KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Disclosure of Financial Viability				POLICY #: 8.01-P	
DEPARTMENT: Accounting					
Effective Date: 2001-08	Review/Revised Date: 9/27/2023	DMHC	X	PAC	
		DHCS	X	QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

_____ Date _____
Emily Duran
Chief Executive Officer

_____ Date _____
Chief Financial Officer

_____ Date _____
Controller

_____ Date _____
Senior Director of Provider Network

POLICY[i]

KHS will maintain a system to evaluate and monitor the financial viability of all Network Providers, Subcontractors and Downstream Subcontractors that accept financial risk for the provision of covered services including, but not limited to other Managed Care Plans, independent Physician/Provider associations, medical groups, hospitals, risk-bearing organizations as defined by 28 CCR section 1300.75.4(b), Federal Qualified Health Centers (FQHC), and other clinics. KHS will also monitor the financial viability of providers contracted to perform long-term care services to ensure those providers have the administrative and financial capacity to meet contractual obligations and requirements necessary to comply with legal requirements.

DEFINITIONS

Terminology	Description
Organization	Section 1300.75.4(b) "Organization" means a risk-bearing organization as defined in Health and Safely

	Code Section 1375.4(g). An organization includes as entity that contracts directly with the plan or subcontracts with another organization to arrange for the health care services of a plan's enrollees and meets the requirements of Health and Safety Code section 1375.4(g).
Risk-Bearing Organization	(1.) A professional medical corporation, other form of corporation controlled by physicians and surgeons, a medical partnership, a medical foundation exempt from licensure pursuant to subdivision (l) of Section 1206, or another lawfully organized group of physicians that delivers, furnishes, or otherwise arranges for or provides health care services, but does not include an individual or a health care service plan, and that does all of the following: (A) Contracts directly with a health care service plan or arranges for health care services for the health care service plan's enrollees. (B) Receives compensation for those services on any capitated or fixed periodic payment basis. (C) Is responsible for the processing and payment of claims made by providers for services rendered by those providers on behalf of a health care service plan that are covered under the capitation or fixed periodic payment made by the plan to the risk-bearing organization. Nothing in this subparagraph in any way limits, alters, or abrogates any responsibility of a health care service plan under existing law. (2) Notwithstanding paragraph (1), risk-bearing organizations shall not be deemed to include a provider organization that meets either of the following requirements: (A) The health care service plan files with the department consolidated financial

	statements that include the provider organization. (B) The health care service plan is the only health care service plan with which the provider organization contracts for arranging or providing health care services and, during the previous and current fiscal years, the provider organization's maximum potential expenses for providing or arranging for health care services did not exceed 115 percent of its maximum potential revenue for providing or arranging for those services.

PROCEDURE

The disclosure of financial viability of any Network Providers, Subcontractors, and Downstream Subcontractors that accept financial risk for the provision of Covered Services including, but not limited to other Managed Care Plans, independent Physicians/Provider associations, medical groups, hospitals, risk-bearing organizations as defined by 28 CCR section 1300.75.4(b), Federal Qualified Health Centered (FQHC), and other clinics, as well as any provider contracted to perform long-term care services shall be presented in a report format acceptable to Kern Health Systems. The report shall include all relevant, financial information that may be necessary to determine financial viability including but not limited to the most recent audited financial statements, and most recent monthly and year-to-date financial statements.

Failure to maintain financial viability or to submit verification thereof constitutes a material breach of the Provider Services Agreement or Professional Services Agreement and may result in disciplinary action and/or termination as per Provider Services Agreement Section 7.03 or the or corrective action and termination clauses within the Professional Services Agreement.

REFERENCE

[i] **Revision 2023-5:** Definitions and regulatory language added. DHCS approval received on 8/25/2023 and DMHC approval received on 8/30/2023. On 5/25/2023, the policy was approved to comply with 2024 OR, R.0075. **Revision 2023- 2:** Policy revised for network providers performing LTC services per DHCS APL 22-018, LTC 2 and LTC 3, revisions received DHCS approval on 3/1/2023 and DMHC approval on 4/11/2023 (Filing No 20231416). **Revision 2016-11:** The 2016 version was approved to comply with 2024 OR, R.0018 on 10/14/2022. Policy review/revision past due. Signatures updated. **Revision 2001-08:** Routine Revision. Formerly: Policy #8.13.

Additional references include:

- 3.1.7 DHCS Contract
- CCR Title 28, 1300.75.4
- HSC 1375.4