Kern Family Health Care®

Provider MANUAL

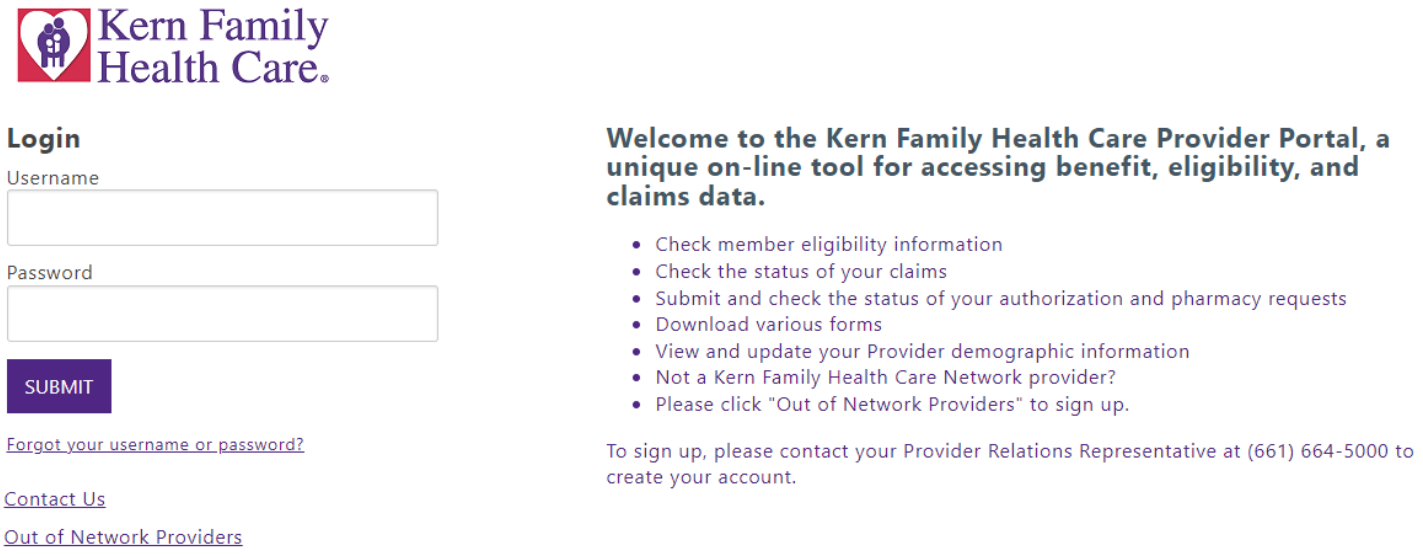
Last updated: November 4, 2025

This manual is revised periodically. For the most recent version, please visit the KFHC website at: kernfamilyhealthcare.com or call the Provider Network Management Department at (661) 632-1590 or (800) 391-2000. Providers can dial 5, a silent prompt created for Providers to bypass other queues.

Table of Contents

Quick Reference

Visit our website to access the Kern Family Healthcare (KFHC) Provider Portal, search for a network provider, view and download KFHC Policies and Procedures, and many other helpful resources are available at [www.kernfamilyhealthcare.com.](http://www.kernfamilyhealthcare.com)



Key Contacts

Department	Contact Information
Kern Family Health Care (KFHC)	2900 Buck Owens Blvd Bakersfield, CA 93308 Monday – Friday 8:00 am – 5:00 pm 661-632-1590 (Bakersfield) 1-800-391-2000 (Outside of Bakersfield) **Providers can dial 5**, a silent prompt created specifically for providers to bypass other queues.
KFHC Provider Relations Representative	1-800-391-2000
KFHC Advice Nurse Line	1-800-391-2000 Available 24 hours a day, 7 days a week
Claims Department	**Submit electronic claims to any of the following:** • Change Health • Office Ally • SSI Group Use KHS Payer ID: 77039 • Cognizant Use KHS Payer ID: KERNH (Professional) UERNH (Institutional) **Paper Claims:** Kern Family Health Care – Claims Department P.O. Box 85000 Bakersfield, CA 93380-9998
Transportation Department	661-632-1590 (Bakersfield) 1-800-391-2000 (Outside of Bakersfield) Choose option 3. Available 24 hours a day, 7 days a week for urgent or after-hours assistance. Transportation should be requested at least 5 days in advance.
Interpreting Services and Language Line **In-Person interpreting**	661-632-1590 (Bakersfield) 1-800-391-2000 (Outside of Bakersfield)

Department	Contact Information
Eligibility Verification	KFHC Provider Portal KFHC DIVA 661-664-5185 AEVS 1-800-456-2387 If above options unavailable: • KFHC Member Services Department: • 661-632-1590 (Bakersfield) • 1-800-391-2000 (Outside of Bakersfield) **Providers can dial 5**, a silent prompt created specifically for providers to bypass other queues.
California Relay Services	If you **do not** have a TTY device in your office: • 1-800-735-2922 If you do have a TTY device in your office: • 1-800-735-2929
Denti-Cal	1-800-322-6284 Smile California | Medi-Cal Dental Program
California Children's Services (CCS)	Kern County Public Health Services Department 2nd Floor, Bakersfield, CA 93306 661-868-0504 Fax 661-868-0280 Kern County Public Health Department (kernpublichealth.com)
Kern Behavioral Health and Recovery Services (KBHRS)	Mental Health Administration 661-868-6600 Non-crisis Adult Care 661-868-8080 Crisis Line Toll Free 1-800-991-5272 Crisis Line 661-868-8000
Vision Services Plan	1-800-877-7195 VSP Vision Care | Vision Insurance
Authorization Submission	Kern Provider Portal (kernfamilyhealthcare.com)
Pharmacy Prior Authorization	Medi-Cal Rx | Homepage

Section 1: Introduction

About Kern Health Systems

Kern Health Systems (KHS) was established by the Kern County Board of Supervisors in April 1993 as the County's Local Initiative. In Kern County, Medi-Cal is operated through a Two-Plan Model consisting of a "local initiative" health plan and a commercial plan. Kern Health Systems (KHS) is the local initiative managed care plan in Kern County. Currently, Anthem Blue Cross Partnership and Kaiser Permanente are the commercial plans.

KHS is a Knox-Keene licensed Health Plan and is regulated by the California Department of Managed Health Care (DMHC), the California Department of Health Care Services (DHCS), and the federal government's Centers for Medicare and Medicaid Services (CMS).

Kern Family Health Care Provider Network

Kern Family Health Care (KFHC) Members have access to a compressive network of providers that includes primary care providers, specialists, hospitals, and urgent care facilities.

Our Mission

KHS is dedicated to improving the health status of our members through an integrated managed health care delivery system for Kern County.

KHS Core Values

The Core Values articulate the foundation of KHS's culture and the guiding principles that will help shape decision-making.

Governing Board and Committees

The KHS Board of Directors are appointed by the Kern County Board of Supervisors; it includes physicians, safety-net providers, hospitals, and community representatives. For more information regarding the Board & Committees or to view past agendas, visit www.kernfamilyhealthcare.com. The following is a list and description of the KHS Advisory Committees:

Finance Committee
The Finance Committee reviews, approves, and makes recommendations to KHS' Board of Directors on all financial and contractual matters that are presented by KHS' staff in support of administrative and management operations. It ensures KHS' financial stability by providing oversight on its budget.

Physician Advisory Committee (PAC)
The PAC serves as an advisor to the Board of Directors on health care issues, peer review, provider discipline and credentialing/re-credentialing decisions. The committee is responsible for reviewing provider grievances and/or appeals, provider quality issues, and other peer review matters as directed by the KHS Chief Medical Officer or designee.

Quality Improvement/Utilization Management Committee (QI/UM)
The QI/UM Committee oversees all covered health care services delivered to members by systematic methods that develop, implement, assess, and improve the integrated health delivery systems of KHS.

Drug Utilization Review (DUR)
The DUR Committee oversees retrospective medication prescribing practices by providers and assesses usage patterns by members. The committee is composed of Physician and Pharmacist providers as well as internal staff. If you would like to serve on the committee, please contact the Director of Pharmacy or Medical Director.

Public Policy/Community Advisory Committee (PP/CAC)
Provides a mechanism for structured input from KFHC members regarding how our operations impact the delivery of their care. The role of the PP/CAC is to implement and maintain community linkages.

*If you are interested in becoming a member of any of the above listed committees, please contact **KHS Quality Improvement Department** at 661-664-5000.

Intent of the Provider Manual

Our provider network is a critical component in serving our mission. We want this manual to be a useful guide which will offer a general overview of information, tools, and guidance needed for you and your staff to facilitate care and services for KFHC Members. If you have any questions, need assistance, or have suggestions for improving the manual, please contact the **Provider Network Management Departmen**t at 1-800-391-2000. **Providers can dial 5**, a silent prompt created specifically for providers to bypass other queues.

If the terms of your Agreement differ from the information in this Provider Manual, the Agreement will supersede. In addition, if there are conflicts between the Manual and current State or federal laws and regulations governing the provision of health care services, those laws and regulations will supersede this Manual.

How to Use the Provider Manual

Providers can search particular topics by reviewing the table of contents or by using the Adobe/PDF search function. For more detailed information, please refer to Kern Health System policies, procedures located at www.kernfamilyhealthcare.com, if you do not have internet access a hard copy will be provided.

Search tip: To search for a specific topic, hit Ctrl + F on your keyboard to activate the "Find" function, if you are using a PC. If you are using a Mac, hit Command + F.

CoC will not be authorized for providers whose contracts have been terminated or not renewed due to medical disciplinary reasons, fraud, or other criminal issues.

Section 2: Eligibility

Eligibility

- Eligibility needs to be checked every visit and can be checked in multiple ways:
    - **KHS Provider Portal:**
        - Kern Provider Portal (kernfamilyhealthcare.com)
    - **DIVA:**
        - 661-664-5185
    - **AEVS:**
        - 1-800-456-2387
    - **Medi-Cal website:**
        - Medi-Cal: Login to Medi-Cal
        - Providers should ensure members do not have Other Health Coverage (OHC), including Medicare, by checking the member's eligibility on the Medi-Cal website. If the member has OHC, then the provider must instruct the member to coordinate their care through their OHC.

PCP and/or Health Plan Changes

- KFHC members can switch PCP's anytime they choose.
- KFHC members can switch health plans (KFHC to Anthem Blue Cross or Kaiser* & vice versa) month to month.
  **Must meet specific criteria for enrollment to Kaiser.*

Termination of PCP/Member Relationship

- PCPs can discharge a member by providing a letter requesting member reassignment to their Provider Relations Representative.
- PCP is required to provide care to the member for 30 days after notification sent to KFHC.

Medi-Cal Enrollment

Individuals who wish to enroll in KFHC must have been determined eligible for the Medi-Cal program through the Kern County Department of Human Services, or the Social Security Administration.

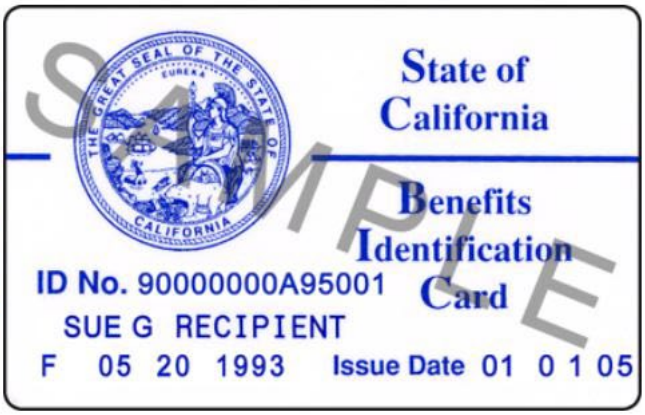
Medi-Cal recipients must re-certify their eligibility annually. It is not uncommon for individuals or families to lose Medi-Cal eligibility and then regain it at a later date. Eligibility for Medi-Cal can also be effective retroactively in some cases. Please note that a member's eligibility must be verified *before delivery of services* and that the KFHC Member Identification (ID card) *alone* is not a guarantee of eligibility.

The state of California issues a plastic Medi-Cal ID card known as the Benefits Identification Card, or BIC. The BIC shows the member's name, date of birth, 14-digit identification number and the card issue date.

The Kern County Department of Human Services may issue a temporary, emergency "paper card" when the Member cannot wait for the state to issue the BIC.

The new "Poppy" BIC design will be provided to newly eligible recipients and recipients requesting replacement cards. Providers are responsible for verifying the recipient is eligible for services and is the recipient to whom the card was issued. Both BIC designs should be accepted by providers

"Poppy" design



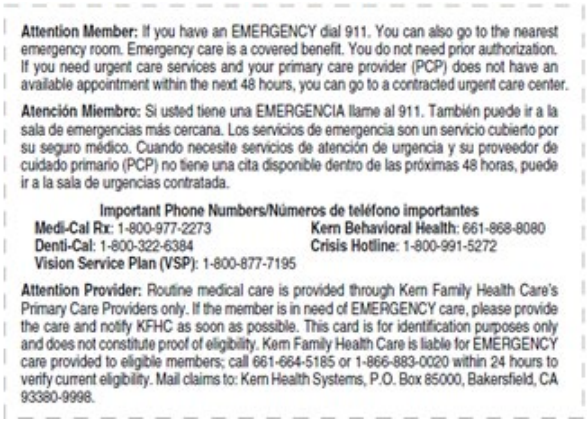
"Blue and White" design

KFHC Member Identification Card

KFHC issues all new Members an Identification Card to be presented to Providers at the time Covered Services are requested. Please note that the KFHC ID card alone should not be considered verification of Member eligibility. The KFHC ID card is issued for identification purposes only and does not guarantee eligibility.

Front KFHC Member Card

Back KFHC Member Card



Verifying Member Eligibility

All providers should verify eligibility on the date that the service is rendered. A Referral or Authorization is not sufficient to guarantee that the patient is eligible on the date of service. **Eligibility can be checked in various ways:**

KFHC Provider Portal

To check eligibility via the KFHC Provider Portal, select Members on the banner or use the Member Quick Search option on the portal home page.

Automated Eligibility Verification System (AEVS)

AEVS, the State Medi-Cal automated eligibility verification system, is a tool that is available 24/7 to verify a member's eligibility. To use AEVS please call (800) 456-2387 and have your Provider Identification Number (PIN) ready. A confirmation number will be provided which should be maintained to document the verification of eligibility.

KFHC DIVA Automated Eligibility Line

DIVA is another automated tool that is available 24/7 to verify a member's eligibility status, including, but not limited to, other healthcare coverage (name and effective dates), and assigned provider name and PRV#. To use DIVA, please call (661) 664-5185 and provide the Member's KFHC identification number or Medi-Cal identification number.

KFHC Member Services Department
Member Services Representatives are available to assist with non-eligibility related inquiries Monday through Friday from 8:00 a.m. to 5:00 p.m. To contact the Member Services Department, call 1-(800) 391-2000. Providers can select option 5, a silent prompt created specifically for providers to bypass other queues.

Primary Care Provider (PCP) Assignment

PCPs are the primary provider of covered services for Members and play a crucial role in coordinating care. For this reason, the selection or assignment of each Member to a PCP is of critical importance.

PCP Selection & Change
Members can find available PCP's using the KFHC Provider Directory or the online "Find a Provider" search tool located on the https://www.kernfamilyhealthcare.com/ home page. Members can change their PCP by logging onto the Member Portal located at https://www.kernfamilyhealthcare.com/ or by downloading the free KFHC mobile application, LINK. Members can also make a PCP change by calling Member Services at 661-632-1590 (Bakersfield) or 800-391-2000 (outside of Bakersfield). Providers should encourage their assigned KFHC members to create and register a KFHC Member Portal account. Each member who registers a KFHC Member Portal account will receive a $10.00 gift card as an incentive.

Clinic Assignment
Every Medi-Cal enrollee has a right by law to access medical services through a Federally Qualified Health Center (FQHC). If a member chooses a FQHC, it must be contracted with KFHC. The enrollee may either choose a FQHC provider or a FQHC clinic.

PCP Auto Assignment
KFHC members are assigned a Primary Care Provider (PCP) upon enrollment. If KFHC does not receive a PCP selection for a new Medi-Cal member one will be assigned by KFHC through a default, automatic method of assignment. Every effort will be made to provide new members the opportunity to change a PCP assignment provided through the automatic assignment process to the PCP of their choice. This action is part of the New Member Entry (NME) process where the Member Services Department will make two attempts by phone to contact every new member within the first thirty days of enrollment.

All members receive an enrollment packet with their PCP identified in the welcome letter. This packet is mailed within seven days of enrollment.

✓ **To allow better access to care, Members can change their PCP at any time via Member Portal, KFHC Mobile Link App or by calling the Member Services Department.**

For more information, see KHS Policy & Procedures: Policy 5.06

- https://www.kernfamilyhealthcare.com/providers/policies-and-procedures/

Termination of PCP/Member Relationship – Policy 5.18-P

Primary Care Providers can discharge a member from their practice for the following reasons:

- Documented Communication Problems
- Inappropriate Behavior
- Multiple Missed Appointments
- Non-Compliance, Etc.

PCPs may initiate this process if they have demonstrated efforts to establish a good patient/provider relationship and ultimately feel the member would be better served by another PCP.

Process:

- PCP will send their Provider Relations Representative a letter requesting a member be reassigned and will include a detailed description of the reason for discharge.
- The Provider Relations Representative will send the PCP a letter acknowledging receipt of the request to discharge the member.
- The KHS Member Services Department will contact the member and assist in the selection of a new PCP.

Member Disenrollment

Disenrollment of Medi-Cal members is processed by Health Care Options, an enrollment contractor approved by the California Department of Health Care Services (DHCS). KFHC does not enroll or disenroll members. Members requesting disenrollment or information about the disenrollment process are referred to the enrollment contractor, Health Care Options.

For cases requiring mandatory disenrollment, KFHC may request the disenrollment of a member under specific guidelines set by DHCS such as: Out of Area, Incarceration, etc. Please note that final disenrollment decisions are handled entirely by DHCS.

Section 3: Utilization Management Program

Initial Health Appointment (IHA)

- The IHA must be completed within 120 days of enrollment with KFHC.
- If an IHA is not present in the medical record, the reason must be documented in the record (member's refusal, missed appointments, etc.).
- Access the KFHC Provider Portal for a list of patients who need an IHA.
- Elements required include the following:
    - Complete history and physical
    - Individual Health Education
    - Behavioral Assessment
    - Core set of preventative services
    - Test results must be documented in the members file even if the test was performed by an outside agency (pap smear, mammograms, etc.)

KFHC Utilization Management Department (UM), policies and procedures support the provision of quality health care services. The goal of UM is to provide Members with the right care, in the right venue, within the most appropriate timeframe. The key objective of the Program is to improve access to care, maintain the highest quality, and create healthy outcomes while providing the most cost-effective care possible.

Preventative Care Services

PCPs are required to ensure that all age and risk appropriate preventive services are provided to assigned members. Members may schedule an appointment for preventive care (including an Initial Health Assessment) by calling their PCP.

When a request is made for CHDP services (Child Health and Disability Prevention), an appointment should be offered for the member to be examined within 2 weeks of the request. If the member cannot be seen within the two-week timeframe because the member refused to offer appointments, refusal should be documented. If the member encounters difficulty in scheduling an appointment, he/she may call KFHC Member Services at 661-632-1590 (Bakersfield) or 1-800-391-2000 (outside of Bakersfield) for assistance.

For more information see KHS Policy and Procedure: Policy 3.05-P

- https://www.kernfamilyhealthcare.com/providers/policies-and-procedures/

Initial Health Appointment (IHA) Policy - 3.05-P

The Department of Health Care Services (DHCS) requires that each PCP complete an Initial Health Assessment (IHA) for all Medi-Cal members. The IHA is a comprehensive assessment that is completed during the member's initial visit(s) with his or her primary care provider, or mid-level providers that are qualified to perform patient history and physicals. The purpose of the IHA is to assess and set the baseline for managing the acute, chronic, and preventive health needs of the member.

All new KFHC Members must receive an Individual Health Assessment with their primary care provider. For Medi-Cal members, the IHA must be completed within **120 days** of enrollment. PCP's compliance with this standard will be assessed during audits.

An IHA:

- Must be performed by a Provider within the primary care medical setting.
- Is not necessary if the Member's Primary Care Physician (PCP) determines that the Member's medical record contains complete information that was updated within the previous 12 months.
- Must be provided in a way that is culturally and linguistically appropriate for the Member.
- Must be documented in the Member's medical record.

The assessment allows members to obtain necessary health care and preventive services, which can lead to positive health outcomes and improvement in their overall health status. An IHA must include all the following:

- A history of the Member's physical and mental health.
- An identification of risks.
- An assessment of the need for preventive screens or services.
- Health education; and
- The diagnosis and plan for treatment of any diseases

Exemption of the IHA Requirement

If any member, including emancipated minors, or a member's parent or guardian, refuses an

IHA, this should be documented in the member's medical record with a statement signed by the member. IHAs do not need to be performed if both of the following conditions are satisfied:

A. The member's medical record contains complete information, updated within the previous 12 months, consistent with the KFHC assessment requirements for the member's age group and gender.
B. Based upon review of the prior medical record, the provider reviews and signs off in the medical record that the patient is current.

Scheduling IHAs

As PCPs receive their assigned patient panels, the Providers' offices should contact members to schedule an IHA to be performed within the time limit. If the provider/staff is

unable to contact the member, he/she should contact the KFHC Member Services Department for assistance.

In these cases, KFHC Member Services staff initiate attempts to contact the member via telephone and/or letter and coordinate with the PCP's office to secure a timely appointment. Contact attempts and results are documented by both the PCP and KFHC Member Services staff.

✓ **If an IHA is not present in the medical record, the reason must be documented in the record (member's refusal, missed appointments, etc.).**

Immunizations

Providers are responsible for assuring that all members are fully immunized. Children should be immunized in accordance with the most recent childhood immunization schedule and recommendations published by the Advisory Committee on Immunization Practices (ACIP) or the Medi-Cal Provider Manual. Adults should be immunized in accordance with the most current California Adult Immunization recommendations.

PCPs are responsible for tracking and the documentation of immunizations for KHS plan members. The member's medical record should have a clearly designated area that identifies the member's immunization history and record. This should include documentation of the following:

- All attempts to provide immunizations.
- Provision of instructions as to how to obtain necessary immunizations
- The receipt of vaccines or proof of prior immunizations.
- Proof of any voluntary refusal of vaccines in the form of a signed statement by the member or responsible party. If the member or responsible party refuses to sign this statement, the refusal must be noted in the medical record.
- Immunization record (PM298).
- Date the Vaccine Information Statement (VIS) is provided to the member and its publication date.

Following Member's IHA and all other health care visits which results in an immunization, member-specific immunization information shall be reported to appropriate immunization registry.

For more information see KHS Policy and Procedure: Policy 3.05

- https://www.kernfamilyhealthcare.com/providers/policies-and-procedures/

Referral Process

Referral Process Policy 3.22

Referral Process

- Requests for referral are submitted via the KFHC portal. Requesting provider must include pertinent medical records, diagnosis, and treatment codes, and member data which support the referral request and will assist the specialty provider in the assessment and delivery of services.
- Urgent referrals may be submitted via the KFHC portal.
- All requests for scheduled hospital/facility admissions must be approved by KFHC.
- Admissions shall be to contracted facilities unless an exception occurs, and special authorization has been granted by KFHC.
- A retrospective authorization for urgent or emergent services may be requested within 60 days of services being rendered.

***If on-line submission via the KFHC online portal is unavailable, please submit referral via fax to our Utilization Management Department at 661-664-5190. (Fax submission will only be accepted by contracted providers when the portal is offline or by exception).**

- It is the responsibility of the PCP to follow-up with the specialist for the results of care and fulfill the responsibilities of a primary care physician.

Time Requirement

- The PCP initiates referrals to qualified contracted providers for specialty care within 1 working day of the decision to refer the member.

Paper Referrals

- Submitted via fax must include:
- The signature of the referring PCP must appear on the Referral/Prior Authorization Form.
- A signature stamp is acceptable if KFHC is in receipt of certification that the use of such a signature stamp is authorized by the PCP.

Notification

- When a referral is authorized, the approved authorization is forwarded to the rendering/requested provider.
- The requesting provider is notified within 24 hours of the decision, and the member is notified of the referral authorization within 48 hours of the decision.
- The referral disposition form and criteria used to deny any referral are returned to the referring provider within 24 hours of the denial.
- Member notification of a denial stating the reason for the denial is sent to the member within 48 hours.
- To request a copy of the criteria used to make the determination or to discuss the decision, please call 1- (661)-664-5083 within 2 business days of the denial.

A routine request for referral authorization is initiated by submitting a Referral/ Prior Authorization Form via the KFHC Provider Portal. The request must include pertinent medical records, diagnoses and treatment codes, and member data which support the referral and will assist the specialty provider in the assessment and delivery of services.

Prescribing physicians may request authorization by completing the Prior Authorization Request form, attaching clinical documentation to support the request, and submitting it by one of the following ways:

- KFHC Provider Portal
  - Kern Provider Portal (kernfamilyhealthcare.com)
- Utilization Management Department
  - Phone: 1-(661) 664-5083
  - Fax: 1-(661) 664-5190
- Mail:
  - Utilization Management Department
    Kern Health Systems
    2900 Buck Owens Blvd.
    Bakersfield, CA 93308

Please note that mailing may cause delays due to postal delivery time.

Provider and Member Notification

Results of the utilization review for non-urgent referrals are communicated by Utilization Management Staff (UM), to the Provider and Member as outlined in the following table. **Notification to provider is provided via KHS Provider Portal or fax.**

Result of Review	Provider Notice	Member Notice
Approved	**Referring:** Approved Referral/Prior Authorization Form (within 24 hours of the decision). Initial notification may be oral and/or electronic fax. Written notification is within 2 working days of making the decision. **Specialist:** Approved Referral/Prior Authorization Form and any pertinent medical records and diagnostics (within 24 hours of the decision). Initial notification may be oral and/or electronic fax. Written notification is within 2 working days of making the decision. **OR** **Hospital:** Hospital Notification Letter (within 24 hours of the decision).	Notice of Referral Approval (within 48 hours of the decision).
Deferred	**Referring:** Copy of Notice of Action Letter and the Referral/Prior Authorization Form (within 24 hours of the decision). Initial notification may be oral and/or electronic fax. Written notification is within 2 working days of making the decision. **OR** **Hospital:** Requests for hospital services are not deferred.	Notice of Action Documents (within 2 business days of the decision). Documents include all the following: • Notice of Action -Delay letter • Your rights Under Medi-Cal Managed Care. Medi-Cal members only. Form to File a State Hearing. Medi-Cal members only.
Modified (Initial request for a service or treatment)	**Referring:** Copy of Notice of Action Letter and modified Referral/ Prior Authorization Form (within 24 hours of the agreement). Initial notification may be oral and/or electronic fax. Written notification is within 2 working days of making the decision. **Specialist:** Modified Referral/Prior Authorization Form and any pertinent medical records and diagnostics (within 24 hours of the agreement). Initial notification may be oral and/or electronic fax. Written notification is within 2 working days of making the decision.	Notice of Adverse Determination Documents, (within 2 business days of the decision). Documents include all of the following: • Notice of Adverse Determination –Modify • Your Rights Under Medi-Cal Managed Care. Medi-Cal members only. Form to File a State Hearing. Medi-Cal members only.

Result of Review	Provider Notice	Member Notice
Terminated or Reduced (Subsequent request for a continuing service or treatment that was previously approved)	**Treating:** Copy of Notice of Adverse Determination Letter sent to the member (within 24 hours of the decision). Initial notification may be oral and/or electronic fax. Written notification is within 2 working days of making the decision.	Notice of Adverse Determination Documents, (within 2 business days of the decision and at least 10 days before the date of action unless falls under exceptions listed in KFHC Policy 3.22-P. Documents include all of the following: • Notice of Adverse Determination –Terminate • Your rights Under Medi-Cal Managed Care. Medi-Cal members only. Form to File a State Hearing. Medi-Cal members only.
Denied (Included those carve out services that are denied as not covered by KFHC)	**Referring:** Copy of Notice of Adverse Determination Letter (within 24 hours of the decision). Initial notification may be oral and/or electronic fax. Written notification is within 2 working days of making the decision. **OR** **Hospital:** Hospital Notification Letter (within 24 hours of the decision).	Notice of Adverse Determination Documents, (within 2 business days of the decision). Documents include all of the following: • Notice of Adverse Determination –Denial • Your rights Under Medi-Cal Managed Care. Medi-Cal members only. Form to File a State Hearing. Medi-Cal members only.

**Utilization Management will provide copies of criteria used to make medical necessity determinations as requested by calling 1-(661)-664-5083 or toll free at 1-800-391-2000 during business hours Monday - Friday.*

UM review criteria include but not limited to:

- 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 Title 22 Guidelines,
- CA DHCS All Plan Letters (APL),
- DMHC All Plan Letters,

- CA DHCS Policy and Procedure Letters (PPL),
- MCG Health LLC (Milliman Care Guidelines,)
- 42 CFR section 438.915, 438.206.

To request for a Peer-to-Peer discussion with our Physician Reviewer regarding adverse determinations (denials), you may call 661-664-5083 or toll free at 1-800-391-2000 during business hours Monday - Friday.

For more information see KHS Policy and Procedure: Policy 3.05-P, 3.09-P, and 3.22-P (page 11)

- https://www.kernfamilyhealthcare.com/providers/policies-and-procedures/

Denials and Appeals

Denials and Appeals

  - Denials based on medical necessity require MD review.
  - Administrative denials can be completed by non-physician UM staff.
- KHS appeal form (located on the KHS website) must be completed in its entirety with documentation supporting the appeal.
- Appeals may be filed by the beneficiary or provider prior to the service being rendered and before 60 days. After 60 days a new request is required.
- If the provider is filing on behalf of the beneficiary, the appeal must be accompanied with the beneficiary's written consent.
- Appeals returned for additional information must be received within 30 working days of receipt.
  - Treating providers can be modified without the provider's permission based on access, prior relationships/COC, or plan preference.

Only the Chief Medical Officer, or their designee may deny an authorization request based on medical necessity within the DHCS timelines of 1-5 days for routine requests **and within 72 hours for expedited/urgent requests.** Kern Health System (KHS) ensures that fiscal and administrative management considerations do not influence medical decisions, including those made by subcontractors, Network Providers, and Providers.

Reasons for possible denial include:

- Not a covered benefit
- Not medically necessary
- Continue conservative management
- Services should be provided by a PCP
- Experimental or investigational treatment
- Member made unauthorized self-referral to provider
- Inappropriate setting
- Covered by hospice
- Services carved out of KHS's contract with the California Department of Healthcare Services

Sample Provider Appeal Form:

Kern Family Health Care™

PROVIDER AUTHORIZATION APPEAL RESOLUTION REQUEST

INSTRUCTIONS

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF APPEAL and EXPECTED OUTCOME.
- Provide additional information to support the description of the appeal.
- Fax the form along with any attachments to: (661) 664-4303
- Or mail the completed form to: Kern Family Health Care – Grievance and Appeals
  2900 Buck Owens Boulevard
  Bakersfield, CA 93308

*PROVIDER NAME:	*PROVIDER ID NUMBER:
*PROVIDER ADDRESS:	
*PROVIDER PHONE NUMBER:	

* MEMBER NAME:		*DATE OF BIRTH:
* KFHC ID Number:	MEMBER ADDRESS/PHONE NUMBER	*ORIGINAL AUTH NUMBER: (Please complete a separate form for each appeal)

* **DESCRIPTION OF APPEAL** (must include a clear explanation of the basis upon which you believe KHS's action is incorrect):

EXPECTED OUTCOME:

*Provider Contact Name (please print) | Title | ( ) *Phone Number

*Signature | *Date | ( ) *Fax Number

*All provider appeals submitted on a member's behalf must include the member's, their parent's (if a minor) or other authorized representative's signature and date indicating provider has their consent to file this appeal.

Member, Parent or Authorized Representative's Signature:_____ Date:_____

Kern Family Health Care received this appeal on _____. If you have a question regarding this appeal, please call the KFHC Member Services Department at 1-800-391-2000 and ask to speak with a Grievance Coordinator.

_____
Acknowledgement of Receipt (signature)

Visit Kern Family Health Care (Cloudinary.Com) to download the Provider Appeal Form.

Urgent Referrals

Outpatient Urgent Referrals

Prior authorization for emergent medical conditions is not required when:

- There is 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.

KFHS does require a retrospective referral from the requested provider for Urgent services within 60 days of the date of service.

Hospital/Facility Authorization

All Providers must request authorization for scheduled hospital/facility admission from KFHC Utilization Management Department. Admissions will be to contracted facilities unless an exception occurs and the KFHC UM Department has granted special authorization.

Lab, X-Ray and Assistant Services

Routine lab and x-ray services do not require pre-authorization but must be directed to KFHC contracted providers. Non-emergent specialty x-ray procedures require pre-authorization. Contracted providers must be utilized for all non-emergent lab and imaging procedures. Please reference Prior Authorization list located under the Provider Resources section of the Kern Family Health Care website at: www.kernfamilyhealthcare.com.

Covered Services That Do NOT Require Prior Authorization/Referral

Please reference prior authorization (PA) list on the “Quick Links” section of the KHS Provider Connection (Portal) Kern Provider Portal (kernfamilyhealthcare.com).

Please note, the PA list is updated the first of each month and it is the provider/facilities responsibility to check for any updates prior to rendering services.

