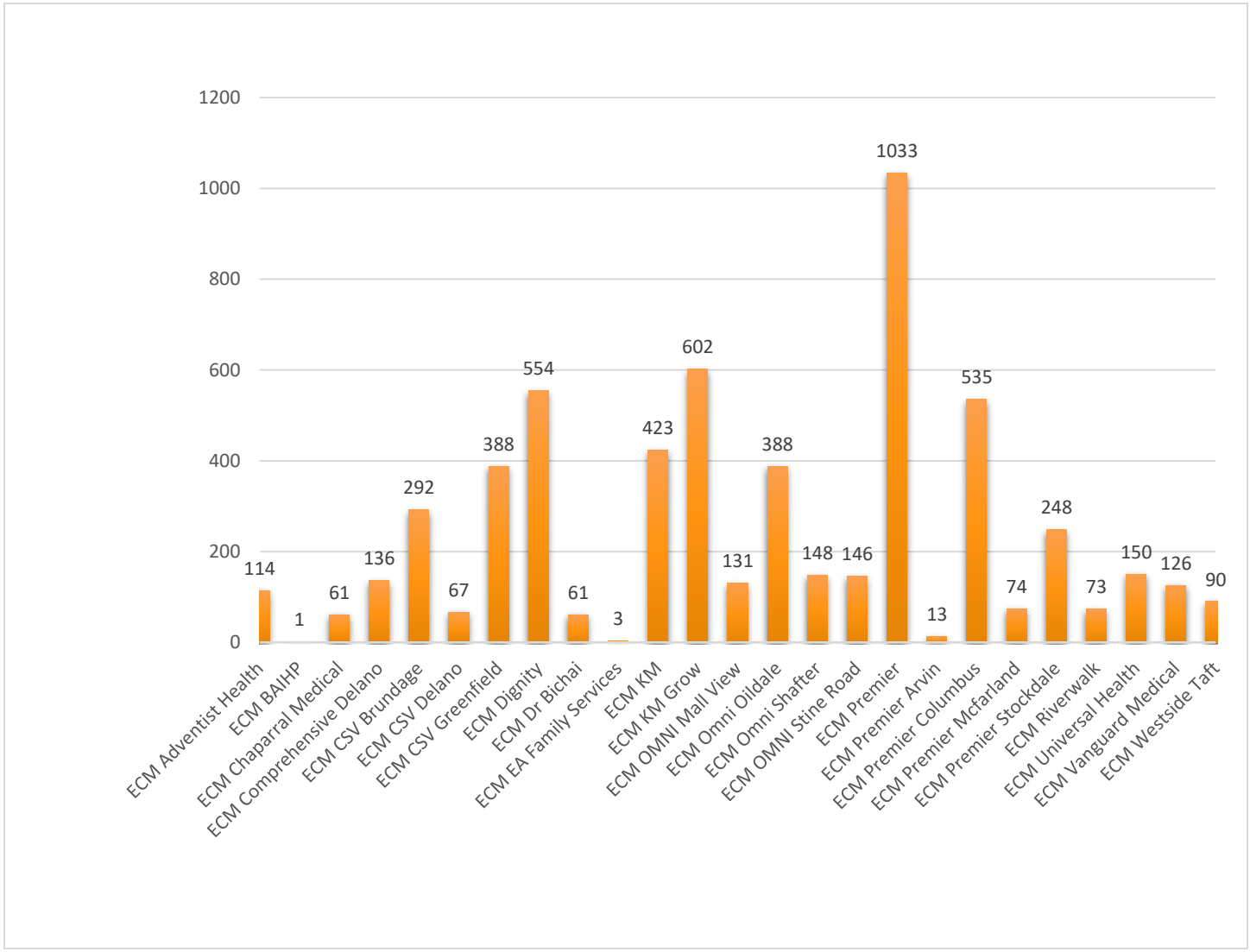
ECM Population amount by site Quarter 2 2023

Total Population: 4,721

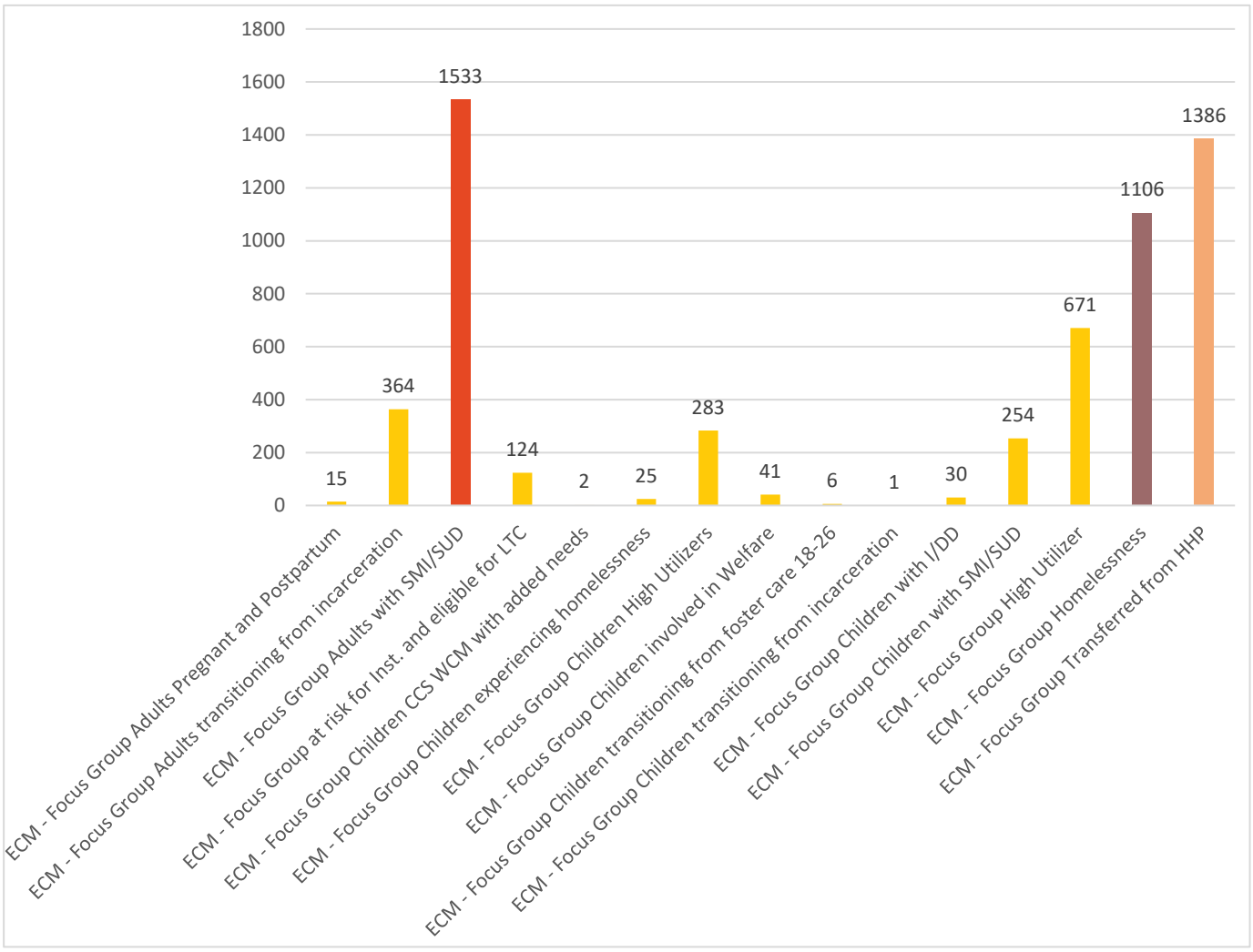


ECM Population amount by site Quarter 3 2023

Total Population: 5,858

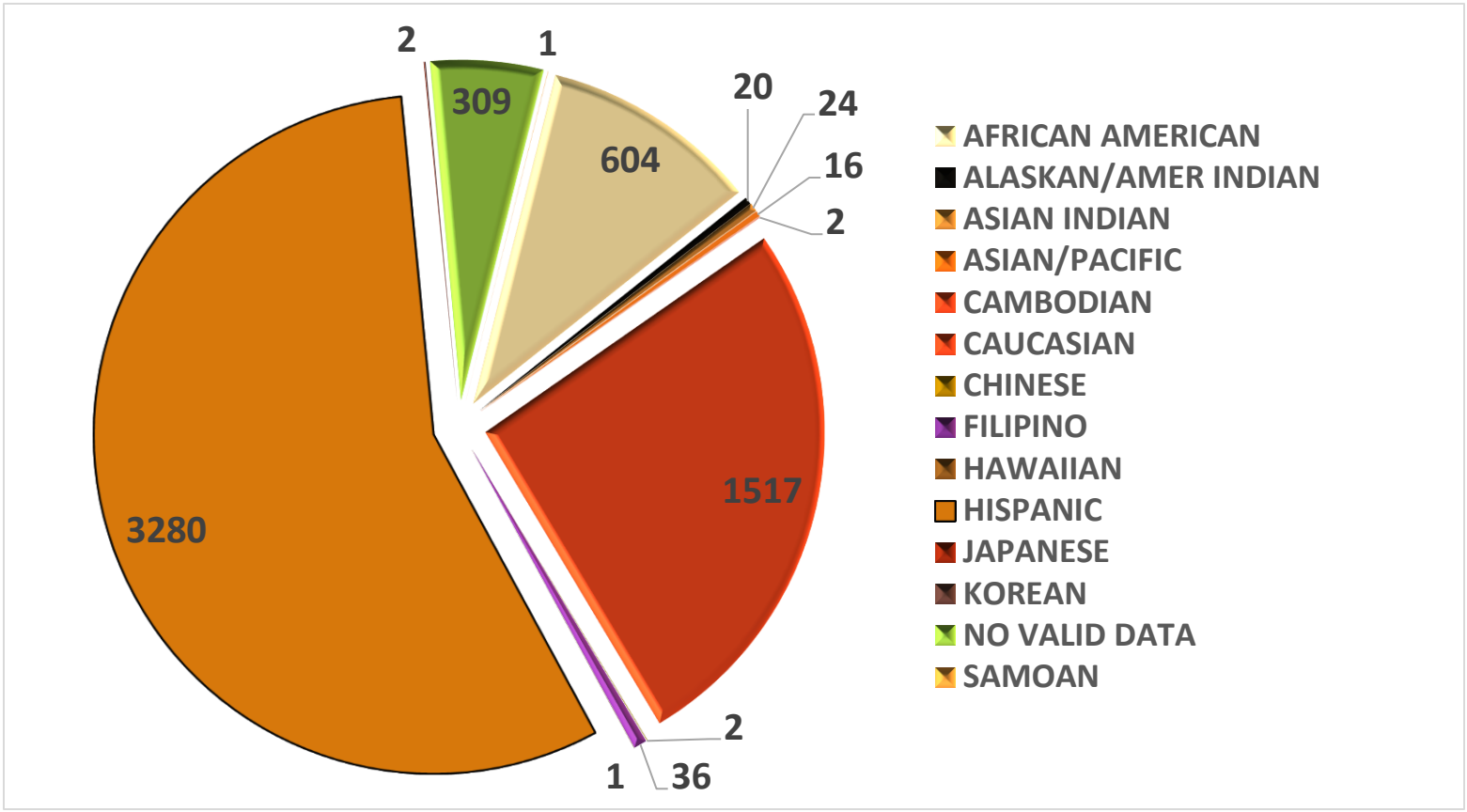


ECM Population amount by site Quarter 3 2023 by POF



Ethnicity

In the Enhanced Care Management program we pride ourselves on maintaining the alignment in values shared throughout Kern Family Health Care in serving a diverse population. As denoted in the below graph (Ethnicity table), the largest ethnic group served by our ECM providers is the Hispanic population which constitutes 56% of the total ECM population (as of Q3), while a smaller population identify as other ethnic groups such as African American, Caucasian, Alaskan/American Indian, etc. We proudly boast a robust bilingual staff serving our membership throughout all 25 of our locations and continue to look at ways to be more equitable to all our ethnic groups in ECM.



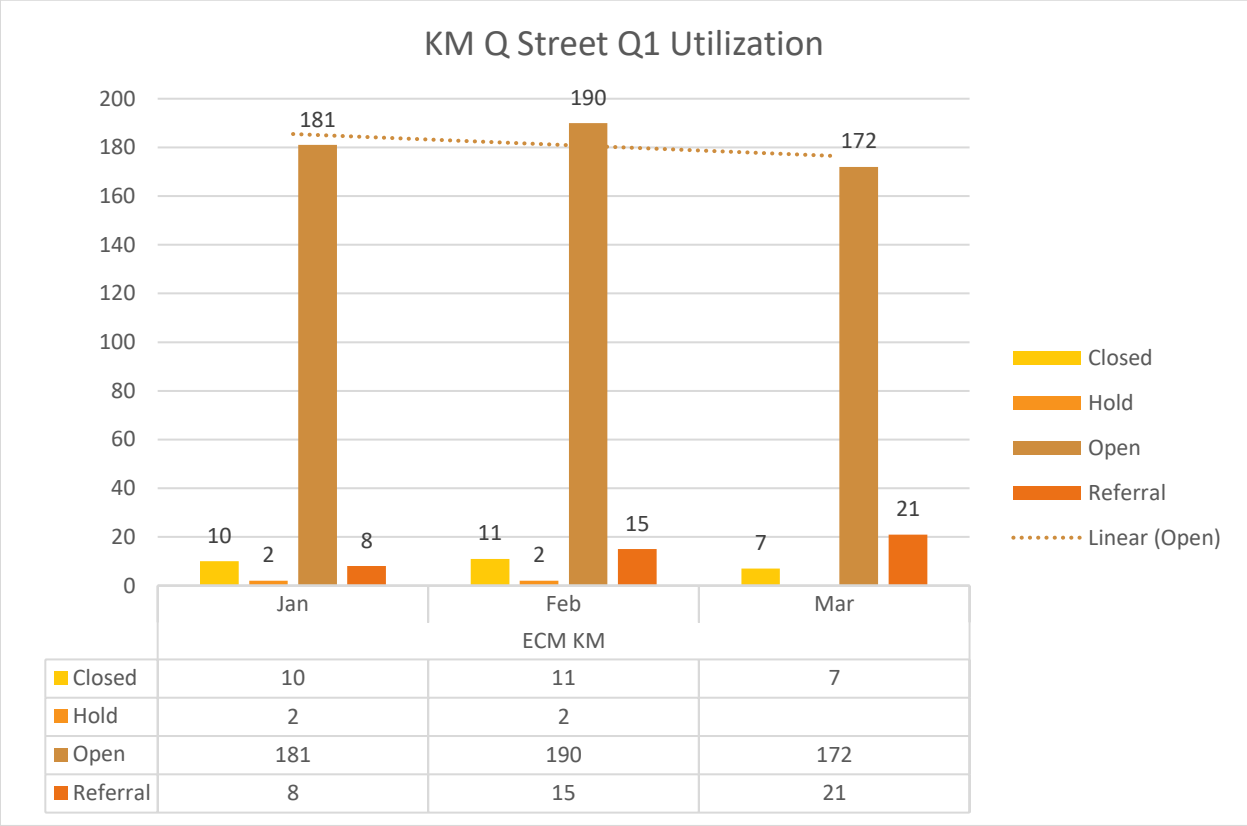
ECM cost saving measure:

Emergency Department utilization for enrolled ECM members in the 1st, 2nd and 3rd quarters

Transition of care is a core service of Enhanced Care Management, and we continually process improve our member outreach strategy alongside our sites to increase the velocity and success of engagement with our members when transitions occur from one care setting to another. Our goal is to prevent the probable causes of repeat emergency department or inpatient utilization, achievable by a three-prong approach of engagement, education and health behavior modeling. In the event the member utilizes services for whatever cause, our sites are trained (and incentivized) to use utilization reports and internal tracking mechanisms to get in contact with the relevant site for coordination of safe discharge and to contact within 48 hours of discharge to help identify any outpatient barriers to access or variables. Below is the site-by-site quarter outlay of total utilization of emergency room visits by engaged ECM members through all of our sites as generated by our internal Business Intelligence team.

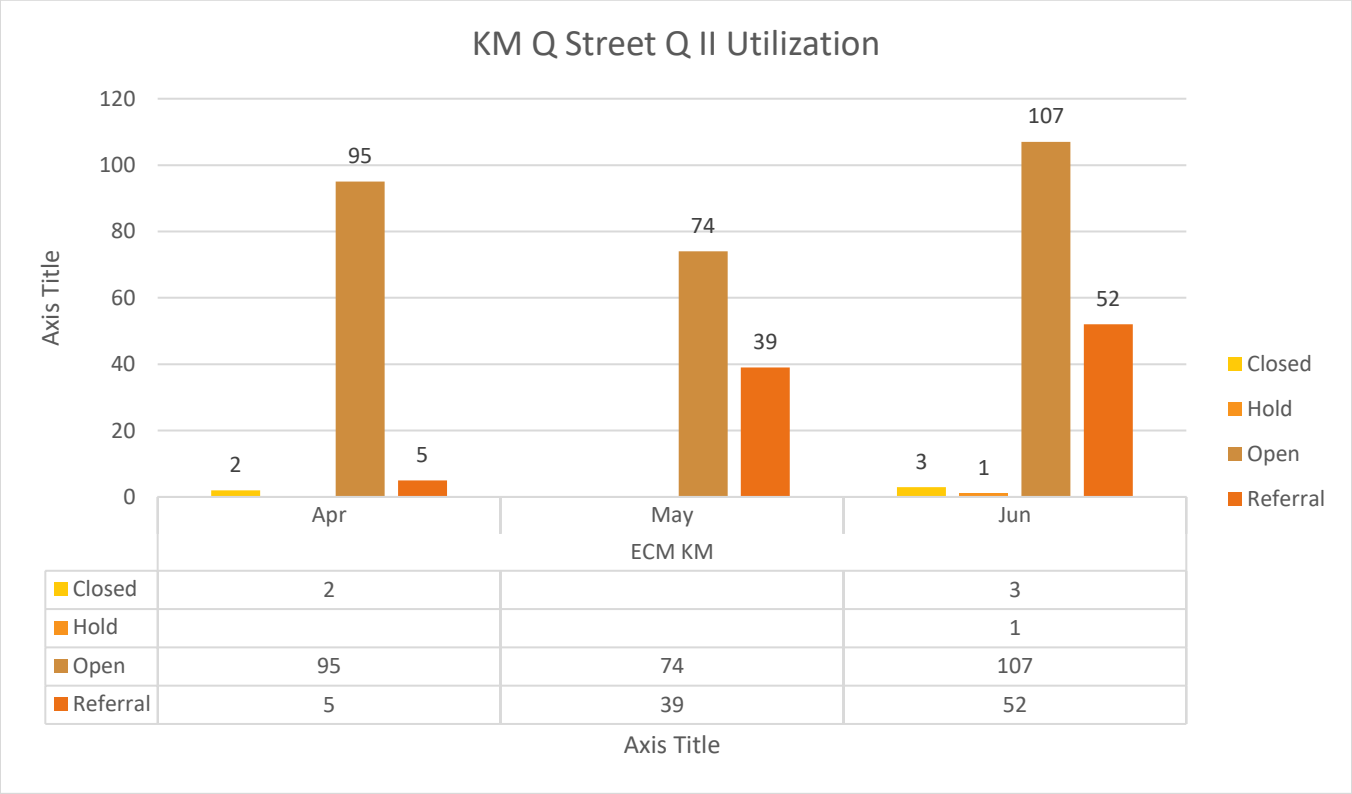
Kern Medical:

Q I Total Enrolled Population: 730



ECM KM	Jan	Feb	Mar
Closed	10	11	7
Hold	2	2	
Open	181	190	172
Referral	8	15	21

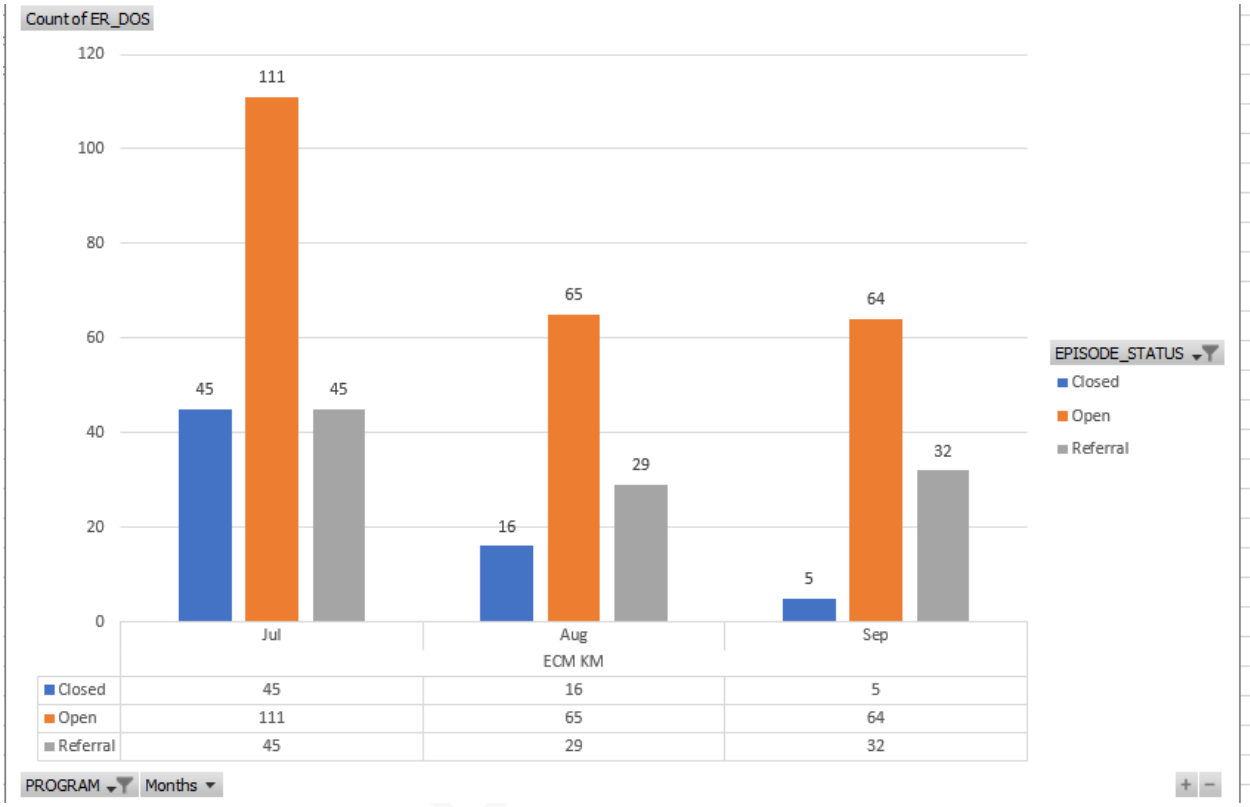
Quarter II KM Q Street Total Enrolled Population: 381



	Apr	May	Jun
Closed	2		3
Hold			1
Open	95	74	107
Referral	5	39	52

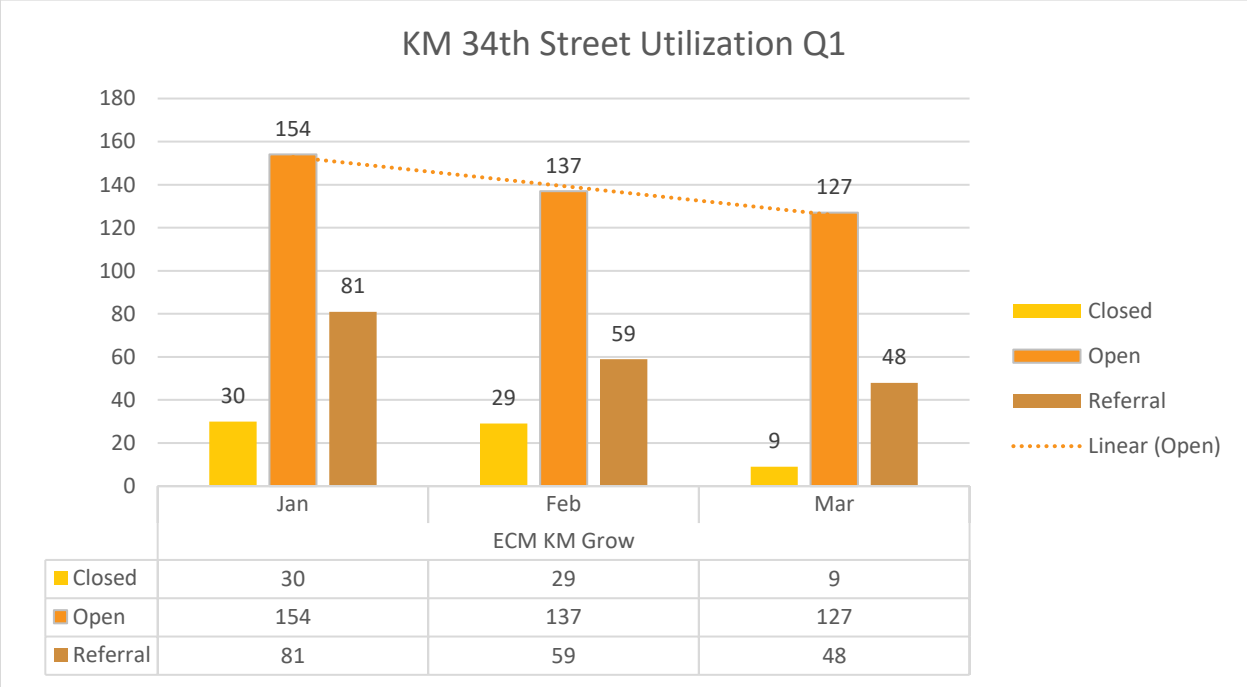
KM Q Street Q III Utilization

Total Population: 423



Kern Medical 34th Street:

Quarter I Total Enrolled Population: 628

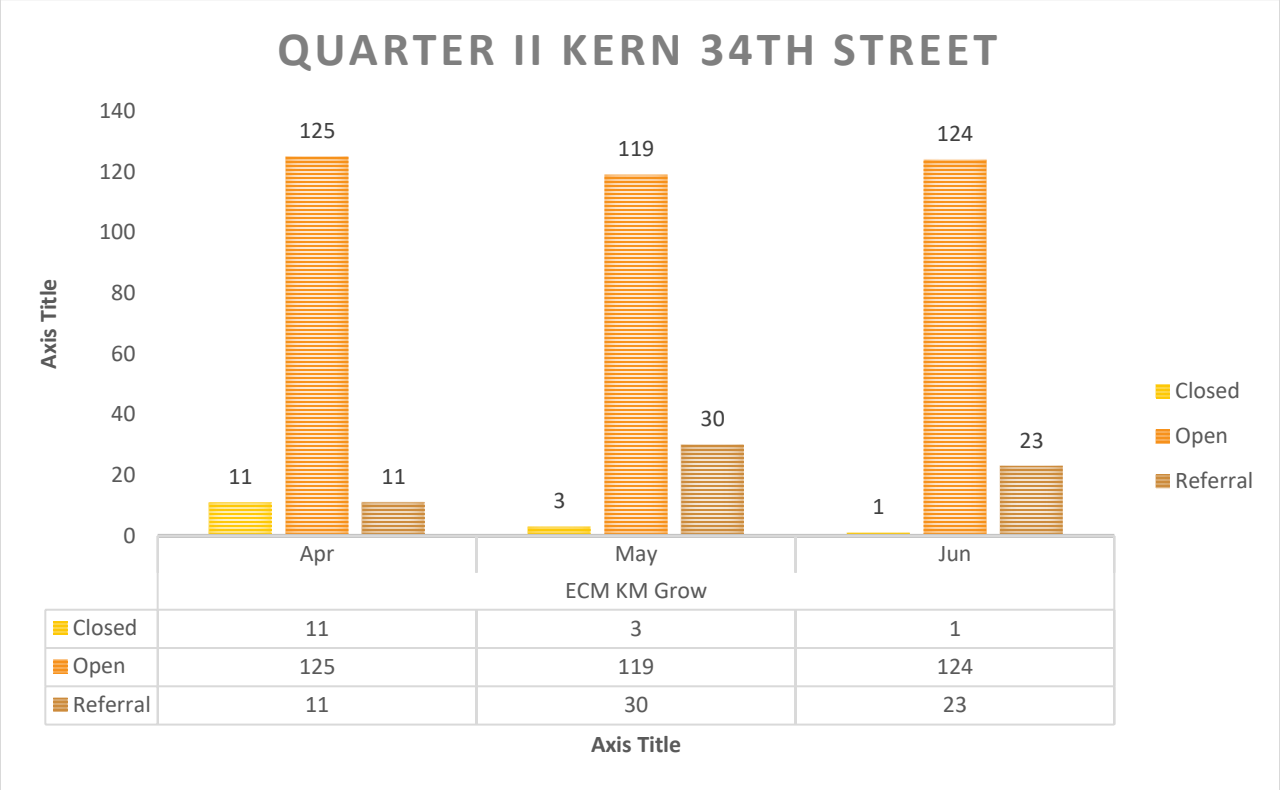


ECM KM Grow

	Jan	Feb	Mar
Closed	30	29	9
Open	154	137	127
Referral	81	59	48

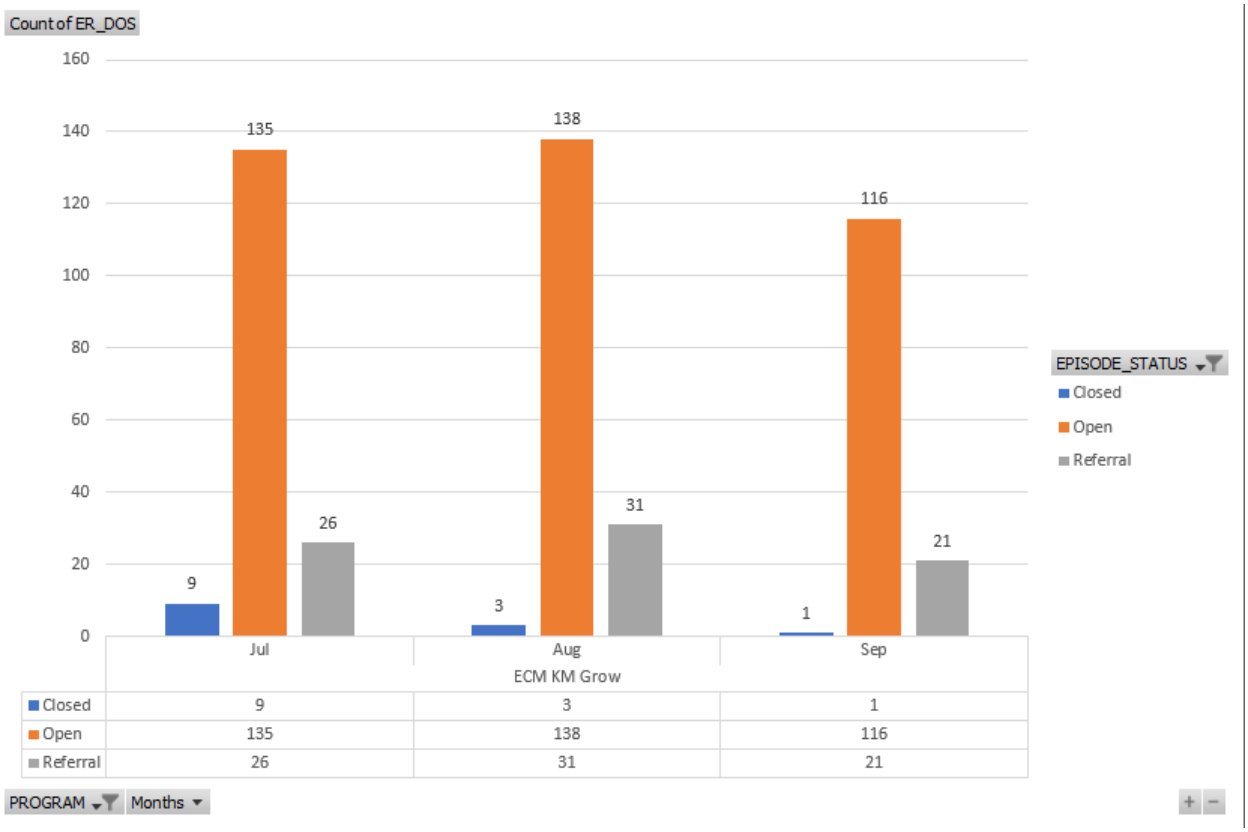
Kern Medical 34th Street:

Quarter II Total Enrolled Population: 597



Kern Medical 34th Street:

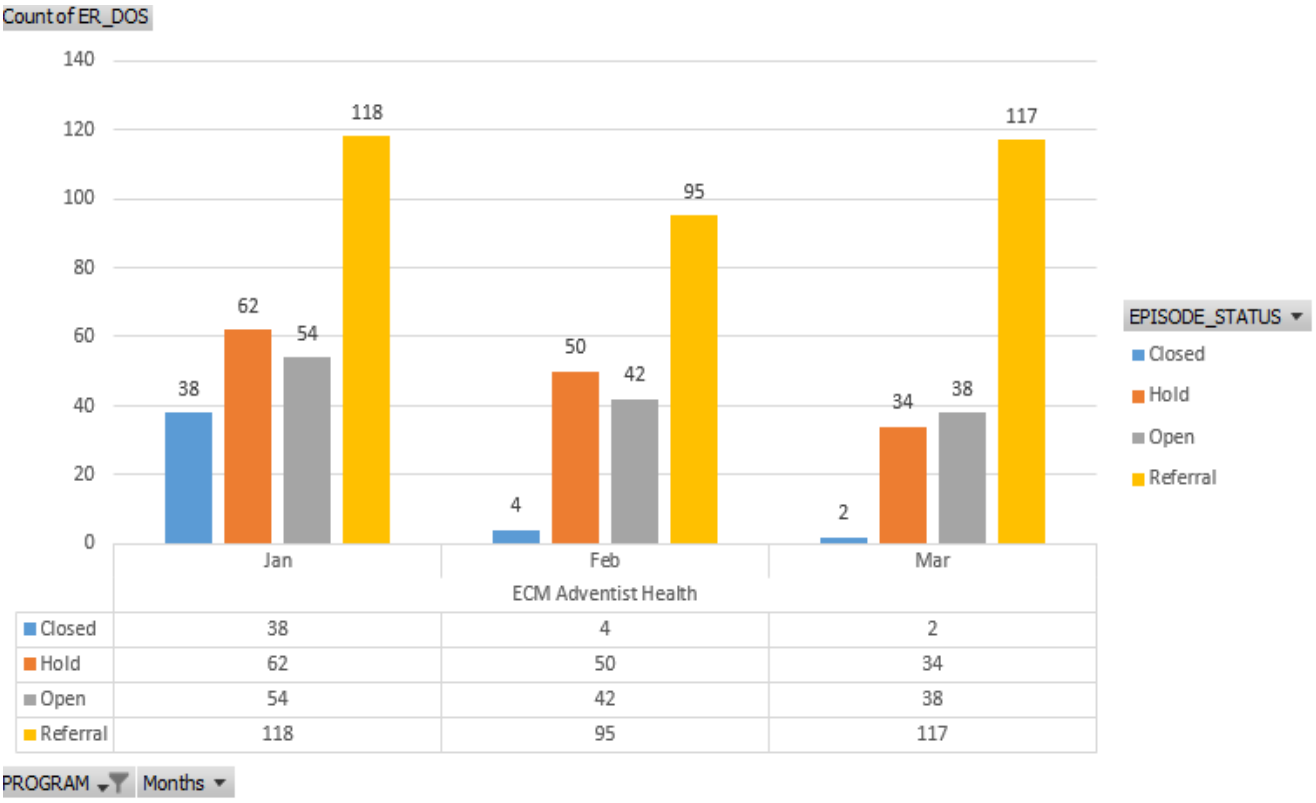
Quarter III Total Enrolled Population: 602



Adventist Health:

Quarter I

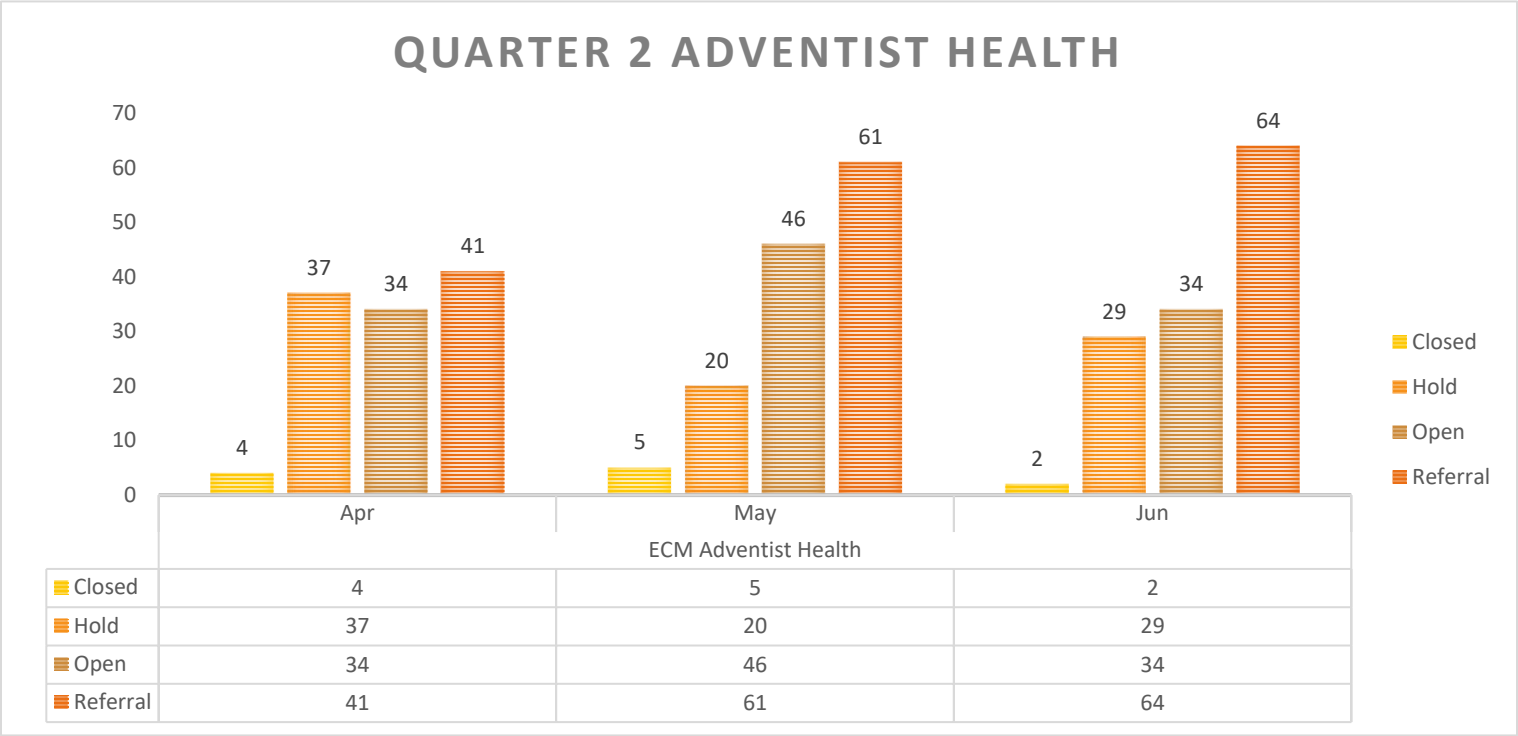
Total Enrolled Population: 138



	Jan	Feb	Mar
Closed	38	4	2
Hold	62	50	34
Open	54	42	38
Referral	118	95	117

Quarter II Adventist Health

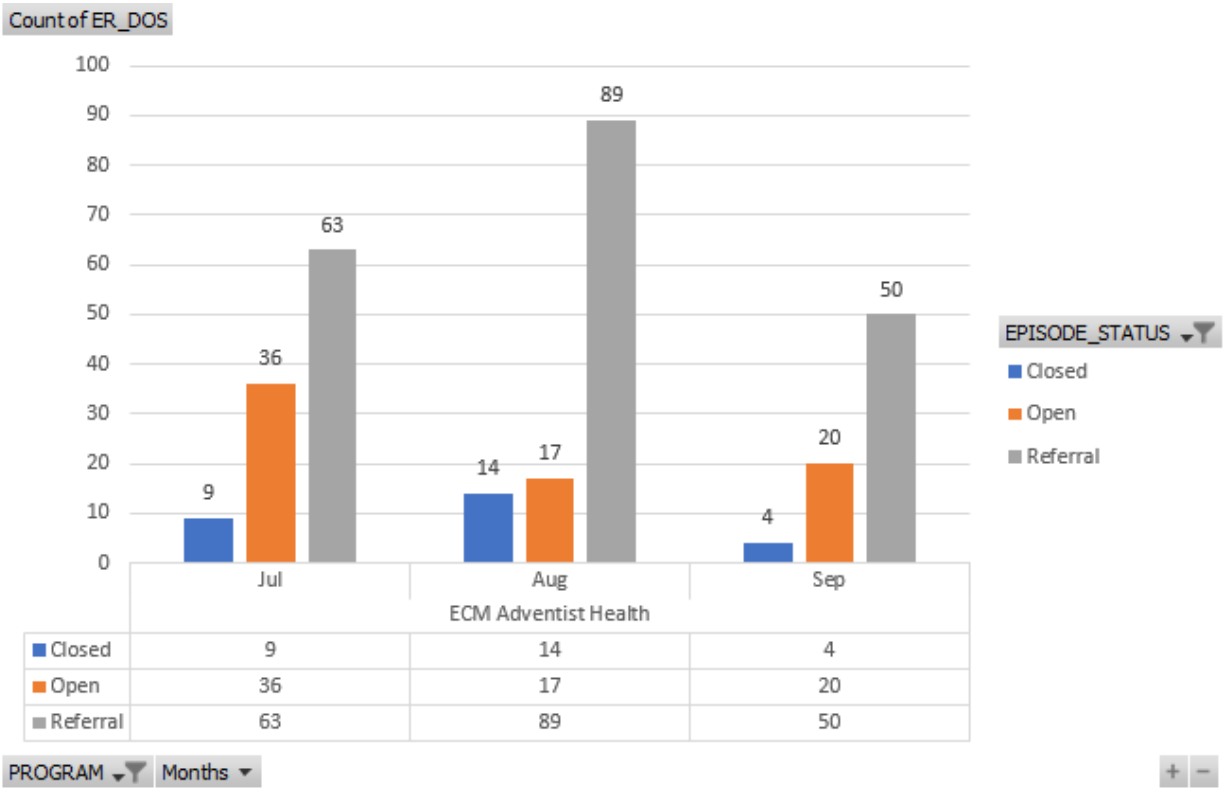
Total Enrolled Population: 158



	ECM Adventist Health		
	Apr	May	Jun
Closed	4	5	2
Hold	37	20	29
Open	34	46	34
Referral	41	61	64

Quarter III Adventist Health

Total Enrolled Population: 114



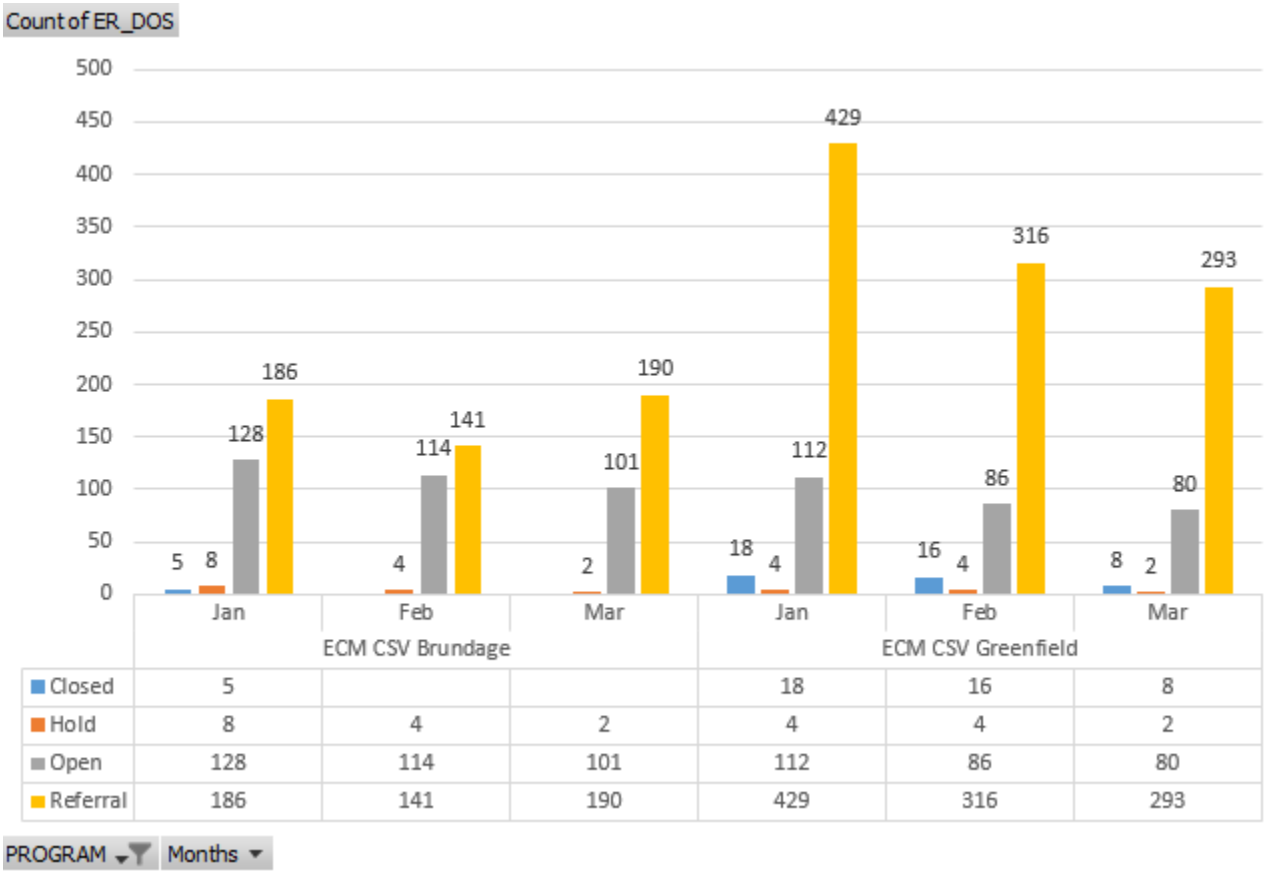
	Jul	Aug	Sep
Closed	9	14	4
Open	36	17	20
Referral	63	89	50

Clinica Sierra Vista Greenfield and First Street

Quarter I Total Enrolled Population:

Greenfield – 385

First Street - 373



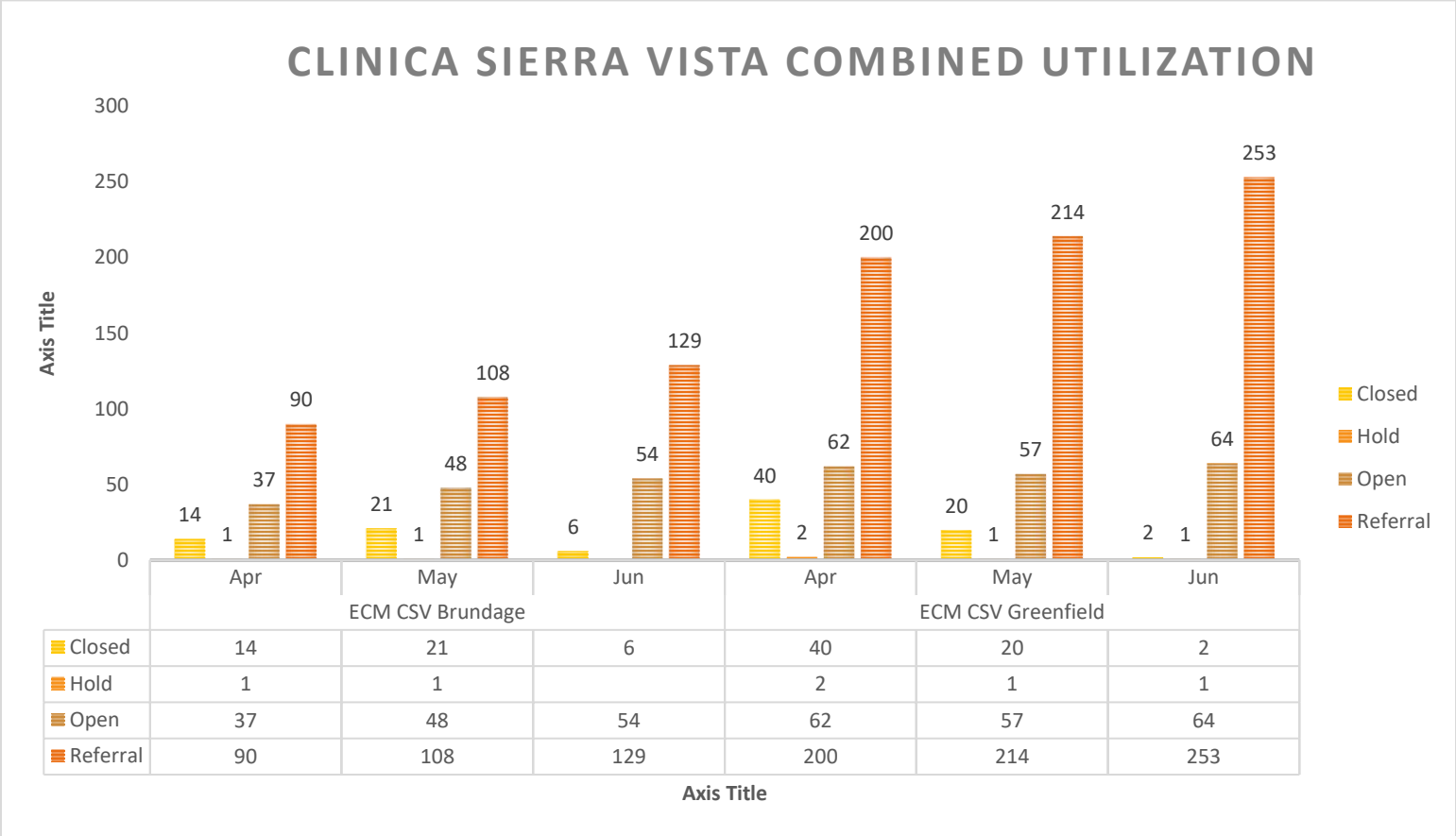
	ECM CSV Brundage			ECM CSV Greenfield		
	Jan	Feb	Mar	Jan	Feb	Mar
Closed	5			18	16	8
Hold	8	4	2	4	4	2
Open	128	114	101	112	86	80
Referral	186	141	190	429	316	293

PROGRAM Months

Quarter II Total Enrolled Population:

Greenfield – 368

First Street - 272

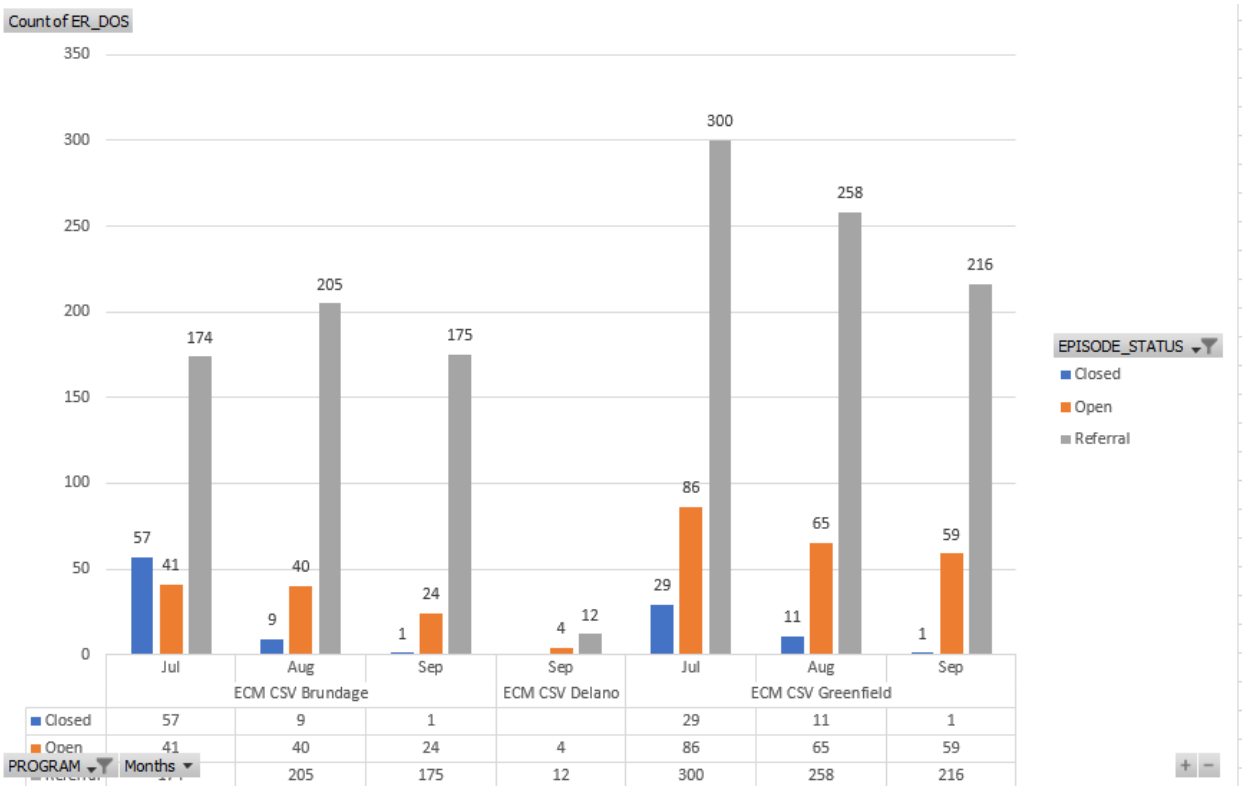


	ECM CSV Brundage			ECM CSV Greenfield		
	Apr	May	Jun	Apr	May	Jun
Closed	14	21	6	40	20	2
Hold	1	1		2	1	1
Open	37	48	54	62	57	64
Referral	90	108	129	200	214	253

Quarter III Total Enrolled Population:

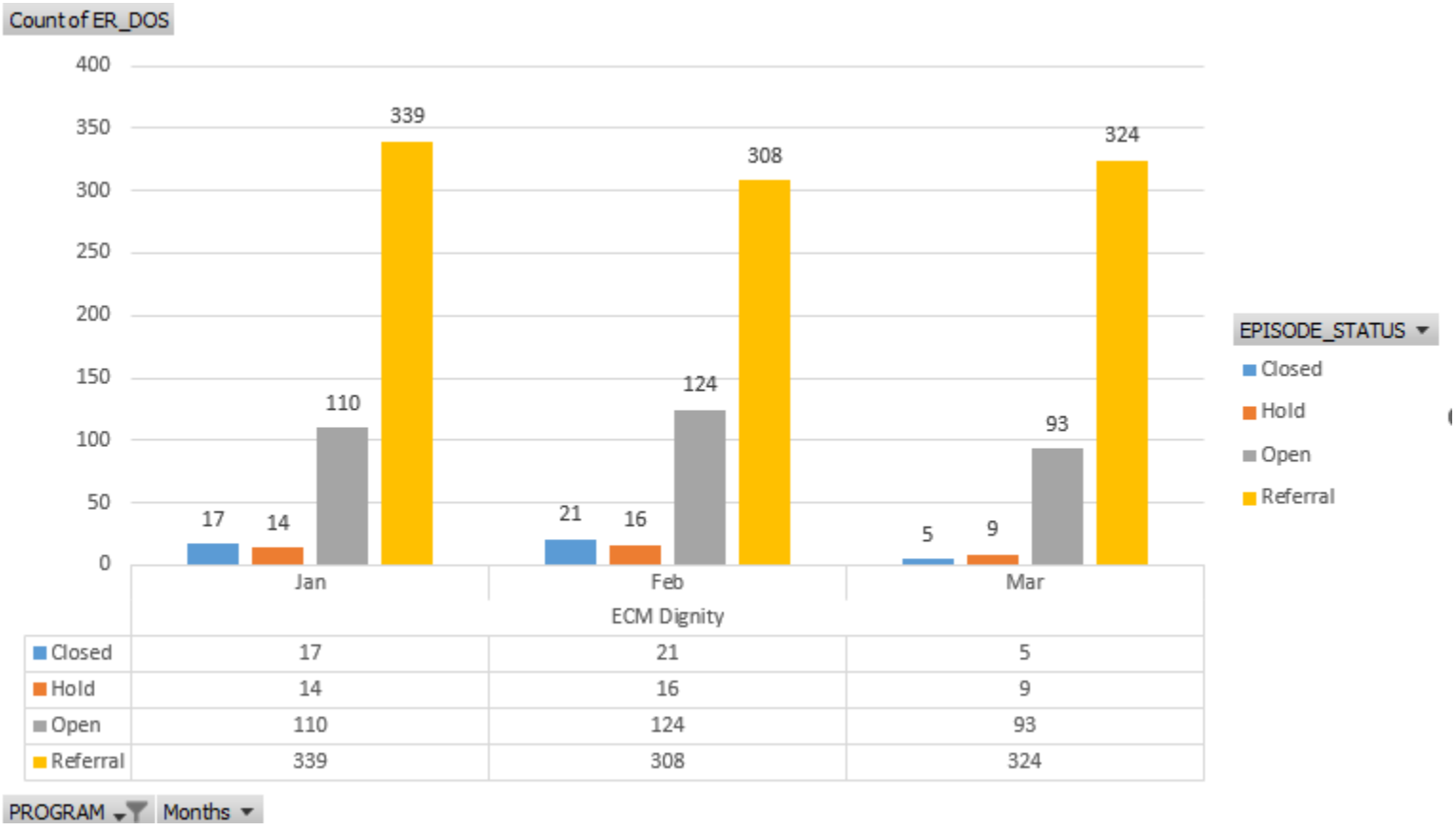
Greenfield – 388

First Street - 292



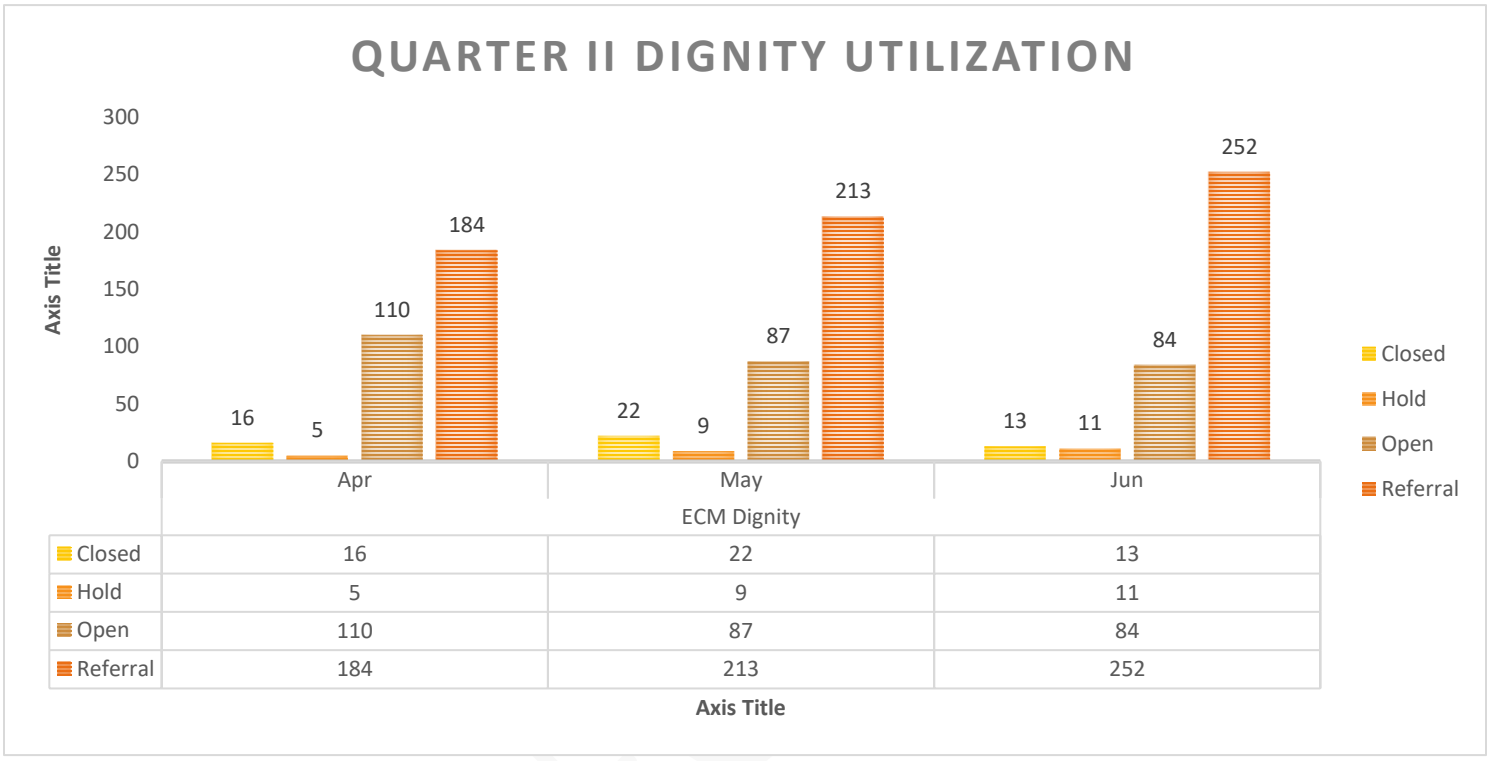
Dignity

Quarter I Total Enrolled Population: 475



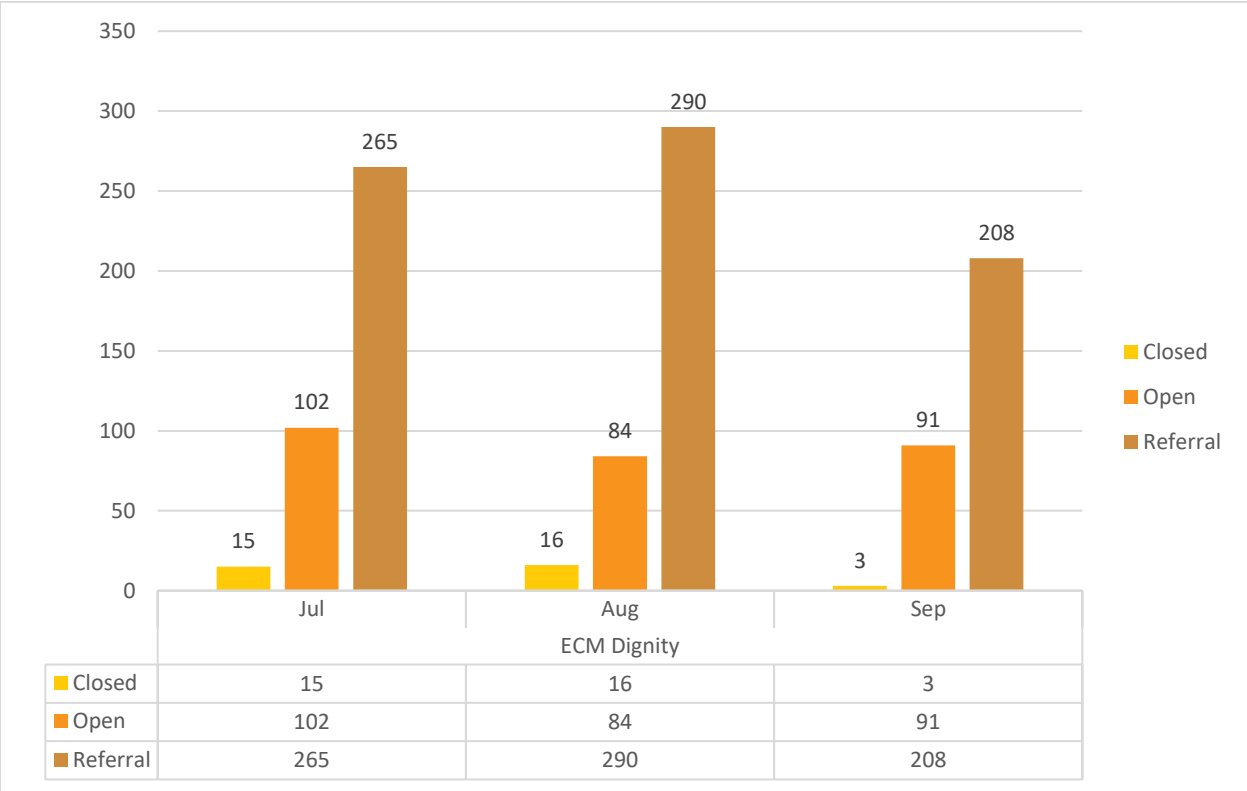
ECM Dignity	Jan	Feb	Mar
Closed	17	21	5
Hold	14	16	9
Open	110	124	93
Referral	339	308	324

