KERN HEALTH SYSTEMS

REGULAR MEETING OF THE QI/UM COMMITTEE

Thursday, May 26th, 2022
At
7:00 A.M.

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

The public is invited

For more information, call (661) 664-5000

Agenda

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

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

Virtual Meeting
Thursday, May 26th, 2022

7:00 A.M.

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

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

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

STAFF RECOMMENDATION SHOWN IN CAPS

PUBLIC PRESENTATIONS

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

COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

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

CA-6) QI/UM Committee Summary of Proceedings February 24th, 2022 – APPROVE

7) Physician's Advisory Committee (PAC) Summary of Proceedings 1st Quarter 2022– RECEIVE AND FILE
- February 2022
- March 2022

CA-8) Public Policy and Community Advisory Summary of Proceedings 1st Quarter 2022 RECEIVE AND FILE
- March 2022

Pharmacy Reports

CA-9) Pharmacy TAR Log Statistics 1st Quarter 2022– RECEIVE AND FILE

Quality Improvement Department Summary Reports

10) Quality Improvement Department Summary Reports 1st Quarter 2022– APPROVE
- COVID-19 Updates
- Potential Quality Issues (PQI) Notifications
  - PQI Audit Summary
- Facility Site Reviews (FSRs)
  a. Initial Full Site Reviews
  b. Periodic Full Site Reviews
  c. Interim/ Focus Reviews
- Quality Improvement Projects
  a. Performance Improvement Projects (PIPs)
  b. MCAS Member Incentive and Engagement Project
  c. SWOT Project
- MCAS Accountability Set (MCAS) Updates
- Policy and Procedure and other program documents

UM Department Summary Reports

11) Combined UM Reporting 1st Quarter 2022– APPROVE
- Executive Summary
- VSP DER Effectiveness Report – APPROVE
- VSP- Medical Data Summary- APPROVE
- Policies and Procedures

Kaiser Organization Summary Reports

CA-12) Kaiser Reports **(PROPRIETARY AND CONFIDENTIAL)**

- KFHC APL Grievance Report-1st Quarter 2022– RECEIVE AND FILE
- KFHC Volumes Report -1st Quarter 2022– RECEIVE AND FILE
- Kaiser Reports will be available upon Request

Member Services Department Summary Reports

13) Grievance Operational Board Update – APPROVE

- Executive Summary
- 1st Quarter 2022

14) Grievance Summary Reports – APPROVE

- Executive Summary
- 1st Quarter 2022

Provider Network Management Department Summary Reports

15) Re-credentialing Report 1st Quarter 2022– APPROVE

CA-16) Board Approved New Contracts Report – RECEIVE AND FILE

CA-17) Board Approved Providers Report – RECEIVE AND FILE

CA-18) Provider Relations Network Review Report 1st Quarter 2022– RECEIVE AND FILE

- Executive Summary

Policies and Procedures

19) 2.70- I Potential Quality of Care Issues- RECEIVE AND FILE

20) 2.72- I Provider Preventable Conditions- RECEIVE AND FILE

21) 3.22-P Referral and Authorization Process HP- RECEIVE AND FILE

22) 3.25-P Prior Authorization Services and Procedures- RECEIVE AND FILE

Health Education Department Summary Report

CA-23) Health Education Activity Report 1st Quarter 2022-APPROVE

- Executive Summary

ADJOURN MEETING TO THURSDAY JULY 28TH,2022, @ 7:00 A.M.
IF COMMITTEE APPROVES DATE

AMERICANS WITH DISABILITIES ACT
(Government Code Section 54953.2)

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

APPENDIX

1. QI_UM Committee Meeting Cover Sheet- Page 1
2. QI_UM Agenda February 24th, 2022 - Pages 2-5
3. QI/UM Committee Summary of Proceedings –Pages 6-10
4. Physician's Advisory Committee (PAC) Summary of Proceedings- Pages 11-17
5. Public Policy and Community Advisory Summary of Proceedings- Pages 18-20
6. Pharmacy TAR Log Statistics Reports- Pages 21-23
7. Quality Improvement Department Summary Reports- Pages 24-60
8. Combined UM Report- Pages 61- 95
9. Kaiser Reports- Page 96
10. Member Services Reports – Pages 97-106
11. Provider Relations Reports- Pages 107-179
12. QI_UM Policy and Procedures-Pages 180-226
13. Health Education- Pages 227-248

SUMMARY OF PROCEEDINGS

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

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

Virtual Meeting
Thursday, February 24, 2022
7:00 A.M.

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

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

Members Absent: Jennifer Ansolabehere, PHN; Philipp Melendez, MD

Meeting was called to order at 7:06 A.M. by Dr. Martha Tasinga, M.D., Chief Medical Officer

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

STAFF RECOMMENDATION SHOWN IN CAPS

PUBLIC PRESENTATIONS

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

COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

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

3) Announcements – **N/A**

4) Closed Session – **N/A**

5) CMO Report – **Dr. Martha Tasinga gave committee overview of the current happenings in our Population Health Management Program:**

- **Major Organ Transplant- over 100 members getting evaluated for transplant, are on the transplant waitlist, or have received their transplant**
- **Transition of Care- revamped our TOC program to include an internal Case Management process to help prevent readmissions**
- **We're working on establishing other PHM programs like the Potentially Preventable Admissions (PPA) program, Diabetes program, Congestive Heart Failure (CHF)—etc.**

CA-6) QI/UM Committee Summary of Proceedings November 11th, 2021 – APPROVED
Arya-Kennedy: All Ayes

7) Physician's Advisory Committee (PAC) Summary of Proceedings 4th Quarter 2021–RECEIVED AND FILED
Arya-Kennedy: All Ayes
- October 2021
- November 2021
- December 2021

CA-8) Public Policy and Community Advisory Summary of Proceedings 4th Quarter 2021 – APPROVED
Arya-Kennedy: All Ayes

CA-9) Pharmacy & Therapeutics Committee Summary of Proceedings 4th Quarter 2021 - RECEIVED AND FILED
Arya-Kennedy: All Ayes

Pharmacy Reports – Arya-Kennedy: All Ayes
CA-10) Pharmacy TAR Log Statistics 4th Quarter 2021– RECEIVED AND FILED

- Executive Summary

Quality Improvement Department Summary Reports
Kennedy-Arya: All Ayes
11) Quality Improvement Department Summary Reports 4th Quarter 2021– APPROVED

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

Ms. Jane Daughenbaugh, Director of Quality Improvement, reviewed with the committee the executive summary for the 4th quarter QI Department reports. Some key points discussed were:

1. **COVID-19 Updates**
    - **There was a significant increase of new COVID cases in the last week of December 2021, compared to earlier in the quarter.**
2. **Potential Inappropriate Care (PIC) Notifications**
    - **There was a 32% increase in PIC notifications compared to previous quarter. This increase is due to assigning PICs to a nurse sooner in the receipt process which reflects more real time volumes.**
3. **Facility Site Reviews (FSR) and Medical Record Review (MRR) Description**
    - **Special DHCS Site Review Audit: DHCS conducted a random Full Scope Site Review Audit on December 7th-9th for nine KHS Providers. KHS's certified Master Trainer, QI Director and QI Manager attended the audits to provide support to our providers as well as the DHCS auditors.**

4. **Quality Improvement Projects**
    - **Health Care Disparity in WCV (Well Care Visits ages 3-21) focusing on annual well care visits.**
    - **Child/Adolescent Health Asthma Medication Ratio (AMR) focusing on increasing the level of compliance for members 5-21 years of age by approximately 15%.**
    - **Outreach activities by the Population Health Management (PHM) team included outreached to 39 eligible members.**
5. **MCAS Committee**
    - **2022 Provider Pay-for-Performance (P4P) Program being re-structured with payouts based on "pool reimbursement" to support compliance with MCAS measures and IHA's.**
    - **Member Engagement & Rewards Program (MERP) Campaigns: The Committee approved adding Blood Lead Screening, Breast Cancer Screening, and Cervical Cancer Screening to 2022 campaigns.**
6. **MCAS Updates**
    - **The MY2021 rates we have for the 4th quarter are admin rates only and do not include medical record reviews (MRR) and supplemental data. We anticipate medical record review abstraction to begin in February 2022.**

UM Department Reports – Arya-Kennedy: All Ayes

12) Combined UM Reporting 4th Quarter 2021– APPROVED
- Executive Summary
- Policies and Procedures

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

- **Utilization Management reporting structure was changed late in the 4th Quarter.**
- **DHCS request for corrective action plan to remediate all findings. UM has been working collaboratively with KHS Health Services and Compliance departments to ensure our policies and practices are compliant with both state and federal regulatory agencies.**
- **Q4 ongoing efforts to support Cal-AIM new benefits implementations caused a great strain on the UM/HS analytical team. 2 staff members were repurposed and began training in Dec. 2021 to assist with the following programs: Major Organ Transplants; Enhanced Case Management; Community Support Services.**
- **Process Improvement Projects are going to transfer into Quarter 1 of 2022 to align with UM & KHS goals.**

Kaiser Organization Summary Reports

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

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

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

14) Grievance Operational Board Update – APPROVED

- Executive Summary
- 4th Quarter 2021

15) Grievance Summary Reports – APPROVED

- Executive Summary
- 4th Quarter 2021

Amy Carrillo, Member Services Manager, went over the Grievance reports with the committee.

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

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

CA-17) Board Approved New Contracts Report – RECEIVED AND FILED

CA-18) Board Approved Providers Report – RECEIVED AND FILED

CA-19) Provider Relations Network Review Report 4th Quarter 2021– RECEIVED AND FILED

- Executive Summary

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

Policies and Procedures – Park-Kennedy: All Ayes

20) 3.22-P Referral and Authorization Process - APPROVED

21) 3.25-P Prior Authorization Services and Procedures – APPROVED

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

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

Meeting adjourned by Dr. Martha Tasinga, M.D., Medical Director @ 8:12 A.M. to Thursday, May 26, 2022 at 7:00 A.M.

SUMMARY OF PROCEEDINGS

PHYSICIAN ADVISORY COMMITTEE (VIRTUAL) MEETING

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

Wednesday, February 2, 2022
7:00 A.M.

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

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

COMMITTEE RECONVENED

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

Members Absent: None

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

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

STAFF RECOMMENDATION SHOWN IN CAPS

PUBLIC PRESENTATIONS

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

COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

2) On their own initiative, Committee members may make an announcement or a report on their own activities. They may ask a question for clarification, make a referral to staff or take action to have staff place a matter of business on a future agenda (Gov. Code Sec. 54954.2[a])
    - **Jake Hall, Deputy Director of Provider Contracts at KHS announced we currently have 2 Physician Advisory Committee openings. One for a Family Practitioner, and other for a Practitioner at Large.**

ADJOURNED TO CLOSED SESSION @ 7:11 A.M.

CLOSED SESSION

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

Initial Applications (Comprehensive Reviews):

#11 – MD – Reprimanded by the Connecticut Medical Board for alleged medication subscribing through telemedicine platform. Provider's explanation received and reviewed in detail indicating MD immediately stopped working for telehealth company and paid civil penalties.

#12 – KD – NPDB settlement; Texas Medical Board Reprimand and Health plan termination reviewed in detail. Provider's explanations for each event received and reviewed in detail and determined provider complied and completed reprimand order and has had no further incidents and holds unrestricted California license and hospital privileges.

#13 – GL – California Nursing Board reported provider's license surrender in 2004 due to diversion of narcotics; in 2011 license was restored with 3-years' probation which was successfully completed in 2017. Provider complied and completed all probationary terms and conditions with no further incidents and holds unrestricted California license.

#14 – SR – NDPB settlement resulting in a $600K settlement alleging complications required additional surgeries and patient demise after performing laparoscopic peritoneal dialysis catheter placement. Provider's explanation was received and reviewed in detail indicating patient's co-morbidities and morbid obesity made the procedures very complicated and provider recognized complexity of the surgery immediately and called for additional assistant surgeon.

#15 PV – MBC issued 7-years' probation after provider failed to report financial records and maintain adequate records related to Smart-Lipo procedures. In 2019 license was fully restored and all probationary requirements have been completed with no further incidents. Provider indicates in their explanation she no longer performs Smart-Lipo procedures, and is only requesting network participation in Pediatrics.

Recredentialing (Comprehensive Reviews):

•Comprehensive reviews were conducted for recredentialing applications, and all were found to be related to performance indicators for grievances; however, there was no additional adverse information reported from a primary source or any malpractice case(s) that resulted in settlement or judgment made on behalf of the practitioners within the previous 5 years.

•# 4 – PRV006365 – Provider self-disclosed temporary suspension of privileges at AH-Bakersfield due to aggressive behavior. MD entered Behavior Contract and suspension was lifted. Provider explanation was received and reviewed in detail as provider acknowledged his behavior and agreed to comply with the hospital Behavior Contract.

Delegated Credentialing Activities:

•2021 - 3rd Quarter Reports: The 3rd Quarter reports were received with no significant changes in credentialing program, policies/procedures or provider network was reported.
•Tertiary Facilities Delegated Credentialing Audit Summary for 2021 was accepted as presented with no corrective action plans noted.

COMMITTEE RECONVENED TO OPEN SESSION @ 7:50 A.M.

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

5) Tertiary Facilities Delegated Credentialing Audit Summary for 2021 – APPROVED
Patel-Amin: All Ayes

6) Review KHS Policy 3.43-P Hospice Services – APPROVED
Amin-Hair: All Ayes

7) Review VSP Reports – APPROVED
Amin-Parmar: All Ayes
- **Hadassah Perez, Director of UM presented the reports, but also announced that it was agreed with the PNM department that the VSP reports will now be reported in the QI/UM Committee meetings only, and no longer be presented in PAC.**

8) Medi-Cal Pharmacy Update – DISCUSSION
- **Bruce Wearda shared how the transition has rolled out thus far. Eligibility issues, long wait times, and delayed authorization turn around were identified as major topics DHCS is working on. He shared some of the issues MCRx was experiencing. He relayed that MCRx had relaxed and suspended Drug Utilization Review (DUR) edits, and most all authorizations are being approved. These are temporary fixes.**

MEETING ADJOURNED BY DR. MARTHA TASINGA, M.D., C.M.O. @ 8:13 A.M. TO WEDNESDAY, MARCH 2, 2022 @ 7:00 A.M

AMERICANS WITH DISABILITIES ACT
(Government Code Section 54953.2)

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

SUMMARY OF PROCEEDINGS

PHYSICIAN ADVISORY COMMITTEE (VIRTUAL) MEETING

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

Wednesday, March 2, 2022
7:00 A.M.

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

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

COMMITTEE RECONVENED

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

Members Absent: None

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

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

STAFF RECOMMENDATION SHOWN IN CAPS

PUBLIC PRESENTATIONS

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

COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

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

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

CLOSED SESSION

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

Pre-Delegation Credentialing Audit Results – Confirmed

Yolanda reported the KHS PNM completed the pre-delegation credentialing audit requirements for ConferMed on 12/29/21. Additional documentation was requested regarding the status of ConferMed's additional policy updates for CR.1.-C Credentialing System Controls which are currently in review and will be submitted upon final review and approved. The KHS Provider Network Management Department found no findings during this pre-delegation audit and recommends Delegated Credentialing Agreement be extended to ConferMED for multi-specialty services (Peer to Peer E-Consults).
Motion made by Patel, seconded by Hair: All Ayes

Initial Applications (Comprehensive Reviews):

#2 – DML– NPDB settlement and Medical Board of California probation issued and completed surrounding weight loss practice in which a patient alleged prescription

caused renal disease. Provider explanation received and reviewed and there have been no further cases and provider indicates she closed her weight loss practice and only practices urgent care and emergency medicine.

#3 – L/Inc – Organizational provider self-disclosed claims/loss statement report from 01/2016 through 02/2021 reporting 51 Closed Cases and 5-Open cases. Information was received and reviewed.

Recredentialing (Comprehensive Reviews):

•Comprehensive reviews PRV033690 & PRV001409 were conducted for recredentialing applications, and all were found to be related to performance indicators for grievances; however, there was no additional adverse information reported from a primary source or any malpractice case(s) that resulted in settlement or judgment made on behalf of the practitioner within the previous five years.
•# 3 – PRV002087 – Provider is currently on 5-yrs Probation as a result of allegations related to failing to properly prescribe and document prescriptions. PA Explanation received and is in compliance with quarterly monitoring reports by the supervisor and is part of ongoing monthly monitoring.
•# 4 – PRV004853 – Provider received Public Reprimand from the Medical Board of California resulting from a medical record-keeping violation and deficiency during the transition to a new EMR. Texas Medical Board took similar action based on MBC Action. Provider explanation was received and reviewed with no further actions or incidence and is in compliance with completing the medical record keeping course.

COMMITTEE RECONVENED TO OPEN SESSION @ 7:45 A.M.

CA-4) Minutes for KHS Physician Advisory Committee meeting on February 2, 2022 – APPROVED
Amin-Patel: All Ayes

5) Review KHS Policy 3.24-P Pregnancy and Maternity Care – APPROVED
Lascano-Amin: All Ayes

MEETING ADJOURNED BY DR. MARTHA TASINGA, M.D., C.M.O. @ 8:24 A.M. TO WEDNESDAY, APRIL 6, 2022 @ 7:00 A.M

SUMMARY

PUBLIC POLICY/COMMUNITY ADVISORY COMMITTEE

KERN HEALTH SYSTEMS
2900 Buck Owens Boulevard
Bakersfield, California 93308

Regular Meeting
Tuesday, March 29, 2022

11:00 A.M.

COMMITTEE RECONVENED

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

Meeting called to order by Louie Iturriria, Director of Marketing and Public Relations, at 11:00 AM.

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

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

COMMITTEE ACTION SHOWN IN CAPS

PUBLIC PRESENTATIONS

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

PUBLIC PRESENTATIONS

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

COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

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

- **Alan Avery, Chief Operating Officer of KHS, announced that our current CEO Douglas Hayward, will be retiring July 6, 2022, and the Board of Directors is very close to deciding on who our new CEO will be. More to come on this next meeting.**

CA-3) Minutes for Public Policy/Community Advisory Committee meeting on December 14, 2021
APPROVED
Hefner-Sanchez: 11 Ayes; 2 Absent – Wood, Ochoa

CA-4) Report on March 2022 Medi-Cal Membership Enrollment
RECEIVED AND FILED
Hefner-Sanchez: 11 Ayes; 2 Absent – Wood, Ochoa

CA-5) Report on KFHC Grievance Summary for fourth quarter ending December 31, 2021
RECEIVED AND FILED
Hefner-Sanchez: 11 Ayes; 2 Absent – Wood, Ochoa

CA-6) Report on Health Education for fourth quarter ending December 31, 2021
RECEIVED AND FILED
Hefner-Sanchez: 11 Ayes; 2 Absent – Wood, Ochoa

CA-7) Report on Population Health Management for fourth quarter ending December 31, 2021
RECEIVED AND FILED
Hefner-Sanchez: 11 Ayes; 2 Absent – Wood, Ochoa

8) Proposed Appointments to the Kern Health Systems Public Policy/Community Advisory Committee
APPROVED
Hefner-Hernandez Colin: 11 Ayes; 2 Absent – Wood, Ochoa

- **Caitlin Criswell will be stepping down from the PP/CAC committee effective after today's meeting. She has been hired on at KHS as a Member Services Representative.**
- **Rukiyah Polk was voted on as a new member of the PP/CAC committee effective today. She has been a KHS member for 1 ½ years.**
- **Kaelsun Singh Tyiska was voted on as a new member of the PP/CAC committee effective today. He has been a KHS member for 7 ½ years.**

9) Report on KFHC Grievances for 4th Quarter ending December 31, 2021
RECEIVED AND FILED
Garcia-Louey: 11 Ayes; 2 Absent – Wood, Ochoa

10) Report on KFHC COVID-19 Vaccination Plan
RECEIVED AND FILED
Louey-Garcia: 11 Ayes; 2 Absent – Wood, Ochoa

- **Michelle Bravo asked the percentage of people who received a booster shot.**
- **Quon Louey asked if we have improved our minority percentages.**
- **Note: The requested information above was sent to all committee members on 04/07/22.**

11) Report on KFHC Fall 2022 Member Newsletter
RECEIVED AND FILED
Hefner-Hernandez Colin: 11 Ayes; 2 Absent – Wood, Ochoa

- **Alex Garcia suggested new idea to get member's feedback on the newsletters, such as adding a QR code on the newsletter itself.**
- **Cecelia Hernandez-Colin suggested covering the topic of hemorrhoids in a future newsletter.**
- **Beatriz Basulto suggested adding more information for the elderly population. For example, how to get the most out of their benefits, and articles of how to take care of themselves.**

Meeting adjourned by Louie Iturriria, Director of Marketing and Public Relations, at 11:58 AM to June 28, 2022 at 11:00 AM.

KERN HEALTH SYSTEMS | PROVIDER bulletin

QI Executive Summary -- Pharmacy Report – Prior Authorizations

Background

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

***Please note: Pharmacy services were carved out to Medi-Cal Rx beginning 1/1/22. Some supplies and medical devices are still processed through KFHC. This reflects those requests.

Action

For Informational Purposes Only

No items of concern identified.

Quarter/Year of Audit	2022	2022	2022	2022								
Month Audited	Jan	Feb	Mar	April								
Total TAR's for the month	151	54	48	43								
Turn Around Time Compliant	100%	100%	100%	100%								
Notice of Action Compliant	100%	100%	100%	100%								
APPROVED TAR'S												
Timeliness - Reviewed & Returned in 1 busines day	2/2	0	1/1	2/2								
Date Stamped	2/2	0	1/1	2/2								
Fax copy attached	2/2	0	1/1	2/2								
Decision marked	2/2	0	1/1	2/2								
DENIED TAR'S												
Timeliness - Reviewed & Returned in 1 business day	0	0	0	0								
Initally Denied - Signed by Medical Dir and/or Pharm	0	0	0	0								
Letter sent within time frame	0	0	0	0								
Date Stamped	0	0	0	0								
Fax copy attached	0	0	0	0								
Decision marked	0	0	0	0								
Correct form letter, per current policies used	0	0	0	0								
NOA Commentary Met	0	0	0	0								
MODIFIED TAR'S												
Timeliness - Reviewed & Returned in 1 business day	0	0	0	0								
Date Stamped	0	0	0	0								
Fax copy attached	0	0	0	0								
Decision marked	0	0	0	0								
Correct form letter, per current policies used	0	0	0	0								
NOA Commentary Met	0	0	0	0								
DUPLICATE TAR'S												
Timeliness - Reviewd & Returned in 1 business day	0	0	1/1	0								
Date Stamped	0	0	1/1	0								
Fax copy attached	0	0	1/1	0								
CANCELLED *												

Returned to Provider to submit to MCRx	125	42	28	25								

* Total number of TAR's

Kern Health Systems
Quality Improvement Department
Executive Summary
1st Quarter 2022

This report provides a summary of key activities and issues related to the Quality Improvement (QI) Department during the 1st Quarter of 2022.

I. COVID-19 Updates

There was a significant decrease in new COVID cases and hospitalizations during the 1st quarter of this year. A backlog of Provider Site and Medical Record Reviews had developed because of the pandemic. All Managed Care Plans (MCPs) experienced this and were required to submit a plan to resolve the backlog. KHS' backlog is on track to be completed no later than the end of June.

II. Potential Quality of Care (PQI) Notifications

Based on raw numbers, there was a 58% increase in PQI referrals or 51% increase using the rate per 1k members. The increase in referrals was first noticed in the 4th quarter of 2021. The increase may be due to a change in process to refer all grievances with a validated PQI to the Quality Department for a full investigation. The process change was made as part of resolving a finding during the DHCS annual audit last year related to inaccurate identification of PQIs when a grievance is received.

The rates of PQIs by Severity Level had a shift of fewer Level 0 PQIs, No Quality of Care Concern, and a higher number of Level 1 PQIs, Potential for Harm. Level 1 PQIs increased by approximately 4 ½ % and Level 0 PQIs decreased by a similar rate. This shift may be due to a change in QI RN staff and QI Medical Director staff. Initiation of PQI RN audits in Q3 of 2021 has led to increased consistency in how PQIs are processed and investigated.

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

Special DHCS Site Review Audit: DHCS conducted a random Full Scope Site Review Audit on December 7th-9th for nine KHS Providers. KHS's certified Master Trainer, QI Director and QI Manager attended the audits to provide support to our providers as well as the DHCS auditors. 7 of 8 providers had Critical Element Findings and all had standard findings. Corrective Action Plans (CAPs) were issued and completed within the required time frame.

Effective in Q4 of 2021, we changed identification in this QI Quarterly report to use DHCS' standard of 80% or higher to identify providers who passed. Prior to that, we were using 90%, meaning they had no deficiencies in Critical Elements, Pharmaceutical or Infection Control. Scoring 80% - 89% is considered a "conditional pass" and requires a CAP only for the elements that were non-compliant. A score below 80% is considered a Fail and requires a CAP for the entire site or medical record review.

All site reviews completed in the 1st quarter passed and 2 medical record reviews failed. CAPs were issued for providers with scores below 90%.

IHA's percentage for MRRs: In Q1 2022, 167 medical records reviewed. 51 out of 65 pediatric records reviewed or 78% had compliant IHAs. 86 out of 102 adult records reviewed or 84% had compliant IHAs. Education was provided to all providers with non-compliant IHAs.

IV. Quality Improvement Projects

A. ***Performance Improvement Projects:***
   1. Health Care Disparity in WCV (Well Care Visits ages 3-21) focusing on annual well care visits. Kern Pediatrics has partnered with us on this project. The overarching goal is to increase compliance with the preventive health service by 10% points. The PIP is currently in the Intervention Testing Phase.
   2. Child/Adolescent Health Asthma Medication Ratio (AMR) focusing on increasing the level of compliance for members 5-21 years of age by approximately 15%. This measure focuses on proper use of asthma controller medication versus overutilization of rescue medications. This PIP is also in the Intervention Testing Phase.

B. ***SWOT Analysis and Action Plan Project***: The current SWOT action plan is focused on the Children's health domain with actions such as conducting quarterly meetings with the top 30 KHS providers for collaboration on MCAS compliance; engaging with community based organizations to promote children's health services, etc. After discussion with our DHCS nurse consultant, we are partnering with Health Education to provide Bakersfield City School District with point of care gift cards for closing gaps in care.

C. **PDSAs**: One PDSA is focused on the Breast Cancer Screening (BCS) and to offer mobile mammography to members in rural areas near Taft. The first offering was on October 29, 2021, in Taft and a 2nd offering was delayed from March to May due to a contracting issue with the mobile mammography vendor.

   The 2nd PDSA is focused on the infant well care visits for babies 0-15 months partnering with Clinica Sierra Vista. Outcomes of the first cycle proved that live telephonic outreach was most successful. The second cycle will be expanded for more live telephonic outreach to members and appointment reminders will be sent out.

D. **COVID QIP**: The final update report for the COVID-19 Quality Improvement Project was submitted to DHCS in February and was approved and closed on March 14, 2022. The 3 Strategies successfully completed included:
   - Distribution of a COVID-19 informational flyer to Kern Behavioral Health and Recovery Services staff to distribute to KHS members they serve
   - KHS support to the Latino COVID-19 Task Force to provide vaccination pop-up clinics
   - An educational flyer for women of child-bearing age on COVID-19 virus and receiving the vaccine while pregnant or trying to become pregnant. We partnered with the Kern County Black Infant Health Program to support Black or African American women receiving this information.

V. MCAS Committee

Highlights from the committee were reviewed and discussion of the following items occurred:
- Review of Mobile Mammogram events with a recommendation to develop a Mobile Preventive Health program.

- Review of member outreach conducted for the MERP campaign in March.
- Review of MY2021 MCAS compliance rates to date. Final rates due no later than June 1st.
- Review of a new report taking a closer look by provider at MCAS results, including non-compliant members seen by their PCP within the past 90 days. The committee identified this as an opportunity for discussion at the quarterly provider meetings the QI Department is conducting.

VI. MCAS Member Engagement and Rewards Program

A Member Engagement and Rewards Program outreach campaign was conducted 3/3/22-3/11/22 and included focus on

- Initial Health Assessment (IHA),
- Prenatal & Postpartum Care (PPC-Pre & PPC-Post),
- Child and Adolescent Well-Care Visits (WCV),
- Well-Child Visits in the First 30 Months (W30),
- Chlamydia Screening in Women (CHL),
- Breast Cancer Screening (BCS),
- Cervical Cancer Screening (CCS), &
- Blood lead screening (LSC).

Results for this campaign should be available in the June 2022 report.

VI. MCAS Updates

The MCAS Audit and Rate Submission for MY2021 is underway and will wrap up by June 1st. Final rates submitted to DHCS and NCQA will be presented in the next QI-UM Committee meeting.

There are more measures meeting the Minimum Performance Level and showing improvement compared to MY2020.

Potential Quality of Care Issues (PQI) Audit

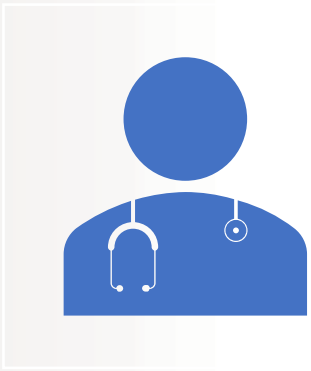
1st Quarter 2022 Summary

Presented by: Kailey Collier, RN

KERN HEALTH SYSTEMS

PQI Audit Overview

Quarterly clinical auditing process developed for monitoring of PQI reviews.



Purpose: Ensure compliance with KHS policies and procedures, and appropriate clinical assessment and documentation.

KERN HEALTH SYSTEMS

PQI Audit Process

- QI Manager conducts quarterly audits of 3 cases completed for each QI RN who performs PQI reviews.
- Audit results that do not achieve a passing score of 90%
  - QI Manager follows corresponding action plan and addresses areas of deficiency with assigned QI RN to remedy deficiencies within 5 business days.
  - Corrections to be reflected on next audit

PQI Audit Findings 1st Quarter 2022

- RNs audited: 5
- PQI cases per RN: 3
- Total cases audited: 15
- Overall scores: 100% (All RNs)

- Minor Issue:
  - 1 RN did not include a primary diagnosis for 2 of the 3 cases. These were corrected and will be an area of focus for 2nd Quarter Audit.

Policy 2.72-I, Provider Preventable Conditions, Updates

Presented by Jane Daughenbaugh, Quality Improvement Director

May 2022

KERN HEALTH SYSTEMS

Change of Policy Primary Ownership

Previously fell under Utilization Management

Due to the need to follow through with any Quality of Care issues, primary policy ownership shifted to Quality Improvement (QI)

Definition of Other Provider Preventable Conditions (OPPCs)

- Added more detail to identify what these are and who defines the conditions
  - CMS Pub 100-03 Medicare National Coverage Determinations (NCDs)– defines surgical or invasive procedures
  - 42 CFR §447.26(b) references NCDs and adds additional stipulations such as conditions identified by the State using evidence-based guidelines and had a negative impact for the beneficiary

Clarified Reporting Process

1

KHS required to report any PPC it identifies

2

Sources of information used to identify a PPC clarified

3

Hospital Acquired Conditions (HAC) list to identify PPC removed & replaced with link to CMS' ICD-10 HAC List website

Ensures most current list of conditions used

4

Reporting now done electronically through DHCS' online reporting portal

Use of pdf form no longer accepted by DHCS

Laid Out Notifications & Follow-up

QI, Claims and Compliance Leadership notified when PPC validated

Claims Department ensures payment is not made for services provided to treat impacts of the PPC

Compliance retains a copy of KHS' investigation summary and notification to DHCS for regulatory purposed.

Updated Potential Quality of Care Issues Policy 2.70-I

Updated 2.70-1 Potential Quality Issues Policy to identify a PQI referral will be received for validated PPCs

Included source of referrals related to a PPC either from the daily PPC report or from Utilization Management review work

KERN HEALTH SYSTEMS

QUALITY IMPROVEMENT DEPARTMENT

QUATERLY QI-UM COMMIITTEE REPORT

Q1 2022

KERN HEALTH SYSTEMS
Quality Improvement Department Quarterly QI-UM Committee Report
Q1 2022

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

I. COVID-19 Updates
II. Potential Inappropriate Care (PIC) Notifications
III. Site & Medical Record Reviews
    a. Initial Site & Medical Record Reviews
    b. Periodic Site & Medical Record Reviews
    c. Critical Elements
    d. Initial Health Assessments
    e. Interim Reviews
    f. Site Review Corrective Action Plans (CAPs)
IV. Quality Improvement Projects
    a. Performance Improvement Projects (PIPs)
    b. Member Engagement & Rewards Program (MERP)
    c. SWOT Action Plan
    d. PDSA's
    e. COVID QIP
V. Managed Care Accountability Set (MCAS) Updates
VI. Policy and Procedures and other program documents
VII. Appendix A: March 2022 MCAS Committee Minutes

I. COVID-Update:

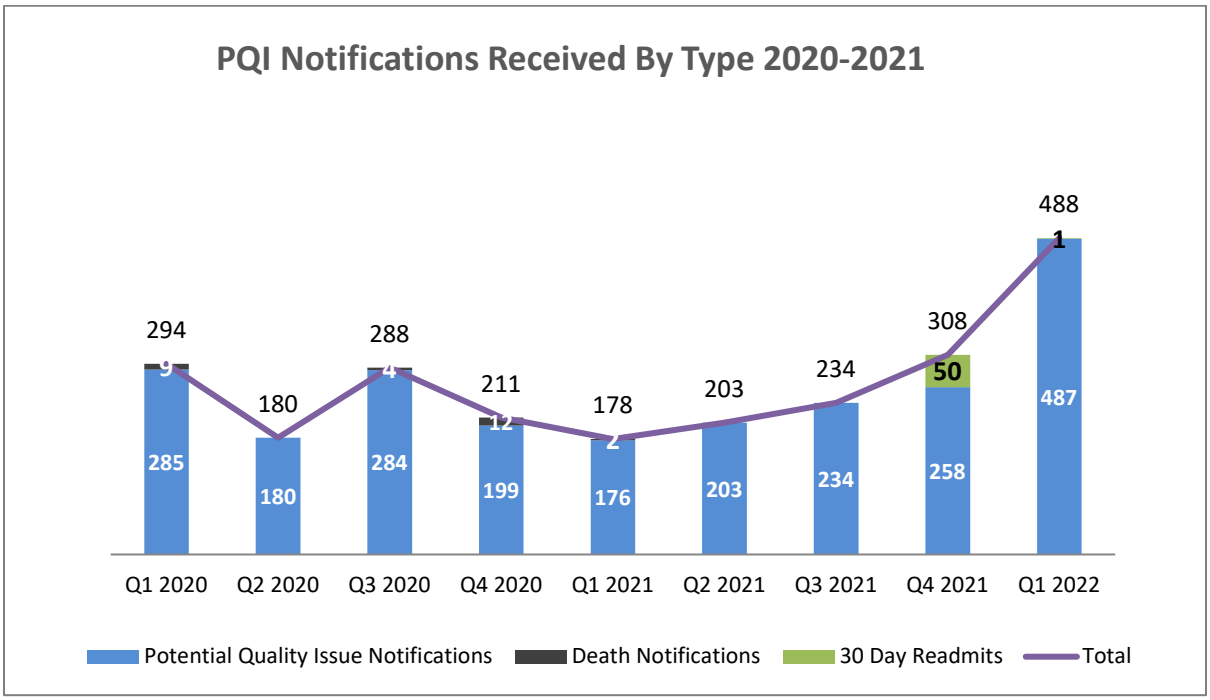
Per Kern County Public Health Department, there was a significant decrease in the new COVID cases by end of Q1 2022 compared to previous quarter. The rate of COVID cases have been inconsistent over the course of the month. However, the COVID cases are declining. Compliance with most MCAS measures continues to be a challenge.

The QI Department is continuing to complete the backlog of facility site and medical record reviews resulting from the pandemic. We continue to anticipate resolving the backlogs by end of June 2022.

II. Potential Quality of Care Issue (PQI) Notifications:

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

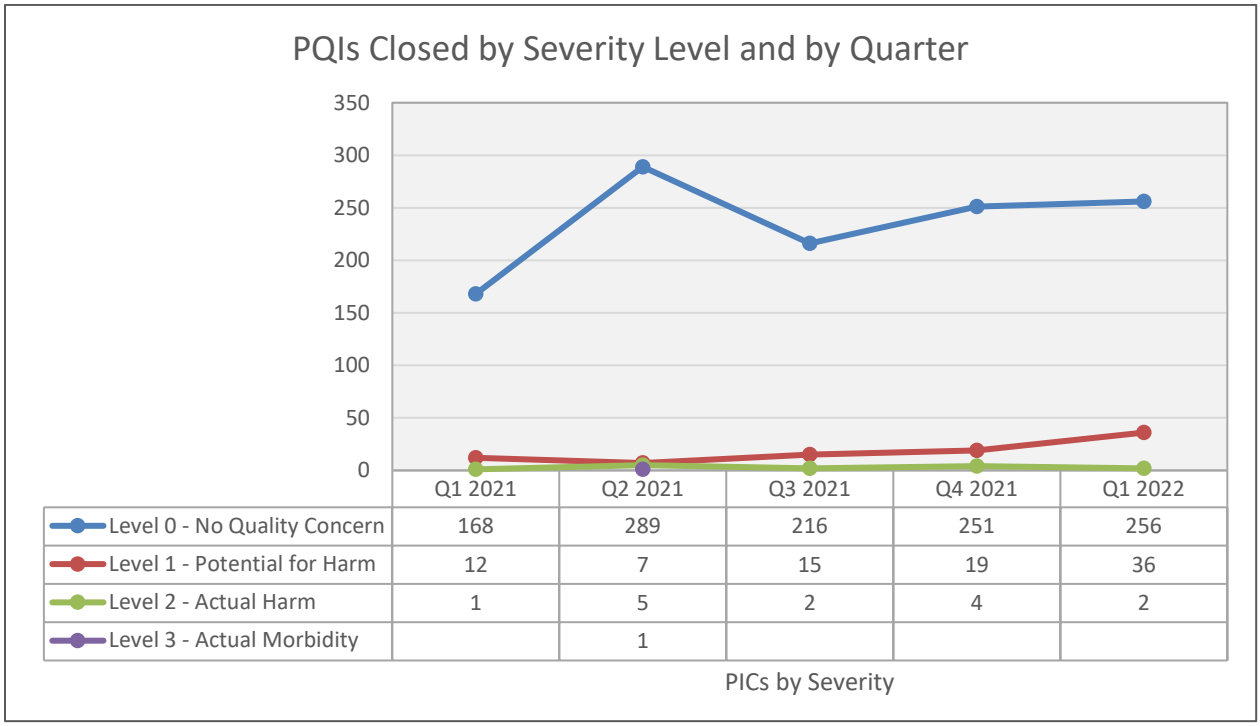
- Level 0 = No Quality-of-Care Concern
  - Follow-up = Track and Trend and/or Provider Education
- Level 1 = Potential for Harm
  - Follow-up = Track and trend the area of concern for the specific provider and the Medical Director or their designee may provide additional actions that are individualized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



From the above charts, we received a total of 488 notifications for the 1st Quarter of 2022. This is a 58% increase in the notifications compared to previous quarter. Please note: Beginning in January 2022, we noticed an increase in our Grievance volume. During this time, we also received more than 3 times the average monthly new membership. Also, KHS has been performing more outreach than ever with various campaigns. The risks associated with performing outreach is the potential to increase call volume and then the opportunity for the member to express dissatisfaction. We anticipate that the increase in grievance notifications may be due to a decrease in COVID cases and members going back to their provider. These are possible factors attributing to the increased Grievances. However, we will continue to monitor for any specific trends.

The first quarter 30 Day Readmission reviews will be completed by the end of May. Due to the increased volume of PQIs and changes to the grievance review process, additional resources were pulled to complete these reviews which impacted our ability to complete 30 Day Readmissions reviews in the first quarter. The graph above reflects the readmissions completed from Q4 2021 forward. A minimum of 50 readmissions have been reviewed in previous quarters. However, it was not until Q4 of last year that we were able to systematically report that volume.

PQIs Closed by Severity Level:



Above chart displays that majority of the PQIs are level 0's and there are no trends identified among the PQIs closed by Severity.

Below is the table with the percentage of PQIs by severity.

Severity Level	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022
Level 0 - No Quality Concern	92.82%	95.70%	92.70%	91.61%	87.07%
Level 1 - Potential for Harm	6.63%	2.32%	6.44%	7.57%	12.24%
Level 2 - Actual Harm	0.55%	1.66%	0.86%	1.46%	0.68%
Level 3 - Actual Morbidity		0.33%			

There is a notable increase in Level 1 PQIs for the 1st quarter. This may be reflective of the initiation of PQI audits by the QI Manager in the 3rd quarter of last year.

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

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

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

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

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

Critical Elements:

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

- Exit doors and aisles are unobstructed and egress (escape) accessible.
- Airway management equipment, appropriate to practice and populations served, are present on site.
- Only qualified/trained personnel retrieve, prepare or administer medications.
- Office practice procedures are utilized on-site that provide timely physician review and follow-up of referrals, consultation reports and diagnostic test results.
- Only lawfully authorized persons dispense drugs to patients.
- Personal protective equipment (PPE) is readily available for staff use.
- Needle stick safety precautions are practiced on-site.
- Blood, other potentially infectious materials (specimens) and regulated wastes (sharps/biohazardous non-sharps) are placed in appropriate leak-proof, labeled containers for collections, processing, storage, transport, or shipping.
- Spore testing of autoclave/steam sterilizer is completed (at least monthly, with documented results).

Scoring and Corrective Action Plans

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

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

Corrective Action Plans (CAPs)

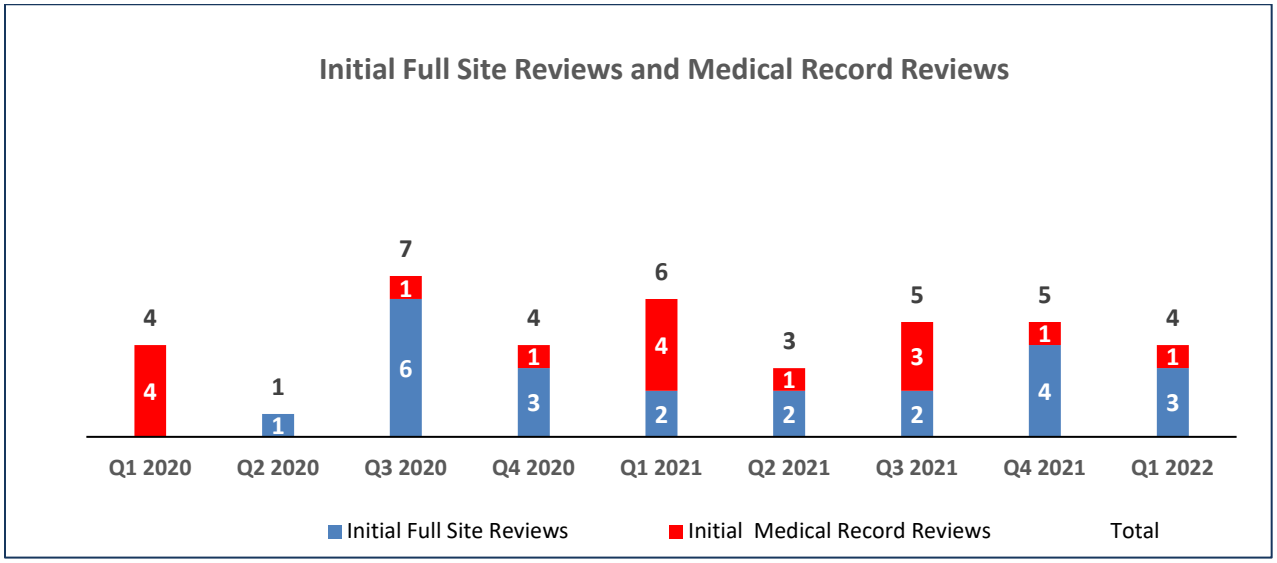
A CAP is issued when an initial, periodic, or focus review has deficiencies identified. DHCS requires follow up at 10 days for failure of any critical element, follow up for other failed elements at 45 days, and if not corrected by the 45 day follow up, at 90 days after a CAP has been issued. Most CAPs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

Special DHCS Site Review Audit:

DHCS conducted a random Full Scope Site Review Audit between December 7th-December 9th, 2021. There were 8 provider site reviews conducted during this Audit. KHS's certified Master Trainer, QI Director and QI Manager attended the audits to provide support to our providers as well as the DHCS auditors. The findings were provided by DHCS and KHS' QI Master Trainer is responsible for issuing CAPs to the providers just as we do when we conduct the review. 7 of the 8 providers had CE CAPs (CE findings required completion of corrective actions within 10 business days) and all 8 providers had standard CAPs, which were all closed timely by 02/25/22. Below is the Audit report:

Site	FSR Score	FSR CAP Required	MRR Score	MRR CAP Required
Provider A	87%	Yes	79%	Yes
Provider B	92%	Yes	97%	No
Provider C	94%	Yes	96%	No
Provider D	86%	yes	75%	Yes
Provider E	96%	Yes	92%	No
Provider F	95%	Yes	97%	No
Provider G	88%	Yes	96%	No
Provider H	86%	Yes	86%	Yes
Average overall score for all sites	90	NA	90	NA

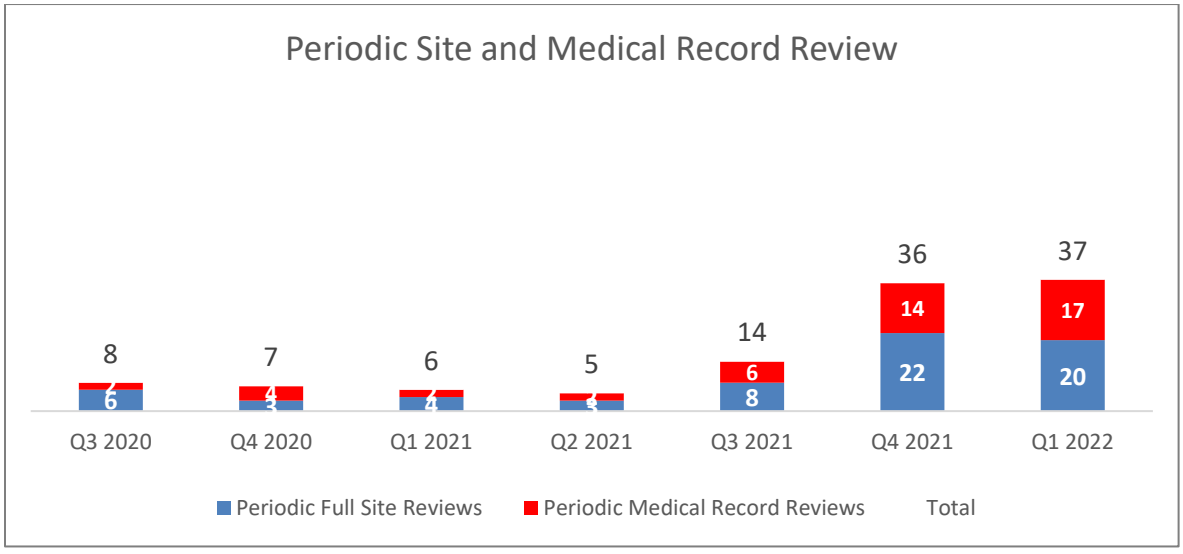
A. Initial Facility Site Review and Medical Record Review Results:



The number of initial site and medical record reviews is determined by the number of new providers requesting to join KHS' provider network. There were 3 IFSRs and 1IMRR conducted in Q1 of 2022.

B. Periodic Full Site and Medical Record Reviews

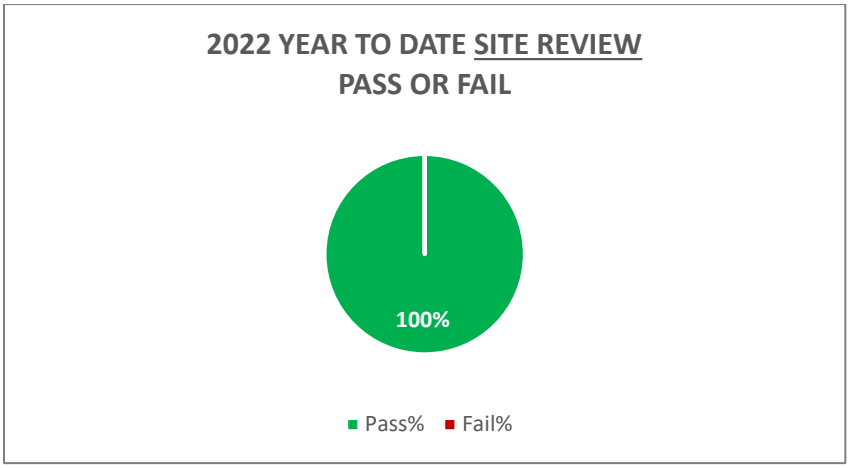
Periodic reviews are required every 3 years. The due date for Periodic FSRs is based on the last Initial or Periodic FSR that was completed. The volume of Periodic Reviews is not controlled by KHS. It is based on the frequency dictated by DHCS.