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

- Primary Care from a KFHC contracted Primary Care Provider
- Dental – Providers are expected to refer to Denti-Cal.
- Hospice – Outpatient services.
- Basic prenatal care - Members may self-refer to a KFHC contracted OB/GYN or family practice physician.
- Vision - PCP or member may initiate a referral to VSP contracting optometrists.
- Mental Health - Referrals for mental health services may be generated by self-referral, provider of care, KFHC Case Managers, school systems, or employers.
- Family Planning - Members may access Family Planning Services by self-referral to an appropriate qualified practitioner/provider such as: FQHC, Federally Funded Family Planning Clinic and Public Health Clinic.
- Abortion - Prior authorization is not required unless inpatient hospitalization for the performance of the abortion is requested.
- Gynecology (OB/GYN) - Members may self-refer to any contracted OB/GYN specialist.
- Emergency Care/ Urgent Care
- HIV Testing and STD Services
- Cancer Screening

✓ **The Prior Authorization Form and supporting documentation may be required for KFHC tracking purposes.**

Obtaining a Second Opinion

***All requests for second opinions are reviewed by the medical director**

Requests for second opinions may be initiated by the Member or Provider and should document the initial opinion and the person requesting the second opinion. All requests for second opinions are reviewed by the KFHC Chief Medical Officer or their designee. Authorization or denial of the second opinion is accomplished within 72 for urgent requests and within 5 business days for routine requests.

For more information see KHS Policy and Procedure: Policy 3.05, 3.09, and 3.22

- https://www.kernfamilyhealthcare.com/providers/policies-and-procedures/

California Children Services (CCS)

California Children Services

Once member is accepted by the CCS program, KFHC continues to work with CCS to coordinate care.

CCS is a statewide program managed by the Department of Health Care Services (DHCS) and is administered in Kern County by the Kern County Public Health Services Department. The CCS program requires authorization for health care services related to children under the age of 21 with a CCS-eligible medical condition. These services are not covered by KFHC therefore KFHC does not give prior authorization for payment of services related to CCS eligible conditions. Authorization for such services must be received from the CCS program.

CCS eligible conditions are those physically handicapped conditions defined in Title 22, California Code of Regulations (CCR) §41515.1. The following include examples of CCS-eligible conditions, but are not limited to:

- Cystic fibrosis
- Heart disease
- Infectious diseases producing major sequelae
- Hemophilia
- Cancer
- Cerebral palsy
- Traumatic injuries

For an overview of the CCS program, please visit the California Department of Health Care Services (DHCS) website by clicking here: California Children's Services, or the local office visit the Kern County Public Health Services Department website by clicking here: California Children's Services | Kern County, CA.

Providers are responsible for identifying members with CCS eligible conditions and for making prompt referrals of such members to the local CCS program and to KFHC. Providers must notify the KFHC Utilization Management Department of members with a potential CCS condition via an authorization which can be submitted on the KFHC Provider Portal.

Referrals to CCS are also accepted from any source, health professionals, parents, legal guardians, school nurses, KFHC, etc. Members may also self-refer. Once a member is accepted by the CCS program, KFHC continues to work with CCS to coordinate care. CCS referrals are tracked by the KFHC UM Department to ensure follow through of services to members.

CCS Referral Process
Referral of CCS eligible conditions by a KFHC contracted Provider involves notification of both CCS and KFHC. Referrals to the local CCS program may be initiated via telephone, same-day mail, or fax to:

California Children's Services
1800 Mt. Vernon Avenue, 2nd Floor
Bakersfield, CA 93306-3302

Phone: 661-868-0504
Fax: 661-868-0268

The initial referral should be followed by submission of supporting medical documentation sufficient to allow for eligibility determination by the CCS Program.

For more information see KHS Policy and Procedure: Policy 3.16

- https://www.kernfamilyhealthcare.com/providers/policies-and-procedures/

Emergency and Urgent Care Services Policy 3.31-P

Emergency services **do not** require prior authorization. Emergency services are covered services required by a member as the result of a medical condition that manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention could result in one or more of the following: Place the health of the member in serious jeopardy.

- Cause serious impairment to bodily functions.
- Cause serious dysfunction of any bodily organ or part.
- Death

Post Stabilization Care

When the treating physician believes additional health care services are needed before a member can be safely discharged or transferred after stabilization of an emergency condition, the treating physician should contact our UM Department within 24 hours to notify KHS of the post-stabilization services. KHS does not require prior authorization for post-stabilization services.

Recuperative Care Services

The recuperative care benefit is a short-term patient recovery facility where members can temporarily stay after being discharged from the hospital. The following items are

covered when they are medically necessary and meet KFHC prior authorization of coverage and utilization review requirements:

- Lodging accommodations and meals
- Transportation for follow-up appointments
- Onsite nursing services
- Social Services referrals

Urgent Care Services

Urgent care services **do not** require prior authorization. Urgently needed services are covered services provided when the member is temporarily absent from a service area or when, as a result of an unforeseen illness or injury, medical services are required without delay and the services could not be obtained reasonably through a normal appointment with a contracted provider. Contracted Urgent Care facilities can be found in the KFHC Provider Directory or by using the Find a Provider search tool on our website, Home | Kern Family Health Care.

Advice Nurse Line

Members can call the KFHC Advice Nurse Line at 1-(661) 632-1590 or 1-800-391-2000 24 hours a day, 365 days a year to get medical advice via telephone when their doctor's office is closed or can't be reached.

For more information see KHS Policy and Procedure: Policy 3.39-P (Page 16)

- https://www.kernfamilyhealthcare.com/providers/policies-and-procedures/

Community Based Adult Services (CBAS)

The primary objectives of the program are to restore or maintain optimal capacity for self-care to frail elderly persons or adults with disabilities, age 18 or older; and delay or prevent inappropriate or personally undesirable institutionalization as well as foster a partnership with the participant, the family and/or caregiver, the primary care physician, and the community in working toward maintaining personal independence.

Each CBAS participant shall receive ALL the following basic CBAS benefits as bundled services on each day of attendance at the CBAS center:

- Professional nursing services
- Social Services and/or personal care services
- Family and/or caregiver training and support
- Therapeutic activities; and
- One meal offered daily.

Continuity of Care (CoC)

Continuity of Care (CoC) allows members to continue receiving covered services from a provider whose contract has been terminated, up to a maximum of 12 months upon request. The Utilization Management (UM) Department will work with the terminated provider to facilitate a safe transfer of care to a contracted provider, either as soon as feasible or if an agreement cannot be reached with the terminated provider.

CoC authorization is required for the following conditions upon a member's request:

Health Condition	Time Period
Acute Conditions	For the entire duration of the condition
Serious Chronic Conditions	For the time necessary to complete a course of treatment and arrange for a safe transition to another provider *This period is limited to 12 months from the contract termination date and is determined by KHS in consultation with the member and the terminated provider, consistent with professional standards.*
Pregnancy and Postpartum	For the duration of the three trimesters and the immediate postpartum period of 12 months.
Care of a Child	For children from birth to 36 months, up to 12 months from the contract termination date
Terminal Illness	For the duration of the illness.
Scheduled Surgery or Procedure	If authorized by KHS as part of a documented treatment plan and scheduled to occur within 180 days of the contract termination date

CoC will not be authorized for providers whose contracts have been terminated or not renewed due to medical disciplinary reasons, fraud, or other criminal issues.

A member may submit a request for CoC from a terminated provider by calling or submitting a written request to:

Kern Family Health Care
Utilization Management Department
2900 Buck Owens Blvd
Bakersfield, CA 93308
1-800-391-2000

For more information see KHS Policy and Procedure: Policy 3.39

- https://www.kernfamilyhealthcare.com/providers/policies-and-procedures/

Affirmation Statement

KFHC UM Department and UM Committee are involved in the evaluation and improvement of quality care and services and agree to appropriately approve and deny services and discourage under-utilization.

KFHC affirms that:

- UM decision making is based only on appropriateness of care and service and the existence of coverage.
- Contracted entities do not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service care.
- Contracted entities do not offer financial incentives to UM decision makers that encourage decisions that result in denials of care or under-utilization.
- Member healthcare is not compromised.
- Practitioners are ensured independence and impartiality in making referral decisions that will not influence:
    - Hiring
    - Compensation
    - Termination
    - Promotion
    - Any other similar matter

Section 4: Population Health Management

Under the direction of the DHCS, KHS moved toward a population health approach that prioritizes prevention, early intervention and whole-person care. The vision is to strengthen and reinforce primary care as the foundation of health care for all KHS members, address the social determinants of health (SDOH), and break down the siloes to accessing equitable, accessible, and quality health care across the continuum.

In January 2023, DHCS launched the **Population Health Management (PHM) Program,** which is a cornerstone of the California Advancing and Innovating Medi-Cal (CalAIM). The PHM Program seeks to establish a cohesive, statewide approach to all populations that brings together and expands upon many existing population health strategies. Under PHM, Medi-Cal Managed Care (MCMC) plans, and their networks and partners will be responsive to individual member needs within the communities they serve while also working within a common framework and set of expectations.

PHM is a comprehensive, accountable plan of action for addressing member needs and preferences and building on their strengths and resiliencies across the continuum of care which:

- Builds trust and meaningfully engages with members
- Gathers, shares, and assesses timely and accurate data on member preferences and needs to identify efficient and effective opportunities for intervention through processes such as data-driven risk stratification, predictive analytics, identification of gaps in care, and standardized assessment processes
- Addresses upstream factors that link to public health and social services
- Supports all members staying healthy
- Provides care management for members at higher risk of poor outcomes
- Provides transitional care services for members transferring from one setting or level of care to another; and
- Identifies and mitigates Social Determinants of Health (SDOH) to reduce disparities.

PHM provides care coordination under three general categories-Basic Population Health Management, Care Management Services, and Transitional Care Services. With the many upcoming requirements, PHM is a journey rather than a destination. Provider updates will be sent introducing any new programs or updates.

Care Management

The Care Management Department Staff, consisting of Registered Nurses, Social Workers, and Care Management Assistants, manage a complex population who are identified by a predictive modeler as well as by a variety of referral sources, including Physician and Community Resource referrals. These are members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services.

Additionally, Basic Population Health Management provides the basic set of services and supports, including primary care, to which all the populations served by Medi-Cal Managed Care plans have access.

- BPHM is an approach to care that ensures that needed programs and services are made available to each member, regardless of their risk tier, at the right time in the right setting. BPHM includes federal requirements for care coordination.
- Goals for BPHM and Care Management ensure that every member:
    - Has a source of care that is appropriate, ongoing, and timely to meet the members' needs.
    - Is assigned and engaged with a primary care provider (PCP) to include preventative services.
    - Has access to an appropriate level of care management through person-centered interventions, care coordination, navigation, and referrals across all health care and social needs.

Referrals to Care Management

Referrals may originate from multiple sources including, but not limited to, self-referral, caregiver, PCPs or Specialists, discharge planners at medical facilities, and internal departments at Kern Health Systems such as Utilization Management, Health Education, and Member Services.

Provider referrals for Care Management can be made by contacting us at:

- Phone: 1-800-391-2000
- Alternatively: 661-632-1590
- TTY: 711
- Web**:** https://www.kernfamilyhealthcare.com/

Care Plans

Individualized Care Plans are created for these members following an assessment and communicated to the PCP for collaboration. Once care coordination planning is implemented, there is follow up, assistance with transitions of care, and efficient communication post transition to prevent readmission and maintain progress. The

eventual goal of Care Management services is for the member to achieve self-management and discharge from the program. The Care Management Department helps members maintain optimum health and/or improved functional capability, educate members regarding their health, and reinforce the PCP prescribed treatment plan. These efforts are anticipated to decrease costs and improve quality through focusing on the delivery of care at the appropriate time and in the appropriate setting.

Complex Care Management Program
Complex Care Management is the systematic coordination and assessment of care and services provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources.

Nurse Care Managers help arrange health care needs and navigate the system to facilitate appropriate delivery of care and services.

This is accomplished through:

1. Promotion and support of the Medical Home as the source of the member's primary healthcare and source of specialty referrals, and enhancing this with the necessary social, care management and medical support to facilitate comprehensive patient-centered planning.
2. Identification and elimination of potential barriers to seeking and receiving appropriate care within their designated medical home (e.g., housing, transportation, childcare, etc.).

How to refer Members to Complex Care Management (CCM) Program? Contact us:

- Phone: 1-800-391-2000
- Alternatively: 661-632-1590
- TTY: 711
- Web**:** https://www.kernfamilyhealthcare.com/

Palliative Care

Palliative Care is a covered benefit geared towards patients with uncontrolled chronic illnesses and are not eligible, or decline, hospice care. Palliative Care services must receive prior authorization from KFHC. Palliative care consists of patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. The Palliative Care benefit will connect members with a palliative care team trained to focus on symptom management and who understand advance care planning and end of life complexities.

Eligible Members

Members eligible for Palliative Care are expected to have one (1) year or less life expectancy, be in the advanced stage of illness, have received appropriate patient-desired medical therapy, or for whom patient desired medical therapy is no longer effective, and have started to access the hospital or emergency department as a means to manage late-stage illness. Members should also have one or more of the following disease-specific eligibility criteria:

- Congestive heart failure (CHF): hospitalized due to CHF as primary diagnosis (no further invasive interventions planned) OR NYHA III or higher AND EF <30% or significant comorbidities.
- Chronic obstructive pulmonary disease (COPD): FEV1<35% predicted and 24 hour and O2 requirement less than 3L/min OR 24-hour O2 requirement >3L/min.
- Advanced cancer: any stage III or IV solid organ cancer, leukemia or lymphoma AND Karnofsky Performance Scale score < 70 OR treatment failure of 2 lines of chemotherapy
- Liver disease: evidence of irreversible liver damage, serum albumin less than 3.0, and International Normalized Ratio (INR) greater than 1.3, AND ascites, spontaneous bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices OR evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score of greater than 19.

Palliative Care Services

Eligible palliative care services include advanced care planning, palliative assessment and consultation with a palliative care team, care coordination, pain and symptom management, and mental health and medical social services for counseling and support. Providers interested in learning more regarding the criteria for providing palliative care services, please contact the KFHC Providers Relations Department. For additional information regarding this new benefit, please refer to the **DHCS APL 18-020** *(Revised):*

- https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-020.pdf

Transition of Care Services

The Transitional Care Model (TCM) is an evidence-based solution that demonstrates improved quality and cost outcomes for high-risk members 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 readmitted, the time between their discharge and readmission is longer and the number of days spent in the hospital is shorter than expected.

- *Improvements in health outcomes after hospital discharge.* Patients who received TCM demonstrate improvements in physical health, functional status, and quality of life.

- *Enhancement in patient and family caregiver experience with care.* Overall patient satisfaction is increased among patients receiving TCM. TCM also aims to lessen the burden among family members by reducing the demands of caregiving and improving family functioning.

A Transition Care Services (TCS) Care Manager is assigned as a single point of contact to members once they are identified as being admitted to a hospital. The TCS Care Manager is responsible for ensuring completion of all transitional care management services in a culturally and linguistically appropriate manner during their transition, including their discharge follow-up.

The TCS Care Manager is responsible for coordinating and ensuring that the member receives all the appropriate TCS, regardless of setting and including but not limited to discharge facilities and community base organizations. In addition, the TCS Care Manager collaborates and communicates with the members' physicians (including PCPs), discharge planners, and service providers to facilitate safe and successful transition.

All the tasks do not need to directly be completed by the care manager, but they must ensure all transitional care management activities occur, including:

1) discharge risk assessment,
2) discharge planning documentation, and
3) necessary post-discharge services & follow-ups.

TCS case management will end once the member has been connected to all the needed services, including but not limited to all that are identified in the discharge risk assessment or discharge planning document.

For those who have ongoing unmet needs, eligibility for Enhance Care Management (ECM) or Complex Care Management (CCM) and other KHS specialty services should be reconsidered. If this occurs, the TCS Care Manager connects the member through a referral.

If a member has been discharged from the hospital within the past 15 days and need assistance with their care or have any questions, please contact us at:

- Phone: 1-800-391-2000
- Alternatively: 661-632-1590
- TTY: 711
- Web**:** https://www.kernfamilyhealthcare.com/

Major Organ Transplant

Effective January 2022, KHS is responsible for coordination and payment associated with Major Organ Transplants (MOT). To ensure Members who are referred for MOT can seamlessly access care and services needed, KHS offers a Transplant Case Management program.

Specialty-trained transplant case managers serve as a resource for Members enrolled in the MOT Case Management Program. They establish dialogue and support that last throughout the duration of the member's treatment plan. The transplant case manager will remain in frequent contact with the member and throughout the enrollment. During the months or years prior to the transplant, the transplant case manager coordinates all needs that the member has. At the time of the actual transplant, the transplant case manager also coordinates with the member's caregivers reviewing travel and lodging benefits.

The transplant case manager follows the member's admission and continued stay review during the initial transplant period and calls to speak with either the member or the caregiver frequently. The Case Manager follows Members throughout the phases of transplant until one year after transplant.

Provider referrals for Case Management can be made by calling 1-800-391-2000.

Long Term Care

Effective January 1, 2023, the LTC benefit for Skilled Nursing Facilities (SNF) was carved-in to Medi-Cal managed care statewide. The Kern Health System, (KHS), Long Term Care Program provides a comprehensive integrated process that evaluates and manages the utilization of health care services and resource delivery to members requiring long term care (LTC) services. KHS has established mechanisms for identification, authorization, and coordination of services through a designated KHS LTC team to support the LTC Program. The Long-Term Care Program assures that:

- Services delivered is consistent with the medical care needs of the member.
- Service is delivered at the appropriate time.
- Members receive appropriate quantity and quality of services.
- Members have access to a comprehensive set of services based on their needs and preferences across the continuum of care.

*DHCS Policy: **APL 23-004** (Supersedes APL 22-018) Skilled Nursing Facilities—Long Term Care Benefit Standardization and Transition of Members to Managed Care).*

- https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-004.pdf

Services

1. Nursing Facility Services

Kern Health Systems (KHS) authorizes utilization of nursing facility services for members when medically necessary. KHS ensures access to licensed long-term care facilities to members in need of long-term care services. These facilities include:

- Skilled Nursing Facilities (SNF),
- Sub-acute Facilities (pediatric and adult)
- Intermediate Care Facility for the Developmentally Disabled

KHS members receive services that are medically necessary and consistent with their diagnoses and Level of Care (LOC) requirements. Authorization of these services considers the individual needs of the member such as comorbid conditions, behavioral health, and ADL management needs that might exist and the ability of the local health care delivery system to meet these members' needs.

2. Facility Therapy Services

Facility therapy services are performed as part of the nursing facility inclusive services which is covered under the facility's per diem rate.

3. Specialized Rehabilitative Services

Providers submits a Treatment Authorization Request (TAR) for specialized rehabilitative services exceeding the nursing facility inclusive services when it is determined that additional services must be rendered to attain or maintain the highest practicable plan of care.

4. Other Health Coverage

KHS provides medically necessary Medi-Cal services that are not covered by Medicare and for reimbursement to Medicare providers when total Medicare costs, including deductibles and coinsurance, do not exceed the Medi-Cal allowable FFS reimbursement rates.

- KHS coordinates benefits for members residing in LTC facility with OHC programs or entitlements.
- For SNF services provided to Members who are dually eligible for Medi-Cal and Medicare, KHS will pay the full deductible and coinsurance in accordance with APL 13-003, Coordination of Benefits.

5. Care Management

KHS ensures Members, receiving LTC SNF services, will have access to a comprehensive set of services based on their needs and preferences across the continuum of care, including Basic Population Health Management (BPHM), complex care management, care management programs, and Community Supports. KHS assigns each LTC member to the LTC team.

Provider referrals for Care Management can be made by contacting us at:

- Phone: 1-800-391-2000
- Alternatively: 661-632-1590
- TTY: 711
- Web**:** https://www.kernfamilyhealthcare.com/

Doula Benefits

Effective January 1, 2023, KHS covers doula services, pursuant to Title 42 of the Code of Federal Regulations, Section 440.130(c), as preventive services and on the written recommendation of a physician or other licensed practitioner of the healing arts acting within their scope of practice under state law.

Doulas serving Medi-Cal beneficiaries provide person-centered, culturally competent care that supports the racial, ethnic, linguistic, and cultural diversity of beneficiaries while adhering to evidence-based best practices. Doula services are aimed at

preventing perinatal complications and improving health outcomes for birthing parents and infants.

Services could be at the beneficiary's home, as part of an office visit, in a hospital, or in an alternative birth center. Services include health education, advocacy, and physical, emotional, and nonmedical support.

Covered Services
Although prior authorization is not required, a recommendation for doula services must be requested in writing and will include the following services:

1. One initial visit.
2. Up to eight additional visits that may be provided in any combination of prenatal and postpartum visits.
3. Support during labor and delivery (including labor and delivery resulting in a stillbirth), abortion or miscarriage.
4. Up to two extended three-hour postpartum visits after the end of a pregnancy.

Doulas offer various types of support, including perinatal support and guidance; health navigation; evidence-based education and practices for prenatal, postpartum, childbirth, and newborn/infant care; lactation support; development of a birth plan; and linkages to community-based resources.

Coverage also includes comfort measures and physical, emotional, and other nonmedical support provided during labor and delivery.

Non-Covered Services
Doula services do not include diagnosis of medical conditions, provision of medical advice, or any type of clinical assessment, exam, or procedure.

The following services are not covered under Medi-Cal or as doula services:

- Belly binding (traditional/ceremonial)
- Birthing ceremonies (i.e., sealing, closing the bones, etc.)
- Group classes on babywearing
- Massage (maternal or infant)
- Photography
- Placenta encapsulation
- Shopping
- Vaginal steams
- Yoga

For additional information about doula benefits, and doula provider requirements and qualifications, the full APL can be found by visiting:

- https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL-23-024.pdf

Baby Steps and Baby Steps Plus Program

The Department of Health Care Services (DHCS) requires that all Medical Manage Care Plans to offer evidence-based disease management programs in line with NCQA requirements. Such programs should specifically target (at minimum) diabetes, cardiovascular disease, asthma, and depression and must incorporate health interventions, target members for engagement, and seek to close care gaps for the cohort members participating in the interventions with a focus on equity and health disparities.

The Kern Health Systems (KHS), Baby Steps Program provides all KHS Members who are pregnant mental health screening for depression during their pregnancy and postpartum. According to CDC, Postpartum depression, which can last months or years after giving birth, can affect a mother's ability to bond with and care for her baby (2023). If left untreated, it can impact the mother's health and may cause sleeping, eating, and behavioral problems for the baby (CDC 2023). When maternal depression is effectively treated and managed, it benefits both mother and child. In addition, Baby Steps program identify and address any gaps in care and Social Determinants of Health (SDOH) to reduce disparities. Care Coordinators are available to refer and link KHS members to other health care benefits and community resources for better health outcomes. Prenatal and Postpartum health education, including newborn healthcare education and resources are provided to the KHS member. The KHS Baby Steps Plus Program provides short-term and long-term care management for KHS high risk pregnant members. Given that the goal of prenatal care is positive birth outcomes and health mothers, this program provides the members information, motivations, and assistance in obtaining early, consistent, and appropriate prenatal and postpartum care. This includes addressing SDOH and health equity. Baby Steps Plus provides care management and care coordination by a nurse case manager throughout the members' enrollment.

Eligible Members

1. Pregnant KHS Members
    - Can enroll into the program at any time during their pregnancy.
    - Can choose to participate in the Baby Steps or Baby Steps Plus program.
2. Definition of High-Risk Pregnancy for Baby Steps Plus Program
    - Preexisting health conditions
    - Pregnancy related health conditions
    - Lifestyle factors (including smoking, drug addiction, alcohol abuse and exposure to certain toxins)
    - Age (under 17 when pregnant or over 35 years old)

How to refer Members to Baby Steps/Baby Steps Plus Program? Contact us:

- Phone: 1-800-391-2000
- Alternatively: 661-632-1590
- TTY: 711
- Web**:** https://www.kernfamilyhealthcare.com/

Children with Special Healthcare Needs (CSHCN) Program

The Kern Family Health Care (KFHC), Children with Special Health Care Needs (CSHCN) program helps children under 21years of age who have complex health problems. This program has a special team that works together to help members who are in the CSHCN program and their families.

The CSCHN Program offers the members, and their families care case management services. This includes individualized health and medical education, linkages to community resources and assistance to transportation, lodging, and meals. The program ensures all the members' doctors and care teams work together. This includes the members:

- Primary Care Provider (PCP)
- Specialty Care Provider
- Other medical resources

The program help guide the members to move from CCS to adult medical care before they turn 21 years old.

Eligible Members

- KFHC active members

- Under 21 years of age
- Have at least one or more complex chronic condition

How to refer Members to KAY Program? Contact us:

- Phone: 1-800-391-2000
- Alternatively: 661-632-1590
- TTY: 711
- Web**:** https://www.kernfamilyhealthcare.com/

Kids and Youth (KAY) Transition Program

Kern Health Systems (KHS) Kids and Youth (KAY) Transition Program identify KHS California Children's Services (CCS) members ages 18 up to 20 years of age to provide transition planning assistance prior to transitioning out of CCS Services. The goal of this

program is coordinating and preparing the adolescent KHS member, and their family move from pediatric health care to adult health care. This includes their medical home, specialty providers, community resources. In addition, the program encourages the KHS members and equips them with necessary information, tools, linkages to resources that will guide them as they progress and assume adult roles and responsibilities.

Eligible Members

1. KHS members with CCS eligible/diagnosis
    - CCS eligible condition means a medical condition that qualifies a child to receive medical services under the CCS Program, as specified in 22 CCR section 41515.1 et seq.
    - Examples of CCS-eligible conditions include but are not limited to, chronic medical conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries, and infectious diseases producing major sequalae.
2. Has an active/open CCS case
3. Ages 18 years old up to twenty years of age.

How to refer Members to KAY Program? Contact us:

- Phone: 1-800-391-2000
- Alternatively: 661-632-1590
- TTY: 711
- Web**:** https://www.kernfamilyhealthcare.com/

Section 5: Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

For members under age 21, KHS will provide a more robust range of medically necessary services than they do for adults that include standards set forth in federal and state law. This includes the contractual obligation to provide the EPSDT benefit in accordance with the AAP/Bright Futures periodicity schedule.

Early and periodic screening, diagnostic and treatment (EPSDT) services:

- Children under 21 years old are covered for well-child visits. Well-child visits are a comprehensive set of preventive, screening, diagnostic, and treatment services.
- KHS will make appointments and provide transportation to help children get the care they need.
- Preventive care can be regular health check-ups and screenings to help find problems early. Regular check-ups identify any issues with medical, dental, vision, hearing, mental health, and any substance use disorders. KHS covers screening services any time there is a need for them, even if it is not during a regular check-up. KHS must make sure that all children enrolled get needed shots at the time of any health care visit.
- When a problem is found during a check-up or screening, KHS covers the care that is medically necessary to correct or help any physical or mental health issues. All these services are at no cost to members and include:
    - Doctor, nurse practitioner, and hospital care
    - Immunizations
    - Lead screening
    - Physical, speech/language, and occupational therapies
    - Home health services, which could be medical equipment, supplies, and appliances
    - Treatment and rehabilitative services for mental health and substance use disorders
    - Treatment for vision, hearing, and dental issues and disorders, which could be eyeglasses, hearing aids, and orthodontics
    - Behavioral Health Treatment for autism spectrum disorders and other developmental disabilities
    - Case management, targeted case management, and health education

A service need not cure a condition in order to be covered under EPSDT. Services that maintain or improve the child's current health condition are also covered under EPSDT because they "ameliorate" a condition. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. Services

are covered when they prevent a condition from worsening or prevent development of additional health problems. The common definition of “ameliorate” is to “make more tolerable.” Additional services must be provided if determined to be medically necessary for an individual child.

Topical Fluoride Varnish

Fluoride varnish is a form of topical fluoride that is more effective in preventing tooth decay than other forms of topical fluoride, and more practical and safer to use with young children. As part of a CHDP Health Assessment, a CHDP provider is required to conduct an oral exam, which may include a fluoride varnish application.

Fluoride varnish training information is available to network providers and their staff through the KHS website: https://www.kernfamilyhealthcare.com/providers/provider-resources/.

Instructions include:

1. How to obtain Fluoride Varnish supplies
2. Fluoride varnish application and periodic dental assessments
3. Parental anticipatory guidance
4. Referring children to a dentist for a dental examination and care at one year of age per CHDP guidelines
5. Coordination of member care with dental professionals

Once the 45-minute training is completed, CHDP will provide some initial start-up materials to the provider and issue a certificate of completion.

Blood Lead Screening

Federal law requires children to be screened for elevated blood levels (BLLs) as part of required prevention services offered through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.

The California Department of Public Health’s California Childhood Lead Poisoning Prevention Branch (CLPPB) issues guidance for all California providers pursuant to these regulations and required blood lead standards of care.

Guidelines are as follows:

1. Provide oral or written anticipatory guidance to the parent(s) or guardian(s) of a child that at a minimum, includes information that children can be harmed by exposure to lead. This anticipatory guidance must be performed at each periodic health assessment, starting at 6 months of age, and continuing until 72 months of age.
2. Perform BLL testing on all children in accordance with the following:
    a) At 12 months and at 24 months of age.

b) When the health care provider performing a periodic health assessment becomes aware that a child 12 to 24 months of age has no documented evidence of BLL test results taken at 12 months of age or thereafter.
c) When the health care provider performing a periodic health assessment becomes aware that a child 24 to 72 months of age has no documented evidence of BLL test results taken when the child was 24 months of age or thereafter.
d) Whenever the health care provider performing a periodic health assessment of a child 12 to 72 months of age becomes aware that a change in circumstances has placed the child at increased risk of lead poisoning, in the professional judgement of the provider.
e) When requested by the parent or guardian.
f) The health care provider is not required to perform BLL testing if:
    i. A parent or guardian of the child, or other person with legal authority to withhold consent, refuses to consent to the screening.
    ii. If in the professional judgement of the provider, the risk of screening poses a greater risk to the child's health than the risk of lead poisoning.
    iii. Providers must document the reasons for not screening in the child's medical record.

Documentation must be included in the member's medical record indicating the reason for not performing the blood lead screening.

Screenings may be conducted using either the capillary (finger stick) or venous blood sampling methods; however, the venous method is preferred because it is more accurate and less prone to contamination. All blood lead screenings should be billed using appropriate and current CPT coding.

Additional resources:

- https://www.dhcs.ca.gov/services/Medi-Cal-For-Kids-and-Teens/Documents/EPSDT-Provider-Training-BD-June-2024.pdf
- https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/Pages/prov.aspx
- https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL20-016.pdf

For more information see KHS Policy and Procedure: Policy 3.13

- https://www.kernfamilyhealthcare.com/providers/policies-and-procedures/

To refer a member to Kern Family Health Care (KFHC) for care coordination services, contact us:

- Phone: 1-800-391-2000
- Alternatively: 661-664-5099
- TTY: 711
- Web**:** https://www.kernfamilyhealthcare.com/

Section 6: Enhanced Care Management

The Enhanced Care Management (ECM) program was implemented in January 2022 as part of the CalAIM Initiative. The DHCS released APL 23-032 on December 22, 2023, superseding APL 21-012 from September 15, 2021.The most recent ECM Policy Guide was updated by DHCS in August of 2024. ECM is an intensive case management program that uses an interdisciplinary approach to address the member's physical, behavioral, and social needs.

ECM is a whole-person approach to care that addresses both the clinical and non-clinical needs of both high-cost and/or high-need members through the systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. ECM Program Goals are to improve care coordination, integrate services, facilitate community resources, address social determinants of health, improve overall health outcomes, decrease inappropriate utilization and duplication of services, and provide same-day access for our members. Members who enroll in ECM retain their PCP and the ECM Care Team communicates with the PCP regarding the Member throughout their enrollment. ECM is a free and voluntary benefit that is available to eligible KFHC members.

Member Eligibility

Member eligibility is determined by the Department of Health Care Services (DHCS) as follows:

A. Adults experiencing homelessness as defined by lacking adequate nighttime residence; primary residence that is a public or private place not designed for or ordinarily used for habitation; living in a shelter; exiting an institution into homelessness; will imminently lose housing in next 30 days; individuals fleeing domestic violence; or defined as homeless under other federal statues:
    - And have at least one complex physical, behavioral, or developmental health need with inability to successfully self-manage, for whom coordination of services would likely result in improved health outcomes and/or decreased utilization of high-cost services.

B. Adults At Risk for Avoidable Hospital or Emergency Department Utilization:
    - Adults with five or more emergency room visits in a six-month period that could have been avoided with appropriate outpatient care or improved treatment adherence.
    - And/or three or more unplanned hospital and/or short-term skilled nursing facility stays in a six-month period that could have been avoided with appropriate outpatient care or improved treatment adherence.

