KERN HEALTH SYSTEMS

EXECUTIVE QUALITY IMPROVEMENT HEALTH EQUITY COMMITTEE (EQIHEC) MEETING

Thursday, February 8, 2024
at
7:00 a.m.

2900 Buck Owens Blvd.
Bakersfield, CA 93308
1ST Floor Board Room

For more information, call (661) 664-5000

AGENDA

Executive Quality Improvement Health Equity Committee (EQIHEC) Meeting

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

Thursday, February 8, 2024

7:00 A.M.

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

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

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

STAFF RECOMMENDATION SHOWN IN CAPS

PUBLIC PRESENTATIONS

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

COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

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

3) Chief Medical Officer & Chief Health Equity Officer Update

CA-4) QI-UM Committee Q4 2023 Summary of Proceedings– APPROVE

CA-5) Physician Advisory Committee (PAC) Q4 2023 Summary of Proceedings – APPROVE

CA-6) Public Policy – Community Advisory Committee (PP-CAC) Q4 2023 Summary of Proceedings – APPROVE

CA-7) Drug Utilization Review (DUR) Committee Q4 2023 Summary of Proceedings - APPROVE

CA-8) Pharmacy TAR Log Statistics Q4 2023 – RECEIVE AND FILE

CA-9) Kaiser Reports **(PROPRIETARY AND CONFIDENTIAL)**

- KFHC APL Grievance Report Q4 2023 – RECEIVE AND FILE
- KFHC Volumes Report for Q4 2023 – RECEIVE AND FILE
- Kaiser Reports will be available upon request.

10) Health Equity Transformation Steering Committee

- 2024 Health Equity Strategy PowerPoint Presentation – APPROVE
- HETSC Charter - APPROVE
- HETSC Workplan – APPROVE

11) Credentialing Statistics Q4 2023 – APPROVE

12) Board Approved New & Existing Contracts Report – APPROVE

13) Credentialing & Recredentialing Summary Report – APPROVE

14) Network Review Q4 2023 – APPROVE

15) Enhanced Case Management Program Report Q4 2023 – APPROVE

16) Health Education Activity Report Q4 2023 – APPROVE

17) Grievance Operational Board Update Q4 2023 – APPROVE

18) Grievance Summary Reports Q4 2023 – APPROVE

19) Quality Improvement Program Reporting Q4 2023 – APPROVE
- 2024 QI Program Description – APPROVE
- 2023 QI Work Plan Evaluation – APPROVE
- 2024 QI Work Plan

20) Utilization Management Program Reporting Q4 2023 – APPROVE
- 2024 UM Program Description - APPROVE
- 2023 UM Work Plan Evaluation – APPROVE
- 2024 UM Work Plan

21) Population Health Management (PHM) Reporting - APPROVE
- PHM 2023 Program Highlights
- PHM Committee Charter

ADJOURN MEETING TO THURSDAY, MAY 9, 2024 @ 7:00 A.M.

AMERICANS WITH DISABILITIES ACT
(Government Code Section 54953.2)

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

SUMMARY

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

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

Thursday, November 30, 2023

COMMITTEE RECONVENED

MEMBERS:

Jennifer Ansolabehere, NP, RN, Kern County Public Health
Dr. Satya Arya, MD, ENT
Debra Cox, BA, Director of Quality Improvement at Omni Family Health
Danielle Colayco, PharmD, MS, Executive Director of Komoto Family Foundation
Todd Jeffries, Director of Business Development at Bakersfield Community Healthcare
Allen Kennedy, President/CEO of Quality Team DME
Dr. Michael Komin, MD, Family Medicine
Dr. Philipp Melendez, MD, OB/GYN
Dr. Chan Park, MD, Family Medicine
Dr. Abdolreza Saadabadi, MD, Psychiatrist, KHS Behavioral Health Medical Director
Dr. Martha Tasinga, MD, CMO at KHS (Dr. John Miller, MD alternate)

ROLL CALL: 8 Present; 2 Absent – Cox, Park

MEETING CALLED TO ORDER AT 7:05 A.M. BY DR. TASINGA, MD, KHS CHIEF MEDICAL OFFICER

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

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

COMMITTEE ACTION SHOWN IN CAPS

PUBLIC PRESENTATIONS

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. **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.**

DANIELLE COLAYCO ANNOUNCED THAT KOMOTO JUST RECEIVED ACCREDITATION FOR THEIR FIRST COMMUNITY HEALTH WORKER (CHW), CONSUELO ROBLES, AND THEY ARE IN THE PROCESS OF SUBMITTING THE APPLICATION FOR THEIR SECOND CHW, SANDRA HERNANDEZ.

DURING DISCUSSION, DR. MELENDEZ MENTIONED THE DIFFICULTY OF FOLLOWING UP WITH PATIENTS TO ENSURE THAT THEY RECEIVE THEIR MAMMOGRAMS AFTER HE WRITES THE ORDERS. DANIELLE RESPONDED THAT HEALTHCARE PROFESSIONALS CAN EMPLOY CHW'S TO HELP WITH THE FOLLOW-UP AND EDUCATION REGARDING THE IMPORTANCE OF PREVENTIVE SCREENINGS.

CA-3) QI-UM Committee Q3 2023 Summary of Proceedings – APPROVED
Arya-Kennedy: 8 Ayes; 2 Absent – Cox, Park

CA-4) Physician Advisory Committee (PAC) Q3 2023 Summary of Proceedings – APPROVED
Arya-Kennedy: 8 Ayes; 2 Absent – Cox, Park

CA-5) Public Policy – Community Advisory Committee (PP-CAC) Q3 2023 Summary of Proceedings – APPROVED
Arya-Kennedy: 8 Ayes; 2 Absent – Cox, Park

CA-6) Drug Utilization Review (DUR) Committee Q3 2023 Summary of Proceedings – APPROVED
Arya-Kennedy: 8 Ayes; 2 Absent – Cox, Park

CA-7) Pharmacy TAR Log Statistics Q3 2022 – RECEIVED AND FILED
Arya-Kennedy: 8 Ayes; 2 Absent – Cox, Park

CA-8) Kaiser Reports (PROPRIETARY AND CONFIDENTIAL)
Arya-Kennedy: 8 Ayes; 2 Absent – Cox, Park

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

9) Credentialing Statistics Q3 2023 – APPROVED
Melendez-Arya: 8 Ayes; 2 Absent – Cox, Park

10) Board Approved New & Existing Contracts Report – APPROVED
Melendez-Arya: 8 Ayes; 2 Absent – Cox, Park

11) Credentialing & Recredentialing Summary Report – APPROVED
Melendez-Arya: 8 Ayes; 2 Absent – Cox, Park

YOLANDA HERRERA, CREDENTIALING MANAGER, PRESENTED ITEMS 9, 10, AND 11 FOR 3RD QUARTER 2023. THERE WERE NO COMMITTEE COMMENTS OR QUESTIONS AFTER THE PRESENTATION.

12) Network Review Q3 2023 – APPROVED
Arya-Jeffries: 8 Ayes; 2 Absent – Cox, Park

JAMES WINFREY, PROVIDER NETWORK MANAGER, PRESENTED THE NETWORK REVIEW REPORT FOR 3RD QUARTER 2023. THERE WERE NO COMMITTEE COMMENTS OR QUESTIONS AFTER THE PRESENTATION.

13) Enhanced Case Management Program Report Q3 2023 – APPROVED
Kennedy-Melendez: 8 Ayes; 2 Absent – Cox, Park

DAN DIAZ, ECM CLINICAL MANAGER, PRESENTED THE ECM DEPARTMENT REPORT FOR 3RD QUARTER 2023. THERE WERE NO COMMITTEE COMMENTS OR QUESTIONS AFTER THE PRESENTATION.

14) Health Education Activity Report Q3 2023 – APPROVED
Melendez-Arya: 8 Ayes; 2 Absent – Cox, Park

ISABEL SILVA, SENIOR DIRECTOR OF WELLNESS AND PREVENTION, PRESENTED THE HEALTH EDUCATION DEPARTMENT REPORT FOR 3RD QUARTER 2023. THERE WERE NO COMMITTEE COMMENTS OR QUESTIONS AFTER THE PRESENTATION.

15) Grievance Operational Board Update Q3 2023 – APPROVED
Melendez-Jeffries: 8 Ayes; 2 Absent – Cox, Park

16) Grievance Summary Reports Q3 2023 – APPROVED
Melendez-Jeffries: 8 Ayes; 2 Absent – Cox, Park

AMY CARRILLO, MEMBER SERVICES MANAGER, PRESENTED THE GRIEVANCE DEPARTMENT REPORTS FOR 3RD QUARTER 2023.

TODD JEFFRIES ASKED ABOUT OUR KAISER MEMBERS. AMY CLARIFIED THAT BEGINNING 01/01/24, KHS WILL NO LONGER MANAGE KAISER MEMBERS. THEY WILL BE THE SOLE RESPONSIBILITY OF KAISER, WE WILL NO LONGER HAVE ANY RESPONSIBILITY FOR THESE MEMBERS.

17) Quality Improvement Program Reporting Q3 2023 – APPROVED
Melendez-Jeffries: 8 Ayes; 2 Absent – Cox, Park

KAILEY COLLIER, DIRECTOR OF QUALITY PERFORMANCE, PRESENTED THE QI DEPARTMENT REPORT FOR 3RD QUARTER 2023. THERE WERE NO COMMITTEE COMMENTS OR QUESTIONS AFTER THE PRESENTATION.

18) Utilization Management Program Reporting Q3 2023 – APPROVED
Melendez-Jeffries: 8 Ayes; 2 Absent – Cox, Park

- Policy 3.20-P Sensitive Services
- Policy 3.21-P Family Planning Services
- Policy 3.53-P Cancer Treatment
- Policy 3.84-P Long Term Care Transitions
- Policy 3.94-P Multipurpose Senior Services Program

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

POLICIES WERE NOT INCLUDED IN THE PACKET IN ERROR, AMY DANIEL TO SEND THEM OUT VIA EMAIL AFTER THE MEETING, AND COMMITTEE MEMBERS WILL SEND IN THEIR APPROVAL OR SUGGESTIONS FOR CHANGES IF ANY.

MISTY DOMINGUEZ WENT OVER THE 2023 UM PROGRAM DESCRIPTION AND ASKED COMMITTEE FOR THEIR APPROVAL.

SHE ALSO PRESENTED AND ASKED THE COMMITTEE TO APPROVE TO ADOPT THE UPDATED UM CRITERIA FOR SPECIALTY CARE REFERRAL GUIDELINES, AND PEER TO PEER GUIDELINES.

DR. MILLER GAVE OVERSIGHT ON PERISCOPE. PERISCOPE IS A COMPANY STAFFED BY PHYSICAL AND OCCUPATIONAL THERAPISTS

THAT PROVIDES DURABLE MEDICAL EQUIPMENT (DME) EVALUATIONS TO DETERMINE WHAT THE MEMBER'S ACTUAL EQUIPMENT NEEDS ARE.

FOR EXAMPLE, IF A PROVIDER REQUESTS A POWER WHEELCHAIR FOR A MEMBER, KHS CAN HAVE PERISCOPE EVALUATE THE PATIENT IN THEIR HOME TO SEE IF THE REQUEST IS APPROPRIATE. THEY MAY AGREE WITH THE INITIAL REQUEST, SUGGEST ALTERNATIVES (A SPECIFIC TYPE OF WHEELCHAIR/ACCESSORY) OR EVEN RECOMMEND OTHER DME EQUIPMENT (SUCH AS A BEDSIDE COMMODE) THAT WAS NOT ORIGINALLY REQUESTED BY THE PROVIDER.

ALLEN KENNEDY COMMENTED THAT HE AND HIS COMPANY HAVE WORKED WITH PERISCOPE IN THE PAST, AND THEY ARE VERY GOOD. HE HIGHLY RECOMMENDS THEM.

19) Population Health Management Program Reporting Q3 2023 – APPROVED
Melendez-Ansolabehere: 8 Ayes; 2 Absent – Cox, Park

MICHELLE CURIOSO, DIRECTOR OF POPULATION HEALTH MANAGEMENT, PRESENTED THE PHM DEPARTMENT REPORT FOR 3RD QUARTER 2023.

DR. MICHAEL KOMIN ASKED ABOUT A SYSTEM BEING IN PLACE FOR OPEN AUTHORIZATION NOTIFICATIONS.

MICHELLE CURIOSO ANSWERED, PHM SENDS A REMINDER LETTER EVERY MONTH NOTIFYING PROVIDERS OF APPROVED AUTHORIZATION REQUESTS THAT WERE ISSUED ON BEHALF OF ONE OR MORE OF THEIR ELIGIBLE PATIENTS FOR WHICH THERE IS NO ASSOCIATED CLAIM TO THE AUTHORIZATION.

MEETING ADJOURNED AT 8:39 A.M. TO THURSDAY, FEBRUARY 8, 2024 @ 7:00 A.M

COMMITTEE: ***PHYSICIAN ADVISORY COMMITTEE***
DATE OF MEETING: ***OCTOBER 4, 2023***
CALL TO ORDER: ***7:03 AM BY MARTHA TASINGA, MD - CHAIR***

Members Present On-Site:	Martha Tasinga, MD – KHS Chief Medical Officer Hasmukh Amin, MD – Network Provider, Pediatrics	Ghohar Gevorgyan, MD – Network Provider, Family Med. David Hair, MD - Network Provider, Ophthalmology Miguel Lascano – Network Provider, OB/GYN	Ashok Parmar, MD– Network Provider, Pain Medicine Raju Patel, MD - Network Provider, Internal Medicine
Members Virtual Remote:	None		
Members Excused=E Absent=A	Atul Aggarwal, MD - Network Provider, Cardiology (A)		
Staff Present:	Alan Avery, KHS, Chief Operating Office Michelle Curioso, KHS, PHM Director Amy Daniel, KHS Executive Health Svcs Coordinator Misty Dominguez, KHS, UM Director	Jake Hall, KHS, Deputy Director of Contracting Yolanda Herrera, KHS Credentialing Manager Yesenia Sanchez, KHS Credentialing Coordinator	

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Public Comments	Martha Tasinga, MD, Committee Chair, asked for public comment. None were present.	*N/A*	*N/A*
Committee Comments	Martha Tasinga, MD, Committee Chair, asked for committee member announcements or reports. Bruce Wearda, Director of Pharmacy informed the member that DHCS has issued the following update regarding COVID Vaccines at their Pharmacy Directors Meeting held 9/27/23: "COVID-19	☑ **CLOSED**: Informational only.	*N/A*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	vaccines will remain carved-out as both a medical and pharmacy benefit until further notice, at least through 12/31/24 for now. This includes COVID vaccines for ages 0-18 years of age. Medical claims for COVID vaccines for this age group would be billed in a similar manner as other VFC vaccines. The difference being that the administration fees will be $40 across the board for now, instead of the usual $9 fee for VFC vaccines." Dr. Amin shared his practice has seen COVID Vaccination decline rate increase to around 85% as members are choosing not to get vaccinated for COVID. Flu vaccine remains steady with an approximate 20% decline rate.		
Quorum	Attendance / Roll Call	Committee quorum requirement met.	N/A
CLOSED SESSION	Adjourned to closed session at 7:10 am	N/A	*N/A*
	<u>Peer Review Reports</u> **CREDENTIALING REPORT** **Mental Health Pre-Approvals from 9/28/2023:** In compliance with Senate Bill 2581, Dr. Tasinga, KHS CMO, pre-approved the Mental/Behavioral Health providers as listed on the 9/28/2023 Credentialing Report, all meeting clean file criteria, in compliance with the 60-day turnaround requirements. Mental Health Providers were accepted as presented with no additional questions or alternative actions. **INITIAL CREDENTIALING REPORT** Initial Applicants List Dated 10/04/2023: There were no comprehensive reviews presented for review. Initial applicants meeting clean file review were accepted as presented with no additional questions or alternative actions.	☑ **ACTION**: Dr. Amin moved to approve the Credentialing, Recredentialing and New Vendor Contracts from the reports dated October 4, 2023, seconded by Dr. Parmar. Motion carried.	*10/4/23*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	RECREDENTIALING REPORT **Recredentialing Providers List Dated 10/04/2023:** Recredentialing meeting clean file review were accepted as presented with no additional questions or alternative actions. Recredentialing with comprehensive reviews were conducted for the listed providers below for review of additional adverse information and/or information related to malpractice case(s) that resulted in settlement or judgment made on behalf of the practitioner within the previous three years: • Member Grievances: All Providers with significant Member & Quality Grievances were reviewed with no quality of service or care issues reported as significant trends or concern requiring further review, questions or alternative actions recommended by this committee. • PRV006889 - Reviewed information regarding NPDB 2023 $29,000: Alleged surgery should not have been performed due to previous cholecystectomy. Pt seen under previous name few years earlier and surgical history of prior gallbladder procedure was not included. Provider explanation reviewed and recommend approval of continued network participation as there have been no additional settlements. • PRV007278 - Reviewed information regarding NPDB 2023 $2Million: Alleged failure to diagnose infective process and C4 fracture resulting in spinal cord injury with quadriplegia. Provider explanation reviewed and settled in agreement with provider and hospital. Recommend approval of continued network participation as there have been no additional settlements. • PRV029412 - Reviewed previously disclosed (in January 2023) provider deviation from standard of care issuing permanent exemptions for 2-pts with reactions that are not listed as contraindication or precaution form for future immunizations. Provider explanation reviewed and education course in pediatric immunizations completed. Recommend		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	approval of continued network participation as there have been no additional settlements. • PRV006213 - Reviewed 5 years probation eff 11/10/21 with regard to Sterile Compounding Permit to be monitored for appropriate manufacturing, handling distributing and billing/charging for any drug, device or controlled substance. Recommend approval of continued network participation with monthly monitoring to ensure compliance with terms of probation. **Closed session adjourned back to Open Session.**		
OLD BUSINESS	There was no old business to present	N/A	*N/A*
NEW BUSINESS	**Approval of Minutes** The Committee's Chairperson, Martha Tasinga MD, presented the meeting minutes for approval.	☑ **ACTION**: Dr. Hair moved to approve minutes of September 6, 2023, seconded by Dr. Amin. Motion carried.	*10/4/23*
	Pharmacy Criteria Bruce Wearda, KHS Director of Pharmacy, presented the current criteria for Physician Administered Drugs (PAD) and others that are managed as part of the medical benefit that will be managed by common pharmaceutical utilization management and coverage tools. While the Medi-Cal Manual and Milliman (MCG) criteria does not often provide enough guidance, internal guidelines have been created through either the established approved formulary and/or the previous Pharmacy & Therapeutics Committee, including collaboration with specialist within the network and other professional practice references. Bruce informed the members that while KHS is in process of NCQA Accreditation process, and until the P&T Committee is re-established at KHS, the proposed guidelines have been brought to the PAC meeting for review and approval to accept the general conditions of	☑ **ACTION**: Dr. Parmar moved to approve Pharmacy Criteria Guidelines, seconded by Dr. Patel. Motion carried. Criteria Presented: • Chronic Migraine Management – Botulinum Toxin • Colony Simulating Factors • Crysvita (burosumab-twza) • Erythropoiesis Stimulating Agents (ESAs) • Parenteral Iron Supplements • Krystexxa (Pegloticase) • Nucala (Mepolizumab) and Xolair (Omalizumab) for Asthma • Pulmonary Arterial Hypertension - prostanoids • Reblozyl (Luspatercept-aamt) • Recombinant Human Parathyroid Hormone – Forteo & Tymlos • Tardive Dykinesia & Involuntary Movement • Teppeza (Teprotumumab-trbw) • Thrombopoietin Recepton Agonists • Uplizna (inebilizumb-Cdon) • Xolair (Omalizumab) for Chronic Idiopathic Urticaria	*10/4/23*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	least costly version to manage the condition and accept criteria presented as attached to the meeting agenda. Committee members questioned how the authorization process will work including the notification process if an alternate drug is approved. Misty Dominguez, UM Director confirmed that a decision letter will be sent if an alternate drug is approved informing the physician. Bruce also stated for physician administered drug infusions done in the office, there is a "prior authorization" process in place and in most instances a bio-similar drug will be selected unless there is a clinical reason provided for the brand name drug. This process does not apply to the retail medications administered through DHCS Medi-Cal RX program.		
OPEN FORUM	Dr. Tasinga informed the committee members that beneficiary identification cards will be going out to all members and will include the PCP Name and phone number as this has been a request of our providers and committee members.	☑ **CLOSED**: Informational only.	*N/A*
NEXT MEETING	Next meeting will be held Wednesday, November 8, 2023	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 8:22 AM ***Respectfully submitted: Yolanda Herrera, CPMSM, CPCS***	**N/A**	*N/A*

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

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

COMMITTEE: ***PHYSICIAN ADVISORY COMMITTEE***
DATE OF MEETING: ***NOVEMBER 8, 2023***
CALL TO ORDER: ***7:03 AM BY MARTHA TASINGA, MD - CHAIR***

Members Present On-Site:	Martha Tasinga, MD – KHS Chief Medical Officer Atul Aggarwal, MD - Network Provider, Cardiology	Miguel Lascano – Network Provider, OB/GYN	Ashok Parmar, MD– Network Provider, Pain Medicine Raju Patel, MD - Network Provider, Internal Medicine
Members Virtual Remote:	None		
Members Excused=E Absent=A	Hasmukh Amin, MD – Network Provider, Pediatrics (E)	Ghohar Gevorgyan, MD – Network Provider, FP (E) David Hair, MD - Network Provider, Ophthalmology (E)	
Staff Present:	Alan Avery, KHS, Chief Operating Office Michelle Curioso, KHS, PHM Director Amy Daniel, KHS Executive Health Svcs Coordinator Misty Dominguez, KHS, UM Director	Jake Hall, KHS, Deputy Director of Contracting Yolanda Herrera, KHS Credentialing Manager Yesenia Sanchez, KHS Credentialing Coordinator John Miller, MD - KHS Medical Director	Sukhpreet Sidhu, MD - KHS Medical Director Magdee Hugais – KHS QI Director Bruce Wearda – KHS Pharmacy Director

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

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
CLOSED SESSION	Adjourned to closed session at 7:10 am	N/A	*N/A*
	<u>Peer Review Reports</u> **CREDENTIALING REPORT** **Mental Health Pre-Approvals from 10/31/2023:** In compliance with Senate Bill 2581, Dr. Tasinga, KHS CMO, pre-approved the Mental/Behavioral Health providers as listed on the 10/23/2023 Credentialing Report, all meeting clean file criteria, in compliance with the 60-day turnaround requirements. Mental Health Providers were accepted as presented with no additional questions or alternative actions. **INITIAL CREDENTIALING REPORT** Initial Applicants List Dated 11/08/2023: There was one initial application presented for comprehensive review. • PRV059466 - Reviewed information regarding NPDB Settlement 2017 $175,000: Alleged administered an excessive and potentially lethal amount of potassium resulting in hyperkalemia and cardiac arrest; failure to provide sufficient monitoring and order appropriate lab monitoring of serium potassium. Provider explanation reviewed and recommend approval of network participation as there have been no additional settlements. **RECREDENTIALING REPORT** **Recredentialing Providers List Dated 10/04/2023:** Recredentialing meeting clean file review were accepted as presented with no additional questions or alternative actions. Recredentialing with comprehensive reviews were conducted for the listed providers below for review of additional adverse information and/or information related to malpractice case(s) that resulted in settlement or judgment made on behalf of the practitioner within the	☑ **ACTION**: Dr. Patel moved to approve the Credentialing, Recredentialing and New Vendor Contracts from the reports dated November 8, 2023, seconded by Dr. Aggarwal. Motion carried.	*11/08/23*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	previous three years: • Member Grievances: All Providers with significant Member & Quality Grievances were reviewed. Dr. Tasinga reported there were no quality of service or care issues identified as significant trends or concern requiring further review. There were no additional questions or alternative actions recommended by this committee. • PRV004211 – Provider has completed MBC Probation meeting all terms and conditions successfully and was removed from probation by the MBC in February 2023. Recommend approval of continued network participation as there have been no additional issues reported. **MONTHLY MONITORING (ONGOING REVIEW)** • PRV071683 –MBC has issued Accusation filed 8/3/23 and was received via MBC Alert dated, 9/20/23. Accusation alleges infant delivered with neurological exam and dx of metabolic acidosis and neonatal ischemic encephalopathy & convulsions. Provider explanation received and escalated to CMO for review. Provider response accepted and recommend adding to the Monthly Monitoring Report to monitor results of the MBC decision on this case. Recommend continued network participation with monthly monitoring. **Closed session adjourned back to Open Session.**		
OLD BUSINESS	There was no old business to present	N/A	*N/A*
NEW BUSINESS	**Approval of Minutes** The Committee's Chairperson, Martha Tasinga MD, presented the meeting minutes for approval.	☑ **ACTION**: Dr. Lascano moved to approve minutes of October 4, 2023, seconded by Dr. Patel. Motion carried.	*11/08/23*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Pharmacy Criteria Bruce Wearda, KHS Director of Pharmacy, presented the current criteria for Physician Administered Drugs (PAD) and others that are managed as part of the medical benefit that will be managed by common pharmaceutical utilization management and coverage tools. While the Medi-Cal Manual and Milliman (MCG) criteria does not often provide enough guidance, internal guidelines have been created through either the established approved formulary and/or the previous Pharmacy & Therapeutics Committee, including collaboration with specialist within the network and other professional practice references. Bruce informed the members that while KHS is in process of NCQA Accreditation process, and until the P&T Committee is re-established at KHS, the proposed guidelines have been brought to the PAC meeting for review and approval to accept the general conditions of least costly version to manage the condition and accept criteria presented as attached to the meeting agenda. Bruce also stated for physician administered drug infusions done in the office, there is a "prior authorization" process in place and in most instances a bio-similar drug will be selected unless there is a clinical reason provided for the brand name drug. This process does not apply to the retail medications administered through DHCS Medi-Cal RX program. Dr. Parmar asked how frequently we had requests for the drug, Crysvita. Bruce stated that is it rare, however NCQA requires us to state the criteria used (sic) regardless of how often requested. Dr. Aggarwal asked about the PCSK9 inhibitor criteria. He wanted to know if it was KHS' responsibility or Medi-cal's responsibility. Dr. Tasinga stated that these are typically self-administered and are handled by Medi-cal Rx, however, in some instances, if they were done in a physician's office they would be reviewed by KHS.	☑ **ACTION**: Dr. Parmar moved to approve Pharmacy Criteria Guidelines, seconded by Dr. Patel. Motion carried. Criteria Presented: • Asthma Monoclonal Antibody Criteria • Botulinum Toxin Criteria – Anal Fissure Management • Botulinum Toxin Criteria – Cervical Dystonia and Spasticity • Botulinum Toxin Criteria – Overactive Bladder (OAB) and Neurogenic • Burosumab-twza (Crysvita) Criteria • Calcitonin Gene-Related Peptide (CGRP) Criteria – erenumab (Aimovig), • fremanezumab (Ajovy), galcanezumab (Emgality), eptinezumab (Vyepti) • General Review Process and Considerations for Pharmacy Services • IV Iron Criteria • IV Magnesium Criteria • PCSK9 Inhibitor Criteria – alirocumab (Praluent), evolocumab (Repatha)	*11/08/23*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
OPEN FORUM		☑ **CLOSED**: Informational only.	*N/A*
NEXT MEETING	Next meeting will be held Wednesday, December 6, 2023	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 8:08 AM ***Respectfully submitted: Amy L. Daniel, Executive Health Services Coordinator***	**N/A**	*N/A*

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

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

COMMITTEE: ***PHYSICIAN ADVISORY COMMITTEE***
DATE OF MEETING: ***DECEMBER 6, 2023***
CALL TO ORDER: ***7:05 AM BY MARTHA TASINGA, MD - CHAIR***

Members Present On-Site:	Martha Tasinga, MD – KHS Chief Medical Officer Atul Aggarwal, MD - Network Provider, Cardiology	Miguel Lascano – Network Provider, OB/GYN Abdolreza Saadabadi, MD – KHS Behavioral Health Medical Director	Ashok Parmar, MD– Network Provider, Pain Medicine Raju Patel, MD - Network Provider, Internal Medicine
Members Virtual Remote:	None		
Members Excused=E Absent=A	Hasmukh Amin, MD – Network Provider, Pediatrics (E)	Gohar Gevorgyan, MD – Network Provider, FP (E) David Hair, MD - Network Provider, Ophthalmology (E)	
Staff Present:	Alan Avery, KHS, Chief Operating Office Michelle Curioso, KHS, PHM Director Amy Daniel, KHS Executive Health Svcs Coordinator Misty Dominguez, KHS, UM Director	Jake Hall, KHS, Deputy Director of Contracting Yolanda Herrera, KHS Credentialing Manager Yesenia Sanchez, KHS Credentialing Coordinator John Miller, MD – KHS Medical Director	Sukhpreet Sidhu, MD – KHS Medical Director Bruce Wearda – KHS Director of Pharmacy Magdee Hugais – KHS Director of QI

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

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
CLOSED SESSION	Adjourned to closed session at 7:12 am	N/A	*N/A*
	<u>Peer Review Reports</u> **CREDENTIALING REPORT** **Mental Health Pre-Approvals from 12/01/2023:** In compliance with Senate Bill 2581, Dr. Tasinga, KHS CMO, pre-approved the Mental/Behavioral Health providers as listed on the 12/01/2023 Credentialing Report, all meeting clean file criteria, in compliance with the 60-day turnaround requirements. Mental Health Providers were accepted as presented with no additional questions or alternative actions. **INITIAL CREDENTIALING REPORT** Initial Applicants List Dated 12/06/2023: There was one initial application presented for comprehensive review. • PRV001901- Reviewed information regarding NPDB Settlement 2017 $10,000: Alleged failure to discontinue Vasotec in pregnant mother, baby born with septo-optic dysplasia, patent ductus arteriosus, adrenal insufficiency, hypothyroidism, and absent septum pellucidum. *Provider explanation received and accepted with recommendation to add to provider network.* **RECREDENTIALING REPORT** **Recredentialing Providers List Dated 12/06/2023:** Recredentialing meeting clean file review were accepted as presented with no additional questions or alternative actions. Recredentialing with comprehensive reviews were conducted for the listed providers below for review of additional adverse information and/or information related to malpractice case(s) that resulted in settlement or judgment made on behalf of the practitioner within the previous three years:	☑ **ACTION**: Dr. Amin moved to approve the Credentialing, Recredentialing and New Vendor Contracts from the reports dated December 6, 2023, seconded by Dr. Parmar. Motion carried.	*12/6/23*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	• Member Grievances: All Providers with significant Member & Quality Grievances were reviewed. Dr. Tasinga reported there were no quality of service or care issues identified as significant trends or concern requiring further review. There were no additional questions or alternative actions recommended by this committee. • PRV001029 – Accreditation Survey Completed however, has not been updated on website. Per AAAHC Surveyor, report is being finalized and should be available mid-December. *Recommend modified recredentialing contingent upon receipt of active/compliant accreditation.* • PRV011679/PRV011676 – Self reported monetary fines - 2/31/21: TX Pharmacy Board: DHP/VA Monetary Penalty $500 due to substandard care or skill level 12/19/19: MI Pharmacy Board: Dispensing Error / Monetary Fine $2,000. *Provider explanation received and accepted with recommendation for continued network participation*. **MONTHLY MONITORING (ONGOING REVIEW)** • No new monthly monitoring to report. **Closed session adjourned back to Open Session.**		
OLD BUSINESS	There was no old business to present	N/A	*N/A*
NEW BUSINESS	**Approval of Minutes** The Committee's Chairperson, Martha Tasinga MD, presented the meeting minutes for approval.	☑ **ACTION**: Dr. Patel moved to approve minutes of November 8, 2023, seconded by Dr. Parmar. Motion carried.	*12/6/23*
	Pharmacy Criteria Bruce Wearda, KHS Director of Pharmacy, presented the current criteria for Pharmacy Utilization Management Guidelines for: • General Review Process & Considerations • Medical Supplies and Device Criteria	☑ **ACTION**: Dr. Amin moved to approve Pharmacy Criteria Guidelines, seconded by Dr. Paarmar. Motion carried.	*12/6/23*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	Delegated Credentialing Tertiary Summary Q3 2023 Yolanda Herrera KHS Credentialing Manager, presented the 3rd Quarter Delegated Credentialing Reports and Group Rosters for the tertiary facilities, VSP, Kaiser and ConferMED. During 3rd Quarter, delegates reported Credentialing Committee dates for initial credentialing, recredentialing and terminations. • There were no significant changes in the delegated entities credentialing program or performance. • There were no identified changes in the delegated entities provider network that would limit specialty access to our members. • Additionally, there were no identified improvement activities reported	☑ **ACTION**: Dr. Amin moved to approve the Delegated Credentialing Tertiary Summary 3rd Quarter 2023 Report dated December 6, 2023, seconded by Dr. Parmar. Motion carried.	*12/6/23*
	P&P 4.01-P Credentialing Program – Revised Yolanda Herrera KHS Credentialing Manager, presented the revisions to Policy and Procedure 4.01-P Credentialing Program as follows: • Added monitoring process for Non-Discriminatory Credentialing • Added accepted primary sources for credentialing • Revised Area of Practice / Provider Directory • Added practitioner rights • Revised provisional credentialing & clean file approval process • Revised Locum Tenens – Retro-Approval 14-Calendar days only • Added provider notification of recredentialing adverse decisions within 60-days • Added Initial and Ongoing Assessment of Organizational Providers • Added NPDB Continuous Query Reports • Added Professional Liability Policy Certificates to have the named provider on the face sheet, declaration page or Roster included.	☑ **ACTION**: Dr. Amin moved to approve the revisions for P&P 4.01-P Credentialing Program, seconded by Dr. Parmar. Motion carried.	*12/6/23*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
OPEN FORUM	**<u>Physician Extender Requirements</u>** Dr. Parmar requested review of the Physician Extender requirements of 6-month formal training or 1-year work experience in a sub-specialty field. Dr. Tasinga informed the members that KHS has been reluctant to remove this requirement in the past due to risk to the organization of new physician extenders who may not have the necessary experience in a sub-specialty area and/or lack of proper supervision. Dr. Tasinga further explained that those who work in the specialty setting for the first year gain the experience, training and knowledge base that qualifies them for network participation. Other members shared their thoughts and practices within their settings following guidelines from CMS Incident to Physician Billing; Patient evaluated by MD with exam and then the physician lays out a treatment plan for the physician extender to follow.	☑ **CLOSED**: Informational discussion only.	*N/A*
NEXT MEETING	Next meeting will be held Wednesday, February 7, 2024	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned at 8:09 am ***Respectfully submitted: Amy L. Daniel, Executive Health Services Coordinator***	**N/A**	*N/A*

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

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

SUMMARY

PUBLIC POLICY/COMMUNITY ADVISORY COMMITTEE

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

Tuesday, December 12, 2023

COMMITTEE RECONVENED

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

ROLL CALL: 10 Present; 2 Absent – Yadira Ramirez, Kaelsun Singh Tyiska

Meeting called to order by Louie Iturriria, Senior Director of Marketing and Member Engagement, at 11:02 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 26, 2023 -
APPROVED
Hefner-Wood: 10 Ayes; 2 Absent – Ramirez, Singh Tyiska

CA-4) Report on December 2023 Medi-Cal Membership Enrollment
- RECEIVED AND FILED
Hefner-Wood: 10 Ayes; 2 Absent – Ramirez, Singh Tyiska

CA-5) Report on Health Education for Q3 2023 -
RECEIVED AND FILED
Hefner-Wood: 10 Ayes; 2 Absent – Ramirez, Singh Tyiska

6) Member Services - Grievance Operational Report and Grievance Summary for Q3 2023 -
APPROVED
Louey-Hernandez Colin: 10 Ayes; 2 Absent – Ramirez, Singh Tyiska

MS. WOOD INQUIRED ABOUT PULLING KAISER HISTORICAL DATA TO USE IN COMPARISON FOR FUTURE 2024 REPORTING.

MR. LOUEY ASKED ABOUT THE GRIEVANCE NUMBERS THAT WE REPORT TO THE STATE, AND IT WAS CLARIFIED BY AMY CARRILLO THAT IN OUR GRIEVANCE COUNTS TO THE STATE, WE COMBINE THE MEMBERS ASSIGNED TO KAISER INTO THOSE REPORTS. THE STATE RECOGNIZES THE KAISER ASSIGNED MEMBERS AS THE RESPONSIBILITY OF KHS. AS OF 01/01/24, KHS WILL NO LONGER MANAGE KAISER MEMBERS.

MS. HEFNER ASKED WHO WILL TAKE CARE OF THE KAISER MEMBERS AFTER 01/01/24, AND IT WAS CLARIFIED THAT THEY WILL BE THE SOLE RESPONSIBILITY OF KAISER BEGINNING 01/01/24, AND KHS WILL NO LONGER HAVE ANY RESPONSIBILITY FOR THESE MEMBERS.

7) Health Equity – Community Advisory Committee 2024 Changes and Elections – APPROVED – (PLEASE SEE ATTACHMENT WITH ELECTION RESULTS)
Hefner-Wood: 10 Ayes; 2 Absent – Ramirez, Singh Tyiska

8) Health Education – KFHC Summer 2024 Member Newsletter -
APPROVED
Louey-Hefner: 10 Ayes; 2 Absent – Ramirez, Singh Tyiska

MS. WOOD SUGGESTED “WATER SAFETY” AS A TOPIC TO ADD IN SUMMER 2024 NEWSLETTER.

MR. MCALISTER ASKED WHAT INFORMATION WOULD BE SHARED IN THE UPCOMING NEWSLETTER IN REGARD TO THE MEDI-CAL EXPANSION. HE OFFERED HIS ASSISTANCE IN WHAT INFORMATION TO INCLUDE FOR THE MEMBERS.

MR. CABALLERO SUGGESTED “FOOD INSECURITY AND WHERE TO FIND HELP” AS A TOPIC TO ADD IN SUMMER 2024 NEWSLETTER.

MEETING ADJOURNED BY LOUIE ITURRIRIA, SENIOR DIRECTOR OF MARKETING AND MEMBER ENGAGEMENT, AT 12:27 PM TO MARCH 26, 2024 AT 11:00 AM

COMMITTEE: ***DRUG UTILIZATION REVIEW (DUR) COMMITTEE***
DATE OF MEETING: ***NOVEMBER 20, 2023***
CALL TO ORDER: ***6:34 P.M. BY MARTHA TASINGA, MD - CHAIR***

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

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
Public Comments	Martha Tasinga, MD, Committee Chair, asked for public comment. None were present.	*N/A*	*N/A*
Committee Comments	Martha Tasinga, MD, Committee Chair, asked for committee member announcements or reports. ** Dr. Hoffmann stated she is having problems with Long Acting Injectables (LAI), particularly obtaining the 2nd dose of a 2-shot regimen. It will eventually be covered under a prior authorization. ** Dr. Tasinga asked Dr. Hoffmann to send in some examples for us to forward to DHCS.	Bruce Wearda informed committee that DHCS will be conducting their routine audit beginning November 28, 2023. Dr. Tasinga shared several points with the committee: • Regarding MCAS, KHS has been moved off the red list. • 70% of our members are going in for a PCP visit within 7 days. (Leading the State) • Less than 10% of KHS members visited the ER vs PCP	*N/A*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
		• Beginning 01/01/24, KHS is expecting membership to increase by 60,000+ members. • KHS plans to be NCQA accredited in 2025 • Beginning in 2024, we will be implementing several new committees, and we will have open positions to fill. These committees will report to the QIHEC instead of the Board of Directors.	
Quorum	Attendance / Roll Call	Committee quorum requirement met.	*N/A*
CLOSED SESSION	N/A	N/A	*N/A*
OLD BUSINESS **6**	**Orlissa/Myfembree Update** Bruce Wearda followed up on a question from Dr. Srinivas about coverage of the Orlissa/Myfembree. Bruce stated that both are listed on Medi-cal's CDL and should be covered. Dr. Srinivas commented the issues seem to be resolving and she understands that the drugs should not require an auth.	N/A	*N/A*
NEW BUSINESS **CA-3** **CA-4** **CA-5**	**Approval of Minutes** The Committee's Chairperson, Martha Tasinga MD, presented the meeting minutes for approval. Report of Plan Utilization Metrics – RECEIVED AND FILED Educational Articles – RECEIVED AND FILED	☑ **ACTION**: Dr. Srinivas moved to approve minutes of September 25, 2023, seconded by Ms. Bell.	*11/20/23*
7	**Executive Order N-01-19: Medi-Cal Rx Update** Mr. Wearda informed the committee that beginning December 1, 2023 Medi-Cal was modifying their coverage criteria for continuous glucose meters (CGM). Handling of authorization requests for the supplies/devices would also be changing. Medi-Cal will expand coverage from Type 1 diabetes only to Type 1, Type 2, and Gestational. (Type 2 diabetics need either regular insulin use or demonstrate hypoglycemia.) Authorizations will be approved for one year. Gestational diabetes authorization requests will cover through the due date, plus one year.	☑ **ACTION**: N/A	*11/20/23*

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS/ ACTION	DATE RESOLVED
	All supplies (monitors, receivers, transmitters) will be authorized on one request.		
NEXT MEETING	Next meeting will be held Monday, March 18, 2024 at 6:30 pm	☑ **CLOSED**: Informational only.	*N/A*
ADJOURNMENT	The Committee adjourned 7:16 pm. ***Respectfully submitted: Amy Daniel, KHS Executive Health Services Coordinator***	**N/A**	*11/22/23*

The foregoing minutes were APPROVED AS PRESENTED on: _____ _____

Date Name

The foregoing minutes were APPROVED WITH MODIFICATION on: _____ _____

Date Name

Quarter/Year of Audit	2024
Month Audited	January
Total TAR's for the month	54
# of TAR's Audited	3
Name of Auditor	Christina Kelly
% TAT Met	100%
% Denial Comments Met	0%
APPROVED TAR'S	
Provider notified of approval decision within 24 hours of receipt of all required information.	3/3
Stamped with date of receipt.	3/3
Approval marked.	3/3
Chronic medications have date range indicated.	3/3
Fax/send to portal confirmation attached.	3/3
DENIED TAR'S	
Signed by the licensed pharmacist or Medical Director.	0
Provider notified of denial decision within 24 hours of receipt of all required information.	0
Letter sent to member within 3 business days of denial.	0
Stamped with date of receipt.	0
Denial marked.	0
Fax/send to portal confirmation attached.	0
NOA Commentary Met (simple, concise, appropriate reading level)	0
Name of Criteria used to make decision	0
MODIFIED TAR'S	
Signed by the licensed pharmacist or Medical Director if the medication is changed (one drug entity to another).	0
The patient is notified within 3 business days if the medication is changed. If only the dosage form is changed (tablets to syrup, etc.), the dosage remains the same (1/2 tablet of a higher strength to supply the same mg of whole tablet, etc.), no notification is required.	0
If the duration of therapy is changed, the therapy is sufficient to allow the provider opportunity to request additional therapy. No notice is required.	0
Stamped with date of receipt.	0
Modification marked.	0
Fax/send to portal confirmation attached.	0
Name of Criteria used to make decision	0
DUPLICATE/CANCEL TAR'S	
Timeliness - Reviewd & Returned in 24 Hr	0
Stamped with date of receipt.	0
Duplicate or Cancel marked.	0
Fax/send to portal confirmation attached.	0

To: EQIHEC

From: Pawan Gill, Health Equity Manager

Date: 02/08/24

Re: Health Equity Transformation Steering Committee (HETSC)

Background:

+

The Health Equity Office (HEO) was officially launched on January 3, 2023 in response to the 2024 DHCS contractual requirements and the pursuit of NCQA Accreditation. The mission of the Health Equity Office is to improve the health and well-being of our members and the communities through the delivery of trusted, high quality, cost effective and accessible healthcare to all, regardless of their zip code, race, ethnicity, preferred language, cultural preference or personal history. The HEO is responsible for developing an annual workplan which is informed by both quantitative and qualitative analysis that includes clinical and non-clinical interventions in support of equitable service delivery for our members. The HETSC is structured to receive valuable input from employees, members, providers and the community through the development of five Regional Access Committees (RACs), a Provider Health Equity and Learning Committee and Justice, Equity, Diversity & Inclusion committee.

Discussion:

The purpose of the Charter is to provide the following information about the Health Equity Transformation Steering Committee (HETSC):

- Description of HETSC
- Function
- Composition
- Frequency of Meetings
- 2024 Meeting Schedule

Fiscal Impact: None

Requested Action: Consideration of proposed HETSC Charter and 2024 Workplan for approval

KERN HEALTH SYSTEMS

Health Equity Transformation Steering Committee (HETSC)

Charter

Description of Committee:

The Health Equity Steering Transformation Committee (HETSC) is a subcommittee of the Executive Quality Improvement Health Equity Committee (EQIHEC). The HETSC is established to ensure that KHS remains an organization that understands and addresses social and racial justice and health equity to meet member needs. The HETSC is responsible for implementing organizational-wide initiatives that promote social and racial justice and health equity through various internal and external programs, activities and trainings. Qualitative data is solicited through the HETSC's three formal subcommittees: Regional Access Committees (RACs), Provider Health Equity & Learning (HEAL) Network and the Diversity, Equity, Inclusion & Belonging (DEIB) Committee. The HETSC participates in the EQIHEC by assigning HETSC designee(s) to regularly participate and provide input in the EQIHEC meeting. The HETSC is responsible for submitting and presenting regularly scheduled summaries of HEISW formal reports to the EQIHEC reflective of planned activities, goals, interventions, and ongoing goal progress.

Function:

The HETSC areas of responsibility and focus include but are not limited to:

1. Development of Internal Resources: The focus is to provide learning opportunities and activities for staff to promote personal and professional growth and understanding around issues of social and racial justice, equity, diversity, inclusion, and cultural humility.

2. Provider Network Development: The focus is on specific regional needs and existing skills of the provider network around health equity and provide training, resources, and support to providers to help build on their professional skills and help ensure they provide culturally sensitive and equitable treatment to all members.

3. Member Advocacy & Community Engagement: The focus is to promote ways that members can be educated about and provide feedback regarding their experiences with providers, KHS, and other systems in which their health is affected. Member feedback will be utilized to inform strategies developed to advocate for members' needs. The secondary focus is to sponsor and or participate in community events that are geared toward social and racial justice, develop initiatives that engage the community, impact health disparities, and help erase the stigmas surrounding mental health and substance use.

4. Human Resources Enhancement: The focus is to work on recruitment, retention, and promotion of a more diverse workforce, as well as to ensure KHS has a welcoming and inclusive environment for all employees. The HR department is responsible for creating, implementing, and overseeing DEI policies and practices that have a direct impact on the workforce and its stakeholders. Also, the HR department is committed to upholding the highest standards for prioritizing equitable and inclusive practices and ensuring that the organization is representative of the communities it serves. By working closely with all

departments and stakeholders, this workgroup will partner with the HR department to help ensure that the organization is inclusive, equitable, and responsive to the needs of the employees and communities it serves.

5. Monitoring and Evaluation for Continuous Improvement: The focus is to identify how effectively KHS staff apply internal QIHEP policies and procedures in the day-to-day operations and undertakings they perform. The HETSC has established objectives to address health disparities to include:

A.) Increase the awareness of health equity and quality and implement strengthened, expanded and/or new health equity quality activities to support providers and members ultimately reducing health inequities within KHS' membership.

B.) Ensure services provided to members promote equity and are free of implicit bias or discrimination.

C.) Implement programs that address the causes of inequity that members and their communities experience, food insecurity, housing problems, tobacco use, and other concerns.

D.) Analyze existence of significant health care disparities in clinical areas.

. E.) Reduce health disparities among members by implementing targeted quality improvement programs.

F.) Promote physician involvement in health equity/ disparities and activities.

G.) Conduct focused groups or key informant interview with cultural or linguistic minority members to determine how to meet their needs.

H.) Address social determinants of health.

I.) Developing the programs and policies to support the objectives.

Composition:

The HETSC is an internal workgroup that engages and collaborates with various business units from multiple KHS departments and across the organization that are involved in the development, execution and monitoring and evaluation of Health Equity programs and initiatives for members. Committee members will include representatives from the following departments:

Population Health Management	Quality Improvement	Enhanced Care Management
Health Education	Quality Performance	Community Engagement
Provider Network Management	Member Engagement	Marketing
Behavioral Health	Member Services	Community Support Services

KERN HEALTH SYSTEMS

HETSC (HEO)

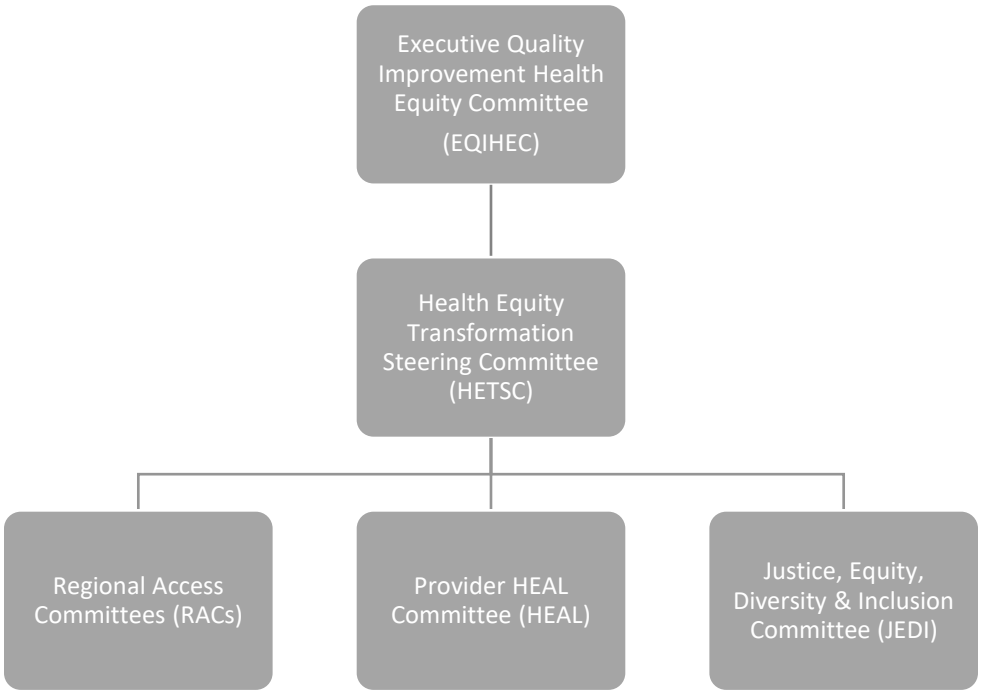
Meeting Schedule 2024

Months	Day
January	3rd Wednesday of the week
April	3rd Wednesday of the week
July	3rd Wednesday of the week
October	3rd Wednesday of the week

KERN HEALTH SYSTEMS

HETSC (HEO)

Structure



HEO Committee Meetings

Proposed Schedule

Committee Name	Acronym	Meeting Week/Month	Q1 Meeting Month	Q2 Meeting Month	Q3 Meeting Month	Q4 Meeting Month	Notes
Executive Quality Improvement Health Equity Committee	EQIHEC	2nd	February	May	August	November	Shift based on the Board Meeting schedule and holidays
Health Equity Transformation Steering Committee	HETSC	3rd	January	April	July	October	Will give time to prepare report to the EQIHEC
Diversity, Equity, Inclusion and Belonging Committee	DEIBC	1st	January	April	July	October	Will give time to get directive from EQIHEC and prepare report for HETSC
Provider HEAL Committee	HEAL	3rd	Nov/Dec (previous year)	March	June	September	Will give time to get directive from EQIHEC and prepare report for HETSC
Regional Advisory Committee	RAC	2nd	Nov/Dec (previous year)	March	June	September	Will give time to get directive from EQIHEC and prepare report for HETSC

KERN HEALTH SYSTEMS

2024 Kern Health Systems Health Equity Strategy

Context and Goals

Traco Matthews
Chief Health Equity Officer

February 15, 2024

AGENDA

1. Why Health Equity Matters, and 2023 Actions and Results
2. 2024 Health Equity Goals & Roadmap
3. Our Approach, and Our Request

Kern Family Health Care®

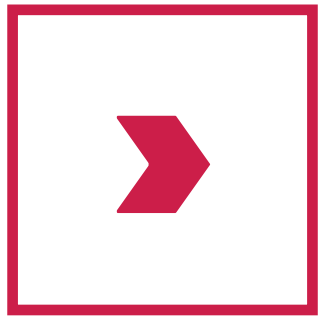
Health Equity Defined

Past

Repairing or adjusting for the deficiencies of the past

Present

Ensuring full engagement and participation in the present



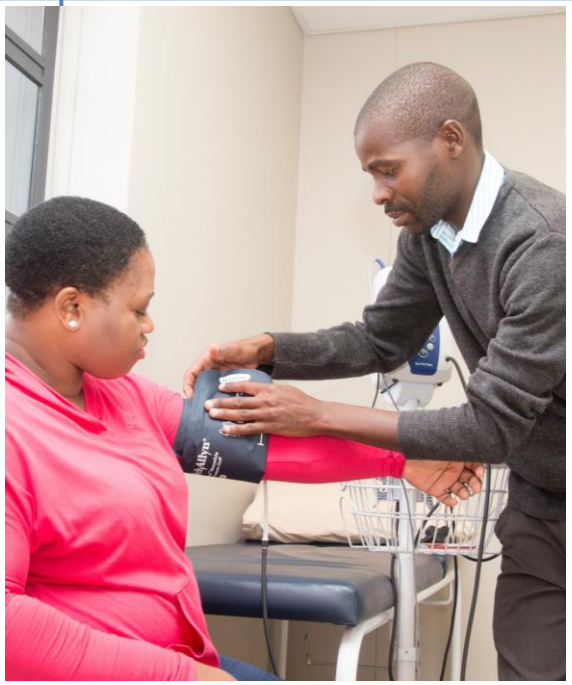
Future

Anticipating disequalization in the future and working to mitigate it

KHS definition: the mission of our KHS Health Equity Office is to improve the health and well-being of our members and the communities we serve through the delivery of trusted, high quality, cost-effective, and accessible health care to all, regardless of their zip code, race, ethnicity, preferred language, cultural preferences, or personal history.

Equity involves addressing inequalities in the past, present, and future

Demonstrated Through

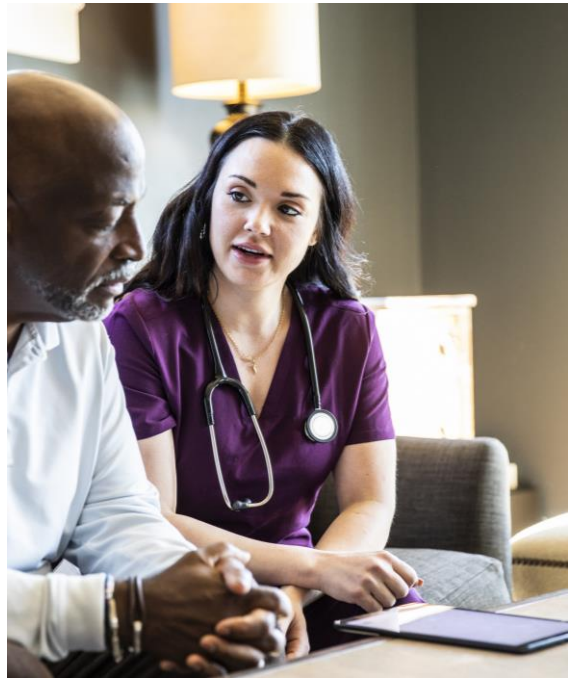


Focused, knowledgeable clinical interventions

Quality, MCAS, Utilization Management, Population Health Management, Wellness & Prevention., etc.

Customized non-clinical interventions

Marketing, Member Engagement, Community Engagement, HR, Member Services, Procurement, etc.



Member-centric evaluations

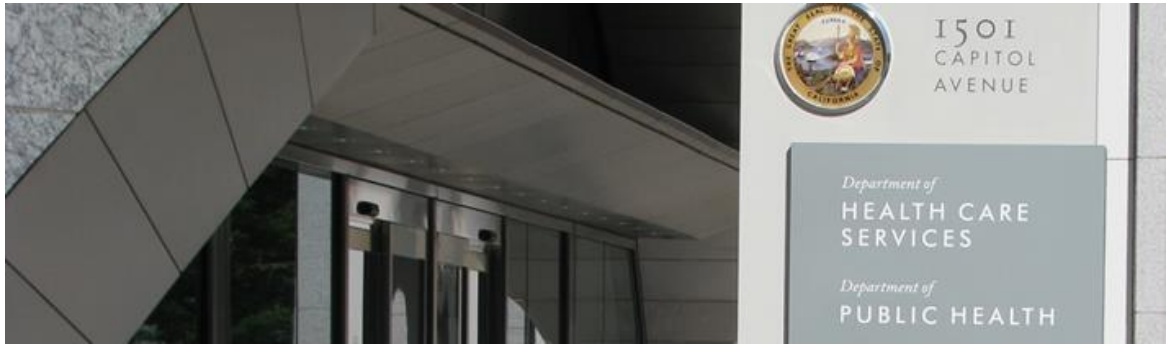
Of individual experiences

Strengthening trust

With historically marginalized communities

The Stakes

Kern has especially vulnerable members and is required to have a Health Equity office and plan.



Kern's Health Profile

Kern has some of the most vulnerable members in California

- Bottom 10 CA county in death rates, STDs, and infant mortality
- African American asthma 4x the next race/ethnicity
- Teen birth double CA average, prenatal care below CA average
- Obesity and suicide rates above CA averages

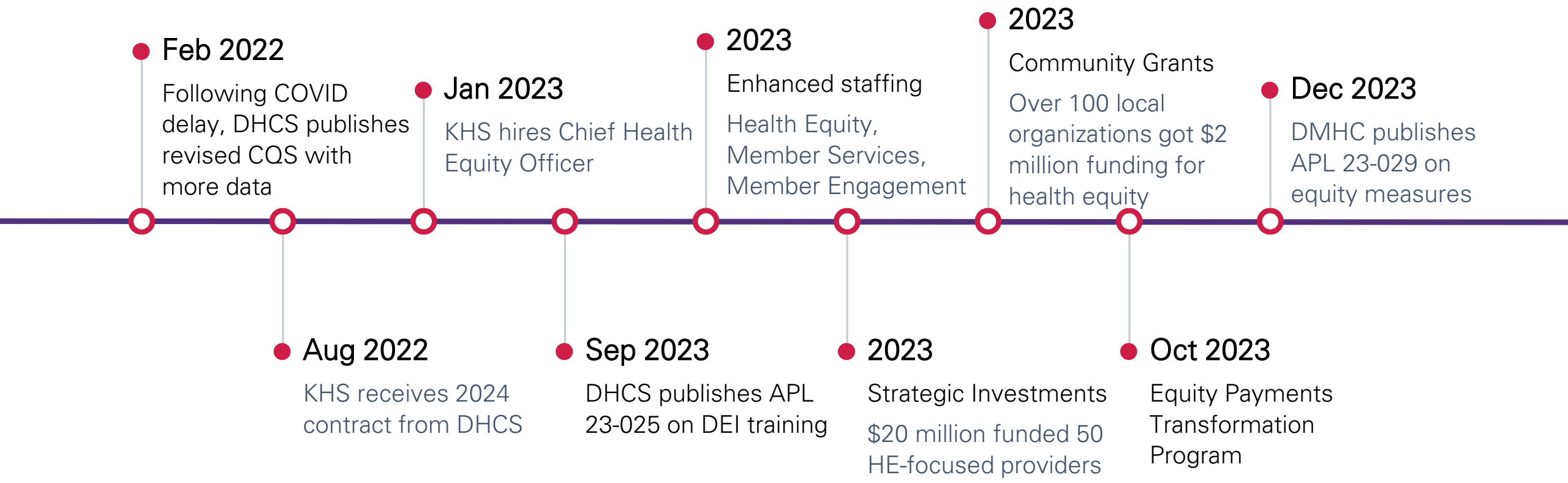
Why This Matters for KHS

KHS requires a Health Equity office and plan

- The Department of Health Care Services 2024 contract mandates a Chief Health Equity Officer, Health Equity Office, and a Quality Improvement Health Equity Transformation Program (QIHETP) for plans.
- The contract also necessitates a Quality Improvement Health Equity Committee (Executive Committee) and NCQA Health Equity Accreditation (NCQA HEA), emphasizing our continued commitment to excellence.
- KHS's strategic objective is to ameliorate Managed Care Accountability Set (MCAS) scores and close health disparity gaps in our community, hence the need for an independent NCQA Health Equity Accreditation.

Sequence of Events

KHS has long been involved in health equity initiatives like MCAS, Cultural Linguistics, Population Health Management and more. As we transition to a more strategic approach, we remain grateful to those who've dedicated their time to this crucial work. Our new division aims to enhance our organizational effectiveness in this area.



2023 KHS Health Equity Actions: Operational Readiness for 2024

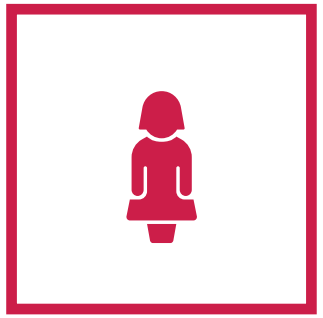
Under the 2024 DHCS Contract, KHS completed various corporate strategies by 2023, overseen by the Chief Health Equity Officer. All policies have been approved by DHCS and all programs were launched ahead of the mandated dates.

- ✓ Hired a Chief Health Equity Officer
- ✓ Established a Health Equity Office and hired staff
- ✓ Developed and submitted a Quality Improvement Health Equity Transformation Program (QIHETP) to DHCS
- ✓ Established an Executive Quality Improvement Health Equity Committee co-chaired by the CMO and CHEO
- ✓ Completed and submitted all required new policies related to health equity
- ✓ Began preparing for Health Equity Accreditation (HEA) though the National Committee for Quality Assurance (NCQA)
- ✓ Designed a Diversity, Equity, Inclusion, and Belonging (DEIB) program for KHS

2023 Health Equity Office Results

Launch of the new Equity Payments Transformation Program

Launched the Equity Payments Transformation Program for local Providers; achieved a high grant approval rate relative to other plans.



Launch of the Kern Health Equity Partnership (KHEP)

KHEP launched in 2024 as a collaboration between local health entities to promote health equity in Kern County.

Representation on national and state health equity panels

CHEO represented the Central Valley on panels for CA Health Care Foundation, RISE Conferences in New Orleans and Carlsbad.

CHEO appointed to CA State Racial Equity Commission

CHEO was appointed to the California Racial Equity Commission in 2024 to represent the Central Valley.

2023 marked significant results and stronger representation for Kern Health Systems in promoting health equity, especially in the Central Valley, and across the state.

2024 Goals: Employees, Members, Providers, and Community

Engage and develop employees with training, culture initiatives and DEI programs

Introduce health equity training, support 2024 culture initiatives and expand diversity, equity and inclusion program for employees

Focus on member wellness, prevention, health equity and quality improvement

Implement new wellness and prevention programs, advance health equity transformation efforts and enhance population health management for members

Provide incentives and training for providers

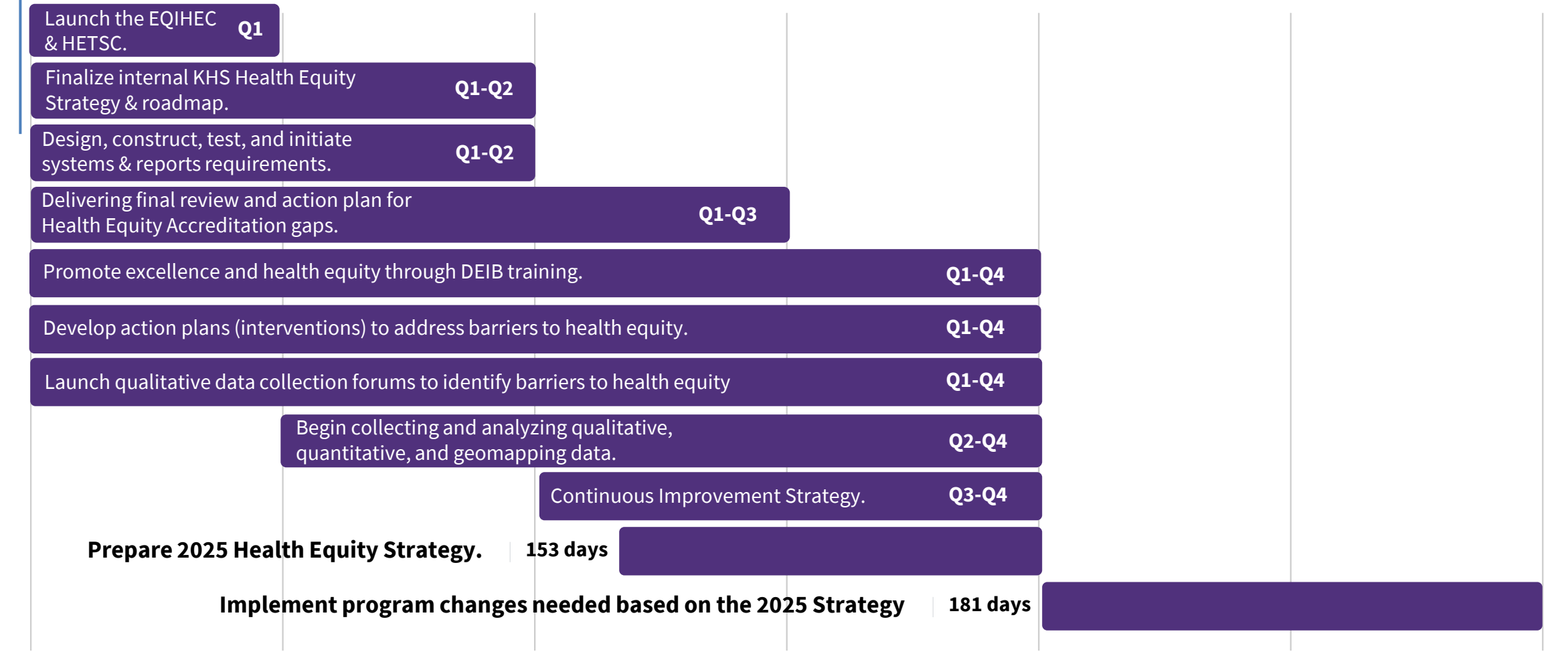
Engaging with providers to offer incentives and develop health equity training to improve care

Build relationships and invest in communities

Strengthen connections in communities through investments, relationship building and listening

Strategic goals aim to advance health equity through engagement across employees, members, providers and communities.

2024-2025 Strategic Roadmap



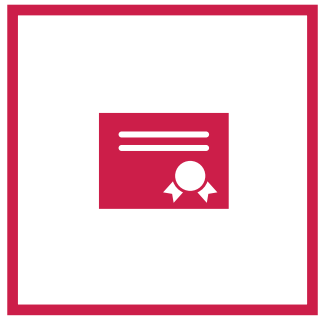
Board Request – Receive, File, and Note

1) Support for KHS's health equity goals and aspirations

Provide tangible support through approval of new partnerships, programs, and funding to advance KHS's mission for health equity.

2) Participation on committees

Selected board members are requested to participate in KHS committees and work groups focused on health equity initiatives (i.e. Executive Committee).



3) Engagement with selected health equity trainings

Commit to completing health equity trainings and workshops to increase knowledge and skills as they are rolled out the new 2-3 years.

By partnering closely with KHS on these requests, we can work together to significantly advance health equity in our community.

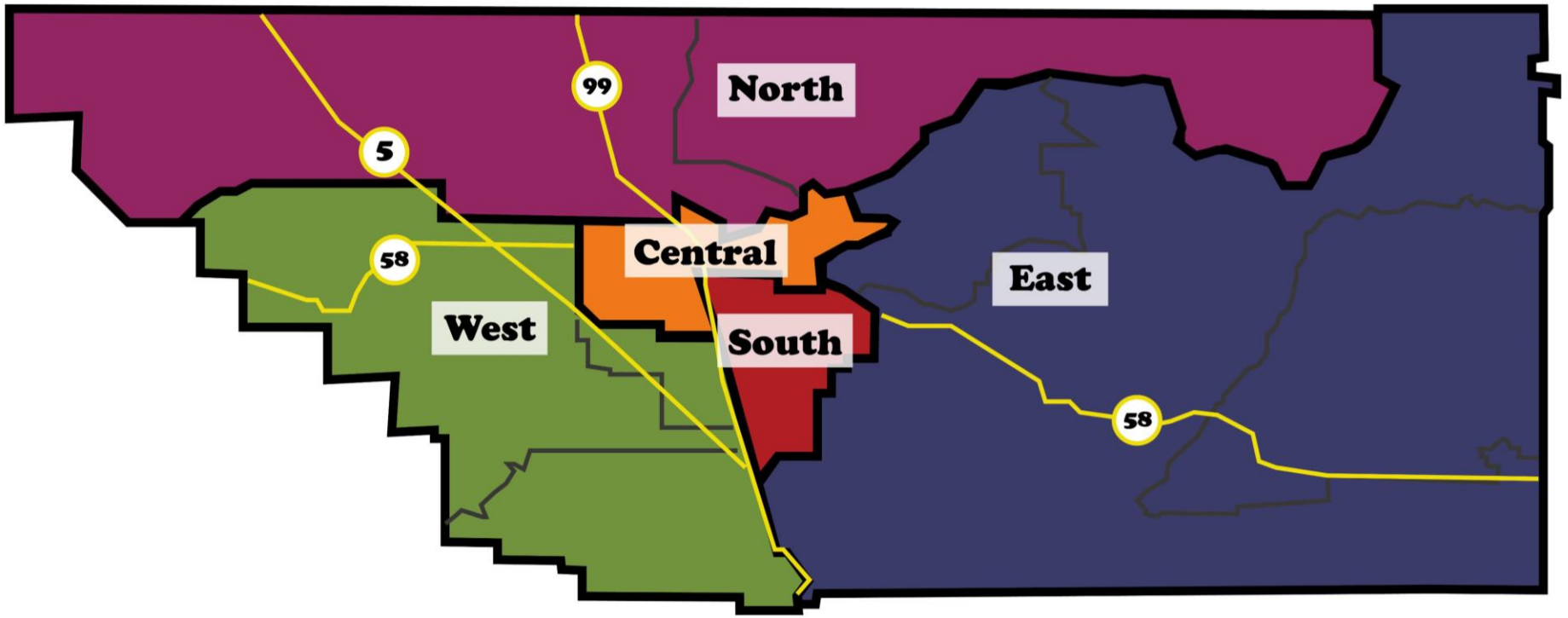
2024 Kern Health Systems - Health Equity Office Work Plan

YEARLY OBJECTIVE	GOAL	RESPONSIBLE PERSON(S)	Activities/ Interventions	Timeframe	Previously Identified Issue
ACCESS (PROVIDER)					
Scope of Activity: Determine member access to provider network by ensuring geographic accessibility of choice of providers via mapping of the provider network by level of care; auditing samples of Member Services notes to ensure that a choice of					
Member Needs Assessment	Conduct an annual member needs assessment. Identified gaps in the provider network will be addressed through the recommendations of the Network Adequacy Committee.	Director of Provider Network Management	Run report to assess needs of members. Review with stakeholders. Adjust provider network as necessary.	Q1-Q2	No
Multicultural Practices Provider Survey	Assesss provider cultural responsiveness. Additional goals and objectives with a timetable for implementation are documented in the C&L	Director of Provider Network Management	Conduct Survey Review results Adjust provider network and/ or address gaps	Q1-Q2	No
Collection of Providers' Race/Ethnicity Demographic Data	Expand and increase data integrity and reportability related to the the Collection of Provider's Demographic data to enable more effective decision making	Director of Provider Network Management & HEO Manager	Run current report, identify areas of opportunity to validate & update existing data and expand data collection	Q2-Q3	
Collection of Providers' Race/Ethnicity Demographic Data	Assess provider's race/ethnicity demographic profile to that of the member race/ethnicity profile	Director of Provider Network Management	Invoices to assess utilization of services. Review reports with stakeholders. Take corrective actions	Q2-Q3	No
Provider Training on Language Resources	Offer KHS contracted providers access and availability of language assistance resources	Director Member Services	Run report to assess needs of members. Review with stakeholders.	Q3-Q4	No
Assess KHS Provider Network Language Capabilities	Assesss provider language capabilities to that of the KHS member language needs.	Director, Member Services	needs of members. Review with stakeholders. Add to Provider Directory	Q3-Q4	No
ACCESS (Member)					
Scope of Activity: Ensure consumer access services by reviewing the answer and abandonment rates of telephone calls to the KHS Member Services line; monitoring the provision of interpretation and translation services; and evaluating penetration					
Utilization of Language Assistance Resources	Assess utilization of language assistance resources for organizational functions	Director, Member Services	invoices to assess utilization of services. Review reports with stakeholders. Take corrective actions	Q1-Q2	No
Identification of Threshold and Notification Languages	Identify threshold languages for members at 1,000 or 5% (whichever is less) and notification languages for members at 200	Director, Member Services	Run Annual Report Share with Stakeholders Update Vital Documents Process	Q1-Q2	No
COMPLAINTS AND GRIEVANCES					
Scope of Activity: Ensure the proper and timely handling of complaints and grievances.					
Grievances are written in clear, easy-to-understand language.	100% of grievance resolution letters are easy to understand and written in a language no greater than 6th grade.	Complaints and Grievances Manager	Run quarterly reports to assess grievance resolution letters. Review reports with stakeholders. Take corrective actions as necessary.	Q1	Yes
Improve tracking mechanism of grievances	Enhance current tracking mechanism to capture and easily report types of grievances (particularly discrimination related) and monitor regularly to identify trends	Complaints and Grievances Manager/HEO	Assess current report, add necessary columns and include in HESTC report	Q1	No
EXECUTIVE MANAGEMENT					
COUNTY					
Share CLAS Progress with Stakeholders	Share CLAS progress with stakeholders, including obtaining MHC distinction	Sr Director of Wellness & Prevention	Share with Stakeholders	Q2-Q3	No
Annual evaluation of the CLAS program	Conduct annual evaluation of the CLAS program	Sr Director of Wellness & Prevention	Share with Stakeholders Identify and address areas for improvement	Q2-Q3	No

Assessment of KHS Workforce Demographics	Analyze KHS workforce demographics	Health Equity Officer	workforce activities. Review with stakeholders. Monitor workforce demographics for hiring	Q1	No
Diversity, Equity and Inclusion (DEI) Task Force Development	Development of the KHS DEI Task Force will serve as the stepping stone to mobilize efforts around implementation of DEI practices, policies, engagement, climate pulse checks, and training opportunities.	Health Equity Officer	Solicit workforce participation for task force development Establish task force with regular occuring meeting schedule	Q1-Q2	No
Organizational Climate Assessment	Conduct Annual Organizational Climate Assessment	Health Equity Officer	Develop KHS Organizational Climate Assessment Tool Facilitate Organizational	Q1	No
Diversity, Equity and Inclusion (DEI) Training	Develop organization- wide divesity, equity and inclusion training curriculum	Health Equity Officer	Assess organizational training needs Create DEI Training Curriculum	Q1-Q3	No
Ensure Bilingual KHS Workforce	Maintain a bilingual Member Services Department workforce that is representative of 5% of the population	Director of Human Resources Director of Member Services	Maintain Member Service Staffing Share with Stakeholders Add to Qualified	Q1	No
Bi-Lingual Staff Competency Assessment	Conduct Language Proficiency Test for all new bilingual applicants	Director of Human Resources Director of Member Services	Facilitate LPT Assessment Provide LPT assessment scores	Q1-Q4	No
Staff Experience with Language Assistance Resources	Assess baseline of staff experience with language resources	Director of Member Services	Run Annual Report Share with Stakeholders Identify and address	Q1 & Q3	No
QUALITY MANAGEMENT					
Scope of Activity: Demonstration of appropriate quality management strategies, as incorporated into the QM Program Description and Work Plan, and additional quality activities around specific service areas such as BHRS, BH-PH coordination,					
Reduce language disparities among Asian speaking members	Reduce language disparities among Asian speaking members getting screening for breast cancer by 5 % in comparison to other groups.	Health Equity Officer Director of Quality	Run quarterly report to assess IET measures. Review reports with stakeholders. Take corrective actions as necessary.	Q1-Q4	No
Reduce disparities among Hispanic Members	Improve manamgent of Diabetes by reducing A1c levels in Hispanic members by 2024. Improve the good control rate by 5 % by 2024.	Health Equity Officer Director of Quality	Run quarterly report to assess IET measures. Review reports with stakeholders. Take corrective actions as necessary.	Q1-Q4	No
CONSUMER/FAMILY SATISFACTION					
Scope of Activity: Qualitative review of overall member satisfaction, via Consumer Satisfaction Team reports and the timely resolution of issues raised					
Assessment of member experience with Language Resources	Assess baseline of member experience with language resources	Director of Member Services	Run Annual Report Share with Stakeholders Identify and address areas for improvement	Q1 & Q3	No
HEO Regional Listening Sessions	Gather qualitative data directly from members and the community regarding their experience	Health Equity Office	Assess baseline of member experience for medical access, quality and trust	Q1	No

2024 Health Equity Office

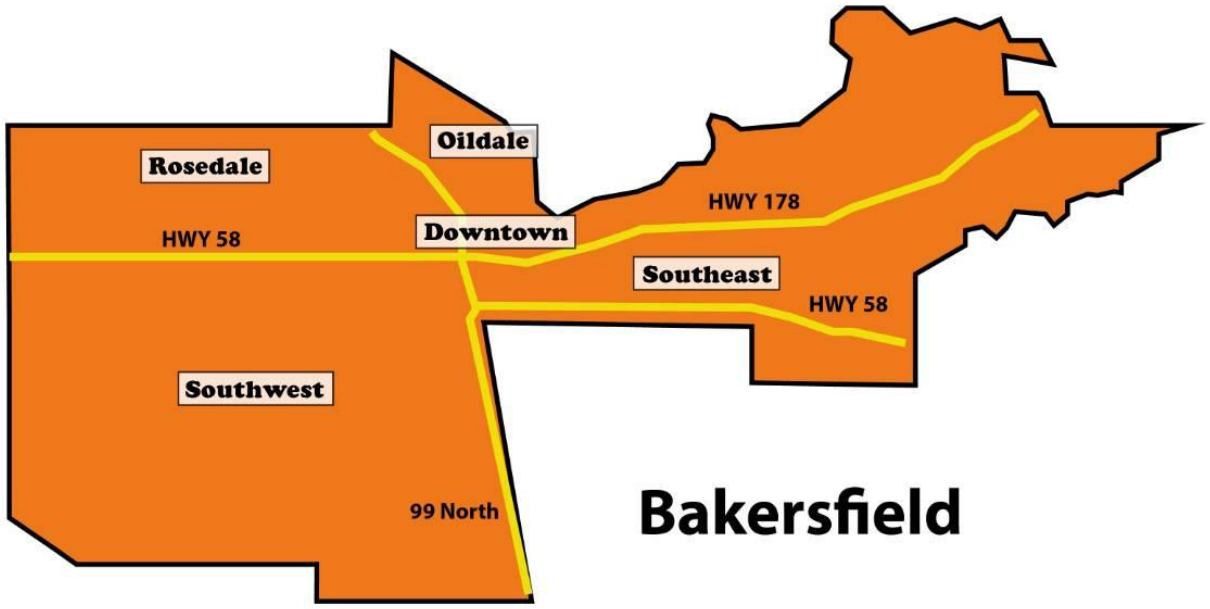
Kern County Regional Map (5 Regions)



Central Kern – Bakersfield Community Profile

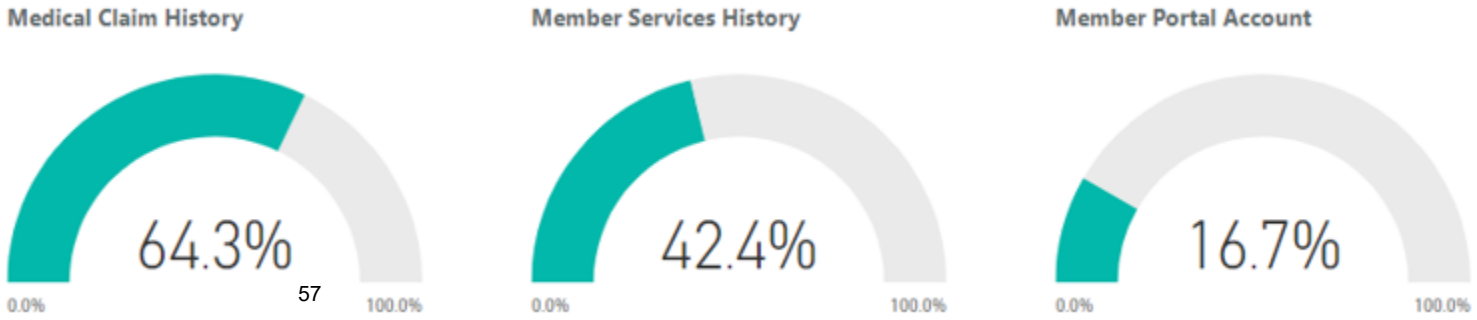
264,287 Members

- Ethnicity chart:
  - Hispanic 60%
  - Caucasian 16%
  - African American 7%
- Top languages:
  - English 73%
  - Spanish 26%
  - Arabic 1%



Top Medical Conditions: Hypertension, Persistent Asthma, Disorders of Lipid Metabolism, Diabetes, Depression

Current Programs: Kidney Disease Program (PHM), Baby Steps Program
Target Pop: AA population and well 93308 & 93305 zipcodes (W&P, PHM), Asthma Class Series, Diabetes Prevention (onsite KHS & Online)



Northern Kern Community Profile

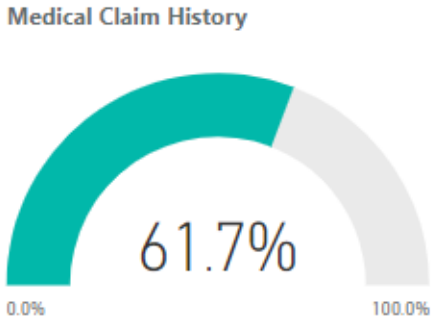
60,363 Members

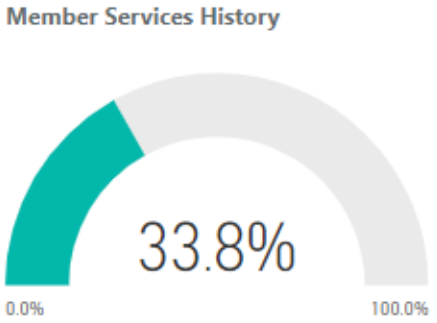
- Ethnicity chart:
  - Hispanic 82%
  - Filipino 4%
  - Caucasian 4%

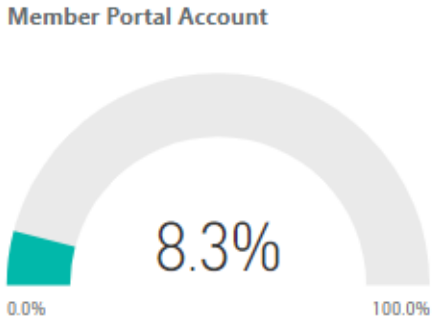
- Top languages:
  - English 51%
  - Spanish 48%
  - Tagalog 1%

Top Medical Conditions: Disorder of Lipid Metabolism, Hypertension, Persistent Asthma, Diabetes, Low Back Pain(McFarland & Lost Hills – Anemia)

Current Programs: Kidney Disease Program (PHM), Nurturing Parent Class (English & Spanish sessions – Shafter),







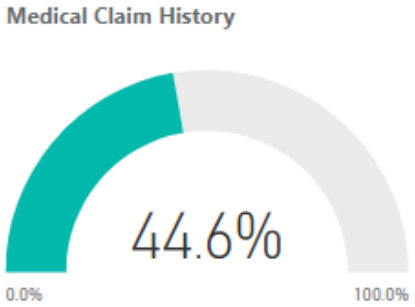
Eastern Kern Community Profile

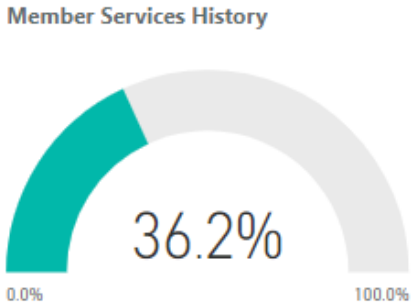
33,442 Members

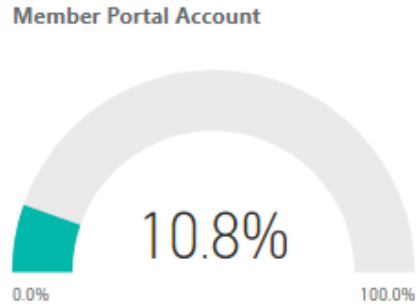
- Ethnicity chart:
  - Caucasian 44%
  - Hispanic 34%
  - African American 10%
- Top languages:
  - English 89%
  - Spanish 11%

Top Medical Conditions: Depression, Disorder of lipid metabolism, Hypertension, Persistent Asthma`

Current Programs: Kidney Disease Program (PHM),







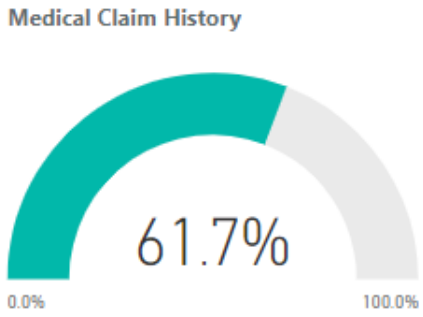
West Kern – Community Profile

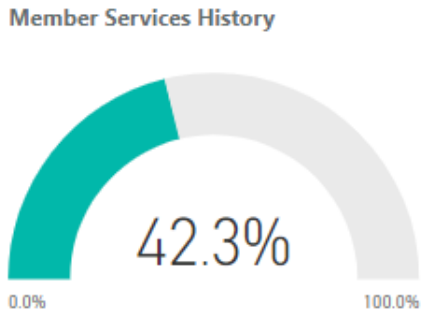
14,721 Members

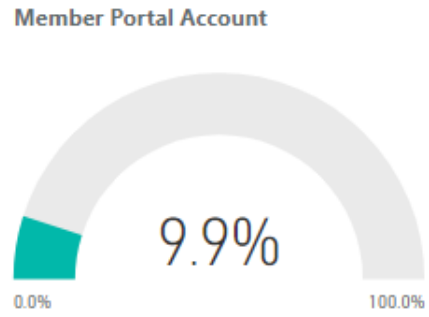
- Ethnicity chart:
  - Hispanic 55%
  - Caucasian 31
  - African American 1%
- Top languages:
  - English 59%
  - Spanish 41%
  - Arabic .5%

Top Medical Conditions: Disorders of Lipid Metabolism, Hypertension, Persistent Asthma, Depression

Current Programs: Kidney Disease Program (PHM),







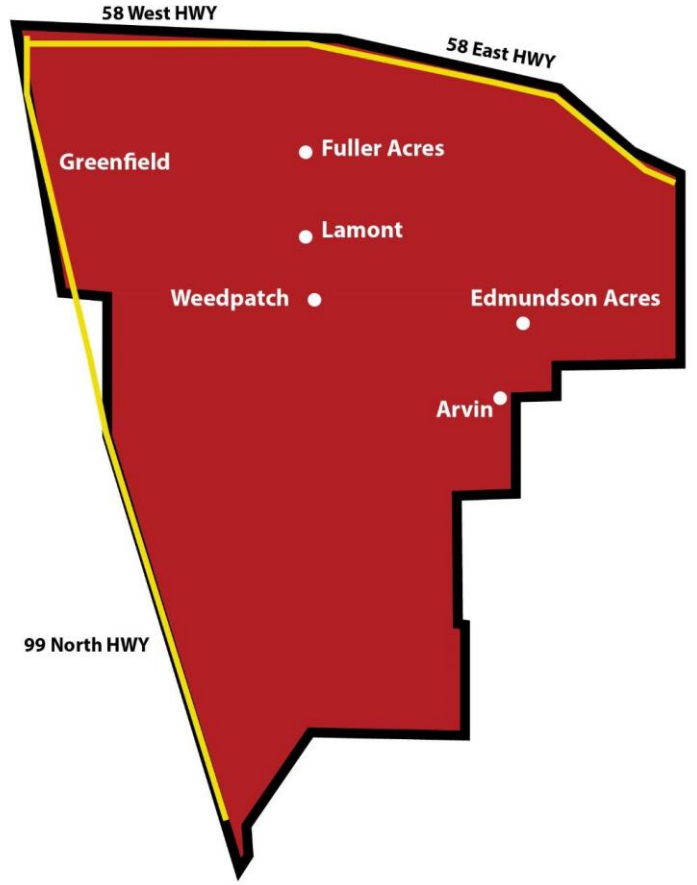
South Kern – Community Profile

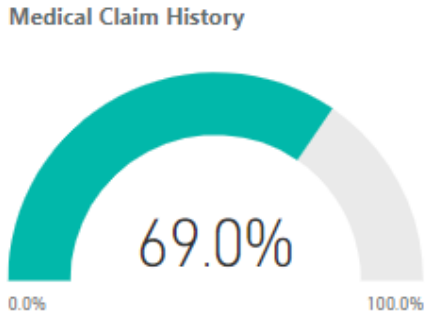
25,252 Members

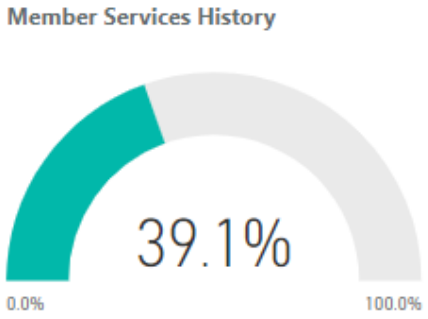
- Ethnicity chart:
  - Hispanic 89%
  - Caucasian 3%
  - African American .5%
- Top languages:
  - Spanish 63%
  - English 37%
  - Arabic .5%

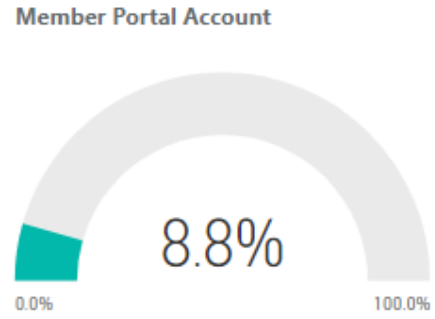
Top Medical Conditions:
Disorders of Lipid Metabolism, Hypertension, Persistent Asthma, Diabetes

Current Programs:
Kidney Disease Program (PHM),









HEO Community Engagement Efforts

- Community Listening Sessions have been hosted in: Bakersfield, Lamont, Delano & Taft. East Kern TBA.

