KERN HEALTH SYSTEMS

REGULAR MEETING OF THE QI/UM COMMITTEE

Thursday, February 24th, 2022
At
7:00 A.M.

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

The public is invited

For more information, call (661) 664-5000

Agenda

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

Kern Health Systems
4th Floor Kern River Room
2900 Buck Owens Boulevard
Bakersfield, California 93308

Virtual Meeting
Thursday, February 24th, 2022

7:00 A.M.

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

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

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

STAFF RECOMMENDATION SHOWN IN CAPS

PUBLIC PRESENTATIONS

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

COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

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

CA-6) QI/UM Committee Summary of Proceedings November 11th, 2021 – APPROVE

7) Physician's Advisory Committee (PAC) Summary of Proceedings 4th Quarter 2021– RECEIVE AND FILE
- October 2021
- November 2021
- December 2021

CA-8) Public Policy and Community Advisory Summary of Proceedings 4th Quarter 2021 RECEIVE AND FILE
- December 2021

CA-9) Pharmacy & Therapeutics Committee Summary of Proceedings 4th Quarter 2021- RECEIVE AND FILE
- November 2021

Pharmacy Reports

CA-10) Pharmacy TAR Log Statistics 4th Quarter 2021 – RECEIVE AND FILE

Quality Improvement Department Summary Reports

11) Quality Improvement Department Summary Reports 4th Quarter 2021 – APPROVE
- COVID-19 Updates
- Potential Inappropriate Care (PIC) Notifications
- Facility Site Reviews (FSRs)
    a. Initial Full Site Reviews
    b. Periodic Full Site Reviews
    c. Interim/ Focus Reviews
- Quality Improvement Projects
    a. Performance Improvement Projects (PIPs)
    b. MCAS Member Incentive and Engagement Project
    c. SWOT Project
- MCAS Accountability Set (MCAS) Updates
- Policy and Procedure and other program documents

UM Department Summary Reports

12) Combined UM Reporting 4th Quarter 2021– APPROVE

- Executive Summary
- VSP DER Effectiveness Report – APPROVE
- VSP- Medical Data Summary- APPROVE
- Policies and Procedures - APPROVE

Kaiser Organization Summary Reports

CA-13) Kaiser Reports **(PROPRIETARY AND CONFIDENTIAL)**

- KFHC APL Grievance Report-4th Quarter 2021– RECEIVE AND FILE
- KFHC Volumes Report 4th Quarter 2021– RECEIVE AND FILE
- Kaiser Reports will be available upon Request

Member Services Department Summary Reports

14) Grievance Operational Board Update – APPROVE

- Executive Summary
- 4th Quarter 2021

15) Grievance Summary Reports – APPROVE

- Executive Summary
- 4th Quarter 2021

Provider Network Management Department Summary Reports

16) Re-credentialing Report 4th Quarter 2021– APPROVE

CA-17) Board Approved New Contracts Report – RECEIVE AND FILE

CA-18) Board Approved Providers Report – RECEIVE AND FILE

CA-19) Provider Relations Network Review Report 4th Quarter 2021– RECEIVE AND FILE

- Executive Summary

Policies and Procedures

20) 3.22-P Referral and Authorization Process HP-APPROVE

21)3.25-P Prior Authorization Services and Procedures-APPROVE

Health Education Department Summary Report

CA-22) Health Education Activity Report 4th Quarter 2021-APPROVE

- Executive Summary

ADJOURN MEETING TO THURSDAY, MAY 26th, 2022 @ 7:00 A.M.
IF COMMITTEE APPROVES DATE

AMERICANS WITH DISABILITIES ACT
(Government Code Section 54953.2)

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

APPENDIX

1. QI_UM Committee Meeting Cover Sheet- Page 1
2. QI_UM Agenda February 24th, 2022 - Pages 2-5
3. QI/UM Committee Summary of Proceedings – Pages 6-11
4. Physician's Advisory Committee (PAC) Summary of Proceedings- Pages 12-21
5. Public Policy and Community Advisory Summary of Proceedings- Pages 22-23
6. Pharmacy & Therapeutics Committee Summary of Proceedings- Pages 24-26
7. Pharmacy TAR Log Statistics Reports- Pages 27-28
8. Quality Improvement Department Summary Reports- Pages 29-48
9. Combined UM Report- Pages 49-75
10. Kaiser Reports- Page 76
11. Member Services Reports – Pages 77-86
12. Provider Relations Reports- Pages 87-139
13. QI/UM Policies and Procedures- Pages 140-168
14. Health Education- Pages 169-182

SUMMARY OF PROCEEDINGS

Quality Improvement (QI) / Utilization Management (UM) Committee
(VIRTUAL) MEETING

Kern Health Systems
4th Floor Kern River Room
2900 Buck Owens Boulevard
Bakersfield, California 93308

Virtual Meeting
Thursday, November 11, 2021

7:00 A.M.

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

Members Present: Satya Arya, MD; Danielle C Colayco, PharmD; Allen Kennedy; Philipp Melendez, MD; John Miller, MD; Chan Park, MD; Martha Tasinga, MD, CMO

Members Absent: Jennifer Ansolabehere, PHN; Maridette Schloe MS, LSSBB

Meeting was called to order at 7:07 A.M. by Dr. Martha Tasinga, M.D., Chief Medical Officer

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

STAFF RECOMMENDATION SHOWN IN CAPS

PUBLIC PRESENTATIONS

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

COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

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

3) Announcements – **N/A**

4) Closed Session – **N/A**

5) CMO Report – **Dr. Martha Tasinga gave committee overview of the following:**
   - **Physician Services: (PCPs, Specialists, Hospitalist, Other Professional and Urgent Care.**
   - **The combined PMPM prescription cost remains below budget for all aid categories except for SPDs. We continue to analyze utilization patterns and cost of utilization to identify ways to better manage this benefit.**
   - **We saw an increase in hospital outpatient visits starting in June 2021 and continuing in August.**

CA-6) QI/UM Committee Summary of Proceedings July 29th, 2021 – APPROVED
Arya-Kennedy: All Ayes

7) Physician's Advisory Committee (PAC) Summary of Proceedings 3rd Quarter 2021–RECEIVED AND FILED
Melendez-Kennedy: All Ayes
   - July 2021 – No PAC Meeting
   - August 2021
   - September 2021

CA-8) Public Policy and Community Advisory Summary of Proceedings Quarters 2 and 3 for 2021 – APPROVED
Arya-Kennedy: All Ayes

- June 2021
- September 2021

CA-9) Pharmacy & Therapeutics Committee Summary of Proceedings 3rd Quarter 2021 - RECEIVED AND FILED
Arya-Kennedy: All Ayes

- March 2021

Pharmacy Reports – Arya-Kennedy: All Ayes
CA-10) Pharmacy TAR Log Statistics 3rd Quarter 2021– RECEIVED AND FILED

- Executive Summary

Quality Improvement Department Summary Reports
Melendez-Arya: All Ayes
11) Quality Improvement Department Summary Reports 3rd Quarter 2021– APPROVED

- Executive Summary
- COVID-19 Updates
- Potential Inappropriate Care (PIC) Notifications
- Facility Site Reviews (FSRs)
- Quality Improvement Projects
- MCAS Committee
- Policy and Procedures

Ms. Jane Daughenbaugh, Director of Quality Improvement, reviewed with the committee the executive summary for the 3rd quarter QI Department reports. Some key points discussed were:

1. **COVID-19 Updates**
   - **In August a resurgence of COVID cases started and has remained at a heightened rate of new cases, but steady.**
2. **Potential Inappropriate Care (PIC) Notifications**
   - **There was a slight decline in new PIC referrals during the 3rd quarter, but no trend has been identified. A new report showing the volume of PICs by severity level is included in the report.**
3. **Facility Site Reviews (FSR) and Medical Record Review (MRR) Description**
   - **For safety reasons, we have not been able to allow our nurses to go onsite to provider offices for these reviews. This has created a barrier in getting more nurses certified to do these reviews. We anticipate this barrier being removed after the holidays depending on the course of the current pandemic.**
4. **Quality Improvement Projects**
   - **Health Care Disparity in WCV (Well Care Visits ages 3-21) focusing on annual well care visits.**

- **Child/Adolescent Health Asthma Medication Ratio (AMR) focusing on increasing the level of compliance for members 5-21 years of age by approximately 15%.**

5. **MCAS Committee**
    - **The second campaign was completed in July and the measures included were: Initial Health Assessments, Prenatal and Postpartum Care, and Well-Child Visits for infants, children, and adolescents.**
6. **MCAS Updates**
    - **We are still running below minimum performance levels. Several efforts are underway aimed at increasing the compliance rates.**

UM Department Reports - Melendez-Arya: All Ayes

12) Combined UM Reporting 3rd Quarter 2021– APPROVED
- Executive Summary
- Policies and Procedures

Hadassah Perez, Director of Utilization Management, reviewed with the committee the UM Department reports. Some key points discussed were:

- **The 2021 membership enrollment reached over 308,000 in Q3 2021. Additional benefit coverage and broadening interdisciplinary collaboration to support the membership growth will continue through the remainder of 2021 and into 2022.**
- **Two Regulatory audits were completed this quarter.**
- **Department of Health Care Services (DHCS) virtual audit was September 13th through September 20th.**

Kaiser Organization Summary Reports

CA-13) Kaiser Reports **(PROPRIETARY AND CONFIDENTIAL)**
- KFHC APL Grievance Report-3rd Quarter 2021– RECEIVED AND FILED
- KFHC Volumes Report 3rd Quarter 2021– RECEIVED AND FILED
- Kaiser Reports will be available upon Request

VSP Organization Summary Reports

14) VSP Reports – **Melendez-Arya: All Ayes**
- VSP DER Effectiveness Report – APPROVED
- VSP- Medical Data Summary- APPROVED
- VSP Monthly Call Response Summary- APPROVED

Member Services Department Summary Reports – Arya-Park: All Ayes

15) Grievance Operational Board Update – APPROVED

- Executive Summary
- 3rd Quarter 2021

16) Grievance Summary Reports – APPROVED

- Executive Summary
- 3rd Quarter 2021

Nate Scott, Member Services Manager, went over the Grievance reports with the committee.

Provider Network Management Department Summary Reports
Arya-Kennedy: All Ayes

17) Re-credentialing Report 3rd Quarter 2021– APPROVED
CA-18) Board Approved New Contracts Report – RECEIVED AND FILED
CA-19) Board Approved Providers Report – RECEIVED AND FILED
CA-20) Provider Relations Network Review Report 3rd Quarter 2021– RECEIVED AND FILED

- Executive Summary

Melissa Lopez, Provider Relations Manager, presented to the committee all initial and re-credentialing files for providers and facilities were approved.

A question brought up from the committee was asked that in the Provider Portal, is there a way to check our members' vaccination status. If so, where they can find that feature? Melissa answered - the vaccine information is only available to the members primary care physician on the KHS Provider Portal. However, you can complete the Vaccination Log for incentive.

Policies and Procedures – Melendez-Arya: All Ayes

21) APL 20-006- Site Reviews: Facility & Medical Records Review– APPROVED
22) 3.43- P Hospice Services– APPROVED
23) 11.22 P Linguistic Services– APPROVED
24) 11.23-I Cultural and Linguistic Services– APPROVED
25) 11.24-I Health Education– APPROVED
26) 11.26 Translation of Written Member Materials– APPROVED

Health Education Department Summary Report – Arya-Kennedy: All Ayes

CA-27) Health Education Activity Report 2nd Quarter 2021-APPROVED

- Executive Summary
- 2021 Population Needs Assessment Report
- 2021 Population Needs Assessment Highlights
- Policies and Procedures

Meeting adjourned by Dr. Martha Tasinga, M.D., Medical Director @ 8:17 A.M. to Thursday, February 24, 2022 at 7:00 A.M.

AMERICANS WITH DISABILITIES ACT
(Government Code Section 54953.2)

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

SUMMARY OF PROCEEDINGS

PHYSICIAN ADVISORY COMMITTEE (VIRTUAL) MEETING

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

Wednesday, October 6, 2021

7:00 A.M.

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

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

COMMITTEE RECONVENED

Members Present: Hasmukh Amin, M.D.; David Hair, M.D.; Miguel Lascano, M.D.; Ashok Parmar, M.D.; Raju Patel, M.D., Martha Tasinga, M.D., C.M.O.

Members Absent: None

Meeting called to order at 7:06 A.M. by Dr. Martha Tasinga, M.D., C.M.O.

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

STAFF RECOMMENDATION SHOWN IN CAPS

PUBLIC PRESENTATIONS

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

COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

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

   - **Dr. Lascano announced the funeral for Mark Root, MD will be held Friday October 8th 2021 at St. Francis Church.**

ADJOURNED TO CLOSED SESSION @ 7:09 A.M.

CLOSED SESSION

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

Initial Applicants #2 (J.D.) and #3 (C.F.) met the WPAC criteria to provide hormone therapy as researched by Dr. John Miller. WPAC is a strong advocate to have multi-provider types available to members for hormone therapy. Dr. Tasinga informed the members that the updated new WPAC criteria was recently revised.

**Comprehensive review was conducted for initial applicant #6 (N.S.) and the recredentialing comprehensive reviews were all related to performance indicators for grievances; however, there was no additional adverse information reported from a primary source or any malpractice case(s) that resulted in settlement or judgment made on behalf of the practitioner within the previous five years.
Dr. Tasinga informed the members that the grievance process will be updated to look at the number of cases per 100k members to better depict the averages.**

PRV000525 – Refer to Peer Review minutes related to this item related to contract termination.
PRV000536 - Refer to Peer Review minutes related to this item. Motion – Amin / Second – Patel allowing provider to proceed with additional location request in Delano CA.
PRV000403 - Refer to Peer Review minutes related to this item related to tracking and trending list.

COMMITTEE RECONVENED TO OPEN SESSION @ 7:42 A.M.

CA-4) Minutes for KHS Physician Advisory Committee meeting on September 1, 2021 – APPROVED
Patel-Amin: All Ayes

5) Review VSP Reports – APPROVED
Amin-Parmar: All Ayes

MEETING ADJOURNED BY DR. MARTHA TASINGA, M.D., C.M.O. @ 7:49 A.M. TO WEDNESDAY, NOVEMBER 3, 2021 @ 7:00 A.M

AMERICANS WITH DISABILITIES ACT
(Government Code Section 54953.2)

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

SUMMARY OF PROCEEDINGS

PHYSICIAN ADVISORY COMMITTEE (VIRTUAL) MEETING

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

Wednesday, November 3, 2021
7:00 A.M.

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

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

COMMITTEE RECONVENED

Members Present: Hasmukh Amin, M.D.; David Hair, M.D.; Miguel Lascano, M.D.; Ashok Parmar, M.D.; Raju Patel, M.D., Martha Tasinga, M.D., C.M.O.

Members Absent: None

Meeting called to order at 7:03 A.M. by Dr. Martha Tasinga, M.D., C.M.O.

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

STAFF RECOMMENDATION SHOWN IN CAPS

PUBLIC PRESENTATIONS

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

COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

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

ADJOURNED TO CLOSED SESSION @ 7:05 A.M.

CLOSED SESSION

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

    - Cardiac Catheterizations – DISCUSSION

Dr. Miller provided background information regarding the increase request for invasive procedures, left heart catherization's (LHC) and LHC with coronary angiography with limited information to support the medical necessity for requesting this procedure. Several case examples were provided from various cardiology groups. Dr. Tasinga provided some examples of her discussions with the providers where there was very little information provided by the cardiologist. Members discussed the apparent need to education all cardiologist in the network on the guidelines for these invasive procedures and that many are unnecessary or do not meet medical necessity. Motion was made, seconded, and carried for Dr. Tasinga to draft a letter to be sent to all cardiologists informing them that, as part of our UM process, we will be reviewing our network of cardiologist practices to determine if the supporting documentation supports Milliman criteria and/or the American Board of Cardiology as we monitor under and over utilization of invasive procedures with little supporting documentation to support medical necessity.

Credentialing/Recredentialing

- **Initial Applicants #2 (B.C.) and #3 (G.N.) were discussed regarding their adverse information related to malpractice case(s) that resulted in settlement for B.C. and Probation of Licensure for G.N. during the time the provider was an RN. The committee reviewed the provider explanations in detail and there being no issue of concern, providers were recommended for network participation.**
- **Initial Applicant #3 (M.R.N.) – members reviewed in detail the extensive MBC Probation Settlement and Disciplinary Order for this provider, including a malpractice settlement in 2020. MBC Probation was made effective 9/3/2020 for 5-years with various terms and conditions that continue to be monitored. Of note, the provider's practice monitor provided further information noting that the provider does not have full surgical privileges at this time and is only "assisting" in surgery. Members discussed the clinical work being done by the provider may be acceptable to bring into the network; however, as a neurosurgeon it is the responsibility of the committee to ensure members can receive full care by the specialist who is able to perform surgery rather than be referred to another specialist. Motion was made, seconded and carried to table this request pending additional review of the provider's ability to fulfill their duties as a specialist.**

- **Comprehensive review was conducted for those recredentialing files where there was adverse information related to performance indicators for grievances; reported from a primary source or a malpractice case(s) that resulted in settlement or judgment made on behalf of the practitioner within the previous five years. PRV001778**
- **# 8 – PRV001778 – 2020 MBC Probation terms and conditions have been previously reviewed upon issuance and the provider continues to remain compliant with probationary requirements which are monitored monthly by Credentialing Supervisor.**

COMMITTEE RECONVENED TO OPEN SESSION @ 7:46 A.M.

CA-4) Minutes for KHS Physician Advisory Committee meeting on October 6, 2021 – APPROVED
Amin-Hair: All Ayes

5) Quality Improvement Updated Site and Medical Record Review Policy & Procedure Presentation – APPROVED

- **Kailey Collier, Quality Improvement Manager gave presentation to committee. The changes she went over in the Power Point presentation will be effective 01/01/2022.**

MEETING ADJOURNED BY DR. MARTHA TASINGA, M.D., C.M.O. @ 7:49 A.M. TO WEDNESDAY, DECEMBER 1, 2021 @ 7:00 A.M

AMERICANS WITH DISABILITIES ACT
(Government Code Section 54953.2)

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

SUMMARY OF PROCEEDINGS

PHYSICIAN ADVISORY COMMITTEE (VIRTUAL) MEETING

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

Wednesday, December 1, 2021
7:00 A.M.

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

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

COMMITTEE RECONVENED

Members Present: Hasmukh Amin, M.D.; David Hair, M.D.; Ashok Parmar, M.D.; Raju Patel, M.D., Martha Tasinga, M.D., C.M.O.

Members Absent: Miguel Lascano, M.D.

Meeting called to order at 7:05 A.M. by Dr. Martha Tasinga, M.D., C.M.O.

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

STAFF RECOMMENDATION SHOWN IN CAPS

PUBLIC PRESENTATIONS

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

COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

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

ADJOURNED TO CLOSED SESSION @ 7:10 A.M.

CLOSED SESSION

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

Recredentialing comprehensive reviews were conducted, and all issues were related to performance indicators for grievances; however, there was no additional adverse information reported from a primary source or any malpractice case(s) that resulted in settlement or judgment made on behalf of the practitioner within the previous five years. Information accepted as presented.

COMMITTEE RECONVENED TO OPEN SESSION @ 7:30 A.M.

CA-4) Minutes for KHS Physician Advisory Committee meeting on November 3, 2021 – APPROVED
Parmar-Patel: All Ayes

5) Review VSP Reports – APPROVED
Patel-Amin: All Ayes

6) Medi-Cal Pharmacy Update – DISCUSSION

Bruce shared the latest updates regarding Enteral Feedings, Diabetic Supplies, and other Supplies/Devices with the committee. Bruce also relayed that there will be changes to how vaccines will be reimbursed and processed at the Pharmacy level. Instead of billing part to Medi-cal Rx as a Pharmacy claim, and part as a Medical claim to the Health Plan, all components (vaccine, dispensing fee, Admin fee) will be billed on a Pharmacy claim to Medi-Cal Rx. He also mentioned that other changes to the CDL will be effective 12/01/2021 in preparation for both Medi-Cal Rx and CalAIM.

7) Review KHS Policies:

Policy 3.23-P Provider Appeals Regarding Authorizations – APPROVED
Policy 3.25-P Prior Authorization Services and Procedures – APPROVED
Patel-Amin: All Ayes

MEETING ADJOURNED BY DR. MARTHA TASINGA, M.D., C.M.O. @ 8:02 A.M. TO WEDNESDAY, FEBRUARY 2, 2022 @ 7:00 A.M

AMERICANS WITH DISABILITIES ACT
(Government Code Section 54953.2)

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

SUMMARY

PUBLIC POLICY/COMMUNITY ADVISORY COMMITTEE

KERN HEALTH SYSTEMS
2900 Buck Owens Boulevard
Bakersfield, California 93308

Regular Meeting
Tuesday, December 14, 2021

11:00 A.M.

COMMITTEE RECONVENED

Members: Janet Hefner, Jennifer Wood, Jasmine Ochoa, Mark McAlister, Cecilia Hernandez-Colin, Beatriz Basulto, Jose Sanchez, Tammy Torres, Yadira Ramirez, Caitlin Criswell, Michelle Bravo, Alex Garcia, Quon Louey
ROLL CALL: 11 Present; 2 Absent – Yadira Ramirez, Caitlin Criswell

Meeting called to order by Louie Iturriria, Director of Marketing and Public Relations, at 11:01 AM.

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

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

COMMITTEE ACTION SHOWN IN CAPS

PUBLIC PRESENTATIONS

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

COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

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

CA-3) Minutes for Public Policy/Community Advisory Committee meeting on September 28, 2021
APPROVED
Garcia-Hefner: 11 Ayes; 2 Absent – Ramirez, Criswell

CA-4) Report on December 2021 Medi-Cal Membership Enrollment
RECEIVED AND FILED
Garcia-Hefner: 11 Ayes; 2 Absent – Ramirez, Criswell

CA-5) Report on KFHC Grievance Summary for third quarter ending September 30, 2021
RECEIVED AND FILED
Garcia-Hefner: 11 Ayes; 2 Absent – Ramirez, Criswell

CA-6) Report on Health Education for third quarter ending September 30, 2021
RECEIVED AND FILED
Garcia-Hefner: 11 Ayes; 2 Absent – Ramirez, Criswell

7) Report on KFHC Grievances for third quarter ending September 30, 2021
RECEIVED AND FILED
Hefner-Hernandez Colin: 11 Ayes; 2 Absent – Ramirez, Criswell

8) Report on KFHC COVID-19 Vaccination Efforts
RECEIVED AND FILED
Garcia-Hernandez Colin: 11 Ayes; 2 Absent – Ramirez, Criswell

9) Report on Enhanced Care Management and Community Support
RECEIVED AND FILED
Garcia-Louey: 11 Ayes; 2 Absent – Ramirez, Criswell

10) Report on Population Health Management for third quarter ending Sept. 30, 2021
RECEIVED AND FILED
Hernandez Colin-Basulto: 11 Ayes; 2 Absent – Ramirez, Criswell

Meeting adjourned by Louie Iturriria, Director of Marketing and Public Relations, at 11:59 AM to March 29, 2022 at 11:00 AM.

SUMMARY OF PROCEEDINGS

PHARMACY & THERAPEUTICS (P&T) COMMITTEE (VIRTUAL MEETING)

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

Virtual Meeting
Wednesday, November 17, 2021

6:30 P.M.

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

COMMITTEE MEMBERS PRESENT: Alison Bell, Pharm. D; Kimberly Hoffmann, Pharm. D; Vasanthi Srinivas, M.D.; Martha Tasinga, M.D., C.M.O.; Joseph Tran, Pharm. D; Bruce Wearda, R.Ph., Director of Pharmacy

COMMITTEE MEMBERS ABSENT: Dilbaugh Gehlawat, M.D.; Sam Ratnayake, M.D.; Sarabjeet Singh, M.D.

Meeting called to order at 6:39 P.M. by Dr. Martha Tasinga, M.D.

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

STAFF RECOMMENDATION SHOWN IN CAPS

PUBLIC PRESENTATIONS

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

COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

2) On their own initiative, Committee Members may make an announcement or a report on their own activities. They may ask a question for clarification, make a referral to staff or take action to have staff place a matter of business on a future agenda (Gov. Code Sec. 54954.2[a])
    - **Bruce announced to committee that there were some late Medi-cal Rx updates, that came after the packet was sent out. Therefore, we will discuss the updates during item #5.**

CA-3) Minutes for KHS Pharmacy &Therapeutics Committee meeting(s) on Sept 22, 2021 – APPROVED
Srinivas-Bell: All Ayes

CA-4) Report of Plan Utilization Metrics – RECEIVED AND FILED
Srinivas-Bell: All Ayes

5) Executive Order N-01-19: Medi-Cal Rx Update – DISCUSSION
    - **Dr. Srinivas asked if Medi-Cal Rx is going to have a formulary book like the one KHS has given to their providers. Bruce stated they will have a formulary list (CDL), but it will only be available online.**
    - **Bruce shared the latest updates regarding Enteral Feedings, Diabetic Supplies, and other Supplies/Devices with the committee. Bruce also relayed that there will be changes to how vaccines will be reimbursed and processed at the Pharmacy level. Instead of billing part to Medi-cal Rx as a Pharmacy claim, and part as a Medical claim to the Health Plan, all components (vaccine, dispensing fee, Admin fee) will be billed on a Pharmacy claim to Medi-Cal Rx. He also mentioned that other changes to the CDL will be effective 12/01/2021 in preparation for both Medi-Cal Rx and CalAIM. Therefore, to align with these changes the committee decided to add Chlorhexidine mouth rinse, Triamcinolone 0.1% paste, and Sennosides 8.2 mg tablets. Bell made a motion to accept this addition, and it was seconded by Srinivas.**

6) Drug Utilization Review (DUR) – DISCUSSION
   - **Bruce reiterated some of the duties and expectations of what the DUR committee would be asked to do. One of these duties is reporting Opioid Utilization in regard to the SUPPORT ACT.**
   - **Kim Hoffmann asked several questions. Including how the process of the transition would go, what are the guidelines, such as, what are pharmacies to do/not do, will they be comparing us to other Health Plans.**
   - **Bruce responded that we will not be compared to other plans, this is just more of a report. There is no right or wrong answer.**

7) Committee Membership Candidate Introductions – DISCUSSION
   - **Committee Membership Vacancies**
   - **There were a total of (4) candidate biographies presented to replace the committee vacancy. They each gave a brief description of themselves and stated why they would like to be part of the DUR Committee.**

ADJOURNED TO CLOSED SESSION @ 7:42 P.M.

CLOSED SESSION

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

8) Committee Membership – VOTE
   - **Committee voted to fill the vacancy on the DUR Committee with candidate James Patrick "Pat" Person.**

COMMITTEE RECONVENED TO OPEN SESSION @ 7:58 P.M.

MEETING ADJOURNED AT 8:02 P.M. BY DR. MARTHA TASINGA, M.D., C.M.O. TO WEDNESDAY, MARCH 30, 2022 @ 6:30 P.M.

AMERICANS WITH DISABILITIES ACT
(Government Code Section 54953.2)

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

KERN HEALTH SYSTEMS | PROVIDER bulletin

QI Executive Summary -- Pharmacy Report – Prior Authorizations

Background

KHS as part of a Medicaid Managed Care system is regulated by two governing bodies, the Department of Managed Health Care (DMHC) and the State of California's Medicaid division of the Health Department, Department of Health Care Services (DHCS) better known as Medi-Cal. They have regulations that specify turnaround times for processing along with other elements of how the prior authorization (Treatment Authorization Request (TAR)) is handled. Some of these elements include a licensed individual reviewing, if denied, the criteria used, a Notice of Action (NOA) letter sent to the member, among others. The following report depicts how the plan is doing in respect to these required actions. KHS conducts a monthly audit of 5% of the TARs received for the month reviewed. The following report shows how many of the sample met the required actions in accordance to the requirements.

Action

For Informational Purposes Only

No items of concern identified.

Quarter/Year of Audit	2021	2021	2021	2021	2021	2021	2021	2021	2021	2021	2021	2021
Month Audited	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Total TAR's for the month	3011	2991	3511	3457	3243	3360	3313	3087	3132	3179	3074	3094
Turn Around Time Compliant	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Notice of Action Compliant	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
APPROVED TAR'S												
Timeliness - Reviewed & Returned in 1 busines day	95/95	83/83	92/92	101/101	102/102	86/86	98/98	79/79	89/89	87/87	94/94	95/95
Date Stamped	95/95	83/83	92/92	101/101	102/102	86/86	98/98	79/79	89/89	87/87	94/94	95/95
Fax copy attached	95/95	83/83	92/92	101/101	102/102	86/86	98/98	79/79	89/89	87/87	94/94	95/95
Decision marked	95/95	83/83	92/92	101/101	102/102	86/86	98/98	79/79	89/89	87/87	94/94	95/95
DENIED TAR'S												
Timeliness - Reviewed & Returned in 1 business day	40/40	45/45	63/63	54/54	43/43	56/56	42/42	51/51	41/41	53/53	43/43	36/36
Initally Denied - Signed by Medical Dir and/or Pharm	40/40	45/45	63/63	54/54	43/43	56/56	42/42	51/51	41/41	53/53	43/43	36/36
Letter sent within time frame	40/40	45/45	63/63	54/54	43/43	56/56	42/42	51/51	41/41	53/53	43/43	36/36
Date Stamped	40/40	45/45	63/63	54/54	43/43	56/56	42/42	51/51	41/41	53/53	43/43	36/36
Fax copy attached	40/40	45/45	63/63	54/54	43/43	56/56	42/42	51/51	41/41	53/53	43/43	36/36
Decision marked	40/40	45/45	63/63	54/54	43/43	56/56	42/42	51/51	41/41	53/53	43/43	36/36
Correct form letter, per current policies used	40/40	45/45	63/63	54/54	43/43	56/56	42/42	51/51	41/41	53/53	43/43	36/36
NOA Commentary Met	40/40	45/45	63/63	54/54	43/43	56/56	42/42	51/51	41/41	53/53	43/43	36/36
MODIFIED TAR'S												
Timeliness - Reviewed & Returned in 1 business day	0	0	0	0	0	0	0	0	0	0	0	0
Date Stamped	0	0	0	0	0	0	0	0	0	0	0	0
Fax copy attached	0	0	0	0	0	0	0	0	0	0	0	0
Decision marked	0	0	0	0	0	0	0	0	0	0	0	0
Correct form letter, per current policies used	0	0	0	0	0	0	0	0	0	0	0	0
NOA Commentary Met	0	0	0	0	0	0	0	0	0	0	0	0
DUPLICATE TAR'S												
Timeliness - Reviewd & Returned in 1 business day	3/3	11/11	9/9	4/4	7/7	10/10	17/17	10/10	14/14	10/10	2/2	6/6
Date Stamped	3/3	11/11	9/9	4/4	7/7	10/10	17/17	10/10	14/14	10/10	2/2	6/6
Fax copy attached	3/3	11/11	9/9	4/4	7/7	10/10	17/17	10/10	14/14	10/10	2/2	6/6

Kern Health Systems
Quality Improvement Department
Executive Summary
4th Quarter 2021

This report provides a summary of key activities and issues related to the Quality Improvement (QI) Department during the 4th Quarter of 2021. The full set of reports follows the executive summary.

I. COVID-19 Updates

There was a significant increase of new COVID cases in the last week of December 2021 compared to earlier in the quarter. Primary impacts from the pandemic include:

- Compliance rates with most MCAS measures,
- Continuation of KHS efforts to promote members to receive the COVID vaccination along with encouraging delivery of preventive care services, and
- Completion of the backlog of facility site and medical record reviews resulting from the pandemic.

II. Potential Inappropriate Care (PIC) Notifications

There was a 32% increase in PIC notifications compared to previous quarter. This increase is due to assigning PICs to a nurse sooner in the receipt process which reflects more real time volumes. Although we have been including readmissions in our PIC notification volume, going forward we will delineate between standard PIC referrals and 30-day readmissions for reporting purposes.

The rates of PICs by Quality of Care Severity Level have remained consistent with greater than 90% of them being classified as Level 0, No Quality Concern. Fluctuations between 2% - 7% for Level 1 are not statistically valid due to the small volume (range between 7 and 19 episodes per quarter). The same is true for Level 2 and Level 3.

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

Special DHCS Site Review Audit: DHCS conducted a random Full Scope Site Review Audit on December 7th-9th for nine KHS Providers. KHS's certified Master Trainer, QI Director and QI Manager attended the audits to provide support to our providers as well as the DHCS auditors. The findings were provided by DHCS and KHS' QI Master Trainer issued CAPs to those providers. Critical Element findings required completion of corrective actions within 10 business days which was completed. The full Audit report is expected in Q1 2022 and corrective actions for non-critical elements will need to be completed within 45 days of receiving the report.

During the 4th quarter there were:

- 4 Initial FSRs and 1 MRRs completed
- 22 Periodic FSRs and 14 MRRs completed

Trends for pass/fail rates remain consistent with slightly more providers failing elements of the FSR versus the MRR. All critical elements except exit doors and Airway Management were at a 100% for the FSRs. The one provider that did not score 100% received a CAP and deficiencies were corrected within 10 business days.

There have been no trends identified in the top deficiencies for FSRs and MRRs. There were four 45-day follow ups completed for CAP closure in Q4 of 2021.

IHA's percentage for MRRs: In Q4 2022, 162 medical records reviewed. 154 of the 162 records included a completed IHA and 8 or 5% were non-compliant for IHA completion. Information and education were provided to the non-compliant providers

IV. Quality Improvement Projects

1. ***Performance Improvement Projects:***
   a. Health Care Disparity in WCV (Well Care Visits ages 3-21) focusing on annual well care visits. Kern Pediatrics has agreed to partner on us with this project. The overarching goal is to increase compliance with the preventive health service by 10% points. This Health Equity PIP is currently in the first cycle of intervention testing. Comparing WCV rates for Kern Pediatrics for ages 8-10 from September 2021 (32.27%) before the campaign to December 2021 (41.95%) after the campaign, the rates increased by 9.38%. Comparing MY2020 December rate and MY2021 December, the rates showed 6.26% increase.
   b. Child/Adolescent Health Asthma Medication Ratio (AMR) focusing on increasing the level of compliance for members 5-21 years of age by approximately 15%. This measure focuses on proper use of asthma controller medication versus overutilization of rescue medications. This PIP is in the 2nd Cycle of intervention testing.

      Outreach activities by the Population Health Management (PHM) team included outreached to 39 eligible members. 4 members have accepted to participate in KHS' asthma program and 4 declined. Results for members ages 5-21, assigned to Central California Asthma Coalition (CCAC) Asthma Improvement Project providers showed a slight improvement of 0.8% for MY2021 (49.41%) compared to MY2020 (48.62). Whereas members assigned to Population Health Management providers demonstrated almost 22% improvement compliance for MY2021 (65.96%) compared to MY2020 (45.10%).

2. ***SWOT Analysis and Action Plan Project***: The current SWOT action plan is focused on the Children's health domain with actions such as conducting quarterly meetings with the top 30 KHS providers for collaboration on MCAS compliance; engaging with community based organizations to promote children's health services, etc. This is a collaborative effort with DHCS providing input and suggestions as the project moves forward.

3. ***PDSAs***: One PDSA is focused on the Breast Cancer Screening (BCS) and to offer mobile mammography to members in rural areas near Taft. The first offering was on October 29, 2021, in Taft and a 2nd offering is in the planning phase. The 2nd PDSA is focused on the infant well care visits for babies 0-15 months. We are partnering with Clinica Sierra Vista (CSV) to conduct member outreach via robocalls phone calls.

4. ***COVID QIP***: Flyers were distributed to Kern Behavioral Health and Recovery Services and to Aegis, a substance use disorder provider. Provider Relations Representatives are encouraging PCPs to address preventive health screenings when members come in for either the COVID vaccination or other health care service. Adventist Health is partnering with Kern Medical to provide immunizations along with the COVID vaccine to eligible youth through their mobile immunization clinic. Robocalls to members who have not received their COVID vaccine have been underway since the end of November.

V. MCAS Committee

Highlights from the committee were reviewed and discussion of the following items occurred:

- 2022 Provider Pay-for-Performance (P4P) Program being re-structured with payouts based on "pool reimbursement" to support compliance with MCAS measures and IHA's.
- Member Engagement & Rewards Program (MERP) Campaigns: The Committee approved adding Blood Lead Screening, Breast Cancer Screening, and Cervical Cancer Screening to 2022 campaigns.

VI. MCAS Member Engagement and Rewards Program

Campaign #3 was completed in October with a combination of mailers and robocalls for outreach. Measures included were Initial Health Assessments, Timely prenatal and postpartum care, and infant and child/adolescent well care visits. There has been slight improvement specifically for WCV compared to MY2020 MCAS compliance rates. Although there has not been notable improvement in the remaining measures for 2021, the MERP campaigns last year likely prevented further decline in our MCAS compliance rates due to the pandemic.

VI. MCAS Updates

The MCAS Audit and Rate Submission for MY2021 started in October and will wrap up by June 1st.
The MY2021 rates we have for the 4th quarter are admin rates only and do not include medical record reviews (MRR) and supplemental data. We anticipate medical record review abstraction to begin in February 2022. **Compared to previous months all the measures except two (PPC-Pre and W30 (0-15M)) showed improvement in the rate.**

KERN HEALTH SYSTEMS

QUALITY IMPROVEMENT DEPARTMENT

QUATERLY QI-UM COMMIITTEE REPORT

Q4 2021

KERN HEALTH SYSTEMS
Quality Improvement Department Quarterly QI-UM Committee Report
Q4 2021

The purpose of this report is to provide a summary of the quarterly 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. COVID-19 Updates
II. Potential Inappropriate Care (PIC) Notifications
III. Site & Medical Record Reviews
    a. Initial Site & Medical Record Reviews
    b. Periodic Site & Medical Record Reviews
    c. Critical Elements
    d. Initial Health Assessments
    e. Interim Reviews
    f. Site Review Corrective Action Plans (CAPs)
IV. Quality Improvement Projects
    a. Performance Improvement Projects (PIPs)
    b. Member Engagement & Rewards Program (MERP)
    c. SWOT Action Plan
    d. PDSA's
    e. COVID QIP
V. Managed Care Accountability Set (MCAS) Updates
VI. MCAS Committee Minutes-Appendix A
VII. Policy and Procedures and other program documents

I. COVID-Update:

As per Kern County Public Health Department, there was a significant increase of new COVID cases in the last week of December 2021 compared to the beginning of the month. The rate of COVID cases have been inconsistent throughout the quarter. This has impacted compliance with most MCAS measures. The QI Department continues coordinating with other departments on efforts to prompt the COVID vaccination and encourage delivery of preventive care services. The QI Department is continuing to complete the backlog of facility site and medical record reviews resulting from the pandemic.

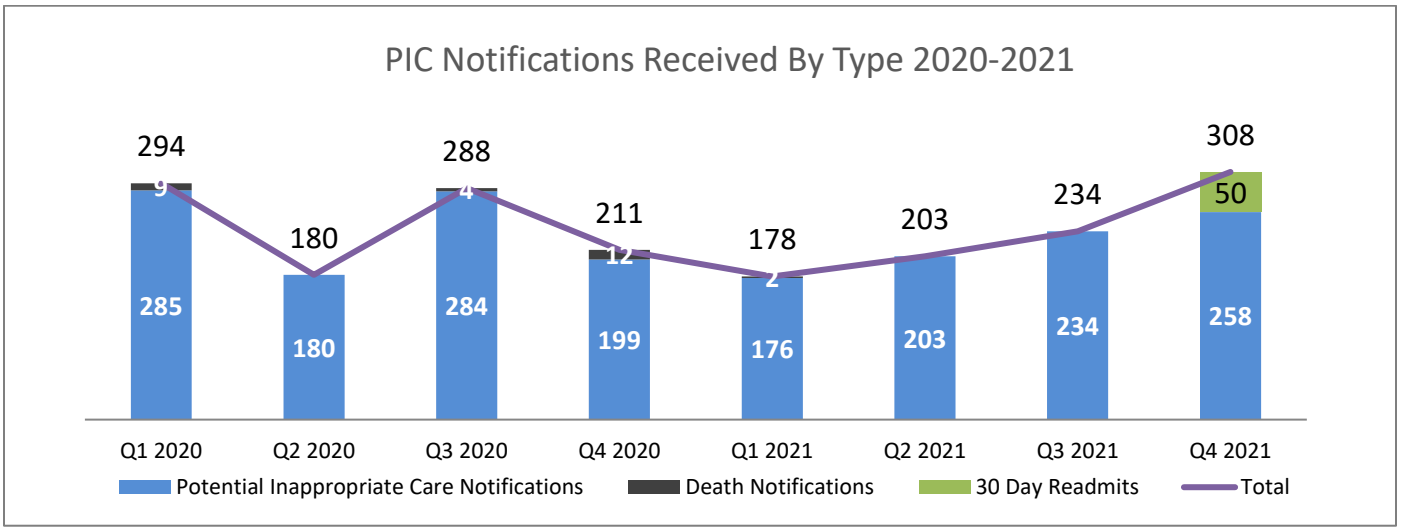
II. Potential Inappropriate Care (PIC) Notifications:

QI receives notifications from various sources to review for PIC issues.

On receipt of a PIC issue, a high-level review is completed by a QI RN to determine what level of Potential Quality Issue exists.

