KERN HEALTH SYSTEMS

REGULAR MEETING OF THE QI/UM COMMITTEE

Thursday, November 14th, 2019
At
7:00 A.M.

At
2900 Buck Owens Boulevard
4th Floor Kern River Room
Bakersfield, CA 93308

The public is invited

For more information, call (661) 664-5000

AGENDA

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

KERN HEALTH SYSTEMS
4th Floor Kern River Room
2900 Buck Owens Boulevard
Bakersfield, California 93308

Regular Meeting
Thursday, November 14th, 2019

7:00 A.M.

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

COMMITTEE MEMBERS: Jennifer Ansolabehere, PHN; Satya Arya, MD; Danielle C Colayco, PharmD; MS; Felicia Crawford, RN; Allen Kennedy; Philipp Melendez, MD; Chan Park, MD; Maridette Schloe; MS, LSSBB; Martha Tasinga; MD, CMO

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

STAFF RECOMMENDATION SHOWN IN CAPS

PUBLIC PRESENTATIONS

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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
4) Closed Session
5) CMO Report

CA-6) QI/UM Committee Summary of Proceedings August 22nd, 2019 – RECEIVE AND FILE

7) Physician's Advisory Committee (PAC) Summary of Proceedings 3rd Quarter – APPROVE
   - August 2019
   - September 2019

CA-8) Pharmacy TAR Log Statistics 3rd Quarter 2019 – RECEIVE AND FILE
   - July 2019
   - August 2019
   - September 2019

9) QI Focus Review Report 3rd Quarter 2019 – APPROVE
   - Critical Elements Monitoring
   - IHEBA Monitoring
   - IHA Monitoring

10) QI Site Review Summary Report 3rd Quarter 2019 – RECEIVE AND FILE
11) QI SHA Monitoring Report 3rd Quarter 2019 – RECEIVE AND FILE

Kaiser Reports

CA-12) Kaiser Reports **(PROPRIETARY AND CONFIDENTIAL)**
   - KFHC APL Grievance Report-3rd Quarter 2019 –RECEIVE AND FILE
   - KFHC Volumes Report 3rd Quarter 2019 – RECEIVE AND FILE

VSP Reports

13) VSP Reports
- Medical Data Collection Summary Report 2019– APPROVE
- VSP DER Effectiveness Report – APPROVE

Member Services

14) Grievance Operational Board Update - APPROVE
- 3rd Quarter 2019

15) Grievance Summary Reports – APPROVE
- 3rd Quarter 2019

CA-16) Call Center Report – RECEIVE AND FILE
- 3rd Quarter 2019

Provider Relations

17) Re-credentialing Report 3rd Quarter 2019 – RECEIVE AND FILE

CA-18) Board Approved New Contracts – RECEIVE AND FILE
- Effective September 1st, 2019
- Effective October 1st, 2019

CA-19) Board Approved Providers Reports – RECEIVE AND FILE
- Effective September 1st, 2019
- Effective October 1st, 2019

CA-20) Provider Relations Network Review Report 3rd Quarter 2019– RECEIVE AND FILE

Disease Management

21) Disease Management 3rd Quarter 2019 Report – APPROVE

Policies and Procedures

22) QI/UM Policies and Procedures – APPROVE
- 3.40 I Continuity of Care for New Members
- 3.65 I Utilization Management Nurse After Hours on Call Support
- 3.75 I Health Risk Assessment

Health Education Reports

23) Health Education Activity Report 3rd Quarter 2019 – APPROVE

UM Department Reports

24) Combined UM Reporting 3rd Quarter 2019 – APPROVE

ADJOURN TO THURSDAY, February 20th, 2020 AT 7:00 A.M.

AMERICANS WITH DISABILITIES ACT
(Government Code Section 54953.2)

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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, August 22, 2019
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, PHN; Satya Arya, MD; Danielle C Colayco, PharmD; MS; Allen Kennedy; Philipp Melendez, MD; Chan Park, MD; Maridette Schloe; MS, LSSBB; Martha Tasinga; MD, CMO

Members Absent: Felicia Crawford, RN; Paula Zandi

Meeting called to order at 7:02 A.M. by Dr. Martha Tasinga, M.D., C.M.O.

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.

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PUBLIC PRESENTATIONS

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COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

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3) Announcements – **None**

4) Closed Session – **N/A**

5) CMO Report – **Dr. Tasinga informed the committee that we just completed our DHCS audit, and we will get the results in 30-60 days.**

CA-6) QI/UM Committee Summary of Proceedings May 23rd, 2019 – RECEIVED AND FILED
Park-Arya: All Ayes

7) Physician's Advisory Committee (PAC) Summary of Proceedings 2nd Quarter – APPROVED
- April 2019
- May 2019
- June 2019

Arya-Kennedy: All Ayes

CA-8) Pharmacy TAR Log Statistics 2nd Quarter 2019 – RECEIVED AND FILED
- April 2019
- May 2019
- June 2019

Park-Arya: All Ayes

9) QI Focus Review Report 2nd Quarter 2019 – APPROVED
- Critical Elements Monitoring
- IHEBA Monitoring

- IHA Monitoring

Melendez-Arya: All Ayes

10) QI Site Review Summary Report 2nd Quarter 2019 – RECEIVED AND FILED
Park-Arya: All Ayes

11) QI SHA Monitoring Report 2nd Quarter 2019 – RECEIVED AND FILED
Park-Arya: All Ayes

Kaiser Reports

CA-12) Kaiser Reports **(PROPRIETARY AND CONFIDENTIAL)**

- Kaiser 2018 QI Program Evaluation
- Kaiser 2019 QI Work Plan
- Kaiser 2019 QI Program Description
- Kaiser 2018 UM Program Evaluation
- Kaiser 2019 UM Work Plan
- Kaiser 2019 UM Program Description

Park-Arya: All Ayes

VSP Reports

13) VSP Reports

- Medical Data Collection Summary Report 2019– APPROVED
- VSP DER Effectiveness Report – APPROVED

Arya-Kennedy: All Ayes

Member Services

14) Grievance Operational Board Update - APPROVED

- 1st Quarter 2019

15) Grievance Summary Reports – APPROVED

- 1st Quarter 2019

CA-16) Call Center Report – RECEIVED AND FILED

- 2nd Quarter 2019

Melendez-Arya: All Ayes

Provider Relations

17) Re-credentialing Report 2nd Quarter 2019 – RECEIVED AND FILED
Melendez-Arya: All Ayes

CA-18) Board Approved New Contracts – RECEIVED AND FILED

- Effective May, 1st, 2019
- Effective June 1st, 2019
- Effective July 1st, 2019

Park-Arya: All Ayes

CA-19) Board Approved Providers Reports – RECEIVED AND FILED

- Effective May, 1st, 2019
- Effective June 1st, 2019
- Effective July 1st, 2019

Park-Arya: All Ayes

CA-20) Provider Relations Network Review Report 2nd Quarter 2019– RECEIVED AND FILED

Park-Arya: All Ayes

Disease Management

21) Disease Management 2nd Quarter 2019 Report – APPROVED
Melendez-Arya: All Ayes

Policies and Procedures

22) QI/UM Policies and Procedures – APPROVED

- 2.26 I Hospital Re - Admissions - Quality of Care Issues
- 2.26 I Hospital Re - Admissions - Attachment A

Melendez-Arya: All Ayes

Health Education Reports

23) Health Education Activity Report 2nd Quarter 2019 – APPROVED
Melendez-Arya: All Ayes

- **The Fall/Winter Member newsletter is in development and covers various topics including maternal mental health, opioid abuse, cancer, pain management and positive parenting.**
- **KHS has offered another cycle of school wellness grant funds to public schools in Kern County as well as an internship program for college students. 7 sites have been awarded and represent Bakersfield, Oildale, Delano and Lake Isabella.**
- **KHS has engaged in an asthma pilot with the Central California Asthma Collaborative to provide asthma education through home visits, patient advocacy and care coordination to 40 members. Results of the pilot will be share towards the middle of 2020.**
- **KHS initiated a Member Engagement Pregnancy Project to educate and inform members on the importance of regular and timely prenatal care in hopes of reducing the premature birth rate for the plan. Strategies include personalized pregnancy guides, provider education, and targeted outreach in select areas. A survey is scheduled to be completed in the Fall to evaluate the impact of these engagement strategies.**

QI Department Reports

24) KHS 2018 QI Program Evaluation – RECEIVED AND FILED

25) KHS 2019 QI Program Description – RECEIVED AND FILED

Kennedy-Melendez: All Ayes

26) KHS 2019 QI Work Plan – RECEIVED AND FILED
Kennedy-Melendez: All Ayes

- **The Director of Quality Improvement provided a summary of each document, how it supports the QI Program, and opened the discussion for any input.**

UM Department Reports

27) Combined UM Reporting 2nd Quarter 2019 – APPROVED
28) KHS 2018 UM Program Evaluation - RECEIVED AND FILED
29) KHS 2019 UM Program Description - RECEIVED AND FILED
Melendez-Chan: All Ayes

Meeting adjourned by Dr. Martha Tasinga, M.D., C.M.O. @ 8:19 A.M.
to Thursday, November 14, 2019 at 7:00 A.M.

AMERICANS WITH DISABILITIES ACT
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SUMMARY OF PROCEEDINGS

PHYSICIAN ADVISORY COMMITTEE MEETING

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

Wednesday, August 7, 2019

7:00 A.M.

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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., Raju Patel, M.D., Martha Tasinga, M.D., C.M.O.

Members Absent: Jacqueline Paul-Gordon, M.D.

Meeting called to order at 7:00 A.M. by Dr. Martha Tasinga, M.D., C.M.O.

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STAFF RECOMMENDATION SHOWN IN CAPS

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COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

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ADJOURNED TO CLOSED SESSION @ 7:01 A.M.

CLOSED SESSION

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

- **PRV000383 – Dr. Tasinga informed the members that a medical record audit was conducted after a concern was identified from the Claims Department on claims submitted by the provider for surgical procedures:**

    1. **Not typically performed by a Family Practitioner,**
    2. **Claims submitted with no prior authorization,**
    3. **Concerns identified from the review of the records regarding medical necessity, and**
    4. **Quality of documentation during pre/intra/post operative care.**

Of the 414 records requested, the provider submitted 178; however, there were many records missing portions of information, post follow-up visits and lack of pathology specimen outcomes.

There were 7-primary procedures performed by provider PRV000383:

1. **Percutaneous Tenotomies of various areas shoulders, hands, knees**
2. **EGDs**
3. **Colonoscopies**
4. **Mass/Growth excisions**

5. **Nasal polyps with turbinate obstruction**
6. **Arthroscopies**
7. **Spinal Medial Branch Block with Anesthetic or Steroid injections**

The findings were summarized by Jane Daughenbaugh, Director of Quality Improvement, whose departmental review concluded that many of the surgical procedures are outside the scope of the provider's practice as a Family Practitioner. Jane informed the committee members that many of the records not provided were for bursa drainage and this should be part of the above listed procedures for re-review in 2020. Committee members discussed the findings and concurred that the documentation/terminology does not match with what was actually being performed. Provider's record documentation does not support or make sense to understand what was actually done to the member.

Dr. Tasinga informed the members that the following recommendation be imposed requiring provider PRV000383 submit prior authorizations effective September 1, 2019 for all procedures. Each request will be reviewed by Medical Director and the decision will be determined using evidence-based medical necessity guidelines and for what is allowed by his/her scope of practice as a Residency trained Family Practitioner.

Claims submitted after 9/1/19 that do not follow prior authorization process will be be paid. Also recommended, a 6 month re-review to determine if the provider is following KHS Policy and Procedures, specifically, following prior authorization processes and medical record review to support the care and services being rendered to our members. Committee agreed there are several issues including incomplete and/or lack of sufficient documentation to support the services rendered. It was highly suggested by the Committee members to watch the provider's claim history very closely for the next 3-6 months. With regard to the recredentialing of provider PRV000383, it was suggested to modify recredentialing for 6 months and returned for consideration in March 2020, along with the medical record re-review. Amin-Parmar

- **E.B., MD (Initial Provider) Yolanda informed the members that action on the initial application of E.B., MD needs to be completed. Committee members were reminded that the provider does have a multiple felony conviction by pleading guilty on 05/05/2017 to two counts of violating California Penal Code ("PC") § 549, soliciting or referring business with intent to violate the insurance code, and one count of PC § 186.11(a)(2) as confirmed with legal counsel. In addition to the felony convictions and the restrictions on practice, imposed by the Superior County of California County of Riverside, additional information was obtained by KHS Credentialing Staff indicating the provider failed to disclose and/or omitted on application his suspension from the California Worker's Compensation Program, suspension from**

Rancho Mirage Surgery Center with an 805 Reporting indicating the termination/revocation of staff privileges. Motion was made to deny the initial application (Amin/Tasinga) and recommendation will be presented at the next BOD meeting.

COMMITTEE RECONVENED TO OPEN SESSION @ 7:55 A.M.

CA-4) Minutes for KHS Physician Advisory Committee meeting on June 5, 2019 – APPROVED
Parmar-Patel: All Ayes (Consent items CA-4 through CA-14)

UM Reports

CA-5) UM 2019 Program Description – RECEIVED AND FILED
CA-6) UM 2018 Program Evaluation – RECEIVED AND FILED
CA-7) VSP Medical Data Collection Summary Report – RECEIVED AND FILED
CA-8) VSP Diabetic Exam Reminder Effectiveness Report – RECEIVED AND FILED

QI Reports

CA-9) QI 2019 Program Description – RECEIVED AND FILED
CA-10) QI 2018 Program Evaluation – RECEIVED AND FILED
CA-11) QI 2019 Work Plan – RECEIVED AND FILED

Kaiser Reports

CA-12) Kaiser Quality Program Description – RECEIVED AND FILED
CA-13) Kaiser Quality Program Evaluation – RECEIVED AND FILED
CA-14) Kaiser Quality Work Plan – RECEIVED AND FILED

15) Review Policy 2.26-I Hospital and Re-Admissions – Quality of Care Issues – APPROVED
Hair-Parmar: All Ayes

16) Review Policy 2.57-I Clinical and Public Advisory Committee 2019 – APPROVED
Hair-Parmar: All Ayes

17) Review Policy 2.57-I (Attachments A-D) Committee Appointment attachments – APPROVED
Hair-Parmar: All Ayes

18) Review Policy 3.56-P Services for Children with Special Health Care Needs 2019 – APPROVED
Hair-Parmar: All Ayes

19) Review Policy 3.65-I Utilization Management Nurse after Hours On-Call Support 2019 – APPROVED
Hair-Parmar: All Ayes

MEETING ADJOURNED BY MARTHA TASINGA, M.D., C.M.O. @ 7:56 A.M.
TO WEDNESDAY, SEPTEMBER 4, 2019 AT 7:00 A.M.

AMERICANS WITH DISABILITIES ACT
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SUMMARY OF PROCEEDINGS

PHYSICIAN ADVISORY COMMITTEE MEETING

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

Wednesday, September 4, 2019
7:00 A.M.

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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., Raju Patel, M.D., Jacqueline Paul-Gordon, M.D., Martha Tasinga, M.D., C.M.O.

Members Absent: None

Meeting called to order at 7:01 A.M. by Dr. Martha Tasinga, M.D., C.M.O.

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COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

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

CLOSED SESSION

3) Closed Session regarding peer review of a provider (Welfare and Institutions Code Section 14087.38(o)) – **BY A VOTE OF 8-0, THE COMMITTEE APPROVED PROVIDERS RECOMMENDED FOR INITIAL CREDENTIALING AND RECREDENTIALING.**

Dr. Tasinga provided the members with a broad overview of the discussion from the Board of Directors meeting in regard to Provider PRV000383. Dr. Tasinga provided a chronology of events for new members of the committee, to bring them to the current status of this provider.

The Board of Directors referred the original recommendation back to PAC for further review and determination if this practitioner should remain in our network. Dr. Tasinga reported, to date, there have been no complaints to this provider's practice as a primary care physician. In question; however, remain those procedures that were performed outside the scope of the standard family practitioner coupled with limited medical record documentation, lack of operative reports, and pathology reports. Extensive discussion ensued regarding the status of the audit for this provider and his failure to provide 178 requested medical records. This raised unsettling concerns for the quality of care being rendered to our patients and possible breach of contract specific to UM/QI participation upon request.

A motion was made, seconded and carried to recredential PRV000383 for a period of 6-months only as per his credentialed specialty of family practice in primary care

specific to E&M codes only. If after 6-months, the following criteria are met:

- **No further quality of care issues are discovered;**
- **Provider continues to perform the approved procedures as authorized by UM, and;**
- **Auditing of the requested medical records by March 2020 is presented to PAC, then further extension of recredentialing can be considered at that time.**

COMMITTEE RECONVENED TO OPEN SESSION @ 7:47 A.M.

CA-4) Minutes for KHS Physician Advisory Committee meeting on August 7, 2019 – APPROVED
Patel-Egbikuadje: All Ayes

5) Review KHS Complex Case Management Program Description – APPROVED
- **Jane Daughenbaugh, KHS Director of Quality Improvement suggested to add the reporting structure to the program description.**

Parmar-Egbikuadje: All Ayes

6) Health Dialog Delegated Oversight Report – **Item held until next month. We did not have a quorum at the time of this item being reviewed.**

MEETING ADJOURNED BY DR. MARTHA TASINGA, M.D., C.M.O. @ 8:09 A.M.
TO WEDNESDAY, OCTOBER 2, 2019 AT 7:00 A.M.

AMERICANS WITH DISABILITIES ACT
(Government Code Section 54953.2)

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Quarter/Year of Audit	2019	2019	2019	2019	2019	2019	2019	2019	2019	2019	2019	2019
Month Audited	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Total TAR's for the month	3359	2956	3287	3373	3661	3419	3453	3783	3180			
Compliant	100%	100%	100%	100%	100%	100%	100%	100%	100%			
APPROVED TAR'S												
Timeliness - Reviewed & Returned in 1 busines day	76/76	75/75	69/69	74/74	87/87	67/67	75/75	83/83	65/65			
Date Stamped	76/76	75/75	69/69	74/74	87/87	67/67	75/75	83/83	65/65			
Fax copy attached	76/76	75/75	69/69	74/74	87/87	67/67	75/75	83/83	65/65			
Decision marked	76/76	75/75	69/69	74/74	87/87	67/67	75/75	83/83	65/65			
DENIED TAR'S												
Timeliness - Reviewed & Returned in 1 business day	63/63	46/46	70/70	61/61	51/51	75/75	54/54	68/68	75/75			
Initally Denied - Signed by Medical Dir and/or Pharm	63/63	46/46	70/70	61/61	51/51	75/75	54/54	68/68	75/75			
Letter sent within time frame	63/63	46/46	70/70	61/61	51/51	75/75	54/54	68/68	75/75			
Date Stamped	63/63	46/46	70/70	61/61	51/51	75/75	54/54	68/68	75/75			
Fax copy attached	63/63	46/46	70/70	61/61	51/51	75/75	54/54	68/68	75/75			
Decision marked	63/63	46/46	70/70	61/61	51/51	75/75	54/54	68/68	75/75			
Correct form letter, per current policies used	63/63	46/46	70/70	61/61	51/51	75/75	54/54	68/68	75/75			
MODIFIED TAR'S												
Timeliness - Reviewed & Returned in 1 business day	0	0	0	0	0	0	0	0	0			
Date Stamped	0	0	0	0	0	0	0	0	0			
Fax copy attached	0	0	0	0	0	0	0	0	0			
Decision marked	0	0	0	0	0	0	0	0	0			
Correct form letter, per current policies used	0	0	0	0	0	0	0	0	0			
DUPLICATE TAR'S												
Timeliness - Reviewd & Returned in 1 business day	12/12	12/12	16/16	17/17	15/15	8/8	19/19	20/20	10/10			
Date Stamped	12/12	12/12	16/16	17/17	15/15	8/8	19/19	20/20	10/10			
Fax copy attached	12/12	12/12	16/16	17/17	15/15	8/8	19/19	20/20	10/10			

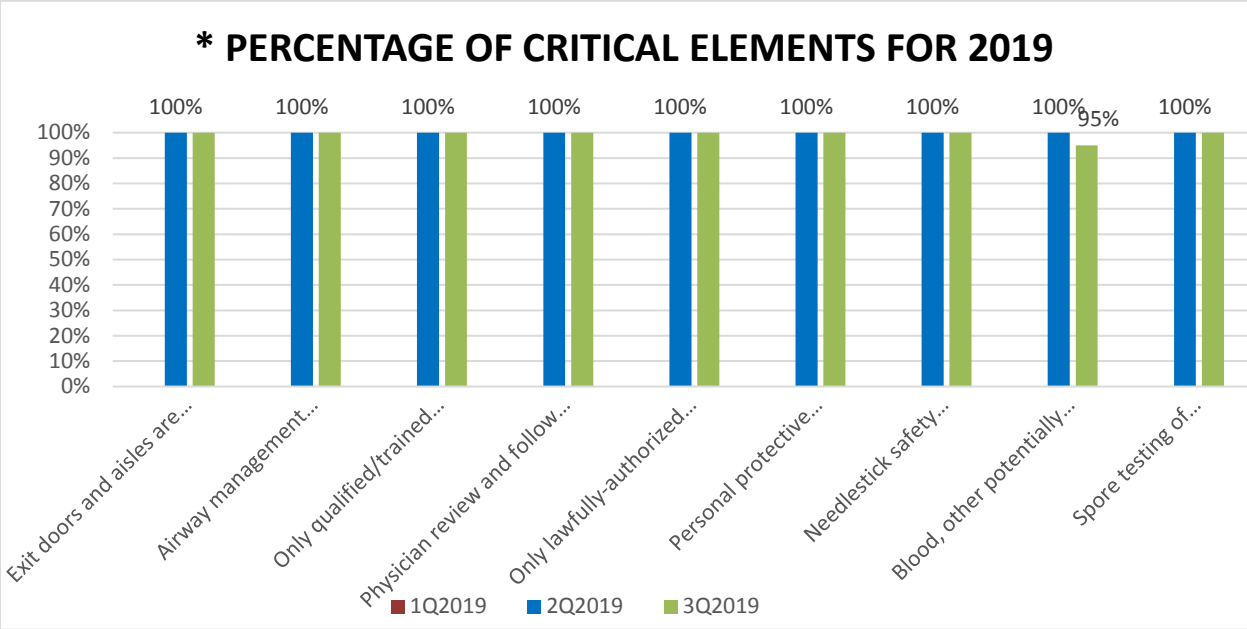
Kern Health Systems
Focus Review Summary Report
Q3 2019

Critical Elements (CE) Description: KHS is responsible for systematic monitoring of all PCP and OB/GYN sites between each regularly scheduled, full scope site review surveys. This monitoring includes the nine (9) critical elements.

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. Needle stick 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).

These nine critical survey elements are related to the potential for adverse effect on patient health or safety which 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 review or monitoring visit must be corrected by the provider within 10 business days of the survey date. Sites found deficient in any critical element during a Focus Review are required to correct 100% of the survey deficiencies, regardless of survey score.

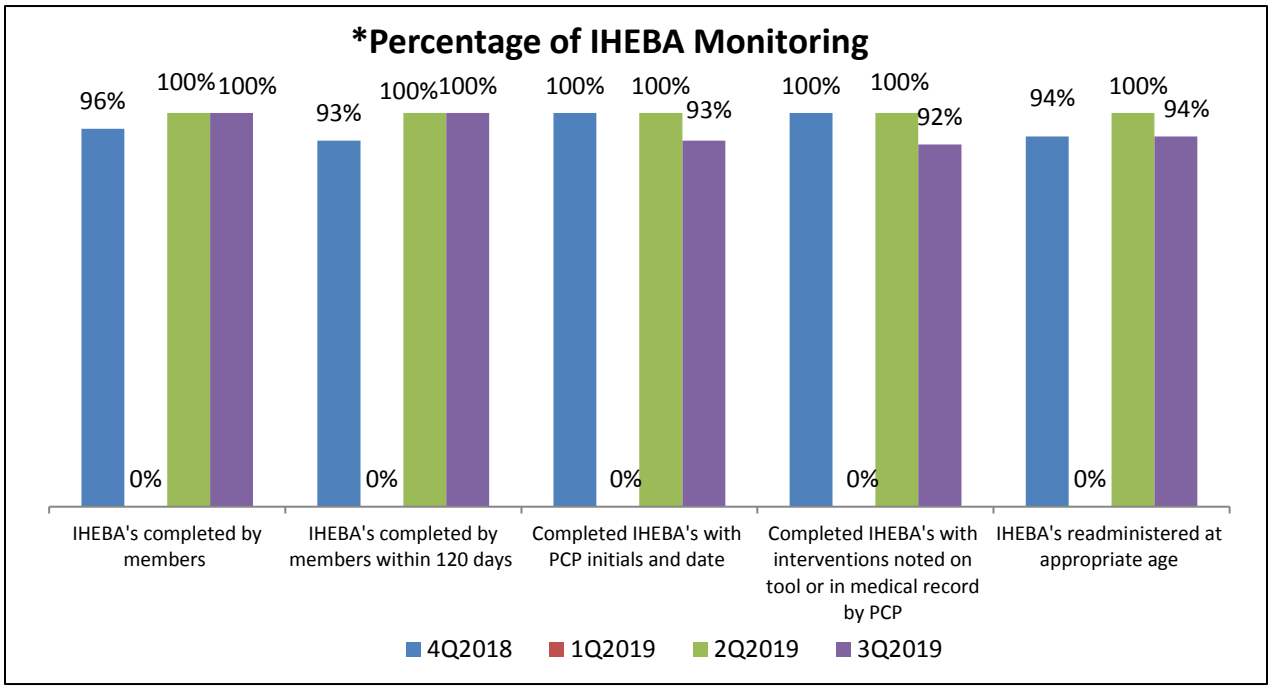
Other performance assessments may include previous deficiencies, patient satisfaction, grievance, and utilization management data. The PCP and/or site contact are notified of all critical element deficiencies found during a survey or monitoring visit. The PCP and/or site contact are required to correct 100% of the survey deficiencies regardless of the survey score.



* **Note:** There is no data for the 1st Quarter of 2019 due to HEDIS Review Activity.

Analysis for Critical Elements: All providers evaluated over the last 2 Quarters scored 100% in all areas with one exception. The area with an opportunity for improvement was in the 3th Quarter of 2019. It was related to Blood, other potentially infectious materials (specimens) and regulated wastes (sharps/biohazardous non-sharps) are placed in appropriate leak-proof, labeled containers for collection, processing, storage, transport or shipping. A Corrective Action Plan (CAP) was issued and the deficiency was corrected.
**Note: For the full description of critical elements on the axis, please refer to the 9 critical elements mentioned on the first page.

Individual Health Education Behavioral Assessment (IHEBA) Description: The IHEBA, commonly referred to as the Staying Healthy Assessment, is performed during the Initial Health Assessment (IHA). Thereafter, the PCP must re-administer the IHEBA at the appropriate age intervals. The minimum performance level (MPL) is 80%.



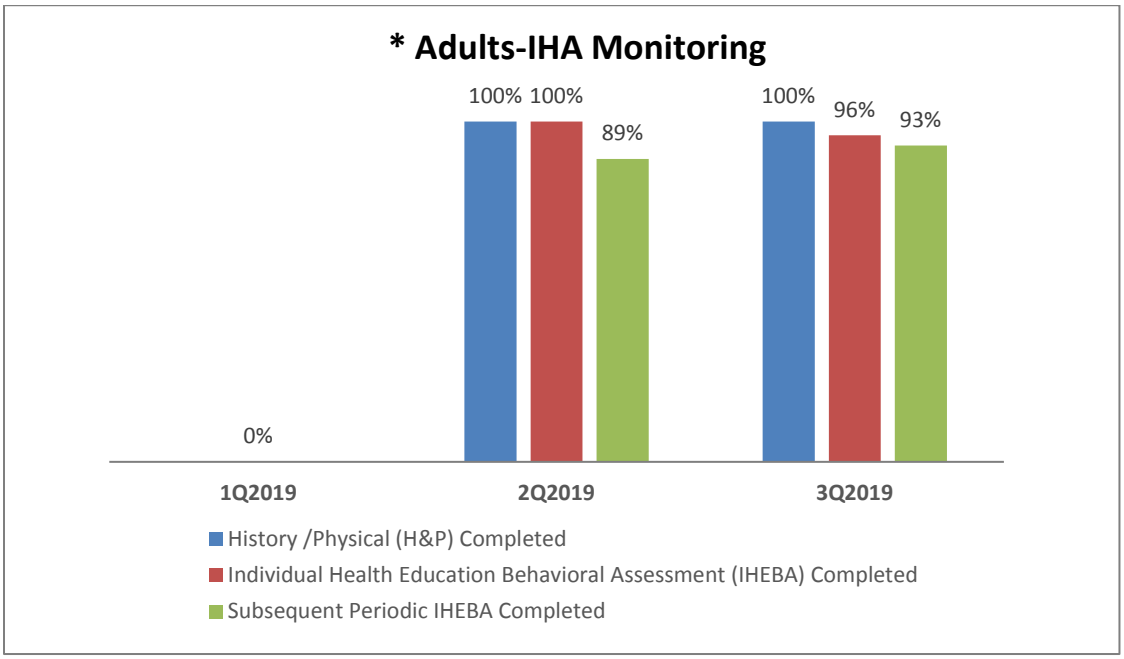
* **Note:** There is no data for the 1st Quarter of 2019 due to HEDIS Review Activity.

IHEBA Results: In the 3rd Quarter of 2019, 115 records were audited from 21 different providers. The providers surveyed scored 100% in 2 out of 5 areas. The areas for improvement noted were:

- Completed IHEBA's with PCP initials and date
- Completed IHEBA's with interventions noted on tool or in medical record by PCP
- IHEBA's re-administered at appropriate age

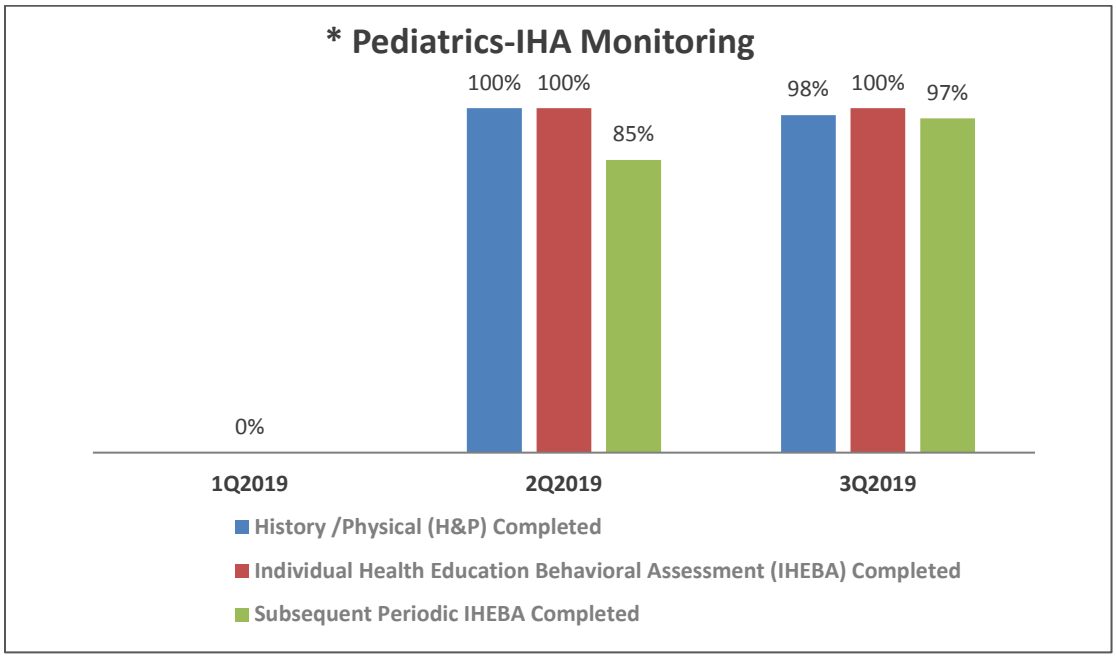
Corrective Action Plans (CAPS) were issued and the deficiencies were corrected.

Initial Health Assessment (IHA) Description: An IHA must be provided to each member within 120 days of enrollment. As PCP's receive their assigned members, the practitioner's office contacts the member to schedule an IHA to be performed within the 120 day time limit. If the practitioner is unable to contact the member, he/she contacts the KHS Member Services Department for assistance. Contact attempts and results are documented by both the PCP and member services staff. The MPL is 80% for this measure, and IHAs are performed on both adult and child members.



* **Note:** There is no data for the 1st Quarter of 2019 due to HEDIS Review Activity.

Adult IHA Results: No IHA records were reviewed in the 1st Quarter of 2019 because of HEDIS. In the 3rd Quarter of 2019, there were 21 providers evaluated out of which 13 providers had adult IHA records. Among the 13 providers we had a total of 59 Adult IHA records reviewed. The providers scored 100% in 1 out of 3 areas. The areas of improvement noted were Individual Health Education Behavioral Assessment (IHEBA) Completed and Subsequent Periodic IHEBA Completed. Corrective Action Plans (CAPS) were issued and the deficiencies were corrected.



***Note:** There is no data for the 1st Quarter of 2019 due to HEDIS Review Activity.

Pediatric IHA Results: In the 1st Quarter of 2019 no Pediatric records for focus reviews were evaluated because of HEDIS. However, in 3rd Quarter 2019 there were 21 providers evaluated and 13 pediatric records reviewed. Among the 13 providers we had a total of 38 Pediatrics-IHA records reviewed. Surveyed scored 100% in 1 out of 3 categories. The areas most in need of improvement were History /Physical (H&P) Completed and Subsequent Periodic IHEBA Completed. Corrective Action Plans (CAPS) were issued and the deficiencies were corrected.

Kern Health Systems
Facility Site Review Summaries
Full Site Review-Site and Medical Record Review Report
Q3 2019

Full Site Review (FSR) and Medical Record Review (MRR) Description:

Certified Site Reviewers perform a Facility Site Review on all contracted primary care provider sites (including OB/GYNs and pediatricians) as well as providers who serve a high volume of SPD beneficiaries. Per PL 14-004, certified site reviewers complete FSRs and MRRs for providers credentialed per DHCS and MMCD contractual and policy requirements.

An Initial Full Site Review (IFSR) is completed as part of the credentialing process on new providers at sites that have not previously been reviewed before being added to the KHS provider network. An IFSR is also completed when an existing KHS provider moves to a new site location. Approximately 3 months after the completion of an IFSR, an Initial Medical Record Review (IMRR) is conducted on sites other than Urgent Care (UC) Facilities. A passing FSR score is considered "current" if it is dated within the last three (3) years.

Subsequent Periodic Full Site Reviews (PFSRs) are conducted as part of the re-credentialing process for providers three (3) years after completion of the IFSR and every three (3) years thereafter.

Scoring and Corrective Action Plans

Provider sites that receive a FSR or MRR score with an Exempted Pass (90% or above, without deficiencies in critical elements) are not required to complete a corrective action plan (CAP). All sites that receive a Conditional Pass (80-89%, or 90% and above with deficiencies in critical elements) are required to complete a CAP addressing each of the noted deficiencies. The compliance level categories for both the FSR and MRR are as listed below:

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

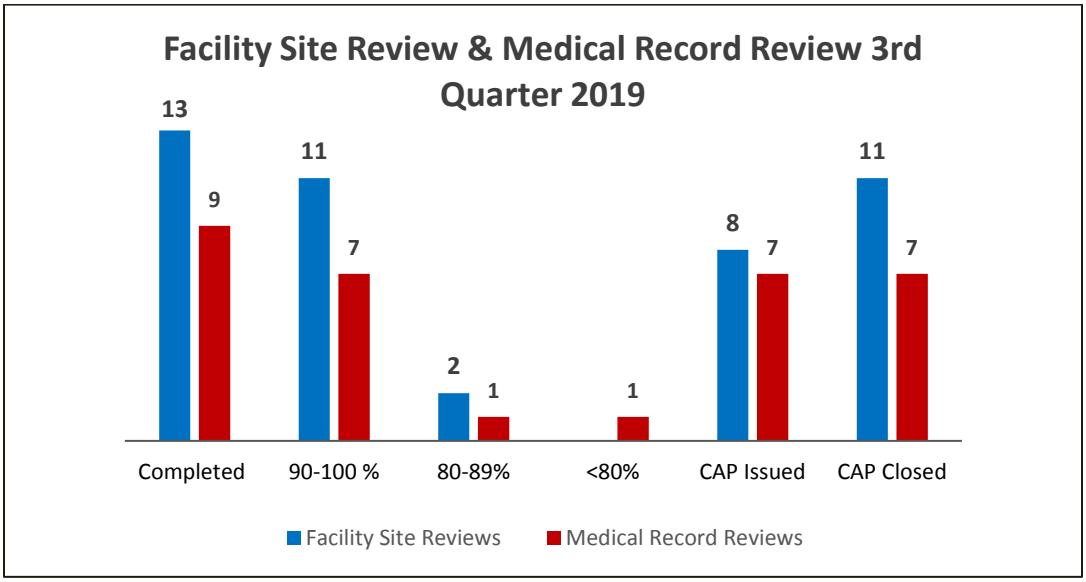
Corrective Action Plans (CAPs)

A CAP is issued when an initial, periodic, or focus review has deficiencies identified. DHCS requires follow up at 10 days for failure of any critical element, follow up for other failed elements at 45 days, and if not corrected by the 45 day follow up, at 90 days after a CAP has been issued. The majority of CAPs issued are corrected and completed within the 45 Day follow up period. Providers are encouraged to speak with us if they have questions or encounter issues with CAP completion. QI nurses provide education and support during the CAP resolution process.

Critical Elements

There are nine critical elements related to the potential for adverse effect on patient health or safety and include the following:

- Exit doors and aisles are unobstructed and egress (escape) accessible.
- Airway management equipment, appropriate to practice and populations served, are present on site.
- Only qualified/trained personnel retrieve, prepare or administer medications.
- Office practice procedures are utilized on-site that provide timely physician review and follow-up of referrals, consultation reports and diagnostic test results.
- Only lawfully-authorized persons dispense drugs to patients.
- Personal protective equipment (PPE) is readily available for staff use.
- Needle stick safety precautions are practiced on-site.
- 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.
- Spore testing of autoclave/steam sterilizer is completed (at least monthly, with documented results).



Facility Site Review and Medical Record Review Results:

A total of 13 Site Reviews were completed in the 3rd Quarter of 2019. Out of the 13 completed, 3 were initial site Reviews and 10 were periodic site reviews.

