KERN HEALTH SYSTEMS

REGULAR MEETING OF THE QI/UM COMMITTEE

Thursday, August 24, 2017
at
7:00 A.M.

at
9700 Stockdale Highway
1st Floor Conference Room
Bakersfield, CA 93311

The public is invited

For more information, call (661) 664-5000

AGENDA

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

KERN HEALTH SYSTEMS
1st Floor-Conference Room
9700 Stockdale Highway
Bakersfield, California 93311

Regular Meeting
Thursday, August 24th, 2017

7:00 A.M.

All agenda item supporting documentation is available for public review at Kern Health Systems in the Administration Department, 9700 Stockdale Highway, Bakersfield, 93311 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, P.H.N; Satya Arya, M.D.; Felicia Crawford, RN; Bruce Taylor, DO; Maridette Schloe MS, LSSBB;Danielle C Colayco, PharmD, MS

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])

3) Announcements:
- Introduction- Special Guest, Dr. Philipp Melendez

4) Closed Session:

CA-5) QI/UM Committee Summary of Proceedings May 25th, 2017 – RECEIVE AND FILE

CA-6) Physician's Advisory Committee (PAC) Summary of Proceedings – RECEIVE AND FILE
- April 05, 2017
- May 03, 2017
- May 31, 2017

CA-7) Pharmacy 2017 TAR Log Statistics 1st Quarter – RECEIVE AND FILE
- April 2017
- May 2017
- June 2017

CA-8) Focus Review Report 2nd Quarter 2017 – RECEIVE AND FILE
- Critical Elements Monitoring Ending June 30th, 2017
- IHEBA Monitoring Ending June 30th, 2017
- IHA Monitoring Ending June 30th, 2017
- KRC Monitoring Ending June 30th, 2017
- CCS Monitoring Ending June 30th, 2017
- Perinatal Care Monitoring Ending June 30th, 2017

CA-9) Site Review Summary Report 2nd Quarter 2017 – RECEIVE AND FILE

CA-10) SHA Monitoring Report 2nd Quarter 2017 – RECEIVE AND FILE

CA-11) Kaiser UM DME Authorization Denial Report – RECEIVE AND FILE
- 1st Quarter 2017

CA-12) Kaiser KHS Health Plan Dental Report– RECEIVE AND FILE

- 2nd Quarter 2017

CA-13) Kaiser APL Grievance Report – RECEIVE AND FILE
- 2nd Quarter 2017

CA-14) Kaiser KHS CBA Report – RECEIVE AND FILE
- 2nd Quarter 2017

CA-15) Kaiser KHS Mental Health Report – RECEIVE AND FILE
- 2nd Quarter 2017

CA-16) Kaiser 2016 QI Program Evaluation – RECEIVE AND FILE (287 pp) Color
Full document can be accessed on the KHS Website at the following link: http://www.kernfamilyhealthcare.com/page.asp/csasp/DepartmentID.1478/cs/SectionID.2967/cs/PageID.15850/csasp.html

CA-17) Kaiser 2017 QI Program Description – RECEIVE AND FILE (399 pp) Color
Full document can be accessed on the KHS Website at the following link: http://www.kernfamilyhealthcare.com/page.asp/csasp/DepartmentID.1478/cs/SectionID.2967/cs/PageID.15850/csasp.html

CA-18) Kaiser 2017 Quality Improvement Work Plan– RECEIVE AND FILE (86 pp)
Full document can be accessed on the KHS Website at the following link: http://www.kernfamilyhealthcare.com/page.asp/csasp/DepartmentID.1478/cs/SectionID.2967/cs/PageID.15850/csasp.html

CA-19) VSP Medical Data Collection Summary Reports – RECEIVE AND FILE
- May 2016-April 2016
- June 2016-May 2017
- July 2016-June 2017
- August 2016- July 2017

Member Services

CA-20) 2017 Q1 Call Center Report – RECEIVE AND FILE
- Kern Health Systems/Kaiser

CA-21) Comparative Tabulated Grievance Reports – RECEIVE AND FILE
- 1st Quarter 2017

CA-22) Grievance Summary Reports – RECEIVE AND FILE
- 1st Quarter 2017

Provider Relations

CA-23) 2nd Q 2017 Re-Credentialing Report – RECEIVE AND FILE

CA-24) Board Approved New Contracts – RECEIVE AND FILE
- Effective May 2017
- Effective June 2017

CA-25 Board Approved Providers Reports – RECEIVE AND FILE
- May 1, 2017
- June 1, 2017

CA-26) 2017 Full Time Equivalency (FTE) & Provider to Enrollee Ratios Report – RECEIVE AND FILE

CA-27) 1st Q 2017 Access Grievance Review Report – RECEIVE AND FILE

CA-28) 2nd Q 2017 Access Monitoring Report – RECEIVE AND FILE

Disease Management

CA-29) Disease Management Report – RECEIVE AND FILE
- 2nd Quarter 2017

Health Education Reports

30) Health Education Activities Reports
    - 2nd Quarter 2017 - APPROVE

QI Department Reports

31) HEDIS 2017 Rate Tracking-Final Rates June 14, 2017- RECEIVE AND FILE
32) HEDIS 2017 Compliance Audit Final Report of Findings for KFHC - RECEIVE AND FILE

UM Department Reports

33) 2nd Q 2017 Combined UM Reporting – APPROVE
34) Policies and Procedures 3.10-3.26 – RECEIVE AND FILE
    - 3.10-P Specialty Nutrition Consultation
    - 3.14-P Mental Health Services
    - 3.26-P New Medical Technology
35) Policies and Procedures 3.73-3.50 – RECEIVE AND FILE
    - 3.73-I Medical Decision Making
    - 3.40-I Continuity of Care for New Members
    - 3.50-P Medical Transportation Services

Next regular meeting: November 16, 2017

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, 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 OF PROCEEDINGS

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

KERN HEALTH SYSTEMS
1st Floor-Conference Room
9700 Stockdale Highway
Bakersfield, California 93311

Regular Meeting
Thursday, May 25, 2017
7:00 A.M.

All agenda item supporting documentation is available for public review at Kern Health Systems in the Administration Department, 9700 Stockdale Highway, Bakersfield, 93311 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.

Members Present: Jennifer Ansolabehere, P.H.N; Satya Ayra, M.D.; Bruce Taylor, DO; Maridette Schloe MS, LSSBB; Danielle C Colayco, PharmD, MS

Members Absent: Felicia Crawford, RN

Meeting called to order by Dr. Irwin Harris, M.D. @ 7:02 A.M.

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])

3) Announcements:
- **Form 700**
- **Introduction-Special Guests, Allen Kennedy from Quality Team and Dr. Chan Park from GMA Healthcare**

4) Closed Session: **Closed session began 7:05 A.M. – Committee discussed and agreed that both nominations will be accepted, and each nominee will need to attend 3 QI-UM meetings.**

CA-5) QI/UM Committee Summary of Proceedings March 2nd, 2017 – RECEIVED AND FILED

CA-6) Physician Advisory Committee (PAC) Summaries of Proceedings – RECEIVED AND FILED
- February 2017
- March 2017

CA-7) Pharmacy 2017 TAR Log Statistics 1st Quarter – RECEIVED AND FILED
- January 2017
- February 2017
- March 2017

CA-8) Focus Review Report 1st Quarter 2017 – RECEIVED AND FILED
- Critical Elements Monitoring Ending March 31st, 2016
- IHEBA Monitoring Ending March 31st, 2017
- IHA Monitoring Ending March 31st, 2017
- KRC Monitoring Ending March 31st, 2017

- CCS Monitoring Ending March 31st, 2017
- Perinatal Care Monitoring Ending March 31st, 2017

CA-9) Site Review Summary Report 1st Quarter 2017 – RECEIVED AND FILED
CA-10) SHA Monitoring Report 1st Quarter 2017 – RECEIVED AND FILED
CA-11) VSP Medical Data Collection Summary Reports – RECEIVED AND FILED

- January 2016-December 2016
- February 2016-January 2017
- March 2016-February 2017
- April 2016- March 2017

CA-12) VSP QI Work Plan Evaluation 2016 – RECEIVED AND FILED
CA-13) VSP QI Program Description 2016 – RECEIVED AND FILED
CA-14) Kaiser UM DME Authorization Denial Reports – RECEIVED AND FILED

- 4th Quarter 2016

CA-15) Kaiser KHS Health Plan Dental Reports– RECEIVED AND FILED

- 1st Quarter 2017

CA-16) Kaiser Grievance Reports – RECEIVED AND FILED

- 1st Quarter 2017

CA-17) Kaiser KHS SPD Reports – RECEIVED AND FILED

- 4th Quarter 2016
- 1st Quarter 2017

CA-18) Kaiser KHS CBA Reports – RECEIVED AND FILED

- 4th Quarter 2016
- 1st Quarter 2017

Member Services

CA-19) 2017 Q1 Call Center Report – RECEIVED AND FILED

- Kern Health Systems/Kaiser
- 2017 Health Dialog Health Information Line Summary
- 2017 Health Coach Call Listening Report - Q1

CA-20) Comparative Tabulated Grievance Reports – RECEIVED AND FILED

- 4th Quarter 2016

CA-21) 2016 Grievance Summary Reports – RECEIVED AND FILED

- 4th Quarter 2016

Provider Relations

CA-22) 1st Q 2017 Re-credentialing Report – RECEIVED AND FILED
CA-23) Board Approved New Contracts – RECEIVED AND FILED

- January 2017
- February 2017

CA-24 Board Approved Providers Reports – RECEIVED AND FILED

- March1, 2017
- April 1, 2017

CA-25) 1st Q 2017 After-Hours Calls Survey Results – RECEIVED AND FILED
CA-26) 1st Q 2017 Appointment Availability Survey Results – RECEIVED AND FILED

Disease Management

CA-27) Disease Management Reports – RECEIVED AND FILED

- 4th Quarter 2016

- 1st Quarter 2017

Health Education Reports

28) Health Education Activities Reports
- 1st Quarter 2017 - APPROVED
- 4th Quarter 2016 - RECEIVED AND FILED

Arya- Ansolabehere: All Ayes

QI Department Reports

29) 2016 QI Program Evaluation Executive Summary – APPROVED
30) 2016 QI Program Evaluation – RECEIVED AND FILED
31) 2017 QI Program Description – RECEIVED AND FILED
32) 2017 QI Work Plan – RECEIVED AND FILED
33) Policy and Procedure 2.22-P – RECEIVED AND FILED
- 2.22-P Attachment D Ancillary Services
- 2.22-P Attachment E CBAS

34) Policies and Procedures 217-235– RECEIVED AND FILED
- 2.17-P Access - Treatment of a Minor 2017-01
- 2.29-P Emergency Protocol and Disaster Plan 2017-01
- 2.30-I Health Education 2017-01
- 2.35-P Disease Management 2017-01

Arya- Ansolabehere: All Ayes

UM Department Reports

35) 2017 1st Q Combined UM Reporting – APPROVED
36) 2017 UM Program Description – RECEIVED AND FILED
37) 2016 UM Program Evaluation – RECEIVED AND FILED
38) Policies and Procedures– RECEIVED AND FILED
- 3.33-P Admission-Discharge Notification 2017-01
- 3.36-P Asthma Treatment and Management 2017-01
- 3.37-P Specialty Nutrition Consultation 2017-01

Arya-Taylor: All Ayes

Meeting adjourned by Dr. Irwin Harris, M.D. @ 8:11 A.M.
to Thursday, August 24, 2017

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, 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 OF PROCEEDINGS

PHYSICIAN ADVISORY COMMITTEE MEETING

KERN HEALTH SYSTEMS
9700 Stockdale Highway
1st Floor Board Room
Bakersfield, California 93311

Wednesday, April 5, 2017
7:00 A.M.

All agenda item supporting documentation is available for public review at Kern Health Systems in the Administration Department, 9700 Stockdale Highway, Bakersfield, 93311 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.

PLEASE REMEMBER TO TURN OFF ALL CELL PHONES, PAGERS OR ELECTRONIC DEVICES DURING MEETINGS.

COMMITTEE RECONVENED

Members Present: Hasmukh Amin, M.D., Angela Egbikuadje, PD.MS, Ph.D; David Hair, M.D., Miguel Lascano, M.D., Ashok Parmar, M.D., Jacqueline Paul-Gordon, M.D.

Members Absent: Raju Patel, M.D.

Meeting called to order at 7:00 A.M. by Dr. Irwin Harris, M.D.

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 MEMBER OF THE COMMITTEE 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 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 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!

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) Minutes for KHS Physician Advisory Committee meeting on March 1, 2017 – APPROVED
Amin-Lascano: All Ayes

ADJOURNED TO CLOSED SESSION @ 7:02 A.M.

CLOSED SESSION

4) 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.**

Reviewed matrix created by Dr. Harris re: the chronology of events of Dr. Esposo's history with KHS and other facilities. Committee then reviewed matrix of events. Dr. Harris' recommendation is to approve his application for KHS provider network since his privileges have been reinstated at (BMH). He currently works at Clinica La Victoria as PCP only. (Amin/Parmar made motion to approve Dr. Esposo application.) ** RETRO APPROVAL REQUESTED BY EMILY

Discussed Mojave Pharmacy w/Committee. Mojave Pharmacist in charge has a current accusation filed by the California Board of Pharmacy alleging excessive furnishing of controlled substances and failure to exercise or implement best professional judgment with regard to dispensing or furnishing controlled substances. Dr. Harris' recommendation for recredentialing

approval and adding this provider to the monthly monitoring log.

Also Akanno was discussed extensively on recredentialing report.
Dr. Harris provided the committee with information regarding Dr. Akanno's PACE report, as a result from CDCR 2016 clinical privilege suspension. PACE Report revealed a level 3 deficiency in knowledge, judgment and completeness of medical records. Dr. Harris' recommendation is a modified recredentialing approval for 1-year, with a review of 10 medical records on a quarterly basis. Motion made by Amin & Lascano seconded.

COMMITTEE RECONVENED TO OPEN SESSION @ 7:29 A.M.

5) Review of Proposed Vascular Criteria – Guest: Dr. Hao D. Bui, M.D. – DISCUSSION
Guest Dr. Samarany, MD FACC, RPVI – Cardiologist: His final recommendation was the member needs to be referred to a vascular specialist.
Questions raised/recommendations from committee:
Doug: Need to find out when are these procedures necessary? What are the circumstances where we would approve this procedure? Third, how costly is this to the plan currently? If we were to begin requiring the testing, is it more expensive to do the testing than the procedure?
His recommendation is to further research these questions & bring back to next meeting.
Dr. Paul-Gordon strongly recommended need to use compression stockings, and enforce than rule upon all patients.
Dr. Harris to contact Dr. Bui and get him to come into meeting to educate committee.
- **Hold until future meeting**

6) Review Policy 3.40-I Continuity of Care for New Members – RECEIVED AND FILED

7) Review Policy 3.50-P Medical Transportation Services – RECEIVED AND FILED

MEETING ADJOURNED BY DR. IRWIN HARRIS, M.D. @ 8:15 A.M. TO WEDNESDAY, MAY 3, 2017 AT 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 OF PROCEEDINGS

PHYSICIAN ADVISORY COMMITTEE MEETING

KERN HEALTH SYSTEMS
9700 Stockdale Highway
1st Floor Board Room
Bakersfield, California 93311

Wednesday, May 3, 2017
7:00 A.M.

All agenda item supporting documentation is available for public review at Kern Health Systems in the Administration Department, 9700 Stockdale Highway, Bakersfield, 93311 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.

PLEASE REMEMBER TO TURN OFF ALL CELL PHONES, PAGERS OR ELECTRONIC DEVICES DURING MEETINGS.

COMMITTEE RECONVENED

Members Present: Hasmukh Amin, M.D., Angela Egbikuadje, PD.MS, Ph.D; David Hair, M.D., Ashok Parmar, M.D., Raju Patel, M.D., Jacqueline Paul-Gordon, M.D.

Members Absent: Miguel Lascano, M.D.

Meeting called to order at 7:01 A.M. by Dr. Irwin Harris, MD

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 MEMBER OF THE COMMITTEE 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 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 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!

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) Minutes for KHS Physician Advisory Committee meeting on April 5, 2017 – APPROVED
Amin-Paul Gordon: All Ayes

ADJOURNED TO CLOSED SESSION @ 7:03 A.M.

CLOSED SESSION

4) 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.**

COMMITTEE RECONVENED TO OPEN SESSION @ 7:24 A.M.

5) Review Diabetic Exam Reminder Effectiveness Report for Q1 of 2017 – RECEIVED AND FILED – **Dr. Hair expressed concern over the effectiveness of VSP's diabetic eye exam outreach. Emily Duran to review VSP contract to see what the requirements are. Emily & Deb to follow up.**

6) Review of Varicose Vein Criteria - DISCUSSION - **Doug Hayward, CEO gave overview to committee. KHS is in process of designing a payment methodology, and this subject will be brought back to the committee at a later time.**

7) Scope of Practice for Primary Care Doctors – DISCUSSION – **Held until next meeting. Dr. Harris asked several committee members to bring information with them to next meeting to further discuss.**

MEETING ADJOURNED BY DR. IRWIN HARRIS, M.D. @ TO
WEDNESDAY, MAY 31, 2017 AT 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 OF PROCEEDINGS

PHYSICIAN ADVISORY COMMITTEE MEETING

KERN HEALTH SYSTEMS
9700 Stockdale Highway
1st Floor Board Room
Bakersfield, California 93311

Wednesday, May 31, 2017
7:00 A.M.

All agenda item supporting documentation is available for public review at Kern Health Systems in the Administration Department, 9700 Stockdale Highway, Bakersfield, 93311 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.

PLEASE REMEMBER TO TURN OFF ALL CELL PHONES, PAGERS OR ELECTRONIC DEVICES DURING MEETINGS.

COMMITTEE RECONVENED

Members Present: Hasmukh Amin, M.D., Angela Egbikuadje, PD.MS, Ph.D; Miguel Lascano, M.D., Ashok Parmar, M.D., Jacqueline Paul-Gordon, M.D.

Members Absent: David Hair, M.D., Raju Patel, M.D.

Meeting called to order at 7:04 A.M. by Dr. Irwin Harris, M.D.

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 MEMBER OF THE COMMITTEE 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 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 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!

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]) - **Dr. Amin stated Gemcare is opening more local facilities and also spoke about urgent cares not referring members back to their PCP, causing the PCP to do repetitive workups and tests/labs. Dr. Paul-Gordon also commented that she is displeased with the urgent care's habit of not forwarding records to the PCP after a visit, and sometimes she prefers to refer her patients to the ER because of this.**

CA-3) Minutes for KHS Physician Advisory Committee meeting on May 3, 2017 – APPROVED
Amin-Parmar: All Ayes

ADJOURNED TO CLOSED SESSION @ 7:13 A.M.

CLOSED SESSION

4) Closed Session regarding peer review of a provider (Welfare and Institutions Code Section 14087.38(o)) – **BY A VOTE OF 5-0, THE COMMITTEE APPROVED PROVIDERS RECOMMENDED FOR INITIAL CREDENTIALING AND RECREDENTIALING.**

COMMITTEE RECONVENED TO OPEN SESSION @ 7:48 A.M.

5) Scope of Practice for Primary Care Doctors – DISCUSSION - **Questions were asked regarding how KHS monitors the scope of practice for PCP. Dr. Amin suggested a more stringent referral process and development of additional criteria to delineate acceptable guidelines. In addition, PCP typically will practice in alignment with their training and experience levels. Dr. Egbijuadje**

commented that she has experienced issues where members refuse to see a particular provider who they have been referred to and this impacts the PCP ability to perform their role as the member's first line of care coordination.

6) Process by which KHS can adopt other criterion sources, such as: accepted national criteria, criteria adopted by other large national health plans, standards of practice as described in "Up to Date" and guidelines adopted by medical associations and societies - DISCUSSION – **HELD UNTIL NEXT MEETING**

MEETING ADJOURNED BY DR. IRWIN HARRIS, M.D. @ 8:13 A.M.
TO WEDNESDAY, AUGUST 2, 2017 AT 7:00 A.M.

**** THERE WILL BE NO PAC MEETING IN JULY ****

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.

Quarter/Year of Audit	**2017**
Month Audited	**April**
Total TAR's for the month	**2333**
	100%
APPROVED TAR'S	
Timeliness - Reviewed & Returned in 1 busines day	**47/47**
Date Stamped	**47/47**
Fax copy attached	**47/47**
Decision marked	**47/47**
DENIED TAR'S	
Timeliness - Reviewed & Returned in 1 business day	**44/44**
Initally Denied - Signed by Medical Director and/or Pharmacist	**44/44**
Letter sent within time frame	**44/44**
Date Stamped	**44/44**
Fax copy attached	**44/44**
Decision marked	**44/44**
Correct form letter, per current policies used	**44/44**
MODIFIED TAR'S	
Timeliness - Reviewed & Returned in 1 business day	**0**
Date Stamped	**0**
Fax copy attached	**0**
Decision marked	**0**
Correct form letter, per current policies used	**0**
DUPLICATE TAR'S	
Timeliness - Reviewd & Returned in 1 business day	**7/7**
Date Stamped	**7/7**
Fax copy attached	**7/7**

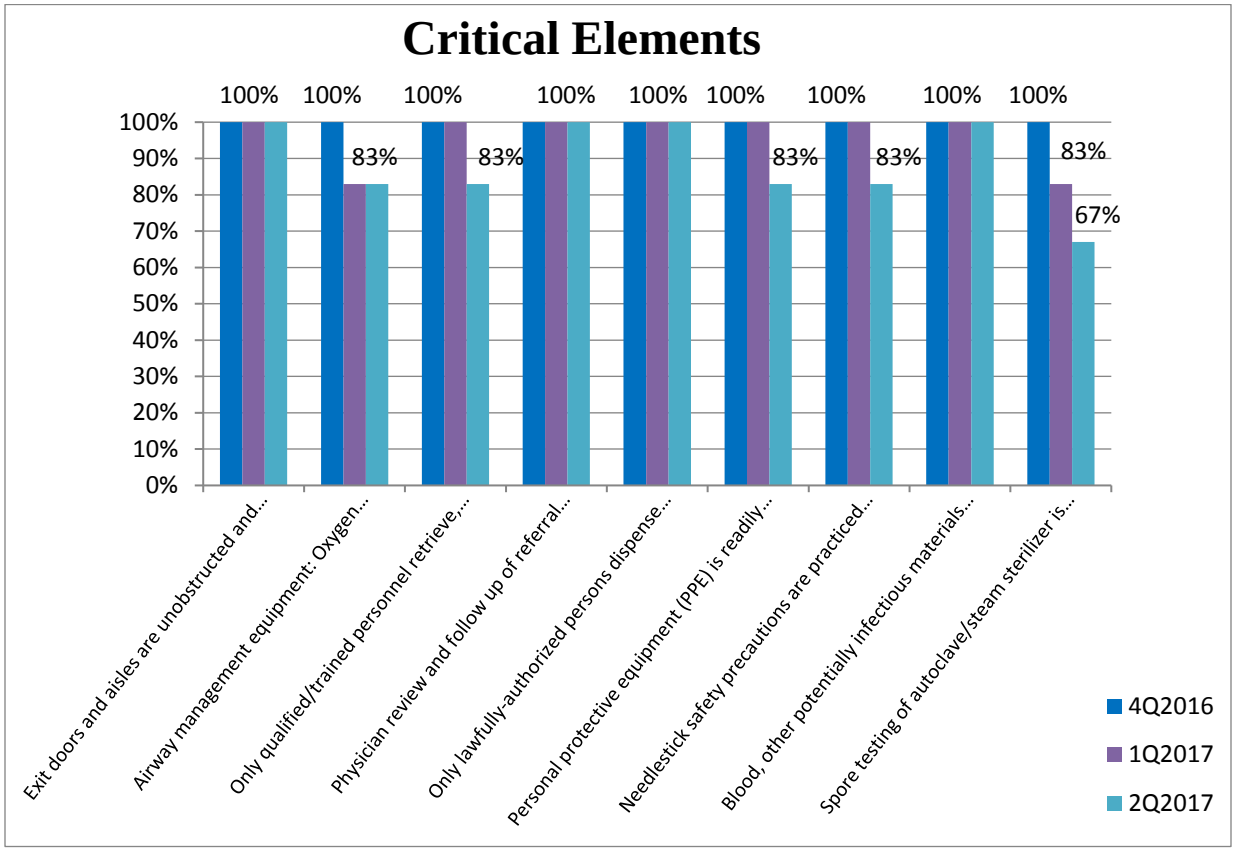
Quarter/Year of Audit	**2017**
Month Audited	**May**
Total TAR's for the month	**2832**
APPROVED TAR'S	
Timeliness - Reviewed & Returned in 1 busines day	**58/58**
Date Stamped	**58/58**
Fax copy attached	**58/58**
Decision marked	**58/58**
DENIED TAR'S	
Timeliness - Reviewed & Returned in 1 business day	**51/51**
Initally Denied - Signed by Medical Director and/or Pharmacist	**51/51**
Letter sent within time frame	**51/51**
Date Stamped	**51/51**
Fax copy attached	**51/51**
Decision marked	**51/51**
Correct form letter, per current policies used	**51/51**
MODIFIED TAR'S	
Timeliness - Reviewed & Returned in 1 business day	**0**
Date Stamped	**0**
Fax copy attached	**0**
Decision marked	**0**
Correct form letter, per current policies used	**0**
DUPLICATE TAR'S	
Timeliness - Reviewd & Returned in 1 business day	**8/8**
Date Stamped	**8/8**
Fax copy attached	**8/8**

Quarter/Year of Audit	**2017**
Month Audited	**June**
Total TAR's for the month	**2818**
APPROVED TAR'S	
Timeliness - Reviewed & Returned in 1 busines day	**74/74**
Date Stamped	**74/74**
Fax copy attached	**74/74**
Decision marked	**74/74**
DENIED TAR'S	
Timeliness - Reviewed & Returned in 1 business day	**42/42**
Initally Denied - Signed by Medical Director and/or Pharmacist	**42/42**
Letter sent within time frame	**42/42**
Date Stamped	**42/42**
Fax copy attached	**42/42**
Decision marked	**42/42**
Correct form letter, per current policies used	**42/42**
MODIFIED TAR'S	
Timeliness - Reviewed & Returned in 1 business day	**0**
Date Stamped	**0**
Fax copy attached	**0**
Decision marked	**0**
Correct form letter, per current policies used	**0**
DUPLICATE TAR'S	
Timeliness - Reviewd & Returned in 1 business day	**11/11**
Date Stamped	**11/11**
Fax copy attached	**11/11**
	11/11

Focus Review Summary Report

Critical Elements Reviews: Six (6) providers were evaluated in 2nd Quarter 2017.

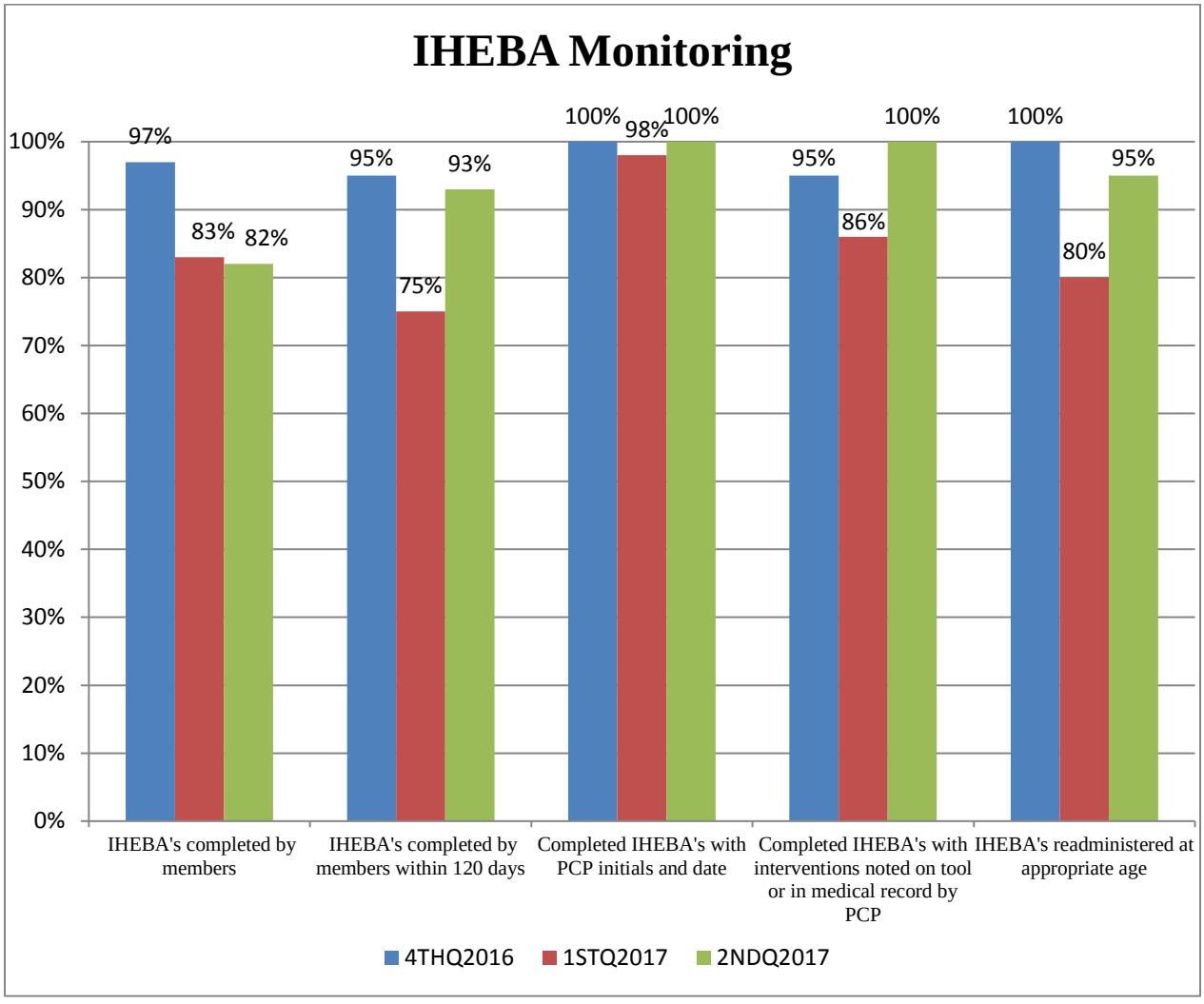
SUMMARY: KHS is responsible for systematic monitoring of all PCP sites between each regularly scheduled full scope site review surveys which includes the nine (9) critical elements. Other performance assessments may include previous deficiencies, patient satisfaction, grievance, and utilization management data. The PCP and/or site contact are notified of all critical element deficiencies found during a full scope site survey, focused survey or monitoring visit. PCP and/or site contact are required to correct 100% of the survey deficiencies regardless of the survey score.



All six providers evaluated in the 2nd Quarter scored 100% in 4 out of 9 areas and 83% in 4 out of 9 areas. The area with the most need for improvement was the one related to the spore testing of autoclave/steam sterilizer with documented results at least monthly. The score for this area in the 2nd Quarter was 67%. Correction Action Plans (CAPs) have been implemented with the providers showing deficiencies and follow-up visits will be conducted.

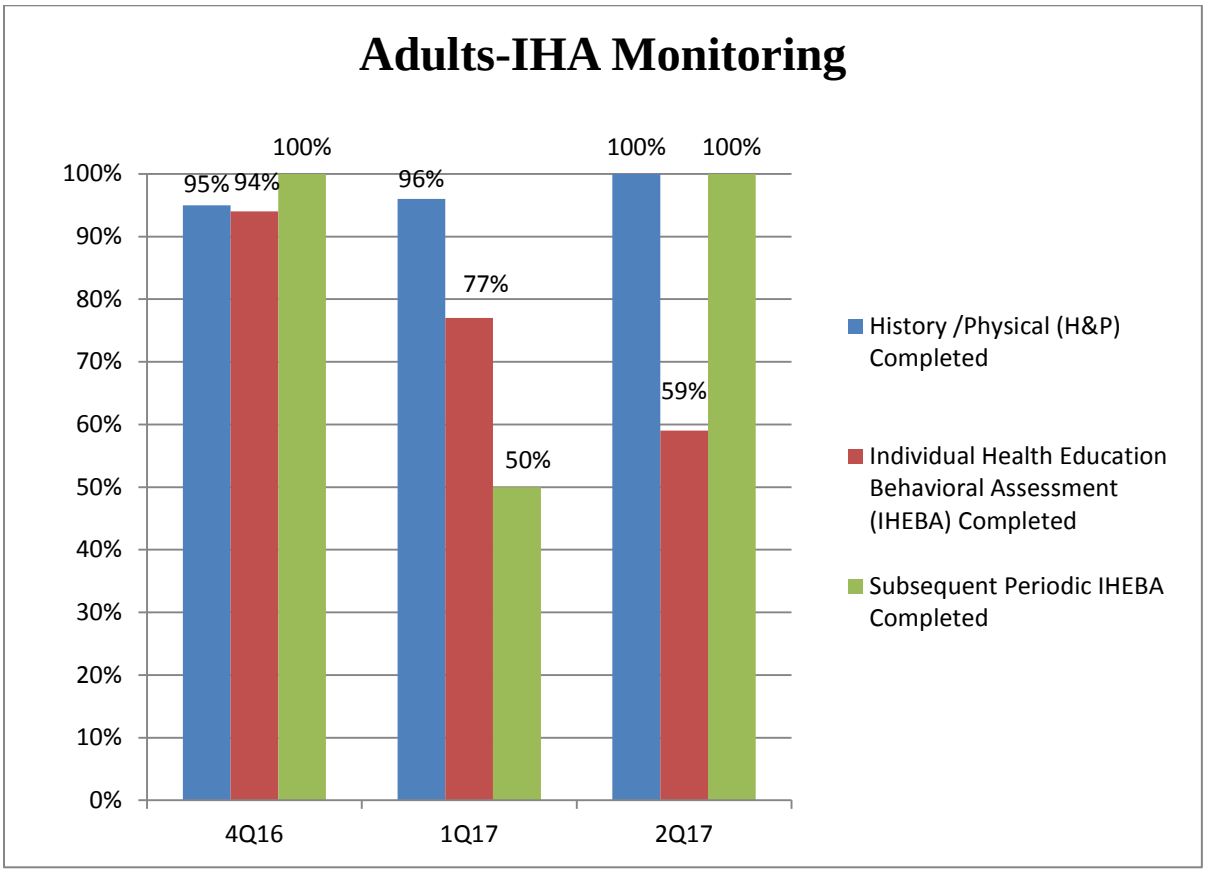
IHEBA Reviews: In 2nd Quarter 2017, six (6) providers and 56 Charts were reviewed. The average compliance rate for all five categories in 2nd Quarter 2017 was 94%.

SUMMARY: The initial Individual Health Education Behavioral Assessment (IHEBA), commonly referred to as the Staying Healthy Assessment, shall be performed during the Initial Health Assessment (IHA); thereafter, the PCP must re-administer the IHEBA at the appropriate age intervals. For those providers having members complete the IHEBA, performance has improved in all elements.



Initial Health Assessment Reviews: In the 2nd Quarter 2017, six (6) providers were reviewed. There were twenty-one (21) Adult records and twenty-three (23) Pediatric records reviewed.

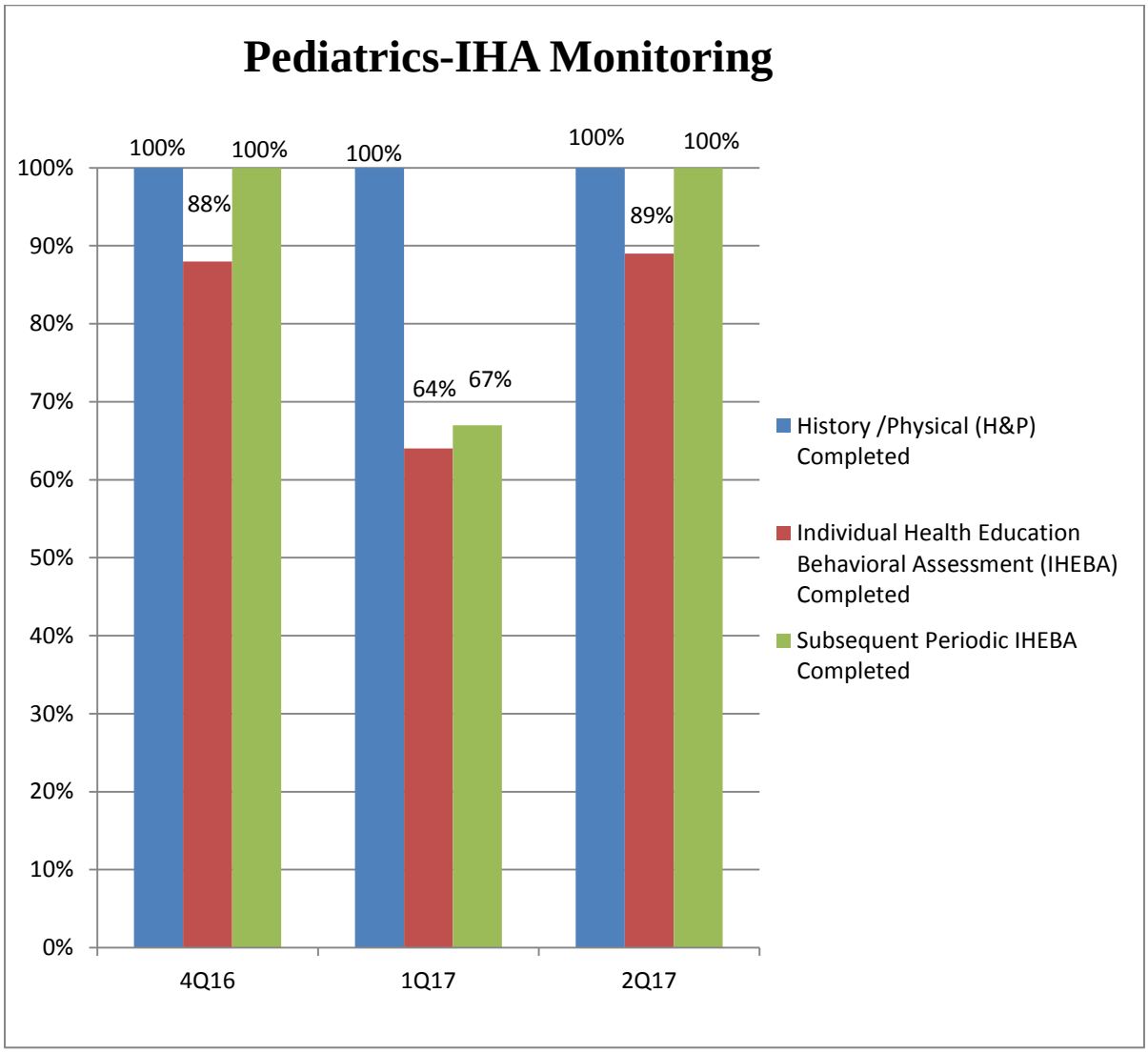
SUMMARY: An Initial Health Assessment (IHA) must be provided to each member within 120 days of enrollment. As PCP's receive their assigned panels, the Practitioner's office should contact members to schedule an IHA to be performed within the 120 day time limit. If the practitioner/staff is unable to contact the member, he/she should contact KHS Member Services Department for assistance. Contact attempts and results are documented by both the PCP and Member Services staff.



The number of H&Ps completed in the IHA Adult charts reviewed has remained high over the last 3 quarters with an average of 97%. However, the number of initial IHEBAS completed has shown a steady decrease from 94% in 4Q16, to 77% in 1Q17, then down to 59% in 2Q17. The number of subsequent Periodic IHEBAs completed returned to 100% in 2Q17.

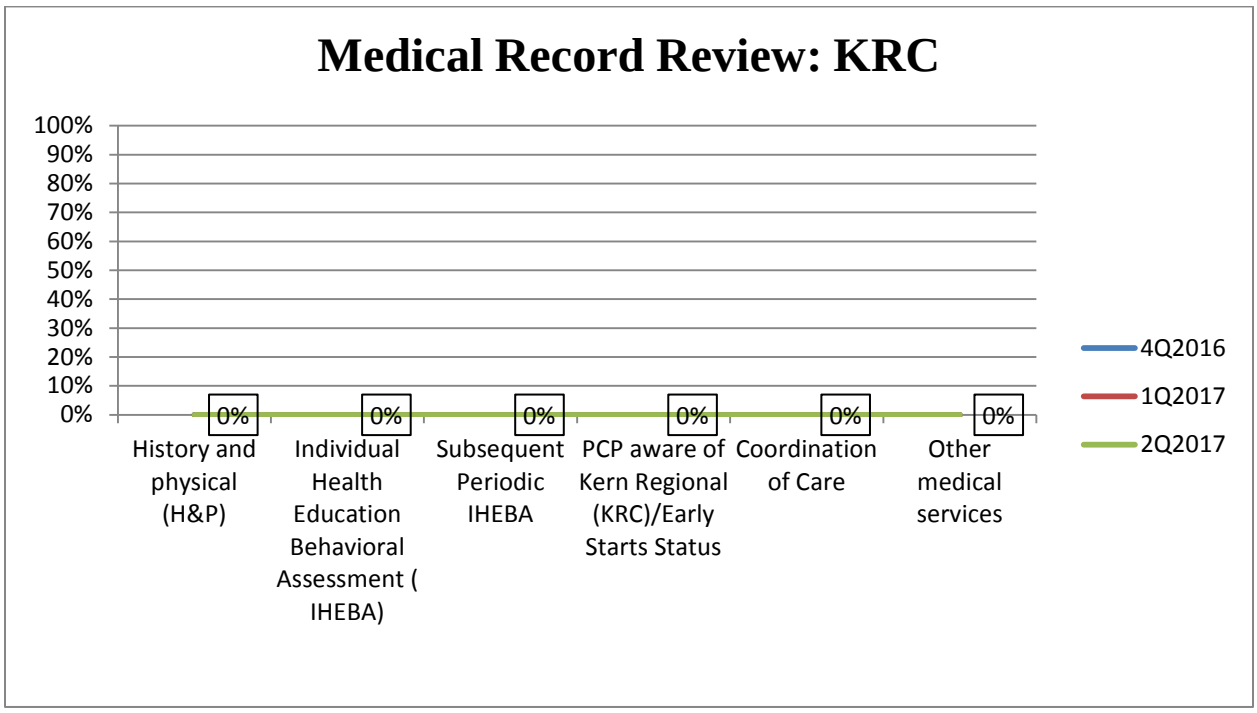
Both adult and pediatric providers perform H&Ps during the initial health assessment. The initial IHEBA/Staying Health Assessment should be performed during the IHA. Performance in Pediatric IHEBA use remains higher than in the adult population for all elements. Corrective Action Plans were implemented for all deficiencies and follow-up visits will be conducted.

The number of History/Physicals (H&P) completed in the pediatric charts reviewed was 100% for the last 3 quarters. Individual Health Education Behavioral Assessments (IHEBAs) holds the greatest opportunity for improvement. Subsequent Periodic IHEBAS completed varied as well. The completion rate returned to 100% from 1Q17. Corrective Action Plans for deficiencies have been implemented and follow-up visits will be conducted.



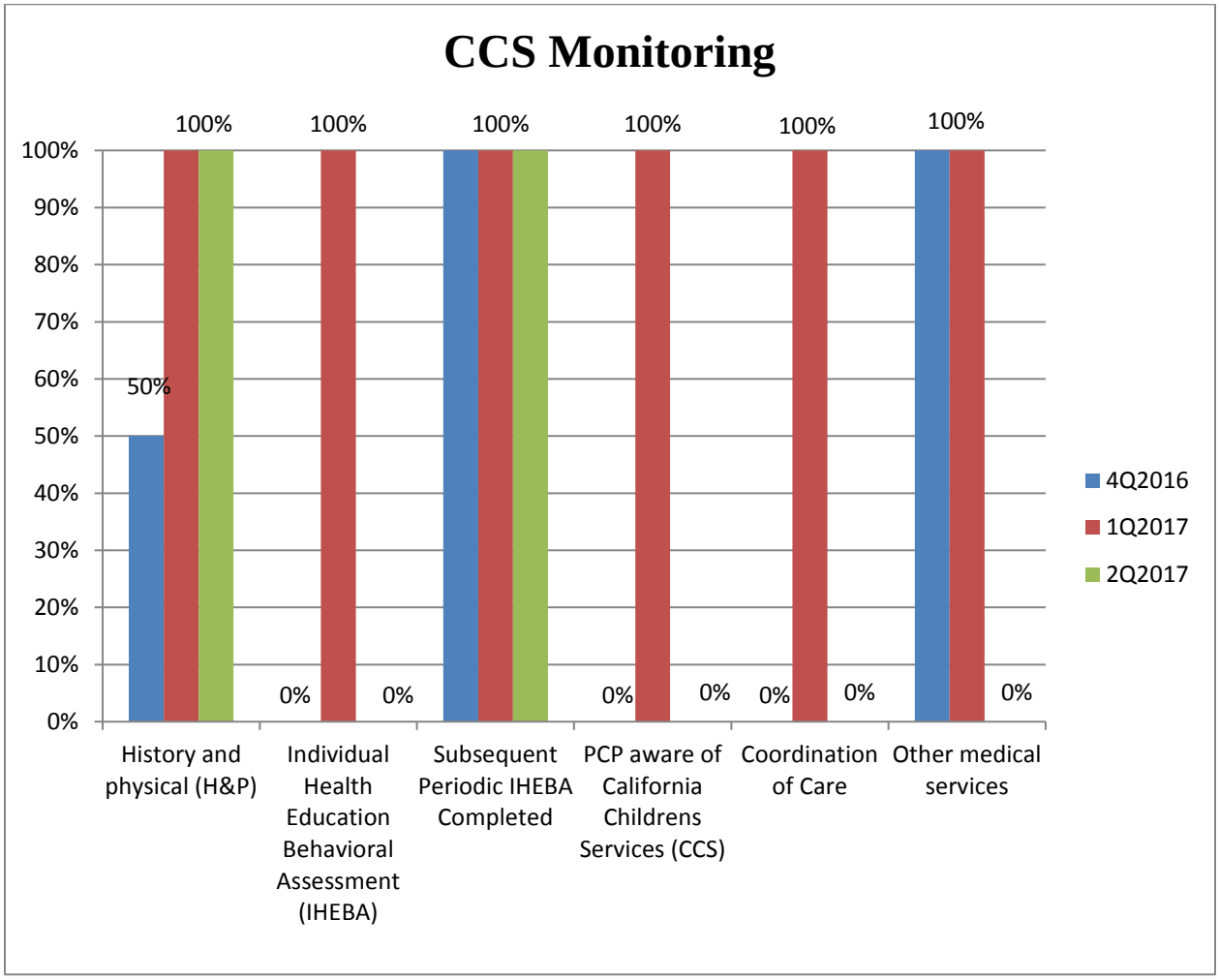
KRC Reviews: No data to report in the last four quarters.

SUMMARY: KHS ensures the provision of primary care interventions and other medically necessary covered services unrelated to the KRC and/or Early Starts eligible condition. Medical record review showed appropriate primary care and other necessary intervention although historically, the denominator for this measure is small.



CCS Reviews: In 2nd Quarter 2017, six (6) providers and two (2) CCS charts were reviewed.

SUMMARY: KHS ensures the provision of primary care interventions and other medically necessary covered services unrelated to the CCS eligible condition through medical record review evidenced by appropriate primary care and other necessary intervention. KHS collaborates with CCS, the CCS Specialist, and the PCP as necessary to ensure continuity of the member's care.



In 2nd quarter 2017 CCS monitoring all providers surveyed scored 100% in these two areas:

- History and physical (H&P)
- Subsequent Periodic IHEBAs completed

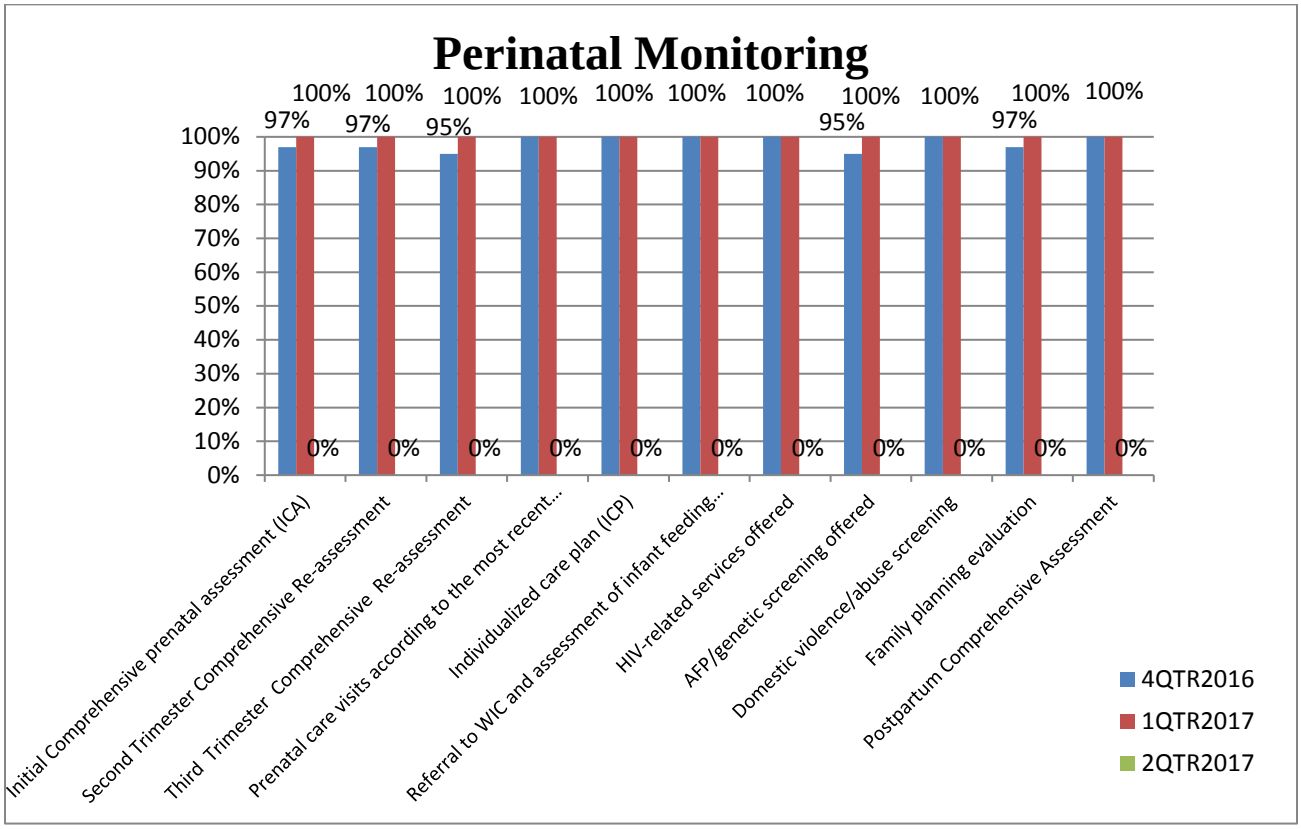
Opportunities for Improvement were found in the following areas:

- Individual Health Educational Behavioral Assessment (IHEBA)
- PCP aware of CCS
- Coordination of Care
- Other medical services needed

Perinatal Reviews: Out of the six providers surveyed in 2nd Quarter 2017 there were no perinatal charts reviewed.

SUMMARY: KHS will encourage optimum maternity care as appropriate for all pregnant members. Maternity care includes prenatal care, delivery, postpartum care, education, high risk interventions, and genetic counseling, screening, and referral. All pregnancy providers shall utilize a multi-disciplinary approach to perinatal care. All pregnant KHS members will receive case coordination of Obstetric and Comprehensive Perinatal Services to the degree warranted by the State Department of Healthcare Services (DHCS) combined standardized risk assessment tools. Maternity care will be provided in accordance with the most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG).

OB patients are routinely monitored through the QI Department's medical record reviews. Timeliness of prenatal and postpartum care is monitored for HEDIS. When appropriate, the QI nurse implements a CAP for the KHS provider and notifies Provider Relations for follow-up. The QI department collects data on these members and reports the aggregate findings to the QI/UM Committee on a regular basis in order to determine necessary interventions. There is a variance from quarter to quarter depending on the number of providers reviewed. There were no Perinatal Charts Reviewed in 2Q17.

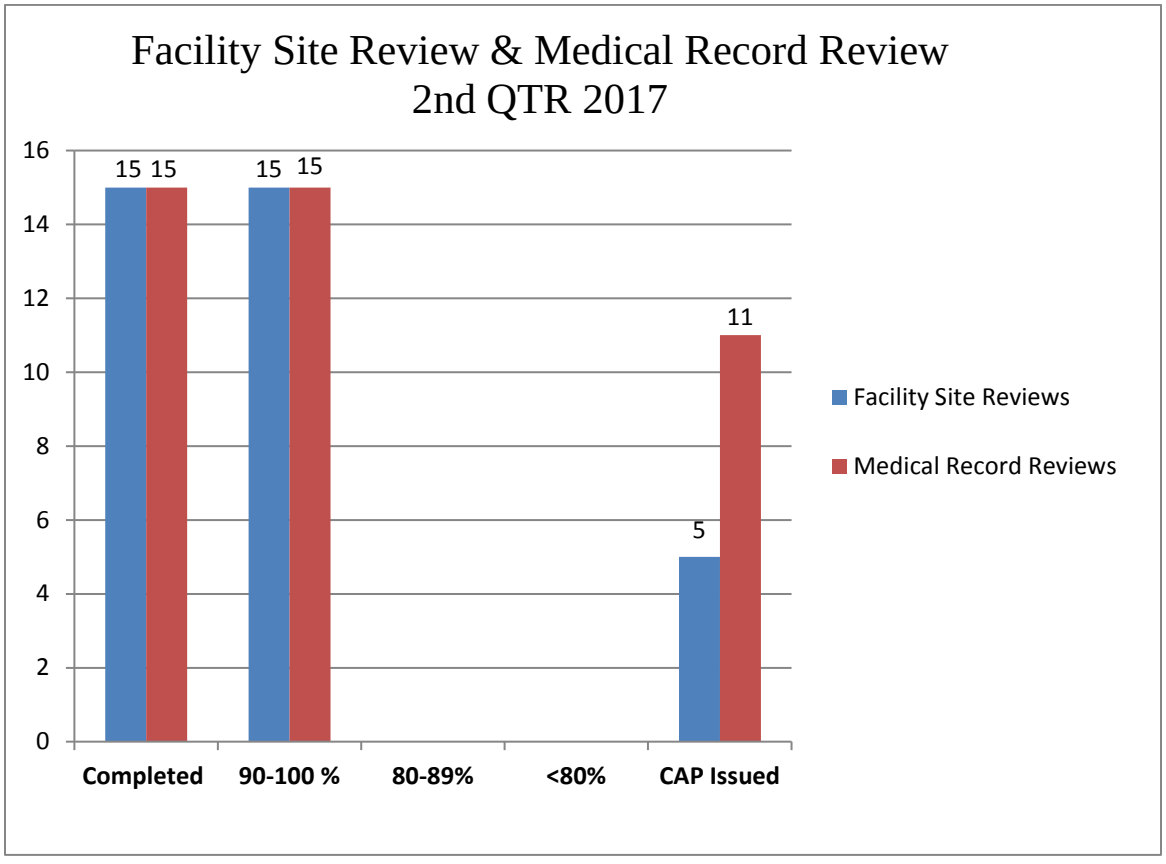


KERN HEALTH SYSTEMS
SITE REVIEW SUMMARY REPORT

Disciplinary Involvement: Quality Improvement and Provider Relations
Data Retrieval Method: Chart Review, Observation, Interview/Survey, Physical Inspection
Department: Quality Improvement
Monitoring Period: April 1, 2017- June 30, 2017

A total of fifteen (15) Office Site Reviews were completed in the 2nd Quarter. Out of the fifteen (15) completed, three (3) were Initial Reviews and 12 (12) were Periodic Reviews. Three (3) out of the fifteen (15) performed were by Health Net, and one was Urgent Care Only.

A total of fifteen (15) Medical Record Reviews were completed in the 2nd Quarter. Four (4) out of fifteen (15) were Initial Medical Record Reviews and eleven (11) were Periodic Medical Record Reviews. There were five (5) Facility Site Review Caps issued and eleven (11) Medical Record Review Caps issued. Eight (8) Medical Record Review caps were closed, and six (6) Full Site Review Caps were closed.



Description of Process: Certified Site Reviewers perform a facility site review on all contracted primary care providers (including OB/GYNs and pediatricians) as well as providers who serve a high volume of SPD beneficiaries. Per APL 15-023 and PL 14-004, certified site reviewers complete site and medical record reviews for providers credentialed per DHCS and MMCD contractual and policy requirements. A site review shall be completed as part of the initial Credentialing process if a new provider at a site that has not previously been reviewed is added to a contractor's provider network.

A site review need not to be repeated, as part of the initial Credentialing process if a new provider is added to a provider site that has a current passing site survey score. A site review survey need not to be repeated as part of the re-credentialing process if the site has a current passing site survey score. A passing Site Review Survey shall be considered "current" if it is dated within the last 3 years, and need not to be repeated until the due date of the next scheduled site review survey or when determined necessary through monitoring activities by the plan

Scoring and Corrective Action Plans

QI/UM Committee approved Policy #CP232 and #CP233 as the Scoring and Corrective Action Plan Policies for all Provider Site Reviews

Facility sites that receive an Exempted Pass (90% or above, without deficiencies in critical elements) will not be required to complete a corrective action plan (CAP), unless required by the plan or local plan collaborative. All sites that receive a Conditional Pass (80-89%, or 90% or above with deficiencies in critical elements) will be required to establish a CAP that addresses each of the noted deficiencies. The compliance level categories for both the facility site review and medical record review are the same as listed below:

Exempted Pass: 90% or above
Conditional Pass: 80-89%
Not Pass: below 80%

Facility sites that receive an Exempted Pass (90% or above) for medical record review will not be required to complete a CAP for medical record review. On-site CAP follow up visits are intended to verify that processes are in place to remedy deficiencies.

Nine critical survey elements related to the potential for adverse effect on patient health or safety have a scored "weight" of two points. All other survey elements are weighted at one point. All critical element deficiencies found during a full scope site survey, focused survey, or monitoring visit shall be corrected by the provider within 10 business days of the survey date. Sites found deficient in any critical element during a Full Score Site Survey shall be required to correct

100% of the survey deficiencies, regardless of survey score. Critical elements include the following nine criteria:

1. Exit doors and aisles are unobstructed and egress (escape) accessible.
2. Airway management equipment, appropriate to practice and populations served, are present on site.
3. Only qualified/trained personnel retrieve, prepare or administer medications.
4. Office practice procedures are utilized on-site that provide timely physician review and follow-up of referrals, consultation reports and diagnostic test results.
5. Only lawfully-authorized persons dispense drugs to patients.
6. Personal protective equipment (PPE) is readily available for staff use.
7. Needlestick safety precautions are practiced on-site.
8. Blood, other potentially infectious materials (specimens) and regulated wastes (sharps/biohazardous non-sharps) are placed in appropriate leak-proof, labeled containers for collections, processing, storage, transport or shipping.
9. Spore testing of autoclave/steam sterilizer is completed (at least monthly, with documented results).

Top Facility Site Review Deficiencies

- Individual Health Education Behavioral Assessment (IHEBA)
- Documentation of education/training for non-licensed medical personnel in maintained on site
- Sterilized packages are labeled with sterilization date and load identification information

Top Medical Record Review Deficiencies

- There is no documentation on checking of emergency equipment/supplies for expiration and operating status at least monthly.
- Errors are corrected according to legal medical documentation standards
- Member's assigned primary care physician (PCP) is identified
- Primary language and linguistic service needs of non-or-limited –English proficient (LEP) or hearing –impaired persons are prominently noted
- Adult Immunizations
- Chlamydia screening
- Cervical Cancer Screening

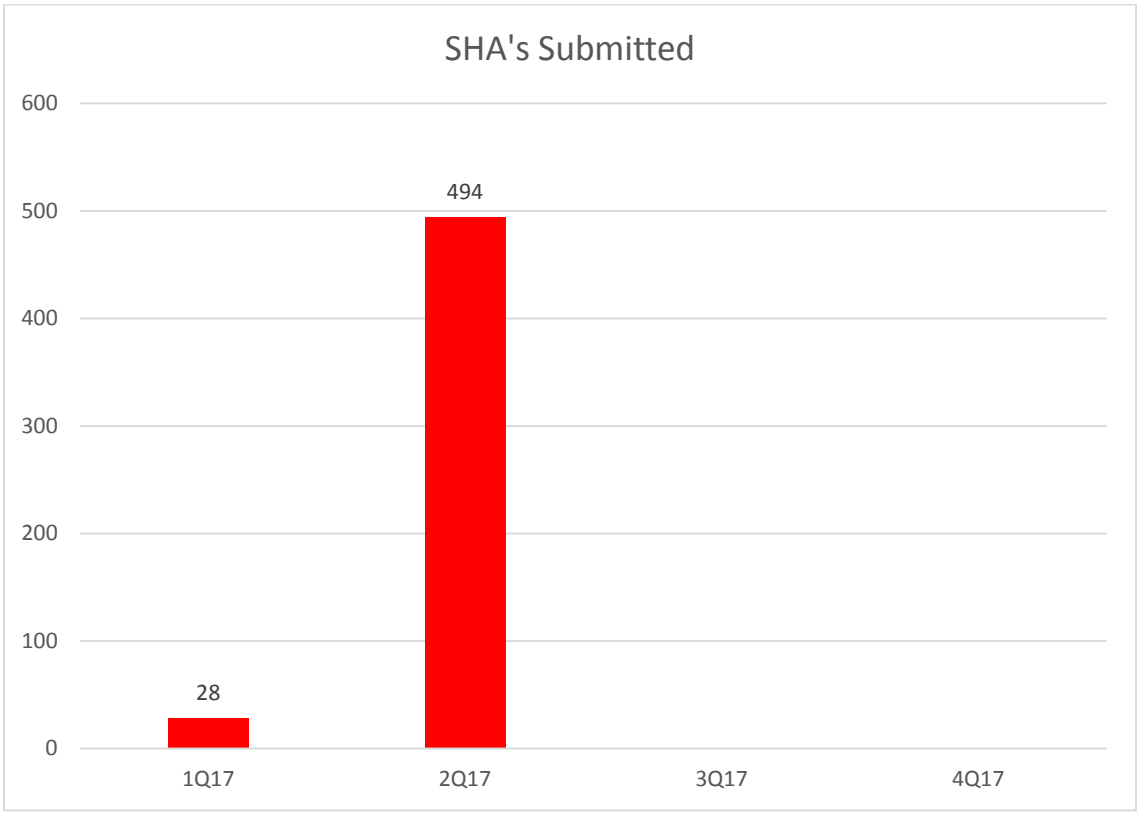
Providers are responsible for coming into compliance with the full site review criteria. KHS felt it would be in the best interest of our members to work with the providers to get them into compliance with the requirements at the time of our follow-up review and/or re-credentialing. If it is found that a site remains out of compliance and/or has a failing score, disciplinary action may be imposed.

KERN HEALTH SYSTEMS
STAYING HEALTH ASSESSMENTS MONITORING

SUMMARY: In addition to a disease management program, KHS attempts to identify opportunities to improve the health of the members who have been identified with health needs. During the course of P4P and HEDIS audits QI nurses identify those patients with positive Staying Healthy Assessments in their medical record. These positive SHAs are shared with Health Education to evaluate clinical follow-up and to assist them in developing their curriculum. The QI department collects data (shown below) on these members and reports the aggregate findings to the QI/UM Committee on a regular basis. There is a variance from quarter to quarter depending on the providers reviewed.

Staying Healthy Assessment Monitoring

During routine audits of medical records, QI RNs validate that a Staying Healthy Assessment was completed yearly. During 2nd Quarter 2017, there were 494 positive SHAs sent to Health Education. The majority were obtained during HEDIS. We anticipate that the number will decrease as the year progresses.



