COMMITTEE: ***EXECUTIVE QUALITY IMPROVEMENT HEALTH EQUITY COMMITTEE (EQIHEC)***
DATE OF MEETING: ***March 18, 2025***
CALL TO ORDER: ***7:18 AM BY TRACO MATTHEWS, CHAIR***

Members Present On-Site:	Jennifer Ansolabehere, KC Public Health Satya Arya, MD - ENT. Danielle Colayco, PharmD – Komoto Martha Tasinga, KHS Chief Medical Officer	Allen Kennedy – Quality Team DME Chan Park, MD – Vanguard Family Medicine Philipp Melendez, MD – OB/GYN	Rukiyah Polk - CAC Chair Jasmine Ochoa – Health Equity Manager of Public Health Traco Matthews – KHS Chief Health Equity Officer (Non-Voting)
Members Virtual Remote:			
Members Excused=E Absent=A	Debra Cox – Omni Family Health (A) Todd Jeffries – Bakersfield Community Healthcare (A)		
Staff Present:	Michelle Curioso - Director of Pop Health Management Pawan Gill - Health Equity Manager Sukhpreet Sidhu, MD - Pop Health Medical Director Anastasia Lester - Sr. Health Equity Analyst John Miller - Quality Improvement Medical Doctor Ann StoryGarza - Assistant General Counsel Amy Sanders - Member Services Manger	Magdee Hugais - Director of Quality Improvement Kailey Collier - Director of Quality Performance Maninder Khalsa - Medical Director Christine Pence - Senior Director of Health Services Nate Scott - Member Services Director Steven Kinnison - NCQA Manager Alma Garcia – NCQA Accreditation Specialist	Vanessa Nevarez - Health Equity Coordinator Greg Panero - Provider Network Analytics Abdolreza Saadabadi, MD - BH Medical Director Isabel Silva - Senior Director of Wellness & Prevention Melinda Santiago - Director of Behavioral Health Steve Pocasangre - NCQA Accreditation Specialist James Winfrey - Deputy Director of Provider Network

Agenda Item	Discussion/Conclusion	Recommendations/Action	Date Resolved
Quorum	10 of 12 committee members present; Debra Cox and Todd Jeffries were absent.	Committee quorum requirements met.	N/A
Call to Order	Traco Matthews, Chair, called meeting to order at 7:18 am.	N/A	N/A
Public Presentation	Julie Skelton, RN, addressed the EQIHEC in public comment with serious concerns regarding treatment denials for cancer patients, particularly young Hispanic women and men. She cited repeated denials by KHS based on current NCG Health Ambulatory Criteria, despite patients meeting national guidelines, including cases involving personal or family history of breast cancer. Ms. Skelton emphasized that national guidelines allow for screenings starting at age 50 – or earlier if clinical requirements are met – and that these guidelines, which	• Dr. Tasinga will meet with the cancer center offline to discuss guidelines and criteria.	3/18/25

	certified providers are obligated to follow, should be added to KHS's criteria. She shared that these denials have led to delayed surgeries or the need for second surgeries. Dr. Tasinga acknowledged the concern and stated that many denials occur due to incomplete clinical information provided during the request process. She clarified that while NCG guidelines are nationally recognized, the guidelines reference by Ms. Skelton are not recognized by NCQA, which informs KHS policy. Dr. Tasinga committed to discussing the matter further offline with the cancer center.		

Agenda Item	Discussion/Conclusion	Recommendations/Action	Date Resolved
Committee Announcements	Traco Matthews gave the opportunity for member updates. • There were no committee announcements.		
Committee Minutes	**Approval of Minutes** CA-3) The Committee's Chairperson, Traco Matthews, presented the EQIHEC Minutes for approval.	**Action:** • Philipp M. first, Satya A. second. All aye's. Motion carried.	3/18/25
Old Business	There was no old business to present.	N/A	N/A
New Business	**Consent Agenda Items** • CA-4) Behavioral Health Advisory Committee (BHAC) Minutes from January 15, 2025. • CA-5) Health Equity Transformation Steering Committee (HETSC) Minutes from February 11, 2025. • CA-6) Network Advisory Committee (NAC) Minutes from February 27, 2025. • CA-7) Pharmacy Drug Utilization Review (DUR) Minutes from November 25, 2025. • CA-8) Physician Advisory Committee (PAC) October 2, 2024, Redacted Summary of Proceedings. • CA-9) Physician Advisory Committee (PAC) November 6, 2024, Redacted Summary of Proceedings. • CA-10) Physician Advisory Committee (PAC) December 4, 2024, Redacted Summary of Proceedings. • CA-11) Population Health Management Committee	**Action:**	

	(PHMC) Minutes from December 4, 2024. • CA-12) Utilization Management Committee (UMC) Minutes from December 11, 2024. • CA-13) Quality Improvement Workgroup (QIW) Minutes from December 12, 2024. • CA-14) Quality Improvement Workgroup (QIW) Minutes from March 7, 2025. • CA-15) Wellness & Prevention (W&P) -Q3 2024 W&P Report -Q3 2024 C&L Report -Q4 2024 W&P Report -Q4 2024C&L Report • A motion to approve Consent Agenda Items was requested	• Satya A. first, Chan P. second. All aye's. Motion carried.	3/18/25
	16) Quality Improvement Workgroup (QIW) • Magdee H. presented an overview of the Quality Improvement Trilogy documents which consists of the 2024 Quality Program Evaluation, the 2025 Quality Improvement Health Equity Program Description, and the 2025 Quality Improvement Work Plan. These documents provide a comprehensive assessment of program performance, outline strategic priorities for the coming year, and establish measurable goals to enhance clinical care, service quality, and member experience. • Magdee H. presented the 2024 Quality Performance Evaluation. A motion to approve was requested. • Magdee H. presented the 2025 Quality/Health Equity Program Description. A motion to approve was requested. • Magdee H. presented the 2025 Quality Improvement Work Plan. A motion to approve was requested. **17) Quality Performance (QP)** • Kailey C. presented the Quality Performance Q1 2025 report which provides a summary of the quarterly	**Action:** • Informational only. • Allen K. first, Satya A. second. All aye's. Motion carried. • Satya A. first, Allen K second. All aye's. Motion carried. • Satya A. first, Chan P. second. All aye's. Motion carried. • Chan P. first, Satya A. second. All aye's. Motion carried.	3/18/25 3/18/25 3/18/25 3/18/25

	activities and outcomes for the department. A motion to approve was requested.		
	18) Health Equity Transformation Steering Committee (HETSC)		
	• Pawan G. presented the 2025 Health Equity Workplan. She explained that the Health Equity Program Description and the Health Equity Program Workplan were combined in 2025 to form the QIHE Program Description as mentioned by Magdee H. at the beginning of the EQIHEC meeting. A motion to approve was requested.	• Philipp M. first, Allen K. second. All aye's. Motion carried.	3/18/25
	• Pawan G. presented the updated JEDI Charter as it is an integral part of the Health Equity Office strategy. A motion to approve was requested.	• Jasmine O. first, Satya A. second. All aye's. Motion carried.	3/18/25
	• Pawan G. provided a Health Equity Division update to the committee which covered Health Equity trainings in 2025, Equity and Practice Transformation (EPT) and Doula updates.	• Informational only.	
	19) Behavioral Health Advisory Committee (BHAC)		
	• Melinda S. presented the Behavioral Health Department National Committee for Quality Assurance Continuity and Coordination Between Medical and Behavioral Health Care report. Melinda S. also shared that a Tribal Liaison, the Bakersfield American Indian Health Project (BAIHP), was invited to be on the BHAC to enhance health outcomes for American Indian and Alaska Native communities. Melinda S. asked the committee if they had any recommendations on how the Behavioral Health Department can meet their goal of 10% penetration rate (right now it is at 1%). Traco M. asked how our collaboration with Kern Behavioral Health Recovery Systems is. Melinda S. responded that she would share the collaboration data	• Jennifer A. first, Allen K. second. All aye's. Motion carried.	3/18/25

	at the third quarter EQIHEC meeting. A motion to approve the BHAC Q1 2025 report was requested.		
	20) Member Services		
	• Amy S. presented the Q4 2024 Operational Board Report that covers grievance trends. She stated that Q4 is historically slow and therefore dropped by 10%. A motion to approve was requested.	• Philipp M. first, Satya A. second. All aye's. Motion carried.	3/18/25
	• Amy S. presented the Q4 2024 Grievance Summary Report that provides the types of grievances that are received. Dr. Tasinga commented on the quality-of-care grievances stating that every call is a quality of care. A motion to approve was requested.	• Allen K. first, Satya A. second. All aye's. Motion carried.	3/18/25
	• Amy S. presented the Member Services Email Audit Summary Report which states that emails must achieve a monthly average score of 90% or higher and 100% of email must have a response within 1 business day; both conditions were met. A motion to approve was requested.	• Satya A. first, Jasmine O. second. All aye's. Motion carried.	3/18/25
		• Satya A. left the meeting at 8:27am.	3/18/25
	21) Utilization Management (UM)		
	• Dr. Khalsa presented the Q4 2024 UM report which contains a synopsis of both quantitative and qualitative analysis that reflect the performance of the UM department in Q4 2024. A motion to approve was requested.	• Philipp M. first, Allen K. second. All aye's. Motion carried.	3/18/25
	• Christine P. presented the 2024 UM Workplan Evaluation which provides an evaluation of the progress towards the goals and workplan from 2024. A motion to approve was requested.	• Philipp M. first, Chan P. second. All aye's. Motion carried.	3/18/25
	• Christine P. presented the 2025 UM Workplan that covers the success of the goals and planned interventions set by the UM department. A motion to approve was requested.	• Rukiyah P. first, Allen K. second. All aye's. Motion carried.	3/18/25

	• Christine P. presented the UM Department Hierarchy of Criteria Report which discloses that new technology reviews that do not have established criteria and guidelines will be reviewed using HAYES. If a new technology has not been evaluated by HAYES, then KHS will send the specific case for independent medical review for appropriateness of use. A motion to approve was requested.	• Philipp M. first, Allen K. second. All aye's. Motion carried.	3/18/25
	22) Network Adequacy Committee (NAC)		
	• Greg P. presented the NAC Q1 2025 report that provided an overview of the Plan's network adequacy standards, monitoring activities, findings, and process improvements. Greg P. asked the committee to comment on how the NAC can improve. A motion to approve was requested.	• No response was provided from the committee. • Philip M. first, Allen K. second. All aye's. Motion carried. • Philipp M. left the meeting at 8:55am.	3/18/25 3/18/25 3/18/25
	23) Pop Health Management (PHM)		
	• Michelle C. presented a report on Improving Mental Healthcare Access in East Kern County due to a previous discussion at EQIHEC regarding limited access to maternal healthcare in East Kern. The report includes findings from her SWOT analysis, along with feedback gathered from both internal and external partners. Additionally, the report includes recommendations for improving maternal health outcomes and reducing disparities in access to care. Michelle C. requested insight and feedback from the committee. A motion to approve was requested.	• No response was provided from the committee. • Jennifer A. first, Jasmine O. second. All aye's. Motion carried.	3/18/25 3/18/25

	<u>24) Wellness & Prevention (W&P)</u> • Isabel S. presented the 2024 Annual Wellness Report that summarizes department goals, objectives, and activities performed in 2024. Daniella C. asked what the departments success factors were. Isabel S. responded that partnering directly with parks and rec was the best success. Daniella C. asked how she can refer patients to the W&P activated and programs. Isabel S. responded that class locations such as the City of Delano are great about posting information. Additionally, there are flyers on the KHS website.	• Allen K. first, Danielle C. second. All aye's. Motion carried. • Chan P. left the meeting at 9:20am	3/18/25

Agenda Item	Discussion/Conclusion	Recommendations/Action	Date Resolved
Open Forum	Traco M. gave an update on the DHCS Transforming Maternal Health Model Press Conference that took place at Bakersfield Memorial Hospital on February 5, 2025. The day consisted of a tour of the birthing center at Bakersfield Memorial, a tour of the Bakersfield American Indian Health Project facility, a tour of Kern Medical, and a discussion led by KHS with Kern County Public Health. The DHCS and CA Surgeon General were in attendance and so impressed by Kern County that they have demanded that all areas follow what we do.	Informational only.	N/A
Next Meeting	The next meeting will be held Tuesday, June 17, 2025, at 7:15am.	Informational only.	N/A
Adjournment	The Committee adjourned at 9:23am. ***Respectfully Submitted:*** ***Vanessa Nevarez, Health Equity Project Coordinator***	• Danielle C. first, Jennifer A. second. All aye's. Motion carried.	N/A

For Signature Only – EQIHEC Minutes 3/25/25

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____
Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____
Date Name

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COMMITTEE: **DRUG UTILIZATION REVIEW (DUR) COMMITTEE**
DATE OF MEETING: **FEBRUARY 24, 2025**
CALL TO ORDER: **6:32 P.M. BY DR. MARTHA TASINGA, CMO, CHAIR**

Members Present On-Site:	Alison Bell, PharmD – Geriatrics Dilbaugh Gehlawat, MD – Network Provider, Pediatrician Kimberly Hoffmann, PharmD – Psychiatric	Martha Tasinga, MD – KHS Chief Medical Officer Bruce Wearda, RPh – KHS Director of Pharmacy	
Members Virtual Remote:	James "Patrick" Person, RPh – Retail Abdolreza Saadabadi, MD – Network Provider, Psy.D.	Sarabjeet Singh, MD - Network Provider, Cardiology	
Members Excused=E Absent=A	Joseph Tran, PharmD – Specialty (A) Vasanthi Srinivas, MD – Network Provider, OB/GYN (E)		
Staff Present:	Amy Daniel, KHS Executive Health Srvs Coordinator	John Miller, MD, KHS Medical Director Sukhpreet Sidhu, MD, KHS Medical Director	

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirement met.	*N/A*
APPROVAL OF MINUTES	The Committee's Chairperson, Bruce Wearda, RPh, presented the meeting minutes for approval.	☑ **ACTION**: Dr. Dilbaugh Gehlawat moved to approve minutes of November 25, 2024, seconded by Alison Bell. 7 approved, 0 nays.	*02/24/25*
OLD BUSINESS	• None	N/A	
NEW BUSINESS	• Report of Plan Utilization Metrics Bruce Wearda reviewed this information with the committee. The committee had no further comments. • Educational Articles	Received and Filed.	*02/24/25*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	2024 Immunization Update: COVID-19, Influenza, RSV, Pneumococcal, Polio, Meningococcal, HiB, HepB, and Mpox Dr. Gehlawat had some questions about how to bill for Vaccines for Children (VFC). VFC Programs were explained for both Pharmacy and Medical Billing. All vaccine billing was then further explained. • DUR General Topics 1. Medicare <u>D-SNP Application</u> Bruce Wearda announced that our DSNP application was submitted and accepted. Kim Hoffmann inquired about expected membership, formulary, and processing PA's. Dr. Tasinga shared a Medicare plan is complex, and it was hard to find partners that would meet CMS requirements and KHS' vision and goals. Bruce stated that our PBM for Medicare will be Med-Impact. They will be processing the prior-authorizations and managing the formulary. KHS will be monitoring these delegated functions. <u>IRA 2nd Round</u> The next 15 drugs that Medicare will negotiate prices was presented. Dr. Sarabjeet Singh had a question regarding weight loss drugs and what diagnosis are they covered under? Bruce explained the difference between weight loss and diabetes indications. The same drug could be used for both conditions but may only be covered for a specific condition. Rules for Medi-Cal and Medicare differ.	☑ **ACTION**: N/A	

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	2. CAHP Bruce shared the latest publication from California Association of Health Plans with the committee. 3. NCQA Dr. Kimberly Hoffmann asked what the importance of NCQA is, and why or why not have we not sought it previously. Dr. Tasinga answered that it was not required by Medi-Cal before and now it is.		
OPEN FORUM	Topics of discussion brought up were: • Kim Hoffmann revisited the structure and function regarding the P&T and formulary. • Dr. Gehlawat shared more insight on obesity in members 12 and up.	☑ **ACTION**: N/A	*02/24/25*
NEXT MEETING	Next meeting will be held Monday, May 19, 2025 at 6:30 pm	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned 7:35 pm.	☑ **ACTION**: Kim Hoffmann moved to adjourn the meeting. It was seconded by Dr. Dilbaugh Gehlawat. 8 Ayes, 0 Nays.	*02/24/25*

Respectfully submitted: Amy Daniel, KHS Executive Health Services Coordinator

For Signature Only – Drug Utilization Review Committee Minutes 02/24/25

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____

Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____

Date Name

KERN HEALTH SYSTEMS

COMMITTEE: ***PHYSICIAN ADVISORY COMMITTEE***
DATE OF MEETING: ***FEBRUARY 5, 2025***
CALL TO ORDER: ***7:02 AM BY MARTHA TASINGA, MD – KHS CHIEF MEDICAL DIRECTOR***

Members Present On-Site:	Martha Tasinga, MD – KHS Chief Medical Officer Atul Aggarwal, MD – Network Provider, Cardiology	Miguel Lascano – Network Provider, OB/GYN Raju Patel, MD - Network Provider, Internal Medicine	
Members Virtual Remote:	Hasmukh Amin, MD – Network Provider, Pediatrics David Hair, MD - Network Provider, Ophthalmology Ashok Parmar, MD– Network Provider, Pain Medicine		
Members Excused=E Absent=A	Gohar Gevorgyan, MD – Network Provider, FP (E)		
Staff Present:	Jake Hall, Deputy Director of Contracting Amy Daniel, Executive Administrative Yolanda Herrera, Credentialing Manager (REMOTE)	Magdee Hugais, Director of Quality Improvement John Miller MD, QI Medical Director Abdolreza Saadabadi MD, BH Medical Dir. (REMOTE)	Yesenia Sanchez, Credentialing Coordinator Sukhpreet Sidhu MD, PHM Medical Director Bruce Wearda, Director of Pharmacy

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements met.	N/A
Call to Order	Dr. Martha Tasinga MD, KHS Chief Medical Officer, called the meeting to order at 7:02 AM.		N/A
Committee Minutes	**Approval of Minutes** Dr. Tasinga presented the meeting minutes of December 4, 2024 for review and approval.	☑ **ACTION**: Dr. Lascano moved to approve minutes of December 4, 2024, seconded by Dr. Patel. Motion carried.	*2/5/25*

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
PEER REVIEW REPORTS ACTIVITIES	**Peer Review Reports** **CREDENTIALING REPORT** **Mental Health Pre-Approvals from Reports dated 12/26/2024 and 02/03/2025:** [redacted] **INITIAL CREDENTIALING REPORT** Initial Applicants List Dated **02/05/2025.** The clean files were accepted as presented with no additional discussion. The following initial applications were presented for comprehensive review: • [redacted]	☑ **ACTION:** [redacted] ☑ **ACTION:** [redacted]	*2/5/25*

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	[redacted] [redacted] **RECREDENTIALING REPORT** **Recredentialing Providers Lists Dated 02/05/2025.** Recredentialing files meeting clean file review were accepted as presented with no additional questions or alternative actions. There were no comprehensive reviews for recredentialing. Dr. [redacted] [redacted]		

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	NEW VENDOR CONTRACTS New Vendor Contracts List Dated February 20, 2025, were accepted as presented with no additional questions or comments by the committee members. **MONTHLY MONITORING – DISCIPLINARY ACTIONS OR ADVERSE EVENTS:** Yolanda Herrera, KHS Credentialing Manager reported on the January and February 2025 Monthly Monitoring of Disciplinary Actions and/or Adverse Events. [redacted]	☑ **ACTION**: [redacted] ☑ **ACTION**: [redacted]	*2/5/25* *2/5/25*

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Delegated Credentialing 2024 Annual Oversight Reports Yolanda Herrera KHS Credentialing Manager informed the committee of the results of the 2024 Annual Oversight Reporting for the following delegated provider groups: • **KHS utilized the Health Industry Collaborative Efforts Delegated Credentialing Shared Audit process in lieu of conducting our own. The results identified compliant credentialing programs with no opportunities for improvement as well as no findings of unauthorized credentialing system or file modifications:** 1. CHLA Medical Group (NCQA Accredited: No / CVO Andros Accredited Expires 8/26/25) **Audit Type:** HICE CA Shared Audit Tool Performed 7/26/2024 by Cigna **Audit Score**: 100% **Credentialing System Controls**: Reports dated 6/2/23-6/2/24 – No findings of unauthorized modifications. **Opportunity for Improvement:** No opportunities for improvement identified 2. UCLA Medical Group (NCQA Accredited: Yes / Expires: 8/14/2026) **Audit Type:** HICE CA Shared Audit Tool Performed 9/30/2024 by HealthNet **Audit Score**: 100% **Credentialing System Controls**: Reports dated 7/1/23-6/30/24 – No findings of unauthorized modifications. **Opportunity for Improvement:** No opportunities for improvement identified 3. USC Care Medical Group (NCQA Accredited: No) **Audit Type:** HICE CA Shared Audit Tool Performed 11/18/2024 by Aetna **Audit Score**: 100% **Credentialing System Controls**: Reports dated 8/1/23-	☑ **ACTION**: Dr. Lascano moved to approve the Delegated Credentialing 2024 Annual Oversight Report for CHLA Medical Group, UCLA Medical Group, USC Care Medical Group, Child Net (Valley Children's), Vision Services Plan and American Logistics as presented, seconded by Dr. Patel. Motion carried.	*2/5/2025*

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	9/30/24 – No findings of unauthorized modifications. **Opportunity for Improvement:** No opportunities for improvement identified 4. Child Net (aka: Valley Children's Hospital) (NCQA Accredited: No) **Audit Type:** HICE CA Shared Audit Tool Performed 10/21/2024 by Kaiser **Audit Score**: 100% **Credentialing System Controls**: Reports dated 9/12/23-10/2/24 – No findings of unauthorized modifications. **Opportunity for Improvement:** No opportunities for improvement identified • **Desk-top audit was conducted for the following delegated group. The results identified compliant credentialing programs with no opportunities for improvement as well as no findings of unauthorized credentialing system or file modifications:** 5. Vision Service Plan (aka: VSP) (NCQA Accredited: Yes / Expires: 1/27/26) **Audit Type:** KHS Desk-top Audit Performed on 8/16/2024 by Yolanda Herrera KHS Credentialing Manager. **Audit Score**: 100% **Credentialing System Controls**: Reports dated Q1 2023-Q4 2024 – No findings of unauthorized modifications. **Opportunity for Improvement:** No opportunities for improvement identified • **Desk-top audit was conducted for the following delegated group. The file review was not applicable as AL is an administrative only vendor for coordinating transportation scheduling. KHS credentials all transportation vendors with a direct contract between KHS and the vendor. There was a**		

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	minor opportunity for improvement to AL's Policy #3 to include required language from APL 22-013 DHCS Screening and Enrollment requirements. 6. American Logistics (aka: AL Transportation Admin) (NCQA Accredited: N/A) **Audit Type:** KHS Desk-top Audit Performed on 12/10/2024 by Yolanda Herrera KHS Credentialing Manager. **Audit Score**: 99% **Credentialing System Controls**: not applicable. **Opportunity for Improvement:** AL P&P #3 Medi-Cal Policy dated 10.17.2022 is missing required language on Page 3 specific to the denied or lack of DHCS Medi-Cal FFS enrollment requirements. Corrective Action Plan requested: Update P&P #3 Due within 90-days upon notification by KHS Compliance.		
	KHS Credentialing System Controls 2024 Annual Report Yolanda Herrera KHS Credentialing Manager presented the 2024 Annual Credentialing System Controls Report. As required by NCQA Credentialing Standards for Credentialing System Controls Oversight, at least annually, KHS monitors compliance with its credentialing controls Policy and Procedure. The annual review was conducted by monitoring the following: 1. Identifying all modifications to credentialing and recredentialing information that did not meet KHS's policy and procedure for modifications, if any; 2. Analyzing all instances of modifications that did not meet KHS's policy and procedures, if any; 3. Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three consecutive quarters, if applicable. **Audit Results**: The Credentialing System can identify all modifications made in the system. Monthly Reports are received (Credentialing@khs-net.com) and Cred Mgr reviews all system modifications by authorized personnel and by modification type:	☑ **ACTION**: Dr. Lascano moved to approve the 2024 Annual Credentialing System Controls Report as presented, seconded by Dr. Patel. Motion carried.	2/5/25

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	insert, update and deletions. There were no unauthorized modifications found in the credentialing system database during the date range reviewed. Additionally, a sampling 5%, of 28 Initials files and 25 Recredentialing e-files were reviewed for inappropriate documentation or updates based on information integrity assessment indicators for 2025. During this sampling, there were no inappropriate documentation or updates identified in the sampled files reviewed. System modification for January - December 2024 did not reveal any unauthorized personnel making any inappropriate changes to the credentialing system database. The 58 electronic file sample reviews also did not reveal any inappropriate documentation or updates that do not align with our KHS System Controls current Policy, no falsification of credentialing dates, no fraudulently altering or creating documents for any required activity.		
	KHS 2024 Annual Confidentiality and Non-Discriminatory Monitoring Report Yolanda Herrera KHS Credentialing Manager presented the 2024 Annual Confidentiality and Non-Discriminatory Monitoring Report. For 2024, KHS PNM Credentialing processed a combined 1,055 credentialing and recredentialing provider files. There were no providers denied network participation and 72-applications withdrawn for various reasons. **Monitoring Activities:** • Policy and Procedure 23.05-P Credentialing Program is reviewed annually and states that the organization does not base credentialing decisions on an applicant's race, ethnic/national identity, gender, age, sexual orientation or patient's insurance coverage (e.g., Medicaid) in which the practitioner specializes **(P&P Approval dates: 10/3/2024)** • Effective February 7, 2024, to affirm compliance, the voting members of the Physician Advisory Committee sign a	☑ **ACTION**: Dr. Lascano moved to approve the 2024 Annual Confidentiality and Non-Discriminatory Monitoring Report as presented, seconded by Dr. Patel. Motion carried.	*2/5/25*

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	confidentiality and non-discrimination statement. **Signatures obtained for 2025, remote members will be sent the confidentiality and non-discrimination statement via email for signature and return.** • During 2024, there were no reports made to the Credentialing Manager alleging discrimination at the credentialing or recredentialing level while applications were in-process, denied or approved. The Non-Discrimination Annual Summary is a detailed review of provider demographics by age, gender, and specialty type. There were no outliers identified to indicate a discriminatory practice in the KHS Credentialing Program.		
OLD BUSINESS	**Bariatric Surgery Quality of Care Issues** Dr. Miller informed the members that the follow-up review is still in process and anticipates completion in 1st Quarter 2025.	☐ **PENDING**: Dr. Miller conduct random 10-case review in 6-months as follow-up on this issue.	*Pending*
NEW BUSINESS	**Pharmacy Criteria** Bruce Wearda presented the Pharmacy criteria submitted for approval under pharmaceutical covered medical benefit as follows: • Somatostatin Analogs; Amphotericin B; Amyloidosis; Asthma Monoclonal Antibody; Beremagene Geperpavec; Fabry Disease; Gaucher Disease; Givosiran; Hyaluronic Acid; Immune Globulin; Inflixmab; Myathenia Gravis; Nusinersen; Primary Hyperoxaluria Type 1	☑ **ACTION**: Dr. Patel moved to approve the Pharmacy criteria (listed below), seconded by Dr. Lascano. Motion carried.	*2/5/25*
OPEN FORUM	There was no open discussion.	☑ **CLOSED** – Informational Only	*N/A*
NEXT MEETING	Next meeting will be held Wednesday, March 5, 2025	Informational only.	*N/A*

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
ADJOURNMENT	The Committee adjourned at 7:55 AM. **Respectfully submitted: Amy Daniel, KHS Executive Health Services Coordinator**	**N/A**	*N/A*

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For Signature Only – Physician Advisory Committee Minutes 02/05/2025:

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____
Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____
Date Name

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KERN HEALTH SYSTEMS

COMMITTEE: ***PHYSICIAN ADVISORY COMMITTEE***
DATE OF MEETING: ***MARCH 5, 2025***
CALL TO ORDER: ***7:02 AM BY MARTHA TASINGA, MD – KHS CHIEF MEDICAL DIRECTOR***

Members Present On-Site:	Martha Tasinga, MD – KHS Chief Medical Officer Miguel Lascano – Network Provider, OB/GYN	Ashok Parmar, MD– Network Provider, Pain Medicine Raju Patel, MD - Network Provider, Internal Medicine	
Members Virtual Remote:	Atul Aggarwal, MD – Network Provider, Cardiology Hasmukh Amin, MD – Network Provider, Pediatrics David Hair, MD - Network Provider, Ophthalmology		
Members Excused=E Absent=A	Gohar Gevorgyan, MD – Network Provider, FP (E)		
Staff Present:	Alan Avery, Chief Operations Officer Michelle Curioso, Director of Population Health Amy Daniel, Executive Administrative Jake Hall, Deputy Director of Contracting	Yolanda Herrera, Credentialing Manager Magdee Hugais, Director of Quality Improvement John Miller MD, QI Medical Director Abdolreza Saadabadi MD, BH Medical Dir. (REMOTE)	Yesenia Sanchez, Credentialing Coordinator Sukhpreet Sidhu MD, PHM Medical Director Bruce Wearda, Director of Pharmacy

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements met.	N/A
Call to Order	Dr. Martha Tasinga MD, KHS Chief Medical Officer, called the meeting to order at 7:02 AM.		N/A
Committee Minutes	**Approval of Minutes** Dr. Tasinga presented the meeting minutes of February 5, 2025 for	☑ **ACTION**: Dr. Patel moved to approve minutes of February 5, 2025, seconded by Dr. Lascano. Motion carried.	*3/5/25*

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	review and approval.		
PEER REVIEW REPORTS ACTIVITIES	**Peer Review Reports** **CREDENTIALING REPORT** **Mental Health Pre-Approvals from Reports dated 03/03/2025:** [redacted]. **INITIAL CREDENTIALING REPORT** Initial Applicants List Dated **03/05/2025.** The clean files were accepted as presented with no additional discussion. The following initial applications were presented for comprehensive review: • [redacted] [redacted] **RECREDENTIALING REPORT** **Recredentialing Providers Lists Dated 03/05/2025.** Recredentialing files meeting clean file review, report dated 3/5/2025, were accepted as presented with no additional questions or	☑ **ACTION**: Dr. Patel moved to approve the Credentialing, Recredentialing and New Vendor Contracts from the reports dated 03/03/2025, and 03/05/2025, seconded by Dr. Lascano. Motion carried. ☑ **ACTION**: Dr. Patel moved to approve Comprehensive Reviews for BC & DL as listed, seconded by Dr. Lascano. Motion carried.	*3/5/25* *3/5/25*

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	alternative actions. [redacted] **NEW VENDOR CONTRACTS** New Vendor Contracts List Dated **March 5, 2025**, were accepted as presented with no additional questions or comments by the committee members. **MONTHLY MONITORING – DISCIPLINARY ACTIONS OR ADVERSE EVENTS:** [redacted]	☑ **ACTION**: [redacted]	*3/5/25*

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	[redacted]		

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Delegated Credentialing 4th Quarter 2024 HICE Quarterly Reports Yolanda Herrera KHS Credentialing Manager informed the committee that the 4th Quarter 2024 HICE Delegated Oversight Reports have all been received and reviewed for CHLA Medical Group, ConferMED, Valley Children's Child Net, Vision Services Plan, UCLA Medical Group and USC Medical Group. Semi-Annual Rosters have also been received. During 4th Quarter 2024, delegates reported Credentialing Committee dates for initial credentialing, recredentialing and terminations. There were no significant changes in provider network that would affect KHS members. **There were no identified issues.**	☑ **ACTION**: Dr. Patel moved to approve the Delegated Credentialing 4th Quarter 2024 HICE Quarterly Reports for CHLA Medical Group, ConferMED, Valley Children's Child Net, Vision Services Plan, UCLA Medical Group and USC Medical Group as presented, seconded by Dr. Lascano. Motion carried.	*3/5/25*
	KHS Organizational Providers – Assessment Report Yolanda Herrera KHS Credentialing Manager presented the KHS Organizational Providers Assessment Report. This report is utilized to track and monitor organizations/facility providers are in good standing with state and federal regulatory bodies, accrediting bodies when applicable or have an onsite quality assessment if the provider is not accredited. KHS traditionally credentials the organizational/facility providers as part of the assessment and have been updating the assessment tool upon approval by PAC. KHS Credentialing Staff continue to monitor those organizations/facilities that exceed the 36-month validation as we strive to ensure the verification dates are conducted within the 36-months. KHS Credentialing Staff will recredential these organizations and facilities sooner to ensure the approval dates are at least every 34-months to ensure the verification dates are compliant.	☑ **ACTION**: Dr. Patel moved to approve the KHS Organizational Providers Assessment Report as presented, seconded by Dr. Parmar. Motion carried.	*3/5/25*
OLD BUSINESS	**Bariatric Surgery Quality of Care Issues** Dr. Miller informed the members that the follow-up review is still in process.	☐ **PENDING**: Dr. Miller conduct random 10-case review in 6-months as follow-up on this issue.	***Pending***

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
NEW BUSINESS	**PQI Threshold Methodology & Selection**: Magdee Hugais, Director of Quality Improvement presented the Potential Quality Issues (PQI) Threshold Methodology and selection criteria. The purpose is to provide a detailed justification for the selection of 0.99 PQI per 1000 interactions as the threshold for identifying underperforming providers in PQI analysis. This threshold supports Policy 2.70-I by outlining the statistical methodology, rationale, and expected impact of this threshold on provider performance evaluation. Providers with any Level 3 will continue to be brought to the PAC for review.	☑ **ACTION**: Dr. Patel moved to approve the PQI Threshold Methodology and Selection Criteria and Guidelines as presented, seconded by Dr. Lascano. Motion carried	*3/5/25*
	PQI Track and Trend Jan-Mar 2025 Magdee Hugais, Director of Quality Improvement presented the January – March PQI Track and Trend Reports. The report lists the providers who are currently on "Track and Trend" all of which are Level 1 (Potential for Harm) assigned severity level; however, there are no cases rising to PAC review. These providers will be monitored for 3-months and if no further issues, will then be removed. Most cases tend to be service type issue with the facility or staff member, and most are resolved with information letter and response. The clinical policy and procedure for Corrective Action Plans is in development and will outline this process.	☑ **ACTION**: Dr. Raju Patel moved to approve the PQI Track and Trend Report for January – March 2025 as presented, seconded by Dr. Miguel Lascano. Motion carried	*3/5/25*
	<u>Pharmacy Criteria</u> Bruce Wearda presented the Pharmacy criteria submitted for approval under pharmaceutical covered medical benefit as follows: • Abatacept • Certolizumab • Golimumab • Gonadotropin • Guselkumab • Inebilzumb • Lovotibeglogene • Mirikizumab	☑ **ACTION**: Dr. Raju Patel moved to approve the Pharmacy criteria (listed below), seconded by Dr. Ashok Parmar. Motion carried.	*3/5/25*

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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	• Neuromyelitis • Risankizumab • Rituximab • Tildakizumab • Tocilizumab • Ustekinumab • Vedolizumab		
OPEN FORUM	There was no open discussion.	☑ **CLOSED** – Informational Only	*N/A*
NEXT MEETING	Next meeting will be held Wednesday, April 2, 2025	Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 8:03 AM. **Respectfully submitted: Amy Daniel, KHS Executive Health Services Coordinator**	**N/A**	*N/A*

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For Signature Only – Physician Advisory Committee Minutes 03/05/2025:

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____
Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____
Date Name

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KERN HEALTH SYSTEMS

COMMITTEE: ***POPULATION HEALTH MANAGEMENT COMMITTEE***
DATE OF MEETING: ***MARCH 5, 2025***
CALL TO ORDER: ***11:01 AM BY SUKHPREET SIDHU, MD - CHAIR***

Members Present On-Site:	Paula De La Riva-Barrera, Manager at First 5 Kern Lordes Bucher, Administrator at KCSOS	Dixie Denmark-Speer, SS Director at Height Street SNF Desiree Escobedo, Admissions at Height Street SNF Ashok Parmar MD, Pain Mgmt.	Sukhpreet Sidhu, MD PHM Medical Director Curt Williams, Director Homeless/Foster at KCSOS
Members Virtual Remote:	Alissa Lopez, Administrator at KCBHRS Dr. Vivek Radhakrishan, Primary Care ECM Provider	Colleen Philley, Program Director at KC Aging & Adult Martin Reynoso, Supervisor at KC Aging & Adult	
Members Excused=E Absent=A	Maria Bermudez, Asst. Director at Dept. of Human Services (E) Christopher Boyd, Licensed Clinical Psychologist (E) Brynn Carrigan, Director at KC Public Health (E) Cristina Castro, Recovery Specialist at KCBHRS (E) Valerie Civelli, MD at LTC Premier Valley Med. Group (E)	Babita Datta, MD OB/GYN at Wasco Medical Plaza (E) Minty Dillon, Administrator at Premier Valley Medical Grp (E) Laura Hasting, NP at Priority Urgent Care (E) Kristine Khuu, Assistant Director at Kern Regional Ctr. (E) Gina Lascon, DON at Delano SNF (E) Lito Morillo, Executive Director at KC Human Services (E)	Jasmine Ochoa, Manager at KC Public Health (E) Cody Rasmussen, Administrator at Height Street SNF (E) Jennie Sill, Administrator at KCBHRS (E) Alejandra Vargas, BOM at Height Street SNF (E)
Staff Present:	Missy Clendenen, RN PHM LTC Case Manager Amy Daniel, Executive Health Services Coordinator Shellby Dumlao, Special Programs Nurse Consultant Pawan Gill, Health Equity Manager Russell Hasting, PHM Manager of CM Loni Hill-Pirtle, Director of ECM	Magdee Hugais, KHS Director of QI Diane Lay, RN, CCM, PHM Triage Nurse III Jacinto Marcelo II, Director of Special Programs John Miller, MD QI Medical Director Noehmi Morfin, RN PHM Clinical Auditor & Trainer Adriana Salinas, Director of Community & Social Services	Nate Scott, Senior Director of Member Services Melinda Santiago, Director of Behavioral Health Isabel Silva, Senior Director of Wellness & Prevention Elliott Smith, PHM Outreach Specialist Ty Williams, PHM Outreach Specialist

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements met.	N/A
Call to Order	Sukhpreet Sidhu, MD, KHS PHM Medical Director called the meeting to order at 11:01 AM.		N/A
Committee Minutes	**Approval of Minutes** The minutes of December 4, 2024 were presented for review and approval.	☑ **ACTION**: Paula De La Rive-Barrera moved to approve minutes of December 4, 2024, seconded by Dr. Parmar. Motion carried.	*3/5/2025*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Welcome & Introduction **Committee Member Announcements:** Members and KHS Staff introduced themselves and from the facility/organization they are representing.	☑ **CLOSED**: Informational discussion only.	*3/5/2025*
REVIEW AND APPROVAL	**Review and Approval of Policy** Michelle Curioso, Director of PHM presented the following PHM Policy and Procedures for approval: • Health Risk Assessment Policy • Risk Stratification and Segmentation Policy • Critical Incidents Letter to LTC There were no additional questions or comments from the committee members.	☑ **ACTION**: Dr. Parmar moved to approve the listed Policy and Procedures, seconded by Paula De La Riva-Barrera. Motion carried.	*3/5/2025*
OLD BUSINESS	**Maternal Access to Care** Michelle Curioso, Director of PHM presented the Maternal Access to Care after conducting SWOT Analysis and one-on-one interviews with Community Partners. The following highlights were noted: • WIC clinics and KHS services, such as care management and coordination, offer valuable support for maternal health. • Ridgecrest Regional Hospital now provides labor and delivery services (since January 2025). • New location of Bartz Altadonna Community Health Center in Boron for prenatal and postpartum care. • Local non-profit organizations such as Omni in Tehachapi and Clinica Sierra Vista in Ridgecrest can be leveraged to increase healthcare access Additional advocating for funding will be requested through Transforming Maternal Health Model and similar state and federal programs and also exploring use of mobile health units for prenatal and postpartum care including telehealth and virtual follow-ups.	☑ **ACTION**: Dr. Parmar moved to approve the Maternal Access to Care, seconded by Curt Williams. Motion carried.	*3/5/2025*
NEW BUSINESS	**The Impact of Major Organ Transplant (MOT) Program** Russell Hasting, PHM Manager of CM, presented the Impact of Major Organ Transplant Program. Russell reviewed the MOT Program Phases and Wait List times for each member as follows:	☑ **CLOSED**: Informational only.	*3/5/2025*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Age Range = 24 - 64 years Organ / Male / Female / Transplants Bone Marrow / 2 / 2 / 4 Heart / 1 / / 2 Kidney / 1 / 5 / 3 Kidney, Pancreas / 1 / / 1 Kidney, Liver / / 1 / 1 Liver / 1 / / 3 Grand Total / 6 / 8 / 14 Two of the 14 transplant members were readmitted to the hospital within 30-days of surgery, the research shows readmissions are linked to lower survival rates with complications arising within the first 30-days after major organ transplants. Readmissions is a critical factor for identifying preventable factors that the case managers can collaborate with treatment centers during follow-up to ensure adherence to treatment plans.		
	Long Term Care 3rd Annual Summit Michelle Curioso, Director of PHM presented the Long Term Care 3rd Annual Summit of medical professionals and administrators for networking, program updates and state reports. We are seeking committee members to assist in selecting topics to present, identifying potential speakers, and suggesting venue ideas.	☑ **CLOSED**: Dr. Parmar moved to approve the information presented, seconded by Paula De La Riva-Barrera. Motion carried.	
OPEN FORUM	**Open Forum** Michelle Curioso, Director of PHM informed the members that in preparation for the Board of Directors meeting in April, the following documents will be sent to the committee members for review and approval. 1. **PHM Program Description:** This document outlines the programs and projects implemented by the Population Health Management Department, detailing the services provided to members. 2. **PHM Strategy 2024:** This is our work plan for 2024, outlining goals, objectives, interventions, completion percentages, and outcomes. 3. **PHM Strategy 2025:** This work plan for 2025 includes our goals, objectives, and interventions.	☐ **Pending**: Email to be sent by Michelle Curioso requesting committee review and approval.	*6/4/2025*
NEXT MEETING	Next meeting will be held Wednesday, June 4, 2025 at 11:00 am	☑ **CLOSED**: Informational only.	*N/A*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
ADJOURNMENT	The Committee adjourned at 12:02 pm. ***Respectfully submitted: Amy L. Daniel; Executive Health Services Coordinator***	**N/A**	*N/A*

For Signature Only – Quality Improvement Committee Minutes 03/05/2025

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____
Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____
Date Name

KERN HEALTH SYSTEMS

COMMITTEE: ***UTILIZATION MANAGEMENT COMMITTEE***
DATE OF MEETING: ***FEBRUARY 26, 2025***
CALL TO ORDER: ***12:07 PM BY MANINDER KHALSA, MD, UM MEDICAL DIRECTOR - CHAIR***

Members Present On-Site:	Ashok Parmar, MD –Specialist Pain Medicine	Parikshat Sharma, MD – Outpatient Specialist	
Members Virtual Remote:	Maninder Khalsa, MD – KHS UM Medical Director	Abdolreza Saadabadi, MD - Psychologist	Karan Srivastava, MD – Kern Medical
Members Excused=E Absent=A	Philipp Melendez, MD – OB/GYN (A)		
Staff Present:	Linda Corbin, Health Services Consultant (Remote) Amy Daniel, Executive Health Services Coordinator Dan Diaz, CCM Manager, RN Erin Endes, Health Services Manager (Remote)	Alma Garcia, NCQA Accreditation Specialist Amanda Gonzalez, Director of UM Loni Hill-Pirtle, Director of Enhanced Case Mgmt. Kulwant Kaur, UM Outpatient Clinical Supervisor RN	Steve Pocasangre, NCQA Accreditation Specialist Christine Pence, Senior Director for Health Services Melinda Santiago, Director of Behavioral Health Nate Scott, Director of Member Services

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements were not met as the composition as described in the committee charter are still in development and recruiting participating providers.	N/A
Call to Order	Dr. Maninder Khalsa, KHS UM Medical Director called the meeting to order at 12:07 PM.		N/A
Committee Minutes	**Approval of Minutes** The minutes of December 11, 2024 were presented for review and approval.	☑ **ACTION**: Dr. Parikshat Sharma moved to approve minutes of December 11, 2024, seconded by Dr. Ashok Parmar. Motion carried.	N/A
OLD BUSINESS	There was no old business to present.	N/A	N/A
NEW BUSINESS	**Welcome & Introduction** **Introductions:** Dr. Khalsa welcomed the members of UM Committee.	☑ **CLOSED**: Informational only.	N/A

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Policy Review and Approval Dr. Khalsa informed the committee that the following policy and procedures were revised and sent out prior to committee meeting for review and approval. • Policy 3.07-P Vision Care (Review on HOLD) • Policy 3.16-P California Children's Services • Policy 3.26-P New Medical Technology • Policy 3.39-P Continuity of Care by Terminated Provider • Policy 30.55 Appropriate Non-Licensed UM Staff and Licensed Professionals Christine informed the members that Policy 3.07-P was not ready for review and will be presented at the next meeting. Members reviewed the policies presented and had no further discussion or input on these revisions and new policies.	☑ **ACTION**: Dr. Sharma moved to approve the policy and procedure revisions for 3.16, 3.26, 3.39, and 30.55 as presented, seconded by Dr. Saadabadi. Motion carried.	*2/26/25*
	UM Report 4th Quarter 2024 Dr. Khalsa presented the 4th 2024 UM Report. The following highlights were noted: • UM Timeliness of Decisions – KHS remains compliant at 98.8% for Urgent and 99% for Routine timelines. • UM Referral Notification is complaint at 100% • Outpatient Referrals – has increased to 100817 from last quarter which was 95657. • Adult & Pediatric Referrals – remain consistent in comparison to past quarters. • Denial Percentage – 4th Quarter is averaging 2.7% denied referrals. • IRR Q4 Results – All staff and Med Directors have successfully passed the required IRR testing with passing score of 95% or higher • Internal Auditing for 4th Quarter included delayed referrals from October 1 – December 31, 2024. Audit results were shared with UM Staff with appropriate staff reminders identified in this audit.	☑ **CLOSED**: Report accepted as presented with no further discussion or questions from the committee members.	*2/26/25*

<table>
<tr><th>AGENDA ITEM</th><th>DISCUSSION / CONCLUSIONS</th><th>RECOMMENDATIONS/ ACTION</th><th>DATE RESOLVED</th></tr>
<tr><td></td><td><u>UM/Internal Auditing Activities</u>

Christine Pence reported on the UM Auditing Activities that included monitoring the process of referrals that have been delayed by the UM Department. A review of 10 files were reviewed for the month of October – December 2024.

<table><tr><th></th><th>October</th><th>November</th><th>December</th></tr><tr><td>Total referrals for the month</td><td>37,663</td><td>30,180</td><td>31,392</td></tr><tr><td>Total referrals that were delayed</td><td>88</td><td>66</td><td>67</td></tr><tr><td>Percent of referrals delayed</td><td><1%</td><td><1%</td><td><1%</td></tr><tr><td>Audit sample size</td><td>10 referrals</td><td>10 referrals</td><td>10 referrals</td></tr></table>
Audit results were shared with UM Staff with appropriate staff reminders identified in this audit.</td><td>☑ CLOSED: Report accepted as presented with no further discussion or questions from the committee members.</td><td>2/26/25</td></tr>
<tr><td></td><td><u>HICE Reviews</u>

Christine Pence reported on the HICE Reviews which is the industry standard for monitoring UM Key Metrics. All metrics for UM passed which included: Inpatient Metrics, Referral/Requests Metrics, ER Metrics, Turnaround Time Metrics, and Behavioral Health Metrics.</td><td>☑ CLOSED: Report accepted as presented with no further discussion or questions from the committee members.</td><td>2/26/25</td></tr>
<tr><td></td><td><u>ALLMed Update</u>

Christine Pence reported that AllMed has started performing preservice reviews and appeals. KHS is monitoring their performance to ensure compliance with regulation and accreditation standards.</td><td>☑ CLOSED: Report accepted as presented with no further discussion or questions from the committee members.</td><td>2/26/25</td></tr>
<tr><td></td><td><u>2024 UM Workplan Evaluation</u>

Christine Pence reported on the 2024 UM Workplan Evaluation
The identified goals were all met and found to be compliant.
There were some noted interventions include policy updates, enhancement of letters to be clearer and more concise, UM daily monitoring processes, and JIVA improvements where indicated.</td><td>☑ ACTION: Dr. Sharma moved to approve the 2024 UM Workplan Evaluation as presented, seconded by Dr. Saadabadi. Motion carried</td><td>2/26/25</td></tr>
</table>

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	2025 UM Workplan Christine Pence presented the 2025 UM Workplan. The Workplan goals were identified which will include the following: • Goal 1: Meet NCQA UM standards. Obtain at least an 80% for UM standard reviews and pass all must-pass UM standards • Goal 2: Ensure consistent application of medical necessity determination criteria by maintaining a Inter-rater reliability pass rate of 100% • Goal 3: Ensure 100% of potentially eligible cases will be identified and referred to California Children's Services (CCS) • Goal 4: Monitor UM review process to ensure compliance with regulatory standards. Maintain at least a 95% timeliness rate for regulatory required prior authorization requests Christine informed the members that the 2025 UM Program Description has been completed and submitted to DHCS and is pending review.	☑ **ACTION**: Dr. Sharma moved to approve the 2025 UM Workplan as presented, seconded by Dr. Saadabadi. Motion carried	*2/26/25*
OPEN FORUM	**Open Forum** There were no further open items presented for discussion or comment by the committee members. • **Committee Attestations**: members were asked to complete and sign UM Attestations for 2025.	☑ **CLOSED**: Informational discussion only.	*N/A*
NEXT MEETING	Next meeting will be held Wednesday, May 14, 2025 at 12:00 PM	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 12:55 PM ***Respectfully submitted: Amy L. Daniel; Executive Health Services Coordinator***	**N/A**	*N/A*
AMENDMENT	1. Approval of 2025 UM Program Description 2. Approval of 2024 UM Workplan Evaluation Summary 3. Approval of additional Hierarchy Description	1. Approved electronically March 31, 2025 2. Approved electronically March 31, 2025 3. Approved electronically March 22, 2025	

For Signature Only – Utilization Management Committee Minutes 2/26/2025

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____

Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____

Date Name

KERN HEALTH SYSTEMS

To: KHS EQIHEC Meeting

From: Nate Scott

Date: June 17, 2025

Re: Executive Summary 2024 Grievance Analysis

Background

Executive Summary 2024 Grievance Analysis:
This report was created as part of the Plan's NCQA Accreditation. NCQA holds health plans, like KHS, to higher standards to make sure quality health care is available to all members. NCQA has specific criteria for grievance reporting that KHS must follow. This is to identify deficiencies and improve overall care and services provided to our members.

NCQA requires KHS to set goals regarding grievances received by plan members. Our goals are as follows:

- No more than ten (10) grievances per one thousand (1,000) members, per year.
- No more than two (2) grievances per grievance category, per one thousand (1,000) members, per year.

NCQA has five (5) grievance categories:

- Access
- Attitude and Service
- Billing and Financial Issues
- Quality of Care
- Quality of Practitioner Office Site.

The Department of Health Care (DHCS) has more than forty (40) grievance categories that KHS must report on. To ensure compliance with requirements from both regulators, KHS mapped all the DHCS grievance categories to the five NCQA categories.

NCQA also requires KHS to perform Qualitative and Quantitative analysis of plan grievances. This is to provide statistical data and trend characteristics of our member grievances. In addition of the Plan review of individual member grievances, KHS used feedback from our members

received through our Regional Advisory Committee (RAC) meetings and our Member Satisfaction Survey to help with our analysis. We found that while we were meeting our goals listed above, there is room for improvement in certain areas of access and care provided to our members.

Conclusion: While the Plan met the goals of fewer than ten (10) grievances per one thousand (1,000) members per year and fewer than two (2) grievances per grievance category per one thousand (1,000) members per year, the Plan will focus on continued improvement in the areas of Quality of Care, Access to Care and Quality of Service.

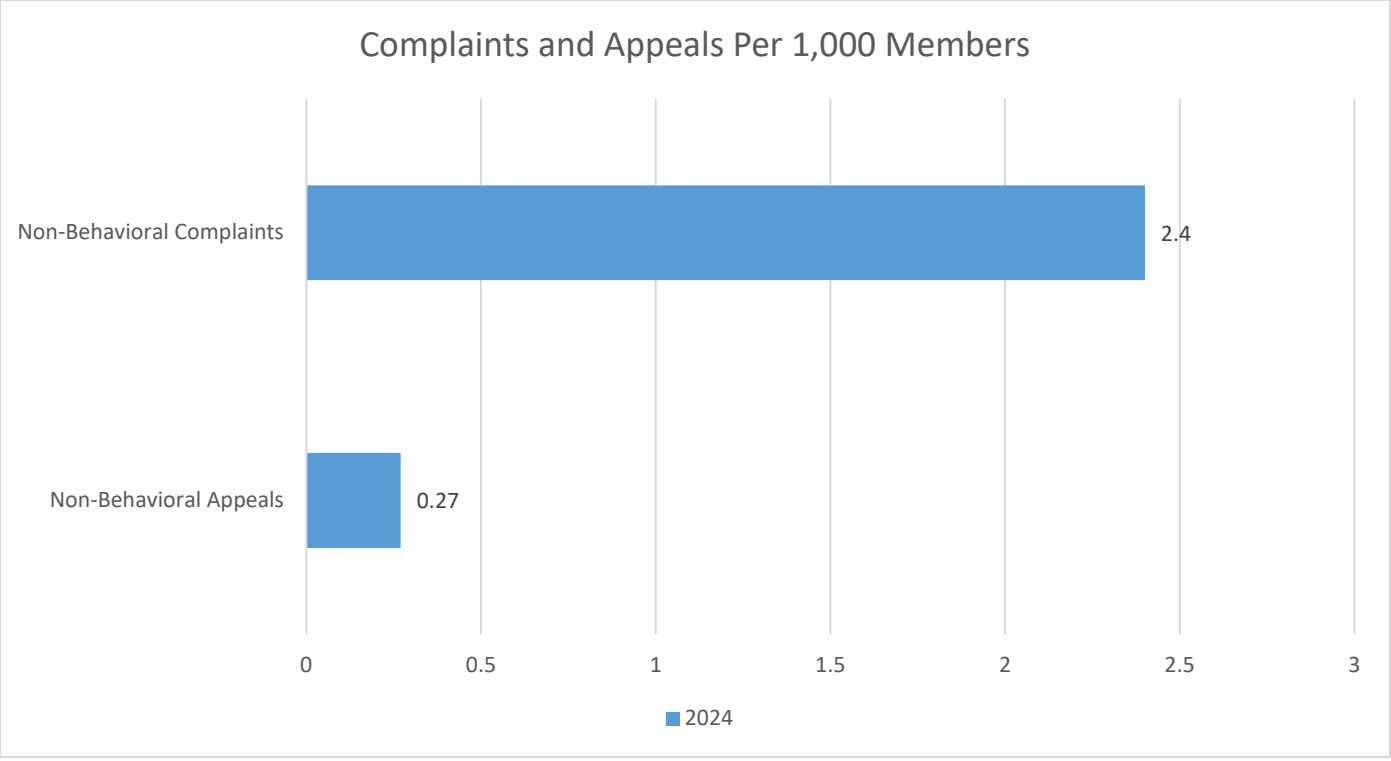
Action: Receive and file.

Non-Behavioral Health Complaints and Appeals Report
Date Written: May 9, 2025

Methodology: All complaints are processed by a Grievance Coordinator and assigned a specific grievance classification. Grievances are discussed during a weekly Grievance Workgroup meeting to ensure there is a clear and concise resolution to each member's grievance. Grievance information is then presented quarterly to the Plan's Board of Directors, Community Advisory Committee (CAC) and Executive Quality Improvement Health Equity Committee (EQIHEC) meetings. All reports are prepared by pulling data from logs, the Plan's core information systems, and reviewing individual case files as necessary. Grievance reporting is prepared and/or reviewed by Member Services Management to ensure accurate information is presented.

Report prepared and reviewed by
Gilma Arias, Member Services Supervisor
Danesha Makes, Member Services Supervisor
Marleny Martinez, Member Services Supervisor
Amy Sanders, Member Services Manager

Timeframe for report: January 1, 2024 - December 31, 2024



Non-Behavioral Healthcare Complaints

The following tables provides data on non-behavioral healthcare complaints filed in 2024. Kern Health Systems (KHS) has an overall non-behavioral health grievance goal of 10 per 1000 members per year and 2 grievances per grievance category per 1000 members per year.

Table 1: Complaint Volume Report – Non-Behavioral Health

Category	2024			
	Complaints Total	**Complaints Per 1,000 Members Per Year**	**Performance Goals**	**Performance Goals Met?**
Access	3807	0.78	<2	Yes
Attitude and Service	4646	0.96	<2	Yes
Billing and Financial Issues	96	0.02	<2	Yes
Quality of Care	3107	0.64	<2	Yes
Quality of Practitioner Office Site	5	<.01	<2	Yes
Total	**11661**	**2.40**	**<10**	**Yes**

Quantitative Analysis: In 2024, a total of 11,661 non-behavioral healthcare complaints were filed, totaling 2.40 complaints per 1000 members per year. KHS met our goals of <10 grievances per 1000 members per year and <2 grievances per grievance category per 1000 members for the year.
In 2024, the top three categories for grievances were Access, Attitude and Service and Quality of Care.

Non-Behavioral Healthcare Appeals

The following tables provides data on non-behavioral healthcare appeals filed in 2024. Kern Health Systems has overall category goal of 10 per 1000 members per year and 2 appeals per grievance category per 1000 members per year.

Table 1: Appeal Volume Report – Non-Behavioral Healthcare

Category	2024			
	Complaints Total	**Complaints Per 1,000 Members Per Year**	**Performance Goals**	**Performance Goals Met?**
Access	0	0	<2	Yes
Attitude and Service	0	0	<2	Yes
Billing and Financial Issues	0	0	<2	Yes
Quality of Care	1292	0.27	<2	Yes
Quality of Practitioner Office Site	0	0	<2	Yes
Total	**1292**	**0.27**	**<10**	**Yes**

Quantitative Analysis: In 2024, a total of 1,292 non-behavioral healthcare appeals were filed, totaling 0.27 complaints per 1000 members per year, with <1 grievance per grievance category per 1000 members per year. Overall, Kern Health Systems maintained the overall grievance and per category performance goal.
In 2024, the top category for appeals was Quality of Care. This was due to the fact that UM appeals are categorized as Quality of Care. However, most of these appeals are not true quality of care issues as the UM department follows medical necessity criteria when making prior authorization and appeals decisions, and the overturn rate for appeals for cases with no new information is minimal. Most overturned cases are a result of the new information provided to make the appropriate decision.

Combined Qualitative Analysis for Complaints and Appeals:
Qualitative Analysis: The top three categories for grievances and appeals were Access, Attitude and Service and Quality of Care. When reviewed against the 2024 CAHPS Member Satisfaction Survey (which would be for measurement year 2023), we found common areas for improving quality even though the goals were met. Since the goals were met for these categories, a detailed barrier analysis was not needed. The Plan has been taking a number of actions to ensure that quality is maintained, and this is one of the reasons that the complaints for measurement year 2024 are low.

The actions described below are some of the reasons the goals were met, including actions taken to implement a culture of continuous quality improvement:

- For Access, the number of complaints decreased by 10.32%. KHS has continued to incorporate street medicine and telehealth throughout 2024 to alleviate access to care challenges.
- For Attitude and Service, the number of complaints decreased by 8.29%. KHS implemented the following improvement strategies based on the CAHP Member Satisfaction Survey results:
    - Regional Advisory Committees (RAC) meetings throughout Kern County effective April 2024. Engaging a gathering of members and community residents who share their personal experiences with health care in their region.
    - Learn ways to expand member engagement activities to assist members with coordination of care.
    - Discover opportunities for ways to improve member and provider communication through technology using multiple modalities.
- For Quality of Care, the number of complaints decreased by 4.9%. As a result of the CAHPS Member Satisfaction Survey, Quality of Care is being addressed by educating and engaging providers to encourage improvement for how well doctors communicate with members.

KHS will implement the following improvement strategies in 2025 based on the 2024 CAHPS Member Satisfaction Survey responses:

- Evaluate current member and provider education pertaining to coordination of care to improve collaborative health practices between provider disciplines and member understanding of the needed inter-provider communication relationship.
- Create educational content on social media, website, and member portals to support members' confidence in asking needed questions and understanding their health status.
- Analyze grievances and call tracking to identify key causes of the low scores for Rating of Specialist and strategize ways to improve member satisfaction.

Conclusion: While the Plan met the goals of fewer than ten (10) grievances per one thousand (1,000) members per year and fewer than two (2) grievances per classification per one thousand (1,000) members per year, the Plan will focus on continued improvement in the areas of Quality of Care, Access to Care and Quality of Service.

KERN HEALTH SYSTEMS

To: KHS EQIHEC

From: Isabel Silva, Senior Director of Wellness and Prevention

Date: June 17, 2025

Re: 1st Quarter 2025 Wellness & Prevention Department Reports

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Background

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

Discussion

Enclosed are the quarterly Wellness and Prevention Department reports summarizing all activities performed during the 1st quarter of 2025:

- Q1 2025 Wellness & Prevention Activities Report
- Q1 2025 Cultural and Linguistic Services Activities Report

Fiscal Impact

None.

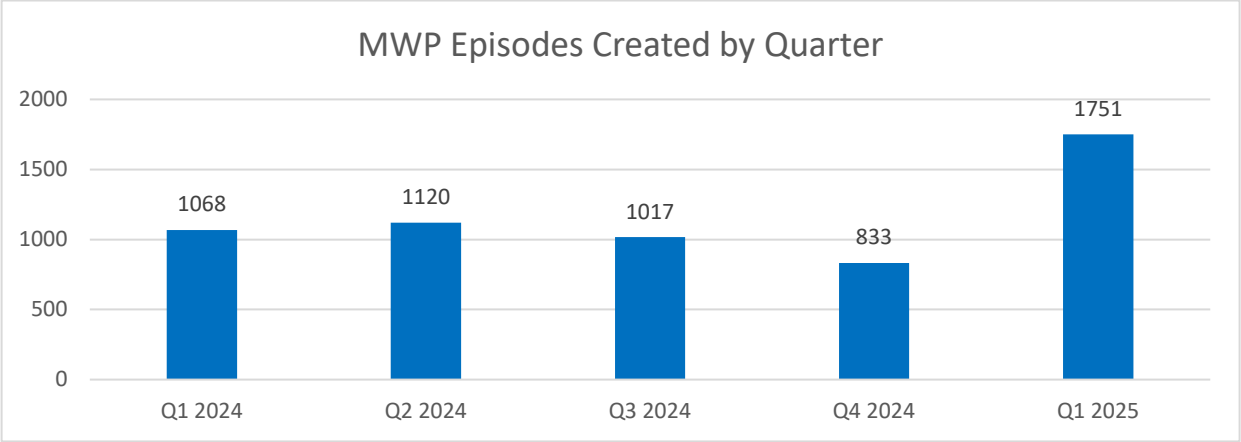
Requested Action

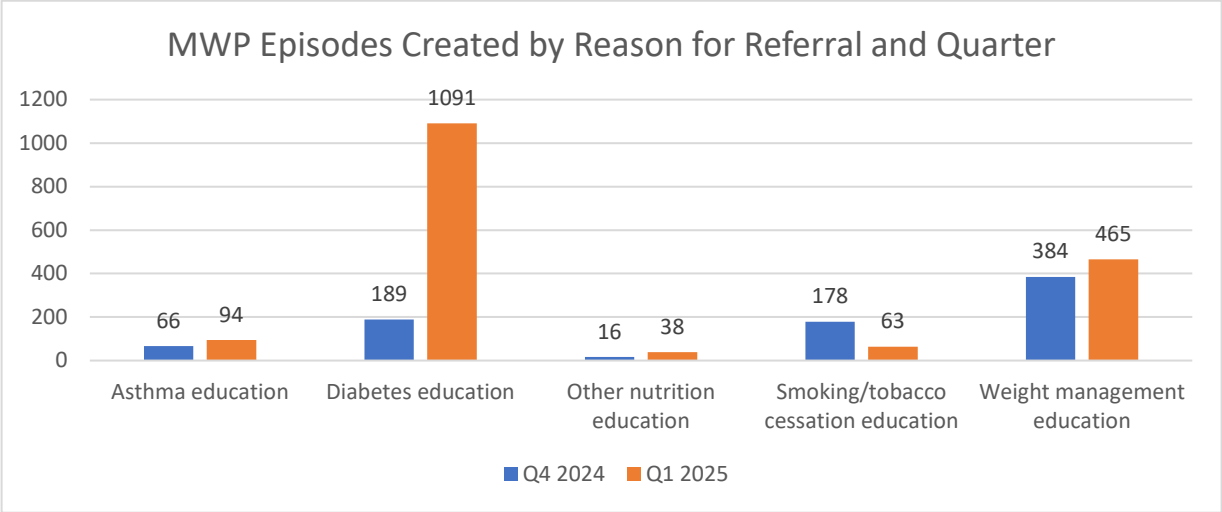
Review and approve.

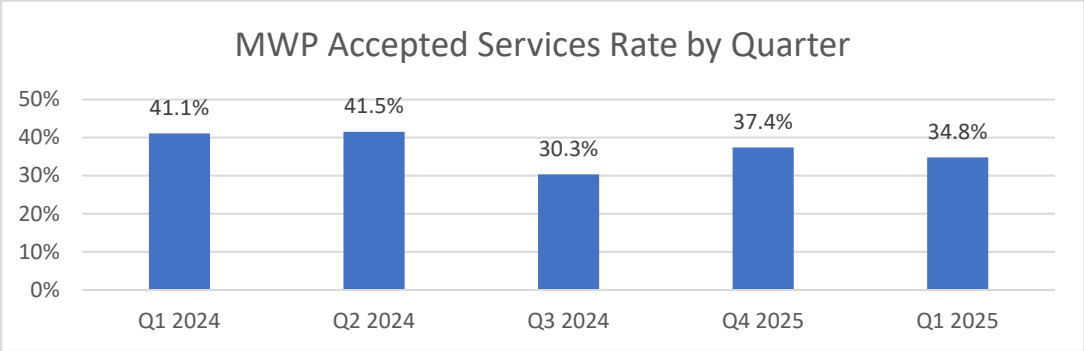
Member Wellness and Prevention

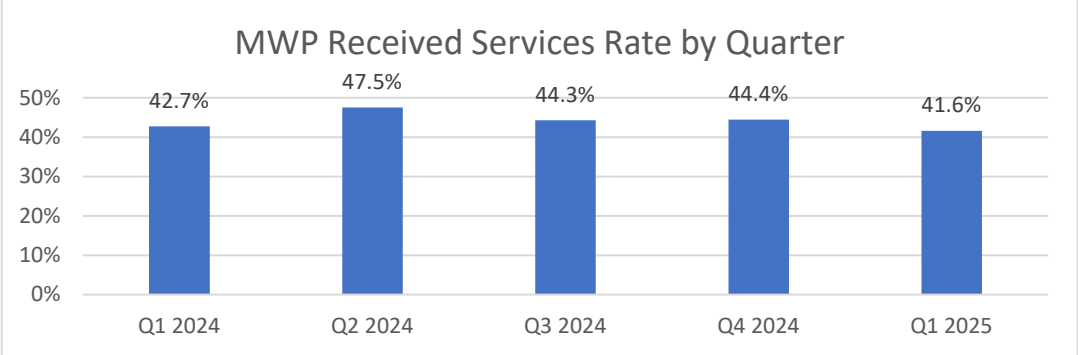
Health Education Referrals

During Q1 2025, there were 1,752 referrals for Member Wellness and Prevention (MWP) services, which is a 110.2% increase in comparison to the previous quarter. In Q1 2025, the MWP team directed outreach efforts to register members for the diabetes management and weight management programs. Outreach for the in-person classes focused on members living in central, east, and north Bakersfield, Shafter, and Wasco. As for the virtual classes, outreach focused on the outlying communities and members 35-49 years of age (the age group most likely to use video meeting apps). The health education service acceptance rate decreased from 37.4% in Q4 2024 to 34.8% in Q1 2025. The received services rate decreased from 44.4% in Q4 2024 to 41.6% Q1 2025.





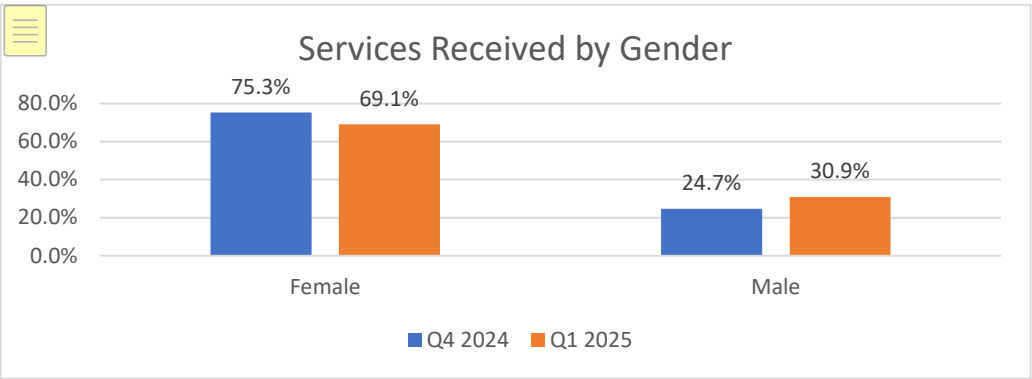


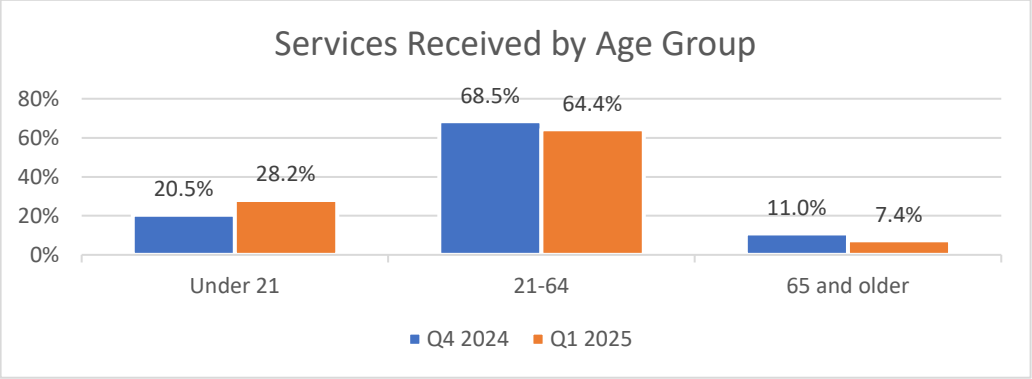


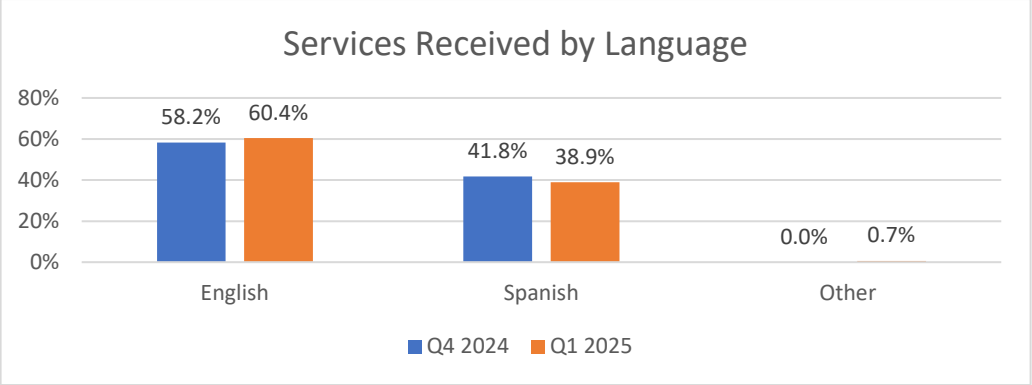
Member Demographics

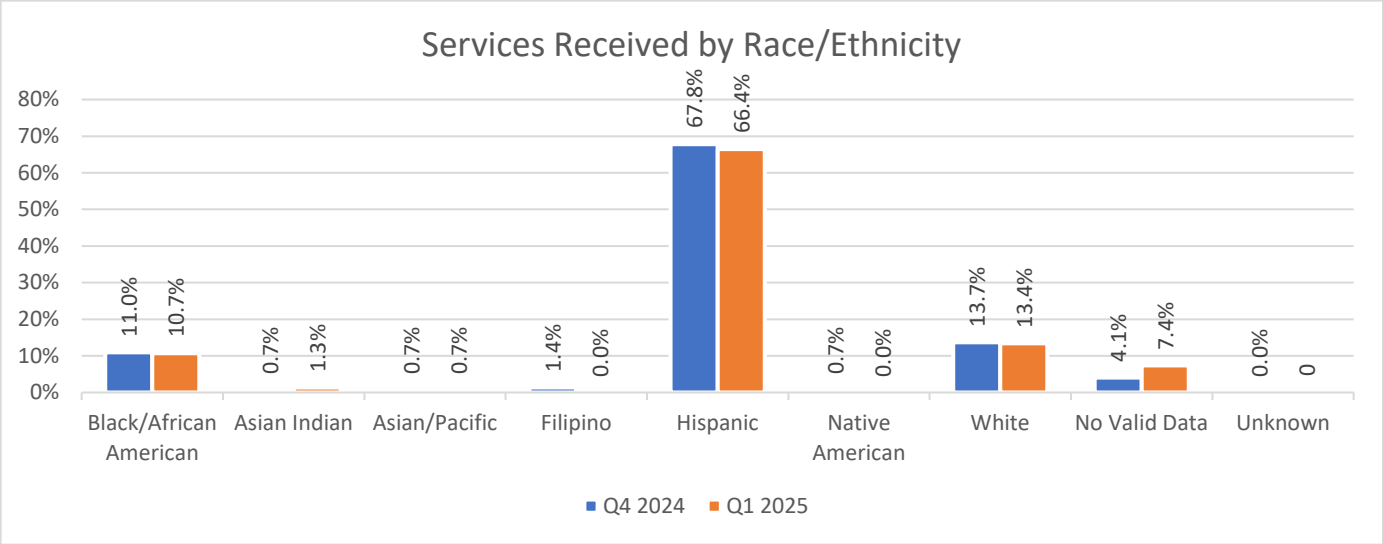
KHS provides services to a culturally and linguistically diverse member population in Kern County. A demographic analysis of the members who received services included the following findings:

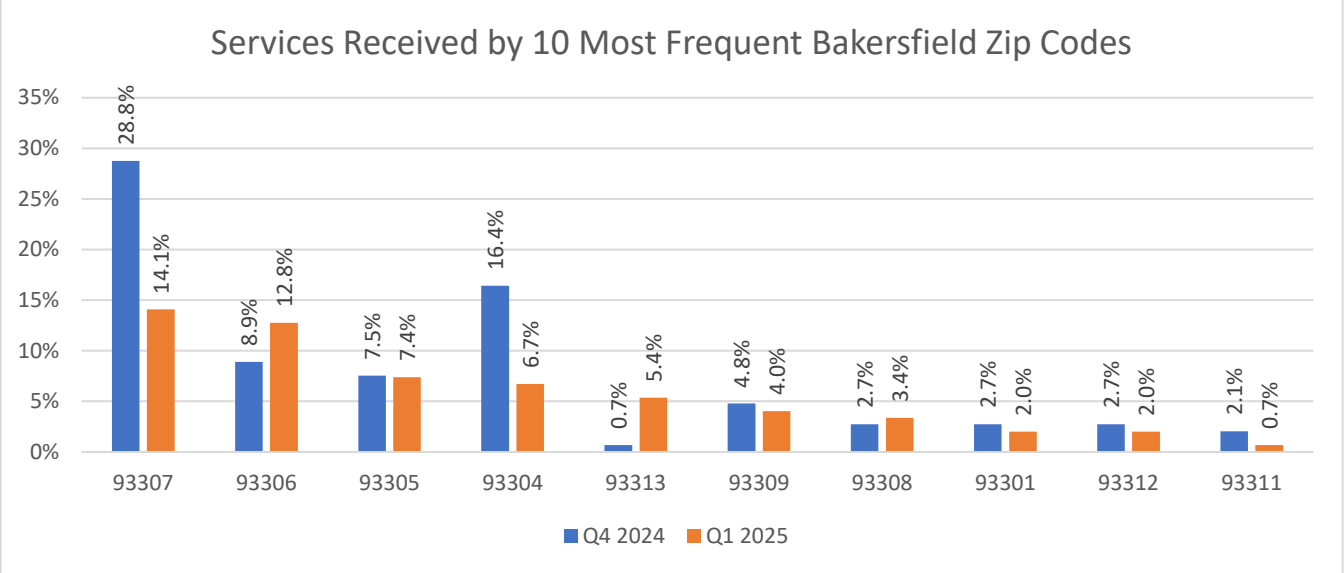
1. The largest age groups were 21-64 years (64.4%) followed by members under 21 years of age (28.2%).
2. A breakdown of member classifications by race and language preferences revealed that most members who received services were Hispanic (66.4%) and preferred to receive services in English (60.4%).
3. Most members who received services resided in Bakersfield with the highest concentration in the 93307 area.
4. Among the outlying areas of the county, Shafter accounted for the largest share of members who received services (21.5%).


Services Received by Gender
80.0%
60.0%
40.0%
20.0%
0.0%
75.3%
69.1%
24.7%
30.9%
Female
Male
Q4 2024
Q1 2025


Services Received by Age Group
80%
60%
40%
20%
0%
20.5%
28.2%
68.5%
64.4%
11.0%
7.4%
Under 21
21-64
65 and older
Q4 2024
Q1 2025


Services Received by Language
80%
60%
40%
20%
0%
58.2%
60.4%
41.8%
38.9%
0.0%
0.7%
English
Spanish
Other
Q4 2024
Q1 2025


Services Received by Race/Ethnicity
80%
70%
60%
50%
40%
30%
20%
10%
0%
11.0%
10.7%
0.7%
1.3%
0.7%
0.7%
1.4%
0.0%
67.8%
66.4%
0.7%
0.0%
13.7%
13.4%
4.1%
7.4%
0.0%
0
Black/African American
Asian Indian
Asian/Pacific
Filipino
Hispanic
Native American
White
No Valid Data
Unknown
Q4 2024
Q1 2025


Services Received by 10 Most Frequent Bakersfield Zip Codes
35%
30%
25%
20%
15%
10%
5%
0%
28.8%
14.1%
8.9%
12.8%
7.5%
7.4%
16.4%
6.7%
0.7%
5.4%
4.8%
4.0%
2.7%
3.4%
2.7%
2.0%
2.7%
2.0%
2.1%
0.7%
93307
93306
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93313
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93308
93301
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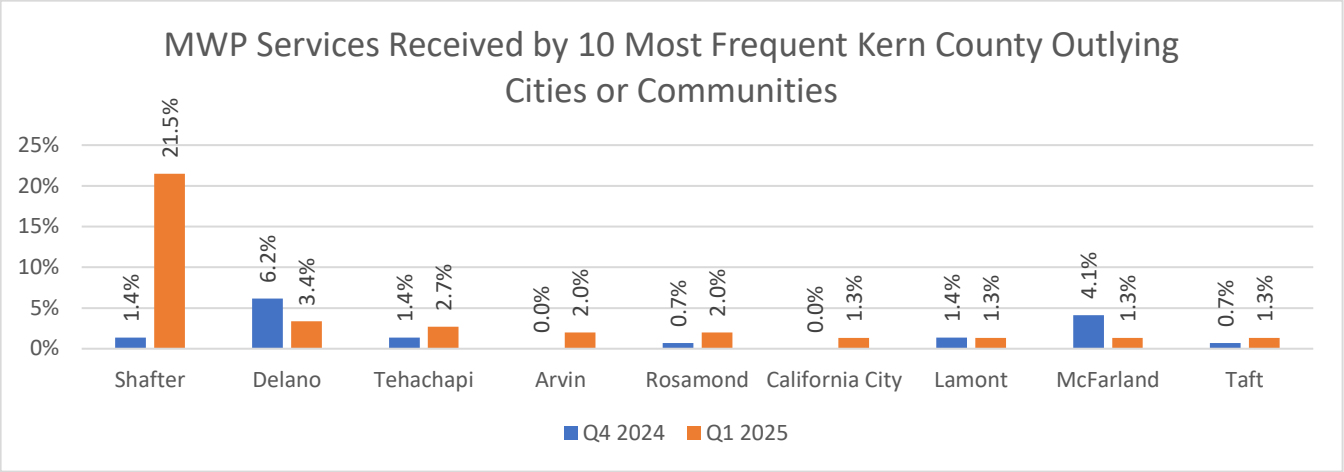
93311
Q4 2024
Q1 2025



Health Education Class Service Audit

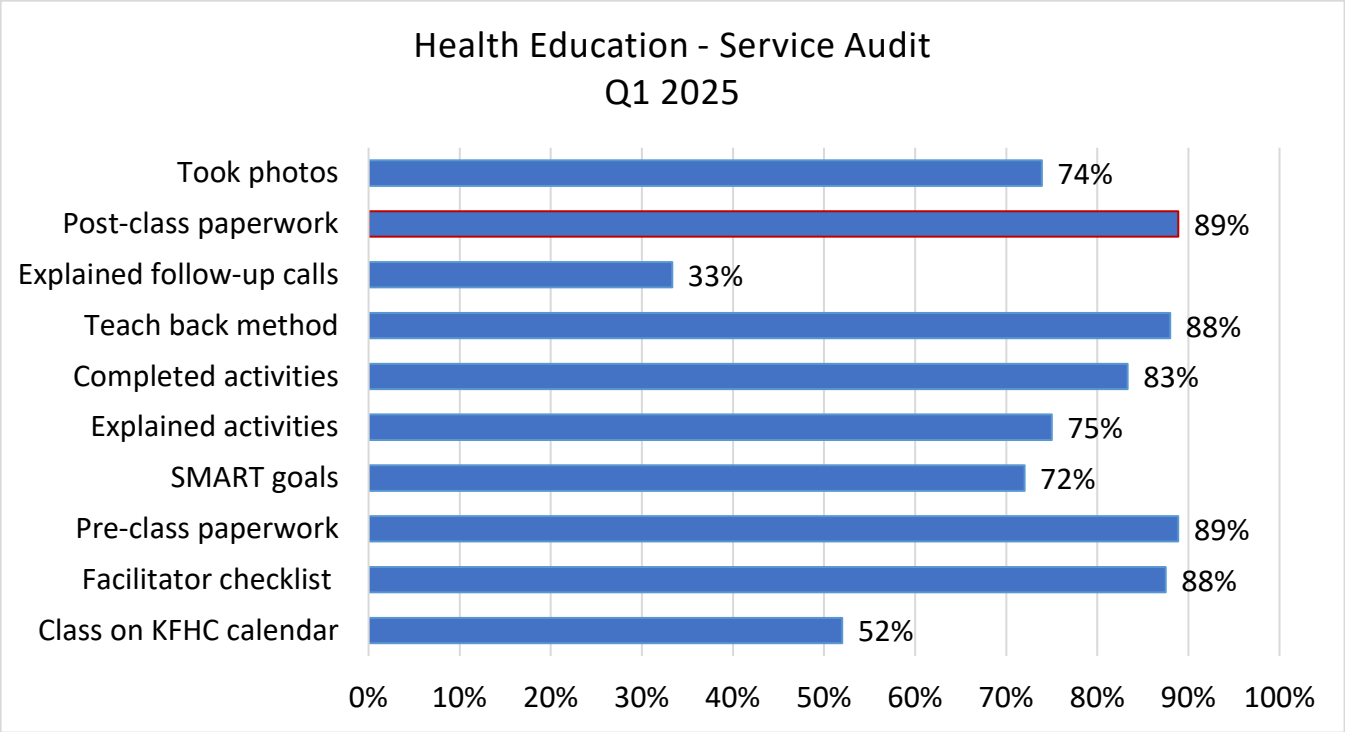
The Health Education Class Service Audit Tool considers a variety of markers to determine the quality of Health Education Class Services being provided to members. It includes observations on planning and preparation, implementation and delivery, and member engagement during health education classes.

In Q1 2025, class facilitators demonstrated mastery in the following areas:

- Starting on time
- Preparing class supplies
- Tracking participants
- Explaining difficult concepts
- Covering or discussing myths
- Checking for and responding to member questions
- Being in control of the class
- Using different engagement strategies
- Speaking loud and clear

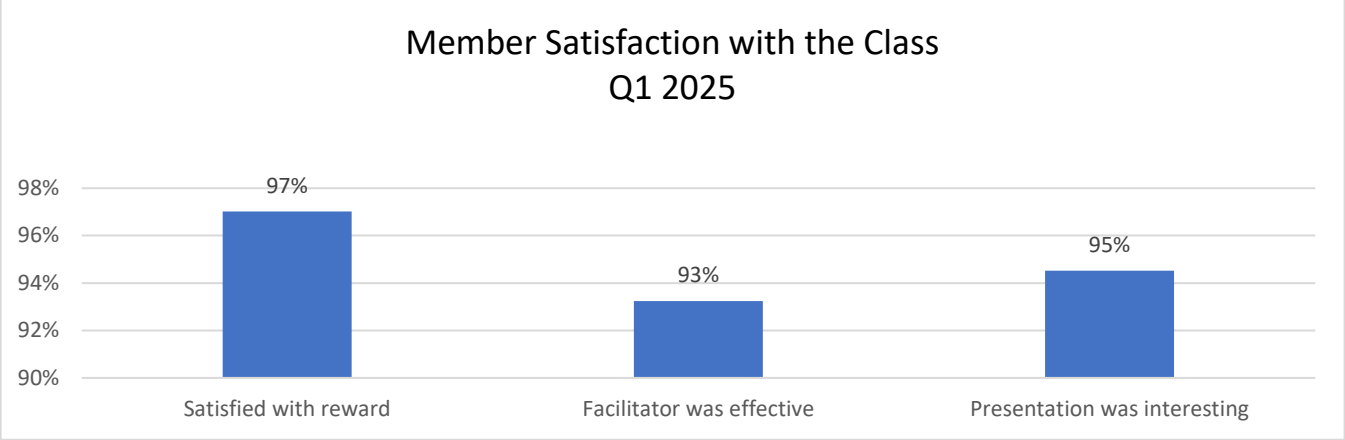
Areas of improvement included:

- Explaining follow-up calls as part of the program
- Ensuring class is posted on the KFHC calendar
- SMART goals
- Explaining class activities



Health Education Class Evaluations

Health Education classes include an evaluation questionnaire for participants. The questionnaire is administered at the end of the class session or series. Findings revealed high ratings of 93% or higher with three measures of class satisfaction as shown in the chart below**.**



Below is an analysis of the findings from open-ended questions for Q1 2025.

What did you like most about the class?

Participants were asked what they liked most about the class. More than 91% percent of participants expressed satisfaction with the class and suggested no change. More than half of the members who responded shared the following responses:

- Appreciated clear and engaging communication style of instructors.
- High value placed on interactive learning and peer engagement.
- Relevant and practical health and nutrition topics.
- Clear explanations and easy-to-understand material were highlighted.
- Clear explanations and easily understandable content.
- Effective and engaging teaching methods and presentation style.
- Helpful materials and resources enhancing the learning experience.

How could we improve the class?

Participants were asked how the class could be improved. Responses included:

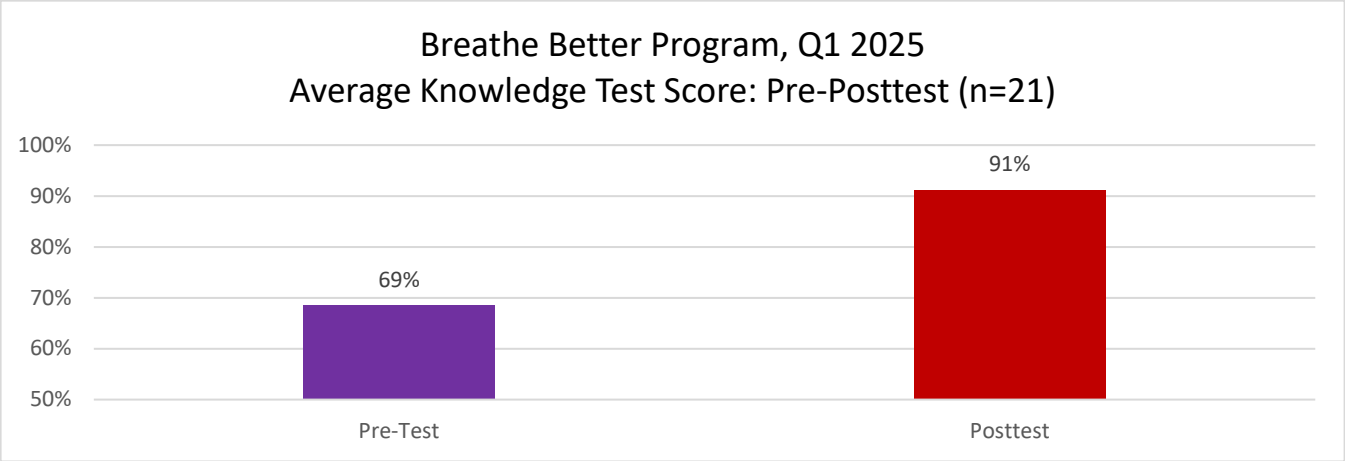
- There were some suggestions regarding the physical environment, such as lighting or seating.
- Some suggested making the class more accessible or inclusive for all participants.
- Participants expressed interest in more frequent classes or additional opportunities.
- A few participants suggested minor improvements, such as more activities or specific content adjustments.

In addition, members referred to the Kick It California (KIC) Quitline are surveyed to gauge satisfaction with this service. No satisfaction survey responses were collected during this quarter. No member accepted services to KIC in Q1.

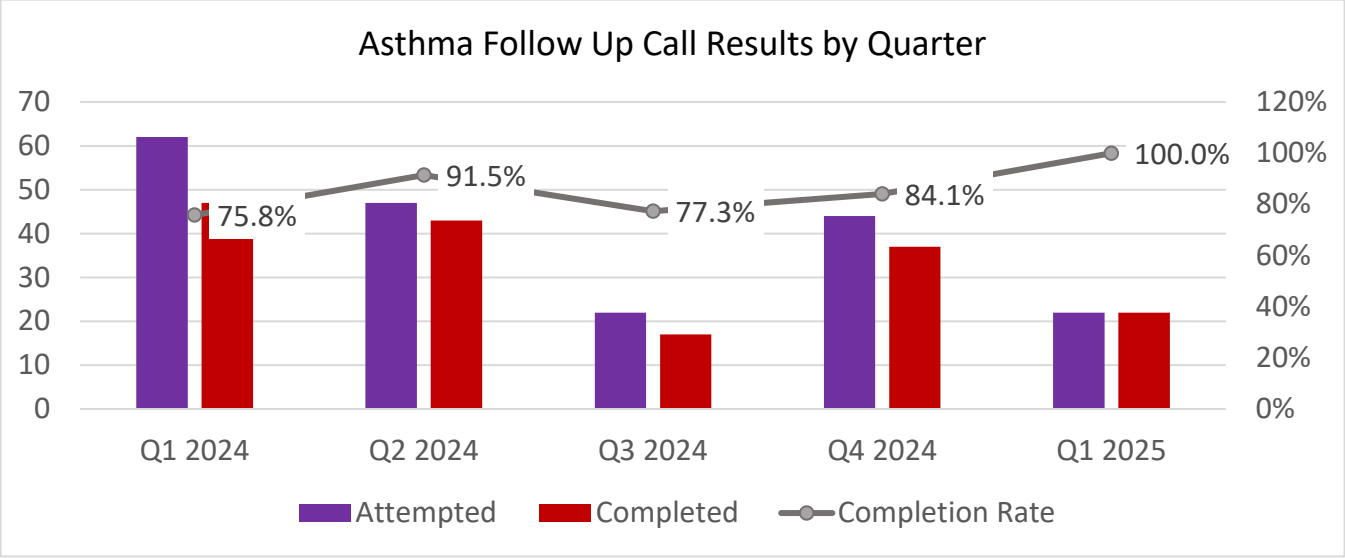
Evaluation of Wellness and Prevention Program Effectiveness

Asthma: Breathe Better Program

The asthma education program consists of 2 classes and at least 2 follow-up calls. A pre and posttest questionnaire is administered each series. During Q1 2025, findings revealed there was a 22-percentage point increase in average knowledge test score after completing the series. The largest increases were in understanding what an asthma trigger is, common asthma symptoms, and knowing when to use controller inhalers as directed by their health care provider.



Members who have attended the KFHC Breathe Better Asthma Classes are offered asthma follow up calls. These calls occur at 1 month, 3 months, and 6 months (optional or only if needed) after attending the classes. During the follow up call, members are screened to determine if asthma symptoms are well controlled using the Asthma Control Test (ACT) screening tool. An ACT score of 20 or higher is an indicator of well controlled asthma. During Q1 2025, 100% of members completed an asthma follow up call. This was an increase of 84.1% from the previous quarter. There was an improvement in average ACT score for both members under 12 years of age and those 12 years and older when comparing the initial assessment to the 3 month follow up calls. There was no data found for the 1 month and 6 month follow up calls.

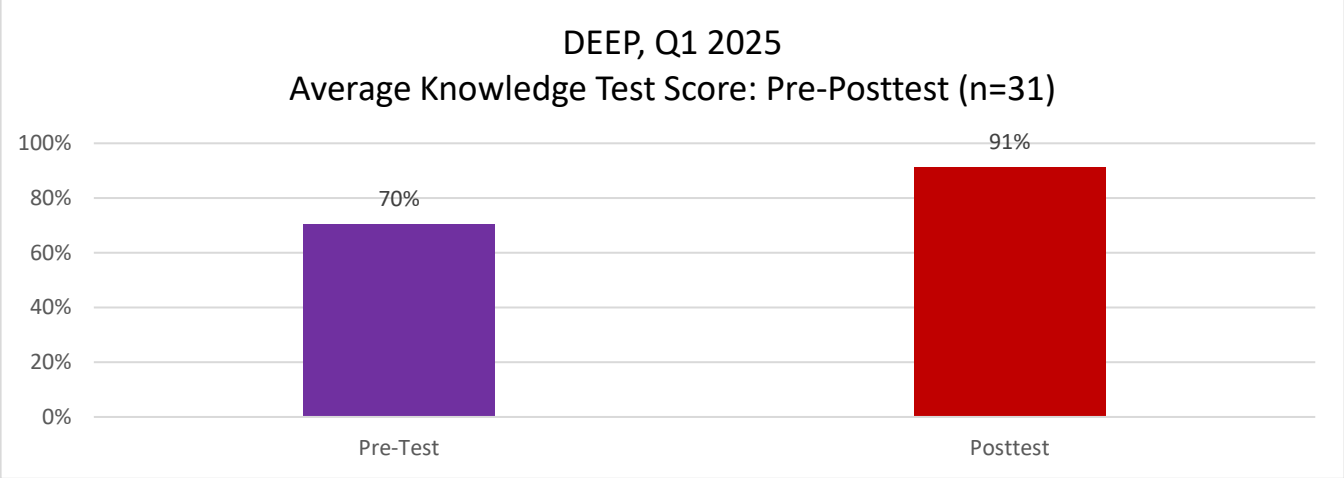


Q1 2025 Average ACT Scores During Asthma Follow Up Calls		
Call Month	<12 years of age	12+ years of age

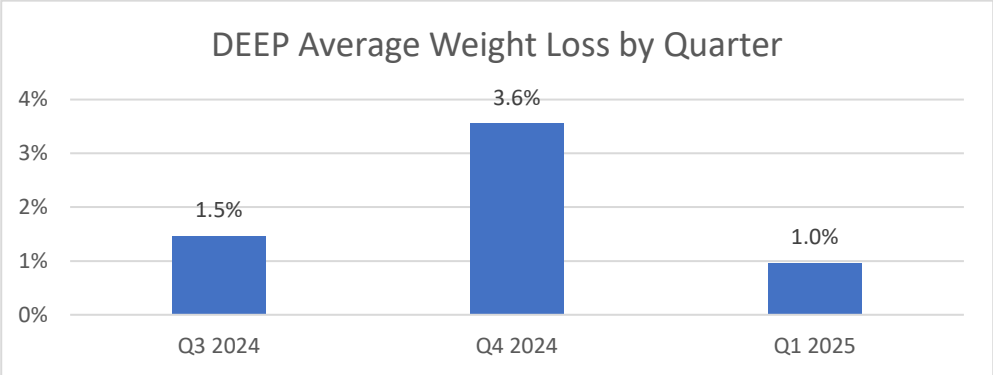
Initial	12	12
3	20	18

Diabetes Education: Diabetes Empowerment Education Program (DEEP)

DEEP is a diabetes self-management program that has been shown to be successful in helping participants take control of their disease and reduce the risk of complications. The program was developed for low-income and racial and ethnic minority populations. During Q1 2025, findings revealed a 21-percentage point increase in average knowledge test score when comparing members who completed a pretest (average 70% score) to members who completed a posttest (average 91% score).

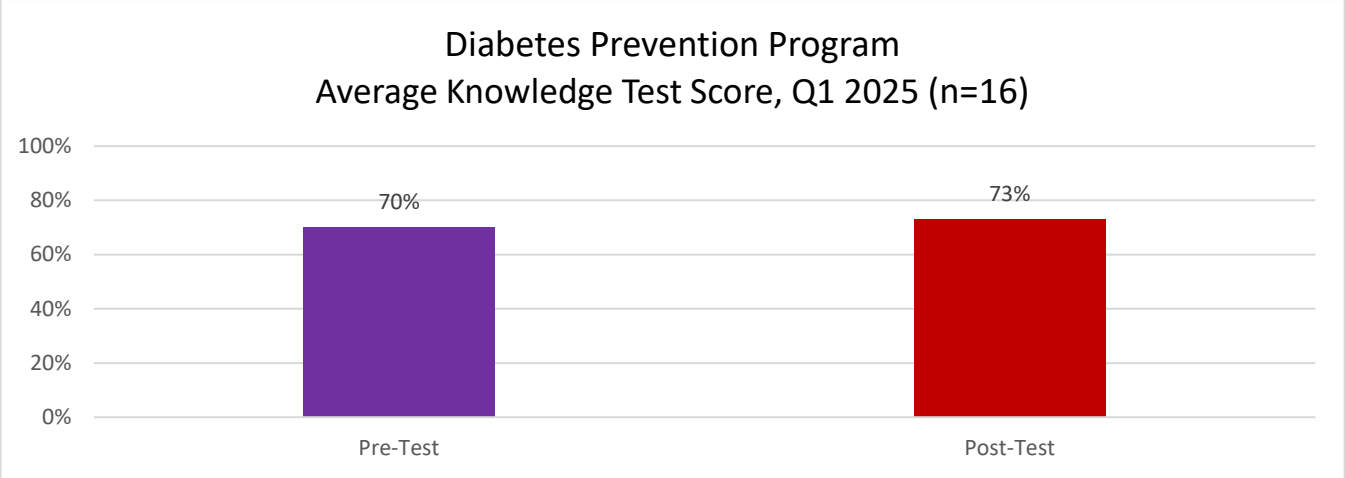


Members who participate in DEEP are weighed in at every class as one way to measure program impact. The bar chart below compares the average weight of participants before and after attending the DEEP program, for class 1 and class 6 during Q3 2024, Q4 2024, and Q1 2025. Overall, the data shows that participants experienced an average weight loss of 1.5% in Q3 2024, 3.6% in Q4 2024, and 1.0% in Q1 2025, suggesting that behavior modifications and recommendations presented during the series may be effective.

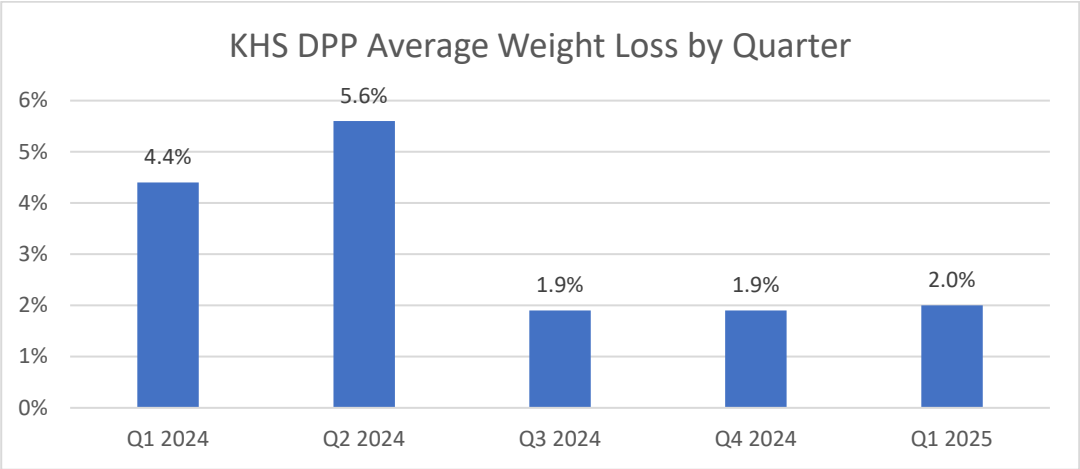


Diabetes Prevention Program (DPP)

The National DPP aims to simplify access to an affordable, high-quality lifestyle change program for individuals with prediabetes or those at risk of type 2 diabetes. The program helps lower their chances of developing type 2 diabetes and enhances their overall health. In Q1, 16 members completed a pretest and posttest. There was an average 3 percent-point increase in knowledge gain for classes 17-20, with an average score of 70% at pretest compared to an average score of 73% at posttest.



Members who participate in DPP are weighed in at every class as one way to measure impact. The initial combined cohort weight is compared with the combined weight at the end of each month to calculate average weight loss per member each month and quarter. The average individual weight loss percentage by quarter is shown in the chart below. A significant drop occurred in Q3 2024 since a Spanish DPP cohort ended in June 2024 and an English cohort started the following month. By the end of Q1 2025, 18 members were enrolled in the KHS English DPP cohort with an average weight loss of 2%. DPP was offered in English and in-person by KHS. DPP was offered in English with a virtual format by California Health Collaborative. By the end of Q1 2025, 5 members were enrolled with an average weight loss of 4.5%.

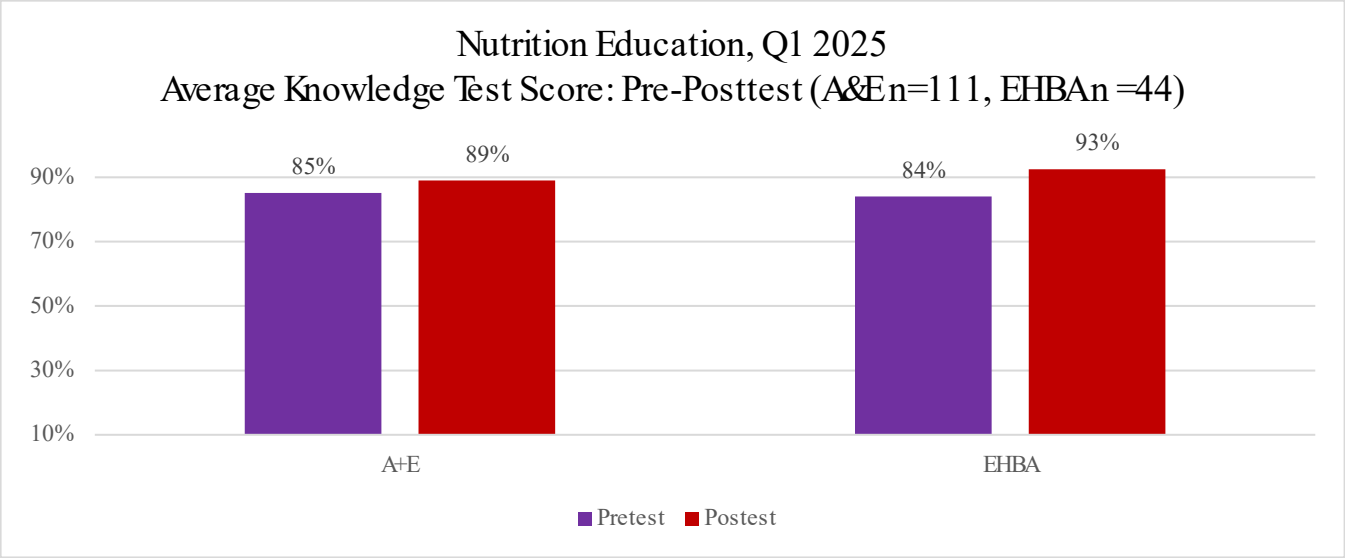


Nutrition and Weight Management: Eat Healthy, Be Active Program and Activity and Eating Class
The nutrition and weight management program includes two curriculums that focus on creating healthy habits around eating and physical activity to reduce the risk of chronic illness among the KFHC members and the Kern County population. In September 2023, the Eat Healthy, Be Active (EHBA) curriculum, a 6-class series, along with the Activity and Eating (A&E) one-time class were launched. Each class lasts about 90 minutes. Evidence shows that these programs can positively impact behavior around physical activity and nutrition. A pre and posttest questionnaire is distributed per class.

During Q1 2025, findings revealed that among those members who completed the core pre and posttest for EBHA or A&E, there was a combined average 7-percentage point increase in knowledge gained after completing classes.

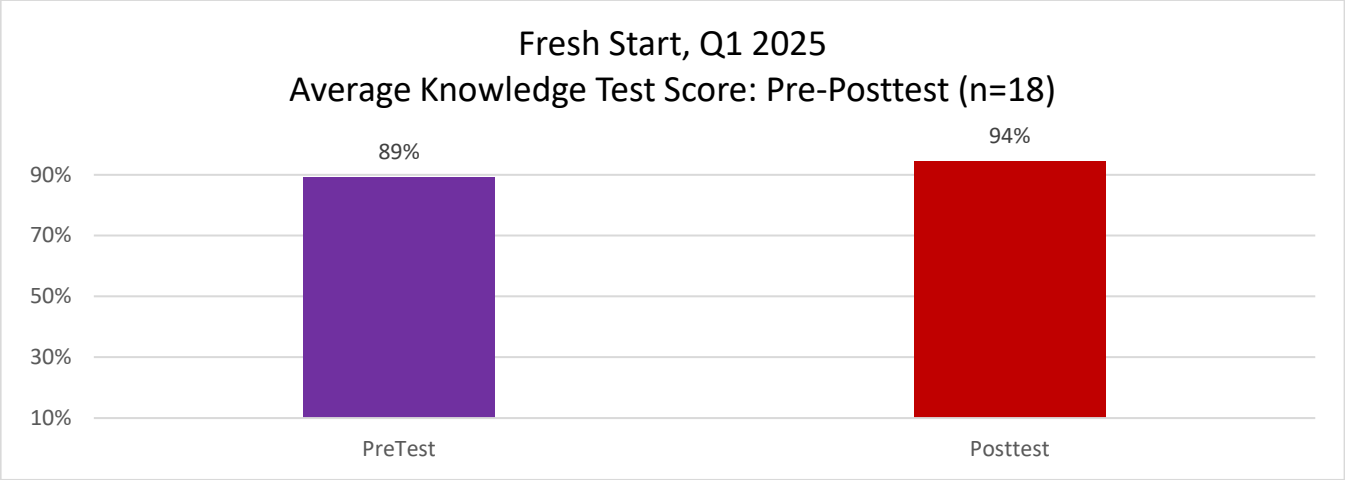
- Members who completed a pretest scored an average of 85% in correct answer compared to an average posttest score of 91%.
- The largest increase in knowledge from pre- to posttest was observed among members who attended the EHBA course (6 classes) – a 9-percentage point increase.

There was also an increase in awareness of the relationship between calorie intake and physical activity, the five recommended food groups, and daily recommended exercise for adults.



Smoking/Tobacco Cessation: Fresh Start

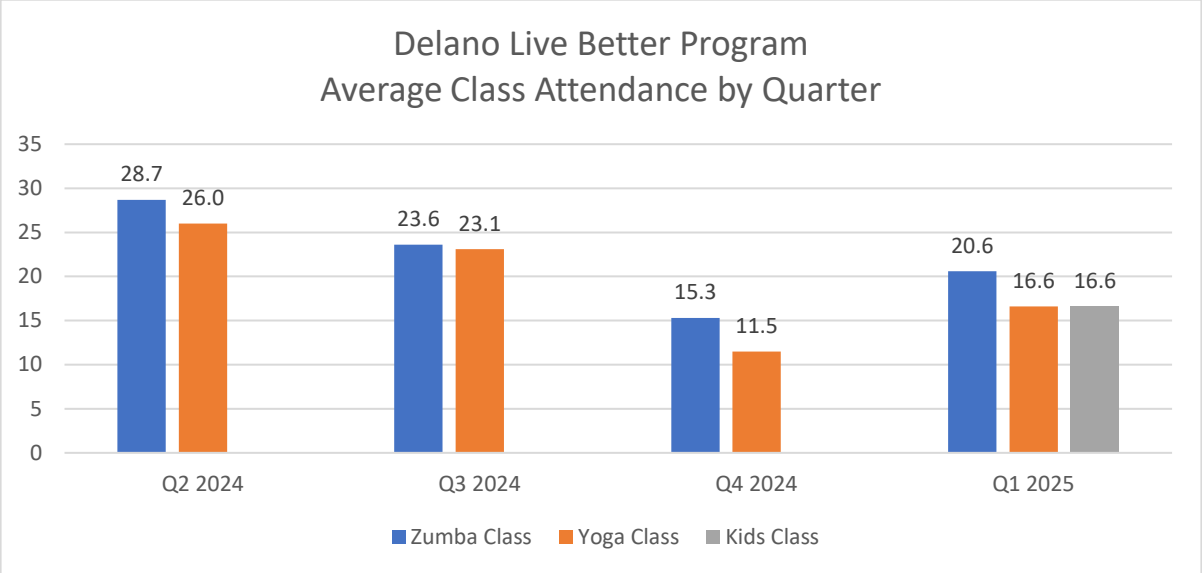
The Fresh Start program has the goal of reducing harm from tobacco products. Knowledge tests are implemented each series. In Q1 2025, 18 members completed a pretest and/or posttest, with a total of 27 tests completed during this period. There was a 5-percentage point increase in average knowledge score between pretest and posttest responses. Members appear to have gained knowledge on the concept of how ambivalence affects their emotions and feelings, different nicotine replacement therapies (NRTs), and writing down a personal quit plan.



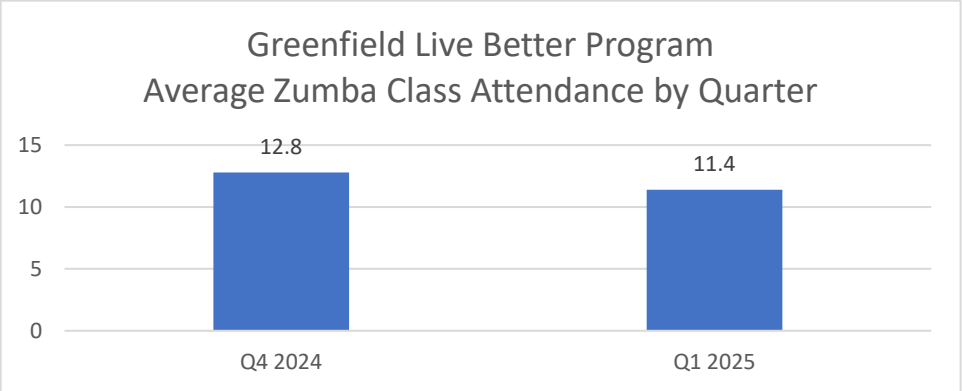
Community Health and Wellness

Live Better Program

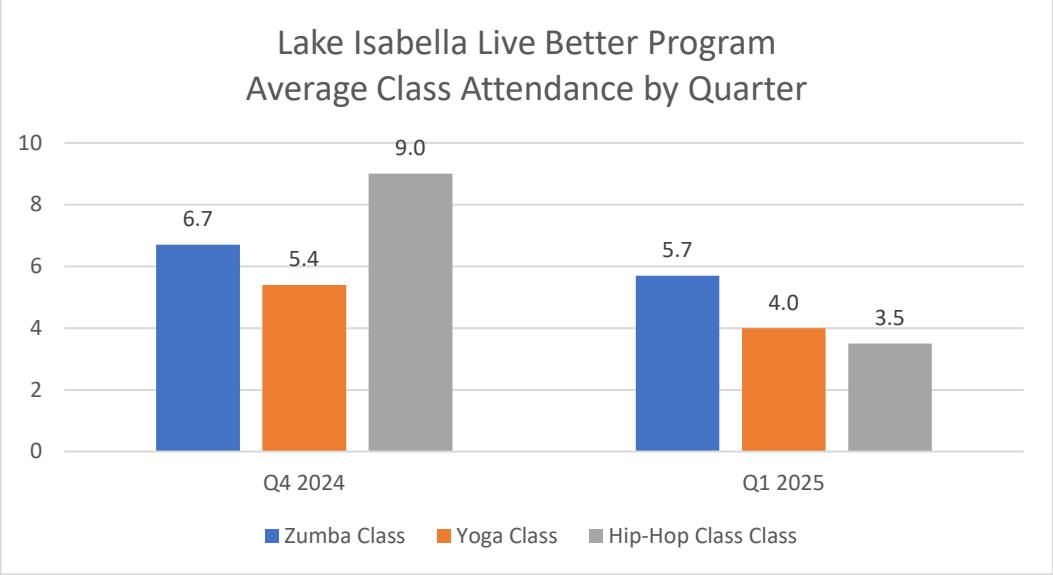
The Live Better Kids program launched successfully with high participation in Kids Zumba, Yoga, and Fit Camp. Feedback has been very positive, with kids enjoying the sessions. To boost awareness, the City of Delano included the Kids Fit Camp flyer in water bill mailings to approximately 11,000 households. The adult program also remains strong, offering two weekly sessions, each of Yoga and Zumba. Average attendance in Q1 2025 for the Zumba, yoga, and kids classes was 20.6, 16.6, and 16.6, respectively.



The Live Better program in Greenfield remains active, with ongoing promotion of Zumba classes and continued delivery of Eat Healthy, Be Active Program sessions at the Greenfield Family Resource Center. We are also exploring the possibility of establishing a direct contract with the Greenfield Walking Group to strengthen community engagement moving forward. Zumba class attendance averaged 11.4 in Q1 2025.



The Live Better program in Lake Isabella continues to thrive with steady community engagement and strong ongoing promotion. The Kern River Valley Family Resource Center facilitated one health education class this quarter. Although attendance was low with just one participant, efforts are underway to increase outreach. Kern River Valley and Danica's School of Dance are collaborating by sharing a calendar and cross-promoting events to boost participation. Average attendance in Q1 2025 for the Zumba, yoga, and hip-hop classes was 5.7, 4.0, and 3.5, respectively.



Other Wellness and Prevention Activities

Highlights of other initiatives and activities during Q1 2025 included:

- Worked with Kern Health Partnership to organize and promote Community Health Conversation events in Q1 2025 in Lake Isabella and Ridgecrest. Participants shared feedback on the most important thing to live healthy and health topics they wanted to learn more about.
- Developing a hypertension awareness and education program. The program will involve partnering

with libraries across Kern County to create an unstaffed resource table for community residents to check their blood pressure using blood pressure monitors. These tables would also have educational materials and resources to connect community residents to other heart health resources.

- Signed an agreement with Iron Valley Fitness Gym to offer a free 3-month gym membership program to 200 KFHC members through July 8, 2025. The program will include a text message campaign and gym attendance tracking.
- Offered the Activity and Eating Class for parents at Stella Hills Elementary School.
- Installed 6 car seats for members who attended the KFHC Winter Wellness Wonderland event. The installation process consisted of education on state laws and information on expiration dates followed by a demonstration on how to properly install the car seat.
- Partnered with First 5 Kern, Anthem Blue Cross and Kern County Public Health to launch a Parent Immunization Survey. The purpose of the survey is to understand parent perspectives and concerns around vaccines in order to develop a county-wide promotion strategy.
- New MOUs with Kern County Public Health, Kern County Probations and CAPK and CSV WIC have been executed. These MOUs are required by the DHCS for Managed Care Plans to build stronger partnerships with county agencies and other community-based organizations and foster better coordination of services.

Executive Summary

Report Date: April 25, 2025

OVERVIEW

Kern Health Systems' Cultural and Linguistic (C&L) Services Program helps ensure that comprehensive, culturally, and linguistically competent services are provided to plan members with the intent of improving health outcomes, reducing risk for disease and empowering plan members to be active participants in their health care. The Executive Summary below highlights the larger efforts currently being implemented by the C&L Team. Following this summary reflects the statistical measurements for the C&L Services Program detailing the ongoing activity for Q1 of 2025.