- Special Population sessions for 2024:
  - South Asian Forum
  - LGBTQIA++
  - Muslim/Arabic Community
  - Filipino Community
  - Indigenous

KERN HEALTH SYSTEMS

To: **KHS EQIHEC Committee**

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

Date: **January 29, 2024**

Re: **Credentialing Statistics 4th Quarter 2023 & 2023 Year-End Summary**

Background

During 4th Quarter monitoring/reporting period October 1, 2023 through December 31, 2023 there were a total of 159 Initially Credentialed Providers and 135 Recredentialed Providers.

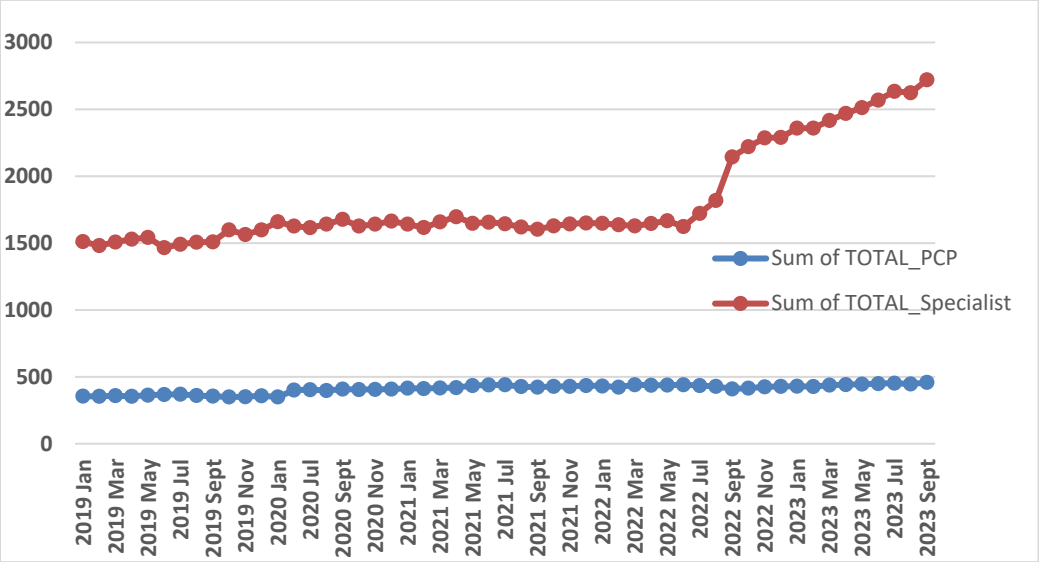
38 New Contracts were processed and approved:

1	**Ambulatory Surgery Center**	**2**	**ABA Specialist**
1	**CBAS**	**2**	**Doula Providers**
12	**Comm Support Svcs/ECM/CBO**	**2**	**Mental Health Groups**
3	**DME**	**1**	**Primary Care Group**
1	**Hospice**	**1**	**Registered Dietician**
1	**Prosthetics & Orthotics**		
3	**Skilled Nursing Facility/CHLF**		
2	**Transportation**	**6**	**SPECIALTY CONTRACTS:**
			Specialties: Neurosurgery, Peds GI, Endocrinology, Ophthalmology, Family Planning, IM/SNF

Discussion

- All credentialing and recredentialing files were approved as presented.
  - PCPs increased from 474 to 489 (As of Oct 2023 - Excluding out of area telehealth)
    33-PCP additions included 18-Physicians and 15-NP/PA
    20-PCP Terminations from the network
  - Specialists increased from 2,820 to 3,106 (As of Oct 2023)
    286-Specialists added to the network
    (Includes non-licensed BH Technicians and Delegated Tertiary Specialists)
    86-Specialist terminations
  - No significant trends identified for termed PCP or Specialist Providers
- All New Contracts were approved.
  - There were 4-contracts withdrawn due to not meeting credentialing requirements.
    - 2-ASCs not accredited; 1-Transporation insurance not met; and 1 SNF-quality issues not met.

PCP / Specialist Summary:



2023 Year End Credentialing Statistics:

- Credentialing processed 523 initial applications (433 in 2022 – **20.7% increase**)
- Credentialing processed 548 recredentialing (478 in 2022 – **14.6% increase**)
- Credentialing processed 156 additional locations (125 in 2022 – **24.8% increase**)
- New Contracts processed 80 (67 in 2022 – **19.4% increase**)
- Termed Contracts 21 (27 in 2022 – **22.2% decrease**)
- 2023: There were no providers denied network participation and 41-applications withdrawn for various reasons.

KERN HEALTH SYSTEMS
CONTRACTS CREDENTIALING SUMMARY
2023

Month	New Contracts	Termed Contracts	Credentialing	Recredentialing	Deferred, Modified and Delayed
January	NO BOD				
February	6	5	67	53	0
March	7	0	35	57	0
April	5	4	48	54	0
May	3	0	45	74	0
June	3	0	40	66	0
July	NO BOD				
August	9	4	74	62	0
September	9	0	54	48	0
October	13	5	62	46	0
November	8	0	46	36	0
December	17	3	52	52	0
Total YTD	**80**	**21**	**523**	**548**	
			Total Credentialing Files Approved YTD:	**1071**	
			Additional locations	**156**	

Fiscal Impact: N/A

Requested Action: Informational Only

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

Report Date: December 8, 2023

Department: Provider Network Management

Monitoring Period: October 1, 2023 through December 31, 2023

Population:

Providers	Credentialed	Recredentialed
MD's	59	58
DO's	5	1
DC's	1	1
PA's	7	11
NP's	28	22
CRNA's	1	1
DPM's	3	1
OD's	1	1
RD's	1	0
BCBA's	11	4
CNM's	5	0
Mental Health	13	7
Doula's	2	0
Ancillary	13	28
Comm Supp Svcs	5	0
Enhanced Care/Case Mgmt	4	0
TOTAL	**159**	**135**

Specialty	Providers Credentialed	Providers Recredentialed	Providers Sent to PAC	Providers Not Approved
Addiction Medicine	1	0	1	0
Allergy & Immunology	0	1	1	0
Anesthesiology / CRNA	2	3	5	0
Autism / Behavioral Analyst	11	4	15	0
Cardiology	3	3	6	0
Chiropractor	1	1	2	0
Dermatology	2	0	2	0
Doula	2	0	2	0
Emergency Medicine	0	1	1	0
Endocrinology	2	0	2	0
Family Practice	20	26	46	0
Gastroenterology	3	0	3	0
General Practice	2	9	11	0
General Surgery	5	5	10	0
Gynecology/Oncology	1	0	1	0
Hematology/Oncology	1	2	3	0
Hospitalist	10	1	11	0
Infectious Disease	2	1	3	0

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

Specialty	Providers Credentialed	Providers Recredentialed	Providers Sent to PAC	Providers Not Approved
Internal Medicine	6	13	19	0
Mental Health	13	7	20	0
Nephrology	4	0	4	0
Neurological Surgery	4	0	4	0
Neurology	1	1	2	0
Obstetrics & Gynecology	15	3	18	0
Optometry	1	1	2	0
Orthopedic Surgery / Hand Surg	2	2	4	0
Otolaryngology	1	0	1	0
Pain Management	2	0	2	0
Pathology	0	1	1	0
Pediatrics	4	9	13	0
Physical Medicine & Rehab	0	1	1	0
Podiatry	3	1	4	0
Psychiatry	12	3	15	0
Pulmonary	0	1	1	0
Radiation Oncology	1	2	3	0
Radiology	8	4	12	0
Registered Dieticians	1	0	1	0
Thoracic Surgery	1	0	1	0
Urology	1	1	2	0
Vascular Surgery	0	2	2	0
TOTAL	**148**	**109**	**257**	**0**

ANCILLARY	Providers Credentialed	Providers Recredentialed	Providers Sent to PAC	Providers Not Approved
Ambulance	0	1	1	0
Comm. Based Adult Services	1	0	1	0
Dialysis Center	0	1	1	0
DME	3	0	3	0
Home Health	0	2	2	0
Hospice	1	2	3	0
Hospital / Tertiary Hospital	0	3	3	0
Pharmacy	0	4	4	0
Pharmacy/DME	0	3	3	0
Physical / Speech Therapy	0	1	1	0
Prosthetics & Orthotics	1	0	1	0
Radiology	0	2	2	0
SNF /Congregate Living	3	1	4	0
Surgery Center	1	1	2	0
Transportation	2	2	4	0
Urgent Care	1	5	6	0
Community Support Services	5	0	5	0
Enhanced Care/Case Mgmt	4	0	4	0
TOTAL	**22**	**28**	**50**	**0**

Defer = 0 **Denied = 0**

KERN HEALTH SYSTEMS
Board Approved Effective 10/01/2023

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

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

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

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

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

KERN HEALTH SYSTEMS
Board Approved Effective 11/01/2023

PROVIDER NAME	LEGAL NAME/DBA/ADDRESS	SPECIALTY	CONTRACT STATUS	PROV PRV	VENDOR PRV	PAC APPROVED - EFFECTIVE DATE
Eslami, Setare MD	Arise Psychiatric Medical Group, Inc 1500 Haggin Oaks Blvd, Suite 202 5201 White Ln Bakersfield CA 100 Willow Plaza Ste 309 Visalia CA	Psychiatry	New Contract	PRV075865	PRV075857	Yes Eff 10/1/23
Lui, Kingwai DO	Arise Psychiatric Medical Group, Inc 1500 Haggin Oaks Blvd, Suite 202 5201 White Ln Bakersfield CA 100 Willow Plaza Ste 309 Visalia CA	Psychiatry	New Contract	PRV050554	PRV075857	Yes Eff 10/1/23
Ma, Albert MD	Arise Psychiatric Medical Group, Inc 1500 Haggin Oaks Blvd, Suite 202 5201 White Ln Bakersfield CA 100 Willow Plaza Ste 309 Visalia CA	Psychiatry / Child & Adolescent Psychiatry	New Contract	PRV003969	PRV075857	Yes Eff 10/1/23
Mazzullo, Joseph NP	Arise Psychiatric Medical Group, Inc 1500 Haggin Oaks Blvd, Suite 202 5201 White Ln Bakersfield CA 100 Willow Plaza Ste 309 Visalia CA	Psychiatry / Child & Adolescent Psychiatry	New Contract	PRV057658	PRV075857	Yes Eff 10/1/23
Moreno, Raymond BCBA	Prism Behavioral Solutions 4900 California Avenue Ste. 210B Bakersfield CA	QASP / Behavioral Analyst	Existing	PRV093629	PRV069746	Yes Eff 10/1/23
Ragins, Kyle MD	Bright Heart Health Medical Group 2960 Camino Diablo Ste. 105 Walnut Creek CA	Addiction Medicine	Existing	PRV047896	PRV061628	Yes Eff 10/1/23
Shenasan, Goli MD	Kern County Hospital Authority 1700 Mt Vernon Ave Bakersfield CA	Psychiatry	Existing	PRV081352	ALL SITES	Yes Eff 10/1/23
Uybadin, Ayce BCBA	Adelante Behavioral Health ABA LLC 2005 Eye Street Ste. 8 Bakersfield CA	QASP / Behavioral Analyst	Existing	PRV093865	PRV067923	Yes Eff 10/1/23
Uybadin, Maxim BCBA	Adelante Behavioral Health ABA LLC 2005 Eye Street Ste. 8 Bakersfield CA	QASP / Behavioral Analyst	Existing	PRV093866	PRV067923	Yes Eff 10/1/23
Apollo Surgery Center, LLC	Apollo Surgery Center, LLC 43944 15th St W, Suite 101 Lancaster CA	Ambulatory Surgery Center	NEW	PRV091352	PRV091352	Yes Eff 11/1/23
Dhillon, Manprit	Antelope Valley Neuroscience Med Group 42135 10th Street West Ste 301 Lancaster CA	Neurosurgery	NEW	PRV006624	PRV030410	Yes Eff 11/1/23
Farrukh, Abdallah MD	Antelope Valley Neuroscience Med Group 42135 10th Street West Ste 301 Lancaster CA	Neurosurgery	NEW	PRV006277	PRV030410	Yes Eff 11/1/23
Galindo, Guadalupe NP-C	Jasleen Duggal MD Inc dba: Kern Endocrine Center 3008 Sillect Ave Ste 240 Bakersfield CA	Endocrinology	NEW	PRV012780	PRV000402	Yes Eff 11/1/23
Heart Beat Med Transit LLC	Heart Beat Med Transit LLC 8720 Harris Rd Ste 102A Bakersfield CA	Transportation	NEW	PRV093867	PRV093867	Yes Eff 11/1/23
Manning Gardens Care Center Inc	Manning Gardens Care Center Inc 2113 E Manning Ave Fresno CA	SNF	NEW	PRV081661	PRV081661	Yes Eff 11/1/23

Royal Congregate Living Facility	Spiritus Home Health Care Inc dba: Royal Congregate Living Facility 3100 Mildwood Ct Lancaster CA	SNF / CHLF	NEW	PRV093883	PRV093883	Yes Eff 11/1/23
Tehachapi ADHC Inc	Tehachapi ADHC Inc 123 West F Street Tehachapi CA	CBAS	NEW	PRV093233	PRV093233	Retro Approval 10/1/2023
The Bra Shoppe	Elizabeth Sotelo dba: The Bra Shoppe 1400 Calloway Dr #202 Bakersfield CA	DME	NEW	PRV088728	PRV088728	Yes Eff 11/1/23
Wang, Hongtao MD	Valley Gastroenterology Institute Inc. 1191 E Herndon Ave #103 Fresno CA	Pediatric Gastroenterology	NEW	PRV086077	PRV086077	Yes Eff 11/1/23
Williams, Kori NP-C	Jasleen Duggal MD Inc dba: Kern Endocrine Center 3008 Sillect Ave Ste 240 Bakersfield CA	Endocrinology	NEW	PRV087359	PRV000402	Yes Eff 11/1/23
Avant-Ortiz, Kendra NP	Accelerated Urgent Care *All locations 212 Coffee Rd Ste 100 Bakersfield CA	Family Practice / UC	Existing	PRV092686	ALL SITES	Yes Eff 11/1/23
Bahram, Bashir MD	Adventist Health Reedley 406 James St Shafter CA 501 6th Street Taft CA	Family Practice	Existing	PRV092690	ALL SITES	Yes Eff 11/1/23
Balli, Swetha MD	Clinica Sierra Vista 1685 East Home Ave Fresno CA	Family Practice	Existing	PRV080744	PRV0000002	Yes Eff 11/1/23
Bedrosian, Ania CRNA	Regional Anesthesia Associates 1700 Mt Vernon Ave Bakersfield CA	Anesthesiology	Existing	PRV087758	PRV037540	Yes Eff 11/1/23
Braga, Angelica Maria NP-C	Kern County Hospital Authority 9300 Stockdale Hwy Ste 100 Bakersfield CA	OB/GYN	Existing	PRV091047	ALL SITES	Yes Eff 11/1/23
Cavallaro, Grace MD	OBHG California PC 420 34th Street Bakersfield CA	OBG / Hospitalist	Existing	PRV056112	PRV000384	Yes Eff 11/1/23
Cervantes, Frank NP-C	Clinica Sierra Vista 8787 Hall Road Lamont CA	Family Practice	Existing	PRV093008	PRV0000002	Yes Eff 11/1/23
Crum, Charles MD	Kern Radiology Medical Group *All Locations 2301 Bahamas Dr. Bakersfield CA	Diagnostic Radiology	Existing	PRV038039	ALL SITES	Yes Eff 11/1/23
D'Souza, Steffi MD	Omni Family Health 210 N Chester Ave Bakersfield CA	Family Practice	Existing	PRV092687	PRV0000019	Yes Eff 11/1/23
Duquette, Julie MD	LA Laser Center PC, *All Locations 5600 California Ave Ste 101 Bakersfield CA	Dermapathology	Existing	PRV090578	PRV013922	Yes Eff 11/1/23
Fawibe, Oluwatosin MD	Dignity Health Medical Group 3838 San Dimas St Bakersfield CA	General Surgery	Existing	PRV093545	PRV012886	Yes Eff 11/1/23
Finberg, Kurt MD	OBHG California PC 420 34th Street Bakersfield CA	OBG / Hospitalist	Existing	PRV006296	PRV000384	Yes Eff 11/1/23
Huerta-Galindo, Juan MD	Clinica Sierra Vista 625 34th Street Ste 100 & 200 Bakersfield CA	Internal Medicine	Existing	PRV092065	PRV000002	Yes Eff 11/1/23
George, Kimberly CNM	OBHG California PC 420 34th Street Bakersfield CA	OBG / Hospitalist	Existing	PRV085537	PRV000384	Yes Eff 11/1/23
Goldenberg, Mitchell MD	Ridgecrest Regional Hospital 105 E Sydnor Ave Ste 100 Ridgecrest CA	Urology	Existing	PRV092037	ALL SITES	Yes Eff 11/1/23
Kaur, Amandeep NP-C	Clinica Sierra Vista 8787 Hall Road Lamont CA	Family Practice & Pediatrics	Existing	PRV092064	PRV0000002	Yes Eff 11/1/23
Khanna, Rohit MD	Kern Radiology Medical Group *All Locations 2301 Bahamas Dr. Bakersfield CA	Diagnostic Radiology	Existing	PRV065516	ALL SITES	Yes Eff 11/1/23
Lai, Hobart DO	Kern County Hospital Authority 1111 Columbus Street Bakersfield CA	Internal Medicine	Existing	PRV090577	ALL SITES	Yes Eff 11/1/23

Lin, Tzu Lu DPM	Stockdale Podiatry Group *All Locations 110 New Stine Rd Bakersfield CA	Podiatry	Existing	PRV092219	PRV000332	Yes Eff 11/1/23
Ludwig, Benjamin MD	Kern Radiology Medical Group *All Locations 2301 Bahamas Dr. Bakersfield CA	Diagnostic Radiology	Existing	PRV093880	ALL SITES	Yes Eff 11/1/23
Martins, Korinna CNM	OBHG California PC 420 34th Street Bakersfield CA	OBG / Hospitalist	Existing	PRV086081	PRV000384	Yes Eff 11/1/23
McClendon, Freddie MD	Regional Anesthesia Associates 1700 Mt Vernon Ave Bakersfield CA	Anesthesiology	Existing	PRV006434	PRV037540	Yes Eff 11/1/23
Neequaye, Aileen NP-C	Institute of Advanced Gastroenterology 9802 Stockdale Hwy Ste 102 Bakersfield CA	Gastroenterology	Existing	PRV093881	PRV000330	Yes Eff 11/1/23
Nweze, Margaret NP-C	Universal Healthcare Services - CCPM 8303 Brimhall Rd Bldg 1500 3550 Q Street Ste. 201 & 202 Bakersfield CA	Pain Management	Existing	PRV093169	ALL SITES	Yes Eff 11/1/23
Ortiz, Adolfo NP-C	Accelerated Urgent Care *All locations 212 Coffee Rd Ste 100 Bakersfield CA	Family Practice / UC	Existing	PRV093482	ALL SITES	Yes Eff 11/1/23
Patel, Mukesh PA-C	Kern Neurosurgical Institute 5329 Office Center Court Ste 110 Bakersfield CA 93309	Neurosurgery	Existing	PRV000851	PRV012900	Yes Eff 11/1/23
Peters, Kristen NP-C	Kern County Hospital Authority 1800 Mt Vernon Ave Bakersfield CA	Trauma Surgery	Existing	PRV092689	ALL SITES	Yes Eff 11/1/23
Ramirez, Sanggitha PA-C	Kern County Hospital Authority 3551 Q Street Ste 100 Bakersfield CA	Orthopedic Surgery	Existing		ALL SITES	Yes Eff 11/1/23
Saba JoAnn MD	Clinica Sierra Vista 217 Kern Ave McFarland CA	Pediatrics	Existing	PRV046682	PRV0000002	Yes Eff 11/1/23
Schleicher, Laura CNM	OBHG California PC 420 34th Street Bakersfield CA	OBG / Hospitalist	Existing	PRV091756	PRV000384	Yes Eff 11/1/23
Sosnowski, Rafal MD	Kern Radiology Medical Group *All Locations 2301 Bahamas Dr. Bakersfield CA	Diagnostic Radiology	Existing	PRV070167	ALL SITES	Yes Eff 11/1/23
Stafford, Leslee NP-C	Kern County Hospital Authority 1800 Mt Vernon Ave Bakersfield CA	Trauma Surgery	Existing	PRV092067	ALL SITES	Yes Eff 11/1/23
Stevens, Sydney MD	Kern Radiology Medical Group *All Locations 2301 Bahamas Dr. Bakersfield CA	Diagnostic Radiology	Existing	PRV085448	ALL SITES	Yes Eff 11/1/23
Tran, Sonny DC	Vanguard Medical Corporation 565 Kern Street Shafter CA	Chiropractic	Existing	PRV092765	ALL SITES	Yes Eff 11/1/23
Pedi Center Urgent Care - Niles St	Universal Urgent Care and Occ Med 6500 Niles St Bakersfield CA 93306	Urgent Care (Pedi Center)	Existing	PRV093882	PRV093882	Yes Eff 11/1/23
Upadhyaya, Jigisha MD	OBHG California PC 420 34th Street Bakersfield CA	OBG / Hospitalist	Existing	PRV006360	PRV000384	Yes Eff 11/1/23
Wade, Evelyn CNM	OBHG California PC 420 34th Street Bakersfield CA	OBG / Hospitalist	Existing	PRV072419	PRV000384	Yes Eff 11/1/23
Weibell, Nicholai DO	OBHG California PC 420 34th Street Bakersfield CA	OBG / Hospitalist	Existing	PRV085448	PRV000384	Yes Eff 11/1/23
Wellman, Richard MD	OBHG California PC 420 34th Street Bakersfield CA	OBG / Hospitalist	Existing	PRV071781	PRV000384	Yes Eff 11/1/23
Willliams, Richard	Kern County Hospital Authority 3551 Q Street Ste 100 Bakersfield CA	Neurosurgery	Existing	PRV049900	ALL SITES	Yes Eff 11/1/23
Work, Rosanne OD	Clinica Sierra Vista 625 34th Street Ste 100 & 200 Bakersfield CA	Optometry	Existing	PRV092688	PRV0000002	Yes Eff 11/1/23

KERN HEALTH SYSTEMS
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PROVIDER NAME	LEGAL NAME/DBA/ADDRESS	SPECIALTY	CONTRACT STATUS	PROV PRV	VENDOR PRV	PAC APPROVED - EFFECTIVE DATE
Acevedo, Jessica BCBA	Jasmine Nyree Education Center 6800 District Blvd Bakersfield CA	Qualified Autism Provider / Behavioral Analyst	Existing	PRV094447	PRV035797	**Yes** **Eff 11/1/23**
Aran, Marlina LFMT	Clinica Sierra Vista 2000 Physicians Blvd. Bakersfield CA	Marriage/Family Therapy	Existing	PRV094138	PRV000002	**Yes** **Eff 11/1/23**
Beasley, Randolph LMFT	Clinica Sierra Vista 625 34th Street Ste 100 Bakersfield CA	Marriage/Family Therapy	Existing	PRV094137	PRV000002	**Yes** **Eff 11/1/23**
Bhanver, Inder MD	Clinica Sierra Vista 7800 Niles Street Bakersfield CA	Psychiatry	Existing	PRV092766	PRV000002	**Yes** **Eff 11/1/23**
Cruz, Alicia LCSW	Adventist Health Reedley 1025 N Douty St Hanford CA	Clinical Social Worker	Existing	PRV094420	PRV040784	**Yes** **Eff 11/1/23**
Felix, Veronica BCBA	Cristina Franco dba: Avanza Behavior Solutions 7721 Gallup Drive Bakersfield CA	Qualified Autism Provider / Behavioral Analyst	Existing	PRV068617	PRV090719	**Yes** **Eff 11/1/23**
Frazier, Sheri LCSW	Clinica Sierra Vista 815 Dr. MLK Blvd Bakersfield CA	Clinical Social Worker	Existing	PRV089557	PRV000002	**Yes** **Eff 11/1/23**
Gagnon, John BCBA	Learning Arts 1800 Westwind Dr. Ste. 403 Bakersfield CA	QASP / Behavioral Analyst	Existing	PRV094421	PRV052185	**Yes** **Eff 11/1/23**
Ninomiya, Joe LFMT	Clinica Sierra Vista 7800 Niles Street Bakersfield CA	Marriage/Family Therapy	Existing	PRV093176	PRV000002	**Yes** **Eff 11/1/23**
Okeke, Ekwy NP-C	Clinica Sierra Vista 625 34th Street Ste 100 Bakersfield CA	Psychiatry Nurse	Existing	PRV094134	PRV000002	**Yes** **Eff 11/1/23**
Seif, Atih MD	Premier Valley Medical Group *All Loc 5401 White Lane Hanford CA	Psychiatry	Existing	PRV091051	PRV047600	**Yes** **Eff 11/1/23**
Stephens, Michael BCBA	Learning Arts 1800 Westwind Dr. Ste. 403 Bakersfield CA	QASP / Behavioral Analyst	Existing	PRV094422	PRV052185	**Yes** **Eff 11/1/23**
Harish, Gorli MD	Family Planning and Associates Medical Group Inc. dba: FPA Womens Health 2500 H Street Bakersfield CA	Family Planning	**New Contract**	PRV043821	PRV005669	**Yes** **Eff 12/1/23**
Spohn, Jennifer NP-C	Family Planning and Associates Medical Group Inc. dba: FPA Womens Health 2500 H Street Bakersfield CA	Family Planning	**New Contract**	PRV095013	PRV005669	**Yes** **Eff 12/1/23**
Heavenly Hospice Care, Inc.	Heavenly Hospice Care, Inc. 514 Commerce Ave Ste G Palmdale CA	Hospice	**New Contract**	PRV082813	PRV082813	**Yes** **Eff 12/1/23**
Independent Living Systems LLC	Independent Living Systems LLC 500 North Brand Suite 675 Glendale CA	Enhanced Care / Case Management	**New Contract**	PRV094478	PRV094478	**Yes** **Eff 12/1/23**
Libertana	JSI Acquisition Inc dba: Libertana 5805 Sepulveda Blvd Ste. 605 Sherman Oaks CA	Enhanced Care / Case Management	**New Contract**	PRV092542	PRV092542	**Yes** **Eff 12/1/23**
Pathway Family Services	Pathway Family Services 2600 G Street Bakersfield CA	Enhanced Care / Case Management	**New Contract**	PRV093425	PRV093425	**Yes** **Eff 12/1/23**
Universal Healthcare MSO LLC	Universal Healthcare MSO LLC 5500 Ming Avenue Ste. 170 Bakersfield CA	Enhanced Care / Case Management	**New Contract**	PRV093424	PRV093424	**Yes** **Eff 12/1/23**
Yummy Mummy LLC	Yummy Mummy LLC 1751 2nd Avenue Ste. 203 New York NY	DME	**New Contract**	PRV095014	PRV095014	**Yes** **Eff 12/1/23**
Parimoo, Nakul MD	Clinica Sierra Vista 625 34th Street Ste 100 & 200 Bakersfield CA	Nephrology	Existing	PRV059466	PRV000002	**Yes** **Eff 12/1/23**
Bajwa, Rajwinder NP-C	Ajitpal S. Tiwana MD 2700 F Street Ste 100 Bakersfield CA 4701 Panama Ln Ste E-3 Bakersfield	Family Practice	Existing	PRV043134	PRV029409	**Yes** **Eff 12/1/23**

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Bath, Amanpreet MD	Kern County Hospital Authority 1111 Columbus St Bakersfield CA	Internal Medicine	Existing	PRV010580	ALL SITES	**Yes** **Eff 12/1/23**
Bautista, Catalina PA-C	Omni Family Health 1530 E. Manning Ave Reedley CA	Family Practice	Existing	PRV093007	PRV000019	**Yes** **Eff 12/1/23**
Becerra Ramirez, Milagros MD	Clinica Sierra Vista 625 34th Street Ste 100 & 200 Bakersfield CA	Family Practice	Existing	PRV093861	PRV000002	**Yes** **Eff 12/1/23**
Chen, Shan-Shan MD	Clinica Sierra Vista 625 34th Street Ste 100 & 200 Bakersfield CA	Nephrology	Existing	PRV079919	PRV000002	**Yes** **Eff 12/1/23**
Elhofy, Susan PA	LA Laser Center PC, *All Locations 5600 California Ave Ste 101 Bakersfield CA	Dermatology	Existing	PRV095012	PRV013922	**Yes** **Eff 12/1/23**
Gowd, Pampana MD	Centric Health 2901 Sillect Ave Ste 100 Bakersfield CA	Cardiovascular Disease	Existing	PRV091254	PRV000503	**Yes** **Eff 12/1/23**
Heidari-Foroushani, Arash MD	Dignity Health Medical Group 3838 San Dimas St Ste B231 3838 San Dimas St Ste A100 Bakersfield CA	Infectious Disease	Existing	PRV000624	PRV012886	**Yes** **Eff 12/1/23**
Hurtado, Roxana NP-C	Accelerated Urgent Care *All locations 212 Coffee Rd Ste 100 Bakersfield CA	Family Practice / UC	Existing	PRV093396	ALL SITES	**Yes** **Eff 12/1/23**
Kamath, Sonia MD	Clinica Sierra Vista 625 34th Street Ste 100 & 200 Bakersfield CA	Nephrology	Existing	PRV056248	PRV000002	**Yes** **Eff 12/1/23**
Kapp, Lacey PA-C	Grossman Medical Group 420 34th Street Bakersfield CA	Plastic Surgery	Existing	PRV088824	PRV000405	**Yes** **Eff 12/1/23**
Kim, Paul DPM	Stockdale Podiatry Group *All Locations 110 New Stine Rd Bakersfield CA	Podiatry	Existing	PRV093480	PRV000332	**Yes** **Eff 12/1/23**
Kim, Solomon DPM	Stockdale Podiatry Group *All Locations 110 New Stine Rd Bakersfield CA	Podiatry	Existing	PRV093481	PRV000332	**Yes** **Eff 12/1/23**
Nasrawin, Nancy MD	Clinica Sierra Vista 815 Dr. Martin Luther King Jr. Blvd Bakersfield CA	Family Practice	Existing	PRV072667	PRV000002	**Yes** **Eff 12/1/23**
Nunez, Evangelina PA-C	Omni Family Health 2505 Merced St Fresno CA	Family Practice	Existing	PRV093158	PRV000019	**Yes** **Eff 12/1/23**
Oyola Torres, Eduardo MD	Kern Radiology Medical Group *All Locations 2301 Bahamas Dr. Bakersfield CA	Diagnostic Radiology	Existing	PRV094445	ALL SITES	**Yes** **Eff 12/1/23**
Perez, Marilyn PA-C	Clinica Sierra Vista 625 34th Street Ste 100 & 200 Bakersfield CA	Internal Medicine	Existing	PRV093175	PRV000002	**Yes** **Eff 12/1/23**
Schatz, Robert MD	Ridgecrest Regional Hospital 1111 N China Lake Blvd Ste 190 Ridgecrest CA	Cardiovascular Disease	Existing	PRV093787	ALL SITES	**Yes** **Eff 12/1/23**
Shearer, Charmaine NP-C	Omni Family Health 655 S Central Valley Hwy Shafter CA	Family Practice	Existing	PRV093479	PRV000019	**Yes** **Eff 12/1/23**
Taveros, Mel-Clark MD	North Kern South Tulare District dba: Gloria Nelson Center 1500 6th Ave Delano CA	Pediatrics	Existing	PRV031357	PRV000319	**Yes** **Eff 12/1/23**
Thor, Jana DO	Ridgecrest Regional Hospital 1011 N China Lake Blvd Ridgecrest CA	OB/GYN	Existing	PRV005110	ALL SITES	**Yes** **Eff 12/1/23**
White, James MD	Stockdale Radiology Physician Services 4000 Empire Dr Ste 100 Bakersfield CA *All Locations	Diagnostic Radiology	Existing	PRV093859	PRV000396	**Yes** **Eff 12/1/23**
Williams, Mark MD	Kern Radiology Medical Group *All Locations 2301 Bahamas Dr. Bakersfield CA	Diagnostic Radiology	Existing	PRV001779	ALL SITES	**Yes** **Eff 12/1/23**

KERN HEALTH SYSTEMS
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Wilson, Christopher DO	Pain Institute of California Inc 9802 Stockdale Hwy Suite 105 Bakersfield CA	Pain Medicine	Existing	PRV090576	PRV000510	**Yes** **Eff 12/1/23**
Win, Yin MD	Clinica Sierra Vista 625 34th Street Ste 100 & 200 Bakersfield CA	Nephrology	Existing	PRV051222	PRV000002	**Yes** **Eff 12/1/23**

KERN HEALTH SYSTEMS
Board Approved Effective 10/01/2023

Legal Name DBA	Specialty	Address	Vendor PRV #	Contract Effective Date
Awakened Consulting, Inc	Marriage/Family Therapy	728 21st St Bakersfield CA Phone - 661-472-5668 Fax - 661-829-7301	PRV082141	Retro Approval 9/1/2023
Jonathan Rizo dba: Rizo Psychological & Behavioral Health Services	ABA	930 Truxtun Ave Ste 206 Bakersfield CA Phone - 661-932-7243 Fax - none	PRV092319	Retro Approval 9/1/2023
Positive Behavior Supports Corporation	ABA	3815 Ming Ave #352 Bakersfield CA Phone - 855-832-6727 Fax - 772-675-9100	PRV092347	Retro Approval 9/1/2023
Environmental Alternatives DBA: EA Family Services	ECM-Case Management	3201 F Street Bakersfield CA	PRV090574	Retro Approval 9/1/2023
Pantogran LLC dba: Center for Autism and Related Disorders (CARD)	ABA Provider	8302 Espresso Drive Ste. 100 Bakersfield CA Phone 661-771-3351 Fax - 661-255-4053	PRV091753	Retro Approval 9/1/2023
Cal City Urgent Care INC. A California Professional Medical Corporation DBA: Cal City Urgent Care	Urgent Care Clinic	8100 California City Blvd California City CA Phone - 818-651-6608 Fax - 818-584-2703	PRV087138	10/1/2023
Coachella Valley Anesthesia, A Prof Corp	Anesthesiology	420 34th Street Bakersfield CA	PRV087931	10/1/2023
Mijo Yoon DBA: Joy Service	Transportation	2211 Brundage Ln Ste A Bakersfield CA Phone - 661-472-3122 Fax - none	PRV092736	10/1/2023
Bakersfield American Indian Health Project	ECM-Case Management	501 40th Street Bakersfield CA Phone - 661-327-4030 Fax - None	PRV092023	10/1/2023

KERN HEALTH SYSTEMS
Board Approved Effective 11/01/2023

LEGAL NAME/ DBA	Specialty	Address	VENDOR PRV	Contract Effective Date
Apollo Surgery Center, LLC	Ambulatory Surgery Center	43944 15th St W, Suite 101 Lancaster CA 93534 P - 661-579-4700 F - 661-579-4001	PRV091352	11/1/2023
Antelope Valley Neuroscience Med Grp dba: Antelope Valley Neuroscience	Specialty	42135 10th St West Ste 301 Lancaster CA 93534 P - 661-945-6931 F - 661-945-4592	PRV030410	11/1/2023
Arise Psychiatric Medical Group, Inc	Mental Health	1500 Haggin Oaks Blvd. Suite 202 Bakersfield CA 93301 P - 661-735-3887 F - 661-836-5545	PRV075857	**Retro Approval 10/1/2023**
Bakersfield Community Health Center, Inc.	CSS CBO – Nursing Facility Transition/Diversion to Assisted Living Facility; Community Transition Services/Nursing Facility Transition to Home	1801 Oak Street Bakersfield CA 93301	PRV068672	**Services Effective 7/1/2023**
Environmental Alternatives DBA: EA Family Services	CSS CBO – Housing Deposit, Housing Navigation, Housing Tenancy and Sustaining	3201 F Street Bakersfield CA	PRV090574	11/1/2023
Heart Beat Med Transit LLC	Transportation	8720 Harris Rd Ste 102A Bakersfield CA 93311 P - 661-569-1648 F - None	PRV093867	11/1/2023
Hongtao Wang dba: Valley Gastroenterology Institute Inc	Pediatric Gastroenterology	1191 E Herndon Ave #103 Fresno CA P - 559-794-2168 F - 559-272-1387	PRV086077	11/1/2023
Jasleen Duggal MD Inc dba: Kern Endocrine Center	Multi-Spec	3008 Sillect Avenue Ste. 240 Bakersfield CA 93311 P - 661-748-1999 F - 661-748-1815	PRV000402	11/1/2023
Manning Gardens Care Center Inc	SNF	2113 E Manning Ave Fresno CA 93725 P - 559-834-2586 F - 559-834-2540	PRV081661	11/1/2023
Seven Oaks Medical Group Inc	PCP - Primary Care	9900 Stockdale Hwy Ste. 107 Bakersfield CA 93311	PRV087294	11/1/2023
Spiritus Home Health Care Inc dba: Royal Congregate Living Facility	Congregate Health Living Facility	3100 Mildwood Ct Lancaster CA 93536 P - 661-579-6898 F - 661-244-0115	PRV093883	11/1/2023
Elizabeth Sotelo dba: The Bra Shoppe	DME	1400 Calloway Dr Ste 202 Bakersfield CA 93312 P - 661-835-8120 F - 661-558-0659	PRV088728	11/1/2023
Tehachapi ADHC Inc	CBAS	123 West F Street Tehachapi CA 93561 Tehachapi CA 93561 P - 661-863-9998 F - 661-383-0007	PRV093233	**Retro Approval 10/1/2023**

KERN HEALTH SYSTEMS
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LEGAL NAME/ DBA	Specialty	Address	VENDOR PRV	Contract Effective Date
Hollywood Eye Associates	Ophthalmology	3801 San Dimas Bldg A Bakersfield CA Phone - 661-460-7640 Fax - None listed	PRV095015	12/1/2023
Family Planning and Associates Medical Group Inc. dba: FPA Womens Health	Family Planning	2500 H Street Bakersfield CA Phone - 661-633-5266 Fax - 909-494-7549	PRV005669	12/1/2023
Heavenly Hospice Care, Inc.	Hospice	514 Commerce Ave Ste G Palmdale CA Phone - 818-666-4015 Fax - 661-206-8415	PRV082813	12/1/2023
Independent Living Systems LLC	Enhanced Care / Case Management	500 North Brand Suite 675 Glendale CA Phone - 888-262-1292 Fax - 818-245-6735	PRV094478	12/1/2023
Pathway Family Services	Enhanced Care / Case Management	2600 G Street Bakersfield CA Phone - 661-325-2570 Fax - 661-843-7183	PRV093425	12/1/2023
Universal Healthcare MSO LLC	Enhanced Care / Case Management	5500 Ming Avenue Ste. 170 Bakersfield CA Phone - 661-679-7540 Fax - 661-735-5863	PRV093424	12/1/2023
Yummy Mummy LLC	DME	1751 2nd Avenue Ste. 203 New York NY Phone -855-879-8669 Fax - 855-291-5930	PRV095014	12/1/2023

KERN HEALTH SYSTEMS

To: KHS QI-UM Committee

From: Provider Network Management Department

Date: 02/08/2024

Re: Provider Network Management - Network Review Q4, 2023

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

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

Fiscal Impact: N/A

Requested Action: Request to approve and file PNM Q4 2023 report.

KERN HEALTH SYSTEMS

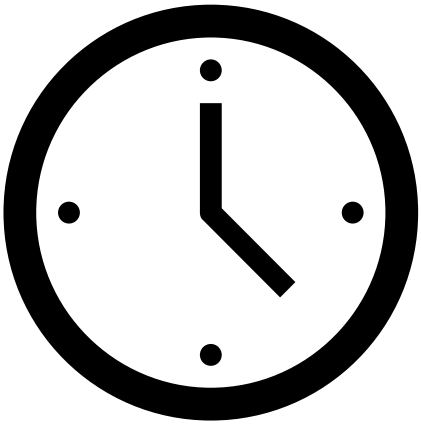
Provider Network Management
Network Review
Quarter 4, 2023

- **After-Hours Survey Report**
- **Provider Accessibility Monitoring Survey**
- **Access Grievance Review (Q2 2023 Review Period)**
- **Geographic Accessibility & DHCS Network Certification**
- **Network Adequacy & Provider Counts**
- **DHCS Quarterly Monitoring Report/Response Template (QMRT) (Q3 2023 Review Period)**

KERN HEALTH SYSTEMS

After-Hours Survey Report

Quarter 4, 2023



AFTER-HOURS CALLS

Q4, 2023

Introduction

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

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

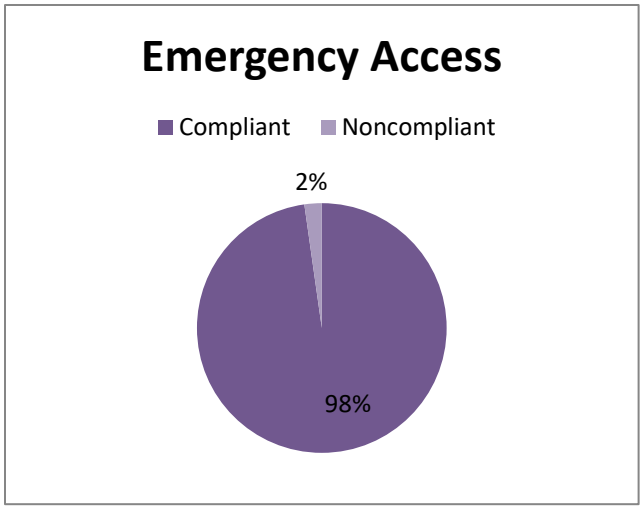
2.) For urgent matters, Provider's answering machine must provide an on-call number. If an answering service is used, the member must receive a call back from an on-call member of your office within 30 minutes of call.

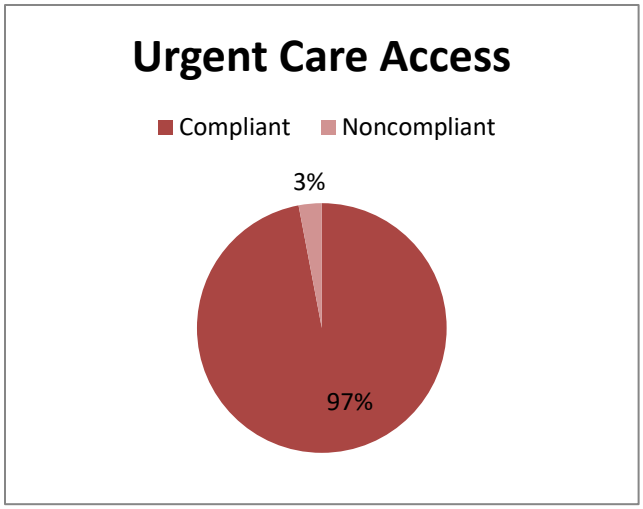
An initial survey is conducted by Health Dialog; the results are forwarded to the Plan's Provider Network Analyst Team who make additional follow up calls based on compliant/noncompliant data received from the survey vendor.

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

Results

During Q4 2023 134 provider offices were contacted. Of those offices, 131 were compliant with the Emergency Access Standards and 130 were compliant with the Urgent Care Access Standards.





AFTER-HOURS CALLS

Q4, 2023

Tracking, Trending, and Provider Outreach

The Plan utilizes the after-hours survey calls to monitor compliance at a network-wide level. The Plan was found compliant with Emergency Access and Urgent Access remaining in line with prior quarters, with percentages in Q4 2023 above 90%.

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

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

For Q4 2023, two offices were identified as noncompliant with both the emergency access and urgent access standards, two offices were identified as noncompliant with only the urgent access standard, and one office was identified as noncompliant with only the emergency access standard. The Plan's Provider Relations Representatives conducted targeted education and sent a letter notifying the provider groups of the survey results and Plan policy (template attached).

One office was found to be noncompliant with the after-hours access standards for two consecutive quarters. The Plan has reached out to the provider and scheduled a meeting to discuss becoming compliant in Q1 2024.

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

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,

Kristie Onaindia
Provider Relations Supervisor
(661) 595-2906

3.10 Telephone Accessibility

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

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

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

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

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

3.11 Full-time equivalent (FTE) Provider to Member Ratios

KHS shall maintain a provider network capacity of the following full-time equivalent provider to member ratios:

Primary Care Physicians	1:2,000
Total Physicians	1:1,200

4.0 MONITORING

The Provider Relations Department shall be responsible for monitoring Plan compliance with access standards.

4.1 Quarterly Access Review

On a quarterly basis KHS will conduct a review of Plan's compliance with after hours and appointment availability access standards. This will include, but is not limited to after hours survey calls, appointment availability survey, a review of access grievances, and a review of data received from the 24-Hour Telephone Triage Service employed by KHS (as outlined in *KHS Policy and Procedure 3.15-I 24-hour Telephone Triage Service).* Based on this review, KHS will take action as applicable including appropriate provider education; if a provider continues to be found out of compliance based on the results of the quarterly review, the provider may be issued a corrective action plan (CAP) as described in *KHS Policy and Procedure #4.40-P Corrective Actions Plans*

The appointment availability survey will consist of quarterly calls made to a sample of contracted primary care and specialist providers (included mental health providers) to assess the provider's and the Plan's level of compliance with appointment availability standards.

The after hours survey calls will consist of quarterly calls made to all contracted primary care provider offices to assess the provider's and the Plan's level of compliance with after-hours standards.

As appropriate, results of the annual Member (§4.3) and Provider (§4.4) Satisfaction surveys will be incorporated into KHS' quarterly access review for additional tracking and trending.

Results of the KHS's quarterly access review will be reported to the QI/UM Committee as outlined in §5.0 - Reporting.

4.2 Geographic Accessibility Analysis

As needed, but at least annually, KHS will conduct a geographic accessibility analysis to ensure compliance with Driving Time/Miles standards and applicable regulatory requirements.

4.3 Appointment Rescheduling

As outlined above, 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 this policy.

For primary care providers, compliance with the process for the rescheduling of missed appointments shall be monitored via the medical record review survey process, outlined in 2.22-P *Facility Site Review.*

Appointment availability of a rescheduled appointment will be monitored by KHS via the survey process outlined above in § 4.1 *Quarterly Access Review.* The standard and monitoring process for the availability of a rescheduled appointment shall be equal to

Provider Accessibility Monitoring Survey

Quarter 4, 2023

Provider Accessibility Monitoring Survey

Q4, 2023

Introduction

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

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

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

A random sample of 15 primary care provider offices, 15 specialist offices, 5 non-physician mental health offices, 5 ancillary offices, and 5 OBGYN offices was contacted during Q4 2023 to monitor network compliance with the following accessibility metrics.

Appointment Availability Survey Results

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

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

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

Of the primary care providers surveyed, the Plan compiled the wait time in hours to determine the average wait time for an urgent primary care appointment. The Plan compiled the wait time in days to determine the average wait time for a non-urgent primary care appointment. The average wait time for an urgent primary care appointment was **19.7 hours**. The average wait time for a non-urgent primary care appointment was **3.7 days**. **Based on these results, the Plan was determined to be compliant in both the urgent and non-urgent time standards for primary care appointments in Q4 2023.**

Of the specialist providers surveyed, the Plan compiled the wait time in hours to determine the average wait time for an urgent specialist appointment. The Plan compiled the wait time in days to determine the average wait time for a non-urgent specialist appointment. The average wait time for an urgent specialist appointment was **79.3 hours**. The average wait time for a non-urgent specialist appointment was **8.1 days**. **Based on these results, the Plan was determined to be compliant in both the urgent and non-urgent time standards for specialist appointments in Q4 2023.**

Of the non-physician mental health providers surveyed, the Plan compiled the wait time in days to determine the average wait time for an appointment with a non-physician mental health provider. The average wait time for a non-physician mental health provider appointment was **3.6 days**. **Based on these results, the Plan was determined to be compliant with the time standard for a mental health appointment in Q4 2023.**

Of the ancillary providers surveyed, the Plan compiled the wait time in days to determine the average wait time for an appointment with the ancillary provider. The Plan's average wait time for an ancillary appointment was **4.4 days**. **Based on these results, the Plan was determined to be compliant with the time standard for an ancillary appointment in Q4 2023.**

Of OB/GYN providers surveyed, the Plan compiled the wait time in days to determine the average wait time for a first prenatal appointment with an OB/GYN. The Plan's average wait time for a first prenatal appointment with an OB/GYN was **2.0 days**. **Based on these results, the Plan was determined to be compliant with the time standard for an OB/GYN first prenatal appointment in Q4 2023**

Tracking, Trending, and Provider Education based Appointment Availability

The Plan reviewed the appointment availability results of the Q4 2023 provider accessibility monitoring survey against the results of prior quarters. The Plan recognized increases in the wait time for Urgent and Non-Urgent PCP, Urgent and Non-Urgent Specialist, Non-Physician Mental Health, and Ancillary appointments. The Plan recognized a minor decrease in wait time for OB/GYN appointments. The Plan does not consider these changes as a trend at this time as the results are in line with prior quarters and are compliant with time standards.

Average urgent wait time in hours	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023
Primary Care	38.2	26.1	18.5	22.2	18.8	19.7
Specialist	76.6	44.9	113.7	63.5	31.6	79.3

Provider Accessibility Monitoring Survey

Q4, 2023

Average wait time in days	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023
Primary Care	4.3	2.8	3.5	1.9	3.6	3.7
Specialist	12.2	6.9	11.7	9.6	5	8.1
Non-Physician Mental Health	2.7	4.4	5.4	6.2	0.8	3.6
Ancillary	0	2	2.2	5.4	1.8	4.4
OB/GYN	4.0	6.2	6.6	4.2	2.2	2.0

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

For all providers identified as newly noncompliant during Q4 2023, the Plan sent letters notifying the providers of the survey results and Plan policy (template attached).

Follow-up Survey Results

In Q4 2023, the Plan conducted a follow-up survey, resurveying all providers found to be previously noncompliant with appointment availability standards in Q3 2023. The previously noncompliant providers consisted of 2 primary care providers and 2 specialists.

Based on the results of this follow-up survey, the Plan identified 1 primary care provider and 1 specialist are now compliant. However, the remaining primary care provider continues to be noncompliant and the remaining specialist is no longer contracted with the Plan. The Plan is currently working to schedule a meeting between the provider and the Plan's Director of Provider Management and/or Provider Relations Supervisor to discuss the results of the survey and the Plan's accessibility standards. The Plan will continue to work with any and all providers to offer any assistance to facilitate them in becoming compliant.

Hours Of Operation

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

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

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

Provider Accessibility Monitoring Survey

Q4, 2023

Return Call Response Times

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

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

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

The Plan compiled provider responses to calculate an average response time for an Urgent Medical call. The average response time for Urgent Medical calls was **23.5 minutes** for Q4 2023. **Based on these results, the Plan was determined to be compliant with the response time standard for Urgent Medical Calls in Q4 2023.**

The Plan compiled provider responses to calculate an average response time for a Non-Urgent Medical call. The average response time for Non-Urgent Medical calls was **15.2 hours** for Q4 2023. **Based on these results, the Plan was determined to be compliant with the response time standard for Non-Urgent Medical Calls in Q4 2023.**

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

All individual office results were compliant with the urgent and non-urgent response time standards.

Phone Answering Timeliness Results

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

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

The Plan compiled collected data to calculate an average rings to answer. The average rings to answer was **1.9 rings**. **Based on these results, the Plan was determined to be compliant with the rings to answer standard in Q4 2023.**

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

Provider Accessibility Monitoring Survey

Q4, 2023

In-office Wait Times

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

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

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

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

The Plan compiled provider responses to calculate an average in-office wait time. The average in-office wait time was **15.7 minutes** for Q4 2023. **Based on these results, the Plan was determined to be compliant with the in-office wait time standard for Q4 2023.**

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

KERN HEALTH SYSTEMS

«Date»

«Location_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 «Quarter» «Year», KHS contacted your office and conducted an appointment availability survey in regards to scheduling «Standard» «Provider_Specialty» appointment with «Providers_Full_Name». 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,

Kristie Onaindia
Provider Relations Supervisor
(661) 595-2906

661-664-5000
FAX 661-664-5151
kernhealthsystems.com
2900 Buck Owens Boulevard, Bakersfield, CA 93308-6316

Additionally, KHS shall ensure its network of providers meets compliance with time and distance standards as required by the Department Health Care Services' (DHCS) annual network certification.

For geographic service areas (zip codes) found to not meet the above standards, KHS shall maintain alternative access standards, to be filed and approved with the DHCS and DMHC.

3.5.1 Member Assistance (AB 1642)

For zip code/specialty combinations in which KHS maintains an approved alternative access standard from the DHCS, the Member Services Department will assist members with obtaining appointments with applicable specialists within time and distance standards. KHS will make best effort to establish member-specific case agreement for an appointment with a specialist within time and distance standards, in-line with ad-hoc contracting procedures outlined in 4.25-P *Provider Network and Contracting*; member-specific case agreement will be offered at no less than the Medi-Cal FFS rate, agreed upon by the Plan and provider, and must be made within the most recent year. KHS will arrange transportation to appointments within time and distance and timely access standards if a member-specific case agreement cannot be made; transportation services will be arranged in line with 5.15-I *Member Transportation Assistance.*

3.6 Appointment Waiting Time and Scheduling:

The "appointment waiting time" means the time from the initial request for health care services by a Member or the Member's treating provider to the earliest date offered for the appointment for services inclusive of the time for obtaining authorization from the plan, and completing any other condition or requirement of the plan or its contracting providers. KHS shall ensure that Members are offered appointments for covered health care services within a time period appropriate for their condition. Members must be offered appointments within the following timeframes:

Type of Appointment	Time Standard
Urgent care appointment for services that do not require prior authorization[1]	Within 48 hours of a request
Urgent appointment for services that require prior authorization	Within 96 hours of a request
Non-urgent primary care appointment	Within 10 business days of a request
Non-urgent appointment with a specialist	Within 15 business days of a request
Non-urgent appointments with a physician mental	Must offer the appointment within 10 business

health care provider	days of 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 for the diagnosis or treatment of injury, illness, or other health condition	Within 15 business days of a request
Pediatric CHDP Physicals	Within 2 weeks upon request
First pre-natal OB/GYN visit	The lesser of 10 business days or within 2 weeks upon request

Exceptions to Appointment Waiting Time and Scheduling:

Preventive Care Services and Periodic Follow Up Care:
Preventive care services and periodic follow up care, including but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice.

Advance Access:
A primary care provider may demonstrate compliance with the primary care time-elapsed access standards established herein through implementation of standards, processes and systems providing advance access to primary care appointments as defined herein.

Appointment Rescheduling:
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 this policy.

Extending Appointment Waiting Time:
The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the Member's medical record that a longer waiting time will not have a detrimental impact on the Member's health.

Telemedicine:
To the extent that telemedicine services are appropriately provided as defined per §2290.5(a) of the Business & Professions Code, these services shall be considered in determining compliance with the access standards hereby established. Prior to the delivery of health care via telemedicine, the provider must obtain verbal and written informed consent from the enrollee or the enrollee's legal representative. The

KERN HEALTH SYSTEMS

Access Grievance Review

Quarter 4, 2023

(Q2 2023 Review Period)

Provider Network Management

Access Grievance Review

Q4, 2023 (Q2 2023 Review Period)

KERN HEALTH SYSTEMS

Introduction and KHS Policy and Procedure

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

Categorization

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

Grievance Totals

There were **one hundred and sixty-nine (169)** access-related grievances in Q2 2023. In **one hundred and thirty-four (134)** of the cases in Q2 2023, no issues were identified and were closed in favor of the Plan. The remaining **thirty-five (35)** cases in Q2 2023 were closed in favor of the enrollee; the KHS Grievance Department sent letters to the providers involved in these cases, notifying them of the outcome.

The **thirty-five (35)** grievances in Q2 2023 that were closed in favor of the enrollee were forwarded to the Plan's Provider Network Management Department. For each of these grievances, the members initial complaint, the provider's response, the Members Service Department's investigation, and the Grievance Committee's decision are reviewed by the Provider Network Management Department.

The access grievances found in favor of the enrollee for Q2 2023 categorized by the KHS Grievance Department as follows:

Timely Access	**24**
Provider Availability	**0**
Technology / Telephone	**11**

Access Grievance Review

Q4, 2023 (Q2 2023 Review Period)

Tracking and Trending

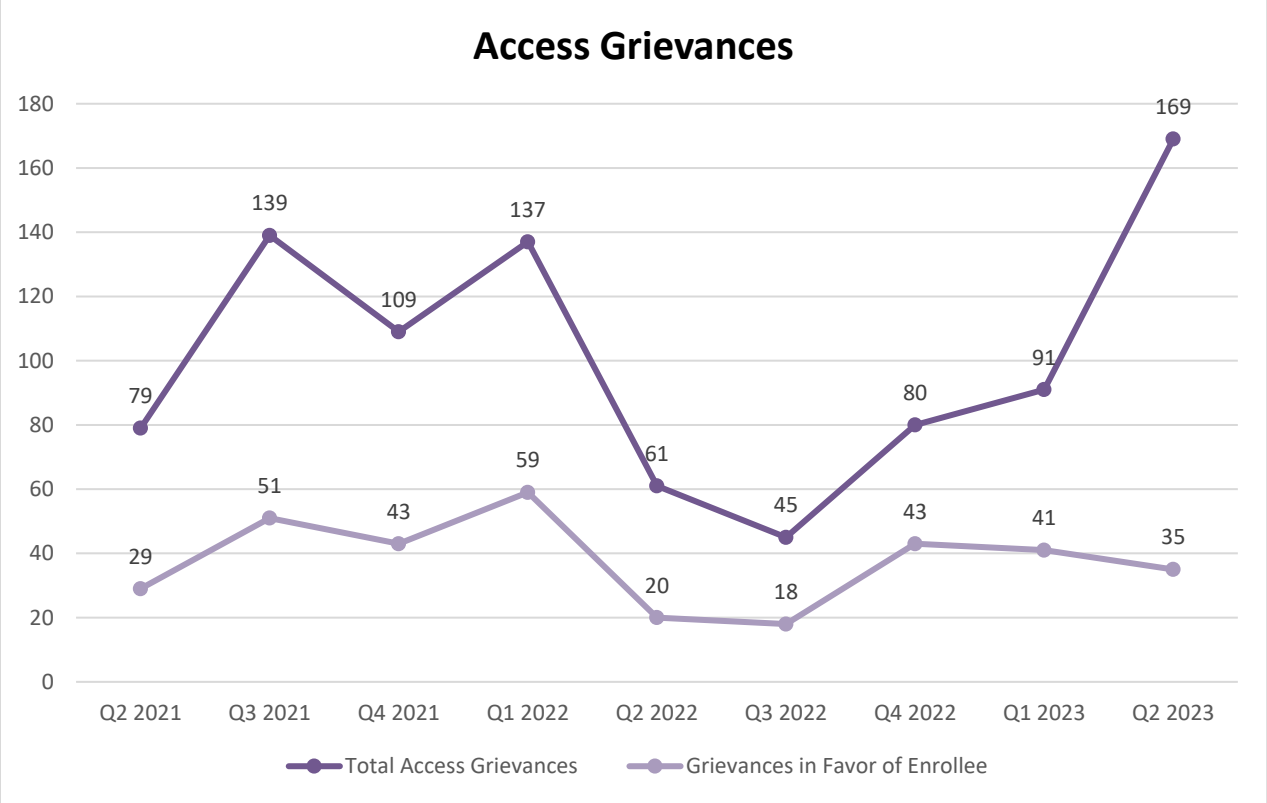
The Provider Network Management Department reviewed all access grievances found in favor of the enrollee received in Q2 2023 to identify any potential access issues or trends within the Plan's network or amongst the Plan's contracted providers. In addition to a review conducted against prior quarters, the Plan reviews Access Grievances against outcomes of other monitoring conducted as part of the quarterly *Provider Network Management, Network Review* (e.g. Appointment Availability Survey, DHCS' QMRT review, Network Adequacy).

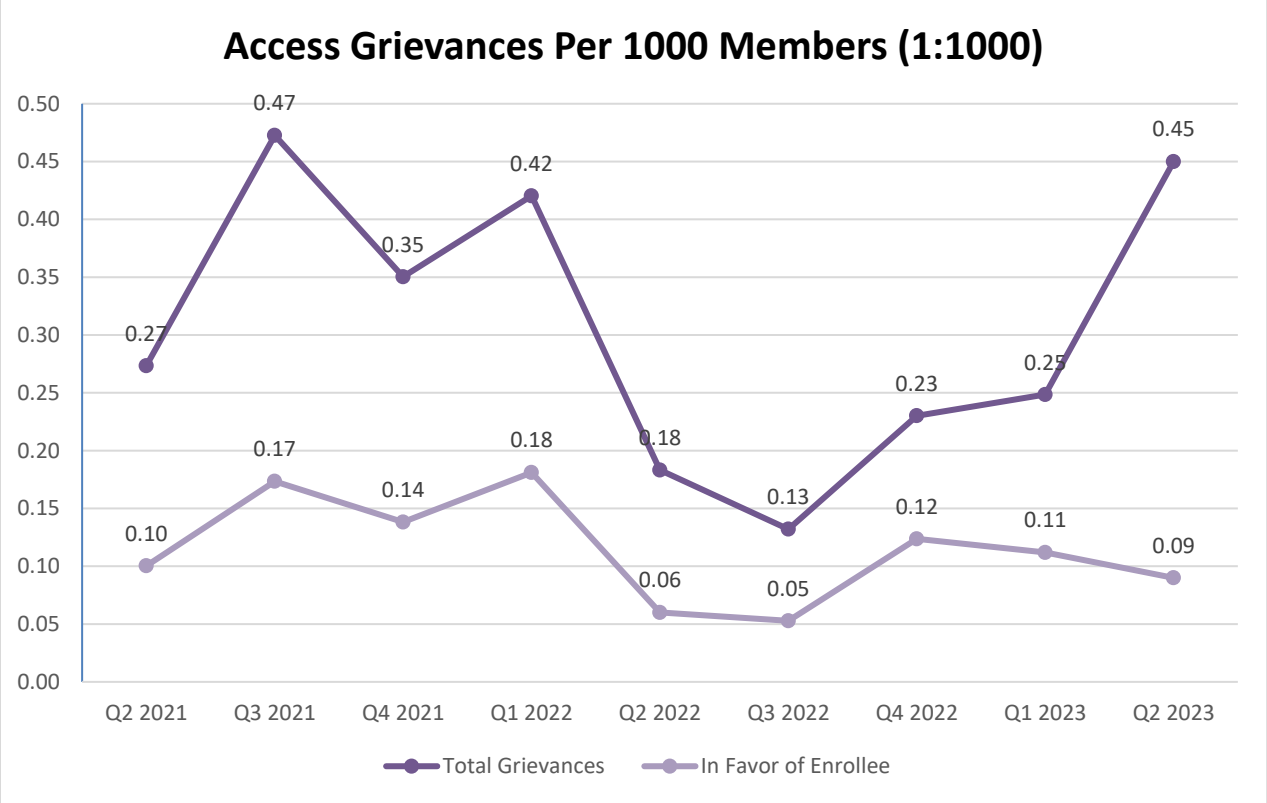
Upon review of Q2 2023 access grievances, the Plan identified the grievances increased from Q1 2023 to Q2 2023. The Plan's Access Grievances Per 1000 members for grievances found in favor of the enrollee decreased to 0.09 in Q2 2023 from 0.11 in Q1 2023. The increase in access grievances is due to a DHCS audit finding for Quality-of-Care grievances, which required new grievance processes to be put in place beginning August 1, 2022. One of the new processes required exempt grievances to be reviewed by the Quality Improvement department to ensure no Quality-of-Care grievances were missed. Because all exempt grievances were sent to the Quality Improvement department, more access grievances were identified. Moving forward, the Plan believes these increases will be the new normal count.

The Plan reviews grievances across a four-quarter rolling review period. Trends that are identified are reviewed with the Provider Relations Manager on a case-by-case basis to develop a target-based strategy to address. During Q2 2023, the Plan did not identify any trends; however, the Plan recognizes the increase of Timely Access grievances and the decrease of Provider Availability grievances. The Plan believes this is due to grievances incorrectly being identified as Provider Availability when the grievance is actually Timely Access. The Plan will continue to monitor access grievances for potential trends via the quarterly access grievance review.

Access Grievance Review

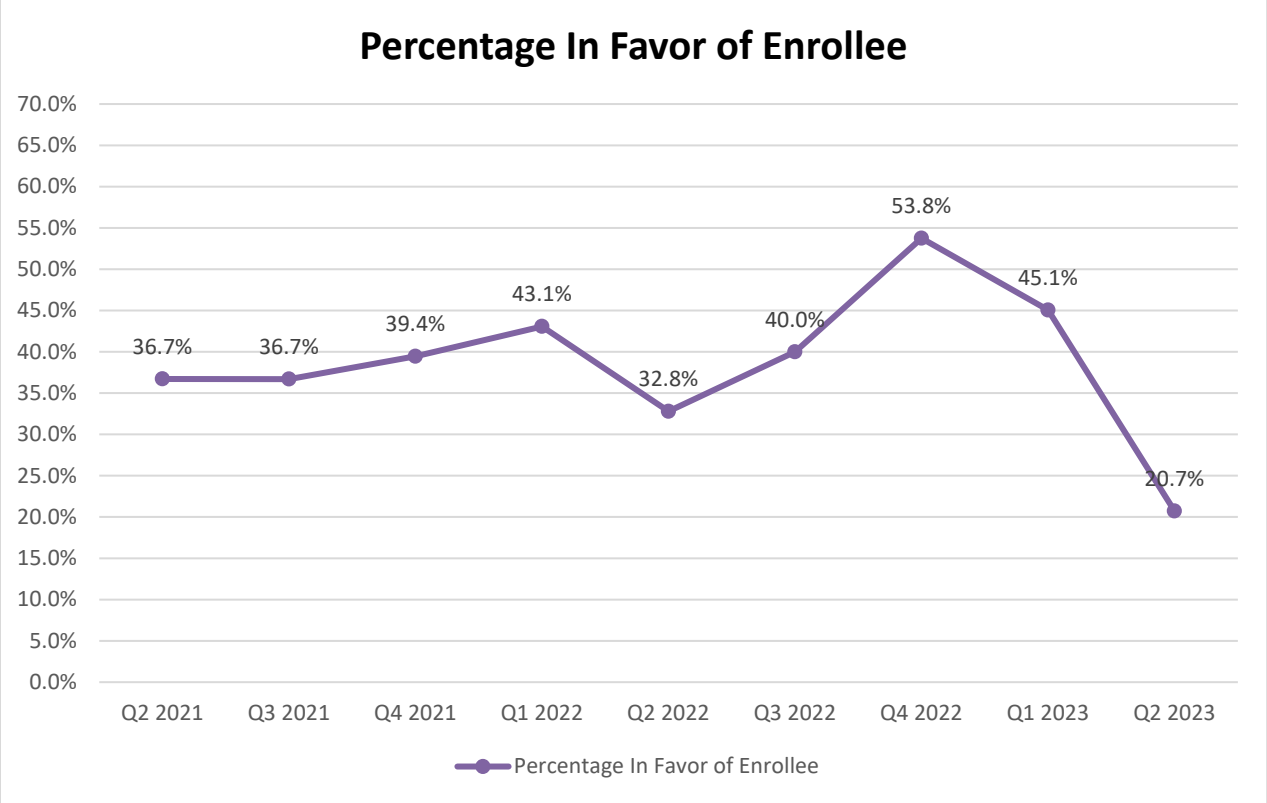
Q4, 2023 (Q2 2023 Review Period)

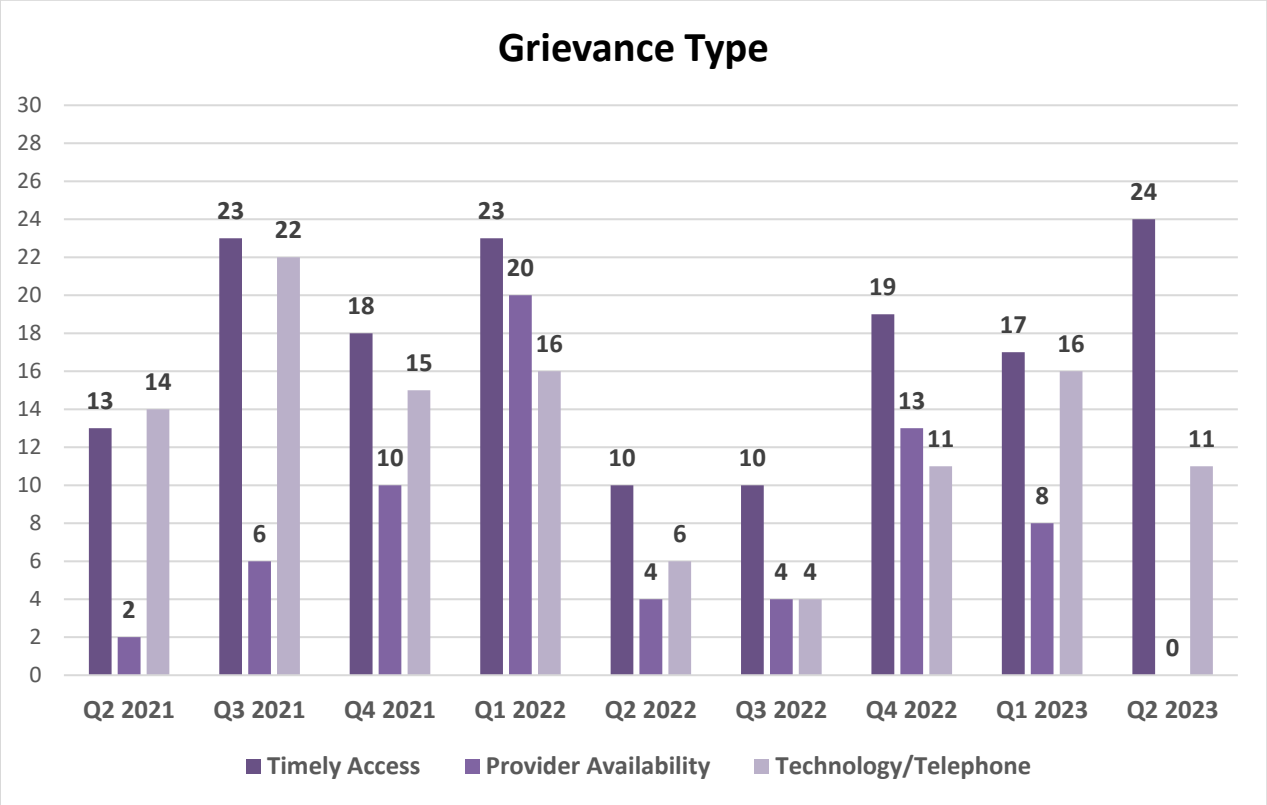




Access Grievance Review

Q4, 2023 (Q2 2023 Review Period)





Access Grievance Review

Q4, 2023 (Q2 2023 Review Period)

KERN HEALTH SYSTEMS

Exempt Grievances

On a quarterly basis, the Plan's Provider Network Management Department reviews all exempt grievances to identify potential trends amongst the provider network. For Q2 2023, there were a total of **1,867** exempt grievances.