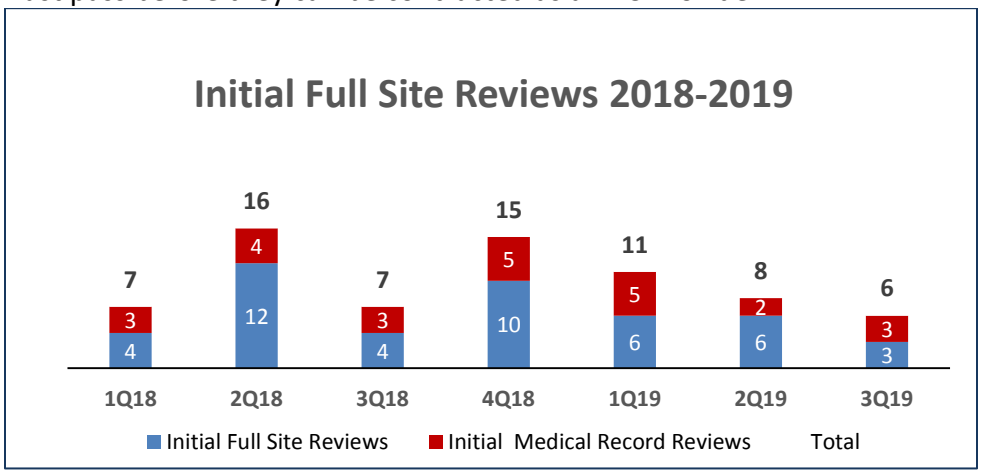
A total of 9 Medical Record Reviews were completed in the 3rd Quarter of 2019. There were no initial medical record reviews, and all of them were Periodic Medical Record Reviews.

For the medical record reviews that scored less than 80% CAP was issued with a 45 day follow up completed and pending 90 day follow up.

There were 8 Facility Site Review CAPs issued and 7 Medical Record Review CAPs issued. 11 Full Site Review CAPs were closed, and 7 Medical Record Review CAPs were closed.

Kern Health Systems
Facility Site Review Summaries
Full Site Review-Site and Medical Record Review Report
Q3 2019

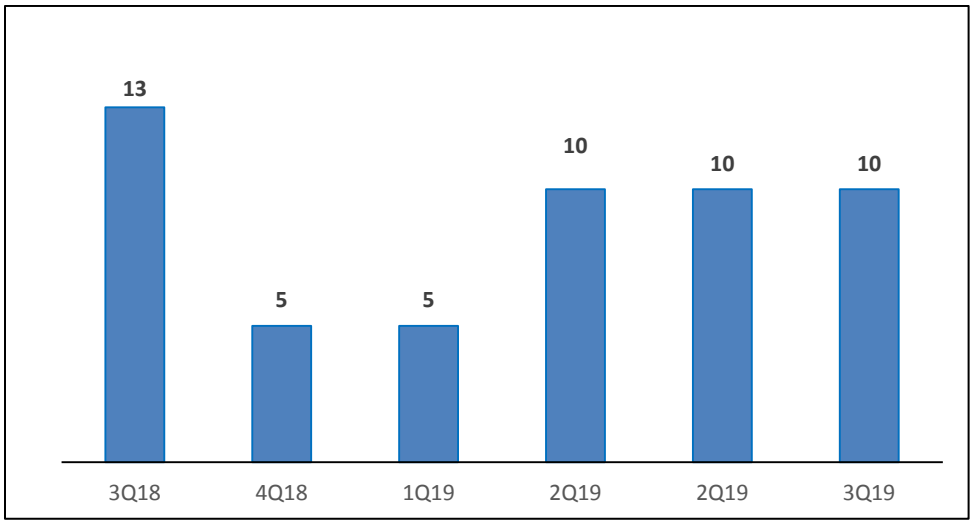
Initial Full Site Reviews: An Initial Full Site Review is required to be completed and the provider must pass before they can be contracted as a KHS Provider.



No trends are identified, and this chart simply reflects the volume of new providers in KHS's Network.

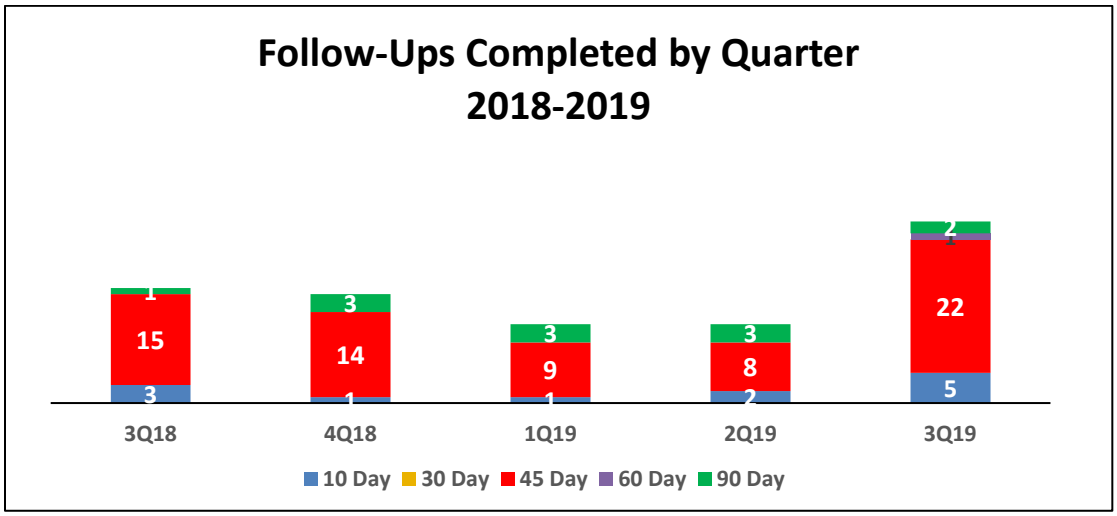
Periodic Full Site Reviews

Periodic Full Site Reviews are required every 3 years. The due date for Periodic FSRs is based on the last Initial or Periodic FSR that was completed. The volume of Periodic Reviews is not controlled by KHS. It is based on the frequency dictated by DHCS.



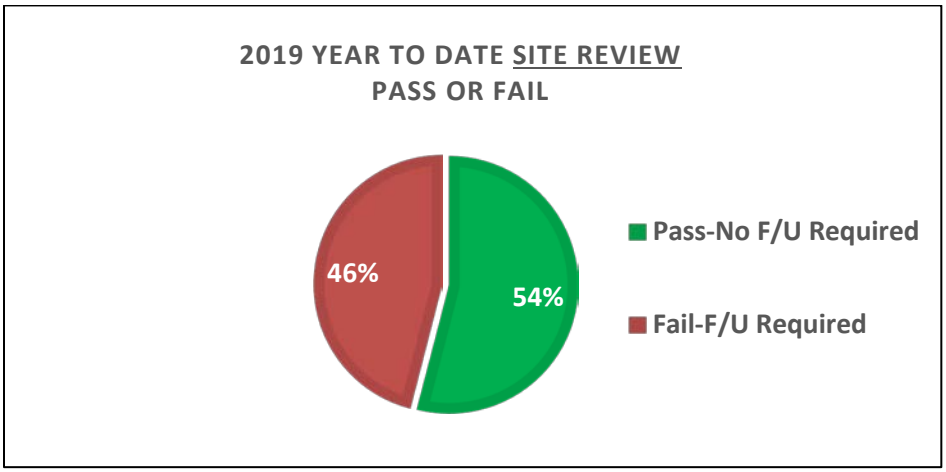
This above chart simply reflects the number of Periodic Full Site Reviews that were due and completed for each quarter.

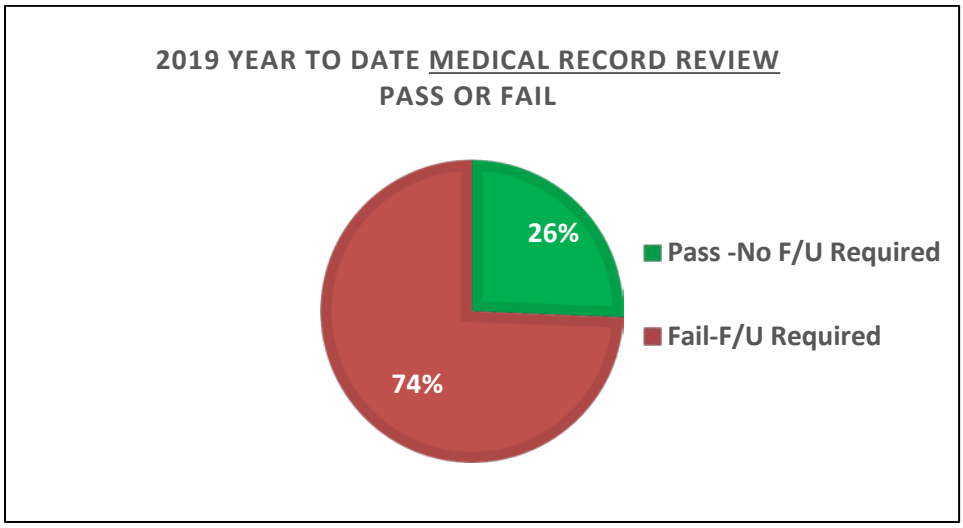
Facility Site Review and Focus Review Corrective Action Plans (CAPs):



In the 3rd Quarter of 2019 there were five 10 Day Follow-ups, twenty two 45 Day Follow-ups, one 60 day and two 90 Day Follow-ups completed.

Year to Date (YTD) Initial and Periodic FSR Pass or Fail Rate:





In 2019 YTD 54% of the Initial and Periodic site reviews performed passed on the first visit and 46% required follow-up. There are typically more follow-ups required for Medical Record Reviews. 26% of the Medical Records Reviews performed to date passed on the first visit and 74% required additional follow-up.

Top 3 Facility Site Review Deficiencies

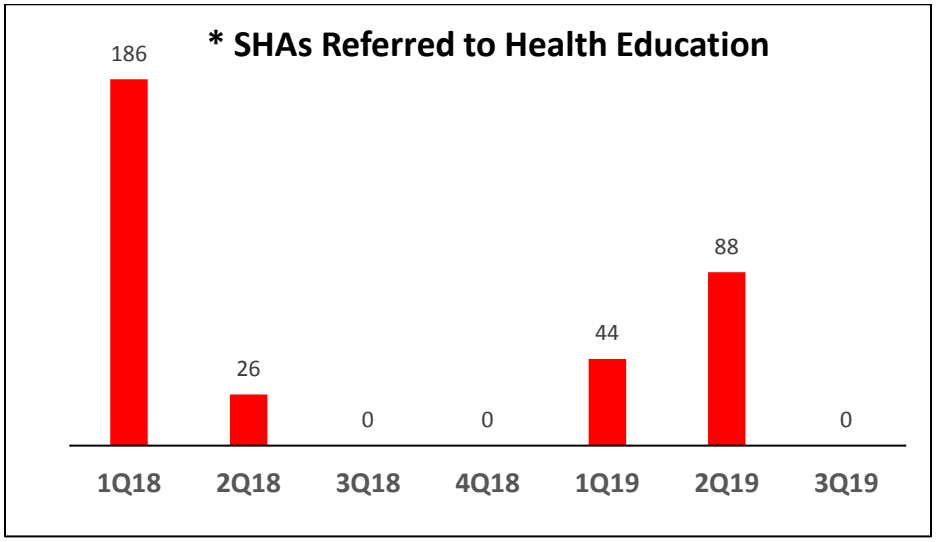
1. Expired Medications found in site
2. No evidence of Physician and Staff Education (Child/Elder Abuse, Sensitive Services)
3. Tracking of referral process thru closures

Top 3 Medical Record Review Deficiencies

1. Cervical Cancer Screening
2. Staying Healthy Assessments
3. TB Screenings

Kern Health Systems
Staying Healthy Assessments Monitoring
Q3 2019

Staying Healthy Assessment (SHA) Description: KHS works to identify members with unmet health needs. During the course of HEDIS audits, QI nurses identify members with positive SHA results in their medical record indicative of an unmet health need. These positive SHAs are shared with the Health Education (HE) Department to evaluate clinical follow-up and provide them with education. The QI department gathers the SHAs identified as part of their HEDIS file review. The number of SHAs collected and referred to HE is listed below. There is a variance from quarter to quarter depending on the number of HEDIS records reviewed. When HEDIS reviews are not occurring no SHAs are gathered.



* **Note**: During the 3rd and 4th quarters of 2018 and 3rd Quarter of 2019 HEDIS reviews were not conducted, and no SHAs were gathered.

SHA Monitoring Results

During routine audits of medical records, QI RNs validate that an SHA was completed yearly. During Q1 of 2018 there were 186 positive SHAs sent to Health Education. This increase was related to the number of records reviewed for HEDIS. In Q2 of 2018 there was a decrease with only 26 SHAs submitted at the end of HEDIS. There were no SHA's were referred to HE in Q3 and Q4 of 2018 since HEDIS reviews did not occur during those time frames. Tracking of SHAs resumed when HEDIS season began again with 44 SHA's submitted in Q1 of 2019 and 88 SHA's submitted in Q2 of 2019. For 3Q of 2019 there were no SHA,s noted.

We are in the process of implementing new tool for facility site reviews. To know whether a SHA is completed or not is included in the medical record portion.

KERN HEALTH SYSTEMS

CA-12) KAISER REPORTS (PROPRIETARY AND CONFIDENTIAL)

661-664-5000
FAX 661-664-5151

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

Medical Data Collection Summary Report

Period Covered: October, 2018 through September, 2019
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:	27,104	
Diabetes?:	1,359	5.0%
Diabetic Retinopathy:	159	.6%
Glaucoma:	222	.8%
Hypertension:	1023	3.8%
High Cholesterol	401	1.5%
Macular Degeneration:	38	.1%

Estimated Number of Cases

Total Members:	248,194	
Diabetes?:	5,586	2.3%
Diabetic Retinopathy:	492	.2%
Glaucoma:	937	.4%
Hypertension:	24,481	9.9%
High Cholesterol	37,319	15.0%
Macular Degeneration:	301	.1%

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

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
2018	October	598	22	23	45
	November	770	41	41	82
	December	853	52	64	116
2019	January	8,557	327	340	667
	February	8,910	414	314	728
	March	265	24	14	38
	April	1,012	60	33	93
	May	553	40	15	55
	June	729	60	4	64
	July	591	30	0	30
	August	541	16	0	16
	September	4,151	10	0	10
Totals		**27,530**	**1,096**	**848**	**1,944**

LTM Effectiveness* : 7 %

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

Grievance Report

- The DMHC requires KHS Management report/review/discuss quarterly grievances with the KHS Board of Directors.

Category	Q3 2019	Status	Issue	Q2 2019	Q1 2019	Q4 2018	Q3 2018
Access to Care	**34**		Appointment Availability	32	41	32	59
Coverage Dispute	**3**		Authorizations and Pharmacy	9	14	12	21
Medical Necessity	**214**		Questioning denial of service	244	228	240	267
Other Issues	**16**		Miscellaneous	13	9	10	7
Quality of Care	**65**		Questioning services provided. All cases forwarded to Quality Dept.	26	29	22	30
Quality of Service	**0**		Questioning the professionalism, courtesy and attitude of the office staff. All cases forwarded to PR Department	1	6	3	2
Exempt	**1515**		Member dissatisfaction calls, that are not regarding a coverage or medical necessity issue, resolved within one business day.	1321	1216	1082	1212
Total Grievances, Appeals and Exempt Cases	**1847**			1646	1543	1401	1598

KERN HEALTH SYSTEMS
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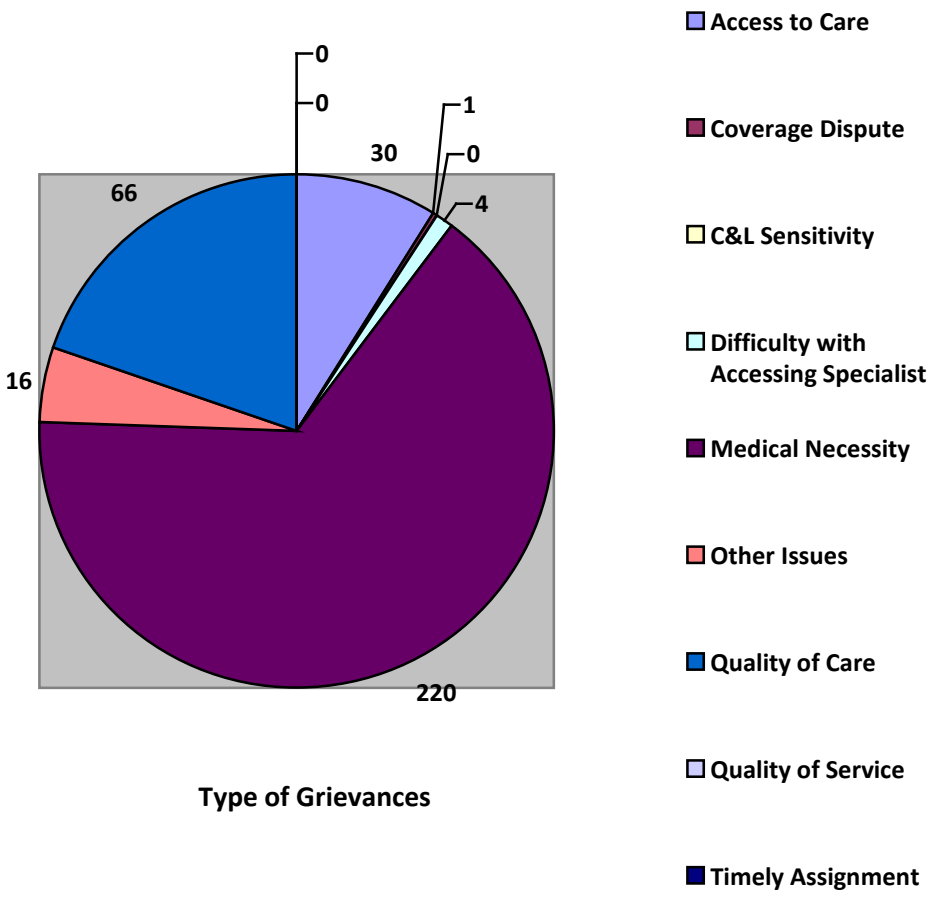
Additional Insights-Grievance & Appeal Detail

Issue	3rd Quarter Grievances	Upheld Plan Decision	Overturned Ruled for Member	Still Under Review
Access to Care	30	17	5	8
Coverage Dispute	3	0	0	3
Specialist Access	4	2	2	0
Medical Necessity	214	125	48	41
Other Issues	16	11	3	2
Quality of Care	65	22	18	25
Quality of Service	0	0	0	0
Total	332	177	76	79

3rd Quarter 2019 Grievance Summary

Issue	Number	In Favor of Health Plan	In favor of Enrollee	Still under review
Access to care	30	23	7	0
Coverage dispute	1	1	0	0
Cultural and Linguistic Sensitivity	0	0	0	0
Difficulty with accessing specialists	4	2	2	0
Medical necessity	220	164	56	0
Other issues	16	12	4	0
Quality of care	66	35	31	0
Quality of service	0	0	0	0
Timely assignment to provider	0	0	0	0



Type of Grievances

Grievances per 1,000 Members = 1.29

During the third quarter of 2019, there were three hundred and thirty seven formal grievances and appeals received. One hundred cases were closed in favor of the Enrollee; two hundred and thirty seven cases were closed in favor of the Plan. All of these cases closed within thirty days. One hundred and one cases were received from SPD (Seniors and Persons with Disabilities) members. One hundred and thirteen cases were received from Medi-Cal Expansion members.

3rd Quarter 2019 Grievance Summary

Access to Care

There were thirty grievances pertaining to access to care. Twenty three cases closed in favor of the Plan. Seven cases closed in favor of the Enrollee. The following is a summary of these issues:

Ten members complained about the lack of available appointments with their Primary Care Provider (PCP). Eight of the cases 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 of the cases closed in favor of the Enrollee after the response indicated the office may not have provided appropriate access to care.

Eighteen members complained about the wait time to be seen for a Primary Care Provider (PCP) appointment. Thirteen 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 as a walk-in, which are not held to Access to Care standards. Five cases closed in favor of the Enrollee after the response indicated the member was not seen within the appropriate wait time for an appointment.

One member complained about the telephone access with their Primary Care Provider (PCP) appointment. This case closed in favor of the Plan after the response indicated the member was provided with the appropriate telephone access.

One member complained about the wheelchair access with their Primary Care Provider (PCP) appointment. This case closed in favor of the Plan after the response indicated the member was provided with the appropriate access.

Coverage Dispute

There was one grievances pertaining to a Coverage Dispute issue. The case closed in favor of the Plan. The following is a summary of this issue:

One member complained about the denial of a referral authorization request. The case closed in favor of the Plan and the decision was upheld after it was determined that the request was appropriately denied as the requested services are not a covered benefit.

Cultural and Linguistic Sensitivity

There were no grievances pertaining to Cultural and Linguistic Sensitivity.

Difficulty with Accessing a Specialist

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

One member complained about the lack of available appointments with a specialist. The case closed in favor of the Plan after the response indicated the offices provided appropriate access to care based on the Access to Care Standards for specialty appointments.

Three members complained about the wait time to be seen for a specialist appointment. One case closed in favor of the Plan after the response indicated the member was seen within the appropriate wait time for an appointment. Three cases closed in favor of the Enrollee after the responses indicated the member may not have been seen within the appropriate wait time for an appointment.

Medical Necessity

There were two hundred and twenty grievances pertaining to Medical Necessity. One hundred and sixty four of the cases were closed in favor of the Plan. Fifty six of the cases closed in favor of the Enrollee. The following is a summary of these issues:

One hundred and sixty six members complained about the denial or modification of a referral authorization request. One hundred and ten 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. Three cases were closed in favor of the Plan and modified. Fifty three cases were closed in favor of the Enrollee as it was determined medical necessity was met and the denials were overturned.

Fifty four members complained about the denial or modification of a TAR. Fifty one of the cases were closed in favor of the Plan as it was determined there was no supporting documentation submitted with the TAR to support the criteria for medical necessity of the requested medication and the denial was upheld. Three cases were closed in favor of the Enrollee as it was determined medical necessity was met and the denials were overturned.

Other Issues

There were sixteen grievances pertaining to Other Issues. Twelve of the cases were closed in favor of the Plan. Four of the cases closed in favor of the Enrollee. The following is a summary of these issues:

Two members complained they felt discriminated against due to the color of their skin as they were the last patients to be seen during the day. These cases closed in favor of the Plan after the response from the providers indicated the members received the appropriate services and were not discriminated against.

One member complained she felt that she was being taken advantage of for not speaking English due to not being seen as scheduled and asked to return later that afternoon. This case closed in favor of the Plan after the response from the provider indicated they were running behind scheduled and it was not their intent to make member feel that way.

One member complained they felt discriminated against by staff due to using foul language and ignored by provider. This case closed in favor of the Enrollee as response from provider to get an interpretation of the event was not received.

One member complained they felt targeted by KHS staff for being rude and hateful. This case closed in favor of the Plan after the recorded calls were reviewed and no issue was identified.

3rd Quarter 2019 Grievance Summary

One member complained that they felt provider was behaving inappropriately. This case closed in favor of the Plan after the response indicated member's allegations were unfounded.

One member complained that they felt discriminated against for being homeless due to feeling threatened by office staff. This case closed in favor of the Plan after the response stated member was asked to leave the clinic due to being belligerent towards staff.

One member complained that staff were discussing patient medical history in the lobby where others could hear the conversation. This case closed in favor of the Enrollee as response from provider to get an interpretation of the event was not received. This case was sent to Compliance for further review.

Two members were involved in a car accident while being transported to a medical appointment or service by an Uber driver. KHS Transportation coordinated the Uber trips. These cases closed in favor of the Enrollee, as they were involved in a car accident. Incidents reported by transportation vendor.

One member complained they felt discriminated against for the medication they were taking due to a provider refusing to see them. This case closed in favor of the Plan after the response from the provider stated he did not accept to see the member as a new patient after reviewing the CURES report indicating member attempted to obtain narcotics from multiple physicians.

One member complained they felt discriminated against for their race and appearance due to being intimidated to leave the clinic. This case closed in favor of the Plan after the provider indicated the member was not discriminated against and was asked to leave due to being aggressive towards staff.

One member complained provider refused to treat them as a walk-in patient after being placed in exam room due to missing appointments. This case closed in favor of the Plan after the response from the provider indicated the member was non-compliant with treatment and not following up with specialist.

One member complained they wanted reimbursement for medications paid out of pocket a year prior. This case closed in favor of the Plan as a TAR for medication was not submitted to KFHC at that time and there was no denial at pharmacy level.

One member complained they felt discriminated against for filing a complaint against her previous PCP as her new PCP refused to prescribe pain medication. This case closed in favor of the Plan after the response from provider indicated member refused to do any lab work and did not agree with the recommended treatment plan.

One member complained they felt a staff was inappropriately contacting member through social media. This case closed in favor of the Plan after response denied all allegations. This case was sent to Compliance for further review.

3rd Quarter 2019 Grievance Summary

Quality of Care

There were sixty six grievances involving Quality of Care issues. Thirty five cases were closed in favor of the Plan. Thirty one cases were closed in favor of the Enrollee. The following is a summary of these issues:

Thirty three members complained about the quality of care received from a Primary Care Provider (PCP). Seventeen cases were closed in favor of the Plan. Sixteen cases closed in favor of the Enrollee. All records/responses were sent to QI for further review and investigation.

Twenty one members complained about the quality of care received from a specialty provider. Eleven cases were closed in favor of the Plan. Ten cases closed in favor of the Enrollee. All records/responses were sent to QI for further review and investigation.

Eleven members complained about the quality of care received from providers staffed by an urgent care, hospital, or non-hospital affiliated clinic. Seven of these cases closed in favor of the Plan. Four of the cases closed in favor of the Enrollee. All records/responses were sent to QI for further review and investigation.

One member complained about the quality of care received from a driver staffed by Non-Emergency Medical Transport (NEMT). The case closed in favor of the Enrollee and all records/responses were sent to QI for further review and investigation.

Quality of Service

There were no grievances pertaining to Quality of Service.

Timely Assignment to Provider

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

Kaiser Permanente Grievances

During the third quarter of 2019, there were fifty seven grievances and appeals received by KFHC members assigned to Kaiser Permanente. Once case closed in favor of the Plan. Fifty one cases were closed in favor of the Enrollee. Five cases are still pending closure at the time of this report.

Access to Care

There were five grievances pertaining to Access to Care. The following is a summary of these issues:

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

One member complained about the lack of appointment availability for a Primary Care Provider. This case closed in favor of the Enrollee.

One member complained about the lack of appointment availability for a Specialist. This case closed in favor of the Enrollee.

One member complained about the lack of language accessibility. This case closed in favor of the Enrollee.

Coverage Dispute

There were five appeals pertaining to Coverage Dispute. The following is a summary of these issues:

Five members complained about a non-covered or out-of-network service they requested; however, were not covered. One case closed in favor of the Plan and service was not covered. Four of the cases closed in favor of the Enrollee and services were provided.

Medical Necessity

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

Four members complained about a service they requested; however, were not approved. All four cases closed in favor of the Enrollee and services were provided.

Quality of Care

There was one grievance pertaining to quality of care. The following is a summary of this issue:

One member complained about the quality of care they received. This case closed in favor of the Enrollee.

Quality of Service

There were forty two grievances pertaining to Quality of Service. The following is a summary of these issue.

Forty two cases complained about the services being inadequate at a facility. Thirty seven cases were closed in favor of the Enrollee. Five cases are still open and pending review.

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	Q3 2019	65701	1640	64061	0:00:24	0:07:32	2.5%	87%	Y	Y
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KERN HEALTH SYSTEMS
3rd Quarter 2019
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

Report Date: October 1, 2019

Department: Provider Relations

Monitoring Period: July 1, 2019 through September 30, 2019

Population:

Providers	Credentialed	Recredentialed
MD's	33	44
DO's	12	2
AU's	0	0
DC's	2	0
AC's	0	0
PA's	7	5
NP's	23	9
CRNA's	1	2
DPM's	1	0
OD's	2	0
ND's	0	0
RD's	1	0
BCBA's	8	1
Mental Health	8	1
Ocularist	0	0
Ancillary	5	11
OT	0	0
TOTAL	**103**	**75**

Specialty	Providers Credentialed	Providers Recredentialed	Providers Sent to PAC	Providers Not Approved
Acupuncture	0	0	0	0
Allergy & Immunology	0	0	0	0
Anesthesiology / CRNA	1	5	6	0
Audiology	0	0	0	0
Autism / Behavioral Analyst	8	1	9	0
Cardiology	1	2	3	0
Chiropractor	2	0	2	0
Colon & Rectal Surgery	0	1	1	0
Critical Care	0	0	0	0
Dermatology	0	1	1	0
Emergency Medicine	4	3	7	0
Endocrinology	2	1	3	0
Family Practice	17	11	28	0
Gastroenterology	1	1	2	0
General Practice	2	2	4	0
General Surgery	6	4	10	0
Genetics	0	0	0	0
Gynecology	0	0	0	0

KERN HEALTH SYSTEMS
3rd Quarter 2019
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

Specialty	Providers Credentialed	Providers Recredentialed	Providers Sent to PAC	Providers Not Approved
Gynecology/Oncology	0	1	1	0
Hematology/Oncology	0	0	0	0
Hospitalist	0	1	1	0
Infectious Disease	2	0	2	0
Internal Medicine	7	3	10	0
Mental Health	8	0	8	0
Mid Wife	0	0	0	0
Naturopathic Medicine	0	0	0	0
Neonatology	0	0	0	0
Nephrology	0	1	1	0
Neurological Surgery	1	1	2	0
Neurology	1	1	2	0
Obstetrics & Gynecology	6	2	8	0
Ocularist	0	0	0	0
Occupational Therapy	0	0	0	0
Ophthalmology	2	1	3	0
Optometry	2	0	2	0
Orthopedic Surgery / Hand Surg	0	1	1	0
Otolaryngology	0	2	2	0
Pain Management	6	3	9	0
Pathology	0	0	0	0
Pediatrics	1	4	5	0
Physical Medicine & Rehab	1	2	3	0
Plastic Sugery	0	0	0	0
Podiatry	1	0	1	0
Psychiatry	2	1	3	0
Pulmonary	0	2	2	0
Radiation Oncology	0	0	0	0
Radiology	14	9	23	0
Registered Dieticians	1	0	1	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	2	2	0
KHS Medical Directors	0	0	0	0
TOTAL	**99**	**71**	**170**	**0**

KERN HEALTH SYSTEMS
3rd Quarter 2019
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

ANCILLARY	Providers Credentialed	Providers Recredentialed	Providers Sent to PAC	Providers Not Approved
Ambulance	0	0	0	0
Cardiac Sonography	0	0	0	0
Comm. Based Adult Services	1	0	1	0
Dialysis Center	0	0	0	0
DME	0	2	2	0
Hearing Aid Dispenser	0	0	0	0
Home Health	0	0	0	0
Home Infusion/Compounding	0	0	0	0
Hospice	2	0	2	0
Hospital	0	1	1	0
Laboratory	0	1	1	0
Lactation Consultant	0	0	0	0
MRI	0	0	0	0
Ocular Prosthetics	0	0	0	0
Pharmacy	1	2	3	0
Pharmacy/DME	0	1	1	0
Physical / Speech Therapy	0	0	0	0
Prosthetics & Orthotics	0	0	0	0
Radiology	0	0	0	0
Skilled Nursing	0	0	0	0
Sleep Lab	0	0	0	0
Surgery Center	1	2	3	0
Transportation	0	0	0	0
Urgent Care	0	2	2	0
TOTAL	**5**	**11**	**16**	**0**

Defer = 0 **Denied = 1**

KERN HEALTH SYSTEMS
3rd Quarter 2019
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

KERN HEALTH SYSTEMS
3rd Quarter 2019
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

Kern Health Systems
Board Approved Effective 09/01/19

Legal Name DBA Name	Specialty	Provider #	Group #	Address	Contract Effective Date
B&D Hospice Services	Hospice & Palliative Care	PRV036355	PRV036355	1701 Westwind Dr Ste. 208 Bakersfield CA 93301	9/1/2019
Hullander and Mozingo, GP Dba: Pacific Pain Physicians	Pain Medicine	PRV050652	PRV050652	5601 Auburn St Ste A Bakersfield CA 93306	9/1/2019
Kern Medical Surgery Center, LLC	ASC	PRV048599	PRV048599	9300 Stockdale Hwy Ste. 200 Bakersfield CA 93311	Retro - Eff 6/15/2019
Autism Learning Partners, LLC	ABA	PRV055002	PRV055002	1201 24th St Ste B110 Bakersfield CA 93301	9/1/2019
Unity First Hospice Care, Inc.	Hospice	PRV051915	PRV051915	2525 Colorado Blvd Ste. E Los Angeles CA 90041	9/1/2019
Gregory A. Stainer, MD, FACS, A Professional Medical Corporation	Opthalmology	PRV039569	PRV039569	215 China Grade Loop Bakersfield CA 93308	9/1/2019

Kern Health Systems
Board Approved Effective 10/01/19

Legal Name	Specialty	Provider #	Group #	Address	Comments	Contract Effective Date
Jasmine Nyree Centers	ABA	PRV035797	PRV035797	6800 District Blvd. Bakersfield CA 93313	Existing credentialed providers	10/1/2019
Joseph Moza, MD, Inc.	General Surgery	PRV032495	PRV055769	901 Olive Drive Bakersfield CA 93308	Existing credentialed provider	10/1/2019
THV Enterprises Inc.	CBAS	PRV055636	PRV055636	3025 Fairfax Road Bakersfield CA 93306		10/1/2019
Lancaster Pharmacy Inc	Pharmacy	PRV055657	PRV055657	1841 West Avenue I Ste 107 Lancaster CA 93534		10/1/2019

Kern Health Systems
Board Approved Effective 09/01/19

	NAME	LEGAL NAME/ADDRESS	PROVIDER#	GROUP #	SPECIALTY	CONTRACT STATUS	PAC APPROVED - EFFECTIVE DATE
1	B&D Hospice Services	B&D Hospice Services 1701 Westwind Dr Ste. 208 Bakersfield CA 93301	PRV036355	PRV036355	Hospice & Palliative Care	**New Contract**	**Yes Eff 9/1/19**
2	Hullander, Robert MD	Hullander and Mozingo, GP Dba: Pacific Pain Physicians 5601 Auburn St Ste A Bakersfield CA 93306	PRV051763	PRV050652	Pain Medicine	**New Contract**	**Yes Eff 9/1/19**
3	Kern Medical Surgery Center, LLC	Kern Medical Surgery Center, LLC 9300 Stockdale Hwy Ste. 200 Bakersfield CA 93311	PRV048599	PRV048599	Surgery Center	**New Contract**	**Yes Retro - Eff 6/15/2019**
4	Pires, David DO	Hullander and Mozingo, GP Dba: Pacific Pain Physicians 5601 Auburn St Ste A Bakersfield CA 93306	PRV053401	PRV050652	Pain Medicine	**New Contract**	**Yes Eff 9/1/19**
5	Torres, April BCBA	Autism Learning Partners, LLC 1201 24th St Ste B110 Bakersfield CA 93301	PRV055000	PRV055002	Behavior Analyst / Qualified Autism Services Provider	**New Contract**	**Yes Eff 9/1/19**
6	Unity First Hospice Care, Inc.	Unity First Hospice Care, Inc. 2525 Colorado Blvd Ste. E Los Angeles CA 90041	PRV051915	PRV051915	Hospice	**New Contract**	**Yes Eff 9/1/19**
7	Walia, Sandeep MD	Gregory A. Stainer, MD, FACS, A Professional Medical Corporation 215 China Grade Loop Bakersfield CA 93308	PRV055003	PRV039569	Opthalmology	**New Contract**	**Yes Eff 9/1/19**
8	Eckard, Donald DO	Renaissance Imaging Medical Assoc, Inc. *All Locations 44105 W 15th Street Ste. 100 Lancaster CA 93534	PRV055004	PRV000324	Diagnostic Radiology	Existing	**Yes Eff 9/1/19**
9	Holt, Peter MD	Renaissance Imaging Medical Assoc, Inc. *All Locations 44105 W 15th Street Ste. 100 Lancaster CA 93534	PRV055005	PRV000324	Diagnostic Radiology	Existing	**Yes Eff 9/1/19**
10	Koh, Wei Loong Glenn MD	Kern County Hospital Authority 1700 Mt Vernon Avenue Bakersfield CA 93306	PRV052844	ALL KM SITES	General Surgery	Existing	**Yes Eff 9/1/19**
11	Popa, Theodore MD	United Neuroscience, Inc. 3838 San Dimas St Ste. A140 Bakersfield CA 93301	PRV054427	PRV030840	Neurology	Existing	**Yes Eff 9/1/19**
12	Shah, Samir MD	Renaissance Imaging Medical Assoc, Inc. *All Locations 44105 W 15th Street Ste. 100 Lancaster CA 93534	PRV055006	PRV000324	Diagnostic Radiology	Existing	**Yes Eff 9/1/19**
13	Albelais, Maria BCBA	California Psychcare, Inc. 624 E Commerce Dr Unit E Palmdale CA 93551	PRV055007	PRV011225	Behavior Analyst / Qualified Autism Services Provider	Existing	**Yes Eff 9/1/19**
14	Besoyan, Audrie Anne NP-C	Clinica Sierra Vista 1305 Bear Mountain Blvd Arvin 1611 1st St Bakersfield	PRV053087	PRV000002	Family Practice	Existing	**Yes Eff 9/1/19**