1. Interpreter Requests

- Language Breakdown:
  - ✓ Top OPI languages
  - ✓ Top Onsite languages
  - ✓ Top VRI languages

2. Service Monitoring

- ✓ Linguistic Performance:
  - ✓ 100% completion of written translations
  - ✓ 100% Vendor Over-the-Phone (OPI) Interpreter Call Monitoring
  - ✓ 98% members satisfaction with bilingual KHS staff communications
  - ✓ 99% of KHS calls and 98% of vendor calls reviewed did not have difficulty communicating with members in a non-English language.
  - ✓ 100% members satisfaction with in-person interpreter
  - ✓ 100% members satisfaction with telephonic interpreter
  - ✓ 96% members satisfaction with KHS and vendor translations
  - ✓ 99% KHS staff satisfaction with vendor Over-the-Phone Interpreter (OPI) communications

3. C&L Trainings

- ✓ C&L Grievance Provider Training
- ✓ Interpreter Access Survey
- ✓ KHS Bilingual Staff Training

Respectfully submitted,

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

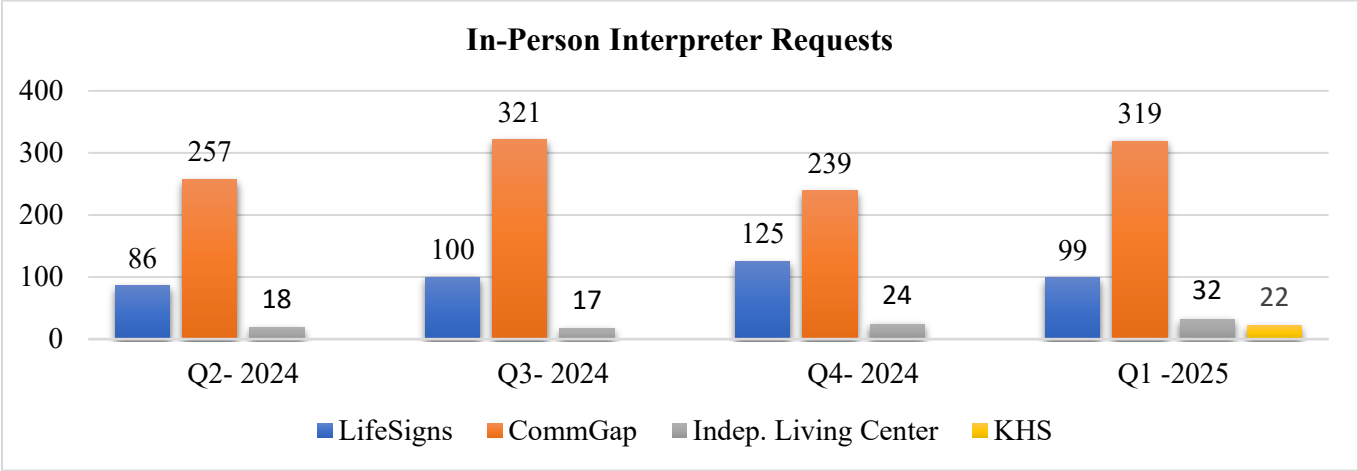
Cultural and Linguistic Services

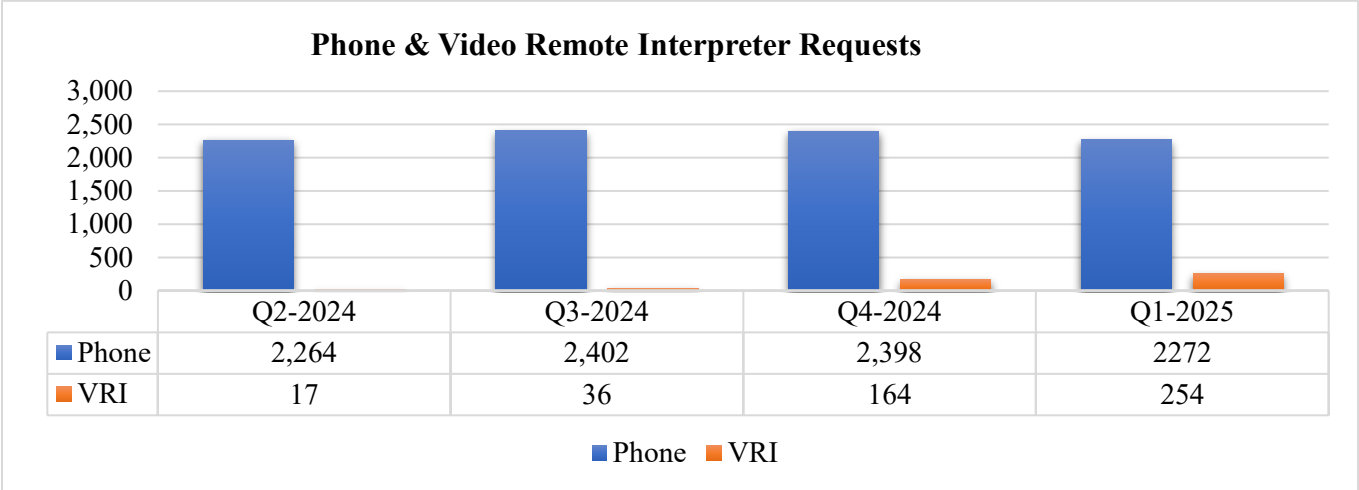
Interpreter Requests

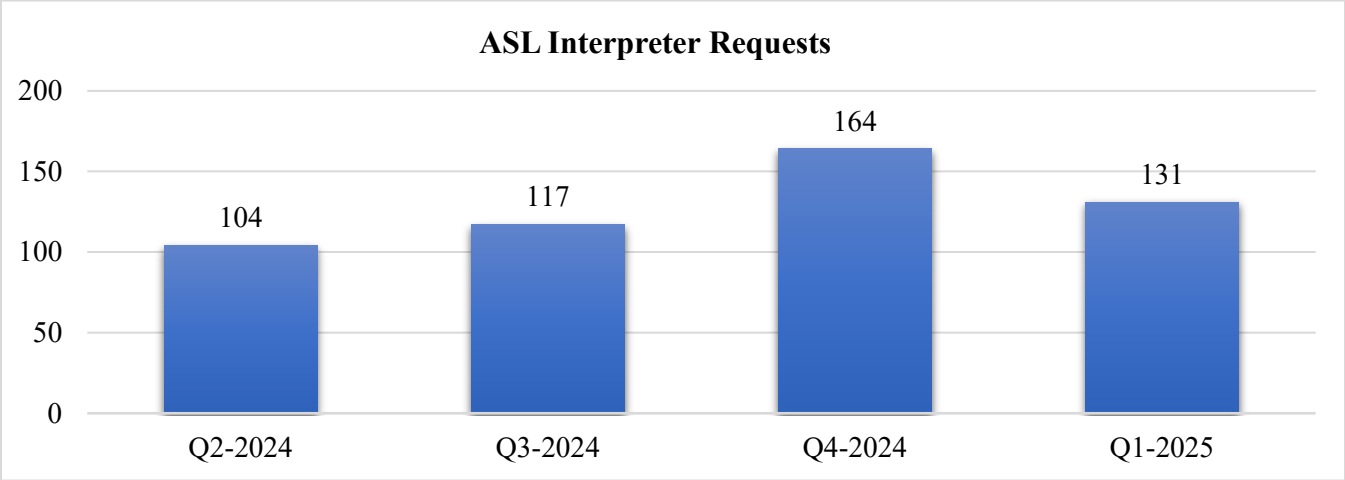
During this quarter, there were 341 requests for Face-to-Face Interpreting, 2,272 requests for Telephonic Interpreting, 254 for Video Remote Interpreting (VRI) and 131 requests for an American Sign Language (ASL) interpreter. The top three languages requested are shown as follows.

Interpreting Languages Requested
Phone and Video Remote
Spanish
Punjabi
Arabic

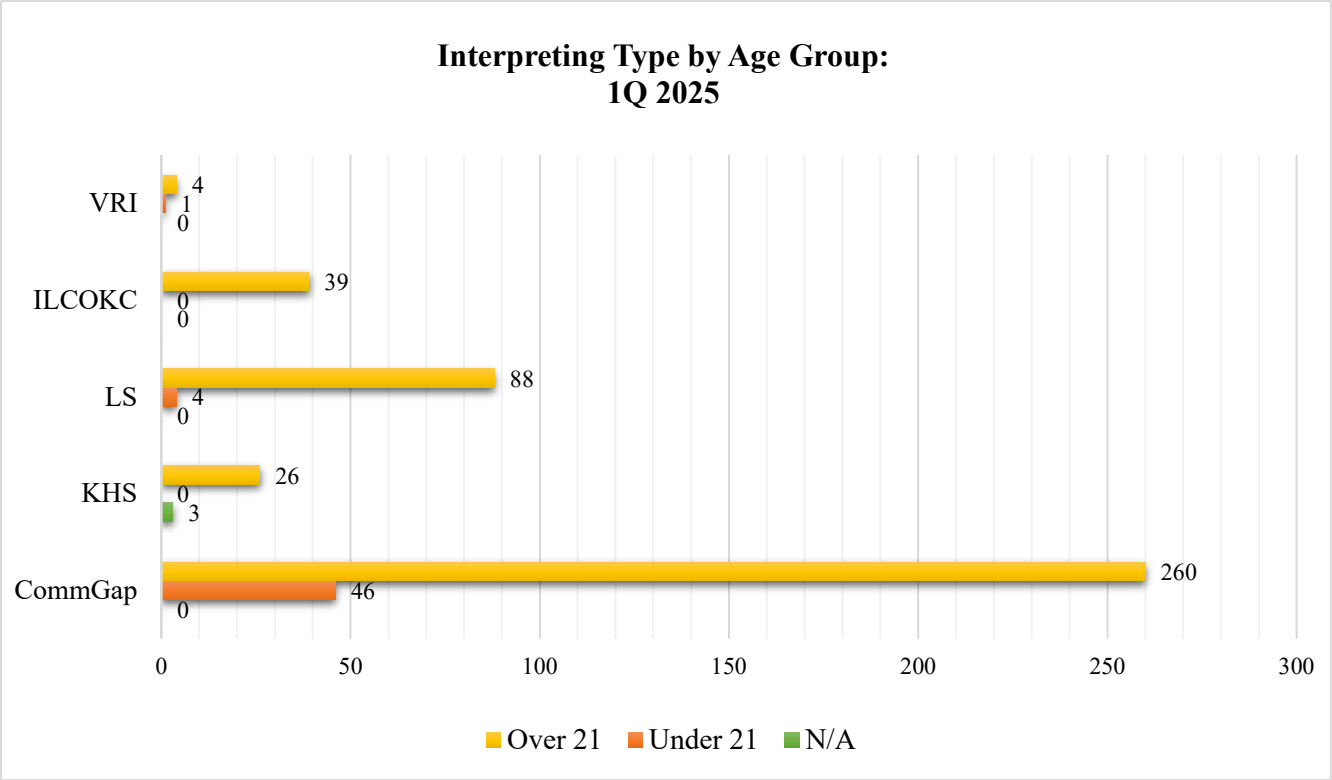
Interpreting Languages Requested
In-person
Spanish
ASL
Punjabi





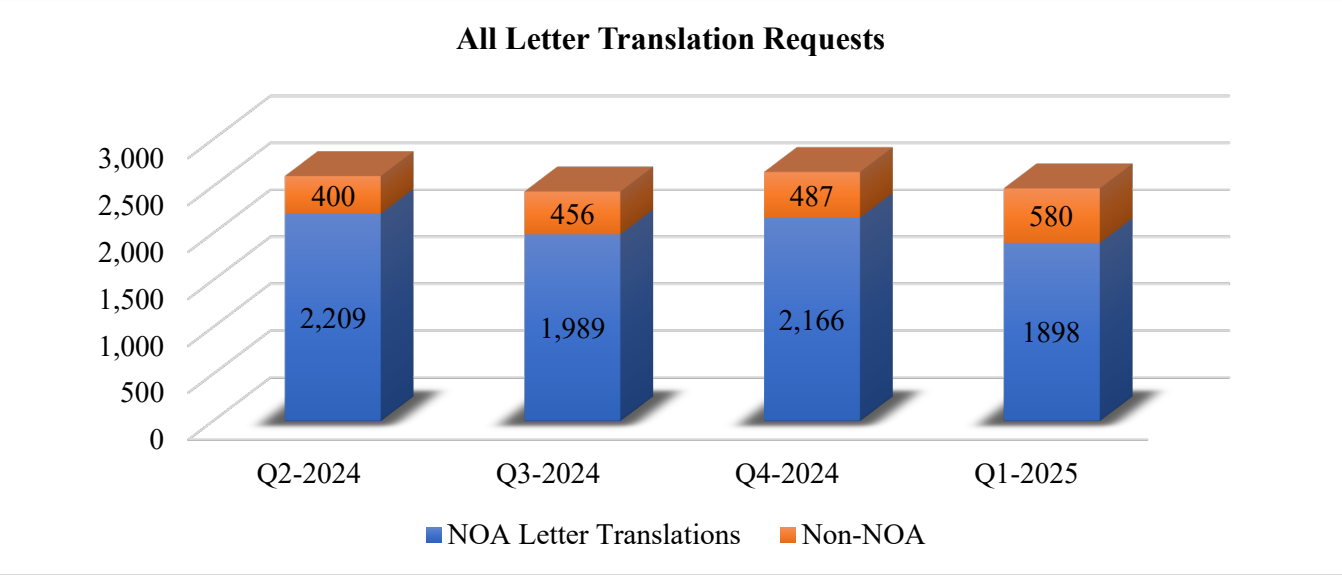


The following data shows that of all interpreting services completed, 417 were offered to adult members, 51 to members under the age of 21, and 3 not applicable due to the nature of the interpreting.

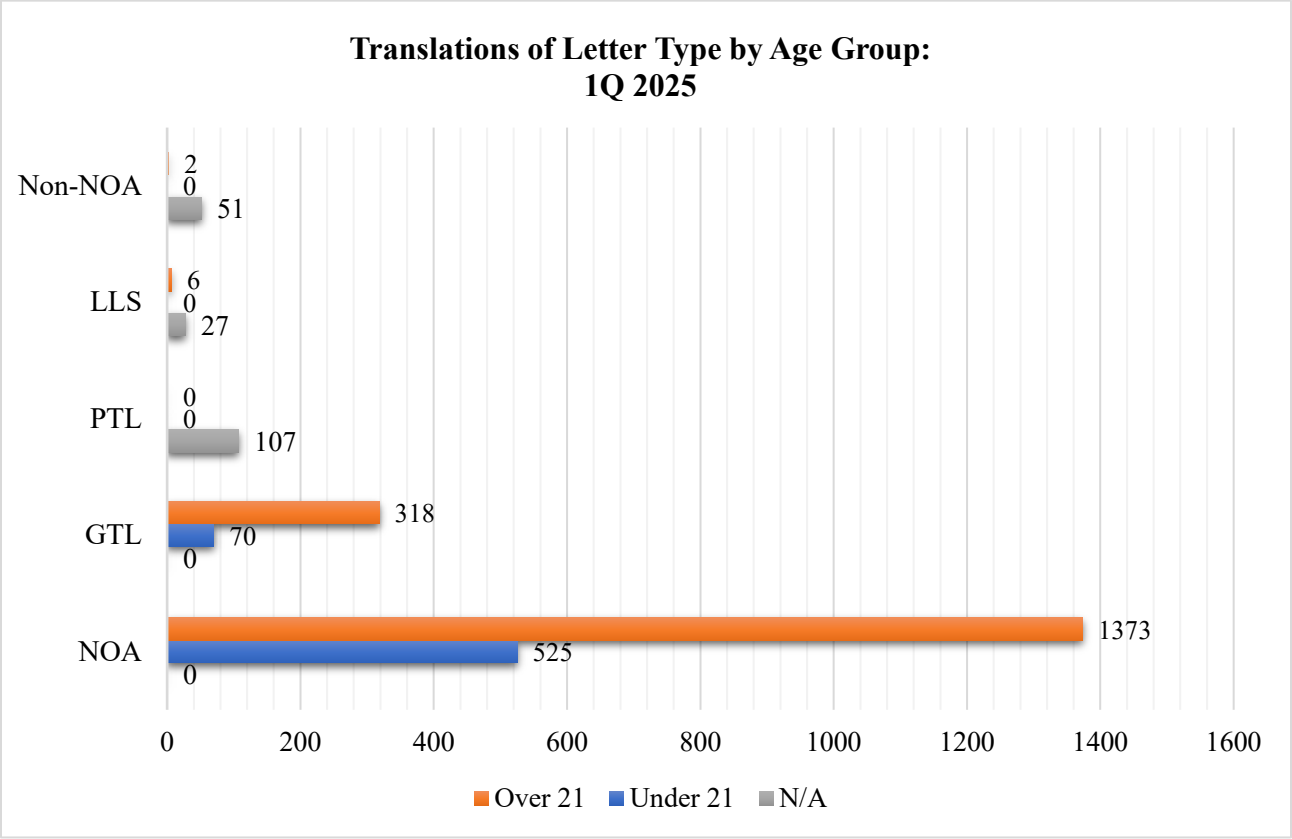


Written Translations

The C&L department coordinates the translation of written documents for members. Translations are performed in-house by qualified translators or outsourced through a contracted translation vendor. During this quarter, 2,478 requests for written translations were received and completed.



During the 1st Quarter of 2025, the KHS Cultural & Linguistics (C&L) Department breaks down translation types into four major categories: Notice of Action (NOA) letters, Grievance letters (GTL), Provider Termination Letters (PTL), Language Line Servies (LLS) and Non-NOA letters (consisting of all other translations that don't fit in the other categories, including, but not limited to: fliers, consent letters, educational materials, slide decks, surveys, and braille, etc.). Kern Health Systems classified the translations by age groups, showing that translation services were offered to 1699 to adult members, while 595 to members under the age of 21, and 185 not applicable due to the nature of the translation.



Cultural and Linguistic Services Audits

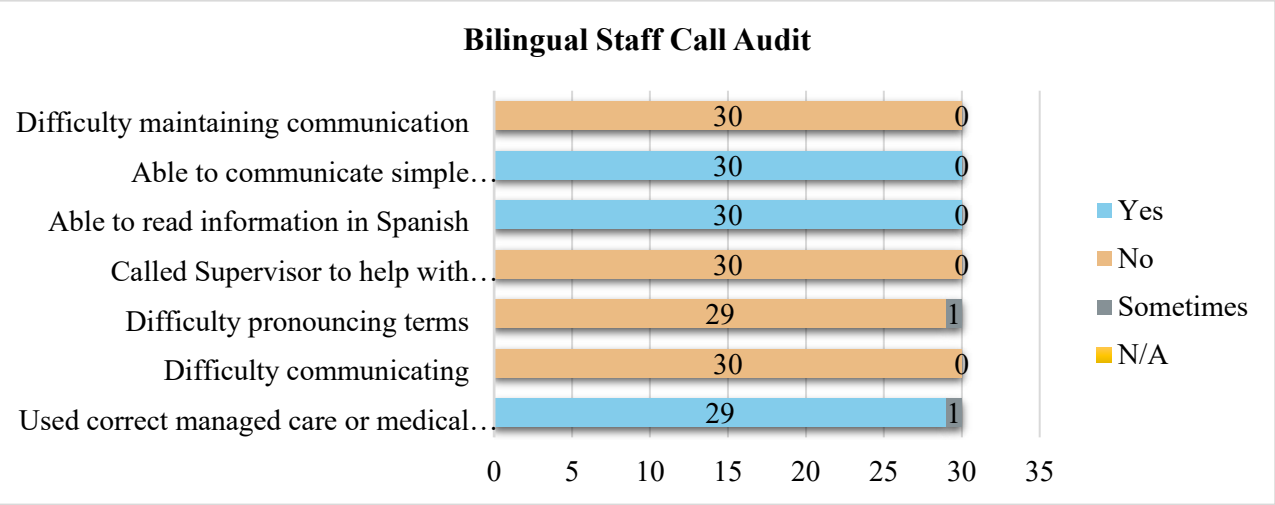
Vendor Over-the-Phone (OPI) Interpreter Call Monitoring

During this quarter, Language Line Solutions conducted an audit on 30 random OPI interpreter services calls. These calls were randomly selected from the vendors monthly invoices. Calls audited were in Korean, Mandarin, Punjabi, Spanish, Vietnamese, Arabic, Thai, Tagalog, and Dari languages. Calls were evaluated on the following items: Interpreter's Customer Service, Interpretation Skills, and the ability to follow the Code of Ethics and Standards of Practice. Audit findings revealed 100% of calls "Met Expectations."

Call Number	Interpreter ID	Status	Language	Annual Compliance Training Date	Medical Interpreter Skills Assessment Date	Medical Interpreter Skills Assessment Result	QA Observation Date	QA Observation Score
CR-0512325870	211873	Active	KOREAN	4/15/2024	2/7/2017	Pass	03/10/25	3/3
CR-0512329530	411188	Active	SPANISH	6/30/2024	3/8/2023	Pass	03/10/25	3/3
CR-0512330559	392258	Active	SPANISH	4/26/2024	11/29/2022	Pass	01/30/25	3/3
CR-0512438708	437205	Active	SPANISH	2024 new hire, same with column I	8/30/2024	Pass	02/18/25	3/3
CR-0512446372	455637	Active	PUNJABI	2024 new hire, same with column I	10/13/2024	Pass	01/16/25	3/3
CR-0512464192	460282	Inactive	SPANISH	2024 new hire, same with column I	11/22/2024	Pass	02/03/25	3/3
CR-0512472367	452663	Active	VIETNAMESE	2024 new hire, same with column I	9/10/2024	Pass	01/07/25	3/3
CR-0512467167	459902	Active	PUNJABI	2024 new hire, same with column I	11/19/2024	Pass	01/20/25	3/3
CR-0512477299	463561	Inactive	SPANISH	2024 new hire, same with column I	12/26/2024	Pass	02/05/25	3/3
CR-0512472255	429879	Inactive	SPANISH	2024 new hire, same with column I	7/19/2024	Pass	02/28/25	3/3
CR-0521484923	418622	Active	PUNJABI	4/17/2024	7/5/2023	Pass	01/22/25	3/3
CR-0521499597	461296	Active	THAI	2024 new hire, same with column I	12/6/2024	Pass	03/13/25	3/3
CR-0521605217	420908	Active	PUNJABI	4/16/2024	9/6/2023	Pass	02/26/25	3/3
CR-0521598466	436342	Active	SPANISH	2024 new hire, same with column I	8/20/2024	Pass	02/24/25	3/3
CR-0521609323	448678	Active	TAGALOG	2024 new hire, same with column I	7/22/2024	Pass	01/13/25	3/3
CR-0521617356	411106	Active	SPANISH	6/5/2024	3/31/2023	Pass	02/24/25	3/3
CR-0521648666	461591	Active	DARI	2024 new hire, same with column I	12/19/2024	Pass	02/07/25	3/3
CR-0521624725	447576	Inactive	SPANISH	2024 new hire, same with column I	7/9/2024	Pass	03/07/25	3/3
CR-0521624373	455608	Active	SPANISH	2024 new hire, same with column I	12/13/2024	Pass	02/12/25	3/3
CR-0521649947	414206	Active	SPANISH	5/23/2024	5/9/2023	Pass	01/29/25	3/3
CR-0529398791	463686	Active	PUNJABI	2024 new hire, same with column I	12/30/2024	Pass	01/31/25	3/3
CR-0529388087	453560	Active	SPANISH	2024 new hire, same with column I	9/24/2024	Pass	01/24/25	3/3
CR-0529400464	422518	Active	SPANISH	6/5/2024	10/16/2023	Pass	01/23/25	3/3
CR-0529411425	458110	Inactive	MANDARIN	2024 new hire, same with column I	11/5/2024	Pass	02/05/25	3/3
CR-0529425584	448571	Active	ARABIC	2024 new hire, same with column I	6/28/2024	Pass	01/06/25	3/3
CR-0529430783	436644	Active	SPANISH	2024 new hire, same with column I	4/10/2024	Pass	03/05/25	3/3
CR-0529453364	429286	Active	SPANISH	2024 new hire, same with column I	1/29/2024	Pass	01/08/25	3/3
CR-0529452095	402346	Active	SPANISH	5/28/2024	5/26/2023	Pass	03/10/25	3/3
CR-0529454010	464894	Active	SPANISH	2024 new hire, same with column I	1/2/2025	Pass	02/10/25	3/3
CR-0529462266	447674	Active	TAGALOG	2024 new hire, same with column I	7/16/2024	Pass	01/23/25	3/3

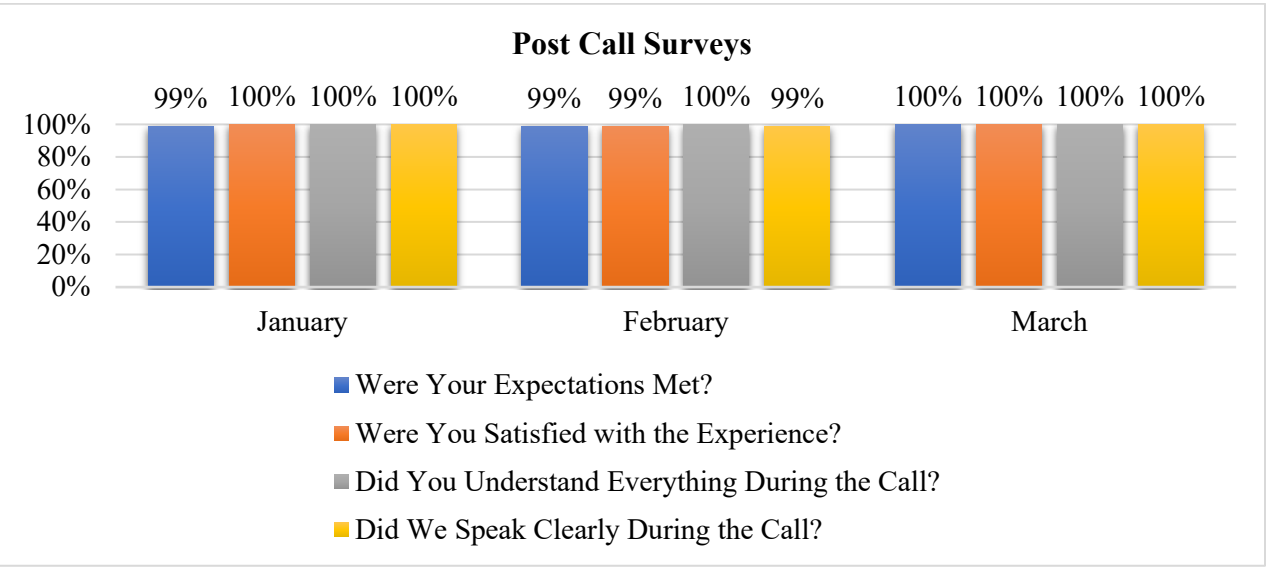
Bilingual Staff Call Audit

During this quarter, a total of 30 Spanish audio calls from KHS member facing departments were reviewed to assess the linguistic performance of the bilingual staff. The calls were audited using a group of measures to identify any potential difficulty communicating with members in a language other than English as shown below in the chart. Findings revealed that 99% of bilingual staff did not have difficulty communicating with members in a non-English language.



Post Call Surveys

During this quarter, a total of 10,359 Spanish Post Call Surveys were collected from members for all KHS member facing departments to assess the linguistic performance of the bilingual staff. KHS' post call survey evaluates a member's call experience by language. Findings revealed that 100% of members are satisfied with the linguistic performance of bilingual staff.

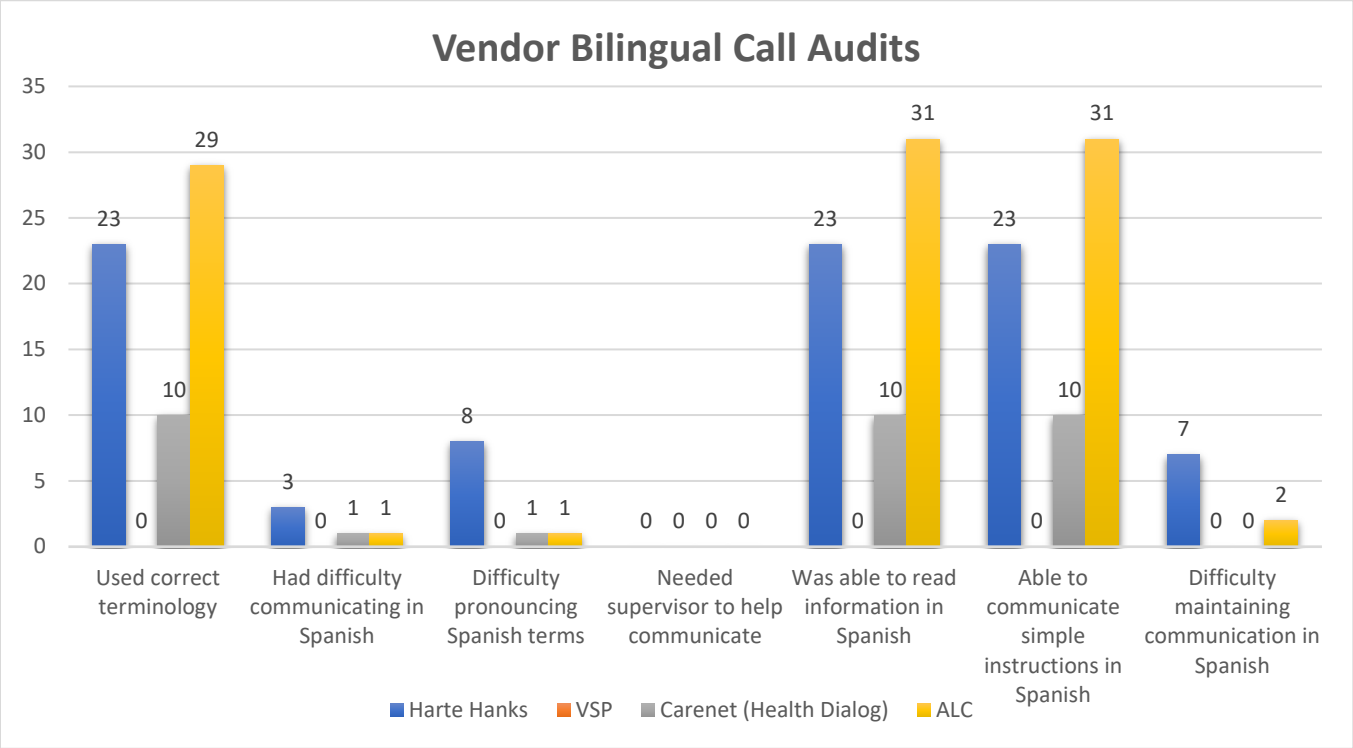


Vendor Bilingual Call Audits

During this quarter, a total of 188 Spanish audio calls were received from contracted vendors with KHS. These vendors include: ALC Transportation, Carenet, and Harte Hanks. These audio calls were reviewed to assess the linguistic performance of the vendor's bilingual staff. Findings

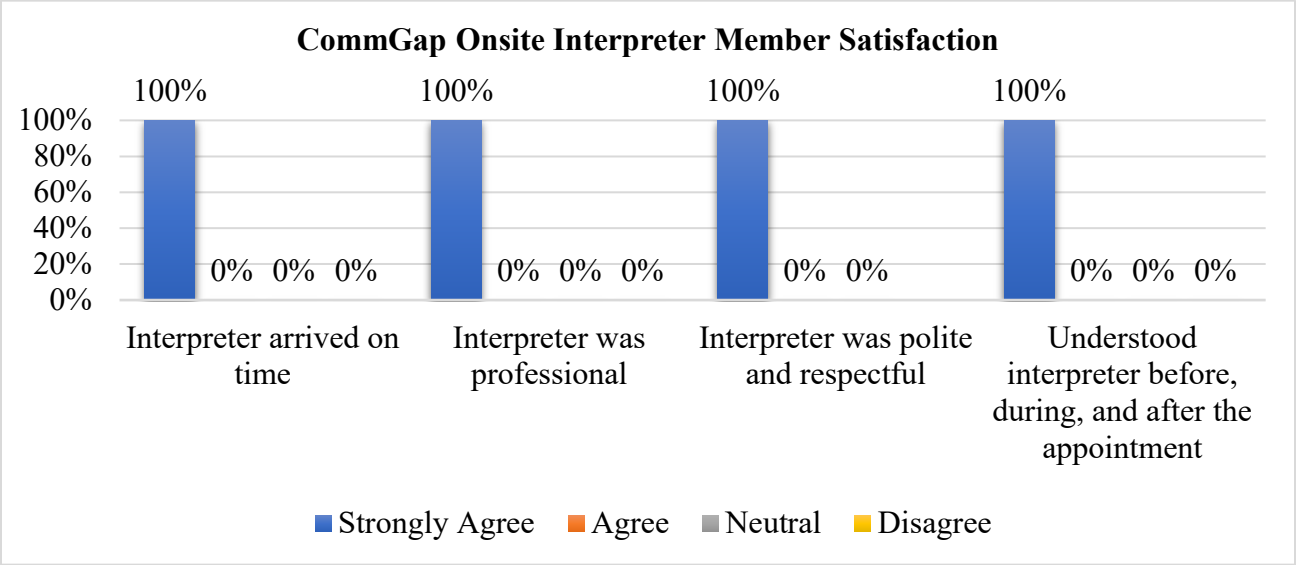
revealed that 98% of bilingual staff did not have difficulty communicating with members in a non-English language.

Note: Up to April 2025 we haven't received recording from calls made by VSP, data will be provided in Q2 of 2025.



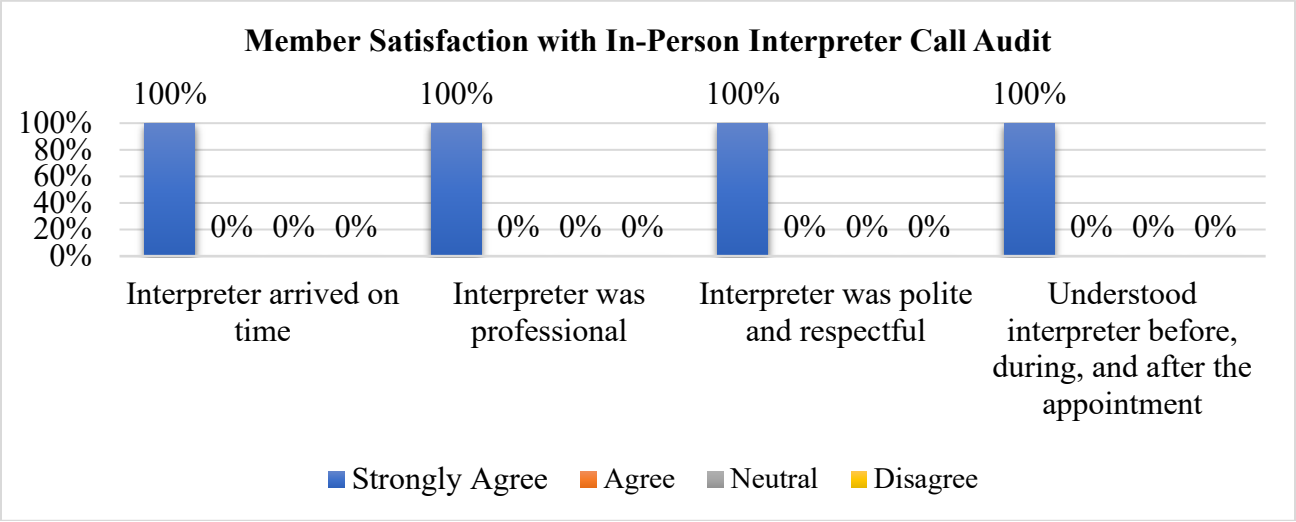
CommGap Onsite Interpreting Member Satisfaction Survey

During this quarter, an interpreter satisfaction survey was sent out by our vendor CommGap who surveyed 21 members after their onsite encounter with their provider. Of the 21 surveys sent out, 100% of respondents "Strongly Agreed" that they were satisfied with the interpreter services they received from the vendor.



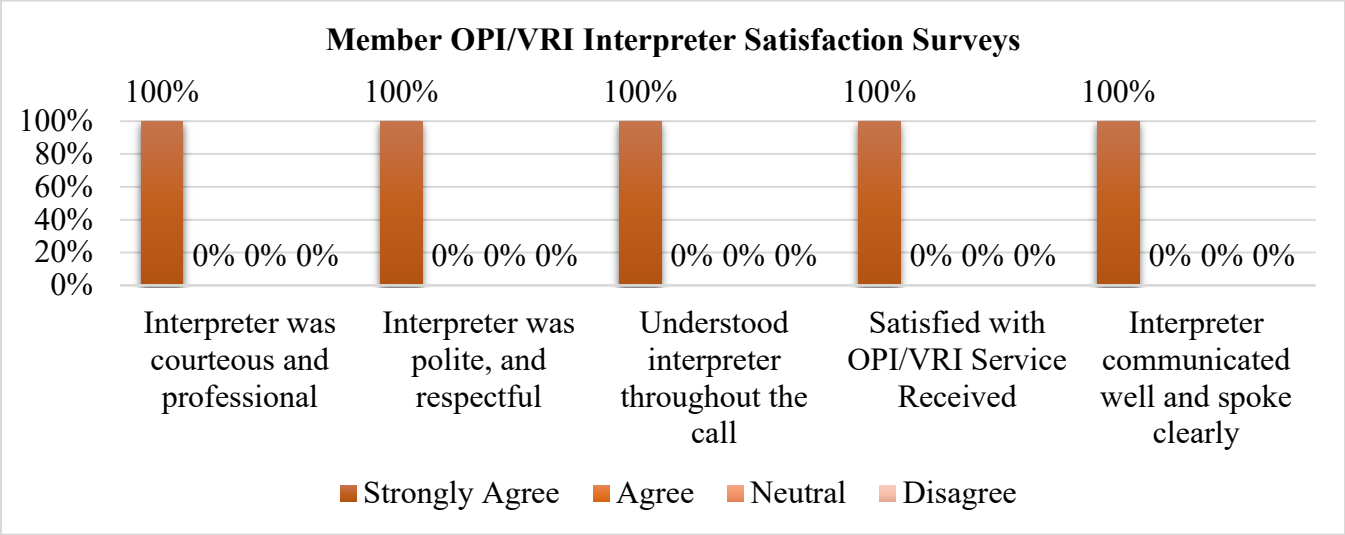
Member In-person Interpreting Satisfaction Call Surveys

During this quarter, a total of 31 satisfaction surveys were collected from members who received in-person interpreting services and more than 100% of members reported they "Strongly Agreed" being satisfied with their interpreter.



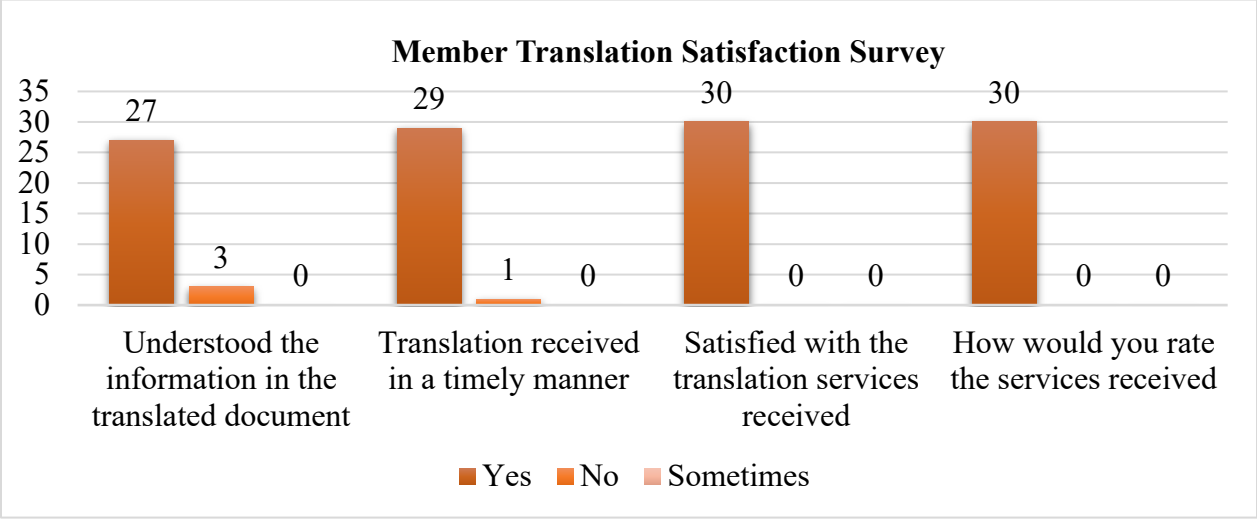
Member OPI & VRI Interpreting Satisfaction Call Surveys

During this quarter, a total of 31 satisfaction surveys were collected from members who received Over-The-Phone (OPI) and Video Remote (VRI) interpreting services. Of the 31 surveys, 28 responses were for OPI services, and 3 responses were for VRI services. The survey concluded with 100% of members reporting they "Strongly Agreed" being satisfied with the OPI/VRI interpreter services they received.



Translation Member Satisfaction Survey

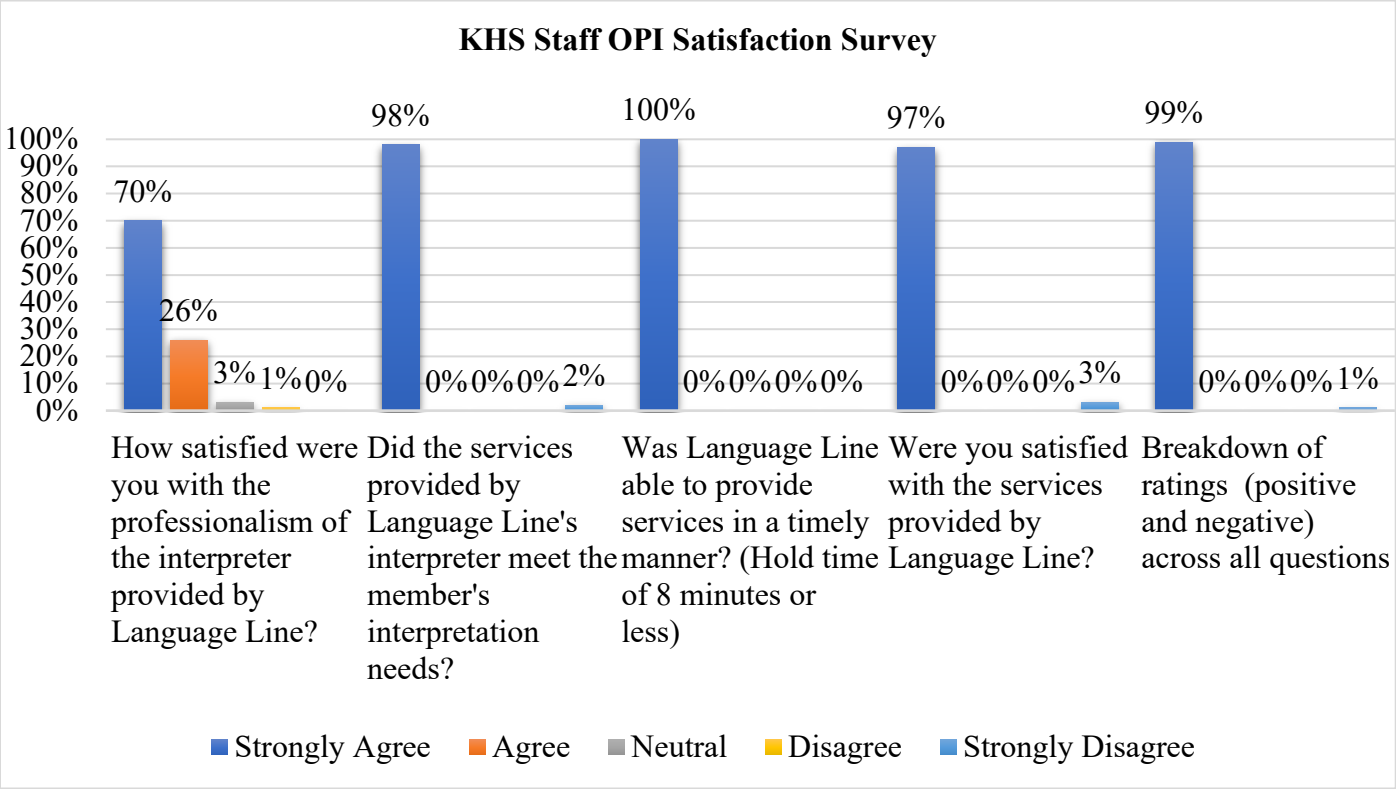
During this quarter, a total of 30 translation satisfaction call surveys were conducted for members who received a translation completed by C&L translators and by our vendor Language Line Solutions. This survey is to determine the members satisfaction regarding our translation services. Of the 30 calls completed, 96% of members were satisfied with the services received.



KHS Staff Satisfaction Over-the-Phone (OPI) Survey

During this quarter, a total of 110 surveys were received from KHS member facing department staff regarding their satisfaction with our vendor Language Line Services concerning over-the-

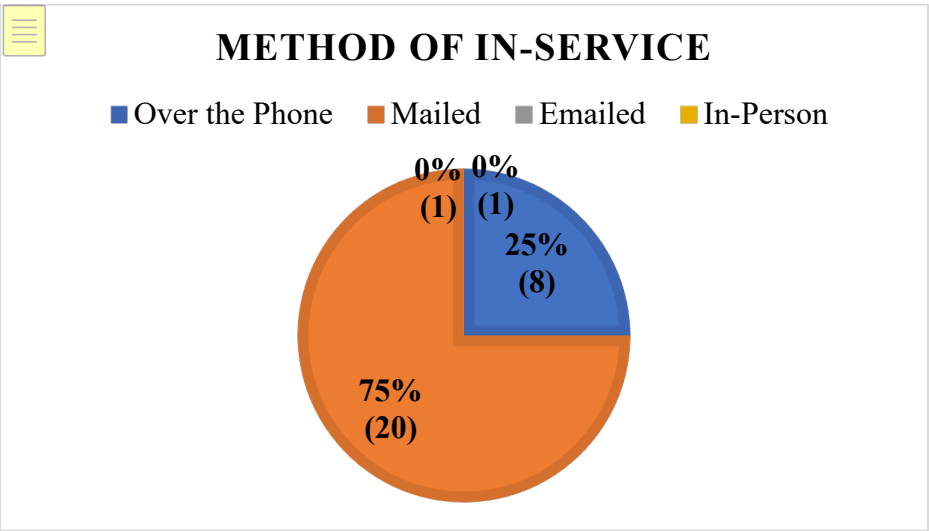
phone interpretation. Findings revealed that 99% of KHS staff are satisfied with the linguistic performance of our vendors' interpreters.



C&L Trainings

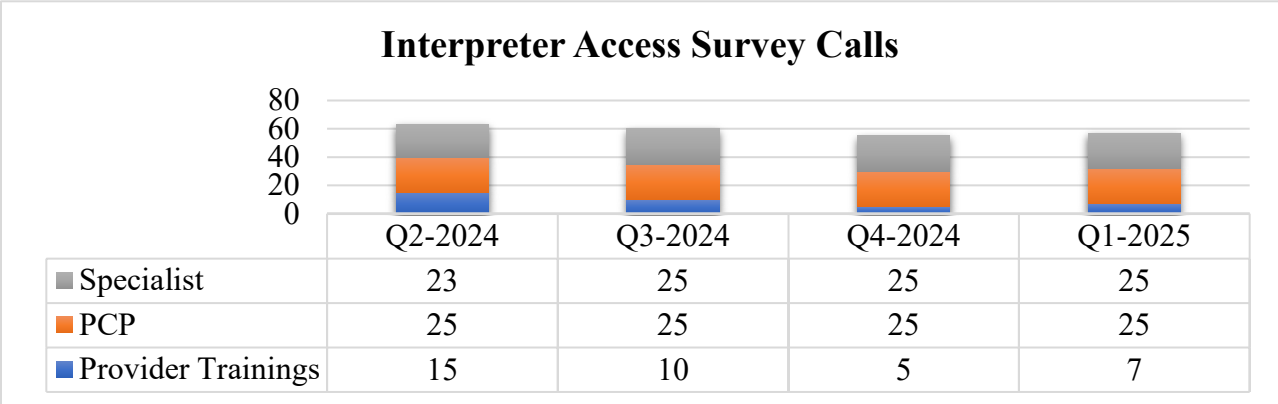
C&L Grievance Provider Trainings

During this quarter, 18 Cultural and Linguistic (C&L) related grievances were filed against providers contracted with Kern Family Health Care (KFHC) due to a lack of language access for members. For this quarter, 18 contracted providers were contacted, and a C&L Services in-service was provided. The C&L team conducted a total of 43 calls to these providers. These call attempts were tracked and marked either successful (provided an in-service over the phone or via providers 'preferred method) or unsuccessful (unable to reach someone or provider refused). Those that were successful were provided the in-service via telephone, mail, email, and/or in-person. Those that were unsuccessful were provided the in-service via mail.



Interpreter Access Survey Calls

Each quarter, the Provider Network Management (PNM) department conducts an interpreter access survey among KHS providers. During Q1, 25 PCPs and 25 Specialists participated in this survey. Of these providers, 1 needed a refresher training on KHS' C&L services.



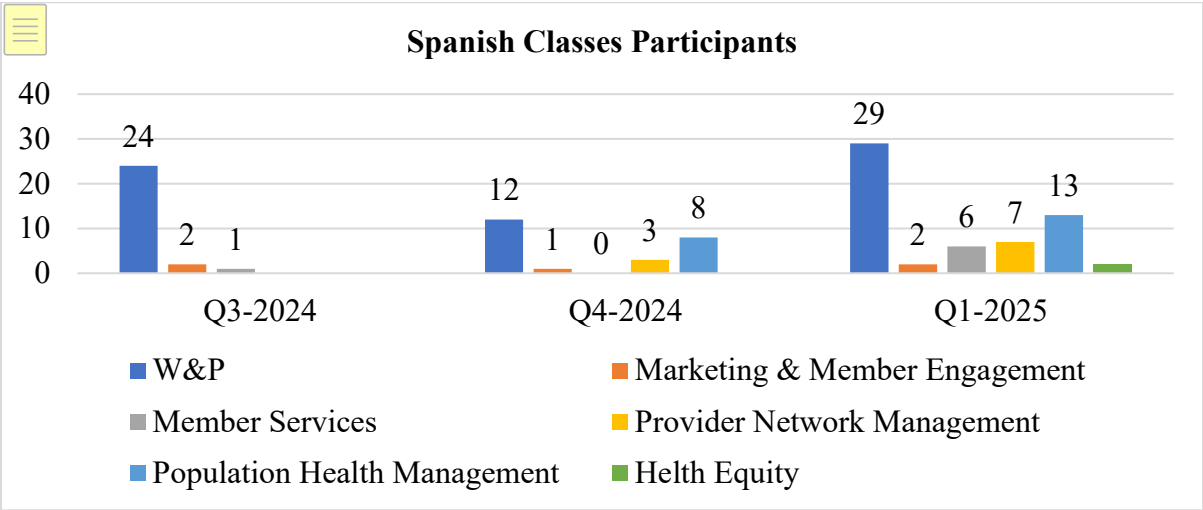
	Q2-2024	Q3-2024	Q4-2024	Q1-2025
Specialist	23	25	25	25
PCP	25	25	25	25
Provider Trainings	15	10	5	7

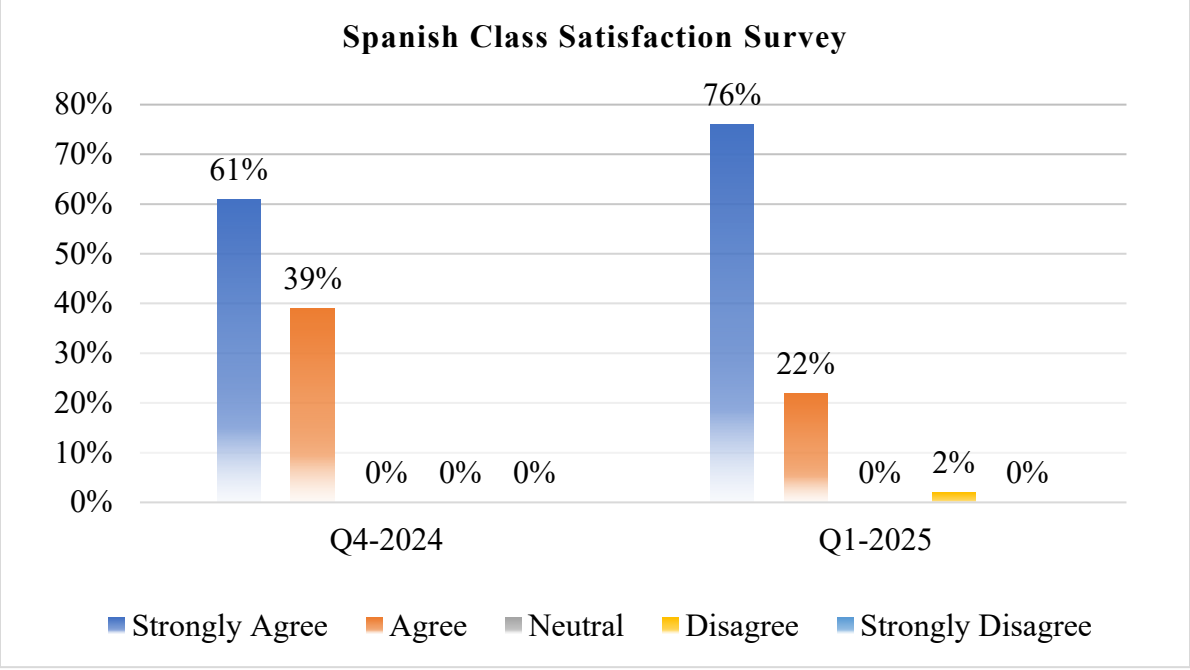
KHS Bilingual Staff Training

The C&L Department supports the professional development of all KHS internal staff, especially those who are bilingual, by offering a cycle of trainings to enhance their Spanish skills. During Q1 2025, two classes were held in person with a total of 52 participants, and one online class with 7 participants, employees that attended the classes were from several KHS departments such as MS, PHM, C&L, W&P, Member Engagement, and ECM.
The classes give participants the opportunity to practice the 4 skills in a language, including reading, writing, speaking and listening. For this quarter's classes, the topics covered were

medical terminology and verbs - part 1: conjugation basics (regular/irregular, present and future), in which participants completed listening, reading and writing exercises; as well as speaking activities where they had the chance to practice conversations using medical terminology, and the proper conjugation of verbs in Spanish.

Compared to the class offered in Q4, there was an increase of 28 attendees. During the classes, all attendees completed a pre and a post survey, which helps us understand their expectations as well as their satisfaction and areas of improvement for the class.





KERN HEALTH SYSTEMS

To: KHS EQIHEC

From: Pawan Gill, Health Equity

Date: June 17, 2025

Re: HEO/HETSC Update

Background:

Please find attached the updated version of the 2025 Health Equity Office Workplan for your review and approval.

This version reflects recent adjustments made to align with NCQA HE accreditation standards. Key updates include:

- Addition of completion dates for each activity.
- A new notes section to provide additional context or progress updates.
- Minor formatting changes to improve clarity and consistency

Additionally, we are seeking feedback on the Q1 Regional Access Committee (RAC) Report**.** This report formalizes the information previously shared in PowerPoint presentations and is designed to be a resource for multiple departments. It can be leveraged to support Population Needs Assessments, inform departmental workplans**,** and ensure that the qualitative feedback gathered through the RACs is meaningfully incorporated into organizational planning and improvement efforts.

Your review and approval of the updated workplan, as well as your feedback on the new RAC report format, are appreciated

Discussion Items:

- 2025 Updated Workplan
- 2025 Q1 RAC Report
- HEO/HETSC Updates - Presentation

Fiscal Impact: None.

Requested Action:
2025 HEO Workplan - review & approve.
2025 Q1 RAC Report - receive & file.
2025 HEO Department Updates - receive & file.

2025 Health Equity Office - Workplan

GOAL	OBJECTIVE	RESPONSIBLE PERSON(S)	ACTIVITIES/INTERVENTIONS	MEASURE(S)	TARGET DATE OF COMPLETION	PREVIOUSLY IDENTIFIED ISSUE	DATE COMPLETED	STATUS & DESCRIPTION OF STATUS
MEMBER DOMAIN (45%)								
Focus on member wellness, prevention, reducing health disparity and quality improvement/performance								
Create and maintain a comprehensive report of all organizational wide health equity related programs and interventions to better inform development of key programs and initiatives	Identify, track & report organizational wide, HE related targeted interventions/programs and develop effective tracking mechanism to capture and report health equity related programming	HEO Manager	Create tracking sheet of all targeted interventions including lead dept, focus population, etc.	HETSC reviews organization-wide targeted intervention and discuss engagement strategy for existing pro	12/31/2025	No		Presented draft at first quarter HETSC meeting for additional input
Enhance organizational workflows to improve the effectiveness of designed interventions in service of members	Create organization process flow that formalizes HEO engagement in initial design phase of developing targeted interventions or programs	HEO Manager in partnership with COSA & BI	Create template and process for launch of new health equity related intiatives	Completion of template; review at HETSC & EQIHEC	12/31/2025			Updated target date to Q4; Cosa restructure
Member Needs Assessment	Conduct an annual member needs assessment. Identified gaps in the provider network will be addressed through the recommendations of the Network Adequacy Committee.	Director of Provider Network Management	Run report to assess needs of members. Review with stakeholders. Adjust provider network as necessary.	Percentage increase of providers; # of findings taken to NAC	8/8/2025	No		Ongoing
Collection of Providers' Race/Ethnicity Demographic Data	Expand and increase data integrity and reportability related to the the Collection of Provider's Demographic data to enable more effective decision making	Director of Provider Network Management & HEO Manager	Run current report, identify areas of opportunity to validate & update existing data and expand data collection	# of providers with updated demographic collection categories, data sharing capabilities etc	9/30/2025	No		Ongoing
Share CLAS Progress with Stakeholders	Share CLAS progress with stakeholders, including obtaining MHC distinction	Sr Director of Wellness & Prevention	Share with Stakeholders		8/31/2025	No		Ongoing
Annual evaluation of the CLAS program	Conduct annual evaluation of the CLAS program	Sr Director of Wellness & Prevention	Share with Stakeholders Identify and address areas for improvement	# of actionable items taken to committee; # of actions taken to address gaps	12/31/2025	No		Ongoing
Improve tracking mechanism of grievances	Enhance current tracking mechanism to capture and easily report types of grievances (particularly discrimination related) and monitor regularly to identify trends	Complaints and Grievances Manager & HEO	Assess current report, add necessary columns and include in HESTC report	Create tracking mechanism with a minmum 2 year look back to establish initial tracking mechanism for grievances with a focus on HE	9/30/2025	No		Adjusted to Q3. Received log from MS; +ing to JIVA
Assessment of member experience with Language Resources	Assess baseline of member experience with language resources	Cultural & Linguistics Manager and HEO	Run Annual Report Share with Stakeholders Identify and address areas for improvement	# of actionable items taken to committee; # of actions taken to address gaps	12/31/2025	No		Ongoing, Q1 data collected.
PROVIDER DOMAIN (15%)								
Provide training, programmatic support and incentives ato provider network to ensure the delivery of quality care to all members								
Multicultural Practices Provider Survey	Assess provider cultural responsiveness. Additional goals and objectives with a timetable for implementation are documented in the C&L	Director of Provider Network Management	Conduct Survey Review results Adjust provider network and/ or address gaps	# of actionable items taken to committee; # of actions taken to address gaps	8/8/2025	No		in Process
Assess KHS Provider Network Language Capabilities	Assesss provider language capabilities to that of the KHS member language needs.	Director of Provider Network Management	needs of members. Review with stakeholders. Add to Provider Directory	By December 31, 2025, KHS will increase language access through translation and/or interpreter services to at least 20 events where specific language needs are determined.	12/31/2025	No		in Process
Provider Training on Language Resources	Offer KHS contracted providers access and availability of language assistance resources	Director of Provider Network Managementor/ Cultural & Linguistics Manager	Run report to assess needs of members. Review with stakeholders.	HEO to review current provider resources available to providers re: language assistance resources - expand current offerings	7/31/2025	No		annually, last completed July 2024.
Collection of Providers' Race/Ethnicity Demographic Data	Assess provider's race/ethnicity demographic profile to that of the member race/ethnicity profile	Director of Provider Network Management/Credentialing Manager	Assess race/ethnicity profiles of providers to members Review reports with stakeholders. Take corrective actions	Initial measurement: Meet with at least 2 districts; Once launched measures will be performance based on specific intervention	8/31/2025	No		Ongoing
COMMUNITY DOMAIN (25%)								
Build relationships and invest in communities & community based orgnzations (CBOs)								
HEO Regional Listening Sessions	Gather qualitative data directly from members and the community regarding their experience	Health Equity Office	Assess baseline of member experience for medical access, quality and trust	On an annual basis, conduct Regional Listening sessions in each of the 5 designated regions of Kern.	3/31/2025	No	4/2/2025	East - 3/11/25, North - 3/19/25, West 3/21/25, Central 3/25/25, South 4/2/25
Regional Access Committees's	Gather qualitative data directly from members and the community regarding their experience	Health Equity Office	Assess baseline of member experience for medical access, quality and trust	By December 31, 2024, a process will be implemented to track the organizational diversity of community partners outreached for each RAC.	12/31/2025	No		Assigned 2024 RAC Outreach Lookback 5/24
Develop Comprehnsive Community Investment Strategy	Assess KHS community investments to ensure equitable and effective use of organizational resources	Health Equity Office	Track, analyze and report community investments by activity (sponsorships, contracts, community grants programs), identify areas of improvement & address gap	By December 31, 2024, a process will be implemented to effectively track organizational investments in the community across departments.	12/31/2025	No		Tracking spreadsheet disseminated; working with Business Intelligence (BI) to create dashboard

Develop Comprehensive School Partnership Strategy	Assess KHS school partnership strategy to ensure equitable and effective use of organizational resources and maximize impact	Health Equity Office	Streamline and formalize educational partnerships with schools; co-create a strategy with district and multiple KHS depts on health initiatives	Initial measurement: Meet with at least 2 districts; Once launched measures will be performance based on specific intervention	11/30/2025	No		BCSD Meeting Dates 1/28/25, 4/11/25
EMPLOYEE DOMAIN (15%)								
Engage and develop employees with training, culture inititiaves, and state-mandated DEIB programs. Ensure employments practices are fair & equitable.								
Assessment of KHS Workforce Demographics	Analyze KHS workforce demographics	Health Equity Manager & HR	workforce activities. Review with stakeholders. Monitor workforce demographics for hiring		9/30/2025	No		Previous lookback completed 7/12/24
Diversity, Equity and Inclusion (DEI) Task Force Development	Development of the KHS DEI Task Force will serve as the stepping stone to mobilize efforts around implementation of DEI practices, policies, engagement, climate pulse checks, and training opportunities.	Health Equity Manager & HR	Solicit workforce participation for task force development Establish task force with regular occuring meeting schedule		At least quarterly	No	1/16/25 3/19/25 5/15/25	Monthly Meetings established
Organizational Climate Assessment	Conduct Annual Organizational Climate Assessment	Health Equity Manager & HR	Develop KHS Organizational Climate Assessment Tool in conjunction with HR Facilitate Organizational response to results	Launch of survey; survey participation	4/30/2025	No	4/1/2025	Employee Engagement - Trust Index Survey launched
Diversity, Equity and Inclusion (DEI) Training	Develop organization- wide divesity, equity and inclusion training curriculum	Health Equity Officer	Assess organizational training needs Create DEI Training Curriculum		3/31/2025	No	2/25/2025	DEI Cirriclum approval 2/25/25; TGI submitted & delivered; reviewing feedback for changes
Ensure Bilingual KHS Workforce	Maintain a bilingual Member Services Department workforce that is representative of 5% of the population	Director of Human Resources Director of Member Services	Maintain Member Service Staffing Share with Stakeholders Add to Qualified	Stated in goal	4/30/2025	No		Q2 Member Services has 54 of 123 staff certified bilingual employees that are bilingual (44%).
Bi-Lingual Staff Competency Assessment	Conduct Language Proficiency Test for all new bilingual applicants	Director of Human Resources Director of Member Services	Facilitate LPT Assessment Provide LPT assessment scores	% complete	5/31/2025	No		As of 5/12/2025 we have 141 certified bilingual employees which is 21% of our workforce (141/698 EE)
Staff Experience with Language Assistance Resources	Assess baseline of staff experience with language resources	Cultural & Linguistics Manager & Human Resources	Run Annual Report Share with Stakeholders Identify and address		12/31/2025	No		Ongoing, have completed Q1 data

Kern Family Health Care®

QUARTER 1

BEHAVIROL HEALTH

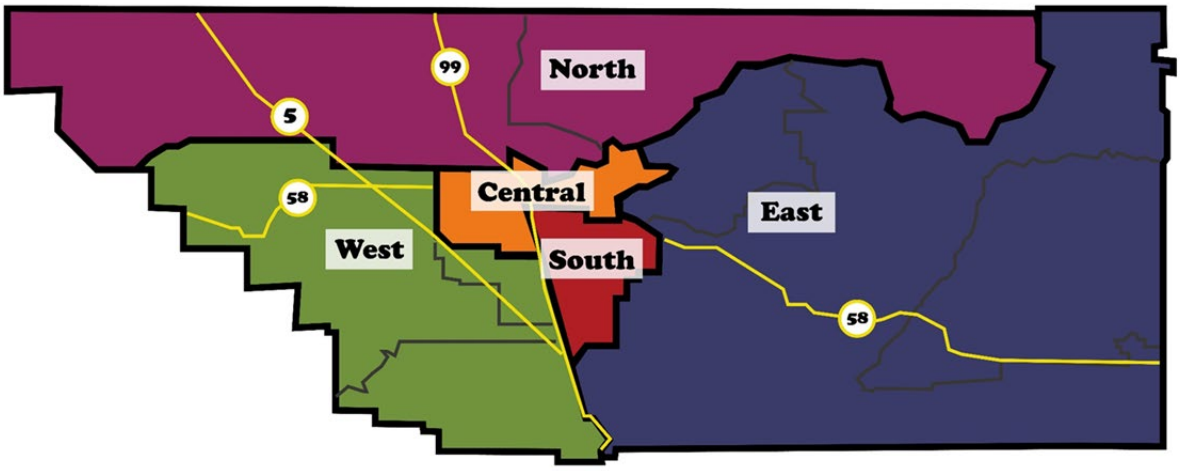
REGIONAL ACCESS COMMITTEES

Quarter 1 Meetings

The Regional Access Committees (RACs) are an opportunity to learn from and educate the communities of Kern County on topics impacting their health and lives. In the first quarter of the year, the topic was Behavioral Health. Each quarter a different topic is chosen and is presented and discussed in the five regions of the county. Every quarter a different city is chosen to represent the region.

In quarter one, the RACs were held in the following cities:

- North – McFarland on March 19, 2025
- East – California City on March 11, 2025
- South – Arvin on April 2, 2025
- West – Fraizer Park on March 21, 2025
- Central – California State University, Bakersfield on March 25, 2025



Each quarter a collaborative team from Kern Health Systems facilitates the RACs. The team includes members from the following departments:

Community Engagement

Cultural Linguistics

Health Equity

Member Engagement

Member Services

Behavioral Health

Each department provides an invaluable piece of the RAC. Community and Member Engagement teams provide the registration, childcare, and note taking during the meeting. The Cultural and Linguistic team provide Spanish interpretation/translation and coordinate interpreter/translation services for languages other than Spanish. The Member Services team provides the community an opportunity to address them membership needs while at the RAC with a live person. Health Equity coordinates each of the RACs and facilitates the meetings. As quarter one's topic was behavioral health, the Behavioral Health team provided a short presentation on what behavioral health is all about before the discussion began.

CALIFORNIA CITY

Date: March 11, 2025
Location: McFarland Middle School Gym
Attendees: 27
- 14 KFHC Members

Predominate Culture: White
Families: 20
Staff: 9
Department Presenter: Courtney Morris

The meeting began with a presentation by the Behavioral Health Manager, Courtney Morris, on what Behavioral Health is and KFHC's ability to provide this service to the community. A discussion was then facilitated by Anastasia Lester, Sr. Health Equity Analyst.

Behavioral Health (BH)

The first questions to the audience were to gage their understanding and utilization of behavioral health services. The audience understood what BH was and would access it through their primary physician. Ms. Lester provided a brief education on self-access and asked if BH services would be used in the community. The group was split.

> *"After [BH] services from KFHC, I got calls, emails, and texts to check and see if I was ok and needed any other services."*

Ms. Lester then asked about barriers to not access BH services. Some of the community responses were that there were no providers that looked like them, cultural barriers, privacy issues, transportation issues, and services not quick enough. A member of the audience educated the room about transportation services and how to access them for not only BH appointments, but all medical appointments. She was a KFHC member.

> *"Not feeling safe is a barrier."*

Telehealth Services

Ms. Lester asked the audience about the use of telehealth services in the community. The community stated they would be open to using the services, but Wi-Fi service was not good in the community. A suggestion of accessing this service at the Community Resource Center (CRC) was brought up and the community stated they would use the service there. Ms. Lester also shared the National Suicide/Crisis Hotline (988) for those who needed services immediately.

Community Behavioral Health Services

Ms. Lester asked if the community had an opportunity to have BH services, what did they feel they would benefit most from. The community stated education, more providers, stress counseling, trauma-informed counseling and mental health first responders.

> *"We need to model behavior, if we don't change culture, it will remain the same."*

Key Takeaways

- Don't want people to know – due to stigma
- Telehealth – digital divide
- Language barriers with providers
- Want providers that mirror the community
- Barrier – Safety - fear of info being used against them
- ** Community requested Mental Health First Aid training
- ** Community stated having BH services at CRC would be used

McFARLAND

Date: March 19, 2025
Location: McFarland Middle School Gym
Attendees: 13
- 10 KFHC Members
Predominate Culture: Hispanic
Families: 9
Staff: 7
Department Presenter: Melinda Santiago

The meeting began with a presentation by the Director of Behavioral Health, Melinda Santiago, on what Behavioral Health is and KFHC's ability to provide this service to the community. A discussion was then facilitated by Anastasia Lester, Sr. Health Equity Analyst.

Behavioral Health (BH)

The first questions to the audience were to gage their understanding and utilization of behavioral health services. Initially the group stated they had not used the services but more than 50% of the room stated they would be open to it. It was later found that people in the audience had used these services.

> *"I wouldn't use behavioral health services because how can I go to someone that doesn't understand me or speak my language."*

Ms. Lester than asked the group if they would share why they wouldn't use behavioral health services. Attendees brough up the issue of cultural differences, being looked at as crazy and the issue of privacy, since the community is small.

Accessing BH Telehealth Services

Ms. Lester then asked about the option of telehealth to get these services. The audience was open to the idea but were not sure what it was or how to access it. Ms. Lester provided a brief overview of telehealth services and explained that if someone can't wait for services that 988 (the National Suicide/Crisis Hotline) is always available to them 24/7. After the explanation, the audience felt in-person or telehealth were both good options depending on the needs of the person asking for services.

> *"I need [BH services] because my husband got a stroke, and I live stressed because I'm living with this. I feel alone, I don't want to get up, but I must because I must help my husband with everything, I get frustrated I don't say nothing to him because I don't want to stress him out. I ask God for patience."*

Teen Perspective

Ms. Lester asked permission to speak with the teens in the room. A young man stated that he goes to his school counselor for help when he is feeling pressure and stress. A young lady stated that these services don't have the same bad stigma at the school, and it is ok to talk to someone.

Conclusion

Ms. Lester concluded the discussion by asking the audience to share a takeaway from the meeting. Three of the attendees stated they would reach out and get help. One attendee stated they would support their child in getting help. Another attendee stated the meeting was amazing and that she was not alone in her feelings. The other attendees sharing they would be champions for this service to make it ok for others to reach out.

Key Takeaways

- Cultural Stigma (Hispanic Culture)
- Information shared about the family can be used against them
- Do not know how to access telehealth services
- Community stated they did not know BH was a covered benefit
- ** Community requested monthly conversations about health topics

FRAZIER PARK

Date: March 21, 2025
Location: Fraizer Park Library
Attendees: 18
- 10 KFHC Members

Predominate Culture: Hispanic
Families: 8
Staff: 10
Department Presenter: Melinda Santiago

The meeting began with a presentation by the Director of Behavioral Health, Melinda Santiago, on what Behavioral Health is and KFHC's ability to provide this service to the community. A discussion was then facilitated by Anastasia Lester, Sr. Health Equity Analyst.

Behavioral Health (BH)

The community stated that many people did not know about BH services and that they were part of their plan. A member stated that there are not a lot of providers and the stigma around looking for services is not supportive. There were five members in the room who stated they had experienced BH services and felt it was helpful and shared their stories. One shared that she continues to seek services when she is struggling. A couple of other members stated they would like to get services and felt that since others said it worked, that it might work for them.

> *"Now that I know, I would like to try it [BH] out. I think it would help me."*

Behavioral Health Barriers

The audience talked about how they would use BH services if there was not so many barriers. The barriers included: language, culture, finding trusted providers, fear of exposing themselves, keeping information private and transportation. Ms. Lester provided information on transportation to services, as well as how to request a specific language for services. Ms. Lester also shared information about the National Suicide/Crisis Hotline (988), so anyone who needs services immediately can access this 24-hour hotline.

> *"In a Hispanic home you can create bad habits, food disorders and therapy is not something you can do, but with this new generation, we need to be more proactive."*

Telehealth Services

Ms. Lester asked if the audience knew what telehealth services were and if they knew that BH service were included. The audience stated about 75% of the room understood what telehealth services were, but only about half the room would use it for BH services. When asked why, the audience stated there were issues with the Wi-Fi services and that people didn't trust the privacy from the community or the providers.

Key Takeaways

- Fear of exposing themselves
- Fear of community finding out – stigma
- Transportation to services
- Community Not aware BH was a telehealth option
- Digital Divide – otherwise would be open to telehealth
- Community isn't aware that this is a covered service
- Cultural stigma (Hispanic Community)
- Cultural stigma (Small Community)

CALIFORNIA STATE UNIVERSITY, BAKERSFIELD

Date: March 25, 2025
Location: CSUB, Dr. Herrera's Class
Attendees: 16
- 5 KFHC Members

Predominate Culture: Hispanic
Families: 0
Staff: 8
Department Presenter: Courtney Morris

The meeting began with a presentation by the Behavioral Health Manager, Courtney Morris, on what Behavioral Health is and KFHC's ability to provide this service to the community. A discussion was then facilitated by Anastasia Lester, Sr. Health Equity Analyst.

This audience were behavioral health professionals working in the field in Kern and neighboring counties.

Behavioral Health (BH)

Ms. Lester asked what led the class to choose behavioral health as their field of study. 90% of the students shared stories of their own personal experience in receiving help and wanting to that for someone else.

Telehealth Services

The class stated that more than 50% have used telehealth services. The class felt this was a good option for services and convenient. The class have seen that there is more supported retention of services. Some of the challenges are finding time, interpreters, and confidentiality.

Engaging the Community

The class stated the best ways to engage the community in receiving behavioral health services were through success stories, addressing barriers (such as transportation) and knowing the person you are sharing information with. The other issue being brought forth was addressing stigma.

> *"Just open-up during conversations with people. Word of mouth brings a lot more people to come to services."*

Stigma

To reduce stigma, the students felt it was important to work on getting the word out about how BH services have positively impacted people's lives. In addition, locate providers that look like and speak the language of the community they serve. Another suggestion was finding people who will champion BH work and share their story.

> *"To reduce stigma, there needs to be a lot of collaboration with churches, community partners, word of mouth, and being consistent with the message."*

Working with Youth

The students spoke about working with youth in the behavioral health field. Youth can struggle with being honest. One issue is that parents want something different out of their services than what the child wants. When working with youth, it is important to connect through the arts, music, hobbies, flexibility and patience.

Key Takeaways

- Barriers
  - Language
  - Privacy
- Telehealth Services - great when can be accessed
- Can be difficult for engagement
- Reduced Stigma by acquiring trusted partners
- Work with youth to help get adults on board
- Need for more providers (all types)

ARVIN

Date: April 2, 2025
Location: Bear Mountain Elementary School
Attendees: 23
- 10 KFHC Members

Predominate Culture: Hispanic
Families: 7
Staff: 8
Department Presenter: Melinda Santiago

The meeting began with a presentation by the Director of Behavioral Health, Melinda Santiago, on what Behavioral Health is and KFHC's ability to provide this service to the community. A discussion was then facilitated by Anastasia Lester, Sr. Health Equity Analyst.

Behavioral Health (BH)

The audience stated they understood what behavioral health was but not everyone had tried it. The audience asked questions about accessing these services. Ms. Lester answered the questions. The audience stated that getting services is something the community does secretly, if at all.

Stigma

The stigma of behavioral health services is the largest barrier stated by the audience. To reduce stigma, the audience suggested sharing real life stories by people that mirror the community. The audience also suggested a county wide slogan that could address the issues of cultural bias's and supporting the work of behavioral health. The message needs to clearly demonstrate that behavioral health services are for the whole family. If a message is created, radio is a great outlet for farmworkers. The audience also suggested making sure the public knew of their options for services and that the services are confidential and can be arranged to be held in private.

> *"Its not a matter of pride, it's a matter of health."*

Telehealth Services

Ms. Lester shared information about BH telehealth services and how to access it. Ms. Lester asked the audience if they would use telehealth services. The community stated that they would be open to it. One member shared his story of using the service and how it impacted him positively. Other members of the audience felt telehealth would be difficult because of privacy and cell service.

> *"I grew up not being able to share my feelings because I am a man, so telehealth would be a great option."*

Provider Challenges

Local community provider, Clinica Sierra Vista (CSV), spoke on the challenges of providing BH services. The no show rate is high, so walk-ins are welcome. CSV provides a reminder call for each appointment. The problem is that because of no shows there are limited providers, and it is difficult to acquire more when they are unable to ensure a full caseload if they contract with them. CSV stated they also provide telehealth service for those who were looking for more privacy or need other options for access.

Key Takeaways

- Cultural stigma (Hispanic Community)
- Did not know BH was an included service
- Barriers
  - Transportation
  - Digital Divide
- Telehealth – open to try
- Local CSV Provider stated the issue of timely service with no shows
- Community suggests promoting BH services in trusted areas:
  - Churches, Local Markets, Schools, etc.

**BAKERSFIELD AMERICAN INDIAN HEALTH PROJECT

Date: January 21, 2025
Location: BAIHP Office
Attendees: 9
Predominate Culture: Native American
Families: 0
Staff: 3
Department Presenter: Melinda Santiago

*** This was a special meeting held as a requirement for the Behavioral Health Outreach and Education Plan required by the Department of Health Care Services.

The meeting began with a presentation by the Director of Behavioral Health, Melinda Santiago, on what Behavioral Health is and KFHC's ability to provide this service to the community. A discussion was then facilitated by Anastasia Lester, Sr. Health Equity Analyst.

Behavioral Health (BH)

The community stated that there are different practices adopted in tribal practices and communities. The largest challenge to services obtained is having culturally trained providers. Culturally trained providers is defined as more than learning about Native practices, but immersing themselves in the culture, while understanding that each tribe is different and has its own culture.

> *"Our culture works on the basis of good medicine versus bad medicine."*

An elder in the discussion, stated that it is not a cultural norm to seek BH services, as a one-to-one meeting with a provider. Culturally, Native persons are more likely to share challenges in circles (Talking or Healing).

Talking or Healing Circles

> *"Talking circles are the socially acceptable way to share information and feelings."*

The audience described about these circles could be used to facilitate behavioral health discussions. Circles are a gathering of Natives, which are facilitated by a trusted member of the tribe. Some circles make Native regalia while sharing and socializing. These circles are used for healing; an elder stated that Native healing comes differently than non-native healing.

Telehealth Services

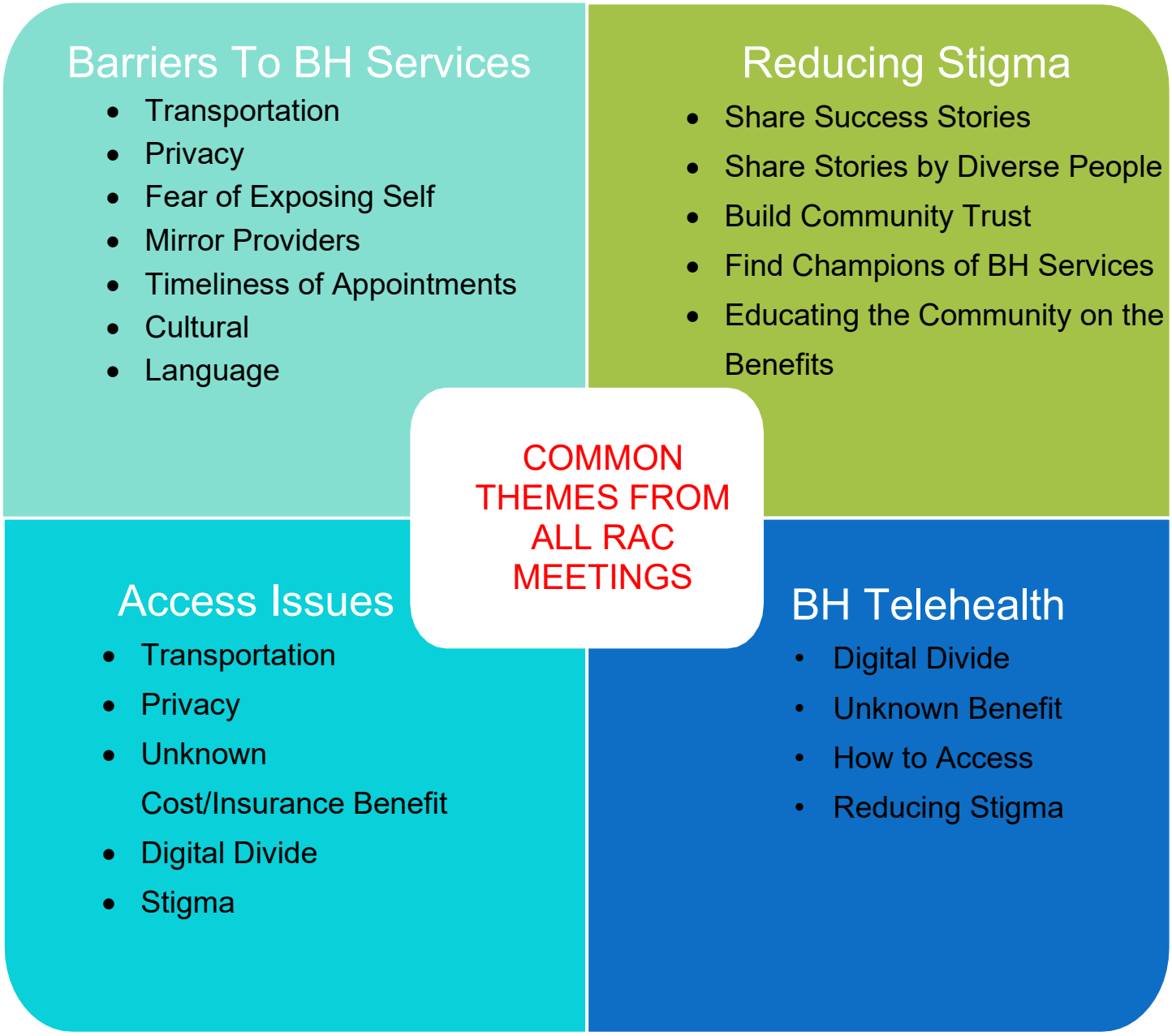
Ms. Lester asked the audience about their thoughts around BH telehealth services. The community stated that many of the tribes or reservations are not in the city limits and internet services are difficult to acquire. Even if the internet services were available, there is still an issue of knowing how to access the services and the use of technology to be able to have an appointment.

> *"Telehealth is not only an issue of how to use it, but also not having access to Wi-Fi, internet, or equipment."*

Key Takeaways

- Digital Divide
- Culturally Trained Providers
- Diversity in tribes
- Talking Circles
- Healing Circles (good vs bad medicine)
- Trusted Leader (champion)

REGIONAL OVERVIEW:



RECOMMENDATIONS:

EDUCATION

- What BH is
- Why BH is important
- How to Access Services
- Included Services
- Transportation Included

MARKETING

- Sharing Real-Life Success Stories around BH
    - Diverse Populations
- Telehealth Option
- Possible Slogan:
    - Not a Matter of Pride, It's a Matter of Health

NEXT QUARTER:

TELEHEALTH SERVICES

North – Lost Hills
Wonderful College Prep Academy
April 10, 2025

East – Ridgecrest
Salvation Army
April 30, 2025

West – Buttonwillow
Buttonwillow Union School
May 6,2025

South – Lamont
Lamont Elementary School District
May 7, 2025

Central – Oildale

- Cabinet Meeting
  Standard School District
  February 14, 2025

- DLAC Committee Mtg
  Standard School District
  March 12, 2025

- Parent Art Day
  Standard Middle School
  April 23, 2025

KERN HEALTH SYSTEMS

2025 HEO UPDATE

Pawan Gill
Health Equity Manager

June 2025

NCQA Health Equity Accreditation

- HEA Accreditation was submitted on June 10th, 2025
- Complex, multi-year effort that required an extraordinary level of coordination across departments, sustained attention to detail and unwavering commitment to excellence.
- This was more than a project – it was a true, organizational wide effort that required deep collaboration and a shared commitment to improving member outcomes by expanding data collection, process development, reporting and analytics and fortifying workplans and accountability measures.
- Preliminary issue report due July 3rd; final score anticipated in August

2025 Training Update

- TGI Training launched: Member Services, UM, Population Health Management, Enhanced Care Management, Community Supports & select QI staff. Over 92% have completed the training.

- DEI Pilot will roll out in Sept or October of 2025 for employees and then extended to all employees, providers, contractors and subcontractors.

EPT Update – Cycle 2 Milestones

- The EPT program is structured in six cycles (0-5) and uses milestones to monitor practice progress. Practices submit deliverables to demonstrate evidence of milestone achievement. Cycle 2 Milestones running from Nov 1, 2024 - May 1, 2025

- Our 12 EPT program participants earned $714,754 payments for 2024 deliverables. Payments were made using the new methodology required by CMS that removed D-SNP members from member counts.

- May 2025 – All 12 practices submitted the first set of 2025 milestones which are currently being reviewed by DHCS. We should receive

Other

- Doula Pearsuite Contract Finalized; 2 pilot Doula's onboarded
- DHCS APL 25-004 Community Reinvestment P&P Compliance Filing
- KHEP Access to Care Study completed
- BIMHI Conference
- 2nd Annual Sexuality & Gender Identity Healthcare Symposium – BC Renegade Event Center Friday, June 20th from 9 am – 3 pm
- Invited to join Intimate Partner Violence (IPV) Community of Practice to strengthen MCP's response to IPV to support survivors across behavioral, maternal and community health domains.

KERN HEALTH SYSTEMS

To: KHS EQIHEC Meeting

From: John Miller, M.D.

Date: June 17, 2025

Re: Quality Improvement Workgroup (QIW)

Background

The 2nd Quarter meeting of the KHS Quality Improvement Workgroup (QIW) took place on May 22, 2025. This committee reports to the Executive Quality Improvement Health Equity Committee (EQIHEC). Committee members include providers and representatives from the community. The meeting covered key updates on quality and safety initiatives, site review performance, appeals and grievances, NCQA accreditation progress, and Enhanced Care Management (ECM) developments.

Discussion

During this session, quorum was met.

1. Quality Performance Updates

- **MCAS MY2024 Preliminary Rates:** KHS demonstrated improvement in 16 of 18 measures, with 12 meeting the Minimum Performance Level (MPL), up from 8 in MY2023.
- **Site Review Enhancements:** A new QP Clinical Supervisor was added. The provider binder was updated with the MY2025 guide and coding references to ensure accuracy and compliance.

2. Quality of Service and Member Safety

- **QOC Grievances & PQI Trends:** No QOC issues required investigation. PQIs closed per 1,000 provider interactions are trending downward.
- **Audit Findings:**
  - 93% accuracy in IHA documentation from a 375-record sample.
  - Lead screening audit showed only 31% full compliance due to documentation gaps.

3. Readmissions Review

- 7 out of 10 reviewed readmission files lacked medication reconciliation and discharge documentation.
- All readmissions were unplanned.
- Action: PHM and UM collaborating to identify high-risk members requiring follow-up care. Data to be used in re-credentialing discussions.

4. NCQA Accreditation

- All required documentation was submitted. File review and closing conference were scheduled for May 27–28, 2025.
- **Update:** Based on review of the evidence provided against applicable standards & guidelines, the National Committee for Quality Assurance (NCQA) Review Oversight Committee has awarded Kern Health Systems the status of Accredited Effective June 10, 2025 for three years!

5. Enhanced Care Management (ECM)

- Over 11,500 members are enrolled across 41 ECM sites.
- 56% identify as Hispanic; site-specific survey results indicate high member satisfaction.
- ECM teams remain available for additional on-site support and performance review.

6. Cultural & Linguistic Services

- **Call Audits:** 99% bilingual call compliance; 100% compliance for OPI Interpreter Services.
- **Policies Approved:**
  - #11.23-I – Cultural and Linguistic Services
  - #11.26-I – Translation of Member Informing Materials

7. Member Wellness & Prevention

- 1st Quarter audit showed high satisfaction (97%) and strong class effectiveness.
- Two indicators fell below 50% for follow-up calls and calendar posting.
- **Policy Approved:**
  - #11.29-P – Community Health Worker

8. QI Work Plan Scorecard

- All 1st Quarter 2025 initiatives were reported as **complete** or **in progress** with no identified barriers.

Conclusion & Next Steps

- No additional issues were raised during the open forum.
- The next QIW meeting is scheduled for August 28, 2025

Fiscal Impact

None.

Requested Action

Approval of committee proceedings.

KERN HEALTH SYSTEMS

QUALITY IMPROVEMENT WORKGROUP (QIW) MEETING

Thursday, May 22, 2025
at
12:00 pm

2900 Buck Owens Blvd.
Bakersfield, CA 93308
2nd Floor - Bear Mountain Room

For more information, call (661) 664-5000

KERN HEALTH SYSTEMS

Quality Improvement Workgroup Subcommittee (QIW)
AGENDA – May 22, 2025

AGENDA ITEM	AGENDA TOPIC	PRESENTER	TIME	ACTION
CALL TO ORDER	Call meeting order / Attendance-Quorum	***Dr. Miller MD, KHS Medical Director, Chair***	*1 min*	*N/A*
APPROVAL OF MINUTES	March 7, 2025 Minutes	***All Voting Members***	*2 min*	*Approval*
OLD BUSINESS	1. Follow-up:	None		*Discussion*
NEW BUSINESS	1. Quality & Safety of Clinical Care a. MCAS b. PIPs c. FSR/PARs/Medical Records d. QOC Grievances & PQIs 2. Quality of Service a. Appeals & Clinical Network b. Readmissions Project 3. NCQA Accreditation 4. ECM Report 5. Cultural and Linguistics Monitoring Q1 6. C&L Policy Changes 11.23, 11.26 7. Member Wellness and Prevention Program Monitoring Q1 8. CHW Policy Changes 9. Workplan Scorecard – Q1	Kailey Collier, QP Dir Magdee Hugais, QI Dir Kalpna Patel, QI Sup Steven Kinnison, NCQA Mgr Dan Diaz, ECM Mgr Cynthia Cardona, C&L Mgr Cynthia Cardona, C&L Mgr Flor Del Hoyo Galvan, W&P Mgr Tiffany Chatman, W&P Mgr Magdee Hugais, QI Dir	*5 min* *5 min* *5 min* *5 min* *5 min* *5 min* *5 min* *5 min* *5 min* *5 min*	*Approval* *Approval* *Approval* *Approval* *Approval* *Approval* *Approval* *Approval* *Approval* *Approval* *Approval*
OPEN FORUM	Open Forum / Committee Members Announcements / Discussion	***Open to all Members***	*5 min*	*Discussion*
NEXT MEETING	Next meeting will be held Thursday, **August 28, 2025 at 12:00 pm**	Informational only		*N/A*
ADJOURNMENT	Meeting Adjournment	***Dr. Miller MD, KHS Medical Director, Chair***		*N/A*

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KERN HEALTH SYSTEMS

COMMITTEE: ***QUALITY IMPROVEMENT WORKGROUP***
DATE OF MEETING: ***MARCH 7, 2025***
CALL TO ORDER: ***12:01 PM BY JOHN MILLER, MD, QI MEDICAL DIRECTOR - CHAIR***

Members Present On-Site:	Dr. John Paul Miller, KHS QI Medical Director, Chair		
Members Virtual Remote:	Danielle Colayco, PharmD, Executive Director Komoto Carmelita Magno, Kern Medical Process Improvement Dir.	Dr. Joseph Hayes, MD – CMO Omni	
Members Excused=E Absent=A	Jennifer Culbertson, Director of Clinical Quality CSV (E) Dr. Irving Ayala-Rodriguez, CSV (E)		
Staff Present:	Cynthia Cardona, CEL Service Manager Kailey Collier, RN, Director of Quality Performance Michelle Curioso, Director of PHM Amy Daniel, Executive Health Services Coordinator Flor Del Hoyo Galvan, Manager of Member Wellness	Mary Jane Dimaano, QI RN I Dan Diaz, RN, ECM Clinical Manager Alma Garcia, NCQA Accreditation Specialist Yolanda Herrera, Credentialing Manager	Loni Hill-Pirtle, Director of Enhanced Case Management Magdee Hugais, Director of QI Steven Kinnison, NCQA Manager Greg Panero, PNM Analytics Program Manager Kalpna Patel, QI Supervisor

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Quorum	Attendance / Roll Call	Committee quorum requirements were not met.	N/A
Call to Order	Dr. John Paul Miller, KHS QI Medical Director called the meeting to order at 12:01 PM.		N/A
Committee Minutes	**Approval of Minutes** The Committee's Chairperson, Dr. John Miller, presented the December 12, 2024 meeting minutes for approval.	☑ **ACTION**: Dr. Hayes moved to approve minutes of December 12, 2024, seconded by Danielle. Motion carried.	3/7/25
OLD BUSINESS	**No Old Business presented.**		N/A
NEW BUSINESS	**Quality Improvement 2024 Evaluation, 2025 Program Description and 2025 Workplan** Magdee Hugais, Director of Quality Improvement, presented the	☑ **CLOSED**: Informational discussion only. ☑ **ACTION**: Dr. Hayes moved to approve the 2024 QI Evaluation,	3/7/25 003

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	2024 QI Evaluation, 2025 Program Description and 2025 Workplan. The following highlights were noted: • Quality of Clinical Care Metrics/Goal were all met except for 2. The 2-goals not met included "Timely submission of all 18 measures and meet MPL for all 18 measures" and Grievances/Appeals Timeliness of resolution within 30-calendar days resulted in a 76% result. • Opportunities for 2025 were shared to strengthen provider engagement strategies to improve compliance; enhance data analytics and timely reporting of concerns; expand access to preventive care and behavioral health services; address health equity challenges by scaling targeted interventions for high-risk populations. • 2025 QIHE Program Description was presented including mission, program overview, authority, organizational structure, roles and responsibilities, and program documents. • 2025 Quality Workplan was also presented outlining the program structure.	2025 Program Description and 2025 Workplan as presented, seconded by Danielle. Motion carried.	
	<u>Quality & Safety of Clinical Care</u> **MCAS** Kailey Collier, Director of Quality Performance presented the 4th Quarter 2024 MCAS 2024 vs. 2023 Comparison. The MCAS report was included in the presentation of the QI Annual Trilogy documents previously reported and approved. In the interest of committee time, the report was accepted as presented with no further discussion or questions from the committee members.	☑ **CLOSED**: Report received and accepted as informational with no additional discussion.	
	<u>Member Satisfaction Results</u> Lela Criswell, Member Engagement, presented 2024 Customer Satisfaction Survey findings. In 2024 Kern Health Systems again selected SPH Analytics, now under Press Ganey (PG), an NCQA-certified survey vendor, to conduct its Measurement Year (MY) 2023 Consumer Assessment of Healthcare Providers and Systems (CAHPS) 5.1 Medicaid Adult Survey. The objective of the CAHPS® study is to measure how well plans are meeting their members' expectations and goals, to determine which areas of service have the greatest effect on members' overall satisfaction, and to identify areas of opportunity for improvement to aid health plans in increasing the quality of provided care.	☑ **CLOSED**: Report received and accepted as informational with no additional discussion.	3/7/25

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	QUALITY OF SERVICE / APPEALS Kalpna Patel, QI Supervisor presented the Quality-of-Care Grievances and Potential Quality of Care issues for 4th Quarter 2024.	☑ **CLOSED**: Report received and accepted as informational with no additional discussion.	3/7/25

Quarter	Total Grievances Received for PQOC	Grievances Classified as PQOCs	Grievances Classified as Non-PQOCs	Total Grievances Closed
Q3 2024	1007	598	409	2755
Q4 2024	924	505	419	2355

Severity Level	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024
Level 0 - No Quality Concern	299	265	162	129	129	85	18	74
Level 1 - Potential for Harm	145	172	138	127	108	75	95	94
Level 2 - Actual Harm	2	4	2	2	0	2	0	2
Level 3 - Actual Morbidity	0	0	0	0	0	0	0	0
Total	446	441	302	258	237	162	113	170

Kalpna presented the following Appeals information:

	Q3 2024	Q4 2024
Member Request	247	184
Provider Request	107	66
Internally Generated	26	14
Total	380	264

Kalpna presented the following Claims/Disputes information:

	Q3 2024	Q4 2024
Inpatient	379	444
Outpatient	829	1050
Total	1208	1494

4th Quarter findings included:
Out of fifty-three **(53)** PCP Regions with compliant IHA that were audited, the following is the score range based on the findings:
• Eighteen (18) PCP region(s) received 100% overall score.
• Fifteen (15) PCP region(s) received 90-99% overall score.

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	• Nine (9) PCP region(s) received 80-89% overall score. • Eleven (11) PCP region(s) received 79% or below overall score Out of eighteen (18) PCP Regions with compliant Blood Lead Screening that were audited, the following is the score based on the findings: • Zero (0) PCP regions received 100% overall score • Zero (0) PCP regions received 90-99% overall score • One (1) PCP region received 80-89% overall score • Seventeen (17) PCP regions received 79% and/or less		
	NCQA Accreditation Steven Kinnison presented the 2025 NCQA Readiness Project Status Report. Project scope, schedule and budget/resources are all on track and teams are finalizing all evidence documentation in PDF, annotate and bookmarking. For HPA each workstream needs to achieve a passing score of 80% to attain accreditation and for HEA an overall passing score of 80%. Survey timeline was presented as well as NCQA "Lingo" for anatomy of a standard.	☑ **CLOSED**: Report received and accepted as informational with no additional discussion.	3/7/25
	Enhanced Care Management Dan Diaz, ECM Manager, presented the ECM 4th Quarter Report. Reporting ECM to the QIW committee provides an opportunity to highlight its role in advancing health and equity objectives within our healthcare organization. By prioritizing patient-centered care, interdisciplinary collaboration, health literacy, data-driven decision-making, and community engagement, ECM contributes to reducing disparities, improving outcomes, and fostering health equity for all individuals, regardless of race, ethnicity, socioeconomic status, or other social determinants of health. Through this discussion, we hope to give better line of sight to the committee key performance measures and our initiatives approach that demonstrate our alignment with the KHS vision for health equity for our members	☑ **CLOSED**: Report received and accepted as informational with no additional discussion.	3/7/25
	Cultural and Linguistics Monitoring 4th Quarter 2024 Cynthia Cardona, C&L Services Manager presented the C&L Monitoring for 4th Quarter Report. • Bilingual staff call audits 100% compliance with no difficulty communicating.	☑ **CLOSED**: Report received and accepted as informational with no additional discussion.	

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	• 97% of members were satisfied with the linguistic performance • 98% of bilingual staff did not have difficulty communicating with members in a non-English language • 100% of audited calls for OPI Interpreter Service met expectations. In the interest of committee time, the report was accepted as presented with no further discussion or questions from the committee members.		
	<u>Member Wellness & Prevention Program Monitoring 4th Quarter 2024</u> Flor Del Hoyo Galvan, W&P Manager, presented the Member Wellness and Prevention Program Monitoring for 4th Quarter Report**.** Areas at 100% • Class is starting on time • Member sign-in • Providing examples for topics, concepts, or myths • Explaining and doing all planned activities Areas below 50% • Covering SMART goals or objectives 100% of audited calls for OPI Interpreter Service met expectations. In the interest of committee time, the report was accepted as presented with no further discussion or questions from the committee members.	☑ **CLOSED**: Report received and accepted as informational with no additional discussion.	
	<u>Workplan Score Card 3rd & 4th Quarter 2024</u> Magdee Hugais, QI Director presented the Workplan Score Card for 3rd and 4th Quarter**.** The QI Workplan Scorecard for the third and fourth quarters was included in the meeting packet and has been updated with results.	☑ **CLOSED**: Report received and accepted as informational with no additional discussion.	
OPEN FORUM	**<u>Open Forum</u>** No additional questions or issues were presented for open forums.	☑ **CLOSED**: Informational only.	N/A

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
NEXT MEETING	Next meeting will be held Wednesday, May 22, 2025 at 12:00 pm	☑ **CLOSED**: Informational only.	N/A
ADJOURNMENT	The Committee adjourned at 1:00 PM. ***Respectfully submitted: Amy L. Daniel; Executive Health Services Coordinator***	**N/A**	N/A

For Signature Only – Quality Improvement Committee Minutes 03/07/2025

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____
Date Name

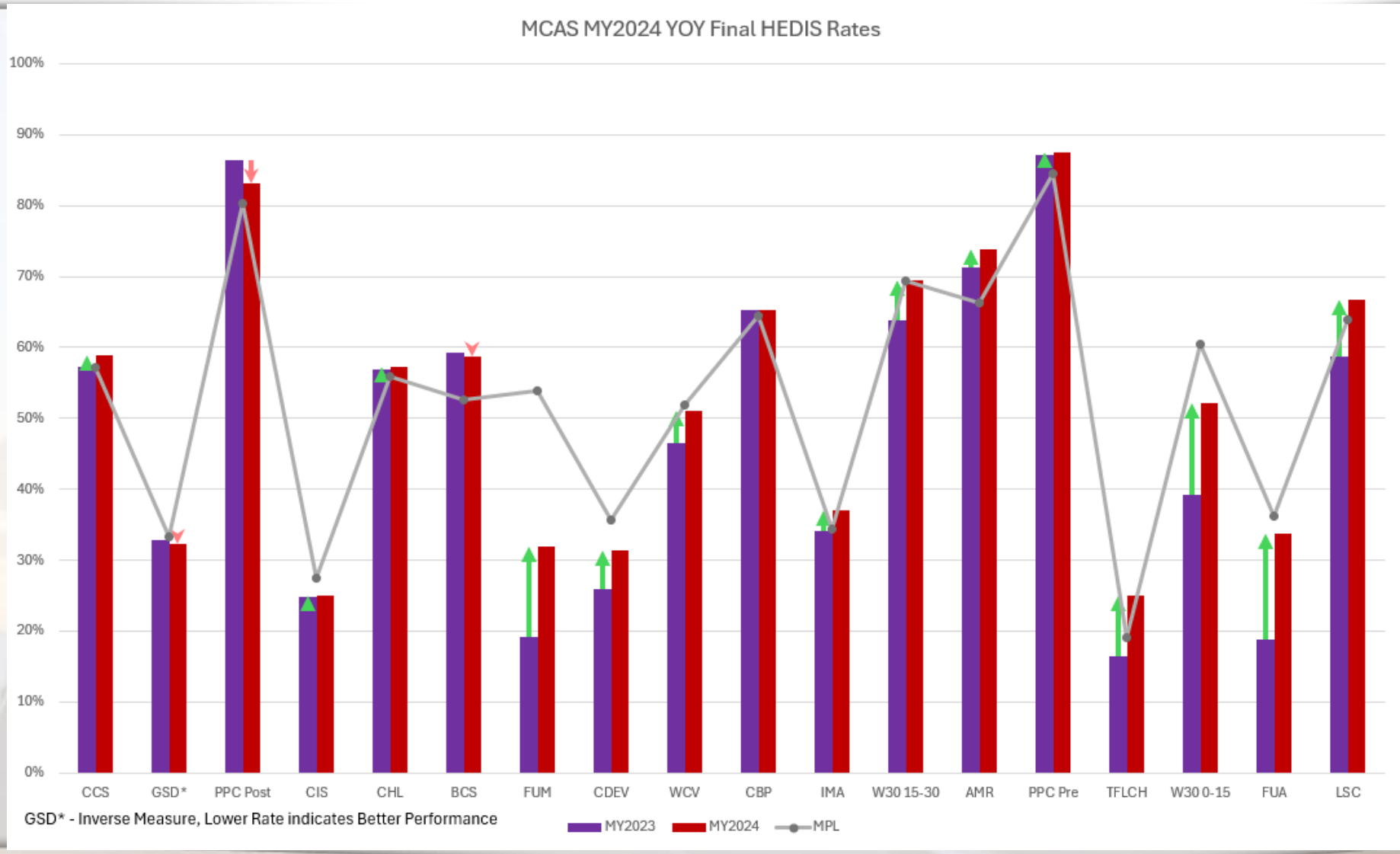
The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____
Date Name

Quality Performance

QIC Meeting
Presented by: Kailey Collier

Preliminary Rates for MY2024

- Meeting MPL for 12 of 18 measures compared to 8 of 18 measures for MY2023
- Improving in 16 of 18 measures
- Additional 4 measures in children's domain



MY2025 vs. MY2024 Trending Performance

14 measures are trending higher than the previous year at the same point in time.

GSD not accurately reflecting compliance

AMR	BCSE	CBP	CCS	CDEV	CHL Adults and Peds
76.06%	49.29%	40.67%	49.59%	18.95%	44.97%
HITS FOR MPL (99)	*HITS FOR MPL 653*	*HITS FOR MPL 7,327*	*HITS FOR MPL 4,892*	*HITS FOR MPL 2,261*	*HITS FOR MPL 899*
+1.06 % change	-0.79 % change	+7.47 % change	+8.68 % change	+3.16 % change	+5.01 % change
May'24 75.00%	May'24 50.08%	May'24 33.20%	May'24 40.91%	May'24 15.79%	May'24 39.96%

CIS	FUA 30 Day Follow-up	FUM 30 Day Follow-up	GSD HBA1C >9%	IMA	LSC
15.06%	20.74%	16.90%	94.05%	29.97%	72.04%
HITS FOR MPL 830	*HITS FOR MPL 87*	*HITS FOR MPL 131*	*HITS FOR MPL 14,008*	*HITS FOR MPL 361*	*HITS FOR MPL (547)*
+2.64 % change	+2.14 % change	+0.99 % change	-18.39 % change	+4.15 % change	+8.99 % change
May'24 12.42%	May'24 18.59%	May'24 15.91%	May'24 75.65%	May'24 25.82%	May'24 63.05%

PPC Post	PPC Pre	TFLCH	W30 0 - 15 Months	W30 15 - 30 Months	WCV
65.57%	62.03%	26.86%	33.84%	64.34%	17.66%
HITS FOR MPL 500	*HITS FOR MPL 769*	*HITS FOR MPL (13,123)*	*HITS FOR MPL 1,143*	*HITS FOR MPL 363*	*HITS FOR MPL 46,396*
+3.81 % change	+28.81 % change	+0.86 % change	-7.48 % change	+2.63 % change	-2.12 % change
May'24 61.76%	May'24 33.22%	May'24 26.00%	May'24 41.33%	May'24 61.71%	May'24 19.77%

MY2025 YTD Performance

- ✓ Meeting MPL for 3 measures
- ✓ Within 5% of MPL for 2 measures

AMR	BCSE	CBP	CCS	CDEV	CHL Adults and Peds
76.06%	49.29%	40.67%	49.59%	18.95%	44.97%
HITS FOR MPL (99)	*HITS FOR MPL 653*	*HITS FOR MPL 7,327*	*HITS FOR MPL 4,892*	*HITS FOR MPL 2,261*	*HITS FOR MPL 899*
MPL: 66.24% Over MPL by 9.82% AMR is not held to MPL.	MPL: 52.68% Under MPL by 3.39%	MPL: 64.48% Under MPL by 23.81%	MPL: 57.11% Under MPL by 7.52%	MPL: 35.70% Under MPL by 16.75%	MPL: 55.95% Under MPL by 10.98%

CIS	FUA 30 Day Follow-up	FUM 30 Day Follow-up	GSD HBA1C >9%	IMA	LSC
15.06%	20.74%	16.90%	94.05%	29.97%	72.04%
HITS FOR MPL 830	*HITS FOR MPL 87*	*HITS FOR MPL 131*	*HITS FOR MPL 14,008*	*HITS FOR MPL 361*	*HITS FOR MPL (547)*
MPL: 27.49% Under MPL by 12.43%	MPL: 36.18% Under MPL by 15.44%	MPL: 53.82% Under MPL by 36.92%	MPL: 33.33% Under MPL by 60.72% Inverted Measure	MPL: 34.30% Under MPL by 4.33%	MPL: 63.84% Over MPL by 8.20%

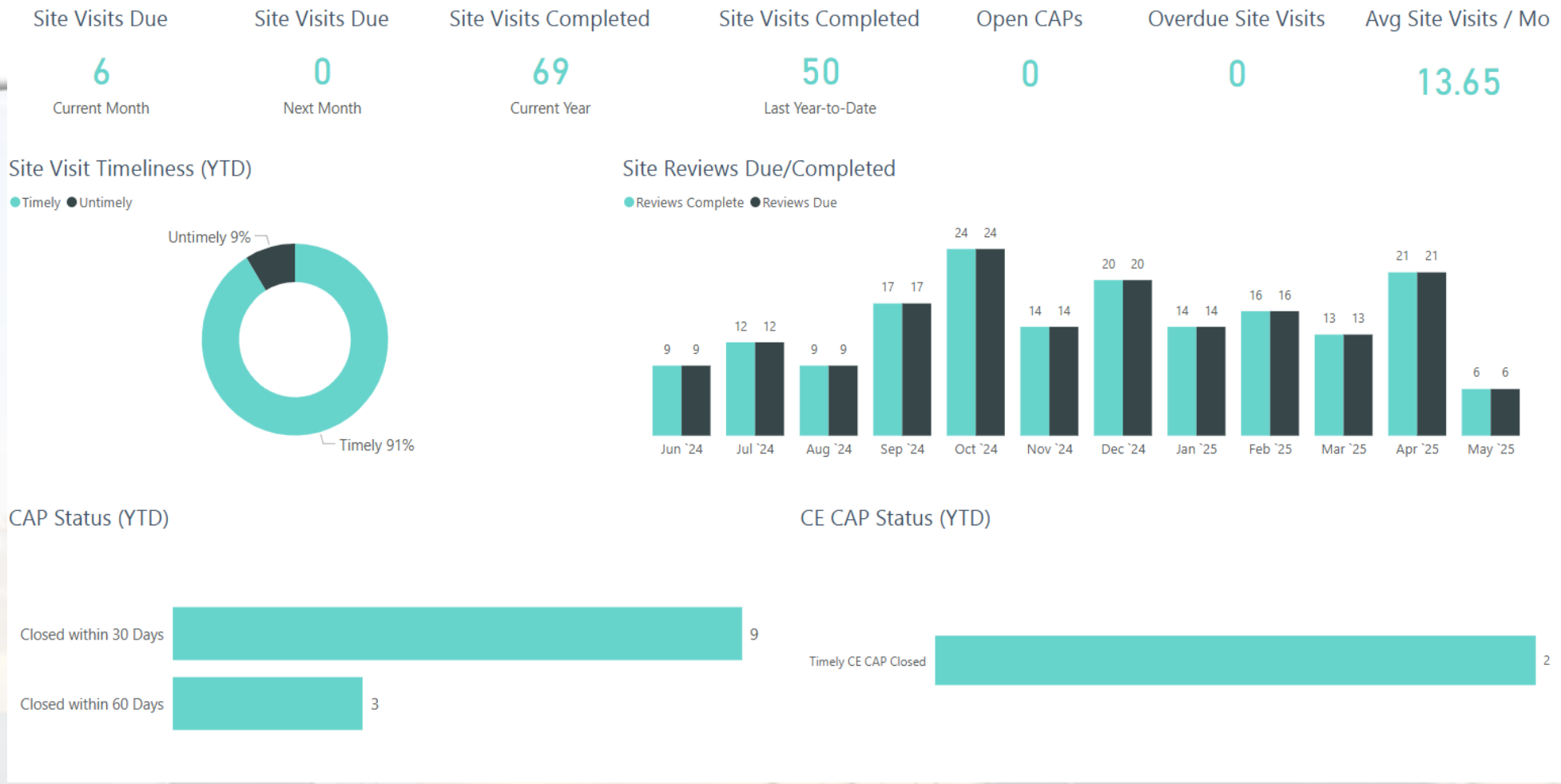
PPC Post	PPC Pre	TFLCH	W30 0 - 15 Months	W30 15 - 30 Months	WCV
65.57%	62.03%	26.86%	33.84%	64.34%	17.66%
HITS FOR MPL 500	*HITS FOR MPL 769*	*HITS FOR MPL (13,123)*	*HITS FOR MPL 1,143*	*HITS FOR MPL 363*	*HITS FOR MPL 46,396*
MPL: 80.23% Under MPL by 14.66%	MPL: 84.55% Under MPL by 22.52%	MPL: 19.00% Over MPL by 7.86%	MPL: 60.38% Under MPL by 26.54%	MPL: 69.43% Under MPL by 5.09%	MPL: 48.07% Under MPL by 30.41%

**GSD reflecting inaccurate compliance rate*

Site Review Updates & Highlights

- QP Clinical Supervisor assigned for Site Review team
- Evaluation process established for Site Reviews to ensure accuracy and compliance
- Tools & Standards, as well as new provider type requirements to be updated June 2026
- DHCS Facility site review oversight audits have been put on hold -TBD
- Poster created for CBP with the six rules to correct a blood pressure for PCP offices to increase compliance rates. Anticipate completion by summer 2025
- Coordination with QI to ensure CSRs prioritize adequate education for providers who have performed below expectations on oversight audits by QI team.
- Provider binders updated to include MY2025 provider guide and coding card for consistency and ease of reference

NEW!



- 2025 YTD - 69 completed reviews compared to 2024 YTD - 50 completed reviews
- Q1 47 reviews completed with 92% pass rate
- Q2 22 reviews completed with 100 % pass rate of 90% or higher
- No open CAPs

For additional Information, please contact:

Kailey Collier, Director of Quality Performance

Quality Improvement Department

The purpose of this report is to provide a quarterly summary of the activities and outcomes for the QI department. It provides a window into Quality-of-Care Grievances and Potential Quality of Care Issues and serves as an opportunity for programmatic discussion and input from the EQIHEC Committee members. Areas covered in the report include:

Contents

1. Grievances and Quality-of-Care (QOC) Classifications
2. Potential Quality Issue (PQI) Notifications
3. Appeals
4. Claims & Disputes
5. IHA Audit
6. LSC Audit
7. Grievance Classification Audit
8. Readmissions
9. Telehealth

Quality Improvement Department

Grievances identified as potential QOC are referred to the Quality Improvement Department for further classification. The QI RNs classify grievances received as Potential QOC for further review, or send back to Grievance coordinators as non-PQOC. Grievances classified as Potential QOC are reviewed and can be closed in favor of the member and referred to the QI Department for further investigation as a Potential Quality Issue (PQI). Potential QOC grievances resolved in favor of the provider are not referred to QI, as this resolution means there was no QOC concern identified to warrant further investigation.

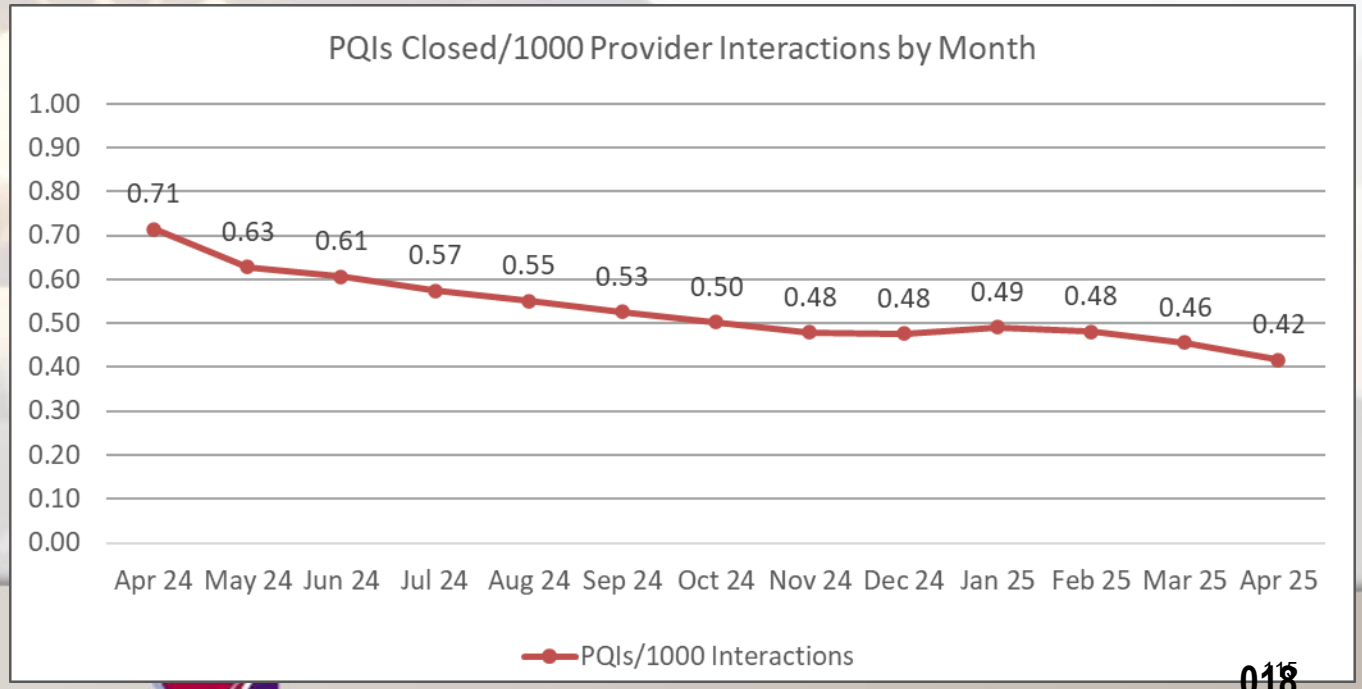
Quarter	Total Grievances Received for PQOC	Grievances Classified as PQOCs	Grievances Classified as Non-PQOCs	Total Grievances Closed
Q3 2024	1007	598	409	2755
Q4 2024	924	505	419	2355
Q1 2025	659	444	215	3006

Quality Improvement Department

Potential Quality Issues (PQI): QI receives notifications from various sources to review for PQI notifications. On receipt of a PQI notification, a QI RN completes a high-level review to determine what level of Potential Quality Issue exists. PQIs are assigned a level based on the outcome of the review.

- Level 0 = No Quality-of-Care Concern - No action taken
- Level 1 = Potential for Harm - Follow-up = Track and trend the area of concern for the specific provider. The Medical Director may provide additional actions that are individualized to the specific case or provider.
- Level 2 = Actual Harm - Follow-up = Corrective Action Plan plus direction from Medical Director or their designee which is individualized to the specific case or provider
- Level 3 = Actual Morbidity or Mortality Failure - Follow-up = Corrective Action Plan plus direction from Medical Director or their designee which is individualized to the specific case or providers

Severity Level	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025
Level 0 - No Quality Concern	129	85	18	74	73
Level 1 - Potential for Harm	108	75	95	94	71
Level 2 - Actual Harm	0	2	0	2	0
Level 3 - Actual Morbidity	0	0	0	0	0
Total	237	162	113	170	144



Quality Improvement Department

Appeals

- Grievance team receives an appeal for denied or modified adverse determination on prior authorizations. Clinical team reviews for medical necessity and sent to Medical Director (MD) for final determination and resolution.