Dignity Quarter II Total Enrolled Population: 538



	Apr	May	Jun
Closed	16	22	13
Hold	5	9	11
Open	110	87	84
Referral	184	213	252

Dignity Quarter III Total Enrolled Population: 554



ECM Dignity	Jul	Aug	Sep
Closed	15	16	3
Open	102	84	91
Referral	265	290	208

Omni Family Health

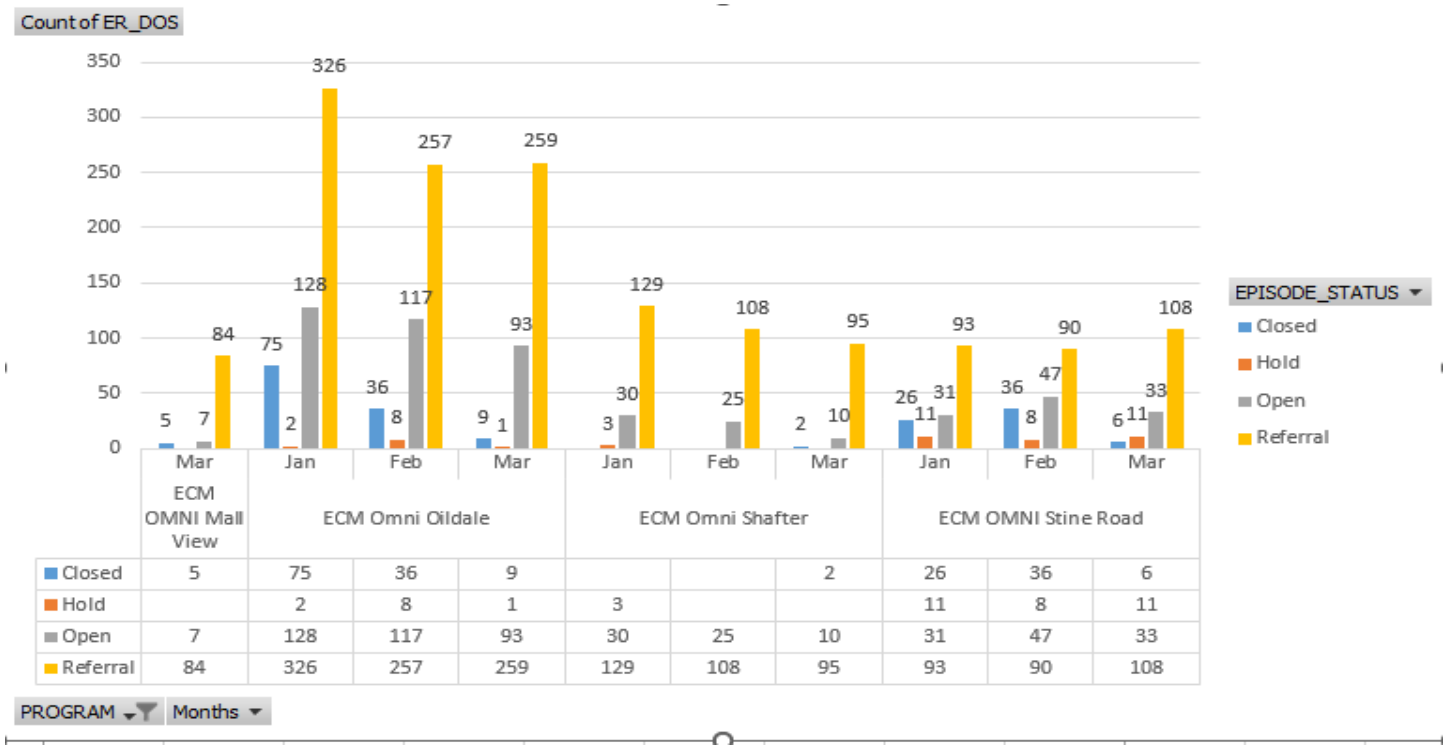
Quarter I Total enrolled population:

Stine Road: 94

Shafter: 116

Oildale: 398

Mall View: 2



	ECM OMNI Mall View	ECM Omni Oildale			ECM Omni Shafter			ECM OMNI Stine Road		
	Mar	Jan	Feb	Mar	Jan	Feb	Mar	Jan	Feb	Mar
Closed	5	75	36	9			2	26	36	6
Hold		2	8	1	3			11	8	11
Open	7	128	117	93	30	25	10	31	47	33
Referral	84	326	257	259	129	108	95	93	90	108

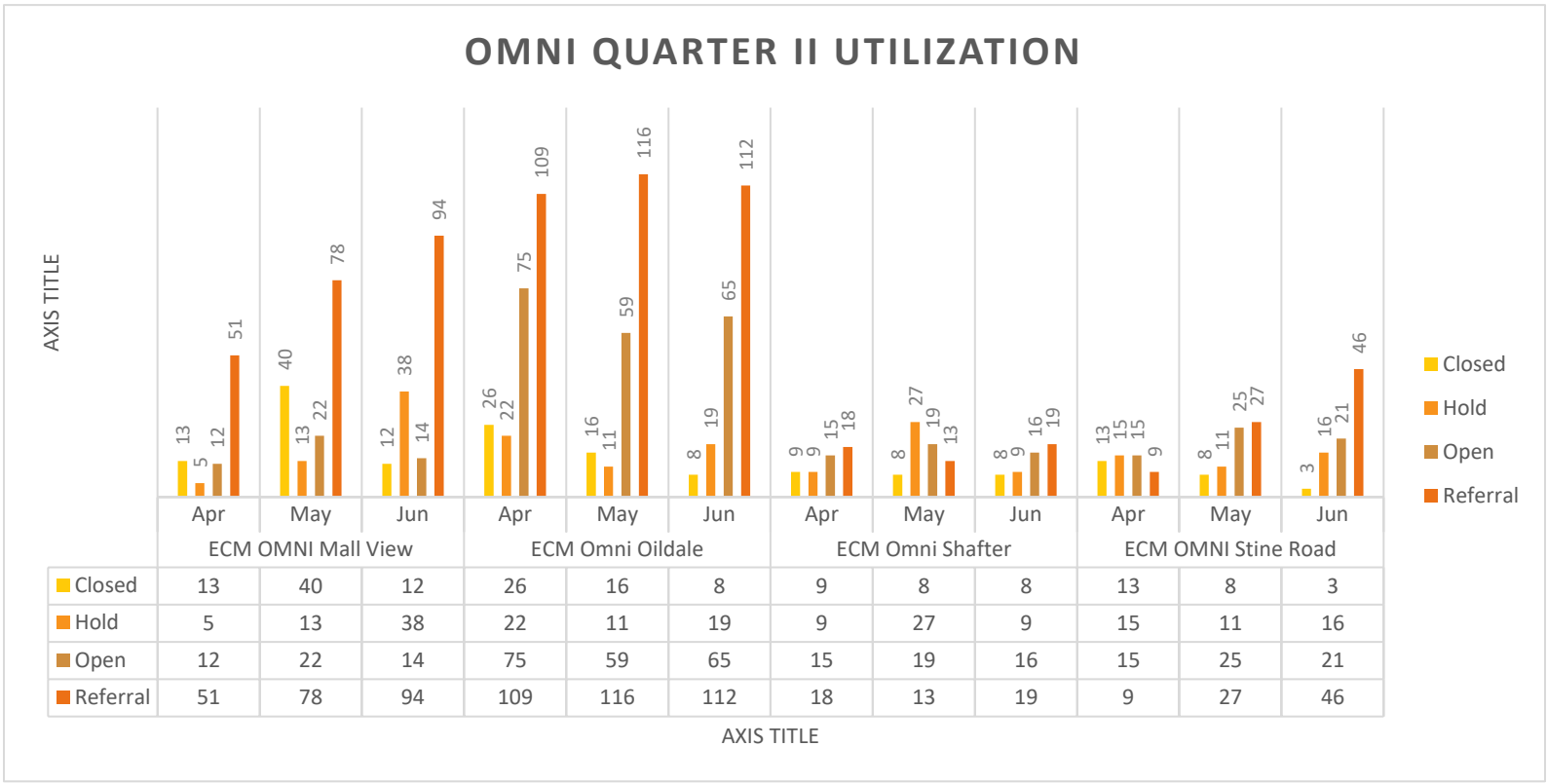
Omni Quarter II Total enrolled population:

Stine Road: 126

Shafter: 140

Oildale: 364

Mall View: 58



	ECM OMNI Mall View			ECM Omni Oildale			ECM Omni Shafter			ECM OMNI Stine Road		
	Apr	May	Jun	Apr	May	Jun	Apr	May	Jun	Apr	May	Jun
Closed	13	40	12	26	16	8	9	8	8	13	8	3
Hold	5	13	38	22	11	19	9	27	9	15	11	16
Open	12	22	14	75	59	65	15	19	16	15	25	21
Referral	51	78	94	109	116	112	18	13	19	9	27	46

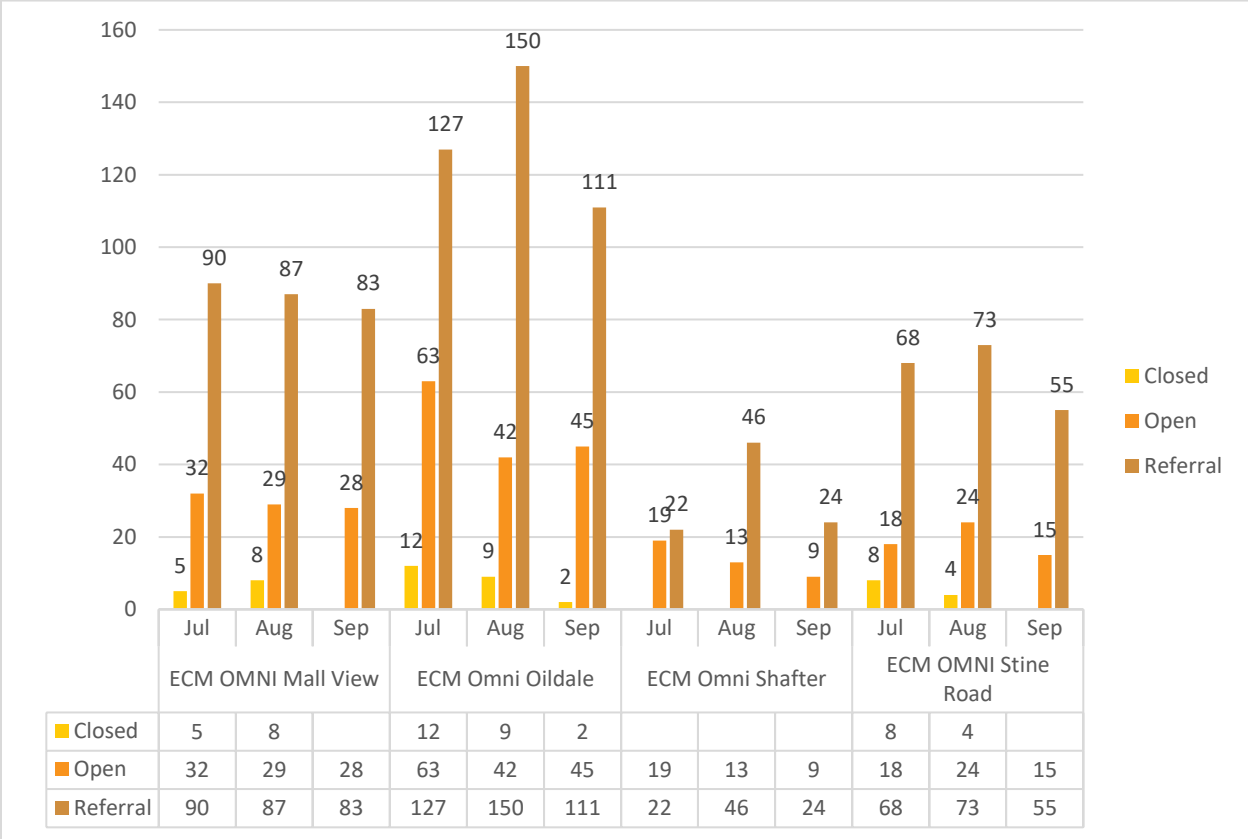
Omni Quarter III Total enrolled population:

Stine Road: 142

Shafter: 148

Oildale: 388

Mall View: 131



	ECM OMNI Mall View			ECM Omni Oildale			ECM Omni Shafter			ECM OMNI Stine Road		
	Jul	Aug	Sep	Jul	Aug	Sep	Jul	Aug	Sep	Jul	Aug	Sep
Closed	5	8		12	9	2				8	4	
Open	32	29	28	63	42	45	19	13	9	18	24	15
Referral	90	87	83	127	150	111	22	46	24	68	73	55

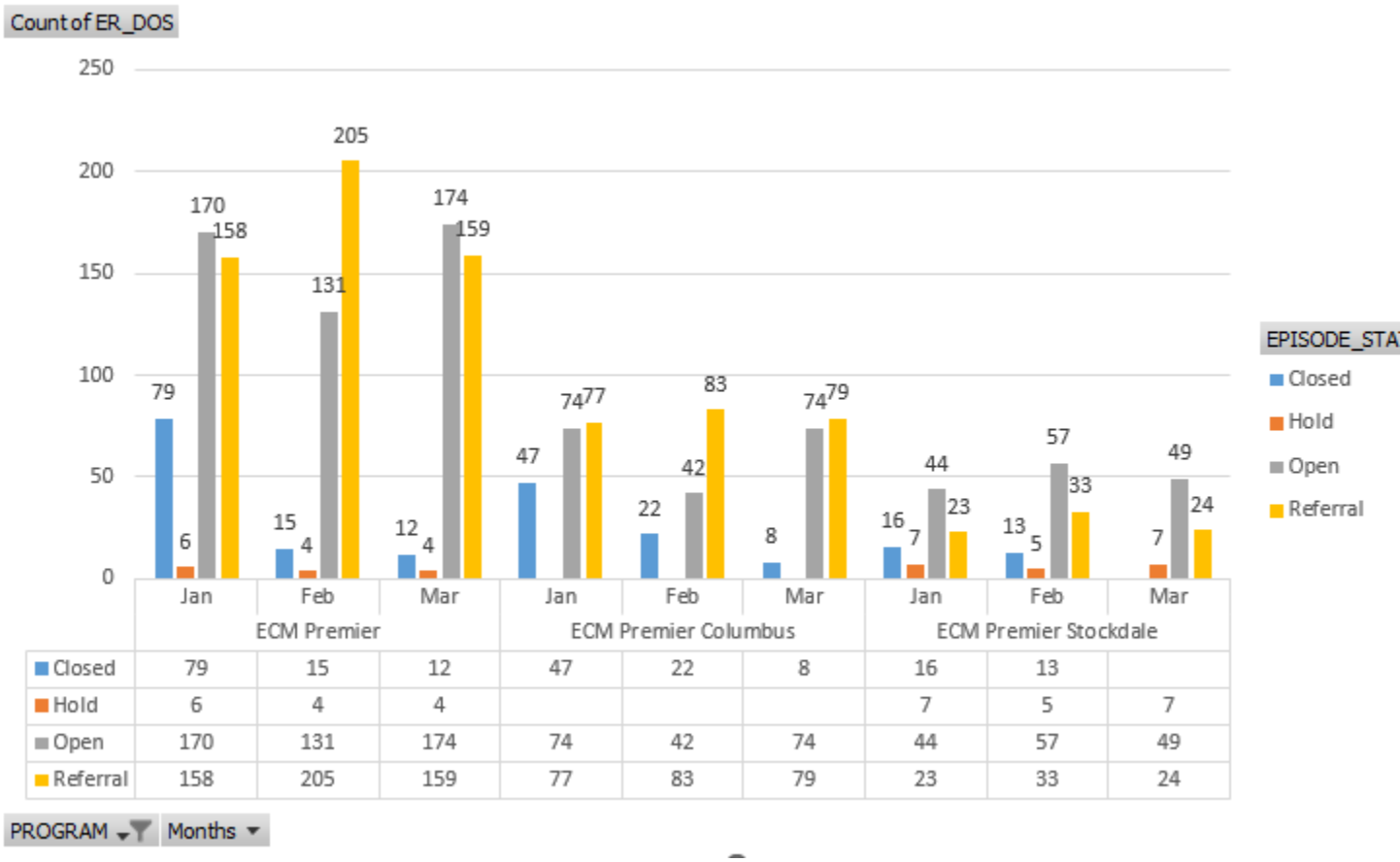
Premier

Quarter I Total Enrolled Population:

White Lane: 731

Stockdale: 199

Columbus: 251



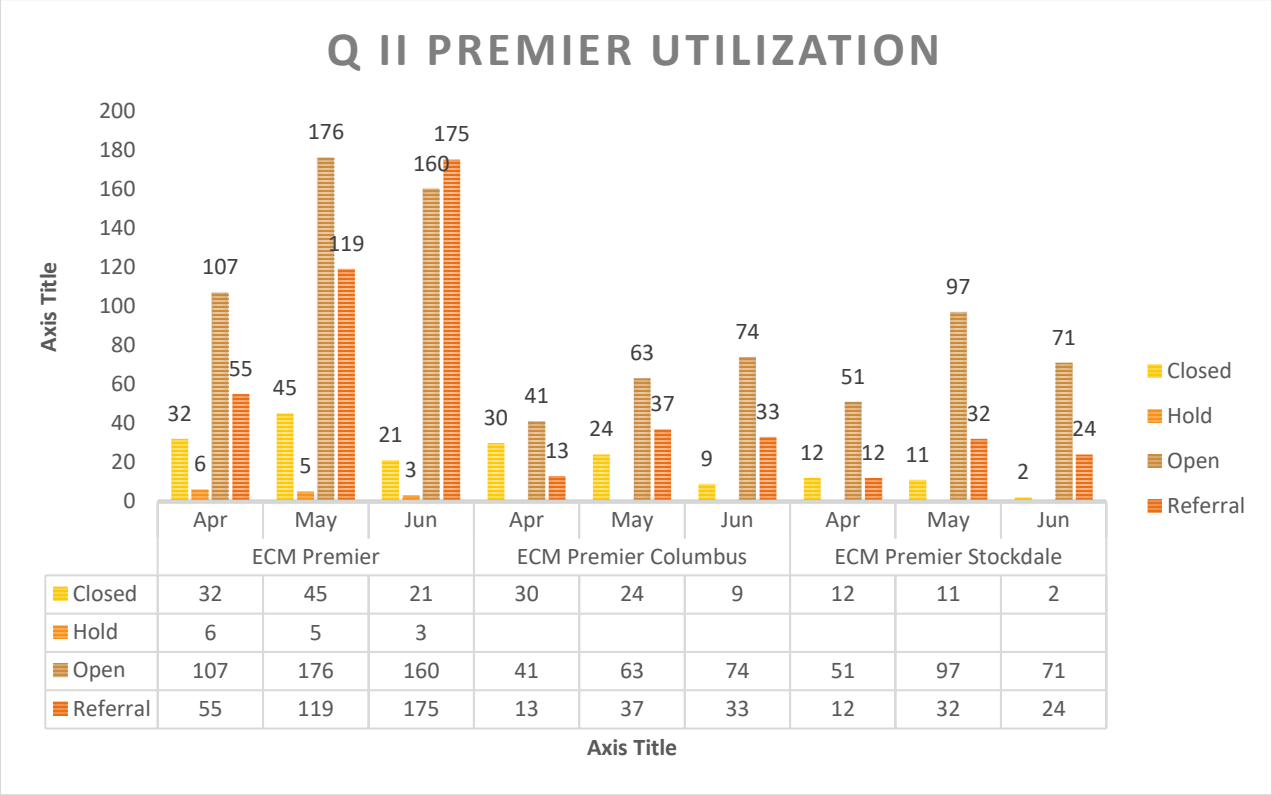
	ECM Premier			ECM Premier Columbus			ECM Premier Stockdale		
Closed	79	15	12	47	22	8	16	13	
Hold	6	4	4				7	5	7
Open	170	131	174	74	42	74	44	57	49
Referral	158	205	159	77	83	79	23	33	24

Premier Quarter II Total Enrolled Population:

White Lane: 808

Stockdale: 218

Columbus: 323



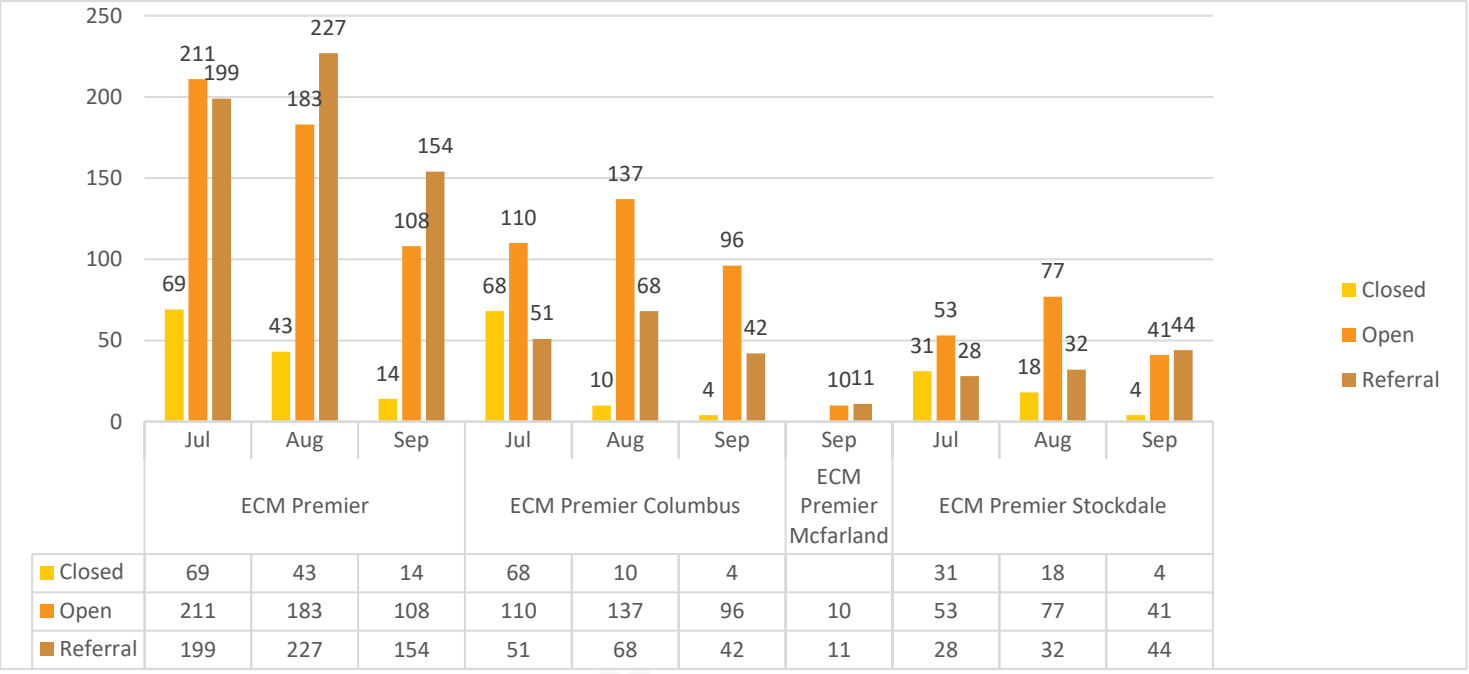
	ECM Premier			ECM Premier Columbus			ECM Premier Stockdale		
	Apr	May	Jun	Apr	May	Jun	Apr	May	Jun
Closed	32	45	21	30	24	9	12	11	2
Hold	6	5	3						
Open	107	176	160	41	63	74	51	97	71
Referral	55	119	175	13	37	33	12	32	24

Premier Quarter III Total Enrolled Population:

White Lane: 1033

Stockdale: 248

Columbus: 535



	ECM Premier			ECM Premier Columbus			ECM Premier Mcfarland	ECM Premier Stockdale		
	Jul	Aug	Sep	Jul	Aug	Sep	Sep	Jul	Aug	Sep
Closed	69	43	14	68	10	4		31	18	4
Open	211	183	108	110	137	96	10	53	77	41
Referral	199	227	154	51	68	42	11	28	32	44

Distributive Model

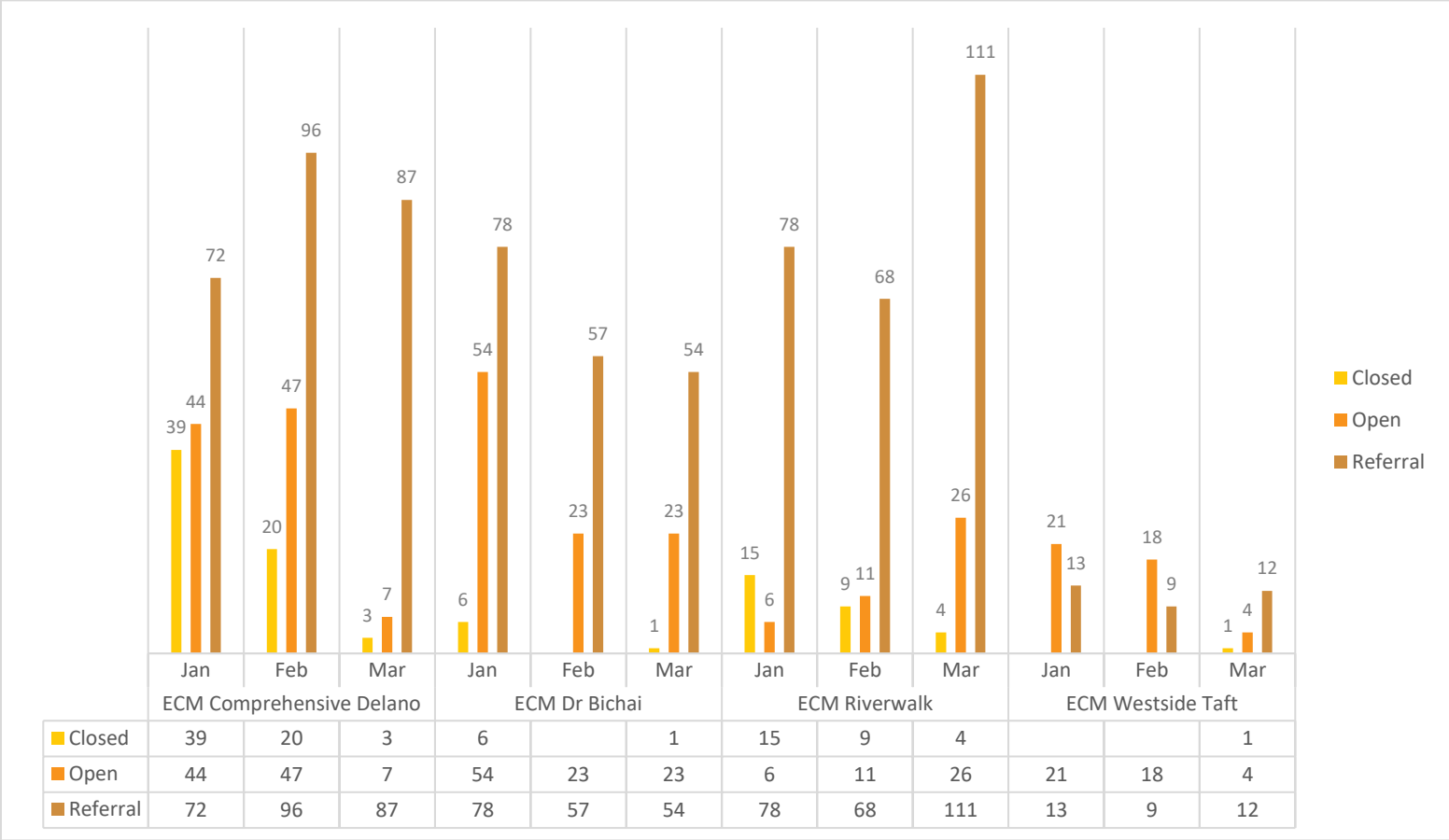
Quarter I Total Enrolled Population

Westside Taft: 102

Coastal Kids: 88

Dr. Bichai: 80

CMG: 117



	ECM Comprehensive Delano			ECM Dr Bichai			ECM Riverwalk			ECM Westside Taft		
	Jan	Feb	Mar	Jan	Feb	Mar	Jan	Feb	Mar	Jan	Feb	Mar
Closed	39	20	3	6		1	15	9	4			1
Open	44	47	7	54	23	23	6	11	26	21	18	4
Referral	72	96	87	78	57	54	78	68	111	13	9	12

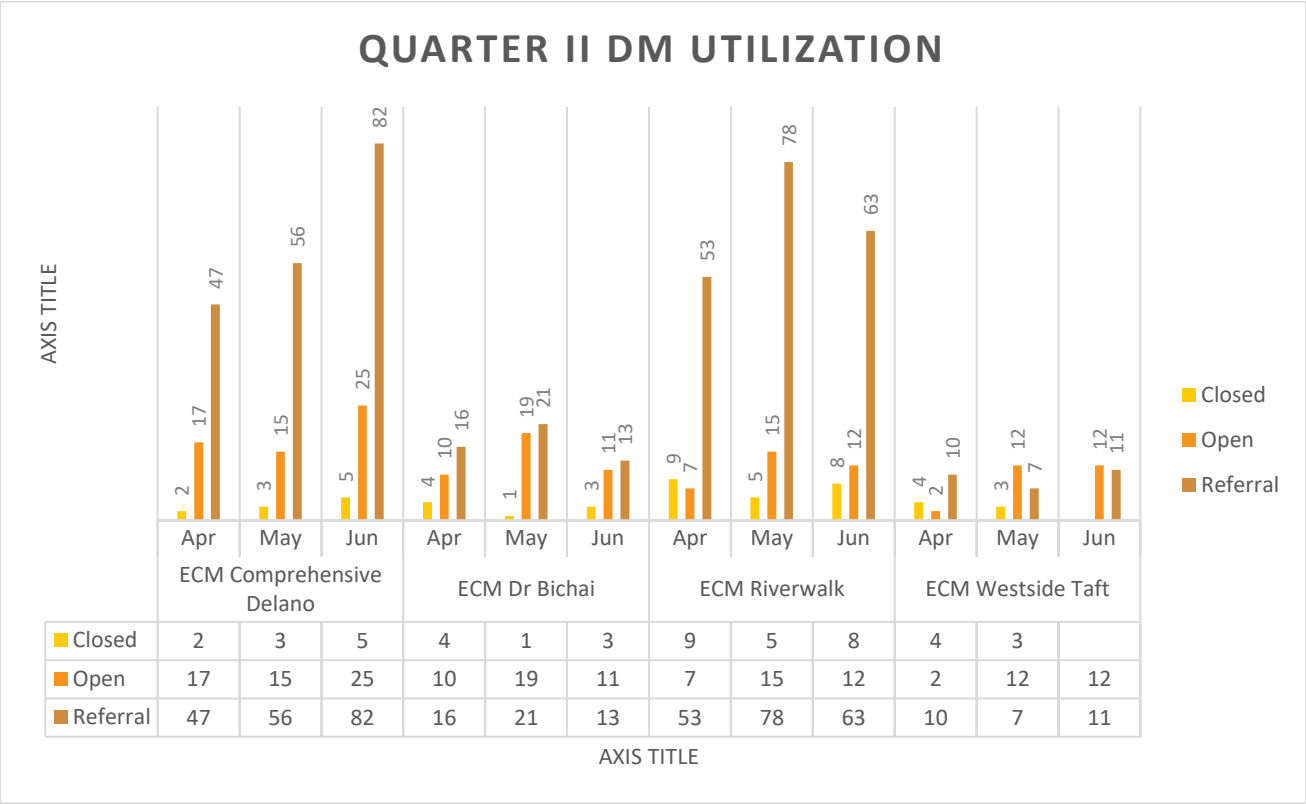
Quarter II Total Enrolled Population

Westside Taft: 82

Coastal Kids: 89

Dr. Bichai: 63

CMG: 128



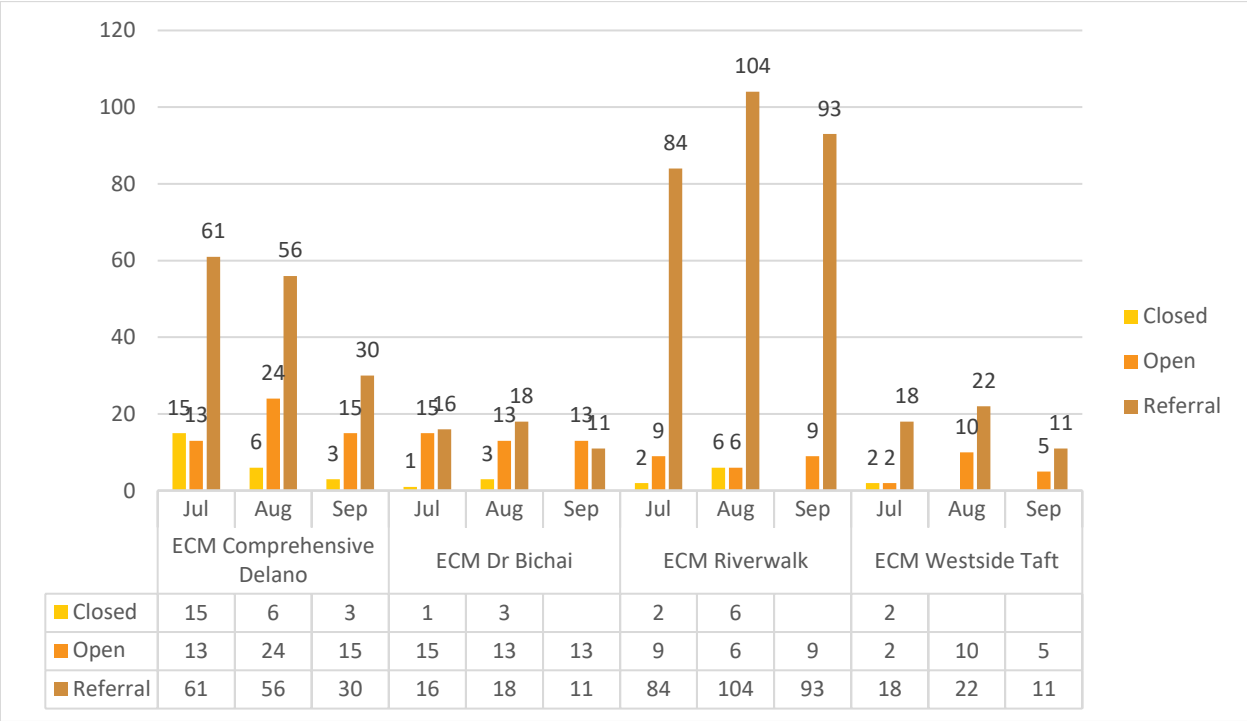
Quarter III Total Enrolled Population

Westside Taft: 98

Coastal Kids: 73

Dr. Bichai: 61

CMG: 136



	ECM Comprehensive Delano			ECM Dr Bichai			ECM Riverwalk			ECM Westside Taft		
	Jul	Aug	Sep	Jul	Aug	Sep	Jul	Aug	Sep	Jul	Aug	Sep
Closed	15	6	3	1	3		2	6		2		
Open	13	24	15	15	13	13	9	6	9	2	10	5
Referral	61	56	30	16	18	11	84	104	93	18	22	11

Total ECM Population: 5858

In accordance to the most recent DHCS IPP Provider milestone requirements our institutional goals moving forward is to use our this quarterly data as a benchmark to incrementally decrease our overall percentage of utilization. As per the IPP requirements, plans must show a net decrease in the rate of emergency department (ED) visits per 1,000 member months for members ages 21 and older and who are eligible for ECM. MUST have positive improvement in periods 4 and 5. We leverage our monthly site meetings to present emergency room utilization trends and totals to the providers and continue to work synergistically to find innovative ways to engage these members in the post discharge event and strategize on ways to prevent the over-utilization of emergency department services.

IPP measures:

4.4.3 ***Quantitative Response Only*** Percentage of members who had ambulatory visits within 7 days post hospital discharge
4.4.4 Quantitative Response Only Rate of emergency department (ED) visits per 1,000 member months for members ages 21 and older and who are eligible for ECM
4.4.5 ***Quantitative Response Only*** Percentage of emergency department (ED) visits with a discharge diagnosis of mental illness or intentional self-harm for members ages 21 and older and who are eligible for ECM who had a follow-up visit with any practitioner within 30 days of the ED visit (31 total days)

4.4.6 ***Quantitative Response Only*** Percentage of emergency department (ED) visits with a discharge diagnosis of alcohol or other drug (AOD) use or dependence for members ages 21 and older and who are eligible for ECM who had a follow-up visit with any practitioner within 30 days of the ED visit (31 total days)
4.4.7 ***Quantitative Response Only*** Percentage of members ages 21 and older and who are eligible for ECM who had an ambulatory or preventive care visit
4.4.8 ***Quantitative Response Only*** The percentage of members 3-20 years of age and who are eligible for ECM who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner
4.4.9 ***Quantitative Response Only*** Percentage of hospital discharges for members ages 21 and older and who are eligible for ECM who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider within 30 days after discharge

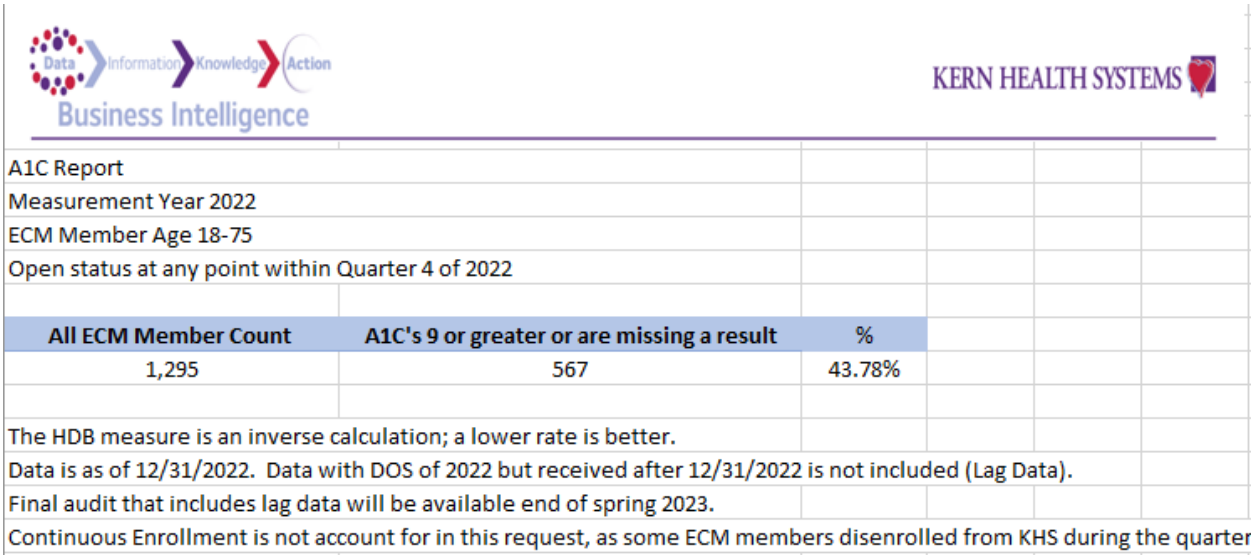
ECM clinical measure:

Hemoglobin A1c Control for Patients With Diabetes – HbA1c Poor Control (> 9%) measure

With our growing population in ECM we understand that our growing footprint in our organization lends the necessity of a shared commitment to the KHS organizational values to the adherance and wholistic improvement in MCAS measures. With this clinical measure, we want to emphasize our commitment in serving the ECM population in this MCAS measure by reinforce member and provider education regarding MCAS measure with and added emphasis on the Hemoglobin A1c Control for Patients with Diabetes – HbA1c Poor Control (> 9%) measure.

Historically with the ECM program we set a benchmark of a minimum of monthly meetings with the sites to discuss all administrative, technical, and clinical needs they may have. As we have evolved and grown in the program we have focused our clinical efforts in these meetings to build a solid focus on MCAS measures and emphasized with the sites the importance of tailoring their coordination/provider workflow to help meet these measures. Below, our internal Business Intelligence team queried the performance ECM member had in this measure as of close of Quarter 4 2022. Our population included members who are in 'Open' status (or engaged) with an ECM site through quarter 1, 2 & 3 and met the thresholds of the measure:

Quarter 4 2022 results:



Data Information Knowledge Action
Business Intelligence

KERN HEALTH SYSTEMS

A1C Report
Measurement Year 2022
ECM Member Age 18-75
Open status at any point within Quarter 4 of 2022

All ECM Member Count	A1C's 9 or greater or are missing a result	%
1,295	567	43.78%

The HDB measure is an inverse calculation; a lower rate is better.
Data is as of 12/31/2022. Data with DOS of 2022 but received after 12/31/2022 is not included (Lag Data).
Final audit that includes lag data will be available end of spring 2023.
Continuous Enrollment is not account for in this request, as some ECM members disenrolled from KHS during the quarter

Quarter 1 progress:

Measure	Population	Members Compliant	Measure Compliant Rate	MPL Goal	HPL Goal
Hemoglobin A1c Testing & Control for Patients With Diabetes Inverse Measure	1,241	813	**61.5%**	50.95	61.27

Quarter 2 Progress:

Measure	Population	Members Compliant	Measure Compliant Rate	MPL Goal	HPL Goal
Hemoglobin A1c Testing & Control for Patients With Diabetes Inverse Measure	1,327	714	**53.8%**	50.95	61.27

Quarter 3 Progress:

Measure	Population	Members Compliant	Measure Compliant Rate	MPL Goal	HPL Goal
Hemoglobin A1c Testing & Control for Patients With Diabetes Inverse Measure	1,518	548	**36.1%**	50.95	61.27

As we move forward with our efforts in the coming year, we plan on rolling out MCAS specific reports that the sites will be held accountable for actionable items leading to completion of the given measure. For the QIC we will continue to track the progress to date through the quarters of the above MCAS measure, work with our internal team to drill down data per site and updating the committee accordingly.

Patient Satisfaction:

Survey Data

In December 2022, the Enhanced Care Management team had sent an experience satisfaction survey out to it's members for resubmission to the plan. As of date of submission to the QIC, we are collecting all return surveys and plan to have resulting data quantified and graphed for further analysis and appropriate action plan formulation as stipulated by the results. Please see the below for survey outline.

ECM Member Survey Summary 2023

• Sample Size: 3500

• Completed Surveys: 488

- Overall ratings for the plan and the Enhanced Care Management (ECM) Program are high.

• 94% of members are very satisfied or satisfied with Kern Family as their health insurance plan.

• 92% are satisfied with their overall experience with the ECM Program.

• 95% are very or somewhat likely to refer the program to family or friends.

- Most participants recognize benefits from participation.

• 75% indicated that they can manage their health care better than 12 months ago.

• 72% indicated that they can keep their symptoms in check better.

• 69% rated their physical health as better, while 64% rated their mental health as better.

• Three areas for improvement: lack of timely appointments, dissatisfaction with wait times for scheduled services, and dissatisfaction with the short amount of time spent with their provider

Kern Family Health Care

SURVEY INSTRUCTIONS

- Answer each question by marking the box to the left of your answer.

Thank you for being part of the Kern Family Enhanced Care Management (ECM) Program. Your feedback on your experiences with this program is needed for us so we ask that you take a few minutes to answer this brief survey. Please know that your responses will remain private, though your input will help us improve our quality of care by better knowing if we are meeting your needs. Please return this survey in the postage paid envelope provided.

EXPERIENCE WITH ECM PROGRAM

1. **When did you first become involved with the Kern Family ECM Program?**
   - ☐ Within the past 12 months
   - ☐ 12 to 24 months ago
   - ☐ Longer than 24 months ago

2. **How easy is it for you to schedule visits with the Kern Family ECM Program?**
   - ☐ Very easy
   - ☐ Somewhat easy
   - ☐ Somewhat hard
   - ☐ Very hard

3. **Do you have a hard time scheduling ongoing visits for any of the following reasons?**
   - ☐ Office hours do not work for my schedule
   - ☐ Available visits are too far in the future
   - ☐ I don't have a way to get to my office visits
   - ☐ Other
   - ☐ I do not have any scheduling issues

Checked on: 10/27/2022, 6:43 pm
To create health literate documents aim for Grade 6 or lower
Flesch-Kincaid Grade: 6.50

EXPERIENCE WITH ECM STAFF

4. **The Kern Family ECM Program is designed to help members manage their care. For each of the following, please check if you have seen or talked with the same person regularly for the past 12 months.**

	YES	NO	N/A
a. Primary care doctor	☐	☐	☐
b. Behavioral Health doctor	☐	☐	☐
c. Other Specialists	☐	☐	☐
d. Care Manager	☐	☐	☐
e. Primary care doctor	☐	☐	☐

Office hours do not work for my schedule
- ☐ Available appointments are too far in the future
- ☐ I have transportation issues
- ☐ Other???
- ☐ I do not have any scheduling issues

5. **Do you visit your assigned Kern Family ECM program physician each time you need care?**
   - ☐ Yes, every time or nearly every time
   - ☐ Yes, most of the time
   - ☐ No, I go to other doctor offices

EXPERIENCE WITH TELEHEALTH

6. **Currently with the COVID situation, the ECM program is using telehealth in place of in-person visits. Have you participated in a telehealth appointment with your ECM team?**
   - ☐ Yes
   - ☐ No
   - ☐ Wasn't aware I could

7. **How happy were you with your most recent telehealth visit?**
   - ☐ Very happy
   - ☐ Somewhat happy
   - ☐ Not at all happy
   - ☐ Haven't had a telehealth visit

Continued Page 2

Kern Family Health Care

8. **How likely are you to keep using telehealth visits?**
   - ▫ Very likely
   - ▫ Somewhat likely
   - ▫ Not at all likely
   - ▫ Haven't had a telehealth visit

9. **If you had the option to choose an in-person or a telehealth visit, which would you most prefer?**
   - ▫ In-person visit
   - ▫ Telehealth visit
   - ▫ Hispanic/Latino

OFFICE VISIT SATISFACTION

10. **Please rate your overall satisfaction with the following aspects of your most recent ECM visit:**

	Very Satisfied	Satisfied	Fair	Dissatisfied	Very Dissatisfied
a. Ease of checking in	▫	▫	▫	▫	▫
b. Friendly office staff	▫	▫	▫	▫	▫
c. Wait time to see the doctor	▫	▫	▫	▫	▫
d. Amount of time spent with the doctor	▫	▫	▫	▫	▫
e. Having all your questions answered	▫	▫	▫	▫	▫
f. Knowing required follow-up care	▫	▫	▫	▫	▫

11. **How satisfied are you when you are able to speak to someone from the ECM Program in a timely manner about your health care issues?**

	Very Satisfied	Satisfied	Fair	Dissatisfied	Very Dissatisfied
a. During normal business hours	▫	▫	▫	▫	▫
b. After normal business hours	▫	▫	▫	▫	▫

12. **How satisfied are you with the Kern Family ECM Member Rewards Program?**
    (Not aware of ▫)

	▫	▫	▫	▫	▫

OVERALL SATISFACTION

	Satisfied	Satisfied	Fair	Dissatisfied	Very Dissatisfied
13. **How satisfied are you with Kern Family as your health insurance plan?**	▫	▫	▫	▫	▫
14. **How satisfied are you with your overall experience with your Kern Health ECM Program?**	▫	▫	▫	▫	▫

15. **How likely are you to refer Kern Health's ECM Program to family or friends?**
    ▫ Very likely ▫ Somewhat likely ▫ Somewhat unlikely ▫ Very unlikely

Continued Page 3

16. Compared to 12 months ago, how would you rate…?

	Much Better	Better	About the Same	Worse	Much Worse
a. Your full physical health	◻	◻	◻	◻	◻
b. Your full mental health	◻	◻	◻	◻	◻
c. How well you can keep your symptoms in check	◻	◻	◻	◻	◻
d. How well you can manage your health care	◻	◻	◻	◻	◻

ABOUT YOU

17. Gender: ◻ Male ◻ Female

18. Age: **need range options – Under 21, 21-30, 31-40, 41-50, 51-65, 65+.**

19. Ethnicity:

◻ African American
◻ Asian
◻ Caucasian / White
◻ Hispanic/Latino

Thank you for participating in our survey!
Please mail the survey back in the enclosed post- age-paid, self-addressed reply envelope or send to: SPH Analytics • P.O. Box 985009
Ft. Worth, TX 76185-5009

If you have any questions, please call 1-866-975-6709 (TTY Call 711).

KERN HEALTH SYSTEMS

To: KHS QI-UM Committee

From: Isabel Silva, MPH

Date: 11/30/2023

Re: 3rd Quarter Health Education Department Report

Background

KHS' contract with DHCS requires that it implements and maintains a health education system that includes programs, services, functions, and resources necessary to provide health education, health promotion and patient education for all members. The contract also requires that KHS have a Cultural and Linguistic Services Program and that KHS monitors, evaluates and takes effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services.

Discussion

Enclosed is the quarterly health education report summarizing all health education, cultural and linguistic activities performed during the 3rd quarter of 2023.

Fiscal Impact

None

Requested Action

Approve and file

Kern Health Systems
Health Education, Cultural and Linguistic Activities Report
3rd Quarter 2023

Executive Summary

Report Date: November 1, 2023

OVERVIEW

Kern Health Systems' Health Education (HE) department provides comprehensive, culturally, and linguistically competent services to plan members with the intent of promoting healthy behaviors, improving health outcomes, reducing risk for disease and empowering plan members to be active participants in their health care. The Executive Summary below highlights the larger efforts currently being implemented by the HE department. Following this summary reflects the statistical measurements for the HE department detailing the ongoing activity for Q3 2023.

Cultural and Linguistics Program

- Linguistic Performance Findings
  - 97% members satisfaction with in-person interpreter
  - 99% member satisfaction with telephonic interpreter
  - 98% members satisfaction with bilingual KHS staff communications
  - 89% of KHS calls reviewed did not have difficulty communicating with members in a non-English language
- C&L In-services
  - 3rd Quarter: Behavioral Health, Utilization Management and Health Education
  - 4th Quarter: Pharmacy, Population Health Management, Member Services, Enhanced Care Management

Health Education Program

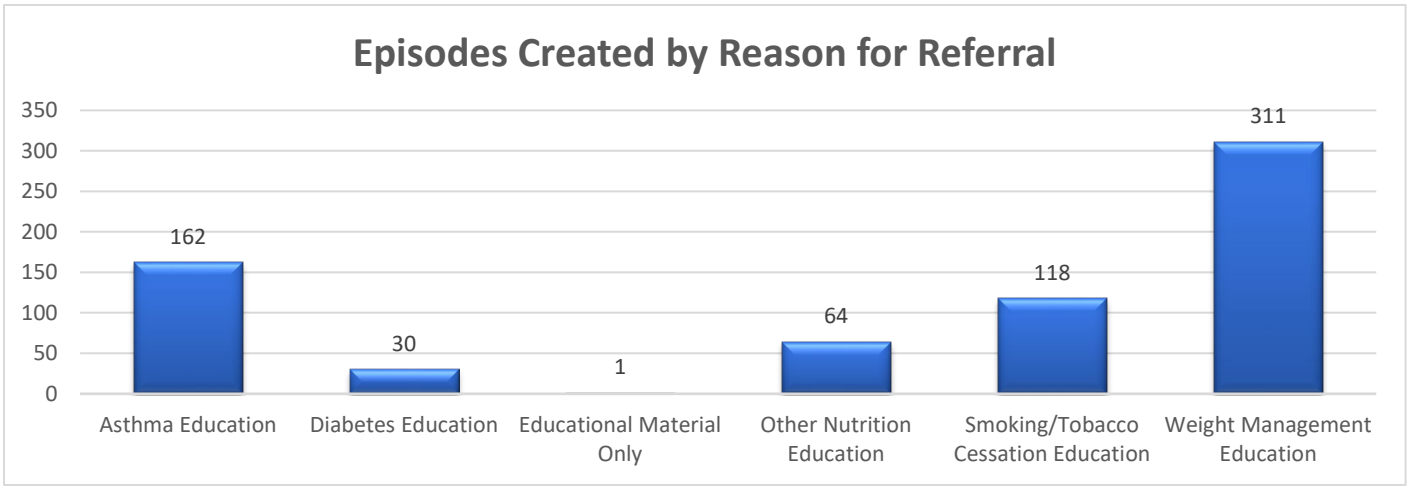
- New Programs:
  - KFHC Live Better Program now offered in Taft
  - Diabetes Education and Empowerment Program (DEEP) – scheduled to launch in Q1 2024
- Health Education Service Findings
  - 97% member satisfaction with classes
  - 5-percentage point increase in member knowledge
  - Diabetes Prevention Program: 7.7% average weight loss with English cohort and 2.6% average weight loss in current Spanish cohort.
  - Facilitator opportunities:
    - Enhanced participant engagement, assessment of participant recall and principles of effective communication and health literacy

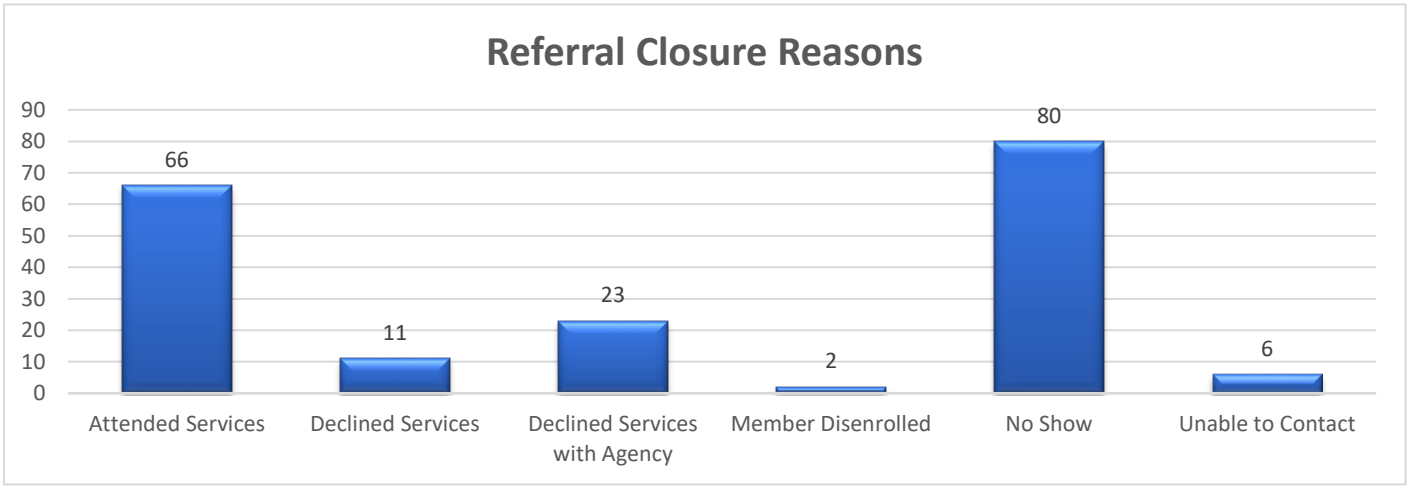
Respectfully submitted,

Isabel Silva, MPH, CHES
Senior Director of Wellness and Prevention

Referrals for Health Education Services

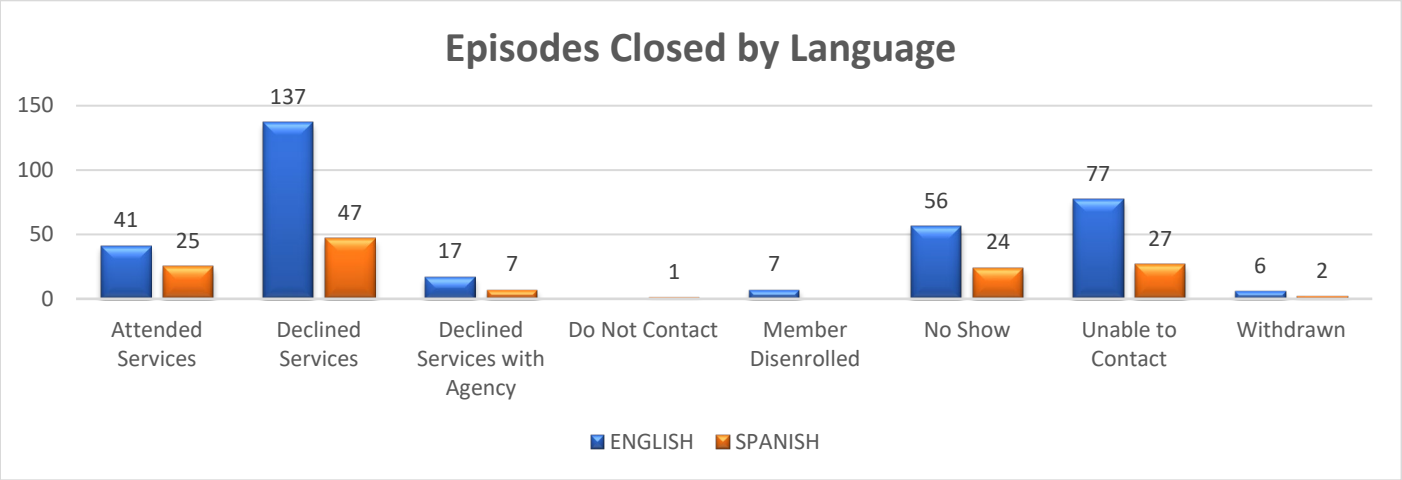
During Q3, there were 686 referrals for health education services which is a 5% decrease in comparison to the previous quarter. Requests for Weight Management continues to be the primary reason for health education services. Additionally, the health education service acceptance rate decreased by 10% between Q2 to Q3 whereas the received services rate decreased from 70% in Q2 to 54% in Q3.