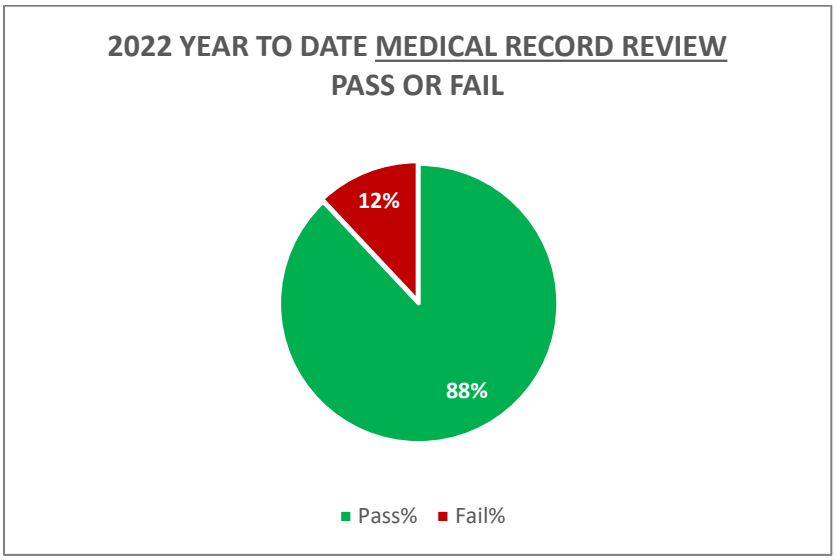
This above chart reflects the number of Periodic Full Site Reviews and Medical record reviews that were due and completed for each quarter. In December 2021, one of our QI RNs earned her certification as a site reviewer. In addition, our MCAS lead RN continued to complete site reviews during the Q4 2021 and Q1 2022. The additional staffing contributed to the increase of the site and medical record reviews completed. This additional staffing allowed us to complete a greater volume review that were backlogged in addition to reviews that were currently due.

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

Effective in Q4 of 2021, we changed identification in this QI Quarterly report to use DHCS' standard of 80% or higher to identify providers who passed. Prior to that, we were using 90%, meaning they had no deficiencies in Critical Elements, Pharmaceutical or Infection Control. Scoring 80% - 89% is considered a "conditional pass" and requires a CAP only for the elements that were non-compliant. A score below 80% is considered a Fail and requires a CAP for the entire site or medical record review.



In 2022 YTD, 100% of the Initial and Periodic site reviews performed passed, none of the sites scored less than 80%. There were 23 site reviews completed YTD We will continue to monitor this for any trends.



In 2022 YTD, 88% of the Initial and Periodic medical reviews performed passed and 12% scored less than 80%. There were 17 medical record reviews conducted YTD and 2 of these reviews failed in the first audit. We will continue to monitor this for any trends.

For Q1 2022, top #3 deficiencies identified for Opportunities for improvement in site reviews are:

1. No evidence of annual trainings for Infection Control/Blood Borne Pathogens/Biohazardous Waste handling
2. Storage areas for regulated medical waste are maintained secure and inaccessible to unauthorized persons – There was no Biohazardous sign on door
3. Sterilized Packages did not contain the load identification number

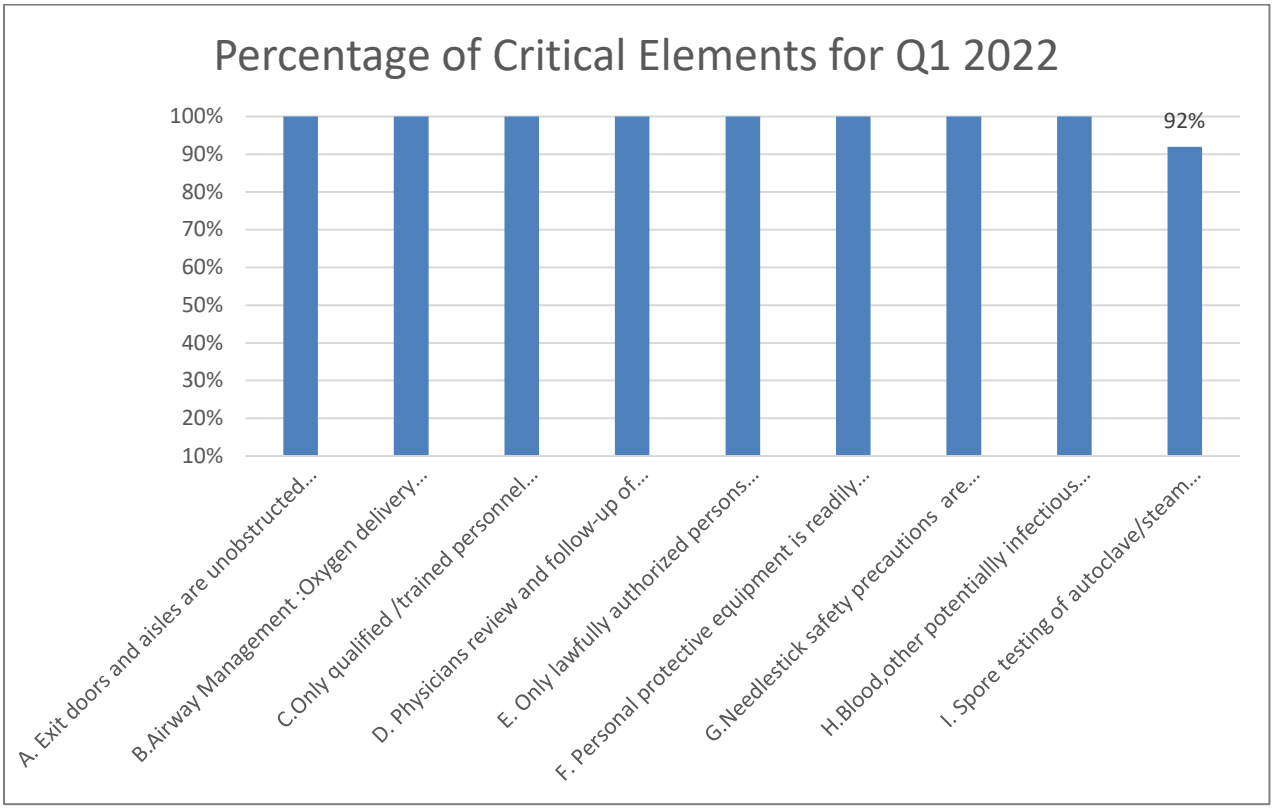
For Q1 2022, top #3 deficiencies identified for Opportunities for improvement in medical record reviews are:

1. Missed Primary Care appointments and outreach efforts/follow up contacts were not documented
2. Chlamydia screens not documented
3. Adult Immunization were not given according to the ACIP guidelines

There are no common deficiencies identified from previous quarter for site reviews and medical record reviews. We will continue to monitor for any issues.

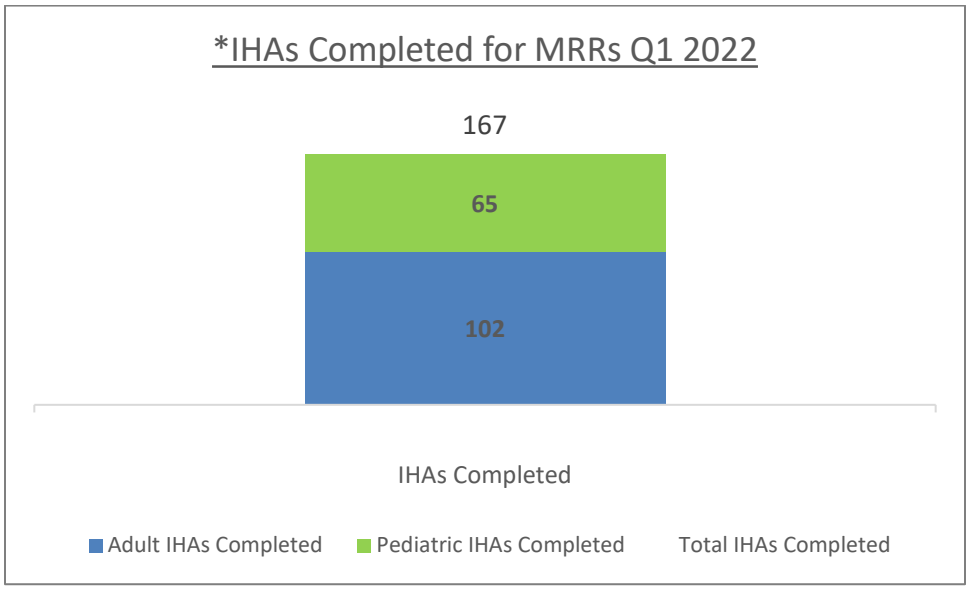
In Q3 of 2021, we began reporting the percentage of compliance from site reviews for the Critical Elements. Compliance with Initial Health Assessments (IHAs) will be reported based on medical record review results for each quarter.

C. Critical Elements Percentage for Site reviews:



From the above chart, all the critical elements except Spore testing of Autoclave were at a 100% for the initial and periodic site reviews. For the one that did not score 100% CAP was issued and deficiencies were corrected within 10 business days.

D. IHA's percentage for MRRs:



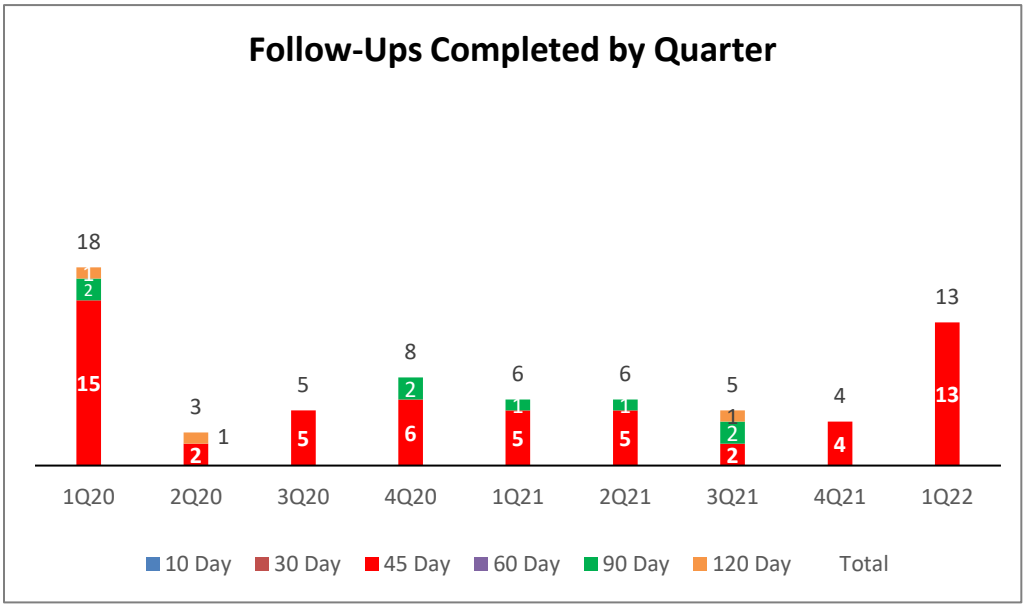
***Percentage-of IHAs completed = IHEBA+SHA's**

For Q1 2022, based on the medical record reviews, 167 IHA's were completed. 65 total pediatric charts and 102 adult charts. 51 out of the 65 pediatric charts were compliant and 9 were non-compliant. Education was provided. 86 out of the 102 were found to be compliant for the adult charts. 16 adult IHA's were found to be non-compliant. Education provided.

Interim Reviews:

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

E. Site Review Corrective Action Plans (CAPs):



There were 13 45-day follow up completed in Q1 of 2022. In December 2021, one of our QI RNs earned her certification as a site reviewer. In addition, our MCAS lead RN continued to complete site reviews during the Q4 2021 and Q1 2022. The additional staffing contributed to the increase of the site and medical record reviews completed. This additional staffing allowed us to complete a greater volume review that were backlogged in addition to reviews that were currently due.

IV. Quality Improvement Projects

A. Performance Improvement Projects (PIPs)

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

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

This PIP targets health care disparities to improve the health and wellness of low-income children and adolescents, ages 3 to 21, through well-care visits. After reviewing the baseline data, narrowed focus has been identified for 8-10-year-old population. We've partnered with Kern Pediatrics to increase the volume of well-care visits among the targeted population by offering weekend clinics specifically for well-care visits, providing various education to providers, staff, and members, and utilizing the MERP campaign to educate and reward members for completing their well-care visits. The Health Equity PIP is currently in the Intervention Testing Phase. The testing phases are conducted in cycles. Currently, we're in Cycle 2 of testing

for the MERP campaign. Mailed flyers were sent out the first week of February and robocalls were conducted in the last week of February.

Child/Adolescent Health-Asthma Medication Ratio (AMR)

This PIP targets children and adolescents ages 5-11 and 12-21 who are non-compliant with their asthma medications. A two-pronged approach is being used for this project. One group of members will utilize the Asthma Mitigation Project (AMP) for focused interventions. A second group will utilize KHS's Asthma Disease Management Program for focused interventions. The AMR PIP is in the intervention testing phase, which is focused on collaborating with KHS providers to educate a subset of our members who are non-compliant with their Asthma medication and develop an Asthma Action Plan for this population. We began the third cycle of testing with Health Education and Pharmacy at the end of March. A Technical Assistance call with HSAG has been scheduled at the beginning of April in preparation for the next progress check-in submission.

B. Member Engagement and Rewards Project (MERP):

MERP robocalls were conducted 3/3/22- 3/11/22. Measures included are Initial Health Assessment (IHA), Prenatal & Postpartum Care (PPC-Pre & PPC-Post), Child and Adolescent Well-Care Visits (WCV), Well-Child Visits in the First 30 Months (W30), Chlamydia Screening in Women (CHL), Breast Cancer Screening (BCS), Cervical Cancer Screening (CCS), & Blood lead screening (LSC). 1st MERP campaign in 2022 is completed. We should be able provide the results with the June 2022 report.

C. SWOT Analysis Project:

After meeting with DHCS, they recommended including more integrated interventions in smart objectives and progress, and to expand strategies outside of KHS to include external partners. The SWOT workgroup is currently re-evaluating and revising SWOT action items and short-term objectives. As an outcome of the feedback from DHCS, we've partnered with Health Education to provide Bakersfield City School District with point of care gift cards for closing gaps in care.

D. PDSAs:

As a result of KHS' MY2020 MCAS scores, Quality Improvement (QI) is performing two PDSA's required by DHCS. Our first PDSA is focused on the Breast Cancer Screening (BCS) measure in the Women's Health Domain. The specific intervention is to measure the volume of successful completion of a Mammogram via the Mobile Mammogram Clinic, which was conducted on October 29, 2021, in Taft. Originally, we planned to conduct our second Mobile Mammogram Clinic Day at Clinica Sierra Vista in Arvin on March 20th. However, due to some contracting challenges, the event was rescheduled for May 1st.

The second PDSA is focused on the Well-Care Visits for 0-30 months of age (W30) measure with a focus on ages 0-15 months. We are partnering with CSV to conduct a two-pronged approach with utilization of robocalls and direct telephonic outreach to get members to schedule their well care visit. The goal is to

increase the MCAS compliance rate for the WCV measure for this age group by 5%. Outcomes of the first cycle proved that live telephonic outreach was most successful. Therefore, we're modifying the intervention for the second cycle to expand the live telephonic outreach to members who received a robocall and a subset of members who received mailers but did not schedule their well care visit. Also, appointment reminders will be sent out via robocalls, live outreach, and text messages. Our next submission is due to DHCS in mid-May.

E. COVID QIP:

The final update report for the COVID-19 Quality Improvement Project was submitted to DHCS in February and was approved and closed on March 14, 2022. The 3 Strategies successfully completed include:

1. Develop an educational flyer for KHS members with Behavioral Health challenges regarding COVID-19 and the vaccine to include both a general flyer and one focused on pregnancy. The flyer was provided to Kern Behavioral Health and Recovery Services staff to distribute to KHS members they serve.
2. KHS is supported the Latino COVID-19 Task Force to provide vaccination pop-up clinics and focused on making the vaccine available in rural areas throughout Kern County. KHS also provided financial support to California State University Bakersfield (CSUB) to provide COVID vaccines to KHS members at the University in partnership with Kern Medical for administration of the vaccine.
3. An educational flyer was developed for women of child-bearing age on the facts about the COVID-19 virus and receiving the vaccine while pregnant or trying to become pregnant. This education included partnering with the local Black Infant Health program to support Black or African American women of receiving this same information.

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

MCAS MY2021 rates below are not considered typical to our plan due to reduction in available services and resources during the pandemic. The rates below reflect the results so far during the MCAS Annual Audit and Rate Submission to NCQA and DHCS. Final rates for MY2021 are anticipated to be submitted by 06/01/2022.

MY2021 MCAS Rate Tracking Report
As of 2022-03-31
Note: These are Preliminary rates awaiting HSAG validation.

Hybrid Measures Held to MPL

Measure		Current MY2021 Rate	MY2021 MPL	MY2020 KHS Rate	Current Vs. MY2020 MPL	Current Vs. MY2020	Numerators Required to meet MPL
CCS	Cervical Cancer Screening	45.01	59.12	54.01	-14.11	▼ -9.00	58
CIS-10	Childhood Immunization Status	19.95	38.2	22.87	-18.25	▼ -2.92	76
CDC-H9*	HbA1c Poor Control (>9.0%)	59.85	43.19	50.85	-16.66	▼ -9.00	69
CBP	Controlling High Blood Pressure <140/90 mm Hg	51.58	55.35	52.07	-3.77	▼ -0.49	16
IMA-2	Immunizations for Adolescents – Combo 2 (meningococcal, Tdap, HPV)	28.95	36.74	33.09	-7.79	▼ -4.14	33
PPC-Pre	Prenatal & Postpartum Care – Timeliness of Prenatal Care	81.62	85.89	70.07	-4.27	▲ 11.55	19
PPC-Post	Prenatal & Postpartum Care – Postpartum Care	84.07	76.4	77.62	7.67	▲ 6.45	0
WCC-BMI	Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents: Body Mass Index Assessment for Children/Adolescents	71.78	76.64	63.50	-4.86	▲ 8.28	20
WCC-N	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Nutrition	61.80	70.11	52.80	-8.31	▲ 9.00	35
WCC-PA	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Physical Activity	62.53	66.18	51.09	-3.65	▲ 11.44	15

CDC-H9* is an inverse measure, low rate indicates better performance.
MRR-Medical Record Reviews

Administrative Measures Held to MPL

Measure		Current MY2021 Rate	MY2021 MPL	MY2020 KHS Rate	Current Vs. MY2020 MPL	Current Vs. MY2020	Numerators Required to meet MPL
BCS	Breast Cancer Screening	53.17	53.93	54.50	-0.76	▼ -1.33	82
CHL	Chlamydia Screening in Women Ages 16 – 24	53.71	54.91	54.02	-1.20	▼ -0.31	123
W30 (0-15M)	Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits.	27.84	54.92	30.55	-27.08	▼ -2.71	907
W30(15-30M)	Well-Child Visits for Age 15 Months–30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits.	50.97	70.67	55.70	-19.70	▼ -4.73	1,254
WCV	Child and Adolescent Well-Care Visits	37.61	45.31	36.16	-7.70	▲ 1.45	9,633

Indicates KHS did not met MPL
Indicates KHS need 5% or less to met MPL
Indicates KHS met or exceeded MPL
Indicates KHS met or exceeded HPL.

Note: The above MY2021 rates for hybrid measure include admin, medical record reviews, and supplemental data. From the above chart, there are 4 hybrid and 2 Admin measures which need less than 5 percentage points to meet MPL. The medical record review abstractions began on 02/15/2022. Compared to previous there are 6 out of 15 measures had shown improvement in their rates. We will continue to monitor our rates throughout the audit, as the abstractions and Claims lag continue until final submission.

Below are the Current MY2022 rates compared to previous MY2021 rates:

Measure	Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
BCS	2021	35.66%	37.10%	▲38.70%	40.39%	42.15%	44.56%	45.89%	47.08%	48.04%	49.13%	50.24%	51.40%
	2022	32.94%	34.63%	▼36.88%									
CBP	2021	0.00%	0.99%	▼ 2.56%	3.51%	4.31%	5.77%	6.22%	6.64%	6.94%	10.00%	12.36%	14.96%
	2022	3.70%	7.57%	▲ 8.13%									
CCS	2021	39.74%	39.81%	▲40.71%	42.05%	43.05%	44.87%	45.78%	46.55%	47.21%	48.11%	48.78%	49.36%
	2022	34.80%	34.53%	▼35.53%									
HBD*	2021	99.87%	95.58%	▲89.09%	81.99%	77.34%	74.82%	72.39%	70.86%	69.64%	68.67%	67.19%	73.98%
	2022	99.88%	94.55%	▼94.51%									
CHL	2021	18.37%	27.83%	▼35.37%	39.07%	43.30%	46.23%	48.38%	50.36%	51.77%	53.75%	54.61%	55.48%
	2022	15.60%	26.43%	▲35.66%									
CIS-10	2021	9.59%	10.78%	▼12.43%	14.47%	15.68%	16.85%	17.30%	17.59%	17.85%	18.23%	18.62%	19.05%
	2022	15.01%	16.54%	▲14.56%									
FUA 30Day follow up	2021	13.04%	12.88%	▲11.68%	11.60%	11.81%	12.46%	13.76%	13.49%	13.82%	13.53%	14.05%	15.60%
	2022	2.90%	7.26%	▼ 8.65%									
FUA 7Day follow up	2021	7.25%	10.43%	▲ 9.28%	7.94%	7.66%	8.14%	8.49%	8.34%	8.40%	8.12%	8.48%	9.96%
	2022	1.45%	2.81%	▼ 2.78%									
FUM 30Day follow up	2021	1.09%	23.53%	▲23.24%	24.26%	23.17%	22.22%	21.65%	21.72%	21.28%	21.40%	20.96%	19.93%
	2022	10.00%	11.88%	▼12.34%									
FUM 7Day follow up	2021	1.09%	10.78%	▲12.68%	13.93%	12.40%	11.25%	11.26%	11.67%	11.09%	11.52%	11.35%	11.05%
	2022	7.50%	6.93%	▼ 5.84%									
IMA-2	2021	21.16%	22.16%	▲23.79%	24.84%	25.73%	26.93%	27.66%	29.43%	29.90%	30.41%	30.70%	30.76%
	2022	20.65%	21.81%	▼22.79%									
LSC	2021	40.77%	42.98%	▲44.79%	46.11%	46.98%	47.90%	48.80%	49.24%	49.57%	49.76%	49.92%	50.05%
	2022	37.45%	39.29%	▼40.27%									
PPC-Pre	2021	25.62%	29.74%	▲31.80%	33.39%	34.99%	38.38%	40.17%	42.28%	43.85%	44.22%	44.32%	44.00%
	2022	17.14%	21.14%	▼24.27%									
PPC-Post	2021	37.74%	46.16%	▲51.23%	56.89%	58.32%	57.22%	57.86%	57.65%	59.06%	63.14%	66.45%	67.11%
	2022	41.50%	44.48%	▼50.57%									
W30 (0-15M)	2021	29.33%	29.77%	▼31.03%	30.74%	30.75%	30.35%	29.98%	30.51%	30.72%	30.94%	31.42%	31.22%
	2022	31.64%	33.30%	▲33.90%									
W30 (15-30M)	2021	38.39%	41.98%	▼44.41%	46.39%	47.65%	48.91%	50.24%	51.09%	51.42%	51.70%	51.90%	51.96%
	2022	41.69%	44.76%	▲46.83%									
WCV	2021	0.00%	1.10%	▼ 3.72%	7.48%	11.19%	17.60%	20.64%	25.00%	28.45%	31.68%	34.40%	36.70%
	2022	1.38%	3.50%	▲ 7.00%									

The above chart displays trending rates for MY2021 and MY2022. As of January 2022, **6 out of 15 (CBP, CIS-10, CHL, W30 - 0-15M, W30 -15-30M, WCV) measures showed improvement compared to this month last year**. HBD* is an inverse measure where the lower rate indicates better performance. Green arrow indicates rate increased and Red arrow indicates rate decreased compared to previous year February 2021.

Please note: LSC, FUM and FUA are newly added measures for MY2022. These measures are currently being configured by our BI team, and the report will be update accordingly.

VI. **Policy Updates:** There were no policy updates as of Q1 2022.

Appendix A

MCAS Committee

Date | time: 03/24/2022 @ 9:00 to 10:00 AM

Location: GoTo Meeting
Click here to join the meeting

Phone Number: (929) 352-2833
Access Code: 746 804 340#

KERN HEALTH SYSTEMS

Meeting Called By: Jane Daughenbaugh

Attendees:

✓ John Miller	☐ Martha Tasinga	☐ Deborah Murr	✓ Jane Daughenbaugh
✓ Kailey Collier	✓ Nate Scott	✓ Monica Bandaru	✓ Marilu Rodriguez
✓ Stephanie Kelly	☐ Isabel Silva	☐ Abigail Romo	✓ Jane MacAdam
✓ Jake Hall	✓ Melissa McGuire	☐ Hadassah Perez	✓ Cesar Delgado
✓ Bruce Wearda	✓ Christina Kelly	✓ Louie Iturriria	✓ Amy Daniel
✓ Jeff Pollock	✓ Christine Pence	✓ Chanell Hull	✓ Brianna Gudmundson
✓ Flor Del Hoyo Galvan	✓ Julie Oxford	☐ Enter Name	☐ Enter Name
☐ Enter Name	☐ Enter Name	☐ Enter Name	☐ Enter Name

Agenda Items

	Topic	Presenter	Time allotted
	Discussion – Committee Redirection	Jane Daughenbaugh	5 minutes
✓	*Jane discussed refocusing the Committee toward being more actionable rather than focused on presentations.* • *She discussed that this is important as DHCS will be imposing heavier sanctions to Managed Care Plans (MCPs) that do not meet MCAS' minimum performance level (MPL)* *Melissa commented that she agrees in the Committee becoming more collaborative in nature*		
	Action Item(s) Follow-Up:		
	• In the spirit of refocusing the Committee, the action items regarding QI's updates on current projects (W30 PDSA, PIPs, and SWOT) will be tabled for now. QI will provide updates if/when actionable data/results are available for further discussion.		

✓	• Breast Cancer Screening (BCS) PDSA
	  ○ Mobile Mammogram Outcomes – to date 2 mobile mammogram clinics have been held in Taft (Fall 2020 & Fall 2021)
	  ○ Next Steps – propose to the Committee the possibility of making mobile preventive care services (i.e., immunizations, lead screening, chlamydia screening, etc.) an organization wide project
		Kailey Collier	10 minutes

	Kailey discussed the following:
	• *Mobile mammogram events held at West Side Health Care District in Taft*
	  ○ *Fall 2020 event had a 72% success rate*
	  ▪ *59 members scheduled an appointment*
	  ▪ *42 or 43 members completed their mammogram*
	  ○ *Fall 2021 event had a 66% success rate*
	• *A third mobile mammogram event is scheduled for 05/01/2022 at Arvin Community Health Center – Clinica Sierra Vista*
	  ○ *BCS was added to the Member Engagement and Rewards Program this year – this may result in an increased success rate for this event*
	Jane proposed expanding out a mobile preventative health services to offer additional services such as immunizations and labs (blood lead screening, chlamydia screening).
	• *This would be extremely beneficial to our members in rural areas of Kern County. We can get creative to reach as many members as possible.*
	• *We would need to determine where to hold these services/events*		

Q&A/Discussion:

- *Christine inquired if there is a way to determine where the services are most needed*
  - *Cesar stated Geo Mapping has been done and is available and he will be presenting a deeper dive in determining gaps in care later in the meeting*
- *Cesar inquired if there have been positive "hits" with billing from these mobile events*
  - *Jane explained that for the PDSA noncompliant members were outreached to and scheduled for the services and a manual count was done of those who completed the services*
    - *BCS rate saw a slight increase in the compliance rate in October*
    - *She explained that these mobile events were held with a small, focused population so it wouldn't show a huge impact to the overall rate, however, based on the outcomes from these smaller groups we could see an impact if these services were expanded*
  - *Stephanie stated we are closer to MPL with BCS than ever before*
  - *Jeff mentioned that even if overall rates don't increase, our members have had the needed care so it can be counted as a success*
- *Dr. Miller inquired if these mobile services were through CSV/Omni or KCPHD*
  - *Jane stated we have been working with Alinea Medical Imaging for the mobile mammogram events – this vendor is located in Southern Calif.*
    - *She went on to say we would need to identify other mobile vendors available locally and if they are willing to work with us*
  - *Dr. Miller commented that anytime you can go to the members it is a great opportunity to provider services*
- *Jane started she will be presenting the expansion of mobile health services to the executives*

Member Engagement & Rewards Program (MERP) Updates

• MERP Dashboard Status Update	Cesar Delgado	5 minutes

✓

Cesar stated the MERP Dashboard was created to show outcomes such as outreach attempts, rewards received, and rewards paid out. He stated the Dashboard is currently functional and in use. BI is in the process of working out some anomalies in the data.

- *Marilu stated there are some issues with the accuracy of the data that need to be ironed out especially in relation to the status of the mailers (sent, returned, etc.)*

Q&A/Discussion:

- *Nate inquired on what is considered "successful"*
  - *Jane stated this was noted in a presentation to the QI/QM Committee and Marilu was asked to send out the information to the group*
- *Jane stated once the dashboard is finalized a link will be shared with the Committee.*

	○ *The dashboard will be used to compare outreach modalities and determine which was most successful*		
	• MERP Campaign #1 2022 Update ○ MCAS Rates before MERP Campaign ○ Status of mailers/robocalls (preliminary) ○ MCAS Rates after MERP Campaign – will be presented at the next meeting	Marilu Rodriguez & Monica Bandaru	5 minutes
	Monica informed the Committee that for the rates prior to the campaigns the dashboard is utilized, however, it is still under construction. *Marilu provided an overview of the 1st MERP campaign of 2022:* • *Campaign in 2022 included IHA, PPC-Pre, PPC-Post, WCV, W30, CHL, BCS, Cervical Cancer Screening, & Blood lead screening included mailers and robocalls for this campaign.* ○ *A total of 62,881 mailers went out on 02/03/2022* • *There were 14,936 Robocalls conducted between 03/03/2022 and 03/11/2022* ○ *7,334 were successful robocalls; robocalls deemed successful by either having a live voice or answering machine pick up.* *Jane informed the Committee that approval for text messaging is still TBD, however, more members have opted in for text messaging than robocalls.* *Q&A/Discussion:* • *Cesar inquired if calls only went to those who opted in* ○ *Marilu stated yes, those not opted in to robocalls received mailers* ○ *Cesar asked a follow-up question – are members only receiving robocalls/mailers as part of the campaign* ▪ *Per Marilu yest at this time until text messaging is available robocalls and mailers are utilized for the MERP campaign* ▪ *Jane stated we are proposing a year-round member outreach including direct member outreach to executive leadership.* • *Nate inquired if members who opt in to robocalls still receive mailers* ○ *Per Marilu because robocall dates were pushed back, all noncompliant members received mailers for the 1st campaign of 2022. Typically, it is only one or the other.* • *Both Nate and Cesar commented they believe mailers should go to all non-compliant members, even if they receive a robocall.* • *Jane informed the Committee that returned mailers receive a live phone call by staff to review the member's gaps in care* • *Nate inquired if the MERP flyer is available on the member portal* ○ *Yes, the MERP flyer is posted on the member portal*		
✓	**MCAS Compliance Rates**		

	• MY 2022 Rates (MCAS Dashboard) • MY 2021 Annual MCAS Audit Update	Monica Bandaru	15 minutes

Monica reviewed MY 2022 rates – Monica to send out reports to the Committee

- *15 measures are held to MPL this year*
- *BI is still working on the MCAS Dashboard to reflect the new MY 2022 measures*

Jane mentioned she had a meeting with BI on 03/23/2022 and they will start adding state mental health encounter data to reflect services provided by the county for the behavioral health measures.

Jane discussed with the Committee that QI is in the middle of MCAS abstractions/medical record review process for MY 2021.

- *Monica shared the preliminary rates through last Friday – she will share this with the Committee as well*
  - *Prenatal & Postpartum Care – Postpartum (PPC-Post) has met the MPL*
  - *Breast Cancer Screening and Chlamydia Screening are <5% away from meeting the MPL*
    - *These are administrative measures and there will be one additional lag run in April which will hopefully increase these rates*

Q&A/Discussion:

- *Cesar inquired what is the denominator of the outstanding chases for those measures close to meeting MPL*
  - *Jane explained 47% of chase records have been received*

✓

MCAS Target Report

• Brief Overview	Jane Daughenbaugh & Cesar Delgado	15 minutes

Cesar provided a brief overview of the MCAS Target Report (Excel) with the Committee

- *The report shows compliant and non-compliant members by both provider group and measure*
- *The report also shows the member's last visits with their PCP (30-60-90 days) and how many of those visits included closure of gaps in care*
- *The report allows us to drill down and focus our efforts*

Jane suggested that providers with a higher percentage of members who are non-compliant and had a visit within the past 90 days may benefit from practice changes to put gaps in care front and center when a patient presents for any PCP visit. For providers with a low percentage of members with gaps in care, it may indicate member outreach is needed to get the patients to come in and see their PCP.

Q&A/Discussion:

- *Jeff inquired if the numbers are "unique"*
  - *Per Cesar it can be done on the "rollup"*

✓	**Wrap-Up:** • Next meeting – Thursday, May 26, 2022		
	Click here to enter notes.		

Action Items

Action Item	Owner	Target Date
Marilu to share a link to the MERP Dashboard once it is fully functional	Marilu Rodriguez	Click to enter a date.
Marilu to send the MCAS Committee the definition of "Successful Outreach" that was presented to the QI/QM Committee	Marilu Rodriguez	Click to enter a date.
Monica will send the excel reports for MCAS MERP Campaign #1, MY 2022 YTD rates, and MY 2021 rates as of 03/18/2022 to the Committee	Monica Bandaru	Click to enter a date.
Utilize the MCAS Target Report to discuss and propose provider practice and member changes to increase MCAS rates	Committee Members	5/26/2022
Action Item	Owner	Click to enter a date.
Action Item	Owner	Click to enter a date.

Utilization Management Executive Summary

This 1st quarter summary marks a period that is full of new starts, transition, and change. Kern Health Systems (KHS) membership continues to experience growth.

KHS was in receipt of the Department of Health Care Services (DCHS) audit summary. As such, Utilization Management (UM), Health Services (HS), and Compliance has started anew with changes to our policies and practices. Policy revisions for 3.22 Referral and Authorization Process and 3.25 Prior Authorization Services and Procedures were completed.

To address deficiencies, UM is transitioning from a reactionary approach to a proactive method to identify and monitor over/under utilization trends. The 1st quarter we targeted providers who have potential underutilization tendencies evidenced by an authorization without an associated claim. To monitor overutilization, we have extended our auditing standards to randomly sample authorizations, providers, and/or codes. Additionally, we have included an auditing process for one unique provider that has radiological self-service approval functions.

Out of obstacles come opportunities. UM's continued struggle with outpatient turnaround time compliance has been transformed into a KHS formal project to address Health Services Process Improvement which includes JIVA enhancements, potential use of automation, and reform of our prior authorization requirements.

New Projects:

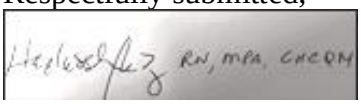
- Medical Loss Ratio
- Health Service Process Improvement
- Long Term Care

Ongoing Projects to support Programs Implemented 1/1/2022:

- Enhanced Care Management (ECM)
- Community Support Services (CSS)
- Major Organ Transplant (MOT)
- Population Health Management (PHM)

The following pages reflect statistical measurements reporting for Utilization Management through 1st quarter 2022.

Respectfully submitted,



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

Utilization Management Reporting

Timeliness of Decision Trending

Summary:

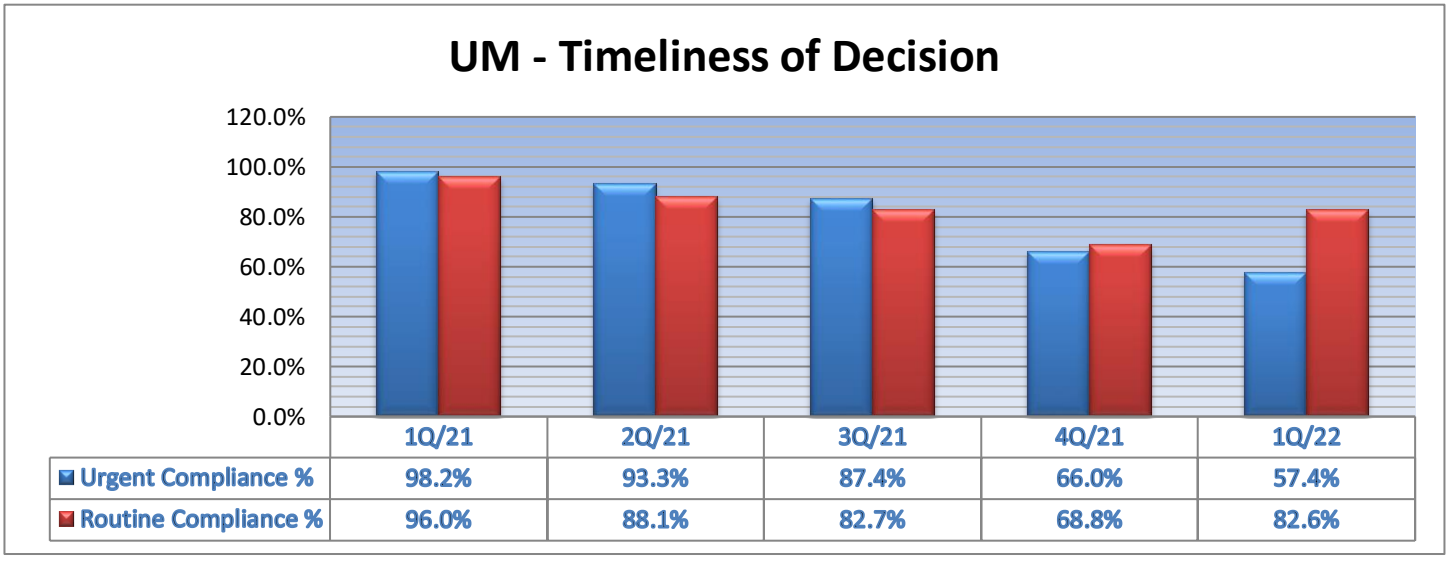
Quarterly audits are conducted to ensure compliance with DMHC requirements, KHS Contractual Agreement with the Department of Health Services, and KHS Policy and Procedures. Referrals are submitted and have specific turn-around-times set for each type of referral.

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

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

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

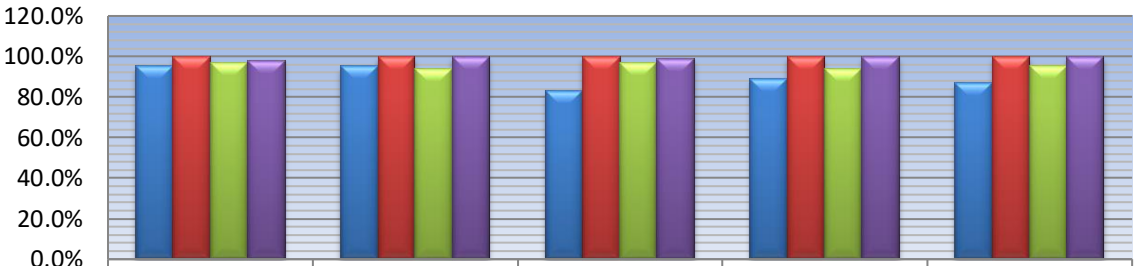
There were 62,099 referrals processed in the 1st quarter 2022 of which 6,387 referrals were reviewed for timeliness of decision. In comparison to the 4th quarter's processing time, routine referrals increased from the 4th quarter which was 68.8% and urgent referrals decreased from the 4th quarter which was 66.0% to 57.4%.



	1Q/21	2Q/21	3Q/21	4Q/21	1Q/22
Urgent Compliance %	98.2%	93.3%	87.4%	66.0%	57.4%
Routine Compliance %	96.0%	88.1%	82.7%	68.8%	82.6%

Audit Criteria:

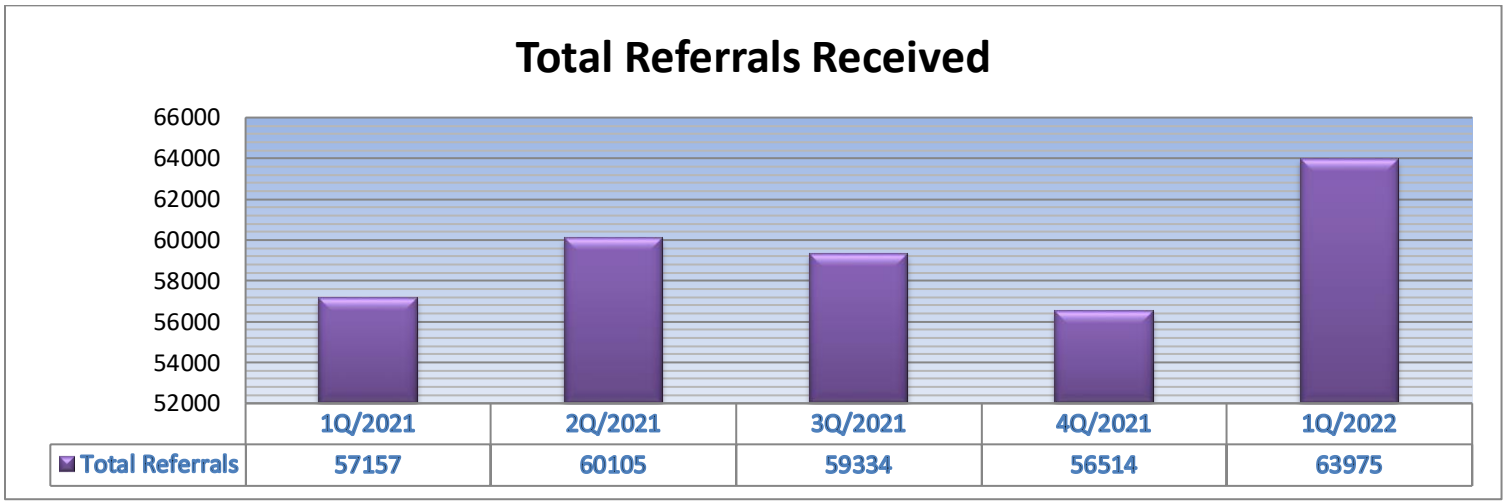
- Member Nofication: Letter of referral decision sent to member within 24 hours
- Provider Notification: Referral is faxed back to the provider with 24 hours of decision
- Criteria Included: Criteria provided to provider on denial reason
- MD Signature: MD Signature included all referrals/NOA letters upon denial

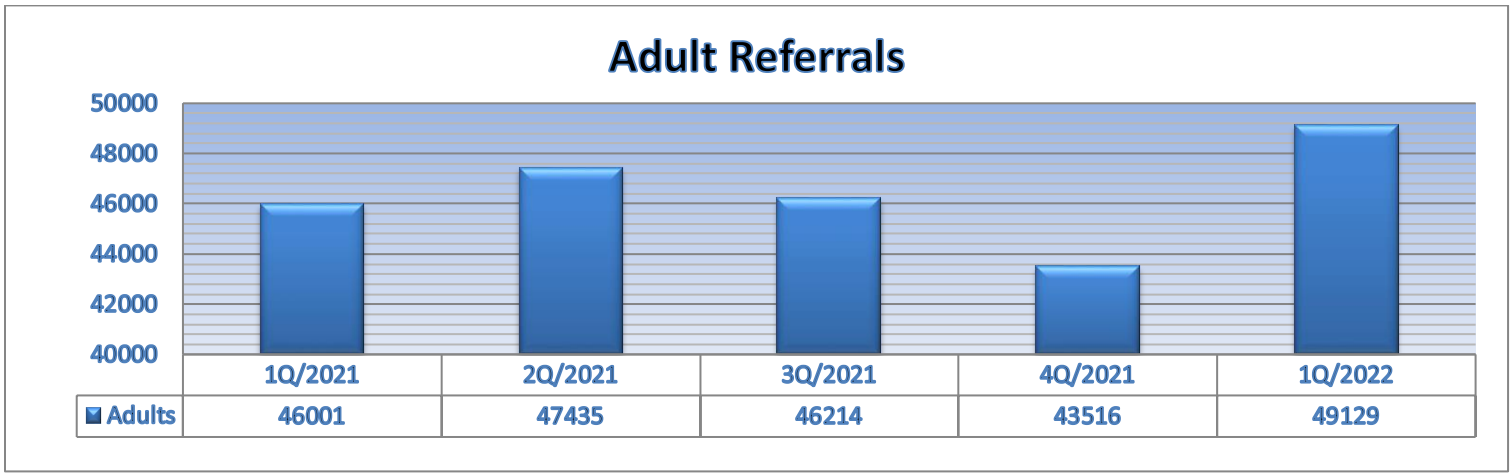


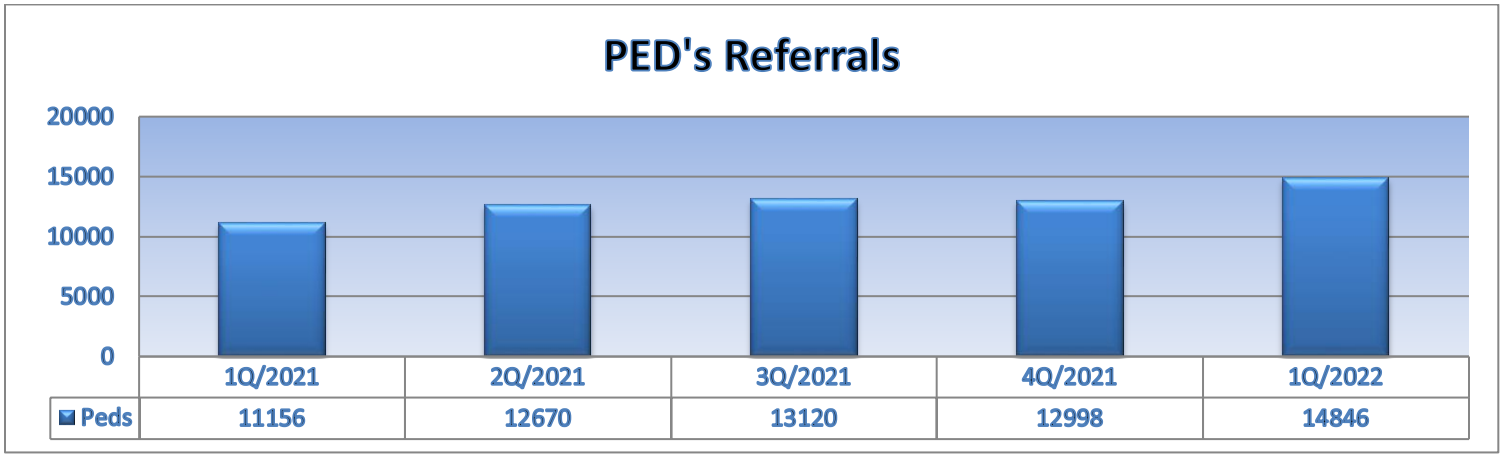
	1Q/21	2Q/21	3Q/21	4Q/21	1Q/22
Member Notification	95.0%	95.0%	83.0%	89.0%	87.0%
Provider Notification	100.0%	100.0%	100.0%	100.0%	100.0%
Criteria Included	97.0%	94.0%	97.0%	94.0%	95.0%
MD Signature Included	98.0%	100.0%	99.0%	100.0%	100.0%

Summary: Overall compliance rate from the 1st Qtr. of 2022 is 96% which had no changes from the 4th Qtr. which was 96%.