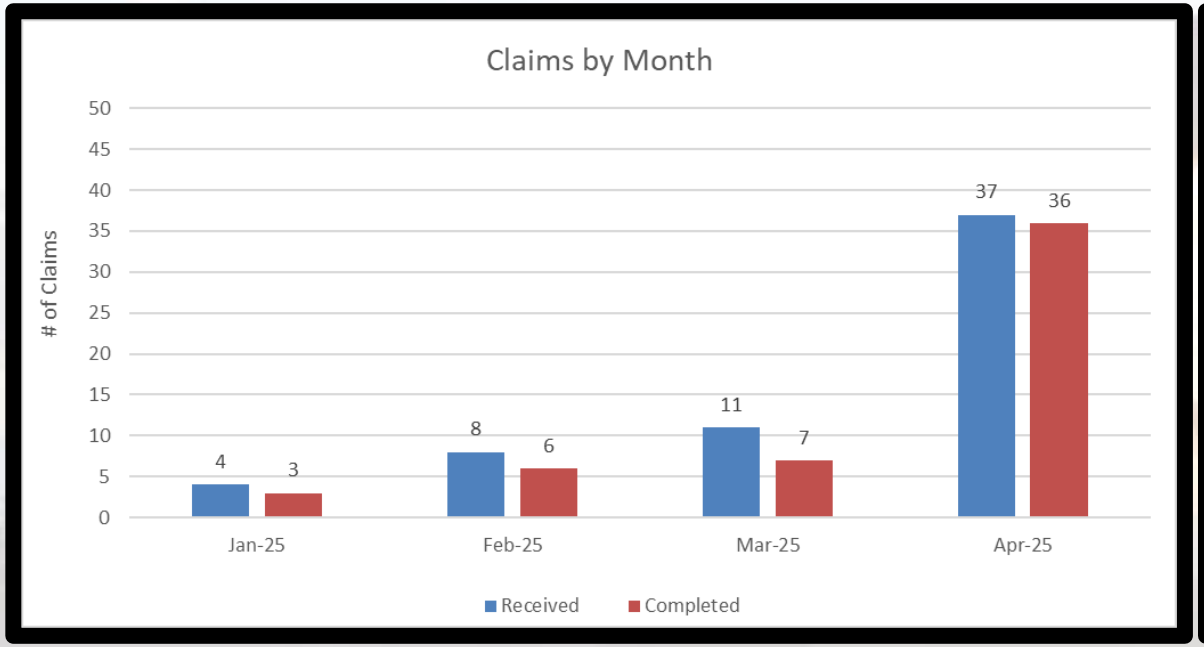
Month	Appeals Completed	Appeals Upheld	Appeals Overturned	% Overturned
Jan 25	59	39	20	34%
Feb 25	71	41	30	42%
Mar 25	59	44	15	25%

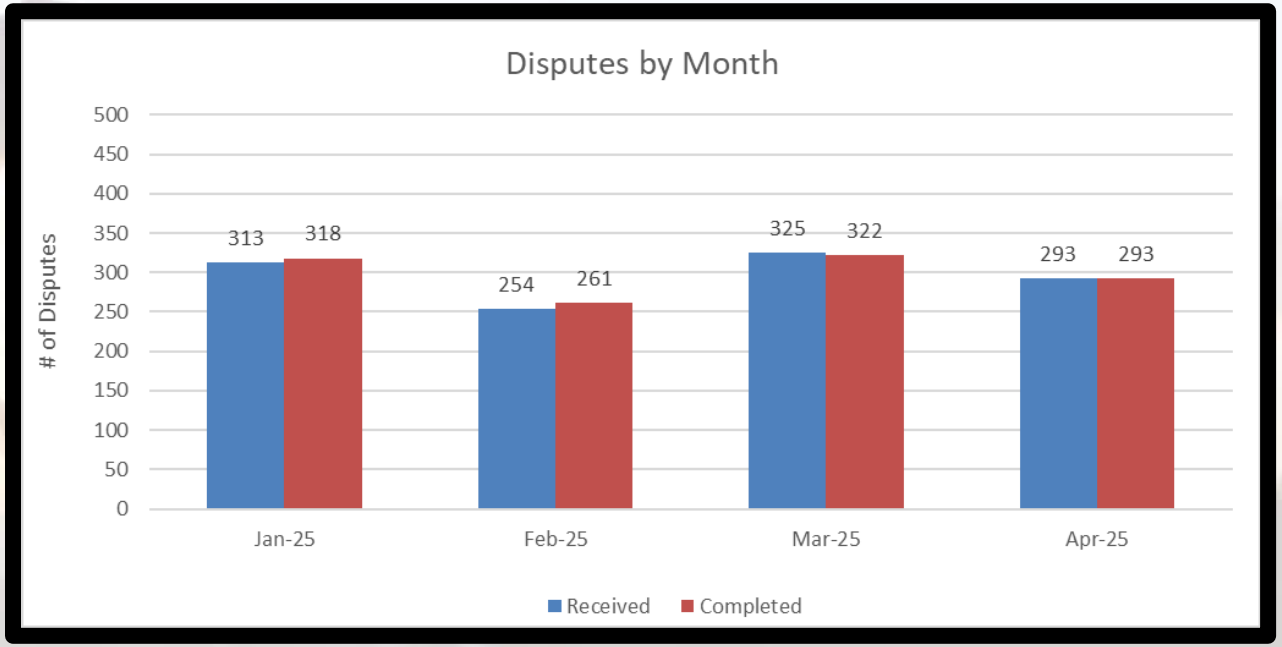
Month	Average TAT (days)	Completed Over 30 (TAT) days
Jan 25	20	3
Feb 25	20	8
Mar 25	17	0

Quality Improvement Department

Claims & Disputes

- Providers submitted denial of payment on claims to the claims departments and disputes on payments, Clinical team reviews each claim or dispute for medical necessity and provides information to claims department to authorize payments.





Quality Improvement Department

Initial Health Appointment Audits

Quarter 1 2025 Findings:

- Sample Size Audited: 375
- Total Members with Compliant IHA: 3,790
- Total PCP Regions Audited: 44
- Accuracy Rate: 93%

Performance Breakdown:

- PCPs scoring 100% = 23
- PCPs scoring 90–99% = 10
- PCPs scoring 80–89% = 7
- PCPs scoring below 80% = 2

Common Issues Identified:

- Missing preventive services assessments (e.g., immunizations, mammograms).
- Lack of health education documentation.
- Incomplete history of physical and/or mental health.
- Missing risk identification.
- IHA not completed within 120 days or not documented per policy.

Quality Improvement Department

Lead Screening in Children Audits

Quarter 1 2025 Findings:

- Total Records Reviewed: 153
- Total PCP Regions Audited: 22
- Fully Compliant Records: 48
- Accuracy Rate: 31%

Performance Breakdown:

- PCPs scoring 100% = 0
- PCPs scoring 90–99% = 1
- PCPs scoring 80–89% = 2
- PCPs scoring below 80% = 18

Common Issues Identified:

- Missing 12- and 24-month lead screenings.
- No documentation of lead prevention guidance.
- Missing test results or refusal forms.

Quality Improvement Department

Grievance Classification Audit

- Total Grievances Reviewed: 50
- Accuracy Rate: 100%

Issues Identified:

- None.

Audit Goal:

- Ensure grievances were accurately classified as “exempt.”

READMISSION

Activity #1:

Methodology:

- Using the inpatient census report, perform chart review of randomly selected readmission cases.

Purpose:

- To identify root causes of readmission.
- To reduce readmission rate.

Measurable Goal:

- HICE UM data: 2024 12.72%
- _____ 2025 (please provide 2025 goal)

Frequency of audit:

- Quarterly review of 10 records

Team Involved:

- KHS QI Specialist / Provider Clinical Oversight team

Readmission

Exclusions:

- Readmission greater than 31 calendar days from the last discharge
- Readmissions that are only an observation stay and do not involve actual hospital admission
- Scheduled readmission episode as planned course of treatment, such as cancer
- Transfer to another hospital with no break between discharge and admission between hospitals
- Member signed out against medical advice (AMA)at the original discharge
- Transfer from out of network to in-network facilities
- Admission is related to behavioral health conditions, e.g., substance abuse, BH -related conditions)
-

Exclusions (cont'd)

- Readmissions due to malignancy (limited to those who are in an active chemotherapy regimen, burns or cystic fibrosis
- Readmissions due to bone marrow transplants
- OB readmissions
- Neonatal and infants
- Transfer of patients to receive care not available at the first facility
- Skilled nursing and rehab facilities

RESULTS

- A total of 10 files were reviewed in the first quarter.

Criteria	Qtr 1
Evidence of medication reconciliation or discharge instructions	7/10
UM referral to case management or PHM	4/10 PHM source: 8 cases had referral to PHM/CM (3) /TOC (3); (2)-declined
Referral to behavioral health	0/10 PHM source: 8 cases referred
Referral for home health assessment	4/10 PHM source: CHW conducts home visits on members not reached by phone *members can be referred to home health without prior authorization

Other Findings (PHM source):

1. No evidence of follow-up from PHM after unsuccessful attempts after referral to PHM or CM.

2. No evidence that PCPs received copies of discharge summaries.

3. All readmissions were unplanned.

4.Medication reconciliation in discharge summary was not done on all patients

5. Unable to verify status on patients referred to TOC clinic.

6. (1) case with 2 readmissions had no evidence of referral to PHM or home health .

7. 7 cases had history of alcohol and substance abuse.

Actions Taken:

On 4/21/25, the team met with PHM Director, along with the Medical Director, QI Director: presented highlights of the PHM Programs and other related policies to support collaborative efforts with UM concurrent and other departments.

PHM is collaborating with UM to identify cases that need intensive follow-up care versus transition of care, high risk vs those that only need education.

#2: Identification of Potential Quality of Care Issue Utilizing Readmission Data

Methodology:

- Using the inpatient (readmission) census report, perform chart review of randomly selected readmission cases.

Purpose:

- To identify any trends in quality-of-care issues
- **Frequency of audit:**
- Quarterly review of 50 records

Team Involved:

- KHS QI Specialist & Medical Director

Identification of Potential Quality of Care Issue Utilizing Readmission Data

PQI Levels:

PQI Level	Description	Follow-up Action
0	No QOC- no lack pf evidence, documents, and/or information to open a PQI case	Closed
1	Potential for Harm: substantiated PQI with documented evidence or possible member injury or harm. Member will be able to recover fully from possible injury/harm with no limitation.	Track and trend the area of concern for the specific provider, and the CMO or their designee or their designee may provide additional actions that are individualized to the specific case or provider
2	Actual Harm: is substantiated PQI with documented evidence or suspected Member inquiry or harm. Injury may be: a). Minor with minimal adverse effects to the Member but is able to recover with minor limitation; or b). Major with major adverse effects or permanent residual effects but is able to recover with some limitation(s).	Implement a Corrective Action Plan plus direction and guidance from CMO/ PAC or their designee that is individualized to the specific case or provider. A. **(Refer to Section- IV. Procedures: B " Processing PQI Referrals" of this policy for more detail)s**
3	Actual Morbidity or Mortality Failure: substantiated PQI with documented evidence or suspected Member injury or harm with a very serious negative outcome Injury presented with permanent disability or mortality	Implement a Corrective Action Plan plus direction from CMO or their designee or their designee that is individualized to the specific case or provider.

Identification of Potential Quality of Care Issue Utilizing Readmission Data

2025 Q1 Result

Month	Level 0	Level I	Level II	Level III	Met exclusion criteria
Jan	18	1	0	0	1 - f
Feb	17				1- b 1- c 1- f **Total= 3**
Mar	8				**2**-f
Total	**43**	**1**	**0**	**0**	**6**

Identification of Potential Quality of Care Issue Utilizing Readmission Data

Exclusion Criteria: Readmissions excluded form review for a potential quality of care concern include the following:

a. Readmissions are only an observation stay and do not involve actual hospital admission.
b. Schedueld readmission as part of a planned curse of treatment such as cancer chemotherapy.
c. Transfers from out of network to in-network facilities.
d. Obstetrical admissions.
e. Member signed out ‘Against Medical Advice” (AMA) at the original discharge.
f. Behavioral health readmission.
g. Transplant related readmissions.
h. Transplant related readmissions.
i. Readmissions are associated with major or metastatic malignancies, opportunistic infections related to HIV, major trauma or poisoning

Identification of Potential Quality of Care Issue Utilizing Readmission Data

Follow-up Action:

1. Continue to monitor cases monthly identified as a QOC issue and track and trend until the QOC is resolved as determined by the medical director.
2. Any identified trends will be discussed with the medical director for any follow-up action.
3. Physician specific trend will be reported to the Provider Network Management for inclusion in the re-credentialing process.

TELEHEALTH SERVICES

Activity:

- Telehealth audit using claims and telehealth records.

Purpose:

- To assess if appropriate documentation was used, in accordance with the California Department of Health Care Services (DHCS) requirements; and
- To monitor compliance with the Kern Health Systems' Policy and Procedure (4.53 Telehealth Services).

Measurable Goal:

- Not yet established.

Frequency of audit:

- Quarterly

Team Involved:

- Clinical Network Oversight team

Telehealth

Criteria:

- Documentation by the provider that non-medical transport for an in-person or face-to-face visit was offered.
- Documentation by the provider that telehealth services are appropriate for the visit.
- Documentation by the provider that the patient was informed about the use of telehealth as voluntary, and verbal or written consent was obtained.
- Documentation that video and face-to-face options were offered when the visit was by audio only.
- Documentation that a video synchronous visit was done to establish a relationship with a new patient.
- Documentation that a visit with a new patient was done by audio only because the patient requested it.
- Documentation that a visit with a new patient was done by audio only because the patient attested that they did not have access to video.
- Documentation of the reason for the visit.
- Documentation of the assessment and plan of care.
- Documentation that instruction for follow-up care was provided.

RESULTS

- There was a total of 109 provider groups that were audited based on the claims submitted and the availability of their medical records.
- This audit include medical practitioners, non-medical practitioners and ABA providers.

Scores	# of Provider Regions
90% and above	3
80-89%	45
70-79%	36
60-69%	16
50-59%	7
40-49%	2

Average Score for KHS Practitioners	76.0%

Criteria Most Frequently Missed

- Documentation by the provider that non-medical transport for an in-person or face-to-face visit was offered.
- Documentation by the provider that the patient was informed about the use of telehealth as voluntary, and verbal or written consent was obtained.
- Documentation that video and face-to-face options were offered when the visit was by audio only.

Actions Taken:

All the groups will be provided with a packet of training educational materials and training resources were provided:

a. Provider requirements for telehealth. Safety Code, Section 1374.13

b. Key Steps to Providing Telehealth Services

c. Sample member consent – written and verbal

d. DHCS Telehealth Online Course – instructions how to access

SAFETY OF CLINICAL CARE:
Provider Clinical Oversight

Background:

Patient safety is an important component in the QI Work Plan. Improving health care quality requires creating a culture of safety and developing systems of care. According to the Institute of Medicine, the key principles are:

- Health care is safe – systems of care is responsible for medical mistakes
- Health care is effective – must use evidence-based medicine and evidence-based practice
- Health care is patient-centered – the secret of patient care is in the caring of the patient
- Health care is timely and efficient – unnecessary delays and prolonged waiting time are dangerous for the patients
- Health care is equitable – provision of health care is not biased

This report serves as a regular tracker and running record for the results of monitoring of selected safety measures. It may incorporate some results of internal audits conducted by KHS staff from various departments.

2025 Quality Improvement Work Plan:

To promote safety of clinical care and provide clinical network oversight for KHS providers, KHS's QI oversight team initiated the quarterly monitoring of selected measures. Under Safety of Clinical Case Section of the QI Work Plan, the team selected the following indicators for monitoring:

- Readmission
- Telehealth
- Asthma
- Initial health assessment
- Blood lead screening

A. Readmission

I. Why Readmission Rate matters:

Readmission is a critical measure in evaluating the effectiveness of clinical care and patient management. Readmissions are considered potentially preventable if they are clinically related to a prior admission within 30 days. By focusing on readmission rates, KHS aims to identify patterns that may indicate gaps in care or areas where additional support could prevent unnecessary hospital returns. This proactive approach allows for timely intervention and the development of strategies to enhance patient outcomes and overall care quality.

According to studies, California has a readmission rate of 14.9% (2019). Higher readmission rates can signal potential issues like overlooked complications, improper treatment, or inadequate discharge planning. Lower readmission rates correlate with higher quality of care.

Historically, KHS's raw admits in 2024 was 22,365 compared to 2023 with 19,993. Raw Readmits in 2024 = 3,341, in 2023 = 3,477; % of readmits was 14.9% in 2024 vs 17.39% in 2023. The goal established for 2024 was 12.72%. (Source: KHS' HICE report 2024)

Objective:

- To improve communication and care coordination to better engage patients and caregivers in discharge plans and, in turn, reduce avoidable readmissions. (CMS HRRP)

KHS Goals:

- Maintain acute care readmission rates at or below MCG Medicaid benchmark each quarter in 2024.
- Refer inpatient members identified as high risk that are discharged members to the designated Transitions of Care post discharge follow up workflow. (KHS HICE 2024 Report)

Methodology for Preventable Readmission:

Random selection of 10 files from the census report on the first month of the monitoring period

- Readmission cases selected will have same or similar diagnosis as the last discharge diagnosis
- Review of the selected files will be done to verify if true readmission with same or similar diagnosis and no quality of care cases is involved

Criteria
1. Evidence of medication reconciliation or discharge instructions
2. UM referral to case management or Population Health Management
3. Referral to behavioral health
4. Referral for home health assessment

Exclusion Criteria:

1. Readmission greater than 31 calendar days from the last discharge
2. Readmissions that are only an observation stay and do not involve actual hospital admission
3. Scheduled readmission episode as planned course of treatment
4. Transfer to another hospital with no break between discharge and admission between hospitals
5. Member signed out against medical advice at the original discharge
6. Readmissions that are planned for repetitive treatments, such as cancer chemotherapy, transfusion for chronic anemia, or other similar repetitive treatments or scheduled elective surgery
7. Readmissions due to malignancy (limited to those who are in an active chemotherapy regimen, burns or cystic fibrosis
8. Readmissions due to bone marrow transplants
9. OB readmissions
10. Neonatal and infants < 1 year of age
11. Transfer from out of network to in-network facilities
12. Transfer of patients to receive care not available at the first facility

13. Skilled nursing and rehab facilities
14. Admission is related to behavioral health conditions, e.g., substance abuse, BH related conditions)

Result: **First Quarter, 2025**

Dx		**Hx**	**Med Reconciliation; D/C Instructions**	**CM/PHM Referral**	**BH Assessment/ Referral**
1. CHF; Heart Failure		Drug abuse; difficulty walking; lives alone	No evidence	No evidence	No evidence (Hx meth abuse)
2. Seizures/ encephalopathy (Hx- multiple convulsions)		Ran out of med (Vinpat) ; hx multiple seizures; hx non-compliance	No evidence	Outreach to member 3x	No evidence (Hx substance abuse)
3. Intractable Vomiting; gastroparesis vs cannabinoid use		Hx DKA; hx cannabis	yes	Declined TOC (CCM closed	No evidence Hx- cannabis use
a. (1st readmission) DKA w ketoacidosis		Hx DKA; alcohol abuse; L arm abscess; non-cooperative	yes	PHM/CM – 3 attempts made- UTC sent ; dtr. Also contacted	No evidence- Hx- alcohol/ narcotic abuse
b. (2nd readmission) readmitted for ketoacidosis; bloody stools		Hx horseshoe kidney; homelessness; L arm abscess	Yes – d/c to snf	yes	No evidence
5.Encephalopathy; altered mental status; hx of 5 ED visit & 3 hospitalization with 6 months		Hx hypokalemia ; neutropenia; west Nile virus; alcohol abuse	yes	Yes TOC referral- outcome unsuccessful; ECM services with Premier (3.5.2025)	No evidence Hx- alcohol usage
6.Neck abscess w MRSA		Hx renal dysfunction; refused wound care	yes	Yes (3.5.2025)	NA

Dx		Hx	Med Reconciliation; D/C Instructions	CM/PHM Referral	BH Assessment/ Referral
7.Abd pain; acute pancreatitis		Pseudocyst of pancreas	yes	Yes – CM referral (no PCP)	No evidence
8. Pneumonia Hx- bipolar disorder; meth abuse		Chronic anxiety, DM	yes	No evidence; ST consult- dysphagia	No evidence Hx- bipolar disorder; meth abuse
9. CKD- stage IV, GERD, melena- multiple comorbidities		Heart failure- meth abuse		ECM/CCM referral	No evidence Hx- meth abuse
10.Sickle cell crisis		Sickle cell; interstitial lung disease		Community support specialist meets criteria for tailored meals	No evidence Hx- mood disorder- PTSD

Quantitative Analysis:

Criteria	1st Quarter (# of yes)	2nd Quarter (# of yes)	3rd Quarter (# of yes)	4th Quarter (# of yes)
Evidence of medication reconciliation or discharge instructions	7/10			
UM referral to case management or Population Health Management	4/10			
Referral to behavioral health	0/10			
Referral for home health assessment	4/10			

- 7 of 10 cases have a history of drug abuse, alcoholism, and psych disorder. No evidence of mental health assessment or follow-up. (referrals may have been done, but records reviewed did not evidence them).
- 2 of the 10 cases did not have evidence of discharge instruction or medication reconciliation
- 8 of the 10 cases had referral to CM or PHM (JIVA) 2 cases- 3 unsuccessful attempts made to member; 1- declined. Need to follow-up status with PHM
- 1 homeless patient
- 6 of the 10 cases had no evidence of home health assessments
- At least 2 patients were non-compliant or refused care.
- One patient ran out of medication or did not take the new prescribed medication.
- 2 out of 10 cases have virtual PCP follow-up scheduled (unable to validate completed actual visit)
- 6 out of 10 cases: readmissions within 7 days; 4 out of 10 cases: readmission within 14 days.
- All readmissions are unplanned.

- Polypharmacy: 2 out of 10 cases
- 10 cases had no evidence that discharge summaries were received by the member's PCP

Qualitative Analysis:
The record review was not conclusive for other data. There was no information about referrals to case management or behavioral health. There was no documentation for home health assessment on some of the eligible patients. In summary, the JIVA platform does not provide information on the aftermath of patient's hospitalization and outcomes of care after the hospital course.

Opportunities for Improvement:

- Collaboration with PHM/CM/TOC
- Collaboration with UM/PHM/BH - conduct training of staff
- Follow-up call to members regarding setting up medication refill, order sent to pharmacy, setting up DME, e.g., oxygen.
- Home Health evaluation on all patients following hospital discharges. Per KHS' procedure, all discharged patients from the hospital are evaluated for home health, no authorization requests needed.
- Hospital Discharge Summary made available to PCP, e.g., via portal or faxed. Obtain claims data to validate follow-up visit with PCP/specialist per discharge summary
- Track admission report vs readmission report

Action Taken:

On 4/21/25, the team met with PHM Director, along with the Medical Director, QI Director: presented highlights of the PHM Programs and other related policies to support collaborative efforts with UM concurrent and other departments.

Ongoing Interventions:
Population Health Management Department supports quality care through multiple processes and programs designed to achieve positive patient outcomes, from illness to optimal health. Cross-functional referrals ensure members benefit fully from services and resources available in KHS and the community, for which they are eligible. Various care management programs and models of care help patients improve their health status and promote optimum level of functioning. Community health workers address patient needs in a culturally sensitive manner and without any type of discrimination, assessing living conditions and utilizing resources to assist patients live a healthy, quality life. The Quality Performance and Improvement Departments collaborate and work with PHM to identify barriers to receiving appropriate care.

The following processes exist in the PHM Department but are not limited to:

- Transition of Care
- Care management/complex case management
- Member Advocacy
- Care coordination
- Referral processes to other programs from other departments and community resources

- Interdisciplinary care team
- Specialty referrals
- Coordination with specialty programs for children, such as California Children's Services (CCS) and Early, Periodic Services, Development and Treatment (EPSDT)
- Coordination with Community-Based Adult Services (CBAS), Enhanced Care Management (ECM), In-Home Support Services (IHSS), Long Term Support and Services (LTSS)
- Health Risk Assessment
- Allied services (home health, community health)

Planned Interventions:

1. Ensure communication with the PCP regarding the patient's admission and discharges.
2. Continue collaboration between QI and PHM to identify patients' health and safety risks.
3. Continue to focus retro-audits on inpatient admissions and readmissions, monitor readmission rates, and collaborate with PHM Department if trends of cases affecting PHM process are noted.
4. Recommend close collaboration with KHS' inpatient care managers and primary care physicians.
5. Recommend collaboration and communication between case management and Transitions of Care (TOC) clinics, i.e., Premiere and Golden facilities.

II. KHS also utilizes the hospital Readmission data to identify any trend in quality of care issues. (See desk top procedure for details)

Objective:

- To evaluate hospital readmissions that occur within 30 days of the first hospital discharge and identify any trends in quality of care issues.

Methodology: see desktop procedure for details:

2025 1st Quarter report (Identification of PQI based on readmission data)

Quantitative analysis

Month	Level 0	Level I	Level II	Level III	Met exclusion criteria
Jan	18	1	0	0	1 - f
Feb	17				1- b 1- c 1- f **Total= 3**
Mar	8				2-f
Total	43	1	0	0	6

Exclusion Criteria: Readmissions excluded form review for a potential quality of care concern include the following:

a. Readmissions are only an observation stay and do not involve actual hospital admission.
b. Schedueld readmission as part of a planned course of treatment such as cancer chemotherapy.
c. Transfers from out of network to in-network facilities.
d. Obstetrical admissions.
e. Member signed out 'Against Medical Advice" (AMA) at the original discharge.
f. Behavioral health readmission.
g. Transplant related readmissions.
h. Transplant related readmissions.
i. Readmissions are associated with major or metastatic malignancies, opportunistic infections related to HIV, major trauma or poisoning

Out of the 50 charts reviewed, 43 were level zero, one case was level 1 and 6 were exclusions. Exclusions include planned treatment, behavioral health readmission and transfer from another facility

Qualitative analysis
For the first quarter of 2025, only one case was identified as Level 1. the patient was initially discharged on 1/4 and then visited ER again on 1/10, which resulted in readmission from 1/13 to 1/19 due to the patient not receiving appropriate treatment from the ER.

Opportunity for Improvement:
A close collaboration between the QI Specialist and UM could facilitate the review process. By identifying exclusions through assignment of codes, QI Specialist can focus on real QOC cases and less time on exclusions.

Interventions:
1. Continue to monitor cases monthly identified as a QOC issue and track and trend until the QOC is resolved as determined by the medical director.
2. Any identified trends will be discussed with the medical director for any follow-up action.
3. Physician specific trend will be reported to the Provider Network Management for inclusion in the re-credentialing process.

B. Telehealth

Why Telehealth matters:

Telehealth means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous and asynchronous store and forward transfers. (B&P Code 2290.5). "Synchronous interaction" means a real-time interaction between a patient and a health care provider at a distant site. "Asynchronous store and forward" means the transmission of a patient's medical information from an originating site to the health care provider at a distant site. (DHCS, Medi-Cal Provider Manual)

Telehealth provides better access to health care while maintaining medical expenses. One of the most successful applications of telehealth is the reduction of health disparities in areas with limited physician access. Approximately 20% of the US population resides in rural areas and only 9% of physicians serve these areas. Telehealth aims to eliminate transportation costs, particularly on patients of low economic status. Similarly, it can improve health literacy by providing patient education and preventing hospitalizations with the assurance of medication adherence. (NIH, National Library of Medicine)

Telehealth makes health care easier to outreach people who live in remote areas. It offers primary health for many conditions. Telehealth makes services convenient for people who have limited ability to move, time or transportation. It offers access to specialists. it improves communication and coordination of care among health care team members and the person getting care. Ultimately, telehealth offers advice for self-management of health care. (Mayo Clinic)

Based upon the DHCS All Plan Letter's requirement of a provider rendering covered services via Telehealth modality, a provider must be enrolled as a Medi-Cal Provider or Non-Physician Medical Practitioner (NMP) affiliated with an enrolled Medi-Cal Group:

- Definition of NMP: A non-physician practitioner (NPP) is a healthcare provider who is not a physician but who practices in collaboration with or under the supervision of a physician. They are also known as mid-level practitioners, physician extenders, and advance practice providers.
- Examples of NPPs include:
    - Physician assistants (PAs)
    - Advanced practice registered nurses (APRNs)
        - Nurse practitioners (NPs)
        - Clinical nurse specialists (CNs)
        - Certified nurse midwives (CNMS)
        - Certified registered nurse anesthetists (CRNAs)

Objective:
To enhance current audit using claims data and improve member care processes.

Goal:
To establish collaborative effort with Department of Health Education

Methodology:
All network practitioners were targeted for review.

- Quarter 1 - providers with 101 and above telehealth encounters, audit 5 charts
- Quarter 2 – providers with 51-100 telehealth encounters, audit 5 charts
- Quarter 3 – providers with 31-50 telehealth encounters, audit 5 charts
- Quarter 4 - providers with 1-30 telehealth encounters, audit all the encounters up to 5 records

1. At the end of the quarter, collect sample charts from all providers (medical and non-medical practitioners) based on the quarter the audit date falls on.
2. Utilize the audit tool developed by KHS to review the following:

a. Provider credentials –
   - CA licensed
   - certified Medi-Cal provider
   - no gov't sanctions

b. Member consent – verbal or written

c. Documentation –
   - Right to in-person services
   - Voluntary nature of consent
   - Availability of transportation to access in-person services when other available resources have been reasonably exhausted
   - Limitations/risks of receiving services via telehealth, if applicable
   - Availability of translation services
   - reason for the visit
   - follow-up instructions

3. Annually or quarterly, as directed by QI leadership, perform quantitative analysis of data.
4. Annually or quarterly, as directed by QI leadership, identify root causes of non-compliance with APL 23-007 and KHS policy.
5. Annually or quarterly, as desired, determine the baseline trends in the utilization of telehealth services.
6. Annually, provide general education to all practitioners regarding the regulatory requirements for providing telehealth services via Provider Bulletin, e-mail, Provider Manual, joint operations meeting between KHS and delegated groups
7. Obtain the percentage of aggregated compliance score:
   a. Numerator – total # of compliant charts reviewed
   b. Denominator – total # of charts in the sample
   c. Multiply the result by 100
8. Report to QI Workgroup quarterly, as directed.
9. Develop a practitioner-specific report on the utilization of telehealth services and the practitioner's compliance with the requirements for telehealth.
   a. Utilize the data as one of the practitioner's quality performance reports.

Criteria
1. Is the rendering telehealth service provider licensed in California and enrolled as a Medi-Cal provider OR non-physician medical practitioner (NMP) affiliated with an enrolled Medi-Cal provider group?
2. Was the availability of non-medical transport offered for an in-person or face -to-face visit?
3. Provider provided documentation that telehealth services is appropriate for this visit.
4. Telehealth provider informed patient about the use of telehealth as voluntary, and verbal or written consent was obtained.
5. If audio only, did patient request audio only?
6. If video synchronous, is it to establish relationship with a NEW patient?
a. If audio only, does patient request audio only?
b. OR did member attest that they have no access to video?
7. Was the reason for the visit documented?

8. Was assessment and plan of care documented?
9. Instruction for follow-up care is documented.

Findings:

The Clinical Network Oversight team conducted medical record reviews to identify barriers and non-compliance with DHCS' regulations on telehealth in the 4th quarter, 2024. Overall, the team audited 109 facilities, which include medical and non-medical practitioners, as well as ABA providers.

Quantitative Analysis:

Based upon the Clinical Network Oversight team's audit, the following are the findings:

- No provider region received a score of 100%
- Three (3) provider regions received 90-99% overall score
- Forty-five (45) provider regions received 80-89% overall score
- Sixty-one (61) provider regions received 79% or below overall score

Qualitative Analysis:

Based on the audit results, the most common deficiencies were:

1. Provider of telehealth service did not offer availabilities of non-medical transport for an in-person or face-to-face visit.
2. Provider of telehealth service did not inform patient about the use of telehealth as voluntary, and verbal or written consent was obtained.
3. Provider of telehealth service did not offer option of video and face-to-face.
4. Criteria #s 5 and 6 (a & b) were most often scored as NA.
5. Some of the providers were non-medical practitioners.

Actions Taken:

For those facilities that did not meet the regulatory requirements, letters explaining their deficiencies were sent to the providers.

As a result of the deficiency letters, overall, the providers expressed frustration because they do not understand the requirements for telehealth.

Opportunities for Improvement:

- Educational training for practitioners to clarify the regulatory requirements.
- Posters or reference guide to assist practitioners and staff to meet regulatory compliance.
- Provider Bulletin to remind practitioners and staff on telehealth requirements.
- Methodology for gathering information was modified to ensure all practitioners in the network are covered.

Planned Interventions:

- Modify the deficiency letter so it gives clear direction to the practitioners.

- Create a checklist of requirements in simple terms that will guide the providers when talking to the members.
- Develop a member consent form listing the items the patients need to know before the telehealth service.

Additional Intervention:

The deficiency letter A packet of educational and training materials was created to provide information to the practitioners. The packet includes:

- Audit Results / Deficiency letter to the practitioner
- Provider requirements for telehealth. The information was taken from the Welfare and Institutions Code Section 14132.725, California Business and Professions Code 2290.5, and Health and Safety Code, Section 1374.13
- Key Steps to Providing Telehealth Services
- Sample member consent – written and verbal
- DHCS Telehealth Online Course – instructions how to access

C. Asthma

Why Asthma monitoring matters:
The California Department of Health Care Services (DHCS) confirmed the coverage of this new Medi-Cal benefit, which covers clinic-based and home-based asthma self-management education and in-home environmental trigger assessments provided by non-licensed professionals, such as Community Health Workers, *promotoras*, and other individuals meeting specified qualifications.

Combined with Medi-Cal's Asthma Remediation program, which covers environmental trigger remediation, California is now a national leader in providing comprehensive asthma home visiting services, which improve health outcomes, reduce health care utilization costs, and reduce asthma disparities. (Regional Asthma Management and Prevention [RAMP])

APS is defined as information about the basic facts of asthma, proper use of long-term controllers and quick relief medications, evidence-based self-management techniques and self-monitoring skills, and actions to mitigate or control environmental exposures that exacerbate asthma symptoms.

‘ "In-home environmental trigger assessments" are defined as the identification of environmental asthma triggers commonly found in and around the home, including allergens and irritants. This assessment will guide self-management education about actions to mitigate or control environmental exposures.

"Poorly controlled asthma" is defined as: 1) Having a score of 19 or lower on the Asthma Control Test, or 2) An asthma-related emergency department visit or hospitalization or two instances of sick or urgent care asthma-related visits in the past 12 months.

Objective:

To provide members with education about asthma, proper use of quick relief and long-term controllers, self-monitoring skills and self-management techniques identify and control environmental exposures that trigger asthma.

Goal:

Reduce incidence of admission of patients with asthma in the ER and hospital.

Methodology:

In addition to the existing desk-top procedure, (see Addendum A) the QI Oversight team will supplement the review to include the clinical aspects of care.

The review will include auditing 5% or 50 charts, whichever is less, the medical records of all patients who had encounters in urgent care, emergency room and hospital in the last six months. The list will be filtered to identify members who had the most number of visits in urgent care centers, emergency rooms or hospitals. A chart review will be conducted to determine presence of co-morbidities and evidence of referrals to case management or PHM, especially for those high-risk patients, Examples are 2 or more co-morbidities, and 2 or more ER or hospital encounters. The frequency of review is every 6 months. Example: if lookback period for the baseline data is July-Dec 2024, final analysis will be completed in Jan 2025. The next audit and analysis will be in July, with a lookback period of Jan-June 2025,

Criteria	Qtr 1	Qtr 2	Qtr 3	Qtr 4
Member has documented co-morbidities	**NA**			**NA**
ER admission within the last 6 months	**NA**			**NA**
Hospital readmission within the last 6 months	**NA**			**NA**
Evidence of referral to CM/PHM	**NA**			**NA**

Findings:

Results of desktop review of asthma claims audit:

Supervising APS Provider: Central California Asthma Collaborative (CCAC)					
		January-March 2024	April-June 2024	July-September 2024	October-December 2024
	Audit Period:	Q1 2024	Q2 2024	Q3 2024	Q4 2024
	Auditor:	Carlos Bello	Carlos Bello	Carlos Bello	Carlos Bello
APS Provider and Paid Claims Summary	Number of APS providers included in the audit:	7	6	5	4
	Percent of APS claims with a KHS credentialed APS provider:	42.86%	66.67%	68.8%	100%
	Number of members included in the audit:	10	15	15	15
	Number of paid claims included in the audit:	13	16	16	15
	Number of paid claim services included in the audit:	18	27	25	28
	Percent of paid APS claims with an asthma diagnosis documented:	100%	100%	100%	100%
	Percent of paid APS claims with documentation of poorly controlled asthma	85%	94%	100%	100%
Asthma Education	Number of paid APS asthma education claims:	13	16	16	15
	Percent of paid APS asthma education claims with documentation that APS asthma education was recommended by a licensed health care provider	15.38%	50.00%	75.00%	93.33%
	Number of members with more than 8 paid units or 2 paid visits of APS asthma education in the past 12 months:	0	1	3	2
	Number of members with more than 4 paid units of APS asthma education in one day in the past 12 months:	0	0	0	0
	For any members that exceeded a limit, was a referral or prior authorization request approved by KHS for all members?	N/A	No	No	No
	Percent of paid APS asthma education claims with a description of nature of service documented:	15.38%	37.50%	25.0%	100%
Home Trigger Assessment	Number of paid APS home assessments:	5	11	9	13
	Percent of APS home assessments with documentation of poorly controlled asthma	100%	100%	100%	100%
	Percent of APS home assessments with documentation that an in-home environmental trigger assessment was recommended by a health care provider	40.0%	72.73%	88.89%	92.31%
	Number of members with more than 2 home assessments in the past 12 months:	0	0	0	0
	For any members that exceeded a limit, was a referral or prior authorization request approved by KHS for all members?	N/A	N/A	N/A	N/A
	Percent of APS home assessment claims with a description of nature of service documented:	20.0%	54.5%	44.4%	100%

Legend:

	90-100% compliance.
	70-89% compliance. Improvement is needed.
	50-69% compliance. Improvement is needed.
	0-49% compliance. Improvement is needed.
	Information or documentation is needed to determine outcome.

Quantitative Analysis:

- Asthma Preventive Services (APS) providers who have not been credentialed by KHS were found to be associated with claims included in the audit.
- There was 1 member in the audit with more than 2 APS asthma education visits in the past 12 months.
- Adequate documentation was not found or provided for some claims in the audit.
- There were 3 members in the audit with more than 2 APS asthma education visits in the past 12 months.
- CCAC provided documentation of the recommendation for APS by a licensed health care provider for most of the claims included in the audit, as requested by KHS, but CCAC did not provide adequate documentation for some claims.

- Authorization requests for the members who had more than 2 APS asthma education visits in the past 12 months are needed.
- The licensed health care provider's signature is needed on 3 of the provider order forms.
- Documentation of the APS recommendation or order from a licensed health care provider for one claim is needed.
- There were two claims where a member had exceeded the APS asthma education visit limits. None had an approved authorization from KHS.
- For 3 claims, the licensed provider order form is missing the signature date.
- The recommendation for APS from a licensed health care provider is missing for one claim.

Qualitative Analysis:

The audit was based on claims data, there is no clinical component.

Action Taken:

After reviewing the data, the QI team recommended adding the following criteria to the audit tool.

Criteria
Member has documented co-morbidities
ER admission within the last 6 months
Hospital readmission within the last 6 months
Evidence of referral to CM/PHM

Opportunity for Improvement:

There is an opportunity to integrate the results with the clinical picture of the patient.

Planned Interventions:

- Incorporate the following above criteria into the existing audit tool.
- Coordinate with COPD program
- Evaluate the outcomes of patients who were provided the health education and environmental assessments.

D. Initial Health Assessment

Why IHA matters:

Objective:
Conduct initial health appointment within 120 days of enrollment with Blue Shield.

Goal:

Methodology:

1. **Initial Health Assessment**

a. Assessment for TB
b. Assessment for tobacco use
c. HPV immunization
d. Age-appropriate immunization
e. Member education

2. **Adult IHA**
   a. Age-appropriate IHA based on current USPSTF guidelines
   b. Documentation for TB
   c. Colon and rectal cancer screening
   d. Complete history and physical
   e. Total cholesterol
   f. Immunization

3. **Female Members**
   a. Breast exam 40 years and over
   b. Mammogram age 50 and over
   c. Chlamydia screening
   d. Cervical cancer screening 21-65 yrs old / cytology
   e. Osteoporosis screening for females 65 and over

4. **OB**
   b. CPSP screening
   c. Initial and trimester assessment completed by OB
   d. CPSP postpartum assessment
      1. Psychosocial assessment
      2. Health Education
      3. Nutrition
      4. Referral to WIC program

***To be reported in 2025 Q2 Work Group**

E. Blood Lead Screening

***To be reported in 2025 Q2 Work Group**

ADDENDUM - Desktop Procedures

A. Readmission

I. Preventable or Unnecessary Readmissions (QI monitoring activity)

a. KHS Business Intelligence (BI) generates a monthly report on all 30-day readmissions.
b. A QI nurse/designee will select a sample of 10 readmission cases with same or related diagnosis per quarter using the KHS Preventable/Unnecessary Readmission Monitoring tool.
c. A quantitative and qualitative gap analysis report will be submitted to KHS QI work Group to identify any barriers and process improvement opportunities.

II. Potential Quality of Care Identification

KHS evaluates hospital readmission that occurs within 30 days of the first hospital discharge to identify any trends in quality-of-care issues.

Methodology:

a. KHS Business Intelligence (BI) Team produces a monthly report of all 3-day readmissions for case review selection.
b. A sample of 50 readmissions (20-1st month; 20-2nd month;10- 3rd month) per quarter will be selected for review to represent a comprehensive review of the entire pool or universe.
c. KHS will narrow the pool only to 50 readmissions for each quarter even if at any time there are 100 more than 30-day readmissions awaiting review for potential inappropriate care identification.
d. QI coordinator will request medical records from the provider or facility and uploads the documents in the medical management system. QI RN reviews the selected cases for any possible quality of care concerns using the SBAR format.
e. After evaluation by the QI RN, an outcome greater than a level "0"is sent to a medical director for final determination whether a potential quality of care (PQI) concern exits and if any follow-up actions are needed.

PQI Level	Description	Follow-up Action
0	No QOC- no lack pf evidence, documents, and/or information to open a PQI case	Closed
1	Potential for Harm: substantiated PQI with documented evidence or possible member injury or harm. Member will be able to recover fully from possible injury/harm with no limitation.	Track and trend the area of concern for the specific provider, and the CMO or their designee or their designee may provide additional actions that are individualized to the specific case or provider
2	Actual Harm: is substantiated PQI with documented evidence or suspected Member inquiry or harm. Injury may be: a). Minor with minimal adverse effects to the Member but is able to recover with minor limitation; or b). Major with major adverse effects or permanent residual effects but is able to recover with some limitation(s).	Implement a Corrective Action Plan plus direction and guidance from CMO/ PAC or their designee that is individualized to the specific case or provider. A. (Refer to Section- IV. Procedures: B " Processing PQI Referrals" of this policy for more detail)s
3	Actual Morbidity or Mortality Failure: substantiated PQI with documented evidence or suspected Member injury or harm with a very serious negative outcome Injury presented with permanent disability or mortality	Implement a Corrective Action Plan plus direction from CMO or their designee or their designee that is individualized to the specific case or provider.

f. Exclusion criteria: Readmissions excluded form review for a potential quality of care concern include the following:
    a. Readmissions are only an observation stay and do not involve actual hospital admission.
    b. Schedueld readmission as part of a planned curse of treatment such as cancer chemotherapy.
    c. Transfers from out of network to in-network facilities.
    d. Obstetrical admissions.
    e. Member signed out 'Against Medical Advice" (AMA) at the original discharge.
    f. Behavioral health readmission.
    g. Transplant related readmissions.
    h. Transplant related readmissions.
    i. Readmissions are associated with major or metastatic malignancies, opportunistic infections related to HIV, major trauma or poisoning.
g. The QI nurse works with QI Medical Director in making the final determination and any follow-up action needed.
h. Tracking & Trending Follow-up: Performed to identity any persistent patterns of concern and opportunities for improvement. All cases

selected for tracking and trending are monitored, at a minimum on a monthly bases. A report is run during the month following the report month for all active track and trend cases. After reviewing the active track and trending cases, the medical director makes a decision to:

1. Stop tracking and trending and close he case due to no quality-of-care issue identified or the identified QOC has been resolved or
2. Continue tracking and trending.

i. An aggregate report of 30-day readmissions to evaluate trending will be presented to the KHS QI Work group and UM committee for review and recommend actions. (Refer to QI P&P 2.70-I)

III. Preventable or Unnecessary Readmissions (QI monitoring activity)

d. KHS Business Intelligence (BI) generates a monthly report on all 30-day readmissions .

e. A QI nurse/designee will select a sample of 10 readmission cases with same or related diagnosis per quarter using the KHS Preventable/Unnecessary Readmission Monitoring tool.

f. A quantitative and qualitative gap analysis report will be submitted to KHS QI work Group to identify any barriers and process improvement opportunities.

Telehealth

Frequency of Monitoring: Quarterly
Scope of Quarterly Monitoring:

- Quarter 1 - providers with 101 and above telehealth encounters, audit 5 charts
- Quarter 2 – providers with 51-100 telehealth encounters, audit 5 charts
- Quarter 3 – providers with 31-50 telehealth encounters, audit 5 charts
- Quarter 4 – providers with 1-30 telehealth encounters, audit all the encounters up to 5 records

Methodology:

1. Every end of the quarter, collect sample charts from all providers (medical and non-medical practitioners) based on the quarter the audit date falls on.
2. Utilize the audit tool developed by KHS to review the following:
    a. Provider credentials –
        ✓ CA licensed
        ✓ certified Medi-Cal provider
        ✓ no gov't sanctions
    b. Member consent – verbal or written
    c. Documentation –
        ✓ Right to in-person services
        ✓ Voluntary nature of consent
        ✓ Availability of transportation to access in-person services when other available resources have been reasonably exhausted
        ✓ Limitations/risks of receiving services via telehealth, if applicable
        ✓ Availability of translation services
        ✓ reason for the visit
        ✓ follow-up instructions
3. Annually or quarterly, as desired, perform quantitative analysis of data.
4. Annually or quarterly, as desired, identify root causes of non-compliance with APL 23-007 and KHS policy.
5. Annually or quarterly, as desired, determine the baseline trends of telehealth utilization.
6. Annually, provide general education to all practitioners regarding the regulatory requirements for providing telehealth services via Provider Bulletin, e-mail, Provider Manual, joint operations meeting between KHS and delegated groups
7. Obtain the percentage of aggregated compliance score:
    a. Numerator – total # of compliant charts reviewed
    b. Denominator – total # of charts in the sample
    c. Multiply the result by 100
8. Report to QI Workgroup annually or quarterly, or as required.
9. Develop a practitioner-specific report on the utilization of telehealth services and the practitioner's compliance with the requirements for telehealth.
    a. Utilize the data as one of the practitioner's quality performance reports.

KHS' Telehealth Audit Tool:

1. Is the rendering telehealth service provider licensed in California and enrolled as a Medi-Cal provider OR non-physician medical practitioner (NMP) affiliated with an enrolled Medi-Cal provider group?
2. Was availability of non-medical transport offered for an in-person or face -to-face visit?
3. Provider provided documentation that telehealth services is appropriate for this visit.
4. Telehealth provider informed patient about the use of telehealth as voluntary, and verbal or written consent was obtained.
5. If video synchronous, is it to establish relationship with a NEW patient?
6. If audio only, was video and face-to-face option offered?
7. a. If audio only, did patient request audio only?
b. OR did member attest that they have no access to video?
8. Was the reason of visit documented?
9. Was assessment and plan of care documented?
10. Instruction for follow-up care is documented.

B. Asthma

Preventive Service Audit Desk Level Procedure (Revised 2/4/2025)

1. Run the CHW and APS Claims Report. Include at least the last 12 months as the search period.
2. Select a random sample of at least 15 claims for each supervising APS provider (per organization).
3. Add the needed details from the selected claims to the APS Audit Tracker file.
    a. Claim number
    b. Date of service (DOS)
    c. Units of APS asthma education service (CPT codes 98960-98962) in the claim
    d. Home assessment included in the claim
    e. Units of APS asthma education in the past 12 months
    f. Number of APS asthma education visits (or dates of service) in the past 12 months
    g. Number of home assessments in the past 12 months
4. Open the monthly APS tracking logs for the audit quarter. They can be found here on SharePoint within each APS provider folder.
5. Search the tracking logs for the DOS that corresponds with each claim included in the audit. Add the APS provider name to each claim on the APS Audit Tracker.
6. Check the list of KHS credentialed APS providers. Indicate the credentialed status for each APS provider on the APS Audit Tracker.
7. Request documentation of the recommendation of APS for a licensed health care provider for all members included in the audit sample.
    a. Prepare a list of members who will be included in the audit for each APS provider.
    b. Create an IR with the KHS Service Manager.
        i. Request that the member list be sent to the corresponding APS provider via SFTP. Briefly explain that the list needs to be sent to complete a quarterly APS audit. This is a regulatory request with medium urgency.
        ii. Attach the approved DERF.
    c. After the IR has been created and IT has confirmed that the file has been transferred to the APS provider's pickup folder on the SFTP site, email the APS provider to let them know the member list for the audit was sent to them via SFTP. Ask the APS provider to send documentation of the following for +++ for each member on the list:
        i. Asthma diagnosis
        ii. Recommendation for APS from a licensed health care provider
        iii. Current diagnosis of poorly controlled asthma, including at least one of the following in the past 12 months:
            1. Asthma Control Test score of 19 or less
            2. One of the following events due to an asthma:
                a. Hospitalization
                b. Emergency department visit
                c. 2 or more urgent care visits
        iv. Brief description of the nature of APS service
    d. Documentation of the APS recommendation or provider order may be found in Jiva. If it is necessary to search Jiva for documentation, see the steps in the next section.

8. When the APS provider has notified KHS that they sent the requested APS documentation via SFTP, look for the files here: P:__Health Education\Asthma Preventive Services
9. Save the documentation files here on SharePoint within the corresponding APS provider folder.
10. Search in the documentation for the remaining details that are needed for the APS Audit Tracker.
    a. Brief description of nature of service
    b. Documentation of asthma diagnosis
    c. Documentation of a recommendation for APS from a licensed health care provider
    d. Documentation of a current diagnosis of poorly controlled asthma
    e. Documentation of a recommendation for an in-home environmental trigger assessment by a licensed health care provider
    f. Type of documentation
    g. Was the documentation adequate?
11. Complete the audit quarter results summary on the APS Audit Summary file for each APS provider. The Audit Summary for each APS provider can be found on SharePoint here within the folder for each APS provider.
12. Email the audit results from the APS Audit Summary to each APS provider.

How to Find APS Documentation in Jiva (Optional)

1. Open Jiva and go to the Member Overview for each member included in the audit.
2. Check the episode list on the left. Search for any asthma remediation episodes within the past 12 months.
    a. Check the episode start date.
    b. Asthma remediation episodes will have a J45 (asthma) diagnosis.
3. Open the Documents section. Search for APS documents with a date that is near the asthma remediation episode start date.
    a. These documents should include documentation of a recommendation for APS by a licensed health care provider.
    b. They may also include an asthma management assessment, a home environmental trigger assessment, and notes about the nature of asthma education provided to the member.

References:

KHS' 2024 HICE Work Plan

DHCS' All Plan Letter 23-007

Population Health Management

CCR, Title 42 Section 440.130(c)

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KERN HEALTH SYSTEMS

QUALITY IMPROVEMENT DEPARTMENT

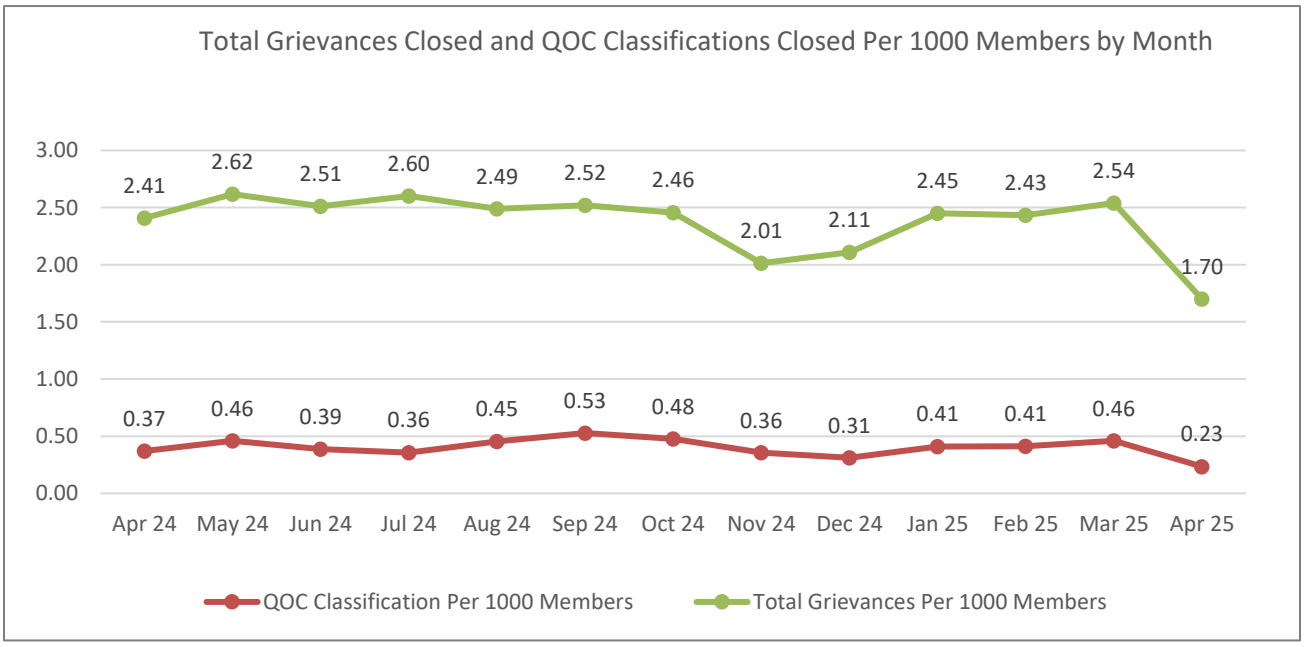
MONTHLY REPORT

APRIL 2025

The purpose of this report is to provide a summary of the monthly activities and outcomes for the QI department. This provides a window into both compliance with regulatory requirements as well as identifying opportunities for improving the quality of care for our members. Areas covered in the report include:

I. Grievances and Quality-of-Care (QOC) Classifications:

Grievances identified as potential QOC are referred to the Quality Improvement Department for further classification. The QI RNs classify grievances received as Potential QOC for further review or send back to Grievance coordinators as non-PQOC. Grievances classified as Potential QOC are reviewed and can be closed in favor of the member and referred to the QI Department for further investigation as a Potential Quality Issue (PQI). Potential QOC grievances resolved in favor of the provider are not referred to QI, as this resolution means there was no QOC concern identified to warrant further investigation.



The above chart represents a comparison of total Grievances Closed and QOC classifications Closed per 1000 KHS members. There was a 33% decrease in total grievances and 49% decrease in QOC classifications closed in April 2025. There are no current trends identified.

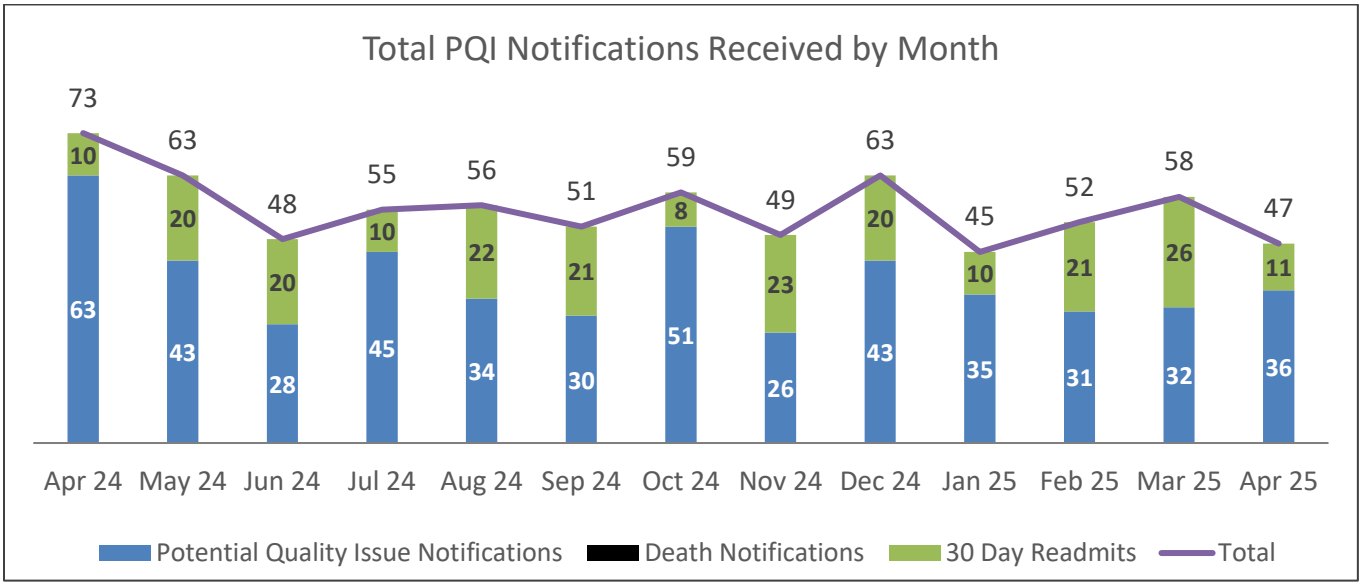
Beginning 2025 QI will monitor the volume of Grievances received for Potential QOC and the resulting classifications. Preliminary data is below:

Month	Total Grievances Received for PQOC	Grievances Classified as PQOCs	Grievances Classified as Non-PQOCs	Total Grievances Closed
Jan 25	215	136	79	993
Feb 25	224	141	83	986
Mar 25	220	167	53	1027
Apr 25	203	147	56	689

II. Potential Quality Issue (PQI) Notifications:

QI receives notifications from various sources to review for PQI notifications. On receipt of a PQI notification, a QI RN completes a high-level review to determine what level of Potential Quality Issue exists. PQIs are assigned a level based on the outcome of the review. The levels assigned are as follows:

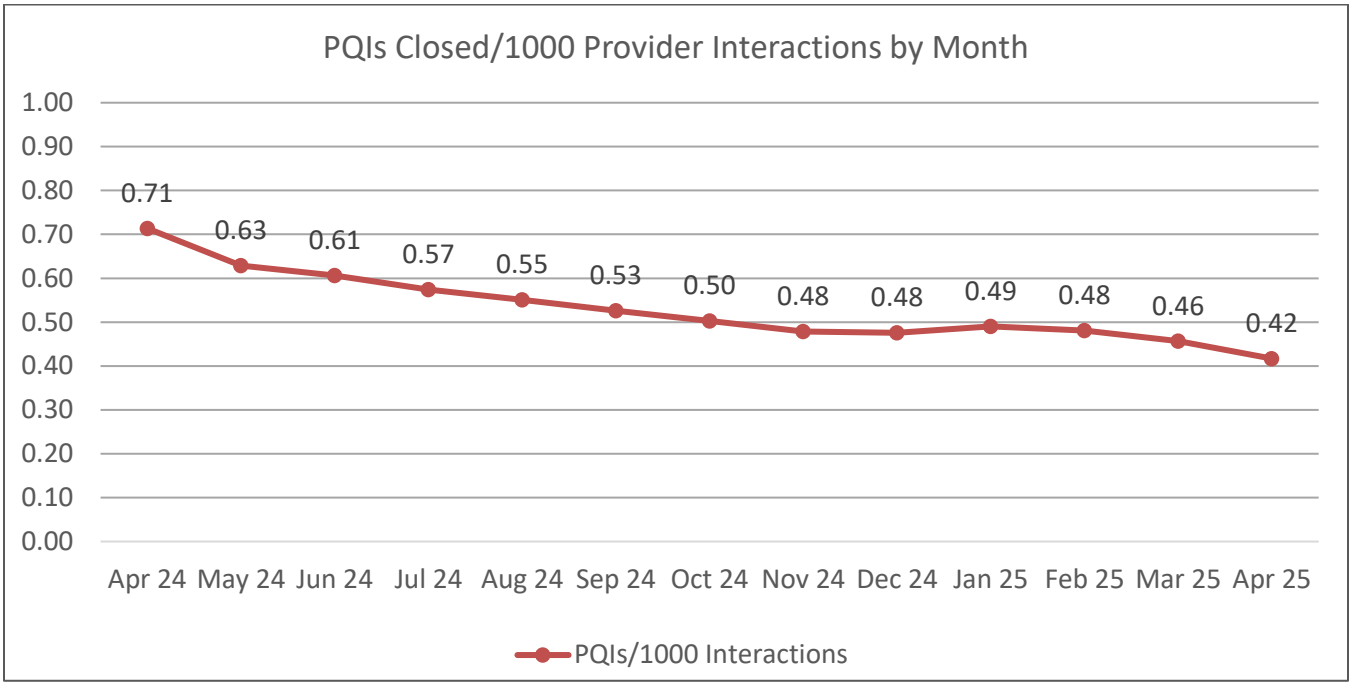
- Level 0 = No Quality-of-Care Concern
  - No action taken
- Level 1 = Potential for Harm
  - Follow-up = Track and trend the area of concern for the specific provider. The Medical Director may provide additional actions that are individualized to the specific case or provider.
- Level 2 = Actual Harm
  - Follow-up = Corrective Action Plan plus direction from Medical Director or their designee which is individualized to the specific case or provider
- Level 3 = Actual Morbidity or Mortality Failure
  - Follow-up = Corrective Action Plan plus direction from Medical Director or their designee which is individualized to the specific case or providers

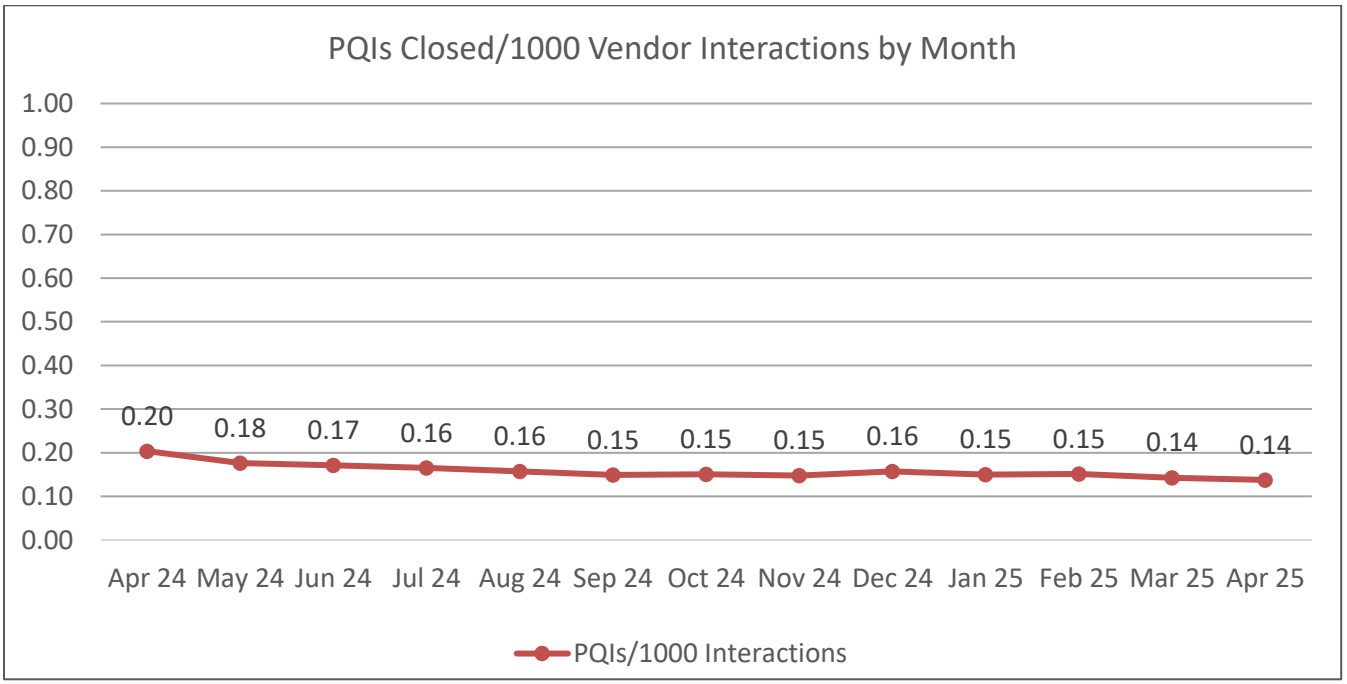


For the month of April 2025, there was a decrease in total volume of notifications but a 13% increase in PQI notifications alone from March 2025.

QI will continue to monitor for any trends. The fifty 30-day readmission reviews conducted each quarter were completed timely for Q1 2025.

QI will begin to display monthly data of PQI notifications received per 1000 provider and vendor interactions. Data is displayed in the two graphs below:





Quality Review Corrective Action Plans:

QI will begin to monitor Quality Review Corrective Action Plans (QR CAPs). QR CAPs are initiated by QI when a provider does not provide the medical records requested for PQI review. Note these are very rare so we expect to see zero to very low volume.

Month	# of CAPs Issued	# of CAPs Closed	# of CAPs Remaining Open	# CAPs Open >45 Days
Jan 25	0	0	0	0
Feb 25	0	0	0	0
Mar 25	0	0	0	0
Apr 25	0	0	0	0

PQIs Closed by Source:

QI will begin to report on total PQIs closed by source. There are several potential sources:

- Grievance PQOC (Internal Grievance)
- Direct Referrals (any department or the Medical Director)
- 30 Day Re-admits (Hospital Discharge)
- Provider Preventable Condition (QR Identified PPC)
- Death Notification

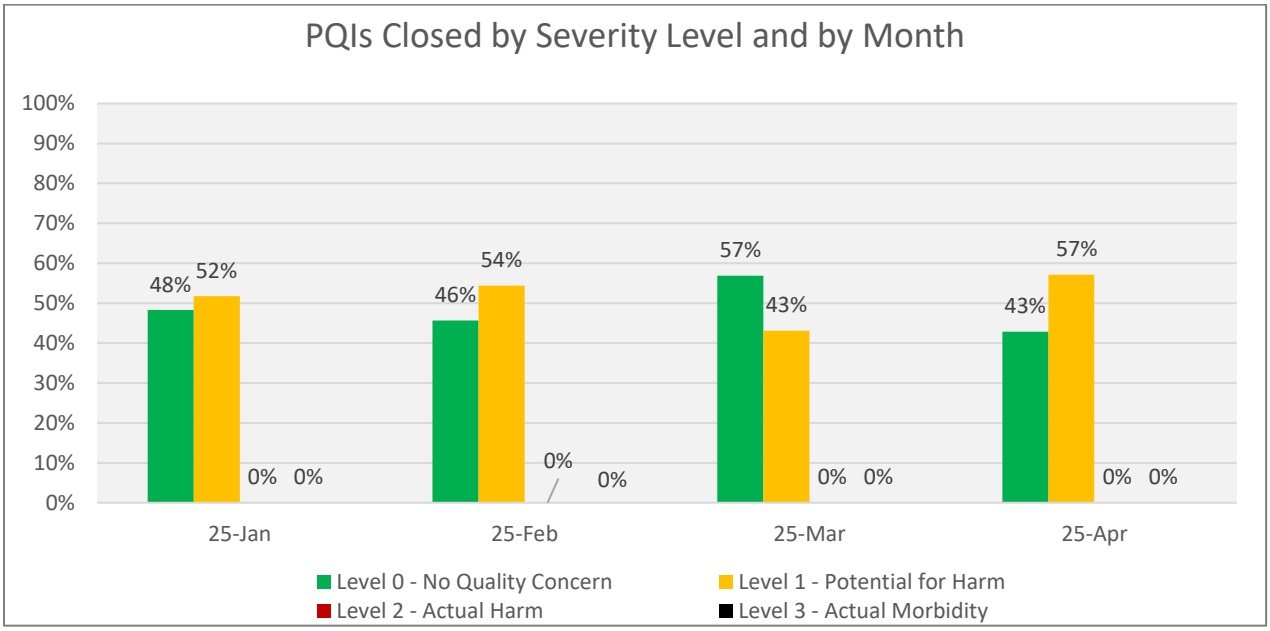
Currently the following are combined:

- Internal Grievance = Grievance PQOC and Direct Referrals

The data below displays volumes by month:

Month	Internal Grievance	Hospital Discharge	QR Identified PPC	Death Notification	Total PQIs Closed
Jan 25	19	10	1	0	30
Feb 25	36	20	1	0	57
Mar 25	32	26	0	0	58
Apr 25	31	11	0	0	42

PQIs Closed by Severity Level:



From the above chart majority of PQIs closed April 2025 were Level – 1. The increase in Level -1 can be attributed to the change in the grievance process where not all grievances come to QI for review only those that are potential QOC, so as a result there may be less Level – 0's to be reviewed. QI will continue to monitor to identify any trends.

Below is the table with the volume of PQIs closed by severity and by month for reference:

Severity Level	Jan 25	Feb 25	Mar 25	Apr 25
Level 0 - No Quality Concern	14	26	33	18
Level 1 - Potential for Harm	15	31	25	24
Level 2 - Actual Harm	0	0	0	0
Level 3 - Actual Morbidity	0	0	0	0
Total	29	57	58	42

PQIs Trending by Provider:

Based on the trending analysis conducted, below are the top 5 outpatient and inpatient providers for the rolling 12 months of May 2024 – April 2025.

Top 5 Outpatient Providers with PQIs:

Top 5 Providers with Level 2 and 3 PQIs	Level 1- PQIs Per 1000 Visits	Level 2- PQIs Per 1000 Visits	Level 3- PQIs Per 1000 Visits	Total Outpatient Visits	Total PQI's Per 1000 Visits
Provider A	0.0	1.90	0.00	526	1.90
Provider B	0.0	0.49	0.00	2,048	0.49

Top 5 Providers for Total PQIs (Level 1-3)	Level 1- PQIs Per 1000 Visits	Level 2- PQIs Per 1000 Visits	Level 3- PQIs Per 1000 Visits	Total Outpatient Visits	Total PQI's Per 1000 Visits
Provider C	0.58	0.00	0.10	10,340	0.68
Provider D	0.56	0.00	0.22	8,956	0.78
Provider E	0.38	0.00	0.00	13,154	0.38
Provider F	0.31	0.00	0.08	12,784	0.39
Provider G	0.24	0.00	0.24	8,305	0.48

From the above data, there were no providers identified with severity Level 3. Provider A and B had one PQI at severity Level 2. Majority of the PQIs were closed at severity Level 1.

Top Inpatient Providers with PQIs:

Top 5 Providers with Level 2 and 3 PQIs	Level 1- PQIs Per 1000 Discharges	Level 2- PQIs Per 1000 Discharges	Level 3- PQIs Per 1000 Discharges	Total Discharges	Total PQI's Per 1000 Discharges
None	0.00	0.00	0.00	0	0.00

Top 5 Providers for Total PQIs (Level 1-3)	Level 1- PQIs Per 1000 Discharges	Level 2- PQIs Per 1000 Discharges	Level 3- PQIs Per 1000 Discharges	Total Discharges	Total PQI's Per 1000 Discharges
Provider A	0.7	0.00	0.00	4581	1.96
Provider B	0.8	0.00	0.00	5023	1.19
Provider C	0.6	0.00	0.00	6763	0.89
Provider D	0.0	0.00	0.00	7566	0.26
Provider E	11.1	0.00	0.00	90	22.22

No inpatient providers had Severity Level – 2 or 3 PQIs. Provider A-E all had less than five Level – 1 PQIs. No issues identified; QI will continue to monitor the data for next rolling 12 months.

Top 5 Providers with 30-Day Re-admissions:

Top 5 Providers for 30 DRA (Level 1-3)	Level 1- PQIs Per 1000 Discharges	Level 2- PQIs Per 1000 Discharges	Level 3- PQIs Per 1000 Discharges	Total Discharges	Total PQI's Per 1000 Discharges
Provider A	0.13	0	0	1	7566.00
Provider B	0.20	0	0	1	5023.00

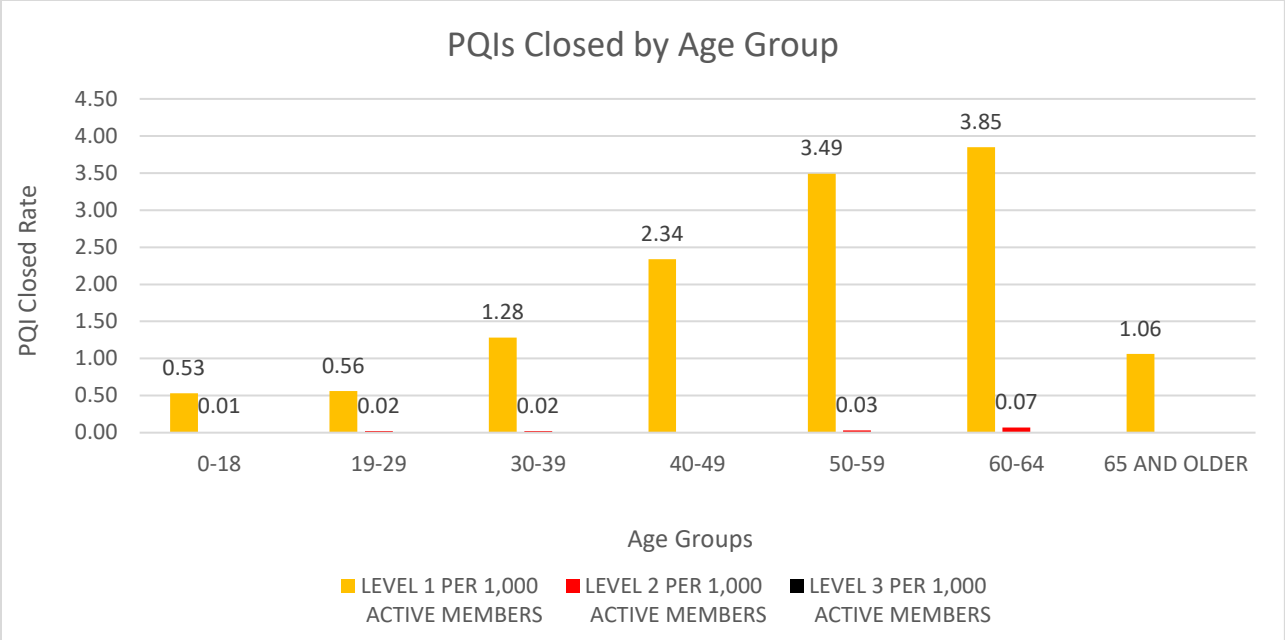
From the above data, none of the providers had a PQI with severity Level 2 or 3. Both providers had only one PQI at Level -1. No concerns identified; QI will continue to monitor for any trends.

PQIs Closed by Health Equity Categories:

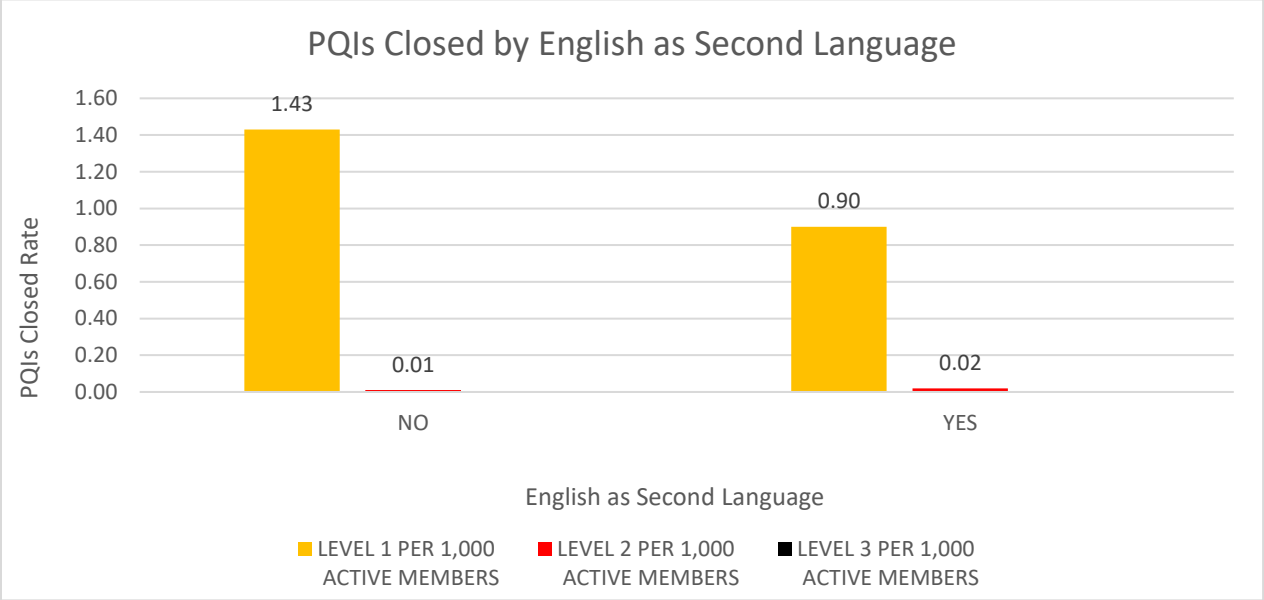
- Age Groups
- English as a second language
- Gender Identity
- Ethnicity
- Sexual Orientation – to be included once data field is available in QNXT

All data below is for the rolling 12 months from May 2024 through April 2025. The PQI closed rate is calculated using volume of PQIs with severity level 1-3 only and with those members who had at least one interaction (active members).

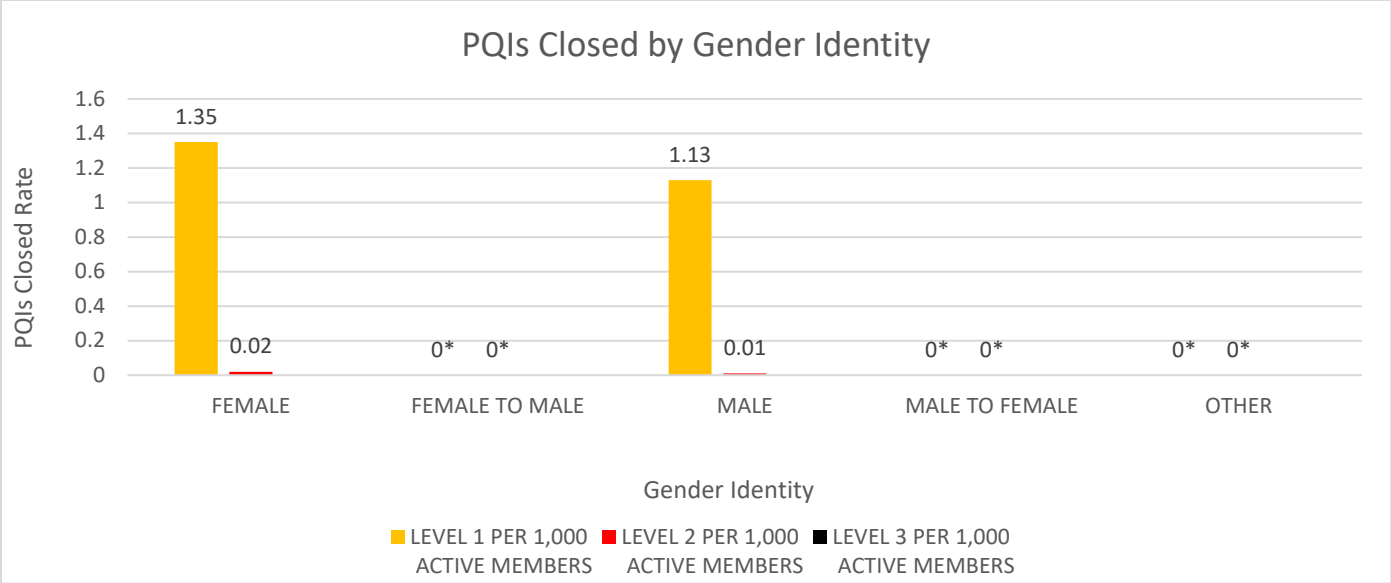
***** Indicates the active member volume was not statistically significant (<30).



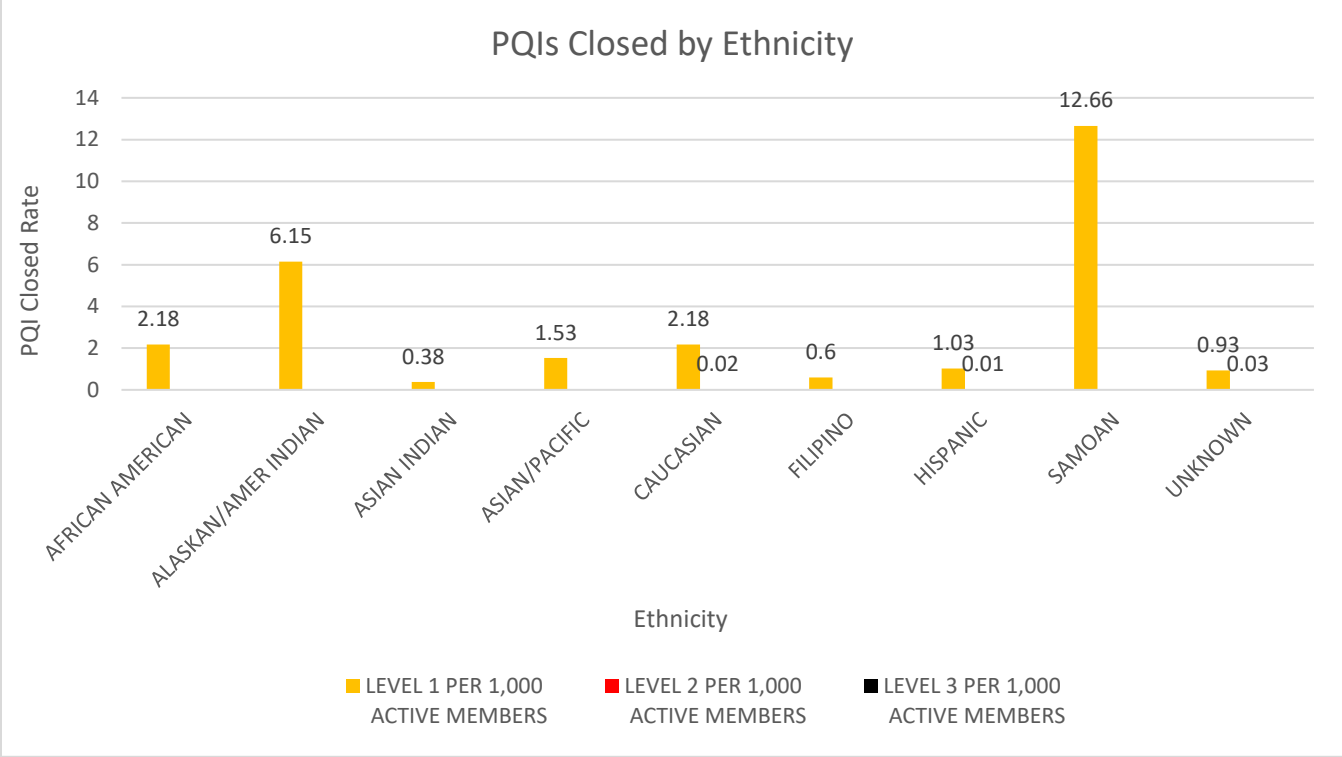
There was no severity level 3's, majority closed as level 1's.



The graph above displays active members where "NO" means English is their first language and "YES" means English is their second language and another is primary. There were no severity level 3s, majority closed as level 1's.



All gender identities able to be captured from QNXT are displayed above. There were no severity level 3s and majority PQIs closed as level 1's. There were active members identified as Female to Male, Male to Female, and Other but no PQIs closed.



Although the Samoan population has the highest PQI rate per 1000 active members, there was only one PQI for this population. Samoan account for ~0.03% of the total KHS membership, and roughly

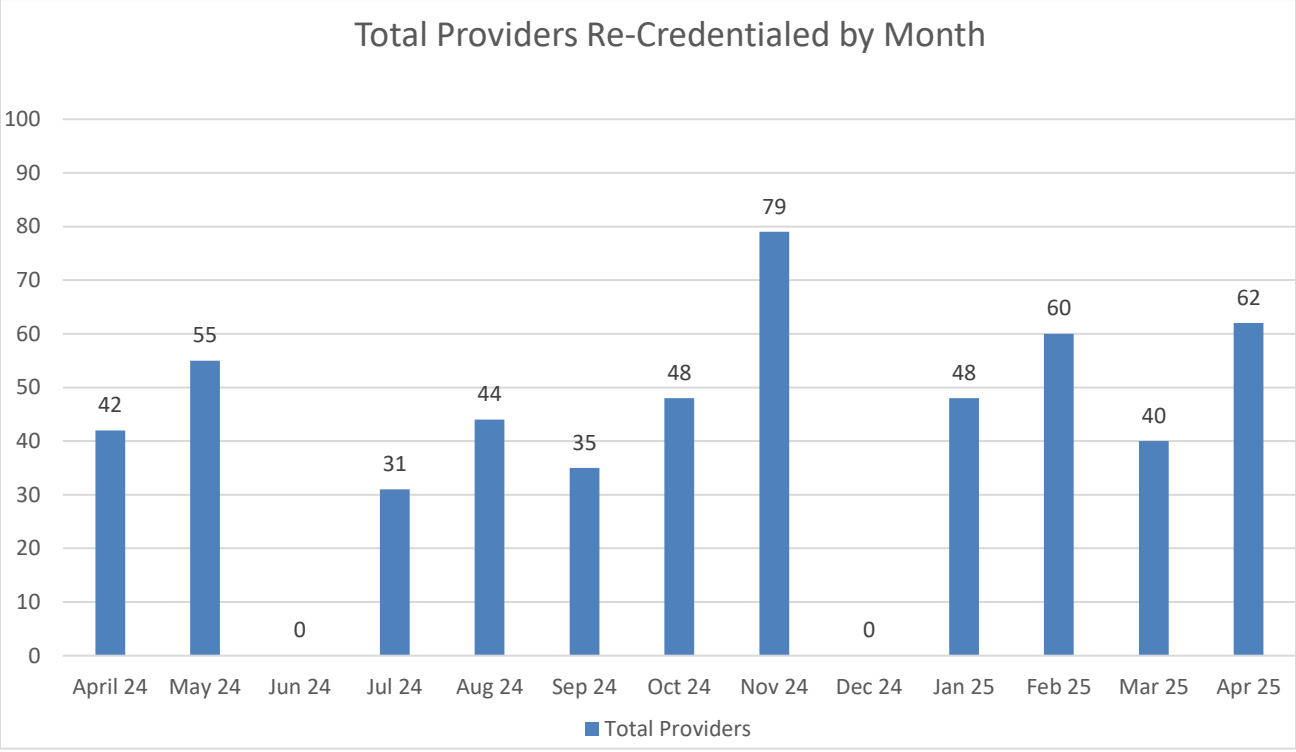
half of the total membership had at least one interaction during the rolling 12 months, which is why the PQIs per 1000 active members rate reflects higher compared to other populations. No concerns identified; QI will continue to monitor for any trends.

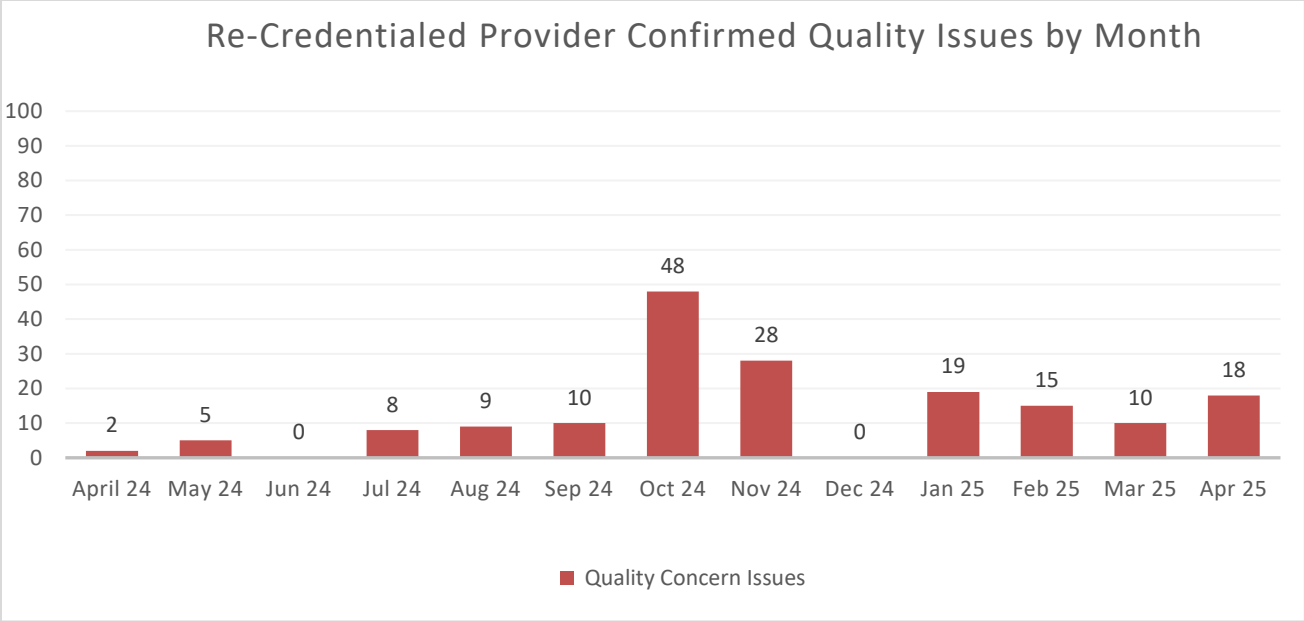
The highest active member volumes per ethnic group are Hispanic and Caucasian. Of these groups, both had the over one hundred PQIs closed with the highest being Hispanic. Hispanic had most cases closed as Level – 1's (210). Only Hispanic (2) and Unknown (1) had Level - 2. No trends or concerns to address at this time and QI will continue to monitor these volumes.

III. Re-credentialing:

Each month, every provider due for re-credentialing undergoes a retrospective three-year review evaluating their quality of care. This information is presented to the Physician Advisory Committee (PAC) and used to determine if there are any concerns or issues to prevent the providers from being re-credentialed.

QI will be reporting on actual quality of care issues found, not all complaints received.

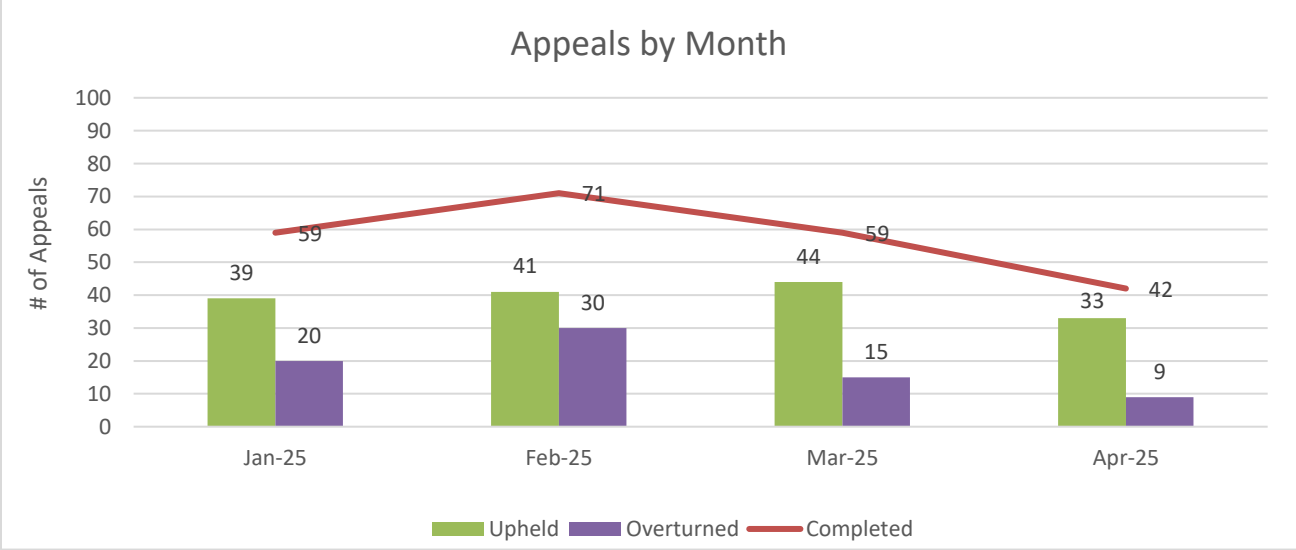


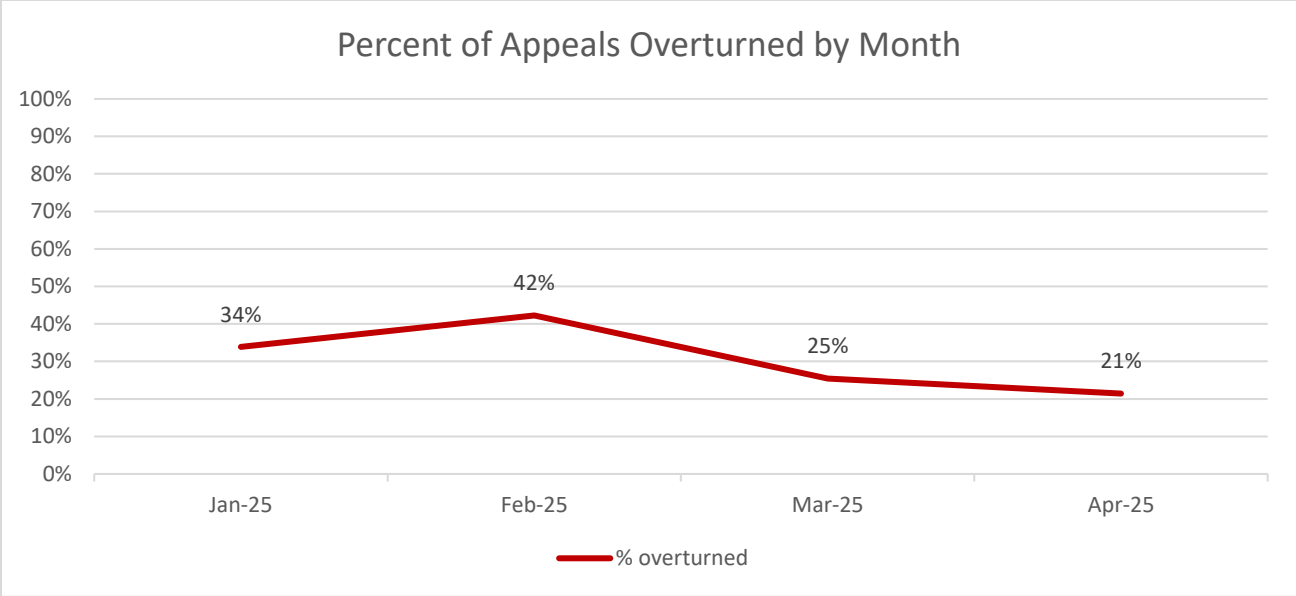


The charts above reflect the total number of Providers re-credentialed followed by total confirmed quality issues by month (closed as severity level 1-3) for April 2025. Of the 62 total providers only seven had at least one quality issue. There were 18 total quality issues among the seven providers, and all were closed at severity level 1.

IV. Appeals:

In March 2025, QI started to report on appeals, claims and disputes with data looking back from January 2025 then ongoing monthly.





Month	Appeals Completed	Appeals Upheld	Appeals Overturned	% Overturned
Jan 25	59	39	20	34%
Feb 25	71	41	30	42%
Mar 25	59	44	15	25%
Apr 25	42	33	9	21%

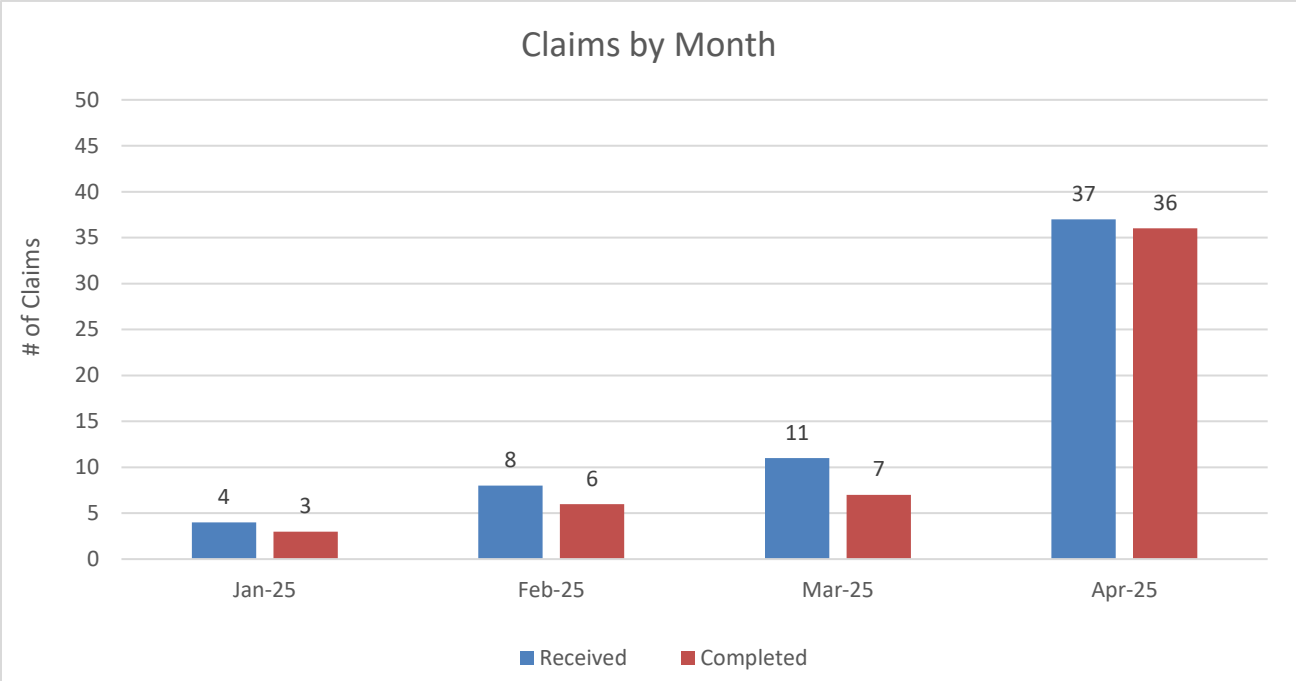
Appeals should be completed within 30 days. The table below lists the volumes of appeal turnaround times (TAT) by month.

Month	Average TAT (days)	Completed Over 30 (TAT) days
Jan 25	20	3
Feb 25	20	8
Mar 25	17	0
Apr 25	13	0

The table below lists the volumes of appeals that were re-opened and changed by reason and month.

Month	Changed Decision Date	Changed Received Date
Jan 25	1	0
Feb 25	0	0
Mar 25	2	0
Apr 25	0	0

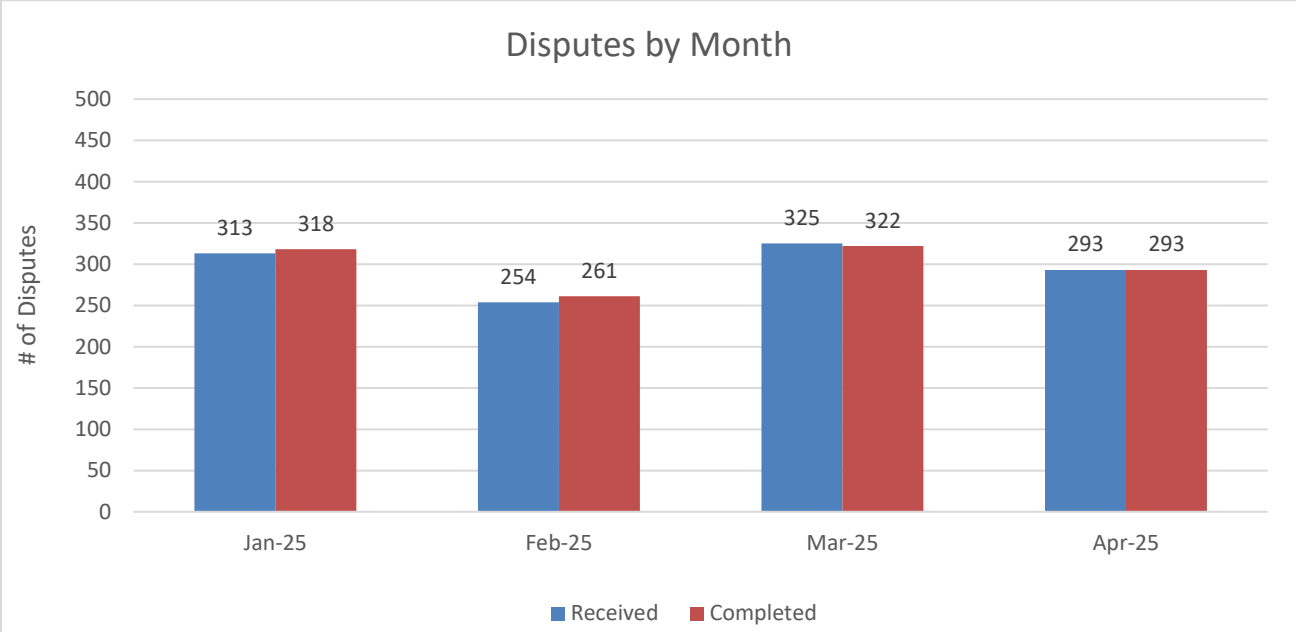
V. Claims:



Month	Claims Received	Claims Completed
Jan 25	4	3
Feb 25	8	6
Mar 25	11	7
Apr 25	37	36

Month	Inpatient Claims	Outpatient Claims
Jan 25	0	0
Feb 25	1	0
Mar 25	0	3
Apr 25	0	1

VI. Disputes:



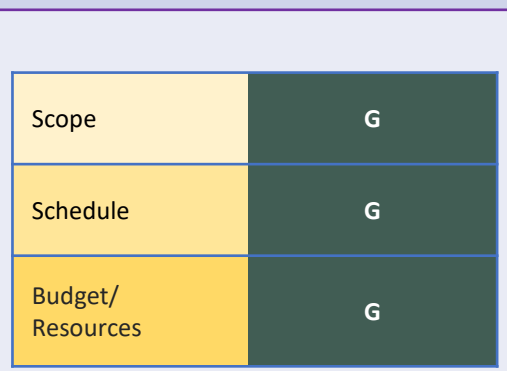
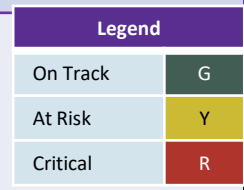
Month	Disputes Received	Disputes Completed
Jan 25	313	318
Feb 25	254	261
Mar 25	325	322
Apr 25	293	293

Month	Inpatient Disputes	Outpatient Disputes
Jan 25	68	245
Feb 25	46	208
Mar 25	66	259
Apr 25	72	221

Month	Level 1 Disputes	Level 2 Disputes
Jan 25	305	8
Feb 25	243	11
Mar 25	320	5
Apr 25	290	3

NCQA Accreditation

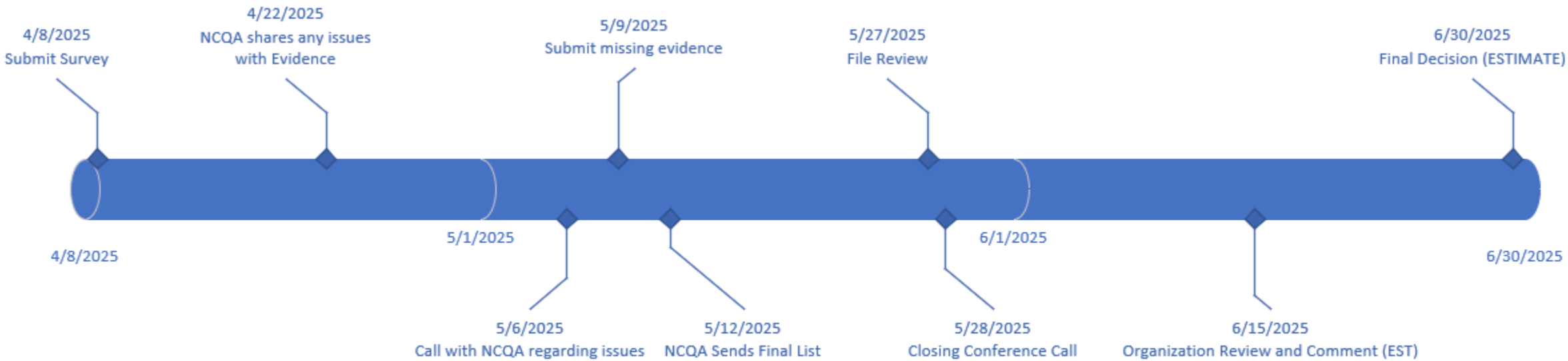
2025 NCQA Readiness Project Status

Project Information	Status
NCQA Accreditation Readiness Health Plan Accreditation (HPA) Workstreams: UM, PHM, QI, NET, CR, ME **Survey Date: April 8, 2025** Health Equity Accreditation (HEA) **Survey Date: June 10, 2025**	 

Key Accomplishments/News since Last Meeting	Next Steps
• HPA projected points finished at 99.24% • CR at 96.88% and UM at 98.81%; all others at 100% • HEA at 97.92% • NCQA identified initial HPA issues; KHS provided responses	• NCQA HPA File Reviews 5/27-5/28 • PDF, annotate & bookmark all final HEA documents • Submit HEA survey on 6/10

	Issues & Risks	Mitigation
1	UM Mock File Review Must Pass Elements – Risk of not passing this Must Pass Element (UM7B)	1.Consultant reviewing all NOA's before being sent to members 2. TMG conducted training on NOA language in 2 sessions

HPA Survey Timeline



KERN HEALTH SYSTEMS

HEA Survey Timeline

Organization IRT Submission	Tue Jun 10 2025
NCQA Submission Check	Thu Jun 12 2025
Organization Corrects Submission	
NCQA Review Part 1	Thu Jul 03 2025
Organization Reviews Issues and Creates Agenda	Wed Jul 09 2025
Survey Call	Thu Jul 10 2025
Organization Responds to Issues	Tue Jul 15 2025
NCQA Review Part 2	Tue Jul 22 2025
NCQA Review Part 2	Tue Jul 22 2025
NCQA Sends Final List	Mon Jul 14 2025
On-Site Survey	Mon Jul 28 2025
Closing Conference Call	Mon Jul 28 2025
NCQA Post Survey Review Part 1	Wed Jul 30 2025
Organization Review and Comment	Sat Aug 16 2025
NCQA Post Survey Review Part 2	
Organization Review ROC Comments	
NCQA Post Survey Review Part 3	
Final Report	
Complete	

KERN HEALTH SYSTEMS

Questions/Notes

- Decisions/Actions
- Next Steps

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS

To: KHS QIW Committee

From: Enhanced Case Management Department

Date: 05/19/2025

Re:

Background

Reporting ECM to the QIW committee provides an opportunity to highlight its role in advancing health and equity objectives within our healthcare organization. By prioritizing patient-centered care, interdisciplinary collaboration, health literacy, data-driven decision-making, and community engagement, ECM contributes to reducing disparities, improving outcomes, and fostering health equity for all individuals, regardless of race, ethnicity, socioeconomic status, or other social determinants of health.

Discussion

Enhanced Care Management (ECM) is a proactive healthcare approach aimed at improving health outcomes for individuals with complex medical needs. As part of our commitment to quality care and advancing health equity, it is essential to provide the QIW with a thorough understanding of how ECM aligns with and supports our overarching goals in this critical area. Through this discussion, we hope to give better line of sight to the committee key performance measures and our initiatives approach that demonstrate our alignment with the KHS vision for health equity for our members.

Fiscal Impact

None

Requested Action

Review and approval of the report as presented by the Enhanced Case Management leadership team.

Enhanced Care Management Quarter I 2025 QIW Report

Background:

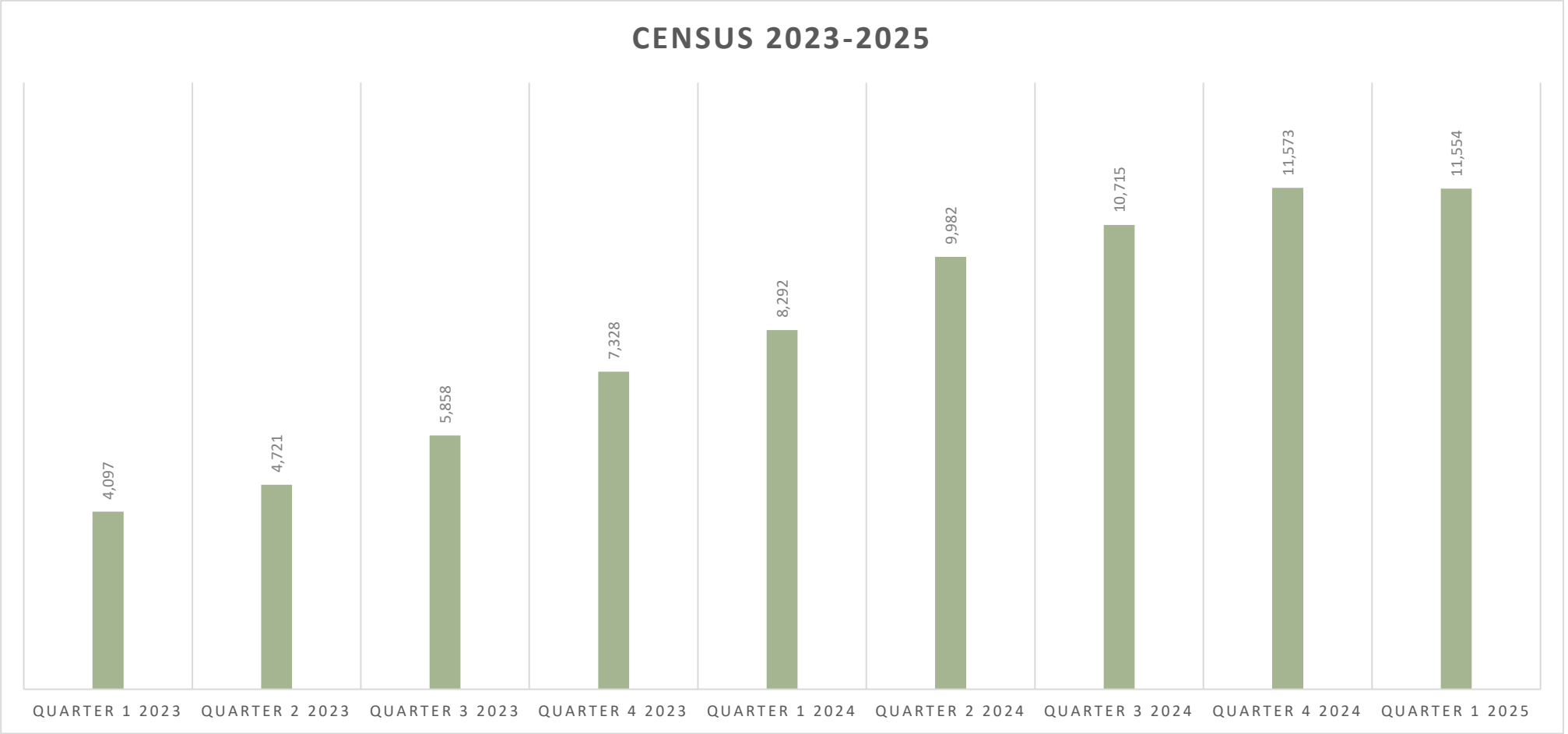
Enhanced Care Management (ECM) is a whole-person, team-based approach to care that looks at both medical and non-medical needs. It's designed for Medi-Cal members who are high-risk, high-need, and often some of the most vulnerable. ECM connects people to the right services through close coordination and hands-on, community-based support. It's all about meeting members where they are and making sure their care is well-organized and truly centered around them. Those who qualify for ECM are grouped into specific categories called "Populations of Focus":

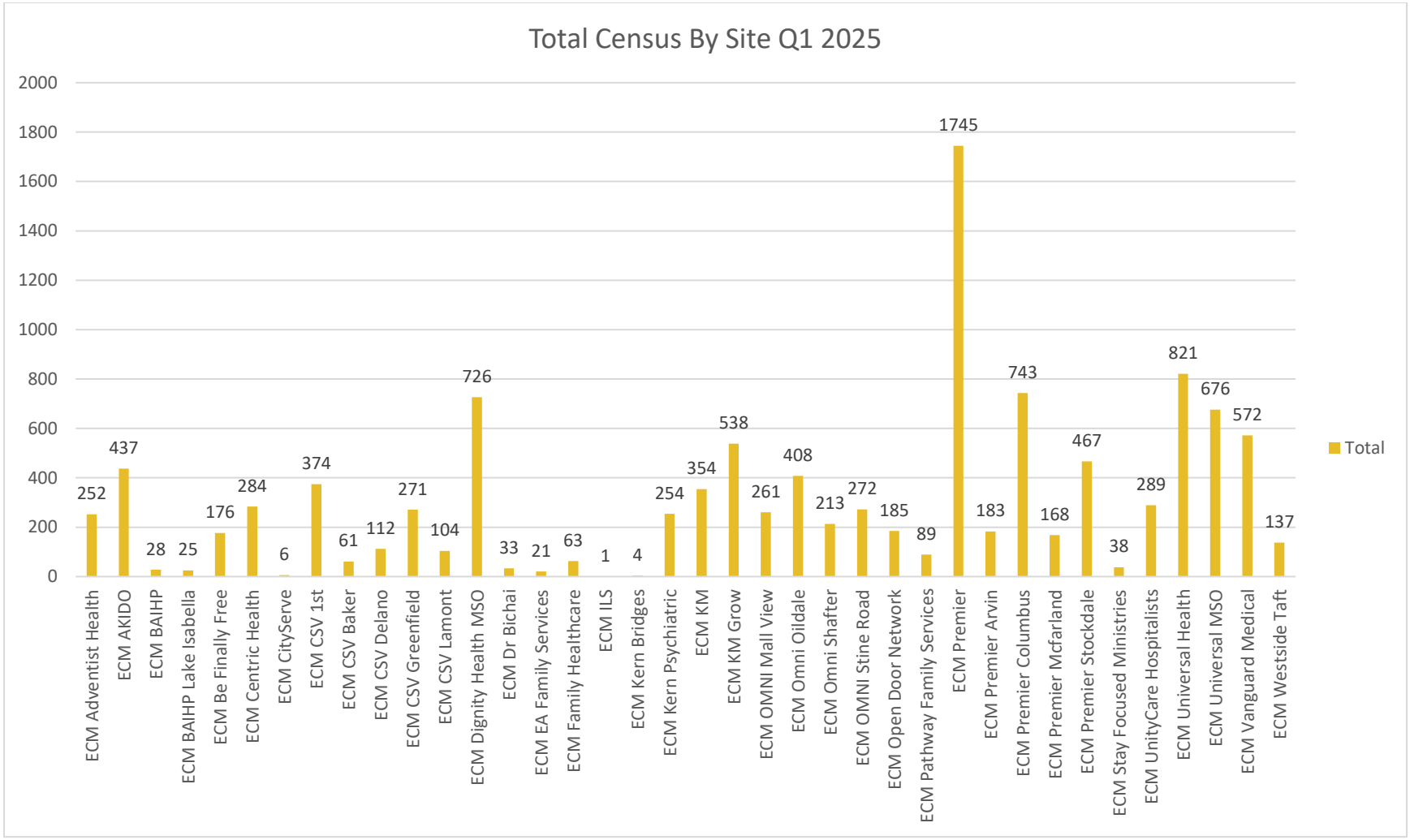
ECM Populations of Focus		Adults	Children & Youth
1a	Individuals Experiencing Homelessness: *Adults without Dependent Children/Youth Living with Them Experiencing Homelessness*	✓	
1b	Individuals Experiencing Homelessness: *Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness*	✓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

ECM Demographic Data

As of May 12th 2025, ECM had a total of 11,554 members currently enrolled in Enhanced Care Management services. These members are stratified into 41 ECM sites via geographic logic and are assigned into the above distinct populations of focus.

Overall population growth from Q1 2023 – Q1 2025

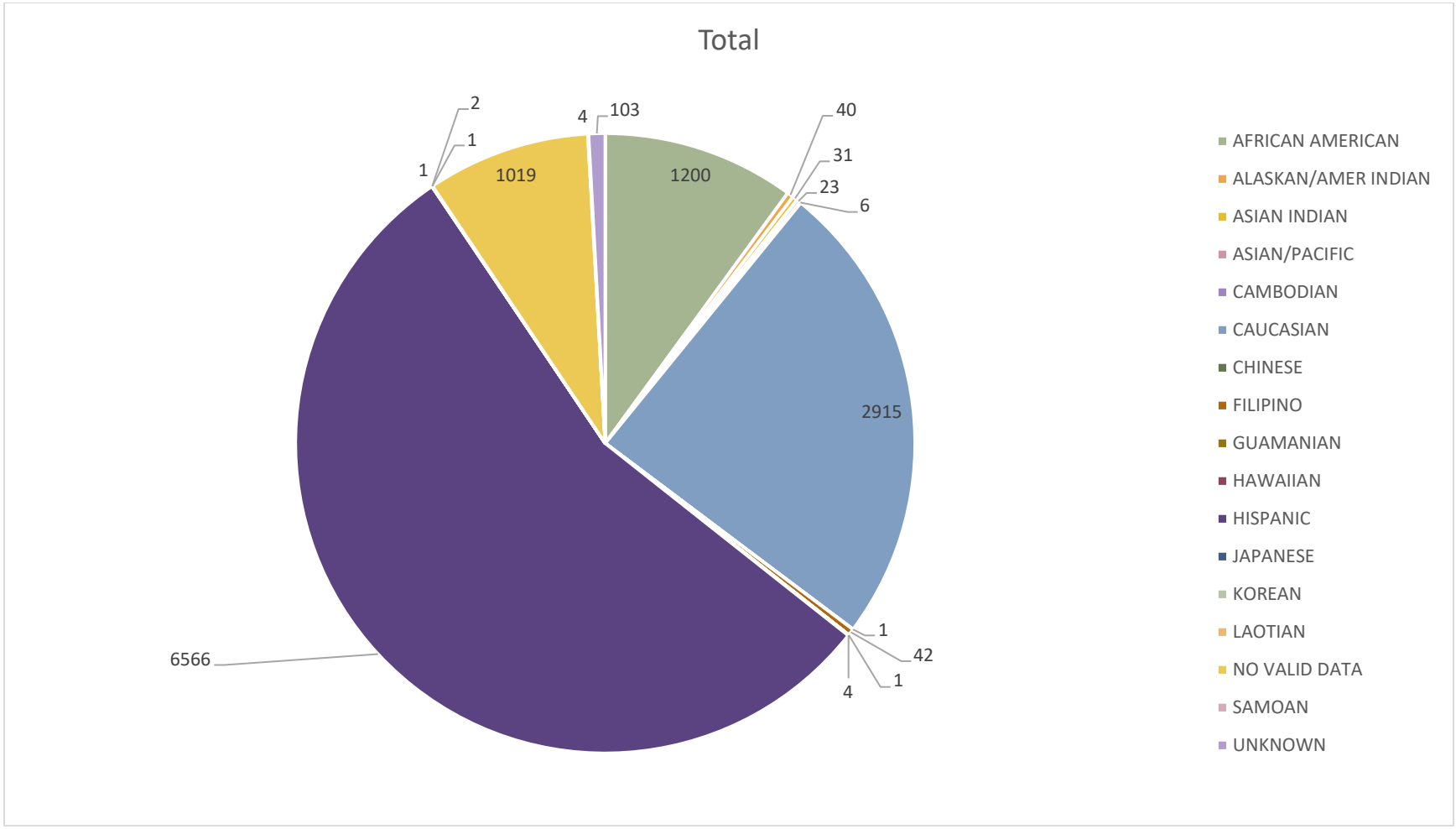



Total Census By Site Q1 2025
2000
1800
1600
1400
1200
1000
800
600
400
200
0
252
437
28
25
176
284
6
374
61
112
271
104
726
33
21
63
1
4
254
354
538
261
408
213
272
185
89
1745
183
743
168
467
38
289
821
676
572
137
ECM Adventist Health
ECM AKIDO
ECM BAIHP
ECM BAIHP Lake Isabella
ECM Be Finally Free
ECM Centric Health
ECM CityServe
ECM CSV 1st
ECM CSV Baker
ECM CSV Delano
ECM CSV Greenfield
ECM CSV Lamont
ECM Dignity Health MSO
ECM Dr Bichai
ECM EA Family Services
ECM Family Healthcare
ECM ILS
ECM Kern Bridges
ECM Kern Psychiatric
ECM KM
ECM KM Grow
ECM OMNI Mall View
ECM Omni Oildale
ECM Omni Shafter
ECM OMNI Stine Road
ECM Open Door Network
ECM Pathway Family Services
ECM Premier
ECM Premier Arvin
ECM Premier Columbus
ECM Premier Mcfarland
ECM Premier Stockdale
ECM Stay Focused Ministries
ECM UnityCare Hospitalists
ECM Universal Health
ECM Universal MSO
ECM Vanguard Medical
ECM Westside Taft
Total

Ethnicity

In the Enhanced Care Management program, we pride ourselves on maintaining the alignment in values shared throughout Kern Family Health Care in serving a diverse population. As denoted in the below graph (Ethnicity table), the largest ethnic group served by our ECM providers is the Hispanic population which constitutes 56 % of the total ECM population (as of Q1 2025), while a smaller population identify as other ethnic groups such as African American, Caucasian, Alaskan/American Indian, etc. We proudly boast a robust bilingual staff serving our membership throughout all 39 of our locations and continue to look at ways to be more equitable to all our ethnic groups in ECM.