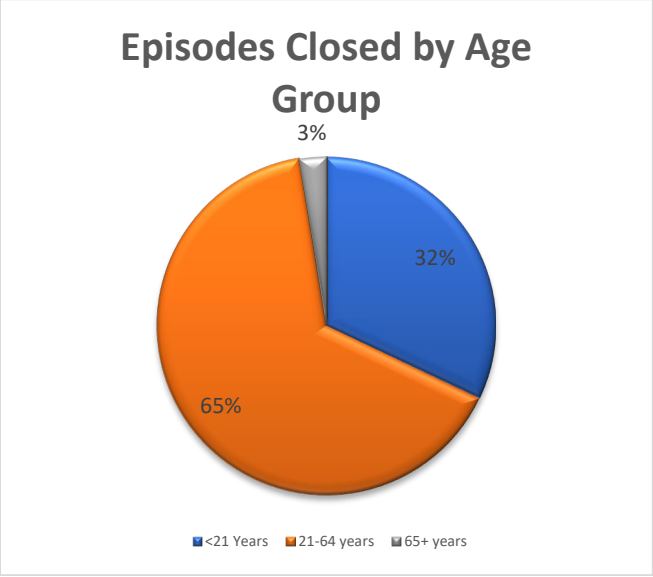


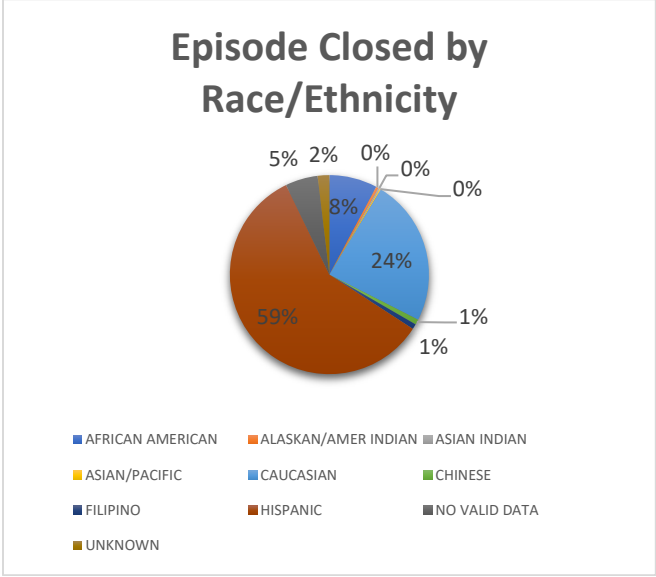


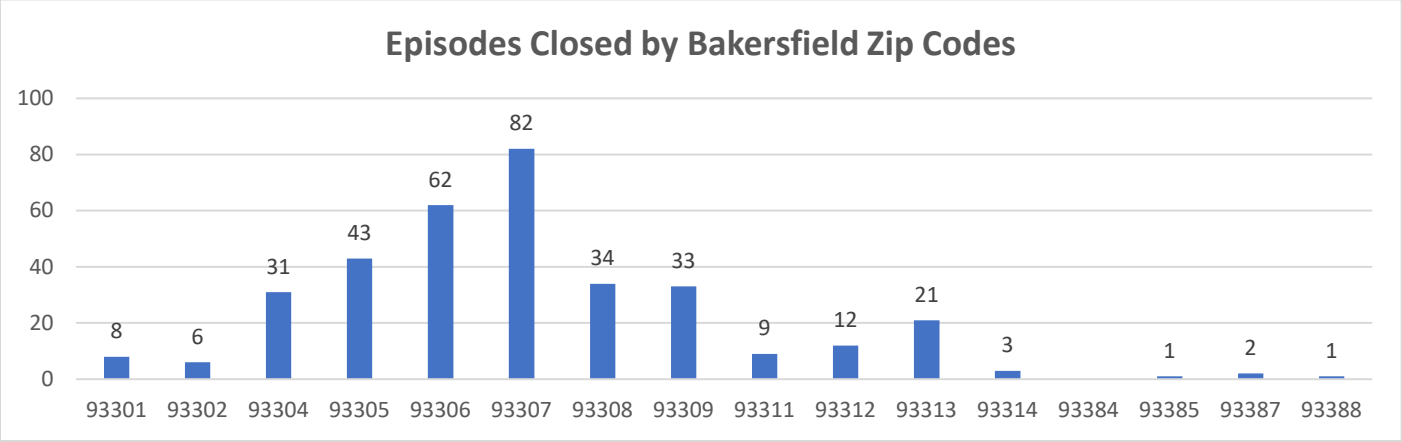
Demographics of Members

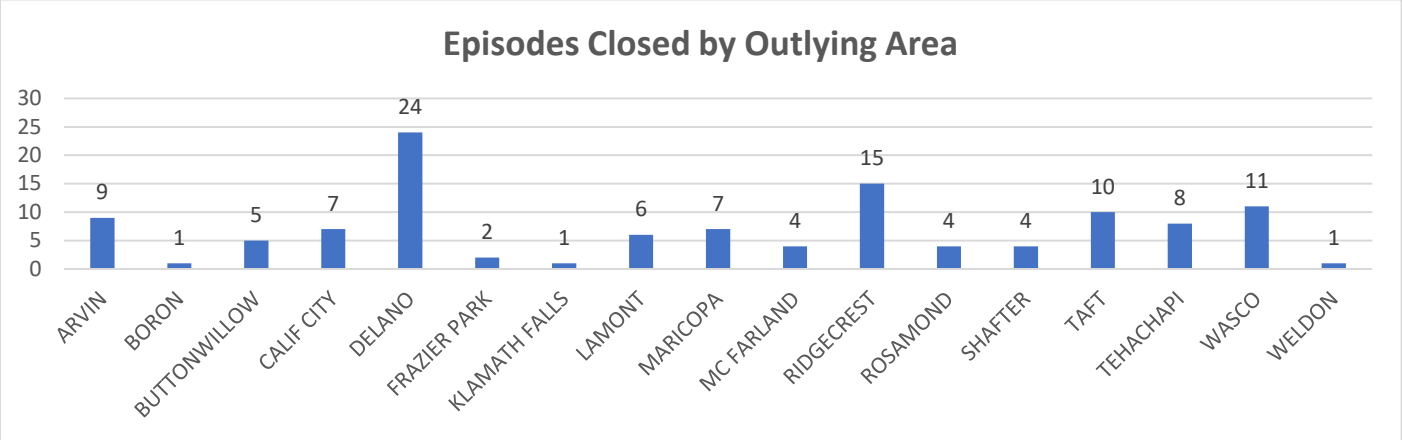
KHS provides services to a culturally and linguistically diverse member population in Kern County. Of the members who received services, the largest age groups were 21-64 years followed by <21 years. A breakdown of member classifications by race and language preferences revealed that many members who received services are Hispanic and preferred to receive services in English. The majority of members who received services reside in Bakersfield with the highest concentration in the 93307 area and Delano in the outlying areas of the county.







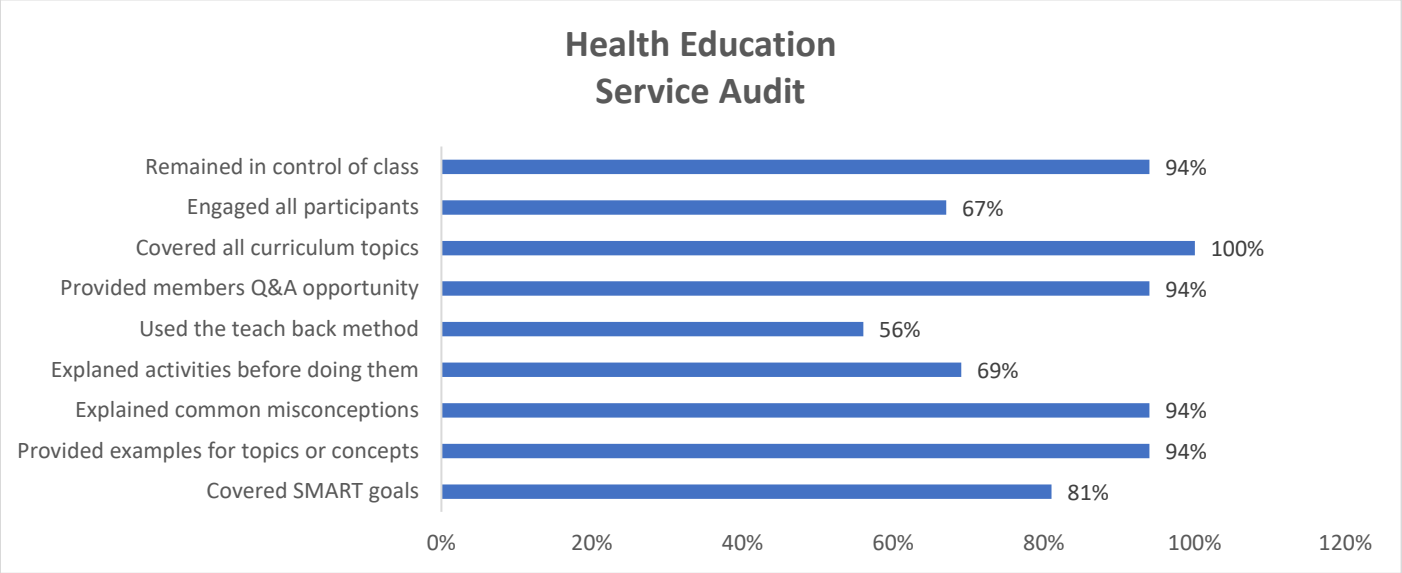




Health Education Service Audit

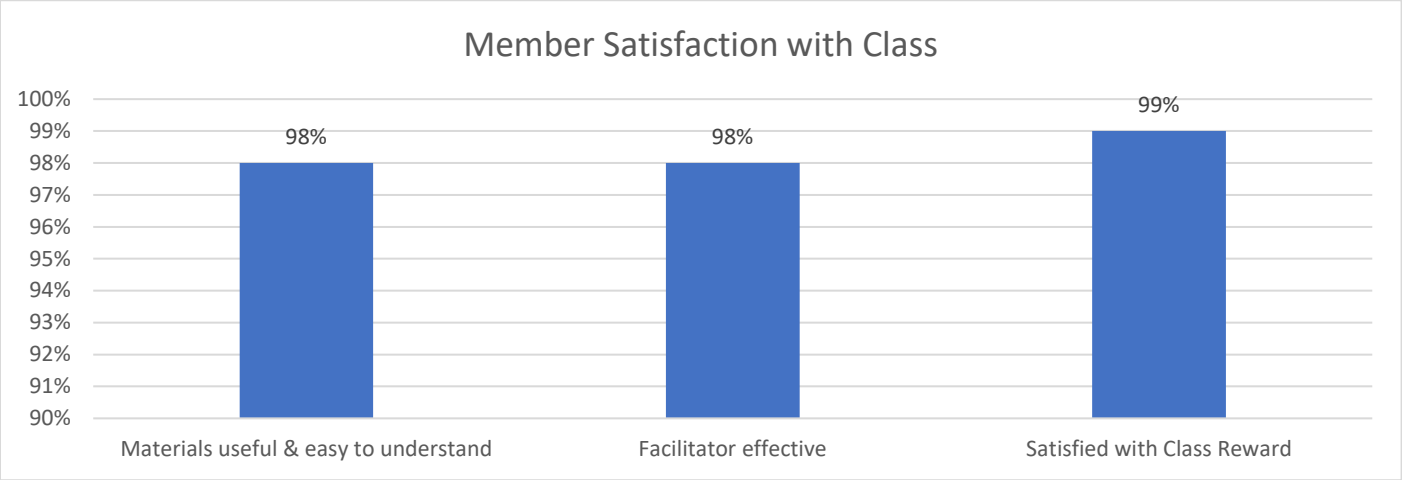
The Health Education Service Audit Tool considers a variety of markers to determine the quality of Health Education Services being provided to members. It includes observations on planning and preparation, implementation and delivery, and member engagement during health education classes. During Q3, 15 classes and 6 facilitators were evaluated. The classes observed were in English or Spanish and represented a variety of combinations among the facilitators and technical assistants. Class format was in-person or virtual.

- Highlights from this period are the facilitators making the information easy for member to understand, scoring 94% on providing examples, discussing common misconceptions, providing members the opportunity to ask questions, and covering all material.
- During this audit period, opportunities were also identified in the planning of classes, focusing on roles and responsibilities and preparation of material in a timely manner. Among facilitators the average score was an 82% proficiency with a range from 65 to 94%.



Health Education Class Evaluations

Health Education classes include an evaluation questionnaire for participants. The questionnaire is provided at the end of the class. Findings revealed that more than 98% of participants were satisfied with the services.



In addition, members referred to the Kick it California (KIC) Quitline were surveyed to gauge satisfaction with this service. Four participants answered when reached out, and only two had received services either by telephone or webchat. Both members found the counseling sessions interesting and easy to follow and that the counseling sessions were effective in helping the member quit or reduce tobacco use.

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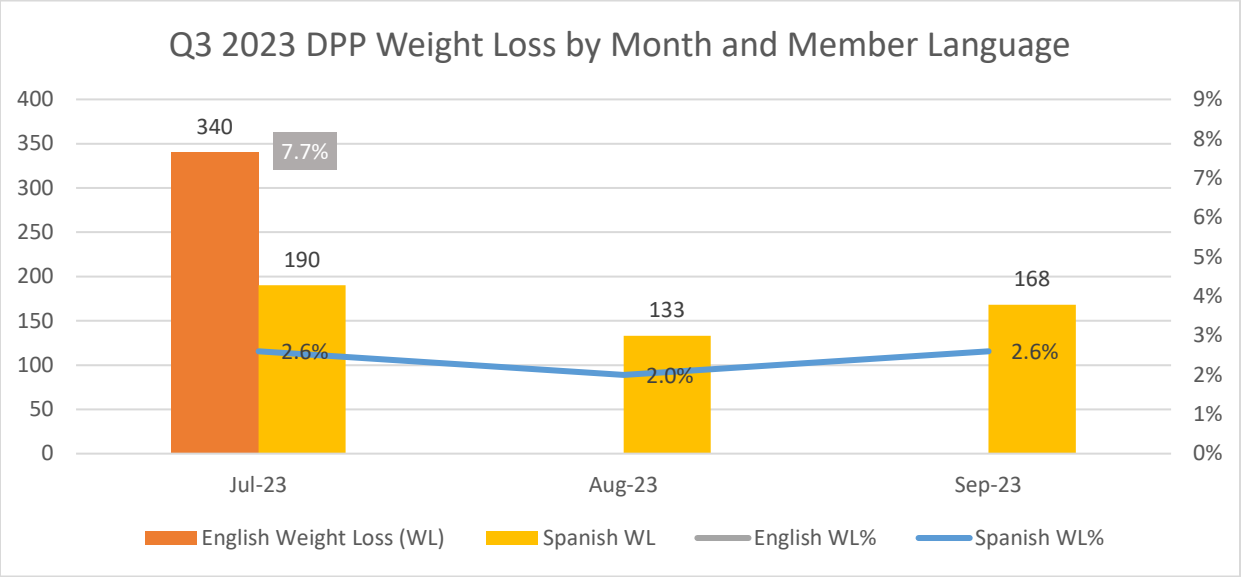
Health Education Program Effectiveness

The Eat Healthy, Be Active curriculum was launched in September 2023. This is a 6-class series, each class lasts about 90 minutes. A pre and posttest questionnaire is distributed per class. During Q3, findings revealed an average 5 percentage point increase in knowledge gained after completing the class series.

The Activity + Eating curriculum was launched in September 2023. This is a 1-time class that lasts about 90 minutes. The evidence shows that it can impact behavior around physical activity. A pre and posttest questionnaire is distributed at each class. During Q3, findings revealed a 5-percentage point increase in knowledge when comparing members who completed a pretest (average 70% correct answers) to members who completed a posttest (average 75% correct answers).

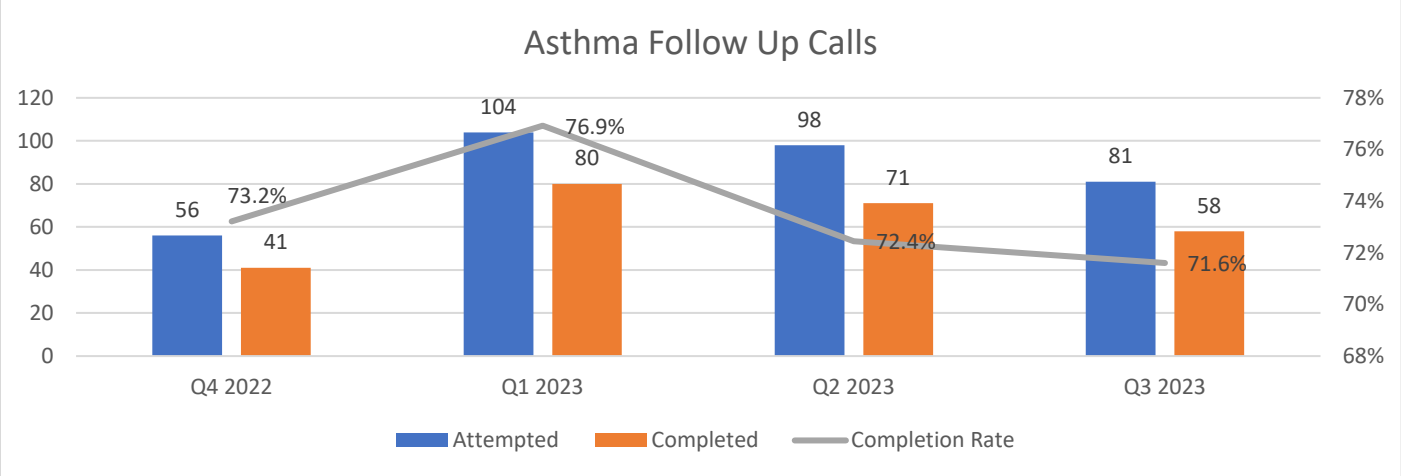
The Fresh Start classes have the goal of reducing harm from tobacco products. Post test questionnaires were implemented in Q3 to field test questions with a class held in English. During this series, members scored an average of 80%, answering an average of 4 of 5 questions correctly. This small cohort demonstrates members have gained knowledge on reducing urges to use tobacco, and the importance of committing to a quit date. Given field testing results, we will begin using these questions as part of the pretest to measure knowledge gain in Q4.

The Diabetes Prevention Program (DPP) is an evidence-based lifestyle change program designed to prevent or delay the onset of type 2 diabetes among at risk members. Weight loss totals and percentages that compare initial combined cohort weight with combined weight at the end of each month in Q3 2023 are shown in the chart below. By the end of Q3 2023, 19 members graduated the English cohort that began in August 2022. The English cohort ended with an average 7.7% weight loss. By the end of September 2023, 36 members were enrolled in the Spanish DPP cohort with an average weight loss of 2.6%.



Asthma Education Effectiveness

Members who have attended the KFHC Breathe Better Asthma Classes are offered asthma follow up calls. These calls occur at 1 month, 3 months, and 6 months after attending the classes. During the follow up call, members are screened to determine if asthma symptoms are well controlled using the Asthma Control Test (ACT) screening tool. An ACT score of 20 or higher is an indicator of well controlled asthma. During Q3 2023, 71.6% of members completed an asthma follow up call. The average ACT score did not improve for members under 12 years old. But it improved slightly for members 12 years and older.



Q3 2023 Average ACT Scores Asthma Follow Up Calls		
Call Month	<12 years of age	12+ years of age
Initial	20.6	14.3
1	19.8	17.3
3	20.3	16.7
6	24*	No data

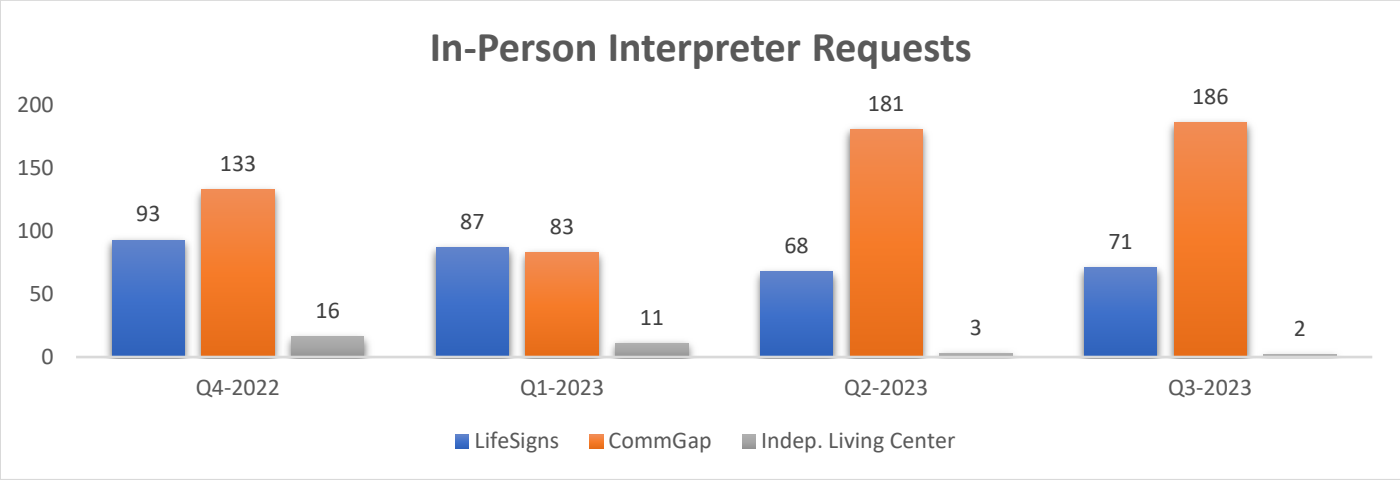
*Small amount of data.

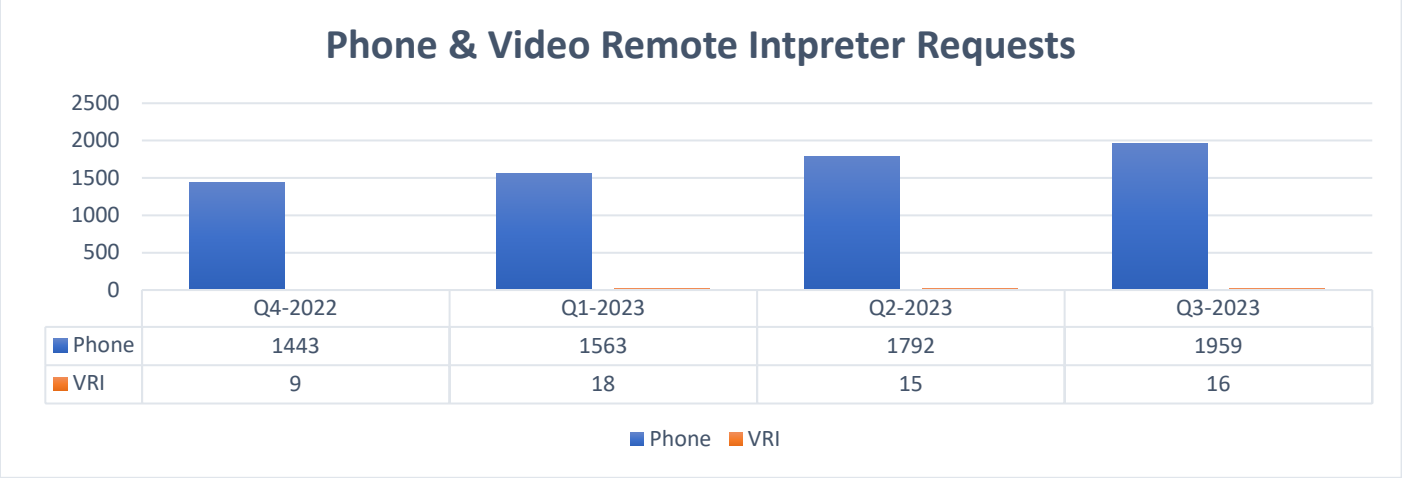
Interpreter Requests

During this quarter, there were 186 requests for Face-to-Face Interpreting, 1,959 requests for Telephonic Interpreting, 16 for Video Remote Interpreting (VRI) and 72 requests for an American Sign Language (ASL) interpreter.

Top Face-to-Face Interpreting Languages Requested Phone and Video Remote
Spanish
Punjabi
Arabic

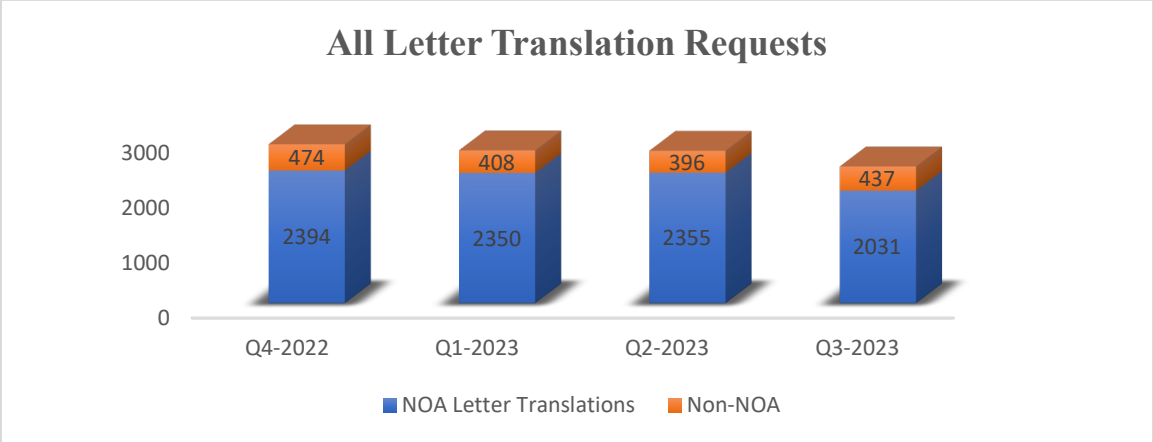
Top Face-to-Face Interpreting Languages Requested In- person
Spanish
Cantonese
Arabic





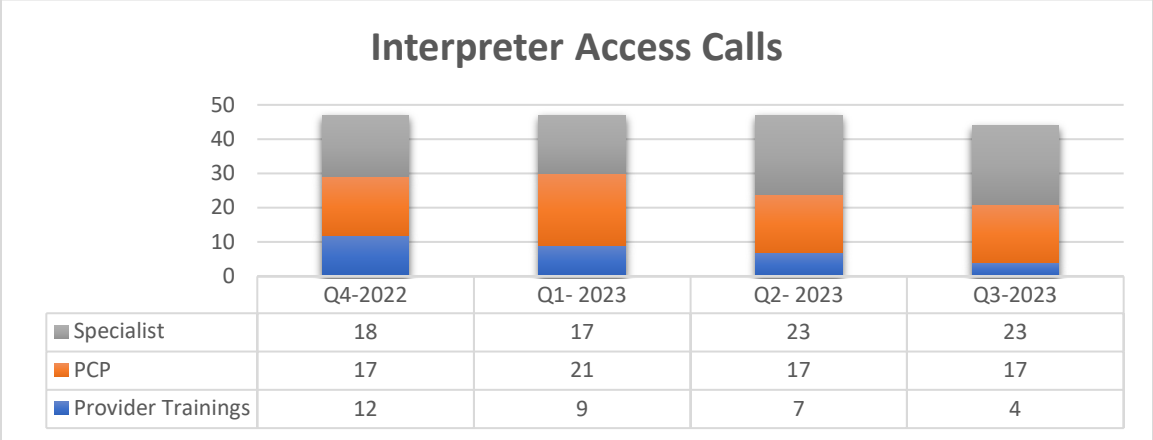
Written Translations

The HE department coordinates the translation of written documents for members. Translations are performed in-house by qualified translators or outsourced through a contracted translation vendor. During this quarter, 2,468 requests for written translations were received.



Interpreter Access Survey Calls

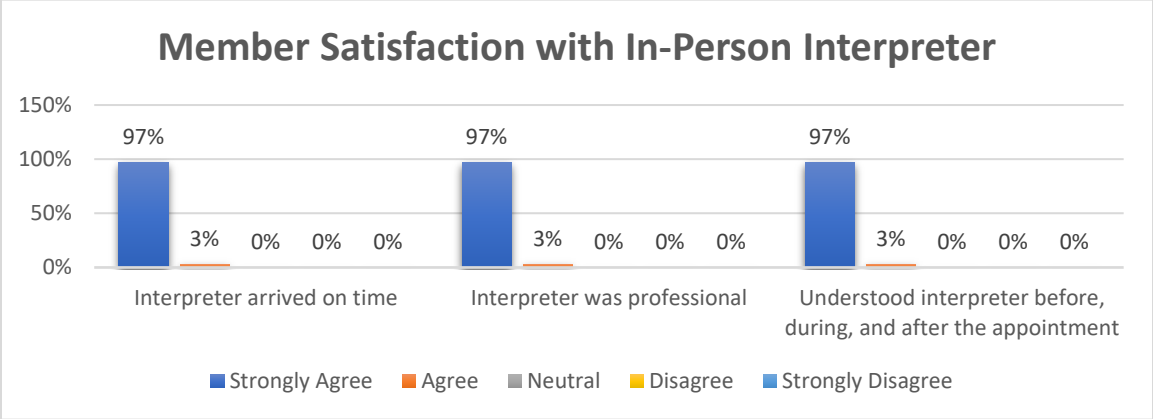
Each quarter, the Provider Network Management department conducts an interpreter access survey among KHS providers. During Q3, 19 PCPs and 22 Specialists participated in this survey. Of these providers, 4 received a refresher training on KHS' C&L services.



	Q4-2022	Q1- 2023	Q2- 2023	Q3-2023
Specialist	18	17	23	23
PCP	17	21	17	17
Provider Trainings	12	9	7	4

Member Satisfaction Surveys

During this quarter, a total of 39 satisfaction surveys were collected from members who received in-person interpreting services and more than 97% of members reported they "Strongly Agreed" or "Agreed" being satisfied with their interpreter.



Over-the-Phone (OPI) Interpreter Call Monitoring

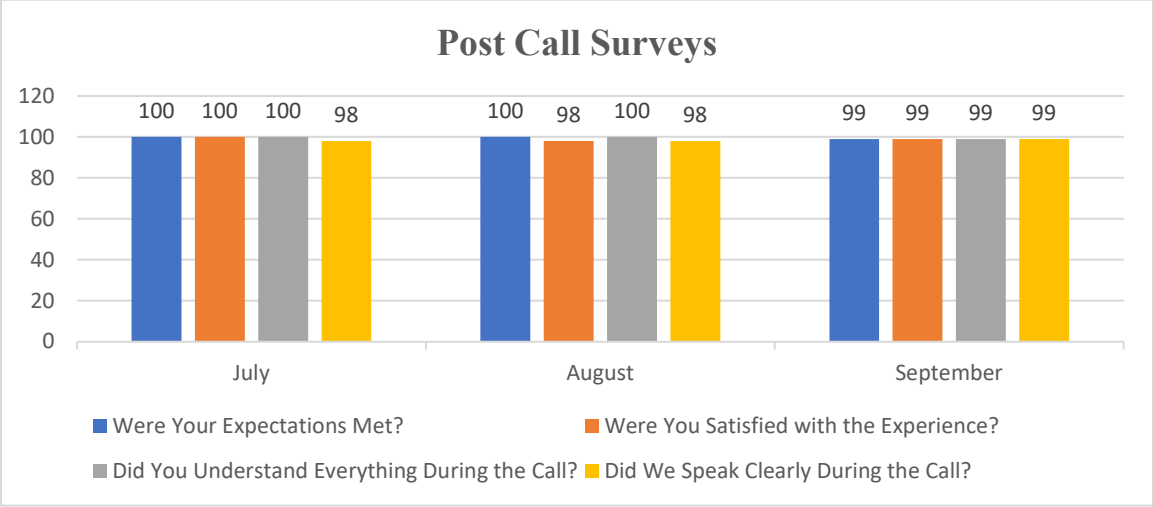
During this quarter, an audit was performed on 30 random OPI interpreter services calls. Calls audited were in Arabic, Ilocano, Mandarin, Punjabi, Spanish, Tagalog, Ukrainian, and Vietnamese. Calls were evaluated for the interpreter's Customer Service, Interpretation Skills, and the ability to follow the Code of Ethics and Standards of Practice. Audit findings revealed 99% of calls Met Expectations.

Bilingual Staff Call Audit

During this quarter, a total of 30 Spanish audio calls from KHS member facing departments were reviewed to assess the linguistic performance of the Bilingual Staff. Findings revealed that 89% of Bilingual staff did not have difficulty communicating with members in a non-English language.

Post Call Surveys

During this quarter, a total of 4,247 Spanish Post Call Surveys were collected from members for all KHS member facing departments to assess the linguistic performance of the Bilingual Staff. KHS' post call survey evaluates member's call experience by language. Findings revealed that 98% of members are satisfied with the linguistic performance of bilingual staff.



KERN HEALTH SYSTEMS

To: KHS QI/UM Committee

From: Nate Scott

Date: November 30, 2023

Re: Executive Summary for 3rd Quarter 2023 Operational Board Update - Grievance Report

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Background

Executive Summary for 3rd Quarter 2023 Operational Board Update - Grievance Report: When compared to the previous four quarters, the following trends were identified related to the Grievances and Appeals received during the 3rd Quarter, 2023.

- There was a slight increase in Grievances and Appeals in Quarter 3, 2023 when compared to Quarter 2, 2023. We can attribute the rise in grievance and appeals to the more than 11% increase in calls received to the Call Center in the 3rd quarter of 2023.
- Of the 1,861 Standard Grievance and Appeal cases, 1,170 were closed in favor of the Plan and 683 cases closed in favor of the Enrollee. At the time of reporting, 8 cases were delayed pending a response and/or medical records from providers.

KHS Standard Grievance and Appeals per 10,000 members = 17.62 per month.

Requested Action

Receive and File

3rd Quarter 2023 Operational Report

Alan Avery
Chief Operating Officer

3rd Quarter 2023 Grievance Report

Category	3rd Quarter 2023	Status	Issue	Q2 2023	Q1 2023	Q4 2022	Q3 2022
Access to Care	303		Appointment Availability	233	123	108	132
Coverage Dispute	0		Authorizations and Pharmacy	0	0	0	0
Medical Necessity	478		Questioning denial of service	420	363	335	346
Other Issues	65		Miscellaneous	55	53	38	30
Potential Inappropriate Care	644		Questioning services provided. All cases forwarded to Quality Dept.	703	758	670	514
Quality of Service	326		Questioning the professionalism, courtesy and attitude of the office staff. All cases forwarded to PR Department	282	216	156	86
Discrimination (New Category)	45		Alleging discrimination based on the protected characteristics	64	62	46	73
Total Formal Grievances	1861			1757	1575	1353	1181
Exempt	2026		Exempt Grievances-	1873	1606	1816	2328
Total Grievances (Formal & Exempt)	3887			3630	3181	3169	3509

*Report with data collected as of 11/16/2023.

KHS Formal Grievances and Appeals per 10,000 members = 17.62/month

Additional Insights-Formal Grievance Detail

Issue	2023 3rd Quarter Grievances	Upheld Plan Decision	Further Review by Quality	Overturned Ruled for Member	Still Under Review
Access to Care	202	140	0	62	0
Coverage Dispute	0	0	0	0	0
Specialist Access	101	61	0	39	1
Medical Necessity	478	180	0	298	0
Other Issues	65	48	0	17	0
Potential Inappropriate Care	644	438	0	202	4
Quality of Service	326	259	0	64	3
Discrimination	45	44	0	1	0
Total	1861	1170	0	683	8

To: KHS QI-UM Committee

From: Nate Scott

Date: November 30, 2023

Re: Executive Summary for 3rd Quarter 2023 Grievance Summary Report

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Background

Executive Summary for the 3rd Quarter Grievance Summary Report:
The Grievance Summary Report supports the high-level information provided on the Operational Report and provides more detail as to the type of grievances KHS receives on behalf of our members.

Kaiser Permanente Grievances and Appeals
During the third quarter of 2023, there were one hundred and ninety-six grievances and appeals received by KFHC members assigned to Kaiser Permanente. Of the one hundred and ninety-six standard grievances and appeals received, one hundred ninety-five cases closed within thirty days; one case was pended and closed after thirty days.

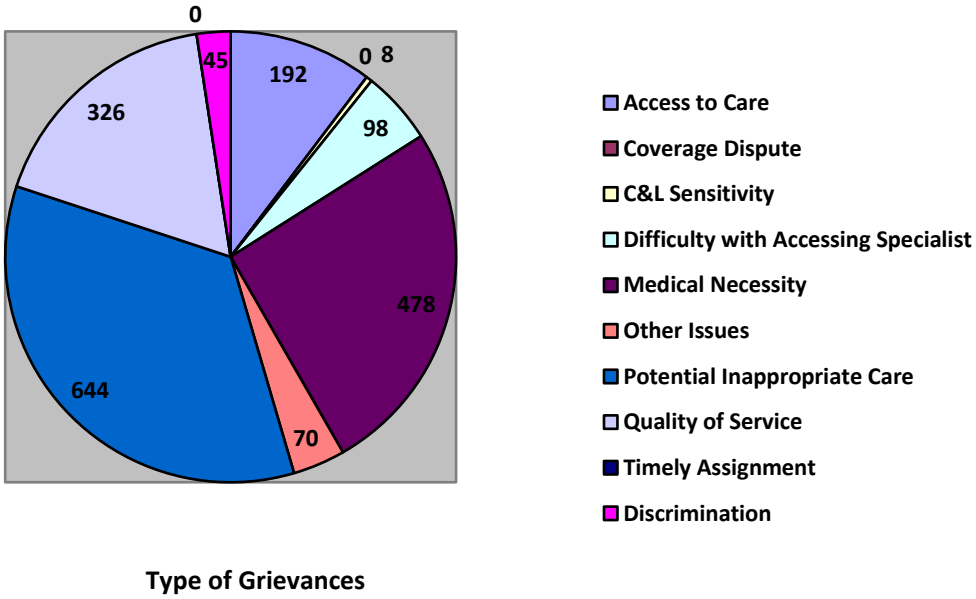
KHS Standard Grievance and Appeal cases per 10,000 members = 16.40 per month.
For KHS members assigned to Kaiser Grievances and Appeals per 10,000 = 32.11 per month.

Requested Action

Receive and File

3rd Quarter 2023 Grievance Summary

Issue	Number	In Favor of Health Plan	Under Review by Q.I	In favor of Enrollee	Still under review
Access to care	192	135	0	57	0
Coverage dispute	0	0	0	0	0
Cultural and Linguistic Sensitivity	8	6	0	2	0
Difficulty with accessing specialists	98	58	0	39	1
Medical necessity	478	180	0	298	0
Other issues	70	50	0	20	0
Potential Inappropriate care	644	438	0	202	4
Quality of service	326	259	0	64	3
Timely assignment to provider	0	0	0	0	0
Discrimination	45	44	0	1	0



KHS Grievances per 10,000 members = 16.86/month

During the third quarter of 2023, there were one thousand, eight hundred and sixty-one standard grievances and appeals received. Six hundred and eighty-three cases were closed in favor of the Enrollee. One thousand one hundred and seventy cases were closed in favor of the Plan. There are eight grievances that are still under review. There were no grievances under review by the KHS Quality Improvement Department. Of the one thousand, eight hundred and sixty-one standard grievances and appeals received, one thousand seven hundred and ninety-two cases closed within thirty days; sixty-one cases were pended and closed after thirty days. There are eight grievances that are still under review.

3rd Quarter 2023 Grievance Summary

Access to Care

There were one-hundred ninety-two grievances pertaining to access to care. One-hundred thirty-five closed in favor of the Plan. Fifty-seven cases closed in favor of the Enrollee. There are no cases still pending review. The following is a summary of these issues:

Ninety-four members complained about the lack of available appointments with their Primary Care Provider (PCP). Sixty-eight cases closed in favor of the Plan after the responses indicated the offices provided the appropriate access to care based on the Access to Care standards. Twenty-six cases closed in favor of the Enrollee after the responses indicated the offices may not have provided appropriate access to care based on Access to Care standards. There are no cases still pending review.

Eighteen members complained about the wait time to be seen for a Primary Care Provider (PCP) appointment. Fourteen cases closed in favor of the Plan after the responses indicated the members were seen within the appropriate wait time for a scheduled appointment or the members were at the offices to be seen as a walk-in, which are not held to the Access to Care standards. Four cases closed in favor of the Enrollee after the responses indicated the members were not seen within the appropriate wait time for a scheduled appointment. There are no cases still pending review.

Forty-two members complained about the telephone access availability with their Primary Care Provider (PCP). Twenty-nine cases closed in favor of the Plan after the responses indicated the members were provided with the appropriate telephone access availability. Thirteen cases closed in favor of the Enrollee after the responses indicated the members may not have been provided with the appropriate telephone access availability. There are no cases still pending review.

Thirty-six members complained about a provider not submitting a referral authorization request in a timely manner. Twenty-four cases closed in favor of the Plan after it was determined the referral authorization request had been submitted in a timely manner. Twelve cases closed in favor of the Enrollee after it was determined the referral authorization request may not have been submitted in a timely manner. There are no cases still pending review.

One member complained about physical access to provider. One case closed in favor of the Enrollee after it was determined the physical access may not have been appropriate. There are no cases still pending review.

One member complained about geographic access to provider. The case closed in favor of the Enrollee after it was determined the geographic access may not have been appropriate. There are no cases still pending review.

Coverage Dispute

There were no grievances pertaining to a Coverage Dispute issue.

Cultural and Linguistic Sensitivity

Eight members complained about the lack of available interpreting services to assist during their appointments. Two cases closed in favor of the Enrollee after the response from the provider indicated the member may not have been provided with the appropriate access to interpreting services. Six cases closed in favor of the Plan after the responses from the providers indicated the members were provided with the appropriate access to interpreting services. There are no cases still pending review.

Difficulty with Accessing a Specialist

There were ninety-eight grievances pertaining to Difficulty Accessing a Specialist. Fifty-eight cases closed in favor of the Plan. Thirty-nine cases closed in favor of the Enrollee. There is one case still under review. The following is a summary of these issues:

Fifty-four members complained about the lack of available appointments with a specialist. Thirty-four cases closed in favor of the Plan after the responses indicated the members were provided the appropriate access to specialty care based on the Access to Care Standards. Nineteen cases closed in favor of the Enrollee after the responses indicated the offices may not have provided appropriate access to care based on Access to Care standards. There is one case still under review.

Six members complained about the wait time to be seen for a specialist appointment. Three cases closed in favor of the Plan after the response indicated the member was provided with the appropriate wait time for a scheduled appointment based on the Access to Care Standards. Three cases closed in favor of the Enrollee after the response indicated the member may not have been provided with the appropriate wait time for a scheduled appointment based on the Access to Care Standards. There are no cases under review.

Nineteen members complained about the telephone access availability with a specialist office. Ten cases closed in favor of the Plan after the response indicated the member was provided with the appropriate telephone access availability. Nine cases closed in favor of the Enrollee after the response indicated the member may have not been provided with the appropriate telephone access availability. There are no cases under review.

Nineteen members complained about a provider not submitting a referral authorization request in a timely manner. Eleven cases closed in favor of the Plan after it was determined the referral authorization request had been submitted in a timely manner. Eight cases closed in favor of the Enrollee after it was determined the referral authorization request may not have been submitted in a timely manner. There are no cases under review.

Medical Necessity

There were four hundred and seventy-eight appeals pertaining to Medical Necessity. One hundred and eighty cases were closed in favor of the Plan. Two hundred and ninety-eight cases were closed in favor of the Enrollee. There are no cases under review. The following is a summary of these issues:

One hundred and eighty of the cases closed in favor of the Plan as it was determined that there was no supporting documentation submitted with the referral authorization requests to support the criteria for medical necessity for the requested specialist or DME item;

therefore, the denials were upheld. Of the cases that were closed in favor of the Plan, two were partially overturned. Two hundred and ninety-eight cases were closed in favor of the Enrollee as it was determined medical necessity was met and the denials were overturned and approved. There are no cases under review.

Other Issues

There were seventy grievances pertaining to Other Issues that are not otherwise classified in the other categories. Fifty cases were closed in favor of the Plan after the responses indicated the appropriate service were provided. Twenty cases closed in favor of the Enrollee after the responses indicated the appropriate service may not have been provided. There are no cases still under review.

Potential Inappropriate Care

There were six hundred and forty-four grievances involving Potential Inappropriate Care issues. These cases were forwarded to the Quality Improvement (QI) Department for their due process. Upon review, four hundred and thirty-eight cases were closed in favor of the Plan, as it was determined a quality-of-care issue could not be identified. Two hundred and two cases were closed in favor of the Enrollee as a potential quality of care issue was identified and appropriate tracking or action was initiated by the QI team. There are four cases still pending further review with QI.

Quality of Service

There were three hundred and twenty-six grievances involving Quality of Service issues. Two hundred and fifty-nine cases closed in favor of the Plan after the responses determined the members received the appropriate service from their providers. Sixty-four cases closed in favor of the Enrollee after the responses determined the members may not have received the appropriate services. There are three cases still under review.

Timely Assignment to Provider

There were no grievances pertaining to Timely Assignment to Provider received this quarter.

Discrimination

There were forty-five grievances pertaining to Discrimination. Forty-four cases closed in favor of the Plan as there was no discrimination found. One case closed in favor of the Enrollee as there was discrimination found. There are no cases still under review. All grievances related to Discrimination, are forwarded to the DHCS Office of Civil Rights upon closure.

Kaiser Permanente Grievances and Appeals

Kaiser Grievances per 10,000 members = 41.25/month

During the third quarter of 2023, there were one hundred and ninety-six grievances and appeals received by KFHC members assigned to Kaiser Permanente. Of the one hundred and ninety-six standard grievances and appeals received, one hundred ninety-five cases closed within thirty days; one case was pended and closed after thirty days.

3rd Quarter 2023 Grievance Summary

Access to Care

There were twenty-six grievances pertaining to Access to Care.

Coverage Disputes

There were twenty-one appeals pertaining to Coverage Disputes.

Medical Necessity

There were nineteen appeals pertaining to Medical Necessity.

Quality of Care

There were seven grievances pertaining to Quality of Care.

Quality of Service

There were one hundred and twenty-three grievances pertaining to a Quality of Service.

To: **KHS QI-UM Committee**

From: **Magdee Hugais, Quality Improvement Director**

Date: **November 30, 2023**

Re: **Quality Improvement Department Report, Q3 of 2023**

Background:

This report provides a summary of key activities and outcomes related to the Quality Improvement (QI) Department during the 3rd quarter of 2023.

Discussion:

See pages 2-6 of this document.

Requested Action:

Review and approval of the report

Additional QI Documents:

- Overview of revisions to
    - 2.70-I Potential Quality Issues (PQI) Policy

KERN HEALTH SYSTEMS

Quality Improvement Department
Executive Summary
3rd Quarter 2023

I. Grievance and Quality-of-Care (QOC) Classifications (page 2)

Grievances received are screened by a nurse to identify any possible quality of care (QOC) issue. All potential QOCs are referred to a medical director for final determination and follow up direction. The current rate of grievances per 1k members is 7.02 and the rate of grievances classified as QOC is 0.95 per 1k members. There was a slight decrease in both the rate of grievances and those classified as QOC from Q2 to Q3 of 2023, but not enough to identify a trend.

II. Potential Quality of Care (PQI) Notifications (page 3)

QI receives notifications from various sources to review PQIs. The rate of PQI notifications in Q3-2023 was 0.63 per 1k members. A QI RN then reviews and determines the level of Quality Issue (Level 0-No Quality-of-Care Concern to Level 3-Actual Morbidity/Mortality Failure).

The rate of PQIs identified as Level 1, Potential Harm to the Member, has increased since the beginning of this year. This is most likely due to 2 factors:

- Addition of clinical review for QOC issues for grievances resulting in more PQI referrals
- A change in the grievance QOC screening process reducing the volume of Level 0, no QOC issue, as referral to the PQI process.

Of the 302 PQIs in Q3-2023, 2 were Level 2 – Actual Harm, and none were Level 3. No trends have been identified at this time.

We reviewed the rate of PQIs by provider for inpatient and outpatient PQIs. The data in the report table (page 7) reflects a rolling 12 months. The results by provider have names de-identified. No trends by provider were identified.

Analysis of PQIs by race and ethnicity is conducted per 1000 members for a rolling 12 months. NO trends or concerns by race and ethnicity currently.

III. Facility Site Reviews (FSR) and Medical Record Review (MRR) (page 11)

4 initial full site reviews were conducted in Q3-2023 and 5 initial Medical Record Reviews were completed. 1 Periodic site review was also completed and 1 periodic medical record review. 100% of site reviews passed. 94% YTD of Medical Record Reviews passed. The 1 site that failed created a Corrective Action Plan and that has been closed completed. QI also conducts mid-cycle interim reviews of facilities to monitor facility compliance. 12 were completed in Q3-2023. The QI department also conducts Physical Accessibility Review Surveys (PARS) and 33 were completed in Q3-2023.

IV. Quality Improvement Projects (page 19)

A. ***Performance Improvement Projects (PIP): (Page 20)***

Our next cycle of PIPs began in August 2023 and runs through 2026. One PIP is focused on Health Equity, specific to the W30 measure, 0-15 months African American Population in Kern County.

The other PIP is considered a non-clinical Behavioral Health PIP, specific to the FUA and FUM measures. We will be partnering with KHS' Behavioral Health Department to ensure success of this PIP.

Initial feedback from HSAG on the first phase of both PIPs has been received, and we are currently reviewing the feedback and will continue to the next phase soon.

V. Managed Care Accountability Set (MCAS) & Red Tier Updates (Page 21)

We have been notified by DHCS that we were removed from Red Tier status and placed into the Orange Tier. The Strike team continues its work on improving all measures with interventions in place. As of November 2023, 17 of 18 measures have improved compared to last year.

KERN HEALTH

SYSTEMS

Policy and Procedure Review/ Revision

Policy & **Procedure 2.70-1 Potential Quality of Care Issues** has been updated by the QI Department. The policy has been approved by the DMHC and DHCS.

Reviewer	Date	Signature
Emily Duran Chief Executive Officer	12/29/2022	
Dr. Martha Tasinga Chief Medical Officer	11/23/2022	M Tasinga
Deborah Murr Chief Health Services Officer	10/24/2022	Deborah Murr, RN, CHSO
Amisha Pannu Senior Director of Provider Network	12/6/22	
Jane MacAdam Director of Compliance and Re_ lato_ Affairs	**12/29/2022**	Jane MacAdam
Nate Scott Director of Member Services	11/17/2022	Nate Scott
Jane Daughenbaugh Director of Quality Improvement	**10/20/2022**	Jane Daughenbaugh

(CEO decision(s))

Board approval required: Yes_ No__ QI/UM Committee approval: Yes_ No_
Date approved by the KHS BOD: _ Date of approved by QI: ____ _
PAC approval: Yes_ No_ Date of approval by PAC: ____ _
Approval for internal implementation: Yes _No_
Provider distribution date: Immediately _____ Quarterly _____ __

Effective date: .....
DHCS submission: _ _ _ _
DMHC submission: ___
Provider distribution: ___

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Potential Quality of Care Issues (PQI)				POLICY #: 2.70-I	
DEPARTMENT: Quality Improvement					
Effective Date: 7/21/2020	Review/Revised Date: 12/29/2022	DMHC		PAC	X
		DHCS		QI/UM COMMITTEE	X
		BOD	X	FINANCE COMMITTEE	

_____ Date _____
Emily Duran
Chief Executive Officer

_____ Date _____
Chief Medical Officer

_____ Date _____
Chief Health Services Officer

_____ Date _____
Senior Director of Provider Network

_____ Date _____
Director of Compliance and Regulatory Affairs

_____ Date _____
Director of Member Services

_____ Date _____
Director of Quality Improvement

IMPACTED DEPARTMENTS:
All Departments

DEFINITIONS:

Complaint: A complaint is the same as a Grievance. When KHS is unable to distinguish between a Grievance and an inquiry, it shall be considered a Grievance.

Corrective Action Plan (CAP): This is a plan approved by the Chief Medical Officer (CMO) to prevent a quality issue from occurring again in the future. A CAP is an agreement between the provider and KHS that describes the problem and appropriate measures to achieve resolution. If the CAP includes reassignment of patients, the CMO or his/her designee notifies the Chief Network Administration Officer to coordinate patient panel changes.

Grievance: A Grievance is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, and the beneficiary's right to dispute an extension of time proposed by KHS to make an authorization decision.

Peer Review. An activity that involves case evaluation by an unbiased practitioner to measure, assess, and improve professional practice and the quality of patient care. The results of peer review activities are used to identify opportunities that include, but are not limited to: improving patient care, improving clinical judgement and technical skills, providing information related to clinical competency determination for reappointment, and as necessary for implementing corrective actions.

Peer. A peer is a practitioner who has expertise in the appropriate subject matter. If the question is one of general medical care, then any unbiased practitioner can serve as a peer reviewer. If there are specialty-specific clinical issues, then the peer reviewer must have sufficient clinical expertise and training to provide an evaluation of the significant issues involved in the review of an individual case or undesirable pattern of care.

External Peer Review. An external peer review consultant will be utilized to address specialty peer review issues if a specific clinical expertise is not available within the KHS practitioner network.

Case. A Peer review case is an event that corresponds to criteria for peer review. A case may be derived from medical staff indicators, sentinel events, third party complaints, or other sources that suggest undesirable processes or outcomes of care.

Potential Inappropriate Care (PIC): This is the term Department of Health Care Services (DHCS) has identified for a Potential Quality of Care issue. They define it as a grievance related to the overuse, underuse, or misuse of health care services[1] It is a possible adverse variation from expected clinician performance, clinical care, or outcome of care. PICs require investigation to determine if an actual quality issue or opportunity for improvement exists.

Potential Quality Issue: A Potential Quality Issue (PQI) is defined as a possible adverse variation from expected clinician performance, clinical care, or outcome of care. PQIs require further investigation to determine whether an actual quality issue or opportunity for improvement exists. Not all PQIs represent quality of care issues.

Quality of Care (QOC) issue: Quality of Care means the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Screening Process: This process includes a complete review of the referral. The QI RN assigned to the episode will determine if further investigation is warranted based on the data gathered in the PQI Referral.

PURPOSE

A. To provide a defined method for identifying and processing PQI issues, to determine opportunities for improvement in delivery of health care to Kern Health System members, and to direct appropriate follow up actions based upon investigative outcomes, risk, and severity. The policy also supports continuous review of the quality of care provided to members to ensure that a level of care, which meets professionally recognized standards of practice, is being delivered to all enrollees and that quality of care problems are identified and corrected for all provider entities. [2]

B. This policy also ensures that KHS' Quality Improvement System (QIS) effectively monitors, evaluates, and takes effective action to address any needed improvements in the quality of care delivered by all Providers rendering services on behalf of KHS in any setting. [3]

POLICY:

C. KHS Departments, Practitioners, Providers, and Healthcare Delivery Organizations (HDOs) shall refer a Potential Quality Issue (PQI) to the KHS Quality Improvement (QI) Department for review and investigation.

D. The PQI process is overseen by the KHS CMO and supported by the Quality Improvement Medical Director (QIMD).

E. The QI Department shall conduct a review of all PQIs by appropriately trained and qualified staff, including QI nurses and the QIMD.

To validate consistency in application of criteria and decision making in screening PQIs to determine if there is an existence of a PQI the KHS QI Department will conduct inter-rater reliability audits on QI nurses at a minimum upon completion of training and annually thereafter. Inter-rater reliability assessments will consist of assessing and scoring case files. Reviewers performing inter rater reliability monitoring will use standardized assessment tools.

PQI Levels are:

- Level 0 = No Quality of Care Concern
  - The PQI is then closed.
- Level 1 = Potential for Harm
  - Follow-up = Track and trend the area of concern for the specific provider, and the CMO or their designee or their designee may provide additional actions that are individualized to the specific case or provider.
- Level 2 = Actual Harm
  - Follow-up = Implement a Corrective Action Plan plus direction from CMO or their designee or their designee that is individualized to the specific case or provider.
- Level 3 = Actual Morbidity or Mortality Failure
  - Follow-up = Implement a Corrective Action Plan plus direction from CMO or their designee or their designee that is individualized to the specific case or provider.

[1] DHCS Managed Care Program Data (MCPD) Primary Care Provider Assignment (PCPA) Technical Documentation, March 27, 2020, version 1.3

[2] Tit. 28, § 1300.70

[3] Title 28, CCR, Section 1300.70 and 42 CFR 438.330

Confidentiality

1. Information related to peer review is protected under California Evidence Code Section 1157 and will remain confidential. Peer review activities will be carried out in a manner to preserve protection from discovery or peer information. Confidential and privileged peer review records consist of the following: peer review forms, correspondence to and from the practitioner regarding practice performance; determination of the Peer Review Committee and any subsequent actions including all letters sent to or received from the practitioner regarding the review. Confidential Peer Review records will be secured in the Credentialing Department confidentialfiles.

2. This Policy will comply with CA Peer Review 805 reporting of specific information regarding licensees to the Medical Board as required.

Health Insurance and Accountability Act Requirements (HIPAA)

Only authorized personnel can review member protected health information (PHI). Authorized persons to view PHI as part of the peer review process include Medical Directors, Peer Review staff and Quality staff, or delegated others. PHI includes, but is not limited to a member's name, address, telephone number email address, social security number, medical record number, healthplan beneficiary number, account numbers, biometric identifiers, and photographs.

POLICY AND PROCEDURES:

I. All PQI referrals are screened by a QI RN to validate determine if a Quality of Care Concern that a PQI issue exists.

A. Cases are reviewed using professionally recognized, evidence-based standards of care to assess care provided.

II. PQI Sources for Identification include, but are not limited to, the following sources:

A. Information gathered through Utilization Management.
B. Referrals from any health plan staff.
C. Facility site reviews.
D. Claims and encounter data.
E. Pharmacy utilization data.
F. Managed Care Accountability Set (MCAS) medical record abstraction process.
G. Medical Record Audits
H. Complaints/Grievances and Appeals from members
I. Provider Preventable Condition (PPC) Reviews
J. Providers or other health care organizations
~~J.~~K. Pharmacy

III. PQI Referrals

A. May be reported by any of the following:

1. Any KHS staff member via the Potential Quality of Care Issue (PQI) Referral Form (Appendix A).
2. If a PPC is identified via the daily PPC report, a PQI episode will be created in KHS' medical management system for review. Refer to Policy 2.72-I Provider Preventable Condition Policy.
3. If a PPC is identified during the Utilization Management (UM) review process, a referral will be made to QI indicating a PPC has been identified for appropriate PPC reporting and PQI review. Refer to Policy 2.72-I Provider Preventable Condition Policy.
4. Any KHS member, member of the community, or provider can call 661.632.1590 (Bakersfield) or 800.391.2000 (outside of Bakersfield), or 711 for TTY/TDD, or they can complete the Grievance form located on KHS' public website and submit it via mail or online.

PROCEDURE

1. PQI referrals will be forwarded to the QI Department.
2.
3. The QI nurse assigned to the grievance opens areview PQI referral cases will open a PQI referral episode and requests any additional medical records required for the PQI investigation. The PQI referral is assigned to a QI nurse to begin the PQI investigation process.
4.
5. Once all information is received the QI RN will screen the case to determine that a QOC Issue may be present.
6.
7. If present the case is referred to the CMO/QI MD physician for review and further determination of whether a QOC is present.

When the medical director determines a QOC is present, a referral to the QI Department is made to complete the PQI investigation process. He she

8. The medical director includes in their final determination include a review a summary of their review and the findings and forward to the KHS CMO.
4.9.

F. For PQIs involving specialty care the CMO /QIMD will forward the case to an external independent physician review entity with expertise in the specialty related field for consultation to further determine if a PQI exists.
    a. Please advise regarding Primary Care

G. Upon completion of the external review the case be returned to The CMO /QIMD for submission to the KHS Physician Advisory Committee-Credentialing and Peer Review Committee (CPRC) for further evaluation. This will include all information reviewed by the external review entity and any guidances made.

H. The QI Department shall trend and analyze individual Practitioner, Provider, HDO, PQI data every six (6) months to identify emerging patterns.
    a. A pattern is defined as two (2) or more Quality of Care (QOC) PQIs, with severity levels 1, 2, 3, 4 and
    b. This data shall be reviewed by the CMO or Designee who shall report any issues and/or emerging patterns to the KHS PAC CPRC for further evaluation and action, as necessary.

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[1] DHCS Managed Care Program Data (MCPD) Primary Care Provider Assignment (PCPA) Technical Documentation, March 27, 2020, version 1.3

[2] Tit. 28, § 1300.70

[3] Title 28, CCR, Section 1300.70 and 42 CFR 438.330

B. PQI Referrals Via a Grievance

1. Grievances received by the KHS Grievance Team are reviewed by a Grievance Coordinator (GC) who makes an initial classification recommendation of the Grievance. See KHS Policy 5.01-P, KHS Member Grievance and Appeals, for classification types.
2. All grievances received are referred to the assigned QI grievance nurse along with a copy of the original grievance to evaluate whether a Quality of Care (QOC) issue may be present. Processing of Grievances follows the timeframes identified in KHS Policy 5.01-P, KHS Member Grievance and Appeals.
3. The QI nurse assigned to review the grievance evaluates whether a QOC issue may be present. If additional information or medical records are needed to complete the screening, it is returned to the GC so they may request that of the member or provider associated with the grievance.
4. If the QI nurse agrees that a QOC grievance exists, it is classified with the appropriate Quality of Care disposition.
5. The QI nurse completes review of the original grievance and any other pertinent information to determine if a QOC may be present and documents a clinical summary of their review.

6. The assigned GC requests records in accordance with Sections IV.B.1 and IV.B.2 below. The requests are made using the forms in Appendix B (Initial and Final Medical Record Request Forms).

7. If the QI RN determines that a QOC may be present, the grievance is referred to the designated medical director physician for review and final determination of whether a QOC is present.

~~8.~~1. When the medical director determines a QOC is present, a referral to the QI Department is made to complete the PQI investigation process.

9. The medical director includes in their final determination a summary of their review and findings.

~~10.~~5. The GC is notified of the outcome of the medical director's QOC review to complete a resolution to the member including a clear and concise explanation of the Plan's decision to the members grievance.