Kern Health Systems
Board Approved Effective 09/01/19

15	Bhalla, Manju NP	Advanced Gastro Medical Associates Dba: Institute of Advanced Gastroenterology 9802 Stockdale Hwy Ste 102 Bakersfield CA 93311	PRV053765	PRV000330	Internal Medicine (GI after 1-yr Exp)	Existing	**Yes Eff 9/1/19**
16	Collord, Thomas NP-C	Central California Foundation for Health Delano Prompt - 1201 Jefferson Street Wasco Medical Plaza - 2300 7th Street	PRV004427	PRV000190 PRV005653	General Practice / Internal Medicine	Existing	**Yes Eff 9/1/19**
17	Davis, Mark MD	Clinica Sierra Vista 1508 Garces Hwy Ste. 1 Delano CA 93215	PRV053086	PRV000002	Family Practice	Existing	**Yes Eff 9/1/19**
18	Dragon, Joseph NP-C	Clinica Sierra Vista 6310 Lake Isabella Blvd Lake Isabella CA 93240	PRV053088	PRV000002	Family Practice	Existing	**Yes Eff 9/1/19**
19	Eckard, Valerie MD	Renaissance Imaging Medical Assoc, Inc. *All Locations 44105 W 15th Street Ste. 100 Lancaster CA 93534	PRV009854	PRV000324	Diagnostic Radiology	Existing	**Yes Eff 9/1/19**
20	Elshire, Harry MD	Kern County Hospital Authority 1700 Mt Vernon Avenue Bakersfield CA 93306	PRV050577	ALL KM SITES	General Surgery	Existing	**Yes Eff 9/1/19**
21	Francisco, Joseph NP-C	Carlos A. Alvarez, MD Inc. 8929 Panama Rd Ste A Lamont CA 93241	PRV052680	PRV030784	Internal Medicine	Existing	**Yes Eff 9/1/19**
22	Frieson, Tiffany RD	Kern Valley Healthcare District 4300 Birch St Ste B Lake Isabella CA 93240	PRV052518	PRV046034 PRV000247	Registered Dietician	Existing	**Yes Eff 9/1/19**
23	Gann, Thomas NP-C	Priority Urgent Care 4821 Panama Lane Ste. A-C Bakersfield CA 93313	PRV055008	PRV038192	Emergency Medicine	Existing	**Yes Eff 9/1/19**
24	Garing, Babyruth NP-C	Priority Urgent Care 4821 Panama Lane Ste. A-C Bakersfield CA 93313	PRV053720	PRV038192	Family Practice	Existing	**Yes Eff 9/1/19**
25	Ghai, Sonia MD	Clinica Sierra Vista 301 Brundage Ln Bakersfield CA 93304	PRV008285	PRV000002	OB/GYN	Existing	**Yes Eff 9/1/19**
26	Gonzaga, Saul BCBA	California Spectrum Services 4865 Truxtun Ave Bakersfield CA 93309	PRV055009	PRV031975	Behavior Analyst / Qualified Autism Services Provider	Existing	**Yes Eff 9/1/19**
27	Govindarajan, Parthasarathy MD	Advanced Gastro Medical Associates Dba: Institute of Advanced Gastroenterology 9802 Stockdale Hwy Ste 102 Bakersfield CA 93311	PRV053761	PRV000330	Gastroenterology	Existing	**Yes Eff 9/1/19**
28	Greenspan, Stacy DO	Renaissance Imaging Medical Assoc, Inc. *All Locations 44105 W 15th Street Ste. 100 Lancaster CA 93534	PRV054616	PRV000324	Diagnostic Radiology	Existing	**Yes Eff 9/1/19**
29	Grewal, Gurpreet NP-C	The Pain Institute of California 9802 Stockdale Hwy Ste 105 Bakersfield CA 93311	PRV010693	PRV000510	Pain Management	Existing	**Yes Eff 9/1/19**

30	Habroun, Namaz BCBA	Center for Autism & Related Disorders Inc 6601 McDivitt Dr Bakersfield CA 93313	PRV055011	PRV032083	Behavior Analyst / Qualified Autism Services Provider	Existing	**Yes** **Eff 9/1/19**
31	Halsted, Mark MD	Renaissance Imaging Medical Assoc, Inc. *All Locations 44105 W 15th Street Ste. 100 Lancaster CA 93534	PRV055012	PRV000324	Diagnostic Radiology	Existing	**Yes** **Eff 9/1/19**
32	Jennings, Nicholle LCSW	Omni Family Health 4900 California Ave Ste 100B Bakersfield 1014 Calloway Dr Bakersfield 1701 Stine Rd Bakersfield	PRV052511	PRV000019	Clinical Social Worker	Existing	**Yes** **Eff 9/1/19**
33	Johnson, Jennifer NP	Centric Health Dba: Kern Endocrine Center 3008 Sillect Ave Ste. 220 Bakersfield CA 93308	PRV045157	PRV000503	Endocrinology	Existing	**Yes** **Eff 9/1/19**
34	Jones, Amber DO	Kern County Hospital Authority 1700 Mt Vernon Ave Bakersfield CA 93306	PRV053089	ALL KM SITES	General Surgery / Surgical Critical Care	Existing	**Yes** **Eff 9/1/19**
35	Juden, Christopher NP-C	Priority Urgent Care 4821 Panama Lane Ste. A-C Bakersfield CA 93313	PRV009093	PRV038192	Emergency Medicine	Existing	**Yes** **Eff 9/1/19**
36	Kalia, Rohit MD	Clinica Sierra Vista 2000 Physicians Blvd Bakersfield CA 93301	PRV053407	PRV000002	Infectious Disease	Existing	**Yes** **Eff 9/1/19**
37	Khatri, Bhavik DO	Oak Hills Medical Corporation Dba: Heart Vascular and Leg Center 5020 Commerce Dr Bakersfield 1408 Commercial Way Ste A Bakersfield 714 Main St Delano	PRV055013	PRV000310	Cardiovascular Disease	Existing	**Yes** **Eff 9/1/19**
38	Ledesma, David DC	Ridgecrest Regional Hopital - RHC 1111 N China Lake Blvd Ste 190 Ridgecrest CA 93555	PRV011497	PRV000279 PRV029495	Chiropractor	Existing	**Yes** **Eff 9/1/19**
39	Leung, Johnny NP	Kern County Hospital Authority 1700 Mt Vernon Ave Bakersfield 1111 Columbus St Bakersfield 9330 Stockdale Hwy Ste 400 Bakersfield	PRV052508	ALL KM SITES	Internal Medicine	Existing	**Yes** **Eff 9/1/19**
40	Liu, John MD	Ridgecrest Regional Hopital - RHC 1111 N China Lake Blvd Ste 190 Ridgecrest CA 93555	PRV003497	PRV029495	Neurological Surgery	Existing	**Yes** **Eff 9/1/19**
41	Liu, Tony DO	LAGS Spine and Sportscare Medical Ctr 3550 Q St Ste 105 Bakersfield CA 93301	PRV055014	PRV000403	Physical Medicine & Rehabilitation	Existing	**Yes** **Eff 9/1/19**
42	Liuzzi, Michelle PsyD	Telehealthdocs Medical Corporation dba: Telehealthdocs Medical Group *All Locations 2215 Truxtun Avenue Ste. 100 Bakersfield CA 93301	PRV045343	PRV036952 PRV053624 PRV053625	Psychology	Existing	**Yes** **Eff 9/1/19**
43	Lopez, Rocio NP-C	San Joaquin Valley Pulmonary Med Grp 3551 Q St Ste 100 Bakersfield 109 Adkisson Way Taft	PRV002187	PRV000354	Internal Medicine	Existing	**Yes** **Eff 9/1/19**

44	Mehta, Snehal MD	Renaissance Imaging Medical Assoc, Inc. *All Locations 44105 W 15th Street Ste. 100 Lancaster CA 93534	PRV055015	PRV000324	Diagnostic Radiology	Existing	**Yes** **Eff 9/1/19**
45	Moradsadeh, Nathaniel MD	Renaissance Imaging Medical Assoc, Inc. *All Locations 44105 W 15th Street Ste. 100 Lancaster CA 93534	PRV055016	PRV000324	Diagnostic Radiology	Existing	**Yes** **Eff 9/1/19**
46	Morovich, Monica LCSW	Omni Family Health 210 N Chester Ave Bakersfield 4900 California Ave Ste 100B Bakersfield 1014 Calloway Dr Bakersfield 1701 Stine Rd Bakersfield	PRV054616	PRV000019	Clinical Social Worker	Existing	**Yes** **Eff 9/1/19**
47	Myers, Brianna PA-C	Clinica Sierra Vista 1305 Bear Mountain Blvd Arvin CA 93203	PRV053405	PRV000002	Family Practice	Existing	**Yes** **Eff 9/1/19**
48	Nachtigall, Bryant DPM	Stockdale Podiatry Group, Inc. 110 New Stine Rd Bakersfield 1519 Garces Hwy Delano 1326 H St Ste. 1 Bakersfield	PRV055017	PRV000332	Podiatry	Existing	**Yes** **Eff 9/1/19**
49	Newman, Barbara MD	Renaissance Imaging Medical Assoc, Inc. *All Locations 44105 W 15th Street Ste. 100 Lancaster CA 93534	PRV055018	PRV000324	Diagnostic Radiology	Existing	**Yes** **Eff 9/1/19**
50	Oakes, Marya NP-C	LAGS Spine and Sportscare Medical Ctr 3550 Q St Ste 105 Bakersfield CA 93301	PRV055019	PRV000403	Pain Medicine	Existing	**Yes** **Eff 9/1/19**
51	O'Connor, Sean PA-C	Clinica Sierra Vista (CSV) Walk-In Clinics 2400 Wible Road Ste. 14 Bakersfield 2000 Physicians Blvd Bakersfield **Additional Affiliation:** Emergency Physicians Urgent Care, Inc. Dba: Accelerated Urgent Care * All locations	PRV051971	PRV000002	Emergency Medicine	Existing	**Yes** **Eff 9/1/19**
52	Ortman, Lindsey NP-C	Priority Urgent Care 4821 Panama Lane Ste. A-C Bakersfield CA 93313	PRV044812	PRV038192	Emergency Medicine	Existing	**Yes** **Eff 9/1/19**
53	Pearlstein, Maura DO	Kern County Hospital Authority 1700 Mt Vernon Avenue Bakersfield CA 93306	PRV052460	ALL KM SITES	General Surgery / Surgical Critical Care	Existing	**Yes** **Eff 9/1/19**
54	Peng, Lifang PA-C	Janardhan Grandhe, MD A Medical Corp Dba: Central Valley Pain Management 6401 Truxtun Ave Ste. B Bakersfield CA 93309	PRV055020	PRV013668	Pain Medicine	Existing	**Yes** **Eff 9/1/19**
55	Pitts, Millicent LMFT	S&T Professional Group, Inc. 2201 F Street Bakersfield CA 93301	PRV032446	PRV000358	Marriage & Family Therapy	Existing	**Yes** **Eff 9/1/19**

56	Rizvi, Muhammad CRNA	Regional Anesthesia Associates, Inc. 1700 Mt. Vernon Ave Bakersfield CA 93306	PRV050253	PRV037540	Certfied Nurse Anesthetist	Existing	**Yes** **Eff 9/1/19**
57	Rodriguez, Vivian BCBA	Bowcor Inc dba: Special Explorers Center 1011 17th Street Bakersfield CA 93301	PRV054601	PRV047660 PRV038625 PRV045393	Behavior Analyst / Qualified Autism Services Provider	Existing	**Yes** **Eff 9/1/19**
58	Rosenstein, Jordan PA-C	Priority Urgent Care 4821 Panama Lane Ste. A-C Bakersfield CA 93313	PRV048589	PRV038192	Family Practice	Existing	**Yes** **Eff 9/1/19**
59	Sabbah, Nathanael MD	Renaissance Imaging Medical Assoc, Inc. *All Locations 44105 W 15th Street Ste. 100 Lancaster CA 93534	PRV054548	PRV000324	Diagnostic Radiology / Nuclear Medicine	Existing	**Yes** **Eff 9/1/19**
60	Shafer, Adam DO	Kern Psychiatric Health and Wellness Ctr 6313 Schirra Ct Ste 1 Bakersfield CA 93313	PRV048044	PRV046499	Psychiatry	Existing	**Yes** **Eff 9/1/19**
61	Shepard, Linda PsyD	Telehealthdocs Medical Corporation dba: Telehealthdocs Medical Group *All Locations 2215 Truxtun Avenue Ste. 100 Bakersfield CA 93301	PRV055021	PRV036952 PRV053624 PRV053625	Psychology	Existing	**Yes** **Eff 9/1/19**
62	Strahan, Teri LCSW	Adventist Health Medical Center Tehachapi 105 West E Street Tehachapi CA 93561	PRV055021	ALL SITES	Clinical Social Worker	Existing	**Yes** **Eff 9/1/19**
63	Talmi, Danit MD	Renaissance Imaging Medical Assoc, Inc. *All Locations 44105 W 15th Street Ste. 100 Lancaster CA 93534	PRV055022	PRV000324	Diagnostic Radiology	Existing	**Yes** **Eff 9/1/19**
64	Truong, Linda OD	Clinica Sierra Vista 2000 Physicians Blvd Bakersfield CA 93301	PRV053403	PRV000002	Optometry	Existing	**Yes** **Eff 9/1/19**
65	Turner, Theresa NP-C	Kern Pediatrics 3941 San Dimas St Ste 101 Bakersfield CA 93301	PRV055023	PRV000342	Pediatrics	Existing	**Yes** **Eff 9/1/19**
66	Varma, Rohit MD	Charles D. Fritch, MD Inc. Dba: Fritch Eye Care Medical Center 8501 Brimhall Rd Ste 401&402 Bakersfield CA 93312	PRV003168	PRV000176	Ophthalmology	Existing	**Yes** **Eff 9/1/19**
67	Villaflor, Georgia NP-C	Kern County Hospital Authority 1700 Mt Vernon Ave Bakersfield CA 93306	PRV051359	ALL KM SITES	General Surgery	Existing	**Yes** **Eff 9/1/19**
68	Zaidi, Syed MD	Renaissance Imaging Medical Assoc, Inc. *All Locations 44105 W 15th Street Ste. 100 Lancaster CA 93534	PRV055024	PRV000324	Diagnostic Radiology	Existing	**Yes** **Eff 9/1/19**

Kern Health Systems
Board Approved Effective 10/01/19

	NAME	LEGAL NAME/ADDRESS	PROVIDER #	GROUP #	SPECIALTY	CONTRACT STATUS	PAC APPROVED - EFFECTIVE DATE
	Lancaster Pharmacy	Lancaster Pharmacy, Inc. 1841 West Avenue I Ste 107 Lancaster CA 93534	PRV055657	PRV055657	Pharmacy	**New Contract**	**Yes Eff 10/1/19**
	THV Enterprises	THV Enterprises 3025 Fairfax Rd Bakersfield CA 93306	PRV055636	PRV055636	Community Based Adult Services	**New Contract**	**Yes Eff 10/1/19**
	Mitchell, Kevin MD	Kern County Hospital Authority Kern Medical 1700 Mt Vernon Ave. Bakersfield CA 93306	PRV055427	ALL KM	General Surgery / Surgery Critical Care	Existing	**Yes Eff 10/1/19**
	Aguirre, Alejandra LCSW	Omni Family Health 4900 California Ave Ste 100B Bakersfield CA 93309	PRV055429	PRV000019	Clinical Social Worker	Existing	**Yes Eff 10/1/19**
	Alegre-Ramirez, Miguel BCBA	Teaching Autistic Children Inc. Dba: Learning Arts 5329 Office Center Ct Ste 150 Bakersfield CA 93309	PRV054586	PRV052185	Behavior Analyst / Qualified Autism Services Provider	Existing	**Yes Eff 10/1/19**
	Alphonso, Afron MD	Universal Urgent Care, PC *All Locations 8325 Brimhall Road Ste. 100 Bakersfield CA 93312	PRV055635	ALL SITES	Family Practice	Existing	**Yes Eff 10/1/19**
	Bromley, Windy NP	Ridgecrest Regional Hospital - RHC 1111 N China Lake Blvd Ste 190 Ridgecrest CA 93555	PRV054045	PRV029495	OB/GYN	Existing	**Yes Eff 10/1/19**
	Brown, Jennifer MD	Clinica Sierra Vista 2000 Physicians Blvd Bakersfield CA 93301	PRV053757	PRV000002	Infectious Disease	Existing	**Yes Eff 10/1/19**
	Cardenas, Erick NP-C	Infusion & Clinical Services Premier Urgent Care of Central California 5401 White Lane Bakersfield CA 93309	PRV053091	PRV000404	Family Practice	Existing	**Yes Eff 10/1/19**
	Deppen, David, NP-C	Emergency Physicians Urgent Care, Inc. Accelerated Urgent Care - 212 Coffee Road Bakersfield CA 93309	PRV055637	ALL SITES	Family Practice	Existing	**Yes Eff 10/1/19**
	Eby, Lauren DO	Clinica Sierra Vista (CSV) Walk-In Clinics 2400 Wible Road Ste. 14 Bakersfield 2000 Physicians Blvd Bakersfield	PRV052513	PRV000002	Family Practice	Existing	**Yes Eff 10/1/19**
	Edwards, Joseph MD	Ridgecrest Regional Hospital - RHC 1111 N China Lake Blvd Ste 190 Ridgecrest CA 93555	PRV053721	PRV000279 PRV029495	OB/GYN	Existing	**Yes Eff 10/1/19**
	Graham, Anne NP-C	Clinica Sierra Vista 301 Brundage Ln Bakersfield 1611 1st St Bakersfield 8787 Hall Rd Lamont	PRV054042	PRV000002	OB/GYN	Existing	**Yes Eff 10/1/19**
	Holloway, Emma BCBA	California Psychcare 732 N Norma St Ste B Ridgecrest CA 93551	PRV055638	PRV011225	Behavior Analyst / Qualified Autism Services Provider	Existing	**Yes Eff 10/1/19**
	Hu, Ben-Hwa MD	Emergency Physicians Urgent Care, Inc. Accelerated Urgent Care - 212 Coffee Road Bakersfield CA 93309	PRV055639	ALL SITES	Family Practice	Existing	**Yes Eff 10/1/19**
	Jones, Oretha NP-C	Ridgecrest Regional Hospital - RHC 1111 N China Lake Blvd Ste 190 Ridgecrest CA 93555	PRV054613	PRV000279	Internal Medicine	Existing	**Yes Eff 10/1/19**
	Jose, Marissa NP-C	Clinica Sierra Vista (CSV) Walk-In Clinics 2400 Wible Road Ste. 14 Bakersfield	PRV054048	PRV000002	Family Practice	Existing	**Yes Eff 10/1/19**
	Keller, Suzanne NP	Kern Psychiatric Health & Wellness Center, Inc. 6313 Schirra Ct Ste 1 Bakersfield CA 93313	PRV012873	PRV046499	Psychiatry	Existing	**Yes Eff 10/1/19**

	Madrid, Suzanne BCBA	Center for Autism and Related Disorders 8302 Espresso Dr Ste 100 Bakersfield CA 93312	PRV055642	PRV032083	Behavior Analyst / Qualified Autism Services Provider	Existing	**Yes** **Eff 10/1/19**
	McKay, Katie LCSW	Omni Family Health 4900 California Ave Ste 100B Bakersfield 210 N Chester Ave Bakersfield 1701 Stine Rd Bakersfield 1215 Jefferson St Delano	PRV054620	PRV000019	Clinical Social Worker	Existing	**Yes** **Eff 10/1/19**
	Mozingo, Ralph DO	Pacfic Pain Physicians 5601 Auburn St Ste A Bakersfield CA 93306	PRV051584	PRV050652	Pain Medicine	Existing	**Yes** **Eff 10/1/19**
	Parish, Ashley, PA-C	Clinica Sierra Vista (CSV) Walk-In Clinics 2400 Wible Road Ste. 14 Bakersfield 2000 Physicians Blvd Bakersfield	PRV054236	PRV000002	Family Practice	Existing	**Yes** **Eff 10/1/19**
	Patel, Vijay MD	Universal Urgent Care, PC *All Locations 8325 Brimhall Road Ste. 100 Bakersfield CA 93312	PRV055656	ALL SITES	Family Practice	Existing	**Yes** **Eff 10/1/19**
	Phan, Christina PA	Omni Family Health 912 Fremont St Delano 21138 Paso Robles Hwy Lost Hills 277 E Front St Buttonwillow	PRV054628	PRV000019	Family Practice	Existing	**Yes** **Eff 10/1/19**
	Punzalan, Rubio MD	Central California Foundation for Health Delano Prompt - 1201 Jefferson Street Wasco Medical Plaza - 2300 7th Street	PRV054588	PRV0056353	General Practice	Existing	**Yes** **Eff 10/1/19**
	Raja, Furqan PA-C	Omni Family Health 4900 California Ave Ste 100B Bakersfield CA 93309 * Floats to all locations	PRV001560	PRV000019	Pediatrics / Internal Medicine	Existing	**Yes** **Eff 10/1/19**
	Saito, Steven MD	Clinica Sierra Vista 7800 Niles St Bakersfield CA 93306	PRV054047	PRV000002	Family Practice	Existing	**Yes** **Eff 10/1/19**
	Sarrafian, Peyman MD	Infusion & Clinical Services Dba: Premier Urgent Care of Central California 901 Olive Dr Bakersfield CA 93308	PRV007414	PRV000404	Family Practice	Existing	**Yes** **Eff 10/1/19**
	Shah, Harshit MD	Dignity Health Medical Foundation dba: Dignity Health Medical Group 9500 Stockdale Highway Ste. 201 Bakersfield CA 93311	PRV029411	PRV012886	Endocrinology	Existing	**Yes** **Eff 10/1/19**
	Shively, Kyle OD	Sabrina Graziano, OD Dba: BeSpectacled Eye Care Optometric Corp 5603 Auburn St Ste A Bakersfield CA 93306	PRV047075	PRV039299	Optometry	Existing	**Yes** **Eff 10/1/19**
	Sladich, Michael DC	Omni Family Health 4900 California Ave Ste 100B Bakersfield CA 93309	PRV036479	PRV000019	Chiropractic	Existing	**Yes** **Eff 10/1/19**
	Thor, Jana DO	OBHG California PC 420 34th St Bakersfield CA 93301	PRV005110	PRV000384	OB/GYN / Hospitalist	Existing	**Yes** **Eff 10/1/19**
	Wetherald, Jennifer DO	Clinica Sierra Vista 301 Brundage Lange Bakersfield CA 93304	PRV054235	PRV000002	OB/GYN	Existing	**Yes** **Eff 10/1/19**
	Yang, Fan MD	Renaissance Imaging Medical Assoc, Inc. *All Locations 44105 W 15th Street Ste. 100 Lancaster CA 93534	PRV054915	PRV000324	Diagnostic Radiology	Existing	**Yes** **Eff 10/1/19**
	Yee, Jaryd MD	Renaissance Imaging Medical Assoc, Inc. *All Locations 44105 W 15th Street Ste. 100 Lancaster CA 93534	PRV055664	PRV000324	Diagnostic Radiology	Existing	**Yes** **Eff 10/1/19**

KERN HEALTH SYSTEMS

Provider Network Management
Network Review
Quarter 3, 2019

- **After Hours Calls**
- **Appointment Availability Survey**
- **Access Grievance Review** (Q2 2019)
- **Geographic Accessibility**
- **Network Adequacy**

KERN HEALTH SYSTEMS

After Hours Calls

Quarter 3, 2019

AFTER HOURS CALLS SURVEY

Q3, 2019

KERN HEALTH SYSTEMS

Introduction

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

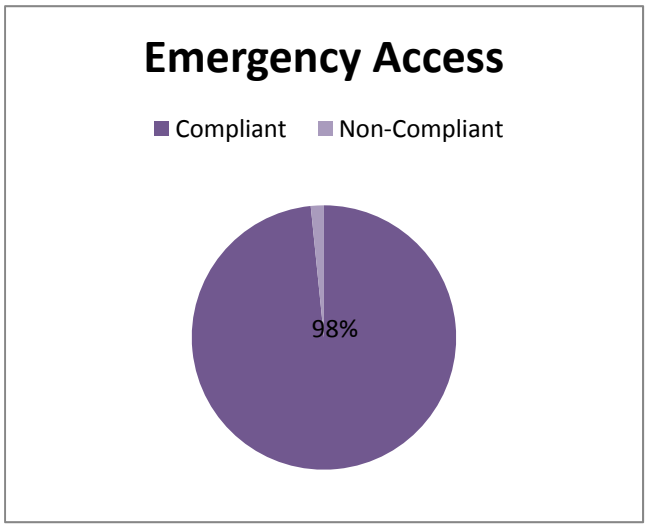
1.) Provider's answering machine or answering service must instruct the member to call 911 if the purpose of the call is a medical emergency.

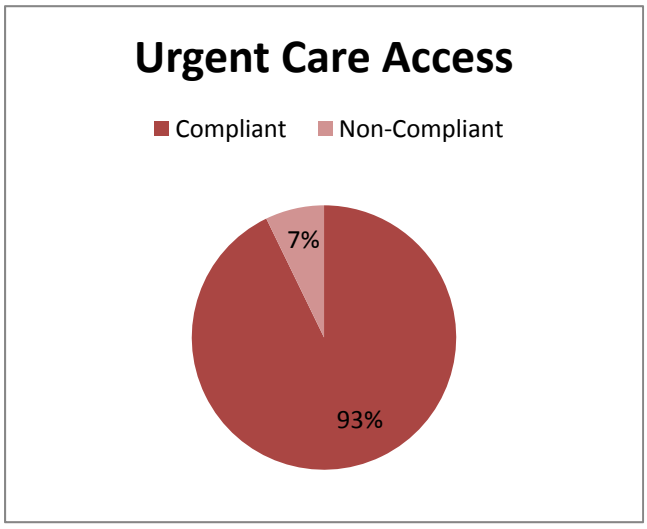
2.) For urgent matters, Provider's answering machine must provide an on-call number. If an answering service is used, the member must receive a call back from an on-call member of your office within 30 minutes of call.

An initial survey is conducted by Health Dialog and then forwarded to the Plan's Provider Network Analysts who make additional calls each quarter based on the results received from the survey vendor. Results are to be reported to the KHS QI/UM Committees and to Executive Staff.

Results

125 provider offices were contacted during Q3 2019. Of those offices, 123 were compliant with the Emergency Access Standards and 116 were compliant with the Urgent Care Access Standards.





AFTER HOURS CALLS SURVEY

Q3, 2019

Trending / Follow –Up / Outreach

The Plan reviewed results against past quarters. The Plan identified four (4) provider groups that were out of compliance for a second quarter in a row. It appears that Plan outreach and education based on the prior quarter's results may have taken place concurrent with the Plan's survey vendor conducting the 3rd quarter afterhours calls – which could be one potential reason for multiple providers remaining out of compliance.

The Plan's Provider Network Management department will conduct outreach and education to all identified provider offices. In addition to sending out a letter (template attached), the results will be provided to each provider office's assigned Plan representative to reach out, inform them of the results, and provide additional coaching on the Plan's after-hours access standards.

KERN HEALTH SYSTEMS

[DATE]

[OFFICE NAME]
Attn: Office Manager
[ADDRESS]
[CITY], [STATE] [ZIP]

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 within 30 minutes of call.

The purpose of this letter is to notify you of the identified non-compliance issues below.

During [QUARTER, YEAR], a call was placed to your office at [PHONE]. The results of that call found that your office was non-compliant with the [STANDARD] afterhours access standard as set forth in the KHS standards in policy 4.30-P *Accessibility Standards*.

For your convenience, I have attached a copy of our Policy related to access standards. Please review this policy with your staff to ensure compliance. Your office will remain on the list of providers to be surveyed for compliance with KHS access standards. In order to ensure member access, it is imperative these standards are regularly evaluated.

Please call me if you have any questions or concerns related to this policy. KHS will assist in any way possible to ensure compliance with these standards.

Sincerely,

Melissa Lopez
Provider Relations Manager
661-617-2642

if unavailable within the network, when medically necessary for the member's condition. This requirement does not prohibit a plan from accommodating an enrollee's preference to wait for a later appointment from a specific contracted provider.

3.8 Office Waiting Time - Maximum

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

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

3.9 Facility Hours

A. Emergency Care - 24 hours per day, 7 days per week

B. After Hours Urgent and Emergency Care - Primary and specialty care providers must provide or arrange afterhours access for treatment of urgent and emergency conditions by telephone and/or personal contact.

C. Each contracted provider shall offer their KHS Medi-Cal members hours of operation that are no less than the hours of operation offered by the contracted provider to other patients or comparable to Medi-Cal FFS, if the provider serves only Medi-Cal beneficiaries.

Office hours, including after-hours availability, should be posted on the outside entrance of the office with the office daytime and after hours phone numbers.

3.10 Telephone Accessibility

Providers and administrative personnel must maintain a reasonable level of telephone accessibility to KHS members. At minimum, the following response times are required:

Nature of Telephone Call	Response Time
Emergency medical or Kern County Mental Health Crisis Unit	Member should be instructed to call 9-1-1 or 661-868-8000
Urgent medical	30 Minutes
Non-urgent medical	By close of following business day
Non-Urgent Mental Health	By close of following business day

	Administrative	By close of following business day

Provider offices must provide procedures to enable patient access to emergency services 24 hours per day, seven days per week. Patients must be able to call the office number for information regarding physician availability, on call provisions or emergency services. An answering machine or service must be made available after normal business hours with direction in non-emergency and emergency situations.

Contracted providers must answer or design phone systems that answer phone calls within six rings. Providers should address each telephone call regarding medical advice or issues promptly and efficiently and must ensure that non-medical personnel do not give medical advice. Only PAs, NPs, RNs and MDs may provide medical advice. A sample policy that providers may incorporate into their own body of policies is included as Attachment A.

KHS provides or arranges for the provision of 24/7 triage screening services by telephone. KHS ensures that telephone triage or screening are provided in a timely manner appropriate for the member's condition, and the triage or screening wait time does not exceed 30 minutes. KHS provides triage or screening services through medical advice lines pursuant to section 1348.8 of the Health & Safety Code. Refer to KHS Policy 3.15-I 24-hour Telephone Triage Service.

4.0 MONITORING

The Provider Relations Department shall use the following sources to study and assure compliance with access standards:

A. Appointment Availability Survey Program
B. Access grievances/1000 member months
C. Member Services Call Center Data
D. Member Satisfaction Survey
E. Annual Provider Satisfaction Survey

4.1 Appointment Availability Survey Program

The Appointment Availability Survey Program assists with monitoring accessibility of care and quality of customer service. Calls are made to contracted primary care, mental health and specialist providers to assess their level of customer service and access compliance. The program also provides intervention and early feedback that identifies and facilitates resolution of access problems and prevents some member complaints.

The Plan will review and evaluate on a quarterly basis the accessibility, availability and continuity of care of PCP's, Specialists, and Mental Health Providers through the *member grievance process, After Hours Access Survey* and *quarterly DMHC reporting.*

4.1.1 Method and Frequency

Calls will be placed to contracted PCPs, mental health providers and specialists during regular business hours on an annual basis. Methodology for this survey will be based on the annually defined DMHC Survey Methodology. The Provider Appointment Availability Survey will be conducted annually.

KERN HEALTH SYSTEMS

Appointment Availability Survey

Quarter 3, 2019

Provider Network Management

Appointment Availability Survey

Q3, 2019

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 fifteen (15) business days of request.**

The survey was conducted internally by KHS staff; compliance is determined using the methodology utilized by the DHCS during the 2017 Medical Audit in which they conducted a similar appointment availability survey. Results are to be reported to the KHS QI/UM Committee.

KHS also utilizes these quarterly calls to monitor contracted provider's **Phone Answering Timeliness.** KHS *Policy 4.30-P Accessibility Standards,* requires "contracted providers must answer or design phone systems that answer phone calls within six rings." In conducting the quarterly appointment availability survey, KHS staff count the rings prior to a provider answering to gauge compliance.

Appointment Availability Survey Results

A random sample of 15 primary care provider offices and 15 specialist offices were contacted during Q3 2019. Of the primary care providers surveyed, the plan compiled the wait time (in days) to determine the Plan's average wait time for a primary care appointment; for Q3 2019, the Plan's average wait time for a primary care appointment was **3.7 days**, and was found to be in-compliance with the 10 business day standard. Of the specialist providers surveyed, the plan compiled the wait time (in days) to determine the Plan's average wait time for a specialist appointment; for Q3 2019, the Plan's average wait time for a specialist appointment was **5.7 days**, and was found to be in-compliance with the 15 business day standard.

While the Plan's average wait time for primary care and specialist appointments was in-compliance with the required standards, during the course of the Q3 2019 survey, the Plan identified two provider offices not in-compliance with the required standard. The Plan is reaching out to these providers via letter to notify them of their non-compliant status and provide a copy of Plan's appointment availability policy and procedure. Additionally, these provider offices will be logged for additional tracking and trending and potential further outreach to measure compliance.

Phone Answering Timeliness Results

Utilizing the methodology outlined above, KHS conducts a phone answering timeliness survey in conjunction with the appointment availability survey. During Q3 2019, all calls were answered within six rings or less, with an average **2 rings** before a call was answered.

KERN HEALTH SYSTEMS

[OFFICE NAME]
[ADDRESS]
[CITY], [STATE] [ZIP]

[DATE]

Attn: Office Manager
RE: Appointment Availability

To Whom It May Concern:

Kern Health Systems (KHS) uses an appointment availability survey program to assess compliance with access standards for Kern Family Health Care (KFHC) Members. The Department of Health Care Services (DHCS), and KHS policy 4.30-P *Accessibility Standards* requires that patients be able to call an office for information regarding physician and appointment availability, on call provisions, or emergency services.

On [DATE] at [TIME], KHS contacted your office and conducted an appointment availability survey in regards to scheduling a [PROVIDER TYPE] appointment. Based on the results of the survey we found your office was not complaint with KHS availability standards. KHS policy requires non-urgent appointments should be within 10 business days for primary care services, within 15 business days for specialty care services and within 48 hours for urgent appointments.

The purpose of this letter is to notify you of the identified non-compliance and to remind you of your contractual obligations related to access standards. Please call me if you have any questions or concerns related to this policy. KHS will assist in any way possible to ensure compliance with these standards.

Sincerely,

Melissa Lopez
Provider Relations Manager
Kern Health Systems
(661) 617-2642
melissa.lopez@khs-net.com

KERN HEALTH SYSTEMS

Access Grievance Review

Quarter 2, 2019

Provider Network Management

Access Grievance Review

Q2, 2019

Introduction and KHS Policy

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".

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.*

During Q2 2019, thirty-three (33) access-related grievances were received and reviewed by the KHS grievance committee. In twenty-five (25) of the cases, no issues were identified and were closed in favor of the plan. The remaining **eight (8) 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, Trending, and Provider Outreach

During the Q2 2019 Access Grievance Review meeting the eight (8) cases that were closed in favor of the enrollee were reviewed against all access grievances received in the previous year.

Of the eight (8) cases reviewed, three (3) grievances were classified as "Difficulty Accessing a Specialist"; one (1) of the grievances was for in-office wait time, one (1) was for appointment availability, and one (1) for phone access. Upon review of these grievances against grievances received in the previous year, the Plan did not identify any trends.

The remaining five (4) cases reviewed were classified as "Access to Care"; one (1) of the grievances was for in-office wait time, and four (4) were for appointment availability. Upon review of these grievances against grievances received in the previous year, the Plan did not identify any trends.

KERN HEALTH SYSTEMS

Quarter 2, 2019 Access Grievances Review Agenda
Date: 11/7/2019

Discussion:

1. **Review access grievances for Q2, 2019**
   - **Identify any trends regarding access**
   - **Conduct file review for grievances closed in favor of the enrollee**

2. **Review Access Grievances for Q2, 2019 against last year of annual grievances**
   - **Identify any trends regarding access**

Name	Title	Date
Melissa Lopez	PR Manager	11/7/2019
Yolanda Herrera	Yolanda Herrera Cred Supv. Analyst	11/7/19
Adi Zavala		11/7/19
James Winfrey	PR Analyst	11/7/19

KERN HEALTH SYSTEMS

Geographic Accessibility

Quarter 3, 2019

Provider Network Management

Geographic Accessibility

Q3, 2019

KERN HEALTH SYSTEMS

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.

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

DHCS Annual Network Certification - 2019

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

As a part of the Annual Network Certification requirement outlined in APL 18-005 and 19-002, the Plan was required to submit geographic access analysis outlining compliance with the above-listed standards. For all zip codes in which the Plan was not compliant with the above standard, the Plan was able to submit alternative access standards to ensure compliance.

The Plan currently maintains a subcontract with Kaiser Permanente (KP) to provide services to a subset of KHS enrollees; DHCS Network Certification required KP contracted providers to be included in the geographic analysis conducted by the Plan. In reviewing the two plans combined provider data, KHS found that KP providers practice in the same geographic areas as KHS providers, and did not cause substantial change to KHS' compliance with geographic accessibility standards.

Geographic Accessibility

Q3, 2019

The Plan completed required network certification reporting in Q1 2019, including the submission of alternative access standard requests based on the results of the Plan's geographic accessibility analysis.

On July 9, 2019 KHS received notification to provide a corrective action plan in response to KHS's 2019 network adequacy evaluation submission to DHCS. DHCS found the Plan to be out of compliance with specialty/geographic area specific time and distance standards.

In response to the received request for a corrective action plan, on August 7, 2019 the Plan provided additional justification for previously submitted alternative access standards and requested the DHCS re-evaluate their original determination. Alternate access standards are granted to health plans that serve areas that include classifications such as Medically Underserved Areas (MUAs), Health Professional Shortage Areas (HPSAs), and rural and sparsely populated geographic areas. (These were the areas DHCS deemed access deficient).

On October 1, 2019, the KHS received notification from DHCS (see attached) of their acceptance of our explanation of why the alternative access standard should apply and determined the matter closed.

During Q3 2019, the Plan reviewed the geographic analysis conducted during Q1 2019 against changes within the provider network during Q3 2019, and did not find any substantial changes that would affect the plan's current geographic accessibility.

DHCS
JENNIFER KENT
DIRECTOR

State of California—Health and Human Services Agency
Department of Health Care Services

GAVIN NEWSOM
GOVERNOR

OCT 0 1 2019

Douglas Hayward, CEO
Kern Health Systems
9700 Stockdale Highway
Bakersfield, CA 93311

RE: 2019 ANNUAL NETWORK CERTIFICATION – CORRECTIVE ACTION PLAN CLOSEOUT

Dear Douglas Hayward:

Kern Health Systems had a corrective action plan (CAP) imposed for failure to meet requirements of the 2019 Annual Network Certification (ANC). As required by the mandates of the CAP, the MCP was required to report to DHCS by providing CAP responses.

This letter signifies that the Department of Health Care Services (DHCS) completed an assessment of Kern Health Systems CAP response and determined that all ANC deficiencies have been resolved. The CAP is hereby closed. Refer to Exhibit A for results.

If you have any questions, please contact Bambi Cisneros, Branch Chief at (916) 345-7941 or bambi.cisneros@dhcs.ca.gov.