Outpatient Referral Statistics





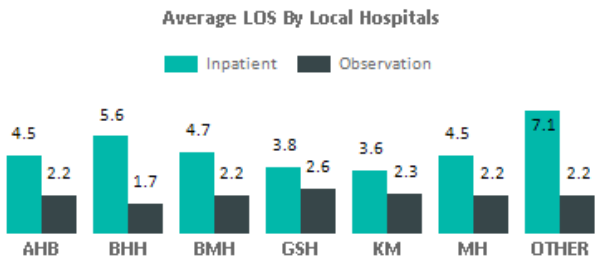


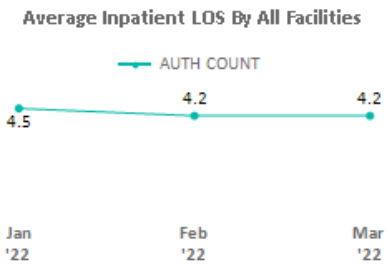
KHS Monthly Inpatient and LOS Report

Report captures Adult Admissions(Inpatient/Observation)

Dates of Discharge Between : 1/1/2022-3/31/2022

Adult Admission(Inpatient/Observation)





Participating Providers

Provider Name	Admit Count	LOS	Avg LOS
	1	3	3.00
ADVENTIST HEALTH BAKERSFIELD	600	2455	4.09
ADVENTIST HEALTH COMMUNITY CAR	37	131	3.54
ADVENTIST HEALTH DELANO	93	421	4.53
ADVENTIST HEALTH MEDICAL CENTE	2	7	3.50
ANTELOPE VALLEY HOSPITAL	13	59	4.54
BAKERSFIELD HEART HOSPITAL	113	590	5.22
BAKERSFIELD MEMORIAL HOSPITAL	687	2840	4.13
DIGNITY HEALTH	1	4	4.00
ENCOMPASS HEALTH REHABILITATIO	1	7	7.00
GOOD SAMARITAN HOSPITAL	120	445	3.71
HOLLYWOOD PRESBYTERIAN MEDICAL	1	2	2.00
KECK HOSPITAL OF USC	76	400	5.26
KERN COUNTY MEDICAL AUTHORITY	700	2428	3.47
KERN VALLEY HEALTHCARE DIST RH	1	5	5.00
KERN VALLEY HEALTHCARE DISTRIC	8	32	4.00
MERCY HOSPITAL	586	2263	3.86
RIDGECREST REGIONAL HOSPITAL	29	166	5.72
SANTA MONICA UCLA MC AND ORTHO	4	73	18.25
UCLA MEDICAL CENTER	18	138	7.67
USC NORRIS CANCER HOSP	5	91	18.20
USC VERDUGO HILLS HOSPITAL	1	3	3.00
VALLEY CHILDRENS HOSPITAL	1	20	20.00
Total	**3098**	**12583**	**4.06**

Non Participating Providers

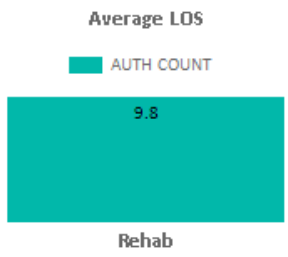
Provider Name	Admit Count	LOS	Avg LOS
ANTELOPE VALLEY HOSPITAL	32	230	7.19
LANCASTER HOSPITAL CORPORATION	12	109	9.08
LOMA LINDA UNIVERSITY MEDICAL	6	67	11.17
FRESNO COMMUNITY HOSPITAL AND	6	38	6.33
HENRY MAYO NEWHALL	5	24	4.80
LAC USC MEDICAL CENTER	5	24	4.80
PACIFICA HOSPITAL OF THE VALLE	4	66	16.50
PROVIDENCE SAINT JOSEPH	4	8	2.00
SALINAS VALLEY HOSPITAL	4	27	6.75
STANFORD MEDICAL CENTER	3	18	6.00
SIERRA VIEW MEDICAL CENTER	3	33	11.00
ST FRANCIS MEDICAL CENTER	3	24	8.00
PROVIDENCE SAINT	3	43	14.33
STANFORD HEALTH CARE	3	63	21.00
GLENDALE ADVENTIST MEDICAL GRO	3	16	5.33
KINDRED HOSPITAL	3	61	20.33
Total	**168**	**1550**	**9.23**

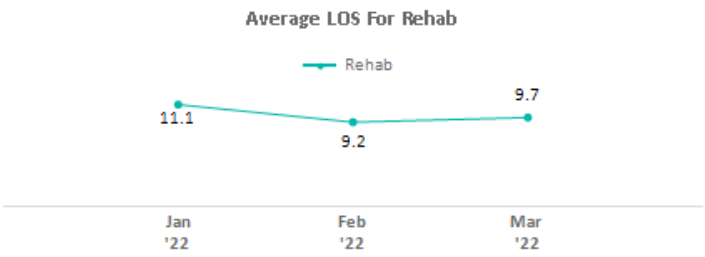
KHS Monthly Inpatient and LOS Report

Report captures Adult Admissions(SNF/Rehabilitation)

Dates of Discharge Between : 1/1/2022-3/31/2022

Adult Admissions (Rehab)





Participating Providers

Provider Name	Admit Count	LOS	Avg LOS
ADVENTIST HEALTH BAKERSFIELD	1	1	1.00
ENCOMPASS HEALTH REHABILITATIO	42	428	10.19
MAXIMUM CARE HOSPICE, INC.	1	1	1.00
Total	**44**	**430**	**9.77**

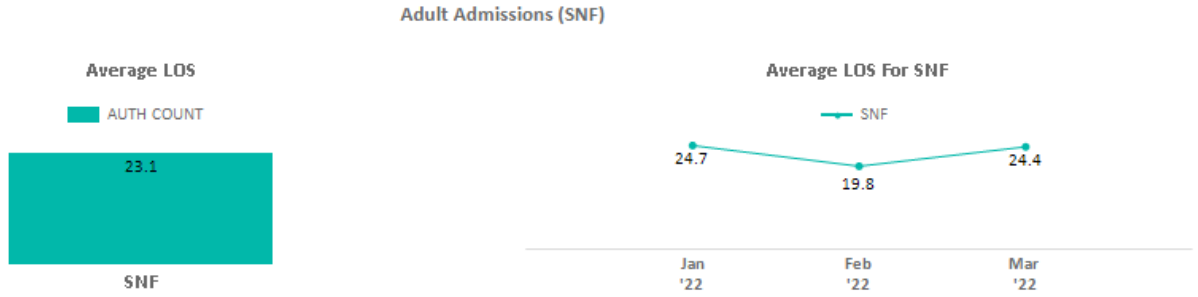
Non Participating Providers

Provider Name	Admit Count	LOS	Avg LOS
Total			**NaN**

KHS Monthly Inpatient and LOS Report

Report captures Adult Admissions(SNF/Rehabilitation)

Dates of Discharge Between : 1/1/2022-3/31/2022



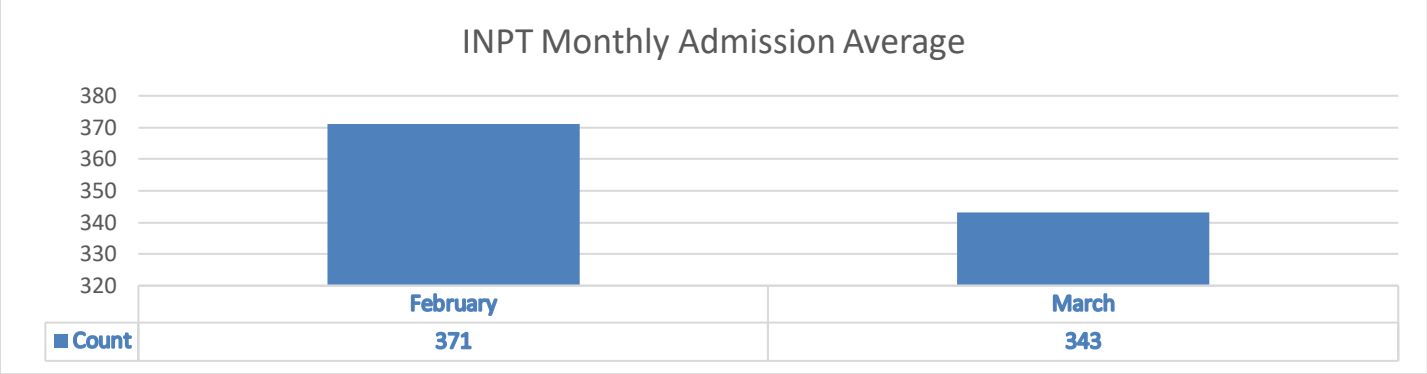
Participating Providers

Provider Name	Admit Count	LOS	Avg LOS
CAPRI IN THE DESERT	6	66	11.00
EVERLASTING HEALTHCARE	3	44	14.67
KINGSTON HEALTHCARE CENTER	5	202	40.40
LIFEHOUSE BAKERSFIELD OPERATIO	1	60	60.00
MAGNIFIQUE CONGREGATE LIVING I	7	232	33.14
NAPOLI IN THE DESERT	13	337	25.92
PARKSIDE CONGREGATE LIVING, IN	13	387	29.77
ROSE DESERT CONGREGATE	3	62	20.67
SAN MARINO IN THE DESERT	16	331	20.69
SORRENTO IN THE DESERT	11	256	23.27
UNITED CARE FACILITIES	61	1055	17.30
VALLEY VIEW CARE CENTER	16	406	25.38
VFP HOMES	11	260	23.64
Total	**166**	**3698**	**22.28**

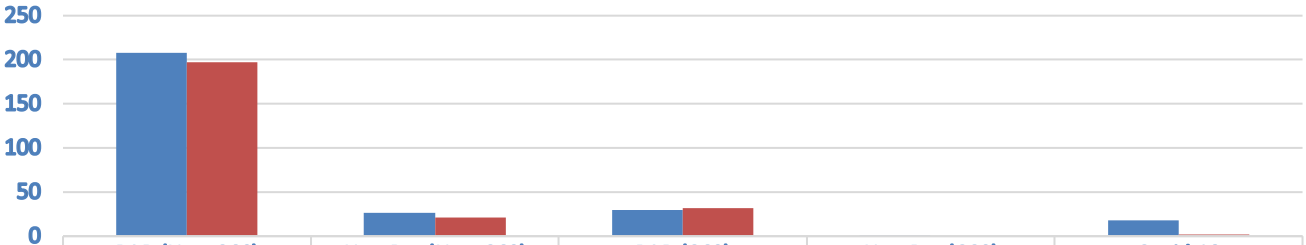
Non Participating Providers

Provider Name	Admit Count	LOS	Avg LOS
PACIFICA HOSPITAL OF THE VALLE	8	242	30.25
DP CARE, INC.	5	78	15.60
LINK TO CARE CONGREGATE HOME	3	129	43.00
SHAFTER NURSING REHAB LLC	2	34	17.00
ROYAL COMFORT CARE, LLC	1	62	62.00
QUALITY CLHF, INC.	1	31	31.00
AURORA CARE	1	7	7.00
TULARE NURSING & REHABILITATIO	1	32	32.00
NEW ORANGE HILLS, INC.	1	34	34.00
SENIOR CONGREGATE LIVING, INC.	1	50	50.00
Total	**24**	**699**	**29.13**

Monthly Average began in February



Acute Monthly Average



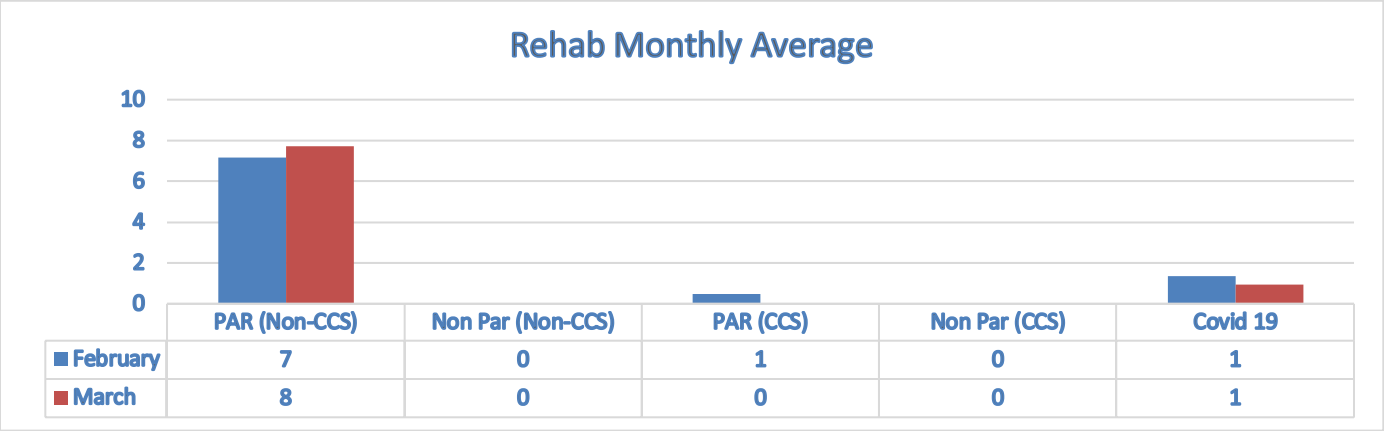
	PAR (Non-CCS)	Non Par (Non-CCS)	PAR (CCS)	Non Par (CCS)	Covid 19
February	208	27	30	1	18
March	197	22	31	0	2

Tertiary Monthly Average

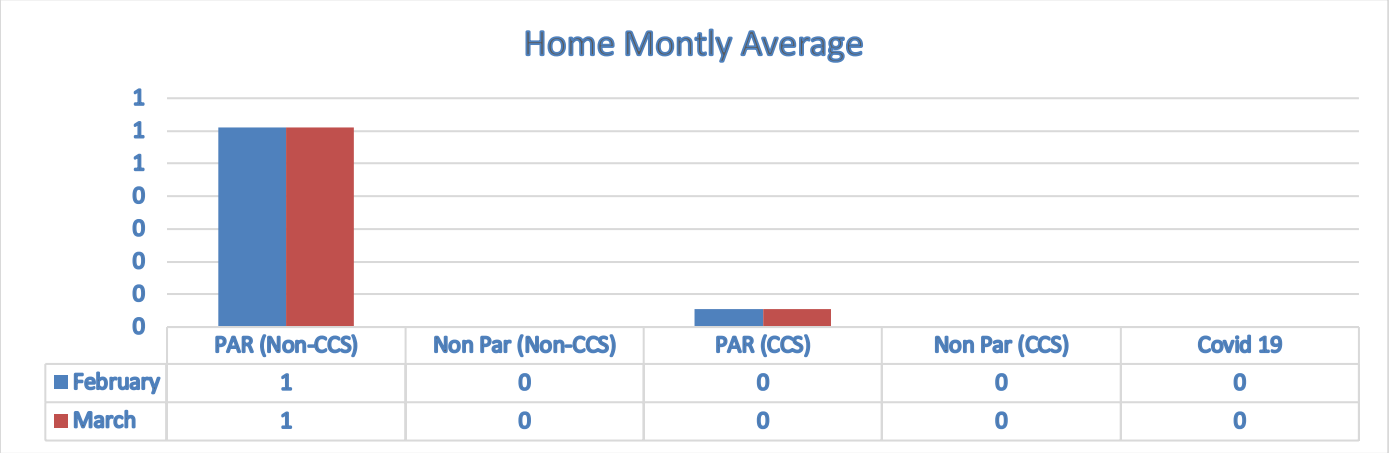
	PAR (Non-CCS)	Non Par (Non-CCS)	PAR (CCS)	Non Par (CCS)	Covid 19
February	12	0	13	0	2
March	11	0	9	0	0

SNF Monthly Average

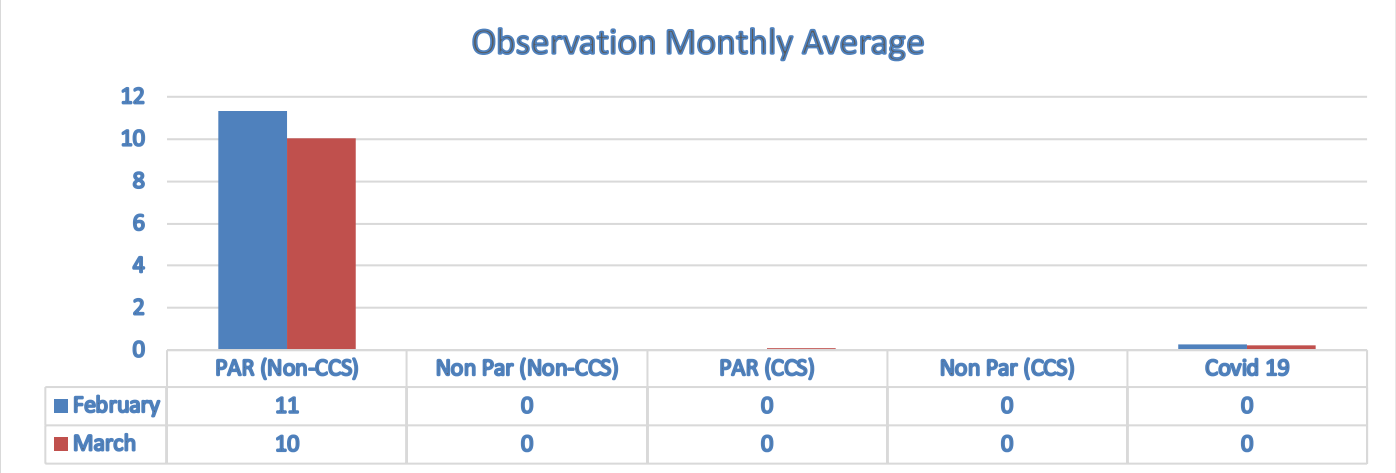
	PAR (Non-CCS)	Non Par (Non-CCS)	PAR (CCS)	Non Par (CCS)	Covid 19
February	46	15	0	0	5
March	46	8	0	0	2



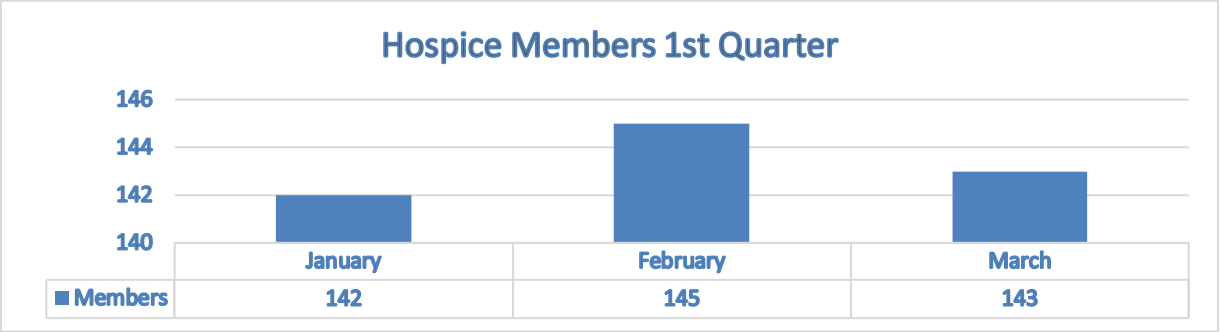
	PAR (Non-CCS)	Non Par (Non-CCS)	PAR (CCS)	Non Par (CCS)	Covid 19
February	7	0	1	0	1
March	8	0	0	0	1



	PAR (Non-CCS)	Non Par (Non-CCS)	PAR (CCS)	Non Par (CCS)	Covid 19
February	1	0	0	0	0
March	1	0	0	0	0



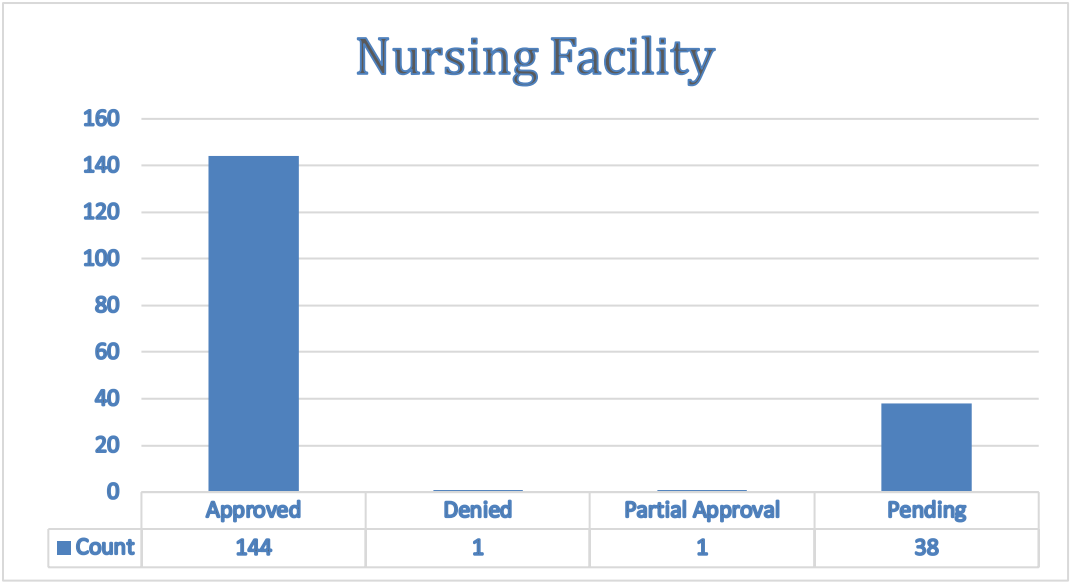
	PAR (Non-CCS)	Non Par (Non-CCS)	PAR (CCS)	Non Par (CCS)	Covid 19
February	11	0	0	0	0
March	10	0	0	0	0

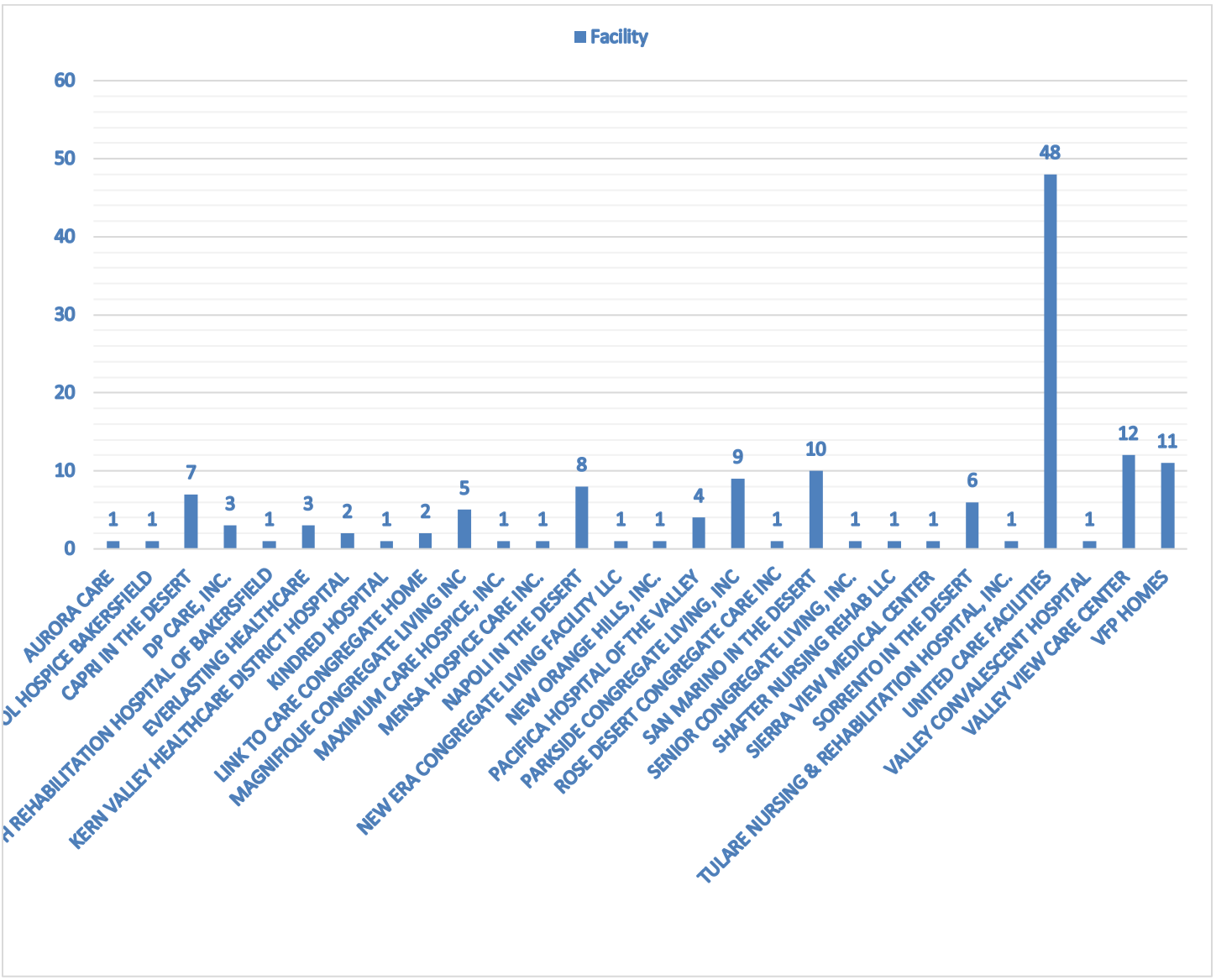


Nursing Facility Services Report

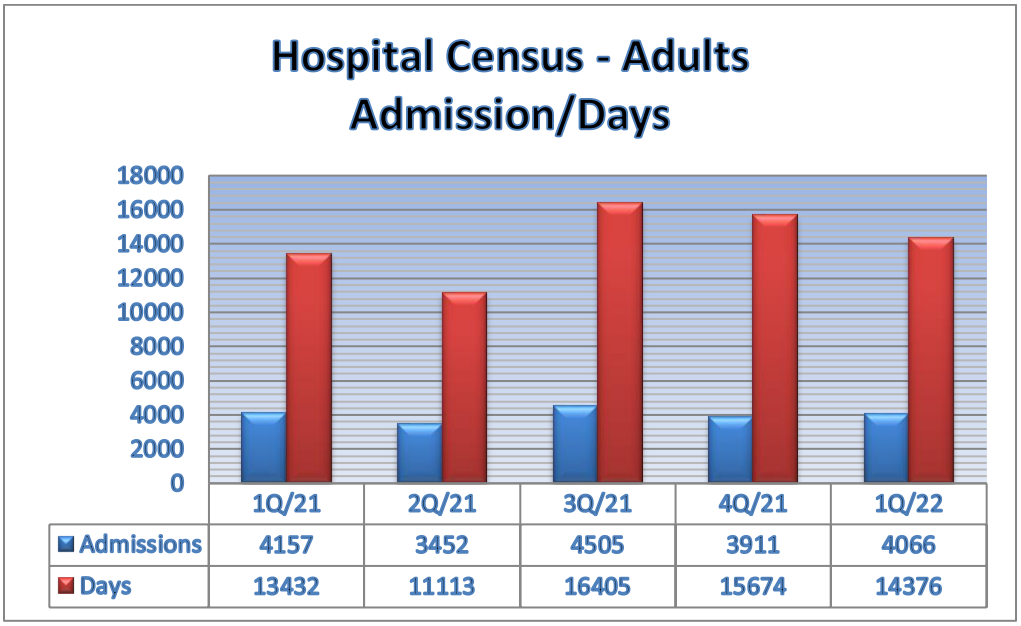
Purpose: Kern Health Systems covers medically necessary Nursing Facility Services for eligible members. KHS members requiring Nursing Facility Services are identified and placed in health care facilities, which provide the level of care most appropriate to the member's medical needs. For members requiring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

Summary: Summary: During the 1st quarter 2022, there were 189 referrals for Nursing Facility Services. The average length of stay was 28.3 days for these members. During the 4th quarter there were only 3 denials of the 238 referrals.

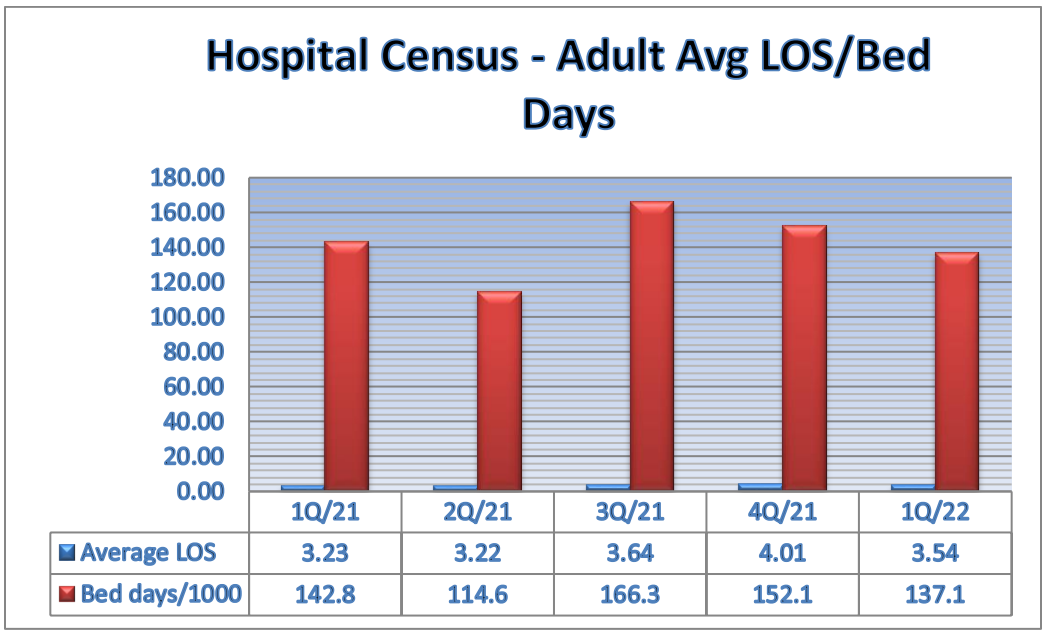



Facility
60
50
40
30
20
10
0
1
1
7
3
1
3
2
1
2
5
1
1
8
1
1
4
9
1
10
1
1
1
6
1
48
1
12
11
AURORA CARE
L HOSPICE BAKERSFIELD
CAPRI IN THE DESERT
DP CARE, INC.
H REHABILITATION HOSPITAL OF BAKERSFIELD
EVERLASTING HEALTHCARE
KERN VALLEY HEALTHCARE DISTRICT HOSPITAL
KINDRED HOSPITAL
LINK TO CARE CONGREGATE HOME
MAGNIFIQUE CONGREGATE LIVING INC
MAXIMUM CARE HOSPICE, INC.
MENSA HOSPICE CARE INC.
NAPOLI IN THE DESERT
NEW ERA CONGREGATE LIVING FACILITY LLC
NEW ORANGE HILLS, INC.
PACIFICA HOSPITAL OF THE VALLEY
PARKSIDE CONGREGATE LIVING, INC
ROSE DESERT CONGREGATE CARE INC
SAN MARINO IN THE DESERT
SENIOR CONGREGATE LIVING, INC.
SHAFTER NURSING REHAB LLC
SIERRA VIEW MEDICAL CENTER
SORRENTO IN THE DESERT
TULARE NURSING & REHABILITATION HOSPITAL, INC.
UNITED CARE FACILITIES
VALLEY CONVALESCENT HOSPITAL
VALLEY VIEW CARE CENTER
VFP HOMES

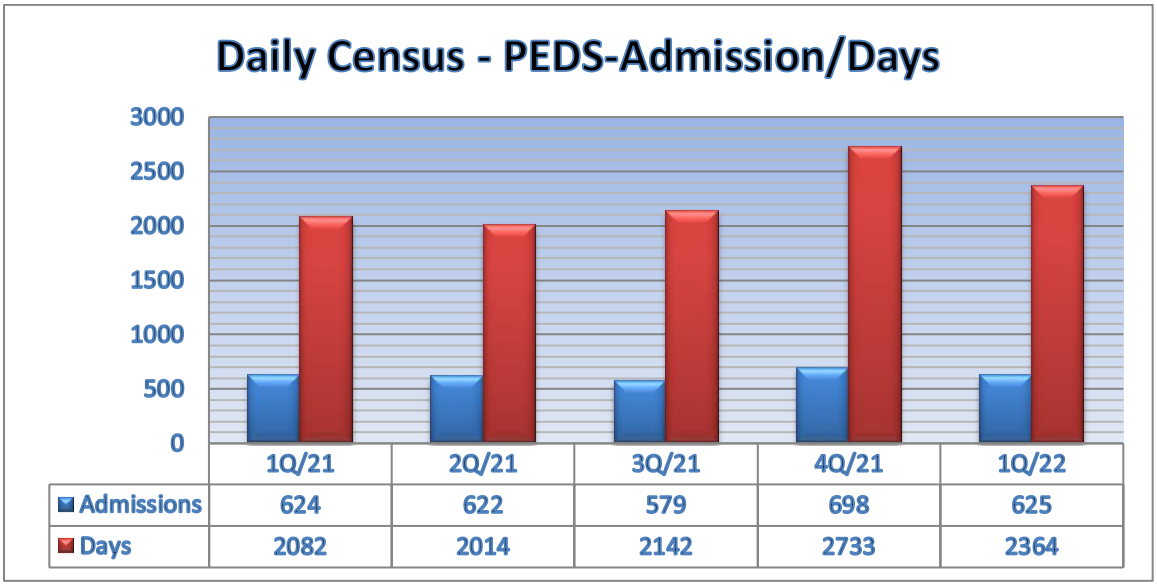
Inpatient 1st Quarter Trending

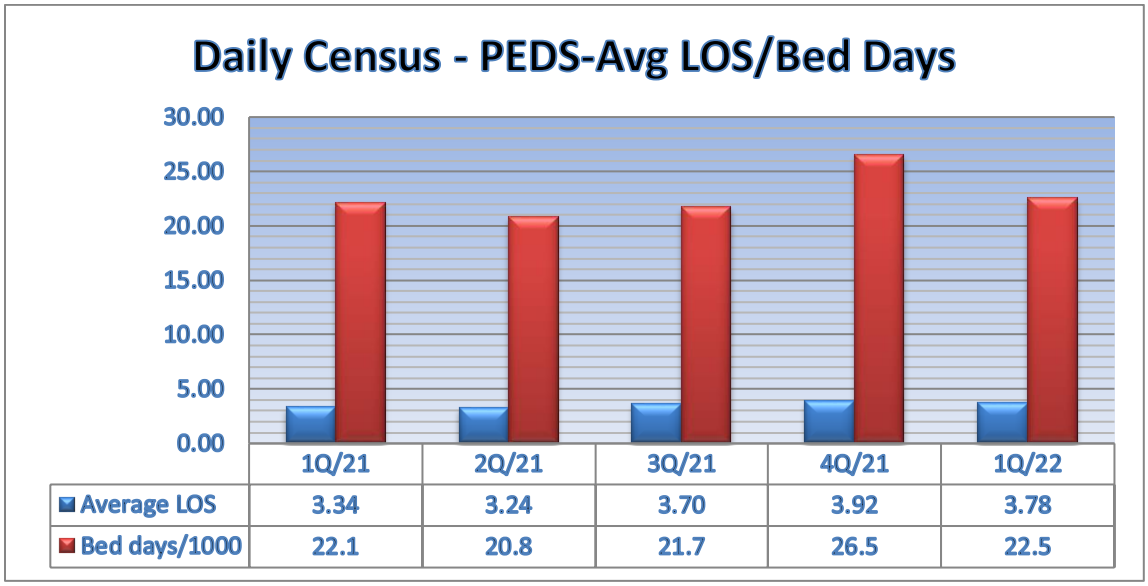


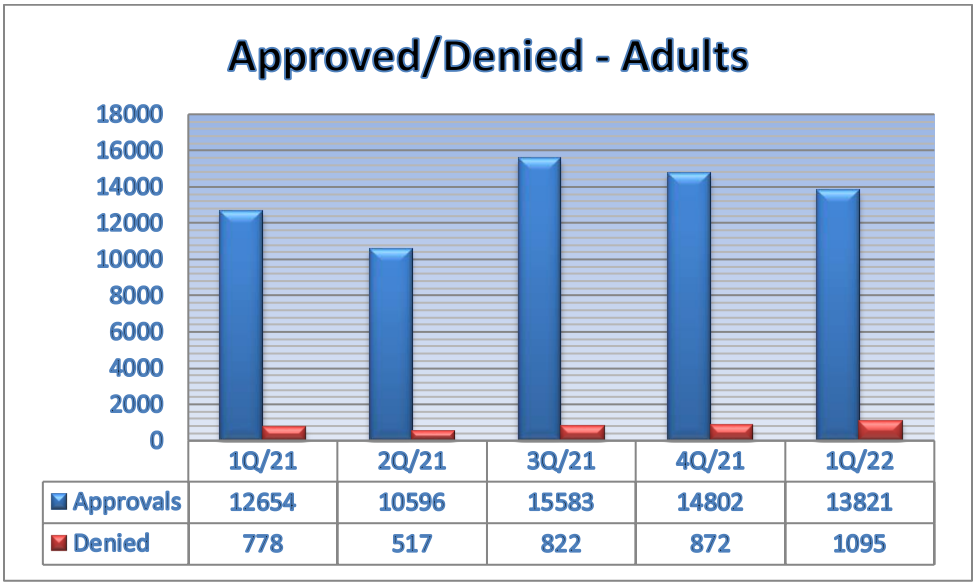
	1Q/21	2Q/21	3Q/21	4Q/21	1Q/22
Admissions	4157	3452	4505	3911	4066
Days	13432	11113	16405	15674	14376



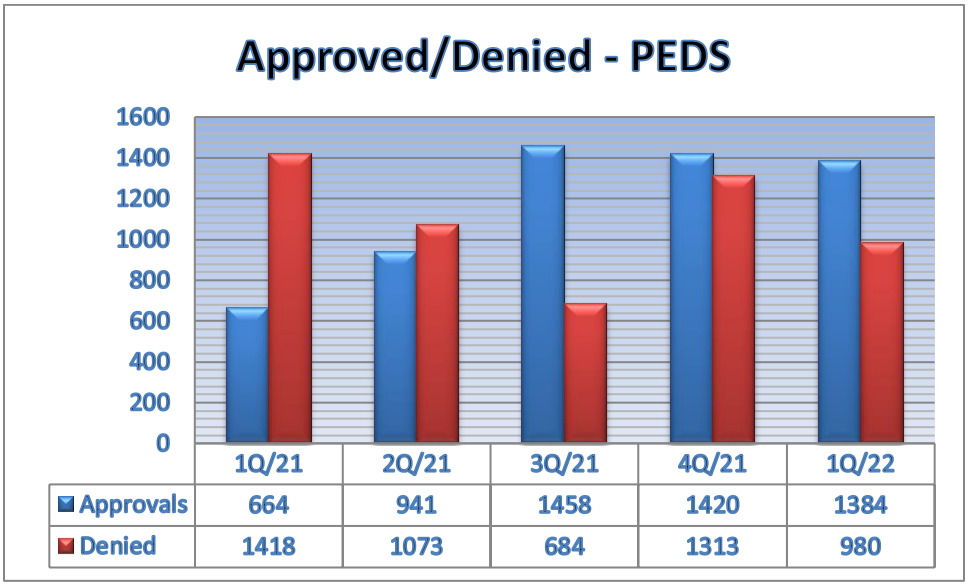
	1Q/21	2Q/21	3Q/21	4Q/21	1Q/22
Average LOS	3.23	3.22	3.64	4.01	3.54
Bed days/1000	142.8	114.6	166.3	152.1	137.1


Daily Census - PEDS-Admission/Days
3000
2500
2000
1500
1000
500
0
1Q/21 2Q/21 3Q/21 4Q/21 1Q/22
Admissions 624 622 579 698 625
Days 2082 2014 2142 2733 2364

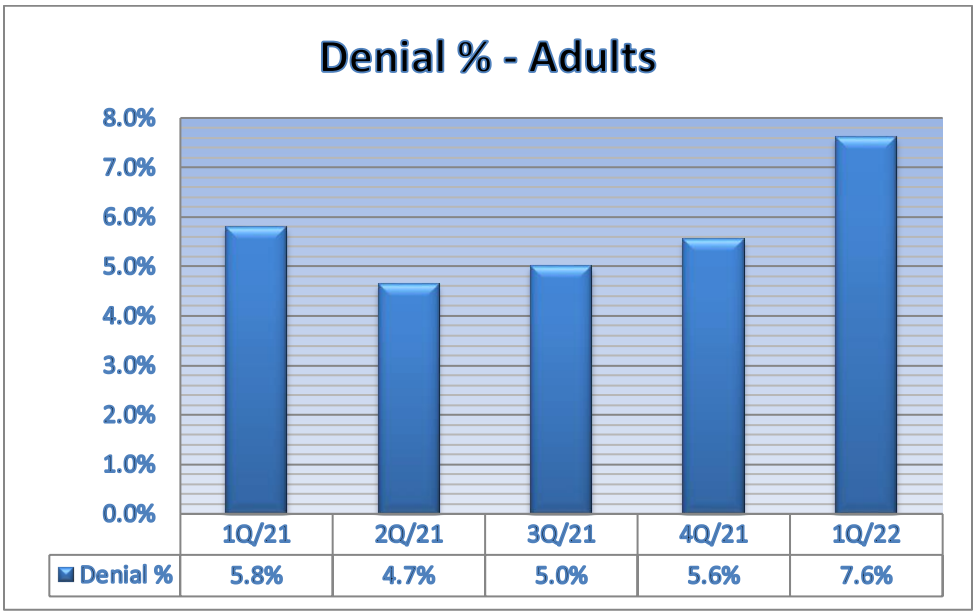

Daily Census - PEDS-Avg LOS/Bed Days
30.00
25.00
20.00
15.00
10.00
5.00
0.00
1Q/21 2Q/21 3Q/21 4Q/21 1Q/22
Average LOS 3.34 3.24 3.70 3.92 3.78
Bed days/1000 22.1 20.8 21.7 26.5 22.5

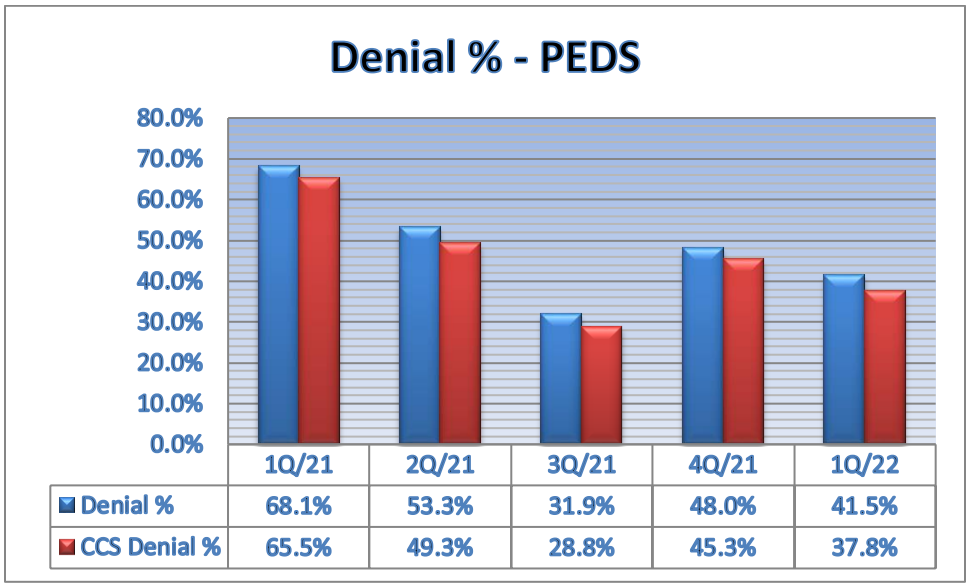


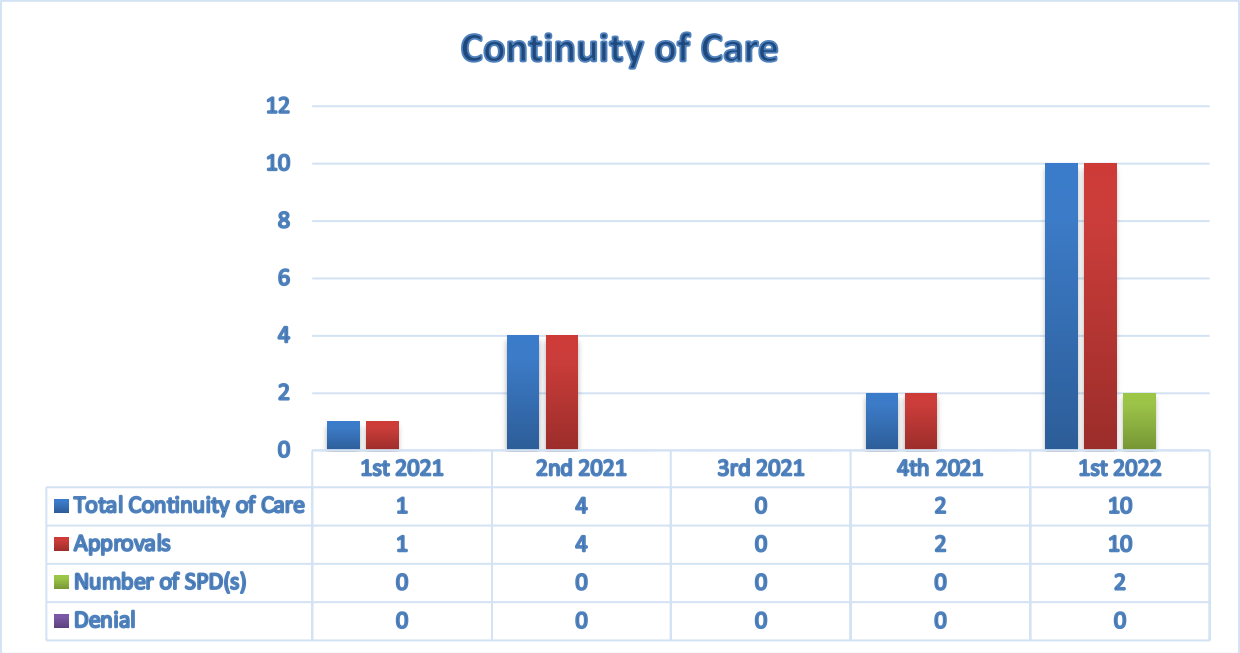
	1Q/21	2Q/21	3Q/21	4Q/21	1Q/22
Approvals	12654	10596	15583	14802	13821
Denied	778	517	822	872	1095



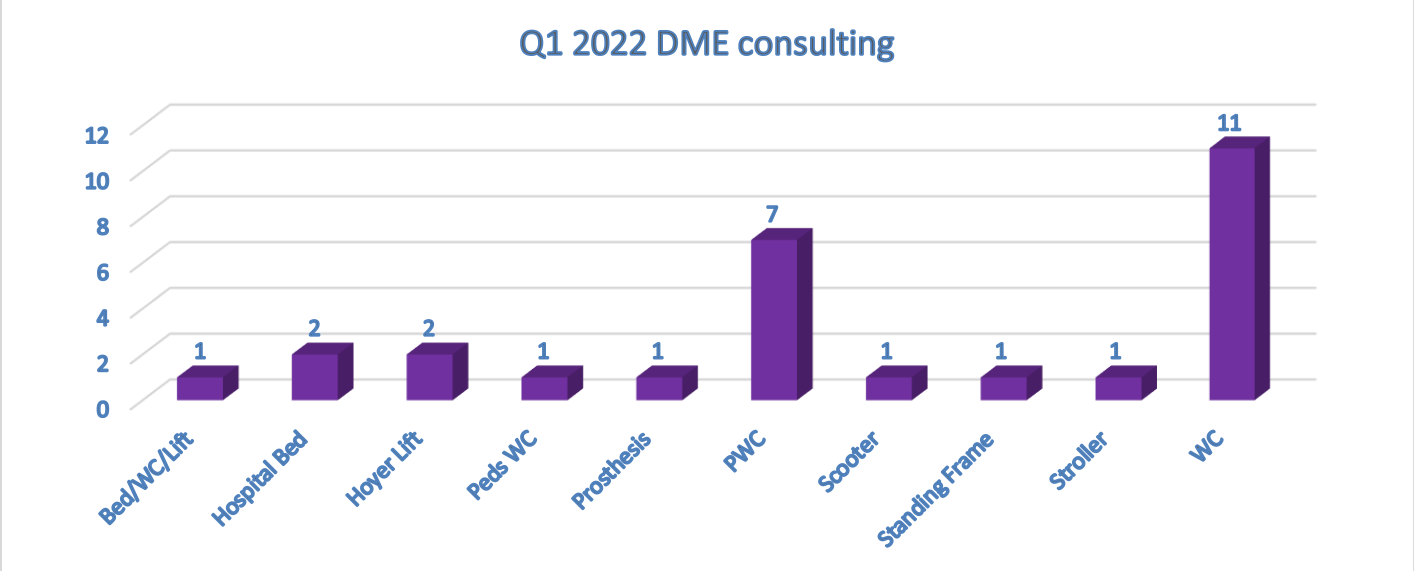
	1Q/21	2Q/21	3Q/21	4Q/21	1Q/22
Approvals	664	941	1458	1420	1384
Denied	1418	1073	684	1313	980

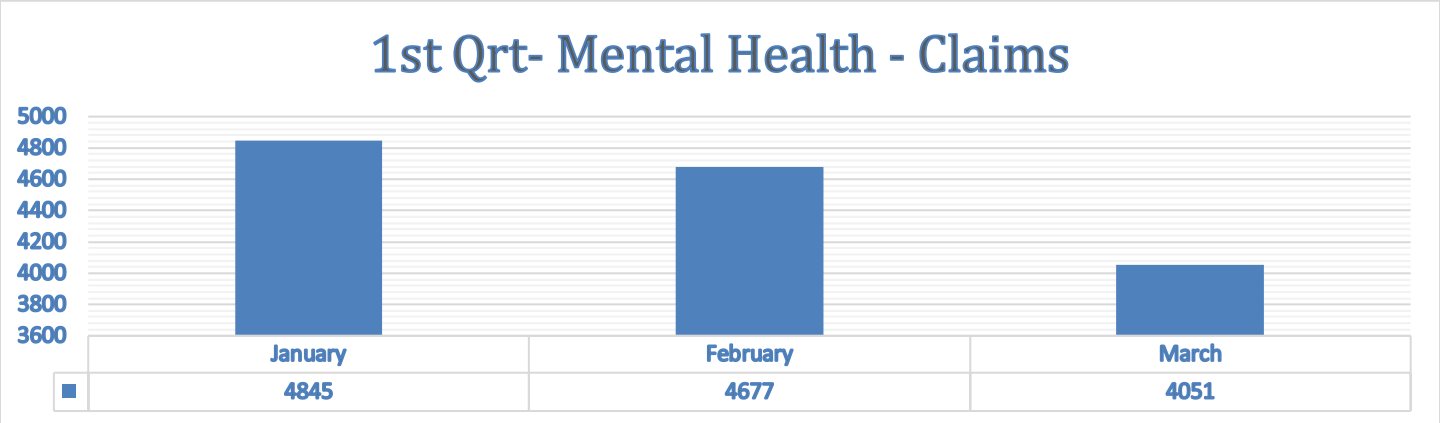

Denial % - Adults
8.0%
7.0%
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
1Q/21
2Q/21
3Q/21
4Q/21
1Q/22
Denial %
5.8%
4.7%
5.0%
5.6%
7.6%


Denial % - PEDS
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
1Q/21
2Q/21
3Q/21
4Q/21
1Q/22
Denial %
68.1%
53.3%
31.9%
48.0%
41.5%
CCS Denial %
65.5%
49.3%
28.8%
45.3%
37.8%



	1st 2021	2nd 2021	3rd 2021	4th 2021	1st 2022
Total Continuity of Care	1	4	0	2	10
Approvals	1	4	0	2	10
Number of SPD(s)	0	0	0	0	2
Denial	0	0	0	0	0





ABA Services

UNIQUE CASES		Total
MEMBER COUNT		198

SEVERITY	Jan	Feb	Mar	Total
Approved FBA	69	88	106	263
Approved Treatment	72	63	62	197
	Jan	Feb	Mar	Total
AGE 7 OR LESS	50	35	38	123
AGE 8 OR GREATER	22	28	24	74
TOTAL	72	63	62	197
% < 7	69.44%	55.56%	61.29%	62.44%
% > 8	30.56%	44.44%	38.71%	37.56%

Initial Health Assessment (IHA) Letters to Members

Letters to the member's PCP with a count of their assigned members who still need an IHA. These letters direct the PCP to the Provider Portal to review their list and perform outreach.