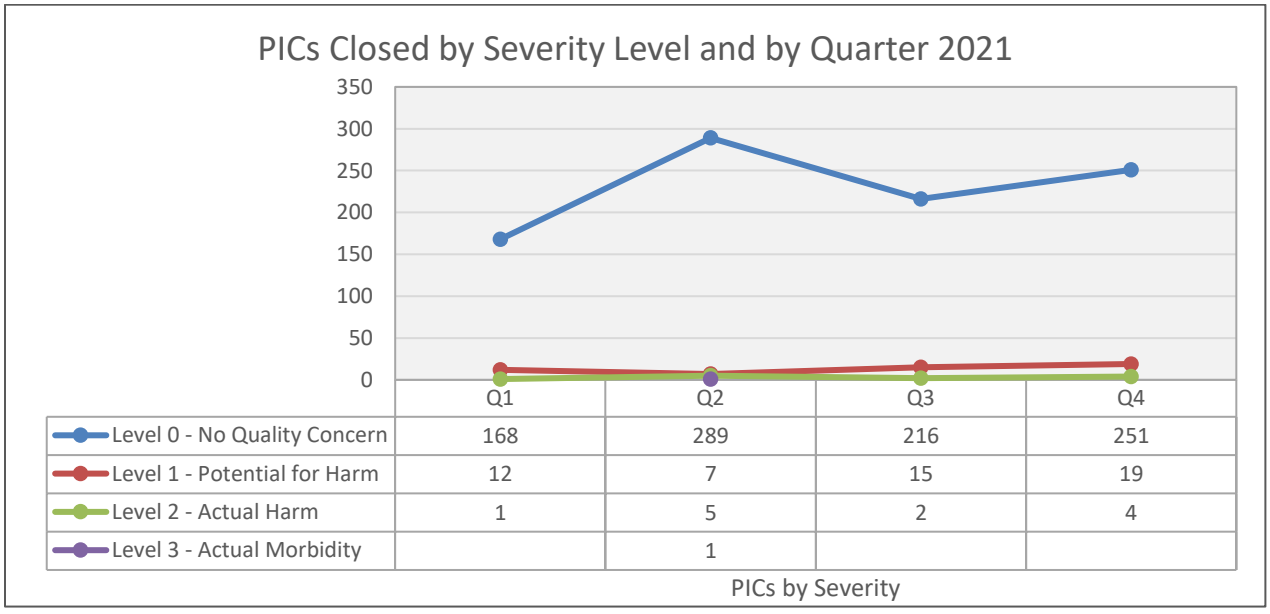
PICs are assigned a level based on the outcome of the review. The levels assigned are as follows:

- Level 0 = No Quality-of-Care Concern
    - Follow-up = Track and Trend and/or Provider Education
- Level 1 = Potential for Harm
    - Follow-up = Track and trend the area of concern for the specific provider and the Medical Director or their designee 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 provider



From the above charts, we received a total of 308 notifications for the 4th Quarter of 2021. This is a 32% increase in the notifications compared to previous quarter. Please note: The PIC notification volume is captured upon assignment to the QI RN's. Due to improvements in our workflow process, PICs are now assigned to the RN's daily. This change reflects an updated, real-time reflection of our PIC volume, which accounts for this increase in PICs for Q4 2021. Although we have been including readmissions in our PIC notification volume, going forward we will delineate between standard PIC referrals and 30-day readmissions for reporting purposes.

PICs Closed by Severity Level:



Above chart displays that majority of the PICs are level 0's and there are no trends identified among the PICs closed by Severity. Below is the table with the percentage of PICs by severity.

Severity Level	Q1	Q2	Q3	Q4
Level 0 - No Quality Concern	93%	96%	93%	92%
Level 1 - Potential for Harm	7%	2%	6%	7%
Level 2 - Actual Harm	0.005%	2%	1%	1%
Level 3 - Actual Morbidity		0.003%		

III. Facility Site Reviews (FSR) and Medical Record Review (MRR) Description:

We are expecting the Department of Health Care Services (DHCS) to require MCPs to resume on-site facility site reviews effective July 1st, 2022, and fully implement APL 20-006 by March 1st, 2021. KHS is doing virtual site and medical record reviews during the pandemic. KHS has submitted a plan to complete the backlog of site reviews that could not be completed due to the pandemic. We anticipate having the backlog completed by June 30th of 2022.

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

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

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

Critical Elements:

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

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

- Blood, other potentially infectious materials (specimens) and regulated wastes (sharps/biohazardous non-sharps) are placed in appropriate leak-proof, labeled containers for collections, processing, storage, transport or shipping.
- Spore testing of autoclave/steam sterilizer is completed (at least monthly, with documented results).

Scoring and Corrective Action Plans

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

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

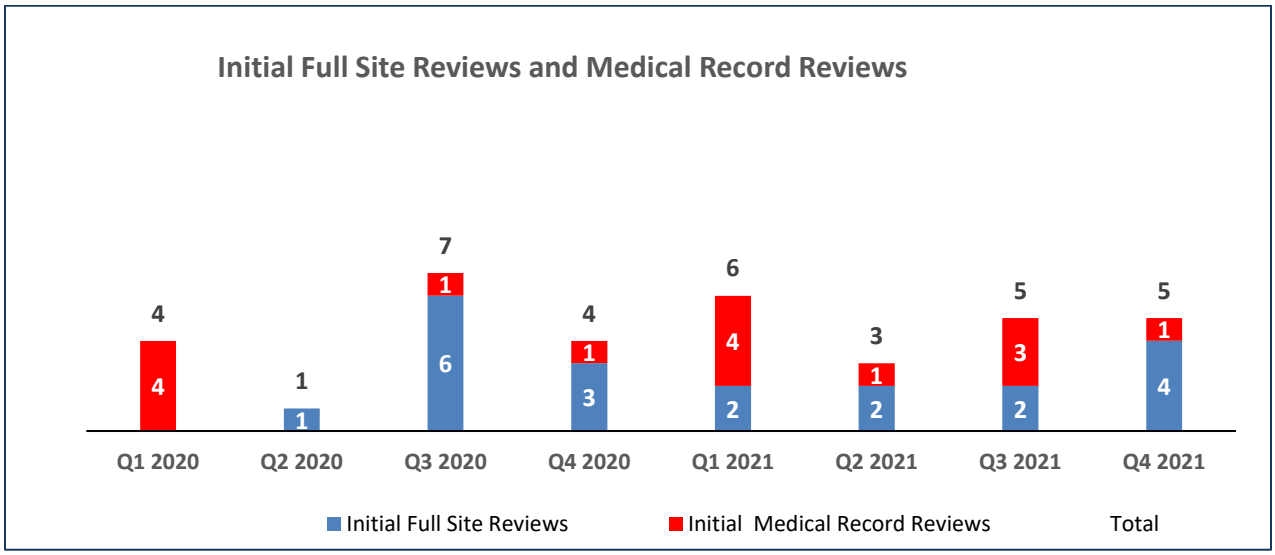
Corrective Action Plans (CAPs)

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

Special DHCS Site Review Audit:

DHCS conducted a random Full Scope Site Review Audit on December 7th-9th for nine KHS Providers. KHS's certified Master Trainer, QI Director and QI Manager attended the audits to provide support to our providers as well as the DHCS auditors. The findings were provided by DHCS and KHS' QI Master Trainer is responsible for issuing CAPs to the providers just as we do when we conduct the review. Critical Element findings required completion of corrective actions within 10 business days which was completed. The full Audit report is expected in Q1 2022 and corrective actions for non-critical elements will need to be completed within 45 days of receiving the report.

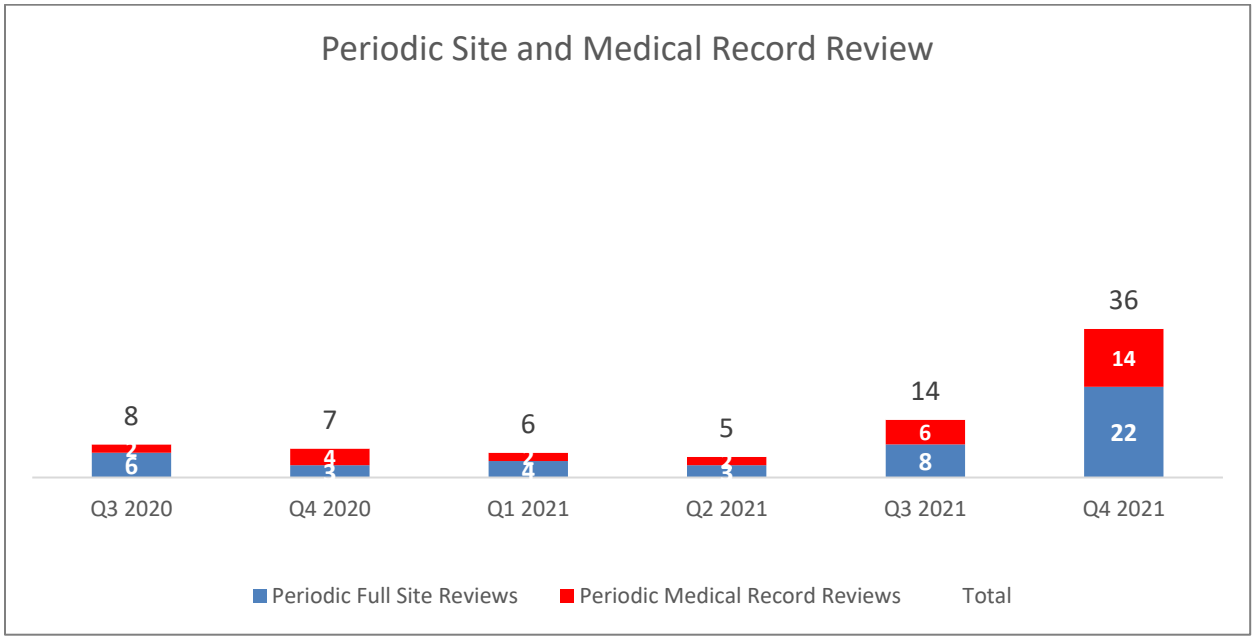
a. Initial Facility Site Review and Medical Record Review Results:



The number of initial site and medical record reviews is determined by the number of new providers requesting to join KHS' provider network. There were four IFSRs and one IMRR conducted in Q4 of 2021.

b. Periodic Full Site and Medical Record Reviews

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

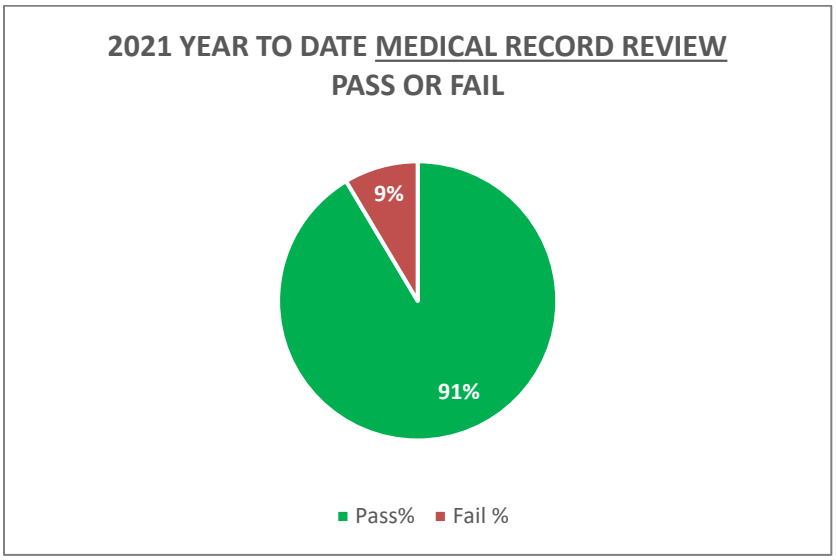


This above chart reflects the number of Periodic Full Site Reviews and Medical record reviews that were due and completed for each quarter. In October 2021, one of our QI RNs earned her certification as a site reviewer. In addition, our MCAS lead RN continued to complete site reviews during the Q4 2021. The additional staffing contributed to the increase of the site and medical record reviews completed for Q4. This additional staffing allowed us to complete a greater volume review that were backlogged in addition to reviews that were currently due.

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

Last quarter we reported pass/fail status based on a CAP being issued for the site and medical record reviews, regardless of the score received for the review. Beginning Q4 2021, we changed our reporting to reflect Pass/Fail based on DHCS standards. When a site score is less than 80% for a FSR or MRR, it is considered a failure.

In 2021 YTD, 95% of the Initial and Periodic site reviews performed passed and 5% scored less than 80% . There were 59 site reviews completed YTD and 3 of these reviews failed in the first audit. We will continue to monitor this for any trends.



In 2021 YTD, 91% of the Initial and Periodic medical reviews performed passed and 9% scored less than 80%. There were 35 medical record reviews conducted YTD and 3 of these reviews were failed in the first audit. We will continue to monitor this for any trends.

For Q4 2021, top #3 deficiencies identified for Opportunities for improvement in site reviews are:

1. Airway Management: Oxygen delivery system, oral airways, nasal cannula, or mask, and Ambu bag
2. Annual Education: Infection control/universal precautions
3. Annual Education: Bloodborne Pathogens

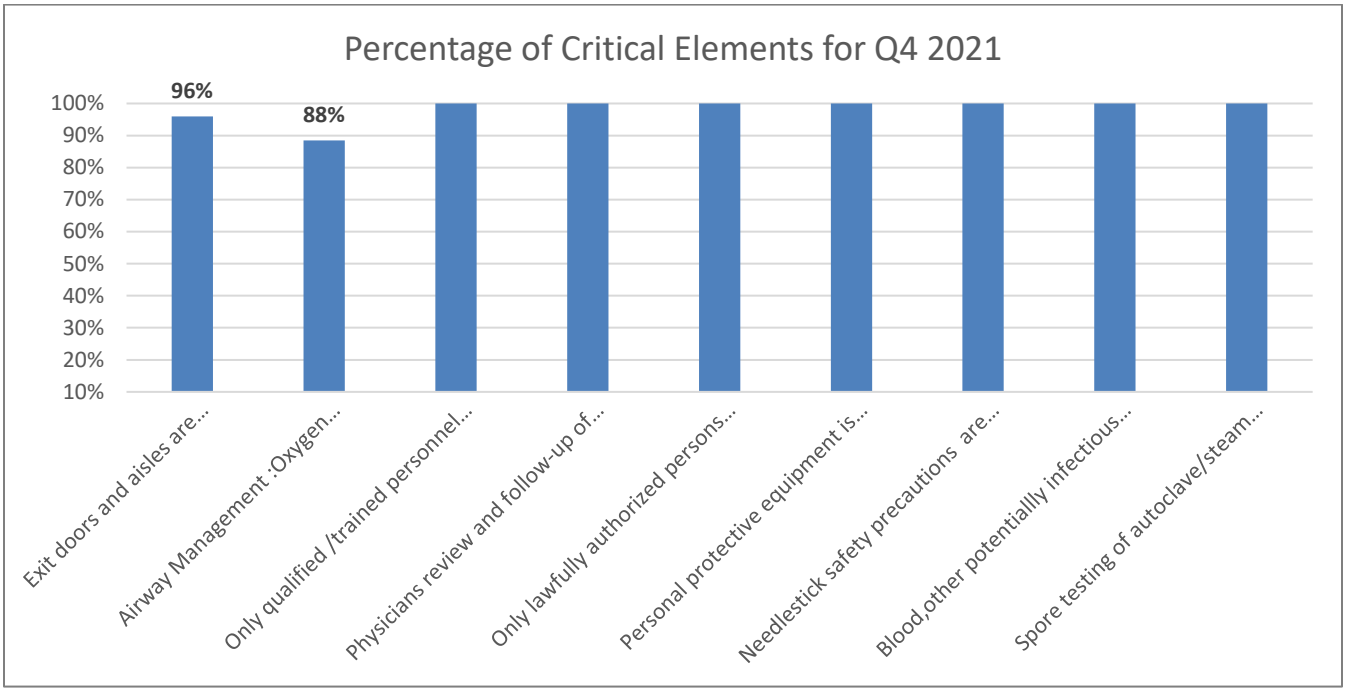
For Q4 2021, top #3 deficiencies identified for Opportunities for improvement in medical record reviews are:

- Advanced Health Care Directive information is offered
- Emergency contact is identified
- Pediatric Immunization given according to ACIP guidelines

There are two common deficiencies identified from previous quarter for site reviews, but none for medical record reviews. We will continue to monitor for any issues.

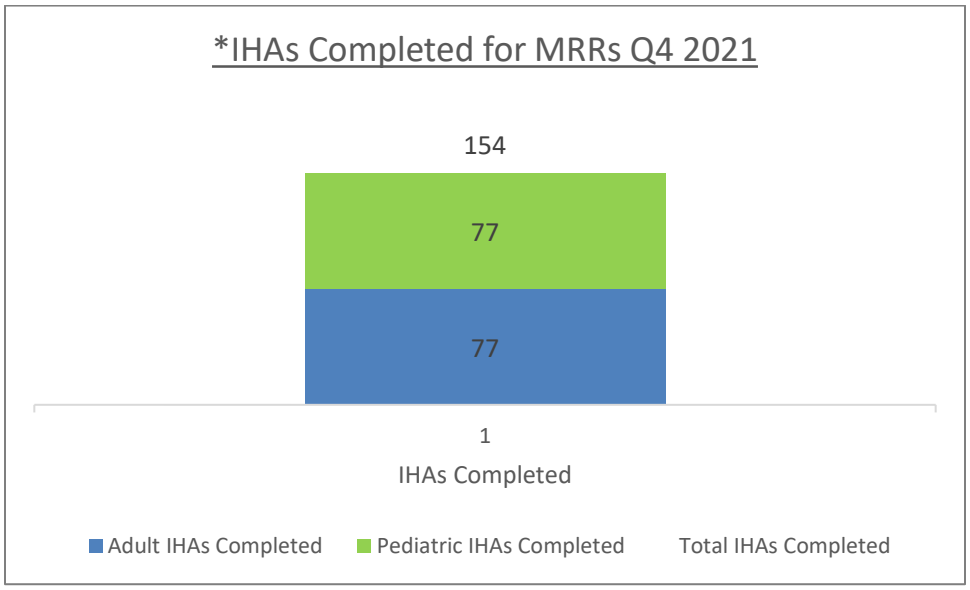
In Q3 of 2021, we began reporting the percentage of compliance from site reviews for the Critical Elements. Compliance with Initial Health Assessments (IHAs) will be reported based on medical record review results for each quarter.

c. Critical Elements Percentage for Site reviews:



From the above chart, all the critical element except exit doors and Airway Management were at a 100% for the initial and periodic site reviews. For the one that did not score 100% CAP was issued and deficiencies were corrected within 10 business days.

d. IHA's percentage for MRRs:



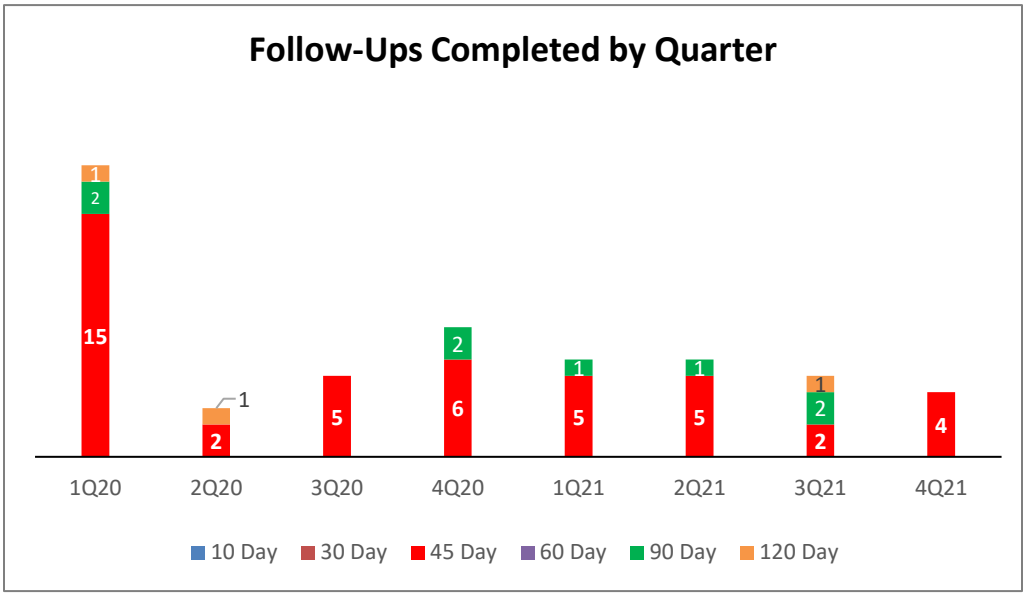
***Percentage-of IHAs completed = IHEBA+SHA's**

For Q4 2022, 162 medical records reviewed and 154 IHAs were completed. 8 records were non-compliant for an IHA. Out of the 154, 77 were adult IHAs and 77 were for Pediatric IHAs. There were 5% non-compliant records for IHA completion identified. For the non-compliant providers, information and education were provided and 45-day follow up is conducted as needed. We will continue to monitor to identify any trends.

Interim Reviews:

Interim Reviews are conducted between Initial and first Periodic Full Site Reviews or between two Periodic Full Site Reviews. Typically, they occur about every 18 months. These reviews are intended to be a check-in to ensure the provider is compliant with the 9 critical elements and as a follow up for any areas found to be non-compliant in the previous Initial or Periodic Full Site Review. Due to the pandemic, KHS has not been conducting Interim Reviews since January of 2021, once we resume doing interim reviews, we will include information about them in this report.

e. Site Review Corrective Action Plans (CAPs):



There were four 45-day follow up completed in Q4 of 2021.

IV. Quality Improvement Projects

a. Performance Improvement Projects (PIPs)

DHCS initiated a cycle of PIPs for 2020-2022 in November of 2020 through the EQRO, HSAG. The 2 current PIPs are:

Health Care Disparity in WCV (Well Care Visits ages 3-21)

The Health Equity (WCV) PIP is currently in Cycle #1 of the intervention testing phase. Initial data on MERP Campaign #3 (robocalls and mailers) is being reviewed. As of 12/27/2021 only 13 mailers were returned by USPS as undeliverable. Data on the robocall status is still being compiled.

Comparing WCV rates for Kern Pediatrics for ages 8-10 from September 2021 (32.27%) before the campaign to December 2021 (41.95%) after the campaign the rates increased 9.38%. Also comparing MY2020 December rate and MY2021 December, the rates showed 6.26% increase.

Child/Adolescent Health-Asthma Medication Ratio (AMR)

The AMR PIP is in Cycle #2 of the intervention testing phase. Outreach activities for Cycle #2 PDSA had been started by the Population Health Management (PHM) team. As of 12/22/2021, they have outreached to 31 of the 39 eligible members. To date, the PHM team has connected with 8 members (4 accepted to join the program and 4 declined).

The results of members ages 5-21, assigned to Group A (Asthma Improvement Project) providers there is a slight improvement of 0.8% for MY2021 (49.41%) compared to MY2020 (48.62). Whereas members assigned to Group B (Population Health Management) providers, there was almost 22% improvement in the rate in MY2021 (65.96%) compared to MY2020 (45.10%).

b. Member Engagement and Rewards Project (MERP):

MERP Campaign #3 was launched with mailers sent the 1st week of October. There was a total of 52,573 households that received mailers. Robocalls were completed on 10/26/21. Measures included were IHA, PPC- Pre, PPC- Post, W30, and WCV. There has been slight improvement specifically for WCV compared to MY2020 MCAS compliance rates. Although there has not been improvement in the remaining measures for 2021, we believe the MERP campaign may have prevented further decline in our MCAS compliance rates due to the pandemic.

c. SWOT Analysis Project:

The SWOT Team received DHCS feedback for revised SWOT Initial Strategies & Action Items on 12/15/2021. DHCS recommended KHS do the following:

- Include action items about child domain that could strongly move the needle in supporting the strategies identified.
- Consider existing resources in geographic areas that can be leveraged for shared activities to promote and support child preventative services.
- Consider existing pharmacies within the community to improve expanded access to immunization via MOU agreements
- Consider non-conventional gift cards or vouchers during point of care between member and provider (Goodwill, Salvation Army Thrift stores or accessible low-cost retail stores)
- Consider existing relationships with community organizations such as first five, etc. the next step is to find common grounds to share on how to promote children's services to families and dyads

Initial progress for each strategy and action item is due to DHCS on February 11th.

d. PDSAs:

As a result of KHS' MY2020 MCAS scores, Quality Improvement (QI) is performing two PDSA's required by DHCS. Our first PDSA is focused on the Breast Cancer Screening (BCS) measure in the Women's Health Domain. The specific intervention is to measure the volume of successful completion of a Mammogram via the Mobile Mammogram Clinic, which was conducted on October 29, 2021 in Taft. Currently, we are in the planning phase for the next mobile mammography clinic for Cycle 2 of the PDSA.

The second PDSA is focused on the W30 measure with a focus on ages 0-15 months. We are partnering with Clinica Sierra Vista (CSV) to conduct a two-pronged approach with utilization of robocalls and direct

telephonic outreach. The goal is to increase the MCAS compliance rate by 5%. We are working with CSV to determine our approach for Cycle 2, which is the next phase of the PDSA.

e. COVID QIP:

Flyers have been distributed to Kern Behavioral Health and Recovery Services. We are awaiting a supply of updated flyers to provide to Aegis, a substance use disorder provider. In addition, Provider Relations Representatives are encouraging PCPs to address preventive health screenings when members come in for either the COVID vaccination or other health care service. Adventist Health is partnering with Kern Medical to provide immunizations along with the COVID vaccine to eligible youth through their mobile immunization clinic. Robocalls to members who have not received their COVID vaccine have been underway since the end of November.

V. Managed Care Accountability Set (MCAS) Updates (also referred to as HEDIS):

MCAS Rates below are not considered typical to our plan due to reduction in available services during the pandemic.

MY2021 MCAS Rate Tracking Report
As of 2021-12-31
Note: These are admin rates only.

Hybrid Measures Held to MPL

Measure		Current MY2021 Rate (as of Dec 31st, 2021)	MY2021 MPL	MY2020 KHS Rate	Current Vs. MY2021 MPL	Current Vs. MY2020 KHS Rate
CCS	Cervical Cancer Screening	49.36	59.12	54.01	-9.76	-4.65
CIS-10	Childhood Immunization Status	19.05	38.2	22.87	-19.15	-3.82
CDC-H9*	HbA1c Poor Control (>9.0%)	67.91	43.19	50.85	-24.72	-17.06
CBP	Controlling High Blood Pressure <140/90 mm Hg	14.96	55.35	52.07	-40.39	-37.11
IMA-2	Immunizations for Adolescents – Combo 2 (meningococcal, Tdap, HPV)	30.76	36.74	33.09	-5.98	-2.33
PPC-Pre	Prenatal & Postpartum Care – Timeliness of Prenatal Care	44.00	85.89	70.07	-41.89	-26.07
PPC-Post	Prenatal & Postpartum Care – Postpartum Care	67.08	76.4	77.62	-9.32	-10.54
WCC-BMI	Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents: Body Mass Index Assessment for Children/Adolescents	29.34	76.64	63.50	-47.30	-34.16
WCC-N	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Nutrition	20.34	70.11	52.80	-49.77	N/A
WCC-PA	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Physical Activity	19.82	66.18	51.09	-46.36	N/A

Administrative Measures Held to MPL

Measure		Current MY2021 Rate (as of Dec 31st, 2021)	MY2021 MPL	MY2020 KHS Rate	Current Vs. MY2021 MPL	Current Vs. MY2020 KHS Rate
BCS	Breast Cancer Screening	51.40	53.93	54.50	-2.53	-3.10
CHL	Chlamydia Screening in Women Ages 16 – 24	55.48	54.91	54.02	0.57	1.46
W30 (0-15M)	Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits.	31.22	54.92	30.55	-23.70	0.67
W30(15-30M)	Well-Child Visits for Age 15 Months–30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits.	51.96	70.67	55.70	-18.71	-3.74
WCV	Child and Adolescent Well-Care Visits	36.70	45.31	36.16	-8.61	0.54

Indicates KHS did not met MPL
Indicates KHS need 5% or less to met MPL
Indicates KHS met or exceeded MPL
Indicates KHS met or exceeded HPL.
N/A' is for measures that were not reported for MY2019

Note: The above current MY2021 rates are admin rates only and does not include medical record reviews (MRR) and supplemental data, so this does not indicate the actual rate for hybrid measures. We anticipate medical record review abstraction to begin in January 2022. **Compared to previous months all the measures except two (PPC-Pre and W30 (0-15M)) showed improvement in the rate.**

Measure	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
BCS												
2020	33.55%	37.55%	44.27%	45.03%	45.82%	46.57%	47.36%	48.30%	48.94%	49.94%	50.73%	▲ 51.61%
2021	35.66%	37.10%	38.70%	40.39%	42.15%	44.56%	45.89%	47.08%	48.04%	49.13%	50.24%	▼ 51.40%
CBP												
2020	0.85%	2.06%	2.53%	2.87%	3.12%	3.21%	3.30%	3.40%	3.60%	4.15%	4.70%	▼ 5.13%
2021	0.00%	0.99%	2.56%	3.51%	4.31%	5.77%	6.22%	6.64%	6.94%	10.00%	12.36%	▲ 14.96%
CCS												
2020	41.01%	41.57%	42.83%	43.49%	44.10%	44.77%	45.46%	46.23%	46.84%	47.70%	48.37%	▼ 49.07%
2021	39.74%	39.81%	40.71%	42.05%	43.05%	44.87%	45.78%	46.55%	47.21%	48.11%	48.78%	▲ 49.36%
CDC HBA1C >9%												
2020	0.00%	0.99%	3.01%	3.03%	84.38%	78.25%	75.43%	73.89%	72.60%	69.21%	66.32%	▼ 64.77%
2021	100.00%	99.74%	96.42%	90.02%	84.24%	81.70%	73.96%	74.00%	70.89%	69.38%	69.40%	▲ 67.91%
CHL												
2020	23.85%	31.72%	36.70%	39.23%	41.73%	44.14%	46.70%	48.98%	50.57%	52.75%	54.07%	▲ 55.68%
2021	18.37%	27.83%	35.37%	39.07%	43.30%	46.23%	48.38%	50.36%	51.77%	53.75%	54.61%	▼ 55.48%
CIS-Combo 10												
2020	9.77%	11.08%	12.65%	14.08%	14.59%	15.12%	15.48%	15.80%	15.98%	16.62%	17.00%	▼ 17.83%
2021	9.59%	10.78%	12.43%	14.47%	15.68%	16.85%	17.30%	17.59%	17.85%	18.23%	18.62%	▲ 19.05%
IMA-Combo 2												
2020	24.84%	26.21%	27.74%	5.07%	30.06%	31.09%	31.75%	32.75%	33.60%	34.16%	34.46%	▲ 34.75%
2021	21.16%	22.16%	23.79%	24.84%	25.73%	26.93%	27.66%	29.43%	29.90%	30.41%	30.70%	▼ 30.76%
PPC-Postpartum												
2020	45.40%	49.50%	52.39%	56.45%	58.38%	59.38%	60.18%	61.23%	61.98%	66.44%	69.35%	▲ 69.93%
2021	37.74%	46.16%	51.23%	56.89%	58.32%	57.22%	57.86%	57.65%	58.19%	62.01%	66.18%	▼ 67.08%
PPC-Prenatal												
2020	28.53%	32.71%	35.68%	37.91%	39.82%	41.98%	43.85%	45.32%	46.10%	46.16%	45.93%	▲ 45.61%
2021	25.62%	29.74%	31.80%	33.39%	34.99%	38.38%	40.17%	42.28%	43.85%	44.22%	44.32%	▼ 44.00%
W30(0-15M)												
2020	31.91%	30.98%	31.27%	30.63%	29.98%	29.65%	29.69%	29.14%	29.92%	29.40%	29.36%	▼ 29.16%
2021	29.33%	29.77%	31.03%	30.74%	30.75%	30.35%	29.98%	30.51%	30.72%	30.94%	31.42%	▲ 31.22%
W30(15-30M)												
2020	44.45%	47.67%	50.03%	51.28%	51.92%	53.12%	53.96%	54.57%	55.30%	55.78%	56.02%	▲ 56.20%
2021	38.39%	41.98%	44.41%	46.39%	47.65%	48.91%	50.24%	51.09%	51.42%	51.70%	51.90%	▼ 51.96%
WCC-BMI												
2020	5.81%	8.64%	11.16%	12.40%	13.97%	16.01%	17.67%	20.33%	22.37%	24.07%	25.49%	▼ 26.61%
2021	0.00%	9.31%	15.51%	18.79%	20.82%	23.30%	24.59%	26.23%	26.46%	27.23%	28.22%	▲ 29.34%
WCC-N												
2020	2.55%	3.96%	5.04%	5.57%	6.31%	7.12%	7.84%	9.03%	10.20%	11.59%	12.68%	▼ 13.43%
2021	0.00%	6.35%	10.51%	12.76%	13.83%	15.84%	16.84%	18.10%	18.22%	18.81%	19.46%	▲ 20.34%
WCC-PA												
2020	1.91%	3.16%	4.15%	4.60%	5.27%	6.04%	6.64%	7.72%	8.87%	10.24%	11.38%	▼ 12.06%
2021	0.00%	5.84%	9.39%	11.77%	12.83%	14.68%	15.74%	17.28%	17.58%	18.36%	19.05%	▲ 19.82%
WCV												
2020	1.93%	4.69%	7.82%	9.62%	11.48%	14.76%	17.28%	20.67%	24.21%	27.41%	30.82%	▼ 33.62%
2021	0.00%	1.10%	3.72%	7.48%	11.19%	17.60%	20.64%	25.00%	28.45%	31.68%	34.40%	▲ 36.70%

The above chart displays trending rates for MY2020 and MY2021. As of December 2021, **8 out of 15 (CBP, CCS, CIS-10, W30-15-30M, WCC-BMI, WCC-N, WCC-PA, WCV) or 53% of the measures showed improvement compared to this**

month last year. CDC-H9 is an inverse measure where the lower rate indicates better performance.  Green arrow indicates rate increased and  Red arrow indicates rate decreased compared to previous year December 2020.

VI. MCAS Committee Minutes-Appendix A

The Q4 MCAS Committee meeting was held on February 3, 2022 and included discussion on the following items:

- Overview of the 2022 Pay-for-Performance (P4P) Program. The program is being re-structured with payouts based on "pool reimbursement." This program is focused on improving our compliance with MCAS measures and IHA's.
- Member Engagement & Rewards Program (MERP) Campaigns #3 and #4 included the following additional measures: Blood Lead Screening, Breast Cancer Screening, and Cervical Cancer Screening.
- Population Needs Assessment (PNA) Action Plan Update
- Preliminary MCAS Compliance Rates reviewed for MY2021- 0 measures meeting Minimum Performance Level (MPL), however 2 measures are 5% or less from MPL. Final rates will be submitted June 1st.
- Update on the SWOT Analysis and Action Plan focused on the children's health domain
- Update on KHS' COVID-19 vaccination initiatives, including member outreach, community partnerships, pop-up clinics, and media campaigns

VII. Policy Updates: There were no policy updates for the month of December 2021.

Utilization Management Executive Summary

At the close of 2021 Kern Health Systems is managing just over 310,000 lives. The Utilization Management (UM) department has been affected by this influx of new members and unfortunately, we have not been able to grow our staff as quickly as our membership. Just as the nation has struggled with the endemic of COVID-19 the departments operations have been performed in the remote setting since 2020 and no definite return to office date has been set.

Utilization Management reporting structure was changed late in the 4th quarter. Dr. Soham Shah Deputy Chief Medical Officer is overseeing of clinical operations and Deb Murr, Chief Health Service Officer purview is administrative oversight.

During the Q3 UM/QI Committee meeting, we acknowledged the Department Health Care Services (DHCS) audit potential finding: UM initiated a pilot that lacked sufficient oversight. The pilot was stopped immediately to address the state's concerns. Due to the cessation of the pilot, there was a marked decline in our Q4 turnaround time (TAT) compliance. The turnaround time compliance rate dropped to 67.4%. However, the TAT rate for calendar year 2021 was 85.1% falling short of the 90% goal.

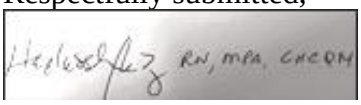
The anticipation of DHCS request for corrective action plan to remediate all findings. UM has been working collaboratively with KHS Health Service and Compliance departments to ensure our policies and practices are compliant with both state and federal regulatory agencies.

Projects:

- Q4 ongoing department efforts to support Cal Aim-Multiyear new benefits implementation caused a great strain on the UM/HS analytical team. We have also repurposed two staff members that began training in December in preparation of the 1/1/2022 go live date for the listed programs:
    - Major Organ Transplants
    - Enhanced Care Management
    - Community Support Services (formerly In Lieu of Service)
- Process Improvement projects are going to transfer into Q1 to align with the UM and KHS 2022 goals.

The following pages reflect statistical measurements reporting for Utilization Management through 4th quarter 2021.

Respectfully submitted,



Hadassah Perez, RN, MPA, BSN, CHCQM-CM
Director of Utilization Management
Kern Health System

Utilization Management Reporting

Timeliness of Decision Trending

Summary:

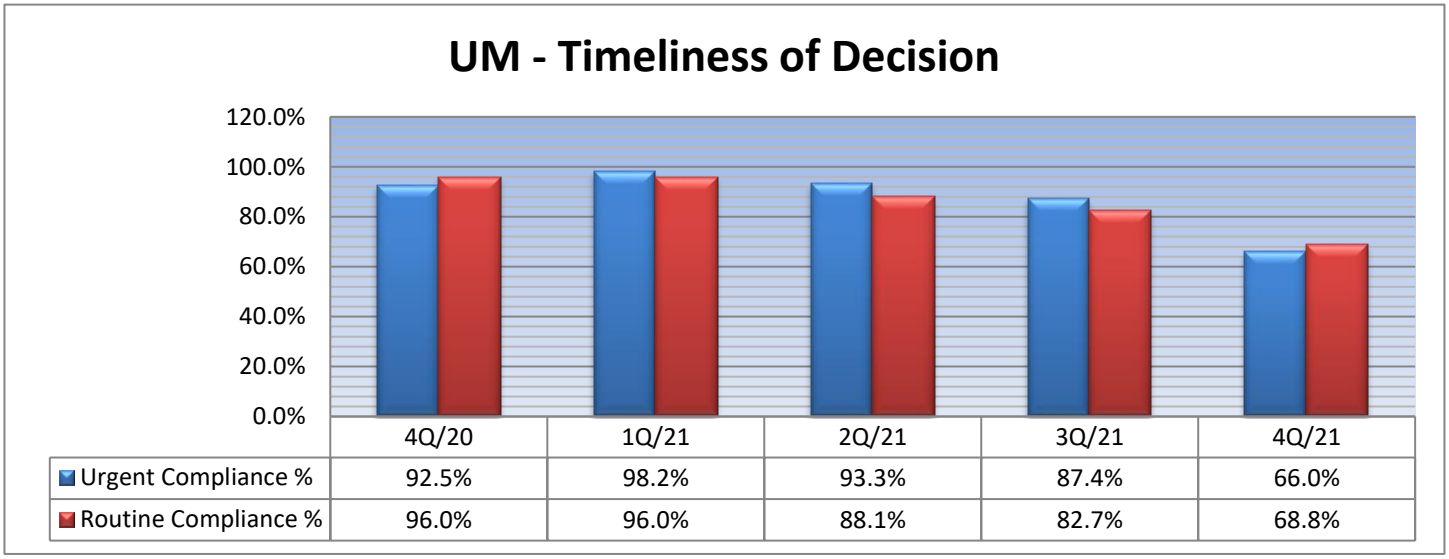
Quarterly audits are conducted to ensure compliance with DMHC requirements, KHS Contractual Agreement with the Department of Health Services, and KHS Policy and Procedures. Referrals are submitted and have specific turn-around-times set for each type of referral.

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

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

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

There were 53,981 referrals processed in the 4th quarter 2021 of which 5,029 referrals were reviewed for timeliness of decision. In comparison to the 3rd quarter's processing time, routine referrals decreased from the 3rd quarter which was 87.4% and urgent referrals decreased from the 3rd quarter which was 82.7% to 66.0%.