Kaiser Foundation Health Plan
Southern California Region
1st Quarter UM DME Report 2017

Kern Family Health

Q1 2017	ALL PLAN MEDI-CAL	Kern Family Health
ENROLLMENT	274809.00	4819.67
ACUTE DAYS/1000 MEMB	231.44	169.97
ACUTE DISCHARGES/1000 MEMB	64.66	70.05
ACUTE ALOS	3.52	2.58
ACUTE READMISSION RATE	0.11	0.00
SNF DAYS/1000 MEMB	14.45	5.76
SNF DISCHARGES/1000 MEMB	0.87	0.82
SNF ALOS	22.95	7.00
INPT PSYCH DAYS/1000 MEMB	4.20	0.37
INPT PSYCH DISCHARGES/1000 MEMB	0.66	0.82
INPT PSYCH ALOS	7.78	0.45
OUTPATIENT VISITS/MEMB	6.99	9.04
ER VISITS/1000 MEMB	420.34	16.20
UM DENIALS**		2
UM AUTHORIZATIONS**		59
TOTAL		61
UM DENIAL RATE		3.3%
UM APPEALS***		0
DME DENIALS**		0
DME AUTHORIZATIONS**		264
TOTAL		264
DME DENIAL RATE		0.0%
DME APPEALS***		1

**UM/DME Denials and UM/DME Referrals or Requests subject to Prior Authorization

***Appeals includes member appeals, complaints, and grievances

KP KHS Dental Report Q2 2017
Excel Screenshot

1. Non-DD Adults Dental General Anesthesia Reporting

A	B	C	D	E	F	G	H	I	J
Plan Code	Plan Name	County	Reporting Period	Number of Requests for Non-DD Adults	Number of Approvals for Non-DD Adults	Number of Denials for Non-DD Adults Due to Requested Documentation Not Submitted	Number of Denials for Non-DD Adults Due to Not Meeting Medical Necessity Criteria	Number of Denials for Non-DD Adults Due to Other Reasons	Other Denial Reasons for Non-DD Adults
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	4	3	0	1	0	
303	KAISER FOUNDATION HEALTH PLAN	Kern	Q2 2017	0	0	0			

2. DD Adults Dental General Anesthesia Reporting

A	B	C	D	E	F	G	H	I	J
Plan Code	Plan Name	County	Reporting Period	Number of Requests for DD Adults	Number of Approvals for DD Adults	Number of Denials for DD Adults Due to Requested Documentation Not	Number of Denials for DD Adults Due to Not Meeting Medical Necessity	Number of Denials for DD Adults Due to Other Reasons	Other Denial Reasons for DD Adults
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	0	0	0	0	0	
303	KAISER FOUNDATION HEALTH PLAN	Kern	Q2 2017						

3. Non-DD Children Dental General Anesthesia Reporting

A	B	C	D	E	F	G	H	I	J
Plan Code	Plan Name	County	Reporting Period	Number of Requests for Non-DD Children	Number of Approvals for Non-DD Children	Number of Denials for Non-DD Children Due to Requested Documentation	Number of Denials for Non-DD Children Due to Not Meeting Medical Necessity	Number of Denials for Non-DD Children Due to Other Reasons	Other Denial Reasons for Non-DD Children
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	175	173	0	1	1	Non-Contracted Provider
303	KAISER FOUNDATION HEALTH PLAN	Kern	Q2 2017	3	3				

A	B	C	D	E	F	G	H	I	J

4. DD Children Dental General Anesthesia Reporting

A	B	C	D	E	F	G	H	I	J
Plan Code	Plan Name	County	Reporting Period	Number of Requests for DD Children	Number of Approvals for DD Children	Number of Denials for DD Children Due to Requested Documentation Not	Number of Denials for DD Children Due to Not Meeting Medical Necessity	Number of Denials for DD Children Due to Other Reasons	Other Denial Reasons for DD Children
303	KERN HEALTH SYSTEMS	Kern	Q2 2017			0		0	
303	KAISER FOUNDATION HEALTH PLAN	Kern	Q2 2017	2	2				

1. Grievance & Appeal Reporting														
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
Plan Code	**Plan Name**	**County**	**Reporting Quarter**	**CIN** 9- characters, 8 digits and 1 letter character	**Accessibility** 1- Excessive long wait time/apt. schedule time 2- Lack of primary care provider availability 3- Lack of Specialist availability 4- Lack of telephone accessibility 5-Lack of language accessibility 6- Lack of facility physical access	**Resolved Accessibility Grievance** 0- Unresolved 1- Resolved in Favor of Member 2- Resolved in Favor of Plan	**Benefits/ Coverage** 1- Dispute over covered services	**Resolved Benefits/ Coverage Grievance** 0- Unresolved 1- Resolved in Favor of Member 2- Resolved in Favor of Plan	**Referral** 1- Plan Refusal to Refer 2- Provider Refusal to Refer 3- Delay in Referral	**Resolved Referral Grievance** 0- Unresolved 1- Resolved in Favor of Member 2- Resolved in Favor of Plan	**Quality of Care/ Service** 1- Inadequate facilities, non-access related 2- Inappropriate ancillary care 3- Inappropriate Hospital Care 4- Inappropriate Provider Care 5- Plan Denial of Treatment 6- Provider Denial of Treatment 7- Poor Provider/Staff Attitude	**Resolved Quality of Service Grievance** 0- Unresolved 1- Resolved in Favor of Member 2- Resolved in Favor of Plan	**Other** Please specify 1 = Other	**Resolved Other Grievance** 0- Unresolved 1- Resolved in Favor of Member 2- Resolved in Favor of Plan
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	96314301A							4	1		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	96485498A							7	1		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	93674388A			1	1						
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	99208773F	3	1								
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	90752246E			1	1						
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	91801272C							7	1		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	92699983E	3	2								
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	98403010C							7	1		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	93842334F			1	1						
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	94084822F							7	1		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	93263974A							7	1		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	95309466A							4	1		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	95432793A			1	2						
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	94323837C							7	1		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	94064997E	1	1								
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	98542833F	1	1								
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	99041821D										
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	96630963F							7	1		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	93807184C							7	1		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	93804350G							7	1		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	94218600A							1	2		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	92495941A							7	1		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	94913779D			1	1						
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	97049157E									1	0
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	95432793A							7	1		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	93394569F							4	1		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	99043587F			1	1						
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	91603555A							4	0		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	96292271C			1	2						
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	97120667D									1	2
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	93208534C							7	1		
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	98004039C	1	1					7	1		

Kaiser KHS Q2 2017 CBA Report
Excel Screen Shot

1. CBAS Services and Assessment Reporting

C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
										CBAS Outcome					
County	Reporting Quarter	No. of Requests for CBAS	No. of Members Assessed for CBAS	No. of Members Ineligible to Receive CBAS	No. of Members Received ECM services	No. of Members Provided CBAS	No. of Members Provided Unbundled Services	No. of CBAS Providers	Average # Days Between Request & Notice of Eligibility	Discharged: Death	Discharged: Long-Term Nursing Facility Placement	Discharged: Other Services	Patient Moved Out of Plan	Patient Chose to Leave CBAS	Patient Transferred to Different CBAS Center
Kern	Q2 2017	0	0	0	0	0	0	0	0	0	0	0	0	0	0

2. CBAS Grievance Reporting

A	B	C	D	E	F	G	H
Plan Code	Plan Name	County	Reporting Quarter	# of Grievances Regarding CBAS Providers	# of Grievances Regarding Contractor Assessment or Reassessment	# of Grievances Regarding Excessive Travel Times to Access CBAS	# of Other CBAS Grievances
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	0	0	0	0

3. CBAS Appeals Reporting

A	B	C	D	E	F	G	H	I	J	K
				(E+F+G)=(H+I+J+K)			(E+F+G)=(H+I+J+K)			
Plan Code	Plan Name	County	Reporting Quarter	# of CBAS Appeals Approved	# of CBAS Appeals Denied	# of CBAS Appeals Withdrawn	# of Appeals Related to Denials or Limited Services	# of Appeals Related to Denial to See Requested Provider	# of Appeals Regarding Excessive Travel Times to Access CBAS	# of Other CBAS Appeals
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	0	0	0	0	0	0	0

4. CBAS Call Center Complaints Reporting

A	B	C	D	E	F
Plan Code	Plan Name	County	Reporting Quarter	Member Calls	Provider Calls
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	0	0

Kaiser KHS Mental Health 2Q17 Report
Excel Screen Shot

1. MH Referrals Reporting

A	B	C	D	F	G	H	I	J	K
Plan Code	Plan Name	County	Reporting Quarter	Total # of Plan Members	# of Referrals by SMHP to MCP	# of Referrals by MCP to SMHP (Within County)	# Referrals to MCP Mental Health Provider	# of Referrals by MCP to SMHP (Other County)	County Code for Referrals to SMHP Outside the County
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	7,747	0	0	161	0	0

3. MH Continuity Of Care Reporting

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
Plan Code	Plan Name	County	Reporting Quarter	Total # of Mental Health COC Approvals	The Average # of Days it took to Approve Request	The Average # of Sessions the COC Request was Approved For	Total # of COC Denials Do not fill in	The Average # of Days it took to Deny COC	Denial Reason: Care Relationship Not Established	Denial Reason: Quality of Care	Denial Reason: Disagreement on the Rate	Denial Reason: Provider Refused to Work with a Managed Care	Denial Reason: Other	Explanation of Denial Reason: Other	# of COC Requests In Process
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	0	0	0	0	0	0	0	0	0	0	0	0
							0								

2. MH Grievance & Appeal Reporting

A	B	C	D	F	G	H	I	J	K	L	M	N	O	P	Q	R
Plan Code	Plan Name	County	Reporting Quarter	Total Grievances Do not fill in	Reason for Grievance: Psychotherapy (Evaluation & Treatment)	Reason for Grievance: Outpatient Services	Reason for Grievance: Laboratory, Supplies, etc.	Reason for Grievance: Access to SMHP	Reason for Grievance: Authorization/ Referral to SMHP	Reason for Grievance: Medication / Pharmacy	Reason for Grievance: All Other	Other Grievance Description	# of Grievances Resolved Within 30 Days	# of Grievance Pending in Plan's Internal Grievance System Less Than 30 Days	# of Grievance Pending in Plan's Internal Grievance System Greater Than	# of Grievances Resolved from a Previous Reporting Period
303	KERN HEALTH SYSTEMS	Kern	Q2 2017	2	0	0	0	0	2	0	0		2	0	0	0
				0												

Kaiser 2016 QI Program Evaluation

Full document can be accessed on the KHS Website at the following link: http://www.kernfamilyhealthcare.com/page.asp/csasp/DepartmentID.1478/cs/SectionID.2967/cs/PageID.15850/csasp.html

Kaiser 2017 QI Program Description

Full document can be accessed on the KHS Website at the following link: http://www.kernfamilyhealthcare.com/page.asp/csasp/DepartmentID.1478/cs/SectionID.2967/cs/PageID.15850/csasp.html

Kaiser 2017 QI Work Plan

Full document can be accessed on the KHS Website at the following link: http://www.kernfamilyhealthcare.com/page.asp/csasp/DepartmentID.1478/cs/SectionID.2967/cs/PageID.15850/csasp.html

Medical Data Collection Summary Report

Period Covered: May, 2016 through April, 2017
Prepared For: KERN HEALTH SYSTEMS - (12049397)

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:	19,404	
Diabetes?:	789	4.1%
Diabetic Retinopathy:	78	.4%
Glaucoma:	24	.1%
Hypertension:	755	3.9%
High Cholesterol	247	1.3%
Macular Degeneration:	25	.1%

Estimated Number of Cases

Total Members:	240,308	
Diabetes?:	5,468	2.3%
Diabetic Retinopathy:	457	.2%
Glaucoma:	908	.4%
Hypertension:	23,830	9.9%
High Cholesterol	36,308	15.1%
Macular Degeneration:	283	.1%

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

Medical Data Collection Summary Report

Period Covered: June, 2016 through May, 2017
Prepared For: KERN HEALTH SYSTEMS - (12049397)

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:	19,636	
Diabetes?:	796	4.1%
Diabetic Retinopathy:	80	.4%
Glaucoma:	28	.1%
Hypertension:	761	3.9%
High Cholesterol	239	1.2%
Macular Degeneration:	31	.2%

Estimated Number of Cases

Total Members:	241,148	
Diabetes?:	5,509	2.3%
Diabetic Retinopathy:	463	.2%
Glaucoma:	915	.4%
Hypertension:	24,004	10.0%
High Cholesterol	36,447	15.1%
Macular Degeneration:	288	.1%

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

Medical Data Collection Summary Report

Period Covered: July, 2016 through June, 2017
Prepared For: KERN HEALTH SYSTEMS - (12049397)

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:	19,991	
Diabetes?:	829	4.1%
Diabetic Retinopathy:	79	.4%
Glaucoma:	33	.2%
Hypertension:	774	3.9%
High Cholesterol	235	1.2%
Macular Degeneration:	36	.2%

Estimated Number of Cases

Total Members:	241,282	
Diabetes?:	5,520	2.3%
Diabetic Retinopathy:	465	.2%
Glaucoma:	916	.4%
Hypertension:	24,051	10.0%
High Cholesterol	36,471	15.1%
Macular Degeneration:	290	.1%

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

Medical Data Collection Summary Report

Period Covered: August, 2016 through July, 2017
Prepared for: KERN HEALTH SYSTEMS - (12049397)

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:	20,096	
Diabetes?:	842	4.2%
Diabetic Retinopathy:	81	.4%
Glaucoma:	52	.3%
Hypertension:	761	3.8%
High Cholesterol	233	1.2%
Macular Degeneration:	39	.2%

Estimated Number of Cases

Total Members:	241,716	
Diabetes?:	5,523	2.3%
Diabetic Retinopathy:	463	.2%
Glaucoma:	916	.4%
Hypertension:	24,067	10.0%
High Cholesterol	36,533	15.1%
Macular Degeneration:	289	.1%

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

A	B	C	D	E	F	G	H	I	J	K
Plan Name	Reporting Quarter	Number of Calls Received Do not fill in	Number of Calls Abandoned	Number of Calls Answered	Average Wait Time (H:MM:SS)	Average Talk Time (H:MM:SS)	Abandonment Rate = D/C Do not fill in	Service Level (0-100)	Member Only Calls (Y/N)	Medi-Cal Only Calls (Y/N)
KERN HEALTH SYSTEMS	Q2 2017	52765	417	52348	0:00:14	0:07:16	0.8%	92%	Y	Y
KAISER FOUNDATION HEALTH PLAN	Q2 2017	925	1	924	0:00:39	0:05:54	0.1%	86%	N	Y
		0					#DIV/0!			
		0					#DIV/0!			
		0					#DIV/0!			
		0					#DIV/0!			
		0					#DIV/0!			
		0					#DIV/0!			
		0					#DIV/0!			
		0					#DIV/0!			
		0					#DIV/0!			
		0					#DIV/0!			
		0					#DIV/0!			
		0					#DIV/0!			
		0					#DIV/0!			
		0					#DIV/0!			
		0					#DIV/0!			
		0					#DIV/0!			
		0					#DIV/0!			
		0					#DIV/0!			
		0					#DIV/0!			
		0					#DIV/0!			
		0					#DIV/0!			
		0					#DIV/0!			
		0					#DIV/0!			
		0					#DIV/0!			
		0					#DIV/0!			
		0					#DIV/0!			
		0					#DIV/0!			
		0					#DIV/0!			
		0					#DIV/0!			

2016-2017 COMPARATIVE TABULATED GRIEVANCES

Kern Family Health Care Grievances	4th Quarter 2016	1st Quarter 2017	1st Quarter 2016
Access to Care (PCP)	**7**	**6**	**13**
Difficulty Accessing Specialist	**0**	**3**	**4**
Quality of Care	**31**	**36**	**59**
Quality of Service	**150**	**119**	**150**
Medical Necessity	**26**	**18**	**41**
Coverage Dispute	**17**	**19**	**25**
Cultural and Lingustic Dissatisfaction	**0**	**2**	**1**
Other Issue	**2**	**5**	**7**
Total Grievances	**233**	**208**	**300**
MCAL (NonSPD) Grievances	**112**	**105**	**143**
SPD Grievances	**44**	**52**	**63**
Expansion Grievances	**77**	**51**	**94**
Cases Upheld by Plan	**182**	**158**	**250**
Cases Found in Favor of the Enrollee	**51**	**49**	**49**
Pending at the time of report	**0**	**1**	**1**
Kaiser Permanente Grievances			
Access to Care (PCP)	**1**	**2**	**2**
Difficulty Accessing Specialist	**0**	**1**	**1**
Quality of Care	**11**	**7**	**1**
Quality of Servive	**7**	**9**	**8**
Medical Necessity	**3**	**6**	**1**
Coverage Dispute	**2**	**0**	**2**
Cultural and Lingustic Dissatisfaction	**1**	**0**	**0**
Other Issue	**1**	**1**	**1**
Total Grievances	**26**	**26**	**16**
State Fair Hearings			
Coverage Dispute	**1**	**3**	**3**
Medical Necessity	**0**	**6**	**4**
Quality of Care	**0**	**0**	**0**
Access to Care	**0**	**0**	**0**
Quality of Service	**0**	**1**	**0**
Other Issues	**0**	**0**	**0**
Total	**1**	**10**	**7**
Cases Found in Favor of the Plan	**1**	**1**	**2**
Cases Found in Favor of the Enrollee	**0**	**0**	**1**
Waiting on Decision or Case not Heard Yet	**0**	**9**	**4**
DMHC Complaints			
Coverage Dispute	0	0	0
Medical Necessity	2	2	1
Quality of Care	1	1	0
Access to Care	0	0	0
Quality of Service	0	1	0
Other Issues	0	0	1
Total	**3**	**4**	**2**
DMHC Complaints Found in Favor of the Plan	**2**	3	1
DMHC Complaints Found in Favor of the Enrollee	1	1	1
Decisions Pending at the time of report	0	0	0

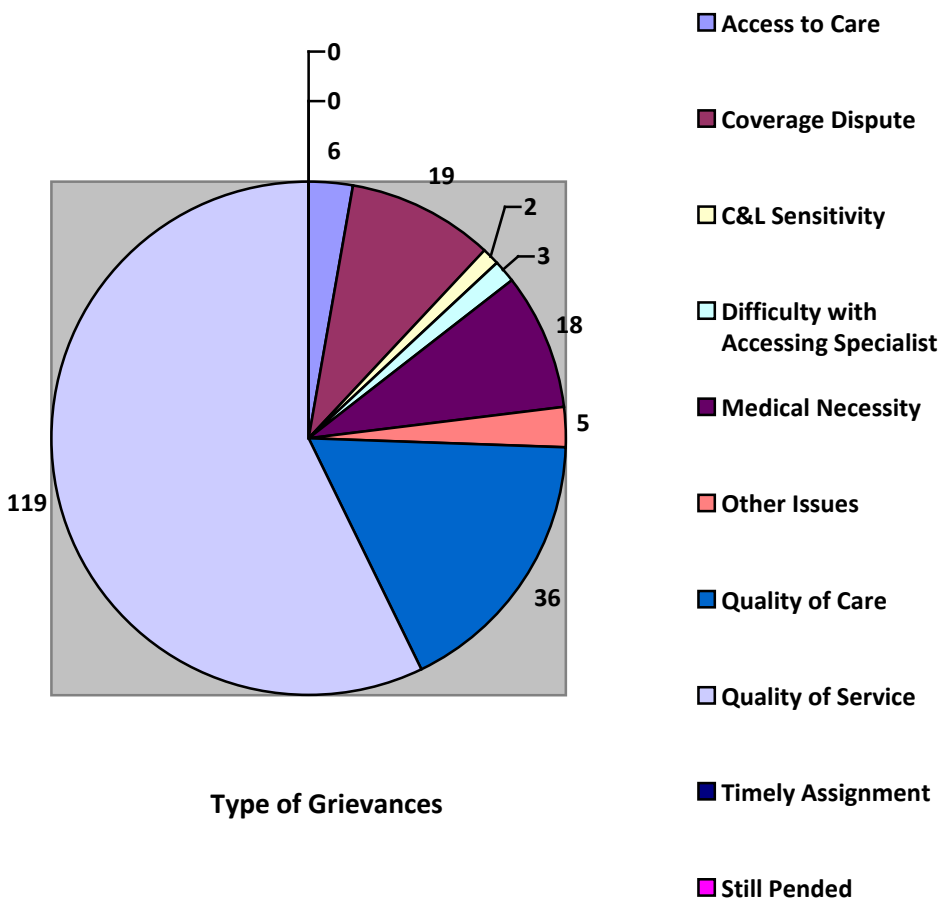
LEGEND OF CATEGORIES
Access to Care (PCP) - Issues related to long wait times or difficulty scheduling PCP appointments.
Difficulty Accessing Specialist - Issues related to difficulty scheduling specialty appointments.
Quality of Care - Dissatisfied with care received from provider, staff or facility staff.
Quality of Service - Dissatisfied with serive received from provider, staff or facility staff.
Medical Necessity - Appeals for denied authorization or medication requests that are denied based on medical necessity.
Coverage Dispute - Appeals for denied authorization or medication requests that are not a covered benefit under KFHC and/or FFS Medi-Cal.
Cultural and Linguistic Dissatisfaction - Issues related to a language barrier or interpretation services.
Other Issue - Any other dissatisfaction not related to any of the above categories.

2016-2017 COMPARATIVE TABULATED GRIEVANCES

Independent Medical Reviews	4th Quarter 2016	1st Quarter 2017	1st Quarter 2016
Delay of Services	0	0	0
Modification of Services	0	0	0
Denial of Services	2	3	3
Total	**2**	**3**	**3**
IMR Cases Found in Favor of the Plan	**1**	0	1
IMR Cases Found in Favor of the Enrollee	1	3	2
Decisions Pending at the time of report	0	0	0
Enrollment Counts vs Grievances Received Per Quarter - Total Enrollment			
Total Enrollment	241,607	247,774	222,155
Grievances per 1,000 Members	0.96	0.84	1.35
Percentage of Grievances	0.096%	0.084%	0.135%
Enrollment Counts vs Grievances Received Per Quarter - MCAL (Non SPD) Members			
Total Enrollment	227,973	234,100	203,985
Grievances per 1,000 Members	0.83	0.67	0.89
Percentage of Grievances	0.083%	0.067%	0.089%
Enrollment Counts vs Grievances Received Per Quarter - SPD Members			
Total Enrollment	13,634	13,674	13,453
Grievances per 1,000 Members	3.22	3.80	1.86
Percentage of Grievances	0.32%	0.38%	0.19%
Enrollment Counts vs Grievances Received Per Quarter - Expansion Members			
Total Enrollment	55,730	58,015	50,935
Grievances per 1,000 Members	1.39	0.88	1.85
Percentage of Grievances	0.14%	0.88%	0.19%
Enrollment Counts vs Grievances Received Per Quarter - Kaiser Members			
Total Enrollment	7,103	7,466	5,542
Grievances per 1,000 Members	3.66	3.48	2.89
Percentage of Grievances	0.37%	0.35%	0.29%

1st Quarter 2017 Grievance Summary

Issue	Number	In Favor of Health Plan	In Favor of Enrollee
Access to care	6	3	3
Coverage dispute	19	19	0
Cultural and Linguistic Sensitivity	2	1	1
Difficulty with accessing specialists	3	2	1
Medical necessity	18	17	1
Other issues	5	5	0
Quality of care	36	26	10
Quality of service	119	86	33
Timely assignment to provider	0	0	0
Still under review	0	0	0



Type of Grievances

Grievances per 1,000 Members = 0.96

During the first quarter of 2017, there were two hundred and eight grievances received. Forty nine cases were closed in favor of the Enrollee and one hundred and fifty nine were closed in favor of the Plan. All of the cases were closed within thirty days of receipt. Forty four cases

were received from SPD (Seniors and Persons with Disabilities) members. One hundred and seven were received from Medi-Cal Expansion members.

Access to Care

There were six grievances pertaining to access to care. Three cases closed in favor of the Plan. Three cases closed in favor of the Enrollee. The following is a summary of these issues.

Three members complained about the lack of available appointments with their Primary Care Provider (PCP). One case closed in favor of the Plan after the responses indicated the office provided appropriate access to care based on the Access to Care Standards for PCP appointments. Two cases closed in favor of the Enrollee after the responses indicated the offices did not provide appropriate access to care based on the Access to Care Standards for PCP appointments.

Three members complained about the wait time to be seen for a Primary Care Provider (PCP) appointment. Two cases closed in favor of the Plan after the responses indicated the member was seen within the appropriate wait time for an appointment or the member was there for a walk-in, which are not held to Access to Care wait time protocol. One case closed in favor of the Enrollee after the response indicated the member was not seen within the appropriate wait time for an appointment.

Coverage Dispute

There were nineteen grievances pertaining to a Coverage Dispute issue. All of the cases closed in favor of the Plan. The following is a summary of these issues:

Thirteen members complained about the denial of a TAR for non-formulary or restricted medications. These cases were found in favor of the Plan. Upon review it was determined that the TARs were appropriately denied as not a covered benefit under the KFHC Drug Formulary.

Six members complained about the denial of a referral authorization request. These cases were closed in favor of the Plan and the decisions were upheld after it was determined that the requests were appropriately denied as the requested services were not a covered benefit or the requested providers were not contracted under KFHC.

Cultural and Linguistic Sensitivity

There were two grievances pertaining to Cultural and Linguistic Sensitivity. One of the cases closed in favor of the Enrollee. One of the cases closed in favor of the Plan. The following is a summary of these issues.

Two members complained about the lack of an interpreter for a scheduled appointment. One case closed in favor of the Plan after the response indicated the office provided appropriate access to an interpreter. One case closed in favor of the Enrollee after the

responses indicated the office failed to reschedule an interpreter when member's appointment was rescheduled.

Difficulty with Accessing a Specialist

There were three grievances pertaining to Difficulty Accessing a Specialist. One of the cases closed in favor of the Enrollee. Two of the cases closed in favor of the Plan. The following is a summary of these issues.

Three members complained about the lack of available appointments with a specialist. Two cases closed in favor of the Plan after the responses indicated the offices provided appropriate access to care based on the Access to Care Standards for specialty appointments. One case closed in favor of the Enrollee after the responses indicated the office did not provide appropriate access to care based on the Access to Care Standards for specialty appointments.

Medical Necessity

There were eighteen grievances pertaining to Medical Necessity. Seventeen of the cases were closed in favor of the Plan. One of the cases closed in favor of the Enrollee. The following is a summary of these issues.

Eighteen members complained about the denial or modification of a referral authorization request. Seventeen of the cases were 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 of the requested specialist or DME item and the denials were upheld. One of the cases closed in favor of the Enrollee after it was determined the authorization may have been denied inappropriately.

No members complained about the denial of a TAR for a medication.

Other Issues

There were five grievances pertaining to Other Issues. All of the cases closed in favor of the Plan. The following is a summary of these issues:

One member complained that she and her children's glasses began falling apart as soon as they were received. This case closed in favor of the Plan after it was determined the member had not contacted the provider's office with any concerns regarding the glasses so they could attempt to fix them.

One member's wife complained that KFHC would not cover a medication because Other Health Coverage (OHC) was showing on the Medi-Cal website and the Plan would not remove the OHC. This case closed in favor of the Plan after it was determined it is not the responsibility of the Plan to remove OHC from the Medi-Cal website.

One member's mother complained about the services received from a mental health provider. This case closed in favor of the Plan after it was determined the provider the mother complained about is with Kern County Mental Health (KCMH). The Plan does not cover mental health services provided through KCMH.

One member complained about the services received from a mental health provider. This case closed in favor of the Plan after it was determined the provider the mother complained about is with Kern County Mental Health (KCMH). The Plan does not cover mental health services provided through KCMH.

One member complained that his glasses began falling apart as soon as they were received. This case closed in favor of the Plan after it was determined the member received his glasses through his employer's provided vision benefits.

Quality of Care

There were thirty six grievances involving Quality of Care issues. Twenty six cases were closed in favor of the Plan. Ten cases were closed in favor of the Enrollee. The following is a summary of these issues:

Twenty four complained about the quality of care received from a Primary Care Provider (PCP). Sixteen cases were closed in favor of the Plan after it was determined that the provider or their staff provided the member with the appropriate care. Eight cases were closed in favor of the Enrollee after review of all medical documents and written responses received indicated that appropriate care may not have been provided.

Six members complained about the quality of care received from a specialty provider. Five cases were closed in favor of the Plan after it was determined that the specialist provided the member with the appropriate care. One case closed in favor of the Enrollee after review of all medical documents and written responses received indicated that appropriate care may not have been provided.

Five members complained about the quality of care received from the provider or staff with a hospital or urgent care. All of the cases were closed in favor of the Plan after review of medical records and written responses received indicated that the members were provided appropriate care.

One member complained about the quality of care received from a pharmacy. This case closed in favor of the Enrollee after it was determined that the provider or their staff may not have provided the member with the appropriate care.

All cases were forwarded to the Quality Improvement (Q.I.) Department for review to determine if further investigation was necessary.

Quality of Service

1st Quarter 2017 Grievance Summary

There were one hundred and nineteen grievances pertaining to Quality of Service. Eighty six were closed in favor of the Plan and thirty three cases were closed in favor of the Enrollee. The following is a summary of these issues:

Forty eight members complained about the service they received from a provider. Thirty seven were closed in favor of the Plan after the written responses were reviewed and it was determined that the service the members received from their providers was appropriate. Eleven cases were closed in favor of the Enrollee after the written responses were reviewed and showed that the members may not have received the appropriate service from their provider. These cases were sent to PR for Tracking and Trending.

Twenty one members complained about the service they received from a provider and their staff members. Fourteen cases were closed in favor of the Plan after the written responses were reviewed and it was determined that the service the members received was appropriate. Seven of the cases were closed in favor of the Enrollee after review of the written responses indicated that the members may not have received the appropriate service from the providers and their staff. These cases were sent to PR for Tracking and Trending.

Forty six members complained about the service received from the staff at a health care facility, pharmacy, or provider's office. Thirty three cases were closed in favor of the Plan after review of the responses indicated that the members received appropriate service at the time of their visits. Thirteen cases were closed in favor of the Enrollee after review of the written response indicated that the members may not have received the appropriate service from the staff at the health care facility, pharmacy or provider's office. These cases were sent to PR for Tracking and Trending.

Two members complained about the services received from the staff with Kern Family Health Care (KFHC). One case closed in favor of the Plan after it was determined the member received appropriate service from the KFHC staff member. One case were closed in favor of the Enrollee after it was determined the member may not have received the appropriate service.

Two members complained about the services received from the staff with the KFCH Nurse Advise Line. One case closed in favor of the Plan after it was determined the member received appropriate service from the staff with the KFHC Nurse Advise Line. One case were closed in favor of the Enrollee after it was determined the member may not have received the appropriate service.

Timely Assignment to Provider

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

1st Quarter 2017 Grievance Summary

Kaiser Permanente Grievances

During the first quarter of 2017, there were twenty six grievances received by KFHC members assigned to Kaiser Permanente. Twenty two cases were closed in favor of the Enrollee and four cases were closed in favor of the Plan.

Access to Care

There were two grievances pertaining to Access to Care. These cases closed in favor of the Enrollee. The following is a summary of these issue.

> Two members complained about the excessive wait time to be seen for an appointment. Both cases closed in favor of the Enrollee.

Coverage Dispute

> There were no grievances pertaining to Coverage Dispute.

Difficulty Accessing a Specialist

There was one grievance pertaining to Difficulty Accessing a Specialist. This case closed in favor of the Enrollee. The following is a summary of this issue.

> One member complained about the excessive wait time to be seen for a specialty appointment. This case closed in favor of the enrollee.

Medical Necessity

There were six grievances pertaining to Medical Necessity. The following is a summary of these issues:

> Six members complained about services they requested not being approved. Five cases were closed in favor of the Enrollee and services were authorized. One case closed in favor of the Plan as the service requested was not medically necessary.

Quality of Care

There were seven grievances pertaining to Quality of Care. Four cases closed in favor of the Enrollees and three cases closed in favor of the Plan. The following is a summary of these issues:

> Seven members complained about the care they received from their providers or non-clinical staff. Four cases were closed in favor of the Enrollees and three cases closed in favor of the Plan.

1st Quarter 2017 Grievance Summary

Quality of Service

There were nine grievances pertaining to Quality of Service. All cases were closed in favor of the Enrollees. The following is a summary of these issues:

Nine members complained about the service they received from their providers or non-clinical staff. All cases were closed in favor of the Enrollees.

Other Issues

There was one grievance pertaining to Other Issues. This case closed in favor of the Plan. The following is a summary of this issue:

One member complained about operations or policy issues, this case was closed in favor of the Plan.

KERN HEALTH SYSTEMS
2nd Quarter 2017
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

Report Date: July 12, 2017

Department: Provider Relations

Monitoring Period: April 1, 2017 through June 30, 2017

Population:

Providers	Credentialed	Recredentialed
MD's	68	90
DO's	3	4
AU's	0	1
DC's	3	0
AC's	3	0
PA's	8	7
NP's	16	13
CRNA's	7	2
DPM's	8	1
OD's	1	1
ND's	0	0
BCBA's	10	0
Mental Health	6	1
Ocularist	0	0
Ancillary	13	30
OT	0	0
TOTAL	**146**	**150**

Specialty	Providers Credentialed	Providers Recredentialed	Providers Sent to PAC	Providers Not Approved
Acupuncture	3	0	3	0
Allergy & Immunology	0	1	1	0
Anesthesiology / CRNA	9	5	14	0
Audiology	0	1	1	0
Autism / Behavioral Analyst	10	0	10	0
Cardiology	1	3	4	0
Chiropractor	3	0	3	0
Colon & Rectal Surgery	0	0	0	0
Critical Care	1	0	1	0
Dermatology	5	0	5	0
Emergency Medicine	9	0	9	0
Endocrinology	1	1	2	0
Family Practice	17	10	27	0
Gastroenterology	0	2	2	0
General Practice	1	10	11	0
General Surgery	2	1	3	0
Genetics	0	0	0	0
Gynecology	0	0	0	0
Gynecology/Oncology	0	0	0	0
Hematology/Oncology	1	3	4	0
Hospitalist	0	0	0	0
Infectious Disease	0	0	0	0
Internal Medicine	6	17	23	0

KERN HEALTH SYSTEMS
2nd Quarter 2017
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

Specialty	Providers Credentialed	Providers Recredentialed	Providers Sent to PAC	Providers Not Approved
Mental Health	6	1	7	0
Mid Wife	0	0	0	0
Naturopathic Medicine	0	0	0	
Neonatology	0	1	1	0
Nephrology	2	3	5	0
Neurological Surgery	0	2	2	0
Neurology	0	0	0	0
Obstetrics & Gynecology	3	10	13	0
Ocularist	0	0	0	0
Occupational Therapy	0	0	0	0
Ophthalmology	2	4	6	0
Optometry	1	1	2	0
Orthopedic Surgery / Hand Surg	2	2	4	0
Otolaryngology	0	0	0	0
Pain Management	2	1	3	0
Pathology	2	1	3	0
Pediatrics	6	13	19	0
Physical Medicine & Rehab	0	1	1	0
Plastic Sugery	0	0	0	0
Podiatry	8	1	9	0
Psychiatry	8	7	15	0
Pulmonary	5	1	6	0
Radiation Oncology	0	0	0	0
Radiology	21	15	36	0
Rheumatology	0	1	1	0
Sleep Medicine	0	0	0	0
Thoracic Surgery	0	1	1	0
Vascular Medicine	0	0	0	0
Vascular Surgery	0	0	0	0
Urology	0	0	0	0
TOTAL	**137**	**120**	**257**	**0**
ANCILLARY				
Ambulance	0	0	0	0
Cardiac Sonography	0	0	0	0
Comm. Based Adult Services	0	0	0	0
Dialysis Center	1	1	2	0
DME	1	2	3	0
Hearing Aid Dispenser	0	0	0	0
Home Health	2	1	3	0
Home Infusion/Compounding	0	0	0	0
Hospice	0	2	2	0
Hospital	1	1	2	0
Laboratory	1	3	4	0
Lactation Consultant	1	0	1	0
MRI	0	0	0	0
Ocular Prosthetics	0	0	0	0
Pharmacy	1	10	11	0
Pharmacy/DME	0	0	0	0

KERN HEALTH SYSTEMS
2nd Quarter 2017
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

ANCILLARY				
Physical / Speech Therapy	3	2	5	0
Prosthetics & Orthotics	0	2	2	0
Radiology	0	0	0	0
Skilled Nursing	0	0	0	0
Sleep Lab	0	1	1	0
Surgery Center	1	3	4	0
Transportation	1	2	3	0
Urgent Care	0	0	0	0
TOTAL	**13**	**30**	**43**	**0**

Defer = 0 **Denied = 0**

KERN HEALTH SYSTEMS
BOARD OF DIRECTORS
NEW VENDOR CONTRACTS
BOD: APRIL 13, 2017

Name	DBA	Specialty	Address	Contract Effective Date
Chadam Associates, Inc A Physical Therapy Corporation	Western Rehabilitation Associates	Physical Therapy	377 S. 10th Street #G Taft Ca 93268	5/1/2017
Dependable Home Health, Inc	Dependable Home Health, Inc	Home Health	16922 Airport Blvd Ste 17, Bldg 1 Mojave, CA 93501	5/1/2017
Guardian Angel Home Care Inc	Guardian Angel Home Care Inc	Home Health	501 East Commerce Center Drive Suite 240 Bakersfield Ca 93309	5/1/2017
Hygeia Medical Group, Inc.	A Breast Pump & More	DME / Breast Pumps	1121 W. Valley Blvd. Ste.I	4/1/2017
Montoya Physical Therapy & Wellness	Montoya Physical Therapy	Physical Therapy	11000 Brimhall Rd Ste # Box 7 Bakersfield Ca 93312	5/1/2017
Prime Pulmonary &Sleep Medicine Center. Inc	Prime Pulmonary &Sleep Medicine Center. Inc	Pulmonary, Critical Care and Sleep Medicine	8305 Brimhall RD, Ste 1601 Bakersfield, CA and 1205 Garces Hwy, Ste 203, Delano, CA	4/1/2017
Z&XY Enterprise Inc	Chinese Medical Center	Acupuncture	4505 Mattnick Drive Bakersfield Ca 93313	5/1/2017
Leah Jarvis BCBA	Jarvis Behavior Consulting	Behavior Analyst	9808 Margery Avenue California City 93505	5/1/2017
Adventist Health Medical Center / Tehachapi Hospital	Adventist Health Medical Center / Tehachapi Hospital	Hospital	115 West E Street	4/1/2017

KERN HEALTH SYSTEMS
BOARD OF DIRECTORS
NEW VENDOR CONTRACTS
MAY 3, 2017

Name	DBA	Specialty	Address	Contract Effective Date
Agia Pharmacy & Café, Inc	Agia Pharmacy & Café	Pharmacy	276 S. Mill Street Ste. A Tehachapi CA 93561	6/1/2017
Huisoon Kim Professional Acupuncture Corp.	Kim's Acupuncture Clinic	Acupuncture	276 S. Mill Street Ste. A Tehachapi CA 93561	6/1/2017
Medical Diagnostic Laboratories LLC	Medical Diagnostic Laboratories	Laboratory / Specialized Laboratory Testing	2439 Kuser Road Hamilton NJ 08690	6/1/2017

Kern Health Systems
Approved Providers Effective 5-01-17

	A	B	C	D	E	F	G
1	NAME	DBA/ADDRESS	Provider #	Pay To #	Effective	Specialty	
2	A Breast Pump and More	Hygeia II Medical Group, Inc dba: A Breast Pump and More 1121 W Valley Blvd, Ste I Tehachapi CA 93301	PRV039475	PRV039475	**4/1/2017**	DME	
3	Dependable Home Health, Inc	Dependable Home Health, Inc. 16922 Airport Blvd Ste 17, Bldg 1 Mojave, CA 93501	PRV031957	PRV031957	**5/1/2017**	Home Health	
4	Guardian Angel Home Care, Inc	Guardian Home Care, Inc. 5001 East Commerce Center Drive Ste 240 Bakersfield CA 93309	PRV039734	PRV039734	**5/1/2017**	Home Health	
5	Montoya Physical Therapy & Wellness	Montoya Physical Therapy & Wellness PC 8501 Brimhall Road Suite 201 Bakersifled CA 93312	PRV039735	PRV039735	**5/1/2017**	Physical Therapy	
6	Bansal, Ruchi MD	Prime Pulmonary & Sleep Medicine Center, Inc 8305 Brimhall Road Ste 1601 Bakersfield CA 93312 Alternate Location: 1205 Garces Hwy Ste 203	PRV039736	PRV039731	**5/1/2017**	Pulmonary Disease	
7	Vaghasia, Pramil MD	Prime Pulmonary & Sleep Medicine Center, Inc 1205 Garces Hwy Ste 203 Delano CA 93215 Alternate Location: 8305 Brimhall Road Ste 1601	PRV039737	PRV039731	**5/1/2017**	Pulmonary Disease	
8	Western Rehabilitation Associates	Chadam Associates Inc, A PT Corp dba: Western Rehabilitation Associates 337 S 10th Street Ste G Taft CA 93268	PRV035326	PRV035326	**5/1/2017**	Physical Therapy	

Kern Health Systems
Approved Providers Effective 5-01-17

	A	B	C	D	E	F	G
9	Zhang, Shujuan AC	Z&XY Enterprises, Inc dba: Chinese Medical Center 4505 Mattnick Drive Bakersfield CA 93313	PRV039873	PRV039745	**5/1/2017**	Acupuncture	
10	Algee, Mark, DC	Omni Family Health 1100 Fourth Street Bldg A Taft CA 93268	PRV038095	PRV000019	**5/1/2017**	Chiropractic	
11	Al Harakeh, Ayman MD	Central California Medical Group 432 Lexington Street Unit A Delano CA 93215	PRV038386	PRV014321	**5/1/2017**	General Surgery	
12	Anderson, Janice LCSW	Lags Spine & Sportscare Medical Center Inc 3550 Q Street Suite 201 Bakersfield CA 93301	PRV036378	PRV000403	**5/1/2017**	Clinical Social Worker	
13	Antes, James PA-C	Ridgecrest Regional Hospital RHC 1111 N China Lake Blvd Ridgecrest CA 93555	PRV010625	PRV000279	**5/1/2017**	Orthopedic Surgery & Family Medicine	
14	Arrache, Natalie BCBA	Center for Autism & Related Disorders 5300 Lennox Avenue Bakersfield CA 93309	PRV038093	PRV032083	**5/1/2017**	Behavior Analyst / Qualified Autism Services Provider	
15	Azimian, Kian MD	Priority Urgent Care 4821 Panama Lane Unit A-C Bakersfield CA 93311	PRV001043	PRV038192	**5/1/2017**	Emergency Medicine	
16	Busch, Deanna BCBA	Center for Autism & Related Disorders 5300 Lennox Avenue Bakersfield CA 93309	PRV039738	PRV032083	**5/1/2017**	Behavior Analyst / Qualified Autism Services Provider	

Kern Health Systems
Approved Providers Effective 5-01-17

	A	B	C	D	E	F	G
17	Carr, Matthew MD	Renaissance Imaging Medical Associates, Inc 1600 Avenue J Lancaster CA 93534 Alternate Locations: 44105 W. 15th Street Ste. 100 Lancaster 38925 Trade Center Drive Ste. E Palmdale	PRV003382	PRV000324	**5/1/2017**	Diagnostic Radiology	
18	Cepeda, Pedro MD	Ridgecrest Regional Hospital RHC 1111 N China Lake Blvd Ste 301 Ridgecrest CA 93555	PRV038410	PRV029495	**5/1/2017**	OB/GYN	
19	Chand, Maureen CRNA	Regional Anesthesia Associates Inc 1700 Mt Vernon Avenue Bakersfield CA 93306	PRV037707	PRV03540	**5/1/2017**	Certified Nurse Anesthetist	
20	Chand, Ravindra MD	Telehealthdocs Medical Group 2215 Truxtun Avenue Bakersfield CA 93301	PRV038252	PRV036952	5/1/2017	Psychiatry	
21	Chang, Geraldine MD	Renaissance Imaging Medical Associates, Inc 1600 Avenue J Lancaster CA 93534 Alternate Locations: 44105 W. 15th Street Ste. 100 Lancaster 38925 Trade Center Drive Ste. E Palmdale	PRV039739	PRV000324	**5/1/2017**	Diagnostic Radiology	
22	Ching, On CRNA	Regional Anesthesia Associates Inc 1700 Mt Vernon Avenue Bakersfield CA 93306	PRV038043	PRV037540	**5/1/2017**	Certified Nurse Anesthetist	
23	Cooper, Paul CRNA	Regional Anesthesia Associates Inc 1700 Mt Vernon Avenue Bakersfield CA 93306	PRV037704	PRV037540	**5/1/2017**	Certified Nurse Anesthetist	
24	DaVita - Seven Oaks Dialysis	DaVita Inc 4651 Corporate Court Bakersfield CA 93311	PRV039147	PRV039147	**5/1/2017**	Outpatient Dialysis Clinc	
25	Desai, Healthy MD	Ridgecrest Regional Hospital dba: Southern Sierra Medical Clinic 1041 N. China Lake Blvd Ste. A Ridgecrest CA 93555	PRV030847	PRV029495	**5/1/2017**	Orthopedic Surgery	
26	Florek, Derek DPM	Omni Family Health 210 N. Chester Avenue Bakersfield CA 93308	PRV038092	PRV000019	**5/1/2017**	Podiatry	

Kern Health Systems
Approved Providers Effective 5-01-17

	A	B	C	D	E	F	G
27	Freeman, John MD	Regional Anesthesia Associates Inc 1700 Mt Vernon Avenue Bakersfield CA 93306	PRV031175	PRV037540	**5/1/2017**	Anesthesiology	
28	Garcia, Baudelia NP	Comprehensive Medical Group of Kern, Inc. 1230 Jefferson Street Delano CA 93215	PRV032444	PRV000258	**5/1/2017**	Internal Medicine	
29	Gonzales, Corey PhD	Telehealthdocs Medical Group 2215 Truxtun Avenue Bakersfield CA 93301	PRV037520	PRV036952	**5/1/2017**	Psychology	
30	Grewal, Gurpreet, FNP-C	Ashok Parmar, MD Inc 8303 Brimhall Road Bldg 1500 Bakersfield CA 93312 **Additional Location:** Universal Urgent Care - 2121 Niles Street	PRV010693	PRV000521 ASHOK PARMAR PRV036257 UNIVERSAL UC NILES PRV012894 UNIVERSAL UC BRIMALL	**5/1/2017**	Pain Medicine	
31	Harbin, Kim CRNA	Regional Anesthesia Associates Inc 1700 Mt Vernon Avenue Bakersfield CA 93306	PRV037705	PRV037540	**5/1/2017**	Certified Nurse Anesthetist	
32	Heer, Jagdipak MD	Priority Urgent Care 4821 Panama Lane Unit A-C Bakersfield CA 93311	PRV000905	PRV038192	**5/1/2017**	Emergency Medicine	
33	Kao, Andrew MD	Advanced Center for Eye Care 1721 Westwind Drive Ste B Bakersfield CA 93301	PRV036300	PRV000314	**5/1/2017**	Ophthalmology	
34	Kaur, Sukhjot NP-C	Infusion & Clinical Services dba: Premier Valley Medical Group, Premier Urgent Care of Central CA, Nephrology Medical Group of Bakersfield 5401 White Lane Bakersfield CA 93309 **Additional Location:** Premier UC - 901 Olive Drive Bakersfield CA 93308	PRV038094	PRV000404	**5/1/2017**	Internal Medicine & Nephrology	

Kern Health Systems
Approved Providers Effective 5-01-17

	A	B	C	D	E	F	G
35	Kim, Robin MD	Regional Anesthesia Associates Inc 1700 Mt Vernon Avenue Bakersfield CA 93306	PRV038042	PRV037540	**5/1/2017**	Anesthesiology	
36	Knoll, Shane BCBA	Holdsambeck & Associates 2535 16th Street Ste 215 Bakersfield CA 93301	PRV039730	PRV031922	**5/1/2017**	Behavior Analyst / Qualified Autism Services Provider	
37	Kwan, Kent MD	Priority Urgent Care 4821 Panama Lane Unit A-C Bakersfield CA 93311	PRV005505	PRV038192	**5/1/2017**	Emergency Medicine	
38	Lee, Benson DO	Kern County Hospital Authority 1700 Mt Vernon Avenue Bakersfield CA 93306	PRV032719	PRV035424 COLUMBUS PRV035423 HOSPITAL PRV055553 STOCKDALE PRV035425 TRUXTUN	**5/1/2017**	Internal Medicine	
39	Lee, Jay PA-C	Ashok Parmar, MD Inc 8303 Brimhall Road Bldg 100 Bakersfield CA 93312 Additional Location: Universal Urgent Care 8325 Brimhall Road Ste. 100 Universal Urgent Care - 2121 Niles Street	PRV038094	PRV000521 ASHOK PARMAR PRV036257 UNIVERSAL UC NILES PRV012894 UNIVERSAL UC BRIMALL	**5/1/2017**	Pain Medicine	
40	McFarland, Bentson MD	Telehealthdocs Medical Group 2215 Truxtun Avenue Bakersfield CA 93301	PRV0357519	PRV036952	**5/1/2017**	Psychiatry	
41	Mercado, Jr, Danilo NP-C	Emergency Physicians Urgent Care, Inc dba: Acclerated Urgent Care 9500 Stockdale Hwy Ste 100 Bakersfield CA 93301 Alternate Locations: 4871 White Lane	PRV036028	PRV032603 STOCKDALE PRV033690 WHITE LANE	**5/1/2017**	Family Medicine	

Kern Health Systems
Approved Providers Effective 5-01-17

	A	B	C	D	E	F	G
42	Munnainathan, Parthiban MD	Omni Family Health 4131 Ming Avenue Bakersfield CA 93309 Alternate Locations: 161 N. Mill Street Tehachapi	PRV037863	PRV000019	**5/1/2017**	Family Medicine	
43	Murphy, Kathleen Ph.D	Telehealthdocs Medical Group 2215 Truxtun Avenue Bakersfield CA 93301	PRV037518	PRV036952	**5/1/2017**	Psychology	
44	Naven, Wade MD	Priority Urgent Care 4821 Panama Lane Unit A-C Bakersfield CA 93311	PRV001593	PRV038192	**5/1/2017**	Emergency Medicine	
45	Ngo, Tri MD	Kern County Hospital Authority 1700 Mt Vernon Avenue Bakersfield CA 93306	PRV037872	PRV035424 COLUMBUS PRV035423 HOSPITAL PRV055553 STOCKDALE PRV035425 TRUXTUN	**5/1/2017**	Diagnostic Radiology	
46	Nguyen, Anthony DPM	Lags Spine & Sportscare Medical Center Inc 3550 Q Street Suite 201 Bakersfield CA 93301	PRV039740	PRV000403	**5/1/2017**	Podiatry	
47	Ogun, Omolade MD	Universal Urgent Care 8327 Brimhall Road Ste 701 Bakersfield CA 93312 Alternate Location: 2121 Niles Street Bakersfield	PRV037071	PRV012894 BRIMHALL PRV036257 NILES	**5/1/2017**	Family Medicine	
48	Patel, Vishal MD	Direct Dermatology 165 St Dominics Drive Ste 140 Manteca CA 95337	PRV039732	PRV012901	**5/1/2017**	Dermatology	
49	Plewinski, Russell CRNA	Regional Anesthesia Associates Inc 1700 Mt Vernon Avenue Bakersfield CA 93306	PRV038044	PRV037540	**5/1/2017**	Certified Nurse Anesthetist	
50	Raza, Syed MD	Clinica Sierra Vista 2400 Wible Road Ste 14 Bakersfield CA 93304	PRV037873	PRV000002	**5/1/2017**	Psychiatry	

Kern Health Systems
Approved Providers Effective 5-01-17

	A	B	C	D	E	F	G
51	Rodriguez, Benjamin BCBA	California Institute of Behavior Analysis Inc dba: LeafWing Center 13440 Ventura Blvd Ste 200 Sherman Oaks CA 914723	PRV039741	PRV038630	**5/1/2017**	Behavior Analyst / Qualified Autism Services Provider	
52	Schenke, Florence CRNA	Regional Anesthesia Associates Inc 1700 Mt Vernon Avenue Bakersfield CA 93306	PRV029613	PRV037540	**5/1/2017**	Certified Nurse Anesthetist	
53	Wall, William MD	Renaissance Imaging Medical Associates, Inc 1600 Avenue J Lancaster CA 93534 Alternate Locations: 44105 W. 15th Street Ste. 100 Lancaster 38925 Trade Center Drive Ste. E Palmdale	PRV039743	PRV000324	**5/1/2017**	Diagnostic Radiology	
54	Wu, Kenny MD	Priority Urgent Care 4821 Panama Lane Unit A-C Bakersfield CA 93313	PRV029613	PRV038192	**5/1/2017**	Emergency Medicine	
55	Yang, Nelson MD	Priority Urgent Care 4821 Panama Lane Unit A-C Bakersfield CA 93313	PRV002177	PRV038192	**5/1/2017**	Emergency Medicine	
56	Farrell, Kenneth PA-C	Acclerated Urgent Care 9500 Stockdale Hwy Ste 100 Bakersfield CA 93311 **Additional Locations:** 4871 White Lane Bakersfield	PRV037667	PRV032603 STOCKDALE PRV033690 WHITE LANE	**5/1/2017**	Emergency Medicine	
57	Federhart, Jay MD	Kern Radiology Medical Group 2301 Bahamas Drive Bakersfield CA 93309 **Additional Locations:** 3838 San Dimas Street Ste A-120 93301 9300 Stockdale Hwy Ste 100 93311 4500 Morning Drive Ste 202 93306 1427 S. Lexington Street Ste A-10 Delano 93215	PRV039746	PRV005565 PRV001405 PRV029441 PRV033045	**5/1/2017**	Radiology, Diagnostic	
58	Givens, Larry MD	Renaissance Imaging Medical Group 44105 W. 15th Street Suite 100 Lancaster CA 93536	PRV006106	PRV000324	**5/1/2017**	Diagnostic Radiology	

Kern Health Systems
Approved Providers Effective 5-01-17

	A	B	C	D	E	F	G
59	Lalezarian, Michael MD	Renaissance Imaging Medical Group 44105 W. 15th Street Suite 100 Lancaster CA 93536	PRV038684	PRV000324	**5/1/2017**	Diagnostic Radiology	
60	Nguyen, Thong MD	Renaissance Imaging Medical Group 44105 W. 15th Street Suite 100 Lancaster CA 93536	PRV030316	PRV000324	**5/1/2017**	Diagnostic Radiology	
61	Jarvis, Leah BCBA	Leah Jarvis dba: Jarvis Behavior Consulting 9808 Margery Avenue California City CA 93505	PRV039744	PRV039744	**5/1/2017**	Behavioral Analyst	
62	Brown, James DPM	Stockdale Podiatry 110 New Stine Road Bakersfield CA 93309	PRV037505	PRV000332	**5/1/2017**	Podiatry	
63	Shellans, Jr., Stephen MD	Priority Urgent Care 4821 Panama Lane Unit A-C Bakersfield CA 93313	PRV001594	PRV038192	**5/1/2017**	General Practice	
64	Esposo, Oriente MD	Clinica La Victoria 3940 San Dimas Street Bakersfield CA 93301 Additional Locations: 1491 White Lane Bakersfield CA 93307 626 Main Street Delano CA 93215	PRV004774	PRV000408 WHITE LANE PRV032448 DELANO PRV034777 SAN DIMAS	**5/1/2017**	Internal Medicine	

Kern Health Systems
Board Approved Effective 6-01-17

	A	B	C	D	E	F	G	H	I	J
1	NAME	DBA/ADDRESS	Specialty	Provider #	Pay To #	Effective				
2	Agia Pharmacy & Café, Inc	Agia Pharmacy & Café 276 S. Mill Street Ste. A Tehachapi CA 93561	Pharmacy	PRV040072	PRV040072	**6/1/2017**				
3	Kim, Huisson AC	Huisoon Kim Professional Acupuncture Corp. dba: Kim's Acupuncture Clinic 1619 S. H Street Bakersfield, CA 93304	Acupuncture	PRV040073	PRV040073	**6/1/2017**				
4	Medical Diagnostic Laboratories LLC	Medical Diagnostic Laboratories 2439 Kuser Road Hamilton NJ 08690	Laboratory / Specialized Laboratory Testing	PRV006929	PRV006929	**6/1/2017**				
5	Andrade, Joseph CRNA	Regional Anesthesia Associates Inc 1700 Mt Vernon Avenue Bakersfield CA 93306	Certified Nurse Anesthetist	PRV007259	PRV037540	**6/1/2017**				
6	Augustine, Mato Topa BCBA	Holdsambeck & Associates 2535 16th Street Ste. 215 & 210 Bakersfield CA 93301	Behavior Analyst / Qualified Autism Services Provider	PRV040126	PRV031922	**6/1/2017**				
7	Banks, Lisa DPM	Brenda Barnes, DPM 2227 19th Street Bakersfield CA 93301	Podiatry	PRV002040	PRV000411	**6/1/2017**				
8	Berke, Jennifer BCBA	California Psychcare, Inc. 4500 California Avenue Ste. 101 Bakersfield CA 93309	Behavior Analyst / Qualified Autism Services Provider	PRV040074	PRV011225	**6/1/2017**				
9	Castillo, Lynnie NP-C	Omni Family Health 4151 Mexicali Drive Bakersfield CA 93313 Alternate Locations: 210 N. Chester Avenue Bakersfield 93308 659 S. Central Valley Highway Shafter 93263	Family Practice	PRV037223	PRV000019	**6/1/2017**				
10	Chawla, Anuj MD	Retina Institute of California 9500 Stockdale Highway Ste. 108 Bakersfield CA 93311	Ophthalmology	PRV035735	PRV000181	**6/1/2017**				
11	De Guzman, Ernest MD	Ridgecrest Regional Hospital RHC 1111 N China Lake Blvd Ridgecrest CA 93555	Psychiatry	PRV038388	PRV029495	**6/1/2017**				

Kern Health Systems
Board Approved Effective 6-01-17

	A	B	C	D	E	F	G	H	I	J
12	Eckel, Gregory MD	Renaissance Imaging Medical Associates, Inc 1600 Avenue J Lancaster CA 93534 **Alternate Locations:** 44105 W. 15th Street Ste. 100 Lancaster 38925 Trade Center Drive Ste. E Palmdale	Diagnostic Radiology	PRV011092	PRV000324	**6/1/2017**				
13	Hasting, Laura NP-C	Acclerated Urgent Care 9500 Stockdale Hwy Ste 100 Bakersfield CA 93311 **Alternate Locations:** 4871 White Lane Bakersfield	Family Practice	PRV004496	PRV032603 PRV033690	**6/1/2017**				
14	Hethumuni, Gamini MD	Telehealthdocs Medical Group 2215 Truxtun Avenue Bakersfield CA 93301	Endocrinology	PRV038445	PRV036952	**6/1/2017**				
15	Ho, Philip MD	Renaissance Imaging Medical Associates, Inc 1600 Avenue J Lancaster CA 93534 **Alternate Locations:** 44105 W. 15th Street Ste. 100 Lancaster 38925 Trade Center Drive Ste. E Palmdale	Diagnostic Radiology	PRV040076	PRV000324	**6/1/2017**				
16	Holm, Maria LCSW	Ridgecrest Regional Hospital 1081 N China Lake Blvd Ridgecrest CA 93555	Clinical Social Worker	PRV040077	PRV000279	**6/1/2017**				
17	Horwitz, Reed MD	Renaissance Imaging Medical Associates, Inc 1600 Avenue J Lancaster CA 93534 **Alternate Locations:** 44105 W. 15th Street Ste. 100 Lancaster 38925 Trade Center Drive Ste. E Palmdale	Diagnostic Radiology	PRV038512	PRV000324	**6/1/2017**				
18	Kanuri, Santhi MD	Kern County Hospital Authority 1700 Mt Vernon Avenue Bakersfield CA 93307 **Alternate Locations:** 1111 Columbus Street Bakersfield 9300 Stockdale Hwy Ste 100 Bakersfield 6401 Truxtun Avenue Ste A-1 Bakersfield	Family Practice	PRV005214	PRV035424 PRV035423 PRV035553 PRV035425	**6/1/2017**				

Kern Health Systems
Board Approved Effective 6-01-17

	A	B	C	D	E	F	G	H	I	J
19	Kesler, Brett DPM	Telehealthdocs Medical Group 2215 Truxtun Avenue Bakersfield CA 93301	Podiatry	PRV011159	PRV036952	**6/1/2017**				
20	La, Quan MD	Renaissance Imaging Medical Associates, Inc 1600 Avenue J Lancaster CA 93534 **Alternate Locations:** 44105 W. 15th Street Ste. 100 Lancaster 38925 Trade Center Drive Ste. E Palmdale	Diagnostic Radiology	PRV040078	PRV000324	**6/1/2017**				
21	Luong-Player, Adelina MD	Premier Pathology Laboratories, Inc 263 N. Pearson Drive Ste. 108 Bakersfield CA 93257	Pathology	PRV012311	PRV029338	**6/1/2017**				
22	Magalong, Mary Grace MD	Telehealthdocs Medical Group 2215 Truxtun Avenue Bakersfield CA 93301	Pulmonary Disease	PRV006660	PRV036952	**6/1/2017**				
23	Mandviwala, Lulua MD	Kern County Hospital Authority 1700 Mt Vernon Avenue Bakersfield CA 93307 **Alternate Locations:** 1111 Columbus Street Bakersfield 9300 Stockdale Hwy Ste 100 Bakersfield 6401 Truxtun Avenue Ste A-1 Bakersfield	Pediatrics	PRV038583	PRV035424 PRV035423 PRV035553 PRV035425	**6/1/2017**				
24	Omaiye, Benjamin NP-C	Infusion & Clinical Services dba: Premier Valley Medical Group, Premier Urgent Care of Central CA, Nephrology Medical Group of Bakersfield 5401 White Lane Bakersfield CA 93309 **Alternate Locations:** Premier UC - 901 Olive Drive 93308 Premier UC - 5401 White Ln 93309 Acclerated UC-9500 Stockdale Hwy Ste 100 93311 Acclerated UC-4871 White Lane 93309	Family Practice	PRV037955	PRV000404	**6/1/2017**				
25	Padilla, Deanna NP-C	Omni Family Health 1014 Calloway Drive Bakersfield CA 93312 **Alternate Locations:** 1012 Calloway Drive 93312 659 S. Central Valley Highway Shafter 93263	Family Medicine	PRV038724	PRV000019	**6/1/2017**				

Kern Health Systems
Board Approved Effective 6-01-17

	A	B	C	D	E	F	G	H	I	J
26	Ponce, Cheri PA-C	LA Laser Center 5600 California Avenue Bakersfield CA 93309	Dermatology	PRV039148	PRV013922	**6/1/2017**				
27	Richardson, Cheryl BCBA	California Psychcare, Inc. 4500 California Avenue Ste. 101 Bakersfield CA 93309	Behavior Analyst / Qualified Autism Services Provider	PRV040081	PRV011225	**6/1/2017**				
28	Shafik, Mark MD	Acclerated Urgent Care 9500 Stockdale Hwy Ste 100 Bakersfield CA 93311 **Alternate Location:** 4871 White Lane Bakersfield	Family Practice	PRR038723	PRV032603 PRV033690	**6/1/2017**				
29	Tawil, Rana MD	Premier Pathology Laboratories, Inc 263 N. Pearson Drive Ste. 108 Bakersfield CA 93257	Pathology	PRV007681	PRV029338	**6/1/2017**				
30	Tolentino, Milie MD	Clinica Sierra Vista 815 Dr. Martin Luther King Blvd Bakersfield CA 93307	Family Practice	PRV038446	PRV000002	**6/1/2017**				
31	Tovmasyan, Varsenik BCBA	California Psychcare, Inc. 4500 California Avenue Ste. 101 Bakersfield CA 93309	Behavior Analyst / Qualified Autism Services Provider	PRV040082	PRV011225	**6/1/2017**				
32	Vajen, Mara PA-C	Acclerated Urgent Care 9500 Stockdale Hwy Ste 100 Bakersfield CA 93311 **Alternate Location:** 4871 White Lane Bakersfield	Family Practice	PRV038387	PRV032603 PRV033690	**6/1/2017**				
33	Venkatesan, Aruna MD	Direct Dermatology 165 Saint Dominics Drive Ste. 140 Manteca CA 95337	Dermatology	PRV040085	PRV012901	**6/1/2017**				
34	Williams-Richmond, Rhonda DC	Clinica Sierra Vista 2000 Physicians Blvd Bakersfield CA 93301	Chiropractic	PRV039018	PRV000002	**6/1/2017**				
35	Hudson, Theresa MD	Clinica Sierra Vista 2525 N Chester Avenue Bakersfield CA 93308	Family Practice	PRV038987	PRV000002	**6/1/2017**				
36	Cheng, Tien MD	Renaissance Imaging Medical Associates, Inc 1600 Avenue J Lancaster CA 93534 **Alternate Locations:** 44105 W. 15th Street Ste. 100 Lancaster 38925 Trade Center Drive Ste. E Palmdale	Diagnostic Radiology	PRV001868	PRV000324	**6/1/2017**				
37										

KERN HEALTH SYSTEMS

FULL TIME EQUIVALENCY (FTE) & PROVIDER TO ENROLLEE RATIOS 2017

FTE & PROVIDER TO ENROLLEE RATIOS

2017

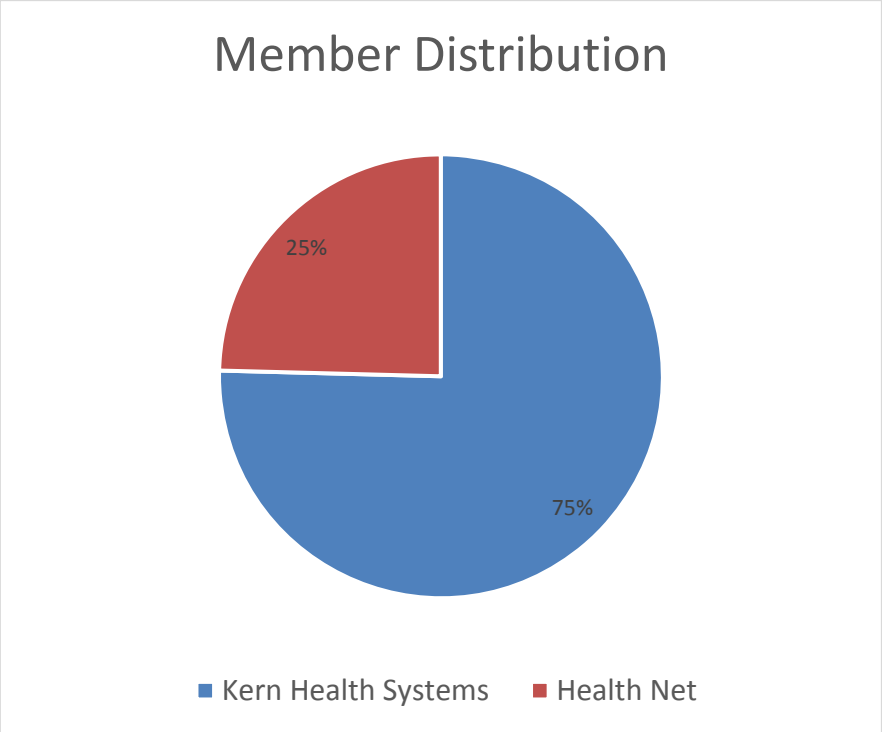
KERN HEALTH SYSTEMS

Introduction

Per CCR § 1300.67.2, Kern Health Systems 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." Per KHS policy, 4.30-P *Accessibility Standards,* §4.5 Full-time equivalent (FTE) Provider to Member Ratios, "Full-time equivalency shall be determined by percentage of members assigned to the two Medi-Cal managed care plans in Kern County. For example, if KHS has 80% of the Medi-Cal managed care members in Kern County, the PCP FTE assumption to calculate the PCP to member ratio will be 80% FTE of all PCPs in the network."