C. Adults with Serious Mental Health and/or Substance Use Disorder Needs:

- Adults experiencing a serious mental illness or suffering from a substance use disorder.
- Adults who meet the eligibility criteria for participation in or obtaining services through County Specialty Mental Health and/or Drug Medi-Cal.
- And are actively experiencing at least one complex social factor influencing their health.
- And meets one (1) or more of the following:
    - Are at high risk for institutionalization, overdose and/or suicide
    - Use crisis services, the emergency rooms, urgent care, or inpatient hospital as sole source of care
    - Experienced two (2) or more emergency department visits, or two (2) or more hospitalizations due to serious mental health issues or SUD in past 12 months
    - Is pregnant or is less than 12 months post-partum

D. Adults who are transitioning from incarceration:

- The individual transitioned from incarceration within the past 12 months and has at least one (1) of the following:
    - Mental illness
    - Substance use disorder
    - Chronic disease
    - Intellectual or developmental disability
    - Traumatic brain injury
    - HIV
    - Pregnancy or Postpartum

E. Individuals living in the community and at Risk for Long-Term-Care Institutionalization:

- Adults who are living in the community who meet the SNF Level of Care (LOC) criteria OR who require lower-acuity skilled nursing, such as time-limited and/or intermittent medical and nursing services, support, and/or equipment for prevention, diagnosis, or treatment of acute illness or injury
- And are actively experiencing at least one complex social or environmental factor influencing their health
- And are able to reside continuously in the community with wraparound supports

F. Adult Nursing Facility Residents Transitioning to the Community:
- Adult nursing facility residents who are interested in moving out of the institution
- And are likely candidates to do so successfully
- And are able to reside continuously in the community

G. Children and Youth Transitioning from a Youth Correctional Facility:
- Children and youth who are transitioning from a youth correctional facility or transitioned from being in a youth correctional facility within the past 12 months

H. Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness:
- Children, Youth, and Families who are experiencing homelessness
- Or are sharing the housing of other persons due to loss of housing, economic hardship, living in hotels, motels, trailer parks, camping grounds, or are living in emergency or transitional shelters.

I. Children and Youth at Risk for Avoidable Hospital or Emergency Department Utilization, with three (3) or more emergency department visits in a 12-month period or two (2) or more unplanned hospital and/or short-term SNF stays in a 12-month period, all of which could have been avoided with appropriate outpatient care or improved treatment adherence.

J. Children and youth enrolled in California Children's Services (CCS) with additional needs beyond the CCS condition:
- Children and youth who are enrolled in CCS or CCS WCM
- And are experiencing at least one complex social factor influencing their health.

K. Children and youth involved in Child Welfare:
- Children and youth who meet one or more of the following conditions:
- Are under age 21 and are currently receiving foster care in California.
- Or are under age 21 and previously received foster care in California or another state within the last 12 months
- Or have aged out of foster care up to age 26 (having been in foster care on their 18th birthday or later) in California or another state
- Or are under age 18 and are eligible for and/or in California's Adoption Assistance Program

- Or are under age 18 and are currently receiving or have received services from California's Family Maintenance program within the last 12 months.

L. Children and youth with serious mental health and/or SUD needs
   - Children and youth who meet the eligibility criteria for participation in or obtaining services through County Specialty Mental Health and/or Drug Medi-Cal.

M. Birth Equity Population of Focus (Adults and Youth):
   - Adults and youth who are pregnant or postpartum (through 12 months period)
   - And are subject to racial and ethnic disparities as defined by the California Public Health data on maternal morbidity and mortality. Currently, four groups have been identified for inclusion, including Black, American Indian, Alaska Native, and Pacific Islander.

Providers can refer potentially eligible Members by submitting an ECM referral through the Provider Portal or by calling KFHC at 1-800-391-2000, option 4. Providers can also make direct referrals by emailing ECM at ecmoutreachspecialist@khs-net.com. As of January 1, 2025, DHCS requires that a standardized referral form be utilized. Non-contracted community-based partners are required to utilize the referral form and may access it on our website at: Enhanced Care Management | Kern Family Health Care. Members and their families can also self-refer by calling KFHC or emailing KFHC as noted above. Members referred for ECM will be evaluated to determine if eligibility criteria are met.

Eligible Members are identified through a weekly stratification process of the entire Kern Health Systems population by utilizing various data points, such as available data feeds, diagnosis codes, claim submissions, etc. Members found to be eligible for ECM by falling into a DHCS-defined population of focus are authorized to receive the ECM benefit for 12 months. Prior to the end of the authorization Members are evaluated to assess if the Member should be reauthorized or transition to another case management program or other service.

ECM Core Services

There are seven core services provided in Enhanced Care Management which include:

- Outreach and Engagement – Contacting eligible members to enroll in ECM.
- Comprehensive Assessment and Care Management Plan – Developing and updating an individualized Care Management Plan to guide each member with needed services and care.

- Enhanced Coordination of Care – Implementation of the members' Care Management Plan with coordinating care and connection for health and community services.
- Comprehensive Transitional Care – Facilitating care transitions between the hospital, nursing homes, other treatment facilities and home.
- Coordination and Referral to Community and Social Support Services – Determining needs and coordinating referrals to address Social Determinants of Health.
- Health Promotion – Educating patients about and supporting them in health behaviors.
- Member and Family Support – Supporting the self-management and decision-making efforts of patients and their family or support team.

If you would like more information regarding Enhanced Care Management, you can call KFHC at 1-800-391-2000, option 4, or go to DHCS Home (ca.gov).

Section 7: Community Support Services

Community Supports are medically appropriate and cost-effective alternative services. Federal regulation allows states to offer Community Supports as an option for Medicaid managed care organizations, and KFHC has elected to offer some Community Support Services (CSS).

Community Supports are designed to help avert or substitute hospital or nursing facility admissions, discharge delays, and emergency department use when provided to eligible members. Community Supports will typically be provided by community-based organizations and providers. ECM Providers may also serve as Community Supports Providers if they have appropriate experience.

Community Supports are an optional service for KFHC to offer and are optional for members to receive. In January 2022, KFHC started offering the following Community Supports:

Community Support Service	Description	Service Provided By:
Asthma Remediation	The program helps members make necessary modifications to their home or living environment, to ensure they can maintain a healthy and supportive lifestyle while living with asthma. This may include the purchasing of air purifiers and other medical supplies.	1. Central California Asthma Collaborative 2. SD Healthcare Consulting 3. Community Wellness Program/Dignity Health 4. CAPK
Housing Transition Navigation Services	The program assists members in their search for available housing options. Options including assisting with completing housing applications, securing required documentation, and providing rental payment assistance.	1. Kern County Housing Authority 2. CAPK 3. St. Vincent Preventative Family Care 4. City Serve Network 5. EA Family Services 6. The Open Door Network 7. Mercy House 8. The Mission at Kern County 9. Akido
Housing Deposits	The program coordinates and secures one time housing funds to support independent living. Funds may be utilized to pay security deposits, initial utility fees, medical equipment, and basic household expenses.	1. Kern County Housing Authority 2. CAPK 3. St. Vincent Preventative Family Care 4. City Serve Network 5. EA Family Services 6. The Open Door Network 7. Mercy House 8. The Mission at Kern County 9. Akido

Community Support Service	Description	Service Provided By:
Housing Tenancy and Sustaining Services	The program provides support and resources to prevent the loss of housing. Support and resources include the education of tenant and landlord rights and responsibilities as well as identifying lease violations such as hoarding.	1. Kern County Housing Authority 2. CAPK 3. St. Vincent Preventative Family Care 4. City Serve Network 5. EA Family Services 6. The Open Door Network 7. Mercy House 8. The Mission at Kern County 9. Akido
Recuperative Care (Medical Respite)	This short-term residential care program helps members continue their recovery following hospitalization and receive post discharge treatment. Other services include transporting members to appointments, as well as providing food and housing assistance.	1. Good Samaritan Healing Center 2. Kern Medical Center 3. Papo Hernandez
Short Term Post Hospitalization	The program assists members with temporary shelter while recovering from a procedure. During the aftercare, members obtain assistance in gaining housing, which allows them to have a higher level of independency.	1. Papo Hernandez, Respite, Rest and Recovery Home 2. Good Samaritan Healing Center

January 1, 2023, the following services started:

- Medically Tailored Meals
- Respite Services
- Sobering Centers

Community Support Service	Description	Service Provided By:
Medically Tailored Meals/Medically Supportive Food	This program helps members who experience chronic conditions achieve their nutritional goals by providing healthy meals or supportive nutritional counseling.	1. GA Food Services 2. Modify Health 3. PurFood, LLC dba Mom's Meals 4. Hunger Not Impossible, dba Bento Foods 5. Roots Food Group 6. Project Food Box
Respite Services	The program finds volunteers or paid caretakers to provide in-home services for a member's loved one, either occasionally or on a regular basis. The services are non-medical in nature.	1. 24 Hour Home Care 2. SD Healthcare Consulting
Sobering Centers	This program is used as alternative destinations for individuals who are found to be publicly	1. Kern Behavioral Health and Recovery Services. 2. City Serve Network

Community Support Service	Description	Service Provided By:
	intoxicated and would otherwise be transported to the emergency department or jail.	

July 1, 2023, the following services started:

- Assisted Living Facility Transition
- Community or Home Transition
- Personal Care and Homemaker Services

Community Support Service	Description	Service Provided By:
Community or Home Transition	The program is designed to help members with financial assistance and information needed to transition from living in medical facilities to living in their own homes. The maximum financial support available is $7,000 per member.	1. Bakersfield Community Healthcare 2. Pathway Assisted Living
Assisted Living Facility Transition	The program enables individuals to live in their community and/or avoid institutionalization whenever possible. The goal is to facilitate nursing facility transition back into a home-like setting and/or prevent future skilled nursing facility admissions.	1. Bakersfield Community Healthcare 2. Pathway Assisted Living
Personal Care and Homemaker Services	The services are offered to individuals who require support with their everyday activities, including but not limited to bathing, dressing, toileting and feeding support for activities of daily living (ADL).	1. 24 Hour Home Care 2. SD Healthcare (Offices in Bakersfield and Delano)

January 2024 the following services will start:

- Day Habilitation Services

Community Support Service	Description	Service Provided By:
Day Habilitation Services	Program assist the Member in acquiring, retaining,and improving self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment.	1. Good Samaritan Healing Center 2. CAPK 3. Psychiatric Wellness Center

July 2024, the following services started:

- Environmental Accessibility Adaptions

Community Support Service	Description	Service Provided By:
Environmental Accessibility Adaptions	This service provides physical adaptations to a home that are necessary to ensure the health, welfare, and safety of the individual, or enabled individual to function with greater independence	1. Habitat for Humanity 2. CAPK

Members Eligible to Receive Community Supports

KFHC must determine eligibility for all pre-approved Community Supports using the DHCS Community Supports policy guide, which contain specific eligibility criteria for each Community Supports. KFHC is also expected to determine that a Community Supports is a medically appropriate and cost-effective alternative to a Medi-Cal Covered Service. When making such determinations, KFHC must apply a consistent methodology to all members within a particular county and cannot limit the Community Supports only to individuals who previously were enrolled in the WPC Pilot.

Making a Referral for Community Supports

Referrals for Community Supports may be made by a physician, internal staff, members or their caregiver, community service agency, hospital or health care provider, or an ECM or Community Supports providers. Referrals are accepted through the provider portal, internal nurses' portal, via secured email or by calling KFHC 1-800-391-2000 and choosing option #6.

Community Supports Authorizations

An authorization through KFHC is required for members to obtain CSS. KFHC staff will utilize the information received on the referral, as well as other data sources (including social determinants of health data) available to determine eligibility. The authorization process entails eligibility screening, and decision-making by KFHC staff. If approved after the KFHC screening/assessment, the member may receive Community Supports. Some Community Supports, such as housing deposits, are limited to once per lifetime and asthma remediation has a rate limitation associated with the services. Utilization management will monitor and approve the services after a detailed review. KFHC will not categorically deny or discontinue a Community Supports irrespective of member outcomes or circumstance. Some Community Supports will require periodic reauthorization by submitting an Authorization Request to the Utilization Management Department, along with any necessary documentation for review.

You can reach the CSS Department by calling KHS at 661-632-1590, option 6 or 1-800-391-2000, option 6.

Section 8: Mental Health Services

Kern Family Health Care (KFHC) is responsible for providing non-specialty mental health services (NSMHS) to members who are experiencing mild to moderate mental health conditions on an outpatient basis. These services will be provided by a licensed healthcare professional who is acting within the scope of their professional license. The goal is to offer accessible and appropriate care for individuals with less complex mental health needs, ensuring timely treatment and support.

However, for members who require specialty mental health services (SMHS) due to more complex or severe mental health conditions, KFHC will refer and coordinate care with the County Mental Health Plan—which is Kern Behavioral Health and Recovery Services (KBHRS). KBHRS is responsible for providing these specialty mental health services, including services for conditions that may be more severe or require a higher level of care, such as inpatient treatment or long-term management.

To ensure that all members receive the necessary care, KFHC (the Managed Care Plan, or MCP) and KBHRS (the Mental Health Plan, or MHP) both play critical roles in the provision of mental and behavioral health services. Both entities must ensure that members are not denied services. It is important to note that APL 22-005, "No Wrong Door for Mental Health Services," prohibits the denial of mental health services regardless of which level of care is needed.

The division of responsibilities between KFHC and KBHRS is outlined as follows:

- KHS-MCP (KFHC): Responsible for providing mild to moderate behavioral or mental health services through non-specialty mental health services (NSMHS).
- Kern BHRS-MHP (KBHRS): Responsible for providing moderate to severe behavioral or mental health services through specialty mental health services (SMHS).

Mental Health Parity

The KFHC Utilization Management (UM) Department works in close collaboration with Kern Behavioral Health and Recovery Services (KBHRS) to ensure seamless delivery of both mental health and physical health services to all KFHC members. This partnership ensures that members receive integrated care, addressing both their physical and mental health needs in a comprehensive manner.

One key aspect of KFHC’s Utilization Management (UM) Program is its commitment to mental health parity. In compliance with mental health and substance use disorder parity laws, KFHC does not impose Quantitative Treatment Limitations (QTL) or Non-Quantitative Treatment Limitations (NQTL) more stringently on mental health services and substance use disorder services than those applied to medical and surgical services.

This means that KFHC's policies and procedures ensure that members seeking mental health or substance use treatment are not subject to more restrictive limitations compared to those seeking medical or surgical services. This approach ensures equitable access to both mental and physical health care, in full compliance with parity requirements, and supports the provision of high-quality care across all areas of health.

Mental Health Benefits

KFHC is committed to ensuring timely access to mental health services for its members. As part of this commitment, KFHC will utilize DHCS-approved screening tools for youth under age 21 and adults aged 21 and over to assess the need for behavioral or mental health services.

The DHCS screening tool is used when members are not currently receiving care and helps to determine the appropriate mental health delivery system for the initial mental health assessment. This ensures that individuals receive the appropriate level of care based on their mental health needs.

Screening Outcomes
Through this screening, the following decisions will be made based on the member's needs:

- **Specialty Mental Health Services (SMHS)**: If a member requires specialty services for moderate to severe conditions, KFHC will coordinate with the Kern Behavioral Health and Recovery Services (KBHRS) Care Coordination Unit to ensure proper linkage to the appropriate services.
- **Non-Specialty Mental Health Services (NSMHS)**: If the member's needs are categorized as mild to moderate, KFHC will coordinate linkage to KFHC's Network Behavioral Health Practitioner for further care.

Direct Access to Behavioral or Mental Health Providers
If a member contacts a Behavioral Health (BH) practitioner directly to receive services, a screening tool is not required. In this case, the BH practitioner will complete a mental health assessment to determine the medical necessity for services, in accordance with APL 22-005 No Wrong for Mental Health Services Policy. This ensures that no member is denied services based on the method they use to seek help.

Role of Primary Care Providers (PCPs)
Primary Care Providers (PCPs) play a key role in the screening and referral process. PCPs will identify when a member requires mental health services based on their own screenings and observations. Once identified, the PCP will refer the member to KFHC to complete the DHCS Screening Tool. KFHC will then assist with coordinating the member's referral to a Behavioral Health (BH) practitioner for further mental health assessment.

Assessment, Referral, and Transition of Care Process
After the initial assessment by the Behavioral Health (BH) practitioner, if it is determined that the member meets the medical necessity criteria for Specialty Mental Health Services (SMHS), the Transition of Care (TOC) process will be initiated. The BH practitioner will complete the DHCS Transition of Care Tool, which is essential for ensuring that members are referred and smoothly transitioned to the appropriate level of care, whether that be Specialty Mental Health Services (SMHS) or Non-Specialty Mental Health Services (NSMHS).

Referral to the Appropriate System

- If the member requires SMHS, the Transition of Care Tool will be submitted to Kern Family Health Care (KFHC), who will facilitate the referral to the Mental Health Plan (MHP) for the necessary specialty mental health services. This ensures that the member receives the specialized care needed for their condition.
- If the member requires NSMHS, KFHC will coordinate the referral to KHS Network Behavioral Health (BH) Providers for non-specialty care, ensuring timely access to outpatient mental health services for mild to moderate conditions.

Transition Back to Lower Level of Care
When a member's condition improves and they no longer require specialty mental health services, the **Transition of Care Tool** will also be used to transition the member back to **non-specialty care** under the **Managed Care Plan (MCP)**. The BH practitioner will complete this tool to ensure a seamless transition back to the appropriate level of care based on the member's improved condition, preventing any gaps in treatment.

NSMHS Covered Services
The NSMHS services include the following mental health benefits administered through KFHC:

1. Individual/group Mental Health evaluation and treatment (psychotherapy);
2. Psychological testing when clinically indicated to evaluate a Mental Health condition;
3. Outpatient services for the purposes of monitoring drug therapy;
4. Psychiatric consultation for medication management;
5. Outpatient laboratory, supplies and supplements;
6. Drug and alcohol Screening, Assessment, Brief Intervention and Referral to Treatment (SABIRT) services
7. Family therapy (composed of two (2) or more family members) for adult Members with a Mental Health condition and child Members under twenty-one (21) who meet criteria as specified in the Medi-Cal Provider Manual.
    a. Family counseling for the sole purpose of treating a couple's relational

problems, including marriage counseling, is not covered.

8. Dyadic Therapy: “Dyadic care is a form of treatment that serves parents or caregivers and children together, targeting family well-being as a mechanism to support healthy child development and mental health.’ (DHCS APL effective January 1, 2023)

Consent for Mental Health Services for Minors

Effective July 1, 2024, minors aged 12 years or older will have the legal right to consent to non-specialty outpatient Medi-Cal mental health treatment or counseling without requiring consent from a parent or legal guardian.

However, it is essential that the Behavioral Health Practitioner applies their clinical judgment and expertise to determine whether the minor is sufficiently mature to understand the nature and purpose of the treatment. The practitioner will assess the minor’s ability to engage in the process of treatment independently, ensuring that they are capable of participating intelligently in the outpatient services without parental or guardian consent.

Responsibilities of Managed Care Plans (MCPs) and Mental Health Plans (MHPs)

Managed Care Plans (MCPs) are responsible for ensuring that minors have the ability to consent to non-specialty outpatient Medi-Cal mental health treatment or counseling. Meanwhile, County Mental Health Plans (MHPs) are tasked with ensuring that minors can consent to specialty mental health outpatient treatment or counseling. This is in alignment with the Family Code section 6924 and the guidance provided by the Department of Health Care Services (DHCS).

For more information see KHS Policy and Procedure: Policy 21.01, 21.02, and 21.05.

- https://www.kernfamilyhealthcare.com/providers/policies-and-procedures/

Section 9: Behavioral Health Treatment (BHT)

Behavioral Health Treatment (BHT) includes professional services and treatment programs, such as Applied Behavioral Analysis (ABA) and other evidence-based behavior intervention programs. These services are designed to develop or restore, to the maximum extent practicable, the functioning of individuals, whether or not they have a diagnosis of autism spectrum disorder (ASD).

The Centers for Medicare and Medicaid Services (CMS) require that all children enrolled in Medi-Cal receive Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screenings. These screenings are crucial for identifying health and developmental issues as early as possible. The screenings must be conducted at regular intervals in accordance with the American Academy of Pediatrics' "Bright Futures" guidelines for preventive pediatric healthcare.

If a screening indicates the need for further evaluation of a child's health, the child must be referred appropriately for medically necessary diagnosis and treatment. This ensures timely access to any needed services and prevents delays in care.

Eligibility for BHT

To be eligible for BHT, members must meet all of the following criteria:

1. Age: The individual must be under 21 years of age.
2. Physician or Psychologist Recommendation: The member must have a recommendation from a licensed physician and surgeon or a licensed psychologist, stating that evidence-based BHT/BIS is medically necessary.
3. Medical Stability: The member must be medically stable.
4. No Need for 24-Hour Monitoring: The member must not require 24-hour medical, or nursing monitoring or procedures typically provided in a hospital or intermediate care facility for persons with intellectual disabilities (ICF/ID).

Coordination of Services

KFHC is responsible for coordinating the provision of BHT/BIS services with other involved entities. This ensures that duplicative services are avoided, promoting a streamlined approach to care that avoids unnecessary overlap and provides the member with the most effective, coordinated treatment plan.

Behavioral Treatment Plan

BHT is provided under a behavioral treatment plan tailored to the specific needs of the member being treated. This plan includes measurable goals that are designed to be achieved within a specific timeline, and it is developed by a BHT provider. The treatment plan serves as a roadmap for the member's progress, outlining the objectives to be reached in a structured and time-sensitive manner.

The behavioral treatment plan must be reviewed, revised, and/or modified no less than once every six months by the BHT provider. This ensures that the plan remains relevant and effective in addressing the member's evolving needs. Additionally, the plan may be adjusted if medically necessary to better support the member's treatment progress or changing circumstances.

BHT may be discontinued under the following conditions:

1. Treatment Goals Achieved: When the member successfully achieves the established treatment goals.
2. Goals Not Met: If the goals set forth in the treatment plan are not met within the designated timeframe.
3. Services No Longer Medically Necessary: If it is determined that BHT services are no longer required based on the member's progress or current needs.

This approach ensures that BHT services remain focused on the member's progress and are provided only as necessary, ensuring effective treatment while avoiding unnecessary services.

For more information see KHS Policy and Procedure: Policy 21.06

- https://www.kernfamilyhealthcare.com/providers/policies-and-procedures/

Section 10: Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT)

Primary Care Providers (PCPs) are required to screen members aged 11 years and older, including pregnant members, for alcohol and drug use. This screening must be conducted in accordance with the recommendations from the American Academy of Pediatrics' Bright Futures Initiative and the United States Preventive Services Task Force (USPSTF), which provides Grade A or B recommendations for such screenings.

By implementing these screening protocols, PCPs play a critical role in identifying members who may be at risk for alcohol and drug misuse, ensuring that appropriate interventions and referrals can be made to support the member's health and well-being.

Screening for Unhealthy Alcohol and Drug Use

Unhealthy alcohol and drug use must be screened using validated screening tools to ensure accuracy and effectiveness. These tools help identify members who may be at risk for substance misuse and ensure appropriate interventions are provided. The following are some of the validated screening tools that can be used:

- Cut Down-Annoyed-Guilty-Eye-Opener Adapted to Include Drugs (CAGE-AID)
- Tobacco, Alcohol, Prescription medication, and other Substances (TAPS)
- National Institute on Drug Abuse (NIDA) Quick Screen for adults
- The single NIDA Quick Screen alcohol-related question can be used specifically for alcohol use screening.
- Drug Abuse Screening Test (DAST-10)
- Alcohol Use Disorders Identification Test (AUDIT-C)
- Parents, Partner, Past and Present (4Ps) for pregnant women and adolescents
- Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT) for non-pregnant adolescents
- Michigan Alcoholism Screening Test Geriatric (MAST-G) for the geriatric population

These tools are designed to provide accurate and effective screening for alcohol and drug use across various age groups and demographics, including pregnant women, adolescents, and the geriatric population.

Assessment for Unhealthy Alcohol Use and Substance Use Disorder (SUD)

When a screening indicates a positive result, validated assessment tools should be used to further evaluate whether unhealthy alcohol use or substance use disorder

(SUD) is present. In some cases, validated assessment tools may be used directly without the need for prior screening, depending on the situation.

The following are some of the validated alcohol and drug assessment tools that can be used:

- NIDA-Modified Alcohol, Smoking and Substance Involvement Screening Test (NM-ASSIST)
- Drug Abuse Screening Test (DAST-20)
- Alcohol Use Disorders Identification Test (AUDIT)

These tools are designed to provide a more in-depth evaluation of the severity of substance use or alcohol-related issues, helping clinicians to determine the appropriate level of care and intervention needed.

Brief Interventions and Referral to Treatment

For KFHC Members whose brief assessments reveal unhealthy alcohol use, brief misuse counseling should be offered as an initial intervention. If the brief assessment indicates a potential alcohol use disorder (AUD) or substance use disorder (SUD), appropriate referrals for additional evaluation and treatment should be made. This may include medications for addiction treatment, as needed.

Alcohol and/or drug brief interventions consist of counseling the member about their alcohol misuse, providing information on additional treatment options, and making necessary referrals or service connections.

Referral Process
Primary Care Providers (PCPs) are required to refer members to KFHC for linkage to the Drug Medi-Cal Organized Delivery System (DMC-ODS), specifically Kern Behavioral Health and Recovery Services (KBHRS). KFHC will outreach to the member and facilitate a warm handoff to the SUD Access Line for the initial brief American ASAM Screening and subsequent linkage to further assessment and counseling when necessary.

Components of Brief Interventions

Brief interventions should include the following key elements to support the member's treatment and recovery journey:

1. Providing feedback to the patient regarding the results of their screening and assessment.
2. Discussing negative consequences that the patient has experienced due to alcohol or drug misuse, and the overall severity of the problem.
3. Supporting the patient in making behavioral changes, providing encouragement and guidance.

4. Discussing and agreeing on plans for follow-up, including referral to additional treatment services if needed.

By integrating these components, brief interventions help to address the immediate needs of the member and set a path for continued care and recovery.

Documentation Requirements

KFHC Member medical records must include comprehensive documentation to ensure continuity of care and proper tracking of alcohol and substance use services. The following must be documented:

1. Service Provided: Clear identification of the service provided, such as the screening or brief intervention.
2. Screening Instrument Details: The name of the screening instrument used, along with the score from the screening, unless the screening tool is embedded in the electronic health record (EHR).
3. Assessment Instrument Details: If an assessment was conducted, the name of the assessment instrument and the score from the assessment must be documented, unless the tool is embedded in the EHR.
4. Referral Information: Documentation must include whether a referral was made to an AUD (Alcohol Use Disorder) or SUD (substance use disorder) program, and where the referral was directed.

Transfer of Care and Record Maintenance

PCPs must maintain accurate and up-to-date documentation of SABIRT services provided to KHS members. In cases where a KHS member transfers from one PCP to another, the receiving PCP must make efforts to obtain the member's prior medical records, including any records related to the provision of preventive services, to ensure continuity of care and avoid duplication of services.

Medication Assisted Treatment (MAT)

PCPs are responsible for providing members who are seeking treatment for opioid use disorder (OUD) with appropriate support and interventions. The following steps should be taken for members with OUD:

1. Offer Medications for Opioid Use Disorder (MOUD): PCPs should offer Medications for Opioid Use Disorder (MOUD) as part of the treatment plan, in accordance with best practices for opioid use disorder management.
2. Referral to KHS for Linkage to Kern Behavioral Health and Recovery Services (KBHRS): PCPs should refer members to KHS for linkage to Kern BHRS for additional support and specialized care.
    - KHS will then outreach to the member and complete a warm handoff to the SUD Access Line, where an initial brief ASAM Screening will be conducted.

- If necessary, linkage to counseling support for opioid use disorder (OUD) will be arranged to ensure the member receives comprehensive care.

By offering MOUD and facilitating access to further treatment through Kern BHRS, KHS Network PCPs play a key role in addressing and managing opioid use disorder for members in need.

For criteria and additional resources please refer to: All Plan Letter 21-014

- https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-014.pdf

For more information see KHS Policy and Procedure: Policy 21.03

- https://www.kernfamilyhealthcare.com/providers/policies-and-procedures/

Section 11: Wellness & Prevention Services

Wellness & Prevention promotes healthy living, improving health outcomes, reducing risks of disease and empowering members to be active participants in their health care.

Members will receive health education services at no charge as part of preventive and primary health care visits.

The goal is to help members be engaged and informed so they can be active participants in their care and the care of their children. The services below are provided in English and Spanish:

- Asthma Education and Management
- Diabetes Prevention
- Diabetes Management
- Nutrition and Weight Management
- Smoking and Tobacco Cessation (includes vaping and chewing)

KFHC Health Education Classes

Health Education Classes are hosted by KFHC and are at no cost to anyone interested. Class dates and times are posted on the KFHC Calendar of Events:

- https://www.kernfamilyhealthcare.com/calendar/

Health Education Class Snapshot

Referral Reason	Class Option for Member	Length	Reward*
Weight management, Nutrition, Physical activity	Activity & Eating (A&E)	1 Class (90min)	$0
Weight management, Nutrition, Physical activity	Eat Healthy Be Active (EHBA)	6 Classes (90min)	$10 per class
Pre-Diabetes	Diabetes Prevention Program (DPP)	26 Classes (60min) in 1 Year	$15 per class Plus, a reward for: • Completing program. • Losing 5% of start weight. • Submitting their A1C results at the end of the program.
Diabetes (A1C Over 6.5%)	Diabetes Empowerment Education Program (DEEP)	6 Weekly Classes (120min)	$20 per class Plus, a reward for: • For attending all 6 class in one series.
Nicotine Use (Vape included)	Fresh Start Tobacco Cessation (FS)	4 Weekly Classes (90min)	$25 per class
Asthma	Breathe Better Asthma	2 Weekly classes (90min)	$15 per class Plus, a reward for up to: • 3 follow-up calls.

FAQs:

Q: How do I refer my patients to these classes?

A: Use the Provider Portal to submit the request to the Health Education/Wellness & Prevention Department.

Q: Who will call the patient after I send over the referral on the portal?

A: KFHC will call the patient within 5 business days from receipt of referral.

Reminders

Most of our classes are offered virtually and in person.

Transportation is available for in-person classes.

Let the patient know to expect a call from KFHC based on your referral.

*Rewards are subject to change at any time. Class or reward updates will be provided to the member during registration with KFHC. All gift cards can take up 8 weeks to process for delivery. Members should inform KFHC of any address change as soon as possible to avoid delays or forfeiting of a lost gift card. Gift cards are not replaced if lost or stolen.

Health Education Referrals

Health education services are available by referral from KFHC staff, members (self-referral), providers, or community service providers. Members can request health education services by phone, the KFHC Member Portal, or the LINK App. Providers can send referrals via the KFHC Provider Portal. Upon receipt of a health education referral, health education staff will contact the member to assess their interest in participating in health education services. Transportation and interpreter services are provided accordingly. The best available health education service is then identified for the member.

For assistance on how to send health education referrals with the KFHC Provider Portal, contact your KHS Provider Relations Representative.

Health Education Materials

KFHC has developed health education brochures addressing important health issues facing our local community. These materials are provided at no cost to providers and members. Contact your Provider Relations Representative for more information on how you can receive health education brochures for your office. They are also available on the KFHC website.

- Control Asthma
- Control COPD
- Control High Blood Pressure
- Diabetes Control
- Growing Up Healthy Series
- Control High Cholesterol
- Eat Healthy
- Urgent Care
- Exercise

Click on the link below to view brochures on each of the topics (Brochures are also available in Spanish):

- https://www.kernfamilyhealthcare.com/members/health-and-wellness-services/education-programs/

KFHC considers the specific needs of Seniors and Persons with Disabilities (SPD). Upon request by the SPD member, family caregiver or provider, KFHC provides educational materials in alternative formats such as Braille, large print, audio, or other appropriate methods. The Wellness & Prevention Department will handle requests for health educational material in alternative formats.

Health Education Resources

Health Education services are also provided to Members through:

- KFHC 24-Hour Advice Nurse Line – In addition to Advice Nurse services, the Health Information Library has an audio library with hundreds of health topics recorded in English and Spanish. The Advice Nurse Line can be reached at 1-800- 391-2000, option 2.
- KFHC Self-Management Tools – Members now have access to patient education resources from our website. The database has information on health conditions, wellness and prevention, and life stages. The page has access to reading materials, videos, and tools to help members make informed decisions. View the KFHC Self-Management tools at Healthwise Knowledgebase.

Family Health, a newsletter that is mailed three times a year to KFHC Members which includes health education and local resources. View current and past newsletters at Newsletters | Kern Family Health Care.

Community Events & Health Fairs – KFHC participates in health fairs and community events to promote personal health awareness and preventive health care to Members and the community. View a list of community events at

https://www.kernfamilyhealthcare.com/members/health-and-wellness-services/education-programs/or https://www.facebook.com/KernFamilyHealthCare.

For more information see KHS Policy and Procedure 3.05:

- https://www.kernfamilyhealthcare.com/providers/policies-and-procedures

Member Rewards

KFHC offers wellness-based rewards for members.

- Blood Lead Screening – $15
- Breast Cancer Screening – $25
- Cervical Cancer Screening – $25
- Childhood Immunization Status - $25
- Hemoglobin A1c Blood Test Screening - $25
- Initial Health Appointment (IHA) –$25
- Postpartum visit - $30
- Prenatal visit in 1st trimester – $30
- Well Baby – $25, for up to 8 visits. Total rewards not to exceed $160 per member.
- Well Care – $25

All rewards are in the form of gift cards. Rewards may take up to 8 weeks to process. Limits apply. Visit Member rewards programs | Kern Family Health Care for a complete list of rewards and detailed information.