ECM

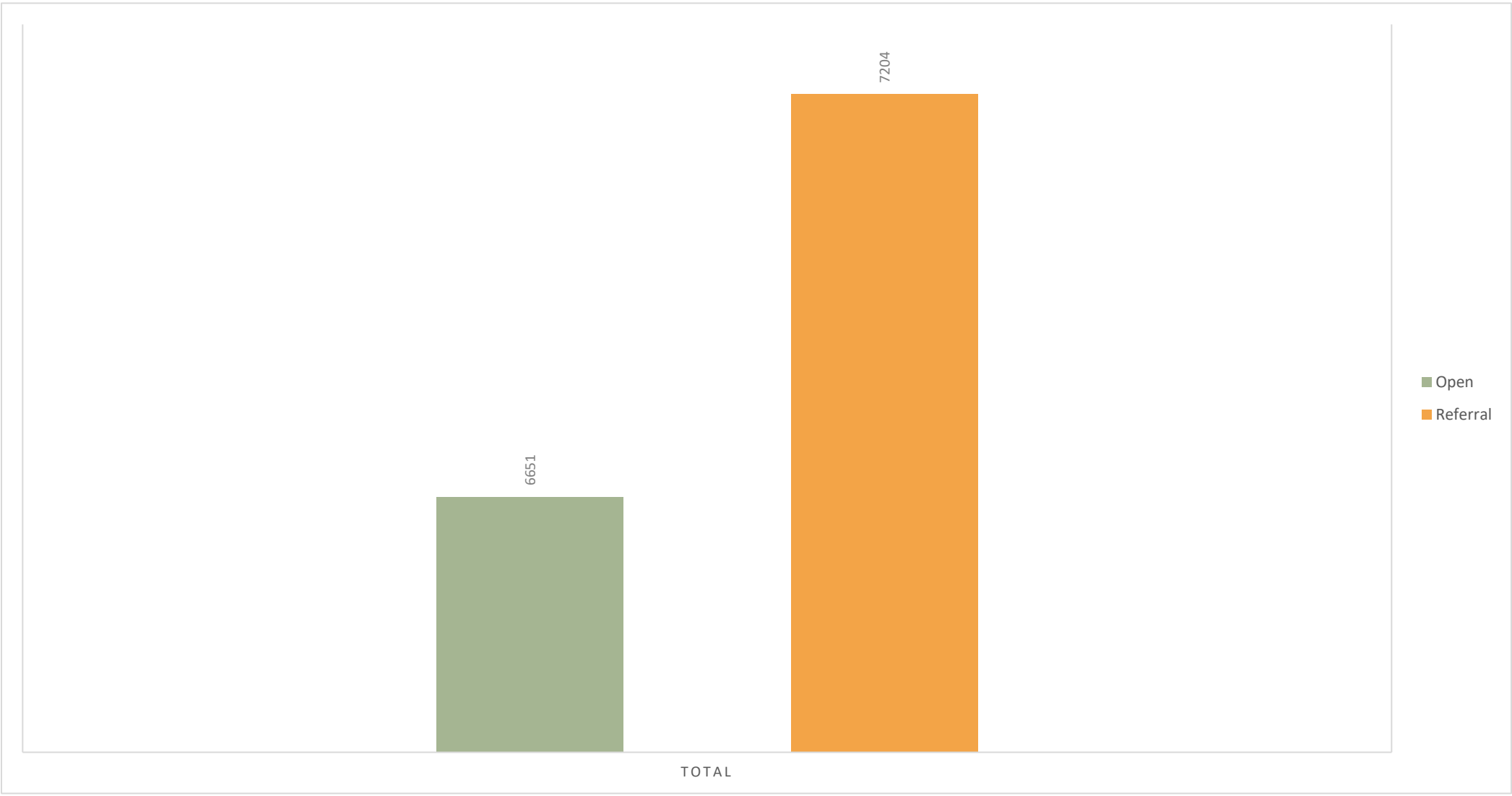

Total
2
1
1
1019
4
103
1200
40
31
23
6
2915
1
42
1
4
6566
AFRICAN AMERICAN
ALASKAN/AMER INDIAN
ASIAN INDIAN
ASIAN/PACIFIC
CAMBODIAN
CAUCASIAN
CHINESE
FILIPINO
GUAMANIAN
HAWAIIAN
HISPANIC
JAPANESE
KOREAN
LAOTIAN
NO VALID DATA
SAMOAN
UNKNOWN

ECM cost saving measure:

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

More recently, we have revamped our ECM incentives package to garner a more metric, outcome based approach in looking at three domains of utilization (avoidable urgent care, inpatient and emergency department visits). At the time of this report, these incentives are being ratified by our internal leadership and will be presented to QIW for further review once approved.

Quarter I 2025 Total ED Utilization by episode status:



Benchmark:

Through the above listed interventions, our ECM team in collaboration with the relevant ECM site will seek to decrease the total number of unique emergency room visits for members who are enrolled in ECM services by 5% in the coming quarter and subsequent quarters. As always we will work closely with our internal reporting team to obtain as realtime of data as possible to vet our interventions.

Outcomes:

For our baseline measurement of Quarter III's open population we experienced 7,105 unique ED visits for the total open population of 10,715.

For Quarter IV's 'Open' population we expereinced 5,245 unique ED visits for the total population of 11,573.

For Quarter I's 'Open' population we experienced 6,651 unique ED visits for the total populatioon of 11,554.

To standardize this, there was a decrease per 1,000 in this period from Q IV 23.4 ED visits per 1,000 from 55.3 per 1,000 in Quarter III.

Q1 Progress:

To standardize this, there was an increase per 1,000 in this period from Q I to 44.9 ED visits from 23.4 ED visits per 1,000 in Q IV. This is still below the baseline of 55.3 per 1,000 in Quarter III.

ECM clinical measure:

Site by Site Focused MCAS Outcomes

Process:

As an ECM department, we have monthly meetings with all of our sites and have a standalone section in these meetings to review MCAS performance with them. There is a concerted prioritization low hanging fruit like BCS, CCS and HBD. From there, the department sends applicable sites a drill down list of all members who are “non-compliant” and need certain screenings.

From there we do quarterly audits where we have another section dedicated to their ability and efforts to close these gaps in care. Additionally, as a desk level procedure to all sites. We train them to use the member profile through the provider portal an leverage the available data to identify these measures per patient.

ECM

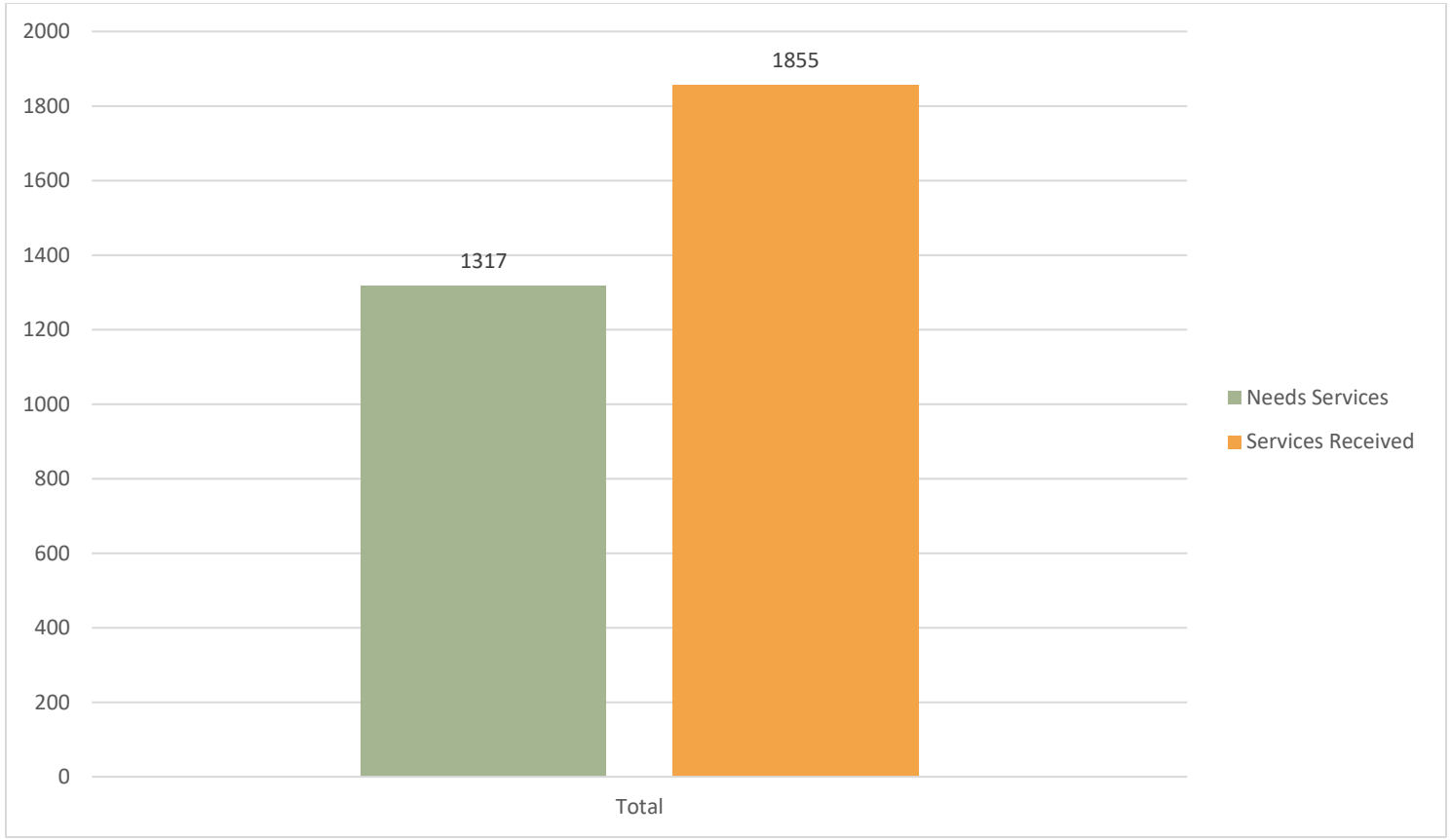
Cervical Cancer Screening

Measure Description: Women who had either the following age-appropriate cervical cancer screenings: • Women 21 to 64 years of age who had cervical cytology performed within the last 3 years.

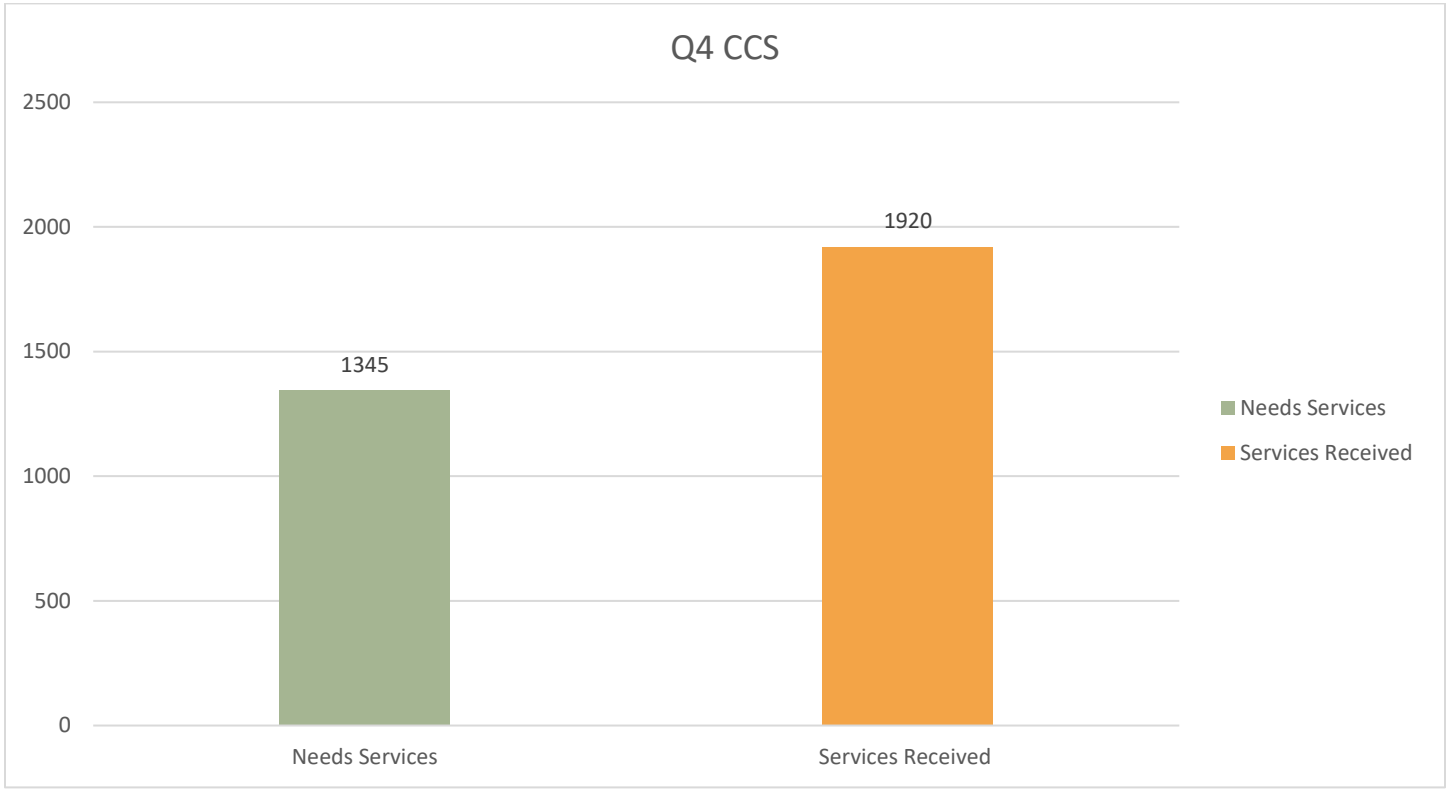
OR

• Women 30 to 64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years and were 30 years of age or older on the date of the test.

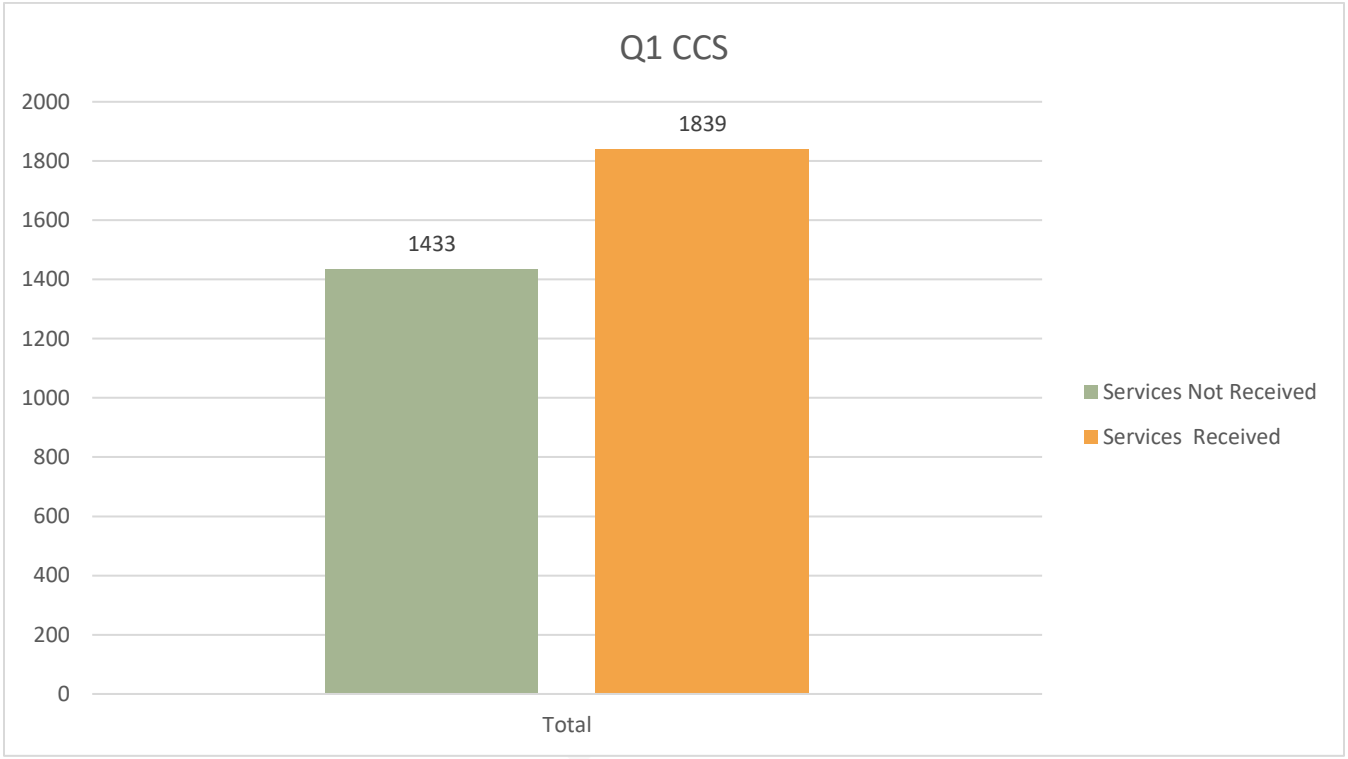
FCM


2000
1800
1600
1400
1200
1000
800
600
400
200
0
1317
1855
Total
Needs Services
Services Received

Q4 Data:


Q4 CCS
2500
2000
1500
1000
500
0
1345
1920
Needs Services
Services Received
Needs Services
Services Received

Q1 Data:



Benchmark:

Through the above listed interventions, our ECM team in collaboration with the relevant ECM site will seek to decrease the total number members needing service by 5% in the coming quarter. As always we will work closely with our internal reporting team to obtain as realtime of data as possible to vet our interventions.

Q4 Outcomes:

We increased our total population of members who have completed CCS qualifying services, while decreasing the members in need of services. This equates to a 4.4% increase in compliant membership and an increase of 2.1% in non-compliant members. *

**Variables to be taken into account would include fluctuations in census and disenrollments per respective site.*

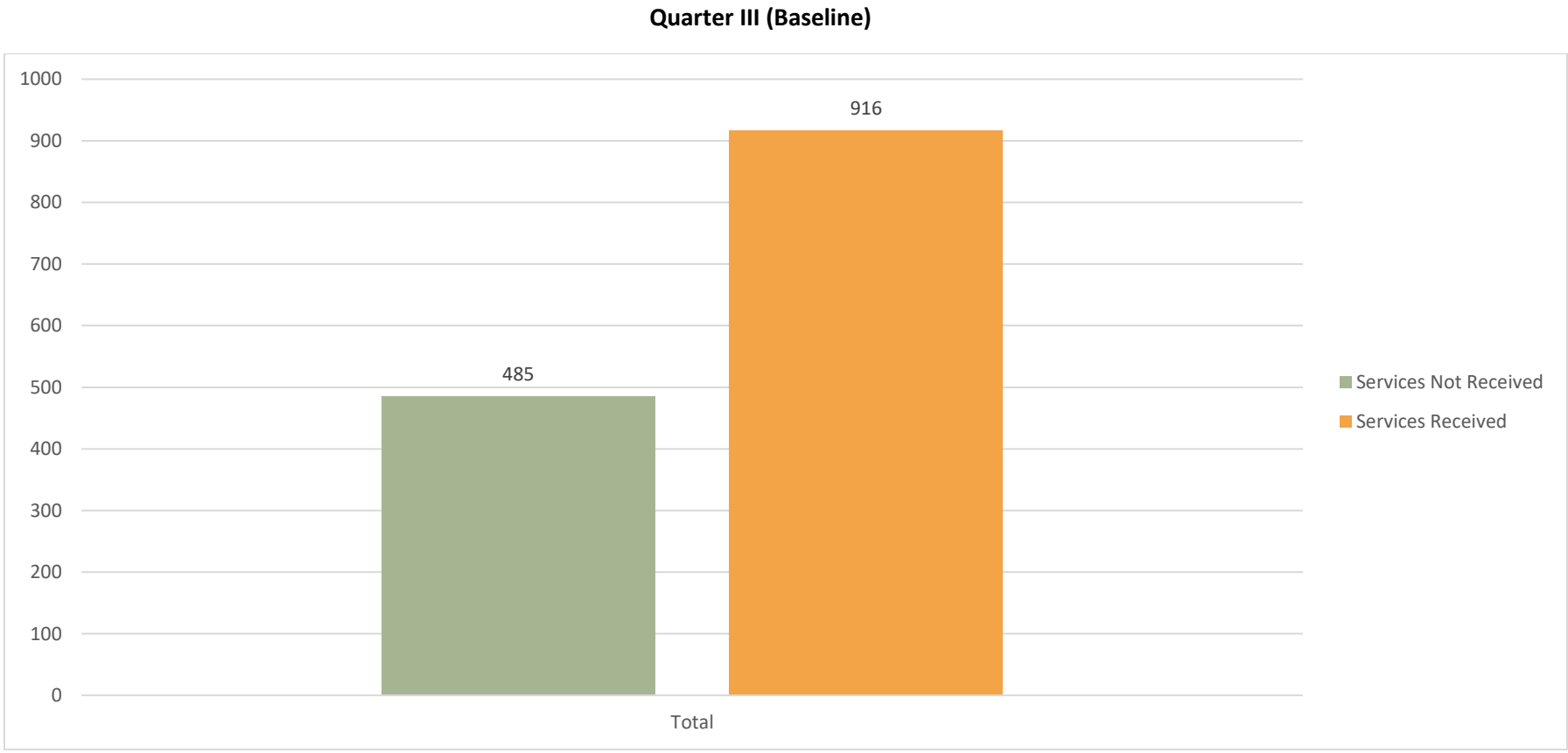
Q1 Outcomes:

Our total quarter in-quarter out population who are in open status to ECM services remianded close to baseline; 3,265 to 3,272 member from Q4 to Q1. We slighhtly decreased our total population of members who have completed CCS qualifying services, while increasing the members in need of services. This equates to a 2.3% increase in non- compliant membership and an decrease of 2.1% in compliant members. *

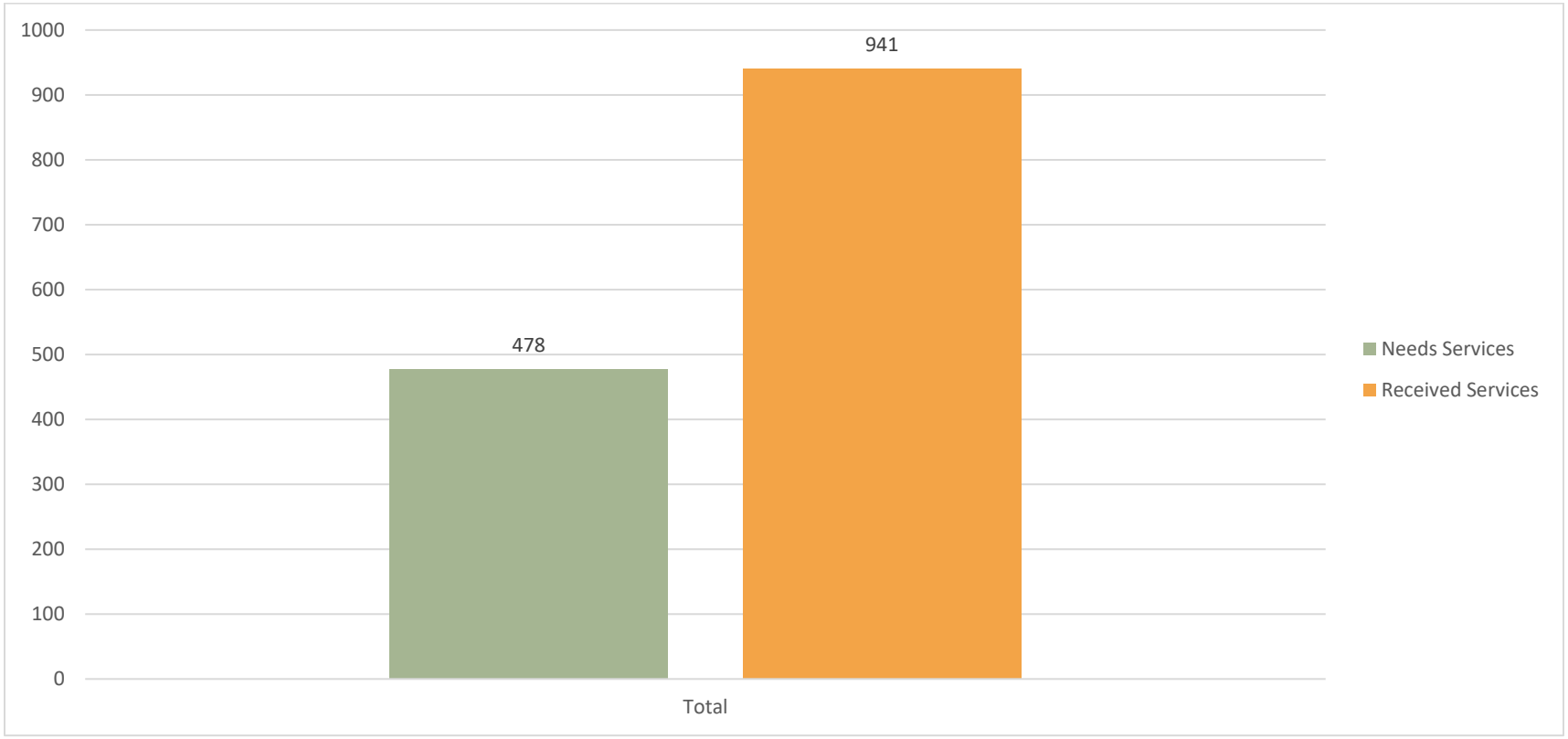
**Variables to be taken into account would include fluctuations in census and disenrollments per respective site.*

Breast Cancer Screening

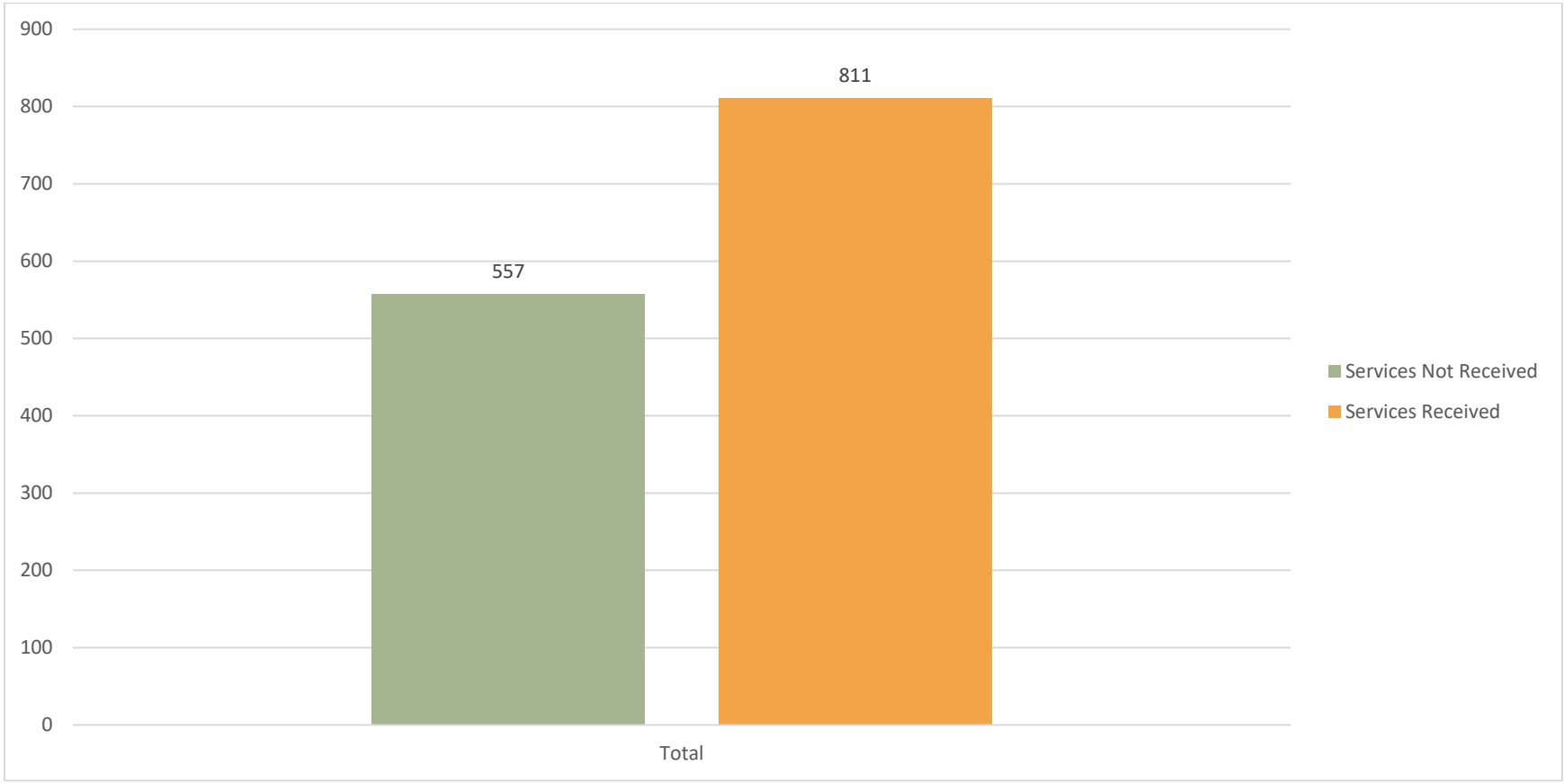
Measure Description: Women ages 50 to 74 years of age who had one or more mammograms to screen for breast cancer any time on or between October 1, two years prior to the measurement year, and December 31 of the measurement year.



Quarter 4 data:



Quarter 1 Data:



Benchmark:

Through the above listed interventions, our ECM team in collaboration with the relevant ECM site will seek to decrease the total number members needing service by 5% in the coming quarter. As always we will work closely with our internal reporting team to obtain as realtime of data as possible to vet our interventions.

Q4 Status:

We increased our total population of members who have completed BCS qualifying services, while decreasing the members in need of services. This equates to a 2.7% increase in compliant membership and a decrease of 2.5% in non-compliant members. *

**Variables to be taken into account would include fluctuations in census and disenrollments per respective site.*

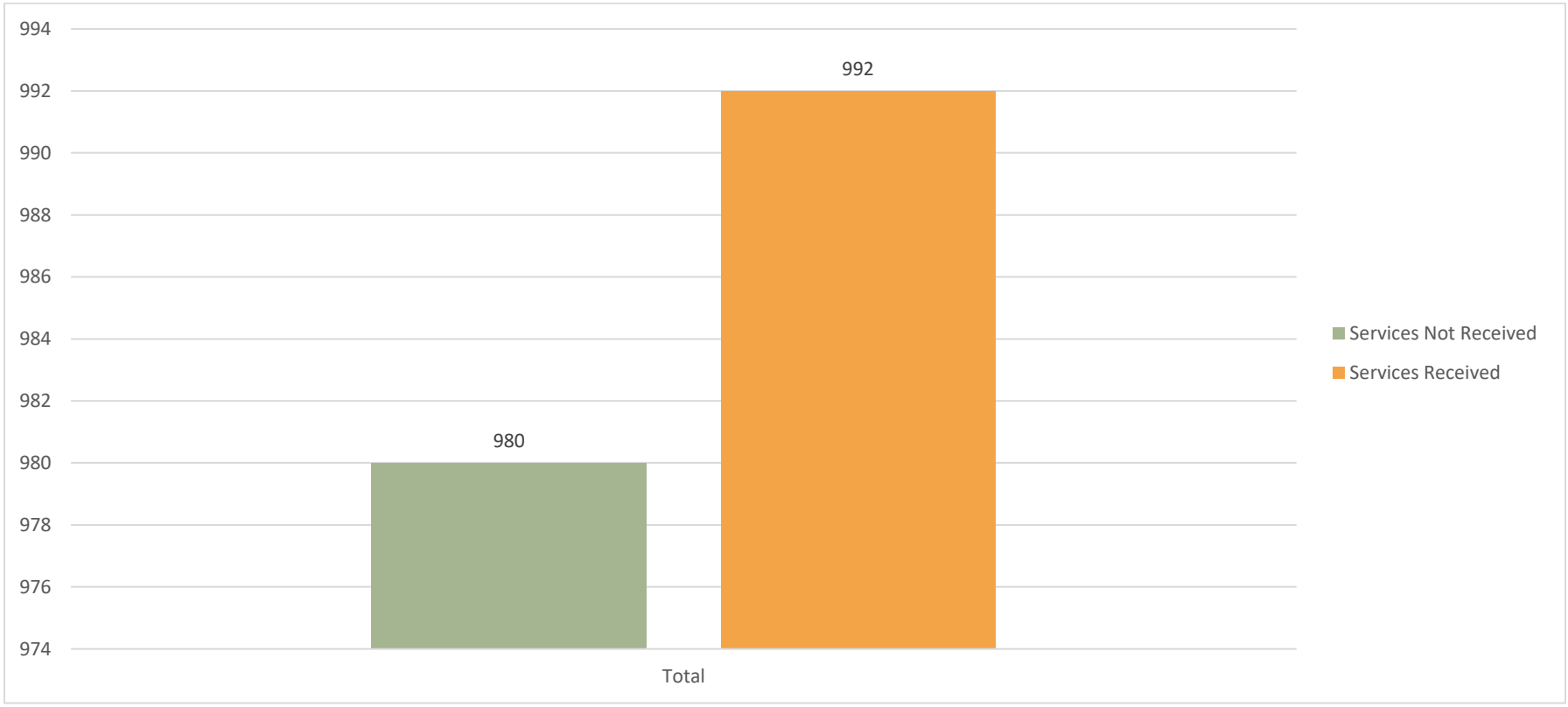
Q1 Status:

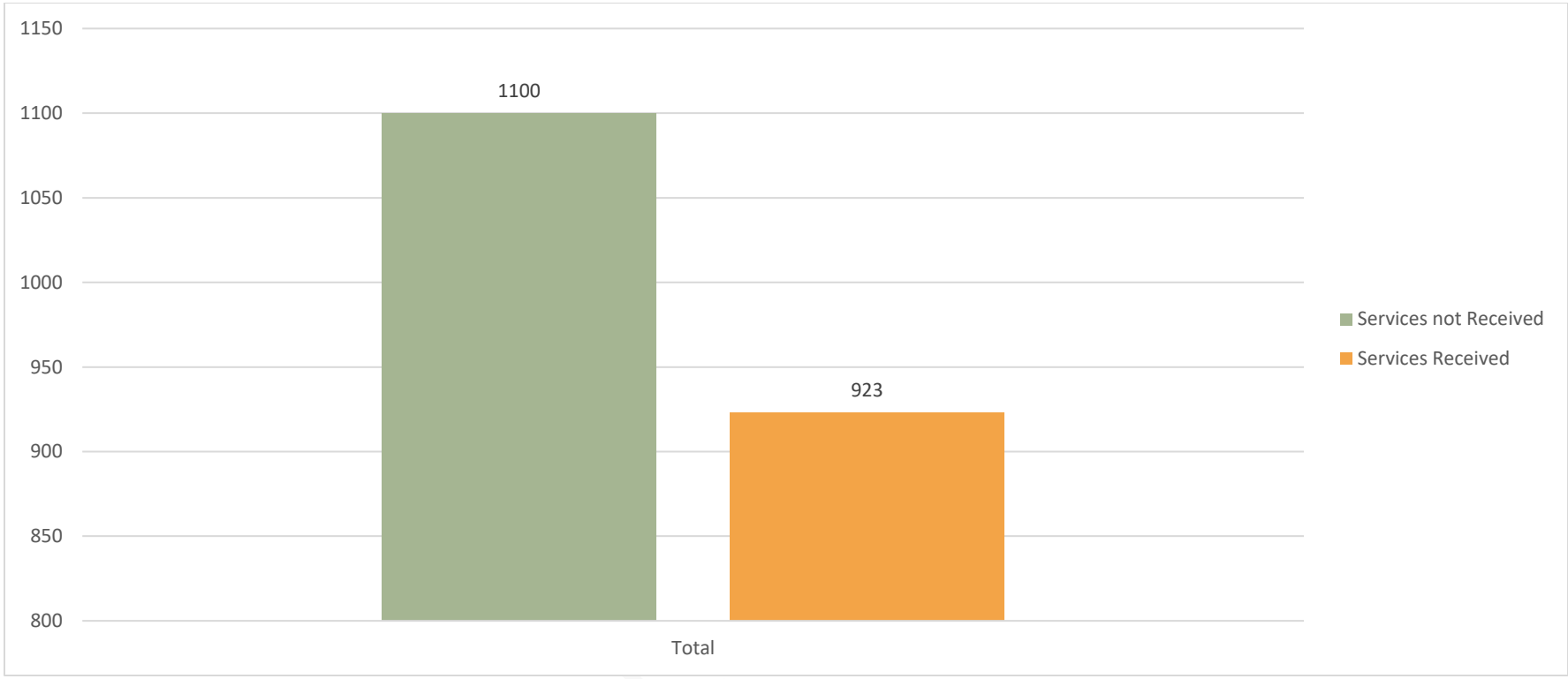
Our total amount of members as compared to Q4 dropped from 1,419 to 1368 total members. Proportionally, we decreased our total population of members who have completed BCS qualifying services, while decreasing the members in need of services. This equates to a 5.2% increase in compliant membership and a increase of 8.1% in non-compliant members. *

**Variables to be taken into account would include fluctuations in census and disenrollments per respective site.*

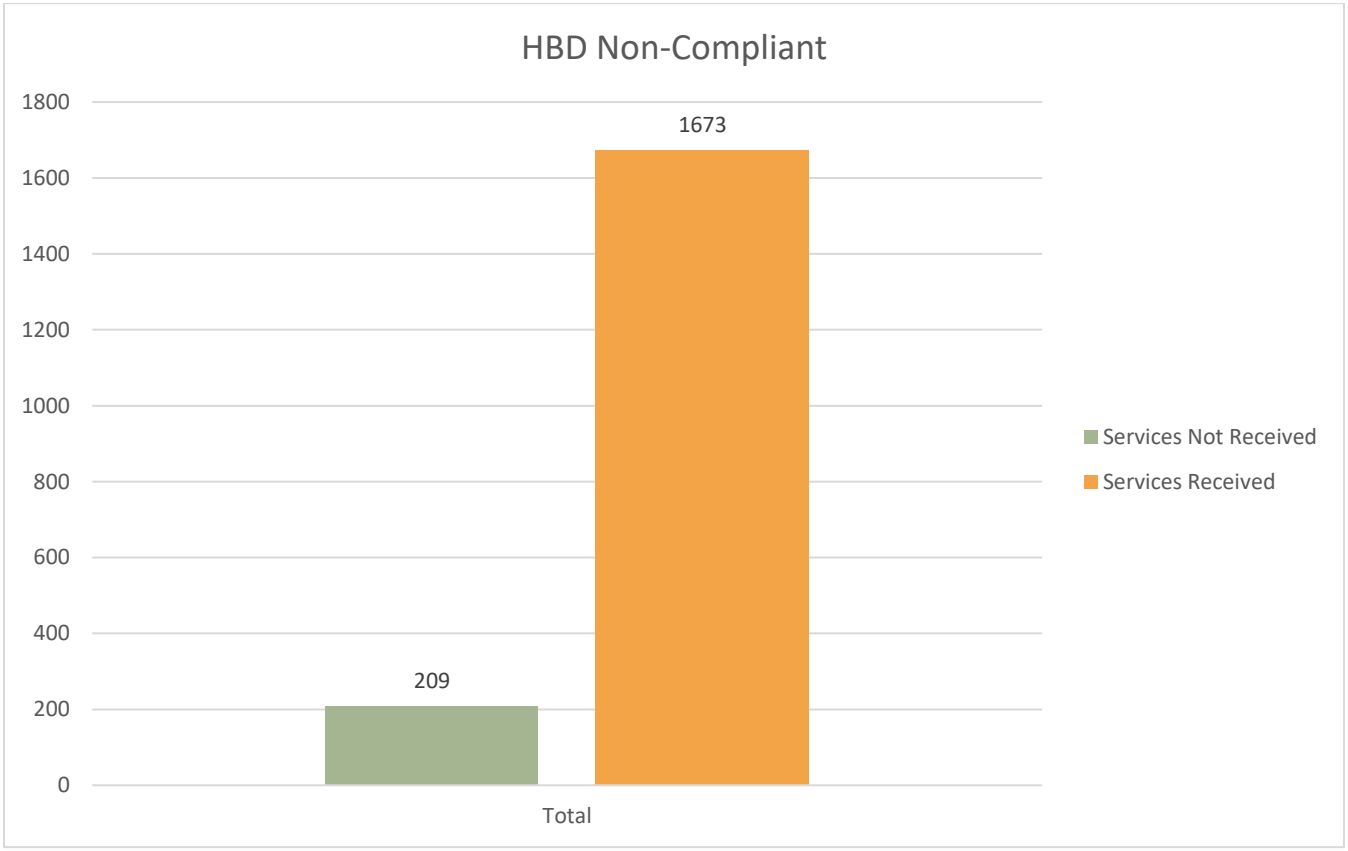
Comprehensive Diabetes Care

Measure Description: Members 18 to 75 years of age with diabetes (type 1 or 2) whose hemoglobin A1c (HbA1c) level was >9.0% during the measurement year.




1150
1100
1050
1000
950
900
850
800
1100
923
Total
Services not Received
Services Received

Quarter 1 Data:



Benchmark:

Through the above listed interventions, our ECM team in collaboration with the relevant ECM site will seek to decrease the total number members needing service by 5% in the coming quarter. As always we will work closely with our internal reporting team to obtain as realtime of data as possible to vet our interventions.

Q4 Status:

We decreased our total population of members who have completed HBD qualifying services, while increasing the members in need of services. This equates to a 11% increase in non-compliant membership and a decrease of 7% in compliant members. *

**Variables to be taken into account would include fluctuations in census,and disenrollments per respective site (which include graduations).*

Q1 Status:

We dramatically increased our total population of members who have completed HBD qualifying services, while decreasing the members in need of services. Quarter on quarter the overall shift of total open population with this measure went from 2,023 to 1,882 total members. This equates to a 32% increase in compliant membership and a decrease of 34.1% in non-compliant members. *

**Variables to be taken into account would include fluctuations in census,and disenrollments per respective site (which include graduations).*

Patient Satisfaction:

Survey Data

The Enhanced Care Management team has historically sent an experience satisfaction survey out to it's members for resubmission to the plan.

As of date of submission to the QIW, we have received our 2025 surveys from our membership. This data has as well been partitioned by site for more drill down on site specific performance.

Questionnaire. Press Ganey (PG) worked with Kern Health Systems to develop the survey instrument. The survey was designed to be administered in English and Spanish, via mail and telephone.

Data collection. Data collection information is detailed in the table below.

Sample design.

- Qualified respondents. The population surveyed includes members who have participated in the ECM Program.
- Sample source. Kern Health Systems supplied the sample, including name, language and contact information for 6,015 eligible members. PG processed the sample through NCOA and phone append process. After deduping by address and phone number, a stratified random sample of 3,500 members was drawn.
- Sample size and response rate.

Data processing and tabulation. PG performed all data entry, data cleaning and verification, and produced detailed tables that summarize the results.

Note:

- Percentages less than 5.0% are not shown in graphs where space does not permit.
- T2B refers to the top-two-box score, which is the percentage of respondents selecting a response from the two most favorable scale options (for example, Very Satisfied or Satisfied).
- Totals reported in graphs and tables may not be equal to the sum of the individual components due to the rounding of all figures.

2023 Survey Response Rate:

- **Sample size and response rate.**

Sample size	Total undeliverable records	Completed surveys			Response rate	Adjusted response rate
		Total	Mail	Phone		
3,500	183	488	281	207	13.9%	14.7%

2024 Survey Response Rate:

- **Sample size and response rate.**

Sample size	Total undeliverable records	Completed surveys			Internet	Response rate	Adjusted response rate
		Total	Mail	Phone			
3,308	151	879	233	577	69	26.6%	27.8%

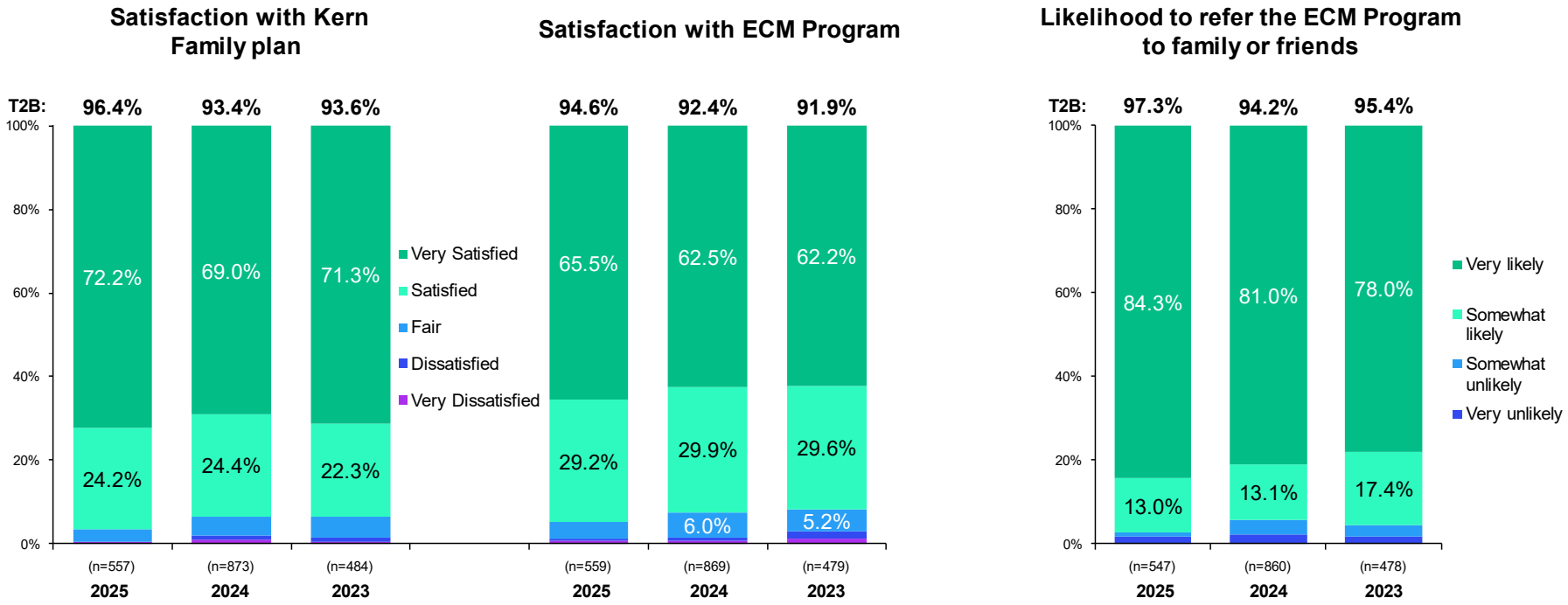
2025 Survey Response Rate:

Sample size	Total undeliverable records	Completed surveys				Response rate	Adjusted response rate
		Total	Mail	Phone	Internet		
2,782	156	566	230	272	64	20.3%	21.6%

ECM

Overall satisfaction

The percentage who are satisfied with Kern Family plan and are likely to refer the ECM Program increased significantly from 2 024. The vast majority are satisfied with the ECM Program.



Q9. How satisfied are you with Kern Family as your health insurance plan? Q10. How satisfied are you with your overall experi ence with your Kern Health ECM Program? Q11. How likely are you to refer Kern Health's ECM Program to family or friends? An arrow ( ) indicates a significantly different result from the previous year.

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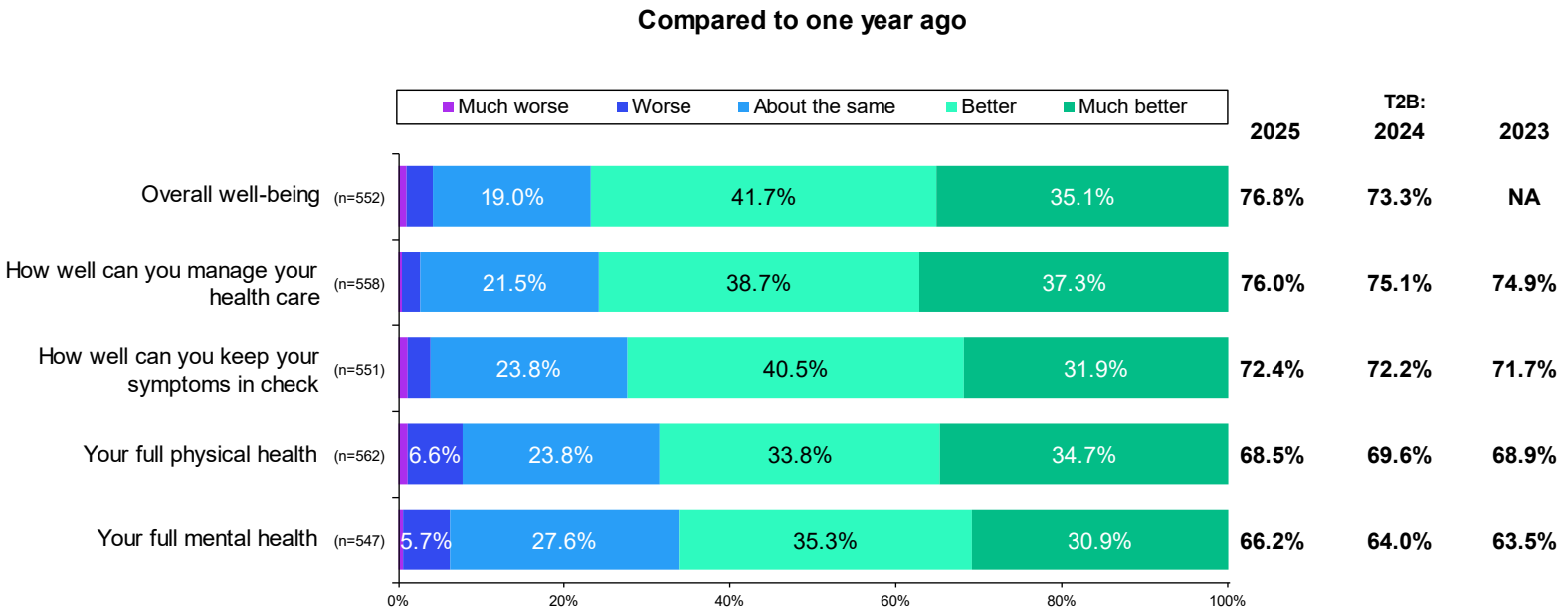
Outcomes

The percentage who indicated that their overall well -being is better compared to one year ago increased slightly from 2024. Scor es for the remaining measures are consistent with 2024.



Q12. Compared to 12 months ago, how would you rate…? An arrow ( ) indicates a significantly different result from the previous year.

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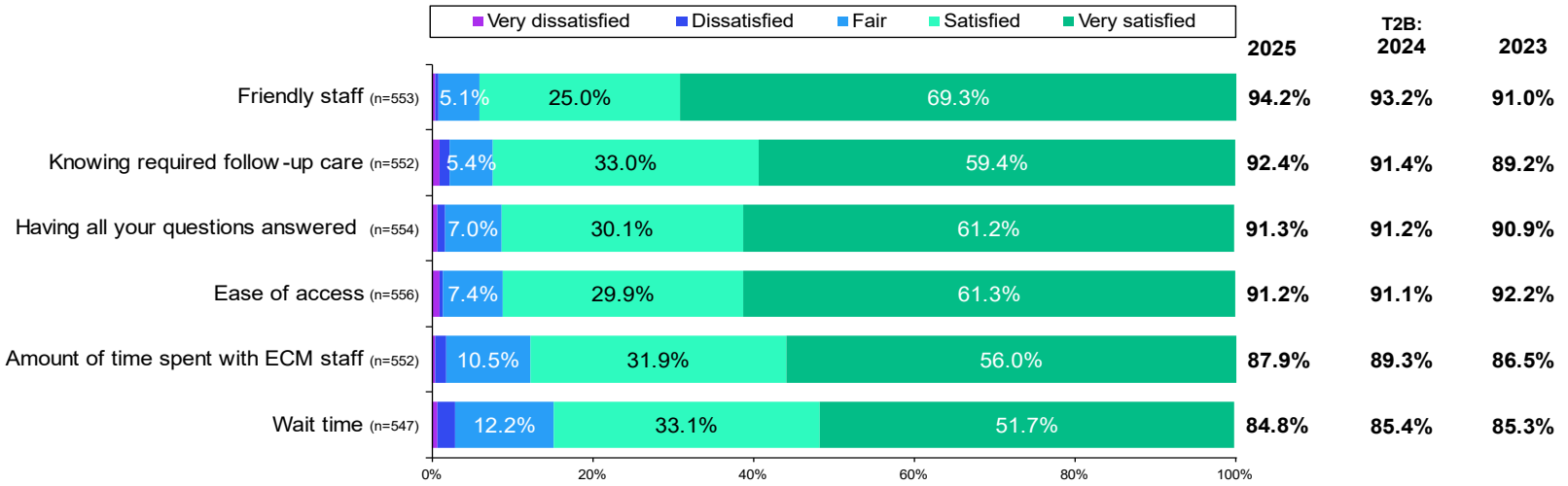
Experience with ECM visit

The majority are satisfied with each aspect of their most recent ECM visit.

Satisfaction with most recent ECM visit



	T2B: 2025	2024	2023
Friendly staff (n=553)	94.2%	93.2%	91.0%
Knowing required follow-up care (n=552)	92.4%	91.4%	89.2%
Having all your questions answered (n=554)	91.3%	91.2%	90.9%
Ease of access (n=556)	91.2%	91.1%	92.2%
Amount of time spent with ECM staff (n=552)	87.9%	89.3%	86.5%
Wait time (n=547)	84.8%	85.4%	85.3%

Q6. Please rate your overall satisfaction with the following aspects of your most recent ECM visit: An arrow ( ) indicates a significantly different result from the previous year.

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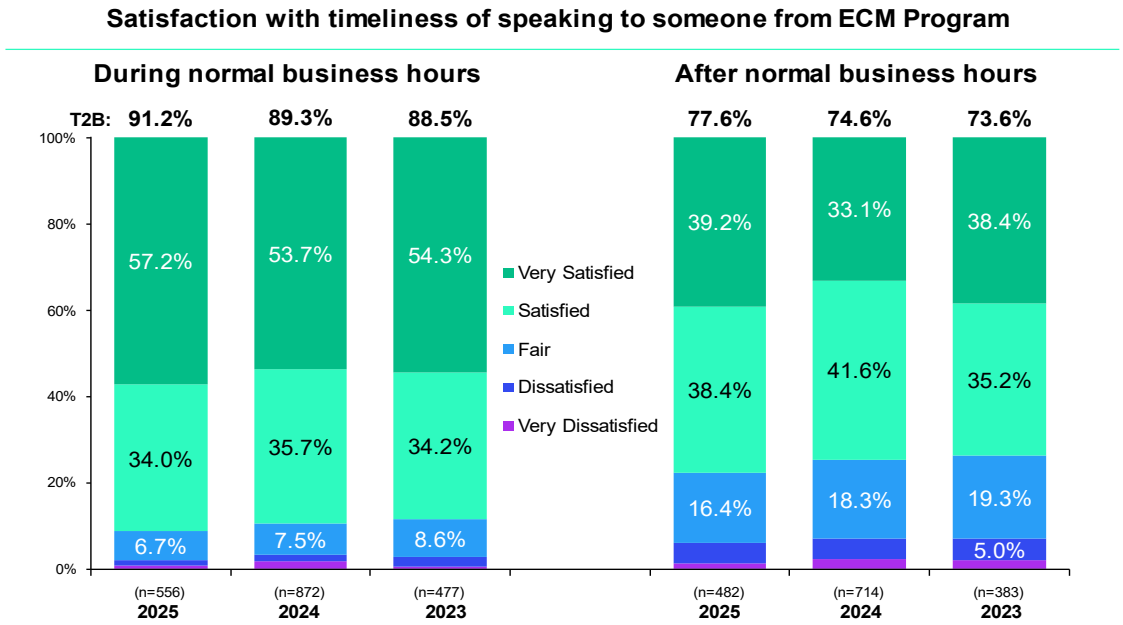
Responsiveness

More than nine in 10 are satisfied that they can speak to someone from the program in a timely manner during normal business hours, while more than three in four are satisfied with the timeliness of the after -hours response.



Q7. How satisfied are you when you are able to speak to someone from the ECM Program in a timely manner about any issues? An arrow ( ) indicates a significantly different result from the previous year.

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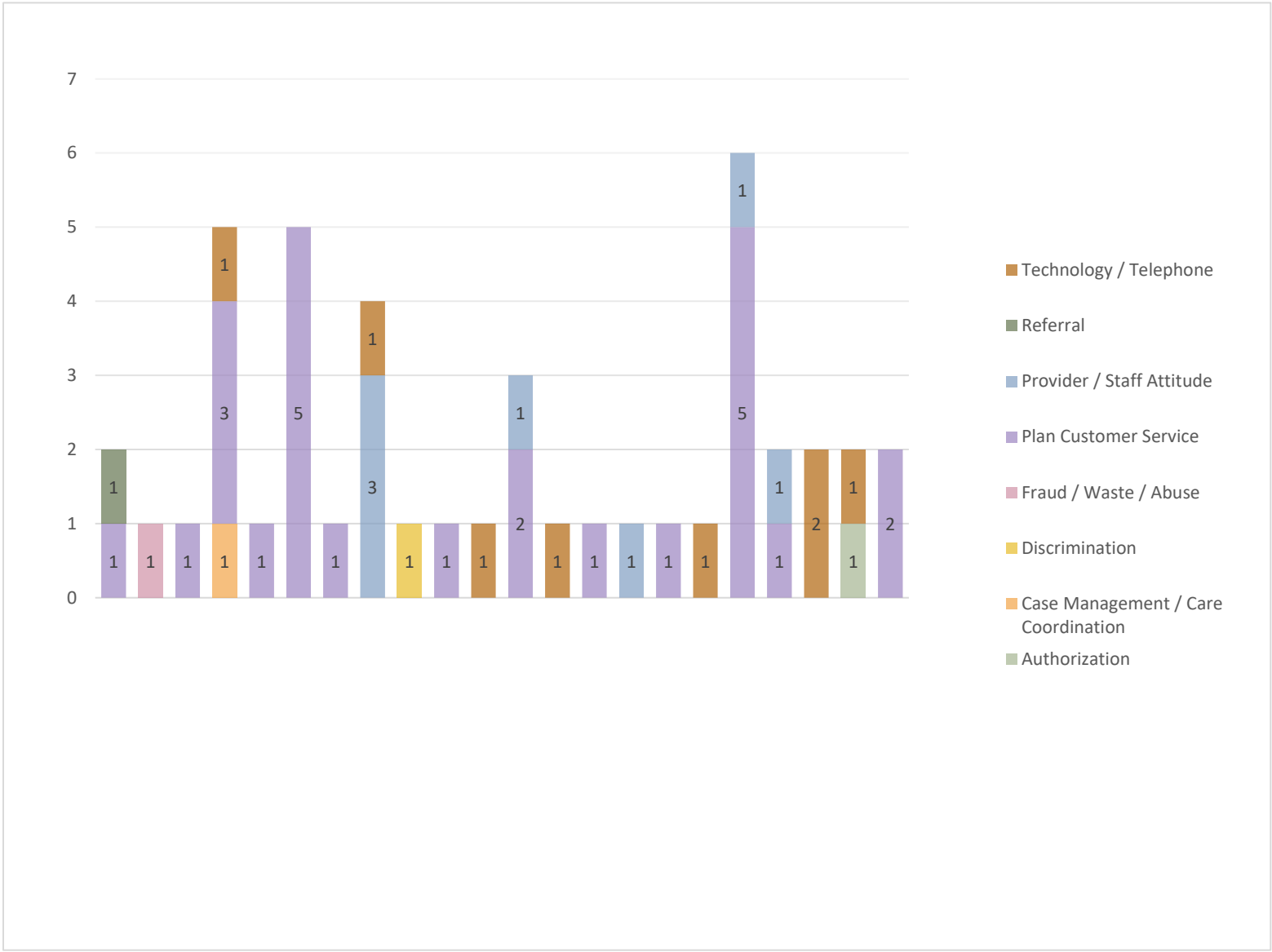
Grievances

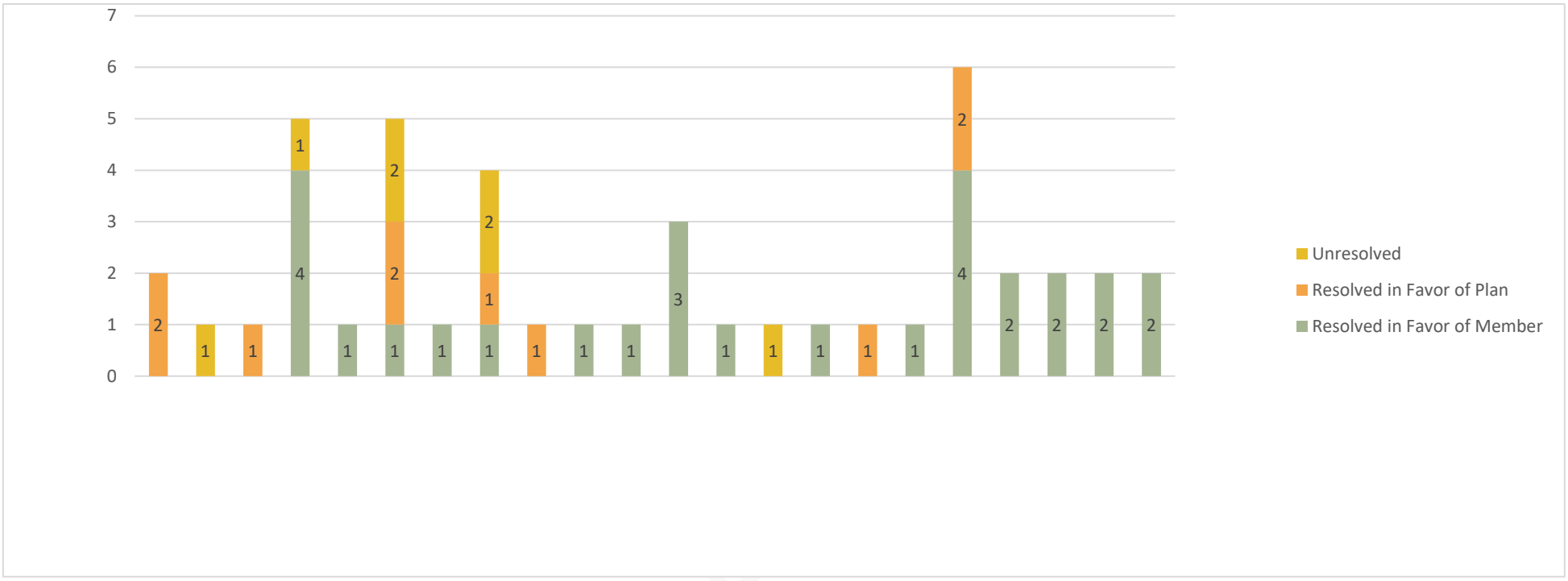
In the Enhanced Care management department, we make a concerted effort to keep our fingers on the patient experience pulse by not only sending the above survey to our members, but also keeping tabs on all ECM related grievances. On top of being a mainstay in the grievance committee meetings, we have standing agenda items for grievance follow up as they pertain to the site. In this effort we not only wish to continue to track and trend all issues related to ECM sites but make the data actionable and directly accessible to our sites for more real time response and action planning.

ECM

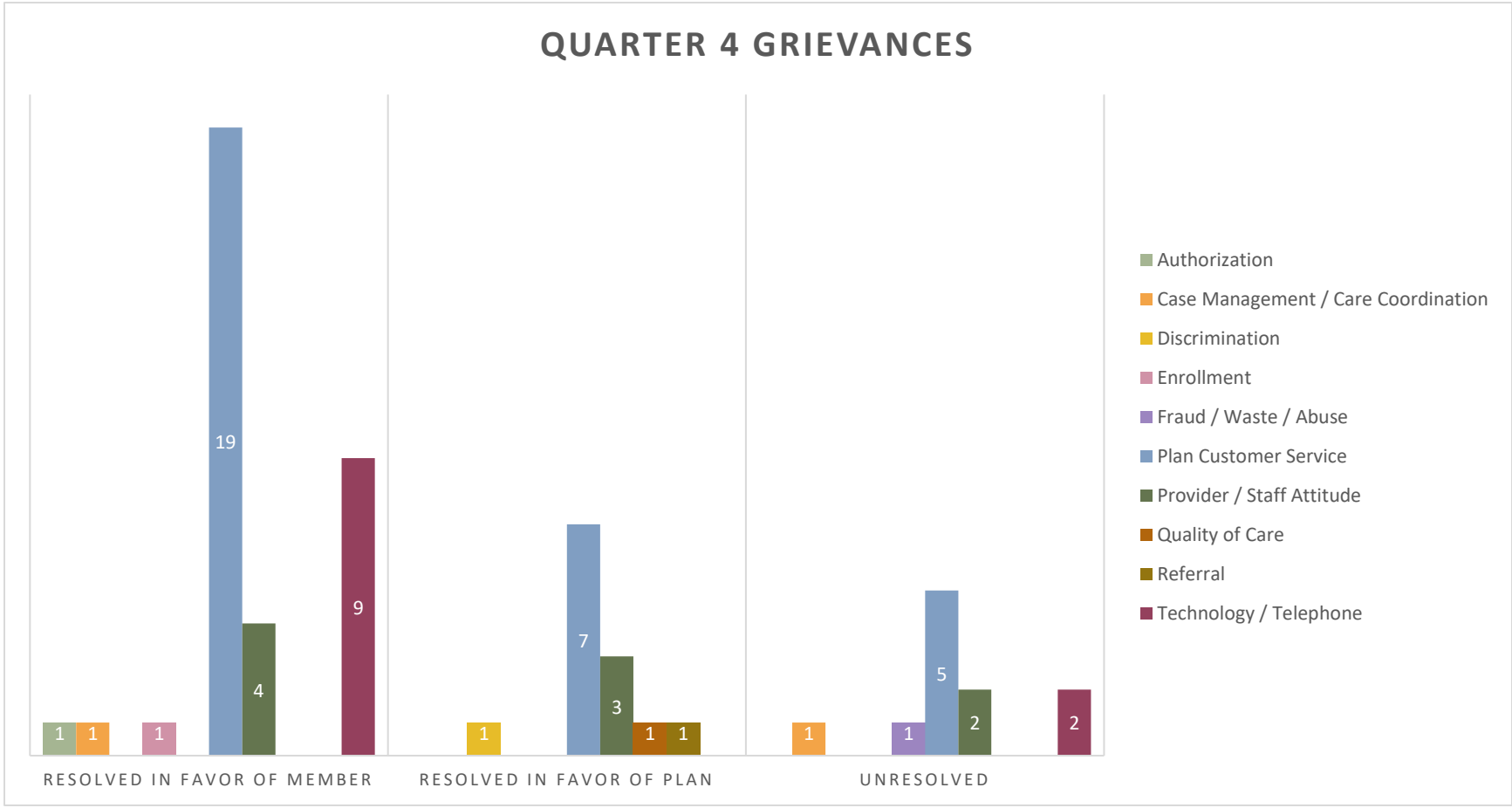
Total grievances by site and by type for Quarter III 2024:



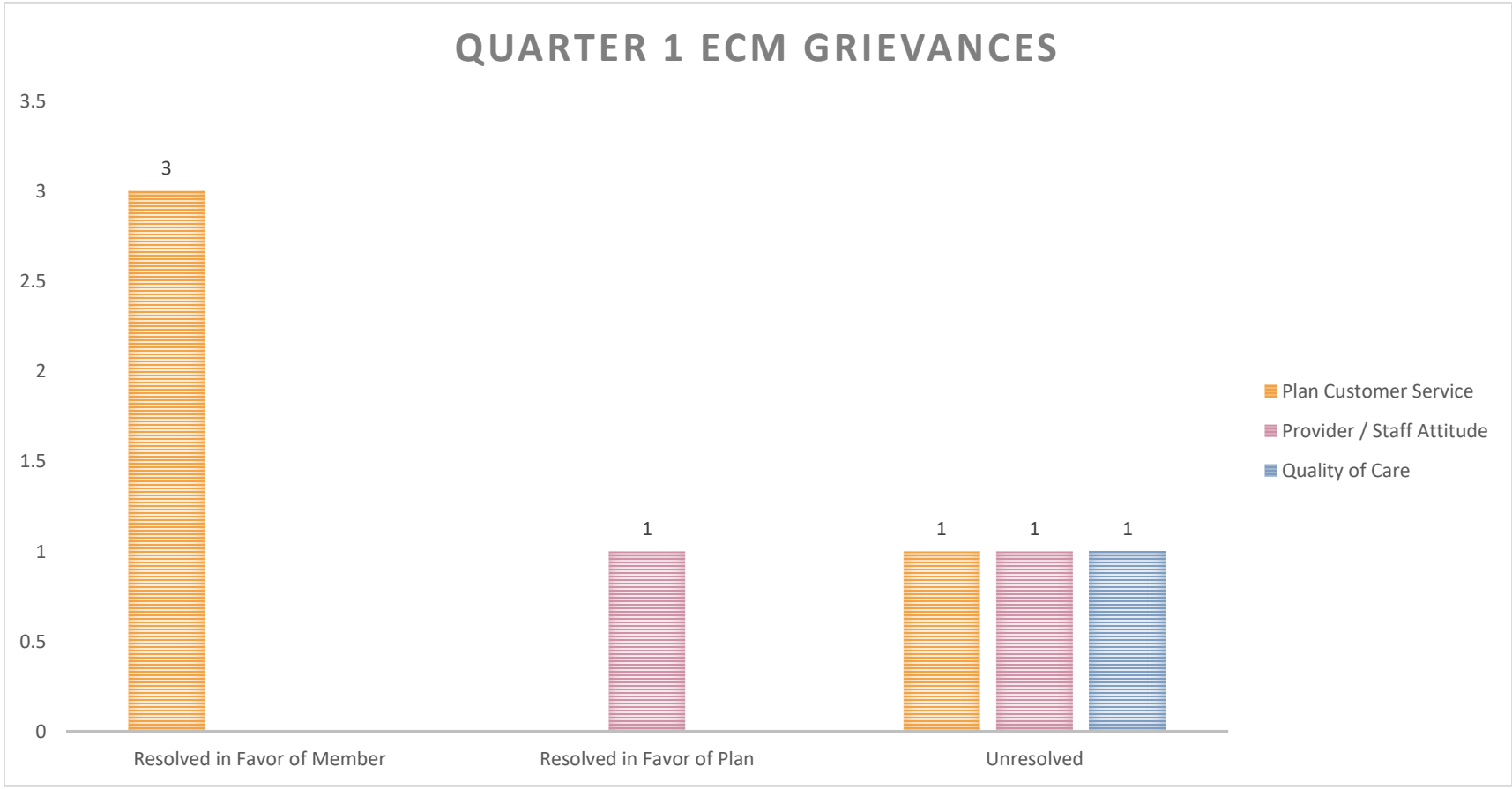
Quarter III Grievances by resolution:



Quarter IV Grievances by resolution and type:



Quarter I Grievances by resolution and type:



Benchmark:

In Quarter III, the ECM sites collectively accrued 45 grievances. Of those 45 grievances, 28 were found in favor of the member, 10 were found in favor of the plan and finally 7 were unresolved at the time of reporting.

In Quarter IV, the ECM sites collectively accrued 59 grievances. Of those 59 grievances, 35 were found in favor of the member, 13 were found in favor of the plan and finally 11 were unresolved at the time of this report.

This represents a **23.8% increase** in overall grievances quarter by quarter.

Quarter 1 Progress:

In Quarter I, the ECM sites collectively accrued 7 grievances. Of those grievances, 3 were found in favor of the member, 1 were found in favor of the plan and finally 3 were unresolved at the time of this report.

This represents a **90.4 % decrease** in overall grievances quarter by quarter.

For our benchmark goals going forward, through the above listed of interventions, we aim to reduce the total quarterly grievance rate by 5% by the next quarter and future quarters going forward. We will continue to accrue all data related to ECM related grievances and report outcomes to this committee.

ECM

Cultural & Linguistic Services Quarterly Audit Findings

Q1 2025

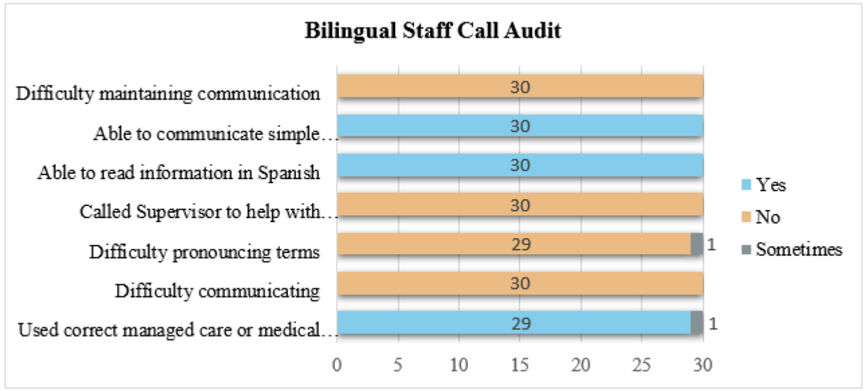
KERN HEALTH SYSTEMS

C&L Services Audit

- Bilingual Staff Call Audit
- Post Call Surveys
- Vendor Bilingual Call Audits
- LLS OPI Interpreter Call Monitoring Audit
- Onsite Interpreting Member Satisfaction Survey
- Member Satisfaction for Over-the-phone (OPI) & Video Remote Interpreting (VRI)
- Translation Member Satisfaction Survey
- KHS Staff Satisfaction Survey for OPI services

Bilingual Call Audits

- **Bilingual Staff Call Audits**
  - 30 Spanish Calls Audited
  - 99% did not have difficulty communicating with members in a non-English language.

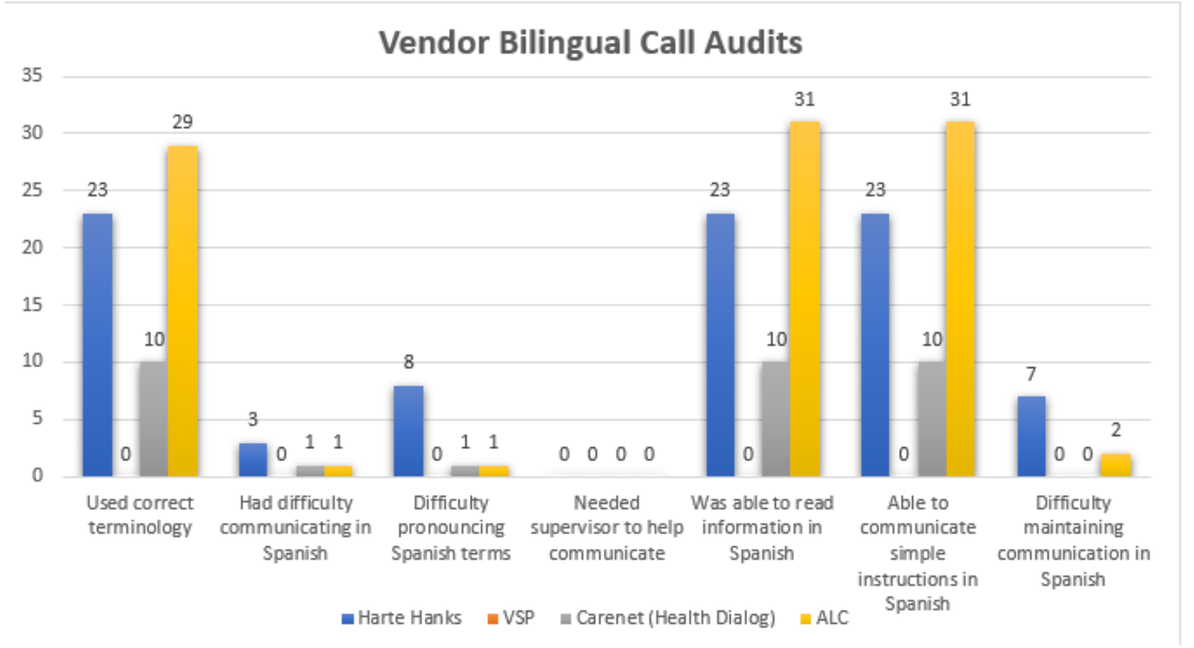


- **Post Call Surveys**
  - 10,359 Spanish Post Call Surveys
  - 98% of members are satisfied with the linguistic performance of bilingual staff.

Vendor Bilingual Call Audits

188 Spanish Audio Call Audits

- American Logistics (ALC)
- Vision Services Provider (VSP)
- Harte Hanks
- Carenet



- *93% of Bilingual staff did not have difficulty communicating with members in a non-English language*

LLS Interpreter Call Monitoring Audit

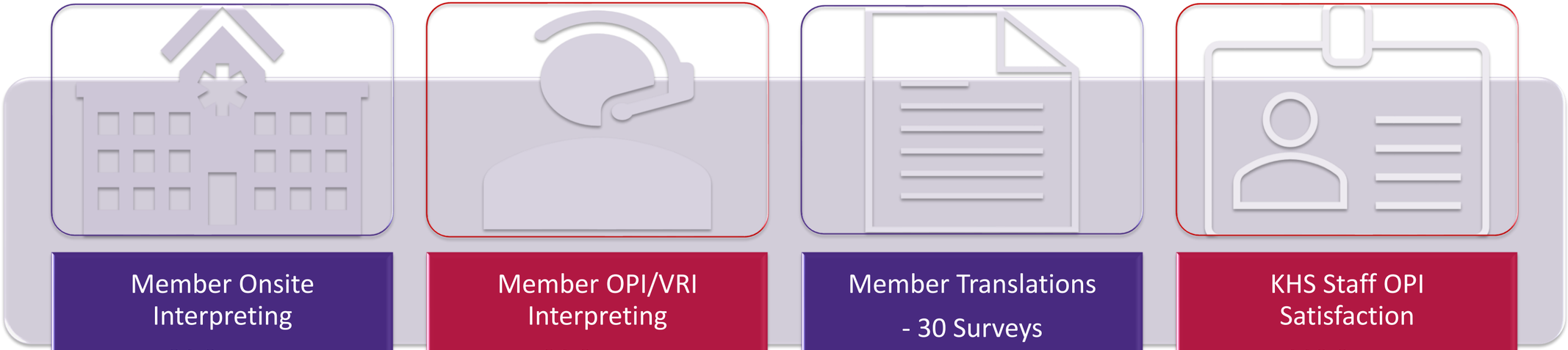
- 30 OPI Interpreter Service Calls
  - *Mandarin*
  - *Punjabi*
  - *Spanish*
  - *Korean*
  - *Thai*
  - *Dari*
  - *Tagalog*
  - *Arabic*
  - *Vietnamese*

LanguageLine Solutions

Call Number	Interpreter ID	Status	Language	Medical Interpreter Skills Assessment Date	Medical Interpreter Skills Assessment Result	QA Observation Date	QA Observation Score
CR-0512325870	211873	Active	KOREAN	2/7/2017	Pass	03/10/25	3/3
CR-0512329530	411188	Active	SPANISH	3/8/2023	Pass	03/10/25	3/3
CR-0512330559	392258	Active	SPANISH	11/29/2022	Pass	01/30/25	3/3
CR-0512438708	437205	Active	SPANISH	8/30/2024	Pass	02/18/25	3/3
CR-0512446372	455637	Active	PUNJABI	10/13/2024	Pass	01/16/25	3/3
CR-0512464192	460282	Inactive	SPANISH	11/22/2024	Pass	02/03/25	3/3
CR-0512472367	452663	Active	VIETNAMESE	9/10/2024	Pass	01/07/25	3/3
CR-0512467167	459902	Active	PUNJABI	11/19/2024	Pass	01/20/25	3/3
CR-0512477299	463561	Inactive	SPANISH	12/26/2024	Pass	02/05/25	3/3
CR-0512472255	429879	Inactive	SPANISH	7/19/2024	Pass	02/28/25	3/3
CR-0521484923	418622	Active	PUNJABI	7/5/2023	Pass	01/22/25	3/3
CR-0521499597	461296	Active	THAI	12/6/2024	Pass	03/13/25	3/3
CR-0521605217	420908	Active	PUNJABI	9/6/2023	Pass	02/26/25	3/3
CR-0521598466	436342	Active	SPANISH	8/20/2024	Pass	02/24/25	3/3
CR-0521609323	448678	Active	TAGALOG	7/22/2024	Pass	01/13/25	3/3
CR-0521617356	411106	Active	SPANISH	3/31/2023	Pass	02/24/25	3/3
CR-0521648666	461591	Active	DARI	12/19/2024	Pass	02/07/25	3/3
CR-0521624725	447576	Inactive	SPANISH	7/9/2024	Pass	03/07/25	3/3
CR-0521624373	455608	Active	SPANISH	12/13/2024	Pass	02/12/25	3/3
CR-0521649947	414206	Active	SPANISH	5/9/2023	Pass	01/29/25	3/3
CR-0529398791	463686	Active	PUNJABI	12/30/2024	Pass	01/31/25	3/3
CR-0529388087	453560	Active	SPANISH	9/24/2024	Pass	01/24/25	3/3
CR-0529400464	422518	Active	SPANISH	10/16/2023	Pass	01/23/25	3/3
CR-0529411425	458110	Inactive	MANDARIN	11/5/2024	Pass	02/05/25	3/3
CR-0529425584	448571	Active	ARABIC	6/28/2024	Pass	01/06/25	3/3
CR-0529430783	436644	Active	SPANISH	4/10/2024	Pass	03/05/25	3/3
CR-0529453364	429286	Active	SPANISH	1/29/2024	Pass	01/08/25	3/3
CR-0529452095	402346	Active	SPANISH	5/26/2023	Pass	03/10/25	3/3
CR-0529454010	464894	Active	SPANISH	1/2/2025	Pass	02/10/25	3/3
CR-0529462266	447674	Active	TAGALOG	7/16/2024	Pass	01/23/25	3/3

- 100% of Audited calls “Met Expectations”

Satisfaction Surveys



Member Onsite Interpreting

- 31 Surveys
- 100% reported “Strongly Agreed” Satisfaction

Member OPI/VRI Interpreting

- 31 Surveys
- -100% “Strongly Agreed” Satisfaction

Member Translations

- 30 Surveys
- 99% “Very Satisfied” Satisfaction

Finding: 6 MBRs Reported not receiving an NOA/GTL Translation

KHS Staff OPI Satisfaction

- 110 Surveys
- 99% “Strongly Agreed” Satisfaction

THANK YOU.!

Cynthia Cardona
Cultural & Linguistics Services Manager

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Cultural and Linguistic Services				POLICY #: 11.23-I	
DEPARTMENT: Health Education					
Effective Date:	Review/Revised Date:	DMHC		PAC	
08/1997	~~12/5/2022~~05/~~2024~~11/2024	DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

_____ Date _____
Emily Duran
Chief Executive Officer

_____ Date _____
Chief Operating Officer

_____ Date _____
Chief Medical Officer

~~_____ Date _____~~
Senior Director of Wellness and Prevention ~~Health Education, Cultural & Linguistics~~

_____ Date _____
~~Chief Health Services Officer~~Senior Director of Health Services

_____ Date _____
~~Deputy Director of Provider Network~~Senior Director of Provider Network

_____ Date _____
Senior Director of Member Services

_____ Date _____
Director of Compliance and Regulatory Affairs

~~_____ Date _____~~
~~Director of Health Education, Cultural & Linguistics~~

PURPOSE:

KHS will comply with the non-discrimination requirements set forth under Section 1557 of the Affordable Care Act (ACA), and state law which prohibits discrimination on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation. This includes posting of the Notice of Non-discrimination, including the abbreviated Non-discrimination Notice, in certain publications and communications, and providing taglines that inform individuals with LEP of the availability of language assistance services.

Commented [AH1]: New policy template requires a purpose statement, I moved some of the existing language over the purpose section, do you agree with this change? Please revise as necessary.

Commented [AH2]: See comment on clean version

POLICY:

Kern Health Systems (KHS) will provide equal access to health services for members who are Limited English Proficient (LEP), deaf or hard of hearing, or blind or have low vision through the provision of auxiliary aids and services for people with disabilities, high quality interpreter and linguistic services, and translated written informing materials to all monolingual or LEP members that speak the prevalent languages identified by DHCS ~~for KHS' service area.~~ or a population group of eligible beneficiaries residing in KHS' service area who indicate the primary language as all languages other than English spoken by 5% of the population or by 1,000 individuals, whichever is less. As required under state and federal law and regulations, DHCS identifies the prevalent non-English languages spoken by eligible beneficiaries throughout the State based on a significant number or percentage of persons who speak each language and provides member informing materials in each prevalent non-English language.

~~KHS will comply with the non-discrimination requirements set forth under Section 1557 of the Affordable Care Act (ACA), and state law which prohibits discrimination on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation. This includes posting of the Notice of Non-discrimination, including the abbreviated Non-discrimination Notice, in certain publications and communications, and providing taglines that inform individuals with LEP of the availability of language assistance services.~~

KHS is responsible for ensuring that delegates comply with ~~will~~ all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including All Plan Letters and Dual Plan Letters. KHS communicates these requirements to all delegated entities and subcontractors.

Language Assistance Services (LAS) will be provided in accordance with the statutory, regulatory, and contractual requirements outlined in the following sources:

- Title VI of the Civil Rights Act of 1964 ~~(42 USC Section 2000d, 45C.F.R. Part 80)~~
- DHCS Contract ~~03-76165 A19~~22-20201
- All Plan Letter 21-004 (Revised)
- ~~MMCD Policy~~All Plan Letter ~~17-002~~19-011
- All Plan Letter 22-002

DEFINITIONS:

Limited English Proficient	A limited ability or inability to speak, read, write, or understand the English language at a level that permits the person to interact effectively

	with health care providers or social service agencies.
Limited English Proficient Members[1]	Any member who is limited English proficient, including those who speak a language other than one of the threshold languages identified by the Department of Health Care Services for Kern County.
Threshold Language	A population group of eligible beneficiaries residing in KHS' service area who indicate the primary language as ~~a language~~all languages other than English~~, and that meet a numeric threshold of 3,000 or~~ spoken by 5% of the ~~eligible beneficiary~~ population or by 1,000 individuals, whichever is ~~lower~~ less.
Concentration Standard Language	A population group of eligible beneficiaries residing in the MCP's service area who indicate their primary language as a language other than English and who meet the concentration standards of 1,000 in a single ZIP code or 1,500 in two contiguous ZIP codes (Concentration Standard Language).
Qualified Interpreter	A person who has demonstrated proficiency in speaking and understanding both English and the language spoken by the LEP member or member with a disability; is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from the language spoken by the LEP member or member with a disability and English, using any necessary specialized vocabulary, terminology, and phraseology; and adheres to generally accepted interpreter ethics principles, including client confidentiality. For members with a disability, qualified interpreters can include sign language interpreters, oral transliterators (person who represent or spell in the characters of another alphabet) and cued language transliterators (person who represent or spell by using a small number of handshapes).
Qualified Translator	A person who adheres to generally accepted translator ethics principles, has demonstrated proficiency in writing and understanding in both written English and the written non-English language(s) in need of translation; and is able to translate effectively, accurately, and impartially to and from such language(s) and English using any necessary specialized vocabulary, terminology, and phraseology.

Commented [cg3]: HE 3B (interpreter competence)

PROCEDURES:

1.0 PROVISION OF SERVICES

LAS are provided free of charge, are accurate and timely and protect the privacy and independence of LEP members. There are two primary types of LAS: oral and written. KHS will not provide members who are LEP, deaf or hard of hearing, or blind or have low vision with services that are more limited in scope or lower in quality than those arranged for others.[2] KHS will monitor that LEP, deaf or hard of hearing, or blind or have low vision members are not subjected to unreasonable delays in receiving appropriate LAS when the need for such services is identified by the provider or requested by the LEP, deaf or hard of hearing, or blind or have low vision.[3]

Oral interpretation services from qualified interpreters are available 24 ~~-~~hours a day at no cost

for medical and non-medical points of contact including membership services, claims, utilization management, population health management, case management, complaints, grievances and appeals, appointment services and member orientation sessions. Oral interpretation is available for all languages and is not limited to KHS' threshold or concentration standard languages. (see Attachment A).

Commented [cg4]: HE 3B (organization functions)

During regular business hours, members who require assistance with their language needs may call the KHS Member Services Department at (661) 632-1590 (Bakersfield) or (800) 391-2000 or the California Relay Service at 711. They will either be assisted by a staff member that is qualified to speak their language or connected to a qualified interpreter.

KHS Providers and members who require after hours assistance with their language needs may call the 24-hour advice nurse line at 1-800-391-2000. The advice nurse line can connect members and providers to KHS' KHS 'contracted telephone interpreting service.

LEP members are not required to accept LAS, although a qualified interpreter may be used to assist in communicating with an LEP member who has refused LAS. KHS prohibits use of an adult or minor child accompanying an LEP member to interpret except when: (1) there is an emergency involving an imminent threat to the safety or welfare of the individual or the public and a qualified interpreter is not immediately available; or (2) the LEP member specifically requests that an accompanying adult interpret, the accompanying adult agrees to provide assistance and reliance on the accompanying adult is appropriate under the circumstances. In such circumstances, KHS must inform LEP members of their right to free interpreter services and ensure that the use of such an interpreter will not compromise the effectives of services or violate the LEP members confidentiality. Documentation of an LEP members refusal to use a qualified interpreter is maintained in the members medical record or KHS member account.

Members who require written materials in another language (English or Spanish) may call the KHS Member Services Department at (661) 632-1590 (Bakersfield), (800) 391-2000 (outside of Bakersfield) 711 during regular business hours.

1.1 Communication withAccess for Members with Disabilities

KHS complies with all applicable requirements of federal and state disability law. KHS ensures access for members with disabilities including but not limited to access to web and electronic content, ramps, elevators, accessible restrooms, designated parking spaces, and accessible drinking water. KHS provides auxiliary aids and services to members with impaired sensory, manual, or speaking skills, including the provision of qualified interpreters and written materials in alternative formats, free of charge and in a timely manner, when such aids and services are necessary to ensure that members with disabilities have an equal opportunity to participate. KHS gives primary consideration to the members request of a particular auxiliary aid or service. Auxiliary aids and services for members who are deaf or hard of hearing include qualified interpreters on-site or through Video Remote Interpreting services, written materials, exchange of written notes, captioning or other effective methods of making aurally delivered information available. Auxiliary aids and services for members who are blind or have low vision include Braille materials, large print materials (no less than 20-

point font) or other effective methods of making visually delivered materials available.

Members or their Authorized Representatives (AR) who require written materials in an alternative format (large print, no less than 20-point Arial font, audio, braille, or electronic format, such as a data CD and other auxiliary aids and services), may call the KHS Member Services Department at (661) 632-1590 (Bakersfield), (800) 391-2000 (outside of Bakersfield) or through the California Relay Service at 711 during regular business hours. KHS staff who receive notice from members or their AR that materials are required in an alternative format will submit the requests to the Member Services Department. The Member Services Department will log the request for materials in alternative format. KHS staff will refer to the KHS systems (QNXT, Jiva) or the Alternative Format Attribute report when coordinating KFHC member mailings, so that materials are mailed in the appropriate format.

Members who request to receive notices and information in an electronic format are informed that information will be mailed unencrypted (not password protected) and may make the information more vulnerable to loss or misuse unless they request an encrypted (password protected) electronic format. If members request information in an encrypted electronic format, KHS provides instructions on how to access the encrypted information.

1.2 Telephone Interpreting Service via Language Line

Calls requiring telephone interpreting services during regular office hours are documented on phone logs by a Member Services Representative (MSR~~).~~) (See Attachment A). The log includes the following information:

A. Member's name
B. Provider's name
C. Date and time of day
D. Language assistance requested
E. Language Line Operator name and ID
F. Approximate length of call
G. Call Reason

The toll-free number for the Language Line is dialed and the MSR identifies which language is being requested, if known. If unsure of the language, the MSR asks for assistance from the Language Line. The appropriate Language Line interpreter joins the call and communication occurs between the member, KHS, and/or provider.

Calls requiring transfer to the Language Line after regular office hours are connected by the KHS on call nurse.

1.3 In-person Interpreting Service

Members and providers may also request in-person interpreting services. During regular business hours, the member/provider may contact the Member Services Department. The Member Service Representative will send either a qualified interpreter employed by KHS or through its contracted vendors, CommGap or LifeSigns, to the provider's office. Future appointments, if necessary, should be scheduled to include a qualified interpreter.

After regular business hours, in-person interpreting services are provided by KHS contracted Hospitals/Urgent Care Facilities from a pool of their employees that are identified as qualified interpreters.

1.4 Video Remote Interpreting (VRI)

During regular business hours, providers may contact the Member Services Department to request assistance in securing VRI services through Language Line Solutions. KHS' use of VRI services comply with federal quality standards. Real-time audio over a dedicated high-speed, wide-bandwidth video connect or wireless connect that delivers high-quality audio without lags or irregular pauses in communication is validated prior to granting providers access to KHS VRI services. KHS also validates that the interpreter and member's face, arms, hands and fingers are large enough to be seen when VRI services that are used for members with a disability. KHS Cultural and Linguistic Services Team performs the VRI validation and provides training to all VRI users.

1.5 Bilingual, Interpreter and Translator Qualifications

Commented [cg5]: HE 3B (internal & external interpreter competence)

KHS employs bilingual staff to directly communicate with KHS members. KHS bilingual staff are required to pass an oral assessment of their bilingual skills and do not perform interpreting services for members. Documentation is kept in the personnel file of each bilingual staff member. KHS offers a qualified interpreter to members with LEP when oral interpretation is a reasonable step to provide meaningful access for the member with LEP. KHS staff utilized as interpreters are required to pass an oral assessment of their bilingual skills and complete an interpreter training program. KHS uses qualified translators when translating written content in paper or electronic form. KHS staff utilized for translations are required to pass a written assessment of their translation skills. These tests are administered by an accredited facility. The documentation is kept in the personnel file for each KHS qualified interpreter and qualified translator. Additionally, KHS staff utilized for interpreting or translation are required to participate in ongoing educational training on interpreting ethics, conduct and confidentiality. Documentation of KHS staff who have completed this training is maintained by the Health Education/Cultural and Linguistics Department.

The telephone interpreting service vendor, Language Line, and the in-person interpreting service vendor, CommGap, are contractually required to assess their employees utilized as interpreters and provide their employees training on interpreting ethics, conduct and confidentiality.

American Sign Language interpreters are assessed by the contracted vendor, LifeSigns. LifeSigns staff and subcontracting interpreters are certified by either the National Association of the Deaf (NAD) or Registry of Interpreters for the Deaf (RID). In addition, most certificate holders have completed professional interpreter training and have extensive professional interpreting experience.

Commented [cg6]: HE 3B (exernal interpreter competence)

Bilingual Oral and Translation Certification Accredited Facilities:

KHS accepts the following certifications from the following agencies to assess internal staff interpretation competence.

- Bakersfield Community College –
    - Tier I - Conversational; one-on-one Oral/Reading exam with the instructor, approx. 15-20 minutes. This exam is a conversation between the test taker and the instructor. There will be a paragraph that for the test taker to read and translate.
    - Tier II - Reading/Writing exam, 90 Minutes. Note: Applicant must present copy of Tier I Certificate to take Tier II exam. This exam will be multiple choice, fill-in, and translation from Spanish to English, English to Spanish and Spanish response in Spanish. The test taker needs to know punctuation and accent marks.
- TransPerfect –
    - TransPerfect Oral Proficiency Exam is a short language proficiency test administered over the phone. It evaluates oral fluency and listening comprehension in English and a target language. Each language is evaluated separately following the same criteria: fluency, pronunciation, grammar/syntax, and listening comprehension.

Commented [cg7]: HE 3B (internal bilingual staff competence)

1.6 Notice of Non-Discrimination and Language Assistance Services Taglines

KHS posts its notice of non-discrimination and language assistance services taglines in the top 18 non-English languages spoken by individuals with LEP in California in at least 12-point font size in the KHS lobby, on the KHS website and includes the notice and taglines in all member information notices targeted to members, potential members, and the public. KHS' informational notices include not only documents intended for the public, such as outreach, education, and marketing materials, but also written notices requiring a response from members or those pertaining to rights or benefits. The nondiscrimination notice contains information on how to file a discrimination grievance directly with KHS and the DHCS Office of Civil Rights (OCR), and Health and Human Services OCR. The taglines inform members, potential members, and the public of the availability of language assistance services.

KHS includes the abbreviated non-discrimination notice and all 18 non-English language assistance services taglines in a conspicuously visible font size in all significant publications and communications that are small-sized, such as postcards, pamphlets, newsletters, brochures, and flyers if these items are printed and/or distributed on paper or folded in a way that is smaller than 8.5x11 inches. The required Non-Discrimination Statement is as follows:

> "Kern Family Health care complies with all applicable state and federal civil rights laws and does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation."

~~2~~2.0 STAFF EDUCATION AND SUPPORT

KHS provides annual training on its language assistance programs, sensitivity, diversity, cultural competency, and health equity to staff *(See KHS Policy and Procedures 11.11-I Cultural Competency).* Training includes but is not limited to:

- KHS policies and procedures for language assistance
- How to work effectively with LEP members and potential members
- How to work effectively with interpreters in person and through video, telephone, and other media
- Understanding the cultural diversity of members and potential members, and sensitivity to cultural differences relevant to deliverable of health care interpretation services.

3.0 PROVIDER EDUCATION AND SUPPORT

Contracted providers and KHS staff who interact with members will participate in a cultural, linguistic and disability education and awareness program. This program will be implemented through group instruction, the provider manual, or workshops. KHS will provide documentation for contracted providers, so they are aware of how to refer members to appropriate linguistic services via ~~KHS's~~KHS' Policies and Procedures. The educational and informational program may include the following:

~~A. The United States Department of Health and Human Service's Guidance Memorandum on Title VI Prohibition against National Origin Discrimination Persons with Limited English Proficiency~~

~~B.~~A. Information on provider legal vulnerability with respect to inadequate provision of interpreter services.

~~C. The National Health Law Institute's report on "Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities," 1998, Executive Summary~~

~~D. Senate Bill 1840 amended the Section 1259, Health and Safety Code~~

B. Title VI of the Civil Rights Act of 1964, Section 1557 of the Affordable Care Act of 2010, 42 CFR section 438.10

C. Use of National Standards for Culturally and Linguistically Appropriate Services (CLAS)

~~E.~~D. DMHC Title 28, Section ~~130067~~1300.67.04: Language Assistance Programs

~~F.~~E. A list of resources to assist medical interpreters

~~G.~~F. Information on appropriate skills for persons who interpret

~~H.~~G. Lists of training and testing resources for maintaining and enhancing interpreter skills

~~I.~~H. Training for practitioners on diversity, equity, and inclusion and how to work effectively with interpreters.

~~3~~4.0 MEMBER EDUCATION

Members who are LEP, deaf or hard of hearing, or blind or have low vision will be informed of their right to free interpreter services and auxiliary aids and services via the Member Handbook.[4] All member materials will be translated into threshold and concentration languages or provided in an alternative format upon request by the member or their AR. *(See KHS Policy and Procedure #~~12.02-I~~11.26 Translation of Written Member Informing*

Materials).

Members will be informed of the availability of language assistance services and alternative formats through new member orientations and the member handbook. All materials that inform a member of his/her rights will include information regarding the member's right to:

A. Interpreter services at no charge when accessing covered health care
B. Not use friends or family members as interpreters, unless specifically requested by the member
C. Request face to face or telephone interpreter services during discussions of complex medical information such as diagnoses of complex medical conditions or discussions of complex procedures
D. Receive informing documents translated into threshold languages [5] or alternative formats
E. File grievances if linguistic needs are not met
F. Member informing material will have the following notice: ATTENTION: If you need help in your language call 1-800-391-2000 (TTY: 711). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call 1-800-391-2000 (TTY: 711). These services are free of charge.

45.0 MONITORING, EVALUATION, AND IMPROVEMENT

Non-standardized vital documents that contain member specific information will contain the following notice: ATTENTION: If you need help in your language call 1-800-391-2000 (TTY: 711). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call 1-800-391-2000 (TTY: 711). These services are free of charge.

Linguistic services are coordinated by the Cultural & Linguistic Services Team. The Cultural & Linguistic Services Manager oversees the educational program(s) developed for KHS staff, Contracted providers, and their staff on interpreter services, implementation of bilingual proficiency guidelines, and the coordination and monitoring of ~~interpreter services.~~member's access to culturally and linguistically appropriate health care services. KHS utilizes the methods listed below to maintain its cultural and linguistic services, conduct ongoing monitoring and evaluation of our cultural and linguistic services program, and identify opportunities for improvement related to members access to culturally and linguistically appropriate services inclusive of the delivery of services to members less than 21 years of age. Strategies for improvement in the identified areas are incorporated into the Cultural and Linguistic Services Program Plan, including populations of focus such as members less than 21 years of age.

~~4~~

5.1 Via the Credentialing and Recredentialing Process

The Quality Improvement Department performs site review audits at the time of credentialing and recredentialing, which includes checking language services provided at provider offices.

45.2 Via the Updating of the Provider Directory Process

When updating the *Provider Directory*, Provider Network Management staff contact each office listed to verify contact information and the language capabilities of the office. This information is used to ensure KHS recruits and retains of culturally and linguistically competent provider network.

45.3 Via the Population Needs Assessment

The *Population Needs Assessment* considers ~~members preferred languages~~cultural and ~~the need for interpreters.~~ linguistic service program gaps. Through the needs assessment findings, KHS ~~identifies gaps in language needs for~~updates its cultural and linguistic services program to align with the needs of our members.

45.4 Via the Grievance Process

Member Services staff log calls related to language barriers with contracted providers. This information is used to track discrepancies between contracted providers stated language capabilities and the services ~~actually~~ received by members.

45.5 Via Survey Calls

KHS' Provider Network Management staff conduct quarterly survey calls to contracted providers. (See Attachment B). The Cultural & Linguistic Services Team conducts annual survey calls to all member facing departments. These calls assess member access to interpreting services. ~~(See Attachment B).~~

45.6 Language Line

Monthly, the Language Line bill is compared to phone logs to validate proper billing. Statistics are compiled on a monthly basis as to the language most frequently requested and the providers that request assistance.

45.7 LifeSigns and Independent Living Center of Kern County

Monthly, the LifeSigns and Independent Living Center of Kern County invoices are compared to the ASL interpreter tracking logs and request forms to validate proper billing. Statistics are compiled on a monthly basis as to the number of sign language interpreters requested and the providers that request assistance.

45.8 CommGap

Monthly, the CommGap invoice is compared to the CommGap interpreter tracking log to validate proper billing. Statistics are compiled on a monthly basis as to the number of onsite interpreters requested, the most frequently requested languages and the providers that request assistance.

5.9 Cultural and Linguistic Services Program Evaluation

Annually, the Cultural and Linguistic Services Team conducts an evaluation of the activities implemented to meet the goals and objectives outlined in the Cultural and Linguistic Services Program.

ATTACHMENTS:

Attachment A: Language Line *Phone Log*
Attachment B: Call Script and Spreadsheet
Attachment C: Spoken/Other Language/ASL Decision Flowcharts
Attachment D: KHS Translation Workflow

Commented [AH8]: Please provide new attachments separately

REFERENCE:

Revised 2024-11: The policy was revised to align with State and Federal requirements and NCQA Standards. **Revision 2022-10:** Policy received DMHC approval on 10/13/2022, Filing No. 20223350**. Revision 2022-08:** DHCS approved policy revisions per APLs 22-002 and 21-004 on 8/1/2022. **Revision 2022-06**: Policy revised to comply with APL22-002 and APL21-004 (REVISED). **Revision 2022-04**: Policy revised to comply with APL22-002. **Revision 2021-08:** Policy updated to align with APL 21-004 Standards for Determining Threshold Languages and renumbered to fit in Health Education series. Formerly 3.71-P. DHCS Approved 11/02/2021**. Revision 2015-08:** Policy moved under Health Education's responsibility. Re-numbered from 11.01-P(E). **Revision 2004-02:** Major revision. Simple relocation of text is not marked as a change. **Formerly:** #5.12 – Interpreters for Non-English Speaking Members.
Revision 2021-04: Policy reviewed by Director of Health Education and Cultural and Linguistics Services. Renumbered to fit in Health Education series. **Revision 2020-10: Revision 2017-11:** Revised to comply with APL17-011 and Section 1557 of the Affordable Care Act**. Revision 01/2017:** Revised to include education and training on interpreting ethics, conduct and confidentiality for all KHS staff that provide translation and/or interpretation service to members. New requirement that Compliance staff make monthly access calls to contracted providers. CAP response to 2016 DMHC audit. **Revision 2015-06:** Policy renumbered to Health Education section as requested and approved by Member Services and Health Services Directors (previously 11.01-I). Health Services to oversee Cultural and Linguistics services. **Revision 2014-03:** Policy revised to comply with 1115 Waiver SPD Enrollment Survey; Potential Deficiency #12. **Revision 2013-06:** Policy revised to comply with DMHC comments on Timely Access. Approved by DHCS as SPD Deliverable 7-F. **Revision 2006-08:** Revised as requested (06/23/2006). **Revision 2005-09:** Routine revision. **Revision 2003-11:** Created per Member Education Department request.

[1] APL17-011
[2] Title VI Civil Right Act of 1964
[3] Title VI Civil Right Act of 1964
[4] Title VI Civil Right Act of 1964
[5] MMCD 99-04

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Translation of Written Member Informing Materials				POLICY #: 11.26-I.	
DEPARTMENT: Health Education					
Effective Date: 2006-02	Review/Revised Date: 11/2024	DMHC		PAC	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

_____ Date _____
Emily Duran
Chief Executive Officer

_____ Date _____
Chief Operating Officer

_____ Date _____
Chief Medical Officer

_____ Date _____
Senior Director of Wellness and Prevention

_____ Date _____
Senior Director of Health Services ~~Chief Health Services Officer~~

_____ Date _____
Senior Director of Member Services

_____ Date _____
Senior Director of Marketing & Public Relations

_____ Date _____
Director of Compliance and Regulatory Affairs

_____ ~~Date~~ _____
~~Director of Health Education, Cultural & Linguistics~~

POLICY[1]:

Kern Health Systems (KHS) will provide quality translated member informing materials to all monolingual or Limited English Proficiency (LEP) members that speak the identified threshold or concentration standard languages identified by DHCS or provided in an alternative format upon request by the member or their Authorized Representative.[2] Spanish is Kern County's only prevalent non-English language[3].

Member informing materials will be translated in accordance with the standards outlined in the following sources:

- DHCS Contract Exhibit A, Attachment ~~9~~III, ~~Provision 14~~ (see Attachment C)
- All Plan Letter 21-004: Standards for Determining Threshold Languages (see Attachment D)

Commented [AH1]: Revised to align with DHCS 2024 OR Policy (artifact R.0189) version. Please validate if this still applies.

PURPOSE:

To establish standards for review and translation which will result in a uniform format for the reading level and translation of all member informing materials to be used by KHS members. ~~and~~ W~~w~~hich will ensure that all information released to KHS members is accurate and conforms with KHS policies and procedures.

RELATED POLICIES:

- *KHS Policy and Procedure #12.01-I: Member Materials* – Includes information regarding the distribution of translated member informing materials.

DEFINTIONS

Qualified Translator	A person who adheres to generally accepted translator ethics principles, has demonstrated proficiency in writing and understanding in both written English and the written non-English language(s) in need of translation; and is able to translate effectively, accurately, and impartially to and from such language(s) and English using any necessary specialized vocabulary, terminology, and phraseology.
Threshold Language	A population group of eligible beneficiaries residing in KHS' service area who indicate the primary language as ~~a language~~all languages, other than English~~, and that meet a numeric threshold of 3,000 or~~ spoken by 5% of the ~~eligible beneficiary~~ population or by 1,000 individuals, whichever is ~~lower~~ less.
Concentration Standard Language	A population group of eligible beneficiaries residing in the MCP's service area who indicate their primary language as a language other than English and who meet the concentration standards of 1,000 in a single ZIP code or 1,500 in two contiguous ZIP codes (Concentration Standard Language).
Certificate of Accurate Translation	Translation vendors provide upon request an "attestation" or "certificate of accurate translation" for translated documents to attest to the accuracy of the document.

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Limited English Proficient (LEP)	An individual who does not speak English as his/her primary language and who has limited ability to read, write, speak, or understand English.
Sight Translation	The act of reading something written in one language (source language) and orally expressing it or signing it accurately into another language (target language).
Standard Vital Document	A Kern Family Health Care (KFHC) Plan vital document that does not contain member specific information.
Non-Standard Vital Document	A KFHC Plan vital document that does contain member specific information.

PROCEDURE:

1.0 DOCUMENTS REQUIRING TRANSLATION

Kern Health System's member informing materials are translated into identified threshold or concentration standard languages as determined by DHCS or provided in an alternative format upon request by a member or their Authorized Representative. KHS ensures members have access to full and immediate translation of written materials and critical member information as required by 42 CFR sections 438.10 and 438.404 and W&I Code section 14029.91. Translations include but are not limited to the following informing documents:

A. Member Handbook[3]
B. Provider Directory
C. Marketing materials[2]
D. Form letters including notice of action letters, letters containing important information regarding participation in KHS, and grievance acknowledgement and resolution letters[2]
E. KHS generated preventive care reminders[4]
F. Member surveys[4]
G. Member newsletters[4]
H. Notice of privacy practice
I. Consent forms
J. Enrollee information[2]
K. Welcome packets[2]

Commented [AH2]: Revised to align with DHCS 2024 OR Policy (artifact R.0189) version. Please validate if this still applies.

2.0 PROCESS FOR TRANSLATION AND REVIEW OF MATERIALS[6]

The translation of written member informing materials is coordinated by the Cultural and Linguistics (C&L) Team within the Health Education Department. The table below outlines the steps for the translation and review of materials. The *Translation Tracking Log* is used to track the translation process (see Attachment A). Member requests for alternative formats are also coordinated by the C&L Team *(See KHS Policy and Procedures 11.23-I Cultural & Linguistic Services).*

Step 1	The requesting Department submits the document to the C&L Team to begin the translation process. If regulatory approval of the document is required, the requesting Department submits the document to the Compliance Department prior to submitting a translation request to the C&L Team.

Step 2	The document is submitted to a qualified in-house translator or a contracted vendor for translation. All non-threshold language translations are submitted to the vendor for processing (see *Attachment B- KHS Translation Workflow*).
Step 3	The translated document is reviewed and edited by an internal review committee comprised of bilingual employees and at minimum, one qualified translator. Documents sent to the contracted vendor are also reviewed by a separate qualified translator, editor, and proofreader.
Step 4	If it has been determined that the document is a complex or legal document, the document is back translated for verification. Documents sent to the contracted vendor adhere to the same verification process.
Step 5	The document is formatted and designed.
Step 6	The final translated document is proofread by a qualified translator. The translator who assesses the quality of the translated document is not involved in the original translation. If the document was submitted to a contracted vendor for translation, a written ~~attestation~~Certificate of Accurate Translation is obtained from the vendor and kept on file by the C&L Team.
Step 7	The final translated document is submitted back to the requesting Department. When necessary, the final translated document is submitted to DHCS prior to distribution to the membership.[4]

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2.1 TRANSLATION QUALITY ASSURANCE

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KHS assess the quality of its translations before a document is finalized for approval. If regulatory approval of the document is required, the requesting Department submits the document to the Compliance Department prior to submitting a translation request to the C&L Team. Readability is completed on the Source language prior to submitting translation requests to the C&L department. The threshold target language is also submitted for readability. *See attachment F for vendor Translation Quality Assurance process.*

Each in-house translation request goes through several Quality Assurance stages:

1. ***Editing:*** The editor checks the translation for accuracy and compliance with the translation's specifications; looks for types, grammatical mistakes; and checks style, consistency, and readability etc.

2. ***Terminology Control:*** The translated text is processed with a QA Tool (SDL Trados) to make sure all the terms match the terms on the terminology database

and KFHC glossary. There are several tools available for this purpose.

3. ***Review/Proofreading:*** This is a target-audience review to ensure cultural appropriateness and readability are consistent with KHS {DMHC/DHCS} guidelines. Checking the target text by comparing to the source text.

4. ***Correction:*** The translation goes back to the translator and/or editor with the feedback, and the necessary changes are made.

5. ***Back Translation:*** This is an optional stage, where the translated text is back translated into the original language to ensure there were no omissions, additions, or any alterations to the main message of the text.

6. ***Desktop Publishing:*** After all linguistic steps are complete, we typeset the file so that it matches cultural appropriates, specific preferences, readability, selection images, character sets, page size, etc., according to target language. Translations completed by our contracted vendor are also reviewed in-house upon receipt for cultural appropriateness prior to finalization.

7. ***Proofing:*** In this final stage, a proofer evaluates the final file against the original file looking for compliance with the project specifications.

8. ***Final Step:*** The final translated document is submitted back to the requesting department.

3.0 SIGHT TRANSLATION

Commented [cg4]: HE 3A.3

KHS provides sight translation, using internal or external translators, for information that is not available in translated form, and which must be provided sooner than the time standards for written translation. Sight translation can also be provided to a member who prefers a document to be read in a non-English language or a member who is visually impaired. This can include Vital Information in less commonly requested threshold languages, non-threshold languages and non-vital information in any language.

4.0 TIMELINES

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All newly developed member informing materials are made available in the threshold language within 90 days after the English version is approved by the DHCS.[4] KHS ensures immediate translation of all critical member information within their regulatory timeframes. All non-standard vital documents are translated into KHS' threshold language within a 24-hour turnaround time. All standard vital documents are translated within 5-7 business days. All non-threshold/less commonly requested language documents are translated within 5-10 business days. If the document is submitted to a contracted vendor for translation the request will be submitted with a delineated timeframe to follow KHS' turnaround times. All threshold language document requests are translated internally. Documents submitted to a contracted vendor are for all non-threshold

languages (*See attachment B- KHS Translation Workflow).*

4.1 Non-Standard Vital Documents

- Templates of notices pertaining to denial, reduction, modification or termination of services and benefits and the right to file a grievance or appeal.
- Notification of Practitioner Termination (Provider Termination Letters)

4.2 Standard Vital Documents

- Brochures, patient education materials, appointment cards, registrations forms, and questionnaires.

~~**4.0**~~ **5.0 SUBMISSION OF TRANSLATED DOCUMENTS TO DHCS**

Although DHCS does not approve the translations, KHS submits finalized translations of written member informing materials to DHCS prior to distributing the documents to members when necessary.

6.0 **TRANSLATOR QUALIFICATIONS**

KHS uses qualified translators when translating written content in paper or electronic form. KHS staff utilized for translations are required to pass a written assessment of their translation skills. These tests are administered by an accredited facility. The documentation is kept in the personnel file for each KHS qualified interpreter and qualified translator. Additionally, KHS staff utilized for translation are required to participate in ongoing educational training on ethics, conduct and confidentiality. Documentation of KHS staff who have completed this training is maintained by the Health Education/Cultural and Linguistics Department *(See KHS Policy and Procedures 11.23-I Cultural & Linguistic Services).*

Qualifications for KHS translators include but are not limited to the following:

- Have an in-depth knowledge of U.S. domestic culture, administrative procedures, local and federal legal frameworks, and current affairs including health care, education, and social services.
- For specialized translations, translators, editors, and proofreaders must have at least two years of experience in working with documents on that subject matter or extended proven professional experience working in that industry in addition to the qualifications listed above.
- Has at least one of the following: advanced translation studies degree, equivalent qualification in another specialty plus a minimum of two years documented experience in translation or at least five years of documented professional experience in translation.
- Translation Certification
- Advanced Medical Terminology Certification

The translation service vendor, Language Line, is contractually required to assess their employees utilized as translators and provide their employees training on ethics, conduct and confidentiality. Language Line determines the translator's qualifications and competence to provide a service conforming to their International Standards by obtaining documented evidence that the translator can meet at least one of the following (*see Attachment E- Language Line*

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Interpreter Qualifications and Competence):

Qualifications for contracted LLS translators include but are not limited to the following:

- A recognized graduate qualification in translation from an institution of higher education.
- A recognized graduate qualification in any other field from an institution of higher education plus two years of full-time professional experience in translating.
- Five years of full-time professional experience in translating.