Letters are also mailed to the PCP regarding members who have open authorizations.

Open authorizations are defined as any auth that has not expired and has no claim attached to it. The auth does not need to be fulfilled to no longer be considered open.

Letters are mailed out to each PCP at each location where they have members assigned.

April

- IHA letters mailed - 342
- Open authorization letter mailed – 127

May

- IHA letters mailed – 326
- Open authorization letters mailed - 122

UM Internal Auditing Results

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

Report Date: March 19, 2022

Audit Period: January 1,2022 to March 31, 2022

Sample Size: 10%

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

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

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

Month	January	February	March
Total Referrals Processed	19,418	19,214	23,467
Total Referrals Denied	532	925	1062
Percent of Denials	3%	5%	5%
Percent of Audit	10%	10%	10%
Number of Referrals in Audit **(Not Included: Search and Serve, or Mental Health Referrals)**	41	77	91

Indicators:

1. Referral Turn-around Time
    a. Decision completed within 3 business days for Urgent referrals and 5 business days for routine referrals,
    b. Provider and member notification within 24 hours of decision - Stamp dates on Referral and NOA letter, closed out within compliance.
2. Notice of Action Letter
    a. Spelling/Grammar, Verbiage, and Format
    b. 6th grade reading level
    c. Medi-Cal Criteria applied
    d. Criteria indicated and attached
    e. Recommendations indicated
3. Medical Director / Case Manager Name and Signatures
4. Processing of Referral

January Findings: Out of the **41** Denied referrals reviewed, the following is a breakdown of the findings.

- Nine (9) referrals were found **without** errors from the above indicator
- Twenty-Six (26) errors were found within the Referral Turn-around Time indicator
- One (1) error were found within the Notice of Action Letter indicator
    - One (1) error found with verbiage
    - Zero (0) found with 6th reading level
    - Zero (0) error found with Criteria indicated on letter
    - Zero (0) error found with recommendations to MD.
- Zero (0) error was found within the Medical Director / Case Manager Name and Signatures
- Five (5) error were found within the Processing of the Referrals
    - Two (2) with incorrect partially approved
    - Two (2) with criteria not reviewed and not attached
- All referrals reviewed for medical necessity

Guidelines Applied:

- Nine (9) referrals with Medi -Cal guidelines were used.
- Two (2) referrals with Up-to-Date guidelines were used.
- Fifteen (20) referrals with KHS policy and KHS specialty guidelines used.
- Fourteen (14) referrals with MCG guidelines used
- Five (5) referrals with Administrative Denials which no criteria are required.

February Findings: Out **77** of the Denied referrals reviewed, the following is a breakdown of the findings.

- Sixty-Six (14) referrals were found **without** errors from the above indicator
- Fifty -Five (55) errors were found within the Referral Turn-around Time indicator
- One (3) error was found within the Notice of Action Letter indicator
  - One (1) error found with verbiage
  - Zero (0) found with 6th reading level
  - Zero (0) error found with no Criteria indicated on letter
  - Three (3) error found with recommendations to MD.

- Zero (0) error was found within the Medical Director / Case Manager Name and Signatures
- Eleven (11) errors were found within the Processing of the Referrals with

  - Three (4) with incorrect selection of decisions (partially approved, denied)
  - *Two (2) error found with criteria not attached
  - One (1) error found with no NOA letter
  - *Four (4) errors found with no recommendations to MD

    * Error findings are included in both processing indicator and NOA letter***

- All referrals reviewed for medical necessity

Guidelines Applied:

- Sixteen (16) referrals with Medi -Cal guidelines were used.
- Six (6) referrals with Up-to-Date guidelines were used.
- Thirteen (13) referrals with KHS policy and KHS specialty guidelines used.
- Forty- three (43) referrals with MCG guidelines used
- Six (6) referrals with Administrative Denials which no criteria are required.

Some referrals have applied more than one criterion per MD review**

March Findings: Out of **91** the Denied referrals reviewed; the following is a breakdown of the findings.

- Twenty-five (25) referrals were found **without** errors from the above indicator
- Sixty-four (64) errors were found within the Referral Turn-around Time indicator
- Two (2) errors were found within the Notice of Action Letter indicator
  - One (1) error found with letter format
  - Zero (0) found with 6th reading level
  - One (1) error found with incorrect Criteria indicated on letter
  - One (1) error found with recommendations to MD

- Zero (0) error was found within the Medical Director / Case Manager Name and Signatures

- Five (5) errors were found within the Processing of the Referrals with no criteria attached, incorrect criteria attached.
  - Two (2) with incorrect commentary verbiage
  - Two (2) with missing criteria, not attached
  - One (1) error found with recommendations to MD
- All referrals reviewed for medical necessity

Guidelines Applied:

- Twelve (12) referrals with Medi -Cal guidelines were used.
- Eleven (11) referrals with Up-to-Date guidelines were used.
- Twenty-five (25) referrals with KHS policy and KHS specialty guidelines used.
- Forty (40) referrals with MCG guidelines used
- One (1) referral with Administrative Denials which no criteria are required.

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

Kern Health Systems
Utilization Management Department
Delayed Referral Audit

Kalpna Patel, UM Clinical Trainer & Auditor, RN

Report Date: March 19, 2022

Audit Period: January 1, 2022 to March 1, 2022

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

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

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

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

Month	January	February	March
Total Referrals Processed	19,418	17,748	23,467
Total Referrals Delayed	15	5	3
Percent of Delays	<1%	<1%	<1%
Percent of Audit **(10 percent or 10 referrals whichever is larger)**	10 referral	5 referral	3 referral
Number of Referrals in Audit	10	5	3

1

Indicators:

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

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

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

- Six (6) referral was found **without** errors from the above indicator
- Two (2) error was found within the Processing of Referral with no clinical note or criteria review and approved vs previously delayed.
- Two (2) errors was found within the Referral Turn-around Time indicator
- Zero (0) errors were found within the Notice of Action Letter
- Zero (0) error was found withing the Medical Director / Case Manager Name and Signatures

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

- Two (2) referrals were found **without** errors from the above indicator
- Zero (0) error was found within the Processing of Referral
- Three (3) error was found within the Referral Turn-around Time indicator
- Zero (0) error were found within the Notice of Action Letter
- Zero (0) error was found withing the Medical Director / Case Manager Name and Signatures

March Findings: Out of the **3** delayed referrals reviewed, the following is a breakdown of the findings.

- Zero (0) referrals were found **without** errors from the above indicator
- Two (2) errors were found within the Processing of Referral with reclassify vs delayed.
- Two (2) errors were found within the Referral Turn-around Time indicator
- One (1) error was found within the Notice of Action Letter with no due date in NOA noted.
- Zero (0) error was found withing the Medical Director / Case Manager Name and Signatures

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

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

Report Date: March 19, 2022

Audit Period: January1, 2022 to March 31, 2022

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

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

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

The referrals that qualify for a modification are:

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

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

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

Month	January	February	March
Total Referrals Processed	19,418	19,214	23,467
Total Referrals Modified	154	228	271
Percent of Modifies	1%	1%	1%
Percent of Audit **(10 percent or 10 referrals whichever is larger)**	10%	10%	10%
Number of Referrals in Audit	16	23	28

Indicators:

9. Referral Turn-around Time
    a. Decision completed within 3 business days for Urgent referrals and 5 business days for routine referrals
    b. Provider and member notification within 24 hours of decision - Stamp dates on Referral and NOA letter, closed out within compliance.
10. Notice of Action Letter
    a. Spelling/Grammar, Verbiage, and Format
    b. 6th grade reading level
    c. Approved provider information (name/phone)

11. Medical Director / Case Manager Name and Signatures
12. Processing of Referral

January Findings: Out of the **16** Modified referrals reviewed, the following is a breakdown of the findings.

- Nine (9) referrals were found **without** errors from the above indicator
- Seven (7) errors were found within the Referral Turn-around Time indicator
- Two (2) errors were found within the Processing of Referral with decision approved vs modified and treating provider. Not changes to the services.
- Zero (0) error was found within the Notice of Action Letter

13. Zero (0) error was found within the Medical Director / Case Manager Name and Signatures

February Findings: Out of **23** the Modified referrals reviewed; the following is a breakdown of the findings.

- Eleven (11) referrals were found **without** errors from the above indicator
- Twelve (12) errors were found within the Referral Turn-around Time indicator
- Zero (0) errors were found within the Processing of Referral indicator
- Zero (0) error was found within the Notice of Action Letter
- Zero (0) error was found within the Medical Director / Case Manager Name and Signatures

March Findings: Out of the **28** Modified referrals reviewed, the following is a breakdown of the findings.

- Eight (8) referrals were found **without** errors from the above indicators
- Twenty (20) errors were found within the Referral Turn-around Time indicator
- One (1) errors were found within the Processing of Referral indicator with incorrect commentary.
- Zero (0) error was found within the Notice of Action Letter indicator
- Zero (0) error was found within the Medical Director / Case Manager Name and Signatures

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

Kern Health Systems
Utilization Management Department
Quarterly Provider Over and/or Under Utilization Tool

Report Date: Final Date

Audit Period: Date Range

Sample Size: 30 Medical Records

Purpose: To monitor provider usage for both under and over utilization trends, to identify any trends that are potential fraud, waste, or abuse concerns in compliance with the annual Utilization Management Plan. Quarterly audits of authorizations issued to providers that are found by report to have unusual trends when compared and contrasted, with their peers of the same specialty and/or member panel size in accordance with Kern Health Systems' Policy and Procedure 3.22 Referral and Authorization Process, and KHS Policy and Procedure 3.25-P, Prior Authorization Procedures and Services.

As stated in Policy and Procedures 3.22, Section 11. Documentation, Tracking and Monitoring, KHS will conduct random audits quarterly for purposes of compliance with the referral process and identifying any correspondence issues. Identified Issues will be brought Quality Improvement and Utilization Management Committee on a quarterly basis by the Director of Utilization Management or designee.

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

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

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

Suspicion of any potential fraud, waste, and abuse will be referred to Compliance within two (2) business days of the identification of the suspected FWA.

As stated in KHS Policy and Procedure 3.25-P, Prior Authorization Procedures and Services, some prior authorization requests can be initiated by the provider and approved, if the service is a covered benefit and the provider enters clinical documentation that supports the medical necessity of the requested service. These specific authorizations are randomly audited quarterly to review for efficacy

of the process and to determine if the services would be deemed medically necessary by the KHS Chief Medical Officer or an appointed delegate.

Month	Jan-22	Feb-22	Mar-22
Provider Name: CBCC			
Provider Specialty: Oncology			
Number of Records Audited	7	6	13
Number of Authorizations with overuse or misuse concerns post RN medical record review	0	0	0
Number of Authorizations without Claim			
Number of cases escalated for Independent Medical Review	0	0	0
Number of cases escalated to Compliance	0	0	0
Number of cases of underutilization letter was sent to provider	0	0	0

Audit Summary Findings:

Q1 2022: CBCC utilizes the provider portal to self-authorize radiology services. This provider uses a self-facing criterion, MCG (Milliman Care Guidelines) to determine the medical necessity of radiological services. The process does not allow self-approval for services that are non-covered benefits under MediCAL.

CBCC had a total of 26 unique authorization requests with 46 service lines submitted on behalf of 19 members.

January-there were a total of 7 authorizations for CBCC.

Online authorization 202201100000074 was modified at the request of CBCC after the selected radiology provider was unable to perform the exam. As a result, authorization 202201110000068 was created by UM staff for new provider.

Two additional authorizations were completed by UM staff: 202201100000470 and 202201210000013.

Of the 7 authorizations that were generated in January 2022, 6 of those included clinical documentation from the provider which included recent office visit notes. One authorization 202201270000998 was submitted with just the physician order for the which included the essential elements to process the authorization including patient diagnosis and indication for exam.

Breakdown of types of services for the month of January: MRI brain (2), CT chest (1), CT abdomen (1), Bone Scan (1), MRI abdomen (1), MRI pelvis (1), MRI chest (1) MRI lumbar spine (1) and MRI thoracic spine (1).

7 of 7 of the authorizations that were approved were medically necessary based on the review of the medical records for the services that were authorized.

February- there were a total of 6 authorizations for CBCC. One authorization 202202010000429 required assistance from UM staff. All the requests had clinical documentation from the provider consisting of office visit notes.

Breakdown of service types for the month of February: Pet Scan (1), CT abdomen (2), CT chest (2), MRI brain (1) and Bone Scan (1).

6 of 6 of the authorizations that were approved were medically necessary based on the review of the medical records for the services that were authorized.

March-there were a total of 13 authorizations for CBCC. One authorization was a partial approval 202203020000783 the request for total Body Scan was approved but MRI of the knee was denied-not medically necessary. Authorization 202203240000007 was reviewed and completed by UM staff. Authorization 202203160000008 had multiple services lines 3 were automated and one required UM staff assistance. One member with multiple authorization requests 202203160000009, 202203160000010, 202203280001005 was reviewed and approved by the medical director. All 13 requests were submitted with clinical documentation consisting of office visit notes.

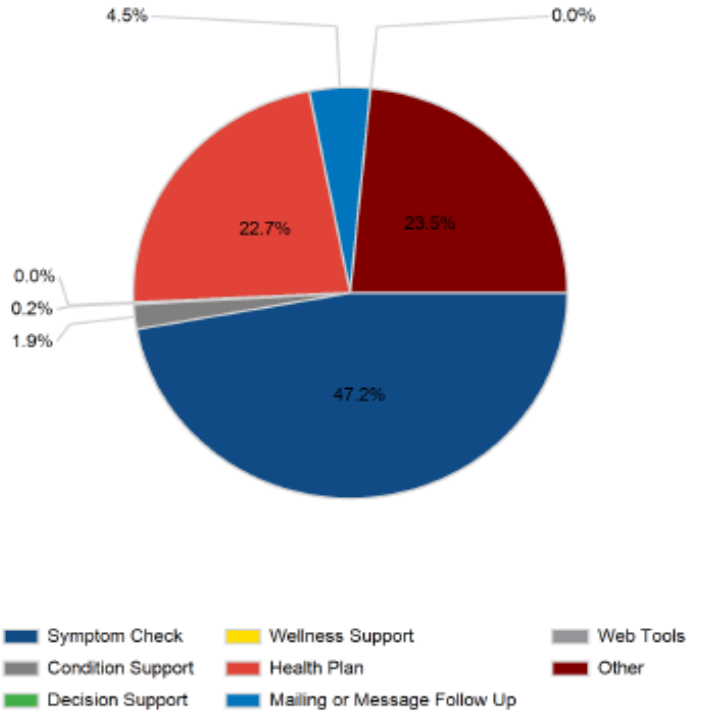
Breakdown of service types for the month of March: MRI brain (1), MRI abdomen (3), MRI pelvis (2), MRI breast (1), Pet Scan (3), Body Scan (1), CT head (1), CT face (1), CT neck (1), CT chest (3), CT abdomen (4), CT pelvis, and MRI knee denied.

13 of 13 of the authorizations that were approved were medically necessary based on the review of the medical records for the services that were authorized. As stated above one authorization request had two services lines: one for a full body scan and the other for MRI of the knee. That authorization was reviewed by the medical director and the full body scan was authorized and the MRI of the knee was deemed not medically necessary. The denial was received prior to services being rendered and will not require any further action.

In summation, of the 26 unique authorization requests that were completed by CBCC all 26 were appropriate and found to be medically necessary diagnostic testing based on the review of clinical documentation submitted by this provider.

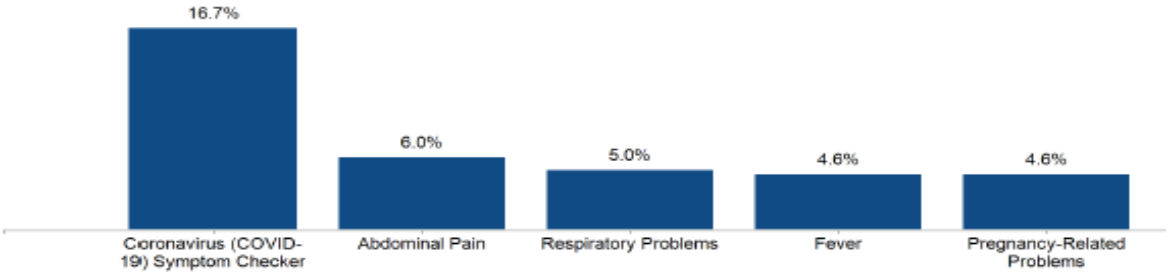
Health Dialog Report

Member Inbound Call Reasons (Jan-2022)

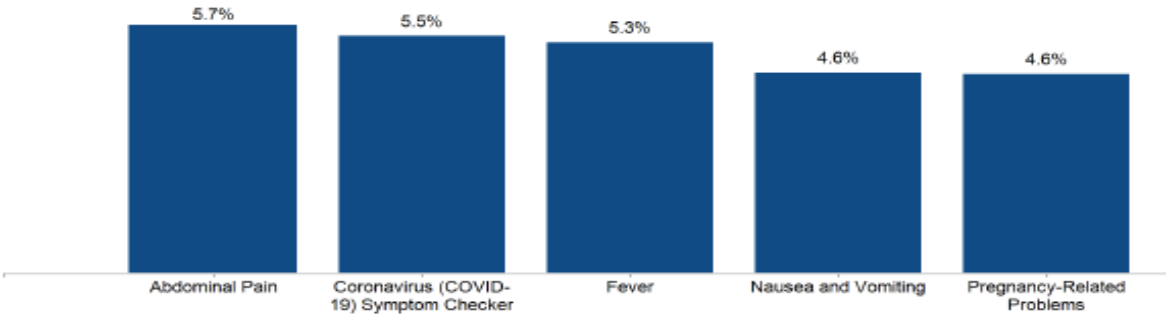


REASON	NUMBER
Symptom Check	291
Condition Support	12
Decision Support	1
Wellness Support	0
Health Plan	140
Mailing or Message Follow Up	28
Web Tools	0
Other	145

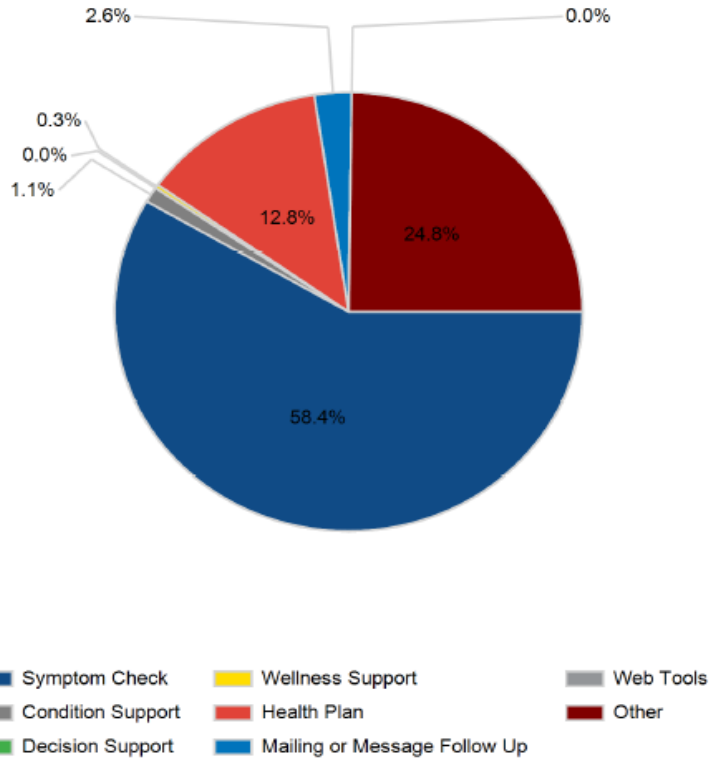
Most Frequent Symptoms - Inbound Symptom Check Calls (Jan-2022)



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

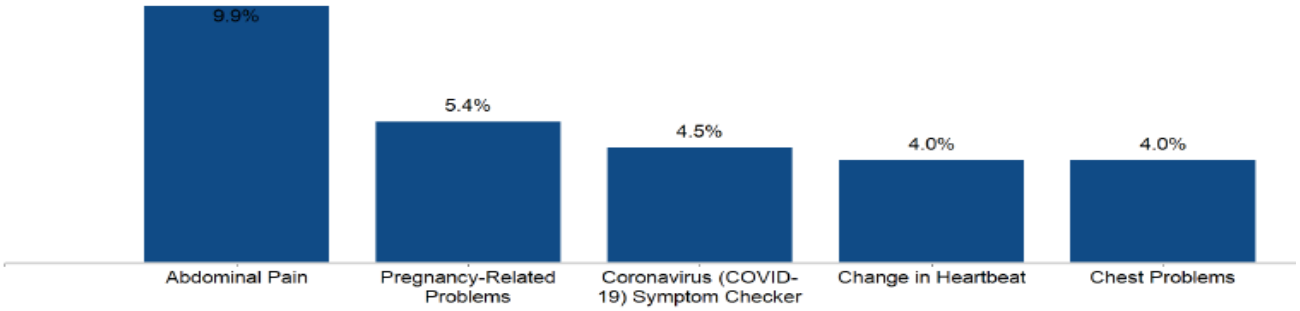


Member Inbound Call Reasons (Feb-2022)

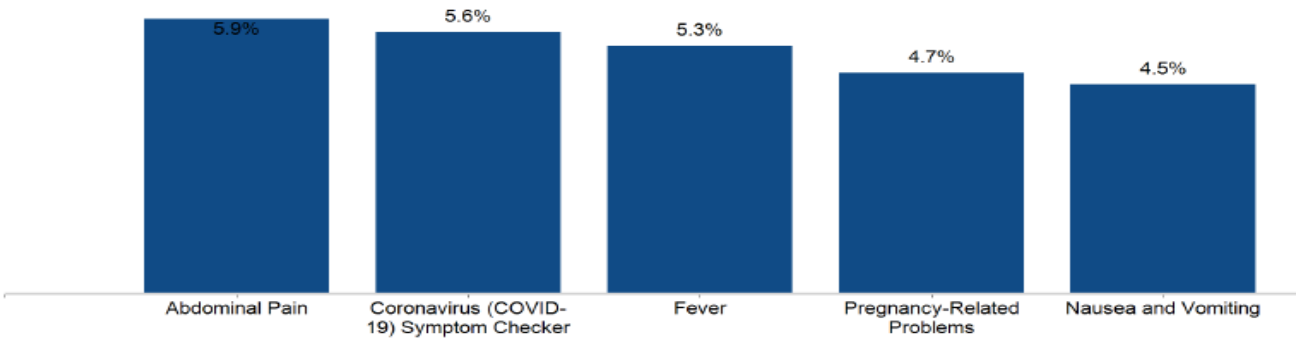


REASON	NUMBER
Symptom Check	205
Condition Support	4
Decision Support	0
Wellness Support	1
Health Plan	45
Mailing or Message Follow Up	9
Web Tools	0
Other	87

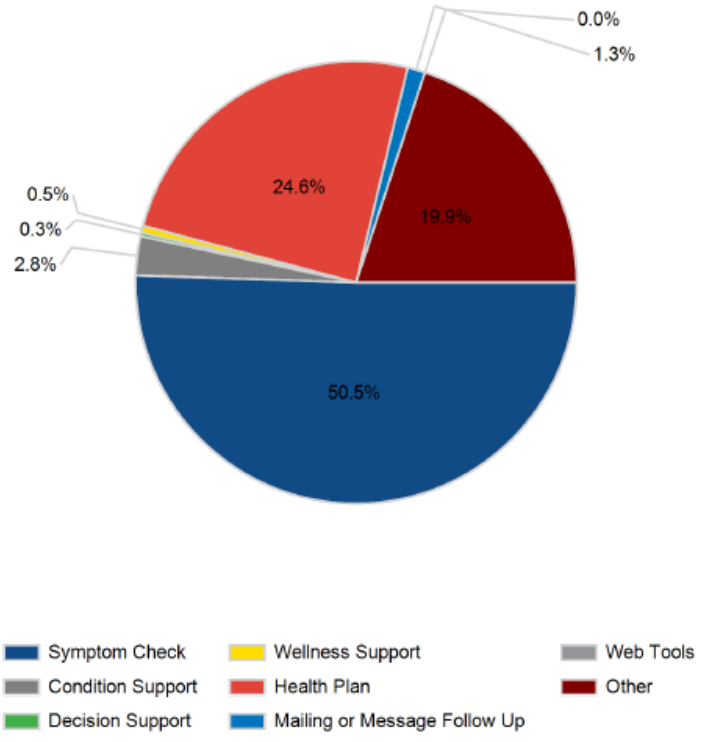
Most Frequent Symptoms - Inbound Symptom Check Calls (Feb-2022)



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

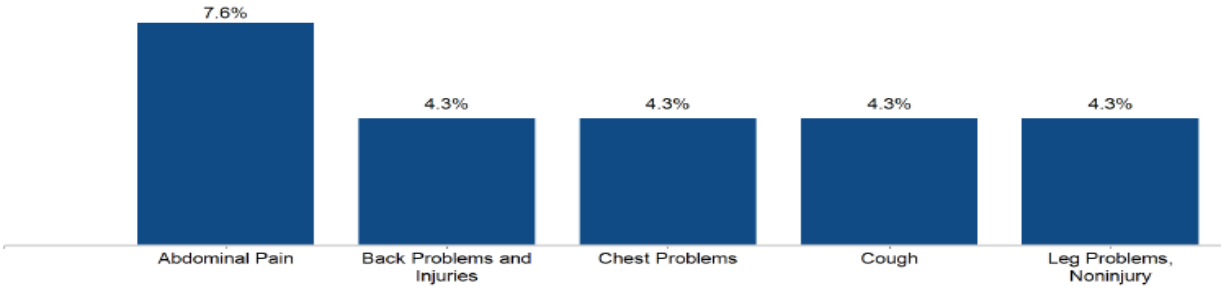


Member Inbound Call Reasons (Mar-2022)

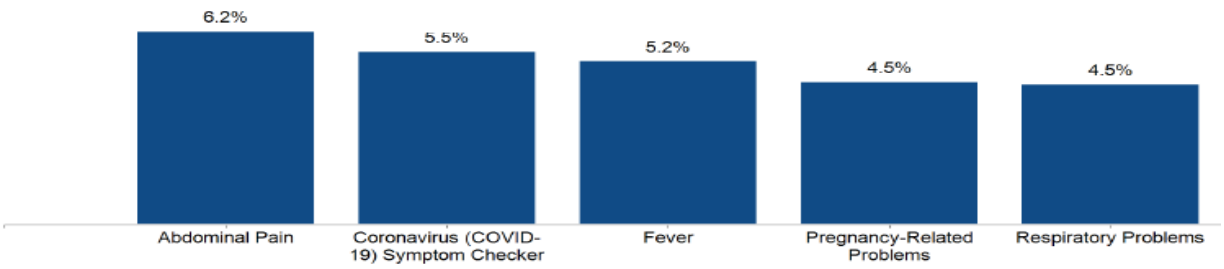


REASON	NUMBER
Symptom Check	195
Condition Support	11
Decision Support	1
Wellness Support	2
Health Plan	95
Mailing or Message Follow Up	5
Web Tools	0
Other	77

Most Frequent Symptoms - Inbound Symptom Check Calls (Mar-2022)



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



Diabetic Exam Reminder Effectiveness Report

Client: - 12049397

Reminder Year:	Reminder Month:	Reminders Sent	Received Exam Within 0-90 Days	Received Exam Within 91-180 Days	Total Exams Within 180 Days
2021	April	383	30	13	43
	May	7,147	171	122	293
	June	265	20	6	26
	July	1,533	69	45	114
	August	573	29	25	54
	September	174	11	7	18
	October	3,896	82	64	146
	November	268	15	5	20
	December	881	33	2	35
2022	January	2,120	57	0	57
	February	231	7	0	7
	March	1,357	3	0	3
Totals		**18,828**	**527**	**289**	**816**

LTM Effectiveness* : 4 %

12-Month Effectiveness (Oct 2020 - Sep 2021) : 6 %

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

Medical Data Collection Summary Report

Period Covered: April, 2021 through March, 2022
Prepared for: KERN HEALTH SYSTEMS - (12049397)

Overview

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

Summary of Findings

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

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

Reported Cases

	Members	
Received Eye Exam:	22,101	
Diabetes[1]:	1,165	5.3%
Diabetic Retinopathy:	256	1.2%
Glaucoma:	392	1.8%
Hypertension:	642	2.9%
High Cholesterol	223	1.0%
Macular Degeneration:	62	.3%

Estimated Number of Cases

Total Members:	313,127	
Diabetes[1]:	7,830	2.5%
Diabetic Retinopathy:	702	.2%
Glaucoma:	1,312	.4%
Hypertension:	33,669	10.8%
High Cholesterol	47,927	15.3%
Macular Degeneration:	448	.1%

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

KAISER REPORTS

(PROPRIETARY AND CONFIDENTIAL)

Available upon Request

KERN HEALTH SYSTEMS

To: QI/UM Committee Meeting

From: Nate Scott

Date: May 26, 2022

Re: Executive Summary for 1st Quarter 2022 Operational Board Update - Grievance Report

---

Background

Executive Summary for 1st Quarter 2022 Operational Board Update - Grievance Report: When compared to the previous four quarters, we have identified the following significant trends as they relate to the Grievances and Appeals received during the 1st Quarter, 2022.

- The reduction in appeals can be attributed to the implementation of Medi-Cal Rx, effective January 1, 2022.
- KHS membership grew substantially in January. The Plan received approximately 12,000 new and re-enrolled members. With the increase in membership, it is expected that grievances, such as Quality of Care and Service complaints, will increase.

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

Requested Action

Receive and File

1st Quarter 2022 Operational Report

Alan Avery
Chief Operating Officer

1st Quarter 2022 Grievance Report

Category	1st Quarter 2022	Status	Issue	Q4 2021	Q3 2021	Q2 2021	Q1 2021
Access to Care	169		Appointment Availability	131	148	90	77
Coverage Dispute	0		Authorizations and Pharmacy	0	0	0	0
Medical Necessity	138		Questioning denial of service	266	329	308	308
Other Issues	41		Miscellaneous	36	18	20	11
Potential Inappropriate Care	479		Questioning services provided. All cases forwarded to Quality Dept.	256	164	183	156
Quality of Service	125		Questioning the professionalism, courtesy and attitude of the office staff. All cases forwarded to PR Department	55	53	31	8
Discrimination (New Category)	15		Alleging discrimination based on the protected characteristics				
Total Formal Grievances	967			744	712	632	560
Exempt	1404		Exempt Grievances-	1431	1520	1570	1179
Total Grievances (Formal & Exempt)	2371			2175	2232	2202	1739

KERN HEALTH SYSTEMS
kernhealthsystems.com

KHS Grievances per 10,000 members = 8.826/month LHPC Averages 3.10-10.120

Additional Insights-Formal Grievance Detail

Issue	2022 1st Quarter Grievances	Upheld Plan Decision	Further Review by Quality	Overturned Ruled for Member	Still Under Review
Access to Care	105	42	0	36	27
Coverage Dispute	0	0	0	0	0
Specialist Access	64	21	0	23	20
Medical Necessity	138	67	0	31	40
Other Issues	41	23	0	7	11
Potential Inappropriate Care	479	133	338	8	0
Quality of Service	125	60	0	19	46
Discrimination	15	9	0	1	5
Total	967	355	338	125	149

KERN HEALTH SYSTEMS

To: QI/UM Committee Meeting

From: Nate Scott

Date: May 26, 2022

Re: Executive Summary for 1st Quarter 2022 Grievance Summary Report

---

Background

Executive Summary for the 1st Quarter Grievance Summary Report:
The Grievance Summary Report supports the high-level information provided on the Operational Report and provides more detail as to the type of grievances KHS receives on behalf of our members. You will notice that for 2022, we have added the new classification of Discrimination to our reporting. As part of the regulatory requirement for Discrimination grievances, all cases processed with this classification are forwarded to the Department of Health Care Services (DHCS) Office of Civil Rights within ten days of the grievance closure.

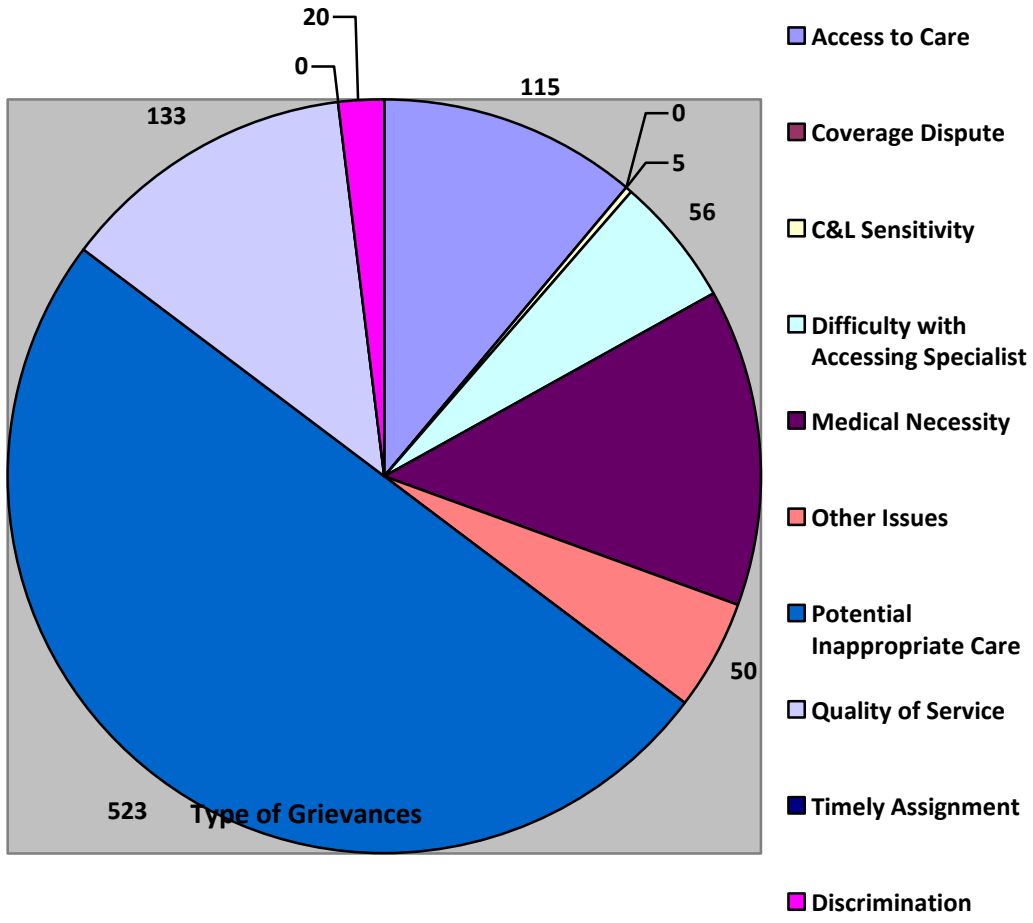
Kaiser Permanente Grievances and Appeals
This report also provides insight into the type of grievance and appeals received on behalf of KHS members assigned to Kaiser Permanente. KHS receives Kaiser's aggregate reporting data, but currently does not have the specific breakdown of the data to report to the committee. We are currently working with our reporting team to retrieve the data from the DHCS report to provide more information on the type of grievances processed for our members assigned to Kaiser.

Requested Action

Receive and File

1st Quarter 2022 Grievance Summary

Issue	Number	In Favor of Health Plan	Under Review by Q.I	In favor of Enrollee	Still under review
Access to care	115	68	0	47	0
Coverage dispute	0	0	0	0	0
Cultural and Linguistic Sensitivity	5	2	0	3	0
Difficulty with accessing specialists	56	27	0	29	0
Medical necessity	142	98	0	44	0
Other issues	50	39	0	11	0
Potential Inappropriate care	523	157	358	8	0
Quality of service	133	98	0	35	0
Timely assignment to provider	0	0	0	0	0
Discrimination	20	19	0	1	0



KHS Grievances per 10,000 members = 9.615/month LHPC Averages 3.10-10.120

During the first quarter of 2022, there were one thousand forty-four standard grievances and appeals received. One hundred seventy-eight cases were closed in favor of the Enrollee. Five hundred and eight cases were closed in favor of the Plan. Three hundred fifty-eight cases have closed and are under review by the KHS Quality Improvement Department. Of the one thousand forty-four standard grievances and appeals received, nine hundred fifty-eight cases closed within thirty days; eighty-six cases were pended and closed after thirty days.

1st Quarter 2022 Grievance Summary

Access to Care

There were one hundred fifteen grievances pertaining to access to care. Sixty-eight closed in favor of the Plan. Forty-seven cases closed in favor of the Enrollee. The following is a summary of these issues:

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

Thirty-four members complained about the wait time to be seen for a Primary Care Provider (PCP) appointment. Twenty cases closed in favor of the Plan after the responses indicated the members were seen within the appropriate wait time for a scheduled appointment or the members were at the offices to be seen as a walk-in, which are not held to Access to Care standards. Fourteen cases closed in favor of the Enrollee after the responses indicated the members were not seen within the appropriate wait time for a scheduled appointment.

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

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

One member complained about physical access availability with their Primary Care Provider (PCP). This case closed in favor of the Plan after it was determined the provider's office does have wheelchair access.

Coverage Dispute

There were no grievances pertaining to a Coverage Dispute issue.

Cultural and Linguistic Sensitivity

Five members complained about the lack of available interpreting services to assist during their appointments. Three cases closed in favor of the Enrollee after the

responses from the providers indicated the members may not have been provided with the appropriate access to interpreting services. Two cases closed in favor of the Plan after the responses from the providers indicated the members were provided with the appropriate access to interpreting services.

Difficulty with Accessing a Specialist

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

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

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

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

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

Seven members complained about the availability with scheduling Non-Emergency Medical Transportation. Four of the cases closed in favor of the Plan after the responses determined the member received the appropriate scheduling from the transportation vendor. Three cases closed in favor of the Enrollee after the response indicated the member may not have been provided with the appropriate scheduling from the transportation vendor.

Medical Necessity

There were one hundred forty-two appeals pertaining to Medical Necessity. Ninety-eight cases were closed in favor of the Plan. Forty-four cases closed in favor of the Enrollee. The following is a summary of these issues:

1st Quarter 2022 Grievance Summary

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

One member complained about the denial or modification of a TAR. One case closed in favor of the Plan, as it was determined there was no supporting documentation submitted with the TAR to support the criteria for medical necessity of the requested medication; therefore, the denial was upheld.

Other Issues

There were fifty grievances pertaining to Other Issues that are not otherwise classified in the other categories. Thirty-nine cases were closed in favor of the Plan after the responses indicated appropriate service was provided. Eleven cases closed in favor of the Enrollee after the responses indicated appropriate service may not have been provided.

Potential Inappropriate Care

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

Quality of Service

There were one hundred thirty-three grievances involving Quality of Service issues. Ninety-eight cases closed in favor of the Plan after the responses determined the members received the appropriate service from their providers. Thirty-five cases closed in favor of the enrollee after the responses determined the members may not have received the appropriate services.

Timely Assignment to Provider

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

Discrimination

There were twenty grievances pertaining to Discrimination. Nineteen cases closed in favor of the Plan as there was no discrimination found. One case closed in favor of the Enrollee after the response determined the member may not have received the appropriate service. All grievances related to Discrimination, are forwarded to the DHCS Office of Civil Rights upon closure.

1st Quarter 2022 Grievance Summary

Kaiser Permanente Grievances and Appeals

During the first quarter of 2022, there were ninety-nine grievances and appeals received by KFHC members assigned to Kaiser Permanente.

Access to Care

There were eleven grievances pertaining to Access to Care.

Coverage Dispute

There were thirteen appeals pertaining to Coverage Dispute.

Medical Necessity

There were nine appeals pertaining to Medical Necessity.

Quality of Care

There were four grievances pertaining to Quality of Care.

Quality of Service

There were sixty-two grievances pertaining to a Quality of Service.

QI/UM

Contracts/Credentialing/Recredentialing
January 1, 2022 - March 31, 2022

Credentialing and Re-Credentialing Providers
93 Providers Initially Credentialed
89 Provider Re-Credentialed
0 Denied

Credentialing and Re-Credentialing Facility
6 Facilities Initially Credentialed
18 Facilities Re-Credentialed
0 Denied

New Contracts Effective 3/1
New Contracts Effective 4/1

9 New Contracts were approved:
1 Applied Behavioral Analysis
1 PCP (Pediatrics)
2 Specialist (Multi-Specialty E-Consults, Gastroenterology)
1 Radiology/MRI Facility
1 DME
1 Hearing Aid Dispenser
1 Home Health
1 Hospice

All credentialing and recredentialing files were approved.

PNM Network Review Quarter 1

Access related reporting table of contents

1. After Hours:

   KHS conducts a survey to assess compliance with after-hours urgent and emergent guidance for members. During Q1, KHS conducted 145 calls resulting in compliance rates as follows

   Emergent 99%

   Urgent 92%

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

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

2. Appointment Availability:

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

   In Q1 2022, KHS conducted a follow-up appointment availability survey, resurveying all providers found to be previously noncompliant in 2021 consisting of 9 primary care, 19 specialist, 2 mental health, 1 ancillary, and 3 OB/GYN providers.

   2 primary care and 6 specialist providers remained noncompliant. Provider Relations Representatives conducted targeted outreach and education to the identified providers regarding their contractual obligation to meet regulatory access standards.

3. Access Grievance Review:

In Q3, there were 139 access related grievances. 85 were found in favor of the plan and no further action was needed. 51 were found in favor of the enrollee. KHS has reviewed the grievance results and no issues/trends were identified. The Plan performed a four-quarter rolling review to identify potential trends in Q1 2022. No trends were identified for any specific providers, groups, or specialty types.

4. Geographic Accessibility & DHCS Network Certification: 152

   As part of its ongoing monitoring the Plan reviews additions/deletions in the provider network against the most recently completed geographic accessibility analysis. The Plan did not identify any additions or deletions in Q1 2022 that would affect AAS.

   On February 23, 2022, the DHCS notified the Plan that the ANC and SNC would be due no earlier than July 1, 2022, due to changes in the requirements relating to the CalAIM initiative.

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

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

5. Network Adequacy and Provider Counts:

   KHS must maintain the following ratios:

   1 PCP for every 2,000 members

   1 Physician for every 1,200 members

   KHS review of network to member ratio is compliant with State regulations and Plan policy. KHS recruitment efforts are on-going. Provider counts remain consistent across the review period.

6. DHCS QMRT (Quarterly Monitoring Report/Response Template)

   DHCS conducts quarterly monitoring of: Provider to Member Ratio, Timely Access (was on hold, resumed 1/1/2022) and questions related to timely access will resume in Q2 2022, Physician Supervisor to Non-Physician Medical Practitioner Ratios, and Out-of-Network requests. No issues were identified.

7. VSP Appointment Availability

   The Plan contracts to VSP for optometric services. VSP notified the Plan of their annual appointment survey. 51% of providers contacted were within the 24 hour Urgent Care standard, and 67% were within the 15 day non-urgent standard. VSP confirmed only one provider was within the Plan's Service Area was contacted and was compliant within both standards. The Plan is currently working with VSP to have a more thorough analysis of the Plan's Service Area completed.

8. DMHC MY 2021 Timely Access Results

   As required by DMHC, the Plan conducts an annual Timely Access Survey. Results for the Plan and the Plan delegate (Kaiser) are included.