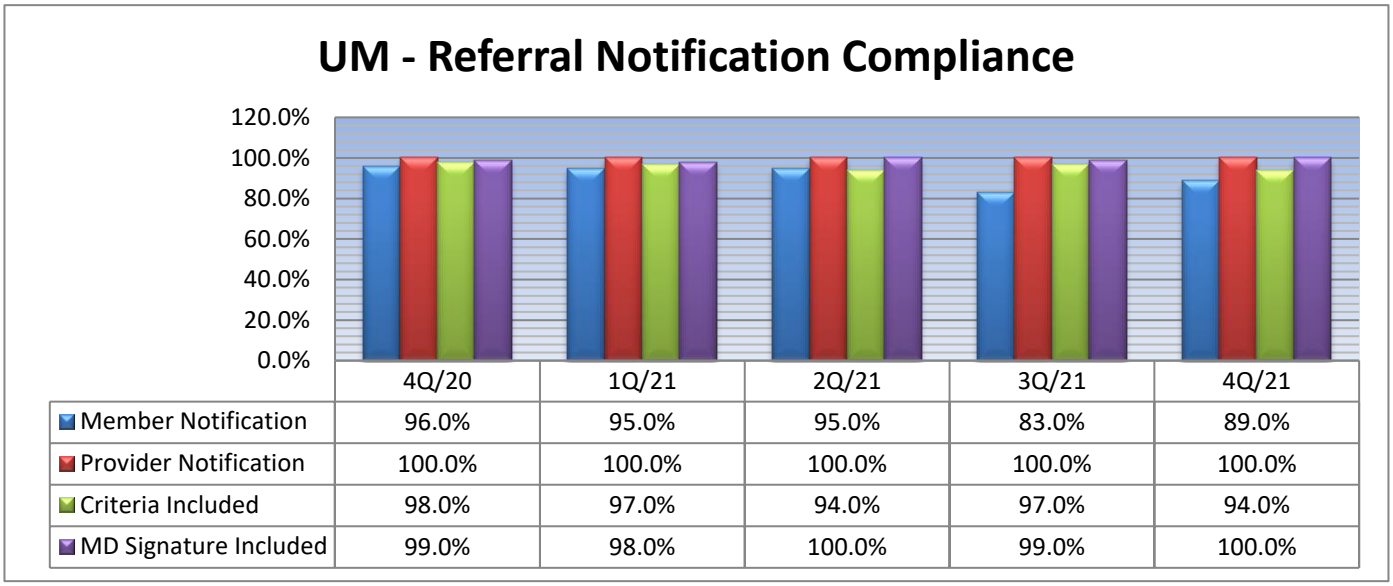


	4Q/20	1Q/21	2Q/21	3Q/21	4Q/21
Urgent Compliance %	92.5%	98.2%	93.3%	87.4%	66.0%
Routine Compliance %	96.0%	96.0%	88.1%	82.7%	68.8%

Audit Criteria:

- Member Nofication: Letter of referral decision sent to member within 24 hours
- Provider Notification: Referral is faxed back to the provider with 24 hours of decision

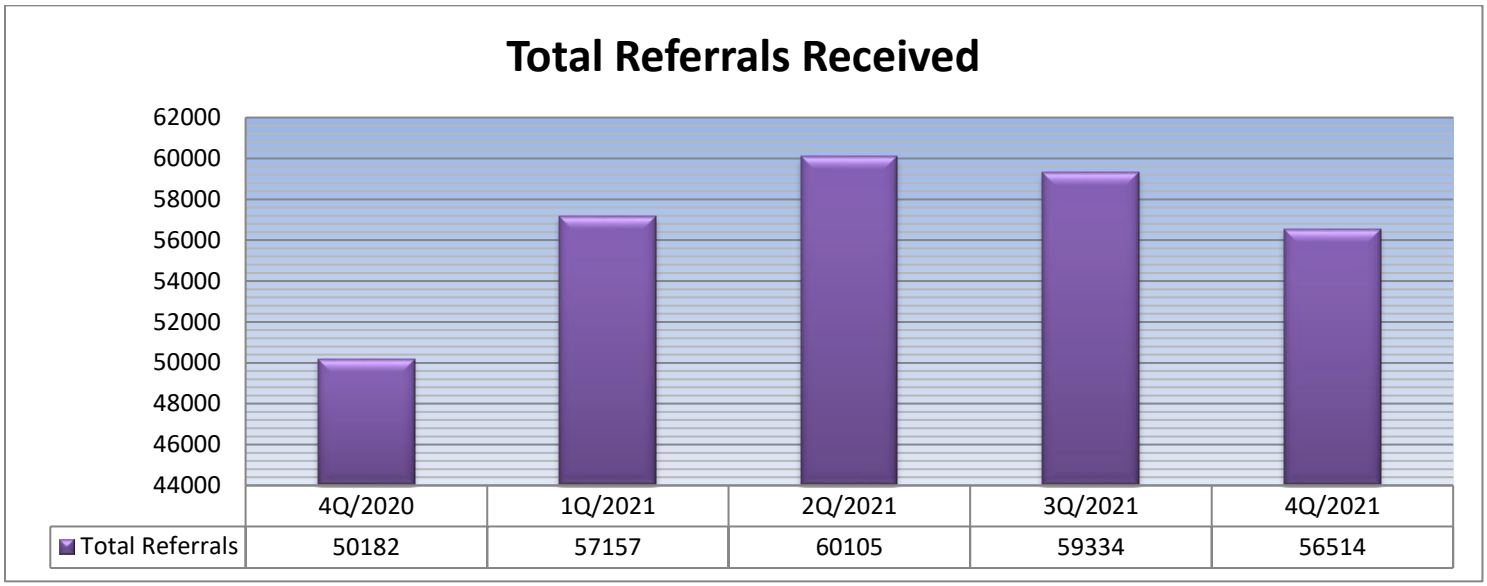
- Criteria Included: Criteria provided to provider on denial reason
- MD Signature: MD Signature included all referrals/NOA letters upon denial

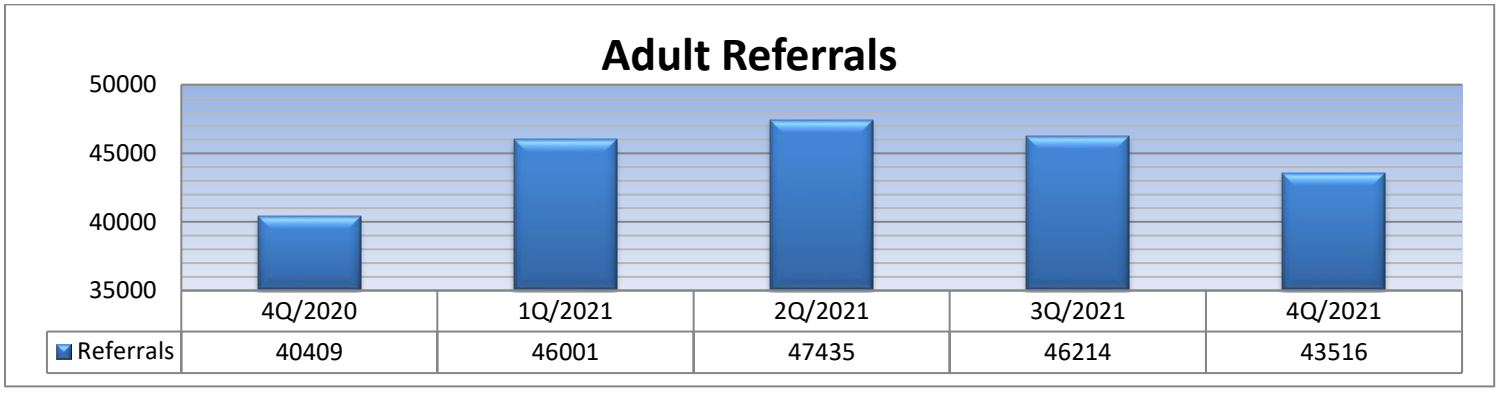


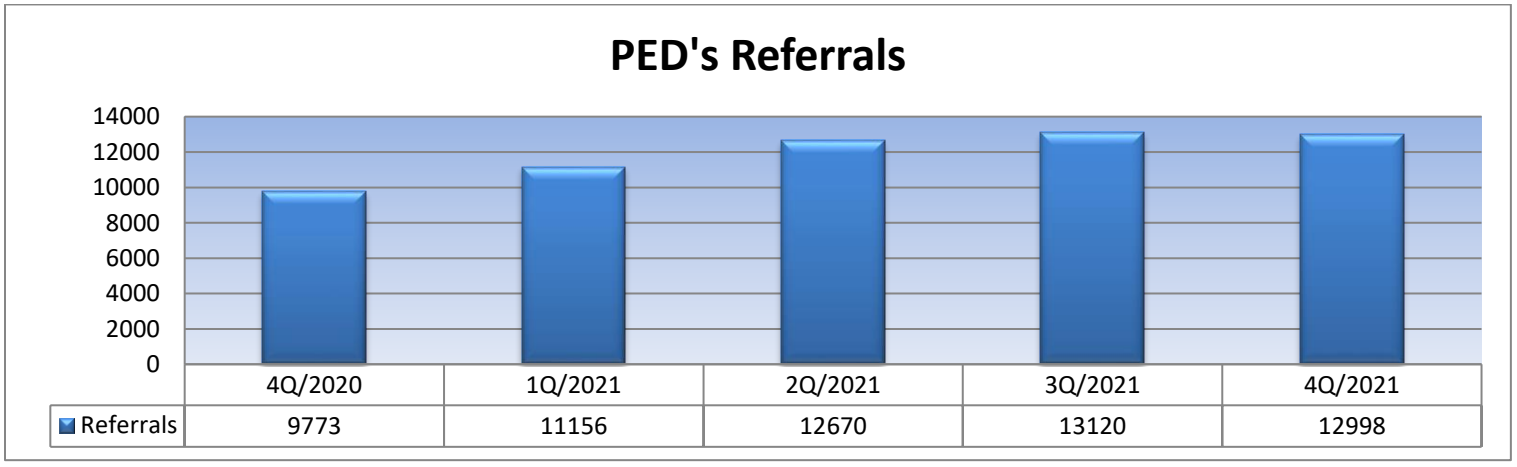
	4Q/20	1Q/21	2Q/21	3Q/21	4Q/21
Member Notification	96.0%	95.0%	95.0%	83.0%	89.0%
Provider Notification	100.0%	100.0%	100.0%	100.0%	100.0%
Criteria Included	98.0%	97.0%	94.0%	97.0%	94.0%
MD Signature Included	99.0%	98.0%	100.0%	99.0%	100.0%

Summary: Overall compliance rate from the 4th Qtr. of 2021 is 96% which increased from the 3rd Qtr. which was 95%.

Outpatient Referral Statistics

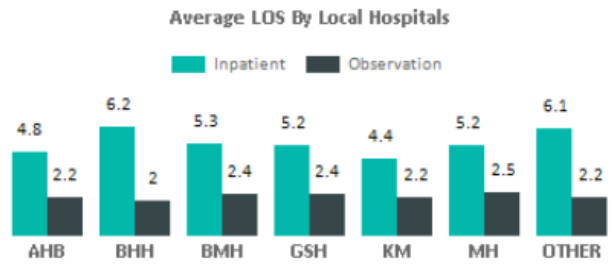


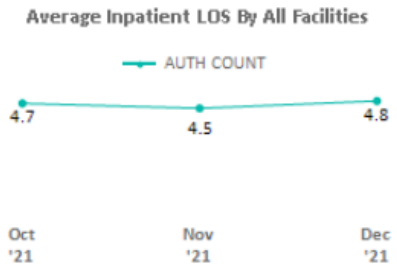




Dates of Discharge Between : 10/1/2021-12/31/2021

Adult Admission(Inpatient/Observation)





Participating Providers

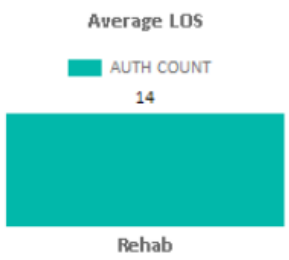
Provider Name	Admit Count	LOS	Avg LOS
ADVENTIST HEALTH BAKERSFIELD	614	2585	4.21
ADVENTIST HEALTH COMMUNITY CAR	41	141	3.44
ADVENTIST HEALTH DELANO	90	266	2.96
ADVENTIST HEALTH MEDICAL CENTE	9	33	3.67
ANTELOPE VALLEY HOSPITAL	3	73	24.33
BAKERSFIELD HEART HOSPITAL	120	704	5.87
BAKERSFIELD MEMORIAL HOSPITAL	706	3322	4.71
ENCOMPASS HEALTH REHABILITATIO	2	25	12.50
GOOD SAMARITAN HOSPITAL	92	432	4.70
HOLLYWOOD PRESBYTERIAN MEDICAL	1	2	2.00
KECK HOSPITAL OF USC	83	420	5.06
KERN COUNTY MEDICAL AUTHORITY	815	3448	4.23
KERN VALLEY HEALTHCARE DIST RH	1	5	5.00
KERN VALLEY HEALTHCARE DISTRIC	7	25	3.57
MERCY HOSPITAL	609	2679	4.40
RIDGECREST REGIONAL HOSPITAL	7	44	6.29
SANTA MONICA UCLA MC AND ORTHO	10	31	3.10
UCLA MEDICAL CENTER	17	78	4.59
USC NORRIS CANCER HOSP	12	113	9.42
VALLEY CHILDREN'S HOSPITAL	1	4	4.00
VENTURA COUNTY MEDICAL CENTER	1	6	6.00
Total	**3241**	**14436**	**4.45**

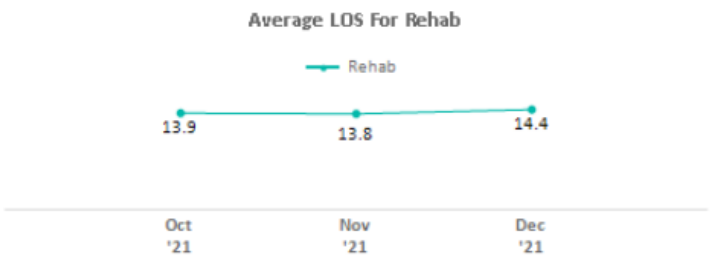
Non Participating Providers

Provider Name	Admit Count	LOS	Avg LOS
ANTELOPE VALLEY HOSPITAL	33	263	7.97
HENRY MAYO NEWHALL	12	66	5.50
LANCASTER HOSPITAL CORPORATION	9	87	9.67
LOMA LINDA UNIVERSITY MEDICAL	8	63	7.88
FRESNO COMMUNITY HOSPITAL AND	6	61	10.17
BEVERLY HOSPITAL	5	14	2.80
LOS ROBLES HOSPITAL AND MC	4	53	13.25
MEMORIAL MEDICAL CENTER	4	44	11.00
SUNRISE HOSPITAL AND MEDICAL	4	24	6.00
UNIVERSITY OF CALIFORNIA DAVIS	3	47	15.67
BARLOW RESPIRATORY	3	70	23.33
SANTA BARBARA COTTAGE HOSPITAL	3	8	2.67
Total	**174**	**1419**	**8.16**

Dates of Discharge Between : 10/1/2021-12/31/2021

Adult Admissions (Rehab)





Participating Providers

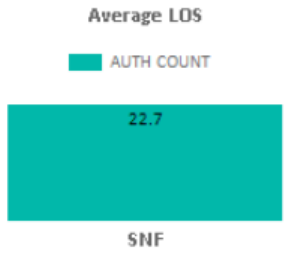
Provider Name	Admit Count	LOS	Avg LOS
ENCOMPASS HEALTH REHABILITATIO	53	749	14.13
Total	**53**	**749**	**14.13**

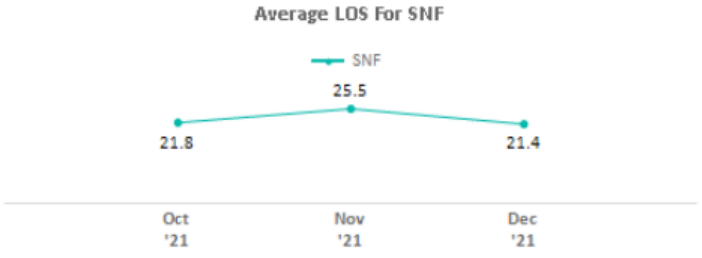
Non Participating Providers

Provider Name	Admit Count	LOS	Avg LOS
CALIFORNIA REHABILITATION INST	1	9	9.00
Total	**1**	**9**	**9.00**

Dates of Discharge Between : 10/1/2021-12/31/2021

Adult Admissions (SNF)



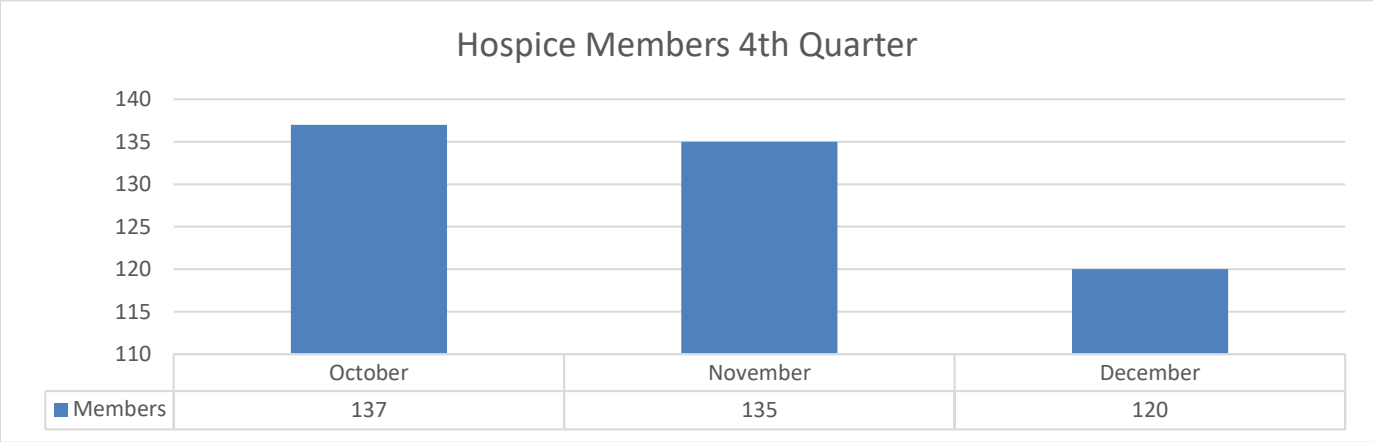


Participating Providers

Provider Name	Admit Count	LOS	Avg LOS
CAPRI IN THE DESERT	7	226	32.29
DELANO POSTACUTE CARE	13	314	24.15
GGNSC SHAFTER LP	1	10	10.00
KINGSTON HEALTHCARE CENTER	6	206	34.33
MAGNIFIQUE CONGREGATE LIVING I	13	317	24.38
NAPOLI IN THE DESERT	10	219	21.90
PARKSIDE CONGREGATE LIVING, IN	16	270	16.88
ROSE DESERT CONGREGATE	5	139	27.80
SAN MARINO IN THE DESERT	5	137	27.40
SORRENTO IN THE DESERT	8	98	12.25
UNITED CARE FACILITIES	73	1304	17.86
VFP HOMES	7	219	31.29
Total	**164**	**3459**	**21.09**

Non Participating Providers

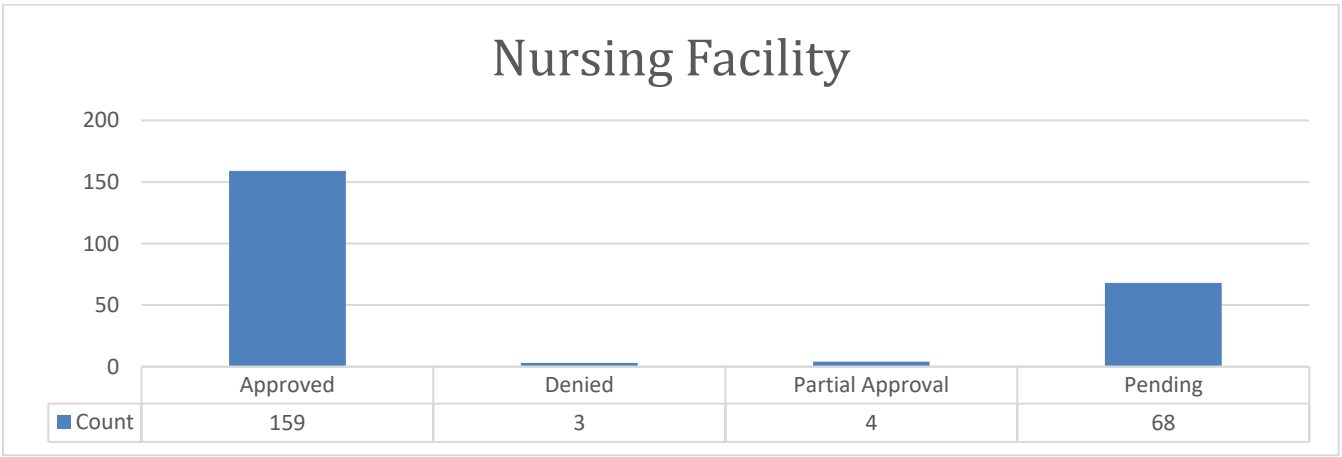
Provider Name	Admit Count	LOS	Avg LOS
PACIFICA HOSPITAL OF THE VALLE	11	245	22.27
SHAFTER NURSING REHAB LLC	6	146	24.33
LINK TO CARE CONGREGATE HOME	5	195	39.00
DP CARE, INC.	2	37	18.50
WINDSOR ARVIN HEALTHCARE, LLC	1	59	59.00
WINDSOR BAKERSFIELD HEALTHCARE	1	63	63.00
GATEWAY HOMES TO INDEPENDENCE	1	69	69.00
HOME OF COMPASSION #2 INC.	1	45	45.00
ROYAL COMFORT CARE, LLC	1	53	53.00
CENTRAL VALLEY SPECIALTY HOSPI	1	36	36.00
Total	**30**	**948**	**31.60**

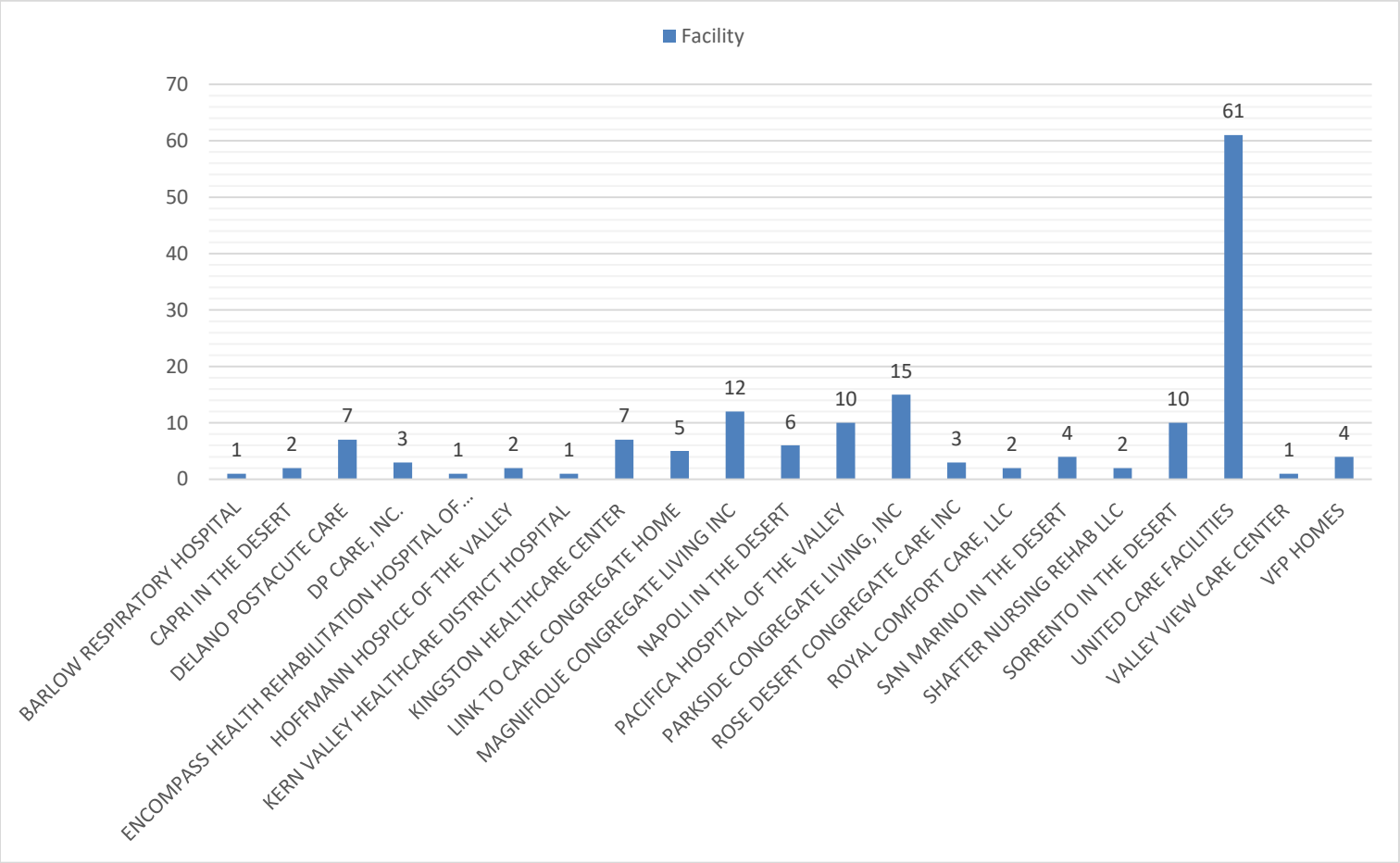


Nursing Facility Services Report

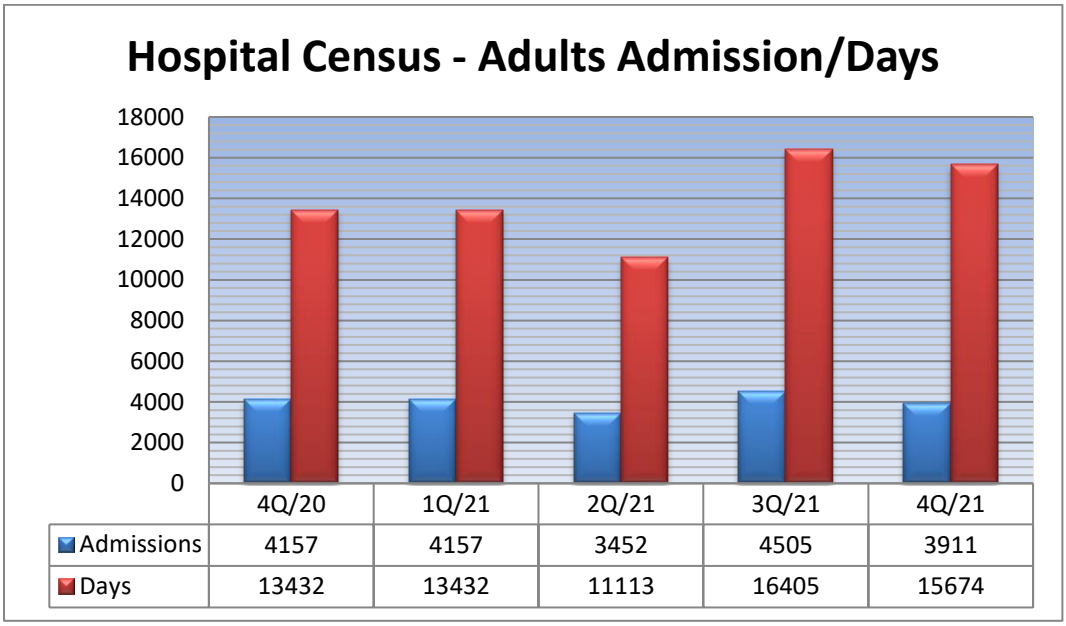
Purpose: Kern Health Systems covers medically necessary Nursing Facility Services for eligible members. KHS members requiring Nursing Facility Services are identified and placed in health care facilities, which provide the level of care most appropriate to the member's medical needs. For members requiring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

Summary: Summary: During the 4th quarter 2021, there were 238 referrals for Nursing Facility Services. The average length of stay was 20.7 days for these members. During the 3rd quarter there was only 2 denials of the 232 referrals.

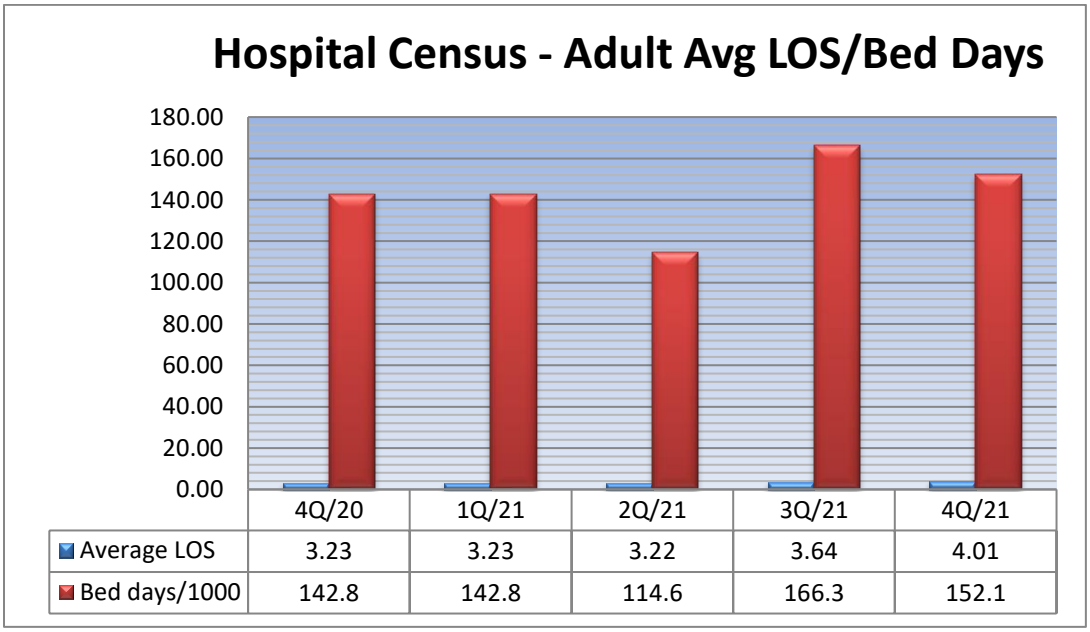



Facility
70
60
50
40
30
20
10
0
1
2
7
3
1
2
1
7
5
12
6
10
15
3
2
4
2
10
61
1
4
BARLOW RESPIRATORY HOSPITAL
CAPRI IN THE DESERT
DELANO POSTACUTE CARE
DP CARE, INC.
ENCOMPASS HEALTH REHABILITATION HOSPITAL OF...
HOFFMANN HOSPICE OF THE VALLEY
KERN VALLEY HEALTHCARE DISTRICT HOSPITAL
KINGSTON HEALTHCARE CENTER
LINK TO CARE CONGREGATE HOME
MAGNIFIQUE CONGREGATE LIVING INC
NAPOLI IN THE DESERT
PACIFICA HOSPITAL OF THE VALLEY
PARKSIDE CONGREGATE LIVING, INC
ROSE DESERT CONGREGATE CARE INC
ROYAL COMFORT CARE, LLC
SAN MARINO IN THE DESERT
SHAFTER NURSING REHAB LLC
SORRENTO IN THE DESERT
UNITED CARE FACILITIES
VALLEY VIEW CARE CENTER
VFP HOMES

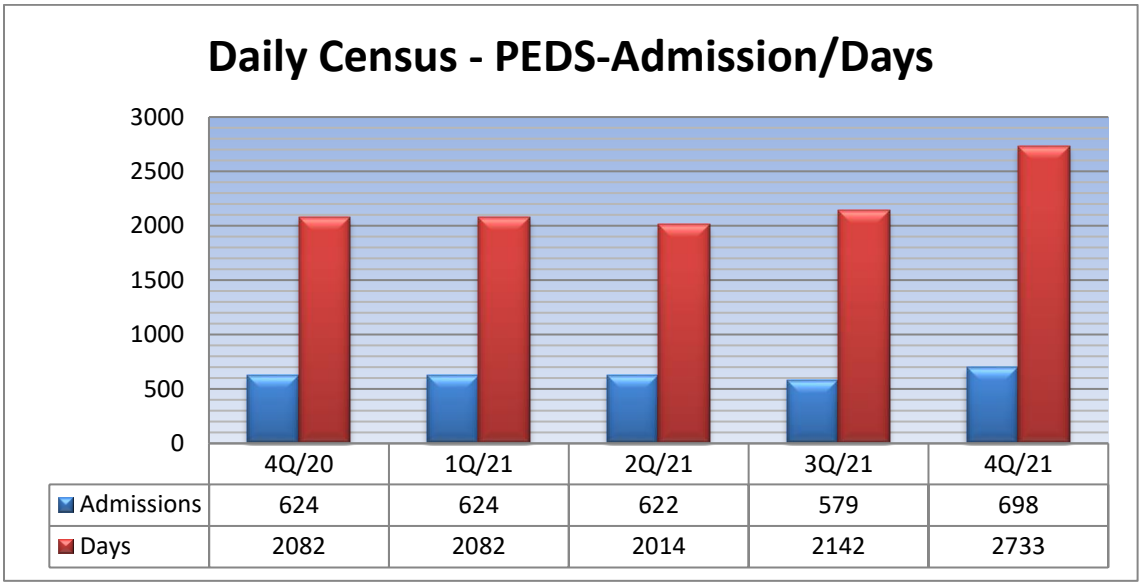
Inpatient 4th Quarter Trending



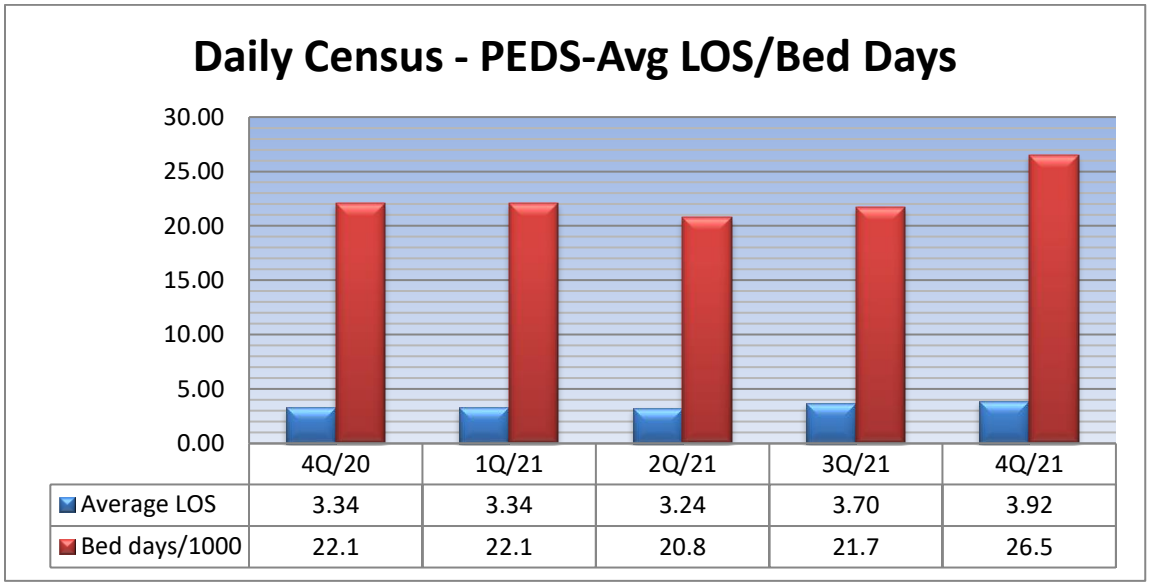
	4Q/20	1Q/21	2Q/21	3Q/21	4Q/21
Admissions	4157	4157	3452	4505	3911
Days	13432	13432	11113	16405	15674



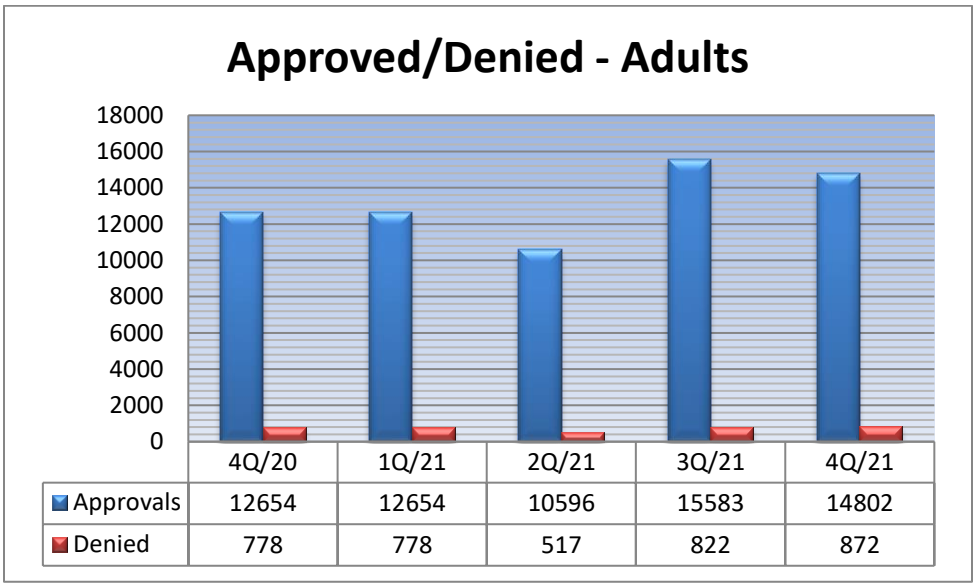
	4Q/20	1Q/21	2Q/21	3Q/21	4Q/21
Average LOS	3.23	3.23	3.22	3.64	4.01
Bed days/1000	142.8	142.8	114.6	166.3	152.1



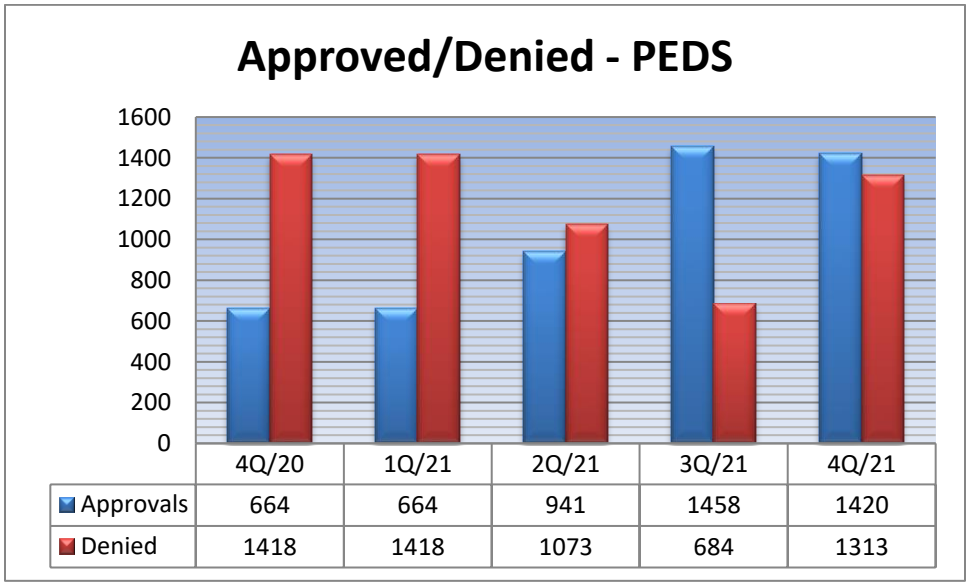
	4Q/20	1Q/21	2Q/21	3Q/21	4Q/21
Admissions	624	624	622	579	698
Days	2082	2082	2014	2142	2733



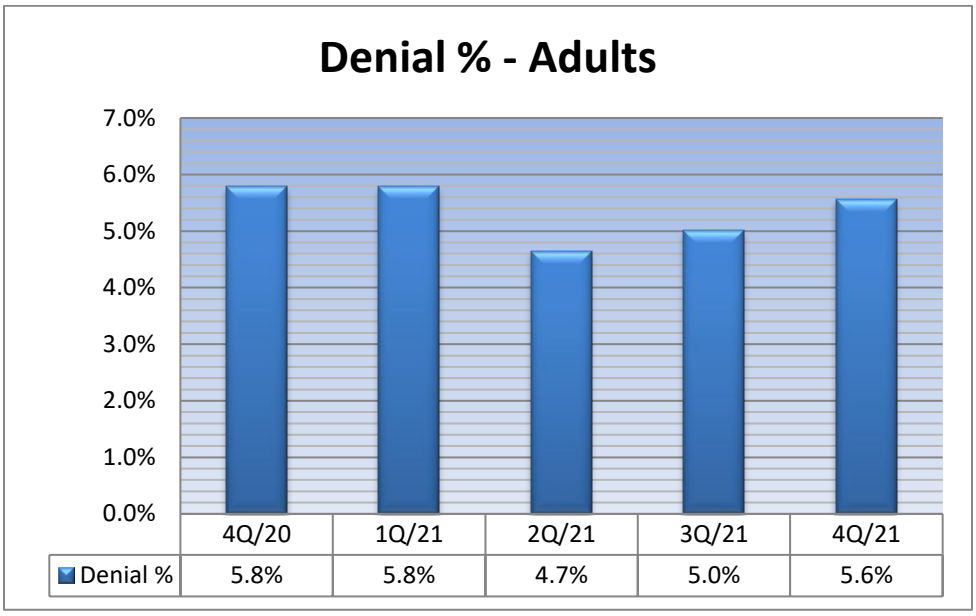
	4Q/20	1Q/21	2Q/21	3Q/21	4Q/21
Average LOS	3.34	3.34	3.24	3.70	3.92
Bed days/1000	22.1	22.1	20.8	21.7	26.5

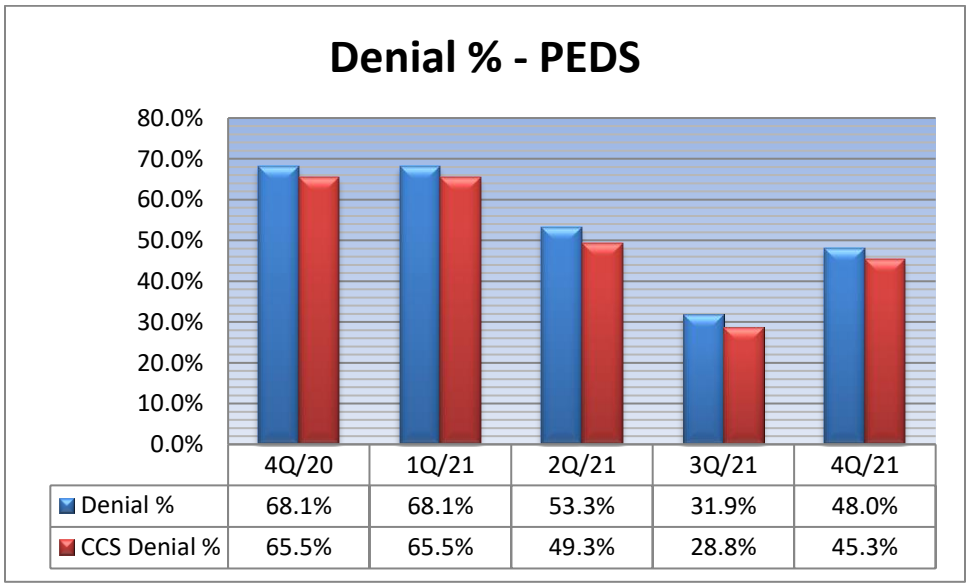


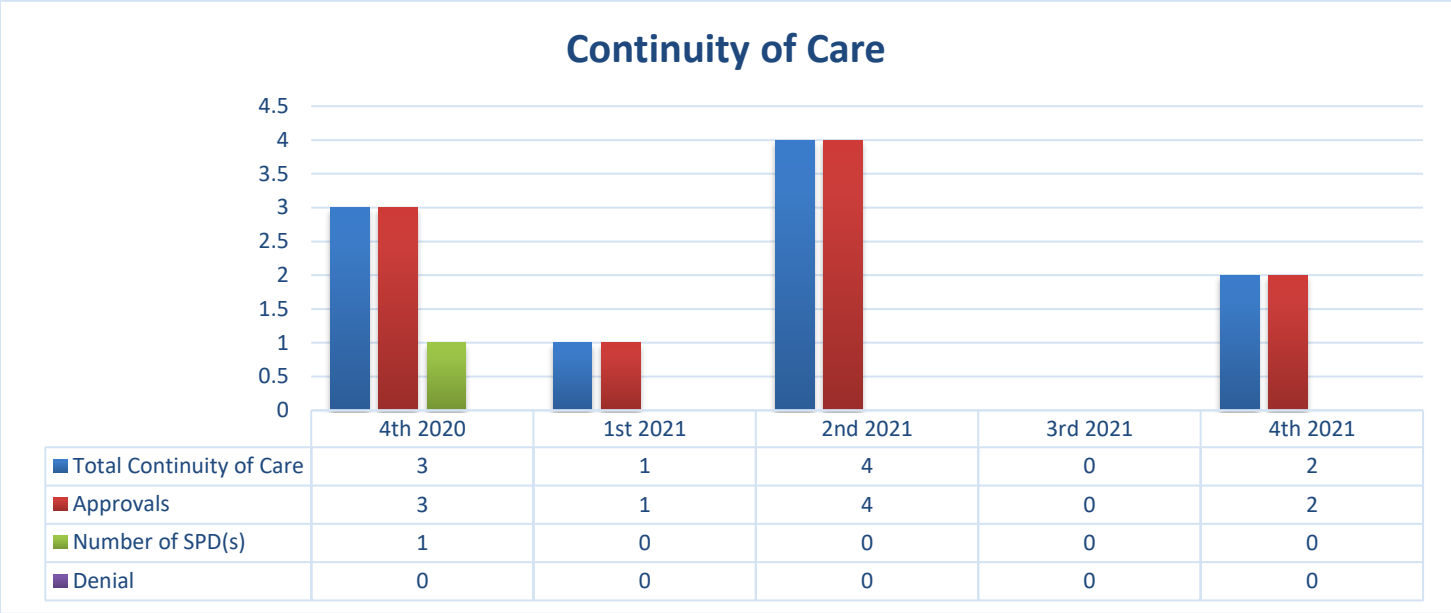
	4Q/20	1Q/21	2Q/21	3Q/21	4Q/21
Approvals	12654	12654	10596	15583	14802
Denied	778	778	517	822	872