Grievance Type	Q4 Count	Q4% of Total	Q1 Count	Q1% of Total	Q2 Count	Q2% of Total
Authorization	31	1.71%	32	1.66%	30	1.61%
Case Management/Care Coordination	4	0.22%	3	0.16%	3	0.16%
Continuity of Care	37	2.03%	6	0.31%	18	1.0%
Denial of Payment Request	0	0.00%	1	0.05%	0	0.00%
Denial of Request to Dispute Financial Liability	0	0.00%	2	0.10%	0	0.00%
Eligibility	1	0.06%	2	0.10%	3	0.16%
Enrollment	1	0.06%	46	2.39%	24	1.29%
Injury	1	0.06%	0	0.00%	3	0.16%
Language Access	13	0.77%	11	0.57%	13	0.7%
Member Informing Materials	0	0.00%	0	0.00%	1	0.05%
Out-of-Network	0	0.00%	4	0.21%	3	0.16%
PHI/Confidentiality/HIPAA	1	0.06%	0	0.00%	1	0.05%
Plan Customer Service	110	6.06%	167	8.68%	168	9.0%
Physical Access	4	0.22%	1	0.05%	0	0.00%
Plan's Reduction/Suspension / Termination of Previously Authorized Service	0	0.00%	3	0.16%	2	0.1%
Provider/Staff Attitude	662	36.47%	776	40.33%	707	37.9%
Provider Availability	114	6.28%	81	4.21%	60	3.21%
Provider Balance Billing	0	0.00%	0	0.00%	1	0.05%
Provider Direct Member Billing	0	0.00%	5	0.26%	4	0.21%
Referral	7	0.39%	35	1.82%	19	1.01%
Scheduling	51	2.81%	47	2.44%	75	4.01%
Technology/Telephone	133	7.33%	152	7.90%	164	8.78%
Timely Access	621	34.21%	517	26.87%	527	28.22%
Timely Response To Auth/Appeal Request	0	0.00%	2	0.10%	0	0.00%
Transportation (Driver Punctuality/Vehicle)	3	0.17%	31	1.61%	41	2.20%
Grand Total	**1,815**		**1,924**		**1,867**	

In reviewing these totals against prior quarters, the Plan recognized exempt grievances decreased from Q1 2023 to Q2 2023. The Plan identified an increase in the percentage of Continuity of Care, Scheduling, Technology/Telephone, Timely Access and Transportation (Driver Punctuality/Vehicle) exempt grievances in Q2 2023. The Plan identified a decrease in the percentage of Enrollment, Provider/Staff Attitude and Provider Availability exempt grievances in Q2 2023.

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

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

2.1.20 Grievance Received Date

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

2.1.21 Grievance Type

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

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

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

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

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

2.1.22 MER COC Disposition Date

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

KERN HEALTH SYSTEMS

Geographic Accessibility & DHCS Network Certification

Quarter 4, 2023

Geographic Accessibility & Network Certification

Q4, 2023

Geographic Accessibility

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

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

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

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

DHCS Annual Network Certification – 2022/2023

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

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

The Plan completed the Accessibility Analysis of the Annual Network Certification (ANC) reporting during Q1 2023. The Plan submitted 51 AAS requests which was in line with the prior Annual Network Certification AAS requests (44). In Q2 2023, the DHCS completed its review of the Plan's AAS requests. The DHCS denied 14 of the Plan's AAS requests and returned to the Plan for revision. The Plan revised the 14 AAS requests and submitted them to the DHCS. As of Q4 2023, the revised AAS requests were still being reviewed by the DHCS.

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

KERN HEALTH SYSTEMS

Network Adequacy & Provider Counts

Quarter 4, 2023

Network Adequacy & Provider Counts

Q4, 2023

Introduction

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

During Q3/Q4 2023, KHS, , 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.*

Per KHS policy, 4.30-P *Accessibility Standards* "Full-time equivalency will be calculated based on the percentage of time allocated to Plan beneficiaries by KHS contracted providers and the Plan's Medi-Cal membership market share. As part of the Plan's Provider Satisfaction survey, the Plan will collect data regarding Plan membership volume for KHS contracted provider. This data will be combined with the most recent available Medi-Cal membership market share data 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. Due to a maximum member assignment of 1,000 mid-level providers serving in the Primary Care capacity, mid-level providers will be counted as .5 of a PCP FTE, prior to percentage calculation."

Survey Methodology and Results

Beginning in 2019, KHS contracted with SPH Analytics (now called Press Ganey) 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 KHS 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 combined with the most recent available Medi-Cal membership market share data to calculate an average FTE percentage which will be applied to the Plan's network of providers when calculating physician-to-enrollee compliance ratios.

KHS utilized Press Ganey, an NCQA certified survey vendor, to conduct the survey for 2023. Press Ganey'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 2023 survey and the Plan's Medi-Cal market share, KHS calculated a network-wide FTE percentage of **62.55% for Primary Care Providers** and **60.40% for Physicians.**

Network Adequacy & Provider Counts

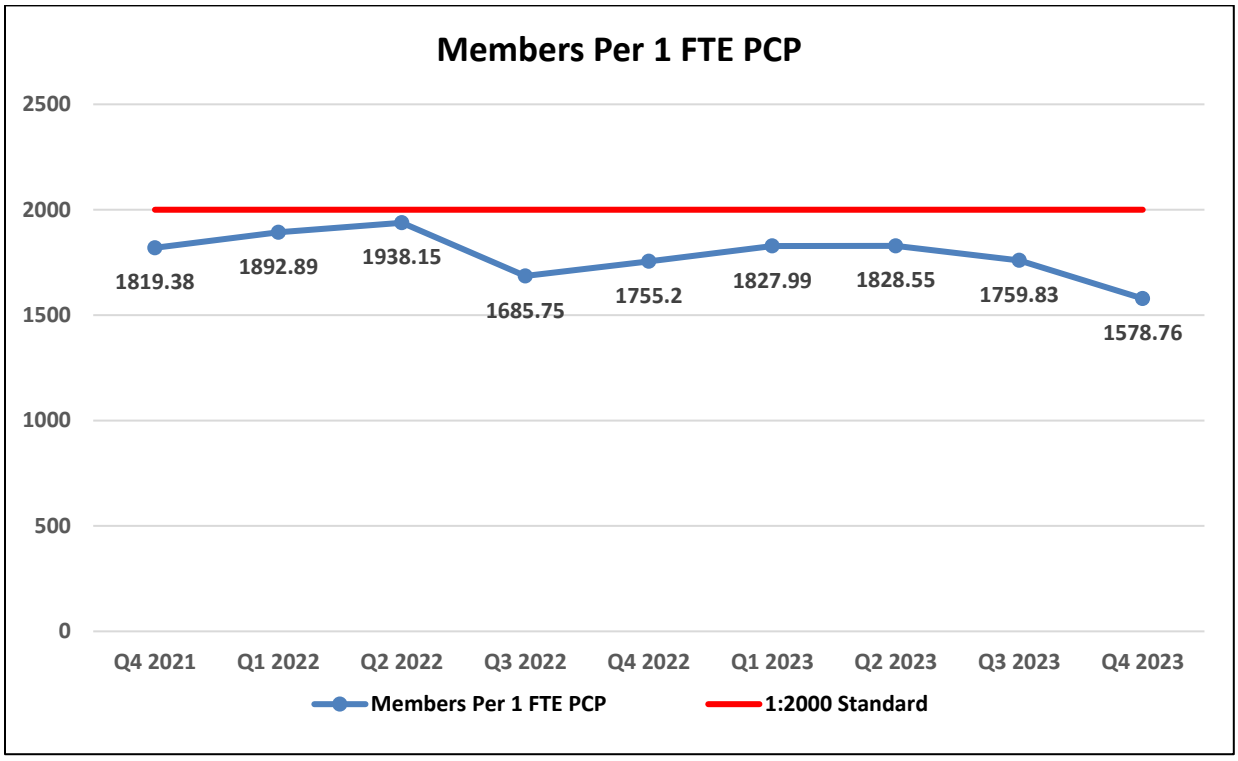
Q4, 2023

Full Time Equivalency Compliance Calculations

Of KHS' 362,818 membership at the close of Q4 2023, 15,219 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 2023, the plan was contracted with 471 Primary Care Providers, a combination of 233 physicians and 238 mid-levels. Based on the FTE calculation process outlined above, with a 58.19% PCP FTE percentage, KHS maintains a total of **220.17 FTE PCPs**. With a membership enrollment of 347,599 utilizing KHS contracted PCPs, KHS currently maintains a ratio of **1 FTE PCP to every 1578.76 members**; KHS is compliant with state regulations and Plan policy.

PCP to Member Ratio

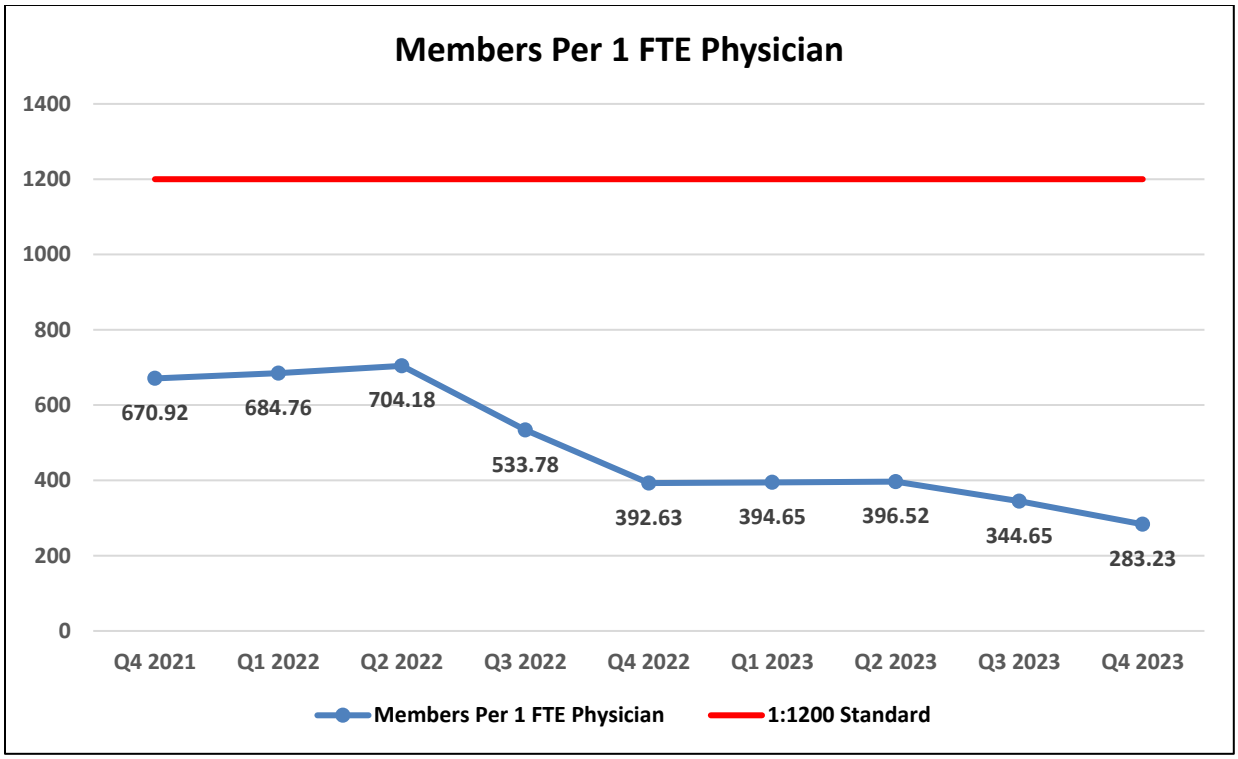


As of the end of Q3 2023, the plan was contracted with 2,032 Physicians. Based on the FTE calculation process outlined above, with a 60.40% Physician FTE percentage, KHS maintains a total of **1227.26 FTE Physicians**. With a total membership enrollment of 347,599 utilizing KHS contracted Physicians, KHS currently maintains a ratio of **1 FTE Physician to every 238.23 members**; KHS is compliant with state regulations and Plan policy.

Network Adequacy & Provider Counts

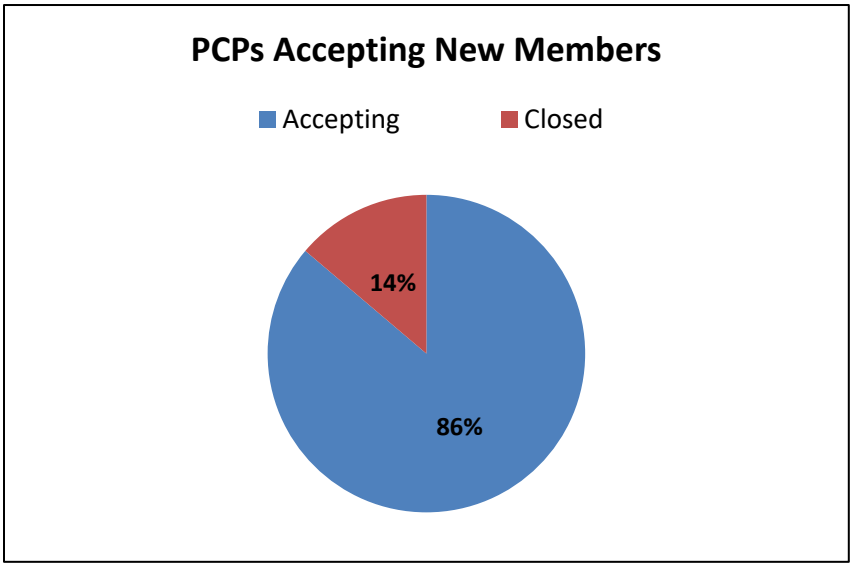
Q4, 2023

Physician to Member Ratio



Accepting New Members (PCP)

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 86% 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.



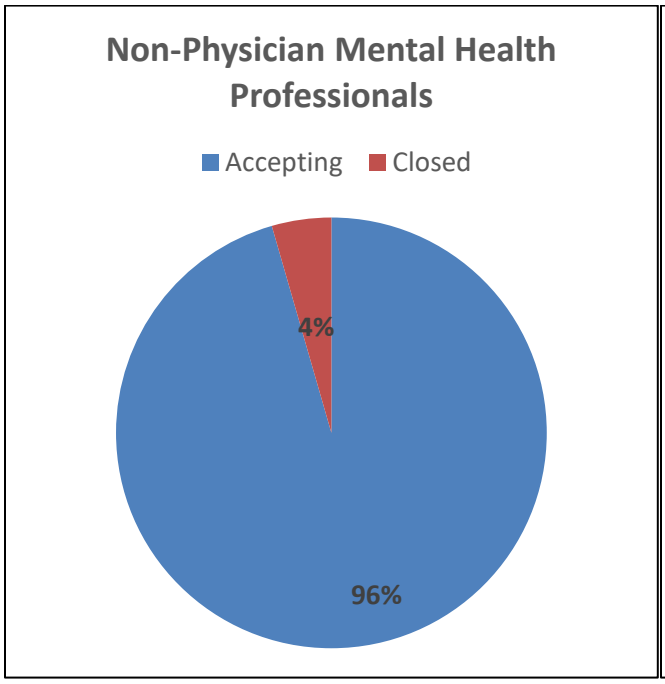
Network Adequacy & Provider Counts

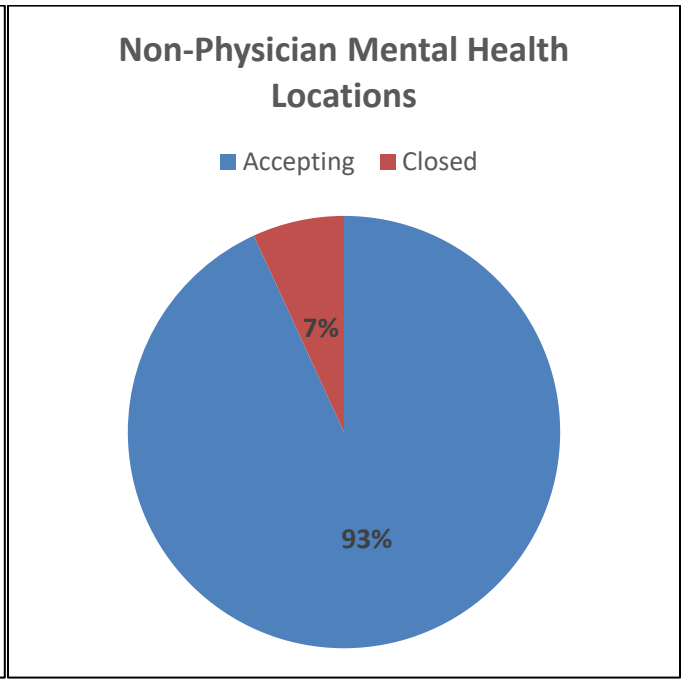
Q4, 2023

Accepting New Members (Non-Physician Mental Health)

Per KHS Policy, *4.30 Access Standards*, the Plan monitors the adequacy of its Non-Physician Mental Health Network to be in line with the standards set by the Department of Managed Health Care (DMHC) All Plan Letter (APL) 23-023. **The Plan calculated that 96% of its Non-Physician Mental Health Providers and 93% of the Non-Physician Mental Health Locations are accepting new members**. The Plan will continue to monitor these percentages quarterly to ensure it maintains an adequate network of Non-Physician Mental Health Providers.

Network Compliance Threshold	At least 75% of counseling non-physician mental health professionals in the network are accepting new patients, or At least 80% of non-physician mental health locations in the network are accepting new patients.
County Compliance Threshold	At least 75% of counseling non-physician mental health professionals in the network are accepting new patients, or At least 80% of non-physician mental health locations in the network are accepting new patients.

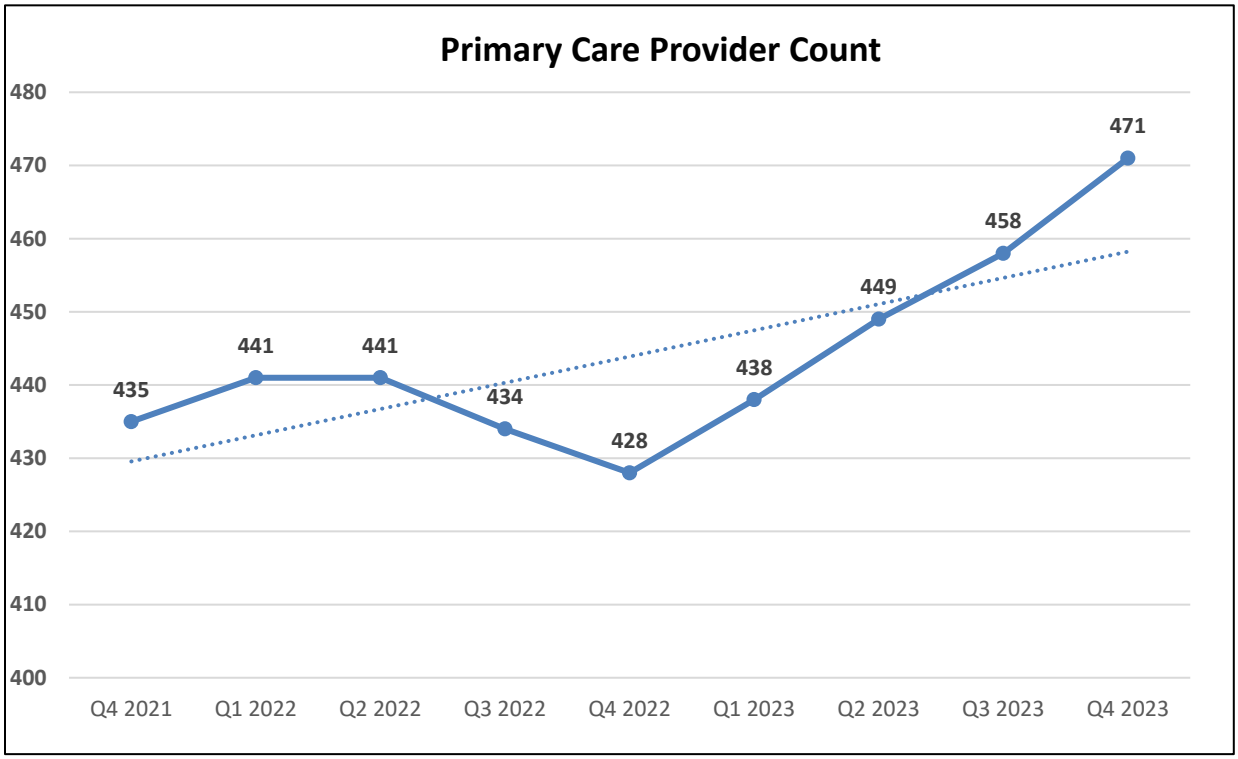


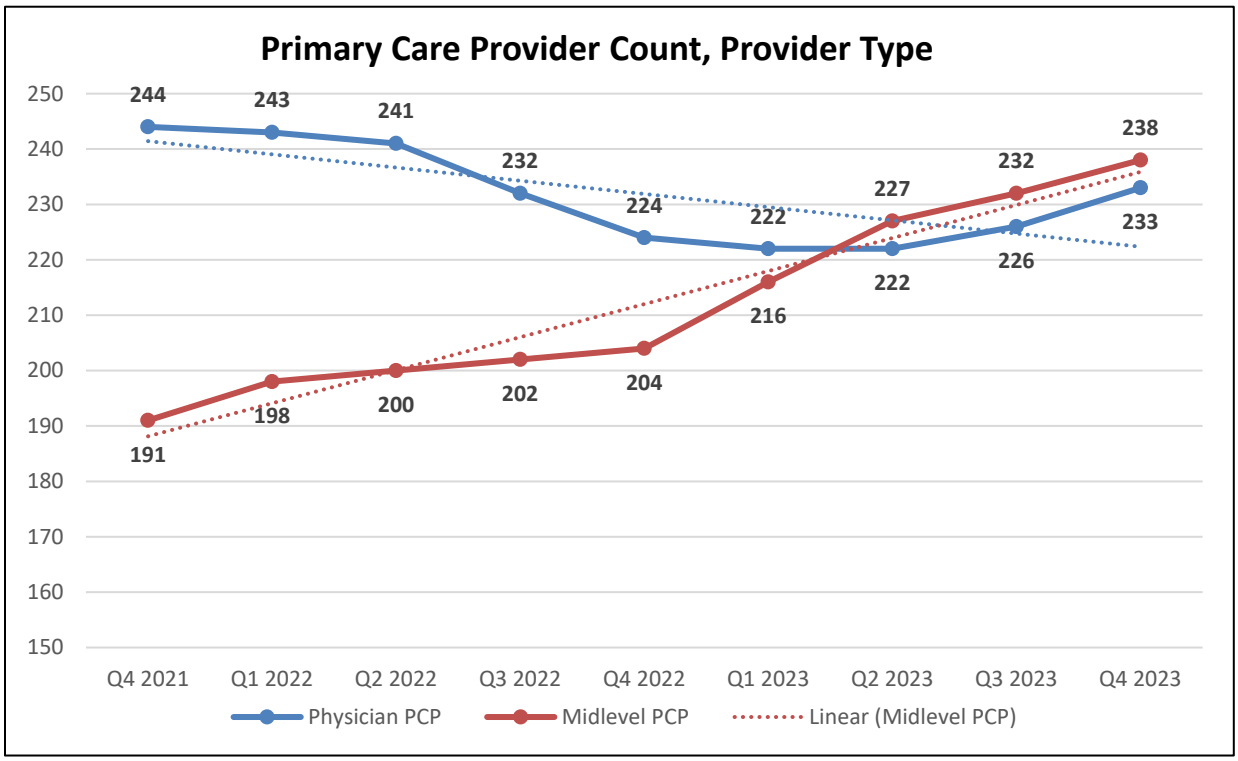


Network Adequacy & Provider Counts

Q4, 2023

Provider Counts – Primary Care Providers



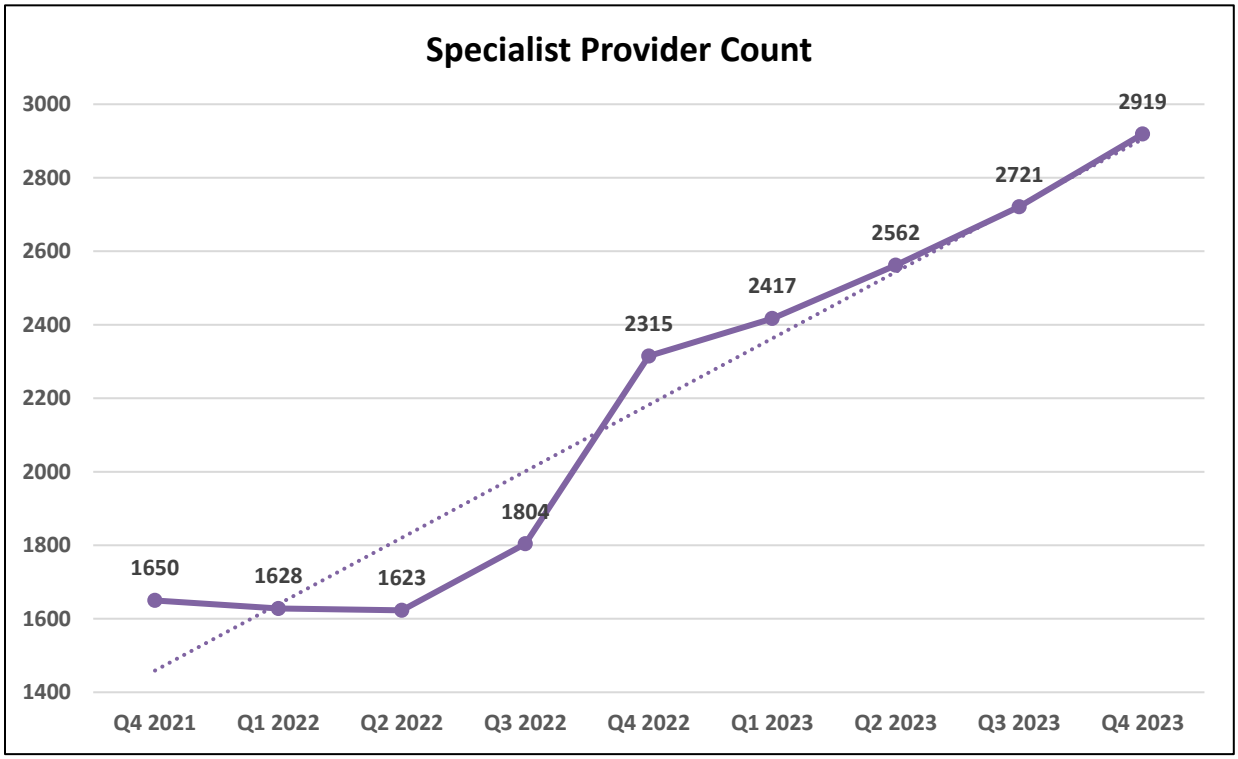


Network Adequacy & Provider Counts

Q4, 2023

KERN HEALTH SYSTEMS

Provider Counts – Specialist Providers



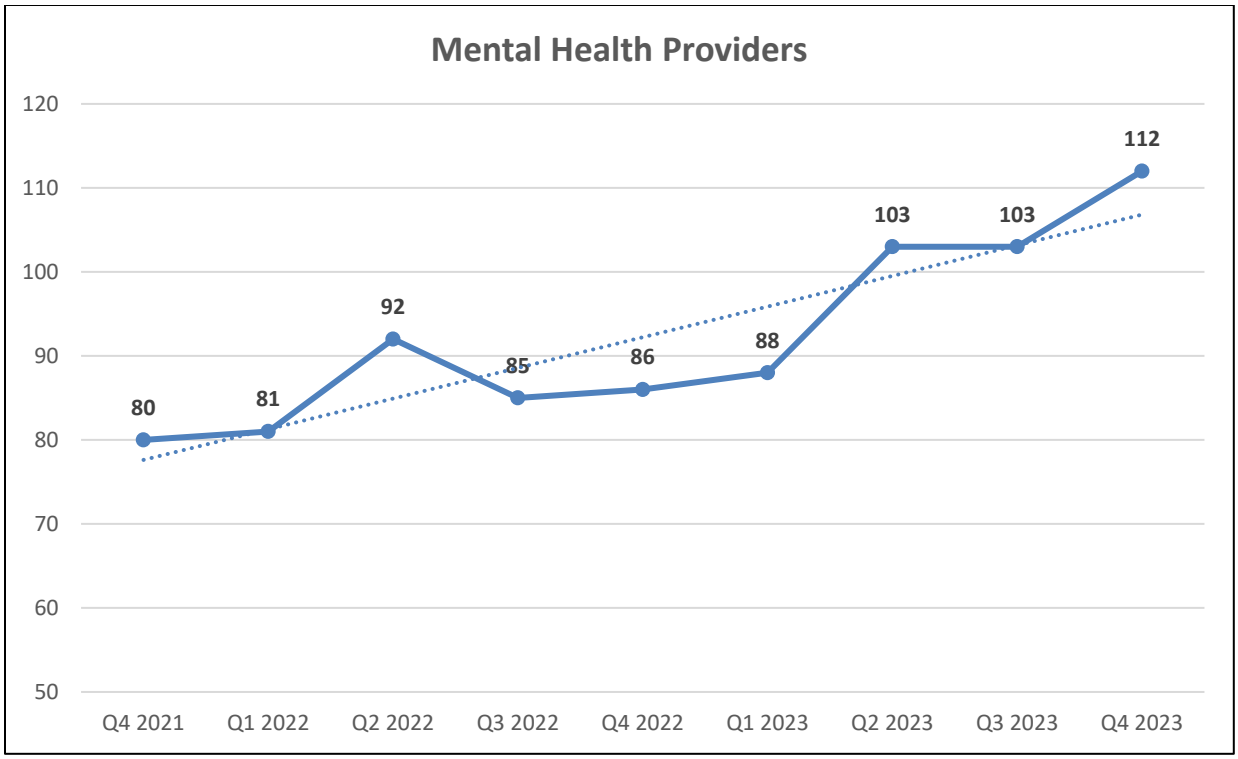
	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023
Cardiology	46	45	45	46	44	43	46	45	46
Dermatology	35	39	39	43	45	46	47	51	53
Endocrinology	24	25	25	26	26	27	25	28	29
Gastroenterology	24	24	26	31	33	33	35	34	35
General Surgery	62	65	60	63	64	63	62	59	67
Hematology	23	20	21	23	23	22	27	22	22
Infectious Disease	8	8	8	12	11	11	11	12	13
Nephrology	28	25	28	36	32	26	27	25	30
Neurology	25	22	26	29	29	33	33	31	33
Oncology	27	26	26	27	26	25	23	25	24
Ophthalmology	28	27	26	30	32	32	29	34	37
Orthopedic Surgery	22	23	26	29	32	32	32	32	32
Otolaryngology	9	9	9	13	14	14	12	15	15
Physical Med & Rehab	10	10	10	9	8	9	9	9	9
Psychiatry	53	54	53	57	65	67	64	68	76
Pulmonary Disease	20	20	20	21	21	21	20	28	25

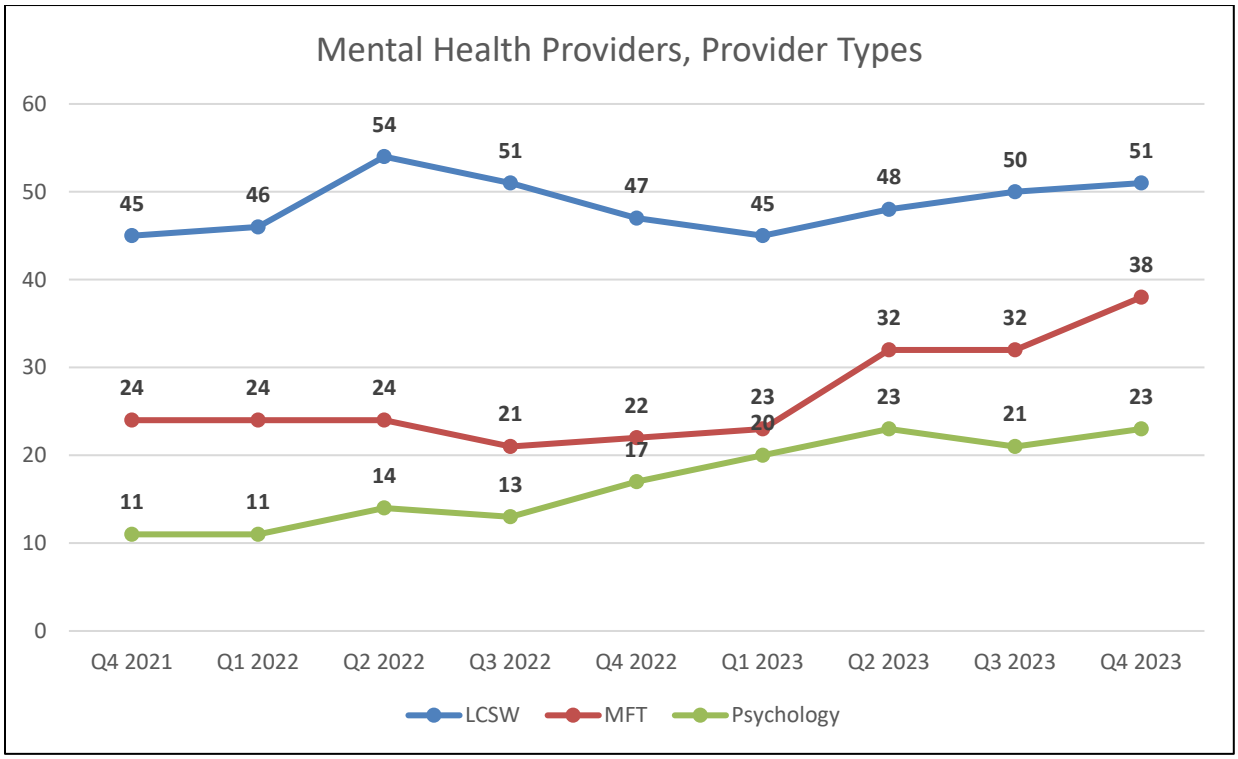
> 5% Increase		> 5% Decrease	
≤ 5% Increase		≤ 5% Decrease	

Network Adequacy & Provider Counts

Q4, 2023

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





Network Adequacy & Provider Counts

Q4, 2023

Provider Counts – Facilities

	2019	2020	2021	2022	Current
Hospital	18	18	21	20	21
Surgery Center	17	19	19	19	20
Urgent Care	17	17	19	22	25

Provider Counts – Other Provider Types

	2019	2020	2021	2022	Current
Ambulance/Transport	13	17	16	15	18
Dialysis	16	18	19	19	19
Home Health	13	13	14	15	15
Hospice	11	13	16	18	19
Pharmacy	139	147	150	145	135
Physical Therapy	29	30	29	32	33

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 2023 report and compared against prior quarters (outlined above) and identified that PCP and Mental Health provider counts continue to haver consistent growth across the review period as illustrated in the graphs.

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

Significant Network Change

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

The Plan initiated the Significant Network Change filing on December 9, 2021 (Filing No. 20214807). The Plan received comment letters from the DMHC on January 10, 2022, March 9, 2022, May 10, 2022, July 8, 2022, August 31, 2022, October 31, 2022, December 21, 2022, February 13, 2023, April 11, 2023, June 9, 2023, August 8, 2023, October 10, 2023, and December 14, 2023. The Plan has responded to all letters within the 30-day timeframe. The Plan continues to work with the DMHC towards approval of this Significant Network Change filling.

KERN HEALTH SYSTEMS

DHCS Quarterly Monitoring Report/Response Template (QMRT)

Quarter 4, 2023

(Q3, 2023 QMRT)

Provider Network Management

Quarterly Monitoring Report/Response Template

Q4, 2023 (Q3, 2023 QMRT)

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 9/22/2023 the Plan's Provider Network Management Department received Q3 2023 QMRT and accompanying reports from the DHCS and during Q4 2023 the Plan's Provider Network Management departments reviewed the following categories:

FTE Provider to Member Ratio

DHCS uses the Plan's 274 file submission to calculate and monitor FTE provider to member ratios. For Q3 2023 QMRT no response was requested from the Plan, and the DHCS review found the Plan to be in compliance with the standard:

Service Area and/or Reporting Unit	FTE PCP Per 2,000 members	FTE Physician Per 1,200 members
Kern	12	39

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*, *Q3 2023*) also found the Plan to be in compliance with regulatory standards.

Timely Access

DHCS' External Quality Review Organization (EQRO) conducts a timely access survey of Plan providers to ensure compliance with provider availability and appointment wait time standards. For Q3 2023 QMRT the Plan was provided with timely access data reporting providers' ability to respond to the timely access survey and providers' ability to meet the next three (3) appointments within timely access standards.

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

Network Report

DHCS uses the Plan's 274 file to generate Network Report in an effort to improve network provider data quality and support compliance with Annual Network Certification and timely access survey. For Q3 2023 QMRT no response was requested from the Plan, and no Network Report data was provided to the Plan. The Plan's standards and monitoring of accessibility are outlined in the Plan's policy and procedure *4.30-P Accessibility Standards.*

Mandatory Provider Types

The Plan is required to contract with at least one of the following Mandatory Provider Types within its service area, where available: Freestanding Birthing Centers (FBC), Certified Nurse Midwife (CNM), Licensed Midwife (LM), and Indian Health Facilities (IHF). For Q3 2023 QMRT no response was requested from the Plan, and no Mandatory Provider Type data was provided to the Plan. The Plan maintains ongoing efforts to identify and contract will all provider types, including the above listed Mandatory Provider Types. This requirement is also reviewed by the Plan and DHCS as part of the Plan's Annual Network Certification. The Plan's most recent submission was found to be in compliance with regulatory requirements.

Physician Supervisor to Non-Physician Medical Practitioner Ratios

DHCS uses the Plan's 274 file submission to calculate and monitor Physician Supervisor to Non-Physician Medical Practitioner Ratios. For Q3 2023 QMRT no response was requested from the Plan, and the DHCS' review found the Plan to be in compliance with the standard:

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

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

Out-of-Network Requests

The Plan reports Out-of-Network (OON) requests to DHCS when a member is requesting to a see a provider or facility when a medically necessary service is not available in the Plan's network. The DHCS analyzes the data to identify potential areas of concern. Based on Q2 2023 data which was provided to the Plan in the Q3 2023 QMRT, the Plan identified Hospital, General Surgery, and ENT/Otolaryngology 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.

To: EQIHEC

From: Dan Diaz, RN – ECM Clinical Manager

Date: 02/08/24

Re: Enhanced Case Management Q4 2023 Reporting

Background:

Enhanced Care Management (ECM) is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high cost and/or high-need Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. Members who will be eligible for ECM are expected to be among the most vulnerable and highest-need Medi-Cal Managed Care Members. ECM plays a pivotal role in addressing health equity by adopting a patient-centered approach that takes into account the unique social, economic, and cultural factors influencing individuals' health outcomes. This program prioritizes proactive and personalized interventions, emphasizing preventive measures and early detection of health disparities. By actively engaging with diverse communities, understanding their specific needs, enhanced care management aims to bridge gaps in healthcare access and outcomes. Additionally, it promotes collaborative partnerships between healthcare providers and community organizations to develop tailored solutions that address the underlying determinants of health disparities, ultimately working towards a more equitable and inclusive healthcare system.

Discussion:

- Description of Enhance Care Management
- Composition of the Populations of Focus as delineated by the DHCS and relative trends
- Cost/Utilization Savings Measures
- Clinical measures
- Feedback Measures
- 2024 Meeting Schedule

Fiscal Impact: None

Requested Action:

Discuss with the committee progress to date with quantitative/qualitative measures and track and trend relevant ECM demographic data with the committee.

Enhanced Care Management Quarter IV QIC Report

Background:

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

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

Populations of Focus live as of January 2024:

- **Birth Equity PoF**:

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

- **Justice-Involved PoF:**

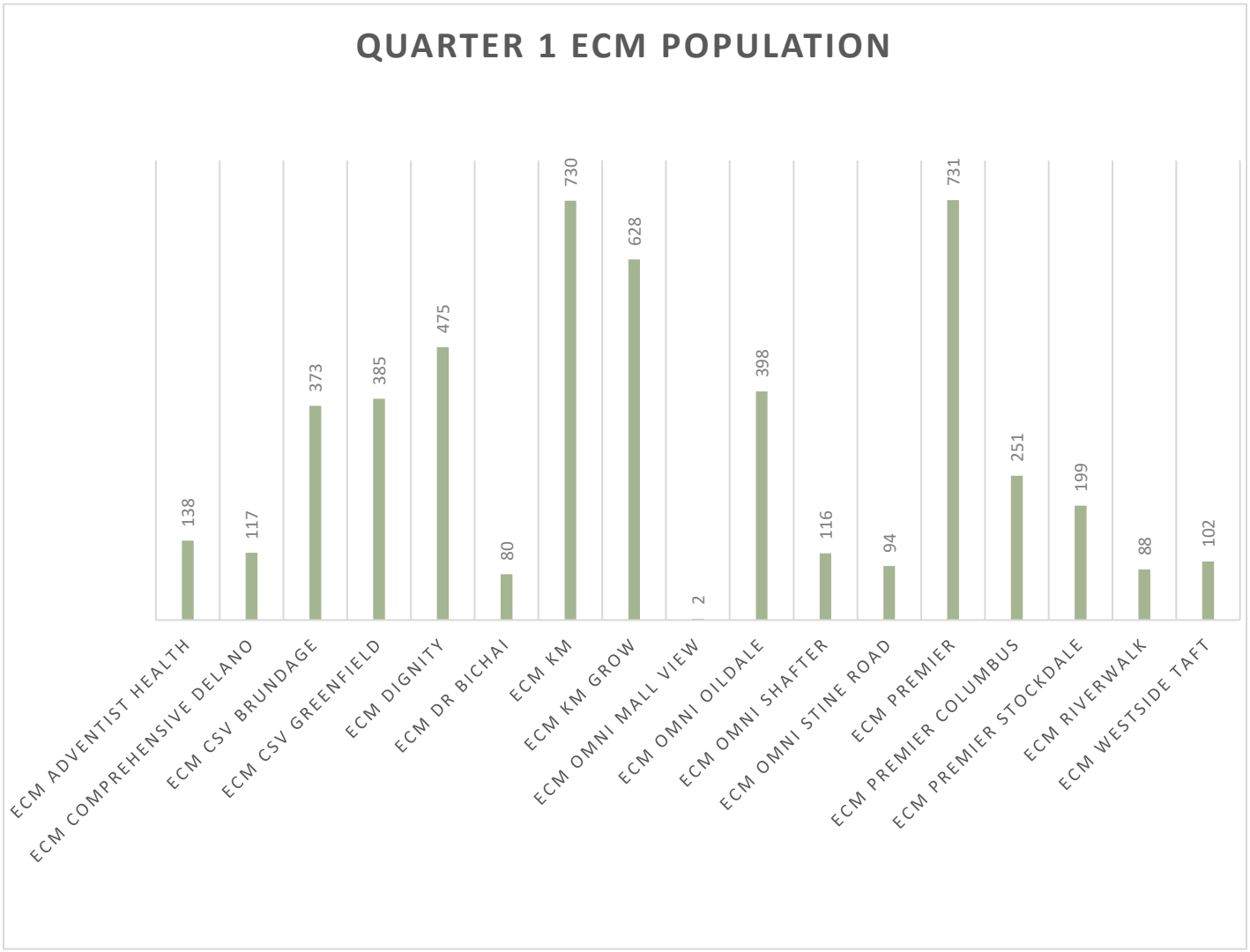
  The ECM team continues to focus on the Justice-Involved Initiative, requiring extensive work and relationship/partnership-building with all correctional facilities throughout the county as the Justice-Involved Initiative goes live throughout the state, as early as 10/1/24 (once DHCS has approved the Readiness Assessment by Correctional Facilities), to be implemented (mandated by DHCS) no later than 9/1/26. The ECM team has worked diligently to contact our local correctional facilities and establish relationships with them in preparation for the Justice-Involved Initiative. We have met with local representatives of the Kern County Sheriff Department, Kern County Probation, and Kern Behavioral Health and Recovery Services, for the county adult and juvenile correctional facilities. We have also continue to meet with the CalAIM representative for the California Department of Corrections and Rehabilitation (CDC-R) for the state adult facilities located in our county.

ECM Demographic Data

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

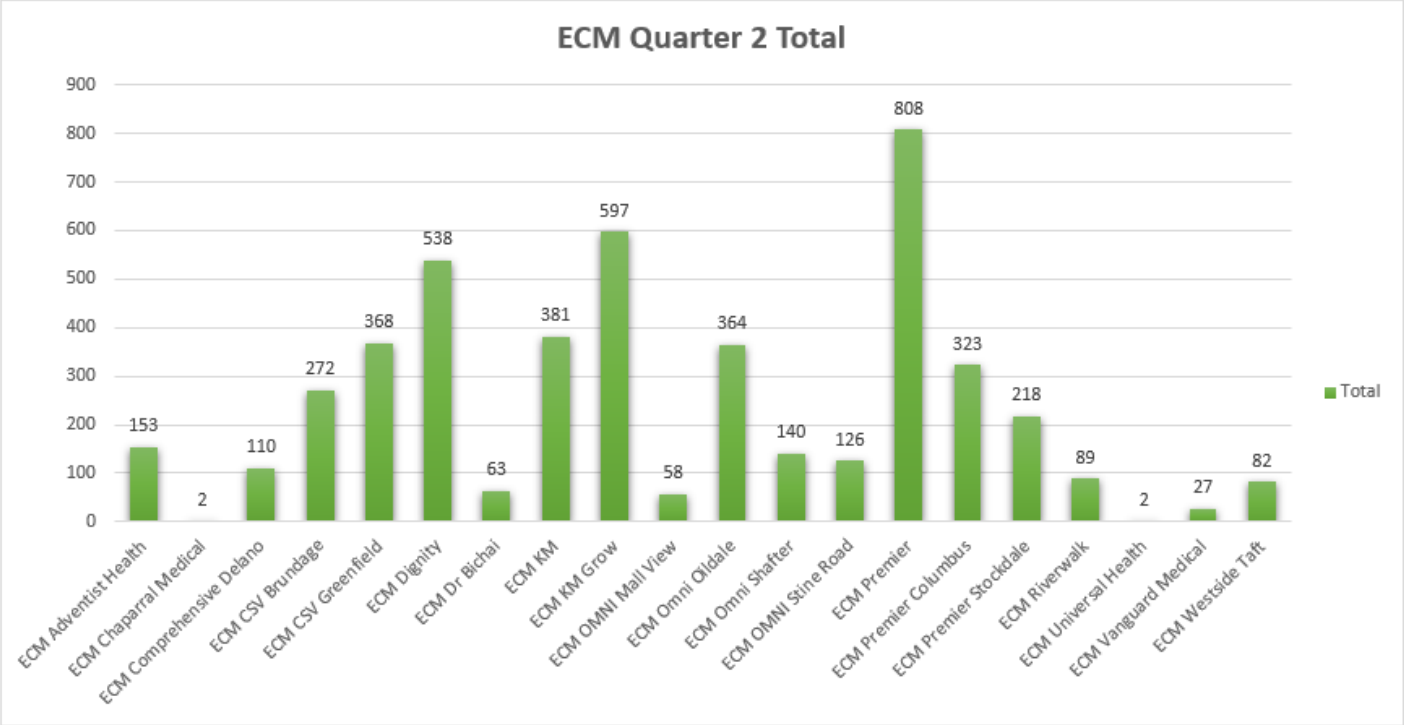
ECM Population amount by site Quarter 1 2023

Total Population: 4,907



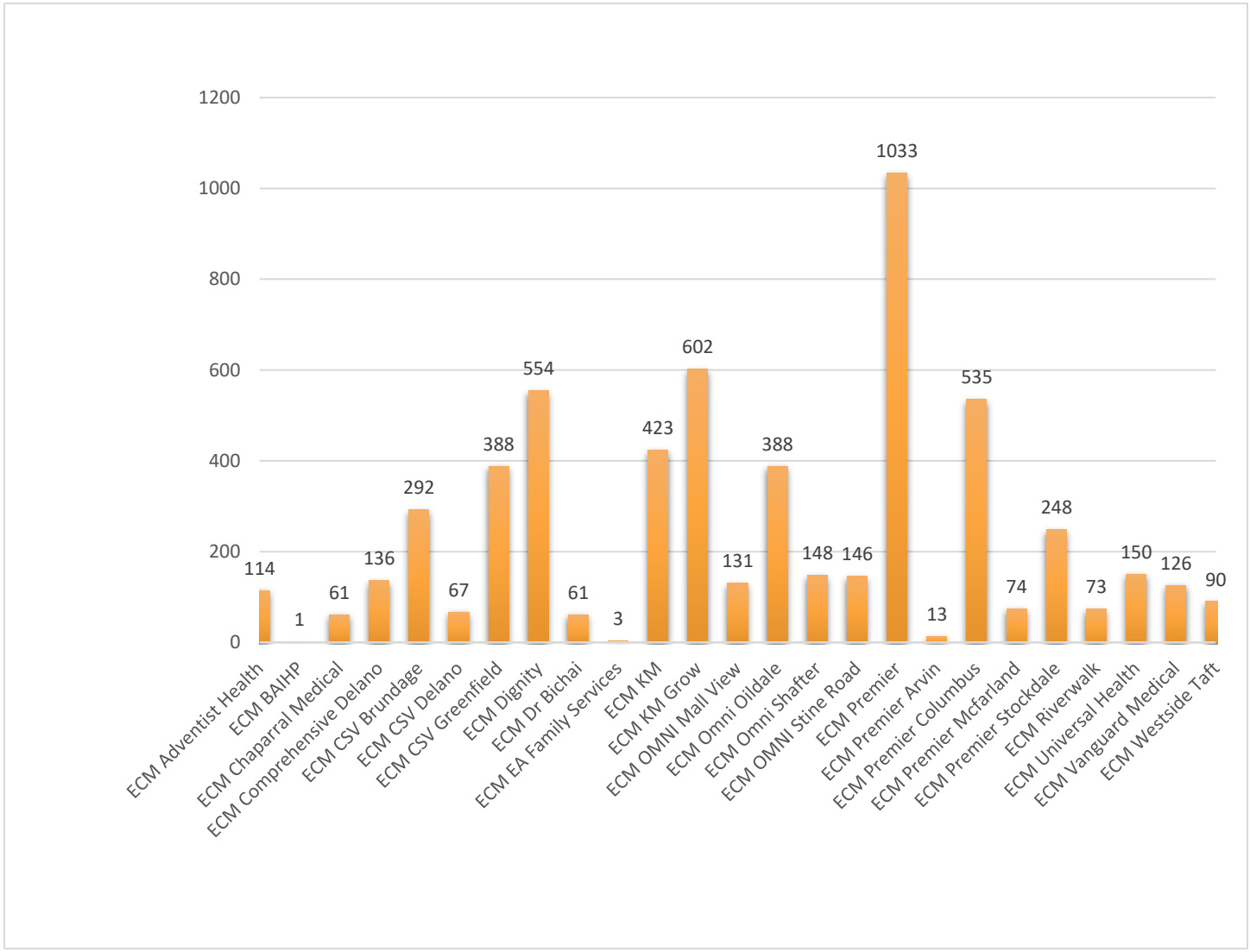
ECM Population amount by site Quarter 2 2023

Total Population: 4,721



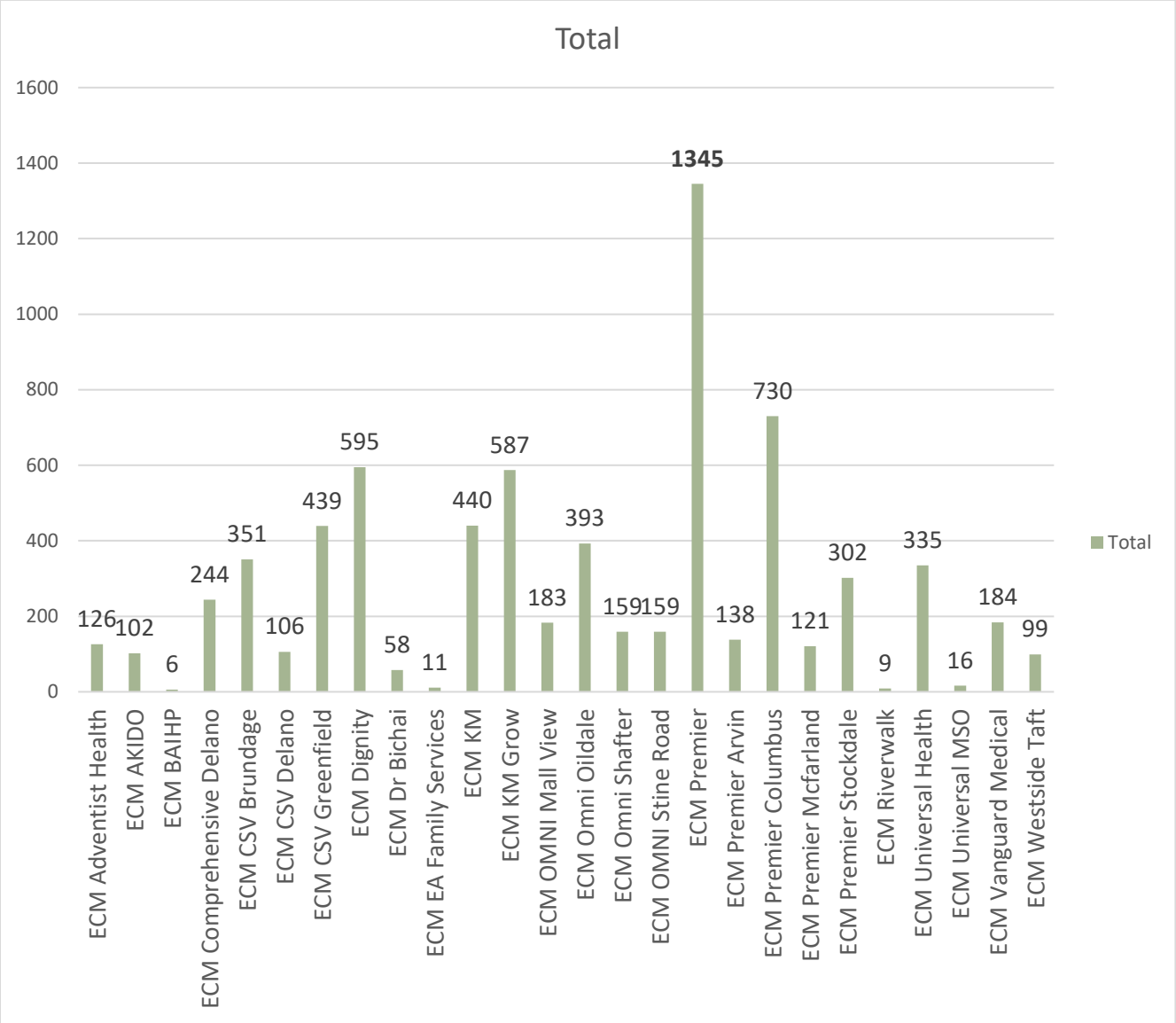
ECM Population amount by site Quarter 3 2023

Total Population: 5,858



ECM Population amount by site Quarter 4 2023

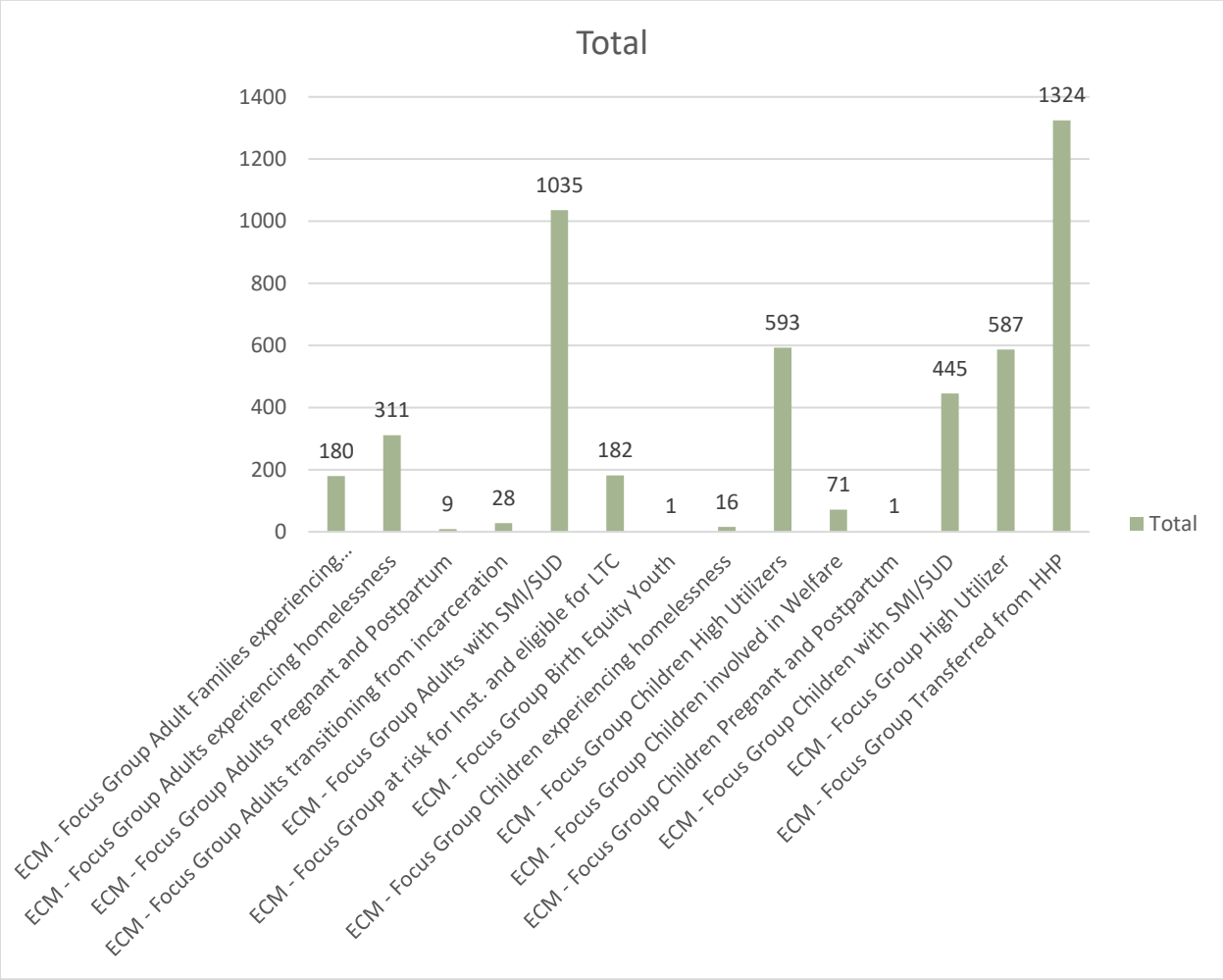
Total Population: 7,328



Net increase Q1 to Q4 2023:

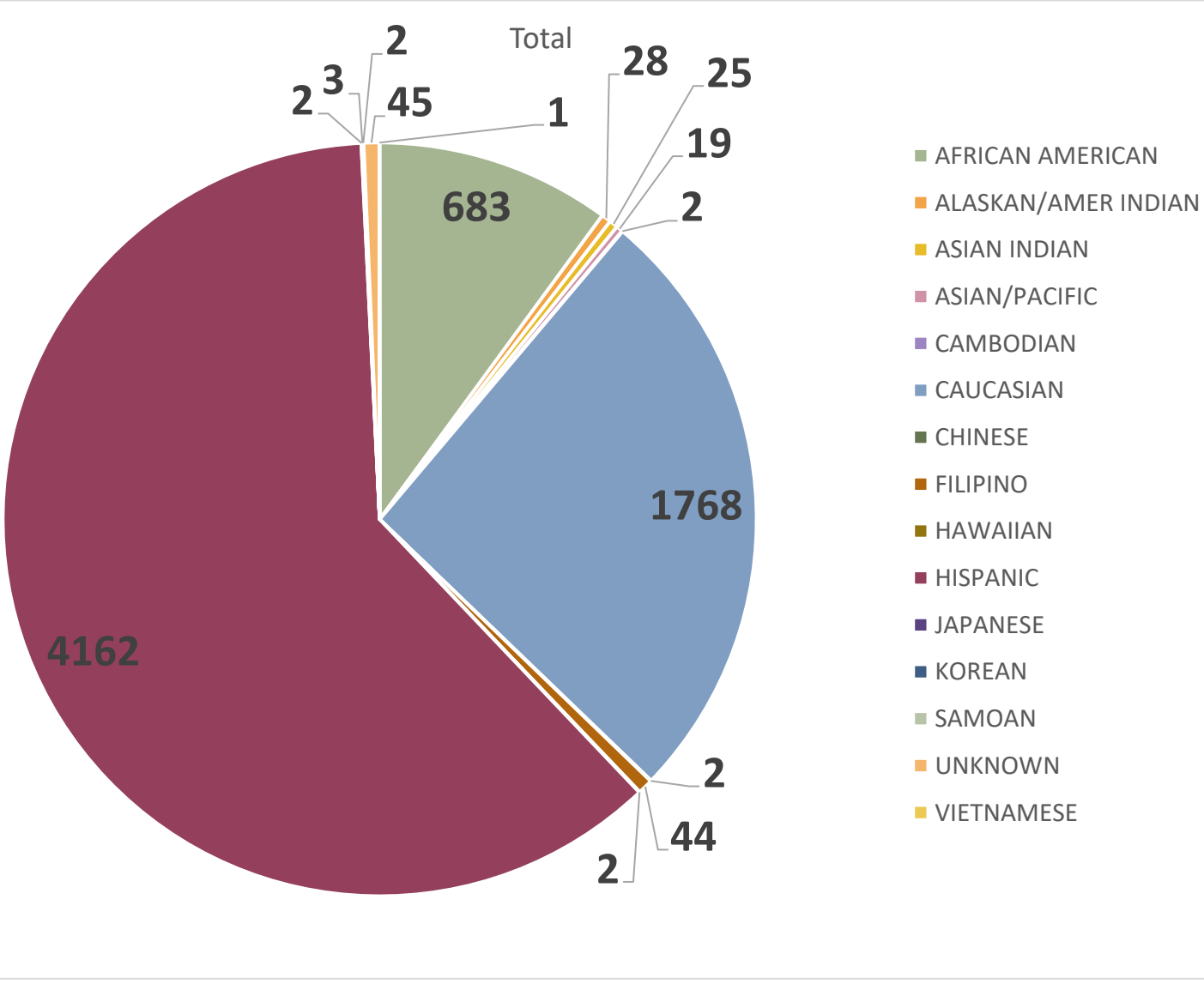
3,231 members

ECM Population amount by site Quarter 4 2023 by POF



Ethnicity

In the Enhanced Care Management program we pride ourselves on maintaining the alignment in values shared throughout Kern Family Health Care in serving a diverse population. As denoted in the below graph (Ethnicity table), the largest ethnic group served by our ECM providers is the Hispanic population which constitutes 56.7% of the total ECM population (as of Q4), while a smaller population identify as other ethnic groups such as African American, Caucasian, Alaskan/American Indian, etc. We proudly boast a robust bilingual staff serving our membership throughout all 28 of our locations and continue to look at ways to be more equitable to all our ethnic groups in ECM.



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

Total Q IV ECM Population: 7,238

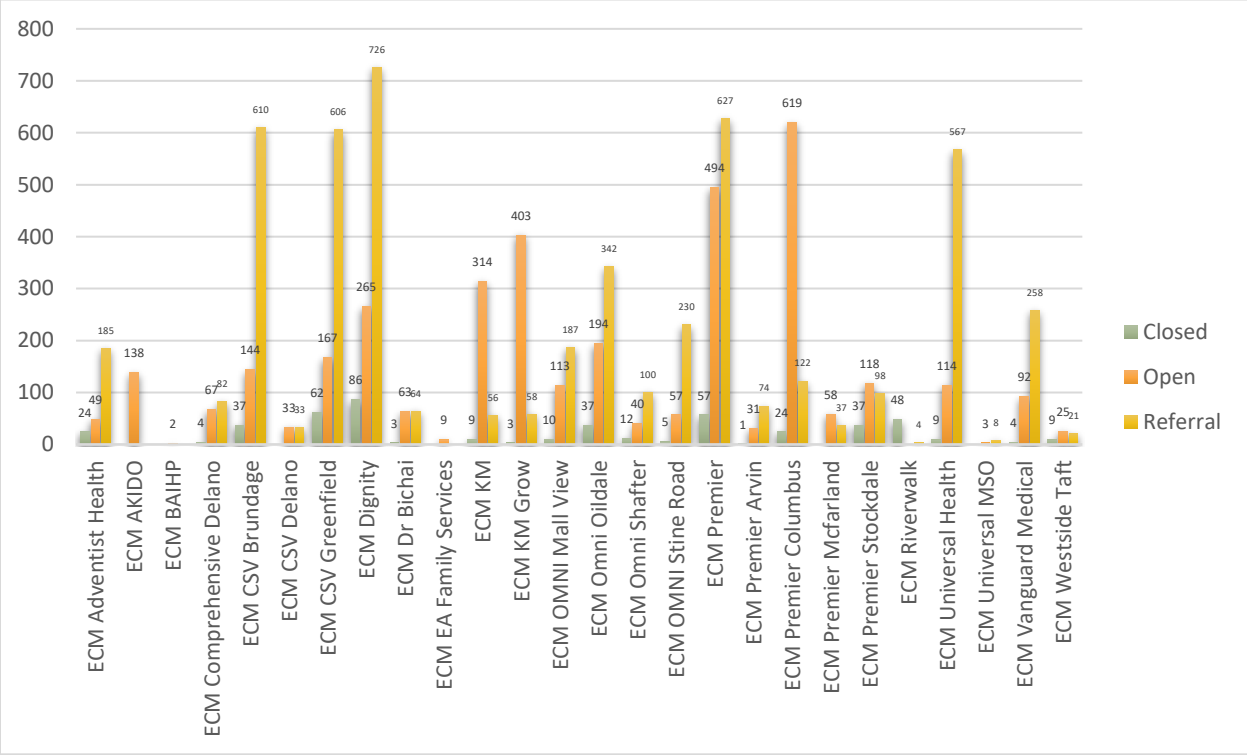
In accordance to the most recent DHCS IPP Provider milestone requirements our institutional goals moving forward is to use our this quarterly data as a benchmark to incrementally decrease our overall percentage of utilization. As per the IPP requirements, plans must show a net decrease in the rate of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

IPP measures:

4.4.3 ***Quantitative Response Only*** Percentage of members who had ambulatory visits within 7 days post hospital discharge
4.4.4 **Quantitative Response Only** Rate of emergency department (ED) visits per 1,000 member months for members ages 21 and older and who are eligible for ECM **- Quarter 1 & 2 (P4P) – 168 out of 1000 or 16.8%** **- Quarter 3 % 4 (preliminary) – 138 of 100 or 13.8%**
4.4.5 ***Quantitative Response Only*** Percentage of emergency department (ED) visits with a discharge diagnosis of mental illness or intentional self-harm for members ages 21 and older and who are eligible for ECM who had a follow-up visit with any practitioner within 30 days of the ED visit (31 total days)

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

Quarter IV Total ED Utilization by site:



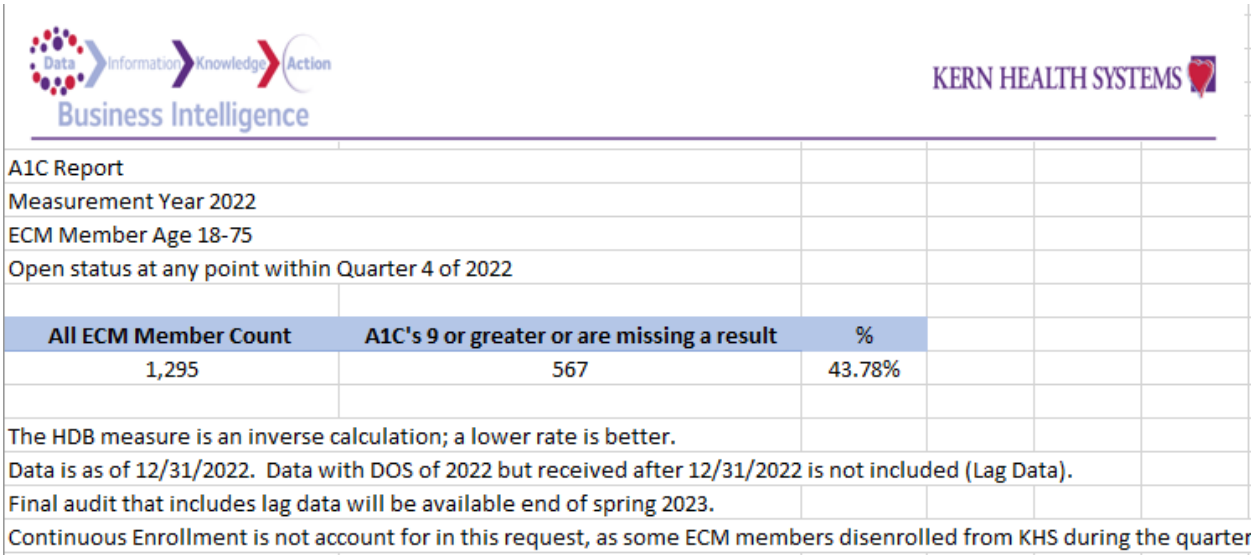
ECM clinical measure:

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

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

Historically with the ECM program we set a benchmark of a minimum of monthly meetings with the sites to discuss all administrative, technical, and clinical needs they may have. As we have evolved and grown in the program we have focused our clinical efforts in these meetings to build a solid focus on MCAS measures and emphasized with the sites the importance of tailoring their coordination/provider workflow to help meet these measures. Below, our internal Business Intelligence team queried the performance ECM member had in this measure as of close of Quarter 4 2023. Our population included members who are in 'Open' status (or engaged) with an ECM site through quarter 1- 4, and met the thresholds of the measure:

Quarter 4 2022 results:



Data Information Knowledge Action
Business Intelligence

KERN HEALTH SYSTEMS

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

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

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

Quarter 1 progress:

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

Quarter 2 Progress:

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

Quarter 3 Progress:

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

Quarter 4 Progress:

Measure	Population	Members Compliant	Measure Compliant Rate	MPL Goal	HPL Goal
Hemoglobin A1c Testing & Control for Patients With Diabetes Inverse Measure	1,596	577	**36.15%**	50.95	61.27

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

Other Measures:

Site	Asthma Medication Ratio	Breast Cancer Screening	Cervical Cancer Screening	Child and Adolescent Well-Care Visits	Childhood Immunization Status	Chlamydia Screening in Women	Controlling High Blood Pressure	Developmental Screening in the First 3 Years of Life	Follow-Up After Emergency Department Visit for Mental Illness	Follow-Up After Emergency Department Visit for Substance Use	Hemoglobin A1c Testing 9% & Control for Patients With Diabetes	Immunizations for Adolescents	Lead Screening in Children	Postpartum Care	Prenatal Care	Prevention: Topical Fluoride for Children	Well-Child Visits in the First 15 Months of Life	Well-Child Visits in the First 30 Months of Life
ECM Adventist Health	0.0%	33.3%	50.0%	35.7%	100.0%	100.0%	36.8%	0.0%	50.0%		70.0%	100.0%	100.0%	100.0%	100.0%	16.7%		100.0%
ECM Chaparral Medical		0.0%	10.0%	0.0%			25.0%			0.0%	100.0%					0.0%		
ECM Comprehensive Delano	100.0%	55.0%	59.4%			50.0%	27.8%				80.0%							
ECM CSV Brundage	20.0%	76.9%	80.9%	81.8%		90.6%	66.7%		100.0%	0.0%	13.5%			80.0%	40.0%	13.6%		
ECM CSV Delano		66.7%	60.0%	100.0%	0.0%	0.0%	100.0%	0.0%			16.7%		100.0%			33.3%	0.0%	100.0%
ECM CSV Greenfield	66.7%	89.4%	77.1%	44.0%		66.7%	66.9%		33.3%	0.0%	24.0%			75.0%	37.5%	12.0%		
ECM Dignity	81.8%	81.1%	69.6%	34.8%	0.0%	54.2%	30.7%	0.0%	33.3%	16.7%	33.0%		100.0%	60.0%	50.0%	16.0%	100.0%	100.0%
ECM Dr Bichai	0.0%	53.8%	45.5%	0.0%		0.0%	30.2%			0.0%	66.7%					0.0%		
ECM KM	100.0%	64.0%	59.8%	0.0%		71.4%	58.9%		0.0%	10.5%	82.9%			45.5%	54.5%	0.0%		
ECM KM Grow	75.0%	87.0%	70.2%	37.5%		70.0%	84.4%		50.0%		43.7%			100.0%	100.0%	12.5%		
ECM OMNI Mall View	100.0%	50.0%	62.2%	62.5%	0.0%	100.0%	62.9%	0.0%		0.0%	20.0%		100.0%	100.0%	33.3%	10.0%	0.0%	0.0%
ECM Omni Oildale	50.0%	65.5%	63.9%	50.0%		71.4%	66.9%			50.0%	29.0%	50.0%		66.7%	55.6%	42.9%		
ECM Omni Shafter	75.0%	69.0%	72.7%	45.5%		60.0%	65.2%	0.0%		0.0%	29.1%			50.0%	0.0%	9.1%		100.0%
ECM OMNI Stine Road	0.0%	60.0%	53.2%	9.1%		81.8%	70.8%		0.0%		21.7%			66.7%	66.7%	9.1%		
ECM Premier	95.7%	72.8%	70.6%	52.8%	22.2%	53.7%	59.5%	25.0%	0.0%	23.5%	35.1%	0.0%	55.6%	56.0%	40.0%	19.8%	57.1%	80.0%
ECM Premier Columbus	100.0%	56.0%	65.9%	33.3%	25.0%	65.5%	41.4%	22.2%	25.0%	19.2%	51.1%	50.0%	25.0%	75.0%	62.5%	33.0%	75.0%	100.0%
ECM Premier Stockdale	100.0%	72.7%	63.0%	41.5%	0.0%	69.6%	37.9%	14.3%	50.0%	28.6%	65.6%	0.0%	80.0%	66.7%	55.6%	33.3%	100.0%	50.0%
ECM Riverwalk	100.0%			61.9%	0.0%	0.0%		40.0%				100.0%	25.0%			41.8%	0.0%	100.0%
ECM Universal Health	100.0%	88.9%	76.5%	61.1%	0.0%	75.0%	56.5%	12.5%			72.2%	0.0%	100.0%	100.0%	25.0%	33.3%	50.0%	66.7%
ECM Vanguard Medical	0.0%	80.0%	62.9%	28.6%		75.0%	58.6%		100.0%		31.6%			100.0%	100.0%	14.3%		
ECM Westside Taft	100.0%	82.6%	60.5%	55.6%		50.0%	71.8%	50.0%		0.0%	33.3%			0.0%	100.0%	44.4%		
Grand Total	**74.8%**	**73.8%**	**67.6%**	**47.3%**	**14.3%**	**67.2%**	**57.7%**	**20.4%**	**26.8%**	**16.3%**	**39.8%**	**43.8%**	**60.7%**	**66.4%**	**48.6%**	**26.9%**	**54.5%**	**80.0%**
MPL	64.8%	65.8%	66.8%	67.8%	68.8%	69.8%	70.8%	71.8%	72.8%	73.8%	74.8%	75.8%	76.8%	77.8%	78.8%	79.8%	80.8%	81.8%

Measures	18
Above MPL	4
Above MPL Rate	22.2%

Patient Satisfaction:

Survey Data

The Enhanced Care Management team has historically sent an experience satisfaction survey out to it's members for resubmission to the plan. As of date of submission to the QIC, we have worked internally with our delegated parties to distribute the surveys out to our membership and will begin receiving response data as early as April 2024.

ECM Member Survey Summary 2023

• Sample Size: 3500

• Completed Surveys: 488

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

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

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

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

- Most participants recognize benefits from participation.

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

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

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

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

Kern Family Health Care

SURVEY INSTRUCTIONS

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

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

EXPERIENCE WITH ECM PROGRAM

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

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

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

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

EXPERIENCE WITH ECM STAFF

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

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

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

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

EXPERIENCE WITH TELEHEALTH

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

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

Continued Page 2

Kern Family Health Care

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

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

OFFICE VISIT SATISFACTION

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

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

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

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

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

	▫	▫	▫	▫	▫

OVERALL SATISFACTION

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

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

Continued Page 3

Kern Family Health Care

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

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

ABOUT YOU

17. Gender: ▫ Male ▫ Female

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

19. Ethnicity:

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

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

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

KERN HEALTH SYSTEMS

To: KHS Executive Quality Improvement Health Equity Committee

From: Isabel Silva, MPH

Date: 2/8/2024

Re: 4th Quarter Wellness & Prevention Department Report

Background

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

Discussion

Enclosed is the quarterly Wellness & Prevention Department report summarizing all health education, cultural and linguistic activities performed during the 4th quarter of 2023.

Fiscal Impact

None

Requested Action

Approve and file

Kern Health Systems
Wellness & Prevention Activities Report
4th Quarter 2023

Executive Summary

Report Date: February 1, 2024

OVERVIEW

Kern Health Systems' Wellness and Prevention (WP) 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 WP department. Following this summary reflects the statistical measurements for the WP department detailing the ongoing activity for Q4 2023.