KERN HEALTH SYSTEMS
1st Quarter 2022
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

Report Date: April 4, 2022

Department: Provider Network Management

Monitoring Period: January 1, 2022 through March 31, 2022

Population:

Providers	Credentialed	Recredentialed
MD's	35	31
DO's	2	3
AU's	0	0
DC's	2	0
AC's	0	0
PA's	5	7
NP's	18	13
CRNA's	0	0
DPM's	0	1
OD's	2	0
ND's	0	0
RD's	0	1
BCBA's	11	10
LM's	0	0
Mental Health	12	5
Ocularist	0	0
Ancillary	6	18
OT	0	0
TOTAL	**93**	**89**

Specialty	Providers Credentialed	Providers Recredentialed	Providers Sent to PAC	Providers Not Approved
Acupuncture	0	0	0	0
Addtiction Medicine	1	0	1	0
Allergy & Immunology	0	0	0	0
Anesthesiology / CRNA	0	0	0	0
Audiology	0	0	0	0
Autism / Behavioral Analyst	11	10	21	0
Cardiology	1	2	3	0
Chiropractor	2	0	2	0
Colon & Rectal Surgery	1	0	1	0
Critical Care	0	1	1	0
Dermatology	3	3	6	0
Emergency Medicine	1	7	8	0
Endocrinology	1	0	1	0
Family Practice	11	16	27	0
Gastroenterology	1	1	2	0
General Practice	2	1	3	0
General Surgery	3	2	5	0

KERN HEALTH SYSTEMS
1st Quarter 2022
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

Specialty	Providers Credentialed	Providers Recredentialed	Providers Sent to PAC	Providers Not Approved
Genetics	0	0	0	0
Gynecology	0	0	0	0
Gynecology/Oncology	0	0	0	0
Hematology/Oncology	0	1	1	0
Hospitalist	3	1	4	0
Infectious Disease	0	0	0	0
Internal Medicine	11	4	15	0
Mental Health	12	5	17	0
MidWife (Certified)	0	0	0	0
MidWife (Licensed)	0	0	0	0
Naturopathic Medicine	0	0	0	0
Neonatology	0	0	0	0
Nephrology	1	1	2	0
Neurological Surgery	1	0	1	0
Neurology	0	1	1	0
Obstetrics & Gynecology	2	4	6	0
Ocularist	0	0	0	0
Occupational Therapy	0	0	0	0
Ophthalmology	0	0	0	0
Optometry	2	0	2	0
Orthopedic Surgery / Hand Surg	2	2	4	0
Otolaryngology	0	0	0	0
Pain Management	0	0	0	0
Pathology	0	1	1	0
Pediatrics	6	2	8	0
Physical Medicine & Rehab	1	0	1	0
Plastic Sugery	0	0	0	0
Podiatry	1	1	2	0
Psychiatry	2	1	3	0
Pulmonary	1	1	2	0
Radiation Oncology	0	0	0	0
Radiology	4	4	8	0
Registered Dieticians	0	1	1	0
Rheumatology	1	0	1	0
Sleep Medicine	0	0	0	0
Thoracic Surgery	0	0	0	0
Urology	1	1	2	0
Vascular Medicine	0	0	0	0
Vascular Surgery	3	1	4	0
KHS Medical Directors	0	0	0	0
TOTAL	**92**	**75**	**167**	**0**

KERN HEALTH SYSTEMS
1st Quarter 2022
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

ANCILLARY	Providers Credentialed	Providers Recredentialed	Providers Sent to PAC	Providers Not Approved
Ambulance	0	0	0	0
Cancer Center	0	0	0	0
Cardiac Sonography	0	0	0	0
Comm. Based Adult Services	0	0	0	0
Dialysis Center	0	0	0	0
DME	2	1	3	0
Hearing Aid Dispenser	1	1	2	0
Home Health	1	1	2	0
Home Infusion/Compounding	0	0	0	0
Hospice	1	1	2	0
Hospital / Tertiary Hospital	0	0	0	0
Laboratory	0	0	0	0
Lactation Consultant	0	0	0	0
MRI	0	0	0	0
Ocular Prosthetics	0	0	0	0
Pharmacy	0	6	6	0
Pharmacy/DME	0	0	0	0
Physical / Speech Therapy	0	1	1	0
Prosthetics & Orthotics	0	1	1	0
Radiology	1	0	1	0
Skilled Nursing	0	2	2	0
Sleep Lab	0	0	0	0
Surgery Center	0	0	0	0
Transportation	0	3	3	0
Urgent Care	0	1	1	0
TOTAL	**6**	**18**	**24**	**0**

Defer = 0 **Denied = 0**

KERN HEALTH SYSTEMS
1st Quarter 2022
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

KERN HEALTH SYSTEMS
1st Quarter 2022
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

KERN HEALTH SYSTEMS
Board Approved Effective 03/01/2022

Legal Name DBA	Specialty	Address	VENDOR PRV	Contract Effective Date
ACES 2020 LLC dba: Aces	ABA Provider	1405 Commercial Way Ste. 120 Bakersfield CA 93309 P - 855-223-7123 F - 619-374-7134	PRV077047	3/1/2022
Central California Asthma Collaborative	Asthma Remediation & Housing Transition	Central California Asthma Collaborative 4991 E. McKinley Avenue Ste. 109 Fresno CA 93727 P- 559-272-4874 F- 559-492-3802	PRV073677	Retro-Eff 1/1/2022
Coastal Kids, A Professional Medical Corporation	Pediatrics	300 Old River Rd Ste. 105 (Primary Addr) 1215 34th Street 9508 Stockdale Hwy Ste. 150 Bakersfield CA	PRV077048	3/1/2022
Corbow Inc dba: The Papo Hernandez Respite, Rest and Recovery Home	Short-Term Post Hospitalization Housing	2813 University Avenue Bakersfield CA 93306	PRV073684	Retro-Eff 1/1/2022
Expert MRI, PC	Radiology / MRI	9802 Stockdale Hwy Ste.106A Bakersfield CA 93311	PRV075346	3/1/2022
Good Samaritan Healing Center LLC dba: Good Samaritan Healing Center	Recuperative Care (Medical Respite)	229 S Chester Avenue Bakersfield CA 93304	PRV070718	Retro-Eff 1/1/2022
Housing Authority of the County of Kern	Housing Tenancy & Sustaining Svcs; Housing Transition/Navigation Svcs & Housing Deposits	601 24th Street Bakersfield CA 93301	PRV073678	Retro-Eff 1/1/2022
Super Care Inc dba: SuperCare Health	DME (O2 & Respiratory Supplies)	3335 Pegasus Dr. Ste. 308 Bakersfield CA 93308	PRV077049	3/1/2022
Western Health Resources dba: Adventist Health Home Care Services - Home Health	Home Health	2800 K Street Bakersfield CA 93301	PRV031946	3/1/2022
Western Health Resources dba: Adventist Health Home Care Services - Hospice	Hospice	1601 New Stine Rd Ste. 103 Bakersfield CA 93309	PRV076645	3/1/2022

KERN HEALTH SYSTEMS

Board Approved Effective 04/01/2022

Legal Name DBA	Specialty	Address	VENDOR PRV	Contract Effective Date
ConferMED of California PC	E-Consults (Peer to Peer)	4600 Campus Drive Ste. 203 Newport Beach CA 92660	PRV077737	4/1/2022
Gastro Care Institute	Gastroenterology / Pathology	1331 W Avenue J Ste. 202 Lancaster CA 93534 P - 661-529-7550 F - 661-529-7560	PRV051043	4/1/2022
WS Audiology California PC	Hearing Aid Dispenser	2530 F Street Ste. 100 Bakersfield CA 93301 P - 661-633-2934 F - 661-633-2393	PRV077821	4/1/2022

KERN HEALTH SYSTEMS

Board Approved Effective 05/01/2022

Legal Name DBA	Specialty	Address	VENDOR PRV	Contract Effective Date
Alfred J. Coppola Jr, MD Inc.	Orthopedic Surgery	300 Old River Road Ste. 200 Bakersfield CA 93311	PRV006326	5/1/2022
Atlas Urgent Care	Walk-In Clinic	5531 Business Park S Bakersfield CA 93309	PRV070835	5/1/2022
Udaya DeSilva MD Inc dba: U.S. Desilva MD, A Medical Corporation	Pain Management	623 W Avenue Q St. Ste. A Palmdale CA 93551	PRV051528	5/1/2022

KERN HEALTH SYSTEMS
Board Approved Effective 03/01/2022

	NAME	DBA/ADDRESS	SPECIALTY	CONTRACT STATUS	PROVIDER PRV	VENDOR PRV	PAC APPROVED - EFFECTIVE DATE
1	Aguilar, Nohely BCBA	ACES 2020 LLC 1405 Commercial Way Ste. 120 Bakersfield CA 93309	Qualified Autism Provider / Behavioral Analyst	New Contract	PRV077046	PRV077047	Yes Eff 3/1/22
2	Central California Asthma Collaborative	Central California Asthma Collaborative 4991 E. McKinley Avenue Ste. 109 Fresno CA 93727 P- 559-272-4874 F- 559-492-3802	CSS/ILOS Asthma Remediation & Housing Transition	New Contract	PRV073677	PRV073677	Yes Retro-Eff 1/1/22
3	Corbow Inc	Corbow Inc dba: The Papo Hernandez Respite, Rest and Recovery Home 2813 University Avenue Bakersfield CA 93306 P - 661-292-0617 F - 661-493-0699	CSS/ILOS Short-Term Post Hospitalization Housing	New Contract	PRV073684	PRV073684	Yes Retro-Eff 1/1/22
4	Expert MRI, PC	Expert MRI, PC 9802 Stcokdale Hwy Ste 106A Bakersfield CA 93311 P - 877-674-8888 F - 877-370-5458	Radiology Clinic	New Contract	PRV075346	PRV075346	Yes Eff 3/1/22
5	Good Samaritan Healing Center LLC	Good Samaritan Healing Center LLC dba: Good Samaritan Healing Center 229 S Chester Avenue Bakersfield CA 93304 P-661-403-6408 F-661-695-5019	CSS/ILOS Recuperative Care (Medical Respite)	New Contract	PRV070718	PRV070718	Yes Retro-Eff 1/1/22
6	Housing Authority of the County of Kern	Housing Authority of the County of Kern 601 24th Street Bakersfield CA 93301 P - 661-631-8500 F - 661-631-1015	CSS/ILOS Housing Tenancy & Sustaining Svcs	New Contract	PRV073678	PRV073678	Yes Retro-Eff 1/1/22

KERN HEALTH SYSTEMS
Board Approved Effective 03/01/2022

	NAME	DBA/ADDRESS	SPECIALTY	CONTRACT STATUS	PROVIDER PRV	VENDOR PRV	PAC APPROVED - EFFECTIVE DATE
7	Super Care Inc	Super Care Inc dba: SuperCare Health 3335 Pegasus Drive Ste. 308 Bakersfield CA 93308 P- 800-206-4880 F-626-709-3442	DME (O_2 & Respiratory Supplies)	New Contract	PRV077049	PRV077049	Yes Eff 3/1/22
8	Thierry, Andrew MD	Expert MRI, PC 9802 Stcokdale Hwy Ste 106A Bakersfield CA 93311	Diagnostic Radiology	New Contract	PRV061773	PRV075346	Yes Eff 3/1/22
9	Western Health Resources (HH)	Western Health Resources dba: Adventist Health Home Care Services - Home Health 2800 K Street Bakersfield CA 93301 P- 661-863-2700 F - 661-631-9716	Home Health	New Contract	PRV031946	PRV031946	Yes Eff 3/1/22
10	Western Health Resources (Hospice)	Western Health Resources dba: Adventist Health Home Care Services - Hospice 1601 New Stine Road Ste. 103 Bakersfield CA 93309 P - 661-836-8250 F - 661-836-8000	Hospice	New Contract	PRV076645	PRV076645	Yes Eff 3/1/22
11	Dhariwal, Manoj MD	Emergency Physicians UC, Inc Accelerated Urgent Care *All Locations 212 Coffee Road Ste. 100 Bakersfield CA 93309	Family Medicine	Existing	PRV077050	ALL SITES	Yes Eff 3/1/22
12	Dharma, Kalamani MD	Pinnacle Women's Health Group, Inc. 2615 Chester Avenue Bakersfield CA 93301	OB/GYN Hospitalist	Existing	PRV049844	PRV033812	Yes Eff 3/1/22
13	Lane, Gregory NP-C	Carlos A. Alvarez, MD Inc. 801 Santa Fe Way Shafter CA 626 Main Street Delano CA 8929 Panama Road Ste. A Lamont CA	Internal Medicine	Existing	PRV076921	ALL SITES	Yes Eff 3/1/22

KERN HEALTH SYSTEMS
Board Approved Effective 03/01/2022

	NAME	DBA/ADDRESS	SPECIALTY	CONTRACT STATUS	PROVIDER PRV	VENDOR PRV	PAC APPROVED - EFFECTIVE DATE
14	Runge, Sara MD	Kern County Hospital Authority 1700 Mt Vernon Avenue 3551 Q Street Ste. 100 Bakersfield CA	General & Vascular Surgery	Existing	PRV074780	ALL SITES	**Yes** **Eff 3/1/22**
15	Verma, Preeti MD	Omni Family Health 1530 E Manning Avenue Reedley CA 93654	Pediatrics	Existing	PRV051486	ALL SITES	**Yes** **Eff 3/1/22**
16	Abou Jaoude, Dory MD	Hospitalist Medicine Phys of Calif Inc dba: Sound Hospitalist of California 2615 Chester Avenue Bakersfield CA 93301	Internal Medicine / Hospitalist	Existing	PRV066407	PRV014433	**Yes** **Eff 3/1/22**
17	Adams, Daniel MD	Omni Family Health 3409 Calloway Dr Bldg 300 Bakersfield 659 S Central Valley Highway Shafter CA	Pediatrics	Existing	PRV075534	PRV000019	**Yes** **Eff 3/1/22**
18	Agustin, Johnny NP-C	Vanguard Medical Corporation 565 Kern Street Shafter CA 845 7th Street Wasco CA 500 Old River Road Ste. 250 Bakersfield	Internal Medicine	Existing	PRV041803	ALL SITES	**Yes** **Eff 3/1/22**
19	Bacus, David NP-C	Emergency Physicians UC, Inc Accelerated Urgent Care *All Locations 212 Coffee Road Ste. 100 Bakersfield CA 93309	Family Practice	Existing	PRV075863	ALL SITES	**Yes** **Eff 1/1/22**
20	Bashtar, Reza MD	Hospitalist Medicine Phys of Calif Inc dba: Sound Hospitalist of California 2615 Chester Avenue Bakersfield CA 93301	Internal Medicine / Hospitalist	Existing	PRV010615	PRV014433	**Yes** **Eff 3/1/22**
21	Benavides, Jancy PA-C	Kern County Hospital Authority 1700 Mt Vernon Avenue 3551 Q Street Ste. 100 Bakersfield CA	General & Vascular Surgery	Existing	PRV075213	ALL SITES	**Yes** **Eff 3/1/22**

KERN HEALTH SYSTEMS
Board Approved Effective 03/01/2022

	NAME	DBA/ADDRESS	SPECIALTY	CONTRACT STATUS	PROVIDER PRV	VENDOR PRV	PAC APPROVED - EFFECTIVE DATE
22	Cabral, Erik MD	LA Laser Center PC *All Locations 5600 California Avenue Ste. 101 & 103 Bakersfield CA 93309	Dermatology	Existing	PRV077051	PRV013922	**Yes** **Eff 3/1/22**
23	Carter, Jack BCBA	Autism Behavior Services Inc 4900 California Avenue Tower B, 2nd Flr Bakersfield CA 93309	Qualified Autism Provider / Behavioral Analyst	Existing	PRV077052	PRV062872	**Yes** **Eff 3/1/22**
24	Caspi, Hen PsyD	Omni Family Health 210 N Chester Avenue Bakersfield CA 912 Fremont Street Delano CA	Psychology	Existing	PRV075805	PRV000019	**Yes** **Eff 3/1/22**
25	Cisneros-Gutierrez, Deysi BCBA	California Psychcare, Inc. 4900 California Avenue Ste. 100-A Bakersfield CA 93309	Qualified Autism Provider / Behavioral Analyst	Existing	PRV076920	PRV011225	**Yes** **Eff 3/1/22**
26	Daniels, Donald PA-C	Adventist Health Comm Ctr - Tehachapi 2041 Belshaw Street Mojave CA 93501	Family Practice	Existing	PRV040282	ALL SITES	**Yes** **Eff 3/1/22**
27	DeYoung, Elliot MD	Renaissance Imaging Med Assoc, Inc. 44105 W 15th Street Ste. 100 Lancaster 38925 Trade Center Dr Ste. E Palmdale	Diagnostic Radiology	Existing	PRV053438	PRV000324	**Yes** **Eff 3/1/22**
28	Felix, Yesenia BCBA	Center for Autism and Related Disorders, LLC 8302 Espresso Drive Ste. 100 Bakersfield CA 93312	Qualified Autism Provider / Behavioral Analyst	Existing	PRV077053	PRV032083	**Yes** **Eff 3/1/22**
29	Fitter, Junaid MD	Bartz-Altadonna Comm Health Center 9300 N. Loop Blvd California City CA 93505	Internal Medicine	Existing	PRV002830	PRV029961	**Yes** **Eff 3/1/22**
30	Goldstein, Dawn MD	Ridgecrest Regional Hospital (RHC) 1011 N China Lake Blvd Ste. A Ridgecrest CA 93555	OB/GYN	Existing	PRV074848	ALL SITES	**Yes** **Eff 3/1/22**
31	Heck, Heather PA-C	Telemedicine Group PC dba: TeleMed2U 3400 Douglas Blvd Ste. 225 Roseville CA 95661	Endocrinology	Existing	PRV077054	PRV061649	**Yes** **Eff 3/1/22**

KERN HEALTH SYSTEMS
Board Approved Effective 03/01/2022

	NAME	DBA/ADDRESS	SPECIALTY	CONTRACT STATUS	PROVIDER PRV	VENDOR PRV	PAC APPROVED - EFFECTIVE DATE
32	Horta, Lizette BCBA	Adelante Behavioral Health ABA LLC 2005 Eye Street Ste. 8 Bakersfield CA 93301	Qualified Autism Provider / Behavioral Analyst	Existing	PRV077055	PRV067923	**Yes** **Eff 3/1/22**
33	Ibrahim, Nuha MD	Ridgecrest Regional Hospital (RHC) 105 E Sydnor Avenue Ste. 100 Ridgecrest CA 93555	Nephrology	Existing	PRV046028	ALL SITES	**Yes** **Eff 3/1/22**
34	Issa, Tammy MD	Kern County Hospital Authority 1111 Columbus Street Bakersfield CA 93305	Internal Medicine	Existing	PRV075290	ALL SITES	**Yes** **Eff 3/1/22**
35	Kaur, Jaspinderjit NP-C	Coastal Kids, A Prof Med Corp. dba: Bakersfield Pediatrics 300 Old River Road Ste. 105 Bakersfield CA 93311	Pediatrics	Existing	PRV074738	PRV077048	**Yes** **Eff 3/1/22**
36	Li, Su-Yu MD	Renaissance Imaging Med Assoc, Inc. 44105 W 15th Street Ste. 100 Lancaster 38925 Trade Center Dr Ste. E Palmdale	Diagnostic Radiology	Existing	PRV031993	PRV000324	**Yes** **Eff 3/1/22**
37	Liu, Charles MD	Adventist Health Physicians Network 2701 Chester Avenue Ste. 102 Bakersfield CA 93301	Neurological Surgery	Existing	PRV003103	PRV053701	**Yes** **Eff 3/1/22**
38	Marasigan, Maria Angelica NP-C	Bartz-Altadonna Comm Health Center 9300 N. Loop Blvd California City CA 93505	Family Practice	Existing	PRV077056	PRV029961	**Yes** **Eff 3/1/22**
39	Meade, Peter MD	Kern County Hospital Authority 1700 Mt Vernon Ave Bakersfield CA 93306	General Surgery	Existing	PRV058957	ALL SITES	**Yes** **Eff 3/1/22**
40	Montero, Winston MD	Universal Healthcare Services, Inc. dba: Central California Pain Management 8303 Brimhall Road Bldg 1500 3550 Q Street Ste. 201 & 202 Bakersfield CA	Physical Medicine & Rehab	Existing	PRV011199	ALL SITES	**Yes** **Eff 3/1/22**
41	Nguyen, Ngoc NP-C	Clinica Sierra Vista (CSV) 67 Evans Road Wofford Heights CA 93285	Family Practice	Existing	PRV074741	PRV000002	**Yes** **Eff 3/1/22**

KERN HEALTH SYSTEMS
Board Approved Effective 03/01/2022

	NAME	DBA/ADDRESS	SPECIALTY	CONTRACT STATUS	PROVIDER PRV	VENDOR PRV	PAC APPROVED - EFFECTIVE DATE
42	Nordhues, Juliana BCBA	Autism Behavior Services Inc 4900 California Avenue Tower B, 2nd Flr Bakersfield CA 93309	Qualified Autism Provider / Behavioral Analyst	Existing	PRV077081	PRV062872	**Yes** **Eff 3/1/22**
43	Nunez, Esmeralda LCSW	Adventist Health Comm Ctr - Tehachapi 105 West E Street Taft CA 9350 N. Loop Blvd California City CA 2041 Belshaw Street Mojave CA	Clinical Social Worker	Existing	PRV077086	ALL SITES	**Yes** **Eff 3/1/22**
44	Paris, Holly PA-C	Ridgecrest Regional Hospital (RHC) 1111 N China Lake Blvd Ste. 190 Ridgecrest CA 93555	General Practice	Existing	PRV075762	ALL STIES	**Yes** **Eff 3/1/22**
45	Parsons, Rosaleen MD	Renaissance Imaging Med Assoc, Inc. 44105 W 15th Street Ste. 100 Lancaster 38925 Trade Center Dr Ste. E Palmdale	Diagnostic Radiology	Existing	PRV075245	PRV000324	**Yes** **Eff 3/1/22**
46	Quick, Nichole MD	Bright Heart Health Medical Group 2960 Camino Diablo Ste. 105 Walnut Creek CA 94597	Addiction Medicine	Existing	PRV077099	PRV061628	**Yes** **Eff 3/1/22**
47	Rabanal, Frances Camille NP-C	Clinica Sierra Vista (CSV) 2000 Physicians Blvd Bakersfield CA 93301	Pediatrics	Existing	PRV075212	PRV000002	**Yes** **Eff 3/1/22**
48	Ramsey, Keith DO	Bartz-Altadonna Comm Health Center 9300 N. Loop Blvd California City CA 93505	Pediatrics	Existing	PRV077100	PRV029961	**Yes** **Eff 3/1/22**
49	Rucker, Burnett MD	West Side Health Care District dba: West Side Family Health Care-RHC 100 E North Street Taft CA 93268	General Practice	Existing	PRV000605	PRV000306	**Yes** **Eff 3/1/22**
50	Saini, Gursharan MD	SJV Medical Group 5801 Truxtun Avenue Bakersfield CA 93309	Pulmonary Disease	Existing	PRV000567	PRV066164	**Yes** **Eff 3/1/22**
51	Samra, Sukhchain NP-C	LA Laser Center PC *All Locations 5600 California Avenue Ste. 101 & 103 Bakersfield CA 93309	Dermatology	Existing	PRV075225	PRV013922	**Yes** **Eff 3/1/22**

KERN HEALTH SYSTEMS
Board Approved Effective 03/01/2022

	NAME	DBA/ADDRESS	SPECIALTY	CONTRACT STATUS	PROVIDER PRV	VENDOR PRV	PAC APPROVED - EFFECTIVE DATE
52	Sanchez, Irene MD	West Side Health Care District dba: West Side Family Health Care-UC 100 E North Street Taft CA 93268	Family Medicine	Existing	PRV037427	PRV000306	**Yes** **Eff 3/1/22**
53	Sanchez, Jessica NP-C	Dignity Health Medical Foundation 3838 San Dimas Street Ste. B-201 Bakersfield CA 93301	Cardiovascular Disease	Existing	PRV077101	PRV012886	**Yes** **Eff 3/1/22**
54	Shnaider, Svetlana NP-C	Bartz-Altadonna Comm Health Center 9300 N. Loop Blvd California City CA 93505	Internal Medicine	Existing	PRV077102	PRV029961	**Yes** **Eff 3/1/22**
55	Singh, Love MD	Ridgecrest Regional Hospital (RHC) 105 E Sydnor Avenue Ste. 100 1111 N China Lake Blvd Ste. 190 Ridgecrest CA 93555	Family Practice	Existing	PRV037624	ALL SITES	**Yes** **Eff 3/1/22**
56	Splawn, Malory NP-C	Kern Valley Healthcare District 4300 Birch Street Lake Isabella CA 93240	Internal Medicine	Existing	PRV077103	PRV046034	**Yes** **Eff 3/1/22**
57	Staudacher, Becky BCBA	Adelante Behavioral Health ABA LLC 2005 Eye Street Ste. 8 Bakersfield CA 93301	Qualified Autism Provider / Behavioral Analyst	Existing	PRV077104	PRV067923	**Yes** **Eff 3/1/22**
58	Stetz, Sharon NP-C	Bright Heart Health Medical Group 2960 Camino Diablo Ste. 105 Walnut Creek CA 94597	Psychiatry	Existing	PRV077105	PRV061628	**Yes** **Eff 3/1/22**
59	Testori, Alessandro MD	Kern County Hospital Authority 1111 Columbus Street Bakersfield CA 93305	Internal Medicine	Existing	PRV075289	ALL SITES	**Yes** **Eff 3/1/22**
60	Valdez, Michael MD	Kern County Hospital Authority 1111 Columbus Street Bakersfield CA 93305	Internal Medicine	Existing	PRV073679	ALL SITES	**Yes** **Eff 3/1/22**
61	Villatoro, Angela NP-C	Clinica Sierra Vista (CSV) 2000 Physicians Blvd Bakersfield CA 93301	Family Practice	Existing	PRV074740	PRV000002	**Yes** **Eff 3/1/22**

KERN HEALTH SYSTEMS
Board Approved Effective 03/01/2022

	NAME	DBA/ADDRESS	SPECIALTY	CONTRACT STATUS	PROVIDER PRV	VENDOR PRV	PAC APPROVED - EFFECTIVE DATE
62	Winkelmann, Richard DO	LA Laser Center PC *All Locations 5600 California Avenue Ste. 101 & 103 Bakersfield CA 93309	Dermatology	Existing	PRV077106	PRV013922	**Yes** **Eff 3/1/22**

KERN HEALTH SYSTEMS
Board Approved Effective 04/01/2022

	NAME	DBA/ADDRESS	SPECIALTY	CONTRACT STATUS	PROVIDER PRV	VENDOR PRV	PAC APPROVED - EFFECTIVE DATE
1	WS Audiology California PC	WS Audiology California PC 2530 F Street Ste 100 Bakersfield CA 93301	Hearing Aid Dispenser	**New Contract**	PRV077821	PRV077821	**Yes** **Eff 4/1/22**
2	L'Archeveque, Dee Maria MD	Emergency Physicians Urgent Care, Inc. dba: Accelerated Urgent Care *All Locations 212 Coffee Road Ste. 101 Bakersfield CA 93309	Emergency Medicine	Existing	PRV002615	ALL SITES	**Yes** **Eff 4/1/22**
3	Lincare Inc. - Lancaster	Lincare Inc. dba: Lincare Inc. - Lancaster 42207 6th Street West, Ste 101 Lancaster CA 93534	DME	Existing	PRV006208	PRV006208	**Yes** **Eff 4/1/22**
4	Acevedo, Jessica BCBA	California Psychcare, Inc. 4900 California Avenue Ste. 100-A Bakersfield CA 93309	Qualified Autism Provider / Behavioral Analyst	Existing	PRV077574	PRV011225	**Yes** **Eff 4/1/22**
5	Adangai, Justina NP-C	Omni Family Health 655 S Central Highway Shafter CA 525 Roberts Lane Bakersfield CA 1701 Stine Road Bakersfield CA - **ECM**	Internal Medicine	Existing	PRV076364	PRV000019	**Yes** **Retro-Eff 3/1/22**
6	Alvarez, Armando MD	Emergency Physicians Urgent Care, Inc. dba: Accelerated Urgent Care *All Locations 212 Coffee Road Ste. 101 Bakersfield CA 93309	Family Practice	Existing	PRV007424	ALL SITES	**Yes** **Eff 4/1/22**

KERN HEALTH SYSTEMS
Board Approved Effective 04/01/2022

	NAME	DBA/ADDRESS	SPECIALTY	CONTRACT STATUS	PROVIDER PRV	VENDOR PRV	PAC APPROVED - EFFECTIVE DATE
7	Anand, Rachna NP-C	Clinica Sierra Vista (CSV) 625 34th Street Ste 100 Bakersfield CA 2400 Wible Rd Bakersfield CA	Psychiatry	Existing	PRV076202	PRV000002	**Yes** **Eff 4/1/22**
8	Bryant, Nicole LCSW	Reedley Community Hospital dba: Adventist Health Community Care - Hanford 1025 N. Douty Street Hanford CA 93230	Clinical Social Worker	Existing	PRV077822	PRV040784	**Yes** **Eff 4/1/22**
9	Cachero, Arsenio NP-C	Stockdale Podiatry Group Inc. 110 New Stine Road Bakersfield CA 93309	Podiatry	Existing	PRV037349	PRV000332	**Yes** **Eff 4/1/22**
10	Coppola, Alfred MD	Pacific Central Coast Health Centers dba: Dignity Health Surgical Specialists - Southwest 300 Old River Road Ste. 200 Bakersfield CA 93311	Orthopedic Surgery	Existing	PRV029330	PRV073605	**Yes** **Eff 4/1/22**
11	Covarrubias Perez, Adriana BCBA	Shih Applied Behavior Analysis 8723 Winlock Street Bakersfield CA 93312	Qualified Autism Provider / Behavioral Analyst	Existing	PRV077736	PRV052861	**Yes** **Eff 4/1/22**
12	Decker, Greg PhD	Reedley Community Hospital dba: Adventist Health Community Care - Hanford 1025 N. Douty Street Hanford CA 93230	Psychology	Existing	PRV077819	PRV040784	**Yes** **Eff 4/1/22**
13	Doi, Nancy PsyD	Reedley Community Hospital dba: Adventist Health Reedley - Selma Central 2141 High Street Selma CA 93662	Psychology	Existing	PRV077823	PRV077724	**Yes** **Eff 4/1/22**

KERN HEALTH SYSTEMS
Board Approved Effective 04/01/2022

	NAME	DBA/ADDRESS	SPECIALTY	CONTRACT STATUS	PROVIDER PRV	VENDOR PRV	PAC APPROVED - EFFECTIVE DATE
14	Egwu, Joy NP-C	Emergency Physicians Urgent Care, Inc. dba: Accelerated Urgent Care *All Locations 212 Coffee Road Ste. 101 Bakersfield CA 93309	Family Practice	Existing	PRV077824	ALL SITES	**Yes** **Eff 4/1/22**
15	Elias, Alexandra MD	Kern County Hospital Authority 3551 Q Street Ste. 100 Bakersfield CA 1700 Mt Vernon Ave Bakersfield CA	Colon & Rectal Surgery	Existing	PRV075804	ALL SITES	**Yes** **Eff 4/1/22**
16	Ercolani, Matthew MD	Adventist Health Physicians Network 2701 Chester Avenue Ste. 102 Bakersfield CA 93301	Urology	Existing	PRV077738	PRV053701	**Yes** **Eff 4/1/22**
17	Flores, Julie LCSW	Reedley Community Hospital dba: Adventist Health Community Care - Hanford 1025 N. Douty Street Hanford CA 93230	Psychology	Existing	PRV077825	PRV040784	**Yes** **Eff 4/1/22**
18	Garcia, Alicia DC	Vanguard Medical Corporation 845 7th St Wasco CA 565 Kern St Shafter CA	Chiropractic	Existing	PRV000858	ALL SITES	**Yes** **Eff 4/1/22**
19	Garcia, Jacqueline BCBA	Matthew T. Dolan dba: Behavioral Education Analysis & Research 26300 Chester Court Tehachapi CA 93561	Qualified Autism Provider / Behavioral Analyst	Existing	PRV077826	PRV060567	**Yes** **Eff 4/1/22**
20	Jain, Nickul MD	Adventist Health Physicians Network 2701 Chester Avenue Ste. 102 Bakersfield CA 93301	Orthopedic Surgery	Existing	PRV045810	PRV053701	**Yes** **Eff 4/1/22**

KERN HEALTH SYSTEMS
Board Approved Effective 04/01/2022

	NAME	DBA/ADDRESS	SPECIALTY	CONTRACT STATUS	PROVIDER PRV	VENDOR PRV	PAC APPROVED - EFFECTIVE DATE
21	Kao, James MD	Ridgecrest Regional Hospital 1041 N China Lake Blvd Ste. B Ridgecrest CA 93555	Gastroenterology	Existing	PRV077827	ALL SITES	**Yes** **Eff 4/1/22**
22	Kotler, John PhD	Reedley Community Hospital dba: Adventist Health Community Care - Hanford 1025 N. Douty Street Hanford CA 93230	Psychology	Existing	PRV077817	PRV040784	**Yes** **Eff 4/1/22**
23	Kumar, Parshotam MD	Omni Family Health 912 Fremont Street Delano CA 93215	Pediatric	Existing	PRV076365	PRV000019	**Yes** **Eff 4/1/22**
24	Leichter, Rhoda MD	Kern County Hospital Authority 3551 Q Street Ste. 100 Bakersfield CA 1700 Mt Vernon Ave Bakersfield CA	Vasculary Surgery	Existing	PRV075288	ALL SITES	**Yes** **Eff 4/1/22**
25	Merino, Anthony PA-C	Emergency Physicians Urgent Care, Inc. dba: Accelerated Urgent Care *All Locations 212 Coffee Road Ste. 101 Bakersfield CA 93309	Family Practice	Existing	PRV048587	ALL SITES	**Yes** **Eff 4/1/22**
26	Mullan, Michael PhD	Reedley Community Hospital dba: Adventist Health Community Care - Sanger 1939 Academy Avenue Sanger CA 93657	Psychology	Existing	PRV077739	PRV048699	**Yes** **Eff 4/1/22**
27	Ngo, Linh OD	Clinica Sierra Vista (CSV) 625 34th Street Ste 100 Bakersfield CA 93301	Optometry	Existing	PRV066490	PRV000002	**Yes** **Eff 4/1/22**

KERN HEALTH SYSTEMS
Board Approved Effective 04/01/2022

	NAME	DBA/ADDRESS	SPECIALTY	CONTRACT STATUS	PROVIDER PRV	VENDOR PRV	PAC APPROVED - EFFECTIVE DATE
28	Rafique, Rabab OD	Ace Eyecare, Inc 1721 Westwind Drive Ste. B Bakersfield CA 93301	Optometry	Existing	PRV077257	PRV041736	**Yes** **Eff 4/1/22**
29	Randolph, Michelle LCSW	Reedley Community Hospital dba: Adventist Health Community Care - Hanford 1025 N. Douty Street Hanford CA 93230	Clinical Social Worker	Existing	PRV077828	PRV040784	**Yes** **Eff 4/1/22**
30	Reyes, Jose DC	Vanguard Medical Corporation 565 Kern Street Shafter CA 845 7th Street Wasco CA	Chiropractic	Existing	PRV034361	ALL SITES	**Yes** **Eff 4/1/22**
31	Sandhu, Supneet NP-C	Sumeet Bhinder, MD, Inc. 6001-A Truxtun Avenue Ste. 160 Bakersfield CA 93309	Rheumatology	Existing	PRV073231	PRV000285	**Yes** **Eff 4/1/22**
32	Waugh, DeAnna PsyD	Reedley Community Hospital dba: Adventist Health Reedley - Selma Central 2141 High Street Selma CA 93662	Psychology	Existing	PRV077829	PRV077724	**Yes** **Eff 4/1/22**
33	Wilde, Aliza LCSW	Bartz-Altadonna Comm Health Center 9300 N. Loop Blvd California City CA 93505	Clinical Social Worker	Existing	PRV077691	PRV029961	**Yes** **Eff 4/1/22**
34	Williams, Shana BCBA	California Psychcare, Inc. 4900 California Avenue Ste. 100-A Bakersfield CA 93309	Qualified Autism Provider / Behavioral Analyst	Existing	PRV029612	PRV011225	**Yes** **Eff 4/1/22**
35	Wint, Mayumi LCSW	Reedley Community Hospital dba: Adventist Health Reedley - Selma Central 2141 High Street Selma CA 93662	Clinical Social Worker	Existing	PRV077830	PRV077724	**Yes** **Eff 4/1/22**

KERN HEALTH SYSTEMS
Board Approved Effective 05/01/2022

NAME	LEGAL NAME/ADDRESS	SPECIALTY	CONTRACT STATUS	PROVIDER PRV	VENDOR PRV	PAC APPROVED - EFFECTIVE DATE
Adam, Nadir MD	Ridgecrest Regional Hospital 1041 N China Lake Blvd Ste. C 105 E Sydnor Avenue Ste. 100 Ridgecrest CA 93555	Colon / Rectal Surgery	Existing	PRV062375	ALL SITES	**Yes** **Eff 5/1/22**
Agar, Trevor LCSW	Omni Family Health 4151 Mexicali Drive Bakersfield CA 93313	Clinical Social Worker	Existing	PRV077573	PRV000019	**Yes** **Eff 5/1/22**
Ahmadi, Shahryar MD	Ridgecrest Regional Hospital 1041 N China Lake Blvd Ste. C Ridgecrest CA 93555	Orthopedic Surgery	Existing	PRV078564	ALL SITES	**Yes** **Eff 5/1/22**
Asher, Ava MD	Bright Heart Health Medical Group 2960 Camino Diablo Ste. 105 Walnut Creek CA 94597	Addiction Medicine	Existing	PRV078565	PRV061628	**Yes** **Eff 5/1/22**
Bell, Jacqueline NP-C	Ridgecrest Regional Hospital 1111 N China Lake Blvd Ste. 190 Ridgecrest CA 93555	Internal Medicine / Pediatrics	Existing	PRV078566	ALL SITES	**Yes** **Eff 5/1/22**
Blanks, Marci NP-C	Alan F. Dakak, MD, Inc dba: Kern Pediatrics 3941 San Dimas Street Ste. 101 Bakersfield CA 93301	Pediatric	Existing	PRV056286	PRV000342	**Yes** **Eff 5/1/22**
Blasic, Vanessa PA-C	Adventist Health Physicians Network 2701 Chester Avenue Ste. 102 Bakersfield CA 93301	Urology	Existing	PRV078567	PRV039910 PRV029329	**Yes** **Eff 5/1/22**
Boyd, Ronald MD	Renaissance Imaging Med Assoc, Inc. 44105 W 15th Street Ste. 100 Lancaster 38925 Trade Center Dr Ste. E Palmdale	Diagnostic Radiology	Existing	PRV054565	PRV000324	**Yes** **Eff 5/1/22**
Butler, Julia PhD	Reedley Community Hospital dba: Adventist Health Community Care - Hanford- 1025 N. Douty Street Hanford Adventist Health Community Care - Kerman - 1000 S. Madera Avenue Kerman CA	Psychology	Existing	PRV078598	PRV040784	**Yes** **Eff 5/1/22**
Campbell, Andrea LCSW	Bright Heart Health Medical Group 2960 Camino Diablo Ste. 105 Walnut Creek CA 94597	Clinical Social Worker	Existing	PRV078599	PRV061628	**Yes** **Eff 5/1/22**
Chen, Liza PA-C	Ravi Patel, MD Inc. dba: Comprehensive Blood & Cancer Ctr 6501 Truxtun Avenue Bakersfield CA 93309	Hematology/ Oncology	Existing	PRV005620	PRV013881	**Yes** **Eff 5/1/22**
Daniels, Trevor PsyD	Telehealthdocs Medical Corporation *All locations 2215 Truxtun Avenue Ste. 100 Bakersfield CA 93301	Psychology	Existing	PRV078600	PRV036952 PRV053624 PRV053625	**Yes** **Eff 5/1/22**

KERN HEALTH SYSTEMS
Board Approved Effective 05/01/2022

De La Cruz, Natalie BCBA	Prism Enterprises, Inc. dba: Prism Behavioral Solutions 4900 California Avenue Ste. 210B-1009 Bakersfield CA 93309	Qualified Autism Provider / Behavioral Analyst	Existing	PRV078601	PRV069746	**Yes** **Eff 5/1/22**
Duginski, Neile LCSW	Reedley Community Hospital dba: Adventist Health Community Care - Hanford - 1025 N. Douty Street Hanford CA 93230	Clinical Social Worker	Existing	PRV078602	PRV040784	**Yes** **Eff 5/1/22**
Dunn, Sheryl LCSW	Reedley Community Hospital dba: Adventist Health Community Care - Hanford - 1025 N. Douty Street Hanford CA 93230	Clinical Social Worker	Existing	PRV078603	PRV040784	**Yes** **Eff 5/1/22**
Farinha, Pedro MD	Ridgecrest Regional Hospital 1041 N China Lake Blvd Ste. B 1111 N China Lake Blvd Ste. 190 Ridgecrest CA 93555	Internal Medicine	Existing	PRV039154	ALL SITES	**Yes** **Eff 5/1/22**
Finley, May NP-C	Ridgecrest Regional Hospital 105 E Sydnor Avenue Ste. 100 Ridgecrest CA 93555	Pain Medicine	Existing	PRV078604	ALL SITES	**Yes** **Eff 5/1/22**
Franco, Magdalena NP-C	Radhey S. Bansal, MD Inc. dba: Comprehensive Medical Group 1230 Jefferson Street Delano CA 93215	Family Practice	Existing	PRV078605	PRV000258	**Yes** **Eff 5/1/22**
Gill, Mona OD	Ace Eyecare, Inc 1721 Westwind Drive Ste. B Bakersfield CA 93301	Optometry	Existing	PRV078606	PRV041736	**Yes** **Eff 5/1/22**
Guy, Jan PA	Vernon Sorenson Urgent Care 3838 San Dimas Street Ste. B-121 Bakersfield CA 93301	Emergency Medicine / Urgent Care	Existing	PRV066031	PRV000216	**Yes** **Eff 5/1/22**
Henderson, Bonnie LCSW	Reedley Community Hospital dba: Adventist Health Community Care - Hanford- 1025 N. Douty Street Hanford CA	Clinical Social Worker	Existing	PRV078607	PRV040784	**Yes** **Eff 5/1/22**
Jalili, Maryam BCBA	Prism Enterprises, Inc. dba: Prism Behavioral Solutions 4900 California Avenue Ste. 210B-1009 Bakersfield CA 93309	Qualified Autism Provider / Behavioral Analyst	Existing	PRV078608	PRV069746	**Yes** **Eff 5/1/22**
Karunasiri, Deepthi MD	Gastro Care Institute 1331 W Ave J Ste. 202 Lancaster CA 93534	Pathology (GI)	Existing	PRV073753	PRV051043	**Yes** **Eff 5/1/22**

KERN HEALTH SYSTEMS
Board Approved Effective 05/01/2022

Kashani, Alejandro PA-C	Emergency Physicians Urgent Care, Inc. dba: Accelerated Urgent Care *All Locations 212 Coffee Road Ste. 101 Bakersfield CA 93309	Family Practice	Existing	PRV078609	ALL SITES	**Yes** **Eff 5/1/22**
Kaur, Sarabjit NP-C	Infusion & Clinical Services Premier Urgent Care of Central California *All Locations 5401 White Lane Bakersfield CA 93309	Internal Medicine	Existing	PRV062479	ALL SITES	**Yes** **Eff 5/1/22**
Lazaga, Cecilia NP-C	Kern County Hospital Authority 1111 Columbus Street Bakersfield CA 93305	Internal Medicine	Existing	PRV077884	ALL SITES	**Yes** **Eff 5/1/22**
Martinez, Breanne BCBA	Teaching Autistic Children Inc. dba: Learning Arts 5329 Office Center Court Ste. 150 Bakersfield CA 93309	Qualified Autism Provider / Behavioral Analyst	Existing	PRV078610	PRV052185	**Yes** **Eff 5/1/22**
Mejia, Anja NP-C	Infusion & Clinical Services *All Locations UC & PCP 5400 Aldrin Court Bakersfield CA 93309 Additional Affiliation: Nephrology Medical Group	Internal Medicine	Existing	PRV076780	ALL SITES	**Yes** **Eff 5/1/22**
Myers, Katherine LCSW	Bright Heart Health Medical Group 2960 Camino Diablo Ste. 105 Walnut Creek CA 94597	Clinical Social Worker	Existing	PRV078611	PRV061628	**Yes** **Eff 5/1/22**
National Seating & Mobility - Van Nuys	National Seating & Mobility, Inc. 16509 Arminta St Van Nuys CA 91406	DME	Existing	PRV077362	PRV077362	**Yes** **Eff 5/1/22**
Neal, Ashley LCSW	Reedley Community Hospital dba: Adventist Health Community Care - Hanford 1025 N. Douty Street Hanford CA	Clinical Social Worker	Existing	PRV078612	PRV040784	**Yes** **Eff 5/1/22**
Orhan, Elmas NP-C	Kern County Hospital Authority 1111 Columbus Street Bakersfield CA 93305	Family Practice	Existing	PRV078193	ALL SITES	**Yes** **Eff 5/1/22**
Ochoa, Mariano BCBA	Prism Enterprises, Inc. dba: Prism Behavioral Solutions 4900 California Avenue Ste. 210B-1009 Bakersfield CA 93309	Qualified Autism Provider / Behavioral Analyst	Existing	PRV078613	PRV069746	**Yes** **Eff 5/1/22**

KERN HEALTH SYSTEMS

Board Approved Effective 05/01/2022

Perez, Angelina BCBA	Center for Autism and Related Disorders, LLC *All Locations dba: CARD 8302 Espresso Drive Ste. 100 Bakersfield CA 93312	Qualified Autism Provider / Behavioral Analyst	Existing	PRV078614	PRV032083	**Yes Eff 5/1/22**
Riley, Michael PA	Vernon Sorenson Urgent Care 3838 San Dimas Street Ste. B-121 Bakersfield CA 93301	Emergency Medicine / Urgent Care	Existing	PRV078615	PRV000216	**Yes Eff 5/1/22**
Romano, Noemi MD	Hospitalist Medicine Phys of Calif Inc dba: Sound Hospitalist of California 2615 Chester Avenue Bakersfield CA 93301	Internal Medicine / Hospitalist	Existing	PRV078616	PRV014433	**Yes Eff 5/1/22**
Singh, Gurjit MD	Centric Health 2901 Sillect Avenue Ste. 100 Bakersfield CA 93308	Cardiovascular Disease / Electrophysiology	Existing	PRV075226	PRV000503	**Yes Eff 5/1/22**
Specht, Sarah NP-C	Alan F. Dakak, MD, Inc dba: Kern Pediatrics 3941 San Dimas Street Ste. 101 Bakersfield CA 93301	Pediatric	Existing	PRV078617	PRV000342	**Yes Eff 5/1/22**
Takei, Christina BCBA	Prism Enterprises, Inc. dba: Prism Behavioral Solutions 4900 California Avenue Ste. 210B-1009 Bakersfield CA 93309	Qualified Autism Provider / Behavioral Analyst	Existing	PRV078618	PRV069746	**Yes Eff 5/1/22**
Tooma Rostamo, Sabrina BCBA	Center for Autism & Related Disorders dba: CARD 8302 Espresso Drive Ste. 100 Bakersfield CA 93312	Qualified Autism Provider / Behavioral Analyst	Existing	PRV078619	PRV032083	**Yes Eff 5/1/22**
Tousi, Sara LCSW	Reedley Community Hospital dba: Adventist Health Community Care - Hanford 1025 N. Douty Street Hanford CA	Clinical Social Worker	Existing	PRV078620	PRV040784	**Yes Eff 5/1/22**
Villarreal, Manuel PsyD	Omni Family Health 210 N Chester Avenue Bakersfield CA 1022 Calloway Drive Bakersfield CA	Psychology	Existing	PRV077885	PRV000019	**Yes Eff 5/1/22**
Vincent, Pamela MD	Bright Heart Health Medical Group 2960 Camino Diablo Ste. 105 Walnut Creek CA 94597	Addiction Medicine	Existing	PRV078621	PRV061628	**Yes Eff 5/1/22**
Wickramasinghe, Kumari MD	Gastro Care Institute 1331 W Ave J Ste. 202 Lancaster CA 93534	Pathology (GI)	Existing	PRV047285	PRV051043	**Yes Eff 5/1/22**

KERN HEALTH SYSTEMS

Board Approved Effective 05/01/2022

Zhu, Gefei MD	Direct Dermatology Professionals P.C. 165 Saint Dominics Drive Ste. 140 Manteca CA 95337	Dermatology	Existing	PRV078622	PRV012901	**Yes** **Eff 5/1/22**

KERN HEALTH SYSTEMS

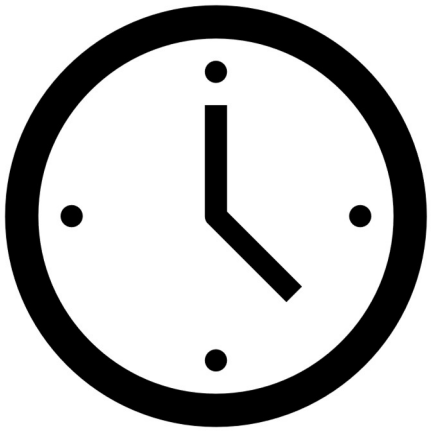
Provider Network Management
Network Review
Quarter 1, 2022

- **After-Hours Survey Report**
- **Appointment Availability Survey Report**
- **Grievance Review (Q3, 2021 Review Period)**
- **Geographic Accessibility & Network Certification**
- **Network Adequacy & Provider Counts**
- **DHCS Quarterly Monitoring Report/Response Template (QMRT) (Q4, 2021 Review Period)**
- **VSP Access and Appointment Availability**
- **DMHC MY 2021 Timely Access Report**

KERN HEALTH SYSTEMS

After-Hours Calls

Quarter 1, 2022



AFTER-HOURS CALLS

Q1, 2022

KERN HEALTH SYSTEMS

Introduction

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

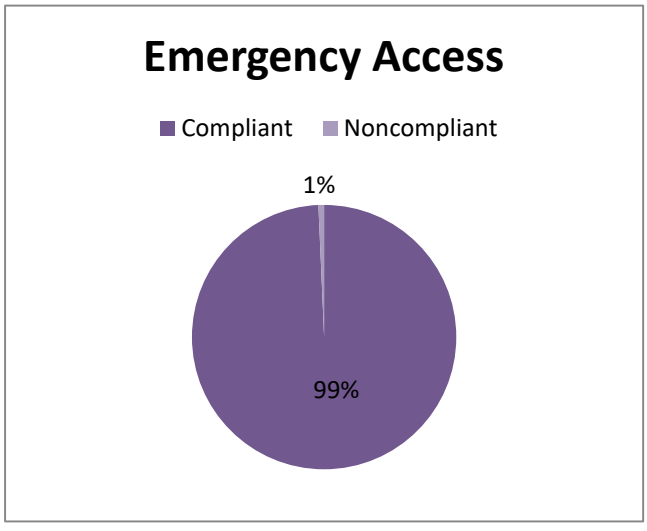
1.) Provider's answering machine or answering service must instruct the member to call 911 if the purpose of the call is a medical emergency.

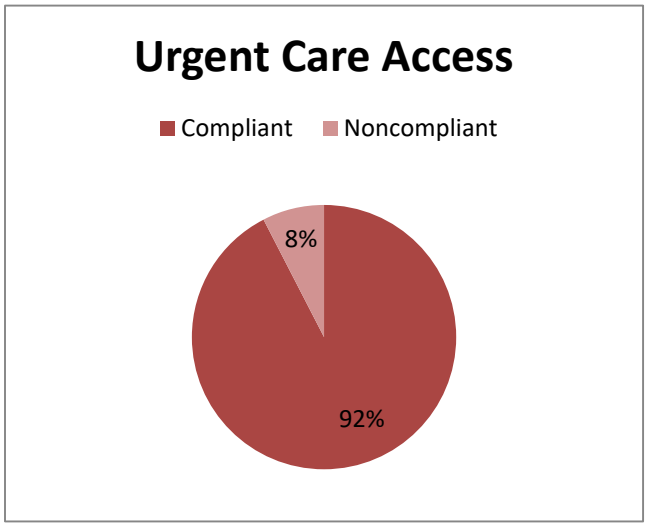
2.) For urgent matters, Provider's answering machine must provide an on-call number. If an answering service is used, the member must receive a call back from an on-call member of your office within 30 minutes of call.

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

Results

During Q1 2022 145 provider offices were contacted. Of those offices, 144 were compliant with the Emergency Access Standards and 134 were compliant with the Urgent Care Access Standards.





AFTER-HOURS CALLS

Q1, 2022

Tracking, Trending, and Provider Outreach

The Plan utilizes the after-hours survey calls to monitor compliance at a network-wide level. The Plan found compliance remained in line with prior quarters, with percentages in Q1 2022 above 90% for both measures.

Compliance with after-hours standard	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022
Emergency Access	94%	97%	96%	94%	98%	99%
Urgent Care Access	91%	92%	91%	89%	96%	92%

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

During Q1 2022, the Plan identified one office which was noncompliant for two consecutive quarters. The Plan's Provider Relations Representatives conducted targeted education with the identified provider group regarding their contractual obligation to meet regulatory access standards.

For all other offices identified with a single instance of noncompliance during Q1 2022, the Plan sent letters notifying the provider group of the survey results and Plan policy (template attached).

Upon review, the Plan has found that the outreach and education conducted via both letter and the Provider Relations Representatives/Manager has seen success, as a percentage of previously noncompliant provider groups which received outreach were found to be compliant during Q1 2022.

KERN HEALTH SYSTEMS

[DATE]

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

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

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

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

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

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

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

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

Sincerely,

Melissa Lopez
Provider Relations Manager
661-617-2642

KERN HEALTH SYSTEMS

Appointment Availability Survey

Quarter 1, 2022

Provider Network Management

Appointment Availability Survey

Q1, 2022

KERN HEALTH SYSTEMS

Introduction

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

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

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

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

The survey was conducted internally by KHS staff; compliance is determined using the methodology utilized by the DHCS during the 2017 Medical Audit in which they conducted a similar appointment availability survey.

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

Appointment Availability Survey

Q1, 2022

Appointment Availability Survey Results

A random sample of 15 primary care provider offices, 15 specialist offices, 5 ancillary offices, 5 mental health offices, and 5 OBGYN offices were contacted during Q1 2022.

Of the primary care providers surveyed, the Plan compiled the wait time in hours to determine the Plan's average wait time for an urgent primary care appointment. The Plan compiled the wait time in days to determine the Plan's average wait time for a non-urgent primary care appointment. The average wait time for an urgent primary care appointment was **20.6 hours** for Q1 2022. The average wait time for a non-urgent primary care appointment was **4.3 days** for Q1 2022. **Based on these results, the Plan was determined to be compliant in both the urgent and non-urgent time standards for primary care appointments in Q1 2022.**

Of the specialist providers surveyed, the Plan compiled the wait time in hours to determine the Plan's average wait time for an urgent specialist appointment. The Plan compiled the wait time in days to determine the Plan's average wait time for a non-urgent specialist appointment. The average wait time for an urgent specialist appointment was **90.5 hours** for Q1 2022. The average wait time for a non-urgent primary care appointment was **11.9 days** for Q1 2022. **Based on these results, the Plan was determined to be compliant in both the urgent and non-urgent time standards for specialist appointments in Q1 2022.**

Of the mental health providers surveyed, the Plan compiled the wait time in days to determine the Plan's average wait time for an appointment with a mental health provider. The Plan's average wait time for a mental health provider appointment was **2.4 days** for Q1 2022. **Based on these results, the Plan was determined to be compliant with the time standard for a mental health appointment in Q1 2022.**

Of the ancillary providers surveyed, the Plan compiled the wait time in days to determine the Plan's average wait time for an appointment with the ancillary provider. The Plan's average wait time for an ancillary appointment was **10.8 days** for Q1 2022. **Based on these results, the Plan was determined to be compliant with the time standard for an ancillary appointment in Q1 2022.**

Of OB/GYN providers surveyed, the Plan compiled the wait time in days to determine the Plan's average wait time for a first prenatal appointment with an OB/GYN. The Plan's average wait time for a first prenatal appointment with an OB/GYN was **3.2 days** for Q1 2022. **Based on these results, the Plan was determined to be compliant with the time standard for an OB/GYN first prenatal appointment in Q1 2022.**

Appointment Availability Survey

Q1, 2022

KERN HEALTH SYSTEMS

Tracking, Trending, and Provider Outreach

The Plan utilizes the quarterly appointment availability survey to monitor compliance at a network-wide level. The Plan reviewed the results of the Q1 2022 appointment availability survey against the results of prior quarters. The Plan recognized an increase in wait time for primary care, specialist, and ancillary non-urgent appointments; the Plan does not consider this increase as a trend at this time as the results are in line with prior quarters. The Plan's average wait time remains within regulatory standards for all appointment types.