Member Distribution

As of Q1 2017, 319,862 Medi-cal members were distributed amongst the two Kern County Medi-cal managed care plans (Kern Health Systems, Health Net). Of those members, 241,216 **(75.41%)** were enrolled under Kern Health Systems, and 78,646 **(24.59%)** to Health Net.



Full Time Equivalency Compliance Calculations

FTE & PROVIDER TO ENROLLEE RATIOS

2017

As of Q1 2017, the plan was contracted with 327 Primary Care Providers, a combination of 181 physicians and 146 mid-levels. Based on the FTE calculation process outlined above, with a 75% membership distribution amongst Kern Medi-cal members, KHS currently maintains a total of 191.21 FTE PCPs. With a total member enrollment of 241,216, KHS currently maintains a ratio of 1 FTE PCP to every 1259.30 members; KHS is compliant with state regulations and Plan policy.

As of Q1 2017, the plan was contracted with 800 Physicians. Based on the FTE calculation process outlined above, with a 75% membership distribution amongst Kern Medi-cal members, KHS currently maintains a total of 603.30 FTE Physicians. With a total membership assignment of 241,216, KHS currently maintains a ratio of 1 FTE Physician to every 399.83 members; KHS is compliant with state regulations and Plan policy

KERN HEALTH SYSTEMS

Access Grievance Review

2017 - Quarter 1

Provider Relations Department

Access Grievance Review

Q1, 2017

KERN HEALTH SYSTEMS

Introduction

On a quarterly basis, KHS' Provider Relations Department reviews all grievances from the previous quarter that were categorized as "Access to Care" or "Difficulty Accessing a Specialist".

During Q1 2017, nine (9) grievances were received and reviewed by the KHS grievance committee. In five (5) of the cases no issues were identified and were closed in favor of the plan. The remaining four (4) cases, were closed in favor of the enrollee; these cases were forwarded to the Plan's Provider Relations Department for further tracking and trending.

Tracking and Trending

During the Q1 Access Grievance Review meeting, the four (4) cases that were closed in favor of the enrollee were reviewed against all access grievances received in the previous year.

No ongoing trends were identified in two (2) of the cases.

Upon review, it was identified that two (2) of the cases were brought against Plan contracted provider groups who had additional access grievances closed in favor of the enrollee within the past year. As of the completion of Q1 2017, one provider group had three (3) grievances due to not meeting the in-office wait time standard, and one provider group had four (4) grievances due to not meeting the appointment with a primary care provider standard, all closed in favor of the enrollee.

KHS Policy/Provider Outreach

Per KHS Policy 4.30 *Accessibility Standards*, the time standard for a primary care appointment is within 10 (ten) business days of the request, and the maximum office wait time for routine or urgent primary care services is one (1) hour.

A Provider Relations Representative has reached out to the two groups identified in the Plans tracking and trending; these groups were coached on the Plan's accessibility standards policies and procedures. The Plan will continue to monitor these providers in future access grievance reviews and will take further action as necessary.

KERN HEALTH SYSTEMS

Quarter 1, 2017 (January – March) Access Grievances Review Agenda
Date: 5/12/17

Discussion:

1. **Review access grievances for Q1 2017**
   - **Identify any trends regarding access**
   - **Conduct file review for grievances closed in favor of the enrollee**

2. **Review Access Grievances for Q1 2017 against last year of annual grievances**
   - **Identify any trends regarding access**

Closed in Favor of the Enrollee	
Access to Care	**3**
Adventist Health - Taft	1
Bichai, William	1
KM	1
Difficulty Accessing Specialist	**1**
USC Keck Hospital	1

Closed in Favor of the Plan	
Access to Care	**3**
Benavides, Vicente	1
Claiborne, Ronnie	1
Softa, Ambika	1
Difficulty Accessing Specialist	**2**
Duggal, Jasleen	1
Larry, De Donato	1

Name	Title	Date
Melissa Lopez	PR Manager	5/12/2017
Doris Hopkins	Grievance Coordinator II	5/12/17
Yolanda Herrera	Cred Coord Lead	5/12/17
James Winfrey	Senior Provider Network Analyst	5/12/17
Adriana Zavala	Sen " " "	5/12/17

KERN HEALTH SYSTEMS

Access Monitoring 2017 - Quarter 2

- **After Hours Calls Results**
- **Appointment Availability Survey Results**
- **Geographic Accessibility Analysis**
- **Access Grievance Review**

KERN HEALTH SYSTEMS

After Hours Calls Results
2017 - Quarter 2

Access Monitoring

Q2, 2017

KERN HEALTH SYSTEMS

After Hours Calls - Introduction

As required by 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:

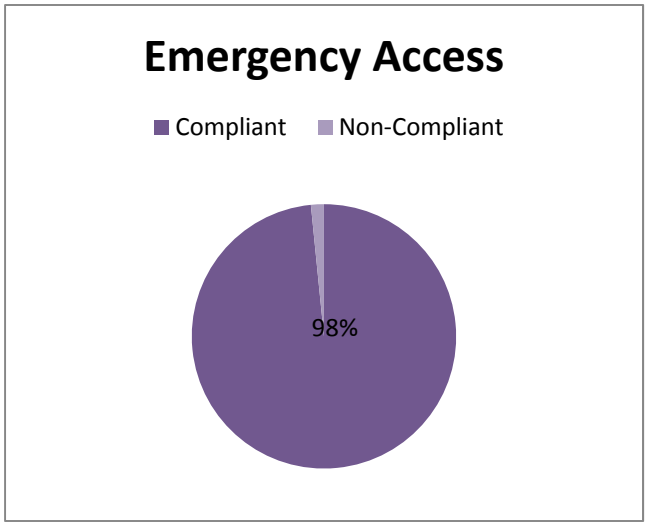
1.) Provider's answering machine or answering service must instruct the member to call 911 if the purpose of the call is a medical emergency.

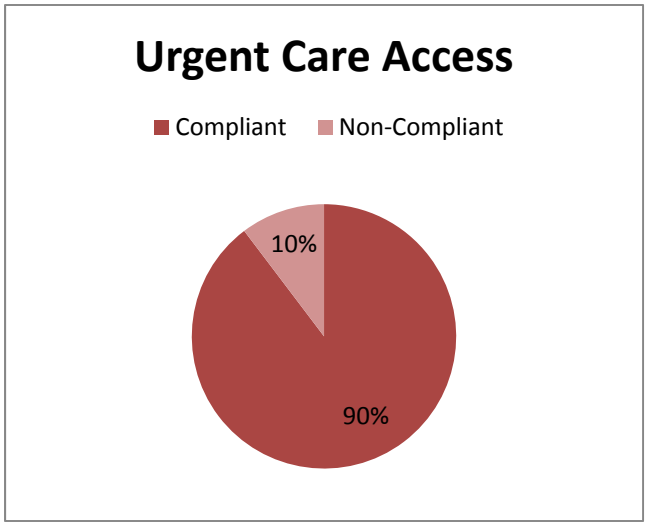
2.) For urgent matters, Provider's answering machine must provide an on-call number. If an answering service is used, the member must receive a call back from an on-call member of your office within 30 minutes of call.

Survey was conducted by Health Dialog. Results are to be reported to the KHS QI/UM Committees and to Executive Staff.

After Hours Calls Results

126 provider offices were contacted during Q1. Of those offices, 124 were compliant with the Emergency Access Standards and 113 were compliant with the Urgent Care Access Standards.





Trending

The Plan reviewed results against past quarters and found that four provider groups were found to be out of compliance with the urgent care access standards for a second quarter in a row. Notices of non-compliance with applicable policy language will be delivered to the four non-compliant provider groups via a Provider Relations Representative office visit/phone call.

Follow –Up / Outreach / Training

Notices and copies of the policy will be mailed to the providers who were found to be out of compliance this quarter.

Out of Compliance Providers:

James Im, MD (Emergency Care Access Standard & Urgent Care Access Standard)

William Bichai, MD Inc. (Emergency Care Access Standard & Urgent Care Access Standard)

Advanced Healthcare of Bakersfield, Inc. (Urgent Care Access Standards)

Brimhall Pediatrics (Urgent Care Access Standards)

Cal City Clinic (Urgent Care Access Standards)

California Medical Clinic (Urgent Care Access Standards)

Clinica Del Valle (Urgent Care Access Standards)

Clinica La Victoria – San Dimas (Urgent Care Access Standards)

Clinica La Victoria – White Lane (Urgent Care Access Standards)

Clinica La Victoria – Delano (Urgent Care Access Standards)

Delano Prompt Care Clinic (Urgent Care Access Standards)

Ridgecrest Regional Hospital RHC (Urgent Care Access Standards)

Wasco Medical Plaza (Urgent Care Access Standards)

KERN HEALTH SYSTEMS

Appointment Availability Survey Results 2017 - Quarter 2

Access Monitoring

Q2, 2017

Appointment Availability Survey - Introduction

As required by the Department of Health Care Services (DHCS) and Title 28 CCR Section 1300.67.2.2, Kern Health Systems (KHS) uses an appointment availability survey to assess compliance with access standards for Kern Family Health Care (KFHC) Members.

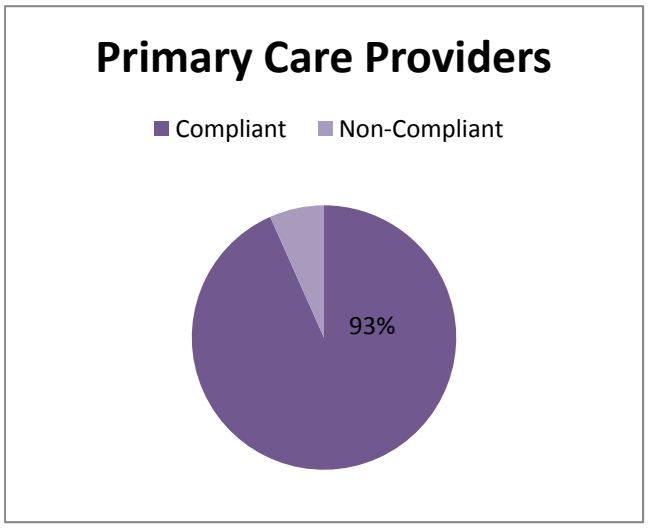
KHS policy and Department regulation require that members must be offered appointments within the following timeframes:

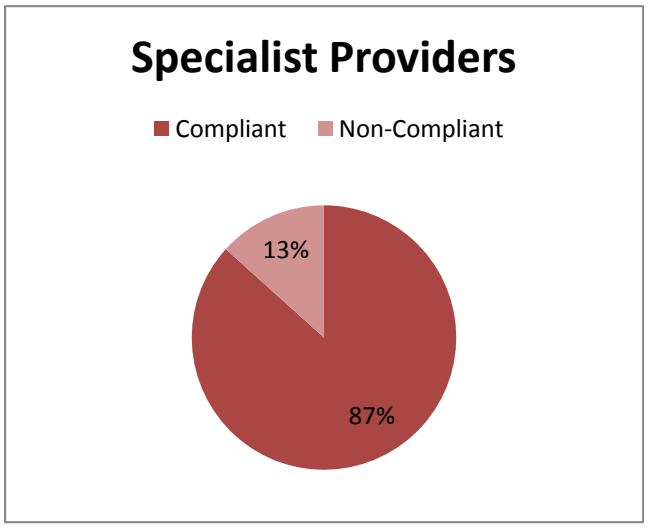
1) Non-urgent primary care appointments – within ten (10) business days of request.
2) Appointment with a specialist – within 15 business days of request;

The survey was conducted internally by KHS staff and utilized the DHCS survey methodology, basing appointment results on the third available appointment offered. Results are to be reported to the KHS QI/UM Committees and to Executive Staff.

Appointment Availability Survey Results

A random sample of 15 primary care provider offices and 15 specialist offices were contacted during Q2 2017. Of the 15 primary care providers surveyed, 14 were compliant with the non-urgent primary care appointment within 10 business day standard and 1 was non-compliant with the standard. Of the 15 specialist providers surveyed, 13 were compliant with the specialist appointment within 15 business day standard, 2 were non-compliant with the standard.





Follow –Up / Outreach / Training

Notices of non-compliance with applicable policy language were delivered to the 3 non-compliant providers via a Provider Relations Representative office visit. Providers who were found to be out of compliance this quarter will be included in future appointment availability surveys for further monitoring.

Out of Compliance Providers:

*Jennifer Thoene, MD – Clinica Sierra Vista – Frazier Mountain Community Health Center (PCP Appointment within 10 days)

*Benston Mcfarland, MD – Telehealth Docs Medical Group (Specialist Appointment within 15 days)

Nelson Madrilejo, MD – Centennial Medical Group (Specialist Appointment within 15 days)

*First two appointments offered by the provider were compliant with applicable standard. KHS bases compliance off the third appointment offered.

KERN HEALTH SYSTEMS

Geographic Accessibility Analysis

2017 - Quarter 2

Access Monitoring

Q2, 2017

Background

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.

In May 2016 the DMHC finalized their process and template for requesting alternative access standards as outlined in Section 1300.67.2.1(b), and released them to plans. In November 2016, the DHCS finalized their process/template and stated that all Knox-Keene Act licensed MCPs should submit alternative time and distance standard requests directly to the DMHC, and the departments would review collaboratively. Utilizing the DMHC template per regulatory instruction, KHS proposed alternate access standards for portions of its service area and received DMHC approval of those proposed alternate standards in November 2016. Approval is still pending with the DHCS and in June 2017 KHS was informed the DHCS is currently in the process of reviewing all alternative access standard requests submitted by plans.

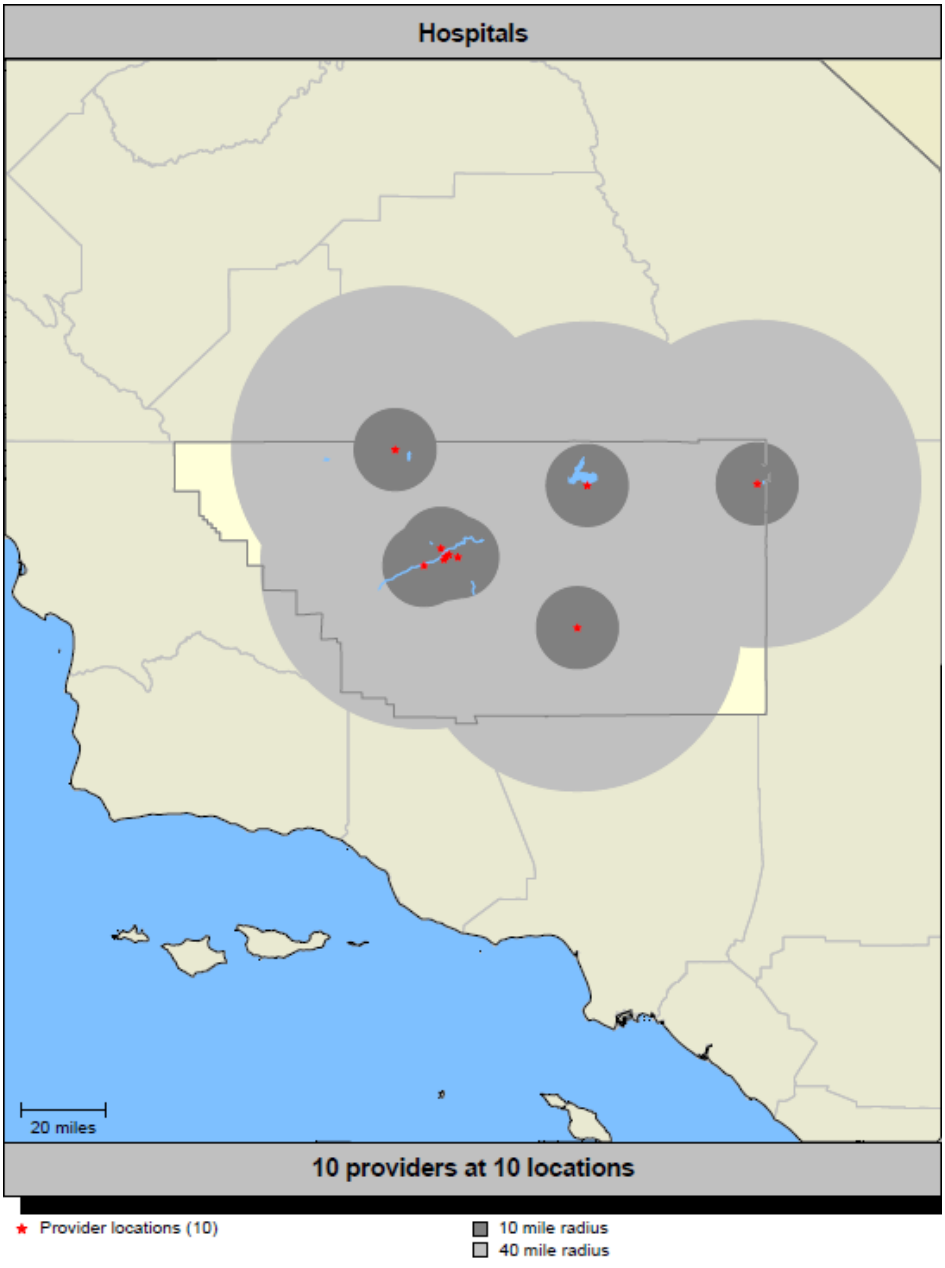
These requirements are currently memorialized in KHS policy and procedure 4.30-P *Accessibility Standards.*

As a part of its ongoing monitoring to ensure compliance with state regulation and reasonable geographic access to care for enrollees, in Q2 2017, KHS had an external vendor (Optum) conduct a geographic accessibility analysis.

DMHC Approved Alternative Access Standards

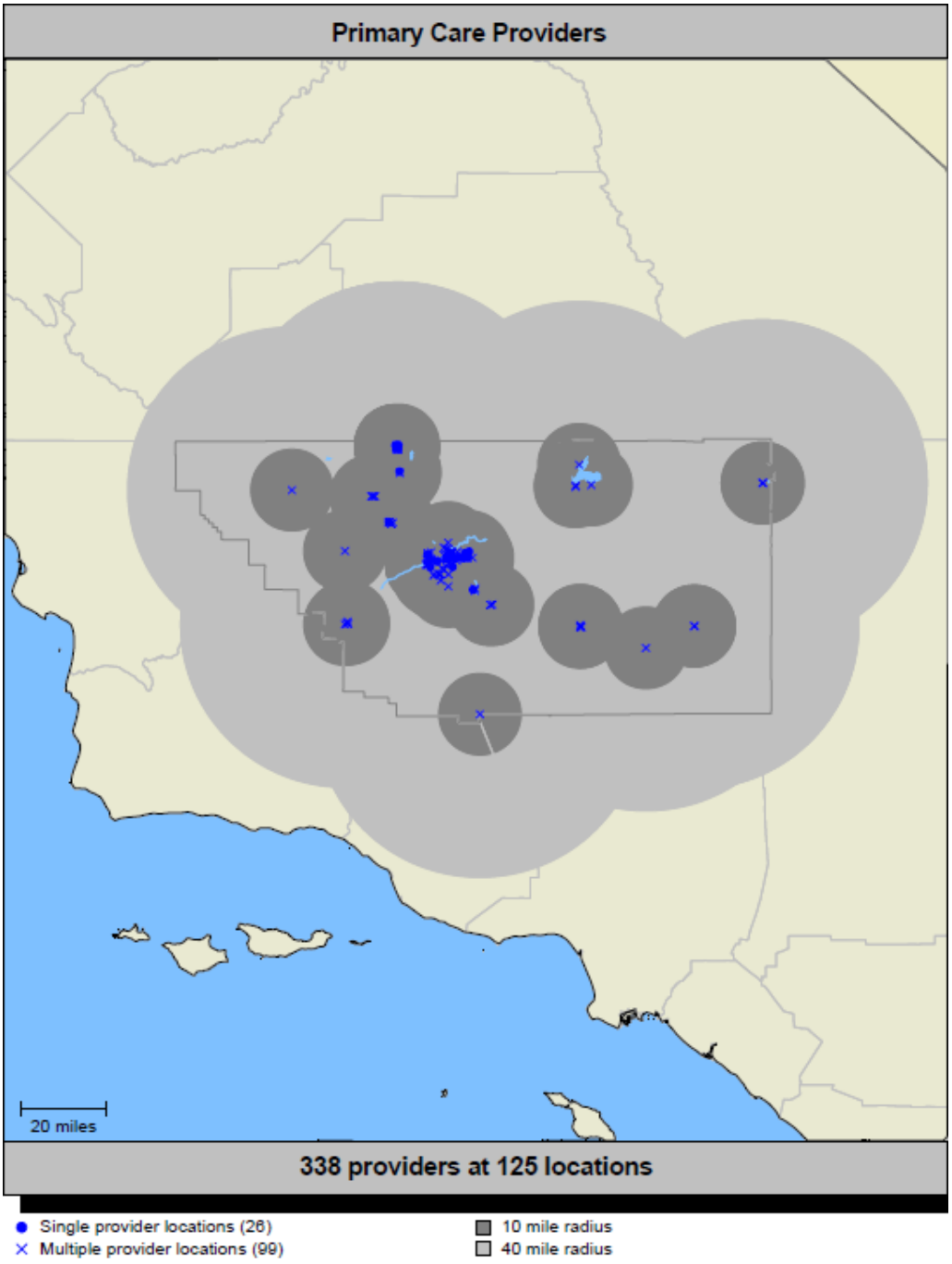
Primary Care Provider - Alternative Access Standards		
Zip Code	**City**	**Alternative Standard (miles)**
93516	Boron	35
93519	Cantil	35
93528	Johannesburg	30
93249	Lost Hills	40
93252	Maricopa	35
93255	Onyx	30
93524	Edwards	45
Hospital - Alternative Access Standards		
Zip Code	**City**	**Alternative Standard (miles)**
93203	Arvin	30
93313	Bakersfield	25
93516	Boron	50
93596	Boron	50
93206	Buttonwillow	40
93504	California City	35
93505	California City	35
93519	Cantil	40
93523	Edwards	45
93524	Edwards	60
93224	Fellows	40
93225	Frazier Park	50
93528	Johannesburg	30
93243	Lebec	50
93249	Lost Hills	60
93252	Maricopa	55
93251	Mc Kittrick	45
93501	Mojave	35
93255	Onyx	35
93222	Pine Mountain Club	40
93560	Rosamond	40
93263	Shafter	30
93268	Taft	40
93276	Tupman	30
93280	Wasco	30
93287	Woody	35

Results



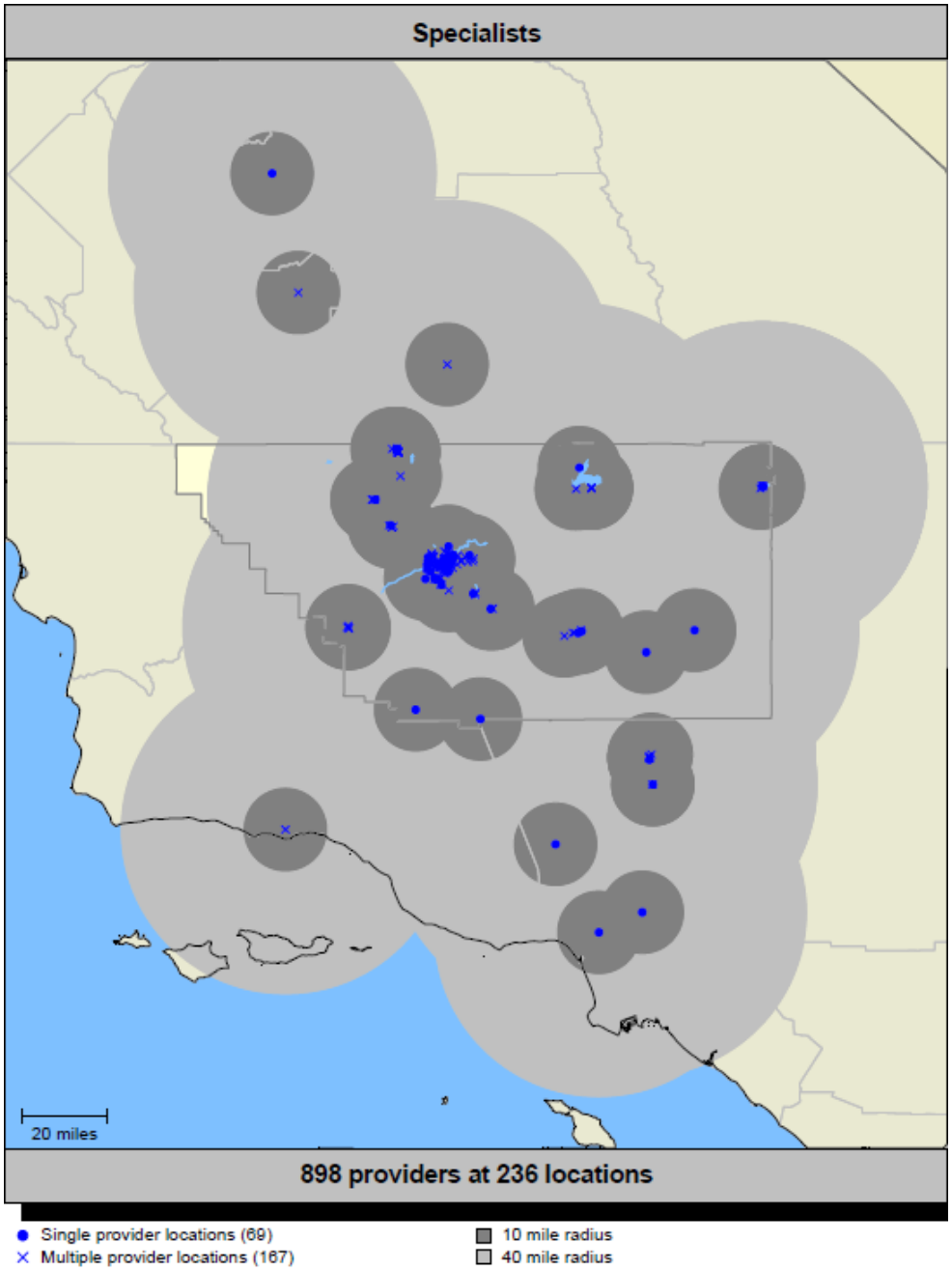
Hospitals

KHS currently maintains DMHC-approved alternative hospital accessibility standards for 26 zip codes within Kern County. The Q2 2017 geographic accessibility analysis found that enrollees in all zip codes within Kern County had access to a hospital within 10 miles, 30 minutes, or an alternate distance standard approved by the DMHC.



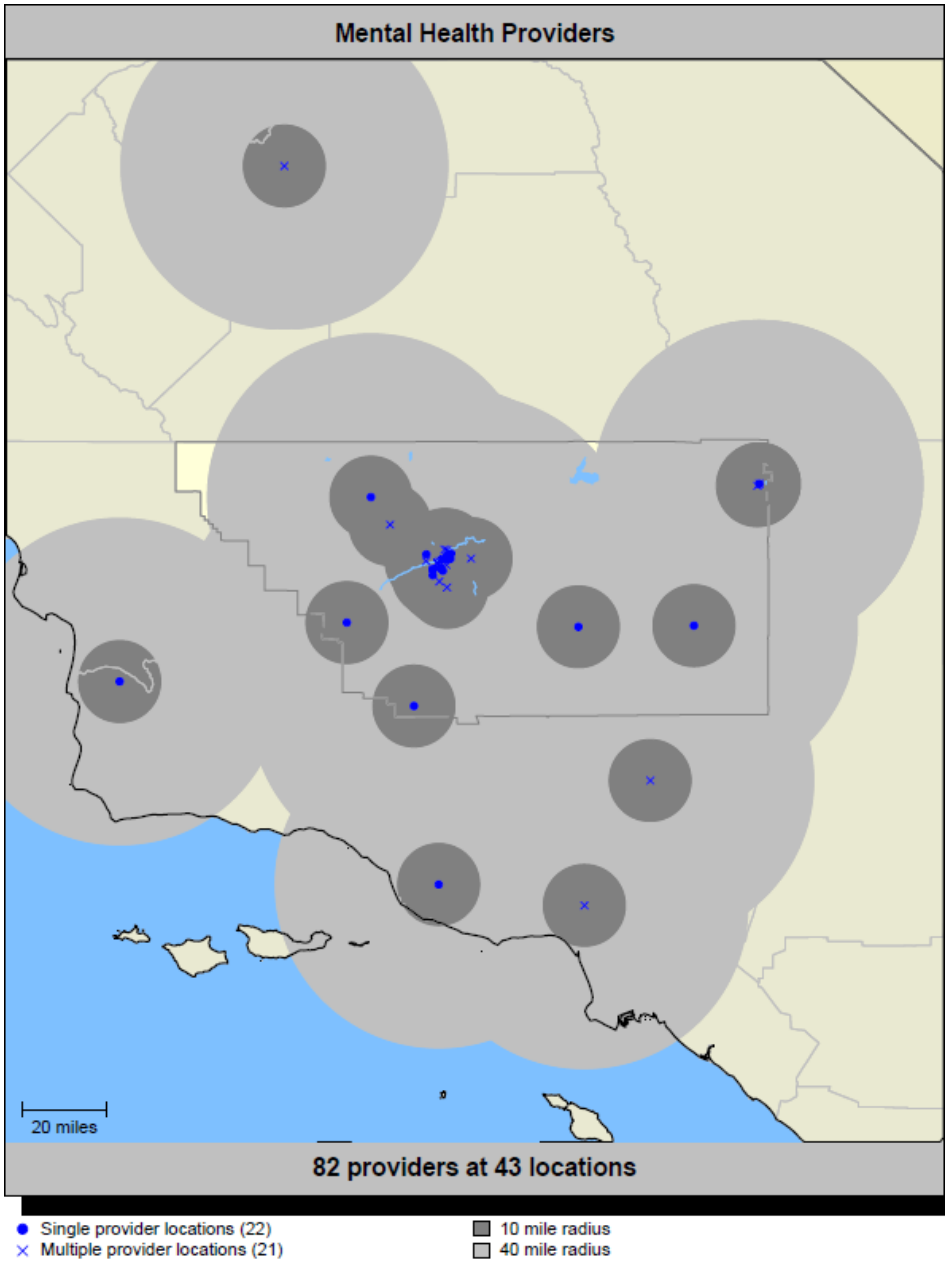
Primary Care Providers

KHS currently maintains DMHC-approved alternative primary care provider accessibility standards for 7 zip codes within Kern County. The Q2 2017 geographic accessibility analysis found that enrollees in all zip codes within Kern County had access to a primary care provider within 10 miles, 30 minutes, or an alternate distance standard approved by the DMHC.



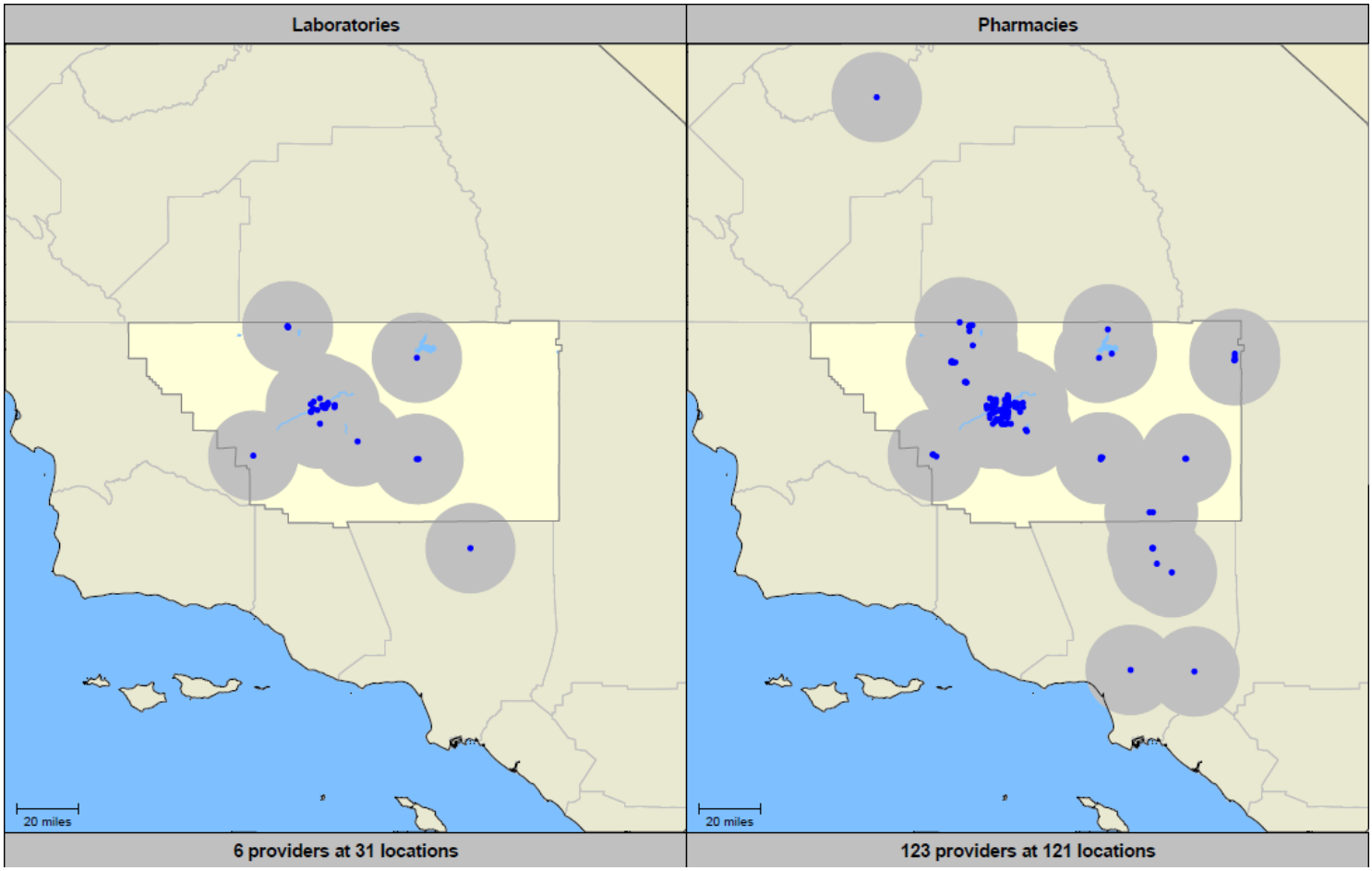
Specialists

Currently, there are no regulatory required standards and KHS does not maintain time or distance standards for accessibility to specialist care. The DHCS is in the process of finalizing new standards for specialist care based on county population. In addition to the Q2 2017 geographic accessibility analysis to specialty care, in Q1 2017, KHS conducted an in-depth geographic accessibility analysis to monitor enrollee access to specific specialty types.



Mental Health Providers

Currently, there are no regulatory required standards and KHS does not maintain time or distance standards for geographic access to mental health providers. The DHCS is in the process of finalizing new standards for mental health providers based on county population. Additionally, KHS utilizes telemedicine to provide mental health services at certain rural locations within the service area that may have not been captured in this analysis.



Laboraties and Pharmacies

Per Section 1300.51 (d)(H)(iv) of the California Code of Regulations, KHS shall ensure that, "[Ancillary laboratory, pharmacy and similar services and goods dispensed by order or prescription on the primary care provider are available from contracting or plan-operated providers at locations (where enrollees are personally served) within a reasonable distance from the primary care provider. Additionally, DHCS is in the process of finalizing new standards for certain ancillary provider types based on county population.

As there is no established time or distance standard for determining geographic accessibility to laboratory and pharmacy services, KHS utilized a 15 mile radius standard in conducting its analysis. KHS found that though there are geographic areas in which enrollees would have to travel farther than the 15 mile standard, these areas were the same in which KHS has DMHC-approved alternative access standards for primary care providers and hospitals.

Conclusions

Based on the results of the Q2 2017 geographic accessibility analysis, KHS found that we are in compliance with all DMHC and DHCS standards, and enrollees throughout the county have reasonable geographic access to care and services. The analysis provided the following results:

Primary Care Providers: All KHS enrollees have access to a Primary Care Provider within the regulatory required standard, or an approved alternative standard.

Hospitals: All KHS enrollees have access to a Hospital within the regulatory required standard, or an approved alternative standard.

Specialists/Mental Health Providers: For provider types in which regulatory agencies, nor KHS, currently maintain a geographic access standard, the analysis assisted in monitoring distance and time access to those services for enrollees.

Pharmacies/Laboratories: KHS found that while there is limited geographic access to these services in certain regions of KHS' service area, these are the same regions in which KHS maintains alternative access standards for PCP and Hospital care; based on these alternative standards, KHS found the access to pharmacy and laboratory services in these regions reasonable.

Looking Forward

Currently the DHCS only maintains standards for access to a Primary Care Physician, the department is in the process of updating and expanding on geographic access standards for other provider types. Upon completion and release of the updated standards, KHS will update applicable internal policies and procedures and monitoring processes to ensure compliance with regulatory requirements, and ensure access to services and care for our enrollees.

Access Grievance Review
2017 - Quarter 2

Access Monitoring

Q2, 2017

Introduction

On a quarterly basis, KHS' Provider Relations Department reviews all grievances from the previous quarter that were categorized as "Access to Care" or "Difficulty Accessing a Specialist".

During Q2 2017, ten (10) grievances were received and reviewed by the KHS grievance committee. In seven (7) of the cases no issues were identified and were closed in favor of the plan. The remaining three (3) cases, were closed in favor of the enrollee; these cases were forwarded to the Plan's Provider Relations Department for further tracking and trending.

Tracking and Trending

During the Q2 Access Grievance Review meeting, the three (3) cases that were closed in favor of the enrollee were reviewed against all access grievances received in the previous year.

Upon review, it was identified that all three (3) of the cases were brought against Plan contracted provider groups who had additional access grievances closed in favor of the enrollee within the past year. As of the completion of Q2 2017, within the past year, one provider group had three (3) grievances due to not meeting the in-office wait time standard, and one had three (3) grievances due to not meeting the standard for appointments with a primary care provider, all closed in favor of the enrollee.

One provider group had prior grievances regarding not meeting the standard for an appointment with a primary care provider, but this quarter had a grievance regarding access to a specialist appointment. As this provider group is a large group with multiple providers/provider types (PCPS & Specialists), and this grievance type is different from past grievances, KHS did not identify this as a trend.

KHS Policy/Provider Outreach

The time standards for access to a primary care appointment, specialist appointment, and in-office wait time are outlined in KHS policy 4.30-P *Accessibility Standards.*

A Provider Relations Representative has reached out to the two groups identified in the Plans tracking and trending; these groups were coached on the Plan's policies and procedures in regards to accessibility standards. The Plan will continue to monitor these providers in future access grievance reviews and will take further action as necessary.

Attachment A – Q2 2017 Access Grievances Review Agenda and Sign in Sheet

KERN HEALTH SYSTEMS

Quarter 2, 2017 (April – June) Access Grievances Review Agenda

Date: 8/2/17

Discussion:

1. **Review access grievances for Q2 2017**
   - **Identify any trends regarding access**
   - **Conduct file review for grievances closed in favor of the enrollee**

2. **Review Access Grievances for Q2 2017 against last year of annual grievances**
   - **Identify any trends regarding access**

Closed in Favor of the Enrollee	**3**
Access to Care	**2**
Bichai, William	1
Clinica Sierra Vista - Niles	1
Difficulty Accessing Specialist	**1**
Kern Medical	1

Closed in Favor of the Plan	**7**
Access to Care	**6**
Bichai, William	1
Clinica Sierra Vista - Arvin	2
Clinica Sierra Vista - East Bakersfield	1
Dakak, Alan	1
Singh, Ravinderjit	1
Difficulty Accessing Specialist	**1**
Kern Family Health Care	1

Name	Title	Date
Adriana Zavala	SPNA	8/2/17
Yolanda Herrera	Cred Lead	8/2/17
Melissa Lopez	PR Manager	8/2/17
James Wintrey	Senior Provider Network Analyst	8/2/17

KERN HEALTH SYSTEMS
DISEASE MANAGEMENT DEPARTMENT QUARTERLY REPORT

Report Date: July 14, 2017

Reporting Period: April 1, 2017 – June 30, 2017

DISEASE MANAGEMENT DEPARTMENT OVERVIEW:

Disease Management is a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant variables in achievement of desirable outcomes. Disease Management supports the physician or practitioner/member relationship and plan of care; emphasizes prevention of exacerbations and complications utilizing evidence-based practice guidelines, and member empowerment strategies, and; evaluates clinical, humanistic, and economic outcomes.

The Disease Management Department performs assessments, coordinates care, monitors and evaluates medical services for members with an emphasis on quality of care, continuity of services, and cost-effectiveness. The three program areas of the Disease Management Department are Diabetes and Hypertension, Asthma and High Risk Pregnancies.

Disease Management Department Staffing:

Position	Quantity
Disease Management RN	4
Disease Management SSC's	4

Case Manager RN Caseload:

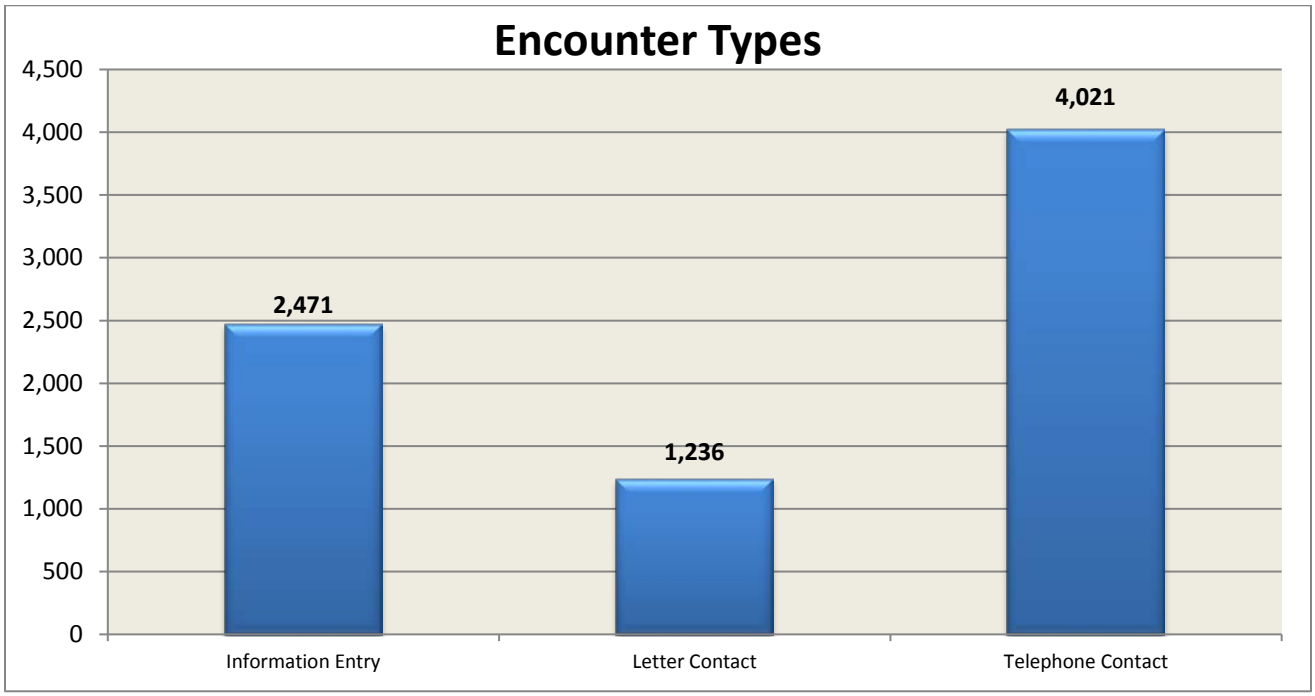
Staff	Caseload
RN 1	161
RN 2	152
RN 3	81
RN 4	108
TOTAL	**502**

DM Program Caseload:

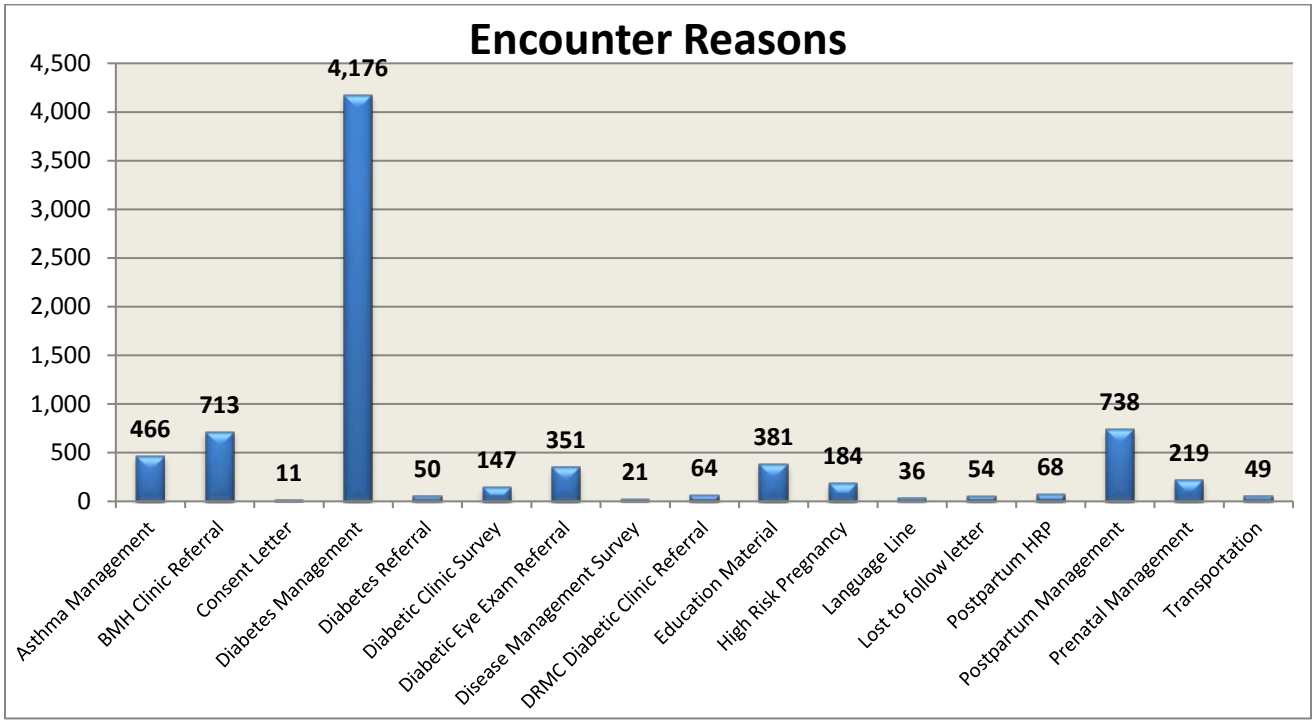
DM Program	Caseload
Asthma	114
Diabetes and Hypertension	370
High Risk Pregnancy	18
TOTAL	**502**

Encounters:

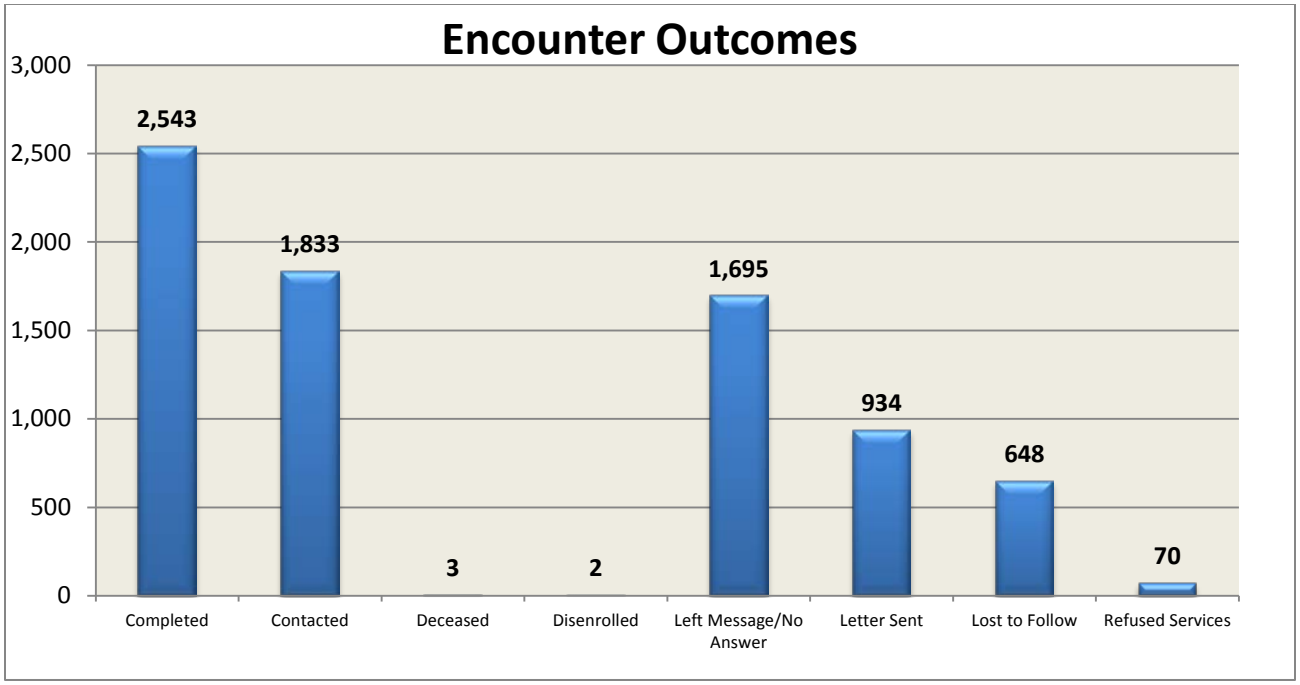
There were a total of 7,728 encounters submitted during this quarter for 2,261 KFHC members and the majority of the encounter types were listed as a Telephone Contact at 52%.



The majority of the encounter reasons at 54% was listed as Diabetes Management.

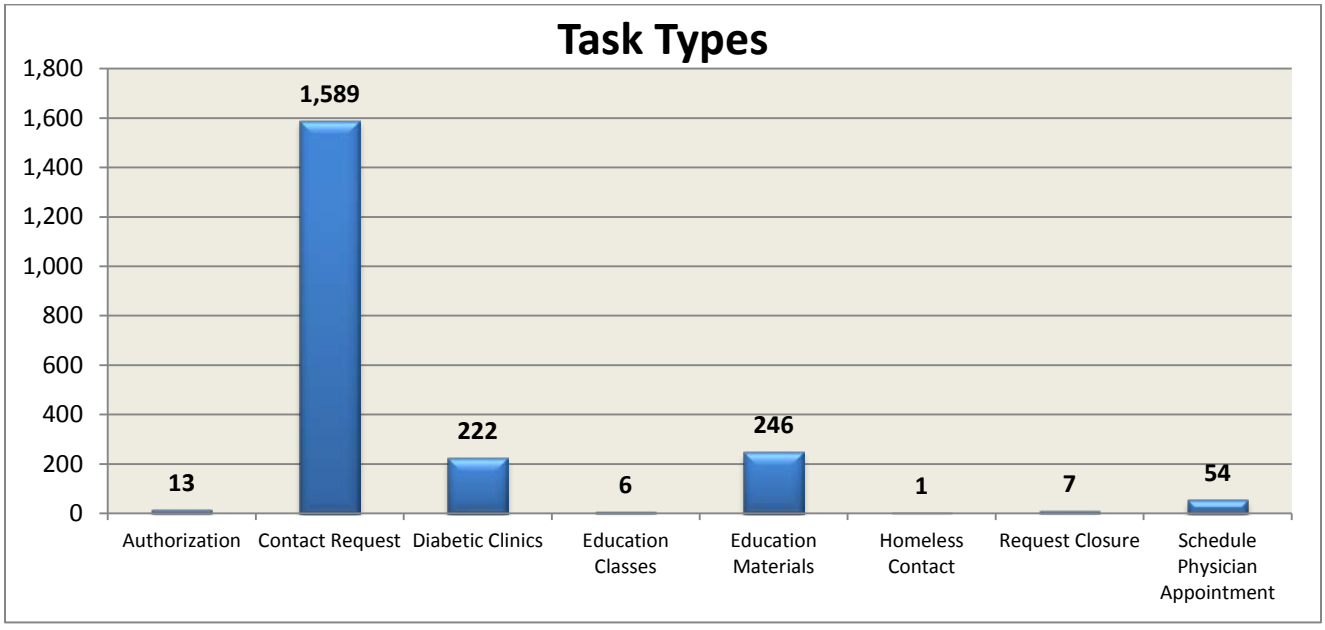


The majority of the encounter outcomes at 33% are listed as completed.

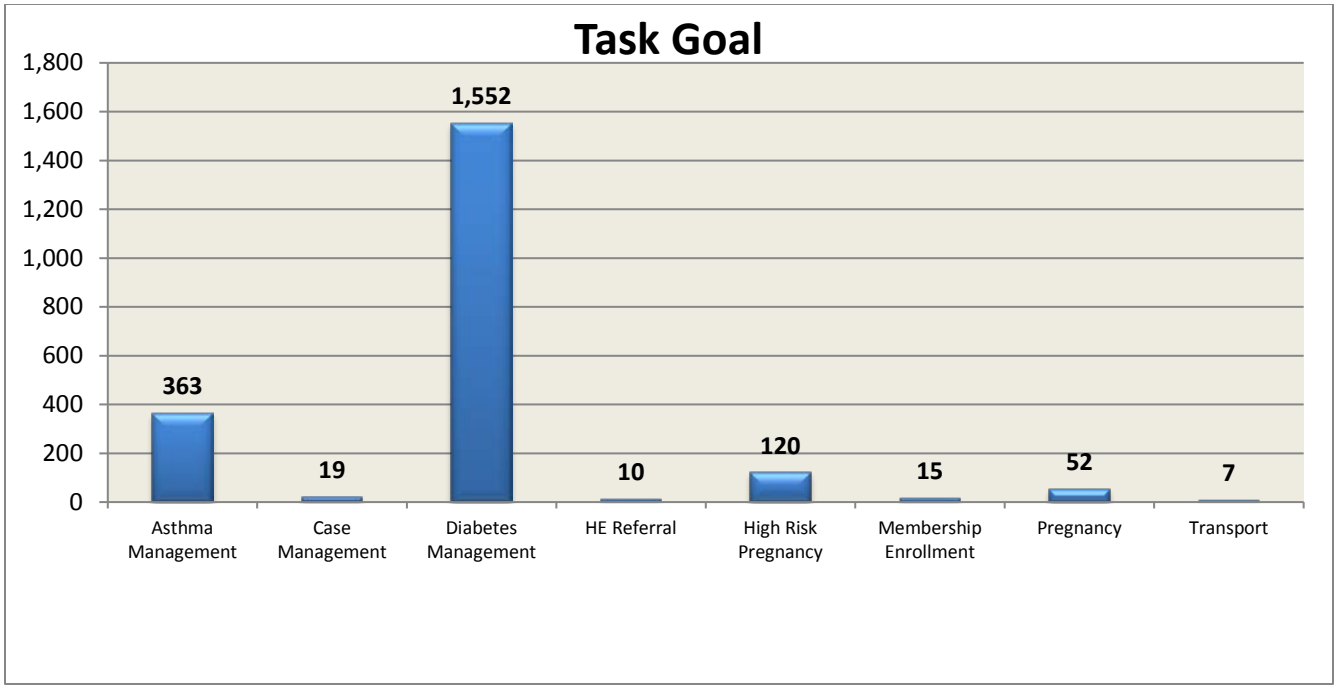


Tasks:

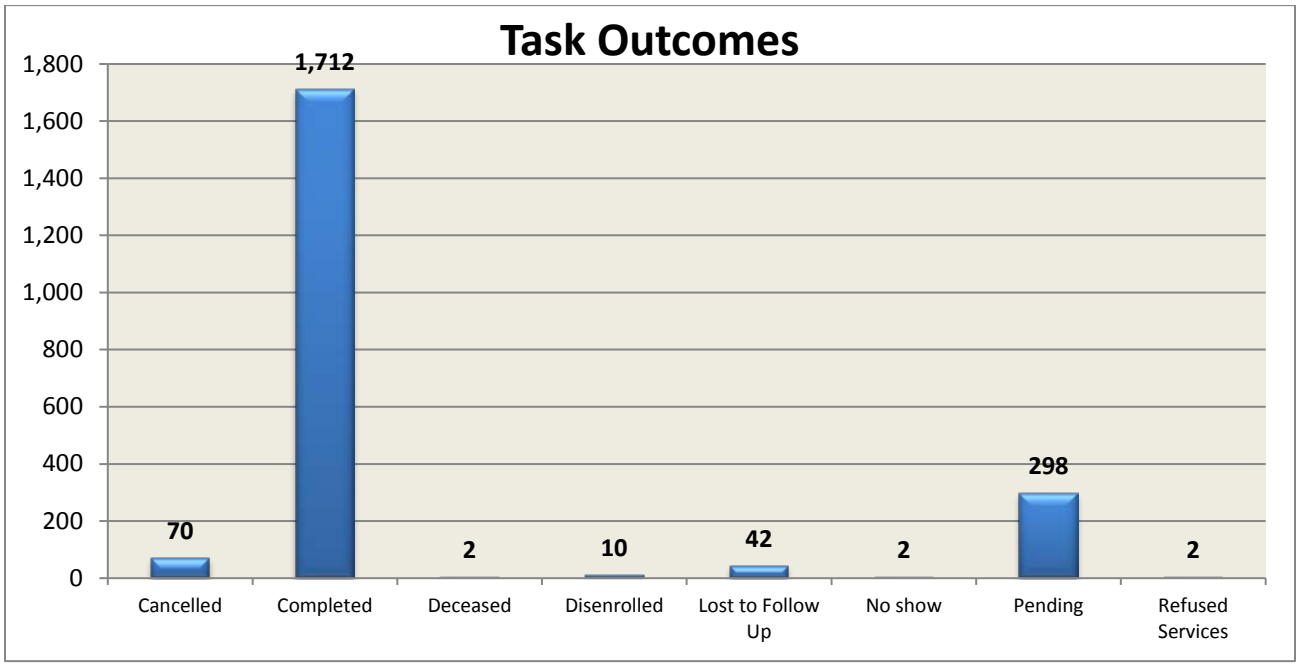
There were a total of 2,138 tasks assigned to the Disease Management department during the quarter for 1,256 KFHC members. The majority of Task Types were Contact Request at 74%.



The majority of task goals at 73% was listed as Diabetes Management.

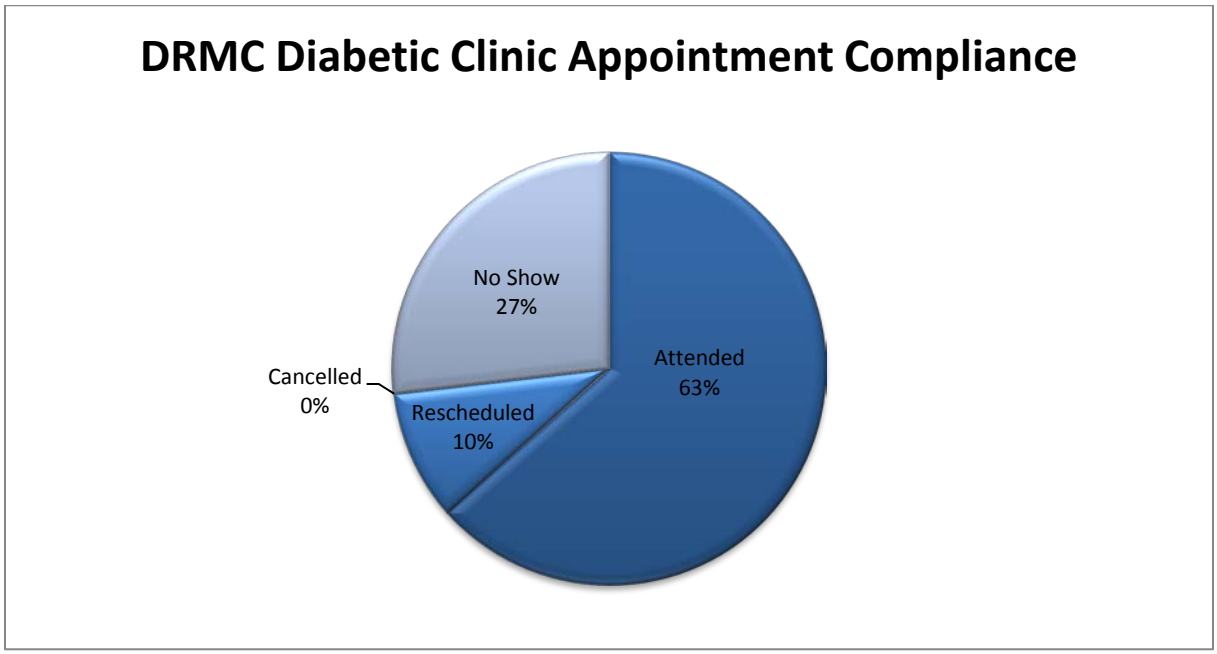


The majority of the task outcomes at 80% are completed.