Sincerely,

Nathan Nau, Chief
Managed Care Quality and Monitoring Division
Department of Health Care Services

Exhibit A: Network Certification CAP Assessment

Exhibit A: Network Certification CAP Assessment

Kern Health Systems
Kern County

Overall MCP Results			Pass	
Provider to Member Ratios			**Status**	**Description of Findings**
PCP Ratio (1: 2,000)			Pass	
Total Physician Ratio (1: 1,200)			Pass	
Time and Distance			**Status**	**Description of Findings**
PCP	Adult		Pass	
	Pediatric		Pass	
OB/GYN	Primary Care		AAS Pass	Closed
	Specialty Care		Pass	
Core Specialists	Adult	Cardiology/ Interventional Cardiology	Pass	
		Dermatology	Pass	
		Endocrinology	Pass	
		ENT/ Otolaryngology	AAS Pass	Closed
		Gastroenterology	Pass	
		General Surgery	Pass	
		Hematology	AAS Pass	Closed
		HIV/AIDS Specialists/ Infectious Diseases	AAS Pass	
		Nephrology	Pass	
		Neurology	AAS Pass	Closed
		Oncology	Pass	
		Ophthalmology	AAS Pass	Closed
		Orthopedic Surgery	Pass	
		Physical Medicine and Rehabilitation	AAS Pass	Closed
		Psychiatry	Pass	
		Pulmonology	AAS Pass	Closed
	Pediatric	Cardiology/ Interventional Cardiology	Pass	
		Dermatology	Pass	
		Endocrinology	Pass	
		ENT/ Otolaryngology	AAS Pass	Closed
		Gastroenterology	Pass	
		General Surgery	Pass	
		Hematology	AAS Pass	Closed
		HIV/AIDS Specialists/ Infectious Diseases	AAS Pass	Closed
		Nephrology	AAS Pass	
		Neurology	AAS Pass	Closed
		Oncology	Pass	
		Ophthalmology	AAS Pass	Closed
		Orthopedic Surgery	Pass	
		Physical Medicine and Rehabilitation	AAS Pass	Closed
		Psychiatry	Pass	
		Pulmonology	AAS Pass	Closed
Mental Health Outpatient Services	Adult		Pass	
	Pediatric		Pass	
Facilities	Hospitals		Pass	
	Pharmacies		Pass	
Mandatory Provider Types			**Status**	**Description of Findings**
FQHC	Includes at least one within the contracted service area		Pass	
RHC	Includes at least one within the contracted service area		Pass	
FBC	Includes at least one within the contracted service area		Pass	
IHF	Contract offered to each IHF within the service area		Pass	
Licensed Midwife	Includes at least one within the contracted service area		Pass	
Certified Nurse Midwife	Includes at least one within the contracted service area		Pass	
Alternative Access Standards			**Status**	**Description of Findings**
Alternative Access Standards Requests			AAS Pass	Closed

KERN HEALTH SYSTEMS

Network Adequacy

Quarter 3, 2019

Provider Network Management

Network Adequacy

Q3, 2019

KERN HEALTH SYSTEMS

Introduction

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

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

Per KHS policy, 4.30-P *Accessibility Standards, §4.5 Full-time equivalent (FTE) Provider to Member Ratios,* "Full-time equivalency shall be determined via an annual survey of KHS' contracted providers to determine the percentage of time allocated to Plan's beneficiaries. The results of the survey will be used to calculate an average FTE percentage which will be applied to the Plan's network of providers when calculating the physician-to-enrollee compliance ratios. The methodology for the survey, results of the survey, and network capacity review of above ratios, will be reported annually to the KHS QI/UM Committee. Due to a maximum member assignment of 1,000 Mid-level providers serving in the Primary Care capacity will be counted as .5 of a PCP FTE, prior to percentage calculation."

Survey Methodology and Results

In 2019, KHS contracted with SPH Analytics to conduct our annual Provider Satisfaction Survey; as a part of that survey, responding providers were asked, "*What portion of your managed care volume is represented by Kern Health Systems?"* Outreach for the survey was placed to every contracted provider within the Plan's network. Responses received, and FTE calculations based on those responses, do not account for providers who refuse to participate in the survey. KHS used the responses collected from Primary Care Providers to calculate the FTE for Primary Care Providers, and used the responses collected from Primary Care Providers and Specialists to calculate the FTE for Physicians.

KHS utilized SPH Analytics, an NCQA certified survey vendor, to conduct the survey for 2019. SPH's methodology involved two waves of mail and Internet, with a third wave of phone follow up to administer the survey; for 2019, the provider survey was conducted from June to August.

Based on the results of 2019 survey, KHS calculated a network-wide FTE of **49.06% for Primary Care Providers** and **43.19% for Physicians.**

Network Adequacy

Q3, 2019

Full Time Equivalency Compliance Calculations

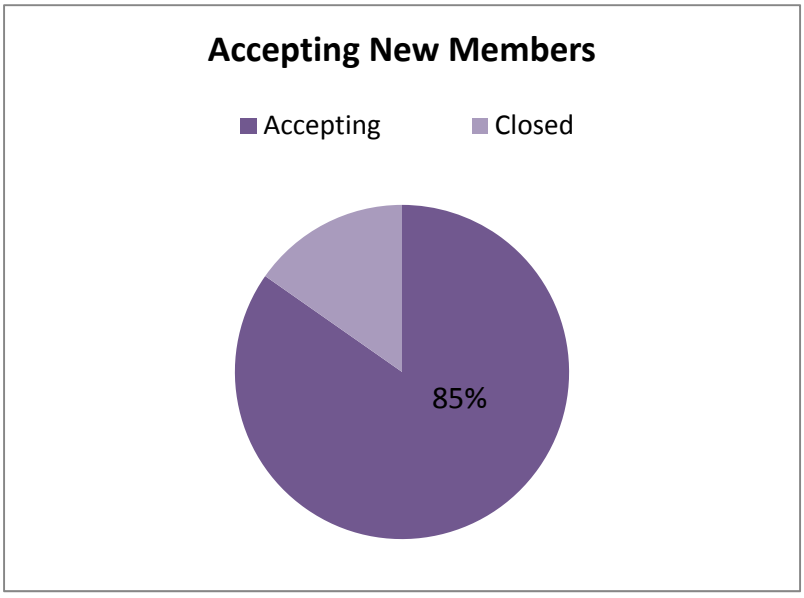
Of KHS' 257,864 membership at time of review, 8,922 were assigned and managed by Kaiser and did not access services through KHS' network of contracted providers; due to this, Kaiser managed membership is not considered when calculating FTE compliance.

As of the end of Q3 2019, the plan was contracted with 380 Primary Care Providers, a combination of 206 physicians and 174 mid-levels. Based on the FTE calculation process outlined above, with a 49.06% PCP FTE, KHS maintains a total of **143.75 FTE PCPs**. With a membership enrollment of 248,942 utilizing KHS contracted PCPs, KHS currently maintains a ratio of **1 FTE PCP to every 1731.79 members**; KHS is compliant with state regulations and Plan policy.

As of the end of Q3 2019, the plan was contracted with 1077 Physicians. Based on the FTE calculation process outlined above, with a 43.19% Physician FTE, KHS a total of **465.11 FTE Physicians**. With a total membership enrollment of 248,942 utilizing KHS contracted Physicians, KHS currently maintains a ratio of **1 FTE Physician to every 535.23 members**; KHS is compliant with state regulations and Plan policy.

Accepting New Members

In addition to the Full Time Equivalency Compliance review conducted above, the Plan monitors adequacy of its Primary Care Network by reviewing the count/percentage of Primary Care Providers (PCP) who are accepting new members. At the end of Q3 2019 the plan maintained a network of 380 Primary Care Providers, a combination of 206 physicians and 174 mid-levels. At the time of this review, 322 Primary Care Providers were accepting new members at a minimum of one Plan-contracted location, a combination of 163 physicians and 159 mid-levels. **The Plan calculated that 85% of the network of Primary Care Providers is currently accepting new members at a minimum of one location**. The Plan will continue to monitor this percentage quarterly to ensure it maintains an adequate network of Primary Care Providers.

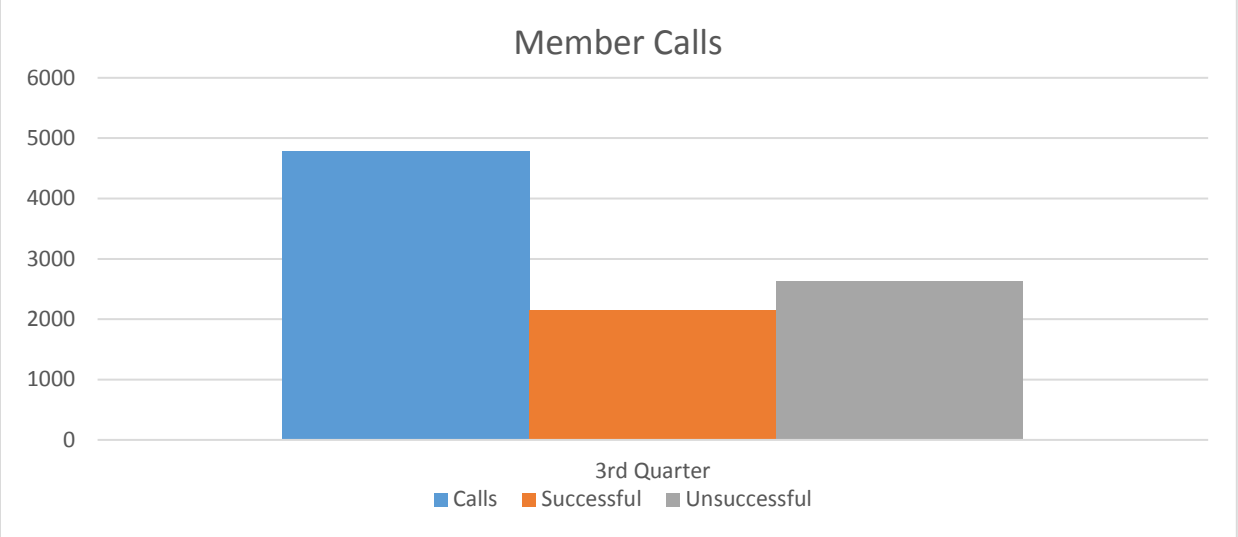


Disease Management Quarterly Report

3rd Quarter, 2019

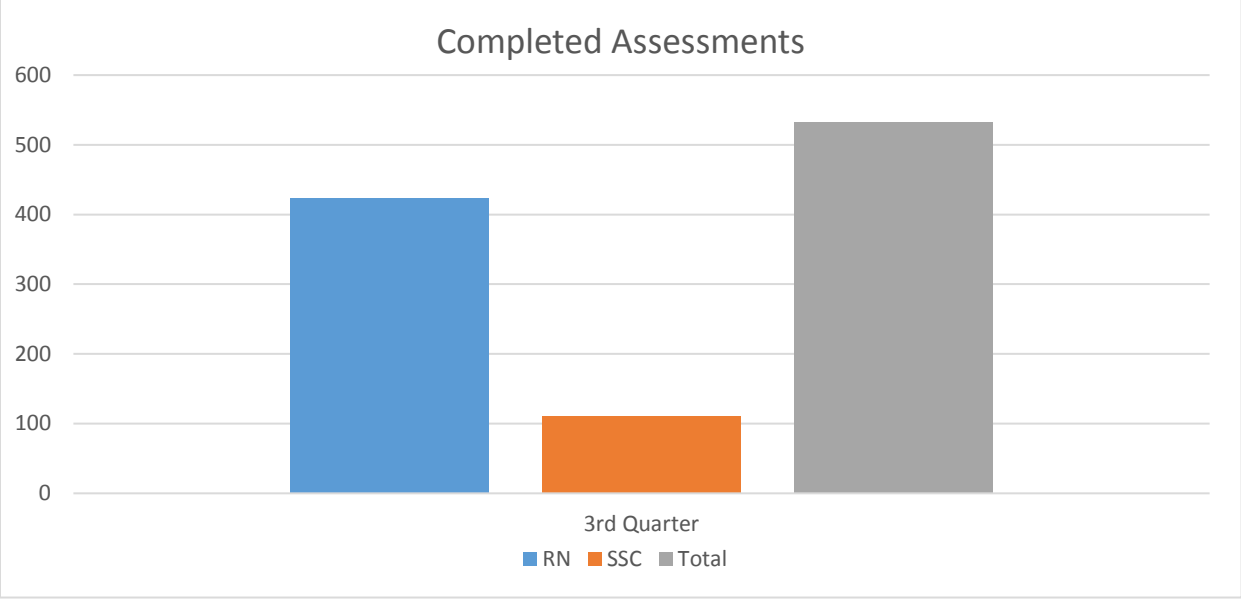
Telephone Calls: A total of 4,781 calls were made by the DM staff during the 3rd Quarter, 2019.

Member Calls Attempted	Successful Calls	Unsuccessful Calls	Total Member Calls	% Contacted
RN	1,253	1,892	3,145	40%
SSC	898	738	1,636	55%
Total	**2,151**	**2,630**	**4,781**	**45%**



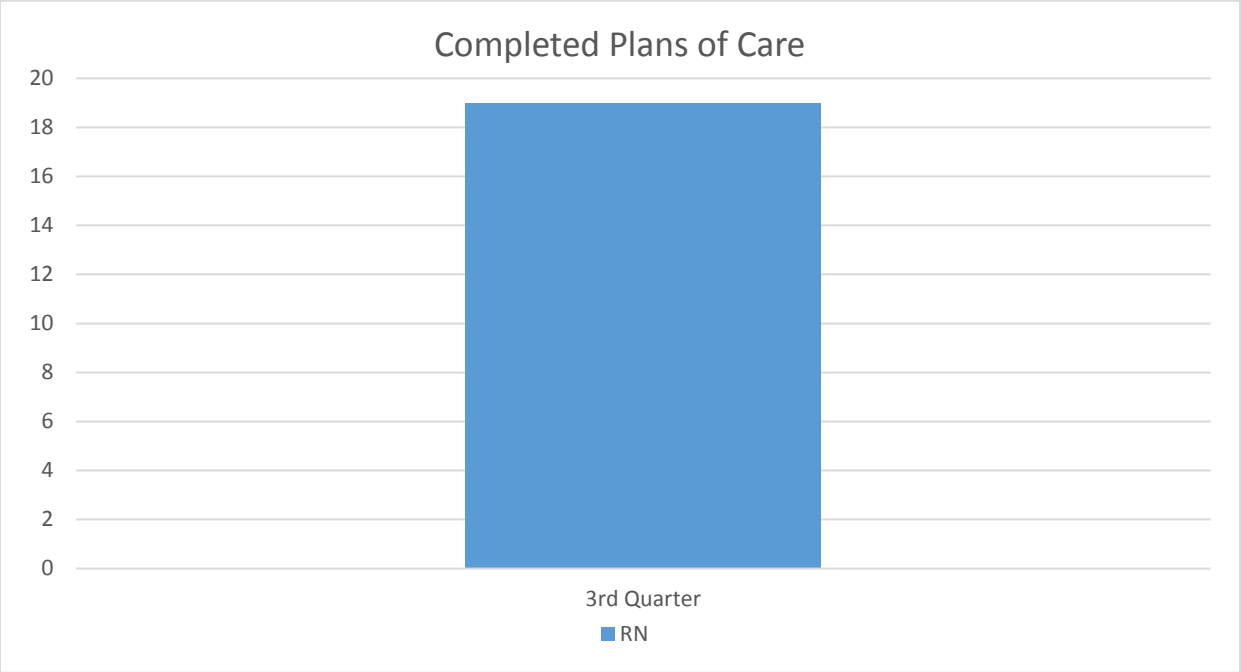
New Assessments Completed.

RN	SSC	Total
423	110	533



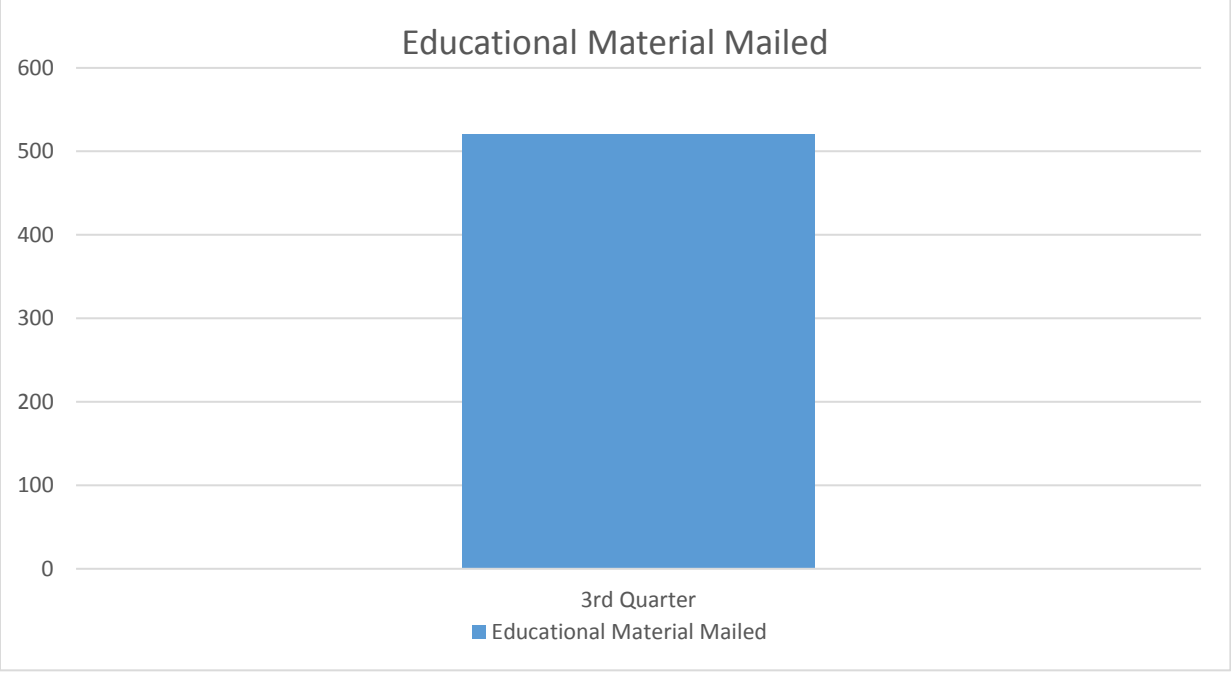
Plans of Care Completed & Closed.

RN
19



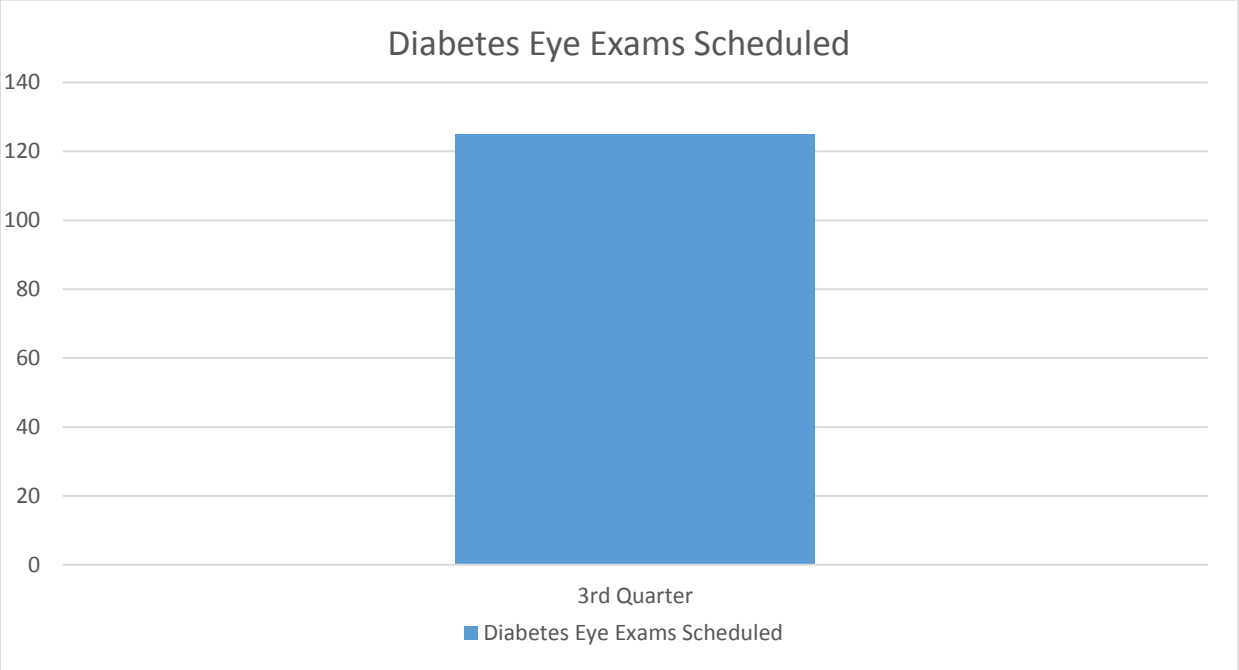
Educational Material Mailed.

520



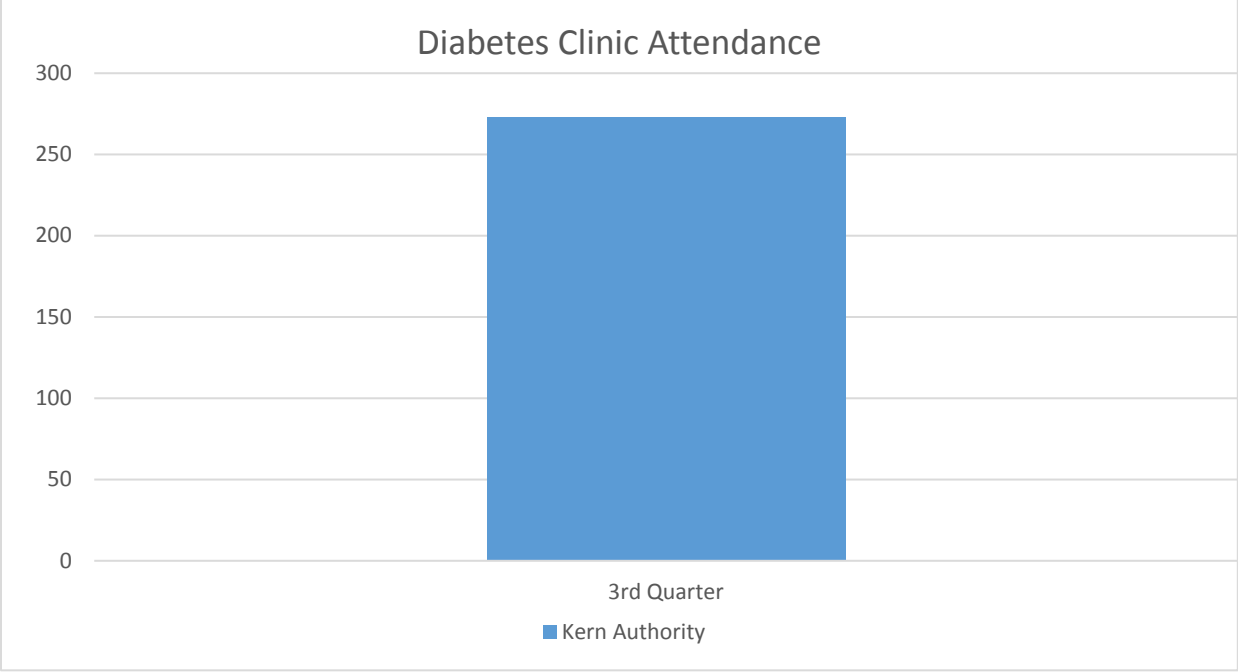
Diabetes Eye Exams Scheduled.

125



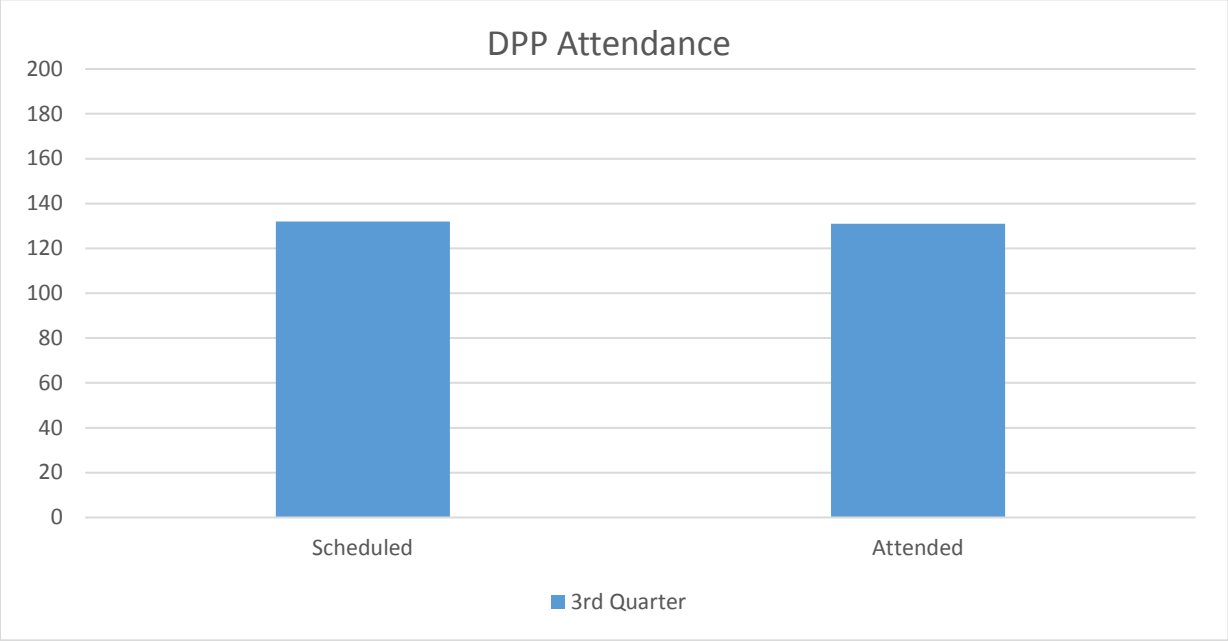
Diabetes Clinic Attendance.

Kern Authority
273



Diabetes Prevention Program: At the end of the 3rd Quarter, 26 members remain enrolled in the program. Classes were held bi-monthly during this reporting period

Sessions Scheduled to Attend	Actual Sessions Attended
132	131



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: 09/24/2019	DMHC		PAC	
		DHCS	X	QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

Douglas A. Hayward
Chief Executive Officer — Date 9/24/19

Chief Medical Officer — Date 9/19/19

Chief Operating Officer — Date 9/16/19

Director of Provider Relations — Date 9/13/19

Senior Director of Health Services — Date 9/11/19

POLICY:
Medi-Cal members assigned a mandatory aid code and who are transitioning from Medi-Cal fee-for-service (FFS) into a Medi-Cal managed care health plan (MCP) have the right to request continuity of care in accordance with state law and the KHS contract, with some exceptions. All KHS members with pre-existing provider relationships who make a continuity of care request to KHS must be given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider. These eligible members may require continuity of care for services they have been receiving through Medi-Cal FFS or through another managed care plan.

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

KHS will provide information to members about their continuity of care rights as well as to providers (both in and out-of-network). KHS will, at a minimum, include information about continuity of care

in provider training and new member orientation materials.

KHS is not required to provide continuity of care for services not covered by Medi-Cal. In addition, provider continuity of care protections do not extend to the following:

1. durable medical equipment,
2. transportation,
3. other ancillary services, and
4. carved-out service providers.

COC does not apply to members who had an option to remain with their previous health plan.[1]

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[2]	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[3]	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[4]	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[5]	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[6]	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[7]	An incurable or irreversible condition that has a high probability of causing death within one year or less.
Terminated Provider[8]	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[9]

KHS will provide continuity of care with an out-of-network provider when:

1. KHS is able to determine that the member has an existing relationship with the provider (self-attestation is not sufficient to provide proof of a relationship with a provider);
   a. An existing relationship means the member has seen an out-of-network primary care provider (PCP) or specialist at least once during the 12 months prior to the date of his or her initial enrollment with KHS for a non-emergency visit, unless otherwise specified in the All Plan Letter (APL18-008).

2. The provider is willing to accept the higher of KHS's contract rates or Medi-Cal FFS rates;
3. The provider meets KHS's applicable professional standards and has no disqualifying quality of care issues (for the purposes of this APL, a quality of care issue means KHS can document its concerns with the provider's quality of care to the extent that the provider would not be eligible to provide services to any other KHS members);
4. The provider is a California State Plan approved provider;
5. The provider supplies KHS with all relevant treatment information, for the purposes of determining medical necessity, as well as a current treatment plan, as long as it is allowable under federal and state privacy laws and regulations.

If a member changes health plans, the 12-month continuity of care period may start over one time. If the member changes health plans a second time (or more), the continuity of care period does not start over, as the member does not have the right to a new 12 months of continuity of care. If the member returns to Medi-Cal FFS and later reenrolls with KHS, the continuity of care period does not start over. If a member changes health plans, this continuity of care policy does not extend to providers that the member accessed through their previous health plan.

1.2 Continuity of Care Process

Members, their authorized representatives on file with Medi-Cal, or their provider, may make a direct request to KHS for continuity of care. When this occurs, KHS will begin to process the request ***within five working days*** following the receipt of the request.

However, as noted below, the request must be ***completed in three calendar days*** if there is a risk of harm to the member. For the purposes of this APL, "risk of harm" is defined as an imminent and serious threat to the health of the member. The continuity of care process begins when KHS starts the process to determine if the member has a pre-existing relationship with the provider.

KHS will accept requests for continuity of care over the telephone, according to the requester's preference, and must not require the requester to complete and submit a paper or computer form if the requester prefers to make the request by telephone. To complete a telephone request, KHS may take any necessary information from the requester over the telephone.

1.2.1 Retroactive Requests for COC

KHS will retroactively approve a continuity of care request and reimburse providers for services that were already provided if the request meets that meets all continuity of care requirements described above, and t the services that are the subject of the request meet the following requirements:

- Occurred after the member's enrollment into the MCP,
- Have dates of services after December 29, 2014;
- Have dates of services that are within 30 calendar days of the first service for which the provider requests retroactive continuity of care retroactive reimbursement;
- Retroactive continuity of care reimbursement requests must be submitted within 30 calendar days of the first service to which the request applies.

KHS will determine if a relationship exists through use of data provided by DHCS to KHS, such as Medi-Cal FFS utilization data. A member or their provider may also provide information to KHS that demonstrates a pre-existing relationship with the provider.

A member's self attestation of a pre-existing relationship is not sufficient proof (instead, actual documentation must be provided), unless KHS makes this option available to the member. Following identification of a pre-existing relationship, KHS determine if the provider is an in-network provider. If the provider is not an in-network provider, KHS will contact the provider and make a good faith effort to enter into a contract, letter of agreement, single-case agreement, or other form of relationship to establish a continuity of care relationship for the member.

1.3 Request Completion Timeline

Each continuity of care request must be completed within the following timelines:

- Thirty calendar days from the date KHS receives the request;
- Fifteen calendar days if the member's medical condition requires more Immediate attention, such as upcoming appointments or other pressing care needs; or,
- Three calendar days if there is risk of harm to the member.

A continuity of care request is considered completed when:

- KHS notifies the member, in the manner outlined above, that the request has been approved;
- KHS and the out-of-network Medi-Cal FFS provider are unable to agree to a rate;
- KHS has documented quality of care issues with the Medi-Cal FFS provider; or
- KHS makes a good faith effort to contact the provider and the provider is non-responsive for 30 calendar days.

1.4 Post Request Process Requirements

If KHS and the out-of-network Medi-Cal FFS provider are unable to reach an agreement because they cannot agree to a rate or KHS has documented quality of care issues with the provider, 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 maintains the right to file a grievance.

If a provider meets all of the necessary requirements including entering into a letter of agreement or contract with KHS, KHS will allow the member to have access to that provider for the length of the continuity of care period unless the provider is only willing to work with KHS for a shorter timeframe. In this case, KHS will allow the member 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.

Upon approval of a continuity of care request, KHS will notify the member of the following within seven calendar days:

- The request approval;
- The duration of the continuity of care arrangement;
- The process that will occur to transition the member's care at the end of the continuity of care period;
- The member's right to choose a different provider from KHS's provider network.

KHS will 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 to an in-network provider at the end of the continuity of care period. This process includes engaging with the member and provider before the end of the continuity of care period to ensure

continuity of services through the transition to a new provider.

1.5 Extended Continuity of Care

KHS may choose to work with a member's out-of-network provider past the 12-month continuity of care period; however, KHS is not required to do so to fulfill the obligations under this APL or KHS's contract.

1.6 Member and Provider Outreach

KHS will inform members of their continuity of care protections and will include information about these protections in member information packets and handbooks. This information will include how the member and provider initiate a continuity of care request with KHS. KHS will translate these documents into threshold languages and make them available in alternative formats, upon request. KHS will provide training to call center and other staff who come into regular contact with members about continuity of care protections.

1.7 Out of Network Provider Referral

An approved out-of-network provider must work with KHS and its contracted network and will not refer the member to another out-of-network provider without authorization from KHS. In such cases, KHS will make the referral, if medically necessary, and if KHS does not have an appropriate provider within its network.

2.0 NON-SPECIALTY MENTAL HEALTH SERVICES – CONTINUITY OF CARE FOR APPROVED PROVIDER TYPES:

KHS is required to cover outpatient mental health services, as outlined in APL 17- 018, for members with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health condition, as defined by the current Diagnostic and Statistical Manual. County Mental Health Plans (MHPs) are required to provide specialty mental health services (SMHS) for members who meet the medical necessity criteria for SMHS. DHCS recognizes that the medical necessity criteria for impairment and intervention for SMHS differ between children and adults. Under the Early and Periodic Screening, Diagnostic, and Treatment benefit, the impairment component of the SMHS medical necessity criteria for members under 21 years of age is less stringent than it is for adults. Therefore, children with a lower level of impairment may meet medical necessity criteria for SMHS.

KHS will provide continuity of care with an out-of-network SMHS provider in instances where a member's mental health condition has stabilized such that the member no longer qualifies to receive SMHS from the MHP and instead becomes eligible to receive non-specialty mental health services from KHS. In this situation, the continuity of care requirement only applies to psychiatrists and/or mental health provider types that are permitted, through California's Medicaid State Plan, to provide outpatient, non-specialty mental health services (referred to in the State Plan as "Psychology").

KHS will allow, at the request of the member, the provider, or the member's authorized representative, up to 12 months continuity of care with the out-of-network MHP provider in accordance with the requirements in this APL. After the continuity of care period ends, the member must choose a mental health provider in KHS's network for non-specialty mental health

services. If the member later requires additional SMHS from the MHP to treat a serious mental illness and subsequently experiences sufficient improvement to be referred back to KHS for non-specialty mental health services, the 12-month continuity of care period may start over one time. If the member requires SMHS from the MHP subsequent to the continuity of care period, the continuity of care period does not start over when the member returns to KHS or changes KHSs (i.e., the member does not have the right to a new 12 months of continuity of care).

3.0 COVERED CALIFORNIA TO MEDI-CAL TRANSITION

This section specifies requirements for populations that undergo a mandatory transition from Covered California to Medi-Cal managed care coverage due to the Covered California yearly coverage renewal determination or changes in a member's eligibility circumstances that may occur at any time throughout the year. These requirements are limited to these transitioning members.

To ensure that continuity of care and coordination of care requirements are met, KHS will ask these members if there are upcoming health care appointments or treatments scheduled and assist them, if they choose to do so, in initiating the continuity of care process at that time according to the provider and service continuity rights described below or other applicable continuity of care rights. When a new member enrolls in Medi-Cal, KHS will contact the member by telephone, letter, or other resources no later than 15 days after enrollment. The requirements noted above in this paragraph must be included in this initial member contact process. KHS will make a good faith effort to learn from and obtain information from the member so that it is able to honor active prior treatment authorizations and/or establish out-of-network provider continuity of care as described below.

KHS will honor any active prior treatment authorizations for up to 60 days or until a new assessment is completed by KHS. A new assessment is considered completed by KHS if the member has been seen by a KHS-contracted provider and this provider has completed a new treatment plan that includes assessment of the services specified by the pre-transition active prior treatment authorization. The prior treatment authorizations must be honored without a request by the member or the provider.

KHS will, at the member's or provider's request, offer up to 12 months of continuity of care with out-of-network providers, in accordance with the requirements in this APL.

4.0 PEDIATRIC PALLIATIVE CARE WAIVER TRANSITIONS

DHCS' Pediatric Palliative Care (PPC) Waiver Program ended on December 31, 2018. Most services previously covered under the waiver are covered under EPSDT. For those individuals currently enrolled in KHS or transitioning from Medi-Cal FFS, KHS will provide continuity of care to out-of-network providers who provided Medi-Cal-covered PPC Waiver Program services to the member for services that are also covered by Medi-Cal under EPSDT. KHS is not required to provide continuity of care for services that were exclusive to the PPC Waiver Program and that are not also covered by Medi-Cal under EPSDT. KHS will allow, at the request of the member, the provider, or the member's authorized representative, up to 12 months continuity of care with the out-of-network provider in accordance with the requirements in APL 18-008.

5.0 SENIORS AND PERSONS WITH DISABILITIES FFS TREATMENT AUTHORIZATION REQUEST CONTINUITY UPON ENROLLMENT

For a newly enrolled Seniors and Persons with Disabilities (SPDs), KHS will honor any active FFS Treatment Authorization Requests (TARs) for up to 60 days or until a new assessment is completed by KHS. A new assessment is considered completed by KHS if the member has been seen by a KHS-

contracted provider and this provider has completed a new treatment plan that includes assessment of the services specified by the pre-transition active prior treatment authorization. The FFS TAR must be honored as outlined above without a request by the member or the provider.

6.0 BEHAVIORAL HEALTH TREATMENT FOR MEMBERS UNDER THE AGE OF 21 UPON TRANSITION

KHS is responsible for providing Early and Periodic Screening, Diagnostic, and Treatment services for members under the age of 21. Services include medically necessary Behavioral Health Treatment (BHT) services that are determined to be medically necessary to correct or ameliorate any physical or behavioral conditions. In accordance with existing contract requirements and the requirements listed in this APL and APL 18-006, Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21, KHS will offer members continued access to out-of-network BHT providers (continuity of care) for up to 12 months if all requirements in this APL are met.

For BHT, an existing relationship means a member has seen the out-of-network BHT provider at least one time during the six months prior to either the transition of services from a Regional Center (RC) to KHS or the date of the member's initial enrollment with KHS if enrollment occurred on or after July 1, 2018. Further, if the member has an existing relationship, as defined above, with an in-network provider, KHS will assign the member to that provider to continue BHT services.

Retroactive requests for BHT service continuity of care reimbursement are limited to services that were provided after a member's transition date into KHS, or the date of the member's enrollment into KHS, if the enrollment date occurred after the transition.

KHS will continue ongoing BHT services until they have conducted an assessment and established a behavioral treatment plan.

6.1 Transition of BHT Services from Regional Center (RC) to KHS

At least 45 days prior to the transition date, DHCS will provide KHS with a list of members for whom the responsibility for BHT services will transition from the Regional Center to KHS, as well as member-specific utilization data. KHS will consider every member transitioning from an RC as an automatic continuity of care request. DHCS will also provide KHS with member utilization and assessment data from the RC prior to the service transition date. KHS is required to use DHCS-supplied utilization data to identify each member's BHT provider(s) and proactively contact the provider(s) to begin the continuity of care process, regardless of whether a member's parent or guardian files a request for continuity of care. If the data file indicates that multiple providers of the same type meet the criteria for continuity of care, KHS will attempt to contact the member's parent or guardian to determine their preference. If KHS does not have access to member data that identifies an existing BHT provider, KHS will contact the member's parent or guardian by telephone, letter, or other resources, and make a good faith effort to obtain information that will assist KHS in offering continuity of care. If the RC is unwilling to release specific provider rate information to KHS, then KHS may negotiate rates with the continuity of care provider without being bound by the usual requirement that KHS offer at least a minimum FFS-equivalent rate. If KHS is unable to complete a continuity of care agreement, KHS will ensure that all ongoing services continue at the same level with a KHS in-network provider until KHS has conducted an evaluation and/or assessment, as appropriate, and established a treatment plan.