Average urgent wait time in hours	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022
Primary Care	N/A	19.1	26.9	28.5	32.9	20.6
Specialist	N/A	57.4	61.6	49.6	54.5	90.5

Average wait time in days	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022
Primary Care	5.2	2.3	3	4	2.5	4.3
Specialist	5.7	10.5	11.4	6	6.3	11.9
Mental Health	N/A	2	8	4.2	2.4	2.4
Ancillary	N/A	1.4	8.6	1	1	10.8
OB/GYN	8.9	10	7.4	4.4	3.8	3.2

*N/A = Not previously surveyed

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

For all providers identified as newly noncompliant during Q1 2022, the Plan sent letters notifying the providers of the survey results and Plan policy (template attached).

Phone Answering Timeliness Results

Utilizing the methodology outlined above, KHS conducts a phone answering timeliness survey in conjunction with the appointment availability survey. During Q1 2022 calls were answered within an average of 1.6 rings.

	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022
Average rings to answer	2.2	2.2	1.5	3.0	1.8	1.6

Appointment Availability Survey

Q1, 2022

Follow-up Survey and Best Practices

In Q1 2022, the Plan conducted a follow-up appointment availability survey, resurveying all providers found to be previously noncompliant in 2021. The previously noncompliant providers consisted of 9 primary care, 19 specialist, 2 mental health, 1 ancillary, and 3 OB/GYN providers.

Based on the results of this follow-up survey, the Plan identified 2 primary care and 6 specialist providers who remained noncompliant with Plan appointment availability standards. The Plan's Provider Relations Representatives conducted targeted outreach and education to the identified providers regarding their contractual obligation to meet regulatory access standards.

During Q1 2022, the Plan received the DHCS' *Best Practices For Improved Timely Access Compliance*, an outline of best practices compiled based on the successful processes of Medi-Cal Managed Care Plans throughout the state. The Plan is in the process of conducting a gap analysis, comparing the best practices outlined by the DHCS with current Plan policies and procedure and working to incorporate, as appropriate. One area of potential improvement, identified by the Plan, is the timeframe in which follow up is conducted for noncompliant providers.

KERN HEALTH SYSTEMS

[DATE]

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

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

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

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

Sincerely,

Melissa Lopez
Provider Relations Manager
661-617-2642

KERN HEALTH SYSTEMS

Access Grievance Review

Quarter 1, 2022

(Q3, 2021 Review Period)

Provider Network Management

Access Grievance Review

Q1, 2022 (Q3, 2021 Review Period)

KERN HEALTH SYSTEMS

Introduction and KHS Policy and Procedure

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

Categorization

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

Grievance Totals

During Q3 2021 **one hundred and thirty-nine (139)** access-related grievances were received and reviewed by the KHS Grievance Committee. In **eighty-five (85)** of the cases, no issues were identified and were closed in favor of the Plan. The remaining **fifty-one (51)**, were closed in favor of the enrollee; the KHS Grievance Department sent letters to the providers involved in these cases, notifying them of the outcome.

The **fifty-one (51)** grievances that were closed in favor of the enrollee were forwarded to the Plan's Provider Network Management Department. For each of these grievances, the members initial complaint, the provider's response, the Members Service Department's investigation, and the Grievance Committee's decision are reviewed by the Provider Network Management Department.

The access grievances found in favor of the enrollee for Q3 2021 were categorized by the KHS Grievance Department as follows:

Timely Access	**23**
Provider Availability	**6**
Technology / Telephone	**22**
Geographic Access	**0**

Tracking and Trending

The Provider Network Management Department reviewed all access grievances found in favor of the enrollee received in Q3 2021 to identify any potential access issues or trends within the Plan's network or amongst the Plan's contracted providers. In addition to a review conducted against prior quarters,

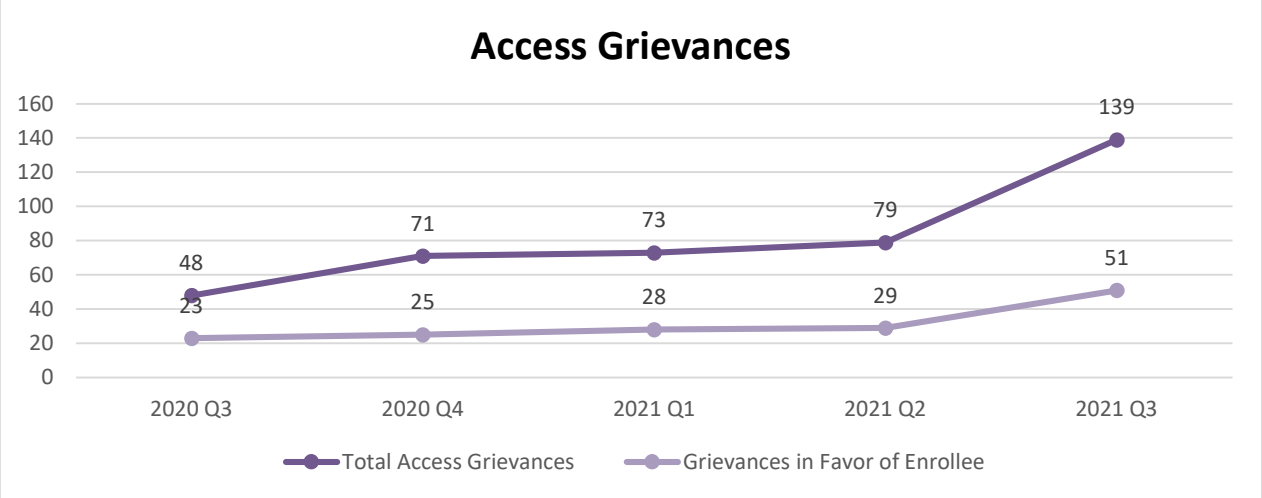
Access Grievance Review

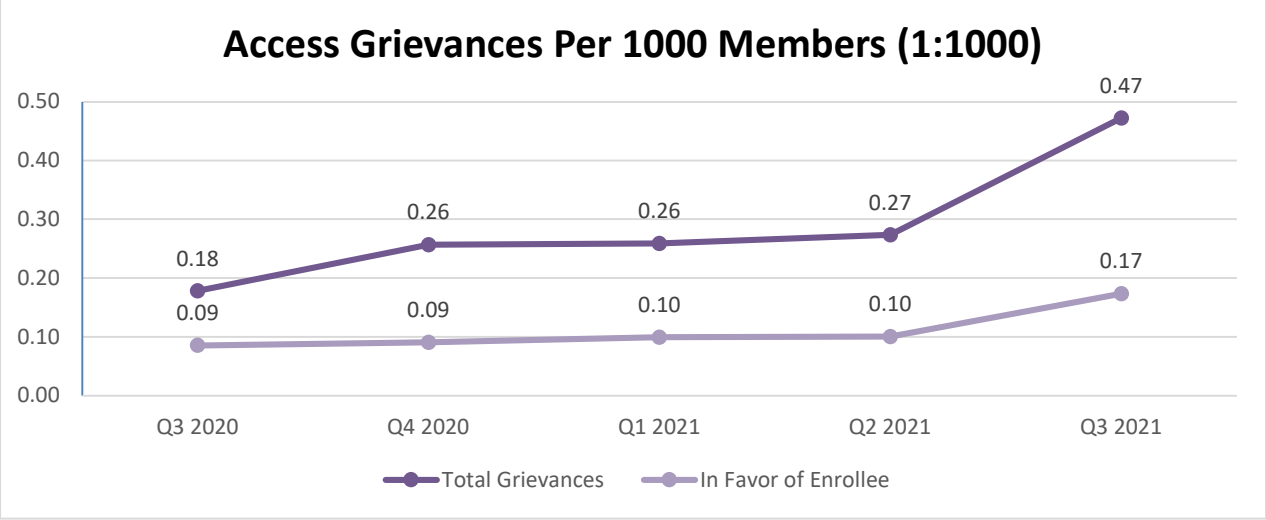
Q1, 2022 (Q3, 2021 Review Period)

the Plan reviews Access Grievances against outcomes of other monitoring conducted as part of the quarterly *Provider Network Management, Network Review* (e.g. Appointment Availability Survey, DHCS' QMRT review, Network Adequacy).

Upon review of Q3 2021 access grievances, the Plan identified an increase in grievances when compared from Q2 2021. The Plan did not identify this increase as an issue or trend at this time due to this being a singular instance. The Plan found that there was an increase in claims submitted along with an increase in call volume to Member Services, indicating that more members were returning to see providers more often. Additionally, the Plan's Access Grievances Per 1000 members for grievances found in favor of the enrollee remains lows, at .017.

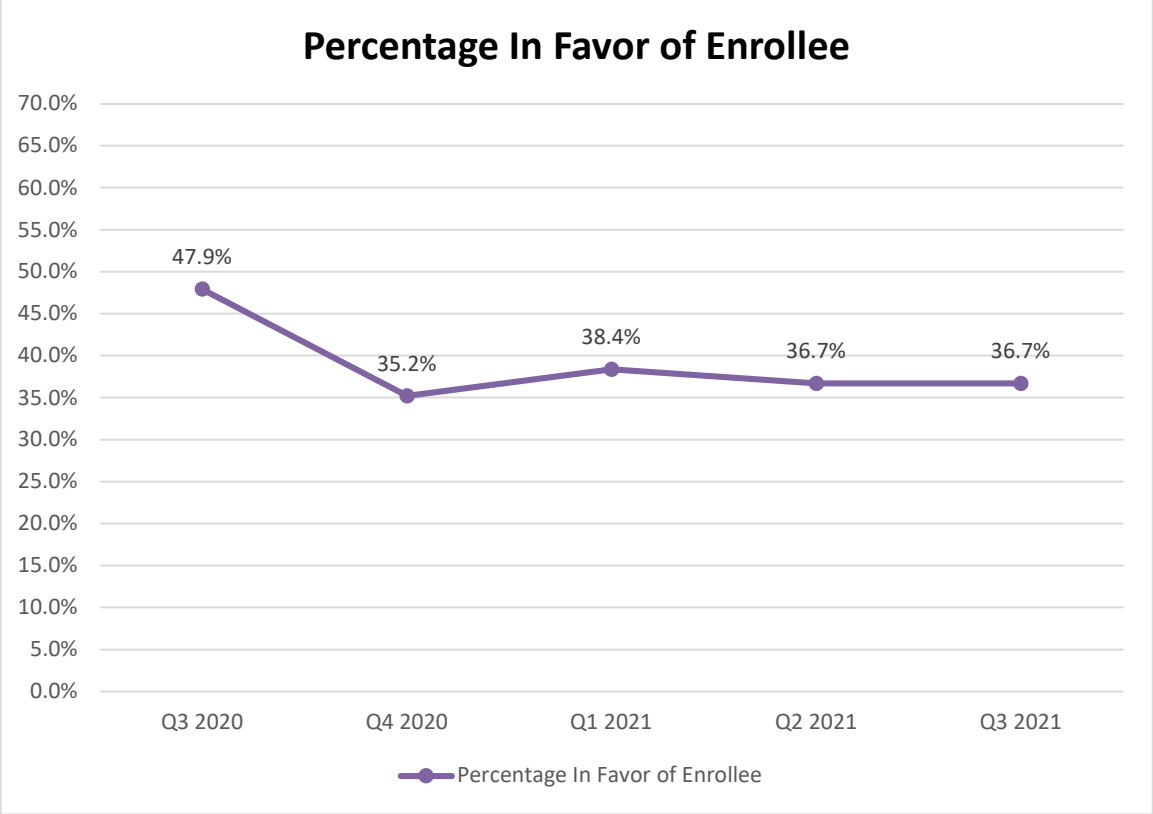
The Plan reviews grievances across a four-quarter rolling review period. Trends that are identified are reviewed with the Provider Relations Manager on a case-by-case basis to develop a target-based strategy to address. As of the Q1 2022 review, the Plan did not identify any trends amongst specific providers, groups, or specialty types. The Plan will continue to monitor access grievances for potential trends via the quarterly access grievance review.

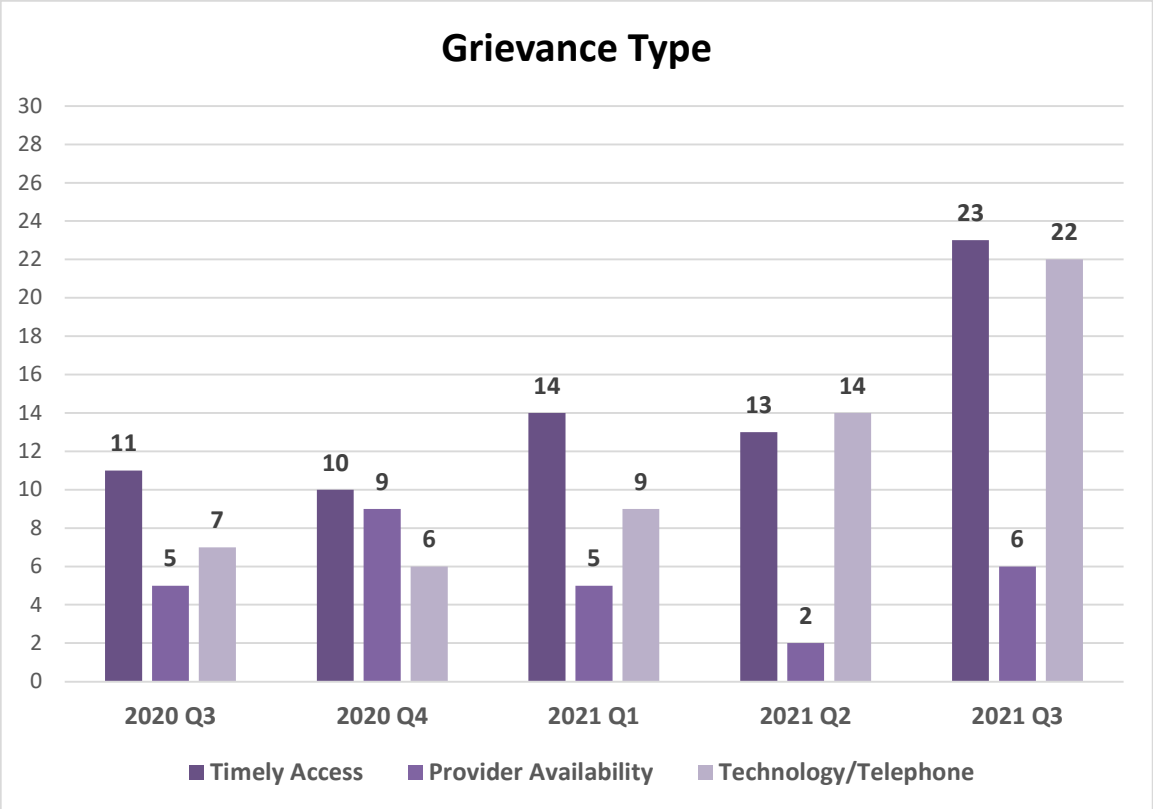




Access Grievance Review

Q1, 2022 (Q3, 2021 Review Period)





Access Grievance Review

Q1, 2022 (Q3, 2021 Review Period)

KERN HEALTH SYSTEMS

Exempt Grievances

On a quarterly basis, the Plan's Provider Network Management Department reviews all exempt grievances to identify potential trends amongst the provider network. For Q3 2021, there were a total of **1,644** exempt grievances.

Grievance Type	Q1 Count	Q1 % of Total	Q2 Count	Q2 % of Total	Q3 Count	Q3 % of Total
Provider / Staff Attitude	721	61.10%	925	58.92%	827	50.30%
Timely Access	137	11.60%	211	13.44%	286	17.40%
Transportation	129	10.90%	154	9.81%	180	10.95%
Provider Availability	58	4.90%	110	7.01%	128	7.79%
Authorization	26	2.20%	51	3.25%	80	4.87%
Technology / Telephone	62	5.30%	64	4.08%	78	4.74%
Referral	20	1.70%	24	1.53%	30	1.82%
Language Access	2	0.20%	5	0.32%	12	0.73%
Billing	11	0.90%	7	0.45%	10	0.61%
Enrollment	3	0.30%	7	0.45%	6	0.36%
Physical Access	3	0.30%	5	0.32%	3	0.18%
Continuity Of Care	1	0.10%	3	0.19%	2	0.12%
Case Management / Care Coordination	3	0.30%	2	0.13%	2	0.12%
Out-of-Network	0	0.00%	1	0.06%	0	0.00%
Geographic Access	0	0.00%	1	0.06%	0	0.00%
Member Informing Materials	2	0.20%	0	0.00%	0	0.00%
Fraud / Waste / Abuse	1	0.10%	0	0.00%	0	0.00%
PHI / Confidentiality / HIPAA	1	0.10%	0	0.00%	0	0.00%
Grand Total	**1180**		**1570**		**1644**	

In reviewing these totals against prior quarters, as of the Q2 2021 review of exempt grievances, the Plan recognized an increase in exempt grievances and reviewed with the Member Services department. At the time, the Plan found that there was an increase in claims submitted along with an increase in call volume to Member Services – indicating that more members were returning to see providers, more often. The count of exempt grievances in Q3 2021 remain consistent with the volume seen in Q2 2021. The Plan identified an increase in the percentage of Timely Access exempt grievances; at this time, the Plan believes this increase is inline with return to care patterns outlined above. The Plan will continue to monitor exempt grievances for potential trends via the quarterly access grievance review.

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

2.1.20 Grievance Received Date

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

2.1.21 Grievance Type

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

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

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

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

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

2.1.22 MER COC Disposition Date

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

KERN HEALTH SYSTEMS

Geographic Accessibility & DHCS Network Certification

Quarter 1, 2022

Provider Network Management

Geographic Accessibility & Network Certification

Q1, 2022

KERN HEALTH SYSTEMS

Geographic Accessibility

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

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

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

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

DHCS Annual Network Certification – 2021/2022

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

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

As previously reported, the Plan does not have any outstanding AAS requests pending with the DHCS and is currently compliant with all above listed standards or a DHCS approved alternate standard.

The Plan maintains ongoing monitoring of the additions and deletions within the provider network against the most recently completed geographic accessibility analysis. The Plan did not identify any

additions or deletions in Q1 2022 that would affect the Plan's ability to provide access within the required time or distance standards and/or require a modification of the Plan's current approved AAS.

On February 25, 2022, the DHCS notified the Plan that the Annual Network Certification (ANC) and Subcontractor Network Certification (SNC) will be due no earlier than July 1, 2022 (Q3 2022). The change to the timeline for the ANC and SNC was due to changes in requirements relating to the CalAIM initiative. The DHCS reported that they would be providing further guidance in a revision to APL 21-006 for the ANC and APL 17-004 for the SNC .

KERN HEALTH SYSTEMS

Network Adequacy & Provider Counts

Quarter 1, 2022

Network Adequacy & Provider Counts

Q1, 2022

Introduction

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

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

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

Survey Methodology and Results

In 2020, KHS contracted with SPH Analytics to conduct our annual Provider Satisfaction Survey; as a part of that survey, responding providers were asked, "*What portion of your managed care volume is represented by Kern Health Systems?"* Outreach for the survey was placed to every contracted provider within the Plan's network. Responses received, and FTE calculations based on those responses, do not account for providers who refuse to participate in the survey. KHS used the responses collected from Primary Care Providers to calculate the FTE for Primary Care Providers, and used the responses collected from Primary Care Providers and Specialists to calculate the FTE for Physicians.

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

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

Network Adequacy & Provider Counts

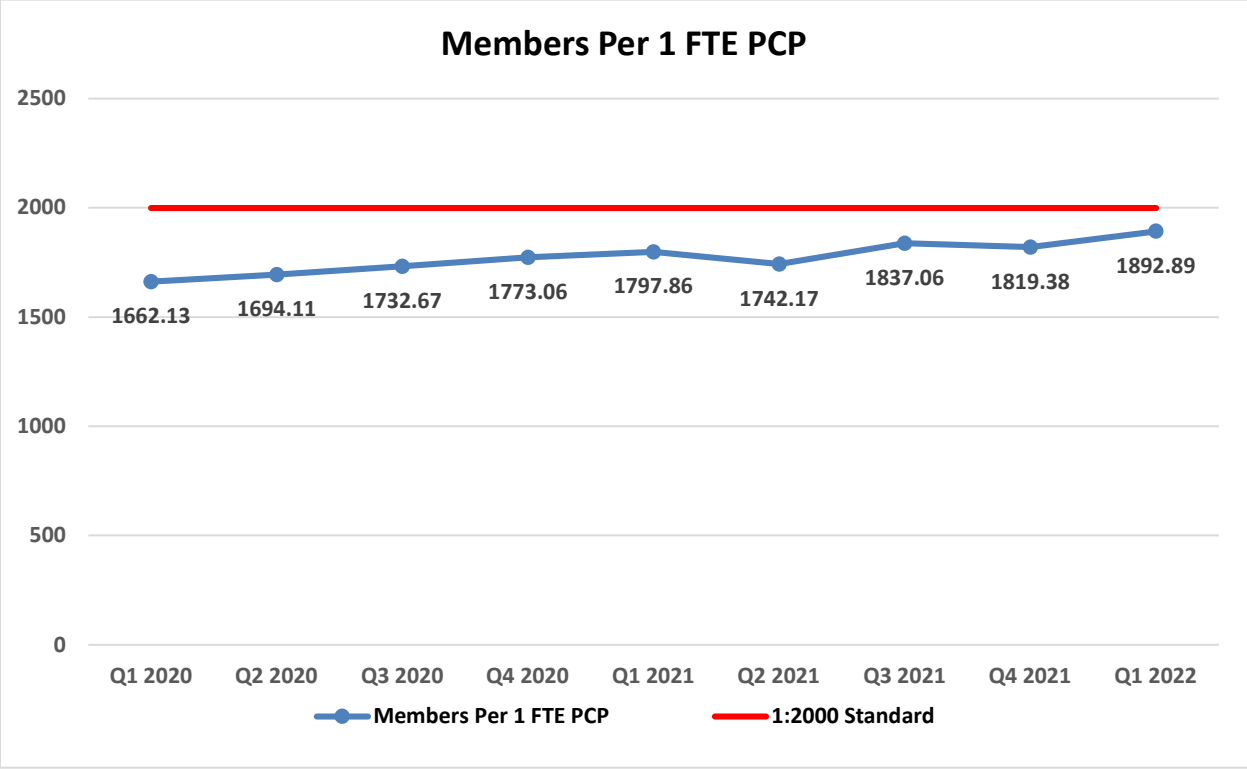
Q1, 2022

Full Time Equivalency Compliance Calculations

Of KHS' 326,012 membership at the close of Q1 2022, 13,269 were assigned and managed by Kaiser and did not access services through KHS' network of contracted providers; due to this, Kaiser managed membership is not considered when calculating FTE compliance.

As of the end of Q1 2022, the plan was contracted with 441 Primary Care Providers, a combination of 243 physicians and 198 mid-levels. Based on the FTE calculation process outlined above, with a 48.31% PCP FTE percentage, KHS maintains a total of **165.22 FTE PCPs**. With a membership enrollment of 312,743 utilizing KHS contracted PCPs, KHS currently maintains a ratio of **1 FTE PCP to every 1892.89 members**; KHS is compliant with state regulations and Plan policy.

PCP to Member Ratio

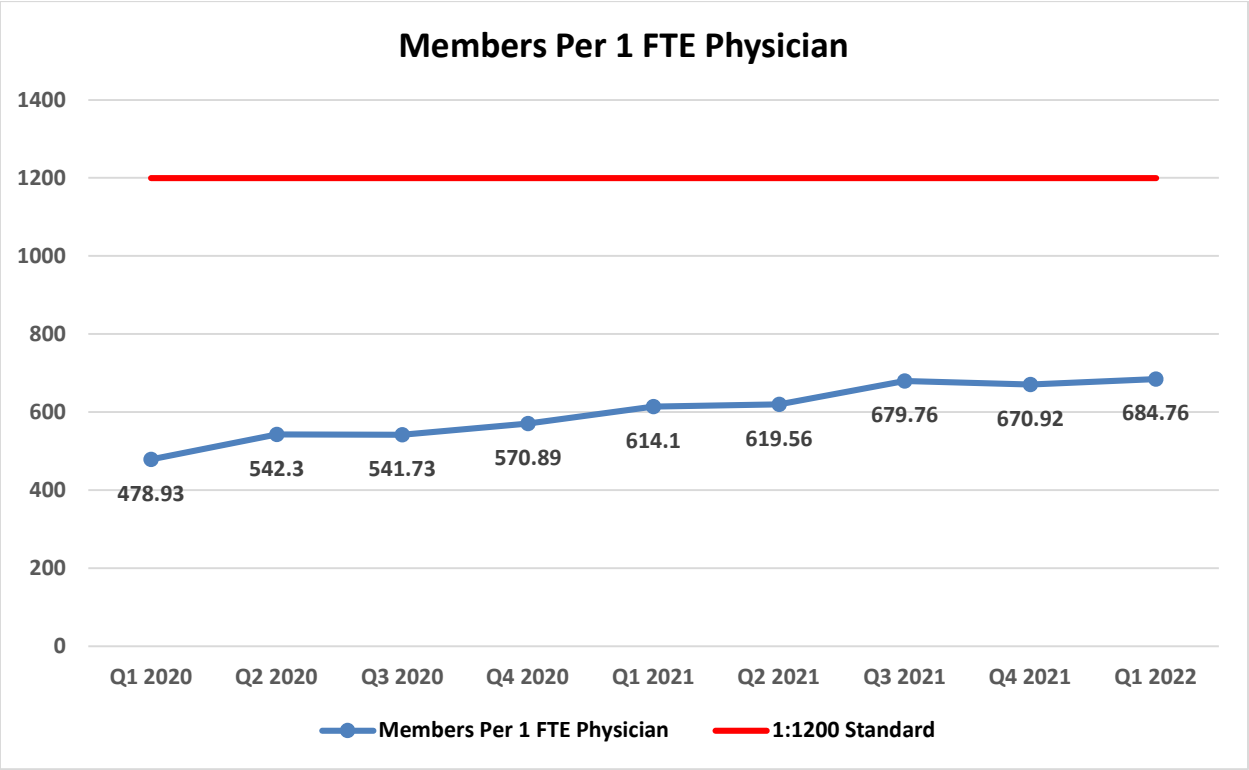


As of the end of Q1 2022, the plan was contracted with 1110 Physicians. Based on the FTE calculation process outlined above, with a 41.22% Physician FTE percentage, KHS maintains a total of **456.72 FTE Physicians**. With a total membership enrollment of 312,743 utilizing KHS contracted Physicians, KHS currently maintains a ratio of **1 FTE Physician to every 684.76 members**; KHS is compliant with state regulations and Plan policy.

Network Adequacy & Provider Counts

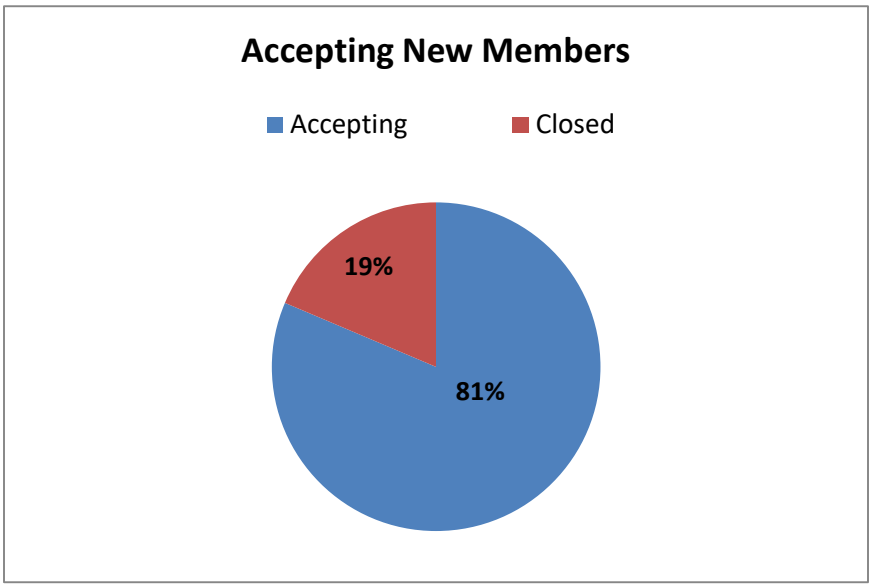
Q1, 2022

Physician to Member Ratio



Accepting New Members

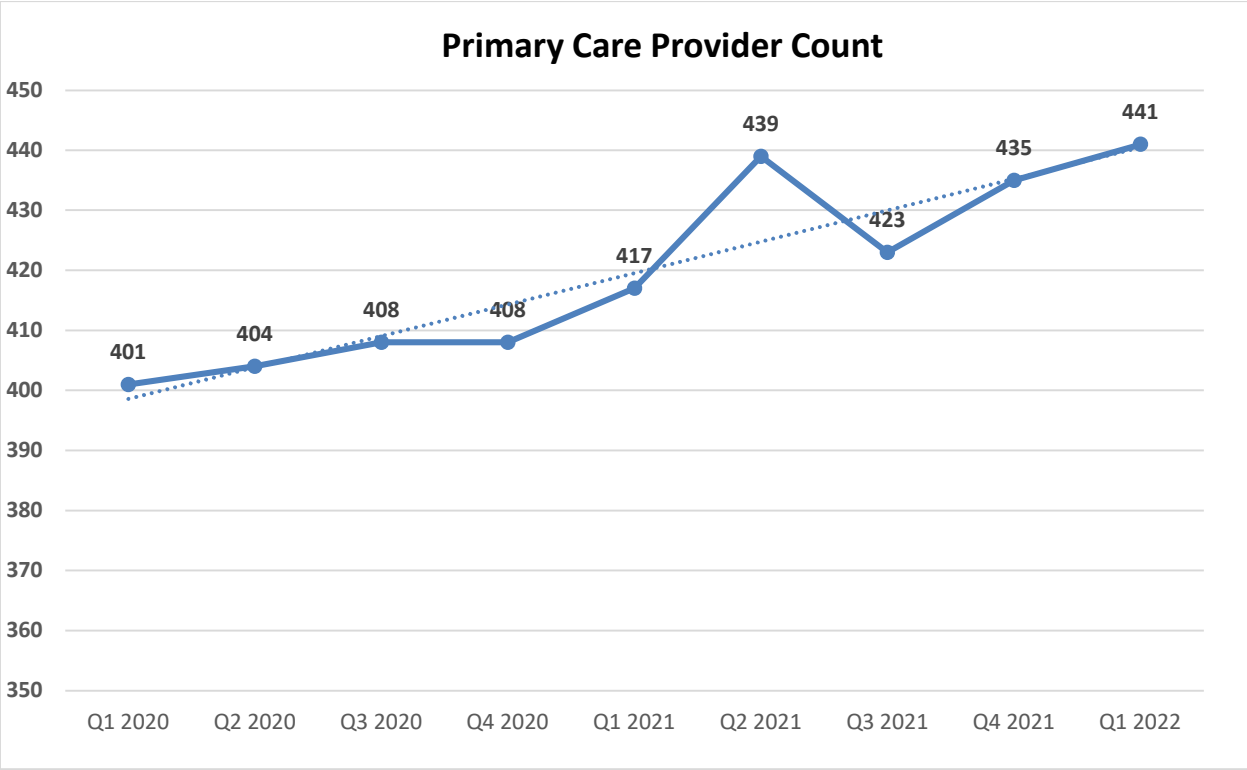
In addition to the Full Time Equivalency Compliance review conducted above, the Plan monitors adequacy of its Primary Care Network by reviewing the count/percentage of Primary Care Providers (PCP) who are accepting new members. **The Plan calculated that 81% of the network of Primary Care Providers is currently accepting new members at a minimum of one location**. The Plan will continue to monitor this percentage quarterly to ensure it maintains an adequate network of Primary Care Providers.

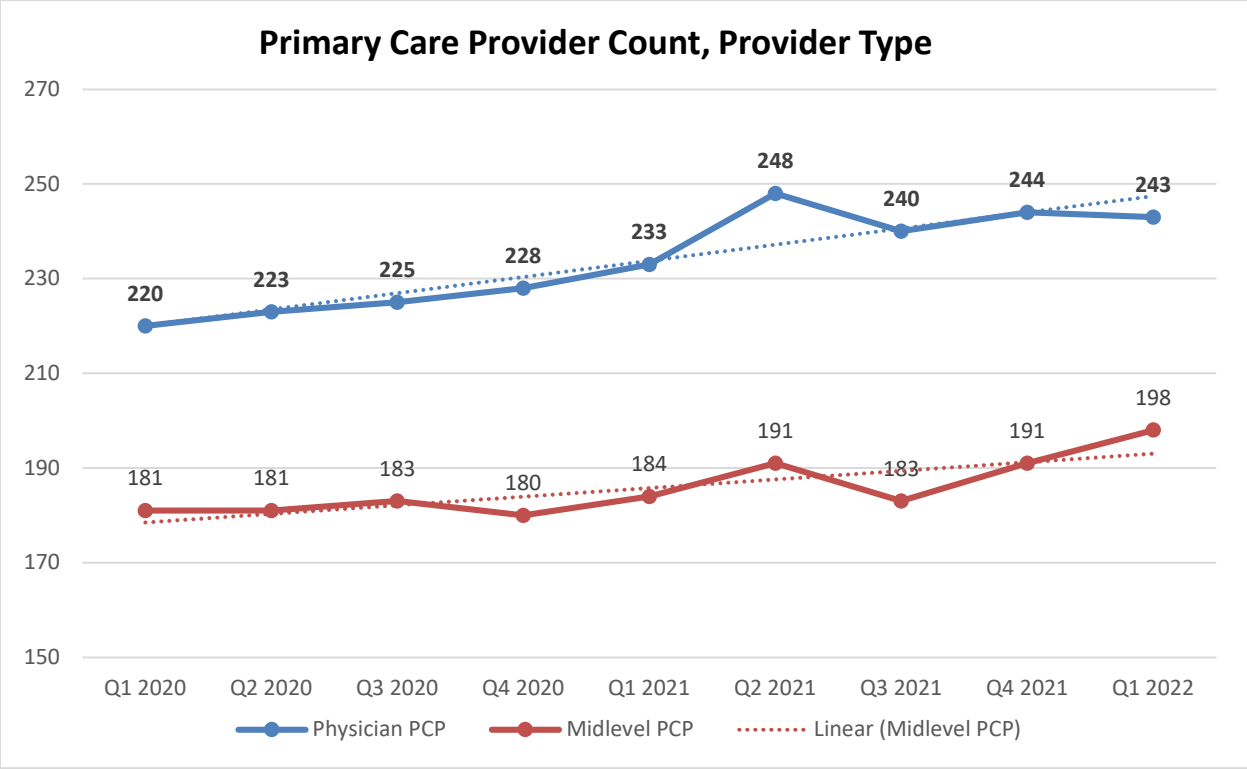


Network Adequacy & Provider Counts

Q1, 2022

Provider Counts – Primary Care Providers

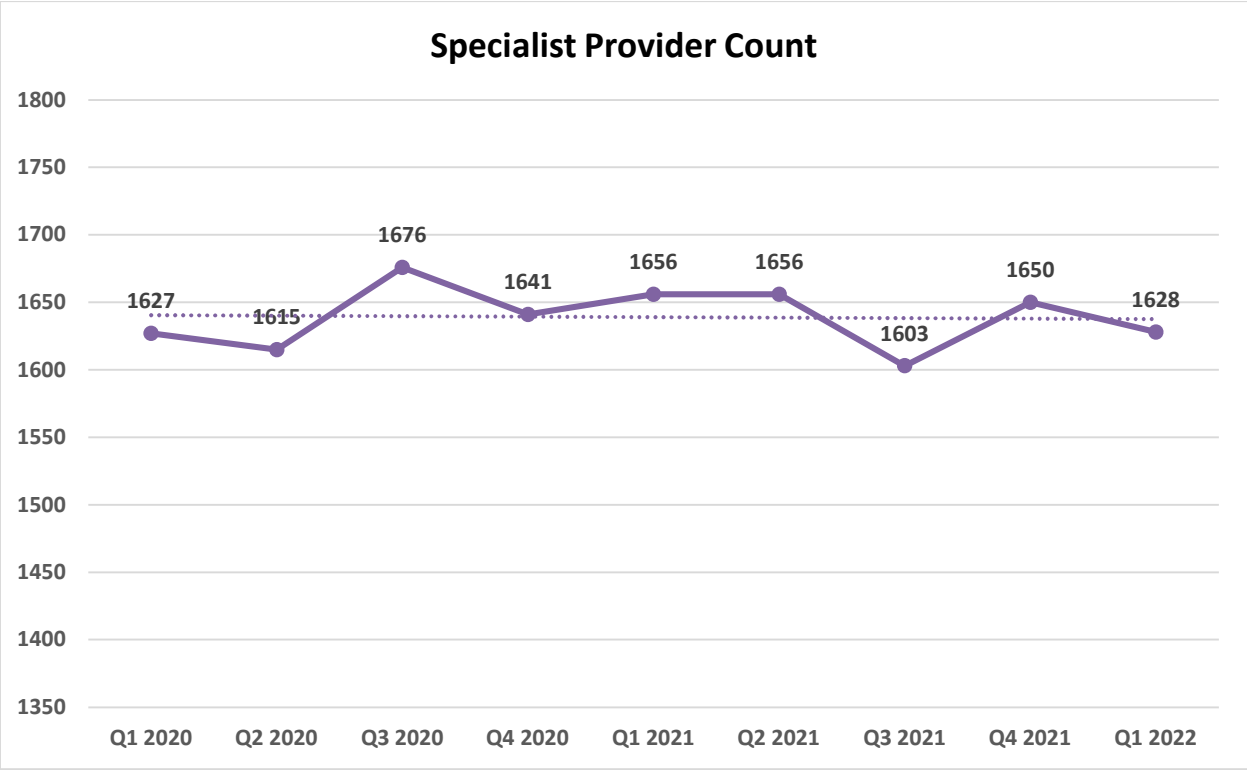




Network Adequacy & Provider Counts

Q1, 2022

Provider Counts – Specialist Providers



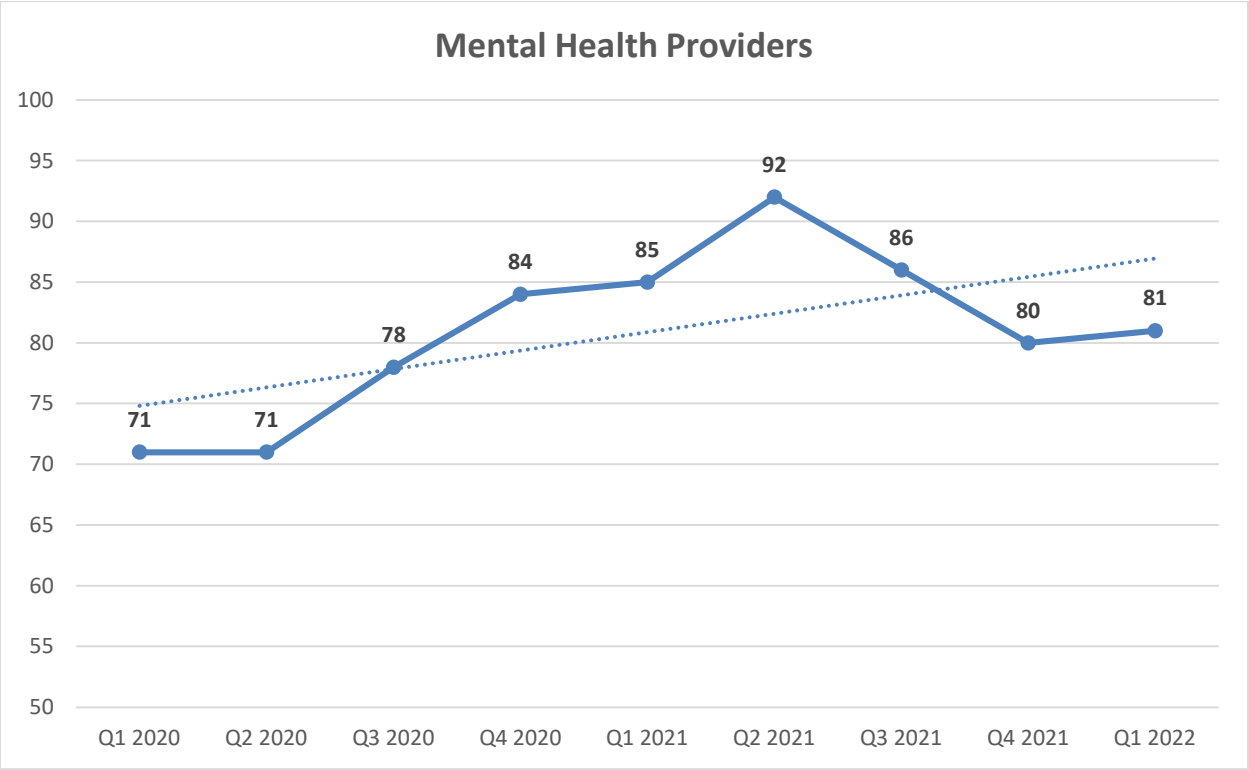
DHCS Core Specialties, Provider Count									
	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022
Cardiology	40	38	42	44	43	42	46	46	45
Dermatology	33	36	35	36	33	34	35	35	39
Endocrinology	20	19	20	24	22	23	23	24	25
Gastroenterology	20	22	22	22	23	22	21	24	24
General Surgery	66	70	68	68	67	63	59	62	65
Hematology	17	18	18	20	20	21	19	23	20
Infectious Disease	9	10	10	10	11	10	8	8	8
Nephrology	22	21	22	23	23	27	27	28	25
Neurology	25	26	25	25	26	25	25	25	22
Oncology	22	24	24	26	26	27	25	27	26
Ophthalmology	33	32	30	29	30	30	29	28	27
Orthopedic Surgery	21	20	21	20	20	21	21	22	23
Otolaryngology	12	10	10	10	8	8	9	9	9
Physical Med & Rehab	27	24	24	24	24	11	10	10	10
Psychiatry	54	53	54	47	47	45	48	53	54
Pulmonary Disease	20	20	20	19	18	17	17	20	20

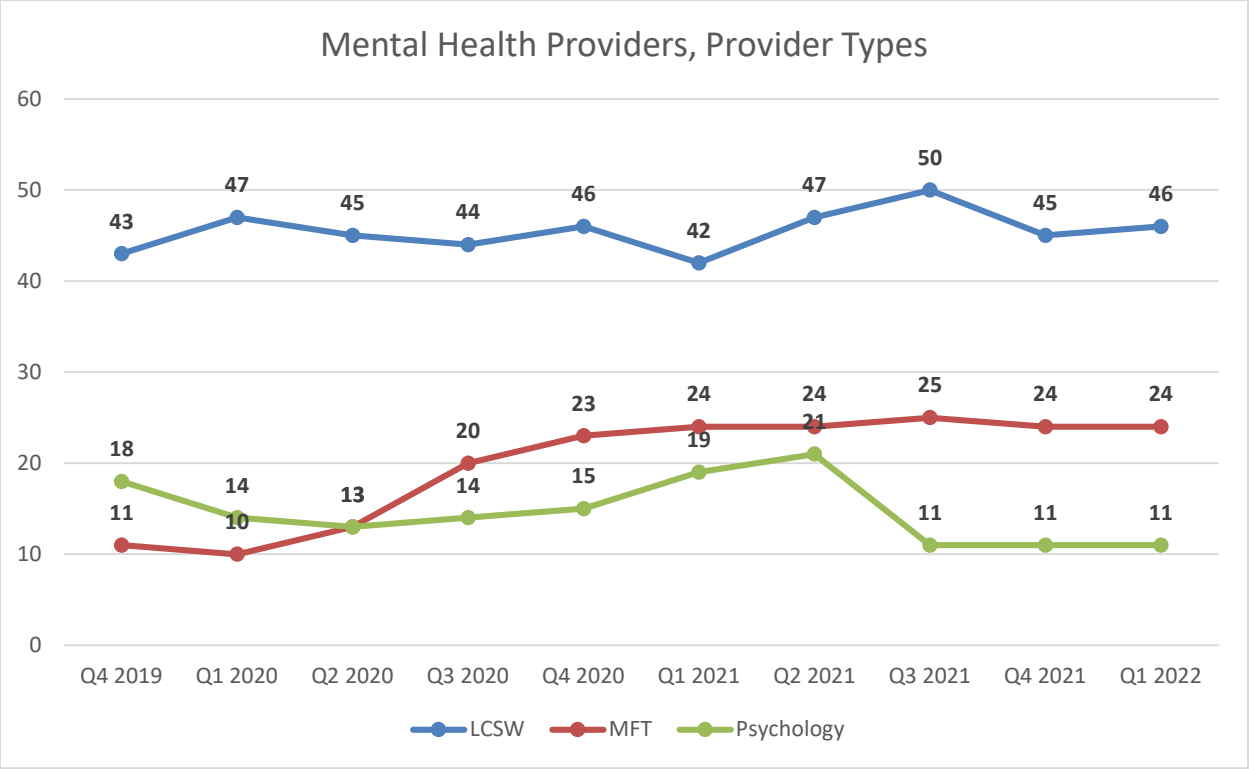
	> 5% Increase		> 5% Decrease
	≤ 5% Increase		≤ 5% Decrease

Network Adequacy & Provider Counts

Q1, 2022

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





Network Adequacy & Provider Counts

Q1, 2022

KERN HEALTH SYSTEMS

Provider Counts – Facilities

	2018	2019	2020	2021	Current
Hospital	18	18	18	21	21
Surgery Center	16	17	19	19	19
Urgent Care	17	17	17	19	19

Provider Counts – Other Provider Types

	2018	2019	2020	2021	Current
Ambulance/Transport	15	13	17	16	15
Dialysis	14	16	18	19	19
Home Health	12	13	13	14	15
Hospice	7	11	13	16	17
Pharmacy	136	139	147	150	146
Physical Therapy	29	29	30	29	29

Tracking and Trending

The Plan utilizes the quarterly Network Adequacy and Provider Counts review to monitor fluctuations within the network. The Plan has reviewed the results of the Q1 2022 report and compared against prior quarters (outlined above) and identified that provider counts remain consistent across the review period as illustrated in the graphs above.

Significant Network Change

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

Based on instruction from the DMHC, the Plan conducted a 12-month look back to calculate potential percent change in the three categories and determined the network had experienced a Significant Network change.

The Plan initiated the Significant Network Change filing with the DMHC on December 9, 2021 (Filing No. 20214807). On January 10, 2022, the Plan received a comment letter from the DMHC related to the

Network Adequacy & Provider Counts

Q1, 2022

Significant Network Change filing; the Plan responded to the comment letter on February 10, 2022.The Plan received an additional comment letter on March 9, 2022 and the Plan continues to work with the DMHC towards approval of this Significant Network Change filling.

KERN HEALTH SYSTEMS

DHCS Quarterly Monitoring Report/Response Template (QMRT)

Quarter 1, 2022

(Q4, 2021 Review Period)

Provider Network Management

Quarterly Monitoring Report/Response Template

Q1, 2022 (Q4, 2021 Review Period)

KERN HEALTH SYSTEMS

Introduction

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

On 01/07/2022 the Plan received Q4 2021 QMRT and accompanying reports from the DHCS and during Q1 2022 the Plan's Provider Network Management departments reviewed the following categories:

FTE Provider to Member Ratio

DHCS uses the Plan's 274 file submission to calculate and monitor FTE provider to member ratios. For Q4 2021 QMRT no response was requested from the Plan, and the DHCS review found the Plan to be in compliance with the standard:

Service Area and/or Reporting Unit	FTE PCP Per 2,000 members	FTE Physician Per 1,200 members
Kern	14	39

The Plan's standards and monitoring of FTE provider to member ratios are outlined in Plan policy and procedure *4.30-P Accessibility Standards*. While the Plan was unable to replicate the above ratios provided by the DHCS, the Plan's own quarterly monitor (*Network Adequacy and Provider Counts*, *Q1 2022*) also found the Plan to be in compliance with regulatory standards.

Timely Access

DHCS' External Quality Review Organization (EQRO) conducts a timely access survey of Plan providers to ensure compliance with provider availability and appointment wait time standards. For Q4 2021 QMRT no response was requested from the Plan, and no survey data was provided to the Plan. The Plan's standards and monitoring of timely access are outlined in Plan policy and procedure *4.30-P Accessibility Standards*. The Plan's own quarterly monitor (*Appointment Availability Survey*, *Q1 2022*) found the Plan to be in compliance with regulatory standards. The Plan was notified that the survey will be restarting January 1, 2022, and questions related to Timely Access will resume on the QMRT Quarter 2 2022.