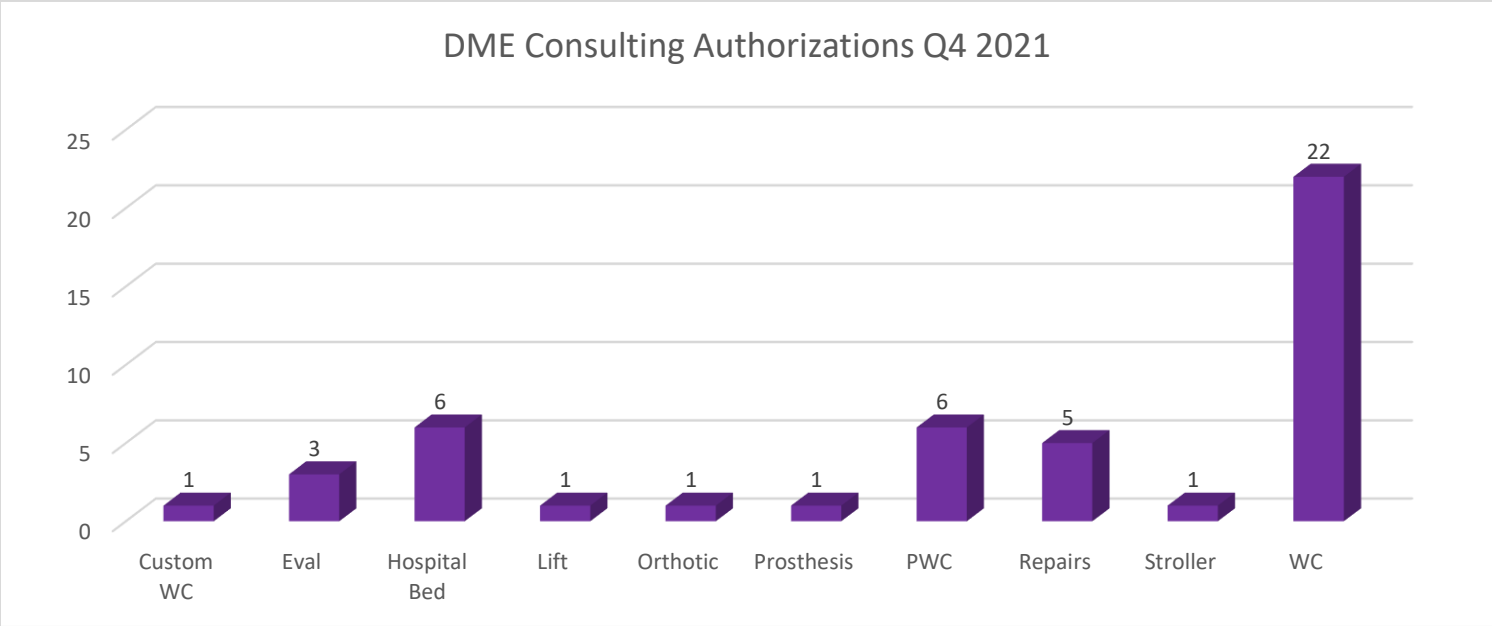
	4Q/20	1Q/21	2Q/21	3Q/21	4Q/21
Approvals	664	664	941	1458	1420
Denied	1418	1418	1073	684	1313

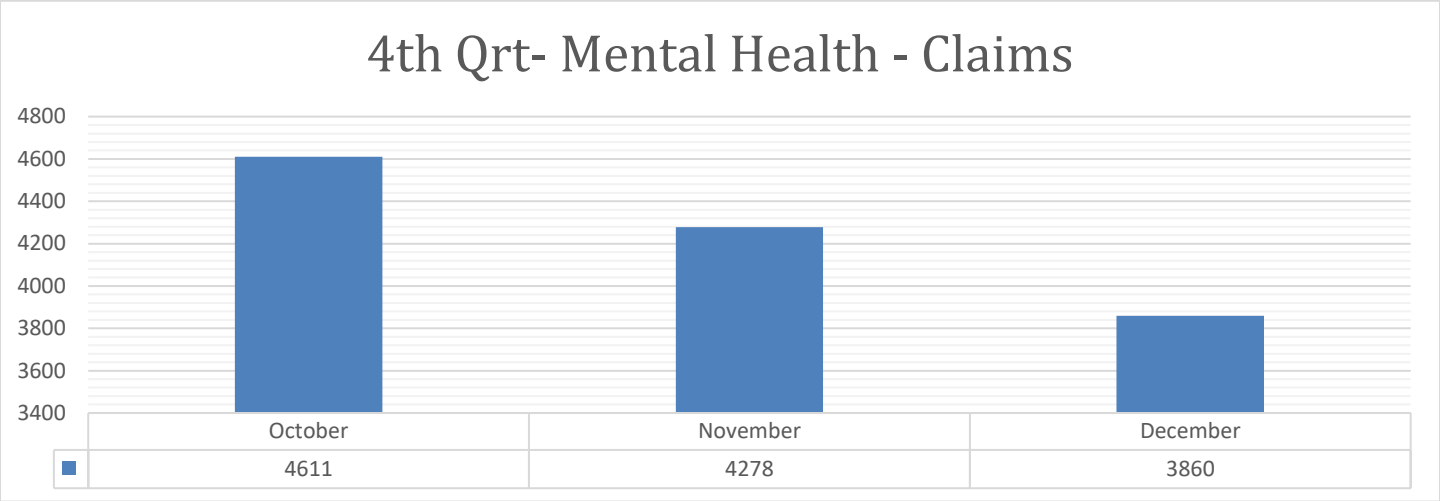

Denial % - Adults
7.0%
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
4Q/20
1Q/21
2Q/21
3Q/21
4Q/21
Denial %
5.8%
5.8%
4.7%
5.0%
5.6%


Denial % - PEDS
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
4Q/20
1Q/21
2Q/21
3Q/21
4Q/21
Denial %
68.1%
68.1%
53.3%
31.9%
48.0%
CCS Denial %
65.5%
65.5%
49.3%
28.8%
45.3%



	4th 2020	1st 2021	2nd 2021	3rd 2021	4th 2021
Total Continuity of Care	3	1	4	0	2
Approvals	3	1	4	0	2
Number of SPD(s)	1	0	0	0	0
Denial	0	0	0	0	0





ABA Services

UNIQUE CASES		Mild	Moderate	Severe	Pending Dx	Total
MEMBER COUNT		42	68	11	169	290
Severity %		14.48%	23.45%	3.79%	58%	100%
SEVERITY	Oct	Nov	Dec	Total		
MILD	17	14	0	31		
MODERATE	20	23	1	44		
SEVERE	2	3	0	5		
Approved FBA	62	69	92	223		
Approved Treatment	54	61	101	216		
PENDING DX	15	21	100	136		
	Oct	Nov	Dec	Total		
AGE 7 OR LESS	37	43	67	147		
AGE 8 OR GREATER	17	18	34	69		
TOTAL	54	61	101	216		
% < 7	68.52%	70.49%	66.34%	68.06%		
% > 8	31.48%	29.51%	33.66%	31.94%		

UM Internal Auditing Results

Kern Health Systems
Utilization Management Department
Denied Referral Audit
By
Kulwant Kaur, UM Clinical Auditor & Trainer, RN

Report Date: January 29, 2022

Audit Period: October 1, 2021 to December 30, 2021

Sample Size: 10%

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

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

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

Month	October	November	December
Total Referrals Processed	18,915	17,748	17,318
Total Referrals Denied	1,233	1,067	595
Percent of Denials	7%	6%	3%
Percent of Audit	10%	10%	10%
Number of Referrals in Audit **(Not Included: Search and Serve, or Mental Health Referrals)**	105	89	47

Indicators:

1. Referral Turn-around Time
    a. Decision completed within 3 business days for Urgent referrals and 5 business days for routine referrals,
    b. Provider and member notification within 24 hours of decision - Stamp dates on Referral and NOA letter, closed out within compliance.
2. Notice of Action Letter
    a. Spelling/Grammar, Verbiage, and Format
    b. Criteria indicated and attached
    c. Recommendations indicated
3. Medical Director / Case Manager Name and Signatures
4. Processing of Referral

October Findings: Out of the **105** Denied referrals reviewed, the following is a breakdown of the findings.

- Fifteen (15) referrals were found **without** errors from the above indicator
- Seventy-five (75) errors were found within the Referral Turn-around Time indicator
- Fifteen (15) errors were found within the Notice of Action Letter indicator
- Three (3) error were found within the Processing of the Referrals
- One (1) error was found within the Medical Director / Case Manager Name and Signatures

November Findings: Out **89** of the Denied referrals reviewed, the following is a breakdown of the findings.

- Three (3) referrals were found **without** errors from the above indicator
- Eighty-six (86) errors were found within the Referral Turn-around Time indicator
- Two (2) errors were found within the Notice of Action Letter indicator
- Two (2) errors were found within the Processing of the Referrals

December Findings: Out of **47** the Denied referrals reviewed, the following is a breakdown of the findings.

- Twenty (20) referrals were found **without** errors from the above indicator
- Twenty-seven (27) errors were found within the Referral Turn-around Time indicator
- Five (5) errors were found within the Notice of Action Letter indicator
- Three (3) errors were found within the Processing of the Referrals

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

Kern Health Systems
Utilization Management Department
Modified Referral Audit
By
Kulwant Kaur, UM Clinical Trainer and Auditor, RN

Report Date: January 28, 2022

Audit Period: October 1, 2021 to December 31, 2021

Sample Size: 10% or 10 per month (whichever is greater)

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

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

The referrals that qualify for a modification are:

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

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

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

Month	October	November	December
Total Referrals Processed	18,915	17,748	17,318
Total Referrals Modified	338	247	149
Percent of Modifies	2%	2%	1%
Percent of Audit **(10 percent or 10 referrals whichever is larger)**	10%	10%	10%
Number of Referrals in Audit	33	25	15

Indicators:

5. Referral Turn-around Time
    a. Decision completed within 3 business days for Urgent referrals and 5 business days for routine referrals
    b. Provider and member notification within 24 hours of decision - Stamp dates on Referral and NOA letter, closed out within compliance.
6. Notice of Action Letter
    a. Spelling/Grammar, Verbiage, and Format
    b. Approved provider information (name/phone)
7. Medical Director / Case Manager Name and Signatures
8. Processing of Referral

October Findings: Out of the **33** Modified referrals reviewed, the following is a breakdown of the findings.

- Four (4) referrals were found **without** errors from the above indicator
- Twenty-four (24) errors were found within the Referral Turn-around Time indicator
- Three (3) error was found within the Processing of Referral
- Zero (0) error was found within the Notice of Action Letter

November Findings: Out of **25** the Modified referrals reviewed, the following is a breakdown of the findings.

- Two (2) referrals were found **without** errors from the above indicator
- Twenty-three (23) errors were found within the Referral Turn-around Time indicator
- One (1) errors were found within the Processing of Referral indicator
- Zero (0) error was found within the Notice of Action Letter

December Findings: Out of the **15** Modified referrals reviewed, the following is a breakdown of the findings.

- Six (6) referrals were found **without** errors from the above indicators
- Four (4) errors were found within the Referral Turn-around Time indicator
- Zero (0) errors were found within the Processing of Referral indicator

- Zero (0)error was found within the Notice of Action Letter indicator

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

Kern Health Systems
Utilization Management Department
Delayed Referral Audit

Kulwant Kaur, UM Clinical Trainer & Auditor, RN

Report Date: January 29, 2022

Audit Period: October 1, 2021 to December 31, 2021

Sample Size: 10% or 10 per month (whichever is greater)

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

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

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

Month	October	November	December
Total Referrals Processed	18,915	17,748	17,318
Total Referrals Delayed	57	5	9
Percent of Delays	<1%	<1%	<1%
Percent of Audit **(10 percent or 10 referrals whichever is larger)**	10 referral	5 referral	9 referral
Number of Referrals in Audit	10	5	9

1

Indicators:

9. Referral Turn-around Time
    a. Delays being done on day 5 of original referral – Final decision no later than 14 days for delays and 28 days for extend delays.

   b. Provider and member notification within 24 hours of decision - Stamp dates on Referral and NOA letter, closed out within compliance.
10. Notice of Action Letter
   a. Spelling/Grammar, Verbiage, and Format
   b. Reason for delay clear and concise
   c. Expected due date listed
11. Medical Director / Case Manager Name and Signatures
12. Processing of Referral.

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

- Four (4) referral was found **without** errors from the above indicator
- Two (2) errors were found within the Processing of Referral.
- Five (5) error was found within the Referral Turn-around Time indicator
- One (1) errors were found within the Notice of Action Letter

November Findings: Out of the **5** delayed referrals reviewed, the following is a breakdown of the findings.

- Three (3) referrals were found **without** errors from the above indicator
- One (1) errors were found within the Processing of Referral.
- One (1) errors were found within the Referral Turn-around Time indicator
- Zero (0) error was found within the Notice of Action Letter

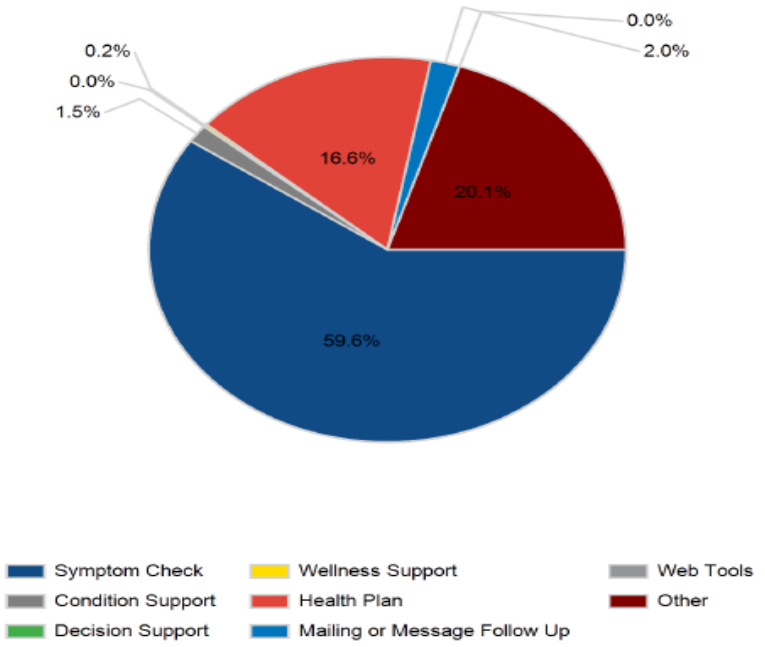
December Findings: Out of the **9** delayed referrals reviewed, the following is a breakdown of the findings.

- Eight (8) referrals were found **without** errors from the above indicator
- Zero (0) errors were found within the Processing of Referral
- One (1) errors were found within the Referral Turn-around Time indicator
- Zero (0) error was found within the Notice of Action Letter

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

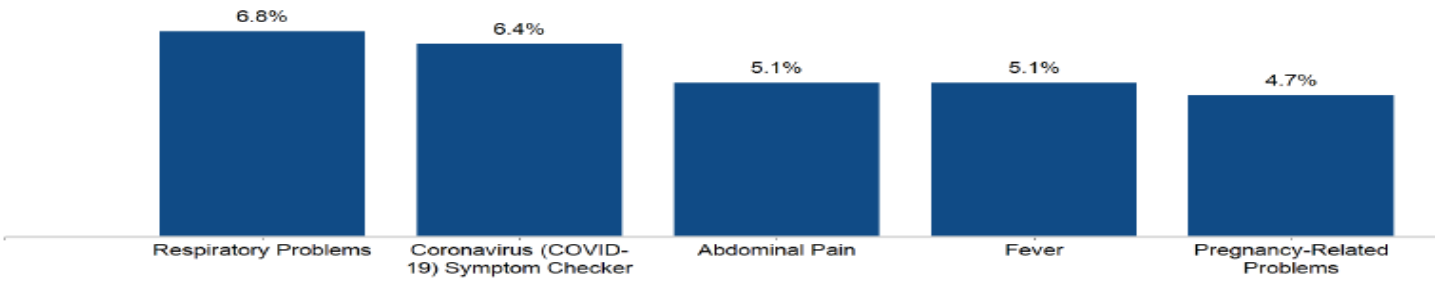
Health Dialog Report

Member Inbound Call Reasons (Oct-2021)

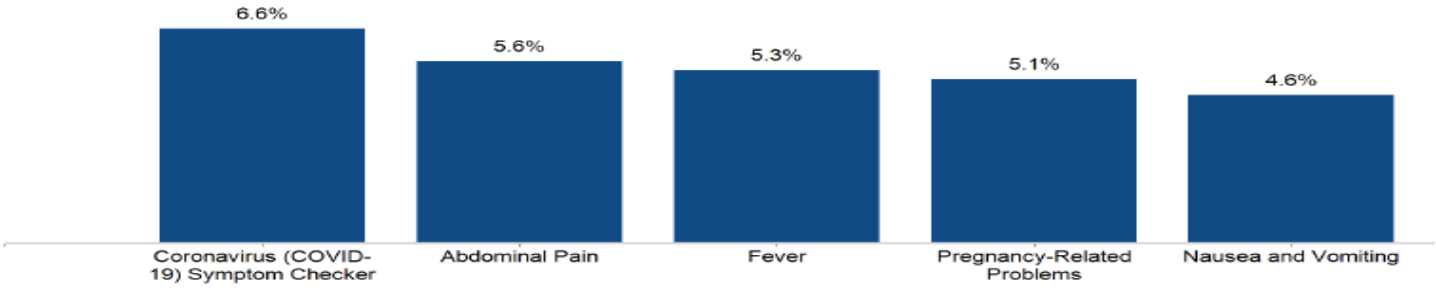


REASON	NUMBER
Symptom Check	240
Condition Support	6
Decision Support	0
Wellness Support	1
Health Plan	67
Mailing or Message Follow Up	8
Web Tools	0
Other	81

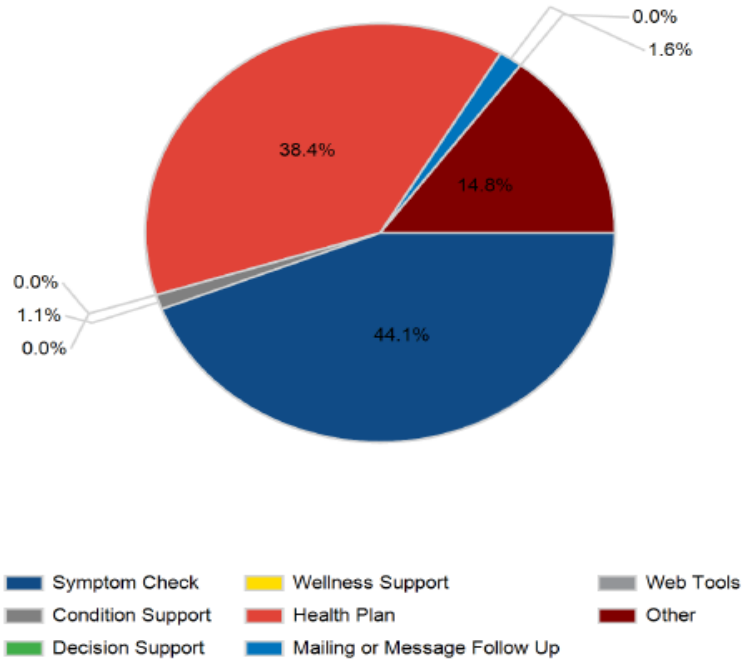
Most Frequent Symptoms - Inbound Symptom Check Calls (Oct-2021)



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

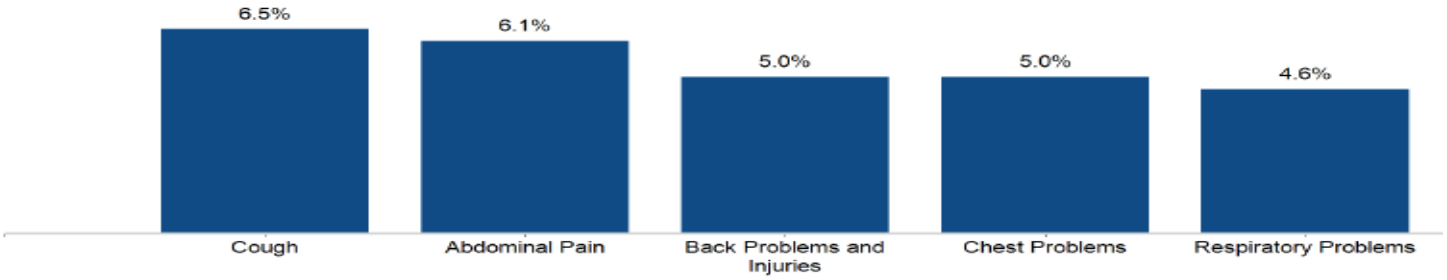


Member Inbound Call Reasons (Nov-2021)

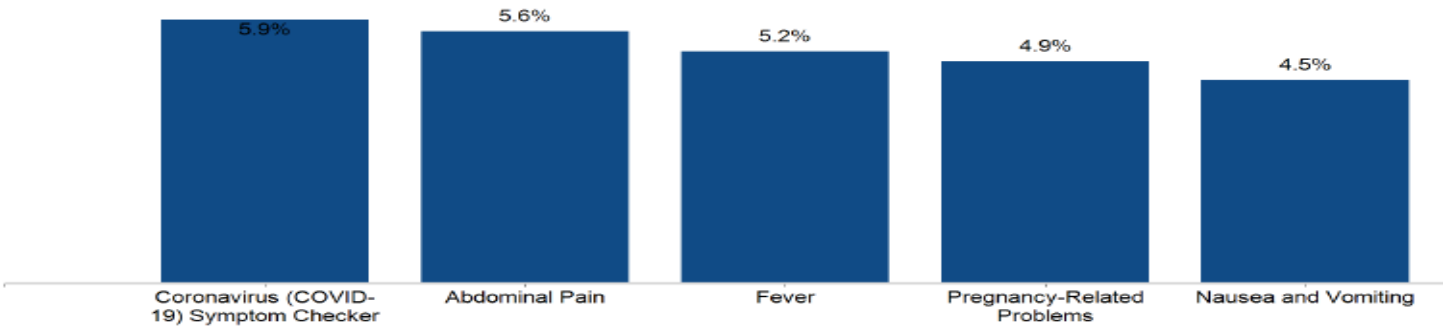


REASON	NUMBER
Symptom Check	271
Condition Support	7
Decision Support	0
Wellness Support	0
Health Plan	236
Mailing or Message Follow Up	10
Web Tools	0
Other	91

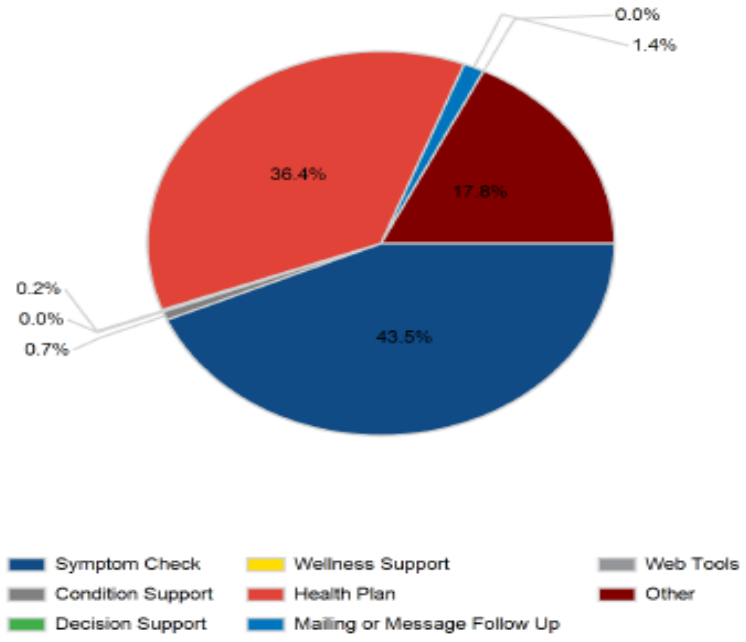
Most Frequent Symptoms - Inbound Symptom Check Calls (Nov-2021)



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

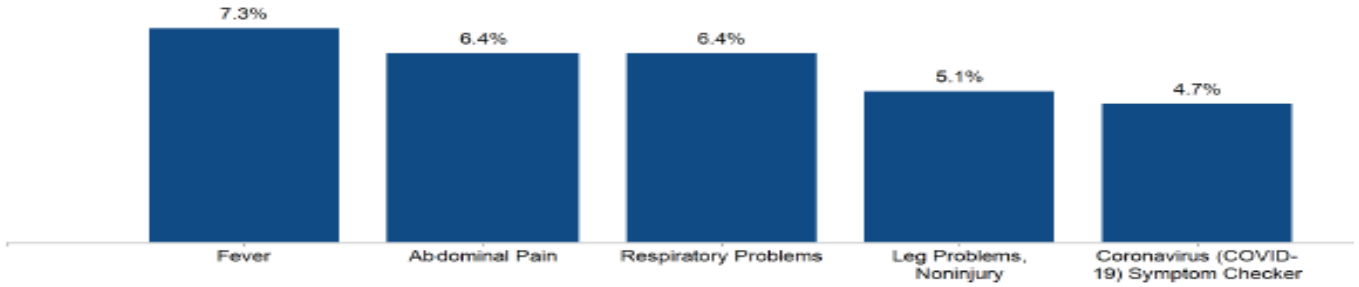


Member Inbound Call Reasons (Dec-2021)

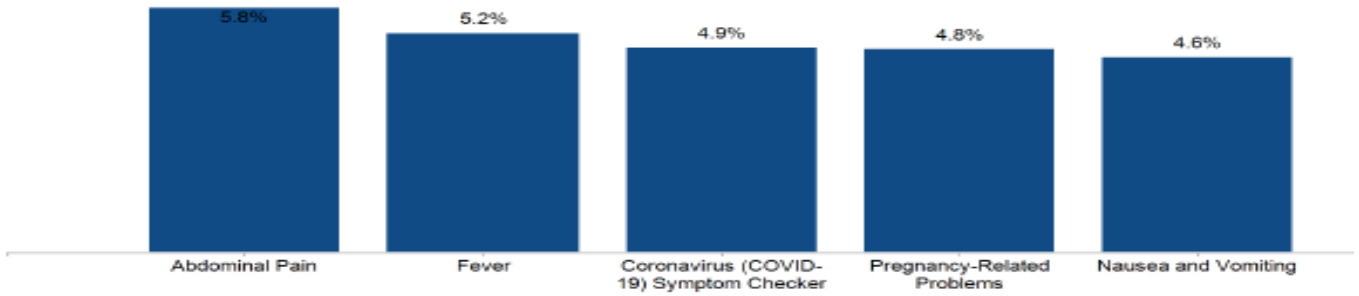


REASON	NUMBER
Symptom Check	240
Condition Support	4
Decision Support	0
Wellness Support	1
Health Plan	201
Mailing or Message Follow Up	8
Web Tools	0
Other	98

Most Frequent Symptoms - Inbound Symptom Check Calls (Dec-2021)



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



Diabetic Exam Reminder Effectiveness Report

Client: - 12049397

Reminder Year:	Reminder Month:	Reminders Sent	Received Exam Within 0-90 Days	Received Exam Within 91-180 Days	Total Exams Within 180 Days
2021	January	518	24	25	49
	February	1,393	63	55	118
	March	326	16	6	22
	April	383	30	13	43
	May	7,147	171	119	290
	June	265	20	6	26
	July	1,533	69	32	101
	August	573	27	10	37
	September	174	11	1	12
	October	3,896	50	0	50
	November	268	6	0	6
	December	881	0	0	0
Totals		**17,357**	**487**	**267**	**754**

LTM Effectiveness* : 4 %

12-Month Effectiveness (Jul 2020 - Jun 2021) : 6 %

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

Medical Data Collection Summary Report

Period Covered: January, 2021 through December, 2021
Prepared for: KERN HEALTH SYSTEMS - (12049397)

Overview

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

Summary of Findings

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

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

Reported Cases

	Members	
Received Eye Exam:	21,995	
Diabetes[1]:	1,147	5.2%
Diabetic Retinopathy:	264	1.2%
Glaucoma:	389	1.8%
Hypertension:	640	2.9%
High Cholesterol	218	1.0%
Macular Degeneration:	67	.3%

Estimated Number of Cases

Total Members:	298,798	
Diabetes[1]:	7,461	2.5%
Diabetic Retinopathy:	663	.2%
Glaucoma:	1,252	.4%
Hypertension:	32,047	10.7%
High Cholesterol	45,762	15.3%
Macular Degeneration:	420	.1%

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

KAISER REPORTS

(PROPRIETARY AND CONFIDENTIAL)

Available upon Request

KERN HEALTH SYSTEMS

To: QI/UM Committee Meeting

From: Nate Scott

Date: February 24, 2022

Re: Executive Summary for 4th Quarter 2021 Operational Board Update - Grievance Report

---

Background

Executive Summary for 4th Quarter 2021 Operational Board Update - Grievance Report: When compared to the previous four quarters, there were no significant trends identified as they relate to the Grievances and Appeals received during the 4th Quarter, 2021.

We cannot predict how many Grievances we will receive on any given day. However, we can assess if a certain event may have led to an increase or decrease in the receipt of grievances. The slight increase in Potential Inappropriate Care grievances from 3rd quarter, 2021, to the 4th quarter, 2021, can be attributed to process modifications implemented after feedback received during our DHCS Member Rights Audit interview, completed in the 3rd Quarter, 2021.

As a reminder, all dissatisfactions as it pertains to Plan benefits or services must be captured as a grievance.

Requested Action

Receive and File

2021 4th Quarter Operational Report

Alan Avery
Chief Operating Officer

4th Quarter 2021 Grievance Report

Total Grievance and Appeals per 1,000 Members = 7.29

Category	4th Quarter 2021	Status	Issue	Q3 2021	Q2 2021	Q1 2021	Q4 2020
Access to Care	131		Appointment Availability	148	90	77	72
Coverage Dispute	0		Authorizations and Pharmacy	0	0	0	0
Medical Necessity	266		Questioning denial of service	329	308	308	317
Other Issues	36		Miscellaneous	18	20	11	14
Potential Inappropriate Care	256		Questioning services provided. All cases forwarded to Quality Dept.	164	183	156	200
Quality of Service	55		Questioning the professionalism, courtesy and attitude of the office staff. All cases forwarded to PR Department	53	31	8	7
Total Formal Grievances	744			712	632	560	610
Exempt**	1431		Exempt Grievances-	1520	1570	1179	1050
Total Grievances (Formal & Exempt)	2175			2232	2202	1739	1660

KERN HEALTH SYSTEMS
kernhealthsystems.com

Additional Insights-Formal Grievance Detail

Issue	4th Quarter Grievances	Upheld Plan Decision	Further Review by Quality	Overturned Ruled for Member	Still Under Review
Access to Care	73	47	0	21	5
Coverage Dispute	0	0	0	0	0
Specialist Access	58	27	0	22	9
Medical Necessity	266	199	0	67	0
Other Issues	36	20	0	8	8
Potential Inappropriate Care	256	144	103	9	0
Quality of Service	55	32	0	12	11
Total	744	469	103	139	33

KERN HEALTH SYSTEMS

To: QI/UM Committee Meeting

From: Nate Scott

Date: February 24, 2022

Re: Executive Summary for 4th Quarter 2021 Grievance Summary Report

---

Background

Executive Summary for the 4th Quarter 2021 Grievance Summary Report:
The Grievance Summary Report supports the high-level information provided on the Operational Report and provides more detail as to the type of grievances KHS receives on behalf of our members. It also provides insight into the grievance and appeals received on behalf of KHS members assigned to Kaiser Permanente.

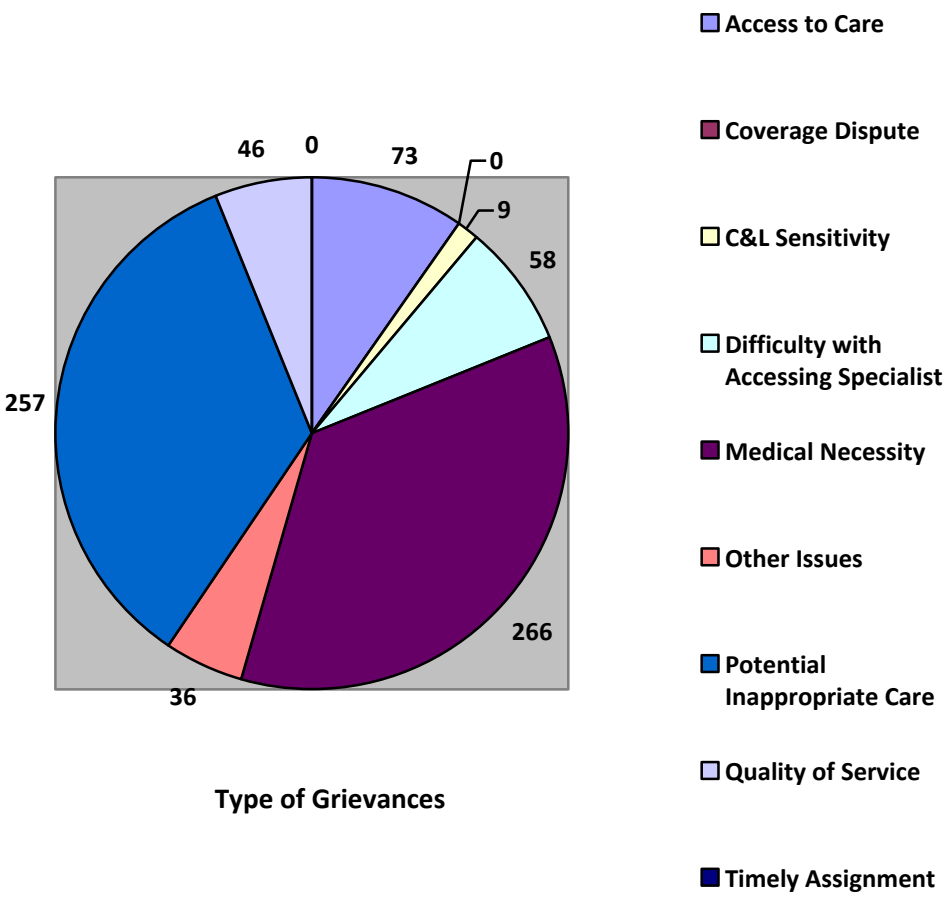
Kaiser Permanente Grievances and Appeals
Due to recent changes to how Medi-Cal Managed Care Plans (MCPs) report their grievance and appeals data, KHS receives Kaiser's aggregate reporting data, but currently does not have the specific grievance and appeal data to report to the committee. KHS and Kaiser are working together to formalize a new process to report this data going forward.

Requested Action

Receive and File

4th Quarter 2021 Grievance Summary

Issue	Number	In Favor of Health Plan	Under Review by Q.I	In favor of Enrollee	Still under review
Access to care	73	50	0	23	0
Coverage dispute	0	0	0	0	0
Cultural and Linguistic Sensitivity	9	3	0	6	0
Difficulty with accessing specialists	58	29	0	29	0
Medical necessity	266	199	0	67	0
Other issues	36	24	0	12	0
Potential Inappropriate care	257	144	104	9	0
Quality of service	46	37	0	9	0
Timely assignment to provider	0	0	0	0	0



Standard Grievances and Appeals per 1,000 Members = 2.50

During the fourth quarter of 2021, there were seven hundred and forty-five standard grievances and appeals received. One hundred and fifty-five cases were closed in favor of the Enrollee. Four hundred and eighty-six cases were closed in favor of the Plan. One hundred and four cases have closed and are under review by the KHS Quality Improvement Department. Of the seven hundred and forty-five grievances and appeals received, six hundred and ninety-eight cases closed within thirty days; forty-seven cases were pended and closed after thirty days.

4th Quarter 2021 Grievance Summary

Access to Care

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

Fourteen members complained about the lack of available appointments with their Primary Care Provider (PCP). Ten cases closed in favor of the Plan after the responses indicated the offices provided appropriate access to care based on Access to Care standards. Four cases closed in favor of the Enrollee after the responses indicated the offices may not have provided appropriate access to care based on Access to Care standards.

Twenty-seven members complained about the wait time to be seen for a Primary Care Provider (PCP) appointment. Nineteen 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 Access to Care standards. Eight cases closed in favor of the Enrollee after the responses indicated the members were not seen within the appropriate wait time for a scheduled appointment.

Twenty-one members complained about the telephone access availability with their Primary Care Provider (PCP). Twelve cases closed in favor of the Plan after the responses indicated the members were provided with the appropriate telephone access availability. Nine cases closed in favor of the Enrollee after the responses indicated the members may not have been provided with the appropriate telephone access availability.

Eleven members complained about a provider not submitting a referral authorization request in a timely manner. Nine cases closed in favor of the Plan after it was determined the referral authorization request had been submitted in a timely manner. 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.

Coverage Dispute

There were no grievances pertaining to a Coverage Dispute issue.

Cultural and Linguistic Sensitivity

Nine members complained about the lack of available interpreting services to assist during their appointments. Six 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. Three 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.

4th Quarter 2021 Grievance Summary

Difficulty with Accessing a Specialist

There were Fifty-eight grievances pertaining to Difficulty Accessing a Specialist. Twenty-nine cases closed in favor of the Plan. Twenty-nine cases closed in favor of the Enrollee. The following is a summary of these issues:

Seventeen members complained about the lack of available appointments with a specialist. Eleven cases closed in favor of the Plan after the responses indicated the members were provided the appropriate access to specialty care based on Access to Care Standards. Six cases closed in favor of the Enrollee after the responses indicated the members may not have been provided with the appropriate access to care based on the Access to Care Standards for specialty appointments.

Seventeen members complained about the wait time to be seen for a specialist appointment. Seven cases closed in favor of the Plan after the responses indicated the offices provided appropriate wait time for an appointment based on Access to Care Standards. Ten cases closed in favor of the Enrollee after the responses indicated the members may not have been provided with the appropriate wait time for a scheduled appointment based on Access to Care Standards.

Thirteen members complained about the telephone access availability with a specialist office. Seven cases closed in favor of the Plan after the responses indicated the members were provided with the appropriate telephone access availability. Six cases closed in favor of the Enrollee after the responses indicated the members may not have been provided with the appropriate telephone access availability.

Eleven members complained about a provider not submitting a referral authorization request in a timely manner. Four cases closed in favor of the Plan after it was determined the referral authorization request had been submitted in a timely manner. Seven cases closed in favor of the Enrollee after it was determined the referral authorization request may not have been submitted in a timely manner.

Medical Necessity

There were two hundred sixty-six appeals pertaining to Medical Necessity. One hundred ninety-nine cases were closed in favor of the Plan. Sixty-seven cases closed in favor of the Enrollee. The following is a summary of these issues:

Two hundred and thirteen members complained about the denial or modification of a referral authorization request. One hundred and fifty-two of the cases were closed in favor of the Plan as it was determined that there was no supporting documentation submitted with the referral authorization requests to support the criteria for medical necessity for the requested specialist or DME item; therefore, the denials were upheld. One case closed in favor of the Plan and was modified. Sixty cases were closed in favor of the Enrollee as it was determined medical necessity was met and the denials were overturned and approved.

4th Quarter 2021 Grievance Summary

Fifty-three members complained about the denial or modification of a TAR. Forty-six cases were closed in favor of the Plan, as it was determined there was no supporting documentation submitted with the TAR to support the criteria for medical necessity of the requested medication; therefore, the denials were upheld. Seven cases were closed in favor of the Enrollee as it was determined medical necessity was met and the denials were overturned and approved.

Other Issues

There were thirty-six grievances pertaining to Other Issues that are not otherwise classified in the other categories. Twenty-four cases were closed in favor of the Plan after the responses indicated appropriate service was provided. Twelve cases closed in favor of the Enrollee after the responses indicated appropriate service may not have been provided.

Potential Inappropriate Care

There were two hundred and fifty-seven grievances involving Potential Inappropriate Care issues. These cases were forwarded to the Quality Improvement (QI) Department for their due process. Upon review, one hundred and forty-four cases were closed in favor of the Plan, as it was determined a quality-of-care issue could not be identified. Nine 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. One hundred and four cases are still pending further review with QI.

Quality of Service

There were forty-six grievances involving Quality of Service issues. Thirty-seven cases were closed in favor of the Plan. Nine cases closed in favor of the Enrollee. The following is a summary of these issues:

Forty-five members complained about the service they received from their providers. Thirty-six cases closed in favor of the Plan after the responses determined the members received the appropriate service from their providers. Nine cases closed in favor of the enrollee after the responses determined the members may not have received the appropriate services.

One member complained about the services they received from a KFHC Case Manager (CM). The case closed in favor of the Plan after the response determined the member received the appropriate service from the CM.

Timely Assignment to Provider

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

Kaiser Permanente Grievances and Appeals

During the fourth quarter of 2021, there were forty-five grievances and appeals received by KFHC members assigned to Kaiser Permanente.

4th Quarter 2021 Grievance Summary

Access to Care

There were five grievances pertaining to Access to Care.

Coverage Dispute

There were six appeals pertaining to Coverage Dispute.

Medical Necessity

There were three cases pertaining to Medical Necessity.

Quality of Care

There were two grievances pertaining to Quality of Care.

Quality of Service

There were twenty-nine grievances pertaining to a Quality of Service.