~~11.~~1. The QI nurse assigned to the grievance opens a PQI referral episode and requests any additional medical records required for the PQI investigation. The PQI referral is assigned to a QI nurse to begin the PQI investigation process.

12. Grievances referred as a PQI are entered into KHS' medical management system. The assessment covers all information on the PQI Notification Referral Form (see Appendix A). Once the referral is submitted in KHS' Medical Management System, an episode is created and moved into a work queue for a QI RN to begin the investigation process.

IV. QI Department PQI REVIEW DESK TOP Procedural PROCES

A. SThe QI nurse assigned to review PQI referral cases will open a PQI referral episode .

V. The QI nurse assigned to review PQI referral cases will open a PQI referral episode.

VI. The QI Nurse shall perform an initial clinical review upon receipt, to determine if the Member has any urgent clinical issues and provide care coordination interventions as needed.

VII. The QI Nurse will determine if any additional records are required for the PQI investigation or if the clinical information needed to determine if a QOC issue is present is already available internally (e.g., through Utilization Management, Case Management, ECM, etc.)

A. A Medical Record Form will be utilized to request the information detailing what is required (***Appendix B).***

B. Once the records have been received, they are uploaded into KHS' Medical Management System for review by the assigned QI nurse.

C. After investigation by the QI RN, a summary of the review is created using the SBAR format (Situation, Background, Assessment, and Recommendation) and presented to the CMO or the QIMD for review and determination for review and further determination of whether a QOC is present.

D. If it is not a quality-of-care issue but rather a service issue after review of the medical records and response from the Provider, the case will be closed, and a provider resolution letter will be sent by the PQI team. Place holder to insert examples of service issues uniform with KHS grievance Dept.

E. When the CMO or QIMD determines the case to be:

1. Level 0 = No Quality-of-Care Concern the PQI is then closed.
2. Level 1 = Potential for Harm then it will require Follow-up = Track and trend the area of concern for the specific provider, and the CMO or QIMD may provide additional actions that are individualized to the specific case or provider.

F. The CMO-QIMD documents follow up actions appropriate for the needed improvement and coordinates those items with the QI RN.

G. For PQIs determined to be a level 2 or greater The CMO or QIMD will request any written information or clarification necessary from the provider regarding the issue in question.

H. PQIs Level 2 or greater will be forwarded for further review as follows:
   3. If it is related to a Primary Care Provider (PCP), it will go to the KHS Physician Advisory Credentialing Peer Review Committee (PAC-CRPR) for further review and action.
   4. If it is related to a Specialty Care Provider (SCP) it will be forwarded to the physician External Review Vendor (ERV).
   5. The physician ERV will review and submit the findings and recommendations back to the KHS-CMO-QIMD. This will include all information reviewed by the external review entity and any guidance's made.
   6. This information will then be forwarded to the PAC-CRPR Committee.

I. For both PCP-SCP PQIs submitted to the PAC-CRPR Committee, all relevant documents and information will accompany the case and copies of all written correspondence and pertinent documents are filed in KHS' Medical Management system.

J. The Physician Advisory Committee is responsible for making determinations for consideration in re-credentialing providers and / or recommending other actions.

K. All PQI-QOC issues are tracked for re-credentialing purposes.

L. The QI Department maintains a PQI log to track the timeliness of case reviews.
   1. The targeted completion time frame for closing PQIs is 120 days.

A. The QI Dept designated staff will support the PAC by ensuring all actions of the peer review body are carried out and monitored in compliance with de-identification, confidentiality, and peer review privileged requirements. Support functions include but are not limited to:
   1. Drafting professional letter(s) requesting responses to specific questionsto providers or other medical entities,
   2. Tracking corrective action plans to assure completion.
   3. Following up as instructed by the peer review body to assure corrective actions have been completed (i.e., follow up with Committee Members, Reviewers, CMO-QIMD on additional coaching, training, CME, etc.).
   4. Tracking reports are submitted weekly to the CMO/QIMD to ensure timely follow-through of all open cases requiring CAPs, Responses, and when completed closing out cases.
   5. Non-compliance with provider responses and corrective actions
   6. All steps are documented in the peer review database system.

~~IV.~~**VIII.**

A. For both PCP-SCP PQIs submitted to the PAC-CRPR Committee, all relevant documents and information will accompany the case and copies of all written correspondence and pertinent documents are filed in KHS' Medical Management system as follows

~~A.~~B. All notifications to and requests of providers shall be sent via certified mail. Communications may be done by phone or fax. However, all notifications and requests will also include written communication and be sent by certified mail to ensure delivery and identify the date of receipt. A copy of the certified mail receipt is scanned and retained within the medical management system episode. A copy of the certified mail signature of delivery and receipt will also be scanned and retained within the case file within the medical management system episode.

~~B.~~C. All PQI referrals received by the QI department will include an investigation of existing clinical documentation that can be used to determine if a QOC issue exists. A QI nurse will screen the PQI referral and determine if any additional records need to be requested or if the clinical information needed to determine if a QOC issue is present are already available (e.g., through Utilization Management, Case Management, Health Homes, etc.). If additional medical records are needed, the QI nurse will identify what records are needed and notify the QI Senior Coordinator (SC) or other designated support staff to initiate the records request.

1. The QI nurse uses the PQI Medical Records Request Form in Appendix B.
    a. When this form is completed and sent to the provider, the QI nurse will upload the form into KHS' Medical Management System.
    b. If there has been no response from the provider within 10 business days of the 1st request, the QI nurse will request records a second time.
    c. The QI nurse will also notify the Provider Network Management (PNM) representative assigned to the provider and include a copy of the records request form to assist with obtaining the requested records.
2. If there has been no response from the provider within 10 business days of the 2nd request, the QI nurse will notify the Chief Medical Officer (CMO) or their designee (a

physician) for a final outcome based on the information available. This will be documented in KHS' Medical Management System.

3. When indicated, a referral to or coordination with KHS's other medical management programs such as, Case Management, Disease Management and Health Homes will be made to coordinate care for complex or challenging member issues.

~~C.~~D. Once the records have been received, they are uploaded into KHS' Medical Management System for review by the assigned QI nurse. After investigation by the QI RN, a summary of the review is created using the SBAR format (Situation, Background, Assessment, and Recommendation) and presented to the CMO or their designee for review and determination in KHS' Medical Management System.

~~D.~~E. When the QI nurse refers the PQI to the CMO or their designee, a task is entered for follow up with the CMO or their designee if no action has occurred by the CMO or their designee within 1 week of referral.

~~E.~~F. The QI nurse contacts CMO, or their designee assigned to the episode to request completion of the PQI referral.

~~F.~~G. If there is still no follow-up by the CMO or their designee, the QI nurse will notify the QI manager for escalation.

All PQI referrals are referred to the CMO or their designee for final determination of severity level and any follow up direction.

~~G.~~H. The CMO or their designee reviews the documentation within KHS' Medical Management System for the indicated PQI issue and documents the final determination of existence of a QOC and the PQI Severity Level.

1. The Medical Director documents follow up actions appropriate for the needed improvement and coordinates those items with the QI RN.

~~H.~~I. PQI Severity Level

1. The PQI severity level is determined by the CMO or their designee following their investigation. The exception to this is Level 0 when it is determined through the screening process completed by a QI RN. Based on the outcome of the review, the episode is designated with a Severity Level of one of the following levels:
   - Level 0 = No Quality of Care Concern
     - The PQI is then closed.
   - Level 1 = Potential for Harm
     - Follow-up = Track and trend the area of concern for the specific provider, and the CMO or their designee or their designee may provide additional actions that are individualized to the specific case or provider.
   - Level 2 = Actual Harm
     - Follow-up = Implement a Corrective Action Plan plus direction from CMO or their designee or their designee that is individualized to the specific case or provider.
   - Level 3 = Actual Morbidity or Mortality Failure
     - Follow-up = Implement a Corrective Action Plan plus direction from CMO or their designee or their designee that is individualized to the specific case or provider.
2. Copies of all written correspondence and pertinent documents are filed in KHS' Medical Management system.

I. The CMO or their designee will request any written information or clarification necessary from the provider for Levels 2 and 3 regarding the issue in question. All QOC issues are tracked for re-credentialing purposes. Input regarding QOC episodes is presented to the Physician Advisory

Committee for consideration in re-credentialing providers or recommending other actions.

M. All correspondence and pertinent documents relateddocuments related to each case are filed in KHS' Medical Management system as follows.
   a. Initial PQI notifications along with records are uploaded in the case file.
   b. A copy of medical records request is attached to the case.
   c. Additional records received are uploaded.
   d. All notifications and requests of providers requiring a written explanation or request for a Corrective Action response shall be sent via certified mail.
      i. Communications may be done initially by phone or fax.
      ii. However, all notifications and requests will be followed up as a written communication and be sent via certified mail to ensure delivery and identify the date of receipt.
      iii. A copy of the certified mail receipt is scanned and retained within the medical management system episode.
      iv. A copy of the certified mail signature of delivery and receipt will also be scanned and retained within the case file within the medical management system episode.
      v. All provider responses are uploaded.

1. If the contracted provider fails to respond to the CMO or their designee's correspondence within 2 weeks of sending the request, the provider will be referred to the Chief Medical Officer (CMO). The CMO will coordinate with the Provider Network Management Department as needed.

J. Corrective Action Plan
   1. The CMO or their designee determines if a CAP is needed. The response to the CAP is expected within 30 calendar days of sending the CAP requirement to the provider. The CMO or their designee uses the Corrective Action Plan Form in Appendix C and completes the following sections:
      a. Date
      b. Provider Name
      c. Deficiency #
      d. Expected Outcomes
   2. The QI nurse creates a task in the medical management system for follow up with the provider if no response to the CAP issues has been received within the expected 30 calendar days.
   3. The QI nurse contacts the provider to request the providers CAP response within 1 week. Contact may be done by phone and documented in the medical management system for the PQI episode. However, written response request within 1 week is sent by the QI nurse from the CMO or their designee via certified mail.
   4. The QI nurse notifies the assigned PNM representative for the provider of the need for the CAP response from the provider.
   5. If there is still no CAP response from the provider, the QI nurse will notify the CMO or their designee for further direction.
   6. The CMO or their designee will attempt to contact the provider and request the CAP response. This may be done by phone and must be documented in the episode in the medical management system.
   7. The QI nurse sets an activity in the episode to follow up with the CMO or their designee if no further response has been received from the provider.
   8. A second CAP request will be sent to the provider via certified.
   9. The QIMD will be notified to perform an outreach call to the provider.

10. QI will notify the Provider Network Management Department if the provider does not respond to the QIMD's call. 3 business days.
11. If the CAP has not been received by day 31, the case is forwarded to the CMO for further determination, including possible review by the Physician Advisory Committee (PAC).

~~8.~~12. The CMO or their designee may refer the PQI to the Physician Advisory Committee for further action.

~~9.~~13. Responses from the provider to a CAP issued are reviewed by the CMO or their designee. That physician makes the determination for acceptance of the CAP as completed. If a CAP response is not accepted, the CMO provides a written response to the provider with input and additional instruction for CAP completion.

~~10.~~14. If the CAP has not been received by day 31, the case is forwarded to the CMO for further determination, including possible review by the Physician Advisory Committee (PAC). Upon completion, the CAP will be reviewed by the CMO or their designee.

~~11.~~15. The CMO or their designee completes the plan portion of the CAP form (Appendix C). The CAP may include but is not limited to:

i. Required attendance at continuing education programs applicable to the issue identified and approved by KHS.
ii. Required training/re-training and/or certification/re-certification for performance of those procedures that require specific training and professional certification.
iii. Track and trend analysis of the adverse quality issues identified in the clinician's practice patterns and
iv. In-service training for clinicians and/or their staff.

K. Tracking and Trending
   1. Tracking and trending is performed to ensure that an identified QOC has been resolved. This is also done to identify any continuing patterns of concerns and opportunities for improvement.
   2. The CMO or their designee requesting the tracking and trending identifies and documents the specific areas for focus. The standard period of time to track and trend is 6 months unless otherwise specified by the CMO or their designee. All cases selected for tracking and trending are logged by the QI SC into KHS' Medical Management System as well as tracked on a spreadsheet.
   3. When a new PQI referral is received, the assigned QI nurse reviews the Track and Trend lg to see if the provider in the new referral is on active track and trending. If the provider is on the active list, the QI nurse notes that in their investigative review and includes that information in the referral to the Medical Director. All PQI referrals in which the provider is on the active Track and Trend log are referred to the CMO or their designee for PQI Severity Level determination and instructions for any follow up actions.

L. Providers with no further QOC occurrences during the duration of time they are actively tracked and trended are moved to the inactive Track and Trend log. Extension of active track and trending occurs at the direction of the CMO or their designee and because of their review of new QOC issues presented to them.

M. Provider-specific trends will be reported to Provider Network Management for inclusion in the re-credentialing process.

~~V.~~IX. AUDITING

A. Each quarter, the QI Manager will conduct an audit of a sample of PQI episodes (Attachment A, PQI Audit Tool) completed per QI nurse who processes PQIs to evaluate that they are
   1. Complying with this policy and procedure,
   2. Employing appropriate clinical assessment skills and
   3. Documenting the PQI referral process properly.

   Any issues identified in the audit will have follow up action with the QI RN documented to support correction.

~~VI.~~X. DELEGATION

KHS is responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. KHS will communicate the policy requirements to all delegated entities and subcontractors. KHS will ensure that all their own policies and procedures, as well as the policies, procedures, and practices of any delegates, sub plans, contracted providers, or subcontracted Independent Physician Associations or medical groups, comply with these requirements and those located in any applicable APL.

REFERENCES:

Policy 2.72-I Provider Preventable Condition Policy
Policy 4.40-P Corrective Action Plans
Policy 4.48-P Provider Disciplinary Action
Policy 5.01-I KHS Member Grievance and Appeals
Policy 5.01-P KHS Member Grievance and Appeals

APL 17-006, Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights"
Title 22, CCR, Section 53858(e)(2) The immediate submittal of all medical quality of care grievances to the medical director for action.
DHCS Managed Care Program Data (MCPD) Primary Care Provider Assignment (PCPA) Technical Documentation, March 27, 2020, version 1.3

APPENDICES & ATTACHMENTS

Appendix A: Potential Inappropriate Care (PQI) Referral
Appendix B: Medical Record Request Form
Appendix C: Corrective Action Plan
Attachment A: Quarterly PQI Nurse Audit Tool

REVISIONS

October 2022: Policy received approval from DMHC 10/14/2022. On 10/26, The policy received minor edits recommended by the MS team. **September 2022:** Policy accepted by DHCS File and Use criteria on 9/23/2022. **May 2022:** Policy approved by the QI/UM Committee. **April 2022:** Updates made to include PPC process and policy reference. **March 2022:** Updates made per DHCS CAP. **February 2022**: Changed the name of PIC to PQI to align with the term used in our contract with DHCS. Changed grievance review process so that all grievances received are reviewed by a QI nurse for evaluation of PQI presence, referral to medical director if a PQI may exist for final determination and further direction. Changed PQI process so that all PQI referrals go to the CMO or designated medical director for severity level determination and direction for follow up. Added verbiage to support assurance that PQI investigations and any CAPs issued are completed. Included additional layer of quarterly auditing for nurses' PQI work. **May 2021:** Clarified time frames throughout the policy to distinguish calendar or business days. Reduced the amount of time response for 2nd request for medical information is due. Changed references to Medical Director to Chief Medical Officer or their designee. Modified who is notified when member re-assignment is planned from the CEO to the Chief Network Administration Officer. Added new Corrective Action Form. **June 2020:** Policy revised to incorporate legal counsel's guidance. Jane Daughenbaugh, Director of Quality Improvement **April 2020** – Policy created Jane Daughenbaugh, Director of Quality Improvement.

Appendix A – PQI Referral Form

Kern Health Systems
Potential Inappropriate Care Referral Form
Confidential Report

OCCURRENCE	
Date of Occurrence: Click here to enter a date.	**QI Referral Date:** Click here to enter a date.
PROVIDER/MEMBER INFORMATION	
Provider First Name: **Provider Last Name:** **Provider NPI Number:** **Street Address1:** **Street Address2:** **City:** **State:** **Zip:** **Phone:** - - **Extension:**	**Member First Name:** **Member Last Name:** **Member ID:** **Street Address1:** **Street Address2:** **City:** **State:** **Zip:** **Phone:** - - **DOB:** ☐ **Male** ☐ **Female**
NARRATIVE DESCRIPTION OF OCCURRENCE (Factual Only)	
Summary of Complaint: **Desired Outcome of Person Filing Grievance:** **Report Prepared by (Name):** **Title:** Select One **Other, Specify:** **Date:** Click here to enter a date. **Date Submitted as PQI to QI Department:** Click here to enter a date. **ALL INFORMATION ABOVE MUST BE COMPLETED BEFORE SENDING TO QI DEPT** **SEND REQUEST TO THE "QI PQOC TEAM" EMAIL DISTRIBUTION**	

Appendix B - QI Department PQI Medical Records Request Form

Kern Family Health Care™

Initial Medical Record Request

DATE: Click here to enter a date.

TO:

COMPANY:

PHONE #:

FROM:

Name

Address: 2900 Buck Owens Blvd, Bakersfield, CA 93308

PHONE:

RE:
DOB:
MBR#:

To Whom It May Concern:
Kern Family Health Care is in the process of reviewing a grievance, regarding the above member. In order to complete our review, we will need the following information: ***All updated medical records from*** Click here to enter a date. ***to current***

*** Please include the following information and forward as soon as possible***

☐ **Registration Sheet**	☐ **Nurses Notes**	☐ **Physician Notes**
☐ **Lab/X-ray Reports**	☐ **Op Reports**	☐ **Signed Consent forms**
☐ **ER Notes**	☐ **Prescriptions**	☐ **Diagnoses**
☐ **History & Physical**	☐ **Physician Orders**	☐ **Discharg Plan (if inpatient)**
☐ **Discharge summary (if inpatient)**	☐ **Pre-op work-up**	☐ **Post-op notes (if inpatient)**
☐ **Pathology report(s)**	☐ **Other:**	

RN Requesting Records: **Date RN Returned Records Needed:** Click here to enter a date.
Please return this letter (or copy) with requested information within **10 days**. If you have any questions, please feel free to email us at QI-PQOC-Team@KHS-net.com or call us at (661) 664-5053. Thank you for your prompt assistance in this matter.

Mail to: Kern Health Systems
2900 Buck Owens Blvd
Bakersfield, CA 93308
Attn: QI Department

or

Fax to: Kern Health Systems
(661) 473-7575
Attn: QI Department

Kern Family Health Care™

Final Medical Record Request

DATE: Click here to enter a date.

TO:

COMPANY:

PHONE #:

FROM:

Name

Address: 2900 Buck Owens Blvd, Bakersfield, CA 93308

PHONE:

RE:
DOB:
MBR#:

To Whom It May Concern:
Kern Family Health Care is in the process of reviewing a grievance, regarding the above member. In order to complete our review, we will need the following information: ***All updated medical records from*** Click here to enter a date. ***to current***

*** Please include the following information and forward as soon as possible***

- ☐ **Registration Sheet**
- ☐ **Lab/X-ray Reports**
- ☐ **ER Notes**
- ☐ **History & Physical**
- ☐ **Discharge summary (if inpatient)**
- ☐ **Pathology report(s)**
- ☐ **Nurses Notes**
- ☐ **Op Reports**
- ☐ **Prescriptions**
- ☐ **Physician Orders**
- ☐ **Pre-op work-up**
- ☐ **Other:**
- ☐ **Physician Notes**
- ☐ **Signed Consent forms**
- ☐ **Diagnoses**
- ☐ **Discharg Plan (if inpatient)**
- ☐ **Post-op notes (if inpatient)**

RN Requesting Records: **Date RN Returned Records Needed:** Click here to enter a date.
Please return this letter (or copy) with requested information within **10 days**. If you have any questions, please feel free to email us at QI-PQOC-Team@KHS-net.com or call us at (661) 664-5053. Thank you for your prompt assistance in this matter.

Mail to: Kern Health Systems
2900 Buck Owens Blvd
Bakersfield, CA 93308
Attn: QI Department

or

Fax to: Kern Health Systems
(661) 473-7575
Attn: QI Department

APPENDIX C – Corrective Action Plan Form

Kern Health Systems
Corrective Action Plan

Date: _____ Provider Name: _____

Deficiency #: _____

Deficiency Description (KHS Completes):

Expected Outcomes (KHS Completes):

Actions Taken (Completed by Provider):

Implementation Date (Completed by Provider): _____

Evidence of Completion/Supporting Documentation if Applicable (Completed by Provider):

Provider Signature Date

_____ _____

KHS Medical Director Name: _____

☐ Approved ☐ Rejected Medical Director Signature _____

Date: _____

Comments:

_____

661-664-5000
661-664-5151

kernhealthsystems.com
2900 Buck Owens Boulevard, Bakersfield, CA 93308-6316

To: KHS QI-UM Committee

From: Misty Dominguez, RN

Date: 11/30/2023

Re: Utilization Management Department Reporting Q3 2023

Background

Utilization Management (UM) continues to be focused on ensuring KHS members receive medically necessary care at the right time in the most appropriate setting. To achieve this goal, UM works diligently to ensure all department processes are regulatorily compliant, staff is well trained, and all decision are made based on medical necessity and in accordance with regulatory directive and the Plan contract with DHCS.

Discussion

This report contains a synopsis of both quantitative and qualitative analytics that reflect the performance of the Utilization Management Department's in the 3rd quarter of 2023.

Fiscal Impact: N/A

Requested Action

- Request to approve and file UM Q3 2023 report.
- Approval of the amended 2023 Utilization Management Program Description.
- Committee approval to adopt the updated UM policies as listed and provided in the electronic meeting packet for review:
    - 3.20-P Sensitive Services 2023-01
    - 3.21-P Family Planning Services 2023-01
    - 3.53-P Cancer Treatment 2022-12
    - 3.84-P Long Term Care Transitions 2023-09
    - 3.94-P Multipurpose Senior Services Program 2022-11
- Committee approval to adopt the updated UM criteria:
    - Specialty Care Referral guidelines
    - Peer to Peer guidelines

Utilization Management Executive Summary

Membership dropped in quarter three of 2023, however, referral volume stayed consistent. KHS membership averaged about 354,000 lives. The Utilization Management Department continues to focus our energy on ensuring all requests for service are processed within regulatory turnaround time standards and determinations are provided both accurately and efficiently. In Q3, 2023 Turnaround time metrics have remained compliant in all quarters of 2023 thus far.

The department did undertake a rapid cycle improvement project this quarter related to an increased number of communications to members written above a 6th grade level. Improvement has been achieved through the process and work continues to ensure full compliance with regulatory directives.

The Utilization Management (UM) Department continues work focused on the adoption of policy that coincides with State directives as we ready ourselves for the initiation of the 2024 DHCS contract and prepare for NCQA initial accreditation survey. Much effort is dedicated to staff education and readiness preparation to administer newly carved in benefits like Phase II of the Long-Term Care benefit and Transition of Care program beginning in January 2024.

In Q3 2023, the Utilization Management Team continues to audit performance to ensure industry standards are met or exceeded as well as analyze available data using a Health Equity lens and identifying areas where additional effort will benefit the population we serve.

The following report reflects Utilization Management performance through 3rd quarter 2023.

Respectfully submitted,

Misty Dominguez

Misty Dominguez, MSN, RN, CCM, NE- BC
Director, Utilization Management
Kern Health Systems

Timeliness of Decision Trending

Summary:

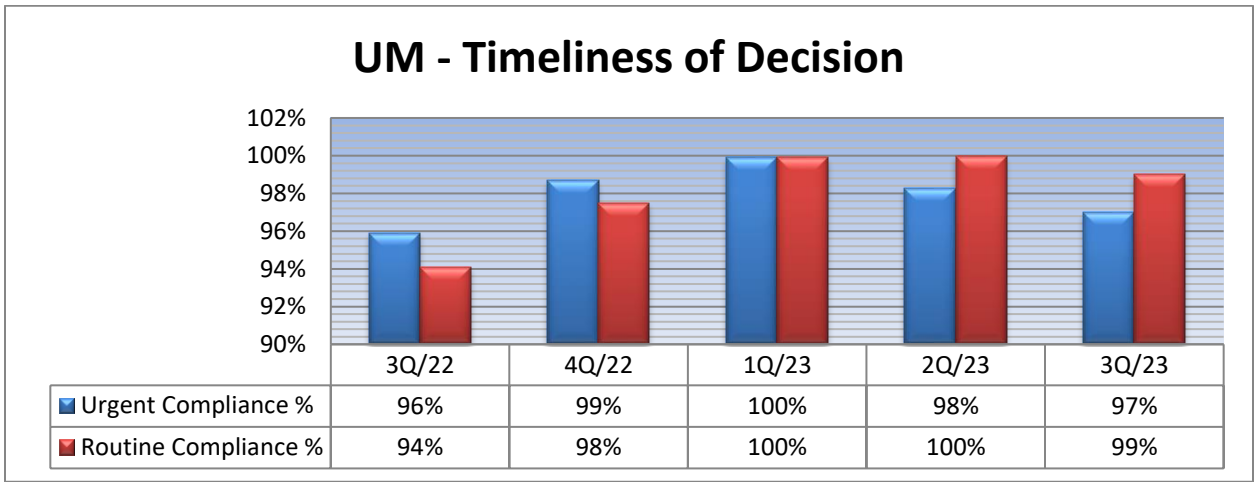
Quarterly audits are conducted to ensure compliance with DMHC requirements, KHS Contractual Agreement with the Department of Health Services, and KHS Policy and Procedures. Referrals are submitted and have specific turn-around-times set for each type of referral.

Providers may indicate 'Urgent' on the referrals indicating a decision needs to be made within 3 business days. Routine/non-emergent referrals must be processed within 5 business days. Once an urgent referral has been reviewed it may be downgraded for medical necessity at which time the provider will be notified via letter that the referral has been re-classified as a routine and nurse will clearly document on the referral "re-classified as routine". Random referrals are reviewed every quarter to observe timeliness. 10% of referrals received are reviewed monthly.

For those referrals that are found to be out of compliance with turn-around-timelines, the case manager and support staff are notified, and importance of timeframes discussed to help ensure future compliance.

Urgent: Response back to Provider in 3 business days
Routine: Response back to Provider in 5 business day

There were 72,414 referrals processed in the 3rd quarter 2023 of which 6,605 referrals were reviewed for timeliness of decision. In comparison to the 2nd quarter's processing time, routine referrals decreased from the 2nd quarter which was 100% and urgent referrals increased from the 2nd quarter which was 98.3% to 98.9%.



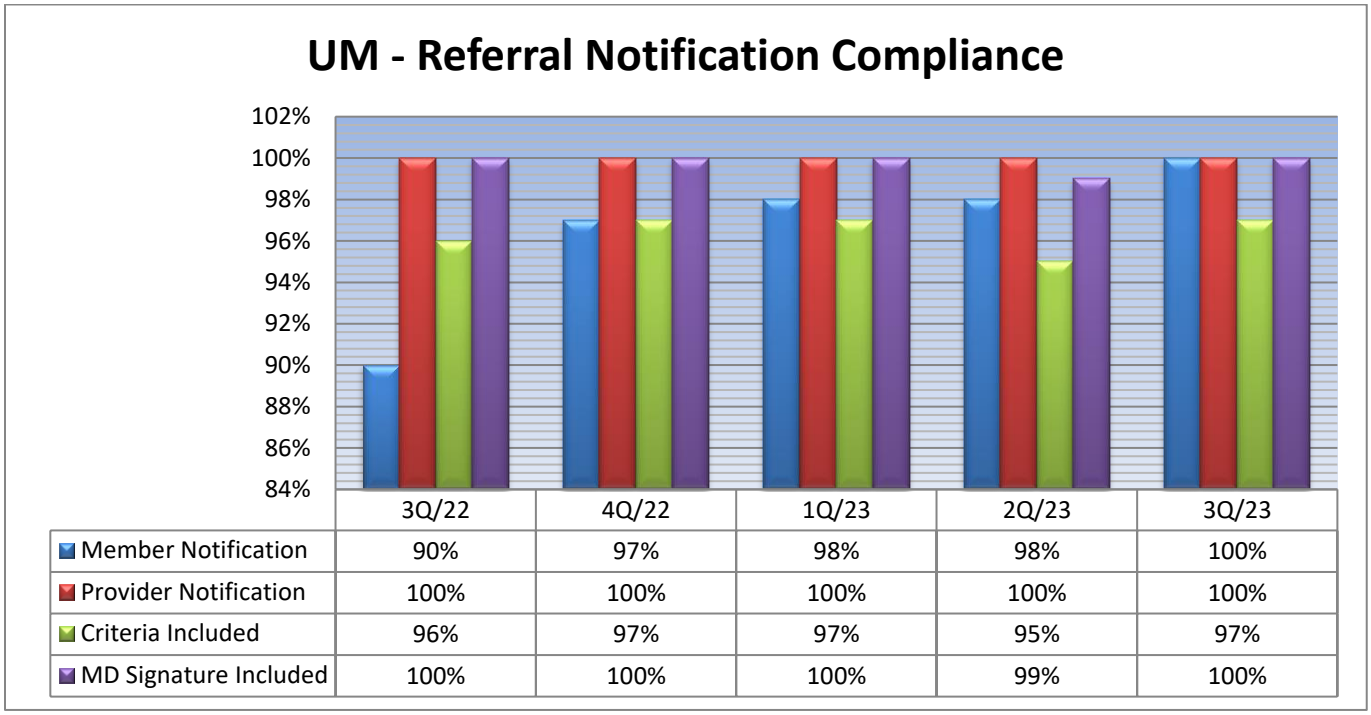
	3Q/22	4Q/22	1Q/23	2Q/23	3Q/23
Urgent Compliance %	96%	99%	100%	98%	97%
Routine Compliance %	94%	98%	100%	100%	99%

Referral Notification Compliance

Audit Criteria:

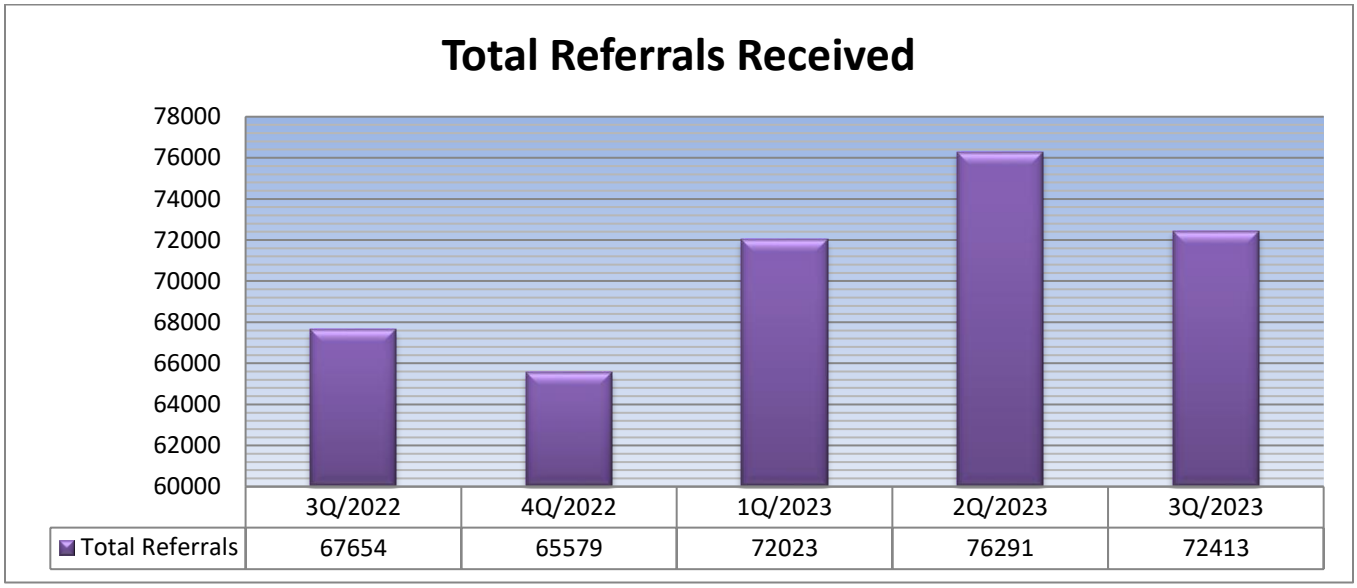
- Member Nofication: Letter of referral decision sent to member within 24 hours
- Provider Notification: Referral is faxed back to the provider with 24 hours of decision
- Criteria Included: Criteria provided to provider on denial reason
- MD Signature: MD Signature included all referrals/NOA letters upon denial

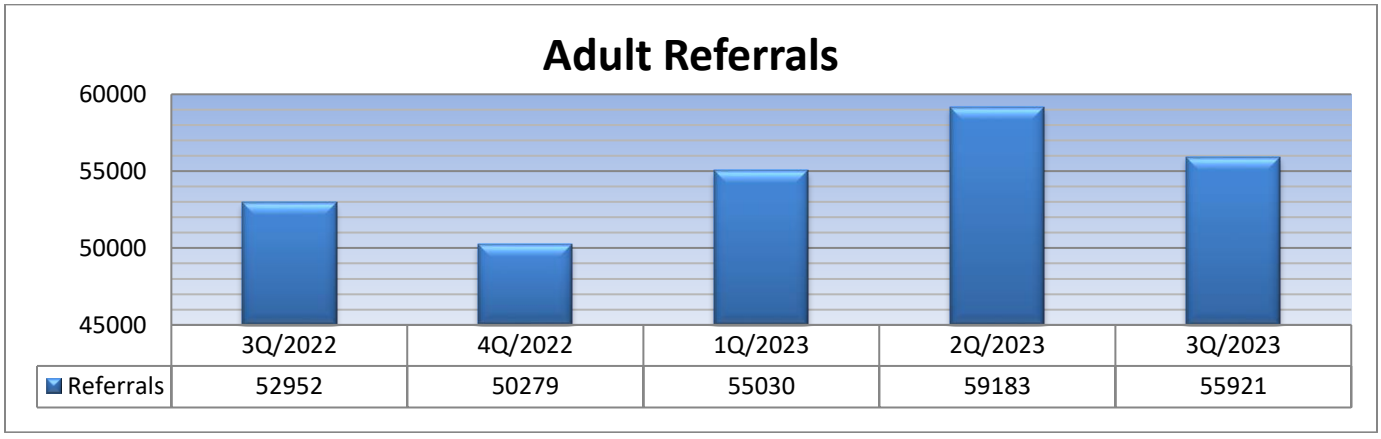
Summary: Overall compliance rate from the 3rd Qtr. of 2023 is 99% which increased from the 2nd Qtr. which was 98%.

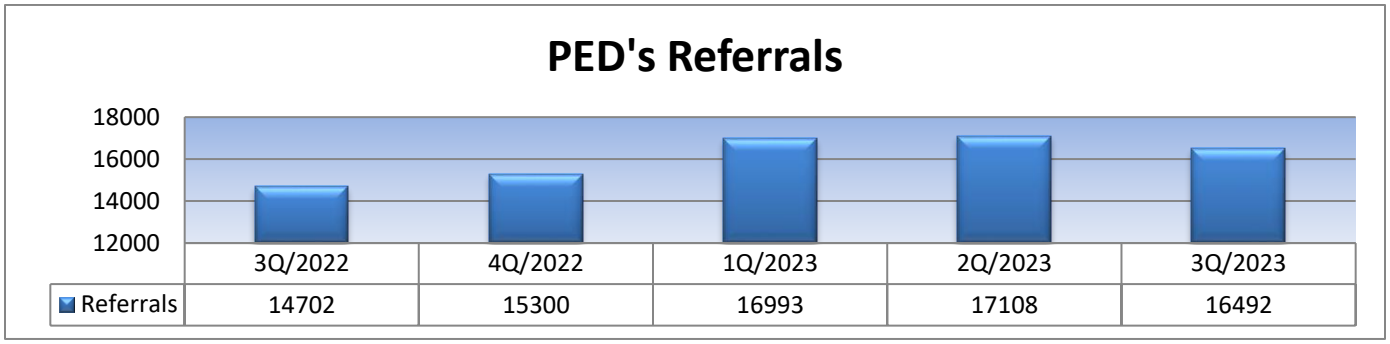


	3Q/22	4Q/22	1Q/23	2Q/23	3Q/23
Member Notification	90%	97%	98%	98%	100%
Provider Notification	100%	100%	100%	100%	100%
Criteria Included	96%	97%	97%	95%	97%
MD Signature Included	100%	100%	100%	99%	100%

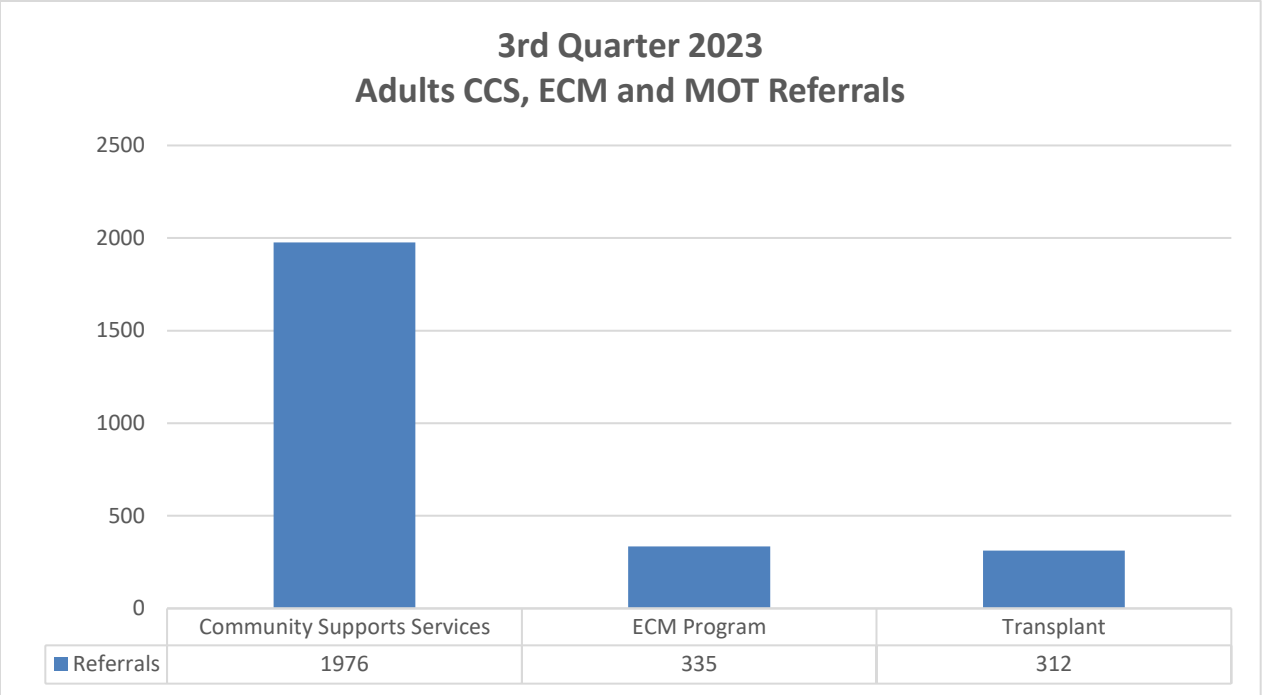
Outpatient Referral Statistics

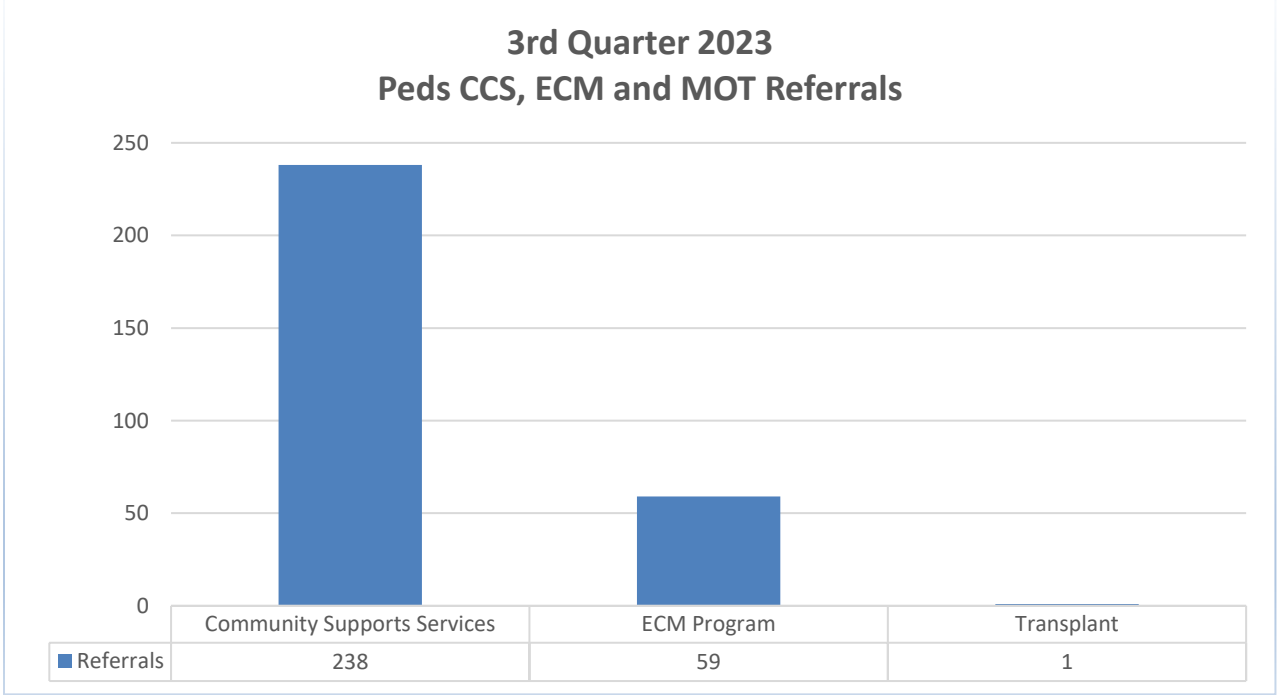






Specialty Referral Management



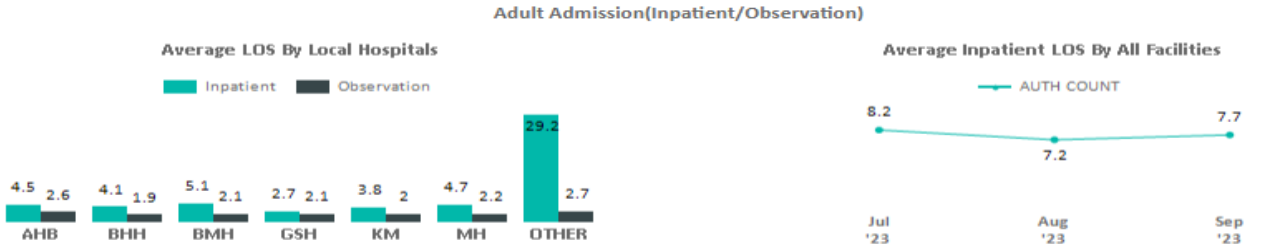


Inpatient Statistics

KHS Monthly Inpatient and LOS Report

Report captures Adult Admissions(Inpatient/Observation)

Dates of Discharge Between : 7/1/2023-9/30/2023



Participating Providers

Provider Name	Admit Count	LOS	Avg LOS
	5	18.0	3.60
2210 SANTA ANA OPCO, LLC	1	180.0	180.00
ADVENTIST HEALTH BAKERSFIELD	806	3141.0	3.90
ADVENTIST HEALTH COMMUNITY CAR	26	78.0	3.00
ADVENTIST HEALTH DELANO	96	320.0	3.33
ADVENTIST HEALTH MEDICAL CENTE	14	41.0	2.93
ANTELOPE VALLEY HOSPITAL	1	3.0	3.00
BAKERSFIELD HEART HOSPITAL	142	487.0	3.43
BAKERSFIELD MEMORIAL HOSPITAL	794	3408.0	4.29
BROOKDALE RIVERWALK SNF (CA)	5	807.0	161.40
CHILDRENS HOSPITAL OF LOS ANGE	1	16.0	16.00
DELANO DISTRICT SKILLED NURSIN	2	180.0	90.00
GOOD SAMARITAN HOSPITAL	37	94.0	2.54
HEIGHT STREET SKILLED CARE	2	270.0	135.00
HUMANGOOD NORCAL	3	347.0	115.67
KECK HOSPITAL OF USC REHAB UN	2	8.0	4.00
KECK HOSPITAL OF USC	88	424.0	4.82
KERN COUNTY MEDICAL AUTHORITY	764	2580.0	3.38
KERN RIVER TRANSITIONAL CARE	6	1000.0	166.67
KERN VALLEY HEALTHCARE DIST RH	1	6.0	6.00
KERN VALLEY HEALTHCARE DISTRIC	15	68.0	4.53
MALIBU BEACH HOLDINGS LLC	9	645.0	71.67
MERCY HOSPITAL	704	2741.0	3.89
PARKVIEW JULIAN, LLC	12	1686.0	140.50
RIDGECREST REGIONAL HOSPITAL	37	1197.0	32.35
SAN JOAQUIN NURSING AND REHABI	4	217.0	54.25
SANTA MONICA UCLA MC AND ORTHO	14	64.0	4.57
SHAFTER NURSING REHAB LLC	4	649.0	162.25
THE REHABILITATION CENTER	29	4410.0	152.07
UCLA DEPT OF MEDICINE PROFESSI	1	5.0	5.00
UCLA MEDICAL CENTER	21	194.0	9.24
USC NORRIS CANCER HOSP	9	49.0	5.44
USC VERDUGO HILLS HOSPITAL	2	2.0	1.00
VALLEY CHILDRENS HOSPITAL	1	1.0	1.00
VALLEY CHILDREN'S HOSPITAL	2	5.0	2.50
VALLEY CONVALESCENT HOSPITAL	5	584.0	116.80
VALLEY VIEW CARE CENTER	3	328.0	109.33
WINDSOR ARVIN HEALTHCARE, LLC	4	554.0	138.50
WINDSOR BAKERSFIELD HEALTHCARE	3	849.0	283.00
Total	**3675**	**27656.0**	**7.53**

Non Participating Providers

Provider Name	Admit Count	LOS	Avg LOS
ANTELOPE VALLEY HOSPITAL	40	468.0	11.70
HENRY MAYO NEWHALL	12	50.0	4.17
RIVERSIDE COMMUNITY HOSPITAL	10	93.0	9.30
PALMDALE REGIONAL MEDICAL CENT	8	87.0	10.88
	7	22.0	3.14
FRESNO COMMUNITY HOSPITAL AND	6	82.0	13.67
CEDARS SINAI MEDICAL CENTER	5	38.0	7.60
RIVERSIDE COUNTY REGIONAL	5	70.0	14.00
SUNRISE HOSPITAL AND MEDICAL	5	30.0	6.00
LOMA LINDA UNIVERSITY MEDICAL	5	52.0	10.40
Total	**239**	**2490.0**	**10.42**

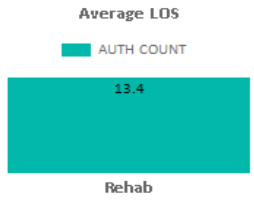
Post-Acute Statistics:

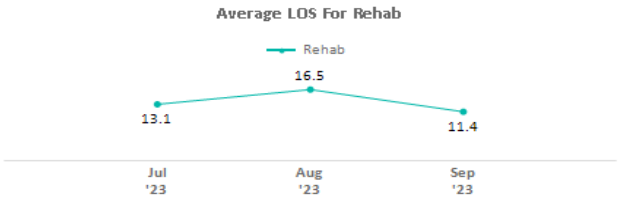
KHS Monthly Inpatient and LOS Report

Report captures Adult Admissions(SNF/Rehabilitation)

Dates of Discharge Between : 7/1/2023-9/30/2023

Adult Admissions (Rehab)





Participating Providers

Provider Name	Admit Count	LOS	Avg LOS
BAKERSFIELD REHABILITATION HOS	4	72.0	18.00
ENCOMPASS HEALTH REHABILITATIO	25	318.0	12.72
Total	**29**	**390.0**	**13.45**

Non Participating Providers

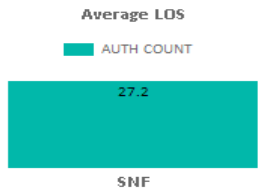
Provider Name	Admit Count	LOS	Avg LOS
Total			**NaN**

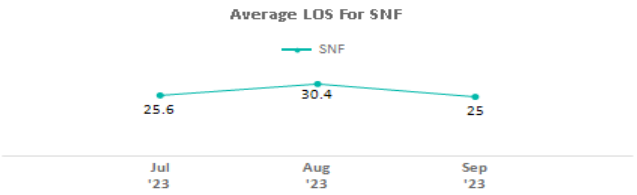
KHS Monthly Inpatient and LOS Report

Report captures Adult Admissions(SNF/Rehabilitation)

Dates of Discharge Between : 7/1/2023-9/30/2023

Adult Admissions (SNF)



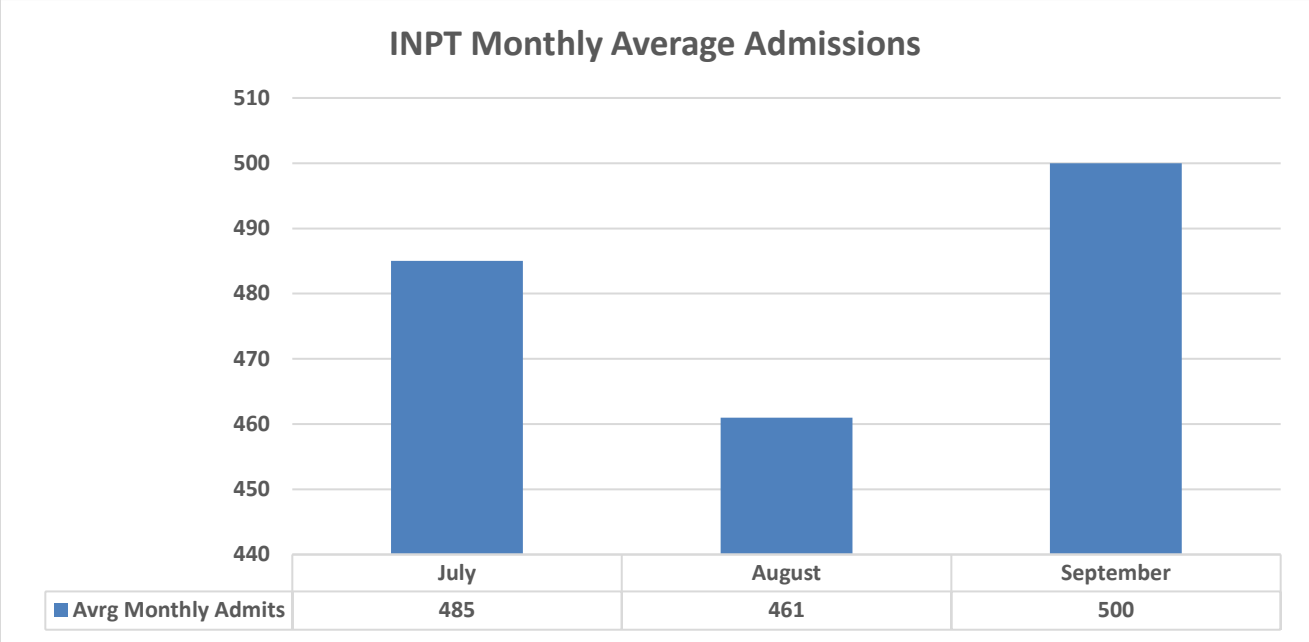


Participating Providers

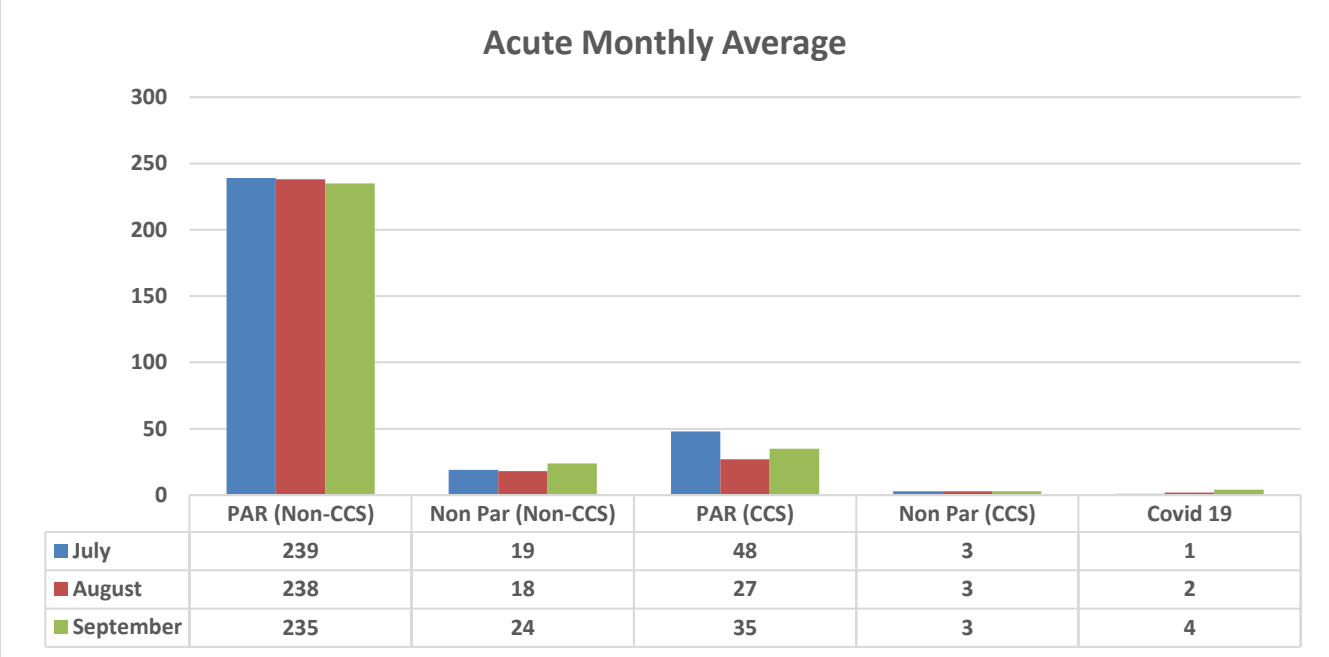
Provider Name	Admit Count	LOS	Avg LOS
ANGEL CONGREGATE LIVING, INC	6	205.0	34.17
BROOKDALE RIVERWALK SNF (CA)	9	154.0	17.11
CAPRI IN THE DESERT	6	210.0	35.00
DELANO DISTRICT SKILLED NURSIN	5	118.0	23.60
EVERLASTING HEALTHCARE	3	240.0	80.00
HEIGHT STREET SKILLED CARE	2	77.0	38.50
MAGNIFIQUE CONGREGATE LIVING I	3	91.0	30.33
MALIBU BEACH HOLDINGS LLC	28	545.0	19.46
NAPOLI IN THE DESERT	11	166.0	15.09
PARKSIDE CONGREGATE LIVING, IN	4	110.0	27.50
PARKVIEW JULIAN, LLC	29	639.0	22.03
ROSE DESERT CONGREGATE	3	143.0	47.67
SAN JOAQUIN NURSING AND REHABI	2	17.0	8.50
SAN MARINO IN THE DESERT	8	289.0	36.13
SHAFTER NURSING REHAB LLC	16	416.0	26.00
SORRENTO IN THE DESERT	5	39.0	7.80
THE REHABILITATION CENTER	20	433.0	21.65
UNITED CARE FACILITIES	1	14.0	14.00
VALLEY CONVALESCENT HOSPITAL	21	299.0	14.24
VALLEY VIEW CARE CENTER	25	912.0	36.48
VFP HOMES	5	71.0	14.20
WINDSOR ARVIN HEALTHCARE, LLC	17	415.0	24.41
WINDSOR BAKERSFIELD HEALTHCARE	18	410.0	22.78
Total	**247**	**6013.0**	**24.34**

Non Participating Providers

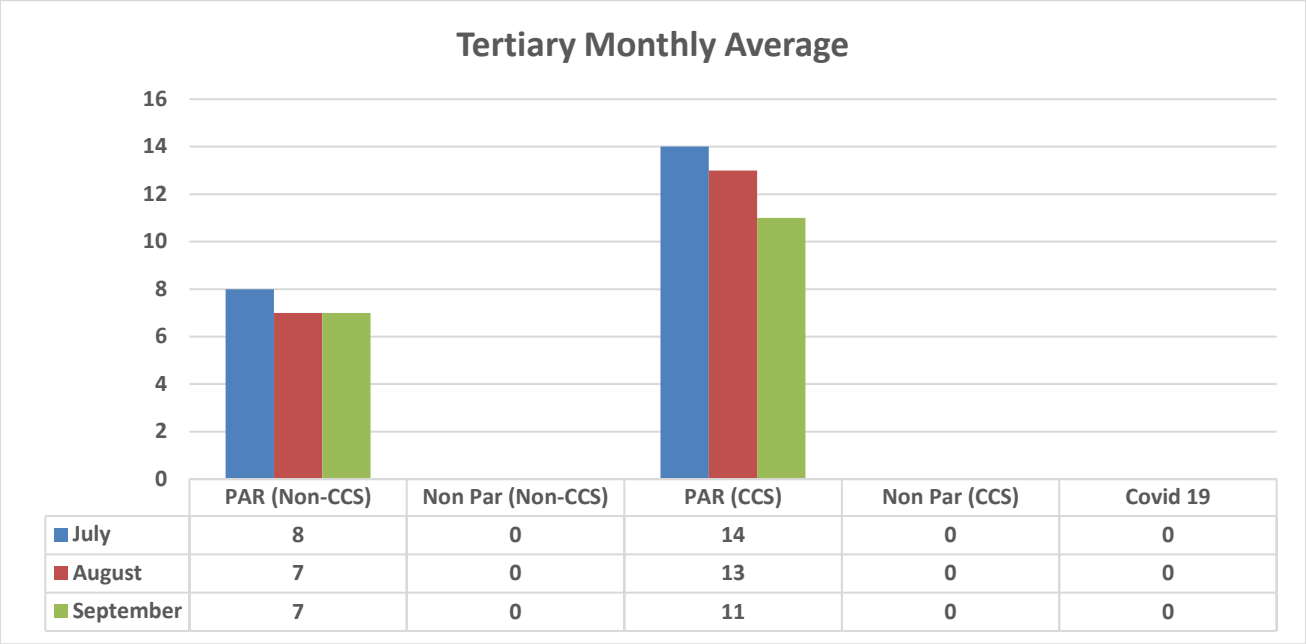
Provider Name	Admit Count	LOS	Avg LOS
LINK TO CARE CONGREGATE HOME	3	247.0	82.33
PINNACLE SIMI VALLEY	2	184.0	92.00
WELLSPRINGS POST ACUTE CENTER	2	57.0	28.50
ALL CARE LIVING HOME	1	257.0	257.00
PORTSIDE HEALTHCARE INC	1	20.0	20.00
RIO BRAVO CONGREGATE LIVING, I	1	141.0	141.00
BEST QUALITY LIVING, INC.	1	99.0	99.00
LAUREL AVENUE LLC	1	30.0	30.00
Total	**12**	**1035.0**	**86.25**



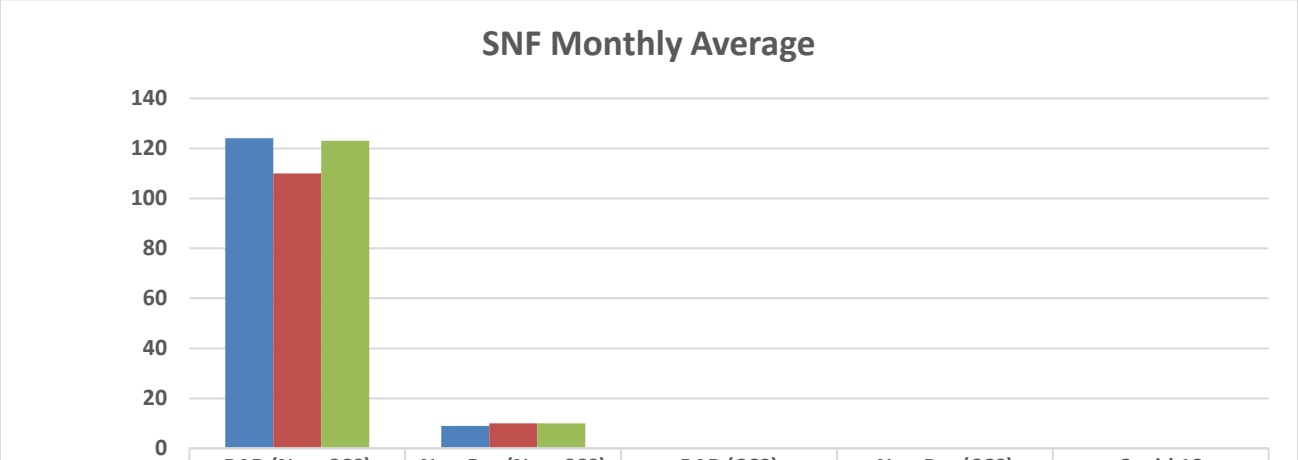
	July	August	September
Avrg Monthly Admits	485	461	500