1. **New Programs**
   - Diabetes Education and Empowerment Program (DEEP) – scheduled to launch in 2/1/2024

2. **4th Quarter Trainings**
   - Cultural and Linguistic Services: CSV-Delano and KHS Depts (Pharmacy, Population Health Management, Member Services, Enhanced Care Management)
   - Health Literacy: KHS Depts (Compliance, Community Support Services, Wellness & Prevention, Health Equity, Marketing, Member Services, Population Health Management, Quality Improvement, Pharmacy and Utilization Management)

3. **Community Events**
   - 4th Quarter: Binational Health and Resource Fair, Healthful Harvest Fair (Arvin), Delano Night Out, Dia De La Familia (Delano), Kern County American Disabilities Association Conference

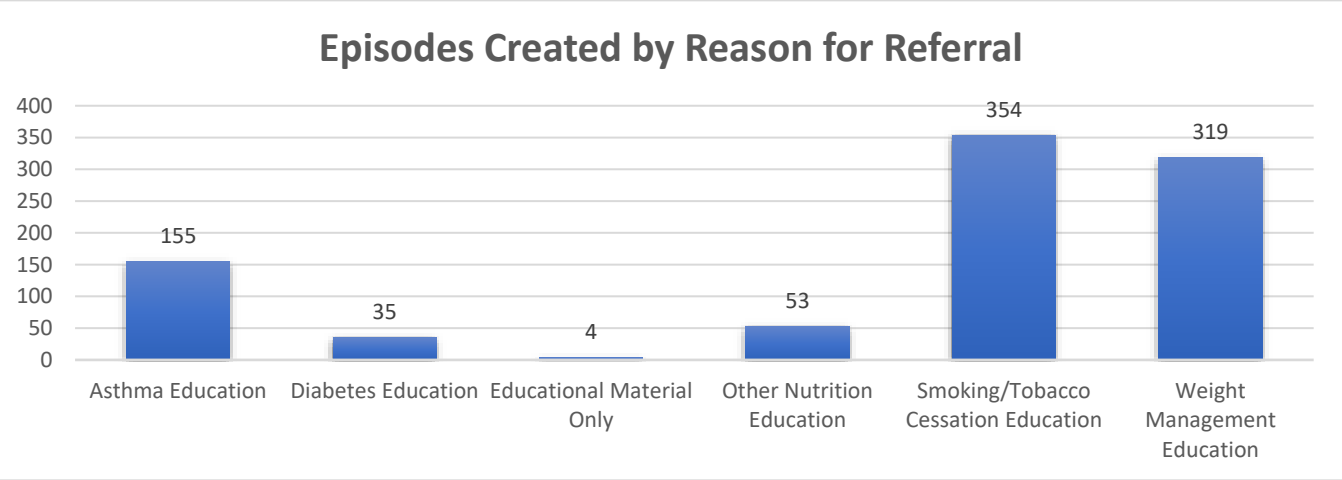
4. **Service Monitoring**
   - Linguistic Performance:
     - ✓ 97% members satisfaction with in-person interpreter
     - ✓ 99% member satisfaction with telephonic interpreter
     - ✓ 98% members satisfaction with bilingual KHS staff communications
     - ✓ 91% of KHS calls reviewed did not have difficulty communicating with members in a non-English language
     - ✓ 97% KHS staff satisfaction with vendor OPI communications
   - Health Education Classes:
     - ✓ 97% member satisfaction with classes
     - ✓ 6-percentage point increase in member knowledge on nutrition and physical activity
     - ✓ Returning Fresh Start members score 100% on knowledge tests
     - ✓ Diabetes Prevention Program: 4.1% average weight loss in current Spanish cohort

Respectfully submitted,

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

Referrals for Member Wellness and Prevention Services

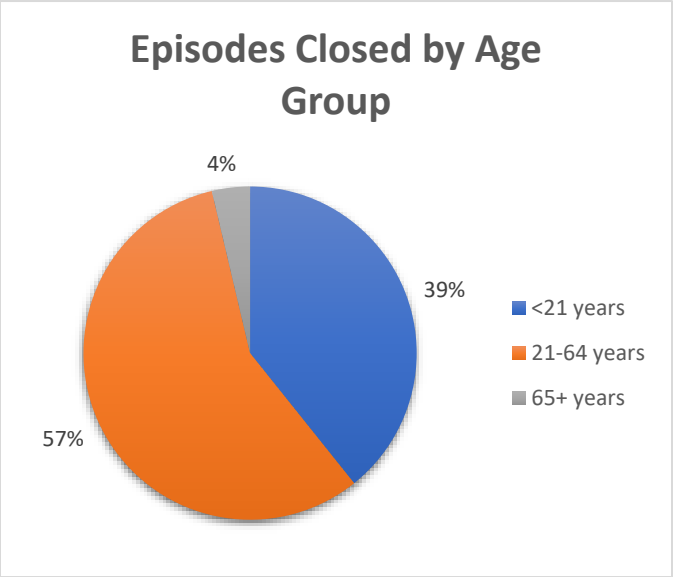
During Q4, there were 686 referrals for Member Wellness and Prevention (MWP) services which is a 25% increase in comparison to the previous quarter. During Q4 the MWP team conducted direct outreach to members listed in the tobacco registry. This led to a shift in the primary reason for services requested from Weight Management to Smoking/Tobacco Cessation. Additionally, the health education class service acceptance rate increased by 2% between Q3 to Q4 whereas the received services rate increased from 39% in Q3 to 48% in Q4.

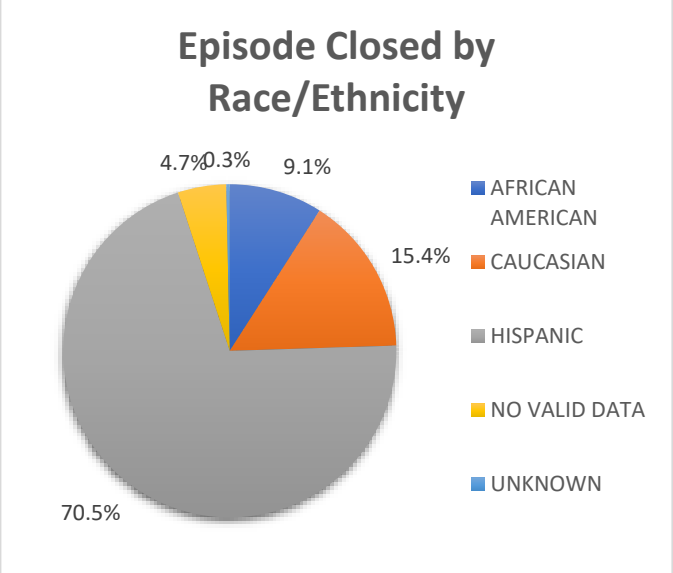


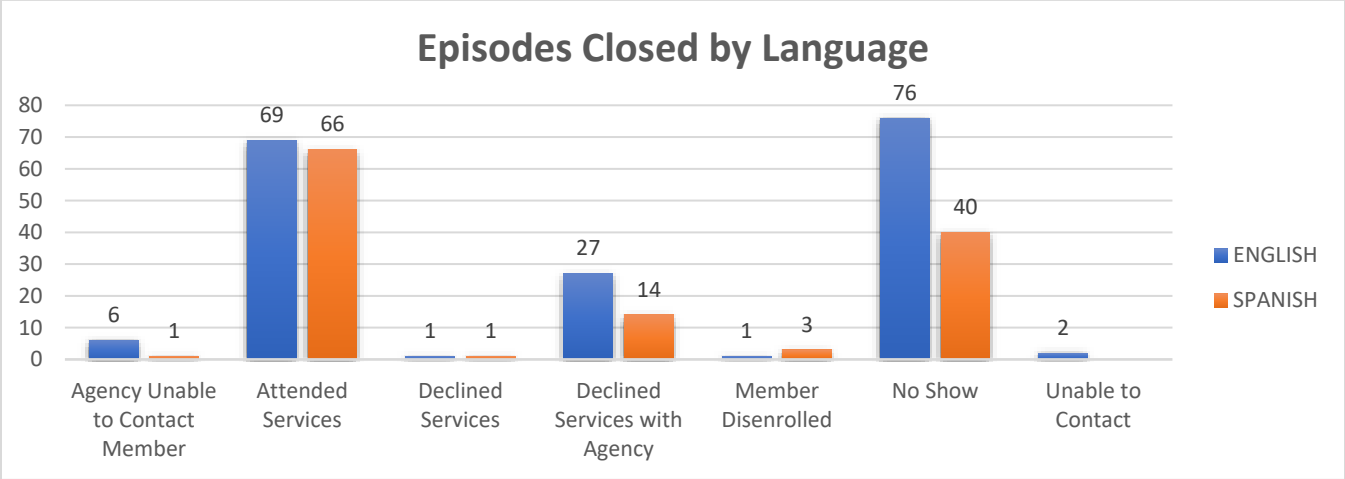
Demographics of Members

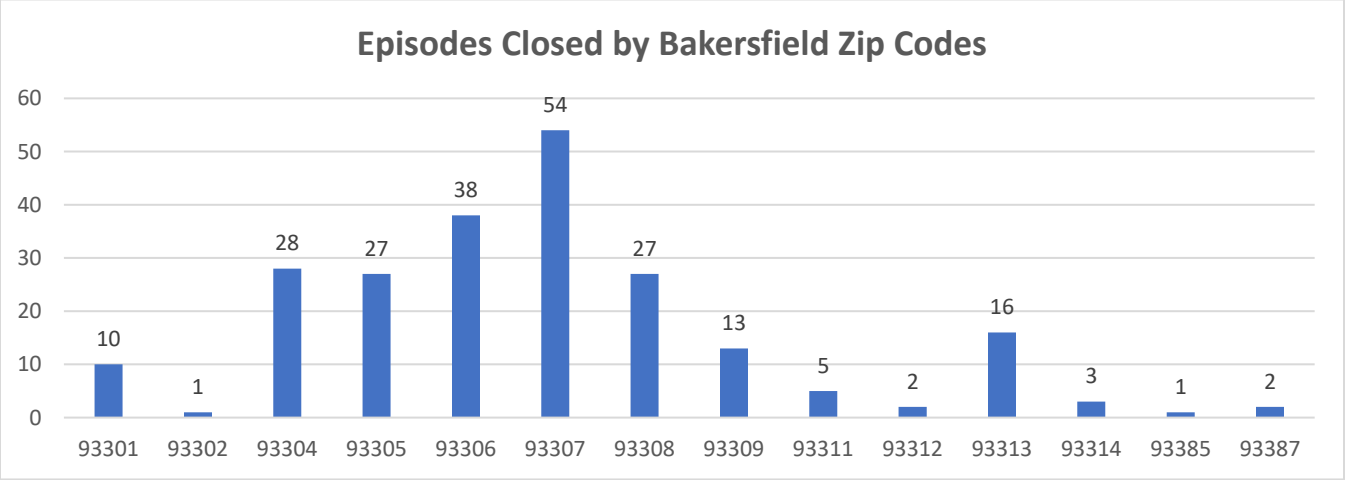
KHS provides services to a culturally and linguistically diverse member population in Kern County. Of the members who received services, the largest age groups were 21-64 years followed by <21 years. A breakdown of member classifications by race and language preferences revealed that many members who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

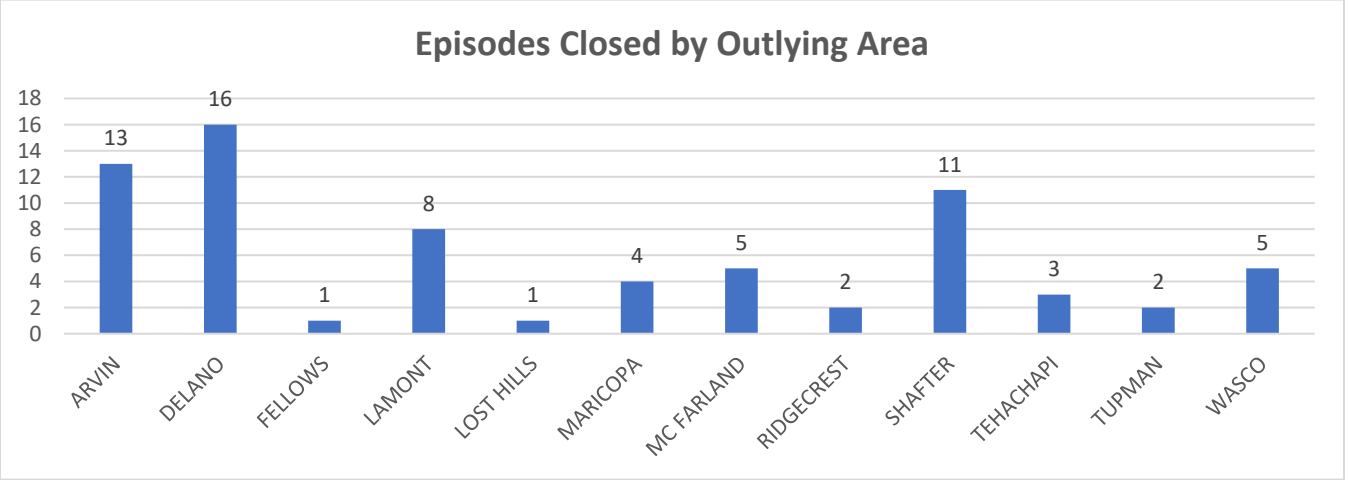
received services reside in Bakersfield with the highest concentration in the 93307 area and Delano in the outlying areas of the county.











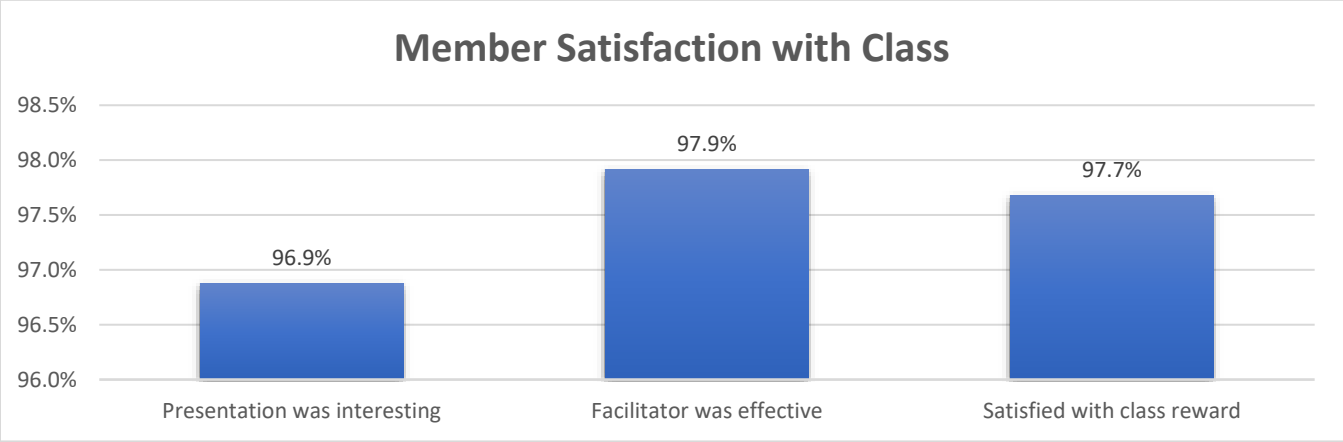
Health Education Class Service Audit

The Health Education Class Service Audit Tool considers a variety of markers to determine the quality of Health Education Class Services being provided to members. It includes observations on planning and preparation, implementation and delivery, and member engagement during health education classes. During Q4, program leads provided an overview of the results from the service audit conducted in Q3. Eight facilitators or co-facilitators attended the meeting. Facilitators reviewed the service audit summary, the class audit tool, and offered their feedback as part of process evaluation. Key terms were defined and explained by program leads.

- Class facilitators agreed to take notes of opportunities identified in summary.
- Performance goals for 2024 include a goal to maintain above 80% on facilitation metrics.
- Service audit results will be reviewed quarterly in 2024.

Health Education Class Evaluations

Health Education classes include an evaluation questionnaire for participants. The questionnaire is provided at the end of the class. Findings revealed that more than 97% of participants were satisfied with the services.

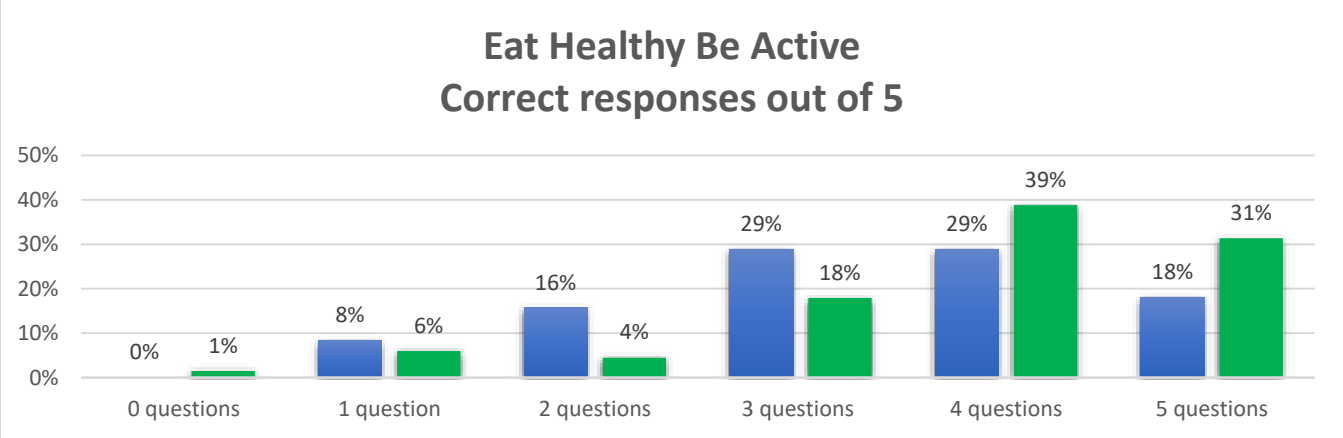


In addition, members referred to the Kick it California (KIC) Quitline were surveyed to gauge satisfaction with this service. Two participants completed the satisfaction survey, and only one had received services either by telephone. This member found the counseling sessions interesting and easy to follow, the counseling sessions were judgement-free and informative; however, the counseling sessions were not effective in helping the member quite or reduce tobacco use.

Health Education Class Effectiveness

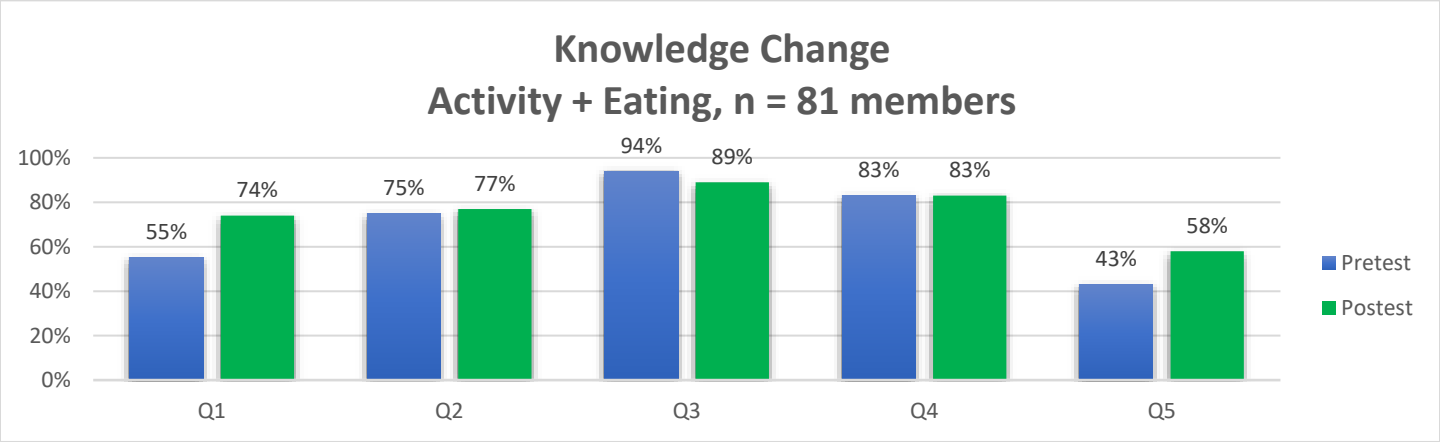
Nutrition: Eat Healthy, Be Active

The Eat Healthy, Be Active curriculum was launched in September 2023. This is a 6-class series, each class lasts about 90 minutes. A pre and posttest questionnaire is distributed per class. During Q4, findings revealed that among those members who completed the pre and posttest, there was an average 7 percentage point increase in knowledge gained after completing classes. About 47% of members respond correctly to 4 out of 5 questions at the pretest compared to 70% at posttest.



Nutrition: Activity + Eating

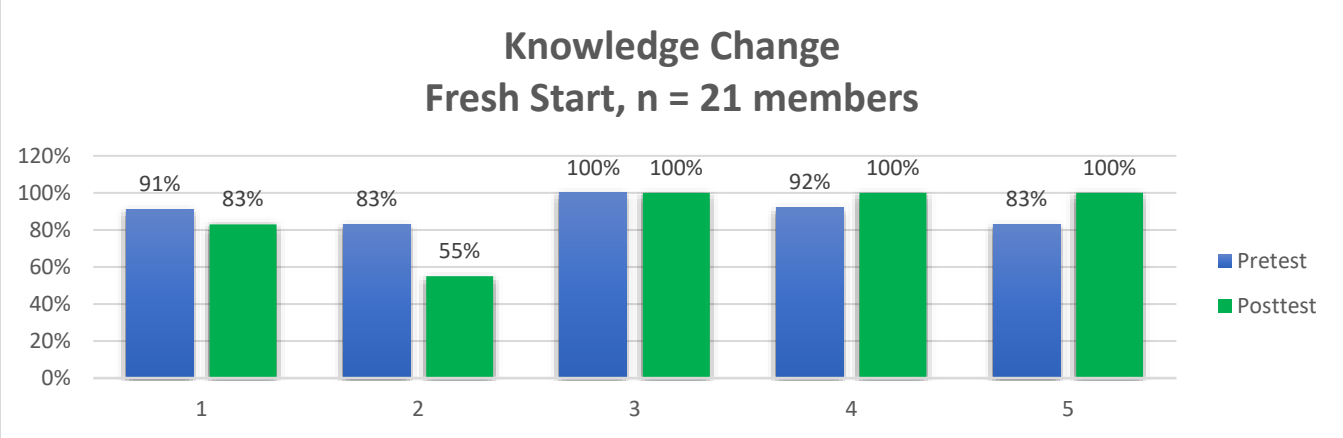
The Activity + Eating curriculum was launched in September 2023. This is a 1-time class that lasts about 90 minutes. The evidence shows that it can impact behavior around physical activity. A pre and posttest questionnaire is distributed at each class. During Q4, findings revealed a 6-percentage point increase in knowledge when comparing members who completed a pretest (average 70% correct answers) to members who completed a posttest (average 76% correct answers).



Members who participated and completed the tests seem to have the most knowledge around the physical activity guidelines and the importance of calories and physical activity to lose weight (i.e. questions 1 and 5). Areas of opportunity for Activity + Eating facilitators exist to improve awareness and knowledge on food groups, nutrients, and the benefits of physical activity.

Smoking/Tobacco Cessation: Fresh Start

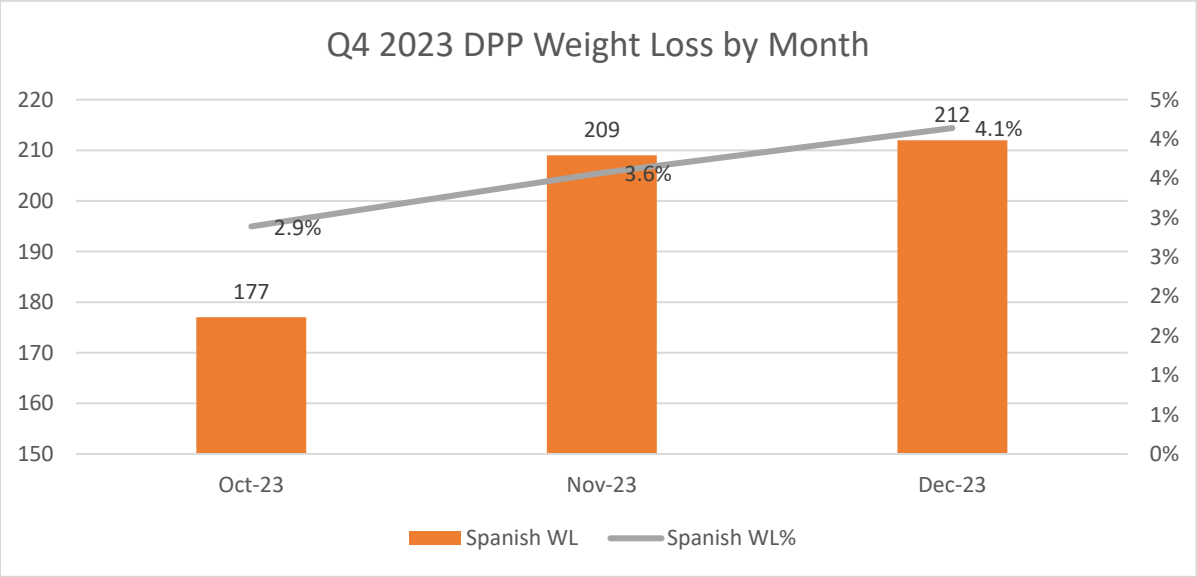
The Fresh Start classes have the goal of reducing harm from tobacco products. Knowledge tests are implemented at each series. Due to technology issues, limited pretests were implemented in Q4. In total, 33 tests were completed by 21 unique members. By the end of the series, 100% of members know that: 1) being aware of their triggers can help them plan to reduce the urge to smoke/vape; and 2) they should commit to a quit date.



Members in Fresh Start benefit from being able to return to classes each month to receive support from class facilitators and their peers. In December there were 5 returning members, who demonstrated 100% scores in pre and posttests.

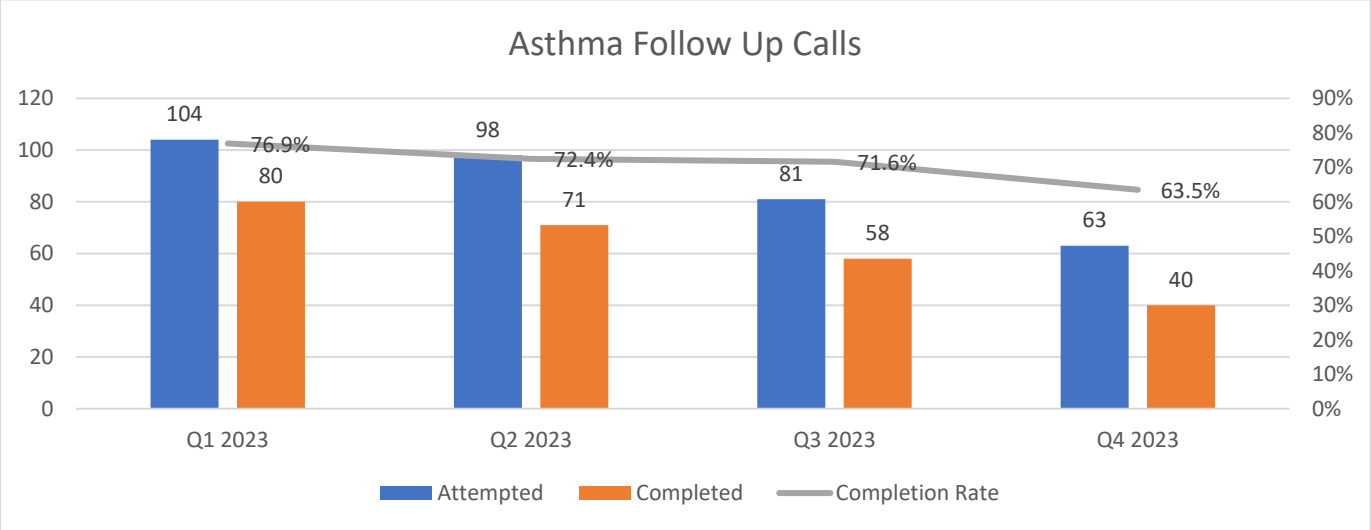
Chronic Disease Prevention and Management: Diabetes Prevention Program

The Diabetes Prevention Program (DPP) is an evidence-based lifestyle change program designed to prevent or delay the onset of type 2 diabetes among at risk members. Weight loss totals and percentages that compare initial combined cohort weight with combined weight at the end of each month in Q4 2023 are shown in the chart below. By the end of Q4 2023, 29 members were enrolled in the Spanish DPP cohort with an average weight loss of 4.1%. There was no English DPP series being offered in Q4 2023.



Chronic Disease Prevention and Management: Asthma Education Effectiveness

Members who have attended the KFHC Breathe Better Asthma Classes are offered asthma follow up calls. These calls occur at 1 month, 3 months, and 6 months after attending the classes. During the follow up call, members are screened to determine if asthma symptoms are well controlled using the Asthma Control Test (ACT) screening tool. An ACT score of 20 or higher is an indicator of well controlled asthma. During Q4 2024, 63.5% of members completed an asthma follow up call. The average ACT score improved slightly for both members under 12 years old and those 12 years and older when comparing the initial assessment to the follow ups.



Q4 2023 Average ACT Scores		
Asthma Follow Up Calls		
Call Month	<12 years of age	12+ years of age
Initial	17.3	16.3
1	21.2	16.0
3	22.4	18.1
6	21*	17.8

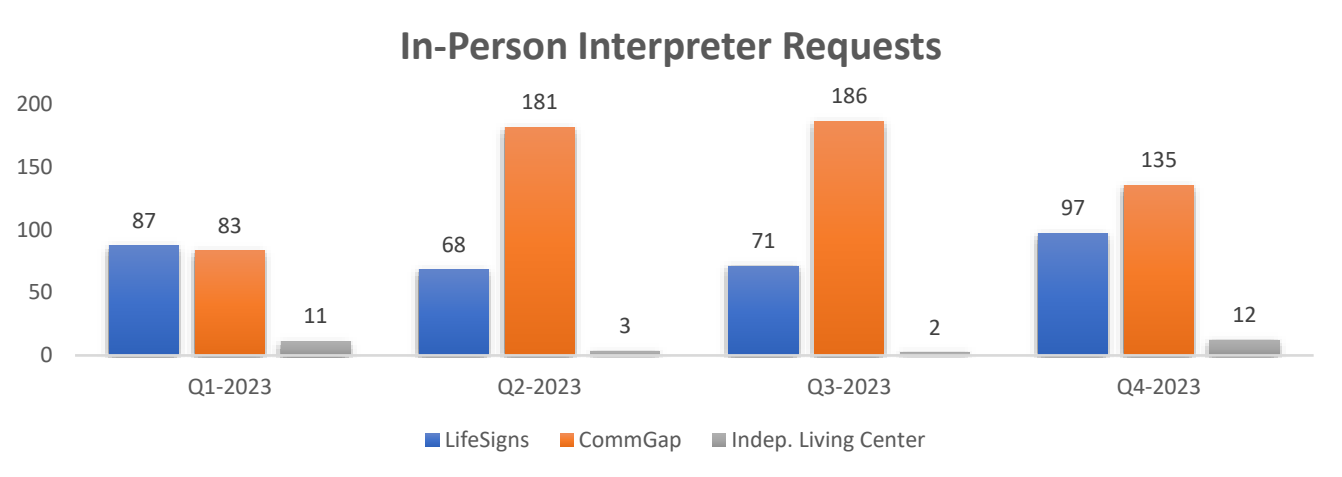
*Unreliable data due to low number of scores.

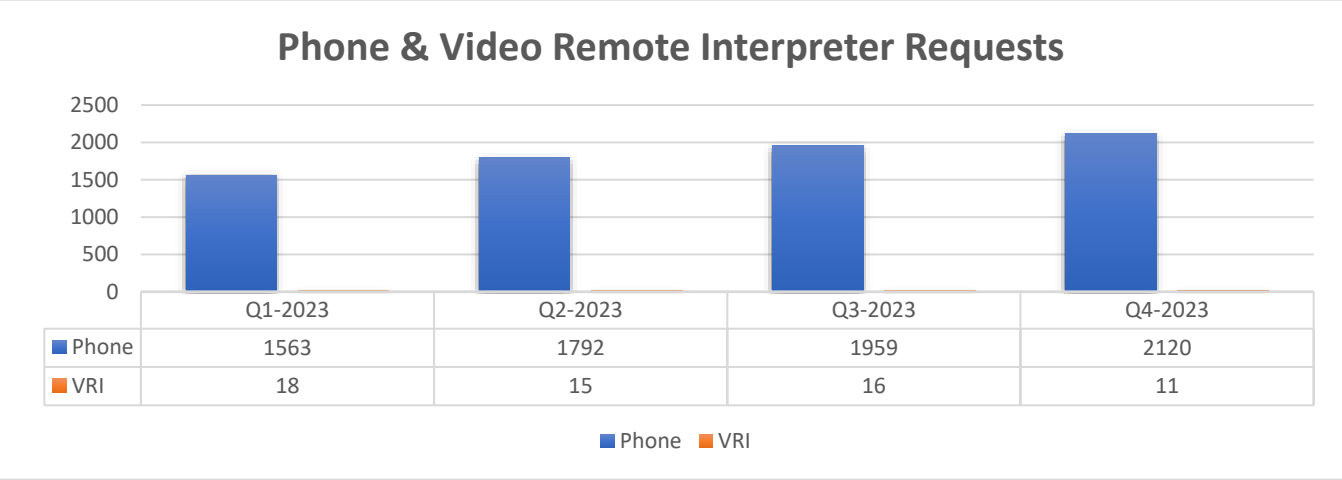
Interpreter Requests

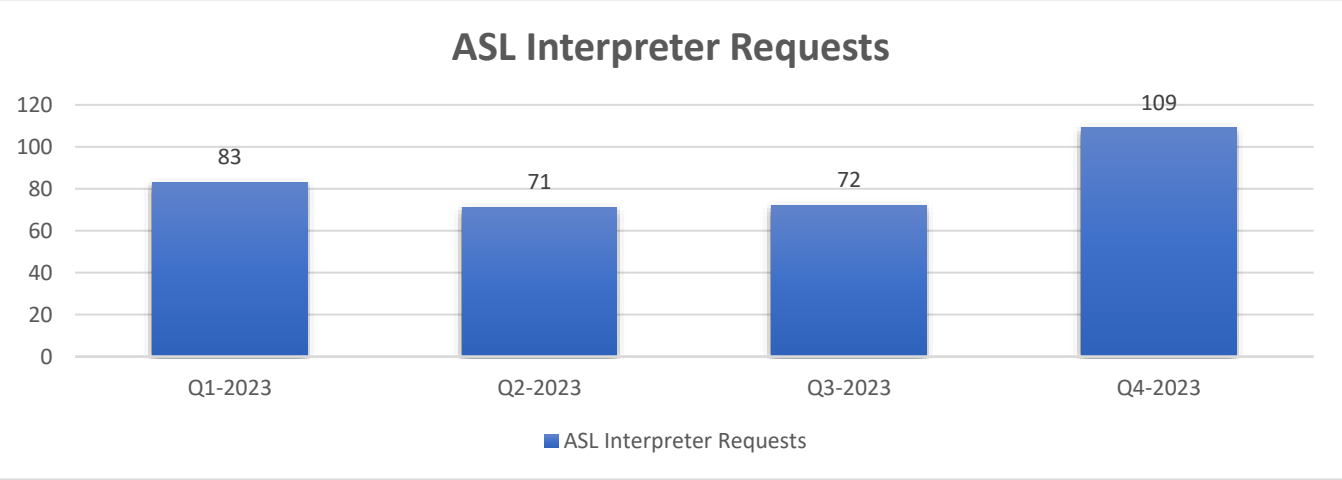
During this quarter, there were 135 requests for Face-to-Face Interpreting, 2,120 requests for Telephonic Interpreting, 11 for Video Remote Interpreting (VRI) and 109 requests for an American Sign Language (ASL) interpreter.

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

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

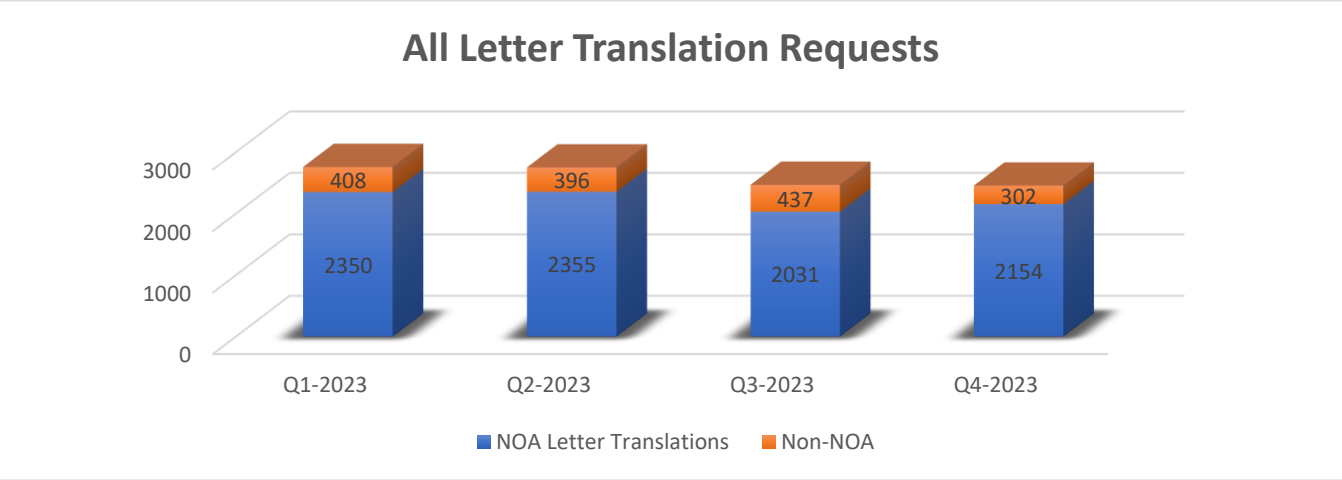






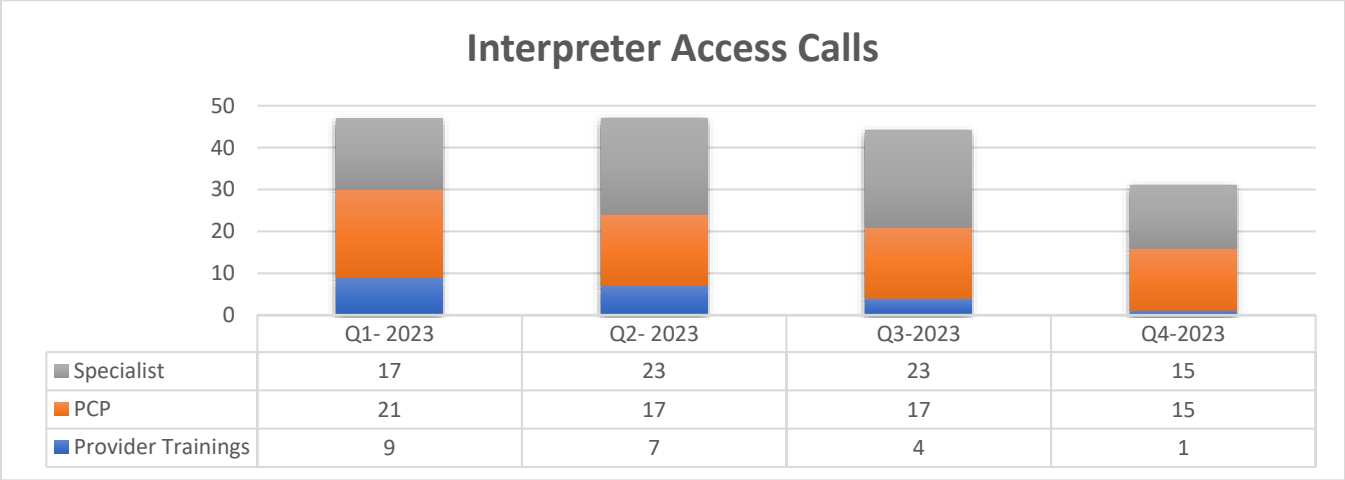
Written Translations

The HE department coordinates the translation of written documents for members. Translations are performed in-house by qualified translators or outsourced through a contracted translation vendor. During this quarter, 2,456 requests for written translations were received.



Interpreter Access Survey Calls

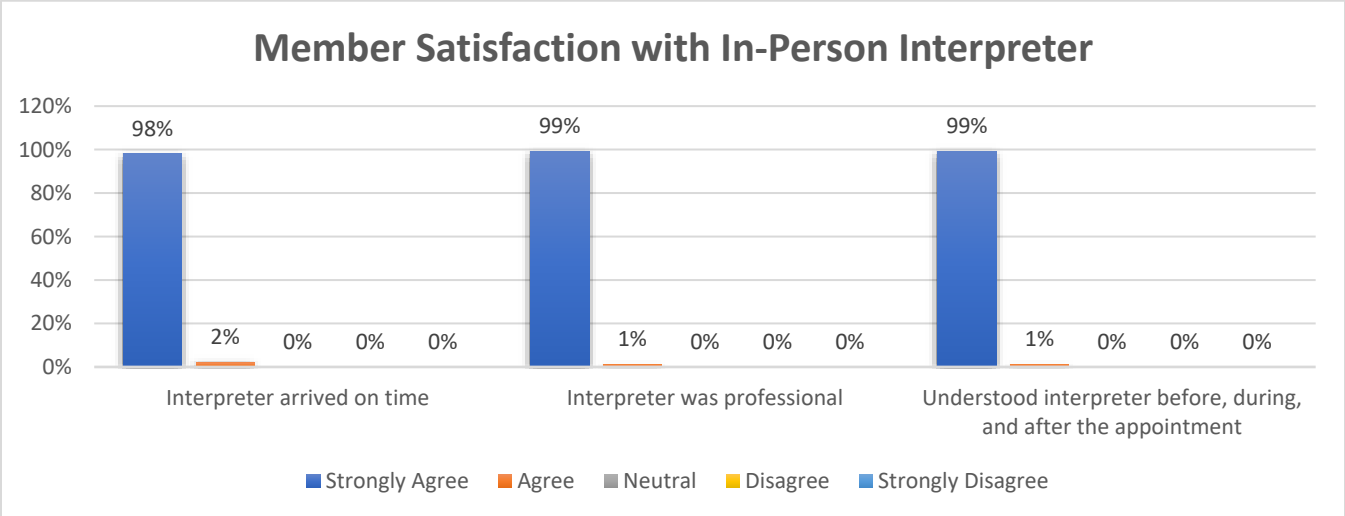
Each quarter, the Provider Network Management department conducts an interpreter access survey among KHS providers. During Q4, 15 PCPs and 15 Specialists participated in this survey. Of these providers, only 1 needed a refresher training on KHS' C&L services.



	Q1- 2023	Q2- 2023	Q3-2023	Q4-2023
Specialist	17	23	23	15
PCP	21	17	17	15
Provider Trainings	9	7	4	1

Member Satisfaction Surveys

During this quarter, a total of 30 satisfaction surveys were collected from members who received in-person interpreting services and more than 98% of members reported they "Strongly Agreed" or "Agreed" being satisfied with their interpreter.



Over-the-Phone (OPI) Interpreter Call Monitoring

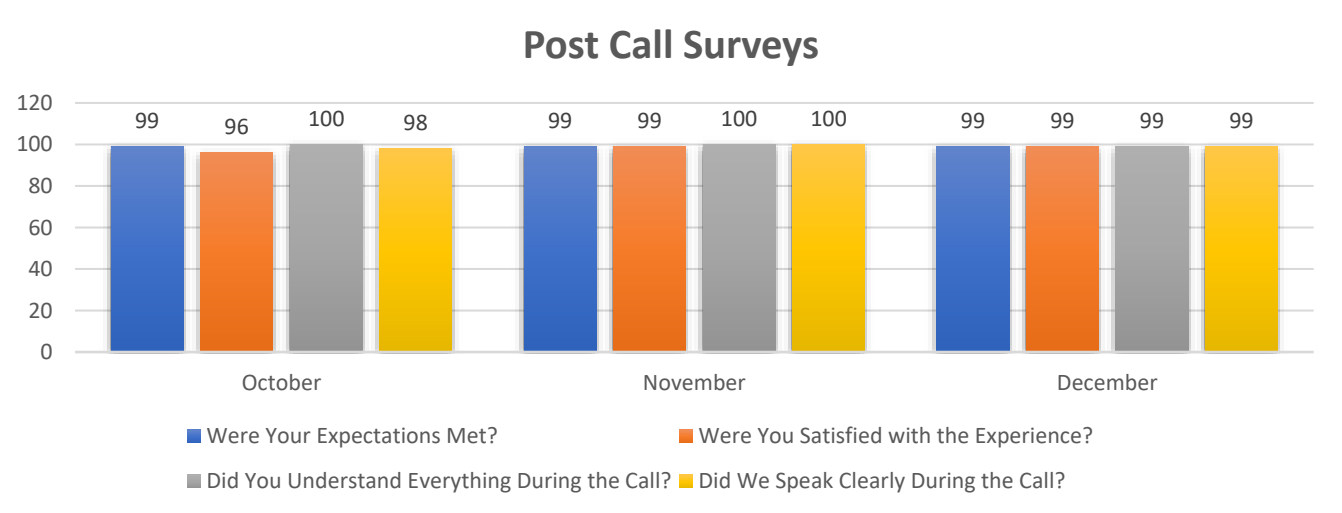
During this quarter, an audit was performed on 30 random OPI interpreter services calls. Calls audited were in Arabic, Khmer, Korean, Mandarin, Punjabi, Spanish, and Tagalog. Calls were evaluated for the interpreter's Customer Service, Interpretation Skills, and the ability to follow the Code of Ethics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

Bilingual Staff Call Audit

During this quarter, a total of 30 Spanish audio calls from KHS member facing departments were reviewed to assess the linguistic performance of the Bilingual Staff. Findings revealed that 98% of Bilingual staff did not have difficulty communicating with members in a non-English language.

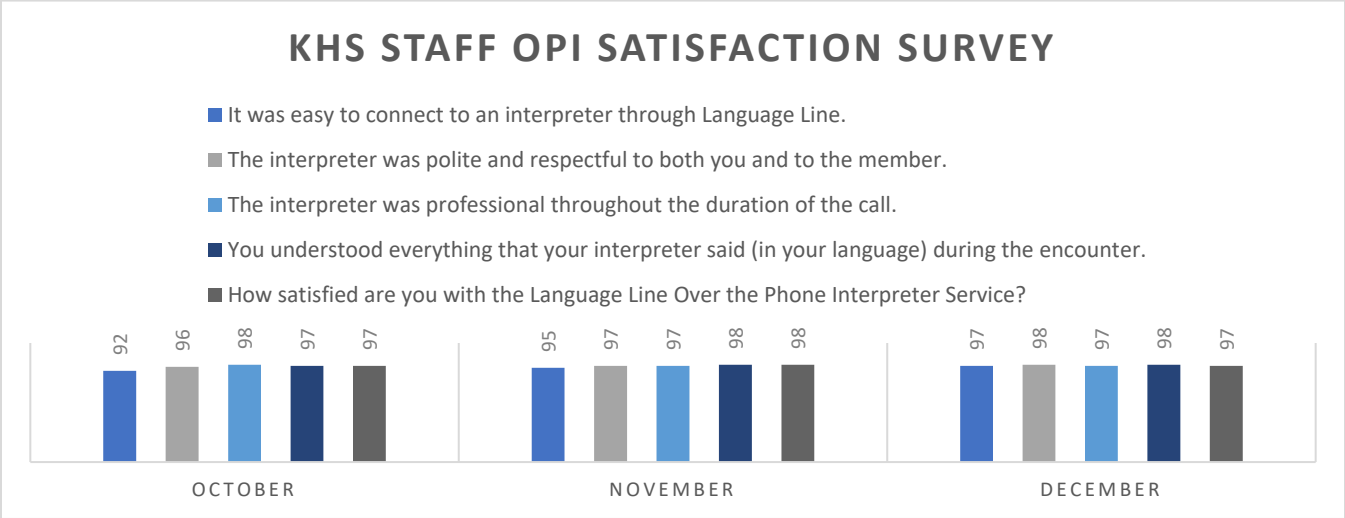
Post Call Surveys

During this quarter, a total of 4,910Spanish Post Call Surveys were collected from members for all KHS member facing departments to assess the linguistic performance of the Bilingual Staff. KHS' post call survey evaluates member's call experience by language. Findings revealed that 98% of members are satisfied with the linguistic performance of bilingual staff.



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

During this quarter, a total of 129 surveys were received from KHS member facing department staff regarding their satisfaction with our vendor Language Line Services concerning over-the-phone interpretation. Findings revealed that 97% of KHS staff are satisfied with the linguistic performance of our vendors' interpreters.



KERN HEALTH SYSTEMS

To: KHS EQIHEC Committee Meeting

From: Nate Scott

Date: February 8, 2024

Re: Executive Summary for 4th Quarter 2023 Operational Board Update - Grievance Report

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Background

Executive Summary for 4th Quarter 2023 Operational Board Update - Grievance Report: When compared to the previous four quarters, the following trends were identified related to the Grievances and Appeals received during the 4th Quarter, 2023.

- There was a slight decrease in Grievances and Appeals in Quarter 4, 2023 when compared to the previous two quarters in 2023. The Plan typically sees a decrease in the number of Grievances and Appeals in the 4th quarter of the year due to fewer business days.
- Of the 1,667 Standard Grievance and Appeal cases, 915 were closed in favor of the Plan and 626 cases closed in favor of the Enrollee. At the time of reporting, 126 cases were delayed pending a response and/or medical records from providers.

KHS Standard Grievance and Appeals per 1,000 members = 3.14 per month.

Requested Action

Receive and File

4th Quarter 2023 Operational Report

Alan Avery
Chief Operating Officer

4th Quarter 2023 Grievance Report

Category2	Q4 2023	Status	Issue	Q3	Q2	Q1 2023	Q4
Access to Care	**347**		Appointment Availability	303	233	123	108
Coverage Dispute	**0**		Authorizations and Pharmacy	0	0	0	0
Medical Necessity	**423**		Questioning denial of service	478	420	363	335
Other Issues	**39**		Miscellaneous	65	55	53	38
Potential Inappropriate Care	**522**		Questioning services provided. All PIC identified cases forwarded to Quality Dept.	644	703	758	670
Quality of Service	**296**		Questioning the professionalism, courtesy and attitude of the office staff. All cases forwarded to PR Department	326	282	216	156
Discrimination (New Category)	**40**		Alleging discrimination based on the protected characteristics	45	64	62	46
Total Formal Grievances	**1667**			1861	1757	1575	1353
Exempt	**1620**		Exempt Grievances	2026	1873	1606	1816
Total Grievances (Formal & Exempt)	**3287**			3887	3630	3181	3169

KHS Grievances per 1,000 members – 3.14/month.
LHPC Average 1.0 – 3.99/month

KERN HEALTH SYSTEMS

Additional Insights-Formal Grievance Detail

Issue	2023 4th Quarter Grievances	Upheld Plan Decision	Further Review by Quality	Overturned Ruled for Member	Still Under Review
Access to Care	**191**	**118**	**0**	**65**	**8**
Coverage Dispute	**0**	**0**	**0**	**0**	**0**
Specialist Access	**156**	**68**	**0**	**74**	**14**
Medical Necessity	**423**	**139**	**0**	**269**	**15**
Other Issues	**39**	**30**	**0**	**6**	**3**
Potential Inappropriate Care	**522**	**308**	**0**	**162**	**52**
Quality of Service	**296**	**216**	**0**	**50**	**30**
Discrimination	**40**	**36**	**0**	**0**	**4**
Total	**1667**	**915**	**0**	**626**	**126**

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS

To: KHS EQIHEC Committee Meeting

From: Nate Scott

Date: February 8, 2024

Re: Executive Summary for 4th Quarter 2023 Grievance Summary Report

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Background

Executive Summary for the 4th Quarter Grievance Summary Report:
The Grievance Summary Report supports the high-level information provided on the Operational Report and provides more detail as to the type of grievances KHS receives on behalf of our members.

Kaiser Permanente Grievances and Appeals
During the fourth quarter of 2023, there were two hundred and seventy-two grievances and appeals received by KFHC members assigned to Kaiser Permanente. Of this, one hundred twenty-four cases closed in favor of the Plan and eighty-two closed in favor of the enrollee. Sixty-six cases were still open for review at the time of reporting.

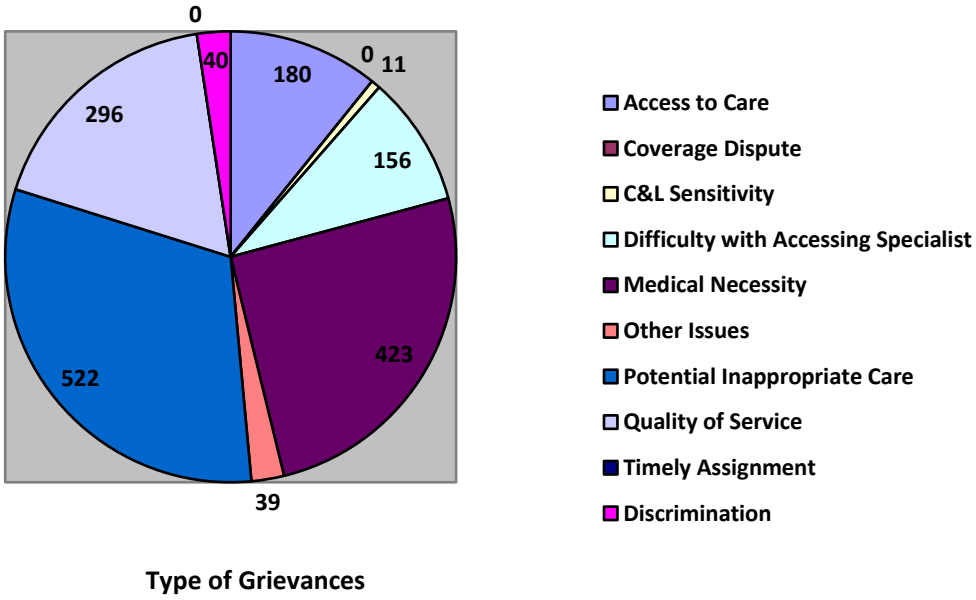
KHS Standard Grievance and Appeal cases per 1,000 members = 3.14 per month.
For KHS members assigned to Kaiser Grievances and Appeals per 1,000 = 5.6 per month.

Requested Action

Receive and File

4th Quarter 2023 Grievance Summary

Ary Issue	Number	In Favor of Health Plan	In favor of Enrollee	Still under review
Access to care	180	111	61	8
Coverage dispute	0	0	0	0
Cultural and Linguistic Sensitivity	11	7	4	0
Difficulty with accessing specialists	156	68	74	14
Medical necessity	423	139	269	15
Other issues	39	30	6	3
Potential Inappropriate care	522	308	162	52
Quality of service	296	216	50	30
Timely assignment to provider	0	0	0	0
Discrimination	40	36	0	4



KHS Grievances and Appeals per 1,000 members = 3.14/month

During the fourth quarter of 2023, there were one thousand, six hundred and sixty-seven standard grievances and appeals received. Six hundred and twenty-six cases were closed in favor of the Enrollee. Nine hundred and fifteen cases were closed in favor of the Plan. There are one hundred and twenty-six grievances that are still under review. Of the one thousand, six hundred and sixty-seven standard grievances and appeals received, one thousand five hundred fifty-nine cases closed within thirty days; one hundred and eight cases were pended and closed after thirty days.

4th Quarter 2023 Grievance Summary

Access to Care

There were one-hundred eighty grievances pertaining to access to care. One-hundred eleven closed in favor of the Plan. Sixty-one cases closed in favor of the Enrollee. There are eight cases still pending review. The following is a summary of these issues:

Seventy-six members complained about the lack of available appointments with their Primary Care Provider (PCP). Fifty-two cases closed in favor of the Plan after the responses indicated the offices provided the appropriate access to care based on the Access to Care standards. Twenty-one cases closed in favor of the Enrollee after the responses indicated the offices may not have provided appropriate access to care based on Access to Care standards. There are three cases still pending review.

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

Forty-five members complained about the telephone access availability with their Primary Care Provider (PCP). Twenty-one cases closed in favor of the Plan after the responses indicated the members were provided with the appropriate telephone access availability. Twenty-one cases closed in favor of the Enrollee after the responses indicated the members may not have been provided with the appropriate telephone access availability. There are three cases still pending review.

Forty-one members complained about a provider not submitting a referral authorization request in a timely manner. Twenty-one cases closed in favor of the Plan after it was determined the referral authorization request had been submitted in a timely manner. Eighteen cases closed in favor of the Enrollee after it was determined the referral authorization request may not have been submitted in a timely manner. There are two cases still pending review.

Coverage Dispute

There were no grievances pertaining to a Coverage Dispute issue.

Cultural and Linguistic Sensitivity

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

Difficulty with Accessing a Specialist

There were one hundred fifty-six grievances pertaining to Difficulty Accessing a Specialist. Sixty-eight cases closed in favor of the Plan. Seventy-four cases closed in favor of the Enrollee. There are fourteen cases still under review. The following is a summary of these issues:

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

Eleven members complained about the wait time to be seen for a specialist appointment. Five cases closed in favor of the Plan after the response indicated the member was provided with the appropriate wait time for a scheduled appointment based on the Access to Care Standards. Five cases closed in favor of the Enrollee after the response indicated the member may not have been provided with the appropriate wait time for a scheduled appointment based on the Access to Care Standards. There is one cases under review.

Fifty-two members complained about the telephone access availability with a specialist office. Twenty-one cases closed in favor of the Plan after the response indicated the member was provided with the appropriate telephone access availability. Twenty-five cases closed in favor of the Enrollee after the response indicated the member may not have been provided with the appropriate telephone access availability. There are six cases under review.

Twenty-four 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. Thirteen cases closed in favor of the Enrollee after it was determined the referral authorization request may not have been submitted in a timely manner. There are two cases under review.

Two members complained about physical access to providers. Two cases closed in favor of the Plan after it was determined the physical access was appropriate. There are no cases still pending review.

Medical Necessity

There were four hundred and twenty-three appeals pertaining to Medical Necessity. One hundred and thirty-nine cases were closed in favor of the Plan. Two hundred and sixty-nine cases were closed in favor of the Enrollee. There are fifteen cases under review. The following is a summary of these issues:

One hundred and thirty-nine of the cases closed in favor of the Plan as it was determined that there was no supporting documentation submitted with the referral authorization requests to support the criteria for medical necessity for the requested specialist or DME item; therefore, the denials were upheld. Of the cases that were closed in favor of the Plan, five were partially overturned. Two hundred and sixty-nine cases were closed in

favor of the Enrollee as it was determined medical necessity was met and the denials were overturned and approved. There are fifteen cases under review.

Other Issues

There were thirty-nine grievances pertaining to Other Issues that are not otherwise classified in the other categories. Thirty cases were closed in favor of the Plan after the responses indicated the appropriate services were provided. Six cases closed in favor of the Enrollee after the responses indicated the appropriate services may not have been provided. There are three cases still under review.

Potential Inappropriate Care

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

Quality of Service

There were two hundred and ninety-six grievances involving Quality of Service issues. Two hundred and sixteen cases closed in favor of the Plan after the responses determined the members received the appropriate service from their providers. Fifty cases closed in favor of the Enrollee after the responses determined the members may not have received the appropriate services. There are thirty cases still under review.

Timely Assignment to Provider

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

Discrimination

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

Kaiser Permanente Grievances and Appeals

Kaiser Grievances per 1,000 members = 5.6/month

During the fourth quarter of 2023, there were two hundred and seventy-two grievances and appeals received by KFHC members assigned to Kaiser Permanente. Eighty-two cases were closed in favor of the Enrollee. One hundred and twenty-four cases closed in favor of the Plan. Sixty-six cases are still open, pending investigation and resolution.

4th Quarter 2023 Grievance Summary

Access to Care

There were eighty-six grievances pertaining to Access to Care. Twenty-nine closed in favor of Enrollee. Thirty-five cases are closed in favor of Plan. Twenty-two cases are still under review.

Medical Necessity

There were nine appeals pertaining to Medical Necessity. One case closed in favor of Enrollee. Four cases closed in favor of Plan. Four cases are still under review.

Other Issues

There were one hundred and thirty-nine grievances pertaining to Other Issues. Forty-two cases closed in favor of Enrollee. Sixty-four cases closed in favor of Plan. Thirty-three cases are still under review.

Potential Inappropriate Care

There were eleven grievances pertaining to Quality of Care. Five cases closed in favor of Enrollee. Six cases closed in favor of Plan.

Quality of Service

There were twenty-five grievances pertaining to a Quality of Service. Five cases closed in favor of Enrollee. Thirteen cases closed in favor of Plan. Seven cases are still under review.

Discrimination

There were two grievances pertaining to Discrimination. Two cases closed in favor of Plan.

To: EQIHEC

From: Magdee Hugais, Director of Quality Improvement

Date: 02/08/24

Re: Quality Improvement Program Documents

Background

The Medi-Cal Managed Care Plan Quality Improvement (QI) Program is defined by three documents:

- The Quality Improvement Program Description,
- The Quality Improvement Program Evaluation, and
- The Quality Improvement Program Workplan

These documents are updated annually and presented to the Executive Quality Improvement Health Equity Committee, and the Board of Directors for review, input, and approval. All program documents were presented and approved in the 1st Quarter 2024 Executive Quality Improvement Health Equity Committee.

Discussion

2023 QI Program Evaluation

The QI Program evaluation presents a summary of the outcomes for the 2023 QI program. It includes outcomes for the workplan along with outcomes for special projects or initiatives. This evaluation plays a key role in the development of the next year's QI Program Description leveraging successes and lessons learned.

2024 QI Program Description

This document provides a comprehensive description of KHS' Quality Improvement Program including governance and key activities of the program. It incorporates new strategies and activities based on results from the previous year's program evaluation as well as new regulatory requirements.

2024 QI Program Work Plan

The QI Program Workplan identifies the primary activities that will occur throughout the current year. Some of them are required from a regulatory standpoint and some are strategic initiatives aimed at improving specific aspects of the QI program such as our Managed Care Accountability Set (MCAS) performance. The activities may be ongoing, recurring, or special projects or improvement plans.

The workplan is a dynamic document that is updated throughout the year based on outcomes realized and priority shifts. Outcomes of the workplan are key to development of the annual program evaluation.

Requested Action

Review and approve the 2023 QI Program Evaluation, 2024 QI Program Description, and 2024 QI Workplan.

Quality Improvement Program, 2024

KERN HEALTH SYSTEMS

Agenda

- 2023 Quality Improvement Program Evaluation
- 2024 Quality Improvement Program Description
- 2024 Quality Improvement Workplan
- Program Direction for 2024

KERN HEALTH SYSTEMS

Quality Improvement 2023 Program Evaluation – Key Actions Completed

MCAS

- Completed analysis of MCAS non-compliance and followed through on strategic action plan for 2023
- Completed 3 Member Engagement & Rewards Campaign
- Added additional sources of data to measure MCAS compliance for greater accuracy with compliance rates
- Implemented team of temporary staff for direct member outreach to set appointments & assist with travel for MCAS gap closure
- Conducted quarterly quality meetings with network providers for MCAS compliance collaboration
- Hosted a Provider education program on the management of Hypertension

NCQA Accreditation

- Achieved 67% of points overall for Health Plan Accreditation, and 22% for Health Equity Accreditation.

Grievances and Potential Quality of Care Issues

- Introduced increased clinical review of grievances to ensure identification of quality of care issue

KERN HEALTH SYSTEMS

Quality Improvement - 2024 Program Description

Overview

- Defines QI Program goals, objectives & functions
- Defines reporting structure and accountability
- Identifies Personnel roles and responsibilities
- Defines program scope & integration throughout organization
- Identifies 2024 QI Plan and Program activities
- Defines QI Process and strategies
- Outlines Provider involvement in meeting QI Program goals and objectives

QI Program Direction for 2024 - Key Strategies

- Continue strategic action plan for MCAS with year-round direct member outreach to support members
- Complete readiness review & action plan for National Committee for Quality Assurance (NCQA) - Health Plan & Health Equity Accreditation to close 44 gaps and increase the percentage of overall points considered passing to 99%
- Align Health Equity Program with the Quality Improvement Program
- Re-structure Quality Improvement-Utilization Management Committee to align with DHCS Comprehensive Quality Strategy Plan – Executive Quality Improvement Health Equity Committee
- Expand KHS use and availability of mobile providers including street medicine teams for preventive health services
- Develop and implement Clinical Network Oversight Team to ensure Providers are following evidence-based practices & guidelines

KERN HEALTH SYSTEMS

Quality Improvement 2024 Workplan

1. Meets NCQA Standards

2. Identifies program's primary activities throughout current year

- Example: MCAS quality measures monitoring, access to care monitoring, grievance investigation involving quality of care.

3. Outlines: QI Work Activity, Special Projects and Performance Improvement Plans

4. Provides feedback for the 2023 QI Program Evaluation Results

- Identifies areas for improvement
- Validates and reinforces initiatives leading to favorable outcomes

5. Continuity and coordination between medical care and Behavioral Health

KERN HEALTH SYSTEMS

Quality Improvement Requested Action

Approve:

- 2023 QI Program Evaluation
- 2024 QI Program Description
- 2024 QI Program Workplan

KERN HEALTH SYSTEMS

Thank You

For questions, please contact:

John Miller, M.D. – Quality Medical Director

Magdee Hugais – Director, Quality Improvement

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS
Quality Improvement Program Description
2024

Mission, Purpose, Goals and Objectives

I. Mission

In a commitment to the community of Kern County and the members of Kern Health Systems (KHS), the Quality Improvement (QI) Program is designed to objectively monitor, systematically evaluate, and effectively improve the health and care of those being served. The KHS Quality Improvement Department manages the Program and oversees activities undertaken by KHS to achieve improved health of the covered population. All contracting providers of KHS participate in the Quality Improvement (QI) program.

II. Purpose

The KHS Quality Improvement Program Description is a written description of the overall scope and responsibilities of the QI Program. The QI Program actively monitors, evaluates, and takes effective action to address any needed improvements in the quality, appropriateness, safety, and outcomes of covered health care services delivered by all contracting providers rendering services to members.

KHS recognizes that a strong QI Program must be the foundation for a successful Managed Care Plan (MCP). In the basic program design and structure, KHS QI systems and processes have been developed and implemented to improve, monitor, and evaluate the quality and safety of care and service provided by contracting providers for all aspects of health care delivery consistent with standards and laws.

The KHS Quality Improvement Program is composed of several systematic processes that monitor and evaluate the quality of clinical care and health care service delivery to KHS members. This structure is designed to:

- Monitor and identify opportunities to monitor, evaluate, and take action to address needed improvements in the quality of care delivered by all KHS network providers rendering services to KHS members.
- Maintain a process and structure for quality improvement with contracting providers that includes identification of quality-of-care problems and a corrective action process for resolution for all provider entities.
- Promote efficient use of health plan financial resources.
- Identify health disparities and take action to support health equity.
- Oversee and direct processes affecting the quality of covered health care services delivered to members, either directly or indirectly.
- Monitor and improve the quality and safety of clinical care for covered services for KHS members.
- Ensure members have access to covered health care in accordance with federal and state regulations, and our contractual obligations with the California Department of Health Care Services (DHCS).

This is accomplished through the development and maintenance of an interactive health care

system that includes the following elements:

1. Development and implementation of a structure for monitoring, evaluating, and taking effective action to address any needed improvements in the quality of care delivered by all KHS network providers rendering services to KHS members.
2. A process and structure for quality improvement with contracting providers. This includes identification of quality-of-care problems and a corrective action process for resolution for all provider entities.
3. Oversight and direction of processes affecting the quality of covered health care services delivered to members, either directly or indirectly.
4. Assurance that members have access to covered health care in accordance with federal and state regulations, and our contractual obligations with the California Department of Health Care Services (DHCS).
5. Monitoring and improvement of the quality and safety of clinical care for covered services for members.

III. Goals and Objectives:

KHS has developed and implemented a plan of activities to encompass a progressive health care delivery system working in cooperation with contracting providers, members, community partners and regulatory agencies. An evaluation of program objectives and progress is performed by the QI Department on an annual basis with modifications as directed by the KHS Board of Directors. The results of the evaluation are considered in the subsequent year's program description. Specific objectives of the QI Program include:

1. Improving the health status of members by identifying potential areas for improvement in the health care delivery system.
2. Developing, distributing, and promoting guidelines for care including preventive health care and disease management through education of members and contracting providers.
3. Developing and promoting health care practice guidelines through maintenance of standards of practice, credentialing, and recredentialing. This applies to services rendered by medical, behavioral health and pharmacy providers.
4. Establishing and promoting open communication between KHS and contracting providers in matters of quality improvement. This includes maintaining communication avenues between KHS, members, and contracting providers to seek solutions to problems that will lead to improved health care delivery systems.
5. Monitoring and oversight of delegated activities.
6. Performing tracking and trending on a wide variety of information including:
    - Over and underutilization data
    - Grievances
    - Potential and actual quality of care issues
    - Accessibility of health care services
    - Compliance with Managed Care Accountability Set (MCAS) preventive health and chronic condition management services
    - Pharmacy services
    - Primary Care Provider facility site and medical record reviews to identify patterns that may indicate the need for quality improvement and that ensure compliance with

State and Federal requirements

7. Promoting awareness and commitment in the health care community toward quality improvement in health care, safety, and service.
8. Continuously identifying opportunities for improvement in care processes, organizations or structures that can improve safety and delivery of health care to members.
9. Providing appropriate evaluation of professional services and medical decision making and to identify opportunities for professional performance improvement.
10. Reviewing concerns regarding quality-of-care issues for members that are identified from grievances, the Public Policy/Community Advisory Committee (PP/CAC), or any other internal, provider, or other community resource.
11. Identifying and meeting external federal and state regulatory requirements for licensure.
12. Continuously monitoring internal processes to improve and enhance services to members and contracting providers.
13. Performing an annual assessment and evaluation of the effectiveness of the QI Program and its activities to determine
    a. How well resources have been deployed in the previous year to improve the quality and safety of clinical care
    b. The quality of service provided to members
    c. Modifications needed to the QI Program
    d. Results of the annual evaluation are presented to the EQIHEC and Board of Directors

Kern Health Care System - Overview

I. Background

Kern Health Systems (KHS), d.b.a. Kern Family Health Care (KFHC), is the Local Initiative managing the medical and mild to moderate behavioral health care for Medi-Cal enrollees in Kern County. Specialty mental health care and substance use disorder benefits are carved out from the KHS Medi-Cal plan and covered by Kern County Behavioral Health and Recovery Services pursuant to a contract between the County and the State. The Kern County Board of Supervisors established KHS in 1993. The Board of Supervisors appoints a Board of Directors, who serve as the governing body for KHS.

KHS recognizes that a strong QI Program must be the foundation for a successful Managed Care Plan (MCP). In the basic program design and structure, KHS QI systems and processes have been developed and implemented to improve, monitor, and evaluate the quality and safety of care and service provided by contracting providers for all aspects of health care delivery consistent with standards and laws.

KHS total membership in 2024 is over 405,000 members with 59% assigned to the County Hospital system and two large Federally Qualified Health Centers (FQHC).

The KHS Quality Improvement Program Description is a written description of the overall scope and responsibilities of the QI Program. The QI Program actively monitors, evaluates, and takes effective action to address any needed improvements in the quality, appropriateness, safety, and outcomes of covered health care services delivered by all contracting providers rendering services to members.

Characteristics of the KHS population include:

- 46% are male and 54% are female.
- 70% of the population have English as their primary language and 29% use Spanish. The remaining 1% is a mix of other languages.
- As of 2021, Kern County ranked 51st out of 58 for residents with a high school diploma or higher and 47th out of 58 with a Bachelor's degree or higher.
- A majority of members reside in Bakersfield. However, the remaining 33.1% are in more rural areas.

Area	Rural Portions per HRSA	KHS Population	Percentage
Bakersfield	No	264,377	65.27%
Delano & North Kern	Yes	34,141	8.43%
Arvin/Lamont	Yes	26,008	6.42%
Shafter/Wasco	Yes	24,597	6.10%
California City & Southeast Kern	Yes	14,187	3.50%
Taft & Southwest Kern	Yes	10,528	2.60%
Tehachapi	Yes	6,967	1.72%
Ridgecrest & Northeast Kern	Yes	9,879	2.44%
Lake Isabella & Kern River Valley	Yes	5,385	1.33%
Lost Hills & Northwest Kern	Yes	2,771	0.68%
Frazier Park & South Kern	Yes	1,941	0.48%
Outside Service Area	N/A	4,274	1.06%

- The following is a breakdown by race and ethnicity of the KHS population:

Ethnic or Racial Group	% KHS Enrollment
Hispanic	63%
Caucasian	17%
No valid data, unknown or other	11%
Black/African American	6%
Asian Indian	1%
Filipino	1%
Asian/Pacific	1%

Kern County's service area has been challenged with provider shortages. Large portions of the county are designated as Health Professional Shortage Areas (HPSA) and Medical Underserved Areas/Populations (MUA/P). These issues are more severe and prevalent in Kern County than other counties within California. The following 4 rural areas are in this classification.

- Taft
- Lost Hills/Wasco
- Fort Tejon
- Lake Isabella

Additional facts about Kern County's Health Behaviors as presented by County Health Rankings &

Roadmaps include higher rates of adult smoking, adult obesity, physical inactivity, alcohol-impaired driving deaths, sexually transmitted infections, and teen births compared to state-wide statistics. Kern County ranked better than California state averages for the food environment index (combination of % of low income and low access to a grocery store), and excessive drinking.

II. Scope:

The KHS QI Program applies to all programs, services, facilities, and individuals that have direct or indirect influence over the delivery of health care to KHS members. This may range from choice of contracted provider to the provision and a commitment to activities that improve clinical quality of care (including behavioral health), promotion of safe clinical practices and enhancement of services to members throughout the organization.

In 2023, KHS developed a Health Equity Program that will integrate and coordinate with the QI Program. The Health Equity Program includes assessment of needs based on race/ethnicity, language, cultural preferences, health disparities and stakeholder engagement. Understanding health disparities is critical to identify the differences in treatment provided to members of different racial/ethnic or cultural groups that are not justified by the underlying health conditions or treatment preferences of patients. KHS will implement multiple programs to monitor, assess and improve healthcare services to reduce health disparities within its membership.

Health Factors			
Health Behaviors	Kern (KE) County	California	United States
Adult Smoking	15%	10%	16%
Adult Obesity	36%	26%	32%
Food Environment Index	7.4	8.9	7.8
Physical Inactivity	33%	22%	26%
Access to Exercise Opportunities	82%	93%	80%
Excessive Drinking	16%	19%	20%
Alcohol-Impaired Driving Deaths	32%	28%	27%
Sexually Transmitted Infections	763.8	599.1	551.0
Teen Births	32	16	19

The scope of the QI Program includes the following elements:

1. The QI Program is designed to monitor, oversee, and implement improvements that influence the delivery, outcome, and safety of the health care of members, whether direct or indirect.
   a. KHS will not unlawfully discriminate against members based on race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status or disability.
   b. KHS will arrange covered services in a culturally and linguistically appropriate manner. The QI Program reflects the population served and applies equally to covered medical and behavioral health services.

2. The QI Program monitors the quality and safety of covered health care administered to members through contracting providers. This includes all contracting physicians, hospitals, vision care providers, behavioral health care practitioners, pharmacists and other applicable personnel providing health care to members in inpatient, ambulatory, and home care settings. New this year is the addition of street medicine providers. Street medicine provider refers to a licensed medical provider who conducts patient visits outside of clinics or hospitals and directly on the street, in environments where unsheltered individuals may be living.

3. The QI Program assessment activities encompass all diagnostic and therapeutic activities, and outcomes affecting members, including primary care and specialty practitioners, vision providers, behavioral health care providers, pharmaceutical services, preventive services, prenatal care, and family planning services in all applicable care settings, including emergency, inpatient, outpatient, and home health.

4. The QI Program evaluates quality of service, including the availability of practitioners, accessibility of services, coordination, and continuity of care. Member input is obtained through member participation on the Public Policy/Community Advisory Committee (PP/CAC), grievances, and member satisfaction surveys.

5. The QI Program activities are integrated internally across appropriate KHS departments. This occurs through multi-departmental representation on the EQIHEC Committee.

6. Mental health care is covered jointly by KHS and Kern County Department of Health. It is arranged and covered, in part, by Kern County Behavioral Health and Recovery Services (KBHRS) pursuant to a contract between the County and the State.

Application of the Quality Improvement Program occurs with all procedures, care, services, facilities, and individuals with direct or indirect influence over the delivery of health care to members.

Quality Improvement Integration: the QI Program includes quality improvement, quality performance, utilization management, risk management, credentialing, member's rights and responsibilities, and preventive health & health education.

As part of KHS' commitment to ensure the rights of our members to quality health care, the following six (6) Rights to Quality Health Care have been adopted:

1. Right to Needed Care
    - Accurately diagnosed and treated.
    - Care is coordinated across all the doctors and specialists.

2. Right to Equitable Care
    - All people, regardless of their gender, race, ethnicity, geographical location, or socioeconomic status receive the good quality health care they need.
    - Developing culturally competent care; for example, by expanding medical

translation services, after-hours appointments, mobile health clinics or telehealth, etc.

3. Right to Place of Care
    - Did the patient go to the right place for care?
    - Is the patient going to the ER or Urgent Care for primary care?
    - Is the patient transitioned to the right place for care?

4. Right to Timely Care
    - Timely access to care.
    - How long did the patient have to wait to get health care appointments and telephone advice?
    - Is the patient up-to-date with their preventative care?

5. Right to Be Part of Your Care
    - Patients and their families are part of the care team and play a role in decisions.
    - Information is shared fully and in a timely manner so that patients and their family members can make informed decisions.

6. Right to Safe Care
    - Conduct continuous quality assurance and improvement.
    - Customer and provider satisfaction surveys or interviews.
    - Chart audits.
    - Site reviews.
    - Administration of medications.

Executive QI Health Equity Committee Structure and Responsibilities

I. Board of Directors (BOD)

The Kern Health System (KHS) Board of Directors (Board) has final authority and accountability for the KHS Quality Improvement Health Equity Program (QIHEP). The Board has delegated the responsibility for development and implementation of the QIHEP to the Executive Quality Improvement Health Equity
Committee (EQIHEC). The EQIHEC is chaired by the KHS's Chief Medical Officer (CMO) and Co-Chaired by the KHS Health Equity Officer. KHS' Chief Medical Officer (CMO) is a physician, Board Certified in his or her primary care specialty, holding a current valid, unrestricted California Physician and Surgeon License. The CMO is an ex-officio member of the BOD and reports to the Chief Executive Officer (CEO). The CMO is the senior healthcare clinician and has the ultimate responsibility for the QIHE Program and assigns authority for aspects of the program to the Chief Equity Officer and Quality Medical Director.

II. Executive Quality Improvement Health Equity Committee (EQIHEC)

The EQIHEC provides overall direction for the continuous improvement process and monitors

that activities are consistent with KHS's strategic goals and priorities. The EQIHEC addresses equity, quality, and safety, of clinical care and service, program scope, yearly objectives, planned activities, timeframe for each activity, responsible staff, monitoring previously identified issues from prior years, and conducts an annual evaluation of the overall effectiveness of the Quality Improvement Health Equity Program (QIHEP) and its progress toward influencing network-wide safe clinical practices. The QIHEP utilizes a population management approach to members, providers, and the community, and collaborates with Local, State, and Federal Public Health Agencies and Programs.

The EQIHEC consists of actively participating clinical and non-clinical providers. The physicians are voting members for clinical decision making. The EQIHEC is comprised of internal and community participants. This process promotes an interdisciplinary and inter-departmental and community approach and drives actions when opportunities for improvement are identified.

The QIHEC members consist of:

Community Attendees:

- Two (2) Participating Primary Care Physicians
- Two (2) Participating Specialty Physicians
- One (1) Federally Qualified Health Center (FQHC) Provider
- Two (2) CAC members
- One (1) Member of Board of Directors consumer
- One (1) Community consumer
- One (1) Pharmacy Provider
- One (1) Kern County Public Health Officer or Representative
- One (1) Home Health/Hospice Provider
- One (1) DME Provider
- One (1) Behavioral Health Provider

Internal KHS

Attendees:

Chief Medical
Officer
Health Equity Officer
Chief Operating Officer
Quality Improvement Medical Director
Director Quality Improvement
Director Quality Performance
Director Utilization Management
Director Population Health Management
Director Behavioral Health
Director of Pharmacy
Health Education & C&L
Director Health Equity
Manager
Provider Relations Director

The EQIHEC Committee is required to meet at least four (4) times annually and more frequently as determined. The activities of the EQIHEC and subcommittees providing information to the EQIHEC are formally documented in transcribed minutes, which summarize each agenda item, the discussion, action taken, and required follow-up. Key activities of the EQIHEC are the review and approval of the QIHE Program and Work-Plan, and QIHE quarterly and annual evaluations. The EQIHEC's findings and recommendations are reported quarterly by the CMO to the BOD.

The EQIHEC monitors and evaluates equity, quality, safety, appropriateness and outcomes of care and services to KHS members.

Activities:

1. Formulates organization-wide improvement activities with QIHE subcommittee support.
2. Identifies appropriate performance measures, standards, and opportunities for performance improvement.
3. Assures QIHE Program activities are compliant with the requirements of accrediting and regulatory agencies, including but not limited to, DHCS, DMHC, CMS, and NCQA.
4. Identifies actions to improve quality and prioritize based on analysis and significance; and indicate how the Committee determines these actions to ensure satisfactory outcomes.
5. Works closely with the IT Department for collection of data strategy and analytics to effectively analyze data related to the goals and objectives and establish performance goals to monitor improvement.
6. Ensures all departments can align project goals and map out responsibilities and deadlines prior to project implementation.
7. Ensures outcomes undergo quantitative and qualitative analyses that incorporate aggregated results over time and compare results against goals and benchmarks.
8. Reviews the analysis and evaluation of QIHE activities of subcommittees and identifies needed actions and ensures follow up as appropriate.
9. Ensures that root cause analyses and barrier analyses are conducted for identified underperformance with appropriate targeted interventions.
10. Reviews and modifies the QIHE program description, annual QI Work Plan, quarterly work plan reports and annual evaluation of the QIHE program as necessary to maintain goals and priorities.
11. Communicates the quality health equity improvement process to practitioners/providers and members through appropriate persons and venues.
12. Ensures that the information available to the Plan regarding accessibility, availability and continuity of care is reviewed and evaluated, including but not limited to information obtained through enrollee and provider surveys, enrollee grievances and appeals, and triage or screening services.
13. Ensures the annual HEDIS, CAHPS and Health Outcomes Survey (HOS) submissions are delivered according to technical specifications and deadlines.
14. Support and assist practitioners and providers to improve safety within their practices.
15. Design and implement strategies to improve compliance.
16. Develop objective criteria and processes to evaluate and continually monitor performance and adherence to the clinical and preventive health guidelines.
17. Meets healthcare industry standards of practice.