Smoking and Tobacco Cessation

KHS requires providers to provide tobacco cessation services to members, including:

- Identify tobacco use
- Conduct initial and annual assessment of tobacco use
- Utilize FDA approved tobacco cessation medications
- Refer to a tobacco cessation program for individual, group, and telephone counseling for members of any age who use tobacco products, such as KHS' Fresh Start Tobacco Program and Kick It California
- Prevent of tobacco use in children and adolescents

Services for pregnant tobacco users

- Ask all pregnant members if they use tobacco or are exposed to tobacco smoke
- Offer all pregnant members at least one face-to-face tobacco cessation counseling session per quit attempt.
- Refer to a tobacco cessation quit line, such Kick it California (previously the California Smokers Helpline) 1-800-300-8086
- Refer to tobacco cessation guidelines by the American College of Obstetrics and Gynecology (ACOG) before prescribing tobacco cessation medications during pregnancy

One of the behavioral change models KFHC is the “5 A's"(Ask, Advise, Assess, Assist, and Arrange). For more information regarding the 5 A’s:

- https://www.ahrq.gov/prevention/guidelines/tobacco/5steps.html

The Other validated behavior change model KFHC recommends is the “5 R’s” (Relevance, Risks, Rewards, Roadblocks, Repetition). For more information regarding the 5 R’s:

- Patients Not Ready To Make A Quit Attempt Now (The "5 R's") | Agency for Healthcare Research and Quality (ahrq.gov)

KFHC encourages providers to implement the USPSTF comprehensive tobacco use treatment recommendations and the DHCS recommended education resources available in All-Plan Letter 16-014.

- https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2016/APL16-014.pdf

Asthma Preventative Services (APS)

Asthma Preventative Services (APS) consist of clinic-based and home-based asthma self-management education and in-home environmental trigger assessments. APS is intended to provide members needed education and skills to mitigate environmental exposures that exacerbate asthma symptoms and self-manage their asthma.

The self-management education portion of APS consists of information about the basic facts of asthma, proper use of long-term and quick relief medications, and evidence-based self-management techniques and self-monitoring skills. The APS in-home environmental trigger assessment can aid in the identification of environmental asthma triggers commonly found in and around the home, including allergens and irritants.

APS may be provided by licensed providers such as physicians, nurse practitioners (NPs), and physician assistants (PAs). These services may also be provided by unlicensed providers such as community health workers (CHWs), promotors, or community health representatives who meet the qualifications of an APS provider.

Members are eligible to receive APS if:

1. They have been diagnosed with asthma,
2. A licensed physician, NP, or PA recommends APS, and
3. One of the following has occurred in the past 12 months:
    - A score of 19 or lower on the Asthma Control Test,
    - An asthma-related emergency department visit or hospitalization, or
    - 2 sick or urgent care asthma-related visits in the past 12 months.

How to refer members for APS:

- Call KFHC at 1- 800-391-2000 or 661-632-1590.
- You can also refer members for APS via the Provider Portal. For assistance, you can contact your Provider Relation Representative.

To learn more about APS, see the Medi-Cal Provider Manual for APS.

Community Health Worker (CHW) Services

Community Health Worker (CHW) services are preventive health services to prevent disease, disability, and other health conditions or their progression; to prolong life; and promote physical and mental health. CHW services include Community Health Integration (CHI) services, which are more targeted services used to address unmet social determinants of health (SDOH) needs that affect the diagnosis and treatment of the member's medical problems. Covered CHW services include:

- Health Education
- Health Navigation
- Non-Clinical Screening and Assessments
- Individual Support or Advocacy

Medi-Cal CHW services are provided by community health workers – non-licensed public health workers – who work with members to connect them with the services they need. They provide services under a **supervising provider**, an enrolled Medi-Cal provider who submits claims for services provided by a CHW while also providing direct/indirect oversight and ensuring that they meet the minimum qualifications to be a community health worker.

For member eligibility criteria, chronic conditions that quality members, or to learn more about CHW worker qualifications, we encourage you to review the Medi-Cal Provider Manual for CHW Services.

How to refer members for CHW Services:
Call KFHC at 800-391-2000 or 661-632-1590 to be connected with a KFHC CHW Provider today.

Section 12: Cultural and Linguistic Services

KFHC will provide equal access to health services for members who are Limited English Proficient (LEP), deaf or hard of hearing, or blind or have low vision by providing appropriate interpreter interpreters and auxiliary aids and services.

The following Language assistance services are available at no cost to Members and Providers:

- 24/7 Over-the-phone interpreter support during medical appointments via Language Line
- Video Remote Interpreting (VRI) support for spoken languages and sign language via Language Line
- American Sign language interpreters via LifeSigns
- In-person interpreter support via KFHC or CommGap
- Services for the hearing or speech impaired via California Relay Services
- Member informing materials in alternative formats (i.e., large print, audio, and Braille)

Interpreter Access to Members

Interpreters must be made available upon request by face to face or via telephone with physicians, physician extenders, registered nurses, or other personnel who provide medical or health care advice to members. Interpreter services must also be available at all pharmacy sites.

Discourage the Use of Family Members as Interpreters

Family members, friends, and especially minors are discouraged from performing interpretive services for KFHC Plan members. The use of family or friends may jeopardize the quality and/or accuracy of information that is relayed to the member and may also present a hardship if the family member or friend must deliver confidential information.

Telephone Interpreting Services

During KFHC Office Hours: Providers and Members may contact the KFHC Member Services Department for an interpreter that is on staff, or a Member Services Representative will connect the Provider or Member with Language Line Solutions- an interpreting service available with over 240 language options.

After KFHC Office Hours: Providers and Members are connected to Language Line Solutions via the KFHC Advice Nurse Line which is available by calling (800) 391-2000. KFHC's telephone interpreter service is available 24-hours a day, 7 days a week.

In-person Interpreter Services

Members or providers may also request in-person interpreter services for a medical appointment. Providers can contact the KFHC Member Services Department to schedule an in-person interpreter. KFHC will send either a qualified KFHC interpreter or a qualified contracted interpreter to the provider's office. Future appointments, if necessary, should be scheduled to include a KFHC staff member/interpreter or contracted interpreter. It is advisable that providers contact KFHC's Member Services Department at least 7 business days in advance of an appointment to request an in-person interpreter.

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

Alternative Format Selection (AFS) Services

Providers are required to document any new AFS that you receive from Kern Family Health Care members at the time of the request. To enter the member's selection into the AFS online screen, please visit: https://afs.dhcs.ca.gov/ or to utilize the AFS Helpline: 1-833-284-0040. For instructions regarding how to submit AFS data online, please visit:

- Alternative-Format-Selection-Application-User-Guide

Examples of Alternative Format Selections (AFS) include:

- Large Print (no less than 20-point Arial font)
- Audio Format
- Accessible Electronic Format
- Braille

To verify if a member requested alternative format, please login to the KFHS Provider Portal:

- https://provider.kernfamilyhealthcare.com/v3app/publicservice/loginv1/login.aspx?bc=1215a844-d81f-4be0-ac1c-92dd137dd90c&serviceid=05411915-5bc6-4527-97a6-45b09eecbde3

Select:

- Provider Practice
- Click Here to Proceed
- Enter Member's CIN or MEM # and Date of Birth
- View Report
- Gaps in Care

If the member has chosen an alternative format, you will see an alternative format indicated under measure:

Measure	Measure Description	Submeasure
Alternative Format Selection for Members with Visual Impairments - Large Font	Alternative Format Selection	AFS 1 Event

Please review this section of the portal for every member and if an alternative format has been selected, all member communications must be provided in the format selected.

If you need assistance or would like to have KHS enter the AFS on your behalf, please contact Member Services at 1-800-391-2000.

KHS offers training on the effective communication requirements of Title II of ADA:

- https://res.cloudinary.com/dpmykpsih/image/upload/kern-site-353/media/1534/better_communication_better_care_-_provider_tools_to_care_for_diverse_populations.pdf

Medical Record Documentation

All providers are required to document the member's language in the medical record. Requests or refusals for interpreter services by members must also be indicated in the member's medical record.

Provider Requirements

Providers are required to report their language capabilities as well as languages spoken by their staff. The information provided is included in the Provider Directory and the KFHC website to assist Members in selecting the best Provider for their needs.

Cultural & Linguistic Resources & Training

To assist KFHC Providers in better communicating with patients that are limited in their English proficiency (LEP), the following resources available on www.kernfamilyhealthcare.com.

- Training: "Effective Use of Interpreters" is available to all KFHC contracted providers
- Desktop displays: Language Line point to language ID display
- Cultural Competency Power Point Training
- Better Communication, Better Care: Provider Tools to Care for Diverse Populations: The material tool kit was produced by a nation-wide team of health care professionals. The material will provide resources to address specific

operational needs that often arise because of changing service requirements and legal mandates.

- Online Courses: HRSA: Effective Communication Tools for Healthcare Professionals

For more information or to schedule a training session, please contact Cynthia Cardona, Cultural & Linguistic Services Manager at 661-617-2498, cynthia.cardona@khs.net.com.

For more information see KHS Policy and Procedure: Policy 11.22

- https://www.kernfamilyhealthcare.com/providers/policies-and-procedures/

Cultural & Linguistic Provider Materials Visit www.kernfamilyhealthcare.com to download Cultural & Linguistics Resources for your office.

Section 13: Transportation Services

American Logistics (AL), a national passenger transportation management company, manages the scheduling component of Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) services. Transportation provided via ambulance and air requires prior authorization through the current KFHC prior authorization process. Travel expenses for meals, parking, and lodging are coordinated with the Major Organ Transplant team and Member Services.

Non-Medical Transportation (NMT)

NMT services are a covered benefit for all KFHC eligible members to obtain medically necessary KFHC or Medi-Cal covered services. NMT does not include transport of the sick, injured, invalid, convalescent, infirm, or otherwise incapacitated members who require to be transported by ambulance. NMT services will be provided at the least costly method that meets the member's needs. Methods of NMT include:

- Mileage Reimbursement:
  Member does not have a working vehicle in the home
  Reimbursement may be paid to a friend or family member for transporting the member to their appointment
  Reimbursement is no less than the current IRS mileage reimbursement rate for medical transport
  Form is available on the KFHC website
- Public Transit Systems via bus pass
- Greyhound Transportation for long distance appointments
- Private Conveyance via Rideshare or Taxi (if available)

Non-Emergency Medical Transportation

NEMT includes transportation by ambulance, wheelchair vans, and gurney vans to or from KFHC covered services and can be used when:

- Medically needed
- Is requested by a treating physician

A member cannot use NMT to get to their appointment because they require assistance to travel.

Prior authorization is not required for NEMT gurney or wheelchair vans. Prior authorization is required for NEMT ambulance. All NEMT transportation services require a Physician Certification Statement (PCS) form to be completed and submitted by the members healthcare provider. The PCS form can be located in the KHS Provider Portal under the Transportation tab. The PCS Form expires 12 months after the form is submitted by the members healthcare provider and is valid for all rides to medical appointments.

****All NEMT trips require door-to-door assistance provided by the driver****

Travel Expenses

Travel expenses are transportation-related costs of reasonably necessary expenses such as meals, parking fees, and lodging that are covered when a member's appointment for a covered health care service requires travel that meets the guidelines and criteria for reimbursement or prepayment for the benefit. The benefit covers the following individuals when a member meets the criteria:

- Member
- Member's accompanying caregiver or attendant
- Minor/disabled Member's accompanying parent/guardian
- Member's major organ transplant donor
- Member's donor's accompanying caregiver or attendant

Coverage Includes:

- Meals when
  - Round trip travel exceeds 4 hours
  - Lodging is approved
- Lodging when a member must be away from their primary residence overnight for an approved medical service
- Tolls and parking fees where required at the member's medical service destination

Scheduling Transportation

Members and Providers can call our Transportation Department, Monday through Friday, from 7:00 am to 6:00 pm, at 661-632-1590 or 1-800-391-2000 and choose option 3. The Transportation Department is available 24 hours a day, 7 days a week for urgent or after-hours assistance.

Payment for Travel Expenses

Members may request reimbursement or prepayment for approved travel expenses. Members must complete the Travel Expenses Form and return it to KFHC no later than 10 business days prior to the approved medical service appointment to request prepayment, Members must submit their request for reimbursement form and receipts or proof of payment within 30 days, and no later than 180 days from the date of their approved and qualifying date of service. Members can find the Travel Expense Request Form on our website.

For more information, see KHS Policy & Procedures: Policy 5.15-

- https://www.kernfamilyhealthcare.com/providers/policies-and-procedures

Receiving Trips

All Transportation Providers and their drivers will be required to use the “American Logistics TP” (**RideCafé)** mobile application. Transportation Providers will receive trips via the mobile application “American Logistics TP.” “American Logistics TP” will provide the ability for KHS to meet and maintain DHCS requirements fo*r APL 22-008, Non-Emergency Medical and Non-Medical Transportation Services and Related Expenses*. Please see link below for more information regarding APL 22-008:

- https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-008.pdf

The “American Logistics TP” mobile application provides the ability to manage assigned drivers and make updates instantly. Other benefits include:

- Real-time updates and based trip tracking resulting in a reduction of manual phone communication and follow-ups
- Usage of the app will aid in the protection of potential issues or concerns regarding FWA

American Logistics (AL) will assign trips based on the Transportation Provider’s location and availability.

American Logistics will provide all transportation Providers training for the utilization of the “American Logistics TP” application.

The mobile application can be downloaded via the App Store, or the Google Play Store by searching “American Logistics TP.”

Sample Physician Certification Statement (PCS) Form

The PCS form is available on the KFHC Provider Portal and on our website at https://www.kernfamilyhealthcare.com/providers/provider-resources/manuals-and-forms/

Section 14: Pharmacy Services

Pharmacy services are covered under Medi-Cal RX.

Most pharmacy services are covered by Medi-Cal Rx beginning January 1, 2022. Examples of these services include, covered drug lists, networks, authorizations, appeals, and some pharmacy dispensed medical supplies and devices.

Medi-Cal RX contact information:

- Fax: 1-800-869-4325
- Call: 1-800-977-2273
- https://medi-calrx.dhcs.ca.gov/home/
- Services that are MCRX's responsibility and may be billed through their pharmacy processor (Magellan) are:
  - Outpatient Medications
  - Condoms
  - Peak Flow Meters
  - Pen Needles
  - Continuous Glucose Monitor/Supplies
  - Blood Pressure Machines
  - Vaccines
  - Diaphragms
  - Aerochambers
  - Diabetic Test Strips
  - Disposable Insulin Delivery Devices (Omnipod/VGo (pumps))
  - Enterals
  - Cervical Caps
  - All Syringes
  - Lancets
  - Over the Counter Emergency Use Authorization COVID-19 Antigen Tests

Pharmacy services covered by KFHC

Beginning January 1, 2025, devices and supplies that are the health plan's responsibility, will no longer process through the PBM SS&C. Until further notice, they will need to be billed electronically to Kern Family Health Care to the Claims Department. Nothing is changing as to what types of devices are billed to Medi-Cal Rx (MCRx) or Kern Family Health Care (KFHC). As a reminder, these are the services that should be billed to KFHC.

If an authorization is needed for the services below, please submit through the KHFC Provider Portal:

- Incontinence Supplies
- Crutches/canes
- Hand Sanitizer
- Nebulizers & Supplies
- Braces (wrist/ankle/back/neck)
- Ostomy Supplies
- Thermometers
- T.E.D. Hose
- Tablet Cutter

Please be sure to include the appropriate HCPCS, NDC, and ICD-10 code for each service billed. They can be billed via the following methods:

- KHS Payer ID: 77039 (Office Ally, SSI, Change Healthcare)

- KHS Payer ID: KERNH (Professional) (Cognizant/Trizetto)
- UERNH (Institutional) (Cognizant/Trizetto)

If a prior authorization is needed for the following services, please submit to **Prime Therapeutics** (PBM vendor for MCRx). The billing of the services should also be to **Prime Therapeutics.**

- Outpatient Medications
- Enterals
- Diaphragms
- Peak Flow Meters
- All Syringes
- Diabetic Test Strips
- Continuous Glucose Monitor/Supplies
- Over the Counter EUA (Emergency Use Authorization) COVID-19 Antigen Tests
- Vaccines
- Condoms
- Cervical Caps
- Aerochambers
- Pen Needles
- Lancets
- Blood Pressure Machines
- Disposable Insulin Delivery Devices (Omnipod/VGo {pumps})

Advanced Practice Pharmacists who are eligible to provide the services as outlined by AB1114 are able to bill for those services after completing an enrollment process with the plan. These services are billed as a medical claim to the plan. [Bill via electronic claims submission (ASC X12n 837Pv.5010)].

Section 15: Telehealth Services

Telehealth is the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.

Each telehealth provider must meet KHS credentialing standards including maintaining an active California medical license and enrollment in the Medi-Cal program. Providers offering services via telehealth must comply with all state and federal laws regarding the confidentiality of health care information, including HIPAA rules related to services performed telehealth.

Certain types of services cannot be appropriately delivered via telehealth. These include services that would otherwise require the in-person presence of the patient for any reason.

Providers furnishing services via audio-only synchronous interactions must also offer those same services via video synchronous interaction to persevere member choice.

Providers furnishing services through video synchronous interaction or audio-only synchronous interaction must do one of the following:

- Offer those same services via in-person, face-to-face contact.
- Arrange for a referral to, and a facilitation of, in-person care that does not require a member to independently contact a different provider to arrange their care.

Reimbursable Services

Existing Covered Services, identified by CPT (Current Procedural Terminology) or Healthcare Common Procedure Coding System (HCPCS) codes and subject to any existing treatment authorization requirements, may be provided via a Telehealth modality only if all the following criteria are satisfied:

- The treating provider at the distant site believes the services being provided are clinically appropriate to be delivered via Telehealth based upon evidence-based medicine and/or best clinical judgment.
- The member has provided verbal or written consent.
- The Medical Record documentation substantiates that the services delivered via Telehealth meet the procedural definition and components of the CPT or HCPCS code(s) associated with the service.
- The services provided via Telehealth meet all state and federal laws regarding the confidentiality of health care information and a member's right to their own medical information.

- The services being rendered via Telehealth are appropriate for a Telehealth visit and not require a patient's presence nor be rendered or billed with a Telehealth modality.

Member Consent

Providers must comply with the following to conduct a visit via Telehealth:

- Inform members about the use of Telehealth prior to rendering services via Telehealth and must obtain verbal or written consent.
- Document verbal or written consent in the member's medical record and made available to KHS and regulatory bodies upon request.
- Explain to the member their right to access any services in-person which are delivered via Telehealth.
- Explain to the member Telehealth is voluntary and they can withdraw their consent to receive treatment via Telehealth at any time with no impact to access Medi-Cal covered services in the future.
- Educate members of their right to obtain Non-Medical Transportation to in-person visits.
- Explain to members any limitations or risks associated with receiving services via Telehealth versus an in-person visit, if applicable.
- Ensure members do not initiate e-consults.

Establishing New Patients

KHS Members can be established as a new patient via Telehealth through the following methods:

- Synchronous video Telehealth visits
- Audio-only synchronous visits if one or more of the following criteria applies:
    - The visit is related to sensitive services (defined in Civil Code section 56.06(n)).
    - The Member requests an audio-only visit.
    - The Member attests they do not have access to video.

Federally Qualified Health Centers (FQHCs), Tribal FQHCs, and Rural Health Clinics (RHC)

Federally Qualified Health Centers (FQHCs), Tribal FQHCs, and Rural Health Clinics (RHC) can conduct new patient visits via asynchronous store and forward modality, defined in BPC section 2290.5(a), if the visit meets all the following:

- The member is physically present at a provider site, or an intermittent site of the provider, at the time the covered service is performed.

- The person who creates the Member's Medical Record at the originating site is an employee or Subcontractor of the Provider, or other person lawfully authorized by the Provider to create a patient Medical Record.
- The Provider determines the billing Provider can meet the applicable standard of care.
- A member who receives Telehealth services must be eligible to receive in-person services from that Provider.

FQHCs, RHCs, and Tribal Health Providers (THPs), are not allowed to be reimbursed for consultations provided via Telehealth modality, e-consult.

Payment

When billing for telehealth services, providers should bill the CPT/HCPC code which best represents the service rendered. Adding the required, appropriate modifier will identify how the services were rendered.

Modifier 93 is to be used for synchronous telephone or other real-time interactive audio only telecommunications systems.

Modifier 95 is to be used for synchronous interactive audio AND visual telecommunications systems.

Modifier GQ is to be used for asynchronous store and forward telecommunications systems.

Appropriate modifiers and place of service 02 (Telehealth Provided Other than in Patient's Home) must be used to identify when the services are delivered through synchronous and asynchronous store and forward telecommunications.

Please reference the Medi-Cal Provider Manual for information: https://files.medi-cal.ca.gov/pubsdoco/Publications.aspx

For additional information please refer to the DHCS All Plan Letter 23-007: Telehealth Services Policy.

- https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-007.pdf

Section 16: Health Equity

KHS's Health Equity Team is committed to improving the health and well-being of members and communities through the delivery of trusted, high quality, cost-effective and accessible health care to all members regardless of their race, ethnicity, sexual orientation, gender identification, language spoken, cultural preferences, personal history or zip code. Our goal is to build effective partnerships with our provider network, community organizations and government agencies to help reduce/eliminate disparities, improve health outcomes and enhance community resiliency by empowering our members and communities and addressing the social determinants of health.

Our efforts within our Provider Network focus will be on:

- Providing Health Equity related training and support for providers and office staff
- Developing capacity and/or assisting providers in data collection and analysis in support
- Assess specific regional needs and identify areas of opportunity for our providers to expand access to services for our members
- Partner with providers to identify funding opportunities to improve access and quality of care for Kern Family Health Care Members

To contact our team or join our Health Equity & Learning Collaborative (HEAL), please reach out to HealthEquity@khs-net.com and a member of our staff will reach out.

Section 17: Quality Improvement

In a commitment to the community of Kern County and the members of KHS, the Quality Improvement (QI) Program is designed to objectively monitor, systematically evaluate, and effectively improve the health and care of our members served. 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 are required to participate in the Quality Improvement (QI) program.

To review KHS' complete QI Program Description and workplan, please visit Kern Family Health Care's website at www.kernfamilyhealthcare.com. Click the Providers tab and then Quality Improvement.

Potential Quality of Care Issues (PQI)

Potential Quality of Care Issues (PQI) are possible adverse deviations from expected clinician performance, clinical care, or outcome of care. PQIs are investigated to determine if an actual quality issue or opportunity for improvement exists. Providers are required to cooperate with investigations KHS' Quality Improvement Department conducts for identified PQIs. If a Quality of Care (QOC) issue is validated after investigation, a corrective action plan or other remediation may be required. All QOC determinations are made by a KHS Medical Director.

Clinical Network Oversight Program

Kern Health Systems (KHS) is committed to ensuring that all network providers deliver high-quality, evidence-based, and patient-centered care. The Clinical Network Oversight Program is designed to support providers in meeting compliance requirements, improving patient outcomes, and aligning with state and national healthcare quality benchmarks.

This program is not just about compliance—it's about creating a structured approach to monitor, evaluate, and enhance the care provided to our members. Through audits, data-driven insights, and collaborative quality improvement initiatives, KHS seeks to ensure consistency, efficiency, and excellence in healthcare delivery.

Why This Program is Important

As healthcare providers, you play a critical role in ensuring members receive safe, effective, and timely care. The Clinical Network Oversight Program benefits both patients and providers by:

- Ensuring Compliance – Meeting DHCS, NCQA, Medi-Cal, and contractual obligations to maintain accreditation and network participation.
- Improving Patient Outcomes – Implementing evidence-based clinical guidelines to enhance the quality of care and reduce disparities.

- Supporting Best Practices – Identifying gaps in care and providing resources, training, and guidance to help providers align with national standards.
- Reducing Risk – Establishing proactive monitoring and Corrective Action Plans (CAPs) to address compliance issues before they escalate.
- Enhancing Provider Collaboration – Offering education, audits, and performance feedback to help providers improve efficiency and documentation practices.

By actively participating in this program, providers can strengthen their practice, enhance patient trust, and contribute to a high-performing healthcare network.

How the Program Works

The Clinical Network Oversight Program operates through structured monitoring and auditing processes that assess provider performance and ensure adherence to quality and regulatory standards. The key components include:

1. Medical Record Audits
   - Reviews of documentation practices, patient outcomes, and compliance with medical guidelines.
   - Conducted by trained KHS clinical auditors following DHCS and NCQA-approved methodologies.
2. Performance Measurement & Data Monitoring
   - Evaluates key indicators such as HEDIS, MCAS, readmission rates, and patient safety measures.
   - Provides transparent feedback to providers on strengths and areas for improvement.
3. Corrective Action Plan (CAP) Process
   - Required when providers do not meet performance thresholds or compliance requirements.
   - Focuses on root cause analysis, education, and re-auditing to ensure sustainable improvements.
4. Provider Education & Support
   - Webinars, toolkits, and provider meetings to address common challenges and best practices.
   - On-demand resources to support compliance and quality improvement efforts.

How Providers Can Help

As trusted partners, your active participation is essential for program success. You can support quality oversight by:

- Ensuring documentation accuracy – Maintain timely, complete, and accurate medical records in compliance with DHCS and NCQA standards.

- Engaging in audits proactively – Collaborate with KHS during medical record reviews and performance evaluations.
- Participating in training & education – Stay informed through webinars, provider toolkits, and KHS support resources.
- Implementing best practices – Follow evidence-based guidelines and adopt corrective action plans if needed.
- Communicating with KHS – Share feedback, concerns, and opportunities for improvement to foster a collaborative approach.

At KHS, we recognize that **providers are the foundation of high-quality healthcare**. The Clinical Network Oversight Program is designed to support, guide, and empower providers, ensuring compliance without adding unnecessary burdens to their workflow. We appreciate your commitment to excellence in patient care and look forward to collaborating with you in our shared mission of improving healthcare outcomes. For any questions, support, or further details, please contact **KHS Quality Improvement Department**.

Section 18: Quality Performance

Medi-Cal Managed Care Accountability Set (MCAS)

The Managed Care Accountability Set (MCAS) is a set of performances measures that the California Department of Health Care Services (DHCS) selects for annual reporting by Medi-Cal managed care health plans (MCPs). Results of compliance with the measures are used by DHCS to evaluate the MCP's performance. Many are HEDIS measures from the National Committee for Quality Assurance (NCQA). Some are from other sources such as the Centers for Medicare & Medicaid (CMS). All of them center around preventive health and chronic condition management.

The measures are listed by Measurement Year (MY) and Report Year (RY). The report year are the compliance rates for the measures in the previous year. An example would be MCAS measures for MY2024 are reported to DHCS in RY2025. DHCS posts the most current list of measures on their website at:

https://www.dhcs.ca.gov/dataandstats/reports/Pages/MgdCareQualPerfEAS.aspx

**Note that the Reporting Year (RY) reflects the measures for the previous measurement year.*

Data Collection
KHS collects and reports MCAS data through a series of coordinated activities, including encounter and claims analysis, data exchange, and medical records data. Some examples of information needed from medical records include specific lab results, immunizations, diabetes care, prenatal and postpartum care, and progress notes. Providers are contractually obligated to provide KHS with access to members' medical records for evaluation of compliance with these measures.

Why is it Important?
Data obtained from MCAS helps KHS focus quality improvement activities, evaluate performance, and identify further opportunities for improvement based on these compliance results. The benchmarks for these measures help providers and KHS identify gaps in care and implement actions to improve care for members.

Tips for Providers
KHS may contact selected medical offices to obtain or access patient medical records as part of the MCAS medical records review process. Allowing KHS' QI Department access to the provider EMR is the most efficient way to accomplish retrieval of the needed medical record information. Here are helpful tips to prepare:

- Keep complete and accurate medical records for patients. Each document in the medical record must contain the member's name and date of birth to be acceptable for MCAS compliance measurements.

- Identify gaps in care at every visit and address them during the visit. If a service cannot be addressed during a visit, schedule a follow up appointment to address the gaps in care.
- To view your group's compliance level with MCAS measures, please login to the KHS Provider Portal.
- Information about members with gaps in care is available for your practice on the KHS Provider Portal. Outreach to patients in need of preventative health or chronic condition management services to ensure their health and well-being.
- MCAS reporting is required by the DHCS, the Centers for Medicare and Medicaid Services (CMS), and the National Committee for Quality Assurance (NCQA). Providers and their staff should become familiar with MCAS measures to understand what KFHC and other health plans are required to report.
- Allowing KHS' access to the EMR or establishing a data exchange for KHS members is the most efficient way to accomplish retrieval of the needed medical record information versus copying or faxing records. Contact your KHS provider representative to initiate providing either or both options.
- MCAS Provider Resources Guide and Common Codes for MCAS Measures documents are available on Kern Family Health Care's website at www.kernfamilyhealthcare.com. Click the Providers tab and then Quality Improvement.

Performance Improvement Projects (PIPs)

KHS is required by DHCS to participate in two (2) Performance Improvement Projects (PIP). PIPs span over an approximate three-year time frame and are broken into four (4) modules using the Plan, Do, Study, Act (PDSA) model. The PDSA method is a way to test a change that is implemented. Going through the prescribed four steps guides the thinking process into breaking down the task into segments and then evaluating the outcome, improving on it, and testing again. Most of us go through some or all of these steps when we implement change in our lives, and we don't even think about it. Having them written down often helps people focus and learn more. Each module for the PIPs is submitted to DHCS or the designated External Quality Review Organization (EQRO) for review, input, and approval incrementally throughout the project. As a requirement for participation in and support of KHS' Quality Improvement Program, select providers may be asked to participate in a particular PIP.

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

- KHS requires all primary care providers locations to undergo a facility site review and medical records review upon contracting by the Quality Performance Department.

- Site Reviews are conducted every 3-years as part of the credentialing verification process along with recredentialing and changes in site locations.
- Site locations that require corrective action plans or other remediation may require interim site reviews annually to ensure compliance is maintained. This is determined at the discretion of the Certified Site Review nurse.
- A KHS Quality Performance (QP) Nurse who is a certified site review nurse will conduct the site review at each PCP location using the DHCS Site Review Tool (including license status, physical accessibility, safety, etc.).
- The FSR date and passing score will be included in the Credentialing and Recredentialing file for submission to the Physician Advisory Committee for consideration and approval.

A Certified Site Review nurse uses the California Department of Health Care Services (DHCS) approved review tools to conduct the review. To view the DHCS mandated tools, visit Kern Family Health Care's website at www.kernfamilyhealthcare.com. Click the Providers tab and then Quality Improvement.

Facility and medical record reviews are intended to ensure that all KHS network providers meet the quality and safety requirements established by the State for treating Medi-Cal members. All KHS network providers are advised that the CA Department of Health Care Services may audit Medi-Cal providers at any time with or without advance notice.

There are three components to the Site Review process:

1. The Facility Site Review (FSR)- The site review is part of the credentialing and re-credentialing process and evaluates the physical aspects of the site for basic requirements in areas such as safety, regulatory compliance, and infection control as well as interviews with office personnel.
2. The Medical Record Review (MRR)- The medical record review survey is conducted three to six months after initial member linkage. It is conducted every three years thereafter and may include an interim review at eighteen-month intervals. It is part of the credentialing and re-credentialing process and focuses on required elements of the medical record.
3. The Physical Accessibility Review (PAR)- The physical accessibility review survey is not a scored review and focuses entirely on physical accessibility of the healthcare site for seniors and persons with disabilities (SPDs).

Site Review Preparation

As part of the of the facility review, KHS QP Nurses review the following potential safety issues that are considered critical elements:

1. Exit doors and aisles are unobstructed and egress (escape) accessible
2. Airway management supplies in place

3. Emergency medicine for anaphylactic reaction management, opioid overdose, chest pain, asthma, and hypoglycemia
4. Qualified/trained personnel retrieve, prepare, or administer medications
5. Physician review and follow-up of referral/consultation reports and diagnostic test results
6. Lawfully authorized persons dispense drugs to patients
7. Drugs and vaccines are prepared and drawn only prior to administration.
8. Personal Protective Equipment (PPE) for Standard Precautions is readily available for staff use
9. Blood, other potentially infectious materials, and Regulated Wastes are appropriately disposed
10. Needlestick safety precautions are practiced on site
11. Proper cold chemical sterilization/high level disinfection process
12. Appropriate PPE is available for Cold chemical sterilization/high level
13. Monthly spore testing of autoclave/steam sterilizer with documented results
14. Autoclave/steam sterilization management of positive mechanical, chemical, and biological indicators of the sterilization process.

If deficiencies are identified during the Facility Site and Medical Record Reviews, a Corrective Action Plan will be issued to the Provider which will include specific corrective actions along with time frames for addressing deficiencies. Providers who do not correct deficiencies will not be assigned new members until corrections are completed and verified and the CAP is closed. Any network provider who does not come into compliance with survey criteria within the established timelines shall be removed from the network and plan members will be reassigned to other network providers.

For more information see KHS Policy and Procedure: Policy 2.71

- https://www.kernfamilyhealthcare.com/providers/policies-and-procedures/

Site Reviews for Street Medicine

Street Medicine Providers who are serving in an assigned PCP capacity are required to undergo an appropriate level site review, either full or condensed review.

For Street Medicine Providers affiliated with a brick-and-mortar facility or that operate a mobile unit, or Van will be required to undergo a condensed FSR and MRR to ensure patient safety and adherence to DHCS standards.

Section 19: Claims Submission

Electronic Claims Submission Required

KHS acceptable clearinghouses:

Office Ally Payer ID: 77039	Change Healthcare (Emdeon, Relay Health) Payer ID: 77039
SSI Payer ID: 77039	Cognizant Professional Payer ID: KERNH Institutional Payer ID: UERNH

There are 4 exceptions that will be accepted via paper submission:

1. Any claim requiring the PM330 (Sterilization Consent Form) or Hysterectomy consent form to be attached. (PM330 or Hysterectomy consent form must be attached)
2. Any claim where contract requires invoice pricing. (Invoice must be attached)
3. Prior KHS claim submission resulted in an EOB where KHS requested documentation to be provided. (Request from KHS or EOB requesting documentation must be attached) Do not include the claim form in this case. Only send the EOB or letter requesting the documentation and the requested documentation NO CLAIM FORM NEEDED
4. Claims with a California Children's Services (CCS) Notice of Action (NOA) which show CCS has denied the case for coverage by CCS

Note: For these claims, a standard CMS/UB04 Red and White claim form must be used.