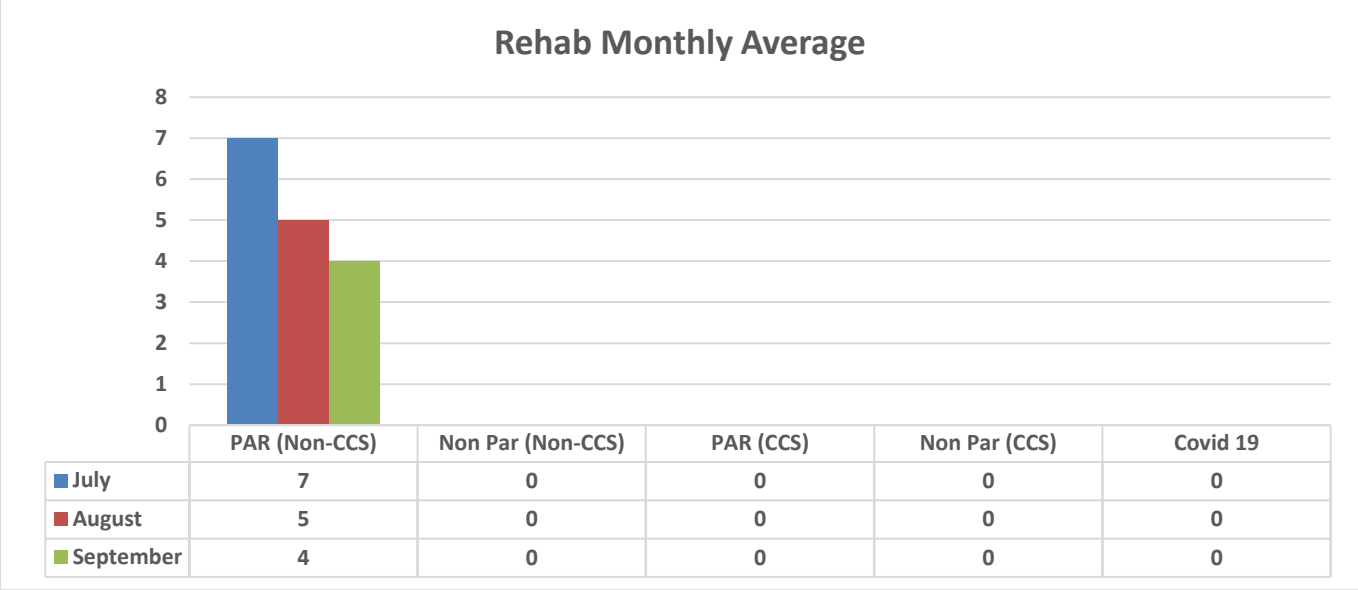
	PAR (Non-CCS)	Non Par (Non-CCS)	PAR (CCS)	Non Par (CCS)	Covid 19
July	239	19	48	3	1
August	238	18	27	3	2
September	235	24	35	3	4



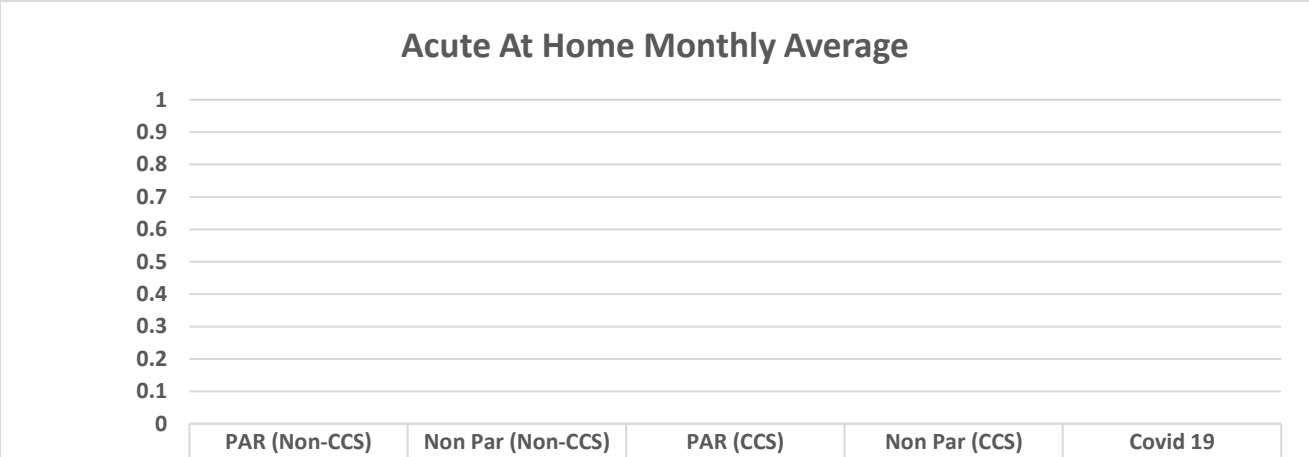
	PAR (Non-CCS)	Non Par (Non-CCS)	PAR (CCS)	Non Par (CCS)	Covid 19
July	8	0	14	0	0
August	7	0	13	0	0
September	7	0	11	0	0



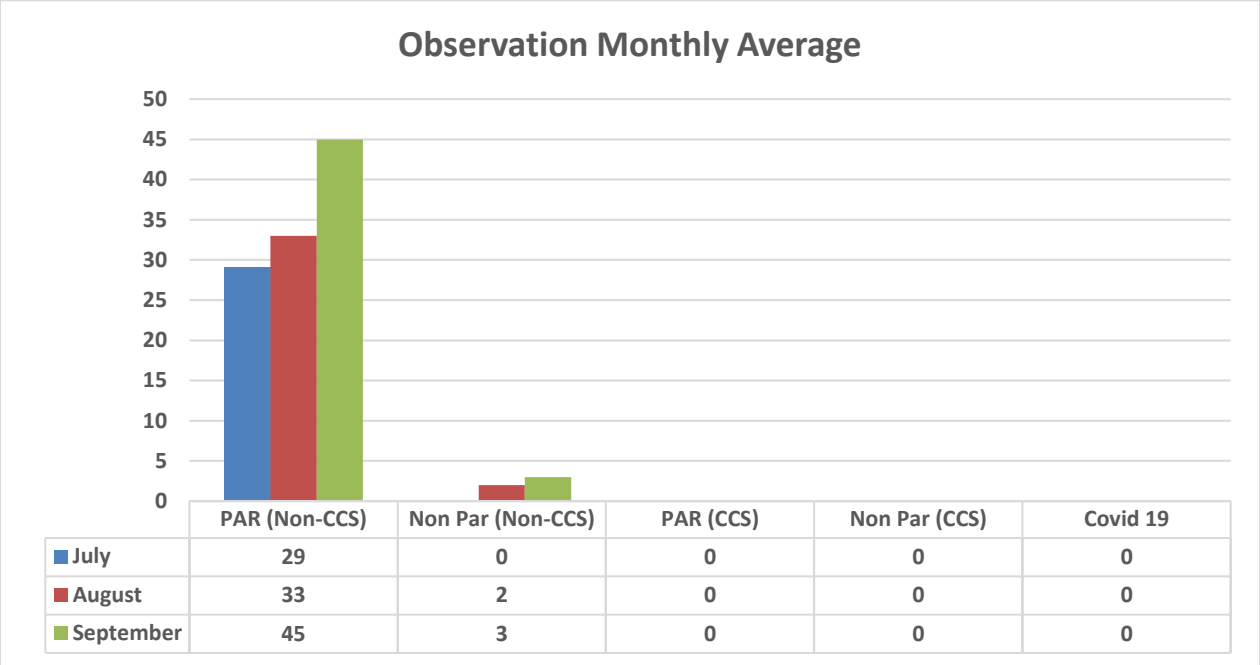
	PAR (Non-CCS)	Non Par (Non-CCS)	PAR (CCS)	Non Par (CCS)	Covid 19
July	124	9	0	0	0
August	110	10	0	0	0
September	123	10	0	0	0



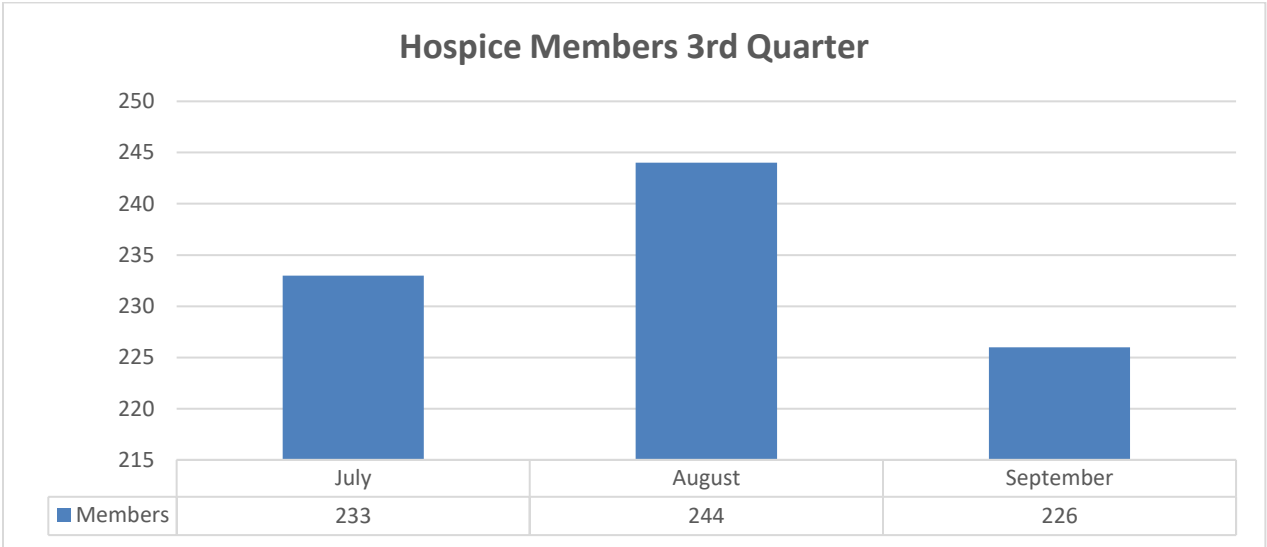
	PAR (Non-CCS)	Non Par (Non-CCS)	PAR (CCS)	Non Par (CCS)	Covid 19
July	7	0	0	0	0
August	5	0	0	0	0
September	4	0	0	0	0



	PAR (Non-CCS)	Non Par (Non-CCS)	PAR (CCS)	Non Par (CCS)	Covid 19
July	0	0	0	0	0
August	0	0	0	0	0
September	0	0	0	0	0



	PAR (Non-CCS)	Non Par (Non-CCS)	PAR (CCS)	Non Par (CCS)	Covid 19
July	29	0	0	0	0
August	33	2	0	0	0
September	45	3	0	0	0

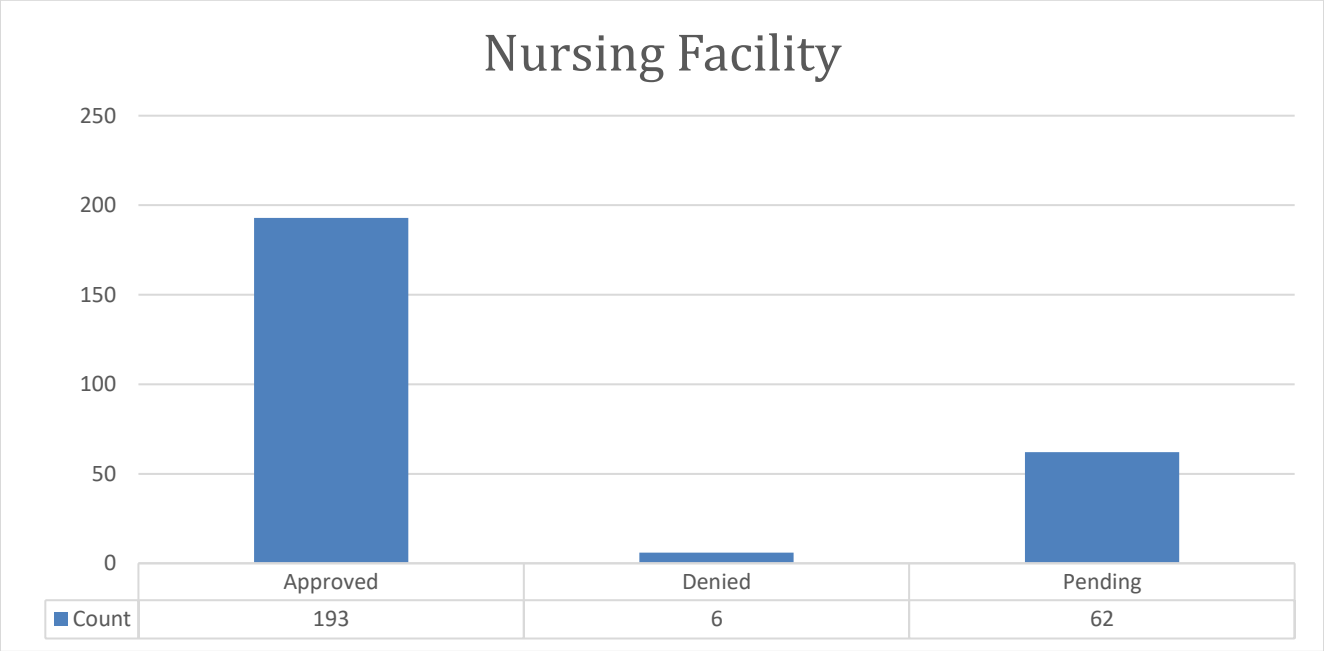


	July	August	September
Members	233	244	226

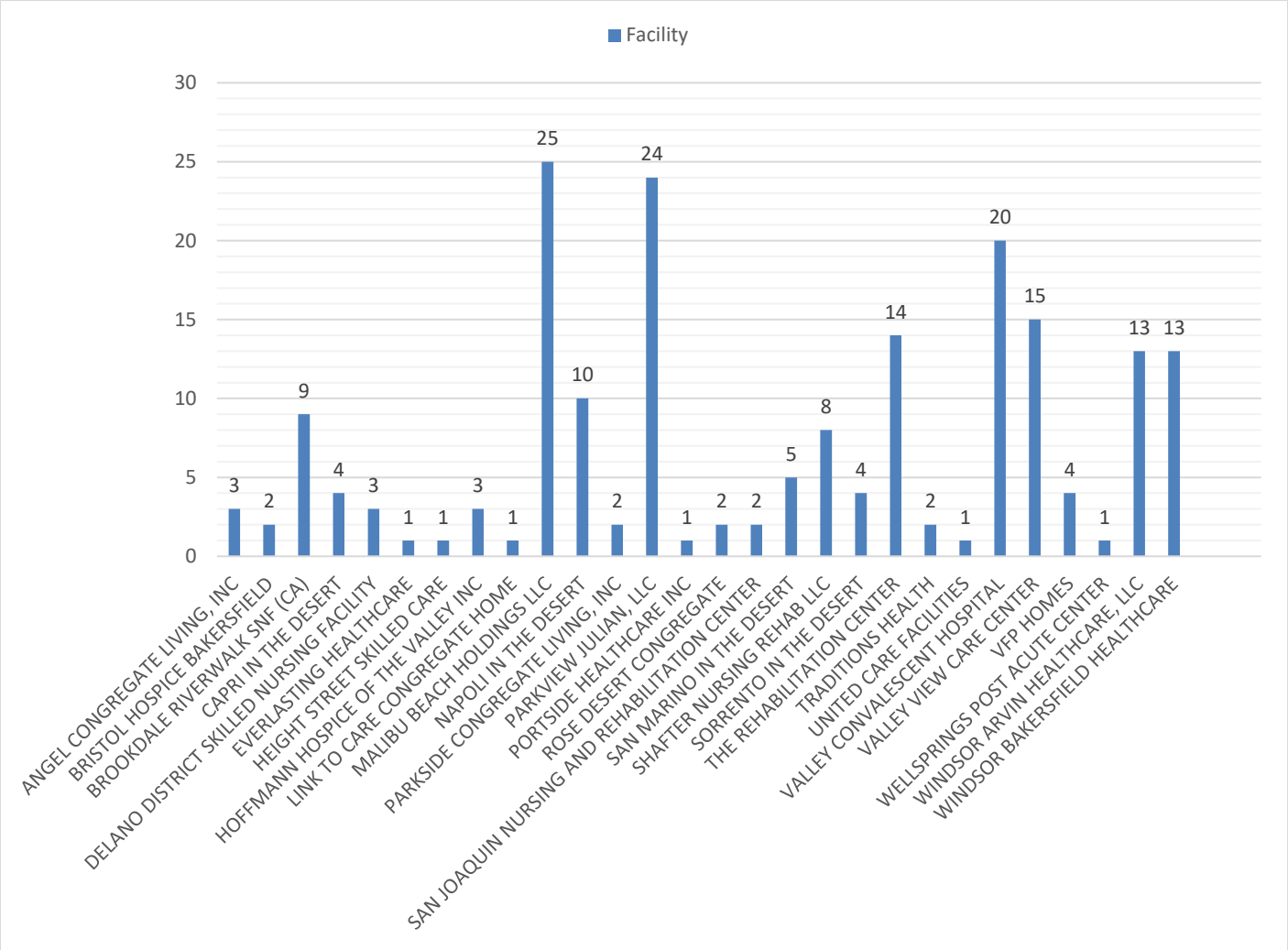
Nursing Facility Services Report

Purpose: Kern Health Systems covers medically necessary Nursing Facility Services for eligible members. KHS members requiring Nursing Facility Services are identified and placed in health care facilities, which provide the level of care most appropriate to the member's medical needs. For members requiring long-term care, monthly and quarterly reporting is completed as per Policy 3.42, Sec. 5, for nursing facility services and to identify any current trends.

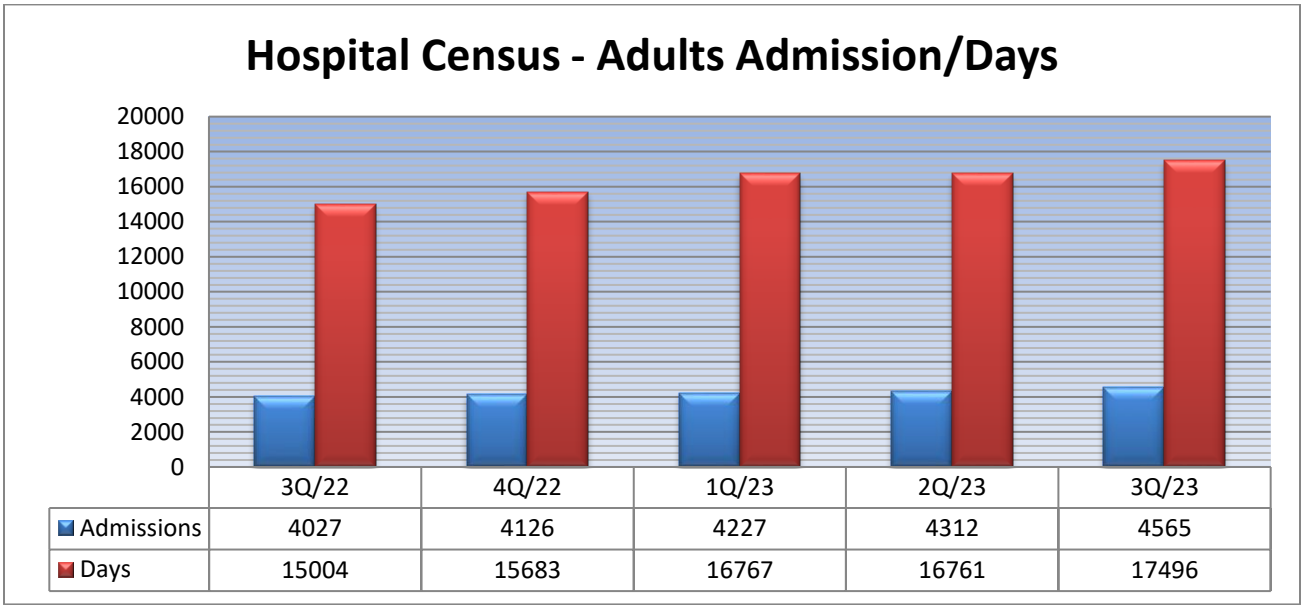
Summary: Summary: During the 3rd quarter 2023, there were 276 referrals for Nursing Facility Services. The average length of stay was 23.8 days for these members. During the 2nd quarter there was only 2 denials of the 297 referrals.



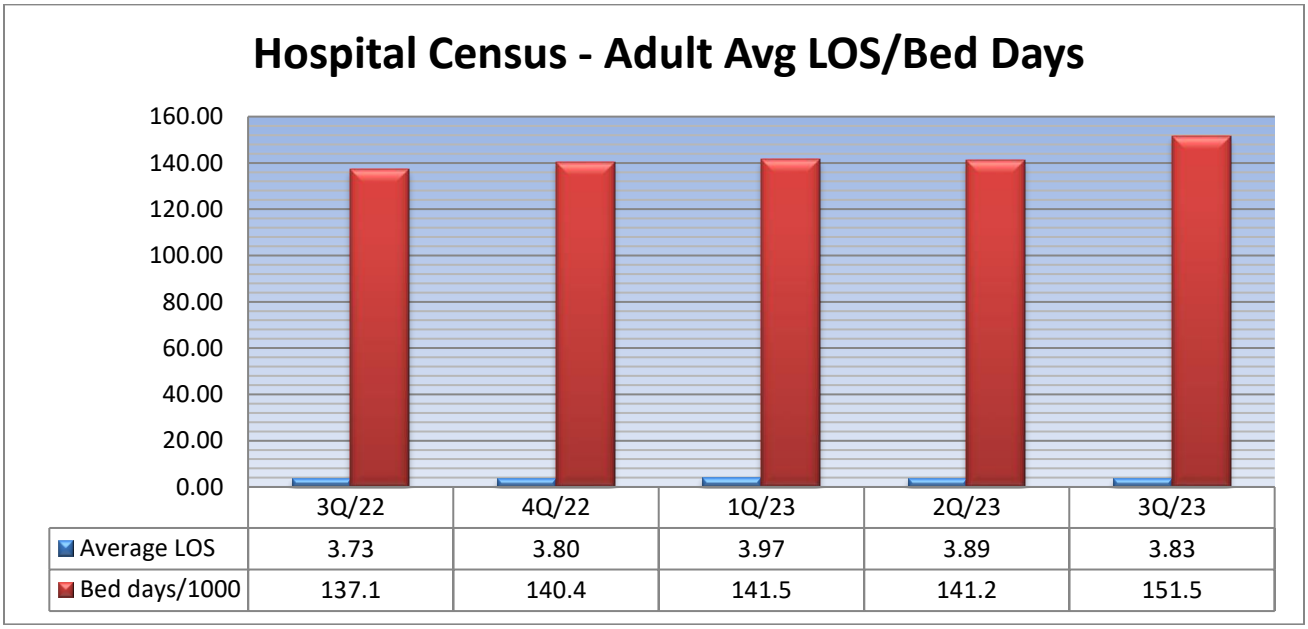
Post-Acute Nursing Facility Services Referral Volume by Location



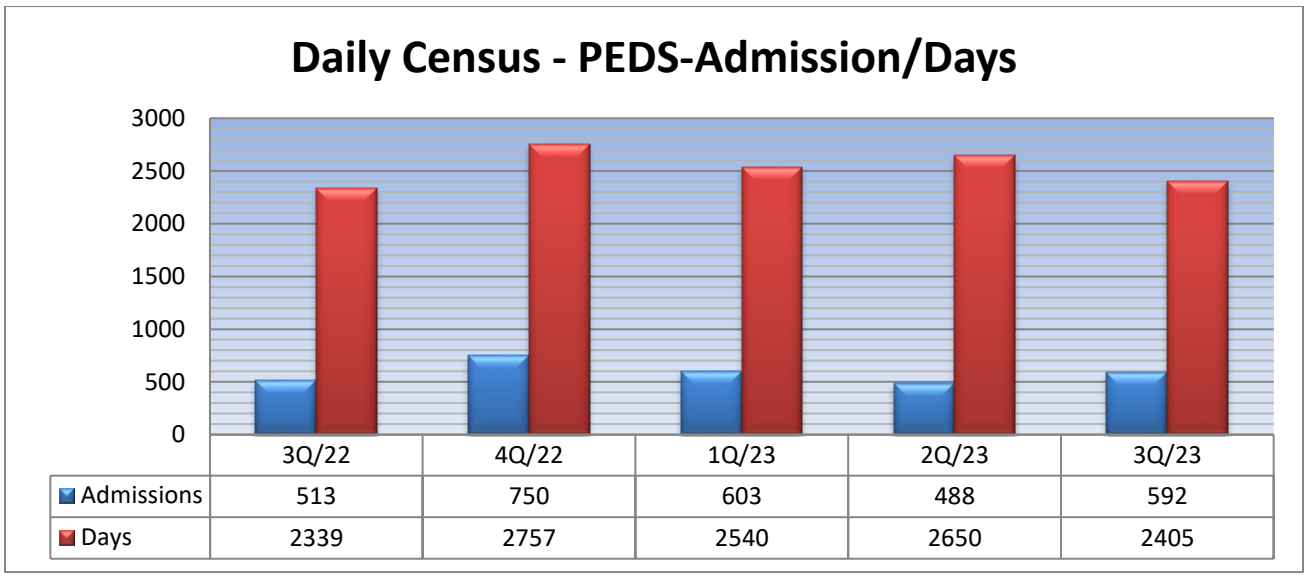
Inpatient 3rd Quarter Trending



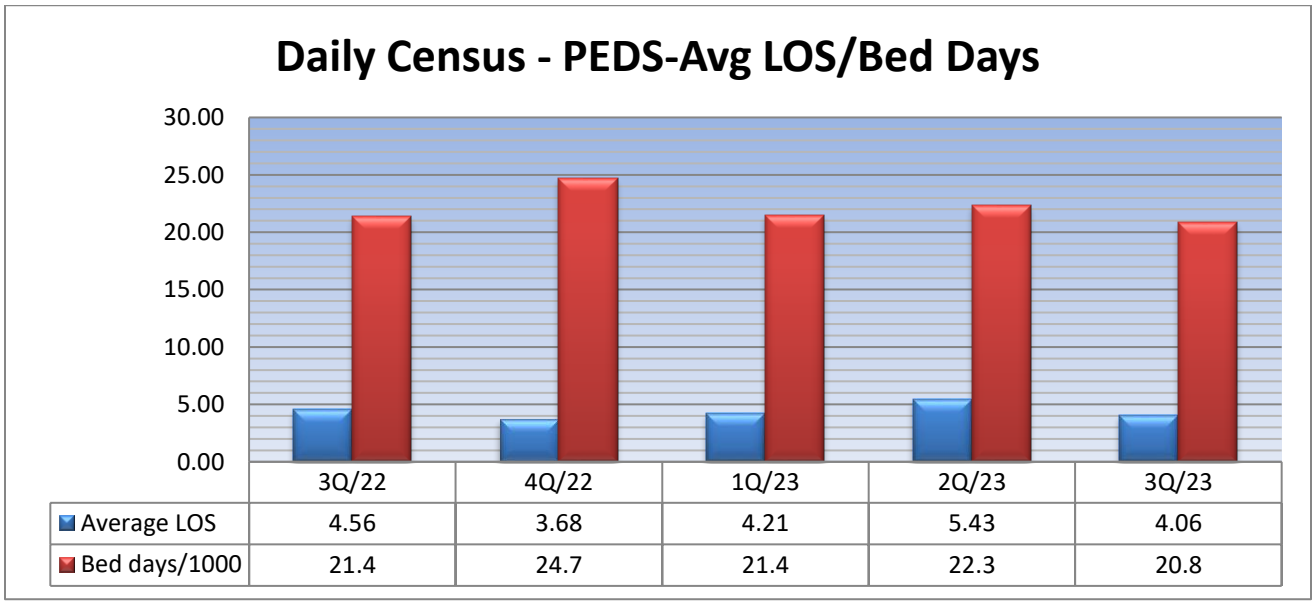
	3Q/22	4Q/22	1Q/23	2Q/23	3Q/23
Admissions	4027	4126	4227	4312	4565
Days	15004	15683	16767	16761	17496



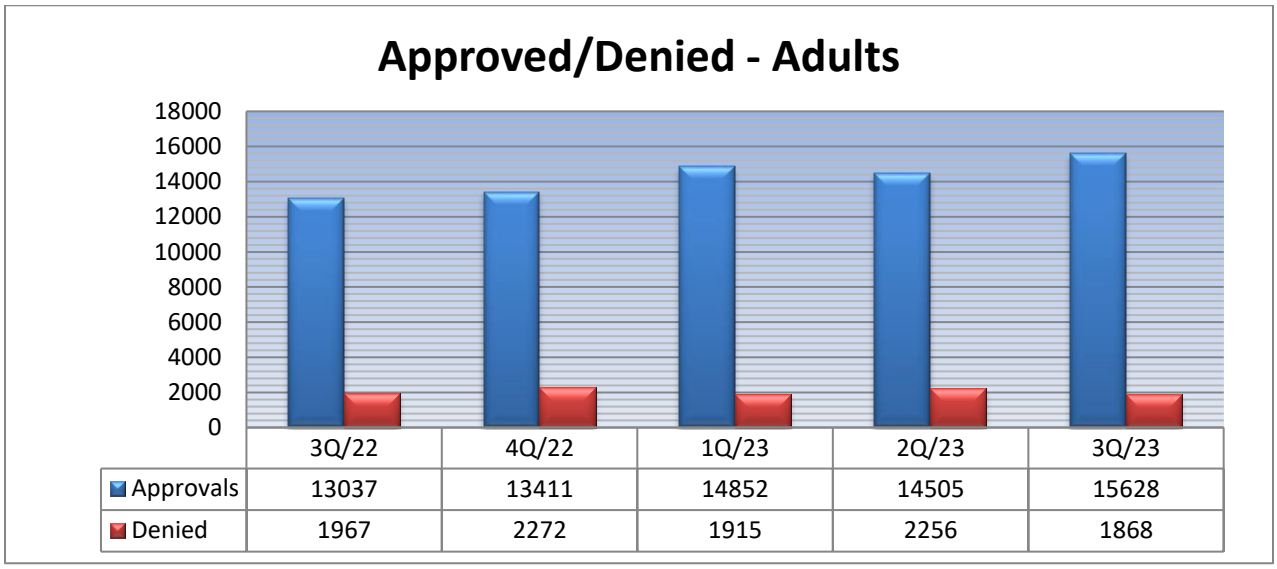
	3Q/22	4Q/22	1Q/23	2Q/23	3Q/23
Average LOS	3.73	3.80	3.97	3.89	3.83
Bed days/1000	137.1	140.4	141.5	141.2	151.5



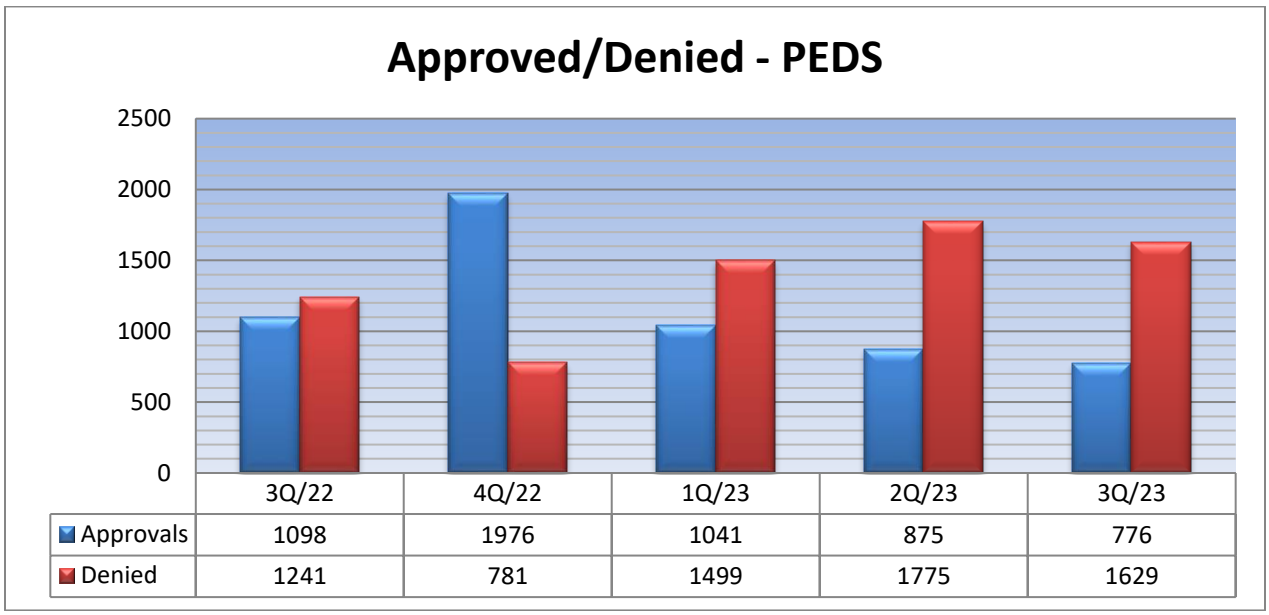
	3Q/22	4Q/22	1Q/23	2Q/23	3Q/23
Admissions	513	750	603	488	592
Days	2339	2757	2540	2650	2405



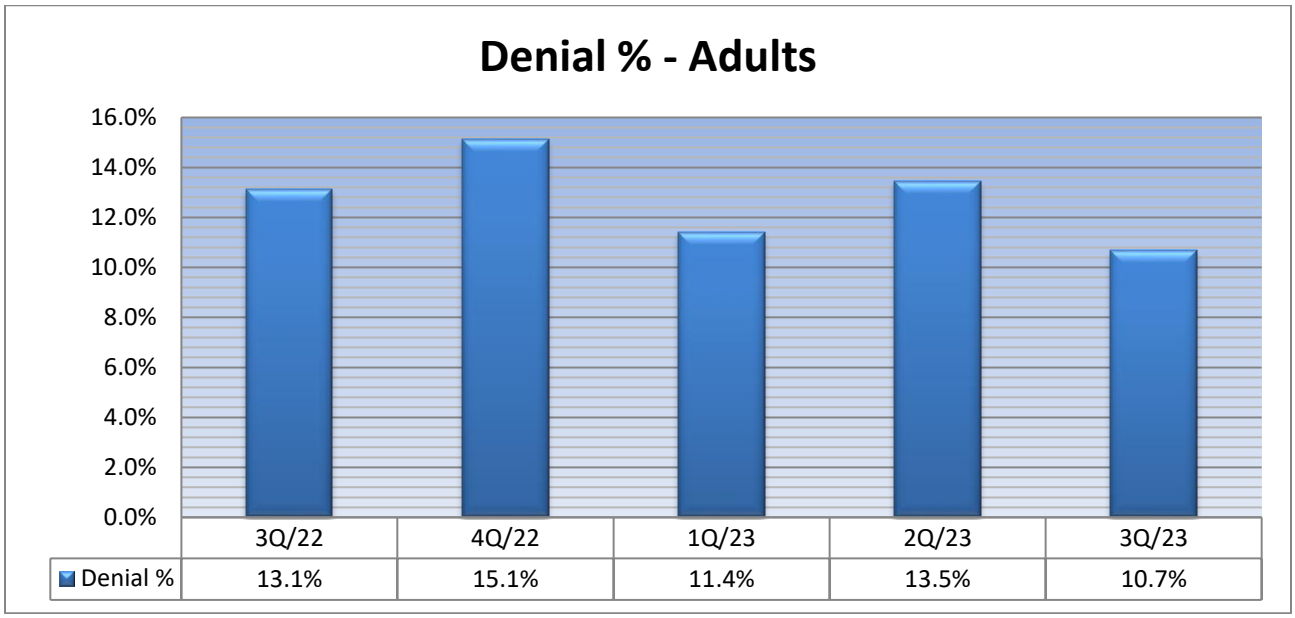
	3Q/22	4Q/22	1Q/23	2Q/23	3Q/23
Average LOS	4.56	3.68	4.21	5.43	4.06
Bed days/1000	21.4	24.7	21.4	22.3	20.8

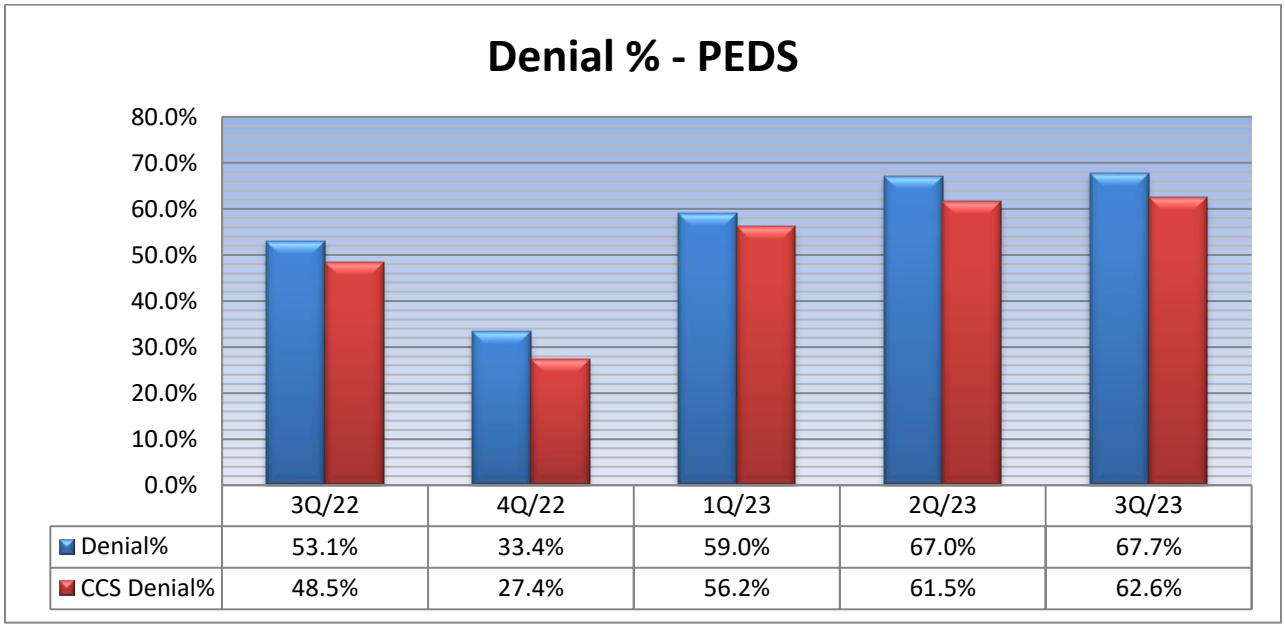


	3Q/22	4Q/22	1Q/23	2Q/23	3Q/23
Approvals	13037	13411	14852	14505	15628
Denied	1967	2272	1915	2256	1868



	3Q/22	4Q/22	1Q/23	2Q/23	3Q/23
Approvals	1098	1976	1041	875	776
Denied	1241	781	1499	1775	1629

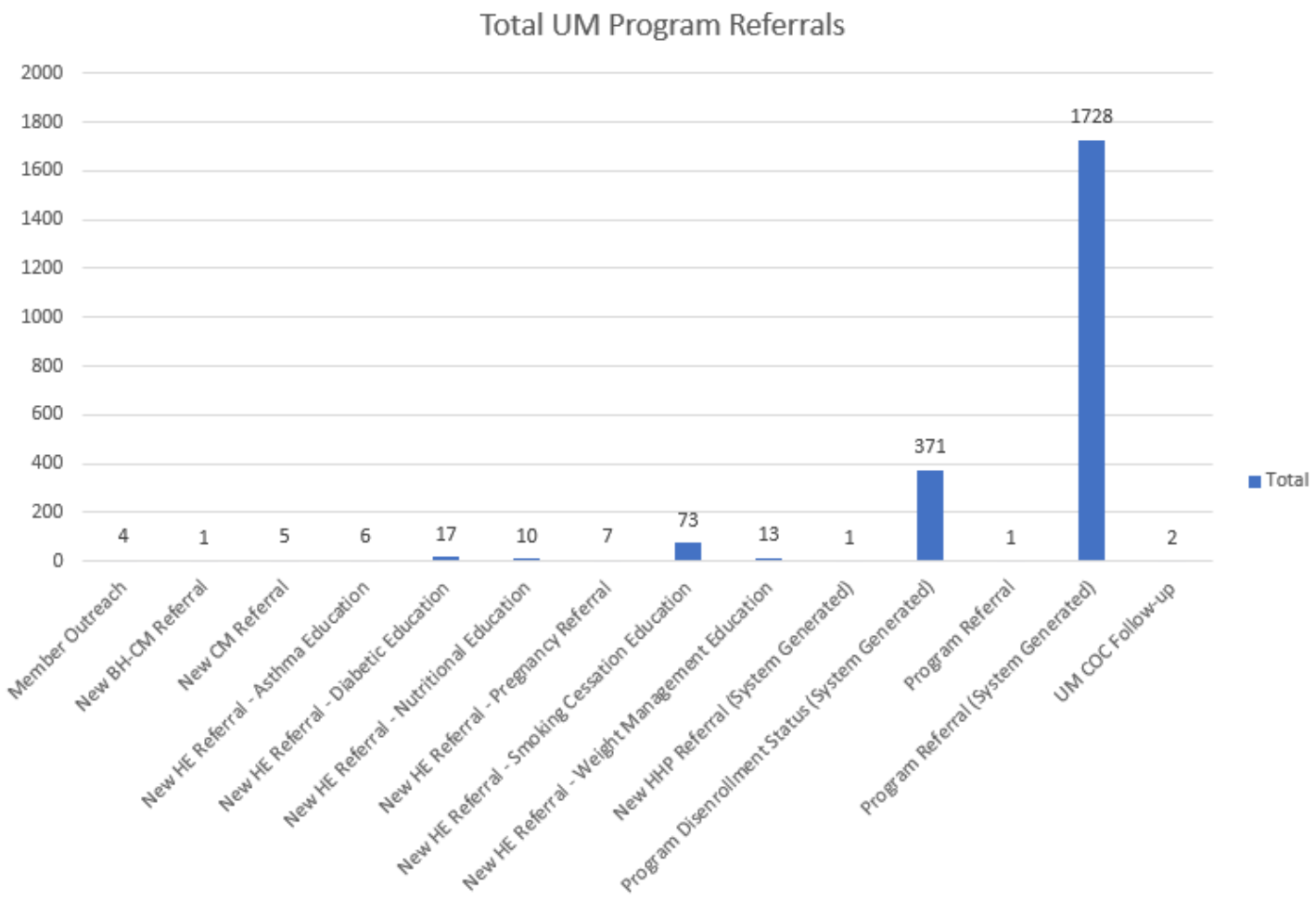

Denial % - Adults
16.0%
14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
3Q/22
4Q/22
1Q/23
2Q/23
3Q/23
Denial %
13.1%
15.1%
11.4%
13.5%
10.7%

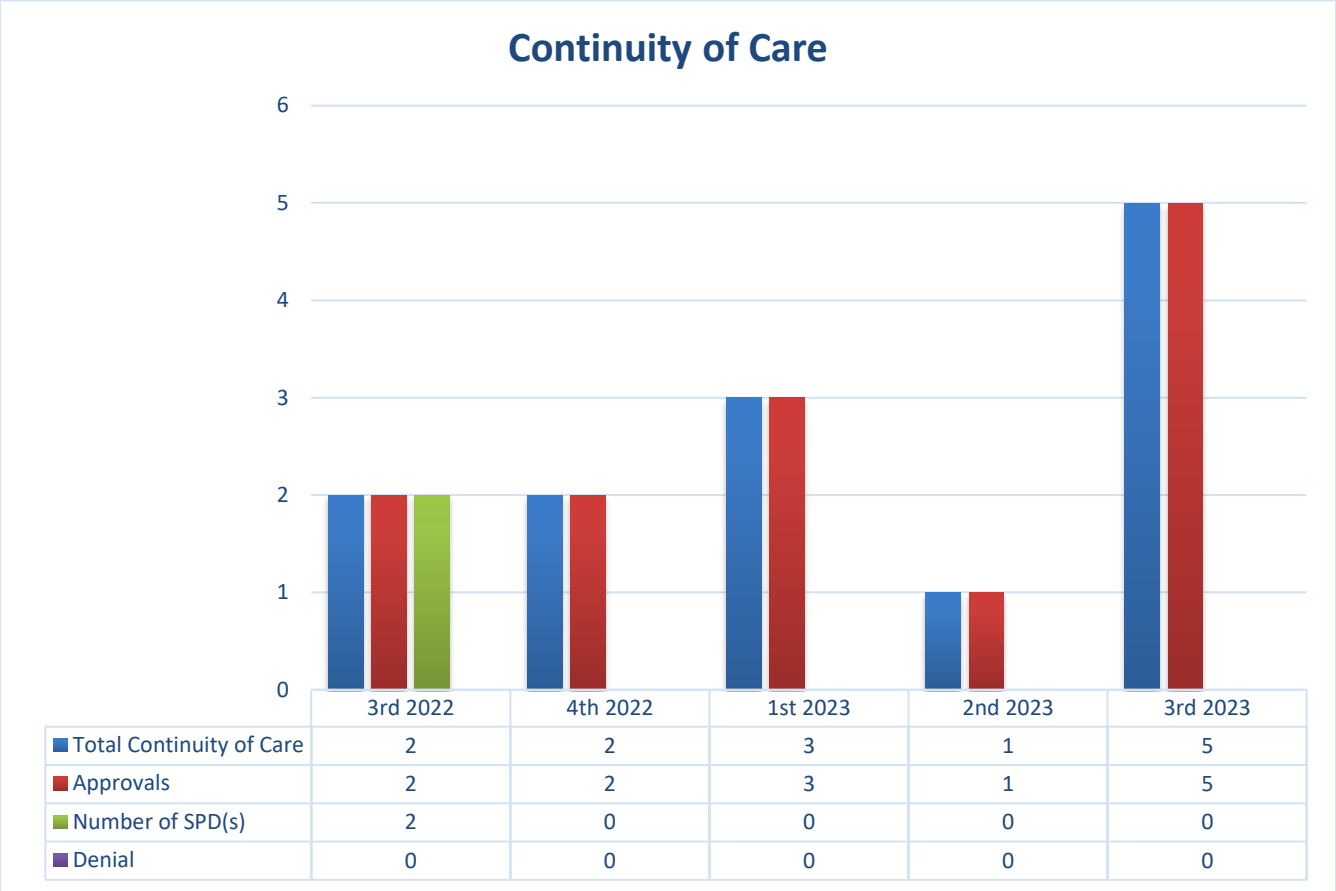

Denial % - PEDS
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
3Q/22
4Q/22
1Q/23
2Q/23
3Q/23
Denial%
53.1%
33.4%
59.0%
67.0%
67.7%
CCS Denial%
48.5%
27.4%
56.2%
61.5%
62.6%

UM Created Activities 3rd Quarter 2023

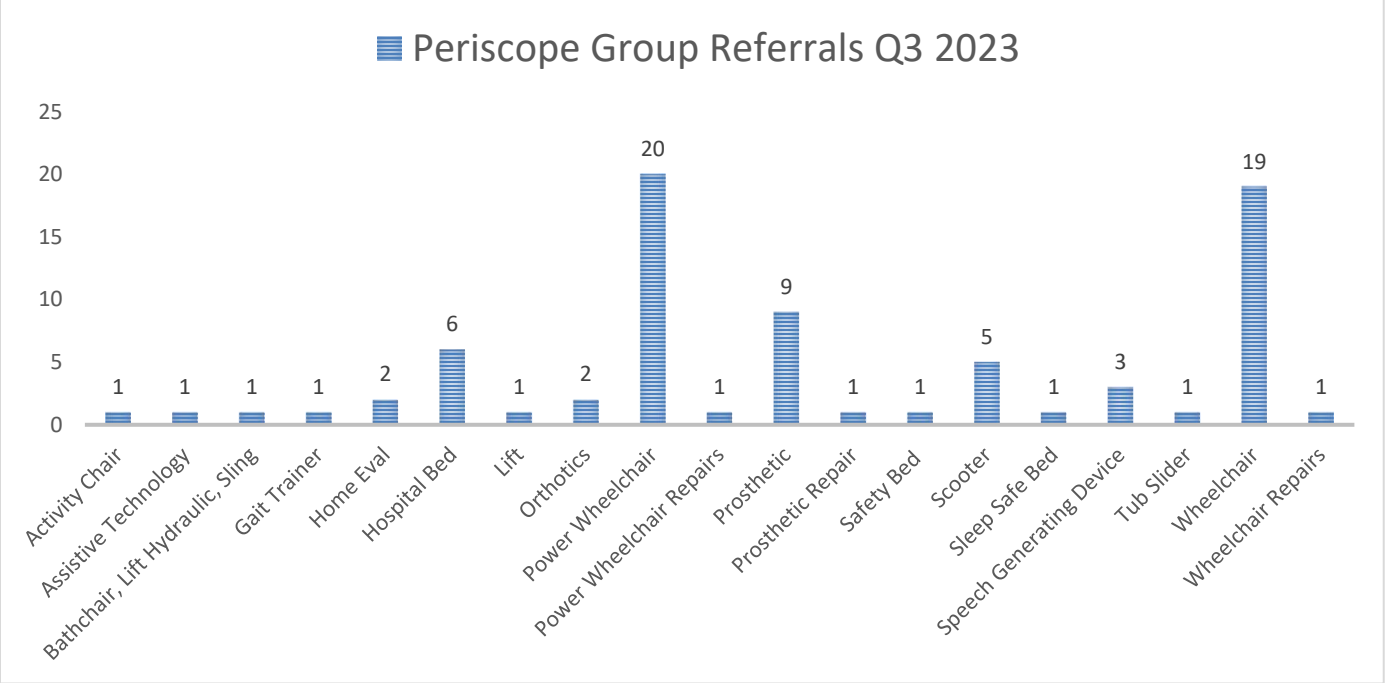
Type	Activity Count
Member Outreach	**4**
CM Periscope Review	3
Referral to Case Management	1
New BH-CM Referral	**1**
Referral to BH Case Management	1
New CM Referral	**5**
Care Coordinator Outreach	1
Referral to Case Management	4
New HE Referral - Asthma Education	**6**
Referral to Health Education	6
New HE Referral - Diabetic Education	**17**
Referral for Health Education	1
Referral to Health Education	16
New HE Referral - Nutritional Education	**10**
Referral for Health Education	1
Referral to Health Education	9
New HE Referral - Pregnancy Referral	**7**
Referral to Health Education	7
New HE Referral - Smoking Cessation Education	**73**
Referral for Health Education	3
Referral to Health Education	70
New HE Referral - Weight Management Education	**13**
Referral for Health Education	2
Referral to Health Education	11
New HHP Referral (System Generated)	**1**
Referral for Health Homes Program	1
Program Disenrollment Status (System Generated)	**371**
ECM Disenrollment - Member well managed	366
ECM Disenrollment - Unable to engage member	5
Program Referral	**1**
Referral to Case Management	1
Program Referral (System Generated)	**1728**
Referral to Comm Supports Asthma Remediation Program	391
Referral to Comm Supports Caregiver Respite Program	101
Referral to Comm Supports Housing Deposits Program	59
Referral to Comm Supports Housing Navigation Services Program	381
Referral to Comm Supports Housing Sustainability Program	73
Referral to Comm Supports NRSF Diversion Program	1
Referral to Comm Supports Personal Care Services Program	36
Referral to Comm Supports Recuperative Care Program	48
Referral to Comm Supports Short Term Post Hospitalization Program	38
Referral to Comm Supports Sobering Centers Program	343
Referral to Comm Supports Tailored Meals Program	79
Referral to ECM Program	145
Referral to LTC Program	33
UM COC Follow-up	**2**

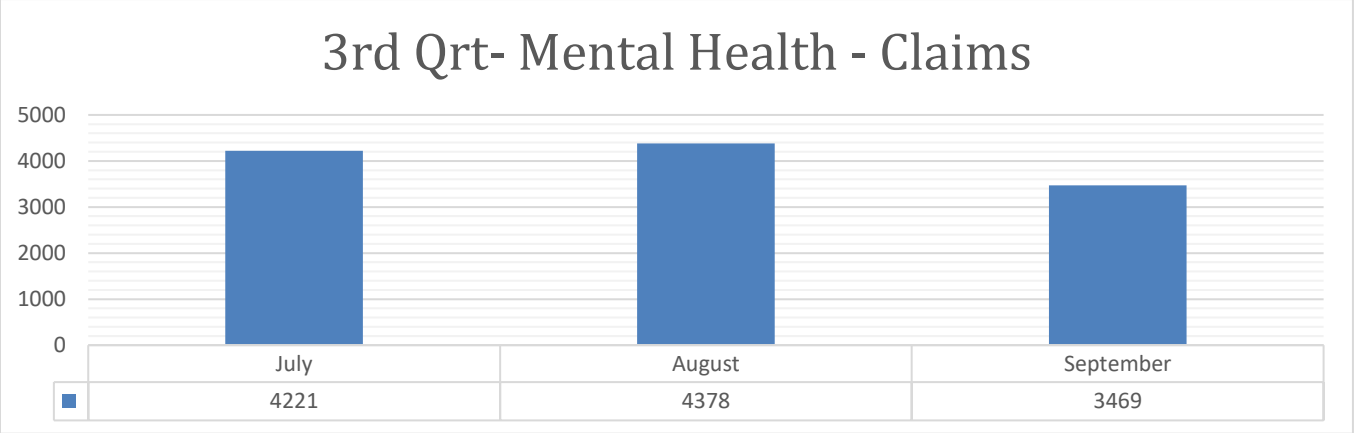
Contact member for acknowledgment of COC request	1
Contact member for provider choice after COC Expiration	1
Grand Total	**2239**





	3rd 2022	4th 2022	1st 2023	2nd 2023	3rd 2023
Total Continuity of Care	2	2	3	1	5
Approvals	2	2	3	1	5
Number of SPD(s)	2	0	0	0	0
Denial	0	0	0	0	0





ABA Services

UNIQUE CASES		Total
MEMBER COUNT		377

SEVERITY	Jul	Aug	Sep	Total
Approved FBA	182	242	281	705
Approved Treatment	84	149	144	377

	Jul	Aug	Sep	Total
AGE 7 OR LESS	60	107	105	272
AGE 8 OR GREATER	24	42	39	105
TOTAL	84	149	144	377
% < 7	71.43%	71.81%	72.92%	72.15%
% > 8	28.57%	28.19%	27.08%	27.85%

Initial Health Assessment (IHA) Letters to Members

Letters to the member's PCP with a count of their assigned members who still need an IHA.
These letters direct the PCP to the Provider Portal to review their list and perform outreach.
Letters are also mailed to the PCP regarding members who have open authorizations.
Open authorizations are defined as any auth that has not expired and has no claim attached to it.
The auth does not need to be fulfilled to no longer be considered open.
Letters are mailed out to each PCP at each location where they have members assigned.

July 2023

- IHA Letters Mailed – 370
- Open Authorization letters mailed – 131

August 2023

- IHA Letters Mailed – 363
- Open Authorization letters mailed – 127

September 2023

- IHA Letters Mailed – 360
- Open Authorization letters mailed – 129

Health Equity

Open Authorization Referred by Current PCP Percentage Table							
Ethnicity	**% Ethnicity**	**Gender**	**% Gender**	Age Group	**% Age**	**ZIP**	**% Zip**
HISPANIC	57.71%	F	54.49%	<21	66.18%	93307	13.22%
CAUCASIAN	15.56%	M	45.51%	>=21 and <=64	31.34%	93306	8.84%
NO VALID DATA	14.24%			>64	2.48%	93313	8.11%
AFRICAN AMERICAN	5.55%					93280	7.52%
ASIAN INDIAN	3.43%					93263	7.09%
UNKNOWN	1.75%					93215	6.43%
ASIAN/PACIFIC	1.10%					93304	6.36%
FILIPINO	0.29%					93309	5.62%
ALASKAN/AMER INDIAN	0.15%					93305	5.41%
JAPANESE	0.07%					93308	4.89%
CHINESE	0.07%					93311	4.38%
LAOTIAN	0.07%					93312	3.07%

Open Authorization Referred by Other than Current PCP Percentage Table							
Ethnicity	**% Ethnicity**	**Gender**	**% Gender**	**Age Group**	**% Age**	**ZIP**	**% Zip**
HISPANIC	59.25%	F	56.77%	<21	42.44%	93307	18.64%
CAUCASIAN	19.52%	M	43.23%	>=21 and <=64	51.05%	93306	9.51%
NO VALID DATA	9.77%			>64	6.51%	93305	7.74%
AFRICAN AMERICAN	7.32%					93304	7.25%
ASIAN INDIAN	1.59%					93308	6.45%
UNKNOWN	1.17%					93215	4.97%
FILIPINO	0.46%					93263	4.79%
ASIAN/PACIFIC	0.46%					93203	4.77%
ALASKAN/AMER INDIAN	0.24%					93309	4.76%
CAMBODIAN	0.06%					93313	4.46%
SAMOAN	0.04%					93280	4.24%
KOREAN	0.03%					93250	2.86%
HAWAIIAN	0.03%					93311	2.79%
VIETNAMESE	0.03%					93241	2.61%
LAOTIAN	0.03%					93301	2.39%
CHINESE	0.01%					93312	2.15%

UM Internal Auditing Results

Delayed Referral Audit:

Kalpna Patel, UM Clinical Trainer & Auditor, RN
Audit Period: July, 2023, to September 30, 2023
Sample Size: 10% or 10 per month (whichever is greater)

Purpose: Quarterly audits of referrals that have been delayed by the UM Department is done to monitor compliance with the Kern Health Systems' Policy and Procedure 3.22 Referral and Authorization Process, Section 4.2.1 Deferrals, Section 4.2.1.1 Extended Deferral.

Policy and Procedures 3.22, Section 4.2.1 Deferrals states – Authorization requested needing additional medical records may be deferred, not denied, until the requested information is obtained. If deferred, the Case Manager follows-up with the referring practitioner/provider within 14 calendar days from the receipt of the request f additional information is not received. Every effort is made at that time to obtain the information. Practitioners/providers are allowed 14 calendar days to provide additional information. On the 14th calendar day from receipt of the original request is approved or denied as appropriate.

Section 4.2.1.1 Extended Deferral states – The time limit may be extended an additional 14 calendar days if the member or the member's provider requests and extension, or KHS UM Department can provider justification for the need for additional information and how it is in the Member's interest. In cases of extension, the request is approved or denied as appropriate no later than the 28 the calendar day from the receipt of the original authorization request.

Month	July	August	September
Total Referrals Processed	22,544	26,396	23,474
Total Referrals Delayed	58	70	62
Percent of Delays	<1%	<1%	<1%
Percent of Audit (10 percent or 10 referrals whichever is larger)	10 referrals	10 referrals	10 referrals
Number of Referrals in Audit	10	10	10

Indicators:

1. Referral Turn-around Time
    - Delays being done on day 5 of original referral – Final decision no later than 14 days for delays and 28 days for extend delays.
    - Provider and member notification within 24 hours of decision - Stamp dates on Referral and NOA letter, closed out within compliance.
2. Notice of Action Letter
    - Spelling/Grammar, Verbiage, and Format
    - 6th grade reading level.
    - Medi-Cal Criteria applied.

- Reason for delay clear and concise
- Expected due date listed.

3. Medical Director / Case Manager Name and Signatures
4. Processing of Referral.

July's Findings: Out of the **10** delayed referrals reviewed, the following is a breakdown of the findings.

- Five (5) referral was found **without** errors from the above indicator.
- Five (5) error were found within the Processing of Referral with decision reason selected as approved or denied instead of "previously delayed." 4/5 were not true delays selected in error
- Zero (0) error was found within the Referral Turn-around Time indicator.
- Zero (0) errors were found within the Notice of Action Letter
- Five (5) errors found with NOA language above 6th grade reading level.
- Zero (0) error was found within the Medical Director / Case Manager Name and Signatures

August Findings: Out of the **10** delayed referrals reviewed, the following is a breakdown of the findings.

- One (1) referral were found **without** errors from the above indicator.
- Zero (2) error was found within the Processing of Referral with decision "delayed" not selected and on cert selected "previously delayed" for a reclassified auth.
- Zero (0) error was found within the Referral Turn-around Time indicator.
- Zero (0) error were found within the Notice of Action Letter
- Nine (9) errors found with above 6th grade reading level.
- Zero (0) error was found withing the Medical Director / Case Manager Name and Signatures

September's Findings: Out of the **10** delayed referrals reviewed, the following is a breakdown of the findings.

- Five (5) referrals were found **without** errors from the above indicator.
- Two (2) errors were found within the Processing of Referral with 1 referral were not a true delay, selected delayed reason in error. 1 referral selected approved instead of delayed.
- Zero (0) errors were found within the Referral Turn-around Time indicator.
- Zero (0) error was found within the Notice of Action Letter
- Four (4) errors found with NOA language above 6th grade reading level.
- Zero (0) error was found withing the Medical Director / Case Manager Name and Signatures

UM Trainer Action: Notice of Action/ Process of Referrals indicator errors have been discussed with individual staff as appropriate and refresher pieces of training have been provided as needed.

Corrective action plan -retraining will be provided to NOA team
Individual emails sent to make correctable changes

Denied Referral Audit:

Kalpna Patel, UM Clinical Auditor & Trainer, RN
Audit Period: July 1, 2023, to September 30, 2023
Sample Size: 10%

Purpose: Quarterly audits of referrals that have been denied by the UM Department is done to monitor compliance with the Kern Health Systems' Policy and Procedure 3.22 Referral and Authorization Process, Section 4.2.3 Denials.