QI/UM

Contracts/Credentialing/Recredentialing
October 1, 2021 - December 31, 2021

Credentialing and Re-Credentialing Providers
90 Providers Initially Credentialed
147 Provider Re-Credentialed
0 Denied

Credentialing and Re-Credentialing Facility
4 Facilities Initially Credentialed
12 Facilities Re-Credentialed
0 Denied

New Contracts Effective 11/1 and 12/1

6 New Contracts were approved:
1 Infusion Therapy
3 Specialist (Obstetrics/Gynecology, Family Planning, Psychology)
1 SNF/CLF
1 Acupuncture

All credentialing and recredentialing files were approved.

PNM Network Review Quarter 4

Access related reporting table of contents

1. After Hours:

   KHS conducts a survey to assess compliance with after-hours urgent and emergent guidance for members. During Q4, KHS conducted 143 calls resulting in compliance rates as follows

   Emergent 98%

   Urgent 96%

   Any providers found to be non-compliant will receive a letter advising of standards.

   1 provider was found to be non-compliant two consecutive quarters and will be contacted by the assigned Provider Relations Representative to review the access standards and where the office was deficient.

   3 providers were found to be non-compliant three consecutive quarters and will be contacted by the Provider Relations Manager to review the access standards and where the office was deficient.

2. Appointment Availability:

   KHS randomly sampled 15 PCP, 15 Specialists, 5 Mental Health, 5 Ancillary, and 5 OB/GYN providers to ensure compliance with phone answering timeliness and appointment availability. All provider types surveyed were compliant with both components surveyed.

3. Access Grievance Review:

   In Q2, there were 79 access related grievances. 50 were found in favor of the plan and no further action was needed. 29 were found in favor of the enrollee. KHS has reviewed the grievance results and no issues/trends were identified. The Plan will be implementing a four-quarter rolling review to identify potential trends effective Q3 2022.

4. Geographic Accessibility & DHCS Network Certification:

As part of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, zip code 93555 (previously carved-out) will be added to the Plan's service area effective January 1, 2022. As part of the DHCS' ongoing network certification efforts the Plan was required to conduct and submit accessibility analysis for this new zip code, and additional AAS request as needed; this was completed and submitted by the Plan during Q3 2021. The Plan received approval from the DHCS in Q4 2021.

As part of its ongoing monitoring the Plan reviews additions/deletions in the provider network against the most recently completed geographic accessibility analysis. As of the end of Q4 2021, the Plan identified one termination affecting the Plan's ability to provide access within required time or distance standards for the terminated provider's specialty – endocrinology. Based on the rural nature of the affected zip codes, the Plan believes alternative access standards were appropriate for the identified specialty/zip codes combination and submitted updated documentation to the DHCS.

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

; a part of the Annual Network Certification requirement, outlined in APL 21-006, the Plan is required to

5. Network Adequacy and Provider Counts:

KHS must maintain the following ratios:

1 PCP for every 2,000 members

1 Physician for every 1,200 members

KHS review of network to member ratio is compliant with State regulations and Plan policy. KHS recruitment efforts are on-going.

During Q4 the Plan recognized an increase in provider totals across multiple provider types; the Plan's network has continued to experience upward trends as illustrated in the graphs included.

6. DHCS QMRT (Quarterly Monitoring Report/Response Template)
   DHCS conducts quarterly monitoring of: Provider to Member Ratio, Timely Access (was on hold, resumed 1/1/2022), Physician Supervisor to Non-Physician Medical Practitioner Ratios, and Out-of-Network requests. No issues were identified.

KERN HEALTH SYSTEMS
4th Quarter 2021
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

Report Date: January 13, 2022

Department: Provider Network Management

Monitoring Period: October 1, 2021 through December 31, 2021

Population:

Providers	Credentialed	Recredentialed
MD's	39	81
DO's	4	9
AU's	0	0
DC's	0	1
AC's	1	0
PA's	7	9
NP's	21	13
CRNA's	0	2
DPM's	3	1
OD's	0	0
ND's	0	0
RD's	1	0
BCBA's	5	8
LM's	0	0
Mental Health	3	2
Ocularist	0	0
Ancillary	5	12
OT	0	0
TOTAL	**89**	**138**

Specialty	Providers Credentialed	Providers Recredentialed	Providers Sent to PAC	Providers Not Approved
Acupuncture	1	0	1	0
Addtiction Medicine	0	0	0	0
Allergy & Immunology	0	0	0	0
Anesthesiology / CRNA	0	2	2	0
Audiology	0	0	0	0
Autism / Behavioral Analyst	5	8	13	0
Cardiology	2	1	3	0
Chiropractor	0	1	1	0
Colon & Rectal Surgery	0	0	0	0
Critical Care	0	0	0	0
Dermatology	0	0	0	0
Emergency Medicine	5	2	7	0
Endocrinology	2	1	3	0
Family Practice	17	22	39	0
Gastroenterology	4	4	8	0
General Practice	1	3	4	0
General Surgery	4	4	8	0

KERN HEALTH SYSTEMS
4th Quarter 2021
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

Specialty	Providers Credentialed	Providers Recredentialed	Providers Sent to PAC	Providers Not Approved
Genetics	0	1	1	0
Gynecology	0	0	0	0
Gynecology/Oncology	0	1	1	0
Hematology/Oncology	1	3	4	0
Hospitalist	4	14	18	0
Infectious Disease	1	3	4	0
Internal Medicine	14	17	31	0
Mental Health	3	2	5	0
MidWife (Certified)	0	0	0	0
MidWife (Licensed)	0	0	0	0
Naturopathic Medicine	0	0	0	0
Neonatology	0	0	0	0
Nephrology	2	3	5	0
Neurological Surgery	1	0	1	0
Neurology	2	2	4	0
Obstetrics & Gynecology	4	6	10	0
Ocularist	0	0	0	0
Occupational Therapy	0	0	0	0
Ophthalmology	0	2	2	0
Optometry	0	0	0	0
Orthopedic Surgery / Hand Surg	0	4	4	0
Otolaryngology	0	1	1	0
Pain Management	1	4	5	0
Pathology	0	1	1	0
Pediatrics	6	11	17	0
Physical Medicine & Rehab	0	1	1	0
Plastic Sugery	0	2	2	0
Podiatry	3	1	4	0
Psychiatry	2	0	2	0
Pulmonary	1	0	1	0
Radiation Oncology	0	0	0	0
Radiology	1	13	14	0
Registered Dieticians	1	0	1	0
Rheumatology	1	2	3	0
Sleep Medicine	0	0	0	0
Thoracic Surgery	0	1	1	0
Urology	1	0	1	0
Vascular Medicine	0	0	0	0
Vascular Surgery	0	2	2	0
KHS Medical Directors	0	2	2	0
TOTAL	**90**	**147**	**237**	**0**

KERN HEALTH SYSTEMS
4th Quarter 2021
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

ANCILLARY	Providers Credentialed	Providers Recredentialed	Providers Sent to PAC	Providers Not Approved
Ambulance	0	0	0	0
Cancer Center	0	0	0	0
Cardiac Sonography	0	0	0	0
Comm. Based Adult Services	0	1	1	0
Dialysis Center	0	4	4	0
DME	0	1	1	0
Hearing Aid Dispenser	0	1	1	0
Home Health	0	0	0	0
Home Infusion/Compounding	1	1	2	0
Hospice	0	0	0	0
Hospital / Tertiary Hospital	0	0	0	0
Laboratory	0	0	0	0
Lactation Consultant	0	0	0	0
MRI	0	0	0	0
Ocular Prosthetics	1	0	1	0
Pharmacy	0	2	2	0
Pharmacy/DME	0	0	0	0
Physical / Speech Therapy	0	0	0	0
Prosthetics & Orthotics	0	0	0	0
Radiology	0	0	0	0
Skilled Nursing	2	0	2	0
Sleep Lab	0	0	0	0
Surgery Center	0	2	2	0
Transportation	0	0	0	0
Urgent Care	0	0	0	0
TOTAL	**4**	**12**	**16**	**0**

Defer = 0 **Denied = 0**

KERN HEALTH SYSTEMS
4th Quarter 2021
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

KERN HEALTH SYSTEMS
4th Quarter 2021
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

Kern Health Systems
Board Approved Effective 12/01/21

Legal Name DBA	Specialty	Address	VENDOR PRV	Contract Effective Date
Bienestar Community Clinic	Primary Care	1619 Cecil Ave. Ste. A Delano CA 93215 P - 661-247-1010 F - No fax number given	PRV074197	12/1/2021
Jungwon Oh dba: EZ ACU & Herb Inc.	Acupuncture	1619 S. H Street Bakersfield CA 93304 P - 661-831-2400 F - 661-831-2430	PRV071955	12/1/2021

Kern Health Systems
Board Approved Effective 1/1/2022

VENDOR PRV	Legal Name DBA	Specialty	Address	Contract Effective Date
PRV075144	John Stolpe BCO, BADO	Ocularist/P&O	18455 Burbank Blvd Ste. 202 Tarzana CA 91356 P - 818-758-1666 F - 818-758-1786	1/1/2022
PRV074469	Nisim Surgical	General Surgery	500 Old River Road Ste. 185 Bakersfield CA 93311 P - 661-748-1886 F - 661-479-5063	1/1/2022
PRV074823	Valley View Care Center LLC	SNF	729 Browning Road Delano CA 93215	**Retro-Eff 12/1/2021**

Kern Health Systems
Board Approved Effective 12/01/21

	NAME	LEGAL NAME/ADDRESS	SPECIALTY	PROVIDER PRV	VENDOR PRV	CONTRACT STATUS	PAC APPROVED - EFFECTIVE DATE
1	Oh, Jungwon AC	Jungwon Oh EZ Acu & Herb, Inc. 1619 S. H Street Bakersfield CA 93304 P - 661-831-2400 F - 661-831-2430	Acupuncture	PRV068632	PRV071955	**New Contract**	**Yes** **Eff 12/1/21**
2	Cullison, Brian MD	Emergency Physicians Urgent Care dba: Accelerated Urgent Care *All Locations 212 Coffee Road Ste. 101 Bakersfield CA 93309	Emergency Medicine	PRV074189	all sites	Existing	**Yes** **Eff 12/1/21**
3	Norrod, Guadalupe NP-C	Emergency Physicians Urgent Care dba: Accelerated Urgent Care *All Locations 212 Coffee Road Ste. 101 Bakersfield CA 93309	Emergency Medicine	PRV074190	all sites	Existing	**Yes** **Eff 12/1/21**
4	Accelerated Urgent Care - Mt. Vernon Ave.	Emergency Physicians Urgent Care dba: Accelerated Urgent Care 2251 Mt Vernon Ave Bakersfield CA 93306 P - 661-885-6060 F - 661-885-6085	Urgent Care Center	PRV074428	PRV074428	Existing	**Yes** **Eff 12/1/21**
5	Agnihotri, Neeraj MD	Adventist Health Medical Center Tehachapi 105 West E Street Tehachapi CA 93561 **Alternate Affiliation:** Adventist Health Bakersfield - Cancer Ctr & ASC	Hematology / Oncology	PRV009540	all sites	Existing	**Yes** **Eff 12/1/21**

Kern Health Systems
Board Approved Effective 12/01/21

	NAME	LEGAL NAME/ADDRESS	SPECIALTY	PROVIDER PRV	VENDOR PRV	CONTRACT STATUS	PAC APPROVED - EFFECTIVE DATE
6	Bajwa, Rajwinder NP-C	Omni Family Health 210 N Chester Avenue Bakersfield CA 93308	Pediatrics/Internal Medicine	PRV043134	PRV000019	Existing	**Yes** **Eff 12/1/21**
7	Flores, Gesselle NP-C	Kern Rural Wellness Center, Inc. dba: Arvin Medical Center 146 N. Hill Street Arvin CA 93203	OB/GYN	PRV046909	PRV000264	Existing	**Yes** **Eff 12/1/21**
8	Garcia, Nelson MD	Bartz-Altadonna Comm Health Center 9300 N. Loop Blvd California City CA 93505	Infectious Disease	PRV066449	PRV029961	Existing	**Yes** **Eff 12/1/21**
9	Ginther, Robert PA-C	Emergency Physicians Urgent Care dba: Accelerated Urgent Care *All Locations 212 Coffee Road Ste. 101 Bakersfield CA 93309	Emergency Medicine	PRV074191	all sites	Existing	**Yes** **Eff 12/1/21**
10	Hernandez, Salvador LCSW	Clinica Sierra Vista 8787 Hall Road Lamont CA 93241	Clinical Social Worker	PRV073324	PRV0000002	Existing	**Yes** **Eff 12/1/21**
11	Hoffman, Jessica NP-C	Omni Family Health 161 N Mill Street Tehachapi CA 93561	Family Practice	PRV072824	PRV0000019	Existing	**Yes** **Eff 12/1/21**
12	Idrees, Muhammad MD	Hospitalist Medicine Physicians of California, Inc. dba: Sound Hospitalist of California 2615 Chester Avenue Bakersfield CA 93301	Internal Medicine / Hospitalist	PRV062488	PRV014433	Existing	**Yes** **Eff 12/1/21**
13	Jose, Marissa NP-C	Carlos A. Alvarez, MD Inc. 8929 Panama Road Ste. A Lamont CA 801 Santa Fe Way Shafter CA	Family Practice	PRV054048	PRV030784 PRV055424	Existing	**Yes** **Eff 12/1/21**
14	Kastner, Mary NP-C	Bright Heart Health Medical Group 2960 Camino Diablo Ste. 105 Walnut Creek CA 94597	Psychiatry	PRV062945	PRV061628	Existing	**Yes** **Eff 12/1/21**

Kern Health Systems
Board Approved Effective 12/01/21

	NAME	LEGAL NAME/ADDRESS	SPECIALTY	PROVIDER PRV	VENDOR PRV	CONTRACT STATUS	PAC APPROVED - EFFECTIVE DATE
15	Kogan, Mark MD	Ridgecrest Regional Hospital (RHC) 1041 N China Lake Blvd Ste. C Ridgecrest CA 93555	Gastroenterology	PRV074191	PRV000279 PRV029495	Existing	**Yes** **Eff 12/1/21**
16	Kubeldis, Nathan DO	Hospitalist Medicine Physicians of California, Inc. dba: Sound Hospitalist of California 2615 Chester Avenue Bakersfield CA 93301	Internal Medicine / Hospitalist	PRV066979	PRV014433	Existing	**Yes** **Eff 12/1/21**
17	Laplana, Geraldine NP-C	Omni Family Health 1701 Stine Road Bakersfield CA 93309	Family Practice	PRV073049	PRV0000019	Existing	**Yes** **Eff 12/1/21**
18	Marcus, Adrianna PA-C	Emergency Physicians Urgent Care dba: Accelerated Urgent Care All Locations 212 Coffee Road Ste. 100 Bakersfield CA 93309	Family Practice	PRV074193	all sites	Existing	**Yes** **Eff 12/1/21**
19	Nseyo, Unwanaobong MD	Ridgecrest Regional Hospital (RHC) 105 E Sydnor Avenue Ste. 100 Ridgecrest CA 93555	Urology	PRV074194	PRV000279 PRV029495	Existing	**Yes** **Eff 12/1/21**
20	Palmer, Jacqueline NP-C	Bartz-Altadonna Comm Health Center 9300 N. Loop Blvd California City CA 93505	Internal Medicine	PRV057729	PRV029961	Existing	**Yes** **Eff 12/1/21**
21	Park, Young In DO	Hospitalist Medicine Physicians of California, Inc. dba: Sound Hospitalist of California 2615 Chester Avenue Bakersfield CA 93301	Internal Medicine / Hospitalist	PRV048154	PRV014433	Existing	**Yes** **Eff 12/1/21**
22	Preciat-Fernandez, Gabriela BCBA	Behavior Frontiers, LLC 5060 California Avenue Ste. 610 Bakersfield CA 93309	Qualified Autism Provider / Behavioral Analyst	PRV074195	PRV046025	Existing	**Yes** **Eff 12/1/21**
23	Rajani, Roshan MD	Ridgecrest Regional Hospital (RHC) 105 E Sydnor Avenue Ste. 100 Ridgecrest CA 93555	Nephrology	PRV048182	PRV000279 PRV029495	Existing	**Yes** **Eff 12/1/21**

Kern Health Systems
Board Approved Effective 12/01/21

	NAME	LEGAL NAME/ADDRESS	SPECIALTY	PROVIDER PRV	VENDOR PRV	CONTRACT STATUS	PAC APPROVED - EFFECTIVE DATE
24	Rittenhouse, Alexis BCBA	Adelante Behavioral Health ABA LLC 2005 Eye Street Ste. 8 Bakersfield CA 93301	Qualified Autism Provider / Behavioral Analyst	PRV074196	PRV067923	Existing	**Yes** **Eff 12/1/21**
25	Roman, Jennifer NP-C	Omni Family Health 655 S Central Valley Highway Shafter CA 93263	Pediatrics/Internal Medicine	PRV072823	PRV0000019	Existing	**Yes** **Eff 12/1/21**
26	Thomas, Anthony MD	Pinnacle Primary Care, Inc. 1520 Brundage Lane 7400 District Blvd Ste. C Bakersfield CA	Pediatrics	PRV000574	PRV000353	Existing	**Yes** **Eff 12/1/21**
27	Tseng, Joshua MD	Kern County Hospital Authority 3551 Q Street Ste. 100 Bakersfield CA 93301	General Surgery	PRV073680	all sites	Existing	**Yes** **Eff 12/1/21**
28	Walia, Sukhpreet MD	Ridgecrest Regional Hospital (RHC) 1041 N China Lake Blvd Ste. C Ridgecrest CA 93555	Gastroenterology	PRV011688	PRV000279 PRV029495	Existing	**Yes** **Eff 12/1/21**
29	Zamudio, Santiago MD	Kern County Hospital Authority 3551 Q Street Ste. 100 Bakersfield CA 93301	General Surgery	PRV000859	all sites	Existing	**Yes** **Eff 12/1/21**

KERN HEALTH SYSTEMS
Board Approved Effective 01/01/2022

	NAME	LEGAL NAME/ADDRESS	SPECIALTY	CONTRACT STATUS	PROVIDER PRV	VENDOR PRV	PAC APPROVED - EFFECTIVE DATE
1	Stolpe, John BCO BADO	John Stolpe BCO, BADO 18455 Burbank Blvd Ste. 202 Tarzana CA 91356	Ocularist / Prosthetic & Orthotics	**New Contract**	PRV075144		**Yes** **Eff 1/1/22**
2	Valley View Care Center	Valley View Care Center, LLC 729 Browning Road Delano CA 93215	SNF	**New Contract**	PRV074823	PRV074823	**Yes** **Retro - Eff 12/1/21**
3	Altavas, Darryl NP-C	Centric Health dba: Kern Endocrine Center 3008 Sillect Ave Ste. 220 4531 Buena Vista Rd Ste. 100 Bakersfield CA	Endocrinology/ Metabolism	Existing	PRV058419	PRV000503	**Yes** **Eff 1/1/22**
4	Bailey, Kevin PA-C	Emergency Physicians Urgent Care, Inc. dba: Accelerated Urgent Care *All Locations 212 Coffee Road Ste. 101 Bakersfield CA 93309	Emergency Medicine	Existing	PRV075151	ALL SITES	**Yes** **Eff 1/1/22**
5	Beblawi, Ihab MD	Ridgecrest Regional Hospital (RHC) 1041 N China Lake Blvd Ste. B Ridgecrest CA 93555	Gastroenterology	Existing	PRV075153	PRV000279 PRV029495 PRV057082	**Yes** **Eff 1/1/22**
6	Dalal, Vivek MD	Coffee Surgery Center, LLC dba: All Kids Dental Surgery Center 2525 Eye Street Ste. 100 Bakersfield CA 93301	Anesthesiology	Existing	PRV040438	PRV000369	**Yes** **Eff 1/1/22**
7	Douglas, Geoffrey MD	Kern County Hospital Authority 1700 Mt Vernon Avenue Bakersfield CA 93306	General Surgery	Existing	PRV050560	ALL SITES	**Yes** **Eff 1/1/22**

KERN HEALTH SYSTEMS
Board Approved Effective 01/01/2022

	NAME	LEGAL NAME/ADDRESS	SPECIALTY	CONTRACT STATUS	PROVIDER PRV	VENDOR PRV	PAC APPROVED - EFFECTIVE DATE
8	Gonzalez Perez, Alejandro MD	West Side Health Care District dba: West Side Family Health Care-RHC dba: West Side Family Health Care-UC 100 E North Street Taft CA 93268	Family Medicine	Existing	PRV074739	PRV000306	**Yes** **Eff 1/1/22**
9	Haytoglu, Tahir MD	Telemedicine Group PC dba: Telemed2U 3400 Douglas Blvd Ste. 225 Roseville CA 95661	Endocrinology/ Metabolism	Existing	PRV075161	PRV061649	**Yes** **Eff 1/1/22**
10	Hearons, Dominga NP-C	Riverwalk Pediatric Clinic, Inc 9508 Stockdale Highway Ste. 150 Bakersfield CA 93311	Pediatrics	Existing	PRV075162	PRV000212	**Yes** **Eff 1/1/22**
11	Hilvers, Tamara MD	West Side Health Care District dba: West Side Family Health Care-RHC dba: West Side Family Health Care-UC 100 E North Street Taft CA 93268	Family Medicine	Existing	PRV074524	PRV000306	**Yes** **Eff 1/1/22**
12	Holloway, Bryon DO	Kern County Hospital Authority 1700 Mt Vernon Avenue Bakersfield CA 93306	General Surgery	Existing	PRV073638	ALL SITES	**Yes** **Eff 1/1/22**
13	Hules, Michelle NP-C	Emergency Physicians Urgent Care, Inc. dba: Accelerated Urgent Care *All Locations 212 Coffee Road Ste. 101 Bakersfield CA 93309	Emergency Medicine	Existing	PRV050622	ALL SITES	**Yes** **Eff 1/1/22**

KERN HEALTH SYSTEMS
Board Approved Effective 01/01/2022

	NAME	LEGAL NAME/ADDRESS	SPECIALTY	CONTRACT STATUS	PROVIDER PRV	VENDOR PRV	PAC APPROVED - EFFECTIVE DATE
14	Machupalli, Surekha MD	Omni Family Health 1701 Stine Rd 4151 Mexicali Dr Bakersfield CA	OB/GYN	Existing	PRV074782	PRV000019	**Yes** **Eff 1/1/22**
15	Manzanares, Lisa DO	Emergency Physicians Urgent Care, Inc. dba: Accelerated Urgent Care *All Locations 212 Coffee Road Ste. 101 Bakersfield CA 93309	Family Medicine	Existing	PRV066433	ALL SITES	**Yes** **Eff 1/1/22**
16	Martin, Adriana LCSW	Bakersfield City School District dba: Center Street Wellness Center 2951 Center Street Bakersfield CA 93306	Clinical Social Worker	Existing	PRV075164	PRV000469	**Yes** **Eff 1/1/22**
17	McDonald, Catherine MD	Clinica Sierra Vista (CSV) 2400 Wible Road Ste. 14 Bakersfield CA 93304	Family Medicine	Existing	PRV073639	PRV0000002	**Yes** **Eff 1/1/22**
18	Mendez, Diego MD	Pinnacle Women's Health Group, Inc. KM -1700 Mt Vernon Avenue AH-Bakersfield - 2615 Chester Avenue BMH - 420 34th Street	OB/GYN / Hospitalist	Existing	PRV000215	PRV033812	**Yes** **Eff 1/1/22**
19	Mendoza, Sheila NP-C	Kern County Neurological Medical Grp 1705 28th Street Bakersfield CA 933091	Neurology	Existing	PRV075163	PRV000308	**Yes** **Eff 1/1/22**

KERN HEALTH SYSTEMS
Board Approved Effective 01/01/2022

	NAME	LEGAL NAME/ADDRESS	SPECIALTY	CONTRACT STATUS	PROVIDER PRV	VENDOR PRV	PAC APPROVED - EFFECTIVE DATE
20	Moni, Caleb BCBA	Teaching Autistic Children Inc. dba: Learning Arts 5329 Office Center Court Ste. 150Bakersfield CA 93309	Qualified Autism Provider / Behavioral Analyst	Existing	PRV075166	PRV052185	**Yes** **Eff 1/1/22**
21	Nabili, Panah DPM	Omni Family Health *Various Locations 4600 Panama Lane Ste. 102B Bakersfield CA 93313	Podiatry / Foot & Ankle Surgery	Existing	PRV073048	PRV0000019	**Yes** **Eff 1/1/22**
22	Pedrow, Jillian BCBA	Behavioral Momentum Services 221 S Montclair St Bakersfield 5121 Stockdale Hwy Ste 214 Bakersfield 120 Annin Avenue Wasco CA	Qualified Autism Provider / Behavioral Analyst	Existing	PRV075167	PRV047917	**Yes** **Eff 1/1/22**
23	Radhakrishnan, Vivek MD	Infusion & Clinical Services dba: Premier Valley Medical Group 5400 Aldrin Court Bakersfield CA 5401 White Lane Bakersfield CA HHP 5401 White Lane Ste. A Bakersfield *Additional Affiliation: Nephrology Medical Group	Internal Medicine	Existing	PRV071746	ALL SITES	**Yes** **Eff 1/1/22**
24	Rodriguez, Monica NP-C	Vanguard Medical Corporation 565 Kern St Shafter CA 845 7th Street Wasco CA 500 Old River Road Ste. 250 Bakersfield	Family Practice	Existing	PRV034773	PRV060341 PRV029452 PRV044703	**Yes** **Eff 1/1/22**

KERN HEALTH SYSTEMS
Board Approved Effective 01/01/2022

	NAME	LEGAL NAME/ADDRESS	SPECIALTY	CONTRACT STATUS	PROVIDER PRV	VENDOR PRV	PAC APPROVED - EFFECTIVE DATE
25	Samra, Karamjeet NP	Infusion & Clinical Services dba: Premier Valley Medical Group 5400 Aldrin Court Bakersfield CA 5401 White Lane Bakersfield CA HHP 5401 White Lane Ste. A Bakersfield	Internal Medicine	Existing	PRV070774	ALL SITES	**Yes** **Eff 1/1/22**
26	Shindy, Waleed MD	Ridgecrest Regional Hospital (RHC) 1041 N China Lake Blvd Ste. C Ridgecrest CA 93555	Gastroenterology	Existing	PRV075168	PRV000279 PRV029495 PRV057082	**Yes** **Eff 1/1/22**
27	Takayama, Christian MD	Bartz-Altadonna Comm Health Center 9300 N. Loop Blvd California City CA 93505	HIV/AIDS Specialist (FP)	Existing	PRV072922	PRV029961	**Yes** **Eff 1/1/22**
28	Tran, Uyen NP-C	Universal Healthcare Services, Inc. dba: Central California Pain Management 8303 Brimhall Road Bldg 1500 3550 Q Street Ste. 201 & 202 Bakersfield CA	Pain Management	Existing	PRV073460	ALL SITES	**Yes** **Eff 1/1/22**
29	Tripp, Elton PA-C	Omni Family Health 1110 West Visalia Road Ste. 102 Exeter CA 93221	Family Practice	Existing	PRV037312	PRV0000019	**Yes** **Eff 1/1/22**
30	Vaysman, Tetyana MD	Kern County Hospital Authority 1111 Columbus Street Bakersfield CA 93305	Internal Medicine	Existing	PRV074781	ALL SITES	**Yes** **Eff 1/1/22**

Provider Network Management
Network Review
Quarter 4, 2021

- **After-Hours Survey Report**
- **Appointment Availability Survey Report**
- **Grievance Review (Q2, 2021 Review Period)**
- **Geographic Accessibility & Network Certification**
- **Network Adequacy & Provider Counts**
- **DHCS Quarterly Monitoring Report/Response Template (QMRT) (Q3, 2021 Review Period)**

KERN HEALTH SYSTEMS

After-Hours Calls

Quarter 4, 2021

AFTER-HOURS CALLS

Q4, 2021

KERN HEALTH SYSTEMS

Introduction

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

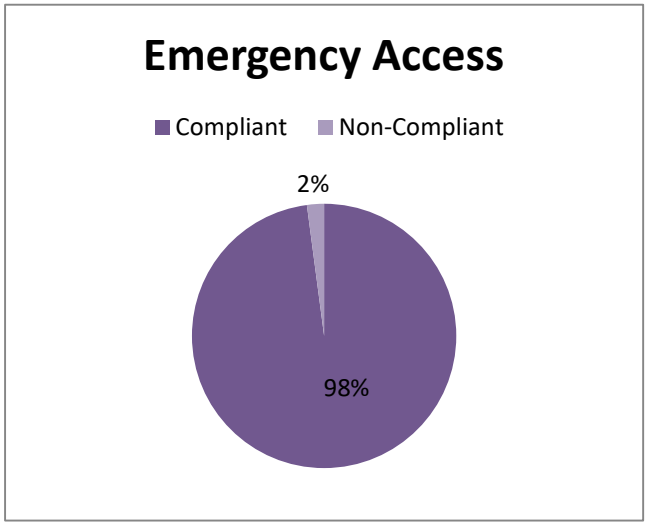
1.) Provider's answering machine or answering service must instruct the member to call 911 if the purpose of the call is a medical emergency.

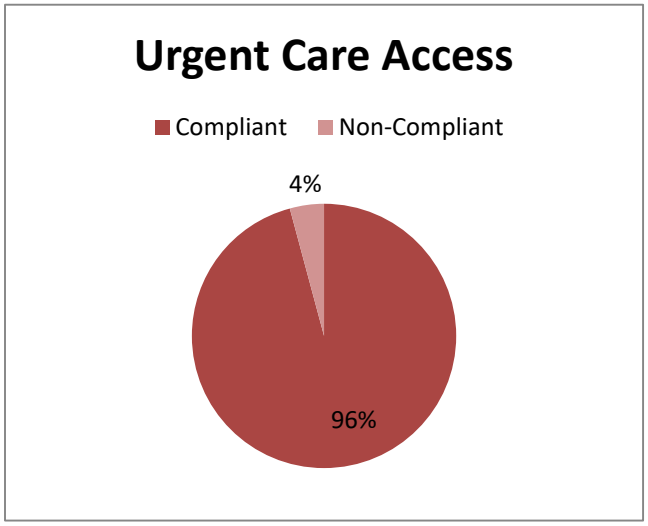
2.) For urgent matters, Provider's answering machine must provide an on-call number. If an answering service is used, the member must receive a call back from an on-call member of your office within 30 minutes of call.

An initial survey is conducted by Health Dialog and then forwarded to the Plan's Provider Network Analysts. Based on the results received from the survey vendor, the analysts make additional calls to confirm if the provider is truly non-compliant. Results are to be reported to the KHS QI/UM Committees and to Executive Staff.

Results

During Q4 2021, 143 provider offices were contacted. Of those offices, 140 were compliant with the Emergency Access Standards and 137 were compliant with the Urgent Care Access Standards.





AFTER-HOURS CALLS

Q4, 2021

Tracking, Trending, and Provider Outreach

The Plan utilizes the after-hours survey calls to monitor compliance at a network-wide level. The Plan identified an increase in compliance across both measures, with emergency access at 98% and urgent care access at 96%.

Compliance with after-hours standard	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021
Emergency Access	97%	94%	97%	96%	94%	98%
Urgent Care Access	90%	91%	92%	91%	89%	96%

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

During Q4 2021, the Plan identified one office which was non-compliant for two consecutive quarters. The Plan's Provider Relations Representatives will conduct targeted education with the identified providers regarding their contractual obligation to meet regulatory access standards.

During Q4 2021, the Plan identified three offices which were non-compliant for three consecutive quarters. The Plan's Provider Relations Manager will conduct outreach to these identified providers, reminding them of their contractual obligation to meet regulatory access standards and that potential corrective action may be put in place if non-compliance continues.

For all other providers identified as non-compliant during Q4 2021, the Plan is sending letters (template attached) notifying the providers of the survey results and advising them of how to become compliant.

Upon review, the Plan has found the targeted education conducted by the Provider Relations Representatives and Manager has seen success as a percentage of previously non-compliant offices which received outreach were found to be compliant during Q4.

KERN HEALTH SYSTEMS

[DATE]

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

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

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

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

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

During [QUARTER, YEAR], a call was placed to your office at [PHONE]. The results of that call found that your office was non-compliant with the [STANDARD] after-hours access standard(s) as set forth in the KHS standards in our policy and outlined above.

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

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

Sincerely,

Melissa Lopez
Provider Relations Manager
661-617-2642

KERN HEALTH SYSTEMS

Appointment Availability Survey

Quarter 4, 2021

Provider Network Management

Appointment Availability Survey

Q4, 2021

KERN HEALTH SYSTEMS

Introduction

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

In line with KHS policies and procedures and Department regulation, the quarterly appointment availability survey monitors:

Type of Appointment	Time Standard
Urgent primary care appointment	Within 48 hours of a request
Non-urgent primary care appointment	Within 10 business days of a request
Urgent appointment with a specialist	Within 96 hours of a request
Non-urgent appointment with a specialist	Within 15 business days of a request
Non-urgent appointments with a non-physician mental health care provider	Must offer the appointment within 10 business days of request
Non-urgent appointment for ancillary services	Within 15 business days of a request
First prenatal OB/GYN visit	The lesser of 10 business days or within 2 weeks upon request

When it is necessary for a provider or enrollee to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the enrollee's health care needs and ensures continuity of care consistent with good professional practice and consistent with the objectives of KHS *Policy 4.30-P Accessibility Standards*. The standard and monitoring process for the availability of a rescheduled appointment shall be equal to the availability of the initial appointment, such that the measure of compliance shall be shared.

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

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

Appointment Availability Survey

Q4, 2021

KERN HEALTH SYSTEMS

Appointment Availability Survey Results

A random sample of 15 primary care, 15 specialist, 5 mental health, 5 ancillary, and 5 OBGYN providers were contacted during Q4 2021.

Of the primary care providers surveyed, the plan compiled the wait time in hours to determine the Plan's average wait time for an urgent primary care appointment. The Plan compiled the wait time in days to determine the Plan's average wait time for a non-urgent primary care appointment. The average wait time for an urgent primary care appointment was **32.9 hours** for Q4 2021. The average wait time for a non-urgent primary care appointment was **2.5 days** for Q4 2021. **Based on these results, the Plan was determined to be compliant in both the urgent and non-urgent time standards for primary care appointments in Q4 2021.**

Of the specialist providers surveyed, the plan compiled the wait time in hours to determine the Plan's average wait time for an urgent specialist appointment. The Plan compiled the wait time in days to determine the Plan's average wait time for a non-urgent specialist appointment. The average wait time for an urgent specialist appointment was **54.5 hours** for Q4 2021. The average wait time for a non-urgent primary care appointment was **6.3 days** for Q4 2021. **Based on these results, the Plan was determined to be compliant in both the urgent and non-urgent time standards for specialist appointments in Q4 2021.**

Of the mental health providers surveyed, the plan compiled the wait time in days to determine the Plan's average wait time for an appointment with a mental health provider. The Plan's average wait time for a mental health provider appointment was **2.4 days** for Q4 2021. **Based on these results, the Plan was determined to be compliant with the time standard for a mental health appointment in Q4 2021.**

Of the ancillary providers surveyed, the plan compiled the wait time in days to determine the Plan's average wait time for an appointment with the ancillary provider. The Plan's average wait time for an ancillary appointment was **1 day** for Q4 2021. **Based on these results, the Plan was determined to be compliant with the time standard for an ancillary appointment in Q4 2021.**

Of OB/GYN providers surveyed, the plan compiled the wait time in days to determine the Plan's average wait time for a first prenatal appointment with an OB/GYN. The Plan's average wait time for a first prenatal appointment with an OB/GYN was **3.8 days** for Q4 2021. **Based on these results, the Plan was determined to be compliant with the time standard for an OB/GYN first prenatal appointment in Q4 2021.**

Appointment Availability Survey

Q4, 2021

KERN HEALTH SYSTEMS

Tracking, Trending, and Provider Outreach

The Plan utilizes the quarterly appointment availability survey to monitor compliance at a network-wide level. The Plan reviewed the results of the Q4 2021 appointment availability survey against prior quarters, and recognized an increase in the average wait time amongst primary care and specialist urgent appointments. The Plan recognized a decrease for primary care, mental health, and OB/GYN non-urgent appointments. Non-urgent specialist appointments had a minimal increase and ancillary appointments remained the same. The Plan does not consider these as trends at this time as they are in line with prior quarters. The Plan's average wait time remains well within regulatory standards for all appointment types.

Average wait time for an urgent appointment in hours	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021
Primary Care	N/A	N/A	19.1	26.9	28.5	32.9
Specialist	N/A	N/A	57.4	61.6	49.6	54.5

Average wait time for an appointment in days	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021
Primary Care	9	5.2	2.3	3	4	2.5
Specialist	8.5	5.7	10.5	11.4	6	6.3
Mental Health	N/A	N/A	2	8	4.2	2.4
Ancillary	N/A	N/A	1.4	8.6	1	1
OB/GYN	8	8.9	10	7.4	4.4	3.8

*N/A = Not previously surveyed

The Plan reviews individual provider/site results against prior quarters. The Plan conducts provider outreach as appropriate and continues quarterly tracking/trending and will report as identified. At this time, the Plan has not identified any potential trends amongst providers and/or specialty types, and the results are in line with prior quarters. The Plan is sending letters (template attached) to providers who were identified to be non-compliant during the Q4 2021 appointment availability survey. All providers found to be non-compliant based on the results of the 2021 survey will be resurveyed during Q1 2022.

Phone Answering Timeliness Results

Utilizing the methodology outlined above, KHS conducts a phone answering timeliness survey in conjunction with the appointment availability survey. During Q4 2021 calls were answered within an average of **1.8 rings**.

	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021
Average rings before call was answered	3.2	2.2	2.2	1.5	3.0	1.8

KERN HEALTH SYSTEMS

[DATE]

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

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

During Q4 2021, KHS contacted your office and conducted an appointment availability survey in regards to scheduling [STANDARD/SPECIALTY] appointment. Based on the results of the survey, we found your office was not complaint with KHS availability standards. With this letter, I have included a copy of KHS policy that outlines required appointment availability standards.

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

Sincerely,

Melissa Lopez
Provider Relations Manager
661-617-2642

KERN HEALTH SYSTEMS

Access Grievance Review

Quarter 4, 2021

(Q2, 2021 Review Period)

Provider Network Management

Access Grievance Review

Q4, 2021 (Q2, 2021 Review Period)

KERN HEALTH SYSTEMS

Introduction and KHS Policy and Procedure

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

Categorization

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

Grievance Totals

During Q2 2021 **seventy-nine (79)** access-related grievances were received and reviewed by the KHS Grievance Committee. In **fifty (50)** of the cases, no issues were identified and were closed in favor of the Plan. The remaining **twenty-nine (29)**, were closed in favor of the enrollee; the KHS Grievance Department sent letters to the providers involved in these cases, notifying them of the outcome.

The **twenty-nine (29)** grievances that were closed in favor of the enrollee were forwarded to the Plan's Provider Network Management Department. For each of these grievances, the members initial complaint, the provider's response, the Members Service Department's investigation, and the Grievance Committee's decision are reviewed by the Provider Network Management Department.

The access grievances found in favor of the enrollee for Q2 2021 were categorized by the KHS Grievance Department as follows:

Timely Access	**13**
Provider Availability	**2**
Technology / Telephone	**14**
Geographic Access	**0**

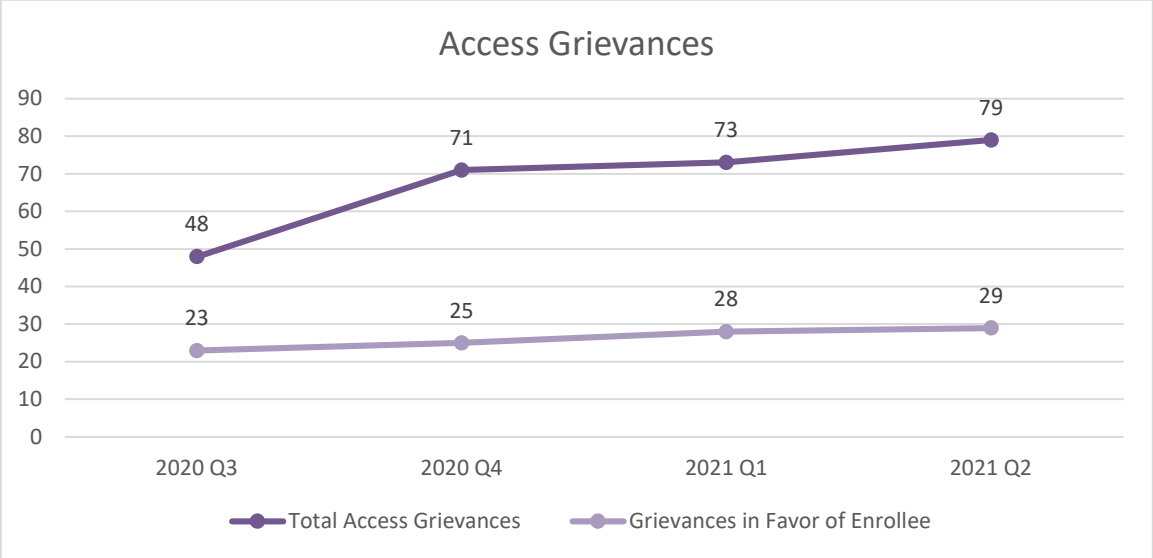
Tracking and Trending

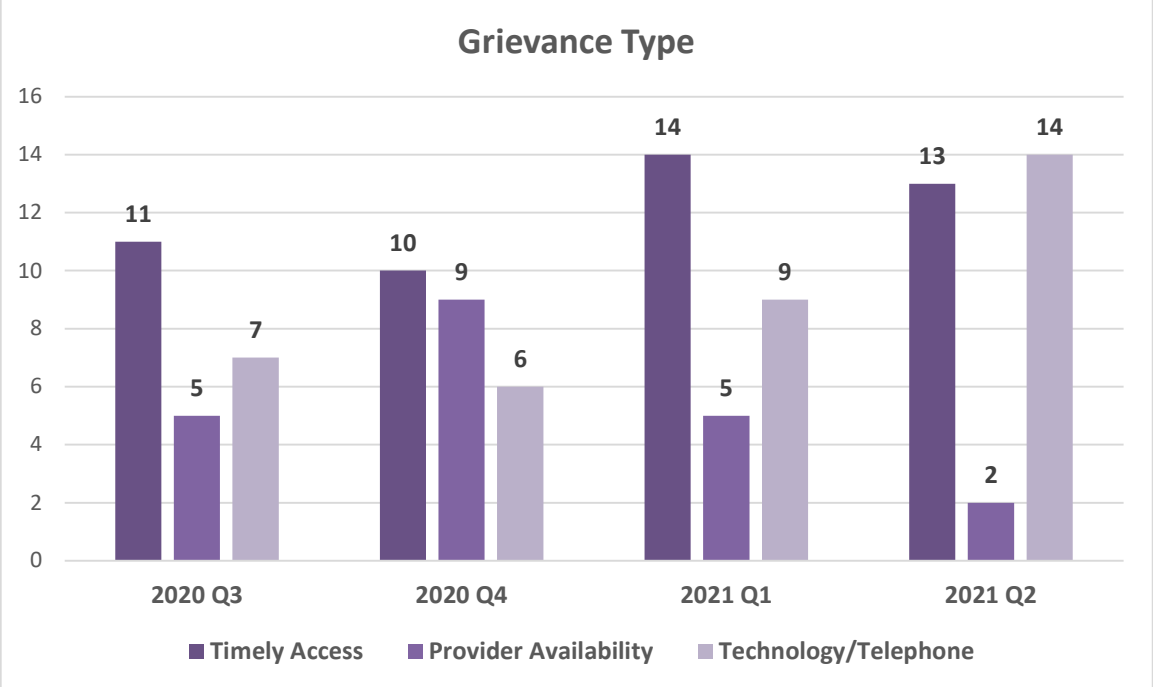
The Provider Network Management Department reviewed all access grievances found in favor of the enrollee received in Q2 2021 to identify any potential access issues or trends within the Plan's network or amongst the Plan's contracted providers. In addition to a review conducted against prior quarters, the Plan reviews Access Grievances against outcomes of other monitoring conducted as part of the quarterly *Provider Network Management, Network Review* (e.g. Appointment Availability Survey, DHCS' QMRT review, Network Adequacy).