18. Improves quality, safety, and equity of care and service to members.
19. Conducts facility site and medical record reviews to ensure and support safe and effective provision of equitable clinical service.
20. Reviews, evaluates, and makes recommendations regarding oversight of delegated activities, such as audit findings, trending, and reports.

III. Quality Improvement Sub-Committees

There are multiple KHS sub-committees in place to support the QIHEC and QIHEP objectives and goals. The activities of the quality subcommittees are formally documented in transcribed minutes, which summarize each agenda item, the discussion, action taken, and follow-up required. This information is reported at a minimum quarterly to the QIHEC in the format of formal reports.

IV. Utilization Management Committee (UMC)

The Utilization Management Committee (UMC) is a subcommittee of the EQIHEC and focuses on the UM activities. The UM Committee supports the EQIHEC in the area of appropriate provision of medical services and provides recommendations for UM activities. The responsibilities of the UMC are to develop, recommend, and refine the UM program policies and procedures, including medical necessity criteria, establishment of thresholds for acceptable utilization levels, and reliability of clinical information with the involvement of appropriate, actively practicing practitioners; and develop and implement a monitoring system to track, compile and evaluate UM measures against pre-established standards and the identification of over and under utilization patterns.

Activities:

1. Establish and implement written utilization management protocols and criteria applicable to the review of medical necessity for inpatient, outpatient and ancillary services.
2. Ensure that UM decisions:
    - Are made independent of financial incentives or obligations.
    - Medical decisions, including those by delegated providers and rendering providers, are not unduly influenced by fiscal and administrative management.
    - Physician compensation plans do not include incentives for denial decisions.
    - Physician and UM decision designees are not rewarded for utilization review decisions.
3. Educate staff, contracted practitioners, and vendors on KHS utilization management policies and procedures to ensure compliance with the goals and objectives of the Utilization Management Program.
4. Review established nationally acceptable utilization benchmarks, medical literature, and outcome data, as applicable.
5. Develop and implement a monitoring system to track, compile and evaluate patterns and variations in care.
6. Continually monitor and evaluate utilization practice patterns of staff and contracted

practitioners and vendors and identify variations in care.

7. Review state regulatory oversight of LTC and CBAS facilities and develop and maintain a process to identify and address quality issues through the credentialing, recredentialing and ongoing monitoring process.
8. Develop and maintain effective relationships with linked and carved-out service providers available to members through County, State, Federal and other community-based programs to ensure optimal care coordination and service delivery.
9. Facilitate and ensure continuity of care for members within and outside of KHS network.
10. Develop and implement performance measures to assure regulatory turn-around-time frames are met.

V. Physician Advisory Committee (PAC)

The functions of the Physician Advisory Committee (PAC) encompass multiple activities to include, serving as the KHS Credentialing and Peer Review QI Subcommittee, overseeing and determining the review and approval of medical technologies and clinical criteria sets, addressing and managing the review of sentinel conditions or adverse events identified for quality concerns, and evaluates as necessary the need to add practitioners to the KHS network, based upon requirements by DHCS, DMHC, CMS, or applicable law. The PAC is actively involved in the establishment of policies related to KHS Code of Conduct, Protected Health Information (PHI) and Fraud Waste and Abuse (FWA). The PAC is comprised of a broad spectrum of KHS participating physician representatives from primary and specialty care and includes at least one behavioral health provider.

PAC-Credentialing and Peer Review

In accordance with state law, minutes will not be submitted but rather a summary of the meeting. The minutes are confidential information protected under California Evidence Code 1157. The responsibilities of the Credentialing/Peer Review Committee are to develop, monitor, and maintain standards for the education, training, and licensure of the KHS network of Participating Practitioners and Health Delivery Organizations, and establish and maintain credentialing/re-credentialing policies and procedures that are consistent with National Committee for Quality Assurance (NCQA) standards, as well as applicable State and Federal laws and regulations. The Credentialing Committee may not base credentialing decisions on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or patient type in which the practitioner specializes.

Activities:

1. Maintain a well-credentialed network of providers and practitioners based on recognized and mandated credentialing standards.
2. Promote continuous improvement in the quality of the care and service provided by the KHS Providers.
3. Investigate patient, member or practitioner complaints or concerns about the quality of clinical care or service provided and to make recommendations for corrective actions, if appropriate.
4. Provide guidance on the overall direction of the credentialing program.
5. Review at least annually the Credentialing Committee Program Description to assure that the program is comprehensive, effective in meeting the goals and standards of KHS

credentialing/ recredentialing procedures and supports the Continuous Quality Improvement process.

6. Evaluate quality concerns related to medical care and make determinations as to whether there is sufficient evidence that the involved practitioner failed to provide care within generally accepted standards.
7. Monitoring the reporting of Provider Preventable Conditions and make recommendations for corrective actions, if appropriate.

PAC-Medical Technologies and Clinical Criteria Sets

1. The PAC uses principles of evidence-based medicine in its evaluation of clinical guidelines oversight and monitoring of the quality and cost-effectiveness of medical care provided to KHS members.
2. Preforms reviews of technologies for use by medical and behavioral staff in the utilization review process.
3. Outlines the medical necessity criteria for coverage for a specific technology, service, or device and as applicable incorporates Federal and State regulations.
4. Ensures KHS does not exert economic pressure to cause institutions to grant privileges to providers that would not otherwise be granted, nor to pressure providers or institutions to render care beyond the scope of their training or experience.
5. Assess standards of health care as applied to members and providers, assist with development of indicators for studies and review guidelines that are promulgated to contracting providers.

PAC-Code of Conduct, Confidentiality, and Fraud Waste and Abuse

The PAC is instrumental in participating in the establishment and maintenance of:

1. Confidentiality policies and procedures for protection of confidential member, practitioner, and provider information in accordance with applicable state and federal regulations.
2. Protection of member identifiable health information by ensuring members' protected health
   information (PHI) is only released in accordance with federal, state, and all other regulatory agencies.
3. Providing oversight in strategies to reduce FWA in provider networks.

Appeals Reviews

The PAC will review aggregate data on member appeals and individual cases as needed. The committee is charged with evaluating and analyzing appeals data to identify systemic patterns of improper services denials and other trends impacting health care delivery to Members by recommending necessary changes and process improvements for any adverse trends identified.

VI. Population Health Management Committee (PHMC)

KHS follows the NCQA definition for Population Health Management: "Population Health Management is a model of care that addresses individuals' health needs at all points along the continuum of care with a "Whole Person" approach supported through participation,

engagement, and targeted interventions for a defined population". The Population Health Management Committee oversees the Population Health Management (PHM) Model of Care (MOC) that addresses individuals' health needs at all points along the continuum of care, including in the community setting, through participation, engagement, and targeted interventions for a defined population. The goal of the PHM MOC is to maintain or improve the physical and psychosocial well-being of individuals and address health disparities through cost effective and tailored health solutions.

The PHMC is a collaborative group that engages business units from multiple KHS departments across the organization that are involved in the development, execution and monitoring and evaluation of programs for members across the continuum of health. Each year a Population Needs Assessment (PNA) is conducted by KHS. The annual PNA describes the overall health and social needs of KHS's membership by analyzing service utilization patterns, disease burden, and gaps in care of members, considering their risk level, geographic location, and age groups. The PHMC members focus on strategies related to the PNA identified gaps and adverse patterns and outcomes to improve the physical and psychosocial well-being of individuals and address health disparities through cost-effective and tailored health solutions. The following departments support the PHMC:

- Care Management
- Case Management
- Utilization Management
- Disease Management
- Social Services
- Quality Management

These departments provide the analysis of service utilization patterns, disease burden, health and functioning of eligible members with chronic medical conditions that may also be exacerbated by significant psychosocial needs, and other gaps in care for KHS members.

The following programs are incorporated into PHM and fall under the administration of the aforementioned Departments:

- Long Term Care (LTC) and Long Term Services and Supports (LTSS)
- Major Organ Transplants (MOT)
- Transitions of Care (TOC)
- California Children's Services (CCS)
- Enhanced Care Management (ECM)
- Community Support Services (CSS)
- Behavioral Health

The PHM strategy focuses on the "whole person" throughout the care continuum to:

- Provide wellness services and intervene on the highest-risk members.
- Improve clinical health outcomes.
- Promote efficient and coordinated health care utilization.
- Maintain cost-effectiveness and quality care.
- Improve access to essential medical, mental health, and social services.
- Improve access to affordable care.

- Ensure appropriate utilization of services.
- Improve coordination of care through an identified point of contact.
- Improve continuity of services for members across transitions in healthcare settings, providers, and health services.
- Improve access to preventive health services.
- Improve beneficiary health outcomes.

Activities:

1. Responsibilities of the committee include leading strategic analytics, evaluation design, clinical and economic evaluation, and optimizing programing, ensuring that PHM addresses health at all points on the continuum of care.
2. Ensures that the medical care provided meets the community standards for acceptable medical care.
3. Collaborates with behavioral health practitioners and entities to ensure appropriate utilization of behavioral health services and continuity and coordination of medical and behavioral healthcare.
4. Improve communications (exchange of information/data sharing) between primary care practitioners, specialists, behavioral health practitioners, and health delivery organizations and ancillary care providers.
5. Monitors appropriate use and monitoring of psychopharmacological medications.
6. Incorporates Population Health Management Model into policies, procedures, and workflows.
7. Improving member access to primary and specialty care, ensuring members with complex health conditions receive appropriate service.
8. Identifies and reduces barriers to needed healthcare and social services for members with complex health conditions.
9. Supports a process for members in resolving their individual barriers to physical and mental wellness.
10. Improve member health status through the delivery of wellness and disease prevention services, programs, and resources by educating and empowering members to effectively use primary and preventive health care services, modify personal health behaviors, achieve, and maintain healthier lifestyles, and follow self-care regimens and treatment therapies for existing medical conditions.
11. Ensures continuity in treatment access and follow-up for members with co-occurring medical, behavioral health, and Substance Use Disorder (SUD) conditions.
12. Promotes routine depression, anxiety, trauma-based care, and SUD screenings are completed and appropriate follow-up referrals are made for adolescent and adult members with chronic health conditions and for women during pregnancy and the postpartum period.
13. Link members to ECM, CSS, SUD Providers and other community-based programs with comprehensive and holistic approaches.

VII. Quality Improvement Health Equity Sub-Committee (HEC)

The Quality Improvement Health Equity Sub-Committee (HEC) is responsible for identification and

management of equity efforts throughout the organization including the planning, organization, and the direction, of the Health Equity Program. The HEC is charged with systematic analysis to identify root causes of health disparities impacting KHS members and collaborating across the organization, with providers, and with other community agencies to eradicate inequities for KHS members served. The HEC reviews and updates relevant health equity policies and procedures and the annual Population Needs Assessment (PNA). From this, the HEC formulates the PNA Action Plan for addressing and mitigating the disparities identified in the PNA. Community Agency Representatives are active HEC participants. The HEC shall monitor, evaluate, and take timely action to address necessary improvements in the quality and equity of care delivered by Network Providers in any setting and take appropriate action to improve upon quality improvement and health equity goals.

The Health Equity Department Manager reports to the Health Equity Officer and is charged with overseeing the day-to-day operations of the Health Equity Department and is responsible for organizing and preparing the HEC agenda, minutes, reporting and committee activities to the Executive Quality Improvement Health Equity Committee (EQIHEC).

The HEC has established objectives to address health disparities to include:

1. Increase the awareness of health equity and quality and implement strengthened, expanded and/or new health equity and quality activities to support providers and members ultimately reducing health inequities within KHS membership.
2. Ensure services provided to members promote equity and are free of implicit bias or discrimination.
3. Implement programs that address the causes of inequity that members and their communities experience including food insecurity, housing problems, tobacco use, and other concerns.
4. Analyze the existence of significant health care disparities in clinical areas.
5. Reduce health disparities among members by implementing targeted quality improvement programs.
6. Promote physician involvement in health equity/disparities and activities.
7. Conduct focused groups or key informant interviews with cultural or linguistic minority members to determine how to meet their needs.
8. Address social determinants of health.

VIII. Grievance Review Committee

The Grievances process addresses the receipt, handling, and disposition of Member Grievances in accordance with the Department of Health Care Services (DHCS) Contract and applicable state and federal statutes, regulations and DHCS All Plan Letters. KHS maintains written records of each Grievance as detailed in Title 28, Section 1300.68(f)(2)(D) of the California Code of Regulations. This committee is a subcommittee of the EQIHEC.

All complaints, grievances, investigations, follow-up, tracking and trending reports are submitted to the Grievance Review Committee. The Grievance Review Committee meets at a minimum four (4) times a year.

Under the direction and oversight of the Chief Operations Officer (COO) or designee, individual and aggregate data on member grievances is reviewed by the Grievance Review Committee. The COO is supported by KHS staff Medical Directors. The committee is charged with evaluating and analyzing Grievance data to identify systemic patterns of improper services denials and other trends impacting health care delivery to Members by implementing necessary changes and process improvements for any adverse trends identified.

Grievances may address, but are not limited to, the following issues:

1. Difficulty obtaining an appointment.
2. Customer service at the provider or practitioner office.
3. Billing issues.
4. Difficulty accessing specialists.
5. Facility Conditions.
6. Confidentiality issues.
7. Refusals of PCP to refer the member for care.
8. Cultural Issues.

All Grievance review reports and discussions and determination activities conducted by the committee are recorded and summarized in formal minutes. A summary of the activities and reports are submitted to the EQIHEC.

IX. Behavioral Health Advisory Committee (BHAC)

The KHS Behavioral Health Advisory Committee (BHAC) is a subcommittee to the EQIHEC and is charged with facilitating collaborative coordination of medical and behavioral health services. The committee will support, review, and evaluate interventions to promote collaborative strategic alignment between KHS and the County Mental Health Plan (MHP) and the Drug Medi-cal Organized Delivery System (DMC-ODS). Kern Behavioral Health and Recovery Services (KBHRS) administers both the MHP and DMC-ODS, treating KHS members with the goal to maintain continuity, reduce barriers to access, linkage to appropriate services, opportunities to integrate care, and provide resources for members with mental illness and/or substance use disorder.

Activities:

1. Review quality monitoring activities conducted by the Plan to measure compliance for network providers, corrective actions, and regulatory requirements regarding behavioral health services, network accessibility and delegation oversight.
2. Provide feedback on implementation of BH clinical guidelines, new BH technology, quality monitoring tools, site/chart review(s), tracking access to care standards, and treatment innovations.
3. Review Plan's adherence and achievement of Medi-Cal Managed Care Accountability Set (MCAS) targets focused on BH.
4. Review Plan's adherence to the quantitative and qualitative analysis for the Evaluation of BH member complaints, appeals, and experience.
5. Review Plan's process for continuity and coordination medical and behavioral health services, methods to exchange information.
6. Review and approve the BH Program Description annually.

7. Review Plan's compliance with overseeing MOU with KBHRS.
8. Provides support to KHS management based on their regular and direct interactions with KHS Members receiving BH Services.

The BHAC is chaired by the KHS Director of Behavioral Health or designee and a credentialed and participating behavioral health provider with an M.D. or approved BH Licensure. BHAC will require two-thirds of the members to be present to establish a quorum. The committee meets at a minimum four (4) times a year.

All BHAC review reports, discussions, and determination activities conducted by the committee are recorded and summarized in formal minutes. A summary of the activities and reports are submitted to the EQIHEC.

X. Pharmacy and Therapeutics/Drug Utilization Review (P&T/DUR) Committee

The Pharmacy and Therapeutics/Drug Utilization Review (P&T/DUR) Committee is a subcommittee that reports to the EQIHEC. The P&T/DUR committee is comprised of KHS pharmacists and contracted providers in the community serving KHS members. The P&T/DUR is responsible for reviewing matters related to the use of medications provided by the KHS contracted provider network. The basic objectives are to specify drugs of choice and address alternatives, based on safety and efficacy; to minimize therapeutic redundancies; and to maximize cost-effectiveness pertaining to drugs administered in the outpatient settings by physicians under KHS' division of responsibility. Medi-Cal RX retains responsibility for formulary drugs carved out to them by the DHCS.

Activities:

1. Pharmacy and formulary utilization, guidelines, and policies and procedures based on clinical evidence and DHCS contractual requirements.
2. Drug Utilization Review.
3. Review of reports to identify members and providers with potentially inappropriate/excessive utilization of medication therapy.

The P&T/DUR Committee meets at a minimum (four) times a year. All P&T/DUR review reports, discussions, and determination activities conducted by the committee are recorded and summarized in formal minutes. A summary of the activities and reports are submitted to the EQIHEC.

XI. Access and Availability and Delegated Vendor Oversight Committee (AADVOC)

The Access & Availability and Delegated Vendor Oversight Committee (AADVOC) is charged with monitoring member accessibility to obtain covered services within the Plan's contracted network of providers and evaluating and overseeing any functions and responsibilities delegated to a subcontracted entity. Access & Availability includes appointment availability, geographic access, and network adequacy, monitored through provider surveys, grievance reviews, geographic mapping and analysis, and provider to member ratio reviews. Delegation reporting will include pre-

delegation evaluation, ongoing delegation oversight activities, and results of any conducted audits.

All AADVOC review reports, discussions, and determination activities conducted by the committee are recorded and summarized in formal minutes. A summary of the activities and reports are submitted to the EQIHEC.

Activities:

1. Ensuring Network accessibility and transparency align with DHCS and DMHC requirements through established quantifiable standards for both geographic distribution and number (ratio of providers to members) of PCPs, high-volume and high impact specialists, including high volume behavioral health practitioners and specific high volume ancillary providers.
2. Ensure the performance of the annual network certification meets requirements.
3. Consistent monitoring of practitioner availability and accessibility of services.
4. Efficient collection and analysis of provider-experience data.
5. Address complex and problematic provider-related issues, grievances, and concerns timely, effectively, and appropriately.
6. Ensure provider adherence to all regulatory and legal requirements in the contracting process.
7. Ensure providers receive training and education in accordance with KHS policies and procedures.
8. Ensure KHS First Tier Entity, Downstream Entity, or Related Entity ("delegated vendor entities") can perform the delegated functions that they are contracted to perform and that they can meet the requirements of all applicable laws and regulations.
9. Pre-delegation and annual audits, review of delegated entity reports.
10. Maintenance of an informed provider network regarding regulatory updates and program requirements.
11. Use data to drive practice improvements.
12. Design and monitor Pay-for-Performance (P4P).

XII. Quality Improvement Committee (QIC)

The QIC is a subcommittee of the EQIHEC. The committee will be chaired by the Chief Medical Officer or designee. The Committee is responsible for ensuring the development, implementation, and monitoring of the KHS QI Program.

The focus of the QIC is on clinical quality, patient safety, and patient and provider experience in four functional areas: HEDIS/Medi-Cal Managed Care Accountability Sets (MCAS), NCQA Accreditation, Quality Improvement, and Network Clinical Oversight.

Activities:

1. Review and approve the QI Program Description, the annual Work Plan, and annual Evaluation of the work plan.
2. Ensure compliance with DHCS facility site review requirements.
3. Review aggregate data of potential quality of care issues (PQIs), identify areas of improvement, and oversee implementation of improvements.
4. Oversee KHS safety program.

5. Oversee the identification of quality-of-care trends and recommend corrective action as needed.
6. Monitor evidence-based care through the HEDIS and Managed Care Accountability Set (MCAS) audit and make recommendations for areas of improvement.
7. Monitor member satisfaction by reviewing the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey Outcomes and address measures of dissatisfaction.

XIII. Public Policy Community Advisory Committee (PP/CAC)

The PP/CAC reports directly to the KHS BOD. The PP/CAC is comprised of a diverse membership pursuant to 22 CCR section 53876(c), comprised primarily of KHS Members, representing member and community engagement stakeholders, community advocates, and traditional and Safety-Net Providers. The goal of the PP/CAC is to establish procedures to permit subscribers and enrollees to participate in establishing the public policy of the plan supported by acts performed by KHS or its employees and staff to assure the comfort, dignity, and convenience of patients who rely on the plan's facilities to provide health care services to them, their families, and the public. The PP/CAC is a standing Committee within KHS and provides a mechanism for structured input from KHS members regarding how KHS operations impact the delivery of their care. Information from the PP/CAC is reported to the EQIHEC to heighten awareness and incorporate PP/CAC recommendations into quality improvement activities.

Activities:

1. Review changes in policy or procedures that affect KHS Members.
2. Provide updates on state policies or issues that affect KHS Members.
3. Allow committee members to have input on issues that have an impact on KHS Members (i.e. marketing materials, KHS website including the web Provider Directory or Doctor Search, the Evidence of Coverage, brochures, flyers, Health Education materials, Radio/TV/Billboard advertisements, incentive ideas/items, etc.).
4. Allow committee members to share experiences that will help KHS improve how care is delivered.
5. Advise on educational and operational issues affecting groups who speak a primary language other than English.
6. Advise on cultural competency.

XIV. Other EQIHEC Formal Informational Reporting Sources

Member Services Information:

Incorporates member experience and data-analysis to identify opportunities for improvement in member satisfaction as identified from Member Satisfaction Surveys, and Member Retention Reports.

Patient Safety:

Patient safety and promoting a supportive environment for network practitioners and other providers to improve patient health outcome and safety. Information about safety issues is received from multiple sources including, but not limited to: member and practitioner grievances, care

management and utilization management activities, adverse issues, pharmacy data such as polypharmacy, facility site reviews, continuity of care activities, and member satisfaction survey results. Many of the ongoing QI Program measurement activities, including measures for accessibility, availability, adherence to clinical practice guidelines and medical record documentation include safety components.

Hospital Quality and Safety
KHS tracks and trends hospital performance to reduce variation and assure consistent and standardized metrics across all contracted hospitals. Sources include: Cal Hospital Compare supplemented with data and reports from Centers for Medicare and Medicaid Services (CMS), California Department of Public Health (CDPH), and the California Maternity Quality Care Collaborative (CMQCC). Each of these entities provides performance comparisons across hospitals along with regional and national benchmarks of quality and safety. Other sources include sentinel event reporting.

Nurse Advice Line (NAL)
Review of KHS contracted nurse advice line reports to include aggregated data sets for assessment and evaluation for the provision of triage and screening.

Data Sources
Data sources include but are not limited to: encounters/claims, pharmacy and lab data through direct, supplemental or health information exchanges, medical record review or facility site review results, and other monitoring and audit results as well as grievances, appeals, and denial overturns, HEDIS results, quality and performance reports, member and provider satisfaction survey results, network access and availability reports, utilization management metrics, annual population health assessment, and the annual QI work Plan evaluation.

Personnel

Reporting relationships, qualifications and position responsibilities are defined as follows:

I. Chief Executive Officer (CEO)
Appointed by the Board of Directors, the CEO has the overall responsibility for KHS management and viability. Responsibilities include: KHS direction, organization and operation, developing strategies for each department including the QI Program, Human Resources direction and position appointments, fiscal efficiency, public relations, governmental and community liaison, and contract approval. The CEO directly supervises the Chief Financial Officer (CFO), CMO, Compliance Department, and the Director of Marketing and Member Services. The CEO interacts with the CMO regarding ongoing QI Program activities, progress towards goals, and identified health care problems or quality issues requiring corrective action.

II. Chief Medical Officer (CMO)
The KHS CMO must have a valid license to practice medicine in the State of California, the ability to effectively function as a member of a team, and excellent written and verbal communication skills. The CMO is responsible to the Board of Directors to provide medical direction for KHS, including professional input and oversight of all medical activities of the QI Program.

The CMO reports to the CEO and communicates directly with the Board of Directors. The CMO devotes the majority of the time to quality improvement activities.

The responsibilities of the CMO include:

- Supervising the following Medical Services departments and related staff: Quality Improvement, Utilization Management, Pharmacy, Health Education and Disease Management.
- Supervising all QI activities performed by the Quality Improvement Department.
- Providing direction for all medical aspects of KHS, preparation, implementation and oversight of the QI Program, medical services management, resolution of medical disputes and grievances, and medical oversight on provider selection, provider coordination, and peer review.
- Developing and implementing medical policy for utilization and QI functions, reviewing current medical practices so that that medical protocols and medical personnel of KHS follow rules of conduct, assigned members are provided healthcare services and medical attention at all locations, and medical care rendered by providers meets applicable professional standards for acceptable medical care and quality. These standards should equal or exceed the standards for medical practice developed by KHS and approved by the California Department of Health Care Services (DHCS) or the California Department of Managed Health Care (DMHC).
- Providing direction to the EQIHEC Committee and associated committees including PAC and P&T/DUR.
- Providing assistance with the study, development and coordination of the QI Program in all areas to provide continued delivery of quality health care for members.
- Assisting the Director of Provider Network Management with provider network development.
- Communicating with the CFO to ensure that financial considerations do not influence the quality of health care administered to members.
- Providing oversight for the development and ongoing revision of the Provider Policy and Procedure Manual related to health care services.
- Executing, maintaining, and updating a yearly QI Program for KHS and an annual summary of the QI Program activities to be presented to the Board of Directors.
- Assuring timely resolution of medical disputes and grievances.
- Working with the appropriate departments to develop culturally and linguistically appropriate member and provider materials that identify benefits, services, and quality expectations of KHS.
- Providing continuous assessment of monitoring activities, direction for member, provider education, and coordination of information across all levels of the QI Program and among KHS functional areas and staff.
- Providing direction for internal and external QI Program functions, and supervision of KHS staff including:
    a. Application of the QI Program by KHS staff and contracting providers.
    b. Participation in provider quality activities, as necessary.
    c. Monitoring and oversight of provider QI programs, activities, and processes.

d. Oversight of KHS delegated and non-delegated credentialing and recredentialing activities.
e. Retrospective review of KHS credentialed providers for potential or suspected deficiencies related to quality of care.
f. Monitoring and oversight of any delegated UM activities.
g. Supervision of Health Services staff in the QI Program including: Director of Quality Improvement, Director of Health Education and Cultural & Linguistics Services, Population Health Management (PHM) Director, Utilization Management (UM) Director, Pharmacy Director, and other related staff.
h. Supervision of all Quality Improvement Activities performed by the QI Department.
i. Monitoring covered medical and behavioral health care provided to ensure they meet industry and community standards for acceptable medical care.
j. Active participation in the functioning of the plan grievance procedures.

III. Chief Operating Officer (COO)

Under direction of the CEO, plans, directs, monitors, coordinates, interprets and administers all functional activities and policies related to Claims, Member Services , and AIS/Compliance departments. The COO is responsible for directing all activities of the Claims, Provider Relations, Member Services, and AIS/Compliance departments for a Knox-Keene Act-licensed health maintenance organization. COO maintains authority for setting policies and procedures for the departments, that are consistent with the policies and procedures set by the KHS Board of Directors and the CEO, and fall in compliance with regulatory requirements. Executive is responsible for and has decision making authority regarding the organization in the absence of the CEO.

IV. Medical Director of Quality

The Medical Director of Quality must have a valid license to practice medicine in the State of California, the ability to effectively function as a member of a team, and excellent written and verbal communication skills. The Medical Director will provide clinical leadership and guidance in the development and measurement of the strategic approach to quality, performance improvement, and patient satisfaction, and safety. As determined by the plan CMO, the Medical Director assists in short- and long-range program planning, total quality management including quality improvement, and external relationships, as well as develops and implements systems and procedures for all medical components of health plan operations.

In collaboration with the CMO and others, the Medical Director creates and implements health plan medical policies and protocols. The Medical Director monitors provider network performance and reports all issues of clinical quality management to the CMO and EQIHEC. Additionally, he or she represents the health plan on various committees and routinely reports to the Board of Directors on credentialing and re-credentialing of network providers. The Medical Director provides medical oversight into the medical appropriateness and necessity of healthcare services provided to Plan members and is responsible for meeting medical cost and utilization performance targets.

Under direction of the Chief Medical Officer:

- Serve as a member of the following committees of the KHS Board of Directors: EQIHEC, PAC, P&T/DUR, Quality Improvement Committee, and Grievance Committee.
- Participates in carrying out the organization's mission, goals, objectives, and continuous quality improvement of KHS.
- Is responsible for reviewing and managing utilization of health care services at all levels of care to achieve high quality outcomes in the most cost-effective manner.
- Provides clinical leadership to the clinical departments staff and works collaboratively with the directors of the other Departments of KHS to ensure compliance with the contractual and regulatory requirements.
- Provide clinical support and education to the network provider in support of standards of care and evidence-based medicine and use of clinical criteria in decision management.
- Represents KHS in the medical community and in general community public relations.
- Participates in the implementation of the KHS Credentialing Program.
- Responsible for Review and identification of area for improvement and provide clinical leadership in the implementation of KHS Quality Improvement Plan and the Utilization Management Plan.
- Lead and/or attend and actively participate in meetings and committees as assigned by the CMO.
- Actively Participates as a member of the Health Services management team.
- Performs duties and responsibilities identified for the Medical Director under the Quality Improvement Plan, the Utilization Management Plan.

V. Behavioral Health Provider

The Behavioral Health Provider is a participating BH provider with an MD or PhD in Psychology and is licensed to practice in California. The Behavioral Provider is involved in all behavioral health aspects of the QI and UM Programs and advises the BHAC Committee aimed at improving behavioral healthcare services. Responsibilities include acting as the chairperson in the KHS Behavioral Health Advisory Committee (BHAC), reports to EQIHEC and provides reports on the key BHAC monitoring activities including but not limited to:

- Exchange of information between PCPs and behavioral health specialists.
- Coordination between KHS and Kern County Managed Behavioral Health Organization (MBHO) and certified SUD providers for substance use disorder services to promote continuity of care.
- Supervision of diagnosis, treatment and referral for members with co-existing medical and behavioral conditions.
- Collaboration with pharmacy for the use of psycho-pharmaceutical medications.
- Identification of social determinants of health, and other potential barriers to receiving BH care, including access.
- Providing substantial involvement in BHAC Committee and other sub-committees through collaboration with CMO.
- Establishing QI and UM policies and procedures relating to behavioral healthcare.
- Participating in quality activities related to continuity and coordination of care between medical and BH practitioners.

VI. Director of Quality Improvement

Under the direction of the KHS CMO, the Director of Quality Improvement will oversee and participate in activities related to quality improvement for the organization and membership by monitoring, assessing and improving performance in ambulatory and inpatient health care delivery or health care related services. The Director will implement the KHS Quality Management Plan and communicate with contract providers regarding required studies and participation. Related duties will include ongoing data collection, medical record reviews, report writing, and collaboration and coordination with other KHS departments, as well as outside agencies.

This position is responsible for quality improvement, health education and disease management functions for KHS. This professional will be responsible for ensuring compliance with the QI work plan, oversight of the design, implementation, analysis and dissemination of utilization and accessibility studies and member and provider satisfaction studies. The Director of QI will also be responsible for overseeing the production, analysis, and dissemination of contractually mandated reports. The Director of QI is also responsible for maintaining compliance with Medi-Cal contractual stipulations for Quality programs. Makes an effective contribution to the KHS business planning and fiscal processes. Is clear about departmental objectives and resource requirements.

The QI Director will keep the KHS quality plan "front and center", reinforcing a shared sense of purpose throughout the organization. Takes a mentoring role and strongly encourages the growth of team members. Ensures that professional development goals are incorporated into team members' annual performance objectives, and regular reviews progress towards attaining them.

Under direction of the CMO and QI Medical Director:

- Designs and implements QI programs that meet the goals of the KHS QI plan and complies with regulatory, contractual, and NCQA requirements.
- Maintains responsibility for all activities of the Quality Improvement staff including policies, procedures, and operations.
- Works in coordination with the Provider Relations Manager of Special Programs to develop grant programs.
- Maintains overall direction and supervision for all ongoing and new projects for the QI program.
- Provides leadership and support to QI staff involved in QI projects.
- Annually updates QI policies and procedures with input from the Quality Improvement Committee.
- Participates as an active member of plan committees requiring preparation, research, and follow-up as requested by the CMO.
- Oversees credentialing processes and all HEDIS related activities.
- Supervises quality of care investigations and reporting.
- Represents KHS as the QI liaison for external subcommittees, behavioral health subcontractor, QI workgroups, etc.
- Assists with interviews, selects, trains, develops and evaluates subordinate staff; provides input to Human Resources regarding disciplinary issues, as required.
- Coordinates QI activities and data collection between KHS departments and KHS contracted providers.
- Prepares the organization for review and the accreditation processes by monitoring of

external contract providers and internal processes.

- Contributes to the overall design of the Pay for Performance Incentive Program in collaboration with Provider Relations department.
- Coordinates and conducts in-depth chart analysis, data collection, and report preparation.
- Summarizes information collected for identification of patterns, trends, and individual cases requiring intensive review.
- Identifies and recommends the initiation of quality improvement studies related to multi-disciplinary quality issues and State required studies.
- Serves as staff support and resource to the Quality Improvement and Utilization Management Committee, the Physician Advisory Committee and other committees, as appropriate.
- Assists in problem identification, data analysis, conclusions, recommendation, action-plan design, follow-up and tracking.
- Implements and facilitate internal Quality Improvement studies and work groups for continuous improvement within the organization.

VII. Senior Director of Contracting and Quality Performance

Under the direction of the COO and CMO, the Senior Director of Contracting and Quality Performance will be responsible for managing the provider contracting and quality performance functions for KHS. This includes maintenance of provider agreements, process improvements, contract and quality performance management, negotiation and re-negotiation of contracts in coordination with Executive Leadership, the Senior Director of Provider Network Management, KHS attorney and staff; oversee and participate in activities related to QI for the organization and membership by monitoring, assessing and improving performance in all health care settings.

Oversees, plans, and implements new and existing healthcare QI and practice transformation initiatives, and education programs specific to the Provider Network; ensures maintenance of Provider QI programs, Pay for Performance, and MCAS in accordance with prescribed quality standards; conducts data collection, reporting and monitoring for key performance measurement activities, leads improvement in operational efficiency, financial performance, staff engagement, and health equity.

This position provides the vital role of maintaining network contracting integrity for KHS. This position will ensure that processes are in place and followed in all negotiations, contracting and payment set-up functions. This position also requires a developed understanding of practice operations, revenue cycle management, performance improvement methods, and QI operations as a whole. Also essential is the ability to direct multi-faceted projects across various settings, departments, and programs. Strong leadership and consensus-building skills are essential.

Essential Functions include:

- Developing and maintaining contracting templates which comply with regulatory and legal requirements, effectively implementing strategic initiatives which meet KHS business needs.
- Mitigating risk and liability when negotiating agreements and informing and advising appropriate KHS staff, CEO and KHS attorney of such risks.

- Developing and maintaining a work plan and timeline for completing contract development/negotiations, ensuring that contracts and amendments are implemented in a timely fashion.
- Plan, implement and manage contracting strategies to ensure development of contracted providers to support existing and future product lines.
- Oversee technical products/software related to fiscal impact reports and rate development for provider contracts.
- Oversee the negotiations for Letter of Agreements and administer the Agreements.
- Negotiate Provider contracts for the provision of all covered benefits including physicians, behavioral health, ancillaries, and hospital agreements.
- Oversight responsibility for the Contract Administration unit including contract development, processing, and maintenance of the Agreements.
- Responsible for coordinating payment with Finance Department for special funding sources such as Provider Proposition initiatives, Hospital Directed payments, and any other provider payments not included in the overall contractual payment structure.
- Responsible for validating provider eligibility of special provider funding and oversight of payouts. This includes auditing payments and creating departmental procedures to ensure compliance of such funding distributions.
- Work closely with the KHS Legal to ensure compliance with regulatory agencies, KHS Policies and Procedures and KHS legal requirements.
- Assisting network providers and their staff with practice transformation plans to shift into value-based care, improving quality and encounter data submissions.
- Identify opportunities for increased provider practice efficiency and leveraging health IT and data to deliver high-quality, culturally competent, equitable, and comprehensive primary, specialty, and ancillary health care.
- Develop practice transformation processes and tools, aimed at building practices' overall capacity for ongoing and sustainable change into high-performing, quality medical practices.
- Helps practices to identify areas of need and helps with efficiency measures to improve availability, through sharing of scorecards, delivering gaps-in-care information and risk reports, sharing of satisfaction results as applicable, and delivering other critical operational and efficiency reports.
- Assist in the contracting portion of KHS Grant process including but not limited to RFP development, grant review, grant contract development.
- Monitors and ensures that key quality activities are completed on time and accurately to present results to key departmental management.
- Leads quality improvement activities meetings and discussions with and between other departments within the organization or with and between key provider network partners.
- Evaluates project/program activities and results to identify opportunities for improvement.
- Any other duties as required ensuring the Health Plan operations are successful.
- Provide oversight of contract system configuration and provider set-up.
- Responsible for Credentialing staff and processes.
- Responsible for Facility Site Review processes.

VIII. Director of Quality Performance

Under the direction of the Senior Director of Contract and Quality Performance, the Director of Quality Performance is responsible for oversight, implementation, and management of new quality improvement initiatives specific to the Provider Network. This includes being responsible for HEDIS and MCAS functions and collaborating and supporting providers to improve health outcomes related to those measures. The Director is also responsible for quality improvement initiatives related to Performance Improvement Projects (PIPs) and Facility Site Reviews (FSRs). The Director will communicate and coordinate with contract providers regarding required studies, participation, and improvement projects. Related duties include ongoing data collection, medical record reviews, report writing, and collaboration with other KHS departments, as well as outside agencies.

The Director of Quality Performance is responsible for HEDIS/MCAS and performance components of the Quality Improvement Program. This position will be responsible for oversight of maintaining compliance with Medi-Cal contractual stipulations for the performance of KHS and KHS contracted providers. In addition, this person will be an effective contributor to the KHS business planning and fiscal processes.

Essential Functions include:

- Builds and develops collaborative relationships vital to the success of programs.
- Assisting network providers and their staff with practice transformation plans to shift into value-based care, improving quality and encounter data submissions.
- Helps practices to identify areas of need and helps with efficiency measures to improve availability, through sharing of scorecards, delivering gaps-in-care information and risk reports, sharing of satisfaction results as applicable, and delivering other critical operational and efficiency reports.
- Monitors and ensures that key quality activities are completed on time and accurately to present results to key departmental management.
- Evaluates project/program activities and results to identify opportunities for improvement.
- Responsible for Quality Performance staff and processes.
- Work collaboratively with Senior Director and Provider Network team to develop physician practice performance profiling on MCAS/HEDIS/STAR metrics, identify opportunities for improvement, and support/manage change implementation.
- Establishes and maintains tracking and monitoring systems for health care quality improvement activities according to regulatory requirements, policies and procedures, and contractual agreements.
- Track and monitor the HEDIS improvement operations.
- Identify opportunities and potential barriers in MCAS/HEDIS
- Research and documents current health care standards for use in performance improvement study design and methodologies related to health outcomes.
- Provides guidance, and oversight to staff regarding study design, methodology, data analysis and reporting of Quality performance improvement projects.
- Works with staff to achieve production, timeliness, accuracy, and quality of work.
- Remains current with Department of Health Care Services and Department of Managed Care policy implementation or revisions.
- Participates in the development, review and updating of policies and procedures.
- Manages and evaluates performance of department staff.

- Coordinates guidelines, studies, and performance improvement activities in concert with the utilization management, quality management, pharmacy services, and population health management teams.
- Remains current with HEDIS/MCAS requirements and participates in planning and implementation of methods to improve HEDIS/MCAS performance.
- Education of providers on HEDIS/MCAS and program goals.
- Ensures compliance with applicable regulatory and reporting requirements.
- Coordinates the regular and systematic review of all potential quality of care issues in accordance with state statute.
- Develops and analyzes reports to monitor and evaluate quality performance in meeting established goals.

IX. Quality Managers

The Quality Manager possesses a master's degree in health or business administration or bachelor's or Associates Degree in Nursing and five (5) years of experience in the direct patient care setting or operations management, or teaching adult learners, and one (1) year of experience in health care Quality Improvement, Utilization Management, or Process Improvement, and two (2) years of management experience.

Under the direction of the Director, the Quality Manager conducts oversight and management of state and regulatory and contractual compliance for the QI program. This includes managing the HEDIS and Managed Care Accountability Set (MCAS) audit and initiatives to improve health outcomes related to those measures. They also manage quality improvement initiatives for Performance Improvement Projects (PIPs), Improvement Plans (IPs), Facility Site Reviews (FSRs), delegation audits, and other external quality reviews. The manager applies clinical knowledge and analytical skills to manage and oversee day-to-day operations of the QI team.

X. QI Program Staffing

The QI and QP Directors oversee staff consisting of the following members:

QI Registered Nurses: The QI nurses possess a valid California Registered Nursing license and three years registered nurse experience in an acute health care setting preferably in emergency, critical and/or general medical-surgical care. The QI nurses assist in the implementation of the QI Program and Work Plan through the quality monitoring process. Staffing will consist of an adequate number of QI nurses with the required qualifications to complete the full spectrum of responsibilities for the QI Program development and implementation. Additionally, the QI nurses teach contracting providers DHCS MMCD standards and KHS policies and procedures to assist them in maintaining compliance.

MCAS/HEDIS Program Manager: The Program Manager possesses a bachelor's degree or higher in Healthcare, Business, Data Science, Project Management or related field. They have at least 2 years' experience in Quality Improvement or in a health care environment with relevant Quality Improvement experience. They also have at least two (2) years' experience in project management work. Under the direction of the Director, the Program Manager manages, plans, coordinates, and monitors Quality Special Programs including but not limited to:

- Annual Managed Care Accountability Set (MCAS) audit and measurement results submission.

- QI Department Strategic Goals and Projects, and Special Programs (such as member incentives and engagement, DHCS-required project improvement plans, site reviews, etc.).

Senior QI Operations Analyst: The Senior QI Operations Analyst reports to the Director and has a master's degree in Business, Statistics, Mathematics, or other related field with academic demonstration of analytical skills from an accredited school or equivalent AND three (3) years working experience with a Managed Care Organization (MCO) or similar type organization. This position provides primary oversight, management and validation of data and reports submission for the annual DHCS MCAS/HEDIS audit. This includes serving as the liaison between the QI Department, vendors and internal KHS Department such as IT. They provide similar management and support for other department audits. They are responsible for providing operational department support for department processes, projects, or other assignments and provide data and reports for ongoing activities such as performance improvement projects.

Senior QI Coordinator: The Senior QI Coordinator roles report to the QI Manager. He/she is a high school graduate and is licensed/certified in CA as either a certified medical assistant (CMA) or licensed vocational nurse (LVN) with either five (5) years of experience for a CMA or two (2) years experience for a LVN in a physician's office. The Senior QI Coordinator assists in department functions related to data collection, data entry, report preparation, record maintenance, and collaboration with other departments, regulatory and contracted agencies. This position will work extensively with MCAS methodology, data collection and intervention development and implementation. The Senior QI Coordinator assists with medical record requests and record preparation for any QI activity. The role also provides administrative support for provider site review activities.

Other KHS Department Leads as needed.

Quality Program Components

I. Population Health Management (PHM)

KHS supports its PHM delivery infrastructure that ensures the needs of its entire population and the delivery of quality care and services to each member are met. Through the Population Needs Assessment (PNA) conducted annually by KHS, the members' health and social needs are identified, and quality-driven strategies are developed to assist these members to the appropriate services offered by the following:

- Care Management Program
- Enhanced Care Management (ECM)
- Complex Case Management
- Transitional Care Services

The following is a list of all PHM Programs:

1. Basic Population Health Management
   - Community Supports Services
   - Maternal Health Outcomes – Baby Steps
2. Wellness and Prevention Programs
   - Nutrition Education Program

- Diabetes Prevention Program
- Diabetes Education Program
- Asthma Education
- School Wellness Grant Program

3. Care Management Programs
   - Care Coordination (i.e., Skilled Nursing Facility Coordination)
   - Complex Case Management (CCM)
4. Special Programs
   - COPD Clinic
   - Transition of Care (TOC) Program
   - ER Navigation
   - Palliative Care Program
   - CHF Clinic
   - Comprehensive Diabetes Program
   - Potentially Preventable Admission (PPA) Program
   - Homebound Program
5. Enhanced Care Management (ECM)

Continuous Quality Assurance and Improvement
Performance metric data are collected monthly, quarterly and aggregated annually to identify and analyze opportunities for improvement of performance. Feedback obtained from the Nurse Case Managers (NCM) and from members via the satisfaction survey are analyzed, trended over time, and correlated to the quality measures and care workflows.

The PHM Program is overseen by the PHM subcommittee and reports to the EQIHEC for all its activities and outcomes of performances.

The PHM Director oversees the Population Health Program and reports to the Chief Medical Officer. There are several different staff involved to support the population health initiatives including but not limited to:

- Case Managers
- Care Coordinators
- Health Educators
- Member outreach staff

The Business Intelligence unit provides the majority of data guiding the population health program. The Quality Performance Department provides HEDIS reporting and analysis, including Gap in Care reporting. There is collaboration between all departments on initiatives and interventions that are part of the Population Health Program.

II. Health Equity Program

a. Cultural and Linguistics
b. Diversity, Equality and Inclusion

KHS gathers race/ethnicity, language, gender identity and sexual orientation data to assist in

providing culturally and linguistically appropriate services (CLAS).

Key Functional Areas

I. Member Grievances and Appeals System

KHS Member Grievance and Appeal system complies with the requirements set forth in the 42 Code of Federal Regulations Sections 438.228 and 438.400 – 424, 28 California Code of Regulations Sections 1300.68 and 1300.68.01, and 22 CCR Section 53858. KHS use all notice templates included in the All-Plan letter 21-011 and ensures timely written acknowledgement and a notice of resolution to the member as quickly as possible.

Grievances with a Potential Quality Issue (PQI) identified are referred to the QI department as a PQI referral for further investigation and action. All potential quality of care issues are reviewed by the KHS CMO or their designee to determine the severity level and follow-up actions needed. All cases are tracked and the data provided to the CMO or designee during the provider credentialing/re-credentialing process. Other actions may include tracking and trending a provider for additional PQIs and/or request(s) for a corrective action plan (CAP) for issues or concerns identified during review. The CMO or their designee may present select cases to the PAC for review and direction as needed.

KHS regularly analyzes grievance and appeals data to identify, investigate, report and act upon trends impacting health care access and delivery to the members.

Grievance Satisfaction Data – KHS reviews Member grievances and satisfaction study results as methods for identifying patient safety issues.

II. Behavioral Health

The KHS responsibility for administering and managing behavioral health and substance use care is dependent on the Medi-Cal member's severity of impairment. For behavioral health, KHS services are typically for treatment of mild to moderate impairment also referred to as non-specialty mental Health. Kern County Medi-Cal Behavioral Organization manages severe mental health impairment referred to as Specialty Mental Health Services.

For substance use disorders KHS provides screening, brief intervention, and counseling (SBIRT) services and refers members for treatment for misuse of alcohol. Active treatment for Medi-Cal members with substance use disorder (SUD) services must be rendered by a SUD Drug Medi-Cal certified program.

KHS covers Behavioral Health Treatment (BHT), including Applied Behavior Analysis (ABA) therapy, for Medi-Cal beneficiaries under the age of 21.

III. Health Education

The Plan's Health Education Department conducts a field-testing process to ensure that written health education materials are understood by members and accessible for the targeted member audience. Newly developed or adapted materials provides opportunities for Plan Members and

their families to review materials prior to their release or publication. Mechanisms for field testing may include, but are not limited to:

1. Review during the PP/CAC meeting.
2. Key informant reviews with Members.
3. Focus groups with targeted members to determine relevance and effectiveness.

All field testing is overseen by a KHS health educator to monitor its appropriateness. Members or the parents/guardians of Members have the opportunity to provide input for the materials being presented including how better to engage the targeted audience. The effectiveness of the chosen mechanism is taken into consideration for future field testing.

IV. Member Services

KHS implements and maintains written policies and procedures that set forth the Member's rights and responsibilities and shall communicate its policies to its Members, Providers, and, upon request, potential members.

Members are also assured of their rights to confidentiality, right to advance directives, and rights to linguistic services.

V. Pharmacy Services

Safety Monitoring: Pharmacy will expand on the current monitoring of opioids/controlled substances as defined by the SUPPORT Act. Though previously managed via prospective Pharmacy Benefit Manager (PBM) rules, KHS will retrospectively review claims for possible action in regard to the Beer's list for geriatric members. KHS will also monitor drug recalls issued by the FDA or manufacturer. Currently for monitoring the potentially inappropriate use of opioids, either, high dose, those without naloxone, and/or in combination with other agents acting on the central nervous system such as benzodiazepines, and muscle relaxants, KHS sends notification letters to the physician on record to evaluate the appropriateness of the regimen for that member.

The Director of Pharmacy or designee participates in interdisciplinary teams weekly to discuss drug regimens of select members. KHS also sends letters to providers regarding drug profiles of members that have been identified as having drug duplications, interactions, and/or missing therapies.

Pharmacy is developing a series of report suites that will identify all HEDIS/MCAS measures we are held accountable for or will be added in the following year (2024). These reports identify members who are non-compliant for that measure, and we will be working with other depts to best close the gap. The approach will incorporate brining in the local pharmacies to help with outreach to the members and providers.

VI. Provider Network

The Provider Network Management (PNM) department is responsible for growing and overseeing the Plan's network of providers and is comprised of: Contracting, Credentialing, Provider Relations, Provider Grants, and Analytics and Regulatory Reporting. The PNM department is headed by the Senior Director of Provider Network. The Deputy Director of Provider Contracts

reports to the Senior Director of Provider Network and oversees Contracting and Credentialing. The Deputy Director of Provider Network reports to the Senior Director of Provider Network and oversees Provider Relations, and Provider Grants, and Analytics and Regulatory Reporting.

The Contracting Team is comprised of a Provider Contracts Supervisor, Contract Specialists, Coordinators. The Contracting Team is responsible for contracting with providers within and adjacent to the network service area to ensure network adequacy for all specialty types. The Contracting department also works with contracted providers to negotiate rates and implement special programs. As needed the Contracting team will negotiate single-case, Letter of Agreements (LOAs) with out-of-network providers.

The Credentialing Team is comprised of a Credentialing Manager and five Credentialing Coordinators. The PNM Credentialing team monitors and tracks provider licenses, certificates, training, Medi-Cal enrollment, and other applicable provider requirements. The Credentialing team also aids in maintaining accurate provider data utilized within Plan's regulatory reporting and provider directory.

The Provider Relations Representative Team is comprised of a Provider Relations Supervisor and seven Provider Relations Representatives. The Provider Relations Representatives are the direct link between the Plan and the Provider. The Provider Representatives are responsible for provider communication and education and conduct outreach to noncontracted providers for potential recruitment.

The Grants Team is comprised of a Grants Manager and a Grants Specialist. The Grants Team is responsible for developing grant programs and identifying and reaching out to providers who may qualify for certain grants from the Plan. The Grants team is responsible for creation and tracking of appropriate grant's milestones and goals. The KHS grant program works to financially aid and encourage innovative efforts to bring beneficial services to our community.

The PNM Analyst team is comprised of the Provider Network Manager, Provider Network Analytics Program Manager, and three Senior Provider Network Analysts. The PNM Analyst Team is responsible for, monitoring network accessibility, network-related regulatory reporting (DMHC Timely Access and Annual Network Review, DHCS Annual Network Certification), the Provider Satisfaction Survey and maintaining the provider directory (in conjunction with credentialing team).

Provider network accessibility is primarily monitored via the Provider Network Management, Quarterly Network Review. The Quarterly Network Review includes, but is not limited to an Access Grievance Review, Provider Accessibility Monitoring Survey, Geographic Accessibility Review, and Network Adequacy/Provider Counts. These reports track and monitor the Plan's regulatory compliance to standards such as: PCP to member and Physician to Member ratios, Appointment Availability, Provider Response times, Provider After-Hours availability, and In-Office wait times. The PNM Analytics Team monitors and tracks members' geographic access to PCP, Specialist, Non-Physician Mental Health, Specialty OB/GYN, and Hospital providers and confirms the geographic access is within regulatory standards. If any provider type/geographic region is not meeting regulatory standards, it is the responsibility the PNM Analytics Team to request an Alternative Access Standard and identify potential providers for recruitment/contracting

activities. The PNM Analytics Team reviews Access Grievance data to determine if any provider, group, or specialty is experiencing the same access issue on a continuous basis. The PNM Analytics Team reports all findings to PNM leadership and the EQIHEC committee.

VII. Utilization Management (Adverse Events/Sentinel Event)

Utilization Management is responsible for coordinating and conducting prospective, concurrent, and retrospective utilization review for medical necessity, appropriateness of hospital admission, level of care/continuum of care, and continued inpatient stay, as appropriate.

The QI Department reviews a sampling of hospital re-admissions that occurred within 30 days of the first hospital discharge each quarter to identify and follow-up on potential inappropriate care issues.

Any issue that warrants further investigation of potential inappropriate care is forwarded from the Utilization Management Department, Member Services Department, or any other KHS Department, to the QI Department for determination whether a PQI issue exists and follow up corrective action based on the severity level of PQI identified. These referrals may include member deaths, delay in service or treatment, or other opportunities for care improvement.

VIII. Business Intelligence (BI) Unit

Functions include:

- Establish advanced health analytics to ensure that leadership has full purview into the population to improve individual experience of care; improve the health of the population while reducing per capital cost of care for populations.
- Create, manage, and continuously improve Corporate Key Performance Indicators (KPI's)
- Reduce operational silos and proactively manage and improve overall operations.
- Provide and validate standard metrics and information around process improved to ensure that project goals, objectives, or Return on Investments (ROI) are achieved.
- Establish data governance over various systems to ensure that reliable data can be consumed for analytics and reporting.
- Manage all operational and regulatory reporting inventory for the organization.

IX. Management and Information System (MIS)

KHS utilizes information provided through the Information Technology (IT), Operations, and Provider Network Management departments.

KHS MIS has the capability to capture, edit, and utilize various data elements for both internal management use and to meet the data quality and timeliness requirements. These include DHCS' encounter data, network provider data, program data, and template data submissions and processes. MIS also has the ability to meet Population Health Management data integration requirements and is able to provide the requested data to DHCS and Centers for Medicare and Medicaid Services upon request.

KHS (MIS) has the capacity to enable interoperability for data exchange with Health Information Technology (HIT) systems and Health Information Exchange (HIE) networks.

KHS MIS supports at a minimum:

- All Medi-Cal eligibility data.
- Information on members enrolled with Kern Health Systems.
- Provider claims status and payment data.
- Health care services delivery encounter data.
- Network provider data.
- Program data.
- Template data.
- Screening and assessment data.
- Referrals including tracking of referred services to follow up with Members to ensure that services were rendered.
- Electronic health records.
- Prior auth requests and specialty referral system.
- Care Management data.
- Care Coordination data.
- Financial information.
- Social drivers of health data.
- Grievance and appeal information.

Quality Work Plan and Activities

The annual QI Work Plan is designed to target specific QI activities, projects, tasks to be completed during the upcoming year, and monitoring and investigation of previously identified issues. A focal activity for the Work Plan is the annual evaluation of the QI Program, including accomplishments and impact on members. Evaluation and planning the QI Program is done in conjunction with other departments and organizational leadership. High volume, high risk or problem prone processes are prioritized.

- The Work Plan is developed by the Quality Improvement Department on an annual basis and is presented to the PAC, EQIHEC and Board of Directors for review and approval. Timelines and responsible parties are designated in the Work Plan.
- The Work Plan includes the objectives and scope of planned projects or activities that address the quality and safety of clinical care and the quality of service provided to members.
- After review and approval of quality study results including action plans initiated by the EQIHEC, KHS disseminates the study results to applicable providers. This can occur by specific mailings or KHS Provider bulletins to contracting providers.
- The activities in the QI Work Plan are annually evaluated for effectiveness.
- QI Work Plan responsibilities are assigned to appropriate individuals.

Components of the QI Work Plan:

Quality and Safety of Clinical Care: KHS evaluates the effect of activities implemented to improve patient safety. Safety measures are monitored by the QI Department in collaboration with other KHS departments, including:

- **Provider Network Management Department –** provider credentialing and recredentialing, using site visits to monitor safe practices and facilities.

- **Member Services Department –** by analyzing and taking actions on complaint and satisfaction data and information that relates to clinical safety.
- **UM Department –** in collaboration with the Member Services Department, by implementing systems that include follow-up to ensure care is received in a timely manner.

1. Quality of Clinical Care

a. Managed Care Accountability Set (MCAS) Measures

KHS is contractually required to submit data and measurement outcomes for specific health care measures identified by DHCS. The measures are a combination of ones selected by DHCS from the library of Healthcare Effectiveness Data and Information Set (HEDIS) and the Core Measures set from the Centers for Medicare and Medicaid Services (CMS). An audit is performed by DHCS's EQRO to validate that the data collection, data used and calculations meet the specifications assigned by DHCS.

DHCS has established minimum performance levels (MPL) for several of the MCAS measures. This benchmark is the 50th percentile based on outcomes published in the latest edition of NCQA's Quality Compass report and the National HMO Average. Results submitted to DHCS for the designated MCAS measures are compared to the NCQA benchmarks to determine the Managed Care Plan's (MCP) compliance. When an MCP does not meet the 50th percentile or better for a measure, DHCS may impose financial penalties and require a corrective action plan (CAP). The following table identifies the MCAS measures KHS is held accountable to meet the 50th percentile or better for measurement year (MY) 2024. Results for the 2023 measures will be calculated and submitted in report year (RY) 2023. The MCAS Measures include:

#	**MEASURE** Total Number = 36 (10 Hybrid and 26 Administrative)	**MEASURE ACRONYM**	**MEASURE TYPE METHODOLOGY**	**HELD TO MPL?**
Behavioral Health Domain				
1	Follow-Up After ED Visit for Mental Illness – 30 days*	FUM	Administrative	Yes
2	Follow-Up After ED Visit for Substance Abuse – 30 days*	FUA	Administrative	Yes
Children's Health Domain				
3	Child and Adolescent Well-Care Visits*	WCV	Administrative	Yes
4	Childhood Immunization Status: Combination 10*	CIS-10	Hybrid/Admin**	Yes
5	Developmental Screening in the First Three Years of Life	DEV	Administrative	Yesiii
6	Immunizations for Adolescents: Combination 2*	IMA-2	Hybrid/Admin**	Yes
7	Lead Screening in Children	LSC	Hybrid/Admin**	Yes

8	Topical Fluoride for Children	TFL-CH	Administrative	Yesiii

9	Well-Child Visits in the First 30 Months of Life – 0 to 15 Months – Six or More Well-Child Visits*	W30-6+	Administrative	Yes
10	Well-Child Visits in the First 30 Months of Life – 15 to 30 Months – Two or More Well-Child Visits*	W30-2+	Administrative	Yes
Chronic Disease Management Domain				
11	Asthma Medication Ratio*	AMR	Administrative	Yes
12	Controlling High Blood Pressure*	CBP	Hybrid/Admin**	Yes
13	Hemoglobin A1c Control for Patients With Diabetes – HbA1c Poor Control (> 9%)*	HBD	Hybrid/Admin**	Yes
Reproductive Domain				
14	Chlamydia Screening in Women	CHL	Administrative	Yes
15	Prenatal and Postpartum Care: Postpartum Care*	PPC-Pst	Hybrid/Admin**	Yes
16	Prenatal and Postpartum Care: Timeliness of Prenatal Care*	PPC-Pre	Hybrid/Admin**	Yes
Cancer Prevention Domain				
17	Breast Cancer Screening*	BCS	ECDS & Admin***	Yes
18	Cervical Cancer Screening	CCS	Hybrid/Admin**	Yes
Report only Measures to DHCS				
19	Ambulatory Care: Emergency Department (ED) Visits	AMB-ED ii	Administrative	No
20	Adults' Access to Preventive/Ambulatory Health Services	AAP	Administrative	No
21	Antidepressant Medication Management: Acute Phase Treatment	AMM-Acute	Administrative	No
22	Antidepressant Medication Management: Continuation Phase Treatment	AMM-Cont	Administrative	No
23	Colorectal Cancer Screening*	COL-E	ECDS	No^^
24	Contraceptive Care—All Women: Most or Moderately Effective Contraception	CCW-MMEC	Administrative	No
25	Contraceptive Care – Postpartum Women: Most or Moderately Effective Contraception – 60 Days	CCP-MMEC60	Administrative	No

#	MEASURE Total Number = 36 (10 Hybrid and 26 Administrative)	MEASURE ACRONYM	MEASURE TYPE METHODOLOGY	HELD TO MPL?
26	Depression Remission or Response for Adolescents and Adults	DRR-E	ECDS	No^^
27	Depression Screening and Follow-Up for Adolescents and Adults	DSF-E	ECDS	No^^
28	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	SSD	Administrative	No
29	Follow-Up After ED Visit for Mental Illness – 7 days*	FUM	Administrative	No
30	Follow-Up After ED Visit for Substance Use – 7 days*	FUA	Administrative	No
31	Follow-Up Care for Children Prescribed Attention- Deficit / Hyperactivity Disorder (ADHD) Medication: Continuation and Maintenance Phase	ADD-C&M	Administrative	No
32	Follow-Up Care for Children Prescribed Attention- Deficit / Hyperactivity Disorder (ADHD) Medication: Initiation Phase	ADD-Init	Administrative	No
33	Metabolic Monitoring for Children and Adolescents on Antipsychotics	APM	Administrative	No
34	Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate	NTSV CB	Administrative	No
35	Pharmacotherapy for Opioid Use Disorder*	POD	Administrative	No^^
36	Plan All-Cause Readmissions*	PCR ii	Administrative	No
37	Postpartum Depression Screening and Follow Up*	PDS-E	ECDS	No^^
38	Prenatal Depression Screening and Follow Up*	PND-E	ECDS	No^^
39	Prenatal Immunization Status	PRS-E	ECDS	No^^
Long Term Care Report Only Measures to DHCS				
40	Number of Out-patient ED Visits per 1,000 Long Stay Resident Days*	HFS	Administrative^	No
41	Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization*	SNF-HAI	Administrative^	No
42	Potentially Preventable 30-day Post-Discharge Readmission*	PPR	Administrative^	No

KHS is contractually required to meet or exceed the DHCS established Minimum Performance Level (MPL) for each required HEDIS measure. For any measure that does not meet the established MPL, or that is reported as a "No Report" (NR) due to an audit failure, an Improvement Plan (IP) is contractually required to be submitted within 60 days of being notified by DHCS of the measures for which IPs are required. Managed Care Plans are required to meet or exceed the performance levels set forth by Department Health Care Services (DHCS) as outlined in their contract. Based on KHS' compliance level for MCAS measures for MY2022, KHS was placed in the orange tier and is completing a cause-and-effect analysis to understand the barriers of not meeting the MPLs.

b. DHCS-required Studies: Performance Improvement Projects (PIP)

KHS is mandated to participate in two (2) PIPs. These PIPs span over an approximate 36 month time frame and are each broken out into four (4) modules. Each module is submitted to HSAG/DHCS for review, input, and approval incrementally throughout the project.

The two new PIPS required by DHCS will include annual submissions for 3 years from 2023-2026. The framework for the new PIPs has been updated by DHCS to align with the CMS protocol.

Clinical PIP:

The new cycle of PIPs began in August 2023 and will run through 2026. The clinical PIP is focused on Health Equity, specific to the W30 0-15 months African American population. KHS submitted the first phase of the PIP design to HSAG in August.

Non-Clinical PIP:

The non-clinical PIP is specific to the FUA and FUM measures with a heavy reliance on the Behavioral Health department for support of interventions. We will be partnering with the Behavioral Health Department, UM, PHM, and any other necessary stakeholders. KHS also submitted the first phase of the PIP design to HSAG in August. HSAG validated and approved the submission with minor feedback to improve the framework.

2. Safety of Clinical Care

a. Facility Site and Medical Record Review – Facility site and medical record reviews are performed before a provider is awarded participation privileges and every three years thereafter. As part of the facility review, KHS QI Nurses review for the following potential safety issues:

- Medication storage practices to ensure that oral and injectable medications, and "like labeled" medications, are stored separately to avoid confusion.
- The physical environment is safe for all patients, personnel, and visitors.
- Medical equipment is properly maintained.
- Professional personnel have current licenses and certifications.
- Infection control procedures are properly followed.
- Medical record review includes an assessment for patient safety issues and sentinel events.
- Bloodborne pathogens and regulated wastes are handled according to established laws.

b. Credentialing/Recredentialing

Assessment and Monitoring: To monitor that contracting providers have the capacity and capability to perform required functions, KHS has a pre-contractual and post- contractual assessment and monitoring system. Details of the activities with standards, tools and processes are found in specific policies and include:

Pre-contractual Assessment of Providers – All providers desiring to contract with KHS must, prior to contracting with KHS, complete a document that includes the following sections:

- Health Care Delivery Systems, including clinical safety, access/waiting, referral tracking, medical records, and health education.
- Credentialing information.

c. **Drug Utilization Review** – KHS performs drug utilization reviews to provide oversight of prescribed medications. DUR is a structured, ongoing program that evaluates, analyzes, and interprets drug usage against predetermined standards and undertakes actions to elicit improvements and measure the results. The objectives of DUR are to improve the quality of patient care by assuring safe and effective drug use while concurrently managing the total cost of care.

d. **Clinical Practice and Preventive Health Guidelines** – Clinical Practice Guidelines are developed using current published literature, current practice standards and expert opinions. They are directed toward specific medical problems commonly found with members. The PAC reviews and approves all Clinical Practice Guidelines and/or Preventive Health Guidelines prior to presentation to EQIHEC Committee. The EQIHEC Committee is responsible for adopting and disseminating Clinical Practice Guidelines for acute, chronic, and behavioral health care services. Guidelines are reviewed every two years and updated if necessary.

3. Quality of Service

a. **Primary Care Physician (PCP) and Specialist Access Studies** – KHS performs physician access studies per KHS Policy 4.30, Accessibility Standards. Reporting of access compliance activities is the responsibility of the Provider Network Management Manager and is reported annually.

b. **PCP and Specialist** Appointment Availability Study KHS members must be offered appointments within the following timeframes:

Type of Appointment	Time Standard
Urgent care appointment for services that do not require prior authorization[1]	Within 48 hours of a request
Urgent appointment for services that require prior authorization	Within 96 hours of a request
Non-urgent primary care appointment	Within 10 business days of a request
Non-urgent appointment with a specialist	Within 15 business days of a request
Non-urgent appointments with a physician mental health care provider	Must offer the appointment within 10 business days of 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 for the diagnosis or treatment of injury, illness, or other health condition	Within 15 business days of a request
Pediatric CHDP Physicals	Within 2 weeks upon request
First pre-natal OB/GYN visit	The lesser of 10 business days or within 2 weeks upon request

c. PCP After-Hours Access

KHS contracts with an after-hours triage service to facilitate after-hours member access to care. The Director of UM reviews monthly reports for timeliness, triage response and availability of contracting providers. Results of the access studies are shared with contracting providers, EQIHEC Committee, Board of Directors and DHCS.

4. Member Safety

KHS continuously monitors patient safety for members and develops appropriate interventions as follows:

- **Coordination of Care Studies** – KHS performs Coordination of Care Studies to reduce the number of acute inpatient stays that were followed by an acute readmission for any diagnosis within 30 days.
- **Interventions** – KHS initiates interventions appropriate to identified issues. Such interventions are based on evaluation of processes and could include distribution of safety literature to members, education of contracting providers, streamlining of processes, development of guidelines, and/or promotion of safe practices for members and providers.

KHS evaluates the effect of activities implemented to improve patient safety. Safety measures are monitored by the QI Department in collaboration with other KHS departments, including:

- **Provider Network Management Department –** provider credentialing and recredentialing, using site visits to monitor safe practices and facilities.
- **Member Services Department –** by analyzing and taking actions on complaint and satisfaction data and information that relates to clinical safety.
- **UM Department –** in collaboration with the Member Services Department, by implementing systems that include follow-up to ensure care is received in a timely manner.

The Director of Member Services presents reports regarding customer service performance and grievances monthly to the CEO, CMO and Chief Operations Officer. At least quarterly, reports are presented to the EQIHEC Committee for review and recommendations.

Member Information on QI Program Activities – A description of QI activities are available to members upon request. Members are notified of their availability through the Member Handbook. The KHS QI Program Description and Work Plan are available to contracting providers upon request.

QUALITY IMPROVEMENT PROCESS

a. Prioritization of Identified Issues – Action is taken on all issues identified to have a direct or indirect impact on the health and clinical safety of members. These issues are reviewed by appropriate Health Services staff, including the CMO, and prioritized according to the severity of impact, in terms of severity and urgency, to the member.

b. Corrective Actions – Corrective Action Plans (CAP) are designed to eliminate deficiencies,

implement appropriate actions, and enhance future outcomes when an issue is identified. CAPs are issued in accordance with *KHS Policy and Procedure 2.70-I Potential Quality of Care Issues (PQI)*. All access compliance activities are reported to the Senior Director of Provider Network who prepares an activity report and presents all information to the CEO, CMO, Chief Operations Officer, Sen, and EQIHEC Committee.

c. **Quality Indicators** – Ongoing review of indicators is performed to assess progress and determine potential problem areas. Clinical indicators are monitored and revised as necessary by the EQIHEC Committee and PAC. Clinical practice guidelines are developed by the DUR Committee and PAC based on scientific evidence. Appropriate medical practitioners are involved in review and adoption of guidelines. The PAC re-evaluates guidelines every two years with updates as needed.

KHS targets significant chronic conditions and develops educational programs for members and practitioners. Members are informed about available programs through individual letters, member newsletters and through KHS Member Services. Providers are informed of available programs through KHS provider bulletins and the KHS Provider Manual. Tracking reports and provider reports are reviewed and studies performed to assess performance. KHS assesses the quality of covered health care provided to members utilizing quality indicators developed for a series of required studies. Among these indicators are the MCAS measures developed by NCQA and CMS. MCAS reports are produced annually as well as throughout the year and have been incorporated into QI assessments and evaluations.

Quality Improvement Strategies

I. Quality Improvement Strategies

The following strategies and key action items were identified for improvement of 3 focused areas:

a. Data Accuracy, Completeness, & Timeliness,
b. QI Training & Resources for KHS staff & providers, and
c. Collaboration & Communication.

Strategies and key action items for the 3 focus areas are as follows:

- Data Accuracy, Completeness, & Timeliness
  - Strategy: Develop process for timely, complete, & accurate data to measure MCAS compliance for strategy development and outcomes analysis
  - Key Actions:
    * Implement an organizational standard data QA process
    * Evaluate options to support consistent data exchange with providers
    * Analyze audit and perform risk management and remediation on any findings to close the gaps
    * Analyze data by geographic areas and identify areas with higher gaps in care
      - Special programs with providers in remote geographic areas (geographic barriers)
      - Mobile clinics in underserved areas
      - Onsite visits to LTC facilities
    * KHS members are stratified by Race, ethnicity & other SDoH data used to target interventions & develop special programs.
    * Utilization & outcome data is stratified to identify areas of underutilization such as

low performance scores on preventive services
    - Target services for CHWs, home visits, doulas etc.
    - Basic Population Health Management Program supported with mobile clinics, and home visits to close gaps

- Training & Resources
    - Strategy: Develop a quality education program to enable KHS staff & providers to develop & implement effective MCAS improvement strategies
    - Key Actions:
        * Develop e-learning courses for KHS staff & providers that align with industry-standard, QI principles and methods. Courses will cover current MCAS measures
        * Identify organizational structure for the role of a Health Equity Officer, as required in the DHCS CQS. This position will be responsible for carrying out the CQS strategies in collaboration with the Quality Improvement and Population Health Management departments
        * Identify and assess members risks guiding the development of care management programs and focused strategies
        * Create strategies to engage members as "owners of their own care". Member Engagement Program - Develop a robust member and community engagement program
        * Develop communication strategies that will focus on keeping families and communities healthy via prevention
        * Create early interventions for rising risk and patient centered chronic disease management
        * Expand on programs that focus on whole person care for high-risk populations, addressing drivers of health
        * Implementation of strategic & corporate goals to incorporate equity in internal staffing recruitment, network development/expansion and implementation of PHM programs

- Collaboration & Communication
    - Strategy: To establish a communication process that supports strategic thought partnership, transparency, & decision-making for MCAS compliance throughout all levels of the organization.
    - Key Actions:
        * Executive Leadership Team will establish a process for communication & collaboration of QI strategies & activities at all levels of the organization.
        * Plan project with CHWs in underserved areas to engage and support members to close care gaps , home visits, working with community centers where members go to meet members,
        * Street medicine – leveraging CalAIM Incentive Program (HHIP)
        * Schools with school wellness program, SBHIP (CalAIM Incentive program), use of school clinics for immunizations, screenings and possible health fairs to close gaps in care
        * Partner with Department of Public Health for early pregnancy identification and support to initiate prenatal care

* ECM sites to close gaps in care,
* Utilize specialist for diabetes management for those with HgA1c above 9,
* PCP incentive programs supporting practice transformation
* Grant funding for telehealth
* Expand transportation providers for members in more remote areas of the county by partnering with CBOs and Provider Practices

Integration of Study Outcomes with KHS Operational Policies and Procedures: KHS assesses study outcomes over time and, as a result of key quality issue identification and problem resolution, develops changes in strategic plans and operational policies and procedures. Study outcomes are assessed and changes may be incorporated into the KHS strategic plan and operational policies and procedures to address those outcomes and incorporate ongoing quality issue solutions into organizational operations.

As previously described, a Strike Team is in place to focus on initiatives that will improve KHS' MCAS scores. The strike team is made up of marketing/member engagement, business intelligence, provider network management, quality, and population health. With this diverse team, key strategies will be developed and monitored closely to identify what the most effective approach in getting members to close their gaps in care and into their primary care physicians for their preventive health services appointments.

Evaluation of KHS' Quality Program

Annual Evaluation of the KHS Quality Improvement Program

On an annual basis, KHS evaluates the effectiveness and progress of the QI Program and Work Plan, and updates the program as needed. The CMO, with assistance from the Quality Medical Director, Director of QI, Pharmacy Director, Director of Health Education and Cultural & Linguistics Services, Director of Marketing, Director of Member Services and Senior Director of QP and Provider Network, documents a yearly summary of all completed and ongoing QI Program activities with documentation of evidence of improved health care or deficiencies, status of studies initiated, or completed, timelines, methodologies used, and follow-up mechanisms.

The report includes pertinent results from QI Program studies, member access to care surveys, physician credentialing and facility review compliance, member satisfaction surveys, and other significant activities affecting medical and behavioral health care provided to members. The report demonstrates the overall effectiveness of the QI Program. Performance measures are trended over time to determine service, safety, and clinical care issues, and then analyzed to verify improvements. The CMO presents the results to the EQIHEC Committee for comment, suggested program adjustments and revision of procedures or guidelines, as necessary. Also included is a Work Plan for the coming year. The Work Plan includes studies, surveys, and audits to be performed, compliance submissions, reports to be generated, and quality activities projected for completion.

The yearly QI Program summary and Work Plan are presented to the Board of Directors for assessment of covered health care rendered to members, comments, activities proposed for the coming year, and approval of changes in the QI Program. The Board of Directors is responsible for the direction of the QI Program and actively evaluates the annual plan to determine areas for improvement. Board of Director Comments, actions and responsible parties assigned to changes are documented in the minutes. The status

of delegated follow-up activities is presented in subsequent Board meetings. A summary of QI activities and progress toward meeting QI goals is available to members and contracting providers upon request by contacting KHS Member Services.

KHS Providers

Provider Participation
KHS contracts with physicians and other types of health care providers. The Provider Network Management Department conducts a quarterly assessment of the adequacy of contracting providers. All PCPs and specialists must meet KHS credentialing and recredentialing standards. Contracting providers must meet KHS requirements for access and availability. Members may select their PCPs based on cultural needs and preferences. The Provider Directory lists additional languages spoken by PCPs or their office staff.

Provider Information – KHS informs contracting providers through its Provider bulletins, letters and memorandums, distribution of updates to the Provider Policy and Procedure Manual, and training sessions.

Provider Cooperation – KHS requires that contracting providers and hospitals cooperate with QI Program studies, audits, monitoring and quality related activities. Requirements for cooperation are included in provider and hospital contract language that describe contractual agreements for access to information.

Provider and Hospital Contracts
Participating provider and hospital contracts contain language that designates access for KHS to perform monitoring activities and require compliance with KHS QI Program activities, standards, and review system.

Provider contracts include provisions for the following:

a. An agreement to participate in the KHS QI Program including cooperation with monitoring processes, the grievance resolution system, and evaluations necessary to determine compliance with KHS standards.

b. An agreement to provide access to facilities, equipment, books, and records as necessary for audits or inspection to ascertain compliance with KHS requirements.

c. Cooperation with the KHS QI Program including access to applicable records and information.

d. Provisions for open communication between contracting providers and members regarding their medical condition regardless of cost or benefits.

Hospital contracts include provisions for the following:

a. An agreement to participate in the KHS QI Program, including cooperation with monitoring processes, the grievance resolution system, utilization review, and evaluations necessary to determine compliance with KHS standards.

b. Development of an ongoing QI Program to address the quality of care provided by the hospital including CAPs for identified quality issues.

c. An agreement to provide access of facilities, equipment, books, and records as necessary for audits or inspection to ascertain compliance with KHS requirements.

d. Cooperation with the KHS QI Program, including access to applicable records and information.

Conflict of Interest:
All committee members are required to sign a conflict-of-interest statement. Committee members cannot vote on matters where they have an interest and must be recuse until the issue has been resolved.

Confidentiality

All members, participating staff and guests of the EQIHEC Committee and subcommittees are required to sign the Committee Attendance Record, including a statement regarding confidentiality and conflict of interest. All KHS employees are required to sign a confidentiality agreement upon hire. Confidentiality agreements are maintained in the practitioner or employee files, as appropriate. All peer review records, proceedings, reports and member records are maintained in a confidential manner in accordance with state and federal confidentiality laws.

Member's Right to Confidentiality:
KHS retains oversight for provider confidentiality procedures. KHS has established and distributed confidentiality standards to contracting providers in the KHS Provider Policy and Procedure Manual. All provider contracts include the provision to safeguard the confidentiality of member medical and behavioral health care records, treatment records, and access to sensitive services in accordance with applicable state and federal laws. As a condition of participation with KHS, all contracting providers must retain signed confidentiality forms for all staff and committee members and provide education regarding policies and procedures for maintaining the confidentiality of members to their practitioners. KHS monitors contracting providers for compliance with KHS confidentiality standards during provider facility and medical records reviews and through the Grievance Process. The EQIHEC Committee reviews practices regarding the collection, use and disclosure of medical information.

Information Security

Fraud, Waste, and Abuse (FWA) – The Quality Improvement Department provides support to the KHS Fraud, Waste, and Abuse program in the following ways:

a. **PQI Referrals** – In the course of screening and investigating PQI referrals, the QI Department consistently evaluates for any possible FWA concerns. All FWA concerns are referred to the KHS Compliance Department for further evaluation and follow up.

b. **FWA Investigations** – The QI Department clinical staff may provide clinical review support to the Compliance Department for FWA referrals being screened or investigated.

c. **FWA Committee –** The Director of QI or their designee is an active member of the KHS FWA Committee to provide relevant input and suggestions for topics and issues presented.

External Audits/Regulatory Audits and Oversight

Enforcement/Compliance: The Director of Quality Improvement is responsible for monitoring and oversight of the QI Program, including enforcement of compliance with KHS standards and required activities. Compliance activities can be found in sections of policies related to the specific monitoring activity. The general process for obtaining compliance when deficiencies are noted, and CAPs are requested, is delineated in policies. Compliance activities not under the oversight of QI are the responsibility of the Compliance Department.

Medical Reviews and Audits by Regulatory Agencies – The KHS Director of Compliance & Regulatory Affairs, in collaboration with the CHSO and the Director of Quality Improvement manages KHS medical reviews and medical audits by regulatory agencies. Recommendations or sanctions received from regulatory agencies for medical matters are addressed through the QI Program. CAPs for medical matters are approved and monitored by the EQIHEC Committee.

Delegation

Delegation: KHS delegates quality improvement activities as follows:

1. In collaboration with other Kern County Health Plans – delegation for Site Reviews as described in APL 20-006, Site Reviews: Facility Site Review and Medical Record Review and the applicable MOU.
2. VSP – delegation of QI and UM processes with oversight through the EQIHEC committee.