KHS may refer to the Continuity of Care section of APL 18-006 for additional requirements and information regarding continuity of care for transitioning members receiving BHT.

7.0 HEALTH HOMES PROGRAM – MEDI-CAL FFS TO MANAGED CARE TRANSITION

KHS will provide continuity of care with an out-of-network provider, in accordance with the requirements of this APL, for Medi-Cal FFS beneficiaries who voluntarily transition to an MCP to enroll in the Health Homes Program (HHP). Because HHP services are provided only through the managed care delivery system, continuity of care with out-of-network-providers is not available for HHP services.

8.0 EXISTING CONTINUITY OF CARE PROVISIONS UNDER CALIFORNIA STATE LAW

In addition to the protections set forth above, KHS members also have rights to protections set forth in current state law pertaining to continuity of care. In accordance with Welfare and Institutions Code Section (§) 14185(b), KHS will allow members 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 member 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.

Additional requirements pertaining to continuity of care are set forth in Health and Safety (HSC) Code § 1373.96 and require health plans in California to, at the request of a member, provide for the completion of covered services by a terminated or nonparticipating health plan provider. Under HSC §1373.96, health plans are required to complete services for the following conditions: acute, serious chronic, pregnancy, terminal illness, the care of a newborn child between birth and age 36 months, and performance of a surgery or other procedure that is authorized by KHS as a part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered member.. This APL does not alter KHS's obligation to fully comply with the requirements of HSC §1373.96. In addition to the requirements set forth in this APL, KHS will allow for completion of covered services as required by §1373.96, to the extent that doing so would allow a member a longer period of treatment by an out-of-network provider than would otherwise be required under the terms of this this APL. KHS will allow for the completion of these services for certain timeframes which are specific to each condition and defined under HSC § 1373.96.

9.0 PREGNANT AND POST-PARTUM BENEFICIARIES

As noted above, HSC §1373.96 requires health plans in California to, at the request of a member, provide for the completion of covered services relating to pregnancy, during pregnancy and immediately after the delivery (the post-partum period), and care of a newborn child between birth and age 36 months, by a terminated or nonparticipating health plan provider. These requirements will apply for pregnant and post-partum members and newborn children who transition from Covered California to Medi-Cal due to eligibility requirements. Please refer to HSC §1373.96 for additional information about applicable circumstances and requirements.

Pregnant and post-partum Medi-Cal members who are assigned a mandatory aid code and are transitioning from Medi-Cal FFS into KHS have the right to request out-of-network provider continuity of care for up to 12 months in accordance with KHS's contract and the general requirements listed in this APL. This requirement is applicable to any existing Medi-Cal FFS provider relationship

that is allowed under the general requirements of this APL (continuity of care for members transitioning from FFS to managed care).

10.0 MEDICAL EXEMPTION REQUESTS

A Medical Exemption Request (MER) is a request for temporary exemption from enrollment into KHS only until the member's medical condition has stabilized to a level that would enable the member to transfer to a KHS provider of the same specialty without deleterious medical effects. A MER is a temporary exemption from KHS enrollment that only applies to members transitioning from Medi-Cal FFS to KHS. A MER should only be used to preserve continuity of care with a Medi-Cal FFS provider under the circumstances described above in this paragraph. KHS is required to consider MERs that have been denied as automatic continuity of care requests to allow members to complete courses of treatment with Medi-Cal FFS providers in accordance with APL 17-007.

11.0 REPORTING

KHS may be required to report on metrics related to any continuity of care provisions outlined in this APL, state law and regulations, or other state guidance documents at any time and in a manner determined by DHCS.

12.0 DELEGATION OVERSIGHT

KHS is responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs, and Policy Letters. These requirements must be communicated by KHS to all delegated entities and subcontractors.

Revision 2019-08: Additional language to comply with APL18-008. **Revision 2018-08:** Policy to comply with APL 18-008. **Revision 2018-04:** Policy revised to comply with DHCS Deliverable BHT 10E. **Revision: 2018-04:** Policy revised by Administrative Director of Health Services to comply with APL 18-008.
Revision 2017-07: Policy revised to comply with APL 17-007 new reporting requirements. Reporting changed from quarterly to monthly beginning July 2017. Instructions and templet provided by DHCS. **Revision 2017-01:** Policy revised to included new attachments; Initial Contact letter provided by Member Services Department and the MER Workflow Process

[1] 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)).

[1] Process to review request must be included in policy (HSC §1373.95(a)(2)(D)).

[1] HSC §1373.96 (e)(1) and (2)

[1] HSC §1376.96 (f)

[1] HSC §1373.95© Per M. Punja of DMHC 6/29/04.

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[1] HSC §1363.96(j). Language result of AB1596(2004).

[2] HSC §1373.96(c)(1)

[3] HSC §1373.96(k)(1)

[4] HSC §1345(i) and 1373.96(k)(3). Clarification of "hospital" requested by DMHC comment 061A (04/16/04).

[5] HSC §1373.65(g)

[6] HSC §1373.96(c)(2)

[7] HSC §1373.96(c)(4)

[8] 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.

[9] HSC §1373.96(c)

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Utilization Management Nurse After Hours on Call Support				POLICY #: 3.65-I	
DEPARTMENT: Utilization Management					
Effective Date: 02/2009	Review/Revised Date: 09/19/2019	DMHC		PAC	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

Douglas A. Hayward
Chief Executive Officer — Date 9/19/19

Chief Medical Officer — Date 9/17/19

Chief Financial Officer — Date 9/13/19

Chief Operating Officer — Date 8/30/19

Chief Information Officer — Date 8/26/19

Senior Director of Health Services — Date 8/21/19

POLICY[i]:
Kern Health Systems (KHS) shall provide after hour support for Utilization Management (UM) administrative functions in direct support of our members. The UM Nurses shall provide this support on a rotational basis.

KHS provides hospitals and providers with administrative nursing support for KHS members particularly in regard to emergency room and post-stabilization decisions in accordance with AB 1203.

The On Call RN will promote coordination and continuity of care and quality management in both the inpatient and ambulatory care settings through after hours support for Utilization Management (UM) administrative and clinical functions by the review of service requests and authorization of payment for specialty care and ancillary services. Additional duties may include discharge planning, care coordination, and telephone triage functions. The reviews will evaluate the appropriateness of care using established criteria and Plan benefit guidelines. All reviews will be conducted on a prospective, concurrent, and retrospective basis. The On Call RN, Remote manages the cases on an ad hoc basis during Saturday and Sunday 24/7 on call rotations.

PROCEDURES:

1.0 DIRECT ONCALL SUPPORT

KHS had dedicated staff who take a rotation, in turn, for providing after hours support as an administrative nurse. This rotation will extend no more than one-weekend in duration per call assignment. The responsibility of the On Call Weekend RN shall be:

1. Carry, at all times, the rotational cell phone provided by KHS
2. Carry, at all times, the KHS issued laptop computer
3. Reply to a call received on the cell phone within 30 minutes
4. Carry a copy of the *Post-stabilization Guidelines* (See Attachment A) and the *Call Tracking Log* (See Attachment B)
5. Provide turnover of the cell phone and on call material each Monday morning.

KHS staff is responsible for safeguarding all KHS issued equipment while in their possession. If the equipment is damaged, lost, or stolen, the KHS staff may be held responsible for replacement at the discretion of Executive management.

2.0 RECEIVING A CALL

When a call is received on the on call cell phone, the nurse shall:

1. Respond to the call in 30 minutes or less
2. Determine the nature of the call and begin capturing the call using the call tracking log.
3. If the call is for post-stabilization admit/transfer, the on call nurse will follow the post-stabilization guidelines provided in the on call packet
4. Upon returning to the office on the next business day, the on call nurse will enter the call log information into the call log section of the UM Sharepoint site and document call information in Medical Management documentation system (MMP) in place with details of the request and outcome. If Authorizations need to be created, they are entered into MMP for processing within 24 hours of the call or the next business day.
5. The on call nurse will report any urgent or extraordinary on-call activity to their immediate supervisor the next business day and if needed, contact the Chief Medical Officer or their designee, and if warranted, the CEO for assistance during a call if an issue is not resolvable without Executive authorization.

3.0 CALL LOG SHEET

The purpose of the call log sheet is to capture pertinent information about the call including member demographics, person/facility requesting, call logistics (date, time, and duration), services reviewed including diagnosis, and outcome of request. The call log should be as detailed as possible to allow for accurate compensation reimbursement.

ATTACHMENTS:
Attachment A – *Post-Stabilization Guidelines*
Attachment B – *Call Tracking Log*

REFERENCE:

Revisions 2019-08: Revisions by Senior Director of Health Services for updated processes.[1] **Revision 2015-03:** Revisions by Administrative Director of Health Services. **Revision 2009-03:** Policy developed by Utilization Department.

Kern Health Systems
Post-Stabilization Guidelines

When receiving a request for post-stabilization stay after normal business hours or weekends:

On-call Nurse Responsibility:

1. Ask why the member was received by the hospital (medical necessity).
2. From the answer to question Number 1, ***IF*** you believe that there may be a question as to whether this was actually an emergency or why the member needs to remain in the hospital, you should call the KHS Medical Director on call for assistance in determining if admitting the member is appropriate.
3. If the admit is appropriate, authorization for one day (or multiple if on a weekend). ***It should be stated that authorization is based on eligibility of the member and that eligibility cannot be determined at that time.***
4. Outpatient Nurses, refer to Inpatient Nurse the following day for follow-up on bed availability.

Medical Director Responsibility:

1. Get an update from the on-call nurse as to the current situation of the member and what is generating the concern of medical necessity.
2. Review the medical necessity of the stay request and determine if appropriate.
3. Instruct the nurse on what steps to take in regard to authorizing the stay or if a transfer is needed.

On-call Nurse Documentation:

Using the call tracking log document the following:

1. Note date, time and person or facility that made the call.
2. Record the reason for the call and what steps were taking to resolve the caller's request.
3. Include member name and admitting diagnosis.
4. Once back in the office, input log information into the UM Sharepoint Log located under Lists as Oncall After Hours Call Log.

Kern Health Systems
Call Tracking Log

Employee Name: _____

Date of Call	Time of Call	Caller/Facility	For Member	Reason for call (include admitting diagnosis) & Resolution

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Health Risk Assessment				POLICY #: 3.75-I	
DEPARTMENT: Health Services – Utilization Management					
Effective Date: 2011-10	Review/Revised Date: 09/05/2019	DMHC		PAC	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

Douglas A. Hayward — Date 9/5/19
Chief Executive Officer

Chief Medical Officer — Date 8/21/19

Chief Financial Officer — Date 8/19/19

Chief Information Officer — Date 8/16/19

Director of Member Services — Date 8/12/19

Senior Director of Health Services — Date 8/5/19

POLICY[i]:

KHS will make every effort to provide a Health Risk Assessment (HRA) either verbally or in written form for each new Seniors and Persons with Disabilities (SPDs) member enrolled with Kern Health Systems within 45 days of enrollment for those identified by the risk stratification method as high risk and within 105 days of enrollment for those identified as low risk for the purpose of developing individualized care management plans for the high risk SPDs.

PURPOSE:

To establish guidelines for providing an HRA to comprehensively assess an SPD member's current health risk within 45 calendar days of plan enrollment for those identified by the risk stratification method as high risk and within 105 days of enrollment for those identified as low risk for the purpose of developing individualized care management plans for the high risk SPD population.

DEFINITIONS:

High Risk	"High risk" for risk assessment purposes means Medi-Cal SPD beneficiaries who are at increased risk of having an adverse health outcome or worsening of their health status if they do not have an individualized care management plan.
New SPD Member	Members with a State aid code of 20, 24, 26, 2E, 2H, 36, 60, 64, 66, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V, 10, 14, 16, 1E, and 1H who have enrolled on or after 6/1/11; members with the same aid codes who re-enrolled on or after 6/1/11 regardless of the break in coverage; at the discretion of KHS, current SPD Medi-Medis; and at the discretion of KHS any other member deemed high risk

PROCEDURE:

1.0 Case Management Department

A Case Management Certified Medical Assistants (CMA) will make every effort to contact every new SPD member or the designated responsible party within the required assessment timeframes, as noted above, that includes repeated efforts: Letter and HRA form followed by at least two phone calls.

1.1 Newly enrolled SPD

Each month upon enrollment into the health plan, an electronic list of all SPD members is forwarded to Case Management staff for initiation of a Health Risk Assessment to determine each member's overall health and promote early identification of potential medical or psychosocial needs to begin coordination of care and facilitate access to services.

1.2 Performance of HRA

All new SPD members are mailed a cover letter, an HRA form in their preferred language, and a self-addressed return envelope within 30 days (see Attachment A) of enrollment by Member Services (MS). Following this, a Member Service Representative (MSR) makes an effort to call the member or the designated responsible party if a phone number has been received by KHS to answer questions and encourage completion of the HRA (see MS P&P 5.08-I). In addition, within 45 days of enrollment a CMA from the Case Management Department will make at least two attempts to contact new SPD members in order to perform the HRA survey using the electronic HRA form (see Attachment B),.

KHS maintains a process for stratifying members into at least two groups based upon the findings of the HRA:

- Those at low risk (needing basic care management) and
- Those at high risk (requiring an Individual Care Plan and Complex care management). "High risk" means members who are at increased risk of having an adverse health outcome or worsening of their health status if they do not have an ICP.

When KHS conduct HRAs for all members, it must include all the following:

- Identification of all medical care needs, including:
  i. Primary care;
  ii. Specialty care;
  iii. Durable medical equipment (DME);
  iv. Medications; and
  v. Any other needs.
- Identification of the referrals a member needs to appropriate community resources and other agencies for services outside KHS's scope of responsibility, including but not limited to the member's need for:
  i. Mental health and behavioral health services;
  ii. Personal care;
  iii. Housing;
  iv. Home-delivered meals;
  v. Energy assistance programs; and
  vi. Services for individuals with intellectual and developmental disabilities.
- Identification of a member's need for and appropriate level of involvement of caregivers;
- Identification of a member's need for help in facilitating timely access to primary care, specialty care, DME, medications, and other health services, including:
  i. The need for referrals to resolve any physical barriers to access; and
  ii. The need for referrals to resolve any cognitive barriers to access.
- Identification of a member's need for help in facilitating communication among the member's health care providers, including:
  i. Primary care and specialty providers; and
  ii. Mental health and substance abuse providers, when appropriate.
- Identification of a member's need for other activities or services that would help the member to optimize his or her health status, including:
  i. Assistance with self-management skills or techniques;
  ii. Health education; and
  iii. Other methods for improving health status.
- Identification of a member's need for coordination of care across all settings, including those outside KHS's provider network;
- Ensuring that a member admitted to a hospital or institution receives appropriate discharge planning; and
- Frequency of contacting member for reassessment (at least annually) and the circumstances or conditions that require KHS to re-determine a member's risk level.
- Utilization of the standardized LTSS referral questions to identify and ensure the proper referral of members who may qualify for and benefit from LTSS services.

Once the HRA has been completed, the member is instructed to disregard the paper HRA form that was mailed to them upon enrollment. All paper HRAs that are returned

with questions answered are data entered into the electronic HRA.

1.3 Case Management Documentation

All HRAs that have been completed are documented in the KHS medical documentation system including the date of the assessment, person who completed the assessment and the language in which the HRA was conducted. Member comments are documented when applicable. .

For Department of Health Care Services (DHCS) reporting purposes, all HRAs completed with or without contact are stored in the KHS documentation repository system.

2.0 Case Management (CM) Department

The CM department will contact all SPD members or the designated responsible party at least annually and re-stratify as necessary as part of our Complex Case management efforts to support this vulnerable population.

2.1 Risk Stratification and HRA Information

KHS shall develop an algorithm methodology for risk stratification methods to identify Members who may benefit from Complex Case Management services, using utilization and claims data, clinical data, a Predictive Modeler Modeling tool, and the Member Evaluation Tool (MET) with incorporated Health Information Form (HIF) questions-*when they exist*, and any other available data, including member and physician self-reported information.

KHS will electronically access member-specific health information, including the member's historical Medi-Cal FFS utilization data provided by DHCS at the time of enrollment. This data may include, but is not limited to:

- Outpatient services,
- Inpatient services,
- Emergency department services,
- Pharmacy, and
- Ancillary services data for the most recent 12 months.

KHS must complete this stratification within 44 calendar days of enrollment. If Fee for Service utilization data and/or MET data is not available, KHS will determine by other means if SPD members are high or low risk.

For risk stratification purposes, "high risk" means Medi-Cal members who are at an increased risk of having an adverse health outcome or worsening of their health status if they do not have an individualized care management plan.

High risk individuals may include but are not limited to members who:
a. Have been on oxygen within the past 90 days;
b. Are residing in an acute hospital setting;
c. Have been hospitalized within the last 90 days, or have had three or more hospitalizations within the past year;
d. Have had three or more emergency room visits in the past year in combination with other evidence of high utilization of services (e.g., multiple prescriptions consistent with the

diagnoses of chronic diseases);
e. Have a behavioral health diagnosis or developmental disability in addition to one or more chronic medical diagnoses or a social circumstance of concern (e.g., homelessness);
f. Have end-stage renal disease, acquired immunodeficiency syndrome (AIDS), and/or a recent organ transplant;
g. Have cancer, and are currently being treated; h. Are pregnant;
i. Have been prescribed antipsychotic medication within the past 90 days;
j. Have been prescribed 15 or more prescriptions in the past 90 days;
k. Have a self-report of a deteriorating condition; and
l. Have other conditions as determined by KHS, based on local resources.

For risk stratification purposes, "low risk" means Medi-Cal members who do not appear to be at increased risk of having an adverse health outcome or worsening of their health status if they do not have an individualized care management plan. These "low risk" members will receive Basic Care Management, and will be reassessed at least annually or when their health status changes.

Basic Care Management refers to services provided by a Primary Care Physician to promote the coordination of medically necessary health care services, the provision of preventive services in accordance with established standards and periodicity schedules, and the continuity of care for members. It includes health risk assessment, treatment planning, coordination, referral, follow-up, and monitoring of appropriate services and resources required to meet an individual's health care needs.

Anytime a new or updated HRA is received or completed the SPD members will be risk stratified as "low risk" or "high risk" based on their answers to the HRA questions.

Upon an SPD member's disenrollment, KHS will ensure all information obtained from the completed MET assessment results are made available to the SPD member's new health plan upon request.

2.2 Case Management Documentation

The KHS eligibility process provides a list of the new SPD members enrolled into the plan. A daily report of re-stratification that lists all SPD members whose time-frame indicates that an annual reassessment is due in conjunction with their enrollment date, and if necessary, the circumstances or conditions that require redetermination of risk level is provided by the Information Technology Department (IT) through end-user reporting tools.

For DHCS reporting purposes, all HRAs completed with or without contact are stored in the KHS M-files documentation repository system to document report specific information and statistics related to the HRA.

3.0 Delegated Oversight Reports and Monitoring

KHS may be required to report on metrics related to any Health Risk Assessments outlined in this APL, state law and regulations, or other state guidance documents at any time and in a manner determined by DHCS.

KHS is responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs, and Policy Letters. These requirements must be communicated by KHS to all delegated entities and subcontractors.

ATTACHMENTS:

- Attachment A – Health Risk Assessment Cover Letter
- Attachment B – Health Risk Assessment Survey

REFERENCE:

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[i] **Revision 2019-04:** Updated to reflect APL 17-013 by Senior Director of Health Services; **Revision 2017-10:** Policy renumbered to fit under Utilization Management oversight as directed by Administrative Director of Health Services. **Revision 2011-10:**

Kern Family Health Care
The Friendly Face
Of Kern Health Systems

Dear Kern Family Health Care Member,

Welcome to Kern Family Health Care (KFHC), your health plan! We are glad you have joined our family.

Enclosed is a Health Risk Assessment (HRA). Please take a few minutes to complete this assessment and send it back to us as soon as possible in the enclosed postage paid envelope.

Completing this assessment will help us to manage your health care needs. We want to work with you to make a plan to improve or maintain your health. Responses will be kept confidential and only shared with health care professionals for your health care.

If you prefer, you can complete the assessment over the phone by calling KFHC at 661-632-1590 (Bakersfield) or 1-800-391-2000 (outside of Bakersfield). If you received the assessment in Spanish, but prefer English, please call us and we will mail you the English version. You can choose to not complete the assessment. If you choose not to participate, please check the "no" box of the last question in the first section of the assessment.

Sincerely,

KFHC Member Services Department

IMPORTANT: 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 (661) 632-1590 or 1-800-391-2000 right away.

Member Name:

Member ID#:

Kern Family Health Care™
The Friendly Face
Of Kern Health Systems

Please take a few minutes to complete this Health Risk Assessment (HRA) and send it back to us as soon as possible in the enclosed postage paid envelope. Completing this assessment will help us to manage your health care needs. We want to work with you to make a plan to improve or maintain your health. Responses will be kept confidential and only shared with health care professionals. You can choose to not complete the assessment by checking the "no" box of the last question in the first section of the assessment. **Para español, llame al 1-800-391-2000.**

MEMBER DEMOGRAPHICS

Please provide the following information.

Address _____ City _____ Zip _____

Telephone Number (Home/Work/Cell/other) _____

Birthdate _____

Medi-Cal Identification Number _____

Preferred Language _____

Do you need California Relay Services to complete this survey? ❑ Yes ❑ No
Do you need an interpreter to complete this survey? ❑ Yes ❑ No
Do you want to participate in this survey? ❑ Yes ❑ No

LIVING SITUATION

1. How many addresses have you had in the last 12 months?
   ❑ 1 ❑ 2 ❑ 3 or more

2. Are you homeless right now or do you have problems with your current living arrangement?
   ❑ Yes ❑ No

3. a. Do you have someone such as a caregiver or other decision maker who is willing to be involved in your care?
   ❑ Yes ❑ No
   b. If yes, check all that apply.
   ❑ Family ❑ Neighbor ❑ Church or community group
   ❑ Significant other ❑ Legal services ❑ Other
   If other, please describe: _____

4. Do you ever think your caregiver has a hard time giving you all the help you need?
   ❑ Yes ❑ No

5. Do you live alone?
   ❑ Yes ❑ No

SUPPORT SERVICES

6. Do you receive services from a home health aide or nurse in your home right now?
   ❑ Yes ❑ No

7. a. Do you need someone to help you with your routine activities of daily living?
   ❑ Yes ❑ No
   b. If yes, do you have someone to help you?
   ❑ Yes ❑ No

8. Which of the following functions do you need help with? Check all that apply.
   ❑ Does not apply ❑ Bathing ❑ Dressing ❑ Using the phone ❑ Utilities
   ❑ Eating ❑ Walking ❑ Climbing stairs ❑ Getting a ride to the doctor/see friends
   ❑ Obtaining food ❑ House chores ❑ Shaving ❑ Washing Dishes/Clothes
   ❑ Brushing teeth ❑ Brushing hair ❑ Shopping ❑ Managing money/writing checks
   ❑ Doing yard work ❑ Preparing meals ❑ Transportation ❑ Going out to visit family/friends
   ❑ Getting out of bed ❑ Using the bathroom/toilet ❑ Keeping track of appointments ❑ Other
   If other, please describe: _____

9. Can you live safely and move easily around in your home?
   ❑ Yes ❑ No
   If no, does the place where you live have:
   ❑ Good lighting ❑ Good heating ❑ Good cooling ❑ Rails for any stairs or ramps
   ❑ Hot water ❑ Indoor toilet ❑ Elevator ❑ A door to the outside that locks
   ❑ Space to use a wheelchair ❑ Clear ways to exit your home
   ❑ Stairs to get into your home or stairs inside your home

10. Do you sometimes run out of money to pay for food, rent, bills, and medicine?
    ❑ Yes ❑ No

11. a. Have you fallen in the last month?
    ❑ Yes ❑ No
    b. Are you afraid of falling?
    ❑ Yes ❑ No

12. Do you need assistance with receiving any of the following community resources? Check all that apply.
    ❑ Government sponsored programs ❑ Maternal and child services ❑ Living assistance
    ❑ Disability ❑ Communicable disease services ❑ Other
    If other, please describe: _____

13. a. Do you have any physical, sensory, or learning problems that prevent you from getting what you need for your health?
    ❑ Yes ❑ No
    b. If yes, what types of problems have you had? _____

14. Have you had any changes in thinking, remembering, or making decisions?
    ❑ Yes ❑ No

15. a. Do you use or need any assistive or medical equipment?
    ❑ Yes ❑ No
    b. If yes, check all that apply.

❑ Wheelchair ❑ Walker ❑ Cane ❑ Scooter ❑ CPAP ❑ Oxygen tank
❑ Nebulizer ❑ Catheters ❑ Supplies (other than diabetic) ❑ Hospital Bed
❑ Toileting device/bedside commode ❑ Other
If other, please describe: _____

16. Have you used an oxygen tank in the past 3 months for more than 30 days?
❑ Yes ❑ No

17. a. Do you need any medical equipment or supplies right now?
❑ Yes ❑ No
b. If yes, what do you need? _____

HEALTH STATUS & SELF-CARE

18. Do you have any of the following health conditions? Check all that apply.
❑ Asthma ❑ Depression ❑ Kidney Failure ❑ Behavioral or mental health condition
❑ Digestive problems ❑ Multiple Sclerosis ❑ Breathing problems ❑ Seizures
❑ Quadriplegia ❑ Cancer ❑ Heart disease ❑ Schizophrenia
❑ Congestive Heart Failure ❑ Hepatitis ❑ HIV/AIDS ❑ COPD, Emphysema
❑ Diabetes ❑ Stroke ❑ Dementia
❑ High Blood Pressure ❑ Other
If other, please describe: _____

19. a. Have you had a significant traumatic event (death, injury, health issues, or personal issues) in the past 3 months?
❑ Yes ❑ No
b. If yes, please describe: _____

20. Have you had, been approved for, or are you waiting for any type of transplant?
❑ Yes ❑ No

21. a. In general, do you feel confident in being able to manage your medical conditions?
❑ Yes ❑ No
b. If no, what would help you better manage your medical condition?
_____

22. a. Do you have concerns about your safety?
❑ Yes ❑ No
b. If yes, what concerns do you have? _____

23. a. Do you need someone to help you track your medications or to remind you to take them regularly?
❑ Yes ❑ No

24. How many medications are you currently taking?
❑ 1-3 ❑ 4-6 ❑ 7-14 ❑ 15 or more

HEALTH SERVICES USAGE

25. a. How many times have you been admitted to the hospital or an inpatient behavioral or mental health facility in the past 3 months?
❑ 1 ❑ 2 ❑ 3 or more

26. How many times have you been seen in the emergency room in the past year?
❑ 1 ❑ 2 ❑ 3 or more

27. When was the last time you saw your primary care provider? 00 / 00 / 0000
month day year

28. Do you see more than one doctor to manage your medical conditions?
❑ Yes ❑ No

29. Do you have any appointments scheduled with your primary care provider or other doctors within the next 3 months?
❑ Yes ❑ No

30. Do you have trouble communicating with your doctor, case manager, or anyone involved with your health?
❑ Yes ❑ No

31. Do you need help answering questions during a doctor's visit?
❑ Yes ❑ No

32. a. Are you pregnant right now?
❑ Yes ❑ No
b. If yes, are you seeing a doctor on a regular basis for this pregnancy?
❑ Yes ❑ No

MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT

33. Do you have more than 4 drinks of alcohol (3 for women) in one day more than once a week?
❑ Yes ❑ No

34. Do you need or receive treatment for any kind of mental health, substance abuse, or emotional problem?
❑ Yes ❑ No

35. Over the past month (30 days), how many days have you felt lonely?
❑ None - I never feel lonely ❑ Less than 5 days ❑ More than half the days (more than 15)
❑ Most days - I always feel lonely

36. Have you been depressed or down most of the day or nearly every day for the last two weeks?
❑ Yes ❑ No

37. Are you afraid of anyone or is anyone hurting you?
❑ Yes ❑ No

38. Is anyone using your money without your okay?
❑ Yes ❑ No

39. Do you smoke or use any tobacco products?
❑ Yes ❑ No

40. a. Is there anything else you want us to know about you or your medical needs?
❑ Yes ❑ No
b. If yes, please describe: _____

KERN HEALTH SYSTEMS
HEALTH EDUCATION, CULTURAL AND LINGUISTIC ACTIVITIES REPORT
Third Quarter 2019

Report Date: October 1, 2019

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.

- 2020 Health Education, Cultural and Linguistics Work Plan
- 2019 Health Education, Cultural and Linguistics Program Evaluation
- Population Needs Assessment
- Pregnancy Engagement Survey

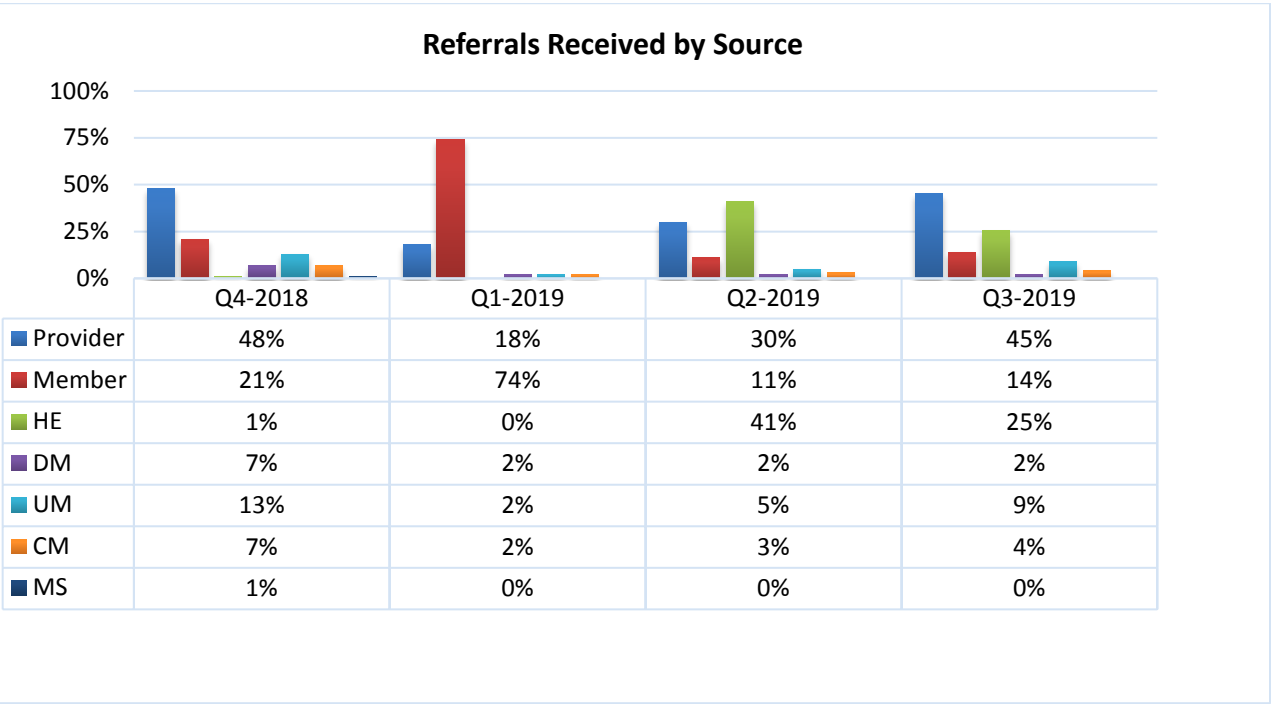
The following pages reflect statistical measurements for the Health Education department detailing the ongoing activity for the 3rd quarter 2019.

Respectfully submitted,
Isabel Silva, MPH, CHES
Director of Health Education, Cultural and Linguistic Services

KERN HEALTH SYSTEMS
HEALTH EDUCATION, CULTURAL AND LINGUISTIC ACTIVITIES REPORT
Third Quarter 2019

REFERRALS FOR HEALTH EDUCATION SERVICES

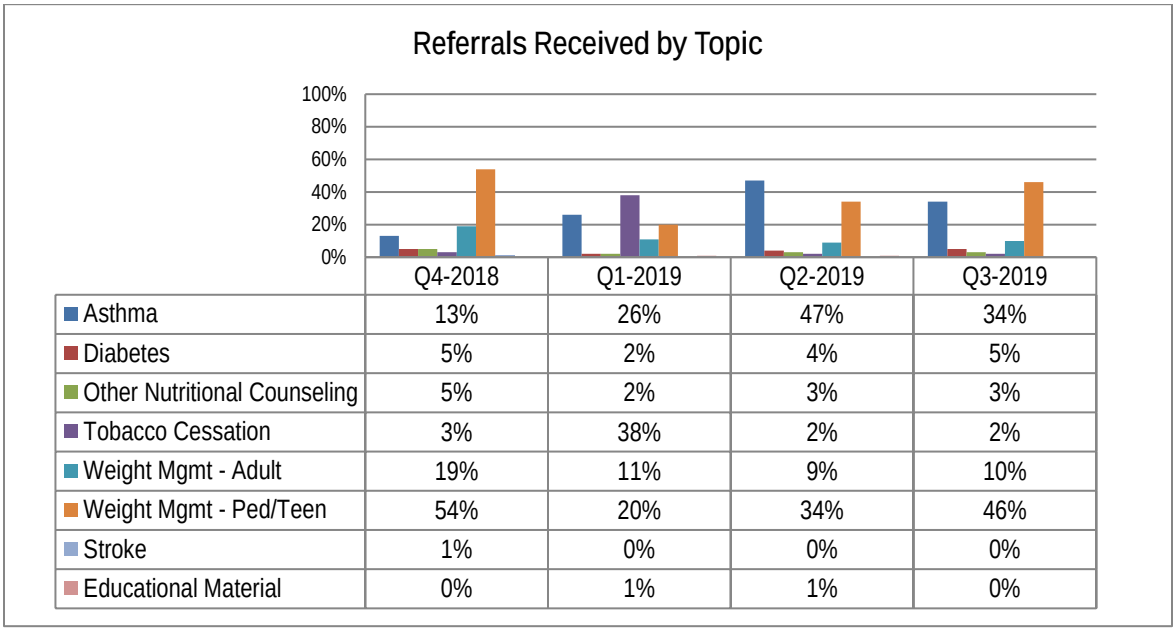
The Health Education Department (HE) receives referrals from various sources. Internal referrals are received from the Kern Health Systems (KHS) Utilization Management (UM), Disease Management (DM), Case Management (CM), Member Services (MS), and Member Portal. Externally, KHS providers submit referrals for health education services according to the member's diagnosis and members can also self-refer for health education services through the Member Portal or by calling Member Services.



	Q4-2018	Q1-2019	Q2-2019	Q3-2019
Provider	48%	18%	30%	45%
Member	21%	74%	11%	14%
HE	1%	0%	41%	25%
DM	7%	2%	2%	2%
UM	13%	2%	5%	9%
CM	7%	2%	3%	4%
MS	1%	0%	0%	0%

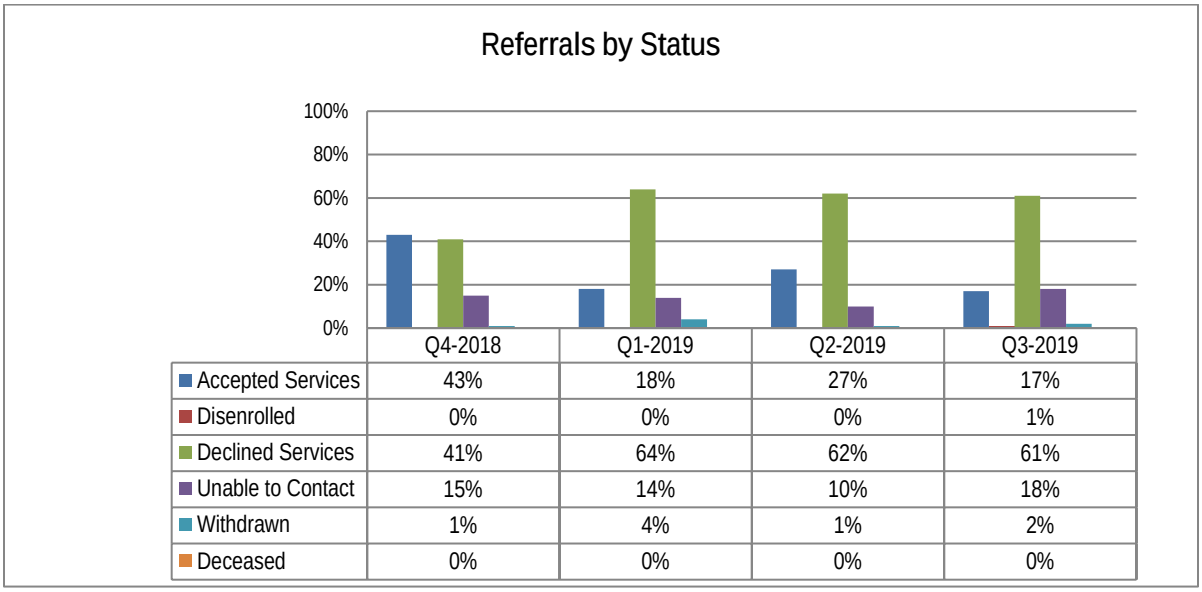
During this quarter, 852 referrals were received which is a 12% decrease in comparison to the previous quarter.

KERN HEALTH SYSTEMS
HEALTH EDUCATION, CULTURAL AND LINGUISTIC ACTIVITIES REPORT
Third Quarter 2019



	Q4-2018	Q1-2019	Q2-2019	Q3-2019
Asthma	13%	26%	47%	34%
Diabetes	5%	2%	4%	5%
Other Nutritional Counseling	5%	2%	3%	3%
Tobacco Cessation	3%	38%	2%	2%
Weight Mgmt - Adult	19%	11%	9%	10%
Weight Mgmt - Ped/Teen	54%	20%	34%	46%
Stroke	1%	0%	0%	0%
Educational Material	0%	1%	1%	0%

The HE department receives referrals for various health conditions. This quarter, referrals for asthma education were still significantly higher than the 1st quarter due to targeted outreach calls performed by the HE department. Weight management referrals also increased to 56% during the 3rd Quarter of 2019.