For the 4 exceptions identified above, claims must be mailed to:

Kern Family Health Care
PO Box 85000
Bakersfield, CA 93380

Any paper claim submissions that do not meet one of the four exceptions above will be rejected and returned to you with instructions to submit electronically.

Claim Submission Timeframes

Claims must be submitted within 180 days from the date of service. COB (Coordination of Benefit) claims must be submitted within 90 days of primary insurance EOB (Explanation of Benefit) issue date (with the exception of Medicare). Medicare will forward any secondary claims directly to KFHC. These are called Crossover claims.

Corrected claim submissions: Must be submitted within 45 days from the original paid claim date or denial date.

Disputes: 365 days (must be submitted via US MAIL utilizing the Provider Claims Dispute Resolution Request Form which can be located on the KHS website)

Claim Requirements

The KFHC claims editing software program ensures all claims received comply with Medi-Cal billing guidelines. Claims submitted incorrectly will be denied. Providers must ensure their billing processes are following KHS guidelines. The Medi-Cal Provider Manual is available online at www.medi-cal.ca.gov.

Claims Submissions

Important Billing Tips

- Before filing a claim, be sure to verify the Member's eligibility.
- Be sure covered services requiring prior authorization have received prior authorization. A list of Prior Authorization Status for CPT Codes is available at www.kernfamilyhealthcare.com
- File claims within the required timely filing requirements.
- Avoid using members Social Security Numbers (SSN) on claims.
- Use Member Client Identification Number (CIN) or the Member ID Number.
- Hospitals, long term care facilities, licensed primary care clinics and emergency medical transportation are excluded from the SSN billing restriction. However, these excluded entities are required to make a good faith effort to obtain the member's CIN information for billing purposes.
- A valid 10-digit NPI must be entered in the billing provider field on the paper claim form or electronic claim submission.
- National Drug Code (NDC) numbers are required for all drugs and certain medical supplies.
- All diagnosis codes are to be submitted to the highest level of specificity, regardless of level used on the authorization.

Our vendors for electronic claims submission are Change Healthcare, Cognizant, Office Ally, and SSI Group. Information on where to file claims is indicated below:

Electronic Claims	Paper Claims for Exceptions Identified Above	Claims Dispute
Clearinghouses include: • Change Healthcare • Office Ally • SSI Group *Payer ID: 77039* • Cognizant *Professional Payer ID: KERNH* *Institutional Payer ID: UERNH*	**Attn: Claims Department** Kern Family Health Care PO Box 85000 Bakersfield, CA 93380 *Do not hand-deliver or mail claims to the KFHC physical address.	**Attn: Claims Department** Kern Family Health Care PO Box 85000 Bakersfield, CA 93380 *Must be submitted using a Provider Claims Dispute Request Form: Provider Claims Dispute Resolution Request

Coordination of Benefits (COB)

State and federal laws require Providers to bill other health insurers prior to billing KFHC. Providers should attempt to be reimbursed for services from any other health insurance program for which the patient is eligible (including Medicare) before submitting a claim to KFHC. Upon receipt of a denial or partial payment from the Members other health insurance, the Provider should submit the claim along with documentation of denial or payment from the primary carrier.

For COB claims, enter the COB information into the electronic claim submission. If you are unsure how to enter, the clearinghouse will be able to direct you as to where to place the COB information. Electronic submission of EOBS and other attachments are not necessary and not being accepted at this time.

Corrected Claims

- Do use Resubmission code 7 in box 22 (CMS1500) or code 0XX7 (XX being the correct type of bill for your facility) in box 4 (UB04) to identify a corrected claim.
- Do send corrected claims electronically unless one of the exceptions listed above on page 42.
- Do include the claim number of the claim you are correcting in box 19 (CMS1500) (Original claim or, if submitted more than once, the last claim with payments on it.) Note, each claim number can only be used once to correct. Example: If you are splitting a billing from the original due to date differences or contract requirements, one claim should be sent as a correction and the other should be sent as a new claim.) If you need assistance, please reach out to your provider representative.
- Do include all services that were performed (whether billed or paid previously), as the corrected submission will negate previous claim in its entirety.

- **Do not submit corrected claims as disputes.** They will be returned to you. Disputes follow the current process and are required to be mailed to the address indicated above.

If you are unsure how to provide the resubmission/frequency code or original claim number electronically, please contact your clearinghouse and they will direct you. Please find additional information below which identifies where KHS needs to receive the information electronically:

Resubmission frequency code:
Loop 2300, Segment CLM, Data Element 05, Composite 01 (CLM0501)

Reference for original claim number:
Loop 2300, Segment REF, Data Element 01 = F8, Data Element 02 = <Original KHS claim Id or if more than 1 - most recent KHS claim Id where paid>

Reporting Provider-Preventable Conditions (PPC)

Provider Preventable Conditions (PPCs) are either Hospital Acquired Conditions (HACs), or Other Provider-Preventable Conditions (OPPCs) as defined under Title 42 of the Code of Federal Regulations (CFR) sections 438.3(g), 434.6(a)(12)(i), and 447.26447.26. Providers must report PPCs to the Department of Health Care Services (DHCS) via the PPC secure online portal. Providers are also required to send KFHC a copy of PPCs submitted to DHCS. Providers must comply with HIPAA and any other relevant privacy laws to ensure the confidentiality of beneficiary information. KFHC will not reimburse providers for PPC-related health care services.
For more information visit:

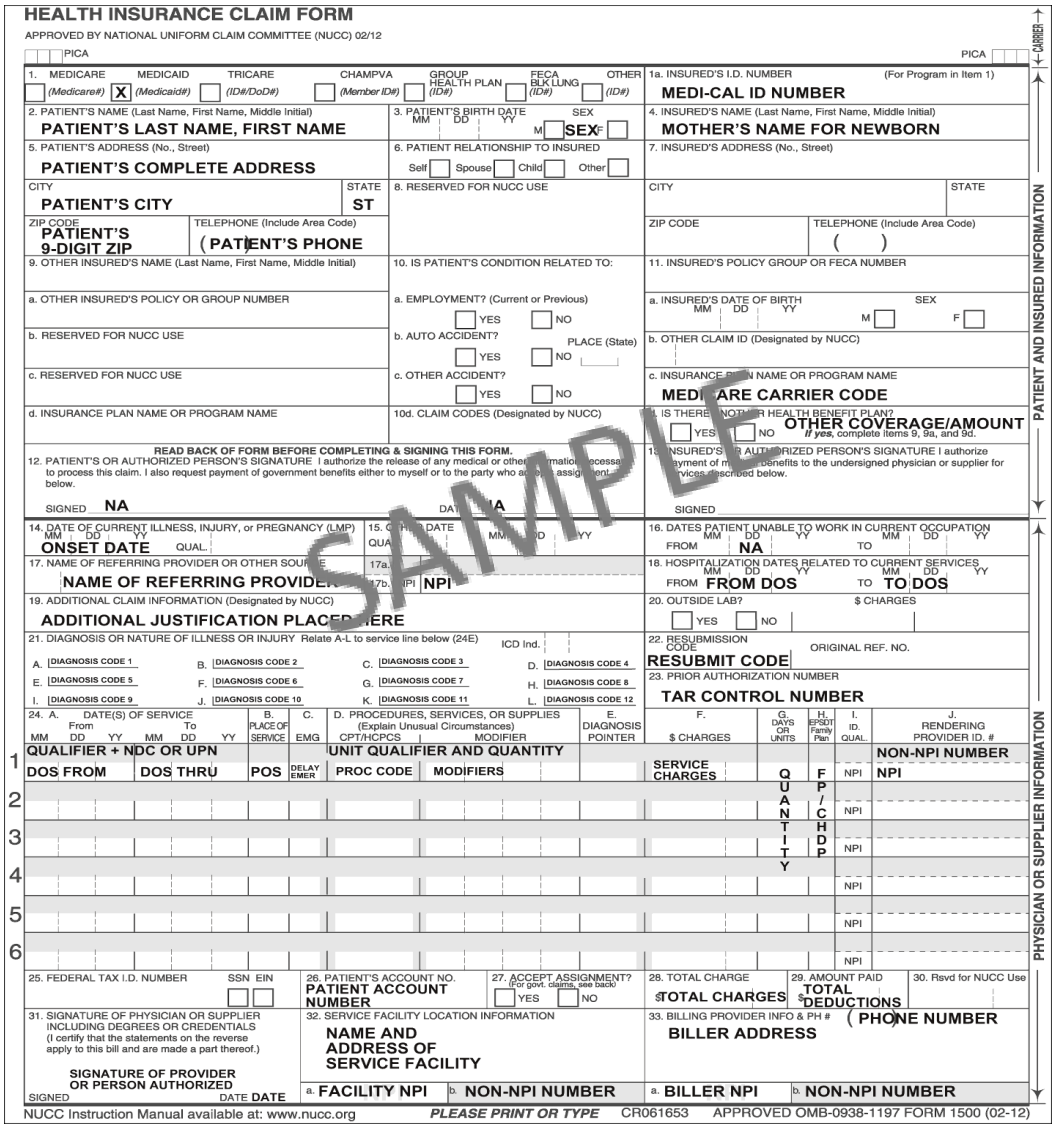
- https://www.dhcs.ca.gov/formsandpubs/publications/Pages/Medi-CalProviderManuals.aspx

Providers can send copies of their PPC submissions by mail, fax or by secure email to:

Kern Health Systems
Attn: Compliance Director
PO Box 85000
Bakersfield, Ca 93380
Fax: (661) 664-5420
PPCreports@khs-net.com

Sample CMS 1500 Format

The CMS 1500 format should be used by physicians, laboratories, and allied health professionals to submit claims for medical services. Durable medical equipment and blood products should also be billed using this format. Pharmacies may also use this form to bill for supplies not billable through the on-line pharmacy claims processing service. Providers should follow the Medi-Cal instructions for completing the CMS 1500 Form, located on the www.cms.gov website. However, this manual may require a difference from the Medi-Cal instructions due to system requirements.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) | MEDICAID X (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): MEDI-CAL ID NUMBER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): PATIENT'S LAST NAME, FIRST NAME

3. PATIENT'S BIRTH DATE MM DD YY | SEX M SEX F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): MOTHER'S NAME FOR NEWBORN

5. PATIENT'S ADDRESS (No., Street): PATIENT'S COMPLETE ADDRESS

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY: PATIENT'S CITY | STATE: ST

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE: PATIENT'S 9-DIGIT ZIP | TELEPHONE (Include Area Code): (PATIENT'S PHONE

ZIP CODE | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: MEDI CARE CARRIER CODE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO: OTHER COVERAGE/AMOUNT
If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED NA | DA NA

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: ONSET DATE | QUAL.

15. OTHER DATE QUAL. | MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY: FROM NA TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: NAME OF REFERRING PROVIDER | 17a. | 17b. NPI NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY: FROM FROM DOS TO TO DOS

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): ADDITIONAL JUSTIFICATION PLACEHERE

20. OUTSIDE LAB? YES NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. DIAGNOSIS CODE 1 | B. DIAGNOSIS CODE 2 | C. DIAGNOSIS CODE 3 | D. DIAGNOSIS CODE 4
E. DIAGNOSIS CODE 5 | F. DIAGNOSIS CODE 6 | G. DIAGNOSIS CODE 7 | H. DIAGNOSIS CODE 8
I. DIAGNOSIS CODE 9 | J. DIAGNOSIS CODE 10 | K. DIAGNOSIS CODE 11 | L. DIAGNOSIS CODE 12

22. RESUBMISSION CODE: RESUBMIT CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: TAR CONTROL NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
QUALIFIER + NDC OR UPN				UNIT QUALIFIER AND QUANTITY							NON-NPI NUMBER
DOS FROM	DOS THRU	POS	DELAY EMER	PROC CODE	MODIFIERS		SERVICE CHARGES	QUANTITY	FP/CHDP	NPI	NPI
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: PATIENT ACCOUNT NUMBER

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE: $TOTAL CHARGES

29. AMOUNT PAID: $TOTAL DEDUCTIONS

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNATURE OF PROVIDER OR PERSON AUTHORIZED

SIGNED DATE DATE

32. SERVICE FACILITY LOCATION INFORMATION: NAME AND ADDRESS OF SERVICE FACILITY

a. FACILITY NPI | b. NON-NPI NUMBER

33. BILLING PROVIDER INFO & PH #: BILLER ADDRESS (PHONE NUMBER

a. BILLER NPI | b. NON-NPI NUMBER

CARRIER

PATIENT AND INSURED INFORMATION

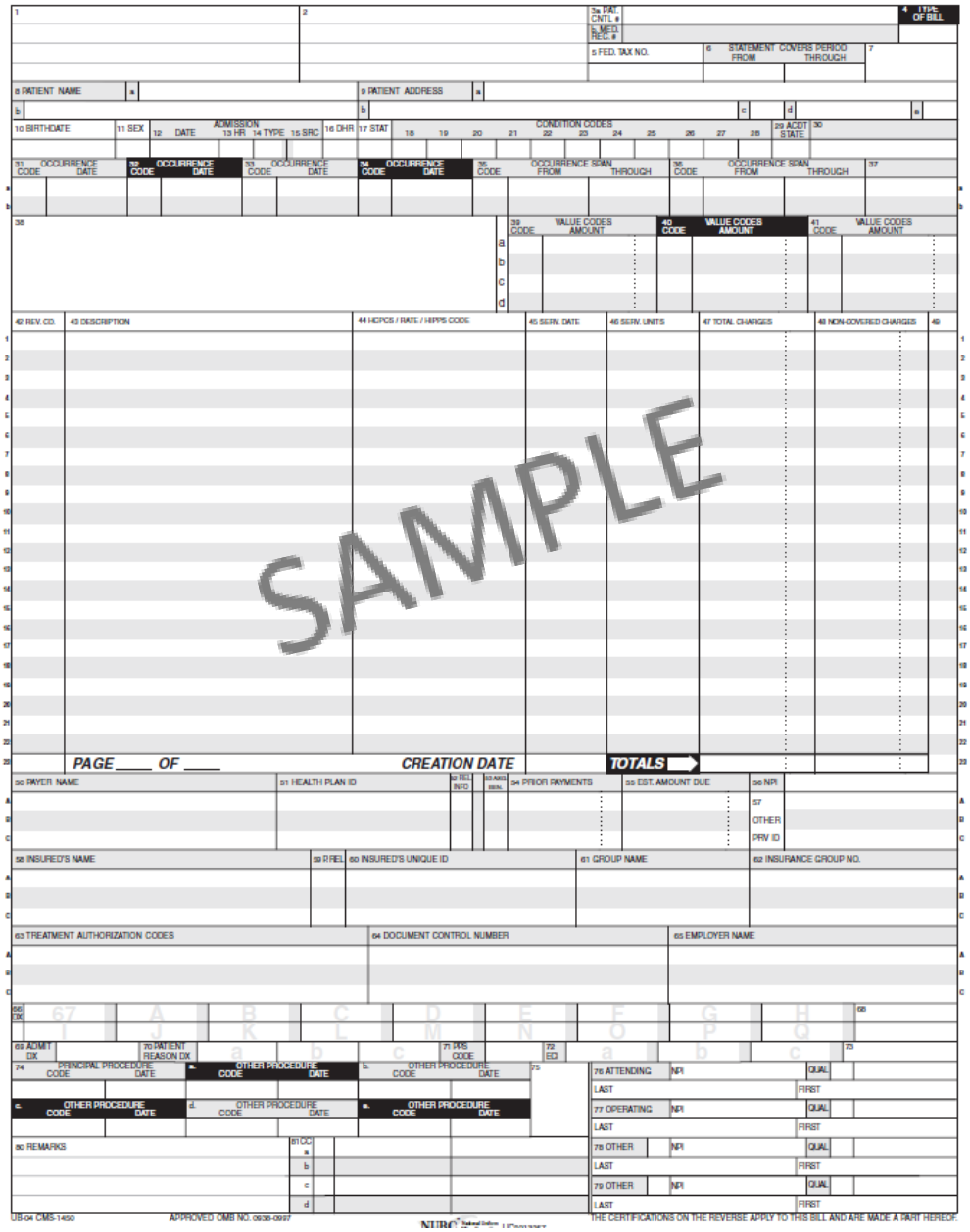
PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

Sample UB-04 (CMS-1450) Format

The UB-04 (CMS 1450) format should be used to submit claims for inpatient Hospital accommodations and ancillary charges and for hospital outpatient services, Ambulatory Surgery Centers, Skilled Nursing Facilities, and Home Health Care agencies. Providers should follow the Medi-Cal instructions for completing the UB-04 (CMS 1450) Form, located on the www.cms.gov website.



Claims for Contracted Providers

In order to receive full compensation, contracted providers should submit to a complete, electronic bill for all covered services rendered within **one hundred and eighty (180) calendar days** following the provision of the covered services.

Claims received after **180 calendar days** following the provision of the covered services are denied with the following exceptions:

A. Other Primary Insurance: Claims submitted within 90 calendar days of the date of the primary carrier's Explanation of Benefits (EOB).

B. California Children's Services: Claims must be submitted within 90 calendar days of the CCS denial letter.

Claims Payment or Denial Timeframes

KFHC will reimburse 90% of clean claims from providers who are in individual or group practices or who practice in shared health facilities, within 30 calendar days of the date of receipt. KFHC will reimburse each completed claim, or portion thereof, as soon as possible, but no later than 45 working days after the date of receipt of the complete claim. In accordance with State regulations, interest will be paid on clean claims not paid within 45 working days of receipt.

Claims Reimbursement

Claims for Providers will be reimbursed according to the terms specified in the Provider's Agreement. Claims for non-contracted providers will be adjudicated primarily in accordance with Medi-Cal guidelines and fee schedules. When no fee schedule exists, KFHC reasonable and customary rates will apply.

Claims Overpayment

When recovery for an overpayment is pursued, KFHC sends a refund request letter to the provider. Within thirty (30) working days of receipt of the letter, the Provider must submit to KFHC either a complete refund of the overpayment, permission to deduct from future claims or, a provider dispute indicating why the provider disagrees with the overpayment identification.

KFHC shall require providers to report to KFHC when it has discovered it has received an overpayment, to return the overpayment to KFHC within sixty (60) calendar days after the date on which the overpayment was identified, and to notify KFHC in writing of the reason for the overpayment.

Providers shall submit the overpayment and written reason to the KFHC Claims Department at the following address:

Claims Department
Kern Health Systems
PO Box 85000
Bakersfield, CA 93380

Claims Payment Disputes

A contracted or non-contracted provider dispute is a provider's written notice challenging, appealing, or requesting reconsideration of a claim that has been denied, adjusted, or contested or seeking resolution of a billing determination or other contract dispute or disputing a request for reimbursement of an overpayment of a claim. Disputes are required by law to be very specific as to what the provider feels was processed incorrectly and specifically how the claim should have been resolved.

Disputes must be submitted within 365 calendar days of the date of KFHC's action, or in the case of inaction, 365 calendar days after the time for contesting/denying claims has expired. Disputes that are returned for additional information must be resubmitted to KFHC within 30 working days of the date of receipt.

Disputes should be mailed to the following address:

Claims Department
Kern Family Health Care
PO Box 85000
Bakersfield, Ca 93380

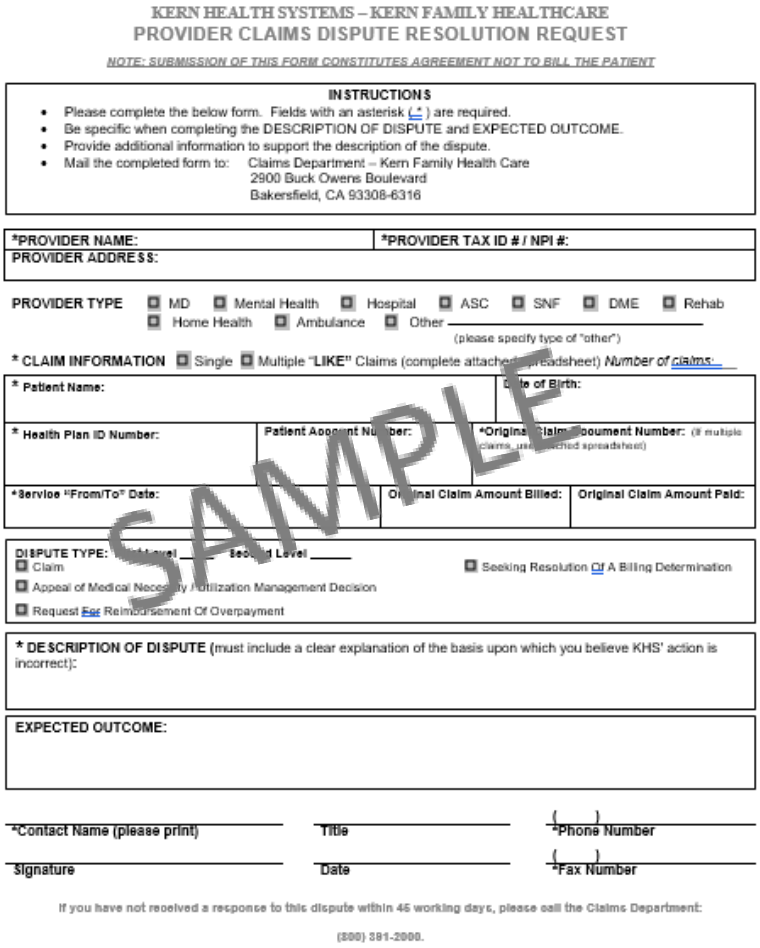
An acknowledgement letter is submitted to the Provider within 15 working days of the receipt date and resolved within 45 working days of the receipt date of the dispute. Providers can make inquiries regarding disputes by calling the KFHC Claims Department.

✓ **Prior to submitting a claims dispute, KFHC encourages Providers to call the KFHC Claims Department to discuss the claim at 661-632-1590 (Bakersfield), 1-800-391-2000 (outside of Bakersfield), dial 5 to bypass other queues (this is a silent prompt), and then 3 to speak with a Claims representative. We can often resolve the issue without the need of a claims dispute, saving both the Provider and KFHC time and effort.**

For further instructions on how to submit a Provider Claims Dispute Resolution Request, please see Policy 6.04-P for medical claims and 13.05-P for pharmacy located on the KFHC website, www.kernfamilyhealthcare.com.

Sample Provider Claims Dispute Resolution Request Form

Claims Disputes must contain the information highlighted below. Disputes that do not contain all the necessary information are returned to the Provider. Supporting documentation must also accompany all disputes. Visit www.kernfamilyhealthcare.com to download the Provider Claims Dispute Form.



KERN HEALTH SYSTEMS – KERN FAMILY HEALTHCARE
PROVIDER CLAIMS DISPUTE RESOLUTION REQUEST

NOTE: SUBMISSION OF THIS FORM CONSTITUTES AGREEMENT NOT TO BILL THE PATIENT

INSTRUCTIONS

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute.
- Mail the completed form to: Claims Department – Kern Family Health Care
  2900 Buck Owens Boulevard
  Bakersfield, CA 93308-6316

*PROVIDER NAME:	*PROVIDER TAX ID # / NPI #:
PROVIDER ADDRESS:	

PROVIDER TYPE ☐ MD ☐ Mental Health ☐ Hospital ☐ ASC ☐ SNF ☐ DME ☐ Rehab ☐ Home Health ☐ Ambulance ☐ Other _____ (please specify type of "other")

* CLAIM INFORMATION ☐ Single ☐ Multiple "LIKE" Claims (complete attached spreadsheet) *Number of claims:* __

* Patient Name:	Date of Birth:
* Health Plan ID Number:	Patient Account Number: / *Original Claim Document Number: (If multiple claims, use attached spreadsheet)
*Service "From/To" Date:	Original Claim Amount Billed: / Original Claim Amount Paid:

SAMPLE

DISPUTE TYPE: 1st Level ___ 2nd Level ___
☐ Claim
☐ Appeal of Medical Necessity / Utilization Management Decision
☐ Request For Reimbursement Of Overpayment
☐ Seeking Resolution Of A Billing Determination

* DESCRIPTION OF DISPUTE (must include a clear explanation of the basis upon which you believe KHS' action is incorrect):

EXPECTED OUTCOME:

*Contact Name (please print) _____ Title _____ *Phone Number ( )

Signature _____ Date _____ *Fax Number ( )

If you have not received a response to this dispute within 45 working days, please call the Claims Department: (800) 391-2000.

For more information see KHS Policy and Procedure: Policy 6.01 and 6.08

- https://www.kernfamilyhealthcare.com/providers/policies-and-procedures/

Section 20: ePayment Center (EPC)

KFHC utilizes a third-party vendor, ePayment Center, to process all payments and remittance advice. You have the option through ePayment to receive payment via Virtual Credit Care, Kern ACH, and paper check. All EOP's are electronic and are only available through ePayment Center.

The first payment that you receive from KFHC will include instructions on how to register with ePayment. If you have any questions, please contact ePayment Center 855-774-4392 or help@epayment.center.

Section 21: Member Rights and Responsibilities

KFHC Members have specific rights and responsibilities outlined under Title 22, California Code of Regulations. KFHC provides this information to members in the Member Handbook (Evidence of Coverage, EOC), member newsletter, on KFHC's website, and upon request.

Members have the right to all of the following:

- To be treated with respect and dignity, giving due consideration to your right to privacy and the need to maintain confidentiality of your medical information such as medical history, mental and physical condition or treatment, and reproductive or sexual health
- To be provided with information about the health plan and its services, including covered services, providers, practitioners, and member rights and responsibilities
- To get fully translated written member information in your preferred language, including all grievance and appeals notices
- To make recommendations about KFHC's member rights and responsibilities policy
- To be able to choose a primary care provider within KFHC's network
- To have timely access to network providers
- To participate in decision making with providers regarding your own health care, including the right to refuse treatment
- To voice grievances, either verbally or in writing, about the organization or the care you got
- To know the medical reason for KFHC's decision to deny, delay, terminate (end), or change a request for medical care
- To get care coordination
- To ask for an appeal of decisions to deny, defer, or limit services or benefits
- To get free interpreting and translation services for your language
- To get free legal help at your local legal aid office or other groups
- To formulate advance directives
- To ask for a State Hearing if a service or benefit is denied and you have already filed an appeal with KFHC and are still not happy with the decision, or if you did not get a decision on your appeal after 30 days, including information on the circumstances under which an expedited hearing is possible
- To disenroll (drop) from KFHC and change to another health plan in the county upon request
- To access minor consent services
- To get free written member information in other formats (such as braille, large-size print, audio, and accessible electronic formats) upon request and in a timely fashion appropriate for the format being requested and in accordance with Welfare and Institutions (W&I) Code section 14182 (b)(12)
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation

- To truthfully discuss information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand, regardless of cost or coverage
- To have access to and get a copy of your medical records, and request that they be amended or corrected, as specified in 45 Code of Federal Regulations (CFR) sections 164.524 and 164.526
- Freedom to exercise these rights without adversely affecting how you are treated by KFHC, your providers, or the State
- To have access to family planning services, Freestanding Birth Centers, Federally Qualified Health Centers, Indian Health Care Providers, midwifery services, Rural Health Centers, sexually transmitted infection services, and emergency services outside KFHC's network pursuant to federal law

Members also have the following responsibilities:

- Treat your health care providers and KFHC staff with respect and courtesy
- Give your providers and KFHC correct information
- Let KFHC and your county know when you change your address, your family status, and when you have other health coverage
- Keep your scheduled medical appointments
- Contact your provider at least 24 hours in advance, or as soon as you know you need to cancel your appointment or your scheduled transportation
- Provide your KFHC member ID card, your picture ID, and your Medi-Cal card to any health care or pharmacy provider when you get health care and pharmacy services
- Understand your health problems and take part in making treatment goals with your provider or practitioner
- Follow the health care instructions and plans that you have agreed on with your provider or practitioner
- Ask questions about medical conditions to understand your provider's explanation and treatment instructions
- Use the emergency room only when you have an emergency
- Call the KFHC 24/7 Nurse Advice Line at 1-800-391-2000 if you are unsure if you have an emergency
- If you receive a bill, or pay for a service that is a covered benefit, call Member Services at 1-661-632-1590 (Bakersfield) or 1-800-391-2000 (outside of Bakersfield) right away to ask for help

Member Handbook/Evidence of Coverage (EOC)

A Member Handbook also known as EOC, is sent to members upon enrollment and annually thereafter. The EOC provides members with a description of the scope of covered services and information about how to access such services under KFHC's Medi-Cal plan. The EOC is available electronically online at

www.kernfamilyhealthcare.com under the “For Members” tab or in hard copy by calling our Provider Services Department at 661-632-1590 (Bakersfield) or toll free 1-800-391-2000.

Our Member Services and Providers Relations Departments are also available to help with questions regarding KFHC’s members’ rights and responsibilities, Monday through Friday, from 8 a.m. to 5:00 p.m.

For more information see KHS Policy and Procedure: Policy 5.05

- https://www.kernfamilyhealthcare.com/providers/policies-and-procedures/

Section 22: Grievance and Appeals

KFHC responds promptly to complaints from either a Provider or a Member. The two types of formal complaints that may be submitted by or on behalf of a member are: a Grievance and an Appeal.

A **Grievance** means a member's written or oral expression of dissatisfaction, regarding KFHC and/or a network Provider, including quality of care concerns and shall include a complaint, dispute, and request for reconsideration or appeal made by a Member or the member's representative. There is **no time frame or deadline** for a member to file a grievance.

An **Appeal** pertains to an Adverse Benefit Determination, a formal request for KFHC to reconsider a determination (e.g., denial, deferral or modification of a decision about health care coverage). An appeal may be filed to request reconsideration of a proposed resolution of a reported grievance. The Member has 60 calendar days from the date on the Notice of Adverse Benefit Determination (NOA) to file an appeal.

Filing a Member Grievance or Appeal

A grievance from a member or a member's representative may be submitted either in person, verbally or in writing in following ways:

- Online via KFHC website: kernfamilyhealthcare.com or Member Portal
- Contact Member Services at 661-632-1590 (Bakersfield), 1-800-391-200 (outside of Bakersfield). Monday-Friday: 8:00 am-5:00 pm.
- By mail or in-person:
  KFHC Member Services Department
  2900 Buck Owen Blvd
  Bakersfield, Ca 93308

Routine Grievances
If possible, the grievance is resolved over the phone before the close of the next business day. An acknowledgement is mailed to the member within five (5) calendar days of receipt of the grievance. The grievance is reviewed by the Grievance Review Committee, and a resolution is provided to the member within thirty (30) calendar days of receipt.

Urgent/Expedited Grievances
If a grievance qualifies as an "urgent grievance", the Member is notified immediately of the classification and of their right to notify the Department of Managed Health Care (DMHC) of the grievance. Urgent Grievances are resolved within seventy-two (72) hours of receipt. In such cases KFHC will attempt to inform the Member as soon as possible. An acknowledgement is mailed to the Member within seventy-two (72) hours of receipt.

Grievances Filed in a Provider's Office
If a member requests to file a grievance in the provider's office, the Provider must supply the member with a *Member Report of Complaint/Grievance* form and provide the following options:

A. Member can call the KFHC Member Services Department at 661-632-1590 or 1-800-391-2000 from the Provider's office to file a grievance verbally or for assistance regarding the complaint/grievance form.
B. The Member may submit the grievance in writing using the *Member Report of Complaint/Grievance* form. Providers are required to make forms and assistance readily available in accordance with California Code of Regulations, Title 28 §1300.68 (b)(7). Providers are also required to email or fax the form to KFHC on the day of receipt to grievance@khs-net.com or send via fax to 661-664-4303. The forms are available in English and Spanish.

A member who files a grievance may not be discriminated against and cannot be dis-enrolled from the provider's office or facility in retaliation of filing a grievance. As part of the KFHC investigation process, the provider is required to respond in writing to the complaint and provide medical records if applicable.

Provider Cooperation
Providers are contractually obligated to submit medical records and, if requested, a written response to the KFHC Grievance Coordinator within seven (7) business days of the date of their receipt of the request or if otherwise specified in the request. Providers who do not comply with contract requirements may be subject to disciplinary action.

Routine Member Appeal
All routine appeals are reviewed by the KFHC Grievance Review Committee and are resolved within 30 calendar days of receipt by the plan. An acknowledgement is mailed within five (5) calendar days of receipt of the appeal. A Provider may submit an appeal in-writing on behalf of a member with member's written consent. All pertinent supporting documentation must be provided to KFHC within the appeal. The Member or Provider, as appropriate, are notified in writing of the appeal resolution.

If the appeal is overturned and approved, KFHC must notify the member within seventy-two (72) hours from the date and time of the decision. A written notice will be mailed to the member, member's representative and/or provider. Unfavorable determinations are submitted to the member, member's representative and/or provider in writing with further rights, including the right to request a State Fair Hearing. Medi-Cal members are also advised of their right to seek an Independent Medical Review from the Department of Managed Health Care (DMHC). Members have the right to request and receive continuation of benefits while the State Fair Hearing is pending and instructions on how to request continuation of benefits, including the timeframe in which the request shall be made must be included.