ATTACHMENTS:

Attachment A - *Translation Tracking Log*

Attachment B – *KHS Translation Workflow*

Attachment C – *DHCS Contract Exhibit A, Attachment 9, Provision 14*

Attachment D - *All Plan Letter 21-004: Standards for Determining Threshold Languages*

Attachment E – *Language Line Interpreter Qualifications and Competence*

Attachment F – Language Line Translation Quality Assurance Process

Revision 2024-11: The policy revised to align with State and Federal Requirements and NCQA Standards 2024. Attachments B-F were added to the policy. Revision 2022-0119: Policy revised to align with DHCS 2024 Contract. Approved for R,0191 on 9/14/2022. Approved for R.0189 on 12/1/2022. Approved for R,0162 on 6/7/2023. [1]**Revision 2021-11:** Policy approved by DHCS, per APL 21-004. **Revisions 2021-08:** Policy revised to comply with APL 21-004. Policy renumber to fit under Health Education and Cultural and Linguistic Services, previously 12.02-I. **Revision 2017-11:** Policy revised to comply with APL 17-011 and §1557 of the Affordable Care Act. **Revision 2006-02:** Routine review. Policy reviewed against DHS Contract 03-76165 (Effective 5/1/2004). **Revision 2003-11:** Created per Member Health Educator Supervisor request. Created to comply with MMCD Policy Letter 99-04. **Formerly:** #110.50 – Translation of Written Informing Materials. Changed during 01/2006 review.

[2] DHCS Contract A-9 14(B)(2)

[3] [7]DHCS Contract A-9 13C)() (1)

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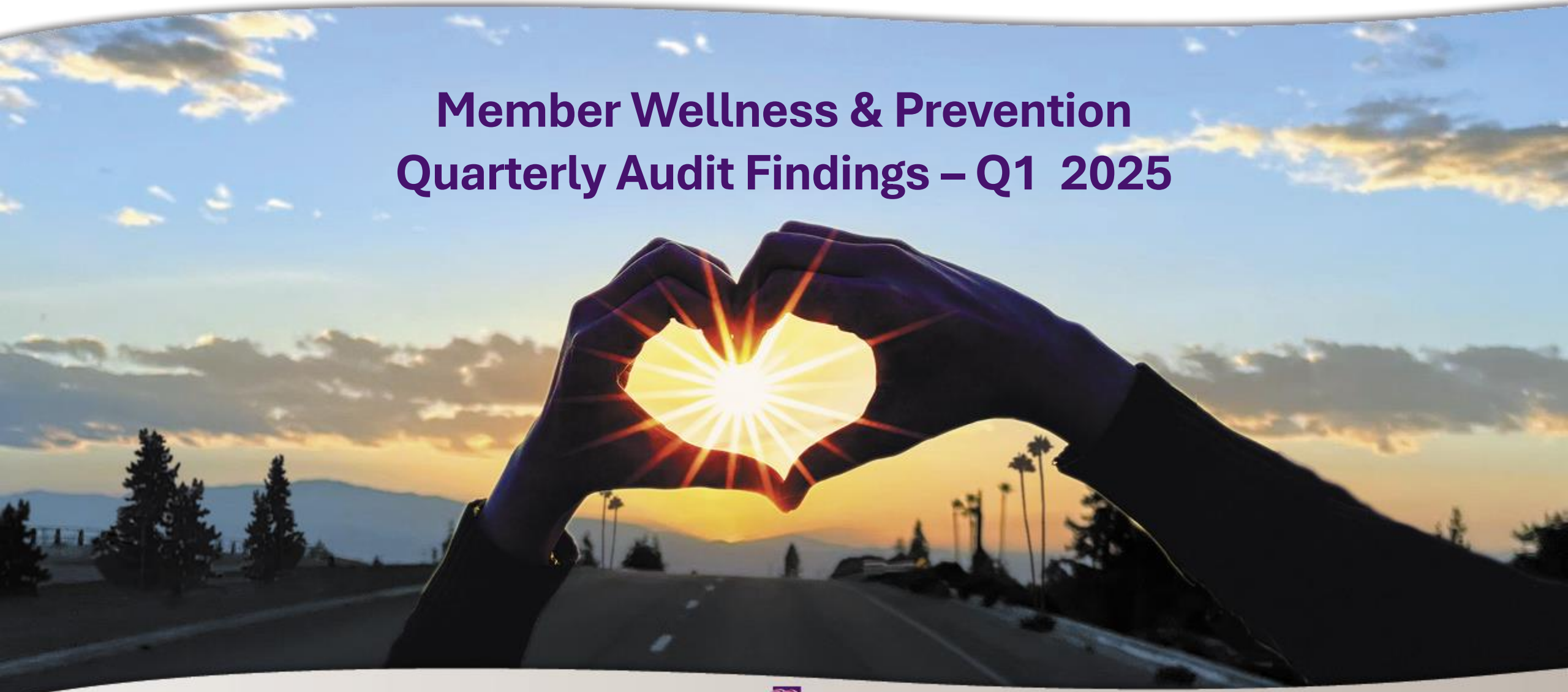
Member Wellness & Prevention
Quarterly Audit Findings – Q1 2025



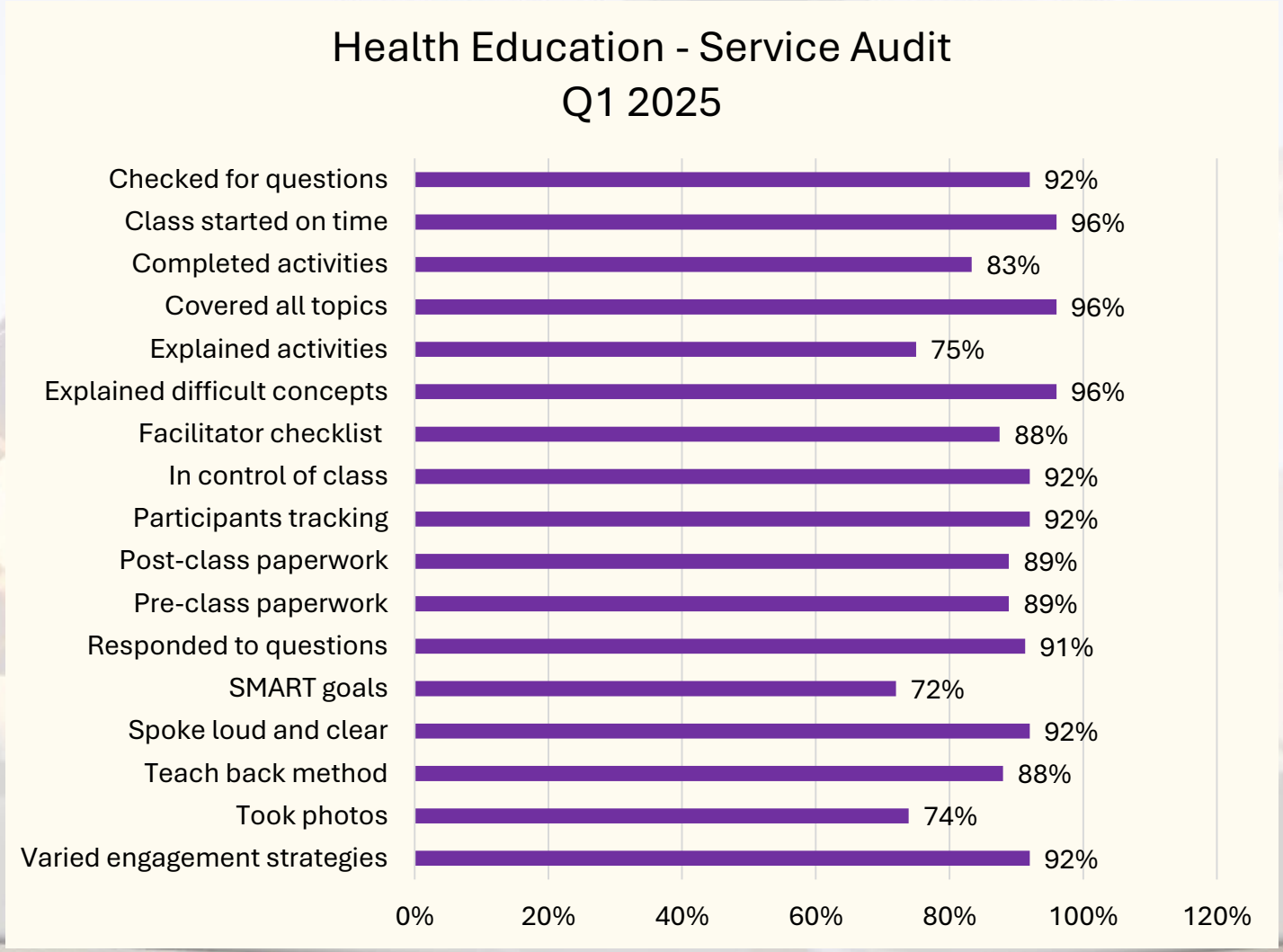
KERN HEALTH SYSTEMS

Health Education Services

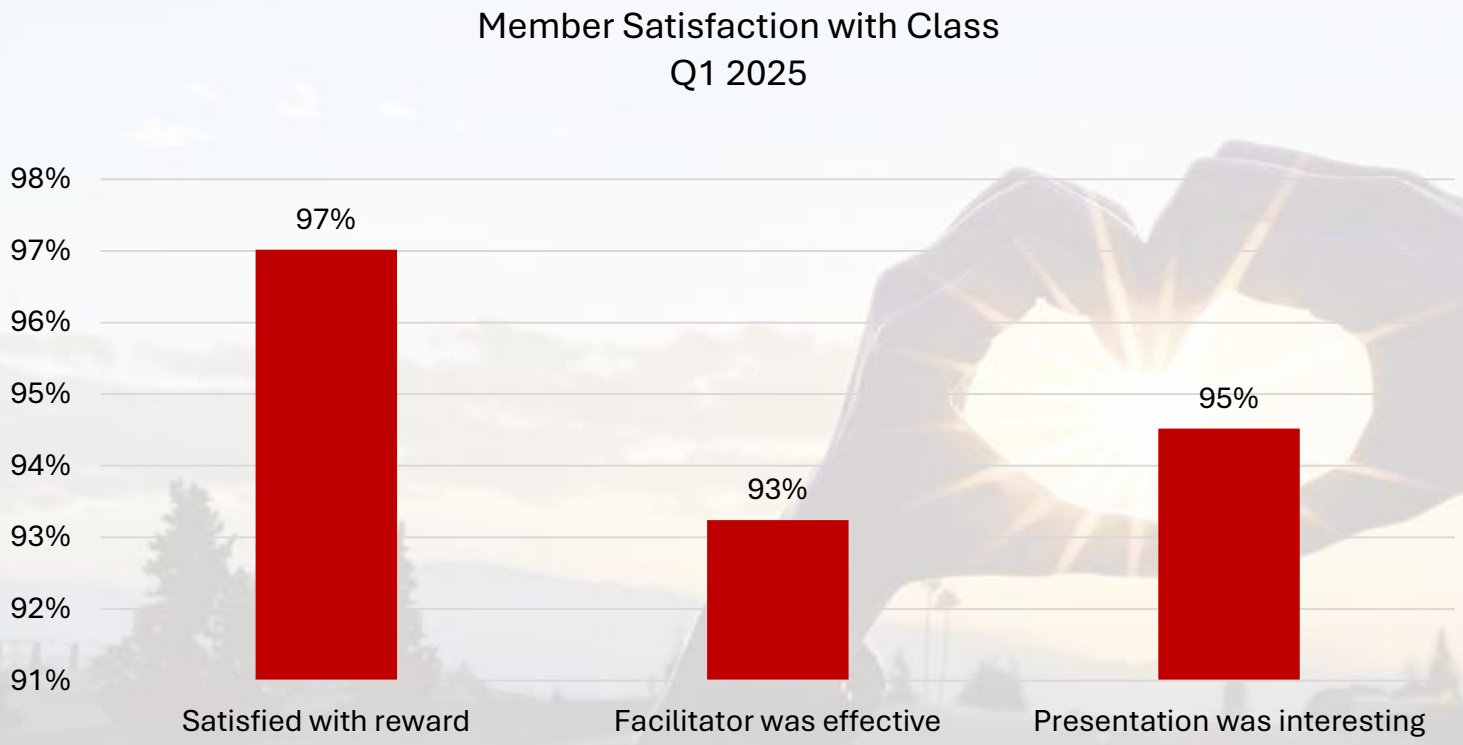
- Service Audit
- Satisfaction Survey
- Class Effectiveness

Service Audit

- Areas at 100%
  - Interpreter scheduled
  - Flyer provided
  - Prepared supplies
  - Covered at least 1 myth
  - Requested cameras on (virtual)
  - Ended class on time
- Areas below 50%
  - Explained follow-up calls
  - Class on KFHC calendar



Satisfaction Survey



Satisfaction Survey

What did you like most about the class?

Class Content
Participants felt the class was thorough, informative, and effective in its current format.
"Everything is good."
"The class was awesome and understandable."
"Everything was perfect.“

Instructor Feedback
Many participants felt no improvement was needed and praised the instructor's delivery and content.
"You guys are doing a great job already."
"I think this was perfect."
"Keep doing what you’re doing.“

General Satisfaction
Overall, many participants were satisfied with the class and felt no changes were necessary.
"Everything is fine."
"Everything was good."
"I think the class is perfect."

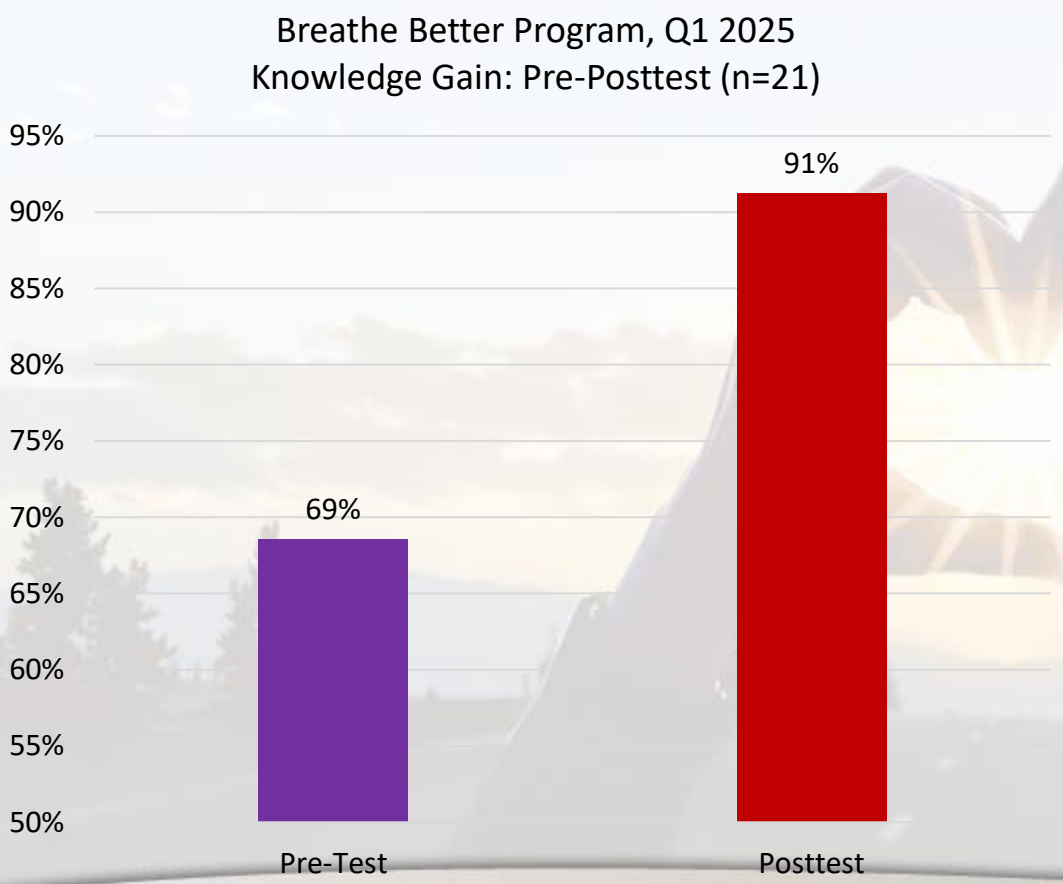
How could we improve the class?

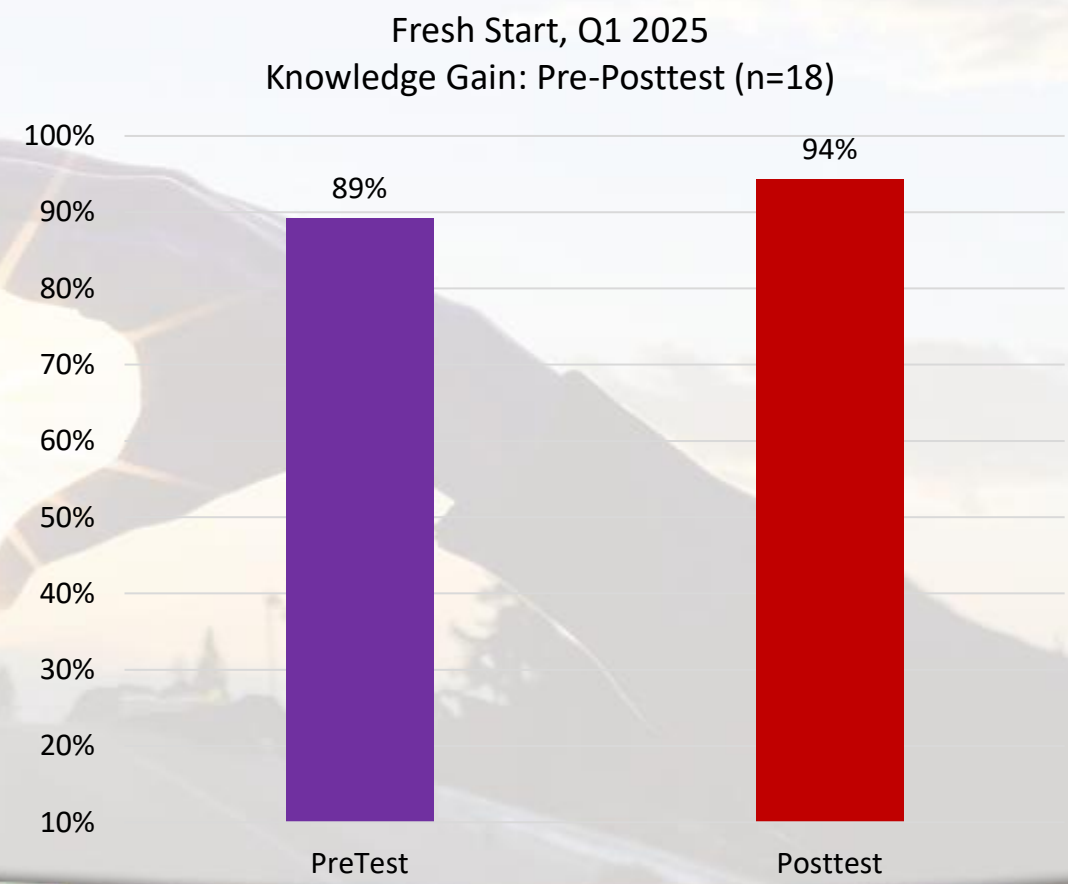
Suggestions for Improvement
A few participants suggested minor improvements, such as more activities or specific content adjustments.
“Provide a request for more Nicotine Free products."
"Make us do a commercial for not smoking and add your struggles."
"Add more fun activities."
"Increase time."

Activities and Engagement
Some felt that the class could be more interactive with additional activities or group involvement.
"Maybe more group activities."
"More hands-on."
"More walking activities."
"More recipes and exercises."
"More alternative food or meals."
"Doing the A1C tests.“

Class Support
The supportive atmosphere was appreciated, with some calling for further encouragement or assistance.
"Supporting us."
"That we, the members, participate more."
"Help with extra food vouchers."

Class Effectiveness





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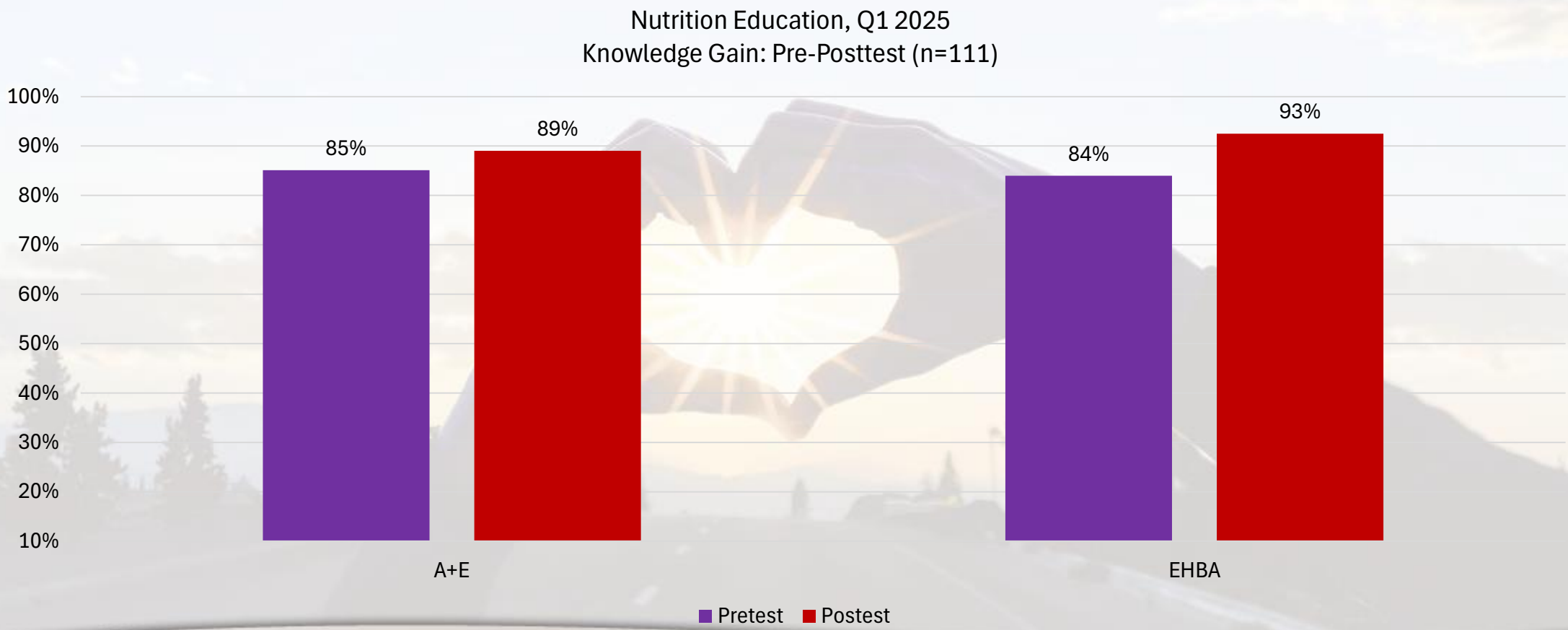

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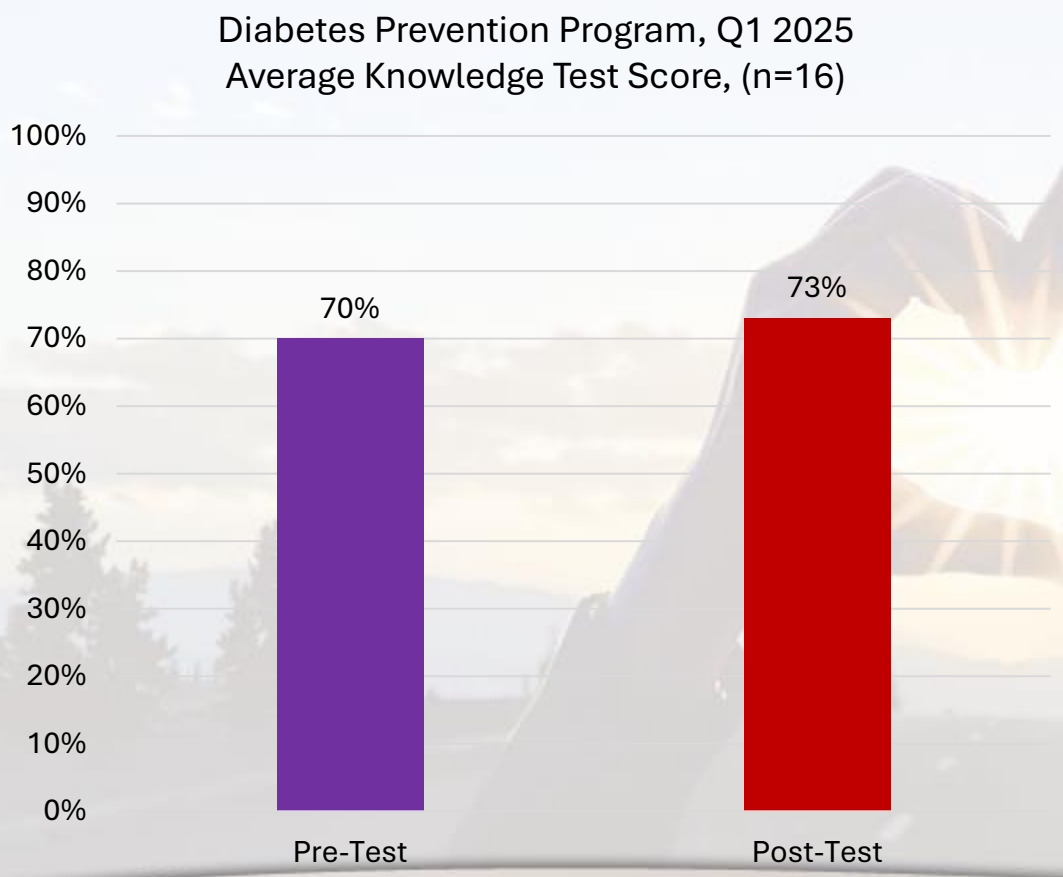

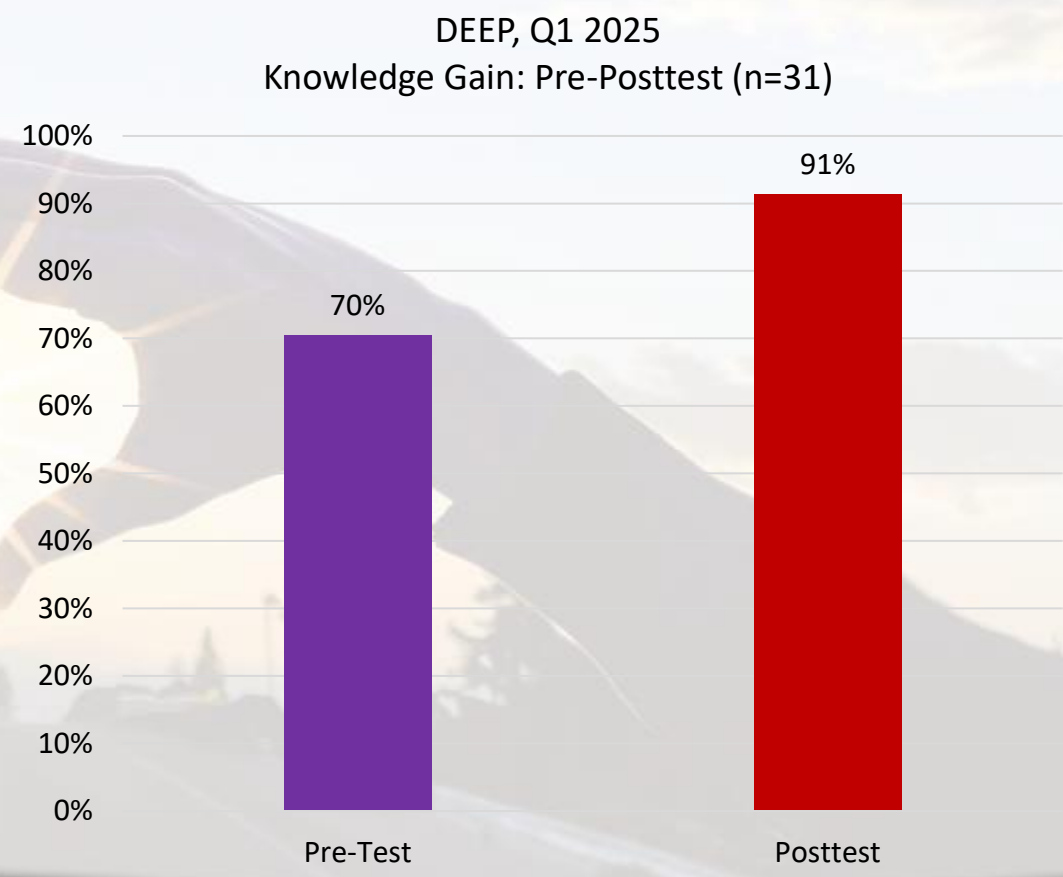

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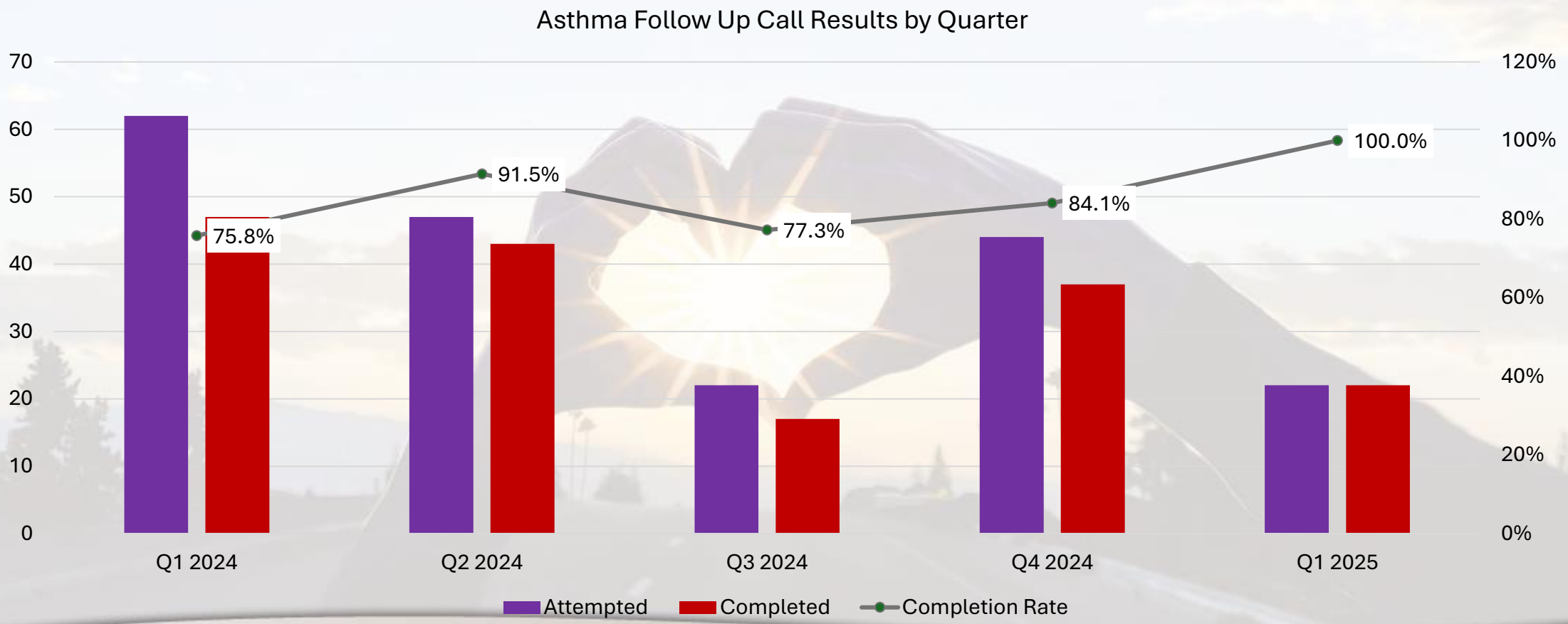

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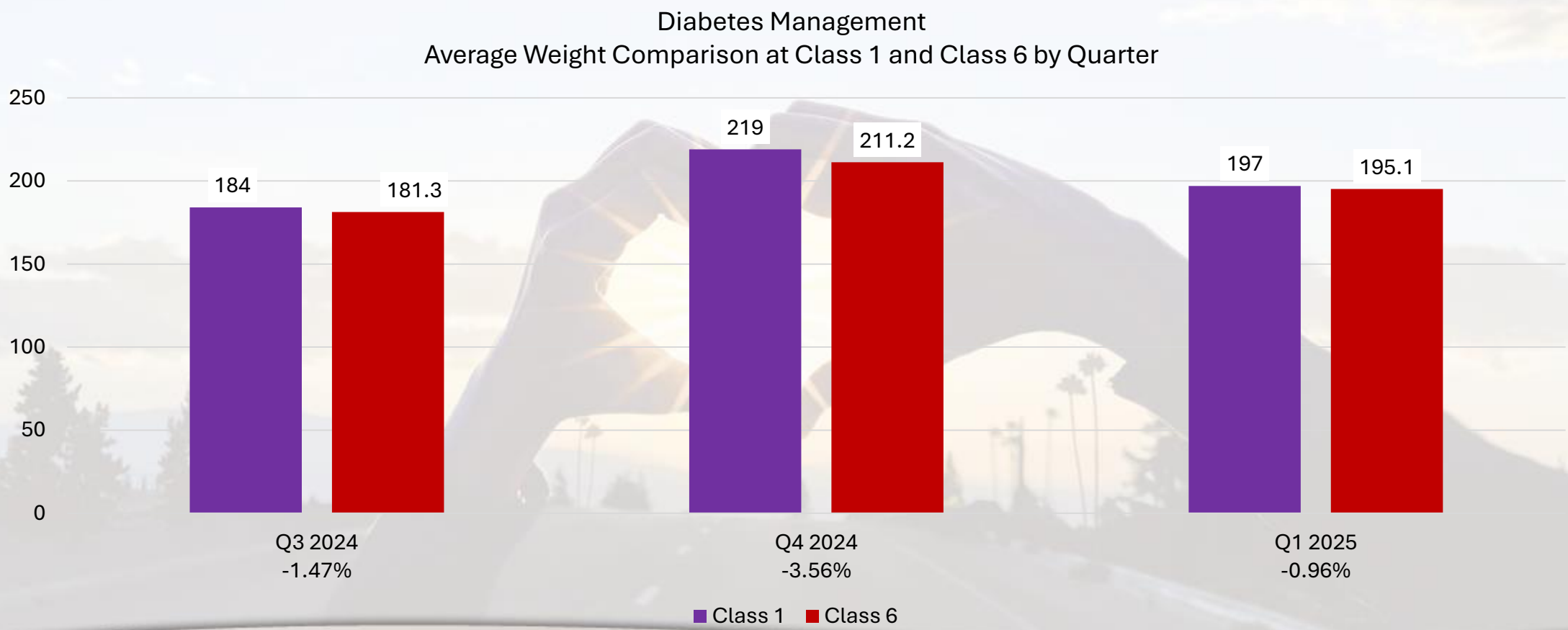

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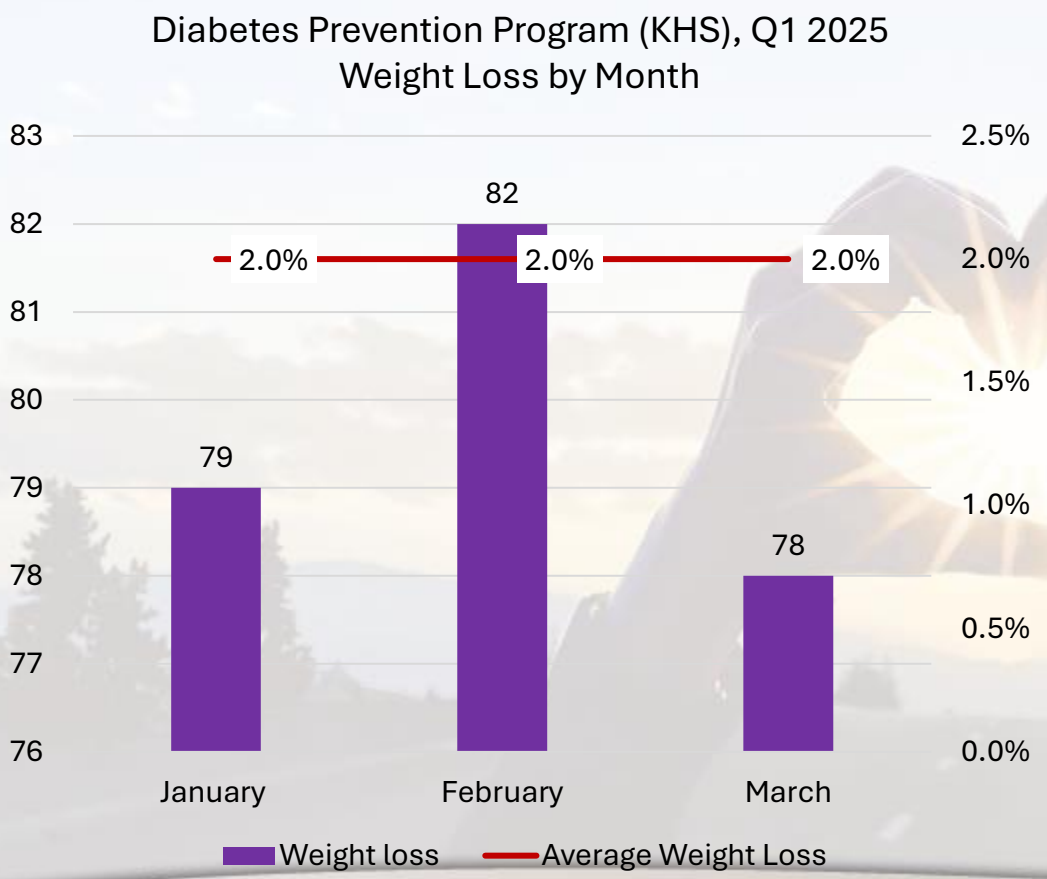

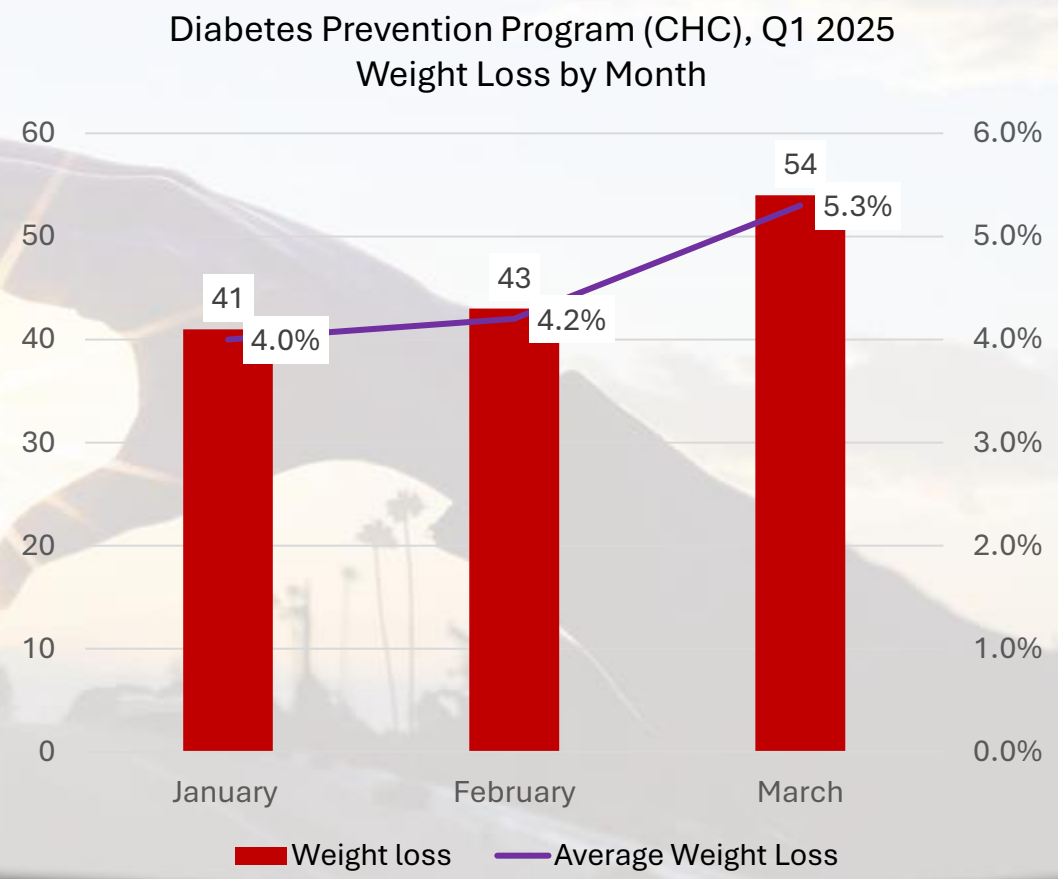

You + Us = **a better day!**

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	Community Health Worker	**Policy #**	11.29-P
Policy Owner	Wellness and Prevention	**Original Effective Date**	3-15-2023
Revision Effective Date	~~7-2024~~1-2025	**Approval Date**	
Line of Business	☒ Medi-Cal ☐ Medicare ☐ Corporate		

I. PURPOSE

The Purpose is to define the process by which Kern Health Systems (KHS) and contracted Community Health Worker (CHW) Providers become qualified to provide CHW services, the covered services, and requirements to be followed to ensure compliance with Department of Health Care Services (DHCS) regulation.

II. POLICY

KHS will provide plan members with the CHW services benefit identified through DHCS All Plan Letter (APL) 24-006.

Per State Plan Amendment (SPA) 22-0001, CHW services are preventive health services as defined in Title 42 Code of Federal Regulations (CFR) Section 440.130 (c). CHW services may assist with a variety of concerns impacting Managed Care Plan (MCP) members, including but not limited to, the control and preventions or chronic conditions or infectious diseases, behavioral health conditions, and need for preventive services.

A. Enforcement

KHS will verify all providers submitting claims for CHW services have completed the CHW application and CHW Supervisor Attestation is submitted through the credentialing department.

B. Certification

1. CHW Provider Requirements and Qualification

   CHWs must have lived experience that aligns with and provides a connection between the CHW, and the community or population being served. This may include, but is not limited to, lived experience related to incarceration, military service, pregnancy and birth, disability, foster system placement, homelessness, mental health conditions or substance use, or being a survivor of domestic or intimate partner violence or abuse and exploitation. Lived

experience may also include shared race, ethnicity, sexual orientation, gender identity, language, or cultural background of one or more linguistic, cultural, or other groups in the community for which the CHW is providing services.
Supervising providers are encouraged to work with CHWs who are familiar with and/or have experience in the geographic communities they are serving. Supervising Providers must maintain evidence of this experience.

CHWs must have lived experience that aligns with Member or population being served. CHWs must demonstrate qualifications through the Certificate Pathway or Work Experience Pathway and must provide proof of completion. A CHW who does not have a certificate of completion and yet has at least 2,000 hours working as a CHW in paid or volunteer positions within the previous three years, will have the ability to earn a certificate of completion, as described above, within 18 months of the first CHW visit provided to a member.

CHW violence prevention services are available to Members who meet any of the following circumstances as determined by a licensed practitioner:

a. The Member has been violently injured as a result of community violence.
b. The Member is at significant risk of experiencing violent injury as a result of community violence.
c. The Member has experienced chronic exposure to community violence.

Note: CHWs must complete a minimum of six (6) hours of additional relevant training annually.

CHWs must meet the following to qualify as an asthma preventive services provider:

a. A certificate from the California Department of Public Health Asthma Management Academy
b. A certificate demonstrating completing of a training program consistent with the National Institute of Health's Guidelines for the Diagnosis and Management of Asthma with core competencies in the following areas:
    i. Basic facts of asthma's impact on the human body, including asthma control
    ii. Roles of medications
    iii. Environmental control measures
    iv. Teaching individuals about asthma self-monitoring
    v. Implementation of a plan of care
    vi. Effective communication strategies including at a minimum cultural and linguistic competency and motivational interviewing.
    vii. Roles of a care team and community referrals
c. And both of the following:
    i. Completed a minimum of sixteen (16) hours of face-to-face client contact focused on asthma management and prevention.

Note: CHWs must complete a minimum of four (4) hours annually of continuing education on asthma.

CHWs must be supervised by a licensed provider, clinic, hospital, community-based organization (CBO), or local health jurisdiction (LHJ).

C. Supervising Provider Requirements

Supervising Providers must be a licensed provider, clinic, hospital (including emergency department), community-based organization (CBO), or local health jurisdiction (LHJ). Supervising Providers do not need to have a licensed Provider on staff in order to contract with KHS to bill for CHW services. Supervising Providers must maintain evidence of the CHWs lived experience and attest that they have verified the CHWs have lived experience that aligns with the population they are serving and have sufficient experience to provide services.

Supervising Providers must maintain evidence of CHW minimum qualifications through one of the following pathways:

1. CHW Certificate

   A valid certificate of completion of a curriculum that attests to demonstrated skills and/or practical training in the following areas: communication, interpersonal and relationship building, service coordination and navigation, capacity building, advocacy, education and facilitation, individual and community assessment, professional skills and conduct, outreach, evaluation and research, and basic knowledge in public health principles and social drivers of health (SDOH), as determined by the Supervising Provider. Certificate programs must also include field experience as a requirement.

2. Violence Prevention Professional Certificate

   For individuals providing CHW violence prevention services only, a Violence Prevention Professional (VPP) Certificate issued by Health Alliance for Violence Intervention or a certificate of completion in gang intervention training form the Urban Peace Institute. A VPP Certificate allows a CHW to provide CHW violence prevention services only. A CHW providing services other than violence prevention services must demonstrate qualification through either the Work Experience Pathway or by completion of a General Certificate.

3. Work Experience Pathway

   An individual who has at least 2,000 hours working as a CHW in paid or volunteer positions within the previous three years and has demonstrated skills and practical training in the areas described above, as determined and validated by the Supervising Provider, may provide CHW services without a certificate of completion for a maximum period of eighteen (18) months. A CHW who does not have a certificate of completion must earn a certificate of completion, as described above, within eighteen (18) months of the first CHW visit provided to a member.

~~No later than March 2025,~~ KHS has established ~~will have approved and operable policies and procedures to effectuate~~ a billing pathway for Supervising Providers, including contracted

hospitals, to claim for provisions of CHW services to Members during an emergency department (ED) visit and/or as outpatient follow-up to an ED visit. Refer to Policy and Procedure 6.01-P Claims Submission Reimbursement.

The Supervising Provider must maintain evidence of the annual the training requirements. CHWs are required to complete a minimum of six (6) hours in relevant training in either a core competency or specialty area. Supervising Providers may provide and/or require additional training, as identified by the Supervising Provider. KHS will monitor to ensure Supervising Providers or their Subcontractors contracting with or employing CHWs are providing adequate supervision and training. Providers will be required to demonstrate verification of supervision and training upon request of KHS.

The Supervising Providers must provide direct or indirect oversight to CHWs. Direct oversight includes, but is not limited to, guiding CHWs in providing services, participating in the development of a plan of care, and following up on the progression of CHW services to ensure that services are provided in compliance with all applicable requirements. Indirect oversight includes, but is not limited to, ensuring connectivity of CHWs with the ordering entity and ensuring appropriate services are provided in compliance with all applicable requirements.

The supervising provider does not need to be the same entity as the provider who made the written recommendation for CHW services. Supervising providers do not need to be physically present at the location when CHWs provide services to beneficiaries. Management and day-to-day supervision of CHWs as employees may be delegated as determined by the supervising provider.

D. Provider Enrollment

The KHS Network Providers will be required to enroll as Medi-Cal Providers if there is a state-level enrollment pathway for them to do so. Supervising Providers, with a state-level Medi-Cal enrollment pathway, must follow the standard process for enrolling through the DHCS' Provider Enrollment Division. Refer to Policy & Procedures (P&P) 4.01P Credentialing.

For the Supervising Providers that do not have a corresponding state-level enrollment pathway, they will not be required to enroll in the Medi-Cal program. Supervising Providers, without a state level Medi-Cal enrollment pathway, must complete the appropriate provider application, Supervising Attestation and Acknowledgement form for submission to KHS Credentialing for review and approval. KHS will verify the supervising provider meets the qualification as a licensed provider, or other acceptable supervising provider designated within a hospital, outpatient clinic, local health jurisdiction (LHJ) or a community-based organization (CBO), employing or otherwise overseeing the CHW, with which Kern Health Systems (KHS) contracts.

III. DEFINITIONS

N/A

IV. PROCEDURES

A. Member Eligibility Criteria

CHW services require a written recommendation submitted to KHS by a physician or other licensed practitioner of the health arts within their scope of practice under state law. For CHW services rendered in the Emergency Department (ED), the treating provider may verbally recommend initiating CHW services and later document the recommendation in the Members medical record. Other licensed practitioners who can recommend CHW services within their scope of practice include physician assistants, nurse practitioners, clinical nurse specialists, podiatrists, nurse midwives, licensed midwives, registered nurses, public health nurses, psychologists, licensed marriage and family therapists, licensed clinical social workers, licensed professional clinical counselors, dentists, registered dental hygienists, licensed educational psychologists, licensed vocational nurses, and pharmacists. The recommending licensed provider does not need to be enrolled in Medi-Cal or be a KHS network provider or be employed by the supervising provider. Referrals will be submitted to KHS by the provider portal and KHS will use JIVA, our internal medical management system, to monitor referrals sent to providers.

Provider must ensure that a member meets eligibility criteria before recommending CHW services. CHW services are considered medically necessary for Members with one or more chronic health conditions (including behavioral health) or exposure to violence and trauma, who are at risk for a chronic health condition or environmental health exposure, who face barriers in meeting their health or health-related social needs, and/or who would benefit from preventive services. The recommending Provider must determine whether a member meets eligibility criteria for CHW services based on the presence of one or more of the following:

1. Diagnosis of one or more chronic health (including behavioral health) conditions, or a suspected mental disorder or substance use disorder that has not yet been diagnosed.
2. Presence of medical indicators of rising risk of chronic disease (e.g., elevated blood pressure, elevated blood glucose levels, elevated blood lead levels or childhood lead exposure, etc.) that indicate risk but do not yet warrant diagnosis of a chronic condition.
3. Any stressful life event presented via the Adverse Childhood Events screening.
4. Presence of known risk factors, including domestic or intimate partner violence, tobacco use, excessive alcohol use, and/or drug misuse.
5. Results of a Social Determinant of Health (SDOH) screening indicating unmet health-related social needs, such as housing or food insecurity.
6. One (1) or more visits to a hospital ED within the previous six (6) months.
7. One or more hospital inpatient stays, including stays at a psychiatric facility, within the previous six (6) months, or being at risk of institutionalization.
8. One (1) or more stays at a detox facility within the previous year.
9. Two (2) or more missed medical appointments within the previous six (6) months.
10. Member expressed need for support in health system navigation or resource coordination services.

11. Need for recommended preventive services, including updated immunizations, annual dental visit, and well childcare visits for children.

CHW violence prevention services are available to Members who meet any of the following circumstances as determined by a licensed practitioner:

1. The Member has been violently injured as a result of community violence.
2. The Member is at significant risk of experiencing violent injury as a result of community violence.
3. The Member has experienced chronic exposure to community violence.

Medi-Cal will provide asthma self-management education to all beneficiaries with a diagnosis of asthma. Beneficiaries must have a current diagnosis of poorly controlled asthma, or on the recommendation of a licensed physician, nurse practitioner (NP), or physician assistant (PA), in order to receive an "in-home environmental trigger assessment."

B. Covered CHW Services

CHW services can be provided as individual or group sessions. The services can also be provided virtually or in-person with locations in any setting including, but not limited to, outpatient clinics, hospitals, homes, or community settings.

Services include:

1. Health Education: Promoting a Member's health or addressing barriers to physical and mental health care, such as through providing information or instruction on health topics.
   Health Education content must be consistent with established or recognized health care standards and may include coaching and goal setting to improve a Member's health or ability to self-manage their health conditions.

2. Health Navigation: Providing information, training, referrals, or support to assist Members to access health care, understand the health care delivery system, or engage in their own care. This includes connecting Members to community resources necessary to promote health; address barriers to care, including connecting to medical translation/interpretation or transportation services; or address health-related social needs. Under Health Navigation, CHWs can also:
   a. Serve as a cultural liaison or assist a licensed health care Provider to participate in the development of a plan of care, as part of a health care team.
   b. Perform outreach and resource coordination to encourage and facilitate the use of appropriate preventive services; or
   c. Help a Member enroll or maintain enrollment in government or other assistance programs that are related to improving their health, if such navigation services are provided pursuant to a plan of care.
3. Screening and Assessment: Providing screening and assessment services that do not require a license and assisting a Member with connecting to appropriate services to improve their health.

4. Individual Support or Advocacy: Assisting a Member in preventing the onset or exacerbation of a health condition, preventing injury, or violence. This includes peer support as well if not duplicative of other covered benefits.

Services may be provided to a parent or legal guardian of a Member under age 21 for the direct benefit of the Member, in accordance with a recommendation from a licensed Provider. If the parent or legal guardian is not enrolled in Medi-Cal, the Member must be present when CHW services are provided. A service for the direct benefit of the Member must be billed under the Member's Medi-Cal ID.

CHWs may render street medicine and the Supervising Provider will bill KHS for any appropriate and applicable services within their scope of service. Covered CHW services do not include any service that requires a license.

CHWs who do not meet the qualifications of an asthma preventive services provider may not provide asthma education or in-home environmental trigger assessments, but they may provide CHW services for health education and navigation to Members with asthma.

Refer to Policy 3.36-P Asthma Treatment and Management

Note: There are no Place of Service restrictions for CHW services.

C. Non-covered CHW Services

1. Clinical case management/care management that requires a license.
2. Childcare
3. Chore services, including shopping and cooking meals.
4. Companion services
5. Employment services
6. Helping a Member enroll in government or other assistance programs that are not related to improving their health as part of a plan of care.
7. Delivery of medication, medical equipment, or medical supply
8. Personal Care services/homemaker services
9. Respite care
10. Services that duplicate another covered Medi-Cal service already being provided to a Member.
11. Socialization
12. Transporting members
13. Services provided to individuals not enrolled in Medi-Cal, except as noted above
14. Services that require a license

CHWs may provide CHW services to Members with mental health and/or substance use disorders. CHW services do not include Peer Support Services as covered under the Drug Medi-Cal, Drug Medi-Cal Organized Delivery System, and Specialty Mental Health Services programs. CHW services are distinct and separate from Peer Support Services.

D. Covered APS Services

Medi-Cal Asthma Preventive Services (APS) will comprise clinic-based asthma self-management education, home-based asthma self-management education and in-home environmental trigger assessments for eligible beneficiaries of any age, as medically necessary, subject to applicable utilization controls. Pursuant to Title 42 of the Code of Federal Regulations, Section 440.130(c).

Refer to Policy 3.36-P Asthma Treatment and Management

E. Documentation Requirements

CHWs are required to document the dates and time/duration of services provided to Members. Documentation should also reflect information on the nature of the service provided and support the length of time spent with the patient that day.

Documentation must be accessible to the Supervising Provider upon their request. Documentation should be integrated into the Member's medical record and available for encounter data reporting. CHW's National Provider Identifier (NPI) number should be included in documentation.

F. Plan of Care

For members who need multiple ongoing CHW services or continued CHW services after twelve (12) units of services as defined in the Medi-Cal Provider Manual, a written care plan must be written by one or more individual licensed providers, with the exception of services provided in the Emergency Department, which may include the recommending Provider and other licensed Providers affiliated with the CHW Supervising Provider.

The Provider ordering the plan of care does not need to be the same Provider who initially recommended CHW services or the Supervising Provider for CHW services. CHWs may participate in the development of the plan of care and may take a lead role in drafting the plan of care if done in collaboration with the Member's care team and/or other Providers referenced in this section. The plan of care may not exceed a period of one year.

The plan of care must:

1. Specify the condition that the service is being ordered for and be relevant to the condition.
2. Include a list of other health care professionals providing treatment for the condition or barrier.
3. Contain written objectives that specifically address the recipient's condition or barrier affecting their health.
4. List the specific services required for meeting the written objectives; and
5. Include the frequency and duration of CHW services (not to exceed the Provider's order) to be provided to meet the plan's objectives.

A licensed Provider must review the Member's plan of care at least every six (6) months from the effective date of the initial plan of care. The licensed Provider must determine if progress is being made toward the written objective and whether services are still medically necessary. If there is a

significant change in the recipient's condition, Providers should consider amending the plan for continuing care or discontinuing services if the objectives have been met.

G. Monitoring

KHS reports all CHW service encounters to DHCS. Monitoring will include verification of CHW's ability to provide attested services. If appropriate training and certification are not able to be verified, Kern Health Systems has the right to recover any paid funds through our recovery process after thirty (30) days of notification. Supervising Providers will complete attestation certifying that their CHWs have the appropriate training, qualifications, and supervision.

KHS will use collected information to assess universal capture rates across KHS membership and implement data strategies. KHS uses the John Hopkins risk stratification tool for risk stratification and segmentation of the KHS population. Other data sources include but are not limited to past and current Member utilization/encounters, data on health risks and clinical care gaps, frequent hospitalizations or ED visits, Member demographics, and SDOH data, referrals and needs assessments. This will allow KHS to identify members who need more care and attention for their overall health and refer to CHWs for support to addressing health care needs. Providers will be required to use data driven approaches to determine and identify priority populations eligible for CHW services.

H. Billing, Claims, and Payments

CHW services must be reimbursed through a CHW Supervising Provider in accordance with its Provider contract. Billing pathways may be structured as a sub-capitated rate, an add-on rate to existing payments, or another billing and payment arrangement agreed upon by KHS and the Provider.

KHS will not require prior authorization for CHW services as they are a preventive service. CHW has quantity limits, with a maximum frequency of four (4) units (two hours) daily per beneficiary. Quantity limits can be applied based on goals detailed in the plan of care. Additional units per day may be provided with KHS approval for medical necessity. KHS will not establish unreasonable or arbitrary barriers for accessing coverage.

KHS adheres to the DHCS contractual requirements related to claims processing and encounter data submissions, including use of approved codes pursuant to the Medi-Cal Provider Manual for CHW Preventive Services. Claims for CHW services must be submitted by the Supervising Provider with allowable current procedural terminology codes as outlined in the Medi-Cal Provider Manual.

KHS, all Subcontractors and Network Providers must not double bill, as applicable, for CHW services that are duplicative to services that are reimbursed through other benefits such as Enhanced Care Management (ECM), which is inclusive of the services within the CHW benefit.

Refer to Policy 14.04-P Prevention, Detection, and Reporting of Fraud, Waste, or Abuse.

Note: Tribal clinics may bill for CHW services at the Fee-for-Service rates using the Current Procedural Terminology (CPT) codes as outlined in the Provider Manual. Pursuant to Welfare and Institutions Code (WIC) 14087.325(d), KHS must reimburse contracted Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHCs) in a manner that is no less than the level and amount of payment that KHS would make for the same scope of services if services were furnished by another Provider type that is not an FQHC or RHC.

I. Access requirements

KHS monitors the accessibility of contracted providers to members to obtain covered services and implements corrective measures when necessary. Refer to Policy 4.30-P Accessibility Standards.

J. Integration with population health management (PHM)

As part of the KHS Population Health Management Readiness Deliverable submission, KHS gained approval for a CHW Integration Plan which describes the Plan's strategies for supporting CHW integration and approach for building sustainable infrastructure and supports. The CHW Integration Framework will remain aligned with APL 22-016 Appendix A CHW Integration Plan.

THE KHS CHW Integration Plan focuses on the following required elements:

1. Integrate CHWs into health care delivery services.
2. Build capacity in Provider Networks to employ CHWs.
3. Communicate to Members about the scope of practice, benefits, and availability of CHW services.
4. Communicate to Providers about the scope of practice, benefits, and availability of CHW services.
5. MCP monitoring strategies.

K. DHCS Monitoring

KHS is responsible for ensuring that their Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, Grievance and Appeal requirements, contract requirements, and other DHCS guidance, including APLs, Policy Letters and Dual Plan Letters. These requirements must be communicated by KHS to all Subcontractors and Network Providers.

V. ATTACHMENTS

Attachment A	N/A

VI. REFERENCES

Reference Type	Specific Reference
Other KHS Policies	4.01-P Credentialing

Other KHS Policies	4.30-P Accessibility Standards
Other KHS Policies	14.04-P Prevention, Detection, and Reporting Fraud, Waste, or Abuse
Other KHS Policies	3.36-P Asthma Treatment and Management

VII. REVISION HISTORY

Action	Date	Brief Description of Updates	Author
Revised	2025-01	The policy was revised to comply with DHCS APL 24-006, the policy was submitted to DHCS on 2/19/2025.	I.S. W&P
Revised	2024-07	Policy revised to comply with requirements of DHCS APL 24-006 and include language from DHCS Asthma Preventive Services (APS) manual. Received DHCS approval on 9-10-2024.	W&P
Revised	2023-12	Policy revised to comply with requirements of DHCS APL 22-016 – Approved by DHCS on 02-12-2024.	PNM
Revised	2023-09	Policy updated to include revised requirements of DHCS APL 22-016.	PNM
Revised	2023-06	Policy updated to include Integration with KHS Population Health Management (PHM) Readiness Deliverable and APL 22-024 PHM Policy Guide requirements aligned with APL 22-016 Appendix A CHW Integration Plan.	PNM
Created	2022-11	Policy was developed to comply with DHCS APL 22-016. DHCS approval was received on 1-19-2023.	PNM

VIII. APPROVALS

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

Regulatory Agencies (if applicable)	**Date Reviewed**	**Date Approved**
Department of Health Care Services (DHCS)	DHCS APL 24-006, 2/19/2025	
Department of Health Care Services (DHCS)	DHCS APL 24-006	9-10-2024

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Department of Health Care Services (DHCS)	APL 22-016, 12-15-2023	02-12-2024
Department of Health Care Services (DHCS)	APL 22-016, 01-19-2023	01-19-2023
Department of Health Care Services (DHCS)	For DHCS APL 24-006 on 8-9-2024	9-10-2024

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

KERN HEALTH SYSTEMS

Policy and Procedure Review

KHS Policy & Procedure: 11.29-P- Community Health Worker

Previous implemented version: 12/6/2024 ~~03-15-2023~~

Reason for revision: ~~On 7-11-2024, the policy was revised to comply with DHCS APL 24-006 requirements and include language from DHCS Asthma Preventive Services (APS) manual. The policy revisions were approved on 9-10-2024 by DHCS. In addition, the policy was transferred from the Provider Network Management Department to the Wellness and Prevention Department. As a result of this transfer, the policy was renumbered from 4.51-P to 11.29-P.~~ The policy was revised to align with DHCS APL 24-006.

Director Approval		
Title	**Signature**	**Date Approved**
Isabel Silva Senior Director of Wellness and Prevention		
Amisha Pannu Senior Director of Provider Network		
Robin Dow-Morales Senior Director of Claims		
Sukhpreet Sidhu Population Health Medical Director		
Michelle Curioso Director of Population Health Management		

Date posted to public drive: _____

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

Kern Health Systems Quality Improvement Annual Work Plan - 2025

Work Plan Update - Q1

Complete
In Progress or No Update
Risk
Barrier

Source	Key Performance Measure	Objective/Metrics	Previously Identified Issue	Measurable Goals	Actions/Improvement Activities	Target Date of Completion	Responsible Staff	Q1 Update
I. Quality Program Structure								
NCQA 1D	QIHE Governance	Conduct quarterly EQIHEC Meetings	No issues identified	Meet quorum of voting members at every meeting		12/31/2025	Quality Improvement Director & Health Equity Manager	**Q1 - 3/18/2025 - Completed Q2 - 6/17/2025 Q3 - 9/2025 Q4 - 12/2025**
NCQA 1C	Annual QI Evaluation of 2024	Summary of completed and ongoing QI activities, trending of results and overall evaluation of effectiveness	No issues identified	Annual approval by the EQIHEC and the BOD		4/17/2025	Quality Improvement Director	**Complete**
NCQA 1A	2025 Quality Improvement Health Equity Program Description	QIHE Program description of committee accountability, functional areas and responsibilities, reporting relationship, resources and analytical support	QI and HE Programs were previously two separate documents.	Annual approval by the EQIHEC and the BOD	Combine QI and HE Program documents and update for 2025	4/17/2025	Quality Improvement Director & Health Equity Manager	**Complete**
NCQA 1B	2025 Annual Quality Improvement Health Equity Work Plan	Yearly planned objectives and activities	No issues identified	Annual approval by the EQIHEC and the BOD		4/17/2025	Quality Improvement Director	**Complete**
DHCS	Policies and Procedures	Annual review of KHS Quality Improvement P&Ps	No issues identified	100% of policies reviewed and updated as needed		12/31/2025	Quality Improvement Director	**In Progress**
NCQA	NCQA Health Plan Accreditation	Attain Health Plan Accreditation	Initial Accreditation	Attain Full Health Plan Accreditation by 1/1/2026		12/31/2025	Quality Improvement Director	**In Progress**
NCQA	NCQA Health Equity Accreditation	Attain Health Equity Accreditation	Initial Accreditation	Attain Full Health Equity Accreditation by 1/1/2026		12/31/2025	Health Equity Manager	**In Progress**
II. Quality of Clinical Care								
DHCS	MCAS Measures	AMR	Met MPL for MY2023/RY2024. No issue	Meet minimum performance levels (MPLs)	none	8/31/2025	Quality Performance Director	**Met MPL**
DHCS	MCAS Measures	BCS	Met MPL for MY2023/RY2024. No issue	Meet minimum performance levels (MPLs)	Measure is part of Member Engagement and Rewards Program	8/31/2025	Quality Performance Director	**Met MPL**
DHCS	MCAS Measures	CHL	Not Meeting MPL	Meet minimum performance levels (MPLs)	Measure is part of Member Engagement and Rewards Program	8/31/2025	Quality Performance Director	**Met MPL**
DHCS	MCAS Measures	CCS	Not Meeting MPL	Meet minimum performance levels (MPLs)	Measure is part of Member Engagement and Rewards Program	8/31/2025	Quality Performance Director	**Met MPL**
DHCS	MCAS Measures	CIS-10	Not Meeting MPL	Meet minimum performance levels (MPLs)	none	8/31/2025	Quality Performance Director	**Risk**
DHCS	MCAS Measures	CBP	Met MPL for MY2023/RY2024. No issue	Meet minimum performance levels (MPLs)	none	8/31/2025	Quality Performance Director	**Met MPL**
DHCS	MCAS Measures	DEV	Not Meeting MPL	Meet minimum performance levels (MPLs)	none	8/31/2025	Quality Performance Director	**Risk**
DHCS	MCAS Measures	IMA-2	Not Meeting MPL	Meet minimum performance levels (MPLs)	none	8/31/2025	Quality Performance Director	**Met MPL**
DHCS	MCAS Measures	LSC	Not Meeting MPL	Meet minimum performance levels (MPLs)	QI Senior Coordinators reached out to Top 10 provider that have less than 150 members to complete Lead Screening in Children before the 2 years of age (LSC)	8/31/2025	Quality Performance Director	**Met MPL**
DHCS	MCAS Measures	FUA-30Day follow up	Not Meeting MPL	Meet minimum performance levels (MPLs)	Working with Tele Doc providers for FUA and FUM to schedule a follow-up visit with 30days.	8/31/2025	Quality Performance Director	**Risk**
DHCS	MCAS Measures	FUM-30Day follow up	Not Meeting MPL	Meet minimum performance levels (MPLs)	Working with Tele Doc providers for FUA and FUM to schedule a follow-up visit with 30days.	8/31/2025	Quality Performance Director	**Risk**
DHCS	MCAS Measures	GSD	Met MPL for MY2023/RY2024. No issue	Meet minimum performance levels (MPLs)	none	8/31/2025	Quality Performance Director	**Met MPL**
DHCS	MCAS Measures	PPC-Pre	Met MPL for MY2022/RY2023. Did not meet MPL for MY2023/RY 2024. No issue	Meet minimum performance levels (MPLs)	Measure is part of Member Engagement and Rewards Program	8/31/2025	Quality Performance Director	**Met MPL**
DHCS	MCAS Measures	PPC-Post	Met MPL for MY2023/RY2024. No issue	Meet minimum performance levels (MPLs)	Measure is part of Member Engagement and Rewards Program	8/31/2025	Quality Performance Director	**Met MPL**

Kern Health Systems Quality Improvement Annual Work Plan - 2025

Source	Key Performance Measure	Objective/Metrics	Previously Identified Issue	Measurable Goals	Actions/Improvement Activities	Target Date of Completion	Responsible Staff	Q1 Update
DHCS	MCAS Measures	TFL-CH	Not Meeting MPL	Meet minimum performance levels (MPLs)	none	8/31/2025	Quality Performance Director	**Met MPL**
DHCS	MCAS Measures	W30(0-15M)	Not Meeting MPL, but significant YOY improvement over the last two years.	Meet minimum performance levels (MPLs)	Measure is part of Member Engagement and Rewards Program	8/31/2025	Quality Performance Director	**Risk**
DHCS	MCAS Measures	W30(15-30M)	Not Meeting MPL, but significant YOY improvement over the last two years.	Meet minimum performance levels (MPLs)	Measure is part of Member Engagement and Rewards Program	8/31/2025	Quality Performance Director	**Met MPL**
DHCS	MCAS Measures	WCV	Not Meeting MPL, but significant YOY improvement over the last two years.	Meet minimum performance levels (MPLs)	Measure is part of Member Engagement and Rewards Program	8/31/2025	Quality Performance Director	**Risk**
DHCS	Clinical PIP: Focus on Health Equity, specific to the W30 0-15 months African American Population	2023-2026 performance improvement project (PIP) overseen by HSAG focused on increasing the number of children ages 0 - 15 months old with completing an annual well care visit.	Did not meet MPL for multiple measures in Children's Domain of Care	Use MY2023 W30 (0-15months) baseline data to develop PIP interventions and get Annual Approval by HSAG.		12/31/2025	Quality Performance Director	**In Progress**
DHCS	Non-Clinical PIP: Specific to FUA and FUM measures	2023-2026 performance improvement project (PIP) overseen by HSAG focused on improving Behavioral Health measures throug provider notivications with in 7-days of the ER visit.	Did not meet MPL for FUA and FUM measures	Use MY2023 baseline data to develop interventions that includes a process for notifying PCPs of ED visits for eligible population. Annual Approval by HSAG		12/31/2025	Quality Performance Director	**In Progress**
IHI/DHCS	Health Equity Sprint Collaborative	Completion of well-care visits for African-American babies and children for W30 and WCV MCAS measures	Did not meet MPL for WCV or W30	Utilize MY2023 data to develop strategic provider partnerships to improve compliance for targeted population	2 provider partnerships and 1 CBO partnership in support of well-care visits	4/1/2025	Quality Performance Director	**Complete**
III. Safety of Clinical Care								
	Patient Safety Program/Clinical Network Oversight	Conduct Quarterly Audits of select measures (IHA, Lead Screening, etc.)	Baseline monitoring. No system of tracking provider performances.	Conduct quarterly monitoring of provider performance	Conduct quarterly monitoring of provider performance	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Quality Improvement Director	**In Progress**
DHCS	Potential Quality of Care Issue (PQI)	Monitoring of PQI volume month over month	No issues identified	<30/month	Continue quarterly monitoring & report findings to QIW	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Quality Improvement Director	**24/month**
DHCS	Potential Quality of Care Issue (PQI)	PQI Rates by Provider	Baseline monitoring	Baseline monitoring	Continue quarterly monitoring & report findings to QIW	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Quality Improvement Director	**0.48/1000 Provider Interactions**
DHCS	Potential Quality of Care Issue (PQI)	PQI Rates by ethnicity, english as a second language, sexual orientation, gender identity	Baseline monitoring	Baseline monitoring	Continue quarterly monitoring & report findings to QIW	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Quality Improvement Director	**In Progress**
DHCS	Potential Quality of Care Issue (PQI)	Timeliness of resolution	No issues identified	Within 120 calendar days	Continue quarterly monitoring & report findings to QIW	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Quality Improvement Director	**100%**
DHCS	Facility Site Review	Conduct on site reviews at the time of initial credentialing or contracting, and every three years thereafter, as a requirement for participation in the California state Medi-Cal Managed Care (MMCD) Program	Issues were identified in Critical Elements while conducting FSR.	Complete FSR and medical record audit of 100% of practitioners due for credentialing or recredentialing	CSR will schedule and complete reviews timely.	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Quality Performance Director	**100%**
DHCS	Physical Accessibility Review Survey (PARS)	Conduct PARS audit with FSR	No issues identified	Complete the PARS audit of 100% of practitioners due for credentialing or recredentialing	QP Senior coorninator will schedule and complete all PARS due 2025	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Quality Performance Director	**100%**
DHCS	Medical Record Review	Conduct medical record review of practitioners due for facility site reviews	Previously identified issues from MRR: 1.Emergency contact not documented 2.Dental/Oral Assessment not documented 3.HIV infection screening not documented	Achieve medical record review score of 85% for each practitioner	CSR will schedule and complete reviews timely.	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Quality Performance Director	**100%**

Kern Health Systems Quality Improvement Annual Work Plan - 2025

Source	Key Performance Measure	Objective/Metrics	Previously Identified Issue	Measurable Goals	Actions/Improvement Activities	Target Date of Completion	Responsible Staff	Q1 Update
	Drug Utilization Review	Treatment Authorization Request (TAR)	No issues identified	72 hrs for urgent, 5 days for routine	Continue quarterly monitoring & report findings to DUR	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Pharmacy Director	**N/A Since 1/1/2025**
	Drug Utilization Review	Physician Administered Drugs (PAD)	No issues identified	72 hrs for urgent, 5 days for routine	Continue quarterly monitoring & report findings to DUR	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Pharmacy Director	**100%**
NCQA	Credentialing/Recredentialing	Credential/recredential practitioners timely	No QOC trends for provider re-credentialing in 2024 to prevent moving forward from a QI perspective	100% timely credentialing/recredentialing of practitioners	Review of trends for Grievances and PQIs, QOC look back review 3 years	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Credentialing Manager	**100%**
IV. Quality of Service								
DHCS	Grievance & Appeals	Timeliness of acknowledgement letters	No issues identified	90% Within 5 calendar days	Continue quarterly monitoring & report findings to QIW	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Member Services Director	**91%**
DHCS	Grievance & Appeals	Timeliness of resolution	No issues identified	90% within 30 calendar days and 72 hours for expedites	Continue quarterly monitoring & report findings to QIW	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Member Services Director	**83%**
DHCS	Access to Care - PCP	Urgent Care within 48 hours	No issues identified	> 80%	Continue quarterly monitoring & report findings to QIW	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Provider Network Management Director	**92%**
DHCS	Access to Care - PCP	Routine Care - 10 business days	No issues identified	> 80%	Continue quarterly monitoring & report findings to QIW	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Provider Network Management Director	**96%**
DHCS	Access to Care - SCP	Urgent Care within 48 hours	No issues identified	> 80%	Continue quarterly monitoring & report findings to QIW	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Provider Network Management Director	**84%**
DHCS	Access to Care - SCP	Routine Care - 15 business days	No issues identified	> 80%	Continue quarterly monitoring & report findings to QIW	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Provider Network Management Director	**96%**
DHCS	Telephone Access to Member Services	Speed of Answer	No issues identified	< 30 seconds	Continue quarterly monitoring & report findings to QIW	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Member Services Director	**11 seconds**
DHCS	Telephone Access to Member Services	Call abandonment rate	No issues identified	< 5%	Continue quarterly monitoring & report findings to QIW	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Member Services Director	**1%**
V. Member Experience								
	CAHPS Survey	Adult and Child Medicad Survey	Getting Needed Care scored lowest in the Adult Survey	Monitor CAHPS Resutls and establish basline for Getting Care needed measure	Trending report on CAHPS results by survey questions	12/31/2025	Member Engagement Manager	**No Update**
VI. Provider Engagement								
	Provider Satisfaction Survey	Would Recommend	No issues identified	Maintain 98th Percentile	Report survey results to QIW annually	9/30/2025	Provider Network Management Director	**No Update**
	Provider Satisfaction Survey	Utilization and Quality Management	No issues identified	Maintain 97th Percentile	Report survey results to QIW annually	9/30/2025	Provider Network Management Director	**No Update**
	Provider Satisfaction Survey	Degree to which the plan covers and encourages preventive care and wellness	No issues identified	Maintain 96th Percentile	Report survey results to QIW annually	9/30/2025	Provider Network Management Director	**No Update**
	Provider Education	Host at least one educational conference for Providers	No issues identified	Host one educational conference for Providers	Medical Management of Obesity for Primary Care Providers Conference	11/30/2025	Quality Improvement Medical Director	**Rheumatology Conference Scheduled 6/3/2025**

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June 11, 2025

Emily Duran
Chief Executive Officer
Kern Health Systems
2900 Buck Owens Blvd
Bakersfield, CA 93308

Dear Mrs. Duran:

Thank you for the opportunity to support your organization in its quality improvement efforts. This letter confirms the outcome of your recent HP Full/Introductory Option survey. Based on review of the evidence provided against applicable standards & guidelines, the National Committee for Quality Assurance (NCQA) Review Oversight Committee has awarded Kern Health Systems the status(es) listed below.

The final assessment report, which addresses any comments you may have submitted on your preliminary report, is available in the survey tool. On the Dashboard, select "View Final Report" from the Actions menu. To update your user rights, follow the instructions in the attached documents, "Log In and Dashboard" and "User Management".

Product Line/ Product	**Accreditation Status**	**Effective Date**	**Expiration Date**
Medicaid-HMO	Accredited	June 10, 2025	June 10, 2028

Your Accreditation status(es) will be added to the NCQA Report Card by the 15th of July. You can download a certificate reflecting your status(es) from my.ncqa.org. Also, for your convenience, you may download the NCQA accreditation seal by visiting our Web site at www.ncqa.org.

If you believe the scoring of any standard does not accurately reflect your organization's compliance, you may request a Reconsideration by the NCQA Reconsideration Committee. To request Reconsideration, submit a written request to NCQA within 30 days that addresses at least one of the grounds for appeal identified under *Reconsideration* in the Policies and Procedures. The request must not exceed 5 pages in length, must include a list of standards for which Reconsideration is being requested, and must state the rationale. A Reconsideration fee specified in the applicable "Pricing and Cancellation Policy" must be paid at the time of the request.

To maintain your Accreditation status(es), your organization must undergo another survey approximately 3 months before the date when your current status expires. That survey will be against the standards in effect on your submission date, and will include an off-site document review and a file review (onsite or virtual) approximately 7 weeks after your submission.

NCQA has tentatively reserved **March 14, 2028** as the date when you submit your completed survey tool to NCQA, and **May 1 - 2, 2028** for your two-day onsite survey. If the proposed dates present a problem, or if you have any questions, submit a question via MyNCQA.

If your Accreditation satisfies a regulatory requirement, you may share the reports in your survey tool with applicable agencies. For support, contact your Accreditation Survey Coordinator (ASC) or submit a question through MyNCQA.

We acknowledge your dedication to quality improvement, which was evident throughout the survey process. NCQA looks forward to working with you and your staff again in the future.

Sincerely,

Sue Matthiesen
Assistant Vice President, Accreditation

SCORE SUMMARY DETAILS

Organization: Kern Health Systems
Standards Year: 2024
Evaluation Option: First Survey
Unit of Assessment: Medicaid HMO

Element level scoring is unique. Some elements require all factors to be met, while others may have a range of factors required to meet 100%.

ELEMENT	TITLE	CURRENT	ISSUES NOT MET	MUST PASS	MUST PASS THRESHOLD	ELEMENTS SUBJECT TO CORRECTIVE ACTION
QI1A	QI Program Structure	Met				
QI1B	Annual Work Plan	Met				
QI1C	Annual Evaluation	Met				
QI1D	QI Committee Responsibilities	Met				
QI1E	Promoting Organizational Diversity, Equity and Inclusion	NA				
QI2A	Practitioner Contracts	Met				

ELEMENT	TITLE	CURRENT	ISSUES NOT MET	MUST PASS	MUST PASS THRESHOLD	ELEMENTS SUBJECT TO CORRECTIVE ACTION
QI2B	Provider Contracts	Met				
QI3A	Identifying Opportunities	Met	✔			
QI3D	Transition to Other Care	Met				
QI4A	Data Collection	Met	✔			
QI4B	Collaborative Activities	Met				
QI5A	Delegation Agreement	NA				
QI5B	Predelegation Evaluation	NA				
QI5C	Review of QI Program	NA				
QI5D	Opportunities for Improvement	NA				
PHM1A	Strategy Description	Met				
PHM1B	Informing Members	Met				
PHM2A	Data Integration	Met				
PHM2B	Population Assessment	Met				
PHM2C	Activities and Resources	Met				
PHM2D	Segmentation	Met				
PHM3A	Practitioner or Provider Support	Met	✔			

ELEMENT	TITLE	CURRENT	ISSUES NOT MET	MUST PASS	MUST PASS THRESHOLD	ELEMENTS SUBJECT TO CORRECTIVE ACTION
PHM3B	Value-Based Payment Arrangements	Met				
PHM4A	Frequency of Health Appraisal Completion	Met				
PHM4B	Topics of Self-Management Tools	Met				
PHM5A	Access to Case Management	Met				
PHM5B	Case Management Systems	Met				
PHM5C	Case Management Process	Met				
PHM5D	Initial Assessment	Met				
PHM5E	Case Management—Ongoing Management	Met				
PHM6A	Measuring Effectiveness	Met				
PHM7A	Delegation Agreement	NA				
PHM7B	Predelegation Evaluation	NA				
PHM7C	Review of PHM Program	NA				
PHM7D	Opportunities for Improvement	NA				
NET1A	Cultural Needs and Preferences	Met				
NET1B	Practitioners Providing Primary Care	Met				
NET1C	Practitioners Providing Specialty Care	Met				

ELEMENT	TITLE	CURRENT	ISSUES NOT MET	MUST PASS	MUST PASS THRESHOLD	ELEMENTS SUBJECT TO CORRECTIVE ACTION
NET1D	Practitioners Providing Behavioral Healthcare	Met				
NET2A	Access to Primary Care	Met				
NET2B	Access to Behavioral Healthcare	Met				
NET2C	Access to Specialty Care	Met				
NET3A	Assessment of Member Experience Accessing the Network	Met				
NET3B	Opportunities to Improve Access to Nonbehavioral Healthcare Services	Met				
NET3C	Opportunities to Improve Access to Behavioral Healthcare Services	Met				
NET4A	Notification of Termination	Met				
NET4B	Continued Access to Practitioners	Met				
NET5A	Physician Directory Data	Met				
NET5B	Physician Directory Updates	Met				
NET5C	Assessment of Physician Directory Accuracy	Met				

ELEMENT	TITLE	CURRENT	ISSUES NOT MET	MUST PASS	MUST PASS THRESHOLD	ELEMENTS SUBJECT TO CORRECTIVE ACTION
NET5D	Identifying and Acting on Opportunities	Met				
NET5E	Searchable Physician Web-Based Directory	Met				
NET5F	Hospital Directory Data	Met				
NET5G	Hospital Directory Updates	Met				
NET5H	Searchable Hospital Web-Based Directory	Met				
NET5I	Usability Testing	Met				
NET5J	Availability of Directories	Not Met	✔			
NET6A	Delegation Agreement	NA				
NET6B	Predelegation Evaluation	NA				
NET6C	Review of Delegated Activities	NA				
NET6D	Opportunities for Improvement	NA				
UM1A	Written Program Description	Met				
UM1B	Annual Evaluation	Met				
UM2A	UM Criteria	Met				
UM2B	Availability of Criteria	Met				
UM2C	Consistency in Applying Criteria	Met				

ELEMENT	TITLE	CURRENT	ISSUES NOT MET	MUST PASS	MUST PASS THRESHOLD	ELEMENTS SUBJECT TO CORRECTIVE ACTION
UM3A	Access to Staff	Met				
UM4A	Licensed Health Professionals	Met				
UM4B	Use of Practitioners for UM Decisions	Met				
UM4C	Practitioner Review of Nonbehavioral Healthcare Denials	Met		✔	100.0	
UM4D	Practitioner Review of Behavioral Healthcare Denials	NA		✔	100.0	
UM4E	Practitioner Review of Pharmacy Denials	Met		✔	100.0	
UM4F	Use of Board-Certified Consultants	Met				
UM5A	Notification of Nonbehavioral Healthcare Decisions	Met		✔	100.0	
UM5B	Notification of Behavioral Healthcare Decisions	NA		✔	100.0	
UM5C	Notification of Pharmacy Decisions	Met		✔	100.0	
UM5D	UM Timeliness Report	Met				
UM6A	Relevant Information for Nonbehavioral Healthcare Decisions	Met				

ELEMENT	TITLE	CURRENT	ISSUES NOT MET	MUST PASS	MUST PASS THRESHOLD	ELEMENTS SUBJECT TO CORRECTIVE ACTION
UM6B	Relevant Information for Behavioral Healthcare Decisions	NA				
UM6C	Relevant Information for Pharmacy Decisions	Met				
UM7A	Discussing a Denial With a Nonbehavioral Healthcare Reviewer	Met				
UM7B	Written Notification of Nonbehavioral Healthcare Denials	Met		✔	100.0	
UM7C	Written Notification of Nonbehavioral Healthcare Appeal Rights/Process	Met		✔	100.0	
UM7D	Discussing a Behavioral Healthcare Denial With a Reviewer	NA				
UM7E	Written Notification of Behavioral Healthcare Denials	NA		✔	100.0	
UM7F	Written Notification of Behavioral Healthcare Appeal Rights/Process	NA		✔	100.0	
UM7G	Discussing a Pharmacy Denial With a Reviewer	Met				
UM7H	Written Notification of Pharmacy Denials	Met		✔	100.0	

ELEMENT	TITLE	CURRENT	ISSUES NOT MET	MUST PASS	MUST PASS THRESHOLD	ELEMENTS SUBJECT TO CORRECTIVE ACTION
UM7I	Written Notification of Pharmacy Appeal Rights/Process	Met		✔	100.0	
UM8A	Internal Appeals	Met	✔			
UM9A	Preservice and Postservice Appeals	Met				
UM9B	Timeliness of the Appeal Process	Met		✔	100.0	
UM9C	Appeal Reviewers	Met				
UM9D	Notification of Appeal Decision/Rights	Met		✔	100.0	
UM9E	Final Internal and External Appeal Files	NA				
UM9F	Appeals Overturned by the IRO	NA				
UM10A	Written Process	NA				
UM10B	Description of the Evaluation Process	NA				
UM11A	Pharmaceutical Management Procedures	Met				
UM11B	Pharmaceutical Restrictions/Preferences	Met				
UM11C	Pharmaceutical Patient Safety Issues	Met				
UM11D	Reviewing and Updating Procedures	Met				
UM11E	Considering Exceptions	NA				
UM12A	UM Denial System Controls	Met		✔	100.0	

ELEMENT	TITLE	CURRENT	ISSUES NOT MET	MUST PASS	MUST PASS THRESHOLD	ELEMENTS SUBJECT TO CORRECTIVE ACTION
UM12B	UM Denial System Controls Oversight	Met				
UM12C	UM Appeal System Controls	Met		✔	100.0	
UM12D	UM Appeal System Controls Oversight	Met				
UM13A	Delegation Agreement	Met	✔			
UM13B	Predelegation Evaluation	NA				
UM13C	Review of the UM Program	NA				
UM13D	Opportunities for Improvement	NA				
CR1A	Practitioner Credentialing Guidelines	Met				
CR1B	Practitioner Rights	Met				
CR1C	Credentialing System Controls	Met		✔	100.0	
CR1D	Credentialing System Controls Oversight	Met				
CR2A	Credentialing Committee	Met				
CR3A	Verification of Credentials	Met		✔	100.0	
CR3B	Sanction Information	Met		✔	100.0	
CR3C	Credentialing Application	Met		✔	100.0	
CR5A	Ongoing Monitoring and Interventions	Met				

ELEMENT	TITLE	CURRENT	ISSUES NOT MET	MUST PASS	MUST PASS THRESHOLD	ELEMENTS SUBJECT TO CORRECTIVE ACTION
CR6A	Actions Against Practitioners	Met				
CR7A	Review and Approval of Provider	Met				
CR7B	Medical Providers	Met				
CR7C	Behavioral Healthcare Providers	NA				
CR7D	Assessing Medical Providers	Met				
CR7E	Assessing Behavioral Healthcare Providers	NA				
CR8A	Delegation Agreement	Met	✔			
CR8B	Predelegation Evaluation	NA				
CR8C	Review of Delegate's Credentialing Activities	Met				
CR8D	Opportunities for Improvement	NA				
ME1A	Rights and Responsibilities Statement	Met				
ME1B	Distribution of Rights Statement	Met				
ME2A	Subscriber Information	Met				
ME2B	Distribution of Subscriber Information	Met				
ME2C	Interpreter Services	Met				

ELEMENT	TITLE	CURRENT	ISSUES NOT MET	MUST PASS	MUST PASS THRESHOLD	ELEMENTS SUBJECT TO CORRECTIVE ACTION
ME3A	Materials and Presentations	Met	✔			
ME3B	Communicating With Prospective Members	Met				
ME3C	Assessing Member Understanding	Met				
ME4A	Functionality: Website	NA				
ME4B	Functionality: Telephone Requests	Met				
ME5A	Pharmacy Benefit Information: Website	NA				
ME5B	Pharmacy Benefit Information: Telephone	NA				
ME5C	QI Process on Accuracy of Information	NA				
ME5D	Pharmacy Benefit Updates	NA				
ME6A	Functionality: Website	Met				
ME6B	Functionality: Telephone	Met				
ME6C	Quality and Accuracy of Information	Met				
ME6D	Email Response Evaluation	Met				
ME7A	Policies and Procedures for Complaints	Met				
ME7B	Policies and Procedures for Appeals	Met				

ELEMENT	TITLE	CURRENT	ISSUES NOT MET	MUST PASS	MUST PASS THRESHOLD	ELEMENTS SUBJECT TO CORRECTIVE ACTION
ME7C	Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals	Met				
ME7E	Annual Assessment of Behavioral Healthcare and Services	Met				
ME8A	Delegation Agreement	NA				
ME8B	Predelegation Evaluation	NA				
ME8C	Review of Performance	NA				
ME8D	Opportunities for Improvement	NA				

NATIONAL COMMITTEE FOR QUALITY ASSURANCE - MEDICAID STATE REGULATION REPORT

This information is being shared as required under the Federal Medicaid Rule for state oversight and may not be used, disclosed, represented, or otherwise communicated to any third party for any other purpose.

PRODUCT: HP2024

ORGANIZATION NAME: Kern Health Systems

MET Count: 155

NOT MET Count: 1

FIRST SURVEY (MEDICAID HMO)	
Accreditation Status	Accredited
Effective Date	6/10/2025
Expiration Date	6/10/2028
Standards Score	125.00
HEDIS + CAHPS Score	NA

Total Score / Possible	125.00 / 126.00

98143 - HP2024 FOR KERN HEALTH SYSTEMS

QI 1

The organization has the QI infrastructure necessary to improve the quality and safety of clinical care and services it provides to its members and to oversee the QI program.

A - QI Program Structure — **NCQA**

Medicaid: Met

Medicaid

The organization's QI program description specifies:

		NCQA ANSWER
1	The QI program structure.	Yes
2	The behavioral healthcare aspects of the program.	Yes
3	Involvement of a designated physician in the QI program.	Yes
4	Involvement of a behavioral healthcare practitioner in the behavioral aspects of the program.	Yes
5	Oversight of QI functions of the organization by the QI Committee.	Yes

	NCQA ANSWER

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 5 factors	The organization meets 3-4 factors	The organization meets 0-2 factors

Data Sources	Documented process
Scope of Review	**Product lines** *For Interim Surveys and First Surveys, this element applies to all product lines.* *For Renewal Surveys, this element applies to the Medicaid product line only.* **Documentation** NCQA reviews the organization's QI program description that is in place throughout the look-back period.

ISSUES		
	Type	OTHER
	Lines	Medicaid
	Statement	Both program descriptions mention delegation of QI activities, however, there are no QI delegates listed in the delegation module. Please confirm if the organization delegates QI activities.
	Contest Element Findings	No
	Organization Comments	
	Organization Statement	Kern Health Systems (KHS) does not currently delegate any Quality Improvement (QI) activities to external entities. The reference to delegation in the QI Program Description was included in error. As no QI functions are delegated, there are no entries listed in the delegation module.

NCQA Support Text
NCQA Response Post Final Report
Factor - Result 1 - Met-Score Yes

ORG SUBMISSION STATEMENT Documentation includes 2024 program description and 2025 program description since the LBP covers both years.

NCQA SUPPORT TEXT This element has no additional NCQA support texts.

B - Annual Work Plan **NCQA Medicaid**: Met

Medicaid

The organization documents and executes a QI program annual work plan that reflects ongoing activities throughout the year and addresses:

		NCQA ANSWER
1	Yearly planned QI activities and objectives.	Yes
2	Time frame for each activity's completion.	Yes
3	Staff members responsible for each activity.	Yes
4	Monitoring of previously identified issues.	Yes
5	Evaluation of the QI program.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 5 factors	No scoring option.	The organization meets 0-4 factors

Data Sources	Documented process, Reports
Scope of Review	**Product lines** *This element applies to Interim Surveys, First Surveys and Renewal Surveys for all product lines.* **Documentation** *For Interim Surveys:* NCQA reviews the organization's QI program annual work plan. The work plan may be a plan for the upcoming year. *For First Surveys:* NCQA reviews the organization's QI program annual work plan including any documented progress on activities. *For Renewal Surveys:* NCQA reviews the organization's most recent and the previous year's QI program annual work plans, including documented progress on activities. NCQA cites two data sources because a documented process (e.g., the QI program annual work plan) is reviewed for all survey types. *For First Surveys and Renewal Surveys,* the organization may supplement a documented process with reports that show progress on annual activities, if the activities are not already included in the work plan.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT	This element has no additional NCQA support texts.

TEXT

C - Annual Evaluation

NCQA

Medicaid: Met

Medicaid

The organization conducts an annual written evaluation of the QI program that includes the following information:

		NCQA ANSWER
1	A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service.	Yes
2	Trending of measures of performance in the quality and safety of clinical care and quality of service.	Yes
3	Evaluation of the overall effectiveness of the QI program and of its progress toward influencing networkwide safe clinical practices.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 2-3 factors	No scoring option.	The organization meets 0-1 factors

Data Sources	Reports
Scope of Review	**Product lines** *This element applies to First Surveys and Renewal Surveys for all product lines.*

Documentation

For First Surveys: NCQA reviews the organization's most recent annual evaluation report.

For Renewal Surveys: NCQA reviews the organization's most recent and the previous year's annual evaluation report.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

D - QI Committee Responsibilities

NCQA

Medicaid: Met

Medicaid

The organization's QI Committee:

		NCQA ANSWER
1	Recommends policy decisions.	Yes
2	Analyzes and evaluates the results of QI activities.	Yes
3	Ensures practitioner participation in the QI program through planning, design, implementation or review.	Yes
4	Identifies needed actions.	Yes
5	Ensures follow-up, as appropriate.	Yes

NCQA ANSWER

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 4-5 factors	The organization meets 3 factors	The organization meets 0-2 factors
Data Sources	Documented process, Reports		
Scope of Review	**Product lines** *This element applies to Interim Surveys, First Surveys and Renewal Surveys for all product lines.* **Documentation** *For All Survey Types:* Factors 1–5 must be performed in each year of the look-back period. *For Interim Surveys:* NCQA reviews up to three sets of QI Committee minutes or QI Committee charter and a timeline for operationalizing the committee, if the committee has not met. If three sets of meeting minutes are not available, NCQA reviews all committee minutes within the look-back period. *For First Surveys:* NCQA reviews up to three sets of QI Committee minutes within the look-back period. If three sets of meeting minutes are not available, NCQA reviews all committee minutes within the look-back period. *For Renewal Surveys:* NCQA reviews up to three sets of QI Committee minutes for each year of the look-back period. If three sets of meeting minutes are not available, NCQA reviews all committee minutes for each year of the look-back period.		

ISSUES This element has no issues.

ORG SUBMISSION Since the EQIHEC meets quarterly, there are only two sets of meeting minutes from within the LBP; therefore, we have

STATEMENT	only submitted two sets of minutes for this element.
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

E - Promoting Organizational Diversity, Equity and Inclusion **NCQA**

Medicaid: NA

Medicaid

The organization:

		NCQA ANSWER
1	Promotes diversity in recruiting and hiring.	NA
2	Offers training to employees on cultural competency, bias or inclusion.	NA

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 1-2 factors	No scoring option.	The organization meets 0 factors

Data Sources	Documented process, Materials
Scope of Review	**Product lines** *This element applies to Interim Surveys, First Surveys and Renewal Surveys for all product lines.*

Documentation

For Interim Surveys: NCQA reviews the organization's policies and procedures for promoting diversity in recruiting and hiring and for offering training to employees.

For First Surveys and Renewal Surveys:

- *For factor 1:* NCQA reviews the organization's policies and procedures or materials in place throughout the look-back period for promoting diversity in recruiting and hiring.
- *For factor 2:* NCQA reviews the organization's policies and procedures in place throughout the look-back period for offering training to employees, and also reviews evidence demonstrating that the organization offered the training at least once during the prior 24 months.

ISSUES

This element has no issues.

ORG SUBMISSION STATEMENT

NA score is due to scoring changes per the Executive Orders.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
Medicaid	Per NCQA's Modifications to Scoring for NCQA Accreditation Surveys memo, this element is NA due to the Executive Orders.	1 2

QI 2

The organization's contracts with practitioners and providers foster open communication and cooperation with QI activities.

A - Practitioner Contracts **NCQA**

Medicaid: Met

Medicaid

Contracts with practitioners specifically require that:

		NCQA ANSWER
1	Practitioners cooperate with QI activities.	Yes
2	Practitioners allow the organization to use their performance data.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data Sources	Documented process, Materials
Scope of Review	**Product lines** *For Interim Surveys and First Surveys, this element applies to all product lines.* *For Renewal Surveys, this element applies to the Medicaid product line only.* **Documentation** *For Interim Surveys:* NCQA reviews one primary care contract and one specialist contract. The contracts do not need to be executed. *For First Surveys and Renewal Surveys:* NCQA reviews three active primary care contracts and three active specialist contracts executed within the look-back period. If the contracts do not address the factors, NCQA reviews a practitioner manual or the

organization's policies and procedures as an extension of the contract in certain circumstances. Refer to *Related information*.

ISSUES	**Type**	DOC
	Lines	Medicaid
	Statement	The organization stated they only have one PCP contract within the look-back period. If the organization does not have the required three primary care contracts within the look-back period, it is acceptable for the look-back period to be expanded. Can the organization confirm they will have at least two more PCP contracts if the look-back period is expanded? Please see “Expanding the look-back period” in Section 2 of the Health Plan Accreditation Policies and Procedures.
	Contest Element Findings	No
	Organization Comments	
	Organization Statement	NCQA has extended the LBP to accommodate previous contracts in order to evaluate against requirements. KHS has provided 2 additional PCP contracts for review.
	NCQA Support Text	
	NCQA Response Post Final Report	
	Factor - Result	1 - Met-Score Yes 2 - Met-Score Yes

ORG SUBMISSION STATEMENT	Please note that only one PCP contract was executed during the 6-month LBP; therefore, we are only submitting 1 PCP contract and 3 Specialty contracts.
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

B - Provider Contracts **NCQA**

Medicaid: Met

Medicaid

Contracts with organization providers specifically require that:

		NCQA ANSWER
1	Providers cooperate with QI activities.	Yes
2	Providers allow the plan to use their performance data.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data Sources	Documented process, Materials
Scope of Review	**Product lines** *This element applies to Interim Surveys and First Surveys for all product lines.* **Documentation** *For Interim Surveys:* NCQA reviews one hospital contract and one contract from another provider type. The contracts do not need to be executed. *For First Surveys:* NCQA reviews one active hospital contract and one active contract from another provider type executed within the look-back period. If the contracts do not address the factors, NCQA reviews a provider manual or the organization's policies and procedures as an extension of the contract in certain circumstances. Refer to *Related information*.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

QI 3

The organization uses information at its disposal to facilitate continuity and coordination of medical care across its delivery system.

A - Identifying Opportunities

NCQA

Medicaid: Met

Medicaid

The organization annually identifies opportunities to improve coordination of medical care by:

		NCQA ANSWER
1	Collecting data on member movement between practitioners.	Yes
2	Collecting data on member movement across settings.	Yes
3	Conducting quantitative and qualitative analysis of data to identify improvement opportunities.	Yes
4	Identifying and selecting one opportunity for improvement.	Yes

		NCQA ANSWER
5	Identifying and selecting a second opportunity for improvement.	Yes
6	Identifying and selecting a third opportunity for improvement.	No
7	Identifying and selecting a fourth opportunity for improvement.	No

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 5-7 factors	The organization meets 3-4 factors	The organization meets 0-2 factors

Data Sources	Reports
Scope of Review	**Product lines** *This element applies to First Surveys and Renewal Surveys for all product lines.* **Documentation** NCQA reviews the organization's medical care coordination data, quantitative and qualitative analysis and four opportunities for improvement selected from the data analysis. *For First Surveys:* NCQA also reviews the organization's most recent annual data collection, analysis and identification of opportunities report. *For Renewal Surveys:* NCQA also reviews the organization's most recent and the previous year's annual data collection, analysis and identification of opportunities reports.

ISSUES	Type	ID

Lines	Medicaid
Statement	The organization confirmed that factors 6 and 7 should be scored not met.
Contest Element Findings	No
Organization Comments	
Organization Statement	KHS confirms that factor 6 & 7 were intentionally marked as Not Met.
NCQA Support Text	The organization confirmed that factors 6 and 7 should be scored not met.
NCQA Response Post Final Report	
Factor - Result	6 - Not met 7 - Not met

ORG SUBMISSION STATEMENT This element has no organization submission statement

NCQA SUPPORT TEXT This element has no additional NCQA support texts.

D - Transition to Other Care **NCQA**

Medicaid: Met

Medicaid

The organization helps with members' transition to other care when their benefit ends, if necessary.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER The organization meets the requirement

SCORING

MET	PARTIALLY MET	NOT MET
The organization meets the requirement	No scoring option.	The organization does not meet the requirement

Data Sources	Documented process, Reports, Materials, Records or files
Scope of Review	**Product lines** *This element applies to First Surveys and Renewal Surveys for all product lines.* **Documentation** NCQA reviews a documented process and three examples (i.e., reports, materials, records or files) of how the requirement is met. The evidence provided by the organization demonstrates that the organization helped members transition to other care, as needed, throughout the look-back period. If the organization has fewer than three examples, NCQA reviews all reports, materials, records or files.

ISSUES	**Type**	DOC
	Lines	Medicaid
	Statement	
	Contest Element Findings	No
	Organization Comments	
	Organization Statement	We have uploaded the applicable policy and examples to address this issue.
	NCQA Support Text	
	NCQA Response Post Final Report	
	Factor - Result	1 - Met-Score Yes

ORG SUBMISSION STATEMENT	Kern Health Systems does not deny under any circumstances using exhaustion of benefit as a denial reason. Rather, all services are reviewed for medical necessity. Kern Health Systems continues coverage of services in circumstances where a benefit may lapse, and member meets medical necessity criteria.
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

QI 4

The organization collaborates with behavioral healthcare practitioners and uses information at its disposal to coordinate medical care and behavioral healthcare.

A - Data Collection **NCQA**

Medicaid: Met

Medicaid

The organization annually collects data about opportunities for collaboration between medical care and behavioral healthcare in the following areas:

		NCQA ANSWER
1	Exchange of information.	Yes
2	Appropriate diagnosis, treatment and referral of behavioral disorders commonly seen in primary care.	Yes
3	Appropriate use of psychotropic medications.	Yes
4	Management of treatment access and follow-up for members with coexisting medical and behavioral disorders.	Yes
5	Primary or secondary preventive behavioral healthcare program implementation.	No
6	Special needs of members with serious mental illness or serious emotional disturbance.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 4-6 factors	The organization meets 2-3 factors	The organization meets 0-1 factors

Data Sources	Reports, Materials
Scope of Review	**Product lines** *This element applies to First Surveys and Renewal Surveys for all product lines.* **Documentation** *For First Surveys:* NCQA reviews the organization's evidence of collaboration (e.g., joint meeting minutes, communications) on data collection and most recent annual data collection report. *For Renewal Surveys:* NCQA reviews the organization's evidence of collaboration (e.g., joint meeting minutes, communications) on data collection and most recent and previous year's annual data collection reports.

ISSUES

Type	DOC
Lines	Medicaid
Statement	The organization confirmed that factor 5 should be scored not met.
Contest Element Findings	No
Organization Comments	
Organization Statement	KHS confirms that factor 5 was intentionally marked as Not Met.
NCQA Support Text	The organization confirmed that factor 5 should be scored not met.
NCQA Response Post Final Report	
Factor - Result	5 - Not met

ORG SUBMISSION This element has no organization submission statement

STATEMENT

NCQA SUPPORT TEXT This element has no additional NCQA support texts.

B - Collaborative Activities **NCQA Medicaid**: Met

Medicaid

The organization annually conducts activities to improve the coordination of behavioral healthcare and general medical care, including:

		NCQA ANSWER
1	Collaborating with behavioral healthcare practitioners.	Yes
2	Quantitative and qualitative analysis of data to identify improvement opportunities.	Yes
3	Identifying and selecting one opportunity for improvement from Element A.	Yes
4	Identifying and selecting a second opportunity for improvement from Element A.	Yes
5	Taking collaborative action to address one identified opportunity for improvement from Element A.	Yes
6	Taking collaborative action to address a second identified opportunity for improvement from Element A.	Yes

SCORING

MET	PARTIALLY MET	NOT MET
The organization meets 4-6 factors	The organization meets 3 factors	The organization meets 0-2 factors

Data Sources	Documented process, Reports, Materials
Scope of Review	**Product lines** *This element applies to First Surveys and Renewal Surveys for all product lines.* **Documentation** *For First Surveys:* NCQA reviews the organization's evidence of collaboration (e.g., joint meeting minutes, communications) on data collected in Element A, analyses, opportunities and actions. *For Renewal Surveys:* NCQA reviews the organization's most recent and the previous year's annual collaborations (e.g., joint meeting minutes, communications) on data collected in Element A, analyses, opportunities and actions. *For factors 5 and 6:* NCQA reviews reports. Depending on the action taken to address identified opportunities, NCQA may also review a documented process or materials.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

QI 5

The organization remains responsible for and has appropriate structures and mechanisms to oversee delegated QI activities.

A - Delegation Agreement NCQA NA

NOT APPLICABLE

The written delegation agreement:

		NCQA ANSWER
1	Is mutually agreed upon.	NA
2	Describes the delegated activities and the responsibilities of the organization and the delegated entity.	NA
3	Requires at least semiannual reporting by the delegated entity to the organization.	NA
4	Describes the process by which the organization evaluates the delegated entity's performance.	NA
5	Describes the process for providing member experience and clinical performance data to its delegates when requested.	NA
6	Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.	NA

NOT APPLICABLE

The written delegation agreement:

		NCQA ANSWER
1	Is mutually agreed upon.	NA

		NCQA ANSWER
2	Describes the delegated activities and the responsibilities of the organization and the delegated entity.	NA
3	Requires at least semiannual reporting by the delegated entity to the organization.	NA
4	Describes the process by which the organization evaluates the delegated entity's performance.	NA
5	Describes the process for providing member experience and clinical performance data to its delegates when requested.	NA
6	Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.	NA

NOT APPLICABLE

The written delegation agreement:

		NCQA ANSWER
1	Is mutually agreed upon.	NA
2	Describes the delegated activities and the responsibilities of the organization and the delegated entity.	NA
3	Requires at least semiannual reporting by the delegated entity to the organization.	NA
4	Describes the process by which the organization evaluates the delegated entity's performance.	NA
5	Describes the process for providing member experience and clinical performance data to its delegates when requested.	NA

		NCQA ANSWER
6	Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.	NA

NOT APPLICABLE

The written delegation agreement:

		NCQA ANSWER
1	Is mutually agreed upon.	NA
2	Describes the delegated activities and the responsibilities of the organization and the delegated entity.	NA
3	Requires at least semiannual reporting by the delegated entity to the organization.	NA
4	Describes the process by which the organization evaluates the delegated entity's performance.	NA
5	Describes the process for providing member experience and clinical performance data to its delegates when requested.	NA
6	Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.	NA

NOT APPLICABLE

The written delegation agreement:

		NCQA ANSWER
1	Is mutually agreed upon.	NA
2	Describes the delegated activities and the responsibilities of the organization and the delegated entity.	NA
3	Requires at least semiannual reporting by the delegated entity to the organization.	NA
4	Describes the process by which the organization evaluates the delegated entity's performance.	NA
5	Describes the process for providing member experience and clinical performance data to its delegates when requested.	NA
6	Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.	NA

NOT APPLICABLE

The written delegation agreement:

		NCQA ANSWER
1	Is mutually agreed upon.	NA
2	Describes the delegated activities and the responsibilities of the organization and the delegated entity.	NA
3	Requires at least semiannual reporting by the delegated entity to the organization.	NA
4	Describes the process by which the organization evaluates the delegated entity's performance.	NA

		NCQA ANSWER
5	Describes the process for providing member experience and clinical performance data to its delegates when requested.	NA
6	Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.	NA

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 5-6 factors	The organization meets 3-4 factors	The organization meets 0-2 factors

Data Sources	Materials
Scope of Review	**Product lines** *This element applies to Interim Surveys, First Surveys and Renewal Surveys for all product lines.* **Documentation** NCQA reviews delegation agreements in effect during the look-back period from up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four. For delegation agreements in place prior to January 1, 2019, the organization may provide documentation that it notified the delegate of the process required in factor 5. This documentation of notification is not required to be mutually agreed upon. Delegation agreements implemented on or after January 1, 2019, must include a description of the process required in factor 5. The score for the element is the average of the scores for all delegates.

ISSUES This element has no issues.

ORG SUBMISSION STATEMENT QI 5 is NA since KHS does not delegate any QI activities.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
NOT APPLICABLE	The organization does not delegate QI activities; therefore, this element is scored NA.	1 2 3 4 5 6

B - Predelegation Evaluation **NCQA** **NA**

NOT APPLICABLE

For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER	NA

SCORING	**MET**	**PARTIALLY MET**	**NOT MET**
	The organization evaluated delegate capacity before delegation began	The organization evaluated delegate capacity after delegation began	The organization did not evaluate delegate capacity

Data Sources	Reports
Scope of Review	**Product lines** *This element applies to Interim Surveys, First Surveys and Renewal Surveys for all product lines.* *This element applies if delegation was implemented in the look-back period.* **Documentation** NCQA reviews the organization's predelegation evaluation from up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four. The score for the element is the average of the scores for all delegates.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	QI 5 is NA since KHS does not delegate any QI activities.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
NOT APPLICABLE	The organization does not delegate QI activities; therefore, this element is scored NA.	1

C - Review of QI Program NCQA NA

NOT APPLICABLE

For arrangements in effect for 12 months or longer, the organization:

		NCQA ANSWER
1	Annually reviews its delegate's QI program.	NA
2	Annually evaluates delegate performance against NCQA standards for delegated activities.	NA
3	Semiannually evaluates regular reports, as specified in Element A.	NA

NOT APPLICABLE

For arrangements in effect for 12 months or longer, the organization:

		NCQA ANSWER
1	Annually reviews its delegate's QI program.	NA
2	Annually evaluates delegate performance against NCQA standards for delegated activities.	NA
3	Semiannually evaluates regular reports, as specified in Element A.	NA

NOT APPLICABLE

For arrangements in effect for 12 months or longer, the organization:

		NCQA ANSWER
1	Annually reviews its delegate's QI program.	NA
2	Annually evaluates delegate performance against NCQA standards for delegated activities.	NA
3	Semiannually evaluates regular reports, as specified in Element A.	NA

NOT APPLICABLE

For arrangements in effect for 12 months or longer, the organization:

		NCQA ANSWER
1	Annually reviews its delegate's QI program.	NA
2	Annually evaluates delegate performance against NCQA standards for delegated activities.	NA
3	Semiannually evaluates regular reports, as specified in Element A.	NA

NOT APPLICABLE

For arrangements in effect for 12 months or longer, the organization:

		NCQA ANSWER
1	Annually reviews its delegate's QI program.	NA

		NCQA ANSWER
2	Annually evaluates delegate performance against NCQA standards for delegated activities.	NA
3	Semiannually evaluates regular reports, as specified in Element A.	NA

NOT APPLICABLE

For arrangements in effect for 12 months or longer, the organization:

		NCQA ANSWER
1	Annually reviews its delegate's QI program.	NA
2	Annually evaluates delegate performance against NCQA standards for delegated activities.	NA
3	Semiannually evaluates regular reports, as specified in Element A.	NA

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 2-3 factors	No scoring option.	The organization meets 0-1 factors

Data Sources	Reports
Scope of Review	**Product lines** *Factor 1 applies to Interim Surveys for all product lines.*

All factors in this element apply to First Surveys and Renewal Surveys for all product lines.

Documentation

NCQA reviews evidence of the organization's review from up to four randomly selected delegates, or all delegates if the organization has fewer than four.

For All Surveys: NCQA reviews the organization's review of the delegate's QI program (factor 1).

For First Surveys: NCQA reviews the organization's most recent annual review, performance evaluation and semiannual evaluation.

For Renewal Surveys: NCQA reviews the organization's most recent and the previous year's annual reviews, performance evaluations and four semiannual evaluations.

The score for the element is the average of the scores for all delegates.

ISSUES

This element has no issues.

ORG SUBMISSION STATEMENT

QI 5 is NA since KHS does not delegate any QI activities.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
NOT APPLICABLE	The organization does not delegate QI activities; therefore, this element is scored NA.	1 2 3

D - Opportunities for Improvement **NCQA** **NA**

NOT APPLICABLE

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization identified and followed up on opportunities for improvement, if applicable.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization identified and followed up on opportunities for improvement, if applicable.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization identified and followed up on opportunities for improvement, if applicable.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization identified and followed up on opportunities for improvement, if applicable.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization identified and followed up on opportunities for improvement, if applicable.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization identified and followed up on opportunities for improvement, if applicable.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

SCORING	**MET**	**PARTIALLY MET**	**NOT MET**
	The organization has acted on identified problems, if any, at least once in each of the past 2 years that the delegation arrangement has been in effect	The organization took inappropriate or weak action, or acted only in the past year	The organization has not acted on identified problems

Data Sources	Documented process, Reports, Materials
Scope of Review	**Product lines** *This element applies to First Surveys and Renewal Surveys for all product lines.* **Documentation** NCQA reviews reports for opportunities for improvement, if applicable, from up to four randomly selected delegates, or from all delegates, if the organization has fewer than four, and for evidence that the organization took appropriate action to resolve issues.

For First Surveys: NCQA reviews the organization's most recent annual review and follow-up on improvement opportunities.

For Renewal Surveys: NCQA reviews the organization's most recent and the previous year's annual reviews and follow-up on improvement opportunities.

The score for the element is the average of the scores for all delegates.

ISSUES

This element has no issues.

ORG SUBMISSION STATEMENT

QI 5 is NA since KHS does not delegate any QI activities.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
NOT APPLICABLE	The organization does not delegate QI activities; therefore, this element is scored NA.	1

PHM 1

The organization has a cohesive plan of action for addressing member needs across the continuum of care.

A - Strategy Description	Has Critical Factors	NCQA
		Medicaid: Met

Medicaid

The strategy describes:

		NCQA ANSWER
1	Goals and populations targeted for each of the four areas of focus.	Yes
2	Programs or services offered to members.	Yes
3	Activities that are not direct member interventions.	Yes
4	How member programs are coordinated.	Yes
5	How members are informed about available PHM programs.	Yes
6	How the organization promotes health equity.	NA

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 4-6 factors	The organization meets 3 factors	The organization meets 0-2 factors

Data Sources	Documented process
Scope of Review	**Product lines** *This element applies to Interim Surveys, First Surveys and Renewal Surveys for all product lines.* NCQA reviews and scores this element for each product line brought forward for Accreditation. **Documentation** NCQA reviews a description of the organization's comprehensive PHM strategy that is in place throughout the look-back period. The strategy may be fully described in one document or the organization may provide a summary document with references or links

to supporting documents provided in other PHM elements. The organization may use a single document to describe a strategy that applies across all product lines if the document also describes differences in strategy to support different populations, by product line.

ISSUES This element has no issues.

ORG SUBMISSION STATEMENT NA score for factor 6 is due to scoring changes per the Executive Orders.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
Medicaid	Per NCQA's Modifications to Scoring for NCQA Accreditation Surveys memo, factor 6 is NA due to the Executive Orders.	6

B - Informing Members **NCQA** Met

Kids and Youth (KAY) Program

The organization informs members eligible for programs that include interactive contact:

		NCQA ANSWER
1	How members become eligible to participate.	Yes
2	How to use program services.	Yes
3	How to opt in or opt out of the program.	Yes

Kids and Youth Transition (KAY-T)

The organization informs members eligible for programs that include interactive contact:

		NCQA ANSWER
1	How members become eligible to participate.	Yes
2	How to use program services.	Yes
3	How to opt in or opt out of the program.	Yes

Complex Case Management (CCM)

The organization informs members eligible for programs that include interactive contact:

		NCQA ANSWER
1	How members become eligible to participate.	Yes
2	How to use program services.	Yes
3	How to opt in or opt out of the program.	Yes

Children with Special Health Care Needs (CSCHN)

The organization informs members eligible for programs that include interactive contact:

		NCQA ANSWER
1	How members become eligible to participate.	Yes
2	How to use program services.	Yes
3	How to opt in or opt out of the program.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 2-3 factors	No scoring option.	The organization meets 0-1 factors

Data Sources	Documented process, Materials
Scope of Review	**Product lines** *This element applies to Interim Surveys, First Surveys and Renewal Surveys for all product lines.* NCQA reviews and scores this element for each program brought forward for Accreditation. The score for this element is the average of the scores for all programs or services. **Documentation** *For Interim Surveys:* NCQA reviews the organization's documented process in effect during the look-back period from up to four randomly selected programs or services that involve interactive contact, or reviews all programs if the organization has fewer than four. *For First Surveys and Renewal Surveys:* NCQA reviews materials used to communicate with members from up to four randomly selected programs or services that involve interactive contact, or reviews all programs if the organization has fewer than four.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

PHM 2

The organization assesses the needs of its population and determines actionable categories for appropriate intervention.