	Q4-2018	Q1-2019	Q2-2019	Q3-2019
Accepted Services	43%	18%	27%	17%
Disenrolled	0%	0%	0%	1%
Declined Services	41%	64%	62%	61%
Unable to Contact	15%	14%	10%	18%
Withdrawn	1%	4%	1%	2%
Deceased	0%	0%	0%	0%

The rate of members who accepted to receive health education services decreased from 27% in the 2nd quarter to 17% in the 3rd quarter of 2019.

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
    - Intro to Gardening
    - Rethink Your Drink
    - Funxercise
    - Healthy Cooking
- Breathe Well Asthma Workshop

Bakersfield Memorial Hospital (BMH):

- Diabetes Management Classes (English only)
- Heart Healthy Classes
- Individual Nutrition Counseling

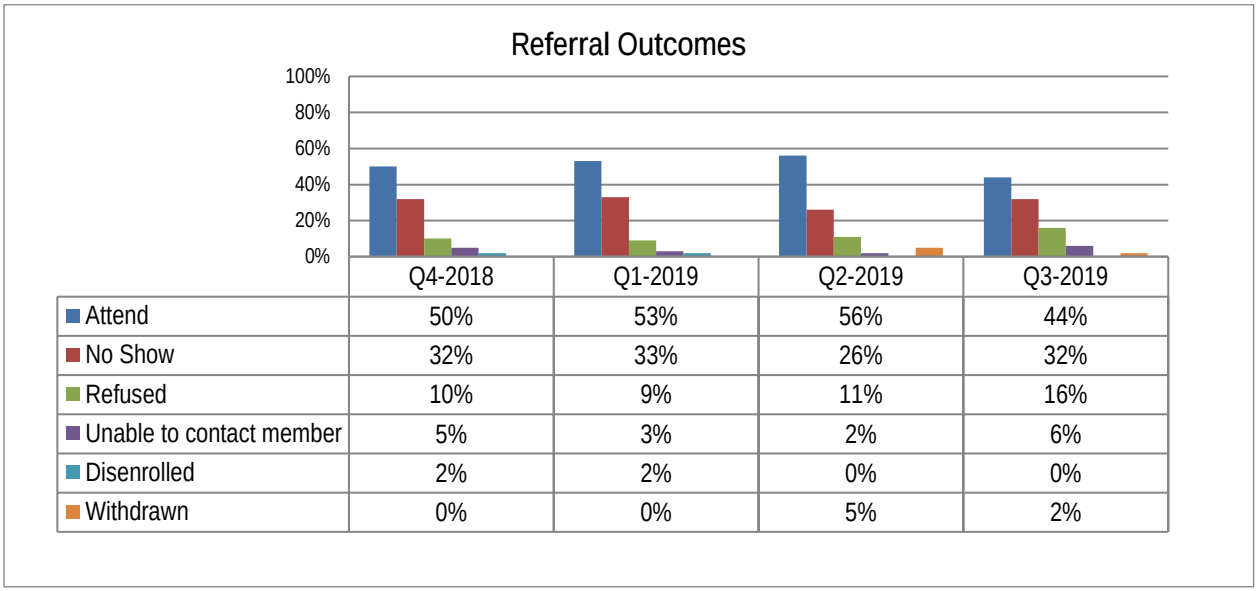
Clinica Sierra Vista (CSV) WIC:

- Diabetes Management Classes
- Heart Healthy Classes

California Smokers' Helpline (CSH):

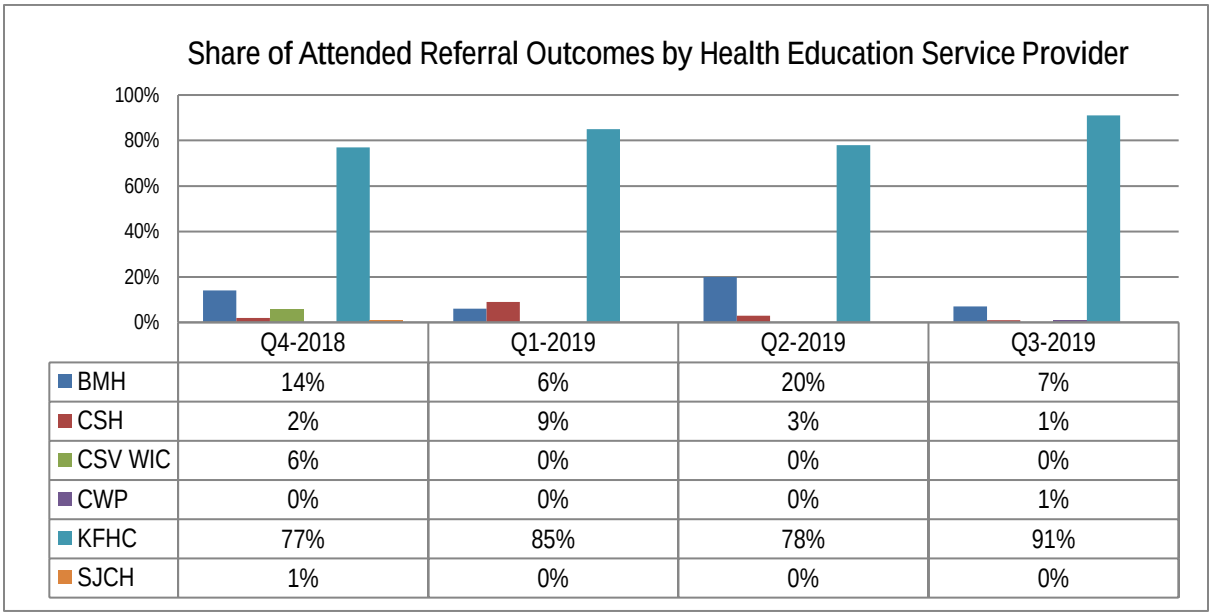
- Telephone Smoking Cessation Counseling

REFERRAL OUTCOMES



	Q4-2018	Q1-2019	Q2-2019	Q3-2019
Attend	50%	53%	56%	44%
No Show	32%	33%	26%	32%
Refused	10%	9%	11%	16%
Unable to contact member	5%	3%	2%	6%
Disenrolled	2%	2%	0%	0%
Withdrawn	0%	0%	5%	2%

During this quarter, the rate of members who received health education services out of all members who accepted services decreased from 56% to 44%.

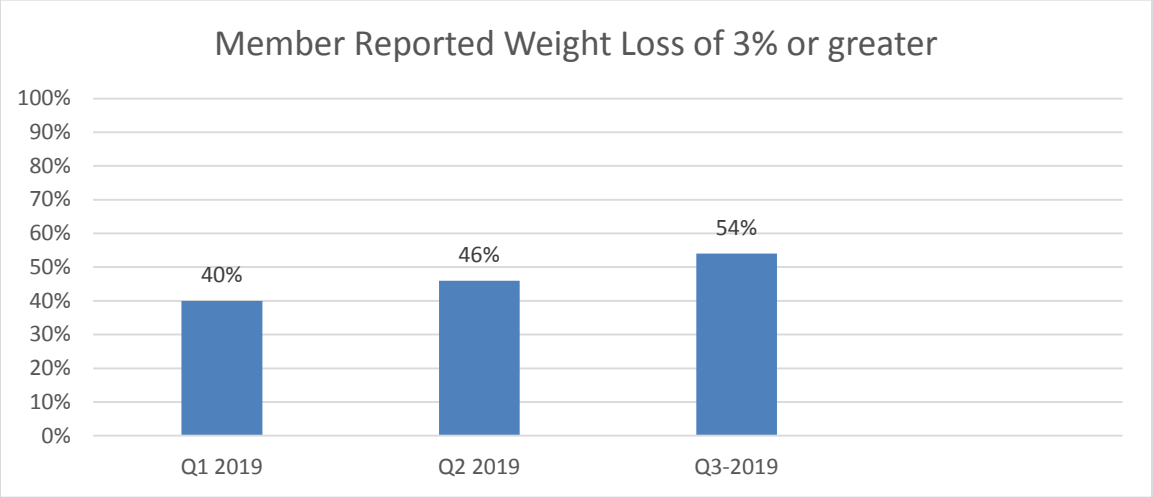


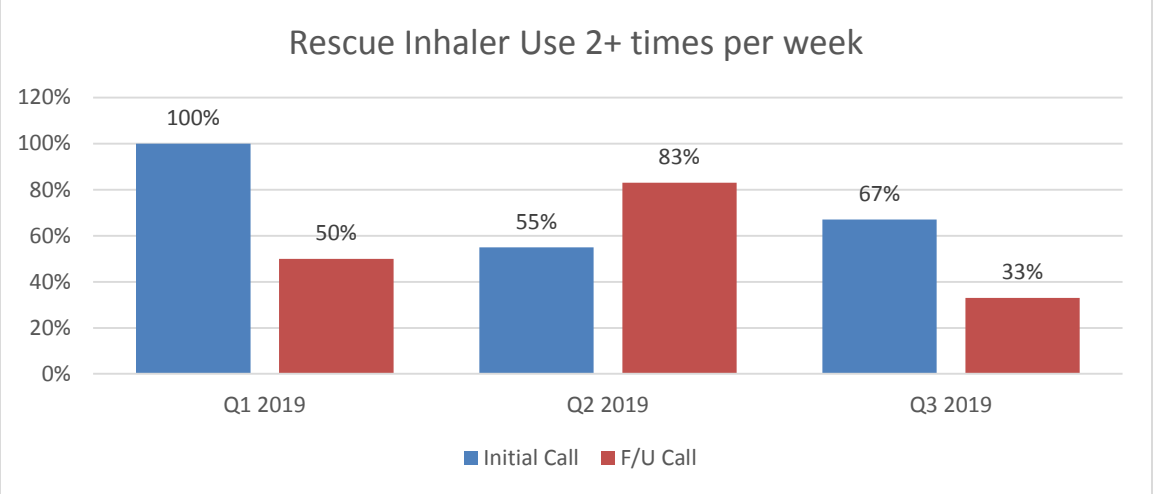
	Q4-2018	Q1-2019	Q2-2019	Q3-2019
BMH	14%	6%	20%	7%
CSH	2%	9%	3%	1%
CSV WIC	6%	0%	0%	0%
CWP	0%	0%	0%	1%
KFHC	77%	85%	78%	91%
SJCH	1%	0%	0%	0%

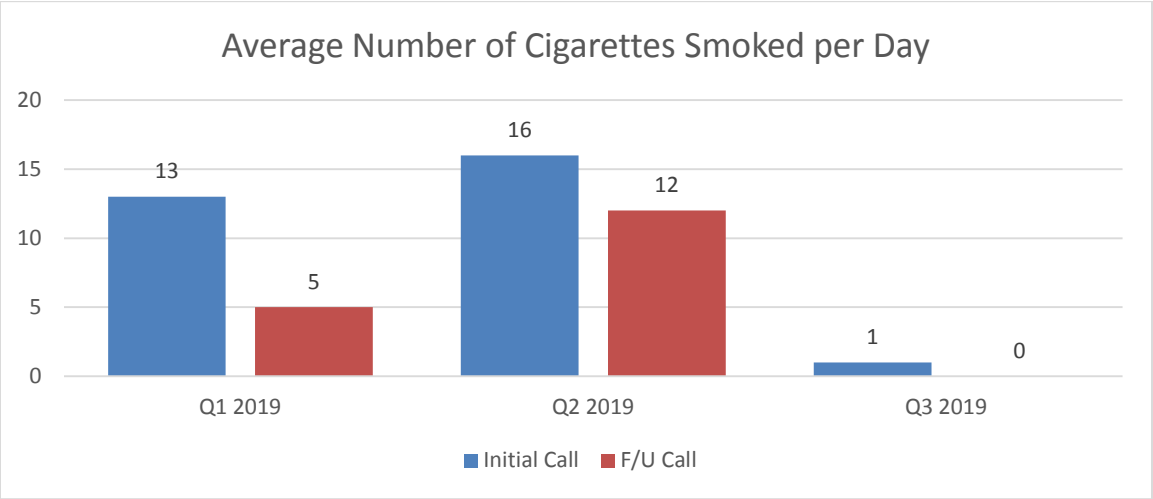
Services through KFHC demonstrates to be the largest share of referral outcomes. This quarter KFHC showed an increase from 78% in the 2nd quarter to 91% in the 3rd quarter of 2019.

Effectiveness of Health Education Services

To evaluate the effectiveness of the health education services provided to members, a 3-month follow up call was conducted on members who received services during the prior quarter. Of the 21 members who participated in the 3 month follow up call, 17 received weight management education, 1 received tobacco cessation education and 3 received asthma management education. All findings are based on self-reported data from the member.

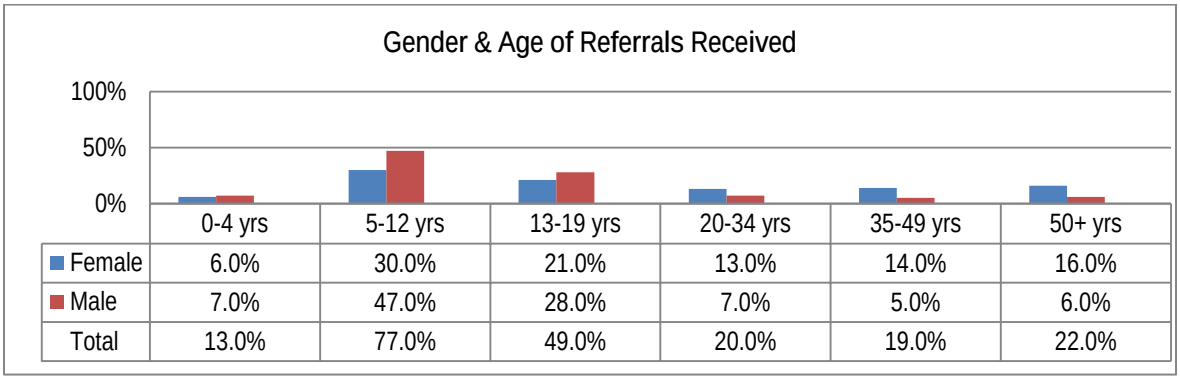






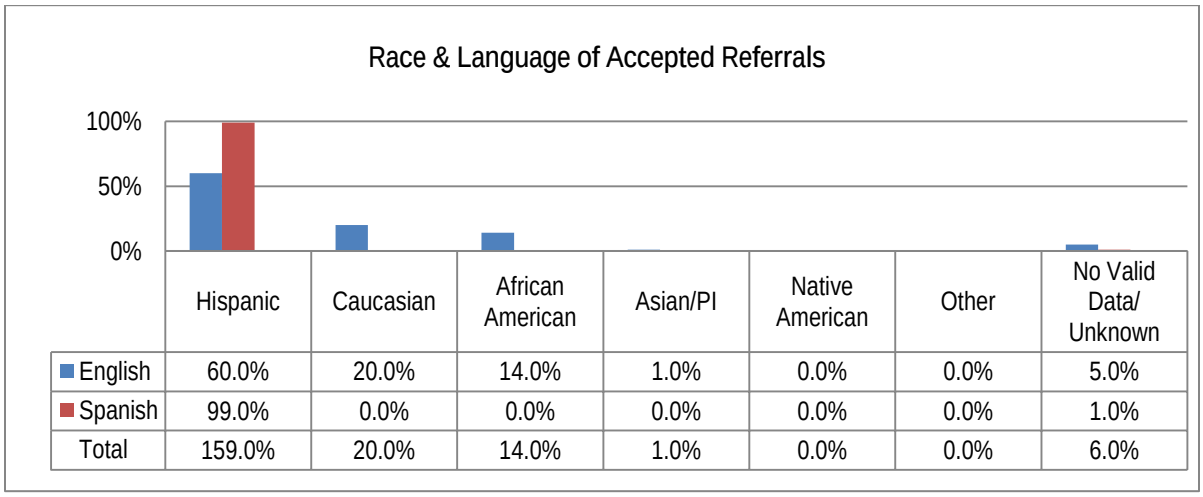
Demographics of Members

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	6.0%	30.0%	21.0%	13.0%	14.0%	16.0%
Male	7.0%	47.0%	28.0%	7.0%	5.0%	6.0%
Total	13.0%	77.0%	49.0%	20.0%	19.0%	22.0%

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



	Hispanic	Caucasian	African American	Asian/PI	Native American	Other	No Valid Data/ Unknown
English	60.0%	20.0%	14.0%	1.0%	0.0%	0.0%	5.0%
Spanish	99.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.0%
Total	159.0%	20.0%	14.0%	1.0%	0.0%	0.0%	6.0%

A breakdown of member classifications by race and language preferences revealed that 99% of members who accepted services are Hispanic and the majority preferred to speak Spanish.

Referrals Accepted by Top Bakersfield Zip Codes			
Q4-2018	**Q1-2019**	**Q2-2019**	**Q3-2019**
93307	93307	93307	93307
93306	93306	93306	93304
93304	93304	93305	93306
93305	93308	93304	93305
93313	93305	93308	93309

KHS serves members in the Kern County area. During this quarter, 86% 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			
Q4-2018	**Q1-2019**	**Q2-2019**	**Q3-2019**
Arvin	Delano	Delano	Arvin
Lamont	Arvin	Wasco	Delano
Shafter	Lamont	Lamont	Shafter
Delano	Wasco	McFarland	Wasco
Wasco	Shafter	Shafter	Lamont
		Arvin	

Additionally, 14% of the members who accepted services reside in the outlying areas of Kern County and the highest concentration of members reside in Arvin.

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 2,137educational packets to members on the following health topics:

Educational Mailings				
	Q4-2018	**Q1-2019**	**Q2-2019**	**Q3-2019**
Anemia	0	1	1	2
Asthma	97	453	427	648
High Cholesterol	21	23	11	11
Diabetes	75	56	53	45
Gestational Diabetes	1	0	5	1
High Blood Pressure	41	29	4	4
COPD	0	0	0	0
Postpartum Care	80	46	4716	602
Prenatal Care	18	56	145	283
Smoking Cessation	17,500	252	13	12
Weight Management	675	713	173	370
WIC	1270	821	64	157
Total	**19,778**	**2,450**	**1,367**	**2,137**

INTERPRETER REQUESTS

Face-to-Face Interpreter Requests

During this quarter, there were 238 requests for face-to-face interpreting services received. KHS employs qualified staff interpreters in Spanish and contracts with the interpreting vendor, CommGap. The majority of these requests were for a Spanish interpreter.

Top Languages Requested			
Q4-2018	**Q1-2019**	**Q2-2019**	**Q3-2019**
Spanish	Spanish	Spanish	Spanish
Punjabi	Vietnamese	Cantonese	Punjabi
Cantonese	Arabic	Punjabi	Arabic
Vietnamese	Cantonese	English	Cantonese
Arabic	Punjabi	Arabic	Mandarin
	Mandarin		

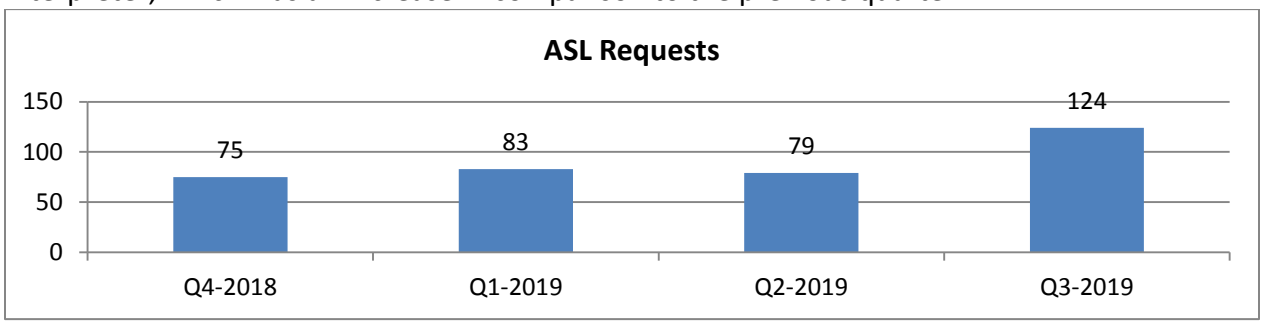
Telephonic Interpreter Requests

During this quarter, there were 1,004 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			
Q4-2018	**Q1-2019**	**Q2-2019**	**Q3-2019**
Spanish	Spanish	Spanish	Spanish
Punjabi	Punjabi	Punjabi	Punjabi
Arabic	Arabic	Arabic	Arabic
Tagalog	Tagalog	Tagalog	Mandarin
Vietnamese	Vietnamese	Mandarin	Tagalog

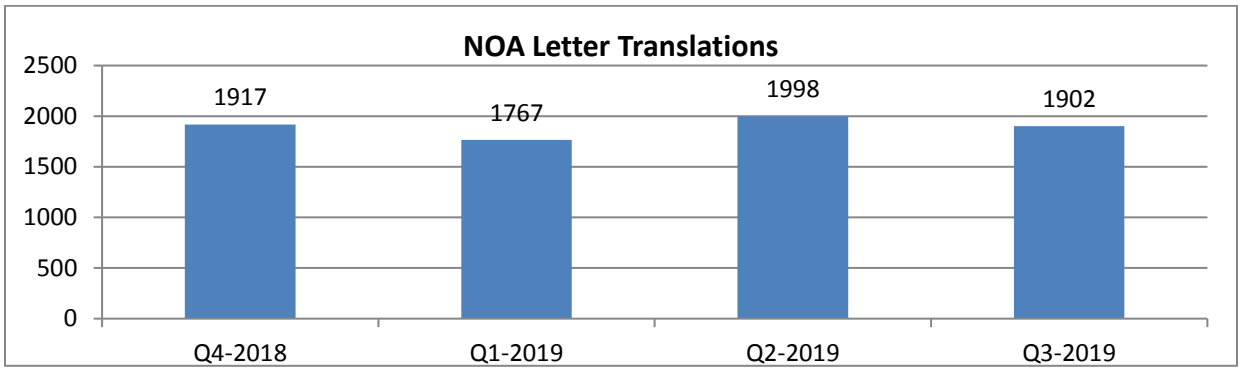
American Sign Language (ASL) Requests

During this quarter, there were a total of 124 requests received for an American Sign Language interpreter, which was an increase in comparison to the previous quarter.



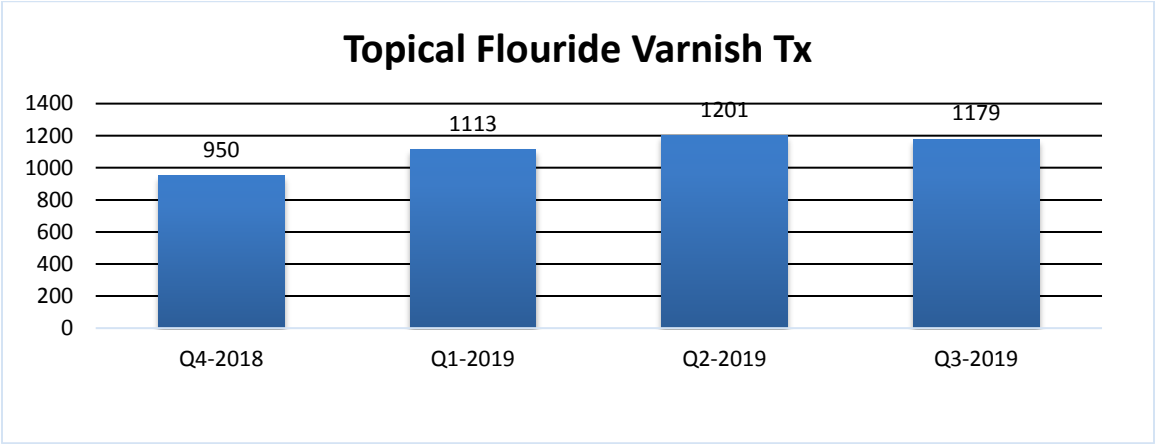
DOCUMENT TRANSLATIONS

The Health Education department coordinates the translation of written documents for members. Translations are performed in-house by qualified translators or outsourced through a contracted translation vendor. During this quarter, 1,902 Notice of Action letters were translated into Spanish for the UM and Pharmacy departments.



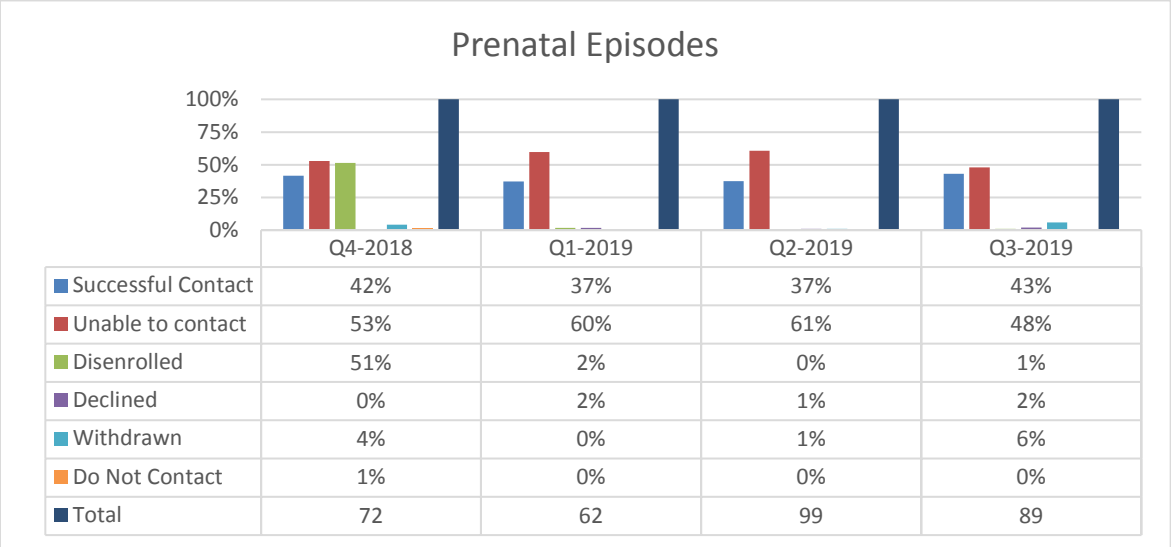
TOPICAL FLUORIDE VARNISH TREATMENTS

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.



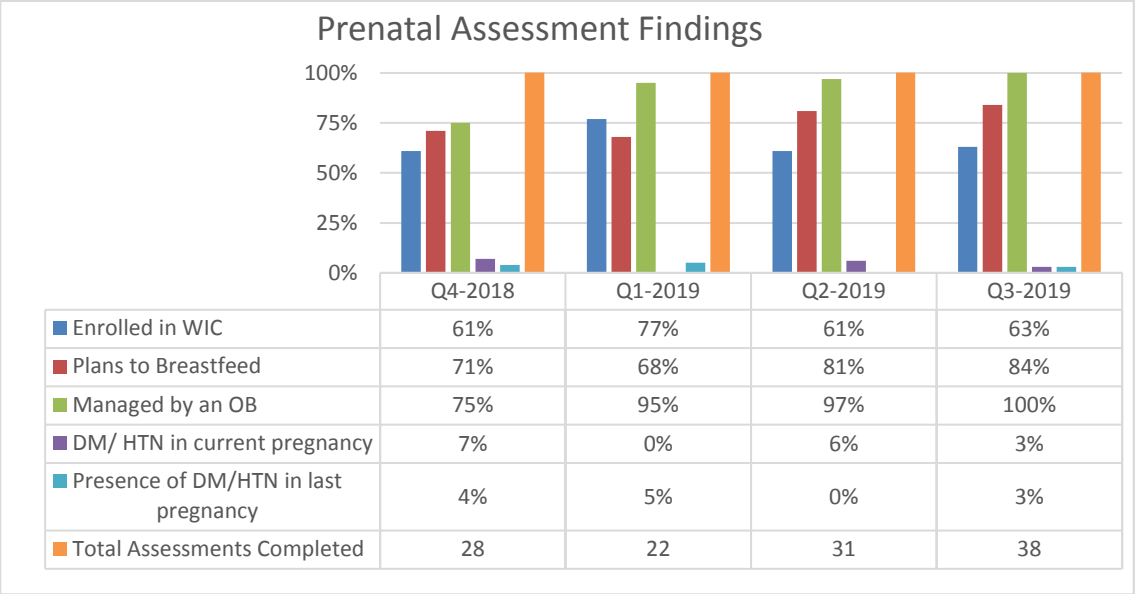
PERINATAL OUTREACH AND EDUCATION

The HE department performs outreach education calls to all members identified as being pregnant in the 1st trimester, a pregnant teen (under age 18), or postpartum due to a C-section or teen pregnancy delivery.



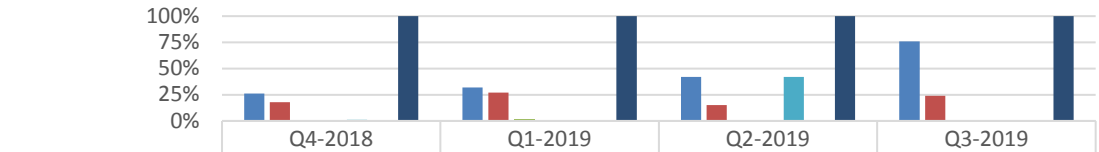
	Q4-2018	Q1-2019	Q2-2019	Q3-2019
Successful Contact	42%	37%	37%	43%
Unable to contact	53%	60%	61%	48%
Disenrolled	51%	2%	0%	1%
Declined	0%	2%	1%	2%
Withdrawn	4%	0%	1%	6%
Do Not Contact	1%	0%	0%	0%
Total	72	62	99	89

During the 3rd quarter, 107 episodes for pregnant members were created and 43% were successfully contacted.



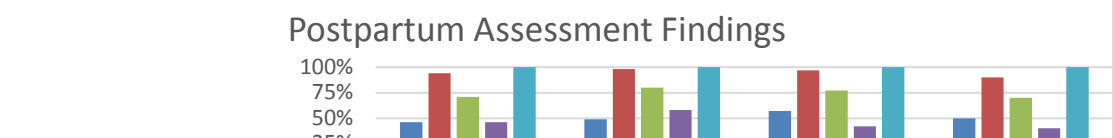
	Q4-2018	Q1-2019	Q2-2019	Q3-2019
Enrolled in WIC	61%	77%	61%	63%
Plans to Breastfeed	71%	68%	81%	84%
Managed by an OB	75%	95%	97%	100%
DM/ HTN in current pregnancy	7%	0%	6%	3%
Presence of DM/HTN in last pregnancy	4%	5%	0%	3%
Total Assessments Completed	28	22	31	38

The total prenatal assessments completed increased from 31 in the 2nd quarter of 2019 to 38 in the 3rd quarter of 2019.



	Q4-2018	Q1-2019	Q2-2019	Q3-2019
Successful Contact	26%	32%	42%	76%
Unable to contact	18%	27%	15%	24%
Disenrolled	0%	1%	0%	0%
Decline	0%	0%	0%	0%
Withdrawn	1%	0%	42%	0%
Do Not Contact	0%	0%	0%	0%
Total	58	76	474	361

During the 3rd quarter, 387 postpartum members were created and 76% were successfully contacted.



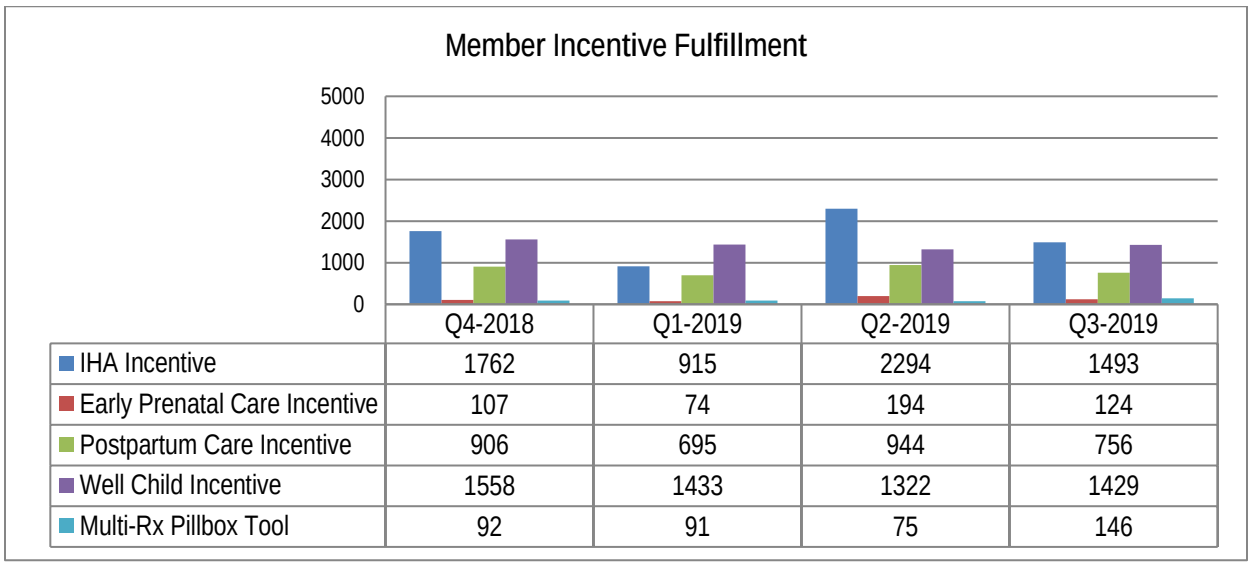
	Q4-2018	Q1-2019	Q2-2019	Q3-2019
Currently Brestfeeding	46%	49%	57%	50%
Newborn saw a doctor after leaving hospital	94%	98%	97%	90%
Newborn added to Medi-Cal case	71%	80%	77%	70%
Aware of Family Planning /Birth Control Options	46%	58%	42%	40%
Total Assessments Completed	28	45	188	273

Postpartum assessments completed increased from 188 assessments in the 2nd quarter of 2019 to 273 assessment completed in the 3rd quarter of 2019.

MEMBER WELLNESS BASED INCENTIVES AND CHRONIC CONDITION TOOLS

During the 3rd quarter of 2019, KHS continued to offer wellness based incentives and one chronic condition tools for members. In January 2019, the IHA incentive was changed to a gift card instead of a first aid kit based on member feedback regarding the incentive. This incentive program was also expanded to provide one incentive per eligible member instead of per household.

- **Initial Health Assessment (IHA)** – newly enrolled members who complete the IHA visit within 120 days of enrollment are mailed a $10 gift card.
- **Early Prenatal Care** – pregnant members who complete prenatal care during the 1st trimester will receive a $30 gift card.
- **Postpartum Care** – members who complete the postpartum visit within 21-56 days following delivery will receive an additional $30 gift card.
- **Well Child** – members ages 12 -23 months who complete a well child visit are mailed a $25 gift card.
- **Multi-Medication** – members on multiple medications and would benefit from a pill box. KHS disease and case management departments identify and mail this tool to members.



	Q4-2018	Q1-2019	Q2-2019	Q3-2019
IHA Incentive	1762	915	2294	1493
Early Prenatal Care Incentive	107	74	194	124
Postpartum Care Incentive	906	695	944	756
Well Child Incentive	1558	1433	1322	1429
Multi-Rx Pillbox Tool	92	91	75	146

Health Services Quarterly Committee Reporting- Reporting Period July 1, 2019 to September 30, 2019

Health Services Overview

The 2019 membership enrollment remained stable at 252,000 in Q3 2019. Additional benefit coverage and broadening interdisciplinary collaboration to support the membership growth will continue through 2019.

- Early, Periodic Screening and Diagnostic Testing (EPSDT) January 2020
- COPD Homebound program 10/1/19
- Housing Collaborative-Case Management for placement and resources
- Respite and Recuperative Care-new contract(s)
- Undocumented enrollees 1/1/2020

The following pages reflect statistical measurements for Utilization Management, Case Management and Disease Management detailing the ongoing compliance activity for the 3rd Quarter 2019.

Respectfully submitted,

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

Utilization Management Reporting

Timeliness of Decision Trending

Summary:

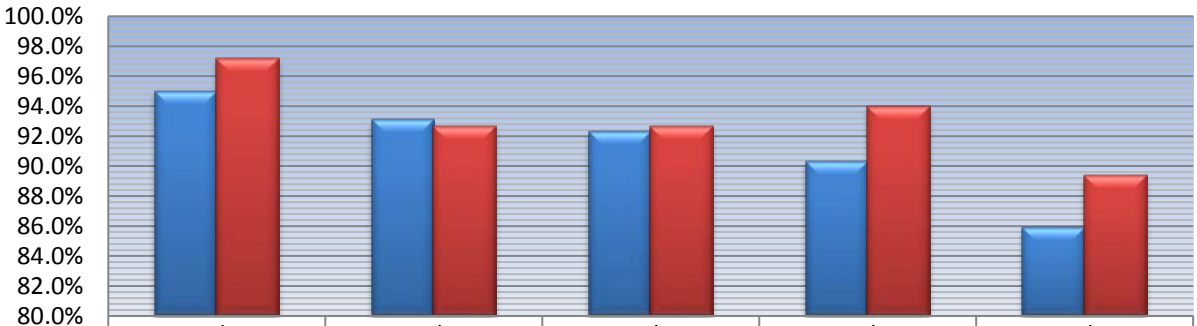
Quarterly audits are conducted to ensure compliance with DMHC requirements, KHS Contractual Agreement with the Department of Health Services, and KHS Policy and Procedures. Referrals are submitted and have specific turn-around-times set for each type of referral.

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 51,699 referrals processed in the 3rd quarter 2019 of which 4,772 referrals were reviewed for timeliness of decision. In comparison to the 2nd quarter's processing time, routine referrals compliance decreased.