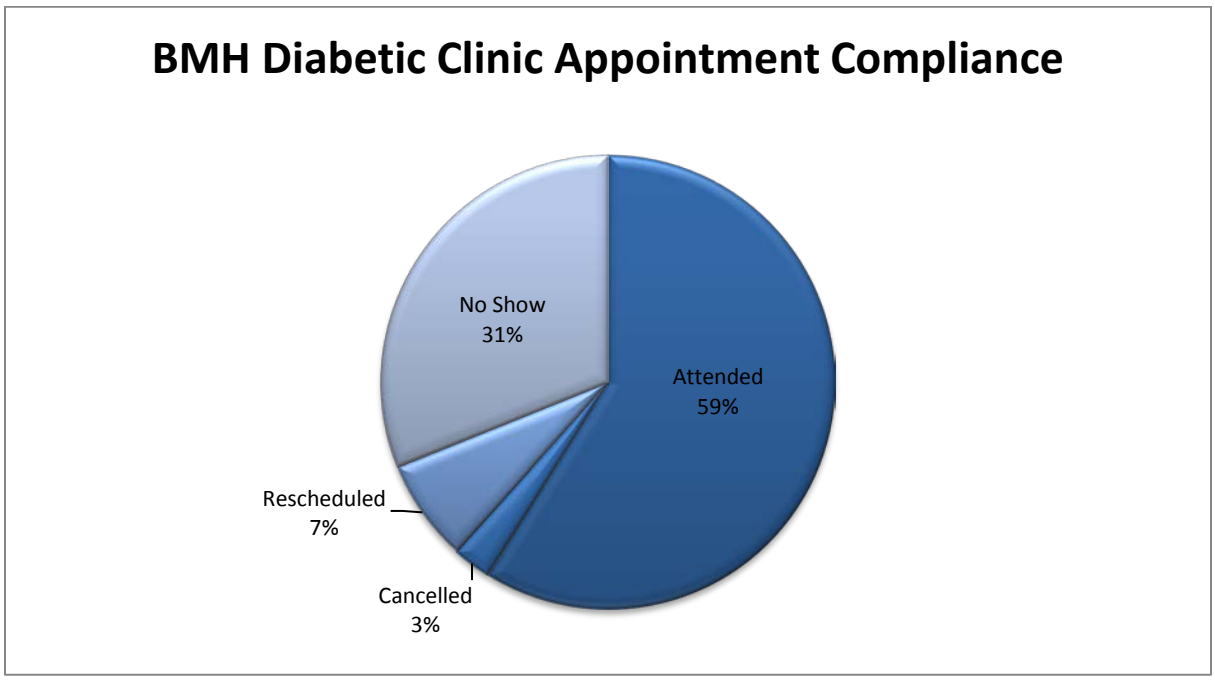
Delano Regional Medical Center (DRMC) Diabetic Clinic

Appointment compliance at the DRMC Diabetic Clinic revealed 63% of members attended their scheduled appointment.



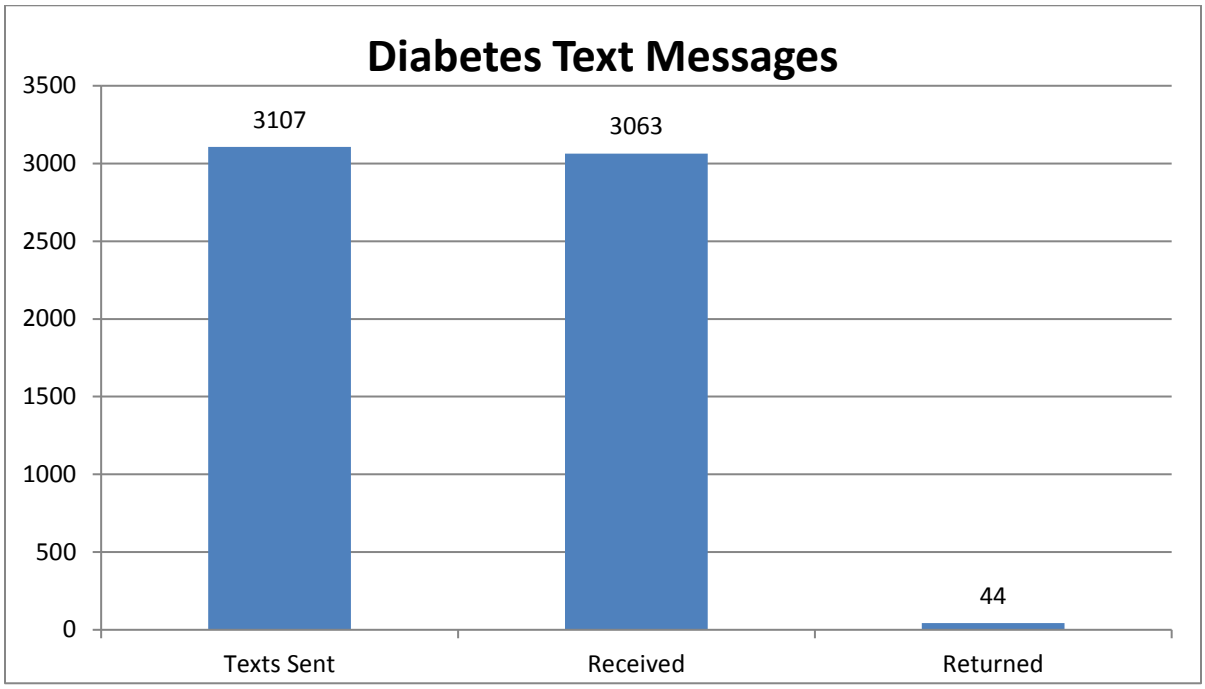
Bakersfield Memorial Hospital (BMH) Diabetic Clinic

Appointment compliance at the BMH Diabetic Clinic revealed 59% of members attended their scheduled appointment.



Diabetes Text Messaging Program

Thirteen diabetes related text messages, totaling 3,107 were sent to members during this quarter. 98.6% of those messages were successfully received by the members.



Propeller Asthma Management Pilot

The one year trial period has ended. KHS' Disease Management Department and Dignity Health partnered with Propeller Health to pilot a digital asthma management program for 20 KHS members with asthma. Through the use of medication sensors, mobile applications and an online dashboard, KHS was able to track the frequency of the controller and rescue asthma inhalers used by each participating member, receive email notifications when a member was identified as in poor control of his/her asthma and identify the geographic location of where the member used their medication (smartphone enrolled members only). Members did not need internet access or a smartphone to participate. By the end of the trial period, 15 members were actively engaged in this pilot and were sending data to the online patient health dashboard hosted by Propeller Health.

Automated Reminder Calls

KHS sends automated reminder calls to members in need of completing specific health actions. During this quarter, there were no automated reminder calls sent with regards to diabetes related screenings.

KERN HEALTH SYSTEMS HEALTH EDUCATION ACTIVITIES REPORT
SECOND QUARTER 2017

Report Date: July 21, 2017

OVERVIEW

Kern Health Systems' Health Education 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.

- School Wellness Grant and Internship Programs
- Fall Member Newsletter
- Video Remote Interpreting Services Pilot
- CommGap now contracted for onsite interpreting services
- Asthma collaboration with KHS QI department and Omni North Chester Health Center
- Preventive Care Calls with KHS QI department

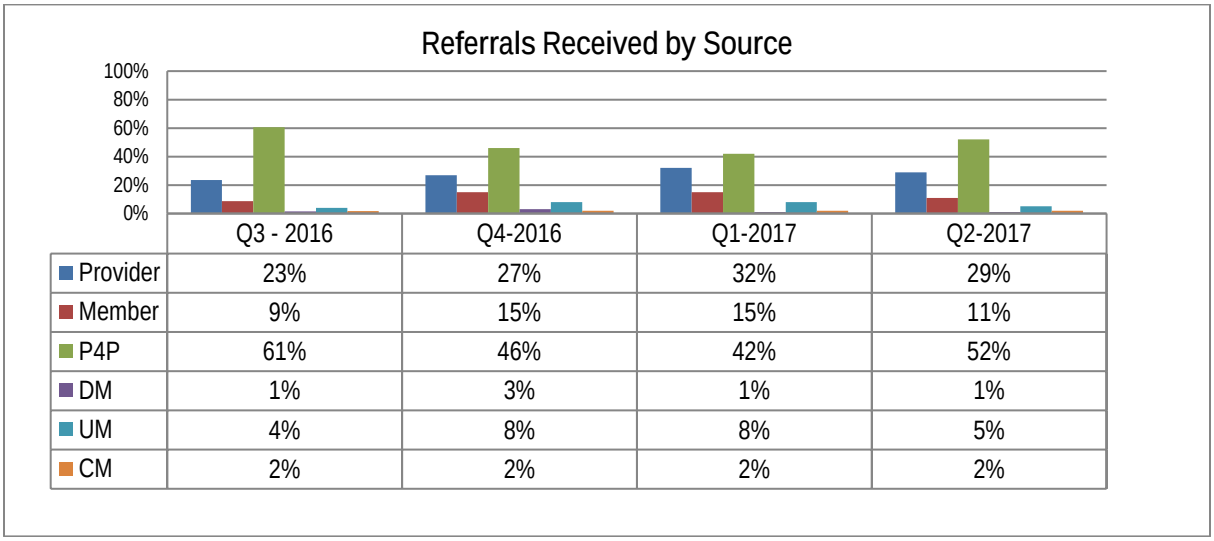
The following pages reflect statistical measurements for the Health Education department detailing the ongoing activity for 2nd quarter 2017.

Respectfully submitted,
Isabel Silva, MPH, CHES

KERN HEALTH SYSTEMS HEALTH EDUCATION ACTIVITIES REPORT
SECOND QUARTER 2017

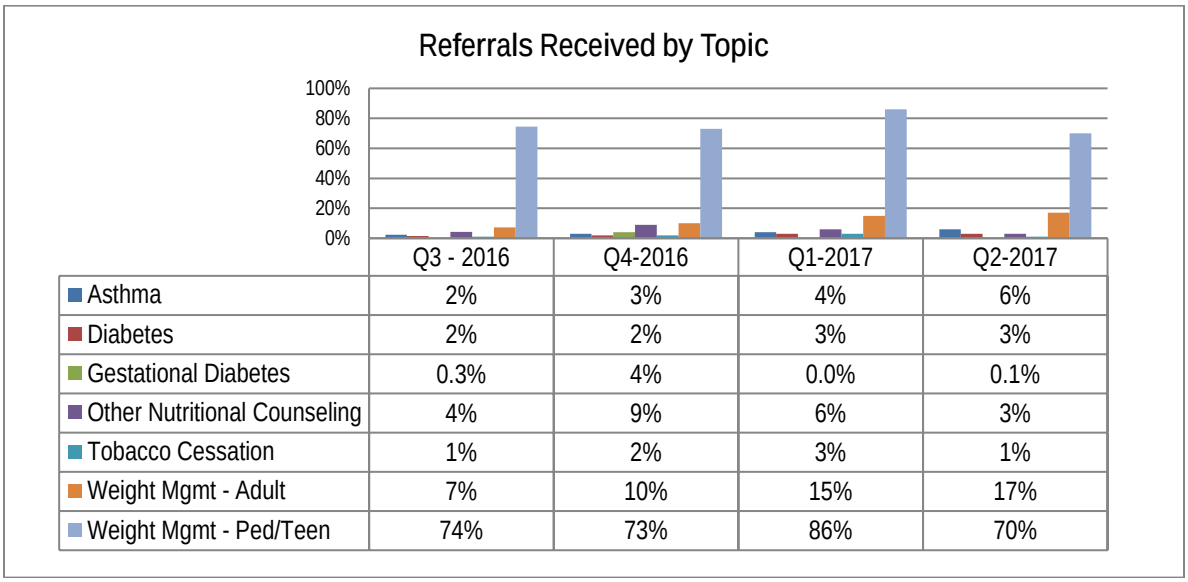
REFERRALS FOR HEALTH EDUCATION SERVICES

The Health Education Department (HE) receives referrals from various sources. Internal referrals are received from the Kern Health Systems (KHS) Utilization Management Department (UM), the Disease Management Department (DM), Case Management (CM), and the Provider Pay for Performance Program (P4P). Externally, KHS providers submit referrals for health education services according to the member's diagnosis. Kern Family Health Care (KFHC) members can also self-refer for health education services.



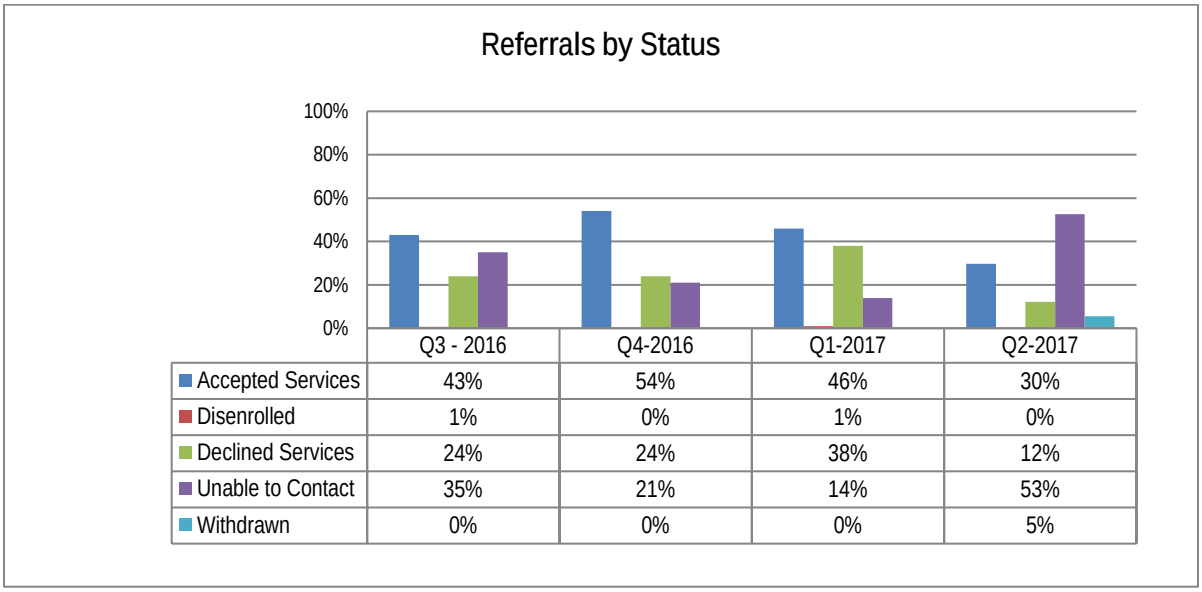
	Q3 - 2016	Q4-2016	Q1-2017	Q2-2017
Provider	23%	27%	32%	29%
Member	9%	15%	15%	11%
P4P	61%	46%	42%	52%
DM	1%	3%	1%	1%
UM	4%	8%	8%	5%
CM	2%	2%	2%	2%

During this quarter, 2,047 referrals were received which is a 91% increase in comparison to the previous quarter. This increase is attributed to the increase in P4P referral submissions.



	Q3 - 2016	Q4-2016	Q1-2017	Q2-2017
Asthma	2%	3%	4%	6%
Diabetes	2%	2%	3%	3%
Gestational Diabetes	0.3%	4%	0.0%	0.1%
Other Nutritional Counseling	4%	9%	6%	3%
Tobacco Cessation	1%	2%	3%	1%
Weight Mgmt - Adult	7%	10%	15%	17%
Weight Mgmt - Ped/Teen	74%	73%	86%	70%

The HE department receives referrals for various health conditions. Weight management education continues to be the most requested service for members. It accounted for 87% of all referrals received in the 2nd Quarter of 2017.



	Q3 - 2016	Q4-2016	Q1-2017	Q2-2017
Accepted Services	43%	54%	46%	30%
Disenrolled	1%	0%	1%	0%
Declined Services	24%	24%	38%	12%
Unable to Contact	35%	21%	14%	53%
Withdrawn	0%	0%	0%	5%

The rate of members who accepted to receive health education services decreased from 46% in the 1st quarter to 30% in the 2nd quarter in 2017.

Member reasons for declining health education services were also collected. During this quarter, the top 3 reasons for referral refusal were due to the following:

1. The member prefers to be mailed educational material.
2. The member is not interested in the services.
3. The member is unable to receive service due to work/school schedule.

HEALTH EDUCATION SERVICE PROVIDERS

The HE department offers various types of services through KHS or through community partnerships.

Kern Family Health Care (KFHC):

- Healthy Eating and Active Lifestyle Workshop
- Breathe Well Asthma Workshop

KERN HEALTH SYSTEMS HEALTH EDUCATION ACTIVITIES REPORT
SECOND QUARTER 2017

Bakersfield Memorial Hospital (BMH):

- Diabetes Management Classes (English only)
- Heart Healthy Classes
- Small Steps to a Healthier Weight (English only)
- Individual Nutrition Counseling
- Kids Weight Management Classes

Community Wellness Program (CWP):

- In-home or group setting for Asthma, Diabetes, Nutrition or Stroke Prevention Education
- Freedom from Smoking Program

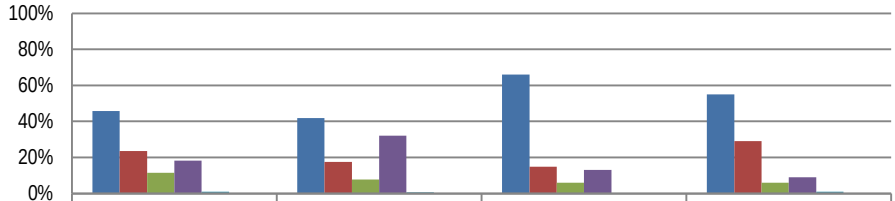
Clinica Sierra Vista (CSV) WIC:

- Diabetes Management Classes
- Heart Healthy Classes

California Smokers' Helpline (CSH):

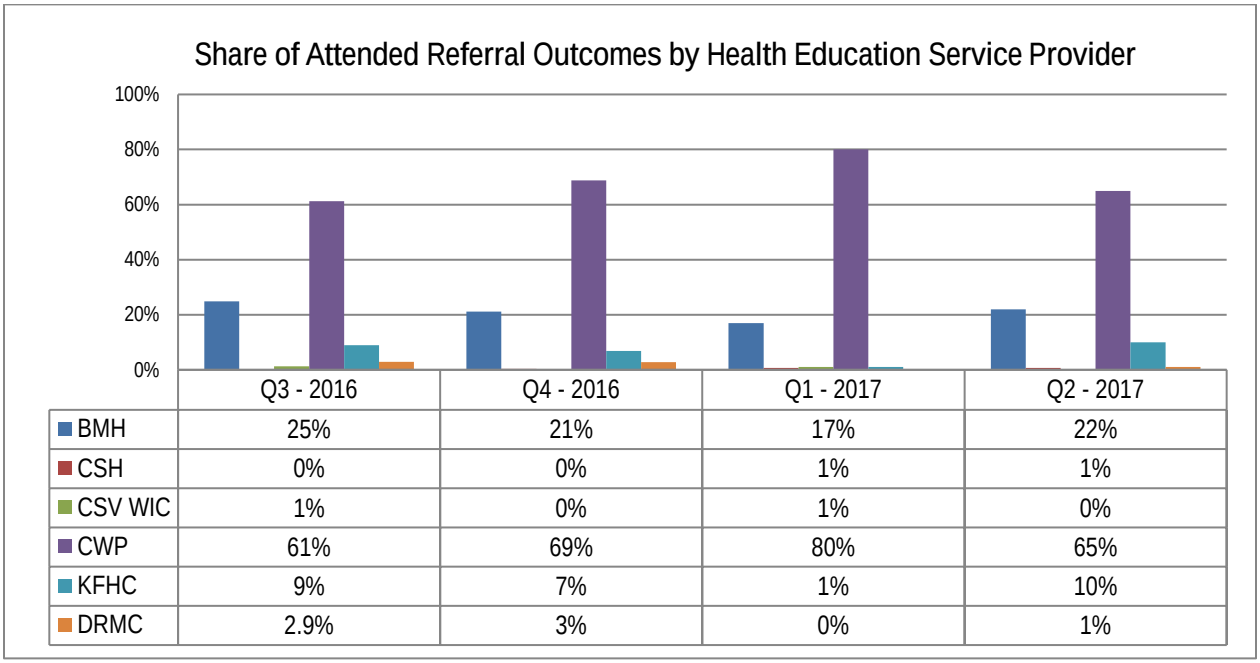
- Telephone Smoking Cessation Counseling

REFERRAL OUTCOMES



	Q3 - 2016	Q4 - 2016	Q1 - 2017	Q2 - 2017
Attend	46%	42%	66%	55%
No Show	24%	18%	15%	29%
Refused	11%	8%	6%	6%
Unable to contact member	18%	32%	13%	9%
Disenrolled	1%	1%	0%	1%
Withdrawn	0%	0%	0.00%	0%

During this quarter, the rate of members who attended or received health education services out of all members who accepted services decreased from a 66% to a 55%.

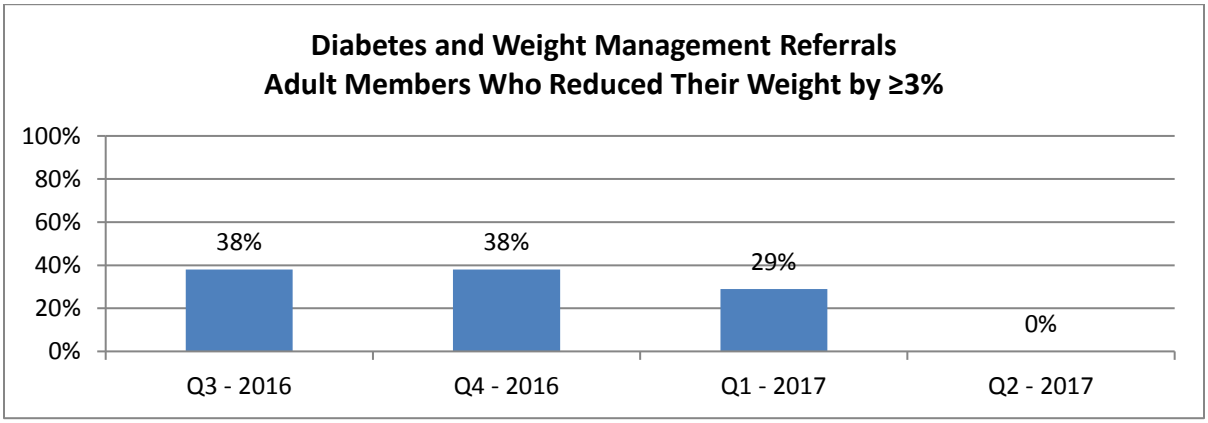


	Q3 - 2016	Q4 - 2016	Q1 - 2017	Q2 - 2017
BMH	25%	21%	17%	22%
CSH	0%	0%	1%	1%
CSV WIC	1%	0%	1%	0%
CWP	61%	69%	80%	65%
KFHC	9%	7%	1%	10%
DRMC	2.9%	3%	0%	1%

Services through CWP continue to account for the largest share of referral outcomes. CWP's share of attended outcomes decreased from 80% to 65% due to an increase in request for services provided directly through KHS.

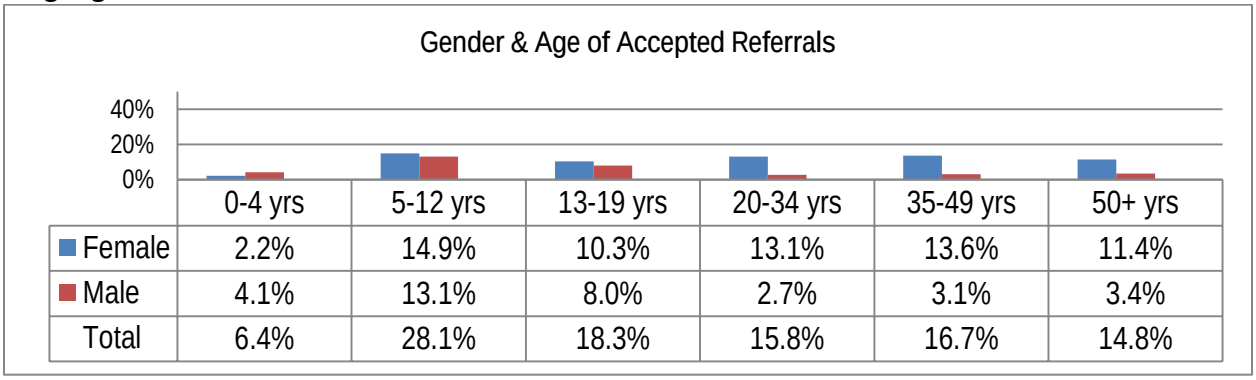
Effectiveness of Health Education Services

To evaluate the effectiveness of the diabetes and weight management health education services provided to members, a 3-month follow up call was conducted on members who received services during the prior quarter. The Health Education department is in the process of revising the evaluation metrics for its health education services which resulted in no follow up calls performed during the 2nd quarter.



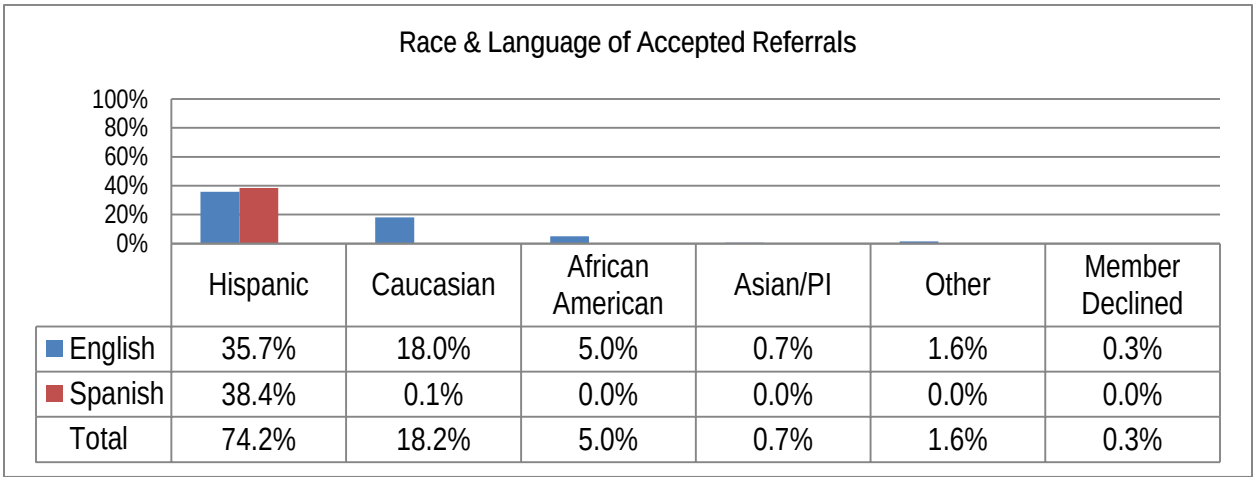
Demographics of Members Served

KHS' provides services to a culturally and linguistically diverse member population. KHS' language threshold is English and Spanish and all services and materials are available in these languages.



	0-4 yrs	5-12 yrs	13-19 yrs	20-34 yrs	35-49 yrs	50+ yrs
Female	2.2%	14.9%	10.3%	13.1%	13.6%	11.4%
Male	4.1%	13.1%	8.0%	2.7%	3.1%	3.4%
Total	6.4%	28.1%	18.3%	15.8%	16.7%	14.8%

Out of the members who accepted to receive health education services, the largest gender-age groups were male ages 5-12 years and female ages 5-12 years.



	Hispanic	Caucasian	African American	Asian/PI	Other	Member Declined
English	35.7%	18.0%	5.0%	0.7%	1.6%	0.3%
Spanish	38.4%	0.1%	0.0%	0.0%	0.0%	0.0%
Total	74.2%	18.2%	5.0%	0.7%	1.6%	0.3%

A breakdown of member classifications by race and language preferences revealed that 38% of members who accepted services are Hispanic and preferred to speak Spanish.

Referrals Accepted by Top Bakersfield Zip Codes			
Q3-2016	**Q4-2016**	**Q1 - 2017**	**Q2-2017**
93307	93307	93306	93307
93306	93306	93307	93306
93305	93304	93304	93305
93304	93305	93305	93304
93309	93309	93301	93308

KHS serves members in the Kern County area with the exception of Ridgecrest. During this quarter, 77% of the members who accepted services reside in Bakersfield and the highest concentration of members were in the 93307 area.

Referrals Accepted by Top Outlying Areas			
Q3-2016	**Q4-2016**	**Q1 - 2017**	**Q2-2017**
Delano	Delano	Delano	Delano
McFarland	Wasco	Shafter	Shafter
Wasco	McFarland	Wasco	Wasco
Lamont	Arvin	Lamont	McFarland
Arvin	Shafter	Arvin	Arvin
Shafter			Taft

Additionally, 23% of the members who accepted services reside in the outlying areas of Kern County and the highest concentration of members continue to be in Delano.

Health Education Mailings

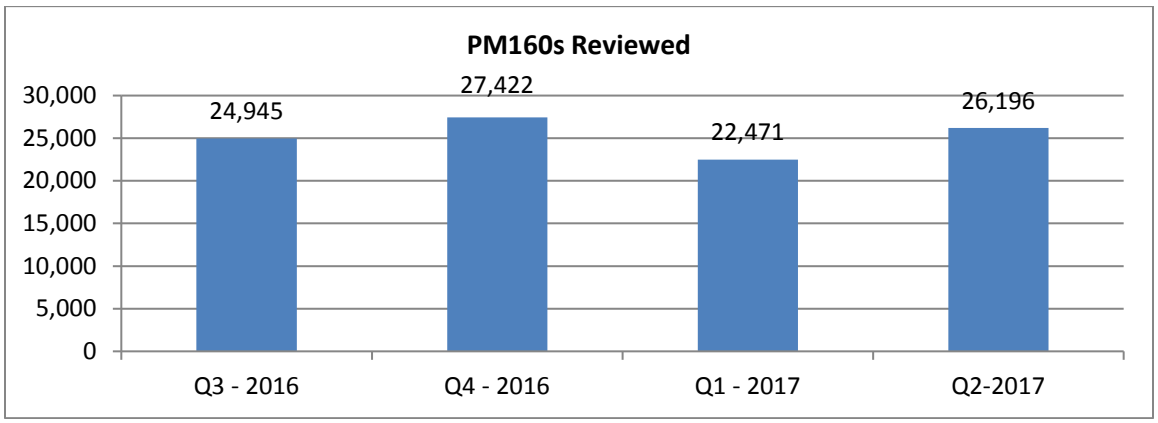
In addition to referrals, the HE department mails out a variety of educational material in an effort to assist members with gaining knowledge on their specific diagnosis or health concern. During this quarter, the HE department mailed 2,011 educational packets to members on the following health topics:

Educational Mailings				
	Q3-2016	**Q4-2016**	**Q1 - 2017**	**Q2-2017**
Anemia	191	151	147	1
Asthma	104	129	84	52
High Cholesterol	16	11	24	8
Diabetes	14	40	31	33
Gestational Diabetes	2	2	0	0
High Blood Pressure	60	52	48	28
Nutrition	8	0	0	0

COPD	0	0	0	1
Postpartum Care	807	676	666	300
Prenatal Care	436	417	354	73
Smoking Cessation	39	27	32	18
Weight Management	2714	2433	2111	1497
Postpartum Incentive	437	511	513	0
Total	**4828**	**4449**	**4010**	**2011**

PM160 PROCESSING

KHS Primary Care Providers (PCP) are required to document pediatric preventive care services on a PM160 and submit these forms to KHS. On a daily basis, the HE department reviews these forms to evaluate for possible health education interventions.



INTERPRETER REQUESTS

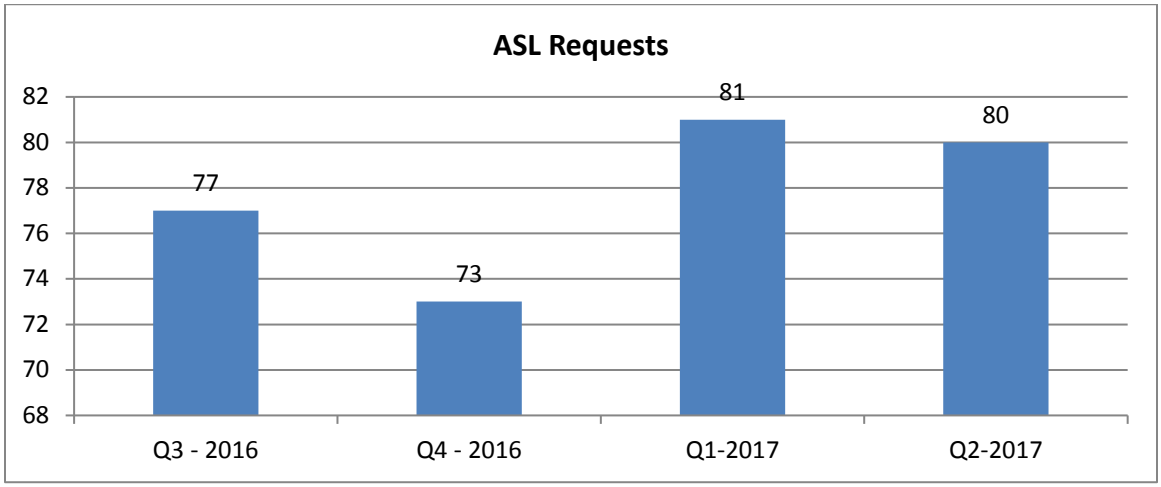
Telephonic Interpreter Requests

During this quarter, there were 517 requests for telephonic interpreting services through KHS' interpreting vendor, Language Line Solutions. The majority of these requests were for a Spanish interpreter.

Top Languages Requested			
Q3-2016	**Q4-2016**	**Q1 - 2017**	**Q2-2017**
Punjabi	Punjabi	Spanish	Spanish
Arabic	Spanish	Punjabi	Punjabi
Spanish	Arabic	Arabic	Arabic
Mandarin	Tagalog	Vietnamese	Tagalog
Tagalog	Vietnamese	Tagalog	Mandarin
Vietnamese			

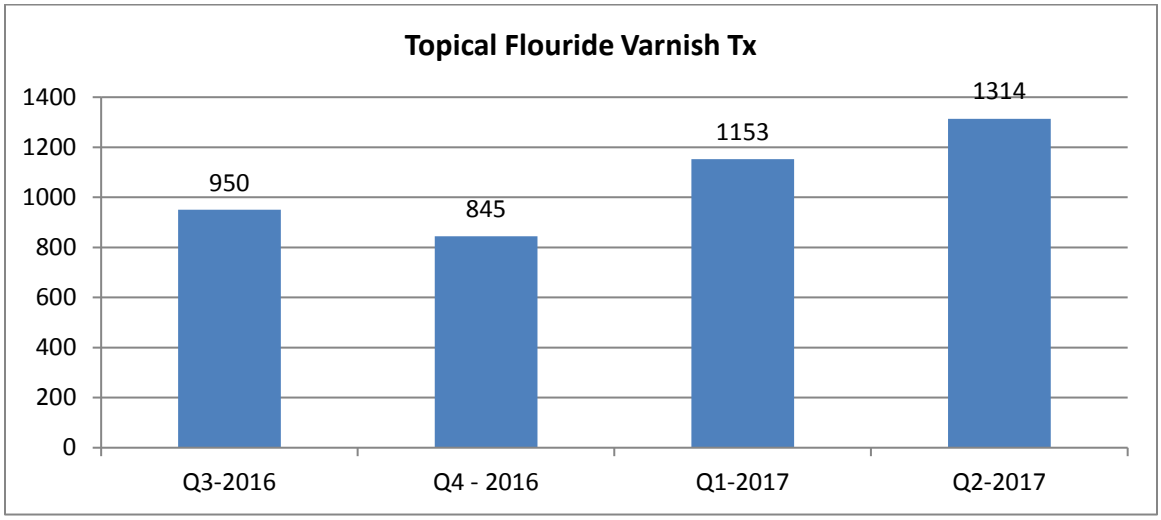
American Sign Language (ASL) Requests

During this quarter, there was a total of 80 requests received for an American Sign Language interpreter, which was a marginal decrease in comparison to the previous quarter.



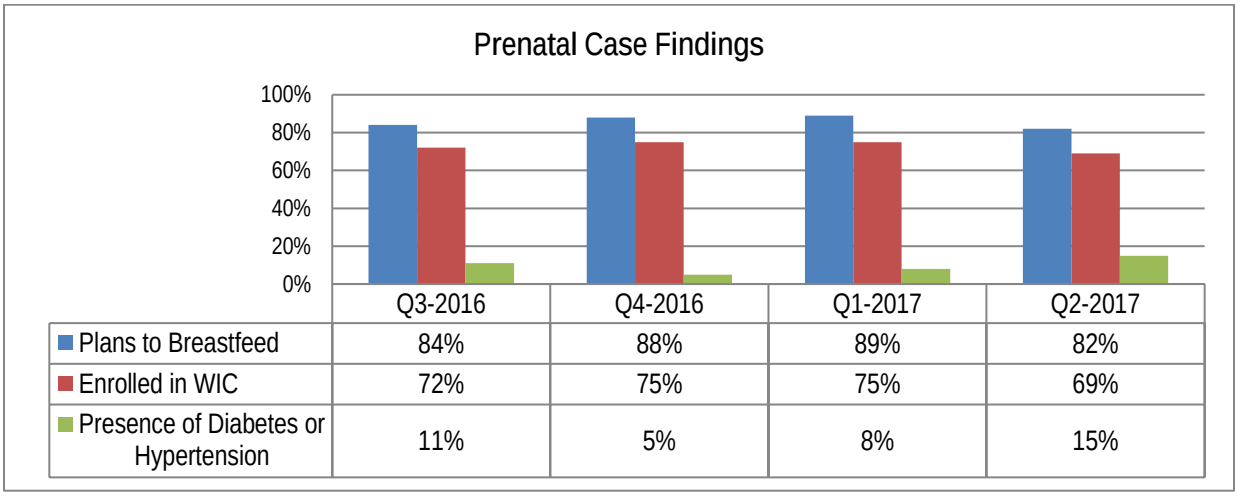
TOPICAL FLUORIDE VARNISH TREATMENTS

Fluoride varnish treatments are effective in preventing tooth decay and more practical and safer to use with young children. KHS covers up to three topical fluoride varnish treatments in a 12-month period for all members younger than 6 years.



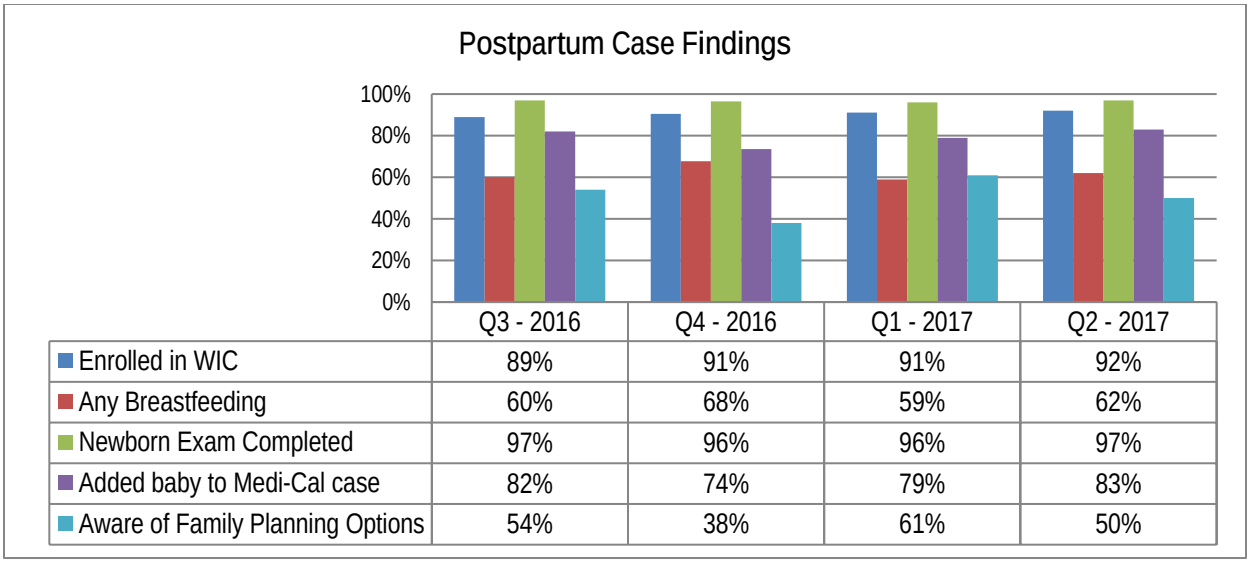
OB CASE MANAGEMENT PROJECT

The HE department performs outreach education calls to all members identified as being pregnant or postpartum.



	Q3-2016	Q4-2016	Q1-2017	Q2-2017
Plans to Breastfeed	84%	88%	89%	82%
Enrolled in WIC	72%	75%	75%	69%
Presence of Diabetes or Hypertension	11%	5%	8%	15%

During this quarter, the HE department successfully contacted 72pregnant members. Members who are not successfully contacted by phone and are at least 18 years of age or older are mailed a letter asking them to contact KHS' HE department as soon as possible.



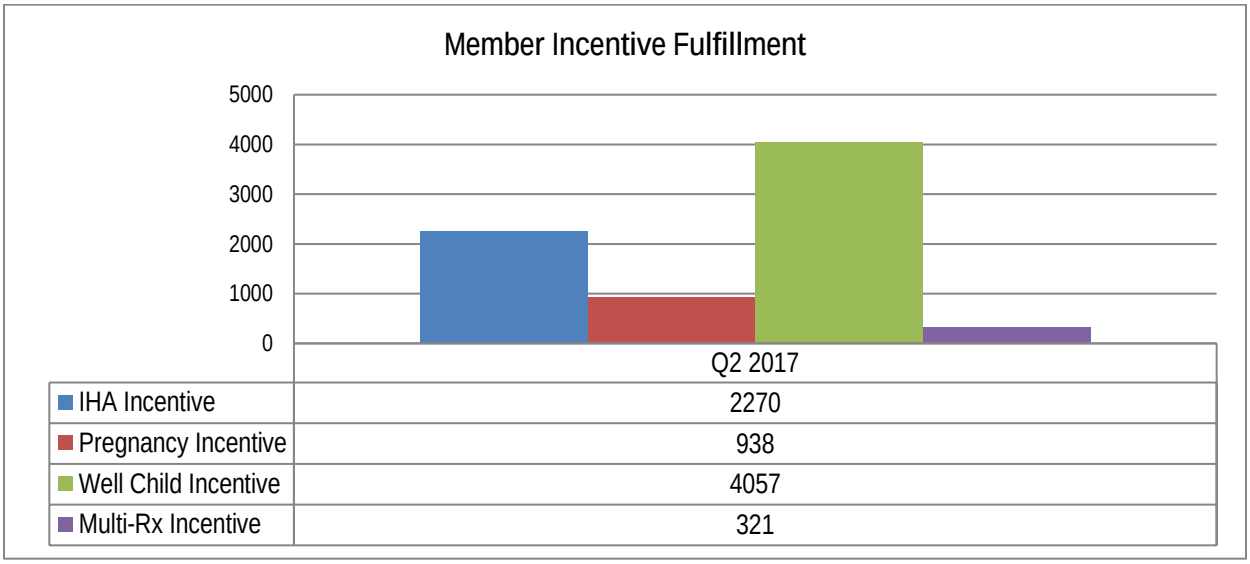
	Q3 - 2016	Q4 - 2016	Q1 - 2017	Q2 - 2017
Enrolled in WIC	89%	91%	91%	92%
Any Breastfeeding	60%	68%	59%	62%
Newborn Exam Completed	97%	96%	96%	97%
Added baby to Medi-Cal case	82%	74%	79%	83%
Aware of Family Planning Options	54%	38%	61%	50%

The HE department successfully contacted 469 postpartum members during this quarter. The rate of members who reported any breastfeeding increased from 59% to 62%.

MEMBER WELLNESS AND CHRONIC CONDITION BASED INCENTIVES

During the 2nd quarter of 2017, KHS implemented three wellness based incentives and one chronic condition based incentive for members.

- **Initial Health Assessment (IHA)** – newly enrolled members who complete the IHA visit within 120 days of enrollment are mailed a first aid kit. There is a limit of one incentive per household.
- **Pregnancy** – pregnant members who completed at least 6 prenatal visits and the postpartum visit within 3-8 weeks are mailed a $65 voucher to redeem diapers, wipes or a portable play yard at Toys R Us or Babies R Us.
- **Well Child** – members ages 12 -23 months who complete a well child visit are mailed a $25 voucher to redeem an umbrella stroller at Toys R Us or Babies R Us.
- **Multi-Medication** – members on multiple medications and would benefit from a pill box. KHS disease and case management departments identify and mail this incentive to members.



Medi-Cal Managed Care

HEDIS® 2017 Compliance Audit™ Final Report of Findings

for

Kern Family Health Care

July 2017

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Overview

Final Audit Statement

This section includes the fully executed Healthcare Effectiveness Data and Information Set (HEDIS®[1]) Final Audit Statement that Health Services Advisory Group, Inc. (HSAG) will submit electronically to the National Committee for Quality Assurance (NCQA).

Audit Management Information

This section includes basic audit information, including the NCQA-licensed organization (LO) information, name of the managed care health plan (MCP) undergoing the audit review, audit timeline, audit team composition, and the list of performance measures validated for reporting year (RY) 2017.

Assessment and Review Findings

This section includes HSAG's findings from the information systems (IS) capabilities assessment, supplemental database review, medical record review validation (MRRV), HEDIS Determination (HD) assessment, and survey sample frame validation assessment. All assessments and reviews were conducted in accordance with NCQA's *HEDIS 2017, Volume 5: HEDIS Compliance Audit™*[2]*: Standards, Policies and Procedures* and *HEDIS 2017, Volume 2: Technical Specifications for Health Plans*.

Audit Results and Associated Rates

This section includes the final audited data submission files and discusses the audit results that can be assigned to a measure and the rationale for their selection.

[1] HEDIS® is a registered trademark of NCQA.

[2] HEDIS Compliance Audit™ is a trademark of NCQA.

2. Final Audit Statement

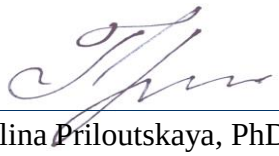
Final Audit Statement

We have examined Kern Family Health Care's (KFHC's) submitted measures for conformity with the Healthcare Effectiveness Data and Information Set (HEDIS) Technical Specifications. This audit followed the NCQA HEDIS Compliance Audit standards and policies and procedures. Audit planning and testing was constructed to measure conformance to the HEDIS Technical Specifications for all measures presented at the time of our audit.

This report is KFHC management's responsibility. Our responsibility is to express an opinion on the report based on our examination. Our examination included procedures to obtain reasonable assurance that the submission presents fairly, in all material respects, the organization's performance with respect to the HEDIS Technical Specifications. Our examination was made according to HEDIS Compliance Audit standards and policies and procedures, and accordingly included procedures we considered necessary to obtain a reasonable basis for rendering our opinion. Our opinion does not constitute a warranty or any other form of assurance as to the nature or quality of the health services provided by or arranged by the organization.

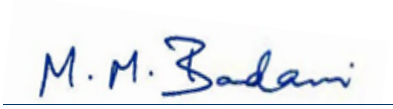
In our opinion, KFHC's submitted measures were prepared according to the HEDIS Technical Specifications and present fairly, in all material respects, the organization's performance with respect to these specifications.

We understand that if the signatures we submit below are electronic, they have the same legal effect, validity and enforceability as original signatures submitted on paper.



Galina Priloutskaya, PhD, MBA, CHCA
(NCQA Certified HEDIS Compliance Auditor)

July 13, 2017
(Date)



Mariyah Badani, JD, MBA, CHCA
(Responsible Officer)

July 13, 2017
(Date)

Organization ID: 1569

Submission ID(s): 4334

3. Audit Management Information

About the NCQA-Licensed Audit Organization

HSAG is an organization licensed by NCQA to conduct HEDIS Compliance Audits.

NCQA-Licensed Organization
Health Services Advisory Group, Inc.
3133 East Camelback Road, Suite 100
Phoenix, AZ 85016

HSAG Practice Leader
Charlie Chapin, MS, CHCA
Director and Practice Leader, Audits/State and Corporate Services

HSAG Audit Director
Mariyah Badani, JD, MBA, CHCA
Director, Audits/State and Corporate Services

Lead Auditor
Galina Priloutskaya, PhD, MBA, CHCA
Consultant

MCP and Audit Scope Information

HSAG conducted the type of audit described below. Basic information about the MCP appears in the table, including the office location(s) involved in the 2017 HEDIS Compliance Audit.

MCP and Audit Scope Information	
Audit Scope:	Medi-Cal Managed Care Program's (MCMC's) External Accountability Set (EAS) Performance Measures
MCP Name:	Kern Family Health Care
Reporting Unit(s):	Kern County
On-site Address:	9700 Stockdale Highway Bakersfield, CA 93311
Contact Responsible for HEDIS Reporting/Audit Seal Contact:	Jada Salamatian, RN Quality Improvement Supervisor jada.salamatian@khs-net.com
NCQA Organization ID:	1569
NCQA Submission ID(s):	4334
Calculation Vendor:	Verscend Technologies, Inc. (Verscend)
Medical Record Review (MRR) Vendor:	Not applicable (NA); MRR conducted "in house"
Survey Vendor:	Survey sample frame validation was not applicable to the scope of the audit.

Final MCP Audit Timeline

The following table shows the major audit tasks, the targeted completion date for each task, and the actual date each task was completed.

Task	Target Date	Actual Date
HSAG sent the HEDIS Record of Administration, Data Management and Processes (Roadmap) packet to KFHC initiating the HEDIS 2017 audit activities.	11/4/16	11/2/16
KFHC submitted completed Roadmap to HSAG.	1/31/17*	1/30/17
Pre-on-site kick-off call conducted.	At least two weeks prior to on-site visit	1/3/17
HSAG submitted preliminary IS Tracking Grid/Roadmap findings to KFHC.	At least two weeks prior to on-site visit	2/2/17
KFHC submitted source code for all measures not covered under NCQA Measure Certification[SM3] to HSAG.	3/1/17*	2/22/17
HSAG finalized approval of all supplemental data and notified KFHC of the results.	3/31/17*	3/29/17
HSAG sent on-site agenda to KFHC.	At least two weeks prior to on-site visit	2/26/17
On-site visit conducted.	4/28/17*	3/29/17
HSAG submitted preliminary audit findings report with interim IS Tracking Grid to KFHC and DHCS.	No later than 10 business days following on-site visit*	4/12/17
Preliminary rate review feedback completed.	5/1/17*	4/18/17
KFHC completed the medical record abstraction process for all measures and sent final numerator-compliant counts for all measures and exclusions for MRRV to HSAG.	5/15/17*	5/15/17
HSAG selected measures from the measure groups and exclusions for MRRV, selected 16 records from each measure selected and exclusions, and informed KFHC of the selections.	5/19/17*	5/17/17
KFHC submitted selected charts to HSAG for MRRV.	5/26/17*	5/24/17

[3] NCQA Measure Certification[SM] is a service mark of NCQA.

Task	Target Date	Actual Date
HSAG sent MRRV results to KFHC.	6/1/17	6/1/17
KFHC submitted final signed HEDIS Roadmap Attestation to HSAG.	6/1/17	5/29/17
KFHC submitted final rates and patient level detail (PLD) files to HSAG. *(MCP lock applied to IDSS submission[s].)*	6/1/17	6/2/17
HSAG approved final rates. *(Auditor lock applied to IDSS submission[s]; MCP submitted auditor-locked submission[s] with attestation[s] to NCQA.)*	6/15/17*	6/13/17
HSAG submitted Final Audit Report to KFHC.	7/17/17*	7/13/17

*NCQA deadline.

Audit Team Composition

HSAG assembled its audit team based on the full complement of skills required for the audit and the particular requirements of the MCP. Some team members, including the lead auditor, participated in the on-site meetings at the MCP's office. The following table lists the role and experience of the team members involved in KFHC's audit.

Audit Team Member	Role	On-Site *(Yes/No)*	Dates of Involvement	Years of Experience*
Galina Priloutskaya, PhD, MBA, CHCA *Consultant*	Lead auditor.	Yes	October 2016–July 2017	12
Charles Chapin, MS, CHCA *Director and Practice Leader, Audits/State and Corporate Services*	Oversight of HEDIS activities and auditor guidance.	No	October 2016–July 2017	22
Mariyah Badani, JD, MBA, CHCA *Director, Audits/State and Corporate Services*	Overall audit team management; supplemental data review management.	No	October 2016–July 2017	12
Tammy GianFrancisco *HEDIS Manager, Audits/State and Corporate Services*	Source code review coordination; management of timelines and deliverables.	No	October 2016–July 2017	14
Lynn Shelby, RN, BSN *Director, MRRV*	Overall MRRV team management.	No	October 2016–July 2017	25
Marge Anderson, RN *Clinical Nurse Review Specialist/Project Manager, MRRV*	MRR and oversight of RN medical record abstractors.	No	October 2016–July 2017	16
Shawni Smith, BS *Director, State & Corporate Services*	MRRV operational oversight and project management.	No	January–July 2017	9
Jenny Starbuck, BA *Project Manager, State & Corporate Services*	Project manager for the HEDIS MRRV activities.	No	January–July 2017	6
Lori Cruz *Project Coordinator, MRRV*	Coordinator for the HEDIS MRRV activities.	No	October 2016–June 2017	4
Dan Moore, MPA *Consultant*	Source code reviewer.	No	January–May 2017	12

*Includes any type of experience related to HEDIS, P4P, and performance measure validation audits, including auditing, project coordination, source code review, medical record review, and project management. Please note the years of experience indicated for the MRRV staff are related to general MRR experience, not specific to HEDIS or performance measure validation audits.

Measures for Reporting Year 2017

HSAG validated the following EAS performance measures required by the California Department of Health Care Services (DHCS) for HEDIS 2017 reporting of the Medi-Cal managed care product line. DHCS required KFHC to report hybrid for measures that allowed the hybrid methodology and allowed sample size reduction according to NCQA's guidelines and based on the auditor's approval. In addition, DHCS required KFHC to report a separate rate for its Seniors and Persons with Disabilities (SPD) population for a selected group of measures as indicated in the table below.

	Performance Measures	Methodology	SPD Stratification*
1	*All-Cause Readmissions (ACR)—State-defined measure*	Admin	Yes
2	*Ambulatory Care: Total (AMBA)*	Admin	Yes
3	*Annual Monitoring for Patients on Persistent Medications (MPM)—Excluding Digoxin*	Admin	Yes
4	*Asthma Medication Ratio (AMR)*	Admin	No
5	*Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)*	Admin	No
6	*Breast Cancer Screening (BCS)*	Admin	No
7	*Cervical Cancer Screening (CCS)*	Hybrid	No
8	*Childhood Immunization Status (CIS)—Combo 3*	Hybrid	No
9	*Children and Adolescents' Access to Primary Care Practitioners (CAP)*	Admin	Yes
10	*Comprehensive Diabetes Care (CDC)—Excluding HbA1c <7.0%*	Hybrid	No
11	*Controlling High Blood Pressure (CBP)*	Hybrid	No
12	*Immunizations for Adolescents (IMA)*	Hybrid	No
13	*Prenatal and Postpartum Care (PPC)*	Hybrid	No
14	*Screening for Clinical Depression and Follow-up Plan (CDF)—State-defined measure*	Admin**	No
15	*Use of Imaging Studies for Low Back Pain (LBP)*	Admin	No
16	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Excluding BMI Percentile*	Hybrid	No
17	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)*	Hybrid	No

*Stratification for selected measures was required by DHCS to identify the SPD population. MCPs reported the rates for the SPD population separately via an Excel reporting template.

**Admin reporting was required for HEDIS 2017; hybrid reporting will be required for HEDIS 2018.

4. Assessment and Review Findings

Information Systems Capabilities Assessment

For the purpose of the HEDIS Compliance Audit, the term "information systems" was used broadly to include KFHC's databases and software environment, electronic/manual data collection procedures, applicable supplemental databases, and abstraction of medical records for hybrid measures. HSAG focused specifically on aspects of KFHC's systems that could impact the HEDIS reporting set.

HSAG reviewed KFHC's IS to assess the MCP's compliance with NCQA's HEDIS IS standards. These standards detail the minimum requirements that information systems and processes should meet in order to report accurate and reliable HEDIS measure rates. For circumstances in which a particular IS standard was not fully met, HSAG evaluated any potential impact on KFHC's HEDIS reporting capabilities. An MCP may not be fully compliant with many of the IS standards, but it may still be able to report all measures.

The section that follows is a summary of HSAG's IS findings that includes a determination of KFHC's compliance with each IS standard as well as any impact on HEDIS reporting.

Note: For HEDIS 2017, NCQA retired the *Call Answer Timeliness* measure and therefore removed IS Standard 6.0—Member Call Center.

Standard	Audit Findings	Impact on Reporting
IS 1.0 Medical Services Data—Sound Coding Methods and Data Capture, Transfer and Entry		
IS 1.1 Industry standard codes (e.g., ICD-10-CM, ICD-10-PCS, CPT[4], DRG, HCPCS) are used and all characters are captured. **IS 1.2** Principal codes are identified and secondary codes are captured. **IS 1.3** Nonstandard coding schemes are fully documented and mapped back to industry standard codes. **IS 1.4** Standard submission forms are used and capture all fields relevant to measure reporting. All proprietary forms capture equivalent data. Electronic transmission procedures conform to industry standards. **IS 1.5** Data entry processes are timely and accurate and include sufficient edit checks to ensure accurate entry of submitted data in transaction files for measure reporting. **IS 1.6** The organization continually assesses data completeness and takes steps to improve performance. **IS 1.7** The organization regularly monitors vendor performance against expected performance standards.	KFHC used the QNXT (TriZetto) claims system for 2016. QNXT had sufficient edits in place to ensure data validity. The MCP primarily used a fee-for-service (FFS) structure for facility and professional services which helped ensure data completeness. There was a small percentage of capitated arrangements for professional services. More than 80 percent of institutional and 87 percent of professional claims data were received electronically. Providers submitted service/claims data on standard forms. KFHC did not use any health encounters data (PM-160) for HEDIS 2017 reporting despite the auditors' recommendations from the previous two years that the MCP should investigate the volume of health encounters data (PM-160) it receives to determine if it would be beneficial for HEDIS reporting. KFHC indicated that it thought the PM-10 would be discontinued in 2016; however, because the PM-160 is still in use, the auditor recommends that the MCP investigate use of PM-160 data for HEDIS 2018. During 2016, some deficiencies were identified with Kaiser Foundation Health Plan, which was contracted to process claims for a portion of the MCP's population. Per HSAG request, KFHC provided State quarterly reports and the corrective action plan that was issued for Kaiser. KFHC used Vision Service Plan (VSP) for vision data. KFHC initiated a joint study with VSP to provide outreach to patients with diabetes and send them reminders for retinal exams. KFHC determined that this campaign increased its retinal exam screening rates by 5 to 7 percentage points. KFHC provided an example of the VSP oversight report along with a list of deficiencies that were	No impact

[4] CPT codes copyright 2016 American Medical Association (AMA). All rights reserved. CPT is a trademark of the AMA. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.

Standard	Audit Findings	Impact on Reporting
IS 1.0 Medical Services Data—Sound Coding Methods and Data Capture, Transfer and Entry		
	identified in 2016. The MCP used Argus HealthCare, Inc. to process pharmacy claims. KFHC acted as a pharmacy benefit manager (PBM)-like entity and performed prior-authorizations, formulary review, medication therapy, and utilization review in-house. Per HSAG request, the MCP provided examples of weekly and quarterly reports used for oversight of the pharmacy claims processing. KFHC was fully compliant with IS standard 1.0 and submitted all requested documentation.	

Standard	Audit Findings	Impact on Reporting
IS 2.0 Enrollment Data—Data Capture, Transfer and Entry		
IS 2.1 The organization has procedures for submitting measure-relevant information for data entry. Electronic transmissions of membership data have necessary procedures to ensure accuracy. **IS 2.2** Data entry processes are timely and accurate and include sufficient edit checks to ensure accurate entry of submitted data in transaction files. **IS 2.3** The organization continually assesses data completeness and takes steps to improve performance. **IS 2.4** The organization regularly monitors vendor performance against expected performance standards.	KFHC continued to use QXNT in 2016. The MCP provided a Roadmap section to address its enrollment system. The full monthly file was obtained and loaded by KFHC's information technology (IT) department along with daily update files. There were sufficient processes in place to ensure data were complete and accurate. KFHC's enrollment staff were responsible for loading the files to the claims transaction system, working errors, and updating/correcting information as needed. The IT department performed daily and monthly reconciliations for enrollment. There were no backlogs of enrollment data during 2016. During 2016, the MCP had a significant increase in its Medi-Cal enrollment, more than 8.6 percent. In order to understand the impact of the increase to HEDIS measure rates, the MCP provided a monthly membership frequency report (a query from Group 1) and addressed enrollment by demographic categories identified in the Roadmap. KFHC was fully compliant with IS standard 2.0.	No impact

Standard	Audit Findings	Impact on Reporting
IS 3.0 Practitioner Data—Data Capture, Transfer and Entry		
IS 3.1 Provider specialties are fully documented and mapped to provider specialties necessary for measure reporting. **IS 3.2** The organization has effective procedures for submitting measure-relevant information for data entry. Electronic transmissions of practitioner data are checked to ensure accuracy. **IS 3.3** Data entry processes are timely and accurate and include edit checks to ensure accurate entry of submitted data in transaction files. **IS 3.4** The organization continually assesses data completeness and takes steps to improve performance. **IS 3.5** The organization regularly monitors vendor performance against expected performance standards.	KFHC used Cactus to house provider credentialing information during 2016 and QNXT to house provider information for claims processing and provider directory production. Both systems captured the unique provider ID, as well as the provider specialty type. Provider data in both systems were reconciled monthly with the California Department of Health Care Services (DHCS) provider directory. Per HSAG request, KFHC provided a brief summary of the State's reporting requirements and its validation processes, including the use of an outside vendor. During the on-site visit, HSAG reviewed KFHC's provider mapping and found it to be compliant with current NCQA requirements. There was an increase in the MCP's provider network due to the increase in membership. Per the State's request, KFHC added 38 qualified autism specialists and 138 behavioral health therapists to its network. KFHC was also responsible for managing its pharmacy network (178 pharmacy locations) and is doing a good job of keeping its pharmacy data current and accurate. Per HSAG request, KFHC verified that it did not submit provider data to any vendors. The MCP also provided a crosswalk of the MCP/Verscend provider data mapping per the auditor's request. HSAG did not identify any issues during the Roadmap review or on-site discussion related to provider data. KFHC was fully compliant with IS standard 3.0.	No impact

Standard	Audit Findings	Impact on Reporting
IS 4.0 Medical Record Review Processes—Training, Sampling, Abstraction and Oversight		
IS 4.1 Forms capture all fields relevant to measure reporting. Electronic transmission procedures conform to industry standards and have necessary checking procedures to ensure data accuracy (logs, counts, receipts, hand-off and sign-off). **IS 4.2** Retrieval and abstraction of data from medical records is reliably and accurately performed. **IS 4.3** Data entry processes are timely and accurate and include sufficient edit checks to ensure accurate entry of submitted data in the files for measure reporting. **IS 4.4** The organization continually assesses data completeness and takes steps to improve performance. **IS 4.5** The organization regularly monitors vendor performance against expected performance standards.	HSAG reviewed KFHC's IS 4 Roadmap pertaining to the policies and procedures for IS standard 4.0. The Roadmap review found these policies and procedures to be consistent with the IS 4.0 requirements. KFHC sampled according to the HEDIS sampling guidelines and assigned measure-specific oversamples. Provider chase logic was reviewed and determined appropriate across the hybrid measures. KFHC staff used Verscend hybrid medical record abstraction tools. HSAG participated in a live demonstration of the Verscend tools and instructions. All fields, edits, and drop-down boxes were reviewed for accuracy against NCQA's HEDIS 2017, Volume 2, Technical Specifications for Health Plans. HSAG reviewed and approved the Verscend tools and instructions on January 6, 2017. KFHC utilized internal staff members to conduct medical record reviews and quality assurance. Staff members were sufficiently qualified and trained in the current year's HEDIS Technical Specifications and the use of KFHC's abstraction tools to accurately conduct medical record reviews. KFHC maintained appropriate quality assurance of reviews, including over-reads of all abstractions resulting in numerator positives or exclusions, and a random sample of numerator negatives. Due to clarifications in 2017 measure specifications and NCQA revisions to the measure specifications since the prior year, a convenience sample was requested for the following measures: • WCC—Counseling for Nutrition and Counseling for Physical Activity • IMA—Combo 2	No impact

Standard	Audit Findings	Impact on Reporting
IS 4.0 Medical Record Review Processes—Training, Sampling, Abstraction and Oversight		
	All convenience samples passed HSAG's review. Of note, for WCC—Counseling for Nutrition and Counseling for Physical Activity, critical errors were identified in the first sample sets and, therefore, second samples were required. However, the second samples for both indicators passed. Kern passed the MRRV process for the following measures and corresponding measure groups: • Group A: Biometrics (BMI, BP) and Maternity—CDC—BP Control (<140/90 mm Hg) • Group B: Anticipatory Guidance and Counseling—WCC—Counseling for Nutrition • Group C: Laboratory—CDC—HbA1c Control (<8.0%) • Group D: Immunizations and Other Screenings—CIS—Combo 3 • Group F: Exclusions—All medical record exclusions KFHC was fully compliant with IS standard 4.0.	