A - Data Integration — **NCQA Medicaid**: Met

Medicaid

The organization integrates the following data to use for population health management functions:

		NCQA ANSWER
1	Medical and behavioral claims or encounters.	Yes
2	Pharmacy claims.	Yes
3	Laboratory results.	Yes
4	Health appraisal results.	Yes

		NCQA ANSWER
5	Electronic health records.	Yes
6	Health services programs within the organization.	Yes
7	Advanced data sources.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 5-7 factors	The organization meets 2-4 factors	The organization meets 0-1 factors

Data Sources	Documented process, Reports, Materials
Scope of Review	**Product lines** *This element applies to Interim Surveys, First Surveys and Renewal Surveys for all product lines.* **Documentation** *For Interim Surveys:* NCQA reviews the organization's documented process for the types and sources of integrated data. *For First and Renewal Surveys:* NCQA reviews reports or materials (e.g., screenshots) for evidence that the organization integrated data types and data from sources listed in the factors. The organization may submit multiple examples that collectively demonstrate integration from all data types and sources, or may submit one example that demonstrates integration of all data types and sources.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement

NCQA SUPPORT TEXT This element has no additional NCQA support texts.

B - Population Assessment **NCQA**

Medicaid: Met

Medicaid

The organization annually:

		NCQA ANSWER
1	Assesses the characteristics and needs, including social determinants of health, of its member population.	Yes
2	Assesses the needs of child and adolescent members.	Yes
3	Assesses the needs of members with disabilities.	Yes
4	Assesses the needs of members with serious mental illness or serious emotional disturbance.	Yes
5	Assesses the needs of members of racial or ethnic groups.	Yes
6	Assesses the needs of members with limited English proficiency.	Yes
7	Identifies and assesses the needs of relevant member subpopulations.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 5-7 factors	The organization meets 2-4 factors	The organization meets 0-1 factors

Data Sources	Documented process, Reports
Scope of Review	**Product lines** *This element applies to Interim Surveys, First Surveys and Renewal Surveys for all product lines.* **Documentation** *For Interim Surveys:* NCQA reviews the organization's policies and procedures. *For First Surveys:* NCQA reviews the organization's most recent annual assessment reports. *For Renewal Surveys:* NCQA reviews the organization's most recent and previous year's annual assessment reports.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

C - Activities and Resources — **NCQA**

Medicaid: Met

Medicaid

The organization annually uses the population assessment to:

		NCQA ANSWER
1	Review and update its PHM activities to address member needs.	Yes
2	Review and update its PHM resources to address member needs.	Yes
3	Review and update activities or resources to address health care disparities for at least one identified population.	Yes
4	Review community resources for integration into program offerings to address member needs.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data Sources	Documented process, Reports, Materials
Scope of Review	**Product lines** *This element applies to Interim Surveys, First Surveys and Renewal Surveys for all product lines.* **Documentation** *For Interim Surveys:* NCQA reviews the organization's policies and procedures. *For First and Renewal Surveys:* NCQA reviews committee minutes or similar documents showing process and resource review and updates.

ISSUES This element has no issues.

ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

D - Segmentation **NCQA**

Medicaid: Met

Medicaid

At least annually, the organization segments or stratifies its entire population into subsets for targeted intervention.

		NCQA ANSWER
1	Segments or stratifies its entire population into subsets for targeted intervention.	Yes
2	Assesses for racial bias in its segmentation or stratification methodology.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 1-2 factors	No scoring option.	The organization meets 0 factors.

Data Sources	Documented process, Reports
Scope of Review	**Product lines** *This element applies to Interim Surveys, First Surveys and Renewal Surveys for all product lines.*

Documentation

For factor 1, NCQA reviews a description of the methods used to segment or stratify the organization's membership, including subsets to which members may be assigned.

- *For First Surveys:* NCQA also reviews the organization's most recent annual report demonstrating implementation.
- *For Renewal Surveys:* NCQA also reviews the organization's most recent and previous year's annual reports demonstrating implementation.

For All Surveys, for factor 2, NCQA reviews the organization's documented process for assessing for racial bias in its segmentation or stratification methodology.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

PHM 3

The organization works with practitioners or providers to achieve population health management goals.

A - Practitioner or Provider Support **NCQA**

Medicaid: Met

Medicaid

The organization supports practitioners or providers in its network to achieve population health management goals by:

		NCQA ANSWER
1	Sharing data.	Yes
2	Offering evidence-based or certified decision-making aids.	Yes
3	Providing practice transformation support to primary care practitioners.	Yes
4	Providing comparative quality information on selected specialties.	No
5	Providing comparative pricing information on selected services.	No
6	Providing training on equity, cultural competency, bias, diversity or inclusion.	NA

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 3-6 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data Sources	Documented process, Reports, Materials
Scope of Review	**Product lines** *This element applies to Interim Surveys, First Surveys and Renewal Surveys for all product lines.* **Documentation** *For Interim Surveys:* NCQA reviews the organization's description of how it supports practitioners or providers.

For First Surveys and *Renewal Surveys:* NCQA reviews the organization's description that is in place throughout the look-back period of how it supports practitioners or providers.

NCQA also reviews materials demonstrating implementation at least once during the prior 24 months or reports showing the information if the support involves sharing or providing information.

For factor 2: NCQA reviews materials for evidence that they were developed using established criteria or certified by a third-party entity.

ISSUES

Type	DOC
Lines	Medicaid
Statement	The organization confirmed that factors 4 and 5 should be scored not met.
Contest Element Findings	No
Organization Comments	
Organization Statement	KHS confirms that factor 4 & 5 were intentionally marked as Not Met.
NCQA Support Text	The organization confirmed that factors 4 and 5 should be scored not met.
NCQA Response Post Final Report	
Factor - Result	4 - Not met 5 - Not met

ORG SUBMISSION STATEMENT

NA score for factor 6 is due to scoring changes per the Executive Orders.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
Medicaid	Per NCQA's Modifications to Scoring for NCQA Accreditation Surveys memo, factor 6 is NA due to the Executive Orders.	6

B - Value-Based Payment Arrangements **NCQA**

Medicaid: Met

Medicaid

The organization demonstrates that it has a value-based payment (VBP) arrangement(s) and reports the percentages of total payments tied to VBP.

NCQA ANSWER The organization meets the requirement

SCORING	**MET**	**PARTIALLY MET**	**NOT MET**
	The organization meets the requirement	No scoring option.	The organization does not meet the requirement

Data Sources	Reports
Scope of Review	**Product lines** *This element applies to First Surveys and Renewal Surveys for all product lines.* NCQA reviews and scores this element for each product line brought forward for Accreditation. **Documentation** *For First Surveys and Renewal Surveys:* NCQA reviews the VBP worksheet to demonstrate that the organization has VBP arrangements in each product line. Worksheets reflect a continuous 12-month period within the look-back period.

ISSUES This element has no issues.

ORG SUBMISSION STATEMENT This element has no organization submission statement

NCQA SUPPORT TEXT This element has no additional NCQA support texts.

PHM 4

The organization helps members identify and manage health risks through evidence-based tools that maintain member privacy and explain how the organization uses collected information.

A - Frequency of Health Appraisal Completion **NCQA**

Medicaid: Met

Medicaid

The organization has the capability to administer a health appraisal (HA) annually.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER The organization meets the requirement

SCORING	**MET**	**PARTIALLY MET**	**NOT MET**
	The organization meets the requirement	No scoring option.	The organization does not meet the requirement

Data Sources	Documented process, Reports, Materials
Scope of Review	**Product lines** *This element applies to First Surveys for all product lines.* **Documentation**

NCQA reviews the organization's documented process for administering annual HAs, or documentation that the organization administered an annual HA to adult members.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

B - Topics of Self-Management Tools **NCQA**

Medicaid: Met

Medicaid

The organization offers self-management tools, derived from available evidence, that provide members with information on at least the following wellness and health promotion areas:

		NCQA ANSWER
1	Healthy weight (BMI) maintenance.	Yes (AC)
2	Smoking and tobacco use cessation.	Yes (AC)
3	Encouraging physical activity.	Yes (AC)

		NCQA ANSWER
4	Healthy eating.	Yes (AC)
5	Managing stress.	Yes (AC)
6	Avoiding at-risk drinking.	Yes (AC)
7	Identifying depressive symptoms.	Yes (AC)

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 5-7 factors	The organization meets 3-4 factors	The organization meets 0-2 factors

Data Sources	Documented process, Materials
Scope of Review	**Product lines** *This element applies to First Surveys and Renewal Surveys for all product lines.* **Documentation** NCQA reviews the organization's policies and procedures for developing evidence based self-management tools, and reviews the organization's self-management tools. Both must be available throughout the look-back period. If the organization can provide a "test" or "demo" log-on ID, NCQA reviews the organization's performance through that mechanism.

If the organization cannot provide a test or demo log-on, NCQA reviews the organization's website or screenshots, supplemented with documents specifying the required features and functions of the site. If screenshots provided include detailed explanations of how the site works, there is no need to provide supplemental documents.

ISSUES This element has no issues.

ORG SUBMISSION STATEMENT Healthwise, Incorporated possesses the NCQA Certification in Self-Management Tools. Attached is our current contract with Ignite Healthwise as well as the NCQA certification.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
Medicaid	Automatic credit is applicable because the organization used an NCQA-Accredited vendor for the self-management tools.	1 2 3 4 5 6 7

PHM 5

The organization helps members with multiple or complex conditions to obtain access to care and services, and coordinates their care.

A - Access to Case Management **NCQA**

Medicaid: Met

Medicaid

The organization has multiple avenues for members to be considered for complex case management services, including:

		NCQA ANSWER
1	Medical management program referral.	Yes
2	Discharge planner referral.	Yes
3	Member or caregiver referral.	Yes
4	Practitioner referral.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data Sources	Documented process, Reports, Materials
Scope of Review	**Product lines** *This element applies to Interim Surveys, First Surveys and Renewal Surveys for all product lines.* **Documentation** NCQA reviews the organization's policies and procedures. *For First Surveys and Renewal Surveys:* NCQA also reviews evidence that the organization has multiple referral avenues in place throughout the look-back period and that it communicates the referral options to members (factor 3) and practitioners (factor 4) at least once during the look-back period.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

B - Case Management Systems **NCQA**

Medicaid: Met

Medicaid

The organization uses case management systems that support:

		NCQA ANSWER
1	Evidence-based clinical guidelines or algorithms to conduct assessment and management.	Yes (AC)
2	Automatic documentation of staff ID, and the date and time of action on the case or when interaction with the member occurred.	Yes (AC)
3	Automated prompts for follow-up, as required by the case management plan.	Yes (AC)

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 3 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data Sources	Documented process, Reports, Materials
Scope of Review	**Product lines** *This element applies to Interim Surveys, First Surveys and Renewal Surveys for all product lines.* **Documentation** NCQA reviews the organization's documented process. *For First Surveys and Renewal Surveys:* NCQA also reviews the organization's complex case management system or annotated screenshots of system functionality. The system must be in place throughout the look-back period.

ISSUES

This element has no issues.

ORG SUBMISSION STATEMENT

Automatic credit due to ZeOmega's achievement of PHM Prevalidation for Jiva, version 6.1+. The attached documentation demonstrates the Prevalidation, eligibility, and a screenshot showing that our version of Jiva matches the solution specified in the Prevalidation letter.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
Medicaid	The organization receives automatic credit for this element as they utilize Jiva version 6.1 and ZeOmega has achieved PHM Prevalidation for Jiva, version 6.1+.	1 2 3

C - Case Management Process NCQA

Medicaid: Met

Medicaid

The organization's complex case management procedures address the following:

		NCQA ANSWER
1	Initial assessment of member health status, including condition-specific issues.	Yes
2	Documentation of clinical history, including medications.	Yes
3	Initial assessment of the activities of daily living.	Yes
4	Initial assessment of behavioral health status, including cognitive functions.	Yes
5	Initial assessment of social determinants of health.	Yes
6	Initial assessment of life-planning activities.	Yes
7	Evaluation of cultural and linguistic needs, preferences or limitations.	Yes
8	Evaluation of visual and hearing needs, preferences or limitations.	Yes
9	Evaluation of caregiver resources and involvement.	Yes
10	Evaluation of available benefits.	Yes
11	Evaluation of community resources.	Yes
12	Development of an individualized case management plan, including prioritized goals and considers member and	Yes

		NCQA ANSWER
	caregiver goals, preferences and desired level of involvement in the case management plan.	
13	Identification of barriers to the member meeting goals or complying with the case management plan.	Yes
14	Facilitation of member referrals to resources and a follow-up process to determine whether members act on referrals.	Yes
15	Development of a schedule for follow-up and communication with members.	Yes
16	Development and communication of a member self-management plan.	Yes
17	A process to assess member progress against the case management plan.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 14-17 factors	The organization meets 8-13 factors	The organization meets 0-7 factors

Data Sources	Documented process
Scope of Review	**Product lines** *This element applies to Interim Surveys and First Surveys for all product lines.* **Documentation** NCQA reviews the organization’s policies and procedures in place throughout the look-back period.

ISSUES This element has no issues.

ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

D - Initial Assessment **NCQA**

Medicaid: Met

Medicaid

An NCQA review of a sample of the organization's complex case management files demonstrates that the organization follows its documented processes for completing the following within 60 calendar days:

		NCQA ANSWER
1	Initial assessment of member health status, including condition-specific issues.	High
2	Documentation of clinical history, including medications.	High
3	Initial assessment of the activities of daily living (ADL).	High
4	Initial assessment of behavioral health status, including cognitive functions.	High
5	Initial assessment of social determinants of health.	High
6	Evaluation of cultural and linguistic needs, preferences or limitations.	High
7	Evaluation of visual and hearing needs, preferences or limitations.	High
8	Evaluation of caregiver resources and involvement.	High

		NCQA ANSWER
9	Evaluation of available benefits.	High
10	Evaluation of available community resources.	High
11	Assessment of life-planning activities.	High
12	Beginning the assessment for at least one factor within 30 calendar days of identifying a member for complex case management.	High

SCORING	MET	PARTIALLY MET	NOT MET
	High (90-100%) on file review for at least 8 factors and medium (60-89%) on file review for any remaining factors	High (90%-100%) or medium (60-89%) on file review for 12 factors	Low (0-59%) on file review for any factor

Data Sources	Records or files
Scope of Review	**Product lines** *This element applies to First Surveys and Renewal Surveys for all product lines.* **Documentation** NCQA reviews initial assessments in a random sample of up to 40 complex case management files. Files are selected from active or closed member cases that were identified during the look-back period and remained open for at least 60 calendar days during the look-back period, from the date when the member was identified for complex case management. The organization must provide the identification date for each case in the file universe.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

E - Case Management—Ongoing Management **NCQA**

Medicaid: Met

Medicaid

An NCQA review of a sample of the organization's complex case management files demonstrates that the organization follows its documented processes for:

		NCQA ANSWER
1	Development of case management plans that include prioritized goals, that take into account member and caregiver goals, preferences and desired level of involvement in the complex case management program.	High
2	Identification of barriers to meeting goals and complying with the case management plan.	High
3	Development of schedules for follow-up and communication with members.	High
4	Development and communication of member self-management plans.	High
5	Assessment of progress against case management plans and goals, and modification as needed.	High

SCORING	MET	PARTIALLY MET	NOT MET
	High (90%-100%) on file review for at least 3 factors and medium (60-89%) on file review for any remaining factors	High (90%-100%) or medium (60-89%) on file review for 5 factors	Low (0-59%) on file review for any factors

Data Sources	Records or files
Scope of Review	**Product lines** *This element applies to First Surveys and Renewal Surveys for all product lines.* **Documentation** NCQA reviews initial assessments in a random sample of up to 40 complex case management files. Files are selected from active or closed cases that were identified during the look-back period and remained open for at least 60 calendar days during the look-back period, from the date when the member was identified for complex case management. The organization must provide the identification date for each case in the file universe.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

PHM 6

The organization has a systematic process to evaluate whether it has achieved its goals and to gain insights into areas needing improvement.

A - Measuring Effectiveness	NCQA
	Medicaid: Met

Medicaid

At least annually, the organization conducts a comprehensive analysis of the impact of its PHM strategy that includes the following:

		NCQA ANSWER
1	Quantitative results for relevant clinical, cost/utilization and experience measures.	Yes
2	Comparison of results with a benchmark or goal.	Yes
3	Interpretation of results.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 3 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data Sources	Reports
Scope of Review	**Product lines** *This element applies to First Surveys and Renewal Surveys for all product lines.*

NCQA reviews and scores this element for each product line brought forward for Accreditation.

Documentation

For First Surveys: NCQA reviews the organization's plan for annual comprehensive analysis of its PHM strategy impact or the organization's most recent annual comprehensive analysis of PHM strategy impact.

For Renewal Surveys: NCQA reviews the organization's most recent and previous annual comprehensive analysis of PHM strategy impact.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

PHM 7

The organization remains responsible for and has appropriate structures and mechanisms to oversee delegated PHM activities.

A - Delegation Agreement **NCQA** **NA**

NOT APPLICABLE

The written delegation agreement:

		NCQA ANSWER
1	Is mutually agreed upon.	NA
2	Describes the delegated activities and the responsibilities of the organization and the delegated entity.	NA
3	Requires at least semiannual reporting by the delegated entity to the organization.	NA
4	Describes the process by which the organization evaluates the delegated entity's performance.	NA
5	Describes the process for providing member experience and clinical performance data to its delegates when requested.	NA
6	Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.	NA

NOT APPLICABLE

The written delegation agreement:

		NCQA ANSWER
1	Is mutually agreed upon.	NA
2	Describes the delegated activities and the responsibilities of the organization and the delegated entity.	NA
3	Requires at least semiannual reporting by the delegated entity to the organization.	NA
4	Describes the process by which the organization evaluates the delegated entity's performance.	NA
5	Describes the process for providing member experience and clinical performance data to its delegates when	NA

		NCQA ANSWER
	requested.	
6	Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.	NA

NOT APPLICABLE

The written delegation agreement:

		NCQA ANSWER
1	Is mutually agreed upon.	NA
2	Describes the delegated activities and the responsibilities of the organization and the delegated entity.	NA
3	Requires at least semiannual reporting by the delegated entity to the organization.	NA
4	Describes the process by which the organization evaluates the delegated entity's performance.	NA
5	Describes the process for providing member experience and clinical performance data to its delegates when requested.	NA
6	Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.	NA

NOT APPLICABLE

The written delegation agreement:

		NCQA ANSWER
1	Is mutually agreed upon.	NA
2	Describes the delegated activities and the responsibilities of the organization and the delegated entity.	NA
3	Requires at least semiannual reporting by the delegated entity to the organization.	NA
4	Describes the process by which the organization evaluates the delegated entity's performance.	NA
5	Describes the process for providing member experience and clinical performance data to its delegates when requested.	NA
6	Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.	NA

NOT APPLICABLE

The written delegation agreement:

		NCQA ANSWER
1	Is mutually agreed upon.	NA
2	Describes the delegated activities and the responsibilities of the organization and the delegated entity.	NA
3	Requires at least semiannual reporting by the delegated entity to the organization.	NA
4	Describes the process by which the organization evaluates the delegated entity's performance.	NA

		NCQA ANSWER
5	Describes the process for providing member experience and clinical performance data to its delegates when requested.	NA
6	Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.	NA

NOT APPLICABLE

The written delegation agreement:

		NCQA ANSWER
1	Is mutually agreed upon.	NA
2	Describes the delegated activities and the responsibilities of the organization and the delegated entity.	NA
3	Requires at least semiannual reporting by the delegated entity to the organization.	NA
4	Describes the process by which the organization evaluates the delegated entity's performance.	NA
5	Describes the process for providing member experience and clinical performance data to its delegates when requested.	NA
6	Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.	NA

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 5-6 factors	The organization meets 3-4 factors	The organization meets 0-2 factors

Data Sources	Materials
Scope of Review	**Product lines** *This element applies to Interim Surveys, First Surveys and Renewal Surveys for all product lines.* **Documentation** NCQA reviews delegation agreements in effect during the look-back period of up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four. Delegation agreements implemented on or after January 1, 2019, must include a description of the process required in factor 5. For delegation agreements in place prior to January 1, 2019, the organization may provide documentation that it notified the delegate of the process required in factor 5. This documentation of notification is not required to be mutually agreed upon. The score for the element is the average of the scores for all delegates.
ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	PHM 7 is NA since KHS does not delegate any PHM activities.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
NOT APPLICABLE	The organization does not delegate PHM activities; therefore, this element is scored NA.	1 2 3

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
		4 5 6

B - Predelegation Evaluation **NCQA** **NA**

NOT APPLICABLE

For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

SCORING	MET	PARTIALLY MET	NOT MET
	The organization evaluated delegate capacity before delegation began	The organization evaluated delegate capacity after delegation began	The organization did not evaluate delegate capacity

Data Sources	Reports
Scope of Review	**Product lines** *This element applies to Interim Surveys, First Surveys and Renewal Surveys for all product lines.* This element applies if delegation was implemented in the look-back period. **Documentation** NCQA reviews the organization's predelegation evaluation of up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four. The score for the element is the average of the scores for all delegates.

ISSUES

This element has no issues.

ORG SUBMISSION STATEMENT

PHM 7 is NA since KHS does not delegate any PHM activities.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
NOT APPLICABLE	The organization does not delegate PHM activities; therefore, this element is scored NA.	1

C - Review of PHM Program NCQA NA

NOT APPLICABLE

For arrangements in effect for 12 months or longer, the organization:

		NCQA ANSWER
1	Annually reviews its delegate's PHM program.	NA
2	Annually audits complex case management files against NCQA standards for each year that delegation has been in effect, if applicable.	NA
3	Annually evaluates delegate performance against NCQA standards for delegated activities.	NA
4	Semiannually evaluates regular reports, as specified in Element A.	NA

NOT APPLICABLE

For arrangements in effect for 12 months or longer, the organization:

		NCQA ANSWER
1	Annually reviews its delegate's PHM program.	NA
2	Annually audits complex case management files against NCQA standards for each year that delegation has been in effect, if applicable.	NA
3	Annually evaluates delegate performance against NCQA standards for delegated activities.	NA

		NCQA ANSWER
4	Semiannually evaluates regular reports, as specified in Element A.	NA

NOT APPLICABLE

For arrangements in effect for 12 months or longer, the organization:

		NCQA ANSWER
1	Annually reviews its delegate's PHM program.	NA
2	Annually audits complex case management files against NCQA standards for each year that delegation has been in effect, if applicable.	NA
3	Annually evaluates delegate performance against NCQA standards for delegated activities.	NA
4	Semiannually evaluates regular reports, as specified in Element A.	NA

NOT APPLICABLE

For arrangements in effect for 12 months or longer, the organization:

		NCQA ANSWER
1	Annually reviews its delegate's PHM program.	NA
2	Annually audits complex case management files against NCQA standards for each year that delegation has been in effect, if applicable.	NA

		NCQA ANSWER
3	Annually evaluates delegate performance against NCQA standards for delegated activities.	NA
4	Semiannually evaluates regular reports, as specified in Element A.	NA

NOT APPLICABLE

For arrangements in effect for 12 months or longer, the organization:

		NCQA ANSWER
1	Annually reviews its delegate's PHM program.	NA
2	Annually audits complex case management files against NCQA standards for each year that delegation has been in effect, if applicable.	NA
3	Annually evaluates delegate performance against NCQA standards for delegated activities.	NA
4	Semiannually evaluates regular reports, as specified in Element A.	NA

NOT APPLICABLE

For arrangements in effect for 12 months or longer, the organization:

		NCQA ANSWER
1	Annually reviews its delegate's PHM program.	NA
2	Annually audits complex case management files against NCQA standards for each year that delegation has been	NA

		NCQA ANSWER
	in effect, if applicable.	
3	Annually evaluates delegate performance against NCQA standards for delegated activities.	NA
4	Semiannually evaluates regular reports, as specified in Element A.	NA

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data Sources	Reports
Scope of Review	**Product lines** *Factor 1 applies to Interim Surveys for all product lines.* *All factors in this element apply to First Surveys and Renewal Surveys for all product lines.* **Documentation** NCQA reviews evidence of the organization's review from up to four randomly selected delegates, or all delegates if the organization has fewer than four. *For All Surveys:* NCQA reviews the organization's review of the delegate's PHM program (factor 1). *For First Surveys:* NCQA reviews the organization's most recent annual review, audit, performance evaluation and semiannual evaluation. *For Renewal Surveys:* NCQA reviews the organization's most recent and the previous year's annual reviews, audits, performance

evaluations and four semiannual evaluations.

The score for the element is the average of the scores for all delegates.

ISSUES This element has no issues.

ORG SUBMISSION STATEMENT PHM 7 is NA since KHS does not delegate any PHM activities.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
NOT APPLICABLE	The organization does not delegate PHM activities; therefore, this element is scored NA.	1 2 3 4

D - Opportunities for Improvement **NCQA** **NA**

NOT APPLICABLE

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization identified and followed up on opportunities for improvement, if applicable.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization identified and followed up on opportunities for improvement, if applicable.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization identified and followed up on opportunities for improvement, if applicable.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization identified and followed up on opportunities for improvement, if applicable.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization identified and followed up on opportunities for improvement, if applicable.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in

effect, the organization identified and followed up on opportunities for improvement, if applicable.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

SCORING	**MET**	**PARTIALLY MET**	**NOT MET**
	The organization has acted on identified problems, if any, at least once in each of the past 2 years that the delegation arrangement has been in effect	The organization took inappropriate or weak action, or acted only in the past year	The organization has not acted on identified problems

Data Sources	Documented process, Reports, Materials
Scope of Review	**Product lines** *This element applies to First Surveys and Renewal Surveys for all product lines.* **Documentation** NCQA reviews reports for opportunities for improvement if applicable of up to four randomly selected delegates, or from all delegates, if the organization has fewer than four, and for evidence that the organization took appropriate action to resolve issues. *For First Surveys:* NCQA reviews the organization's most recent annual review and follow-up on improvement opportunities. *For Renewal Surveys:* NCQA reviews the organization's most recent and previous year's annual reviews and follow-up on improvement opportunities. The score for the element is the average of the scores for all delegates.

ISSUES This element has no issues.

ORG SUBMISSION STATEMENT

PHM 7 is NA since KHS does not delegate any PHM activities.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
NOT APPLICABLE	The organization does not delegate PHM activities; therefore, this element is scored NA.	1

NET 1

The organization maintains an adequate network of primary care, behavioral healthcare and specialty care practitioners (SCP) and monitors how effectively this network meets the needs and preferences of its membership.

A - Cultural Needs and Preferences

NCQA

Medicaid: Met

Medicaid

The organization annually:

		NCQA ANSWER
1	Assesses the cultural, ethnic, racial and linguistic needs of its members.	Yes
2	Adjusts the availability of practitioners within its network, if necessary.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data Sources	Documented process, Reports
Scope of Review	**Product lines** *This element applies to First Surveys and Renewal Surveys for all product lines.* **Documentation** NCQA reviews the organization's data collection methodology (presented as a documented process or within the report), assessment of unmet member needs and characteristics of the practitioner network and documentation of any adjustments made in the network to meet identified needs annually. *For First Surveys:* NCQA reviews the organization's most recent report. *For Renewal Surveys*: NCQA reviews the organization's most recent and previous year's reports.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

B - Practitioners Providing Primary Care **NCQA**

Medicaid: Met

Medicaid

To evaluate the availability of practitioners who provide primary care services, including general medicine or family practice, internal medicine and pediatrics, the organization:

		NCQA ANSWER
1	Establishes measurable standards for the number of each type of practitioner providing primary care.	Yes
2	Establishes measurable standards for the geographic distribution of each type of practitioner providing primary care.	Yes
3	Annually analyzes performance against the standards for the number of each type of practitioner providing primary care.	Yes
4	Annually analyzes performance against the standards for the geographic distribution of each type of practitioner providing primary care.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data Sources	Documented process, Reports
Scope of Review	**Product lines** *This element applies to First Surveys and Renewal Surveys for all product lines.* **Documentation**

NCQA reviews policies and procedures in place throughout the look-back period for factors 1 and 2.

For First Surveys: NCQA also reviews the organization's most recent analysis report for factors 3 and 4.

For Renewal Surveys: NCQA also reviews the most recent and the previous year's annual analysis reports for factors 3 and 4.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

C - Practitioners Providing Specialty Care **NCQA**

Medicaid: Met

Medicaid

To evaluate the availability of specialists in its delivery system, the organization:

		NCQA ANSWER
1	Defines the types of high-volume and high-impact specialists.	Yes
2	Establishes measurable standards for the number of each type of high-volume specialist.	Yes
3	Establishes measurable standards for the geographic distribution of each type of high-volume specialist.	Yes
4	Establishes measurable standards for the geographic distribution of each type of high-impact specialist.	Yes

		NCQA ANSWER
5	Analyzes its performance against the established standards at least annually.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 3-5 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data Sources	Documented process, Reports
Scope of Review	**Product lines** *This element applies to First Surveys and Renewal Surveys for all product lines.* **Documentation** NCQA reviews policies and procedures in place throughout the look-back period for factors 1–4. *For First Surveys:* NCQA also reviews the organization's most recent annual analysis report for factor 5. *For Renewal Surveys:* NCQA also reviews the most recent and the previous year's annual analysis reports for factor 5.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

D - Practitioners Providing Behavioral Healthcare **NCQA**

Medicaid: Met

Medicaid

To evaluate the availability of high-volume behavioral healthcare practitioners in its delivery system, the organization:

		NCQA ANSWER
1	Defines the types of high-volume behavioral healthcare practitioners.	Yes
2	Establishes measurable standards for the number of each type of high-volume behavioral healthcare practitioner.	Yes
3	Establishes measurable standards for the geographic distribution of each type of high-volume behavioral healthcare practitioner.	Yes
4	Analyzes performance against the standards annually.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data Sources	Documented process, Reports
Scope of Review	**Product lines** *This element applies to First Survey and Renewal Surveys for all product lines.* **Documentation** NCQA reviews policies and procedures in place throughout the look-back period for factors 1–3.

For First Surveys: NCQA also reviews the organization's most recent annual analysis report for factor 4.

For Renewal Surveys: NCQA also reviews the most recent and the previous year's annual analysis reports for factor 4.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

NET 2

The organization provides and maintains appropriate access to primary care services, behavioral healthcare services and specialty care services.

A - Access to Primary Care **NCQA**

Medicaid: Met

Medicaid

Using valid methodology, the organization collects and performs an annual analysis of data to measure its performance against its standards for access to:

		NCQA ANSWER
1	Regular and routine care appointments.	Yes

		NCQA ANSWER
2	Urgent care appointments.	Yes
3	After-hours care.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 2-3 factors	The organization meets 1 factor	The organization meets 0 factors

Data Sources	Reports
Scope of Review	**Product lines** *This element applies to First Surveys and Renewal Surveys for all product lines.* **Documentation** *For First Surveys:* NCQA reviews the organization's most recent annual data collection and analysis report. *For Renewal Surveys:* NCQA reviews the organization's most recent and the previous year's annual data collection and analysis reports.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

B - Access to Behavioral Healthcare	Has Critical Factors	NCQA

Medicaid: Met

Medicaid

Using valid methodology, the organization annually collects and analyzes data to evaluate access to appointments for behavioral healthcare for:

		NCQA ANSWER
1	Care for a non-life-threatening emergency within 6 hours.	Yes
2	Urgent care within 48 hours.	Yes
3	Initial visit for routine care within 10 business days.	Yes
4	Follow-up routine care.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data Sources	Documented process, Reports, Materials
Scope of Review	**Product lines** *This element applies to First Surveys and Renewal Surveys for all product lines.* **Documentation**

For First Surveys: NCQA reviews the organization's most recent annual data collection and analysis report for all factors.

For Renewal Surveys: NCQA reviews the organization's most recent and the previous year's annual data collection and analysis reports.

For factor 1 for all surveys: If the organization directs members with non-life-threatening emergencies to the emergency department (ED), NCQA reviews the organization's report, policies or other documentation.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

C - Access to Specialty Care **NCQA**

Medicaid: Met

Medicaid

Using valid methodology, the organization annually collects and analyzes data to evaluate access to appointments for:

		NCQA ANSWER
1	High-volume specialty care.	Yes
2	High-impact specialty care.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data Sources	Reports
Scope of Review	**Product lines** *This element applies to First Surveys and Renewal Surveys for all product lines.* **Documentation** *For First Surveys:* NCQA reviews the organization's most recent data collection and analysis report. *For Renewal Surveys:* NCQA reviews the organization's most recent and the previous year's data collection and analysis reports.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

NET 3

The organization provides members adequate network access for needed health care services.

A - Assessment of Member Experience Accessing the Network	NCQA

Medicaid: Met

Medicaid

The organization annually identifies gaps in networks specific to geographic areas or types of practitioners or providers by:

		NCQA ANSWER
1	Using analysis results related to member experience with network adequacy for nonbehavioral healthcare services from ME 7, Element C and Element D.	Yes
2	Using analysis results related to member experience with network adequacy for behavioral healthcare services from ME 7, Element E.	Yes
3	Compiling and analyzing nonbehavioral requests for and utilization of out-of-network services.	Yes
4	Compiling and analyzing behavioral healthcare requests for and utilization of out-of-network services.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data Sources	Reports
Scope of Review	**Product lines** *This element applies to First Surveys and Renewal Surveys for all product lines.*

NCQA reviews and scores this element for each product line brought forward for Accreditation; only the commercial and Exchange product lines may be combined.

Documentation

For First Surveys: NCQA reviews the organization's most recent report.

For Renewal Surveys: NCQA reviews the organization's most recent and the previous year's reports.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

B - Opportunities to Improve Access to Nonbehavioral Healthcare Services

NCQA Medicaid: Met

Medicaid

The organization annually:

		NCQA ANSWER
1	Prioritizes opportunities for improvement identified from analyses of availability (NET 1, Elements A, B and C), accessibility (NET 2, Elements A and C) and member experience accessing the network (NET 3, Element A, factors 1 and 3).	Yes
2	Implements interventions on at least one opportunity, if applicable.	Yes

		NCQA ANSWER
3	Measures the effectiveness of interventions, if applicable.	NA

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 3 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data Sources	Documented process, Reports, Materials
Scope of Review	**Product lines** *This element applies to First Surveys and Renewal Surveys for all product lines.* NCQA reviews and scores this element for each product line brought forward for Accreditation; only the commercial and Exchange product lines may be combined. **Documentation** *For First Surveys:* NCQA reviews the organization's most recent report. *For Renewal Surveys:* NCQA reviews the organization's most recent and previous year's reports. *For factor 2 for both survey types:* NCQA reviews a documented process, reports or materials, depending on the action taken to address identified opportunities.

ISSUES This element has no issues.

ORG SUBMISSION STATEMENT

- According to 2024 HP Standards and Guidelines, Factor 3 is NA for First Surveys.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
Medicaid	Factor 3 is NA for First Surveys.	3

C - Opportunities to Improve Access to Behavioral Healthcare Services

NCQA

Medicaid: Met

Medicaid

The organization annually:

		NCQA ANSWER
1	Prioritizes opportunities for improvement identified from analyses of availability (NET 1, Elements A and D), accessibility (NET 2, Element B) and member experience accessing the network (NET 3, Element A, factors 2 and 4).	Yes
2	Implements interventions on at least one opportunity, if applicable.	Yes
3	Measures the effectiveness of the interventions, if applicable.	NA

SCORING

MET	PARTIALLY MET	NOT MET
The organization meets 3 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data Sources	Documented process, Reports, Materials
Scope of Review	**Product lines** *This element applies to First Surveys and Renewal Surveys for all product lines.* NCQA reviews and scores this element for each product line brought forward for Accreditation; only the commercial and Exchange product lines may be combined. **Documentation** *For First Surveys:* NCQA reviews the organization's most recent report. *For Renewal Surveys:* NCQA reviews the organization's most recent and previous year's reports. *For factor 2 for both survey types:* NCQA reviews a documented process, reports or materials, depending on the action taken to address identified opportunities.

ISSUES

This element has no issues.

ORG SUBMISSION STATEMENT

- According to 2024 HP Standards and Guidelines, Factor 3 is NA for First Surveys.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
Medicaid	Factor 3 is NA for First Surveys.	3

NET 4

The organization uses information at its disposal to facilitate continuity and coordination of medical care across its delivery system.

A - Notification of Termination **NCQA**

Medicaid: Met

Medicaid

The organization notifies members affected by the termination of a practitioner or practice group in general, family or internal medicine or pediatrics, at least 30 calendar days prior to the effective termination date, and helps them select a new practitioner.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER The organization notifies members at least 30 calendar days prior to the effective date of termination

SCORING

MET	PARTIALLY MET	NOT MET
The organization notifies members at least 30 calendar days prior to the effective date of termination	No scoring option.	The organization does not notify members at least 30 calendar days prior to the effective date of termination

Data Sources	Documented process, Reports, Materials
Scope of Review	**Product lines** *This element applies to First Surveys and Renewal Surveys for all product lines.* **Documentation** NCQA reviews: • The organization's policies and procedures or decision process in place throughout the look-back period, ***and***

- Three reports or materials as evidence that members were notified of practitioner termination throughout the look-back period.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

B - Continued Access to Practitioners **NCQA**

Medicaid: Met

Medicaid

If a practitioner's contract is discontinued, the organization allows affected members continued access to the practitioner, as follows:

		NCQA ANSWER
1	Continuation of treatment through the current period of active treatment, or for up to 90 calendar days, whichever is less, for members undergoing active treatment for a chronic or acute medical condition.	Yes
2	Continuation of care through the postpartum period for members in their second or third trimester of pregnancy.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data Sources	Documented process, Reports, Materials, Records or files
Scope of Review	**Product lines** *This element applies to First Surveys and Renewal Surveys for all product lines.* **Documentation** NCQA reviews: • The organization's policies and procedures in place throughout the look-back period, ***and*** • Three reports, materials, records or files as evidence that the organization met the requirements throughout the look-back period. ◦ NCQA reviews all reports, materials or records or files if the organization has fewer than three.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

NET 5

The organization's directories offer information to members and prospective members that is useful in selecting a physician and hospital.

A - Physician Directory Data **NCQA**

Medicaid: Met

Medicaid

The organization has a web-based physician directory that includes the following physician information:

		NCQA ANSWER
1	Name.	Yes
2	Gender.	Yes
3	Specialty.	Yes
4	Hospital affiliations.	Yes
5	Medical group affiliations.	Yes
6	Board certification.	Yes
7	Accepting new patients.	Yes
8	Languages spoken by the physician or clinical staff.	Yes
9	Office locations and phone numbers.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 8-9 factors	The organization meets 5-7 factors	The organization meets 0-4 factors

Data Sources	Materials
Scope of Review	**Product lines** *For First Surveys, this element applies to all product lines.* *For Renewal Surveys, this element applies to the Medicaid product line only.* **Documentation** NCQA reviews the organization's web-based directory or screenshots of the website that is in place throughout the look-back period.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

B - Physician Directory Updates **NCQA**

Medicaid: Met

Medicaid

The organization updates its web-based physician directory within 30 calendar days of receiving new information from the physician.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER	The organization meets the requirement

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets the requirement	No scoring option.	The organization does not meet the requirement

Data Sources	Documented process, Reports, Materials
Scope of Review	**Product lines** *For First Surveys, this element applies to all product lines.* *For Renewal Surveys, this element applies to the Medicaid product line only.* **Documentation** NCQA reviews: • The organization's policies and procedures in place throughout the look-back period that states the frequency of updates, ***and*** • Three reports or materials as evidence that the directory was updated within 30 calendar days of receipt of new information.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

C - Assessment of Physician Directory Accuracy **NCQA**

Medicaid: Met

Medicaid

Using valid methodology, the organization performs an annual evaluation of its physician directories for:

		NCQA ANSWER
1	Accuracy of office locations and phone numbers.	Yes
2	Accuracy of hospital affiliations.	Yes
3	Accuracy of accepting new patients.	Yes
4	Awareness of physician office staff of physician's participation in the organization's networks.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data Sources	Reports
Scope of Review	**Product lines** *This element applies to First Surveys* and *Renewal Surveys for all product lines*. **Documentation** *For First Surveys:* NCQA reviews the organization's most recent annual report. *For Renewal Surveys:* NCQA reviews the organization's most recent and the previous year's annual reports.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

D - Identifying and Acting on Opportunities

NCQA

Medicaid: Met

Medicaid

Based on results of the analysis performed in Element C, at least annually, the organization:

		NCQA ANSWER
1	Identifies opportunities to improve the accuracy of the information in its physician directories.	Yes
2	Takes action to improve the accuracy of the information in its physician directories.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 2 factors	No scoring option.	The organization meets 0-1 factors

Data Sources	Documented process, Reports
Scope of	**Product lines**

Review	*This element applies to First Surveys and Renewal Surveys for all product lines.* **Documentation** *For First Surveys:* NCQA reviews the organization's most recent annual report. *For Renewal Surveys:* NCQA reviews the organization's most recent and the previous year's annual reports. *For factor 2 for both survey types:* NCQA may also review a documented process, depending on the action taken to address identified opportunities.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

E - Searchable Physician Web-Based Directory **NCQA**

Medicaid: Met

Medicaid

The organization's web-based physician directory includes search functions with instructions for finding the following physician information:

		NCQA ANSWER
1	Name.	Yes
2	Gender.	Yes

		NCQA ANSWER
3	Specialty.	Yes
4	Hospital affiliations.	Yes
5	Medical group affiliations.	Yes
6	Accepting new patients.	Yes
7	Languages spoken by the physician or clinical staff.	Yes
8	Office locations.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 7-8 factors	The organization meets 4-6 factors	The organization meets 0-3 factors

Data Sources	Materials
Scope of Review	**Product lines** *This element applies to First Surveys and Renewal Surveys for all product lines.* **Documentation** NCQA reviews the organization’s web-based directory or screenshots of its web-based directory that is in place throughout the look-back period.

ISSUES This element has no issues.

ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

F - Hospital Directory Data

NCQA

Medicaid: Met

Medicaid

The organization has a web-based hospital directory that includes the following information:

		NCQA ANSWER
1	Hospital name.	Yes
2	Hospital location and phone number.	Yes
3	Hospital accreditation status.	Yes
4	Hospital quality data from recognized sources.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data Sources	Materials

Scope of Review	**Product lines** *For First Surveys, this element applies to all product lines.* *For Renewal Surveys, this element applies to the Medicaid product line only.* **Documentation** NCQA reviews the organization's web-based directory or screenshots of its web-based directory that is in place throughout the look-back period.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

G - Hospital Directory Updates **NCQA**

Medicaid: Met

Medicaid

The organization updates its web-based hospital directory information within 30 calendar days of receiving new information from the hospital.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER	The organization meets the requirement

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets the requirement	No scoring option.	The organization does not meet the requirement

Data Sources	Documented process, Reports, Materials
Scope of Review	**Product lines** *For First Surveys, this element applies to all product lines.* *For Renewal Surveys, this element applies to the Medicaid product line only.* **Documentation** NCQA reviews: • The organization's policies and procedures in place throughout the look-back period that states the frequency of updates, ***and*** • Three reports or materials as evidence showing that the directory was updated within 30 calendar days of receipt of new information.
ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
Medicaid	The organization has provided an attestation to explain that no updates were made to the web-based hospital directory during the look-back period. This attestation is sufficient to meet the requirement in lieu of three examples of evidence showing updates to the directory.	1

H - Searchable Hospital Web-Based Directory	NCQA
	Medicaid: Met

Medicaid

The organization's web-based directory includes search functions for specific data types and instructions for searching for the following information:

		NCQA ANSWER
1	Hospital name.	Yes
2	Hospital location.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data Sources	Materials
Scope of Review	**Product lines** *This element applies to First Surveys and Renewal Surveys for all product lines.* **Documentation** NCQA reviews the organization’s web-based directory or screenshots of its web-based directory that is in place throughout the look-back period.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

I - Usability Testing **NCQA**

Medicaid: Met

Medicaid

The organization evaluates its web-based physician and hospital directories for understandability and usefulness to members and prospective members at least every 3 years, and considers the following:

		NCQA ANSWER
1	Reading level.	Yes
2	Intuitive content organization.	Yes
3	Ease of navigation.	Yes
4	Directories in additional languages, if applicable to the membership.	Yes

SCORING

MET	PARTIALLY MET	NOT MET
The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data Sources	Documented process, Reports
Scope of Review	**Product lines** *This element applies to First Surveys and Renewal Surveys for all product lines.* **Documentation** NCQA reviews the organization's policies and procedures in place throughout the look-back period and evidence that it conducted usability testing.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

J - Availability of Directories **NCQA**

Medicaid: Not Met

Medicaid

The organization makes web-based physician and hospital directory information available to members and prospective members through alternative media, including:

		NCQA ANSWER
1	Print.	No

		NCQA ANSWER
2	Telephone.	No

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data Sources	Documented process, Materials
Scope of Review	**Product lines** *This element applies to First Surveys and Renewal Surveys for all product lines.* **Documentation** NCQA reviews the organization's policies and procedures for making the directories available, other evidence (e.g., scripts for telephone directories, printed screenshots of screens accessed during calls) and a printed sample of the directories available throughout the look-back period.

ISSUES		
	Type	DOC
	Lines	Medicaid
	Statement	The organization provided hospital directories for 2024 and 2025, however, the information in the print directories did not include the same information available in the web-based directories. The print hospital directory did not include hospital accreditation status and hospital quality data; therefore, factor 1 is scored not met. The organization did not provide evidence showing that the telephone directory included the same information as the web-based directory; therefore, factor 2 is

	scored not met.
Contest Element Findings	No
Organization Comments	
Organization Statement	We have uploaded an example of the hospital directory for 2024 and 2025 as requested by surveyor.
NCQA Support Text	The organization provided hospital directories for 2024 and 2025, however, the information in the print directories did not include the same information available in the web-based directories. The print hospital directory did not include hospital accreditation status and hospital quality data; therefore, factor 1 is scored not met. The organization did not provide evidence showing that the telephone directory included the same information as the web-based directory; therefore, factor 2 is scored not met.
NCQA Response Post Final Report	
Factor - Result	1 - Not met 2 - Not met
Type	DOC
Lines	Medicaid
Statement	The organization provided an example of a printable version of the web-based directory. This does not meet the requirement for a print directory. The print physician directories provided do not include the gender or medical group affiliations of physicians; therefore factor 1 is scored not met. The telephone script provided shows the process for providing physician directory information to members but does not provide any information on hospital directories.
Contest Element Findings	No
Organization Comments	
Organization Statement	Originally we submitted the PDF/printable version of the member handbook. If you go onto the web-based version of the provider directory, there is a button at the bottom of the page that says "print." We have uploaded an example of what that looks like. It includes all of the information that appears on the web-based version. The example we are uploading was generated within the LBP on 2/27/2025.

NCQA Support Text	The organization provided an example of a printable version of the web-based directory. This does not meet the requirement for a print directory. The print physician directories provided do not include the gender or medical group affiliations of physicians; therefore factor 1 is scored not met. The telephone script provided shows the process for providing physician directory information to members but does not provide any information on hospital directories.
NCQA Response Post Final Report Factor - Result	1 - Not met 2 - Met-Score Yes

ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.
RECOMMENDATIONS	**The following actions for improvement are recommended for this element:** Ensure that the NET program structure includes: - Print. (NET 5J.1) - Telephone. (NET 5J.2) - Print. (NET 5J.1)

NET 6

The organization remains responsible for and has appropriate structures and mechanisms to oversee delegated network management activities.

A - Delegation Agreement **NCQA** **NA**

NOT APPLICABLE

The written delegation agreement:

		NCQA ANSWER
1	Is mutually agreed upon.	NA
2	Describes the delegated activities and the responsibilities of the organization and the delegated entity.	NA
3	Requires at least semiannual reporting by the delegated entity to the organization.	NA
4	Describes the process by which the organization evaluates the delegated entity's performance.	NA
5	Describes the process for providing member experience and clinical performance data to its delegates when requested.	NA
6	Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.	NA

NOT APPLICABLE

The written delegation agreement:

		NCQA ANSWER
1	Is mutually agreed upon.	NA
2	Describes the delegated activities and the responsibilities of the organization and the delegated entity.	NA
3	Requires at least semiannual reporting by the delegated entity to the organization.	NA

		NCQA ANSWER
4	Describes the process by which the organization evaluates the delegated entity's performance.	NA
5	Describes the process for providing member experience and clinical performance data to its delegates when requested.	NA
6	Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.	NA

NOT APPLICABLE

The written delegation agreement:

		NCQA ANSWER
1	Is mutually agreed upon.	NA
2	Describes the delegated activities and the responsibilities of the organization and the delegated entity.	NA
3	Requires at least semiannual reporting by the delegated entity to the organization.	NA
4	Describes the process by which the organization evaluates the delegated entity's performance.	NA
5	Describes the process for providing member experience and clinical performance data to its delegates when requested.	NA
6	Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.	NA

NOT APPLICABLE

The written delegation agreement:

		NCQA ANSWER
1	Is mutually agreed upon.	NA
2	Describes the delegated activities and the responsibilities of the organization and the delegated entity.	NA
3	Requires at least semiannual reporting by the delegated entity to the organization.	NA
4	Describes the process by which the organization evaluates the delegated entity's performance.	NA
5	Describes the process for providing member experience and clinical performance data to its delegates when requested.	NA
6	Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.	NA

NOT APPLICABLE

The written delegation agreement:

		NCQA ANSWER
1	Is mutually agreed upon.	NA
2	Describes the delegated activities and the responsibilities of the organization and the delegated entity.	NA
3	Requires at least semiannual reporting by the delegated entity to the organization.	NA

		NCQA ANSWER
4	Describes the process by which the organization evaluates the delegated entity's performance.	NA
5	Describes the process for providing member experience and clinical performance data to its delegates when requested.	NA
6	Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.	NA

NOT APPLICABLE

The written delegation agreement:

		NCQA ANSWER
1	Is mutually agreed upon.	NA
2	Describes the delegated activities and the responsibilities of the organization and the delegated entity.	NA
3	Requires at least semiannual reporting by the delegated entity to the organization.	NA
4	Describes the process by which the organization evaluates the delegated entity's performance.	NA
5	Describes the process for providing member experience and clinical performance data to its delegates when requested.	NA
6	Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.	NA

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 5-6 factors	The organization meets 3-4 factors	The organization meets 0-2 factors

Data Sources	Materials
Scope of Review	**Product lines** *This element applies to First Surveys and Renewal Surveys for all product lines.* **Documentation** NCQA reviews delegation agreements in effect during the look-back period from up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four. Delegation agreements implemented on or after January 1, 2019, must include a description of the process required in factor 5. For delegation agreements in place prior to January 1, 2019, the organization may provide documentation that it notified the delegate of the process required in factor 5. This documentation of notification is not required to be mutually agreed upon. The score for the element is the average of the scores for all delegates.
ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	NET 6 is NA since KHS does not delegate any NET activities.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
NOT APPLICABLE	The organization does not delegate NET activities; therefore, this element is scored NA.	1

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
		2 3 4 5 6

B - Predelegation Evaluation **NCQA** NA

NOT APPLICABLE

For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before

delegation began.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

SCORING	MET	PARTIALLY MET	NOT MET
	The organization evaluated delegate capacity before delegation began	The organization evaluated delegate capacity after delegation began	The organization did not evaluate delegate capacity

Data Sources	Reports
Scope of Review	**Product lines** *This element applies to First Surveys and Renewal Surveys for all product lines.* *This element applies if delegation was implemented in the look-back period.* **Documentation** NCQA reviews the organization's predelegation evaluation from up to four randomly selected delegates, or reviewed all delegates if the organization has fewer than four. The score for the element is the average of the scores for all delegates.

ISSUES This element has no issues.

ORG SUBMISSION STATEMENT NET 6 is NA since KHS does not delegate any NET activities.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
NOT APPLICABLE	The organization does not delegate NET activities; therefore, this element is scored NA.	1

C - Review of Delegated Activities **NCQA** NA

NOT APPLICABLE

For arrangements in effect for 12 months or longer, the organization:

		NCQA ANSWER
1	Annually reviews its delegate's network management procedures.	NA
2	Annually evaluates delegate performance against NCQA standards for delegated activities.	NA
3	Semiannually evaluates regular reports, as specified in Element A.	NA

NOT APPLICABLE

For arrangements in effect for 12 months or longer, the organization:

		NCQA ANSWER
1	Annually reviews its delegate's network management procedures.	NA
2	Annually evaluates delegate performance against NCQA standards for delegated activities.	NA
3	Semiannually evaluates regular reports, as specified in Element A.	NA

NOT APPLICABLE

For arrangements in effect for 12 months or longer, the organization:

		NCQA ANSWER
1	Annually reviews its delegate's network management procedures.	NA
2	Annually evaluates delegate performance against NCQA standards for delegated activities.	NA
3	Semiannually evaluates regular reports, as specified in Element A.	NA

NOT APPLICABLE

For arrangements in effect for 12 months or longer, the organization:

		NCQA ANSWER
1	Annually reviews its delegate's network management procedures.	NA
2	Annually evaluates delegate performance against NCQA standards for delegated activities.	NA
3	Semiannually evaluates regular reports, as specified in Element A.	NA

NOT APPLICABLE

For arrangements in effect for 12 months or longer, the organization:

		NCQA ANSWER
1	Annually reviews its delegate's network management procedures.	NA
2	Annually evaluates delegate performance against NCQA standards for delegated activities.	NA

		NCQA ANSWER
3	Semiannually evaluates regular reports, as specified in Element A.	NA

NOT APPLICABLE

For arrangements in effect for 12 months or longer, the organization:

		NCQA ANSWER
1	Annually reviews its delegate's network management procedures.	NA
2	Annually evaluates delegate performance against NCQA standards for delegated activities.	NA
3	Semiannually evaluates regular reports, as specified in Element A.	NA

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 2-3 factors	The organization meets 1 factor	The organization meets 0 factors

Data Sources	Reports
Scope of Review	**Product lines** *This element applies to First Surveys and Renewal Surveys for all product lines.* **Documentation** NCQA reviews evidence of the organization’s review from up to four randomly selected delegates, or all delegates if the

organization has fewer than four.

For First Surveys: NCQA reviews the organization's most recent annual review, performance evaluation and semiannual evaluation.

For Renewal Surveys: NCQA reviews the organization's most recent and the previous year's annual reviews, performance evaluations and four semiannual evaluations.

The score for the element is the average of the scores for all delegates.

ISSUES This element has no issues.

ORG SUBMISSION STATEMENT NET 6 is NA since KHS does not delegate any NET activities.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
NOT APPLICABLE	The organization does not delegate NET activities; therefore, this element is scored NA.	1 2 3

D - Opportunities for Improvement **NCQA** **NA**

NOT APPLICABLE

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization identified and followed up on opportunities for improvement, if applicable.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization identified and followed up on opportunities for improvement, if applicable.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization identified and followed up on opportunities for improvement, if applicable.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization identified and followed up on opportunities for improvement, if applicable.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization identified and followed up on opportunities for improvement, if applicable.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization identified and followed up on opportunities for improvement, if applicable.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

SCORING	**MET**	**PARTIALLY MET**	**NOT MET**
	The organization has acted on identified problems, if any, at least once in each of the past 2 years that the delegation arrangement has been in effect	The organization took inappropriate or weak action, or acted only in the past year	The organization has not acted on identified problems

Data Sources	Documented process, Reports, Materials
Scope of Review	**Product lines** *This element applies to First Surveys and Renewal Surveys for all product lines.* **Documentation** NCQA reviews reports of opportunities for improvement, if applicable, from up to four randomly selected delegates, or from all delegates, if the organization has fewer than four, and for evidence that the organization took appropriate action to resolve issues. *For First Surveys:* NCQA reviews the organization's most recent annual review and follow-up on improvement opportunities. *For Renewal Surveys:* NCQA reviews the organization's most recent and previous year's annual reviews and follow-up on improvement opportunities. The score for the element is the average of the scores for all delegates.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	NET 6 is NA since KHS does not delegate any NET activities.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
NOT APPLICABLE	The organization does not delegate NET activities; therefore, this element is scored NA.	1

UM 1

The organization has a well-structured UM program and makes utilization decisions affecting the health care of members in a fair, impartial and consistent manner.

A - Written Program Description

NCQA

Medicaid: Met

Medicaid

The organization's UM program description includes the following:

		NCQA ANSWER
1	A written description of the program structure.	Yes
2	The behavioral healthcare aspects of the program.	Yes

		NCQA ANSWER
3	Involvement of a designated senior-level physician in UM program implementation.	Yes
4	Involvement of a designated behavioral healthcare practitioner in the implementation of the behavioral healthcare aspects of the UM program.	Yes
5	The program scope and process used to determine benefit coverage and medical necessity.	Yes
6	Information sources used to determine benefit coverage and medical necessity.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 5-6 factors	The organization meets 3-4 factors	The organization meets 0-2 factors

Data Sources	Documented process, Reports
Scope of Review	**Product lines** *For Interim Surveys and First Surveys, this element applies to all product lines.* *For Renewal Surveys, this element applies to the Medicaid product line only.* **Documentation** *For Interim Surveys:* NCQA reviews the organization's UM program description. *For First Surveys and Renewal Surveys:* NCQA reviews the organization’s UM program description. *For factors 3 and 4:* NCQA also reviews three UM Committee minutes or other reports that document active involvement of a senior-level physician and a designated behavioral healthcare practitioner in the UM program throughout the look-back period, or

reviews all UM committee meeting minutes or other reports if the organization has fewer than three.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

B - Annual Evaluation **NCQA**

Medicaid: Met

Medicaid

The organization annually evaluates and updates the UM program, as necessary.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER The organization meets the requirement

SCORING	**MET**	**PARTIALLY MET**	**NOT MET**
	The organization meets the requirement	No scoring option.	The organization does not meet the requirement

Data Sources	Reports
Scope of	**Product lines**

Review

This element applies to all product lines for First Surveys and Renewal Surveys.

Documentation

For First Surveys: NCQA reviews the organization's most recent annual evaluation reports and updates (e.g., updates report, updated UM program description), if applicable.

For Renewal Surveys: NCQA reviews the organization's most recent and previous year's annual evaluation reports and updates (e.g., updates report, updated UM program description), if applicable.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

UM 2

The organization applies objective and evidence-based criteria and takes individual circumstances and the local delivery system into account when determining the medical appropriateness of health care services.

A - UM Criteria	**NCQA**
	Medicaid: Met

Medicaid

The organization:

		NCQA ANSWER
1	Has written UM decision-making criteria that are objective and based on medical evidence.	Yes
2	Has written policies for applying the criteria based on individual needs.	Yes
3	Has written policies for applying the criteria based on an assessment of the local delivery system.	Yes
4	Involves appropriate practitioners in developing, adopting and reviewing criteria.	Yes
5	Annually reviews the UM criteria and the procedures for applying them, and updates the criteria when appropriate.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 4-5 factors	The organization meets 3 factors	The organization meets 0-2 factors

Data Sources	Documented process, Reports, Materials
Scope of Review	**Product lines** *This element applies to all product lines for Interim Surveys, First Surveys and Renewal Surveys.* **Documentation** *For Interim Surveys:* NCQA reviews the organization's policies and procedures for factors 1–5. *For First Surveys and Renewal Surveys:* NCQA reviews: • *For factors 1–3:* The organization's policies and procedures in place throughout the look-back period. • *For factor 4:* Three examples of meeting minutes or reports documenting the involvement of appropriate practitioners

throughout the look-back period, or all UM committee meeting minutes or reports if the organization has fewer than three.
- *For factor 5:* Most recent annual review and update (for *First Surveys*) or most recent and previous year's annual reviews and updates (for *Renewal Surveys*).

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

B - Availability of Criteria **NCQA**

Medicaid: Met

Medicaid

The organization:

		NCQA ANSWER
1	States in writing how practitioners can obtain UM criteria.	Yes
2	Makes the criteria available to its practitioners upon request.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data Sources	Documented process, Reports, Materials
Scope of Review	**Product lines** *This element applies to all product lines for Interim Surveys and First Surveys.* **Documentation** *For Interim Surveys:* NCQA reviews the organization's documented process for making criteria available. *For First Surveys:* NCQA reviews the organization's communication of the criteria availability to each practitioner at least once during the look-back period and that the criteria were made available upon request throughout the look-back period.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

C - Consistency in Applying Criteria — **NCQA Medicaid**: Met

Medicaid

At least annually, the organization:

		NCQA ANSWER
1	Evaluates the consistency with which health care professionals involved in UM apply criteria in decision making.	Yes
2	Acts on opportunities to improve consistency, if applicable.	NA

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data Sources	Documented process, Reports, Materials
Scope of Review	**Product lines** *This element applies to all product lines for First Surveys and Renewal Surveys.* **Documentation** NCQA reviews evaluation results or similar documentation, and evidence (e.g., minutes, policies, procedural updates) that the organization acted on opportunities.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	Factor 2 is NA as KHS has no opportunities to improve consistency since all licensed clinical reviewers have consistently demonstrated successful completion of their assigned IRR cases, meeting all required standards, with no need for remediation or further intervention, for both Quarters 3 and 4, 2024.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
Medicaid	Factor 2 is scored as NA as no opportunities were identified.	2

UM 3

Members and practitioners can access staff to discuss UM issues.

A - Access to Staff **NCQA**

Medicaid: Met

Medicaid

The organization provides the following communication services for members and practitioners:

		NCQA ANSWER
1	Staff are available at least 8 hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues.	Yes
2	Staff can receive inbound communication regarding UM issues after normal business hours.	Yes
3	Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues.	Yes
4	TDD/TTY services for members who need them.	Yes
5	Language assistance for members to discuss UM issues.	Yes

	NCQA ANSWER

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 4-5 factors	The organization meets 3 factors	The organization meets 0-2 factors

Data Sources	Documented process, Materials
Scope of Review	**Product lines** *This element applies to all product lines for Interim Surveys, First Surveys and Renewal Surveys.* **Documentation** *For factors 1–3:* NCQA reviews the organization's policies and procedures that are in place throughout the look-back period for providing communication services to members and practitioners. *For factors 4, 5:* NCQA reviews materials or other evidence that demonstrate services provided to members at least once during the look-back period.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

UM 4

UM decisions are made by qualified health professionals.

A - Licensed Health Professionals	**NCQA**
	Medicaid: Met

Medicaid

The organization has written procedures:

		NCQA ANSWER
1	Requiring appropriately licensed professionals to supervise all medical necessity decisions.	Yes
2	Specifying the type of personnel responsible for each level of UM decision making.	Yes

SCORING	**MET**	**PARTIALLY MET**	**NOT MET**
	The organization meets 2 factors	The organization meets 1 factor	The organization meet 0 factors

Data Sources	Documented process
Scope of Review	**Product lines** *For Interim Surveys and First Surveys, this element applies to all product lines.*

For Renewal Surveys, this element applies to the Medicaid product line only.

Documentation

NCQA reviews the organization's policies and procedures.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

B - Use of Practitioners for UM Decisions **NCQA**

Medicaid: Met

Medicaid

The organization has a written job description with qualifications for practitioners who review denials of care based on medical necessity. Practitioners are required to have:

1. Education, training or professional experience in medical or clinical practice.

2. A current clinical license to practice or an administrative license to review UM cases.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER	The description includes both factors for all appropriate practitioners

SCORING	MET	PARTIALLY MET	NOT MET
	The description includes 2 factors for all appropriate practitioners	The description includes 1 factor for all appropriate practitioners	The description includes 0 factors

Data Sources	Materials
Scope of Review	**Product lines** *For Interim Surveys and First Surveys, this element applies to all product lines.* *For Renewal Surveys, this element applies to the Medicaid product line only.* **Documentation** NCQA reviews the organization's practitioner job descriptions in place during the look-back period.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

C - Practitioner Review of Nonbehavioral Healthcare Denials	Must Pass Element	NCQA
		Medicaid: Met

Medicaid

The organization uses a physician or other health care professional, as appropriate, to review any nonbehavioral healthcare denial based on medical necessity.

During the onsite survey NCQA enters High, Medium, or Low based on the file review results. The organization may do so in its readiness evaluation. However, please mark this field "NA" for submission.

NCQA ANSWER High

SCORING	**MET**	**PARTIALLY MET**	**NOT MET**
	High (90-100%) on file review	Medium (60-89%) on file review	Low (0-59%) on file review

Data Sources	Records or files
Scope of Review	**Product lines** *This element applies to all product lines for First Surveys and Renewal Surveys.* NCQA reviews and scores this element for each product line brought forward for Accreditation; only the commercial and Exchange product line files may be combined. **Documentation** *For First Surveys and Renewal Surveys:* NCQA reviews a random sample of up to 40 nonbehavioral healthcare denial files resulting from medical necessity review for evidence that the files were reviewed by an appropriate practitioner.

ISSUES This element has no issues.

ORG SUBMISSION STATEMENT This element has no organization submission statement

NCQA SUPPORT This element has no additional NCQA support texts.

TEXT

D - Practitioner Review of Behavioral Healthcare Denials	Must Pass Element	NCQA Medicaid: NA

Medicaid

The organization uses a physician or appropriate behavioral healthcare practitioner, as appropriate, to review any behavioral healthcare denial of care based on medical necessity.

During the onsite survey NCQA enters High, Medium, or Low based on the file review results. The organization may do so in its readiness evaluation. However, please mark this field "NA" for submission.

NCQA ANSWER NA

SCORING	MET	PARTIALLY MET	NOT MET
	High (90-100%) on file review	Medium (60-89%) on file review	Low (0-59%) on file review

Data Sources	Records or files
Scope of Review	**Product lines** *This element applies to all product lines for First Surveys and Renewal Surveys.* NCQA reviews and scores this element for each product line brought forward for Accreditation; only the commercial and Exchange product line files may be combined. **Documentation**

For First Surveys and Renewal Surveys: NCQA reviews a random sample of up to 40 behavioral healthcare denial files resulting from medical necessity review for evidence that the files were reviewed by an appropriate practitioner.

ISSUES This element has no issues.

ORG SUBMISSION STATEMENT UM 4D is NA since we did not have any behavioral health files during the LBP.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
Medicaid	There were no BH denial files during the look-back period due to the behavioral health carveout. Therefore, this element is scored NA.	1

E - Practitioner Review of Pharmacy Denials **Must Pass Element** **NCQA**

Medicaid: Met

Medicaid

The organization uses a physician or a pharmacist to review pharmacy denials based on medical necessity.

During the onsite survey NCQA enters High, Medium, or Low based on the file review results. The organization may do so in its readiness evaluation. However, please mark this field "NA" for submission.

NCQA ANSWER High

SCORING

MET	PARTIALLY MET	NOT MET
High (90-100%) on file review	Medium (60-89%) on file review	Low (0-59%) on file review

Data Sources	Records or files
Scope of Review	**Product lines** *This element applies to all product lines for First Surveys and Renewal Surveys.* NCQA reviews and scores this element for each product line brought forward for Accreditation; only the commercial and Exchange product line files may be combined. **Documentation** *For First Surveys and Renewal Surveys:* NCQA reviews a random sample of up to 40 pharmaceutical denial files resulting from medical necessity review for evidence that the files were reviewed by an appropriate practitioner.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

F - Use of Board-Certified Consultants	Has Critical Factors	NCQA
		Medicaid: Met

Medicaid

The organization:

		NCQA ANSWER
1	Has written procedures for using board-certified consultants to assist in making medical necessity determinations.	Yes
2	Provides evidence that it uses board-certified consultants for medical necessity determinations.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 2 factors	The organization meets factor 2 only	The organization meets factor 1 only, or meets 0 factors

Data Sources	Documented process, Reports, Materials, Records or files
Scope of Review	**Product lines** *This element applies to all product lines for Interim Surveys, First Surveys and Renewal Surveys.* **Documentation** *For All Surveys:* For factor 1, NCQA reviews the organization's written policies and procedures for using internal and external board-certified consultants, and reviews the list of board-certified consultants. *For First Surveys and Renewal Surveys:* For factor 2, NCQA also reviews three cases showing the use of external board-certified consultants during the look-back period. If there are not three external cases, NCQA also reviews internal cases, for a total of three cases. If the organization does not use external board-certified consultants, NCQA reviews three internal cases.

ISSUES This element has no issues.

ORG SUBMISSION This element has no organization submission statement

STATEMENT

NCQA SUPPORT TEXT This element has no additional NCQA support texts.

UM 5

The organization makes UM decisions in a timely manner to minimize any disruption in the provision of health care.

A - Notification of Nonbehavioral Healthcare Decisions	Must Pass Element	NCQA
		Medicaid: Met

Medicaid

The organization adheres to the following time frames for notification of non-behavioral healthcare UM decisions:

1. For commercial and Exchange urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners within 24 hours of the request.

2. For Medicare and Medicaid urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request.

3. For urgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request.

4. For commercial and Exchange nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 15 calendar days of the request.

5. For Medicare and Medicaid nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 14 calendar days of the request.

6. For postservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 30 calendar days of the request.

During the onsite survey NCQA enters High, Medium, or Low based on the file review results. The organization may do so in its readiness evaluation. However, please mark this field "NA" for submission.

NCQA ANSWER High

SCORING	**MET**	**PARTIALLY MET**	**NOT MET**
	High (90-100%) on file review	Medium (60-89%) on file review	Low (0-59%) on file review

Data Sources	Records or files
Scope of Review	**Product lines** *This element applies to all product lines for First Surveys and Renewal Surveys.* NCQA reviews and scores this element for each product line brought forward for Accreditation; only the commercial and Exchange product line files may be combined. **Documentation** *For First Surveys and Renewal Surveys:* NCQA reviews a random sample of up to 40 nonbehavioral healthcare denial files resulting from medical necessity review for evidence of timeliness of notification.

ISSUES This element has no issues.

ORG SUBMISSION STATEMENT This element has no organization submission statement

NCQA SUPPORT This element has no additional NCQA support texts.

TEXT

B - Notification of Behavioral Healthcare Decisions	Must Pass Element	NCQA
		Medicaid: NA

Medicaid

The organization adheres to the following time frames for notification of behavioral healthcare UM decisions:

1. For commercial and Exchange urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners within 24 hours of the request.

2. For Medicare and Medicaid urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request.

3. For urgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request.

4. For commercial and Exchange nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 15 calendar days of the request.

5. For Medicare and Medicaid nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 14 calendar days of the request.

6. For postservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 30 calendar days of the request.

During the onsite survey NCQA enters High, Medium, or Low based on the file review results. The organization may do so in its readiness evaluation. However, please mark this field "NA" for submission.

NCQA ANSWER NA

SCORING	MET	PARTIALLY MET	NOT MET
	High (90-100%) on file review	Medium (60-89%) on file review	Low (0-59%) on file review

Data Sources	Records or files
Scope of Review	**Product lines** *This element applies to all product lines for First Surveys and Renewal Surveys.* NCQA reviews and scores this element for each product line brought forward for Accreditation; only the commercial and Exchange product line files may be combined. **Documentation** *For First Surveys and Renewal Surveys:* NCQA reviews a random sample of up to 40 behavioral healthcare denial files resulting from medical necessity review for evidence of timeliness of notification.

ISSUES

This element has no issues.

ORG SUBMISSION STATEMENT

UM 5B is NA since we did not have any behavioral health files during the LBP.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
Medicaid	There were no BH denial files during the look-back period due to the behavioral health carveout. Therefore, this element is scored NA.	1

C - Notification of Pharmacy Decisions **Must Pass Element** **NCQA**

Medicaid: Met

Medicaid

The organization adheres to the following time frames for notifying members and practitioners of pharmacy UM decisions:

1. For commercial and Exchange urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners within 24 hours of the request.

2. For Medicare Part B and Medicaid urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners within 24 hours of the request.

3. For commercial and Exchange urgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request.

4. For Medicare Part B and Medicaid urgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 24 hours of the request.

5. For commercial and Exchange nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 15 calendar days of the request.

6. For Medicare Part B nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request.

7. For Medicaid nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 24 hours of the request.

8. For postservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 30 calendar days of the request.

9. For Medicare Part D urgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 24 hours of receipt of the request.

10. For Medicare Part D nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of receipt of the request.

11. For Medicare Part D postservice decisions, the organization gives electronic or written notification of the decision to members and practitioners

within 14 calendar days of receipt of the request.

During the onsite survey NCQA enters High, Medium, or Low based on the file review results. The organization may do so in its readiness evaluation. However, please mark this field "NA" for submission.

NCQA ANSWER	High

SCORING	**MET**	**PARTIALLY MET**	**NOT MET**
	High (90-100%) on file review	Medium (60-89%) on file review	Low (0-59%) on file review

Data Sources	Records or files
Scope of Review	**Product lines** *This element applies to all product lines for First Surveys* and *Renewal Surveys*. NCQA reviews and scores this element for each product line brought forward for Accreditation; only the commercial and Exchange product line files may be combined. Factors 1–8 apply to commercial, Medicaid and Exchange product lines and Medicare Part B drugs. **Documentation** *For First Surveys and Renewal Surveys:* NCQA reviews a random sample of up to 40 pharmaceutical denial files resulting from medical necessity review for evidence of timeliness of notification.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT	This element has no additional NCQA support texts.

TEXT

D - UM Timeliness Report **NCQA** Met

The organization monitors and submits a report for timeliness of:

		NCQA ANSWER
1	Notification of nonbehavioral UM decisions.	Yes
2	Notification of behavioral UM decisions.	Yes
3	Notification of pharmacy UM decisions.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 2-3 factors	No scoring option.	The organization meets 0-1 factors

Data Sources	Reports
Scope of Review	**Product lines** *This element applies to all product lines for First Surveys* and *Renewal Surveys*. **Documentation** *For First Surveys and Renewal Surveys:* NCQA reviews the organization's timeliness reports.

ISSUES This element has no issues.

ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

UM 6

The organization uses all information relevant to a member's care when it makes coverage decisions.

A - Relevant Information for Nonbehavioral Healthcare Decisions **NCQA**

Medicaid: Met

Medicaid

There is documentation that the organization gathers relevant clinical information consistently to support nonbehavioral healthcare UM decision making.

During the onsite survey NCQA enters High, Medium, or Low based on the file review results. The organization may do so in its readiness evaluation. However, please mark this field "NA" for submission.

NCQA ANSWER High

SCORING

MET	PARTIALLY MET	NOT MET
High (90-100%) on file review	Medium (60-89%) on file review	Low (0-59%) on file review

Data Sources	Records or files
Scope of Review	**Product lines** *This element applies to all product lines for First Surveys and Renewal Surveys.* NCQA reviews and scores this element for each product line brought forward for Accreditation; only the commercial and Exchange product line files may be combined. **Documentation** *For First Surveys and Renewal Surveys:* NCQA reviews a random sample of up to 40 nonbehavioral healthcare denial files resulting from medical necessity review (as defined in UM 1, Element A) for evidence of using relevant clinical information to support UM decision making.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

B - Relevant Information for Behavioral Healthcare Decisions **NCQA**

Medicaid: NA

Medicaid

There is documentation that the organization gathers relevant clinical information consistently to support behavioral healthcare UM decision making.

During the onsite survey NCQA enters High, Medium, or Low based on the file review results. The organization may do so in its

readiness evaluation. However, please mark this field "NA" for submission.

NCQA ANSWER	NA

SCORING	**MET**	**PARTIALLY MET**	**NOT MET**
	High (90-100%) on file review	Medium (60-89%) on file review	Low (0-59%) on file review

Data Sources	Records or files
Scope of Review	**Product lines** *This element applies to all product lines for First Surveys and Renewal Surveys.* NCQA reviews and scores this element for each product line brought forward for Accreditation; only the commercial and Exchange product line files may be combined. **Documentation** *For First Surveys and Renewal Surveys:* NCQA reviews a random sample of up to 40 behavioral healthcare denial files resulting from medical necessity review (as defined in UM 1, Element A) for evidence of using relevant clinical information to support UM decision making.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
Medicaid	There were no BH denial files during the look-back period due to the behavioral health carveout. Therefore, this element is scored NA.	1

C - Relevant Information for Pharmacy Decisions **NCQA**

Medicaid: Met

Medicaid

The organization documents that it consistently gathers relevant information to support pharmacy UM decision making.

During the onsite survey NCQA enters High, Medium, or Low based on the file review results. The organization may do so in its readiness evaluation. However, please mark this field "NA" for submission.

NCQA ANSWER High

SCORING	MET	PARTIALLY MET	NOT MET
	High (90-100%) on file review	Medium (60-89%) on file review	Low (0-59%) on file review

Data Sources	Records or files
Scope of Review	**Product lines** *This element applies to all product lines for First Surveys and Renewal Surveys.* NCQA reviews and scores this element for each product line brought forward for Accreditation; only the commercial and Exchange

product line files may be combined.

Documentation

For First Surveys and Renewal Surveys: NCQA reviews a random sample of up to 40 pharmaceutical denial files resulting from medical necessity review (as defined in UM 1, Element A) for evidence of using relevant clinical information to support UM decision making.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

UM 7

Members and practitioners receive enough information to help them understand a decision to deny care or coverage and to decide whether to appeal the decision.

A - Discussing a Denial With a Nonbehavioral Healthcare Reviewer

NCQA

Medicaid: Met

Medicaid

The organization gives practitioners the opportunity to discuss nonbehavioral healthcare UM denial decisions with a physician or other appropriate reviewer.

During the onsite survey NCQA enters High, Medium, or Low based on the file review results. The organization may do so in its readiness evaluation. However, please mark this field "NA" for submission.

NCQA ANSWER High

SCORING	**MET**	**PARTIALLY MET**	**NOT MET**
	High (90-100%) on file review	Medium (60-89%) on file review	Low (0-59%) on file review

Data Sources	Records or files
Scope of Review	**Product lines** *This element applies to all product lines for First Surveys* and *Renewal Surveys*. NCQA reviews and scores this element for each product line brought forward for Accreditation; only the commercial and Exchange product line files may be combined. **Documentation** *For First Surveys and Renewal Surveys:* NCQA reviews a random sample of up to 40 nonbehavioral healthcare denial files resulting from medical necessity review for evidence that a practitioner has the opportunity to discuss a denial with a reviewer.

ISSUES This element has no issues.

ORG SUBMISSION STATEMENT This element has no organization submission statement

NCQA SUPPORT TEXT This element has no additional NCQA support texts.

B - Written Notification of Nonbehavioral Healthcare Denials	**Must Pass Element**	**NCQA**

Medicaid: Met

Medicaid

The organization's written notification of nonbehavioral healthcare denials, provided to members and their treating practitioners, contains the following information:

		NCQA ANSWER
1	The specific reasons for the denial, in easily understandable language.	High
2	A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based.	High
3	A statement that members can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request.	High

SCORING	MET	PARTIALLY MET	NOT MET
	High (90-100%) on file review for at least 2 factors and medium (60-89%) on file review for any remaining factor	High (90-100%) or medium (60-89%) on file review for 3 factors	Low (0-59%) on file review for any factor

Data Sources	Records or files
Scope of Review	**Product lines** *This element applies to all product lines for First Surveys* and *Renewal Surveys*.

NCQA reviews and scores this element for each product line brought forward for Accreditation; only the commercial and Exchange product line files may be combined.

Documentation

For First Surveys and Renewal Surveys: NCQA reviews a random sample of up to 40 nonbehavioral healthcare denial files resulting from medical necessity review for evidence that denial notices meet all three factors.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

C - Written Notification of Nonbehavioral Healthcare Appeal Rights/Process	**Must Pass Element**	**NCQA**
		Medicaid: Met

Medicaid

The organization's written nonbehavioral healthcare denial notification to members and their treating practitioners contains the following information:

		NCQA ANSWER
1	A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal.	High
2	An explanation of the appeal process, including members' rights to representation and appeal time frames.	High
3	A description of the expedited appeal process for urgent preservice or urgent concurrent denials.	High

		NCQA ANSWER
4	Notification that expedited external review can occur concurrently with the internal appeals process for urgent care.	NA

SCORING	MET	PARTIALLY MET	NOT MET
	High (90-100%) on file review for 3 factors and medium (60-89%) on file review for any remaining factor	High (90-100%) or medium (60-89%) on file review for 4 factors	Low (0-59%) on file review for any factor

Data Sources	Records or files
Scope of Review	**Product lines** *This element applies to all product lines for First Surveys* and *Renewal Surveys*. NCQA reviews and scores this element for each product line brought forward for Accreditation; only the commercial and Exchange product line files may be combined. **Documentation** *For First Surveys and Renewal Surveys:* NCQA reviews a random sample of up to 40 nonbehavioral healthcare denial files resulting from medical necessity review for evidence that denial notices meet all four factors.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
Medicaid	Factor 4 is NA for members covered by Medicaid.	4

D - Discussing a Behavioral Healthcare Denial With a Reviewer **NCQA**

Medicaid: NA

Medicaid

The organization provides practitioners with the opportunity to discuss any behavioral healthcare UM denial decision with a physician, appropriate behavioral healthcare reviewer or pharmacist reviewer.

During the onsite survey NCQA enters High, Medium, or Low based on the file review results. The organization may do so in its readiness evaluation. However, please mark this field "NA" for submission.

NCQA ANSWER NA

SCORING	MET	PARTIALLY MET	NOT MET
	High (90-100%) on file review	Medium (60-89%) on file review	Low (0-59%) on file review

Data Sources	Records or files
Scope of Review	**Product lines** *This element applies to all product lines for First Surveys* and *Renewal Surveys*. NCQA reviews and scores this element for each product line brought forward for Accreditation; only the commercial and Exchange

product line files may be combined.

Documentation

For First Surveys and Renewal Surveys: NCQA reviews a random sample of up to 40 behavioral healthcare denial files resulting from medical necessity review for evidence of opportunity for a practitioner to discuss a denial with a reviewer.

ISSUES This element has no issues.

ORG SUBMISSION STATEMENT This element has no organization submission statement

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
Medicaid	There were no BH denial files during the look-back period due to the behavioral health carveout. Therefore, this element is scored NA.	1

E - Written Notification of Behavioral Healthcare Denials **Must Pass Element** **NCQA**

Medicaid: NA

Medicaid

The organization's written notification of behavioral healthcare denials, that it provided to members and their treating practitioners, contains:

		NCQA ANSWER
1	The specific reasons for the denial, in easily understandable language.	NA
2	A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision was based.	NA

		NCQA ANSWER
3	A statement that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request.	NA

SCORING	MET	PARTIALLY MET	NOT MET
	High (90-100%) on file review for at least 2 factors and medium (60-89%) on file review for any remaining factor	High (90-100%) or medium (60-89%) on file review for 3 factors	Low (0-59%) on file review for any factor

Data Sources	Records or files
Scope of Review	**Product lines** *This element applies to all product lines for First Surveys and Renewal Surveys*. NCQA reviews and scores this element for each product line brought forward for Accreditation; only the commercial and Exchange product line files may be combined. **Documentation** *For First Surveys and Renewal Surveys:* NCQA reviews a random sample of up to 40 behavioral healthcare denial files resulting from medical necessity review for evidence that denial notices meet all three factors.

ISSUES This element has no issues.

ORG SUBMISSION STATEMENT

This element has no organization submission statement

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
Medicaid	There were no BH denial files during the look-back period due to the behavioral health carveout. Therefore, this element is scored NA.	1 2 3

F - Written Notification of Behavioral Healthcare Appeal Rights/Process | **Must Pass Element** | **NCQA Medicaid**: NA

Medicaid

The organization's written notification of behavioral healthcare denials, which it provides to members and their treating practitioners, contains the following information:

		NCQA ANSWER
1	A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal.	NA
2	An explanation of the appeal process, including members' right to representation and appeal time frames.	NA
3	A description of the expedited appeal process for urgent preservice or urgent concurrent denials.	NA
4	Notification that expedited external review can occur concurrently with the internal appeals process for urgent care.	NA

SCORING	MET	PARTIALLY MET	NOT MET
	High (90-100%) on file review for 3 factors and medium (60-89%) on file review for any remaining factor	High (90-100%) or medium (60-89%) on file review for 4 factors	Low (0-59%) on file review for any factor

Data Sources	Records or files
Scope of Review	**Product lines** *This element applies to all product lines for First Surveys* and *Renewal Surveys*. NCQA reviews and scores this element for each product line brought forward for Accreditation; only the commercial and Exchange product line files may be combined. **Documentation** *For First Surveys and Renewal Surveys:* NCQA reviews a random sample of up to 40 behavioral healthcare denial files resulting from medical necessity review for evidence that denial notices meet all four factors.

ISSUES

This element has no issues.

ORG SUBMISSION STATEMENT

This element has no organization submission statement

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
Medicaid	There were no BH denial files during the look-back period due to the behavioral health carveout. Therefore, this element is scored NA.	1 2 3 4

G - Discussing a Pharmacy Denial With a Reviewer **NCQA**

Medicaid: Met

Medicaid

The organization gives practitioners the opportunity to discuss pharmacy UM denial decisions with a physician or pharmacist.

During the onsite survey NCQA enters High, Medium, or Low based on the file review results. The organization may do so in its readiness evaluation. However, please mark this field "NA" for submission.

NCQA ANSWER High

SCORING	**MET**	**PARTIALLY MET**	**NOT MET**
	High (90-100%) on file review	Medium (60-89%) on file review	Low (0-59%) on file review

Data Sources	Records or files
Scope of Review	**Product lines** *This element applies to all product lines for First Surveys and Renewal Surveys.* NCQA reviews and scores this element for each product line brought forward for Accreditation; only the commercial and Exchange product line files may be combined. **Documentation** *For First Surveys and Renewal Surveys:* NCQA reviews a random sample of up to 40 pharmaceutical denial files resulting from medical necessity review for evidence of opportunity for a practitioner to discuss a denial with a reviewer.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

H - Written Notification of Pharmacy Denials **Must Pass Element** **NCQA**

Medicaid: Met

Medicaid

The organization's written notification of pharmacy denials to members and their treating practitioners contains the following information:

		NCQA ANSWER
1	The specific reasons for the denial, in language that is easy to understand.	High
2	A reference to the benefit provision, guideline, protocol or similar criterion on which the denial decision is based.	High
3	A statement that members can obtain a copy of the actual benefit provision, guideline, protocol or similar criterion on which the denial decision was based, upon request.	High

SCORING	MET	PARTIALLY MET	NOT MET
	High (90-100%) on file review for at least 2 factors and medium (60-89%) on file review for any remaining factor	High (90-100%) or medium (60-89%) on file review for 3 factors	Low (0-59%) on file review for any factor

Data Sources	Records or files
Scope of Review	**Product lines** *This element applies to all product lines for First Surveys* and *Renewal Surveys*. NCQA reviews and scores this element for each product line brought forward for Accreditation; only the commercial and Exchange product line files may be combined. **Documentation** *For First Surveys and Renewal Surveys:* NCQA reviews a random sample of up to 40 pharmaceutical denial files resulting from medical necessity review for evidence that denial notices meet all three factors.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

I - Written Notification of Pharmacy Appeal Rights/Process	**Must Pass Element**	**NCQA** **Medicaid**: Met

Medicaid

The organization’s written notification of pharmacy denials to members and their treating practitioners contains the following information:

		NCQA ANSWER
1	A description of appeal rights, including the member's right to submit written comments, documents or other information relevant to the appeal.	High
2	An explanation of the appeal process, including the member's right to representation and the appeal time frames.	High
3	A description of the expedited appeal process for urgent preservice or urgent concurrent denials.	High
4	Notification that expedited external review can occur concurrently with the internal appeal process for urgent care.	NA

SCORING	MET	PARTIALLY MET	NOT MET
	High (90-100%) on file review for 3 factors and medium (60-89%) on file review for any remaining factor	High (90-100%) or medium (60-89%) on file review for 4 factors	Low (0-59%) on file review for any factor

Data Sources	Records or files
Scope of Review	**Product lines** *This element applies to all product lines for First Surveys and Renewal Surveys.* NCQA reviews and scores this element for each product line brought forward for Accreditation; only the commercial and Exchange product line files may be combined. **Documentation** *For First Surveys and Renewal Surveys:* NCQA reviews a random sample of up to 40 pharmaceutical denial files resulting from medical necessity review for evidence that denial notices meet all four factors.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
Medicaid	Factor 4 is NA for members covered by Medicaid.	4

UM 8

There is an established, impartial process for resolving members' disputes and responding to member requests to reconsider a decision they find unacceptable regarding their care and service.

A - Internal Appeals — **NCQA**

Medicaid: Met

Medicaid

The organization's written policies and procedures for registering and responding to written internal appeals include the following:

		NCQA ANSWER
1	For commercial and Exchange, allowing at least 180 calendar days after notification of the denial for the member to file an appeal.	NA
2	For Medicare and Medicaid, allowing at least 60 calendar days after notification of the denial for the member to	Yes

		NCQA ANSWER
	file an appeal.	
3	Documenting the substance of the appeal and any actions taken.	Yes
4	Full investigation of the substance of the appeal, including any aspects of clinical care involved.	Yes
5	The opportunity for the member to submit written comments, documents or other information relating to the appeal.	Yes
6	Appointment of a new person to review an appeal who was not involved in the initial determination and who is not the subordinate of any person involved in the initial determination.	Yes
7	Appointment of at least one person to review an appeal who is a practitioner in the same or a similar specialty.	Yes
8	The decision for a preservice appeal and notification to the member within 30 calendar days of receipt of the request.	No
9	The commercial, Exchange and Medicare decision for a postservice appeal and notification to the member within 60 calendar days of receipt of the request.	NA
10	For Medicaid, the decision for a postservice appeal and notification to the member within 30 calendar days of receipt of the request.	No
11	The decision for an expedited appeal and notification to the member within 72 hours of receipt of the request.	Yes
12	Notification to the member about further appeal rights.	Yes
13	Referencing the benefit provision, guideline, protocol or other similar criterion on which the appeal decision is based.	Yes
14	Giving members reasonable access to and copies of all documents relevant to the appeal, free of charge, upon	Yes

		NCQA ANSWER
	request.	
15	Including a list of titles and qualifications, including specialties, of individuals participating in the appeal review.	No
16	Allowing an authorized representative to act on behalf of the member.	Yes
17	Providing notices of the appeals process to members in a culturally and linguistically appropriate manner.	Yes
18	Continued coverage pending the outcome of an appeal.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 14-18 factors	The organization meets 9-13 factors	The organization meets 0-8 factors

Data Sources	Documented process
Scope of Review	**Product lines** *For Interim Surveys and First Surveys, this element applies to all product lines.* *For Renewal Surveys, this element applies to the Medicaid product line only.* **Documentation** *For Interim Surveys, First Surveys and Renewal Surveys:* NCQA reviews the organization's policies and procedures.

ISSUES		
	Type	OTHER
	Lines	Medicaid

Statement	The organization confirmed that factor 15 should be scored not met.
Contest Element Findings	No
Organization Comments	
Organization Statement	KHS confirms that factor 15 was intentionally marked as Not Met.
NCQA Support Text	The organization confirmed that factor 15 should be scored not met.
NCQA Response Post Final Report	
Factor - Result	15 - Not met
Type	ID
Lines	Medicaid
Statement	The organization confirmed that factors 8 and 10 should be scored not met.
Contest Element Findings	No
Organization Comments	
Organization Statement	KHS concurs with the surveyors findings. Factor 8 & 10 are Not Met.
NCQA Support Text	The organization confirmed that factors 8 and 10 should be scored not met.
NCQA Response Post Final Report	
Factor - Result	8 - Not met 10 - Not met

ORG SUBMISSION STATEMENT

Factors 1 and 9 are NA since we are a Medicaid line of business and those factors apply to commercial and exchange. We are not currently meeting factor 15, but we have plans to resolve this before the reaccreditation survey.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
Medicaid	Factors 1 and 9 are NA for Medicaid product lines.	1 9

UM 9

The organization has a full and fair process for resolving member disputes and responding to members' requests to reconsider a decision they find unacceptable regarding their care and service.

A - Preservice and Postservice Appeals	NCQA
	Medicaid: Met

Medicaid

An NCQA review of the organization's appeal files indicates that they contain the following information:

		NCQA ANSWER
1	Documentation of the substance of appeals.	High
2	Investigation of appeals.	High
3	Appropriate response to the substance of appeals.	High

SCORING	MET	PARTIALLY MET	NOT MET
	High (90-100%) on file review for at least 2 factors and medium (60-89%) on file review for any remaining factor	High (90-100%) or medium (60-89%) on file review for 3 factors	Low (0-59%) on file review for any factor

Data Sources	Records or files
Scope of	**Product lines**

Review

This element applies to all product lines for First Surveys and *Renewal Surveys*.

NCQA reviews and scores this element for each product line brought forward for Accreditation; only the commercial and Exchange product line files may be combined.

Documentation

For First Surveys and Renewal Surveys: NCQA reviews a random sample of up to 40 upheld appeal files for evidence the appeal file contains all three factors.

Appeal files include appeals of any denial of a request for coverage, whether or not the denial resulted from medical necessity review (e.g., medical, behavioral health, pharmacy or personal care services). This includes all medical necessity and benefit decision appeals.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

B - Timeliness of the Appeal Process	**Must Pass Element**	**NCQA**
		Medicaid: Met

Medicaid

The organization adheres to the following time frames for notification of preservice, postservice and expedited appeal decisions.

1. For preservice appeals, the organization gives electronic or written notification within 30 calendar days of receipt of the request.

2. For commercial, Exchange and Medicare postservice appeals, the organization gives electronic or written notification within 60 calendar days of receipt of the request.

3. For Medicaid postservice appeals, the organization gives electronic or written notification within 30 calendar days of the request.

4. For expedited appeals, the organization gives electronic or written notification within 72 hours of receipt of the request.

During the onsite survey NCQA enters High, Medium, or Low based on the file review results. The organization may do so in its readiness evaluation. However, please mark this field "NA" for submission.

NCQA ANSWER High

SCORING	**MET**	**PARTIALLY MET**	**NOT MET**
	High (90-100%) on file review	Medium (60-89%) on file review	Low (0-59%) on file review

Data Sources	Records or files
Scope of Review	**Product lines** *This element applies to all product lines for First Surveys* and *Renewal Surveys*. NCQA reviews and scores this element for each product line brought forward for Accreditation; only the commercial and Exchange product line files may be combined. **Documentation** *For First Surveys and Renewal Surveys:* NCQA reviews a random sample of up to 40 upheld appeal files for evidence of timeliness of decision making. Appeal files include appeals of any denial of a request for coverage, whether or not the denial resulted from medical necessity review (e.g., medical, behavioral health, pharmacy or personal care services). This includes all medical necessity and benefit decision appeals.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

C - Appeal Reviewers **NCQA**

Medicaid: Met

Medicaid

The organization provides nonsubordinate reviewers who were not involved in the previous determination and same-or-similar-specialist review, as appropriate.

During the onsite survey NCQA enters High, Medium, or Low based on the file review results. The organization may do so in its readiness evaluation. However, please mark this field "NA" for submission.

NCQA ANSWER High

SCORING	**MET**	**PARTIALLY MET**	**NOT MET**
	High (90-100%) on file review	Medium (60-89%) on file review	Low (0-59%) on file review

Data Sources	Records or files
Scope of Review	**Product lines** *This element applies to all product lines for First Surveys* and *Renewal Surveys*.

NCQA reviews and scores this element for each product line brought forward for Accreditation; only the commercial and Exchange product line files may be combined.

Documentation

For First Surveys and Renewal Surveys: NCQA reviews a random sample of up to 40 upheld appeal files for evidence of involvement of nonsubordinate and same-or-similar specialist reviewers.

Appeal files include appeals of any denial of a request for coverage, whether or not the denial resulted from medical necessity review (e.g., medical, behavioral health, pharmacy or personal care services). This includes all medical necessity and benefit decision appeals.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

D - Notification of Appeal Decision/Rights	**Must Pass Element**	**NCQA**
		Medicaid: Met

Medicaid

An NCQA review of the organization's internal appeal files indicates notification to members of the following:

		NCQA ANSWER
1	Specific reasons for the appeal decision, in easily understandable language.	High
2	A reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was	High

		NCQA ANSWER
	based.	
3	Notification that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based, upon request.	High
4	Notification that the member is entitled to receive reasonable access to and copies of all documents, free of charge, upon request.	High
5	A list of titles and qualifications, including specialties, of individuals participating in the appeal review.	High
6	A description of the next level of appeal, either within the organization or to an independent external organization, as applicable, along with any relevant written procedures.	High

SCORING	MET	PARTIALLY MET	NOT MET
	High (90-100%) on file review for at least 4 factors and medium (60-89%) on file review for any remaining factors	High (90-100%) or medium (60-89%) on file review for 6 factors	Low (0-59%) on file review for any factor

Data Sources	Records or files
Scope of Review	**Product lines** *This element applies to all product lines for First Surveys* and *Renewal Surveys*. NCQA reviews and scores this element for each product line brought forward for Accreditation; only the commercial and Exchange product line files may be combined. **Documentation**

For First Surveys and Renewal Surveys: NCQA reviews a random sample of up to 40 upheld appeal files for evidence that appeal notices meet all 6 factors.

Appeal files include appeals of any denial of a request for coverage, whether or not the denial resulted from medical necessity review (e.g., medical, behavioral health, pharmacy or personal care services). This includes all medical necessity and benefit decision appeals.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

E - Final Internal and External Appeal Files **NCQA** NA

NOT APPLICABLE

In an NCQA review of denials overturned by the IRO or of the organization's final internal denials, the files contained the following:

		NCQA ANSWER
1	Member notification of independent appeal rights.	NA
2	Member notification about obtaining more information regarding independent appeal rights.	NA
3	A statement that members are not required to bear costs of the IRO, including any filing fees.	NA

NOT APPLICABLE

In an NCQA review of denials overturned by the IRO or of the organization's final internal denials, the files contained the following:

		NCQA ANSWER
1	Member notification of independent appeal rights.	NA
2	Member notification about obtaining more information regarding independent appeal rights.	NA
3	A statement that members are not required to bear costs of the IRO, including any filing fees.	NA

NOT APPLICABLE

In an NCQA review of denials overturned by the IRO or of the organization's final internal denials, the files contained the following:

		NCQA ANSWER
1	Member notification of independent appeal rights.	NA
2	Member notification about obtaining more information regarding independent appeal rights.	NA
3	A statement that members are not required to bear costs of the IRO, including any filing fees.	NA

NOT APPLICABLE

In an NCQA review of denials overturned by the IRO or of the organization's final internal denials, the files contained the following:

		NCQA ANSWER
1	Member notification of independent appeal rights.	NA
2	Member notification about obtaining more information regarding independent appeal rights.	NA
3	A statement that members are not required to bear costs of the IRO, including any filing fees.	NA

NOT APPLICABLE

In an NCQA review of denials overturned by the IRO or of the organization's final internal denials, the files contained the following:

		NCQA ANSWER
1	Member notification of independent appeal rights.	NA
2	Member notification about obtaining more information regarding independent appeal rights.	NA
3	A statement that members are not required to bear costs of the IRO, including any filing fees.	NA

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 2-3 factors	The organization meets 1 factor	The organization meets 0 factors

Data Sources	Records or files
Scope of	**Product lines**

Review

This element applies to commercial and Exchange product lines for First Surveys and *Renewal Surveys*.

Documentation

For First Surveys and Renewal Surveys: NCQA reviews five of the most recently overturned appeals by the IRO, or reviews five final internal denials, if no appeals were overturned by the IRO. If there are fewer than five files, NCQA reviews all files.

NCQA scores this element for each file. The score for the element is the average of the scores for all files.

This file review is independent of the appeal file review performed for UM 9, Elements A–D.

ISSUES

This element has no issues.

ORG SUBMISSION STATEMENT

This element applies to commercial and Exchange product lines for First Surveys and Renewal Surveys.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
NOT APPLICABLE	This element is NA for appeals by members covered by Medicaid.	1 2 3

F - Appeals Overturned by the IRO **NCQA** **NA**

NOT APPLICABLE

In an NCQA review of the organization's files of appeals overturned by the IRO, there is evidence that the organization implemented the IRO's decision in all cases reviewed.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

In an NCQA review of the organization's files of appeals overturned by the IRO, there is evidence that the organization implemented the IRO's decision in all cases reviewed.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

In an NCQA review of the organization's files of appeals overturned by the IRO, there is evidence that the organization implemented the IRO's decision in all cases reviewed.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

In an NCQA review of the organization's files of appeals overturned by the IRO, there is evidence that the organization implemented the IRO's decision in all cases reviewed.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

In an NCQA review of the organization's files of appeals overturned by the IRO, there is evidence that the organization implemented the IRO's decision in all cases reviewed.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER	NA

SCORING	**MET**	**PARTIALLY MET**	**NOT MET**
	The organization meets the requirement	No scoring option.	The organization does not meet the requirement

Data Sources	Records or files
Scope of Review	**Product lines** *This element applies to commercial and Exchange product lines for First Surveys* and *Renewal Surveys*. **Documentation** *For First Surveys and Renewal Surveys:* NCQA reviews five of the most recently overturned appeals by the IRO, or reviews five final internal denials, if no appeals were overturned by the IRO. If there are fewer than five files, NCQA reviews all files. NCQA scores this element for each file. The score for the element is the average of the scores for all files. This file review is independent of the appeal file review performed for UM 9, Elements A–D.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element applies to commercial and Exchange product lines for First Surveys and Renewal Surveys.

NCQA SUPPORT TEXT

LINES	**STATEMENT**	**FACTOR**
NOT APPLICABLE	This element is NA for appeals by members covered by Medicaid.	1

UM 10

The organization has a formal mechanism to evaluate and address new developments in technology and new applications of existing technology for inclusion in its benefits plan to keep pace with changes and to ensure that members have equitable access to safe and effective care.

A - Written Process **NCQA**

Medicaid: NA

Medicaid

The organization's written process for evaluating new technology and the new application of existing technology for inclusion in its benefits plan includes an evaluation of the following:

		NCQA ANSWER
1	Medical procedures.	NA
2	Behavioral healthcare procedures.	NA
3	Pharmaceuticals.	NA
4	Devices.	NA

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data Sources	Documented process
Scope of Review	**Product lines** *This element applies to all product lines for Interim Surveys, First Surveys and Renewal Surveys.* **Documentation** *For Interim Surveys, First Surveys and Renewal Surveys:* NCQA reviews the organization's policies and procedures in place throughout the look-back period.

ISSUES

This element has no issues.

ORG SUBMISSION STATEMENT

UM 10A is NA because the State mandates all benefits and new technology determinations.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
Medicaid	The organization scored NA because the state designates new technology and new applications of existing technology.	1 2 3 4

B - Description of the Evaluation Process **NCQA**

Medicaid: NA

Medicaid

The organization's written evaluation process includes the following:

		NCQA ANSWER
1	The process and decision variables the organization uses to make determinations.	NA
2	A review of information from appropriate government regulatory bodies.	NA
3	A review of information from published scientific evidence.	NA
4	A process for seeking input from relevant specialists and professionals who have expertise in the technology.	NA

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data Sources	Documented process
Scope of Review	**Product lines** *This element applies to all product lines for Interim Surveys, First Surveys and Renewal Surveys.* **Documentation** *For Interim Surveys, First Surveys and Renewal Surveys:* NCQA reviews the organization's policies and procedures in place throughout the look-back period.

ISSUES This element has no issues.

ORG SUBMISSION STATEMENT

UM 10B is NA because the State mandates all benefits and new technology determinations.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
Medicaid	The organization scored NA because the state designates new technology and new applications of existing technology.	1 2 3 4

UM 11

The organization develops, regularly reviews and updates policies and procedures for pharmaceutical management based on sound clinical evidence.

A - Pharmaceutical Management Procedures

NCQA

Medicaid: Met

Medicaid

The organization's policies and procedures for pharmaceutical management include the following:

		NCQA ANSWER
1	The criteria used to adopt pharmaceutical management procedures.	Yes
2	A process to use clinical evidence from appropriate external organizations.	Yes

		NCQA ANSWER
3	A process to include pharmacists and appropriate practitioners in the development of procedures.	Yes
4	A process to provide procedures to practitioners annually and when it makes changes.	NA

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data Sources	Documented process
Scope of Review	**Product lines** *This element applies to all product lines for Interim Surveys, First Surveys and Renewal Surveys.* **Documentation** *For Interim Surveys, First Surveys and Renewal Surveys:* NCQA reviews the organization's policies and procedures in place throughout the look-back period.

ISSUES

This element has no issues.

ORG SUBMISSION STATEMENT

Factor 4 is NA due to pharmacy carveout. The documented we uploaded has the NCQA-Medi-CalRX-Crosswalk that explains the elements that are affected by the carveout. The document states that UM 11A Factor 4 is NA.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
Medicaid	The organization is scored as NA for factor 4 per the pharmacy carve out.	4

B - Pharmaceutical Restrictions/Preferences

NCQA

Medicaid: Met

Medicaid

Annually and after updates, the organization communicates to members and prescribing practitioners:

		NCQA ANSWER
1	A list of pharmaceuticals, including restrictions and preferences.	Yes
2	How to use the pharmaceutical management procedures.	Yes
3	An explanation of limits or quotas.	NA
4	How prescribing practitioners must provide information to support an exception request.	NA
5	The organization's process for generic substitution, therapeutic interchange and step-therapy protocols.	NA

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 4-5 factors	The organization meets 3 factors	The organization meets 0-2 factors

Data Sources	Documented process, Reports, Materials
Scope of	**Product lines**

Review

This element applies to all product lines for Interim Surveys, First Surveys and Renewal Surveys.

Documentation

NCQA reviews the organization's pharmaceutical procedures and lists.

For First Surveys and Renewal Surveys, NCQA also reviews materials distributed to members and prescribing practitioners. The organization may also provide reports to show evidence of distribution to members and practitioners.

ISSUES

This element has no issues.

ORG SUBMISSION STATEMENT

Factors 3, 4, and 5 are NA due to pharmacy carveout. The documented we uploaded has the NCQA-Medi-CalRX-Crosswalk that explains the elements that are affected by the carveout. The document states that UM 11B Factors 3, 4, and 5 are NA. The Crosswalk also directs for us to include the UM 2 evidence with the documentation for UM 11B. We have updated the bookmarks and annotations to say UM 11B, but please note that some of these are the same as the ones in the UM 2 documents.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
Medicaid	The organization is scored as NA for factors 3, 4 and 5 per the pharmacy carve out.	3 4 5

C - Pharmaceutical Patient Safety Issues **NCQA**

Medicaid: Met

Medicaid

The organization's pharmaceutical procedures include:

		NCQA ANSWER
1	Identifying and notifying members and prescribing practitioners affected by a Class II recall or voluntary drug withdrawals from the market for safety reasons within 30 calendar days of the FDA notification.	Yes
2	An expedited process for prompt identification and notification of members and prescribing practitioners affected by a Class I recall.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data Sources	Documented process, Materials
Scope of Review	**Product lines** *This element applies to all product lines for Interim Surveys, First Surveys and Renewal Surveys.* **Documentation** NCQA reviews the organization's policies and procedures in place throughout the look-back period. *For First Surveys and Renewal Surveys:* NCQA also reviews three communications to members and three communications to prescribing practitioners, as applicable, or reviews all communications if the organization has fewer than three each for members and prescribing practitioners.

ISSUES This element has no issues.

ORG SUBMISSION Please note: During the look back period, there were no recalls applicable as defined in Appendix A.

STATEMENT

NCQA SUPPORT TEXT This element has no additional NCQA support texts.

D - Reviewing and Updating Procedures **NCQA Medicaid**: Met

Medicaid

With the participation of physicians and pharmacists, the organization annually:

		NCQA ANSWER
1	Reviews the procedures.	Yes
2	Reviews the list of pharmaceuticals.	Yes
3	Updates the procedures as appropriate.	Yes
4	Updates the list of pharmaceuticals as appropriate.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data Sources	Documented process, Reports, Materials

Scope of Review	**Product lines** *This element applies to all product lines for Interim Surveys, First Surveys and Renewal Surveys.* **Documentation** NCQA reviews the organization's policies and procedures. *For First Surveys and Renewal Surveys:* NCQA also reviews pharmaceutical management committee minutes or similar documentation, and updates to the pharmaceutical procedures, if applicable.
ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	In January 2019, a new law was passed requiring the Medi-Cal pharmacy benefits and services to be administered by the Department of Health Care Services in the fee-for-service delivery system, known as “Medi-Cal Rx.” With the exception of physician administered drugs covered under the medical benefit, pharmacy is carved-out to DHCS. The plan has no covered outpatient drugs as stated by SSA 1927(k)(3). This is described in the DHCS APL 22-012, specifically in the Appendix A. Knowing that PAD and similar drugs covered under the medical benefit are generally limited to a prior authorization list and perhaps a plan preference of generics and biosimilars, the criteria for coverage and how it is communicated follows the medical UM processes. The Physician’s Advisory Committee (PAC) is the primary governing body as there is no P&T and formulary as those functions are carved out to Medi-Cal Rx.
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

E - Considering Exceptions	**Has Critical Factors**	**NCQA**
		Medicaid: NA

Medicaid

The organization has exceptions policies and procedures that describe the process for:

		NCQA ANSWER
1	Making an exception request based on medical necessity.	NA
2	Obtaining medical necessity information from prescribing practitioners.	NA
3	Using appropriate pharmacists and practitioners to consider exception requests.	NA
4	Timely handling of exception requests.	NA
5	Communicating the reason for a denial and an explanation of the appeal process when it does not approve an exception request.	NA

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 4-5 factors	The organization meets 3 factors	The organization meets 0-2 factors

Data Sources	Documented process
Scope of Review	**Product lines** *This element applies to all product lines for Interim Surveys, First Surveys and Renewal Surveys.* **Documentation** NCQA reviews the organization's policies and procedures in place throughout the look-back period.

ISSUES This element has no issues.

ORG SUBMISSION This element is NA for Medi-Cal health plans because they are not responsible for administering a closed formulary for

STATEMENT members.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
Medicaid	The organization scored NA because the plan does not handle exception policies.	1 2 3 4 5

UM 12

The organization develops policies and procedures to monitor compliance of system controls specific to UM denial and appeal notification and receipt dates.

A - UM Denial System Controls **Must Pass Element** **NCQA**

Medicaid: Met

Medicaid

The organization has policies and procedures describing its system controls specific to UM denial notification dates that:

		NCQA ANSWER
1	Define the date of receipt consistent with NCQA requirements.	Yes
2	Define the date of written notification consistent with NCQA requirements.	Yes

		NCQA ANSWER
3	Describe the process for recording dates in systems.	Yes
4	Specify titles or roles of staff who are authorized to modify dates once initially recorded and circumstances when modification is appropriate.	Yes
5	Specify how the system tracks modified dates.	Yes
6	Describe system security controls in place to protect data from unauthorized modification.	Yes
7	Describe how the organization monitors its compliance with the policies and procedures in factors 1–6 at least annually and takes appropriate action, when applicable.	NA

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 7 factors	No scoring option.	The organization meets 0-6 factors

Data Sources	Documented process
Scope of Review	**Product lines** *This element applies to all product lines for Interim Surveys, First Surveys and Renewal Surveys.* **Documentation** NCQA reviews the organization's policies and procedures for its UM denial system security controls. *Factors 1–5* apply to receipt and notification dates, covered in UM 5. *Factor 6* applies to all UM system data for managing denials (not only the dates specified in factors 1–5), covered in UM 4–

UM 7.

Factor 7 requires a monitoring process that covers compliance with all policies and procedures described in factors 1–6.

The organization must have policies and procedures for all factors regardless of the system functionality.

ISSUES

This element has no issues.

ORG SUBMISSION STATEMENT

Factor 7 is NA according to an email received from the NCQA Policy Accreditation Team entitled: Changes to the NCQA Accreditation Standards for the 2024 and 2025 Standards Years.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
Medicaid	Factor 7 is NA based on changes to the NCQA Accreditation Standards for the 2024 and 2025 Standards Years.	7

B - UM Denial System Controls Oversight

NCQA

Medicaid: Met

Medicaid

At least annually, the organization demonstrates that it monitors compliance with its UM denial controls, as described in Element A, factor 7, by:

		NCQA ANSWER
1	Identifying all modifications to receipt and decision notification dates that did not meet the organization's policies and procedures for date modifications.	Yes
2	Analyzing all instances of date modifications that did not meet the organization's policies and procedures for date modifications.	Yes

		NCQA ANSWER
3	Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three consecutive quarters.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 3 factors	No scoring option.	The organization meets 0-2 factors

Data Sources	Reports
Scope of Review	**Product lines** *This element applies to all product lines for First Surveys and Renewal Surveys.* **Documentation** *For First and Renewal Surveys,* NCQA reviews the organization's analysis report, and reviews evidence that the organization identified, analyzed and acted on modifications to receipt and notification dates *(UM 5: Timeliness of UM Decisions)* that did not meet its policies and procedures. This element is scored Met if the organization provides evidence, in lieu of monitoring and analysis reports, of advanced system control capabilities that automatically record dates and prevent changes that do not meet the organization's policies and procedures for date modifications; the system must have both capabilities. *See Examples* below.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement

NCQA SUPPORT TEXT This element has no additional NCQA support texts.

C - UM Appeal System Controls	Must Pass Element	NCQA Medicaid: Met

Medicaid

The organization has policies and procedures describing its system controls specific to UM appeal dates that:

		NCQA ANSWER
1	Define the date of receipt consistent with NCQA requirements.	Yes
2	Define the date of written notification consistent with NCQA requirements.	Yes
3	Describe the process for recording dates in systems.	Yes
4	Specify titles or roles of staff who are authorized to modify dates once initially recorded and circumstances when modification is appropriate.	Yes
5	Specify how the system tracks modified dates.	Yes
6	Describe system security controls in place to protect data from unauthorized modification.	Yes
7	Describe how the organization monitors its compliance with the policies and procedures in factors 1–6 at least annually and takes appropriate action, when applicable.	NA

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 7 factors	No scoring option.	The organization meets 0-6 factors

Data Sources	Documented process
Scope of Review	**Product lines** *This element applies to all product lines for Interim Surveys, First Surveys and Renewal Surveys.* **Documentation** NCQA reviews the organization's policies and procedures for its UM appeal system security controls. *Factors 1–5* apply to receipt and notification dates, covered in UM 8–UM 9. *Factor 6* applies to all UM system data for managing appeals (not only the dates specified in factors 1–5), covered in UM 8–UM 9. *Factor 7* requires a monitoring process that covers compliance with all policies and procedures described in factors 1–6. The organization must have policies and procedures for all factors regardless of the system functionality.

ISSUES

This element has no issues.

ORG SUBMISSION STATEMENT

Factor 7 is NA according to an email received from the NCQA Policy Accreditation Team entitled: Changes to the NCQA Accreditation Standards for the 2024 and 2025 Standards Years.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
Medicaid	Factor 7 is NA based on changes to the NCQA Accreditation Standards for the 2024 and 2025 Standards Years.	7

D - UM Appeal System Controls Oversight **NCQA**

Medicaid: Met

Medicaid

At least annually, the organization demonstrates that it monitors compliance with its UM appeal controls, as described in Element C, factor 7, by:

		NCQA ANSWER
1	Identifying all modifications to receipt and decision notification dates that did not meet the organization's policies and procedures for date modifications.	Yes
2	Analyzing all instances of date modifications that did not meet the organization's policies and procedures for date modifications.	Yes
3	Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three consecutive quarters.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 3 factors	No scoring option.	The organization meets 0-2 factors

Data Sources	Reports
Scope of Review	**Product lines** *This element applies to all product lines for First Surveys and Renewal Surveys.*

Documentation

For First and Renewal Surveys: NCQA reviews the organization's analysis report, and reviews evidence that the organization identified, analyzed and acted on modifications to receipt and notification dates (*UM 8: Policies for Appeals* and *UM 9: Appropriate Handling of Appeals*) that did not meet its policies and procedures.

This element is scored Met if the organization provides evidence, in lieu of monitoring and analysis reports, of advanced system control capabilities that automatically record dates and prevent changes that do not meet the organization's policies and procedures for date modifications; the system must have both capabilities. *See Examples* below.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

UM 13

The organization remains responsible for and has appropriate structures and mechanisms to oversee delegated UM activities.

A - Delegation Agreement **NCQA** Met

AllMed Healthcare Management, LLC

The written delegation agreement:

		NCQA ANSWER
1	Is mutually agreed upon.	Yes
2	Describes the delegated activities and the responsibilities of the organization and the delegated entity.	Yes
3	Requires at least semiannual reporting by the delegated entity to the organization.	Yes
4	Describes the process by which the organization evaluates the delegated entity's performance.	Yes
5	Describes the process for providing member experience and clinical performance data to its delegates when requested.	No
6	Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.	Yes

NOT APPLICABLE

The written delegation agreement:

		NCQA ANSWER
1	Is mutually agreed upon.	NA
2	Describes the delegated activities and the responsibilities of the organization and the delegated entity.	NA
3	Requires at least semiannual reporting by the delegated entity to the organization.	NA
4	Describes the process by which the organization evaluates the delegated entity's performance.	NA
5	Describes the process for providing member experience and clinical performance data to its delegates when	NA

		NCQA ANSWER
	requested.	
6	Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.	NA

NOT APPLICABLE

The written delegation agreement:

		NCQA ANSWER
1	Is mutually agreed upon.	NA
2	Describes the delegated activities and the responsibilities of the organization and the delegated entity.	NA
3	Requires at least semiannual reporting by the delegated entity to the organization.	NA
4	Describes the process by which the organization evaluates the delegated entity's performance.	NA
5	Describes the process for providing member experience and clinical performance data to its delegates when requested.	NA
6	Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.	NA

NOT APPLICABLE

The written delegation agreement:

		NCQA ANSWER
1	Is mutually agreed upon.	NA
2	Describes the delegated activities and the responsibilities of the organization and the delegated entity.	NA
3	Requires at least semiannual reporting by the delegated entity to the organization.	NA
4	Describes the process by which the organization evaluates the delegated entity's performance.	NA
5	Describes the process for providing member experience and clinical performance data to its delegates when requested.	NA
6	Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.	NA

NOT APPLICABLE

The written delegation agreement:

		NCQA ANSWER
1	Is mutually agreed upon.	NA
2	Describes the delegated activities and the responsibilities of the organization and the delegated entity.	NA
3	Requires at least semiannual reporting by the delegated entity to the organization.	NA
4	Describes the process by which the organization evaluates the delegated entity's performance.	NA

		NCQA ANSWER
5	Describes the process for providing member experience and clinical performance data to its delegates when requested.	NA
6	Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.	NA

NOT APPLICABLE

The written delegation agreement:

		NCQA ANSWER
1	Is mutually agreed upon.	NA
2	Describes the delegated activities and the responsibilities of the organization and the delegated entity.	NA
3	Requires at least semiannual reporting by the delegated entity to the organization.	NA
4	Describes the process by which the organization evaluates the delegated entity's performance.	NA
5	Describes the process for providing member experience and clinical performance data to its delegates when requested.	NA
6	Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.	NA

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 5-6 factors	The organization meets 3-4 factors	The organization meets 0-2 factors

Data Sources	Documented process, Materials
Scope of Review	**Product lines** *This element applies to all product lines for Interim Surveys, First Surveys and Renewal Surveys.* **Documentation** NCQA reviews delegation agreements in effect during the look-back period from up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four. All delegation agreements must address the delegate's UM denial and appeal system security controls as noted in the Explanation for all factors. See the *Related information* on boilerplate language for delegation agreements for system controls. *For factor 5:* Delegation agreements implemented on or after January 1, 2019, must include a description of the process required in the factor. For delegation agreements in place prior to January 1, 2019, the organization may provide documentation that it notified the delegate of the process required in factor 5. This documentation of notification is not required to be mutually agreed upon. The score for the element is the average of the scores for all delegates.