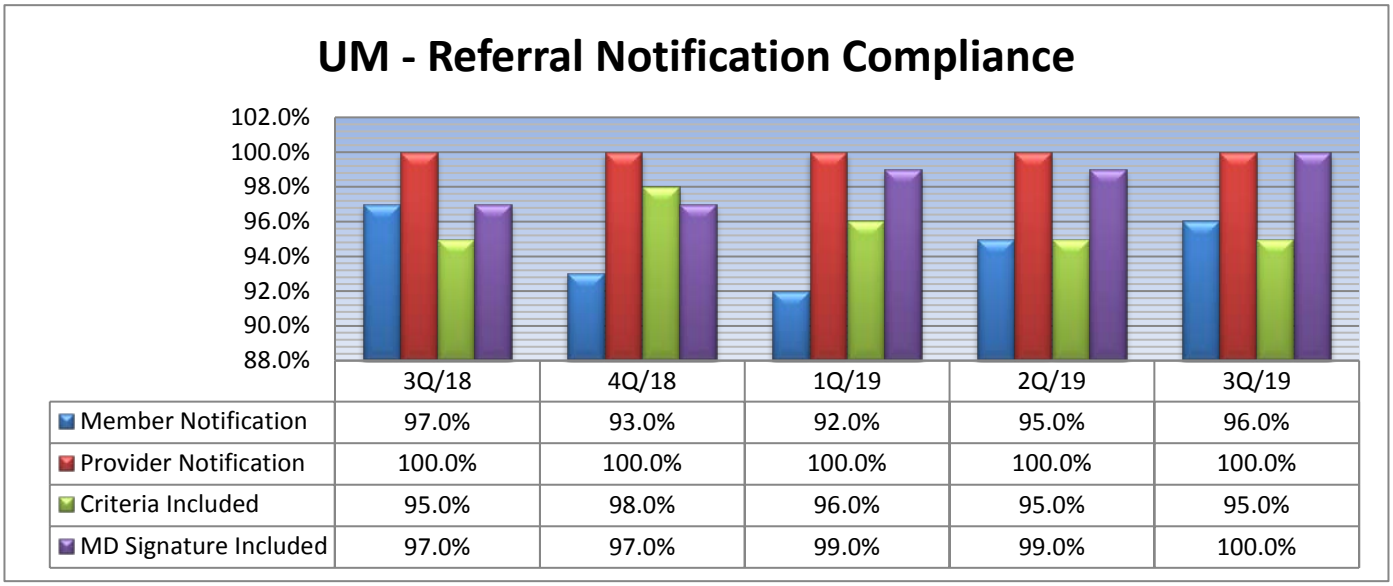


	3Q/18	4Q/18	1Q/19	2Q/19	3Q/19
Urgent Compliance %	95.0%	93.1%	92.3%	90.3%	85.9%
Routine Compliance %	97.2%	92.7%	92.7%	94.0%	89.4%

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

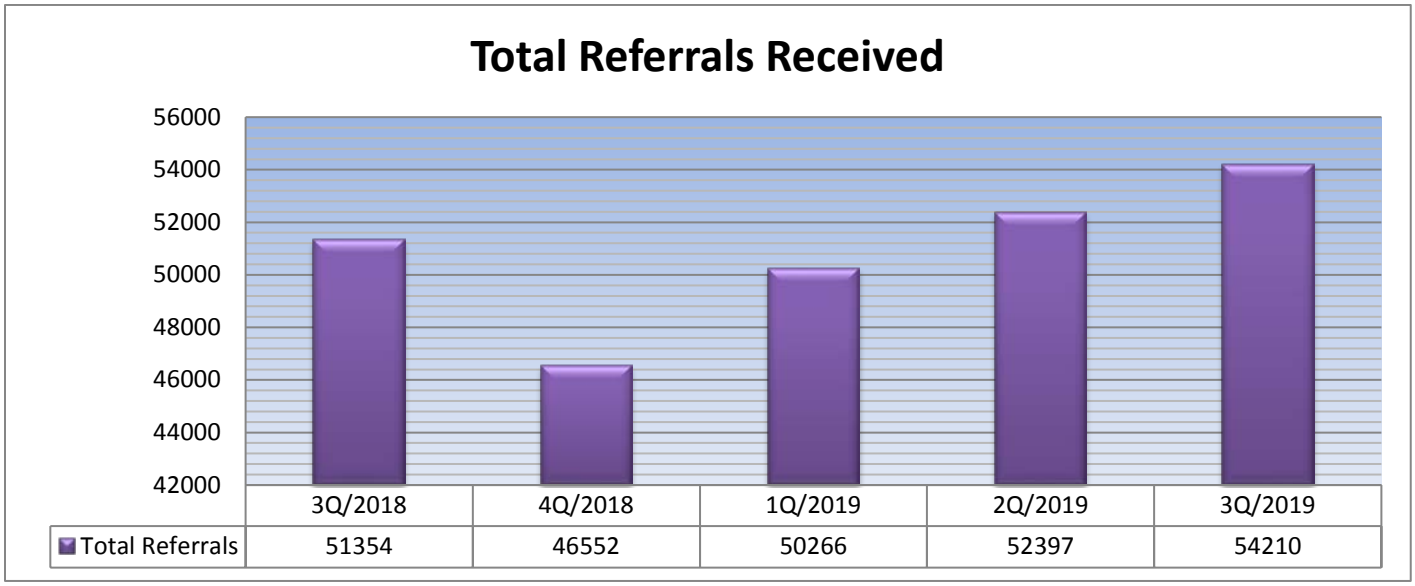
- MD Signature: MD Signature included all referrals/NOA letters upon denial

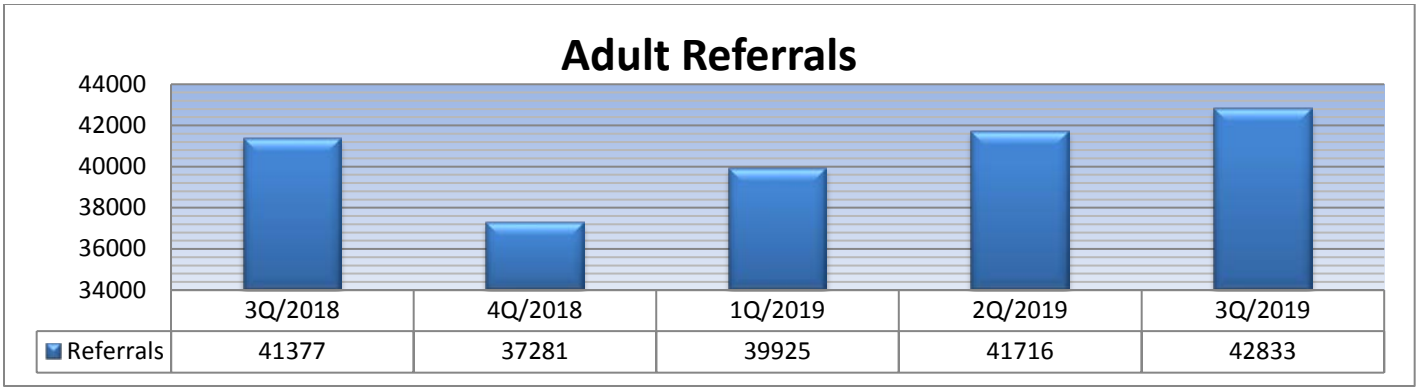


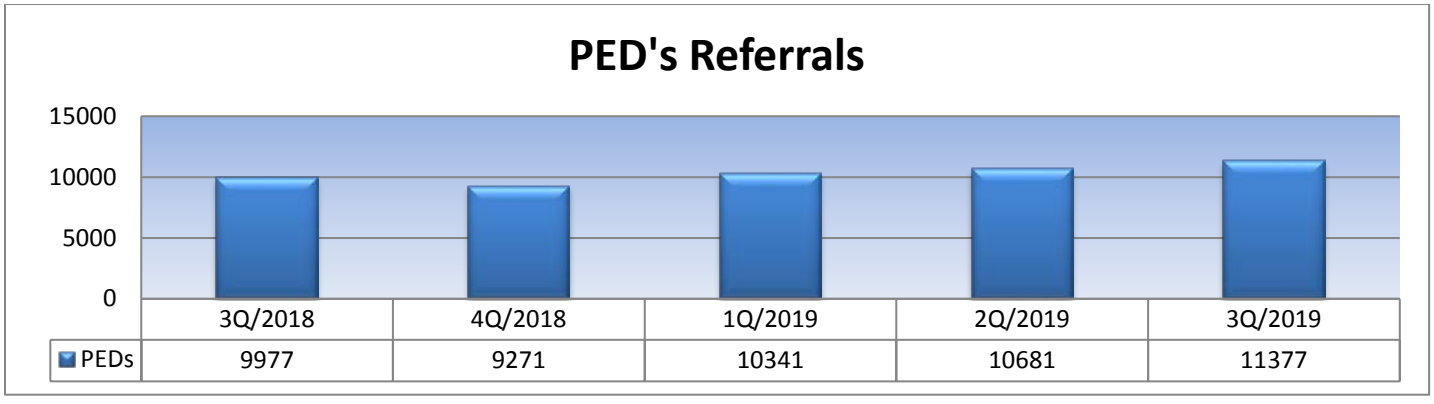
	3Q/18	4Q/18	1Q/19	2Q/19	3Q/19
Member Notification	97.0%	93.0%	92.0%	95.0%	96.0%
Provider Notification	100.0%	100.0%	100.0%	100.0%	100.0%
Criteria Included	95.0%	98.0%	96.0%	95.0%	95.0%
MD Signature Included	97.0%	97.0%	99.0%	99.0%	100.0%

Summary: Overall compliance rate in the 3rd Qtr. of 2019 increased from the 2nd Qtr.

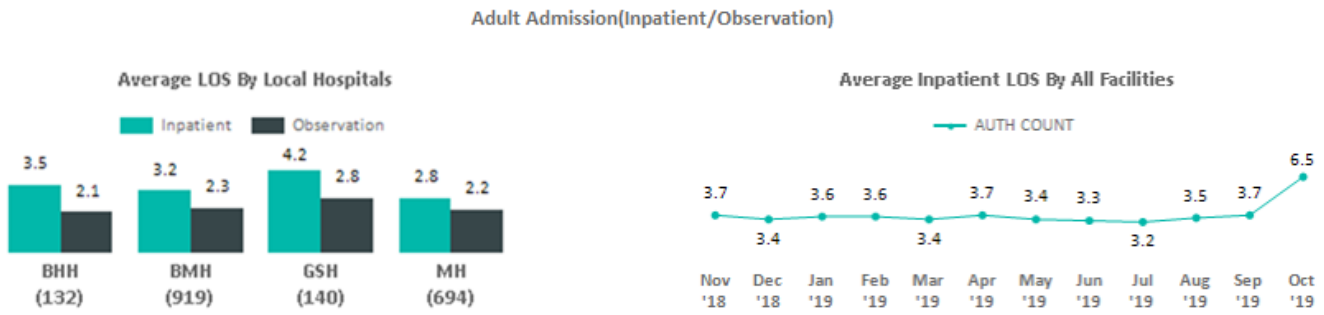
Outpatient Referral Statistics







KHS 3rd Quarter Inpatient and LOS Report



Participating Providers			
Provider Name	**Admit Count**	**LOS**	**Avg LOS**
ADVENTIST HEALTH BAKERSFIELD S	659	2058	3.12
ADVENTIST HEALTH COMMUNITY CAR	3	5	1.67
ADVENTIST HEALTH MEDICAL CENTE	23	40	1.74
ANTELOPE VALLEY HOSPITAL	5	26	5.20
BAKERSFIELD HEART HOSPITAL	132	432	3.27
BAKERSFIELD MEMORIAL HOSPITAL	919	2701	2.94
BELLAGIO IN THE DESERT	3	84	28.00
CHRISTUS SPOHN MEMORIAL HOSPIT	1	1	1.00
CRESCENT MEDICAL CENTER LANCAS	1	2	2.00
DELANO REGIONAL MEDICAL CENTER	70	197	2.81
ENCOMPASS HEALTH REHABILITATIO	1	23	23.00
GGNSC SHAFTER LP	2	24	12.00
GOOD SAMARITAN HOSPITAL	140	522	3.73
GRADY MEMORIAL HOSPITAL CORPOR	1	41	41.00
HOFFMANN HOSPICE OF THE VALLEY	6	115	19.17
KECK HOSPITAL OF USC	88	292	3.32
KERN COUNTY MEDICAL AUTHORITY	640	1833	2.86
KERN COUNTY MEDICAL CLINIC, IN	5	18	3.60
KERN MEDICAL CENTER	52	126	2.42
KERN VALLEY HEALTHCARE DISTRIC	16	41	2.56
KINDRED HOSPITAL LA MIRADA	2	49	24.50
MERCY HOSPITAL	694	1801	2.60
MERCY-MEMORIAL HOME HEALTH	1	1	1.00
PARKVIEW JULIAN	2	30	15.00
RIDGECREST REGIONAL HOSPITAL	1	2	2.00
UCLA MEDICAL CENTER	19	75	3.95
UNITED CARE FACILITIES	8	107	13.38

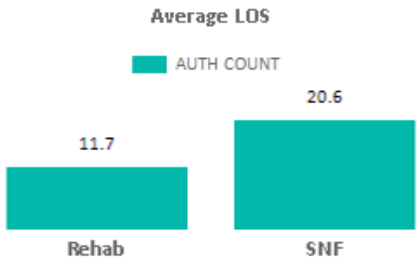
USC NORRIS CANCERHOSPITAL	8	64	8.00
USC VERDUGO HILLS HOSPITAL	1	3	3.00
VALLEY CHILDREN'S HOSPITAL	1	5	5.00
VENTURA COUNTY MEDICAL CENTER	3	9	3.00
VFP HOMES	1	4	4.00
Total	**3508**	**10731**	**3.06**

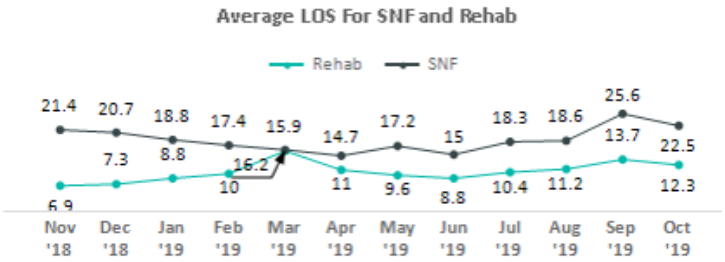
Non Participating Providers			
Provider Name	**Admit Count**	**LOS**	**Avg LOS**
	1	1	1.00
ADVENTIST MEDICAL CENTER	1	1	1.00
AHMC ANAHEIM REG MEDICAL CENTE	3	10	3.33
ANTELOPE VALLEY HOSPITAL	38	195	5.13
BARSTOW COMM HOSPITAL	1	4	4.00
BOZEMAN HEALTH DEACONESS HOSPI	1	3	3.00
CALIFORNIA HOSPITAL MEDICAL CE	1	2	2.00
CENTINELA HOSPITAL MEDICAL GRO	1	1	1.00
CHHP HOLDINGS	2	5	2.50
CHLB, LLC COLLEGE MEDICAL CENT	2	19	9.50
CLOVIS COMMUNTIY MEDICAL CENTE	1	8	8.00
DELANO REGIONAL MEDICAL CENTER	1	45	45.00
DESERT SPRINGS HOSPITAL	1	1	1.00
EL CAMINO HOSPITAL	1	1	1.00
FRESNO COMMUNITY HOSPITAL AND	11	40	3.64
GLENDALE MEMORIAL HO	1	3	3.00
HARBOR - UCLA MED FOUNDATION	1	1	1.00
HENRY MAYO NEWHALL	8	20	2.50
HOSPITALS OF PROVIDENCE TRANSM	1	8	8.00
HUNTINGTON MEMORIAL HOSPITAL	2	10	5.00
KAWEAH DELTA HEALTH CARE DISTR	1	3	3.00
KAWEAH DELTA MEDICAL CENTER	8	57	7.13
KINDRED HOSPITAL SAN GABRIEL	2	60	30.00
LAC USC MEDICAL CENTER	4	15	3.75
LAC/USC MEDICAL CENTER	1	2	2.00
LANCASTER HOSPITAL CORPORATION	7	28	4.00
LEGACY MERIDIAN PARK HOSP	1	2	2.00
LOMA LINDA UNIVERSITY MEDICAL	6	29	4.83
LOS ROBLES HOSPITAL & MC	3	23	7.67

LOVELACE MEDICAL CENTER	1	3	3.00
LOVELACE WOMENS HOSPITAL	2	4	2.00
LUCILE SALTER PACKARD CHILDREN	1	30	30.00
MCKENZIE-WILLAMETTE MEDICAL CE	1	12	12.00
MEMORIAL HOSPITAL OF GARDENA	1	3	3.00
MERCY REDDING	1	11	11.00
MISSION HOSPITAL REGIONAL MEDI	1	2	2.00
MOUNTAINVIEW HOSPITAL	1	1	1.00
OLYMPIA MEDICAL CENTER	1	2	2.00
PARKVIEW COMM	1	3	3.00
PRESBYTERIAN INTERCOMMUNITY HO	2	4	2.00
PRIME HEALTHCARE ANAHEIM, LLC	1	2	2.00
PRIME HEALTHCARE SERVICES	2	5	2.50
PRIME HEALTHCARE SERVICES, INC	1	2	2.00
PROVIDENCE SAINT JOSEPH	1	1	1.00
QUEEN OF THE VALLEY MEDICAL CE	1	1	1.00
REGIONAL MEDICAL CENTER	1	16	16.00
REGIONAL MOUNTAIN VIEW	1	3	3.00
SAINT AGNES MEDICAL CENTER	1	1	1.00
SAINT LOUISE REGIONAL HOSPITAL	1	3	3.00
SCRIPPS MERCY	1	3	3.00
SHERMAN OAKS CONGREGATE LIVING	1	41	41.00
SIERRA VIEW DISTRICT	1	1	1.00
SIERRA VIEW MEDICAL CENTER	1	2	2.00
SOUTHERN CALIFORNIA HOSPITAL	1	1	1.00
SOUTHWEST HEALTHCARE	1	15	15.00
ST DAVIDS S AUSTIN MEDICAL CEN	1	3	3.00
ST JOHNS REGIONAL MEDICAL CENT	1	2	2.00
ST MARY MEDICAL CENTER	1	3	3.00
ST VINCENT MED CTR	1	7	7.00
STANFORD MEDICAL CENTER	3	6	2.00
SUMMERLIN HOSPITAL	1	2	2.00
SUNRISE HOSPITAL AND MEDICAL	1	2	2.00
TEMECULA VALLEY HOSPITAL INC	1	2	2.00
TUCSON MEDICAL CENTER	1	3	3.00
UCSD MEDICAL CENTER	1	3	3.00
UNIVERSITY MEDICAL CENTER	1	3	3.00
UNIVERSITY OF TENNESSEE MEDICA	1	8	8.00
VALLEY PRESBYTERIAN HOSPITAL	1	5	5.00

VICTOR VALLEY GLOBAL MEDICAL C	1	4	4.00
WASHINGTON HOSPITAL	1	2	2.00
WOODLAND MEMORIAL HOSPITAL	1	12	12.00
YAVAPAI REGIONAL MED	1	3	3.00
Total	**160**	**839**	**5.24**

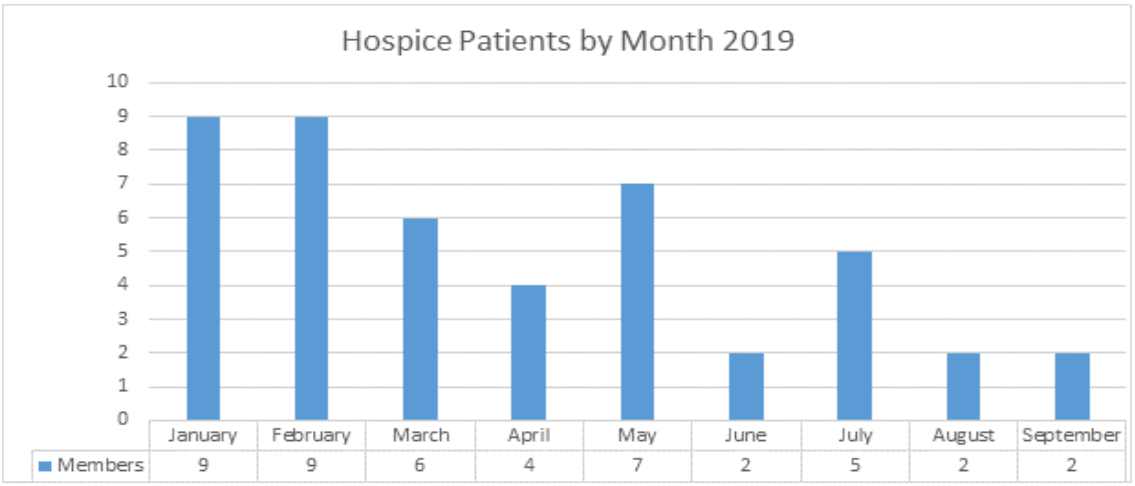
Adult Admissions (SNF/Rehab)

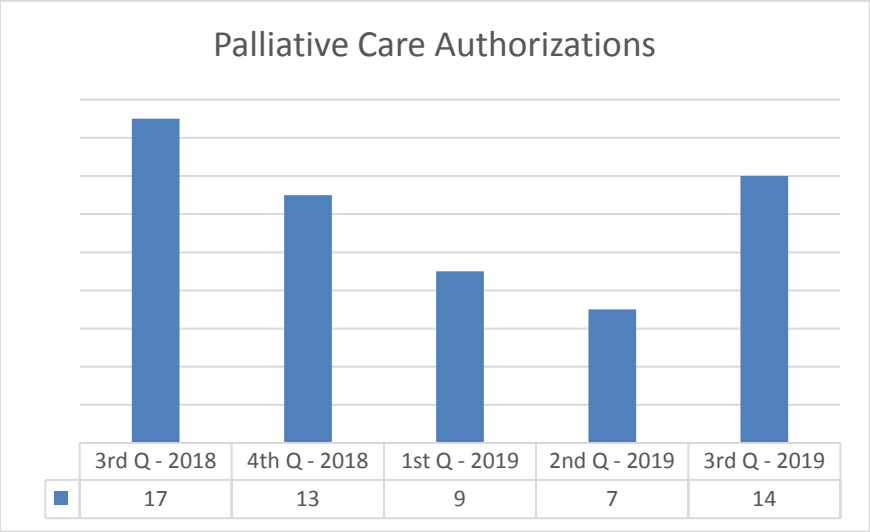




Participating Providers			
Provider Name	**Admit Count**	**LOS**	**Avg LOS**
BAKERSFIELD HEART HOSPITAL	1	2	2.00
BELLAGIO IN THE DESERT	6	140	23.33
CAPRI IN THE DESERT	6	151	25.17
DELANO REGIONAL MEDICAL CENTER	1	2	2.00
ENCOMPASS HEALTH REHABILITATIO	42	521	12.40
GGNSC SHAFTER LP	16	410	25.63
GOLDEN LIVING CENTER	2	59	29.50
HOFFMANN HOSPICE OF THE VALLEY	11	108	9.82
KERN COUNTY MEDICAL AUTHORITY	1	1	1.00
LIFEHOUSE BAKERSFIELD OPERATIO	1	13	13.00
OPTIMAL HOSPICE	1	345	345.00
PARKVIEW JULIAN	10	177	17.70
UNITED CARE FACILITIES	81	1208	14.91
VFP HOMES	7	157	22.43
Total	**186**	**3294**	**17.71**

Non Participating Providers			
Provider Name	**Admit Count**	**LOS**	**Avg LOS**
ALL SEASONS HEALTHCARE, INC	1	90	90.00
ALL VALLEY HEALTHCARE	1	39	39.00
BALDWIN PARK CONGREGATE HOME	1	16	16.00
DELANO POSTACUTE CARE	1	15	15.00
DELANO REGIONAL MEDICAL CENTER	1	5	5.00
EVERGREEN AT ARVIN HEALTHCARE	4	147	36.75
KINDRED HOSPITAL SAN GABRIEL	1	8	8.00
KINGSTON HEALTHCARE CENTER	9	96	10.67
PACIFICA HOSPITAL OF THE VALLE	1	59	59.00
PURE HEART CONG LVING FACITLIT	1	40	40.00
SAN JOAQUIN NURSING AND REHABI	1	69	69.00
Total	**22**	**584**	**26.55**

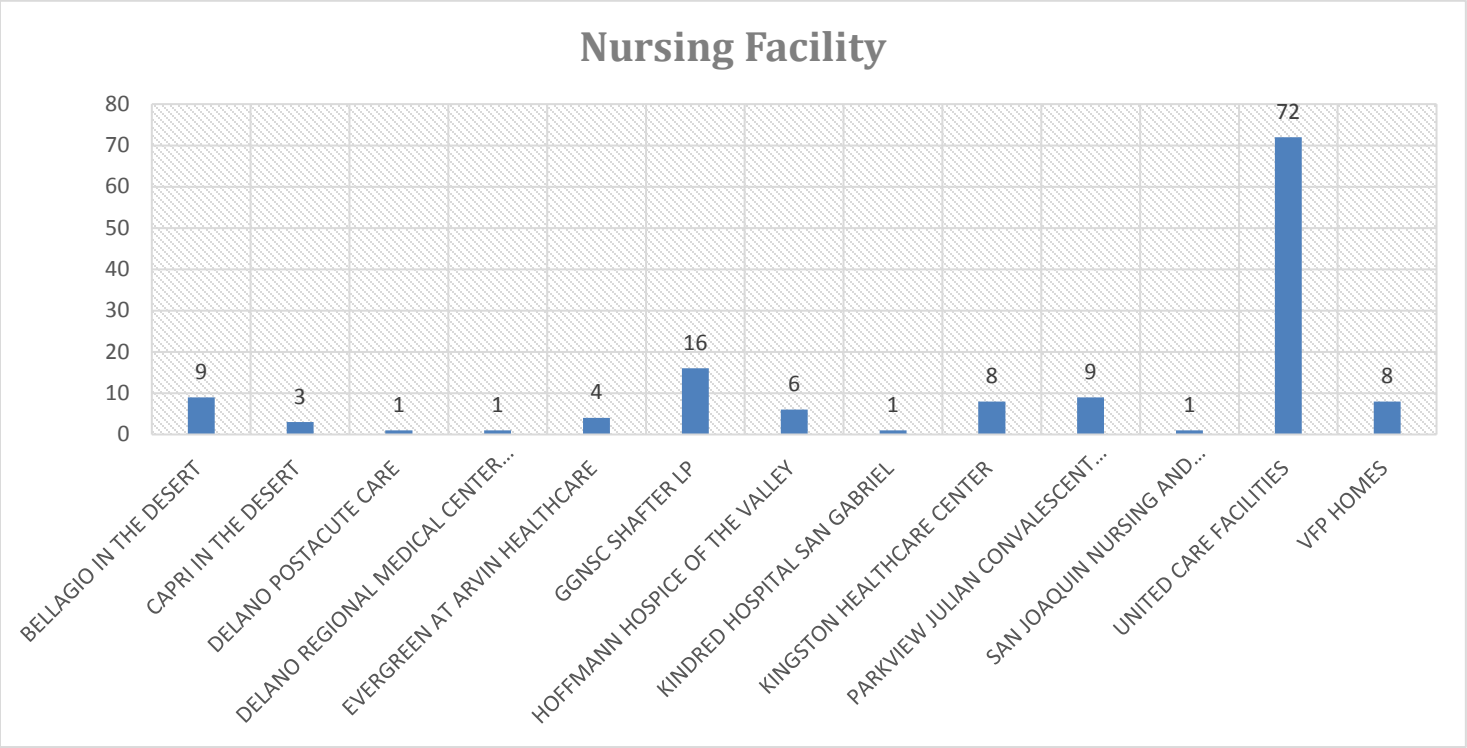




Nursing Facility Services Report

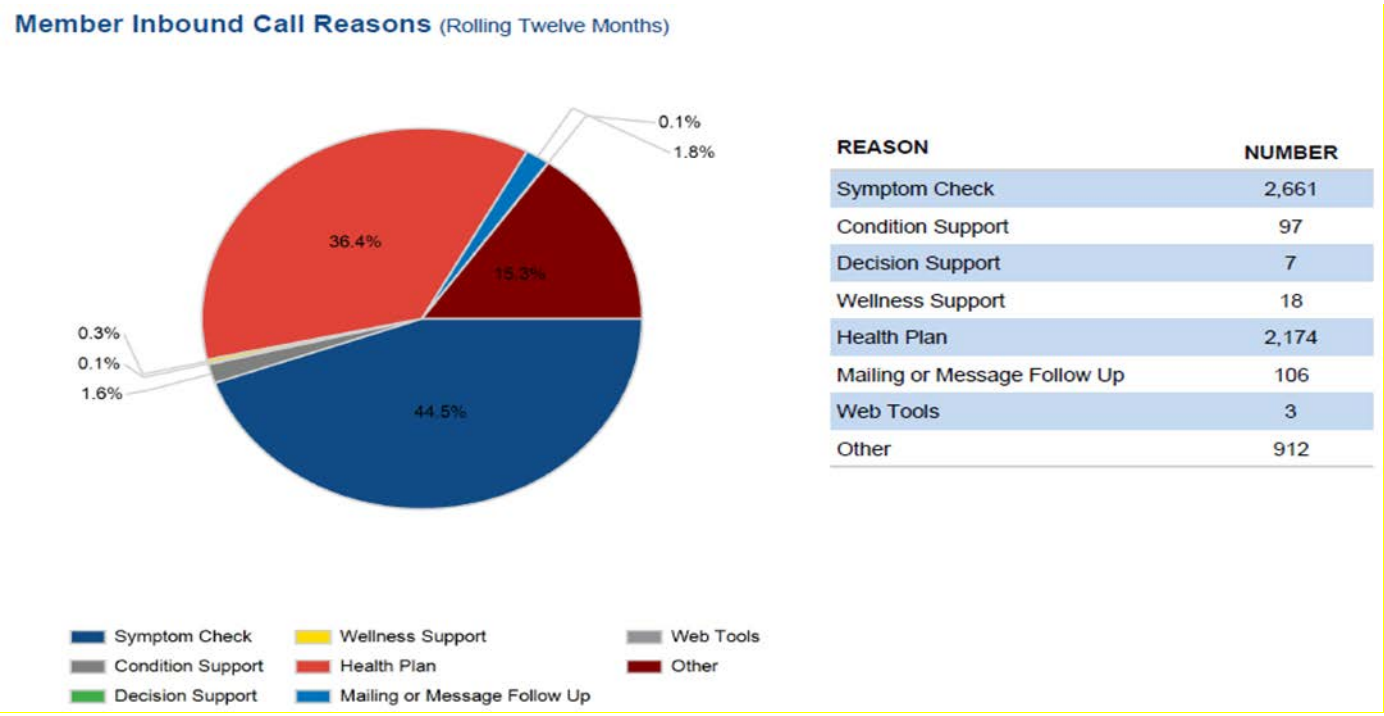
Purpose: Kern Health Systems covers medically necessary Nursing Facility Services for eligible members. KHS members requiring Nursing Facility Services are identified and placed in health care facilities, which provide the level of care most appropriate to the member's medical needs. For members requiring 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 3rd quarter 2019, there were 175 referrals for Nursing Facility Services. The average length of stay was 23.4 days for these members. During the 2nd quarter there was only 3 denials of the 161 referrals.



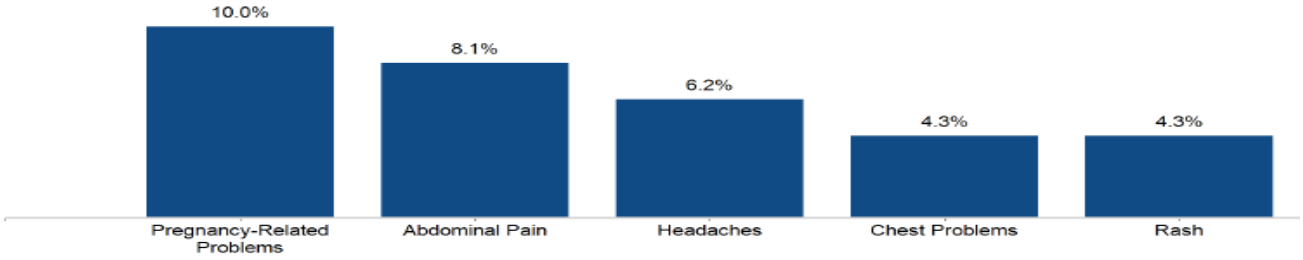
Health Dialog Report

July:

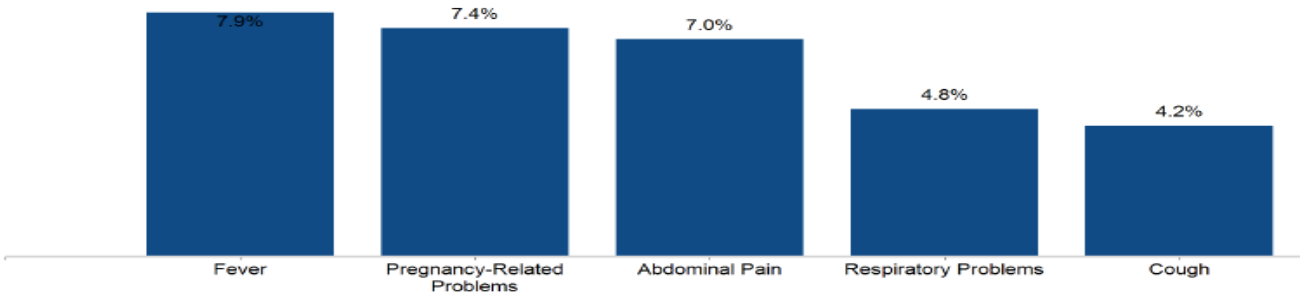


REASON	NUMBER
Symptom Check	2,661
Condition Support	97
Decision Support	7
Wellness Support	18
Health Plan	2,174
Mailing or Message Follow Up	106
Web Tools	3
Other	912

Most Frequent Symptoms - Inbound Symptom Check Calls (Jul-2019)

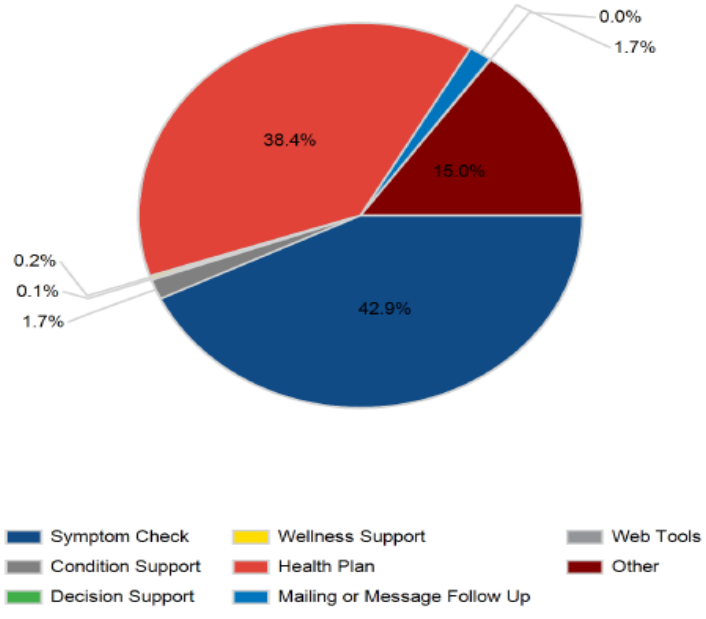


Most Frequent Symptoms - Inbound Symptom Check Calls (Rolling Twelve Months)



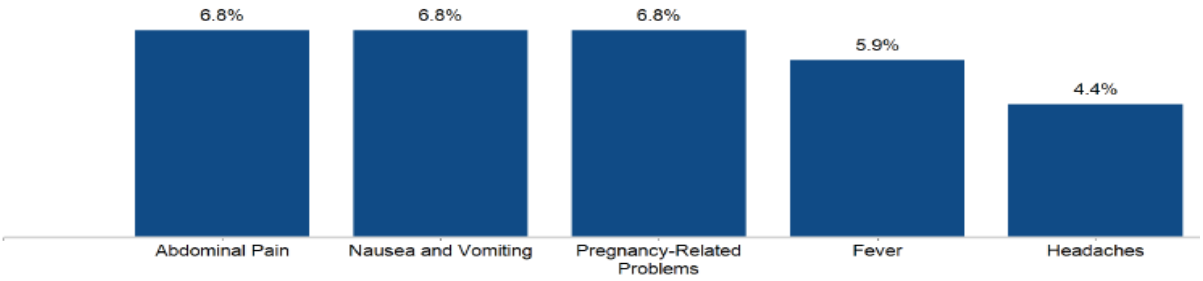
August:

Member Inbound Call Reasons (Rolling Twelve Months)

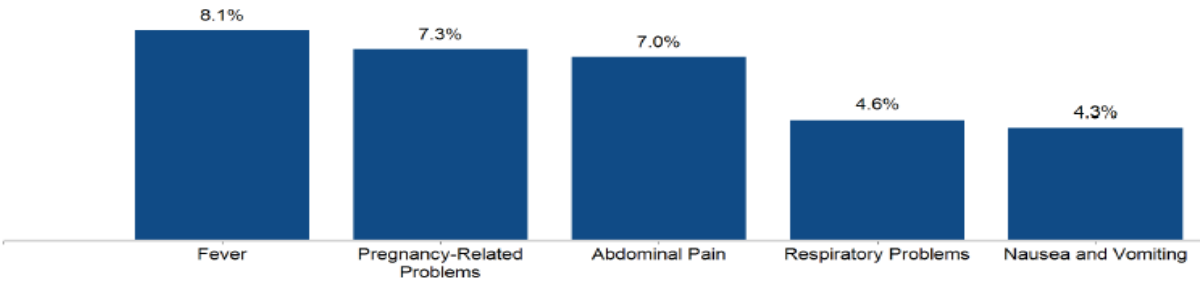


REASON	NUMBER
Symptom Check	2,650
Condition Support	104
Decision Support	8
Wellness Support	14
Health Plan	2,371
Mailing or Message Follow Up	103
Web Tools	3
Other	929

Most Frequent Symptoms - Inbound Symptom Check Calls (Aug-2019)

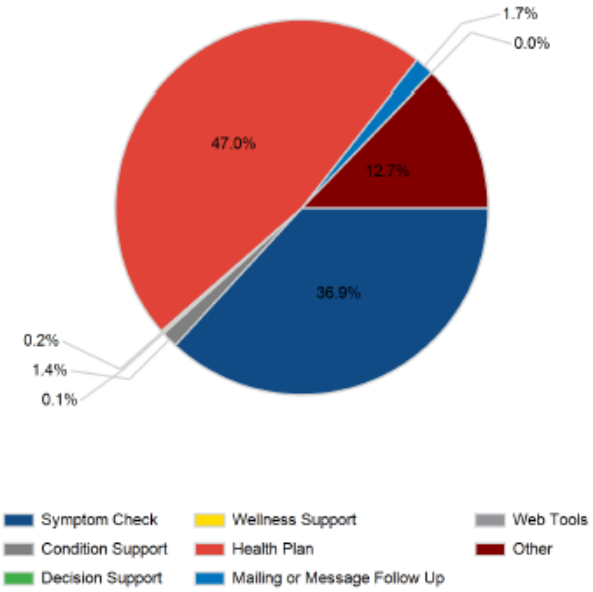


Most Frequent Symptoms - Inbound Symptom Check Calls (Rolling Twelve Months)