Access Grievance Review

Q4, 2021 (Q2, 2021 Review Period)

Upon review of Q2 2021 access grievances, the Plan identified a minimal increase in grievances when compared from Q1 2021 and in line with grievances counts from previous quarters. The Plan did not identify this increase as an issue or trend at this time due to the count being in line with prior quarters. Effective the forthcoming Q3 2022 review, the Plan is implementing a four-quarter rolling review period to identify potential trends. Trends that are identified will be reviewed with the Provider Relations Manager on a case-by-case basis to develop a target-based strategy to address. As of the Q2 2021 review, the Plan did not identify any trends amongst specific providers, groups, or specialty types. The Plan will continue to monitor access grievances for potential trends via the quarterly access grievance review.





Access Grievance Review

Q4, 2021 (Q2, 2021 Review Period)

KERN HEALTH SYSTEMS

Exempt Grievances

On a quarterly basis, the Plan's Provider Network Management Department reviews all exempt grievances to identify potential trends amongst the provider network. For Q2 2021, there were a total of **1,570** exempt grievances.

Grievance Type	Q4 Count	Q4 % of Total	Q1 Count	Q1 % of Total	Q2 Count	Q2 % of Total
Provider / Staff Attitude	606	57.70%	721	61.10%	925	58.92%
Timely Access	122	11.60%	137	11.60%	211	13.44%
Transportation	135	12.90%	129	10.90%	154	9.81%
Provider Availability	60	4.80%	58	4.90%	110	7.01%
Technology / Telephone	50	5.70%	62	5.30%	64	4.08%
Authorization	37	3.50%	26	2.20%	51	3.25%
Referral	9	0.90%	20	1.70%	24	1.53%
Billing	5	0.50%	11	0.90%	7	0.45%
Enrollment	1	0.10%	3	0.30%	7	0.45%
Physical Access	9	0.90%	3	0.30%	5	0.32%
Language Access	5	0.50%	2	0.20%	5	0.32%
Continuity Of Care	4	0.40%	1	0.10%	3	0.19%
Case Management / Care Coordination	0	0.00%	3	0.30%	2	0.13%
Out-of-Network	0	0.00%	0	0.00%	1	0.06%
Geographic Access	0	0.00%	0	0.00%	1	0.06%
Member Informing Materials	4	0.40%	2	0.20%	0	0.00%
Fraud / Waste / Abuse	0	0.00%	1	0.10%	0	0.00%
PHI / Confidentiality / HIPAA	0	0.00%	1	0.10%	0	0.00%
Discrimination	3	0.30%	0	0.00%	0	0.00%
Disability Discrimination	0	0.00%	0	0.00%	0	0.00%
Eligibility	0	0.00%	0	0.00%	0	0.00%
Assault / Harassment	0	0.00%	0	0.00%	0	0.00%
Inappropriate Care	0	0.00%	0	0.00%	0	0.00%
Grand Total	**1050**		**1180**		**1570**	

In reviewing these totals against prior quarters, as of the Q2 2021 review of exempt grievances, the Plan recognized an increase in exempt grievances and reviewed with the Member Services department. The Plan found that there was an increase in claims submitted along with an increase in call volume to Member Services, indicating that more members were returning to see providers more often. The Plan will continue to monitor exempt grievances for potential trends via the quarterly access grievance review.

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

2.1.20 Grievance Received Date

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

2.1.21 Grievance Type

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

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

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

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

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

2.1.22 MER COC Disposition Date

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

KERN HEALTH SYSTEMS

Geographic Accessibility & DHCS Network Certification

Quarter 4, 2021

Provider Network Management

Geographic Accessibility & Network Certification

Q4, 2021

KERN HEALTH SYSTEMS

Geographic Accessibility

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

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

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

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

DHCS Annual Network Certification – 2021

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

As a part of the Annual Network Certification requirement, outlined in APL 21-006, the Plan is required to submit geographic access analysis outlining compliance with the above-listed standards. For all zip codes in which the Plan was not compliant with an above-listed standard, the Plan is able to submit an alternative access standard (AAS) request.

As part of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, zip code 93555 (previously carved-out) will be added to the Plan's service area effective January 1, 2022. In Q3 2021, the Plan submitted accessibility analysis and AAS requests as needed for the new zip code. In Q4 2021, the DHCS approved the Plan's submissions.

Geographic Accessibility & Network Certification

Q4, 2021

As part of its ongoing monitoring the Plan reviews additions/deletions in the provider network against the most recently completed geographic accessibility analysis. As of the end of Q4 2021, the Plan identified one termination affecting the Plan's ability to provide access within required time or distance standards for the terminated provider's specialty – endocrinology. Based on the rural nature of the affected zip codes, the Plan believes alternative access standards were appropriate for the identified specialty/zip codes combination, and submitted updated documentation to the DHCS.

KERN HEALTH SYSTEMS

Network Adequacy & Provider Counts

Quarter 4, 2021

Provider Network Management

Network Adequacy & Provider Counts

Q4, 2021

KERN HEALTH SYSTEMS

Introduction

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

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

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

Survey Methodology and Results

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

KHS utilized SPH Analytics, an NCQA certified survey vendor, to conduct the survey for 2020. SPH's methodology involved two waves of mail and Internet, with a third wave of phone follow up to administer the survey.

Based on the results of 2020 survey, KHS calculated a network-wide FTE percentage of **48.31% for Primary Care Providers** and **41.22% for Physicians.**

Network Adequacy & Provider Counts

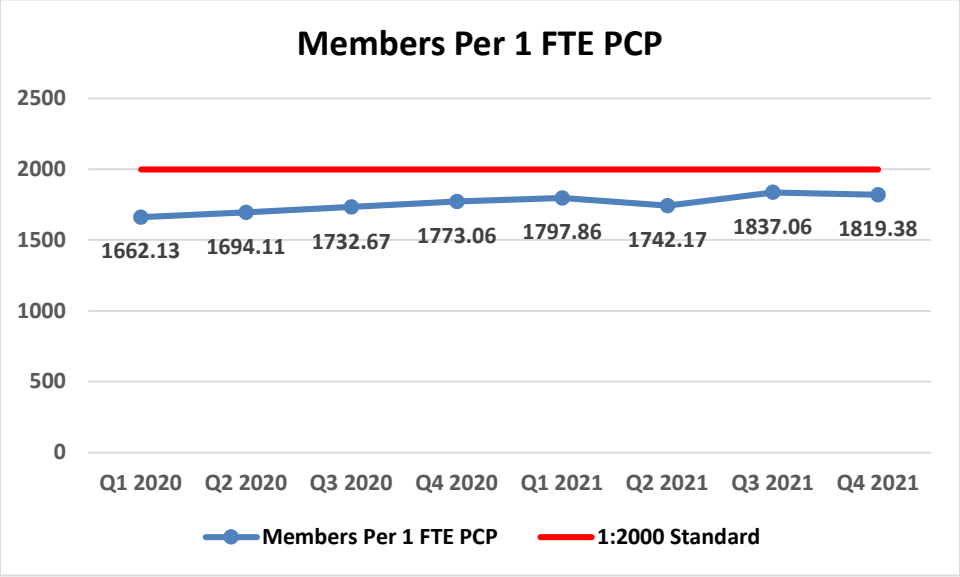
Q4, 2021

Full Time Equivalency Compliance Calculations

Of KHS' 311,119 membership at the close of Q4 2021, 12,722 were assigned and managed by Kaiser and did not access services through KHS' network of contracted providers; due to this, Kaiser managed membership is not considered when calculating FTE compliance.

As of the end of Q4 2021, the plan was contracted with 435 Primary Care Providers, a combination of 244 physicians and 191 mid-levels. Based on the FTE calculation process outlined above, with a 48.31% PCP FTE percentage, KHS maintains a total of **164.01 FTE PCPs**. With a membership enrollment of 298,397 utilizing KHS contracted PCPs, KHS currently maintains a ratio of **1 FTE PCP to every 1819.38 members**; KHS is compliant with state regulations and Plan policy.

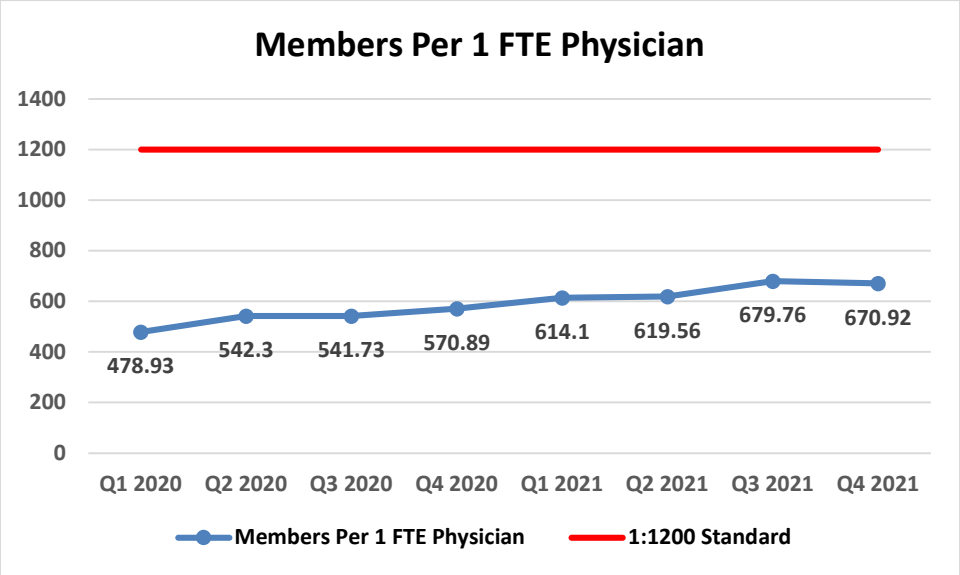
PCP to Member Ratio



As of the end of Q4 2021, the plan was contracted with 1079 Physicians. Based on the FTE calculation process outlined above, with a 41.22% Physician FTE percentage, KHS maintains a total of **444.76 FTE Physicians**. With a total membership enrollment of 298,397 utilizing KHS contracted Physicians, KHS currently maintains a ratio of **1 FTE Physician to every 670.92 members**; KHS is compliant with state regulations and Plan policy.

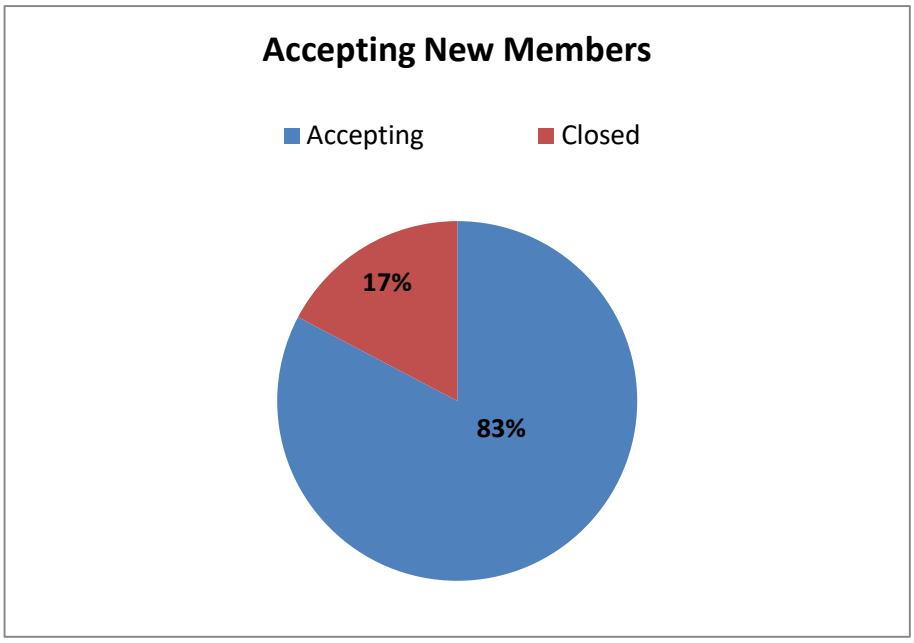
Network Adequacy & Provider Counts

Q4, 2021



Accepting New Members

In addition to the Full Time Equivalency Compliance review conducted above, the Plan monitors adequacy of its Primary Care Network by reviewing the count/percentage of Primary Care Providers (PCP) who are accepting new members. **The Plan calculated that 83% of the network of Primary Care Providers is currently accepting new members at a minimum of one location**. The Plan will continue to monitor this percentage quarterly to ensure it maintains an adequate network of Primary Care Providers.

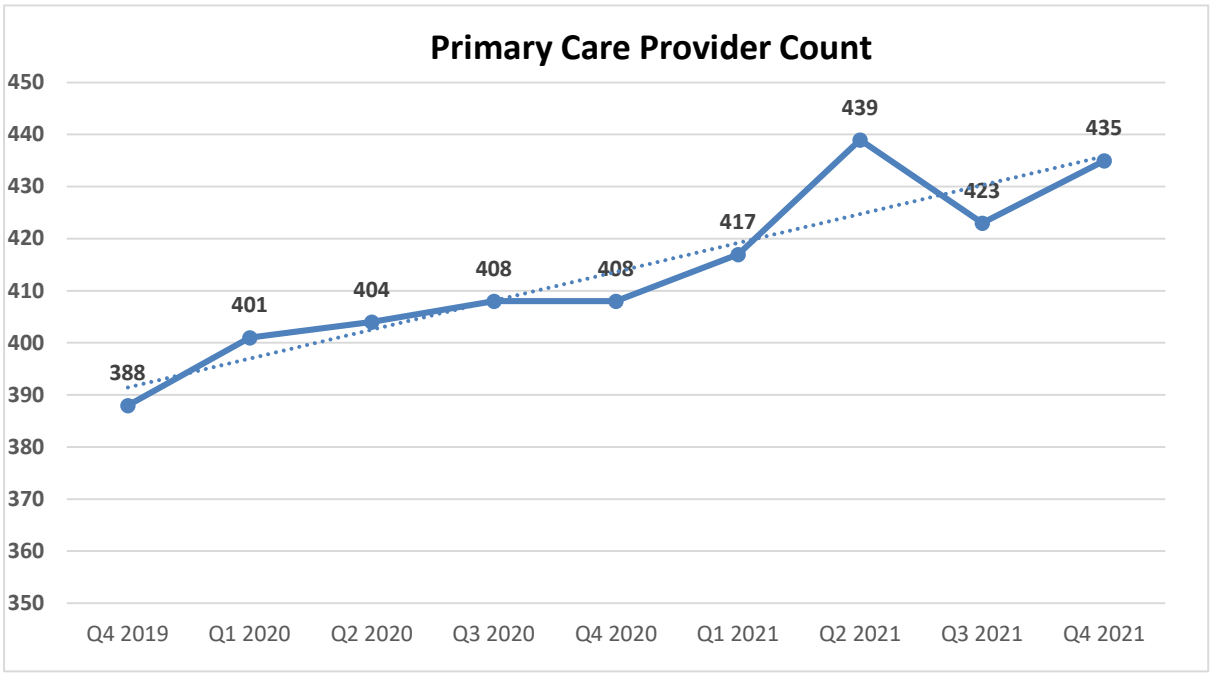


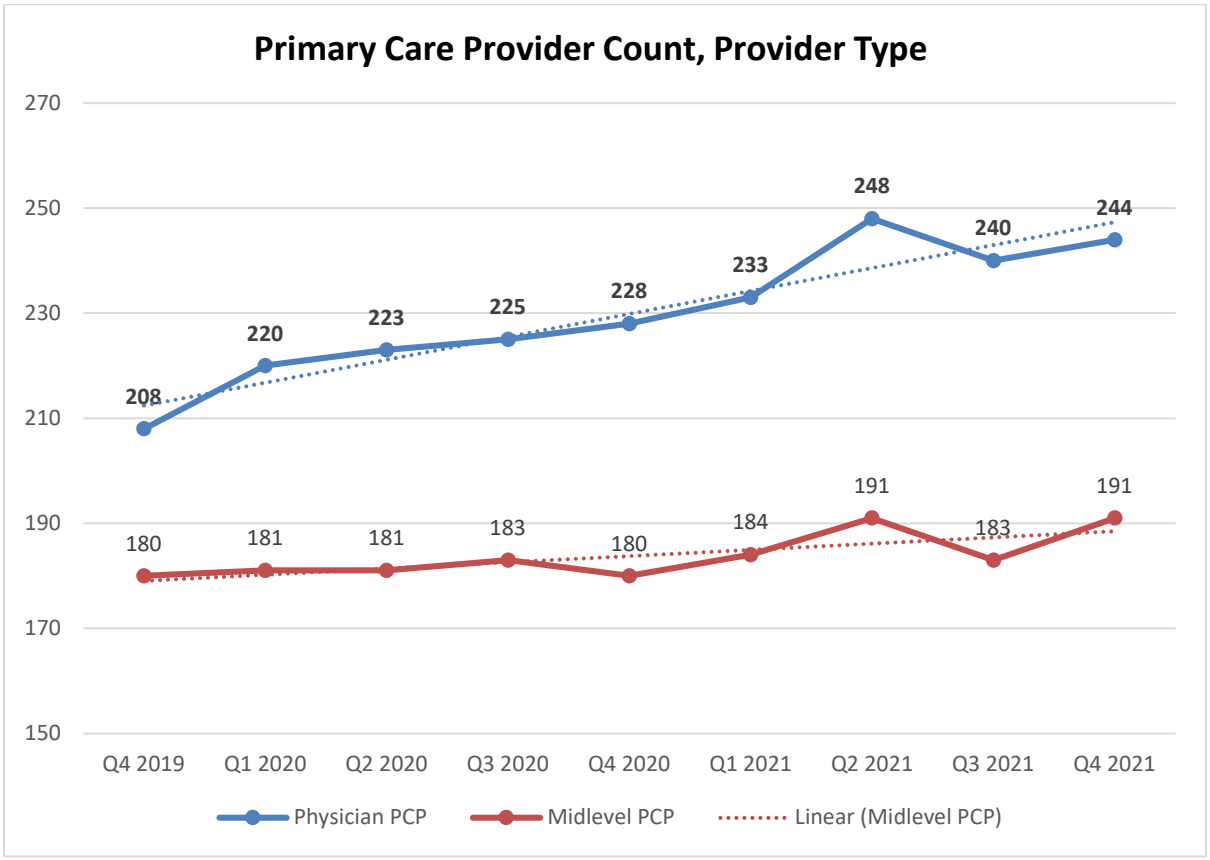
Network Adequacy & Provider Counts

Q4, 2021

KERN HEALTH SYSTEMS

Provider Counts – Primary Care Providers



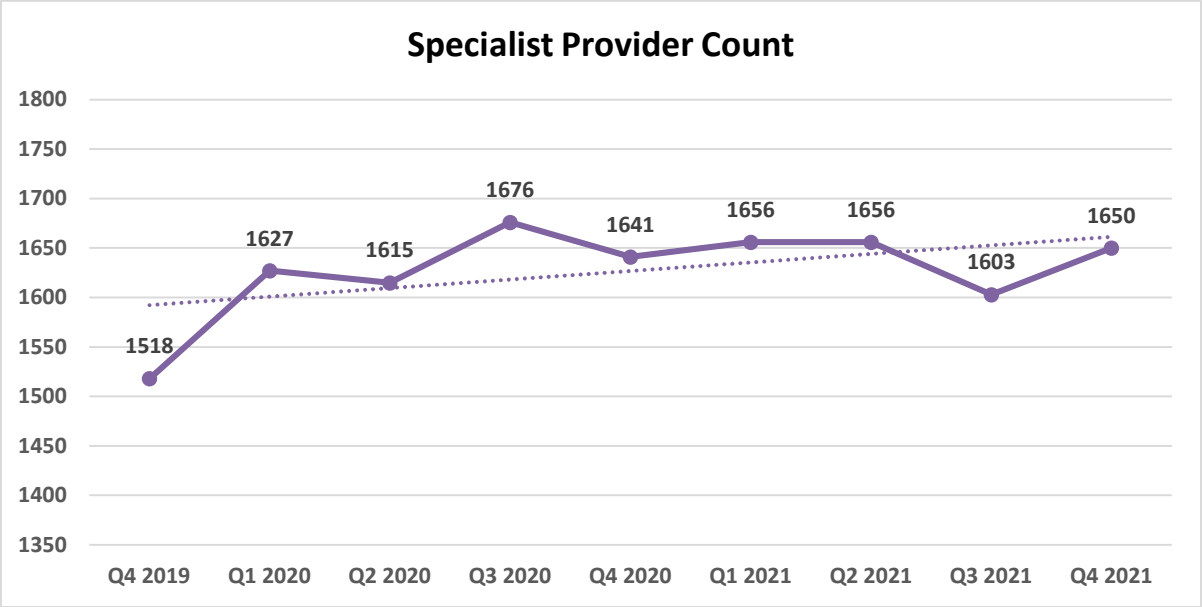


Network Adequacy & Provider Counts

Q4, 2021

KERN HEALTH SYSTEMS

Provider Counts – Specialist Providers



DHCS Core Specialties, Provider Count									
	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021
Cardiology	40	40	38	42	44	43	42	46	46
Dermatology	35	33	36	35	36	33	34	35	35
Endocrinology	20	20	19	20	24	22	23	23	24
Gastroenterology	20	20	22	22	22	23	22	21	24
General Surgery	62	66	70	68	68	67	63	59	62
Hematology	18	17	18	18	20	20	21	19	23
Infectious Disease	10	9	10	10	10	11	10	8	8
Nephrology	22	22	21	22	23	23	27	27	28
Neurology	25	25	26	25	25	26	25	25	25
Oncology	23	22	24	24	26	26	27	25	27
Ophthalmology	32	33	32	30	29	30	30	29	28
Orthopedic Surgery	20	21	20	21	20	20	21	21	22
Otolaryngology	12	12	10	10	10	8	8	9	9
Physical Medicine & Rehab	27	27	24	24	24	24	11	10	10
Psychiatry	54	54	53	54	47	47	45	48	53
Pulmonary Disease	21	20	20	20	19	18	17	17	20

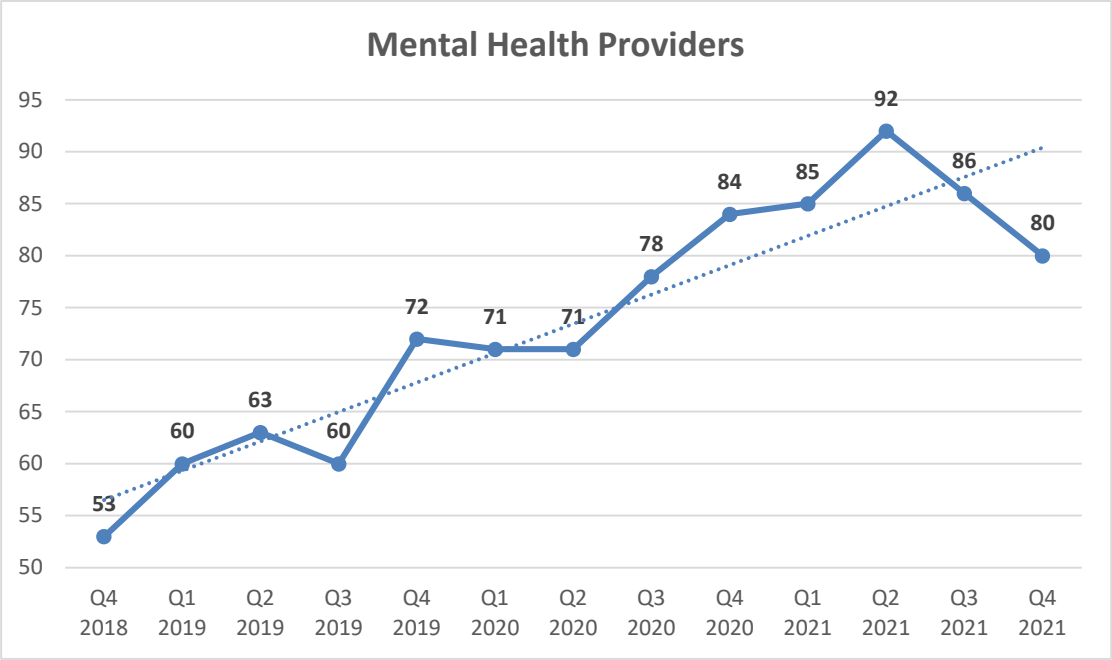
	> 5% Increase		> 5% Decrease
	≤ 5% Increase		≤ 5% Decrease

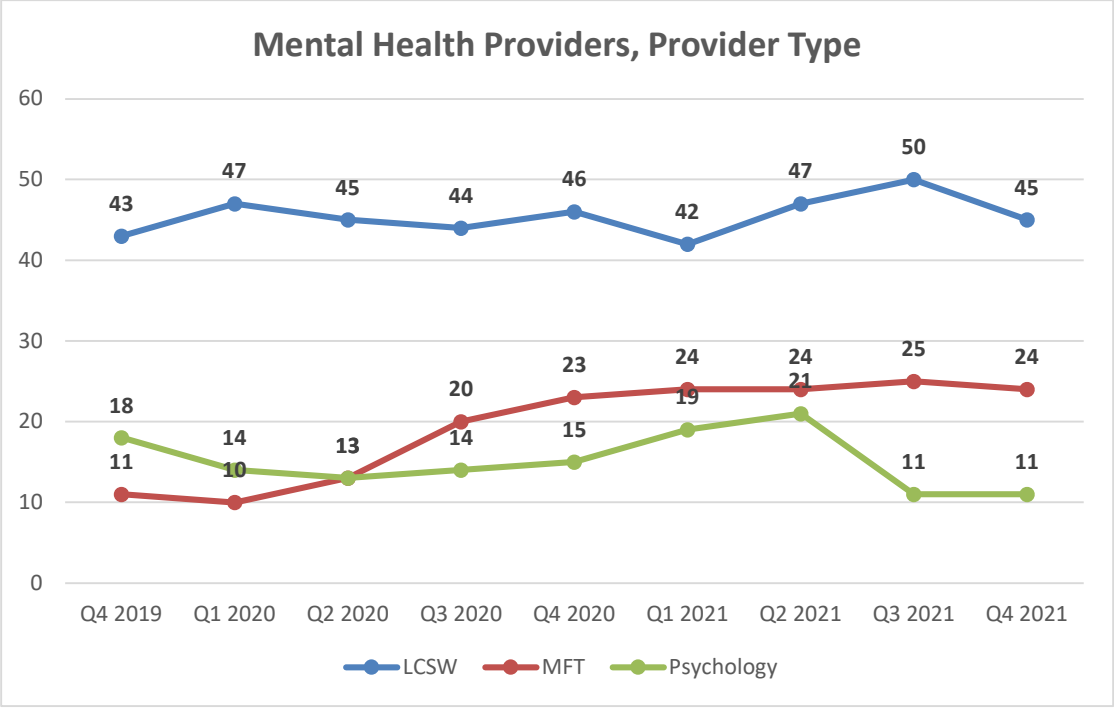
Network Adequacy & Provider Counts

Q4, 2021

KERN HEALTH SYSTEMS

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





Network Adequacy & Provider Counts

Q4, 2021

KERN HEALTH SYSTEMS

Provider Counts – Facilities

	2017	2018	2019	2020	Current
Hospital	18	18	18	18	21
Surgery Center	19	16	17	19	19
Urgent Care	13	17	17	17	19

Provider Counts – Other Provider Types

	2017	2018	2019	2020	Current
Ambulance/Transport	15	15	13	17	16
Dialysis	13	14	16	18	19
Home Health	13	12	13	13	14
Hospice	6	7	11	13	16
Pharmacy	133	136	139	147	150
Physical Therapy	29	29	29	30	29

Tracking and Trending

The Plan utilizes the quarterly Network Adequacy and Provider Counts review to monitor fluctuations within the network. The Plan has reviewed the results of the Q4 2021 report and compared against prior quarters (outlined above) and recognized an increase in provider totals across multiple provider types; the Plan's network has continued to experience upward trends as illustrated in the graphs above.

KERN HEALTH SYSTEMS

DHCS Quarterly Monitoring Report/Response Template (QMRT)

Quarter 4, 2021

(Q3, 2021 Review Period)

Provider Network Management

Quarterly Monitoring Report/Response Template

Q4, 2021 (Q3, 2021 Review Period)

KERN HEALTH SYSTEMS

Introduction

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

On 10/8/2021 the Plan received Q3 2021 QMRT and accompanying reports from the DHCS and during Q4 2021 the Plan's Provider Network Management departments reviewed the following categories:

FTE Provider to Member Ratio

DHCS uses the Plan's 274 file submission to calculate and monitor FTE provider to member ratios. For Q3 2021 QMRT no response was requested from the Plan, and the DHCS review found the Plan to be in compliance with the standard:

Service Area and/or Reporting Unit	FTE PCP Per 2,000 members	FTE Physician Per 1,200 members
Kern	14	40

The Plan's standards and monitoring of FTE provider to member ratios are outlined in Plan policy and procedure *4.30-P Accessibility Standards*. While the Plan was unable to replicate the above ratios provided by the DHCS, the Plan's own quarterly monitor (*Network Adequacy and Provider Counts*, *Q4 2021*) also found the Plan to be in compliance with regulatory standards.

Timely Access

DHCS' External Quality Review Organization (EQRO) conducts a timely access survey of Plan providers to ensure compliance with provider availability and appointment wait time standards. For Q3 2021 QMRT no response was requested from the Plan, and no survey data was provided to the Plan. The Plan's standards and monitoring of timely access are outlined in Plan policy and procedure *4.30-P Accessibility Standards*. The Plan's own quarterly monitor (*Appointment Availability Survey*, *Q4 2021*) found the Plan to be in compliance with regulatory standards. The Plan was notified that the survey will be restarting January 1, 2022.

Network Report

DHCS uses the Plan's 274 file to generate Network Report in an effort to improve network provider data quality and support compliance with Annual Network Certification and timely access survey. For Q3

2021 QMRT no response was requested from the Plan, and no Network Report data was provided to the Plan. The Plan's standards and monitoring of accessibility are outlined in Plan policy and procedure *4.30-P Accessibility Standards.*

Mandatory Provider Types

The Plan is required to contract with at least one of the following Mandatory Provider Types within its service area, where available: Freestanding Birthing Centers (FBC), Certified Nurse Midwife (CNM), Licensed Midwife (LM), and Indian Health Facilities (IHF). For Q3 2021 QMRT no response was requested from the Plan, and no Mandatory Provider Type data was provided to the Plan. The Plan maintains ongoing efforts to identify and contract will all provider types, including the above listed Mandatory Provider Types. This requirement is also reviewed by the Plan and DHCS as part of the Plan's Annual Network Certification. The Plan's most recent submission was found to be in compliance with regulatory requirements.

Physician Supervisor to Non-Physician Medical Practitioner Ratios

DHCS uses the Plan's 274 file submission to calculate and monitor Physician Supervisor to Non-Physician Medical Practitioner Ratios. For Q3 2021 QMRT no response was requested from the Plan, and the DHCS' review found the Plan to be in compliance with the standard:

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

The Plan's standards for Physician Supervisor to Non-Physician Medical Practitioner ratios are outlined in Plan policy and procedure *4.04-P Non-Physician Medical Practitioners – Supervision by Physicians.* While the Plan was unable to replicate the above ratios provided by the DHCS, the Plan calculated its network ratio and found it has 3.72 Physicians Supervisors per Non-Physician Medical Practitioner and was in compliance with the standard.

Out-of-Network Requests

The Plan reports Out-of-Network (OON) requests to DHCS when a member is requesting to a see a provider or facility, when a medically necessary service is not available in the Plan's network. The DHCS analyzes the data to identify potential areas of concern. Based on Q3 2021 data, the Plan identified **Hospital, Specialty Care,** and **OB/GYN** as the three provider types with the highest number of out-of-network requests. The Plan provided a response to the DHCS addressing these three provider types, including the Plan's strategy to reduce the number of requests, barriers/challenges to resolving the number of requests, and contracting/recruiting efforts.

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Referral and Authorization Process				POLICY #: 3.22-P	
DEPARTMENT: Utilization Management					
Effective Date: 01/01/1999	Review/Revised Date: 02/14/2022	DMHC	X	PAC	X
		DHCS	X	QI/UM COMMITTEE	X
		BOD	X	FINANCE COMMITTEE	

_____ Date _____
Douglas A. Hayward
Chief Executive Officer

_____ Date _____
Chief Medical Officer

_____ Date _____
Deputy Chief Medical Officer

_____ Date _____
Chief Operating Officer

_____ Date _____
Chief Health Services Officer

_____ Date _____
Chief Network Administration Officer

_____ Date _____
Director of Pharmacy

_____ Date _____
Director of Claims

_____ Date _____
Director of Member Services

_____ Date _____

Director of Quality Improvement

_____ Date _____

Director of Utilization Management

POLICY:

Kern Health Systems (KHS) will develop, implement, and continuously improve a utilization management (UM) program that ensures appropriate processes are used to review and approve the provision of medically necessary covered behavioral and medical services.[1] For those services which require prior authorization, only KHS UM personnel, the KHS Chief Medical Officer or their designee(s), and the KHS CEO may give authorization for payment by KHS. Services may not be authorized by any other KHS personnel.

Kern Health Systems requires authorization for pre-authorization, concurrent, and retrospective requests for Major Organ Transplant candidates and living donors. These requests will include expedited authorization if needed.

Contracted providers are required to obtain prior authorization, unless special circumstances require use of a non-contracted provider, pre-arranged by KHS or determined by KHS to be emergent or urgent in nature. In order to provide continuity of care, KHS will under certain conditions authorize care by a non-contracted provider. See *KHS Policy and Procedures #3.39 –Continuity of Care by Terminated Providers* and *#3.40 – Continuity of Care for New Members* for details.

The referral and authorization process will conform to the requirements outlined in the following statutory, regulatory, and contractual sources:

- Code of Federal Regulations Title 42 §§431.211; 431.213; and 431.214
- California Health and Safety Code §§1363.5; 1367.01; 1368.1; 1371.4; 1374.16
- California Code of Regulations Title 28 §1300.70(b) and (c)
- California Code of Regulations Title 22 §§51014.1; 51014.2; and 53894
- California Code of Regulations Title 22§ 51303 Investigational Services
- 2004 DHCS Contract Exhibit A-Attachment 5; Exhibit A-Attachment 9; Exhibit A-Attachment 13(8)
- DHCS MMCD Letters 04006 (November 1, 2004) and 05005 (April 11, 2005)

DEFINITIONS:

Request for Acute Continuing Services[2]	Request for extension of approval for acute care services in hospitals when both of the following conditions apply: A. The treating physician has determined that the member cannot safely be discharged because acute care services continue to be medically necessary for one of the following reasons: 1. Further acute care is needed for the purpose of treating the condition or conditions for which the acute care was

Formatted: CM10, Justified

Formatted: Not Highlight

Formatted: Tab stops: Not at 0" + 0.5" + 1" + 1.5" + 2"

Formatted: Font:

	originally approved for an acute admission requiring prior authorization 2. Complications directly related to the diagnosis for which acute care was originally approved have arisen and necessitate further acute care 3. Further care is needed for an illness contracted during the course of an approved acute admission if the illness most likely occurred because the patient was hospitalized 4. Further care is needed for the purpose of treating a diagnosed condition(s) for which a length of stay was previously approved after an emergency or urgent admission 5. Further diagnostic procedures and/or treatments are needed after a previously approved emergency or urgent admission, for which no length of stay was approved and the acute care stay has been at least 5 days in duration at the time of the request B. The medical record contains documentation consistent with (A) above.
Request for Non-Acute Continuing Services[3]	Request for services received by KHS prior to or no later than 10 working days after expiration of the immediately preceding approved authorization for services in the following categories: A. Long-Term Care, specifically Skilled Nursing Facility, and Subacute levels of care B. Chronic Hemodialysis, including all related services C. Hospice Care D. All other non-acute services under the Medi-Cal program when the treating physician substantiates on or with the request that the same level or frequency of services should be continued because the treatment goal approved on the original authorization has not been achieved.

PROCEDURES:

1.0 TYPES OF SERVICES FOR WHICH AUTHORIZATION IS NOT REQUIRED

Unless specifically excluded, all services must be authorized by KHS in accordance with KHS referral policies and procedures. The following services do not require prior authorization:[4]

A. Primary care from a KHS contracted Primary Care Practitioner (PCP).
B. Emergency care[5]. (See *KHS Policy and Procedure #3.31 – Emergency Services* for details and limitations.)
C. Maternity care. Authorization is required for specialty procedures in the OB/GYN area (i.e., amniocentesis, hysterectomy, and LEEP). (See *KHS Policy and Procedure #3.24 – Maternity Care* for details and limitations.)
D. Family planning services and abortion. (See *KHS Policy and Procedure #3.21 – Family*

Planning Services and Abortion for details and limitations.)

E. STD services. (See *KHS Policy and Procedure #3.17 – STD Treatment* for details and limitations.)

F. HIV testing. (See *KHS Policy and Procedure #3.18 – Confidential HIV Testing* for details and limitations.)

G. Sensitive Services[6]. (See *KHS Policy and Procedure #3.20 – Sensitive Services* for details and limitations.)

H. Initial Mental Health Assessment (See *KHS Policy and Procedure #3.14 – Mental Health Services* for details and limitations.)

I. Outpatient Hospice Services (See *KHS Policy and Procedure #3.43 Hospice Services* for details and limitations)

J. Urgent Care

~~J. Kern Health Systems requires authorization for pre-authorization, concurrent, and retrospective requests for Major Organ Transplant candidates and living donors. These requests will include expedited authorization if needed.~~

Although the above services do not require authorization, submission of a *Referral/Prior Authorization Form* and supporting documentation may be required for tracking purposes. See *KHS Policy and Procedure 3.25-P: Prior Authorization Procedures and Services* and the specific scope of service policy for additional information. Absence of an authorization requirement does not relieve the provider of the requirements to use contracting providers (as applicable) and verify eligibility.

1.1 Non-Contracted Providers

With the exception of Family Planning, HIV testing, Initial Mental Health Assessment, and Sexually Transmitted Disease (STD) diagnosis and treatment, prior authorization is required for all non-emergent services performed by non-contracted providers. All requests for such services are reviewed by the KHS Chief Medical Officer, or their designee(s) or UM staff.

See *KHS Policies and Procedures #3.17 – STD Treatment, #3.18-Confidential HIV Testing, and #3.21 – Family Planning Services and Abortion* for additional information on receiving the related services from non-contracted providers.

See *KHS Policy 6.01-P Claims Submission and Reimbursement* for additional information on non-contracted providers.

2.0 VERBAL AUTHORIZATION

Providers and/or members can request verbal authorization for the services indicated in the following table.

Type of Service	Contact Information	Decision and Notification Timeline
Hospice	**Regular business hours:** UM Department (661) 664-5083 or toll free (800) 391-2000	Response within 24 hours.[7]

	After business hours: 24 –hour Telephone Triage Line (800) 391-2000. Must request to speak to KHS administrator on call.	
Non-urgent care following an exam in the emergency room	**Regular business hours:** UM Department (661) 664-5083 or toll free (800) 391-2000 **After business hours:** 24 –hour Telephone Triage Line (800) 391-2000.	Response within 30 minutes or the service is deemed approved.[8]
Post-stabilization	**Regular business hours:** UM Department (800) 391-2000 **After business hours:** 24 –hour Telephone Triage Line (800) 391-2000. Must request to speak to KHS administrator on call.	Response within 30 minutes or the service is deemed approved.[9]
Urgent Care	24 –hour Telephone Triage Line (800) 391-2000.	Prior authorization not required.
Urgent Referrals	**Regular business hours:** UM Department (661) 664-5083 or toll free (800) 391-2000	Response within 72 hours from receipt

Telephone/verbal authorization must be followed by submission of a *Referral/Prior Authorization Form* and supporting documentation.

UM staff follow-up verbal authorization decisions with written notification as outlined in *Section 4.3 –Provider and Member Notification*.

3.0 HOSPITAL AUTHORIZATION

For non-elective hospital admissions, notification of admission must be submitted to KHS as outlined in *KHS Policy and Procedure #3.33 – Hospital/Facility Authorization, Admission, and Discharge*. The admission face sheet may be used in lieu of a *Referral/Prior Authorization Form.* Authorization requests will be processed in the same manner and as outlined in the Routine Authorization section or Retrospective Review Decisions of this procedure as appropriate.

Prior authorization must be obtained for all elective hospital admissions.

4.0 ROUTINE AUTHORIZATION

KHS provides written notification to members of any termination or reduction in behavioral or medical services and any denials, modifications, or delays of referrals. Services denied, delayed, or modified based on medical necessity may be eligible for Independent Medical Review (IMR). See *KHS Policy and Procedure #14.51 – Independent Medical Review* for details on the IMR process.