ISSUES		
	Type	DOC
	Lines	AllMed Healthcare Management, LLC
	Statement	The organization confirmed that factor 5 should be scored not met.
	Contest Element Findings	No
	Organization Comments	

Organization Statement	KHS confirms that factor 5 was intentionally marked as Not Met.
NCQA Support Text	The organization confirmed that factor 5 should be scored not met.
NCQA Response Post Final Report	
Factor - Result	5 - Not met

ORG SUBMISSION STATEMENT	We do not believe that the AllMed contract currently meets Factor 5, but we have plans to address this so that it will meet Factor 5 for the renewal survey.
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

B - Predelegation Evaluation **NCQA** **NA**

AllMed Healthcare Management, LLC

For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

SCORING	MET	PARTIALLY MET	NOT MET
	The organization evaluated delegate capacity before delegation began	The organization evaluated delegate capacity after delegation began	The organization did not evaluate delegate capacity

Data Sources	Reports
Scope of Review	**Product lines** *This element applies to all product lines for Interim Surveys, First Surveys and Renewal Surveys.* *This element applies if delegation was implemented in the look-back period.* **Documentation** NCQA reviews the organization's predelegation evaluation from up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four. The score for the element is the average of the scores for all delegates.

ISSUES

This element has no issues.

ORG SUBMISSION STATEMENT

According to the guidelines for UM 13A, this element is NA if Delegation arrangements have been in effect for longer than the look-back period. Our contract with AllMed Healthcare Management, LLC started on 8/19/2024 which is before the LBP started.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
AllMed Healthcare Management, LLC	The organization scored NA as the delegation agreement has been in effect longer than the look-back period.	1

C - Review of the UM Program NCQA NA

AllMed Healthcare Management, LLC

For arrangements in effect for 12 months or longer, the organization:

		NCQA ANSWER
1	Annually reviews its delegate's UM program.	NA
2	Annually audits UM denials and appeals files against NCQA standards for each year that delegation has been in effect.	NA
3	Annually evaluates delegate performance against NCQA standards for delegated activities.	NA
4	Semiannually evaluates regular reports, as specified in Element A.	NA
5	At least annually, the organization monitors the delegate’s UM denial and appeal system security controls to ensure that the delegate monitors its compliance with the delegation agreement or with the delegate’s policies and procedures.	NA
6	At least annually, the organization acts on all findings from factor 5 for each delegate and implements a quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters.	NA

NOT APPLICABLE

For arrangements in effect for 12 months or longer, the organization:

		NCQA ANSWER
1	Annually reviews its delegate's UM program.	NA
2	Annually audits UM denials and appeals files against NCQA standards for each year that delegation has been in effect.	NA
3	Annually evaluates delegate performance against NCQA standards for delegated activities.	NA
4	Semiannually evaluates regular reports, as specified in Element A.	NA
5	At least annually, the organization monitors the delegate’s UM denial and appeal system security controls to ensure that the delegate monitors its compliance with the delegation agreement or with the delegate’s policies and procedures.	NA
6	At least annually, the organization acts on all findings from factor 5 for each delegate and implements a quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters.	NA

NOT APPLICABLE

For arrangements in effect for 12 months or longer, the organization:

		NCQA ANSWER
1	Annually reviews its delegate's UM program.	NA
2	Annually audits UM denials and appeals files against NCQA standards for each year that delegation has been in effect.	NA
3	Annually evaluates delegate performance against NCQA standards for delegated activities.	NA

		NCQA ANSWER
4	Semiannually evaluates regular reports, as specified in Element A.	NA
5	At least annually, the organization monitors the delegate’s UM denial and appeal system security controls to ensure that the delegate monitors its compliance with the delegation agreement or with the delegate’s policies and procedures.	NA
6	At least annually, the organization acts on all findings from factor 5 for each delegate and implements a quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters.	NA

NOT APPLICABLE

For arrangements in effect for 12 months or longer, the organization:

		NCQA ANSWER
1	Annually reviews its delegate's UM program.	NA
2	Annually audits UM denials and appeals files against NCQA standards for each year that delegation has been in effect.	NA
3	Annually evaluates delegate performance against NCQA standards for delegated activities.	NA
4	Semiannually evaluates regular reports, as specified in Element A.	NA
5	At least annually, the organization monitors the delegate’s UM denial and appeal system security controls to ensure that the delegate monitors its compliance with the delegation agreement or with the delegate’s policies and procedures.	NA
6	At least annually, the organization acts on all findings from factor 5 for each delegate and implements a quarterly	NA

monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters.

NOT APPLICABLE

For arrangements in effect for 12 months or longer, the organization:

		NCQA ANSWER
1	Annually reviews its delegate's UM program.	NA
2	Annually audits UM denials and appeals files against NCQA standards for each year that delegation has been in effect.	NA
3	Annually evaluates delegate performance against NCQA standards for delegated activities.	NA
4	Semiannually evaluates regular reports, as specified in Element A.	NA
5	At least annually, the organization monitors the delegate’s UM denial and appeal system security controls to ensure that the delegate monitors its compliance with the delegation agreement or with the delegate’s policies and procedures.	NA
6	At least annually, the organization acts on all findings from factor 5 for each delegate and implements a quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters.	NA

NOT APPLICABLE

For arrangements in effect for 12 months or longer, the organization:

		NCQA ANSWER
1	Annually reviews its delegate's UM program.	NA
2	Annually audits UM denials and appeals files against NCQA standards for each year that delegation has been in effect.	NA
3	Annually evaluates delegate performance against NCQA standards for delegated activities.	NA
4	Semiannually evaluates regular reports, as specified in Element A.	NA
5	At least annually, the organization monitors the delegate’s UM denial and appeal system security controls to ensure that the delegate monitors its compliance with the delegation agreement or with the delegate’s policies and procedures.	NA
6	At least annually, the organization acts on all findings from factor 5 for each delegate and implements a quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters.	NA

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 5-6 factors	The organization meets 3-4 factors	The organization meets 0-2 factors

Data Sources	Reports
Scope of Review	**Product lines** *Factor 1 applies to Interim Surveys for all product lines.* *All factors in this element apply to First Surveys and Renewal Surveys for all product lines.*

Documentation

NCQA reviews evidence of the organization's review from up to four randomly selected delegates, or all delegates if the organization has fewer than four.

For All Surveys: NCQA reviews the organization's evaluation of the delegate's UM program (factor 1).

For First Surveys: NCQA also reviews the organization's most recent annual review, audit, performance evaluation and semiannual evaluation.

For Renewal Surveys: NCQA also reviews the organization's most recent and the previous year's annual reviews, audits, performance evaluations and four semiannual evaluations.

For First Surveys and Renewal Surveys:

- *For factor 5:* NCQA also reviews the organization's documentation and the delegate's documentation as evidence for monitoring for system controls.
- *For factor 6*: NCQA also reviews the organization's documentation for taking action (or plans to take action) and for implementation of its quarterly monitoring process, as applicable.

The score for the element is the average of the scores for all delegates.

ISSUES

This element has no issues.

ORG SUBMISSION STATEMENT

According to the guidelines for UM 13 C, this element is NA if delegation arrangements have been in effect for less than 12 months. Our contract with AllMed Healthcare Management, LLC started on 8/19/2024.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
AllMed Healthcare Management, LLC	The organization scored NA as the delegation agreement was in effect for less than 12 months.	1 2 3 4 5 6

NCQA SUPPORT TEXT	LINES	STATEMENT	FACTOR

D - Opportunities for Improvement NCQA NA

AllMed Healthcare Management, LLC

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years the organization identified and followed up on opportunities for improvement, if applicable.

Select the choice that most closely reflects the organization's performance

NCQA ANSWER NA

NOT APPLICABLE

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years the organization identified and followed up on opportunities for improvement, if applicable.

Select the choice that most closely reflects the organization's performance

NCQA ANSWER NA

NOT APPLICABLE

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years the organization identified and followed up on opportunities for improvement, if applicable.

Select the choice that most closely reflects the organization's performance

NCQA ANSWER NA

NOT APPLICABLE

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years the organization identified and followed up on opportunities for improvement, if applicable.

Select the choice that most closely reflects the organization's performance

NCQA ANSWER NA

NOT APPLICABLE

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years the organization identified and followed up on opportunities for improvement, if applicable.

Select the choice that most closely reflects the organization's performance

NCQA ANSWER NA

NOT APPLICABLE

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years the organization identified and followed up on opportunities for improvement, if applicable.

Select the choice that most closely reflects the organization's performance

NCQA ANSWER NA

SCORING	MET	PARTIALLY MET	NOT MET
	The organization has acted on identified problems, if any, at least once in each of the past 2 years that the delegation arrangement has been in effect.	The organization took inappropriate or weak action, or acted only in the past year	The organization has not acted on identified problems

Data Sources	Documented process, Reports, Materials
Scope of Review	**Product lines** *This element applies to all product lines for First Surveys and Renewal Surveys.* **Documentation** *For First Surveys and Renewal Surveys:* NCQA reviews reports for opportunities for improvement from up to four randomly selected delegates, or from all delegates, if the organization has fewer than four, and for evidence that the organization took appropriate action to resolve issues. *For First Surveys:* NCQA reviews the organization's most recent annual review and follow-up on improvement opportunities. *For Renewal Surveys:* NCQA reviews the organization's most recent and previous year's annual reviews and follow-up on improvement opportunities. The score for the element is the average of the scores for all delegates.

ISSUES

This element has no issues.

ORG SUBMISSION STATEMENT

According to the guidelines for UM 13D, this element is NA if delegation arrangements have been in effect for less than 12 months. Our contract with AllMed Healthcare Management, LLC started on 8/19/2024.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
AllMed Healthcare Management, LLC	The organization scored NA as the agreement has been in effect for less than 12 months.	1

CR 1

The organization has a rigorous process to select and evaluate practitioners.

A - Practitioner Credentialing Guidelines — **NCQA**

Medicaid: Met

Medicaid

The organization specifies:

		NCQA ANSWER
1	The types of practitioners it credentials and recredentials.	Yes
2	The verification sources it uses.	Yes
3	The criteria for credentialing and recredentialing.	Yes
4	The process for making credentialing and recredentialing decisions.	Yes
5	The process for managing credentialing files that meet the organization's established criteria.	Yes
6	The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner.	Yes
7	The process for notifying practitioners if information obtained during the organization's credentialing process varies substantially from the information they provided to the organization.	Yes
8	The process for notifying practitioners of the credentialing and recredentialing decision within 60 calendar days of the credentialing committee's decision.	Yes
9	The medical director or other designated physician's direct responsibility and participation in the credentialing	Yes

		NCQA ANSWER
	program.	
10	The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law.	Yes
11	The process for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, board certification and specialty.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 9-11 factors	The organization meets 5-8 factors	The organization meets 0-4 factors

Data Sources	Documented process
Scope of Review	**Product lines** *For Interim Surveys and First Surveys, this element applies to all product lines.* *For Renewal Surveys, this element applies to the Medicaid product line only.* **Documentation** NCQA reviews the organization's policies and procedures in effect throughout the look-back period.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement

NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

B - Practitioner Rights **NCQA Medicaid**: Met

Medicaid

The organization notifies practitioners about their right to:

		NCQA ANSWER
1	Review information submitted to support their credentialing application.	Yes
2	Correct erroneous information.	Yes
3	Receive the status of their credentialing or recredentialing application, upon request.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 2-3 factors	No scoring option.	The organization meets 0-1 factors

Data Sources	Documented process, Materials
Scope of Review	**Product lines** *For Interim Surveys and First Surveys, this element applies to all product lines.*

For Renewal Surveys, this element applies to the Medicaid product line only.

Documentation

NCQA reviews the organization's policies and procedures for all three factors.

For First Surveys and Renewal Surveys: NCQA also reviews three materials sent to practitioners throughout the look-back period, or reviews all materials if the organization has fewer than three.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

C - Credentialing System Controls	**Must Pass Element**	**NCQA**
		Medicaid: Met

Medicaid

The organization's credentialing process describes:

		NCQA ANSWER
1	How primary source verification information is received, dated and stored.	Yes
2	How modified information is tracked and dated from its initial verification.	Yes
3	Titles or roles of staff who are authorized to review, modify and delete information, and circumstances when modification or deletion is appropriate.	Yes

		NCQA ANSWER
4	The security controls in place to protect the information from unauthorized modification.	Yes
5	How the organization monitors its compliance with the policies and procedures in factors 1–4 at least annually and takes appropriate action when applicable.	NA

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 5 factors	No scoring option.	The organization meets 0-4 factors

Data Sources	Documented process
Scope of Review	**Product lines** *This element applies to Interim Surveys, First Surveys and Renewal Surveys for all product lines.* **Documentation** NCQA reviews the organization's policies and procedures for its credentialing system security controls. *Factor 1* applies to verification source information from credentialing and recredentialing cycles, covered in CR 3, Elements A–C. *Factor 2* applies to modified credentialing verification information from initial credentialing and recredentialing cycles, covered in CR 3, Elements A–C. *Factors 3, 4* apply to all information associated with credentialing/recredentialing of practitioners, covered in CR 2–CR 5. *Factor 5* requires a monitoring process that covers compliance with all policies and procedures described in factors 1–4. The organization must have policies and procedures for all factors regardless of system functionality.

ISSUES This element has no issues.

ORG SUBMISSION STATEMENT Factor 5 is NA according to an email received from the NCQA Policy Accreditation Team entitled: Changes to the NCQA Accreditation Standards for the 2024 and 2025 Standards Years.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
Medicaid	Factor 5 is NA based on changes to the NCQA Accreditation Standards for the 2024 and 2025 Standards Years.	5

D - Credentialing System Controls Oversight **NCQA**

Medicaid: Met

Medicaid

At least annually, the organization demonstrates that it monitors compliance with its credentialing controls, as described in Element C, factor 5, by:

		NCQA ANSWER
1	Identifying all modifications to credentialing and recredentialing information that did not meet the organization's policies and procedures for modifications.	Yes
2	Analyzing all instances of modifications that did not meet the organization's policies and procedures for modifications.	NA
3	Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three consecutive quarters.	NA

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 3 factors	No scoring option.	The organization meets 0-2 factors

Data Sources	Reports
Scope of Review	**Product lines** *This element applies to all product lines for First Surveys and Renewal Surveys.* **Documentation** *For First and Renewal Surveys:* NCQA reviews the organization's analysis report, and reviews evidence that the organization identified, analyzed and acted only on modifications to credentialing/recredentialing information (CR 2–CR 5) that did not meet its policies and procedures. This element is scored Met if the organization provides evidence, in lieu of monitoring and analysis reports, of advanced system control capabilities that automatically record dates and prevent changes that do not meet the organization's policies and procedures for modifications; the system must have both capabilities. *See Examples* below.

ISSUES

This element has no issues.

ORG SUBMISSION STATEMENT

Factors 2 and 3 NA because the report showed no instances of modifications that did not meet KHS's policies and procedures.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
Medicaid	Factors 2 and 3 are NA because the organization did not identify any modifications that do not meet the organization's policies and procedures.	2 3

CR 2

The organization obtains meaningful advice and expertise from participating practitioners when it makes credentialing decisions.

A - Credentialing Committee **NCQA**

Medicaid: Met

Medicaid

The organization's Credentialing Committee:

		NCQA ANSWER
1	Uses participating practitioners to provide advice and expertise for credentialing decisions.	Yes
2	Reviews credentials for practitioners who do not meet established thresholds.	Yes
3	Ensures that files that meet established criteria are reviewed and approved by a medical director, designated physician or the Credentialing Committee.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 2-3 factors	No scoring option.	The organization meets 0-1 factors

Data	Documented process, Reports

Sources

Scope of Review

Product lines

This element applies to Interim Surveys, First Surveys and Renewal Surveys for all product lines.

Documentation

For Interim Surveys: NCQA reviews Credentialing Committee minutes from three different meetings, or reviews the Credentialing Committee charter, and reviews a timeline for operationalizing the committee, if the committee has not met. If the required meeting minutes are not available for review, NCQA reviews the meeting minutes that are available within the look-back period.

For First Surveys and Renewal Surveys: NCQA reviews Credentialing Committee meeting minutes from three different meetings within the look-back period. If the required meeting minutes are not available for review, NCQA reviews the meeting minutes that are available from within the look-back period.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

CR 3

The organization conducts timely verification of information to ensure that practitioners have the legal authority and relevant training and experience to provide quality care.

A - Verification of Credentials	**Must Pass Element**	**NCQA**
		Medicaid: Met

Medicaid

The organization verifies that the following are within the prescribed time limits:

		NCQA ANSWER
1	A current and valid license to practice.	High
2	A valid DEA or CDS certificate, if applicable.	High
3	Education and training as specified in the explanation.	High
4	Board certification status, if applicable.	High
5	Work history.	High
6	A history of professional liability claims that resulted in settlement or judgment paid on behalf of the practitioner.	High

SCORING	MET	PARTIALLY MET	NOT MET
	High (90-100%) on file review for at least 4 factors and medium (60-89%) on file review for any remaining factors	High (90-100%) or medium (60-89%) on file review for 6 factors	Low (0-59%) on file review for any factor

Data Sources	Records or files
Scope of	**Product lines**

Review

This element applies to First Surveys and Renewal Surveys for all product lines.

Documentation

NCQA reviews verification of credentials within a random sample of up to 40 initial credentialing files and up to 40 recredentialing files for practitioners that were due for recredentialing during the look-back period.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

B - Sanction Information **Must Pass Element** **NCQA**

Medicaid: Met

Medicaid

The organization verifies the following sanction information for credentialing:

		NCQA ANSWER
1	State sanctions, restrictions on licensure and limitations on scope of practice.	High
2	Medicare and Medicaid sanctions.	High

SCORING	MET	PARTIALLY MET	NOT MET
	High (90-100%) on file review for at least 1 factor and medium (60-89%) on file review for any remaining factor	Medium (60-89%) on file review for 2 factors	Low (0-59%) on file review for any factor

Data Sources	Records or files
Scope of Review	**Product lines** *This element applies to First Surveys and Renewal Surveys for all product lines.* **Documentation** NCQA reviews verification of sanctions information within a random sample of up to 40 initial credentialing files and up to 40 recredentialing files for practitioners that were due for recredentialing during the look-back period.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

C - Credentialing Application	Must Pass Element	NCQA
		Medicaid: Met

Medicaid

Applications for credentialing include the following:

		NCQA ANSWER
1	Reasons for inability to perform the essential functions of the position.	High
2	Lack of present illegal drug use.	High
3	History of loss of license and felony convictions.	High
4	History of loss or limitation of privileges or disciplinary actions.	High
5	Current malpractice insurance coverage.	High
6	Current and signed attestation confirming the correctness and completeness of the application.	High

SCORING	MET	PARTIALLY MET	NOT MET
	High (90-100%) on file review for at least 4 factors and medium (60-89%) on file review for any remaining factors	High (90-100%) or medium (60-89%) on file review for 6 factors	Low (0-59%) on file review for any factor

Data Sources	Records or files
Scope of Review	**Product lines** *This element applies to First Surveys and Renewal Surveys for all product lines.* **Documentation** NCQA reviews application and attestation within a random sample of up to 40 initial credentialing files and up to 40 recredentialing

files for practitioners that were due for recredentialing during the look-back period.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

CR 5

The organization identifies and, when appropriate, acts on important quality and safety issues in a timely manner during the interval between formal credentialing.

A - Ongoing Monitoring and Interventions

NCQA Medicaid: Met

Medicaid

The organization implements ongoing monitoring and makes appropriate interventions by:

		NCQA ANSWER
1	Collecting and reviewing Medicare and Medicaid sanctions.	Yes
2	Collecting and reviewing sanctions and limitations on licensure.	Yes

		NCQA ANSWER
3	Collecting and reviewing complaints.	Yes
4	Collecting and reviewing information from identified adverse events.	Yes
5	Implementing appropriate interventions when it identifies instances of poor quality related to factors 1–4.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 4-5 factors	The organization meets 3 factors	The organization meets 0-2 factors

Data Sources	Documented process, Reports, Materials, Records or files
Scope of Review	**Product lines** *This element applies to First Surveys and Renewal Surveys for all product lines.* **Documentation** NCQA reviews the organization's policies and procedures, monitoring reports and documentation of interventions throughout the look-back period.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

CR 6

The organization uses objective evidence and patient-care considerations when deciding on a course of action for dealing with a practitioner who does not meet its quality standards.

A - Actions Against Practitioners

NCQA

Medicaid: Met

Medicaid

The organization has policies and procedures for:

		NCQA ANSWER
1	The range of actions available to the organization.	Yes
2	Making the appeal process known to practitioners.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data Sources	Documented process
Scope of Review	**Product lines**

This element applies to Interim Surveys and First Surveys for all product lines.

Documentation

NCQA reviews the organization's policies and procedures.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

CR 7

The organization evaluates the quality of providers with which it contracts.

A - Review and Approval of Provider **NCQA**

Medicaid: Met

Medicaid

The organization's policy for assessing a health care delivery provider specifies that before it contracts with a provider, and for at least every 36 months thereafter, it:

		NCQA ANSWER
1	Confirms that the provider is in good standing with state and federal regulatory bodies.	Yes
2	Confirms that the provider has been reviewed and approved by an accrediting body.	Yes
3	Conducts an onsite quality assessment if the provider is not accredited.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 2-3 factors	The organization meets 1 factor	The organization meets 0 factors

Data Sources	Documented process
Scope of Review	**Product lines** *This element applies to Interim Surveys and First Surveys for all product lines.* **Documentation** NCQA reviews the organization's policies and procedures in place throughout the look-back period.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

B - Medical Providers	Has Critical Factors	NCQA

Medicaid: Met

Medicaid

The organization includes at least the following medical providers in its assessment:

		NCQA ANSWER
1	Hospitals.	Yes
2	Home health agencies.	Yes
3	Skilled nursing facilities.	Yes
4	Free-standing surgical centers.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data Sources	Documented process
Scope of Review	**Product lines** *This element applies to Interim Surveys and First Surveys for all product lines.* **Documentation** NCQA reviews an organization's policies and procedures in place throughout the look-back period.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

C - Behavioral Healthcare Providers **NCQA**

Medicaid: NA

Medicaid

The organization includes behavioral health care facilities providing mental health or substance abuse services in the following settings:

		NCQA ANSWER
1	Inpatient.	NA
2	Residential.	NA
3	Ambulatory.	NA

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 3 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data Sources	Documented process
Scope of Review	**Product lines** *This element applies to Interim Surveys and First Surveys for all product lines.* **Documentation** NCQA reviews the organization's policies and procedures in place throughout the look-back period.

ISSUES This element has no issues.

ORG SUBMISSION STATEMENT This element is NA because it is not a covered benefit. These services are carved out and covered by the county mental health plan.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
Medicaid	This element is NA because it is not a covered benefit. These services are carved out and covered by the county mental health plan.	1 2 3

D - Assessing Medical Providers **NCQA**

Medicaid: Met

Medicaid

The organization assesses contracted medical health care providers against the requirements and within the time frame in Element A.

NCQA ANSWER The organization meets the requirement

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets the requirement	No scoring option.	The organization does not meet the requirement

Data Sources	Reports, Records or files
Scope of Review	**Product lines** *This element applies to First Surveys and Renewal Surveys for all product lines.* **Documentation** NCQA reviews evidence that the organization assessed the providers in Element B. The organization provides documentation of a tracking mechanism(s) (checklist or spreadsheet); a separate tracking mechanism or report is not required for each provider.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

E - Assessing Behavioral Healthcare Providers **NCQA**

Medicaid: NA

Medicaid

The organization assesses contracted behavioral healthcare providers against the requirements and within the time frame in Element A.

NCQA ANSWER NA

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets the requirement	No scoring option.	The organization does not meet the requirement

Data Sources	Reports, Records or files
Scope of Review	**Product lines** *This element applies to First Surveys and Renewal Surveys for all product lines.* **Documentation** NCQA reviews evidence that the organization assessed the providers in Element C. The organization provides documentation of a tracking mechanism(s) (checklist or spreadsheet); a separate tracking mechanism or report is not required for each provider.

ISSUES This element has no issues.

ORG SUBMISSION STATEMENT This element is NA because it is not a covered benefit. These services are carved out and covered by the county mental health plan.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
Medicaid	This element is NA because it is not a covered benefit. These services are carved out and covered by the county mental health plan.	1

CR 8

The organization remains responsible for credentialing and recredentialing its practitioners, even if it delegates all or part of these activities.

A - Delegation Agreement **NCQA** Met

Children's Hospital Los Angeles Medical Group

The written delegation agreement:

		NCQA ANSWER
1	Is mutually agreed upon.	Yes
2	Describes the delegated activities and the responsibilities of the organization and the delegated entity.	Yes
3	Requires at least semiannual reporting by the delegated entity to the organization.	Yes
4	Describes the process by which the organization evaluates the delegated entity's performance.	Yes
5	Specifies that the organization retains the right to approve, suspend and terminate individual practitioners, providers and sites, even if the organization delegates decision making.	Yes
6	Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.	Yes

UCLA Medical Group

The written delegation agreement:

		NCQA ANSWER
1	Is mutually agreed upon.	Yes
2	Describes the delegated activities and the responsibilities of the organization and the delegated entity.	Yes
3	Requires at least semiannual reporting by the delegated entity to the organization.	Yes
4	Describes the process by which the organization evaluates the delegated entity's performance.	No
5	Specifies that the organization retains the right to approve, suspend and terminate individual practitioners, providers and sites, even if the organization delegates decision making.	Yes
6	Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.	Yes

USC Care Medical Group Inc

The written delegation agreement:

		NCQA ANSWER
1	Is mutually agreed upon.	Yes
2	Describes the delegated activities and the responsibilities of the organization and the delegated entity.	Yes
3	Requires at least semiannual reporting by the delegated entity to the organization.	Yes
4	Describes the process by which the organization evaluates the delegated entity's performance.	No
5	Specifies that the organization retains the right to approve, suspend and terminate individual practitioners,	Yes

		NCQA ANSWER
	providers and sites, even if the organization delegates decision making.	
6	Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.	Yes

VSP Vision Care

The written delegation agreement:

		NCQA ANSWER
1	Is mutually agreed upon.	Yes
2	Describes the delegated activities and the responsibilities of the organization and the delegated entity.	Yes
3	Requires at least semiannual reporting by the delegated entity to the organization.	Yes
4	Describes the process by which the organization evaluates the delegated entity's performance.	Yes
5	Specifies that the organization retains the right to approve, suspend and terminate individual practitioners, providers and sites, even if the organization delegates decision making.	Yes
6	Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.	Yes

NOT APPLICABLE

The written delegation agreement:

		NCQA ANSWER
1	Is mutually agreed upon.	NA
2	Describes the delegated activities and the responsibilities of the organization and the delegated entity.	NA
3	Requires at least semiannual reporting by the delegated entity to the organization.	NA
4	Describes the process by which the organization evaluates the delegated entity's performance.	NA
5	Specifies that the organization retains the right to approve, suspend and terminate individual practitioners, providers and sites, even if the organization delegates decision making.	NA
6	Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.	NA

NOT APPLICABLE

The written delegation agreement:

		NCQA ANSWER
1	Is mutually agreed upon.	NA
2	Describes the delegated activities and the responsibilities of the organization and the delegated entity.	NA
3	Requires at least semiannual reporting by the delegated entity to the organization.	NA
4	Describes the process by which the organization evaluates the delegated entity's performance.	NA

		NCQA ANSWER
5	Specifies that the organization retains the right to approve, suspend and terminate individual practitioners, providers and sites, even if the organization delegates decision making.	NA
6	Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.	NA

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 5-6 factors	The organization meets 3-4 factors	The organization meets 0-2 factors

Data Sources	Materials
Scope of Review	**Product lines** *This element applies to Interim Surveys, First Surveys and Renewal Surveys for all product lines.* **Documentation** NCQA reviews delegation agreements in effect during the look-back period from up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four. All delegation agreements must address the delegate's credentialing system controls as noted in the Explanation for all factors. See the *Related information* on boilerplate language for delegation agreements for system controls. The score for the element is the average of the scores for all delegates.

ISSUES	**Type**	DOC
	Lines	UCLA Medical Group, USC Care Medical Group Inc
	Statement	Factor 4 is now met for CHLA and VSP. No further documentation was provided for UCLA Medical Group and USC Care Medical Group Inc.; therefore, factor 4 is not met for these two delegates.
	Contest Element Findings	No
	Organization Comments	
	Organization Statement	We have uploaded the CHLA and VSP agreements which include descriptions of the process by which KHS monitors the delegate's credentialing system security controls.
	NCQA Support Text	Factor 4 is now met for CHLA and VSP. No further documentation was provided for UCLA Medical Group and USC Care Medical Group Inc.; therefore, factor 4 is not met for these two delegates.
	NCQA Response Post Final Report	
	Factor - Result	4 - Not met
	Type	ID
	Lines	Children's Hospital Los Angeles Medical Group, USC Care Medical Group Inc
	Statement	Please clarify why the delegation agreement for USC Care Medical Group Inc and Children's Hospital Los Angeles Medical Group do not refer to the delegate by its name, instead, "GROUP" is mentioned throughout the entire agreement.
	Contest Element Findings	No
	Organization Comments	
	Organization Statement	We have uploaded the correct version of the CHLA which was executed during the LBP and specifies that Children's Hospital Los Angeles Medical Group will be referred to as "GROUP" throughout the document.
	NCQA Support Text	
	NCQA Response Post Final Report	
	Factor - Result	1 - Met-Score Yes
ORG SUBMISSION	This element has no organization submission statement	

STATEMENT

NCQA SUPPORT TEXT This element has no additional NCQA support texts.

B - Predelegation Evaluation **NCQA** **NA**

Children's Hospital Los Angeles Medical Group

For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

UCLA Medical Group

For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

USC Care Medical Group Inc

For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

VSP Vision Care

For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

SCORING	MET	PARTIALLY MET	NOT MET
	The organization evaluated delegate capacity before delegation began	The organization evaluated delegate capacity after delegation began	The organization did not evaluate delegate capacity

Data Sources	Reports
Scope of Review	**Product lines** *This element applies to Interim Surveys, First Surveys and Renewal Surveys for all product lines.* *This element applies if delegation was implemented in the look-back period.* **Documentation** NCQA reviews the organization's predelegation evaluation from up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four. The score for the element is the average of the scores for all delegates.

ISSUES	**Type**	NARS
	Lines	Children's Hospital Los Angeles Medical Group, UCLA Medical Group, USC Care Medical Group Inc, VSP Vision Care
	Statement	The organization has confirmed this element is NA because all four delegation arrangements have been in effect for longer than the look-back period.
	Contest Element Findings	No
	Organization Comments	
	Organization Statement	CR-8B is NA because all delegation agreements have been in effect for longer than the LBP.
	NCQA Support Text	The organization has confirmed this element is NA because all four delegation arrangements have been in effect for longer than the look-back period.
	NCQA Response Post Final Report	
	Factor - Result	1 - Met-Score NA

ORG SUBMISSION STATEMENT	CR 8B is NA because KHS does not have any predelegation for CR.

NCQA SUPPORT TEXT This element has no additional NCQA support texts.

C - Review of Delegate's Credentialing Activities **NCQA** Met

Children's Hospital Los Angeles Medical Group

For delegation arrangements in effect for 12 months or longer, the organization:

		NCQA ANSWER
1	Annually reviews its delegate’s credentialing policies and procedures.	Yes
2	Annually audits credentialing and recredentialing files against NCQA standards for each year that delegation has been in effect.	Yes
3	Annually evaluates delegate performance against NCQA standards for delegated activities.	Yes
4	Semiannually evaluates regular reports, as specified in Element A.	Yes
5	At least annually, the organization monitors the delegate’s credentialing system security controls to ensure that the delegate monitors its compliance with the delegation agreement or with the delegate’s policies and procedures.	Yes
6	At least annually, the organization acts on all findings from factor 5 for each delegate and implements a quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters.	NA

UCLA Medical Group

For delegation arrangements in effect for 12 months or longer, the organization:

		NCQA ANSWER
1	Annually reviews its delegate’s credentialing policies and procedures.	Yes
2	Annually audits credentialing and recredentialing files against NCQA standards for each year that delegation has been in effect.	Yes (AC)
3	Annually evaluates delegate performance against NCQA standards for delegated activities.	Yes (AC)
4	Semiannually evaluates regular reports, as specified in Element A.	Yes
5	At least annually, the organization monitors the delegate’s credentialing system security controls to ensure that the delegate monitors its compliance with the delegation agreement or with the delegate’s policies and procedures.	Yes (AC)
6	At least annually, the organization acts on all findings from factor 5 for each delegate and implements a quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters.	Yes (AC)

USC Care Medical Group Inc

For delegation arrangements in effect for 12 months or longer, the organization:

		NCQA ANSWER
1	Annually reviews its delegate’s credentialing policies and procedures.	Yes
2	Annually audits credentialing and recredentialing files against NCQA standards for each year that delegation has been in effect.	Yes
3	Annually evaluates delegate performance against NCQA standards for delegated activities.	Yes

		NCQA ANSWER
4	Semiannually evaluates regular reports, as specified in Element A.	Yes
5	At least annually, the organization monitors the delegate's credentialing system security controls to ensure that the delegate monitors its compliance with the delegation agreement or with the delegate's policies and procedures.	Yes
6	At least annually, the organization acts on all findings from factor 5 for each delegate and implements a quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters.	NA

VSP Vision Care

For delegation arrangements in effect for 12 months or longer, the organization:

		NCQA ANSWER
1	Annually reviews its delegate's credentialing policies and procedures.	Yes
2	Annually audits credentialing and recredentialing files against NCQA standards for each year that delegation has been in effect.	Yes (AC)
3	Annually evaluates delegate performance against NCQA standards for delegated activities.	Yes (AC)
4	Semiannually evaluates regular reports, as specified in Element A.	Yes
5	At least annually, the organization monitors the delegate's credentialing system security controls to ensure that the delegate monitors its compliance with the delegation agreement or with the delegate's policies and procedures.	Yes (AC)
6	At least annually, the organization acts on all findings from factor 5 for each delegate and implements a quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters.	Yes (AC)

NOT APPLICABLE

For delegation arrangements in effect for 12 months or longer, the organization:

		NCQA ANSWER
1	Annually reviews its delegate’s credentialing policies and procedures.	NA
2	Annually audits credentialing and recredentialing files against NCQA standards for each year that delegation has been in effect.	NA
3	Annually evaluates delegate performance against NCQA standards for delegated activities.	NA
4	Semiannually evaluates regular reports, as specified in Element A.	NA
5	At least annually, the organization monitors the delegate’s credentialing system security controls to ensure that the delegate monitors its compliance with the delegation agreement or with the delegate’s policies and procedures.	NA
6	At least annually, the organization acts on all findings from factor 5 for each delegate and implements a quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters.	NA

NOT APPLICABLE

For delegation arrangements in effect for 12 months or longer, the organization:

		NCQA ANSWER
1	Annually reviews its delegate’s credentialing policies and procedures.	NA
2	Annually audits credentialing and recredentialing files against NCQA standards for each year that delegation has	NA

		NCQA ANSWER
	been in effect.	
3	Annually evaluates delegate performance against NCQA standards for delegated activities.	NA
4	Semiannually evaluates regular reports, as specified in Element A.	NA
5	At least annually, the organization monitors the delegate's credentialing system security controls to ensure that the delegate monitors its compliance with the delegation agreement or with the delegate's policies and procedures.	NA
6	At least annually, the organization acts on all findings from factor 5 for each delegate and implements a quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters.	NA

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 5-6 factors	The organization meets 3-4 factors	The organization meets 0-2 factors

Data Sources	Reports
Scope of Review	**Product lines** *Factor 1 applies to Interim Surveys for all product lines.* *All factors in this element apply to First Surveys and Renewal Surveys for all product lines.* **Documentation** NCQA reviews evidence of the organization's review from up to four randomly selected delegates, or all delegates if the organization has fewer than four.

For All Surveys: NCQA reviews the organization's evaluation of the delegate's credentialing policies and procedures (factor 1).

For First Surveys: NCQA also reviews the organization's most recent annual audit, performance evaluation and semiannual report evaluation.

For Renewal Surveys: NCQA also reviews the most recent and the previous year's annual reviews, audits, performance evaluations and four semiannual evaluations.

For First Surveys and Renewal Surveys:

- *For factor 5:* NCQA also reviews the organization's documentation and the delegate's documentation as evidence for monitoring for system controls.
- *For factor 6:* NCQA also reviews the organization's documentation for taking action (or plans to take) and implementation of its quarterly monitoring process, as applicable.

The score for the element is the average of the scores for all delegates.

ISSUES

This element has no issues.

ORG SUBMISSION STATEMENT

For all 4 delegates, Factor 6 is NA because there were no findings. Automatic credit for UCLA and VSP since they are both NCQA-accredited.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
UCLA Medical Group, VSP Vision Care	Automatic credit is applicable for all factors except factors 1 and 4 because delegates are NCQA-Accredited.	2 3 5 6
Children's Hospital Los Angeles Medical Group, USC Care Medical Group Inc	Factor 6 is NA because there were no findings.	6

D - Opportunities for Improvement **NCQA** **NA**

Children's Hospital Los Angeles Medical Group

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years, the organization identified and followed up on opportunities for improvement, if applicable.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

UCLA Medical Group

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years, the organization identified and followed up on opportunities for improvement, if applicable.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

USC Care Medical Group Inc

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years, the organization identified and followed up on opportunities for improvement, if applicable.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

VSP Vision Care

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years, the organization identified and followed up on opportunities for improvement, if applicable.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years, the organization identified and followed up on opportunities for improvement, if applicable.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years, the organization identified and followed up on opportunities for improvement, if applicable.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

SCORING	MET	PARTIALLY MET	NOT MET
	The organization has acted on identified problems, if any, at least once in each of the past 2 years that the delegation arrangement has been in effect	The organization took inappropriate or weak action, or acted only in the past year	The organization has not acted on identified problems

Data Sources	Documented process, Reports, Materials
Scope of Review	**Product lines** *This element applies to First Surveys and Renewal Surveys for all product lines.*

Documentation

NCQA reviews reports of opportunities for improvement, from up to four randomly selected delegates, or from all delegates, if the organization has fewer than four, and for evidence that the organization took appropriate action to resolve issues.

For First Surveys: NCQA reviews the organization's most recent annual review and follow-up on improvement opportunities.

For Renewal Surveys: NCQA reviews the organization's most recent and the previous year's annual reviews and follow-up on improvement opportunities.

The score for the element is the average of the scores for all delegates.

ISSUES

This element has no issues.

ORG SUBMISSION STATEMENT

CR 8D is NA since no opportunities were identified during the LBP.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
Children's Hospital Los Angeles Medical Group, UCLA Medical Group, USC Care Medical Group Inc, VSP Vision Care	This element is NA since no opportunities were identified during the look-back period.	1

ME 1

The organization recognizes the specific needs of and maintains a mutually respectful relationship with members.

A - Rights and Responsibilities Statement **NCQA**

Medicaid: Met

Medicaid

The organization's member rights and responsibilities statement specifies that members have:

		NCQA ANSWER
1	A right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.	Yes
2	A right to be treated with respect and recognition of their dignity and their right to privacy.	Yes
3	A right to participate with practitioners in making decisions about their health care.	Yes
4	A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.	Yes
5	A right to voice complaints or appeals about the organization or the care it provides.	Yes
6	A right to make recommendations regarding the organization's member rights and responsibilities policy.	Yes
7	A responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.	Yes
8	A responsibility to follow plans and instructions for care that they have agreed to with their practitioners.	Yes
9	A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 6-9 factors	No scoring option.	The organization meets 0-5 factors

Data Sources	Documented process, Materials
Scope of Review	**Product lines** *For Interim Surveys and First Surveys: This element applies to all product lines.* *For Renewal Surveys: This element applies to the Medicaid product line only.* **Documentation** NCQA reviews the organization's policies and procedures or rights and responsibilities statement that is in place throughout the look-back period.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	Please note that Member Handbook is bookmarked and annotated for several elements. Please follow the bookmarks specific to this element. Since the LBP covers 2024 and 2025, we have included both versions of the Member Handbook.
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

B - Distribution of Rights Statement **NCQA**

Medicaid: Met

Medicaid

The organization distributes its member rights and responsibilities statement to the following groups:

		NCQA ANSWER
1	New members, upon enrollment.	Yes
2	Existing members, if requested.	Yes
3	New practitioners, when they join the network.	Yes
4	Existing practitioners, if requested.	NA

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data Sources	Reports, Materials
Scope of Review	**Product line** *This element applies to First Surveys and Renewal Surveys for all product lines.* **Documentation** *For First Surveys and Renewal Surveys*: NCQA reviews organization materials containing the rights statement distributed to members at enrollment and to practitioners who joined the network during the look-back period. NCQA also reviews the organization's distribution of materials containing the rights statement to existing members and practitioners during the look-back period, if requested.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	Factor 4 is NA since no practitioners requested the rights statement. Please note that Member Handbook is bookmarked and annotated for several elements. Please follow the bookmarks specific to this element. Since the LBP covers 2024 and 2025, we have included both versions of the Member Handbook and Provider Manual.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
Medicaid	Factor 4 is NA if no existing practitioners request the information.	4

ME 2

The organization informs subscribers about benefits and access to medical services.

A - Subscriber Information

NCQA

Medicaid: Met

Medicaid

The organization's written subscriber information specifies:

		NCQA ANSWER
1	Benefits and services included in, and excluded from, coverage.	Yes
2	Pharmaceutical management procedures, if they exist.	NA
3	Copayments and other charges for which members are responsible.	Yes

		NCQA ANSWER
4	Benefit restrictions that apply to services obtained outside the organization's system or service area.	Yes
5	How to obtain language assistance.	Yes
6	How to submit a claim for covered services, if applicable.	Yes
7	How to obtain information about practitioners who participate in the organization.	Yes
8	How to obtain primary care services, including points of access.	Yes
9	How to obtain specialty care and behavioral healthcare services and hospital services.	Yes
10	How to obtain care after normal business hours.	Yes
11	How to obtain emergency care, including the organization's policy on when to directly access emergency care or use 911 services.	Yes
12	How to obtain care and coverage when subscribers are out of the organization's service area.	Yes
13	How to submit a complaint.	Yes
14	How to appeal a decision that adversely affects coverage, benefits or a subscriber's relationship with the organization.	Yes
15	Availability of independent, external review of internal UM final determinations.	Yes
16	How the organization evaluates new technology for inclusion as a covered benefit.	Yes

		NCQA ANSWER

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 12-16 factors	The organization meets 8-11 factors	The organization meets 0-7 factors

Data Sources	Materials
Scope of Review	**Product lines** *This element applies to Interim Surveys, First Surveys and Renewal Surveys for all product lines.* NCQA reviews and scores this element for each product line brought forward for Accreditation. **Documentation** NCQA reviews the organization's subscriber information in place throughout the look-back period.

ISSUES		
	Type	ID
	Lines	Medicaid
	Statement	The organization confirmed that factor 2 is NA due to the pharmacy state carve out.
	Contest Element Findings	No
	Organization Comments	
	Organization Statement	Factor 2 is NA because Pharmacy is carved out by the State.
	NCQA Support Text	The organization confirmed that factor 2 is NA due to the pharmacy state carve out.
	NCQA Response Post Final Report	
	Factor - Result	2 - Met-Score NA

ORG SUBMISSION STATEMENT	Please note that Member Handbook is bookmarked and annotated for several elements. Please follow the bookmarks specific to this element. Since the LBP covers 2024 and 2025, we have included both versions of the Member Handbook.
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

B - Distribution of Subscriber Information **NCQA**

Medicaid: Met

Medicaid

The organization distributes its subscriber information to the following groups:

		NCQA ANSWER
1	New members, upon enrollment.	Yes
2	Existing members, annually.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 2 factors	No scoring option.	The organization meets 0-1 factors

Data Sources	Reports, Materials
Scope of Review	**Product lines** *This element applies to First Surveys and Renewal Surveys for all product lines.*

NCQA reviews and scores this element for each product line brought forward for Accreditation.

Documentation

For First Surveys and Renewal Surveys: NCQA reviews evidence:

- That the organization distributed materials containing subscriber information to new members at enrollment during the look-back period.
- That the organization distributed materials containing subscriber information to existing members annually during the look-back period.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	ME 2B.1 - Pages 2-3 of document: New members are provided a one-page guide in their new member packet directing them where they can access the Member Handbook electronically on the website and how they may request an actual hard copy. ME 2B.2 - Pages 6-17 of document: Existing members are provided an annual mailing that includes guidance directing them to the website to access the Member Handbook electronically and how they may request a hard copy.
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

C - Interpreter Services **NCQA**

Medicaid: Met

Medicaid

Based on the linguistic need of its subscribers, the organization provides interpreter or bilingual services in its Member Services department and telephone functions.

NCQA ANSWER	The organization meets the requirement

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets the requirement	No scoring option.	The organization does not meet the requirement

Data Sources	Reports, Materials, Records or files
Scope of Review	**Product lines** *This element applies to Interim Surveys, First Surveys and Renewal Surveys for all product lines.* **Documentation** *For Interim Surveys:* NCQA reviews information that will be sent to subscribers. *For First Surveys and Renewal Surveys:* NCQA reviews an assessment of subscribers' linguistic needs and contracts (or similar documents) for evidence that the organization provides services throughout the look-back period.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

ME 3

Prospective members receive an accurate description of the organization's benefits and operating procedures.

A - Materials and Presentations	NCQA
	Medicaid: Met

Medicaid

All organizational materials and presentations accurately describe the following information:

		NCQA ANSWER
1	Covered benefits.	Yes
2	Noncovered benefits.	Yes
3	Practitioner and provider availability.	Yes
4	Key UM procedures the organization uses.	No
5	Potential network, service or benefit restrictions.	Yes
6	Pharmaceutical management procedures.	NA

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 5-6 factors	The organization meets 3-4 factors	The organization meets 0-2 factors

Data Sources	Materials
Scope of	**Product lines**

Review

This element applies to Interim Surveys, First Surveys and Renewal Surveys for all product lines.

Documentation

For Interim Surveys: Materials that have been approved by the organization but are not in final layout form are acceptable to meet the requirement.

NCQA reviews the organization's marketing information made available to prospective members within the look-back period.

ISSUES

Type	DOC
Lines	Medicaid
Statement	The organization re-bookmarked the section of the member handbook that speaks to their appeal process; however, this does not meet the requirement for factor 4 that requires the procedures for preservice review, urgent concurrent review, postservice review, and filing an appeal. Therefore, this factor is not met.
Contest Element Findings	No
Organization Comments	
Organization Statement	We have uploaded a copy of the 2024 and 2025 member handbook that provides clarifying bookmarks and annotations.
NCQA Support Text	The organization re-bookmarked the section of the member handbook that speaks to their appeal process; however, this does not meet the requirement for factor 4 that requires the procedures for preservice review, urgent concurrent review, postservice review, and filing an appeal. Therefore, this factor is not met.
NCQA Response Post Final Report	
Factor - Result	4 - Not met

Type	DOC
Lines	Medicaid
Statement	The organization confirmed that factor 6 is NA due to the pharmacy state carveout.
Contest Element Findings	No
Organization Comments	

Organization Statement	ME-3A.6: KHS is confirming that pharmacy is carved out by the state as discussed on the recent Agenda call. The 2024/2025 Member Handbook also references the carve out on pg. 63 (2024) and pg. 65 (2025).
NCQA Support Text	The organization confirmed that factor 6 is NA due to the pharmacy state carveout.
NCQA Response Post Final Report Factor - Result	6 - Met-Score NA

ORG SUBMISSION STATEMENT	Please note that Member Handbook is bookmarked and annotated for several elements. Please follow the bookmarks specific to this element. Since the LBP covers 2024 and 2025, we have included both versions of the Member Handbook.
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

B - Communicating With Prospective Members **NCQA**

Medicaid: Met

Medicaid

The organization uses easy-to-understand language in communications to prospective members about its policies and practices regarding collection, use and disclosure of PHI:

		NCQA ANSWER
1	In routine notification of privacy practices.	Yes
2	The right to approve the release of information (use of authorizations).	Yes
3	Access to medical records.	Yes
4	Protection of oral, written and electronic information across the organization.	Yes

		NCQA ANSWER
5	Information for employers.	NA

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 4-5 factors	The organization meets 3 factors	The organization meets 0-2 factors

Data Sources	Materials
Scope of Review	**Product lines** *This element applies to Interim Surveys, First Surveys and Renewal Surveys for all product lines.* **Documentation** *For Interim Surveys:* Materials that have been approved by the organization but are not in final layout form are acceptable to meet the requirement. NCQA reviews the organization's materials containing PHI use and disclosure policies and procedures communicated to prospective members throughout the look-back period.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	Factor 5 is NA: For product lines sponsored by state or federal government (e.g., Medicare and Medicaid).

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
Medicaid	Factor 5 is NA: For product lines sponsored by state or federal government (e.g., Medicare and Medicaid).	5

C - Assessing Member Understanding

NCQA

Medicaid: Met

Medicaid

The organization systematically takes the following steps:

		NCQA ANSWER
1	Assesses how well new members understand policies and procedures.	Yes
2	Implements procedures to maintain accuracy of marketing communication.	Yes
3	Acts on opportunities for improvement, if applicable.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 2-3 factors	The organization meets 1 factor	The organization meets 0 factors

Data Sources	Reports
Scope of	**Product lines**

Review

This element applies to First Surveys and Renewal Surveys for all product lines.

Documentation

For factors 1, 2: NCQA reviews evidence that the organization completed the required activities at least once during the look-back period.

For factor 3: NCQA reviews evidence that the organization took action at least once during the look-back period, if applicable.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

ME 4

The organization allows members to access and track claims through the claims process on its website and by telephone.

A - Functionality: Website **NCQA**

Medicaid: NA

Medicaid

Members can track the status of their claims in the claims process and obtain the following information on the organization's website in one attempt or contact:

		NCQA ANSWER
1	The stage in the process.	NA
2	The amount approved.	NA
3	The amount paid.	NA
4	The member's cost.	NA
5	The date paid.	NA

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 4-5 factors	The organization meets 2-3 factors	The organization meets 0-1 factors

Data Sources	Documented process, Reports, Materials
Scope of Review	**Product lines** *This element applies to First Surveys for all product lines.* **Documentation** NCQA reviews the organization's website content and functionality against the requirements of this element. Both must be in place throughout the look-back period. If the organization can provide a "test" or "demo" log-on ID, NCQA reviews the organization's performance through that mechanism. If the organization cannot provide a test or demo log-on, NCQA reviews the organization’s website or screenshots of web functionality, supplemented with documents specifying the required features and functions of the site. If screenshots provided

include detailed explanations of how the site works, there is no need to provide supplemental documents.

ISSUES

This element has no issues.

ORG SUBMISSION STATEMENT

This element is NA: If 90% or more of the organization's claims payments (measured in dollars, not in the number of claims processed or encounters) are under capitation and members have no financial responsibility beyond a flat copay. Please note that Member Handbook is bookmarked and annotated for several elements. Please follow the bookmarks specific to this element. Since the LBP covers 2024 and 2025, we have included both versions of the Member Handbook.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
Medicaid	This element is NA: If 90% or more of the organization's claims payments (measured in dollars, not in the number of claims processed or encounters) are under capitation and members have no financial responsibility beyond a flat copay.	1 2 3 4 5

B - Functionality: Telephone Requests

NCQA

Medicaid: Met

Medicaid

Members can track the status of their claims in the claims process and obtain the following information over the telephone in one attempt or contact:

		NCQA ANSWER
1	The stage in the process.	Yes
2	The amount approved.	Yes

		NCQA ANSWER
3	The amount paid.	Yes
4	The member's cost.	Yes
5	The date paid.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 4-5 factors	The organization meets 3 factors	The organization meets 0-2 factors

Data Sources	Documented process, Reports, Materials
Scope of Review	**Product lines** *This element applies to First Surveys for all product lines.* **Documentation** NCQA reviews evidence that the organization’s telephone system meets each factor throughout the look-back period. *For live-person systems:* NCQA reviews policies and procedures, scripts and other resources used by Member Services staff. *For automated systems:* NCQA reviews evidence of functional capability or scripts, supplemented with documents specifying the required features and stating that the telephone system functions as required.

ISSUES This element has no issues.

ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

ME 5

The organization uses its website and telephone communication to inform members about their pharmacy benefit, their financial responsibility for medications and the operations of network pharmacies.

A - Pharmacy Benefit Information: Website

NCQA

Medicaid: NA

Medicaid

Members can complete the following actions on the organization's website in one attempt or contact:

		NCQA ANSWER
1	Determine their financial responsibility for a drug, based on the pharmacy benefit.	NA
2	Initiate the exceptions process.	NA
3	Order a refill for an existing, unexpired mail-order prescription.	NA
4	Find the location of an in-network pharmacy.	NA
5	Conduct a pharmacy proximity search based on ZIP code.	NA

		NCQA ANSWER
6	Determine the availability of generic substitutes.	NA

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 5-6 factors	The organization meets 2-4 factors	The organization meets 0-1 factors

Data Sources	Documented process, Reports, Materials
Scope of Review	**Product lines** *This element applies to First Surveys for all product lines.* **Documentation** NCQA reviews the organization's website content and functionality against the requirements of this element. Both must be in place throughout the look-back period. If the organization can provide a "test" or "demo" log-on ID, NCQA reviews the organization's performance through that mechanism. If the organization cannot provide a test or demo log-on, NCQA reviews the organization’s website or screenshots of web functionality, supplemented with documents specifying the required features and functions of the site. If screenshots provided include detailed explanations of how the site works, there is no need to provide supplemental documents.
ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	ME 5 is NA due to Medi-Cal Rx pharmacy carve out as outlined in the documentation linked to ME 5ABCD.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
LINES	STATEMENT	FACTOR
Medicaid	The organization scored NA as per the pharmacy carve out.	1 2 3 4 5 6

B - Pharmacy Benefit Information: Telephone

NCQA

Medicaid: **NA**

Medicaid

Members can complete the following actions via telephone in one attempt or contact:

		NCQA ANSWER
1	Determine their financial responsibility for a drug, based on the pharmacy benefit.	NA
2	Initiate the exceptions process.	NA
3	Order a refill for an existing, unexpired, mail-order prescription.	NA
4	Find the location of an in-network pharmacy.	NA
5	Conduct a proximity search based on ZIP code.	NA

6	Determine the availability of generic substitutes.	NA

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 5-6 factors	The organization meets 2-4 factors	The organization meets 0-1 factors

Data Sources	Documented process, Reports, Materials
Scope of Review	**Product lines** *This element applies to First Surveys for all product lines.* **Documentation** NCQA reviews evidence of how the organization's telephone system meets each factor throughout the look-back period. *For live-person systems:* NCQA reviews policies and procedures, scripts and other resources used by Member Services staff. *For automated systems:* NCQA reviews evidence of functional capability or scripts, supplemented with documents specifying the required features and stating that the telephone system functions as required.

ISSUES This element has no issues.

ORG SUBMISSION STATEMENT ME 5 is NA due to Medi-Cal Rx pharmacy carve out as outlined in the documentation linked to ME 5ABCD.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
Medicaid	The organization scored NA as per the pharmacy carve out.	1 2 3

NCQA SUPPORT TEXT	LINES	STATEMENT	FACTOR
			4 5 6

C - QI Process on Accuracy of Information **NCQA**

Medicaid: NA

Medicaid

The organization seeks to improve pharmacy benefit information provided on its website and by telephone, by:

		NCQA ANSWER
1	Collecting data on quality and accuracy of information.	NA
2	Analyzing data results.	NA
3	Acting to improve identified deficiencies.	NA

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 2-3 factors	The organization meets 1 factor	The organization meets 0 factors

Data Sources	Documented process, Reports

Scope of Review	**Product lines** *This element applies to First Surveys and Renewal Surveys for all product lines.* **Documentation** *For First Surveys and Renewal Surveys*: NCQA reviews the organization's data collection methodology and most recent data collection, analysis and action reports completed at least once during the look-back period. The methodology may be a separate documented process or described as part of the organization's reports.
ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	ME 5 is NA due to Medi-Cal Rx pharmacy carve out as outlined in the documentation linked to ME 5ABCD.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
Medicaid	The organization scored NA as per the pharmacy carve out.	1 2 3

D - Pharmacy Benefit Updates **NCQA**

Medicaid: NA

Medicaid

The organization updates member pharmacy benefit information on its website and in materials used by telephone staff, as of the effective date of a formulary change and as new drugs are made available or are recalled.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets the requirement	No scoring option.	The organization does not meet the requirement

Data Sources	Documented process, Materials
Scope of Review	**Product lines** *This element applies to First Surveys and Renewal Surveys for all product lines.* **Documentation** NCQA reviews the organization's policies and procedures for updating pharmacy benefit information, and reviews three materials as evidence of updates throughout the look-back period or reviews all materials if the organization has fewer than three.

ISSUES This element has no issues.

ORG SUBMISSION STATEMENT ME 5 is NA due to Medi-Cal Rx pharmacy carve out as outlined in the documentation linked to ME 5ABCD.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
Medicaid	The organization scored NA as per the pharmacy carve out.	1

ME 6

The organization makes it easy for members to decide how to use their benefits.

A - Functionality: Website	**NCQA**
	Medicaid: Met

Medicaid

Members can complete each of the following activities on the organization's website in one attempt or contact:

		NCQA ANSWER
1	Change a primary care practitioner, as applicable.	Yes
2	Determine how and when to obtain referrals and authorizations for specific services, as applicable.	Yes
3	Determine benefit and financial responsibility for a specific service or treatment from a specified provider or institution, if applicable.	NA

SCORING	**MET**	**PARTIALLY MET**	**NOT MET**
	The organization meets 3 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data Sources	Documented process, Reports, Materials
Scope of Review	**Product lines** *This element applies to First Surveys and Renewal Surveys for all product lines.*

Documentation

NCQA reviews the organization's website content and functionality against the requirements of this element. Both must be in place throughout the look-back period.

If the organization can provide a "test" or "demo" log-on ID, NCQA reviews the organization's performance through that mechanism. If the organization cannot provide a test or demo log-on, NCQA reviews the organization's website or screenshots of web functionality, supplemented with documents specifying the required features and functions of the site. If screenshots provided include detailed explanations of how the site works, there is no need to provide supplemental documents.

ISSUES

This element has no issues.

ORG SUBMISSION STATEMENT

Factor 3 is NA since KFHC members do not have any financial responsibility (i.e., co-insurance, deductibles, charges in excess of allowed amounts, differentials in cost between in-network care and out-of-network care, costs that vary for the formulary) for services beyond a flat copay that is always the same fixed dollar amount and cannot be balance-billed by a practitioner, provider or other party.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
Medicaid	Factor 3 is NA since KFHC members do not have any financial responsibility (i.e., co-insurance, deductibles, charges in excess of allowed amounts, differentials in cost between in-network care and out-of-network care, costs that vary for the formulary) for services beyond a flat copay that is always the same fixed dollar amount and cannot be balance-billed by a practitioner, provider or other party.	3

B - Functionality: Telephone **NCQA**

Medicaid: Met

Medicaid

To support financial decision making, members can complete each of the following activities over the telephone within 1 business day:

		NCQA ANSWER
1	Determine how and when to obtain referrals and authorizations for specific services, as applicable.	Yes
2	Determine benefit and financial responsibility for a specific service or treatment from a specified provider or institution.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data Sources	Documented process, Reports, Materials
Scope of Review	**Product lines** *This element applies to First Surveys and Renewal Surveys for all product lines.* **Documentation** NCQA reviews evidence of how the organization's telephone system meets each factor throughout the look-back period. For live-person systems, NCQA reviews policies and procedures, scripts and other resources used by Member Services staff.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT	This element has no additional NCQA support texts.

TEXT

C - Quality and Accuracy of Information

NCQA

Medicaid: Met

Medicaid

At least annually, the organization must evaluate the quality and accuracy of the information it provides to its members via the web and telephone, by:

		NCQA ANSWER
1	Collecting data on quality and accuracy of information provided.	Yes
2	Analyzing data against standards or goals.	Yes
3	Determining causes of deficiencies, as applicable.	Yes
4	Acting to improve identified deficiencies, as applicable.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 4 factors	The organization meets 2-3 factors	The organization meets 0-1 factors

Data Sources	Documented process, Reports
Scope of	**Product lines**

Review

This element applies to First Surveys and Renewal Surveys for all product lines.

Documentation

NCQA reviews the organization’s data collection methodology. The methodology may be a separate documented process or described as part of the organization’s reports.

For First Surveys: NCQA also reviews the organization's most recent annual data collection, analysis and action reports.

For Renewal Surveys: NCQA also reviews the organization's most recent and the previous year's annual data collection, analysis and action reports.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

D - Email Response Evaluation — **NCQA**

Medicaid: Met

Medicaid

The organization:

		NCQA ANSWER
1	Has a process for responding to member email inquiries within 1 business day of submission.	Yes
2	Has a process for annually evaluating the quality of email responses.	Yes

		NCQA ANSWER
3	Annually collects data on email turnaround time.	Yes
4	Annually collects data on the quality of email responses.	Yes
5	Annually analyzes data.	Yes
6	Annually acts to improve identified deficiencies.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 5-6 factors	The organization meets 2-4 factors	The organization meets 0-1 factors

Data Sources	Documented process, Reports
Scope of Review	**Product lines** *This element applies to First Surveys and Renewal Surveys for all product lines.* **Documentation** NCQA reviews the organization's policies and procedures in place throughout the look-back period for factors 1 and 2. *For First Surveys:* NCQA also reviews the organization's most recent annual evaluation report and actions completed within the look-back period for factors 3–6. *For Renewal Surveys:* NCQA also reviews the organization’s previous and most recent annual evaluation report and actions completed within the look-back period for factors 3–6.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

ME 7

The organization has a thorough and consistent process for addressing member complaints and appeals.

A - Policies and Procedures for Complaints **NCQA**

Medicaid: Met

Medicaid

The organization has policies and procedures for registering and responding to oral and written complaints that include:

		NCQA ANSWER
1	Documentation of the substance of complaints and actions taken.	Yes
2	Investigation of the substance of complaints.	Yes
3	Notification to members of the resolution of the complaint and, if there is an adverse decision, the right to appeal.	Yes
4	Standards for timeliness, including standards for urgent situations.	Yes

		NCQA ANSWER
5	Provision of language services for the complaint process.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 4-5 factors	The organization meets 3 factors	The organization meets 0-2 factors

Data Sources	Documented process
Scope of Review	**Product lines** *This element applies to Interim Surveys, First Surveys and Renewal Surveys for all product lines.* **Documentation** NCQA reviews the organization's policies and procedures.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

B - Policies and Procedures for Appeals **NCQA**

Medicaid: Met

Medicaid

The organization has policies and procedures for registering and responding to oral and written appeals of decisions that are not about coverage that include:

		NCQA ANSWER
1	Documentation of the substance of appeals and actions taken.	Yes
2	Investigation of the substance of appeals.	Yes
3	Notification to members of the disposition of appeals and the right to further appeal, as appropriate.	Yes
4	Standards for timeliness, including standards for urgent situations.	Yes
5	Provision of language services for the appeal process.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 4-5 factors	The organization meets 3 factors	The organization meets 0-2 factors

Data Sources	Documented process
Scope of Review	**Product lines** This element applies to Interim Surveys, First Surveys and Renewal Surveys for the commercial, Exchange and Medicaid product lines. **Documentation**

NCQA reviews the organization's policies and procedures.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

C - Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals

NCQA Medicaid: Met

Medicaid

Using valid methodology, the organization annually analyzes nonbehavioral complaints and appeals for each of the five required categories.

NCQA ANSWER The organization meets the requirement

SCORING

MET	PARTIALLY MET	NOT MET
The organization meets the requirement	No scoring option.	The organization does not meet the requirement

Data Sources	Reports
Scope of Review	**Product lines** *This element applies to First Surveys and Renewal Surveys for all product lines.*

NCQA reviews and scores this element for each product line brought forward for Accreditation; only the commercial and Exchange product lines may be combined.

Documentation

For First Surveys: NCQA reviews the organization's most recent annual data collection and analysis report.

For Renewal Surveys: NCQA reviews the organization's most recent and the previous year's annual data collection and analysis report.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

E - Annual Assessment of Behavioral Healthcare and Services **NCQA**

Medicaid: Met

Medicaid

Using valid methodology, the organization annually:

		NCQA ANSWER
1	Evaluates behavioral healthcare member complaints and appeals for each of the five required categories.	Yes
2	Conducts a member experience survey.	Yes

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data Sources	Reports
Scope of Review	**Product lines** *This element applies to First Surveys and Renewal Surveys for all product lines.* NCQA reviews and scores this element for each product line brought forward for Accreditation; only the commercial and Exchange product lines may be combined. **Documentation** *For First Surveys:* NCQA reviews the organization's most recent annual data collection and member experience survey report. *For Renewal Surveys:* NCQA reviews the organization's most recent and the previous year's annual data collection and member experience survey reports.

ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	This element has no organization submission statement
NCQA SUPPORT TEXT	This element has no additional NCQA support texts.

ME 8

The organization remains responsible for and has appropriate structures and mechanisms to oversee delegated Member Experience functions.

A - Delegation Agreement **NCQA** **NA**

NOT APPLICABLE

The written delegation agreement:

		NCQA ANSWER
1	Is mutually agreed upon.	NA
2	Describes the delegated activities and the responsibilities of the organization and the delegated entity and the delegated activities.	NA
3	Requires at least semiannual reporting by the delegated entity to the organization.	NA
4	Describes the process by which the organization evaluates the delegated entity's performance.	NA
5	Describes the process for providing member experience and clinical performance data to its delegates when requested.	NA
6	Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.	NA

NOT APPLICABLE

The written delegation agreement:

		NCQA ANSWER
1	Is mutually agreed upon.	NA
2	Describes the delegated activities and the responsibilities of the organization and the delegated entity and the delegated activities.	NA
3	Requires at least semiannual reporting by the delegated entity to the organization.	NA
4	Describes the process by which the organization evaluates the delegated entity's performance.	NA
5	Describes the process for providing member experience and clinical performance data to its delegates when requested.	NA
6	Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.	NA

NOT APPLICABLE

The written delegation agreement:

		NCQA ANSWER
1	Is mutually agreed upon.	NA
2	Describes the delegated activities and the responsibilities of the organization and the delegated entity and the delegated activities.	NA
3	Requires at least semiannual reporting by the delegated entity to the organization.	NA

		NCQA ANSWER
4	Describes the process by which the organization evaluates the delegated entity's performance.	NA
5	Describes the process for providing member experience and clinical performance data to its delegates when requested.	NA
6	Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.	NA

NOT APPLICABLE

The written delegation agreement:

		NCQA ANSWER
1	Is mutually agreed upon.	NA
2	Describes the delegated activities and the responsibilities of the organization and the delegated entity and the delegated activities.	NA
3	Requires at least semiannual reporting by the delegated entity to the organization.	NA
4	Describes the process by which the organization evaluates the delegated entity's performance.	NA
5	Describes the process for providing member experience and clinical performance data to its delegates when requested.	NA
6	Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.	NA

NOT APPLICABLE

The written delegation agreement:

		NCQA ANSWER
1	Is mutually agreed upon.	NA
2	Describes the delegated activities and the responsibilities of the organization and the delegated entity and the delegated activities.	NA
3	Requires at least semiannual reporting by the delegated entity to the organization.	NA
4	Describes the process by which the organization evaluates the delegated entity's performance.	NA
5	Describes the process for providing member experience and clinical performance data to its delegates when requested.	NA
6	Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.	NA

NOT APPLICABLE

The written delegation agreement:

		NCQA ANSWER
1	Is mutually agreed upon.	NA
2	Describes the delegated activities and the responsibilities of the organization and the delegated entity and the delegated activities.	NA

		NCQA ANSWER
3	Requires at least semiannual reporting by the delegated entity to the organization.	NA
4	Describes the process by which the organization evaluates the delegated entity's performance.	NA
5	Describes the process for providing member experience and clinical performance data to its delegates when requested.	NA
6	Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.	NA

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 5-6 factors	The organization meets 3-4 factors	The organization meets 0-2 factors

Data Sources	Materials
Scope of Review	**Product line** *This element applies to Interim Surveys, First Surveys and Renewal Surveys for all product lines.* **Documentation** NCQA reviews delegation agreements in effect during the look-back period from up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four. For delegation agreements in place prior to January 1, 2019, the organization may provide documentation that it notified the delegate of the process required in factor 5. This documentation of notification is not required to be mutually agreed upon.

Delegation agreements implemented on or after January 1, 2019, must include a description of the process required in factor 5.

The score for the element is the average of the scores for all delegates.

ISSUES This element has no issues.

ORG SUBMISSION STATEMENT ME 8 is NA since KHS does not delegate any ME activities.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
NOT APPLICABLE	The organization does not delegate ME activities; therefore, this element is scored NA.	1 2 3 4 5 6

B - Predelegation Evaluation **NCQA** **NA**

NOT APPLICABLE

For new delegation agreements initiated in the look-back period, the organization evaluates delegate capacity to meet NCQA requirements before delegation began.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For new delegation agreements initiated in the look-back period, the organization evaluates delegate capacity to meet NCQA requirements before delegation began.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For new delegation agreements initiated in the look-back period, the organization evaluates delegate capacity to meet NCQA requirements before delegation began.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For new delegation agreements initiated in the look-back period, the organization evaluates delegate capacity to meet NCQA requirements before delegation began.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For new delegation agreements initiated in the look-back period, the organization evaluates delegate capacity to meet NCQA requirements before delegation began.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For new delegation agreements initiated in the look-back period, the organization evaluates delegate capacity to meet NCQA requirements before delegation began.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

SCORING	**MET**	**PARTIALLY MET**	**NOT MET**
	The organization evaluated delegate capacity before delegation began	The organization evaluated delegate capacity after delegation began	The organization did not evaluate delegate capacity

Data Sources	Reports
Scope of Review	**Product line** *This element applies to Interim Surveys, First Surveys and Renewal Surveys for all product lines.* *This element applies if delegation was implemented in the look-back period.* **Documentation** NCQA reviews the organization's predelegation evaluation from up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four. The score for the element is the average of the scores for all delegates.

ISSUES This element has no issues.

ORG SUBMISSION STATEMENT ME 8 is NA since KHS does not delegate any ME activities.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
NOT APPLICABLE	The organization does not delegate ME activities; therefore, this element is scored NA.	1

C - Review of Performance **NCQA** **NA**

NOT APPLICABLE

For delegation arrangements in effect for 12 months or longer, the organization:

		NCQA ANSWER
1	Semiannually evaluates regular reports, as specified in Element A.	NA
2	Annually evaluates delegate performance against NCQA standards for delegated activities.	NA

NOT APPLICABLE

For delegation arrangements in effect for 12 months or longer, the organization:

		NCQA ANSWER
1	Semiannually evaluates regular reports, as specified in Element A.	NA
2	Annually evaluates delegate performance against NCQA standards for delegated activities.	NA

NOT APPLICABLE

For delegation arrangements in effect for 12 months or longer, the organization:

		NCQA ANSWER
1	Semiannually evaluates regular reports, as specified in Element A.	NA
2	Annually evaluates delegate performance against NCQA standards for delegated activities.	NA

NOT APPLICABLE

For delegation arrangements in effect for 12 months or longer, the organization:

		NCQA ANSWER
1	Semiannually evaluates regular reports, as specified in Element A.	NA
2	Annually evaluates delegate performance against NCQA standards for delegated activities.	NA

NOT APPLICABLE

For delegation arrangements in effect for 12 months or longer, the organization:

		NCQA ANSWER
1	Semiannually evaluates regular reports, as specified in Element A.	NA
2	Annually evaluates delegate performance against NCQA standards for delegated activities.	NA

NOT APPLICABLE

For delegation arrangements in effect for 12 months or longer, the organization:

		NCQA ANSWER
1	Semiannually evaluates regular reports, as specified in Element A.	NA
2	Annually evaluates delegate performance against NCQA standards for delegated activities.	NA

SCORING	MET	PARTIALLY MET	NOT MET
	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data Sources	Reports
Scope of Review	**Product line** *This element applies to First Surveys and Renewal Surveys for all product lines.* **Documentation** NCQA reviews evidence of the organization's review from up to four randomly selected delegates, or all delegates if the organization has fewer than four. *For First Surveys:* NCQA reviews the organization's most recent semiannual and annual performance evaluation reports completed during the look-back period. *For Renewal Surveys:* NCQA reviews the organization's four most recent semi-annual reports and the most recent and previous performance evaluation reports completed during the look-back period.

The score for the element is the average of the scores for all delegates.

ISSUES This element has no issues.

ORG SUBMISSION STATEMENT ME 8 is NA since KHS does not delegate any ME activities.

NCQA SUPPORT TEXT

LINES	STATEMENT	FACTOR
NOT APPLICABLE	The organization does not delegate ME activities; therefore, this element is scored NA.	1 2

D - Opportunities for Improvement **NCQA** NA

NOT APPLICABLE

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years, the organization identified and followed up on opportunities for improvement, if applicable.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years, the organization identified and followed up on opportunities for improvement, if applicable.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years, the organization identified and followed up on opportunities for improvement, if applicable.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years, the organization identified and followed up on opportunities for improvement, if applicable.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years, the organization identified and followed up on opportunities for improvement, if applicable.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER NA

NOT APPLICABLE

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years, the organization identified and followed up on opportunities for improvement, if applicable.

Select the choice that most closely reflects the organization's performance.

NCQA ANSWER	NA

SCORING	**MET**	**PARTIALLY MET**	**NOT MET**
	The organization has acted on identified problems, if any, at least once in each of the past 2 years that the delegation arrangement has been in effect	The organization took inappropriate or weak action, or acted only in the past year	The organization has not acted on identified problems

Data Sources	Documented process, Reports, Materials
Scope of Review	**Product line** *This element applies to First Surveys and Renewal Surveys for all product lines.* **Documentation** NCQA reviews reports of opportunities for improvement from up to four randomly selected delegates, or from all delegates, if the organization has fewer than four, and for evidence that the organization took appropriate action to resolve issues. *For First Surveys:* NCQA reviews the organization's most recent annual review and follow-up on improvement opportunities. *For Renewal Surveys:* NCQA reviews the organization's most recent and the previous year's annual reviews and follow-up on improvement opportunities. The score for the element is the average of the scores for all delegates.
ISSUES	This element has no issues.
ORG SUBMISSION STATEMENT	ME 8 is NA since KHS does not delegate any ME activities.

NCQA SUPPORT TEXT

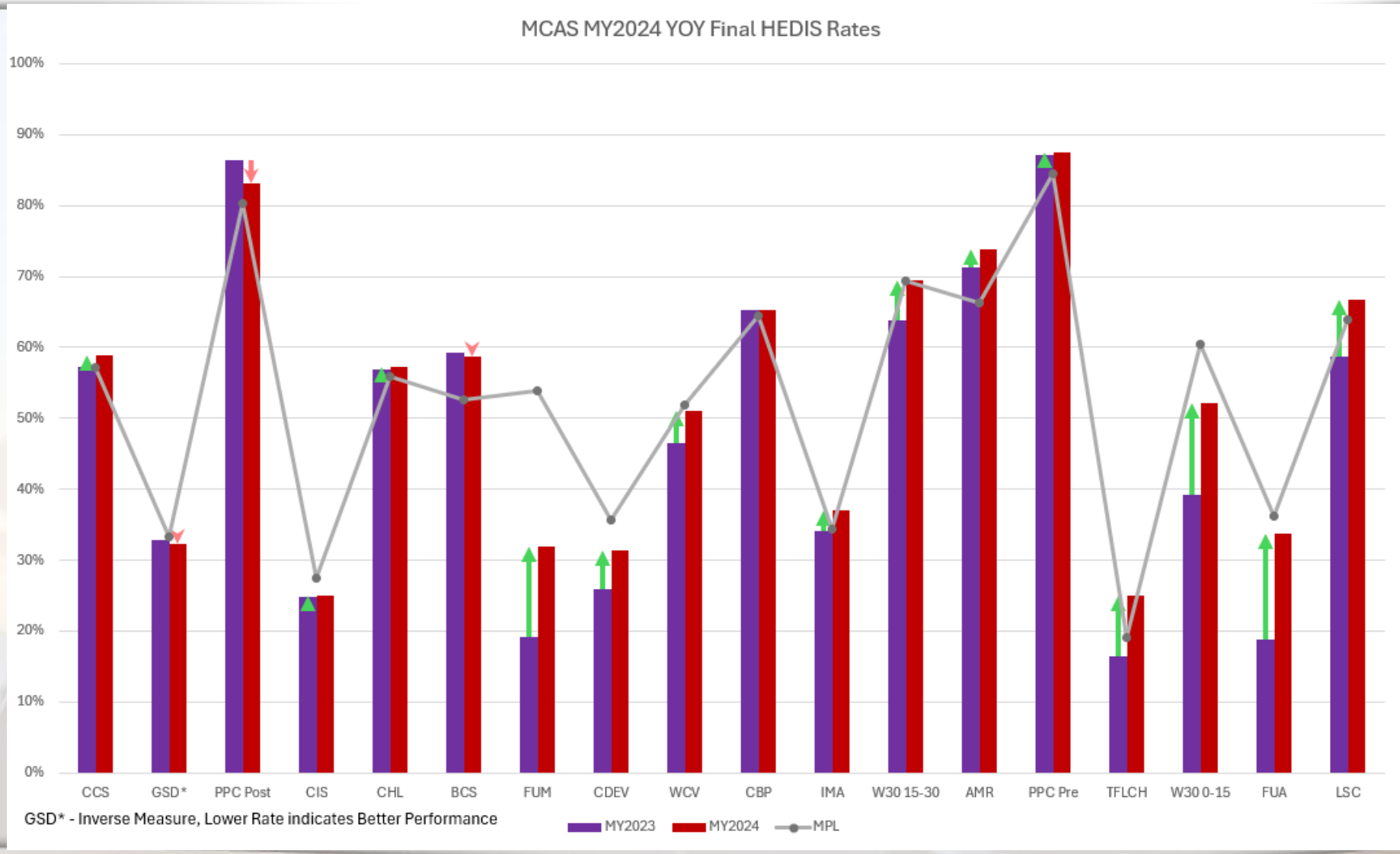
LINES	STATEMENT	FACTOR
NOT APPLICABLE	The organization does not delegate ME activities; therefore, this element is scored NA.	1

Quality Performance

Executive Quality Improvement and Health Equity Committee
June 17, 2025

Preliminary Rates for MY2024

- Meeting MPL for 12 of 18 measures compared to 8 of 18 measures for MY2023
- Improving in 16 of 18 measures
- Additional 4 measures in children's domain



MY2025 vs. MY2024 Trending Performance

13 measures are trending higher than the previous year at the same point in time.

GSD not accurately reflecting compliance

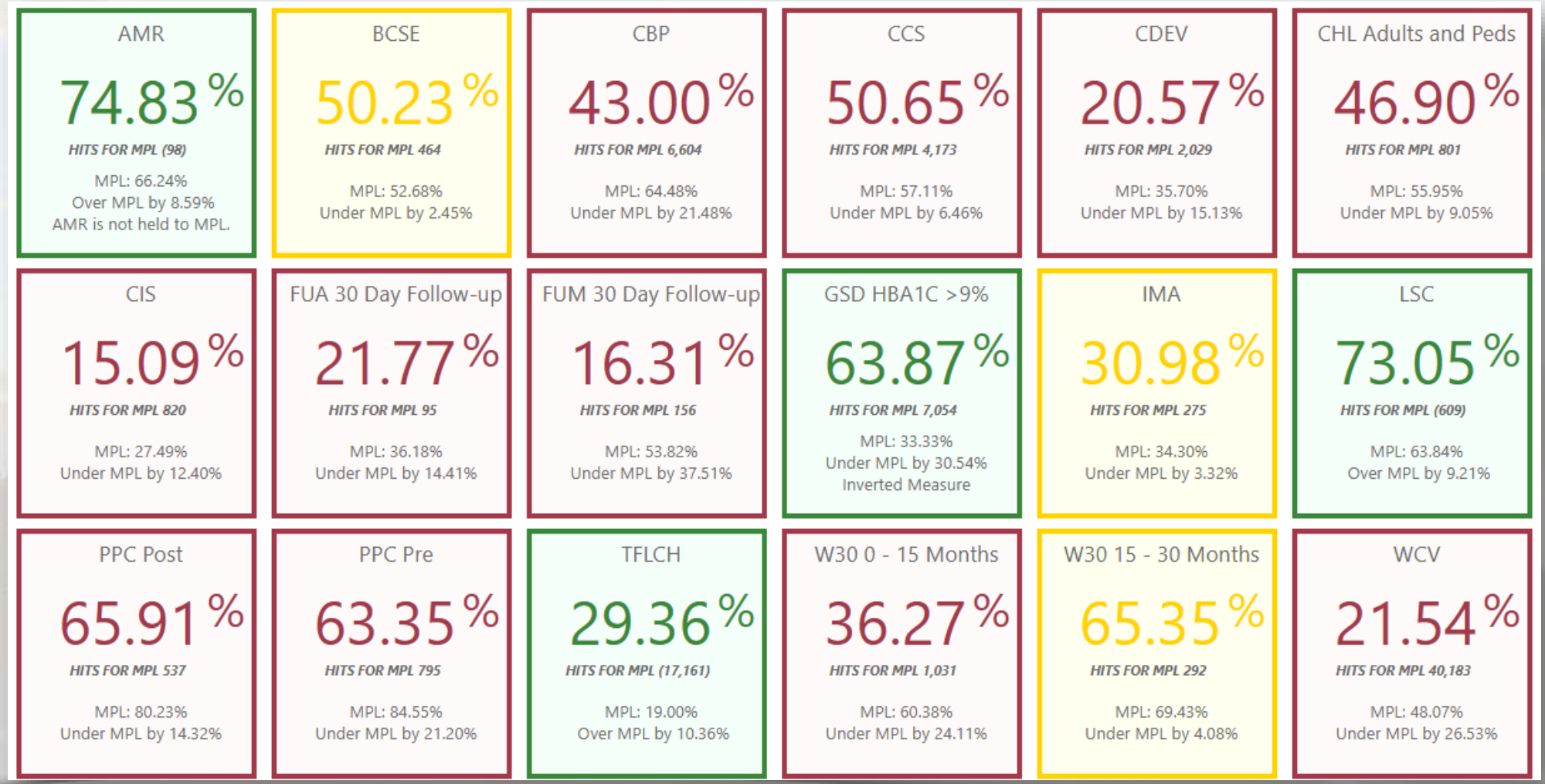
AMR	BCSE	CBP	CCS	CDEV	CHL Adults and Peds
74.83%	50.23%	43.00%	50.65%	20.57%	46.90%
HITS FOR MPL (98)	*HITS FOR MPL 464*	*HITS FOR MPL 6,604*	*HITS FOR MPL 4,173*	*HITS FOR MPL 2,029*	*HITS FOR MPL 801*
-1.19 % change Jun'24 76.02%	-1.19 % change Jun'24 51.42%	+3.14 % change Jun'24 39.86%	+8.55 % change Jun'24 42.09%	+3.17 % change Jun'24 17.40%	+1.27 % change Jun'24 45.63%

CIS	FUA 30 Day Follow-up	FUM 30 Day Follow-up	GSD HBA1C >9%	IMA	LSC
15.09%	21.77%	16.31%	63.87%	30.98%	73.05%
HITS FOR MPL 820	*HITS FOR MPL 95*	*HITS FOR MPL 156*	*HITS FOR MPL 7,054*	*HITS FOR MPL 275*	*HITS FOR MPL (609)*
+2.05 % change Jun'24 13.04%	+0.84 % change Jun'24 20.93%	-3.44 % change Jun'24 19.74%	+7.36 % change Jun'24 71.23%	+3.27 % change Jun'24 27.71%	+8.09 % change Jun'24 64.95%

PPC Post	PPC Pre	TFLCH	W30 0 - 15 Months	W30 15 - 30 Months	WCV
65.91%	63.35%	29.36%	36.27%	65.35%	21.54%
HITS FOR MPL 537	*HITS FOR MPL 795*	*HITS FOR MPL (17,161)*	*HITS FOR MPL 1,031*	*HITS FOR MPL 292*	*HITS FOR MPL 40,183*
+2.76 % change Jun'24 63.15%	+25.80 % change Jun'24 37.55%	+0.18 % change Jun'24 29.18%	-8.24 % change Jun'24 44.51%	+1.80 % change Jun'24 63.56%	-2.76 % change Jun'24 24.31%

MY2025 YTD Performance

- ✓ Meeting MPL for 3 measures
- ✓ Within 5% of MPL for 3 measures



*GSD reflecting inaccurate compliance rate

For additional Information, please contact:

Kailey Collier, Director of Quality Performance
Aurora de la Torre, MCAS Supervisor

KERN HEALTH SYSTEMS

To: KHS EQIHEC Meeting

From: Melinda Santiago, Director of Behavioral Health

Date: June 17, 2025

Re: Behavioral Health Advisory Committee (BHAC)

Background:

KHS has formed a Behavioral Health Advisory Committee to help us enhance the Behavioral Health services for our members. Subcommittee that is comprised of behavioral health practitioners. The committee will support, review, and evaluate interventions to promote collaborative strategic alignment between KHS and the County Behavioral Health Plan (BHP) and the Drug Medi-Cal Organized Delivery System (DMC-ODS). Kern Behavioral Health and Recovery Services (KBHRS) administers both the BHP and DMC-ODS, treating KHS members with the goal to maintain continuity, reduce barriers to access, linkage to appropriate services, opportunities to integrate care with medical care, and provide resources for members with mental illness and/or substance use disorder. This report reflects activities and outcomes for the first quarter of 2025.

Meetings Held:

- April 9, 2025 (Quarter 2)

Discussion Items:

- Behavioral Health Quarter 1, 2025 Updates
  - Developed and implemented a new Policy and Procedure for Minor Consent.
  - Collaborated with COSA and JIVA to enhance provider portal integration.
  - Added a dedicated Behavioral Health tab to the member portal.
  - Continued provider network in person care capacity expansion efforts.
  - Launched data reporting capabilities to better identify trends and performance gaps.
  - Strengthened county coordination with Kern BHRS to support MCAS Measures.
  - Finalized the 2025 Roadmap for integration of Medication-Assisted Treatment (MAT) Services within BH Programs.
  - Maintained performance on FUM (Follow-Up After Emergency Department Visit for Mental Illness) and FUA (Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence) measures.
- Preparation for Launch of 2026 BH Member Experience Surveys (Adults & Children)
  - Survey Format: Reviewed number of questions and maintaining structure for baseline comparison.
  - Focus Areas for Improvement: Access to care and attitude of providers were per

last year's results.
    - Focus areas will be addressed in upcoming provider training initiatives.
- Minor Consent DHCS APL 24-019 Implementation
    - New Resource developed a "Minor Consent to Outpatient Mental Health. Treatment or Counseling Notification" assessment to be available in the provider portal.
- MAT Overview Discussion – Dr. Beare- TABLED
- NSMHS O& E Plan
    - SOGI Assessment.
    - RAC Updates.
    - Website Updates.
    - Provider Training Topics.
- BHAC Calendar: Next meeting will be held Wednesday, July 16, 2025, at 12:00-1:30

Fiscal Impact: None.

Requested Action: Review and approve.

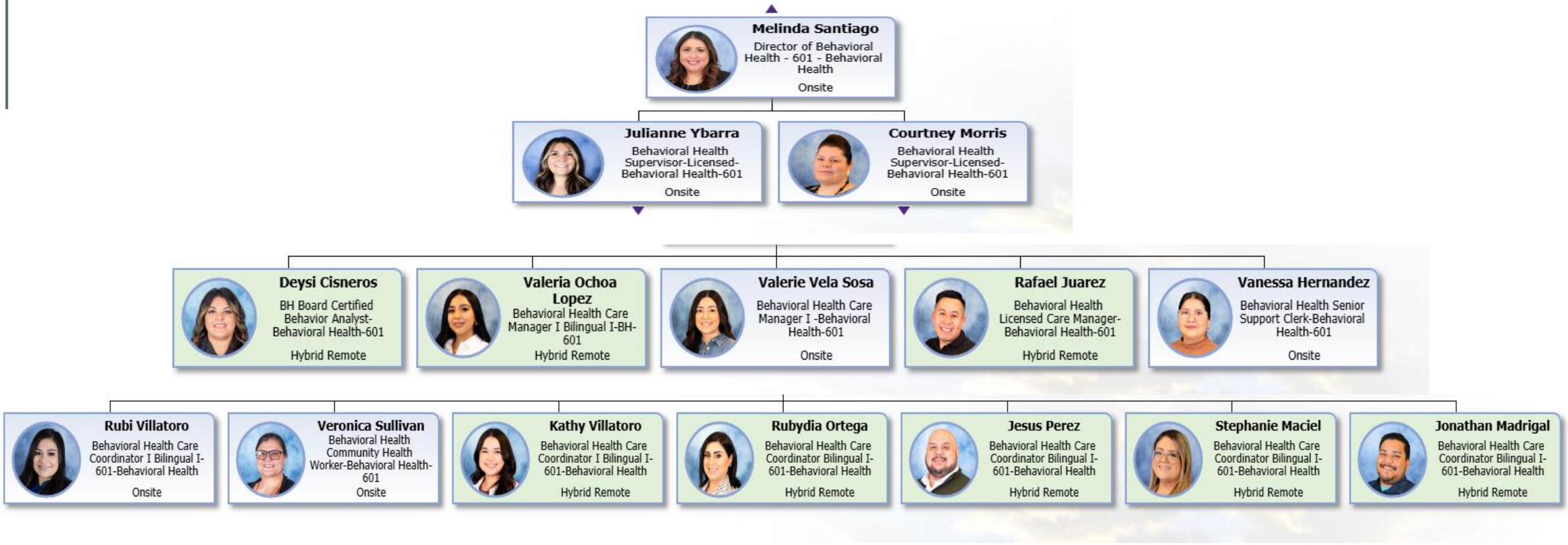
KERN HEALTH SYSTEMS

Melinda Santiago

Director of Behavioral Health

April 8, 2024

BH DEPARTMENT



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BH Updates Q1 2025

Strategy 1: Internal Behavioral Health Department Development

•Highlight **Key Accomplishments**:

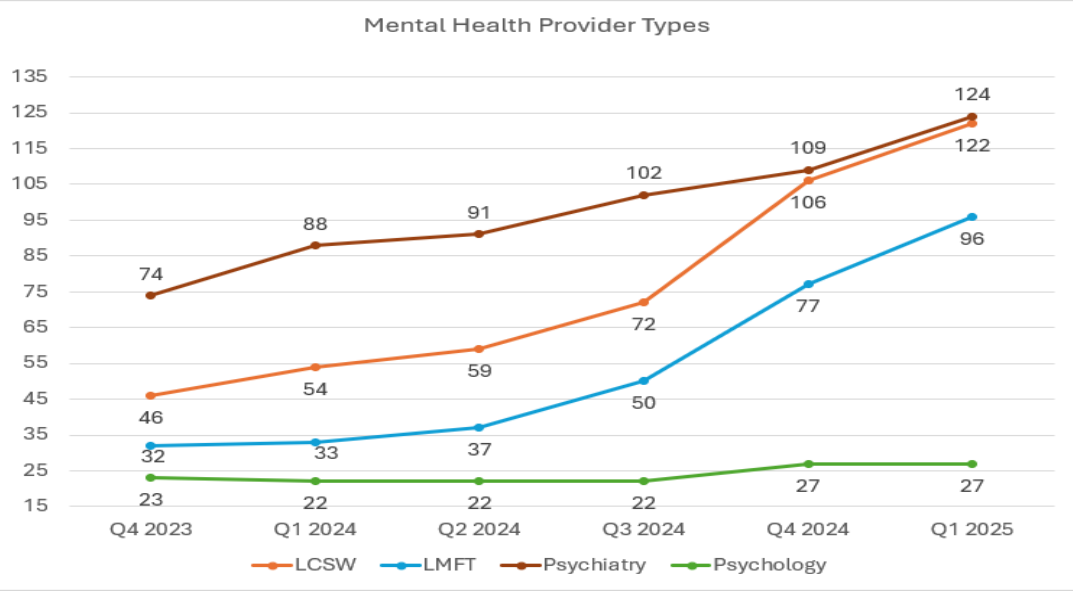
- **Behavioral Health (BH) Program Quality Improvement Framework**:
  - Created Policies and Procedures (P&P) for Minor Consent APL.
  - Collaborated with COSA for JIVA and Provider Portal integration.
- **Data Reporting Improvements**:
  - Ongoing improvement of data capabilities to identify trends and performance gaps.
- **Enhancement of Provider Portal**:
  - Added Behavioral Health tab to member profiles for better data access and care coordination.

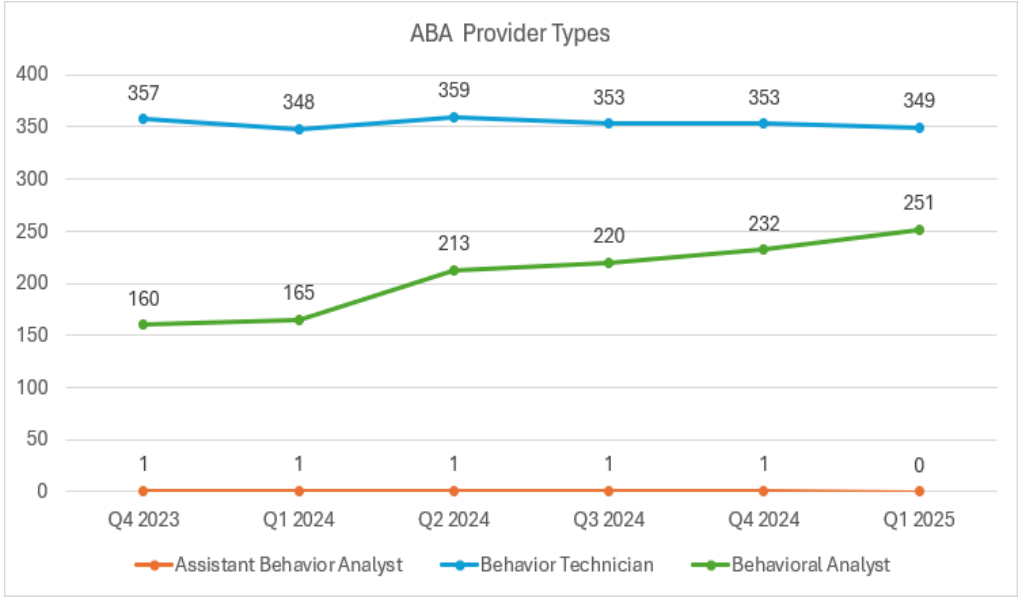
BH Updates Q1 2025

Strategy 2: Mental Health Provider Network Evaluation

•Key Accomplishments:

- Ongoing recruitment and support to expand provider network.
- Addressed provider gaps, particularly in ABA services and in-person care.
- Increase in mental health provider types, e.g., LMFT, LCSW, Psychiatrists.
- Changes in ABA provider network, with an increase in Behavioral Analysts.





BH Updates Q1 2025

Strategy 3: County Behavioral Health Coordination

•Key Accomplishments:

- Initiated **Monthly Care Coordination Meetings** between MCP and MHP.
- Continued work on MOU implementation with MHP and DMC-ODS.
- Collaboration with Kern BHRS for MCAS measures (Follow-Up After Hospitalization and ED Visits).

Strategy 4: Primary Care Provider Roles with SUD/MAT

•Key Accomplishments:

- Finalized the **2025 Roadmap** for integrating MAT services within BH programs.
- Engaged with **PCPs** and **Partnership Health Plan** to enhance MAT services.
- Developed a presentation for the **Behavioral Health Advisory Committee (BHAC)**.

BH Updates

Q1 2025 Highlights

- 12,637 inbound/outbound calls
- 1698 episodes recorded for this quarter
  - Referred Episodes: 568
  - Open Episodes: 558
  - Closed Episodes: 572

BH Care Coordination & Management Referrals	Totals
Initial Screening	353
TOC	290
KBHRS – Screening	69
Other	986

Activities	Totals
Care Coordinator	6,798
Care Manager	1,078
CHW	507

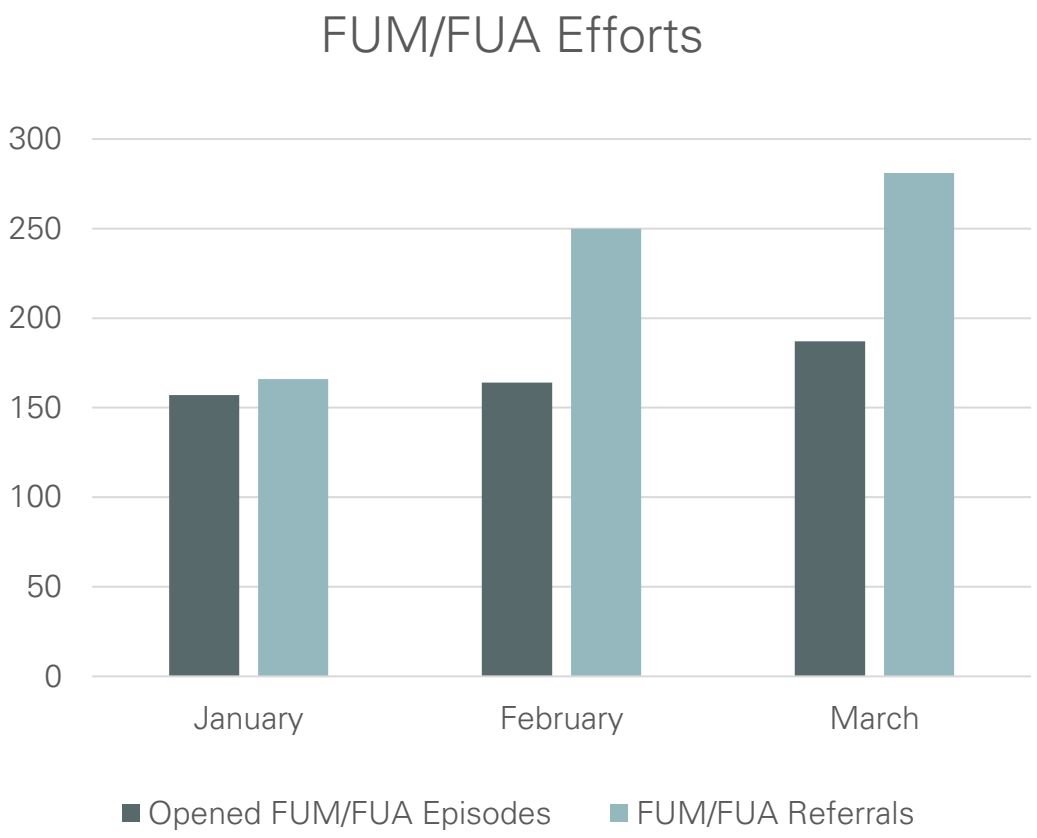
CHW Referrals	Total
Referrals	274
Field Visits	195

BH Updates

Q1 2025 Highlights

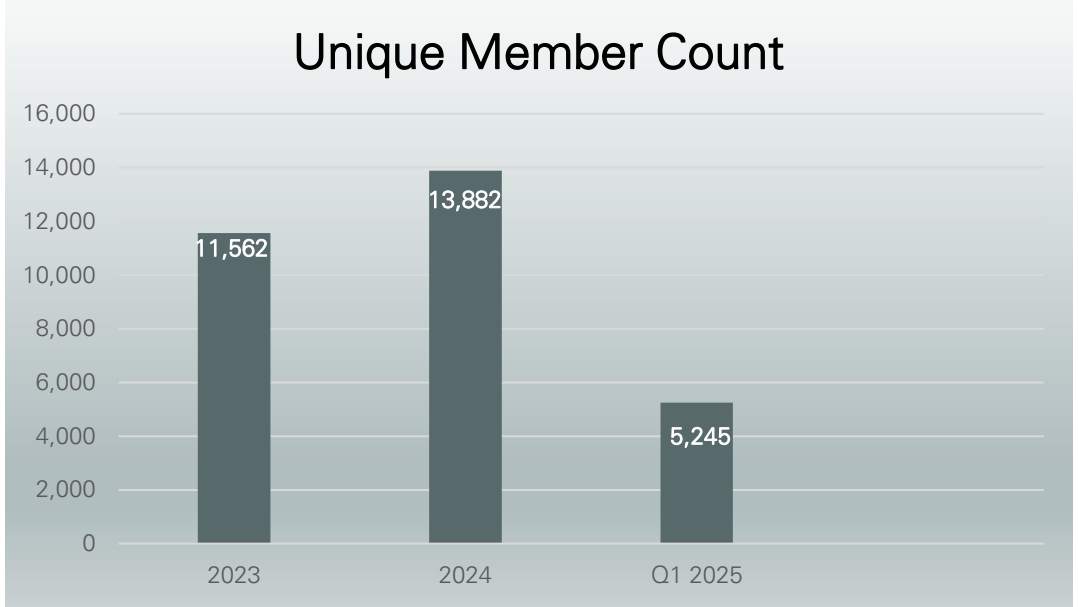
BH Department efforts for FUM/FUA measures

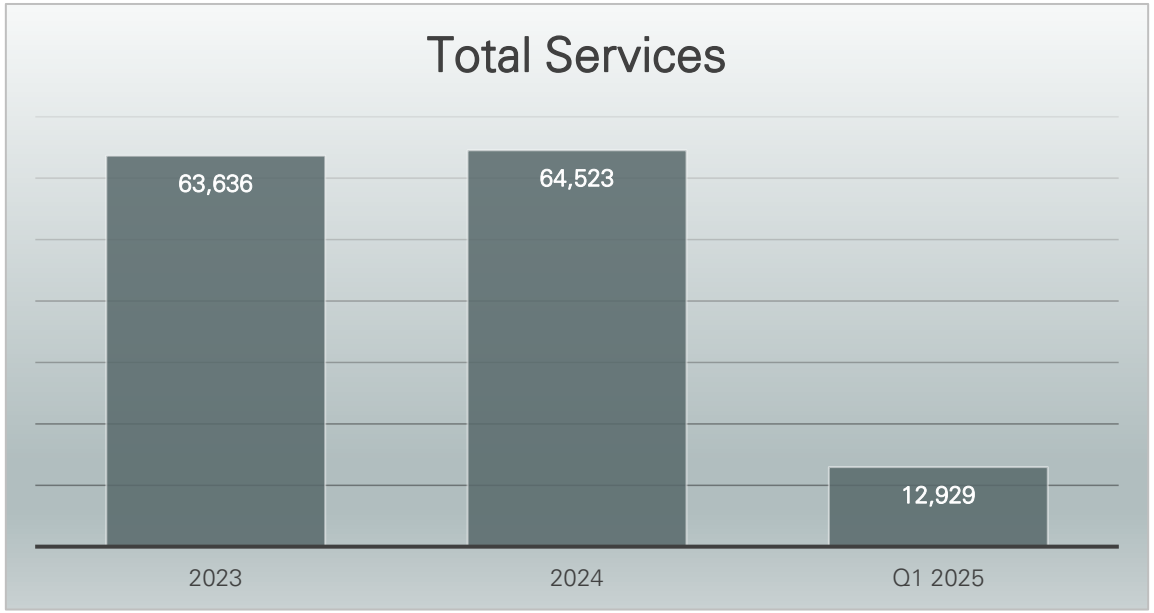
- Total number of unique member referrals for FUM/FUA: 697
    - January: 166
    - February: 250
    - March: 281
- Total # of BH opened episodes For FUM/FUA: 508
    - January: 157
    - February: 164
    - March: 187



BH Updates

Utilization for Non-Specialty Mental Health Services





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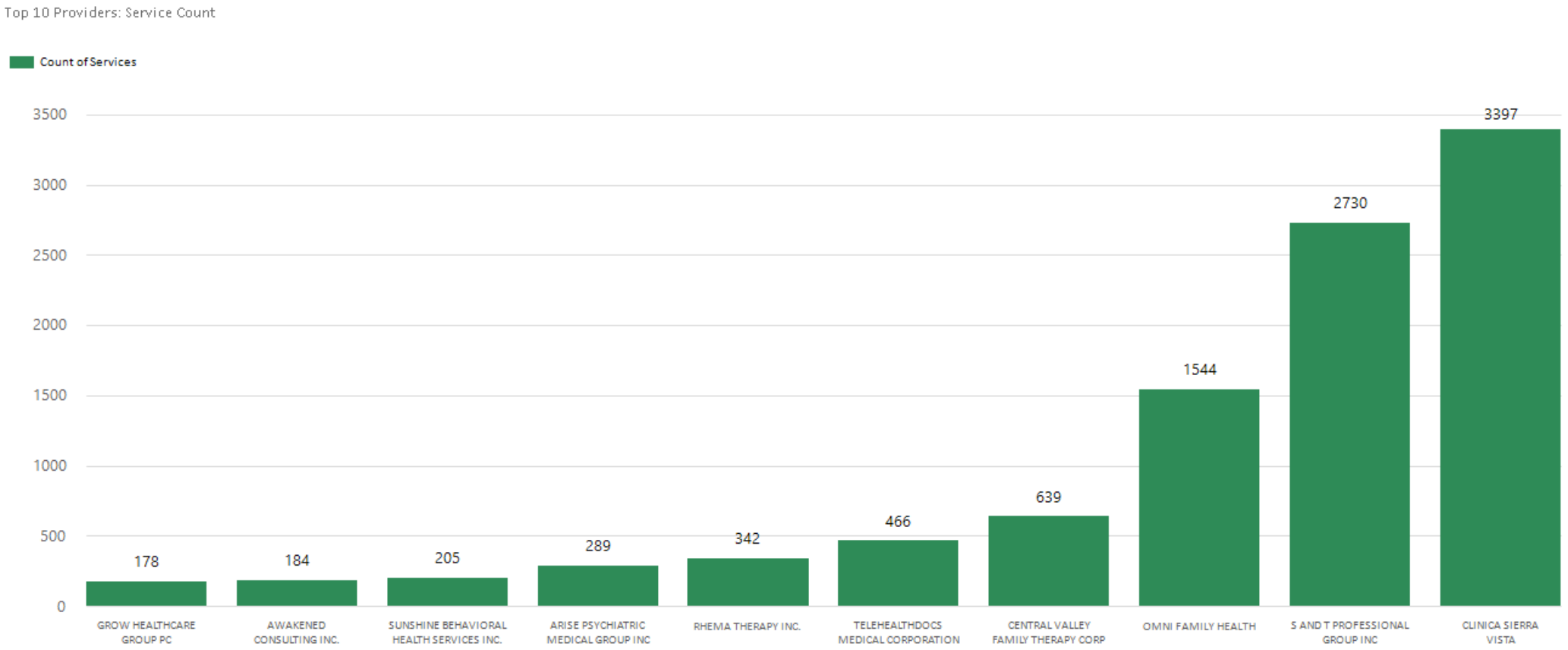
BH Updates for Q1 2025



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Behavioral Health Department Initiatives

CYBHI Statewide Multi-Payer Fee Schedule for School-Linked Behavioral Health Services

Objective:
- Create oversight for scope of work related to Behavioral Health Coverage.
- Develop future state requirements for D-SNP line of business, focusing on behavioral health services across the continuum of care (Outpatient & Inpatient).

Minor Consent to Outpatient Mental Health Treatment or Counseling (APL 24-019) - AB 665
- New Provision:
- Minors Aged 12+ may consent to non-specialty outpatient Medi-Cal mental health treatment or counseling without parental or guardian consent.
- Professional Judgment: The attending professional must determine, based on their clinical expertise, whether the minor is mature enough to make an informed decision about participating in treatment.

Non-Specialty Mental Health Services (NSMHS) Outreach and Education Plan
- Purpose of SB 1019: Address low utilization of Medi-Cal NSMHS.
- Mandates: Annual outreach plans by MCPs targeting members and PCPs.
- Goals: Improve awareness and access, with a focus on culturally and linguistically appropriate outreach.
- Plan Submission: Submitted to DHCS on Dec 31, 2024

D-SNP for Behavioral Health Coverage
- Objective:
- Create oversight for scope of work related to Behavioral Health Coverage.
- Develop future state requirements for D-SNP line of business, focusing on behavioral health services across the continuum of care (Outpatient & Inpatient).

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28. How did that person help you? (*Mark all that apply*)

- ☐ Read the questions to me
- ☐ Wrote down the answers I gave
- ☐ Answered the questions for me
- ☐ Translated the questions into my language
- ☐ Helped in some other way

Thank you for participating in our survey!
Please mail the survey back in the enclosed postage-paid, self-addressed reply envelope or send to:
Press Ganey • P.O. Box 7313
South Bend, IN 46699-0457

If you have any questions, please call 1-866-975-6709.

PressGaney P.O. Box 7313
South Bend, IN 46699-0457

Kern Family Health Care®

SURVEY INSTRUCTIONS

- Answer each question by marking the box to the left of your answer.
- You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:

  ☒ Yes ➔ ***If Yes, Go to Question 1***
  ☐ No

Personally identifiable information will not be made public and will only be released in accordance with federal laws and regulations.

You may choose to answer this survey or not. If you choose not to, this will not affect the benefits you get. You may notice a number on the cover of this survey. This number is ONLY used to let us know if you returned your survey so we don't have to send you reminders.

If you want to know more about this study, please call 1-866-975-6709.

PERSONAL OR FAMILY COUNSELING

People can get counseling, treatment or medicine for many different reasons, such as:

- *For feeling depressed, anxious, or "stressed out"*
- *Personal problems (like when a loved one dies or when there are problems at work)*
- *Family problems (like marriage problems or when parents and children have trouble getting along)*
- *Needing help with drug or alcohol use*
- *For mental or emotional illness*

YOUR COUNSELING AND TREATMENT IN THE LAST 12 MONTHS

*The next questions ask about **your** counseling or treatment. **Do not** include counseling or treatment you got during an overnight stay or from a self-help group.*

1. In the last 12 months, did you call someone to get professional counseling for yourself?

- ☐ Yes ➔ ***If Yes, Go to Question 2***
- ☐ No ➔ ***If No, Go to Question 3***

2. In the last 12 months, how often did you get the professional counseling you needed?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

3. In the last 12 months, when you needed counseling or treatment right away, how often did you see someone as soon as you wanted?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

4. In the last 12 months, not counting the times you needed counseling or treatment right away, how often did you get an appointment for counseling or treatment as soon as you wanted?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

5. In the last 12 months, how many times, if any, did you go to an emergency room or crisis center to get counseling or treatment for yourself?

- ☐ None
- ☐ 1
- ☐ 2
- ☐ 3 or more

6. In the last 12 months, how often were you seen within 15 minutes of your appointment?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

The next questions are about all the counseling or treatment you got in the last 12 months during office, clinic, and emergency room visits as well as over the phone. Please do the best you can to include all the different people you went to for counseling or treatment in your answers.

7. In the last 12 months, how often did the people you went to for counseling or treatment listen carefully to you?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

8. In the last 12 months, how often did the people you went to for counseling or treatment explain things in a way you could understand?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

9. In the last 12 months, how often did the people you went to for counseling or treatment show respect for what you had to say?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

10. In the last 12 months, how often did the people you went to for counseling or treatment spend enough time with you?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

11. In the last 12 months, did you take any prescription medicines as part of your treatment?

- ☐ Yes ➔ ***If Yes, Go to Question 12***
- ☐ No ➔ ***If No, Go to Question 13***

12. In the last 12 months, were you told what side effects of those medicines to watch for?

- ☐ Yes
- ☐ No

13. In the last 12 months, how often were you involved as much as you wanted in your counseling or treatment?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

14. In the last 12 months, were you given information about your rights as a patient?

- ☐ Yes
- ☐ No

15. In the last 12 months, did you feel you could refuse a specific type of medicine or treatment?

- ☐ Yes
- ☐ No

16. Using any number from 0 to 10, where 0 is the worst counseling or treatment possible and 10 is the best counseling or treatment possible, what number would you use to rate all your counseling or treatment in the last 12 months?

Worst counseling or treatment possible — Best counseling or treatment possible

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

The next questions ask about your experience with the company or organization that handles your benefits for counseling or treatment.

17. In the last 12 months, did you call customer service to get information or help about counseling or treatment?

- ☐ Yes ➔ ***If Yes, Go to Question 18***
- ☐ No ➔ ***If No, Go to Question 19***

18. In the last 12 months, how much of a problem, if any, was it to get the help you needed when you called customer service?

- ☐ A big problem
- ☐ A small problem
- ☐ Not a problem

REASONS FOR COUNSELING OR TREATMENT

19. In the last 12 months, was any of your counseling or treatment for help with alcohol use or drug use?

- ☐ Yes
- ☐ No

ABOUT YOU

20. In general, how would you rate your overall mental health now?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

21. And, in general, how would you rate your overall physical health now?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

We'd like to end this survey by asking a few general background questions. This will help us understand the results and allow us to describe the characteristics of everyone who fills out the survey. All of your answers are completely confidential.

22. What is your age now?

- ☐ 18–24
- ☐ 25–34
- ☐ 35–44
- ☐ 45–54
- ☐ 55–64
- ☐ 65–74
- ☐ 75 or older

23. Are you male or female?

- ☐ Male
- ☐ Female

24. What is the highest grade or level of school that you have completed?

- ☐ 8th grade or less
- ☐ Some high school, but did not graduate
- ☐ High school graduate or GED
- ☐ Some college or 2-year degree
- ☐ 4-year college graduate
- ☐ More than 4-year college degree

25. Are you of Hispanic or Latino origin or descent?

- ☐ Yes, Hispanic or Latino
- ☐ No, not Hispanic or Latino

26. What is your race? (*Please mark one or more*)

- ☐ White
- ☐ Black or African-American
- ☐ Asian
- ☐ Native Hawaiian or other Pacific Islander
- ☐ American Indian or Alaska Native
- ☐ Other

27. Did someone help you complete this survey?

- ☐ Yes ➔ ***If Yes, Go to Question 28***
- ☐ No ➔ ***Thank you. Please return the completed survey in the postage-paid envelope.***

26. Is your child of Hispanic or Latino origin or descent?

- ☐ Yes, Hispanic or Latino
- ☐ No, not Hispanic or Latino

27. What is your child's race? (*Please mark one or more*)

- ☐ White
- ☐ Black or African-American
- ☐ Asian
- ☐ Native Hawaiian or other Pacific Islander
- ☐ American Indian or Alaska Native
- ☐ Other

28. What is your age now?

- ☐ 18–24
- ☐ 25–34
- ☐ 35–44
- ☐ 45–54
- ☐ 55–64
- ☐ 65–74
- ☐ 75 or older

29. Are you male or female?

- ☐ Male
- ☐ Female

30. What is the highest grade or level of school that you have <u>completed</u>?

- ☐ 8th grade or less
- ☐ Some high school, but did not graduate
- ☐ High school graduate or GED
- ☐ Some college or 2-year degree
- ☐ 4-year college graduate
- ☐ More than 4-year college degree

31. How are you related to the child?

- ☐ Mother or father
- ☐ Grandparent
- ☐ Aunt or uncle
- ☐ Older sibling
- ☐ Other relative
- ☐ Legal guardian

32. Did someone help you complete this survey?

- ☐ Yes ➔ ***If Yes, Go to Question 33***
- ☐ No ➔ ***Thank you. Please return the completed survey in the postage-paid envelope.***

33. How did that person help you? (*Mark all that apply*)

- ☐ Read the questions to me
- ☐ Wrote down the answers I gave
- ☐ Answered the questions for me
- ☐ Translated the questions into my language
- ☐ Helped in some other way (*Please print*)

_____

_____

_____

_____

Thank you for participating in our survey!
Please mail the survey back in the enclosed postage-paid, self-addressed reply envelope or send to:
Press Ganey • P.O. Box 7313
South Bend, IN 46699-0457

If you have any questions, please call 1-866-975-6709.

PressGaney P.O. Box 7313 South Bend, IN 46699-0457

Kern Family Health Care®

SURVEY INSTRUCTIONS

- Answer each question by marking the box to the left of your answer.
- You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:

  ☒ Yes ➔ ***If Yes, Go to Question 1***
  ☐ No

Personally identifiable information will not be made public and will only be released in accordance with federal laws and regulations.

You may choose to answer this survey or not. If you choose not to, this will not affect the benefits you get. You may notice a number on the cover of this survey. This number is ONLY used to let us know if you returned your survey so we don't have tosend you reminders.

If you want to know more about this study, please call 1-866-975-6709.

PERSONAL OR FAMILY COUNSELING

Children can get counseling, treatment or medicine for many different reasons, such as:

For problems related to attention deficit hyperactivity disorder (ADHD) or other behavior problems

- *Family problems (like when parents and children have trouble getting along)*
- *For mental or emotional illness*
- *For autism or other developmental conditions*
- *Needing help with drug or alcohol use*

YOUR CHILD'S COUNSELING AND TREATMENT IN THE LAST 12 MONTHS

The next questions ask about your <u>child's</u> counseling or treatment. <u>Do not</u> include counseling or treatment during an overnight stay or from a self-help group.

1. In the last 12 months, how often did you get the professional counseling your child needed <u>on the phone</u>?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

2. In the last 12 months, when your child needed counseling or treatment <u>right away</u>, how often did he or she see someone as soon as you wanted?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

3. In the last 12 months, not counting times your child needed counseling or treatment right away, how often did your child get an appointment for counseling or treatment as soon as you wanted?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

4. In the last 12 months, how many times did your child go to an <u>emergency room or crisis center</u> to get counseling or treatment?

- ☐ None
- ☐ 1
- ☐ 2
- ☐ 3 or more

5. In the last 12 months, how often was your child seen within 15 minutes of his or her appointment?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

The next questions are about all the counseling or treatment your child got in the last 12 months in your home, during office, clinic, and emergency room visits as well as over the phone. Please do the best you can to include all the different people your child saw for counseling or treatment in your answers.

6. In the last 12 months, how often did the people your child saw for counseling or treatment listen carefully to you?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

7. In the last 12 months, how often did the people your child saw for counseling or treatment explain things in a way you could understand?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

8. In the last 12 months, how often did the people your child saw for counseling or treatment show respect for what you had to say?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

9. In the last 12 months, how often did the people your child saw for counseling or treatment spend enough time with you?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

10. In the last 12 months, did your child take any prescription medicines as part of his or her treatment?

- ☐ Yes
- ☐ No ➔ ***If No, Go to Question 12***

11. In the last 12 months, were you told what side effects of those medicines to watch for?

- ☐ Yes
- ☐ No

12. In the last 12 months, how often were you involved as much as you wanted in your child's counseling or treatment?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

13. In the last 12 months, how often did your family get the professional help you wanted for your child?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

14. Does your child's language, race, religion, ethnic background or culture make any difference in the kind of counseling or treatment he or she needs?