KHS Board of Directors (Chair) Date

Chief Executive Officer Date

Chairman EQIHE COMMITTEE Date

Kern Health Systems
2023 Quality Improvement Program Work plan

2023 Evaluation

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS
I. QUALITY MANAGEMENT AND IMPROVEMENTS					
A. Annual Review/Approval of QI Program (QIP) Documents					
1. Approval QI Evaluation	Approval of 2022 QI Program Evaluation	5/31/2023	Chief Medical Officer (CMO) / QI Director	None, Met Goal	**Complete**
2. Review/Update and Approval of QI Program Description	Approval of 2023 QI Program Description	5/31/2023	Chief Medical Officer (CMO) / QI Director	None, Met Goal	**Complete**
3. Review/Update and Approval of QI Work Plan	Approval of 2023 QI Work Plan	9/2/2022	Chief Medical Officer (CMO) / QI Director	None, Met Goal	**Complete**
B. Clinical - Focused Studies					
1. State Required				None, Met Goal	**Complete**
1.a Asthma Medication Ration PIP - Improving Asthma Medication Ratio Compliance in Children 5-21 years of age	18 month performance improvement project (PIP) overseen by HSAG focused on improvements with the Asthma Disease Management Program and Asthma Mitigation Project to increase correct medication usage by asthmatic members	06/30/2023	Chief Medical Officer (CMO) / QI Director	None, Met Goal	**Complete**
1.b. Improving the Health and Well Being of low income children, ages 3- 21 years, through Well Child Visits (WCV)	18 month performance improvement project (PIP) overseen by HSAG focused on improvements with increasing the number of children ages 3 - 21 years old with completing an annual well care visit.	06/30/2023	Chief Medical Officer (CMO) / QI Director	None, Met Goal	**Complete**
C. MCAS Quality Measurements Monitoring & Support					
1. MCAS Audit and Rate Submission MY2022/RY2023	Report to State via NCQA and EQRO Auditor, HSAG	7/31/2023	Director of QI Director of Business Intelligence (BI)	None, Met Goal	**Complete**
2 Configure MCAS/HEDIS software for new measures (Cotiviti) MY2022/RY2023	Vendor, Cotiviti, to have all new measures configured, tested and changes approved by NCQA	3/31/2023	QI Director/ BI Director	None, Met Goal	**Complete**
3 Configure KHS data and reports for new measures	KHS to modify data receipt, storage and reports to meet new DHCS MCAS specifications	3/31/2023	QI Director/ BI Director	None, Met Goal	**Complete**
4. Educate KHS Staff on MY2023 measures	KHS to educate internal staff on new requirements for MCAS	3/31/2023	Chief Medical Officer (CMO)/ QI Director	None, Met Goal	**Complete**
5. Educate providers on MY2023 measures	KHS to educate providers on new requirements for MCAS	3/31/2023	Chief Medical Officer (CMO)/ QI Director/ Senior Director Provider Network	None, Met Goal	**Complete**
6. Meet MCAS Compliance Rates for MY2023	Monitor progress in meeting Minimum Performance Level (MPL) of each MCAS measure for 2023 monthly. This will be used to evaluate improvement activities toward meeting all MCAS MPLs.	12/31/2023	Chief Medical Officer (CMO) / QI Director	None, Met Goal	**Complete**

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS
Behavioral Health Domain 6.a Depression Remission or Response for Adolescents and Adults (DRR-E) 6.b Depression Screening and Follow-Up for Adolescents and Adults (DSF-E) 6.c Follow-Up After ED Visit for Mental Illness – 30 days (FUM) 6.d Follow-Up After ED Visit for Substance Abuse – 30 days (FUA)	Meet MPLs ~~DRR-E MPL rate not yet provided by DHCS~~ ~~DSF-E MPL rate not yet provided by DHCS~~ FUM 54.51 FUA 21.24		Chief Medical Officer (CMO) / QI Director	None, Met Goal	**Complete**
Childhood Health Domain 6.e Child and Adolescent Well – Care Visits (WCV) 6.f Childhood Immunization Status – Combination 10 (CIS-10) 6.g Developmental Screening in the First Three Years of Life (DEV) 6.h Immunizations for Adolescents – Combination 2 (IMA-2) 6.i Lead Screening in Children (LSC) 6.j Topical Fluoride for Children (TFL-CH) 6.k Well-Child Visits in the First 30 Months of Life – 0 to 15 Months – Six or More Well-Child Visits (W30-6+) 6.l Well-Child Visits in the First 30 Months of Life – 15 to 30 Months – Two or More Well-Child Visits (W30-2+)	Meet MPLs WCV 48.93 CIS-10 34.79 DEV MPL rate not yet provided by DHCS IMA-2 35.04 LSC 63.99 TFL-CH MPL rate not yet provided by DHCS W30-+6 55.72 W30-+2) 65.83		Chief Medical Officer (CMO) / QI Director	None, Met Goal	**Complete**
Chronic Disease Management Domain 6.m Asthma Medication Ratio (AMR) 6.n Controlling High Blood Pressure (CBP) 6.o Hemoglobin A1c Control for Patients With Diabetes – HbA1c Poor Control (> 9%) (HBD)	Meet MPLs AMR 64.26 CBP 59.85 HBD 39.9		Chief Medical Officer (CMO) / QI Director	None, Met Goal	**Complete**
Reproductive Health Domain 6.p Chlamydia Screening in Women (CHL) 6.q Prenatal and Postpartum Care: Postpartum Care (PPC-Pst) 6.r Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-Pre)	Meet MPLs CHL 55.32 PPC-Pst 77.37 PPC-Pre 85.4		Chief Medical Officer (CMO) / QI Director	None, Met Goal	**Complete**
Cancer Prevention Domain 6.s Breast Cancer Screening (BCS) 6.t Cervical Cancer Screening (CCS)	Meet MPLs BCS 50.95 CCS 57.64		Chief Medical Officer (CMO) / QI Director	None, Met Goal	**Complete**
7. MCAS Improvement Activities	Meet MPL for each MY 2023 MCAS measure	12/31/2023	Chief Medical Officer	None, Met Goal	**Complete**
7.a Health Information Exchange	Establish HIE to support clinical information data sharing that allows timely and accurate data capture for MCAS compliance monitoring	12/31/2023	Business Intelligence Director	None, Met Goal	**Complete**

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS
7.b Provider Electronic Clinical Data Upload	Establish process to upload electronic medical record data upload from providers to support clinical information data access and timely and accurate data capture for MCAS compliance monitoring	12/31/2023	Business Intelligence Director	None, Met Goal	**Complete**
7c. Clinical Assessments in Community Settings	Establish process for KHS Population Health Management and Community & Social Services staff to conduct assessments such as - Health Risk Assessments - Depression Screening - Substances Use Screening in community settings such as homeless shelters, Department of Motor Vehicle offices, Social Security Office, etc. to support identification of member health care needs.	12/31/2023	Population Health Management Director; Director of Community & Social Services	None, Met Goal	**Complete**
7.d. Member Engagement & Rewards Program	Establish year-round, member outreach program focused on members with gaps in care. Redesign MCAS member rewards program to increase motivation for compliance with obtaining preventive health services and follow through with chronic condition self-care.	12/31/2023	Senior Director of Marketing and Member Engagement; Chief Medical Officer	None, Met Goal	**Complete**
7.e. Mobile Preventive Health Services Program	Establish network of providers to provide mobile health care services that will allow KHS to increase access to preventive health services in rural areas of Kern County and in ad hoc community events	6/1/2023	Senior Director of Provider Network; Deputy Director of Provider Contracts	None, Met Goal	**Complete**
7.f. Urgent Care Utilization to Close Gaps in Care	Establish agreements with select urgent care providers to deliver services to close member gaps in care at their center	7/1/2023	Senior Director of Provider Network; Deputy Director of Provider Contracts	None, Met Goal	**Complete**
7.g Provider Collaboration Meetings	Conduct monthly meetings with higher volume providers to review MCAS measure compliance and establish practice interventions to improve rates	6/1/2023	Chief Medical Officer; Director of Quality Improvement; Senior Director of Provider Network	None, Met Goal	**Complete**
7.g. Red Tier Action: Establish process for timely, complete, & accurate MCAS data	Develop process for timely, complete, & accurate data to measure MCAS compliance for strategy development and outcomes analysis	6/1/2023	Director of Business Intelligence; Director of Quality Improvement	None, Met Goal	**Complete**
7.h. Red Tier Action: Develop a Quality education program	Develop a quality education program to enable KHS staff & providers to develop & implement effective MCAS improvement strategies	6/1/2022	Director of Quality Improvement; Chief Medical Officer; Senior Director of Provider Network	None, Met Goal	**Complete**

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS
7.i Red Tier Action: Communication process for organization-wide MCAS information sharing	Establish a communication process that supports strategic thought partnership, transparency, & decision-making for MCAS compliance throughout all levels of the organization	6/1/2023	Executive Leadership Team	None, Met Goal	**Complete**
D. Other On-going Monitoring					
1. 30 day re-admissions	Conduct audit quarterly of 50 30-day hospital readmissions to identify trending related to quality of care and readmission prevention	Quarterly	Chief Medical Officer (CMO) / QI Director	None, Met Goal	**Complete**
2. Potential Quality of Care Issues (PQI)	Complete investigation of all PQIs and any corrective action plans issued	Annually	Chief Medical Officer (CMO) / QI Director	None, Met Goal	**Complete**
2.a. Grievances	Review all grievances for Quality of Care issues and refer those identified to QI Dept as a PQI	Annually	Chief Medical Officer (CMO) / QI Director	None, Met Goal	**Complete**
3. Facility Site Reviews (FSR)	Provider review of physical offices to ensure DHCS site safety and other requirements are met.	Quarterly	Chief Medical Officer (CMO)/ Director QI	None, Met Goal	**Complete**
3.a. Referral Process	Physician Site Monitoring / Quarterly reporting	Quarterly		None, Met Goal	**Complete**
3.b. Initial Health Appointment (IHA)	Physician Site Monitoring / Quarterly reporting	Quarterly		None, Met Goal	**Complete**
3.c. Critical elements	Physician Site Monitoring / Quarterly reporting	Quarterly		None, Met Goal	**Complete**
3.d. Diabetes Care Monitoring	Physician Site Monitoring / Quarterly reporting	Quarterly		None, Met Goal	**Complete**
3.e. Asthma Care Monitoring	Physician Site Monitoring / Quarterly reporting	Quarterly		None, Met Goal	**Complete**
3.f. Maternity Care Monitoring	Physician Site Monitoring / Quarterly reporting	Quarterly		None, Met Goal	**Complete**
3.g. Safety of Care - Autoclave - Bio-hazardous waste - Infection Control	Physician Site Monitoring / Quarterly reporting	Quarterly		None, Met Goal	**Complete**
3.h. Bi-annual repot to DHCS of FSRs completed	Generate and submit report of all site and medical record reviews (both initial, periodic and focus) to DHCS for January through June and July through December in accordance with DHCS report requirements	January 31st July 31st	Chief Medical Officer (CMO) / QI Director	None, Met Goal	**Complete**
F. Provider Availability					
1. Primary Care Practitioners				None, Met Goal	**Complete**
1.a. Numeric Standard - *Network Capacity Report*	Measure and Report to DHS	Annually	Senior Director of Provider Network, Director of Compliance	None, Met Goal	**Complete**
2. Specialty Practitioners				None, Met Goal	**Complete**
2.a. Numeric Standard - *Network Capacity Report*	Measure and Report to DHS	Annually	Senior Director of Provider Network, Director of Compliance	None, Met Goal	**Complete**
2.b. Geographic Standard - Network Capacity Report	Measure and Report	Annually	Senior Director of Provider Network, Director of Compliance	None, Met Goal	**Complete**
G. Provider Access					
1. Primary Care Appointments					
1.a. Preventive Care Appointments Standard	Measure/Report to QI/UM Committee Quarterly	Annually	Senior Director of Provider Network, Director of Compliance	None, Met Goal	**Complete**

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS
1.b. Routine Primary Care Appointments Standard	Measure/Report to QI/UM Committee Quarterly	Annually	Senior Director of Provider Network,Director of Compliance	None, Met Goal	**Complete**
1.c. Urgent Care Appointments Standard	Measure/Report to QI/UM Committee Quarterly	Annually	Senior Director of Provider Network, Director of Compliance	None, Met Goal	**Complete**
1.d. After-hours Care Standard	Measure/Report to QI/UM Committee Quarterly	Annually	Senior Director of Provider Network,Director of Compliance	None, Met Goal	**Complete**
2. Telephone access to Member Services			Senior Director of Provider Network, Director of Compliance		
2.a. Abandonment rate	Measure/Report to QI/UM Committee Quarterly	Quarterly	Senior Director of Provider Network, Director of Compliance	None, Met Goal	**Complete**
2.b. Speed of answer	Measure/Report to QI/UM Committee Quarterly	Quarterly	Senior Director of Provider Network, Director of Compliance	None, Met Goal	**Complete**
3. Mental Health Appointment	Quarterly MOU Meetings/Grievances	As necessary	Director of UM; Director of Population Health Management	None, Met Goal	**Complete**
2.a Life-threatening Emergency Standard (immediate care)	Report as necessary to QI/UM Committee	As necessary	Senior Director of Provider Network, Director of Compliance	None, Met Goal	**Complete**
2.b. Non-life-threatening Emergency Standard	Report as necessary to QI/UM Committee	As necessary	Senior Director of Provider Network, Director of Compliance	None, Met Goal	**Complete**
2.c Urgent needs Standard	Report as necessary to QI/UM Committee	As necessary	Senior Director of Provider Network, Director of Compliance	None, Met Goal	**Complete**
2.d Routine office visit Standard (visit within 10 working days)	Report as necessary to QI/UM Committee	As necessary	Senior Director of Provider Network, Director of Compliance	None, Met Goal	**Complete**
2.e Telephone access to screening and triage Standard	Report as necessary to QI/UM Committee	As necessary	Senior Director of Provider Network, Director of Compliance	None, Met Goal	**Complete**
- Caller reaches non-recorded voice	Report as necessary to QI/UM Committee	As necessary	Senior Director of Provider Network, Director of Compliance	None, Met Goal	**Complete**
- Abandonment rate	Report as necessary to QI/UM Committee	As necessary	Senior Director of Provider Network, Director of Compliance	None, Met Goal	**Complete**
H. Encounters, Complaints, Grievances and Appeals Data Analysis	Report aggregate data quarterly to QI/UM Committee	Quarterly	Director of Member Services	None, Met Goal	**Complete**
I. CAHPS Survey	State administered survey every 2 years - Survey being administered for 2022 in Q1 of 2023 by DHCS/HSAG	9/30/2023	State Administered/CIO/Chief Medical Officer (CMO) / QI Director	None, Met Goal	**Complete**
1. Member data provided to EQRO for 2022	Provide 2022 member data per EQRO specifications	Jan-23	State Administered/CIO/Chief Medical Officer (CMO) / QI Director	None, Met Goal	**Complete**
2. Results reported to QI/UM Committee	Present summary of report to QI/UM Committee for review and identification of improvement actions	12/31/2023	State Administered/CIO/Chief Medical Officer (CMO) / QI Director	None, Met Goal	**Complete**
3. Results reported to practitioners and providers	Report to Physician Advisory Committee	12/31/2023	State Administered/CIO/Chief Medical Officer (CMO) / QI Director	None, Met Goal	**Complete**
J. Continuity of Care Monitoring	Monitored through Grievances, FSR/Peer Review, MCAS	Ongoing	Chief Medical Officer (CMO) / QI Director		
1. Primary Care Practitioner (PCP)	Monitored through Grievances, FSR/Peer Review, MCAS	Ongoing	Chief Medical Officer (CMO) / QI Director	None, Met Goal	**Complete**
2. PCP & Mental Health	Monitored through Grievances, Peer Review, MCAS	Ongoing	Chief Medical Officer (CMO) / QI Director	None, Met Goal	**Complete**
3. Specialist	Monitored through Grievances, Peer Review, MCAS	Ongoing	Chief Medical Officer (CMO) / QI Director	None, Met Goal	**Complete**
K. Delegation of QI Activities	QI/UM delegation to Kaiser and VSP includes evaluation of QI program activities delegated through quarterly and annual report monitoring	12/31/2022	QI Director	None, Met Goal	**Complete**
L. Annual Review of QI Policies and Procedures	Submit to QI/UM Committee and DHCS	Annually and as necessary	Chief Medical Officer (CMO) / QI Director/Director of Compliance	None, Met Goal	**Complete**
M. QI/UM Committee					
1. Reports and agenda items	Gathered from pertinent departments	Quarterly	Chief Medical Officer (CMO) /QI Director	None, Met Goal	**Complete**
2. Minutes	Attached to next meetings agenda and sent to Board of Directors	Quarterly	Chief Medical Officer (CMO) /QI Director	None, Met Goal	**Complete**
3. Form 700 (Statement of Economic Interests)	Send to all committee members yearly	Initial / Yearly December	Chief Medical Officer (CMO) /QI Director	None, Met Goal	**Complete**
4. PO's and Check Requests	Fill out for each member attending meeting	Quarterly	Chief Medical Officer (CMO) /QI Director	None, Met Goal	**Complete**

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS
N. MCAS Member Engagement & Incentive Program	Conduct at least 3 campaigns using Interactive Voice Recognition, Text messaging and Mailers to contact members with Gaps in Care related to the MCAS measures. Outreach is focused on providing health education or reminders about preventive health measures and incentivizing them with a reward for closing a care gap.	Campaign 1 within 1st quarter Campaign 2 within 2nd quarter Campaign 3 within 3rd quarter	QI Director/Health Education Director	None, Met Goal	**Complete**
O. MCAS Committee	Multi-department committee focused on providing strategic direction and oversight of KHS' level of compliance with the MCAS measures. Committee meets at least quarterl.	12/31/2023	Chief Medical Officer	None, Met Goal	**Complete**
1. Update and disseminate MCAS Provider Guide and MCAS Coding Card for MY2022 MCAS Measures	Update the KHS MCAS Provider Guide to reflect measures for MY2023. The guide provides a definition and specifications for each measure, diagnosis and service codes as applicable and tips for achieving compliance. The guide is made available to all KHS providers accountable to meet these measures. The coding card lists the most commonly used service and diagnosis codes for documenting completion of MCAS measures.	3/31/2022	Director of Quality Improvement/Deputy Director of Provider Network	None, Met Goal	**Complete**
NCQA Accreditation	Complete readiness review to identify gaps in compliance with NCQA accreditation for Medicaid Health Plans and separate accreditation for Health Equity. Establish action plan to remediate accreditation compliance gaps. Initiate carrying out action plan that supports KHS to achieve NCQA accreditation for Medicaid Health Plan and for Health Equity no later than 12/31/2025	12/31/2023	Chief Medical Officer Director of Quality Improvement Chief Health Equity Officer	None, Met Goal	**Complete**
II. UTILIZATION MANAGEMENT - See UM Work Plan					
A. Annual Review/Approval of UM Program Documents by KHS QI/UMC and Board of Directors.	Program Description 2023	4/30/2023	Chief Medical Officer (CMO) / UM Director	None, Met Goal	**Complete**
	Program Evaluation 2022	4/30/2023	Chief Medical Officer (CMO) / UM Director	None, Met Goal	**Complete**
III. CREDENTIALING AND RECREDENTIALING					
A. Initial Credentialing Site Visit & Medical Record	Site and Medical Record Reviews done to validate new provider's compliance with DHCS regulatory requirements. Both reviews must be passed before a provider can be added to the KHS Provider Network.	Ongoing	Chief Medical Officer (CMO) /QI Director	None, Met Goal	**Complete**
B. Organization Providers Quality Assessment	Data Reviews are received from QI/UM/Compliance/MS for any opportunities for improvement identified. QI Department performs review of readmissions within 30 days of discharge and member deaths notifications for potential inappropriate care issues.	Quarterly	Chief Medical Officer (CMO) /QI Director	None, Met Goal	**Complete**
1. Hospitals	Tracking grievances, PIC referrals, Deaths Notifications with potential Quality issues, and a sampling of readmissions within 30 days of discharge for possible quality issues related to readmission	Ongoing	Senior Director of Provider Network	None, Met Goal	**Complete**
2. SNF's	Tracking grievances, PIC referrals, and Deaths Notifications with potential Quality issues	Ongoing	Senior Director of Provider Network	None, Met Goal	**Complete**
3. Home Health Agencies	Tracking grievances, PIC referrals, and Deaths Notifications with potential Quality issues	Ongoing	Senior Director of Provider Network	None, Met Goal	**Complete**
4. Free-Standing Surgery Centers	Tracking grievances, PIC referrals, and Deaths Notifications with potential Quality issues	Ongoing	Senior Director of Provider Network	None, Met Goal	**Complete**

ACTIVITY	DETAIL/TASK	TARGET DATE	ACCOUNTABILITY	Risk	STATUS
5. Impatient MH/SA Facilities	Tracking grievances, PIC referrals, and Deaths Notifications with potential Quality issues	Ongoing	Senior Director of Provider Network	None, Met Goal	**Complete**
6. Residential MH/SA Facilities	Tracking grievances, PIC referrals, and Deaths Notifications with potential Quality issues	Ongoing	Senior Director of Provider Network	None, Met Goal	**Complete**
7. Ambulatory MH/SA Facilities	Tracking grievances, PIC referrals, and Deaths Notifications with potential Quality issues	Ongoing	Senior Director of Provider Network	None, Met Goal	**Complete**
C. Ongoing Monitoring of Sanctions and Complaints	Ongoing; time sensitive; sanctions; grievance process	Ongoing	Senior Director of Provider Network/Director of Compliance	None, Met Goal	**Complete**
D. Credentialing / Recredentialing File Audit	Ongoing KHS/Compliance random audits	Ongoing	Senior Director of Provider Network	None, Met Goal	**Complete**
E. Delegated Credentialing	Delegation will be for hospital based practitioners if hospital is TJC accredited	Annually / as necessary	Senior Director of Provider Network	None, Met Goal	**Complete**
F. Annual Review of Credentialing/Recredentialing Policies and Proc	Ongoing	Annually / as necessary	Senior Director of Provider Network	None, Met Goal	**Complete**
IV. MEMBER RIGHTS AND RESPONSIBILITIES					
A. Statement of Members' Rights and Responsibilities	Review, annually / revise as necessary	Annually / as necessary	Director of Member Services	None, Met Goal	**Complete**
B. Distribution of Rights Statement to Members & Practitioners	As necessary	Annually / as necessary	Director of Member Services	None, Met Goal	**Complete**
C. Complaints and Appeals	Aggregate/analyze/report to QI/UM Committee Quarterly	Quarterly	Director of Member Services	None, Met Goal	**Complete**
D. Grievance Report (HFP)	Report number and types of benefit grievances for previous calendar year - geographic region, ethnicity, gender and primary language	Quarterly	Director of Member Services	None, Met Goal	**Complete**
				None, Met Goal	**Complete**
				None, Met Goal	**Complete**
E. Annual Analysis of Privacy and Confidentiality Policies	Review annually / Revise as needed	Ongoing	Director of Compliance	None, Met Goal	**Complete**
F. Delegation of Members' Rights and Responsibilities Activities	Non-delegated. Grievance committee	N/A	Director of Member Services	None, Met Goal	**Complete**
G. Annual Review of Member Rights Policies and Procedures	Non-delegated	N/A	Director of Member Services	None, Met Goal	**Complete**
VI. MEDICAL RECORDS					
A. Review of Medical Record Documentation Standards	Annually / revise as necessary	2023	Chief Medical Officer (CMO) / Director QI	None, Met Goal	**Complete**
B. Distribution of Standards to New Providers	Ongoing / as necessary	Ongoing	Senior Director of Provider Network	None, Met Goal	**Complete**
C. Audit of Medical Records Documentation	Refer to Credentialing/Recredentialing	Ongoing	Chief Medical Officer (CMO) / Director QI / Senior Director of Provider Network	None, Met Goal	**Complete**
D. Annual Review of Policies and Procedures	Annually and as necessary	Ongoing	Chief Medical Officer (CMO) / QI Director	None, Met Goal	**Complete**
VII. AD HOC PROJECTS					

Kern Health Systems

2024 Quality Improvement Program Work plan

Source	Key Performance Measure	Metrics	Previously Identified Issue	Measurable Goals	Actions/Improvement Activities	Target Date of Completion	Responsible Person
QUALITY PROGRAM STRUCTURE							
NCQA 1A	QI Program Description	QI Program description of committee accountability, functional areas and responsibilities, reporting relationship, resources and analytical support	2023 trilogy documents did not meet NCQA requirements	Annual approval by the QIC and the BOD	Presentation of the QI Program to BOD and QIC for review and approval.	April 15, 2024	QI Director
NCQA 1B	Annual QI Work Plan	Yearly planned objectives and activities	2023 trilogy documents did not meet NCQA requirements	Annual approval by the QIC and the BOD	Presentation of the QI Work Plan to BOD and QIC for review and approval.	April 15, 2024	QI Director
NCQA 1C	Annual QI Evaluation	Summary of completed and ongoing QI activities, trending of results and overall evaluation of effectiveness	2023 trilogy documents did not meet NCQA requirements	Annual approval by the QIC and the BOD	Presentation of the QI Evaluation to BOD and QIC for review and approval	July 31, 2024	QI Director
NCQA; DHCS	Policies and Procedures	Review of organization's policies and procedures	No issues identified	Annual approval by the QIC	Presentation of the QI Evaluation to QIC for review and approval	April 15, 2024	QI Director
NCQA 1A	Quality Improvement Health Equity Committee (QIHEC)	Quarterly meetings and maintenance of minutes	New committee establishing 2024	Conduct quarterly meetings, as required by the QM Program	Meet quorum of voting members +at every meeting	December 31, 2024	QI Director
Quality of Clinical Care							
DHCS	MCAS Measures	18 MCAS measures mandated by DHCS to meet minimum performance levels (MPLs)	KHS placed in red tier status due to overall MCAS rates. Improved from Red Tier to Orange Tier from MY2021-MY2022.	All DHCS- mandated MCAS measures must meet the MPL at the 50th percentile 1. Timely Submission of all 18 measures. 2. Meet MPL for all 18 measures we are held accountable.	Based on the Fishbone diagram submitted to DHCS (RED Tier) a) Data management b) Training and resources c) Collaboration and communication	Q1 - April 30, 2024 Q2 - July 31, 2024 Q3 - November 30, 2024 Q 4 - January 31, 2025	QI Director
DHCS	Performance Improvement Projects (PIPs)		PIP topics are selected based on MCAS performance. Childrens Domain and BH are areas of focus				
	Clinical PIP: The clinical PIP will be focused on Health Equity, specific to the W30 0-15 months African American Population.	2023-2026 performance improvement project (PIP) overseen by HSAG focused on increasing the number of children ages 0 - 15 months old with completing an annual well care visit.	Did not meet MPL for multiple measures in Children's Domain of Care	Use MY2023 W30 (0-15months) baseline data to develop PIP interventions and get Annual Approval by HSAG.	Interventions to be established in 2024	December 31, 2024	QI Director
	Non-Clinical PIP: The non-clinical PIP is specific to the FUA and FUM measures with a heavy reliance on the Behavioral Health department and interventions.	2023-2026 performance improvement project (PIP) overseen by HSAG focused on improving Behavioral Health measures through provider notifications with in 7-days of the ER visits.	Did not meet MPL for FUA and FUM measures	Use MY2023 baseline data to develop interventions that includes a process for notifying PCPs of ED visits for eligible population. Annual Approval by HSAG	Interventions to be established in 2024	December 31, 2024	QI Director
DHCS	Potential Quality of care Issue (PQI)	Monitoring of PQI volume month over month.	No issues identified	Monitor if the volume is below the median value of last 12 months.	Monitor Trending Reports	by the end of every month January 31, 2024 February 29, 2024 March 31, 2024 April 30, 2024 May 31, 2024 June 30, 2021 July 31. 2024 August 31, 2024 September 30, 2024 October 31, 2024 November 30, 2024 December 31, 2024	QI Analyst
		PQI Volume by Provider and by Severity	No issues identified	Monitor Total PQI volume with severity level 2 and 3 is below 30 for rolling 12month period.	Monitor Trending Reports	March 31, 2024 June 30, 2024 September 30, 2024 December 31, 2024	QI Analyst
		PQI Volume by Ethnicity and by Severity	No issues identified	Monitor Total PQI volume with severity level 2 and 3 is below 30 for rolling 12month period.	Monitor Trending Reports	March 31, 2024 June 30, 2024 September 30, 2024 December 31, 2024	QI Analyst
NCQA QI 3	Continuity and Coordination of Medical Care - Transitions of Care:	*Collecting data, identifying improvement opportunities and measuring effectiveness*	No issues identified	Will establish baseline for NCQA requirements	Interventions to be established in 2024	December 31, 2024	QI Director
	a) Movement of Members Between Practitioners	example – consult report received by PCPs	No issues identified	Will establish baseline for NCQA requirements	Interventions to be established in 2024	December 31, 2024	FSR Nurse QI Director
	b) Movement of Members Across	example – post partum rate	No issues identified	Will establish baseline for NCQA requirements	Interventions to be established in 2024	December 31, 2024	QI MCAS Analyst

	Settings	Example – post partum rate		Will establish baseline for NCQA requirements	Interventions to be established in 2024	December 31, 2024	QI Director
NCQA QI 4	Continuity and Coordination Between Medical Care and Behavioral Healthcare –	*Collecting data, identifying improvement opportunities and evaluation of effectiveness that improve coordination of behavioral and general medical care:*	No issues identified	Will establish baseline for NCQA requirements	New NCQA requirement. Will develop initiatives to meet NCQA standards.	December 31, 2024	QI Director
	a) Exchange of information	*Ambulatory Medical Record Review* : Example - Presence of consult reports Example – PCP survey regarding satisfaction with coordination of care with BH practitioners	No issues identified	Will establish baseline for NCQA requirements	New NCQA requirement. Will develop initiatives to meet NCQA standards.	December 31, 2024	QI Director
	b) Appropriate diagnosis, treatment and referral of BH disorders seen in primary care	Example – Antidepressant Medication Management (AMM) Example – Follow-up Care or Children Prescribed ADHD medications (ADD)	No issues identified	Increase MCAS result by 2 percentage points from previous year	New NCQA requirement. Will develop initiatives to meet NCQA standards.	December 31, 2024	QI Director
	c) Appropriate use of psychotropic medications	Examples: AMM ; ADD Analysis of pharmaceutical data for appropriateness of a psychopharmacological medication	No issues identified	Increase MCAS result by 2 percentage points from previous year	New NCQA requirement. Will develop initiatives to meet NCQA standards.	December 31, 2024	QI Director
	d) Management of coexisting medical and behavioral disorders	Example: FUH	No issues identified	Will establish baseline for NCQA requirements	New NCQA requirement. Will develop initiatives to meet NCQA standards.	December 31, 2024	QI Director
	a) Primary or secondary preventive behavioral healthcare implementation	Examples: Data on need for stress management program for adults Data on need for prevention of substance abuse program Data on the need for developmental screening of children in primary care settings Data on the need for ADHD screening of children in primary care settings Data on the need for postpartum depression screening	No issues identified	Will establish baseline for NCQA requirements	New NCQA requirement. Will develop initiatives to meet NCQA standards.	December 31, 2024	QI Director
	b) Special needs of members with serious mental illness or serious emotional disturbance	Example: HEDIS measure Diabetes Monitoring for People with Diabetes and Schizophrenia	No issues identified	Will establish baseline for NCQA requirements	New NCQA requirement. Will develop initiatives to meet NCQA standards.	December 31, 2024	QI Director
Safety of Clinical Care							
DHCS	Facility Site Review	*Conduct on site reviews at the time of initial credentialing or contracting, and every three years thereafter, as a requirement for participation in the California state Medi-Cal Managed Care (MMCD) Program*	*Issues were identified in Critical Elements while conducting FSR.*	Complete FSR and medical record audit of 100% of practitioners due for credentialing or recredentialing	CSR will schedule and complete reviews timely.	March 31, 2024 June 30, 2024 September 30, 2024 December 31, 2024	FSR Nurse
DHCS	Physical Accessibility Review Survey (PARS)	Conduct PARS audit with FSR	No issues identified.	Complete the PARS audit of 100% of practitioners due for credentialing or recredentialing	QP Senior coordinator will schedule and complete all PARS due 2024	March 31, 2024 June 30, 2024 September 30, 2024 December 31, 2024	FSR Nurse
DHCS	Medical Record Review	Conduct medical record review of practitioners due for facility site reviews	Previously identified issues from MRR: 1. Emergency contact not documented 2. Dental/Oral Assessment not documented 3. HIV infection screening not documented	Achieve medical record review score of 85% for each practitioner	CSR will schedule and complete reviews timely.	December 31, 2024	FSR Nurse
Kern	Drug Utilization Review	TAR PAD	None	Turnaround Time Timeliness - reviewed and returned in 1 business day TAR=24hrs PAD=5 days routine 3days=urgent	None	March 31, 2024 June 30, 2024 September 30, 2024 December 31, 2024	Pharmacy Director
NCQA	Credentialing/Recredentialing	Credential/recredential practitioners timely	No QOC trends for provider re-credentialing in 2023 to prevent moving forward from a QI perspective	100% timely credentialing/recredentialing of practitioners	Review of trends for Grievances and PQIs, QOC look back review Q3 years	December 31, 2024	Credentialing staff
Quality of Service							
NCQA; DHCS	Grievance and Appeals	a) Timeliness of acknowledgment letters		Within 5 calendar days		March 31, 2024 June 30, 2024 September 30, 2024 December 31, 2024	Grievance and Appeals Manager
		b) Timeliness of resolution		Within 30 calendar days		March 31, 2024 June 30, 2024 September 30, 2024 December 31, 2024	Grievance and Appeals Manager
DHCS; NCQA	Potential Quality of Care Issues (PQI)	a) Timeliness of acknowledgment letters		Within 5 calendar days		March 31, 2024 June 30, 2024 September 30, 2024 December 31, 2024	Grievance and Appeals Manager
		b) Timeliness of resolution		Within 30 calendar days		March 31, 2024 June 30, 2024 September 30, 2024 December 31, 2024	Grievance and Appeals Manager
NCQA; DHCS	Access to Care - PCP	*PCP access for preventive, routine care, urgent care, and after-hours access* Urgent care – w/in 48 hrs. Routine care – 10 business days	Identified Providers that are noncompliant with appointment availability standards	80%	Provider Accessibility Monitoring Survey	March 31, 2024 June 30, 2024 September 30, 2024 December 31, 2024	PNM
		Access to specialty care Urgent care – w/in 48 hrs. a) Routine care – 15 business days				March 31, 2024 June 30, 2024	

	Access to Care - SCP			80%	Provider Accessibility Monitoring Survey	September 30, 2024 December 31, 2024	PNM
DHCS; NCQA	Telephone access to Member Services	a) Speed of answer		≤ 30 seconds	Perform quarterly telephone access audit	March 31, 2024 June 30, 2024 September 30, 2024 December 31, 2024	Customer Service Manager
		b) Call abandonment rate		5%		March 31, 2024 June 30, 2024 September 30, 2024 December 31, 2024	Customer Service Manager
Members' Experience							
Kern	CAHPS survey	Adult and Child Medicaid Survey	Getting Needed Care scored lowest in the Adult Survey categories	Monitor CAHPS Results and establish baseline for Getting Care needed measure	Trending report on CAHPS results by survey questions	31-Dec-24	QI Analyst Health Education TBD
	Member Engagement / Rewards	Establish year-round, member outreach program focused on members with gaps in care. Redesign MCAS member rewards program to increase motivation for compliance with obtaining preventive health services and follow through with chronic condition self-care.	Did not meet MPL	Increase the included MCAS Measure Rates by 2% points by end of the year.	a) Text Messages to members encouraging the scheduling of their appointments for gaps in care with a focus on: Breast Cancer Screening Blood Lead Screening Initial Health Appointment Chlamydia Screening Cervical Cancer Screening Prenatal & Postpartum Care Well-Care Visits Well-Baby Visits in first 30 Months of Life b) Robocalls will be sent out to members that do not receive text messages FUM Got Approved for incentives for MY2024. FUA is Pending Approval	by end of every month January 31, 2024 February 29, 2024 March 31, 2024 April 30, 2024 May 31, 2024 June 30, 2021 July 31. 2024 August 31, 2024 September 30, 2024 October 31, 2024 November 30, 2024 December 31, 2024	QP Director
Provider Engagement							
Kern	Provider Satisfaction Survey				Trend PSS results by survey questions	December 31, 2024	TBD - PNM
	Provider Incentive Program	Improve HBD Measure rate	KHS placed in red tier status due overall MCAS rates	Improve HBD A1C level	Dr. Duggal began a pilot for members with Diabetes. With this pilot, Dr. Duggal is provided a group of members with uncontrolled Diabetes and help get their A1C controlled with the appropriate interventions. This will be an incentive-based reimbursement structure.	by end of every month January 31, 2024 February 29, 2024 March 31, 2024 April 30, 2024 May 31, 2024 June 30, 2021 July 31. 2024 August 31, 2024 September 30, 2024 October 31, 2024 November 30, 2024 December 31, 2024	QI Coordinator
	Provider education	Improve MCAS Measure Rates	Did not Meet MPL	Meet Providers Quarterly	QI coordinator meet Providers to update them on the MCAS Measure Rate performance	by end of every month January 31, 2024 February 29, 2024 March 31, 2024	PNO representative QI Coordinators

Performance Measure		**Barrier/Opportunity for Improvement**	**Previously Identified Issue**	**Intervention**	**Outcome**	**Outcome**	**Outcome**
Program Structure							
Quality of Clinical Care							
MCAS Measures:	MY 2023 MCAS Results:	Providers close to meeting MPL for MCAS Measure Compliance.	Not Meeting MPL	End of the year push through Provider outreach	Baseline data for MY2023		
AMR	<50th percentile	Monitor Measure performance month over month	Report only for MY2022. No issue	none	TBD		
BCS	<50th percentile	Monitor Measure performance month over month	Met MPL for MY2022. No issue	Measure is part of Member Engagement and Rewards Program	TBD		
CHL	<50th percentile	Monitor Measure performance month over month	Not Meeting MPL	Measure is part of Member Engagement and Rewards Program	TBD		
CCS	<50th percentile	Monitor Measure performance month over month	Not Meeting MPL	Measure is part of Member Engagement and Rewards Program	TBD		
CIS-10	<50th percentile	Monitor Measure performance month over month	Not Meeting MPL	none	TBD		
CBP	<50th percentile	Monitor Measure performance month over month	Report only for MY2022. No issue	none	TBD		
DEV	<50th percentile	Monitor Measure performance month over month	Not Meeting MPL	none	TBD		
IMA-2	<50th percentile	Monitor Measure performance month over month	Not Meeting MPL	none	TBD		
LSC	<50th percentile	Did not meet MPL	Not Meeting MPL	QI Senior Co-ordinators reached out to Top 10 provider that have less than 150 members to complete Lead Screening in Children before the 2 years of age (LSC)	% members successfully completed Lead Screening.		
FUA-30Day follow up	<50th percentile	Monitor Measure performance month over month	Not Meeting MPL	Working with Tele Doc providers for FUA and FUM to schedule a follow-up visit with 30days.	% members successfully completed follow-up visit.		
FUM-30Day follow up	<50th percentile	Monitor Measure performance month over month	Not Meeting MPL	Working with Tele Doc providers for FUA and FUM to schedule a follow-up visit with 30days.	% members successfully completed follow-up visit.		
HBD	<50th percentile	Monitor Measure performance month over month	Met MPL for MY2022. No issue	none	TBD		

PPC-Pre	<50th percentile	Monitor Measure performance month over month	Met MPL for MY2022. No issue	Measure is part of Member Engagement and Rewards Program	TBD		
PPC-Post	<50th percentile	Monitor Measure performance month over month	Met MPL for MY2022. No issue	Measure is part of Member Engagement and Rewards Program	TBD		
TFL-CH	<50th percentile	Monitor Measure performance month over month	Not Meeting MPL	none	TBD		
W30(0-15M)	<50th percentile	Monitor Measure performance month over month	Not Meeting MPL	Measure is part of Member Engagement and Rewards Program	TBD		
W30(15-30M)	<50th percentile	Monitor Measure performance month over month	Not Meeting MPL	Measure is part of Member Engagement and Rewards Program	TBD		
WCV	<50th percentile	Monitor Measure performance month over month	Not Meeting MPL	Measure is part of Member Engagement and Rewards Program	TBD		

KERN HEALTH SYSTEMS

Quality Improvement Health Equity Committee ORGANIZATION CHART 2024

KHS Board of Directors

Governing body of the organization and has final authority and accountability for the KHS Quality Improvement -Health Equity Transformation Program (QIHETP).

- Delegates the responsibility for development and implementation of the QIP-QIHETP to the Chief Medical Officer (CMO)
- The (CMO) has established the Quality Improvement Health Equity Committee (QIHEC) and subcommittees to support organization wide quality improvement activities.
- The CMO and Chief Health Equity Officer (CHEO) oversee the day-to-day management & oversight of the QIHE Program
- The BOD gives final approval of the annual QIP and QIHETP Program descriptions and supporting policies.
- The BOD reviews and approves the annual and quarterly QI and QIHET Work Plans and evaluations which contains measures, activities, and focused studies and outcomes.

Executive Quality Improvement Health Equity Committee (QIHEC)

Oversees Organization-wide Quality Improvement Health Equity Activities.
Chaired by the Chief Medical Officer & Co Chaired by the Health Equity Officers

- **Provides overall direction for the continuous improvement process and monitors that activities are consistent with KHS's strategic goals and priorities.**
- **Reviews critical performance measures and goals related to the QI and Health Equity**
- **Reviews progress reports on work plan activities related to the QI and Health Equity**
- **Tracks identified issues and ensures resolution or improvement.**
- **Analyzes and critically evaluates focused study data and trends such as performance improvement projects.**

SUB-COMMITTEES

Utilization Management Committee

The UM Committee supports the QIC in the appropriate provision of medical services.

- Establish and implement written utilization management protocols and criteria.
- Ensure that UM decisions Are made independent of financial incentives or obligations.
- Develops UM Work Plan
- Develop and implement a monitoring system to track, compile and evaluate patterns and variations in care.

Physician Advisory Committee

The functions of the Physician Advisory Committee (PAC) encompass multiple activities to include,

- Serves as the KHS Credentialing and Peer Review QI Subcommittee,
- Determines the review and approval of clinical criteria sets,
- Review of sentinel conditions or adverse events identified for quality concerns,
- Reviews provider grievances and/or appeals, provider quality issues.

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Population Health Mgmt. Committee

Oversees the operation and mgmt. of the PHM Model of Care (MOC) member health needs at all points in continuum of care,

- Leading strategic analytics, evaluation design, clinical and economic evaluation, and optimizing programing,
- Engages business units from multiple KHS departments.
- Development, execution, monitoring, and evaluation of programs for members across the continuum.

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Grievance & Appeals Review Committee

The GRC is a focused subcommittee of the QIHEC and overseen by the CMO or a designated physician for the purpose of collecting data and reviewing A&G trends to address improvement opportunities in the areas of:

- Provider Network mgmt.
- Access and availability,
- Cultural & Linguistic,
- Pharmacy Services
- Utilization Management.
- PHM

Health Equity Steering Transformation Committee

A subcommittee established to ensure that KHS remains an organization that understands and addresses social and racial justice and health equity to meet member needs. Responsible for implementing organizational wide initiatives that promote awareness of health equity and quality health equity through various internal and external activities or training.

Quality Improvement Health EquityCommittee (QIHEC)

SUBCOMMITTEES CONTINUED

Behavioral Health Advisory Committee

To address opportunities to integrate care and resources for members with mental illness and/or substance use disorder. The committee will support, review, and evaluate interventions to promote collaborative strategic alliance with BH/SUD community providers and Kern County BH.
Activities:

- Initiate seamless referral patterns,
- Data sharing methodologies
- Interdisciplinary ICP planning
- Address access to care barriers.

Pharmacy & Therapeutics Drug Utilization Review

Performs Drug Utilization Review (DUR) and quality monitoring by:

- overseeing medication prescribing practices by contracting providers,
- assesses usage patterns by members and assists with study design and clinical guidelines development.
- Monitors for quality issues regarding appropriate drug use for KHS and members.
- Regularly submits reports to the QIHEC. A KHS Board Member participates in P&T committee.

Access and Availability and Delegation Vendor Oversight Committee

- Responsible for ensuring network capacity requirements and accessibility and transparency align with DHCS and DMHC Access & network requirements by meeting compliance with established quantifiable standards for both geographic distribution and numbers (ratio of providers).
- Performs oversight of Delegation. To vendors Educates KHS Network providers on QIHE Standards

Quality Improvement Committee

- Member Experience
- Provider Experience
- Meeting DHCS MCAS minimal standards or better
- Conducting provider site and medical record reviews
- Completing DHCS-required Performance Improvement Projects (PIPs)
- Investigation of Provider Preventable Conditions
- Trending PQIs to identify opportunities for network improvement.

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Diversity Equity Inclusion Belonging Committee

A task force of diverse staff members who are responsible for helping bring about the cultural, and possibly ethical, changes necessary in the workplace. establish a supportive and welcoming workplace environment in which employees of all backgrounds and demographic characteristics.

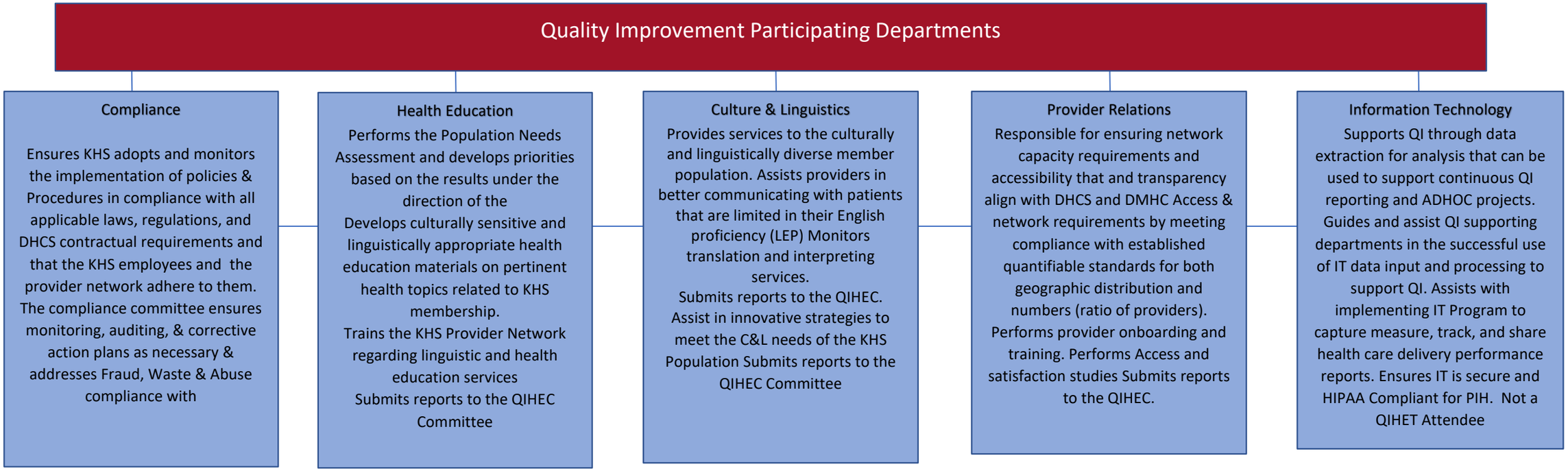
- Increase innovation,
- Foster better decision making,
- Make teams more agile,
- Help achieve better business outcomes,
- Employee engagement.

Public Policy / Community Advisory Committee (CAC) *Stand Alone Committee Delegated by the BOD & Reports Directly to the BOD*

The Public Policy/Community Advisory Committee (PP/CAC) provides a mechanism for structured input from KHS members regarding how KHS operations impact the delivery of their care. The role of the PP/CAC is to implement and maintain community linkages. Activities of the PP/CAC are reported to the QIHEC. Two Members of the KHS BOD are members of the PP/CAC. One PP/CAC committee member serves as the KHS representative to DHCS' Statewide Consumer Advisory Committee. Summaries and actions of the PP/CAC are submitted to the QIHEC Committee by the Director of Member Engagement

FUNCTIONS:

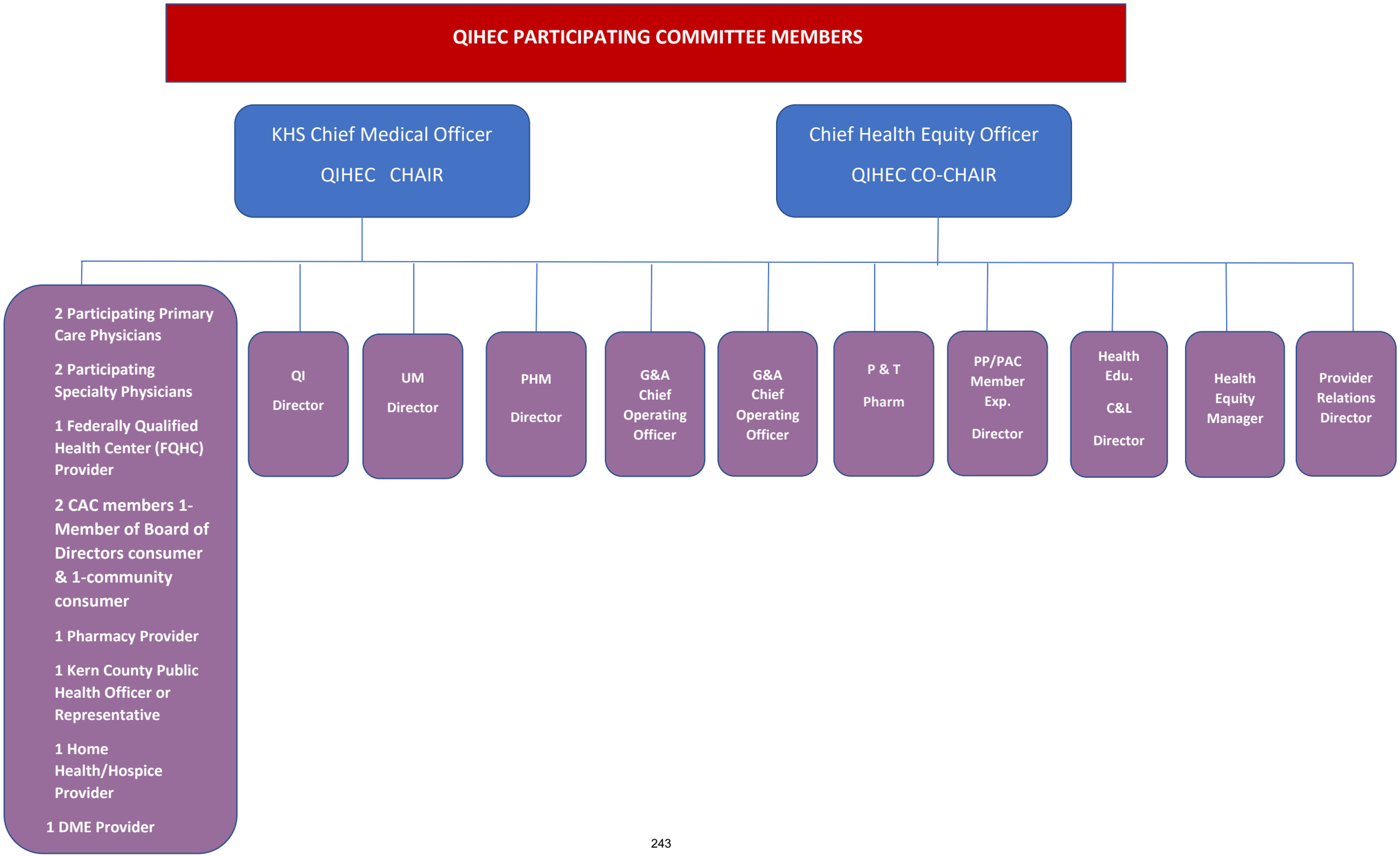
1. Priorities for health education and outreach program
2. Member satisfaction survey results
3. Findings of health education and cultural and linguistic Group Needs Assessment.
4. Plan marketing materials and campaigns.
5. Communication of needs for provider network development and assessment.
6. Community resources and information.
7. Periodically review the KHS grievance processes.
8. Review changes in policy or procedure that affects public policy.
9. Review changes in policy or procedure that affects public policy.
10. Advise on cultural and linguistic issues.
11. Advise on educational and operational issues affecting members who speak a primary language other than English.



Formal WORKPLAN SUBMISSIONS to the QIHEC for Review & Approval & Quarterly and Annual Evaluation

- Utilization Management
- Population Health Management
- Health Equity Transformation
- Quality Improvement

Participating Departments will submit activity reports and updates.


QIHEC PARTICIPATING COMMITTEE MEMBERS
KHS Chief Medical Officer
QIHEC CHAIR
Chief Health Equity Officer
QIHEC CO-CHAIR
2 Participating Primary Care Physicians
2 Participating Specialty Physicians
1 Federally Qualified Health Center (FQHC) Provider
2 CAC members 1-Member of Board of Directors consumer & 1-community consumer
1 Pharmacy Provider
1 Kern County Public Health Officer or Representative
1 Home Health/Hospice Provider
1 DME Provider
QI Director
UM Director
PHM Director
G&A Chief Operating Officer
G&A Chief Operating Officer
P & T Pharm
PP/PAC Member Exp. Director
Health Edu. C&L Director
Health Equity Manager
Provider Relations Director

KERN HEALTH SYSTEMS

To: EQIHEC

From: Beverly Gibbs, Health Services Consultant

Date: 02/08/24

Re: UM Reporting

Background:

UM is focused on ensuring KHS members receive the right care at the right time in the right setting. To achieve this goal, UM works diligently to ensure all department processes are regulatorily compliant, staff is well trained, and all decisions are based made on Medical Necessity.

Discussion:

- 2024 UM Program Description
- 2023 Workplan Evaluation
- 2024 UM Workplan

Fiscal Impact: None

Requested Action: Consideration of proposed documents and 2024 Workplan for approval

UTILIZATION MANAGEMENT

2024 PROGRAM DESCRIPTION

Introduction

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

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

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

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

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

Purpose

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

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

The UMP is a formal Document supported by clinical, operational, and administrative policies and procedures (P&Ps) delineating how UM functions are performed. The UMP and P&Ps are written to adhere to federal and state regulatory requirements to include CA Health & Safety Code, Title 22, Welfare & Institutions Code, CMS Code of Federal Regulations, the CA Department of Health Care Services 22-20202 KHS Contractual Provisions, and current

NCQA Standards and Guidelines. The UM documents are developed through the involvement of actively involved KHS providers in accordance with H&S Code sections 1363.5 and 1367.01 and 28 CCR sections 1300.70(b)(2)(H) and (c).

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

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

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

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

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

UMP Objectives

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

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

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

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

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

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

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

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

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

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

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

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

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

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

There are mechanisms to evaluate the effects of the UM program and process using member and provider satisfaction data, staff interviews and/or other appropriate methods. Identified

sources of dissatisfaction are addressed. When opportunities for improvement are identified, the UMC makes appropriate interventions to change the process.

Statements and Protections

Non-Discrimination Statement

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

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

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

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

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

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

Confidentiality Statement

KHS has established and distributed confidentiality standards to contracting providers in the KHS Provider Policy and Procedure Manual. All provider contracts include the provision to safeguard the confidentiality of member medical and behavioral health care records, treatment records, and access to sensitive services in accordance with applicable state and

federal laws. As a condition of participation with KHS, all contracting providers must retain signed confidentiality forms for all staff and committee members and provide education regarding policies and procedures for maintaining the confidentiality of members to their practitioners. KHS monitors contracting providers for compliance with KHS confidentiality standards during provider facility and medical records reviews and through the Grievance Process.

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

- Members of the UM QI and PAC Committees are required to sign a confidentiality statement that will be maintained in the QI files.
- UM documents are restricted solely to authorized Health Services Department staff, members of the UM, QI, and PAC Committees (PAC performs credentialing conducts Peer Review, Complaints and Grievance, and PQI reviews), and reporting bodies as specifically authorized.
- Confidential documents may include, but are not limited to: UM, QI, and PAC Committees meeting minutes and agendas, QI and Peer Review reports and findings, UM reports, or any correspondence or memos relating to confidential issues where the name of a provider or member are included.
- Confidential documents are stored in locked file cabinets with access limited to authorized persons only, or they are electronically archived and stored on protected drives.
- The confidentiality agreements are maintained in the practitioner or employee files, as appropriate. All peer review records, proceedings, reports and member records are maintained in a confidential manner in accordance with state and federal confidentiality laws.

Health Insurance Portability and Accountability Act (HIPAA)

KHS complies with all applicable HIPAA requirements supported by HIPAA compliance policies. All HIPAA related policies are accessible to UM Physicians and staff on the Kaiser Permanente Intranet compliance site. Ongoing mandatory education is required annually for all staff.

Conflict of Interest Statements

Any individual who has been personally involved in the care and/or service provided to a patient, an event or finding undergoing quality evaluation may not vote or render a decision regarding the appropriateness of such care. All members of the UM, QI, and PAC are required to review and sign a conflict-of-interest statement, agreeing to abide by its terms.

SCOPE of Care Services

The KHS UMP incorporates the monitoring and evaluation for prior authorization, concurrent review, retrospective review, exceptions to prior authorization services and reviews and updates policies and procedures as appropriate at least annually for the following.

- Acute hospital services,
- Subacute services,
- Long-term care including Skilled Nursing Facility (SNF) Care and Rehabilitation Facility services,
- Ambulatory Services,
- Rehabilitative services,
- Emergency and urgent care services,
- Durable Medical Equipment and supplies,
- Ancillary care services, including but not limited to home health care, skilled nursing care,
- Transportation services,
- Selected pharmaceutical services - physician administered drugs (medical drug benefit),
- Laboratory and radiology services,
- Transportation services-Medical and Non-Medical,
- Non-Specialty Mental Health and Substance Use Disorder Services as applicable to KHS contracted scope of coverage in accordance with DHCS KHS 22-20201 Contract Exhibit A. Attachment III,
- Out of Network Care.

Exceptions to the requirement of prior authorization include but are not limited to:

- Primary Care Provider Services,
- Specific OB/GYN services, including midwifes and free-standing birth center facility,
- Abortion Services,
- Dialysis,
- Hospice Care,
- Sexually Transmitted Disease treatments,
- HIV Services,
- Family Planning Services,
- Mental Health evaluations,
- Maternity Care,
- Vision,
- Sensitive Services, both child and adult
- Emergent/Urgent Care, and,
- Other procedures as identified.

Authority and Responsibility

KHS Board of Directors

The Kern Health Systems, the County Health Authority, is an independent public agency that governs Kern Family Health Care. The Board of Directors are appointed by the Kern County Board of Supervisors and includes major healthcare stakeholders, such as physicians, safety-net providers, hospitals, pharmacies, and community representatives. Board meetings are held bi-monthly in: February, April, June, August, October, and December**,** and are open to the public. The Board of Directors (BOD) for KHS assigns the responsibility to lead, direct, and monitor the activities of the UM Program to the KHS Quality Improvement and Utilization Management Committees.

The Board is directly involved with the UM process in the following ways:

- Delegates responsibility for the day-to-day activities and execution of the UMP to the Keren Health System Chief Medical Officer (CMO),
- Approves and supports the UM Program direction, evaluate effectiveness, and resource allocation,
- Appoints individual and/or departments within the KHS organization to provide oversight of the UM Program,
- Evaluate and approve the UM Program Description and UM Program Evaluation annually, providing recommendations as appropriate and track findings.
- Approve the UM policies and procedures needed to maintain the UM Program,
- Receive reports representing UMP activity outcomes, actions taken, and improvements made by the UMC, at a minimum on a quarterly basis.

Program Structure

The UM Program is comprised of various systems and processes which interface with other departments and administrative systems in the delivery of quality and value enhanced care. The link between UM and other clinical and administrative systems must be collaborative to deliver quality care and effective resource management.

The utilization management team of physicians, licensed staff, and unlicensed staff are trained and qualified to assess the clinical information which is used to make utilization management decisions and provide the service within their respective scope of practice. Appropriately licensed health professionals supervise all review decisions.

- KHS utilizes licensed health care professionals to supervise UM activities to:

    a. Provide day to day supervision of assigned UM staff. UM staff who are not qualified health care professionals may approve services when they meet explicit UM auto authorization guidelines under the supervision of a licensed professional
    b. Participate in staff training.

c. Monitor for consistent application of UM criteria by UM staff for each level of UM decision.
d. Monitor documentation for adequacy of relevant clinical information to support non-behavioral, behavioral and /or pharmacy UM decision making.
e. Be available to UM staff on site or by telephone.

- A non-licensed staff may:

a. Review an authorization request against the UM auto approval matrix where no clinical judgment is warranted. If clinical review is warranted, it is routed to the nurse reviewer and to a physician reviewer when further review is needed.

This section outlines the individual program staff and their assigned activities, including approval authority and the involvement of designated physicians.

Chief Medical Officer (CMO)

The Chief Medical Officer is assigned by the KHS BOD to provide oversight of the UMP and UM Department undertakings. He/she holds an unrestricted license to practice medicine in the State of California issued pursuant to Section 2050 of the Business and Professions Code or pursuant to the Osteopathic Act. The CMO is responsible for ensuring that the process by which KHS reviews and approves, modifies, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to KHS members, complies with the requirements of H&S Code 1367.01. The CMO must have the ability to effectively function as a member of the UM team and serves a resource to the UM staff for clinical matters. The CMO is responsible to the Board of Directors to provide medical direction for KHS, including professional input and oversight of all medical activities of the UM Program. The CMO is the UM Committee Chair and or at his or her discretion assigns the UM Chair position to a qualified physician.

The CMO aids with study development and coordination of the UM Program in all areas to provide continued delivery of quality health care for members. The CMO assists the Chief Network Administration Officer with provider network development and works with the CFO to ensure that financial considerations do not influence the quality of health care administered to members. Other responsibilities include but are not limited to:

- Provide direction for all medical aspects of KHS, preparation, implementation and oversight of the UM Program, medical services management, resolution of medical disputes and grievances,
- Principal accountabilities include development and implementation of medical policy for utilization functions, reviewing current medical practices so that that medical protocols and medical personnel of KHS follow rules of conduct, review of UM cases, participation in the UM committee,
- Ensures timely medical necessity review and decisions are made by daily staffing physicians for medical review consultation,
- Evaluates the overall effectiveness of the UM program,

- Evaluates and uses provider and member experience data when evaluating the UM program,
- Ensures that medical decisions are rendered by qualified medical personnel,
- Ensures UM decision making is not influenced by fiscal or administrative management considerations,
- Ensures that the medical care provided meets the current standards for acceptable care,
- Ensure that medical protocols and rules of conduct for practitioner or plan medical personnel are followed.

Medical Director

The Medical Director will provide clinical leadership and guidance in the development and measurement of UM performance improvements and patient satisfaction, and safety and serves as a resource to the UM Department in the day-to-day operations. As determined by the CMO, the Medical Director assists in short-and long-range program planning, total quality management (quality improvement) and external relationships, as well as develops and implements systems and procedures for the medical components of health plan UM and care coordination services.

In collaboration with the Chief Medical Officer and others, the Medical Director creates and implements health plan medical policies and protocols. The Medical Director monitors provider network performance and reports all issues of clinical quality management to the CMO and UM and QI Committees. Additionally, he or she represents the health plan on various committees to include credentialing and re-credentialing of network providers. The Medical Director provides medical oversight into the medical appropriateness and necessity of healthcare services provided to Plan members and is responsible for meeting medical cost and utilization performance targets. Responsibilities include, but are not limited to:

- Participates in carrying out the organization's mission, goals, objectives, and continuous quality improvement of KHS,
- Develops and implements medical policy,
- Resolve grievances related to medical quality of care and service,
- Participates and provide direction in the administration of the QI, UM, and Credentialing Programs by attending committee meetings,
- Detects and corrects inadequate practitioners/provider organizations performance within responsibility level,
- Participates in the development and selection of medical necessity criteria sets used for UM processes,
- Responsible for monitoring and controlling the appropriate utilization of health care services to achieve high quality outcomes in the most cost-effective manner,
- Directly communicates with primary care physicians and other referring physicians to resolve referral issues, research treatment protocols, solicit advice on problem cases, and to assist in development of referral criteria and practice guidelines, and
- Supports, communicates, and collaborates with KHS UM Department staff to ensure efficient UM processes and decision-making practices are compliant,
- Support case managers to resolve case management and referral issues,

- Supports the CMO with projects as assigned.

Director of Utilization Management

, Under the direction of the Chief Medical Officer, the Director of Utilization Management will oversee and participate in activities related to Utilization Management (UM) for the organization and membership by monitoring, assessing, and improving performance in ambulatory and inpatient health care delivery or health care related services. The UM Director will assist in the implementation of the KHS Utilization Management Program Plan and Evaluation and communicate with contract providers regarding required studies and participation. Related duties will include ongoing data collection, medical record reviews, report writing, and collaboration and coordination with other KHS departments, as well as outside agencies.

This position is responsible for collaborative oversight of the Utilization Management functions for KHS. The UM Director will also be responsible for overseeing the production, analysis, and dissemination of contractually mandated reports. This position will assist in ensuring compliance with Medi-Cal contractual stipulations for UM programs. The UM Director will make an effective contribution to KHS's business planning and fiscal processes and will remain clear about departmental objectives and resource requirements. Responsibilities include, but are not limited to:

- Maintains delegated responsibility for activities within the Utilization Management departments,
- Oversees quality of care investigations and reporting,
- Works closely with the Director of Case Management to facilitate needs for members identified as High Risk or requiring coordination of services,
- Ensure coordination of medically necessary services within the plan and with community,
- Coordinates UM activities and data collection between KHS departments and KHS contracted providers,
- Serves as resource to the Quality Improvement and Utilization Management Committee, the Physician Advisory Committee, and other committees, as appropriate,
- Works in a coordinated effort with the UM Health Services Manager and Health Services Program Administrator to ensure the smooth and efficient operations of the outpatient processes,
- Serves as a clinical liaison with contracted facilities and providers and participates in Joint Operations meetings to improve patient care and ensure access standards; Coordinates and conducts in-depth chart analysis, data collection, and report preparation,
- Summarizes information collected for identification of patterns, trends, and individual cases requiring intensive review,
- In coordination with the UM Auditor, performs periodic audits of the Clinical Intake Coordinators and Social Workers of outpatient clinical decisions for appropriateness and accuracy of documentation and summarize and report the results of the audit; and

- Implements and facilitate internal audit studies and work groups for continuous improvement within the organization.

UM Clinical Manager

Under direction of the Director of Utilization Management, this position manages, leads, acts as a subject matter expert, and provides guidance on unit functions and departmental operations, including regarding clinical health outcomes related to population health management, clinical data management and retrieval, reporting standards and State policy and procedure implementation. Develops implements and evaluates clinical programs related to Health Services initiatives. Manages, supervises, mentors and trains assigned staff. Responsibilities include, but are not limited to:

- Direct activities of the Utilization Management staff,
- Oversee staff performance regarding prior authorization, medical necessity determinations, concurrent review, retrospective review, continuity of care, care coordination, and other clinical and medical management programs. These responsibilities extend to behavioral health care services,
- Ensure effective daily operation of the Utilization Management Department utilizing all applicable statutory provisions, contracts and established policies and administrative procedures,
- Maintain optimal staffing patterns based on contractual obligations and current Utilization Management budget,
- Prepare reports and conduct analysis of operations / services as required by departmental, corporate, regulatory, and State requirements,
- Work collaboratively with QI and Pharmacy Departments on identifying required data for reporting,
- Assist in preparation, coordination, and follow up of Utilization Management audits, such as readiness review and DHCS site visits, pertaining to the Utilization Management Department,
- Partner with community agencies and contracted vendors to develop and maintain collaborative contact to assure members have access to the appropriate resources and to avoid duplication of efforts,
- Act as a liaison with outside entities, including but not limited to physicians, hospitals, health care vendors, social services agencies, member advocates, county, and other care entities,
- Participate in coordination of internal and external Provider and Member directed communication regarding issues impacting Utilization Management coordination and delivery, such as medication management, use of generic medications, etc.,
- Establish action plan for assessment and resolution of identified issues,
- Oversee the collaborative efforts of the Supervisors to ensure that all new and existing staff are oriented to organizational and department policies and procedures,
- Ensure that credentials of all licensed staff are verified in accordance with licensing agency initially and prior to expiration date. Maintain current and accurate files of such licensure and ongoing education status,

- Ensure that staff meets minimal skill and clinical knowledge requirements to be successful in assigned role,
- Participate in current process review and development of new and / or revised work processes, policies and procedures relating to Utilization Management responsibilities,
- Provide input into the development of educational material and programs necessary to meet business objectives, members' needs, contractual and regulatory guidelines, and staff professional development,
- Comply with Corporate, Federal, and State confidentiality standards to ensure the appropriate protection of member identifiable health information.

Health Services Manager

The Health Services Manager reports to the Director of Utilization Management and is responsible for the daily management, evaluation, and operations of the health services administrative processes, provide supervisory support to Utilization Management (UM) staff and assist with defining and creation of reports in collaboration with the, UM Analyst/Trainer, and Non clinical staff.

This position will work with the administrative support staff to promote the delivery of quality health care to Kern Health System (KHS) members through comprehensive case management, compliance with KHS policies and procedures, and maintenance of a positive and safe work environment leading to maximum departmental efficiency, accuracy, and quality. Responsibilities include but are not limited to:

- Supervise the functions and activities of the clerical support staff,
- Monitors and reports production and quality of work by clinical and clerical staff,
- Works with clerical staff to achieve production, timeliness, and quality of work,
- Participate with Inter-departmental process improvement teams and planned quality management,
- Assist with development and formalization of departmental budget,
- Assist with development and updating of UM criteria, guidelines, and policies,
- Monitor UM processes for efficiency and accuracy, identifying required changes and coordinating the implementation of required changes,
- Train staff, as appropriate, regarding use of the Medical Management systems,
- Generates reports for CMO and Chief Health Services Officer to support business decisions,
- Research and analyze qualitative and quantitative data, prepare statistical reports, and submit final report to the state contract manager in conjunction with KHS departmental analyst(s) and Senior Health Services Program Administrator,

UM Outpatient Clinical Supervisor

The UM Outpatient Clinical Supervisor reports to the Utilization Management and is responsible for supervising the functions and activities for clinical level positions associated with Outpatient Medical, Behavioral, Mental Health, and Social Services within the UM

Department. The UM Outpatient Clinical Supervisor will work in a coordinated effort with the Director of UM to ensure smooth, efficient, and productive operations within the UM Department, This position will work closely with the KHS Chief Medical Officer and Medical Director(s) in the smooth and efficient operation of the referral and inpatient clinical decision-making process. KHS uses licensed health care professionals to make UM decisions that require clinical judgment. Responsibilities include, but are not limited to:

- Educate and develop UM nursing staff regarding organizational policies, procedures and UM decision making skills,
- Monitor the UM process for efficiency and accuracy, identifying required changes and coordinating the implementation of required changes,
- Participation on inter-departmental process improvement teams and KHS quality management,
- Monitor UM nursing staff (clinical and non-clinical) referral and documentation for accuracy and appropriateness,
- Supervise staff who are not qualified health care professionals when there are explicit UM criteria and no clinical judgment is required, e.g., auto-approvals,
- Coordinate training of staff within the Interrater Reliability Review Tool to all clinical staff, including CMO and Medical Directors to facilitate consistent decisions based on evidence-based guidelines,
- Supervise the appropriate case management in compliance with UM guidelines and KHS Policy and Procedures,
- Monitors and reports production and quality of work by outpatient clinical staff,
- Works with staff to achieve production, timeliness, accuracy, and quality of work,
- Summarize and prepare necessary production reports for management,
- Perform periodically scheduled audits of outpatient clinical decisions for appropriateness and accuracy of documentation,
- Serves as a clinical liaison with contracted facilities and providers and participates in Joint Operations meetings to improve patient care and ensure access standards,
- Ensure coordination of medically necessary services within the plan and with community,
- Remain current with Department of Health Care Services and Department of Managed Care policy implementation or revisions,
- Act as clinical liaison with Member Services, Claims, MIS, and Provider Relations on referral data entry functions.
- Availability to UM staff onsite or by telephone.

<u>UM Inpatient Clinical Supervisor</u>

The UM Inpatient Clinical Supervisor reports to the Director of Utilization Management and is responsible for supervising the functions and activities for clinical level positions associated with Inpatient Medical, Mental, Behavioral, and Social Services within the UM Department. The UM Inpatient Clinical Supervisor will work in a coordinated effort with the Director of UM to ensure smooth, efficient, and productive operations within the UM Department, This position will work closely with the KHS Chief Medical Officer and Medical Director(s) in the

smooth and efficient operation of the referral and inpatient clinical decision-making process. Responsibilities include, but are not limited to:

- Educate and develop UM nursing staff regarding organizational policies, procedures and UM decision making skills,
- Monitor the UM process for efficiency and accuracy, identifying required changes and coordinating the implementation of required changes,
- Participation on inter-departmental process improvement teams and KHS quality management,
- Monitor UM nursing staff referral and documentation for accuracy and appropriateness,
- Coordinate training of staff within the Interrater Reliability Review Tool to all clinical staff, including CMO and Medical Directors to facilitate consistent decisions based on evidence-based guidelines,
- Supervise the appropriate case management in compliance with UM guidelines and KHS Policies and Procedures,
- Monitors and reports production and quality of work by inpatient clinical staff,
- Reviews decisions regarding hospital admissions and length of stay, and outpatient procedures for all care delivered to the KHS membership as related to coordination of services upon discharge,
- Assists with coordinating discharge planning activities with facility discharge planners,
- Benefits interpretation to include coordination of care for medically necessary services that are not covered under the KHS Plan e.g., CCS, Mental Health, Long Term Care, State Waiver Programs,
- Works closely with the Transitional Care team to facilitate needs for members identified as High Risk or requiring coordination of services,
- Identify members who may quality for the Health Homes Program,
- Assist the UM clinical staff in the review of claims for the accuracy and appropriateness of billed charges,
- In coordination with the UM Clinical Auditor, perform periodic audits of the UM Nurse RN of inpatient clinical decisions for appropriateness and accuracy of documentation and summarize and report the results of the audit,
- Works with staff to achieve production, timeliness, accuracy, and quality of work,
- Summarize and prepare necessary production reports for management,
- Perform periodically scheduled audits of inpatient clinical decisions for appropriateness and accuracy of documentation,
- Serves as a clinical liaison with contracted facilities and providers and participates in Joint Operations meetings to improve patient care and ensure access standards,
- Ensure coordination of medically necessary services within the plan and with community,
- Remain current with Department of Health Care Services and Department of Managed Care policy implementation or revisions,
- Act as clinical liaison with Member Services, Claims, MIS, and Provider Relations on referral data entry functions.

UM Nurse and Clinical Intake Coordinators (RN)

Under the direction of the Kern Health Systems (KHS) Director of Utilization Management, the UM Nurse and Clinical Intake Coordinators will promote coordination and continuity of care and quality management in both the inpatient and ambulatory care settings by the review of referrals and authorization of payment for specialty care and ancillary services. The UM Nurse and Clinical Intake Coordinators are supported by a non-clinical team for administrative duties and coordination. The review will evaluate the appropriateness of care using established criteria and Plan benefit guidelines. Review will be conducted on a prospective, concurrent, and retrospective basis. The UM Nurse and Clinical Intake Coordinators manages the required caseload monthly. Responsibilities, include, but are not limited to:

- Promote coordination and continuity of care and quality improvement in both the inpatient and ambulatory care setting,
- Evaluate the appropriateness of care using established criteria and KHS' benefit guidelines,
- Support KHS developed programs through member identification for participation, i.e., Diabetic Clinic, Health Home, Complex Case Management, Recuperative, Palliative, Transitional Care, Health Home, and Social Worker interventions,
- Review and approve specialty and ancillary service referrals using established criteria for purposes of pre-authorization of payment,
- Review and approval of hospital admissions and length of stay, and outpatient procedures for all care delivered to the KHS membership,
- Coordinates discharge planning activities with facility discharge planners,
- Benefits interpretation to include coordination of care for medically necessary services that are not covered under the KHS Plan e.g., CCS, Long Term Care, State Waiver Programs,
- Participates in UM and QI data and statistical gathering, collation, and reporting; and
- Assess for over and underutilization and identify potential fraud, waste, and abuse.

Clinical Auditor/Trainer (RN)

Under the direction of the Director of Utilization Management, the UM Clinical Auditor and Trainer RN is responsible for reviewing Utilization Management (UM) policy and guidelines to ensure staff compliance with policies. Responsibilities include ensuring coordination of services not only within inpatient and outpatient groups, but also between the groups and community. Perform audits on various project reports, Notice of Action notifications, and referrals for compliance. Responsible for reporting findings to management for review and possible corrective action. Provide recommendation for process improvement and assist with action plans for making those corrections. The Clinical Auditor and Trainer RN will work in a coordinated effort with UM Clinical Supervisor(s), Health Services Manager, and Business Analyst to ensure smooth, efficient, and productive operations within the UM Department as directed by the Director of Utilization Management. This position will work closely with the Chief Medical Officer and Medical Director(s) in the smooth and efficient operation of the referral and inpatient clinical decision-making process. Responsibilities include, but are not limited to:

- Train other UM clinical licensed staff as appropriate regarding use of all platforms and core adjudication system as it relates to the UM process,
- Develop and implement staff training for new and existing employees along with internal findings,
- Responsible for written and verbal communication with contract providers and internal KHS staff to promote timely coordination of care and dissemination of KHS policies and procedures,
- In coordination with the UM Senior Auditor/Analyst, perform spot audits of performance of UM Clinical Intake Coordinators and Social Workers and summarize and report the results of the audit to UM Management for process improvement,
- Perform periodic spot audits of inpatient and outpatient clinical decisions for appropriateness and accuracy of documentation,
- Assists in data collection and compilation, of various committee and quarterly reports; and
- Summarize and prepare necessary production reports for management.

Claims and Disputes Review Nurse (RN)

Under the direction of the Director of Utilization Management and in coordination with the Kern Health Systems (KHS) Chief Medical Officer or designee, the Medical Claims Review RN will be responsible for retroactive review of medical service claims and disputes for payment and medical necessity following accurate contract and non-contract guidelines for both Inpatient and Outpatient services. The review will evaluate the appropriateness of care using established criteria and Plan benefit guidelines. Responsibilities include, but are not limited to:

- Reports, track and documents all claims, and disputes review activity in appropriate programs such as QNXT, as well as specially developed internal logs for tracking and trending purposes,
- Perform retro review and approval of specialty and ancillary services referrals using established criteria for purposes of payment,
- Perform retro review and approval of hospital admissions and length of stay, and outpatient procedures for all care delivered to the KHS membership,
- Benefits interpretation to include coordination of care for medically necessary services that are not covered under the KHS Plan e.g., CCS, Long Term Care, State Waiver Programs.

Long Term Care Nurse Reviewer (RN)

Under the direction of the Director of Utilization Management and in coordination with the Kern Health Systems (KHS) Chief Medical Officer or designee, the Long-Term Care Nurse reviewer performs a comprehensive assessment and ongoing reassessments for members referred for long term care (LTC) placement. The assessment process evaluates benefit and medical necessity application of criteria to assure that the member is placed in a health care facility that provides the level of care most appropriate to the member's medical needs. Considerations for placement include:

- Self-determined directive of the member/care giver for the placement,

- Geographical location of placement to maintain members in the community of their choice,
- The unique medical and psychosocial needs of the member,
- Exhaustion of community options/settings to safely maintain the member's health.

Essential Functions:

- Conducts remote and or onsite assessments of member (s) for comprehensive health re-assessments regarding clinical, behavioral and ADL requirements,
- Communicates with LTC Staff and attending health care providers involved in care of the member to coordinate TAR service requests by obtaining complete and accurate information as needed,
- Collects information concerning ongoing eligibility,
- Coordinates with Care Management team and provides updates regarding member health status,
- Participates in collaboration as necessary in member case management and ICT conferences,
- Adheres to all HIPPA standards and confidentiality requirements.

Analyst/Trainer – Removed Senior.

The purpose of this position is to provide support to the UM Management team for report generation, data collection for providing to the UM Clinical Auditor for review. Based on feedback from the UM Auditor, management, and clinical staff, assist in training criteria for staff improvement along with providing one-on-one training to improve staff efficiencies. Responsibilities include, but are not limited to:

- Performs utilization management activities related to data collection, data review and report preparation per KHS Utilization Management Program,
- Assists in the reporting of DHCS and DMHC required reports and Utilization Management's quality studies to meet State contractual requirements,
- Develop and implement staff training for new and existing employees along with internal findings as it relates to the duties of Utilization Management.