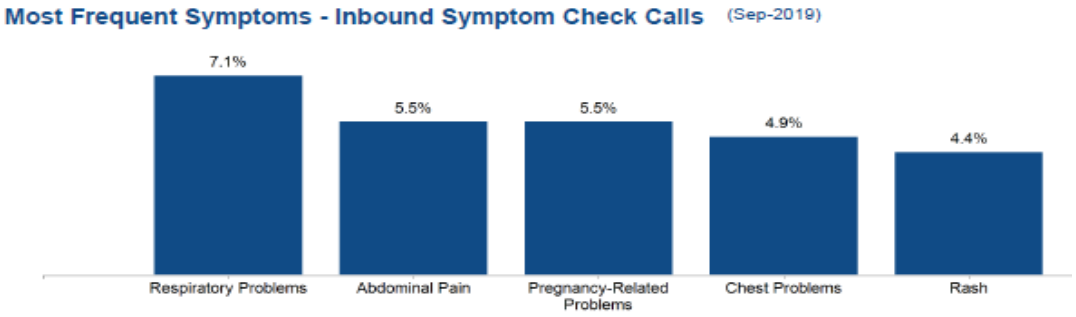


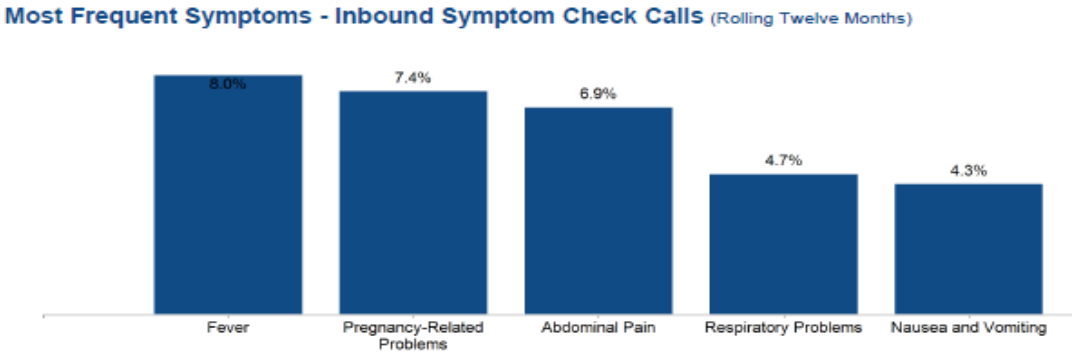
September:

Member Inbound Call Reasons (Rolling Twelve Months)

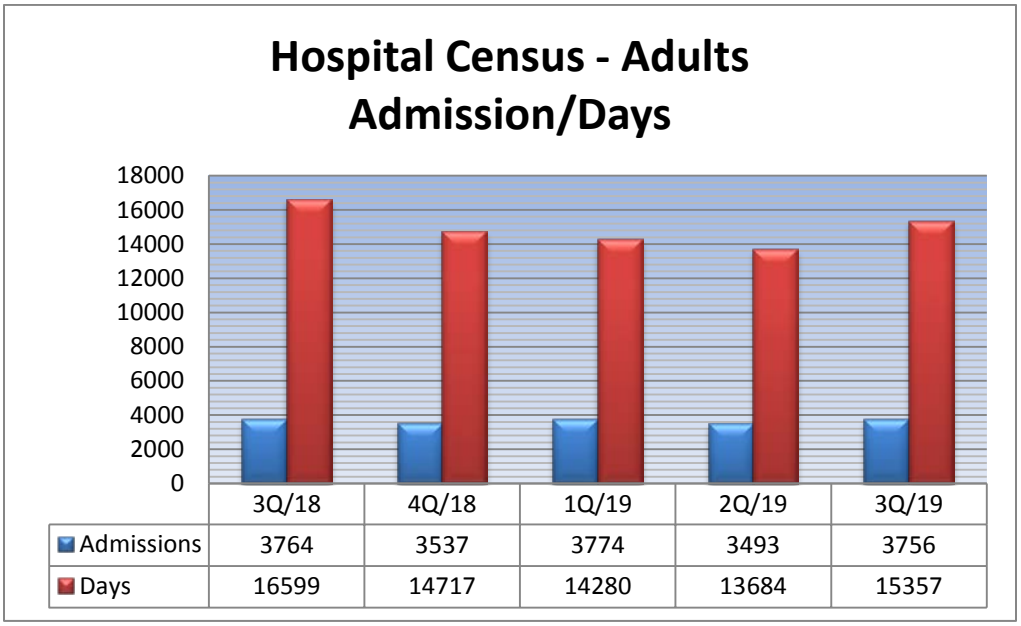


REASON	NUMBER
Symptom Check	2,635
Condition Support	101
Decision Support	6
Wellness Support	15
Health Plan	3,363
Mailing or Message Follow Up	118
Web Tools	2
Other	909

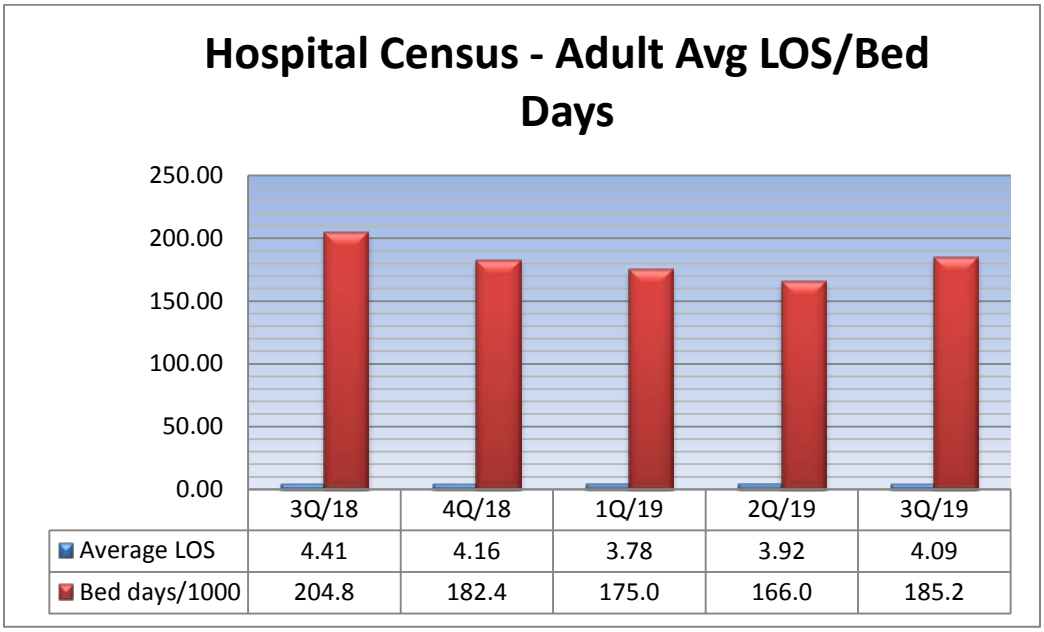




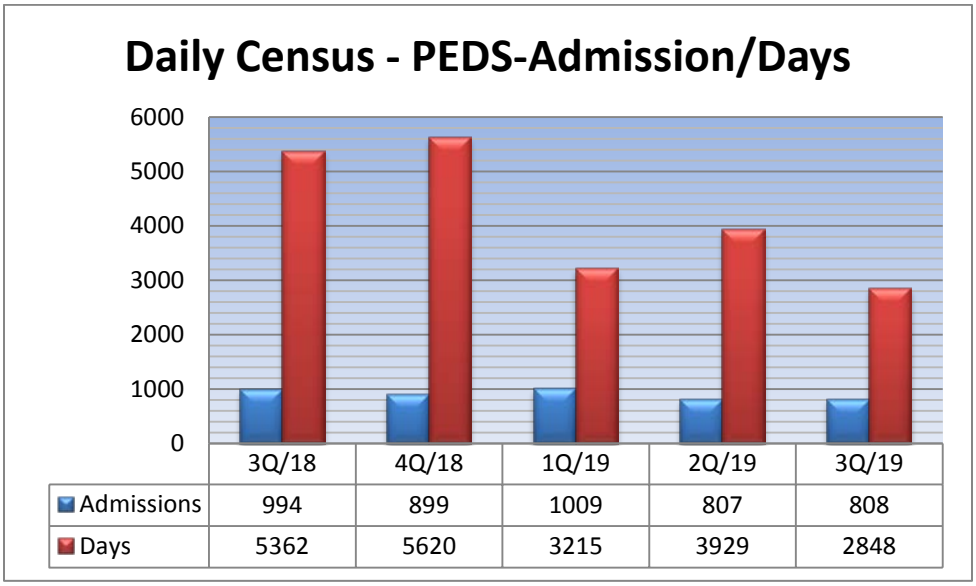
Inpatient 3rd Quarter Trending



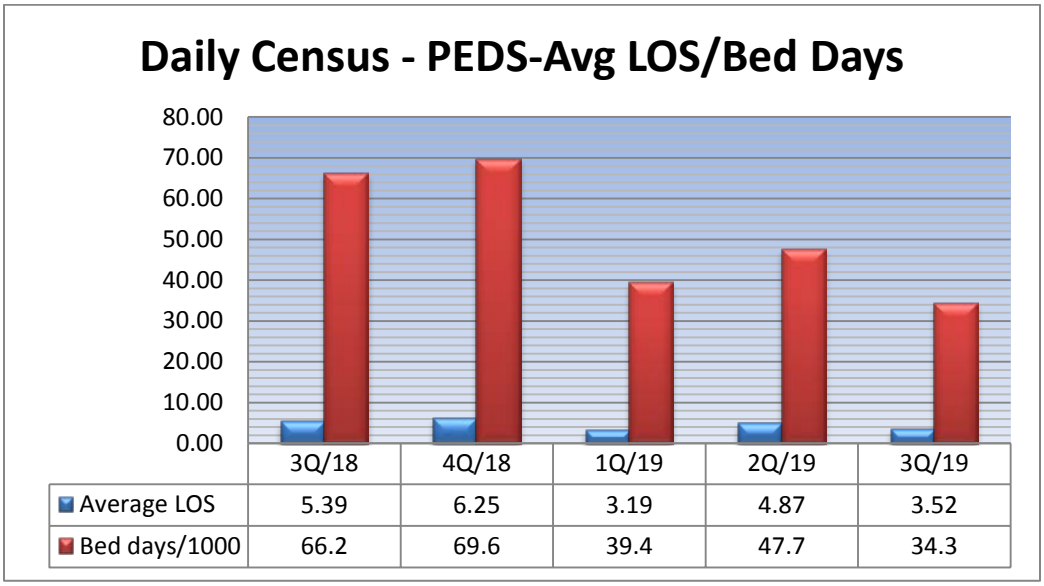
	3Q/18	4Q/18	1Q/19	2Q/19	3Q/19
Admissions	3764	3537	3774	3493	3756
Days	16599	14717	14280	13684	15357



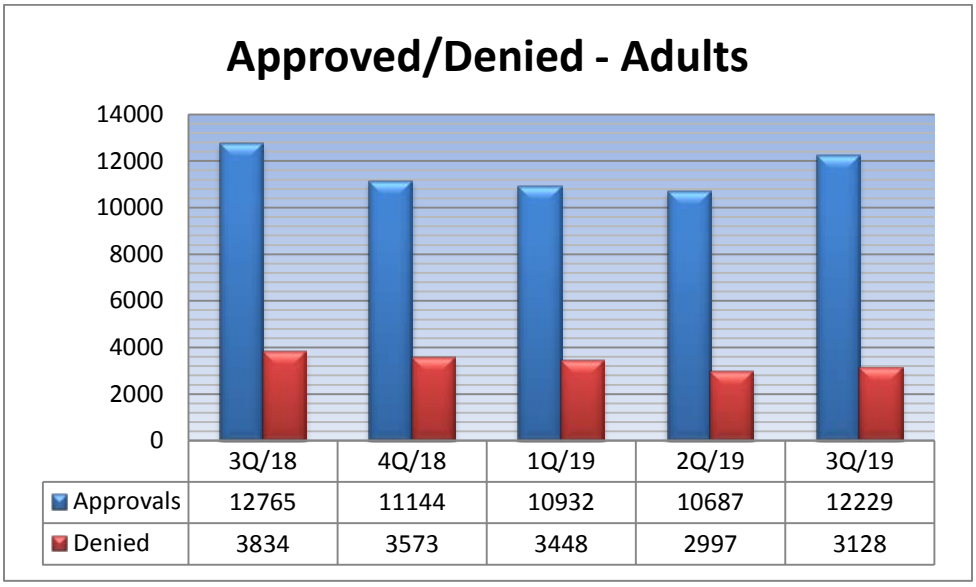
	3Q/18	4Q/18	1Q/19	2Q/19	3Q/19
Average LOS	4.41	4.16	3.78	3.92	4.09
Bed days/1000	204.8	182.4	175.0	166.0	185.2



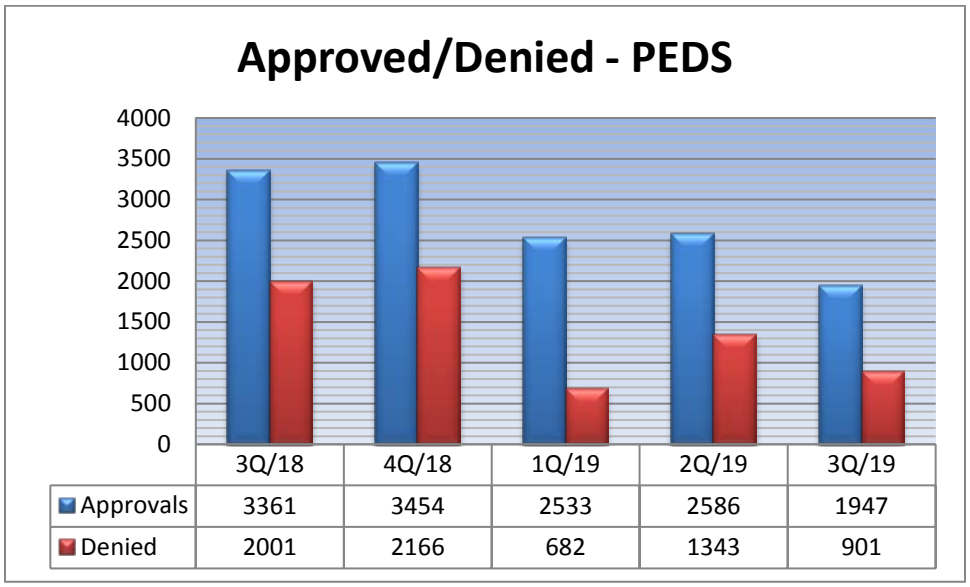
	3Q/18	4Q/18	1Q/19	2Q/19	3Q/19
Admissions	994	899	1009	807	808
Days	5362	5620	3215	3929	2848

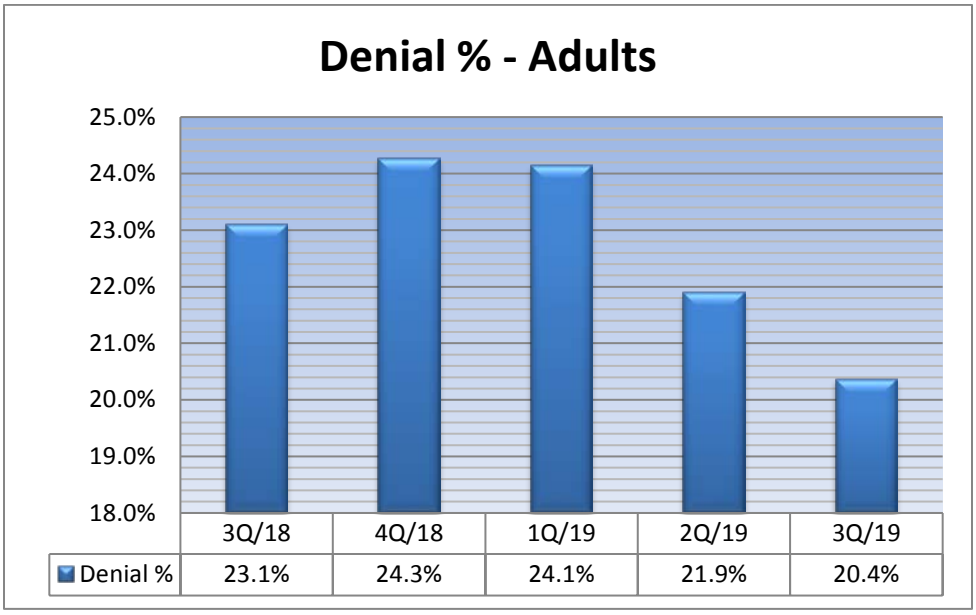


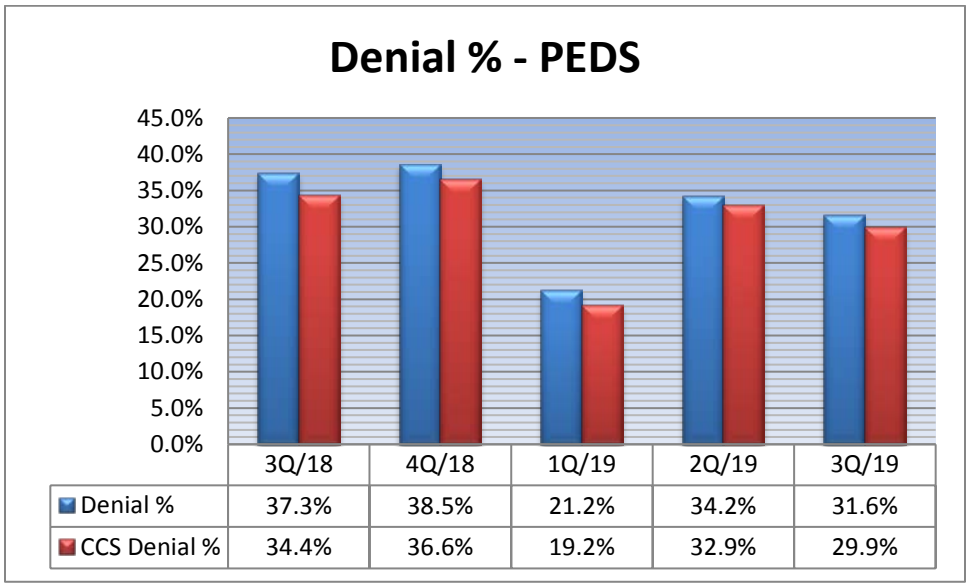
	3Q/18	4Q/18	1Q/19	2Q/19	3Q/19
Average LOS	5.39	6.25	3.19	4.87	3.52
Bed days/1000	66.2	69.6	39.4	47.7	34.3



	3Q/18	4Q/18	1Q/19	2Q/19	3Q/19
Approvals	12765	11144	10932	10687	12229
Denied	3834	3573	3448	2997	3128


Approved/Denied - PEDS
4000
3500
3000
2500
2000
1500
1000
500
0
3Q/18
4Q/18
1Q/19
2Q/19
3Q/19
Approvals
3361
3454
2533
2586
1947
Denied
2001
2166
682
1343
901


Denial % - Adults
25.0%
24.0%
23.0%
22.0%
21.0%
20.0%
19.0%
18.0%
3Q/18
4Q/18
1Q/19
2Q/19
3Q/19
Denial %
23.1%
24.3%
24.1%
21.9%
20.4%



Continuity of Care

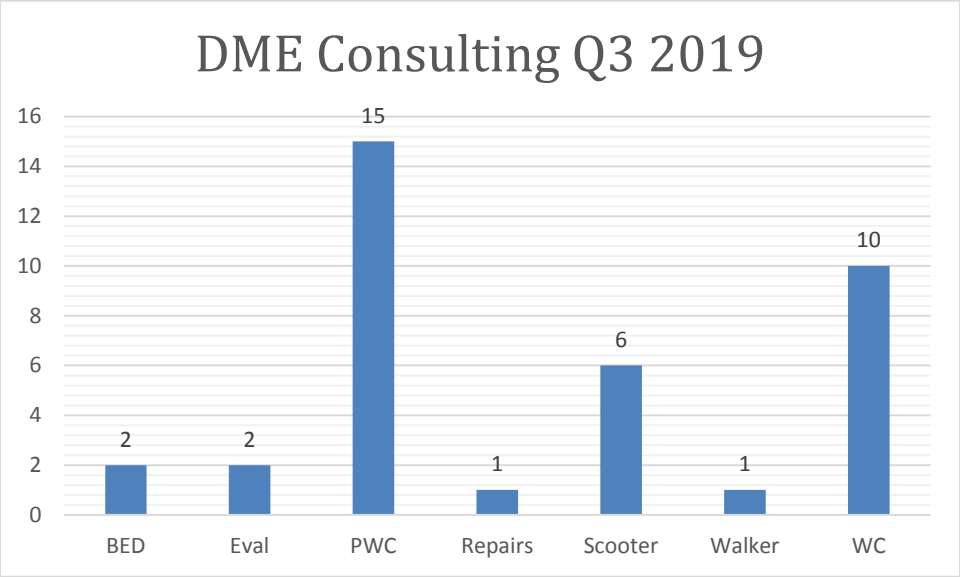
Total Referral – 87

Total Approval – 86

Total Denial - 1

Total SPD COC -31

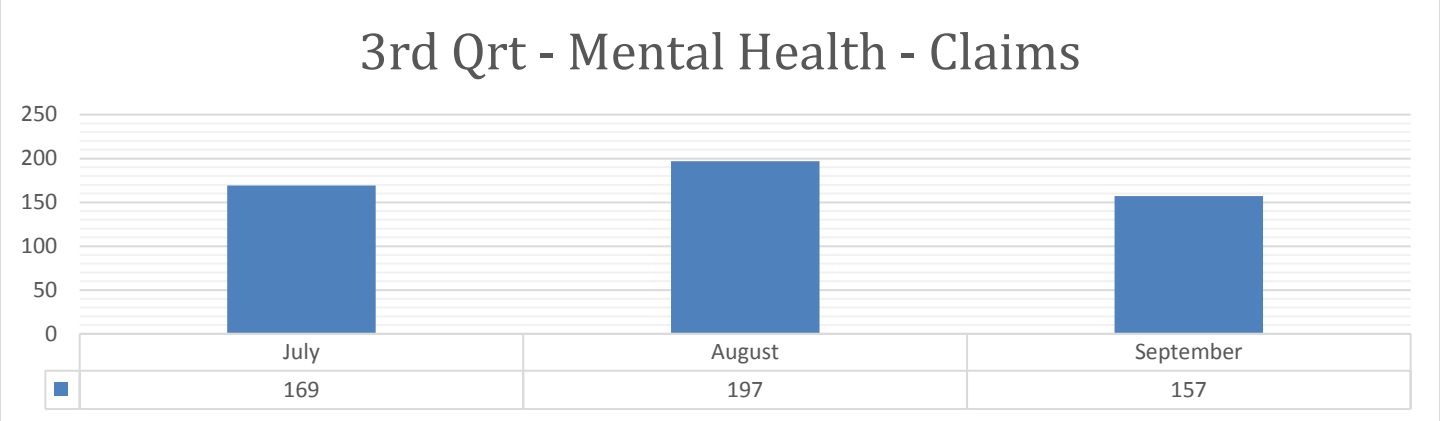
DME Consulting



Autism Reporting

UNIQUE CASES		Mild	Moderate	Severe	Total	Undetermined
MEMBER COUNT		25	83	16	124	41
Severity %		20.16%	66.94%	12.90%	100%	
SEVERITY	Jul	Aug	Sep	Total		
MILD	10	12	3	25		
MODERATE	26	24	33	83		
SEVERE	5	5	6	16		
Approved FBA	32	32	26	90		
Approved Treatment	41	53	42	124		
PENDING DX	21	12	8	41		
	Jul	Aug	Sep	Total		
AGE 7 OR LESS	40	25	31	96		
AGE 8 OR GREATER	22	28	19	69		
TOTAL	62	53	50	165		
% < 7	64.52%	47.17%	62.00%	58.18%		
% > 8	35.48%	52.83%	38.00%	41.82%		

Mental Health



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
2018	October	598	22	23	45
	November	770	41	41	82
	December	853	52	64	116
2019	January	8,557	327	340	667
	February	8,910	414	314	728
	March	265	24	14	38
	April	1,012	60	33	93
	May	553	40	15	55
	June	729	60	4	64
	July	591	30	0	30
	August	541	16	0	16
	September	4,151	10	0	10
Totals		**27,530**	**1,096**	**848**	**1,944**

LTM Effectiveness* : 7 %

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

Medical Data Collection Summary Report

Period Covered: October, 2018 through September, 2019
Prepared for: KERN HEALTH SYSTEMS - (12049397)

Reported Cases

	Members	
Received Eye Exam:	27,104	
Diabetes?:	1,359	5.0%
Diabetic Retinopathy:	159	.6%
Glaucoma:	222	.8%
Hypertension:	1023	3.8%
High Cholesterol	401	1.5%
Macular Degeneration:	38	.1%

Estimated Number of Cases

Total Members:	248,194	
Diabetes?:	5,586	2.3%
Diabetic Retinopathy:	492	.2%
Glaucoma:	937	.4%
Hypertension:	24,481	9.9%
High Cholesterol	37,319	15.0%
Macular Degeneration:	301	.1%

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

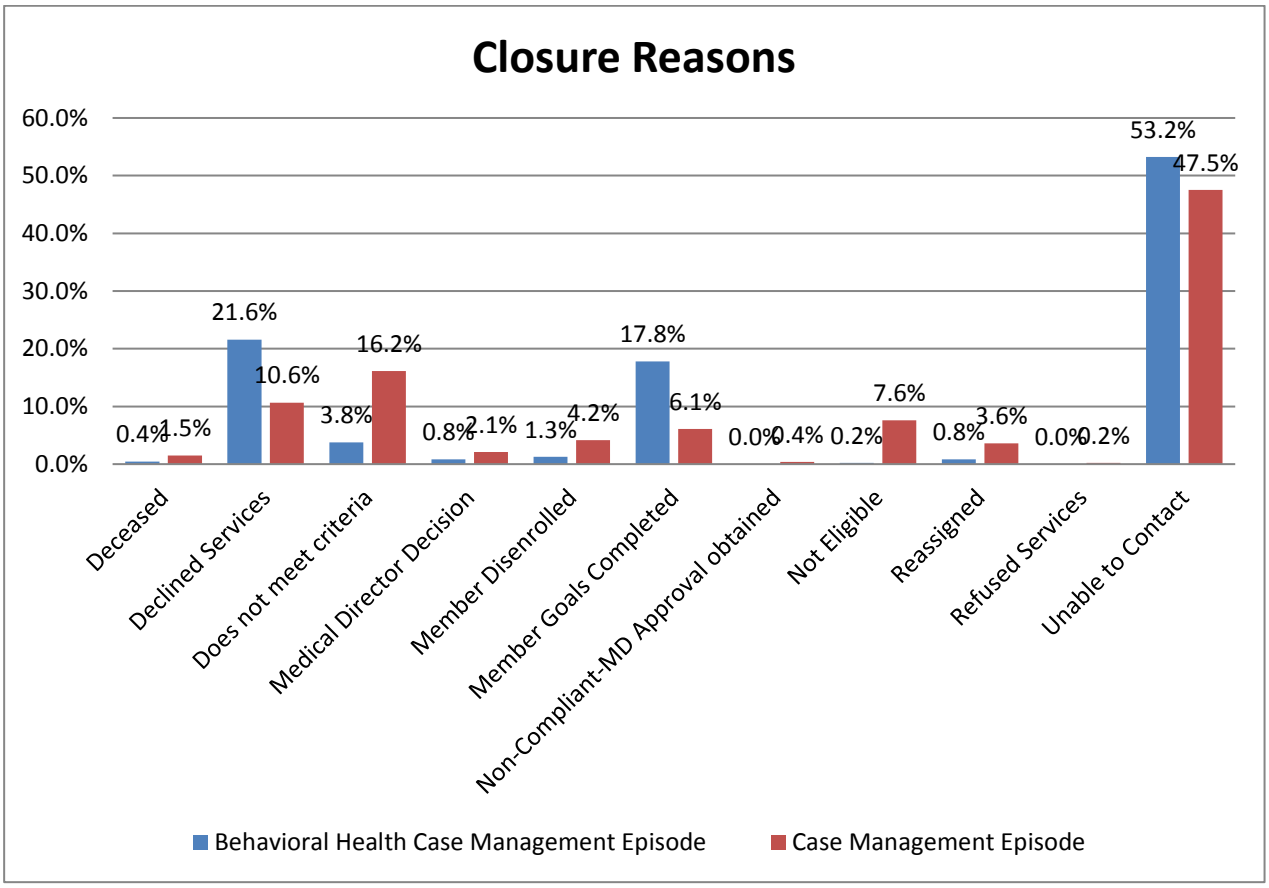
CASE MANAGEMENT DEPARTMENT MONTHLY REPORT

Reporting Period: July 1st, 2019- September 30th, 2019

During the months of July thru September, a total of 1,366 members were managed by the Case Management Department.

Episode Type	Closed Episodes	Open Episodes	Referral Episodes	Total
Case Management	488	156	56	700
Behavioral Health Case Management	551	81	34	666

Episode Source other than ACG Modeler	Behavioral Health Management Episodes	*Percentage*	Case Managem Episodes	*Percentage*
All Internally Generated Complex Case Management	72	11%	159	23%
All Internally Generated Disease Management	1	.001%	0	0%
All Internally Generated Grievance	1	.001%	3	.004%
All Internally Generated Member Request	3	.005%	5	.007%
All Internally Generated Medical Director	1	.001%	5	.007%
All Internally Generated UM Generated	7	1%	28	4%
CM DM HE Facility Based Social Worker	1	.001%	0	0%
BH Mental Health	40	6%	0	0%
CM DM HE Health Education	5	.001%	0	0%
CM DM HE Member Services	21	3%	7	1%
CM DM High ER Utilizer	150	23%	0	0%
Contract Physician/Provider	1	.001%	1	.001%
DM HE Social Worker Case Management	16	2%	3	.004%



Members Closed and Referred to HHP	Behavioral Health Case Management Episode	Case Management Episode
HHP	80	35

Closed Episodes with Admits within 30 days after Closure	Total
Behavioral Health Case Management	34
Case Management	41
Percentage of closed cases Readmitted	4%

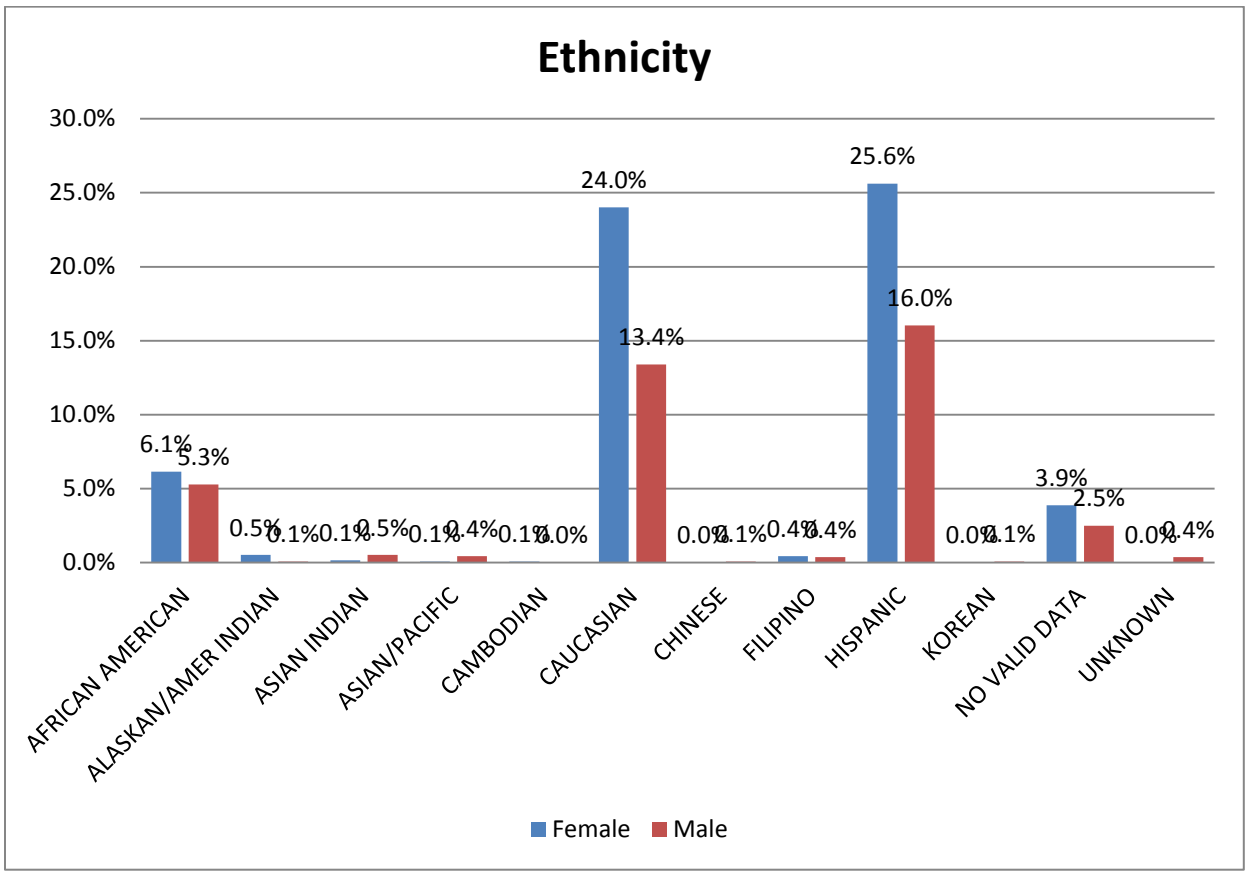
Assessments/Plan of Care	Behavioral Health Case Management Episode	Case Management Episode	Total
Assessments	103	142	245
Plan of Care	94	137	231

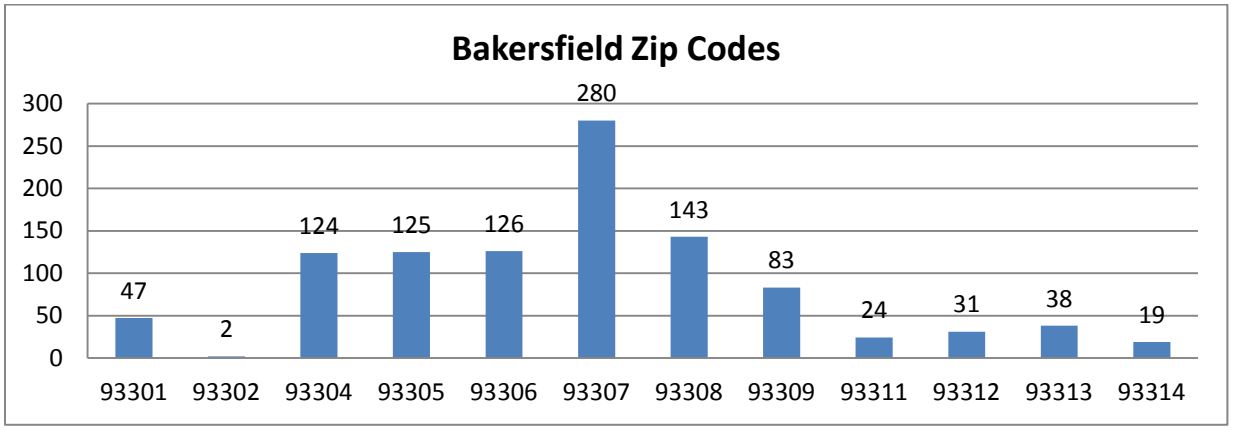
During the month of July thru September, 95% of the members managed were 65 years of age or younger.

Age	<18	18-40	41-65	>65	Total

Case Management	9	261	382	14	666
Behavioral Case Management	2	128	521	49	700

Of the 1,366 members managed during the months of July thru September, the majority of members were female at 61%. The majority of members' ethnicity was Hispanic at 42%.





Outlying Areas

City	Total
ARVIN	15
BEAR VLY SPGS	1
BODFISH	7
BORON	2
BUTTONWILLOW	1
CALIENTE	1
CALIF CITY	15
DELANO	52
FRAZIER PARK	5
INYOKERN	3
KERNVILLE	1
LAKE ISABELLA	15
LAMONT	27
MARICOPA	1
MC FARLAND	18
MOJAVE	11
N/A	15
NORTH EDWARDS	3
NORTHRIDGE	1
OAKLAND	1
ONYX	4
OXNARD	1
ROSAMOND	7
SHAFTER	18
SN LUIS OBISP	1
TAFT	35
TEHACHAPI	34
VAN BUREN	1
WASCO	20
WELDON	3
WOFFORD HTS	5

Notes Completed

Note Source	Behavioral Case Management Episode	Case Management Episode
Activity Note	1,908	1,445
Add Episode Note	143	108
Care Plan Problem Note	250	370
Change Status Note	2,170	2,032
Edit Episode Note	6	191
Episode Note	109	466
Goals	209	395
Interventions	536	410

Letters

Letter Template	Behavioral Health Case Management Episode	Case Management Episode
Appointment Letter English	43	35
Appointment Letter Spanish	6	30
Consent Form English	16	20
Consent Form Spanish	3	16
Discharge English	51	53
Discharge Spanish	13	11
Educational Material	198	189
Mental Health Alert to PCP	10	0
Suicide Hospital Letter to MD	5	0
Unable to Contact	487	531
Welcome Letter Bilingual	110	200

Activity Type

Activity Type	Behavioral Health Case Management Episode	Case Management Episode
Fax	131	187
Letter Contact	631	783
Member Services	41	32
Phone Call	1,338	1,352

Activities Completed

Activities Completed	Total
CMA's	2,737
Nurses	922
Social Workers	837

Activity Name

Activity Name	Behavioral Health Case Management Episode	Case Management Episode
Appointment Reminder Calls	9	28
Basic Needs	4	8
Centric Appointment	1	2
Close Episode for UTC	14	29
Community Resources	62	16
Contact Member	167	81
Contact Pharmacy	2	6
Contact Provider	165	262
Create Work Item	52	33
ER Utilization	1	0
Follow-up with PCP.	0	1
HHP	80	35
ICT	21	23
Incoming Call	2	3
Inpatient Discharge Follow Up	53	128
Language Line	80	93
Mail Appointment Letter	47	14
Mail Authorization	0	6
Mail Consent Letter	17	26
Mail Discharge Letter	63	67
Mail Educational Material	141	193
Mail Pill Box	48	83
Mail Pocket Calendars	70	116
Mail Provider Directory	8	21
Mail Unable to contact letter	91	120
Mail Urgent Care Pamphlet	34	4
Mail Welcome Letter	25	19
Mental Health Alert to PCP	8	0
Palliative Care	1	0
Plan of care	100	138

Provided Information	0	34
Request Medical Records	50	113
Return Mail	20	0
Schedule Physician Appointment	57	51
Transportation	24	43
Verbal consent to be received	624	558

Seniors and Persons with Disabilities (SPDs):

There were a total of 344 SPD members that were enrolled from July thru September, according to the risk stratification reports.

There are a total of 14,163 SPD members through September 2019

SPD Members are stratified into the Complex Case Management Group through use of the John Hopkins Predictive Modeler and represent 42 percent of the Complex Group from July thru September 2019.