Standard	Audit Findings	Impact on Reporting
IS 5.0 Supplemental Data—Capture, Transfer and Entry		
IS 5.1 Nonstandard coding schemes are fully documented and mapped to industry standard codes. **IS 5.2** The organization has effective procedures for submitting measure-relevant information for data entry. Electronic transmissions of data have checking procedures to ensure accuracy. **IS 5.3** Data entry processes are timely and accurate and include edit checks to ensure accurate entry of submitted data in transaction files. **IS 5.4** The organization continually assesses data completeness and takes steps to improve performance. **IS 5.5** The organization regularly monitors vendor performance against expected performance standards.	The MCP utilized multiple standard data sources for supplementing its HEDIS measure rates, including immunizations, lab data from hospitals, and lab vendors. KFHC did not submit any non-standard supplemental data for HEDIS 2017 reporting. 1) The California Immunization Registry (CAIR) was a standard data source that the MCP has used for many years. The data were received on a monthly basis via a secure file transfer protocol (FTP) site. The MCP was successful in 2016 in matching its eligible members with the data received from the registry. 2) Lab results data were received from three lab vendors: Physician's Automated Lab (PAL), LabCorp, and Delano Regional Medical Center (DRMC). Data were received on a monthly basis and met the definitions of external standard supplemental data. For all supplemental databases, the MCP submitted an updated Roadmap table 5.6 that shows the measures each data source is used for and the expected impact the data will have on the rates. The MCP re-submitted a Roadmap attachment 5.1 (data file layout) and attachment 5.3 (business rules) for each data source, and an updated attachment 5.6 (Impact Report). HSAG approved all standard supplemental databases to use for HEDIS 2017 reporting. HSAG strongly recommends that the MCP expand its use of electronic medical record (EMR) data for future HEDIS reporting. KFHC was fully compliant with IS standard 5.0.	No impact

Standard	Audit Findings	Impact on Reporting
IS 7.0 Data Integration—Accurate Reporting, Control Procedures That Support Measure Reporting Integrity		
IS 7.1 Nonstandard coding schemes are fully documented and mapped to industry standard codes. **IS 7.2** Data transfers to HEDIS repository from transaction files are accurate. **IS 7.3** File consolidations, extracts and derivations are accurate. **IS 7.4** Repository structure and formatting are suitable for measures and enable required programming efforts. **IS 7.5** Report production is managed effectively and operators perform appropriately. **IS 7.6** Measure reporting software is managed properly with regard to development, methodology, documentation, version control and testing. **IS 7.7** The organization regularly monitors vendor performance against expected performance standards.	KFHC contracted with Verscend for its HEDIS production. The MCP was responsible for data integration of all data files loaded into the HEDIS repository. Per HSAG request, the MCP submitted a flowchart that provided an overview of its HEDIS data management and an outline of the MCP's and Verscend's responsibilities. For data validation purposes, KFHC used the vendor's Data Audit Tool which provided numerous audit checks and produced a summary report for each source file that was audited. The MCP provided examples of the summary audit reports. There were sufficient processes in place to ensure data integrity, and security and data back-up procedures met standards. Per new NCQA requirements, HSAG selected queries for all groups. The MCP was able to run some of the requested queries on-site; and some were provided post-on-site. KFHC was fully compliant with IS standard 7.0.	No impact

Supplemental Database Review Findings

The HEDIS technical specifications allow MCPs to include supplemental data in the collection and calculation of the HEDIS measures if the MCPs follow the NCQA rules and guidelines for collection, validation, and use of these data. Supplemental data are defined as any health care delivery information that is available outside of the MCP's claims/encounter data system. There are two distinct categories of supplemental data applicable to HEDIS reporting: standard and nonstandard. The auditor must determine which category each supplemental data source belongs to and communicate this to the MCP. All supplemental data are subject to annual audit review. HSAG reviewed the supplemental data in accordance with NCQA's *HEDIS 2017, Volume 5: HEDIS Compliance Audit: Standards, Policies and Procedures*.

HSAG's validation results for the supplemental data sources considered for reporting by KFHC are included in Appendix A.

Medical Record Review Validation Findings

HSAG used the standardized protocol developed by NCQA to validate the integrity of the MRR processes of audited MCPs. NCQA policies and procedures require auditors to perform two steps: (1) review the MRR processes by the MCP, including MRR staff qualifications, training, data collection instruments/tools, accuracy of data collection, vendor oversight, and the method used for combining MRR data with administrative data; and (2) complete MRRV, which involves the validation of the MCP's abstraction accuracy for a sample of cases across the NCQA-designated measure groups and a comparison of HSAG's validation results to the MCP's abstraction results.

HSAG reviewed KFHC's processes for MRR performance for all reported hybrid measures. Data collection tools and training materials were reviewed by HSAG to verify that all key HEDIS data elements were captured.

HSAG completed the MRRV process and reabstracted sample records across the appropriate measure groups and compared the results to KFHC's findings for the same medical records. For each of the validated measures, HSAG randomly selected 16 cases from the MRR numerator positives as identified by the MCP. If fewer than 16 medical records were found to meet numerator compliance, all records were reviewed or additional records from another measure within the same group were added to equal the 16 cases. If an abstraction discrepancy was noted, only critical errors were considered errors. A critical error is defined as an abstraction error that affects the final outcome of the numerator event (i.e., changes a positive event to a negative one). If one critical error was noted, HSAG was required to retest a second sample of 16 records that did not include the original sampled records. If the second sample was free of errors, the measure and measure group passed. If one or more errors were detected, the measure and measure group did not pass validation and could not be reported until all errors were corrected and reviewed by the auditor. If there was not enough time to correct all errors, the MCP was not allowed to report the measure via the hybrid methodology.

In addition to validating numerator positive cases, HSAG also validated the accuracy of exclusion cases. This task was accomplished by sampling exclusions across all measures to determine the appropriateness of the exclusion. If HSAG deemed that an exclusion was not in alignment with NCQA's specifications, the MCP was required to keep the case in the denominator.

HSAG completed the MRRV component of the audit and provided an assessment of KFHC's medical record abstraction accuracy. Appendix B includes the MRRV results, which identifies the measure groups, the validated measures, the number of records validated, with corresponding pass/fail determination. Additional comments on the results of the MRRV process and KFHC's overall compliance with IS standard 4.0 are presented in Section 4: Assessment and Review Findings.

HEDIS Measure Determination Assessment

HSAG used NCQA's HD standards to assess KFHC's compliance with the HEDIS technical specifications. The HD standards describe specific information that is needed for verifying algorithms and rate calculations, proper identification of denominators and numerators, proper use of sampling methodology, and vendor oversight requirements for MCPs that delegate any aspect of HEDIS data collection or reporting to an external vendor. HSAG considered compliance with the IS and HD standards in order to fully assess KFHC's HEDIS reporting capabilities.

Most of this assessment is closely related to the extent to which source code developed for the measures adhered to the measure specifications. Since KFHC used HEDIS Certified Measures to compute the required HEDIS measures, manual source code review for these measures was not required. Instead, HSAG reviewed the software vendor's certification report and verified that each HEDIS measure was indeed certified by NCQA. Since the State-defined *All-Cause Readmissions* and *Screening for Clinical Depression and Follow-up Plan* measures are non-HEDIS measures, manual source code review was conducted according to the specifications provided by DHCS. Appendix C includes the source code review results for the non-HEDIS measures and Appendix D includes the software vendor's certification report.

Survey Sample Frame Validation Findings

Validation of the sample frame for the Consumer Assessment of Healthcare Providers and Systems (CAHPS®[5]) survey was not applicable to the scope of this audit.

[5] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

5. Audit Results and Associated Rates

Each of the audited measures reviewed by HSAG received a final audit result consistent with the NCQA categories listed below. HSAG used a variety of audit methods, including analysis of computer programs, medical record abstraction results, data files, data samples, and staff interviews to produce each measure-specific result. The following table provides the audit finding results that are applicable to the HEDIS measures.

Rate/Result	Comment
R	*Reportable.* A reportable rate was submitted for the measure.
NA	*Small Denominator.* The MCP followed the specifications, but the denominator was too small (<30) to report a valid rate.
NB	*No Benefit.* The MCP did not offer the health benefit required by the measure (e.g., mental health, chemical dependency).
NR	*Not Reported.* The MCP chose not to report the measure.
NQ	*Not Required.* The MCP was not required to report the measure.
BR	*Biased Rate.* The calculated rate was materially biased.
UN	*Un-Audited.* The MCP chose to report a measure that is not required to be audited. This result applies only to a limited set of measures (e.g., measures collected using electronic clinical data systems).

For measures reported as percentages, NCQA has defined significant bias as a deviation of more than five percentage points from the true percentage. (For certain measures, a deviation of more than 10 percentage points in the number of reported events determines a significant bias.)

For some measures, more than one rate is required for HEDIS reporting (e.g., *Childhood Immunization Status* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*). It is possible that KFHC prepared some of the rates required by the measure appropriately, but had significant bias in others. According to NCQA guidelines, KFHC would receive a reportable result for the measure as a whole, but significantly biased rates within the measure would receive a "BR" result, where appropriate.

Appendix E of this report contains the final audited data submission files and associated rates, which display the audit result for each reported measure, the rationale for the assigned result, and any additional comments. The audit results signify which rates are appropriate for inclusion in external reports.

Appendix A. Supplemental Data Validation Results

This appendix contains the supplemental data validation results for KFHC.

Database Name	Database Type	Measure Use	# Records	Status	Final Approval Date
Delano REgional Medical center	Standard	CDC, CIS	2381	Approved	03/23/2017
Immunization	Standard	CIS, IMA	389347	Approved	03/17/2017
Lab Corp	Standard	CDC, CCS, PPC	10420	Approved	03/24/2017
PAL	Standard	CDC, CCS, PPC	7636402	Approved	03/24/2017

Appendix B. Medical Record Review Validation Results

This appendix contains KFHC's medical record review validation results.

HSAG HEALTH SERVICES ADVISORY GROUP

Kern Family Health Care
HEDIS 2017 MR Review Validation Findings

Group	Measure	Rationale	Initial Sample Size	Findings	Follow-up	Final Results
Group A: Biometrics (BMI, BP) & Maternity	CDC-BP <140/90	Significant number of numerator positive cases	16	Pass		5/24/2017 Complete-No Concerns
Group B: Anticipatory Guidance & Counseling	WCC-Nutrition	Significant number of numerator positive cases	16	Pass		5/25/2017 Complete-No Concerns
Group C: Laboratory	CDC-HbA1c Rates	Significant number of numerator positive cases	16	Pass		5/24/2017 Complete-No Concerns
Group D: Immunization & Other Screenings	CIS	Significant number of numerator positive cases	16	Pass		5/25/2017 Complete-No Concerns
Group F: Exclusions	All MR Exclusions	All medical record exclusions	15	Pass		5/30/2017 Complete-No Concerns

Appendix C. Source Code Review Results

This appendix contains KFHC's source code review results for the State-defined *All-Cause Readmissions* and *Screening for Clinical Depression and Follow-up Plan* measures.

HSAG HEALTH SERVICES ADVISORY GROUP

Source Code Review
Summary Report for Kern Family Health Care
2017

Measure			Date Received	Status
All-Cause Readmissions (non-HEDIS State-defined measure)			**1/23/2017**	**Approved**
Standard	**Findings**	**Corrective Action**	**Resolution**	**Date Approved**
HD 1.0 - Denominator Identification	This measure was modified based on the HEDIS PCR measure. Differences between the HEDIS PCR specification and DHCSs Medi-Cal ACR specification (age, continuous enrollment, gap) were discussed with specific programming logic reviewed during a measure walkthrough session with Verscend on 1/23/17. No issues were identified during the measure walkthrough. Denominator and exclusion criteria were met; exclusions within denominator criteria were met.	No follow-up is required.	Compliant with measure specification.	1/23/2017
HD 2.0 - Sampling	NA (admin measure)	NA	NA	1/23/2017
HD 3.0 - Numerator Identification	No discrepancies were found; numerator criteria were met; exclusions within numerator criteria were met.	No follow-up is required.	Compliant with measure specification.	1/23/2017
HD 4.0 - Algorithmic compliance	No discrepancies were found identified.	No follow-up is required.	Compliant with measure specification.	1/23/2017
HD 5.0 - Outsourced or Delegated HEDIS Reporting Function	NA	NA	NA	1/23/2017
Ambulatory Care				**Approved**

Note: The source code review findings pertain only to the version that HSAG has reviewed. Any source code that is approved should not be changed without sending in a revision and explanation for the change. Approved source code indicates HSAG did not find any significant deviations from the current HEDIS Technical Specifications or P4P Clinical Specifications. Source code review is only one part of source code validation; primary source verification and rate validation (includes benchmarking of rates and eligible population sizes) are still necessary. This does not guarantee 100% compliance with the current HEDIS Technical Specifications or P4P Clinical Specifications. The organization is responsible for the source code (regardless of the findings) and should verify the accuracy of the results.

Measure			Date Received	Status
Standard	**Findings**	**Corrective Action**	**Resolution**	**Date Approved**
HD 1.0 - Denominator Identification	Verscend is the MCPs contracted calculation vendor; per NCQA Measure Certification report for Verscend dated 2/14/17 (and updated report dated 3/23/17), this measure passed certification.	NA	NA	5/10/2017
Annual Monitoring for Patients on Persistent Medications (ACE inhibitors or ARBs and Diuretics indicators only)				**Approved**
Standard	**Findings**	**Corrective Action**	**Resolution**	**Date Approved**
HD 1.0 - Denominator Identification	Verscend is the MCPs contracted calculation vendor; per NCQA Measure Certification report for Verscend dated 2/14/17 (and updated report dated 3/23/17), this measure passed certification.	NA	NA	5/10/2017
Asthma Medication Ratio				**Approved**
Standard	**Findings**	**Corrective Action**	**Resolution**	**Date Approved**
HD 1.0 - Denominator Identification	Verscend is the MCPs contracted calculation vendor; per NCQA Measure Certification report for Verscend dated 2/14/17 (and updated report dated 3/23/17), this measure passed certification.	NA	NA	5/10/2017
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis				**Approved**
Standard	**Findings**	**Corrective Action**	**Resolution**	**Date Approved**
HD 1.0 -	Verscend is the MCPs contracted	NA	NA	5/10/2017

Note: The source code review findings pertain only to the version that HSAG has reviewed. Any source code that is approved should not be changed without sending in a revision and explanation for the change. Approved source code indicates HSAG did not find any significant deviations from the current HEDIS Technical Specifications or P4P Clinical Specifications. Source code review is only one part of source code validation; primary source verification and rate validation (includes benchmarking of rates and eligible population sizes) are still necessary. This does not guarantee 100% compliance with the current HEDIS Technical Specifications or P4P Clinical Specifications. The organization is responsible for the source code (regardless of the findings) and should verify the accuracy of the results.

Measure			Date Received	Status
Denominator Identification	calculation vendor; per NCQA Measure Certification report for Verscend dated 2/14/17 (and updated report dated 3/23/17), this measure passed certification.			

Breast Cancer Screening — **Approved**

Standard	Findings	Corrective Action	Resolution	Date Approved
HD 1.0 - Denominator Identification	Verscend is the MCPs contracted calculation vendor; per NCQA Measure Certification report for Verscend dated 2/14/17 (and updated report dated 3/23/17), this measure passed certification.	NA	NA	5/10/2017

Cervical Cancer Screening — **Approved**

Standard	Findings	Corrective Action	Resolution	Date Approved
HD 1.0 - Denominator Identification	Verscend is the MCPs contracted calculation vendor; per NCQA Measure Certification report for Verscend dated 2/14/17 (and updated report dated 3/23/17), this measure passed certification.	NA	NA	5/10/2017

Childhood Immunization Status - Combo 3 — **Approved**

Standard	Findings	Corrective Action	Resolution	Date Approved
HD 1.0 - Denominator Identification	Verscend is the MCPs contracted calculation vendor; per NCQA Measure Certification report for Verscend dated 2/14/17 (and updated report dated 3/23/17), this measure	NA	NA	5/10/2017

Note: The source code review findings pertain only to the version that HSAG has reviewed. Any source code that is approved should not be changed without sending in a revision and explanation for the change. Approved source code indicates HSAG did not find any significant deviations from the current HEDIS Technical Specifications or P4P Clinical Specifications. Source code review is only one part of source code validation; primary source verification and rate validation (includes benchmarking of rates and eligible population sizes) are still necessary. This does not guarantee 100% compliance with the current HEDIS Technical Specifications or P4P Clinical Specifications. The organization is responsible for the source code (regardless of the findings) and should verify the accuracy of the results.

Measure			Date Received	Status
	passed certification.			
Children and Adolescents' Access to Primary Care Practitioners				**Approved**
Standard	**Findings**	**Corrective Action**	**Resolution**	**Date Approved**
HD 1.0 - Denominator Identification	Verscend is the MCPs contracted calculation vendor; per NCQA Measure Certification report for Verscend dated 2/14/17 (and updated report dated 3/23/17), this measure passed certification.	NA	NA	5/10/2017
Comprehensive Diabetes Care (excluding <7 indicator)				**Approved**
Standard	**Findings**	**Corrective Action**	**Resolution**	**Date Approved**
HD 1.0 - Denominator Identification	Verscend is the MCPs contracted calculation vendor; per NCQA Measure Certification report for Verscend dated 2/14/17 (and updated report dated 3/23/17), this measure passed certification.	NA	NA	5/10/2017
Controlling High Blood Pressure				**Approved**
Standard	**Findings**	**Corrective Action**	**Resolution**	**Date Approved**
HD 1.0 - Denominator Identification	Verscend is the MCPs contracted calculation vendor; per NCQA Measure Certification report for Verscend dated 2/14/17 (and updated report dated 3/23/17), this measure passed certification.	NA	NA	5/10/2017
Immunizations for Adolescents				**Approved**
Standard	**Findings**	**Corrective Action**	**Resolution**	**Date Approved**

Note: The source code review findings pertain only to the version that HSAG has reviewed. Any source code that is approved should not be changed without sending in a revision and explanation for the change. Approved source code indicates HSAG did not find any significant deviations from the current HEDIS Technical Specifications or P4P Clinical Specifications. Source code review is only one part of source code validation; primary source verification and rate validation (includes benchmarking of rates and eligible population sizes) are still necessary. This does not guarantee 100% compliance with the current HEDIS Technical Specifications or P4P Clinical Specifications. The organization is responsible for the source code (regardless of the findings) and should verify the accuracy of the results.

Measure				Date Received	Status
Denominator Identification	calculation vendor; per NCQA Measure Certification report for Verscend dated 2/14/17 (and updated report dated 3/23/17), this measure passed certification.				
Prenatal and Postpartum Care					**Approved**
Standard	**Findings**	**Corrective Action**	**Resolution**		**Date Approved**
HD 1.0 - Denominator Identification	Verscend is the MCPs contracted calculation vendor; per NCQA Measure Certification report for Verscend dated 2/14/17 (and updated report dated 3/23/17), this measure passed certification.	NA	NA		5/10/2017
Screening for Clinical Depression and Follow-Up Plan				**2/22/2017**	**Approved**
Standard	**Findings**	**Corrective Action**	**Resolution**		**Date Approved**
HD 1.0 - Denominator Identification	Progamming logic was reviewed during a measure walkthrough session with Verscend on 2/22/17. This measure was generated according to the specifications required by the State. No issues were identified during the measure walkthrough.	No follow-up is required.	NA		2/22/2017
HD 2.0 - Sampling	NA (this measure is being reported by the MCPs administratively for HEDIS 2017).	NA	NA		2/22/2017
HD 3.0 - Numerator Identification	No discrepancies were identified; numerator criteria were met.	No follow-up is required.	NA		2/22/2017

Note: The source code review findings pertain only to the version that HSAG has reviewed. Any source code that is approved should not be changed without sending in a revision and explanation for the change. Approved source code indicates HSAG did not find any significant deviations from the current HEDIS Technical Specifications or P4P Clinical Specifications. Source code review is only one part of source code validation; primary source verification and rate validation (includes benchmarking of rates and eligible population sizes) are still necessary. This does not guarantee 100% compliance with the current HEDIS Technical Specifications or P4P Clinical Specifications. The organization is responsible for the source code (regardless of the findings) and should verify the accuracy of the results.

Measure			Date Received	Status
HD 4.0 - Algorithmic compliance	No discrepancies were identified.	No follow-up is required.	NA	2/22/2017
HD 5.0 - Outsourced or Delegated HEDIS Reporting Function	NA	NA	NA	2/22/2017

Use of Imaging Studies for Low Back Pain — **Approved**

Standard	Findings	Corrective Action	Resolution	Date Approved
HD 1.0 - Denominator Identification	Verscend is the MCPs contracted calculation vendor; per NCQA Measure Certification report for Verscend dated 2/14/17 (and updated report dated 3/23/17), this measure passed certification.	NA	NA	5/10/2017

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents — **Approved**

Standard	Findings	Corrective Action	Resolution	Date Approved
HD 1.0 - Denominator Identification	Verscend is the MCPs contracted calculation vendor; per NCQA Measure Certification report for Verscend dated 2/14/17 (and updated report dated 3/23/17), this measure passed certification.	NA	NA	5/10/2017

Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life — **Approved**

Standard	Findings	Corrective Action	Resolution	Date Approved
HD 1.0 - Denominator	Verscend is the MCPs contracted calculation vendor; per NCQA	NA	NA	5/10/2017

Note: The source code review findings pertain only to the version that HSAG has reviewed. Any source code that is approved should not be changed without sending in a revision and explanation for the change. Approved source code indicates HSAG did not find any significant deviations from the current HEDIS Technical Specifications or P4P Clinical Specifications. Source code review is only one part of source code validation; primary source verification and rate validation (includes benchmarking of rates and eligible population sizes) are still necessary. This does not guarantee 100% compliance with the current HEDIS Technical Specifications or P4P Clinical Specifications. The organization is responsible for the source code (regardless of the findings) and should verify the accuracy of the results.

Source Code Review
Summary Report for Kern Family Health Care
2017

Measure			Date Received	Status
Identification	Measure Certification report for Verscend dated 2/14/17 (and updated report dated 3/23/17), this measure passed certification.			

Note: The source code review findings pertain only to the version that HSAG has reviewed. Any source code that is approved should not be changed without sending in a revision and explanation for the change. Approved source code indicates HSAG did not find any significant deviations from the current HEDIS Technical Specifications or P4P Clinical Specifications. Source code review is only one part of source code validation; primary source verification and rate validation (includes benchmarking of rates and eligible population sizes) are still necessary. This does not guarantee 100% compliance with the current HEDIS Technical Specifications or P4P Clinical Specifications. The organization is responsible for the source code (regardless of the findings) and should verify the accuracy of the results.

Appendix D. NCQA Measure Certification Report

This appendix contains a copy of the NCQA Measure Certification report for the software vendor contracted by KFHC for HEDIS measure calculation and reporting.

NCQA Measure Certification[SM]

Certification Report for **Verscend Technologies, Inc.**

CERTIFICATION OUTCOME

Date of Certification Report	Marrch 23, 2017
Name of Product Containing Certified Measures	Quality Engine
Version of HEDIS Technical Specifications	HEDIS 2017
Vendor ID (for IDSS XML)	2156

MEASURE DETAIL

MEASURE		STATUS	DATE	UNIQUE IDENTIFIER
ABA	Adult BMI Assessment	Pass	10/17/2016	10172016-0094-2220-8773-1380df3fbd99
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Pass	10/18/2016	10182016-0095-9220-8773-a04334668f98
CIS	Childhood Immunization Status	Pass	10/24/2016	10242016-0018-2470-8773-c144253a559c
IMA	Immunizations for Adolescents	Pass	10/25/2016	01292017-0147-4480-8773-8ac4f07851b6
LSC	Lead Screening in Children	Pass	10/24/2016	10242016-0093-5720-8773-194b8c96f512
BCS	Breast Cancer Screening	Pass	12/06/2016	12062016-0013-2270-8773-12e789076499
CCS	Cervical Cancer Screening	Pass	10/24/2016	10242016-0014-2270-8773-5e41bcc6445f
COL	Colorectal Cancer Screening	Pass	10/24/2016	10242016-0056-2650-8773-9083c40f695a
CHL	Chlamydia Screening in Women	Pass	12/02/2016	12022016-0020-2450-8773-20b7df8b0f42
COA	Care for Older Adults	Pass	10/26/2016	10262016-0096-2620-8773-10747d19b6e0
CWP	Appropriate Testing for Children With Pharyngitis	Pass	12/18/2016	12182016-0057-2970-8773-c782404ce3e3
SPR	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	Pass	01/11/2017	01112017-0077-7770-8773-bed4f9618e17

MEASURE		STATUS	DATE	UNIQUE IDENTIFIER
PCE	Pharmacotherapy Management of COPD Exacerbation	Pass	01/30/2017	01302017-0092-7230-8773-3fd7e8973b03
MMA	Medication Management for People With Asthma	Pass	12/02/2016	12022016-0135-6620-8773-efca6020489a
AMR	Asthma Medication Ratio	Pass	12/28/2016	12282016-0136-2670-8773-24319d44844f
CBP	Controlling High Blood Pressure	Pass	11/08/2016	11082016-0023-2270-8773-53e72ac01171
PBH	Persistence of Beta-Blocker Treatment After a Heart Attack	Pass	01/03/2017	01032017-0070-7240-8773-33888ee21166
SPC	Statin Therapy for Patients With Cardiovascular Disease	Pass	12/05/2016	12052016-0150-7720-8773-39315e2da033
CDC	Comprehensive Diabetes Care	Pass	11/09/2016	11092016-0022-2320-8773-5225e49d9fb9
SPD	Statin Therapy for Patients With Diabetes	Pass	11/23/2016	11232016-0151-7730-8773-d0337939cb0a
ART	Disease-Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	Pass	02/12/2017	02122017-0079-2780-8773-10fcea6334f2
OMW	Osteoporosis Management in Women Who Had a Fracture	Pass	12/23/2016	12232016-0059-6690-8773-204d653976ad
AMM	Antidepressant Medication Management	Pass	12/30/2016	12302016-0007-2660-8773-ef05be05cc82
ADD	Follow-Up Care for Children Prescribed ADHD Medication	Pass	02/03/2017	02032017-0078-2330-8773-14c14eb4f46a
FUH	Follow-Up After Hospitalization for Mental Illness	Pass	12/28/2016	12282016-0029-3840-8773-e22c8ff2be78
FUM	Follow-Up After Emergency Department Visit for Mental Illness	Pass	01/21/2017	01212017-0155-3860-8773-61aad025009c
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence	Pass	01/21/2017	01212017-0154-3820-8773-3a2af5448d8c
SSD	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Pass	12/30/2016	12302016-0137-7730-8773-6cde3694f4e7
SMD	Diabetes Monitoring for People With Diabetes and Schizophrenia	Pass	12/29/2016	12292016-0138-7630-8773-c21192b6502d
SMC	Cardiovascular Monitoring for People With Cardiovascular Diseases and Schizophrenia	Pass	12/29/2016	12292016-0139-7620-8773-77823492ac52
SAA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	Pass	12/16/2016	12162016-0140-7220-8773-4ec8a97685b2
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	Pass	12/30/2016	12302016-0144-2760-8773-b5a472533e71
MPM	Annual Monitoring for Patients on Persistent Medications	Pass	12/30/2016	12302016-0080-6760-8773-e4185b91ae85
MRP	Medication Reconciliation Post-Discharge	Pass	10/14/2016	10142016-0097-6770-8773-53f8a0e090f6
NCS	Non-Recommended Cervical Cancer Screening in Adolescent Females	Pass	12/02/2016	12022016-0141-6270-8773-c29e7c1ee981
PSA	Non-Recommended PSA-Based Screening in Older Men	Pass	11/23/2016	11232016-0142-7720-8773-bce92223db50
URI	Appropriate Treatment for Children With Upper Respiratory Infection	Pass	12/02/2016	12022016-0058-8740-8773-2e564fd78cb0
AAB	Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Pass	11/21/2016	11212016-0076-2220-8773-87a7e5a68806
LBP	Use of Imaging Studies for Low Back Pain	Pass	11/17/2016	11172016-0072-5270-8773-a0ba1ae53749
APC	Use of Multiple Concurrent Antipsychotics in Children and Adolescents	Pass	01/20/2017	01202017-0143-2720-8773-798fed35a447
DDE	Potentially Harmful Drug-Disease Interactions in the Elderly	Pass	01/20/2017	01202017-0085-3330-8773-dce5e65369da
DAE	Use of High-Risk Medications in the Elderly	Pass	01/23/2017	01232017-0081-3230-8773-5c07e266bba7
AAP	Adults' Access to Preventive/Ambulatory Health Services	Pass	10/25/2016	10252016-0003-2270-8773-f4a3fc9d4920
CAP	Children and Adolescents' Access to Primary Care Practitioners	Pass	10/25/2016	10252016-0019-2270-8773-51453a835218
ADV	Annual Dental Visit	Pass	12/02/2016	12022016-0006-2380-8773-8e4efbdabb2d
IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Pass	01/19/2017	01192017-0061-4380-8773-db01267cc739
PPC	Prenatal and Postpartum Care	Pass	11/09/2016	11092016-0043-7720-8773-9bd471430cd6

MEASURE		STATUS	DATE	UNIQUE IDENTIFIER
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	Pass	12/02/2016	12022016-0145-2770-8773-586c422be5ea
FPC	Frequency of Ongoing Prenatal Care	Pass	11/18/2016	11182016-0030-3720-8773-4107f6724b39
W15	Well-Child Visits in the First 15 Months of Life	Pass	10/24/2016	10242016-0051-9150-8773-baf2131c1466
W34	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	Pass	10/24/2016	10242016-0052-9340-8773-51d82d4492f0
AWC	Adolescent Well-Care Visits	Pass	10/18/2016	10182016-0002-2920-8773-b61f97268dd3
FSP	Frequency of Selected Procedures	Pass	12/29/2016	12292016-0031-3770-8773-d6402cbb82ab
AMB	Ambulatory Care	Pass	02/01/2017	02012017-0005-2620-8773-1d20d141f02f
IPU	Inpatient Utilization—General Hospital/Acute Care	Pass	01/28/2017	01282017-0035-4780-8773-6322ada7f711
IAD	Identification of Alcohol and Other Drug Services	Pass	02/06/2017	02062017-0060-4230-8773-27eb291e6aba
MPT	Mental Health Utilization	Pass	01/28/2017	01282017-0038-6780-8773-fab2d2612ddc
ABX	Antibiotic Utilization	Pass	02/03/2017	02032017-0075-2290-8773-5266168191ab
HAI	Standardized Healthcare-Associated Infection Ratio	Pass	02/07/2017	02072017-0156-4240-8773-4687e6f25616
PCR	Plan All-Cause Readmissions	Pass	01/12/2017	01122017-0133-7270-8773-d6002f782ffb
IHU	Inpatient Hospital Utilization	Pass	01/29/2017	10252016-0131-4620-8773-0cd5ac47bb5e
EDU	Emergency Department Utilization	Pass	01/18/2017	01182017-0148-3380-8773-af85aa156a0c
HPC	Hospitalization for Potentially Preventable Complications	Pass	01/09/2017	01092017-0149-4720-8773-b43d2af3a1d9
ENP	Enrollment by Product Line	Pass	01/30/2017	01302017-0027-3670-8773-e151c104633c
EBS	Enrollment by State	Pass	02/02/2017	02022017-0082-3270-8773-331895af9fcf
LDM	Language Diversity of Membership	Pass	02/02/2017	02022017-0084-5360-8773-6292fac6873e
RDM	Race/Ethnicity Diversity of Membership	Pass	02/02/2017	02022017-0083-7360-8773-b65d284191cd
TLM	Total Membership	Pass	01/30/2017	01312017-0132-8560-8773-ab10c8379866
CPA	CAHPS 5.0H Adult Survey Layout	Pass	11/10/2016	11102016-0032-2720-8773-f72f41263350
CPC	CAHPS 5.0H Child Survey Layout	Pass	11/09/2016	11102016-0033-2720-8773-06e0541ef7b3
CCC	Children With Chronic Conditions Layout	Pass	11/10/2016	11102016-0033-2720-8773-06e0541ef7b3
DMS	Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults	Not Testing	NA	NA
DRR	Depression Remission or Response for Adolescents and Adults	Not Testing	NA	NA
PDC	Proportion of Days Covered: 3 Rates	Pass	02/01/2017	02012017-0146-7320-8773-61024d72e482
QHP	Qualified Health Plan Enrollee Experience Survey	Pass	11/10/2016	10182016-0157-7470-8773-a7bd0a96bda8
Systematic Sampling		Pass	11/21/2016	11212016-9999-9999-8773-4db04b8a9083

If you have questions about information in this report contact Suzanne Porter, Director, Measure Validation at 202-955-5127 or porter@ncqa.org.
For more information about NCQA Measure Certification, go to: http://www.ncqa.org/hedis-quality-measurement/certified-survey-vendors-auditors-software-vendors/quality-measure-certification

Appendix E. Final Data Submission

This appendix contains the final audited data submission files and associated rates for KFHC.

2017 HEDIS Rate Tracking

Final Rates 6/14/2017

Note: These are preliminary rates awaiting Over-read and HSAG validation.

Hybrid Measures

Measure		Current 2017 Rate	2017 MPL	2017 HPL	2016 KHS Rate	Current Vs. 2017 MPL	Current Vs. 2017 HPL	Current Vs. 2016 KHS	Change In Numerators Required to meet MPL	2016 Health Net	Current Vs. 2016 Health Net
CCS	Cervical Cancer Screening	58.39	48.18	69.95	52.07	10.21	-11.56	6.32	-	43.55	14.84
CIS-3	CIS – Combo 3	64.96	64.30	79.81	66.91	0.66	-14.85	-1.95	-	61.48	3.48
CDC-E	Eye Exam (Retinal) Performed	48.19	44.53	68.11	49.82	3.66	-19.92	-1.63	-	-	-
CDC-HT	HbA1c Testing	84.49	82.98	92.88	84.31	1.51	-8.39	0.18	-	82.48	2.01
CDC-H9 *	HbA1c Poor Control (>9.0%)	39.60	52.31	29.23	47.99	12.71	-10.37	8.39	-	-	-
CDC-H8	HbA1c Control (<8.0%)	51.09	39.80	58.39	40.88	11.29	-7.30	10.21	-	-	-
CDC-N	Medical Attn. for Nephropathy	88.87	88.32	93.56	90.51	0.55	-4.69	-1.64	-	-	-
CDC-BP	Blood Pressure Control <140/90	63.87	52.26	75.73	61.86	11.61	-11.86	2.01	-	-	-
CBP	Controlling High Blood Pressure	57.91	46.87	70.69	50.85	11.04	-12.78	7.06	-	56.05	1.86
IMA-2	Immunizations for Adolescents (Combo 2)	21.65	N/A	N/A	N/A	N/A	N/A	N/A	N/A	-	-
PPC-Pre	Timeliness of Prenatal Care	75.43	74.21	91.00	79.08	1.22	-15.57	-3.65	-	77.97	-2.54
PPC-Pst	Postpartum Care	63.50	55.47	73.61	56.45	8.03	-10.11	7.05	-	-	-
WCC-N	Counseling for Nutrition	67.40	51.84	79.52	66.67	15.56	-12.12	0.73	-	-	-
WCC-PA	Counseling for Phys Activity	61.56	45.09	71.58	57.91	16.47	-10.02	3.65	-	-	-
W-34	Well-Child Visits	69.83	64.72	82.97	67.15	5.11	-13.14	2.68	-	67.22	2.61

* A lower rate indicates better performance therefore the number of required numerators must decrease by the number shown.

Note: For measures shaded in gray, DHCS is not holding MCPs accountable to meet the MPLs for HEDIS 2017 (measurement year 2016).

Administrative Measures

Measure		Current 2017 Rate	2017 MPL	2017 HPL	2016 KHS Rate	Current Vs. 2017 MPL	Current Vs. 2017 HPL	Current Vs. 2016 KHS	Change In Numerators Required to meet MPL
AAB**	Avoidance of Antibiotic Treatment	29.47	22.12	38.91	21.22	7.35	-9.44	8.25	-
AMR	Asthma Medication Ratio	48.38	54.55	70.00	N/A	-6.17	-21.62	N/A	100
BCS	Breast Cancer Screening	50.48	52.24	71.52	N/A	-1.76	-21.04	N/A	-
CAP-1224	12-24 Months	89.65	93.14	97.85	92.64	-3.49	-8.20	-2.99	203
CAP-256	25 Months – 6 Years	80.61	84.83	93.34	82.43	-4.22	-12.73	-1.82	1,248
CAP-711	7-11 Years	81.49	87.91	96.10	82.70	-6.42	-14.61	-1.21	1,630
CAP-1219	12-19 Years	80.21	85.84	94.69	81.16	-5.63	-14.48	-0.95	1,722
CDF	Screening for Clinical Depression	9.29	N/A	N/A	N/A	N/A	N/A	N/A	N/A
LBP**	Use of Imaging for Low Back Pain	66.25	69.88	81.42	76.04	-3.63	-15.17	-9.79	117
MPM-ACE	ACE inhibitors or ARBs	88.40	85.63	92.13	89.26	2.77	-3.73	-0.86	-
MPM-Diu	Diuretics	87.61	85.18	92.28	88.72	2.43	-4.67	-1.11	-

** Rate for these measures derived by an inverse calculation. The number of required numerators must decrease by the number shown.

Note: For measures shaded in gray, DHCS is not holding MCPs accountable to meet the MPLs for HEDIS 2017 (measurement year 2016).

Health Services Quarterly Committee Reporting- Reporting Period April 1, 2017 to June 30, 2017

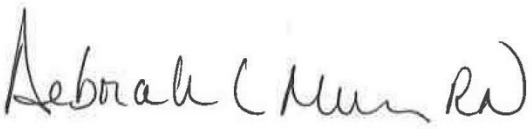
Utilization Management Overview

The 2017 membership enrollment remained stable at 248,000 in Q2 2017. Additional benefit coverage and broadening interdisciplinary collaboration to support the membership growth will continue through 2017.

- Non –Emergency Medical Transportation expansion
- Medical Management Platform-UM October 2017, CM, DM, HE December 2017-January 2018
- Palliative Care-tentative 1/1/2018
- Disease Management Conditions-Hypertension
- Case Management/Social Worker Expansion-PCP Connect and Transitional Care Clinic

The following pages reflect statistical measurements for Utilization Management, Case Management and Disease Management detailing the ongoing compliance activity for the 2nd Quarter 2017.

Respectfully submitted,



Deborah Murr RN, BS HCM
Administrative Director of Health Services
Kern Health System

Timeliness of Decision Trending

Summary:

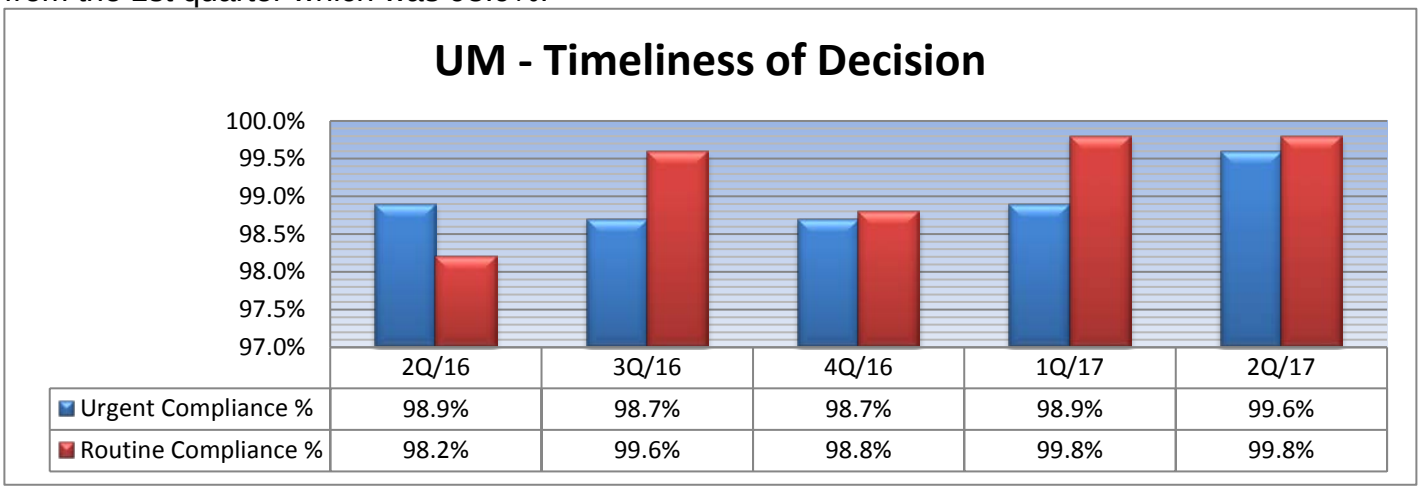
Quarterly audits are conducted to ensure compliance with DMHC requirements, KHS Contractual Agreement with the Department of Health Services, and KHS Policy and Procedures. Referrals are submitted and have specific turn-around-times set for each type of referral.

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

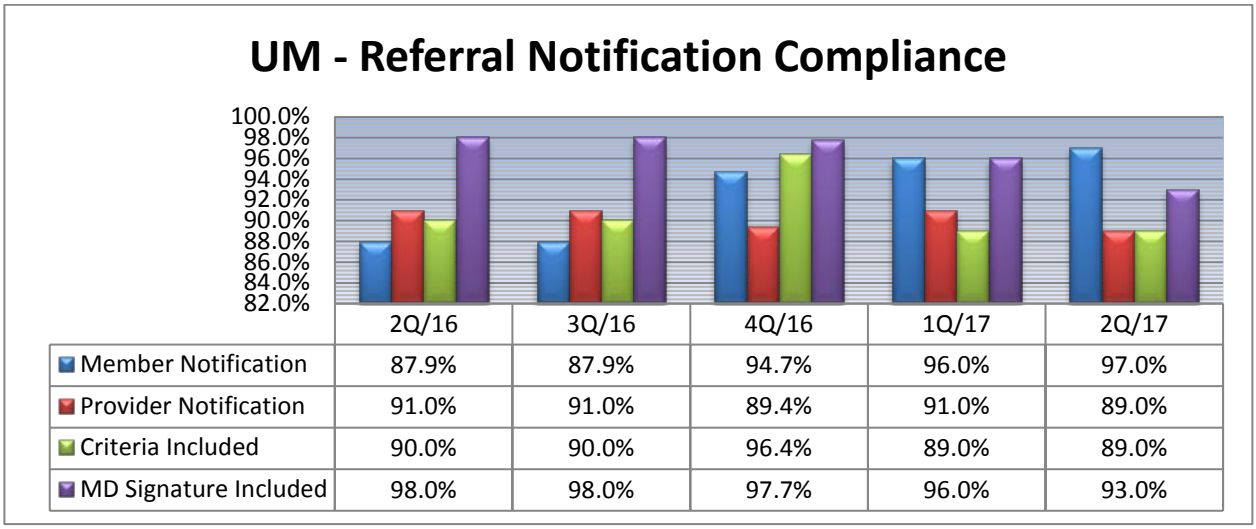
There were 26,391 referrals processed in the 2nd quarter of 2017 of which 2396 referrals were reviewed for timeliness of decision. In comparison to the 1st quarter's processing time, the routine referrals remained the same from the 1st quarter which was 99.8%, and urgent referrals increased from the 1st quarter which was 98.9%.



	2Q/16	3Q/16	4Q/16	1Q/17	2Q/17
Urgent Compliance %	98.9%	98.7%	98.7%	98.9%	99.6%
Routine Compliance %	98.2%	99.6%	98.8%	99.8%	99.8%

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

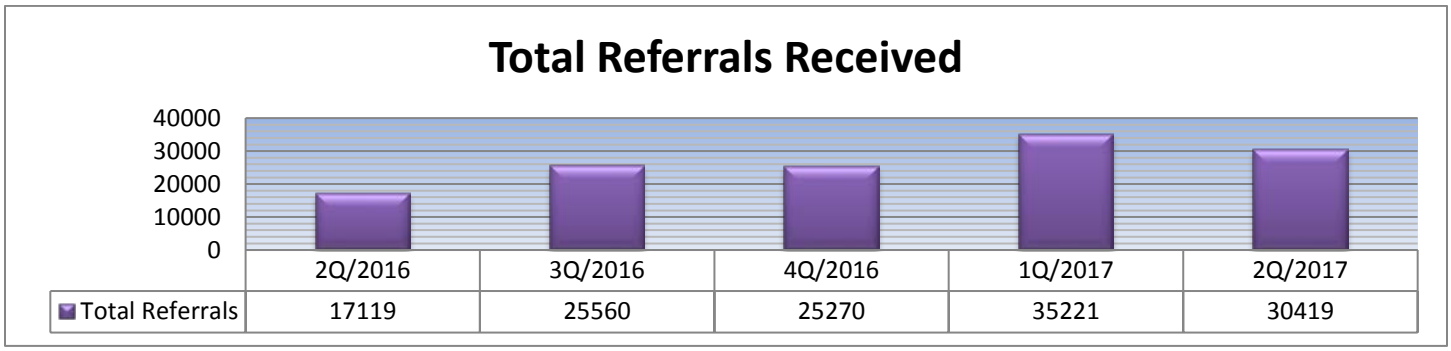


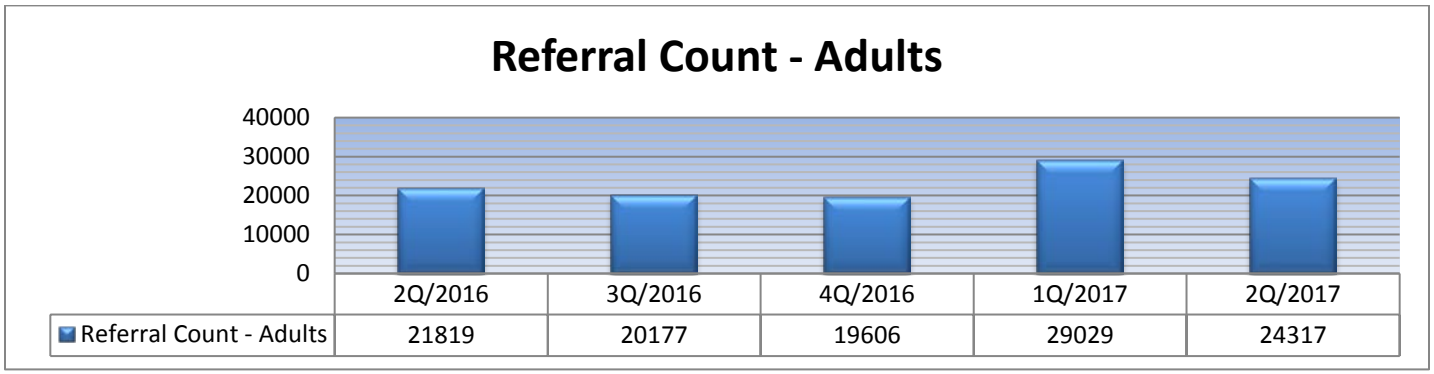
	2Q/16	3Q/16	4Q/16	1Q/17	2Q/17
Member Notification	87.9%	87.9%	94.7%	96.0%	97.0%
Provider Notification	91.0%	91.0%	89.4%	91.0%	89.0%
Criteria Included	90.0%	90.0%	96.4%	89.0%	89.0%
MD Signature Included	98.0%	98.0%	97.7%	96.0%	93.0%

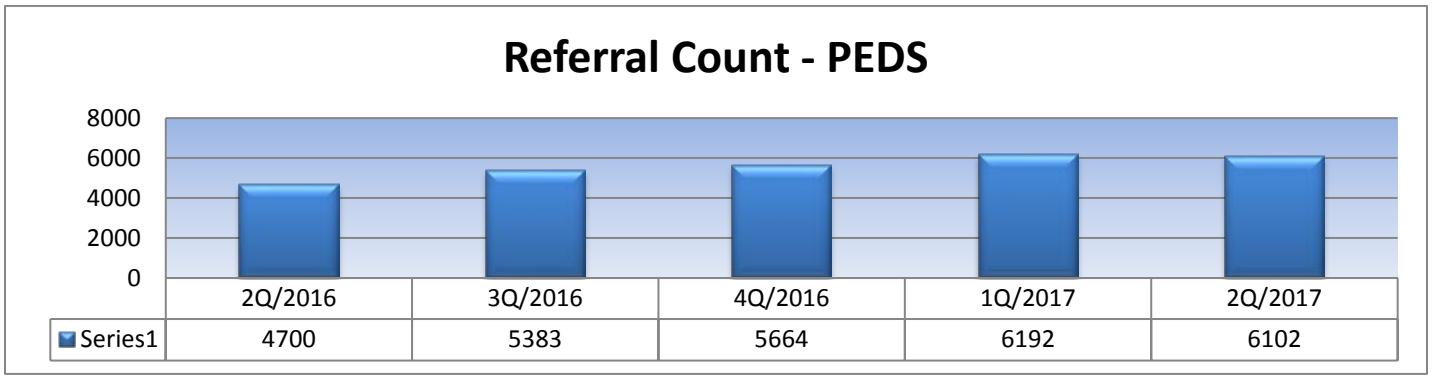
Summary: Overall compliance rate from the 2nd Qtr of 2017 is 92% which decreased from the 1st Qtr which was 93%. **Action:** This compliance audit will be discussed at the UM Staff meeting. Compliance deficiencies have been discussed with individual staff members as appropriate.

Referral Activity

Outpatient Referral Denial Statistics
The overall denial rate for the 2nd quarter is 8%. After elimination of CCS requests, the denial rate is 7% to reflect those denials for medical necessity or other administrative denials.







KHS Monthly Inpatient and LOS Report

Report captures how many members were inpatient during reporting month, excluding CCS denials

Dates of Discharge Between : 04/01/2017-06/30/2017

	20 and Under	Over 20	Totals
Total Inpatient:	1232	6006	**7238**
Total LOS:	6418	23208	**29626**
Average LOS:	5.2	3.9	**4.1**

PAR Facilities	Admits	LOS	Average LOS
Totals :	6732	25313	3.8
Adult Inpatient	4,347	14813	3.4
Adult Observation	805	1305	1.6
Adult Rehab/SNF	398	3171	8.0
Pediatric Inpatient	1178	5967	5.1
Pediatric Rehab/SNF	4	57	14.3

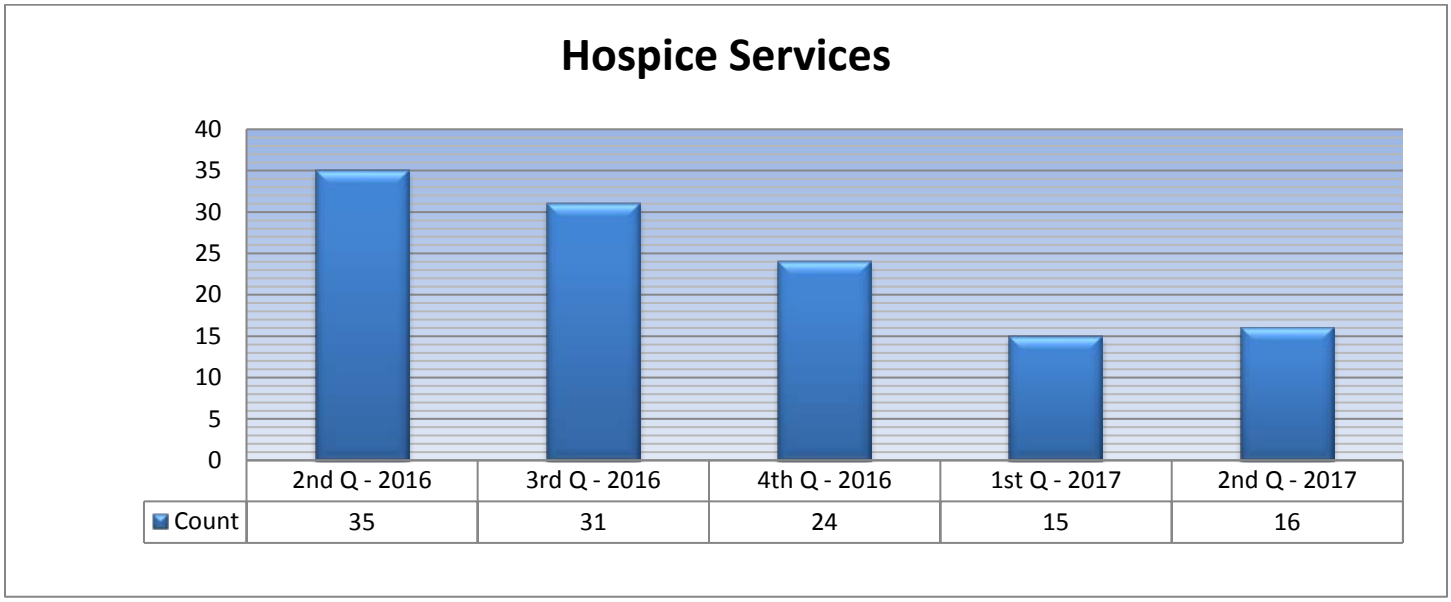
NPAR Facilities	Admits	LOS	Average LOS
Totals :	506	4313	8.5
Adult Inpatient	276	1371	5.0
Adult Observation	21	26	1.2
Adult Rehab/SNF	159	2522	15.9
Pediatric Inpatient	46	323	7.0
Pediatric Rehab/SNF	4	71	17.8

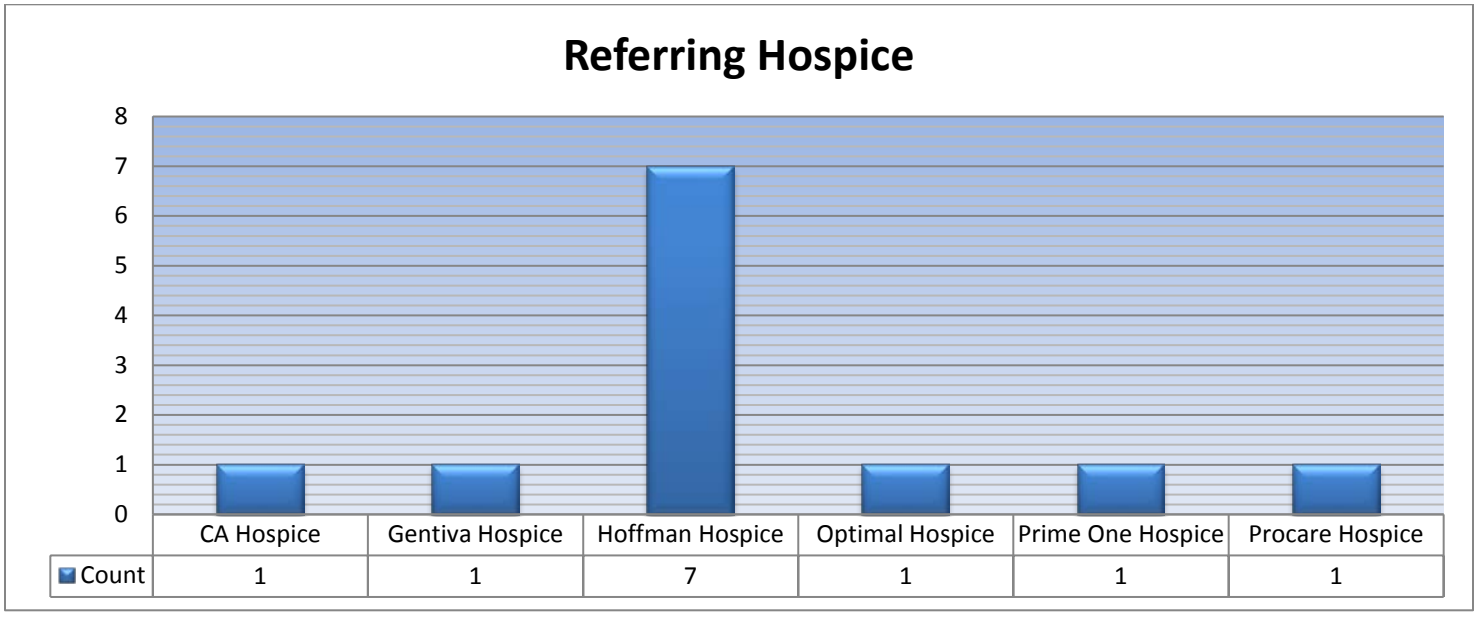
Activity by Facility	Total Inpatient	Total LOS	Average LOS
ADVENTIST HEALTH MEDICAL CENTE	2	0	0.0
ADVENTIST MEDICAL CENTER	5	12	2.4
AMALFI IN THE DESERT	11	136	12.4
ANTELOPE VALLEY HOSP	60	176	2.9
AVENIDA LIVING HOME CARE	3	59	19.7
BAKERSFIELD HEART HOSPITAL	89	258	2.9
BAKERSFIELD MEMORIAL HOSPITAL	1645	5433	3.3
BARSTOW COMM HOSPITA	1	3	3.0
BELLAGIO IN THE DESERT	22	284	12.9
BROOKDALE RIVERWALK SNF	4	80	20.0
CAPRI IN THE DESERT	6	70	11.7
CEDARS SINAI MEDICAL CENTER	10	100	10.0
CEDARS-SINAI	2	4	2.0
CENTRAL VALLEY SPECIALTY HOSPI	1	6	6.0
CHATEAU D' BAKERSFIELD	1	0	0.0
CHILDRENS HOSPITAL OF LOS ANGE	67	414	6.2
CHILDRENS MEDICAL CENTER OF DA	1	2	2.0
CITRUS VALLEY MEDICAL CENTER I	1	5	5.0
CITY OF HOPE NATIONAL MEDICAL	4	6	1.5
CONWAY REGIONAL MEDICAL CENTER	2	6	3.0
COX MEDICAL CENTER BRANSON	1	1	1.0
DELANO REGIONAL MEDICAL CENTER	1	31	31.0
DELANO REGIONAL MEDICAL CENTER	259	544	2.1
DOCTORS MEDICAL CENTER	5	63	12.6
EL CENTRO REGIONAL MEDICAL CEN	4	0	0.0
EVERGREEN AT ARVIN HEALTHCARE	32	525	16.4
EVERGREEN AT BAKERSFIELD, LLC	3	60	20.0

FIRESIDE HEALTH CARE CENTER	1	16	16.0
FOUNTAIN REGIONAL HOSPITAL & M	1	2	2.0
FRESNO COMMUNITY HOSPITAL AND	22	163	7.4
GARFIELD MEDICAL CNT	1	2	2.0
GOLDEN LIVING CENTER - BAKERSF	20	218	10.9
GOLDEN LIVING CENTER - SHAFTER	5	70	14.0
GOLDEN LIVING CENTER FRESNO	3	62	20.7
GOOD SAMARITAN	1	2	2.0
GOOD SAMARITAN HOSPITAL	463	1013	2.2
HARBOR - UCLA MED FOUNDATION	3	8	2.7
HEALTHSOUTH BAKERSFIELD REHABI	283	1763	6.2
HEIGHT STREET SKILLED CARE	1	15	15.0
HENRY MAYO NEWHALL MEMORIAL HO	26	72	2.8
HOFFMANN HOSPICE OF THE VALLEY	15	29	1.9
HOLLYWOOD PRESBYTERIAN MEDICAL	8	13	1.6
HOUSTON METHODIST WEST HOSPITA	1	2	2.0
HUNTINGTON MEMORIAL HOSPITAL	2	6	3.0
KAISER FOUNDATION HOSPITAL SOU	2	2	1.0
KAWEAH DELTA DIST HO	1	2	2.0
KECK HOSPITAL OF USC	2	9	4.5
KECK HOSPITAL OF USC	78	437	5.6
KERN COUNTY MEDICAL AUTHORITY	2	6	3.0
KERN COUNTY MEDICAL AUTHORITY	1056	4640	4.4
KERN VALLEY HEALTHCARE DISTRIC	94	320	3.4
KINDRED HOSPITAL	12	188	15.7
KINDRED HOSPITAL - WESTMINSTER	6	84	14.0
KINDRED HOSPITAL ONTARIO	4	32	8.0
LAC USC MEDICAL CENTER	3	4	1.3
LAC/USC MEDICAL CENTER	1	2	2.0
LAC-USC MEDICAL CTR	5	21	4.2
LIFEHOUSE HEALTH SERVICES	24	370	15.4
LOMA LINDA UNIVERSITY CHILDREN	8	66	8.3
LOMA LINDA UNIVERSITY MEDICAL	9	36	4.0
LOS ROBLES HOSPITAL	1	3	3.0
LUCILE SALTER PACKARD CHILDREN	3	22	7.3
MEMORIAL HOSPITAL OF GARDENA	2	4	2.0
MERCY HOSPITAL	950	2697	2.8
METHODIST HOSP SO CA	1	5	5.0
MISSION HOSPITAL REGIONAL MEDI	1	1	1.0
NORTHERN INYO HOSPIT	1	3	3.0
NORTHRIDGE HOSPITAL MEDICAL CE	4	9	2.3
NORTHWEST TEXAS HEALTHCARE SYS	1	1	1.0
PACIFICA HOSPITAL OF THE VALLE	6	143	23.8
PALMDALE REGIONAL MEDICAL	10	31	3.1
PARK	1	0	0.0
PARKVIEW JULIAN CONVALESCENT H	4	57	14.3
PIONEER MEMORIAL	1	1	1.0

POMONA VALLEY HOSPITAL	1	1	1.0
PROCARE HOSPICE	4	12	3.0
PROVIDENCE HOLY CROSS MEDICAL	2	19	9.5
PROVIDENCE MEDICAL INSTITUTE	4	7	1.8
PROVIDENCE TARZANA MEDICAL CEN	3	4	1.3
RIDGECREST REGIONAL HOSPITAL	5	11	2.2
ROSEWOOD	12	169	14.1
SAINT JOHNS HLTH CTR	1	11	11.0
SAINT MARYS MEDICAL GROUP NARA	2	2	1.0
SAN JOAQUIN COMMUNITY HOSPITAL	1256	4118	3.3
SAN MARINO IN THE DESERT	6	124	20.7
SANTA BARBARA COTTAGE HOSPITAL	2	4	2.0
SANTA CLARA VALLEY MEDICAL	1	8	8.0
SANTA CLARITA POST ACUTE CARE	2	0	0.0
SHARP-CHULA VISTA MEDICAL CENT	1	2	2.0
SIERRA VISTA REGIONAL MEDICAL	2	36	18.0
SORRENTO IN THE DESERT	23	244	10.6
ST JOHNS REGIONAL MEDICAL CENT	2	10	5.0
ST JOSEPH HEALTH	2	8	4.0
ST ROSE HOSPITAL	1	2	2.0
ST VINCENT MED CTR	1	2	2.0
STANFORD MEDICAL	2	11	5.5
SUMMERLIN HOSPITAL MEDICAL CEN	2	2	1.0
SUNNYVALE POST ACUTE CENTER	2	58	29.0
SUNRISE HOSPITAL AND MEDICAL	1	1	1.0
SUTTER DAVIS	4	11	2.8
TEHACHAPI HOSPITAL	1	3	3.0
THE REHABILITATION CENTER OF B	33	528	16.0
TULARE REGIONAL MEDICAL CENTER	1	3	3.0
UCLA MEDICAL CENTER	100	764	7.6
UCSD MEDICAL CENTER	3	42	14.0
UCSD MEDICAL GROUP	2	12	6.0
UCSF MEDICAL CENTER	18	168	9.3
UNITED CARE FACILITIES	39	457	11.7
UNITED CARE NETWORK	11	130	11.8
UNIVERSITY DISRICT MEDICAL CEN	1	3	3.0
UNIVERSITY MEDICAL CENTER OF S	2	2	1.0
USC NORRIS CANCER	6	41	6.8
VALLEY CHILDRENS HOSPITAL	211	1246	5.9
VALLEY CHILDREN'S HOSPITAL	45	187	4.2
VALLEY HOSPITAL MEDICAL CENTER	2	28	14.0
VENTURA COUNTY MEDICAL CENTER	1	4	4.0
VERDE VALLEY MEDICAL CENTER	1	6	6.0
VFP HOMES	5	84	16.8
WHITTIER HOSPITAL MEDICAL CENT	1	4	4.0

Hospice Utilization has increased in the 2nd Quarter 2017. KHS staff are reviewing potential diagnoses that may qualify for specific measures or treatments provided under hospice care which may assist in improving the quality of life and decrease hospitalizations during the end stages of a members chronic disease.