Policy and Procedures 3.22, Section 4.2.3 Denials states – If initial review determines that an authorization request does not meet established utilization criteria, denial is recommended. Only the Associate Medical Director may deny an authorization request. Reasons for possible denial include:

A. Not a covered benefit
B. Not medically necessary
C. Member not eligible
D. Continue conservative management
E. Services should be provided by a PCP
F. Experimental or investigational treatment (See KHS Policy #3.44)
G. Member made unauthorized self-referral to practitioner/provider
H. Services covered by CCS
I. Inappropriate setting
J. Covered by hospice

Month	July	August	September
Total Referrals Processed	22,544	26,396	23,474
Total Referrals Denied	1480	1718	1560
Percent of Denials	6%	6%	6%
Percent of Audit	10%	10%	10%
Number of Referrals in Audit (Not Included: Search and Serve, or Mental Health Referrals)	127	146	136

Indicators:

5. Referral Turn-around Time
    - Decision completed within 3 business days for Urgent referrals and 5 business days for routine referrals,
    - Provider and member notification within 24 hours of decision - Stamp dates on Referral and NOA letter, closed out within compliance.
6. Notice of Action Letter

- Spelling/Grammar, Verbiage, and Format
- 6th grade reading level
- Medi-Cal Criteria applied
- Criteria indicated and attached
- Recommendations indicated

7. Medical Director / Case Manager Name and Signatures
8. Processing of Referral

July's Findings: Out of the **127** Denied referrals reviewed, the following is a breakdown of the findings.

- Ninety-five (95) referrals were found **without** errors from the above indicator.
- Five (5) errors were found within the Referral Turn-around Time indicator- no processed in timely manner.
- Thirty-seven (37) error were found within the Notice of Action Letter indicator.
  - Zero (0) error found with verbiage.
  - Thirty- Three (33) found with above 6th grade reading level.
  - Zero (0) found with missing NOA language on NOA template.
  - One (1) cert found with criteria not reviewed, One cert found with criteria not attached. One cert missing expanded version of criteria.
  - Zero (0) error found with recommendations to MD
- Zero (0) error was found within the Medical Director / Case Manager Name and Signatures.
- Three (3) errors were found within the Processing of the Referral with one cert found processed with incorrect member notes. One cert found with missing commentary on OP notification. One cert found with missing OP notification.

❖ All referrals reviewed for medical necessity

Guidelines Applied and attached:

- Fourteen (14) referrals with Medi -Cal guidelines were used.
- Thirteen (13) referrals with Up-to-Date guidelines were used.
- Thirty -two (32) referrals with KHS policy and KHS specialty guidelines used.
- Sixty-eight (68) referrals with MCG guidelines used.
- Fourteen (14) referrals with Administrative Denials with KHS policy 3.22

Some referrals have applied more than one criterion per MD review**

August's Findings: Out **146** of the Denied referrals reviewed, the following is a breakdown of the findings.

- Ninety-six (110) referrals were found **without** errors from the above indicator.
- Zero (0) errors were found within the Referral Turn-around Time indicator with not processed in timely manner.
- Forty-nine (34) error was found within the Notice of Action Letter indicator

- Two (2) error found with verbiage – with certs closed out prior to Spanish translation completed.
- Thirty-two (32) error found with above 6th grade reading level.
- Two (2) error found with missing criteria not attached.
- Zero (0) error found with recommendations to MD.

- Zero (0) error was found within the Medical Director / Case Manager Name and Signatures
- Three (3) error were found within the Processing of the Referrals

  - One (1) referral processed incorrectly completely would need to be voided and not denied (NCIC level).
  - One (1) referral with voided codes NPA- for tertiary level by NCIC
  - One (1) referral with incorrect MD noted on OP notification commentary

- All referrals reviewed for medical necessity

Guidelines Applied and Attached:

  - Seventeen (17) referrals with Medi -Cal guidelines were used.
  - Fifteen (15) referrals with Up-to-Date guidelines were used.
  - Forty-seven (47) referrals with KHS policy and KHS specialty guidelines used.
  - Sixty -five (65) referrals with MCG guidelines used.
  - Eight (8) referrals with Administrative Denials which no criteria are required.

Some referrals have applied more than one criterion per MD review**

September's Findings: Out of **136** the Denied referrals reviewed; the following is a breakdown of the findings.

- Ninety-seven (108) referrals were found **without** errors from the above indicator.
- Zero (0) errors were found within the Referral Turn-around Time indicator.
- Three (3) error were found within the Notice of Action Letter indicator.
  - Zero (0) error found with verbiage and format.
  - One (1) error found with Missing NOA language from body of letter
  - Twenty-one (21) error found with above 6th grade reading level.
  - Five (5) with partial criteria attached, Missing mcal criteria.
  - Zero (0) error found with no recommendations to MD.
- Zero (0) error was found within the Medical Director / Case Manager Name and Signatures no MD signatures on OP notification.
- Zero (0) error was found within the Processing of the Referrals with selected partial approval vs approved only.
- All referrals reviewed for medical necessity

Guidelines Applied and Attached:

  - Twenty-five (25) referrals with Medi -Cal guidelines were used.
  - Six (6) referrals with Up-to-Date guidelines were used.
  - Thirty-four (34) referrals with KHS policy and KHS specialty guidelines used.

- Ninety (71) referrals with MCG guidelines used.
- Ten (10) referrals with Administrative Denials which no criteria are required.

Some referrals have applied more than one criterion per MD review**

UM Trainer Action: Notice of Action/ Process of Referrals indicator errors have been discussed with individual staff as appropriate and refresher pieces of training have been provided as needed.

Corrective Action plan is to modify NOA language for administrative denials to 6th grade level. MD NOA audits performed to bring down language to below 6th grade level

Modified Referral Audit:

Kalpna Patel, UM Clinical Trainer and Auditor, RN
Audit Period: July1, 2023, to September 30, 2023
Sample Size: 10% or 10 per month (whichever is greater)

Purpose: Quarterly audits of referrals that have been modified by the UM Department is done to monitor compliance with the Kern Health Systems' Policy and Procedure 3.22 Referral and Authorization Process, Section 4.2.2 Modifications

Policy and Procedures 3.22, Section 4.2.2 Modifications states – There may be occasions when recommendations are made to modify an authorization request in order to provide members with the most appropriate care. Recommendations to modify a request are first reviewed by the KHS Chief Medical Officer, or their designee(s).

The referrals that qualify for a modification are:

A. Change in place of service
B. Change of specialty
C. Change of provider or
D. Reduction of service

Under KHS's Knox Keene license and Health and Safety Code §1300.67.2.2 , KHS, as a plan operating in a service area that has a shortage of one or more types of providers is required to ensure timely access to covered health care services, including applicable time-elapsed standards, by referring enrollees to, or, ***in the case of a preferred provider network***, by assisting enrollees to locate, available and accessible contracted providers in neighboring service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the enrollee's health needs. KHS will arrange for the provision of specialty services from specialists outside the plan's contracted network if unavailable within the network, when medically necessary for the enrollee's condition.

KHS's Knox Keene license permits KHS to arrange for the provision of specialty services, which implies that the clause "if either the member or requesting provider disagrees, KHS does not require approval to authorize the modified services.

Month	July	August	September
Total Referrals Processed	22,544	26,396	24,474
Total Referrals Modified	458	515	457
Percent of Modifies	2%	2%	2%
Percent of Audit (10 percent or 10 referrals whichever is larger)	10%	10%	10%
Number of Referrals in Audit	46	50	46

Indicators:

9. Referral Turn-around Time
    - Decision completed within 3 business days for Urgent referrals and 5 business days for routine referrals
    - Provider and member notification within 24 hours of decision - Stamp dates on Referral and NOA letter, closed out within compliance.
10. Notice of Action Letter
    - Spelling/Grammar, Verbiage, and Format
    - 6th grade reading level
    - Medi-Cal Criteria applied
    - Approved provider information (name/phone)
11. Medical Director / Case Manager Name and Signatures
12. Processing of Referral

July's Findings: Out of the **46** Modified referrals reviewed, the following is a breakdown of the findings.

- Ten (10) referrals were found **without** errors from the above indicator.
- Five (5) errors were found within the Referral Turn-around Time indicator not completed in timely manner.
- Four (4) errors was found within the Processing of Referral incorrectly modified from cardio to vascular, member required cardio follow up for cardio issues. One cert found with selected modify in error not a true modification. One cert with incorrect MD noted on OP notification.
- Twenty (28) errors were found within the Notice of Action Letter – language above 6th grade level.
- Zero (0) error was found within the Medical Director / Case Manager Name and Signatures

August's Findings: Out of **50** the Modified referrals reviewed; the following is a breakdown of the findings.

- Twenty-one (21) referrals were found **without** errors from the above indicator.
- Zero (0) errors were found within the Referral Turn-around Time indicator-not mailed out in timely manner.
- Zero (0) error were found within the Processing of Referral indicator.

- One (1) error were found within the Notice of Action Letter- missing NOA language within the body of letter. Missing MD name in commentary of OP notification.
- Twenty-five (25) errors found with above 6th grade reading level.
- Zero (0) error was found within the Medical Director / Case Manager Name and Signatures

September's Findings: Out of the **46** Modified referrals reviewed, the following is a breakdown of the findings.

- Twenty-four (24) referrals were found **without** errors from the above indicators.
- Zero (0) errors were found within the Referral Turn-around Time indicator.
- Zero (0) errors were found within the Processing of Referral indicator.
- Twenty-five (25) errors was found within the Notice of Action Letter indicator- NOA language above 6th grade level.
- Zero (0) error was found within the Medical Director / Case Manager Name and Signatures- one with missing MD signatures on OP notification and one with missing Signatures on NOA

UM Trainer Action: Notice of Action/ Process of Referrals indicator errors have been discussed with individual staff as appropriate and refresher pieces of training have been provided as needed.

Corrective action plan to modify language NOA language for redirections and MD Audits in process to bring down reading to below 6th grade.

NAR/ Appeal Audit

Report Date: October 14, 2023
Audit Period: July 1, 2023, to September 30, 2023

I reviewed **NARs** processed by Donna, Gilrose and Prerna from 3rd Quarter 2023 and following are my findings:

Indicators:

- Spelling/Grammar, Verbiage, and Format
- 6th grade level readability
- Medi-Cal Criteria applied-
- Criteria indicated and attached.
- Recommendations indicated.
- Medical Director / Case Manager Name and Signatures

July's Finding: Out of the **10 NARs** reviewed, the following is a breakdown of the findings:

- **Spelling/Grammar, Verbiage, and Format** -One (1) error found with Missing NOA language on NAR template.
- **6th grade readability-** Ten (10) errors found with above 6th grade reading level.

- **Criteria indicated and attached**- No error found.
- **Recommendations indicated –** No error found.
- **Medical Director / Case Manager Name and Signatures-** No error found.
  Guidelines Applied:
  - One (1) referral with Medi -Cal guidelines were used.
  - Zero (0) referral with UTD guidelines was used.
  - Five (5) referrals with KHS policy and KHS specialty guidelines used.
  - Four (4) referrals with MCG guidelines used

August's Finding: Out of the **10 NARs** reviewed, the following is a breakdown of the findings:

- **Spelling/Grammar, Verbiage, and Format-** One (1) error found with Missing phone number in letter for vendor.
- **6th grade readability –** Four (4) errors found with above 6th reading level.
- **Criteria indicated and attached**- One (1) error found with incorrect Guidelines mentioned in letter. One (1) error found with missing MCG criteria review and not attached to authorization.
- **Recommendations indicated –** No error found.
- **Medical Director / Case Manager Name and Signatures-** No error found.
- **Guidelines Applied:**
  - One (1) referral with Medi -Cal guidelines were used.
  - Two (2) referrals with Up-to-Date guidelines were used.
  - Three (3) referrals with KHS policy and KHS specialty guidelines used.
  - Four (4) referrals with MCG guidelines used.

September's Finding: Out of the **10 NARs** reviewed, the following is a breakdown of the findings:

- **Spelling/Grammar, Verbiage, and Format-** No error found.
- **6th grade readability –** Three (3) errors found with above 6th grade reading level.
- **Criteria indicated and attached**- No error found.
- **Recommendations indicated –** No error found.
- **Medical Director / Case Manager Name and Signatures-** No issue found.
  Guidelines Applied:
  - Zero (0) referral with Medi -Cal guidelines were used.
  - One (1) referral with Up-to-Date guidelines were used.
  - Five (5) referrals with KHS policy and KHS specialty guidelines used.
  - Four (4) referrals with MCG guidelines used.

Action: The errors findings listed above has been discussed with the team.
Corrective Action Plan needed for this audit- 6th grade level NAR wording improved on overturn NAR's which language using HLA tool was provided to staff on July 25, 2023.

6th grade level NAR language for upheld decision– UM team/MD Implementation began on 8/27/23. This audit does not cover this implementation of corrective action plan for Upheld decision.

NOA Audit:

Audit Period: July 1, 2023, to September 30, 2023
I reviewed NOA processed from 3rd quarter 2023.
and following are my findings:

Indicators:

- Spelling/Grammar, Verbiage, Format
- 6th grade reading level
- Criteria indicated and attached.
- Recommendations indicated.
- Medical Director / Case Manager Name and Signatures

July Finding's: Out of the **10 NOAs** reviewed, the following is a breakdown of the findings:

- **Spelling/Grammar, Verbiage, Format** – No Error found.
- **6th grade reading level** -Two (2) error found with reading level above 6th grade level.
- **Criteria indicated and attached**- One (1) error found with missing mcg criteria attached. One (1) error found with missing expanded version of full mcg criteria.
- **Recommendations indicated –** No error found.
- **Medical Director / Case Manager Name and Signatures-** No errors found.

August Finding's: Out of the **10 NOAs** reviewed, the following is a breakdown of the findings:

- **Spelling/Grammar, Verbiage, Format** – One (1) error found with missing Spanish letter NOA language.
- **6th grade reading level** – One (1) error found with reading level above 6th grade level.
- **Criteria indicated and attached**- One (1) error found with missing up to date criteria.
- **Recommendations indicated –** No error found.
- **Medical Director / Case Manager Name and Signatures-** No error found.

September Finding's: Out of the **10 NOAs** reviewed, the following is a breakdown of the findings:

- **Spelling/Grammar, Verbiage, Format** -No error found.
- **6th grade reading level -** One (1) error found with reading level above 6th grade.
- **Criteria indicated and attached**- Four (4) errors found with missing partial criteria.
- **Recommendations indicated –** No error found.
- **Medical Director / Case Manager Name and Signatures-** No error found.

Action: The errors findings listed above has been discussed with the team and refresher pieces of training have been provided as needed.

Corrective action plans, audits conducted for 6th grade language.
NOA team have been sent emails to make necessary corrections.

CBCC OP Auto Approval Referral Audit:
Performed by: Kalpna Patel, RN, UM Clinical Auditor &Trainer

Audit Period: July 1, 2023, to September 30, 2023
Sample Size: 10 % referrals audited (10 Referrals)
Purpose: Quarterly audits of referrals that have been processed for gold card provider to ensure appropriate processes were used to review and approve the provision of medically necessary covered services and monitor compliance with the Kern Health Systems' Policy and Procedure 3.22 Referral and Authorization Process

Month	July to September 2023-3rd quarter
Total Referrals Approved	9
Percent of Audit	9 referrals
Number of Referrals in Audit	9 referrals

Indicators:

13. Processing of Referral
    - Medical Criteria or other criteria applied
    - Clinical documentation from Provider
    - Process of referral based on KHS Policy and Procedure 3.22

3rd Quarter Findings: Out of the 9 Approved referrals reviewed, the following is a breakdown of the findings.

- In summation **Seven (7)** referrals found approved **with** meeting medical necessity criteria and were appropriate and found to be medically necessary based on the review of clinical documentation submitted by the providers.
- In summation **Two (2)** referrals found approved **without** meeting medical necessity criteria.
    - One (1) 202307270000752 referral found with incorrect MCG guideline indictors used that did not include information from clinical notes and were not found to be medically necessary based on the review of clinical documentation submitted by providers. THERE WAS NO DOCUMENTATION OF HA IN NOTES - DOCUMENTED LUNG CA.
    - One (1) 202308310000347 referral with incorrect MCG guideline indictors used that did not include information from clinical notes and were not found to be medically necessary based on the review of clinical documentation submitted by providers. THERE WAS NO DOCUMENTATION OF COGNITIVE OR NEURO DEFIECT.

No corrective action plan needed.

Gold Card - OP Auto Approval Referral Audit
Performed by: Kalpna Patel, RN, UM Clinical Auditor &Trainer

Audit Period: July 1, 2023, to September 30, 2023
Sample Size: 10 % referrals audited (137 Referrals)

Purpose: Quarterly audits of referrals that have been processed for gold card provider to ensure appropriate processes were used to review and approve the provision of medically necessary covered services and monitor compliance with the Kern Health Systems' Policy and Procedure 3.22 Referral and Authorization Process

Month	April – June 2023- 2nd quarter
Total Referrals Approved	1,068
Percent of Audit	10%
Number of Referrals in Audit	107

Indicators:

14. Processing of Referral
    - Medi-Cal Criteria or other criteria applied.
    - Clinical documentation from Provider
    - Process of referral based on KHS Policy and Procedure 3.22

3rd Quarter Findings: Out of the 107 Approved referrals reviewed, the following is a breakdown of the findings.

- In summation **Fifty-nine (59)**) referrals found approved **with** meeting medical necessity criteria and were appropriate and found to be medically necessary based on the review of clinical documentation submitted by the providers.

- In summation **Forty-eight (48)** referrals found approved **without** meeting medical necessity criteria.
  - **Out of the Four-eight (48)** found below is the breakdown of each cert:
    - **Four (4) certs**- found with documentation submitted by requesting providers not meeting guidelines for medical necessity.
      - 202308220001142-Dr. Bui requesting CTA with self – the submitted documentation did not meet MCG guidelines, no documentation of Ankle-brachial index less than or equal to 0.9, or other noninvasive documentation of obstructive occlusive disease [Revascularization being considered (eg, surgery, angioplasty)

- 202309140001355- Dr. Capote requesting MRI Neck and orbit at Kern radiology – submitted documents did not meet MCG guidelines- incorrect MCG code was selected.
- 202309070001130- Dr. Honari requesting Home health services with around the clock, submitted documentation did not meet Mcal criteria- no documentation of why home health is being requested no skilled need, i.e., wound care, medications etc.
- 202308160000883- Dr. Najjar requesting MPI pharmacology stress test at Kern radiology, submitted documentation did not meet MCG guidelines- no documentation of Exercise treadmill testing alone is or would be unreliable and Need for pharmacologic testing,

❖ **Forty-four (44)** certs total – errors found with <u>no documentation submitted by requesting providers</u> to support request.

Out of Fifty -six (44)- Seven (7) certs submitted by PCP and other specialties.

- 202307060001046
- 202307140001230
- 202307170000954
- 202308030001148
- 202308140001142
- 202309220000892
- 202307200000483

❖ **Out of Fifty -six (44) Forty-seven (40) certs submitted by (Dr. Bui's Group- Dr. Bui, Dr. Capote, Dr. Honari, Dr. Nguyen)**

- 202307030000105
- 202307070000830
- 202307110001262
- 202307120000822
- 202307140001230
- 202307250000569
- 202308010001405
- 202308030001148
- 202308080000463
- 202308090001258
- 202308140001142
- 202309080000934
- 202309200000110
- 202307030000307
- 202307100000455
- 202307180000504
- 202307260000730

- 202307280000866
- 202308090000134
- 202308160001172
- 202308260000023
- 202309010000987
- 202309110000982
- 202307030000591
- 202307100000471
- 202307120001009
- 202307190000429
- 202307270000546
- 202308030001176
- 202308090000312
- 202308140000752
- 202308210000654
- 202308300001362
- 202309180000144
- 202309220000829
- 202307070000874
- 202308030000857
- 202308140001130
- 202308250000238
- 202309120001300

Corrective Action Plan: Provider education required for notes submission to meet medical necessity guidelines.

OP Auto Approval Referral Audit

Performed by: Kalpna Patel, RN, UM Clinical Auditor &Trainer
Audit Period: July 1,2023 to September 30, 2023
Sample Size: 30 Referrals
Purpose: Quarterly audits of referrals that have been processed for auto-approval by the UM Staff and Online to ensure appropriate processes were used to review and approve the provision of medically necessary covered services and monitor compliance with the Kern Health Systems' Policy and Procedure 3.22 Referral and Authorization Process

Month	July – September 2023- 3rd quarter
Total Referrals Approved	39,153
Percent of Audit	>1%
Number of Referrals in Audit	30

Indicators:

15. Processing of Referral
    - Medi-Cal Criteria or other criteria applied.

- Clinical documentation from Provider
- Process of referral based on KHS Policy and Procedure 3.22

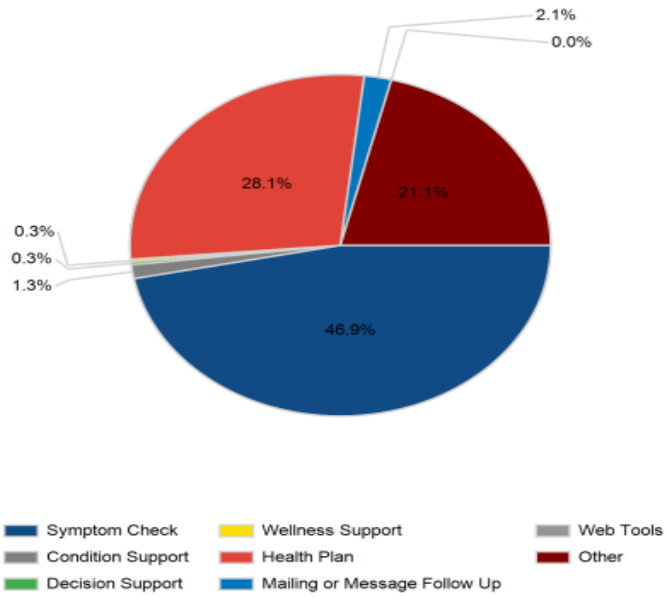
3rd Quarter Findings: Out of the 30 Approved referrals reviewed, the following is a breakdown of the findings.

- In summation **Twenty-eight (28**) referrals found approved **with** meeting medical necessity criteria and were appropriate and found to be medically necessary based on the review of clinical documentation submitted by the providers.
- In summation **Two (2)** referrals found approved **without** meeting medical necessity criteria.
  - Out of the Two (2) found below is the breakdown of each cert:
    - One cert number 202308120000098- Online approval- PCP, Juan Corona requesting MRI Hip. The request did not meet MCG guidelines for medical necessity. Documentation from provider did not include x-rays, Bone scan, pain duration on physical exam.
    - One cert number 202307250000708- PCP, Alessandro Testori requesting for neurology evaluation. Documentation submitted did not indicate the reason why neurology was being requested.

Corrective action plan: Provider education required.

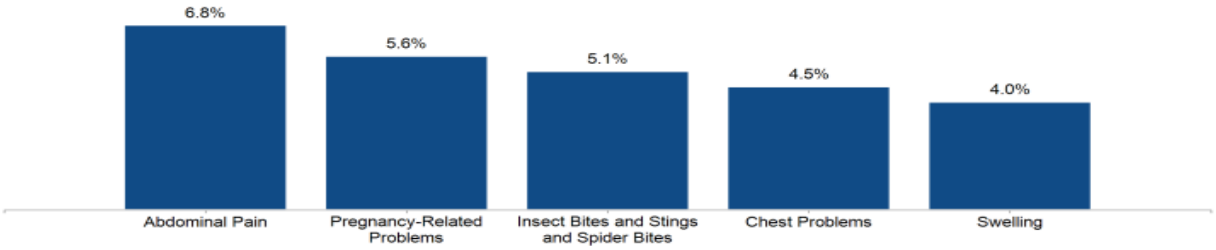
Health Dialog Report

Member Inbound Call Reasons (Jul-2023)

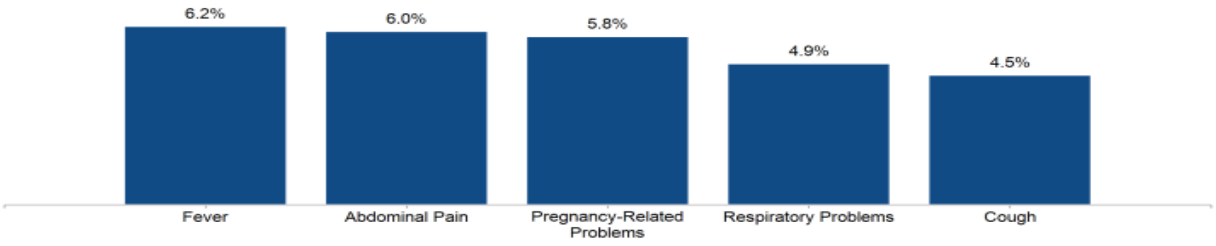


REASON	NUMBER
Symptom Check	180
Condition Support	5
Decision Support	1
Wellness Support	1
Health Plan	108
Mailing or Message Follow Up	8
Web Tools	0
Other	81

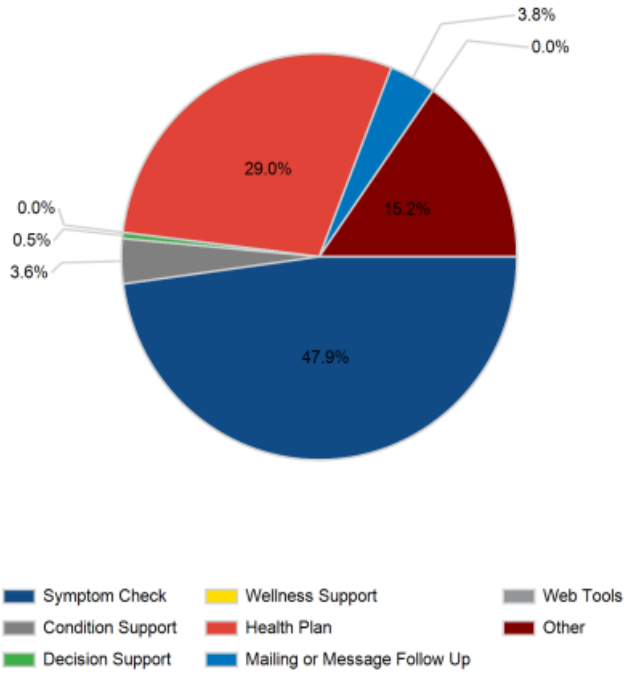
Most Frequent Symptoms - Inbound Symptom Check Calls (Jul-2023)



Most Frequent Symptoms - Inbound Symptom Check Calls (Rolling Twelve Months)

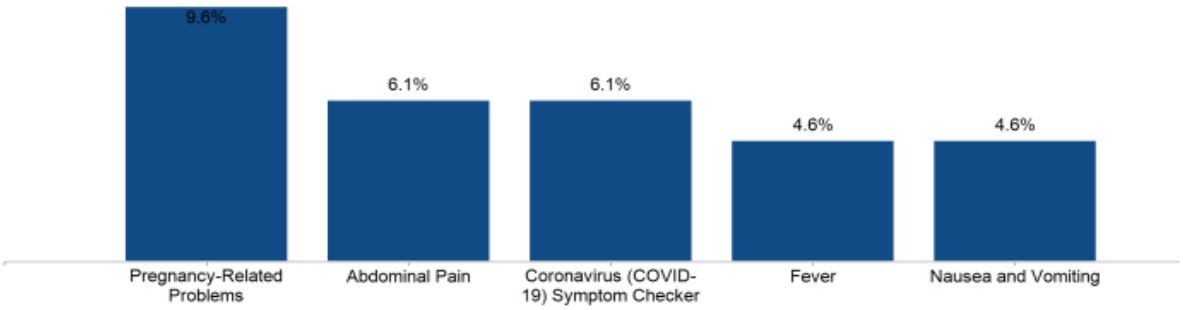


Member Inbound Call Reasons (Aug-2023)

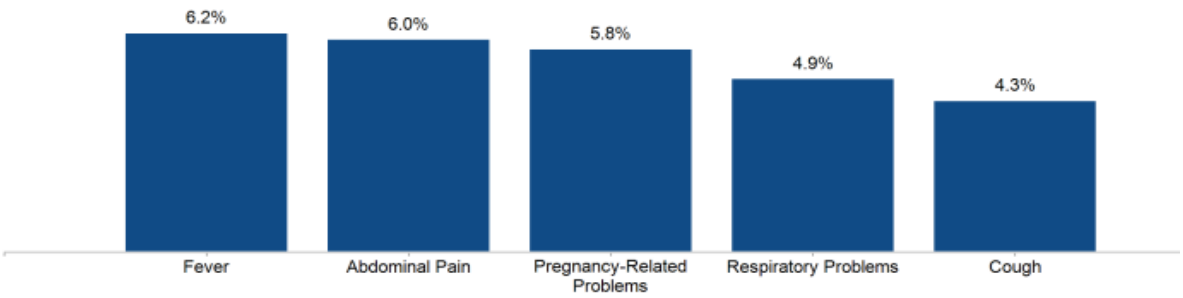


REASON	NUMBER
Symptom Check	201
Condition Support	15
Decision Support	2
Wellness Support	0
Health Plan	122
Mailing or Message Follow Up	16
Web Tools	0
Other	64

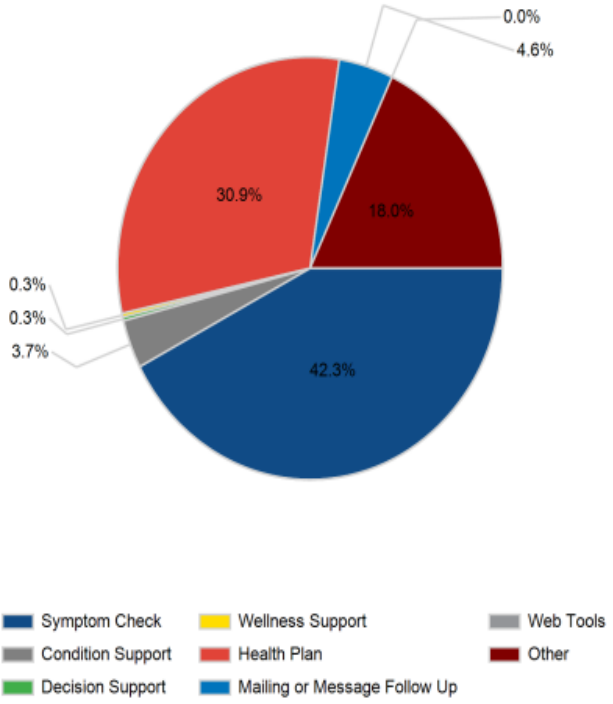
Most Frequent Symptoms - Inbound Symptom Check Calls (Aug-2023)



Most Frequent Symptoms - Inbound Symptom Check Calls (Rolling Twelve Months)

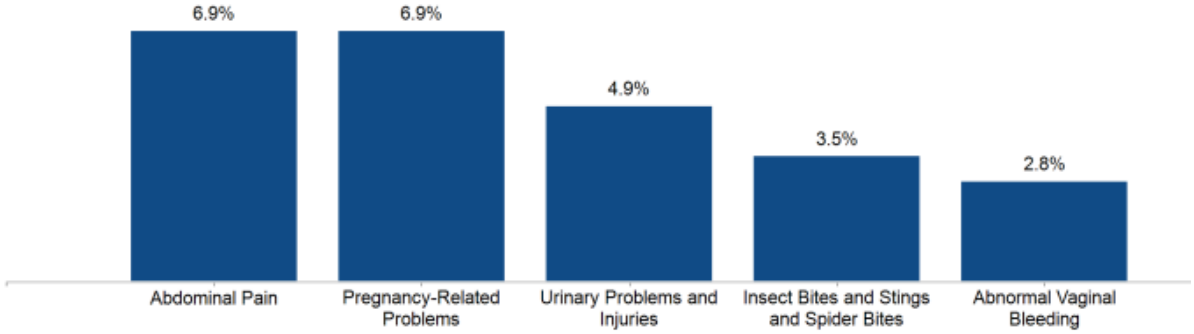


Member Inbound Call Reasons (Sep-2023)

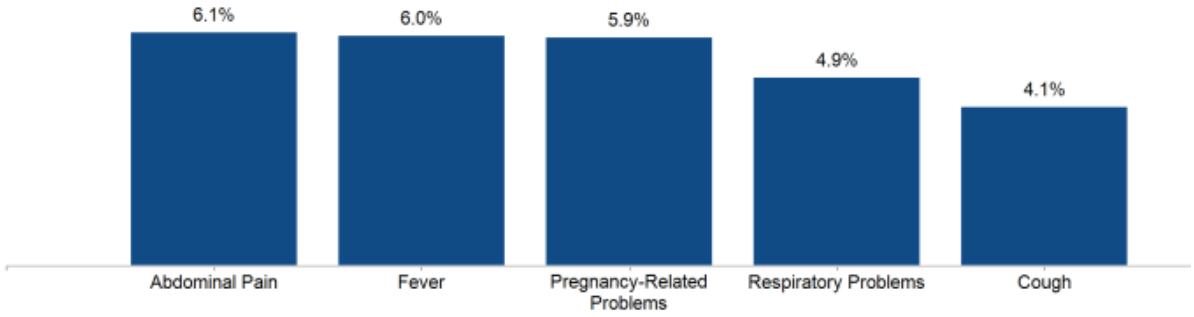


REASON	NUMBER
Symptom Check	148
Condition Support	13
Decision Support	1
Wellness Support	1
Health Plan	108
Mailing or Message Follow Up	16
Web Tools	0
Other	63

Most Frequent Symptoms - Inbound Symptom Check Calls (Sep-2023)



Most Frequent Symptoms - Inbound Symptom Check Calls (Rolling Twelve Months)



vsp vision care

Diabetic Exam Reminder Effectiveness Report

Client: KERN HEALTH SYSTEMS - 12049397

Reminder Year:	Reminder Month:	Reminders Sent	Received Exam Within 0-90 Days	Received Exam Within 91-180 Days	Total Exams Within 180 Days
2022	November	3,264	118	95	213
	December	290	12	10	22
2023	January	2,362	97	81	178
	February	362	19	16	35
	March	1,120	49	28	77
	April	1,262	41	38	79
	May	697	33	19	52
	June	7,326	201	76	277
	July	6,038	166	20	186
	August	589	22	0	22
	September	1,423	26	0	26
	October	1,228	5	0	5
Totals		**25,961**	**789**	**383**	**1,172**

LTM Effectiveness* : 5 %

12-Month Effectiveness (May 2022 - Apr 2023) : 6 %

* This figure does not include an estimate of those patients who will return within 90 or 180 days.
It solely calculates based upon the patients who have returned to date for letters sent within the last twelve months.

Medical Data Collection Summary Report
KERN HEALTH SYSTEMS - 12049397
November, 2022 through October, 2023

vsp vision care

Overview
This report shows an aggregate view of your members who have received an eye exam during the reporting period. It also shows the number and percentage of your members that have one or more of the health conditions listed below, as reported by VSP doctors. VSP focuses on the six conditions listed below because they represent some of the most frequent and costly health conditions for which early detection and treatment can reduce or prevent vision loss as well as potentially avoid more costly treatment. VSP can work with your health plan or disease management company by providing them with patient-specific information upon request.

Summary of Findings
The left section below shows how many of your members received an eye exam during the reporting period as well as how many of them had each of the conditions listed (as reported by VSP doctors). The percentages represent the number of people with the respective conditions divided by the total number that received an eye exam. The right section below shows the estimated number of cases in your member population. We use health and demographic statistics provided by the Centers for Disease Control and the US Census. Also, because prevalence rates vary by age, we incorporate patient age data from your VSP eye exam claims for the reporting period.

The estimates for diabetes and hypertension are expected to be higher than the reported rates because approximately 30% of people with diabetes and 50% of people with hypertension are unaware of their condition and would not report it to their VSP doctor. The percentages represent the estimated number of people with the conditions divided by your total membership. Note that diabetes and hypertension are self-reported while the other conditions are reported based on the VSP doctor's findings. This report does not indicate if cases are newly diagnosed or existing.

Reported Cases

	Members	
Received Eye Exam:	25,230	
Diabetes[1]:	1,667	6.6%
Diabetic Retinopathy:	196	.8%
Glaucoma:	626	2.5%
Hypertension:	683	2.7%
High Cholesterol	314	1.2%
Macular Degeneration:	116	.5%

Estimated Number of Cases

Total Members:	346,880	
Diabetes[1]:	10,554	3.0%
Diabetic Retinopathy:	1,024	.3%
Glaucoma:	1,784	.5%
Hypertension:	44,181	12.7%
High Cholesterol	54,883	15.8%
Macular Degeneration:	692	.2%

[1] Patients managing their diabetes can avoid medical costs from $2,000 to over $4,000 annually versus those not managing it.

Kern Health Systems

Department: Utilization Management

Subject: Peer-to-Peer Requests

A peer-to-peer review is a scheduled conversation during which an ordering, treating Practitioner and the Medical Director discuss criteria used to make a coverage determination. The process is utilized to obtain a prior authorization approval or reverse a previously denied prior authorization request.

The following practitioners may request a peer-to-peer review up to 2 business days from the date of the decision notification:

- A Physician, Podiatrist, Dentist, Nurse Practitioner, Midwife, or Physician's Assistant who is managing the member's care and ordering the item or service.
- A Facility's CMO or Medical Director.

Peer to Peer discussion may be considered when all of the following apply:

- A requested authorization has been denied as not medically necessary or not meeting applicable medical criteria,
- The service has not yet been performed,
- A formal member appeal has not yet been filed,
- The peer-to peer review request occurs within 2 business days from date of determination notification,
- The Practitioner has new clinical information or evidenced-based clinical guidelines to reasonably support the medical necessity for the service requested,
- The information is provided at time of peer-to-peer request.

If the above conditions are met, the Practitioner will be asked to provide the following:

- Member name, date of birth, and KHS Member ID if available,
- Authorization number associated with the request,
- Direct contact number for the Practitioner.

If the request does not meet the peer-to-peer process guidelines, the Practitioner will be advised of the Appeal or Dispute process.

The KHS Chief Medical Officer or designated Medical Director will return the Practitioner's call within 2 business days.

If after the discussion the original decision is overturned, the authorization will be updated based on the new information and sent to the Practitioner and member within 1 business day from the time the new decision was made.

If the decision is unchanged, the Practitioner will be informed of the Appeal process as outlined in the notice of action letter.

Kern Health Systems
Criteria

Department: Utilization Management

Subject: Specialty Care Referral Guideline

Specialty referral is indicated when:

- The treatment or diagnosis is outside the scope of practice of the Primary Care Practitioner.
- The Primary Care Practitioner is unable to make a diagnosis despite appropriate work-up of symptoms.
- The member is not responding to the current treatment plan.
- The requested Specialist is appropriate to manage the symptom/complex diagnosis/ treatment plan, etc.
- The requested Specialist is able to manage the age of member.
- The Specialist request is substantiated by received suppportive documentation.
- Tertiary care speciality referrals are appropriate when treatment is not available from a local participating provider.

****Specialty referrals to tertiary care or to an out of area/network provider requires Medical Director Review****

UTILIZATION MANAGEMENT

2023 PROGRAM DESCRIPTION

Introduction

Kern Health Systems (KHS), d.b.a. Kern Family Health Care (KFHC), is the Local Initiative for the arrangement of medical, social, and behavioral health care for Medi-Cal enrollees in Kern County. KHS is a public agency formed under Section 14087.38 of the California Welfare and Institutions Code. KHS began full operations on September 1, 1996, under the Kern County Board of Supervisors. KHS currently serves more than 330,000 Medi-Cal participants in Kern County. KHS aligns with the California Advancing and Innovating Medi-Cal Initiative by embracing CalAIM's three primary goals:

Identify and manage member risk and need through Whole Person Care Approaches and addressing Social Determinants of Health,

Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility, and

Improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems and payment reform.

KHS strives to be a leader in developing innovative partnerships with the safety net and community providers to support and elevate the health status of KHS members served.

Purpose

The KHS Utilization Management Program (UMP) serves to implement a comprehensive integrated process that actively evaluates and manages utilization of health care resources delivered to all members, and to actively pursue identified opportunities for improvement.

The UMP is intended to outline the methods utilized by KHS to provide a supportive system of care arrangements and services in a standardized, simplified, and focused process to efficiently provide members with comprehensive Whole Person Approaches within available resources and achieve an optimum level of quality health care that is cost-effective.

The UMP is a formal Document supported by clinical, operational, and administrative policies and procedures (P&Ps) delineating how UM functions are performed. The UMP and P&Ps are written to adhere to federal and state regulatory requirements to include CA Health & Safety Code, Title 22, Welfare & Institutions Code, CMS Code of Federal Regulations, the CA Department of Health Care Services 22-20202 KHS Contractual Provisions, and current NCQA Standards and Guidelines. The UM documents are developed through the involvement of actively involved KHS providers in accordance with H&S Code sections 1363.5 and 1367.01 and 28 CCR sections 1300.70(b)(2)(H) and (c).

The UM Program and Policies &Procedures go through a formal process of UM Committee review approval and are reported up to the Quality Improvement Committee and the KHS Board of Directors for final review and approval. In turn the UMP and P&Ps are disbursed and or made available to KHS providers and members through various channels of accessibility.

All activities described in the UM Program are conducted with oversight by the Quality Improvement Committee.

The UMP is housed within the KHS Health Services Department and is supported through the coordination between various internal departments to include:

- Population Health Management,
- Pharmacy,
- Enhanced Care Management,
- Health Education,
- Care Coordination,
- LTSS Department
- Quality Improvement

The success of the UM Program begins with positive patient-practitioner relationships and depends, not on the portioning of services, but on the management and delivery of medically necessary, cost-effective health care designed to achieve optimal health status.

UMP Objectives

KHS develops, implements, and updates as needed (at least annually), the utilization management (UM) program to ensure appropriate processes are used to review and approve the provision of medically necessary covered services for KHS Members. This process incorporates provider, practitioner, and member input along with any regulatory and industry changes to maintain current standards of care and technological advances.

An annual evaluation of the UM Program is prepared and includes a description of the accomplishments of the Plan, work plan, program evaluations, policies, and procedures. It shall also include reporting on the Plan's operation using statistical data and other information regarding the care delivered to members and any suggested revisions. The UM WP & Evaluation will be submitted to the QIC who is responsible for approving the updated UM program.

The UMP is intended to provide a reliable mechanism to review, monitor, evaluate, recommend, and implement actions on identification and correction of potential and actual utilization and resource allocation issues.

The UMP and the UM Department are adequately supported by a designated medical director with sufficient knowledge of managed care and UM process requirements to serves as a departmental resource and oversee that the review process is conducted in accordance with H&S Code section 1367.01.

KHS UMP prohibits medical decisions to be influenced by fiscal and administrative management. Compensation of individuals or entities that conduct UM activities must not be structured to provide incentives to deny, limit, or discontinue medically necessary services.

The KHS UMP will define the methods by which utilization criteria and clinical practice guidelines are selected, developed, reviewed, and modified based upon appropriate and current standards of practice and professional review.

KHS will make available to network providers and members all relevant UM policies and procedures upon request: and, make available to members clinical criteria used by KHS and as applicable subcontractors, and downstream subcontractors, for assessing medical necessity for covered services.

The UMP and processes are developed and carried out to ensure that policies, processes, strategies, evidentiary standards, and other factors used for UM or utilization review are consistently applied to medical, surgical, mental health, and substance use disorder services and benefits.

Through the UMP the monitoring of UM data is performed to detect potential under and over-utilization. Data are monitored across practices and provider sites of PCPs and specialists. Appropriate interventions are implemented whenever under- or over-utilization is identified. Interventions are measured to determine their effectiveness, and further strategies may be implemented to achieve appropriate utilization.

When UM processes are delegated under the UMP KHS will evaluates the ability of the delegates to perform UM activities and monitor performance continuously to ensure delegate compliance and adherence in alignment with the KHS UMP and policies and procedures.

The KHS UMP promotes and ensures the integration of utilization management with quality monitoring and improvement, risk management, credentialing, and population health management activities.

The UMP accommodates member access to Standing Referrals as outlined in H&S Code section, 1374.16.

The UMP accommodates member access to Second Opinions in accordance with 42 CFR section 438.206.

The UMP supports a process of thorough and timely investigations and responses to member and provider reconsideration and appeals associated with utilization issues.

There are mechanisms to evaluate the effects of the UM program and process using member and provider satisfaction data, staff interviews and/or other appropriate methods. Identified sources of dissatisfaction are addressed. When opportunities for improvement are identified, the UMC makes appropriate interventions to change the process.

Statements and Protections

Non-Discrimination Statement

KHS complies with applicable Federal Civil Rights Laws and does not discriminate, exclude people, or treat them differently on the discriminating based on race, color, national origin, religion, ancestry, ethnic group identification, sex, gender identity (including gender expression), sexual orientation, mental disability, medical disability, age, marital status, family/parental status, or income.

KHS will not deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for any health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that an individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily are exclusively available.

In accordance with the Americans with Disabilities Act, KHS will ensure that deliverables developed and produced shall comply with the accessibility requirements of Section 508 of the Rehabilitation Act and the Americans with Disabilities Act of 1973 as amended (29 U.S.C. § 794 (d), and regulations implementing that act as set forth in Part 1194 of Title 36 of the Federal Code of Regulations. In 1998, Congress amended the Rehabilitation Act of 1973 to require Federal agencies to make their electronic and information technology (EIT) accessible to people with disabilities. California Government Code section 11135 codifies section 508 of the Act requiring accessibility of electronic and information technology.

> KHS will provide persons with disabilities who require alternative means of communication for program information to the appropriate alternate format to support their communication needs (e.g., Braille, large print, audiotape, American Sign Language, etc.)

KHS provides free language services to people whose primary language is not English or those with limited English proficiency (LEP). These services include the following:

- Qualified sign language interpreters,
- Information written in other languages,
- Use of California Relay Services for hearing impaired.

Confidentiality Statement

KHS has established and distributed confidentiality standards to contracting providers in the KHS Provider Policy and Procedure Manual. All provider contracts include the provision to safeguard the confidentiality of member medical and behavioral health care records, treatment records, and access to sensitive services in accordance with applicable state and federal laws. As a condition of participation with KHS, all contracting providers must retain signed confidentiality forms for all staff and committee members and provide education regarding policies and procedures for maintaining the confidentiality of members to their practitioners. KHS monitors contracting providers for compliance with KHS confidentiality

standards during provider facility and medical records reviews and through the Grievance Process.

Confidentiality of provider and member information is ensured at all times in the performance of UM activities through enforcement of the following:

- Members of the UM QI and PAC Committees are required to sign a confidentiality statement that will be maintained in the QI files.
- UM documents are restricted solely to authorized Health Services Department staff, members of the UM, QI, and PAC Committees (PAC performs credentialing conducts Peer Review, Complaints and Grievance, and PQI reviews), and reporting bodies as specifically authorized.
- Confidential documents may include, but are not limited to: UM, QI, and PAC Committees meeting minutes and agendas, QI and Peer Review reports and findings, UM reports, or any correspondence or memos relating to confidential issues where the name of a provider or member are included.
- Confidential documents are stored in locked file cabinets with access limited to authorized persons only, or they are electronically archived and stored on protected drives.
- The confidentiality agreements are maintained in the practitioner or employee files, as appropriate. All peer review records, proceedings, reports and member records are maintained in a confidential manner in accordance with state and federal confidentiality laws.

Health Insurance Portability and Accountability Act (HIPAA)

KHS complies with all applicable HIPAA requirements supported by HIPAA compliance policies. All HIPAA related policies are accessible to UM Physicians and staff on the Kaiser Permanente Intranet compliance site. Ongoing mandatory education is required annually for all staff.

Conflict of Interest Statements

Any individual who has been personally involved in the care and/or service provided to a patient, an event or finding undergoing quality evaluation may not vote or render a decision regarding the appropriateness of such care. All members of the UM, QI, and PAC are required to review and sign a conflict-of-interest statement, agreeing to abide by its terms.

SCOPE of Care Services

The KHS UMP incorporates the monitoring and evaluation for prior authorization, concurrent review, retrospective review, exceptions to prior authorization services and reviews and updates policies and procedures as appropriate at least annually for the following.

- Acute hospital services,
- Subacute services,
- Long-term care including Skilled Nursing Facility (SNF) Care and Rehabilitation Facility services,
- Ambulatory Services,
- Rehabilitative services,
- Emergency and urgent care services,
- Durable Medical Equipment and supplies,
- Ancillary care services, including but not limited to home health care, skilled nursing care,
- Transportation services,
- Selected pharmaceutical services - physician administered drugs (medical drug benefit),
- Laboratory and radiology services,
- Transportation services-Medical and Non-Medical,
- Non-Specialty Mental Health and Substance Use Disorder Services as applicable to KHS contracted scope of coverage in accordance with DHCS KHS 22-20201 Contract Exhibit A. Attachment III,
- Out of Network Care.

Exceptions to the requirement of prior authorization include but are not limited to:

- Primary Care Provider Services,
- Specific OB/GYN services, including midwifes and free-standing birth center facility,
- Abortion Services,
- Dialysis,
- Hospice Care,
- Sexually Transmitted Disease treatments,
- HIV Services,
- Family Planning Services,
- Mental Health evaluations,
- Maternity Care,
- Vision,
- Sensitive Services, both child and adult
- Emergent/Urgent Care, and,
- Other procedures as identified.

Authority and Responsibility

KHS Board of Directors

The Kern Health Systems, the County Health Authority, is an independent public agency that governs Kern Family Health Care. The Board of Directors are appointed by the Kern County Board of Supervisors and includes major healthcare stakeholders, such as physicians, safety-net providers, hospitals, pharmacies, and community representatives. Board meetings are held bi-monthly in: February, April, June, August, October, and December**,** and are open to the public. The Board of Directors (BOD) for KHS assigns the responsibility to lead, direct, and monitor the activities of the UM Program to the KHS Quality Improvement and Utilization Management Committees.

The Board is directly involved with the UM process in the following ways:

- Delegates responsibility for the day-to-day activities and execution of the UMP to the Keren Health System Chief Medical Officer (CMO),
- Approves and supports the UM Program direction, evaluate effectiveness, and resource allocation,
- Appoints individual and/or departments within the KHS organization to provide oversight of the UM Program,
- Evaluate and approve the UM Program Description and UM Program Evaluation annually, providing recommendations as appropriate and track findings.
- Approve the UM policies and procedures needed to maintain the UM Program,
- Receive reports representing UMP activity outcomes, actions taken, and improvements made by the UMC, at a minimum on a quarterly basis.

Program Structure

The UM Program is comprised of various systems and processes which interface with other departments and administrative systems in the delivery of quality and value enhanced care. The link between UM and other clinical and administrative systems must be collaborative to deliver quality care and effective resource management.

The utilization management team of physicians, licensed staff, and unlicensed staff are trained and qualified to assess the clinical information which is used to make utilization management decisions and provide the service within their respective scope of practice. Appropriately licensed health professionals supervise all review decisions.

- KHS utilizes licensed health care professionals to supervise UM activities to:

    a. Provide day to day supervision of assigned UM staff. UM staff who are not qualified health care professionals may approve services when they meet explicit UM auto authorization guidelines under the supervision of a licensed professional.
    b. Participate in staff training.

c. Monitor for consistent application of UM criteria by UM staff for each level of UM decision.
d. Monitor documentation for adequacy of relevant clinical information to support non-behavioral, behavioral and /or pharmacy UM decision making.
e. Be available to UM staff on site or by telephone.

- A non-licensed staff may:

a. Review an authorization request against the UM auto approval matrix where no clinical judgment is warranted. If clinical review is warranted, it is routed to the nurse reviewer and to a physician reviewer when further review is needed.

This section outlines the individual program staff and their assigned activities, including approval authority and the involvement of designated physicians.

Chief Medical Officer (CMO)

The Chief Medical Officer is assigned by the KHS BOD to provide oversight of the UMP and UM Department undertakings. He/she holds an unrestricted license to practice medicine in the State of California issued pursuant to Section 2050 of the Business and Professions Code or pursuant to the Osteopathic Act. The CMO is responsible for ensuring that the process by which KHS reviews and approves, modifies, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to KHS members, complies with the requirements of H&S Code 1367.01. The CMO must have the ability to effectively function as a member of the UM team and serves a resource to the UM staff for clinical matters. The CMO is responsible to the Board of Directors to provide medical direction for KHS, including professional input and oversight of all medical activities of the UM Program. The CMO is the UM Committee Chair and or at his or her discretion assigns the UM Chair position to a qualified physician.

The CMO aids with study development and coordination of the UM Program in all areas to provide continued delivery of quality health care for members. The CMO assists the Chief Network Administration Officer with provider network development and works with the CFO to ensure that financial considerations do not influence the quality of health care administered to members. Other responsibilities include but are not limited to:

- Provide direction for all medical aspects of KHS, preparation, implementation and oversight of the UM Program, medical services management, resolution of medical disputes and grievances,
- Principal accountabilities include development and implementation of medical policy for utilization functions, reviewing current medical practices so that that medical protocols and medical personnel of KHS follow rules of conduct, review of UM cases, participation in the UM committee,
- Ensures timely medical necessity review and decisions are made by daily staffing physicians for medical review consultation,
- Evaluates the overall effectiveness of the UM program,

- Evaluates and uses provider and member experience data when evaluating the UM program,
- Ensures that medical decisions are rendered by qualified medical personnel,
- Ensures UM decision making is not influenced by fiscal or administrative management considerations,
- Ensures that the medical care provided meets the current standards for acceptable care,
- Ensure that medical protocols and rules of conduct for practitioner or plan medical personnel are followed.

Medical Director

The Medical Director will provide clinical leadership and guidance in the development and measurement of UM performance improvements and patient satisfaction, and safety and serves as a resource to the UM Department in the day-to-day operations. As determined by the CMO, the Medical Director assists in short-and long-range program planning, total quality management (quality improvement) and external relationships, as well as develops and implements systems and procedures for the medical components of health plan UM and care coordination services.

In collaboration with the Chief Medical Officer and others, the Medical Director creates and implements health plan medical policies and protocols. The Medical Director monitors provider network performance and reports all issues of clinical quality management to the CMO and UM and QI Committees. Additionally, he or she represents the health plan on various committees to include credentialing and re-credentialing of network providers. The Medical Director provides medical oversight into the medical appropriateness and necessity of healthcare services provided to Plan members and is responsible for meeting medical cost and utilization performance targets. Responsibilities include, but are not limited to:

- Participates in carrying out the organization's mission, goals, objectives, and continuous quality improvement of KHS,
- Develops and implements medical policy,
- Resolve grievances related to medical quality of care and service,
- Participates and provide direction in the administration of the QI, UM, and Credentialing Programs by attending committee meetings,
- Detects and corrects inadequate practitioners/provider organizations performance within responsibility level,
- Participates in the development and selection of medical necessity criteria sets used for UM processes,
- Responsible for monitoring and controlling the appropriate utilization of health care services to achieve high quality outcomes in the most cost-effective manner,
- Directly communicates with primary care physicians and other referring physicians to resolve referral issues, research treatment protocols, solicit advice on problem cases, and to assist in development of referral criteria and practice guidelines, and
- Supports, communicates, and collaborates with KHS UM Department staff to ensure efficient UM processes and decision-making practices are compliant,
- Support case managers to resolve case management and referral issues,

- Supports the CMO with projects as assigned.

Chief Health Services Officer (CHSO)

Under direction of the Chief Medical Officer (CMO) this position is responsible for overseeing the activities of the Health Services Departments in support of the company's strategic plan through establishing the strategic vision, and the attendant policies and procedures, initiatives, and functions. The Health Services Department includes Utilization Management, Case and Disease Management, Health Education, and Quality Improvement.

The Chief Health Services Officer provides direct clinical support to the Directors of the Health Services Department for both operational and strategic management. The position is responsible for overseeing the development of quality improvement strategies for the enterprise and clinical programs through the development for population-based clinical quality measures. In addition, the position is responsible for directing the development of the integration of quality into the UM business processes to ensure that all activities are relevant and meeting UM standards.

- Assures compliance with UM work plans, and when necessary, assures compliance with NCQA standards,
- Provides oversight to assure accurate and complete quantitative analysis of clinical data and presentation of results of data analysis pertaining to UM Metrics for KHS applicable committees,
- Tracks Health Services Program performance and results,
- Works with both internal and external customers to promote understanding of health services activities and objectives and to prioritize projects according to corporate goals, monitoring of case management activity and accuracy of decision making is reported to the executive team,
- Ongoing development and monitoring of activities related to identification and tracking of members needing disease management, case management, behavioral health, or autism services, tracking of inpatient members including authorizations of level of care, appropriateness of admissions to non-par facilities and timely transfer to participating facilities are critical to the effectiveness of the UM program,
- Oversees designated activities of department and aids the CMO and appropriate corporate staff in formulating and administering organizational and departmental initiatives,
- Administer and ensure compliance with the National Committee on Quality Assurance (NCQA) standards as determined for accreditation of the health plan,
- Ensures adherence to all contract and regulatory requirements pertaining to UM.

Director of Utilization Management

Under the direction of the Chief Health Services Officer, the Director of Utilization Management will oversee and participate in activities related to Utilization Management (UM) for the organization and membership by monitoring, assessing, and improving performance in ambulatory and inpatient health care delivery or health care related services. The UM Director will assist in the implementation of the KHS Utilization Management Program Plan and

Evaluation and communicate with contract providers regarding required studies and participation. Related duties will include ongoing data collection, medical record reviews, report writing, and collaboration and coordination with other KHS departments, as well as outside agencies.

This position is responsible for collaborative oversight of the Utilization Management functions for KHS. The UM Director will also be responsible for overseeing the production, analysis, and dissemination of contractually mandated reports. This position will assist in ensuring compliance with Medi-Cal contractual stipulations for UM programs. In collaboration with the Chief Health Services Officer, will make an effective contribution to KHS's business planning and fiscal processes and will remain clear about departmental objectives and resource requirements. Responsibilities include, but are not limited to:

- Maintains delegated responsibility in coordination with the Chief Health Services Officer for activities within the Utilization Management departments,
- Shares in direction and supervision for ongoing and new projects for the UM program with the Chief Health Services Officer,
- Oversees quality of care investigations and reporting,
- Works closely with the Director of Case Management to facilitate needs for members identified as High Risk or requiring coordination of services,
- Ensure coordination of medically necessary services within the plan and with community,
- Coordinates UM activities and data collection between KHS departments and KHS contracted providers,
- Serves as resource to the Quality Improvement and Utilization Management Committee, the Physician Advisory Committee, and other committees, as appropriate,
- Works in a coordinated effort with the UM Health Services Manager and Health Services Program Administrator to ensure the smooth and efficient operations of the outpatient processes,
- Serves as a clinical liaison with contracted facilities and providers and participates in Joint Operations meetings to improve patient care and ensure access standards; Coordinates and conducts in-depth chart analysis, data collection, and report preparation,
- Summarizes information collected for identification of patterns, trends, and individual cases requiring intensive review,
- In coordination with the UM Auditor, performs periodic audits of the Clinical Intake Coordinators and Social Workers of outpatient clinical decisions for appropriateness and accuracy of documentation and summarize and report the results of the audit; and
- Implements and facilitate internal audit studies and work groups for continuous improvement within the organization.

<u>UM Clinical Manager</u>

Under direction of the Director of Utilization Management, this position manages, leads, acts as a subject matter expert, and provides guidance on unit functions and departmental

operations, including regarding clinical health outcomes related to population health management, clinical data management and retrieval, reporting standards and State policy and procedure implementation. Develops implements and evaluates clinical programs related to Health Services initiatives. Manages, supervises, mentors and trains assigned staff. Responsibilities include, but are not limited to:

- Direct activities of the Utilization Management staff,
- Oversee staff performance regarding prior authorization, medical necessity determinations, concurrent review, retrospective review, continuity of care, care coordination, and other clinical and medical management programs. These responsibilities extend to behavioral health care services,
- Ensure effective daily operation of the Utilization Management Department utilizing all applicable statutory provisions, contracts and established policies and administrative procedures,
- Maintain optimal staffing patterns based on contractual obligations and current Utilization Management budget,
- Prepare reports and conduct analysis of operations / services as required by departmental, corporate, regulatory, and State requirements,
- Work collaboratively with QI and Pharmacy Departments on identifying required data for reporting,
- Assist in preparation, coordination, and follow up of Utilization Management audits, such as readiness review and DHCS site visits, pertaining to the Utilization Management Department,
- Partner with community agencies and contracted vendors to develop and maintain collaborative contact to assure members have access to the appropriate resources and to avoid duplication of efforts,
- Act as a liaison with outside entities, including but not limited to physicians, hospitals, health care vendors, social services agencies, member advocates, county, and other care entities,
- Participate in coordination of internal and external Provider and Member directed communication regarding issues impacting Utilization Management coordination and delivery, such as medication management, use of generic medications, etc.,
- Establish action plan for assessment and resolution of identified issues,
- Oversee the collaborative efforts of the Supervisors to ensure that all new and existing staff are oriented to organizational and department policies and procedures,
- Ensure that credentials of all licensed staff are verified in accordance with licensing agency initially and prior to expiration date. Maintain current and accurate files of such licensure and ongoing education status,
- Ensure that staff meets minimal skill and clinical knowledge requirements to be successful in assigned role,
- Participate in current process review and development of new and / or revised work processes, policies and procedures relating to Utilization Management responsibilities,
- Provide input into the development of educational material and programs necessary to meet business objectives, members' needs, contractual and regulatory guidelines, and staff professional development,

- Comply with Corporate, Federal, and State confidentiality standards to ensure the appropriate protection of member identifiable health information.

Health Services Manager

The Health Services Manager reports to the Chief Health Services Officer and is responsible for the daily management, evaluation, and operations of the health services administrative processes, provide supervisory support to Utilization Management (UM) staff and assist with defining and creation of reports in collaboration with the UM Senior Auditor/Analyst, UM Senior Analyst/Trainer, and Senior Health Services Program Administrator.