Network Report

DHCS uses the Plan's 274 file to generate Network Report in an effort to improve network provider data quality and support compliance with Annual Network Certification and timely access survey. For Q4 2021 QMRT no response was requested from the Plan, and no Network Report data was provided to the Plan. The Plan's standards and monitoring of accessibility are outlined in Plan policy and procedure *4.30-P Accessibility Standards.*

Mandatory Provider Types

The Plan is required to contract with at least one of the following Mandatory Provider Types within its service area, where available: Freestanding Birthing Centers (FBC), Certified Nurse Midwife (CNM), Licensed Midwife (LM), and Indian Health Facilities (IHF). For Q4 2021 QMRT no response was requested from the Plan, and no Mandatory Provider Type data was provided to the Plan. The Plan maintains ongoing efforts to identify and contract will all provider types, including the above listed Mandatory Provider Types. This requirement is also reviewed by the Plan and DHCS as part of the Plan's Annual Network Certification. The Plan's most recent submission was found to be in compliance with regulatory requirements.

Physician Supervisor to Non-Physician Medical Practitioner Ratios

DHCS uses the Plan's 274 file submission to calculate and monitor Physician Supervisor to Non-Physician Medical Practitioner Ratios. For Q4 2021 QMRT no response was requested from the Plan, and the DHCS' review found the Plan to be in compliance with the standard:

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

The Plan's standards for Physician Supervisor to Non-Physician Medical Practitioner ratios are outlined in Plan policy and procedure *4.04-P Non-Physician Medical Practitioners – Supervision by Physicians.* While the Plan was unable to replicate the above ratios provided by the DHCS, the Plan calculated its network ratio and found it has **3.13** Physicians Supervisors per Non-Physician Medical Practitioner and was in compliance with the standard.

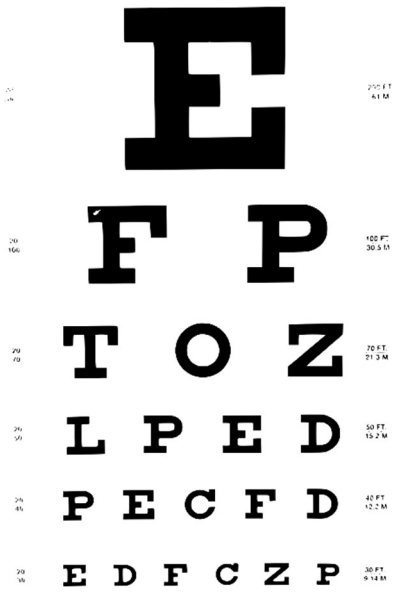
Out-of-Network Requests

The Plan reports Out-of-Network (OON) requests to DHCS when a member is requesting to a see a provider or facility, when a medically necessary service is not available in the Plan's network. The DHCS analyzes the data to identify potential areas of concern. Based on Q4 2021 data, the Plan identified **Hospital, Specialty Care,** and **Pharmacy** as the three provider types with the highest number of out-of-network requests. The Plan provided a response to the DHCS addressing these three provider types, including the Plan's strategy to reduce the number of requests, barriers/challenges to resolving the number of requests, and contracting/recruiting efforts.

KERN HEALTH SYSTEMS

VSP Access and Appointment Availability

Quarter 1, 2022



Provider Network Management

VSP Access and Appointment Availability

Q1, 2022

KERN HEALTH SYSTEMS

Introduction

In accordance with DHCS Contract Exhibit A – Attachment 10(8)(D), vision services are provided to Medi-Cal members pursuant to WIC § 14131.10. Per Kern Health Systems (KHS) *Policy 3.07-P Vision Care*, KHS contracts with Vision Service Plan (VSP) for the management and administration of optometric services for members.

VSP uses an annual appointment availability survey to assess compliance with access standards for Kern Family Health Care (KFHC) Members.

As advised by the VSP Compliance Department, VSP must follow the appointment wait times set by the Department of Managed Health Care (DMHC). VSP provided their VSP *Policy 7000 Access and Availability* indicating their California appointment access standards:

Type of Appointment	Time Standard
Urgent Care	Within 24 hours
Non-Urgent Appointment for Specialist Care	Within 15 business days

Appointment Availability Survey Results

VSP contracts to a third-party vendor, MDC Research, to conduct their appointment availability survey. The survey consists of contacting 90 providers throughout California and requesting appointment times for urgent and routine appointments. The providers selected are based on the number of providers in the counties as a percentage of total provider in the state.

On January 18, 2022, the Plan was notified of the results VSP's 2021 annual appointment availability survey. VSP reported 51% of the providers contacted were within the 24-hour urgent care standard and 67% of the providers were within the 15 day non-urgent specialist care standard.

As the providers that were contacted are located throughout California, these results are not indicative to the appointment times experienced by the Plan's members. The Plan reached out to VSP to determine which, if any, providers in the Plan's service area were contacted. VSP reported that one provider in the Plan's service area was contacted and was compliant with urgent and non-urgent appointment availability standards.

Tracking, Trending, and Provider Outreach

Due to the fact that only one provider from the Plan's service area was contacted for the survey, the Plan has reached out to VSP to obtain additional appointment availability information with regards to the Plan's members. VSP has reported that they will conduct a more thorough analysis of the providers within the Plan's service area to provide the Plan with additional information. As of Q1 2022, the Plan

has not received any additional information from VSP regarding appointment availability within the Plan's service area.

VSP conducts educational outreach to all providers who are not compliant with appointment availability standards. VSP reminds all non-compliant providers of the required appointment availability standards for urgent and non-urgent appointments.

KERN HEALTH SYSTEMS

MY 2021 DMHC Timely Access Reporting

MY 2021 DMHC Timely Access Reporting

Introduction

As required by the Department of Managed Health Care (DMHC) and outlined in Kern Health Systems (KHS) policy *4.30-P Accessibility Standards, § DMHC Annual Timely Access Compliance Report* "On an annual basis KHS shall conduct and submit a Timely Access Compliance report to the Department of Managed Health Care (DMHC). KHS will employ the methodology, survey tool, and submission/templates for the appropriate measurement year as instructed by the DMHC."

Measurement Year 2021 Timely Access Reporting

For Measurement Year (MY) 2021, the DMHC Timely Access Reporting was made up of two main components, an Annual Provider Network Report and an Annual Timely Access Compliance Report.

The Annual Provider Network Report consisted of seven reports designed to capture a snapshot of the Plan's contracted network and service area as of December 31, 2021. The seven reporting areas were *PCPs, Specialists, Mental Health, Other Contracted Providers, Hospitals and Clinics, Service Area and Enrollment,* and *Telehealth.* The Plan utilized the DMHC required reporting forms to submit this information.

The Annual Timely Access Compliance Report required a submission of:

A. Policy and Procedures
B. Rate of Compliance - *Provider Appointment Availability Survey (PAAS)*
C. Non-Compliance Data
D. Policy and Procedures for Advanced Access
E. Plan and Contractor Use of Triage, Telemedicine, Health I.T.
F. Provider and Enrollee [Satisfaction] Surveys

As it had done the year prior, the Plan utilized internal staff to conduct the MY 2021 PAAS, employing the methodology, survey tool, and reporting templates for MY 2019 as required by the DMHC (for MY2021 Plans were instructed to use MY2019 methodology and materials).

The Plan submitted all Timely Access Reporting requirements to the DMHC on March 31, 2022.

External Vendor Validation

Outlined in DMHC All-Plan Letter 19-008, the Department requires all plans to utilize an external vendor to validate a plan's timely access data and conduct a quality assurance review of the health plan's *Timely Access Compliance Report* prior to submission to the DMHC. For MY 2021, KHS engaged Health Management Associates (HMA) to conduct the external validation. As a part of their data validation and quality assurance, HMA conducted a pre-survey review of the provider contact list, and post survey review of submission data, ensuring networks were identified correctly, methodology utilized was consistent with DMHC guidelines, formatting of submission files was accurate and correct, survey was conducted during appropriate timeframes, and all data submitted appears accurate and correct.

MY 2021 DMHC Timely Access Reporting

Upon initial review of the data, HMA identified seven remediable findings KHS was able to correct prior to submission to the DMHC. There were no non-remediable findings.

MY 2021 PAAS Results

Per the DMHC MY 2019 PAAS Methodology used for MY 2021, KHS surveyed five provider types: *Primary Care Providers, Specialists, Ancillary, Non-Physician Mental Health,* and *Psychiatrists.* Results of the survey were reported per provider type, and then within each provider type, per county.

The DMHC is still in the process of formulating an appropriate rate of compliance to compare plans' results against.

Provider Survey Type	County	Number of Providers within County/Network	Rate of Compliance for Non-Urgent Appointments Available within 15 Days	
Ancillary	Kern	58	100%	
Ancillary	Los Angeles	5	100%	
Provider Survey Type	**County**	**Number of Providers within County/Network**	**Rate of Compliance Urgent Care Appointments Available within 96 Hours**	**Rate of Compliance Non-Urgent Appointments Available within 10 Days**
Non-Physician Mental Health Provider	Kern	60	85%	92%
Non-Physician Mental Health Provider	Telehealth	18	100%	100%
Provider Survey Type	**County**	**Number of Providers within County/Network**	**Rate of Compliance Urgent Care Appointments Available within 48 Hours**	**Rate of Compliance Non-Urgent Appointments Available within 10 Days**
PCP	Kern	239	81%	94%
PCP	Telehealth	7	100%	100%
Provider Survey Type	**County**	**Number of Providers within County/Network**	**Rate of Compliance Urgent Care Appointments Available within 96 Hours**	**Rate of Compliance Non-Urgent Appointments Available within 15 days**
Specialist Physicians	Kern	78	78%	90%
Specialist Physicians	Telehealth	12	10%	40%
Psychiatry	Kern	33	92%	69%
Psychiatry	Telehealth	14	64%	45%

MY 2021 DMHC Timely Access Reporting

Plan-to-Plan Arrangement Review – Kaiser Permanente

The Plan currently maintains a subcontract with Kaiser Permanente (KP) to provide full health plan services to a subset of KHS enrollees. KP contracted providers are not included as a part of the PAAS completed by KHS staff. KP is responsible for conducting their own PAAS as a part of their annual Timely Access Reporting to the DMHC. In their separate submissions to the DMHC, the two plans are able to link their data by reference, via the DMHC e-filling web portal.

As an oversight measure of our subcontract, KHS communicates with KP to ensure that their data will be submitted within the appropriate time frame and collects a copy of their complete Timely Access Reporting submission for review.

The DMHC is still in the process of formulating an appropriate rate of compliance to compare plans' results against.

Provider Survey Type	**County**	**Rate of Compliance Non-Urgent Appointment within 15 Days**	
Ancillary	Kern	100.00%	
Provider Survey Type	**County**	**Rate of Compliance Urgent Care Appointments Available within 96 Hours**	**Rate of Compliance Non-Urgent Appointments Available within 10 Days**
Non-Physician Mental Health Provider	Kern	45%	86%
Provider Survey Type	**County**	**Rate of Compliance Urgent Care Appointments Available within 48 Hours**	**Rate of Compliance Non-Urgent Appointments Available within 10 Days**
PCP	Kern	73%	90%
Provider Survey Type	**County**	**Rate of Compliance Urgent Care Appointments Available within 96 Hours**	**Rate of Compliance Non-Urgent Appointments Available within 15 days**
Specialist Physicians	Kern	87%	87%
Psychiatry	Kern	67%	78%

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Potential ~~Inappropriate~~ Quality of Care Issues (PQI)				POLICY #: 2.70-I	
DEPARTMENT: Quality Improvement (QI)					
Effective Date: ~~7/21/2020~~7/1/2022	Review/Revised Date:	DMHC		PAC	X
		DHCS		QI/UM COMMITTEE	X
		BOD	X	FINANCE COMMITTEE	

_____ Date _____
Douglas A. Hayward
Chief Executive Officer

_____ Date _____
Chief Medical Officer

_____ Date _____
Chief Health Services Officer

_____ Date _____
Chief Network Administration Officer

_____ Date _____
Director of Compliance

_____ Date _____
Director of Member Services

_____ Date _____
Director of Quality Improvement

RELATED POLICIES:
2.04-P Provider Disciplinary Action
4.40-P Corrective Action Plans
5.01-P KHS Member Grievance and Appeals
5.01-I KHS Member Grievance and Appeals

IMPACTED DEPARTMENTS:
All Departments

DEFINITIONS:

Complaint: A complaint is the same as a Grievance. Where the KHS is unable to distinguish between a Grievance and an inquiry, it shall be considered a Grievance.

Corrective Action Plan (CAP): This is a plan approved by the Chief Medical Officer (CMO) to prevent a quality issue from occurring again in the future. A CAP is an agreement between the provider and KHS that describes the problem and appropriate measures to achieve resolution. If the CAP includes reassignment of patients, the CMO or his/her designee notifies the Chief Network Administration Officer to coordinate patient panel changes.

Grievance: A Grievance is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, and the beneficiary's right to dispute an extension of time proposed by the KHS to make an authorization decision.

Potential Inappropriate Care (PIC): This is the term Department of Health Care Services (DHCS) has identified for a Potential Quality of Care issue. They define it as a grievance related to the overuse, underuse, or misuse of health care services[1] It is a possible adverse variation from expected clinician performance, clinical care, or outcome of care. PICs require investigation to determine if an actual quality issue or opportunity for improvement exists.

Potential Quality Issue: A Potential Quality Issue (PQI) is defined as a possible adverse variation from expected clinician performance, clinical care, or outcome of care. PQIs require further investigation to determine whether an actual quality issue or opportunity for improvement exists. Not all PQIs represent quality of care issues.

Quality of Care (QOC) issue: Quality of Care means the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.~~This is an adverse deviation from expected clinical care or outcome of care as validated through investigation and as part of the PICPQI process.~~

Screening Process: This process includes a complete review of the referral. The QI RN assigned to the episode will determine if further investigation is warranted based on the data gathered in the ~~PIC~~PQI Referral.

PURPOSE
To provide a defined method for identifying and processing ~~PIC~~PQI issues, to determine opportunities for improvement in delivery of health care to Kern Health System members, and to direct appropriate follow up actions based upon investigative outcomes, ~~risk~~risk, and severity. The policy also supports

[1] DHCS Managed Care Program Data (MCPD) Primary Care Provider Assignment (PCPA) Technical Documentation, March 27, 2020, version 1.3

continuous review the quality of care provided to members to ensure that a level of care which meets professionally recognized standards of practice is being delivered to all enrollees and that quality of care problems are identified and corrected for all provider entities.[2]

This policy also ensures that KHS' Quality Improvement System (QIS) effectively monitors, evaluates, and takes effective action to address any needed improvements in the quality of care delivered by all Providers rendering services on behalf of KHS in any setting.[3]

POLICY AND PROCEDURES:

I. All ~~PIC~~PQI referrals are screened by a QI RN to validate that a ~~PIC~~PQI issue exists.

A. Cases are reviewed using professionally recognized, evidence-based standards of care to assess care provided.

~~I.~~II. ~~PIC~~PQI Sources for Identification include, but are not limited to, the following sources:

A. Information gathered through Utilization ~~Management;~~Management.
B. Referrals from any health plan ~~staff;~~staff.
C. Facility site ~~reviews;~~reviews.
D. Claims and encounter ~~data;~~data.
E. Pharmacy utilization ~~data;~~data.
F. Managed Care Accountability Set (MCAS) medical record abstraction ~~process;~~process.
G. Medical Record Audits
H. Complaints/Grievances and Appeals from members
~~H.~~I. Provider Preventable Condition (PPC) Reviews
~~I.~~J. Providers or other health care organizations

~~II.~~III. ~~Pic~~PQI ~~R~~referrals ~~submission~~

A. May be reported by any of the following:
   1. Any KHS staff member via the Potential ~~Inappropriate~~ Quality of Care Issue (~~PIC~~PQI) Referral Form (Appendix A~~;~~).
   2. If a PPC is identified via the daily PPC report, a PQI episode will be created in KHS' medical management system for review. Refer to Policy 2.72-I Provider Preventable Condition Policy.
   ~~1.~~3. If a PPC is identified during the Utilization Management (UM) review process, a referral will be made to QI indicating a PPC has been identified for appropriate PPC reporting and PQI review. Refer to Policy 2.72-I Provider Preventable Condition Policy.~~–~~
   ~~2.~~4. Any KHS member, member of the community, or provider can call 661.632.1590 (Bakersfield) or 800.391.2000 (outside of Bakersfield), or they can complete the Grievance form located on KHS' public website and submit it via mail or online.

B. ~~PIC~~PQI Referrals ~~from the KHS Grievance Team~~Via a Grievance
   1. Grievances received by the KHS Grievance Team are reviewed by a Grievance Coordinator (GC) who makes an initial classification of the Grievance. See KHS Policy 5.01-P, KHS Member Grievance and Appeals, for classification types.
   2. ~~Once the GC makes an initial classification~~All grievances received ~~, it is~~ are ~~distributed~~ referred to the assigned QI grievance nurse ~~Grievance Committee for review~~ along with a copy of the original ~~G~~grievance to evaluate whether a PQI may be present. Processing of Grievances

[2] Tit. 28, § 1300.70
[3] Title 28, CCR, Section 1300.70 and 42 CFR 438.330

follows the timeframes identified in KHS Policy 5.01-P, KHS Member Grievance and Appeals.

3. ~~A~~ The QI ~~RN~~ nurse assigned to review the grievance ~~on the Grievance Committee also nurse~~ evaluates whether a PQI may be present. If additional information or medical records are needed to complete the screening, they may request that of the member or provider associated with the grievance.~~reviews the original Grievance and classification~~.
4. The QI nurse completes review of the original grievance and any other pertinent information to determine if a PQI ~~exists~~may be present and documents a clinical summary of their review.
5. If the QI RN determines that a PQI may be present, the grievance is referred to the designated medical director physician for review and final determination of whether a PQI is present.
6. When the medical director determines a PQI is present, a referral to the QI Department is made to complete the PQI investigation process.
7. The medical director includes in their final determination a summary of their review and findings.
8. The GC is notified of the outcome of the medical director's PQI review to complete notification to the member including a clear and concise explanation of the Plan's decision to the members grievance.~~.~~
9. The QI nurse assigned to the grievance opens a PQI referral episode and requests any additional medical records required for the PQI investigation. The assigned GC requests records in accordance with Sections IV.B.1 and IV.B.2 below. The requests are made using the forms in Appendix B (Initial and Final Medical Record Request Forms). The PQI referral is assigned to a QI nurse to begin the PQI investigation process.

~~3.~~10. T~~he QI RN reports to the Grievance Committee whether they agree with the original classification or whether they have determined it to be a different classification.~~

~~4.~~11. Grievances ~~classified~~ referred as a ~~PIC~~PQI are entered into KHS' medical management system. The assessment covers all information on the ~~PIC~~ PQI Notification Referral Form (see Appendix A). Once the referral is submitted in KHS' Medical Management System, an episode is created and moved into a work queue for a QI RN to begin the investigation process.

~~III.~~IV. ~~PIC~~PQI REVIEW PROCESS

A. All notifications to and requests of providers shall be sent via certified mail. Communications may be done by phone or fax. However, all notifications and requests will also include written communication and be sent by certified mail to ensure delivery and identify the date of receipt. A copy of the certified mail receipt is scanned and retained within the medical management system episode. A copy of the certified mail signature of delivery and receipt will also be scanned and retained within the medical management system episode.

~~A.~~B. All ~~PIC~~PQI referrals received by the QI department will include an investigation of existing clinical documentation that can be used to determine if a QOC issue exists. A QI nurse~~RN~~ will screen the ~~PIC~~PQI referral and determine if any additional records need to be requested or if the clinical information needed to determine if a QOC issue is present are already available (~~e.g.~~e.g., through Utilization Management, Case Management, Health Homes, etc.). If additional medical records are needed, the QI nurse~~RN~~ will identify what records are needed and notify the ~~SCC~~ QI Senior Coordinator (SC) or other designated support staff to initiate the records request.

1. The QI ~~RN~~ nurse uses the ~~PIC~~PQI Medical Records Request Form in Appendix B.

a. When this form is completed and sent to the provider, the QI ~~RN~~ nurse will upload the form into KHS' Medical Management System.

b. If there has been no response from the provider within 10 business days of the 1st request, the QI nurse ~~RN~~ will request records a second time.

c. The QI nurse~~RN~~ will also notify the Provider Network Management (PNM) representative assigned to the provider and include a copy of the records request form to assist with obtaining the requested records.

2. If there has been no response from the provider within ~~5~~ 10 business days of the 2nd request, the QI ~~RN~~ nurse will notify the Chief Medical Officer (CMO) or their designee (a physician) for a final outcome based on the information available. This will be documented in KHS' Medical Management System.
3. When indicated, a referral to or coordination with KHS's other medical management programs such as, Case Management, Disease Management and Health Homes will be made to coordinate care for complex or challenging member issues.

C. Once the records have been received, they are uploaded into KHS' Medical Management System for review by the assigned QI nurse~~RN~~. After investigation by the QI RN, a summary of the review is created using the SBAR format (Situation, Background, Assessment, and Recommendation) and presented to the CMO or their designee for review and determination in KHS' Medical Management System.

D. When the QI nurse refers the PQI to the CMO or their designee, a task is entered for follow up with the CMO or their designee if no action has occurred by the CMO or their designee within 1 week of referral

E. The QI nurse contacts CMO, or their designee assigned to the episode to request completion of the PQI referral.

~~B.~~F. If there is still no follow-up by the CMO or their designee, the QI nurse will notify the QI manager for escalation.

~~1. If there is no evidence that a QOC issue exists, the QI RN documents a summary in SBAR format and closes the episode as a Level 0 – No Quality of Care Concern.~~

All PQI referrals are ~~ny referral with a QOC issue identified is~~ referred to the CMO or their designee for final determination of severity level and any follow up direction.

~~C.~~G. The CMO or their designee reviews the documentation within KHS' Medical Management System for the indicated ~~PIC~~PQI issue and documents the final determination of existence of a QOC and the ~~PIC~~PQI Severity Level.

1. The Medical Director documents follow up actions appropriate for the needed improvement and coordinates those items with the QI RN.

~~D.~~H. ~~PIC~~PQI Severity Level

1. The ~~PIC~~PQI severity level is determined by the CMO or their designee following their investigation. The exception to this is Level 0 when it is determined through the screening process completed by a QI RN. Based on the outcome of the review, the episode is designated with a Severity Level of one of the following levels:
    - Level 0 = No Quality of Care Concern
        - The ~~PIC~~PQI is then closed.
    - Level 1 = Potential for Harm
        - Follow-up = Track and trend the ~~particular area~~area of concern for the specific provider, and the CMO or their designee or their designee may provide additional actions that are individualized to the specific case or provider.
    - Level 2 = Actual Harm
        - Follow-up = Implement a Corrective Action Plan plus direction from CMO or

their designee or their designee that is individualized to the specific case or provider.

- Level 3 = Actual Morbidity or Mortality Failure
  - Follow-up = Implement a Corrective Action Plan plus direction from CMO or their designee or their designee that is individualized to the specific case or provider.

2. Copies of all written correspondence and pertinent documents are filed in KHS' Medical Management system.

~~E.~~I. The CMO or their designee will request any written information or clarification necessary from the provider for Levels 2 and 3 regarding the issue in question. All QOC issues are tracked for re-credentialing purposes. Input regarding QOC episodes is presented to the Physician Advisory Committee for consideration in re-credentialing providers or recommending other actions.

1. If the contracted provider fails to respond to the CMO or their designee's correspondence within 2 weeks of sending the request, the provider will be referred to the Chief Medical Officer (CMO). The CMO will coordinate with the Provider Network Management Department as needed.

F. Corrective Action Plan

1. The CMO or their designee determines if a CAP is needed. The response to the CAP is expected within 30 calendar days of sending the CAP requirement to the provider. The CMO or their designee uses the Corrective Action Plan Form in Appendix C and completes the following sections:
   a. Date
   b. Provider Name
   c. Deficiency #
   d. Expected Outcomes
2. The QI nurse creates a task in the medical management system for follow up with the provider if no response to the CAP issues has been received within the expected 30 calendar days.
3. The QI nurse contacts the provider to request the providers CAP response within 1 week. Contact may be done by phone and documented in the medical management system for the PQI episode. However, written response request within 1 week is sent by the QI nurse from the CMO or their designee via certified mail.
4. The QI nurse notifies the assigned PNM representative for the provider of the need for the CAP response from the provider.
5. If there is still no CAP response from the provider, the QI nurse will notify the CMO or their designee for further direction.
6. The CMO or their designee will attempt to contact the provider and request the CAP response. This may be done by phone and must be documented in the episode in the medical management system.
7. The QI nurse sets an activity in the episode to follow up with the CMO or their designee if no further response has been received from the provider.

~~1.~~8. The CMO or their designee may refer the PQI to the Physician Advisory Committee for further action.

~~2.~~9. Responses from the provider to a CAP issued are reviewed by the CMO or their designee. That physician makes the determination for acceptance of the CAP as completed. If a CAP response is not accepted, the CMO provides a written response to the provider with input and additional instruction for CAP completion.

~~3.~~10. If the CAP has not been received by day 31, the case is forwarded to the CMO for further determination, including possible review by the Physician Advisory Committee

(PAC)~~.~~ . Upon completion, the CAP will be reviewed by the CMO or their designee

~~4.~~11. The CMO or their designee completes the plan portion of the CAP form (Appendix C)~~.~~ . The CAP may include but is not limited to:

i. Required attendance at continuing education programs applicable to the issue identified and approved by ~~KHS;~~KHS.

ii. Required training/re-training and/or certification/re-certification for performance of those procedures that require specific training and professional ~~certification;~~certification.

iii. Track and trend analysis of the adverse quality issues identified in the clinician's practice patterns and

iv. In-service training for clinicians and/or their staff.

G. Tracking and Trending

1. Tracking and trending is performed to ensure that an identified QOC has been resolved. This is also done to identify any continuing patterns of concerns and opportunities for improvement.
2. The CMO or their designee requesting the tracking and trending identifies and documents the specific areas for focus. The standard period of time to track and trend is 6 months unless otherwise specified by the CMO or their designee. All cases selected for tracking and trending are logged by the QI ~~SSC~~ SC into KHS' Medical Management System as well as tracked on a spreadsheet.
3. When a new ~~PIC~~PQI referral is received, the assigned QI ~~RN~~ nurse reviews the Track and Trend log to see if the provider in the new referral is on active track and trending. If the provider is on the active list, the QI ~~RN~~ nurse notes that in their investigative review and includes that information in the referral to the Medical Director. All ~~PIC~~PQI referrals in which the provider is on the active Track and Trend log are referred to the CMO or their designee for ~~PIC~~PQI Severity Level determination and instructions for any follow up actions.

H. Providers with no further QOC occurrences during the duration of time they are actively tracked and trended are moved to the inactive Track and Trend log. Extension of active track and trending occurs at the direction of the CMO or their designee and ~~as a result of~~because of their review of new QOC issues presented to them.

I. Provider-specific trends will be reported to Provider Network Management for inclusion in the re-credentialing process.

V. AUDITING

A. Each quarter, the QI Manager will conduct an audit of a sample of PQI episodes (Attachment A, PQI Audit Tool) completed per QI nurse who processes PQIs to evaluate that they are

1. Complying with this policy and procedure,
2. Employing appropriate clinical assessment skills and
3. Documenting the PQI referral process properly.

Any issues identified in the audit will have follow up action with the QI RN documented to support correction.

~~V.~~VI. DELEGATION

A. KHS is responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. KHS will communicate the policy requirements to all delegated entities and

subcontractors. KHS will ensure that ~~all of~~all their own policies and procedures, as well as the policies, procedures, and practices of any delegates, sub plans, contracted providers, or subcontracted Independent Physician Associations or medical groups, comply with these requirements and those located in any applicable APL.

REFERENCES:

Policy 2.72-I Provider Preventable Condition Policy
Policy 2.04-P Provider Disciplinary Action
~~**Policy 2.26-I** Hospital Re-admissions – Quality of Care Issues (retired policy)~~
Policy 4.40-P Corrective Action Plans
Policy 5.1-I KHS Member Grievance and Appeals
Policy 5.01-P KHS Member Grievance and Appeals
APL 17-06, Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights"
Title 22, CCR, Section 53858(e)(2) The immediate submittal of all medical quality of care grievances to the medical director for action.
DHCS Managed Care Program Data (MCPD) Primary Care Provider Assignment (PCPA) Technical Documentation, March 27, 2020, version 1.3

APPENDICES & Attachments

Appendix A Potential Inappropriate Care (~~PIC~~PQI) Referral
Appendix B Medical Record Request Form
Attachment A: Quarterly PQI Nurse Audit Tool

REVISIONS

February 2022: Changed the name of PIC to PQI to align with the term used in our contract with DHCS. Changed grievance review process so that all grievances received are reviewed by a QI nurse for evaluation of PQI presence, referral to medical director if a PQI may exist for final determination and further direction. Changed PQI process so that all PQI referrals go to the CMO or designated medical director for severity level determination and direction for follow up. Added verbiage to support assurance that PQI investigations and any CAPs issued are completed. Included additional layer of quarterly auditing for nurses' PQI work. **May 2021:** Clarified time frames throughout the policy to distinguish calendar or business days. Reduced the amount of time response for 2nd request for medical information is due. Changed references to Medical Director to Chief Medical Officer or their designee. Modified who is notified when member re-assignment is planned from the CEO to the Chief Network Administration Officer. Added new Corrective Action Form. **June 2020:** Policy revised to incorporate legal counsel's guidance. Jane Daughenbaugh, Director of Quality Improvement **April 2020** – Policy created Jane Daughenbaugh, Director of Quality Improvement.

Appendix A – ~~PIC~~PQI Referral Form

Kern Health Systems
Potential Inappropriate Care Referral Form
Confidential Report

OCCURRENCE	
Date of Occurrence: Click here to enter a date.	**QI Referral Date:** Click here to enter a date.

PROVIDER/MEMBER INFORMATION	
Provider First Name: **Provider Last Name:** **Provider NPI Number:** **Street Address1:** **Street Address2:** **City:** **State:** **Zip:** **Phone:** - - **Extension:**	**Member First Name:** **Member Last Name:** **Member ID:** **Street Address1:** **Street Address2:** **City:** **State:** **Zip:** **Phone:** - - **DOB:** ☐ **Male** ☐ **Female**

NARRATIVE DESCRIPTION OF OCCURRENCE (Factual Only)

Summary of Complaint:

Desired Outcome of Person Filing Grievance:

Report Prepared by (Name): **Title:** **Select One** **Other, Specify:**

Date: Click here to enter a date.

Date Submitted as PQI to QI Department: Click here to enter a date.

ALL INFORMATION ABOVE MUST BE COMPLETED BEFORE SENDING TO QI DEPT

SEND REQUEST TO THE "QI PQOC TEAM" EMAIL DISTRIBUTION

Appendix B - QI Department ~~PIC~~PQI Medical Records Request Form

Kern Family Health Care™

Initial Medical Record Request

DATE: Click here to enter a date.

TO:

COMPANY:

PHONE #:

FROM:

Name

Address: 2900 Buck Owens Blvd, Bakersfield, CA 93308

PHONE:

RE:
DOB:
MBR#:

To Whom It May Concern:
Kern Family Health Care is in the process of reviewing a grievance, regarding the above member. In order to complete our review, we will need the following information: ***All updated medical records from*** Click here to enter a date. ***to current***

*** Please include the following information and forward as soon as possible***

☐ **Registration Sheet**	☐ **Nurses Notes**	☐ **Physician Notes**
☐ **Lab/X-ray Reports**	☐ **Op Reports**	☐ **Signed Consent forms**
☐ **ER Notes**	☐ **Prescriptions**	☐ **Diagnoses**
☐ **History & Physical**	☐ **Physician Orders**	☐ **Discharg Plan (if inpatient)**
☐ **Discharge summary (if inpatient)**	☐ **Pre-op work-up**	☐ **Post-op notes (if inpatient)**
☐ **Pathology report(s)**	☐ **Other:**	

RN Requesting Records: **Date RN Returned Records Needed:** Click here to enter a date.
Please return this letter (or copy) with requested information within **10 days**. If you have any questions, please feel free to email us at QI-PQOC-Team@KHS-net.com or call us at (661) 664-5053. Thank you for your prompt assistance in this matter.

Mail to: Kern Health Systems
2900 Buck Owens Blvd
Bakersfield, CA 93308
Attn: QI Department

or

Fax to: Kern Health Systems
(661) 473-7575
Attn: QI Department

Kern Family Health Care™

Final Medical Record Request

DATE: Click here to enter a date.

TO:

COMPANY:

PHONE #:

FROM:

Name

Address: 2900 Buck Owens Blvd, Bakersfield, CA 93308

PHONE:

RE:
DOB:
MBR#:

To Whom It May Concern:
Kern Family Health Care is in the process of reviewing a grievance, regarding the above member. In order to complete our review, we will need the following information: ***All updated medical records from*** Click here to enter a date. ***to current***

*** Please include the following information and forward as soon as possible***

- ☐ **Registration Sheet**
- ☐ **Lab/X-ray Reports**
- ☐ **ER Notes**
- ☐ **History & Physical**
- ☐ **Discharge summary (if inpatient)**
- ☐ **Pathology report(s)**
- ☐ **Nurses Notes**
- ☐ **Op Reports**
- ☐ **Prescriptions**
- ☐ **Physician Orders**
- ☐ **Pre-op work-up**
- ☐ **Other:**
- ☐ **Physician Notes**
- ☐ **Signed Consent forms**
- ☐ **Diagnoses**
- ☐ **Discharg Plan (if inpatient)**
- ☐ **Post-op notes (if inpatient)**

RN Requesting Records: **Date RN Returned Records Needed:** Click here to enter a date.
Please return this letter (or copy) with requested information within **10 days**. If you have any questions, please feel free to email us at QI-PQOC-Team@KHS-net.com or call us at (661) 664-5053. Thank you for your prompt assistance in this matter.

Mail to: Kern Health Systems
2900 Buck Owens Blvd
Bakersfield, CA 93308
Attn: QI Department

or

Fax to: Kern Health Systems
(661) 473-7575
Attn: QI Department

APPENDIX C – Corrective Action Plan Form

Kern Health Systems
Corrective Action Plan

Date: _____ **Provider Name:** _____

Deficiency #: _____

Deficiency Description (KHS Completes):

Expected Outcomes (KHS Completes):

Actions Taken (Completed by Provider):

Implementation Date (Completed by Provider): _____

Evidence of Completion/Supporting Documentation if Applicable (Completed by Provider):

Provider Signature **Date**

_____ _____

KHS Medical Director Name: _____

☐ Approved ☐ Rejected **Medical Director Signature** _____

Date: _____

Comments:

_____

661-664-5000
661-664-5151

kernhealthsystems.com
2900 Buck Owens Boulevard, Bakersfield, CA 93308-6316

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Provider Preventable Conditions (PPC)				POLICY #: 3.69 I2.721 I	
DEPARTMENT: Utilization Management Administrative Director of Health Services Quality Improvement- Director of Quality Improvement					
Effective Date: 02/2015	Review/Revised Date: 12/18/2018 04/12/2022	DMHC		PAC	X
		DHCS		QI/UM COMMITTEE	X
		BOD		FINANCE COMMITTEE	

_____ Date _____
Douglas A. Hayward
Chief Executive Officer

_____ Date _____
Chief Medical Officer

_____ Date _____
Chief Operating Officer

_____ Date _____
ChiefAdministrative Director of Health Services Officer

_____ Date _____
Director of Quality Improvement

_____ Date _____
Director of Compliance and Regulatory Affairs

_____ Date _____
Director of Claims

POLICY:

Under Section 2702 of the Patient Protection and Affordable Care Act (Pub. L. 111-148) (the ACA) and federal regulations at 42 CFR.447.26, and Title 42 of the Code of Federal Regulations (CFR)

Sections 438.3(g), 434.6(a)(12)(i), and 447.26, and Welfare and Institutions Code Section 14131.11, prohibit ~~the~~ payment of Medicaid/Medi-Cal funds to a provider for the treatment of a Provider Preventable Condition (PPC), except when the PPC existed prior to the initiation of treatment for that beneficiary by that provider. A provider must report the occurrence regardless of whether or not the provider seeks Medi-Cal reimbursement for services to treat the PPC. Reporting a PPC for a Medi-Cal beneficiary does not preclude the reporting of adverse events, pursuant to Health and Safety Code (H&S Code), Section 1279.1, to the California Department of Public Health (CDPH).

~~Kern Health Systems (KHS) implemented policies that conform to the federal requirements on PPCs, effective for dates of service on or after July 1, 2012.~~

A provider reports a PPC by completing and submitting the Medi-Cal Provider-Preventable Conditions (PPC) Reporting Form (See Attachment A). Providers must submit the form within five days of discovering the event and confirming that the patient is a Medi-Cal beneficiary. When KHS becomes aware of a PPC, the KHS Quality Improvement (QI) Department submits the PPC to DHCS via the DHCS online reporting portal. Evaluation of any claims received for payment of services provided related to a PPC are reviewed by a KHS Medical Director to determine if any clinical services billed are related to the PPC for the purpose of determining reimbursement.

DEFINITIONS:

Provider Preventable Conditions (PPCs) are conditions that meet the definition of a "health care-acquired condition" or an "other provider preventable condition" as defined below and by the Centers for Medicare & Medicaid Services (CMS) in federal regulations at 42 CFR.447.26(b). PPCs include both ~~the~~ "Health Care Acquired Conditions" (HCACs) and "Other Provider Preventable Conditions" (OPPCs). ~~CMS further defined OPPCs as conditions that: 1) are identified by the State Plan, 2) are reasonably preventable through the application of procedures supported by evidence-based guidelines, 3) have negative consequence for the beneficiary, and 4) are auditable.~~

Health Care Acquired Conditions (HCACs) means a condition occurring in any inpatient hospital setting, identified as a HAC by the Secretary under section 1886(d)(4)(D)(iv) of the Act for purposes of the Medicare program identified in the State plan as described in section 1886(d)(4)(D)(ii) and (iv) of the Act; other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients.~~are conditions occurring in an inpatient hospital setting that Medicare designates as hospital-acquired conditions (HACs) pursuant to section 1886(d)(4)(D)(iv) of the Social Security Act (SSA) (as described in Section 1886(d)(4)(D)(ii) and (iv) of the SSA), with the exception of deep vein thrombosis (DVT)/pulmonary embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients.~~

Other Provider Preventable Conditions (OPPCs) means a condition occurring in any health care setting that meets the following criteria:
(i) Is identified in the State plan.
(ii) Has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines.
(iii) Has a negative consequence for the beneficiary.

(iv) Is auditable.
(v) Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient. CMS Pub 100-03 Medicare National Coverage Determinations defines surgical or invasive procedures as operative procedures in which skin or mucous membranes and connective tissue are incised or an instrument is introduced through a natural body orifice. ~~are conditions that meet the requirements of an "other provider preventable condition" pursuant to 42 CFR §447.26(b). OPPCs may occur in any healthcare setting and are divided into two sub-categories.~~

~~a) National Coverage Determinations (NCDs):NCDs are mandatory OPPCs under 42 CFR. 447.26(b) and mean any of the following conditions that occur in any health-care setting:~~
~~Wrong surgical or other invasive procedure performed on a patient~~
~~Surgical or other invasive procedure performed on the wrong body part~~
~~Surgical or other invasive procedure performed on the wrong patient~~

LTC facilities need only report other provider-preventable conditions (OPPCs) ~~include:~~. LTC facilities include the following facilities:

- ~~•~~ Freestanding skilled nursing facilities,
- Freestanding or distinct part intermediate care facilities,
- Intermediate care facilities/developmentally disabled – habilitative,
- Intermediate care facility/developmentally disabled,
- Intermediate care facility/developmentally disabled – nursing,
- Freestanding and distinct part subacute facilities (adult and pediatric), and
- Distinct part skilled nursing facilities.

~~For each of (i) through (iii) above, the term "surgical or other invasive procedure" is as defined in CMS Medicare guidance on NCDs.~~
~~b) Additional Other Provider Preventable Conditions (Additional OPPCs)~~
~~Additional OPPCs are state-defined OPPCs that meet the requirements of 42 CFR. 447.26(b).~~

PROCEDURES:

1. **Identification of Potential Provider Preventable Conditions**
   As part of the PPC identification process, KHS will ensure the following:
   a) Review of encounter data submitted by ~~network~~ all providers for evidence of PPCs that must be ~~be reported~~be reported via ~~the~~ DHCS' online reporting portal ~~beginning on the date of the issuance of this APL~~. Internally generated reports utilizing claims data are screened by Claims and ~~Utilization management~~Quality Improvement clinical staff for prompt identification of a PPC.
   b) ~~Report each~~ PPCs are submitted according to ~~per the~~ instructions ~~for the online reporting portal.~~ on the DHCS website, Medi-Cal Guidance on Reporting Provider-Preventable Conditions.
   c) ~~Issue a special notice informing~~KHS providers will be informed regarding regulatory requirements ~~all of~~ that all ~~their~~ network providers ~~that they~~ must ~~report~~ PPCs to DHCS using ~~the~~ DHCS' online reporting portal~~online reporting portal~~.
   d) ~~Require n~~Network providers must also ~~to also~~ send ~~them~~ a copy of all PPCs submitted to DHCS' online reporting portal~~the online portal~~ to KHS to support appropriate claims adjudication.

e) The ~~Compliance Department~~ Quality Improvement Department will retain copies ~~and maintain a log~~ of all PPC submissions to DHCS along with the original daily report and summary of the investigation outcome.

KHS will designate a ~~staff member~~QI clinical staff member to ~~screen and identify~~investigate any PPC~~s~~ identified in the daily ~~encounter data~~PPC report. QI clinical staff will reference The Centers for Medicare and Medicaid Services (CMS) website for the most current CMS ICD-10 Hospital Acquired Condition (HAC) List to determine if the diagnoses codes or events are reportable as defined by DHCS. ~~and ensure that each PPC is reported via the online reporting portal. KHS' designated PPC screener can help identify PPCs in encounter data from network providers who are not enrolled as Medi-Cal providers. Medi-Cal enrolled providers have already been informed of these requirements and are likely to be reporting their PPCs via the online portal. However, the designated PPC screener might identify PPCs in encounter data that network providers may have inadvertently overlooked. Therefore, KHS must screen our encounter data for PPCs and issue a special notice informing all our network providers of this reporting requirement.~~

~~KHS is responsible for ensuring that our delegates comply with all applicable state and federal laws and regulations, and other contract requirements, including applicable APLs and Dual Plan Letters. DHCS' readiness review process includes a review of KHS' delegation oversight. MCPs must receive prior approval from DHCS for each delegate.~~

~~Upon notification of admissions to acute care facilities within the provider network and a monthly review of encounter data submitted by network providers who are not enrolled as Medi-Cal providers, KHS staff will reference the DHCS PPC List at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-payment/HospitalAcqCond/icd10_hacs.html to determine if the diagnoses codes or events are reportable as defined by the DHCS.~~

~~Examples of HCAC include:~~

~~Air embolism~~
~~Blood incompatibility~~
~~Catheter-associated urinary tract infection (UTI)~~
~~Falls and trauma that result in fractures, dislocations, intracranial injuries, crushing injuries, burns and electric shock~~
~~Foreign object retained after surgery~~
~~Iatrogenic pneumothorax with venous catheterization (October 1, 2012)~~
~~Manifestations of poor glycemic control~~
~~Diabetic ketoacidosis~~
~~Non-ketotickenotic hyperosmolar coma~~
~~Hypoglycemic coma~~
~~Secondary diabetes with ketoacidosis~~
~~Secondary diabetes with hyperosmolarity~~
~~Stage III and IV pressure ulcers~~
~~Surgical site infection following:~~
~~Mediastinitis following coronary artery bypass graft (CABG)~~
~~Bariatric surgery, including laparoscopic gastric bypass, gastroenterostomy and laparoscopic gastric restrictive surgery~~
~~Orthopedic procedures for spine, neck, shoulder, and elbow~~
~~Cardiac implantable electronic device (CIED) procedures (October 1, 2012)~~

~~Vascular catheter-associated infection~~
~~For non-pediatric/obstetric population, deep vein thrombosis (DVT)/ pulmonary embolism (PE) resulting from:~~
~~Total knee replacement~~
~~Hip replacement~~

2. Notification after discovery of potential Provider Preventable Conditions (PPC)

"Discovery" refers to when a provider first learns that a Medi-Cal patient had a Provider Preventable Condition (PPC) and confirms that the patient is a Medi-Cal beneficiary. The Department of Health Care Services (DHCS) understands that this might be after the patient has been discharged, including discovery during coding and billing. Discovery can occur in 3 locations:~~.~~

- ~~h~~Hospital or LTC facility,
- ~~p~~Provider office, or
- ~~h~~Health plan ~~level~~.

Any PPC events validated by the designated QI clinical staff member will be reported to the QI Supervisor or Manager. The QI Manager or their designee will submit the PPC via DHCS' online reporting portal. A copy of the report submitted in DHCS' online reporting portal will be retained by the QI Department along with a copy of the daily report and investigation summary. KHS' Compliance Department also receives and retains a copy of the DHCS notification and KHS report with investigation summary.

The QI Manager or their designee will notify KHS' Claims Management team at claimsmanagement@khs-net.com along with the Compliance Department at compliance@khs-net.com of any PPC reported to DHCS. The email will include a~~A~~ copy of the original encounter claims report of the PPC with the investigation summary and a copy of the online report submission to DHCS.

If the PPC is identified at the health plan during Utilization Management's (UM) ~~concurrent~~ review of medical records or through any other communications, the KHS UM staff will ~~complete the DHCS Form 7107 and forward to the Compliance department for submission to the DHCS~~submit a Potential Quality Issue (PQI) referral to the Quality Improvement Department and indicate that they have identified a PPC. KHS' QI Department will follow the process for validation of the PPC outlined above and ~~as well as~~ process the PQI referral in accordance with Policy 2.70-I, Potential Quality ~~of Care~~ Issue. ~~will use DHCS' secure online reporting portal to report PPCs to DHCS. Notification of all pending PPC events are forwarded to Finance for reconciliation for claims payment. *See Policy 6.01-P Claims Submission and Reimbursement.*~~

~~KHS is also responsible to ensure that all delegated entities remain compliant with the PPC process outlined in the policy.~~

3. Delegation

KHS is responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and

Policy Letters. KHS will communicate the policy requirements to all delegated entities and subcontractors. KHS will ensure that all their own policies and procedures, as well as the policies, procedures, and practices of any delegates, sub plans, contracted providers, or subcontracted Independent Physician Associations or medical groups, comply with these requirements and those located in any applicable APL.

ATTACHMENTS: None

~~❖ Attachment A – DHCS Form 7107 Provider Preventable Conditions (PPC) Reporting Form~~

REFERENCE:

Policy 6.01-P Claims Submission and Reimbursement
Policy 2.70-I Potential Quality Issue ~~Issue~~
Section 2702 of the Patient Protection and Affordable Care Act (Pub. L. 111-148)
Title 42 CFR.447.26,
Title 42 CFR 438.3(g), 434.6(a)(12)(i), and 447.26,
Welfare and Institutions Code Section 14131.11
Health and Safety Code (H&S Code), Section 1279.1
CMS Pub 100-03 Medicare National Coverage Determinations

Revisions April 2022: Changed policy ownership to the Quality Improvement Department; Policy number changed from 3.69-I to 2.72-I. Added clarifications to the process for reporting PPCs to DHCS' online portal, KHS retention of PPC reporting; verified all regulatory references; added links to DHCS and CMS sites ~~2020 12: Updates to policy by Director of QI upon review of PPC received an in accordance to APL 17-009.~~ **Revision 2018-11:** Updates to policy by Administrative Director of Health Services following internal audit review for APL 17-009**. Revision 2017-11:** Policy revised by Administrative Director of Health Services. **Revision 2015-02:** Policy developed by Utilization Department to comply with DHCS All Plan Letter 13-007.

KERN HEALTH SYSTEMS

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

_____ Date _____
Douglas A. Hayward
Chief Executive Officer

_____ Date _____
Chief Medical Officer

_____ Date _____
Deputy Chief Medical Officer

_____ Date _____
Chief Operating Officer

_____ Date _____
Chief Health Services Officer

_____ Date _____
Chief Network Administration Officer

_____ Date _____
Director of Pharmacy

_____ Date _____
Director of Claims

_____ Date _____
Director of Member Services

_____ Date _____

Director of Quality Improvement

_____ Date _____

Director of Utilization Management

POLICY:

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

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

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

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

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

DEFINITIONS:

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

Formatted: CM10, Justified

Formatted: Not Highlight

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

Formatted: Font:

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

PROCEDURES:

1.0 TYPES OF SERVICES FOR WHICH AUTHORIZATION IS NOT REQUIRED

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

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

Planning Services and Abortion for details and limitations.)

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

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

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

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

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

J. Urgent Care

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

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

1.1 Non-Contracted Providers

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

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

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

2.0 VERBAL AUTHORIZATION

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

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

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

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

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

3.0 HOSPITAL AUTHORIZATION

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

Prior authorization must be obtained for all elective hospital admissions.

4.0 ROUTINE AUTHORIZATION

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

4.1 Request for Authorization

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

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

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

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

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

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

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

4.2 Utilization Review

Utilization review includes the actions outlined in the following table.

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

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

4.2.1 Deferrals

Authorization requests needing additional medical records may be deferred, not denied, until the requested information is obtained. If deferred, the UM Clinical Intake Coordinator UM Clinical Intake Coordinator follows-up with the referring provider within 14 calendar days from the receipt of the request if additional information is not received. Every effort is made at that time to obtain the information. Providers are allowed 14 calendar days to provide additional information[18]. On the 14th calendar day from receipt of the original authorization request, the request is approved or denied as appropriate.

4.2.1.1 Extended Deferral

The time limit may be extended an additional 14 calendar days if the member or the Member's provider requests an extension, or KHS UM Department can provide justification for the need for additional information and how it is in the Member's interest. In cases of extension, the request is approved or denied as

appropriate no later than the 28th calendar day from receipt of the original authorization request.