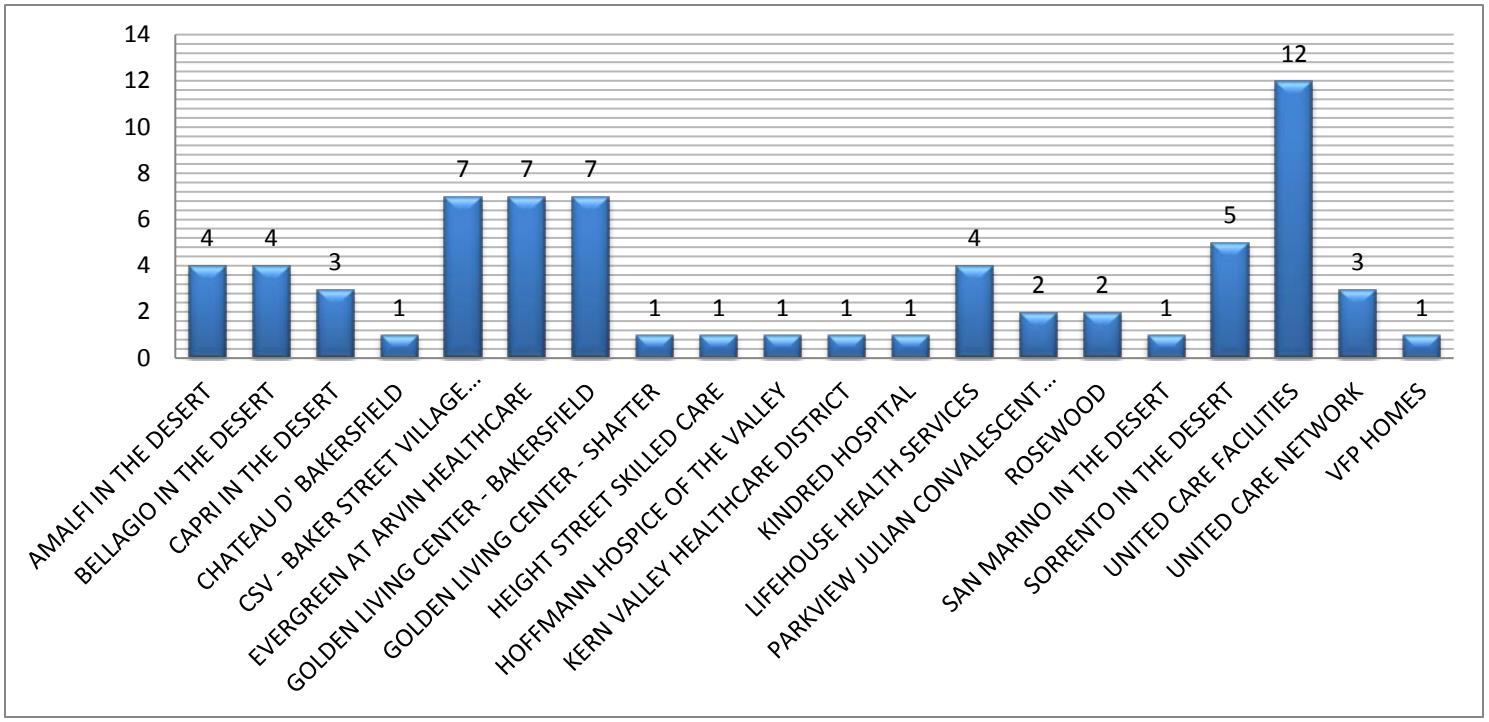




Nursing Facility Services Report

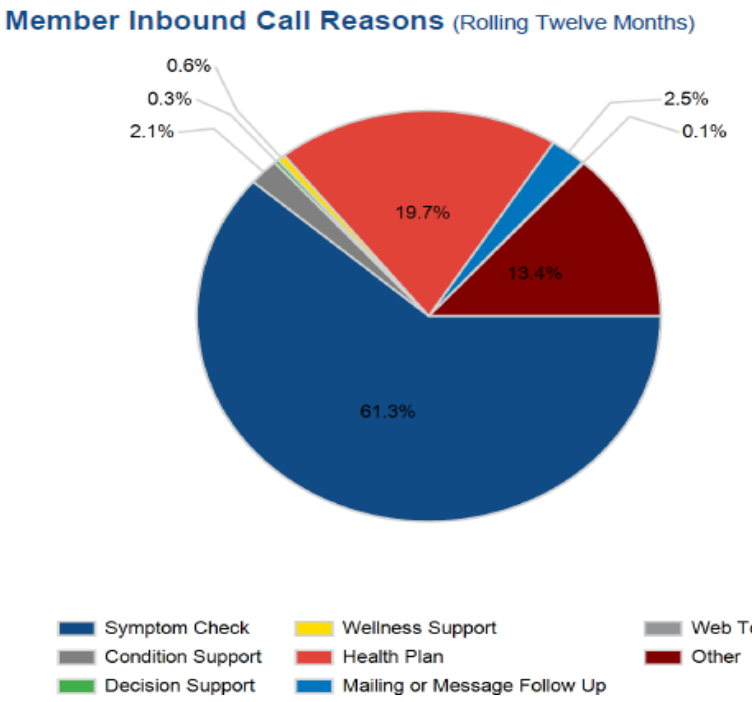
Purpose: Kern Health Systems covers medically necessary Nursing Facility Services for eligible members. KHS members requiring Nursing Facility Services are identified and placed in health care facilities, which provide the level of care most appropriate to the member's medical needs. For members requiring long-term care, KHS coordinates the members care and initiates disenrollment per DHCS criteria. 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 2nd quarter 2017, there were 69 referrals for Nursing Facility Services. The average length of stay was 21 days for these members. During the 1st quarter there were only 3 denials of the 103 referrals.

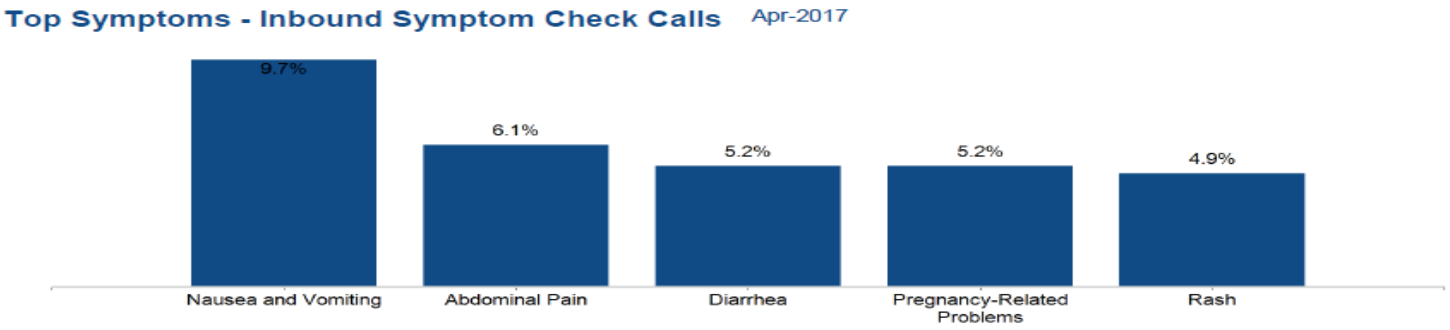


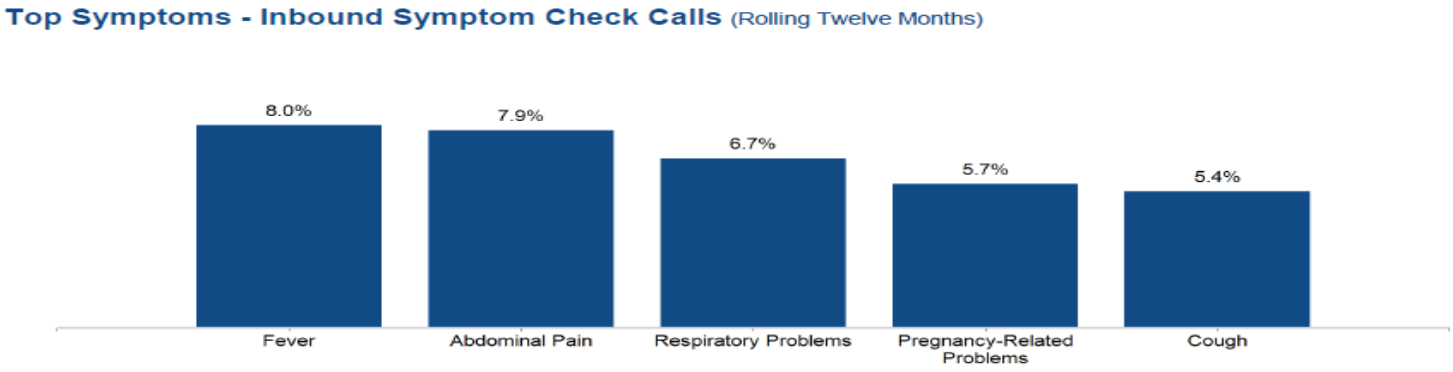
Health Dialog Report

April:



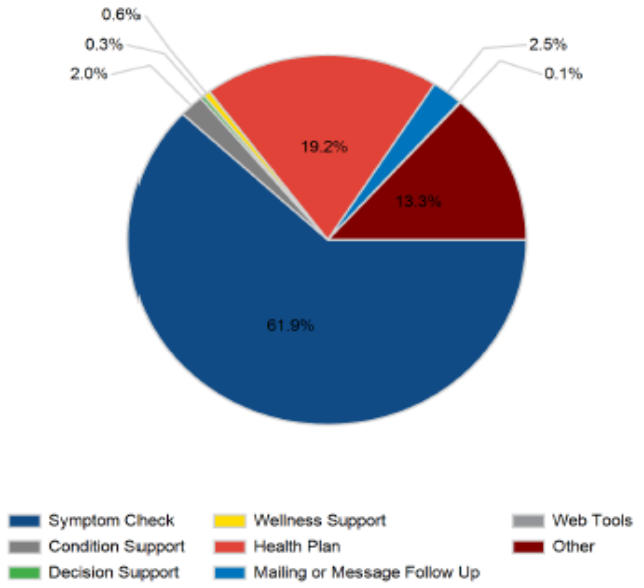
REASON	NUMBER
Symptom Check	1,781
Condition Support	61
Decision Support	9
Wellness Support	16
Health Plan	573
Mailing or Message Follow Up	73
Web Tools	3
Other	388





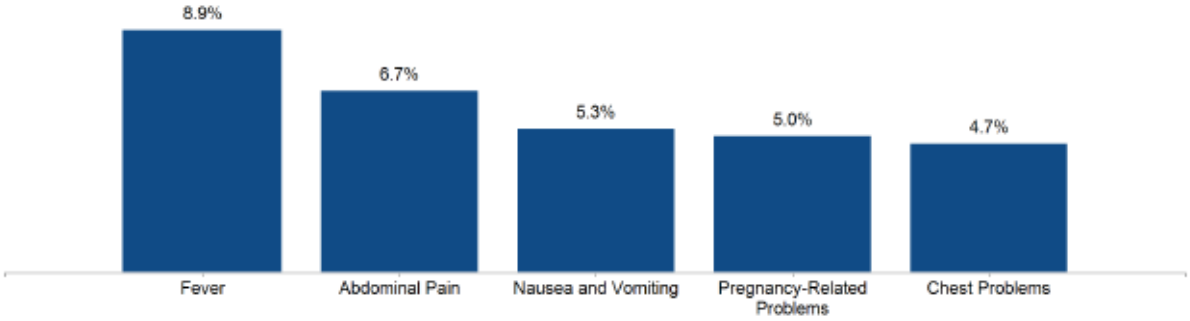
May:

Member Inbound Call Reasons (Rolling Twelve Months)

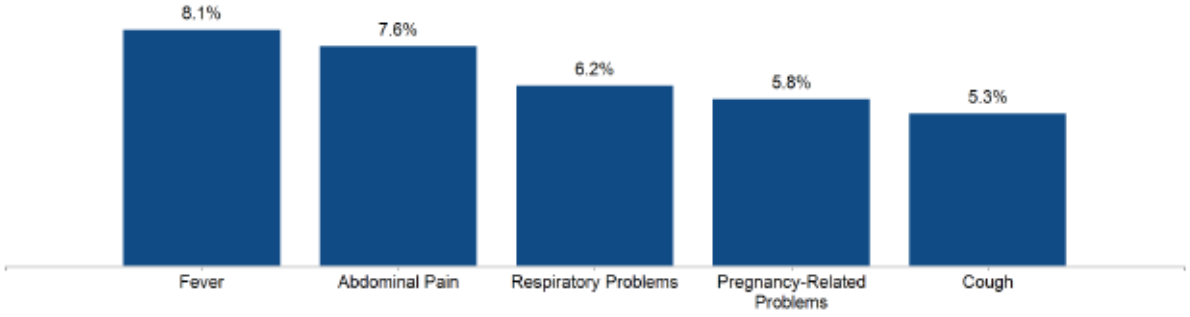


REASON	NUMBER
Symptom Check	2,095
Condition Support	68
Decision Support	11
Wellness Support	19
Health Plan	650
Mailing or Message Follow Up	86
Web Tools	3
Other	451

Top Symptoms - Inbound Symptom Check Calls (May-2017)

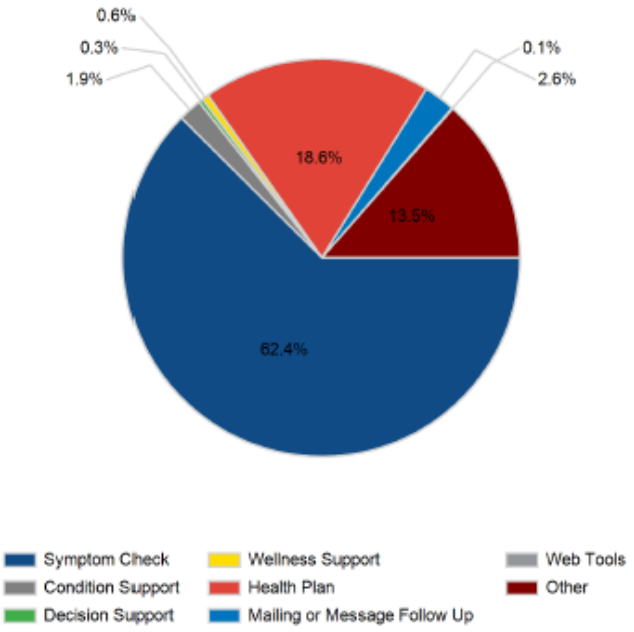


Top Symptoms - Inbound Symptom Check Calls (Rolling Twelve Months)



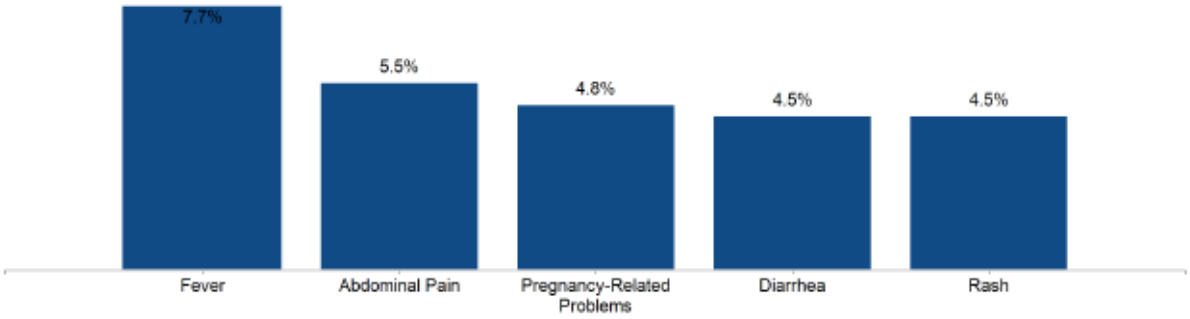
June:

Member Inbound Call Reasons (Rolling Twelve Months)

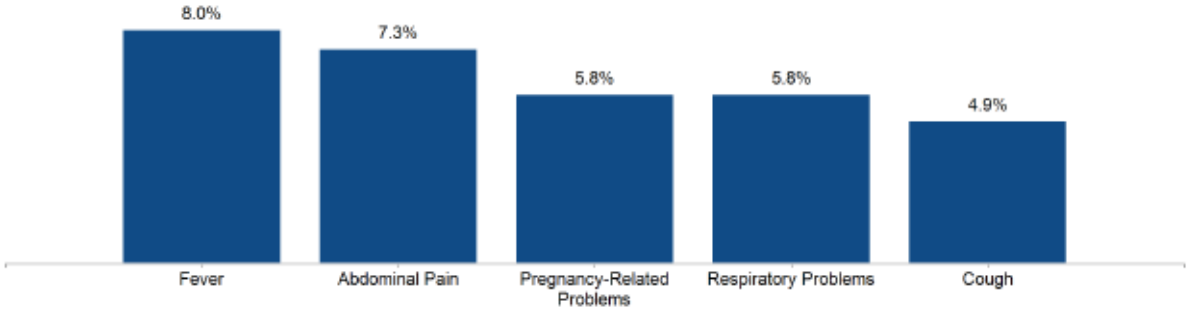


REASON	NUMBER
Symptom Check	2,373
Condition Support	73
Decision Support	13
Wellness Support	21
Health Plan	708
Mailing or Message Follow Up	98
Web Tools	3
Other	513

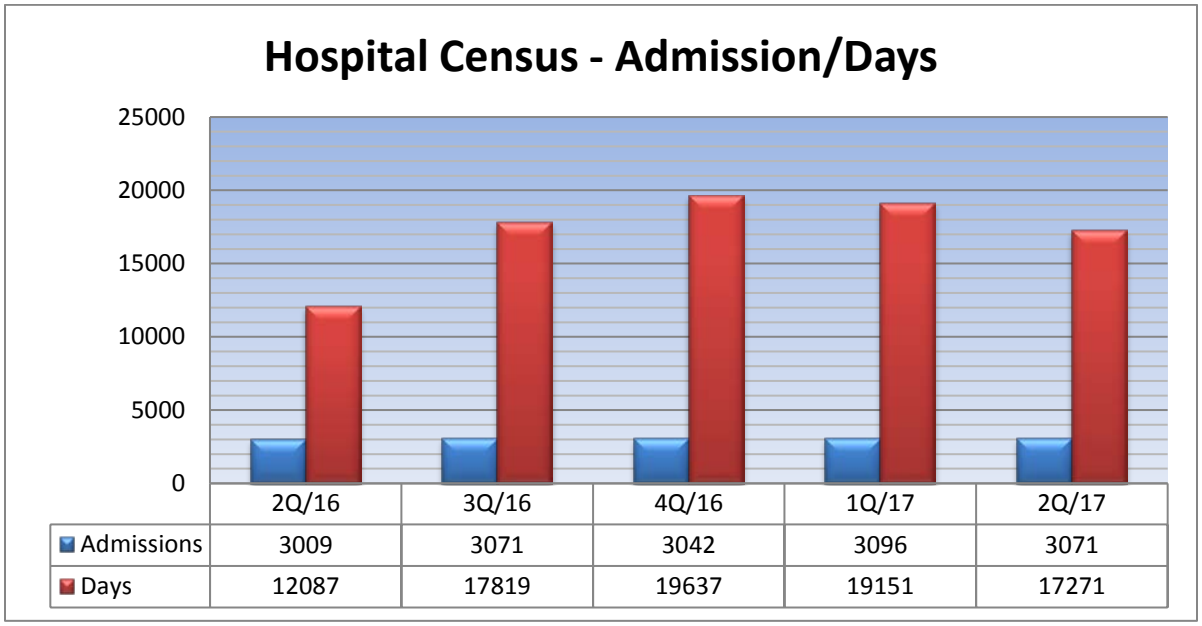
Top Symptoms - Inbound Symptom Check Calls (Jun-2017)



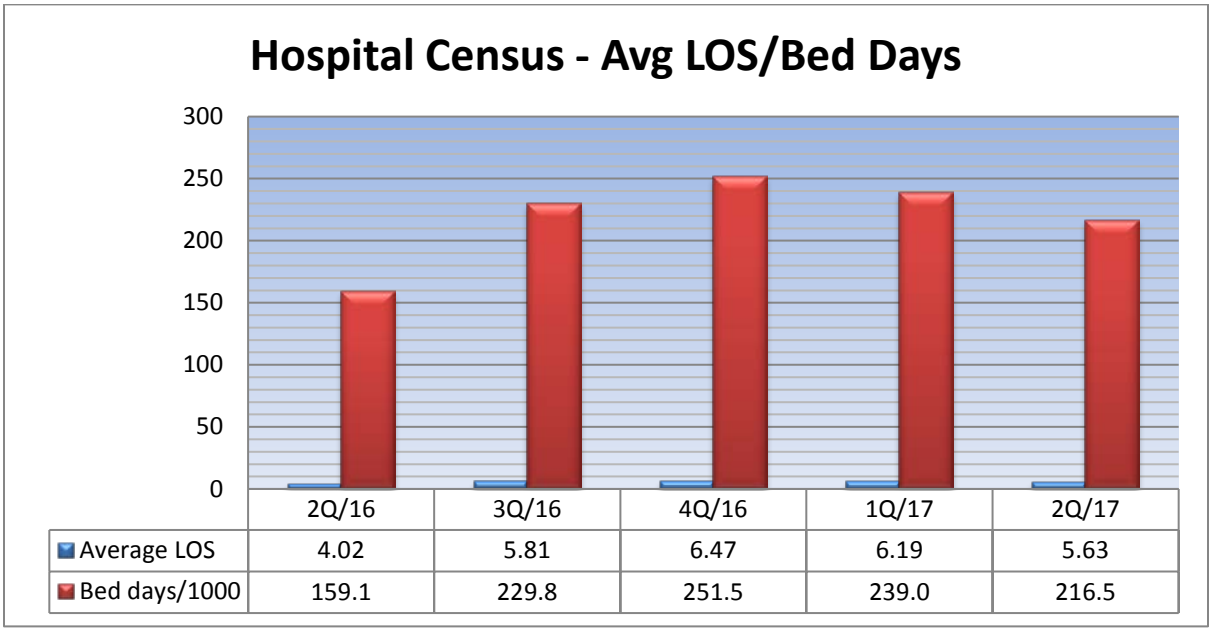
Top Symptoms - Inbound Symptom Check Calls (Rolling Twelve Months)



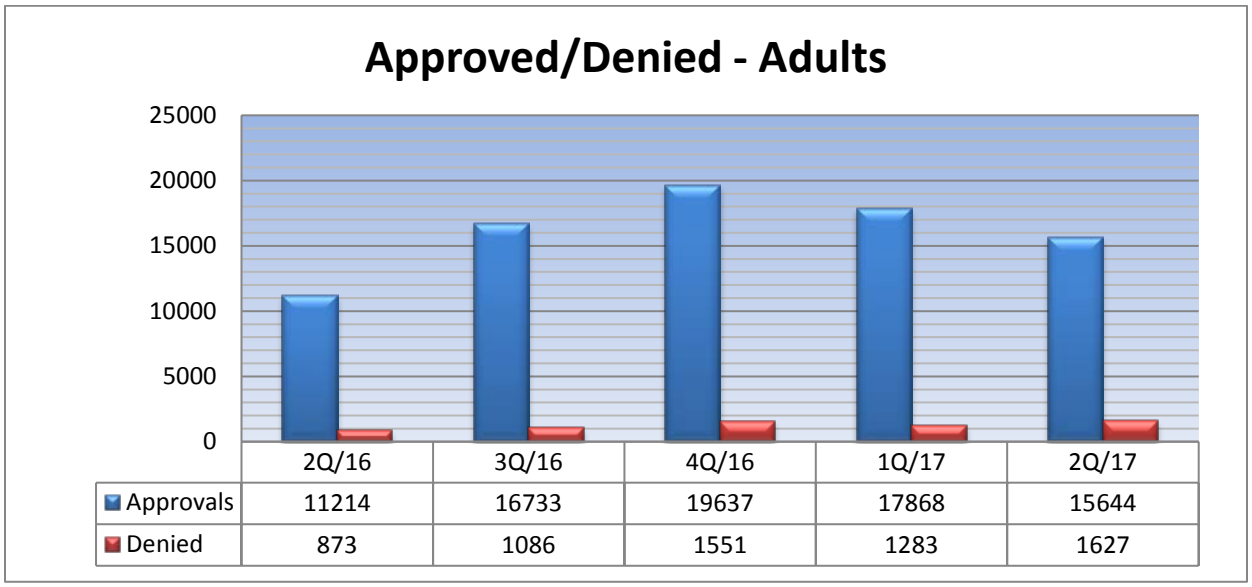
Inpatient 2nd Quarter Trending

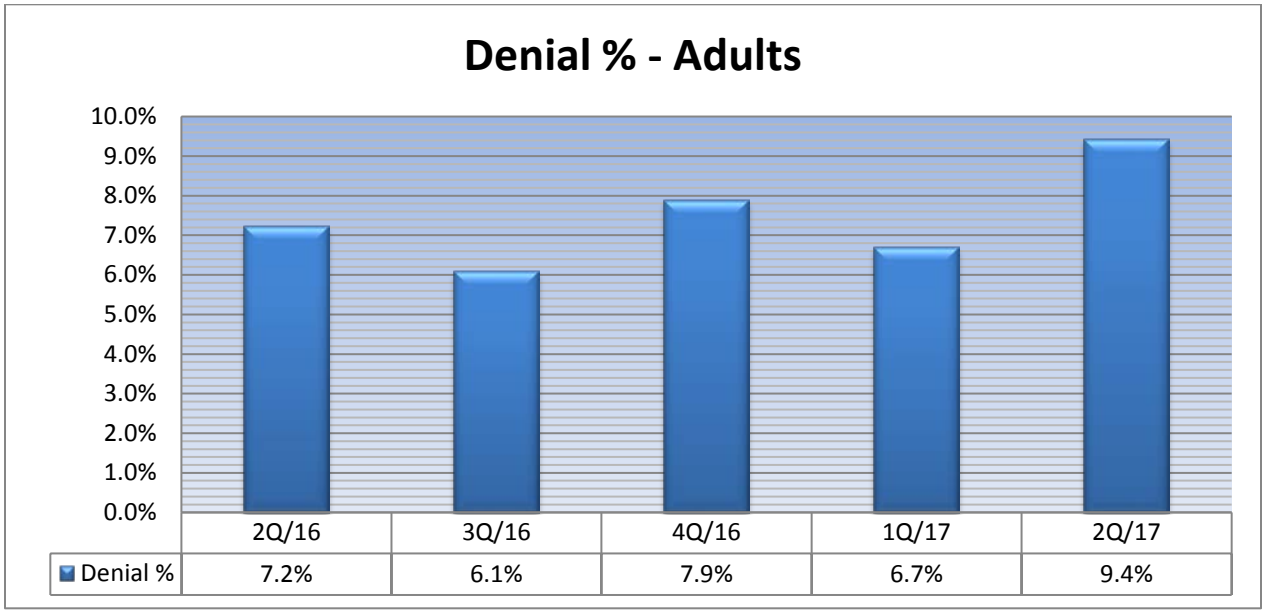


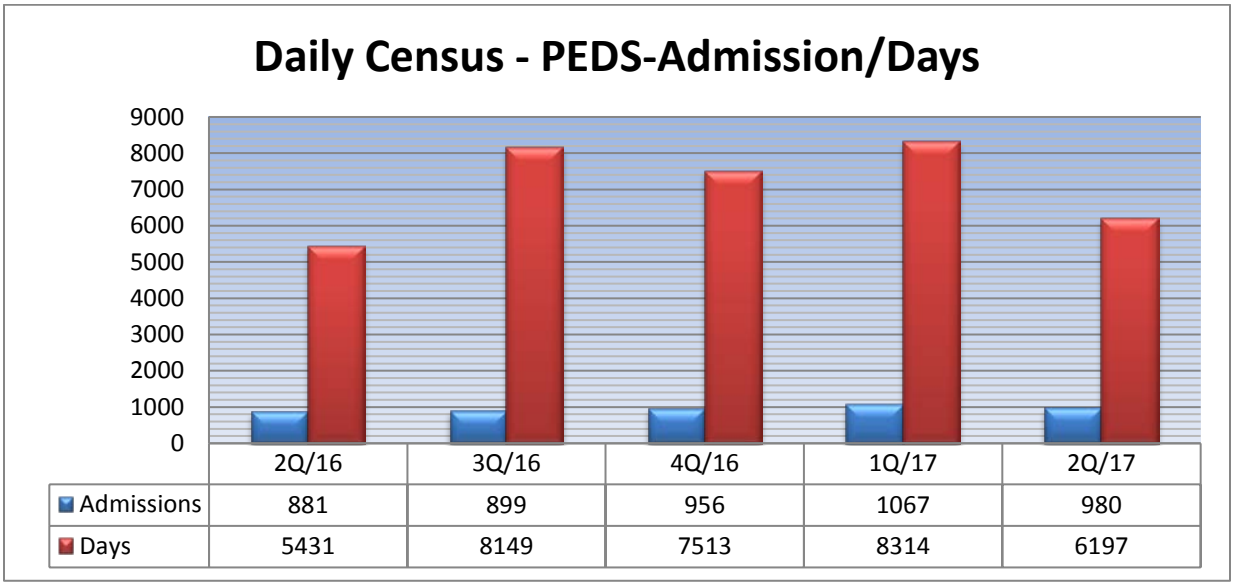
	2Q/16	3Q/16	4Q/16	1Q/17	2Q/17
Admissions	3009	3071	3042	3096	3071
Days	12087	17819	19637	19151	17271



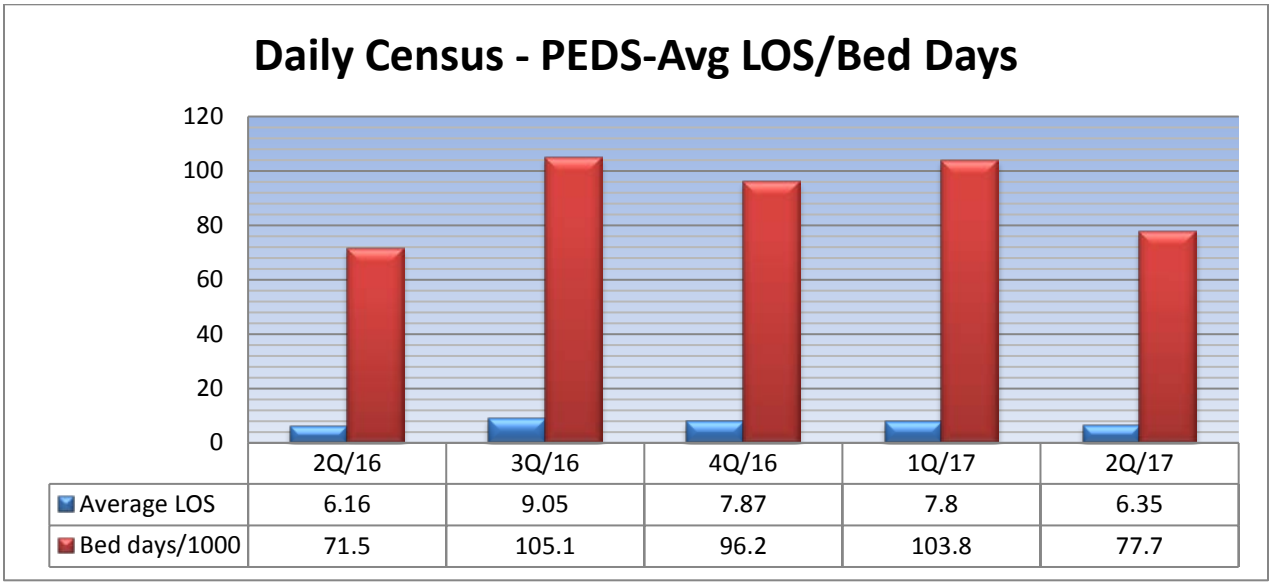
	2Q/16	3Q/16	4Q/16	1Q/17	2Q/17
Average LOS	4.02	5.81	6.47	6.19	5.63
Bed days/1000	159.1	229.8	251.5	239.0	216.5


Approved/Denied - Adults
25000
20000
15000
10000
5000
0
2Q/16
3Q/16
4Q/16
1Q/17
2Q/17
Approvals
11214
16733
19637
17868
15644
Denied
873
1086
1551
1283
1627

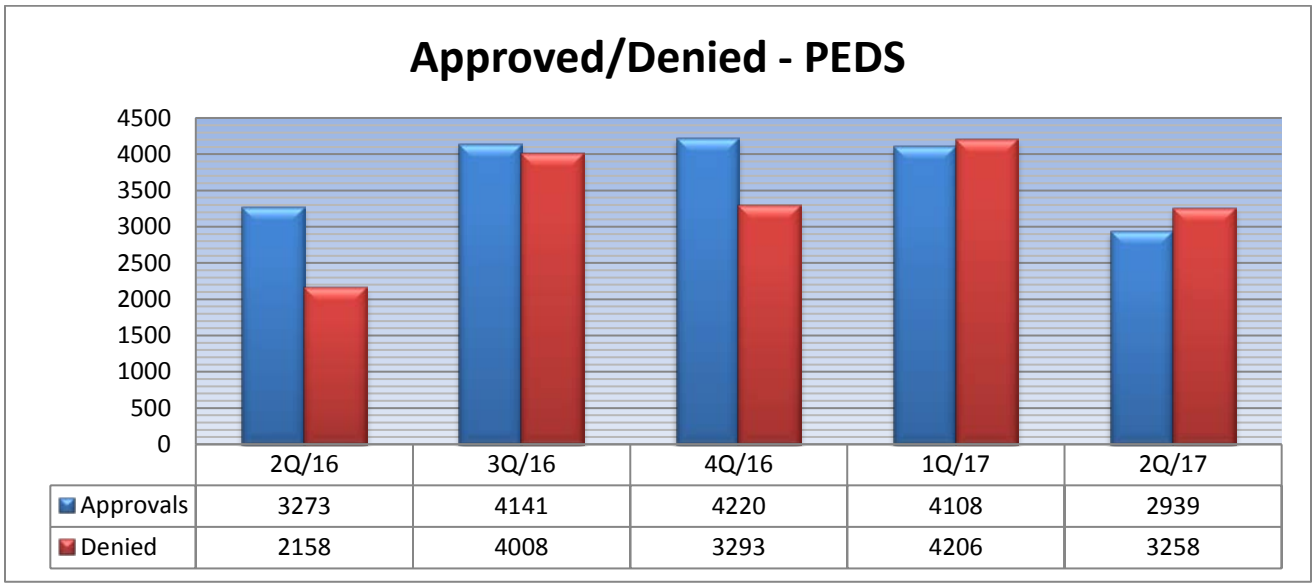

Denial % - Adults
10.0%
9.0%
8.0%
7.0%
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
2Q/16
3Q/16
4Q/16
1Q/17
2Q/17
Denial %
7.2%
6.1%
7.9%
6.7%
9.4%



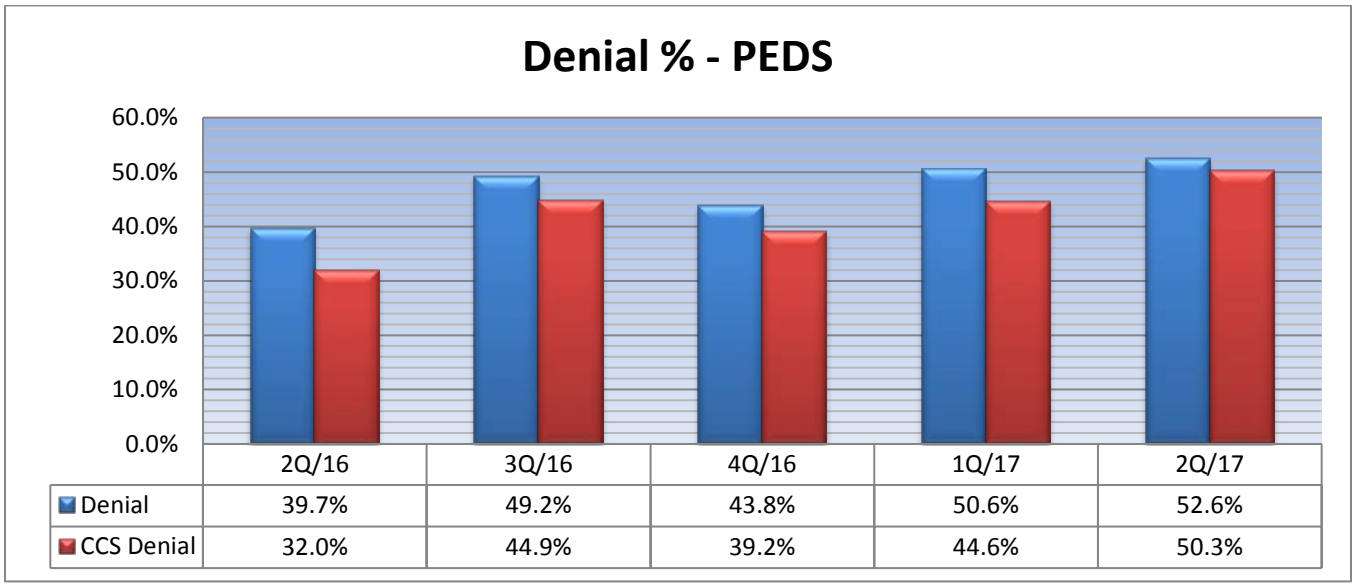
	2Q/16	3Q/16	4Q/16	1Q/17	2Q/17
Admissions	881	899	956	1067	980
Days	5431	8149	7513	8314	6197



	2Q/16	3Q/16	4Q/16	1Q/17	2Q/17
Average LOS	6.16	9.05	7.87	7.8	6.35
Bed days/1000	71.5	105.1	96.2	103.8	77.7



	2Q/16	3Q/16	4Q/16	1Q/17	2Q/17
Approvals	3273	4141	4220	4108	2939
Denied	2158	4008	3293	4206	3258



	2Q/16	3Q/16	4Q/16	1Q/17	2Q/17
Denial	39.7%	49.2%	43.8%	50.6%	52.6%
CCS Denial	32.0%	44.9%	39.2%	44.6%	50.3%

Continuity of Care

Total Referral – 2

Total Approval – 2

Total SPD COC -1

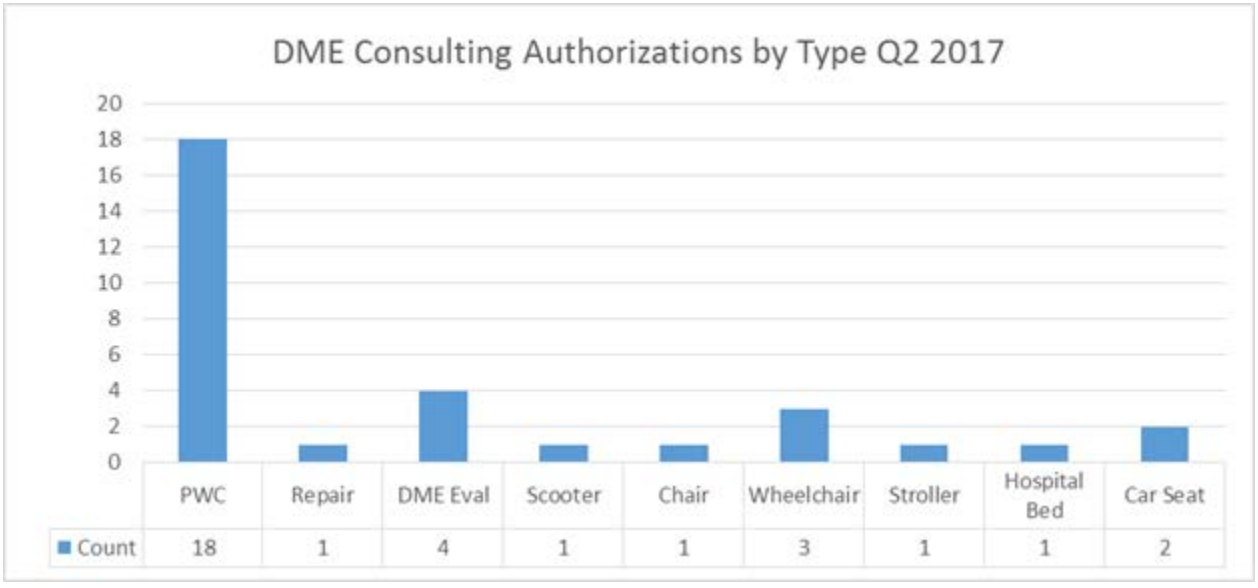
UM Provider Disputes

Total Disputes – 7

Favor of Provider -6

Favor of Plan – 1

DME Consulting



Autism Reporting

UNIQUE CASES		Mild	Moderate	Severe	Total	Undetermined
PRE TRANSITION	23	3	7	1	11	12
POST TRANSITION	357	46	102	22	170	187
Total - Eligible	380	49	109	23	181	199
Severity %		27%	60%	13%		
Age 7 or less		12	27	10	49	58
Age 8 or greater		10	16	3	29	29
% < 7		24%	55%	20%		
% > 8		34%	55%	10%		
AUTHS PER MO/MEMBER	APRIL	MAY	JUNE			
Members	53	52	63			
TOTAL	53	52	63			
SEVERITY	APRIL	MAY	JUNE			
MILD	6	8	10			
MODERATE	17	10	16			
SEVERE	3	15	7			
Approved FBA						
Approved Treatment						
PENDING DX	28	33	26			
TOTAL	54	66	59			
	APRIL	MAY	JUNE			
AGE 7 OR LESS	32	34	18			
AGE 8 OR GREATER	22	20	41			
TOTAL	54	54	59			
% < 7	59%	63%	31%			
% > 8	41%	37%	69%			

Diabetic Exam Reminder Effectiveness Report

Client: - 12049397

Reminder Year:	Reminder Month:	Reminders Sent	Received Exam Within 0-90 Days	Received Exam Within 91-180 Days	Total Exams Within 180 Days
2016	July	372	5	3	8
	August	234	18	10	28
	September	380	30	14	44
	October	39	7	3	10
	November	83	8	4	12
	December	5,008	208	135	343
2017	January	687	31	15	46
	February	224	10	1	11
	March	188	18	1	19
	April	155	12	0	12
	May	105	7	0	7
	June	516	3	0	3
Totals		**7,991**	**357**	**186**	**543**

LTM Effectiveness* : 7 %

12-Month Effectiveness (Jan 2016 - Dec 2016) : 7 %

KERN HEALTH SYSTEMS
CASE MANAGEMENT DEPARTMENT MONTHLY REPORT

Report Date: July 7th, 2017

Reporting Period: April 1st, 2017 – June 30th, 2017

CASE MANAGEMENT DEPARTMENT OVERVIEW:

The goal of the Case Management Department is to help members maintain optimum health and/or improved functional capability, educate members regarding their health and reinforce the PCP prescribed treatment plan. These efforts are anticipated to decrease costs and improve quality through focusing on the delivery of care at the appropriate time and in the appropriate setting.

Complex Case Management is the systematic coordination and assessment of care and services provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. Complex Case Management includes Basic Case Management. Basic Case Management means a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs. Services are provided by the Primary Care Physician (PCP) or by a PCP-supervised Physician Assistant (PA), Nurse practitioner (NP), or Certified Nurse Midwife, as the Medical Home. Coordination of carved out and linked services are considered basic case management services.

Members in the Complex Case Management Group and members assigned to the Case Management Team will be assigned a Nurse Care Manager and respective support staff. The team will focus on comprehensive coordination of services based on patient-specific needs to improve increase the quality and impact of the health care and supportive services the member is receiving. This will be accomplished through:

- Promotion and support of the Medical Home as the source of the member's primary healthcare and source of specialty referrals, and enhancing this with the necessary social, care management and medical support to facilitate comprehensive patient-centered planning
- Identification and elimination of potential barriers to seeking and receiving appropriate care within their designated medical home (e.g., housing, transportation, child care, nutrition, mental and behavioral health needs, identification of culturally competent providers and appropriate access, discharge and transitional care planning, health education, etc.)
    - Potential assessment and education modules may include:
        1. Social needs
        2. Medical and/or behavioral health home
        3. Appointment attendance
        4. Urgent symptom management
        5. Medication and treatment adherence
        6. Behavioral risk
        7. Condition-specific self-management

As a result of this assessment, the Case Manager will:

- Contact the Primary Care Physician as needed to identify areas where he/she would like assistance (e.g., improving medication compliance)
- Identify communication preferences when more than one provider is involved in the medical care (e.g., does the PCP prefer all coordination go through his/her office or should the disease manager reach out to the specialist as appropriate?)
- Determine the type and frequency of information the PCP wants going forward
- Develop the person-centered care plan in conjunction with the PCP using predictive modeling risk scores with clinical based rules and medical management platforms (e.g., Milliman Care Guidelines, KHS internal criteria, etc.)

The following processes and activities are in place for Case Management/Coordination of Care:

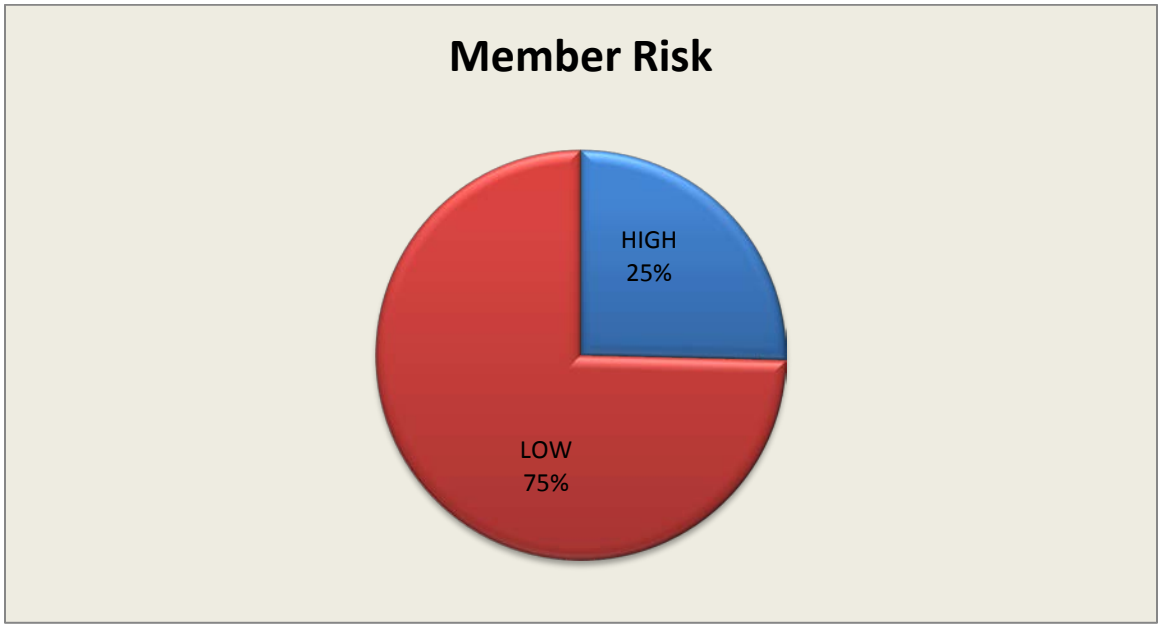
- Collaborate with PCPs for basic CM services
- Arrange and track referrals to specialists
- Track referrals and coordination of car for carved out and other out-of-network services and providers
- Identify community resources and refer members
- Offer health education services
- Implement continuous quality improvement activities

Case Management Team Staffing:

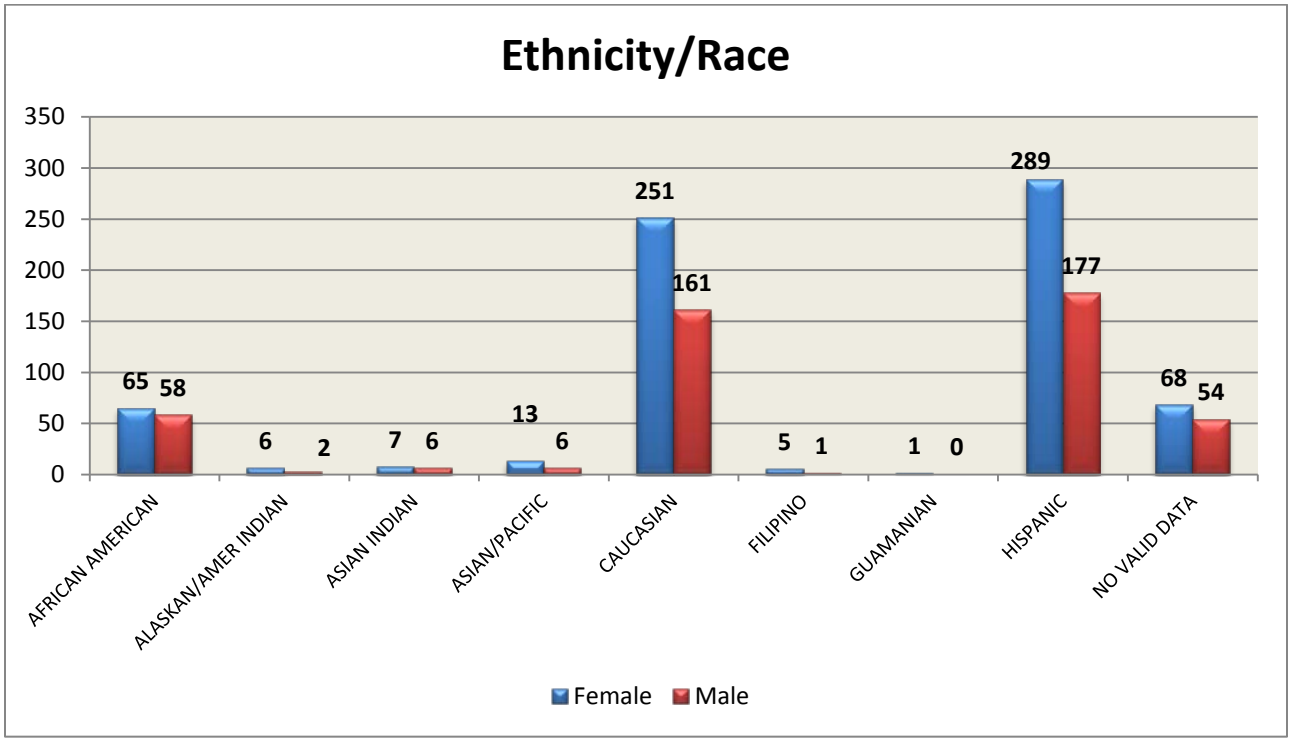
April -June 2017 Case Management Staffing:

Position	Quantity
Case Management RN	8
Case Management CMA's	6
Case Management MSW	6
Case Management Sr. Analyst and Trainer	1

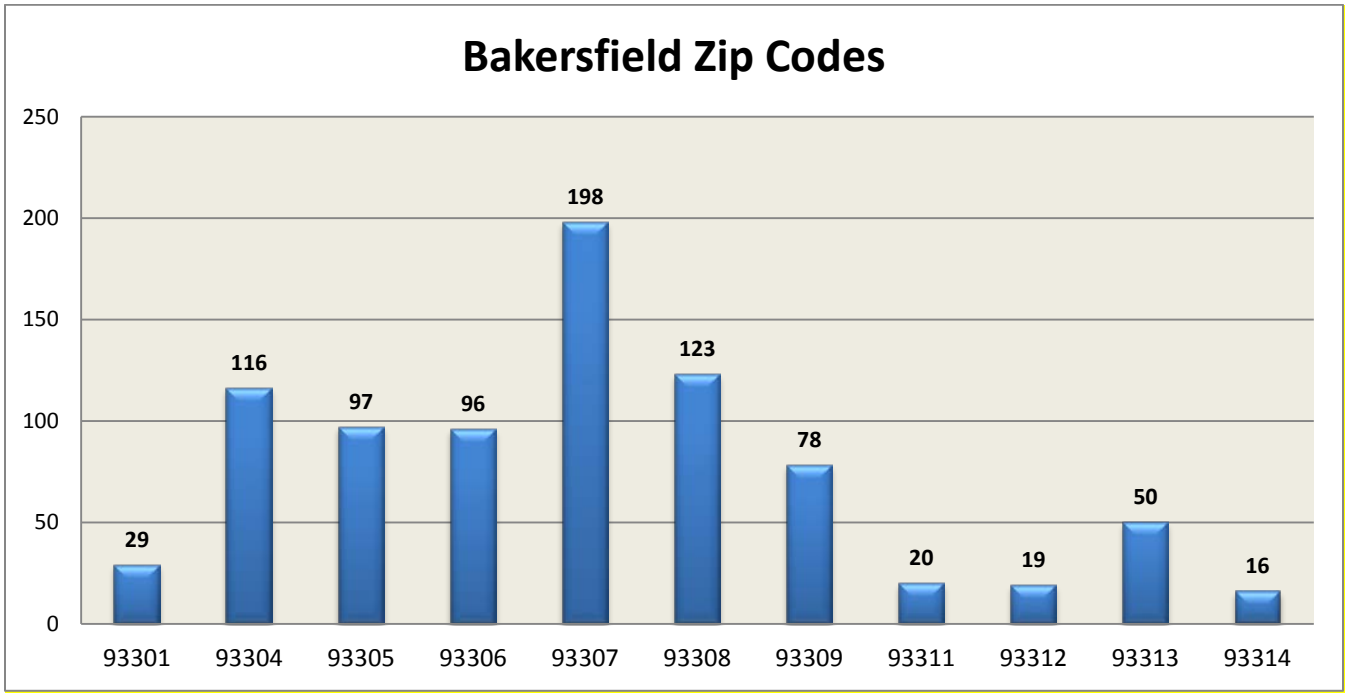
During this 2nd Quarter 2017, there were a total of 1,853 KFHC members that were managed by the CM staff department. The majority of the members at 75% are low risk.



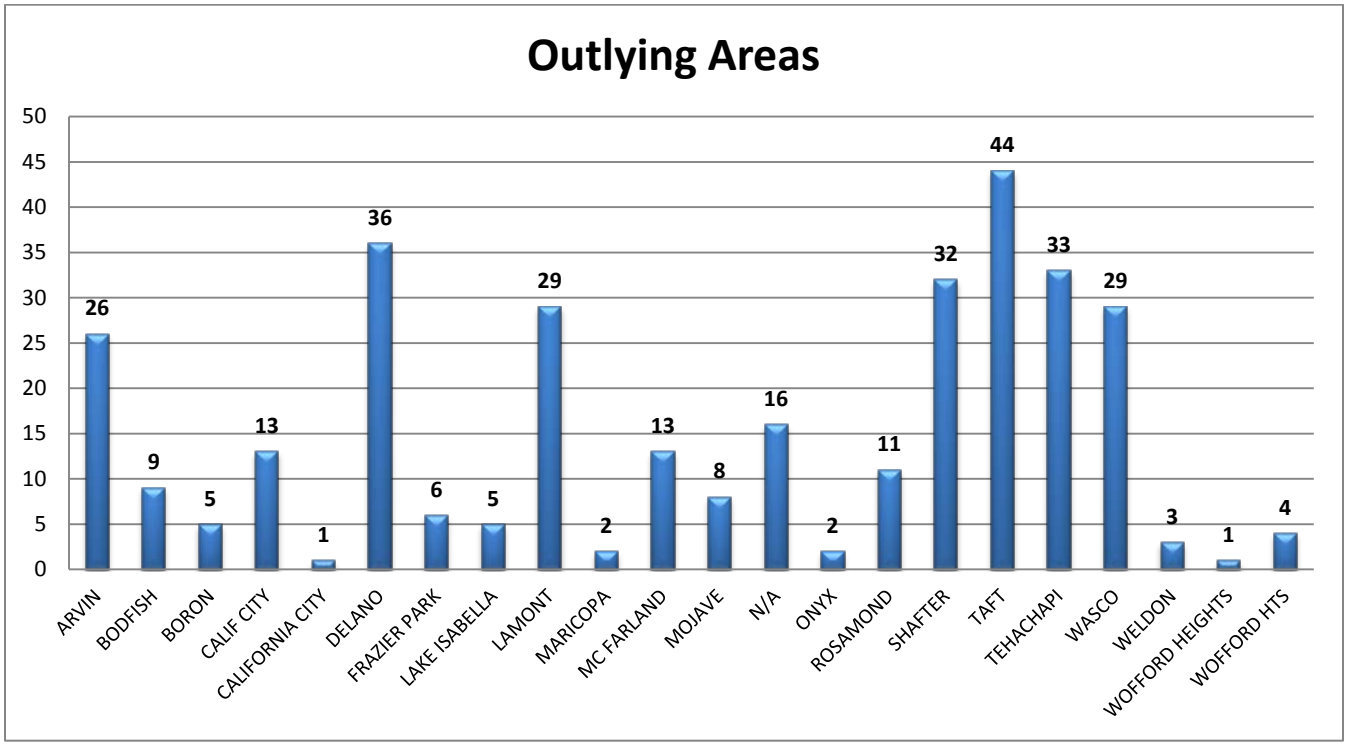
Majority of the members managed during the 2nd Quarter 2017 were female at 60%. The majority of the members managed this quarter at 40% are Hispanic.



The majority of the members that were managed during the 2nd Quarter 2017 reside in Bakersfield at 72%. Of the members from Bakersfield, the majority at 24% reside in the 93307 zip code.

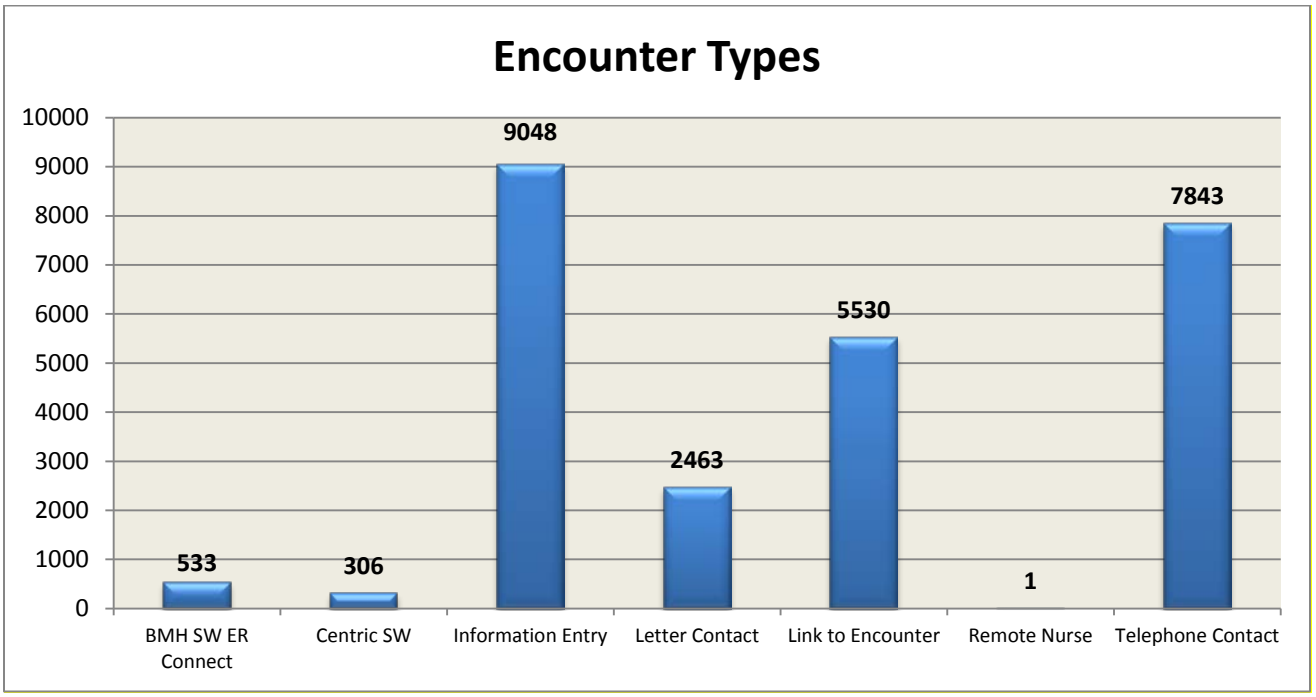


Of the outlying areas, majority of the members at 13% reside in Taft.

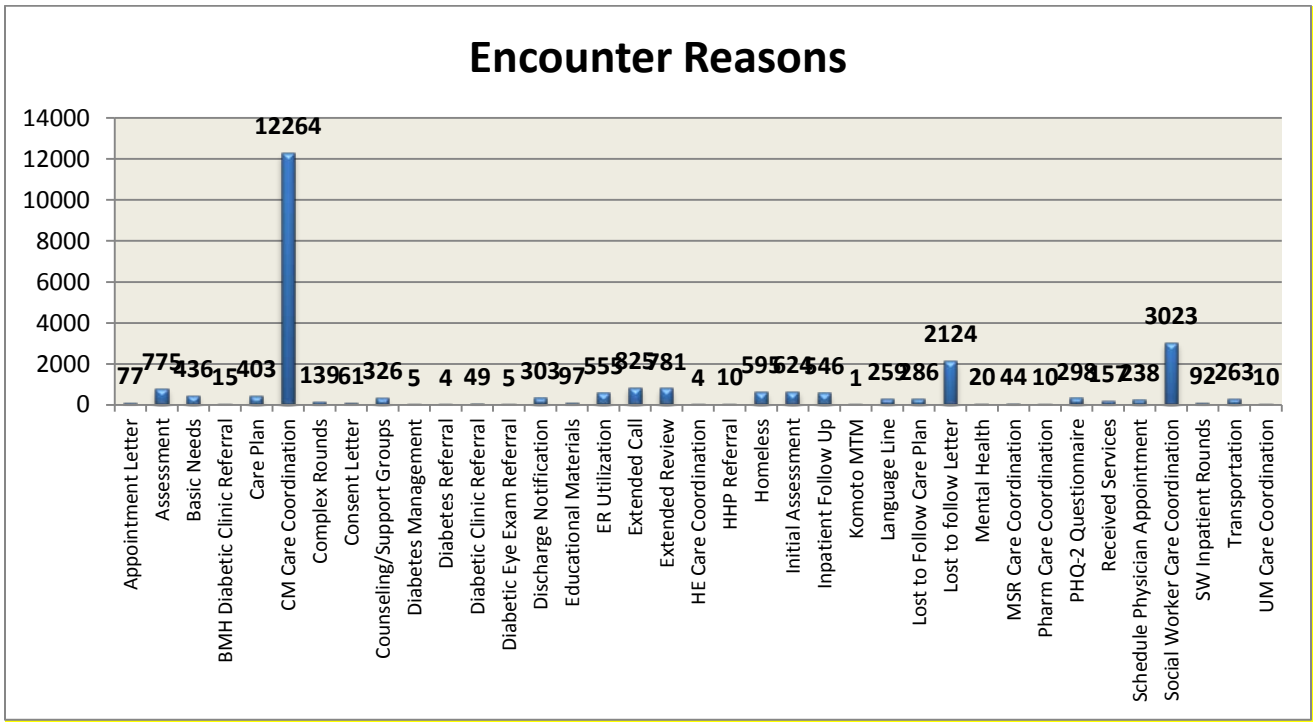


Encounters:

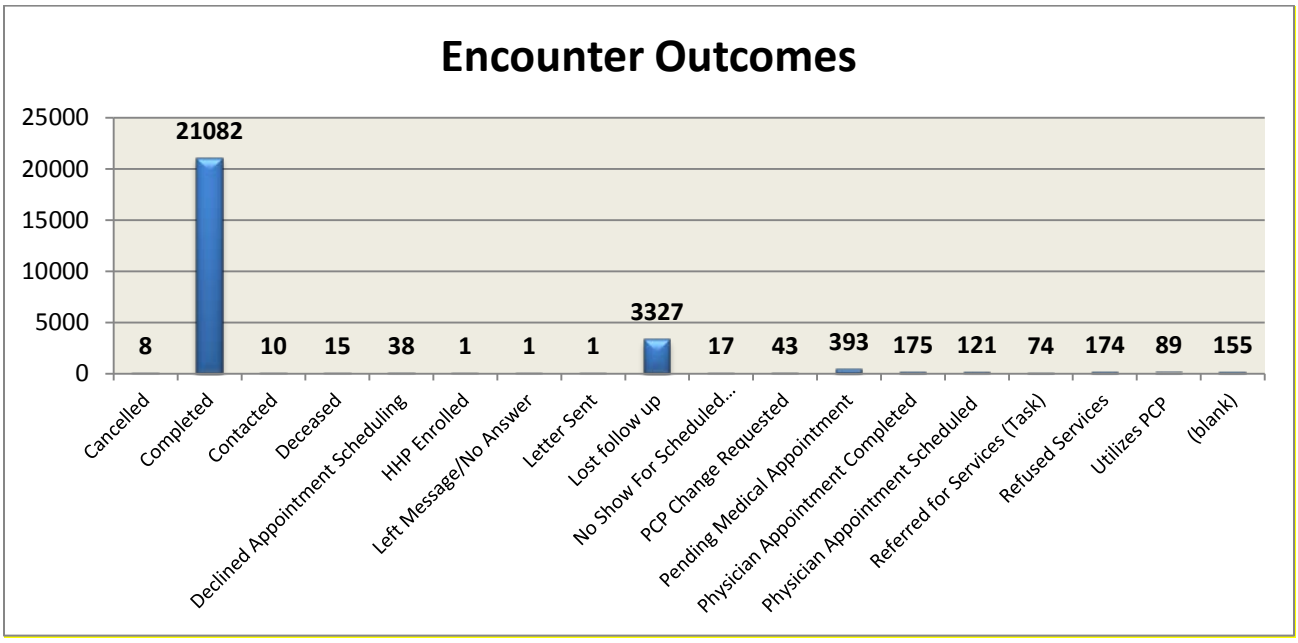
There were a total of 25,724 encounters submitted during the 2nd Quarter for 1,653 KFHC members and the majority of the encounter types were listed as Information Entry at 35%.