A member can request a State Fair Hearing by phone or mail:

- **By Phone**: 1-800-743-8525 (TTD 1-800-952-8349)
- **By Fax**: 1-833-281-0905
- **By Mail**: Complete form included with appeal resolution notice and mail to:

California Department of Social Services
State Hearings Division
PO Box 944243, Mail Station 21-37
Sacramento, CA 94244-2430

Expedited Appeals
If an expedited appeal is requested and the expedited criteria is met, the Member will receive verbal notification of the resolution within seventy-two (72) hours, and a written notice will be mailed within **seventy-two (72) hours.**

✓ **When requesting an appeal on behalf of a Member, Provider must complete the provider appeal form and include the Member's written consent before filing the appeal. A link to the Provider Appeal form can be found here:**

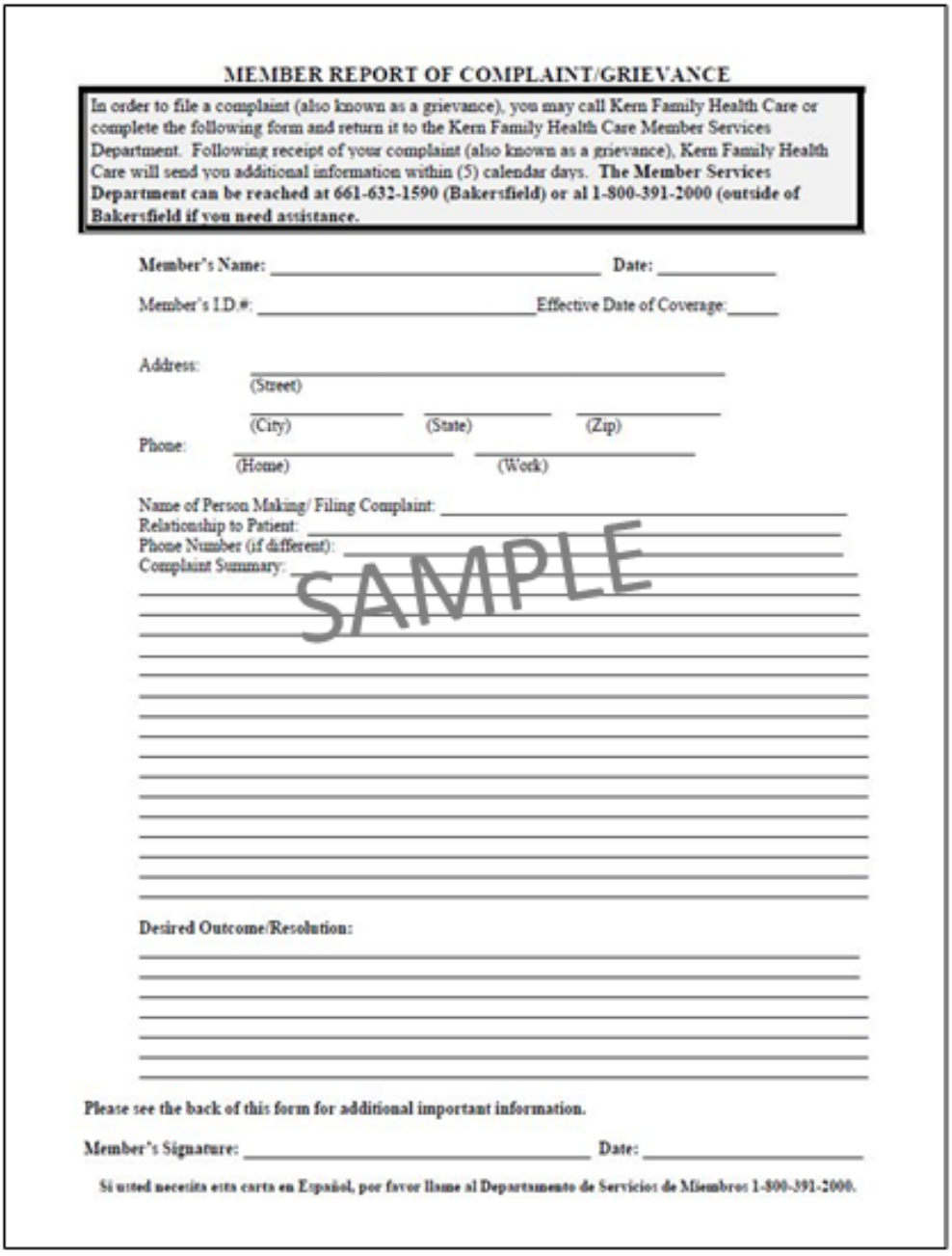
- https://res.cloudinary.com/dpmykpsih/image/upload/kern-site-353/media/1758/provider-appeal-form-updated.pdf

For more information see KHS Policy and Procedure: Policy 5.01

- https://www.kernfamilyhealthcare.com/providers/policies-and-procedures/

Member Report of Complaint/Grievance

Members are encouraged but not required to submit their grievance in writing using the Member Report of Complaint/Grievance form. The Complaint/Grievance form is available on the KFHC's website at https://www.kernfamilyhealthcare.com/ An Online Grievance Form is also available on the KFHC website. Member Services staff can assist with filling out the form. This form is also available in Spanish.



MEMBER REPORT OF COMPLAINT/GRIEVANCE

In order to file a complaint (also known as a grievance), you may call Kern Family Health Care or complete the following form and return it to the Kern Family Health Care Member Services Department. Following receipt of your complaint (also known as a grievance), Kern Family Health Care will send you additional information within (5) calendar days. **The Member Services Department can be reached at 661-632-1590 (Bakersfield) or al 1-800-391-2000 (outside of Bakersfield if you need assistance.**

Member's Name: _____ Date: _____

Member's I.D.#: _____ Effective Date of Coverage: _____

Address: _____
(Street)

_____ _____ _____
(City) (State) (Zip)

Phone: _____ _____
(Home) (Work)

Name of Person Making/ Filing Complaint: _____
Relationship to Patient: _____
Phone Number (if different): _____
Complaint Summary: _____

SAMPLE

Desired Outcome/Resolution:

Please see the back of this form for additional important information.

Member's Signature: _____ Date: _____

Si usted necesita esta carta en Español, por favor llame al Departamento de Servicios de Miembros 1-800-391-2000.

Grievance Dispositions

KFHC will classify the Grievance using the following dispositions based on the information provided in the members' complaint.

Abuse / Neglect / Exploitation	Grievances related to cases involving potential or actual patient harm.
Assault / Harassment	Grievance related to the physical, emotional, or sexual misconduct by a medical professional.
Authorization	Grievance related to the timeliness of an authorization or communication regarding the result (approval, denial or modification) of the authorization
Barriers / Impeded Access to Labor and Delivery Doula Services	Grievances related to barriers and/or impeded access to labor and delivery doula services.
Barriers / Impeded Access to Postpartum Doula Services	Grievances related to barriers and/or impeded access to postpartum doula services.
Barriers/ Impeded Access to Prenatal Doula Services	Grievances related to barriers and/or impeded access to prenatal doula services.
Case Management / Care Coordination	Grievance related to case management or care coordination.
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.
Denial of Payment Request	Grievance related to the denial, in whole or in part, of a member's request of payment for a service.
Denial of Request to Dispute Financial Liability	Grievance related to the denial of a member's request to dispute financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.
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.

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.
Driver Punctuality	Grievance related to driver showing up outside of the scheduled pick-up time to transport the member to their appointment. Driver showed up either early, late, or not at all.
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 dis-enrolled from plan, providers, or any of its health network, etc.
Expedited Appeal Request Denied	Grievances related to a plan denying a request for an expedited appeal.
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.
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.
Inappropriate Care	Grievance related to the overuse, under-use, or misuse of Medi-Cal covered services.
Injury	Grievance related to a member incurring a physical injury.

Language Access	Grievance related to the inability to access or concerns with linguistic and interpreter services at the providers office.
LTC (Long Term Care) - Other	Other Long-Term Care (LTC) service-related grievance not covered in other listed LTC grievances
LTC (Long Term Care) - Facility/Provider grievances	Grievance related to interactions with the provider/Facility staff/representatives, including but not limited to, inappropriate behavior, poor attitude, rudeness, mistreatment, misconduct, or unsafe conditions.
LTC (Long Term Care) - Timely Access	Grievance related to timely access to an approved LTC Facility within the timeframe requirements set forth in Welfare and Institutions Code section 14197
LTC (Long Term Care) - Transportation	Grievance related to member experiencing difficulties in arranging, scheduling, or accessing transportation services to LTC placement
Member Informing Materials	Grievance regarding written materials provided in alternative formats or translation in threshold languages.
Out-of-Network	Grievance related to inability to obtain services from a non-contracted provider.
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.
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.
Plan Customer Service	Grievance related to interactions with the plan's staff/representatives (e.g., member services, plan marketing agents), including but not limited to, inappropriate behavior, poor attitude, rudeness, mistreatment, or long wait times.

Plan's Failure to Meet Timeframes for Resolution	Grievances related to a plan not meeting the timeframes for resolution of grievances and appeals provided at 42 CFR §438.408(b)(1) and (2)
Plan's Reduction/Suspension / Termination of Previously Authorized Service	Grievances related to a plan reducing or suspending or termination a service that was previously authorized.
Provider / Staff Attitude	Grievance related to interactions with the provider's staff/representatives (e.g., nonclinical staff such as provider offices or facilities), including but not limited to, inappropriate behavior, poor attitude, rudeness, mistreatment, or long wait times.
Provider Availability	Grievance related to the inability to see providers during normal hours of operation or concerns with the providers' hours of operation.
Provider Balance Billing	A provider bills the insurance and then bills the member for the remaining balance, which is prohibited for Medi-Cal members. This often occurs when the provider's billing system is set up for commercial insurance payers, who allow for co-payments and co-insurance, which is prohibited for Medi-Cal.
Provider Direct Member Billing	A provider bypasses the insurance and bills the member for the full bill. This often occurs when the provider does not have the member's insurance on file or when the provider is non-contracted.
Quality of Care	Grievances related to complaints about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care provided by a provider or the plan.
Referral	Grievance related to the MCP's processing of referrals to covered services.
Rural Member Denied Out of Network Request	Grievances related to a plan's denial of an enrollee's request to exercise their right, under 42 CFR §438.52 (b)(2)(ii), to obtain services outside the network (only applicable to residents of rural areas with only one MCO)

Scheduling	Grievance related to member experiencing difficulties in arranging, scheduling, or accessing transportation services
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.
Timely Access	Grievance related to timely access to a state plan approved provider within the time-frame requirements based on type of appointment and condition of member's health.
Timely Response to Auth / Appeal Request	Grievances related to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).
Vehicle	Grievance related to the transportation vehicle's cleanliness, not having wheelchair access or other requirements under the American with Disability Act, or issues related to the state of the vehicle that jeopardizes the member's safety.

Section 23: Provider Services

New Provider In-Service

Provider orientations (In-Service) will be conducted for all contracted providers and their staff within ten days of becoming active with KFHC's provider network. If an unexpected emergency occurs and the provider is unable to complete the training within the ten-day timeframe, the contract effective date will be postponed. Therefore, the contracted provider is made aware that they may not provide services to Plan members, until the provider completes training.

Provider Directory Updates

KFHC is required to provide accurate information regarding their Provider Network. Contracted providers are responsible to ensure KFHC has accurate directory information for their office. In addition, KFHC asks all contracted providers to attest to the accuracy of their reported provider directory information in accordance with the frequency and time frames defined in Health and Safety Code section 1367.27 (SB-137). KHS utilizes Gaine, an outside vendor, to conduct outreach for directory accuracy.

To update your provider directory information, you may:

- Make updates via KFHC Provider Portal
    - https://provider.kernfamilyhealthcare.com/v3app/publicservice/loginv1/login.aspx?bc=1215a844-d81f-4be0-ac1c-92dd137dd90c&serviceid=05411915-5bc6-4527-97a6-45b09eecbde3
- Contact your Provider Relations Representative
- Contact the KFHC Member Services Department, 661-632-1590 (Bakersfield) or 1-800-391-2000 (outside of Bakersfield)
- Email: ProviderDirectoryFeedback@khs-net.com

Providers can direct members or prospective members' questions or comments regarding directory inaccuracies to the Member Services Department at 661-632-1590 (Bakersfield) or 1-800-391-2000 (outside of Bakersfield).

In addition to contacting KFHC, Providers may also direct the member or a prospective member to the California Department of Managed Health Care at 1-888-466-2219 to report any inaccuracy with the KFHC Provider Directory.

Provider Bulletin

Provider Bulletins are valuable updates, information, and action requests. Bulletins are distributed on an as-needed basis primarily to provide timely notification of new plan information, including changes in regulations relating to Medi-Cal Managed Care. Bulletins are faxed and posted online at www.kernfamilyhealthcare.com.

Provider Portal

The KFHC Provider Portal (Provider Connection) is one of the most beneficial resources to help with:

- **Verify member eligibility**: Providers can verify eligibility by KFHC ID number, CIN, member's name, and date of birth.
- **Check claim status**: Providers can review submitted claims and determine payment status.
- **Online Authorizations**: Providers can submit authorization requests electronically as well as check status of submitted referrals.
- **TAR**: Providers can submit electronic TAR's and check status of submitted requests.
- **Other resources available**: monthly membership lists, download various forms, P4P scoreboard, etc.
- **View and update** your Provider demographic information.

To obtain access to the KFHC Provider Portal, please contact your office designated admin user. If you are unsure who your admin user is, please contact your Provider Relations Representative or the Provider Network Management Department at 661-632-1590.

Resources available on KFHC Website

The policies, procedures, forms, and documents referenced in this manual can also be found at www.kernfamilyhealthcare.com under the For Providers tab. The For Provider section is the hub of information for providers, including the latest bulletins, regulatory updates, and training opportunities.

For more information see KHS Policy and Procedure: Policy 4.23

- https://www.kernfamilyhealthcare.com/providers/policies-and-procedures/

Section 24: Credentialing and Recredentialing

Join our Network

KHS requires all practitioners, non-physician medical practitioners, and Organizational Providers (Facilities/Institutions) to be contracted and credentialed. Practitioners or Providers interested in contracting with KHS should submit a contract inquiry to PRContracting@khs-net.com to initiate the process.

All Providers must meet the initial screening criteria (additional criteria may be required specific to the provider's specialty or services provided:

1. Be enrolled with the State Department of Health Care Services Fee-For-Service (FFS) Program
2. Must not have opted out of the Medicare Program
3. Must not be sanctioned, excluded, debarred or suspended from participating in any state or federal Medicare or Medicaid/Medi-Cal programs for any reason
4. Practitioner or Provider application and credentials be approved by the KHS Physician Advisory Committee.
5. Submit partially signed KHS Contract Service Agreement
6. Any additional criteria determined upon receipt of your contract inquiry request.

Credentialing

All healthcare providers are required to be contracted and credentialed in accordance with KFHC credentialing criteria and standards of the Department of Health Care Services (DHCS), National Committee on Quality Assurance (NCQA), and Centers for Medicare & Medicaid Services (CMS) in order to treat KFHC Members and to be reimbursed for non-emergent services. To maintain health care quality standards, Members will not be assigned or referred to providers who have not completed the credentialing process. Thereafter, providers are required to be recredentialed within 36 months of initial credentialing or last recredentialing approval date in order to continue with network participation.

DHCS Medi-Cal Enrollment

All healthcare providers, where there is a state pathway for enrollment, must be actively enrolled and approved to participate in the State DHCS Medi-Cal FFS Program and CMS Program in order to participate in all KFHC lines of business. Failure to meet DHCS Medi-Cal FFS requirements, NCQA and CMS requirements may be cause for denial or removal from KFHC's network.

As of January 1, 2018, Managed Care Plans (MCPs) are required to maintain contracts with their network providers (Plan-Provider Agreement) and perform credentialing and recredentialing activities on an ongoing basis. Title 42 CFR, Part 438 and Part 455

(Subparts B and E), including Section 438.214 now requires states to screen and enroll, and periodically revalidate, all network providers of managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans. These requirements apply to both existing contracting network providers as well as prospective network providers that have a state-level state pathway must enroll in the Medi-Cal FFS Program. This includes, but not limited to, current and prospective NMT/NEMT providers who must also be screened, enrolled and approved through DHCS Medical Fee-for-Service in accordance with APL 22-013 Screen and Enrollment and KHS policies and procedures, 4.43-P Medical Enrollment and Policy and 5.15-P Member Transportation Assistance to be considered for KHS network.

MCP providers may apply for enrollment through the electronic Provider Application for Validation and Enrollment (PAVE) portal. For instructions and training on how to apply using the PAVE Portal go to http://www.dhcs.ca.gov/provgovpart/Pages/PAVE.aspx. Provider Enrollment instructions and requirements are available on the Medi-Cal website at https://www.dhcs.ca.gov/provgovpart/Pages/Provider-Enrollment-Options.aspx.

The MCPs' screening and enrollment requirements are separate and distinct from their credentialing and recredentialing processes. If you are not enrolled and have questions, please contact your Provider Relations Representative who will be able to assist and guide you to the DHCS PAVE Portal.

Organizational Providers, Facilities, and/or Pharmacies with multiple business locations are required to enroll those locations who meet established place of business requirements as defined in Title 22 of the CCR Section 51000.60. Locations must be enrolled under the parent National Provider Identification (NPI) Number or enrolled under each individual NPI Number.

Ground Transportation Providers – DHCS permits enrollment of ground transportation providers at the "entity-level" which refers to the company acting as an individual applicant. Transportation Brokers do not currently have an enrollment pathway through DHCS, however, **if the broker is providing rides to members (NEMT or NMT services), the broker or the transportation vendor used by the broker must be enrolled as an NEMT or NMT provider. Additional information can be found at** https://www.dhcs.ca.gov/services/medi-cal/Pages/Transportation.aspx.

Community Support Services

If a Community Supports provider type has an existing state-level Medi-Cal enrollment pathway (e.g., a Home Health Agency, Residential Care Facility for the Elderly, Durable Medical Equipment provider, etc.), that provider must be enrolled as a Medi-Cal provider.

• This requirement applies regardless of tax status (i.e., non-profit or for-profit).

• For CBOs or other provider types that do not have a state-level Medi-Cal enrollment pathway, enrollment is not required at this time, and KFHC is responsible for vetting and contracting with those entities directly.

Behavioral Health Treatment (BHT) Service Providers

On March 14, 2025, the Department of Health Care Services (DHCS) introduce two new regulatory provider bulletins that directly impact enrollment procedures for Behavioral Health Treatment (BHT) service providers. The new Medi-Cal enrollment opportunities for Qualified Autism Service (QAS) provider organizations, QAS individuals, and Community-Based Organizations (CBOs).

Beginning **May 5, 2025**, QAS provider organizations and individuals delivering behavioral health treatment services are eligible to apply for enrollment in the Medi-Cal program.

Applications must be submitted electronically through the **Provider Application and Validation for Enrollment (PAVE)** portal and must include all required supporting documentation.

For detailed enrollment guidelines, documentation requirements, and access to the online application system.

- https://mcweb.apps.prd.cammis.medi-cal.ca.gov/references/provider-enrollment
- https://www.dhcs.ca.gov/provgovpart/Pages/QAS-Stakeholder-Hearing-Q-and-A-3-14-2025.aspx
- https://www.dhcs.ca.gov/provgovpart/Pages/QAS-Provider-Organizations-and-QAS-Individuals-and-CBOs-Offering-BHT-Services-Medi-Cal-Enrollment.aspx

Initial Credential Application Process

Applicants must submit a signed application and supporting documentation to the KFHC Quality Performance Contracting/Credentialing Department or the Provider Network Management Department. Applications are available on the KFHC website, www.kernfamilyhealthcare.com, under the For Providers tab, or through the Provider Network Management Department. Applications will be reviewed by the Provider Network Management Department for accuracy and completeness, verification of enrollment with the State Department of Health Care Services Medi-Cal FFS Program (if applicable) and have a signed provider agreement. KFHC will render a decision within **120 days** from the signature date, and if approved, the provider will receive an official letter within 30 days of credentialing approval with an effective date.

Pursuant to California Assembly Bill 2581, the initial credentialing decision for behavioral health providers (including mental health and substance use disorder provider types), is to be completed within **60 days** after receiving a complete

credentialing application. Behavioral health providers will be notified within 7-business days to verify receipt and inform the applicant whether the application is complete or incomplete.

Confidentiality
The information obtained during the credentialing process, whether directly from the provider, or from another source, will be treated as confidential information.

Application Review and Verification
The Physician Advisory Committee (PAC) shall serve as the Credentials Committee. The PAC is responsible for peer review and credentialing/re-credentialing decisions. Credentialing and Recredentialing verification processes comply with NCQA credentialing standards as they pertain to primary source verification.

KFHC monitors the initial credentialing process and will ensure that providers considered for network participation and continued participation are in good standing and meet the required criteria identified in Policy and Procedure 4.01-P Credentialing before being accepted in the network. The criteria include but is not limited to:

- Application is signed and dated with attestation by the applicant of the correctness and completeness of the application including statements by the applicant:
    - Reasons for any inabilities to perform the essential functions of the position with or without accommodations.
    - History of loss of license and/or felony conviction(s); including but not limited to plea of nolo contendere to felony, misdemeanor to any crime involving moral turpitude or otherwise relating to the provider's fitness or ability to practice medicine or deliver health care services or involving fraud, abuse of the Medi-Cal program or any patient, or otherwise substantially related to the qualifications, functions, or duties of a provider of services.
    - History of loss or limitation of privileges including any disciplinary activity.
    - Lack of present illegal drug and alcohol use.
    - Practitioner race, ethnicity and languages (optional to disclose)
- Valid, unrestricted, and current State license to practice in California
- Current and valid federal Drug Enforcement Agency (DEA) registration for the State
- Current NPI number
- Graduation from an approved medical/professional school and completion of an accredited residency or specialty program
- Board Certification, if applicable

- Clinical privileges in good standing at a participating hospital or alternative admitting arrangements in writing indicating the admitting provider's full name, hospitalist group's name or transfer agreement in place for admissions
- Work history
- Claims history and/or disciplinary actions from National Practitioner Data Bank (NPDB)
- History of any sanctions, exclusions or debarments imposed by Medi-Cal, Medicaid, Medicare and System for Award Management
- Current adequate professional and general liability insurance
- Sanctions or limitations on licensure from State agencies or licensing boards
- Validation of approved Medi-Cal enrollment status with the Department of Health Care Services.

Facility Site Review (FSR) for Primary Care Locations

- KFHC also requires its primary care locations to undergo a facility site review by the Quality Performance Department.
- Facility Site Reviews (FSR) are conducted every 3 years as part of the credentialing verification process along with recredentialing and changes in site locations.
- A KHS Quality Performance Nurse will conduct the facility site review at each PCP location using the DHCS Site Visit Tool (including license status, physical accessibility, safety, etc.).
- The FSR date and passing score will be included in the Credentialing and Recredentialing file for submission to the Physician Advisory Committee for consideration and approval.

FSR for Street Medicine

- Street Medicine Providers who are serving in an assigned PCP capacity are required to undergo an appropriate level site review, either full or condensed review.
- For Street Medicine Providers affiliated with a brick-and-mortar facility or that operate a mobile unit or Van will be required to undergo a condensed FSR and MMR to ensure patient safety.

Recredentialing

KFHC also requires its Providers to be recredentialed every 36 months. The only exceptions include active military assignments, maternity/medical leave of absence or sabbatical. The recredentialing criteria includes but is not limited to:

- Attestation by the applicant of the correctness and completeness of the application including statements by the applicant:
    - Reasons for any inabilities to perform the essential functions of the position with or without accommodations;
    - History of loss of license and/or felony conviction(s); including but not limited to plea of nolo contendere to felony, misdemeanor, to any crime involving moral turpitude or otherwise relating to the provider's fitness or ability to practice medicine or deliver health care services or involving fraud, abuse of the Medi-Cal program or any patient, or otherwise substantially related to the qualifications, functions, or duties or the provider of services:
    - History of loss or limitation of privileges including any disciplinary activity.
- Lack of present illegal drug and alcohol use
- Valid, unrestricted, and current State license to practice in California
- Professional liability claims history since initial credentialing or last recredentialing cycle
- National Practitioner Data Bank (NPDB)
- Current and valid Drug Enforcement Agency (DEA) registration
- Current NPI number
- Recent sanctions, exclusions or debarments imposed by Medi-Cal, Medicaid, Medicare, and System for Award Management
- Current adequate professional and general liability insurance
- Sanctions or limitations on licensure from State agencies or licensing boards
- Revalidation of Medi-Cal enrollment status
- Performance reviews which include Quality Improvement, Utilization Management, Member Services, and Compliance.
- Facility site review results, if applicable

Recommendations

The PAC recommends acceptance or denial of an applicant to the Board of Directors as follows:

If the recommendation is for DENIAL, the applicant receives written notification **within 30-days** of the decision and supporting reasons. If the denial is due to medical quality of care, the appeal process is included. If the recommendation is for APPROVAL, the supporting information is transmitted to the Board of Directors. The applicant receives written notification of the decision.

Practitioner Rights

In the event there is information obtained by the credentialing staff that substantially differs from that supplied by the applicants, the credentialing staff will contact the applicant to have them either correct or provide an explanation of the differences. Practitioners have the right to correct erroneous information submitted during the application process; corrections must be submitted in writing (or email) to the PNM Department Attention: Credentialing within 10-calendar days of the notification.

Practitioners have the right, upon request, to review the information submitted in support of their credentialing application; additionally, practitioners have the right to:

- Review information obtained by KHS for the purpose of evaluating their credentialing and recredentialing application. This includes information obtained from outside sources such as malpractice carriers or state licensing boards but does not extend to review of information from references, or recommendations protected by law from disclosure. Practitioners may submit their request for review to their Provider Relations Representative via email, letter or fax.
- Correct erroneous information.
- Be informed of the status of his/her application during the credentialing process, upon request.
- To be notified, in writing, the initial credentialing decisions within 60-days from the date the decision was made.

Non-Physician Medical Practitioners (Mid-Levels)

Contracted Providers are required to ensure all employed non-physician extenders (Mid-Levels) who will support the physician treating a KFHC Member must also meet the credentialing requirements and receive credentialing approval prior to seeing or treating a KFHC Member beneficiary.

Non-Physician Extenders include:

- Physician Assistants (PA)
- Nurse Practitioners (NP)

Employed extenders must complete and sign the Supervising Physician Agreement with a Provider who is credentialed and contracted in the KFHC Network. Policy and Procedure 4.04-P Non-Physician Medical Practitioners outlining the training and experience requirements for Nurse Practitioners and Physician Assistants requesting to be credentialed in a specific sub-specialty.
Specifically, Section 2.0 Scope of Mid-Level Practitioners addresses the credentialing will be dependent of the Nurse Practitioner or Physician Assistants formal training and experience in the field of sub-specialty practice, such as Cardiology, Nephrology, Rheumatology etc. The policy has a footnote outlining the requirements as follows:

“Mid-level training is variable. Not only are there differences between Nurse Practitioners and Physician Assistants, but there are significant differences between the programs themselves. In addition, some mid-levels go on to receive formal “specialty” training in areas like OB, peds, surgery, ortho, oncology, etc. KHS will require either 6-months formal training in a program or one year of full-time experience in the field which credentialing is requested.”
As a public plan, KHS must ensure our members are treated by trained and experienced providers. Abiding by our current Policy & Procedure requiring formal training in a specialized field or 1-year experience in the specialized field for NPs and PAs is essential.

Certified Nurse Practitioner Providers

Certified Nurse Practitioner Providers (CNPs) are permitted to render services as independent practitioners without physician supervision or standardized procedures.

To qualify as an independent practitioner, participants must be:

1. Licensed as a Nurse Practitioner by the California Board of Registered Nursing as a designated qualification/certification as 103-Group Setting practice independently without physician supervision or standardized procedures;
2. Holds a National Certification by a national certifying body accredited by the National Commission for Certifying Agencies or the American Board of Nursing Specialties and recognized by the Board;
3. Enrolled as an independent provider in the DHCS Medi-Cal FFS Program.
4. If national board certification expires, the NP must immediately begin practicing under physician supervision and standardized procedures. The NP can only resume practicing as a 103 NP without standardized procedures once they have regained their national board certification.

Credentialing Requirements for Organizations Providers (Facility and Ancillary Providers)

KFHC will contract with institutions or organizations where Members are directed to receive services. All new facilities, pharmacies, and ancillary (non-practitioner) providers must meet credentialing requirements and meet all applicable state and federal regulations, accreditation standards and the Policy and Procedures of KFHC as part of the initial credentialing, recredentialing and on-going monitoring processes.

Organizational Providers must:

A. Submit a completed, signed, and dated Organizational Application and supporting documentation.
B. Provider must be physically located in and providing services in Kern County for
C. one year prior to application.
D. Must be in good standing with KHS, state and federal agencies.

E. Provide evidence of valid license to operate or practice in State of California, when applicable.
F. Have current professional and general liability insurance ($1mil occurrence/$3mil aggregate)
G. Must be able to submit claims electronically.
H. Must be able to participate in the KHS electronic funds transfer (EFT) program.
I. Provide evidence of Accreditation or DHCS state survey/approval within three (3)-years of the date of application. Hospitals and Ambulatory Surgery Centers must remain accredited by The Joint Commission (TJC) or other nationally CMS-recognized accrediting body.
J. Laboratory providers must provide proof of accreditation status, Clinical Laboratory Improvement Amendments (CLIA) Certificate, and submit lab results/data to KHS electronically.
    - As defined by CLIA, waived tests are "simple laboratory examinations and procedures that have an insignificant risk of an erroneous result." Examples of waived tests include: dipstick urinalysis, fecal occult blood, urine pregnancy tests, and blood glucose monitoring. Physician offices should only be performing CLIA waived testing. Physician offices must have a CLIA Certificate of Waiver and must follow the manufacturer's instructions.
    - The Food and Drug Administration (FDA) determines which tests meet these criteria when it reviews manufacturer's applications for test system waiver. For a list of waived tests sorted by analyte name, visit the FDA website at CLIA – Currently Waived Analytes:
        - https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfClia/analyteswaived.cfm
K. Durable medical equipment (DME) providers must be able to service KFHC Members seven (7) days a week.
L. Meets the requirements for Medi-Cal FFS enrollment and is approved with DHCS as defined by the DHCS APL 19-004 and/or within the established process outlined in KHS Policy & Procedure 4.43-P Medi-Cal Enrollment Policy

Provider Directory, Attestation of Practice Information, Changes or Terminations

In December 2016, The Department of Managed Health Care (DMHC) released Senate Bill (SB) 137 indicating uniform standards and timely updates for all Managed Care Plan Provider Directories. Provider Directory Standards allow members to receive and search accurate, up-to-date information regarding physicians, hospitals, clinics and other contracted providers with the KFHC network.

In an effort to provide Member and Providers with the most current information, KFHC's Provider Director is updated on a routine basis. In addition, KFHC has an agreement with Symphony IHA, powered by Availity, allowing providers to verify and attest to the accuracy of their information. Provider can submit their updates via Availity Attestation or submit changes, additions and deletions to their KFHC Provider Relations Representative.

By notifying KFHC with any practice changes, you are not only complying with your Provider Agreement, but you are also ensuring KFHC is in compliance with the DHCS and DMHC provider data regulations. The following are changes that require immediate notification:

- Change to Mailing and/or Pay To addresses
- Adding additional rendering physician or other provider types
- Adding or changing business owners, officers, and managers
- Changes in member age limitations and new member acceptance
- Changes in office hours
- Changes in language capabilities provided at your office

Locum Tenens now requires credentialing – NCQA Requirement

Effective 7/1/2025, KHS is no longer permitted to grant Locum Tenens for "Practitioners within the Scope of Credentialing" and now requires credentialing under the following circumstances:

- FULL Credentialing is required if practitioners is working 60-calendar days or more. Full credentialing and committee approval process is required.
- PROVISIONAL Credentialing is required if practitioner is working less than 60-calendar days.

Moving, Retiring or Terminating Network Participation

If a provider is terminating from the KFHC Network, every effort must be made to ensure our requirements to the State and to our members are met. This includes proper notification to Members and reassignment to another participating KFHC provider as appropriate. As a provider, it is important to notify your KFHC Provider Relations Representative, in writing, at least 60-days prior to any changes to your practice, including but not limited to a provider moving, retiring, or resigning. As required by our contract with the DHCS, KFHC must notify DHCS of provider terminations, which includes but no limited to the following: termination date, reason for termination and provider reassignments, if applicable.

If you, the Contract owner, have decided to leave the KFHC Network, please submit a notification in writing via email to KFHC Provider Contracting Department at prcontracting@khs-net.com, 0-days in advance for notification of business closure, retirement, or resignation from KFHC.

Changes to your Tax ID Number, DBA or legal business name, including purchases by another owner may require a new Provider Agreement requiring 60-days notification to process these types of changes. Notifications regarding transfer of ownerships are not acceptable.

Providers must also ensure that access to Member's medical records are readily available to ensure any coordination or transfer of care to another provider may occur, as required by your Contract Agreement, and by State regulations.

Adverse Issues, Complaints, Exclusion, Debarment, Sanction, Suspension, or Ineligibility

On an ongoing basis, KFHC conducts a comprehensive ongoing monitoring process of its contracted providers for any potential adverse issues, complaints, sanctions, exclusions or debarments from federal and state programs to ensure appropriate action is taken when instances of poor quality are identified, or the professional conduct of a Provider is or is reasonably likely to be detrimental to Member's safety. On a monthly basis, the Credentialing Department reviews the required federal and state databases within 30-calendar days of the release of the report. Supporting documentation for any identified Provider is prepared by the Credentialing Department for review by the Chief Medical Officer, or designee, for the Physician Advisory Committee. ***In the event a contracted facility, ancillary organization or licensed/certified practitioner is found to be listed on the federal or state database as excluded, sanctioned or debarred, immediate action, up to and including termination from the provider network, will be taken in accordance with 45 CFR (Code of Federal Regulations) Part 76, KHS Policy and Procedure and contractual agreement. Should you or any provider affiliated under your provider service agreement become excluded, debarred, or suspended or ineligible to receive state or federal funds, you are required to notify KHS immediately.***

A provider may be reviewed any time at the request of the QI/UM Committee, the PAC, the Chief Executive Officer, the Chief Medical Officer, or the Board of Directors. All issues identified are reviewed by the Physician Advisory Committee. Adverse actions determined to be reportable are reported to the appropriate agencies as directed by the Physician Advisory Committee in accordance with all State and federal regulations, accreditation standards, and the Policies and Procedures of KFHC.