- ☐ Yes
- ☐ No ➔ ***If No, Go to Question 16***

15. In the last 12 months, was the care your child received responsive to those needs?

- ☐ Yes
- ☐ No

16. Using any number from 0 to 10, where 0 is the worst counseling or treatment possible and 10 is the best counseling or treatment possible, what number would you use to rate all your child's counseling or treatment in the last 12 months?

- ☐ 0 Worst counseling or treatment possible
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 Best counseling or treatment possible

17. In general, how would you rate your child's overall mental health now?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

YOUR CHILD'S HEALTH PLAN FOR COUNSELING OR TREATMENT

*The next questions ask about your experience with your child's health plan for **counseling or treatment**.*

18. In the last 12 months, did you call the health plan's customer service to get information or help about counseling or treatment for your child?

- ☐ Yes
- ☐ No ➔ ***If No, Go to Question 20***

19. In the last 12 months, how much of a problem, if any, was it to get the help you needed for your child when you called the health plan's customer service?

- ☐ A big problem
- ☐ A small problem
- ☐ Not a problem

REASONS FOR COUNSELING OR TREATMENT

20. In the last 12 months, was any of your child's counseling or treatment for problems related to ADHD or other behavior problems?

- ☐ Yes
- ☐ No

21. In the last 12 months, was any of your child's counseling or treatment for family problems or mental or emotional illness?

- ☐ Yes
- ☐ No

22. In the last 12 months, was any of your child's counseling or treatment for autism or other developmental problems?

- ☐ Yes
- ☐ No

23. In the last 12 months, was any of your child's counseling or treatment for help with alcohol use or drug use?

- ☐ Yes
- ☐ No

ABOUT YOU AND YOUR CHILD

24. What is your child's age now?

- ☐ Less than 1 year old

☐☐ YEARS OLD (*write in*)

25. Is your child male or female?

- ☐ Male
- ☐ Female

Provider Notification Request Form
Minor Consent to Outpatient Mental Health Treatment or Counseling Notification

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Provider Portal Information

- **Referring Provider First and Last Name:** Referring Provider First and Last Name
- **Referring Provider TAX ID:** Referring Provider Tax ID
- **Referring Provider NPI:** Referring Provider NPI

Minor Consent Notification:
The Behavioral Health Practitioner must use their clinical judgment and expertise to determine whether the minor is mature enough to participate in these services independently, without parental or guardian consent.

Minor Consent Obtained:

- ☐ **Yes** (New Consent was determined)
- **Consent Date:** MM/DD/YYYY

Change of Status on Minor Consent: (Any change in status will terminate the minor consent)

- **Date of Change:** MM/DD/YYYY
- **New Consent Status:**
  - ☐ **Minor consent revoked by Provider**
  - ☐ **Parental consent obtained**
- **Additional Notes:** Include any relevant information, such as communication with parent/guardian, legal notices, or other context that may apply.

Confidential Correspondence: (If no alternate address is provided, all mailing will be suppressed.)

- **Provide alternate address:**
  - Street Address: _____
  - City: _____
  - State/Zip Code: _____

Provider Attestation:
By electronically submitting this request in the Provider Portal, I attest that the above information is accurate and complete.

MAT (Medication-Assisted Treatment) Framework in PCP Settings

Best Practices and Adaptation from Street Medicine to PCP Offices

Melinda Santiago, LMFT
Director of Behavioral Health
Kern Health Systems
&
Dr. Matthew Beare
Clinica Sierra Vista

4/9/2025

Introduction of MAT in PCP Settings

Definition of MAT: Medication-Assisted Treatment (MAT) is the use of FDA-approved medications alongside counseling and behavioral therapies to treat substance use disorders, particularly opioid addiction.

Purpose of the Presentation: To explore how MAT can be effectively implemented in Primary Care Physician (PCP) settings and review best practices, while adapting approaches used in Street Medicine to a traditional office environment.

MAT Process in PCP Settings

Step 1

Initial Assessment

- Comprehensive assessment of the patient's medical, psychological, and substance use history.
- Identify the need for MAT and suitability for opioid use disorder treatment.

Step 2

Medication Selection

- Common medications used: Methadone, Buprenorphine, Naltrexone.
- Consideration of the patient's specific condition and preferences.

Step 3

Counseling and Behavioral Therapy

- Integration of therapy with medication.
- Use of individual or group counseling, cognitive-behavioral therapy (CBT), and contingency management.

Step 4

Ongoing Monitoring and Adjustment

- Regular follow-ups for medication adherence, side effects, and therapy progress.
- Adjusting the treatment plan based on patient needs.

Gathering Requirements for MAT

Medical Necessity	• DSM-5 criteria for opioid use disorder (OUD). • History of inadequate response to outpatient or inpatient detox.
Clinical Criteria	• Assessment of physical and mental health status. • Ability to participate in therapy and counseling.
Documentation and Compliance	• Ensuring all required documentation is completed for insurance or funding purposes. • Compliance with local and state regulations regarding MAT.

Establishing a Quality Improvement (QI) Framework for MAT

Monitoring Program Effectiveness

- Set clear metrics for treatment success (e.g., retention rates, reduced substance use).
- Regular patient outcome reviews (e.g., toxicology screenings, abstinence from opioids).

Auditing and Reviewing

- Regular audits of documentation, prescribing practices, and patient progress.
- Ensure consistent adherence to best practices for MAT.

Feedback and Continuous Improvement

- Gathering feedback from patients and staff.
- Implementing changes based on audit findings and feedback to optimize MAT processes.

Best Practices for MAT in PCP Settings

Comprehensive Screening and Assessment

- Incorporating structured screening tools for opioid use disorder (e.g., CAGE-AID, DAST).
- Regularly reassessing the patient's readiness for MAT.

Patient-Centered Care

- Involving patients in decision-making about their treatment plan.
- Addressing barriers to adherence (e.g., transportation, stigma, socioeconomic factors).

Coordination with Behavioral Health Providers

- Collaboration with counselors, therapists, and addiction specialists to enhance treatment.
- Incorporating telehealth options for remote behavioral therapy.

Building a Non-Stigmatizing Environment

- Fostering an empathetic, patient-centered atmosphere.
- Training staff to reduce stigma related to substance use disorders.

Adapting Street Medicine Approaches to PCP Setting

- **Outreach and Community Connection**
  - **Street Medicine:** Direct outreach to patients where they are located, focusing on building trust.
  - **PCP Office:** Proactive outreach to high-risk populations through local community programs, referrals, or patient education.
- **Holistic Approach**
  - **Street Medicine:** Treating the whole person with an emphasis on harm reduction and empathy.
  - **PCP Office:** Extending harm reduction strategies by integrating mental health, social services, and MAT under one roof.
- **Reducing Barriers to Care**
  - **Street Medicine:** Flexibility in care delivery to meet the patient where they are.
  - **PCP Office:** Extended hours, transportation assistance, and telehealth options to facilitate access.

Referral Process for MAT Members

Initial Screening and Eligibility

- Use of standardized screening tools to identify candidates for MAT.
- Collaboration with mental health professionals, addiction specialists, and case managers.

Referral Pathways

- Clear communication with external providers for specialty MAT clinics.
- Integration of MAT into the broader care plan, considering medical, behavioral, and social needs.

Follow-up and Coordination

- Structured follow-up calls or visits to ensure patients remain engaged.
- Referral back to PCP after completing an inpatient or intensive outpatient program.

Key Challenges in PCP MAT Implementation

Stigma and Misconceptions	• Overcoming negative perceptions about MAT within healthcare settings.
Training and Education	• Ensuring that PCPs and office staff are trained in addiction medicine, harm reduction techniques, and effective MAT prescribing.
Limited Resources	• Addressing the lack of resources for MAT, especially in underserved areas.
Collaboration and Communication	• Fostering effective communication between PCPs, addiction specialists, and behavioral health teams.

Questions and Discussion

- **Summary of Key Takeaways**
  - MAT can be an effective treatment for opioid use disorder in the PCP setting with the right resources, approach, and collaboration.
- **Next Steps**
  - Develop training programs for PCP staff.
  - Establish referral pathways and community partnerships.
  - Implement a QI framework for ongoing assessment and improvement.

SOGI Assessment

Do you think of yourself as:

☐ Straight or heterosexual ☐ Lesbian or gay
☐ Bisexual ☐ Queer, pansexual, and/or questioning
☐ Don't know ☐ Decline to answer ☐ Information unavailable
☐ Something else; please describe: _____

Do you think of yourself as:

☐ Male ☐ Female ☐ Transgender man/trans man/female-to-male (FTM)
☐ Transgender woman/trans woman/male-to-female (MTF)
☐ Genderqueer, neither exclusively male nor female
☐ Decline to answer ☐ Information unavailable
☐ Additional gender category (or other); please describe: _____

What sex was originally listed on your birth certificate?

☐ Male ☐ Female ☐ Unknown
☐ Decline to answer ☐ Information unavailable

What is your name as you would like it to appear on your health records? _____

What are your pronouns?

☐ He/him ☐ She/her ☐ They/them ☐ Decline to answer
☐ Information unavailable
☐ Other: _____

Outreach and Education on Behavioral Health: Addressing Barriers & Stigma

Melinda Santiago, LMFT
Behavioral Health Director

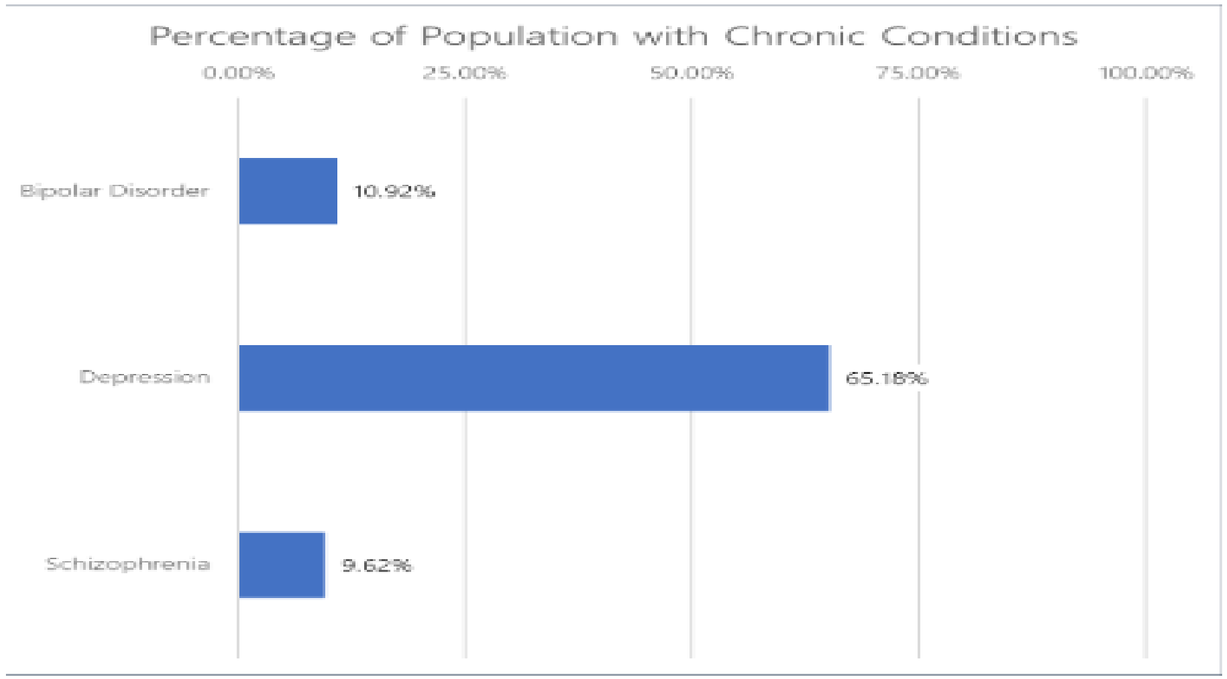
KERN HEALTH SYSTEMS

Behavioral Health Overview

- **What is Behavioral Health?**
  - Definition: Behavioral health is the connection between behaviors and the health and well-being of the body, mind, and spirit.
  - Includes mental health, substance use, and other behaviors impacting well-being.
- **Some examples of behavioral health concerns are:**
  - Life changes, frustration, and stress
  - Anxiety, Depression, Grief and loss
  - Autism, attention-deficit/hyperactivity disorder (ADHD)
  - Drug or alcohol use
  - Traumas and Post-traumatic stress disorder (PTSD)

Current State of Behavioral Health:

- Low utilization of Medi-Cal Non-Specialty Mental Health Services (NSMHS) currently 3% of total membership for KFHC



Behavioral Health Services Available?

- **KFHC members can find support by calling the KFHC Behavioral Health Department, who will help you:**
  - Understand your mental health benefits.
  - Find mental health providers in your area.
  - Make an appointment.
- **Covered Services:**
  - Individual, family, or group therapy.
  - Visits with a psychiatrist.
  - Psychological testing.
  - Emotional support during and after pregnancy through the child's first year of life.

Outreach and Education Plan

- **In 2025, the Behavioral Health Department will join RAC to present the NSMHS (Network of Support for Mental Health Services) Outreach and Education Plan.**
  - These discussions will focus on:
    - Improving access to behavioral health services.
    - Providing culturally sensitive care.
    - Addressing barriers to care.
    - Developing effective outreach and education strategies.
    - Raising awareness about mental health resources available through KHS.

The Barriers to Behavioral Health Care

- **Access to Services:**
  - Limited availability of mental health professionals.
  - Geographic, financial, and system barriers.

- **Stigma and Misunderstanding:**
  - Social stigma surrounding mental health issues.

- **Cultural and Language Barriers:**
  - Mistrust in the healthcare system.
  - Lack of culturally competent care.

Understanding the Impact of Stigma

- **What is Stigma:**
  - Negative stereotypes or prejudices that contribute to societal rejection of those with behavioral health challenges.

- **Consequences of Stigma:**
  - Prevents individuals from seeking help.
  - Increases isolation, anxiety, and mental health deterioration.
  - Undermines public policy and access to resources.

THANK YOU.!

Questions?

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS

To: KHS EQIHEC

From: Michelle Curioso, Director of Population Health Management

Date: June 17, 2025

Re: Integrated ED Intervention Programs: Connecting Members to the Right Care at the Right Time

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Background:

Kern Health Systems (KHS) continues to address rising emergency department (ED) utilization and preventable inpatient (IP) admissions through a dual-strategy approach:

1. ER Utilizers Connection and Support Program – Targets high-frequency ED users and connects them with long-term, community-based care through personalized care coordination.
2. ER Navigation Program – Engages members in real-time during ED visits to prevent unnecessary admissions by facilitating post-discharge care and treatment plan adherence.

These programs represent a system-wide effort to address both upstream and point-of-care contributors to ED overutilization, improve member outcomes, and reduce avoidable costs.

Discussion:

The ER Utilizers Connection and Support Program was created by KHS to reduce avoidable ED visits among high-frequency users in the Greater Bakersfield area. It provides personalized, team-based care coordination through social workers, nurses, and community health workers. Since launching in June 2024, the program has supported over 620 members and conducted more than 7,000 care activities, addressing needs such as primary care access, behavioral health, housing, and chronic disease support. Early outcomes show reduced ED use and improved member engagement, including cases of sustained health improvements. To address outreach and data limitations, KHS is developing a follow-up program and exploring real-time ED alerts to enhance impact and reach.

The ER Navigation Program, in partnership with Premier Valley Medical Group, aims to reduce unnecessary hospital admissions by engaging members during ED visits. A multidisciplinary team stationed onsite at local hospitals provides real-time care coordination, discharge planning, and connections to follow-up services. The program focuses on members at risk of inpatient admission within one day of their ED visit. The program helped avoid inpatient admissions at Bakersfield Memorial and Mercy Bakersfield through targeted interventions. Higher admission rates at hospitals without the intervention highlight the opportunity to expand the program for broader system-wide impact.

Fiscal Impact: None.

Requested Action: Review and approve.

Kern Family Health Care™

Population Health Management Quarter 1 Report

Michelle Curioso, Director of PHM

June 17, 2025

Integrated ED Intervention Programs: Connecting Members to the Right Care at the Right Time

The ER Utilizers Connection and Support Program and the ER Navigation Program are housed within the Population Health Management (PHM) Department because they are aligned with the department's mission: to improve health outcomes across the member population through proactive care, social needs intervention, and the reduction of unnecessary healthcare utilization.

At the heart of PHM's work is a commitment to addressing the full spectrum of factors that influence health. This includes not only clinical issues but also behavioral health, housing instability, food insecurity, and other social determinants. The ER Utilizers and ER Navigation programs are designed precisely to address these concerns. They work by reducing inappropriate reliance on emergency departments, fostering continuity of care, and ensuring members are connected to the right services at the right time—whether those are clinical, behavioral, or community-based.

These programs are driven by a data-informed approach. Within the PHM framework, teams routinely analyze utilization and risk data to identify members who are high-risk or frequent users of the emergency department. Using this information, the programs conduct targeted outreach and interventions to engage members before they reach a point of crisis. By leveraging risk stratification models, the PHM team can prioritize care coordination efforts and tailor support to those most in need.

Furthermore, the programs depend on seamless cross-functional coordination, which is a core strength of PHM. The department brings together multidisciplinary teams—including nurses, social workers, and community health workers—to provide integrated care. These teams work collaboratively across medical, behavioral health, and social service domains, and they maintain close partnerships with hospitals, providers, and community organizations. Such integrated workflows are essential for executing complex, person-centered interventions that span different systems of care.

Another critical reason these programs reside within PHM is their focus on prevention and cost-effective care. The ER Utilizers Program intervenes early to prevent recurrent ED use by connecting members with primary care and resolving underlying social or medical issues. Similarly, the ER Navigation Program offers timely, post-ED outreach that steers members toward appropriate outpatient services. Both programs exemplify PHM's goal of moving away from reactive care and toward proactive, preventative strategies that improve quality and reduce system-wide costs.

The PHM Department is structured to support longitudinal monitoring and continuous program evaluation. These programs provide rich insights into patterns of emergency department utilization, allowing PHM teams to assess outcomes over time, refine interventions, and develop future strategies for high-risk populations. This ongoing evaluation capability is essential for ensuring the effectiveness and sustainability of the initiatives.

In summary, the ER Utilizers Connection and Support Program and the ER Navigation Program are vital components of the PHM Department because they embody its mission and methods. Through targeted, data-driven interventions and cross-system coordination, these programs not only reduce avoidable healthcare use but also deliver meaningful improvements in member health and well-being.

ER Utilizers Connection and Support Program

Background

Frequent users of emergency departments (EDs) represent a critical intersection of unmet healthcare needs, systemic inefficiencies, and social determinants of health. These individuals often rely on the ER not only for urgent care but also for issues that could be more appropriately managed in outpatient or community-based settings. This pattern of utilization contributes significantly to healthcare system strain, unnecessary costs, and suboptimal outcomes for patients.

Introduction

Between July 2023 and June 2024, Kern Health Systems (KHS) identified 969 members who visited the Emergency Department (ED) five or more times. Many of these visits were for non-emergency concerns—issues that could have been better addressed in primary care or community-based settings. Recognizing this trend, KHS developed the ER Utilizers Connection and Support Program**,** a new initiative aimed at reducing avoidable ED use through personalized care coordination and community engagement.

The program began as a pilot in June 2024 and transitioned into a formal offering by September 2024. Its primary goal is to connect high ED utilizers with more appropriate levels of care, offering structured support and navigation services to help members achieve better health outcomes.

Integrated Care Team Approach

At the heart of the program is a team-based model that includes a social worker, a community health worker, a case management assistant, and a nurse case manager as needed. Together, this team provides a wide range of services, including comprehensive assessments, evaluations of social determinants of health, the development of individualized care plans, and care coordination tailored to each member's unique needs.

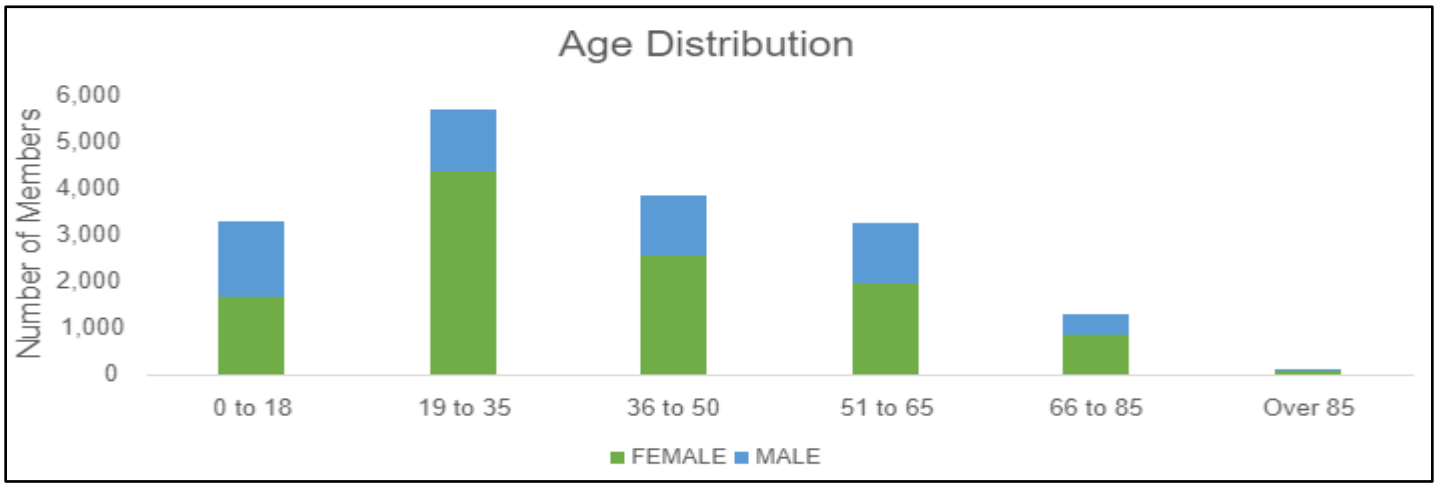
Criteria

To qualify, participants must be adult KHS members residing in the Greater Bakersfield area and must have had more than three ED visits in the past six months.

Program Implementation and Data Analysis

Between June 2024 and April 2025, 620 members received support through the program, with the team completing over 7,000 care coordination activities. The most frequently addressed member needs included establishing relationships with primary care providers, connecting with local urgent care clinics, accessing mental health and substance use services, and obtaining support for food, housing, diabetes education, and financial stability.

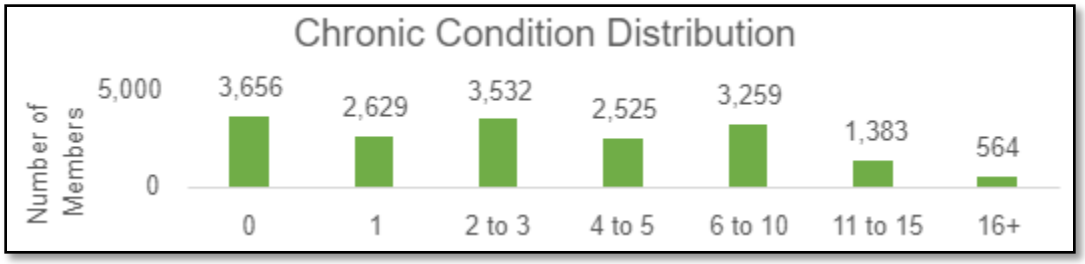
Table 1: Age Distribution



Note: The age distribution of ER utilizers reveals significant trends across different age groups and between genders. Utilization is highest among young adults aged 19 to 35**,** with a noticeable dominance of female members**,** who account for the vast majority in this group. This age range represents the peak in emergency room visits, suggesting a heightened need for medical services among young women.

- Following this peak, ER utilization gradually declines through the 36 to 50 and 51 to 65 age brackets. Females continue to outnumber males, although the gender gap narrows in the older cohorts.
- Children and adolescents in the 0 to 18 group show moderate ER use, with females slightly outnumbering males. Interestingly, utilization drops sharply among individuals 66 years and older, with the Over 85 age group showing the lowest number of ER visits. In these oldest age groups, the number of male and female utilizers is nearly equal, indicating reduced gender disparity in advanced age.
- Overall, the data highlights a clear trend: young adult females are the most frequent ER utilizers, and usage steadily declines with age. Gender differences are more pronounced in younger age groups and become less significant among seniors.

Table 2: Chronic Condition Distribution

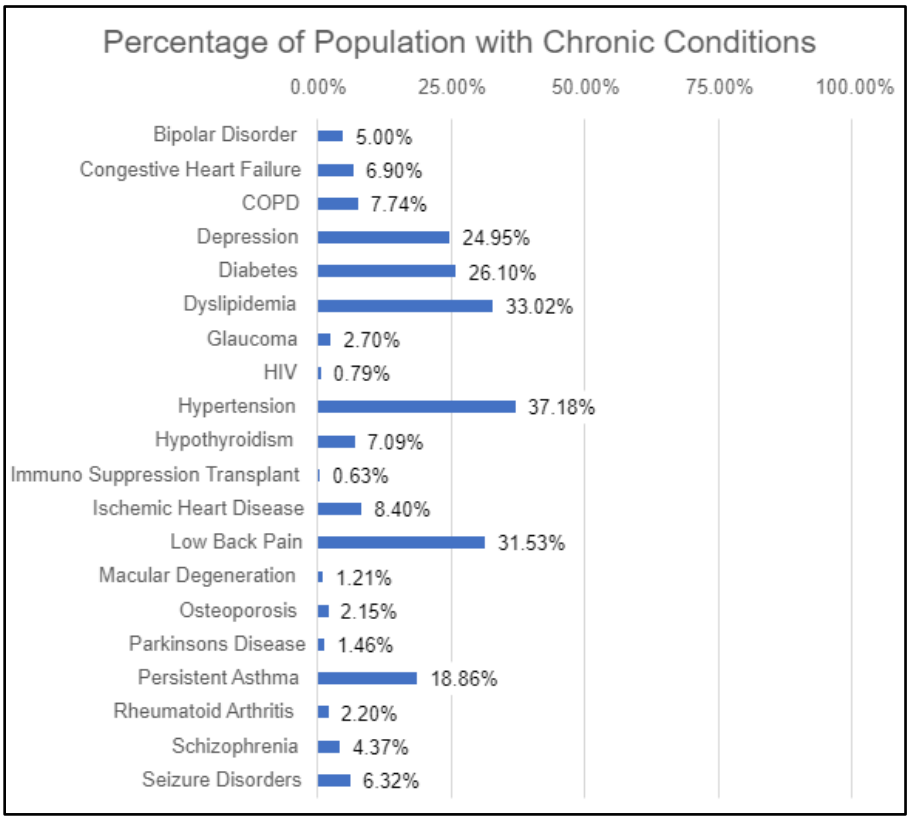


Note: The distribution of chronic conditions among members shows a broad range, with notable groupings at both ends of the spectrum. The largest group consists of members with no chronic conditions**,** totaling 3,656 individuals. This is closely followed by members with 2 to 3 chronic conditions (3,532) and those with 6 to 10 chronic conditions (3,259), indicating that while many members are relatively healthy, a significant portion are managing multiple chronic illnesses.

A considerable number of members also fall into the 1-condition (2,629) and 4 to 5-condition (2,525) categories, further suggesting a substantial population with early or moderate levels of chronic disease burden.

Notably, the number of members with more severe chronic condition loads declines sharply. Only 1,383 members have 11 to 15 conditions, and just 564 members manage 16 or more. This steep drop may reflect the increasing complexity and potentially limited survivability associated with a high number of chronic conditions.

Table 3: Percentage of Population with Chronic Conditions



Note: These top five conditions collectively represent a critical intersection of physical and mental health issues. Their high prevalence suggests the need for coordinated, multi-disciplinary care strategies to manage comorbidities and improve outcomes across the population.

1. The data reveals that hypertension is the most prevalent chronic condition, affecting 37.18% of the population. This high percentage reflects the widespread nature of high blood pressure and underscores its significance as a key public health concern, especially due to its strong association with cardiovascular events.
2. Following closely, dyslipidemia—characterized by abnormal cholesterol or lipid levels—is present in 33.02% of the population. This condition often coexists with hypertension and diabetes, further compounding cardiovascular risk.
3. Low back pain ranks third, impacting 31.53% of individuals. Its high prevalence highlights both its chronic nature and the potential for it to impair quality of life and productivity, making it a leading cause of physical disability.
4. In fourth place is diabetes, affecting 26.10% of the population. The burden of diabetes is particularly concerning due to its long-term complications and healthcare costs, as well as its correlation with other top conditions like hypertension and dyslipidemia.
5. Depression rounds out the top five, with a prevalence of 24.95%. This underscores the substantial mental health needs of the population and the importance of integrating behavioral health into chronic disease management.

Success Story
One compelling example of the program's impact involves a 50-year-old male who visited the ED three times in one week with symptoms of chest pain, headaches, and a 30-pound unexplained weight loss. Through care coordination, he was connected to a primary care provider, received medically tailored meals, attended a pulmonology appointment, and was educated on how and when to use urgent care, the ED, and the Nurse Advice Line. He was diagnosed with Valley Fever, began appropriate treatment, and has not returned to the ED in the ten months since enrolling in the program. He later contacted KHS to praise the support he received, particularly from his care coordinator Julia.

Challenges Encountered
While the program has demonstrated early success, it has also faced several challenges. These include limitations in eligibility criteria, delays due to the absence of real-time ED visit notifications, and difficulty in contacting and maintaining engagement with members. Additionally, by the time outreach occurs, a member's chief complaint may have already resolved.

Program Augmentation
To address the need for long-term follow-up, KHS is developing a complementary initiative—the ER Wellness and Support Advocate Program. This program will focus on sustaining improvements in health among stabilized members, ensuring they do not revert to using the ED as their primary source of care. It will involve ongoing screening for behavioral health and social needs, continued care coordination, and referral back to social workers as conditions change. Staffing will include a dedicated case management assistant.

Looking Ahead
1. PHM will continue to track long-term emergency department utilization among managed members to assess resource use and cost-effectiveness.
2. PHM is also exploring opportunities to broaden its scope to include special populations, such as children, pregnant women, and individuals with chronic conditions like diabetes and COPD.
3. A key long-term objective is to implement a real-time ED visit notification system to improve timely interventions and care coordination.

Through this evolving, person-centered approach, KHS continues to advance its mission of improving member health outcomes by connecting individuals with the right care, at the right time, and in the right setting.

Conclusion
The ER Utilizers Connection and Support Program has proven to be a vital initiative in addressing preventable emergency department (ED) utilization among Kern Health Systems (KHS) members. By identifying high utilizers and offering personalized, team-based care coordination, the program has successfully redirected hundreds of members toward more appropriate, community-based care solutions. Early outcomes—such as the resolution of unmet medical needs, reduced ED visits, and strong member engagement—demonstrate the program's potential for long-term impact.

Despite encountering challenges such as outreach limitations and delayed data, the program's adaptive design has paved the way for ongoing improvements, including the development of the ER Wellness and Support Advocate Program. As KHS continues to refine and expand this model, including plans for real-time ED alerts and targeted support for special populations, it reaffirms its commitment to delivering timely, holistic, and equitable care. The program stands as a testament to the power of proactive, person-centered healthcare in improving outcomes and reducing system strain.

ER Navigation Program

Overview

Kern Health Systems (KHS) Emergency Room (ER) Navigation Program helps members at risk of requiring acute care by offering immediate access to care and coordinating their care and services, ensuring they follow their treatment plans, and providing education on health management after being discharged from the ER. The program focuses on preventing avoidable hospital admission and improving health outcomes through services such as discharge planning, referrals to specialized programs (e.g., Health Homes, COPD, Diabetes) and access to follow-up care such as outpatient infusion, wound care, and physician services.

KHS partners with Premier Valley Medical Group to deliver these ER Navigation services. Their multidisciplinary team—comprising physicians, nurses, and social workers—is stationed onsite at local hospitals to engage with patients directly during their ER visits.

Program Eligibility Period = Q1-Q4 2024 IP Admit = Within 1 Day of ER DOS

Table 1: *No ER Intervention Billed*

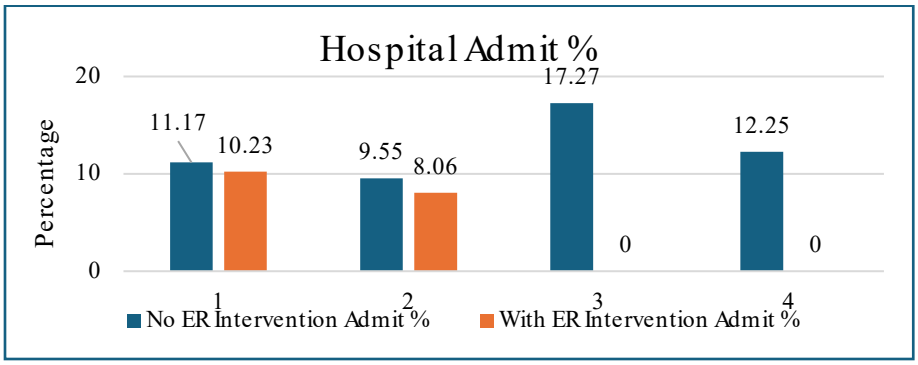
Hospital	ER PPA Claim Count	IP Admit Count	Admit %
Bakersfield Memorial	6,688	747	11.17%
Mercy Bakersfield	5,982	571	9.55%
Adventist Bakersfield	4,741	819	17.27%
Kern Medical	4,596	563	12.25%

Table 2: *With ER Intervention Billed*

Hospital	ER PPA Claim Count	IP Admit Count	Admit %	IP Admits Saved
Bakersfield Memorial	1173	120	10.23%	63
Mercy Bakersfield	1365	110	8.06%	89

Note: Table 1 and Table 2 compares hospital performance for cases with and without ER intervention, specifically looking at the number of emergency room (ER) claims and inpatient (IP) admissions.

Table 3 *Hospital Admission Rates: Comparison of ER Interventions vs. No ER Interventions*



Note: This graph compares the percentage of patient admissions at four hospitals in Bakersfield, broken down by those requiring ER intervention versus those who did not. BMH and Mercy have low differences between

the two categories, with slightly higher percentages of patients being admitted without ER intervention. Adventist and KM show a significant contrast, with no ER intervention admissions recorded at all.

Bakersfield Memorial

1. Without intervention, the hospital had an admission rate of 11.17% (747 out of 6,688 ER claims).
2. With intervention, the admission rate dropped to 10.23% (120 out of 1,173 ER claims).
3. IP Admits Saved: 63, indicating that the intervention was effective in reducing unnecessary admissions.

Mercy Bakersfield

1. Without intervention, the hospital had an admission rate of 9.55% (571 out of 5,982 ER claims).
2. With intervention, the admission rate dropped to 8.06% (110 out of 1,365 ER claims).
3. IP Admits Saved: 89, indicating that the intervention successfully reduced the admission rate, resulting in a significant number of saved admits.

Analysis of Results

1. Adventist Bakersfield and Kern Medical have higher admission rates than Bakersfield Memorial and Mercy Bakersfield.
2. In both hospitals with ER intervention (Bakersfield Memorial and Mercy Bakersfield), the intervention led to a reduction in inpatient admissions.
3. Mercy Bakersfield saw a greater reduction in the admission rate (from 9.55% to 8.06%), resulting in more IP admits saved (89). In contrast, Bakersfield Memorial saved fewer admits (63) with a smaller reduction in the admit rate.

Conclusion

The interventions implemented at Bakersfield Memorial and Mercy Bakersfield resulted in a clear reduction in inpatient admissions, with Mercy Bakersfield showing a more substantial decrease. Comparatively, Adventist Bakersfield and Kern Medical had higher admission rates, indicating potential for future improvement. Overall, these findings suggest that the intervention was effective in reducing unnecessary admissions, with Mercy Bakersfield demonstrating the most significant impact.

Population Health Management
Quarter 1 Report

Michelle Curioso, Director of PHM

June 17, 2025

KERN HEALTH SYSTEMS

Integrated ED Intervention Programs: Connecting Members to the Right Care at the Right Time

The ER Utilizers Connection and Support Program and the ER Navigation Program are housed within the Population Health Management (PHM) Department because they are aligned with the department's mission: to improve health outcomes across the member population through proactive care, social needs intervention, and the reduction of unnecessary healthcare utilization.

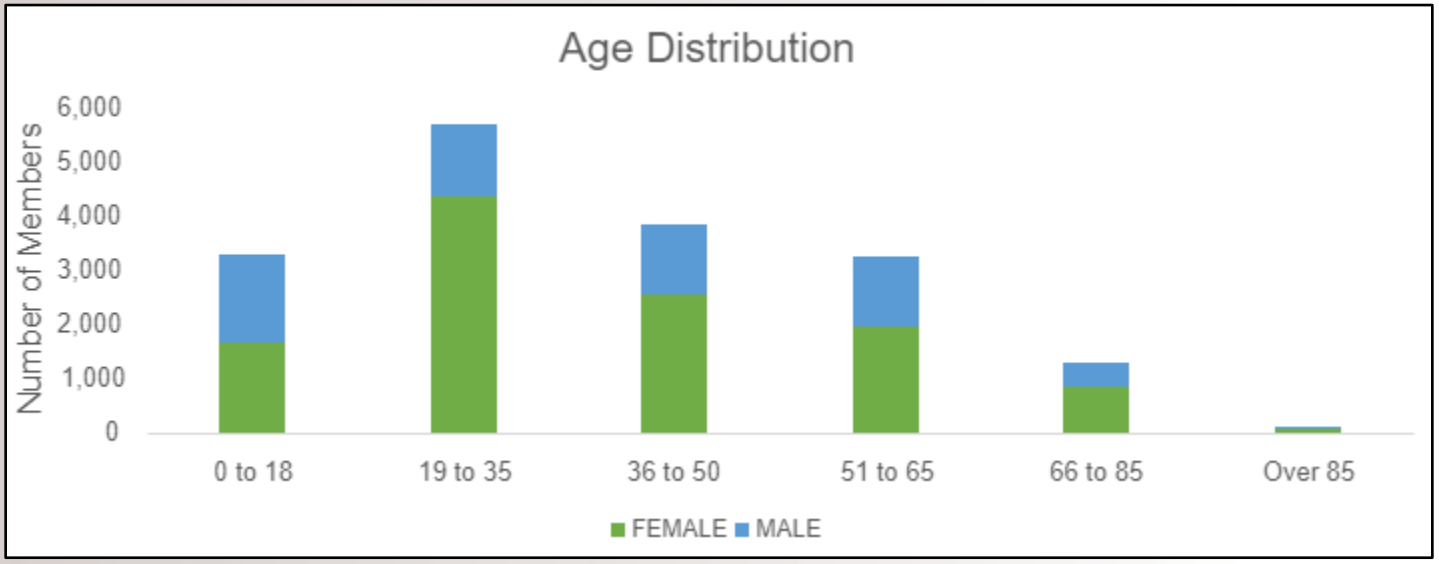
ER Utilizers Connection and Support Program: 12-month Update

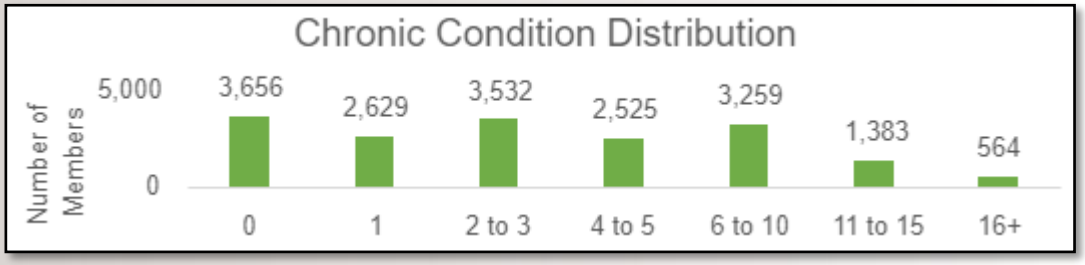
Background

- **Members who frequently visit the Emergency Department (ED) often seek care for non-emergency issues that could be more effectively addressed in a more appropriate healthcare setting.**

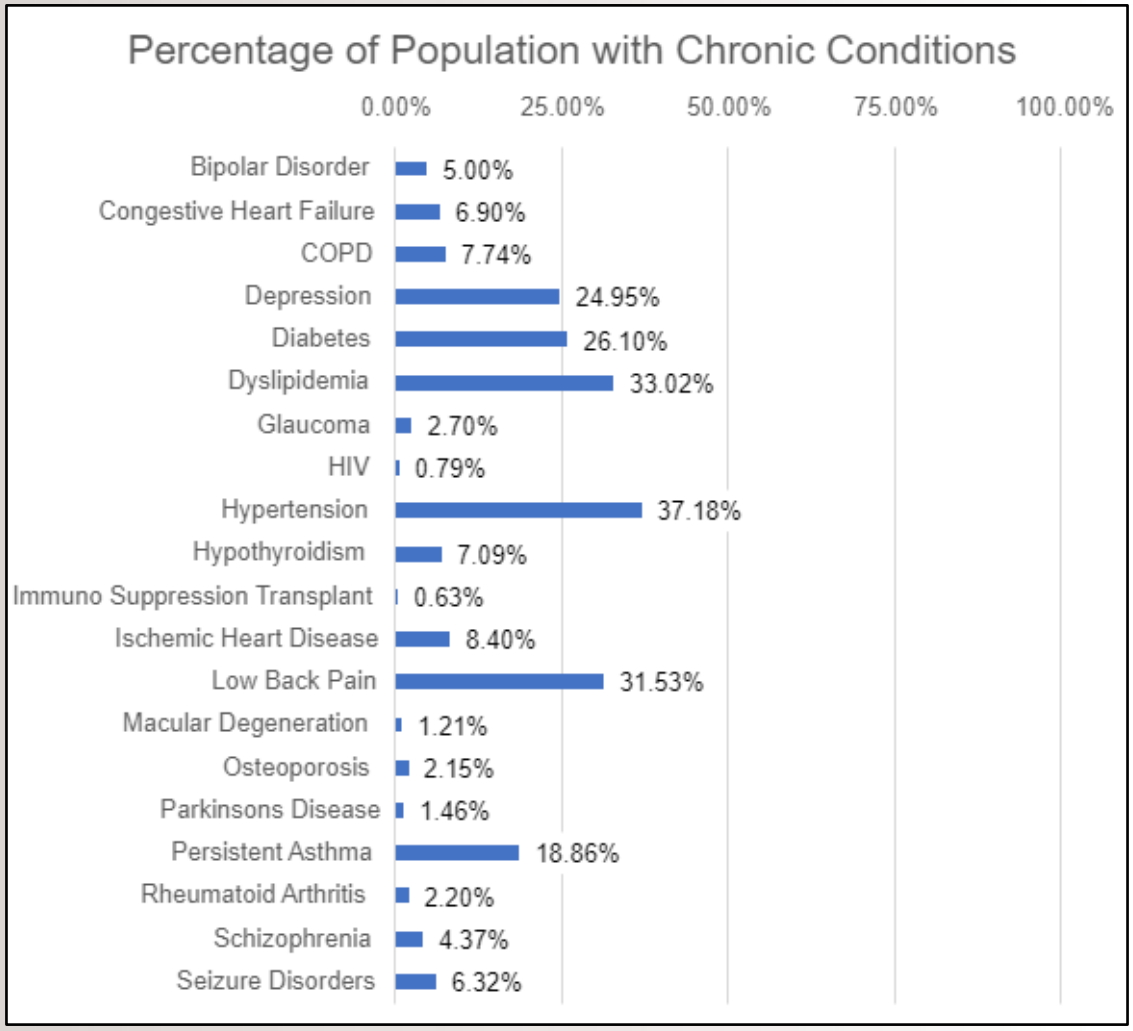
- **From July 2023 through June 2024, 969 KHS members had five or more ED visits.**

Population of Focus





Population of Focus



Program Overview

-Pilot launched 6/2024

- Formal program started 9/2024

Program Purpose:

- Provide Care Coordination for members who frequent the Emergency Department for issues that would be better managed in a different setting

Program Services:

- Comprehensive Assessment
  - Assess Social Determinants of Health
- Individualized Care Plan
- Care Coordination
- Community Health Worker

Program Eligibility and Staffing

Eligibility

- Adult KHS member residing in Greater Bakersfield area
- More than three ER visits in the last six months

Pilot Program Staffing

- Social Worker x 1
- Nurse Case Manager (as needed)
- Case Management Assistant x 1
- Community Health Worker x 1

Program Updates

- 620 members provided care coordination June 2024 – April 2025
  - 7,039 activities completed by team
    - Resources needed by members:
      - Establishing with PCP
      - Local Urgent Cares
      - Mental Health & Substance Abuse Services
      - Food
      - Housing
      - Diabetes Education
      - Financial Support

Success Stories

Case Study #1

- 50-year-old male with 3 ER visits in one week with complaints of chest pain, headaches, and recent unexplained weight loss of 30 pounds
  - Member was provided care coordination, assisting with the following:
    - Establishing member with Primary Care Provider
    - Medically Tailored Meals Program
    - Pulmonology appointment
    - Education re: Appropriate usage of Urgent Care vs Emergency Dept, Nurse Advice Line
  - **Outcome**: Member got a Valley Fever diagnosis, received appropriate treatment, and has not utilized an Emergency Department since being enrolled 10 months ago.
    - Member reached out to KHS to praise Julia's assistance in managing his care and were very appreciative of our services.

Success Stories

Case Study #2

- 38-year-old female with 6 recent ER visits
  - Member had history of SOB, chronic pain, PTSD, Depression, OCD, Dissociative Identity Disorder, and schizophrenia
  - Member was provided care coordination, assisting with the following:
    - Establishing member with Primary Care Provider
    - Establishing member with Mental Health Care Provider
    - Food Supply through multiple resources
    - Medically Tailored Meals Program
    - Back to School supplies for member's children
    - Housing Assistance through Community and Social Services Program
    - Education re: Appropriate usage of Urgent Care vs Emergency Dept, Nurse Advice Line, and Advanced Healthcare Directives
  - **Outcome**: Member got re-established with her providers and has had only 1 ER visit since being enrolled in 6/2024.

Challenges

- Eligibility Criteria
- Data
  - No real-time notification channels
  - Chief Complaint already resolved
- Establishing and maintaining contact with members

ER Wellness and Support Advocate Program

Program Purpose

- Provide ongoing support to high ER Utilizers once their health has stabilized to ensure long-term positive health outcomes. Goal is to prevent member from reverting to using ER as primary source of healthcare.

Program Services

- Administer screening tools to identify members with issues related to behavioral health and social determinants of health
- Provide Care Coordination
- Refer back to Social Worker as needed when status changes

Program Staffing

- Case Management Assistant x 1

Next Steps & Discussion

- Track long-term ER usage for members managed
  - Look at overall resource and cost summaries
- Address Special Focus Populations
  - Children
  - Pregnant Women
  - Specific Chronic Diseases (e.g. - Diabetes, COPD)
- Establish real-time ER Visit notification system (long-term project)

ER Navigation Program

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The program focuses on preventing avoidable hospital admission and improving health outcomes through services such as discharge planning, referrals to specialized programs (e.g., Health Homes, COPD, Diabetes) and access to follow-up care such as outpatient infusion, wound care, and physician services.

Contracted with PVMG consisting of:

- Physician
- RNs/LVNs
- Social Worker

Facility based and available by phone.

Program Eligibility Period = Q1-Q4 2024 IP Admit = Within 1 Day of ER DOS

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KERN HEALTH SYSTEMS

To: KHS EQIHEC

From: Christine Pence, Senior Director of Health Services

Date: June 17, 2025

Re: Utilization Management Department Reporting Q1 2025

Background

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

Discussion

This report contains a synopsis of both quantitative and qualitative analytics that reflect the performance of the Utilization Management Department's in the 1st quarter of 2025.

Fiscal Impact

N/A

Background

UM is focused on ensuring KHS members received the right care at the right time in the right setting. To achieve this goal, UM works diligently to ensure all department processes are regulatory compliant, staff is well trained, and all decisions are bases made on Medical Necessity.

Discussion

Quarter 1 2025 UM Report

Fiscal Impact

None

Requested Action: Review and approve.

Utilization Management Executive Summary

The Utilization Management (UM) department experienced a notable increase in referral requests during the first quarter of 2025, with volumes rising 10% compared to Q4 2024 and 18% compared to Q1 2024. This upward trend has led to increased staffing demands. In response, the UM department continues to evaluate and refine internal processes to enhance efficiency, ensuring that timeliness and quality standards are maintained despite growing workloads.

Efforts to improve communication with members and provider remain a priority. The UM team has focused on aligning communications with NCQA and Medi-cal standards, particularly through the enhancement of Notice of Action (NOA) letters. These letters are written at a 6th-grade reading level and clearly articulate the rational behind the decisions in a concise and understandable manner. These improvements are expected to positively impact our NCQA accreditation review.

In addition to the approval of the Q1 2025 report, the UM Committee approved the following policies on May 13, 2025:

- Policy 3.07-P Vision Care
- Policy 3.55-I Coordination of Care for Out-of-Network Services

The UM team also continues to conduct performance audits to ensure compliance with industry standards. The UM team applies a Health Equity lens to data analysis to identify areas where targeted efforts can better serve our diverse member population.

The following report provides a detailed overview of Utilization Management performance through the first quarter of 2025.

Respectfully submitted,
Christine Pence, MPH, RN, RD
Senior Director for Health Services

Timeliness of Decision Trending

Summary:

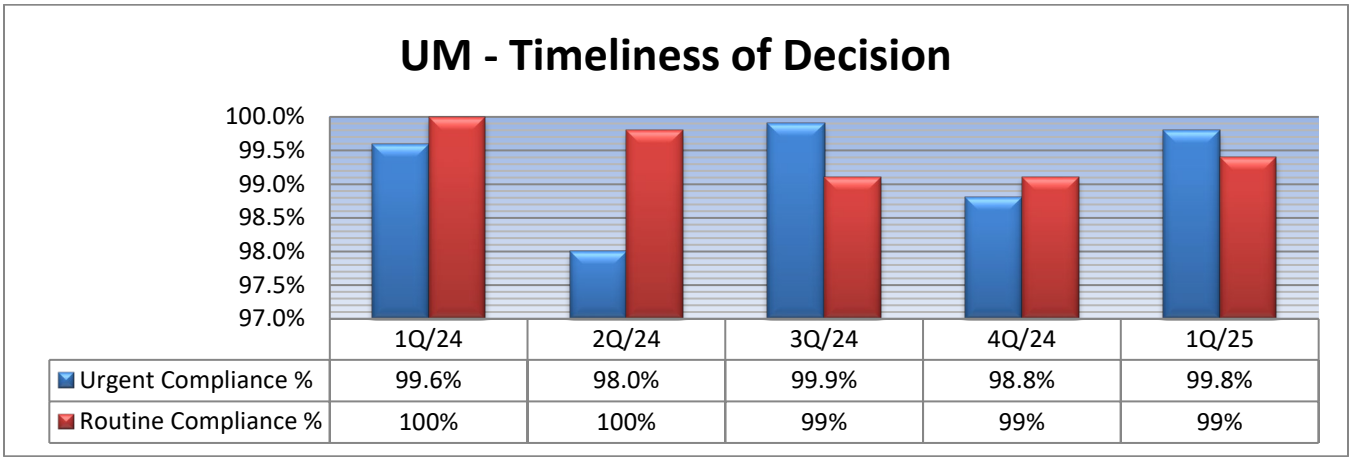
Quarterly audits are conducted to ensure compliance with DMHC requirements, KHS Contractual Agreement with the Department of Health Services, and KHS Policy and Procedures. Referrals are submitted and have specific turn-around-times set for each type of referral.

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 104,505 referrals processed in the 1st quarter 2025 of which 9,935 referrals were reviewed for timeliness of decision. In comparison to the 4th quarter's processing time, routine referrals increased from the 4th quarter which was 99.0% and urgent referrals increased from the 4th quarter which was 98.8%.



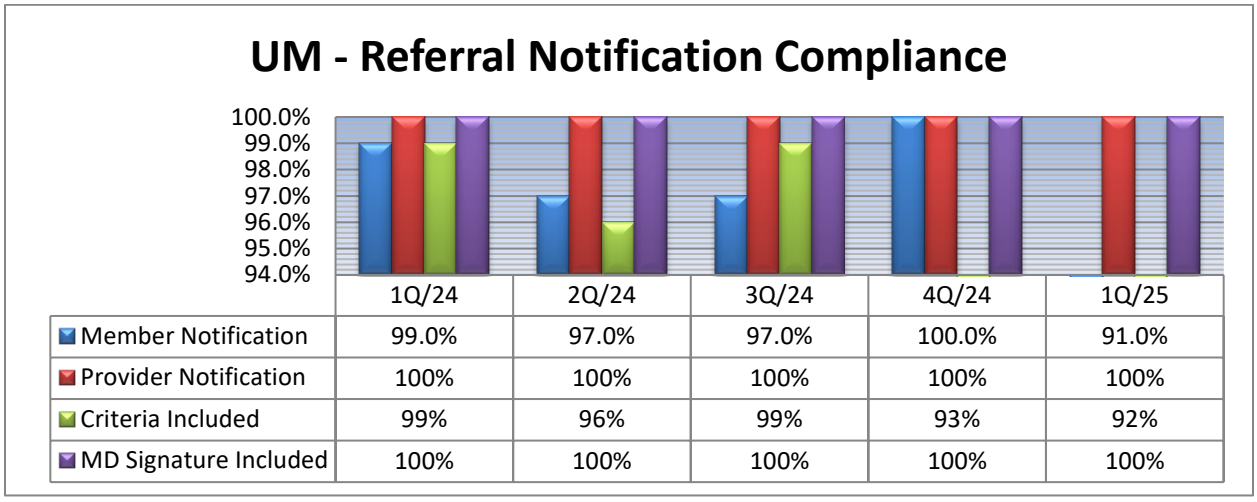
	1Q/24	2Q/24	3Q/24	4Q/24	1Q/25
Urgent Compliance %	99.6%	98.0%	99.9%	98.8%	99.8%
Routine Compliance %	100%	100%	99%	99%	99%

Referral Notification Compliance

Audit Criteria:

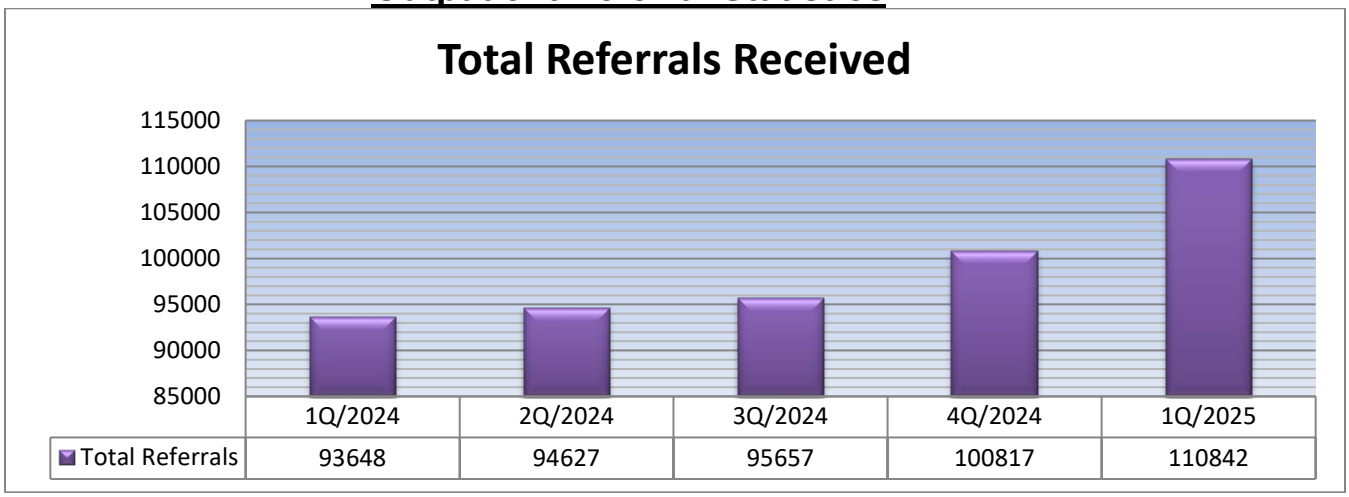
- Member Nofication: Letter of referral decision sent to member within 24 hours
- Provider Notification: Referral is faxed back to the provider with 24 hours of decision
- Criteria Included: Criteria provided to provider on denial reason
- MD Signature: MD Signature included all referrals/NOA letters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

Summary: Overall compliance rate from the 1st Qtr. of 2025 is 96.0% which decreased from the 4th Qtr. which was 98.3%

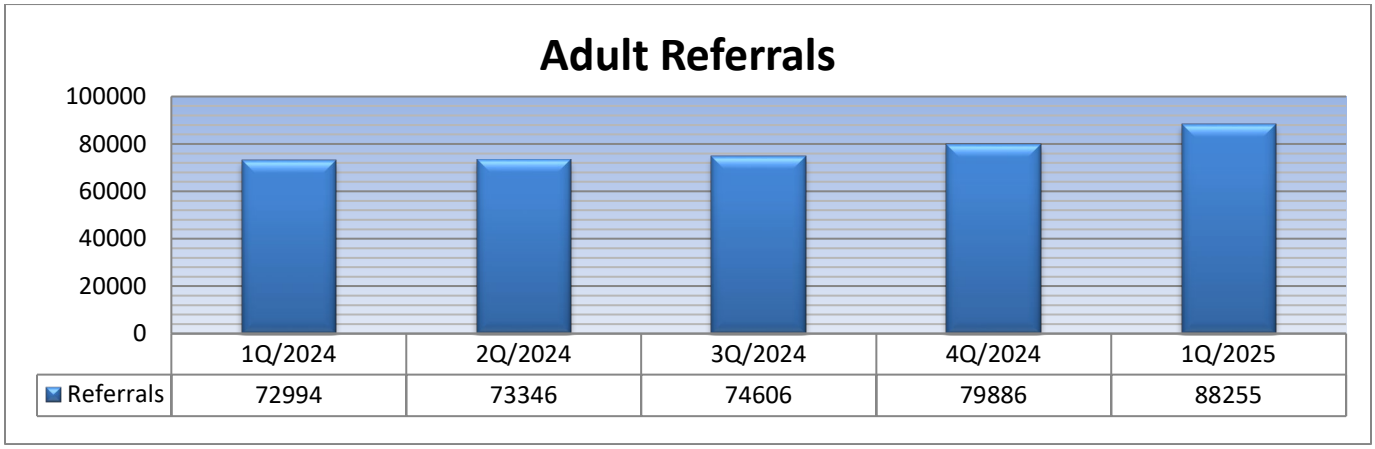


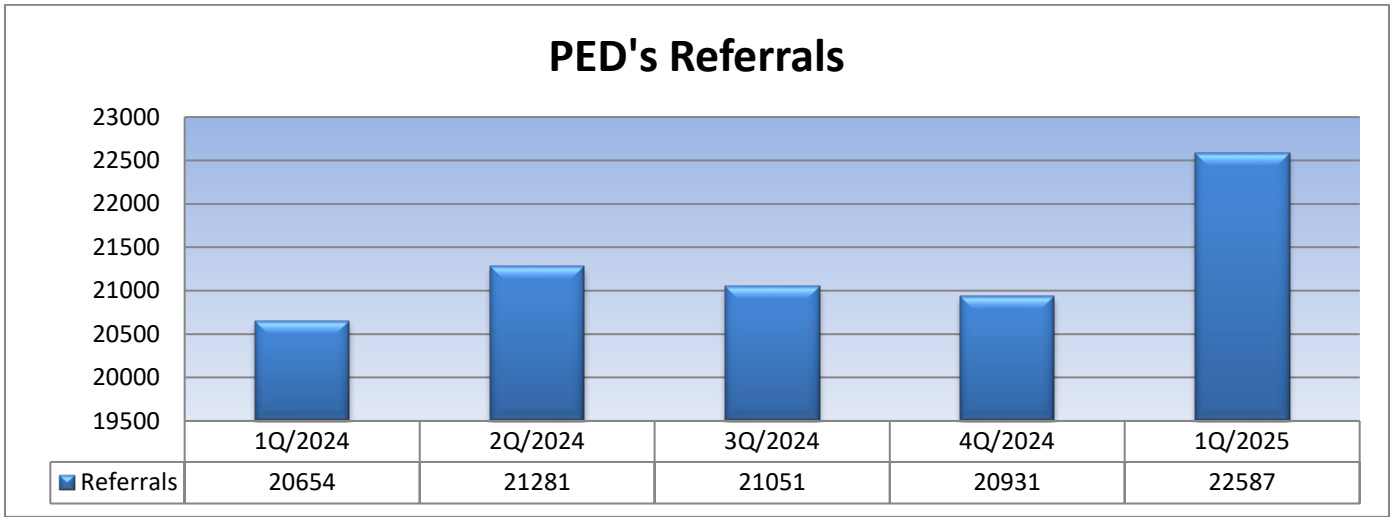
	1Q/24	2Q/24	3Q/24	4Q/24	1Q/25
Member Notification	99.0%	97.0%	97.0%	100.0%	91.0%
Provider Notification	100%	100%	100%	100%	100%
Criteria Included	99%	96%	99%	93%	92%
MD Signature Included	100%	100%	100%	100%	100%

Outpatient Referral Statistics



	1Q/2024	2Q/2024	3Q/2024	4Q/2024	1Q/2025
Total Referrals	93648	94627	95657	100817	110842

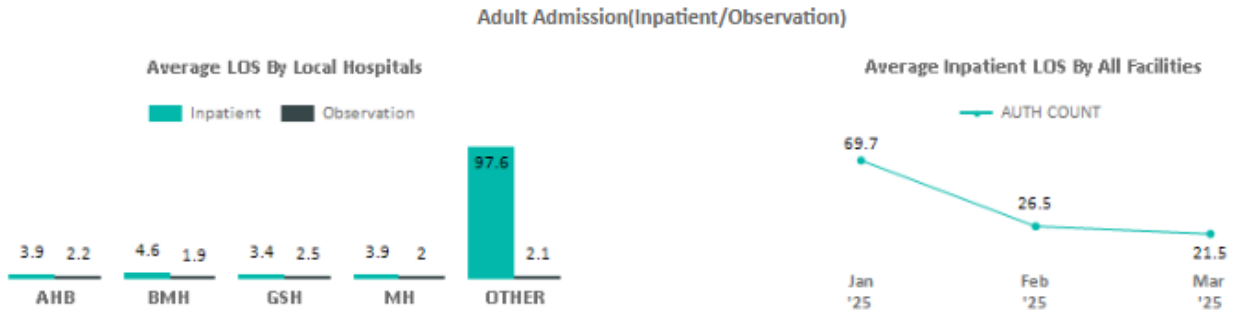

Adult Referrals
100000
80000
60000
40000
20000
0
1Q/2024
2Q/2024
3Q/2024
4Q/2024
1Q/2025
Referrals
72994
73346
74606
79886
88255


PED's Referrals
23000
22500
22000
21500
21000
20500
20000
19500
1Q/2024
2Q/2024
3Q/2024
4Q/2024
1Q/2025
Referrals
20654
21281
21051
20931
22587

KHS Monthly Inpatient and LOS Report

Report captures Adult Admissions(Inpatient/Observation)

Dates of Discharge Between : 1/1/2025-3/31/2025

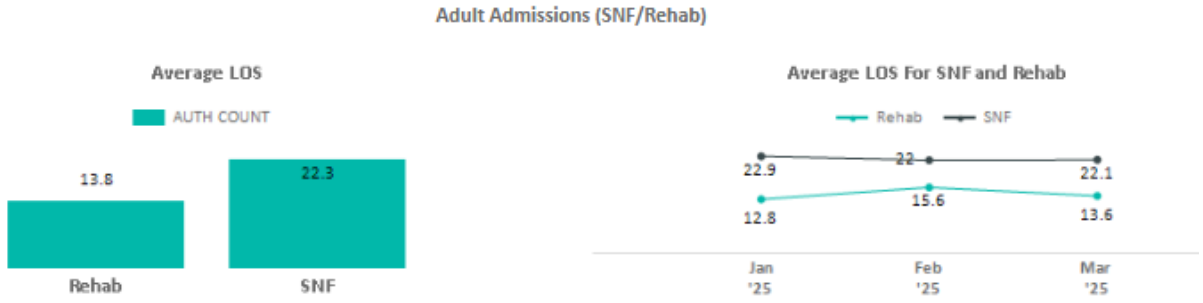


Post-Acute Statistics:

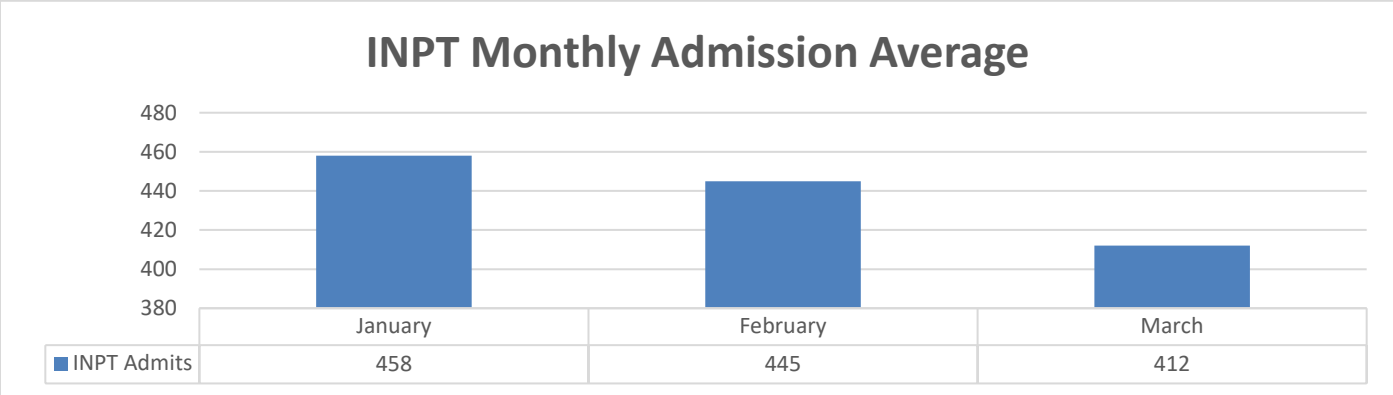
KHS Monthly Inpatient and LOS Report

Report captures Adult Admissions(SNF/Rehabilitation)

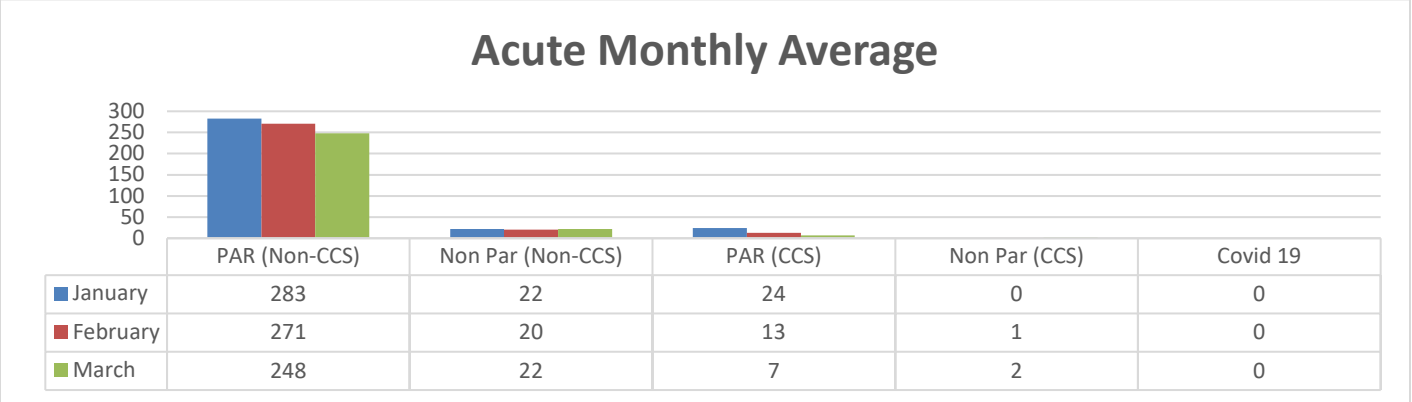
Dates of Discharge Between : 1/1/2025-3/31/2025



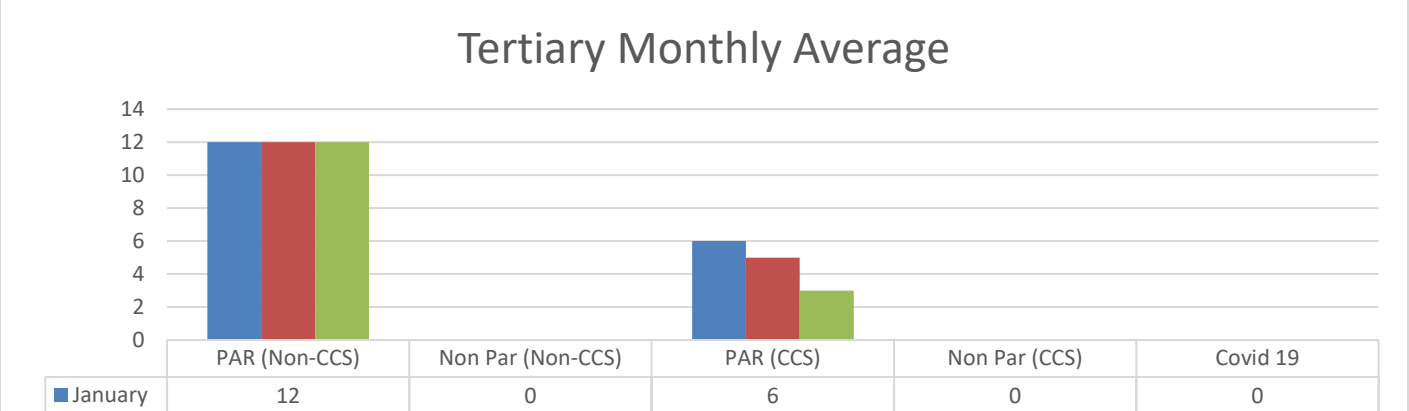
Inpatient Statistics Averages 1st Qtr. 2025



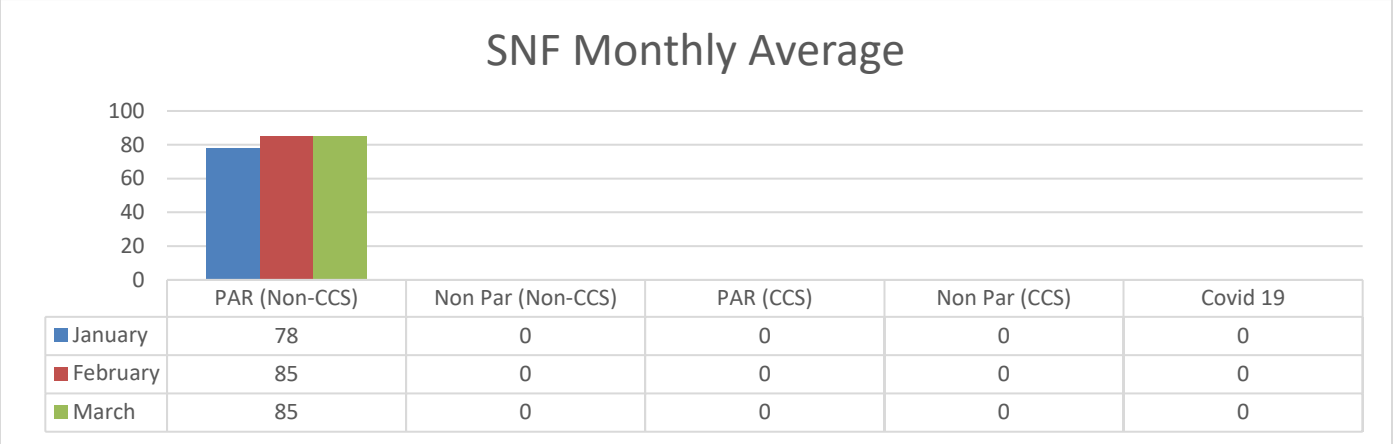
	January	February	March
INPT Admits	458	445	412



	PAR (Non-CCS)	Non Par (Non-CCS)	PAR (CCS)	Non Par (CCS)	Covid 19
January	283	22	24	0	0
February	271	20	13	1	0
March	248	22	7	2	0



	PAR (Non-CCS)	Non Par (Non-CCS)	PAR (CCS)	Non Par (CCS)	Covid 19
January	12	0	6	0	0
February	12	0	5	0	0
March	12	0	3	0	0



	PAR (Non-CCS)	Non Par (Non-CCS)	PAR (CCS)	Non Par (CCS)	Covid 19
January	78	0	0	0	0
February	85	0	0	0	0
March	85	0	0	0	0

Internal Auditing Results

Delayed Referrals - Quarter 1, 2025

Audit Period:
January 1, 2025 – March 31, 2025

Completion Date:
April 29, 2025

udit Sample Size:
10 Referrals per month

	January	February	March
Total referrals for the month	34,424	33,841	36,240
Total referrals that were delayed	58	58	98
Percent of referrals delayed	<1%	<1%	<1%
Audit sample size	10 referrals	10 referrals	10 referrals

Purpose:
This is a quarterly audit performed to monitor the process of referrals that have been delayed by the Utilization Management (UM) Department to ensure that the procedures followed are compliant with Kern Health Systems' Policy and Procedure 3.22-P Referral and Authorization Process, Sections 4.2.1 and 4.2.1.1.

KHS Policy and Procedures 3.22-P, section 4.2.1 Deferrals states, "Authorization requests needing additional medical records may be deferred, not denied, until the requested information is obtained. If deferred, the UM Clinical Intake Coordinator follows-up with the referring provider within 14 calendar days from the receipt of the request if additional information is not received. Every effort is made at that time to obtain the information. Providers are allowed 14 calendar days to provide additional

information. On the 14th calendar day from receipt of the original authorization request, the request is approved or denied as appropriate."

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

Audit Indicators:

1. Notices to member after referral was delayed.
    - Member Notice of Adverse Determination documents mailed within 2 business days of the decision.
2. Notice of Action Letter
    - NOA Delay letter attached with correct language and font size selected.
    - Accurate spelling, grammar, verbiage, and format.
    - The reason for delaying the authorization is clear and concise.
    - An anticipated decision due date is provided.
    - NOA language is at or below 6th grade readability per Flesch-Kincaid scale.
3. Signatures
    - Case Manager information on the delayed NOA letter:
        i. NOA Letters as applicable:
            1. Signature(s)
            2. Name
            3. Title
            4. Phone Number
    - Medical Director information on the extended delay NOA letter:
        i. NOA Letters as applicable:
            1. Signature
            2. Name
            3. Title
            4. Specialty
4. Processing of Referral
    - Appropriately delayed for additional medical records.
    - Delay completed on a routine authorization (not on urgent request).
    - Delay completed on the fifth working day of receipt.
    - Service line(s) appropriately chosen.
5. Final Decision Process
    - A final decision to approve or deny a delayed referral was made within fourteen (14) calendar days from the original receipt of the request.
    - A final decision to approve or deny a referral that the delay was extended by the medical director was made within 28 calendar days from the original authorization request.

6. Criteria Process
    - Delay criteria cited and attached if indicated

January Audit Findings:

Out of the ten (10) delayed referrals that were audited, the following is a breakdown of the findings:

- Notices to Member
    - Zero (0) errors found
- Notice of Action Letter
    - Zero (0) errors found

- Signatures and Credentials
    - Zero (0) errors found
- Processing of Referral
    - Two (2) errors withing processing of the referral:
        - 202501090001051 -The request was delayed for notes; however, the auth was internally generated after Periscope in-home DME evaluation and the delay was not indicated. Delay process also would be applied to all codes and was not.
        - 202501130001641 -The denial NOA was not set to print (mailed) nor was the OP Notification Forms. Unclear why this was delayed for clinical notes as there were clinical notes in the web note and stated the reason for the biopsy was to differentiate essential tremor (ET) vs ET and Parkinson's Disease. The auth was then denied due to lack of information.

- Final Decision Process
    - One (1) error found:
        - 202501090001051 -Decision was made outside of TAT. The Medical Director attempted to modify the request to Periscope, but this was generated after the evaluation had been completed. The citation does not include the wheelchair info.
- Criteria Process
    - Zero (0) errors found

February Audit Findings:

Out of the ten (10) delayed referrals that were audited, the following is a breakdown of the findings:

- Notices to Member
    - Three (3) errors found:
        - 202502140000698 -Delay letter completed, but not set to print
        - 202502130000422 -Delay letter completed, but not set to print
        - 202502210001475 -Delay letter not sent to team for completion
- Notice of Action Letter

- Zero (0) errors found
- Signatures and Credentials
  - Zero (0) errors found
- Processing of Referral
  - One (1) error found:
    - 202502280001383 -Auth was modified but added code was not delayed therefore shows a different due date. No final document generated after modification done.

- Final Decision Process
  - Zero (0) errors found
- Criteria Process
  - Zero (0) errors found

March Audit Findings:

Out of the ten (10) delayed referrals that were audited, the following is a breakdown of the findings:

- Notices to Member
  - Zero (0) errors found.
- Notice of Action Letter
  - Zero (0) errors found.
- Signatures and Credentials
  - Zero (0) errors found.
- Processing of Referral
  - Zero (0) errors found.

- Final Decision Process
  - Zero (0) errors found.
- Criteria Process
  - Zero (0) errors found

Corrective Action Plan (CAP):

1. Email to management with audit findings.

Denied Referrals - Quarter 1, 2025

Audit Period:

January 1, 2025 – March 31, 2025

Report Completion Date:

April 29, 2025

Audit Sample Size:

30 referrals total for each month.

Current denied audit exclusions:
-Pharmacy denials
-CCS denials
-Kern County Mental Health denials
-Search and Serve denials
-VSP denials
-Denti-Cal denials
-Retro denials
-Kern Regional denials
-Duplication of Services

	January	February	March
Total referrals processed for the entire month: (total number of referrals approved, modified, denied etc. during the month)	34,424	33,841	36,240
Total referrals denied for medical necessity: (total of all referrals in the green + red rows on workbook)	669	932	998
Percent of referrals denied: (this is the total referrals denied for medical necessity in the green + red rows divided by the total referrals processed for the entire month)	<2%	<3%	<3%
Number of referrals in audit	30	30	30

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

Policy and Procedures 3.22, Section 4.2.3 Denials states, if initial review determines that an authorization request does not meet established utilization criteria, denial is recommended. Only the Associate Medical Director may deny an authorization request. Reasons for possible denial include:
A. Not a covered benefit
B. Not medically necessary
C. Member not eligible
D. Continue conservative management.
E. Services should be provided by a PCP
F. Experimental or investigational treatment (See KHS Policy #3.44)
G. Member made unauthorized self-referral to practitioner/provider
H. Services covered by CCS
I. Inappropriate setting
J. Covered by hospice

Audit Indicators:

7. Notices to member after referral was denied
    - Member Notice of Adverse Determination documents mailed within 2 business days of the decision.
8. Criteria attached:
    - Cited criteria attached
9. Notice of Action Letter
    - NOA Denial letter attached with correct language and font size selected.
    - Accurate spelling, grammar, verbiage, and format.
    - The reason for denying the authorization is clear and concise.
    - NOA language is at or below 6th grade readability per Flesch-Kincaid scale.
    - Criteria cited appropriately
10. Signatures
    - Medical Director information on the denial NOA letter:
        i. NOA Letters as applicable:
            1. Signature(s)
            2. Name
            3. Title
            4. Specialty
11. Processing of Referral

January Audit Findings:

Out of the thirty (30) denied referrals that were audited, the following is a breakdown of the findings:

- Notices to Member
    - Two (2) errors found
        - 202501220000097 -Delay letter completed, but not set to print
        - 202501280001287 -Delay letter outside of timeframes (MD decision 01/28/25, but NOA printed 01/31/25)
- Criteria Attached
    - Three (3) errors found
        - 202501240000260 -MCG guidelines cited, but not attached
        - 202501180000016 -Medi-Cal guidelines cited, but not attached
        - 202501180000057 -Medi-Cal guidelines cited, but not attached
- Notice of Action Letter
    - Two (2) errors found
        - 202501310000313 -NOA bullet point formatting errors
        - 202501310000727 -Grammer error on NOA "nor" should be "not"
        - 202501240000260 -Repeat "heart" in the NOA letter.
- Signatures and Credentials
    - Zero (0) errors found
- Processing of Referral
    - Three (3) errors found
        - 202501240000260 -Should have been delayed for records

        - 202501310000727 -NOA team denied the follow up visit, but MD did not document a decision for this in the commentary and should have been clarified.
        - 202501280001287 -Provider notice not within 24hr of MD decision.
- Guidelines cited and attached:
    - Eight (8) cited Medi-Cal guidelines.
    - Twenty-three (23) cited MCG guidelines.
    - Three (3) cited KHS Policies.

    **Some referrals may have cited more than one criterion.

February Audit Findings:

Out of the thirty (30) denied referrals that were audited, the following is a breakdown of the findings:

- Notices to Member
    - Three (3) errors found
        - 202502030000066 -MD decision on 02/04/25 and NOA letter not until 02/07/25.
        - 202502110002111 -MD decision on 02/13/25 and NOA letter not until 02/18/25.
        - 202502270000567 -MD decision on 02/28 and NOA letter not until 03/05/25.
- Criteria Attached
    - One (1) error found
        - 202502260000284 -Incorrect MCG criteria uploaded for facet joint injections but should be for epidural steroid injection.
- Notice of Action Letter
    - Zero (0) errors found
- Signatures and Credentials
    - Zero (0) errors found
- Processing of Referral
    - Zero (0) errors found
- Guidelines cited and attached:
    - Seven (7) cited Medi-Cal guidelines.
    - Twenty-five (25) cited MCG guidelines.
    - Three (3) cited KHS Policies.

    **Some referrals may have cited more than one criterion.

March Audit Findings:

Out of the thirty (30) denied referrals that were audited, the following is a breakdown of the findings:

- Notices to Member
    - Five (5) errors found

        - 202503210001372 -MD Decision 03/24, NOA printed 03/27
        - 202503310001426 -MD Decision 04/02, NOA printed 04/04
        - 202503180001930 -MD decision 03/20/25, NOA printed 03/24/25
        - 202503130000529 -MD decision 03/16/25, NOA printed 03/19/25
        - 202503210000842 -MD decision 03/24/25, NOA printed 03/28/25
- Criteria Attached
    - One (1) error found
        - 202503280000445 -Medi-Cal cited, but not attached

- Notice of Action Letter
    - One (1) error found
        - 202503090000036 -Grammar error "bgenetic" on NOA letter
- Signatures and Credentials
    - Zero (0) errors found
- Processing of Referral
    - Zero (0) errors found
- Guidelines cited and attached:
    - Eleven (11) cited Medi-Cal guidelines.
    - Twenty-two (22) referrals cited MCG guidelines.
    - One (1) cited KHS Policies.

      **Some referrals may have cited more than one criterion.

Corrective Action Plan (CAP):

1. Email sent to UM Management with audit findings.

Modified Referrals - Quarter 1, 2025

Audit Period:
January 1, 2025 – March 31, 2025

Report Completion Date:
April 29, 2025

Audit Sample Size:
10 referrals per month

	January	February	March
Total referrals processed for the entire month: (total number of referrals approved, modified, denied etc. during the month)	34,424	33,841	36,240
Total referrals that were modified	505	432	458
Percent of referrals that were modified	<2%	<2%	<2%
Number of referrals in audit	10	10	10

Purpose:
Quarterly audits of referrals that were modified by the Utilization Management (UM) Department are performed to monitor compliance with the Kern Health Systems' Policy and Procedure 3.22 Referral and Authorization Process, Section 4.2.2 Modifications

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

The referrals that qualify for a modification are:

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

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

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

Audit Indicators:

12. Notices to member after referral was modified
    - Member Notice of Adverse Determination documents mailed within 2 business days of the decision.
13. Notice of Action Letter
    - NOA Modify letter attached with correct language and font size selected.
    - Accurate spelling, grammar, verbiage, and format.
    - The reason for modifying the authorization is clear and concise.
    - Approved provider information given (name/phone)
14. Signatures
    - Medical Director information on the denial NOA letter:
        i. NOA Letters as applicable:
            1. Signature(s)
            2. Name

3. Title
4. Specialty

15. Processing of Referral

January Audit Findings:

Out of the ten (10) modified referrals that were audited, the following is a breakdown of the findings:

- Notices to Member
  - Zero (0) errors found
- Notice of Action Letter
  - Zero (0) errors found
- Signatures and Credentials
  - Zero (0) errors found
- Processing of Referral
  - One (1) error found
    - Code E26512 still shows "Return to Clinical Reviewer". Initial MD template had XXX… and YYY and NOA team had to send cert back. Notice to provider not within 24hrs. Final document is missing.

February Audit Findings:

Out of the ten (10) modified referrals that were audited, the following is a breakdown of the findings:

- Notices to Member
  - One (1) error found
    - 202502180001074 -NOA letter completed, but not mailed (not sent to print)
- Notice of Action Letter
  - Five (5) errors found
    - 202502260002091 -NOA letter missing service requested
    - 202502250002241 -Above 6th grade reading level at 7.00 and RE section is not concise and could say "Spine Surgery" rather than being confusing. Inpatient Admission for Neck Spine Fuse/Removal, Insert Spine Fixation Device, SP Bone Allograft Structure Add-On (Your doctor asked us to give you an extra hospital stay (called “inpatient”) for surgery to reduce pressure on the nerves in the back)
    - 202502190003901 -Repeated verbiage "Standard wheelchair"
    - 202502040001158 -RE section is not concise: Out-of-Network (OON) Rheumatology Consultation and Follow-up Visit (Rheumatologist Consult + Follow-up, Lupus Center San Diego, OON Rheumatologist: An expert doctor on health problems that cause swelling in the body)

        - 202502180001074 -Duplicate verbiage in letter "Specialist" and "Surine" instead of urine. Other noted grammar issues "An urology consultation" and colon spacing error. "KHS" used in NOA letter.
- Signatures and Credentials
    - Zero (0) errors found
- Processing of Referral
    - Zero (0) errors found

March Audit Findings:
Out of the ten (10) modified referrals that were audited, the following is a breakdown of the findings:

- Notices to Member
    - Zero (0) errors found
- Notice of Action Letter
    - Zero (0) errors found
- Signatures and Credentials
    - Zero (0) errors found
- Processing of Referral
    - Zero (0) errors found

Corrective Action Plan (CAP):

1. Email with findings to UM Management with findings.

NAR/ Appeal Audit

Audit Period:
January 1, 2025 – March 31, 2025

Report Completion Date:
April 3, 2025

Audit Sample Size:
Thirty (30) total NAR/Appeal audits for the quarter. This includes ten (10) randomly selected NAR/Appeal audits from each month in the audit period.

Appeals Nurses:
Tuddao, Gilrose, RN
Patel, Prerna, RN
Morales, Julieta, RN
Patel, Viral, RN

Purpose:
Quarterly audits of appeals that have been processed for a previously denied or modified referral to ensure appropriate processes were used to review and monitor

compliance with the Kern Health Systems' Policy and Procedure 3.23 Appeals Regarding Authorizations.

Audit Indicators:

- NAR spelling, grammar, verbiage, and format
- Sixth grade readability level
- Criteria indicated and attached
- Recommendations indicated
- Medical Director / Case Manager name and signatures
- Overall process
- Hierarchy of criteria used

January Audit Findings:

10 Out of the **30** NARs audited, the following is a breakdown of the findings:

- **NAR spelling, grammar, verbiage, and format:** Zero (0) errors found on the NAR.
- **Sixth grade readability:** Zero (0) errors found within the sixth-grade readability.
- **Criteria indicated and attached:** Zero (0) error found.
- **Recommendations indicated:** Zero (0) errors found.
- **Medical Director / Case Manager name and signatures:** Zero (0) errors found.
- **Overall Process:** Zero (0) errors found on process.
- **Hierarchy of criteria used:** Zero (0) error found.

February Audit Findings:

10 Out of the **30** NARs audited, the following is a breakdown of the findings:

- **NAR spelling, grammar, verbiage, and format:** Zero (0) errors found on the NAR.
- **Sixth grade readability:** Zero (0) errors found within the sixth-grade readability.
- **Criteria indicated and attached:** One (1) error found. Cert 202501170000231 – MCG criteria was not uploaded into Jiva.
- **Recommendations indicated:** Zero (0) errors found.
- **Medical Director / Case Manager name and signatures:** Zero (0) errors found.
- **Overall Process:** One (1) error found. Cert 202501170001147 – Nurse cited MCG criteria for incorrect service in the NOA language.
- **Hierarchy of criteria used:** One (1) error found for hierarchy of criteria used. Cert 202501130001701– MD used MCG criteria and there is MCAL criteria for foot orthotics.

March Audit Findings:

10 Out of the **30** NARs audited, the following is a breakdown of the findings:

- **NAR spelling, grammar, verbiage, and format:** Zero (0) errors found.
- **Sixth grade readability:** Zero (0) errors found within the sixth-grade readability.

- **Criteria indicated and attached:** Zero (0) errors found.
- **Recommendations indicated:** Zero (0) errors found.
- **Medical Director / Case Manager name and signatures:** Zero (0) errors found.

- **Overall Process:** Zero (0) errors found on process.
- **Hierarchy of criteria used:** Zero (0) error found.

Total # of appeals audited	Number of appeals with deficiencies	% of accuracy rate
30	3	90%

Corrective Action Plan (CAP):

a. Staff has been notified that criteria was not attached for Cert 202501170000231 and it has been attached.
b. Staff has been notified of the process error in cert 202501170001147.
c. Staff has been notified hierarchy of criteria was not used in cert 202501130001701.

NOA Audit:

Utilization Management Department Internal Audit:
Notice of Action (NOA) Team Audits - Quarter 1, 2025

Audit Period:
January 1, 2025 – March 31, 2025

Report Completion Date:
May 12, 2025

Audit Sample Size:
Thirty (30) total for the quarter consists of ten (10) randomly selected referrals from each month in the audit period.

Purpose:
Quarterly audits of the NOA Team are done to monitor for accuracy and ensure appropriate processing of referrals that were previously denied or modified and to monitor compliance with the Kern Health Systems' Policy and Procedure 3.22 Referral

and Authorization Process.

Audit Indicators:

a. NOA spelling, grammar, verbiage, and format
b. 6th grade reading level
c. Criteria indicated and attached.
d. Recommendations indicated.
e. Medical Director / Case Manager name and signatures
f. Mailed within timeframes

January Audit Findings:

Out of the **10** NOAs audited, the following is a breakdown of the findings:

- **NOA spelling, grammar, verbiage, and format:** Zero (0) errors found.
- **6th grade readability:** Zero (0) errors found with language above readability.

Criteria indicated and attached: One (1) error was found with Hierarchy Criteria indications within cert below:

- Cert 202501030000894

- **Recommendations indicated:** Zero (0) error was found.
- **Medical Director / Case Manager name and signatures:** Zero (0) errors found.
- **Mailed within timeframes:** Zero (0) error found

February Audit Findings:

Out of the **10** NOAs audited, the following is a breakdown of the findings:

- **NOA spelling, grammar, verbiage, and format:** One (1) error was found with NOA indicator.
  - Cert 202502180001074- No NOA was completed
- **6th grade readability:** Zero (0) error found.
- **Criteria indicated and attached:** One (1) error was found with Hierarchy Criteria.
  - Cert 202502220000110
- **Recommendations indicated:** Zero (0) errors found.
- **Medical Director / Case Manager name and signatures:** Zero (0) errors found.
- **Mailed within timeframes:** Three (3) errors were found within TAT issue
  - Cert 202502130000422
  - Cert 202502210001475
  - Cert 202502180001074

March Audit Findings:

Out of the **10** NOAs audited, the following is a breakdown of the findings:

- **NOA spelling, grammar, verbiage, and format:** Zero (0) errors found.
- **6th grade readability:** Zero (0) errors found.
- **Criteria indicated and attached:** Zero (0) errors found.
- **Recommendations indicated:** Zero (0) errors found.
- **Medical Director / Case Manager name and signatures:** Zero (0) errors found.
- **Mailed within timeframes:** Zero (0) errors found; however,

Corrective Action Plan (CAP):

UM Management sent the results of the audit for review. Error will be discussed with staff during 1:1 meeting.

Non-Clinical IRR Results

KHS - 2025 IRR Q1 Results

All Non-Clinical Staff in UM must successfully pass Quarterly IRR testing to demonstrate competency and understanding of the review process.

Results:

All staff were able to complete 1st Quarter IRR Quiz for NCIC process review. Staff were given a total of 10 questions for NCIC review process to meet our passing standards of 95 percent or better.

All non-clinical staff members participated and has completed the required IRR testing in Learning Management System (LMS) with a passing score of 100 percent.

Below is a breakdown of the findings:

	Number of Staff	# Questions Tested	%of staff who got 95% or higher after 3 attempts

All Non-Clinical Staff Results:	35	10	100% (35 passed over 35 staff)

Refresher training conducted on demand as needed and upon hiring via LMS.

Respectfully submitted,
Clarissa Cisneros
UM OP Administrative Support Supervisor

Clinical

Milliman Care Guidelines Interrater Reliability (IRR)

2025 - Quarter 1 Results

All Utilization Management (UM) clinical staff reviewers must complete and successfully pass quarterly MCG IRR testing to demonstrate competency and ensure compliance with regulatory standards and guidelines.

Methodology:

All licensed clinical reviewing staff members are given three (3) attempts to complete the assigned case studies with a minimum passing score of 95% or higher.

Outpatient clinical staff reviewers are given a total of five (5) Ambulatory Care (AC) case studies with a minimum of fifteen (15) questions.

Inpatient clinical staff reviewers are given one (1) General Recovery Care (GRC) case study and one (1) Inpatient and Surgical Care (ISC) case study with a minimum of twenty (20) questions.

Medical Directors, Management, and clinical trainers are given four (4) AC cases and one (1) ISC or GRC case with a minimum of twenty (20) questions.

Remediation:

- If a staff member does not pass the first attempt, they are required to complete the related MCG online training modules before making a 2nd attempt.
- If a staff does not pass the 2nd attempt , they must complete a refresher training /coaching session with Trainer or Supervisor prior to making the 3rd attempt.
- If a staff does not pass the 3rd attempt, they will be required to retest with thirty (30) additional questions from their corresponding assigned case studies.

2025- Quarter 1 Cases:

Outpatient Staff:

Reviewers were given the following cases with 15 total questions:

2025-AC-402 -Familial Hypercholesterolemia – APOB, LDLR, and PCSK9 Genes

2025-AC-403 -Holter Monitor (24-Hour to 48-Hour Continuous Monitoring)

2025-AC-404 -Mammography

2025-AC-405 -Dysphagia Rehabilitation -

2025-AC-406 -Obesity – Referral Management

Inpatient Staff:

Reviewers were given the following cases with 28 total questions:

- 2024- ISC - 102: Hyperemesis Gravidarum: Observation Care / Hyperemesis Gravidarum
- 2024-GRC-202: Neonatology GRG

Medical directors, management, and clinical trainer

- Reviewers were given the following cases with 23 total questions:
- 2025-AC-402 -Familial Hypercholesterolemia – APOB, LDLR, and PCSK9 Genes
- 2025-AC-403 -Holter Monitor (24-Hour to 48-Hour Continuous Monitoring)
- 2025-AC-404 -Mammography -
- 2025-AC-405 -Dysphagia Rehabilitation
- 2024-GRC-202: Neonatology GRG

<u>2025 - Quarter 1 Results:</u>

Summary of findings:

All licensed staff reviewers and medical directors have participated and successfully passed the required IRR testing with a passing score of 95% or higher.

Below is a breakdown of the findings:

	# of Staff	# Total Questions	# of Attempts to Pass	% of staff that scored 95% or higher within 3 attempts
OP Nurse(s):	10	15	3	10/10 = 100%
IP Nurses:	15	28	3	15/15 = 100%
Medical Director:	6	23	3	6/6 = 100%

Director/ Manager/Supervisor	3	23	3	3/3 = 100%
Trainer:	1	23	3	1/1 = 100%

Corrective Action Plan:

1. Six (6) clinical staff members failed the first attempt, they have successfully completed the related MCG online training modules before making the 2nd attempt.
2. All other (29) licensed clinical reviewers have successfully passed within the allotted first attempt on their assigned IRR cases.
3. Newly hired staff will participate in MCG IRR training during the onboarding process.

KERN HEALTH SYSTEMS

To: KHS EQIHEC Meeting

From: Nate Scott

Date: June 17, 2025

Re: Executive Summary for 1st Quarter 2025 Operation Board Update - Grievance Report

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Background

When compared to the previous four quarters, the following grievance trends were identified.

- There was an increase in the Plan's grievance volume in the 1st quarter, 2025, compared to the previous four quarters. Historically, this has been a recurring pattern in the 1st quarter of each year. The overall volume of Grievances and Appeals increased 9% from the 4th quarter. Access to Care, Quality of Care, and Quality of Service grievances remained the three largest grievance categories. The volume of Exempt grievances increased as well, up 5.7% from the previous quarter. No other significant trends were identified.

KHS Grievance and Appeals per 1,000 members = 2.46 per month.

Requested Action: Review and approve.

1st Quarter 2025 Operational Report

Alan Avery
Chief Operating Officer

1st Quarter 2025 Grievance Report

Category	4th Quarter 2024	Status	Issue	Q4 2024	Q3 2024	Q2 2024	Q1 2024
Access to Care	713		Appointment Availability	603	601	541	384
Coverage Dispute	0		Authorizations and Pharmacy	0	0	0	0
Medical Necessity	192		Questioning denial of service	241	290	357	385
Other Issues	141		Miscellaneous	134	106	118	64
Potential Inappropriate Care	535		Questioning services provided. All cases forwarded to Quality Dept.	476	532	538	572
Quality of Service	654		Questioning the professionalism, courtesy and attitude of the office staff. All cases forwarded to PR Department	509	525	417	338
Discrimination (New Category)	81		Alleging discrimination based on the protected characteristics	71	62	81	60
Total Formal Grievances	2316			2034	2116	2052	1803
Exempt	683		Exempt Grievances	644	858	1177	1881
Total Grievances (Formal & Exempt)	2999			2678	2974	3229	3684

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Additional Insights-Formal Grievance Detail

Issue	2024 4th Quarter Grievances	Upheld Plan Decision	Further Review by Quality	Overturned Ruled for Member	Still Under Review
Access to Care	317	198	0	116	3
Coverage Dispute	0	0	0	0	0
Specialist Access	396	226	0	165	5
Medical Necessity	192	126	0	66	0
Other Issues	141	119	0	22	0
Potential Inappropriate Care	535	450	0	76	9
Quality of Service	654	510	0	137	7
Discrimination	81	79	0	2	0
Total	2316	1708	0	584	24

KERN HEALTH SYSTEMS

To: KHS EQIHEC Meeting

From: Nate Scott

Date: June 17, 2025

Re: Executive Summary for 1st Quarter 2025 Grievance Summary Report

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Background

The Grievance Summary Report supports the high-level information provided on the Operation Board Report and provides more detail as to the type of grievances KHS receives on behalf of our members.

For the 1st quarter, 2025, we had two thousand, nine hundred, ninety-nine (2,999) Grievances and Appeals (G&A) received. Here are the top three grievance categories:

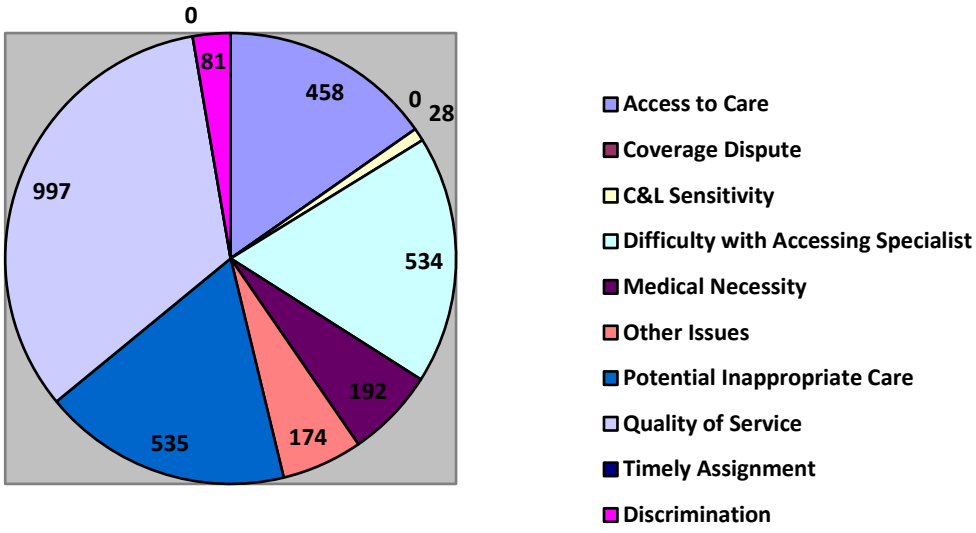
- Access to Care/Difficulty Accessing Specialists at 33.1% of grievances received.
- Quality of Service at 33.24% of grievances received.
- Quality of Care at 17.83% of grievances received.

Of the 2,999 G&A received:

- 2,316 (77.2%) G&A were Standard Grievances and took up to 30 days to investigate and resolve.
- 683 (22.8%) G&A were Exempt Grievances and were resolved within one business day.
- 1,267 (42.2%) closed in Favor of the Enrollee
- 1,708 (57%) closed in Favor of the Plan/Provider
- 24 (.8%) are still open for review.

Requested Action: Review and approve.

Issue	Number	In Favor of Health Plan	In favor of Enrollee	Still under review
Access to care	458	179	278	1
Coverage dispute	0	0	0	0
Cultural and Linguistic Sensitivity	28	13	14	1
Difficulty with accessing specialists	534	232	296	6
Medical necessity	192	126	66	0
Other issues	174	119	55	0
Potential Inappropriate care	535	450	76	9
Quality of service	997	510	480	7
Timely assignment to provider	0	0	0	0
Discrimination	81	79	2	0



Type of Grievances

KHS Grievances and Appeals per 1,000 members = 2.47/month

During the 1st quarter of 2025, there were two thousand nine hundred and ninety-nine grievances and appeals received. Two thousand three hundred and sixteen cases were standard, and six hundred eighty-three cases were exempt and closed within one business day. One thousand seven hundred and eight cases were closed in favor of the Plan. One thousand two hundred and sixty-seven cases were closed in favor of the Enrollee. There are twenty-four cases still under review. Of the two thousand nine hundred and ninety-nine, two thousand eight hundred and twenty-nine cases closed within thirty days; one hundred and seventy cases were pended and closed after thirty days.

Access to Care

There were four hundred and fifty-eight grievances pertaining to access to care. Two hundred and ninety cases were standard, and one hundred and sixty-eight were exempt cases that closed within one business day. One hundred and seventy-nine cases closed in favor of the Plan. Two hundred and seventy-eight cases closed in favor of the Enrollee. There is one case pending review. The following is a summary of these issues:

One hundred and ninety-six members complained about the lack of available appointments with their Primary Care Provider (PCP). Fifty-one cases closed in favor of the Plan after the responses indicated the offices provided the appropriate access to care based on the Access to Care standards. One hundred and forty-five cases closed in favor of the Enrollee after the responses indicated the offices may not have provided appropriate access to care based on the Access to Care standards. There are no cases pending review.

Thirty-eight members complained about the wait time to be seen by a Primary Care Provider (PCP) appointment. Seventeen cases closed in favor of the Plan after the responses indicated the members were seen within the appropriate wait time for a scheduled appointment or the members were at the offices to be seen as a walk-in, which are not held to the Access to Care standards. Twenty-one cases closed in favor of the Enrollee after the response indicated the member was not seen within the appropriate wait time for a scheduled appointment. There are no cases pending review.

One hundred and eleven members complained about the telephone access availability with their Primary Care Provider (PCP). Forty-three cases closed in favor of the Plan after the responses indicated the members were provided with the appropriate telephone access availability. Sixty-seven cases closed in favor of the Enrollee after the responses indicated the members may not have been provided with the appropriate telephone access availability. There is one case pending review.

One-hundred and twelve members complained about a provider not submitting a referral authorization request in a timely manner. Sixty-seven cases closed in favor of the Plan after it was determined the referral authorization request had been submitted in a timely manner. Forty-five cases closed in favor of the Enrollee after it was determined the referral authorization request may not have been submitted in a timely manner. There are no cases pending review.

One member complained about physical access to a provider. One case closed in favor of the Plan after it was determined the physical access provided was appropriate.

Coverage Dispute

There were no grievances pertaining to a Coverage Dispute issue.

Cultural and Linguistic Sensitivity

There were twenty-eight members that complained about the lack of available interpreting services to assist during their appointments. Eighteen were standard cases and ten were exempt cases that closed within one business day. Thirteen cases closed in favor of the Plan after the responses from the providers indicated the members were provided with the appropriate access to interpreting services. Fourteen cases closed in favor of the Enrollee after the responses from the providers indicated the members may not have been provided with the appropriate access to interpreting services. There is one case still under review.

Difficulty with Accessing a Specialist

There were five hundred and thirty-four grievances pertaining to Difficulty Accessing a Specialist. Four hundred and five were standard cases and one hundred and twenty-nine were exempt cases that closed within one business day. Two hundred and thirty-two cases closed in favor of the Plan. Two hundred and ninety-six cases closed in favor of the Enrollee. There are six cases still under review. The following is a summary of these issues:

Ninety members complained about a provider not submitting a referral authorization request in a timely manner. Thirty-six cases closed in favor of the Plan after it was determined the referral authorization request had been submitted in a timely manner. Fifty-two cases closed in favor of the Enrollee after it was determined the referral authorization request may not have been submitted in a timely manner. There are two cases under review.

One hundred and nine members complained about experiencing difficulties in arranging, scheduling, or accessing transportation services. Forty-eight cases closed in favor of the Plan after the responses indicated the members were provided the appropriate services. Sixty-one cases closed in favor of the Enrollee after the responses indicated the members may not have been provided with the appropriate services. There are no cases under review.

Fifty-two members complained about the driver showing up outside of the scheduled pick-up time to transport the member to their appointment. Twenty-four cases closed in favor of the Plan after the response indicated the member was provided with the appropriate wait time for a scheduled appointment. Twenty-eight cases closed in favor of the Enrollee after the response indicated the member may not have been provided with the appropriate wait time for a scheduled appointment. There are no cases under review.

One hundred and thirty-four members complained about the lack of available appointments with a specialist. Fifty-eight cases closed in favor of the Plan after the responses indicated the members were provided with the appropriate access to specialty care based on the Access to Care Standards. Seventy-four cases closed in favor of the Enrollee after the responses indicated the offices may not have provided the appropriate access to care based on the Access to Care standards. There are two cases under review.

One hundred and twelve members complained about the telephone access availability with a specialist office. Forty-six cases closed in favor of the Plan after the response indicated the member was provided with the appropriate telephone access availability. Sixty-four cases closed in favor of the Enrollee after the response indicated the member may not have been provided with the appropriate telephone access availability. There are two cases under review.

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

Five members complained about geographic access to a specialist provider. Three cases closed in favor of the Plan after it was determined the geographic access provided was appropriate. Two cases closed in favor of the Enrollee after it was determined the geographic access provided may not have been appropriate. There are no cases under review.

Two members complained about physical access to a specialist provider. One case closed in favor of the Plan after it was determined the physical access was appropriate. One case closed in favor of the Enrollee after it was determined the physical access may not have been appropriate. There are no cases under review.

Medical Necessity

There were one hundred and ninety-two appeals pertaining to Medical Necessity. One hundred and twenty-six 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 for the requested specialist or DME item; therefore, the denials were upheld. Of the cases that were closed in favor of the Plan, two were partially overturned. Sixty-six were closed in favor of the Enrollee. There are no cases under review.

Other Issues

There were one hundred and seventy-four grievances pertaining to Other Issues that are not otherwise classified in the other categories. One hundred and forty-one were standard cases and thirty-three were exempt cases that closed within one business day. One hundred and nineteen cases closed in favor of the Plan after the responses indicated the appropriate service was provided. Fifty-five cases closed in favor of the Enrollee after the responses indicated the appropriate service may not have been provided. There are no cases under review.

Potential Inappropriate Care

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

Quality of Service

There were nine hundred and ninety-seven grievances involving Quality of Service issues. Six hundred and fifty-four were standard cases and three hundred and forty-three were exempt cases that closed within one business day. Five hundred and ten cases closed in favor of the Plan after the responses determined the members received the appropriate service from their providers. Four hundred and eighty cases closed in favor of the Enrollee after the responses determined the members may not have received the appropriate services. There are seven cases still under review.

Timely Assignment to Provider

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

Discrimination

There were eighty-one standard grievances pertaining to Discrimination. Seventy-nine cases closed in favor of the Plan as there was no discrimination found. Two cases closed in favor of the Enrollee. There are no cases under review. All grievances related to Discrimination are forwarded to the DHCS Office of Civil Rights upon closure.

KERN HEALTH SYSTEMS

To: KHS EQIHEC

From: Isabel Silva, Senior Director of Wellness and Prevention

Date: June 17, 2025

Re: 2025 Wellness & Prevention Department Roadmap

Background

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

Discussion

Enclosed is the 2025 Wellness and Prevention Department Roadmap summarizing the goals, objectives and activities planned for 2025 to meet KHS' contractual requirements with DHCS for wellness, prevention, health education and cultural and linguistic services.

Fiscal Impact

None.

Requested Action

Review and approve.

Wellness & Prevention Department 2025 Roadmap

June 17, 2025

KERN HEALTH SYSTEMS

2025 Goals & Objectives

1. **Actively Engage Members in Wellness & Prevention Programs**
   - Increase awareness of preventive care and wellness and prevention programs
   - Increase enrollment into programs
   - Assemble region specific teams to engage members into enrolling in programs
2. **Enhance quality and accessibility of cultural and linguistic services**
   - Implement quality assurance processes through quarterly audits and surveys
   - Provide ongoing training and professional development for KHS staff
   - Develop an interpreter basics training program for provider offices
3. **Implement community-base initiatives aimed at promoting and enhancing health and wellness**
   - Partner with CBOs to expand Live Better Program sites
   - Launch school wellness grant program
   - Collaborate with schools, FRCs and other agencies to implement new initiatives aimed at childhood injury and illness prevention
4. **Execute and operationalize MOUs and APLs per DHCS contract**
   - Submit quarterly progress reports to DHCS
   - Facilitate quarterly MOU meetings with each agency
   - Operationalize MOU provisions upon MOU execution
   - Hire additional liaisons to ensure MOU requirements are met

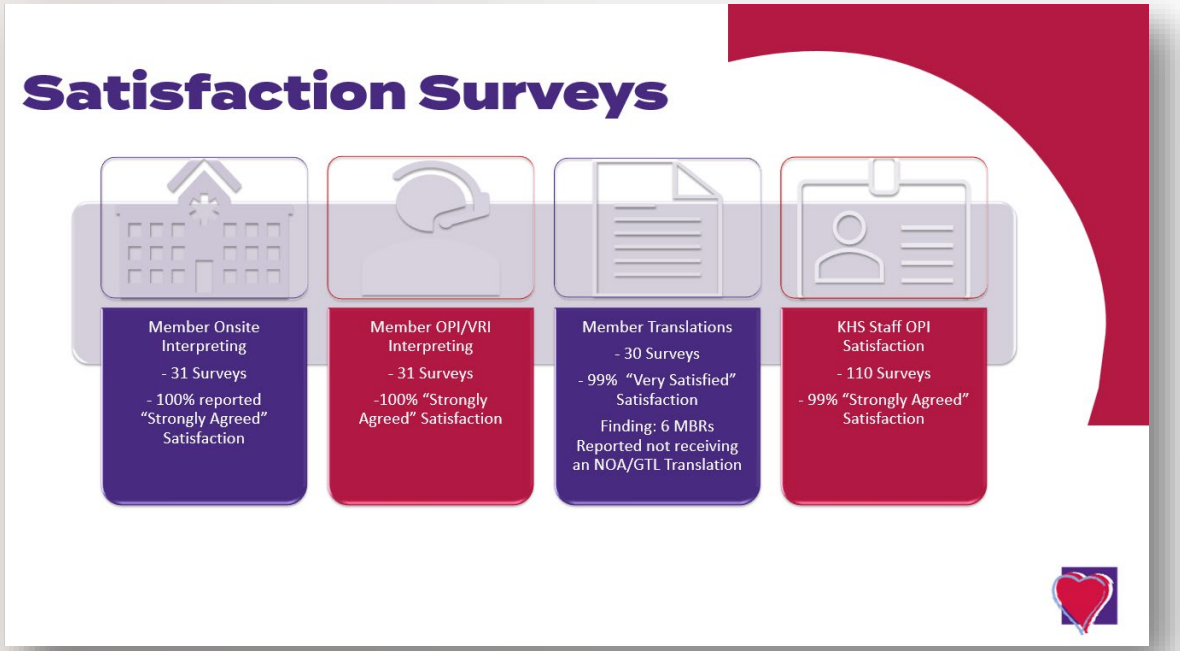
Goal 1 Results – Actively Engage Members in Wellness & Prevention Programs

1. **Increase awareness of preventive care and wellness and prevention programs**
   - Wellness campaigns - use of social media and text message to share informational health messages and promote classes
   - Revamping program outreach material
   - Departmental in-services to member-facing departments on program updates.
   - American Lung Association Partnership for online self-paced asthma basics program.
   - Provider Engagement:
     - CHW Provider Conversations Webinar (May)
     - Asthma Preventative and Remediation Services Provider Webinar (June)

2. **Increase enrollment into programs**
   - Kern County Library Classes
   - CHC agreement continuation
   - Increased facilitator capacity in asthma, diabetes management and tobacco cessation
   - Provider In-services
   - Kick It California Outreach (June)
   - Obesity Management Program with Universal Healthcare Services (June)
   - Cooking classes at Bakersfield College or Shafter Grow culinary arts programs
3. **Assemble region specific teams to engage members into enrolling in programs**
   - Defined regions and staff to cover 3 regions: Central (Bakersfield), North and South Kern
   - Cross-trained teams to deliver at least 4 of 6 programs in each region
   - Collaborate with member-facing departments to cross-promote programs and services within each region

Goal 2 Results - Enhance quality and accessibility of cultural and linguistic services

1. **Implement quality assurance processes through quarterly audits and surveys**
   - Continue monthly audio recording audits for Member Services and linguistic service vendors
   - Continue member satisfaction surveys on quality of translations, interpreters and bilingual staff (phone, in person, video remote)
   - Continue KHS staff survey with phone interpreter vendor
2. **Provide ongoing training and professional development for KHS staff**
   - KHS Spanish Communication Classes
     - Offered every other month. 100+ KHS staff attended to date
     - Topics:
       - Medical Terminology
       - Verbs Part 1: Conjugation Basics
       - Verbs Part 2: Preterite, Imperfect, Indicative and Subjunctive
       - Phone Etiquette/Customer Service Skills Basics
       - Understanding False Friends & Spanglish
       - Articles and Pronouns
   - Interpreter Modality Guide
     - Assigning best interpreter mode by appointment type
   - National Certification for Interpreters and Translators
     - Certification Commission for Healthcare Interpreters
     - American Translators Association
3. **Develop an interpreter basics training program for provider offices**
   - Interpreter Basics Training Program
     - 4th Quarter
     - 20-25 provider office staff
     - Incentive: Reimburse for BC Tier 1 test fees



Goal 4 Results – Implement community-base initiatives aimed at promoting and enhancing health and wellness

1. Partner with CBOs to expand Live Better Program sites

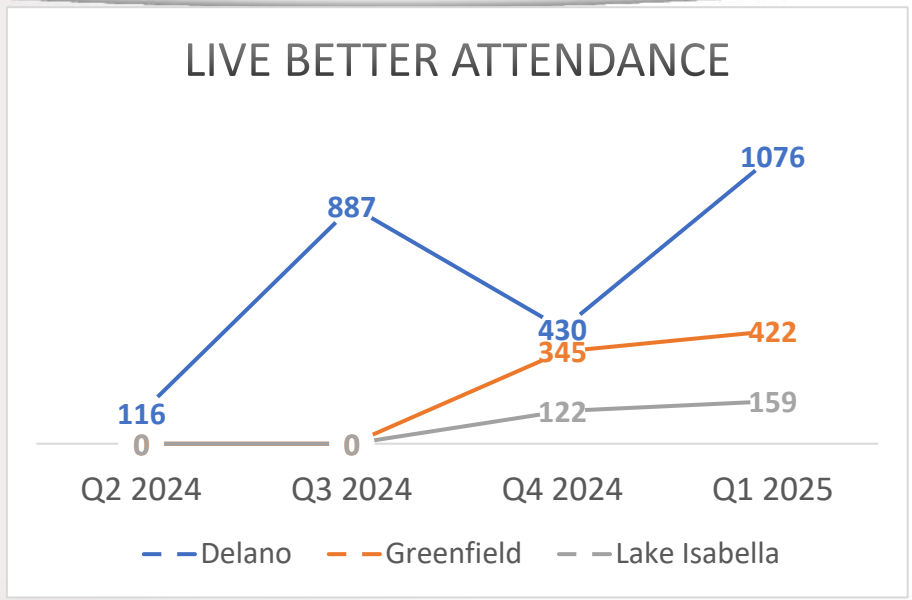
- Tentative new sites: Shafter (June), Tehachapi, Bakersfield
- McFarland Iron Valley Fitness (June)
- Read Your Beats Kern –(July)

2. Launch School Wellness Grant Program

- 10 schools awarded: Bakersfield, Ridgecrest, Lamont, Wasco, Shafter
- 1st All Schools Meeting (May); 2nd In-Person All Schools Meeting: October

3. Collaborate with schools, FRCs and other agencies to implement new initiatives aimed at childhood injury and illness prevention

- Kern County Immunization Coalition Parent Survey
  - Partnership with First 5 Kern, Kern Public Health, Anthem, schools, CSV and CAPK
- Baby Shower
  - June 7 at David Head Center (Lamont)
  - Focus on Maternal Mental Health, Mother and Infant Nutrition, Infant Safety and Navigating Pregnancy
  - Next event: Q3 (tentative). Location TBD



Goal 4 - Execute and operationalize MOUs and APLs per DHCS contract

Purpose:

Build partnerships with 3rd party entities to ensure member care is coordinated and Members have access to community-based resources in order to support whole-person care

Required MOUs:

- 2024-2025: In Home Support Services, Regional Centers, Local Health Departments, Child Welfare, WIC, First 5, County Behavioral Health
- 2026: Corrections, Local Education Agencies
- MOU Public Postings

Required Activities:

1. Submit quarterly progress reports to DHCS
2. Facilitate quarterly MOU meetings with each agency
3. Operationalize MOU provisions upon MOU execution
    - Data exchange, Quality Improvement Activities, Referrals, Case Coordination and Collaboration, Training and Education
4. Ensure required liaisons meet MOU and APL requirements (i.e. Tribal liaison)

Thank you! Questions?

Isabel Silva, MPH

Senior Director of Wellness & Prevention

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