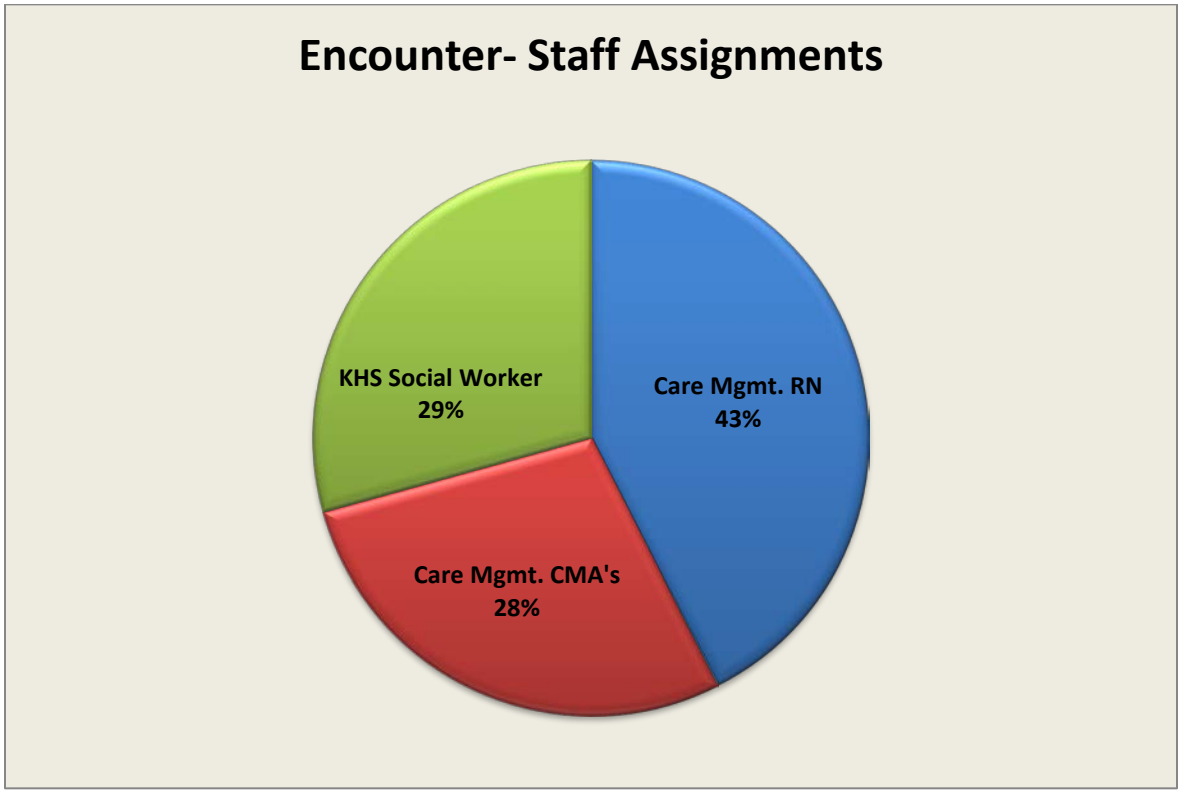
Majority of the encounter reasons at 48% was listed as CM Care Coordination.


Encounter Reasons
14000
12000
10000
8000
6000
4000
2000
0
77
775
436
15
403
12264
139
61
326
5
4
49
5
303
97
553
825
781
4
10
595
624
546
1
259
286
2124
20
44
10
298
157
238
3023
92
263
10
Appointment Letter
Assessment
Basic Needs
BMH Diabetic Clinic Referral
Care Plan
CM Care Coordination
Complex Rounds
Consent Letter
Counseling/Support Groups
Diabetes Management
Diabetes Referral
Diabetic Clinic Referral
Diabetic Eye Exam Referral
Discharge Notification
Educational Materials
ER Utilization
Extended Call
Extended Review
HE Care Coordination
HHP Referral
Homeless
Initial Assessment
Inpatient Follow Up
Komoto MTM
Language Line
Lost to Follow Care Plan
Lost to follow Letter
Mental Health
MSR Care Coordination
Pharm Care Coordination
PHQ-2 Questionnaire
Received Services
Schedule Physician Appointment
Social Worker Care Coordination
SW Inpatient Rounds
Transportation
UM Care Coordination

Majority of the encounter outcomes at 82% are listed as Completed.

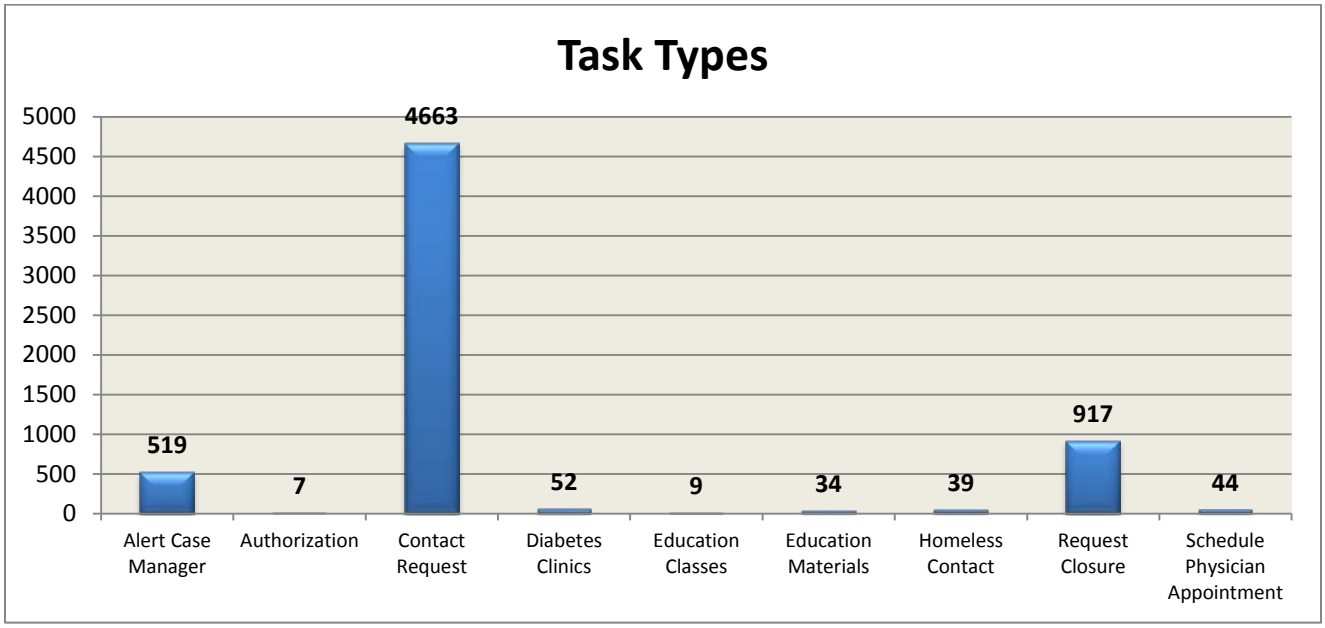


Majority of the encounters were completed by the Care Management RN's at 43%.

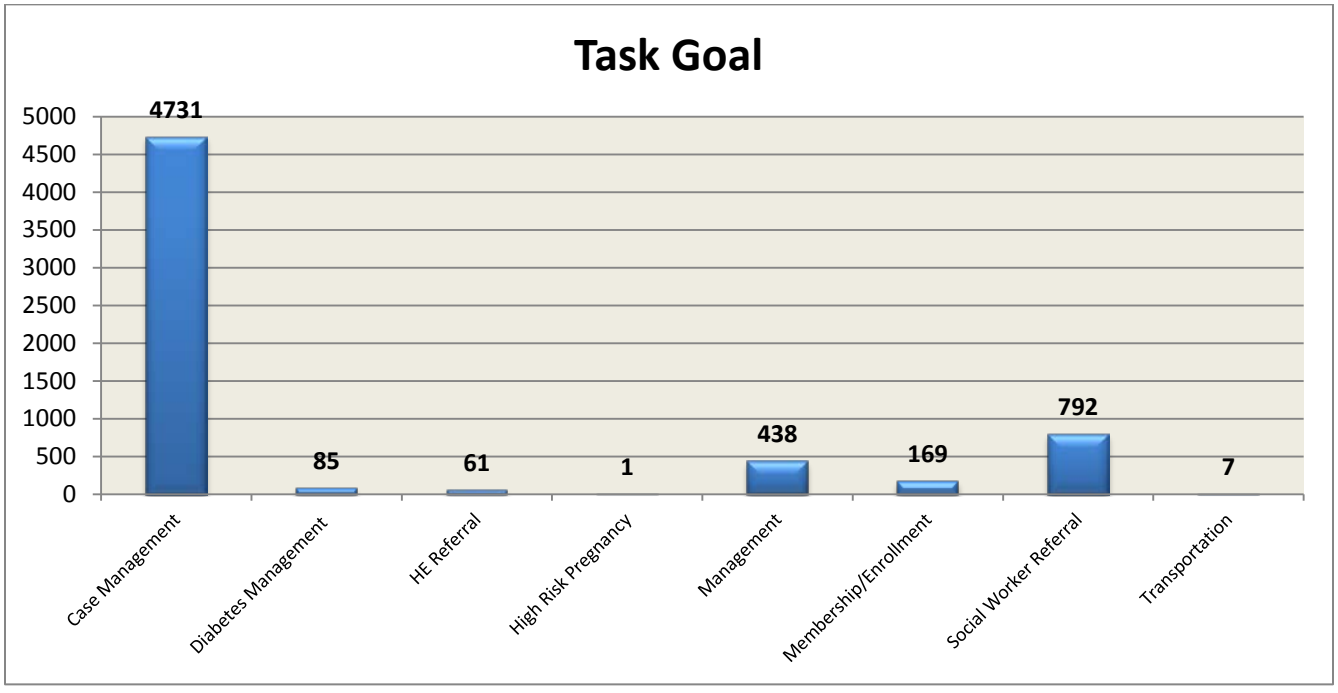


Tasks:

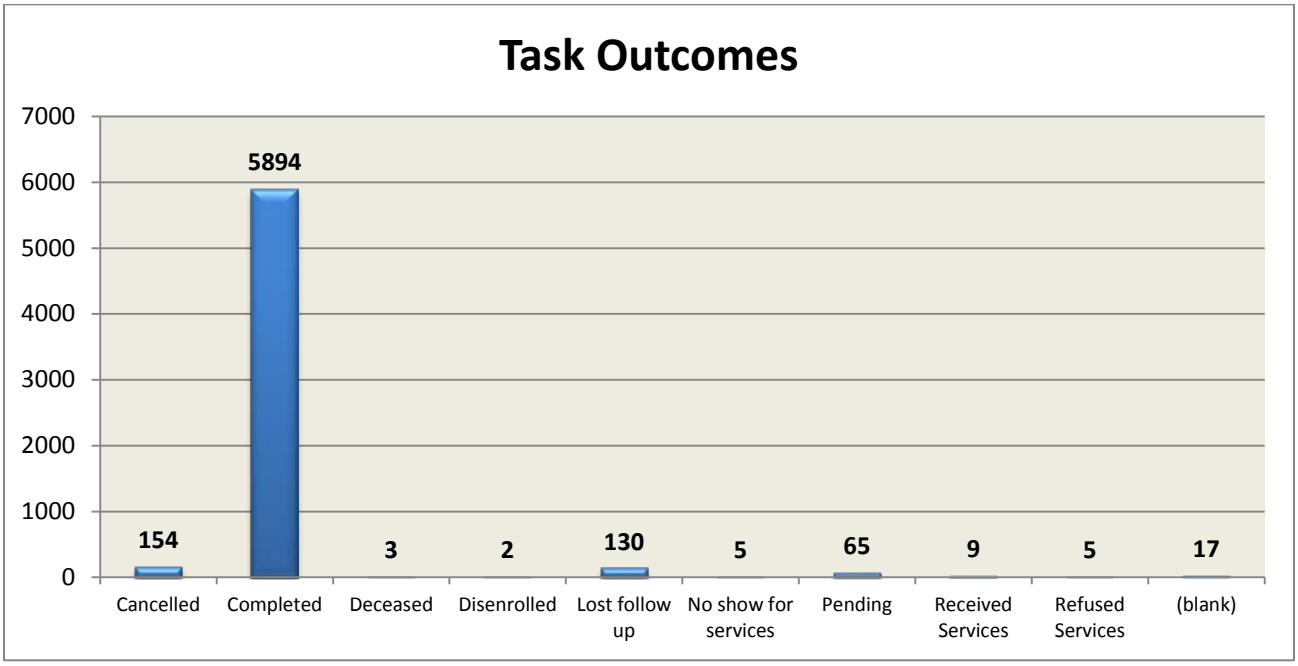
There were a total of 6,282 tasks submitted during the 2nd Quarter for 1,653 KFHC members. The majority of Task Types were Contact Request at 74%.



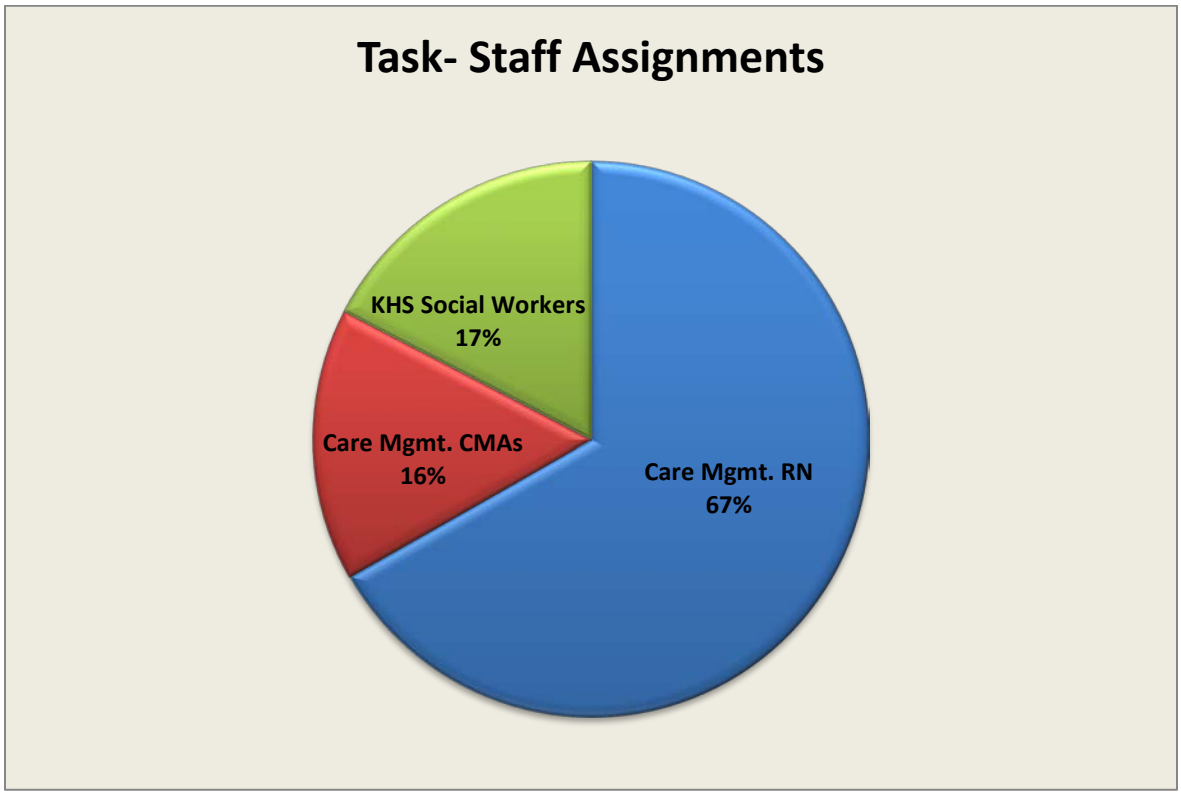
Majority of task goals during the 2nd Quarter at 75% were listed as Case Management.



Majority of the task outcomes at 94% are completed.



Majority of the tasks were assigned by the Case Management RN' at 67%.



Seniors and Persons with Disabilities (SPDs):

There were a total of 482 SPD members that were enrolled during the 2nd Quarter 2017, according to the high risk stratification report. Of the 482 SPD members, 23% are stratified as high risk.

There are a total of 13,001 SPD members to date. Of the 13,001 SPD members, 25% are stratified as high risk.

SPD Members are stratified into the Complex Case Management Group through use of the John Hopkins Predictive Modeler and represent on the average 48 percent of the Complex Group during the 2nd Quarter.

KERN HEALTH SYSTEMS
DISEASE MANAGEMENT DEPARTMENT QUARTERLY REPORT

Reporting Period: April 1, 2017 – June 30, 2017

DISEASE MANAGEMENT DEPARTMENT OVERVIEW:

Disease Management is a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant variables in achievement of desirable outcomes. Disease Management supports the physician or practitioner/member relationship and plan of care; emphasizes prevention of exacerbations and complications utilizing evidence-based practice guidelines, and member empowerment strategies, and; evaluates clinical, humanistic, and economic outcomes.

The Disease Management Department performs assessments, coordinates care, monitors and evaluates medical services for members with an emphasis on quality of care, continuity of services, and cost-effectiveness. The three program areas of the Disease Management Department are Diabetes and Hypertension, Asthma and High Risk Pregnancies.

Disease Management Department Staffing:

Position	Quantity
Disease Management RN	4
Disease Management SSC's	4

Case Manager RN Caseload:

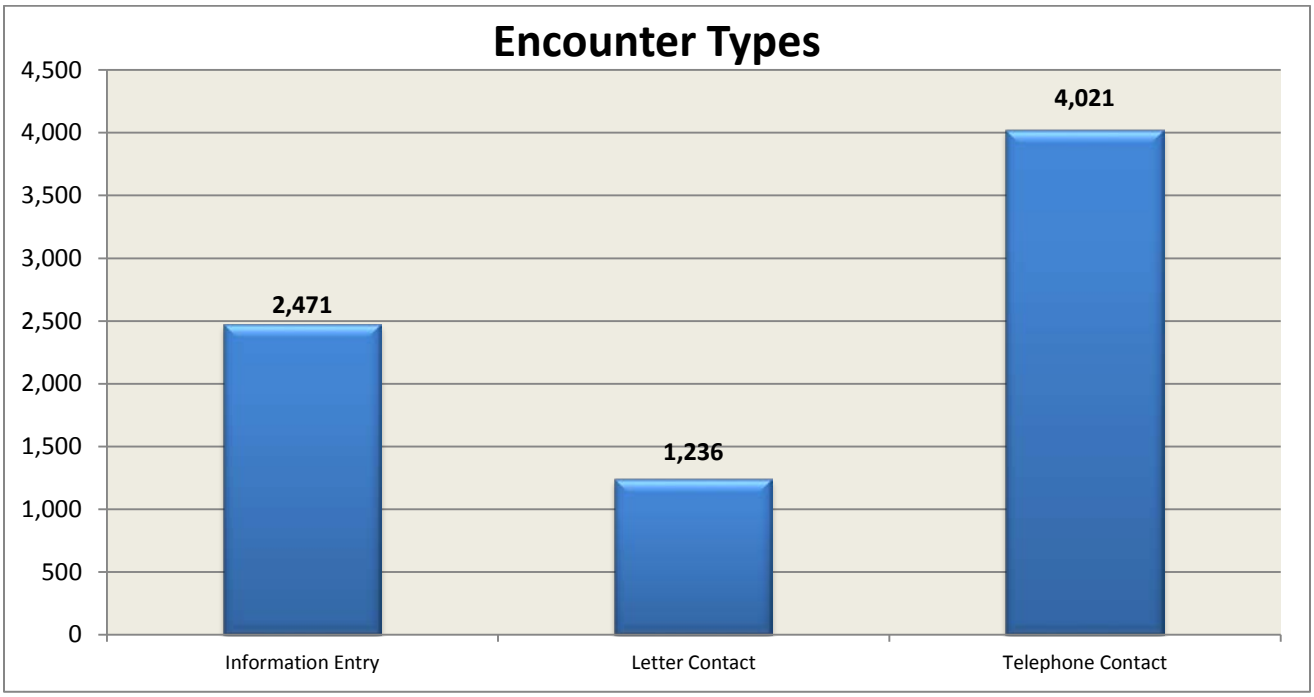
Staff	Caseload
RN 1	161
RN 2	152
RN 3	81
RN 4	108
TOTAL	502

DM Program Caseload:

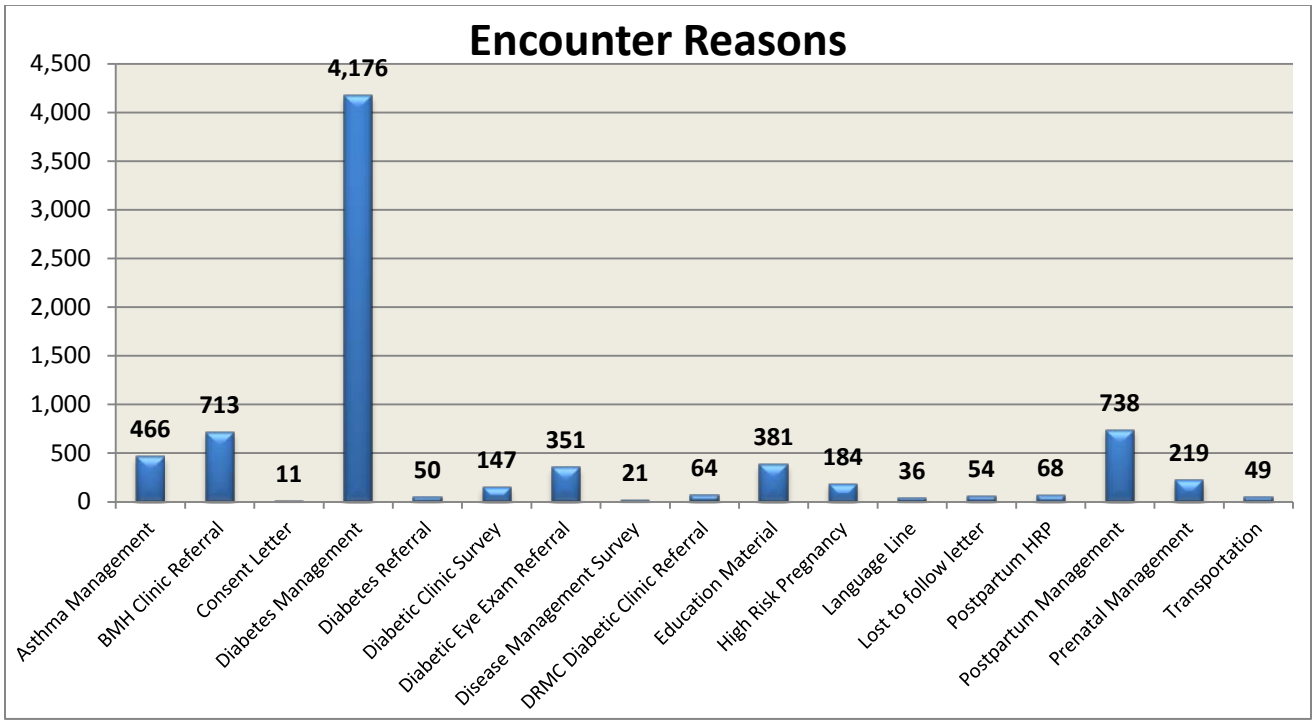
DM Program	Caseload
Asthma	114
Diabetes and Hypertension	370
High Risk Pregnancy	18
TOTAL	502

Encounters:

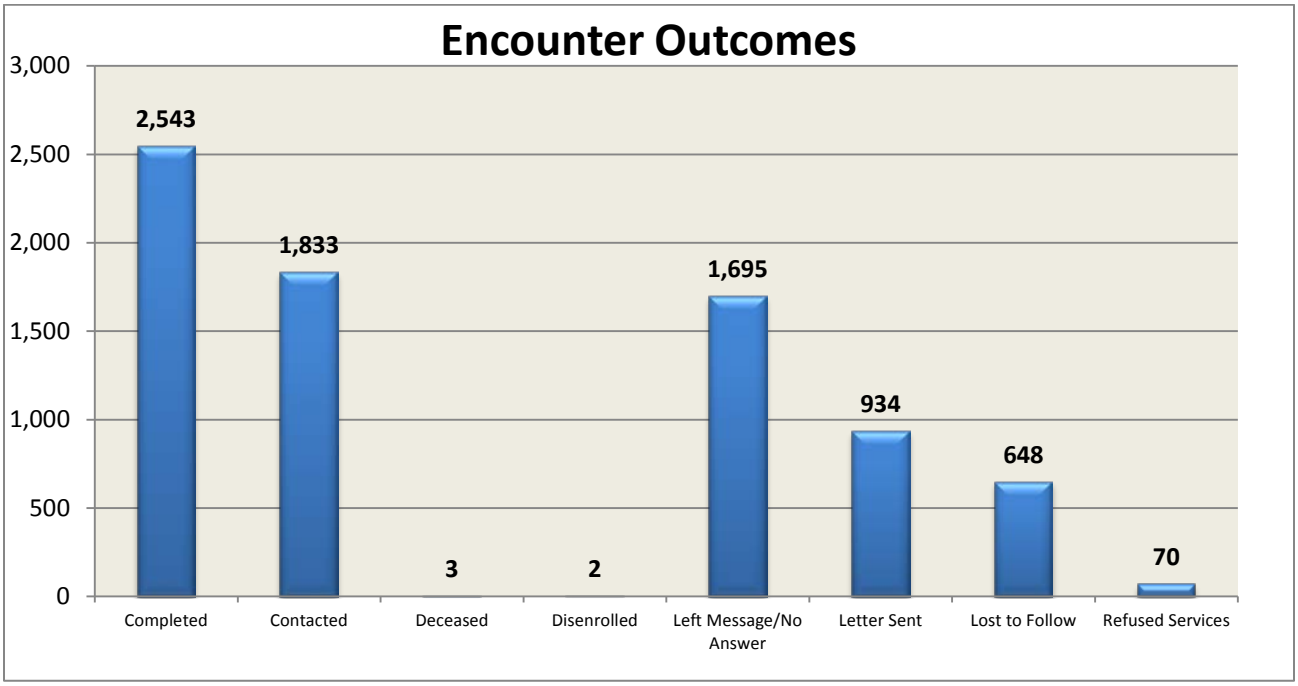
There were a total of 7,728 encounters submitted during this quarter for 2,261 KFHC members and the majority of the encounter types were listed as a Telephone Contact at 52%.



The majority of the encounter reasons at 54% was listed as Diabetes Management.

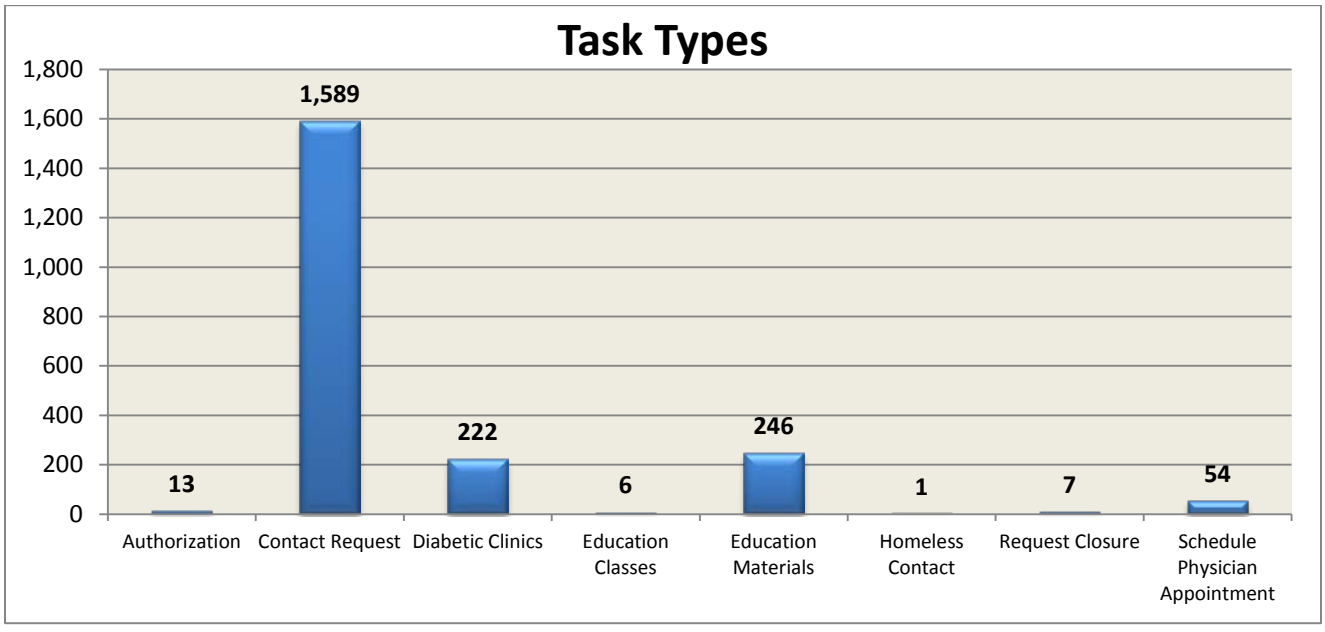


The majority of the encounter outcomes at 33% are listed as completed.

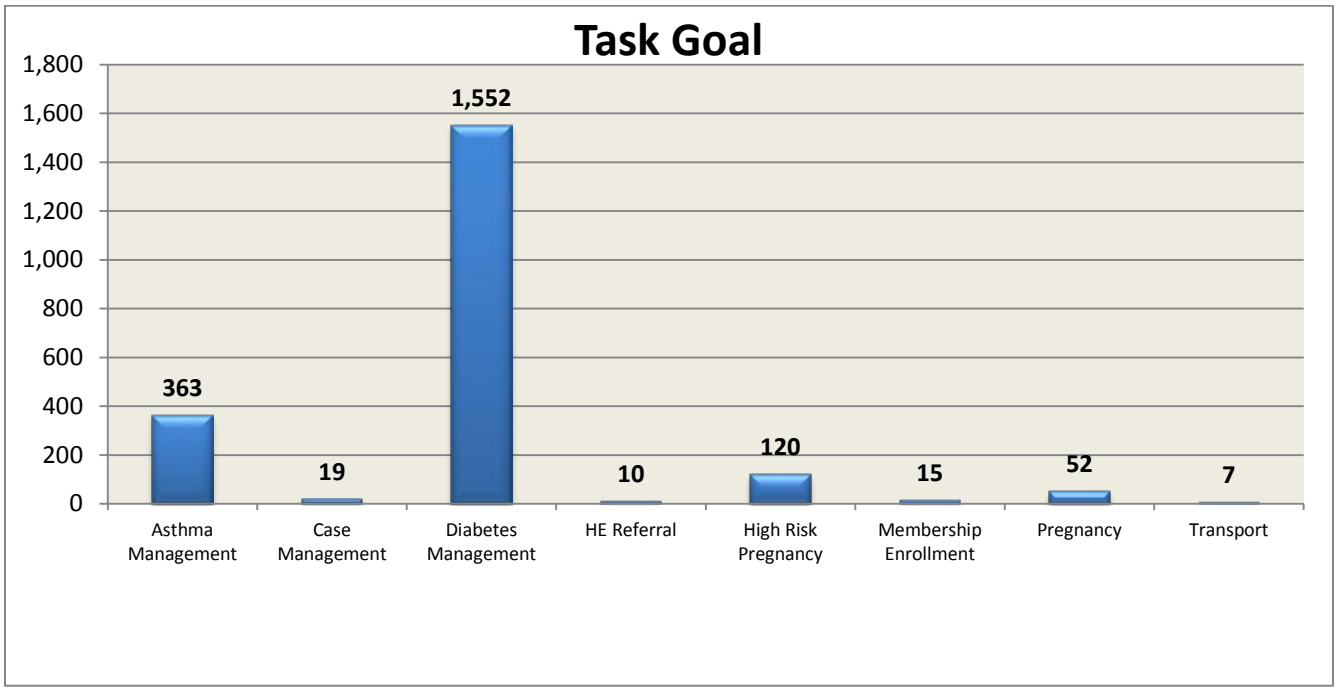


Tasks:

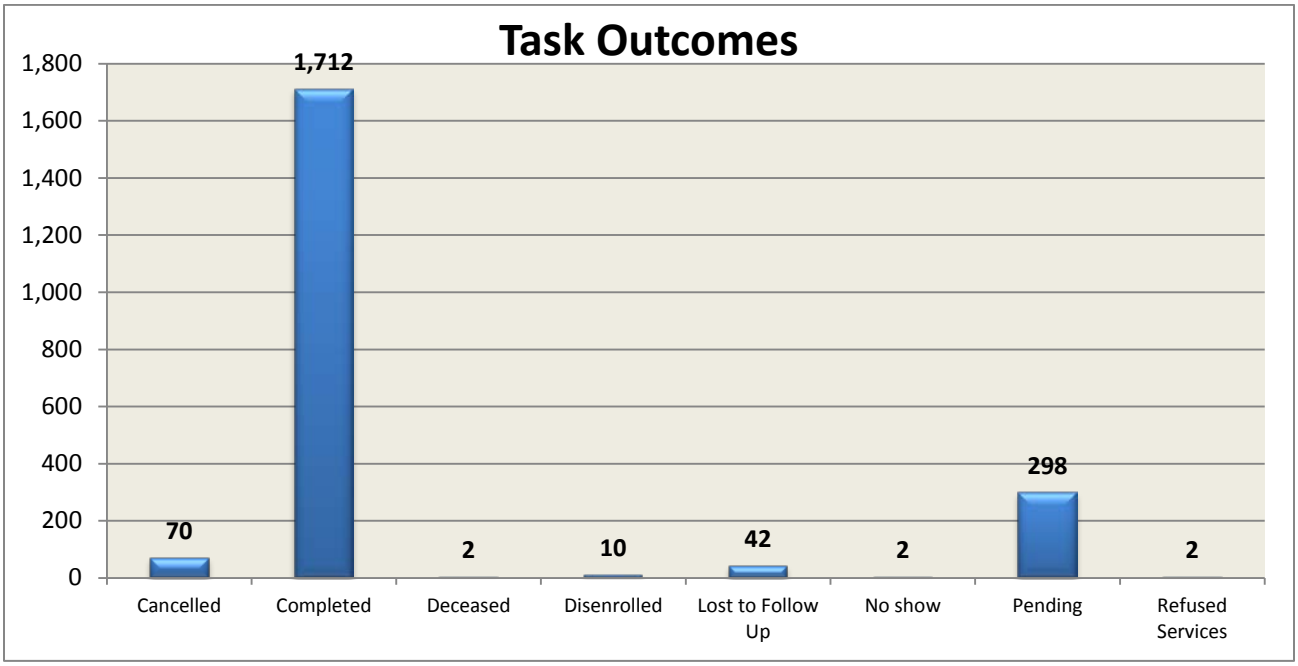
There were a total of 2,138 tasks assigned to the Disease Management department during the quarter for 1,256 KFHC members. The majority of Task Types were Contact Request at 74%.



The majority of task goals at 73% was listed as Diabetes Management.

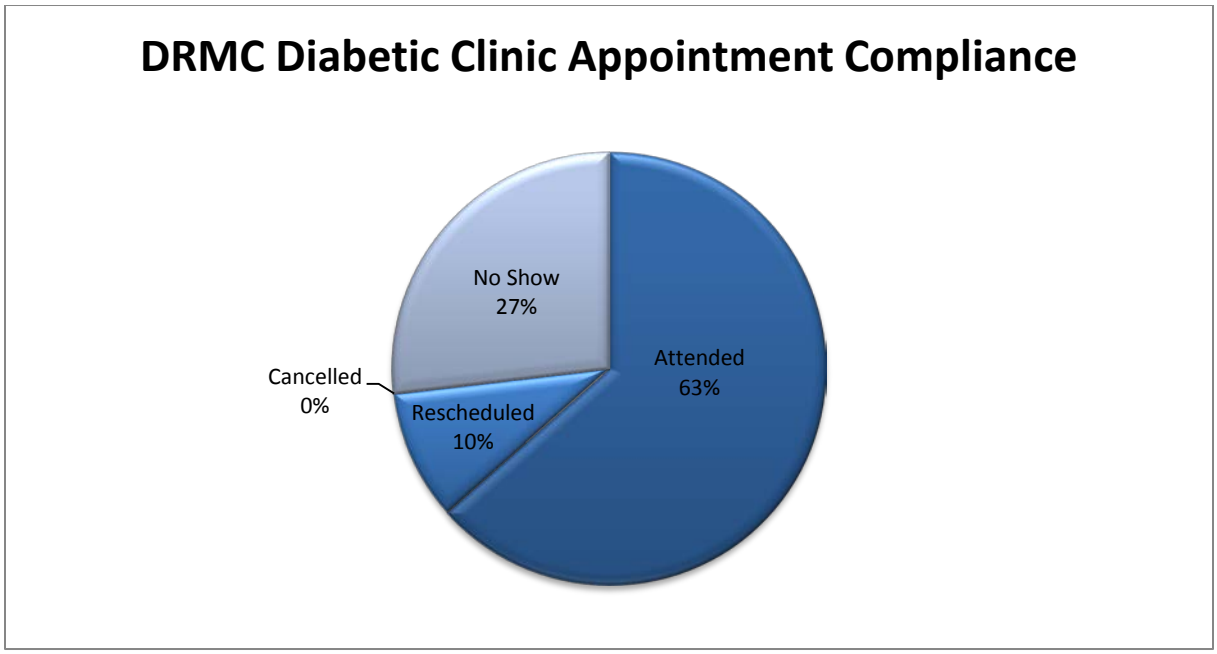


The majority of the task outcomes at 80% are completed.



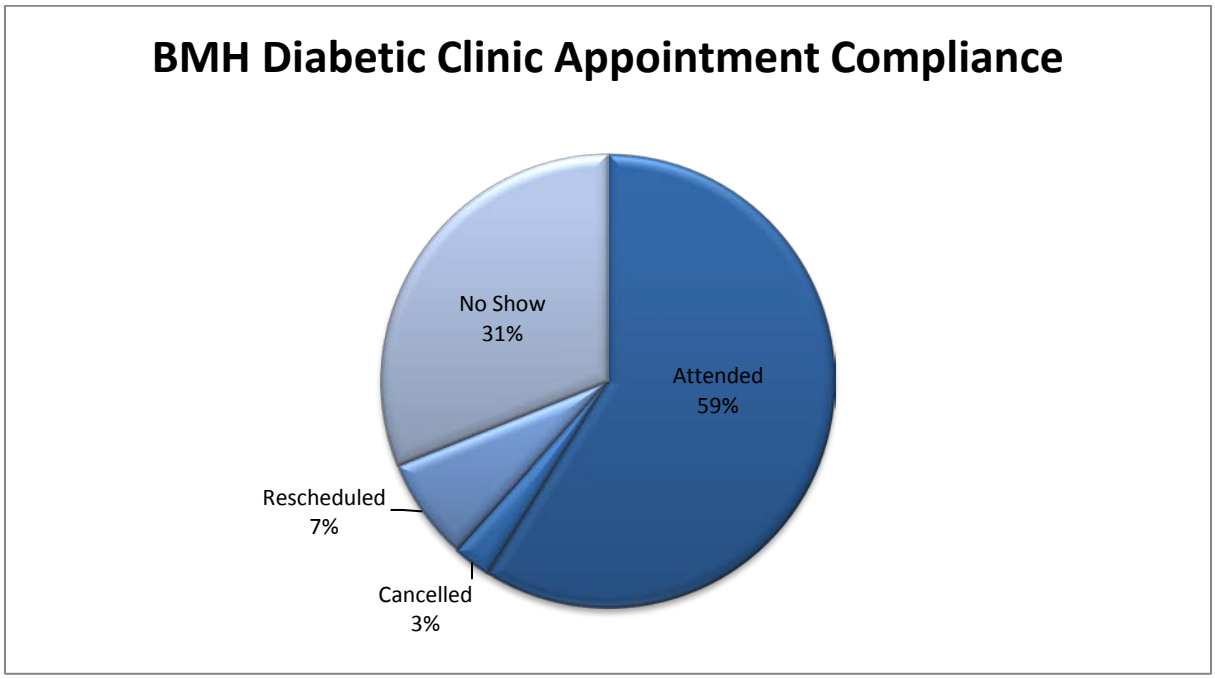
Delano Regional Medical Center (DRMC) Diabetic Clinic

Appointment compliance at the DRMC Diabetic Clinic revealed 63% of members attended their scheduled appointment.



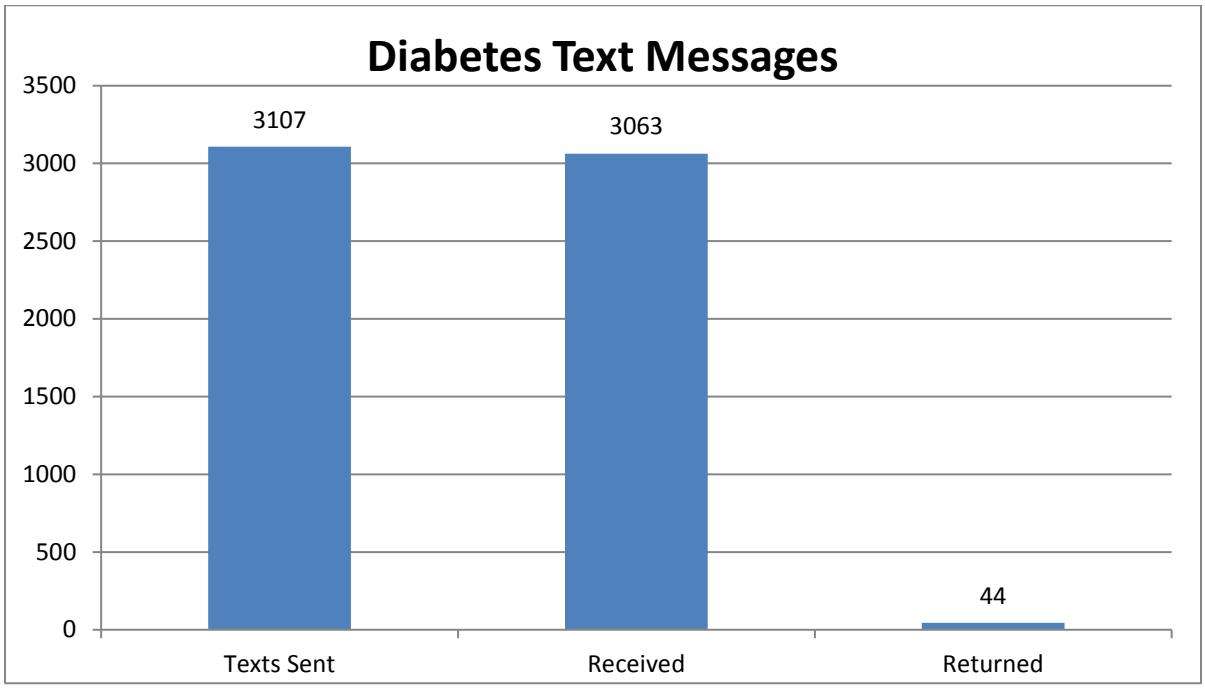
Bakersfield Memorial Hospital (BMH) Diabetic Clinic

Appointment compliance at the BMH Diabetic Clinic revealed 59% of members attended their scheduled appointment.



Diabetes Text Messaging Program

Thirteen diabetes related text messages, totaling 3,107 were sent to members during this quarter. 98.6% of those messages were successfully received by the members.



Propeller Asthma Management Pilot

The one year trial period has ended. KHS' Disease Management Department and Dignity Health partnered with Propeller Health to pilot a digital asthma management program for 20 KHS members with asthma. Through the use of medication sensors, mobile applications and an online dashboard, KHS was able to track the frequency of the controller and rescue asthma inhalers used by each participating member, receive email notifications when a member was identified as in poor control of his/her asthma and identify the geographic location of where the member used their medication (smartphone enrolled members only). Members did not need internet access or a smartphone to participate. By the end of the trial period, 15 members were actively engaged in this pilot and were sending data to the online patient health dashboard hosted by Propeller Health.

Automated Reminder Calls

KHS sends automated reminder calls to members in need of completing specific health actions. During this quarter, there were no automated reminder calls sent with regards to diabetes related screenings.

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Alcohol and Substance Abuse Treatment Services				POLICY #: 3.10-P	
DEPARTMENT: Health Services - Utilization Management					
Effective Date: 08/1997	Review/Revised Date: 04/17/2017	DMHC	X	PAC	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

Douglas A. Hayward
Chief Executive Officer — Date 4/07/17

Chief Medical Officer — Date

Chief Operating Officer — Date 4/17/17

Director of Claims — Date 4/17/17

Administrative Director of Health Services — Date 4/14/17

POLICY:

Alcohol and substance abuse treatment services available under the Short-Doyle Medi-Cal (SDMC) program as defined in Title 22, Section 51341.1, outpatient heroin detoxification as defined in Title 22, Section 51328 are excluded from the Kern Health Systems (KHS) Medi-Cal contract,[1] and the implementation of covered tobacco cessation services.

KHS providers will make best efforts to identify members requiring alcohol, tobacco cessation or substance abuse treatment services. Providers will arrange their referral to the Kern County Behavioral and Recovery Services (KCBRS) for appropriate services provided through the Alcohol and Other Drugs Program, including outpatient heroin detoxification providers.[2]

To design and define systematic methods to identify and refer KHS plan members requiring alcohol and drug treatment services to KCBRS, and to identify, treat and refer KHS plan members for covered tobacco cessation services.

PROCEDURE:

1.0 ACCESS

KHS, KHS Contracted Providers and KCBRS work collaboratively to coordinate referrals for chemical dependency and tobacco cessation services. Primary Care Providers (PCPs) identify members requiring chemical dependency and tobacco cessation services through evaluations during office visits or during the initial health assessment. PCPs refer members to KHS, KCBRS or to community and volunteer organizations within the community as appropriate.

KCBRS referrals should be made to the following address and/or phone number:

Kern County Behavioral and Recovery Services
2001, 28th Street
Bakersfield, California 93301
(661) 868-6600
24 hour crisis intervention (661) 868-8000

KHS assists members in locating available treatment service sites.[3] To the extent that treatment slots are not available in the KCBRS Alcohol and other Drugs Program, KHS pursues placement outside of Kern County.[4]

2.0 PROVISION OF SERVICES

2.1 Chemical Dependency

KHS covers psychotherapeutic medications, on the KHS formulary or approved with a TAR, prescribed by PCPs or KCBRS psychiatrists. Psychotherapeutic medications listed in Bulletin #420 are excluded from KHS coverage and should be billed to Fee-For-Service Medi-Cal.

KHS covers the History and Physical examination by a contract PCP if indicated prior to outpatient detoxification services and any associated laboratory studies.

Chemical dependency services are provided by and are the responsibility of KCBRS.

In addition to the SHA, the Primary Care Provider (PCP) must administer a Screening, Brief Intervention, Referral and Treatment (SBIRT) questionnaire to determine if alcohol use requires additional treatment beyond the scope of the Primary Care Provider. If answers to specific questions indicate the need for expanded treatment modalities beyond the brief interventions of three 15 minute sessions in person or by phone by the PCP, a second screening test such as the Audit C will be performed and can be billed separately as a screening tool. Once the need for additional services is determined, the PCP will refer the member to the County System of Care for expanded services covered under Medi-Cal Fee-For-Service.

Coordination of services will follow guidelines outlined in the Memorandum of Understanding (MOU).

Providers performing the SBIRT questionnaire must attest to having completed the required hours of professional experience and specific training on the SBIRT under the recommendations of the US Preventative Services Task Force (USPSTF).

2.2 Tobacco Cessation

KHS covers comprehensive tobacco cessation services including Federal Drug Administration (FDA) approved medication and individual, group and telephone counseling.

2.2.1 FDA-Approved Tobacco Cessation Medication (for non-pregnant adults of any age)

KHS covers all FDA-approved tobacco cessation medications for adults who use tobacco products. This includes over-the-counter medications with a prescription from the provider per the below table. At least one FDA-approved tobacco cessation medication is available without prior authorization.

Medication	Prescription Needed
Buproprian SR	Yes
Varenicline	Yes
nicotine gum	No
nicotine inhaler	Yes
nicotine lozenge	No
nicotine nasal spray	Yes
nicotine patch	No*

*A prescription generic version is also available

- KHS will provide a 90-day treatment regimen of medications without other requirements, restrictions, or barriers.
- KHS will cover any additional medications once approved by the FDA to treat tobacco use.
- KHS will not require members to receive a particular form of tobacco cessation service as a condition of receiving any other form of tobacco cessation services.
- While counseling is encouraged, KHS will not require members to attend classes or counseling sessions prior to receiving a prescription for an FDA-approved tobacco cessation medication.

2.2.2 Individual, Group, and Telephone Counseling for Members of Any Age Who Use Tobacco Products

KHS collaborates with county tobacco control program(s) to identify other local group tobacco cessation counseling resources.

According to and as required by APL 16-014, KHS will:

- Ensure that individual, group, and telephone counseling is offered to members who wish to quit smoking, whether or not those members opt to use tobacco cessation medications;
- Ensure that providers review the SHA's questions on tobacco use with members which

will constitute individual counseling when the conditions in Policy Letter (PL) 13-001 are met;

- Encourage that providers or other office staff use the "5 A's" (**A**sk, **A**dvise, **A**ssess, **A**ssist, and **A**rrange), the "5 R's" (**R**elevance, **R**isks, **R**ewards, **R**oadblocks, and **R**epetition), or other validated behavior change models when counseling members;
- Ensure that a minimum of four (4) counseling sessions of at least ten (10) minutes in duration are covered for at least two separate quit attempts per year without prior authorization. MCPs must offer individual, group, and telephone counseling without cost to the members;
- Ensure that providers refer members to the California Smokers' Helpline (1-800-NO-BUTTS), a free statewide quit smoking service operated by the University of California San Diego (see below) or other comparable quit line services; and
- Encourage providers to use the Helpline's web referral, or if available, the e-referral systems.

2.2.3 Services for Pregnant Women

Because of the serious risk of smoking to the pregnant smoker and fetus, whenever possible, pregnant members should be offered tailored, one-on-one counseling exceeding minimal advice to quit smoking.

KHS will require that providers will, at a minimum:

- Ask all pregnant women if they use tobacco or are exposed to tobacco smoke. Pregnant members who smoke should get assistance with quitting throughout their pregnancy.
- Offer all pregnant smokers at least one face-to-face counseling session per quit attempt. Face-to-face tobacco-cessation counseling services may be provided by or under supervision of a physician, legally authorized to furnish such services under state law.
- Refer pregnant members who use tobacco to a tobacco cessation quit line, such as the Helpline. These tobacco cessation counseling services are covered for 60 days after delivery, plus any additional days needed to end the respective month.
- Refer to the tobacco cessation guidelines provided by the American College of Obstetrics and Gynecology (ACOG) before prescribing tobacco cessation medications during pregnancy. KHS shall post ACOG guidelines on the KHS website for providers.

2.2.4 Prevention of Tobacco Use in Children and Adolescents

KHS will cover medically necessary tobacco cessation services to members, including counseling and pharmacotherapy, as required for children up to age 21 under Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.

Coverage includes the provision of anticipatory guidance and risk-reduction counseling regarding tobacco use.

KHS requires that primary care providers provide interventions, including education or counseling, in an attempt to prevent initiation of tobacco use in school-age children and adolescents. Services shall be provided in accordance with the American Academy of Pediatrics Bright Futures periodicity schedule and anticipatory guidance, as periodically updated.

3.0 CASE MANAGEMENT AND COORDINATION OF CARE

KHS continues to cover and provide primary care and other services unrelated to the alcohol and substance abuse treatment.[5] KHS coordinates services between the PCP and the treatment programs.[6]

3.1 PCP and KCBRS Chemical Dependency Provider Responsibilities

KHS PCPs forward pertinent medical records/documentation to KCBRS. KCBRS providers are responsible for communicating with the member's PCP as needed and appropriate and for supplying the PCP with appropriate medical records/documentation.

KHS PCPs are responsible to monitor that the member is following up with chemical dependency appointments. KHS Case Mangers assist PCPs who are encountering difficulty referring members for services or who are having difficulty with non-compliant members, by contacting the member/KCBRS to determine the nature of the difficulty and intercede/facilitate as needed.

KHS Providers continue to provide care for the physical health of the member, and the PCP communicates with the member's chemical dependency provider as needed and appropriate.

After consultation with the member's PCP, the KCBRS chemical dependency provider refers the member back to the PCP for ongoing care at such time that it is determined that the member no longer requires care from the KCBRS provider. The PCP provides ongoing medical care and refers back to KCBRS for chemical dependency follow-up as needed.

3.1.2 Hospitalization of a Member

If a member is hospitalized for chemical dependency services and requires medical treatment, the admitting chemical dependency Provider will contact the PCP for consultation and development of treatment plan. Members who require transfer to a medical bed for treatment of a medical condition are transferred by the PCP to the appropriate level of acute care. The chemical dependency provider continues to consult with the PCP regarding treatment of the member. When medically stable, the member is either discharged by the PCP with appropriate follow-up by KCBRS chemical dependency provider and the PCP, or transferred back to the inpatient treatment facility by the chemical dependency provider. Upon discharge, the member is instructed to follow-up with the KCBRS chemical dependency provider and the PCP, as appropriate.

3.1.3 KHS and KCBRS Liaisons

There is a designated liaison for KHS who serves as the liaison for KCBRS. Issues which require resolution are directed to these individuals for discussion and problem resolution

3.2.1 Identifying Tobacco Users

PCP's are responsible for identifying and tracking tobacco users. KHS will monitor provider compliance for identifying tobacco users and will utilize track tobacco users for better coordination of tobacco cessation benefits as required through the review of:

- PM160's

- The SHA during chart reviews
- The NME program

All reviews resulting in identified tobacco users are forwarded to the Health Education Department.

3.2.2 Tracking Treatment Utilization of Tobacco Users

KHS will track treatment utilization of tobacco use through the review of utilization data from the *Tobacco Registry Report* (See Attachment A) that includes internal data from provider and pharmacy claims encounters.

4.0 PROVIDER AND MEMBER EDUCATION

4.1 Chemical Dependency Provider Education

KHS providers are educated regarding chemical dependency carve-outs, PCP responsibilities, and referral procedures through Provider Orientations and the *Provider Administrative Manual.*

4.2 Tobacco Cessation Member Education

KHS will provide information to members who use tobacco about the availability of tobacco cessation services and identify those that are provided at no cost. Members are given the option of choosing which services to use. Additionally, KHS coordinates with the agency providing the tobacco cessation services to pay for the cost of the member to receive those services.

4.3 Tobacco Cessation Provider Education

KHS will use the USPHS "Clinical Practice Guideline, Treating Tobacco Use and Dependence: 2008 Update," for provider training on tobacco cessation treatments. This document informs and educates clinicians regarding effective strategies and approaches for providing tobacco cessation treatment for all populations, including specific recommendations for pregnant women. KHS will encourage providers to implement the USPHS' comprehensive tobacco use treatment recommendations.

KHS will include tobacco cessation training with other provider trainings as required in DHCS contracts. These trainings must include:

- Requirements for comprehensive tobacco cessation member services included in this policy in accordance with APL 16-014;
- Overview of the "Clinical Practice Guideline, Treating Tobacco Use and Dependence: 2008";
- How to use and adopt the "5 A's", the "5 R's", or other validated model for treating tobacco use and dependence in the provider's clinic practice;
- Special requirements for providing services for pregnant tobacco users; and
- Advising providers about available online courses in tobacco cessation. These resources are posted on the KHS website.

5.0 CONFIDENTIALITY

KHS and KHS contracted providers will maintain and protect the confidentiality of members' medical information regarding inpatient and outpatient alcohol and drug services.

Confidentiality of member information is described in *KHS Policy and Procedure #2.27 - Medical Records and Other Protected Health Information - Content, Maintenance, and Security and KHS Policy and Procedure #2.28-P: Medical Records and Other Protected Health Information – Privacy, Use, and Disclosure.*

ATTACHMENTS

- ❖ Attachment A: Tobacco Registry Report

REFERENCE:

[1] **Revision 2017-04:** Policy revised to comply with ALP 16-014. Titles updated. **Revision 2014-08:** Policy submitted as part of DMHC Mental Health Carve-In(12-2013) Material Modification. DMHC approval pending as of 08/2014. **Revision 2009-03:** Routine revision. **2005-11:** Routine review. Policy reviewed against DHS Contract 03-76165 (Effective 5/1/2004).
[2] DHS Contract A-11 (6)
[3] DHS Contract A-11 (6)
[4] DHS Contract A-11 (6)
[5] DHS Contract A-11 (6)
[6] DHS Contract A-11 (6)

KERN HEALTH SYSTEMS

Governed Reporting System

Attachment A

Tobacco Registry Report

Report captures all members who meet criteria used to identify tobacco users on or after 1/1/16

Member Source ID	Tobacco User	Pregnant Tobacco User	Prior Tobacco User	Cessation Product	Cessation Counseling	Tobacco Exposure	Newborn Tobacco Exposure	New Member Question	Number of Conditions Met
MEMBER#	Y	N	Y	N	N	N	N	N	2
MEMBER#	N	Y	N	Y	Y	Y	N	Y	1
MEMBER#	Y	N	Y	N	N	N	N	N	5

Tobacco Registry Report

Report captures all members who meet criteria used to identify tobacco users on or after 1/1/16

Member Source Id	Member Group Name	Referral Date	Language	Member Effective Date	Member Name	Date of Birth	Address	City	State	Zip	Current Age	Provider ID	Provider Name	Member Region	Home Phone	Number of Flags	First Date	Last Flag Updated	DOS	Last Update Paid
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	CA	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	CA	[illegible]	45	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	CA	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Mental Health Services				POLICY #: 3.14-P	
DEPARTMENT: Health Services - Utilization Management					
Effective Date: 10/2000	Review/Revised Date: 04/17/2017	DMHC		PAC	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

Douglas A. Hayward
Chief Executive Officer — Date 4/17/17

Chief Medical Officer — Date

Chief Operating Officer — Date 4/17/17

Director of Claims — Date 4/17/17

Administrative Director of Health Services — Date 4/14/17

POLICY[1]:

All specialty mental health services or Serious Emotional Disorders (inpatient and outpatient) are carved out of the Medi-Cal Product contract and are therefore excluded from Kern Health Systems (KHS) coverage.[2] KHS shall cover outpatient mental health services that are within the scope of practice of Primary Care Providers[3] or when performed for mild to moderate mental health conditions on an outpatient basis by a licensed mental health provider. Members who need specialty mental health services are referred to and are provided mental health services by an appropriate Medi-Cal Fee-For-Service (FFS) mental health provider or to the local mental health plan for specialty mental health services.[4]

Treatment for Serious Emotional Disturbances is provided by the Kern County Behavioral and Recovery Services (KCBRS).

KHS' responsibility to provide services related to mental health conditions is described in this policy and procedure. The KHS Utilization Management Department (UM) collaborates with the KCBRS in the delivery of mental and physical health services to KHS Plan members.

KHS will coordinate and/or provide mental health services as appropriate in accordance with the statutory, regulatory, and contractual requirements outlined in the following sources:

- California Health and Safety Code §1374.72
- DHCS Contract Exhibit A – Attachment 10 (7)(D); Attachment 11 (5); and Attachment 12 (3) (Medi-Cal Product only)

PURPOSE:

To provide guidelines for the provision and/or coordination of mental health services.

DEFINITIONS

Serious Emotional Disturbance (SED)[5]	One or more of the mental disorders as identified in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, other than a primary substance abuse disorder or developmental disorder, that result in behavior inappropriate to the child's age according to the expected developmental norms. Members of this target population shall meet one or more of the following criteria: A. As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self care, school functioning, family relationships, or ability to function in the community; and either of the following occur: 1. The child is at risk of removal from home or has already been removed from the home 2. The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment B. The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder C. The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.
Severe Mental Illness (SMI)[6]:	Includes schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa.
Specialty Mental Health Services[7]	Mental health services outside the scope of practice of Primary Care Providers
Mild to Moderate Mental Health Services	Includes Mental Retardation, Learning Disorders, Motor Skills Disorders, Communication Disorders, Autistic or Pervasive

	Disorders, Developmental Disorders, Tic Disorders, Delirium, Dementia, and Amnestic and other Cognitive Disorders, Mental Disorders due to General Medical Condition, Substance Related Disorders, Sexual Dysfunctions, Sleep Disorders, Antisocial Personality Disorder, or Other Conditions that may be a Focus of Clinical Attention, except Medication-Induces Movement Disorders which are included

PROCEDURE:

1.0 ACCESS [8]

KHS and KCBRS work collaboratively to coordinate referrals for mental health services that are excluded from coverage by KHS.[9] Services that are the responsibility of KHS are subject to utilization management protocols as described in *KHS Policy and Procedure #3.22-P: Referral and Authorization Process* and other KHS policies specific to the type of service/supplies provided. KHS will continue to be responsible for the arrangement and payment of all medically necessary Medi-Cal physical health care services, not otherwise excluded by contract, to beneficiaries who require specialty mental health services.

Primary Care Providers (PCPs) are required to provide outpatient mental health services within their scope of practice.[10] These include services for members diagnosed with minor depression, minor anxiety, or uncomplicated grief reaction.

Primary care providers will identify the need for a mental health screening and refer to a specialist within the contracted network. Upon assessment, the mental health specialist can assess the mental health disorder and the level of impairment and refer members that meet medical necessity criteria to the Mental Health Plan (MHP) for a Specialty Mental Health Services (SMHS) assessment. When a member's condition improves under SMHS and the mental health providers in the plan and the County System of care coordinate care, the member may return to the mental health provider in KHS network.

Services beyond the PCP's scope of practice should be referred as described below.

Referrals for mental health services may be generated by the provider of care, KHS UM Case Managers, school systems, employers, or self referrals. To ensure confidentiality, KHS has a designated UM Mental Health Case Manager (MHCM) or Social Worker that is responsible for all aspects of the member's mental health care and the coordination of physical health care when indicated. Referrals for Medi-Cal members may be sent either directly to KCMHD or to KHS for forwarding to KCBRS.