For questions regarding the credentialing or recredentialing process, contact Provider Network Management Department at 800-391-2000, dial 5 to bypass other queues.

For more information see KHS Policy and Procedure:

- 23.21-P Site Review and Medical Record Review
- 23.05-P Credentialing Program

- 23.06-P Non-Physician Medical Practitioners
- 4.40 Corrective Action Plans
- 4.43 Medi-Cal Enrollment Policy
- 4.47 CLIA Certification Requirements
- 4.48 Provider Disciplinary Actions
- https://www.kernfamilyhealthcare.com/providers/policies-and-procedures/

Section 25: Accessibility Standards and Timely Access

Appointment Waiting Time and Scheduling

KFHC adheres to patient care access and availability standards as required by the Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC). These standards are to ensure Medi-Cal beneficiaries are offered appointments for care within a time period appropriate for their condition. Members must be offered appointments within the following timeframes:

Type of Appointment	Time Standards
Urgent care appointment for services that do not require prior authorization	Within 48 hours of a request
Urgent appointment for services that do 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 non-physician mental health care provider	Must offer the appointment within 10 business days of request
Non-urgent follow-up appointment with a non-physician mental health care provider, for those undergoing a course of treatment for an ongoing mental health condition	Within 10 business days from prior appointment date
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

Telephone Accessibility

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

Nature of Telephone Calls	Response Time
Emergency medical or Kern County Mental Health Crisis Unit	Member should be instructed to call 911 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.

Office Waiting Time – Maximum

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

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

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 KHS policy 4.30-P Accessibility Standards-Timely Access.

Monitoring Access Standards

KFHC will monitor all network Providers using the following sources to study and assure compliance with access standards:

- Quarterly Provider Accessibility Monitoring Survey
- Quarterly After-hours Call Survey
- Access Grievance Review
- Annual Appointment Availability Survey
- Provider and Member Satisfaction Survey

Instances of Noncompliance – Quarterly Surveys

KHS will take the following action for provider identified as noncompliant during the Plan's quarterly survey and afterhours survey:

Quarter	Action
First Quarter Noncompliant	KHS will send the provider a letter notifying them of their noncompliance and educating them on Plan accessibility standards
Second Quarter Noncompliant	In addition to a second letter, a Plan Provider Relations Representative and a member of Provider Network Management team will make contact with the provider, either in person or via phone, and notify them of their noncompliance and educate them on Plan accessibility standards
Third Quarter Noncompliant	The Plan will issue a corrective action plan, in line with *KHS Policy and Procedure #4.40-P Corrective Action Plan*

For more information see KHS Policy and Procedure: Policy 4.30

- https://www.kernfamilyhealthcare.com/providers/policies-and-procedures/

Section 26: Proposition 56

California voters approved Proposition 56 on November 8, 2016, which increased the excise tax rate on cigarettes and tobacco products. A portion of the tobacco tax revenue goes to the Department of Health Care Services (DHCS) to help fund specific DHCS health care programs including but not limited to:

Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services

APL 23-017 – Eligible providers who evaluate children and adults for trauma that occurred within the first 18 years of life receive a minimum reimbursement for conducting a qualified ACEs screening. Eligible providers must complete a one-time state-sponsored trauma-informed care training and self-attest to the completion of the training program. Please see APL for more information:

- https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-017.pdf

Proposition 56 Directed Payments for Developmental Screening Services

APL 23-016 – Eligible providers will receive directed payments for qualified developmental screening service performed in accordance with the AAP/Bright Futures periodicity schedule and guidelines. Please see APL for more information:

- https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-016.pdf

Proposition 56 Directed Payments for Family Planning Services:

APL 23-008 – Intended to enhance the quality of patient care by offering an enhanced payment to eligible providers in California who offer family planning services as outlined in APL 23-008. Please see APL for more information:

- https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-008.pdf

Services include but are not limited to:

- Long-acting contraceptives
- Contraceptives (other than oral) when provided as a medical benefit
- Emergency contraceptives when provided as a medical benefit
- Pregnancy testing
- Sterilization procedures

Proposition 56 Directed Payments for Private Screenings:

APL 23-0115 – Qualified providers who provide and bill for medical pregnancy termination services. Please see APL for more information:

- https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-015.pdf

Kern Health Systems (KHS) will make two separate payments. The first payment will be for the original claim submission, paying per Medi-Cal fee schedule/or contracted rate. The second payment will occur the following month for the supplemental payment amount outlined in the APL's listed above. KHS utilizes Zelis to provide remittance advice which will include sufficient information to uniquely identify the qualifying service for which payment was made. To obtain access to Zelis, please contact 1-877-828-8770. **Please reference Section 20: Zelis.**

Payment will be made in accordance based on the timely payments' standards outlined in the contract for a clean claim or accepted encounter which meets the criteria outlined in the APL's listed above. General claim processing rules apply.

Providers wishing to file a grievance as a result of payment or process issues related to any of the APL's listed above, or for any additional questions, please contact your Provider Relations Representative at 1-800-391-2000 or reference KHS Policy 4.03-P, Provider Disputes Regarding Issues other than Claims:

- https://www.kernfamilyhealthcare.com/providers/policies-and-procedures/

Section 27: Fraud, Waste, and Abuse (FWA)

At KFHC we are deeply committed to acting ethically and responsibly in a culture of compliance, ethics, and integrity. KFHC cooperates with the California Department of Health Care Services (DHCS) in working to identify Medi-Cal Fraud, Waste, and Abuse (FWA).

Abuse: means practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medi-Cal program.

Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal (as defined in Title 42, Code of Federal Regulations Section 455.2) and W&I Code section 14043.1(i).

Waste: The overutilization or inappropriate utilization of services and misuse of resources.

Laws and Regulations

False Claims Act (Federal – 31 U.S.C. § 3729-3733; California – C.G.C. § 12650-12656): The California and Federal False Claim Acts (FCAs) make it illegal to submit claims for payment to Medicare or Medicaid that you know or should know are false or fraudulent. Filing false claims may result in fines of up to three times the programs' loss plus $11,000 per claim. Under the civil FCA, no specific intent to defraud is required. The civil FCA defines "knowing" to include not only actual knowledge but also instances in which the person acted in deliberate ignorance or reckless disregard of the truth or falsity of the information. Further, the civil FCA contains a whistleblower provision that allows private individuals to file a lawsuit on behalf of the United States and entitles whistleblowers to a percentage of any recoveries. There also is a criminal FCA (18 U.S.C. § 287). Criminal penalties for submitting false claims include imprisonment and criminal fines.

Fraud, Waste, and Abuse Investigations

The KFHC Compliance Department is responsible for implementing administrative and management policies and procedures designed to prevent and detect Fraud, Waste, and Abuse. The Compliance Department independently conducts, coordinates, and reports audit and investigation activities for the purpose of preventing and detecting Fraud, Waste, or Abuse in the delivery of health care services to KFHC Members. The

Compliance Department also provides analysis and recommendations regarding the activities reviewed or investigated.

Additionally, the Compliance Department conducts monitoring to identify potential FWA. Monitoring activity includes but is not limited to:

- Random claim audits.
- Verification of Services (VOS), which requests members to verify that services for which KFHC has been billed, have actually been received.
- Data mining projects to search for claim activity that appears unusual or to be a potential outlier.

Initial findings may prompt preliminary investigation reports for cases of potential Fraud, Waste, or Abuse. Preliminary investigation findings are forwarded to the appropriate federal or state investigating agency in accordance with our DHCS contract, state or federal law.

KFHC will report to the DHCS all cases of suspected Fraud and/or Abuse where there is reason to believe that an incident of Fraud and/or Abuse has occurred by subcontractors, members, providers, or employees. KFHC will conduct, complete, and report to the DHCS, the results of a preliminary investigation of suspected Fraud and/or Abuse within ten (10) working days from the date that KFHC first became aware of or noticed such activity.

Other actions and measures that may be taken based on potential FWA investigations include but are not limited to:

- Provider requests for medical records and/or responses
- Provider education
- Provider monitoring and audits
- Corrective Action Plans (CAP).
- Overpayment recoveries.
- Prepayment review which requires medical records to be submitted with all related claims.
- Suspension of payments.
- Suspension and/or termination of the Provider's contract and participation with the Plan.

Providers are required to comply with any requests from KFHC for medical records or responses related to a report of potential FWA, or any of the above-mentioned monitoring activities. Records and responses must be submitted to the Plan timely, within ten (10) days of the request, as outlined in Provider's contract.

Member FWA Examples

- Using or allowing someone else to use their KFHC Member ID Card.
- Not residing in California or Kern County.
- Deliberately providing misinformation to obtain services or coverage.
- Failing to report changes in income which may affect Medi-Cal eligibility
- Failing to report Other Health Coverage.
- Selling and/or forging prescriptions.
- Utilizing, or allowing others to utilize, KHS transportation services for purposes other than intended.

Provider FWA Examples

- Charging Members for covered services.
- Soliciting or receiving kickbacks.
- Falsifying or altering medical records.
- Billing and Coding Issues:
    - Billing for services not rendered.
    - Billing for services that are not medically necessary.
    - Using an incorrect CPT, HPCS and/or diagnosis code to have services covered or to obtain greater reimbursement.
    - Billing for services performed by another provider, not the rendering provider.
    - Upcoding and/or billing codes not supported by the medical record.
    - Unbundling services that should be billed together.

Reporting Suspected FWA

Suspicious activities must be reported to KFHC within ten (10) working days of identification of the suspected Fraud, Waste, or Abuse. Reports may be reported by phone, in writing, or in person to the KFHC Compliance Department. It is recommended, but not required, that written reports be submitted on a FWA Referral Form. Please see link below:

- https://www.kernfamilyhealthcare.com/members/report-fraud/

Kern Family Health Care
Director of Compliance & Regulatory Affairs
2900 Buck Owens Blvd
Bakersfield, CA 93308
1-800-391-2000

If you have questions about Compliance efforts, please contact your Provider Relations Representative.

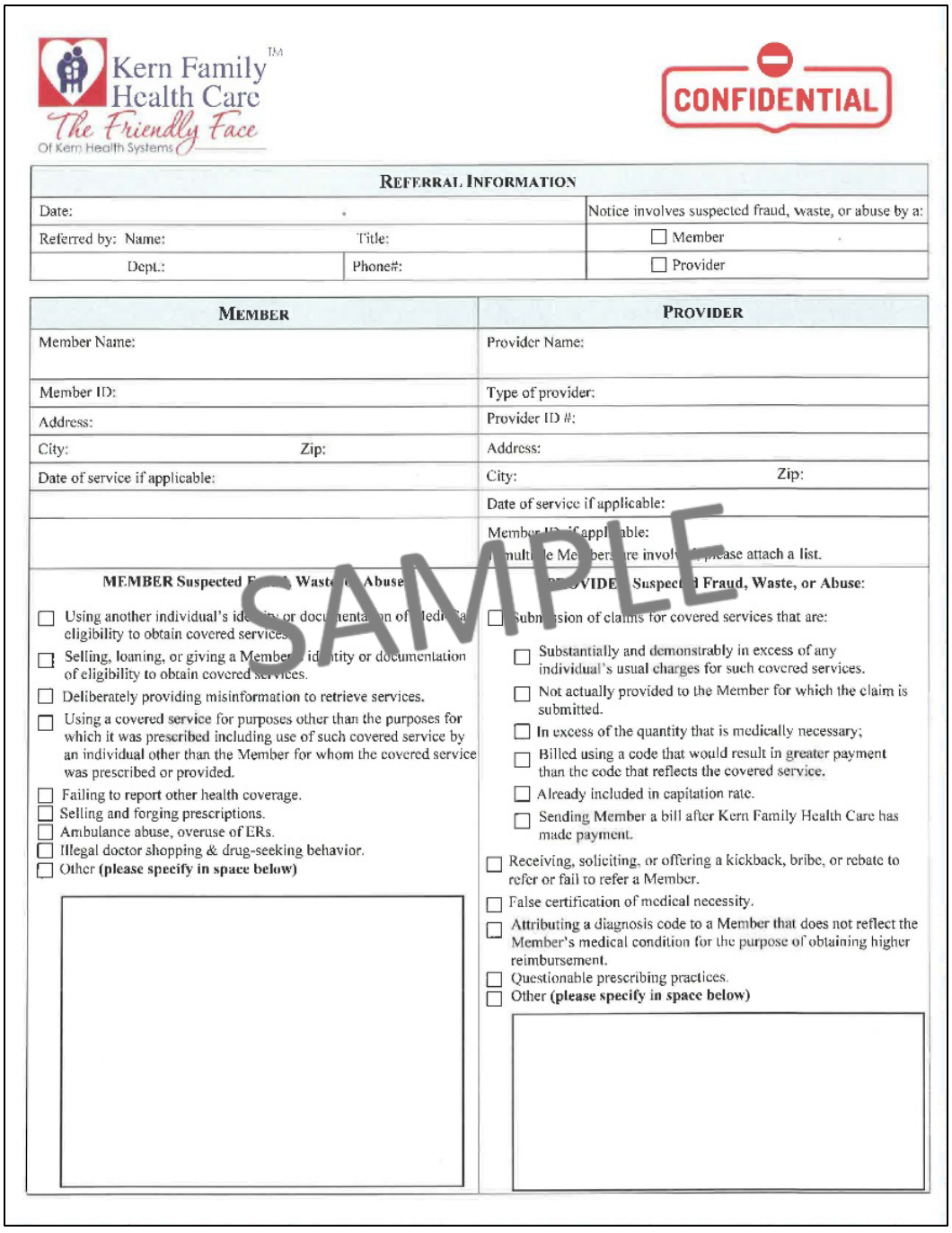
For more information see KHS Policy 14.04-P, Prevention, Detection, and Reporting of Fraud, Waste, or Abuse

- www.kernfamilyhealthcare.com/providers/policies-and-procedures/

Sample FWA Referral Form

The FWA Referral form is located on the kernfamilyhealthcare.com website under the For Providers tab:

- www.kernfamilyhealthcare.com/members/report-fraud/



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REFERRAL INFORMATION

Date:	Notice involves suspected fraud, waste, or abuse by a:
Referred by: Name: Title:	☐ Member
Dept.: Phone#:	☐ Provider

MEMBER	PROVIDER
Member Name:	Provider Name:
Member ID:	Type of provider:
Address:	Provider ID #:
City: Zip:	Address:
Date of service if applicable:	City: Zip:
	Date of service if applicable:
	Member ID # if applicable: Multiple Members are involved, please attach a list.

MEMBER Suspected Fraud, Waste, or Abuse:

- ☐ Using another individual's identity or documentation of medical eligibility to obtain covered services.
- ☐ Selling, loaning, or giving a Member's identity or documentation of eligibility to obtain covered services.
- ☐ Deliberately providing misinformation to retrieve services.
- ☐ Using a covered service for purposes other than the purposes for which it was prescribed including use of such covered service by an individual other than the Member for whom the covered service was prescribed or provided.
- ☐ Failing to report other health coverage.
- ☐ Selling and forging prescriptions.
- ☐ Ambulance abuse, overuse of ERs.
- ☐ Illegal doctor shopping & drug-seeking behavior.
- ☐ Other **(please specify in space below)**

PROVIDER Suspected Fraud, Waste, or Abuse:

- ☐ Submission of claims for covered services that are:
  - ☐ Substantially and demonstrably in excess of any individual's usual charges for such covered services.
  - ☐ Not actually provided to the Member for which the claim is submitted.
  - ☐ In excess of the quantity that is medically necessary;
  - ☐ Billed using a code that would result in greater payment than the code that reflects the covered service.
  - ☐ Already included in capitation rate.
  - ☐ Sending Member a bill after Kern Family Health Care has made payment.
- ☐ Receiving, soliciting, or offering a kickback, bribe, or rebate to refer or fail to refer a Member.
- ☐ False certification of medical necessity.
- ☐ Attributing a diagnosis code to a Member that does not reflect the Member's medical condition for the purpose of obtaining higher reimbursement.
- ☐ Questionable prescribing practices.
- ☐ Other **(please specify in space below)**

SAMPLE

Section 28: Member Privacy: HIPAA, CMIA, and Other Privacy Regulations

KFHC is committed to protecting the privacy of the Plan's members in accordance with all Federal laws and regulations, including: the Health Insurance Portability and Accountability Act (HIPAA), the Health Information Technology for Economic and Clinical Health (HITECH) Act, California laws, the Confidentiality of Medical Information Act (CMIA), the Insurance Information and Privacy Practices Act (IIPPA), and all other regulations protecting member's health information. KFHC will comply with the more protective privacy and security standards set forth in applicable State or Federal laws when those laws provide greater protection than HIPAA or CMIA for the member whose information is concerned and will treat any violation of more protective standards as a breach or security incident.

Examples of laws that provide additional and/or stricter privacy protections to certain types of confidential information include, but are not limited to, the Information Practices Act, California Civil Code sections 1798-1798.78, Confidentiality of Alcohol and Drug Abuse Patient Records 42 CFR part 2, W&I section 5328, and Health and Safety Code section 11845.5.

KFHC expects all providers to follow the standards and practices set forth in the above regulations regarding member privacy and protecting health information. KHFC uses physical, technical, and administrative safeguards to protect Protected Health Information (PHI) and Personal Information (PI) as defined under the HIPAA Security Rule. Covered entities range from the smallest provider to the largest multi-state health plan. Therefore, the Security Rule is flexible and scalable to allow providers to analyze their own needs and implement solutions appropriate for their specific environments.

Protected Health Information (PHI) is any individually identifiable health information, including demographic information. PHI includes a member's name, including initials; address, including street address, city, county, and zip code; phone number; email addresses; medical information; Social Security number; card identification number; date of birth; financial information; race/ethnicity; language; gender identity or sexual orientation; and any other unique identifying number, characteristic, or code.

The privacy rules also provide KFHC members with certain rights, such as the right to examine and get a copy of their medical records, restrict access, request confidential communications, and request corrections.

Providers must have written policies and processes for the appropriate protection, use, and disclosure of health information; providing members with access to their medical records; and responding to requests for amendments, restrictions, and accounting of disclosures. Providers must designate a privacy and security official responsible for responding to member requests and establishing policies and procedures that define responsibilities and expectations regarding privacy and security.

KFHC expects providers and their staff to undergo HIPAA training upon hire and annually thereafter. As a safeguard for electronically transmitted protected health information, KFHC requires that all files transmitted electronically be sent securely and any email that contains member information is encrypted.

Privacy incidents involving KFHC Members should be reported to KFHC. KFHC will submit potential privacy incidents in accordance with DHCS standards, which require an initial report within 24 hours of the discovery of the incident and a final report within ten (10) working days after the discovery.

Reporting privacy incidents regarding KFHC Members to KFHC does not absolve the provider from their obligations to report privacy incidents to CDPH, OCR, or any other governing body.

For more information see KHS Policy and Procedure: Policy 14.03

- www.kernfamilyhealthcare.com/providers/policies-and-procedures/

To submit HIPAA concerns directly to KHS's Compliance Department for further review, please send an email to HIPAA Team email, hipaateam@khs-net.com. If email contains sensitive information or Personal Health Information (PHI), remember to send the email and any included documentation via secure email.

Below are additional resources related to the privacy laws and regulations that may be helpful:

- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HIPAAPrivacyandSecurity.pdf
- https://www.hhs.gov/hipaa/for-professionals/faq/index.html
- eCFR: 45 CFR Part 164 -- Security and Privacy
- California Code, CIV 56.06.

Section 29: Provider Disputes on Issues other than Authorizations and Claim Payment

A contracted or non-contracted provider can express dissatisfaction by completing a Provider Dispute Resolution Request Form:

The Provider Dispute Resolution Request Form must contain the following information:

- Provider Name
- Provider tax identification number
- Provider contact information
- Clear explanation of the issue and provider's position thereon
- Any applicable supporting documentation

A dispute that does not contain all necessary information will be returned to the provider. The dispute must be mailed to the following address:

Kern Health Systems
Attn: Provider Network Management
2900 Buck Owens Blvd
Bakersfield, Ca 93308

The Provider Dispute Resolution Request Form can be located on the KHS website:

- https://res.cloudinary.com/dpmykpsih/image/upload/kern-site-353/media/8be10a75368540ceabbaad882af2b013/provider-dispute-resolution-request-form.pdf

For more information see KHS Policy and Procedure: Policy: 4.03

- https://www.kernfamilyhealthcare.com/providers/policies-and-procedures/

Section 30: Marketing

Compliance with Laws and Regulations

The Department of Health Care Services (DHCS) has established guidelines for appropriate marketing activities for the Medi-Cal Managed Care Program. Providers should familiarize themselves with these guidelines to avoid sanctions, fines, or suspension of membership.

KFHC Marketing Materials

If you are interested in receiving marketing material including the KFHC Member Newsletter, Member Handbook, Provider Directory or brochures, please contact the Kern Family Health Care Provider Network Management Department at 1-800-391-2000.

Acceptable Marketing Methods

As a Medi-Cal health care provider, you may:

- Tell your patients the name of the health plan or plans with which you are affiliated.
- Actively encourage your patients to seek out and receive information and enrollment material that will help them select a Medi-Cal health care plan for themselves and their family.
- Provide patients with the phone number of the outreach and enrollment or member services departments of the plan(s) with which you are affiliated.
- Provide patients with the toll-free phone number of Health Care Options (HCO), the DHCS enrollment contractor (1-800-430-4263) and inform patients of locations and times when they may receive information from HCO about selecting a health plan or provider. This number is specifically for beneficiary questions. HCO provides enrollment and disenrollment information and activities, presentations, and problem resolution functions.

Prohibited Marketing Methods

As a Medi-Cal health care provider, you may NOT:

- Tell patients they could lose their Medi-Cal health benefits if they do not choose a particular health plan.
- Make any reference to competing plans, e.g., comparing plans in a positive or negative manner.
- Engage in marketing practices which discriminate against prospective members based on race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status or disability.
- Sign an enrollment application for the member.

Use of Name and Logo

The Kern Health Systems (KHS) and Kern Family Health Care (KFHC) names carry considerable value, particularly for external entities seeking to associate themselves with our organization. Moreover, the role of KHS as a public agency requires that our names and reputation be preserved and protected, and that activities and organizations associated with the KHS name(s) must be consistent with our mission and purpose. Thus, requests for an Endorsement, including Letter of Support (LOS) and use of a KHS name or logo, shall be approved by KHS.

An external entity may submit a request for an Endorsement if the entity is a community-based, non-profit organization, or health care partner. Such requests shall require the written approval of the KHS Chief Executive Officer (CEO) or designee. Written requests from external entities shall include the following information, as appropriate:

1. The name, background, description of the organization seeking a LOS or use of a KHS name or logo and the organization's contact information. Also include any other entity whose name will appear on the document, project, or event;
2. Name of the program or project, and name of the program or project director, or primary contact;
3. Description of the project, event, publication, or other purpose for which a KHS name or logo will be used and why;
4. Intended audience for the project, event, or publication for which a name or logo will be used;
5. Time frame during which a name or logo is requested to be used; and
6. A proof of the name/logo as it will appear

All requests shall be submitted at least thirty (30) days in advance of the date for which the LOS or use of a name or logo is requested, or if in a shorter amount of time, at the discretion of the KHS CEO or designee, so long as such request is submitted to the CEO or designee in a reasonable and sufficient amount of time so that KHS can complete a meaningful review and evaluation of the request.

The KHS Marketing Department will notify the organization that requests a LOS or use of a name or logo in writing after the determination is made. Organizations shall enter into a written agreement with KHS restricting the use of a KHS name or logo before being permitted to use the name or logo. Use or reproduction of the KHS name or logo by external entities shall be restricted by KHS, in accordance with federal and state trademark rules and regulations. Any external entity that is no longer in good standing with KHS shall update its marketing materials and cease the use of a KHS name or logo.

Definitions:

Endorsement means either (1) a Letter of Support or (2) KHS's approval for another entity to use a KHS name or logo in connection with that entity's project, event, document, program, or initiative. Endorsement does not include any sponsorship,

educational activity, purchased service, presentation, attendance at an event, activity that is included in the definition of Marketing Activities, or joint development of an event, seminar, symposium, educational program, public information campaign, or similar event.

Letter of Support (LOS) is a letter supporting a community-based organization or health care partner detailing compelling reasons why the organization or project is credible and of value to the community and conveying the relationship between KHS and the organization, thereby lending credibility to the organization requesting support. LOS does not include a formal partnership agreement or interagency agreement.

Marketing Activity is any activity conducted by or on behalf of KHS where information regarding the services offered by KHS is disseminated in order to persuade or influence eligible beneficiaries to enroll or to educate members and promote optimal program use and participation. Marketing also includes any similar activity to secure the endorsement of any individual or organization on behalf of KHS.

The Kern Health Systems Name and Logo Use Protocol follows guidelines outlined in Kern Health Systems Policy & Procedure # 9.05-I

Section 31: Policies and Procedures

KHS policies and procedures are updated and reviewed as needed. All current versions of Kern Health Systems' Policies and Procedures can be accessed on the KFHC website at www.kernfamilyhealthcare.com.

- Click on Providers tab
- Click on Policies and Procedures link or click here.

Contents of this manual are subject to change at any time. To ensure you are reviewing the most recent version, accessed on the KFHC website at www.kernfamilyhealthcare.com.

Glossary

Term	Definition
Acute Condition	A medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.
Accrual	The amount of money that is set aside to cover expenses. The accrual is the plan's best estimate of what those expenses are and (for medical expenses) is based on a combination of data from the authorization system, the claims system and the lag studies, and the plan's prior history.
Actuarial Assumptions	The assumptions that an actuary uses in calculating the expected costs and revenues of the plan. Examples include utilization rates, age and sex mix of enrollees, and cost for medical services.
ADA	Americans with Disabilities Act.
Administrative Costs	Means only those costs that arise out of the operation of the plan excluding direct and overhead costs incurred in the furnishing of health care services, which would ordinarily be incurred in the provision of these services whether or not through a plan.
Advance Directive	A written instruction such as a living will or durable power of attorney for health care, recognized under state law, relating to the provision of health care when a member is incapacitated.
AIDS Beneficiary	Means a member for whom a Diagnosis of Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) has been made by a treating Physician based on the definition most recently published in the Mortality and Morbidity Report from the Centers for Disease Control and Prevention.
Ambulatory Care	A type of health services that are provided on an outpatient basis.
Allied Health Personnel	Specially trained, licensed, or credentialed health workers other than Physicians, podiatrists and Nurses.
Appropriately Qualified Healthcare Professional	A PCP, specialist, or other licensed health care provider, who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the illness, disease, or condition associated with the request for a Second Opinion.

Term	Definition
Ambulatory Surgical Center (ASC)	A facility other than a hospital that provides outpatient surgery.
Authorized Representative	Any individual authorized by a member, or under state law, to act on his or her behalf in obtaining an Organization Determination or in dealing with any level of the Appeal process.
Balance Billing	The practice of a provider billing a patient for all charges not paid by the insurance plan. KHS prohibits providers from balance billing members in most cases.
Basic Case Management	A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs. Services are provided by the Primary Care Physician (PCP) or by a PCP- supervised Physician Assistant (PA), Nurse practitioner (NP), or Certified Nurse Midwife, as the Medical Home. Coordination of carved out and linked services are considered basic case management services.
Beneficiary Assignment	The act of the California Department of Health Care Services (DHCS) or DHCS' enrollment contractor of notifying a beneficiary in writing of the health plan in which the beneficiary shall be enrolled if the beneficiary fails to timely choose a health plan. If, at any time, the beneficiary notifies DHCS or DHCS' enrollment contractor of the beneficiary's health plan choice, such choice shall override the beneficiary assignment and be effective as provided in Exhibit A, Attachment 16, Provision 2 of KHS' contract with DHCS.
Beneficiary Identification Card (BIC)	A permanent plastic card issued by the State to Medi-Cal recipients that is used by facilities and providers to verify Medi-Cal eligibility and health plan enrollment.
Business Associate	A person or organization that performs a function or activity on behalf of KHS but is not a KHS employee. A Business Associate can also be a Covered Entity in its own right.
California Advancing and Innovating Medi-Cal (CalAIM)	A long-term commitment to transform and strengthen Medi-Cal, offering Californians a more equitable, coordinated, and person-centered approach to maximizing their health and life trajectory.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal

Term	Definition
	audits or monitoring activities by KHS, the State or Federal oversight agency, or designated representatives. Delegates may be required to complete CAPs to ensure they are in compliance with statutory, regulatory, contractual, KHS policy, and other requirements identified by KHS and its regulators.
Capitation	A set amount of money received or paid out; it is based on membership rather than on services delivered and usually is expressed in units of per member per month (PM/PM) and may be varied by such factors as age and health status of the enrolled member.
Capitation Rate	The percentage of the gross Capitation Payment that KHS receives from DHCS on behalf of Members for the delivery of Covered Services.
Care Coordination	Services which are included in Basic Case Management, Complex Case Management, Comprehensive Medical Case Management Services, Person Centered Planning and Discharge Planning, and are included as part of a functioning Medical Home.
Carve-out	A service that is covered under Medi-Cal and restricted from MCP coverage according to the DHCS contract.
Case Management	A collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet a Member's health needs through communication and available resources to promote quality cost-effective outcomes. This generally is a dedicated function in the utilization department.
Catastrophic Coverage Limitation	The date beyond which Contractor is not at risk, as determined by the Director, to provide or make reimbursement for illness of or injury to beneficiaries which results from or is greatly aggravated by a catastrophic occurrence or disaster, including, but not limited to, an act of war, declared or undeclared, and which occurs subsequent to enrollment.
California Children Services (CCS)	Services authorized by the CCS program for the diagnosis and treatment of the CCS eligible conditions of a specific Member.
CCS Eligible Condition	Means a physically handicapping condition defined in Title 22 CCR Section 41800.

Term	Definition
CCS Program	Public health program which assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of 21 years who have CCS eligible conditions.
Center of Excellence	Facilities that are approved by the California Department of Health Care Services (DHCS) or the Centers for Medicare and Medicaid (CMS) to provide specific transplant services.
Claims and Eligibility Real-Time System (CERTS)	Claims and Eligibility Real-Time System - the mechanism for verifying a recipient's Medi-Cal or County Medical Services Program (CMSP) eligibility by computer.
Children's Health and Disease Prevention (CHDP)	Children's Health and Disease Prevention.
Chronic Health Condition	A condition with symptoms presents for three (3) months or longer. Pregnancy is not included in this definition.
Client ID Number (CIN)	Client ID number.
Claims Resubmission	The process by which a Provider requests PHC to re-review an initial claim outcome.
Clean Claim	A claim for Covered Services that has no defect, impropriety, or particular circumstance requiring special treatment that prevents timely payment within thirty (30) calendar days after receipt of such claim.
Clinical Trials	Trials certified to meet the qualifying criteria and funded by National Institute of Health, Centers for Disease Control and Prevention, Food and Drug Administration (FDA), Department of Veterans Affairs, or other associated centers or cooperative groups funded by these agencies. Criteria for Clinical Trials include the following characteristics: 1. The principal purpose of the Clinical Trial is to test if the intervention potentially improves a participant's health outcomes; 2. The Clinical Trial is well supported by available scientific and medical information or is intended to clarify or establish the health outcomes of interventions already in common clinical use;

Term	Definition
	3. The Clinical Trial does not unjustifiably duplicate existing studies; 4. The Clinical Trial is designed appropriately to answer the research question being asked in the trial; 5. The Clinical Trial is sponsored by a credible organization or individual capable of successfully executing the proposed Clinical Trial; 6. The Clinical Trial complies with federal regulations relating to the protection of human subjects; and 7. All aspects of the Clinical Trial are conducted according to the appropriate standards of scientific integrity.
Closed Panel	A Primary Care Provider (PCP) who has requested that new members not be assigned to their practice, or whose maximum number of assigned members has been reached.
Centers for Medicare and Medicaid Services (CMS)	Centers for Medicare and Medicaid Services.
Coordination of Benefits (COB)	An agreement that uses language developed by the National Association of Insurance Commissioners and prevents double payment for services when a subscriber has coverage from two or more sources. The agreement gives the order for what organization has primary responsibility for payment and what organization has secondary responsibility for payment. KHS is the payer of last resort in most cases.
Code of Conduct	The statement setting forth the principles and standards governing KHS' activities to which KHS' Board of Directors, employees, contractors, and agents are required to adhere.
Cold-Call Marketing	Means any unsolicited personal contact by KHS with a potential Member for the purpose of marketing (as identified within the definition of Marketing).
Complex Case Management	The systematic coordination and assessment of care and services provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. Complex Case Management includes Basic Case Management.