Auditor/Analyst (Removed Senior)

This position provides the vital link between inpatient and outpatient as it relates to case managing members moving from hospital to home care. This position will ensure that processes are in place and followed in support of all members seeking care. This is a proactive audit of UM processes as they are in motion to catch and prevent errors. This position will link the social worker, case managers and medical directors in direct support of members under case management. Responsibilities include, but are not limited to:

- Performs audit of staff referral processing as it relates to compliance, accuracy, and performance levels,

- Reviews available reports and data to analyze the accuracy of staff performance as it relates to timeliness of referral processing, accuracy of data entry and appropriateness of decisions,
- Prepares State mandated report requirements as scheduled by the DHCS for management review and approvals,
- Reviews post-activity audit findings to UM Management to ensure compliance and to review where further training opportunity exist.

Director of Pharmacy

Qualifications for the Pharmacy Director include possession of a California State Board of Pharmacy registered pharmacy license, two years of health plan related pharmacy experience at a supervisory level or four years of pharmacy practice in a similar setting as a hospital or group purchasing organization. This position reports to the Chief Medical Officer (CMO).

KHS performs drug utilization reviews (DUR) to provide oversight of prescribed medications. DUR is a structured, ongoing program that evaluates, analyzes, and interprets drug usage against predetermined standards and undertakes actions to elicit improvements and measure the results. The objectives of DUR are to improve the quality of patient care by assuring safe and effective drug use while concurrently managing the total cost of care. Responsibilities include, but are not limited to:

- Participates and serves as the Chairperson on the Pharmacy & Therapeutics/Drug Utilization Review (P&T/DUR) Committee,
- Medication coverage management Development of applicable policies and guidelines Drug utilization review,
- Drug prior authorization for medications covered under the medical benefit,
- Implementation of cost-effective utilization management measures for medications covered under the medical benefit,
- Participation in provider education initiatives such as academic detailing with plan physicians,
- Assisting with development of Clinical Practice Guidelines,
- Other duties as assigned by the Chief Medical Officer,
- Coordination for opioid prescriptions and safeguards to prevent overutilization,
- Creation of clinically efficacious and cost-effective management programs,
- Development, implementation, and monitoring of clinical strategies to improve quality of care for members as well as provide clinical consultative services to contracting providers and KHS staff as necessary to support clinical programs,

Behavioral Health Director

The KHS Behavioral Health Director is an LFMT who is actively involved in implementing and evaluating the behavioral health aspects of the UM program supported by a PsyD BH Provider for clinical input. This Director provides administrative oversight of KHS's behavioral health activities including coordinating substance use services, behavioral health screening processes and collaborates with the DHCS managed behavioral health

organization(s) designated to provide specialty mental health services to Kern members. The Behavioral Health Director works in tandem with the various department, UM, Health Education, Health Equity, quality Management in supporting behavioral delivery of services optimally. The assigned activities for this position include:

- Supports quality improvement activities applicable to behavioral health,
- Facilitates network adequacy,
- Participates in collaborative department activities processes,

Behavioral Health Clinical Provider

Is a Licensed PsyD and supports the Behavioral Health Director with clinical matters pertaining to BH as follow:

- Reviews UM behavioral cases and evaluates behavioral health treatment services requests,
- Reviews BH treatment requests for autism spectrum disorders,
- Assists in the selection and distribution of BH educational resources and information to support primary care providers in BH processes,
- Serves on the QI, UM, Pharmacy and Therapeutics and Credentials Committees and Internal Quality Improvement committee including Substance Use Internal Quality Improvement Subcommittee
- Involved in the review, update and approval of behavioral health criteria

Committees

Utilization Management Committee

The Utilization Management (UM) Committee is established as a standing sub-committee of the KHS Quality Improvement Committee and reports to the Governing Board through the Standing Committee. The Committee structures and processes are clearly defined, and responsibility is assigned to appropriate individuals. The UMC is reliant on the involvement of appropriate, actively practicing practitioners representing primary and specialty care. A quorum of at least 3 physicians must be present at each meeting. The UM Committee meets on a regular basis, at least quarterly. Only physicians have voting privileges on the UM Committee. Additional UM Committee meetings or subcommittee meetings are scheduled at the discretion of the UM Committee Chairman. The UM Committee members serve a two-year term with the possibility of reappointment, and terms are staggered to allow for continuity on the Committee. During the period of time between UM Committee meetings, the Medical Director or physician designee may function as an interim decision-maker to resolve any UM issues that may need expediting.

Minutes of committee actions are documented and maintained.

The Utilization Management Committee oversees the implementation of the UMP and promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UM

Committee is multi-disciplinary and monitors continuity and coordination of care as well as under and overutilization of services. Any perceived or actual utilization management problems are reviewed by the UM Committee. The Quality Improvement and Utilization Management Committees work together on overlapping issues. The responsibilities of the UMC are to develop, recommend, and refine the UM program policies and procedures, including medical necessity criteria, establishment of thresholds for acceptable utilization levels, and reliability of clinical information. and develop and implement a monitoring system to track, compile and evaluate UM measures against pre-established standards and the identification of over and under and utilization patterns.

Key Activities include:

1. Establish and implement written utilization management protocols and criteria applicable to the review of medical necessity for institutional, ambulatory, and ancillary services.
2. Ensure that UM decisions:
    - Are made independent of financial incentives or obligations,
    - Medical decisions, including those by delegated providers and rendering providers, are not unduly influenced by fiscal and administrative management,
    - Physician compensation plans do not include incentives for denial decisions,
    - Physician and UM decision designees are not rewarded for utilization review decisions.
3. Educate staff, contracted practitioners, and vendors on KHS utilization management policies and procedures to ensure compliance with the goals and objectives of the Utilization Management Program.
4. Review established nationally acceptable utilization benchmarks, medical literature, and outcome data, as applicable.
5. Develop and implement a monitoring system to track, compile and evaluate patterns and variations in care.
6. Initiate necessary procedural revisions to prevent the recurrence of problematic utilization issues.
7. Identify specific services that are over-utilized or under-utilized and develop appropriate responses to these findings.
8. Continually monitor and evaluate utilization practice patterns of staff and contracted practitioners and vendors and identify variations in care.
9. Review state regulatory oversight of LTC and CBAS facilities.
10. Develop and maintain a process to identify and address quality issues for submission to QI and credentialing, recredentialing and ongoing monitoring process.
11. Develop and maintain effective relationships with linked and carved-out service providers available to members through County, State, Federal and other community-based programs to ensure optimal care coordination and service delivery.
12. Facilitate and ensure continuity of care for members within and outside of KHS network.
13. Develop and implement performance measures to assure regulatory turn-around-time frames are met.

UMC Reports

Oversight of Utilization of services through review of reports regarding major aspects of the Utilization Management Program of the Plan. The analysis of, and the actions taken in respect to, these reports are submitted quarterly to the UMC. They are prepared by various UM Department designees for presentation. Such reports may include, but are not limited to, the following:

a. Quarterly Utilization Management Work Plan Metrics with Quantitative and Qualitative analytics measured against industry and KHS internal benchmarks & Goals,
b. Summaries of UM Program updates,
c. Behavioral Health,
d. Pharmacy,
e. Updates / revisions to UMP policies and procedures,
f. Criteria for UM decision-making,
g. Status of completed and on-going UM activities,
h. Organizational changes made throughout the year,
i. Inter-Rater Reliability Audits,
j. Response to new legislation that affect the UM process,
k. Analysis of the outcomes of improvement activities,
l. Under and Over Utilization Studies,
m. Barriers encountered which defer or delay the achievement of UM goals,
n. Evaluation of overall effectiveness of the UM program,
o. Satisfaction surveys,
p. UM auditing activities,
q. UM/QI Interface Activities,
r. UM/ Credentialing Interface Activities.

Utilization Management and Quality Improvement Interface

The Utilization Management Committee and Quality Improvement Committee interact to ensure that services delivered and managed are of high quality and are appropriate, cost-effective, efficient, and accessible. The UMC employs a system of reporting utilization information and identifying areas of service such as medical, surgical, ancillary, pharmacy, and behavioral health. Through the aggregation and evaluation of UM data, when patterns of care or service issues suggest they are inappropriate or deviate from industry standard, they are reported for further evaluation to the QI Committee.

The QI Committee performs oversight of UM activities conducted by KHS to maintain quality health care and effective and appropriate control of medical costs through monitoring of medical practice patterns and utilization of services. This committee also develops and enforces the quality improvement process with respect to contracting providers, and other health plan functional areas with oversight by the CMO.

Key components of the QI Program structure and requirements include the continuous review of the quality of care provided to members, to assure that quality, comprehensive health care,

and services are provided to KHS members through an ongoing, systematic evaluation and monitoring process that facilitates continuous quality improvement to include:

- A level of care which meets professionally recognized standards of practice is being delivered to all members,
- Quality of care problems are identified and corrected for all provider entities,
- Physicians and appropriate licensed behavior providers to include psychologists are an integral part of the QA program,
- Appropriate care which is consistent with professionally recognized standards of practice is not withheld or delayed for any reason, including a potential financial gain and/or incentive to the plan providers, and/or others; and
- KHS does not exert economic pressure to cause institutions to grant privileges to health care providers that would not otherwise be granted, nor to pressure health care providers or institutions to render care beyond the scope of their training or experience.

The scope of the UM licensed staff extends beyond the management of referrals. While performing UM activities, any quality-of-care concerns may be addressed with the practitioners or provider organizations and are reported to the QI department. Collaboration between UM and QI is essential to ensure the delivery of quality care to the plan's membership. The UM team supports QI efforts in the identification of potential quality of care issues, reporting adverse occurrences identified while conducting UM case review, improvement of Healthcare Effectiveness Data and Information Set (HEDIS®) scoring by referrals to care coordination, and care coordination efforts to ensure members are seen by the appropriate provider for their condition.

Through UM data aggregation and analytics when adverse QI patterns are discovered they will be submitted to the QI Committee through formal reports for review and to make recommendations and take action as are necessary to ameliorate the conditions. These activities will be documented in the meeting minutes.

Data Sources

KHS has identified the following as sources that may provide useful and meaningful data for analyzing compliance with standards of utilization as well as those of quality:

a. Access to care studies,
b. Providers' telephone triage systems,
c. Medication utilization reports for prescription medications,
d. Institutional Data,
e. Claims Data,
f. Referral Patterns,
g. Timeliness of Service,
h. Ancillary Service utilization,
i. Outpatient Data,
j. Member Complaints/Grievances,
k. Appeals Review,
l. Provider surveys,

m. Satisfaction surveys,
n. Care follow-up, especially ER and Urgent Care facilities,
o. Medical Records Reviews.

Physician Advisory Committee (PAC)

The functions of the Physician Advisory Committee (PAC) encompass multiple activities related to UM and QI to include, serving as the KHS Credentialing and Peer Review QI Subcommittee, overseeing and determining the review and approval of medical technologies and clinical criteria sets, addressing and managing the review of sentinel conditions or adverse events identified for quality concerns, and evaluates as necessary the need to add practitioners to the KHS network, based upon requirements by DHCS, DMHC, CMS, or applicable law. The PAC is actively involved in the establishment of policies related to KHS Code of Conduct, Protected Health Information (PHI) and Fraud Waste and Abuse (FWA). The PAC is comprised of a broad spectrum of KHS participating physician representatives from primary and specialty care and includes at least one behavioral health provider. The PAC is also involved in developing, adopting, and reviewing criteria. All protocols, technology, and criteria sets are reviewed and approved or modified as needed on current clinical and medical evidence

PAC- Credentialing and Peer Review

In accordance with state law, minutes will not be submitted but rather a summary of the meeting. The minutes are confidential information protected under California Evidence Code 1157. The responsibilities of the Credentialing/Peer Review Committee are to develop, monitor, and maintain standards for the education, training, and licensure of the KHS network of Participating Practitioners and Health Delivery Organizations, and establish and maintain credentialing/re-credentialing policies and procedures that are consistent with National Committee for Quality Assurance (NCQA) standards, as well as applicable State and Federal laws and regulations. UM information is shared with the PAC. The PAC may not base credentialing decisions on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or patient type in which the practitioner specializes.

Activities:

1. Maintain a well-credentialed network of providers and practitioners based on recognized and mandated credentialing standards,
2. Promote continuous improvement in the quality of the care and service provided by the KHS Providers,
3. Investigate patient, member or practitioner complaints or concerns about the quality of clinical care or service provided and to make recommendations for corrective actions, if appropriate.
4. Provide guidance on the overall direction of the credentialing program,
5. Review at least annually the Credentialing Committee Program Description to assure that the program is comprehensive, effective in meeting the goals and standards of KHS credentialing/ recredentialing procedures and supports the Continuous Quality Improvement process,

6. Evaluate quality concerns related to medical care and make determinations as to whether there is sufficient evidence that the involved practitioner failed to provide care within generally accepted standards,
7. Monitoring the reporting of Provider Preventable Conditions.

PAC-Medical Technologies and Clinical Criteria Sets

1. The PAC uses principles of evidence-based medicine in its evaluation of clinical guidelines oversight and monitoring of the quality and cost-effectiveness of medical care provided to KHS members. PAC also reviews and modifies all protocols, technologies, and criteria sets as needed based on current clinical, and medical evidence.
2. Preforms reviews of technologies for use by medical and behavioral staff in the utilization review process,
3. Outlines the medical necessity criteria for coverage for a specific technology, service, or device and as applicable incorporates Federal and State regulations,
4. Ensures KHS does not exert economic pressure to cause institutions to grant privileges to providers that would not otherwise be granted, nor to pressure providers or institutions to render care beyond the scope of their training or experience,
5. Assess standards of health care as applied to members and providers, assist with development of indicators for studies and review guidelines that are promulgated to contracting providers.

PAC-Code of Conduct, Confidentiality, and Fraud Waste and Abuse

The PAC is instrumental in participating in the establishment and maintenance of:

1. Confidentiality policies and procedures for protection of confidential member, practitioner, and provider information in accordance with applicable state and federal regulations,
2. Protection of member identifiable health information by ensuring members' protected health information (PHI) is only released in accordance with federal, state, and all other regulatory agencies,
3. Providing oversight in strategies to reduce FWA in provider networks.

Reporting Relationship

- The PAC reports recommendations to the QI and UM Committee quarterly,
- The QI and/UM Committees report PAC recommendations to the Board of Directors quarterly through the Chief Medical Officer or their designee.

Pharmacy and Therapeutics/Drug Utilization Review Committee (P&T/DUR)

Key Responsibilities

- Objectively appraise, using principles of evidence-based medicine to evaluate and select pharmaceutical products. This is an ongoing process to ensure the optimal use

of therapeutic agents. Products are evaluated based on efficacy, safety, ease of use and cost;

- Evaluate the clinical use of medications and develop policies for managing drug use and administration;
- Monitor for quality issues regarding appropriate drug use for KHS and members. This includes Drug Utilization Review (DUR) and Drug Use Evaluation (DUE) programs;
- Provide recommendations regarding protocols and procedures for the use of non-preferred medications;
- Provide recommendations regarding educational materials and programs about drug products and their use to contracting providers;
- Recommend disease state management or treatment guidelines for specific diseases or medical or behavioral health conditions. These guidelines are a recommended series of actions, including drug therapies, concerning specific clinical conditions;
- Monitor and assess contracting pharmacy activities as needed through review of audits and pharmacy profiling;
- Review elements and format of the preferred drug lists, including prior authorization lists;
- Review parameters of prescribing practices for frequency of refills and the number of refills that may be dispensed at one time;
- Make recommendations to the QI/UM Committee for prescribing parameters;
- Review quality of care issues that arise pertaining to the prescribing and dispensing of medications;
- Report to the QI/UM Committee situations that may indicate substandard quality of care.

Membership

1	KHS Chief Medical Officer (Chairperson) or designee
1	KHS Director of Pharmacy (Alternate Chairperson)
1	KHS Board Member
1	Retail/Independent Pharmacist
1	Retail Chain Pharmacist
1	Specialty Practice Pharmacist
1	Geriatric Practice Pharmacist
1	Geriatric Practice Physician
1	Pediatrician
1	Internist
1	PCP/General Practice Medical Doctor
1	OB/GYN Practitioner
1	BH Provider MD or PsyD
1	Provider at Large

Reporting Relationship

- The P&T meets quarterly with additional meetings as necessary.
- The P&T/DUR reports recommendations to the QI and UM Committee quarterly,

Utilization Management Process

Medical Necessity and Clinical Criteria

The KHS UM Program and contracted entities in accordance with KHS performing utilization management review functions utilize nationally recognized evaluation criteria and standards that are objective and based on medical evidence in making decisions to approve, modify, defer, deny, or terminate services. KHS has specific criteria to determine the medical necessity and clinical appropriateness of medical, behavioral, and pharmaceutical services requiring approval. The criteria or guidelines are:

- Developed with involvement from actively practicing health care providers (behavioral and non-behavioral), including non-staff network practitioners to apply, adopt, and review criteria

- All criteria sets will be reviewed and evaluated, updated, and modified as necessary, at least annually and when appropriate by the Physician Advisory Committee (PAC) and the QI/UM Committee.

- Any new criteria that KHS would like to adopt will be subjected to review and evaluation by the PAC and the QI/UM Committee prior to its approval and implementation by the organization.

Regulations and Criteria Guidelines (Hierarchy of Criteria)
KHS Physician Reviewers will use the hierarchy of KHS UM criteria to make UM decision in the following order:

1. Health Plan eligibility and coverage
2. Federal and state mandated criteria

    - California Code of Regulations Title 22,
    - California Code of Regulations Title 28,
    - CMS Code of Regulations Title 42,
    - California Health and Safety Code §§1363.5; 1367.01; 1371.4; 1374.16,
    - Medi-Cal Provider Manuals,
    - CA DHCS All Plan Letters (APL),
    - DMHC All Plan Letters,
    - CA DHCS Policy and Procedure Letters (PPL),
    - 42 CFR section 438.915, 438.206.
    - Standardized Behavioral Health criteria (Title 9, DSM-V)

3. Nationally recognized criteria set

- MCG Health LLC (Milliman Care Guidelines,)
- UpToDate

4. Peer Reviewed Journal or Published Resources

In January 2019, a new law was passed requiring the Medi-Cal pharmacy benefits and services to be administered by the Department of Health Care Services in the fee-for-service delivery system, known as "Medi-Cal Rx.". With the exception of medically administered drugs, pharmacy is carved-out to DHCS.

UM decision making criteria shall be available to the public upon request. When making UM determinations KHS shall disclose the criteria or guidelines for the specific procedures or conditions requested. If it is determined to apply charges in disclosing criteria, the charges will be limited to reasonable fees for copying and postage costs when electronic communication means of disclosing criteria is not available.

For those instances when criteria are applied as the basis of a decision to modify, delay, or deny services in a specified case under review, the criteria shall be disclosed to the provider and the enrollee used in that specified case.

All criteria disclosures will be accompanied with the following clause, "The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."

The KHS UM Program will also review and present internally generated and other outside criterions to the Physician Advisory Committee (PAC) and the QI/UM Committee for direction in the development and/or adoption of specific criteria to be utilized by the KHS UM staff.

When making medical necessity decisions, UM staff obtains relevant clinical information such as patient medical records from the requesting provider and appropriate specialists by telephone or by fax to finalize the UM decision. Clinical information is provided to the Chief Medical Officer or their designee to support the decision-making process. Examples of clinical information include the following but is not limited to:

- History and physicals,
- Office and ancillary service notes,
- Treatment plans and Progress notes,
- Health Risk Assessments,
- Psychosocial history,
- Risk Stratification,
- Diagnostic results, such as laboratory results, or radiology results,
- Specialty Consultation records, including photographs, operative, and pathology reports,
- Pharmacy profiles,

- Telehealth communications,
- Behavioral Health/Mental Health records,
- Information regarding benefits and any changes as required under the Department of Healthcare Services (DHCS) contract and Department of Managed Healthcare (DMHC) Knox Keene Licensure.

The review considers individual patient needs and the characteristics of the local delivery system. Based on patient circumstances, applicable UM criteria may be modified to a given instance. Medical judgment and decision making is individualized based on the member's condition and as applicable, discussed with the physician/practitioner reviewer, and requesting physician to render an appropriate decision relative to Kern's policies:

- Age,
- Sex/gender,
- Comorbidities,
- Complications,
- Home environment, as appropriate,
- Progress toward accomplishing treatment goals,
- Family support,
- Previous treatment regimens,
- Psychosocial situation and needs,
- Benefit structure including coverage for post-acute or home care services when needed.

Consideration of the delivery system and availability of services to include but not be limited to:

- Availability of inpatient, outpatient, and transitional services,
- Availability of highly specialized services, such as transplant facilities or cancer centers,
- Availability of skilled nursing facilities, subacute care facilities or home care in the organization's service area to support the patient after hospital discharge,
- Availability of outpatient services in lieu of inpatient services such as surgery-centers vs inpatient surgery,
- Local hospitals' ability to provide all recommended services within the estimated length of stay,

Criteria Notifications

Members are notified of the availability of UM criteria either in writing upon request or on the website and through the EOC Member Handbook mailed to all members.

Availability of the UM criteria upon request may be done in person or by telephone.

Practitioners are notified of the availability of UM criteria, either in writing upon request or on the website and through the provider manual upon onboarding, provider portal, and annual Provider network education. Providers are also notified, annually, through Plan newsletters and mailings, of the process by which such information may be obtained. KHS may also mail

the criteria to practitioners who do not fax, email or have internet access. KHS maintains a UM Criteria Disclosure log to document a criteria request made by a practitioner or a member & member representative. The UM Department maintains a UM Disclosure Log to document any criteria requests made by a member or its representative or practitioner and peer-to-peer review requests.

Members receive pertinent criteria information with every -Notice of Action (NOA)-denial letter, by mail.

KHS also contracts with a third-party independent medical review organization which provides objective, unbiased medical determinations to support effective decision making based only on medical evidence.

The reviewing practitioners base their determinations on their training, experience, the current standards of practice in the community, published peer-reviewed literature.

For complex specialty reviews the UM medical staff refers the case for review to a licensed, board- certified practitioner in the same or similar specialty as the requested service.

Referral Management

Referral management is designed to determine medical necessity utilizing established criteria based on an assessment of the member's clinical condition, diagnosis and requested treatment plan. Each case is evaluated individually, and sound medical criteria applied as appropriate.

Referrals and requests for prior authorization of services are to be submitted by the provider of service to the KHS UM department by fax or through KHS's Online Services portal, which is a Secure Electronic Internet system. The following information must be provided on all requests.

- Member demographic information,
- Provider demographic information,
- Requested service/procedure to include specific CPT/HCPCS code(s),
- Member diagnosis (Using current ICD Code sets),
- Clinical indications necessitating service or referral,
- Pertinent medical history, treatment, or clinical data,
- Location of service to be provided,
- Requested length of stay for all inpatient requests,
- Proposed date of procedure for all outpatient surgical requests.

Pertinent data and information are required to enable a thorough assessment of medical necessity. If information is missing or incomplete, the requestor will be notified and given an opportunity to submit additional information.

Contract providers are obligated to refer members to KHS network providers, and/or providers approved through the Utilization Management Letter of Agreement process, unless medical necessity or emergency dictates otherwise. Physician requested Out of Area/Out of Network

referrals are processed through Provider Relations Department with Letters of Agreement (LOA) for financial reimbursement methodology. KHS utilizes a member centric medical management documentation platform, JIVA system by ZeOmega, to house all clinical information for each member.

Emergency Room Visits

Emergency room visits where a prudent layperson, acting reasonably, would believe an emergency condition exists, DO NOT require prior authorization.

Pre-authorization

With the exception of specific services that do not require medical necessity or prior authorization to include but are not limited the following: OB/GYN, Abortion Services, treatment for Sexually Transmitted Disease, HIV services, Sensitive services, Family Planning Services, Maternity Care, Transportation, Vision, COVID 19 Vaccines Emergent/Urgent care, and Mental Health (initial mental health and substance use disorder (SUD) assessments), PCP services from a KHS contract PCP, and services listed outside of the Prior Authorization List, most non-urgent specialty care must be pre-authorized by KHS in accordance with KHS referral policy and procedures in accordance with H&S Code section 1367.01. Requests for services are submitted either by fax or electronic online submission to KHS for review and processing.

For those services requiring pre-authorization, only KHS UM Clinical Staff and/or KHS Chief Medical Officer or designee(s), including the Physician Advisory Panel staff, may give authorization for payment by KHS. Denials, delays/extended delay, modifications, and terminations are performed in accordance with the Knox Keene license and DHCS contract. Only qualified health care professionals with appropriate clinical expertise in treating medical or behavioral health condition and disease or Long-Term Services and Supports (LTSS) needs supervise the review of decisions including service reductions and denials made in whole or in part, based on medical necessity. KHS utilizes both board certified internal MD staff as well as contracted vendor(s), Advanced Medical Review (AMR), for medical necessity reviews as additional guidance and evidence based scholarly references to ensure appropriate medical decision making. KHS maintains a list of board-certified consultants that includes contact information, e.g., phone numbers, names, specialties) and makes the list available to all UM staff as a reference for contacting those consultants. When external consultants are not able to share their names for proprietary reasons, they will provide KHS with centralized contact information and a list of the specialties of all board-certified consultants

KHS will review prior authorizations for physician administered drugs, medical supplies, and enteral nutritional products billed on a medical claim.

Physician administered drugs (PAD) and others that are managed as part of the medical benefit will be managed by common pharmaceutical utilization management and coverage tools. Generic versions of the branded drug, biosimilars, and follow on drugs are the preferred drugs. Preferred drug lists and prior authorization lists are derived from this concept. Any limitations

associated with these drugs will be communicated. Appropriate professionals of physicians and pharmacists from the P&T/DUR committee will approve protocols and policies regarding this governance annually. KHS will monitor quality and safety measures for those drugs under its purview. PAD drugs and others that fall under the management of KHS as they apply, will be reviewed to enhance the safety and quality of our members. Drug recalls, those identified on the Beers list of potentially inappropriate for the elderly, and opioid and similar controlled drugs as identified in SUPPORT Act are monitored.

Regular analytics are completed to reevaluate the need for prior authorization requirements as part of over and underutilization monitoring. KHS has a specialty referral system to track and monitor referrals requiring prior authorization. All network providers are made aware of the specialty referral processes and tracking procedures.

Concurrent Review

A request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care. Requests for authorization are reviewed within 5 working days or 72 hours based on the urgency of the request.

Inpatient Concurrent Review and Continued Stay

Concurrent review is the process of continual reassessment of the medical necessity and appropriateness of acute inpatient care during a hospital admission in order to justify the continued level of care. The concurrent review process is conducted by California licensed Registered Nurses by review of the member's medial record, reviewing the hospital's case management notes, dialoguing with the attending physician and other members of the health care team, and speaking with the patient and/or family or significant other, as needed.

Hospitalizations are concurrently reviewed for appropriate length of stay and discussed during scheduled rounding meetings with the KHS CMO (or designee) if medical necessity cannot be established. Concurrent reviews are performed collaboratively with KHS contracted hospitalist groups and/or providers and KHS RN staff to determine medical necessity of admission, length of stay, and post discharge dispositions.

Through the hospitalist program, the UM Nurse can authorize referral requests for member discharge planning and coordination of services for post-acute care.

Discharge Planning

UM Nurse and/or the UM Social Worker will assess member's post hospital continuing care needs and will collaborate with the provider organization's discharge planning staff to make arrangements for appropriate post-acute services pertinent to the member's recovery such as SNF, Acute Rehabilitation, DME, Home Health, specialist follow-up visits, community resources, and any other services identified. Recuperative Care and Transitional Care Clinics

are designed to address potentially avoidable readmission, recidivism, and improve health through member empowerment and early intervention.

Skilled Nursing/Sub acute/ Long-Term Acute/Rehabilitation Facility Review

Review of all Skilled Nursing and Rehabilitation Facility confinements are performed by licensed professionals to ensure medical necessity of continued stay and the appropriateness of level and duration of care. This review is conducted telephonically using written KHS medical policy, Title 22 criteria, and/or MCG Criteria. Requests for authorization are reviewed within 24 hours of notification of admission. The UM team facilitates discharge planning in collaboration with the facility care team and makes referrals to KHS case management and social services as appropriate.

Consideration of available services in the local service area or delivery system, and the ability to meet the member's specific health care needs are evaluated as part of applying criteria and the development of an ongoing plan of care and discharge plan.

Retrospective Review

For those services requiring prior authorization, retrospective review for payment of claims is initiated when no prior authorization was obtained by the practitioner or provider organization. Retrospective review is also initiated for services performed by a non-contracted provider or when no authorization was obtained before completion of the service. Members, practitioners, and provider organizations are notified by mail/online of the UM/ claims decision.

Utilization Management Decision Timeframes

Decisions to approve, modify, or deny a requested health care service are based on medical necessity and urgency of the request, and are appropriate for the nature of the member's condition. KHS remains compliant with the defined timelines under the DHCS contract. When the member faces an imminent and serious threat to his or her health, including, but not limited to, potential loss of life, limb, or other major bodily function, decisions to approve, modify or deny requests from provider, shall be made in a timely fashion appropriate for the nature of the member's condition, not to exceed 72 hours after the Plan's receipt of the information reasonably necessary and requested by the Plan to make a determination.

- **Emergency Care**: no prior authorization is required.
- **Post-Stabilization**: within 30 minutes of a provider's request for authorization, or the service is deemed approved.
- **Non-Urgent Care** following an exam in the emergency room: KHS must respond to a provider's request for post-stabilization services within 30 minutes or the service is deemed approved.
- **Concurrent Review** of authorization for a treatment regimen: 5 working days or less, consistent with the urgency of the member's medical condition.
- **Retrospective Authorization**: retrospective authorization requests are processed within a reasonable established time limit, not to exceed 365 calendar days from the

date of services; decisions to the provider and member are made within 30 calendar days of the receipt of information.

- **Routine Authorizations**: no longer than 5 working days from receipt of information and no longer than 14 calendar days from the receipt of the request; an extra 14 calendar days may be extended when member or provider requests an extension, and justified by KHS upon request by DHCS and in the member's best interest.
- **Expedited Authorization:** Decision must be made no longer than 72 hours after receipt of the request for services. Extension may be granted to an additional 14 calendar days when member or provider requests an extension.
  and justified by KHS upon request by DHCS and in the member's best interest.
- **Hospice Services:** No prior authorization is required for inpatient and outpatient hospice services.
- **Therapeutic Enteral Formula**: KHS complies with applicable DHCS PLs and APLs, W&I Code section 14103.6, and H&S Code section 1367.01.
- **Physician Administered Drugs**: KHS complies with same timeframes as other medical services.

Inter-Rater Reliability (IRR)

KHS assesses the consistency with which physician and non-physician reviewers apply UM criteria in decision making and evaluates Inter-Rater Reliability. An Inter-Rater Reliability (IRR) process is deployed to evaluate and ensure that UM criteria are applied consistently for UM decision-making. Bi-annually, both physicians and staff involved with making UM decisions participate in the IRR process. The Director of UM selects specific topics for completion by the UM clinical staff. The IRR training module records the completion for each user, along with the test results. KHS UM Management staff evaluates competency utilizing the MCG IRR training module for necessary remediation and education. Successful completion is required as a fulfillment of the clinical staff outlined job duties. The following types of reviews/reviewers are audited:

- Nurse Coordinator Review of Inpatient Services,
- Nurse Coordinator Review of Outpatient Services,
  Nurse Coordinator Review of Long-Term Care Services,
- Physician Reviewers,
- Behavioral Health Reviewer,
- Nurse Coordinator Review of Claims/Disputes and Appeals review for Outpatient Services and Inpatient Services.
- Non-licensed UM and Care Management Coordinators processing referral requests.

Ongoing Training

KHS provides and encourages ongoing staff training. Areas of opportunity includes seminars, conferences, workshops, training by KHS Learning and Development department, and specialty specific training by contracted practitioners and provider organizations. Network providers also receive training on the procedures and services requiring prior authorization for medically necessary services including the necessary timeframes within 30 days of start of

contract. The role of Analyst /Trainer and UM Clinical Auditor/Trainer receives direction on the training needs of specific staff members from the UM Department leaders where areas of improvement regarding error rates indicate the need for additional training of staff member(s).

The Clinical Intake Coordinators and UM Nurse staff utilize established criteria for referral review and determination. Quarterly random audits are conducted to ensure compliance of the referral process and inter-rater reliability and are reported to UM Management for process improvement and staff education. Results of the findings are presented to the CMO and reported to the QI/UM Committee.

UM Determinations

Denial Determinations

Denial determinations may occur at any time during the review process. Only the Chief Medical Officer, or a physician designee acting through the designated authority of the Chief Medical Officer, has the authority to render a denial determination based on medical necessity.

A denial determination may occur during continued stay/concurrent review in which case notification and/or discussion with the treating practitioner and the Health Plan physician adviser/Chief Medical Officer or physician designee is offered. (Peer to Peer)

Denial determinations may occur at different times and for various reasons including but not limited to:

- At the time of prior authorization when the requested service is not medically indicated.
- When timely notification was not received from a facility for an inpatient stay to foster transfer of a medically stable patient,
- When an inpatient facility fails to notify KHS of an admission within one business day of the admission or appropriate clinical information is not received,
- Or after services are rendered at claims review when the services were not authorized, or are medically unnecessary,
- A denial may also occur for inappropriate levels of care or inappropriate care.

Notwithstanding previous authorization, payment for services may be denied if it is found that information previously given in support of the authorization was inaccurate.

KHS offers the practitioner the opportunity to discuss any denial or potential denial determination based on lack of medical necessity with the Chief Medical Officer, or a physician reviewer designee.

The referring practitioner, provider and member are notified of the denial through a Notice of Action (NOA) letter, translated in both English and Spanish with non-discrimination clauses and tagline notations.

The denial notification states the reason for the denial in terms specific to the member's condition or service request and in language that is easy to understand and references the criterion used in making the determination, so the member and provider have a clear understanding of the rationale for the denial and enough information to file an appeal.

All recommended denials are reviewed by the CMO or designee(s), except for administrative denials that are not based on medical necessity and performed by the UM RN Clinical Intake Coordinators/UM Nurse. Services denied, delayed/extended delay, terminated, or modified based on medical necessity may be eligible for an Independent Medical Review.

The Department of Health Care Services and Department of Managed Health Care provide direction to and oversight of the process of issuing written notification of non-coverage to KHS members.

KHS complies with DHCS Notice of Action Template requirements for Medi-Cal to include applicable inserts on how to file an appeal, DMHC information, translation services. This process is outlined in the KHS policies and procedures related to processing referrals.

The Health Plan does not compensate any individual involved in the utilization process to deny care or services for our members nor do we encourage or offer incentives for denials.

Appeals of Adverse Medical Necessity Denials and Benefit Determinations

A member, a member's authorized representative, or a provider acting on behalf of a member, has 60 calendar days from the date of determination to submit an appeal request in response to a Notice of Action (NOA) letter. A member or a member's authorized representative may initiate an appeal by contacting KHS's Member Services department. An appeal initiated in this way is considered a Member Appeal and will be referred to the KHS Grievance and Appeals department for processing. A provider may also request an appeal on behalf of a member, with written consent from that member, by faxing or writing KHS's UM Department.

After receipt of the request for appeal, KHS will provide written acknowledgement to the member and provider that is dated and postmarked within five (5) business days of receipt of the appeal. KHS has 30 calendar days from the receipt of the appeal request to render a determination.

The Chief Medical Officer or physician designee reviews the request for appeal if the determination was based on medical necessity. The Chief Medical Officer or physician designee may request further information from the provider such as:

- Diagnostic information,
- Clinical justification,
- Previous treatment,
- Opinions from specialists or other providers,
- Evidence from the scientific literature prior to processing the request.

The provider is expected to respond to a request for further information within the 30-calendar day determination time frame. If the provider does not respond to the request for further information within that time frame, the appeal can be extended no more than 14 calendar days.

When a decision has been made, the provider and/or member, if applicable, are notified in writing within five (5) business days with a Notice of Appeal Resolution (NAR) letter. KHS is not required to notify the member of a decision when the member is not at financial risk for the services being requested (post stabilization concurrent reviews).

If the provider or member is dissatisfied with the appeal determination, a second level appeal or grievance may be filed.

If KHS's determination specifies the requested service is not a covered benefit, KHS shall include in its written response the provision in the Contract, Evidence of Coverage, or Member Handbook that excludes the service.

The response shall either identify the document and page where the provision is found, direct the provider and member to the applicable section of the contract containing the provision, or provide a copy of the provision and explain in clear concise language how the exclusion applies to the specific health care service or benefit request.

Expedited Appeals of Adverse Benefit Determinations

Expedited appeals may be initiated by the member or the provider. A member may initiate an expedited appeal by calling the Member Services Department. A provider may initiate an expedited appeal on behalf of a member with written consent by faxing or writing the KHS UM Department. If the request for expedited appeal is not accompanied by written consent from the member, the Plan will proceed with the request.

Expedited appeals are performed by KHS only when, in the judgment of the Chief Medical Director or Physician Designee, a delay in decision-making may seriously jeopardize the life or health of the member.

KHS refers the expedited appeal request to the Chief Medical Officer or Physician Designee for decision on the appeal. The Chief Medical Officer or Physician Designee is expected to make a decision as expeditiously as the medical condition requires, but no later than 72 hours after the receipt of the request for an expedited appeal.

Expedited reviews are also granted to all requests concerning admissions, continued stay or other health care services for a member who has received emergency services but has not been discharged from a facility.

KHS provides verbal confirmation of its decisions concurrent with mailing of written notification no later than 72 hours after receipt of an expedited appeal. If the expedited appeal involves a concurrent review determination, the member continues to receive services until a decision is made and written notification is sent to the provider. KHS is not required to notify

the member of a concurrent decision as the member is not at financial risk for the services being requested.

Appeal Rights

A member may ask for assistance from a patient advocate, provider, ombudsperson or any other person to represent them in their request.

A member may also request a State Hearing if a member has filed an appeal and received a "Notice of Appeal Resolution" letter upholding the initial denial of service or in instances of deemed exhaustion. Information on how to obtain an expedited State Hearing is included as a part of the "Notice of Appeal Resolution" letter to the member.

Member grievance and appeal information is included in the member handbook, distributed annually in the member newsletter, and is posted on the KHS website.

It is the responsibility of the Member Services Director and the Member Services Department to ensure:

- Member Rights and Responsibilities are included in the member handbook which is mailed to all new members and posted on the KHS website,
- Members are advised of their appeals rights when the adverse determination NOA is mailed to them.

Members are notified of all revisions to the Member Rights and Responsibilities statement in the member newsletter following revisions.

Independent Medical Review

Medi-Cal members can request independent medical review (IMR) on denied appeals involving medical necessity, including requests related to experimental/investigational services and receipt of out of Plan Emergency Department services. The DMHC administers the IMR program in the State of California at no cost to the member in compliance with applicable statutory requirements and accreditation standards. The IMR decision is binding on KHS.

Depending on the complexity of certain medical condition, KHS may require additional expertise in determining medical necessity for certain diagnosis and related procedures. Utilizing a nationally recognized and comprehensive review solution as a supplement to these difficult cases will provide the KHS CMO and Medical Directors with comprehensive medical recommendations utilizing case-specific patient information and history and industry standard guidelines including treatment protocols supported by current scientific evidence-based medicine to promote quality health care. Each review will be assigned to the IMR Reviewer who will be in an appropriate specialty or who will possess specific knowledge appropriate to the request of the treating provider. The IMR Physician Advisors will be specifically trained in Medicare/Medicaid rules and regulations based upon California state guidelines and remain

well versed in the ongoing regulatory landscape to ensure up to date legislative rulings are current in the review process.

All services will be performed based on specific turnaround times which are calculated from the time the request and all related materials are received by the IMR reviewer. Submission of requests via a secure portal are completed by the KHS Clinical Intake Coordinator (CIC) on behalf of the CMO or designee at their direction only. It is the responsibility of the submitting CIC to track the progress of the review to ensure receipt based on the recommended turnaround timeline. The designated turnaround times will align with all DHCS timelines for medical decision making as outlined in KHS contract.

UM Programs and Service Descriptions

Mental (Behavioral) Health Services

KHS responsibilities are limited to mild to moderate mental health conditions rendered in the outpatient setting. Psychotropic drug therapy remains carved out and provided under the Fee for Service MCAL payment structure by the County Mental Health Plan. Referrals for mental health services may be generated by the practitioner, KHS Social Workers, KHS' 24-hour contracted advice and triage nurses, school systems, employers, family, or the member.

KHS do not administer triage and referral process.

Members needing immediate crisis intervention may self-refer to the Emergency Room or to the Kern County Behavioral and Recovery Services' Crisis Stabilization Unit. This information is provided to the members through the member handbook, and periodically, through the member newsletter. Mental Health Services for Medi-Cal participants are a covered benefit as described under the Kern Health Systems Health Plan in the contract with the Department of Health Care Services (DHCS).

KHS administers the mental health benefit as well as coordinating the benefit with the Kern Behavioral Health and Recovery Services (KBHRS) through a Memorandum of Understanding (MOU) and other contracted provider groups for their covered services. Quality issues including those occurring in different sites of behavioral healthcare services such as psychology groups or levels of behavioral healthcare such as outpatient psychiatrist visits are assessed through review of member grievances, member satisfaction study results, interactions with members, and quarterly meetings with KBHRS. KHS UM staff is available to assist KBHRS with complex cases and facilitate coordination and continuity of care between providers when transitioning between mild to moderate and extreme and pervasive mental health conditions.

Members who meet medical necessity criteria for medical conditions may receive Voluntary Inpatient Detoxification (VID) services in a general acute care hospital. VID services are carved-out (non-capitated) of the managed care contract and covered through the Medi-Cal

Fee for Service program. Inpatient detoxification must be the primary reason for the member's voluntary inpatient admission.

KHS complies with Mental Health Parity requirements as required by Title 42, CFR, §438.930. The policies and procedures are consistently applied to medical/surgical, mental health and substance use disorder benefits. KHS's Utilization Management program does not impose Quantitative Treatment Limitations (QTL), or Non-Quantitative Treatment Limitations (NQTL) more stringently on covered mental health and substance use disorder services than are imposed on medical/surgical services in accordance with the parity in mental health and substance use disorder requirements in 42 CFR 438.900 et seq.

KHS adheres to appropriate utilization management processes to review, approve, modify, deny, and delay the provision of medical, mental health, and substance use disorder services to demonstrate compliance with mental health parity.

Behavioral Health Therapy (BHT) and Behavioral Intervention Services (BIS)

KHS provides coverage for all medically necessary BHT services for eligible beneficiaries under 21 years of age. This applies to any health condition, including children diagnosed with autism spectrum disorder (ASD)4 and children for whom a licensed physician, surgeon, or psychologist determines that BHT services are medically necessary.

Transitional Care Program

The Transitional Care Model (TCM) is an evidence-based solution to these challenges. The TCM has consistently demonstrated improved quality and cost outcomes for high-risk, cognitively intact, and impaired older adults when compared to standard care in reductions; in preventable hospital readmissions for both primary and co-existing health conditions; improvements in health outcomes; enhanced patient experience with care; and a reduction in total health care costs.

- *Avoidance of hospital readmissions for primary and complicating conditions***.** TCM has resulted in fewer hospital readmissions for patients. Additionally, among those patients who are re-hospitalized, the time between their discharge and readmission is longer and the number of days spent in the hospital is generally shorter than expected.

- *Enhancement in patient and family caregiver experience with care.* Overall patient satisfaction is increased among patients receiving TCM. In ongoing studies, TCM also aims to lessen the burden among family members by reducing the demands of caregiving and improving family functioning.

- *Improvements in health outcomes after hospital discharge.* Patients who received TCM have reported improvements in physical health, functional status, and quality of life.

Collaborative care is the cornerstone of the TCM model. Collaborating partner's staff will form the interdisciplinary clinic that provides biopsychosocial and diagnostic screenings and

evaluations, medication management, care management, treatment planning and intervention services, as well as general medical services for the identified population. The main goals of integration include:

- Foster cross-system partnerships,
- Quality and value-based system of care,
- Create robust inpatient discharge coordination and develop cross-system transfer of care protocols,
- Expand strategies and educational opportunities,
- Improve patient experience and quality outcomes; and
- Implement model of care that is sustainable and cost effective.

Major Organ Transplant

Effective January 1, 2022, KHS will expand coverage to cover all major organ transplants, in addition to the current benefit of kidney transplant services. The UM Nurse and Clinical Intake Coordinator will work closely with the Major Organ Transplant Program team to ensure these vulnerable members are connected to this care coordination program to help assist and support them in navigating this complex process.

Long Term Care

Effective January 1, 2023, KHS will be administering the Medi-Cal Long Term Benefit for qualifying members. Long term care may be required due to physical or mental conditions that need continuous skilled nursing services; for Medi-Cal managed care, the LTC benefit for these services includes room and board and other covered services medically necessary for care. Kern Health Systems ensures access to licensed long-term care facilities to members in need of long-term care services. These facilities may include, a. Skilled Nursing Facilities b. Sub-acute Facilities (pediatric and adult), and c. Intermediate Care Facilities. A member in need of long-term care is identified by his/her physician, health care clinician, acute care attending physician, case managers or discharge planners. To support appropriate utilization management, case management and service coordination to maintain the member at the LTC level of care, KHS follows specific protocols and standards for determining levels of care and authorizing services that are consistent with policies established by the Federal Centers for Medicare and Medicaid Services (CMS) and in accordance with: a. 22 CCR § 51335 Title 22. Social Security Division 3. Health Care Services Subdivision 1. California Medical Assistance Program (Refs & Annos) Chapter 3. Health Care Services Article 4. Scope and Duration of Benefits § 51335. Skilled Nursing Facility Services.

Second Opinions

Members have a right to a second opinion by a qualified medical professional. A request for second opinion is reviewed to determine whether KHS has appropriately qualified medical professionals with knowledge and expertise in the member's condition who can evaluate the member and provide a second opinion. If so, the member is re-directed within the plan to obtain

second opinion. When an appropriate, qualified physician is not available within the plan, an out of area/out of network referral with LOA is authorized.

Telemedicine/Telehealth

Telemedicine and other remote monitoring capability are a growing trend in the evaluation of a member's health. Telemedicine allows for HIPAA compliant medical information to be exchanged from one site to another via electronic communications to improve the member's clinical health status using two-way video, email, smart phones, wireless tools, and other virtual/telephonic communication modalities technology. No additional prior authorization is required for telemedicine, only the service is subject to those contained in the Prior Authorization list and limited to those KHS contracted providers who have demonstrated adequate office space, availability of a patient navigator, and suitable telemedicine equipment to connect with a remote medical group. This allows KHS additional options to serve members in both local and rural areas to improve primary care and specialty access and reduce wait times.

Emergency Services

KHS complies with all applicable requirements of Consolidated Omnibus Budget Reconciliation Act (COBRA) and California Health and Safety Code Section 1371.4. KHS shall reimburse providers for emergency services and care provided to members, until the care results in stabilization of the member. An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention may be expected to result in any of the following:

- An imminent and serious threat to health including, but not limited to, the potential loss of life, limb, or other major bodily function.
- A delay in decision making would be detrimental to the member's life or health or could jeopardize the member's ability to regain maximum function.

KHS strives to strengthen our collaborations with community entities to reduce costs, improve the patient experience, and improve the health of the populations we serve. Strategies are reviewed annually to determine the best approach to reducing inappropriate ER utilization. These include:

- Broaden access to Primary Care Services,
- Focus/enroll high utilizers into Case Management programs,
- Target members with behavioral health problems.

Emergency Services and Hospital Admissions Out of Plan Screening and Stabilization

KHS does not require prior authorization for emergency services. Post-service claims review (for out of plan emergency care) considers whether the member's decision to Present to the Emergency Department was reasonable under the circumstance.

Post-stabilization

KHS requires review and authorization for all out of plan post-stabilization care, and follows all statutory requirements and accreditation standards in making post-stabilization care authorization decisions.

Completion of Covered Services

KHS, at the request of a member, provides for the completion of covered services by a terminated provider or by a nonparticipating provider. The completion of the covered service shall be provided by a terminated provider to a member who, at the time of the contract's termination, was receiving services to include:

- Acute Condition,
- Chronic Condition,
- Pregnancy,
- Terminal Illness,
- Care of a Newborn (between birth and 36 months of age),
- Performance of a surgery or other procedure authorized by the plan as part of a course of treatment,
- Applied Behavioral Analysis,
- Mental Health Condition.

The plan may require a non-participating provider, whose services are continued, to agree in writing to the same contractual terms and conditions that are imposed upon providers under current contract.

Standing Referrals

Occasionally a member will have a disease that requires prolonged treatment by or numerous visits to a specialty care provider. Once it is apparent that a member will require prolonged specialty services, UM may issue a standing referral and provide a determination within three working days from the request date made by the member or the PCP after obtaining all appropriate medical records and information. The referral must be made within four working days of the date of the proposed treatment plan. A standing referral is an authorization that covers more visits than an initial consultation and customary follow-up visits and typically includes proposed diagnostic testing or treatment. Members are referred to providers who have completed a residency encompassing the diagnosis and treatment of the applicable disease entity.
A standing referral may be limited by number of visits and/or length of time. It is only valid during periods when the member is eligible with KHS. A standing referral may be issued to contracted or non-contracted providers as deemed appropriate by the Chief Medical Officer, or their designee(s). The Director of Provider Relations will negotiate letters of agreement for services not available within the network.

Collaboration of Services

The scope of the UM licensed staff extends beyond the management of referrals. While performing UM activities, any quality-of-care concerns may be addressed with the practitioners or provider organizations and are reported to the QI department. Collaboration between UM and QI is essential to ensure the delivery of quality care to the plan's membership.

Continuity of Care is provided upon enrollment for those members with established relationships with Primary Care Providers, Specialists, and ancillary providers to promote uninterrupted services that may have been initiated prior to the member's enrollment with KHS.

KHS is also required to provide beneficiaries with continuity of care from a non-participating provider or from a terminated provider, subject to certain conditions. The beneficiaries must be given the option to continue treatment for up to 12 months.

KHS must provide continuity of care with an out-of-network provider when KHS is able to determine that the beneficiary has an ongoing relationship with the provider (self-attestation is not sufficient to provide proof of a relationship with a provider); the provider is willing to accept the higher of the KHS's contract rates or Medi-Cal Fee for Service rates; and the provider meets KHS's applicable professional standards and has no disqualifying quality of care issues.

Collaboration with other outside agencies such as Kern Regional Center, Department of Public Health, Department of Mental Health, Homeless Coalition and Housing Authority, Department of Aging and Health and Human Services, California Children Services, Denti-Cal, and other internal KHS departments and coordination of services for the KFHC membership is an important aspect of the UM process. The UM Nurse and Clinical Intake Coordinator assist the members in obtaining carved-out services and when necessary, coordinate and provide services not covered by the carved-out practitioner/provider.

The UM Nurse and Clinical Intake Coordinator coordinates Mental Health services with Kern Behavioral Health and Recovery Services through a Memorandum of Understanding pursuant to a contract between the County and the State. This coordination is essential to provide members with a seamless transition between mental health services beyond the scope of KHS responsibility to manage mild to moderate symptomatology and the more severe diagnosis under the responsibility of the County System of Care.

In addition, KHS UM staff also coordinates autism spectrum disorder (ASD) and Behavioral Intervention services with Kern Regional Center (KRC) through a Memorandum of Understanding. This coordination is essential in order to provide members with uninterrupted medical and supportive services as they transition between the systems of care.

The UM Nurse and Clinical Intake Coordinator also coordinates Specialty children's services with California Children's Services (CCS) through a Memorandum of Understanding. This

coordination is essential in order to provide members with uninterrupted medical services as they transition between the systems of care.

Regularly scheduled quarterly (or more often if deemed necessary) Joint Operations Meetings are held with Mental Health, CCS, and Regional Center partners to promote coordination, quality, and timely decisions regarding member's identified needs.

The UM Nurse and Clinical Intake Coordinator also identifies members who are eligible and could benefit from KHS internal programs such as Health Homes Program, Complex Case Management, Disease Management, and Transitional Care programs in order to link them to additional supportive services to improve member health outcomes. Member health education and disease management are important components in member Case Management. Improvement of the member's health is a collaborative effort between the member and the member's practitioner, KHS Health Education, Disease management, UM Nurse and Clinical Intake Coordinator, and numerous community partnerships.

Continuity of Care

Continuity of Care with an Out-of-Network Provider for Medi-Cal Members Transitioning into Medi-Cal Managed Care

Medi-Cal members assigned a mandatory aid code and who are transitioning from Medi-Cal fee-for-service (FFS) into a Medi-Cal managed care assigned to KHS have the right to request continuity of care in accordance with state law, DHCS All Plan Letter (APL18-008) and the DHCS-KHS contract, with some exceptions. All KHS members with pre-existing provider relationships who make a continuity of care request to KHS will be given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider. These eligible members may require continuity of care for services they have been receiving through Medi-Cal FFS or through another Managed Care Plan. The following guidelines will be applied:

1. KHS is able to determine that the member has an existing relationship with the provider (self-attestation is not sufficient to provide proof of a relationship with a provider):
    a. An existing relationship means the member has seen an out-of-network primary care provider (PCP) or specialist at least once during the 12 months prior to the date of his or her initial enrollment with KHS for a non-emergency visit, unless otherwise specified in the All-Plan Letter (APL18-008).
2. The provider is willing to accept the higher of KHS's contract rates or Medi-Cal FFS rates,
3. The provider meets KHS's applicable professional standards and has no disqualifying quality of care issues (for the purposes of this APL, a quality-of-care issue means KHS can document its concerns with the provider's quality of care to the extent that the provider would not be eligible to provide services to any other KHS members),
4. The provider is a California State Plan approved provider,

5. The provider supplies KHS with all relevant treatment information, for the purposes of determining medical necessity, as well as a current treatment plan, as long as it is allowable under federal and state privacy laws and regulations.

Continuity of Care – Terminated Providers

Continuity of care will be provided in accordance with the statutory, regulatory, and contractual requirements outlined in the following sources: California Health and Safety Code §§ 1373.65; 1373.95; and 1373.96.

Upon member request, KHS' Utilization Management (UM) Department will utilize defined guidelines as outlined in California Health and Safety Code §§ 1373.65; 1373.95; and 1373.96 to authorize as appropriate continuity of care with a terminated provider who has been providing care for an acute condition or a serious chronic condition, for a high-risk pregnancy, or for a pregnancy that has reached the second or third trimester. In cases involving an acute condition or a serious chronic condition, KHS shall furnish the member with health care services on a timely and appropriate basis from the terminated provider for up to 90 days or a longer period if necessary for a safe transfer to another provider as determined by the plan in consultation with the terminated provider, consistent with good professional practice. In the case of a pregnancy, the plan shall furnish the enrollee with health care services on a timely and appropriate basis from the terminated provider until postpartum services related to the delivery are completed or for a longer period if necessary for a safe transfer to another provider as determined by the plan in consultation with the terminated provider, consistent with good professional practice.

Continuity of care will not be authorized with a provider whose contract has been terminated or not renewed for reasons relating to medical disciplinary cause or reason[i] or fraud or other criminal activity.

Delegation

Delegation of Utilization Management Functions

KHS has the discretion to delegate, and the responsibility to oversee, UM functions performed by either Kaiser Foundations Health Plan in support of the KHSUM goals and objectives. KHS also has discretion to delegate responsibility, in whole or in part, for UM to contracted affiliated providers. KHS retains accountabilities for all delegated Utilization Management activities conducted for members and ensures that delegated UM processes are designed to meet member service and access needs.

On an annual basis, KHS performs a comprehensive assessment of the delegated UM activities to include a UM file review. The entity's annual evaluation of delegated UM functions and assessment summaries of activities are presented to KHS Medical leadership for review and approval.

Should there be any concerns regarding failure of a delegated entity to carry out delegated activities, KHS will determine corrective action plans up to and including revocation of the delegated activities. All submitted corrective action plans are monitored by the KHS Compliance department and evaluated until KHS determines that full correction action has been implemented.

UM Delegation to Affiliated Providers

When UM activities are delegated to contract affiliated providers, KHS retains responsibility and oversight of the delegated functions. The delegation is subject to an executed delegation agreement in which UM activities are clearly defined, including:

- Reporting requirements for the delegated entity,
- Reporting requirements for KHS to the delegated entity,
- Evaluation process of the delegated entity's responsibilities,
- KHS Approval of the delegated entity's UM program and processes,
- Mechanisms for evaluating the delegated entity's program reports,
- The delegated entity's ability to collect performance data necessary to assess member experience and clinical experience, as applicable,
- KHS right to revoke and terminate a delegation agreement.

Delegation of UM Activities

KHS has delegation oversight activities/processes for pre-delegation evaluation, delegation oversight activities, and regular reporting used to monitor delegates according to the standards established by KHS, licensing, and regulatory bodies. KHS may delegate Utilization Management (UM) and Pharmacy functions/activities to entities with established Quality Improvement and Utilization Management programs and policies consistent with licensure and regulatory requirements.

KHS remains accountable for and has appropriate structures and mechanisms to oversee delegated activities even if it delegates all or part of these activities. KHS tracks and processes all KHS member's UM activity internally with the exception of Kaiser assigned MCAL members whose UM functions are delegated as part of a two-way agreement under contractual requirement with DHCS.

Delegation Agreement Process

KHS provides ongoing monitoring of UM activities that are delegated to contract providers. The delegated functions are reviewed and approved on an annual basis by the QI/UM and Delegation committees. A comprehensive delegation audit is conducted by KHS at a minimum annually. A delegation agreement, including a detailed list of activities delegated and reporting requirements is signed by both the delegate and KHS.

The delegation agreement outlines the responsibilities and activities of the physician network and the managed care organization that is delegated to provide utilization management services.
Delegates undergo a pre-delegation audit (survey) conducted by KHS to assure that the Medical Group/IPA is capable in its ability to meet the standards of the Plan and those of the Act and the rules there under and has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities.
The delegation agreement includes the following:

- Mutually agreed upon before delegation starts,
- Describes the delegated activities and the responsibilities of KHS and those of the contracted entity and the delegated activities,
- For each activity, KHS has identified the documented reporting requirements at least semi-annually and delegated activities of the delegated entity to KHS,
- Describes the process by which KHS evaluates the delegated entity's performance for providing member experience and clinical performance data to its delegates when requested,
- Describes the remedies available if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.

Joint Operations meetings are conducted quarterly in addition to an annual delegation audit to ensure compliance with DHCS regulatory requirements.

Delegated Triage Services

KHS contracts with a third-party vendor to provide 24/7, weekend and holiday triage services for all KHS members. The vendor provides not only triage services but also supports a member-initiated Health Library to promote education on a varying number of topics. Reports are generated monthly to monitor their activities as well as identify member patterns during execution of after hour services. Joint Operations meetings are conducted quarterly to ensure compliance with DHCS regulatory requirements.

Delegated Vision Care

Vision Care is delegated to a 3rd party vendor and capitated for all vision services. Reports are generated monthly to monitor their activities as well as identify utilization patterns. Joint Operations meetings are conducted quarterly to ensure compliance with DHCS regulatory requirements.

KHS contracts with a vendor, Health Dialog, to perform 24-hour Nurse Advice and triage call center activity and provides summary reports detailing the utilization of services at scheduled intervals. The report is reviewed for trending of ER and Urgent Care usage based on total usage compared against deferment back to the PCP and Home/Self Help care. Monthly touchpoints are scheduled to address any issues or trends identified. Actions plans are developed if utilization patterns raise concerns for escalation. Health Dialog provides a Health

Audio Library for member self-service of specific health topics or acute/chronic condition education.

All delegated entities are required to support and adhere to the same regulatory reporting and access standards as KHS. KHS has the responsibility to the Delegated or Subcontractor's agreement to revoke the delegation of activities or obligations or specify other remedies in instances where DHCS or KHS determine that the Subcontractor has not performed satisfactorily.

Complete delegated oversight audits are conducted at least annually, and more often if warranted, to ensure all aspects of KHS's contract are performed to the standards outlined by DHCS and DMHC.

KHS will determine corrective action plans up to and including revocation of the delegated activities. All submitted corrective action plans are monitored by the KHS Compliance department and evaluated until KHS determines that full correction action has been implemented.

Under and Over Utilization

KHS monitors under- and over-utilization of services through various aspects of the UM process including Behavioral Health Services. Through the referral authorization process, the UM Clinical Intake Coordinator/UM Nurse monitors under and over-utilization of services and intervenes accordingly including non-specialty mental health services utilization data for both adult and pediatric members.

- The UM department monitors underutilization of health service activities through collaboration with the QI department. The UM department sends correspondence notifying the practitioners and members of the carved-out services and a reminder to see their primary care provider for all other health care services not addressed by the carved-out specialty care provider for gaps in care closure,
- Over-utilization of services is monitored through several functions. Reports are reviewed to analyze unfulfilled authorizations or gaps in care to determine interventions directed to ameliorate any identified adverse trends,
- Upon request, KHS will report to DHCS all its internal reporting mechanisms used to detect member utilization and provider prescribing patterns,
- KHS monitors utilization data to appropriately identify members eligible for

Medical Loss Ratio

Medical Loss Ratio (MLR) is a metric used in managed health care and health insurance to measure medical costs as a percentage of premium revenues. KHS has placed major emphasis on the reduction of MLR to monitor and manage utilization within the health plan. Areas of focus include achieving an overall Key Performance Indicators (KPI) metrics Goal of <92% across all lines of business-SPD, Family/Other, and Expansion. Dashboards provide transparency to the plan's Executive leadership of all identified KPI.

Resource Management

Resource Management activities focus on the prudent and clinically appropriate allocation of resources for the provision of health care services. These activities are not subject to direct regulation under the Knox-Keene Act. The UM Program monitors and provides oversight of coordinated performance related to Utilization/Resource Management across the continuum to include:

- Drug Utilization,
- Laboratory Utilization,
- Product Utilization,
- Radiology Utilization,
- Surgical Utilization.

Evaluation of New Medical Technologies

KHS evaluates a variety of web-based interactive applications for future consideration of medical technologies adoption. KHS MIS department develops and implements new technologies as they emerge to provide efficient methods of tracking member activity and report generation. UM clinical staff have direct access to various websites for review and reference for discussions on innovative methods not currently in use by KHS that may be implemented in the delivery of healthcare to KHS members. New technologies are vetted with MCAL guidelines for coverage, then forwarded to the PAC and QI/UM committees before board approval.

KHS evaluates and addresses new developments in technology and new applications of existing technology for inclusion in its benefit plan to keep pace with changes and to ensure members have equitable access to safe and effective care.

Written process includes an evaluation of the following:

- Medical Procedures,
- Behavioral healthcare procedures,
- Pharmaceuticals,
- Devices.

Description of the Evaluation Process- KHS written evaluation process includes the following:

- The process and decision variables KHS use to make determinations,
- A review of information from appropriate government regulatory bodies,
- A review of information from published scientific evidence,
- A process for seeking input form relevant specialists and professionals with expertise in the technology.

The following information is gathered, documented, and considered for determination:

- Proposed procedure/treatment/medication device,
- Length of time the treating practitioner has been performing the procedure/treatment,
- Number of cases the practitioner has performed,

- Privileging or certification requirements to perform this procedure,
- Outcome review: mortality during a global period, one year out and five years out; other known complications, actual and anticipated,
- Identification of other treatment modalities available,
- Consideration as to whether Medicare/Medi-Cal approves the service/procedure,
- Whether the medication/procedure is FDA approved,
- Literature search findings,
- Input from network Specialist.

The CMO, or designee, or other clinical department directors, consult specialists, market colleagues, the Physicians Advisory Committee (PAC) and/or the Pharmacy and Therapeutics Committee (P&T) as needed to assist in making coverage determinations and/or recommendations.

Medical Reviews and Audits by Regulatory Agencies

KHS' Director of Compliance and Regulatory Affairs, in collaboration with the CMO, Chief Health Services Officer, and other Health Services clinical leadership, provides direct oversight to all KHS medical audits and other inquiries by our regulatory agencies, DHCS and DMHC. Recommendations or sanctions received from regulatory agencies for medical matters are addressed through the QI/UM Program. CAPs for medical matters are approved and monitored by the QI/UMC.

Integration of Study Outcomes with KHS Operational Policies and Procedures

KHS assesses study outcomes over time and, as a result of key quality issue identification and problem resolution, develops changes in strategic plans and operational policies and procedures. Study outcomes are assessed, and changes may be incorporated into the KHS strategic plan and operational policies and procedures to address those outcomes and incorporate ongoing quality issue solutions into organizational operations.

Provider and Member Satisfaction

Satisfaction Surveys are conducted annually by the KHS Member Services and Provider Relations Department. Results are shared with the Executive leadership and other KHS departments. Any unsatisfactory areas of the UM process are re-evaluated by the KHS Chief Medical Officer or designee, Chief Health Services Officer, and the Director of Utilization Management to develop and implement strategies to ameliorate deficiencies.

KHS participates in the Consumer Assessment of Health Plan Survey (CAHPS) Member Satisfaction Survey and utilizes these results in the assessment of member experience with the UM program. Analysis of grievance and appeal data related to UM is also monitored as a part of the member experience review.

KHS contracts with physicians and other types of health care providers. Provider Relations conducts assessments of the network adequacy of contracting providers. All PCPs and

specialists must meet KHS credentialing and recredentialing standards. Contracting providers must meet KHS requirements for access and availability. Members may select their PCPs based on cultural needs and preferences. The Provider Directory lists additional languages spoken by PCPs or their office staff and includes other information related to disability accommodations and hours of operation. The Provider Directory is 274 compliant with DHCS requirements and is available to members in printed or electronic versions.

Annual Program Evaluation

On an annual basis, KHS evaluates and revises as necessary, the UM Program Description and Evaluation. The Chief Medical Officer, in collaboration with the Chief Health Services Officer, documents a yearly summary of all completed and ongoing UM Program activities with documentation of evidence of improved health care or deficiencies, status of studies initiated, or completed, timelines, methodologies used, and follow-up mechanisms. The UM summary also includes the program scope, processes, information sources used to determine benefit coverage and medical necessity, and the level of involvement of the senior-level physician and designated behavioral healthcare practitioner in the UM program. A written evaluation of the UM Program is prepared and reported to the QI/UM Committee and Board of Directors annually.

As Part of the annual evaluation an Executive Summary is developed to analyze and evaluate the annual undertakings and effectiveness of the UM Program Where the evaluation shows that the program has not met its goals, the organization recommends appropriate changes incorporated into the subsequent annual UM Program Descriptions.

On an annual basis, the QI/UM Committee and Board of Directors will set thresholds for at least four data types, such as admission data, ER utilization, practitioner performance and behavioral health against the established thresholds to detect under-and over utilization.

Record Retention

KHS maintains all records and documents necessary to disclose how it discharges its obligations under the state contract. These records and documents will disclose the quantity of Covered Services provided, the quality of those services, the manner and amount of payment made for those services, the persons eligible to receive Covered Services, the way KHS administered its daily business, and the cost thereof.

In addition, and in accordance with 42 CFR section 438.3(u), KHS will retain the following information for no less than ten years and allow auditing entities to inspect and audit:

- Member Grievance and Appeal records as required in 42 CFR section 438.416,
- Base data as defined in 42 CFR section 438.5(c),
- MLR reports as required in 42 CFR section 438.8(k), and
- Data, information, and documentation specified in 42 CFR section 438.604, 438.606, 438.608, and 438.610.

Records relating to prior authorization requests, including any Notices of Action (NOA) will meet the retention requirements as described in Exhibit E, Section 1.22 (Inspection and Audit of Records and Facilities).

_____ Date _____

KHS Board of Directors (Chair/Designee)

_____ Date _____

Chief Executive Officer

_____ Date _____

Chief Medical Officer

[i] As defined in B&P Code §805(a)

KERN HEALTH SYSTEMS

UTILIZATION MANAGEMENT WORKPLAN 2023 EVALUATION

INTRODUCTION:	The goal of the utilization management department is to ensure members we serve receive high quality care in the right setting at the right time. To ensure this goal is met, the utilization management department proposes the following interventions.

GOAL 1:	Ensure that qualified, licensed, healthcare professionals assess clinical information used for clinical decision making.

INTERVENTIONS:	**GOAL:**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1. Ensure high quality new hire orientation training is provided to all new clinical staff. 2. Provide annual continuing education opportunities for the clinical staff. 3. Review and revise staff orientation materials, manuals and processes. 4. Implement verification process to validate continuing education completion and verification of certifications.	100% compliance with maintaining records of professional licenses and credentialing for staff that support clinical decision making.	Utilization Review Manager	Ongoing

EVALUATION: GOAL MET

KHS utilizes the following criteria sets for UM decision making.

Regulations and Criteria Guidelines (Hierarchy of Criteria)

KHS Physician Reviewers will use the hierarchy of KHS UM criteria to make UM decision in the following order:

1. **Health Plan eligibility and coverage**
2. **Federal and state mandated criteria**
   - California Code of Regulations Title 22,
   - California Code of Regulations Title 28,
   - CMS Code of Regulations Title 42,
   - California Health and Safety Code §§1363.5; 1367.01; 1371.4; 1374.16,
   - Medi-Cal Provider Manuals,
   - CA DHCS All Plan Letters (APL),
   - DMHC All Plan Letters,
   - CA DHCS Policy and Procedure Letters (PPL),
   - 42 CFR section 438.915, 438.206.
   - Standardized Behavioral Health criteria (Title 9, DSM-V)
3. **Nationally recognized criteria set for application of medical necessity.**
   - MCG Health LLC (Milliman Care Guidelines,)
   - UpToDate
4. **Peer Reviewed Journal or Published Resources**
5. **Preventive Health**
   - *The Guide to Clinical Preventive Services Report (Report on the US Preventive Services Task Force)*[i]
   - *AAP Recommendations for Preventive Pediatric Health Care*
   - *CHDP Medical Guidelines*

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

For medical necessity nationally recognized criteria, the UM nurses and physician reviewers utilize **MCG Guidelines**. MCG guideline criteria sets offer evidence-based care guidelines for various care settings and conditions, developed by clinical editors, and based on peer-reviewed papers and research studies. The care guidelines are utilized by the KHS staff for outpatient referrals and procedures and inpatient concurrent hospital admission stays. The UM licensed staff reviewers undergo significant training as part of the new hire orientation process and then at regular intervals throughout the year to include, one-to-one training, UM inpatient concurrent review staff huddles, denied, modified case reviews, and inpatient denial reviews. Licensed staff UM reviews are monitored through a random selection of each reviewer's file reviews on a monthly basis as they apply to utilizing MCG guidelines.

For other criteria selection and application as listed in the embedded table, these criteria are also included in the trainings. During 2023 a specialized training Inservice was arranged. The training module included criteria access resource links, best practices, and hierarchical selection requirements in conformance with Medi-Cal regulations. Other aspects of the training covered application of benefits, how to locate and utilize the Medi-Cal Provider Manulas and specialized Medi-Cal Programs.

A designated Medical Criteria policy and procedure was developed in 2023 to facilitate more detailed guidance with UM criteria selection process. Previously a short summary of medical necessity criteria was contained within the UM Program.

The proficiency of staff adherence to application of medical necessity is also measured through the Inter-rater Reliability (IRR) audit process as defined in the following goal 2.

This function will continue for 2024 as part of the new staff onboarding process, ongoing hands on licensed staff training, formal training modules, and updated procedural guides as needed.

GOAL 2: GOAL MET	Compliance with hierarchy of decision making, ensuring consistent application of medical necessity determination criteria.		
INTERVENTIONS:	**GOAL:**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1. Quarterly completion of Milliman Care Guideline Inter Rater-Reliability (MCG IRR) 2. MCG training annual and as needed based on changes to the guidelines. 3. Annual review of Medi-Cal guideline training and for hire.	Inter-rater-reliability pass rate of **100%**	Utilization Review Manager	Ongoing

EVALUATION: GOAL MET

For clarification the goal indicator was set at 100% and still stands but with clarification in what constitutes a pass rate as follows:

The Inter-rater-reliability compliance rate is 100% for licensed reviewers with a passing score of 80% or greater for each IRR Case Review and with the concession that if they failed a case they were educated and retrained and a retest of 2 cases transpired after the retraining.

Quarter 1-2023				
Total Staff	**# of cases**	**Initial results**	**Quarter results**	**Retest Results**
40 staff	**2**	**32 passed in full. 8 with 1 or 2 case fail**	**80%**	**8 retest full pass**
Quarter 2-2023				
Total Staff	**# of cases**	**Initial results**	**Quarter results**	**Retest Results**
40 staff	**2**	**32 passed in full. 8 with 1 or 2 case fail**	**80%**	**8 retest full pass**
Quarter 3-2023				
Total Staff	**# of cases**	**Initial results**	**Quarter results**	**Retest Results**
40 staff	**2**	**38 passed in full. 2 with 1 or 2 case fail**	**95%**	**2 retest full pass**
Quarter 4-2023				
Total Staff	**# of cases**	**Initial results**	**Quarter results**	**Retest Results**
40 staff	**2**	**38 passed in full. 2 with 1 or 2 case fail**	**95%**	**2 retest full pass**
YTD Compliance Rate 87.5% = 100% of GOAL				

This audit function will continue for 2024 as part of the KHS HICE Work Plan Report.

For 2024 the UM Work Plan selected by KHS is the Health Industry Collaborative Effort Template. The HICE Work Plan has been adopted by all of the CA Medi-Cal Health Plans as the standard. Within the HICE WP TATS are measured and reported quarterly.

GOAL 3: MET	Ensure compliance with legislative and regulatory directives.		
INTERVENTIONS:	**GOAL:**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1. Participate in all appropriate legislative and regulatory workgroups and/or activities that may impact the UM department. 2. Update department policies and *procedures* to reflect these changes. 3. Implement a policy and procedure review plan to ensure directives are operationalized. 4. Participate in monthly compliance committees, and Program Metrics Reporting (PMR) to review and monitor compliance to standards.	All new APLs will be reviewed, and policies updated to comply with new APL directives and other Federal and State regulations.	Utilization Management Director	Ongoing with Quarterly Review

EVALUATION: GOAL MET

2023 was a dynamic year for KHS health services due to legislative and regulatory changes pertaining to Medi-Cal Managed Care. The DHCS 2024 Contract driven by the many CalAIM transformational goals to improve more coordinated person centered and equitable health care served as a prerequisite of KHS's obligation to demonstrate readiness with the new DHCS Contract before the 1/1/2024 contract go live date. This process involved substantial revisions of standing programs and policies and procedures as well as the creation of many new ones. In doing this desk top procedures, documentation practices, new job roles and descriptions, and technology and reporting support functions consequently transpired to fulfill the necessary obligatory functions.

The health services committee structure was expanded by the creation of a Quality Improvement Health Equity Transformation Committee (QIHETC) as the umbrella committee for all health service quality functions. The KHS internal existing health service committees as well as newly developed committees were converted to subcommittees to support, monitor and report the 2024 new contract requirements applying to each health services area to ensure compliance. In addition to the 2024 contract, multiple DHCS and Department of Managed Health Care (DMHC) APLs were released to guide operational and administrative requirements.

Staff training pertaining to the newly instituted documents and activities were instituted through review of the policies and programs and collaborative meetings to facilitate best practices. New policies and programs were submitted to the UM/QI Committee for 2023 for review and approval as per the standard.

The Goal was met KHS UM, QI, and PHM departments successfully met the submission requirements in full.

This audit function will continue for 2024 as a compliance requirement. All new APLs will be reviewed, and policies updated to comply with new APL directives and other Federal and State regulations.

Of note, in addition to the mandated regulation as defined, KHS is undergoing NCQA Accreditation. A GAP analysis for NCQA Standard adherence was performed throughout 2023. All GAPS were addressed and documents and processes that were identified in the GAP analysis were rectified with implementation, corrections, or augmentation practices to meet 2023 standards. This process will be a carry over for 2024. The most current 2024 NCQA Accreditation Standards will be cross-walked to KHS health services activities to ensure compliance.

GOAL 4: NOT MET	Ensure separation of medical decisions from fiscal considerations.		
INTERVENTIONS:	**GOAL:**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1. Circulate to all Physician and Nurse reviewers an attestation that states: "Utilization Management decisions are based on medical necessity and medical appropriateness does not compensate physicians or nurse reviewers for denials. KHS does *not* offer incentives to encourage denials of coverage or service". 2. Ensure this education is provided to all Utilization Management staff.	100% compliance with distribution and receipt of completion of affirmative statement about financial incentives.	Utilization Management Manager	Annually

EVALUATION: GOAL NOT MET but WITH FOLLOW THROUGH in 2023 to RECTIFY for 2024

The Affirmative Statement was not disseminated to UM staff and the UM Committee participants in a timely manner as planned for 2023. Of note the Conflict-of-Interest Policy and Disclosure Statement was distributed to the committee attendees and UM participating staff but did not fully meet the requirements of the Affirmative Statement. Also, of note in accordance with regulatory requirements the structure of the UM referral review process is organized in accordance with DHCS and DMHC requirements of ensuring there is separation of financial influences on medical necessity decision making.

The Affirmative Statement has been developed for 2024. The Affirmative Statement will be distributed to UM staff by the KHS Human Resources Department. The Affirmative Statement is now added as a standing agenda item for the UM Committee and will be required to be signed annually by each committee member as well as throughout the year for any newly participating committee attendee.

The 2023 UM Program has been updated to include a description and process pertaining to the Affirmative statement.

The KHS website will be updated in 2024 with the affirmative statement under the Utilization Management section.

This Affirmative Statement will be implemented in 2024 and as a regulatory requirement, carried through from year to year.

GOAL 5:	Ensure compliance with regulatory standards.		
INTERVENTIONS:	**GOAL:**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1. File reviews to validate regulatory standards are met. 2. Education, both ongoing and remedial will be provided to staff on any issues revealed during the file review process	Documented use of guidelines in medical necessity determinations will be in compliance with State, Federal and other regulatory requirements 95%	Utilization Review Manager and Supervisor	Quarterly

EVALUATION: GOAL MET

Clinical nurses underwent annual training consisting of best practices and compliance requirements for UM medical necessity and application of criteria and benefit review cases to include denial / delay / modified. The UM supervisor was responsible for performing the monthly audits. The audit entails selecting 5 random cases from the universe for each reviewer for the given audit month. The case documents, medical necessity criteria selected by the reviewer and the reviewers written rational and decision determinations were cross referenced to the Notice of Action Letter as follows:

a. Spelling/Grammar, Verbiage, and Format,
b. Medi-Cal Criteria applied,
c. Criteria indicated and attached,
d. Recommendations to MD indicated.

UM - Referral Notification Compliance

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

Any deficiencies identified were followed through with one-to-one continued training until they met the threshold goal of 85% and then subsequently the threshold was moved up to 95%. Ongoing remedial training as needed was provided throughout the year. The number of UM staff reviewers audited totaled 16 each month. File reviews for physician reviewers were conducted quarterly. The number of MD reviewers audited each month totaled 3.

The Goal was met for all reviewers of meeting an initial threshold 85% and then met or exceeded 95% thereafter.

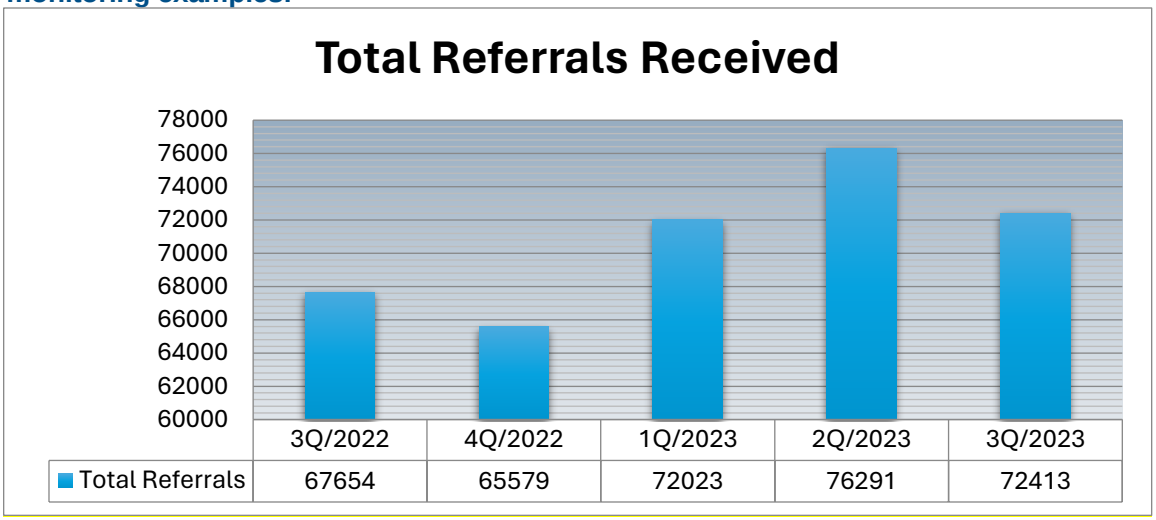
This audit function will continue for 2024 as a best practice.