This position will work with the administrative support staff to promote the delivery of quality health care to Kern Health System (KHS) members through comprehensive case management, compliance with KHS policies and procedures, and maintenance of a positive and safe work environment leading to maximum departmental efficiency, accuracy, and quality. Responsibilities include but are not limited to:

- Supervise the functions and activities of the clerical support staff,
- Monitors and reports production and quality of work by clinical and clerical staff,
- Works with clerical staff to achieve production, timeliness, and quality of work,
- Participate with Inter-departmental process improvement teams and planned quality management,
- Assist with development and formalization of departmental budget,
- Assist with development and updating of UM criteria, guidelines, and policies,
- Monitor UM processes for efficiency and accuracy, identifying required changes and coordinating the implementation of required changes,
- Train staff, as appropriate, regarding use of the Medical Management systems,
- Generates reports for CMO and Chief Health Services Officer to support business decisions,
- Research and analyze qualitative and quantitative data, prepare statistical reports, and submit final report to the state contract manager in conjunction with KHS departmental analyst(s) and Senior Health Services Program Administrator,

UM Outpatient Clinical Supervisor

The UM Outpatient Clinical Supervisor reports to the Director of Utilization Management and is responsible for supervising the functions and activities for clinical level positions associated with Outpatient Medical, Behavioral, Mental Health, and Social Services within the UM Department. The UM Outpatient Clinical Supervisor will work in a coordinated effort with the Director of UM to ensure smooth, efficient, and productive operations within the UM Department, as directed by the Chief Health Services Officer. This position will work closely with the KHS Chief Medical Officer and Medical Director(s) in the smooth and efficient operation of the referral and inpatient clinical decision-making process. KHS uses licensed health care professionals to make UM decisions that require clinical judgment. Responsibilities include, but are not limited to:

- Educate and develop UM nursing staff regarding organizational policies, procedures and UM decision making skills,

- Monitor the UM process for efficiency and accuracy, identifying required changes and coordinating the implementation of required changes,
- Participation on inter-departmental process improvement teams and KHS quality management,
- Monitor UM nursing staff (clinical and non-clinical) referral and documentation for accuracy and appropriateness,
- Supervise staff who are not qualified health care professionals when there are explicit UM criteria and no clinical judgment is required, e.g., auto-approvals,
- Coordinate training of staff within the Interrater Reliability Review Tool to all clinical staff, including CMO and Medical Directors to facilitate consistent decisions based on evidence-based guidelines,
- Supervise the appropriate case management in compliance with UM guidelines and KHS Policy and Procedures,
- Monitors and reports production and quality of work by outpatient clinical staff,
- Works with staff to achieve production, timeliness, accuracy, and quality of work,
- Summarize and prepare necessary production reports for management,
- Perform periodically scheduled audits of outpatient clinical decisions for appropriateness and accuracy of documentation,
- Serves as a clinical liaison with contracted facilities and providers and participates in Joint Operations meetings to improve patient care and ensure access standards,
- Ensure coordination of medically necessary services within the plan and with community,
- Remain current with Department of Health Care Services and Department of Managed Care policy implementation or revisions,
- Act as clinical liaison with Member Services, Claims, MIS, and Provider Relations on referral data entry functions.
- Availability to UM staff onsite or by telephone.

<u>UM Inpatient Clinical Supervisor</u>

The UM Inpatient Clinical Supervisor reports to the Director of Utilization Management and is responsible for supervising the functions and activities for clinical level positions associated with Inpatient Medical, Mental, Behavioral, and Social Services within the UM Department. The UM Inpatient Clinical Supervisor will work in a coordinated effort with the Director of UM to ensure smooth, efficient, and productive operations within the UM Department, as directed by the Chief Health Services Officer. This position will work closely with the KHS Chief Medical Officer and Medical Director(s) in the smooth and efficient operation of the referral and inpatient clinical decision-making process. Responsibilities include, but are not limited to:

- Educate and develop UM nursing staff regarding organizational policies, procedures and UM decision making skills,
- Monitor the UM process for efficiency and accuracy, identifying required changes and coordinating the implementation of required changes,
- Participation on inter-departmental process improvement teams and KHS quality management,

- Monitor UM nursing staff referral and documentation for accuracy and appropriateness,
- Coordinate training of staff within the Interrater Reliability Review Tool to all clinical staff, including CMO and Medical Directors to facilitate consistent decisions based on evidence-based guidelines,
- Supervise the appropriate case management in compliance with UM guidelines and KHS Policies and Procedures,
- Monitors and reports production and quality of work by inpatient clinical staff,
- Reviews decisions regarding hospital admissions and length of stay, and outpatient procedures for all care delivered to the KHS membership as related to coordination of services upon discharge,
- Assists with coordinating discharge planning activities with facility discharge planners,
- Benefits interpretation to include coordination of care for medically necessary services that are not covered under the KHS Plan e.g., CCS, Mental Health, Long Term Care, State Waiver Programs,
- Works closely with the Transitional Care team to facilitate needs for members identified as High Risk or requiring coordination of services,
- Identify members who may quality for the Health Homes Program,
- Assist the UM clinical staff in the review of claims for the accuracy and appropriateness of billed charges,
- In coordination with the UM Clinical Auditor, perform periodic audits of the UM Nurse RN and Social Workers of inpatient clinical decisions for appropriateness and accuracy of documentation and summarize and report the results of the audit,
- Works with staff to achieve production, timeliness, accuracy, and quality of work,
- Summarize and prepare necessary production reports for management,
- Perform periodically scheduled audits of inpatient clinical decisions for appropriateness and accuracy of documentation,
- Serves as a clinical liaison with contracted facilities and providers and participates in Joint Operations meetings to improve patient care and ensure access standards,
- Ensure coordination of medically necessary services within the plan and with community,
- Remain current with Department of Health Care Services and Department of Managed Care policy implementation or revisions,
- Act as clinical liaison with Member Services, Claims, MIS, and Provider Relations on referral data entry functions.

<u>UM Nurse and Clinical Intake Coordinators (RN)</u>

Under the direction of the Kern Health Systems (KHS) Director of Utilization Management, the UM Nurse and Clinical Intake Coordinators will promote coordination and continuity of care and quality management in both the inpatient and ambulatory care settings by the review of referrals and authorization of payment for specialty care and ancillary services. The UM Nurse and Clinical Intake Coordinators are supported by a non-clinical team for administrative duties and coordination. The review will evaluate the appropriateness of care using established criteria and Plan benefit guidelines. Review will be conducted on a prospective, concurrent,

and retrospective basis. The UM Nurse and Clinical Intake Coordinators manages the required caseload monthly. Responsibilities, include, but are not limited to:

- Promote coordination and continuity of care and quality improvement in both the inpatient and ambulatory care setting,
- Evaluate the appropriateness of care using established criteria and KHS' benefit guidelines,
- Support KHS developed programs through member identification for participation, i.e., Diabetic Clinic, Health Home, Complex Case Management, Recuperative, Palliative, Transitional Care, Health Home, and Social Worker interventions,
- Review and approve specialty and ancillary service referrals using established criteria for purposes of pre-authorization of payment,
- Review and approval of hospital admissions and length of stay, and outpatient procedures for all care delivered to the KHS membership,
- Coordinates discharge planning activities with facility discharge planners,
- Benefits interpretation to include coordination of care for medically necessary services that are not covered under the KHS Plan e.g., CCS, Long Term Care, State Waiver Programs,
- Participates in UM and QI data and statistical gathering, collation, and reporting; and
- Assess for over and underutilization and identify potential fraud, waste, and abuse.

Clinical Auditor/Trainer (RN)

Under the direction of the Director of Utilization Management, the UM Clinical Auditor and Trainer RN is responsible for reviewing Utilization Management (UM) policy and guidelines to ensure staff compliance with policies. Responsibilities include ensuring coordination of services not only within inpatient and outpatient groups, but also between the groups and community. Perform audits on various project reports, Notice of Action notifications, and referrals for compliance. Responsible for reporting findings to management for review and possible corrective action. Provide recommendation for process improvement and assist with action plans for making those corrections. The Clinical Auditor and Trainer RN will work in a coordinated effort with UM Clinical Supervisor(s), Health Services Manager, and Business Analyst to ensure smooth, efficient, and productive operations within the UM Department as directed by the Director of Utilization Management. This position will work closely with the Chief Medical Officer and Medical Director(s) in the smooth and efficient operation of the referral and inpatient clinical decision-making process. Responsibilities include, but are not limited to:

- Train other UM clinical licensed staff as appropriate regarding use of all platforms and core adjudication system as it relates to the UM process,
- Develop and implement staff training for new and existing employees along with internal findings,
- Responsible for written and verbal communication with contract providers and internal KHS staff to promote timely coordination of care and dissemination of KHS policies and procedures,
- In coordination with the UM Senior Auditor/Analyst, perform spot audits of performance of UM Clinical Intake Coordinators and Social Workers and summarize and report the results of the audit to UM Management for process improvement,

- Perform periodic spot audits of inpatient and outpatient clinical decisions for appropriateness and accuracy of documentation,
- Assists in data collection and compilation, of various committee and quarterly reports; and
- Summarize and prepare necessary production reports for management.

Claims and Disputes Review Nurse (RN)

Under the direction of the Director of Utilization Management and in coordination with the Kern Health Systems (KHS) Chief Medical Officer or designee, the Medical Claims Review RN will be responsible for retroactive review of medical service claims and disputes for payment and medical necessity following accurate contract and non-contract guidelines for both Inpatient and Outpatient services. The review will evaluate the appropriateness of care using established criteria and Plan benefit guidelines. Responsibilities include, but are not limited to:

- Reports, track and documents all claims, and disputes review activity in appropriate programs such as QNXT, as well as specially developed internal logs for tracking and trending purposes,
- Perform retro review and approval of specialty and ancillary services referrals using established criteria for purposes of payment,
- Perform retro review and approval of hospital admissions and length of stay, and outpatient procedures for all care delivered to the KHS membership,
- Benefits interpretation to include coordination of care for medically necessary services that are not covered under the KHS Plan e.g., CCS, Long Term Care, State Waiver Programs.

Long Term Care Nurse Reviewer (RN)

Under the direction of the Director of Utilization Management and in coordination with the Kern Health Systems (KHS) Chief Medical Officer or designee, the Long-Term Care Nurse reviewer performs a comprehensive assessment and ongoing reassessments for members referred for long term care (LTC) placement. The assessment process evaluates benefit and medical necessity application of criteria to assure that the member is placed in a health care facility that provides the level of care most appropriate to the member's medical needs. Considerations for placement include:

- Self-determined directive of the member/care giver for the placement,
- Geographical location of placement to maintain members in the community of their choice,
- The unique medical and psychosocial needs of the member,
- Exhaustion of community options/settings to safely maintain the member's health.

Essential Functions:

- Conducts remote and or onsite assessments of member (s) for comprehensive health re-assessments regarding clinical, behavioral and ADL requirements,

- Communicates with LTC Staff and attending health care providers involved in care of the member to coordinate TAR service requests by obtaining complete and accurate information as needed,
- Collects information concerning ongoing eligibility,
- Coordinates with Care Management team and provides updates regarding member health status,
- Participates in collaboration as necessary in member case management and ICT conferences,
- Adheres to all HIPPA standards and confidentiality requirements.

Social Worker (MSW)/Licensed Clinical Social Worker (LCSW)

The Master of Social Worker or Licensed Clinical Social Worker primary duties are to identify and assist members that are displaying a complex variety of social and or emotional needs and usage of services reflective of abuse, lack of compliance to medical or pharmaceutical instructions, or self-destructive habits. The MSW or LSCW coordinates with these members and the member's PCP to provide better medical management and to track and gauge the effectiveness of that effort. Responsibilities include, but are not limited to:

- Responsible for the promotion of coordination, continuity of care and quality improvement in both the inpatient and ambulatory care settings,
- Assists the members with psychosocial and discharge planning needs as well as community resources,
- Performs reviews available reports for frequent usages of services and inappropriate usage of services by members,
- Identifies environmental impediments to client or patient progress through both personal or telephonic interviews and review of medical records,
- Investigates suspected child/elder abuse or neglect cases and notify authorized protective agencies when necessary.
- Refers member to community resources to assist in recovery from mental or physical illness and to provide access to services such as financial assistance, legal aid, housing, or education.
- Advocates for members to resolve crises and demonstrate proficiency in de-escalation and interventional techniques,
- Provides assistance and education to members as appropriate and in coordination with disease management, works to improve member participation in regular testing and screening along with follow-up visits to their PCP,
- Works collaboratively with the Care Management team to assist with identified social issues,
- Provide guidance and recommendations for the Behavioral and Mental Health Benefits (mild to moderate), including autism spectrum disorders and behavioral intervention.

Senior Operational Analyst

This position is responsible for providing an advanced role in the analysis of health care information as it relates to multiple disciplines for functional departments within the organization. The Senior Operational Analyst (OA) position is a resource with an ability in

providing experience within integrated reporting, data analytics, process improvement, departmental metrics, and data integrity based on the collection, association, review, and the interpretation of data and operational processes. The OA will provide the skills necessary for report writing and presentation and performs detailed business analytics that contribute to and support the UM Department's dashboard reporting efforts.

Senior Analyst/Trainer

The purpose of this position is to provide support to the UM Management team for report generation, data collection for providing to the UM Clinical Auditor for review. Based on feedback from the UM Auditor, management, and clinical staff, assist in training criteria for staff improvement along with providing one-on-one training to improve staff efficiencies. Responsibilities include, but are not limited to:

- Performs utilization management activities related to data collection, data review and report preparation per KHS Utilization Management Program,
- Assists in the reporting of DHCS and DMHC required reports and Utilization Management's quality studies to meet State contractual requirements,
- Develop and implement staff training for new and existing employees along with internal findings as it relates to the duties of Utilization Management.

Senior Auditor/Analyst

This position provides the vital link between inpatient and outpatient as it relates to case managing members moving from hospital to home care. This position will ensure that processes are in place and followed in support of all members seeking care. This is a proactive audit of UM processes as they are in motion to catch and prevent errors. This position will link the social worker, case managers and medical directors in direct support of members under case management. Responsibilities include, but are not limited to:

- Performs audit of staff referral processing as it relates to compliance, accuracy, and performance levels,
- Reviews available reports and data to analyze the accuracy of staff performance as it relates to timeliness of referral processing, accuracy of data entry and appropriateness of decisions,
- Prepares State mandated report requirements as scheduled by the DHCS for management review and approvals,
- Reviews post-activity audit findings to UM Management to ensure compliance and to review where further training opportunity exist.

Director of Pharmacy

Qualifications for the Pharmacy Director include possession of a California State Board of Pharmacy registered pharmacy license, two years of health plan related pharmacy experience

at a supervisory level or four years of pharmacy practice in a similar setting as a hospital or group purchasing organization. This position reports to the Chief Medical Officer (CMO).

KHS performs drug utilization reviews (DUR) to provide oversight of prescribed medications. DUR is a structured, ongoing program that evaluates, analyzes, and interprets drug usage against predetermined standards and undertakes actions to elicit improvements and measure the results. The objectives of DUR are to improve the quality of patient care by assuring safe and effective drug use while concurrently managing the total cost of care. Responsibilities include, but are not limited to:

- Participates and serves as the Chairperson on the Pharmacy & Therapeutics/Drug Utilization Review (P&T/DUR) Committee,
- Medication coverage management Development of applicable policies and guidelines Drug utilization review,
- Drug prior authorization for medications covered under the medical benefit,
- Implementation of cost-effective utilization management measures for medications covered under the medical benefit,
- Participation in provider education initiatives such as academic detailing with plan physicians,
- Assisting with development of Clinical Practice Guidelines,
- Other duties as assigned by the Chief Medical Officer,
- Coordination for opioid prescriptions and safeguards to prevent overutilization,
- Creation of clinically efficacious and cost-effective management programs,
- Development, implementation, and monitoring of clinical strategies to improve quality of care for members as well as provide clinical consultative services to contracting providers and KHS staff as necessary to support clinical programs,

Behavioral Health Director

The KHS Behavioral Health Director is an is an LFMT who is actively involved in implementing and evaluating the behavioral health aspects of the UM program supported by a PsyD BH Provider for clinical input. This Director provides administrative oversight of KHS's behavioral health activities including coordinating substance use services, behavioral health screening processes and collaborates with the DHCS managed behavioral health organization(s) designated to provide specialty mental health services to Kern members. The Behavioral Health Director works in tandem with the various department, UM, Health Education, Health Equity, quality Management in supporting behavioral delivery of services optimally. The assigned activities for this position include:

- Supports quality improvement activities applicable to behavioral health,
- Facilitates network adequacy,
- Participates in collaborative department activities processes,
- ,

Behavioral Health Clinical Provider

Is a Licensed PsyD and supports the Behavioral Health Director with clinical matters pertaining to BH as follow:

- Reviews UM behavioral cases and evaluates behavioral health treatment services requests,
- Reviews BH treatment requests for autism spectrum disorders,
- Assists in the selection and distribution of BH educational resources and information to support primary care providers in BH processes,
- Serves on the QI, UM, Pharmacy and Therapeutics and Credentials Committees and Internal Quality Improvement committee including Substance Use Internal Quality Improvement Subcommittee

Committees

Utilization Management Committee

The Utilization Management (UM) Committee is established as a standing sub-committee of the KHS Quality Improvement Committee and reports to the Governing Board through the Standing Committee. The Committee structures and processes are clearly defined, and responsibility is assigned to appropriate individuals. The UMC is reliant on the involvement of appropriate, actively practicing practitioners representing primary and specialty care. A quorum of at least 3 physicians must be present at each meeting. The UM Committee meets on a regular basis, at least quarterly. Only physicians have voting privileges on the UM Committee. Additional UM Committee meetings or subcommittee meetings are scheduled at the discretion of the UM Committee Chairman. The UM Committee members serve a two-year term with the possibility of reappointment, and terms are staggered to allow for continuity on the Committee. During the period of time between UM Committee meetings, the Medical Director or physician designee may function as an interim decision-maker to resolve any UM issues that may need expediting.

Minutes of committee actions are documented and maintained.

The Utilization Management Committee oversees the implementation of the UMP and promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UM Committee is multi-disciplinary and monitors continuity and coordination of care as well as under and overutilization of services. Any perceived or actual utilization management problems are reviewed by the UM Committee. The Quality Improvement and Utilization Management Committees work together on overlapping issues. The responsibilities of the UMC are to develop, recommend, and refine the UM program policies and procedures, including medical necessity criteria, establishment of thresholds for acceptable utilization levels, and reliability of clinical information. and develop and implement a monitoring system to track, compile and evaluate UM measures against pre-established standards and the identification of over and under and utilization patterns.

Key Activities include:

1. Establish and implement written utilization management protocols and criteria applicable to the review of medical necessity for institutional, ambulatory, and ancillary services.
2. Ensure that UM decisions:
    - Are made independent of financial incentives or obligations,
    - Medical decisions, including those by delegated providers and rendering providers, are not unduly influenced by fiscal and administrative management,
    - Physician compensation plans do not include incentives for denial decisions,
    - Physician and UM decision designees are not rewarded for utilization review decisions.
3. Educate staff, contracted practitioners, and vendors on KHS utilization management policies and procedures to ensure compliance with the goals and objectives of the Utilization Management Program.
4. Review established nationally acceptable utilization benchmarks, medical literature, and outcome data, as applicable.
5. Develop and implement a monitoring system to track, compile and evaluate patterns and variations in care.
6. Initiate necessary procedural revisions to prevent the recurrence of problematic utilization issues.
7. Identify specific services that are over-utilized or under-utilized and develop appropriate responses to these findings.
8. Continually monitor and evaluate utilization practice patterns of staff and contracted practitioners and vendors and identify variations in care.
9. Review state regulatory oversight of LTC and CBAS facilities.
10. Develop and maintain a process to identify and address quality issues for submission to QI and credentialing, recredentialing and ongoing monitoring process.
11. Develop and maintain effective relationships with linked and carved-out service providers available to members through County, State, Federal and other community-based programs to ensure optimal care coordination and service delivery.
12. Facilitate and ensure continuity of care for members within and outside of KHS network.
13. Develop and implement performance measures to assure regulatory turn-around-time frames are met.

<u>UMC Reports</u>

Oversight of Utilization of services through review of reports regarding major aspects of the Utilization Management Program of the Plan. The analysis of, and the actions taken in respect to, these reports are submitted quarterly to the UMC. They are prepared by various UM Department designees for presentation. Such reports may include, but are not limited to, the following:

a. Quarterly Utilization Management Work Plan Metrics with Quantitative and Qualitative analytics measured against industry and KHS internal benchmarks & Goals,
b. Summaries of UM Program updates,
c. Behavioral Health,
d. Pharmacy,
e. Updates / revisions to UMP policies and procedures,

f. Criteria for UM decision-making,
g. Status of completed and on-going UM activities,
h. Organizational changes made throughout the year,
i. Inter-Rater Reliability Audits,
j. Response to new legislation that affect the UM process,
k. Analysis of the outcomes of improvement activities,
l. Under and Over Utilization Studies,
m. Barriers encountered which defer or delay the achievement of UM goals,
n. Evaluation of overall effectiveness of the UM program,
o. Satisfaction surveys,
p. UM auditing activities,
q. UM/QI Interface Activities,
r. UM/ Credentialing Interface Activities.

Utilization Management and Quality Improvement Interface

The Utilization Management Committee and Quality Improvement Committee interact to ensure that services delivered and managed are of high quality and are appropriate, cost-effective, efficient, and accessible. The UMC employs a system of reporting utilization information and identifying areas of service such as medical, surgical, ancillary, pharmacy, and behavioral health. Through the aggregation and evaluation of UM data, when patterns of care or service issues suggest they are inappropriate or deviate from industry standard, they are reported for further evaluation to the QI Committee.

The QI Committee performs oversight of UM activities conducted by KHS to maintain quality health care and effective and appropriate control of medical costs through monitoring of medical practice patterns and utilization of services. This committee also develops and enforces the quality improvement process with respect to contracting providers, and other health plan functional areas with oversight by the CMO.

Key components of the QI Program structure and requirements include the continuous review of the quality of care provided to members, to assure that quality, comprehensive health care, and services are provided to KHS members through an ongoing, systematic evaluation and monitoring process that facilitates continuous quality improvement to include:

- A level of care which meets professionally recognized standards of practice is being delivered to all members,
- Quality of care problems are identified and corrected for all provider entities,
- Physicians and appropriate licensed behavior providers to include psychologists are an integral part of the QA program,
- Appropriate care which is consistent with professionally recognized standards of practice is not withheld or delayed for any reason, including a potential financial gain and/or incentive to the plan providers, and/or others; and
- KHS does not exert economic pressure to cause institutions to grant privileges to health care providers that would not otherwise be granted, nor to pressure health care providers or institutions to render care beyond the scope of their training or experience.

The scope of the UM licensed staff extends beyond the management of referrals. While performing UM activities, any quality-of-care concerns may be addressed with the practitioners or provider organizations and are reported to the QI department. Collaboration between UM and QI is essential to ensure the delivery of quality care to the plan's membership. The UM team supports QI efforts in the identification of potential quality of care issues, reporting adverse occurrences identified while conducting UM case review, improvement of Healthcare Effectiveness Data and Information Set (HEDIS®) scoring by referrals to care coordination, and care coordination efforts to ensure members are seen by the appropriate provider for their condition.

Through UM data aggregation and analytics when adverse QI patterns are discovered they will be submitted to the QI Committee through formal reports for review and to make recommendations and take action as are necessary to ameliorate the conditions. These activities will be documented in the meeting minutes.

Data Sources

KHS has identified the following as sources that may provide useful and meaningful data for analyzing compliance with standards of utilization as well as those of quality:

a. Access to care studies,
b. Providers' telephone triage systems,
c. Medication utilization reports for prescription medications,
d. Institutional Data,
e. Claims Data,
f. Referral Patterns,
g. Timeliness of Service,
h. Ancillary Service utilization,
i. Outpatient Data,
j. Member Complaints/Grievances,
k. Appeals Review,
l. Provider surveys,
m. Satisfaction surveys,
n. Care follow-up, especially ER and Urgent Care facilities,
o. Medical Records Reviews.

Physician Advisory Committee (PAC)

The functions of the Physician Advisory Committee (PAC) encompass multiple activities related to UM and QI to include, serving as the KHS Credentialing and Peer Review QI Subcommittee, overseeing and determining the review and approval of medical technologies and clinical criteria sets, addressing and managing the review of sentinel conditions or adverse events identified for quality concerns, and evaluates as necessary the need to add practitioners to the KHS network, based upon requirements by DHCS, DMHC, CMS, or applicable law. The PAC is actively involved in the establishment of policies related to KHS Code of Conduct, Protected Health Information (PHI) and Fraud Waste and Abuse (FWA). The PAC is

comprised of a broad spectrum of KHS participating physician representatives from primary and specialty care and includes at least one behavioral health provider.

PAC- Credentialing and Peer Review

In accordance with state law, minutes will not be submitted but rather a summary of the meeting. The minutes are confidential information protected under California Evidence Code 1157. The responsibilities of the Credentialing/Peer Review Committee are to develop, monitor, and maintain standards for the education, training, and licensure of the KHS network of Participating Practitioners and Health Delivery Organizations, and establish and maintain credentialing/re-credentialing policies and procedures that are consistent with National Committee for Quality Assurance (NCQA) standards, as well as applicable State and Federal laws and regulations. UM information is shared with the PAC. The PAC may not base credentialing decisions on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or patient type in which the practitioner specializes.

Activities:

1. Maintain a well-credentialed network of providers and practitioners based on recognized and mandated credentialing standards,
2. Promote continuous improvement in the quality of the care and service provided by the KHS Providers,
3. Investigate patient, member or practitioner complaints or concerns about the quality of clinical care or service provided and to make recommendations for corrective actions, if appropriate.
4. Provide guidance on the overall direction of the credentialing program,
5. Review at least annually the Credentialing Committee Program Description to assure that the program is comprehensive, effective in meeting the goals and standards of KHS credentialing/ recredentialing procedures and supports the Continuous Quality Improvement process,
6. Evaluate quality concerns related to medical care and make determinations as to whether there is sufficient evidence that the involved practitioner failed to provide care within generally accepted standards,
7. Monitoring the reporting of Provider Preventable Conditions.

PAC-Medical Technologies and Clinical Criteria Sets

1. The PAC uses principles of evidence-based medicine in its evaluation of clinical guidelines oversight and monitoring of the quality and cost-effectiveness of medical care provided to KHS members. PAC also reviews and modifies all protocols, technologies, and criteria sets as needed based on current clinical, and medical evidence.
2. Preforms reviews of technologies for use by medical and behavioral staff in the utilization review process,
3. Outlines the medical necessity criteria for coverage for a specific technology, service, or device and as applicable incorporates Federal and State regulations,

4. Ensures KHS does not exert economic pressure to cause institutions to grant privileges to providers that would not otherwise be granted, nor to pressure providers or institutions to render care beyond the scope of their training or experience,
5. Assess standards of health care as applied to members and providers, assist with development of indicators for studies and review guidelines that are promulgated to contracting providers.

PAC-Code of Conduct, Confidentiality, and Fraud Waste and Abuse

The PAC is instrumental in participating in the establishment and maintenance of:

1. Confidentiality policies and procedures for protection of confidential member, practitioner, and provider information in accordance with applicable state and federal regulations,
2. Protection of member identifiable health information by ensuring members' protected health information (PHI) is only released in accordance with federal, state, and all other regulatory agencies,
3. Providing oversight in strategies to reduce FWA in provider networks.

Reporting Relationship

- The PAC reports recommendations to the QI and UM Committee quarterly,
- The QI and/UM Committees report PAC recommendations to the Board of Directors quarterly through the Chief Medical Officer or their designee.

Pharmacy and Therapeutics/Drug Utilization Review Committee (P&T/DUR)

Key Responsibilities

- ♦ Objectively appraise, using principles of evidence-based medicine to evaluate and select pharmaceutical products. This is an ongoing process to ensure the optimal use of therapeutic agents. Products are evaluated based on efficacy, safety, ease of use and cost;
- ♦ Evaluate the clinical use of medications and develop policies for managing drug use and administration;
- ♦ Monitor for quality issues regarding appropriate drug use for KHS and members. This includes Drug Utilization Review (DUR) and Drug Use Evaluation (DUE) programs;
- ♦ Provide recommendations regarding protocols and procedures for the use of non-preferred medications;
- ♦ Provide recommendations regarding educational materials and programs about drug products and their use to contracting providers;
- ♦ Recommend disease state management or treatment guidelines for specific diseases or medical or behavioral health conditions. These guidelines are a recommended series of actions, including drug therapies, concerning specific clinical conditions;
- ♦ Monitor and assess contracting pharmacy activities as needed through review of audits and pharmacy profiling;

- ♦ Review elements and format of the preferred drug lists, including prior authorization lists;
- ♦ Review parameters of prescribing practices for frequency of refills and the number of refills that may be dispensed at one time;
- ♦ Make recommendations to the QI/UM Committee for prescribing parameters;
- ♦ Review quality of care issues that arise pertaining to the prescribing and dispensing of medications;
- ♦ Report to the QI/UM Committee situations that may indicate substandard quality of care.

Membership

1	KHS Chief Medical Officer (Chairperson) or designee
1	KHS Director of Pharmacy (Alternate Chairperson)
1	KHS Board Member
1	Retail/Independent Pharmacist
1	Retail Chain Pharmacist
1	Specialty Practice Pharmacist
1	Geriatric Practice Pharmacist
1	Geriatric Practice Physician
1	Pediatrician
1	Internist
1	PCP/General Practice Medical Doctor
1	OB/GYN Practitioner
1	BH Provider MD or PsyD
1	Provider at Large

Reporting Relationship

- The P&T meets quarterly with additional meetings as necessary.
- The P&T/DUR reports recommendations to the QI and UM Committee quarterly,

Utilization Management Process

Medical Necessity and Clinical Criteria

The KHS UM Program and contracted entities in accordance with KHS performing utilization management review functions utilize nationally recognized evaluation criteria and standards that are objective and based on medical evidence in making decisions to approve, modify, defer, deny, or terminate services. KHS has specific criteria to determine the medical necessity and clinical appropriateness of medical, behavioral, and pharmaceutical services requiring approval. The criteria or guidelines are:

- Developed with involvement from actively practicing health care providers including non-staff network practitioners to apply, adopt, and review criteria,

- All criteria sets will be reviewed and evaluated, updated, and modified as necessary, at least annually and when appropriate by the Physician Advisory Committee (PAC) and the QI/UM Committee.

- Any new criteria that KHS would like to adopt will be subjected to review and evaluation by the PAC and the QI/UM Committee prior to its approval and implementation by the organization.

Regulations and Criteria Guidelines (Hierarchy of Criteria)
KHS Physician Reviewers will use the hierarchy of KHS UM criteria to make UM decision in the following order:

1. Health Plan eligibility and coverage
2. Federal and state mandated criteria

    - California Code of Regulations Title 22,
    - California Code of Regulations Title 28,
    - CMS Code of Regulations Title 42,
    - California Health and Safety Code §§1363.5; 1367.01; 1371.4; 1374.16,
    - Medi-Cal Provider Manuals,
    - CA DHCS All Plan Letters (APL),
    - DMHC All Plan Letters,
    - CA DHCS Policy and Procedure Letters (PPL),
    - 42 CFR section 438.915, 438.206.
    - Standardized Behavioral Health criteria (Title 9, DSM-V)

3. Nationally recognized criteria set
    - MCG Health LLC (Milliman Care Guidelines,)
    - UpToDate

4. Peer Reviewed Journal or Published Resources

In January 2019, a new law was passed requiring the Medi-Cal pharmacy benefits and services to be administered by the Department of Health Care Services in the fee-for-service delivery system, known as “Medi-Cal Rx.”. With the exception of medically administered drugs, pharmacy is carved-out to DHCS.

UM decision making criteria shall be available to the public upon request. When making UM determinations KHS shall disclose the criteria or guidelines for the specific procedures or conditions requested. If it is determined to apply charges in disclosing criteria, the charges will be limited to reasonable fees for copying and postage costs when electronic communication means of disclosing criteria is not available.

For those instances when criteria are applied as the basis of a decision to modify, delay, or deny services in a specified case under review, the criteria shall be disclosed to the provider and the enrollee used in that specified case.

All criteria disclosures will be accompanied with the following clause, "The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."

The KHS UM Program will also review and present internally generated and other outside criterions to the Physician Advisory Committee (PAC) and the QI/UM Committee for direction in the development and/or adoption of specific criteria to be utilized by the KHS UM staff.

When making medical necessity decisions, UM staff obtains relevant clinical information to finalize UM decisions, but the process should not be burdensome for the member, the practitioner, or the organization's staff. Clinical information is provided to the Chief Medical Officer or their designee to support the decision-making process. Examples of clinical information include the following but is not limited to:

- History and physicals,
- Office and ancillary service notes,
- Treatment plans and Progress notes,
- Health Risk Assessments,
- Psychosocial history,
- Risk Stratification,
- Diagnostic results, such as laboratory results, or radiology results,
- Specialty Consultation records, including photographs, operative, and pathology reports,
- Pharmacy profiles,
- Telehealth communications,
- Behavioral Health/Mental Health records,
- Information regarding benefits and any changes as required under the Department of Healthcare Services (DHCS) contract and Department of Managed Healthcare (DMHC) Knox Keene Licensure.

The review considers individual patient needs and the characteristics of the local delivery system. Based on patient circumstances, applicable UM criteria may be modified to a given instance. Medical judgment and decision making is individualized based on the member's condition and as applicable, discussed with the physician/practitioner reviewer, and requesting physician to render an appropriate decision relative to Kern's policies:

- Age,
- Sex/gender,
- Comorbidities,
- Complications,

- Home environment, as appropriate,
- Progress toward accomplishing treatment goals,
- Family support,
- Previous treatment regimens,
- Psychosocial situation and needs,
- Benefit structure including coverage for post-acute or home care services when needed.

Consideration of the delivery system and availability of services to include but not be limited to:

- Availability of inpatient, outpatient, and transitional services,
- Availability of highly specialized services, such as transplant facilities or cancer centers,
- Availability of skilled nursing facilities, subacute care facilities or home care in the organization's service area to support the patient after hospital discharge,
- Availability of outpatient services in lieu of inpatient services such as surgery-centers vs inpatient surgery,
- Local hospitals' ability to provide all recommended services within the estimated length of stay,

Criteria Notifications

Members are notified of the availability of UM criteria either in writing upon request or on the website and through the EOC Member Handbook mailed to all members.

Availability of the UM criteria upon request may be done in person or by telephone.

Practitioners are notified of the availability of UM criteria, either in writing upon request or on the website and through the provider manual upon onboarding, provider portal, and annual Provider network education. Providers are also notified, annually, through Plan newsletters and mailings, of the process by which such information may be obtained. KHS may also mail the criteria to practitioners who do not fax, email or have internet access. KHS maintains a UM Criteria Disclosure log to document a criteria request made by a practitioner or a member & member representative. The UM Department maintains a UM Disclosure Log to document any criteria requests made by a member or its representative or practitioner and peer-to-peer review requests.

Members receive pertinent criteria information with every -Notice of Action (NOA)-denial letter, by mail.

KHS also contracts with a third-party independent medical review organization which provides objective, unbiased medical determinations to support effective decision making based only on medical evidence.

The reviewing practitioners base their determinations on their training, experience, the current standards of practice in the community, published peer-reviewed literature.

For complex specialty reviews the UM medical staff refers the case for review to a licensed, board- certified practitioner in the same or similar specialty as the requested service.

Referral Management

Referral management is designed to determine medical necessity utilizing established criteria based on an assessment of the member's clinical condition, diagnosis and requested treatment plan. Each case is evaluated individually, and sound medical criteria applied as appropriate.

Referrals and requests for prior authorization of services are to be submitted by the provider of service to the KHS UM department by fax or through KHS's Online Services portal, which is a Secure Electronic Internet system. The following information must be provided on all requests.

- Member demographic information,
- Provider demographic information,
- Requested service/procedure to include specific CPT/HCPCS code(s),
- Member diagnosis (Using current ICD Code sets),
- Clinical indications necessitating service or referral,
- Pertinent medical history, treatment, or clinical data,
- Location of service to be provided,
- Requested length of stay for all inpatient requests,
- Proposed date of procedure for all outpatient surgical requests.

Pertinent data and information are required to enable a thorough assessment of medical necessity. If information is missing or incomplete, the requestor will be notified and given an opportunity to submit additional information.

Contract providers are obligated to refer members to KHS network providers, and/or providers approved through the Utilization Management Letter of Agreement process, unless medical necessity or emergency dictates otherwise. Physician requested Out of Area/Out of Network referrals are processed through Provider Relations Department with Letters of Agreement (LOA) for financial reimbursement methodology. KHS utilizes a member centric medical management documentation platform, JIVA system by ZeOmega, to house all clinical information for each member.

Emergency Room Visits

Emergency room visits where a prudent layperson, acting reasonably, would believe an emergency condition exists, DO NOT require prior authorization.

Pre-authorization

With the exception of specific services that do not require medical necessity or prior authorization to include but are not limited the following: OB/GYN, Abortion Services, treatment for Sexually Transmitted Disease, HIV services, Sensitive services, Family Planning Services, Maternity Care, Transportation, Vision, COVID 19 Vaccines Emergent/Urgent care,

and Mental Health (initial mental health and substance use disorder (SUD) assessments), PCP services from a KHS contract PCP, and services listed outside of the Prior Authorization List, most non-urgent specialty care must be pre-authorized by KHS in accordance with KHS referral policy and procedures in accordance with H&S Code section 1367.01. Requests for services are submitted either by fax or electronic online submission to KHS for review and processing.

For those services requiring pre-authorization, only KHS UM Clinical Staff and/or KHS Chief Medical Officer or designee(s), including the Physician Advisory Panel staff, may give authorization for payment by KHS. Denials, delays/extended delay, modifications, and terminations are performed in accordance with the Knox Keene license and DHCS contract. Only qualified health care professionals with appropriate clinical expertise in treating medical or behavioral health condition and disease or Long-Term Services and Supports (LTSS) needs supervise the review of decisions including service reductions and denials made in whole or in part, based on medical necessity. KHS utilizes both board certified internal MD staff as well as contracted vendor(s), Advanced Medical Review (AMR), for medical necessity reviews as additional guidance and evidence based scholarly references to ensure appropriate medical decision making. KHS maintains a list of board-certified consultants that includes contact information, e.g., phone numbers, names, specialties) and makes the list available to all UM staff as a reference for contacting those consultants. When external consultants are not able to share their names for proprietary reasons, they will provide KHS with centralized contact information and a list of the specialties of all board-certified consultants

KHS will review prior authorizations for physician administered drugs, medical supplies, and enteral nutritional products billed on a medical claim.

Physician administered drugs (PAD) and others that are managed as part of the medical benefit will be managed by common pharmaceutical utilization management and coverage tools. Generic versions of the branded drug, biosimilars, and follow on drugs are the preferred drugs. Preference is also given to the degree of invasiveness and place of service that will appropriately manage the condition. Oral is preferred over injectable, over infusion, and self-administered, home setting before a facility. Preferred drug lists and prior authorization lists are derived from this concept. Any limitations associated with these drugs will be communicated. Appropriate professionals of physicians and pharmacists from the P&T/DUR committee will approve protocols and policies regarding this governance annually. KHS will monitor quality and safety measures for those drugs under its purview. PAD drugs and others that fall under the management of KHS as they apply, will be reviewed to enhance the safety and quality of our members. Drug recalls, those identified on the Beers list of potentially inappropriate for the elderly, and opioid and similar controlled drugs as identified in SUPPORT Act are monitored.

Regular analytics are completed to reevaluate the need for prior authorization requirements as part of over and underutilization monitoring. KHS has a specialty referral system to track and monitor referrals requiring prior authorization. All network providers are made aware of the specialty referral processes and tracking procedures.

Concurrent Review

A request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care. Requests for authorization are reviewed within 5 working days or 72 hours based on the urgency of the request.

Inpatient Concurrent Review and Continued Stay

Concurrent review is the process of continual reassessment of the medical necessity and appropriateness of acute inpatient care during a hospital admission in order to justify the continued level of care. The concurrent review process is conducted by California licensed Registered Nurses by review of the member's medial record, reviewing the hospital's case management notes, dialoguing with the attending physician and other members of the health care team, and speaking with the patient and/or family or significant other, as needed.

Hospitalizations are concurrently reviewed for appropriate length of stay and discussed during scheduled rounding meetings with the KHS CMO (or designee) if medical necessity cannot be established. Concurrent reviews are performed collaboratively with KHS contracted hospitalist groups and/or providers and KHS RN staff to determine medical necessity of admission, length of stay, and post discharge dispositions.

Through the hospitalist program, the UM Nurse can authorize referral requests for member discharge planning and coordination of services for post-acute care.

Discharge Planning

UM Nurse and/or the UM Social Worker will assess member's post hospital continuing care needs and will collaborate with the provider organization's discharge planning staff to make arrangements for appropriate post-acute services pertinent to the member's recovery such as SNF, Acute Rehabilitation, DME, Home Health, specialist follow-up visits, community resources, and any other services identified. Recuperative Care and Transitional Care Clinics are designed to address potentially avoidable readmission, recidivism, and improve health through member empowerment and early intervention.

Skilled Nursing/Sub acute/ Long-Term Acute/Rehabilitation Facility Review

Review of all Skilled Nursing and Rehabilitation Facility confinements are performed by licensed professionals to ensure medical necessity of continued stay and the appropriateness of level and duration of care. This review is conducted telephonically using written KHS medical policy, Title 22 criteria, and/or MCG Criteria. Requests for authorization are reviewed within 24 hours of notification of admission. The UM team facilitates discharge planning in collaboration with the facility care team and makes referrals to KHS case management and social services as appropriate.

Consideration of available services in the local service area or delivery system, and the ability to meet the member's specific health care needs are evaluated as part of applying criteria and the development of an ongoing plan of care and discharge plan.

Retrospective Review

For those services requiring prior authorization, retrospective review for payment of claims is initiated when no prior authorization was obtained by the practitioner or provider organization. Retrospective review is also initiated for services performed by a non-contracted provider or when no authorization was obtained before completion of the service. Members, practitioners, and provider organizations are notified by mail/online of the UM/ claims decision.

Utilization Management Decision Timeframes

Decisions to approve, modify, or deny a requested health care service are based on medical necessity and urgency of the request, and are appropriate for the nature of the member's condition. KHS remains compliant with the defined timelines under the DHCS contract. When the member faces an imminent and serious threat to his or her health, including, but not limited to, potential loss of life, limb, or other major bodily function, decisions to approve, modify or deny requests from provider, shall be made in a timely fashion appropriate for the nature of the member's condition, not to exceed 72 hours after the Plan's receipt of the information reasonably necessary and requested by the Plan to make a determination.

- **Emergency Care**: no prior authorization is required.
- **Post-Stabilization**: within 30 minutes of a provider's request for authorization, or the service is deemed approved.
- **Non-Urgent Care** following an exam in the emergency room: KHS must respond to a provider's request for post-stabilization services within 30 minutes or the service is deemed approved.
- **Concurrent Review** of authorization for a treatment regimen: 5 working days or less, consistent with the urgency of the member's medical condition.
- **Retrospective Authorization**: retrospective authorization requests are processed within a reasonable established time limit, not to exceed 365 calendar days from the date of services; decisions to the provider and member are made within 30 calendar days of the receipt of information.
- **Routine Authorizations**: no longer than 5 working days from receipt of information and no longer than 14 calendar days from the receipt of the request; an extra 14 calendar days may be extended when member or provider requests an extension, and justified by KHS upon request by DHCS and in the member's best interest.
- **Expedited Authorization:** Decision must be made no longer than 72 hours after receipt of the request for services. Extension may be granted to an additional 14 calendar days when member or provider requests an extension.
  and justified by KHS upon request by DHCS and in the member's best interest.
- **Hospice Services:** KHS only requires prior authorization for inpatient hospice care in accordance with 22 CCR section 51003 and all applicable DHCS APLs.

- **Therapeutic Enteral Formula**: KHS complies with applicable DHCS PLs and APLs, W&I Code section 14103.6, and H&S Code section 1367.01.
- **Physician Administered Drugs**: KHS complies with same timeframes as other medical services.

Inter-Rater Reliability (IRR)

KHS assesses the consistency with which physician and non-physician reviewers apply UM criteria in decision making and evaluates Inter-Rater Reliability. An Inter-Rater Reliability (IRR) process is deployed to evaluate and ensure that UM criteria are applied consistently for UM decision-making. Bi-annually, both physicians and staff involved with making UM decisions participate in the IRR process. The Director of UM selects specific topics for completion by the UM clinical staff. The IRR training module records the completion for each user, along with the test results. KHS UM Management staff evaluates competency utilizing the MCG IRR training module for necessary remediation and education. Successful completion is required as a fulfillment of the clinical staff outlined job duties. The following types of reviews/reviewers are audited:

- Nurse Coordinator Review of Inpatient Services,
- Nurse Coordinator Review of Outpatient Services,
  Nurse Coordinator Review of Long-Term Care Services,
- Physician Reviewers,
- Behavioral Health Reviewer,
- Non-licensed UM and Care Management Coordinators processing referral requests.

Ongoing Training

KHS provides and encourages ongoing staff training. Areas of opportunity includes seminars, conferences, workshops, training by KHS Learning and Development department, and specialty specific training by contracted practitioners and provider organizations. Network providers also receive training on the procedures and services requiring prior authorization for medically necessary services including the necessary timeframes within 30 days of start of contract. The role of Senior Analyst /Trainer and UM Clinical Auditor/Trainer receives direction on the training needs of specific staff members from the UM Department leaders where areas of improvement regarding error rates indicate the need for additional training of staff member(s).

The Clinical Intake Coordinators and UM Nurse staff utilize established criteria for referral review and determination. Quarterly random audits are conducted to ensure compliance of the referral process and inter-rater reliability and are reported to UM Management for process improvement and staff education. Results of the findings are presented to the CMO and reported to the QI/UM Committee.

UM Determinations

Denial Determinations

Denial determinations may occur at any time during the review process. Only the Chief Medical Officer, or a physician designee acting through the designated authority of the Chief Medical Officer, has the authority to render a denial determination based on medical necessity.

A denial determination may occur during continued stay/concurrent review in which case notification and/or discussion with the treating practitioner and the Health Plan physician adviser/Chief Medical Officer or physician designee is offered. (Peer to Peer)

Denial determinations may occur at different times and for various reasons including but not limited to:

- At the time of prior authorization when the requested service is not medically indicated or not a covered benefit,
- When timely notification was not received from a facility for an inpatient stay to foster transfer of a medically stable patient,
- When an inpatient facility fails to notify KHS of an admission within one business day of the admission or appropriate clinical information is not received,
- Or after services are rendered at claims review when the services were not authorized, or are medically unnecessary,
- A denial may also occur for inappropriate levels of care or inappropriate care.

Notwithstanding previous authorization, payment for services may be denied if it is found that information previously given in support of the authorization was inaccurate.

KHS offers the practitioner the opportunity to discuss any denial or potential denial determination based on lack of medical necessity with the Chief Medical Officer, or a physician reviewer designee.

The referring practitioner, provider and member are notified of the denial through a Notice of Action (NOA) letter, translated in both English and Spanish with non-discrimination clauses and tagline notations.

The denial notification states the reason for the denial in terms specific to the member's condition or service request and in language that is easy to understand and references the criterion used in making the determination, so the member and provider have a clear understanding of the rationale for the denial and enough information to file an appeal.

All recommended denials are reviewed by the CMO or designee(s), except for administrative denials that are not based on medical necessity and performed by the UM RN Clinical Intake Coordinators/UM Nurse. Services denied, delayed/extended delay, terminated, or modified based on medical necessity may be eligible for an Independent Medical Review.

The Department of Health Care Services and Department of Managed Health Care provide direction to and oversight of the process of issuing written notification of non-coverage to KHS members.

KHS complies with DHCS Notice of Action Template requirements for Medi-Cal to include applicable inserts on how to file an appeal, DMHC information, translation services. This process is outlined in the KHS policies and procedures related to processing referrals.

The Health Plan does not compensate any individual involved in the utilization process to deny care or services for our members nor do we encourage or offer incentives for denials.

Appeals of Adverse Medical Necessity Denials and Benefit Determinations

A member, a member's authorized representative, or a provider acting on behalf of a member, has 60 calendar days from the date of determination to submit an appeal request in response to a Notice of Action (NOA) letter. A member or a member's authorized representative may initiate an appeal by contacting KHS's Member Services department. An appeal initiated in this way is considered a Member Appeal and will be referred to the KHS Grievance and Appeals department for processing. A provider may also request an appeal on behalf of a member, with written consent from that member, by faxing or writing KHS's UM Department.

After receipt of the request for appeal, KHS will provide written acknowledgement to the member and provider that is dated and postmarked within five (5) business days of receipt of the appeal. KHS has 30 calendar days from the receipt of the appeal request to render a determination.

The Chief Medical Officer or physician designee reviews the request for appeal if the determination was based on medical necessity. The Chief Medical Officer or physician designee may request further information from the provider such as:

- Diagnostic information,
- Clinical justification,
- Previous treatment,
- Opinions from specialists or other providers,
- Evidence from the scientific literature prior to processing the request.

The provider is expected to respond to a request for further information within the 30-calendar day determination time frame. If the provider does not respond to the request for further information within that time frame, the appeal can be extended no more than 14 calendar days.

When a decision has been made, the provider and/or member, if applicable, are notified in writing within five (5) business days with a Notice of Appeal Resolution (NAR) letter. KHS is not required to notify the member of a decision when the member is not at financial risk for the services being requested (post stabilization concurrent reviews).

If the provider or member is dissatisfied with the appeal determination, a second level appeal or grievance may be filed.

If KHS's determination specifies the requested service is not a covered benefit, KHS shall include in its written response the provision in the Contract, Evidence of Coverage, or Member Handbook that excludes the service.

The response shall either identify the document and page where the provision is found, direct the provider and member to the applicable section of the contract containing the provision, or provide a copy of the provision and explain in clear concise language how the exclusion applies to the specific health care service or benefit request.

Expedited Appeals of Adverse Benefit Determinations

Expedited appeals may be initiated by the member or the provider. A member may initiate an expedited appeal by calling the Member Services Department. A provider may initiate an expedited appeal on behalf of a member with written consent by faxing or writing the KHS UM Department. If the request for expedited appeal is not accompanied by written consent from the member, the Plan will proceed with the request.

Expedited appeals are performed by KHS only when, in the judgment of the Chief Medical Director or Physician Designee, a delay in decision-making may seriously jeopardize the life or health of the member.

KHS refers the expedited appeal request to the Chief Medical Officer or Physician Designee for decision on the appeal. The Chief Medical Officer or Physician Designee is expected to make a decision as expeditiously as the medical condition requires, but no later than 72 hours after the receipt of the request for an expedited appeal.

Expedited reviews are also granted to all requests concerning admissions, continued stay or other health care services for a member who has received emergency services but has not been discharged from a facility.

KHS provides verbal confirmation of its decisions concurrent with mailing of written notification no later than 72 hours after receipt of an expedited appeal. If the expedited appeal involves a concurrent review determination, the member continues to receive services until a decision is made and written notification is sent to the provider. KHS is not required to notify the member of a concurrent decision as the member is not at financial risk for the services being requested.

Appeal Rights

A member may ask for assistance from a patient advocate, provider, ombudsperson or any other person to represent them in their request.

A member may also request a State Hearing if a member has filed an appeal and received a "Notice of Appeal Resolution" letter upholding the initial denial of service or in instances of deemed exhaustion. Information on how to obtain an expedited State Hearing is included as a part of the "Notice of Appeal Resolution" letter to the member.

Member grievance and appeal information is included in the member handbook, distributed annually in the member newsletter, and is posted on the KHS website.

It is the responsibility of the Member Services Director and the Member Services Department to ensure:

- Member Rights and Responsibilities are included in the member handbook which is mailed to all new members and posted on the KHS website,
- Members are advised of their appeals rights when the adverse determination NOA is mailed to them.

Members are notified of all revisions to the Member Rights and Responsibilities statement in the member newsletter following revisions.

Independent Medical Review

Medi-Cal members can request independent medical review (IMR) on denied appeals involving medical necessity, including requests related to experimental/investigational services and receipt of out of Plan Emergency Department services. The DMHC administers the IMR program in the State of California at no cost to the member in compliance with applicable statutory requirements and accreditation standards. The IMR decision is binding on KHS.

Depending on the complexity of certain medical condition, KHS may require additional expertise in determining medical necessity for certain diagnosis and related procedures. Utilizing a nationally recognized and comprehensive review solution as a supplement to these difficult cases will provide the KHS CMO and Medical Directors with comprehensive medical recommendations utilizing case-specific patient information and history and industry standard guidelines including treatment protocols supported by current scientific evidence-based medicine to promote quality health care. Each review will be assigned to the IMR Reviewer who will be in an appropriate specialty or who will possess specific knowledge appropriate to the request of the treating provider. The IMR Physician Advisors will be specifically trained in Medicare/Medicaid rules and regulations based upon California state guidelines and remain well versed in the ongoing regulatory landscape to ensure up to date legislative rulings are current in the review process.

All services will be performed based on specific turnaround times which are calculated from the time the request and all related materials are received by the IMR reviewer. Submission of requests via a secure portal are completed by the KHS Clinical Intake Coordinator (CIC) on behalf of the CMO or designee at their direction only. It is the responsibility of the submitting CIC to track the progress of the review to ensure receipt based on the recommended turnaround timeline. The designated turnaround times will align with all DHCS timelines for medical decision making as outlined in KHS contract.

UM Programs and Service Descriptions

Mental (Behavioral) Health Services

KHS responsibilities are limited to mild to moderate mental health conditions rendered in the outpatient setting. Psychotropic drug therapy remains carved out and provided under the Fee for Service MCAL payment structure by the County Mental Health Plan. Referrals for mental health services may be generated by the practitioner, KHS Social Workers, KHS' 24-hour contracted advice and triage nurses, school systems, employers, family, or the member.

KHS do not administer triage and referral process.

Members needing immediate crisis intervention may self-refer to the Emergency Room or to the Kern County Behavioral and Recovery Services' Crisis Stabilization Unit. This information is provided to the members through the member handbook, and periodically, through the member newsletter. Mental Health Services for Medi-Cal participants are a covered benefit as described under the Kern Health Systems Health Plan in the contract with the Department of Health Care Services (DHCS).

KHS administers the mental health benefit as well as coordinating the benefit with the Kern Behavioral Health and Recovery Services (KBHRS) through a Memorandum of Understanding (MOU) and other contracted provider groups for their covered services. Quality issues including those occurring in different sites of behavioral healthcare services such as psychology groups or levels of behavioral healthcare such as outpatient psychiatrist visits are assessed through review of member grievances, member satisfaction study results, interactions with members, and quarterly meetings with KBHRS. KHS UM staff is available to assist KBHRS with complex cases and facilitate coordination and continuity of care between providers when transitioning between mild to moderate and extreme and pervasive mental health conditions.

Members who meet medical necessity criteria for medical conditions may receive Voluntary Inpatient Detoxification (VID) services in a general acute care hospital. VID services are carved-out (non-capitated) of the managed care contract and covered through the Medi-Cal Fee for Service program. Inpatient detoxification must be the primary reason for the member's voluntary inpatient admission.

KHS complies with Mental Health Parity requirements as required by Title 42, CFR, §438.930. The policies and procedures are consistently applied to medical/surgical, mental health and substance use disorder benefits. KHS's Utilization Management program does not impose Quantitative Treatment Limitations (QTL), or Non-Quantitative Treatment Limitations (NQTL) more stringently on covered mental health and substance use disorder services than are imposed on medical/surgical services in accordance with the parity in mental health and substance use disorder requirements in 42 CFR 438.900 et seq.

KHS adheres to appropriate utilization management processes to review, approve, modify, deny, and delay the provision of medical, mental health, and substance use disorder services to demonstrate compliance with mental health parity.

Behavioral Health Therapy (BHT) and Behavioral Intervention Services (BIS)

Autism Spectrum Disorder (ASD) encompasses several conditions that were previously diagnosed separately: autistic disorder, pervasive development disorder not otherwise specified (PDD-NOS) and Asperger syndrome. Primary Care Providers or other specialists can submit a prior authorization request for the Comprehensive diagnostic evaluation by a psychiatrist, psychologist, or neurologist. Upon completion of the Comprehensive diagnostic evaluation that results in a diagnosis of a qualifying ASD or another condition that would benefit from ABA services, ABA services will be reviewed in the usual manner as any other medical or behavioral service request to KFHC. KHS is responsible for coverage of the BHT benefit which includes non-ASD diagnosis and provides provisions for Continuity of Care for members.

Transitional Care Program

The Transitional Care Model (TCM) is an evidence-based solution to these challenges. The TCM has consistently demonstrated improved quality and cost outcomes for high-risk, cognitively intact, and impaired older adults when compared to standard care in reductions; in preventable hospital readmissions for both primary and co-existing health conditions; improvements in health outcomes; enhanced patient experience with care; and a reduction in total health care costs.

- *Avoidance of hospital readmissions for primary and complicating conditions***.** TCM has resulted in fewer hospital readmissions for patients. Additionally, among those patients who are re-hospitalized, the time between their discharge and readmission is longer and the number of days spent in the hospital is generally shorter than expected.

- *Enhancement in patient and family caregiver experience with care.* Overall patient satisfaction is increased among patients receiving TCM. In ongoing studies, TCM also aims to lessen the burden among family members by reducing the demands of caregiving and improving family functioning.

- *Improvements in health outcomes after hospital discharge.* Patients who received TCM have reported improvements in physical health, functional status, and quality of life.

Collaborative care is the cornerstone of the TCM model. Collaborating partner's staff will form the interdisciplinary clinic that provides biopsychosocial and diagnostic screenings and evaluations, medication management, care management, treatment planning and intervention services, as well as general medical services for the identified population. The main goals of integration include:

- Foster cross-system partnerships,

- Quality and value-based system of care,
- Create robust inpatient discharge coordination and develop cross-system transfer of care protocols,
- Expand strategies and educational opportunities,
- Improve patient experience and quality outcomes; and
- Implement model of care that is sustainable and cost effective.

Major Organ Transplant

Effective January 1, 2022, KHS will expand coverage to cover all major organ transplants, in addition to the current benefit of kidney transplant services. The UM Nurse and Clinical Intake Coordinator will work closely with the Major Organ Transplant Program team to ensure these vulnerable members are connected to this care coordination program to help assist and support them in navigating this complex process.

Long Term Care

Effective January 1, 2023, KHS will be administering the Medi-Cal Long Term Benefit for qualifying members. Long term care may be required due to physical or mental conditions that need continuous skilled nursing services; for Medi-Cal managed care, the LTC benefit for these services includes room and board and other covered services medically necessary for care. Kern Health Systems ensures access to licensed long-term care facilities to members in need of long-term care services. These facilities may include, a. Skilled Nursing Facilities b. Sub-acute Facilities (pediatric and adult), and c. Intermediate Care Facilities. A member in need of long-term care is identified by his/her physician, health care clinician, acute care attending physician, case managers or discharge planners. To support appropriate utilization management, case management and service coordination to maintain the member at the LTC level of care, KHS follows specific protocols and standards for determining levels of care and authorizing services that are consistent with policies established by the Federal Centers for Medicare and Medicaid Services (CMS) and in accordance with: a. 22 CCR § 51335 Title 22. Social Security Division 3. Health Care Services Subdivision 1. California Medical Assistance Program (Refs & Annos) Chapter 3. Health Care Services Article 4. Scope and Duration of Benefits § 51335. Skilled Nursing Facility Services.

Second Opinions

Members have a right to a second opinion by a qualified medical professional. A request for second opinion is reviewed to determine whether KHS has appropriately qualified medical professionals with knowledge and expertise in the member's condition who can evaluate the member and provide a second opinion. If so, the member is re-directed within the plan to obtain second opinion. When an appropriate, qualified physician is not available within the plan, an out of area/out of network referral with LOA is authorized.

Telemedicine/Telehealth

Telemedicine and other remote monitoring capability are a growing trend in the evaluation of a member's health. Telemedicine allows for HIPAA compliant medical information to be exchanged from one site to another via electronic communications to improve the member's clinical health status using two-way video, email, smart phones, wireless tools, and other virtual/telephonic communication modalities technology. No additional prior authorization is required for telemedicine, only the service is subject to those contained in the Prior Authorization list and limited to those KHS contracted providers who have demonstrated adequate office space, availability of a patient navigator, and suitable telemedicine equipment to connect with a remote medical group. This allows KHS additional options to serve members in both local and rural areas to improve primary care and specialty access and reduce wait times.

Emergency Services

KHS complies with all applicable requirements of Consolidated Omnibus Budget Reconciliation Act (COBRA) and California Health and Safety Code Section 1371.4. KHS shall reimburse providers for emergency services and care provided to members, until the care results in stabilization of the member. An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention may be expected to result in any of the following:

- An imminent and serious threat to health including, but not limited to, the potential loss of life, limb, or other major bodily function.
- A delay in decision making would be detrimental to the member's life or health or could jeopardize the member's ability to regain maximum function.

KHS strives to strengthen our collaborations with community entities to reduce costs, improve the patient experience, and improve the health of the populations we serve. Strategies are reviewed annually to determine the best approach to reducing inappropriate ER utilization. These include:

- Broaden access to Primary Care Services,
- Focus/enroll high utilizers into Case Management programs,
- Target members with behavioral health problems.

Emergency Services and Hospital Admissions Out of Plan Screening and Stabilization

KHS does not require prior authorization for emergency services. Post-service claims review (for out of plan emergency care) considers whether the member's decision to Present to the Emergency Department was reasonable under the circumstance.

Post-stabilization

KHS requires review and authorization for all out of plan post-stabilization care, and follows all statutory requirements and accreditation standards in making post-stabilization care authorization decisions.