Term	Definition
Comprehensive Medical Case Management Services	Services provided by a Primary Care Provider in collaboration with the Contractor to ensure the coordination of Medically Necessary health care services, the provision of preventive services in accordance with established standards and periodicity schedules and the continuity of care for Medi-Cal enrollees. It includes health risk assessment, treatment planning, coordination, referral, follow-up, and monitoring of appropriate services and resources required to meet an individual's health care needs.
Contracting Providers	A physician, nurse, technician, teacher, researcher, hospital, home health agency, nursing home, or any other individual or institution that contracts with KHS to provide medical services to Members.
Cost Avoid	Contractor requires a provider to bill all liable third parties and receive payment or proof of denial of coverage from such third parties prior to Contractor paying the provider for the services rendered.
Covered Entity	A health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a transaction covered by Title 45, Code of Federal Regulations, Section 160.
Credentialing	The recognition of professional or technical competence. The process involved may include registration, certification, licensure and professional association membership.
Criteria	Clinical statements that help determine the appropriateness of a proposed medical intervention. Criteria are an objective tool used to support a clinical rationale for decision-making and are an integral component of a utilization management program. Criteria also aid in protecting against over-utilization and under-utilization of clinical resources. Criteria are: 1. Clinically based on best practice, clinical data. and medical literature; 2. Patient-specific, allowing for each patient's presentation to be considered; and 3. Objective, rule-based, and reliable, allowing for consistently replicable reviews.
Community Support Services (CSS)	A program under CalAIM, offering "Community Supports," such as housing supports and medically tailored meals, which will play a fundamental role in meeting enrollees' needs for health hand health-related services that address social drivers of health.

Term	Definition
Delivery	A live birth that generates a Vital Record for the State of California.
Department of Health and Human Services (DHHS)	A federal agency responsible for the management of the Medicaid Program.
Department of Health Care Services (DHCS)	A single State Department responsible for the administration of the Federal Medicaid (referred to as Medi-Cal in California) Program, CCS, CHDP, and other health related programs.
Diagnosis of AIDS	A clinical diagnosis of AIDS that meets the most recent communicable disease surveillance case definition of AIDS established by the federal Centers for Disease Control and Prevention (CDC), United States Department of Health and Human Services, and published in the Morbidity and Mortality Weekly Report (MMWR) or its supplements, in effect for the month in which the clinical diagnosis is made.
Dietitian/Nutritionist	A person who is registered or eligible for registration as a Registered Dietitian by the Commission on Dietetic Registration (Business and Professions Code, Chapter 5.65, Sections 2585 and 2586).
Discharge Planning	Planning that begins at the time of admission to a hospital or institution to ensure that necessary care, services and supports are in place in the community before individuals leave the hospital or institution in order to reduce readmission rates, improve Member and family preparation, enhance Member satisfaction, assure post-discharge follow- up, increase medication safely and support safe transitions.
Disenrollment	The process of termination of coverage. Termination of coverage usually occurs when the KHS member's Medi-Cal eligibility status has changed to a Share of Cost (SOC) benefit, or the member is no longer eligible for Medi-Cal benefits. A member may also choose to change to the other Medi-Cal Managed Care Plan within the county. (See also Mandatory Disenrollment)
Department of Mental Health (DMH)	A State agency, in consultation with the California Mental Health Directors Association (CMHDA) and California Mental Health Planning Council, which sets policy and administers for the delivery of community based public mental health services statewide.

Term	Definition
Department of Managed Health Care (DMHC)	A state agency governing managed health care plans, sometimes referred to as Health Maintenance Organizations (HMO) and is responsible for enforcing the Knox-Keene Health Care Service Plan Act of 1975 and other related laws and regulations.
Disproportionate Share Hospital (DSH)	A health facility licensed pursuant to Health and Safety Code, Chapter 2, Division 2, to provide acute inpatient hospital services, which is eligible to receive payment adjustments from the State pursuant to Welfare and Institutions Code, Section 14105.98.
External Accountability Set (EAS)	A set of HEDIS® and DHCS-developed performance measures selected by DHCS for evaluation of health plan performance.
Enhanced Care Management (ECM)	A program under CalAIM that focuses on person-centered care management provided to the highest-need Medi-Cal enrollees, primarily through in-person engagement where enrollees live, seek care, and choose access to services.
Eligible Beneficiary	Any Medi-Cal beneficiary residing within KHS' service area with a mandatory aid code.
Emergency Medical Condition	A medical condition that is manifested by acute symptoms of sufficient severity including severe pain such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1. Placing the health of the Member (or, if the Member is a pregnant woman, the health of the Member and her unborn child) in serious jeopardy; 2. Serious impairment to bodily functions; or 3. Serious dysfunction of any bodily organ or part.
Emergency Services	Covered Services furnished by a Provider that are needed to evaluate or stabilize an Emergency Medical Condition.
Encounter	Any single medically related service rendered by (a) medical provider(s) to a member enrolled in KHS during the date of service. It includes, but is not limited to, all services for which KHS incurred any financial liability.
Encrypt	The process of encoding messages or information in such a way that only authorized parties can read it.

Term	Definition
Enrollment	Means the process by which an Eligible Beneficiary becomes a Member of KHS.
Explanation of Benefits (EOB)	A statement mailed to a member or covered insured explaining how and why a claim was or was not paid; the Medicare version is called an EOMB (also see ERISA).
Evidence of Coverage (EOC)	Evidence of Coverage.
External Quality Review Organization (EQRO)	A Peer Review Organization (PRO), PRO-like entity, or accrediting body that is an expert in the scientific review of the quality of health care provided to Medicaid beneficiaries in the State's Medicaid managed care plans.
Experimental Services	Drugs, equipment, procedures, or services that are in a testing phase undergoing laboratory or animal studies prior to testing in humans.
Facility	Any premise that is: 1. Owned, leased, used or operated directly or indirectly by or for the Contractor or its Affiliates for purposes related to this Contract, or 2. Maintained by a provider to provide services on behalf of the Contractor.
Facility Services	The room charge, supplies, equipment, and ancillary services associated with the provision of a medical procedure to a member in an inpatient or outpatient hospital facility or Ambulatory Surgical Center (ASC).
Federal Financial Participation (FFP)	Federal expenditures provided to match proper State expenditures made under approved State Medicaid plans.
Fee-For-Service (FFS)	A method of payment based upon per unit or per procedure billing for services rendered to a member.
FFS Medi-Cal	The component of the Medi-Cal Program which Medi-Cal providers are paid directly by the State for services not covered under the Medi-Cal Contract.
Finance Committee	Committee responsible for reviewing, approving and making recommendations to KHS' Board of Directors on all financial and contractual matters that are presented by KHS' staff in support of administrative and

Term	Definition
	management operations. It ensures KHS' financial stability by providing oversight on its budget.
Financial Performance Guarantee	Cash or cash equivalents which are immediately redeemable upon demand by DHCS, in an amount determined by DHCS, which shall not be less than one full month's capitation.
Financial Statements	Financial Statements which include a Balance Sheet, Income Statement, Statement of Cash Flows, Statement of Equity and accompanying footnotes prepared in accordance with Generally Accepted Accounting Principles.
Family Medical Leave Act (FMLA)	Family Medical Leave Act.
Formulary	A listing of drugs that a physician may prescribe. The physician is requested or required to use only formulary drugs unless there is a valid medical reason to use a non-formulary drug in which case a Treatment Authorization Request (TAR) may be submitted with supporting documentation for review and consideration of coverage.
Federally Qualified Health Center (FQHC)	An entity defined in Section 1905 of the Social Security Act (42 United States Code Section 1396d(l)(2)(B)).
Federally Qualified Health Maintenance Organization (FQHMO)	A prepaid health delivery plan that has fulfilled the requirements of the HMO Act, along with its amendments and regulations, and has obtained the Federal Government's qualification status under Section 1310(d) of the Public Health Service Act (42 USC §300e).
Full-time Equivalent (FTE)	Full-time Equivalent of one full-time employee. For example, two part-time employees are 0.5 FTE each, for a total of 1 FTE.
Fiscal Year (FY)	Any 12-month period for which annual accounts are kept. The State Fiscal Year is July 1 through June 30th. The federal Fiscal Year is October 1 through September 30.
Grievance	An oral or written expression of dissatisfaction, including any complaint, dispute, request for reconsideration, or appeal made by a Member.

Term	Definition
Health Care Options (HCO)	Program established to provide assistance to Medi-Cal beneficiaries who are required or elect to enroll in a Medi-Cal Managed Care Plan.
Homeless and Housing Incentive Program (HHIP)	An incentive program which aims to improve health outcomes and access to whole person care services by addressing housing insecurity and instability as a social determinant of health for Medi-Cal population.
Health Maintenance Organization (HMO)	An organization that is not a federally qualified HMO, but meets the State Plan's definition of an HMO including the requirements under Section 903(m)(2)(A)(ivii) of the Social Security Act. An Organization that, through a coordinated system of health care, provides or assures the delivery of an agreed upon set of comprehensive health maintenance and treatment services for an enrolled group of persons through a predetermined periodic fixed prepayment. A health plan that places at least some of the providers at risk for medical expenses, and a health plan that utilized primary care physicians as gatekeepers (although there are some HMOs that do not).
Health Effectiveness Data Information Set (HEDIS)	A set of standardized performance measures designed to provide purchasers and consumers with relevant information on health plan performance and facilitate the comparison of managed care organizations. HEDIS is sponsored, supported, and maintained by the National Committee for Quality Assurance (NCQA)
HEDIS Compliance Audit	An audit process that uses specific standards and guidelines for assessing the collection, storage, analysis, and reporting of HEDIS® measures. This audit process is designed to ensure accurate HEDIS® reporting.
Health Insurance Portability and Accountability Act (HIPAA)	Health Insurance Portability and Accountability Act. Kassebaum-Kennedy Act, also known as the Health Insurance Portability and Accountability Act of 1996 establishes national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addresses the security and privacy of health data. Adopting these standards will improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in health care.

Term	Definition
Home Health Care	Limited part-time or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech-language therapy, medical social services, Durable Medical Equipment, medical supplies, and other services.
Health Risk Assessment (HRA)	A DHCS approved mechanism or algorithm to identify newly enrolled SPD beneficiaries with higher risk and more complex health care needs. HRA surveys are administered to newly enrolled SPDs within 45 days of enrollment.
In Home Supportive Services (IHSS)	Provides in-home services to Seniors and Persons with Disabilities (SPD).
Indian Health Programs	Facilities operated with funds from the Indian Health Service (IHS) under the Indian Self- Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area. (See Title 22, §55000.)
International Classification of Diseases, 9th revision, clinical modification (ICD-9 CM)	The classification of disease by diagnosis codified into 6-digit numbers. (ICD-9 CM will be replaced by ICD-10
Intermediate Care Facility (ICF)	An facility that is licensed as an ICF by DHCS or a hospital or skilled Nursing Facility which meets the standards specified in Title 22 CCR §51212 and has been certified by DHCS for participation in the Medi-Cal program.
Initial Health Appointment (IHA)	A tool designed to identify potential critical health factors and that is completed by a Member during initial enrollment period. The weighted scoring of the answers stratifies health interventions based on the overall score.
Independent Medical Review (IMR)	A program that was created by the California Legislature to provide health plan members the opportunity for an objective review of a request for services or treatment that was denied, modified or delayed by the health plan. If the member's issue qualifies for an IMR, the review performed by doctors outside of the member's health plan at the expense of the health plan.
Informed Consent	The process by which a treating Provider informs a Member or a Member's Authorized Representative about the procedure, indications, contraindications, significant risks, alternate treatment approaches, and

Term	Definition
	answers questions regarding the procedure prior to the procedure being performed.
Independent Practice Association (IPA)	An organization that has a contract with a managed care plan to deliver services in return for a single capitation rate. The IPA in turn contracts with individual providers to provide the services either on a capitation basis or on a fee-for-service basis.
Incentive Payment Programs (IPP)	Incentive Programs that are intended to support the implementation, expansion of ECM & CSS programs and infrastructure development of these programs.
Joint Commission on the Accreditation of Health Care Organizations (JCAHO)	An organization composed of representatives of the American Hospital Association, the American Medical Association, American College of Physicians, the American College of Surgeons, and the American Dental Association. JCAHO provides health care accreditation and related services that support performance improvement in health care organizations.
Knox-Keene Health Care Service Plan Act of 1975	The law that regulates HMOs and is administrated by the DMHC, commencing with Section 1340, Health and Safety Code.
Letter of Agreement (LOA)	A short term agreement with a non-par provider for services to a member.
Limited Data Set	Protected Health Information that uses the indirect identifiers (State, town or city, zip codes, dates of service, birth, and death) and excludes direct identifiers of the Member or the Member's relatives, employers, or household members.
Line of Business (LOB)	A health plan that is set up as a line of business within another, larger organization usually an insurance company. This legally differentiates it from a freestanding company or a company set up as a subsidiary. It may also refer to a unique product type (e.g., Medicaid) within a health plan.
Long Term Care (LTC)	A variety of services that help Members with health or personal needs and activities of daily living over a period of time. Long Term Care may be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities.
Managed Health Care	A system of health care delivery managing the cost of health care, the quality of that health care, and the access to that care. Common denominators include a

Term	Definition
	panel of contracted providers that is less than the entire universe of available providers, some type of limitations on benefits to subscribers who use non-contracted providers (unless authorized to do so), and some type of authorization system. Managed health care is actually a spectrum of systems, ranging from so-called managed indemnity, through PPOs, POS, open panel HMOs, and closed panel HMOs.
MBC	Medical Board of California: - The state agency that licenses medical doctors, investigates complaints, disciplines those who violate the law, conducts physician evaluations, and facilitates rehabilitation where appropriate.
(Managed Care Plan) MCP	A generic term applied to a managed care plan. At times referred to by the term HMO as it encompasses plans that do not conform exactly to the strict definition of an HMO.
Marketing	Any activity conducted by or on behalf of KHS where information regarding the services offered by KHS is disseminated in order to persuade or influence Medi-Cal beneficiaries to enroll. Marketing also includes any similar activity to secure the endorsement of any individual or organization on behalf of KHS.
Marketing Materials	Materials produced in any medium, by or on behalf of KHS that can reasonably be interpreted as intended to market to potential enrollees.
Marketing Representative	A person who is engaged in marketing activities on behalf of KHS.
Medi-Cal Eligibility Data System (MEDS)	The automated eligibility information processing system operated by the State which provides on-line access for recipient information, update of recipient eligibility data and on-line printing of immediate need beneficiary identification cards.
Medical Home	A place where a member's medical information is maintained and care is accessible, continuous, comprehensive and culturally competent. A Medical Home shall include at a minimum: a Primary Care Provider (PCP) who provides continuous and comprehensive care; a physician-directed medical practice where the PCP leads a team of individuals who collectively take responsibility for the ongoing care of a member; whole person orientation where the PCP is

Term	Definition
	responsible for providing all of the member's health care needs or appropriately coordinating care; optimization and accountability for quality and safety by the use of evidence-based medicine, decision support tools, and continuous quality improvement; ready access to assure timely preventive, acute and chronic illness treatment in the appropriate setting; and payment which is structured based on the value of the patient-centered medical home and to support care management, coordination of care, enhanced communication, access and quality measurement services. This definition can change to include all standards set forth in W&I Code 14182(c)(13)(B).
Medical Loss Ratio	The ratio between the cost to deliver medical care and the amount of money that was taken in by a plan. Insurance companies often have a medical loss ratio of 92% or more; tightly managed HMOs may have a medical loss ratio of 75% to 85%, although the overhead (or administrative cost ratio) is concurrently higher. The medical loss ratio is dependent on the amount of money brought in as well as the cost of delivering care; thus, if the rates are too low, the ratio may be high, even though the actual cost delivering care is not really out of line.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury or to improve the functioning of a malformed body member. Social Security Act Title XVIII 1862(a)(1)(A); when determining the Medical Necessity of Covered Services for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the standards set forth in Title 22 CCR §§51340 & 51340.1.
Medical Records	Written documentary evidence of treatments rendered to plan members.
Member	Any Eligible Beneficiary who is enrolled in KHS' plan.
Member Appeal	A request for review of a request for a service or treatment that has been denied, modified or delayed.

Term	Definition
Mental Health Provider	A person or entity that is licensed, certified, or otherwise recognized or authorized under state law governing the healing arts to provide Mental Health Services and that meets the standards for participation in the Medicare program. Mental Health Providers include clinics, hospital outpatient departments, certified residential treatment facilities, Skilled Nursing Facilities, psychiatric health facilities, hospitals, and licensed mental health professionals, including psychiatrists, psychologists, licensed clinical social workers, marriage, family and child counselors, and registered nurses authorized to provide Mental Health Services.
Member Evaluation Tool (MET)	Information collected from a health information form completed by beneficiaries at the time of enrollment by which they may self-identify disabilities, acute and chronic health conditions, and transitional service needs. KHS shall receive the MET from the enrollment broker with the enrollment file and shall use the MET for early identification of members' healthcare needs. For newly enrolled SPD beneficiaries KHS must use the MET as part of the health risk assessment (HRA).
Mid-Level Practitioner	A Registered Nurse Practitioner (RNP), Nurse Practitioner (NP), Certified Nurse Midwife (CNM), Physician Assistant (PA), Certified Registered Nurse Anesthetist (CRNA), Optometrist, Acupuncturist, Licensed Clinical Social Worker (LCSW), or Chiropractor.
Minimum Performance Level	Refers to a minimum requirement performance of KHS on each of the External Accountability Set measures.
Minimum Necessary	The principle that, to the extent practical, individually identifiable health information should be disclosed or used only to the extent needed to support the purpose of the disclosure or use, including Payment and Health Care Operations.
Minor Consent Services	Covered Services of a sensitive nature which minors do not need parental consent to access, related to: 1. Sexual assault, including rape. 2. Drug or alcohol abuse for children 12 years of age or older. 3. Pregnancy. 4. Family planning.

Term	Definition
	5. Sexually transmitted diseases (STDs), designated by the Director, in children 12 years of age or older. 6. Outpatient mental health care for children 12 years of age or older who are mature enough to participate intelligently and where either (1) there is a danger of serious physical or mental harm to the minor or others or (2) the children are the alleged victims of incest or child abuse.
Midlevel Practitioner (MLP)	A physician's assistant, clinical nurse practitioners, nurse midwives (Non-Physician Medical Practitioners).
Medi-Cal Managed Care Division (MMCD) Policy Letter or All Plan Letter	A document that has been dated, numbered, and issued by the Medi-Cal Managed Care Division, and provides clarification of Contractor's obligations pursuant to this Contract, and clarifies mandated changes in State or federal statutes or regulations, or pursuant to judicial interpretation, but does not add new obligations to the contract.
National Committee on Quality Assurance (NCQA)	A not-for-profit organization responsible for evaluating and publicly reporting on the quality of managed care plans.
NCQA Licensed Audit Organization	Is an entity licensed to provide auditors certified to conduct HEDIS® Compliance Audits.
Newborn Child	A child born to a member during her membership or the month prior to her membership.
Non-Contracted Provider	A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of PHC or a Physician Group.
Non-Emergency Medical Transportation	Ambulance, litter van and wheelchair van medical transportation services when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care, per Title 22 CCR §§51323, 51231.1, and 51231.2, rendered by licensed providers.
Non-Medical Transportation	Transportation of members to medical services by passenger car, taxicabs, or other forms of public or private conveyances provided by persons not registered as Medi-Cal providers. Does not include the transportation of sick, injured, invalid, convalescent,

Term	Definition
	infirm, or otherwise incapacitated members by ambulances, litter vans, or wheelchair vans licensed, operated and equipped in accordance with State and local statutes, ordinances or regulations.
Non-Par	A shorthand term for a non-participating provider (i.e. one who has not signed an agreement with a plan to provide services).
Not Reported	1) Contractor calculated the measure but the result was materially biased; 2) Contractor did not calculate the measure even though a population existed for which the measure could have been calculated; and/or, 3) Contractor calculated the measure but chose not to report the rate.
Notice of Privacy Practices (NPP)	Notice provided to a Member that describes PHC's practices in the use and disclosure of Protected Health Information, Member rights, and PHC legal duties with respect to Protected Health Information.
Nurse	A person licensed by the California Board of Nursing as, at least, a Registered Nurse (RN).
Other Health Care (OHC)	The responsibility of an individual or entity, other than KHS or the member, for the payment of the reasonable value of all or part of the healthcare benefits provided to a member. Such OHCs may originate under any other State, Federal or local medical care program or under other contractual or legal entitlement, including, but not limited to, a private group or indemnification program. This responsibility may result from a health insurance policy or other contractual agreement or legal obligation, excluding tort liability.
Open Panel	A contracted PCP whose member assignment has not reached the maximum allowed or who has not requested for his/her panel to be closed or restricted.
Out-of-Area	Outside of the Service Area.
Out-of-Network	Outside of the selected Physician Group's participating provider network within the Service Area.
Outpatient Care	Treatment provided to a member who is not confined in a health care facility.

Term	Definition
Pay for Performance (P4P)	A program that incentivizes Primary Care Providers (PCPs) to improve quality of care in MCAS and other quality measures
Pharmacy & Therapeutics Committee (P&T Committee)	Committee monitors the KHS Formulary, oversees medication prescribing practices by contracting providers, assesses usage patterns by members and assists with study design and clinical guidelines development.
Physician Advisory Committee (PAC)	Committee serves as an advisor to the Board of Directors on health care issues, peer review, provider discipline and credentialing/recredentialing decisions. This committee is responsible for reviewing provider grievances and/or appeals, provider quality issues, and other peer review matters as directed by the KHS Chief Medical Officer or designee.
Par Provider	A shorthand term for participating provider (i.e. one who has signed an agreement with a plan to provide services).
Pharmacy Benefits Manager (PBM)	A contracted entity that processes pharmacy claims for an MCP or other health plan.
(Primary Care Provider) PCP	A person responsible for supervising, coordinating, and providing initial and primary care to patients including initiating referrals and maintaining the continuity of patient care. A PCP may be a physician or non-physician medical practitioner.
Pediatric Sub-acute Care	Health care services needed by a person who is under 21 years of age who uses a medical technology that compensates for the loss of vital bodily function. Medical Necessity criteria are described in the Physician's Manual of Criteria for Medi-Cal Authorization.
Public Employee Retirement System (PERS)	Public Employee Retirement System.
Person-Centered Planning	A highly individualized and ongoing process to develop individualized care plans that focus on a person's abilities and preferences. Person-centered planning is an integral part of Basic and Complex Case Management and Discharge Planning.
Pharmaceutical Services	Covered drugs and related professional services provided to a Member pursuant to applicable state and federal laws, PHC's Pharmacy Services Program

Term	Definition
	Manual, and the standard of practice of the pharmacy profession of the state in which the Pharmacy is located.
Pharmacy	An area, place, or premises licensed by the State Board of Pharmacy in which the profession of pharmacy is practiced and where Prescriptions are compounded and dispensed, and for the purpose of this policy, the licensed dispensing area of a community clinic.
Protected Health Information (PHI)	All individually identifiable health information that is transmitted electronically, maintained in any electronic medium, or transmitted or maintained in any other form or medium. This information has been created or received by Partnership Advantage and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Physician	A person duly licensed as a physician by the Medical Board of California.
Physician Incentive Plan	Any compensation arrangement between KHS and a physician or a physician group that may not directly or indirectly have the effect of reducing or limiting services provided to members under the DHCS Contract.
Per Member, Per Month (PMPM)	Specifically applies to revenue or cost for each enrolled member each month.
Policy Letter	A document that has been dated, numbered, and issued by the Medi-Cal Managed Care Division, provides clarification of MCPs' obligations pursuant to the DHCS Contract, and may include instructions to MCPs regarding implementation of mandated changes in state or federal statutes or regulations, or pursuant to judicial interpretation.
Population Health Management (PHM)	A program under CalAIM. MCPs will be required to implement a whole-system, person-centered strategy that includes assessments of each enrollee's health risks and health-related social needs, focuses on wellness and prevention, and provides care management and care transitions across delivery systems and settings.

Term	Definition
Point of Service (POS)	A plan where members do not have to choose how to receive services until they need them.
Post-Payment Recovery	KHS pays the provider for the services rendered and then uses all reasonable efforts to recover the cost of the services from all liable third parties.
Post-Stabilization Services	Covered Services that are provided after a Member is stabilized following an Emergency Medical Condition in order to maintain the stabilized condition or, under the circumstances described in 42 CFR 438.114(e) to improve or resolve the Member's condition.
Potential Enrollee	A Medi-Cal recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program but is not yet an enrollee of a specific plan.
Public Policy/Community Advisory Committee (PP/CAC)	Committee 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.
Practitioner	A licensed independent practitioner including but not limited to a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OPT), Registered Physical Therapist (RPT), Occupational Therapist (OT), Speech and Language Therapist.
Preventive Care	Health care designed to prevent disease and/or its consequences.
Primary Care	A basic level of health care usually rendered in ambulatory settings by general practitioners, family practitioners, internists, obstetricians, pediatricians, and mid-level practitioners. This type of care emphasized caring for member's general health needs as opposed to specialists focusing on specific needs.
Prior Authorization	A formal process requiring a health care to obtain advance approval to provide specific services or procedures.
Provider Grievance	An oral or written expression of dissatisfaction, including any complaint, dispute, request for reconsideration, or

Term	Definition
	appeal made by a provider. DHCS considers complaints and appeals the same as a grievance.
Public Benefit Program	Programs including the Medi-Cal program, social security disability insurance benefits, and Supplemental Security Income/State Supplementary Program for the Aged, Blind and Disabled (SSI/SSP).
Quality of Care (QC)	The degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.
Quality Improvement (QI)	Result of an effective Quality Improvement System.
(Quality Improvement/Utilization Management) QI/UM Committee	Committee oversees all covered health care services delivered to members by systematic methods that develop, implement, assess and improve the integrated health delivery systems of KHS.
Quality Improvement Projects (QIPs)	Studies selected by MCPs, either independently or in collaboration with DHCS and other participating health plans, to be used for quality improvement purposes. The studies include four phases and may occur within a 24-month time frame.
Quality Improvement Systems (QIS)	Systematic activities to monitor and evaluate the medical care delivered to members according to the standards set forth in regulations and contract language. Contractor must have processes in place, which measure the effectiveness of care, identify problems, and implement improvement on a continuing basis.
Quality of Service (QOS)	Service issue resulting in inconvenience or dissatisfaction to member.
Quality Indicators	Measurable variables relating to a specific clinic or health services delivery area which are reviewed over a period of time to screen delivered health care and to monitor the process or outcome of care delivered in that clinical area.
Remittance Advice (RA)	Remittance Advice.
Reason Codes	The alpha/numeric codes used to identify each issue within a Member's Appeal or Grievance.
Recredentialing	The process by which KHS or a delegated entity verifies the qualifications of Practitioners in order to make

Term	Definition
	determinations relating to their continued eligibility for participation in.
Referral Authorization Request	A request for a treatment, procedure, or service to be performed by a requested specialist or professional services in a health care setting, normally outside the requesting practitioner's office.
Rural Health Clinic (RHC)	An entity defined in Title 22 CCR Section 51115.5.
Safety-net Provider	Any provider of comprehensive primary care or acute hospital inpatient services that provides these services to a significant total number of Medi-Cal and charity and/or medically indigent patients in relation to the total number of patients served by the provider. Examples of safety-net providers include Federally Qualified Health Centers; governmentally operated health systems; community health centers; Rural and Indian Health Programs; disproportionate share hospitals; and public, university, rural and children's hospitals.
Sanction	Action taken by a state regulator including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on a failure to comply with statutory, regulatory, contractual, KHS policy, and other requirements related to KHS' contractual and licensure requirements.
Second Opinion	A consult visit to an Appropriately Qualified Health Care Professional in order for a Member or Contracted Provider who is treating the Member, to receive the additional information for the Member to make an informed decision regarding care and treatment.
Self-Referral	Any service or specialty appointment that a Member may schedule and obtain without having to seek a Provider's request for Direct Referral Authorization or Pre-service Review (i.e., women's health services and covered immunizations). Sensitive Services: means those services related to: a) Family Planning b) Sexually Transmitted Disease (STD) c) Human Immunodeficiency Virus testing
Serious Chronic Condition	A medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature, and that either:

Term	Definition
	1. Persists without full cure or worsens over an extended period, or 2. Requires ongoing treatment to maintain remission or to prevent deterioration.
Service Appeal	An appeal involving an organizational determination regarding provision of services prior to a member's receipt of such services (i.e. denial of a request for prior authorization of services).
Service Location	Any location at which a member obtains any health care services provided by KHS under the terms of the DHCS contract.
Skilled Nursing Facility (SNF)	As defined in Title 22CCR Section 51121(a), any institution, place, building, or agency which is licensed as a SNF by DHCS or is a distinct part or unity of a hospital, meets the standard specified in Section 51215 of these regulations (except that the distinct part of a hospital does not need to be licensed as a SNF) and has been certified by DHCS for participation as a SNF in the Medi-Cal program. Section 51121(b) further defines the term "Skilled Nursing Facility" as including terms "skilled nursing home", "convalescent hospital", "nursing home", or "nursing facility".
Share of Cost (SOC)	The amount of money a client pays or is obligated to pay before Medi-Cal pays.
Senior and Persons with Disabilities (SPD)	Medi-Cal beneficiaries who fall under specific Aged and Disabled aid codes as defined by the DHCS.
Specialty Care Center	A center that is accredited or designated by the state or federal government, or by a voluntary national health organization, as having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.
Specialty Mental Health Provider	A person or entity who is licensed, certified or otherwise recognized or authorized under state law governing the healing arts and who meets the standards for participation in the Medi-Cal program to provide specialty mental health services.
Specialty Mental Health Services	A. Rehabilitative services, including mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services,

Term	Definition
	and psychiatric health facility services; B. Psychiatric inpatient hospital services; C. Targeted Case Management; D. Psychiatric services; E. Psychologist services; and F. EPSDT supplemental Specialty Mental Health
Supplemental Security Income (SSI)	Supplemental Security Income is the program authorized by Title XVI of the Social Security Act for aged, blind, and disabled persons.
Standing Referral	A referral by a PCP to a specialist for more than one visit to the specialist, as indicated in the treatment plan, if any, without the PCP having to provide a specific referral for each visit.
State	In the context of discussion concerning the regulatory requirements of KHS, means the State of California.
Stop Loss	A form of reinsurance that provides protection for medical expenses above a certain limit, generally on a year- by-year basis. This may apply to an entire health plan or to any single component. For example, the health plan may have stop-loss reinsurance for cases that exceed $100,000. After a case hits $100,000, the plan receives 80% of expenses in excess of $100,000 back from the reinsurance company for the rest of the year. Another example would be the plan providing a stop-loss to participating physicians for referral expenses over $2,000. When a case exceeds that amount in a single year, the plan no longer deducts those costs from the physician's referral pool for the remainder of the year.
Subacute Care	As defined in Title 22 CCR Section 51124.5, a level of care needed by a patient who does not require hospital acute care but who requires more intensive licensed skilled nursing care than is provided to the majority of patients in a SNF.
Subcontract	A written agreement entered into by KHS with any of the following: A. A provider of health care services who agrees to furnish covered services to members. B. Any other organization or person(s) who agree(s) to perform any administrative function or service for KHS specifically related to fulfilling KHS' obligations to the DHCS under the terms of the DHCS contract.

Term	Definition
Sub-Subcontractor	Any party to an agreement with a subcontractor descending from and subordinate to a subcontract, which is entered into for the purpose of providing any goods or services connected with the obligations under KHS' contract with the DHCS.
Treatment Authorization Request (TAR)	A request for the prior authorized coverage for a non-formulary or formulary restricted drug by a provider and is usually submitted by the pharmacy that the member utilizes for prescription fills.
Targeted Case Management (TCM)	Services which assist Medi-Cal members within specific target groups to gain access to needed medical, social, educational and other services. In prescribed circumstances, TCM is available as a Medi-Cal benefit as a discrete service, as well as through state or local government entities and their contractors.
Terminal Illness	An incurable or irreversible condition that has a high probability of causing death within one (1) year or less.
Tertiary healthcare	Specialized consultative care, usually on referral from primary or secondary medical care personnel, by specialists working in a center that has personnel and facilities for special investigation and treatment.
Third Party Liability (TPL)	Third Party Liability.
TPTL	The responsibility of an individual or entity other than KHS or the member for the payment of claims for injuries or trauma sustained by a member. This responsibility may be contractual, a legal obligation, or as a result of, or the fault or negligence of, third parties (e.g. auto accidents or other personal injury casualty claims or Workers' Compensation appeals).
Traditional Provider	Any physician who has delivered services to Medi-Cal beneficiaries within the last six months either through FFS Medi-Cal or a MCP. The term includes physician and hospital providers only, either profit or non- profit entities, publicly or non-publicly owned and operated.
Transitional Medi-Cal	Persons discontinued from AFDC due to loss of 30 1/3 or increased earnings that will continue to receive Medi-Cal with no share of cost for at least 8 months and possibly up to 14 months.
Treatment	Activities undertaken on behalf of a member including the provision, coordination, or management of health care and related services; the referral to, and

Term	Definition
	consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Un-Bundling	The practice of a provider billing for multiple components of service that were previously included in a single fee. For example, if dressings and instruments were included in a fee for a minor procedure, the fee for the procedure remains the same, but there are now additional charges for the dressings and instruments. Unprocessable Claim: Any claim that: 1. Is incomplete or is missing required information; or 2. Contains complete and necessary information, however, the information provided is invalid.
Urgent Care	Services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (i.e. sore throats, fever, minor lacerations, and some broken bones).
Utilization Review	The process of evaluating the necessity, appropriateness, and efficiency of the use of medical services, procedures and Facilities.
Vaccines for Children (VFC)	Federally funded program that provides free vaccines for eligible children (including all Medi-Cal eligible children aged 18 or younger) and distributes immunization updates and related information to participating providers. Providers contracting with KHS are eligible to participate in this program.
Vision Services Plan (VSP)	A KHS contracted provider delegated to provide optometry services to KHS members
Working day (s):	Means State calendar (State Appointment Calendar, Standard 101) working day (s).