GOAL 6:	Monitoring of the utilization management review process.		
INTERVENTIONS:	**GOAL:**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1. Utilize business intelligence reports monthly and as needed as a tool for systematic oversight of the prior authorization process. 2. Assess staffing requirements lo complete the prior authorization process timely and ensure an adequate budget is allocated to meet the staffing needs.	Track and trend authorization activity on a monthly basis including: 1. Number of prior authorization requests submitted, approved, deferred, denied, modified as well as 2. Denials appealed and overturned.	Utilization Management Director and Manager	Monthly

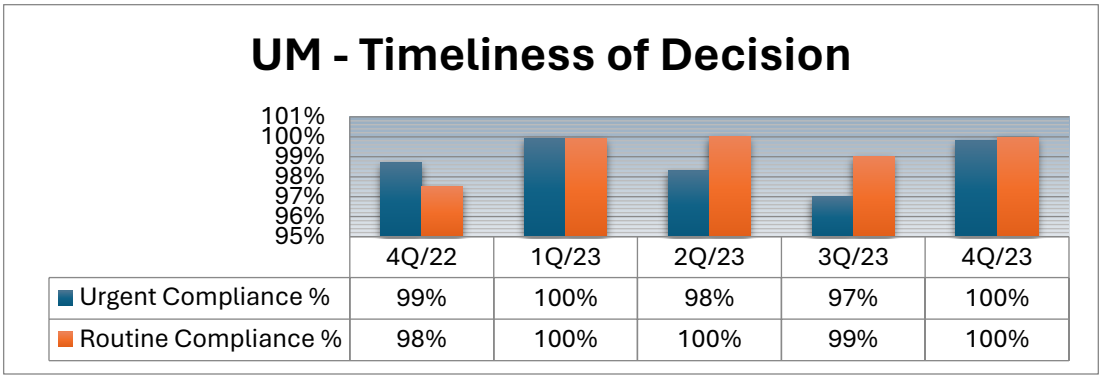
EVALUATION: GOAL MET

The Utilization Management Department utilizes business intelligence reports monthly and as needed as a tool for systematic oversight of the prior authorization process as well as continuing to apply the proven principles of managed care through prospective, concurrent, and retrospective review. The goal of the UM Department is to ensure that the medical necessity review process is completed in a time sensitive, efficient manner while aligning practice with all regulatory and statutory requirements.

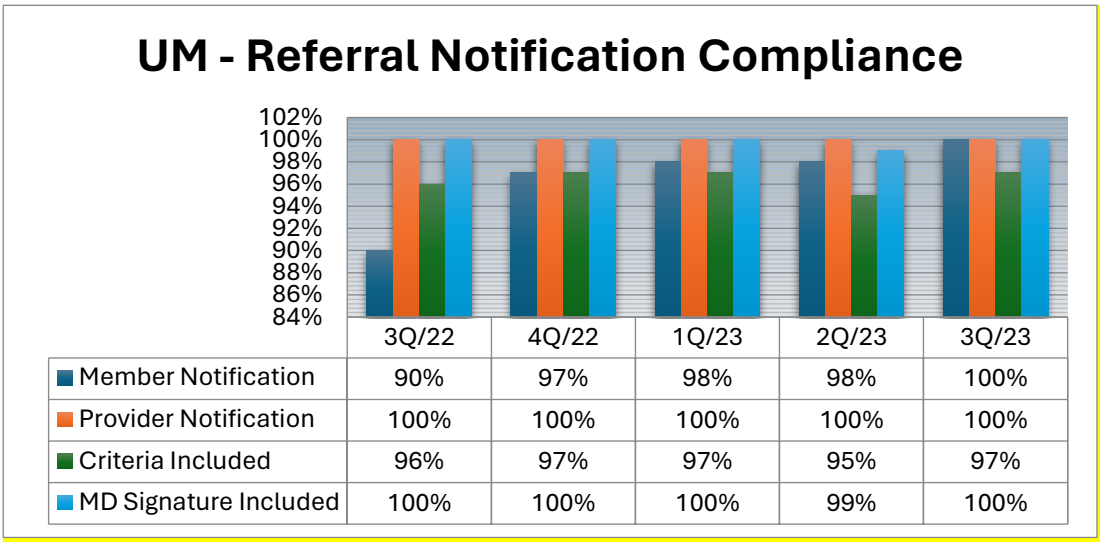
Report monitoring examples:



	3Q/2022	4Q/2022	1Q/2023	2Q/2023	3Q/2023
Total Referrals	67654	65579	72023	76291	72413



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



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

Multiple report monitoring activities were developed to support the management of authorization referral request processing during each business day serves as a means to effectively assess staff availability matched to volume demands. The reports for timeliness are run at intervals throughout the day. The compliance threshold goal for referral processing timeliness turnaround times (TATS) compliance activities is 95%.

The UM Supervisor is responsible for this function. Monitoring includes measuring ageing from the time each auth requests are received, the status of the request, routine or urgent, the current volume of requests in the queue & the processing of the NOAs evaluated to the number of staff available to meet the demand. For days of high volume and unprocessed auth requests nearing close to the ending turnaround time (TAT), the UM supervisor & UM trainer served as a back-up resource in processing auth requests to assist in maintaining compliance.

To mitigate any adverse TAT trends found in each given month, a monthly management UM huddle meeting transpired to review the processing results, with a drill down on the causation of any cases that failed to meet requirements. This process was supported with ongoing training of staff and continued evaluation of work processes to identify opportunities for streamlining processes.

With these changes KHS facilitated a quarter-over-quarter improvement in cumulative compliance. As follows is an example of monitoring report.

Month	January	February	March
Total Referrals Processed	24,335	22,963	26,776
Total Referrals Delayed	43	55	43
Percent of Delays	<1%	<1%	<1%
Percent of Audit (10 percent or 10 referrals whichever is larger)	10 referrals	10 referrals	10 referrals
Number of Referrals in Audit	10	10	10

1

Indicators:

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

The overall 2023 compliance score met the 95% compliance goal.

This audit function will continue for 2024 as part of the KHS HICE Work Plan Report.

For 2024 the UM Work Plan selected by KHS is the Health Industry Collaborative Effort Template. The HICE Work Plan has been adopted by all of the CA Medi-Cal Health Plans as the standard.

GOAL 7:	Compliance with timeliness of processing. Turn Around Times (TAT**)**		
INTERVENTIONS:	**GOAL:**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1. Monitoring of the Turn Around Time (TAT) by type on a routine basis using business intelligence reporting tools. 2. Weekly evaluation to identify barriers to meeting utilization management timeline standards, 3. Develop action plans to address deficiencies. 4. Ongoing focus on meeting TAT requirements. 5. Monthly Management review or TAT results, with drill down on all cases that fail to meet TAT requirements.	Compliance with DHCS turn-around timeframes. >/= 95% by type of request.	Utilization Review Manager and Supervisor	Daily

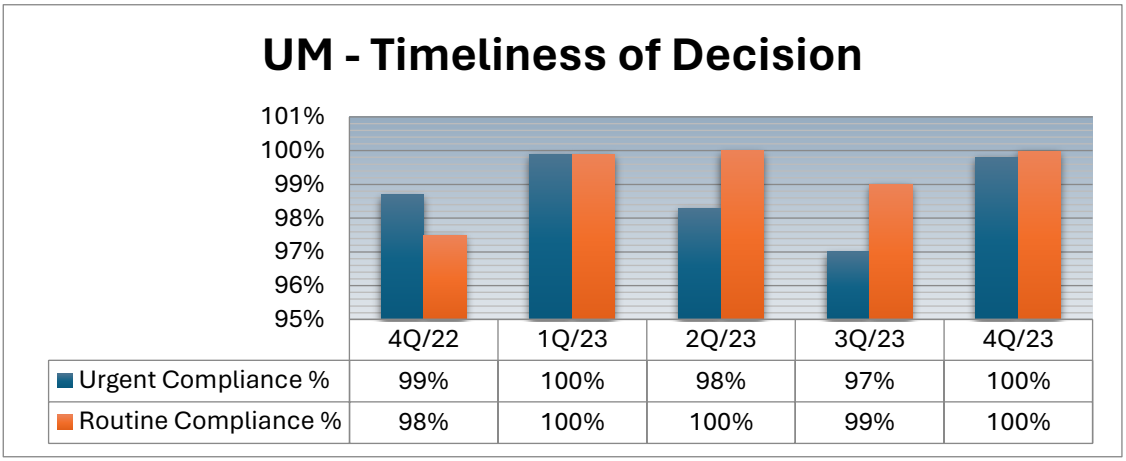
6. Ongoing training or staff and evaluation of work processes to identify opportunities for streamlining process.			

EVALUATION: GOAL MET

As indicated in GOAL # 6, multiple monitoring reports to monitor authorization processing TATs were developed. Training for this topic was done extensively throughout the year to include initially at year opening and then during UM Of them one report specifically monitors the time frame from when the auth was received by the UM Department
As follows: Routine the initial time is established from the day following receipt with a TAT of 5 business days to be completed in full.
For and time stamped via the urgent the time frame begins in at the hour, minute, and second of KHS receipt of the request. i.e. date provider portal, fax, or call-in requests by which the time of the call in is recorded by the UM representative in receipt of the verbal request. The Turn around time is 72 hours. Urgent requests are prioritized.

The compliance goal is 95% for routine and urgent.

This report is run in the a.m. and then at other pre-established intervals with a 2pm final report run to ensure timeliness is meeting regulatory TAT compliance before each business day's end.



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

This process will continue as part of the 2024 UM Work Plan. Within the HICE WP TATS are measured and reported quarterly.

GOAL 8:	Consistency with which criteria are applied in UM decision-making and opportunities for improvement are acted upon.		
INTERVENTIONS:	**GOAL:**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1. Conduct quarterly interrater Reliability (IRR) testing of healthcare professionals involved in UM decision making.	Physician and nonphysician UM reviewer 5 file achieving passing score on MCG IRR Tool.	Clinical Supervisor	Quarterly

EVALUATION: GOAL MET

Please refer to goals 2.

For 2024 the IRR testing process will expand to non-licensed UM staff to evaluate and as needed optimize UM efficiencies. The focus of the non-licensed IRR process will focus on administrative proficiency standards such as verification of benefits, checking the UM system to ensure a service is not duplicative or requested within the benefit period, ensuring medical necessity records are attached and following protocols to collect the records and so on..

GOAL 9:	Appeals and Dispute Management Compliance		
INTERVENTIONS:	**GOAL:**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1. Monthly analysis of UM Appeals by volume, number of upheld vs overturned, and associated turn-around times. 2. Analyze the UM appeal review to identify trends. 3. Identify opportunities for removing or adjusting prior authorization requirements or criteria based on appeals data that are regularly overturned. 4. Ensure appeals are processed by specialty-matched physicians.	Ensure >/= 90% accuracy of all determinations while complying with regulatory tum-around times	Utilization Review Manager and Supervisor	Monthly

EVALUATION: GOAL MET

As planned, Appeal outcomes were monitored and reported throughout 2023. Data reports and analytics occurred regarding appeals turn around times and appeals overturn and upheld trends. Appeals were categorized by specific services to include:

1. DME
2. Outpatient
3. Inpatient
    - Acute rehab
    - Inpatient procedures
4. Home Health

The category with the highest number of upheld denial determinations was the DME category reflecting a 57.03% denial upheld rate for not medically indicated or technical denial due to the DME provider not complying with KHS prior authorization procedures.

For all categories, the highest percentage of denial determinations occurred due to lack of information being received during the UM review process to support the medical necessity for the service request. Of note, a denial determination that transpires due to lack of information does not ensue until after 3 provider outreach attempts to collect the necessary information has been performed by UM and the information still has not been received. To comply with regulatory UM medical necessity decision making and timeliness standards a denial is rendered. The denial notification to the member and provider includes a detailed description of the KHS appeals process to serve as an avenue to further facilitate an additional review of the service request if the information is

submitted. A significant number of overturns to approval for the appeals data in general were due to the plan receiving additional information from providers during the appeals process to justify the medical necessity of the request.

This activity is reported in the following format indicating the total number of Appeals service requests and the final determination of overturned, upheld or partially upheld. For 2023 there were no partial upheld determinations.

As a DHCS contractual requirement, KHS submits Appeals data routinely to the department to include an aging TAT.. There have been no derogatory trends identified in terms of TATs.

Appeal Decision Summary Report By Service Type

From: 1/1/2023 To: 12/31/2023

Client: STATE OF CALIFORNIA

Employer: Kern Health Systems (KHS)

Group: Medi-Cal

Appeal Level : All

Service Type	Total Services Requested	Total Number Of Requests Overturned	Total Number Of Request Upheld(Full Upheld)	Full Upheld Rate For Current Reporting Period	Total Number Pending	Total Number Partial Upheld	Full And Partial Upheld Rate
Durable Medical Equipment	612	261	349	57.03%	2	0	57.03%
Outpatient Referral	2026	1251	769	37.96%	6	0	37.96%
Acute Rehab Hospital	3	2	1	33.33%	0	0	33.33%
Home Health	51	35	16	31.37%	0	0	31.37%
Inpatient Procedure	139	111	28	20.14%	0	0	20.14%

When there is a specific provider trend of not complying with proper service request medical records and documentation submission in accordance with KHS policies and protocols, the Provider Network Department is notified to assist in educating the provider and instituting steps to mitigate any adverse trends that may create a barrier to members receiving timely medically necessary services.

For 2024 Appeals monitoring and reporting will continue as a category in the UM Work Plan.

GOAL 10:	Monitoring of over and under utilization		
INTERVENTIONS:	**GOAL:**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1. Conduct monthly review of the following UM metrics by AIDE code: Acute bed days per thousand, average length of stay. Acute care stay, ER visits per thousand. all-cause readmissions, readmissions within 30 days, C-Section ratio. 2. Aggregate LOS specialty referral review Assessments on a biannual basis.	5% improvement of current statistical baseline.	Medical Director	Monthly

EVALUATION: GOAL MET

Multiple activities were planned and carried through to include routine reporting to the UM Committee throughout 2023 to include:

1. Initial Health Assessment (IHA) Letters to Members

Goal ensuring this service is not underutilized and newly assigned and existing members undergo an Initial Health Appointment to ensure they are assessed and receive necessary services and care. The UM department performs the following activities and reports the results to the UMC monthly:

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

Monthly Report Initial Health Appointment IHA and Unused Member Authorizations
July 2023 • IHA Letters Mailed – 370 • Open Authorization letters mailed – 131. August 2023 • IHA Letters Mailed – 363 • Open Authorization letters mailed – 127. September 2023 • IHA Letters Mailed – 360 • Open Authorization letters mailed – 129

For 2024 the IHA process will continue. Additionally, another study will be added to further address over/under utilization practices such as members as a whole with unused authorizations that have been approved to ensure they receive services if still medically indicated by their PCP or specialist.

Referrals for non-contracted providers has been identified to be over-utilized substantially based on the volume of this referral type as well as underutilizing qualified credentialed contracted in-network providers capable of delivering the services. and from a quality management perspective familiar with KHS established policies and procedures and data exchange management. A strategy to reduce these referrals is underway for 2024.

GOAL 11:	Consistent referral of members for specialty program consideration originating from utilization management.

INTERVENTIONS:	GOAL:	RESPONSIBLE TEAM MEMBER:	COMPLETION DATE:
1. Assessment of each member with an inpatient encounter with the purpose of Identifying a condition that would warrant additional specialty care management and *refer* for consideration prior to encounter closure. 2. Review of member encounter data via business intelligence reports to identify those with qualifying conditions or social determinants of health that may benefit from enhance care coordination services and refer.	25% increase of referrals over current baseline each quarter until >/= 90% of eligible members are referred *for* specialty program consideration.	Utilization Review Manager and Supervisor	Ongoing

EVALUATION: **GOAL MET WITH IDENTIFIED EXCEPTION**

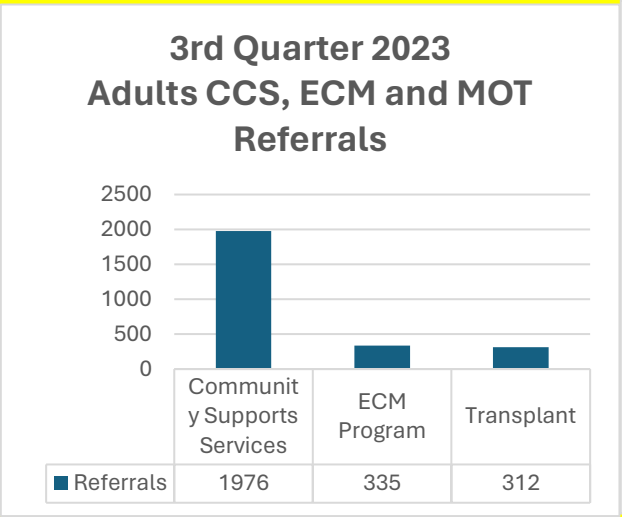
In congruence with the established goal. Multiple program referral strategies were implemented throughout the course of 2023 to ensure the assessment of each member that underwent an episode of an inpatient care encounter and had an identifying condition that would warrant additional specialty care coordination and services would be referred to a supportive service. For those meeting the need for specialized support they were referred to a variety of programs and or services. The 2 areas of referral support involving the highest percentage of referred members were health education and ECM/Community supports.

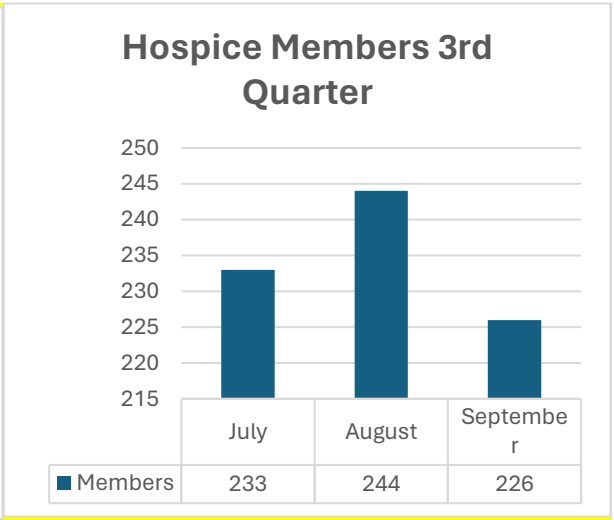
To validate if there was a 25% increase in the specialized program referral volume, multiple referral and tracking report interfaces were put in place to measure those UM referral activities to the other services.

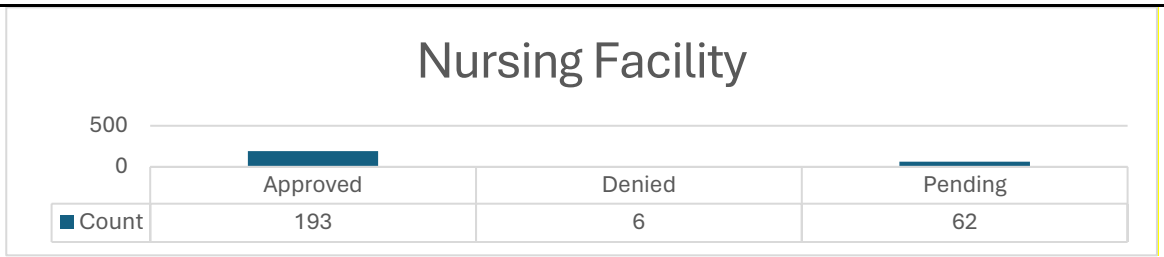
Of note, while the reporting formats did track the referrals no further measurements were incorporated to measure if there was actual member participation and if so the completion of participation with the activities to achieve a specific goal. If there was not member participation there were no efforts to validate why the participation did not occur such as refusal, unable to contact and so forth.

Also the comparative baseline measurement from 2022 to 2023 was unclear.

Examples of the referral to service reports include the following:







Member Specialized Program and Activity Referrals	Count of Activity
Member Outreach	**16**
CM Periscope Review	16
New CM Referral	**34**
CM Periscope Review	1
Member identified intervention	1
Referral to Case Management	31
Referral to Health Education	1
HE Referral - Asthma Education	**8**
HE Referral - Diabetic Education	**16**
New HE Referral - Nutritional Education	**8**
New HE Referral - Pregnancy Referral	**18**
New HE Referral - Smoking Cessation Education	**41**
New HE Referral - Weight Management Education	**15**
Program Referral	**2**
Referral to Case Management	1
Referral to COPD Program	1

Community Supports	Count of Activity
Program Referral (System Generated)	**2054**
Referral to Comm Supports Asthma Remediation Program	443
Referral to Comm Supports Caregiver Respite Program	93
Referral to Comm Supports Comm NF Transition Program	1
Referral to Comm Supports Housing Deposits Program	42
Referral to Comm Supports Housing Navigation Services Program	389
Referral to Comm Supports Housing Sustainability Program	56
Referral to Comm Supports NRSF Diversion Program	5
Referral to Comm Supports Personal Care Services Program	158
Referral to Comm Supports Recuperative Care Program	64
Referral to Comm Supports Short Term Post Hospitalization Program	40
Referral to Comm Supports Sobering Centers Program	186
Referral to Comm Supports Tailored Meals Program	151
Referral to ECM Program	172
Referral to LTC Program	254

The referral program strategy and intervention will be carried through to 2024. For 2024 a 2023 baseline for each service will be measured and compared throughout 2024 on the reports. Additionally follow through with the referral will be conducted and documented to provide further insight into the effectiveness of the increased referrals as it pertains to supporting the members with specific goals.

GOAL 12:	Coordination of care with California Children's Services (CCS).		
INTERVENTIONS:	**GOAL:**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1. Daily inpatient census will be reviewed, and any eligible member will be referred lo CCS for service authorization request. 2. Weekly review of CCS business intelligence report to validate member's ambulatory referrals are authorized and encounters processed appropriately. 3. Quarterly review or reports to identify CCS eligible members that are near age out and referral to Case Management to facilitate smooth transition of provisions of care.	100% of eligible cases will be identified care will be coordinated with CCS as appropriate.	Utilization Review Manager and Supervisor	Quarterly

EVALUATION: GOAL MET

As planned California Childrens Services (CCS) were monitored for inpatient institutional services and ambulatory care services.

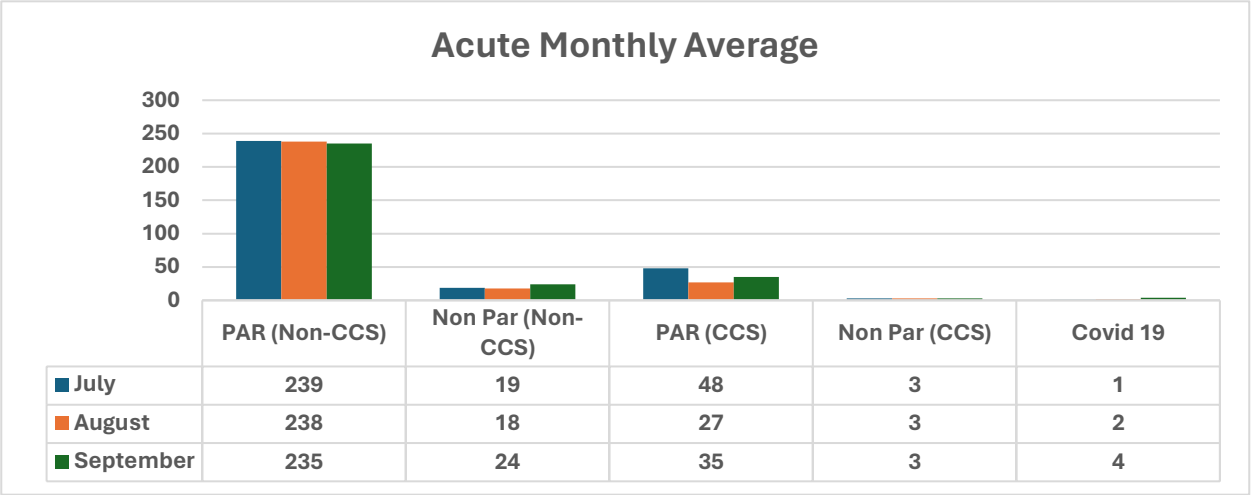
Business intelligence reports were created to capture CCS inpatient episodes of care for 2 categories to include general acute care and tertiary care. The episodes were aggregated from the KHS daily inpatient census for pediatric encounters. The inpatient concurrent review nurses collaboratively verified through the UM designated CCS team to confirm members with a CCS condition if they had been approved by CCS and had a CCS authorization SAR on file as well as confirming the hospital the member was admitted to is CCS paneled.the report reflects this as CCS par (participating or CCS Non-par.

All CCS cases identified through this process that have a SAR are considered a carve out from KHS's management of the actual CCS condition and financial responsibility. The UM team retains responsibility for supporting and authorizing the coordination of all other services not related to the CCS condition for the member, i.e., preventive health, incidental illnesses, routine care, injuries, etc.

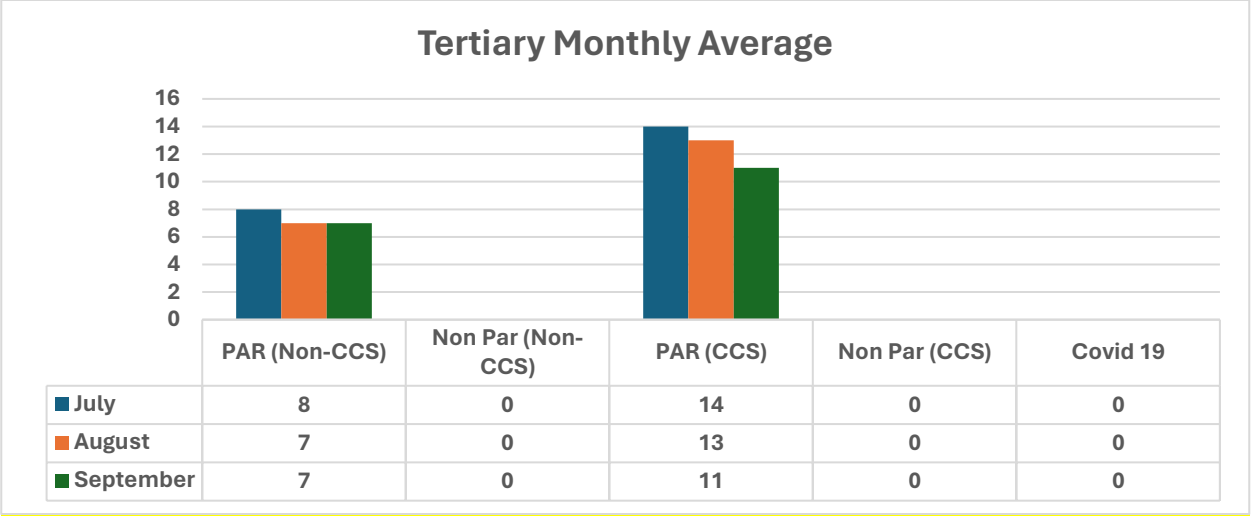
On an average there are approximately 235 inpatient general acute stays for pediatric members with CCS eligible conditions and 10 for tertiary.

In the event a member has a CCS condition but has not undergone an assessment by CCS which is indicated when the member does not have a SAR the UM CCS coordinators/nurses refer the case to CCS.

Example:



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



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

2023

CCS Outpatient Report

Case Totals:	**480**

Authorizations Count: 1050 for CCS Cases

CCS reporting will continue through 2024 as a UM standard and go through UMC outside of the 2024 work plan. CCS because it is a carved out service is not included in the HICE Work Plan

KERN HEALTH SYSTEMS

2024 UTILIZATION MANAGEMENT WORKPLAN

INTRODUCTION:	The goal of the utilization management department is to ensure members we serve receive high quality care in the right setting at the right time. To ensure this goal is met, the utilization management department proposes the following interventions.

GOAL 1:	Ensure that qualified, licensed, healthcare professionals assess clinical information used for clinical decision making.

2023 INTERVENTIONS:	**2024 GOAL(s):**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1. Ensure high quality new hire orientation training is provided to all new clinical staff. 2. Provide annual continuing education opportunities for the clinical staff. 3. Review and revise staff orientation materials, manuals and processes. 4. Implement verification process to validate continuing education completion and verification of certifications.	100% compliance with maintaining records of professional licenses and credentialing for staff that support clinical decision making to ensure KHS members receive medically necessary care at the right time in the most appropriate setting.	Utilization Review Manager	Ongoing

2024 Planned Interventions/Activities:

1. Ensure high quality new hire orientation training is provided to all new clinical and non-clinical staff.
2. Provide annual continuing education opportunities for the clinical and non-clinical staff.
3. Review and revise staff orientation materials, manuals and processes at least annually and as needed.
4. Implement verification process to validate continuing education completion and verification of certifications.
5. For medical necessity nationally recognized criteria, the UM nurses and physician reviewers will continue to utilize the **MCG Guidelines**. MCG guideline criteria sets offer evidence-based care guidelines for various care settings and conditions, developed by clinical editors, and based on peer-reviewed papers and research studies. The care guidelines are utilized by the KHS staff for outpatient referrals and procedures and inpatient concurrent hospital admission stays. The UM licensed staff reviewers will continue to undergo significant training as part of the new hire orientation process and then at regular intervals throughout the year to include, one-to-one training, UM inpatient concurrent review staff huddles, denied, modified case reviews, and inpatient denial reviews. Licensed staff UM reviews are monitored through a random selection of each reviewer's file reviews on a monthly basis as they apply to utilizing MCG guidelines.
6. A specialized training Inservice will be arranged in 2024. The training module included criteria access resource links, best practices, and hierarchical selection requirements in conformance with Medi-Cal regulations. Other aspects of the training covered application of benefits, how to locate and utilize the Medi-

Cal Provider Manuals and specialized Medi-Cal Programs.

7. KHS UM medical leadership will ensure adherence to a designated Medical Criteria policy and procedure developed in 2023 to facilitate more detailed guidance with UM criteria selection process. The proficiency of staff adherence to application of medical necessity is also measured through the Inter-rater Reliability (IRR) audit process as defined in the following goal. **This function will continue for 2024 as part of the new staff onboarding process, ongoing hands-on licensed staff training, formal training modules, and updated procedural guides as needed.**

GOAL 2:	Compliance with hierarchy of decision making, ensuring consistent application of medical necessity determination criteria.		
2023 INTERVENTIONS:	**GOAL(s):**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1. Quarterly completion of Milliman Care Guideline Inter Rater-Reliability (MCG IRR) 2. MCG training annual and as needed based on changes to the guidelines. 3. Annual review of Medi-Cal guideline training and for hire.	Inter-rater-reliability pass rate of **100%**	Utilization Review Manager	Ongoing

2024 Planned Interventions/Activities:

1. Quarterly completion of Milliman Care Guideline Inter Rater-Reliability (MCG IRR)
2. MCG training annual and as needed based on changes to the guidelines.
3. Annual review of Medi-Cal guideline training and for hire.
4. The Inter-rater-reliability compliance rate will continue to be 100% for licensed reviewers with a passing score of 80% or greater for each IRR Case Review and with the concession that if they failed a case they were educated and retrained and a retest of 2 cases will transpire after the retraining.
5.

Providers Criteria

Regulations and Criteria Guidelines (Hierarchy of Criteria)
KHS Physician Reviewers will use the hierarchy of KHS UM criteria to make UM decision in the following order:

1. Health Plan eligibility and coverage
2. Federal and state mandated criteria
   - California Code of Regulations Title 22,
   - California Code of Regulations Title 28,
   - CMS Code of Regulations Title 42,
   - California Health and Safety Code §§1363.5; 1367.01; 1371.4; 1374.16,
   - Medi-Cal Provider Manuals,
   - CA DHCS All Plan Letters (APL),
   - DMHC All Plan Letters,
   - CA DHCS Policy and Procedure Letters (PPL),
   - 42 CFR section 438.915, 438.206.
   - Standardized Behavioral Health criteria (Title 9, DSM-V)
3. Nationally recognized criteria set
   - MCG Health LLC (Milliman Care Guidelines,)
   - UpToDate
4. Peer Reviewed Journal or Published Resources

Preventive Health
KHS will maintain and communicate preventive care protocols to providers. Preventive care will be provided in accordance with the following accepted guidelines:

- *The Guide to Clinical Preventive Services Report (Report on the US Preventive Services Task Force)*[i]
- *AAP Recommendations for Preventive Pediatric Health Care*
- *CHDP Medical Guidelines*
- *ACOG*

GOAL 3:	Ensure compliance with legislative and regulatory directives.		
2023 INTERVENTIONS:	**GOAL(s):**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1. Participate in all appropriate legislative and regulatory workgroups and/or activities that may impact the UM department. 2. Update department policies and *procedures* to reflect these changes. 3. Implement a policy and procedure review plan to ensure directives are operationalized. 4. Participate in monthly compliance committees, and Program Metrics Reporting (PMR) to review and monitor compliance to standards.	All new APLs will be reviewed, and policies updated to comply with new APL directives and other Federal and State regulations.	Utilization Management Director	Ongoing with Quarterly Review

2024 Planned Interventions/Activities:

1. Continue to participate in all appropriate legislative/regulatory and NCQA accrediting workgroups and/or activities that may impact the UM department.
   a. KHS will continue to demonstrate readiness with the DHCS 2024 Contract driven by the many CalAIM transformational goals to improve more coordinated person centered and equitable health care served.
   b. KHS will adhere to the expanded health services committee structure with the creation of a Quality Improvement Health Equity Transformation Committee (QIHETC) as the umbrella committee for all health service quality functions. The KHS internal existing health service committees as well as newly developed committees were converted to subcommittees to support, monitor and report the 2024 new contract requirements applying to each health services area to ensure compliance. In addition to the 2024 contract, multiple DHCS and Department of Managed Health Care (DMHC) APLs were released to guide operational and administrative requirements.
   c. Continue to comply with 2024 NCQA Standards and Guidelines in preparation for the 2025 NCQA accreditation process. ***The most current 2024 NCQA Accreditation Standards will be cross-walked to KHS health services activities to ensure compliance.***
2. Continue to update department policies and *procedures* to reflect these changes.
3. Implement a policy and procedure review plan to ensure directives are continuously operationalized throughout 2024.
4. Continue to participate in monthly compliance committees, and Program Metrics Reporting (PMR) to review and monitor compliance to standards.
5. Staff training will be continuous pertaining to the newly instituted documents and activities instituted through review of the policies and programs and collaborative meetings to facilitate best practices.
6. **All new APLs in 2024 will continue to be reviewed, and policies updated to comply with new APL directives and other Federal and State regulations.**

GOAL 4:	Ensure separation of medical decisions from fiscal considerations.		
2023 INTERVENTIONS:	**2024 GOAL(s):**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1. Circulate to all Physician and Nurse reviewers an attestation that states: "Utilization Management decisions are based on medical necessity and medical appropriateness does not compensate physicians or nurse reviewers for denials. KHS does *not* offer incentives to encourage denials of coverage or service". 2. Ensure this education is provided to all Utilization Management staff.	100% compliance with distribution and receipt of completion of affirmative statement about financial incentives.	Utilization Management Manager	Annually

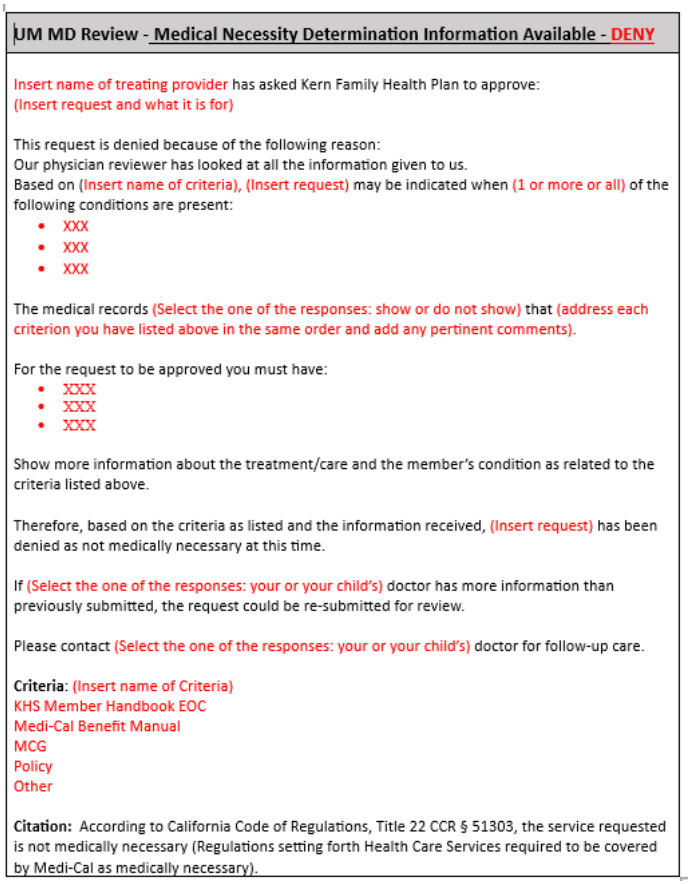
2024 Planned Interventions/ Activities:

1. Circulate to all Physician and Nurse reviewers an attestation that states: "Utilization Management decisions are based on medical necessity and medical appropriateness does not compensate physicians or nurse reviewers for denials. KHS does *not* offer incentives to encourage denials of coverage or service" in accordance with DHCS and DMHC requirements of ensuring there is separation of financial influences on medical necessity decision making. The Affirmative Statement will be distributed to UM staff by the KHS Human Resources Department.
2. Ensure this education is provided to all Utilization Management staff upon onboarding and annually.
3. The Affirmative Statement is now added as a standing agenda item for the UM Committee and will be required to be signed annually by each committee member as well as throughout the year for any newly participating committee attendee.
4. The KHS website will be updated in 2024 with the affirmative statement under the Utilization Management section.
5. **This Affirmative Statement will be implemented in 2024 and as a regulatory requirement, carried through from year to year.**

GOAL 5:	Ensure compliance with regulatory standards.		
2023 INTERVENTIONS:	**2024 GOAL(s):**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1. File reviews to validate regulatory standards are met. 2. Education, both ongoing and remedial will be provided to staff on any issues revealed during the file review process	Documented use of guidelines in medical necessity determinations will be in compliance with State, Federal and other regulatory requirements 95%	Utilization Review Manager/Trainor and Supervisor	Quarterly

2024 Planned Interventions/Activities:

1. File reviews will continue to be conducted by UM trainor/designee monthly or as determined by UM leadership. Clinical nurses will at least annually receive training consisting of best practices and compliance requirements for UM medical necessity and application of criteria and benefit review cases to include denial / delay / modified. Methodology will include a selection of 5 random cases from the universe for each staff being reviewed. The case documents, medical necessity criteria selected by the reviewer and the reviewers written rational and decision determinations will be cross referenced to the Notice of Action Letter as follows:
    a. Spelling/Grammar, Verbiage, and Format,
    b. Medi-Cal Criteria applied,
    c. Criteria indicated and attached,
    d. Recommendations to MD indicated.
2. Fille review will ensure 95% compliance with referral decision making and member and provider notification timeliness standards in congruence with regulatory and accrediting standards.
3. Any deficiencies identified will be followed through with one-to-one continued training until they meet the threshold goal of 95%in 2024 (threshold was 85% in 2023).
4. Ongoing remedial training as needed will be provided throughout the year.
5. A new medical review template will be implemented for the UM clinical review team (nurses and physicians). The template is used as a standard in the Medi-Cal industry and encompasses a formatted sequential process to apply medical criteria and rationale for any adverse determinations based on the individual needs of the member.



UM MD Review - Medical Necessity Determination Information Available - DENY

Insert name of treating provider has asked Kern Family Health Plan to approve:
(Insert request and what it is for)

This request is denied because of the following reason:
Our physician reviewer has looked at all the information given to us.
Based on (Insert name of criteria), (Insert request) may be indicated when (1 or more or all) of the following conditions are present:

- XXX
- XXX
- XXX

The medical records (Select the one of the responses: show or do not show) that (address each criterion you have listed above in the same order and add any pertinent comments).

For the request to be approved you must have:

- XXX
- XXX
- XXX

Show more information about the treatment/care and the member's condition as related to the criteria listed above.

Therefore, based on the criteria as listed and the information received, (Insert request) has been denied as not medically necessary at this time.

If (Select the one of the responses: your or your child's) doctor has more information than previously submitted, the request could be re-submitted for review.

Please contact (Select the one of the responses: your or your child's) doctor for follow-up care.

Criteria: (Insert name of Criteria)
KHS Member Handbook EOC
Medi-Cal Benefit Manual
MCG
Policy
Other

Citation: According to California Code of Regulations, Title 22 CCR § 51303, the service requested is not medically necessary (Regulations setting forth Health Care Services required to be covered by Medi-Cal as medically necessary).

6. **This file review audit function will continue for 2024 as a best practice.**

GOAL 6:	Monitoring of the utilization management review process.		
2023 INTERVENTIONS:	**2024 GOAL(s):**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1. Utilize business intelligence reports monthly and as needed as a tool for systematic oversight of the prior authorization process. 2. Assess staffing requirements to complete the prior authorization process timely and ensure an adequate budget is allocated to meet the staffing needs.	Track and trend authorization activity on a monthly basis including: 1. Number of prior authorization requests submitted, approved, deferred, denied, modified and maintain compliance timeliness rate of 95 %. 2. Denials appealed and overturned compliance rate of 5 % or <.	Utilization Management Director and Manager	Monthly

2024 Planned Interventions/Activities:

1. Utilize business intelligence reports monthly and as needed as a tool for systematic oversight of the prior authorization process in a time sensitive, efficient manner while aligning practice with all regulatory and statutory requirements.
2. Assess staffing requirements to complete the prior authorization process timely; maintain compliance threshold goal of 95% or better.
3. Multiple report monitoring activities will continue to be updated/ developed to support the management of authorization referral request processing during each business day serves as a means to effectively assess staff availability matched to volume demands.
4. To mitigate any adverse TAT trends found in each given month, a monthly management UM huddle meeting will continue to transpire to review the processing results, with a drill down on the causation of any cases that failed to meet requirements. This process will be supported with ongoing training of staff and continued evaluation of work processes to identify opportunities for streamlining processes.
5. Ensure an adequate budget is allocated to meet the staffing needs.
6. **This audit function will continue for 2024.**

GOAL 7:	Compliance with timeliness of processing. Turn Around Times (TAT**)**

2023 INTERVENTIONS:	2024 GOAL(s):	RESPONSIBLE TEAM MEMBER:	COMPLETION DATE:
1. Monitoring of the Turn Around Time (TAT) by type on a routine basis using business intelligence reporting tools. 2. Weekly evaluation to identify barriers to meeting utilization management timeline standards, 3. Develop action plans to address deficiencies. 4. Ongoing focus on meeting TAT requirements. 5. Monthly Management review or TAT results, with drill down on all cases that fail to meet TAT requirements. 6. Ongoing training or staff and evaluation of work processes to identify opportunities for streamlining process.	Compliance with DHCS/ DMHC/NCQA turn-around timeframes. >/= 95% by type of request.	Utilization Review Trainor/ Manager and Supervisor	Daily

2024 Planned Interventions/Activities:

1. Monitoring of the Turn Around Time (TAT) by type on a routine basis using business intelligence reporting tools.
2. Weekly evaluation to identify barriers to meeting utilization management timeline standards.
3. Develop action plans to address deficiencies.
4. Ongoing focus on meeting TAT requirements.
5. Monthly Management review or TAT results, with drill down on all cases that fail to meet TAT requirements multiple monitoring reports to monitor authorization processing TATs were developed.
6. Ongoing training or staff and evaluation of work processes to identify opportunities for streamlining process.
   a. Routine request: the initial time is established from the day following receipt with a TAT of 5 business days to be completed in full.
   b. For time stamped via the urgent the time frame will begin in at the hour, minute, and second of KHS receipt of request. i.e. date provider portal, fax, or call-in requests by which the time of the call in is recorded by the UM representative in receipt of the verbal request. The Turnaround time is 72 hours. Urgent requests will be prioritized.
   c. The compliance goal is 95% for routine and urgent.
7. **This process will continue as part of the 2024 UM Work Plan.**

GOAL 8:	Consistency with which criteria are applied in UM decision-making and opportunities for improvement are acted upon.

2023 INTERVENTIONS:	2024 GOAL(s)	RESPONSIBLE TEAM MEMBER:	COMPLETION DATE:
1. Conduct quarterly interrater Reliability (IRR) testing of healthcare professionals involved in UM decision making.	Physician and nonphysician UM reviews 5 files achieving passing score on	Clinical Supervisor	Quarterly

	MCG IRR Tool.		

2024 Planned Interventions/Activities:

1. Conduct quarterly interrater Reliability (IRR) testing of healthcare professionals involved in UM decision making (clinical – Physician reviewers/nurses and non-clinical staff such as coordinators.
2. For 2024 the IRR testing process will expand to non-licensed UM staff to evaluate and as needed to optimize UM efficiencies. The focus of the non-licensed IRR process will focus on administrative proficiency standards such as verification of benefits, checking the UM system to ensure a service is not duplicative or requested within the benefit period, ensuring medical necessity records are attached and following protocols to collect the records and so on.
3. The file review process will include application of the approved UM criteria.

GOAL 9:	Appeals and Dispute Management Compliance		
2023 INTERVENTIONS:	**2024 GOAL(s):**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1. Monthly analysis of UM Appeals by volume, number of upheld vs overturned, and associated turn-around times. 2. Analyze the UM appeal review to identify trends. 3. Identify opportunities for removing or adjusting prior authorization requirements or criteria based on appeals data that are regularly overturned. 4. Ensure appeals are processed by specialty-matched physicians.	Ensure >/= 90% accuracy of all determinations while complying with regulatory tum-around times	Utilization Review Manager and Supervisor	Monthly

2024 Planned Interventions/Activities:

1. Monthly analysis of UM Appeals by volume, number of upheld vs overturned, and associated turn-around times.
2. Analyze the UM appeal review to identify trends.
3. Identify opportunities for removing or adjusting prior authorization requirements or criteria based on appeals data that are regularly overturned.
4. Ensure appeals are processed by specialty-matched physicians
5. Appeals will continue to be tracked and trended according to the number of Appeals cases overturned, upheld or partially upheld.
6. As a DHCS contractual requirement, KHS will continue to submit Appeals data routinely to the department to include an aging TAT.
7. When there is a specific provider trend of not complying with proper service request medical records and documentation submission in accordance with KHS policies and protocols, the Provider Network Department will be notified to assist in educating the provider and instituting steps to mitigate any adverse trends that may create a barrier to members receiving timely medically necessary services.
8. **2024 Appeals monitoring and reporting will continue as a category in the UM Work Plan.**

GOAL 10:	Monitoring of over and under utilization		
INTERVENTIONS:	**GOAL (s):**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1. Conduct monthly review of the following UM metrics by AIDE code: Acute bed days per thousand, average length of stay. Acute care stay, ER visits per thousand. all-cause readmissions, readmissions within 30 days, C-Section ratio. 2. Aggregate LOS specialty referral review Assessments on a biannual basis.	5% improvement of current statistical baseline.	UM Medical Director	Monthly

2024 Planned Interventions/Activities:

1. Conduct monthly review of the following UM metrics by AIDE code: Acute bed days per thousand, average length of stay. Acute care stay, ER visits per thousand. all-cause readmissions, readmissions within 30 days, C-Section ratio.
2. Will continue to aggregate LOS specialty referral review Assessments on a biannual basis.
3. **For Underutilization:**
   a. The UM department will continue to perform the following activities and reports the results to the UM/QI Committee at least quarterly:

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

   b. **Th IHA process will continue in 2024.**
4. **Overutilization**
   a. Track and identify members going to ER during regular PCP business hours for non-emergent conditions
      - Conduct PCP access and availability study during normal business hours.
      - Report of auditor findings will be sent to PCP identifying members who were not able to access PCP.
      - PCPs will do outreach educational calls in collaboration with KHS designated staff as determined.
5. Continue to track & trend over- utilization of non-contracted providers and under-utilization of qualified contracted in-network providers.

GOAL 11:	Consistent referral of members for specialty program consideration originating from utilization management.		
2023 INTERVENTIONS:	**2024 GOAL(s):**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**

1. Assessment of each member with an inpatient encounter with the purpose of Identifying a condition that would warrant additional specialty care management and *refer* for consideration prior to encounter closure. 2. Review of member encounter data via business intelligence reports to identify those with qualifying conditions or social determinants of health that may benefit from enhance care coordination services and refer.	25% increase of referrals over current baseline each quarter until >/= 90% of eligible members are referred *for* specialty program consideration.	Utilization Review Manager and Supervisor	Ongoing

2024 Planned Interventions/Activities:

1. Assessment of each member with an inpatient encounter with the purpose of Identifying a condition that would warrant additional specialty care management and *refer* for consideration prior to encounter closure.
2. Review of member encounter data via business intelligence reports to identify those with qualifying conditions or social determinants of health that may benefit from enhance care coordination services and refer.
3. The referral program strategy and intervention will be carried through to 2024. In 2023, a baseline was established for each service and will be measured and compared throughout 2024 on the reports. Additionally, follow through with the referral will be conducted and documented to provide further insight into the effectiveness of the increased referrals as it pertains to supporting the members with specific goals.

GOAL 12:	Coordination of care with California Children's Services (CCS).		
2023 INTERVENTIONS:	**2024 GOAL(s):**	**RESPONSIBLE TEAM MEMBER:**	**COMPLETION DATE:**
1. Daily inpatient census will be reviewed, and any eligible member will be referred to CCS for service authorization request. 2. Weekly review of CCS business intelligence report to validate member's ambulatory referrals are authorized and encounters processed appropriately. 3. Quarterly review or reports to identify CCS eligible members that are near age out and referral to Case Management to facilitate smooth transition of provisions of care.	100% of eligible cases will be identified care will be coordinated with CCS as appropriate.	Utilization Review Manager and Supervisor	Quarterly

2024 Planned Interventions/Activities:

1. California Childrens Services (CCS) will continue to be monitored for inpatient institutional services and ambulatory care services.

   a. Business intelligence reports will continue to be utilized to capture CCS inpatient episodes of care for 2 categories to include general acute care and tertiary care. The episodes are aggregated from the KHS daily inpatient census for pediatric encounters. The inpatient concurrent review nurses will collaboratively verify through the UM designated CCS team to confirm members with a CCS condition if they had been approved by CCS and had a CCS authorization SAR on file as well as confirming the hospital the member was admitted to is CCS paneled. The report reflects this as CCS par (participating or CCS Non-par.

   b. All CCS cases identified through this process that have a SAR are considered a carve out from KHS's management of the actual CCS condition and financial responsibility. The UM and PHM teams will retain responsibility for supporting and authorizing the coordination of all other services not related to the CCS condition for the member, i.e., preventive health, incidental illnesses, routine care, injuries, etc.

2. CCS reporting will continue through 2024 as a UM standard and go through UMC outside of the 2024 work plan. CCS is a carved-out service and is not included in the 2024 HICE Work Plan .

To: EQIHEC Committee

From: Michelle Curioso, Director of Population Health Management

Date: 02/08/24

Re: Population Health Management Committee (PHMC)

Background:
The Population Health Management (PHM) Department was officially launched on January 1, 2023. PHM is an initiative led by DHCS, which is a cornerstone of the California Advancing and Innovating Medi-Cal (also known as CalAim). The DHCS developed a framework that broaden delivery systems, program, and payment reform across the Medi-Cal Program. The purpose of PHM is to engage members with their health care and address social determinants of health and gaps in care while reducing costs.

Discussion:
The purpose of the Annual Report 2023 is to provide updates on PHM Special Programs.

- Major Organ Transplant
- Baby Steps Plus
- Integration of Community Health Workers
- Triage Team
- Complex Case Management

In addition, the Charter provides information about the Population Health Management Committee (PHMC) which includes the following:

- Description of PHMC
- Function
- Composition
- Frequency of Meetings
- 2024 Meeting Schedule

Fiscal Impact: None

Requested Action: Review for approval.

Kern Family Health Care™

Population Health Management 2023 Program Highlights

Michelle Curioso
Director of Population Health Management
January 27, 2024

Major Organ Transplant Program

The Kern Health Systems (KHS) offers MOT members care management and coordination services to improve their clinical and psychosocial outcomes. The MOT Program includes major organ transplants for kidneys, liver, lung, heart, intestines, bone marrow, as well as the Simultaneous Liver Kidney (SLK) transplant and the Simultaneous Kidney Pancreas (SKP) transplant, all requiring specialized individual approaches by the care manager to each member to be more effective for individualized interventions—lessening the burden of care and achieving greater health outcomes. The MOT Program receives referrals from multiple sources such as primary care physicians, specialists, or self-referral. Eligible members have the option to accept or decline MOT services. Each member goes through three distinct MOT phases: evaluation, waitlisted and post-transplant.

Previous studies have identified a hospitalization rate of greater than 30% within the first 30-days after discharge from the initial transplant hospitalization (Ho-Ting, et. al, 2016). Not only does this reflect a reduction in a patient's health status, but it also represents a significant burden on healthcare delivery systems. According to the Journal of Transplantation, hospital readmission is an important metric for measuring quality of patient care, and readmission rates are a leading indicator of patient survival for transplant recipients (Kaplan & Sweeney, 2012). Research shows the more members are readmitted to hospitals, the more likelihood that these members will not survive from the results of their major organ transplant procedures (Famure, et. al., 2021).

In the MOT Program, of the 270 members, 57 members completed their transplant. These members had been enrolled in the MOT Program and received case management and care coordination services. The transplant recipients who had participated in the KHS MOT Program had zero (0) readmission rates and 30-day organ rejection.

Major Organ Transplant
Time Period: January through December 2023

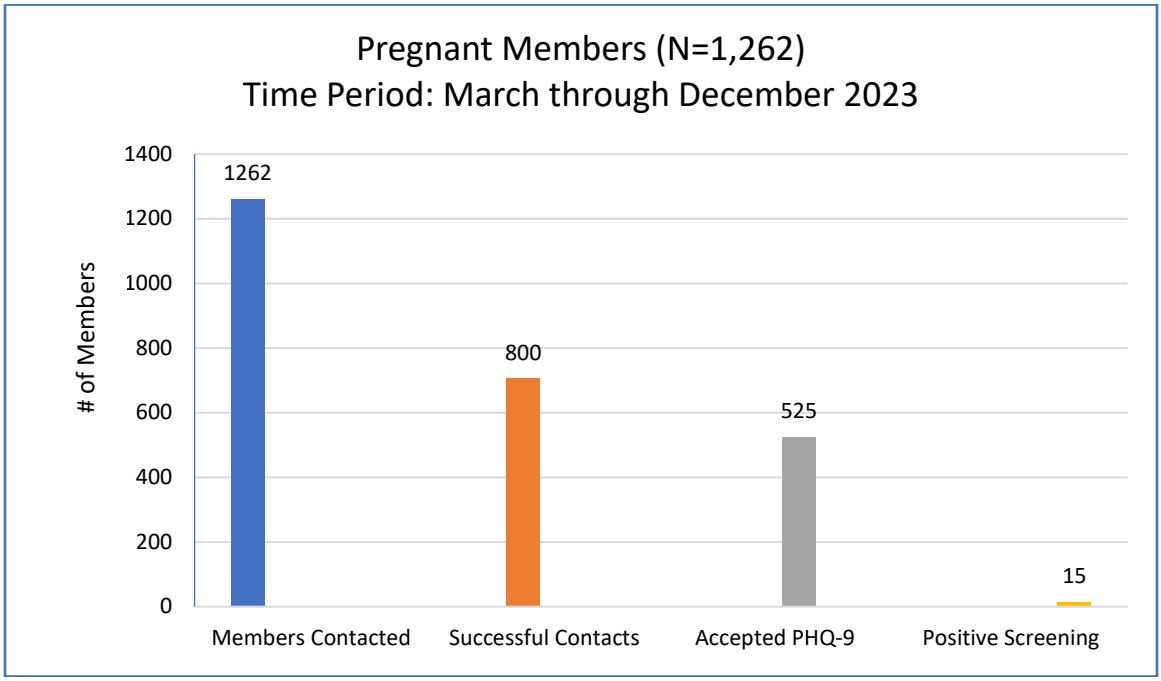
Phases	Kidney	Liver	Lung	Bone Marrow	Heart	Intestine	Cornea	SPK	SLK	Phase Totals
Evaluation	91	36	3	12	6	0	0	0	1	149
Wait Listed	73	12	0	3	0	1	0	0	4	93
Post Transplant (<1 year)	12	8	0	6	2	0	0	0	0	28
Organ Totals	176	56	3	21	8	1	0	0	5	270

Post Transplant	28
Finished 1-year Post Transplant	29
Completed Transplant	57

Baby Steps (previously known as Maternal Mental Health)

According to the Centers for Disease Control (CDC) and Prevention, about 1 in 8 women suffers symptoms of postpartum depression. On March 2023, we implemented PHQ-9 screening to all pregnant and postpartum women and identified those who are at risk for depression and need further evaluation. The PHQ-9 is an evidence-based model tool, nine-item questionnaire, and the tool is administered to screen for depression in adult.

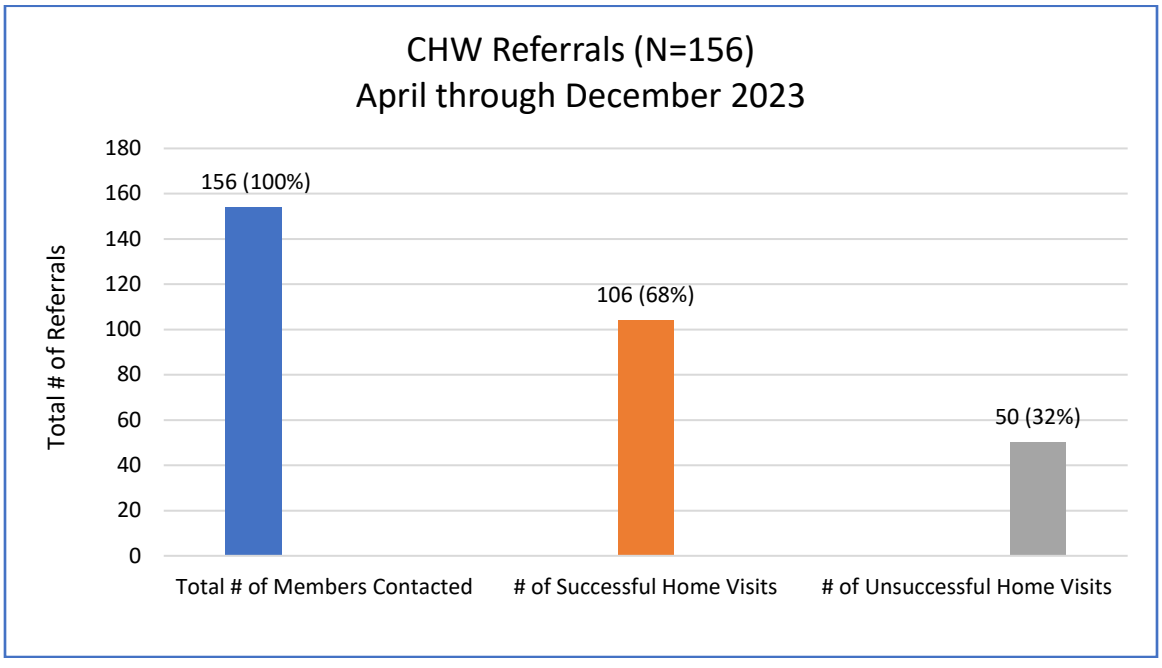
- There were 1,262 (100%) pregnant and postpartum moms who were contacted.
- Of the 1,262, there were 800 (63%) successful contacts.
- Of the 800 successful contacts, there were 525 (66%) mothers who accepted to be screened for depression.
- Of the 525 who were screened, there were 15 (3%) positive screening and referred to Behavioral Health for further interventions.



Integration of Community Health Workers

On April 2023, the Integration of Community Health Workers in Population Health Management (PHM) Department was implemented. This integration allows us to find hard-to-reach populations, health navigation, health education, provide support/advocacy, and safety check so they can be connected to Care Management and Care Coordination Services and to their Primary Care Physician.

- There are 2 Community Health Workers in the Population Health Management Department.
- From April through December 2023, there were 156 members who were referred to the CHWs. Some members were enrolled in our Complex Care Management and others were enrolled in the Major Organ Transplant Program.
- Of the 156 referrals, there were 106 successful contacts with the members.
- This is an overall **68% success rate**.
- Home visits were made in various geographical areas in Kern County such as Taft, Lamont, Arvin, Delano, McFarland, Shafter, and Wasco.
- As a result of these successful contacts, Member's case remained open for continuation of Care Management services.
- In the past, three contact attempts (2 phone calls and a letter sent to member) were made before closing these referrals. Now, the CHWs are able to make home visits before closing the Member's case.
- Contracted providers are highly encouraged to utilize CHW services. Since CHW services are a preventive service, KHS does not require prior authorization for CHW services; however, quantity limits can be applied based on goals detailed in the plan of care.



Triage Team

Triage of referrals is the entry point into receiving Care Management (CM) service in Population Health Management Department. This is a multidisciplinary approach to ensure the needs of the members are addressed in a timely manner. The Triage Team comprises of a Registered Nurse and 2 Certified Medical Assistants under the supervision of the Manager of Special Programs.

The PHM Triage Nurse receives incoming referrals, determines eligibility, identifies levels of complexity, prioritizes urgent referrals, and appropriately assigns referrals to staff based on level of acuity. The Triage Team takes referrals that can be resolved in 2-3 phone calls with members.

The Triage Team received a total of 9,415 referrals. Of the 9,415 (100%) referrals, 5,058 (54%) referrals were assigned to the Triage Team to provide care coordination. Of the 9,415 referrals, 796 (8%) were referred to Case Management and Baby Steps Program.

Time Period: July through December 2023

Months	Care Coordination				Survey	Referrals to PHM Programs		Reviewed	Total
	Total # of Referrals (Care Coordination by Triage Team))	Total # of completed calls (ECM, HRA & CHRA Callbacks, Misc.)	Total # Referred to Community Services	Total # of DME referrals	Total # completed HRAs by CMAs	Total # of Baby Steps Referrals	Total # referred to CM services	Total # ECMs (Reviewed & Closed) (Includes QNXT Calls and Referrals)	
July	37	467	7	5	3	90	2	629	1240
August	28	701	36	2	13	83	10	653	1526
September	91	866	12	0	1	68	15	584	1637
October	164	581	9	1	1	88	8	597	1449
November	230	800	13	7	4	83	163	806	2106
December	539	444	14	4	8	97	89	262	1457
Total	1089	3859	91	19	30	509	287	3531	**9415**

Complex Care Management (CCM) Program

The Complex Care Management (CCM) Program provides intensive, personalized care management and service coordination to these members who have complex medical and psychosocial/social determinants of health needs. Care Managers help members to maneuver through the various health care systems in collaboration with stakeholders who include members and their families, medical professionals, and health insurers. The CCM team consists of Registered Nurses (RNs), Social Workers (SWs), and Certified Medical Assistants (CMAs).

The data provides historical and comparison to utilization and cost during and after members receive CCM services. This helps to steer programmatic changes based on the effectiveness of the services rendered. To evaluate the impacts of CCM services on KHS members, Resource Utilization and associated cost summary data for KHS members receiving CCM services during Quarter 2 of 2023 (Q2-2023) were obtained (See Appendix A) and analyzed. The duration of CM interventions was 1 month to 13 months. Members who have complex and unstable medical and/psychosocial issues with identified barriers were reviewed and discussed in the Interdisciplinary Care Team (ICT).

The utilization and cost summary report compared the resource utilization and associated costs of KHS members in CCM six months prior to enrolling into CCM versus while they received CCM services. The data was categorized by the setting of the services utilized and included Office, Outpatient, Emergency, Inpatient, and Urgent Care settings (See Appendix A).

Appendix A

Data Information Knowledge Action
Business Intelligence

KERN HEALTH SYSTEMS

CM Member Goals Completed - 64 Unique Members

Utilization Summary Q2 2023

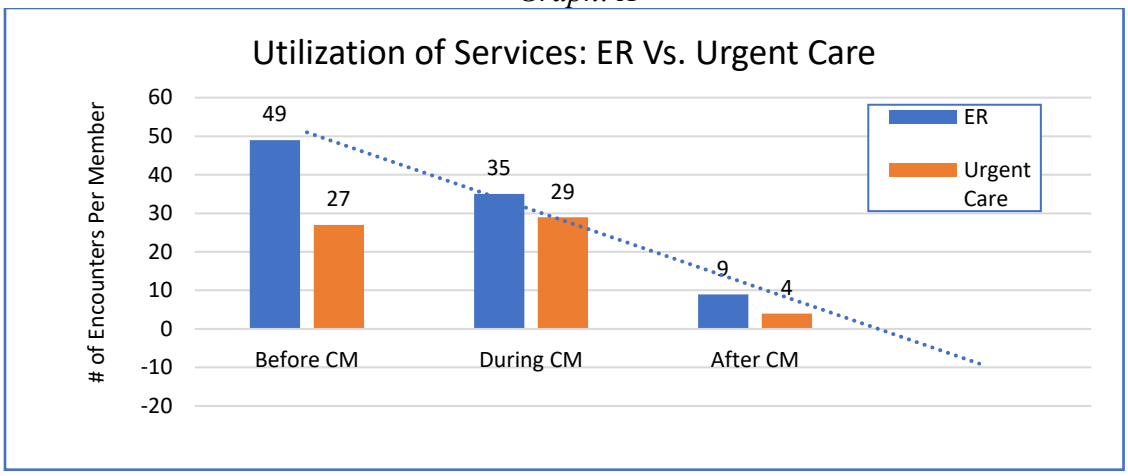
	Office	Outpatient	Emergency	Inpatient	Urgent Care
6 Months Before Case Management					
Encounters	197	707	49	14	27
per Episode	3.08	11.05	0.77	0.22	0.42
Member %	69%	88%	33%	16%	25%
per Member	4.48	12.63	2.33	1.40	1.69
During Case Management					
Encounters	236	1,010	35	5	29
per Episode	3.69	15.78	0.55	0.08	0.45
Member %	100%	94%	31%	8%	27%
per Member	3.69	16.83	1.75	1.00	1.71
6 Months After Case Management					
Encounters	35	108	9	0	4
per Episode	0.55	1.69	0.14	0.00	0.06
Member %	56%	56%	9%	0%	5%
per Member	0.97	3.00	1.50	0.00	1.33

Cost Summary Q2 2023

	Office	Outpatient	Emergency	Inpatient	Urgent Care	Total
6 Months Before Case Management						
Total	$13,562	$152,195	$38,059	$186,674	$2,094	$392,583
per Episode	$212	$2,378	$595	$2,917	$33	$6,134
per Member	$308	$2,718	$1,812	$18,667	$131	$23,637
During Case Management						
Total	$15,665	$175,653	$19,384	$30,713	$2,435	$243,849
per Episode	$245	$2,745	$303	$480	$38	$3,810
per Member	$245	$2,928	$969	$6,143	$143	$10,427
6 Months After Case Management						
Total	$2,524	$19,326	$4,599	$0	$347	$26,796
per Episode	$39	$302	$72	$0	$5	$419
per Member	$70	$537	$766	$0	$116	$1,489

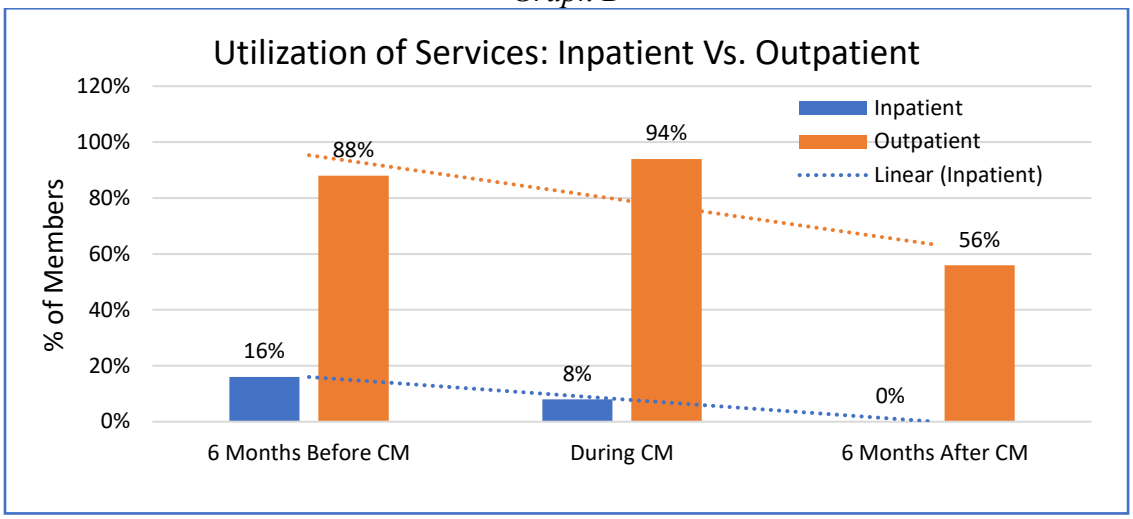
There was a significant change in the number of encounters for several categories. However, the data collected for the "6 months after CM" is inconclusive due to most contracting providers have not yet submitted their billing claims for services rendered. Most notably, the data below showed the following results (Graph A, B & C):

Graph: A



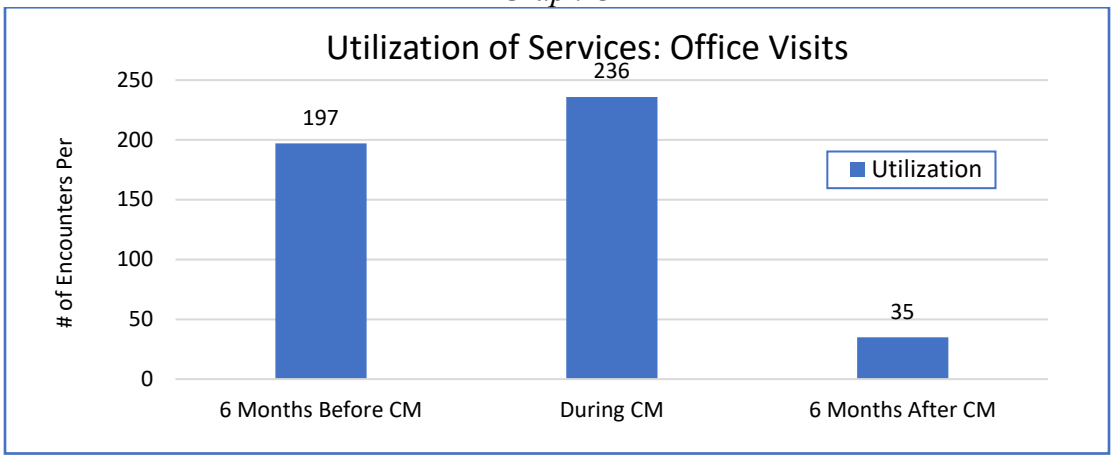
Result: Utilization of Emergency Services decreased 25% during case management.

Graph B



Results: Inpatient Services utilization decreased 29% during case management. The # of members who utilized inpatient services decreased by 50%. Outpatient Services utilization increased 33% during case management.

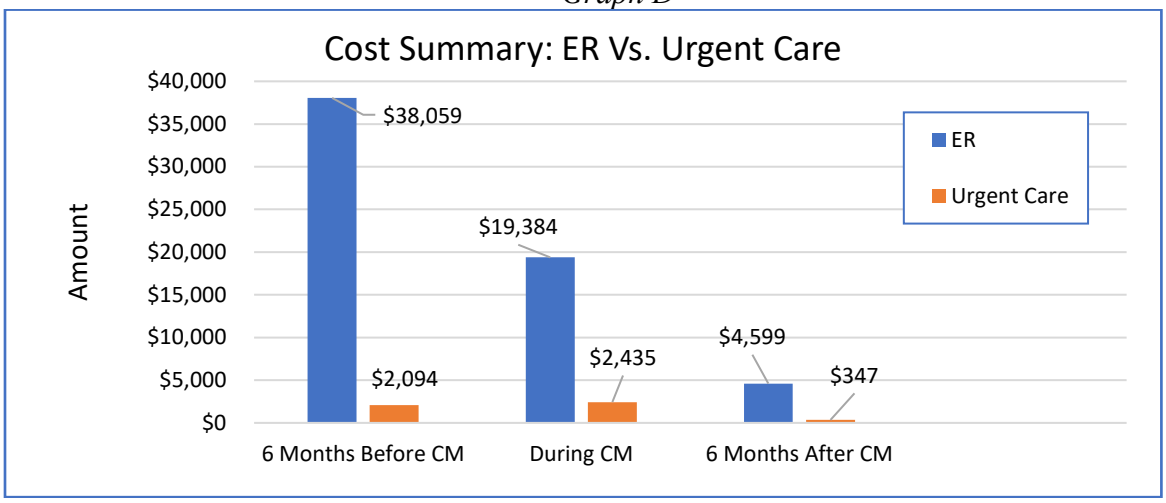
Graph C



Result:100% of members utilized office setting services while in CCM versus only 69% prior to CCM enrollment.

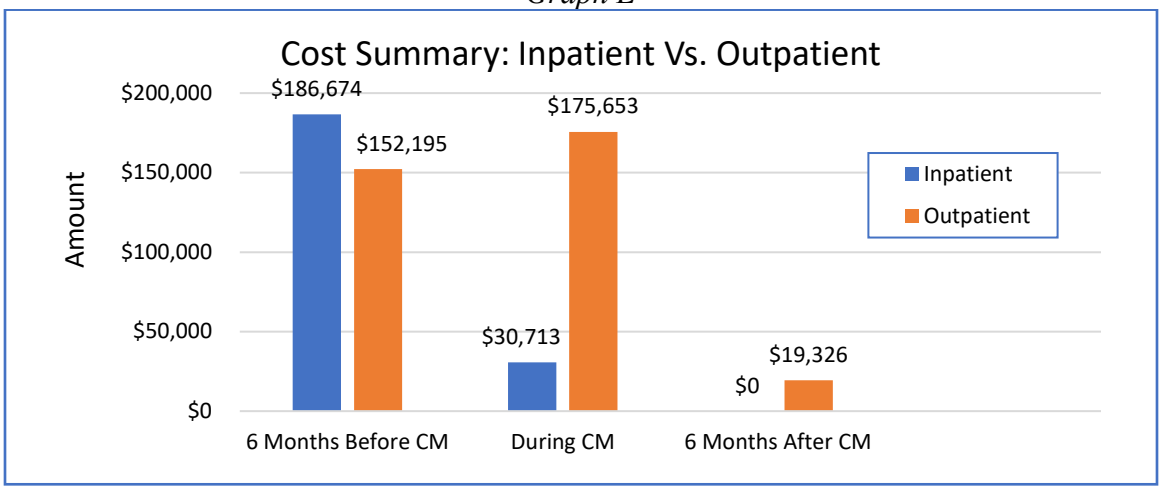
The total cost of services rendered to the 64 unique members for the six months prior to enrollment into CCM was $392,583. This translates to a Per Member Per Month (PMPM) cost of $1,022. This compares to a PMPM of $540 for the same members while enrolled in CCM. Overall, the total costs of PMPM **decreased by 53%** while being case managed. Note: the data collected for the "6 months after CM" is inconclusive due to most contracting providers have not yet submitted their billing claims for services rendered

Graph D



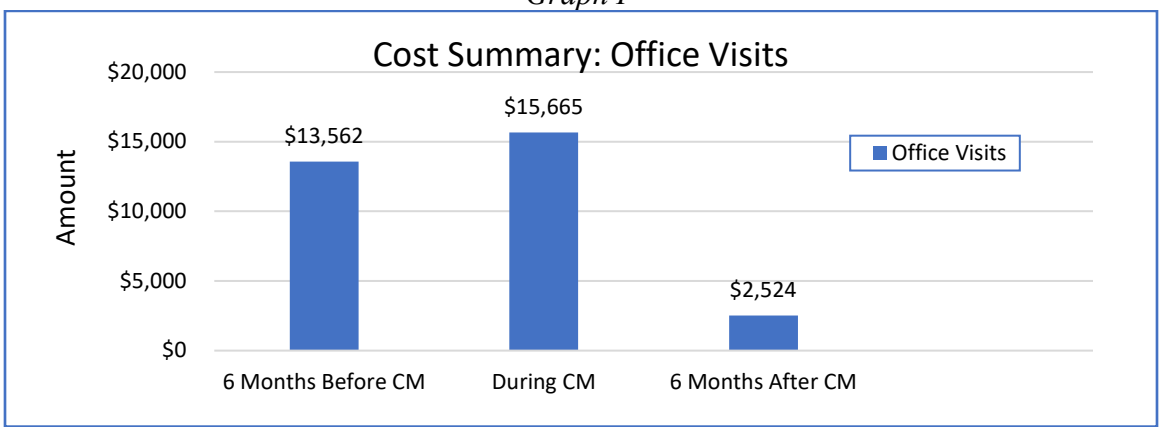
Result: Total costs associated with Emergency services **decreased by nearly 50%** while being case managed.

Graph E



Result: Total costs associated with Inpatient services decreased by more than 80% while being case managed.

Graph F



Result: Slight increase on the office visits while members are being case managed**.**

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KERN HEALTH SYSTEMS

Population Health Management Committee (PHMC)

Charter

Description of Committee

KHS follows the NCQA definition for Population Health Management: "Population Health Management (PHM) is a model of care that addresses individuals' health needs at all points along the continuum of care with a "Whole Person" approach supported through participation, engagement, and targeted interventions for a defined population".

The PHM Committee (PHMC) oversees the PHM Model of Care (MOC) that addresses individuals' health needs at all points along the continuum of care, including in the community setting, through participation, engagement, and targeted interventions for a defined population. The goal of the PHM MOC is to maintain or improve the physical and psychosocial well-being of individuals and address health disparities through cost effective and tailored health solutions.

Each year a Population Needs Assessment (PNA) is conducted by KHS. The annual PNA describes the overall health and social needs of KHS's membership by analyzing service utilization patterns, disease burden, and gaps in care of members, considering their risk level, geographic location, and age groups. The PHMC members focus on strategies related to the PNA identified gaps and adverse patterns and outcomes to improve the physical and psychosocial well-being of individuals and address health disparities through cost-effective and tailored health solutions.

Function – The activities of the committee include the following, but not limited to the following:

1. Leads strategic analytics, evaluation design, clinical and economic evaluation, and optimize programing, ensure that PHM addresses health at all points on the continuum of care.
2. Ensures that the medical care provided meets the community standards for acceptable medical care.
3. Collaborates with behavioral health practitioners and entities to ensure appropriate utilization of behavioral health services and continuity and coordination of medical and behavioral healthcare.
4. Improves communications (exchange of information- data sharing) between primary care practitioners, specialists, behavioral health practitioners, and health delivery organizations and ancillary care provider.
5. Identity and address social determinants of health and gaps in care.

Composition –The PHMC is a collaborative group that engages business units from multiple KHS departments and across the organization that are involved in the development, execution and monitoring and evaluation of programs for members across the continuum of health.

- 2 participating contracted providers providing PHM services
- 1 OB/GYN provider
- 1 Pediatrician
- 1 representative from Kern Regional Center (KRC)
- 1 representative from Kern County Aging and Adult Services
- 1 representative from Kern County Department of Human Services
- 1 representative from Kern County Public Health
- 1 representative from Kern Behavioral Health & Recovery Services
- 1 representative from Federally Qualified Health Centers (FQHCs)

- 1 representative from First 5 Kern
- 1 representative from Skilled Nursing Facility

Other KHS attendees:

- Chief Medical Officer or Representative
- PHM Medical Director
- Director of PHM
- PHM Manager of Case Management
- PHM Manager of Special Program
- Chief Health Equity Officer or Representative
- Senior Director of Member Engagement or Representative
- Director of Behavioral Health
- Director of Health Education
- Director of Enhanced Care Management
- Director of Member Services
- Director of Quality Improvement

The various departments within KHS work collaboratively to ensure members receive comprehensive and holistic care to draw expertise of multiple professions and dive into a wide pool of resources. Furthermore, these departments provide the analysis of service utilization patterns, disease burden, health and functioning of eligible members with chronic medical conditions that may also be exacerbated by significant psychosocial needs, and other gaps in care for KHS members.

Meetings - The PHMC meets quarterly with additional meetings as necessary.

KERN HEALTH SYSTEMS

Population Health Management Committee (PHMC)

Meeting Schedule 2024

Months	Day
March	1st Wednesday of the week
June	1st Wednesday of the week
September	1st Wednesday of the week
December	1st Wednesday of the week