Completion of Covered Services

KHS, at the request of a member, provides for the completion of covered services by a terminated provider or by a nonparticipating provider. The completion of the covered service shall be provided by a terminated provider to a member who, at the time of the contract's termination, was receiving services to include:

- Acute Condition,
- Chronic Condition,
- Pregnancy,
- Terminal Illness,
- Care of a Newborn (between birth and 36 months of age),
- Performance of a surgery or other procedure authorized by the plan as part of a course of treatment,
- Applied Behavioral Analysis,
- Mental Health Condition.

The plan may require a non-participating provider, whose services are continued, to agree in writing to the same contractual terms and conditions that are imposed upon providers under current contract.

Standing Referrals

Occasionally a member will have a disease that requires prolonged treatment by or numerous visits to a specialty care provider. Once it is apparent that a member will require prolonged specialty services, UM may issue a standing referral and provide a determination within three working days from the request date made by the member or the PCP after obtaining all appropriate medical records and information. The referral must be made within four working days of the date of the proposed treatment plan. A standing referral is an authorization that covers more visits than an initial consultation and customary follow-up visits and typically includes proposed diagnostic testing or treatment. Members are referred to providers who have completed a residency encompassing the diagnosis and treatment of the applicable disease entity.
A standing referral may be limited by number of visits and/or length of time. It is only valid during periods when the member is eligible with KHS. A standing referral may be issued to contracted or non-contracted providers as deemed appropriate by the Chief Medical Officer, or their designee(s). The Director of Provider Relations will negotiate letters of agreement for services not available within the network.

Collaboration of Services

The scope of the UM licensed staff extends beyond the management of referrals. While performing UM activities, any quality-of-care concerns may be addressed with the practitioners or provider organizations and are reported to the QI department. Collaboration between UM and QI is essential to ensure the delivery of quality care to the plan's membership.

Continuity of Care is provided upon enrollment for those members with established relationships with Primary Care Providers, Specialists, and ancillary providers to promote uninterrupted services that may have been initiated prior to the member's enrollment with KHS.

KHS is also required to provide beneficiaries with continuity of care from a non-participating provider or from a terminated provider, subject to certain conditions. The beneficiaries must be given the option to continue treatment for up to 12 months.

KHS must provide continuity of care with an out-of-network provider when KHS is able to determine that the beneficiary has an ongoing relationship with the provider (self-attestation is not sufficient to provide proof of a relationship with a provider); the provider is willing to accept the higher of the KHS's contract rates or Medi-Cal Fee for Service rates; and the provider meets KHS's applicable professional standards and has no disqualifying quality of care issues.

Collaboration with other outside agencies such as Kern Regional Center, Department of Public Health, Department of Mental Health, Homeless Coalition and Housing Authority, Department of Aging and Health and Human Services, California Children Services, Denti-Cal, and other internal KHS departments and coordination of services for the KFHC membership is an important aspect of the UM process. The UM Nurse and Clinical Intake Coordinator assist the members in obtaining carved-out services and when necessary, coordinate and provide services not covered by the carved-out practitioner/provider.

The UM Nurse and Clinical Intake Coordinator coordinates Mental Health services with Kern Behavioral Health and Recovery Services through a Memorandum of Understanding pursuant to a contract between the County and the State. This coordination is essential to provide members with a seamless transition between mental health services beyond the scope of KHS responsibility to manage mild to moderate symptomatology and the more severe diagnosis under the responsibility of the County System of Care.

In addition, KHS UM staff also coordinates autism spectrum disorder (ASD) and Behavioral Intervention services with Kern Regional Center (KRC) through a Memorandum of Understanding. This coordination is essential in order to provide members with uninterrupted medical and supportive services as they transition between the systems of care.

The UM Nurse and Clinical Intake Coordinator also coordinates Specialty children's services with California Children's Services (CCS) through a Memorandum of Understanding. This

coordination is essential in order to provide members with uninterrupted medical services as they transition between the systems of care.

Regularly scheduled quarterly (or more often if deemed necessary) Joint Operations Meetings are held with Mental Health, CCS, and Regional Center partners to promote coordination, quality, and timely decisions regarding member's identified needs.

The UM Nurse and Clinical Intake Coordinator also identifies members who are eligible and could benefit from KHS internal programs such as Health Homes Program, Complex Case Management, Disease Management, and Transitional Care programs in order to link them to additional supportive services to improve member health outcomes. Member health education and disease management are important components in member Case Management. Improvement of the member's health is a collaborative effort between the member and the member's practitioner, KHS Health Education, Disease management, UM Nurse and Clinical Intake Coordinator, and numerous community partnerships.

Continuity of Care

Continuity of Care with an Out-of-Network Provider for Medi-Cal Members Transitioning into Medi-Cal Managed Care

Medi-Cal members assigned a mandatory aid code and who are transitioning from Medi-Cal fee-for-service (FFS) into a Medi-Cal managed care assigned to KHS have the right to request continuity of care in accordance with state law, DHCS All Plan Letter (APL18-008) and the DHCS-KHS contract, with some exceptions. All KHS members with pre-existing provider relationships who make a continuity of care request to KHS will be given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider. These eligible members may require continuity of care for services they have been receiving through Medi-Cal FFS or through another Managed Care Plan. The following guidelines will be applied:

1. KHS is able to determine that the member has an existing relationship with the provider (self-attestation is not sufficient to provide proof of a relationship with a provider):
    a. An existing relationship means the member has seen an out-of-network primary care provider (PCP) or specialist at least once during the 12 months prior to the date of his or her initial enrollment with KHS for a non-emergency visit, unless otherwise specified in the All-Plan Letter (APL18-008).
2. The provider is willing to accept the higher of KHS's contract rates or Medi-Cal FFS rates,
3. The provider meets KHS's applicable professional standards and has no disqualifying quality of care issues (for the purposes of this APL, a quality-of-care issue means KHS can document its concerns with the provider's quality of care to the extent that the provider would not be eligible to provide services to any other KHS members),
4. The provider is a California State Plan approved provider,

5. The provider supplies KHS with all relevant treatment information, for the purposes of determining medical necessity, as well as a current treatment plan, as long as it is allowable under federal and state privacy laws and regulations.

Continuity of Care – Terminated Providers

Continuity of care will be provided in accordance with the statutory, regulatory, and contractual requirements outlined in the following sources: California Health and Safety Code §§ 1373.65; 1373.95; and 1373.96.

Upon member request, KHS' Utilization Management (UM) Department will utilize defined guidelines as outlined in California Health and Safety Code §§ 1373.65; 1373.95; and 1373.96 to authorize as appropriate continuity of care with a terminated provider who has been providing care for an acute condition or a serious chronic condition, for a high-risk pregnancy, or for a pregnancy that has reached the second or third trimester. In cases involving an acute condition or a serious chronic condition, KHS shall furnish the member with health care services on a timely and appropriate basis from the terminated provider for up to 90 days or a longer period if necessary for a safe transfer to another provider as determined by the plan in consultation with the terminated provider, consistent with good professional practice. In the case of a pregnancy, the plan shall furnish the enrollee with health care services on a timely and appropriate basis from the terminated provider until postpartum services related to the delivery are completed or for a longer period if necessary for a safe transfer to another provider as determined by the plan in consultation with the terminated provider, consistent with good professional practice.

Continuity of care will not be authorized with a provider whose contract has been terminated or not renewed for reasons relating to medical disciplinary cause or reason[i] or fraud or other criminal activity.

Delegation

Delegation of Utilization Management Functions

KHS has the discretion to delegate, and the responsibility to oversee, UM functions performed by either Kaiser Foundations Health Plan in support of the KHSUM goals and objectives. KHS also has discretion to delegate responsibility, in whole or in part, for UM to contracted affiliated providers. KHS retains accountabilities for all delegated Utilization Management activities conducted for members and ensures that delegated UM processes are designed to meet member service and access needs.

On an annual basis, KHS performs a comprehensive assessment of the delegated UM activities to include a UM file review. The entity's annual evaluation of delegated UM functions and assessment summaries of activities are presented to KHS Medical leadership for review and approval.

Should there be any concerns regarding failure of a delegated entity to carry out delegated activities, KHS will determine corrective action plans up to and including revocation of the delegated activities. All submitted corrective action plans are monitored by the KHS Compliance department and evaluated until KHS determines that full correction action has been implemented.

UM Delegation to Affiliated Providers

When UM activities are delegated to contract affiliated providers, KHS retains responsibility and oversight of the delegated functions. The delegation is subject to an executed delegation agreement in which UM activities are clearly defined, including:

- Reporting requirements for the delegated entity,
- Reporting requirements for KHS to the delegated entity,
- Evaluation process of the delegated entity's responsibilities,
- KHS Approval of the delegated entity's UM program and processes,
- Mechanisms for evaluating the delegated entity's program reports,
- The delegated entity's ability to collect performance data necessary to assess member experience and clinical experience, as applicable,
- KHS right to revoke and terminate a delegation agreement.

Delegation of UM Activities

KHS has delegation oversight activities/processes for pre-delegation evaluation, delegation oversight activities, and regular reporting used to monitor delegates according to the standards established by KHS, licensing, and regulatory bodies. KHS may delegate Utilization Management (UM) and Pharmacy functions/activities to entities with established Quality Improvement and Utilization Management programs and policies consistent with licensure and regulatory requirements.

KHS remains accountable for and has appropriate structures and mechanisms to oversee delegated activities even if it delegates all or part of these activities. KHS tracks and processes all KHS member's UM activity internally with the exception of Kaiser assigned MCAL members whose UM functions are delegated as part of a two-way agreement under contractual requirement with DHCS.

Delegation Agreement Process

KHS provides ongoing monitoring of UM activities that are delegated to contract providers. The delegated functions are reviewed and approved on an annual basis by the QI/UM and Delegation committees. A comprehensive delegation audit is conducted by KHS at a minimum annually. A delegation agreement, including a detailed list of activities delegated and reporting requirements is signed by both the delegate and KHS.

The delegation agreement outlines the responsibilities and activities of the physician network and the managed care organization that is delegated to provide utilization management services.
Delegates undergo a pre-delegation audit (survey) conducted by KHS to assure that the Medical Group/IPA is capable in its ability to meet the standards of the Plan and those of the Act and the rules there under and has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities.
The delegation agreement includes the following:

- Mutually agreed upon before delegation starts,
- Describes the delegated activities and the responsibilities of KHS and those of the contracted entity and the delegated activities,
- For each activity, KHS has identified the documented reporting requirements at least semi-annually and delegated activities of the delegated entity to KHS,
- Describes the process by which KHS evaluates the delegated entity's performance for providing member experience and clinical performance data to its delegates when requested,
- Describes the remedies available if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.

Joint Operations meetings are conducted quarterly in addition to an annual delegation audit to ensure compliance with DHCS regulatory requirements.

Delegated Triage Services

KHS contracts with a third-party vendor to provide 24/7, weekend and holiday triage services for all KHS members. The vendor provides not only triage services but also supports a member-initiated Health Library to promote education on a varying number of topics. Reports are generated monthly to monitor their activities as well as identify member patterns during execution of after hour services. Joint Operations meetings are conducted quarterly to ensure compliance with DHCS regulatory requirements.

Delegated Vision Care

Vision Care is delegated to a 3rd party vendor and capitated for all vision services. Reports are generated monthly to monitor their activities as well as identify utilization patterns. Joint Operations meetings are conducted quarterly to ensure compliance with DHCS regulatory requirements.

KHS contracts with a vendor, Health Dialog, to perform 24-hour Nurse Advice and triage call center activity and provides summary reports detailing the utilization of services at scheduled intervals. The report is reviewed for trending of ER and Urgent Care usage based on total usage compared against deferment back to the PCP and Home/Self Help care. Monthly touchpoints are scheduled to address any issues or trends identified. Actions plans are developed if utilization patterns raise concerns for escalation. Health Dialog provides a Health

Audio Library for member self-service of specific health topics or acute/chronic condition education.

All delegated entities are required to support and adhere to the same regulatory reporting and access standards as KHS. KHS has the responsibility to the Delegated or Subcontractor's agreement to revoke the delegation of activities or obligations or specify other remedies in instances where DHCS or KHS determine that the Subcontractor has not performed satisfactorily.

Complete delegated oversight audits are conducted at least annually, and more often if warranted, to ensure all aspects of KHS's contract are performed to the standards outlined by DHCS and DMHC.

KHS will determine corrective action plans up to and including revocation of the delegated activities. All submitted corrective action plans are monitored by the KHS Compliance department and evaluated until KHS determines that full correction action has been implemented.

Under and Over Utilization

KHS monitors under- and over-utilization of services through various aspects of the UM process including Behavioral Health Services. Through the referral authorization process, the UM Clinical Intake Coordinator/UM Nurse monitors under and over-utilization of services and intervenes accordingly including non-specialty mental health services utilization data for both adult and pediatric members.

- The UM department monitors underutilization of health service activities through collaboration with the QI department. The UM department sends correspondence notifying the practitioners and members of the carved-out services and a reminder to see their primary care provider for all other health care services not addressed by the carved-out specialty care provider for gaps in care closure,
- Over-utilization of services is monitored through several functions. Reports are reviewed to analyze unfulfilled authorizations or gaps in care to determine interventions directed to ameliorate any identified adverse trends,
- Upon request, KHS will report to DHCS all its internal reporting mechanisms used to detect member utilization and provider prescribing patterns,
- KHS monitors utilization data to appropriately identify members eligible for

Medical Loss Ratio

Medical Loss Ratio (MLR) is a metric used in managed health care and health insurance to measure medical costs as a percentage of premium revenues. KHS has placed major emphasis on the reduction of MLR to monitor and manage utilization within the health plan. Areas of focus include achieving an overall Key Performance Indicators (KPI) metrics Goal of <92% across all lines of business-SPD, Family/Other, and Expansion. Dashboards provide transparency to the plan's Executive leadership of all identified KPI.

Resource Management

Resource Management activities focus on the prudent and clinically appropriate allocation of resources for the provision of health care services. These activities are not subject to direct regulation under the Knox-Keene Act. The UM Program monitors and provides oversight of coordinated performance related to Utilization/Resource Management across the continuum to include:

- Drug Utilization,
- Laboratory Utilization,
- Product Utilization,
- Radiology Utilization,
- Surgical Utilization.

Evaluation of New Medical Technologies

KHS evaluates a variety of web-based interactive applications for future consideration of medical technologies adoption. KHS MIS department develops and implements new technologies as they emerge to provide efficient methods of tracking member activity and report generation. UM clinical staff have direct access to various websites for review and reference for discussions on innovative methods not currently in use by KHS that may be implemented in the delivery of healthcare to KHS members. New technologies are vetted with MCAL guidelines for coverage, then forwarded to the PAC and QI/UM committees before board approval.

KHS evaluates and addresses new developments in technology and new applications of existing technology for inclusion in its benefit plan to keep pace with changes and to ensure members have equitable access to safe and effective care.

Written process includes an evaluation of the following:

- Medical Procedures,
- Behavioral healthcare procedures,
- Pharmaceuticals,
- Devices.

Description of the Evaluation Process- KHS written evaluation process includes the following:

- The process and decision variables KHS use to make determinations,
- A review of information from appropriate government regulatory bodies,
- A review of information from published scientific evidence,
- A process for seeking input form relevant specialists and professionals with expertise in the technology.

The following information is gathered, documented, and considered for determination:

- Proposed procedure/treatment/medication device,
- Length of time the treating practitioner has been performing the procedure/treatment,
- Number of cases the practitioner has performed,

- Privileging or certification requirements to perform this procedure,
- Outcome review: mortality during a global period, one year out and five years out; other known complications, actual and anticipated,
- Identification of other treatment modalities available,
- Consideration as to whether Medicare/Medi-Cal approves the service/procedure,
- Whether the medication/procedure is FDA approved,
- Literature search findings,
- Input from network Specialist.

The CMO, or designee, or other clinical department directors, consult specialists, market colleagues, the Physicians Advisory Committee (PAC) and/or the Pharmacy and Therapeutics Committee (P&T) as needed to assist in making coverage determinations and/or recommendations.

Medical Reviews and Audits by Regulatory Agencies

KHS' Director of Compliance and Regulatory Affairs, in collaboration with the CMO, Chief Health Services Officer, and other Health Services clinical leadership, provides direct oversight to all KHS medical audits and other inquiries by our regulatory agencies, DHCS and DMHC. Recommendations or sanctions received from regulatory agencies for medical matters are addressed through the QI/UM Program. CAPs for medical matters are approved and monitored by the QI/UMC.

Integration of Study Outcomes with KHS Operational Policies and Procedures

KHS assesses study outcomes over time and, as a result of key quality issue identification and problem resolution, develops changes in strategic plans and operational policies and procedures. Study outcomes are assessed, and changes may be incorporated into the KHS strategic plan and operational policies and procedures to address those outcomes and incorporate ongoing quality issue solutions into organizational operations.

Provider and Member Satisfaction

Satisfaction Surveys are conducted annually by the KHS Member Services and Provider Relations Department. Results are shared with the Executive leadership and other KHS departments. Any unsatisfactory areas of the UM process are re-evaluated by the KHS Chief Medical Officer or designee, Chief Health Services Officer, and the Director of Utilization Management to develop and implement strategies to ameliorate deficiencies.

KHS participates in the Consumer Assessment of Health Plan Survey (CAHPS) Member Satisfaction Survey and utilizes these results in the assessment of member experience with the UM program. Analysis of grievance and appeal data related to UM is also monitored as a part of the member experience review.

KHS contracts with physicians and other types of health care providers. Provider Relations conducts assessments of the network adequacy of contracting providers. All PCPs and

specialists must meet KHS credentialing and recredentialing standards. Contracting providers must meet KHS requirements for access and availability. Members may select their PCPs based on cultural needs and preferences. The Provider Directory lists additional languages spoken by PCPs or their office staff and includes other information related to disability accommodations and hours of operation. The Provider Directory is 274 compliant with DHCS requirements and is available to members in printed or electronic versions.

Annual Program Evaluation

On an annual basis, KHS evaluates and revises as necessary, the UM Program Description and Evaluation. The Chief Medical Officer, in collaboration with the Chief Health Services Officer, documents a yearly summary of all completed and ongoing UM Program activities with documentation of evidence of improved health care or deficiencies, status of studies initiated, or completed, timelines, methodologies used, and follow-up mechanisms. The UM summary also includes the program scope, processes, information sources used to determine benefit coverage and medical necessity, and the level of involvement of the senior-level physician and designated behavioral healthcare practitioner in the UM program. A written evaluation of the UM Program is prepared and reported to the QI/UM Committee and Board of Directors annually.

As Part of the annual evaluation an Executive Summary is developed to analyze and evaluate the annual undertakings and effectiveness of the UM Program Where the evaluation shows that the program has not met its goals, the organization recommends appropriate changes incorporated into the subsequent annual UM Program Descriptions.

On an annual basis, the QI/UM Committee and Board of Directors will set thresholds for at least four data types, such as admission data, ER utilization, practitioner performance and behavioral health against the established thresholds to detect under-and over utilization.

Record Retention

KHS maintains all records and documents necessary to disclose how it discharges its obligations under the state contract. These records and documents will disclose the quantity of Covered Services provided, the quality of those services, the manner and amount of payment made for those services, the persons eligible to receive Covered Services, the way KHS administered its daily business, and the cost thereof.

In addition, and in accordance with 42 CFR section 438.3(u), KHS will retain the following information for no less than ten years and allow auditing entities to inspect and audit:

- Member Grievance and Appeal records as required in 42 CFR section 438.416,
- Base data as defined in 42 CFR section 438.5(c),
- MLR reports as required in 42 CFR section 438.8(k), and
- Data, information, and documentation specified in 42 CFR section 438.604, 438.606, 438.608, and 438.610.

Records relating to prior authorization requests, including any Notices of Action (NOA) will meet the retention requirements as described in Exhibit E, Section 1.22 (Inspection and Audit of Records and Facilities).

_____ Date _____

KHS Board of Directors (Chair/Designee)

_____ Date _____

Chief Executive Officer

_____ Date _____

Chief Medical Officer

[i] As defined in B&P Code §805(a)

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS
POPULATION HEALTH MANAGEMENT QUARTERLY REPORT

Background

The Case Management Department has transitioned to Population Health Management (PHM) on January 1, 2023. PHM is an initiative led by DHCS, which is a cornerstone of the California Advancing and Innovating Medi-Cal (also known as CalAim). The DHCS developed a framework that broaden delivery systems, program, and payment reform across the Medi-Cal Program.

PHM brings health concerns into focus and addresses ways that resources can be allocated to improve the health of a defined group, health equity and quality of care for all Medi-Cal members (Southern New Hampshire University, 2023). The purpose of PHM is to engage members with their health care and address social determinants of health and gaps in care while reducing costs. The primary care physician is the quarterback who catches problems early with screening and refers patients to specialists, if needed. PHM is an interdisciplinary effort in collaboration with hospitals, federally qualified health care center, county agencies, schools, regional centers, and other partnering agencies. Overall, PHM strives to deliver the right care to the right patient at the right time.

Introduction

The Kern Health System, (KHS) PHM Department provides a comprehensive integrated process that evaluates and manages the utilization of health care services and resource delivery to members. The program identifies members' health care and social needs which supports improved health outcomes for individuals. When a KHS member enrolls in PHM, they receive:

- Health care support from registered nurse
- A care plan based on recommended treatment
- Assistance from a social worker and certified medical assistants, as needed
- Help coordinating services among providers
- Assistance in finding community service

In collaboration with medical providers and partnering agencies, the department helps members access resources and preventative services and ensures that members stay healthy. The team is comprised of Registered Nurse Case Managers, Social Workers, Certified Medical Assistants, Community Health Workers, and Outreach Specialists.

Purpose

The purpose of this report is to provide updates on PHM's progress and successes on its activities. The report identifies the following:

- Demographics of members
- Level of acuity of care management
- Reasons of closure or exiting from Care Management Program
- Resources to address gaps in care and social determinants of health
- Total number of Seniors and Persons with Disabilities (SPDs)
- Action items and opportunities for improvement

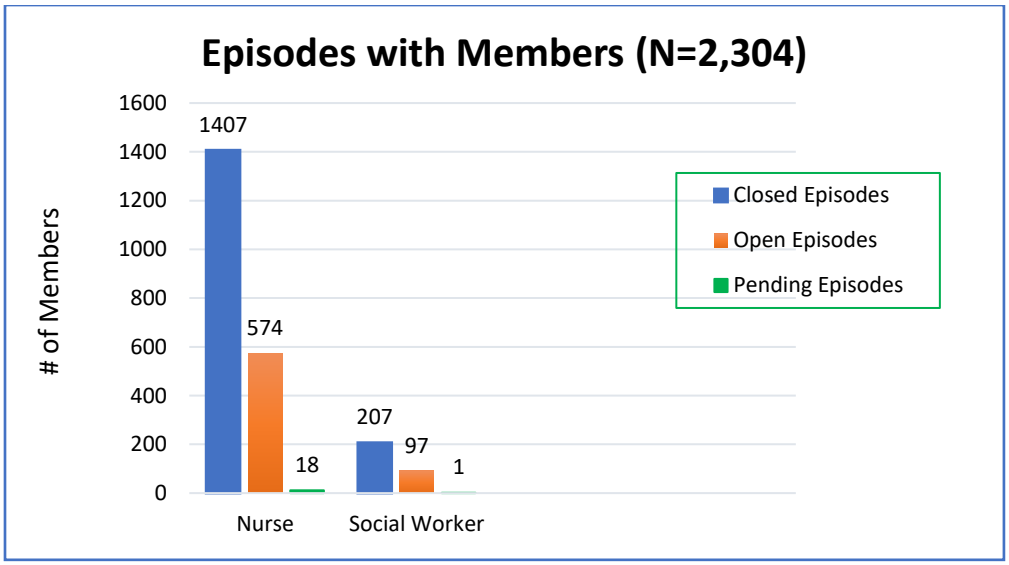
The data is generated through KHS' electronic health record, JIVA system The reporting period is July 1, 2023 through September 30, 2023.

Data

Graph 1: Episodes with Members

During the months of July through September (Quarter 3), a total of 2,304 members were managed by the Population Health Management Department. In comparison to Quarter 2, there has been a 1% slight decrease in members.

- Quarter 1 = 1,970 members
- Quarter 2 = 2,400 members
- Quarter 3 = 2,304 members

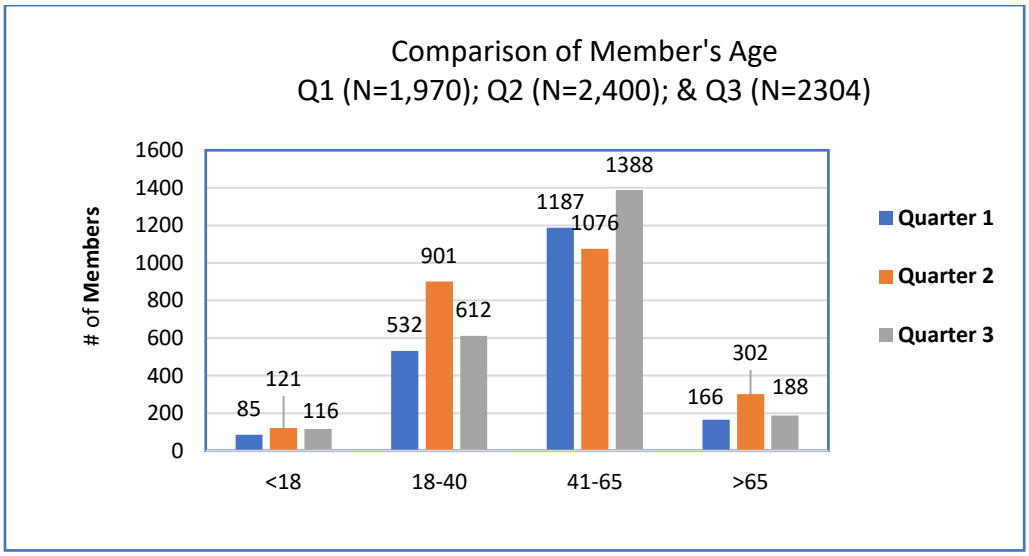


The Nurses provide medical coordination of care and services to members and help navigate the healthcare system to facilitate the appropriate delivery of care and services. The Social Workers plan and implement social service delivery programs, promote coordination, continuity of care, and quality management in support of KHS members. Both Nurses and Social Workers ensure member's case is appropriately closed. Reasons for closures include successful completion of goals in the care plans, lost to follow up and declined program services.

KERN HEALTH SYSTEMS

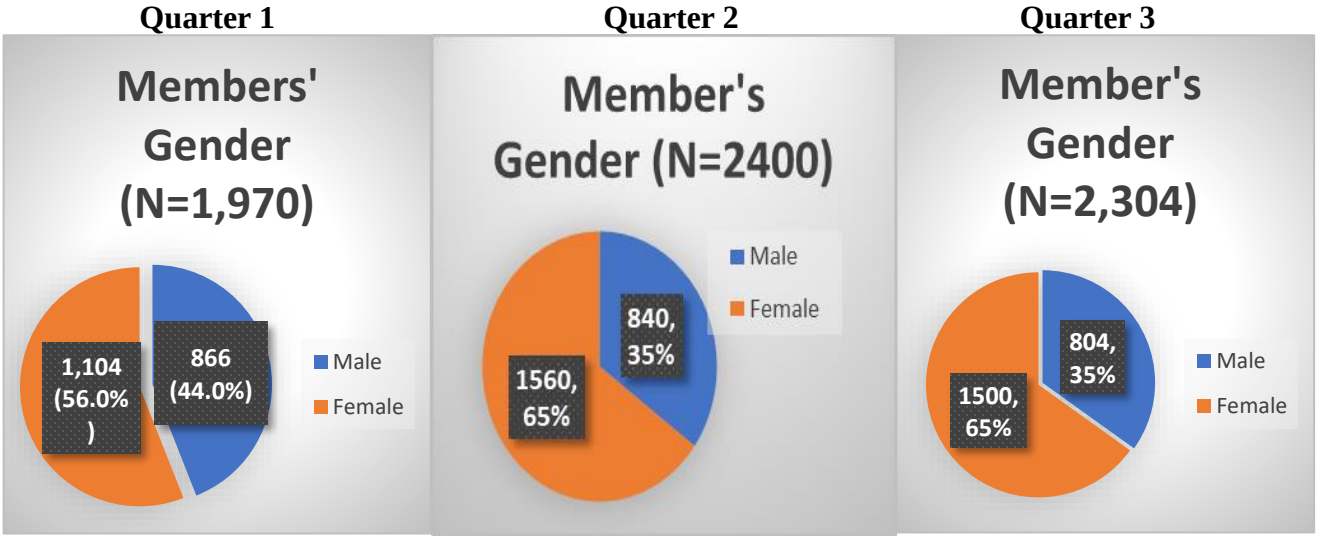
Graph 2: Member's Age

During the months of July through September, of the 2,304 members, there were 1,388 (60%) members who were 41-65 of age, 612 (27%) members were 18-40 of age, 188 (8%) members were ages greater than 65 of age, and 116 (5%) were less than 18 of age.



Graph 3: Gender

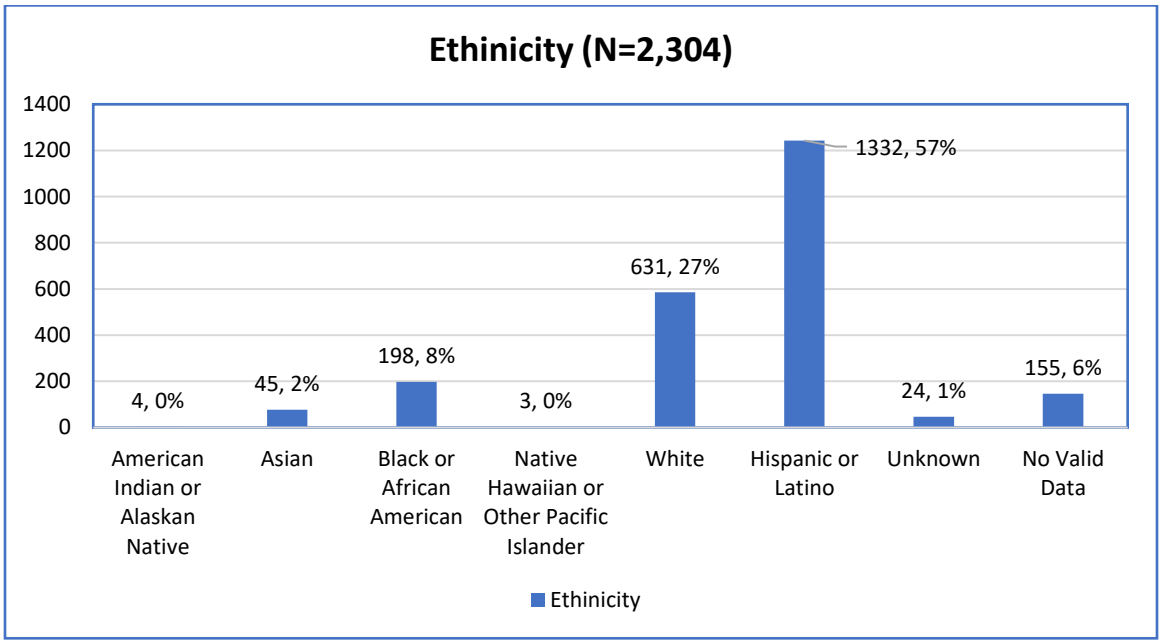
Of the 2,304 members managed during the months of July through September, there were 65.0% members who were female and 35.0% members who were male.



KERN HEALTH SYSTEMS

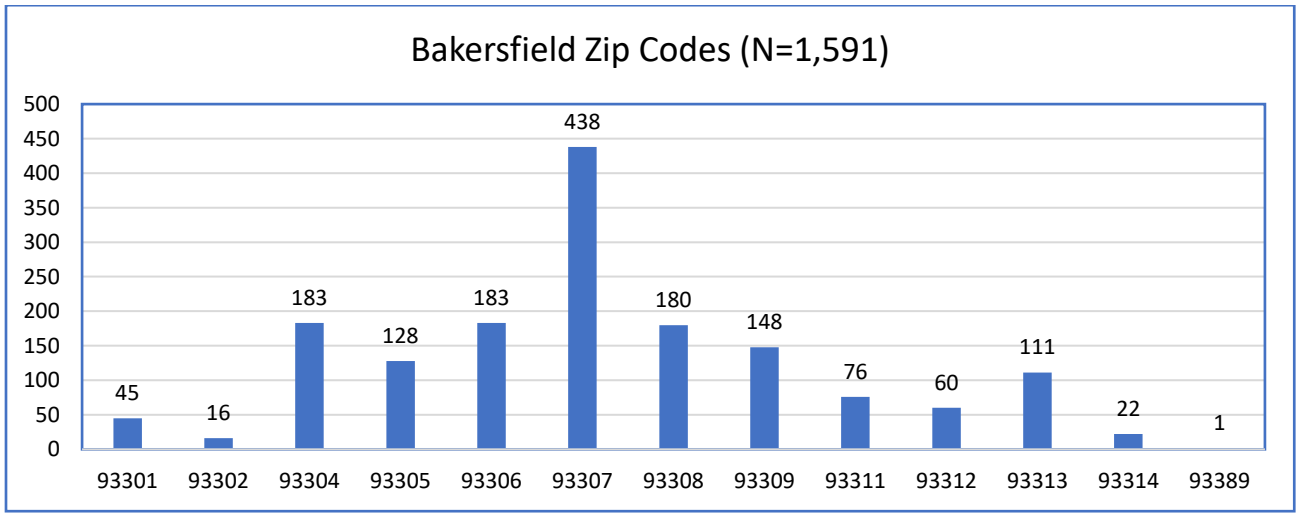
Graph 4: Ethnicity

KHS members are diverse with most members (57%) identifying as Hispanic and small proportion are American Indian or Alaskan Native, Asian, and Native Hawaiian or Other specific Islander. Spanish-language education, documents, and services will continue to be needed as the Hispanic population continues to grow.



Graph 5: Member's by Zip Codes

The top 3 zip codes where members reside are in 93307, 93304 and 93306. Even when members have health insurance coverage, these individuals with limited funds, mobility issues, or lack of transportation options still may not be able to get the care they need, especially those that live in the outskirts of Bakersfield.



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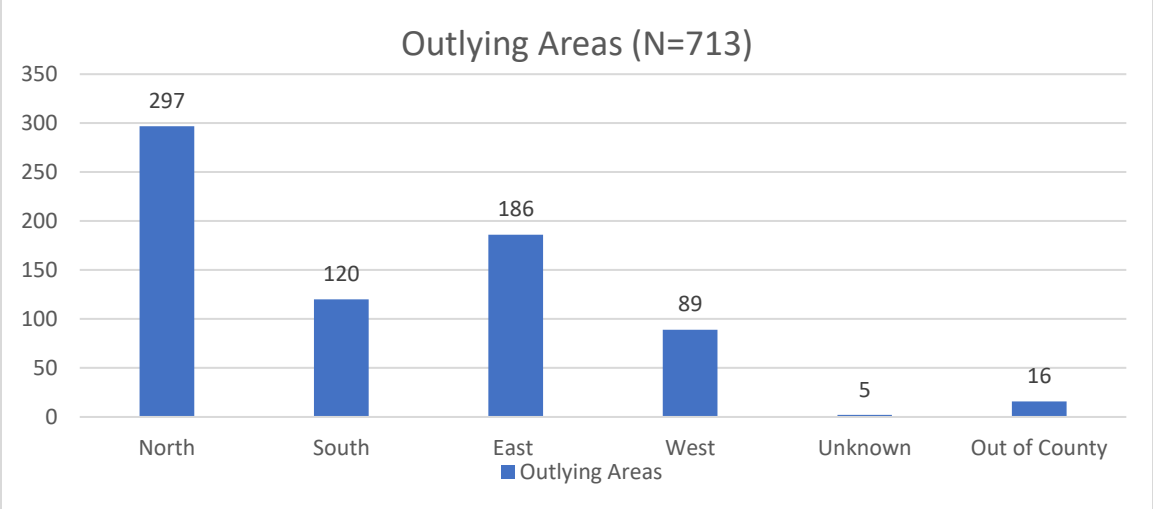
Graph 6: Members Residing in Outlying Areas

The data illustrate the total number of members who reside in the outlying areas. Outlying areas is defined as any areas outside of greater Bakersfield. This is the dividing boundaries:

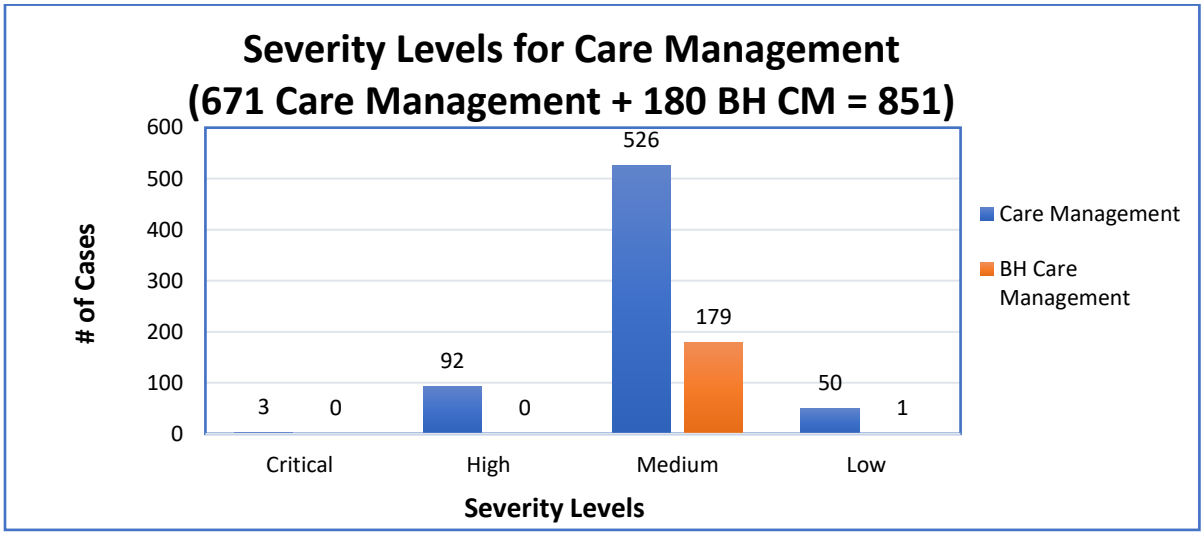
- Any areas situated south of 58 = South Kern (e.g. Arvin, Lamont, and Lebec)
- Any areas situated north of 46 = North Kern (e.g. Delano, McFarland, and Wasco)
- Any areas situated east of 99/5 = East Kern (e.g. Lake Isabella, Ridgecrest, and Mojave)
- Any areas situated west of 99/5 = West Kern (e.g. Buttonwillow, Taft, and Maricopa)



Graph 7: Severity Levels for Case Management

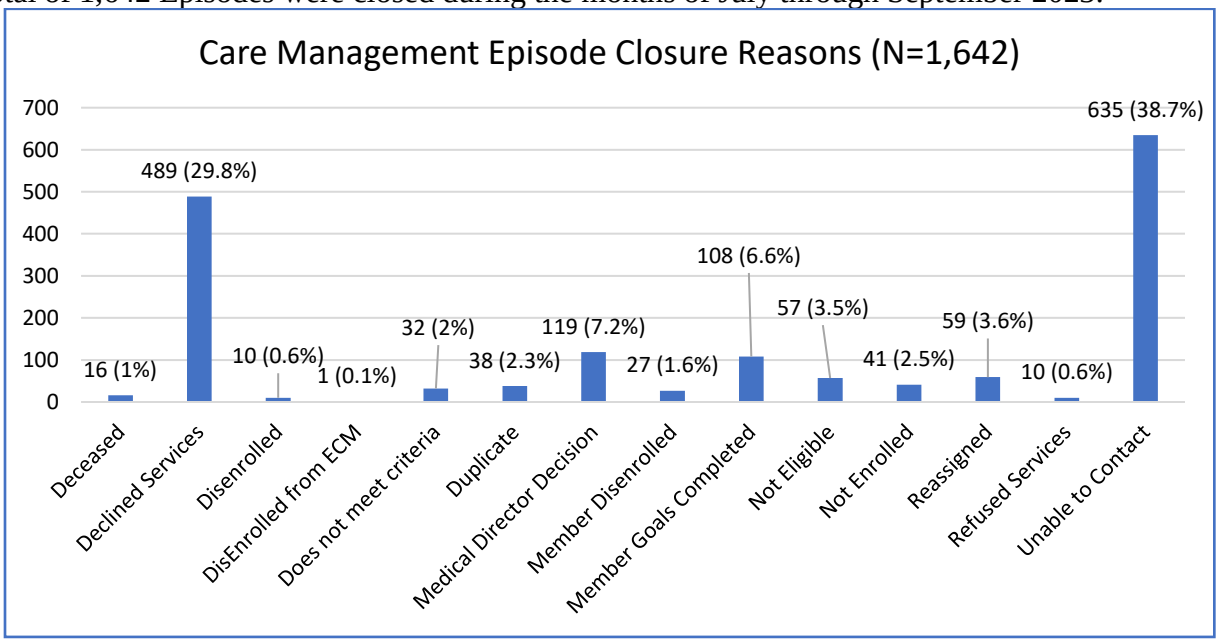
PHM assign members to risk tiers that are critical, high, medium, and low risk levels, with the goal of determining appropriate care management programs or other specific services. These members are assigned to appropriate staff.

1. Critical-Requires minimum of weekly contact and significant care coordination assistance with acute needs.
    - Examples include frequent admits with ER visits, Falls, limited adherence to provider instructions, care plan, caregiver, or unstable social situation, including lack of support or caregiver burnout.
2. High-Requires minimum contact every two-four week and has active care coordination needs.
    - Examples include an admit or ER visit within 6 months or fall with injury within the last 6 months, SNF admission within last year, questionable adherence with medications and/or care plan, or social issues.
3. Medium- Minimum contact every 30 days. Member in process of change and requires minimum support and follow up with care coordination.
    - Examples include no admits or ER visits in the past year, no mechanical falls, adherent with medications and care plan, no outstanding social issues, significant provider engagement/control.
4. Low-Case Management not required. Provide educational materials and recommendations as needed, confirm care coordination is in effect and plan for closure.



Graph 8: Case Management Episode Closure Reasons

A total of 1,642 Episodes were closed during the months of July through September 2023.

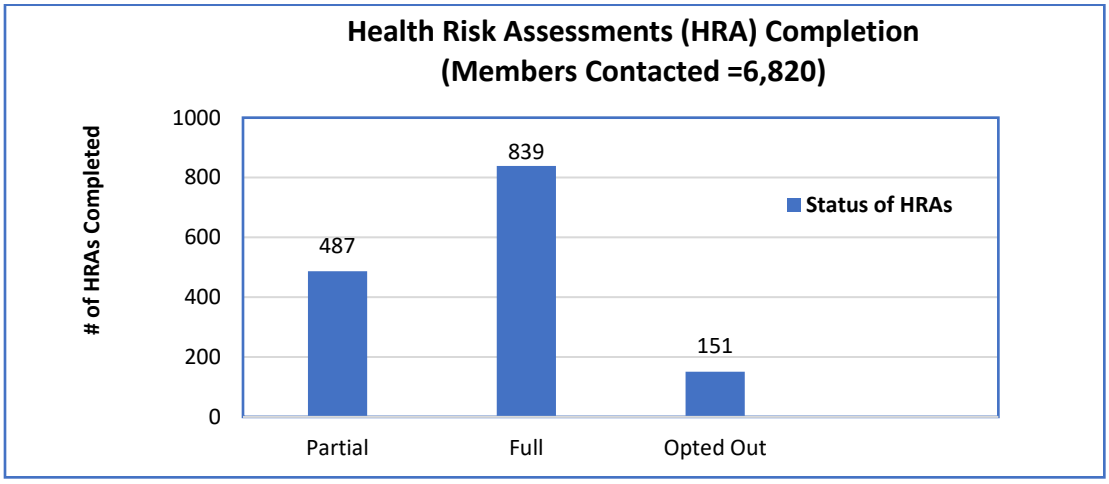


There are opportunities to increase the number of completions with member goals (6.6%). One strategy is to conduct a random chart audit to review member's goals and ensure goals are simple and realistic. About 38.7% of members were closed due to unable to contact. Members who are receiving services This also includes members who are engaged and actively participating with their plans of care and receiving services but suddenly, these members are unable to contact for various reasons. There are opportunities to clearly define this category, and separate members who are receiving services. PHM will work toward decreasing the percentage of members to decline (29.8%) KHS services/programs. PHM will obtain feedback from members on reasons why they declined services.

#	Reasons for Closure	Definition
1	Declined services	Contacted members but declined KHS services
2	Does not meet criteria	individuals are enrolled in hospice, possess Medicare benefits (e.g. Kaiser), and reside in long term care facility for >30 days
3	Duplicate	Duplicate referrals
4	Medical director decision	Transferred to another KHS program/services
5	Member disenrolled	Members dropped from the KHS, moved out of county, have secondary insurance
6	Member goals completed	Successfully achieved goals in the plan of care
7	Non-compliant—MD approval obtained	Members who are noncompliant with care, exhausted all resources and reviewed by medical director
8	Not eligible	members who are not eligible for KHS services
9	Reassigned	Reassigned members to another staff
10	Refused services	Currently receiving case management services but no longer desire to continue with services
11	Unable to contact	Lost to follow up, exhausted all resources to contact members. This also includes members who are engaged, actively participates with care but all the sudden unable to contact members for whatever reasons.

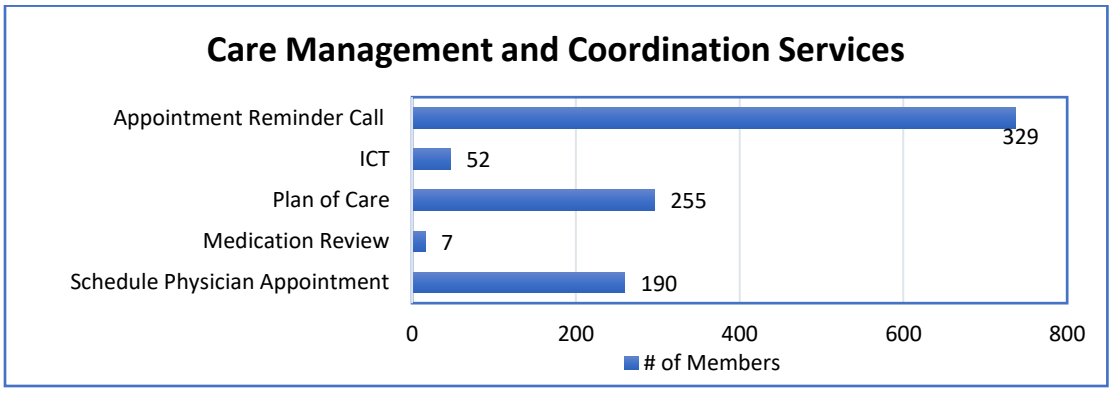
Graph 9: SPD Health Risk Assessment Information

During July through September, a total of 6,820 members were successful contacts made by KHS vendor. Only 12% (839) members fully completed the HRA, 7% (487) partially completed the HRA, and 2% (151) opted out.



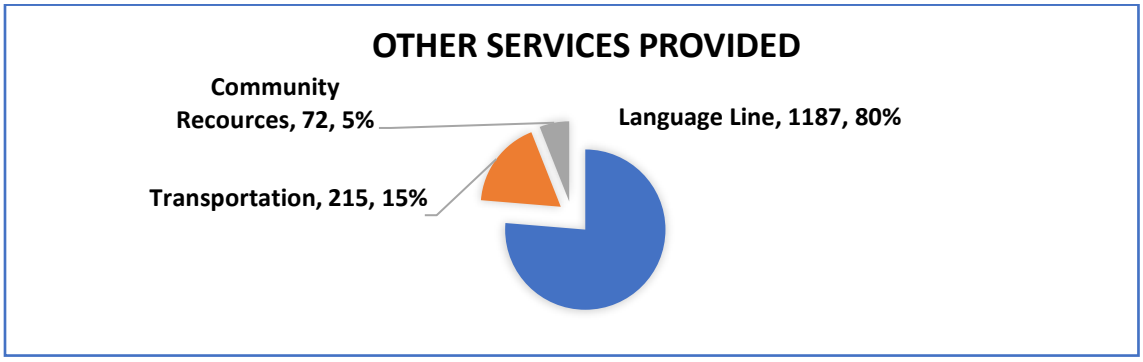
Graph 10: Care Management and Coordination Services

The graph illustrates the various types of care management and coordination services provided to members. These services include schedule physician appointments, appointment reminder calls medication reviews, and develop plans of care. The member's challenges/barriers with their care are presented in the interdisciplinary care team (ICT) to obtain guidance from the team.



Graph 11: Other Services Provided to Members

Other services that are available to the members include language line for language interpreting and translation service; transportation services to get to their medical appointments; and referral to various community resources (e.g., Food Bank, Housing Authority, and In Home Supportive Services, etc.).



Graph 12: Seniors and Persons with Disabilities (SPDs)

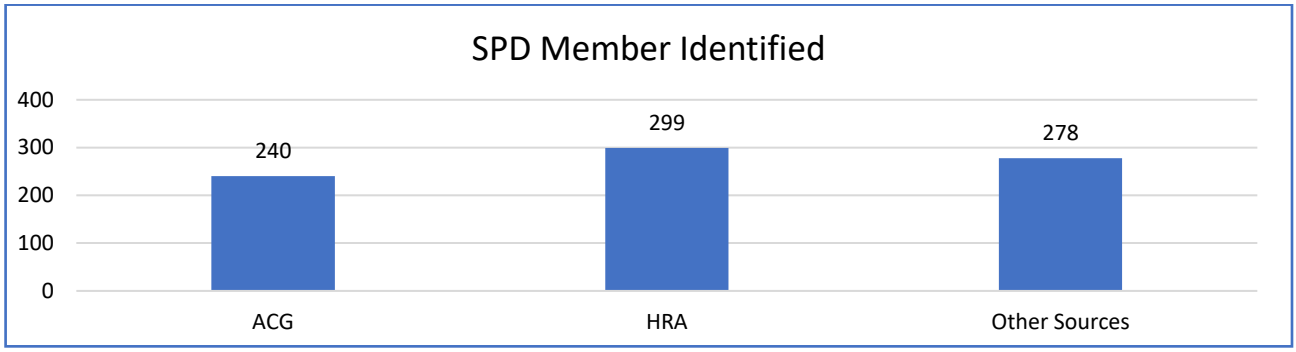
SPD Members are identified for Complex Case Management using the John Hopkins Adjusted Clinical Groups (ACG) Predictive Modeler, Health Risk Assessments and other sources including member requests and outside and internal requests. This allows KHS to identify populations with similar characteristics and develop targeted interventions.

The ACG Modeler is run monthly to identify members at risk of hospitalizations in six (6) months and members with the greatest need for health intervention or care management. These members are enrolled in complex care management. Members with multiple co-morbidities are identified and referred to KHS specialty programs and services.

SPD Members are identified for Complex Care Management through use of the John Hopkins Predictive Modeler, through Health Risk Assessments and other sources including member requests and outside and internal requests.

The SPD population represents a total of 35.5 percent (817) of the Complex Group in July thru September 2023. The John Hopkins Predictive Modeler identified SPD's represent 29.4% percent of

the SPD's identified in the Complex Group in July thru September 2023. HRA identified SPD members represent 36.6% and other sources of SPD members represent 34%.



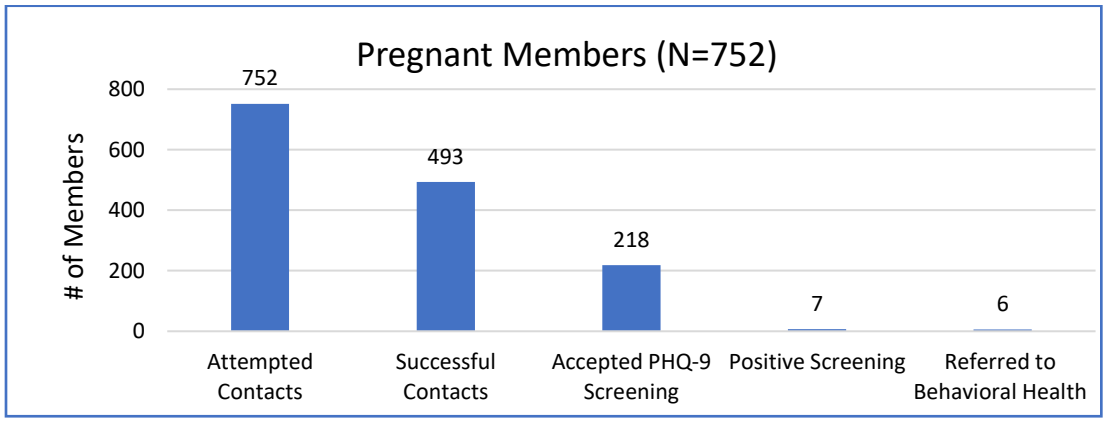
Graph 13: Maternal Mental Health Program (Baby Steps)

According to the Centers for Disease Control (CDC) and Prevention, about 1 in 8 women suffers symptoms of postpartum depression. The rate of depression diagnoses at delivery is increasing, and it was seven times higher in 2015 than in 2000 (CDC 2023). On average, 13% of women have symptoms of depression after birth of baby (CDC 2023). Wisner et al.3 (2013) suggests that among women who screen positive for depression in the postpartum period, the onset of depression occurs before delivery for the majority of women (ACOG). Wisner et al. found that depression onset occurred prior to pregnancy among 27% of women, during pregnancy for 33%, and in the postpartum period for the remaining 40% (ACOG).

In March 2023, we implemented PHQ-9 screening to all pregnant and postpartum women and launched the Maternal Mental Health (MMH) Program. The purpose of the Maternal Mental Health Program is to:

- Provide mental health screening for women during pregnancy and postpartum.
- Identify those who are at risk for depression and need further evaluation.

In September 2023, the Baby Steps Program was transferred to Population Health Management. The MMH Program was integrated in the Baby Steps Program. The MMH Program is now known as Baby Steps Program.

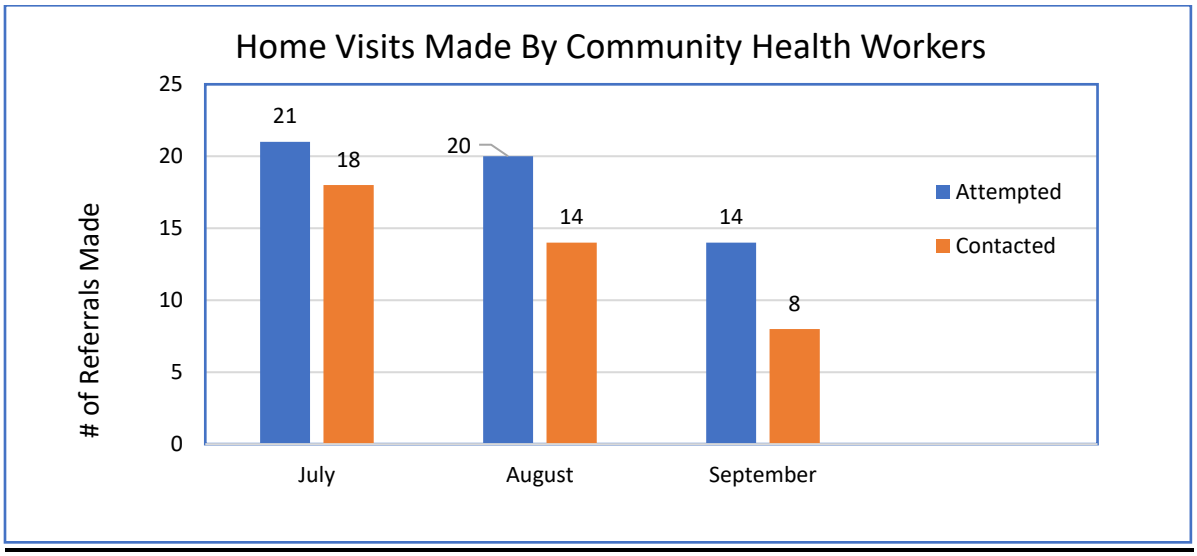


The Patient Health Questionnaire-9 (PHQ-9)—a nine-item questionnaire and an evidenced-based tool is administered to screen for depression in adult. Of the 752 pregnant and postpartum moms contacted, there were 493 successful contacts. Of the 493, there were 218 pregnant and postpartum mothers that accepted screening. Of the 218 mothers screened, there were 7 positive screening and referred to Behavioral Health for further interventions. Of the 7 positive screening, 1 declined Behavioral Health services.

Graph 14: Integration of Community Health Workers

Medi-Cal covers community health worker (CHW) services, pursuant to Title 42 of the Code of Federal Regulations, Section 440.130(c), as preventive services and on the written recommendation of a physician or other licensed practitioner of the healing arts within their scope of practice under state law. CHW services are defined as preventive health services delivered by a CHW to prevent disease, disability, and other health conditions or their progression; to prolong life; and to promote physical and mental health.

In Quarter 3, there were 55 referrals made to the CHWs due to various reasons such as unable to contact, safety check and health education. Of the 55 referrals, there were 40 successful contacts with the members. This is a 73% success rate. As a result of these successful contacts, Member's case remained open for continuation of Care Management services.



KERN HEALTH SYSTEMS

Long Term Care Program

Effective January 1st, Medi-Cal managed care plans now cover LTC benefit for Skilled Nursing Facility. This transition makes it more consistent and reduce complexity in the benefits provided by managed care and FFS statewide. In the past, KHS covered medically necessary services for Members up to 1 month in the Long-Term Care Facilities. Members are then disenrolled from the MediCal Plan to Medi-Cal FFS. The Long-Term Care Program assures that:

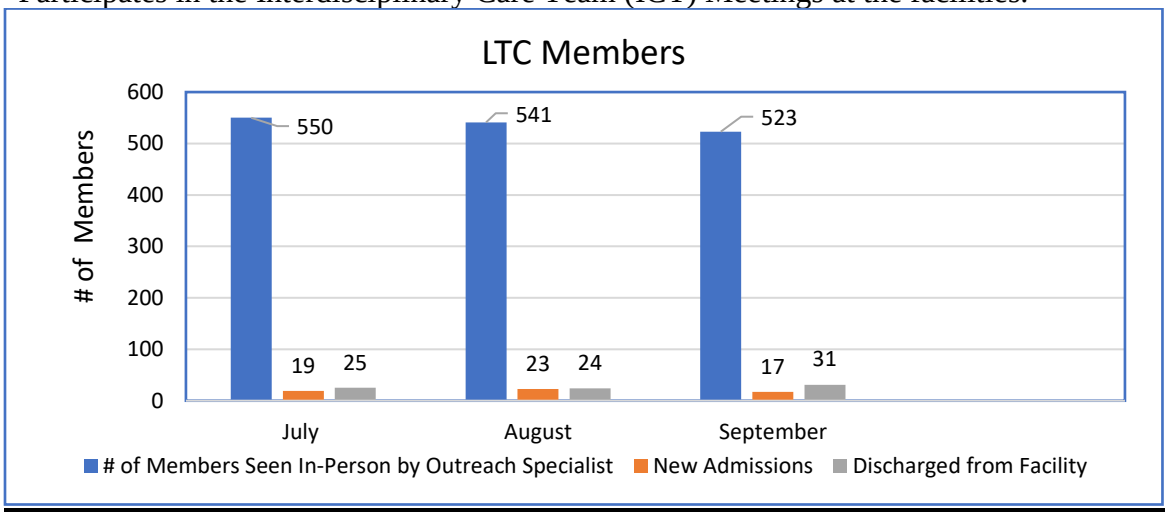
- The setting the service is delivered is consistent with the medical care needs of the member,
- Service is delivered at the appropriate time,
- Members receive appropriate quantity and quality of services,
- Members have access to a comprehensive set of services based on their needs and preferences across the continuum of care.

In Quarter 3, there was a total of 59 new admissions, and 80 discharges in the LTC facilities.
KHS ensures that every patient:

- Can transition to the least restrictive level of care that meets their needs and is aligned with their preferences in a timely manner without interruptions in care.
- Receives the support and coordination needed to have a safe and secure transition with the least burden on the patient as possible.
- Continues to have the needed support and connections to services that make them successful in their new environment.

In Quarter 3, the Outreach Specialists saw 1,614 members in-person at the skilled nursing facilities. The Outreach Specialists conduct site visits every month at the skilled nursing facilities to make sure the member is happy, administer PHQ-2 screening and address any concerns or questions the Members may have. We recently hired an RN Case Manager in the LTC Program. The RN Case Manger provides the following:

- Provides care management/coordination to our high-risk members.
- Reviews and obtains clinical information.
- Makes facility site visits to the Members to assess quality of care and address needs/concerns.
- Participates in the Interdisciplinary Care Team (ICT) Meetings at the facilities.



KERN HEALTH SYSTEMS

Previous Action Items

#	Action Items	Status
1	Staff will attend Trauma Informed Care Training. We will be scheduling training on Motivational Interviewing.	Completed
2	Working on screening forms to be available/accessible for members via Member Portal.	Completed
3	Include updates on Long Term Care (LTC) Program for Q3.	Completed

Roll Over Action Items:

1. We will evaluate the effectiveness, benefits, and impacts of Care Managements, and include in the Quarter 4 report.

Conclusions

The PHM team continues to work on gaps to ensure compliance with National Committee for Quality Assurance (NCQA). As the end of the year is approaching, we will need to evaluate the effectiveness of various programs such as Care Management Program within the PHM Department. We will continue to aggregate clinical and non-clinical data, identify the highest-risk patients, mitigate social determinants of health to reduce disparities; and support all members to stay healthy. By seamlessly coordinating the efforts of healthcare providers and streamlining communication, PHM ensures that patients receive comprehensive and timely care.