Kern County Behavioral and Recovery Services
2151 College Ave.
Bakersfield, CA 93305
Fax: (661) 868-8087

OR

Kern Health Systems

Mental Health Case Manager
9700 Stockdale Highway
Bakersfield, CA 93311
Fax: (661) 664-5190

Members needing immediate crisis intervention may self refer to the Crisis Stabilization Unit due to the availability of an on-site Mental Health staff 24 hours a day. The Memorandum of Understanding (MOU) with the county mental health plan allows Members in need of urgent and emergency care, including person-to-person telephone transfers, to be referred to the county crisis program during their call center hours.

1.1 Accessing Specialty Mental Health Care from KCBRS Practitioners

KCBRS reviews referrals and refers the member to the appropriate KCBRS mental health provider. KCBRS coordinates the care between the member and the designated mental health provider. Arrangements for appointments are per KCBRS established protocols.

KHS or the mental health provider may submit the request directly to KCBRS for review and approval/denial for outpatient treatment of Serious Emotional Disorders or Inpatient Mental Health Services. If the follow-up visits are denied, KCBRS will discuss alternatives with the mental health provider and follow established KCBRS protocol.

Services Provided by CMHP for Children and adults who meet medical necessity or EPSDT criteria for Medi-Cal Specialty Mental Health Services include:

Mental Health Services (assessments plan development, therapy, rehabilitation and collateral)
Medication Support
Day Treatment Services and Day Rehabilitation
Crises Intervention and Crises Stabilization
Targeted Case Management
Therapeutic Behavior Services

Residential Services Provided by CMHP
Adult Residential Treatment Services
Crises Residential Treatment Services

Inpatient Services
Acute Psychiatric Inpatient Hospital Services
Psychiatric Inpatient Hospital Professional Services
Psychiatric Health Facility services

Services Provided by County Alcohol or Other Drug Programs for: Children and adults who meet medical necessity or EPSDT criteria for Drug Medi-Cal Substance Use Disorder Services
Outpatient Drug Free
Intensive Outpatient (newly expanded to additional populations)
Residential Services (newly expanded to additional populations)

Narcotic Treatment Program
Naltrexone
Voluntary Inpatient Detoxification Services
If a beneficiary with a mental health diagnosis is not eligible for MHP services because the adult beneficiary's level of impairment is mild to moderate, or, for adults and children, the recommended treatment does not meet criteria for Medi-Cal specialty mental health services, then KHS will ensure the provision of the outpatient mental health services listed or other appropriate services within the scope of the MCP's covered services.

KH S will ensure its network providers refer beneficiaries with significant impairment resulting from a covered mental health diagnosis to the county MHP. Also, when the beneficiary has a significant impairment, but the diagnosis is uncertain, KHS will ensure that the beneficiary is referred to the MHP for further assessment.

2.0 COVERED SERVICES

Effective January 1, 2014, the following outpatient mental health benefits will be available to KHS members:

1. Individual and group mental health evaluation and treatment (psychotherapy)
2. Psychological testing when clinically indicated to evaluate a mental health condition
3. Psychiatric consultation for medication management
4. Screening and Brief Intervention (SBI)
5. Outpatient laboratory, supplies and supplements- Laboratory testing may include tests to determine a baseline assessment before prescribing psychiatric medications or to monitor side effects from psychiatric medications. Supplies may include laboratory supplies. Supplements may include vitamins that are not specifically excluded in the Medi-Cal formulary and that are scientifically proven effective in the treatment of mental health disorders (although none are currently indicated for this purpose).
6. Drugs (excluding anti-psychotic drugs which are covered by Medi-Cal Fee-For-Service)

PCPs are required to provide outpatient mental health services within their scope of practice.[11] KHS is responsible to provide emergency mental health services to all members.[12] 24 hour Mental Health Crisis services are available via the crisis hotline at (800) 991-5272. Member's will continue to have access to an existing relationship with a mental health provider in an emergency or urgent care situation and care will be coordinated through communications with the MHP and emergency room personnel. KHS Case Management Registered Nurses are available 24/7/365 at 661/331-7656 to provide support and coordination of services to providers involved in member's mental health evaluation and care. All specialty mental health services (inpatient and outpatient) are carved out of the KHS Medi-Cal LOB.

KHS will cover outpatient mental health services to beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning (assessed by a licensed mental health professional through the use of a Medi-Cal-approved clinical tool or set of tools resulting from a mental health disorder, as defined in the current Diagnostic and Statistical Manual (DSM). The clinical tool will define the provisional diagnosis, functional impairment resulting from the mental disorder, probability of deterioration or other risk factors linked to the mental disorder, or if a alcohol drug dependence or abuse disorder is present. The clinical assessment tools used will be specific for 2 age groups:
1 Child 0-17 years of age (see Attachment B) and,

2 Adult 18 years of age or older (see Attachment C).
The referral algorithm will determine which system of care is appropriate to deliver the necessary mental health services for maximum patient outcomes.

Conditions that the DSM identifies as relational problems (e.g. couples counseling, family counseling for relational problems) are not covered as part of the new benefit by KHS nor by an MHP. All services must be provided in a culturally and linguistically appropriate manner.

Medically necessary services are defined as reasonable and necessary services to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis and treatment of disease, illness, or injury. These include services to:
1. Diagnose a mental health condition and determine a treatment plan;
2. Provide medically necessary treatment for mental health conditions (excluding couples and family counseling for relational problems) that result in mild or moderate impairment; and,
3. Refer adults to the county MHP for specialty mental health services when a mental health diagnosis covered by the MHP results in significant impairment; or refer children under age 21 to the MHP for specialty mental health services when they meet the criteria for those services.

The number of visits for mental health services is not limited as long as the beneficiary meets medical necessity criteria.

2.1 Non -Mental Health Covered Services

The following medically necessary services remain the responsibility of KHS[13]:

A. Emergency room professional services to include services provided by psychiatrists, psychologists, licensed clinical social workers, marriage family and child counselors, or other specialty mental health provider for mild to moderated mental health diagnoses. See *KHS Policy and Procedure #3.31-P: Emergency Services* for additional information on emergency services.

B. Facility charges for emergency room visits which do not result in a psychiatric admission

C. All laboratory and radiology services when these services are necessary for the diagnosis, monitoring, or treatment of a mental health condition. Services must be performed by a contracted provider whenever possible and are subject to utilization review as outlined in the applicable KHS scope of service policy.

D. Emergency medical transportation services necessary to provide access to emergency mental health services within KHS's mental health provider network.

E. All non-emergency medical transportation as described in *KHS Policy and Procedure #5.15 – Non-Medical Transportation* required to access Medi-Cal covered mental health services, subject to a written prescription by a KHS Mental Health Network Provider, Services must be performed by a contracted provider whenever possible and are subject to utilization review as outlined in the applicable KHS scope of service policy.

F. All Medi-Cal covered psychotherapeutic drugs not otherwise excluded that are prescribed by the member's PCP or a psychiatrist.[14] (See Attachment A for a list of

excluded drugs.)

3.0 DOCUMENTATION

Hard copies of referrals received by KHS are filed in the member's KHS mental health chart for any follow-up or tracking purposes. This includes any referrals from mental health providers for medical services.

4.0 COORDINATION OF CARE, MONITORING, AND REPORTING[15]

KHS has established and maintains mechanisms to identify members who require non-covered psychiatric services and make appropriate referrals.[16] KHS continues to cover and facilitate the provision of primary care and other services unrelated to the mental health treatment and coordinate services between the Primary Care Practitioner and the psychiatric service provider(s).[17] KHS coordinates care with KCBRS in accordance with a Memorandum of Understanding that meets the requirements of DHCS Contract Exhibit A – Attachment 12 (3).[18]

Referrals for mental health services received by KHS or delegated contractor are reviewed for appropriateness then entered into the referral system and mailed to either the Contracted Behavioral Health provider or the KCBRS access supervisor. If for any reason the referral is not appropriate for mental health, the MHCM notifies the submitter to discuss the case for alternatives of care.

4.1 PCP Responsibilities

PCPs are responsible to monitor that the member is following up with mental health appointments. The KHS MHCM or delegated contractor assists the PCP in the coordination of the member's care when requested and upon verification of the release of mental health information from the member.

Basic Case Management Services are provided by the Primary Care Provider, in collaboration with KHS, and shall include:

- Initial Health Assessment (IHA) performed within 120 calendar days of enrollment
- California Child Health and Disability Prevention (CHDP) assessment and ensure immunization compliance
- Individual Health Education Behavioral Assessment (IHEBA) performed within 60 calendar days of enrollment for members under the age of 18 months and within 120 calendar days for members over the age of 18 months; and that all existing Members who have not completed an IHEBA, must complete it during the next preventative care office visit according to the Staying Healthy Assessment (SHA) periodicity.
- Identification of appropriate providers and facilities (such as medical, rehabilitation, and support services) to meet Member care needs
- Direct communication between the provider and Member/family
- Member and family education, including healthy lifestyle changes when warranted; and
- Coordination of carved-out and linked services, and referral to appropriate community resources and other agencies.

KHS will ensure that:

a) Primary Care Providers shall use the DHCS updated SHA questionnaires and forms, DHCS 7098 A through I, the AAP Bright Futures assessment tools, or a DHCS-approved alternative approved IHEBA, per MMCD Policy Letter PL 13-001.

b) The IHEBA is:

i) Administered and reviewed by the Primary Care Provider during a scheduled office visit, according to the SHA periodicity schedule: 0-6 months, 7-12 months, 1-2 years, 3-4 years, 5-8 years, 9-11 years, 12-17 years, and every 3-5 year for adults and seniors;

ii) Reviewed at least annually by the Primary Care Provider with Members during a scheduled office visit.

iii) Re-administered by the Primary Care Provider at the appropriate SHA periodicity age-intervals.

iv. Based on the Member's identified behavioral risks and willingness to make lifestyle changes, the Primary Care Provider shall provide tailored heath education counseling, intervention, referral, and follow-up during the initial IHEBA administration, re-administration, and annual review of the assessment;

v. The Primary Care Provider must sign, print their name, and date the "Clinic Use Only" section of the SHA for newly administered, re-administered, or annually reviewed SHAs. The Primary Care Provider must check the appropriate boxes to indicate the specific behavioral topics and counseling, anticipatory guidance, referral, and follow-up provided to the Member; and

vi. Documentation equivalent to the SHA must be kept by Primary Care Providers who use AAP's Bright Futures or a DHCS-approved alternative IHEBA.

vii. In addition to the SHA, the Primary Care Provider (PCP) must administer a Screening, Brief Intervention, Referral and Treatment (SBIRT) questionnaire to adults ages 18 years or older to determine if alcohol misuse or have engaged in risky or hazardous drinking behavior that requires additional treatment beyond the scope of the Primary Care Provider. Each member is granted at least one expanded screening, using a validated screening tool, per year. If a member answers "yes" to the alcohol prescreen question in the SHA, a second screening test such as the AUDIT-C will be performed and can be billed separately as a screening tool. If the results of the expanded screening indicate a potential alcohol misuse problem, the PCP must offer (or refer) the member for brief intervention, one to three sessions (which may be combined). If the expanded screening indicates that a member might have an alcohol use disorder (whether or not the member definitely meets DSM criteria for alcohol use disorder), then the member must be referred to local alcohol and drug programs for further evaluation and treatment to receive expanded services covered under Medi-Cal Fee-For-Service. Expanded treatment modalities beyond the brief interventions of three 15 minute sessions maybe conducted in person, by telehealth, by phone, or by the PCP. Providers may provide brief intervention services on the same date of service as the expanded screen or on

subsequent days. These sessions may also be combined in one or two visits or administered as three separate visits.

viii. Treatment for alcohol use disorders is not a service covered under this health coverage.

viv. Providers performing the SBIRT questionnaire must attest to having completed the required hours of professional experience and specific training on the SBIRT under the recommendations of the Department of Health Care Services (DHCS).

c) KHS shall provide Members with the following:

i. Information on the purpose of the IHEBA/SHA or SBIRT and assurances that the IHEBA will be kept confidential in the Member's Medical Record, prior to the administration of the IHEBA/SHA or SBIRT;

ii. Assistance in completing the SHA, IHEBA/SHA or SBIRT translations, interpretation services, accommodation for any disability as needed; and

iii. Information on the Member's right to omit or not answer any assessment question, or to decline to complete the entire assessment.

iv. When a member transfers to another PCP, the receiving PCP must obtain prior records. If no documentation is found, the PCP must provide and document the service.

4.2 Mental Health Provider Responsibilities

The mental health provider is required to directly refer members needing medical care to the KHS MHCM or delegated contractor. Referrals are processed in accordance with *KHS Policy and Procedure #3.22-P: Referral and Authorization Process*.

If a member requires medical treatment while admitted to a mental health treatment facility, the admitting mental health provider contacts the PCP for consultation and development of the treatment plan. Members who require transfer to a medical bed for treatment of a medical condition will be transferred by the PCP to the appropriate level of acute care. The KCBRS provider continues to consult with the PCP regarding treatment of the member. When the member is medically stable, the member will either be discharged by the PCP with appropriate follow-up by KCBRS and the PCP, or will be transferred back to the inpatient treatment facility by the KCBRS provider. Upon discharge, the member is instructed to follow-up with the KCBRS and the PCP, as appropriate.

KHS shall make appropriate referrals for Members needing Specialty Mental Health Services as follows:

i) For those Members with a tentative psychiatric diagnosis which meets eligibility criteria for referral to the County Mental Health Plan (CMHP), as defined in MMCD Mental Health Policy Letter 00-01 Revised, the Member shall be referred to the CMHP in accordance with the Memorandum of Understanding (MOU) between Contractor and the CMHP as stipulated in Exhibit A, Attachment 12, Provision 3, Local Health Department CMHP Coordination for the coordination of Specialty Mental Health

Services to Members.

ii) For those Members whose psychiatric diagnosis is not covered by the CMHP, but is a covered diagnosis, the Member shall be referred to an appropriate Medi-Cal mental health provider within KHS's provider network. KHS shall consult with the CMHP as necessary to identify other appropriate community resources and to assist the Member to locate available non-covered mental health services available through the Medi-Cal FFS program. Any time a member requires medically necessary Outpatient Mental Health Service that is not available within the provider network, KHS shall ensure access to out-of-network and Telehealth mental health providers as necessary to meet access requirements.

iii) KHS may negotiate with the MHP to provide the outpatient mental health services when the MCP covers payment for these services. Disputes between KHS and the CMHP regarding this section shall be addressed collaboratively within the Contract as specified by the MOU to achieve a timely and satisfactory resolution. If KHS and the CMHP cannot agree, disputes shall be resolved pursuant to Title 9, CCR, Section 1850.505. Any decision rendered by DHCS regarding a dispute between KHS and CMHP concerning provision of mental health services or Covered Services required under this Contract shall not be subject to the dispute procedures specified in Exhibit E, Attachment 2, Provision 18 regarding Disputes.

4.3 Monitoring

The KHS MHCM or delegated contractor actively coordinates all services between the member and providers. Any problems identified in coordination of care are reported to the Chief Medical Officer and Administrative Director of Health Services for intervention/resolution. The Chief Medical Officer and/or Administrative Director of Health Services may submit the problem to the KHS QI/UM Committee for review and action, as appropriate.

5.0 REIMBURSEMENT

Reimbursement for mental health services is made per contract agreement. Claims must be submitted in accordance with *KHS Policy and Procedure #6.01-P: Claims Submission and Reimbursement* and other KHS policies specific to the type of service/supplies provided.

KCBRS sub-contractors should not submit claims directly to KHS.

KCBRS must submit all DHCS required encounter data to KHS with transmitted claims.

6.0 PROVIDER REQUIREMENTS

Providers under contract with KHS must meet the requirements outlined in *KHS Policy and Procedure #4.01* – P, *Credentialing*.

KHS provides mental health services through health care providers who are acting within the scope of their licensure and acting within their scope of competence, established by education,

training and experience.[19] Supervising licensed providers (one per clinic or practice) give attestation of having completed SBIRT training within 12 months of initiating service (one time requirement). Trained non-licensed providers (including but not limited to health educators, Certified Addiction Counselors, health coaches, medical assistants, and non-licensed behavioral assistants) may provide SBIRT services if they meet the following requirements, which must be met before rendering services:

i. Be under the supervision of a licensed provider listed in 4.01-P, §7.7(B).
ii. Complete a minimum of 60 documented hours of professional experience such as coursework, internship, practicum, education or professional work within their respective field. This experience should include a minimum of four hours of training directly related to SBIRT services (such as motivational interviewing).
iii. Complete a minimum of 30 documented hours of face-to-face client contact within his or her respective field. (This requirement is in addition to the 60 hours of clinical professional experience described above.) This may include internships, on-the-job training, or professional experience and SBIRT services training.

7.0 PROVIDER RESOURCES

KHS providers are educated regarding mental health carve-outs, PCP responsibilities, licensed mental health professionals responsibilities, and referral procedures through orientations and through this policy and procedure which is included in the *KHS Provider Manual*.

8.0 DISPUTES WITH KCBRS

Disputes between KHS and KCBRS shall be resolved pursuant to Title 9, CCR, Section 1850.505.[20]

ATTACHMENTS

- Attachment A – *Excluded Psychotherapeutic Drugs*
- Attachment B – *Child 0-17 Behavioral Health Screening form*
- Attachment C – *Adult Behavioral Health Screening form*

---

[1] **Revision 2017-04:** Section 5.0 Tobacco Cessation Services removed from policy. To be incorporated into policy 3.10-P. Titles updated. **Revision 2015-11:** Minor addition to reference on page 13 Section (i). No material change, revision date revised. **Revision 2015-03:** Tobacco Cessation Services added to comply with all plan Letter (APL) **14-006. Revision 2015-01: Minor** revisions incorporated due to internal audit of APL 13-021 Outpatient Mental Health Services. Attachments updated. **Revision 2014-03:** Revised to comply with SBIRT Deliverable AIR #1, training requirements added. **Revision 2014-02:** Major revision to policy for Mental Health and SBIRT. References to Healthy Families removed. Revisions provided by Director of Health Services. **Revision 2009-03:** Routine review. **Revision 2005-11:** Routine review. Policy reviewed against DHS Contract 03-76165 (Effective 5/1/2004). **Revision 2004-02:** Routine revision. Revised per DHS Comment 04/30/01. Reformatted according to scope of services template (sections simply moved from one part of the policy to another or to the associated internal policy are not marked as redline). Reviewed policy against AB88, DHS Contract, and MRMIB Contract and regulations to ensure compliance. **Revision 2001-02:** Changes requested by UM. **Revision 2000-10:** Routine revision.

[2] DHS Contract A-11 (6)(A)(1)

[3] DHS Contract A-10 (8)(E)(1)

[4] DHS Contract A-10 (8)(E)(3)

[5] Health and Safety Code §1374.72 (e)

[6] Health and Safety Code §1374.72 (d)

[7] DHS Contract A-10 (8)(E)(3)
[8] DHS Contract A-11 (6)(A)(2)
[9] DHS Contract §6.7.3.3(A)
[10] DHS Contract §6.7.3.3 (A)
[11] DHS Contract §6.7.3.3 (A)
[12] Health and Safety Code §1374.72. These services are not exempted per the DMHC Healthy Families exemption filing (024A).
[13] DHS Contract A-10 (8)(E)(2)
[14] DHS Contract A-10 (8)(E)(1)
[15] *Medical case management required as well as coordination of services with the Specialty Mental Health Provider 6.7.3.3B.*
[16] DHS Contract A-10 (8)(E)(4)
[17] DHS Contract A-10 (8)(E)(4)
[18] DHS Contract A-10 (8)(E)(4) and A-11 (6)(B) and MRMIB Contract §V(D)

[20] DHS Contract A-11 (5)(A)(3)

Psychiatric Drugs

The following psychiatric drugs are carved out under Kern Health Systems benefit coverage:

- Amantadine HCl
- Aripiprazole
- Asenapine (Saphris)
- Benztropine Mesylate
- Biperiden HCl
- Biperiden Lactate
- Chlorpromazine HCl
- Chlorprothixene
- Clozapine
- Fluphenazine Decanoate
- Fluphenazine Enanthate
- Fluphenazine HCl
- Haloperidol
- Haloperidol Decanoate
- Haloperidol Lactate
- Iloperidone (Fanapt)
- Isocarboxazid
- Lithium Carbonate
- Lithium Citrate
- Loxapine HCl
- Loxapine Succinate
- Lurasidone Hydrochloride
- Mesoridazine Mesylate
- Molindone HCl
- Olanzapine
- Olanzapine Fluoxetine HCl
- Olanzapine Pamoate Monohydrate (Zyprexa Relprevv)
- Paliperidone (Invega)
- Paliperidone Palmitate (Invega Sustenna)
- Perphenazine
- Phenelzine Sulfate
- Pimozide
- Proclyclidine HCl
- Promazine HCl
- Quetiapine
- Risperidone
- Risperidone Microspheres
- Selegiline (transdermal only)
- Thioridazine HCl
- Thiothixene
- Thiothixene HCl
- Tranylcypromine Sulfate
- Trifluoperazine HCl
- Triflupromazine HCl
- Trihexyphenidyl
- Ziprasidone
- Ziprasidone Mesylate

Child 0-17 Behavioral Health Screening Form for Assessment and Treatment as Medically Necessary

MEMBER INFO

Patient Name: _____ Date of Birth: ___/___/___ ☐ M ☐ F

Medi-Cal # (CIN): _____ Current Eligibility: _____ Language/cultural requirements: _____

Address: _____ City: _____ Zip: _____ Phone: (___) _____

Caregiver/Guardian: _____ Phone: (___) _____

Documents Included: ☐ **Required consent completed** ☐ MD notes ☐ H&P ☐ Assessment ☐ Other: _____

Primary Care Provider _____ Phone: (___) _____

Referring Provider Name: _____ Phone: (___) _____

Referring/Treating Provider Type: ☐ PCP ☐ MFT/LCSW ☐ ARNP ☐ Psychiatrist ☐ Other _____

List A: Provisional Diagnosis/Diagnosis, if known	**List B:** Functional impairment in life domain resulting from mental disorder	**List C:** Probability of deterioration/Risk factors linked to mental disorder	**List D:** SUD
☐ Schizophrenia/Psychotic Disorder ☐ Bipolar Disorder ☐ Depression ☐ Anxiety Disorder ☐ Impulse Control Disorder ☐ Adjustment Disorder ☐ Personality Disorder (except Antisocial Personality Disorder) ☐ Eating Disorder ☐ Pervasive Development Disorder (except Autism) ☐ Disruptive Behavior/Attention Deficit D/O ☐ Feeding and eating, Elimination D/O ☐ Other disorders of infancy, childhood, adolescence ☐ Somatoform disorders ☐ Factitious Disorders ☐ Dissociative Disorders ☐ Paraphilias ☐ Gender Identity Disorder	☐ Independent living skills (e.g. notable difficulties dressing, grooming, cleaning, following parental instructions) ☐ Social relations (current interference that affects current relationships) ☐ Medical Self Care (notable difficulty following medical instructions) ☐ Educational/Vocational/Employment / Meaningful Activity (disruptive behavioral problems with school or other age appropriate activities)	☐ Psychiatric hospitalizations – 2 or more in last 6 months ☐ Suicidal/Violent Behaviors current or in the last 6 months. ☐ Self-injurious behaviors that required medical attention in last 6 months	☐ Alcohol Abuse ☐ Alcohol Dependence ☐ Drug Abuse ☐ Drug Dependence

	Referral Algorithm	
1	Remains in **PCP care/** Therapy only with **Kern Health Systems Contracted Provider**	☐ Diagnosis with none in List B or C
2	Refer to **Kern Health Systems Behavioral Health Utilization Management Department** Fax (661)664-5190	☐ Uncertain diagnosis or diagnosis not in List A ☐ ***Mild – Moderate*** impairment in List B and none in list C
3	Refer to **Kern County Mental Health** for assessment (661) 868-1554	☐ Diagnosis in List A and 1+ ***Significant*** impairment in List B ☐ Diagnosis in List A and 1+ in List C
4	Refer to **Kern County Mental Health Gate Team** Alcohol & Drug Program (661) 868-6453	☐ 1 from list D

Additional Relevant Clinical Information (medications, psychiatric/substance abuse history, trauma history):

_____

_____

For Receiving Clinician Use ONLY

Assigned Case Manager/MD/Therapist Name: _____ Phone: (___) _____

Date communicated assessment outcome with referral source: _____

Kern Health Systems
Kern County Mental Health

October 2014

Adult Behavioral Health Screening Form for Assessment and Treatment as Medically Necessary

MEMBER INFO

Patient Name: _____ Date of Birth: ____/____/____ ☐ M ☐ F

Medi-Cal # (CIN): _____ Current Eligibility: _____ Language/cultural requirements: _____

Address: _____ City: _____ Zip: _____ Phone: (____) _____

Caregiver/Guardian: _____ Phone: (____) _____

Documents Included: ☐ **Required consent completed** ☐ MD notes ☐ H&P ☐ Assessment ☐ Other: _____

Primary Care Provider _____ Phone: (____) _____

Referring Provider Name: _____ Phone: (____) _____

Referring/Treating Provider Type ☐ PCP ☐ MFT/LCSW ☐ ARNP ☐ Psychiatrist ☐ Other _____

List A: Provisional Diagnosis/Diagnosis, if known	**List B:** Functional impairment in life domain below resulting from the mental disorder	**List C:** Probability of deterioration/Risk factors linked to mental disorder	**List D:** Substance Use Disorder
☐ Schizophrenia/Psychotic Disorder ☐ Bipolar Disorder ☐ Depression ☐ Anxiety Disorder ☐ Impulse control Disorder ☐ Adjustment Disorder ☐ Personality Disorder (except Antisocial Personality Disorder) ☐ Eating Disorder ☐ Disruptive Behavior/Attention Deficit D/O ☐ Somatoform Disorders ☐ Factitious Disorders ☐ Dissociative Disorders ☐ Paraphilias ☐ Gender Identity Disorder	☐ Independent living skills (e.g. notable difficulty cooking, cleaning, self-management, Activities of Daily Living, using transportation, residential instability/homelessness in last 30 days) ☐ Social Relations (current interference that affects current relationships) ☐ Medical Self Care (notable difficulty following medical instructions) ☐ Vocational/Employment/Meaningful Activities (disruptive behavior problems with work/education/volunteer performance)	☐ Persistent symptoms & impairments after 2 medication trials ☐ 2 or more psychiatric hospitalizations in the past 12 months ☐ Present LPS (Mental Health) Conservatorship ☐ Suicidal/Violent Behaviors current or in the last 6 months. ☐ Self-injurious behaviors that required medical attention in last 6 months	☐ Failed SBI (screening & brief intervention at primary care ☐ Alcohol Abuse (with failed SBI) ☐ Alcohol Dependence (with failed SBI) ☐ Drug Abuse ☐ Drug Dependence

	Referral Algorithm	
1	Remains in **PCP care/** Therapy only with **Kern Health Systems Contracted Provider**	☐ Diagnosis with none in List B or C
2	Refer to **Kern Health Systems Behavioral Health Utilization Department** Fax (661) 664-5190)	☐ Uncertain diagnosis or diagnosis not in List A ☐ ***Mild – Moderate*** impairment in List B and none in list C
3	Refer to **Kern County Mental Health** for assessment (661) 868-1554	☐ Diagnosis in List A and 1+ ***Significant*** impairment in List B ☐ Diagnosis in List A and 1+ in List C
4	Refer to **Kern County Mental Health Gate Team** Alcohol & Drug Program (661) 868-6453	☐ 1 from list D

Additional Relevant Clinical Information (medications, psychiatric history, substance abuse or trauma history): _____

For Receiving Clinician Use ONLY

Assigned Case Manager/MD/Therapist Name: _____ Phone: (____) _____

Date communicated assessment outcome with referral source: _____

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: New Medical Technology – Coverage Decisions				POLICY #: 3.26-I	
DEPARTMENT: Health Services - Utilization Management					
Effective Date: 07/2009	Review/Revised Date: 03/03/2017	DMHC	X	PAC	
		DHCS	X	QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

Douglas A. Hayward — Date 3/3/17
Chief Executive Officer

Chief Medical Director — Date

Chief Operating Officer — Date 3/2/17

Director of Claims — Date 3/1/17

Director of Pharmacy — Date 2/28/17

Administrative Director of Health Services — Date 2/27/17

POLICY:
Kern Health Systems (KHS) will evaluate for coverage new medical technologies and new applications of existing medical technologies. The review will include, but is not limited to, medical procedures, drugs, and devices.

PROCEDURES:

1.0 INITIATION OF REVIEW

1.1 Reactive Review

Reactive reviews are initiated by a practitioner request for new medical technology. Each request for reactive review identified or received by KHS is forwarded to

Utilization Management (UM). The UM Case Manager, R.N. completes the *Review of New Medical Technology Form.* (See Attachment A). The Case Manager reviews the form for completeness and generates/obtains additional information, e.g. a literature search as indicated. When all available information has been retrieved, the form is forwarded to the Chief Medical Officer (CMO), or his/her designee for review and consideration.

Case-by-case reviews are processed within fifteen working days.

1.1.1 Urgent and Emergency Reviews

Urgent reviews are those which require prompt attention, in that a delay in a coverage determination beyond twenty-four hours may potentially impact the member in a medical manner. Urgent reviews are facilitated with all information available during the time the request must be processed.

Emergency reviews are those which require immediate attention and determination because there is a potential threat to life or limb. Emergency reviews are processed within the work day in which the issue is brought to KHS's attention.

1.2 Proactive Reviews

Proactive reviews may result upon the identification of new technology in published sources. These sources may include the following:

A. HAYES
B. Professional journals
C. Pharmacy newsletters
D. Professional conferences

New technology reviews which come to KHS' attention are prioritized by the CMO, or his/her designee for further review and consideration for benefit coverage.

For selected technologies, the *Review of New Medical Technology Form* is completed by a UM case manager and appropriate additional information is obtained.

Proactive technology review determinations will be made with the intention to apply the determination to all appropriate situations/requests.

2.0 INVESTIGATION AND CONSIDERATION PROCESS

The following information is gathered, documented on the *Review of New Medical Technology Form*, and considered for determination:

A. Proposed procedure/treatment/medication device
B. Length of time the treating practitioner has been performing the procedure/treatment
C. Number of cases the practitioner has performed
D. Privileging or certification requirements to perform this procedure
E. Outcome review: mortality during a global period, one year out and five years out; other known complications, actual and anticipated
F. Identification of other treatment modalities available
G. Consideration as to whether Medicare/Medi-Cal approves the service/procedure

H. Whether the medication/procedure is FDA approved
I. Literature search findings
J. Input from network Specialist

The CMO, or designee, or the Director of Pharmacy, consults 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.

2.1 Approvals

All reviews by the CMO, or his/her designee which result in recommendation for approval of the new medical technology result in the following:

A. All coverage determinations resulting from review of new medical technologies are overseen by the UM/QI Committee
B. A *Benefit Interpretation-Policy* is written by the Administrative Director of Health Services.

2.2 Denials

Reviews resulting in denial for coverage are written as a *Benefit Interpretation.* The *Benefit Interpretation* is written by the Administrative Director of Health Services. If the review was generated through a reactive review, the denial is processed in accordance with *KHS Policy and Procedure #3.22 – Referral Process.*

ATTACHMENTS:

- Attachment A - *Review of New Medical Technology Form*

REFERENCE:

Revision 2017-02: Reviewed by Health Services, titles updated. Three (3) year review requested by Compliance. **Revision 2014-03**: Policy reviewed by Director of Health Services due to 1115 SPD Survey. Reference of inclusion in KHS benefit package removed by Director of Pharmacy. **Revision 2009-06:** Created per QI request.

REVIEW OF NEW MEDICAL TECHNOLOGY FORM

Member Name: _____ **Date:** _____

Employer: _____

Requesting Practitioner: _____

Proposed Treating Practitioner: _____

Proposed Procedure/Treatment/Medication: _____

_____

_____

Facility: _____

Professional Cost: _____

Anticipated LOS: _____ **Facility Cost:** _____

1. **How long has treating practitioner been performing this procedure or treatment?**

   _____

2. **How Many cases has he/she performed?** _____

3. **Is privileging or certification required to perform this procedure?**

   Yes _____ **No** _____

4. **Outcomes Review:**

   - **Mortality during global period?** _____
   - **Mortality during 1 year out?** _____
   - **Mortality during 5 years out?** _____

(Outcome Review, cont'd.)

- **Other known complications/risks, actual and anticipated?**

_____

_____

5. **Are there other treatment modalities available?**

_____

_____

6. **Medicare approved?** _____

7. **FDA approved?** _____

8. **Hayes Directory review?** _____

9. **Literature Search?** _____

10. **Review by Network Practitioners:**

Name	**Specialty**
_____	_____
_____	_____
_____	_____
_____	_____

11. **Chief Medical Officer Review:**

_____

_____

_____

12. **Other comments:** _____

_____

_____

13. **Send for External Review? Yes** _____ **No** _____

14. **Cover? Yes** _____ **No** _____

15. **Notify Benefits Coordination? Yes** _____ **No** _____

_____ _____

Chief Medical Officer **Date**

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Medical Decision Making				POLICY #: 3.73-I	
DEPARTMENT: Health Services – Utilization Management					
Effective Date: 04/2009	Review/Revised Date: 04/10/2017	DMHC		PAC	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

Douglas A. Hayward
Chief Executive Officer — Date 4/20/17

Chief Medical Officer — Date

Chief Financial Officer — Date 4/6/17

Chief Operating Officer — Date 4/5/17

Director of Compliance and Regulatory Affairs — Date 3-24-17

Deborah L. Murphy
Administrative Director of Health Services — Date 3/17/17

POLICY:
Kern Health Systems (KHS) will implement procedures as outlined in the following statutory, regulatory, and contractual sources:

- Welfare and Institutions Code §§ 14087.38(h)
- California Code of Regulations Title 22 §53857
- Health and Safety Code Section 1367(g)
- DHCS Contract Exhibit A- Attachment 1(6)
- DHCS Contract Exhibit A- Attachment 14 (2) (G)

PROCEDURES:

1.0 APPOINTMENT PROCESS

The medical affairs of KHS are under the direction and supervision of the KHS Chief Medical Officer or their designee(s) who are approved/appointed by the KHS Board of Directors. Lines of authority originate with the Board of Directors which serves as the governing body for KHS. The Chief Medical Officer or their designee(s) shall report to the Chief Executive Officer and the KHS Board of Directors.

Physician Advisors are selected and appointed by the Chief Medical Officer and approved by the Board of Directors.

Any change in the status of the Chief Medical Officer, will be reported to the Department of Managed Health Care (DMHC) within five (5) days and the Department of Health Care Services (DHCS) within ten (10) days[i] by KHS Director of Compliance.

2.0 MEDICAL DIRECTOR RESPONSIBILITIES

The KHS Chief Medical Officer or their designee(s) are responsible for ensuring medical decisions are rendered by qualified medical personnel and that the medical care provided meets the standards for acceptable medical care, as well as ensuring that medical protocols and rules of conduct for plan medical personnel are followed.

KHS maintains the organizational and administrative capacity to provide services to our members. All medical decisions are rendered by the qualified Chief Medical Officer, or Medical Director(s), unhindered by fiscal and administrative management considerations. In addition, any decision based on medical necessity or otherwise, shall be reviewed by a different Medical Director, or Physician Reviewer, who did not take part in any prior decision making processes.

The KHS Chief Medical Officer, or their designee(s) are also responsible for:

A. Developing and implementing medical policy
B. Resolving grievances related to medical quality of care
C. Actively participating in the functioning of the plan grievance procedures and the Quality Improvement Program[ii].

3.0 PHYSICIAN ADVISORS RESPONSIBILITIES

a. There shall be five (5) Physician Advisors(s) who are responsible for ensuring medical decisions are rendered by qualified medical personnel and that the medical care provided meets the standards for acceptable medical care, as well as ensuring that medical protocols and rules of conduct for plan medical personnel are followed.
b. KHS maintains the organizational and administrative capacity to provide services to our members. All medical decisions are rendered by a qualified Chief Medical Officer, Medical Director(s), or Physician Advisor (s), unhindered by fiscal and administrative management considerations.
c. Any decision based on medical necessity or otherwise may be reviewed by one of the five Advisors who did not take part in any prior decision making processes.
d. Any decision by a Physician Advisor may be appealed by the patient to the Medical Director or Associate Medical Director for review and final decision.

e. A Physician Advisor shall not review any case in which he has at any point in time been involved in the patient's treatment or diagnosis.
f. A Physician Advisor shall not review any case of a family member known to be related to the physician by blood or marriage.

4.0 MONITORING

All aspects of the medical delivery system will be monitored to assure fiscal considerations do not adversely affect member's care through various advisory committees. The following committees (*See KHS Policy #10.01-I Committee Appointment)* have been established within KHS to identify potential quality issues and to promote quality medical decision making:

A. Quality Improvement Committee
B. Utilization Management Committee
C. Physician Advisory Committee
D. Grievance Committee-Internal KHS staff only
E. Fraud, Waste, and Abuse Committee-Internal KHS staff only.

REFERENCE:

Revision 2017-03: Policy assigned/renumbered to Health Services as requested by Administration. Additional language added to conform to DHCS Contract Exhibit A, Attachment 14 (2) (G). Review by County Counsel to include language for Physician Advisory Panel. **2013-10:** Review requested by Director of Quality Improvement, Health Education and Disease Management. **Responsible department head changed from Chief Compliance Officer to Department of Health Services per COO. Revision 2009-04:** Created at the request of KHS Chief Executive Officer.
DHCS Contract 03-76165 Exhibit A, Attachment 1(7)
Title 22 §53857

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Continuity of Care for New Members				POLICY #: 3.40-I	
DEPARTMENT: Health Services - Utilization Management					
Effective Date: 01/1996	Review/Revised Date: 2/6/2017	DMHC		PAC	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

Douglas A. Hayward
Chief Executive Officer — Date 2/6/17

Chief Medical Officer — Date

Chief Operating Officer — Date 2/3/17

Director of Provider Relations — Date 2/2/17

Administrative Director of Health Services — Date 2/1/17

POLICY:
New Kern Family Health Care (KFHC) Members transferred from Fee For Service (FFS) Medi-Cal who have been assigned a mandatory aid code will be provided continuity of care (COC) in accordance statutory, regulatory, and contractual requirements.

For COC pertaining to terminated provider are described in Policy 3.39-P.

COC requirements do not obligate Kern Health Systems (KHS) to cover services or provide benefits that are not otherwise covered under the terms and conditions of the Plan contract.[1]

COC does not apply to providers of durable medical equipment, transportation, other ancillary services, and carved out services.

COC does not apply to members who had an option to remain with their previous health plan.[2]

COC for drugs and medications is addressed in *KHS Policy and Procedure #13.01-P: Drug Treatment and Non-Formulary Treatment Request.*

DEFINITIONS:

Acute condition[3]	Medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.
Existing Relationship	The member has seen a primary care provider (PCP) or specialist at least once during the 12 months prior to the date of his or her initial enrollment unless otherwise specified in this policy.
Individual Provider[4]	A person who is licensed as defined in Section 805 of the Business and Professions Code or a person licensed under Chapter 2 (commencing with Section 1000) of Division 2 of the Business and Professions Code.
Medical Exemption Request (MER)	A request to the Department of Health Care Services (DHCS) for temporary exemption from Managed Care Plan (MCP) enrollment until the Medi-Cal beneficiary's condition has stabilized to enable a transfer to an MCP provider of the same specialty without deleterious medical effects.
New Member	A new member is an enrollee who has transitioned from FFS Medi-Cal or another qualifying government program and is assigned a mandatory aid code.
Provider[5]	Any professional person, organization, health facility (including a hospital), or other person or institution licensed by the state to deliver or furnish health care services.
Provider group[6]	Includes a medical group, independent practice association, or any other similar organization.
Quality of Care Issue	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 beneficiaries.
Serious chronic condition[7]	Medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature, and that does either of the following: A. Persists without full cure or worsens over an extended period of time B. Requires ongoing treatment to maintain remission or prevent deterioration
Terminal Illness[8]	An incurable or irreversible condition that has a high probability of causing death within one year or less.

Terminated Provider[9]	A practitioner, provider group, or hospital whose contract to provide services for KHS is terminated or not renewed by any of the contracting parties.

PROCEDURES:

1.0 QUALIFYING FOR CONTINUITY OF CARE[10]

KHS will make every effort to assign and authorize existing providers for new members when the member has an applicable pre-existing provider relationship in order to continue treatment whether the provider is in or out-of-network.

1.1 In-Network

New members are assigned to a KHS contracted PCP upon enrollment as described in Policy 5.06-P. A new member is eligible to continue treatment with a KHS contracted specialist upon request and when medically necessary per Section 3.0 of this policy.

1.2 Out of Network

A new member is eligible for COC with an out-of-network when:

A. It is determined that the member has an existing relationship with the provider per Section 3.0 of this policy;
B. The provider is willing to accept the higher of KHS' contract rates or Medi-Cal FFS rates;
C. The provider meets KHS' credentialing and professional standards and has no disqualifying quality of care issues;
D. The provider is a California State Plan approved provider; and
E. The provider submits to KHS all relevant treatment information for the purposes of determining medical necessity, including current treatment plan as allowed under federal and state privacy laws and regulations.

1.3 Qualifying Conditions

The following conditions warrant authorization for continuity of care:

A. An acute condition for the duration of the condition
B. A serious chronic condition for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by KHS in consultation with the member and treating provider and consistent with good professional practice. Time period is limited to 12 months from the effective date of enrollment,
C. Pregnancy, during pregnancy and immediately after the delivery (the post-partum period). Time period is limited to 12 months from the effective date of enrollment.
D. A terminal illness for the duration of the illness.
E. The care of a child between birth and age 36 months. Time period is limited to 12 months from the effective date of enrollment.
F. Behavioral Health Treatment coverage for children diagnosed with Autism Spectrum disorder (ASD). Time period is limited to 12 months from the effective date of enrollment.

G. Performance of a surgery or other procedure that is authorized by the prior health plan as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the effective date of coverage. The surgery or procedure will be reviewed to ensure that it is medically necessary. Surgeries or procedures determined to not be medically necessary will not be authorized.[11]

1.4 Covered California

KHS Member Services shall contact members who have transferred from Covered California within 15 days of enrollment to initiate continuity of care if needed. Member services will communicate with appropriate Utilization Management (UM) Team to coordinate review of prior active treatment authorizations.

Prior active treatment authorizations with an out-of-network provider may be approved for up to 60 days or until the member has seen a KHS contracted provider that completes a new assessment including a new treatment plan. The new treatment plan must include the services specified by the prior active treatment authorization.

1.5 Seniors and Persons with Disabilities (SPDs)

KHS shall coordinate continuity of care for newly enrolled SPDs. Prior active treatment authorizations with an out-of-network provider may be approved for up to 60 days or until the member has seen a KHS contracted provider that completes a new assessment including a new treatment plan. The new treatment plan must include the services specified by the prior active treatment authorization.

1.6 Behavioral Health Treatment (BHT) Coverage for Members with ASD

KHS shall coordinate continuity of care of BHT services for members diagnosed with ASD when:

A. The member has seen the provider at least one time during the six months prior to the transfer of BHT services from the Kern Regional Center to KHS, or
B. The member has seen the provider at least one time during the six months prior to enrollment if enrollment occurred on or after September 15, 2014; and
C. The requirements in Section 1.2 of this policy are met for out-of-network BHT providers.

Retroactive requests for BHT service COC reimbursement is limited to services that were provided after September 15, 2014, or the date of the member's enrollment if occurring after September 15, 2014.
KHS shall continue coverage of ongoing BHT services for out-of-network BHT services until a comprehensive diagnostic evaluation, assessment and an established treatment plan is completed.

1.7 Medical Exemption Requests (MER)

KHS receives MER data when a Medi-Cal beneficiary has been denied a MER from the DHCS (see MER definition). KHS shall automatically coordinate continuity of care for those members who are denied a Medical Exemption Request from the

Department of Health Care Services (DHCS) (See Attachment C). Upon notification of a MER beneficiary, KHS shall send an initial contact letter to the beneficiary notifying him/her that we are trying to contact them to complete the Continuity of Care process (See attachment B).

2.0 REQUEST FOR CONTINUITY OF CARE[12]

Upon enrolling in a health plan offered by Kern Health Systems, a new member, the member's authorized representative on file with Medi-Cal, or their provider, may request that he/she continue to receive care from an existing provider. A member may submit a request by either calling or submitting a written request to the following -address/phone number:

Member Services Department
Kern Family Health Care
9700 Stockdale Highway
Bakersfield, CA 93311
1-800-391-2000
661-632-1590

The request must include the member's name, KHS identification number, employer (if any), current treating provider with address and phone number, clinical diagnosis, when the treatment started, and current treatment plan if known. Requests may be made utilizing the *Request for Continuity of Care* form. (See Attachment A). This form is available to members upon request and is not a requirement to begin the COC process.

Requests are processed through efforts coordinated by Member Services and Utilization Management.

The COC process begins when KHS determines if the beneficiary has a pre-existing relationship with the provider. KHS will begin processing the request within **five (5) working days** of receipt or within **three (3) calendar days** of receipt if there is risk of harm (imminent and serious threat) to the health of the member.

KHS shall determine if a relationship exists through the use of data provided by DHCS, such as Medi-Cal FFS utilization data and/or information provided from the requested provider. A beneficiary may not attest to a pre-existing relationship; instead, actual documentation must be provided.

2.1 Retroactive Requests

KHS shall accept and approve retroactive requests for continuity of care that meet all continuity of care requirements. The services that are the subject of the request must have occurred after the beneficiary's enrollment into KHS, and KHS must have the ability to demonstrate that there was an existing relationship between the beneficiary and provider prior to the beneficiary's enrollment into the plan. In addition to the requirements described in Section 1.0 of this policy, KHS shall only approve retroactive requests that meet the following requirements:

A. Have dates of services that occur after the effective date of August 26, 2015 (not applicable for BHT services for members diagnosed with ASD, see Section 1.6 of this policy);
B. Have dates of services within 30 calendar days of the first date of service for which the provider is requesting, or has previously requested, continuity of care retroactive reimbursement; and
C. Are submitted within 30 calendar days of the first service for which retroactive continuity of care is being requested.

3.0 REQUEST REVIEW[13]

Requests are reviewed on a case by case basis. Qualifying requests received by Member Services are submitted to the appropriate UM Team. The decision regarding the request is made by the Chief Medical Officer or designee and is not unduly influenced by fiscal or administrative management. Reasonable consideration is given to the potential clinical effect on a member's treatment caused by a change in provider.

The following actions are taken for review of each case:

A. The Member Services Representative or Clinical Intake Coordinator requests a treatment plan from the treating provider. The treatment plan is reviewed and discussed with KHS Chief Medical Officer or designee with the appropriate level of clinical expertise.

B. For out-of-network providers, the Director of Provider Relations or designee, upon verification that the provider's professional qualifications are appropriate, attempts to negotiate an agreement with the treating provider as outlined in *Section 6.0 – Negotiation with the Treating Provider.*

C. The decision is made in a timely manner appropriate for the nature of the member's medical condition and per Section 4.0.

4.0 PROCESS TIMELINE

Each continuity of care request must be completed within the following timeline:

A. Thirty calendar days from the date received;
B. Fifteen calendar days if the Member's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or,
C. Three calendar days if there is risk of harm to the member.

A continuity of care request is considered completed when:

A. The member is informed of his or her right of continued access per Section 5.0 of this policy;
B. KHS and the out-of-network FFS or prior Medi-Cal provider are unable to agree to a rate;
C. KHS has documented quality of care issues; or
D. KHS makes a good faith effort to contact the provider and the provider is non-responsive for 30 calendar days.

5.0 MEMBER NOTICE

Upon approval of a continuity of care request, the member will be notified within seven calendar days The Member Notice of Approval shall include:

A. The request approval;
B. The duration of the continuity of care arrangement;
C. The process that will occur to transition the member's care at the end of the continuity of care period; and
D. The member's right to choose a different provider from KHS's provider network.

KHS shall also notify the member 30 calendar days before the end of the continuity of care period about the process that will occur to transition the member's care at the end of the continuity of care period.

If the requested provider and KHS are unable to negotiate as outlined in Section 6.0 of this policy, KHS will offer the member an in-network alternative. If the member does not make a choice, the member will be referred or assigned to an in-network provider. If the member disagrees with the result of the continuity of care process, the member has the right to file a grievance and/or appeal.

6.0 NEGOTIATION WITH AN OUT-OF-NETWORK TREATING PROVIDER[14]

KHS will make every effort to negotiate with a qualified provider for the purpose of continuing the treatment of a newly enrolled member per Section 1.0 of this policy as follows:

A. The treating provider must agree in writing to be subject to the same contractual requirements imposed upon currently contracted providers providing similar services in the same or a similar geographic area. This includes quality management, utilization management, and credentialing. If the provider does not agree to or fails to comply with these requirements, KHS will not be obligated for the continuity of care with the provider.
B. Unless otherwise agreed, KHS shall pay the provider the higher of KHS provider contract rates or Medi-Cal FFS rates. If the provider does not accept the payment rate and does not agree to comply with the KHS quality management, utilization management and credentialing policies, KHS is not obligated to approve the request for continuity of care with the provider.
C. If a provider meets all of the necessary requirements including agreeing to a letter of agreement or contract with KHS, the member will have access to that provider for the length of the continuity of care period specified in Section unless the provider is only willing to work with KHS for a shorter timeframe. In this case, KHS must allow the beneficiary to have access to that provider for the shorter period of time.

At any time, members may change their provider to an in-network provider regardless of whether or not a continuity of care relationship has been established. When the continuity of care agreement has been established, KHS will work with the provider to establish a care plan for the member.

7.0 TRANSFER OF CARE

KHS shall initiate the transfer of care of a member to a KHS contracted provider by

collaborating with the member and the treating provider at the end of the COC period or as soon as the member's condition has stabilized to a level that enables a transfer of care. The transfer of care may also occur as soon as the current treatment plan has been completed or it has been determined that an agreement cannot be reached with the treating provider. All pertinent medical records are transferred and assistance with making an appointment is provided if necessary.

The KHS UM Clinical Intake Coordinator/Social Worker continues to follow the care of the member by requesting progress notes and coordinating any care that the member may need so that a safe and appropriate transition to a contract provider can be made when the member's condition allows.

8.0 EXTENDED COC FOR OUT-OF-NETWORK PROVIDERS

KHS may choose to work with the member's out-of-network provider past the approved continuity of care period if the member's condition warrants an extension subject to medical review.

In accordance with W&I Code §14185(b), KHS must allow beneficiaries to continue use of any (single-source) drugs that are part of a prescribed therapy (by a contracting or non-contracting provider) in effect for the beneficiary immediately prior to the date of enrollment, whether or not the drug is covered by KHS, until the prescribed therapy is no longer prescribed by the KHS contracting provider.

9.0 MEMBER LIABILITY[15]

The amount of, and the requirement for payment of, co-payments during the continuity of care period are the same as would be paid if the member were receiving care from a contracted provider. There is no member liability for Medi-Cal enrollees unless the member has not informed the provider of his or her health insurance coverage information, i.e. Medi-Cal or Kern Family Health Care identification card.

10.0 TRACKING AND REPORTING

The KHS UM Clinical Intake Coordinator logs all requests for continuity of care for a new member. Periodic reports are presented by the Administrative Director of Health Services to the QI/UM Committee. Member Services will provide Utilization Management with a new monthly member report for UM Case Managers review for transition of care needs.

11.0 PROVIDER AND MEMBER EDUCATION

Members and providers may request a copy of this policy and procedure from KHS either verbally or in writing. KHS provides information to members of their continuity of care protections in their New Member information packet and handbook. This information includes how the member and provider initiate a continuity of care request with KHS. These documents are also available in Spanish and can be made available in alternative formats, upon request. KHS must provide training to call center and other staff who come into regular contact with beneficiaries about beneficiary continuity of care protections. The KHS Member Handbook (EOC) contains information to new members of the qualified benefit of completion of care[16]. The KHS *Member Handbook* is distributed as outlined in *KHS Policy and Procedure #12.12-I: Member Handbook.*

ATTACHMENTS:

- Attachment A: *Request for Continuity of Care* form
- Attachment B: *Initial Contact letter*
- Attachment C: *MER Process*

REFERENCE:

Revision 2017-01: Policy revised to included new attachments; Initial Contact letter provided by Member Services Department and the MER Workflow Process.

[1] HSC §1373.96(i). Statement requested by DMHC Comment 061A (04/16/04).

[2] HSC §1363.96(j). Language result of AB1596(2004).

[3] HSC §1373.96(c)(1)

[4] HSC §1373.96(k)(1)

[5] HSC §1345(i) and 1373.96(k)(3). Clarification of "hospital" requested by DMHC comment 061A (04/16/04).

[6] HSC §1373.65(g)

[7] HSC §1373.96(c)(2)

[8] HSC §1373.96(c)(4)

[9] Definition requested by DMHC Comment 061A (04/16/04). Per M. Punja we cannot use the definition included in the Insurance Code. Although there is no definition included in the HSC, DMHC expectation is that terminated providers include those whose contract is terminated or not renewed by either party.

[10] HSC §1373.96(c)

[12] Deleted 30 days from enrollment deadline. Per M. Punja @ DMHC we can include a deadline only if we include an exception for "good cause". DMHC position is that since the statute doesn't impose a deadline, the plan cannot limit a member's rights by imposing a deadline. As a compromise with the Plans, an exception for "good cause" was determined to be acceptable. (See DMHC Comments 061A (04/16/04)).

[13] Process to review request must be included in policy (HSC §1373.95(a)(2)(D)).

[14] HSC §1373.96 (e)(1) and (2)

[15] HSC §1376.96 (f)

[16] HSC §1373.95© Per M. Punja of DMHC 6/29/04.

KERN FAMILY HEALTH CARE
REQUEST FOR CONTINUITY OF CARE

You may use this form to request that you be allowed to continue receiving treatment from a provider that is not contracted with KFHC. Requests should be mailed to the following address:

Member Services Department
Kern Family Health Care
9700 Stockdale Highway
Bakersfield, CA 93311

If you have questions or need help filling out this form, or would prefer to make your request over-the-phone, please call our Utilization Management Department at 1-800-391-2000.

We will review your request and send you a letter that explains our decision.

Member Name, Phone Number and Address	
KFHC Identification Number	
Treating Provider Name, Address, and Phone Number	
Clinical Diagnosis	
Date Treatment Started	
Current Treatment Plan (if known)	

Si usted necesita esta carta en Español, por favor llame al Departamento de Servicios de Miembros al (800) 391-2000

Member Name
Address
City, State, Zip

Date

Continuity of Care

Thank you for selecting Kern Family Health Care (KFHC) and welcome to our plan. We want to make sure any care you are currently receiving is not interrupted. Please contact our Member Services Department at (661) 632-1590 or 1 (800) 391-2000 if outside of Bakersfield, so we can assist you and answer any questions that you might have. You may have appointments scheduled with providers not in our network and we want to work with you and your treating providers to make sure your care is continued.

We look forward to hearing from you.

Sincerely,

Kern Family Health Care
Member Services Department

Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call Kern Family Health Care's Member Services Department at 1-800-391-2000 right away. (Footnote: Title 28 1300.67.04 (c) 2A,)

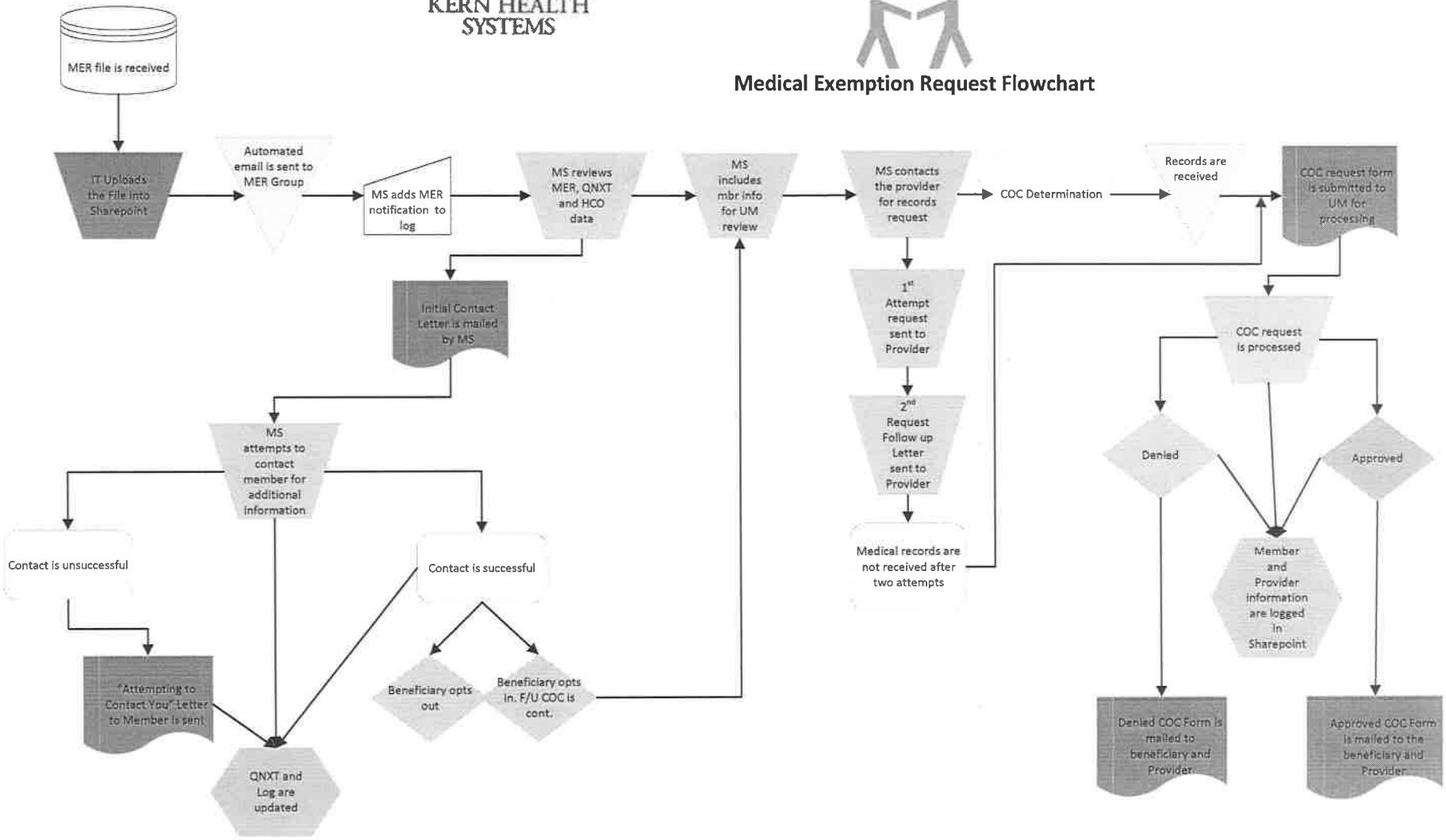
Si usted necesita esta carta en Español, por favor llame al Departamento de Servicios de Miembros al (800) 391-2000

IMPORTANTE: ¿Puede leer esta carta? Si no, nosotros le podemos ayudar a leerla. Además, usted puede recibir esta carta escrita en su propio idioma. Para obtener ayuda gratuita, llame ahora mismo al Departamento de Servicios para Miembros al 1-800-391-2000. (Footnote: Title 28 1300.67.04 (c) 2A.)

If you need this letter in English, please call the Member Services Department at (800) 391-2000.

KERN HEALTH SYSTEMS

Medical Exemption Request Flowchart



KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Medical Transportation Services				POLICY #: 3.50-P	
DEPARTMENT: Health Services – Utilization Management					
Effective Date: 11/1996	Review/Revised Date: 2/7/2017	DMHC		PAC	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

Douglas A. Hayward — Date 2/7/17
Chief Executive Officer

Chief Medical Officer — Date

Chief Operating Officer — Date 2/6/17

Director of Marketing and Member Services — Date 2/3/17

Administrative Director of Health Services — Date 2/8/17

POLICY:

Kern Health Systems (KHS) will provide ambulance transportation via community contract providers (when possible) for medically necessary conditions. Reimbursement for ambulance transportation is contingent upon eligibility at the date of service and will be reimbursed based on contract agreement.

When transport is medically necessary, the member shall be transported to the closest available contract facility capable of providing appropriate services when the member's condition is non-emergent. Members shall be transported to non-contract facilities when contract facility saturation occurs or when the patient's medical condition would be compromised by bypassing a non-contract facility.

DEFINITIONS:

Emergency Medical Condition[i]	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: A. Placing the member's health (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, B. Serious impairment to bodily functions C. Serious dysfunction of any bodily organ or part; or D. With respect to a pregnant woman who is having contractions, inadequate time to effect a safe transfer to another hospital before delivery, or that transfer may impose a threat to the health and safety of the woman or the unborn child.

PROCEDURES:

1.0 ACCESS

Prior authorization is not required for medical transportation services for emergency medical conditions. Members may access ambulance services for emergency medical conditions by calling:

A. 911 (Recommended access)

B. KHS Utilization Management at 1-800-391-2000. This is not recommended nor required for life threatening emergencies where response time is vital.

Prior authorization is required for non-emergent medical transportation services. Authorization requests should be submitted and are processed in accordance with *KHS Policy and Procedure #3.22-P: Referral and Authorization Process.*

1.1 Eligibility Determination

The State of California Department of Health Services (DHS) determine Plan membership and eligibility. KHS Plan eligibility may be verified by:

A. Calling KHS at 1-800-391-2000, 24 hours a day.

1.2 Medical Necessity Guidelines

Medical Transportation Services will be considered to be medically necessary if a patient meets any of the following conditions[ii]:

A. Was transported in an emergency situation, i.e., as a result of an accident, injury, or acute illness

B. Needed to be restrained

C. Was unconscious or in shock

D. Required oxygen or other emergency treatment on the way to his/her destination

E. Had to remain immobile because of a fracture that had not been set or the possibility of a fracture

F. Sustained an acute stroke or myocardial infarction
G. Was experiencing severe hemorrhage
H. Was bed-confined before and after the ambulance trip
I. Could be moved only by stretcher

Non-emergent services that meet the medical necessity guidelines listed above are not exempt from prior authorization requirements.

2.0 COVERED SERVICES

Covered Medical Transportation Services include emergency ambulance transportation to the first hospital which actually accepts the member for emergency care. This includes ambulance and ambulance transport services provided through the "911" emergency response system.

Covered Medical Transportation Services also include non-emergency transportation for the transfer of a member from a hospital to another hospital or facility, or facility to home when the transportation is:

A, Medically necessary, and
B. Requested by a contracted provider, and
C. Authorized in advance by KHS.

2.1 Exclusions

Coverage for public transportation including transportation by airplane, passenger car, taxi, or other forms of public conveyance is not covered. KFHC will not pay for any ambulance services if it is determined that the services were not performed, an emergency condition did not exist, the bill is fraudulent or incorrect, or the member was not eligible at the time of service.

3.0 REIMBURSEMENT

Claims must be submitted and will be processed in accordance with *KHS Policy and Procedure #6.01-P: Claims Submission and Reimbursement.* Claims must be submitted with the following documents/information:

A. Documentation of medical necessity.
B. Trip sheet

3.1 Member Liability

If KHS denies payment of a claim due to lack of medical necessity, reimbursement may be sought from KHS members only if the ambulance provider informed the member at the time of service that the service may not be medically necessary and the member may be at risk for payment. Documentation of the member notification of possible denial of coverage, including member signature, must be obtained by the provider prior to transport. This documentation must be submitted upon billing KHS for services.

REFERENCE:

Revision 01/2017: Policy revisions provided by Health Services. Direct orders from Base Station §1.2 (J) removed, previously added by KHS however no explanation/requirement found.[i] **Revision 2006-11:** Routine revision. Revised per DHS Workplan Comments 7c (04/26/06). **Revision 2001-07:** Revised per DHS Comment Letter (04-30-01). **Formerly: #3.50 – Ambulance Transportation Services (2001-07):** Renamed to indicate all forms of transportation services are described in the policy. During 05/2006 review.

Same definition used in *KHS Policy and Procedure #3.31-P: Emergency Services.* HSC §1317.1(b) and (c) and 2004 DHS Contract Exhibit E – Attachment 1(31). Combines the least restrictive elements of both definitions. Title 22 §51056 also has a similar definition.

[ii] Medicare Carriers Manual §2125(2)(a)