4.1 Request for Authorization

A routine authorization request is initiated by submission of a *Referral/Prior Authorization Form* (See Attachment A) either via fax, mail or online submission. Participating providers treating member must submit the request for authorization via the online submission process. The request must include pertinent medical records and member data which support the medical necessity of the services requested in the referral and will assist the specialist in the assessment and delivery of services. KHS requests only the information reasonably necessary to make a determination regarding the request.[10]

The PCP or specialty provider treating the member must initiate referrals to qualified contract providers for specialty care or services in a time frame appropriate to the acuity of the member's condition. Provider is defined as any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.

Referral forms must be filled out completely, with all pertinent patient information and supporting documentation. The signature of the contracted referring physician or contracted mid-level must appear on the form unless submitted electronically via the online submission process.

In order to submit a referral request online, the provider is required to have internet access and as well as access to the KHS Provider Portal. The Provider Relations and MIS departments will facilitate online authorization access and provide instructions on its use.

Completed *Referral/Prior Authorization Forms* and necessary medical records unable to be submitted electronically should be submitted to the KHS Utilization Management Department via fax or mail.

Utilization Management
Kern Health Systems
2900 Buck Owens Boulevard
Bakersfield, CA 93308
Fax: (661) 664-5190

The date of receipt for routine referral/authorization requests that are received by KHS after 3:00 PM will be the next business day.[11] The 3:00 cut off time does not apply to services which require verbal authorization as described in Section 2.0 of this policy.

4.2 Utilization Review

Utilization review includes the actions outlined in the following table.

Action	Timeline	Comments
Review by UM staff		UM staff reviews the referral against established KHS guidelines. Requests are classified as urgent when the member's condition is such that he/she faces an imminent and serious threat to his or her health including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process would be detrimental to the member's life or health or could jeopardize his/her ability to regain maximum function[12]. If a referral does not qualify as an urgent referral, the provider will be notified with a *Re-classification Letter* stating the referral does not meet the criteria for an urgent review (See Attachment K).
Review by Chief Medical Officer, Medical Director, or Physician Advisor		Required if the referral does not meet established criteria for medical necessity. This excludes administrative denials.

Action	Timeline	Comments
Decision (defer, approve, modify, terminate/reduce, or deny)	**Routine**: Five working days of receipt.[13] **Urgent**: within 72 hours from receipt of request (as appropriate for the nature of the member's condition) of the receipt of all information reasonably necessary and requested.[14] **Concurrent Review for Treatment Regimen Already in Place**: Five working days or consistent with urgency of medical condition.[15] **Standing Referral:** Within three business days the date the request and receipt of all appropriate medical records and other items of information necessary to make the determination. (See Section 6.0)[16]	Requests needing additional medical records may be deferred according to the timeliness standards outlined in Sections 4.2.1 and 4.2.1.1 of this document. Urgent referrals are not deferred, as requests for additional information are handled via telephone within 72 hours of receipt. In the case of concurrent review, care will not be discontinued until the treating provider has been notified of the decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of the member.[17] The date of action must be determined in compliance with the notice requirements outlined in Section 4.3.2 of this document.

4.2.1 Deferrals

Authorization requests needing additional medical records may be deferred, not denied, until the requested information is obtained. If deferred, the UM Clinical Intake Coordinator 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[18]. On the 14th calendar day from receipt of the original authorization request, the request is approved or denied as appropriate.

4.2.1.1 Extended Deferral

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.

4.2.2 Modifications

There may be occasions when recommendations are made to modify an authorization request in order to provide members with the most appropriate care. Recommendations to modify a request based on medical necessity are first reviewed by the Chief Medical Officer, Medical Director, Physician Advisor(s), or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider.

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.

In the case of radiology requests, modifications to the appropriateness of contrast in performing the study may be changed based on accepted protocols that have been developed by credentialed radiologist's and approved by the PAC. These types of modifications can be done without discussing the modification with the requesting provider. Modifications to the type of study require a discussion and approval by the requesting provider in accordance to KHS DHCS contract.

4.2.3 Denials

If initial review determines that an authorization request does not meet established utilization criteria for medical necessity, denial is recommended. Only the Chief Medical Officer, Medical Director, Physician Advisor(s), or a licensed health care professional who is licensed in the state of California and who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider may deny an authorization request based on medical necessity.[19] See *KHS Policy 3.73-I Medical Decision Making* for additional information.

Reasons for possible denial include:

A. Not a covered benefit
B. Not medically necessary
C. Continue conservative management
D. Services should be provided by a PCP
E. Experimental or investigational treatment (See KHS Policy #14.51-P, §1.1)
F. Member made unauthorized self-referral to provider
G. Inappropriate setting
H. Covered by hospice
~~H.~~ Covered by California Children's Services
I.

Formatted: Indent: Left: 0.75"

Formatted: Indent: Left: 0.75", Numbered + Level: 1 + Numbering Style: A, B, C, … + Start at: 1 + Alignment: Left + Aligned at: 1" + Tab after: 1.25" + Indent at: 1.25", Tab stops: 1.75", List tab

4.2.4 Administrative Denials

Administrative denials are denials for requested services that are determined by a qualified health professional that are not made, whole or in part, on the basis of medical necessity.

Often times, these decisions are to facilitate services that are either a carve out from benefits provided under Kern Health Systems health plan coverage or additional local or out of area resources that will be financially responsible for the requested service based on
diagnosis or other criteria.

The following denials will be considered Administrative in nature and can be denied by the UM Clinical Intake Coordinator without prior review by the Chief Medical Officer or their designee(s) for Medi-Cal:

- Referral to Kern Regional Center
- Referral to Mental Health
- Referral to Search and Serve
- Referral for CCS covered conditions
- Referral for VSP services
- Retrospective referral requests received more than sixty (60) calendar days from date of service
- Duplicate requests for services that have already been approved and not yet utilized
- Co-Signatures from provider or supervising provider for mid-level or resident not on referral request.

KHS UM Clinical Intake Coordinators apply critical thinking skills and sound judgment prior to performing an administrative denial. These administrative denials can only be performed if they will not subject the member to a poor outcome based on the decision for service. Administrative denials are exempt from the appeal process.

If the UM Clinical Intake Coordinator is unable to determine if the denial would adversely affect the member or uncertain of the type of denial, the UM Clinical Intake Coordinator should forward the denial to a Chief Medical Officer, or their designee(s) for review and recommendations.

4.2.5 Denials to Terminally Ill Members

KHS is required to provide members and providers with notification of denial for a prior authorization request for services within 5 business days or less. The notification to the member will provide all of the following information:

a. Statement clearly explaining the specific medical and scientific reasons for denying coverage.
b. Description of any alternative treatments, services, or supplies covered by the plan, if any.
c. Information regarding member's rights, including appeal and grievance options and forms.
d. Copies of KHS grievance procedures or complaint form, or both. The complaint form shall provide an opportunity for the enrollee to request a conference as part of KHS grievance system provided under Section 1368(a)(3). See KHS Policy and Procedure #5.01-P: Grievance Process for additional information.

Formatted: Indent: Left: 1"

A terminal illness is defined as an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of covered services shall be provided for the duration of a terminal illness, which may exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a new enrollee.

4.3 Provider and Member Notification

Results of the utilization review for non-urgent referrals are communicated by UM staff to the provider and member as outlined in the following table. Notification to providers is provided via the method of submission, either online portal, mail, or facsimile.[20]

The term "Action," has been replaced with "Adverse Benefit Determination." The definition of an "Adverse Benefit Determination" encompasses all previously existing elements of "Action" under federal regulations with the addition of language that clarifies the inclusion of determinations involving medical necessity, appropriateness, setting, covered benefits, and financial liability.

An "Adverse Benefit Determination" is defined to mean any of the following actions taken by KHS:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
2. The reduction, suspension, or termination of a previously authorized service.
3. The denial, in whole or in part, of payment for a service.
4. The failure to provide services in a timely manner.
5. The failure to act within the required timeframes for standard resolution of Grievances and Appeals.
6. For a resident of a rural area with only one MCP, the denial of the beneficiary's request to obtain services outside the network.

7. The denial of a beneficiary's request to dispute financial liability.

Beneficiaries must receive written notice of an Adverse Benefit Determination. KHS will utilize DHCS-developed, standardized NOA templates for common scenarios (denial, delay, modification, termination) and corresponding "Your Rights" attachments to comply with new federal regulations. The following five distinct NOA templates accommodate actions that MCPs may commonly take:

1. Denial of a treatment or service
2. Delay of a treatment or service
3. Modification of a treatment or service
4. Termination, suspension, or reduction of the level of treatment or service currently underway
5. Carve-out of a treatment or service

~~Effective July 1, 2017,~~ KHS shall utilize the revised NOA templates and corresponding "Your Rights" attachments. KHS shall not make any changes to the NOA templates or "Your Rights" attachments without prior review and approval from DHCS, except to insert information specific to beneficiaries as required. A~~LL~~ll P~~LAN~~lan L~~ETTER~~etter 21-011 ~~SUPERSEDES~~ supersedes A~~LL~~ll P~~LAN~~lan L~~ETTER~~etter 17-006. KHS has updated NOA templates based on the 2021 revision.

Section 1557 of the Affordable Care Act (ACA) prohibits discrimination on the basis of race, color, national origin, sex, age, or disability. On May 18, 2016, the United States Department of Health and Human Services (HHS), Office for Civil Rights (OCR) issued the Nondiscrimination in Health Program and Activities Final Rule to implement Section 1557. Federal regulations require KHS to post nondiscrimination notice requirements and language assistance taglines in significant communications to beneficiaries. "Nondiscrimination Notice" and "Language Assistance" taglines templates provided by DHCS will be used by KHS to make modifications or create new templates. DHCS review and approval must be obtained prior to use. These templates must be sent in conjunction with each of the following significant notices sent to beneficiaries: Adverse Benefit Determination, Grievance acknowledgment letter, Appeal acknowledgment letter, Grievance resolution letter, and NAR.

Result of Review	Provider Notice	Member Notice
Approved	**Referring**: Approved *Referral/Prior Authorization Form* (within 24 hours of the decision).[21] **Specialist**: Approved *Referral/Prior Authorization Form* and any pertinent medical records and diagnostics (within 24 hours of the decision). **OR** **Hospital**: *Hospital Notification Letter* (within 24 hours of the decision). See Attachment to *KHS Policy and Procedure #3.33 – Admission/Discharge Notification and Authorization Process for Contracted Facilities.*	*Notice of Referral Approval* (within 48 hours of the decision). See Attachment B.
Deferred	**Referring**: Copy of Notice of Adverse Determination Letter and the *Referral/Prior Authorization Form* (within 24 hours of the decision)[22]. **OR** **Hospital**: Requests for hospital services are not deferred.	Notice of Adverse Determination Documents (within 2 business days of the decision).[23] Documents include all of the following: ❖ *Notice of Adverse Determination - Delay* letter. (Attachment C) ❖ *Your Rights Under Medi-Cal Managed Care* (Attachment G) Medi-Cal members only ❖ *Form to File a State Hearing* (Attachment H). Medi-Cal members only

Result of Review	Provider Notice	Member Notice
Modified (Initial request for a service or treatment)	**Referring**: Copy of Notice of Adverse Determination Letter and modified *Referral/Prior Authorization Form* (within 24 hours of the agreement).[24] **Specialist**: Modified *Referral/Prior Authorization Form* and any pertinent medical records and diagnostics (within 24 hours of the agreement).	Notice of Adverse Determination Documents. (within 2 business days of the decision).[25] Documents include all of the following: ❖ *Notice of Adverse Determination – Modify* (Attachment D) ❖ *Your Rights Under Medi-Cal Managed Care* (Attachment G) Medi-Cal members only ❖ *Form to File a State Hearing* (Attachment H). Medi-Cal members only
Terminated or Reduced (Subsequent request for a continuing service or treatment that was previously approved)	**Treating:** Copy of Notice of Adverse Determination Letter sent to the member (within 24 hours of the decision).	Notice of Adverse Determination Documents. (within 2 business days of the decision and at least 10 days before the date of action unless falls under exceptions listed in section 4.3.2 of this document).[26] Documents include all of the following[27]: ❖ *Notice of Adverse Determination – Terminate* (Attachment F) ❖ *Your Rights Under Medi-Cal Managed Care* (Attachment G) Medi-Cal members only ❖ *Form to File a State Hearing* (Attachment H). Medi-Cal members only

Result of Review	Provider Notice	Member Notice
Denied (Includes those carve out services that are denied as not covered by KHS).[28]	**Referring**: Copy of Notice of Adverse Determination Letter (within 24 hours of the decision).[29]. **OR** **Hospital**: *Hospital Notification Letter* (within 24 hours of the decision). See Attachment to *KHS Policy and Procedure #3.33 – Admission/Discharge Notification and Authorization Process for Contracted Facilities.*	Notice of Adverse Determination Documents (within 2 business days of the decision).[30]Documents include all of the following: ❖ *Notice of Adverse Determination – Denial* (Attachment E) ❖ *Your Rights Under Medi-Cal Managed Care* (Attachment G) Medi-Cal members only ❖ *Form to File a State Hearing* (Attachment H). Medi-Cal members only

The Notice of Adverse Determination letters together with the indicated enclosures contain all of the required elements for both provider and member notice of delay, denial, or modification including the following[31]:

A. The action taken
B. A clear and concise explanation of the reason for the decision (including clinical reasons for decisions regarding medical necessity)[32]
C. A description of the criteria/guidelines used
D. A citation of the specific regulations or plan authorization procedures supporting the action[33]
E. Information on how to file a grievance with KHS including the Plan's name address and phone number
F. Information regarding a Medi-Cal member's right to a State Fair Hearing including:
    1. The method by which a hearing may be obtained
    2. That the member may either be self-represented or represented by an authorized third party such as legal counsel, relative, friend, or any other person
    3. The time limit for requesting a fair hearing.
    4. The toll free number for obtaining information on legal service organizations for representation.
G. Information regarding the member's right to an Independent Medical Review with DMHC
H. DMHC required language regarding grievances[34]
I. The following information in cases of delay:
    1. Disclosure of the information requested but not received, the expert reviewer to be consulted, or the additional examinations or tests required in order to make a decision
    2. The anticipated date on which a decision may be rendered

J. Name and telephone number of the Chief Medical Officer, or their designee(s)[35]

4.3.1 Urgent Referrals

In the case of urgent referrals, the UM Clinical Intake Coordinator provides written notification to the provider on the same day as the decision via facsimile or the online portal.

4.3.2 Termination or Reduction of a Continuing Service That Was Previously Approved[36]

Use of the *Notice of Adverse Determination – Terminate* letter and the timeliness guidelines outlined in this section apply in any of the following conditions:

A. KHS intends to reduce or terminate authorization for a medical service prior to expiration of the period covered by the authorization.[37]

B. KHS intends to take either of the following actions on a request for non-acute continuing services as defined in the Definitions section of this document:[38]
   1. Termination: Denial
   2. Reduction: Approval at less than the amount or frequency requested and less than the amount or frequency approved on the immediately preceding authorization. There is no reduction if a shorter time period of services than requested is approved, as long as the amount or frequency of services during that period has not been reduced from the previously approved level.

C. KHS intends to terminate (deny) a request for acute continuing services as defined in the Definitions section of this document[39]. There is no termination if less than the full number of days requested is approved. Such notices must be personally delivered to the member in his/her hospital room unless the member's treating physician has certified in writing that such personal delivery may result in serious harm to the member. In such cases, the notice shall be mailed to the member or his/her beneficiary.

Unless specifically covered by one of the exceptions below, KHS will mail the Notice of Adverse Determination Documents to the member at least 10 days before the date of action.[40]

KHS will mail the Notice of Adverse Determination Documents to the member at least 5 days before the date of action if[41]:

A. KHS has facts indicating that action should be taken because of probable fraud by the member; and
B. The facts have been verified, if possible, through secondary sources.

KHS will mail the Notice of Adverse Determination Documents not later than the date of action if any of the following conditions apply[42]:

A. KHS has factual information confirming the death of the member
B. KHS receives a clear written statement signed by the member that:
   1. The member no longer wishes services; or
   2. The member gives information that requires termination or reduction of services and indicates that he/she understands that this must be the result of

supplying that information;

C. The member has been admitted to an institution where he is ineligible under the plan for further services
D. The member's whereabouts are unknown and the post office returns KHS mail directed to the member indicating no forwarding address (See 42 CFR Sec. 431.231 (d) for procedure if the recipient's whereabouts become known);
E. KHS establishes the fact that the recipient has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth
F. A change in the level of medical care is prescribed by the member's physician;

4.3.2.1 State Fair Hearings Regarding Terminations or Reductions

In cases where a State Fair Hearing is pending for a terminated or reduced service, authorization for services shall be maintained or begin as outlined in California Code of Regulations Title 22 §51014.2.

5.0 Retrospective Authorization Request:

Retrospective authorization request may be submitted within sixty (60) calendar days of the date of service for outpatient/office visits/procedures that are identified as an additional procedure performed during an authorized visit or an unauthorized visit or procedure that is deemed urgent or emergent. All supporting documentation must be included with the request. Any outpatient/office referral request that requires prior authorization received by KHS with a date of service greater than sixty (60) calendar days will be denied by the UM Clinical Intake Coordinator. UM Clinical Intake Coordinators will review the retrospective request and approve if the information received meets medical necessity for the services rendered, and the services were in conjunction with an approved visit or are identified as urgent or emergent in nature**.** All retrospective reviews will be completed within 30 calendar days. Failure to obtain prior authorization by the provider due to eligibility verification for previously scheduled appointments are not considered urgent or emergent requests. A Notice of Adverse Determination Denial Letter will be generated if the referral is denied. Providers are encouraged to contact KHS UM department directly via phone at 1-800-391-2000 if an authorization is needed for the same day. Most requests can be accommodated if documentation is received for review to determine medical necessity.

If KHS is not notified of a hospital admission, the decision for authorization request may also be submitted within sixty (60) calendar days from date of admission. All supporting documentation must be included with the request for retrospective authorization. The UM Nurse RN will review the retrospective request and approve if the information received meets medical necessity for the services rendered. All retrospective reviews will be completed within 30 calendar days. Authorization for payment may not be given if facility fails to notify KHS of admission and the admission is other than emergent in nature. A Notice of Adverse Determination Denial Letter will be generated if the referral is denied.

5.1 Claim Denials for Services Performed without Obtaining Prior Authorization:

Claims submitted by KHS contract and non-contract providers are matched against authorizations entered into the claims payment system. Providers are required to determine a member's eligibility and obtain prior authorization before initiating non emergent services. If

the provider fails to obtain prior authorization or retrospective authorization as defined in 5.0 for non-emergent services, the claim(s) for those services will be denied. Procedures and services for which no authorization paperwork is required are described in KHS Policy and Procedure 3.25-P: Prior Authorization Procedures and Services.

Requests for retrospective payment for unauthorized services may be reviewed at the discretion of the health plan, and the decision to review will be based on the documentation submitted detailing the extenuating circumstances that explains why the prior authorization request was not submitted. All such requests must include complete medical records. Requests for retrospective authorization submitted only with records, will not be reviewed for medical necessity; but, instead denied as prior authorization was not obtained.

Providers may submit a Claims Dispute in accordance with KHS Policy 6.04-P.

6.0 STANDING REFERRALS[43]

Occasionally a member will have a disease that requires prolonged treatment by or numerous visits to a specialty care provider. Once it is apparent that a member will require prolonged specialty services, UM may issue a standing referral to a specialist or specialty care center that has expertise in treating the condition or disease for the purpose of having the specialist coordinate the members health care. The referral shall be made if the primary care physician, in consultation with the specialist or specialty care center if any, and the Chief Medical Officer or their designee(s) determines that this specialized medical care is medically necessary for the enrollee. A standing referral is an authorization that covers more visits than an initial consultation and customary follow-up visits and typically includes proposed diagnostic testing or treatment without the primary care physician having to provide a specific referral for each visit. A treatment plan may be deemed to be not necessary provided that a current standing referral to a specialist is approved by KHS.

Conditions that may be best treated using a standing referral may be life-threatening, degenerative, or disabling and include, but are not limited to, HIV and AIDS.

A standing referral and treatment plan may limit the number of visits to the specialist, limit the period of time that the visits are authorized, or require that the specialist provide the primary care physician with regular reports on the health care provided to the member. After the referral is made, the specialist shall be authorized to provide health care services that are within the specialist's area of expertise and training to the member in the same manner as the member's primary care physician, subject to the terms of the treatment plan. It is only valid during periods when the member is eligible with KHS.

A standing referral may be issued to contracted or non-contracted providers as deemed appropriate by the Chief Medical Officer, or their designee(s). The Chief Network Administration Officer, or their designee(s), will negotiate letters of agreement for services not available within the network. Members with a need for a standing referral are referred to providers who have completed a residency encompassing the diagnosis and treatment of the applicable disease entity. Members with a need for a standing referral to a physician with a specialized knowledge of HIV medicine are referred to an HIV/AIDS specialist as outlined in *KHS Policy and Procedure #4.01-P: Credentialing*.

Determinations regarding standing referrals are made within three business days of the date of request

and receipt of all appropriate medical records and other items of information necessary to make the determination. Once a determination is made, the referral is made within four business days of the date the proposed treatment plan, if any, is submitted to the plan Chief Medical Officer, or their designee(s).[44]

6.1 Treatment Plan

The Chief Medical Officer or their designee(s) may require the treating provider to submit a treatment plan setting forth the expected course of diagnosis and treatment including projected number of visits, proposed therapies, requirements for communication between the treating provider and PCP, and a means for assessing the patient. A treatment plan may be deemed not necessary provided that the appropriate referral to a specialist or specialty care center is approved by KHS or its contracting provider. The Chief Medical Officer, or their designee(s) reviews the treatment plan for appropriateness and may use specialists to assist in the review as needed.

7.0 CRITERIA AND GUIDELINES[45]

Review criteria are consistently applied. Review criteria include, but are not limited to:

A. Medi-Cal guidelines-DHCS/DMHC~~MCG (Milliman Care Guidelines)~~

B. ~~H~~MCG (Milliman Care Guidelines)~~ospice criteria~~

C. Up to Date~~DME criteria~~

D. ~~Level of care – skilled vs. custodial~~ guidelines~~Nationally Accredited Scholarly~~Professional Society Organizations

Examples:

a. American Academy of Pediatrics

b. American Academy of ~~Orthopaedic~~Orthopedic Surgeons

c. American College of Cardiology

~~E. Medi-Cal guidelines-DHCS/DMHC~~

~~F. Medicare guidelines~~

~~G. Internally developed criteria using evidence based, national clinical standards by KHS licensed professional and processed through various internal committee for review, adoption, and final implementation.~~

~~H. Up to Date~~

KHS discloses or provides for disclosure to the commissioner, contract providers, or enrollees, the process and criteria KHS uses to authorize, modify, or deny health care services under the benefits provided by the Plan, including coverage for subacute care, transitional inpatient care, or care provided in skilled nursing facilities.[46]

~~The criteria are:~~

~~A. Developed with the involvement of KHS committees made up of practicing health care providers as outlined in *KHS Policy and Procedure #3.04-I*~~

~~B. Developed using sound clinical principals and processes as appropriate~~

~~C. Evaluated and updated if necessary at least annually~~

~~D. Disclosed to the provider and enrollee if used as basis for a decision to deny, delay, or modify services in a specified case under review~~

Formatted: Font: Times New Roman, 12 pt

Formatted: Font: Times New Roman, 12 pt

Formatted: Font: Times New Roman, 12 pt

Formatted: Indent: Left: 0"

Formatted: Indent: Left: 0.25", First line: 0", Tab stops: Not at 1.38" + 2.5"

Formatted: Indent: Left: 0.25", Tab stops: Not at 1.38" + 2.5"

Formatted: Indent: Left: 0.25", First line: 0", Tab stops: Not at 1.38" + 2.5"

7.1 Disclosure of Criteria to the Public

KHS makes available to the public upon request, criteria or guidelines for specific procedures or conditions requested. [47] Beneficiaries may request, free of charge, copies of all documents and records relevant to the NOA, including criteria or guidelines used.

All requests for criteria/guidelines from the public are directed to the Chief Health Services Officer or their designee. He/she speaks with the requestor and makes the necessary arrangements to provide a copy of the criteria/guideline and cover letter. (See Attachment I). The request is logged in the *Public Request for Criteria Log*. (See Attachment J).

8.0 APPEALS PROCESS

Both providers and members may appeal a denied/modified referral.

Provider appeals must be submitted and are processed in accordance with *KHS Policy and Procedure #3.23-P: Practitioner/Provider Appeals Regarding Authorization*. Member appeals must be submitted and are processed in accordance with *KHS Policy and Procedure #5.01-P: Grievance Process*.

DHCS has deemed it necessary to create two distinct "Your Rights" attachments to accommodate the following scenarios:

1) Beneficiaries who receive a NOA and
2) Beneficiaries who receive a Notice of Appeal Resolution (NAR). A NAR is a formal letter informing a beneficiary that an Adverse Benefit Determination has been overturned or upheld.

While the "Your Rights" attachment sent out to beneficiaries who receive a NOA will contain general information on State Hearing and IMR rights, the notice will primarily inform the beneficiary on how to request an Appeal with KHS. A State Hearing form will not be attached, as the beneficiary would need to exhaust the MCP's Appeal process first. Similarly, an IMR form will not be attached, as the beneficiary would also need to exhaust the MCP's Appeal process prior to requesting an IMR unless the Department of Managed Health Care (DMHC) determines that an expedited review is warranted due to extraordinary and compelling circumstances. Requirements pertaining to IMRs remain unchanged.

Conversely, the "Your Rights" attachment sent out to beneficiaries who receive a NAR that upholds the original Adverse Benefit Determination will not contain information on how to file a request for an Appeal as the beneficiary will have already exhausted the MCP's Appeal process. The notice will primarily inform the beneficiary on how to request a State Hearing and/or IMR. State Hearing and IMR application forms will be attached as appropriate.

9.0 SPECIALIST SERVICES

Upon receipt of authorization from KHS, the specialist provides the authorized medical services within the normal scope of the designated specialty. In compliance with access standards, specialists should contact members to schedule appointments for care following the receipt of authorizations.

9.1 PCP Notification

The specialist is required to communicate the assessment, findings, and recommended treatment plan to the member's PCP in writing in a timely manner as the patient's condition warrants.

It is the responsibility of the PCP to contact the specialist should the PCP disagree with the diagnostic or treatment plan of the specialist and/or additional services authorized by the plan. In the case of continued disagreement between the PCP and the specialist, the specialist and/or PCP should contact the KHS Chief Medical Officer, or their designee(s), who will take appropriate action.

9.2 Requests for Authorization of Additional Services

Specialists must initiate a referral for all services not authorized on the initial referral form that require prior authorization as outlined in *KHS Policy and Procedure 3.25-P: Prior Authorization Procedures and Services.* Referrals from specialists are handled in the same manner as referrals from PCPs.

9.3 Specialty Consultations via Telemedicine

Telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve the member's clinical health status through the use of two way video, email, smart phones, wireless tools and other forms of telecommunications technology. No prior authorization is required for all consultations performed utilizing telemedicine and limited to those KHS contracted providers who have demonstrated adequate office space, availability of a patient navigator, and suitable telemedicine equipment to connect with a remote medical group.

10.0 REFERRAL GUIDELINES FOR SPECIFIC TYPES OF CARE

Prior authorization requirements for specific services can be found in the scope of services policy. Procedures and services for which no authorization paperwork is required are described in *KHS Policy and Procedure 3.25-P: Prior Authorization Procedures and Services*.

10.1 Coordination of Covered Services[48]

KHS shall arrange for the timely referral and coordination of covered services if a member's provider has a religious or ethical objection to perform various types of services.

The UM Department will arrange and coordinate the services by referring the member to another provider who does not have religious or ethical objections in providing the covered services. The process for the coordination of care shall not generate additional expenses to DHCS.

11.0 DOCUMENTATION, TRACKING, AND MONITORING [49]

Letters regarding authorization requests, including those sent by KHS to both members and providers, are retained as outlined in *KHS Policy and Procedure #10.51-I: Records Retention.*[50]

KHS tracks all referral requests through the KHS computerized MIS system. Requests are entered into the system at the time of authorization. The UM Department maintains adequate staffing to manage referrals in a timely manner.

For referrals that contain requests for medications, the KHS UM Clinical Intake Coordinators will

review guidelines for appropriateness. Referrals may be routed to the Pharmacy department, as appropriate, for determination of medical necessity. The Pharmacy department will notify the UM department within 24-hours of the decision.

On occasion, referrals will be routed to the Health Education department for further review. Health Education will notify the UM department within 24-hours of the results of the review.

If a potential quality of care is identified during review of medical records for prior authorization or concurrent review requests, the UM staff will notify the QI department via currently defined processes for review. After the initial screening is completed, the QI RN drafts a summary of findings. The nurse will assign the review to the QI Medical Director or their physician designee to determine whether a Quality of Care Issue exists and to take action. The QI Medical Director or their physician designee reviews the records for internal or external quality of care issues and opportunities for improvement. The QI nurse works with the QI Medical Director or their physician designee for any follow up actions requested. Follow up action may include both internal and external opportunities for improvement. Internal issues will be discussed with the relevant department(s) and a mitigation plan developed as appropriate. The QI nurse and QI Medical Director or their physician designee will coordinate for external quality of care issues to identify who will communicate with the external provider and the necessary follow up actions. See *KHS Policy and Procedure #2.70 – Potential Inappropriate Care (PIC)* for details on the QI PIC review process.

Where indicated a referral to KHS's other medical management programs such as Case Management will be made to manage complex or challenging member issues.

It is the PCPs responsibility to track referrals and follow-up care. To assist in this effort KHS provides the PCP with access to view submitted referrals through an online provider portal. Providers/vendors are able to monitor the referrals received, closed and decision dates. The PCP should investigate all open authorizations and follow up with the member as necessary. PCP follow-up and documentation is monitored by the Quality Improvement Department through facility site review.[51]

KHS will conduct random audits quarterly to document department compliance with documentation of provider notification within 24 hours of decision by method of submission.

KHS will conduct random audits quarterly for purposes of compliance with the referral process and identifying any correspondence issues. Issues will be brought to the attention of the Director of Utilization Management for corrective action.

An Inter-Rater Reliability (IRR) process is deployed to evaluate and ensure that UM criteria are applied consistently for UM decision-making. Bi-annually, both physicians and staff involved with making UM decisions participate in the IRR process. Results are reported to Compliance Department, Chief Medical Officer, and Chief Health Services Officer.

Semiannual random audits are conducted by the Director of Compliance to ensure staff compliance requirements related to member and provider notification of deferred, modified, and denied referrals. A sample of thirty deferred, thirty modified, and thirty denied referrals are reviewed semi-annually. Any unjustified non-compliant trend is discussed with the responsible UM Clinical Intake

Coordinator. Results of the audit are reported as outlined in *Section 14.0 – Reporting.*

KHS monitors under- and over-utilization of services through various aspects of the UM process. Through the referral authorization process, the UM Clinical Intake Coordinator/UM Nurse monitors under and over-utilization of services and intervenes accordingly. The UM department monitors underutilization of health service activities through collaboration with the QI department.

Concerns for possible overutilization or fraud, waste, or abuse by a provider are evaluated using various reports and analytics. Appropriate follow up is completed to ameliorate any identified adverse trends and may include any of the following:

a. Provider education on criteria and/or documentation requirements.
b. Discussion with provider or provider's staff on concerns or trends noted.
c. Referral to Physician Advisory Committee and/or Fraud, Waste, Abuse Committee.
d. Provider corrective action plan (CAP) as outlined in *KHS Policy and Procedure #4.40-P Corrective Action Plans.*

Formatted

Formatted

Formatted

Formatted

12.0 PCP FOLLOW-UP AND DOCUMENTATION

It is the responsibility of the PCP to follow-up with the specialist to ascertain the results of care and fulfill the responsibilities of PCP.

PCP office staff should coordinate and confirm the specialist appointment and notify the patient either in person or by phone. The PCP should call the specialist if necessary and must complete a referral slip for office staff to schedule an appointment for the patient. The patient should be provided with the specialist's name, address, and phone number. If prior authorization is required for the appointment, office staff should date a copy of the referral slip and place in a tickler file system for future follow up. Upon receipt of authorization, the appointment should be scheduled and patient notified.

PCP office staff should call specialists to follow-up on appointments. Any missed appointments should be documented in the member's medical record. PCP office staff should contact the member to encourage him/her to reschedule the appointment. Contacts with the member should be documented in the member's chart.

A log of all external referrals should be maintained to ascertain receipt of consult reports. The specialist should be contacted if the report is not received in a timely manner.

Documenting emergency and follow-up care in the patient medical record and monitoring and follow-up of on-going conditions, medications, and abnormal diagnostic reports are responsibilities of the PCP. PCPs should review all diagnostic tests (lab, x-ray, etc.) and consult reports within 10 days of receipt. The PCP should initial and date all diagnostic test results and consult reports prior to filing in the medical record. PCP staff should follow-up on all diagnostic test results not received in a timely manner.

The PCP shall work in a cooperative manner with KHS and Utilization Management personnel to monitor and manage hospital admissions (either by the PCP, designated hospitalist or treating specialist), continued stay, and hospital discharge planning and documentation of same.

13.0 REPORTING

Reports are submitted as outlined in the following table.

Reported To	Report	Due Date	Responsibility
QI/UM Committee	Results of UM referral audits	Semi-annually	Director of Utilization Management
QI/UM Committee	Results of QI audit of referral follow up by PCP as described in *Section 11.0 – Documentation, Tracking, and Monitoring*	Quarterly	Director of Quality Improvement,

14.0 DELEGATED OVERSIGHT

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

ATTACHMENTS:

Attachment A: *Referral/Prior Authorization Form*
Attachment B: *Notice of Referral Approval*[52]
Attachment C: *Notice of Action - Delay*[53]
Attachment D: *Notice of Action - Modify*[54]
Attachment E: *Notice of Action - Denial*[55]
Attachment F: *Notice of Action - Terminate*[56]
Attachment G: *Your Rights Under Medi-Cal Managed Care*[57]
Attachment H: *Form to File a State Hearing*[58]
Attachment I: *Public Letter – Criteria Request*
Attachment J: *Public Request for Criteria Log*
Attachment K: *Re-classification Letter*

REFERENCE:

2021-11: APL 21-015 Major Organ Transplant; MOT 1: Exhibit A, Attachment 5, Provision 1-5; APL 20-011; California Advancing and Innovating MEDI-CAL (CALAIM) APL Attachment 1 Major Organ Transplants Requirements **2021-04:** Minor revision to language in section 4.2.3 by Director of Utilization Management. **2021-04:** Revisions by Director of Utilization Management per DMHC policy checklist review. **2020-10:** Revisions by Director of Utilization Management to specify behavioral and medical services. **2020-08:** Revisions by Director of Utilization Management for retrospective authorization timeframes and per DMHC Routine Survey (Audit) findings regarding denials to terminally ill members, Notice of Action (NOA) attachment updated to reflect current KHS address. **2018-11:** Updated per APL-18-013 Hepatitis C Virus Treatment Policy by Administrative Director of Health Services. **2018-05**: Revisions by Administrative Director of Health Services per Mega Regulations and DHCS contract updates. Types of Services updated, titles updated, attachments updated. Additional language added in November 2017 on modified services. [1] **2016-09:** Recommendation by Dr. Bennetts to remove reference to Policy 3.44 in §4.2.3. during the DMHC 1115 Waiver SPD/DMHC Routine Survey (Audit). **2015-03:** Administrative Director of Health Services removed NO prior authorization references. **2014-08:** Formatting changes to policy, no material changes. Notice of Action letters **(**NOAs) revised as a result of the DHCS 2013 Medical Audit ending in 2014- CAF-9. "Your Right's Forms" updated to ensure continued compliance. Translation changes made to comply with MMCD APL

05005. **2013-07:** Revision provided by Chief Operating Officer concerning retrospective authorization request. Policy approved by KHS Board of Directors July 2013. 2004 DHS Contract Exhibit A-Attachment 5(1)
[2] 22 CCR §51003(c)(2)
[3] 22 CCR §51003(c)(1). List only includes applicable services.
[4] 2004 DHS Contract Exhibit A – Attachment 5 (2)(F)
[5] HSC §1371.4; 2004 DHS Contract Exhibit A-Attachment 5(2)(F)
[6] New DHS Contract 03-76165 does not contain any definition for sensitive services nor does it include sensitive services in the list of no prior auth services (A-5(2)(F)). The DHS/DMHC Medical Audit (YE Oct03) Finding 1.2.2 is based on the old contract provision 6.5.9.4. Decision was made to go ahead and make policy comply with old contract.
[7] 2004 DHS Contract Exhibit A-Attachment 5(3)(I)
[8] CCR Title 22§53855(a); 2004 DHS Contract Exhibit A-Attachment 5(3)(C)
[9] CCR Title 22§53855(a); 2004 DHS Contract Exhibit A-Attachment 5(3)(B)
[10] HSC §1367.01(g)
[11] ~~Per management request.~~
[12] Definition of urgent request from HSC 1367.01(h)(2)
[13] HSC §1367.01(h); 2004 DHS Contract Exhibit A-Attachment 5(3)(G)
[14] HSC §1367.01(h)(2). Requirement is 72 hours, but per A. Watkins, urgent referrals are processed within 48 hours.
[15] HSC 1367.01 (h)(1); 2004 DHS Contract Exhibit A-Attachment 5(3)(D)
[16] HSC 1374.16(c)
[17] HSC 1367.01 (h)(3)
[18] 14 day requirement found in DHS Contract 03-76165 Exhibit A-Attachment 5 (3)(G). CCR Title 22 Section 53894(b) superceded by the more strict 14 day requirement.
[19] HSC §1367.01(e); 2004 DHS Contract Exhibit A-Attachment 5(2)(A)
[20] HSC §1367.01(h)(4)
[21] HSC §1367.01(h)(3)
[22] Written notice required. HSC §1367.01(h)(3)
[23] Written notification required. HSC §1367.01(h)(3) and (4)
[24] Written notification required. HSC §1367.01(h)(3) and (4)
[25] Written notification required. HSC §1367.01(h)(3) and (4)
[26] Written notification required. HSC §1367.01(h)(3) and (4); 42 CFR §431.211 – 10 day prior to action requirement.
[27] Although the NOA Letter does not indicate any enclosures, it is not clear why the requirements to provide notice would not apply cases of termination or reduction. As such, KHS will include the same enclosures as included with the other types of NOA letters.
[28] (8/31/05). KHS previously sent carve out letters instead of denial notices. DHS has stated that they do not see an exemption for carve out services in SB59 and will not approve ICE's request to substitute a carve out letter for the NOA. ICE has recommended that Plans use the NOA for carved out services.
[29] Written notification required. HSC §1367.01(h)(3) and (4)
[30] Written notification required. HSC §1367.01(h)(3) and (4)
[31] HSC §1367.01(h)(4) and (5) and 1367.24(b); CCR Title 22 §53894
[32] DHS Contract 03-76165 Exhibit A – Attachment 5 (2)(C)
[33] Required for member notice only. CCR Title 22 §53894(d)(3)
[34] Required for member notice only. HSC §1367.24(b)
[35] Only required for provider notice. Although it is not required for member notice, since provider notice is a copy of the member notice, the information is included in the member notice. HSC §1367.01(h)(4)
[36] MMCD Letter 04006 page 3 #5.
[37] 22 CCR §51014.1(c)
[38] 22 CCR §51014.1(e)
[39] 22 CCR §51014.1(f)
[40] 42 CFR §431.211
[41] 42 CFR §431.214
[42] 42 CFR §431.213. Two exceptions in the regs regarding skilled nursing facilities are not included in this policy.
[43] AB1181(Escutia 1998); HSC §1374.16; DHS Contract 03-76165 Exhibit A-Attachment 9(5)
[44] HSC 1374.16(c)
[45] DHS Contract 03-76165 Exhibit A – Attachment 5 (2)(B)
[46] Health and Safety Code §1363.5
[47] Health and Safety Code §1363.5
[48] DHCS Contract Exhibit A – Attachment 9 (4)

[49] HSC §1367.01(j)
[50] DHS Contract 03-76165 Exhibit A – Attachment 5 (2)(G)
[51] CAP response for DHS/DMHC Medical Audit (YE Oct03).
[52] Must include specific service approved (HSC §1367.01(h)(4)
[53] Exact letter required by MMCD 04006 and 05005.
[54] Exact letter required by MMCD 04006 and 05005.
[55] Exact letter required by MMCD 04006 and 05005.
[56] Exact letter required by MMCD 04006 and 05005.
[57] Exact letter required by MMCD 04006 and 05005.
[58] Exact letter required by MMCD 04006 and 05005.

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Prior Authorization Services and Procedures				POLICY #: 3.25-P	
DEPARTMENT: Utilization Management					
Effective Date: 2005-11	Review/Revised Date: 2/14/2022	DMHC		PAC	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

_____ Date _____
Douglas A. Hayward
Chief Executive Officer

_____ Date _____
Chief Medical Officer

_____ Date _____
Deputy Chief Medical Officer

_____ Date _____
Chief Operating Officer

_____ Date _____
Chief Health Services Officer

_____ Date _____
Director of Claims

_____ Date _____
Director of Utilization Management

POLICY:
Procedures/Services included on the *Prior Authorization List* require prior authorization or submission of a Referral/Authorization to KHS ~~in order for~~for claims to be paid for eligible members. All service and procedure request require submission of a *Referral/Prior Authorization form* for approval and/or tracking purposes.

PROCEDURE:

Authorization paperwork is required of the provider for services indicated on the *Prior Authorization* list. Providers are responsible to determine whether a service is on the ~~aforementioned list~~list requiring prior authorization. If prior authorization is not required as indicated by the ~~procedures~~procedure's absence from the prior authorization list, the provider may directly refer a member for services without submitting a *Referral/Prior Authorization Form, either via the online provider portal or fax* at 661-664-5190 to the KHS UM Department. Providers may make an appointment or make arrangements for eligible KFHC members to receive services by KHS contract providers. The Prior Authorization list can be accessed via the Kern Health Systems website at: *http://www.kernfamilyhealthcare.com/files/PA_List.pdf*.

Formatted: Left

The table below lists additional services that are automatically paid if the listed restrictions are met.

SERVICE	RESTRICTIONS
Abortion Services	Prior authorization required for inpatient hospitalization See *KHS Policy and Procedure #3.21 – Family Planning Services and Abortion*
Family Planning	See *KHS Policy and Procedure #3.21 - Family Planning Services and Abortion* Medi-Cal Members may see any qualified contracted or non-contracted provider.
Pregnancy Care	The provider must comply with the utilization protocols related to authorization of additional care scheduled after the member's initial visit. Prior authorization is required for specialty procedures in the OB/GYN area (e.g., amniocentesis and hysterectomy) See *KHS Policy and Procedure #3.24 - Pregnancy and Maternity Care*

Formatted Table

Some prior authorization requests can be initiated by the provider and approved via the KHS online provider portal. If the service is a covered benefit and the provider enters clinical documentation that supports~~,~~ ~~–~~the medical necessity of the requested service, the service will be approved. ~~These specific authorizations are~~Random audits are ~~randomly audited~~ conducted quarterly to review for efficacy of the process and to determine if the services would be deemed medically necessary by the KHS Chief Medical Officer or an appointed delegate. Audit outcomes will be reported to the QI/UM Committee for review and discussion as warranted.

Formatted: Indent: Left: 0.48", First line: 0.02"

~~**REFERENCE:**~~

Revision 2022-02: Revised by Director of Utilization Management 2021-09: –Revised by the Director of Utilization Management to comply with Major Organ Transplant deliverables**. Revision 2017-08:** Updated by Administrative Director of Health Services to include new language and link to new Prior Authorization list. **Revision 2015-03:** Attachment revised by Administrative Director of Health Services. **Revision 2011-11:** Attachment A revised by Director of Health Services. New Attachment D Pediatrics no Authorization list added. **Revision 2011-08:** No

revision to policy. Attachment A update by Director of Health Services. **Revision 2010-10:** Routine review, updated Attachment A – No Authorization list. **Revision 2006-05:** Revised Attachment A. Revision 2005-11: Revised Attachment A. Revision 2005-06: Created per CEO request.

KERN HEALTH SYSTEMS
HEALTH EDUCATION, CULTURAL AND LINGUISTIC ACTIVITIES REPORT
4th Quarter 2021

Report Date: January 6, 2022

OVERVIEW

Kern Health Systems' Health Education (HE) department provides comprehensive, culturally and linguistically competent services to plan members with the intent of promoting healthy behaviors, improving health outcomes, reducing risk for disease and empowering plan members to be active participants in their health care.

The Executive Summary below highlights the larger efforts currently being implemented by the HE department. Following this summary reflects the statistical measurements for the Health Education department detailing the ongoing activity for Q4 2021.

- **Asthma Mitigation Project** – Outreach efforts continue to take place to enroll members into the program in collaboration with the Central California Asthma Collaborative. More than half of the targeted enrollment goal of 230 members has been achieved.

- **Population Needs Assessment –** Data collection efforts and updates are currently underway. Final report and action plan are due to DHCS by June 30, 2022.

- **Baby Steps Program –** The steering committee met in January on the progress of the 2021 activities and activities planned for 2022. Accomplishments in 2021 include adding information on the Baby Steps Program on the KHS website, adding information on the COVID-19 vaccine in the monthly health guide mailings, obtaining member feedback, and facilitating staff in-services. Activities planned for 2022 will include changes to the member portal, identifying new targeted populations, collecting provider feedback, and continuation of staff in-services.

- **Diabetes Prevention Program –** The Health & Wellness Department launched their 2nd DPP cohort on February 2nd, 2021. This year-long program consists of 26 classes held remotely until such time that we are able to resume face-to-face meetings. A total of 90 members accepted the invitation to participate and 51 members attended the first session. Of the 36 members that were still enrolled at the beginning of the quarter and with 25 sessions now completed, 36 remained enrolled in the program at the end of December

- **Cultural and Linguistics Program –** The C&L Bilingual Glossary is in the process of being updated to ensure consistency and to prevent repetitive translation efforts. Translation audits are currently being conducted to verify medical terms that have been added to the Notice of Actions (NOA) letters, grievance letters, and to the KFHC Member Handbook (EOC). There are currently 162 new medical terms that require a translation and definition. Once completed, this glossary will be disseminated amongst KHS departments who conduct in-house translations.

- **Tobacco & Nicotine Cessation Classes** – The California Smoker's Helpline changed its name to Kick It California. Discussions are currently underway on partnering with Kick It California to perform outreach to members identified as users of tobacco and nicotine. An annual educational mailing promoting KHS' Fresh Start Classes is planned for the 1st quarter.

- **School Wellness Grant Program** – KHS will be launching a new cycle of this grant program by the 2nd quarter. This grant program funds schools to implement school wellness programs that aim to improve the physical, social, emotional and behavioral health and wellbeing of students.

- **Student Behavioral Health Incentive Program** – DHCS launched this incentive program in January to expand student access to behavioral health services among Medi-Cal beneficiaries. KHS has had several discussions with Kern County Superintendent of Schools, Kern Behavioral Health and Recovery Services, Health Net and Kaiser with an intent to collaborate and apply for this funding for the county

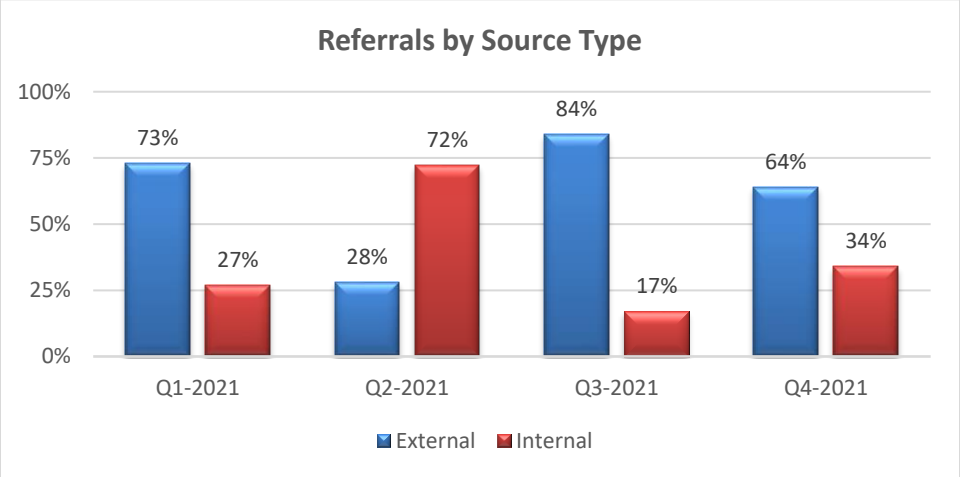
Respectfully submitted,

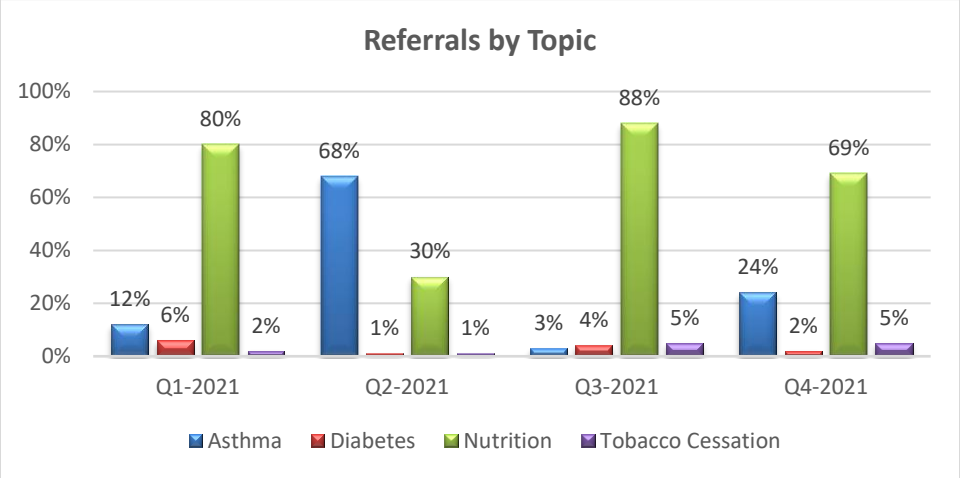
Isabel Silva, MPH, CHES
Director of Health Education, Cultural and Linguistic Service

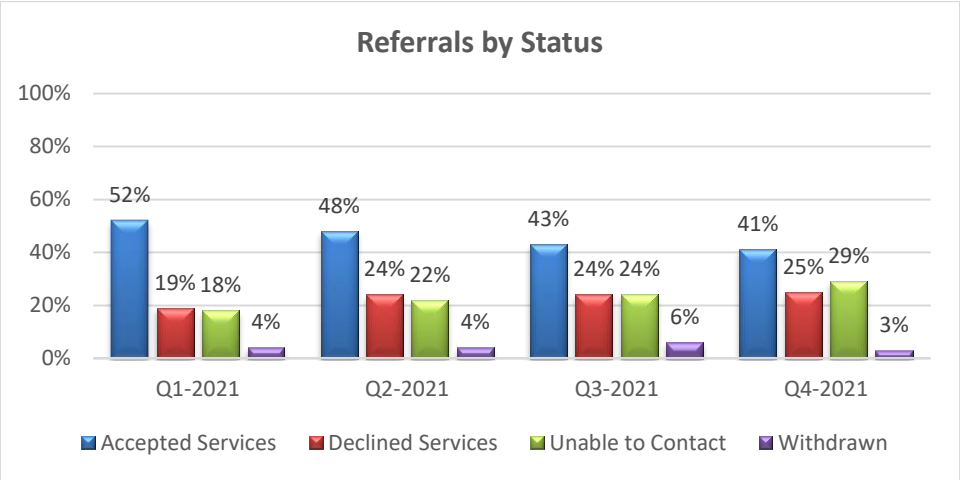
KERN HEALTH SYSTEMS
HEALTH EDUCATION, CULTURAL AND LINGUISTIC ACTIVITIES REPORT
4th Quarter 2021

Referrals for Health Education Services:

Kern Health Systems (KHS) Health Education Department (HE) receives referrals from both internal and external sources. Internal referrals are received from KHS' member facing departments such as Utilization Management, Member Services and Case Management. Externally, KHS providers, members and community partners can request health education services by calling KHS or submitting requests through the member or provider portals. During Q4 2021, there were 835 referrals for health education services which is a 12% increase in comparison to the previous quarter. Requests for Nutrition Education continues to be the primary reason for health education services. Additionally, the rate of members who accepted to receive health education services decreased from 43% in Q3 2021 to 41% in Q4 2021.

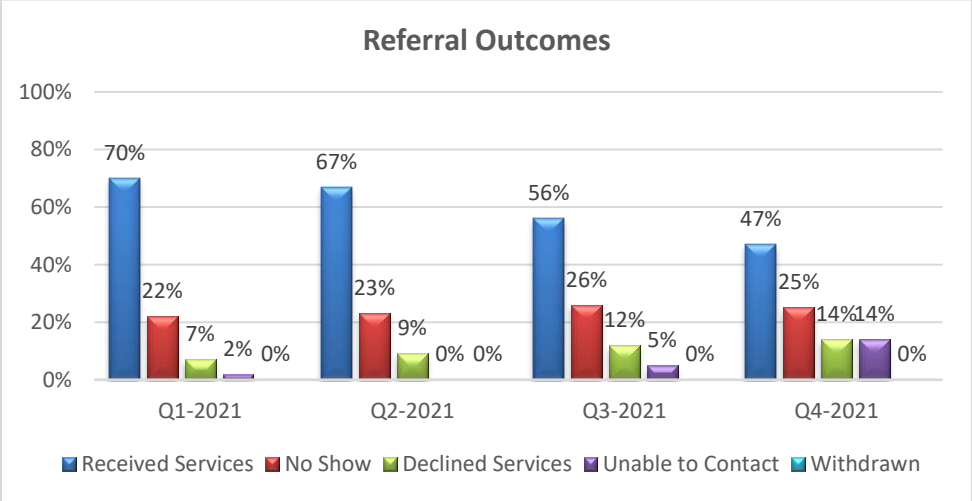






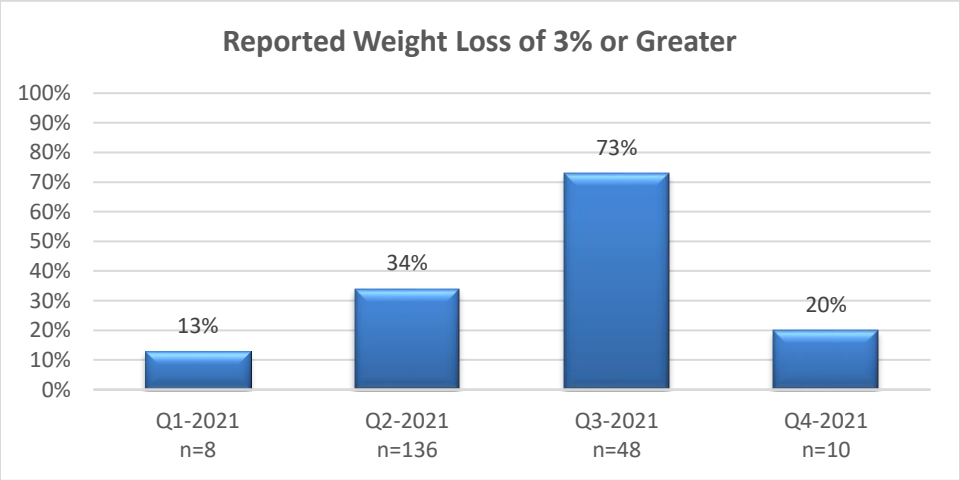
Health Education Referral Outcomes

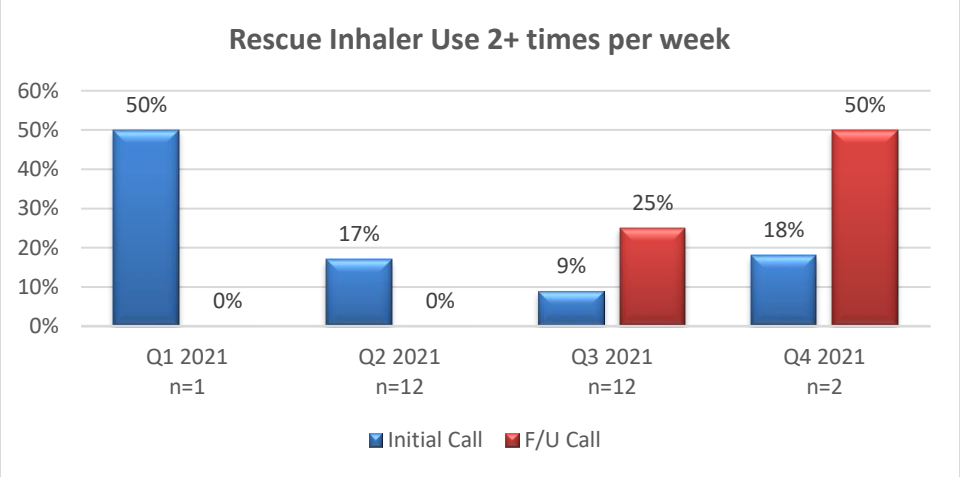
KHS offers various types of services directly through the KHS HE department or through community partnerships. Services through KFHC continues to be the largest share of referral outcomes at 99% for Q4 2021. The rate of members who received health education services decreased from 56% in Q3 2021 to 47% in Q4 2021. The rate of members who do not show for services continues to average at about a quarter of registrants.

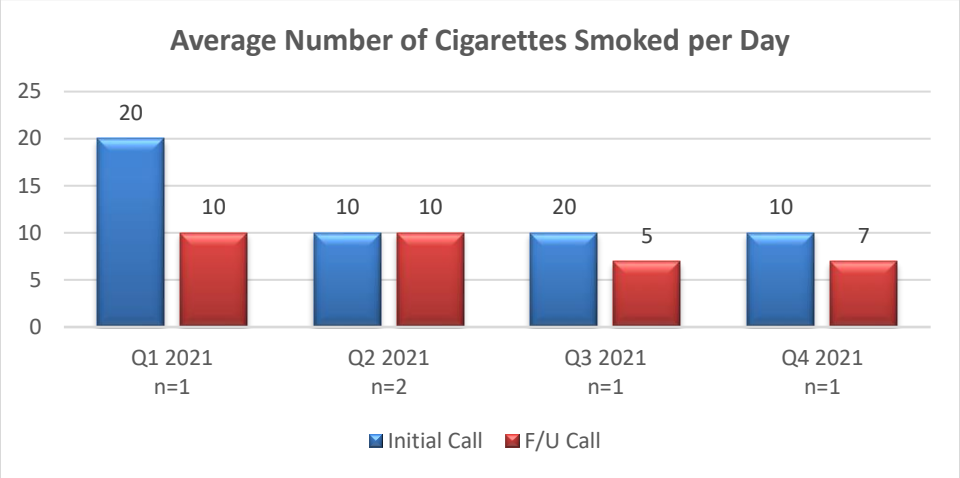


Effectiveness of Health Education Services

To evaluate the effectiveness of the health education services provided to members, a 3-month follow up call is conducted on members who received services during the prior quarter. Of the 12 members who participated in the 3-month follow up call, 10 received Nutrition Education, 1 received Tobacco Cessation and 2 received Asthma Education All findings are based on self-reported data from the member.

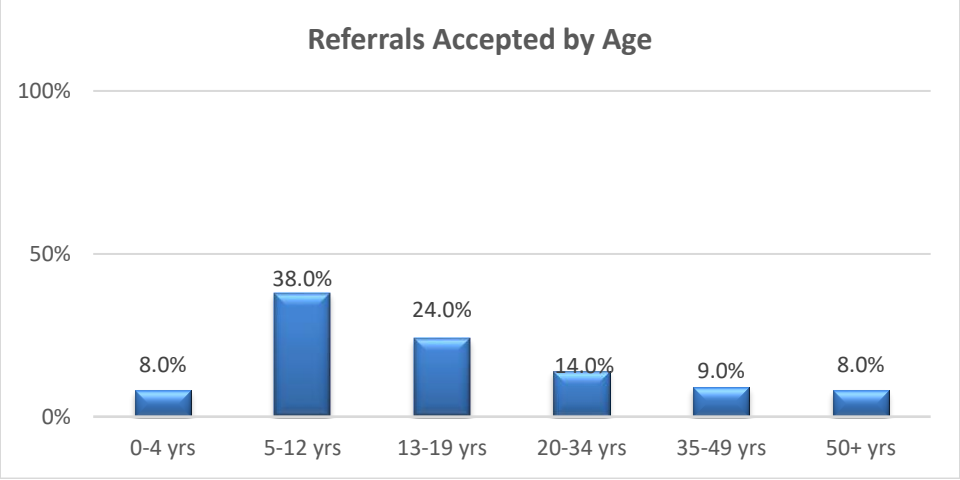


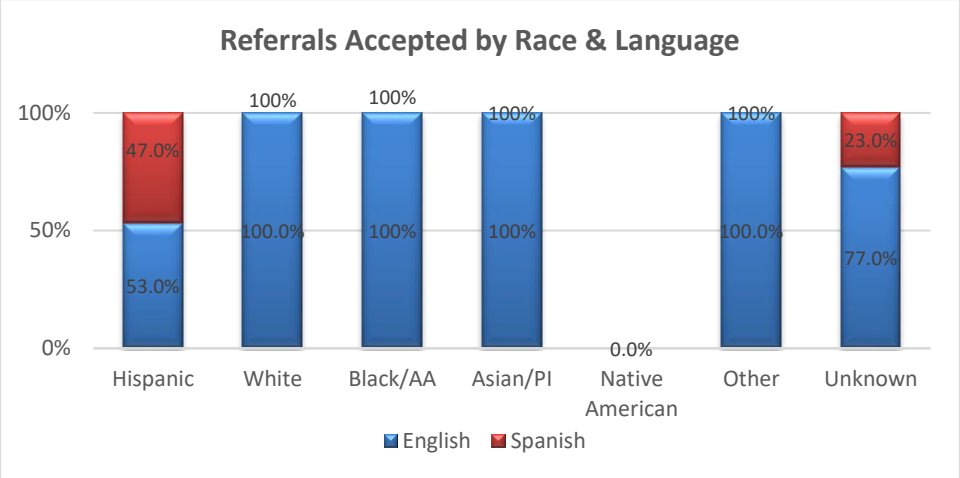




Demographics of Members

KHS' provides services to a culturally and linguistically diverse member population in Kern County. KHS' language threshold is English and Spanish, and all services and materials are available in these languages. When non-threshold language requests are received, KHS utilizes professional interpreters to reduce language communication barriers among members. Out of the members who accepted health education services, the largest age groups were 5-12 years followed by 13-19 years. A breakdown of member classifications by race and language preferences revealed that the majority of members who accepted services are Hispanic and preferred to receive services in Spanish. During this quarter, 73% of the members who accepted services reside in Bakersfield with the highest concentration in the 93307 area. Additionally, 27% of the members who accepted services reside in the outlying areas of Kern County with the highest concentration in Lamont.

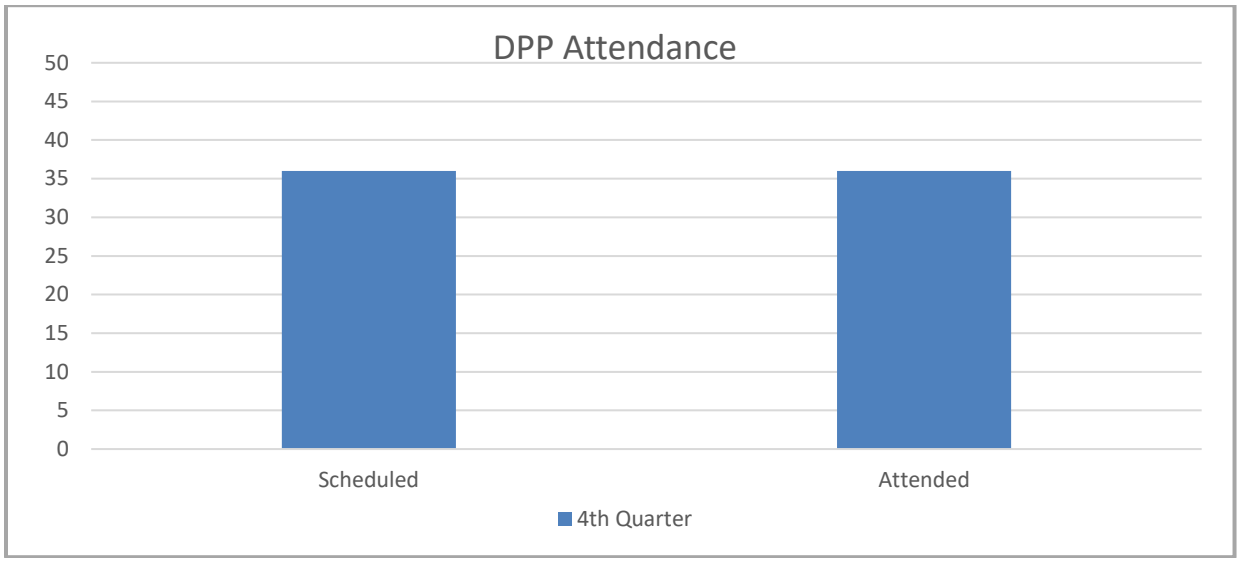




Referrals Accepted by Top Bakersfield Zip Codes			
Q1-2021	**Q2-2021**	**Q3-2021**	**Q4-2021**
93307	93307	93307	93307
93306	93306	93306	93304
93305	93304	93304	93305
Arvin	Lamont	Lamont	Lamont
Lamont	Delano	Arvin	Arvin
Delano	Arvin	Delano	Delano

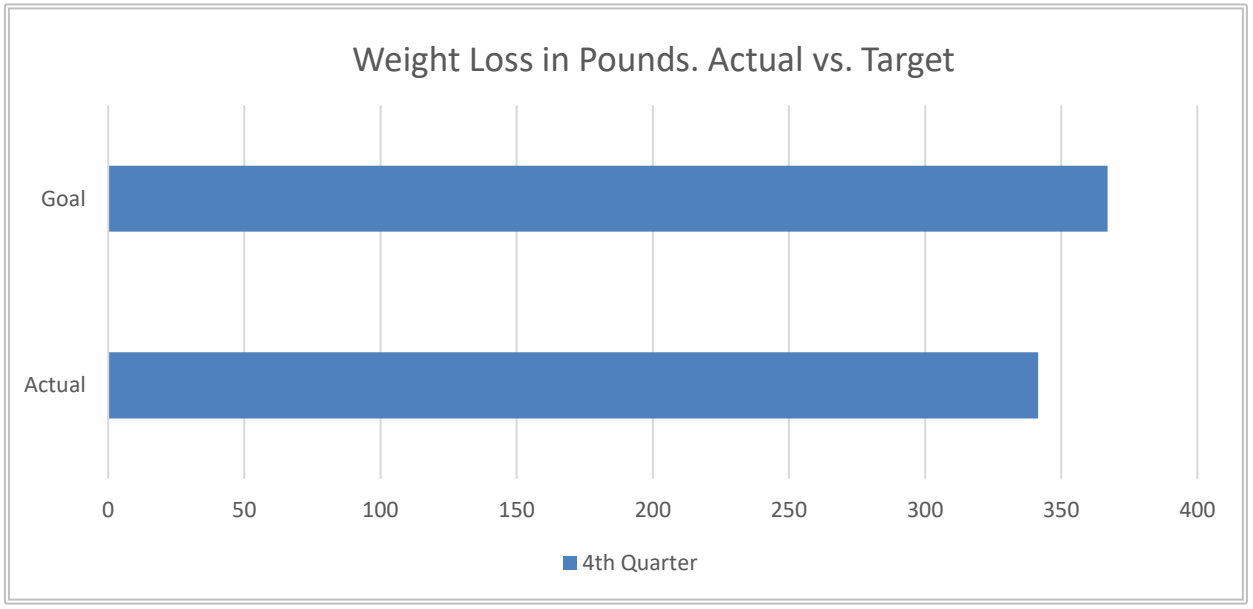
Diabetes Prevention Program: The Health & Wellness Department launched their 2nd DPP cohort on February 2nd, 2021. This year-long program consists of 26 classes held remotely until such time that we are able to resume face-to-face meetings. A total of 90 members accepted the invitation to participate and 51 members attended the first session. Of the 36 members that were still enrolled at the beginning of the quarter and with 25 sessions now completed, 36 remained enrolled in the program at the end of December.

Sessions Scheduled to Attend	Remaining Participants (End December)
36	36



Total Weight Loss: With 92% of the year-long program completed, the class has reached 93% of the required total weight-loss of 5%, or 367lb. 15 members have lost at least 5% of their starting weight.

KHS DPP Weight Loss	CDC Recognition Requirement
341.6lb	367lb



Health Education Mailings

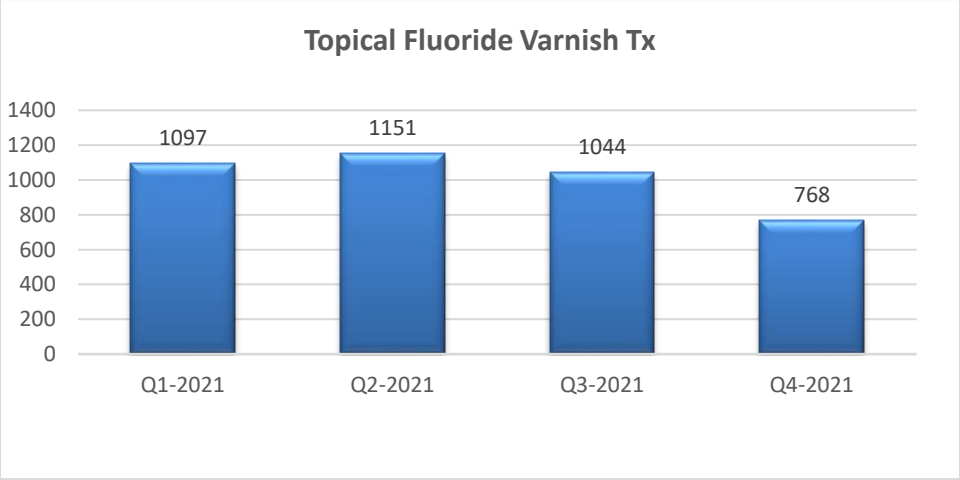
The HE department mails out a variety of educational material in an effort to assist members with gaining knowledge on their specific diagnosis or health concern. During this quarter, the HE department continued to place the majority of educational mailings on hold due to COVID-19 limitations with the exception of the prenatal and postpartum health guides which are outsourced to a contracted vendor. Members were directed to access digital information available on the Kern Family Health Care website.

Educational Mailings

	Q1-2021	Q2-2021	Q3-2021	Q4-2021
Activity and Eating: Small Steps to a Healthier You	0	1	2	3
Control High Cholesterol	0	2	8	0
Diabetes Management	0	3	7	2
Eat Healthy	0	3	11	3
Exercise	0	2	11	4
Prenatal Health Guide	2,650	968	639	540
Postpartum Health Guide	971	1,017	1151	1162
Total	**3,621**	**1,996**	**1,829**	**1714**

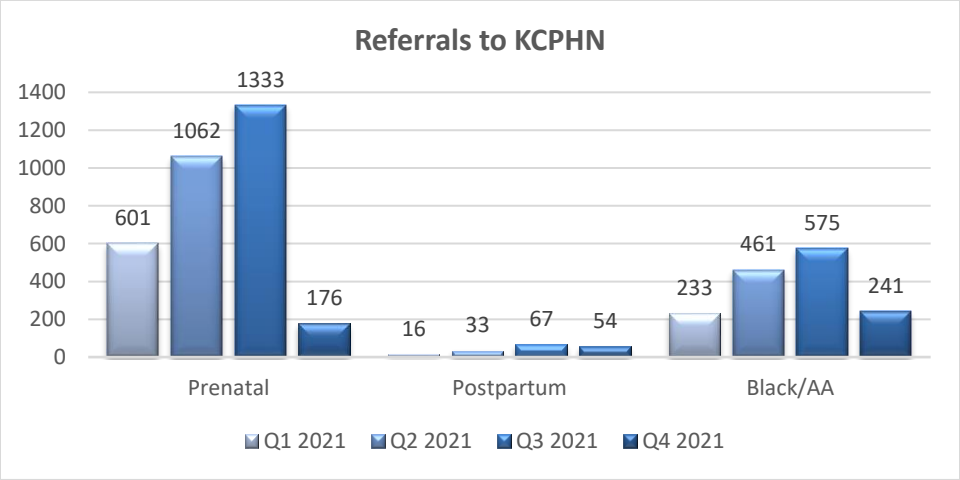
Topical Fluoride Varnish Treatments

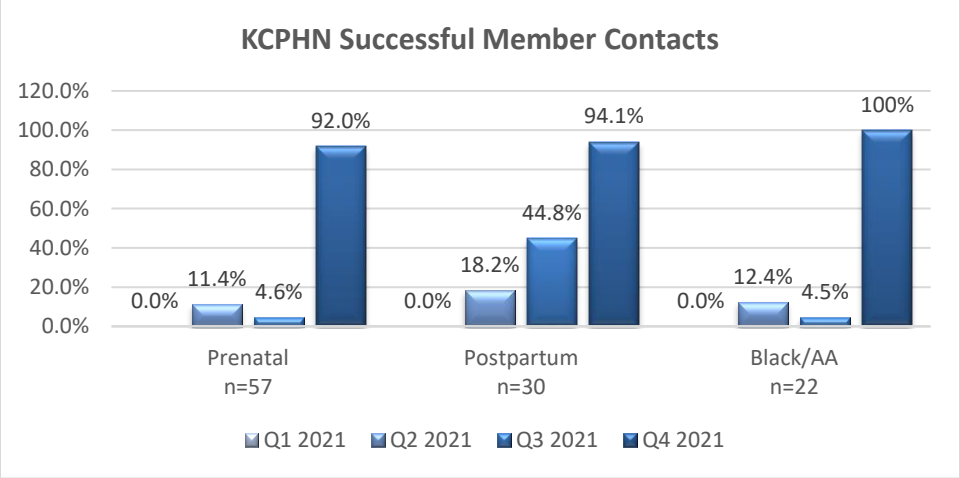
Fluoride varnish treatments are effective in preventing tooth decay and more practical and safer to use with young children. KHS covers up to three topical fluoride varnish treatments in a 12-month period for all members younger than 6 years.



Perinatal Outreach and Education

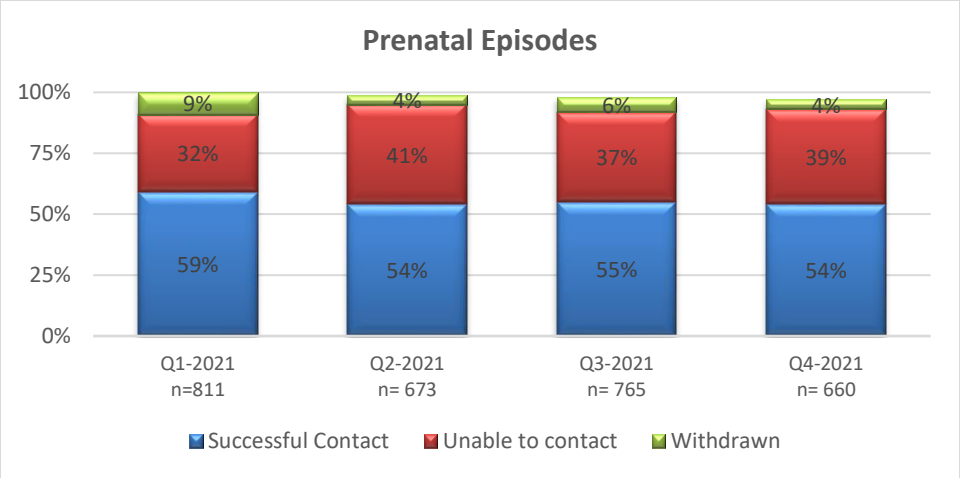
KHS partners with the Kern County Public Health Nursing (KCPHN) division to perform outreach to members residing in the 93308 and 93305 zip codes along with pregnant Black/African American members to encourage timely prenatal and postpartum care. Members who are successfully reached are educated on the importance of timely care and offered enrollment into the KCPHN pregnancy programs such as Black Infant Health. During Q4 2021, KHS referred 471 pregnant and postpartum members to KCPHN. Although KCPHN had limited resources to perform outreach due to COVID-19, they referred 2 members to the Nurse Family Partnership Program (NFP), 12 members to the Pregnancy Outreach Program (POP), 9 members to Black Infant Health (BIH) and 1 to the Unplanned Pregnancy Prevention Program (UPPP).

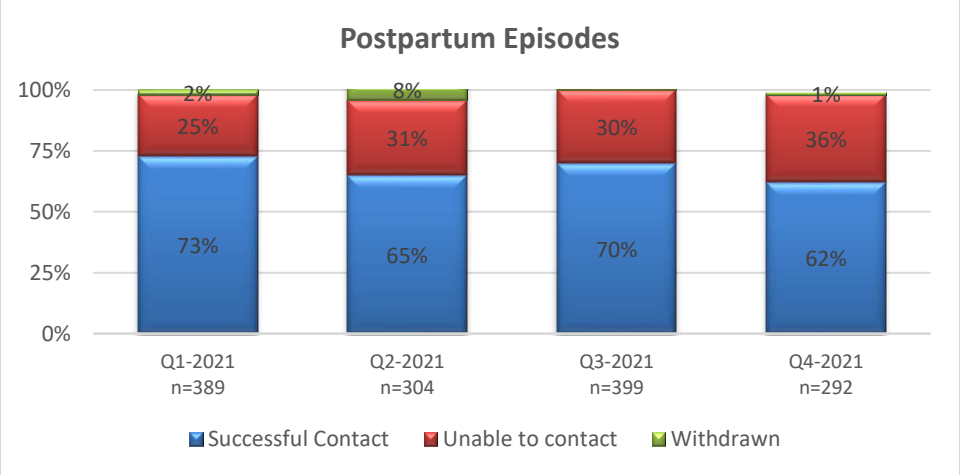


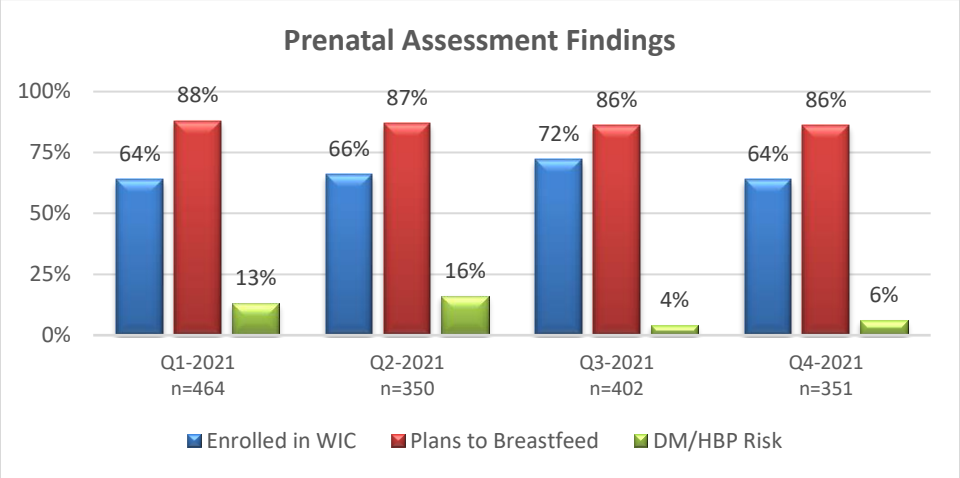


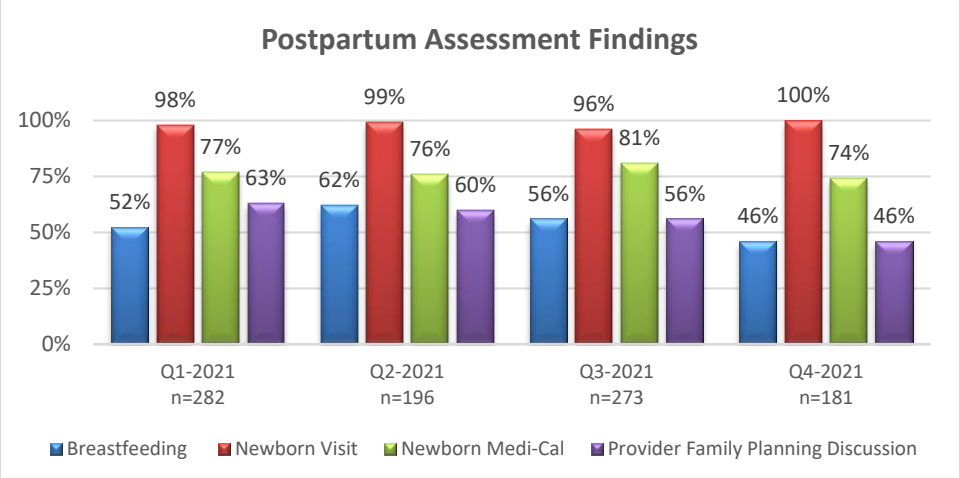
The HE department performs outreach education calls to members with a positive pregnancy test claim, pregnant teens (under age 18), and postpartum members with a Cesarean delivery or teen pregnancy delivery. During the Q4 2021, 660 episodes for pregnant members were completed and the rate of successful contacts

decreased from 55% to 54%. For postpartum members, 292 episodes were completed, and the rate of successful contacts decreased from 70% to 62%. Prenatal assessment findings revealed a 7% decrease in members identified with diabetes or high blood pressure or were at-risk for diabetes or high blood pressure during pregnancy. Postpartum assessment findings revealed a 45% decrease in members reporting that they had already discussed their family planning and birth control options with their provider.









Interpreter Requests

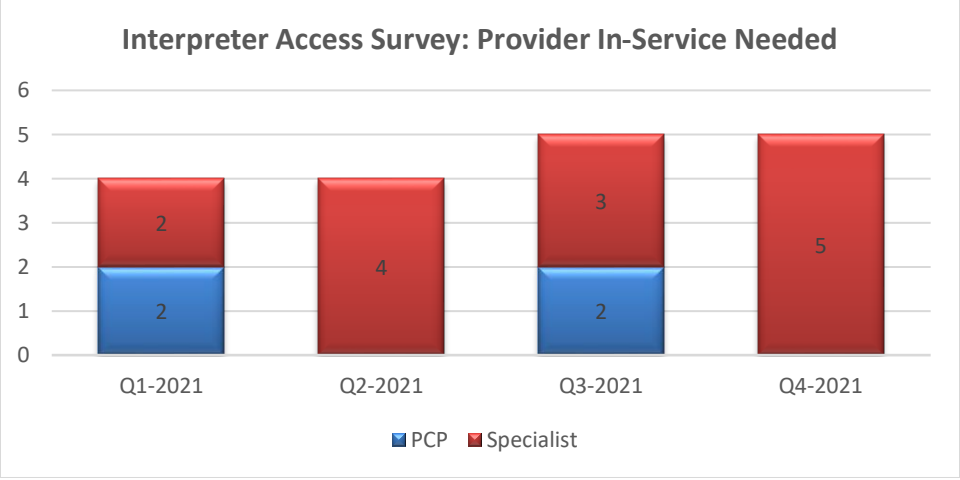
During this quarter, there were 114 requests for Face-to-Face Interpreting, 810 requests for Telephonic Interpreting, 0 for Video Remote Interpreting (VRI) and 76 requests for an American Sign Language (ASL) interpreter.

Top Face-to-Face Interpreting Languages Requested			
Q1-2021	**Q2-2021**	**Q3-2021**	**Q4-2021**
Spanish	Spanish	Spanish	Spanish
Punjabi	Vietnamese	Mandarin	Punjabi
Mandarin	Cantonese	Panjabi	Cantonese

Top Telephonic Interpreting Languages Requested			
Q1-2021	**Q2-2021**	**Q3-2021**	**Q4-2021**
Spanish	Spanish	Spanish	Spanish
Punjabi	Punjabi	Punjabi	Punjabi
Arabic	Arabic	Arabic	Arabic

Interpreter Access Survey Calls

KHS conducts a quarterly Interpreter Access Survey with PCPs and Specialists. A total of 30 providers are contacted of which 15 are PCPs and 15 are Specialists. Of the 30 provider calls conducted in Q4 2021, 5 Specialists will need an in-service on accessing appropriate interpreting services for members.



Written Translations

The HE department coordinates the translation of written documents for members. Translations are performed in-house by qualified translators or outsourced through a contracted translation vendor. During this quarter, 1,749 requests for written translations were received of which 98% were Notice of Action letters translated in-house into Spanish for the UM and Pharmacy departments.