4.2.2 Modifications

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

The referrals that qualify for a modification are:

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

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

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

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

4.2.3 Denials

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

Reasons for possible denial include:

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

Formatted: Indent: Left: 0.75"

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

4.2.4 Administrative Denials

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

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

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

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

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

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

4.2.5 Denials to Terminally Ill Members

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

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

Formatted: Indent: Left: 1"

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

4.3 Provider and Member Notification

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4.3.1 Urgent Referrals

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

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

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

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

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

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

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

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

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

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

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

supplying that information;

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

4.3.2.1 State Fair Hearings Regarding Terminations or Reductions

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

5.0 Retrospective Authorization Request:

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

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

5.1 Claim Denials for Services Performed without Obtaining Prior Authorization:

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

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

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

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

6.0 STANDING REFERRALS[43]

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

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

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

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

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

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

6.1 Treatment Plan

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

7.0 CRITERIA AND GUIDELINES[45]

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

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

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

C. Up to Date~~DME criteria~~

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

Examples:

a. American Academy of Pediatrics

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

c. American College of Cardiology

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

~~F. Medicare guidelines~~

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

~~H. Up to Date~~

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

~~The criteria are:~~

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

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

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

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

Formatted: Font: Times New Roman, 12 pt

Formatted: Font: Times New Roman, 12 pt

Formatted: Font: Times New Roman, 12 pt

Formatted: Indent: Left: 0"

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

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

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

7.1 Disclosure of Criteria to the Public

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

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

8.0 APPEALS PROCESS

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

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

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

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

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

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

9.0 SPECIALIST SERVICES

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

9.1 PCP Notification

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

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

9.2 Requests for Authorization of Additional Services

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

9.3 Specialty Consultations via Telemedicine

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

10.0 REFERRAL GUIDELINES FOR SPECIFIC TYPES OF CARE

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

10.1 Coordination of Covered Services[48]

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

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

11.0 DOCUMENTATION, TRACKING, AND MONITORING [49]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Formatted

Formatted

Formatted

Formatted

12.0 PCP FOLLOW-UP AND DOCUMENTATION

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

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

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

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

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

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

13.0 REPORTING

Reports are submitted as outlined in the following table.

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

14.0 DELEGATED OVERSIGHT

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

ATTACHMENTS:

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

REFERENCE:

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

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

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

KERN HEALTH SYSTEMS

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

_____ Date _____
Douglas A. Hayward
Chief Executive Officer

_____ Date _____
Chief Medical Officer

_____ Date _____
Deputy Chief Medical Officer

_____ Date _____
Chief Operating Officer

_____ Date _____
Chief Health Services Officer

_____ Date _____
Director of Claims

_____ Date _____
Director of Utilization Management

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

PROCEDURE:

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

Formatted: Left

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

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

Formatted Table

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

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

~~**REFERENCE:**~~

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

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

KERN HEALTH SYSTEMS

HEALTH EDUCATION, CULTURAL & LINGUISTIC SERVICES DEPARTMENT

QUARTERLY REPORT

Q1 2022

Table of Contents

Contents

The purpose of this report is to provide a summary of the quarterly activities and outcomes of this department.

Executive Summary

Report Date: April 5, 2022

OVERVIEW

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

The Executive Summary below highlights the larger efforts currently being implemented by the HE department. Following this summary reflects the statistical measurements for the Health Education department detailing the ongoing activity for Q1 2022.

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

- **Population Needs Assessment –** Data collection efforts and updates have been completed. Final report and action plan are under final review and are due to DHCS by June 30, 2022.

- **Baby Steps Program** The steering committee met in January on the progress of the 2021 activities and activities planned for 2022. Accomplishments in 2021 include adding information on the Baby Steps Program on the KHS website, adding information on the COVID-19 vaccine in the monthly health guide mailings, obtaining provider feedback, and facilitating staff in-services. Data showed women in the Taft, 93308, and American Indian women were least likely to be vaccinated against COVID-19. The COVID-19 Q&A flyer was sent to provider offices, school resource centers, and the Bakersfield American Indian Health Project to help inform this subgroup. Activities planned for 2022 will include changes to the member portal, identifying new targeted populations, implementing the action plan to inform providers about this program, collecting member feedback, and continuation of staff in-services.

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

- **Cultural and Linguistics Program –** The C&L Bilingual Glossary is in the process of being

updated to ensure consistency and to prevent repetitive translation efforts. Translation audits are currently being conducted to verify medical terms that have been added to the Notice of Actions (NOA) letters, grievance letters, and to the Member Handbook. There are currently 162 new medical terms that require a translation and definition. Once completed, this glossary will be disseminated amongst KHS departments who conduct in-house translations.

- **Tobacco & Nicotine Cessation Classes** – Efforts are underway on establishing a partnership agreement with Kick It California to perform outreach and counseling to members identified as users of tobacco and nicotine.

- **School Wellness Grant Program** – KHS launched a new cycle of this grant program in February and is currently reviewing applications. This grant program funds schools to implement school wellness programs that aim to improve the physical, social, emotional, and behavioral health and wellbeing of students.

- **Student Behavioral Health Incentive Program** – DHCS launched this incentive program in January to expand student access to behavioral health services among Medi-Cal beneficiaries. KHS has partnered with Kern County Superintendent of Schools, Kern Behavioral Health and Recovery Services, Health Net and Kaiser to apply for this funding to implement programs within 9 school districts in the county. Partnering school districts represent all regions of the county including special education and alternative education.

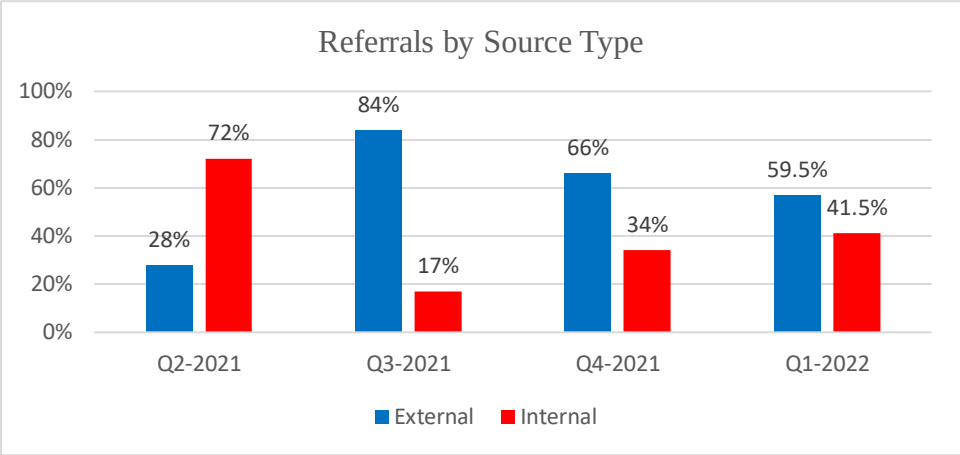
Respectfully submitted,

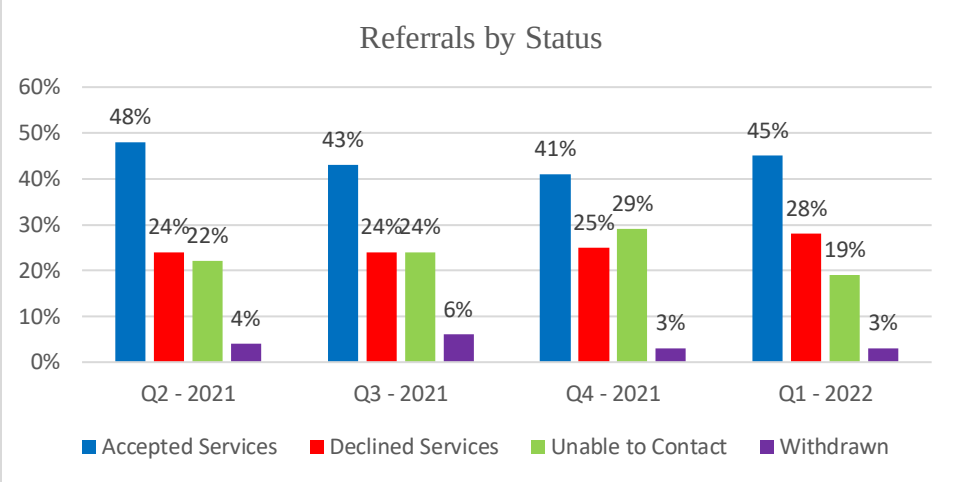
Isabel Silva, MPH, CHES
Director of Health Education, Cultural and Linguistic Services

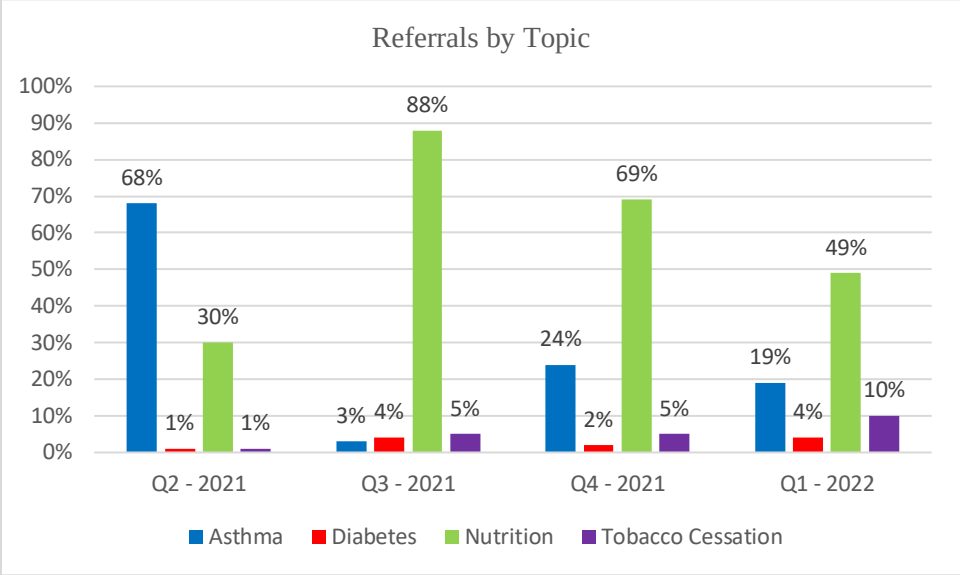
Health Education Services

Referrals for Health Education Services

Kern Health Systems (KHS) Health Education Department (HE) receives referrals from both internal and external sources. Internal referrals are received from KHS' member facing departments such as Utilization Management, Member Services and Case Management. Externally, KHS providers, members and community partners can request health education services by calling KHS or submitting requests through the member or provider portals. During Q1 2022, there were 1213 referrals for health education services which is a 45% increase in comparison to the previous quarter. Requests for Nutrition Education continues to be the primary reason for health education services. Additionally, the rate of members who accepted to receive health education services decreased from 41% in Q4 2021 to 39% in Q1 2022.

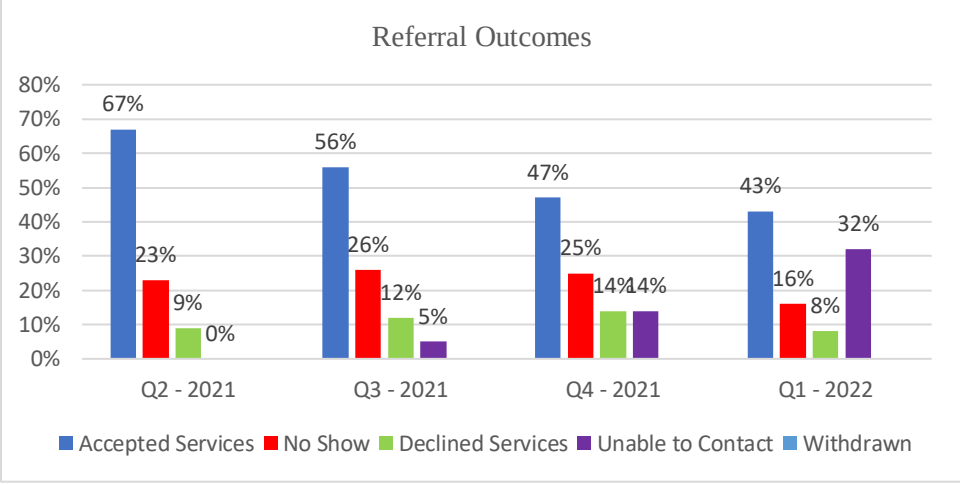






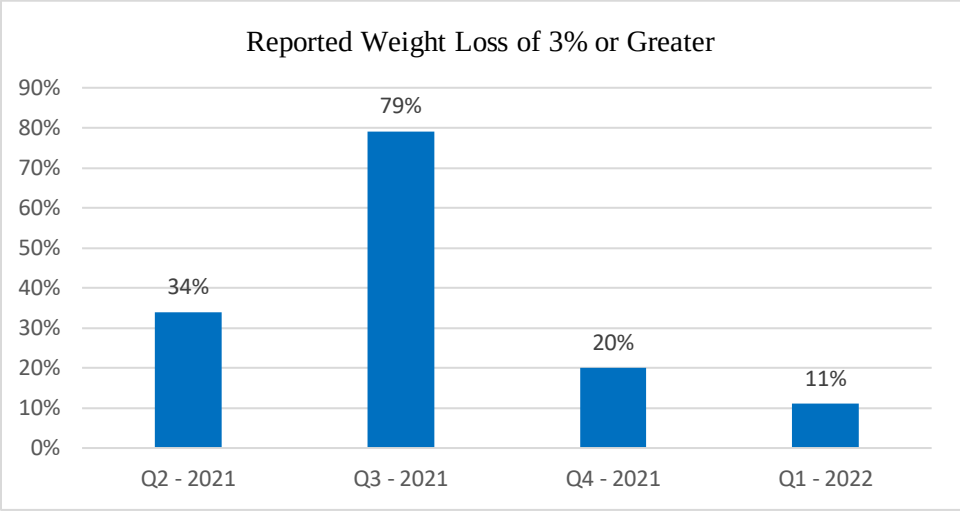
Health Education Referral Outcomes

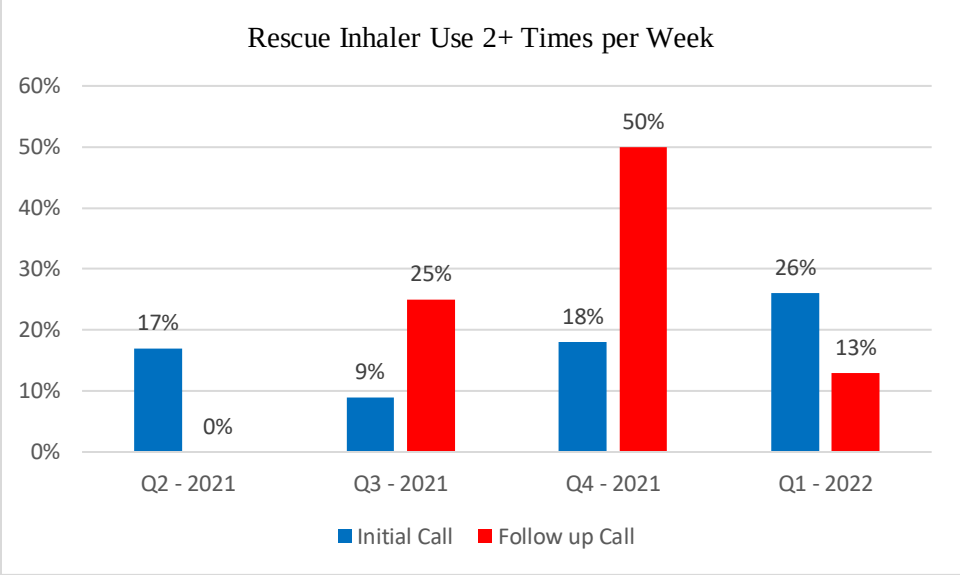
KHS offers various types of services directly through the KHS HE department or through community partnerships. Services through KHS continues to be the largest share of referral outcomes at 97% for Q1 2022. The rate of members who received health education services decreased from 47% in Q4 2021 to 43% in Q1 2022. The rate of members who do not show for services average less than a quarter of registrants.

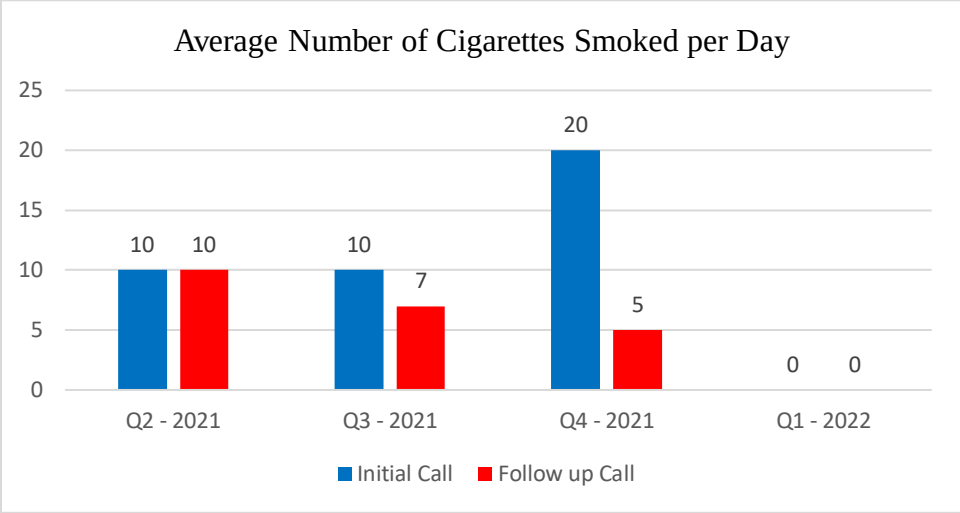


Effectiveness of Health Education Services

To evaluate the effectiveness of the health education services provided to members, a 3-month follow up call is conducted on members who received services during the prior quarter. Of the members who participated in the 3-month follow up call, 45 received Nutrition Education, 0 received Tobacco Cessation and 2 received Asthma Education. All findings are based on self-reported data from the members.

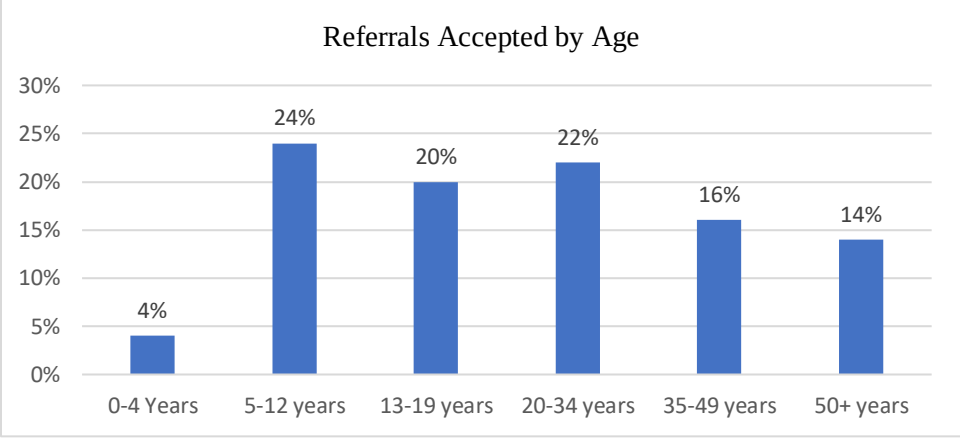


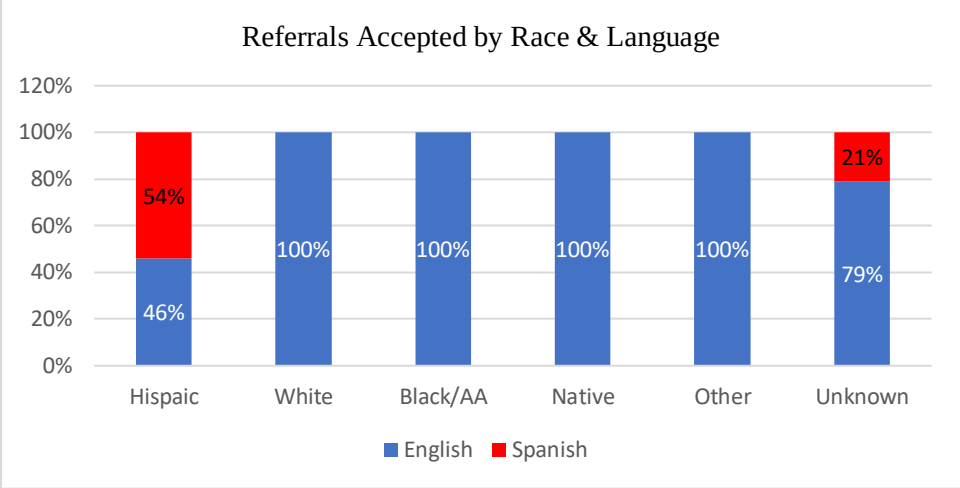




Demographics of Members

KHS provides services to a culturally and linguistically diverse member population in Kern County. KHS' language threshold is English and Spanish, and all services and materials are available in these languages. When non-threshold language requests are received, KHS utilizes professional interpreters to reduce language communication barriers among members. Out of the members who accepted health education services, the largest age groups were 5-12 years followed by 20-34 years. A breakdown of member classifications by race and language preferences revealed that many members who accepted services are Hispanic and preferred to receive services in Spanish. During this quarter, 76% of the members who accepted services reside in Bakersfield with the highest concentration in the 93306 area. Additionally, 24% of the members who accepted services reside in the outlying areas of Kern County with the highest concentration in Lamont.





Referrals Accepted by Top Bakersfield Zip Codes			
Q2-2021	**Q3-2021**	**Q4-2021**	**Q1-2022**
93307	93307	93307	93306
93306	93306	93304	93307
93304	93304	93305	93304
Lamont	Lamont	Lamont	Lamont
Delano	Arvin	Arvin	Arvin
Arvin	Delano	Delano	Wasco

Health Education Mailings

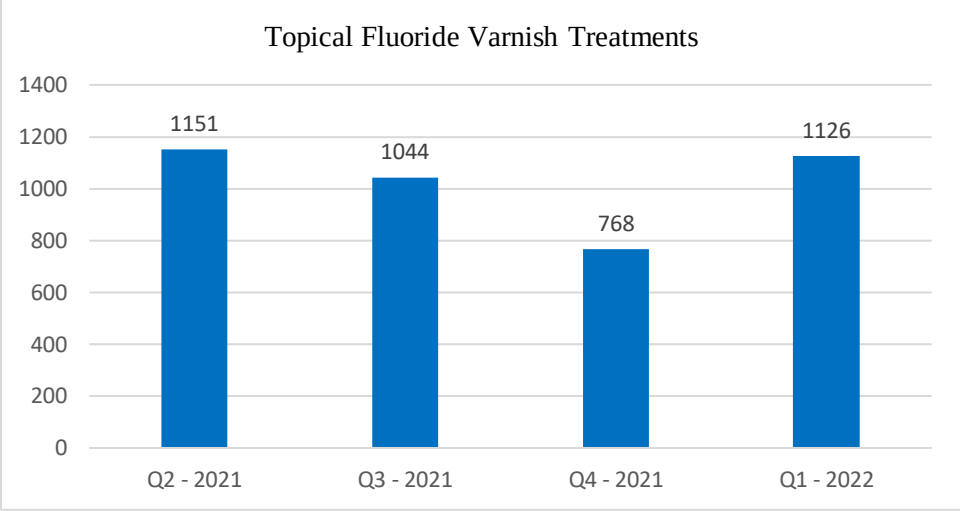
The HE department mails out a variety of educational material to assist members with gaining knowledge on their specific diagnosis or health concern. During this quarter, the HE department continued to place most educational mailings on hold due to COVID-19 limitations except for the prenatal and postpartum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

Educational Mailings

	Q2-2021	Q3-2021	Q4-2021	Q1-2022
Activity and Eating: Small Steps to a Healthier You	1	2	3	1
Control High Cholesterol	2	8	0	0
Diabetes Management	3	7	2	1
Eat Healthy	3	11	3	3
Exercise	2	11	4	3
Prenatal Health Guide	968	639	540	575
Postpartum Health Guide	1017	1151	1162	1083
Tobacco	0	0	0	9493
Total	**1996**	**1829**	**1714**	**11,159**

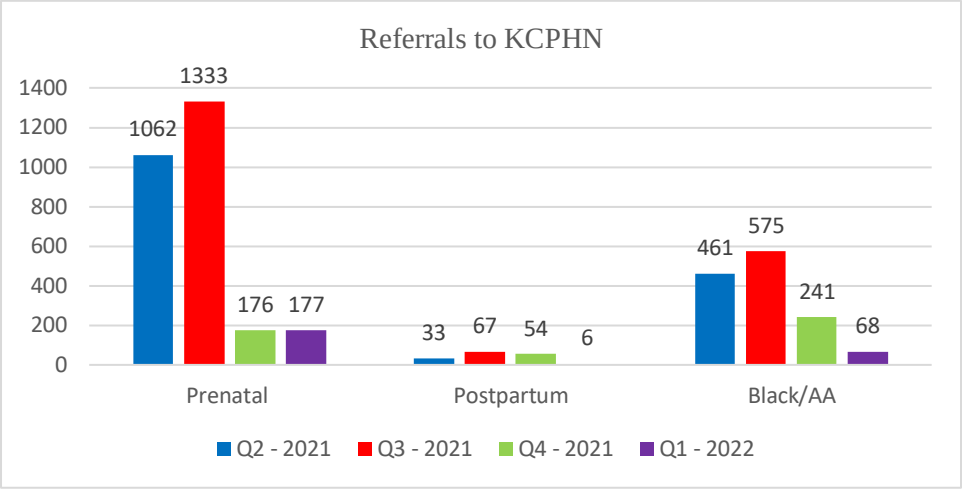
Topical Fluoride Varnish Treatments

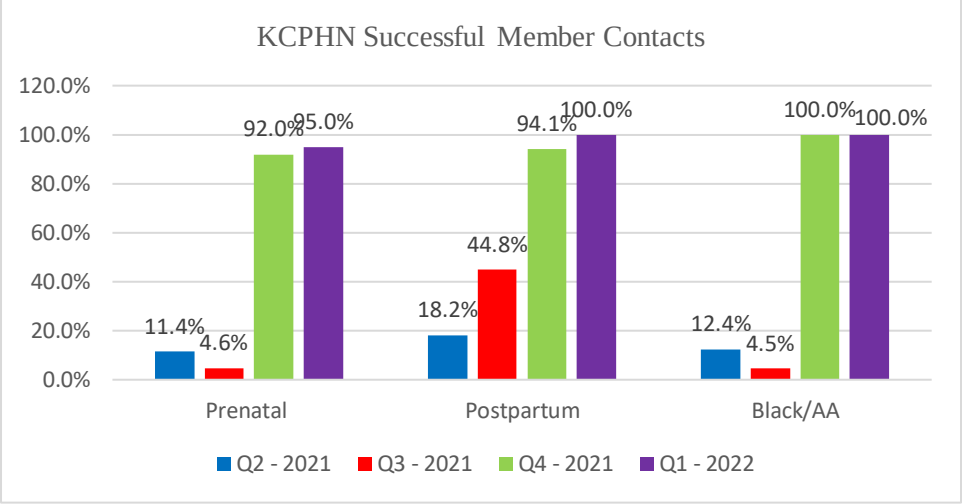
Fluoride varnish treatments are effective in preventing tooth decay and more practical and safer to use with young children. KHS covers up to three topical fluoride varnish treatments in a 12-month period for all members younger than 6 years.



Perinatal Outreach and Education

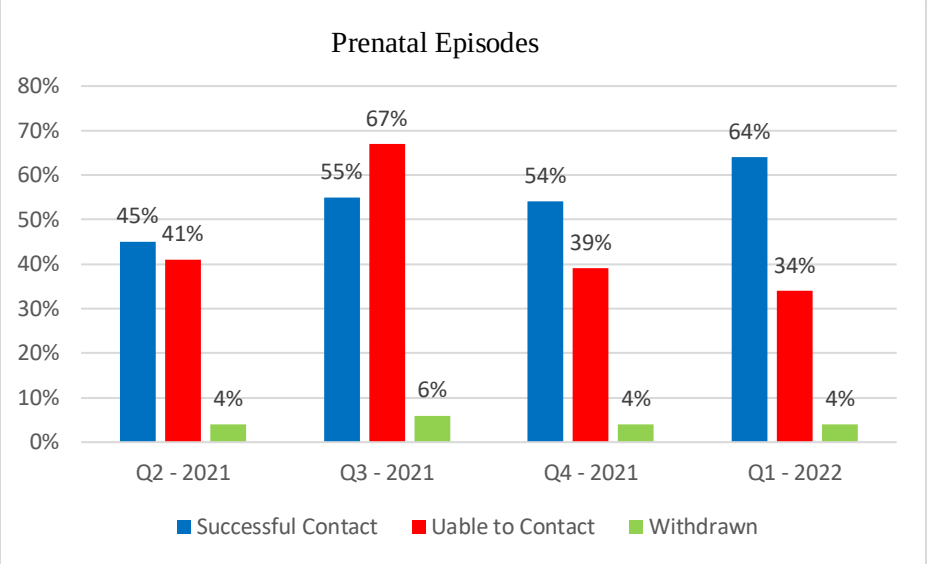
KHS partners with the Kern County Public Health Nursing (KCPHN) division to perform outreach to members residing in the 93308 and 93305 zip codes along with pregnant Black/African American members to encourage timely prenatal and postpartum care. Members who are successfully reached are educated on the importance of timely care and offered enrollment into the KCPHN pregnancy programs such as Black Infant Health. During Q1 2022, KHS referred 251 pregnant and postpartum members to KCPHN. Although KCPHN had limited resources to perform outreach due to COVID-19, they referred 3 members to the Nurse Family Partnership Program (NFP), 1 member to the Pregnancy Outreach Program (POP), 11 members to Black Infant Health (BIH) and 0 to the Unplanned Pregnancy Prevention Program (UPPP).

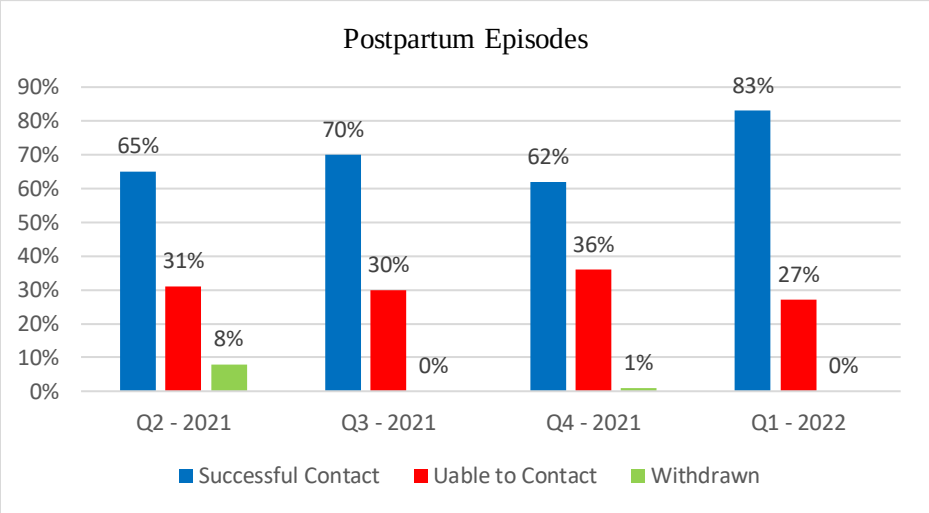


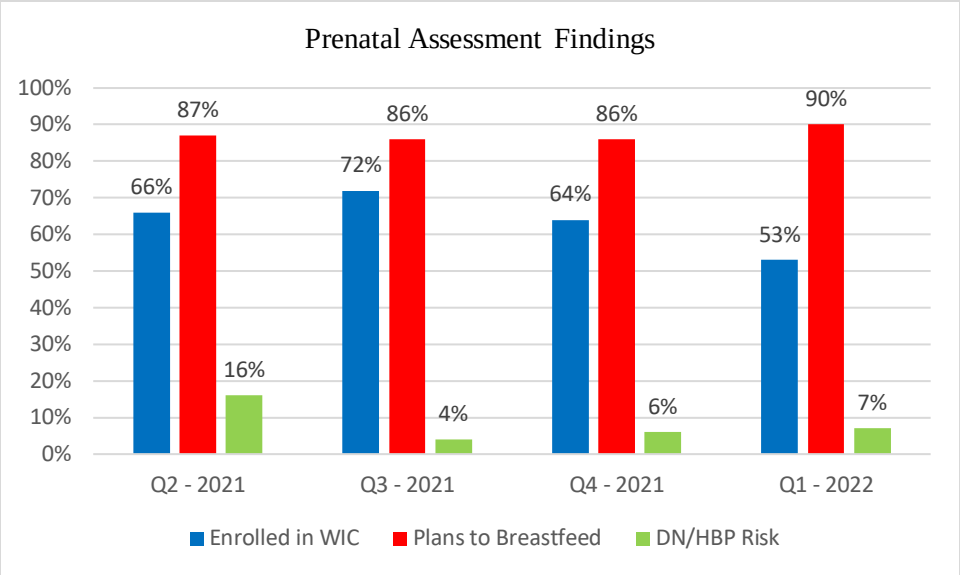


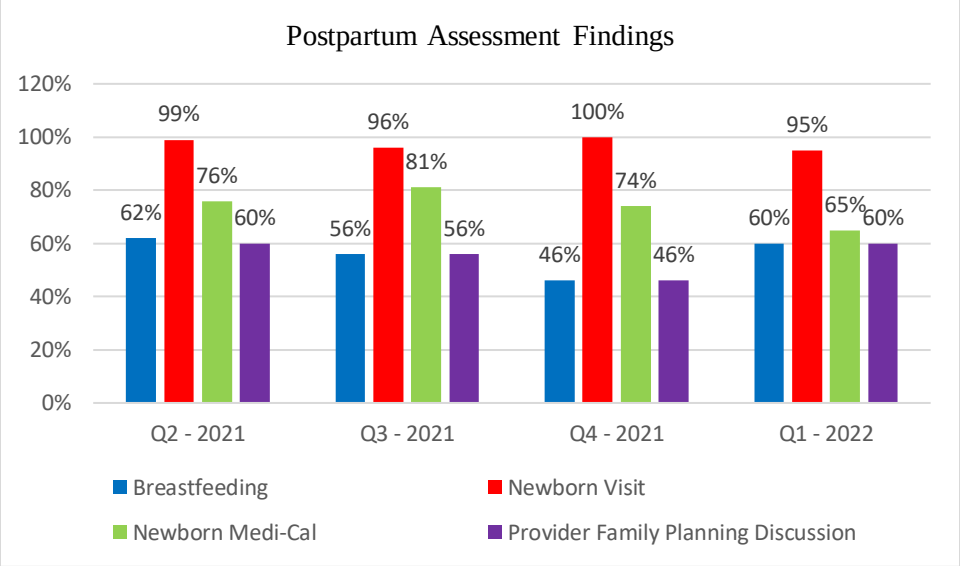
The HE department performs outreach education calls to members with a positive pregnancy test claim, pregnant teens (under age 18), and postpartum members with a Cesarean delivery or

teen pregnancy delivery. During the Q1 2022, 612 episodes for pregnant members were completed and the rate of successful contacts increased from 54% to 64%. For postpartum members, 442 episodes were completed, and the rate of successful contacts increased from 62% to 73%. Prenatal assessment findings revealed a 29% increase in members identified with diabetes or high blood pressure or were at-risk for diabetes or high blood pressure during pregnancy. Postpartum assessment findings revealed a 128.6% increase in members reporting that they had already discussed their family planning and birth control options with their provider.






Prenatal Assessment Findings
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
66%
87%
16%
72%
86%
4%
64%
86%
6%
53%
90%
7%
Q2 - 2021
Q3 - 2021
Q4 - 2021
Q1 - 2022
Enrolled in WIC
Plans to Breastfeed
DN/HBP Risk


Postpartum Assessment Findings
120%
100%
80%
60%
40%
20%
0%
62%
99%
76%
60%
56%
96%
81%
56%
46%
100%
74%
46%
60%
95%
65%
60%
Q2 - 2021
Q3 - 2021
Q4 - 2021
Q1 - 2022
Breastfeeding
Newborn Visit
Newborn Medi-Cal
Provider Family Planning Discussion

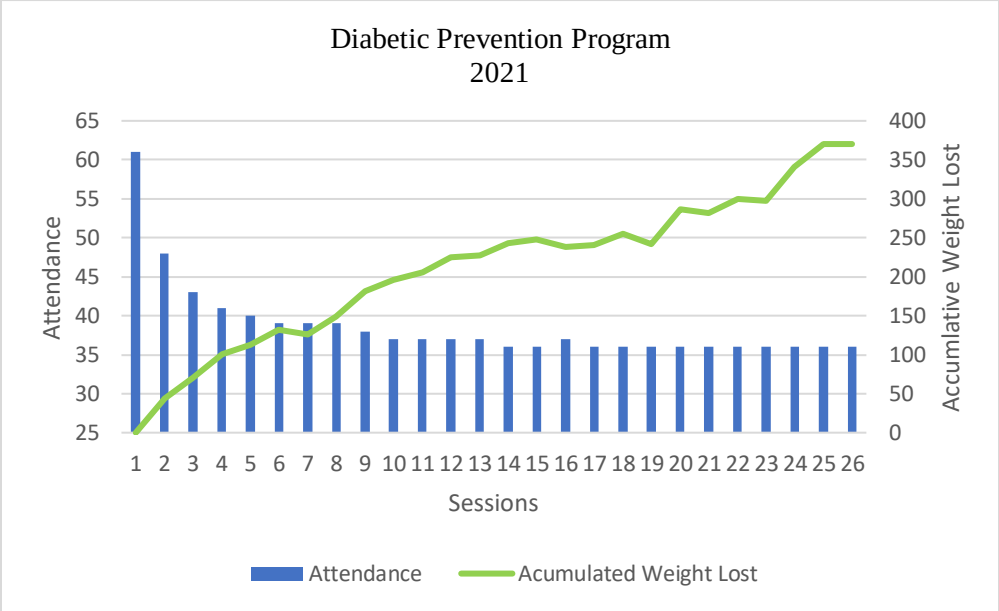
Health & Wellness Programs

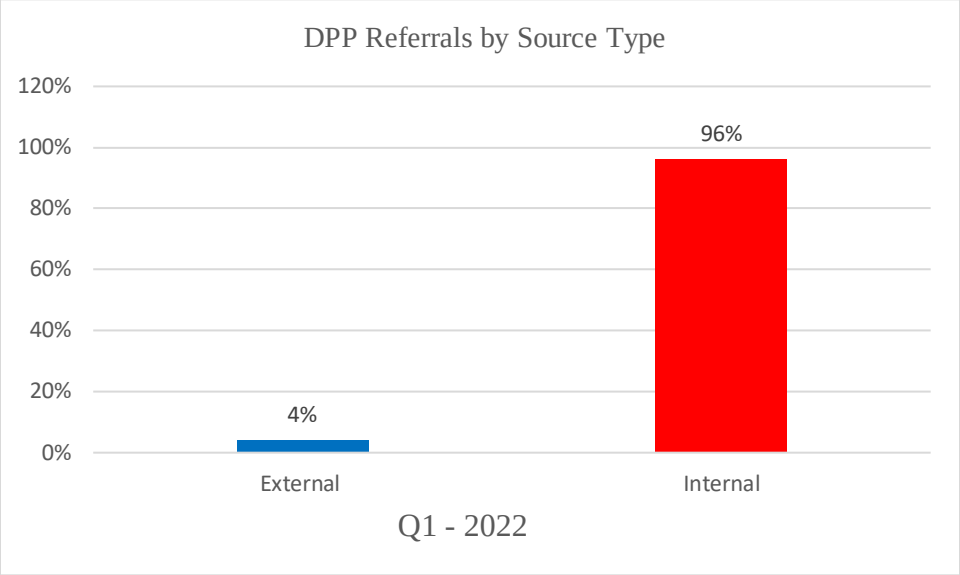
Diabetic Prevention Program

The Diabetic Prevention Program (DPP) is an evidence-based lifestyle change program, taught by peer coaches, designed to prevent, or delay the onset of type 2 diabetes among individuals diagnosed with pre-diabetes who meet the requirements for age, BMI, and prediabetes/risk determination. The participant cannot be pregnant or diagnosed with type 1 or type 2 diabetes at the time of enrollment.

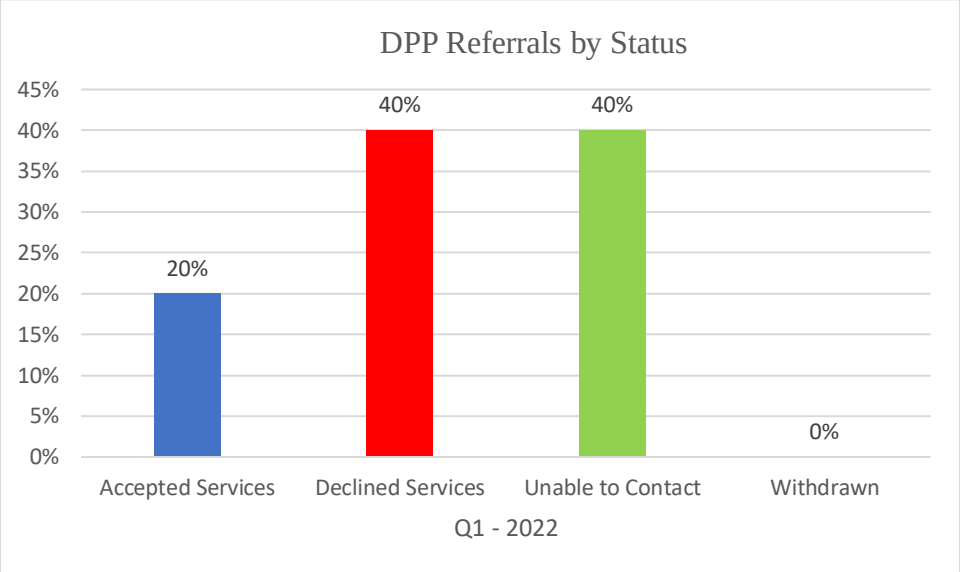
The translated adaptation of the DPP lifestyle intervention is a yearlong structured program consisting of an initial 6-month phase. Within those six months there are 16 weekly classes for the first four months and two classes a week for the next eight weeks. For the last six months one class is offered each month with one additional session offered for support, if individually necessary, for each of the last six months. Each session is facilitated by a trained Lifestyle Coach and offers a CDC-approved curriculum. There are regular opportunities for participants to interact with the Lifestyle Coaches. Each session focuses on behavior modification, managing stress and social support.

January was the conclusion of the 2021 class. There was a graduating class of 36 members. A goal of 5% of weight loss is established at the beginning of the sessions. This year long class had lost a total of 4.79% of total body weight.





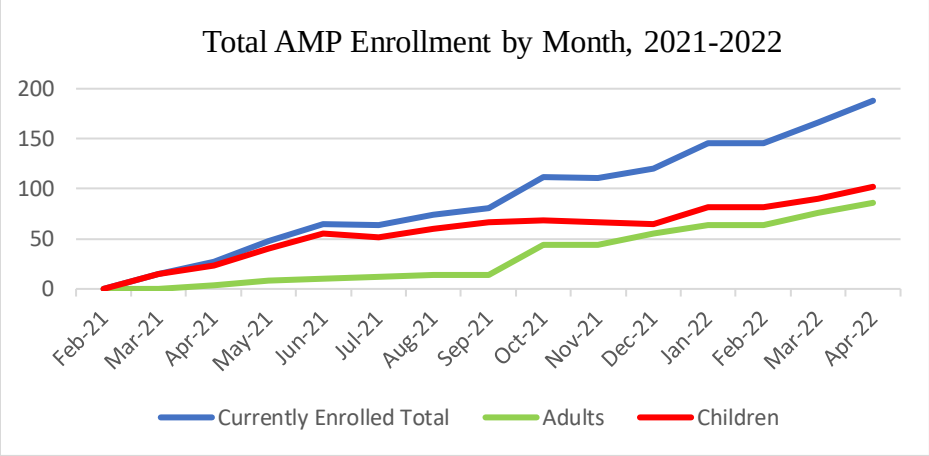
Below is a graph of DPP referrals by Status. During the first quarter, the episodes in JIVA were closed for those members who declined services or whom we were unable to contact. There are episodes open for members who have accepted services and are still in the process of receiving these services.



Asthma Mitigation Project

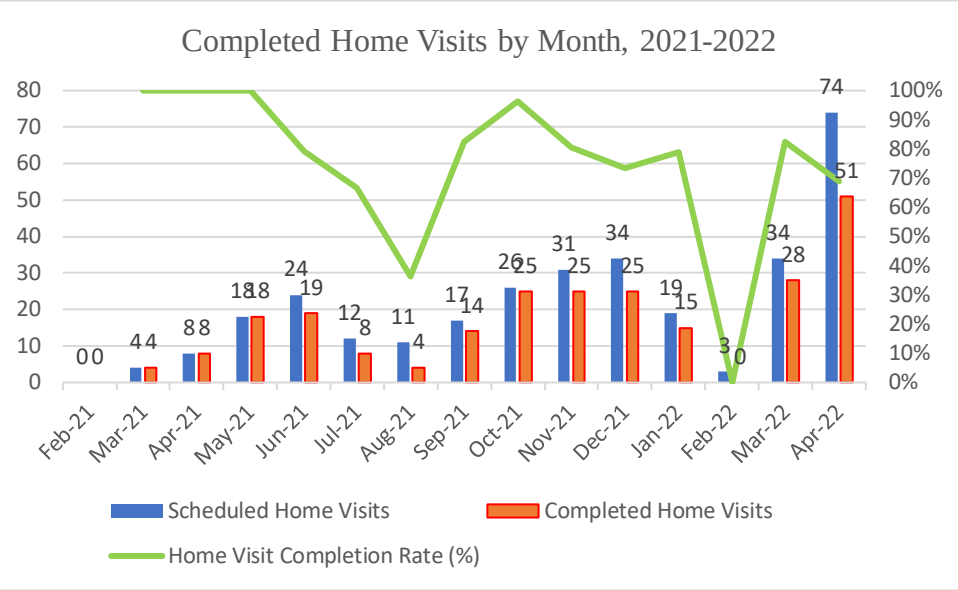
The HE Department has partnered with Central California Asthma Collaborative (CCAC) to offer an asthma home visiting program to members with recent signs of high-risk asthma, such as hospital visits due to asthma emergencies, frequent rescue inhaler use, or frequent asthma symptoms. This program is funded by the Asthma Mitigation Project (AMP), a statewide grant program. The goals of this program are to improve member asthma management and control, decrease exposure to common household asthma triggers, improve asthma outcomes and quality of life, and decrease asthma related costs (especially due to asthma emergencies). Enrollment for each member lasts for at least 12 months.

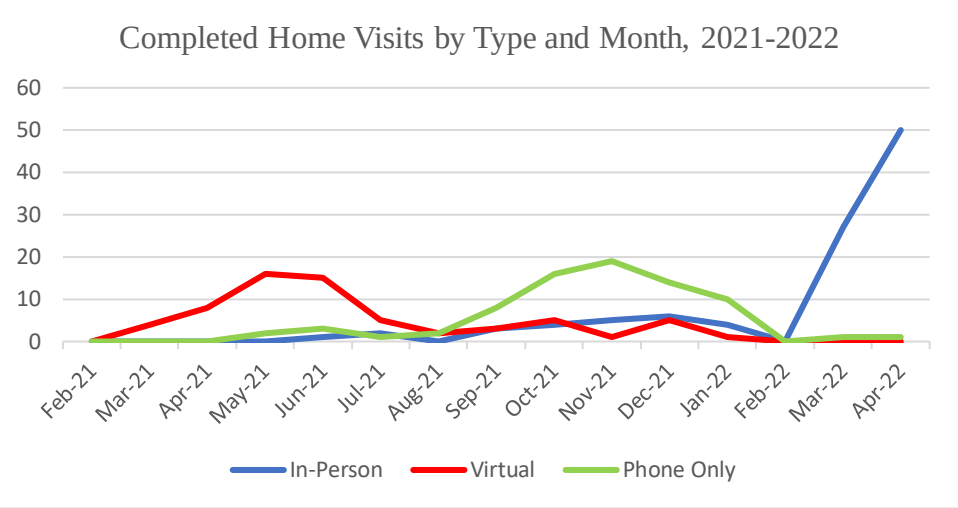
Member outreach for AMP began in February 2021. Program enrollment began in March 2021. The program enrollment goal is 200 by the end of May 2022. This goal is expected to be met at the current pace of enrollment. Enrollment has gradually increased. It is now at 188. So far, 11 members have completed the program.



AMP includes 3 home visits that occur during the initial, 6th, and 12th months of program enrollment. Home visits include a home environmental assessment of asthma triggers and education on asthma and trigger management. Health workers also work with members to develop and implement asthma remediation plans, which may include low-cost products and supplies that reduce exposure to triggers in the home.

Follow up calls occur at the 1st, 2nd, 3rd, and 9th months of the program. They include asthma control assessments and referrals to any needed asthma or community resources. CCAC refers members to Kern County 211 or Community Action Partnership of Kern programs for community resources.


Completed Home Visits by Month, 2021-2022
80
70
60
50
40
30
20
10
0
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
0 0
4 4
8 8
18 18
24 19
12 8
11 4
17 14
26 25
31 25
34 25
19 15
3 0
34 28
74 51
Feb-21
Mar-21
Apr-21
May-21
Jun-21
Jul-21
Aug-21
Sep-21
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
Apr-22
Scheduled Home Visits
Completed Home Visits
Home Visit Completion Rate (%)


Completed Home Visits by Type and Month, 2021-2022
60
50
40
30
20
10
0
Feb-21
Mar-21
Apr-21
May-21
Jun-21
Jul-21
Aug-21
Sep-21
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
Apr-22
In-Person
Virtual
Phone Only

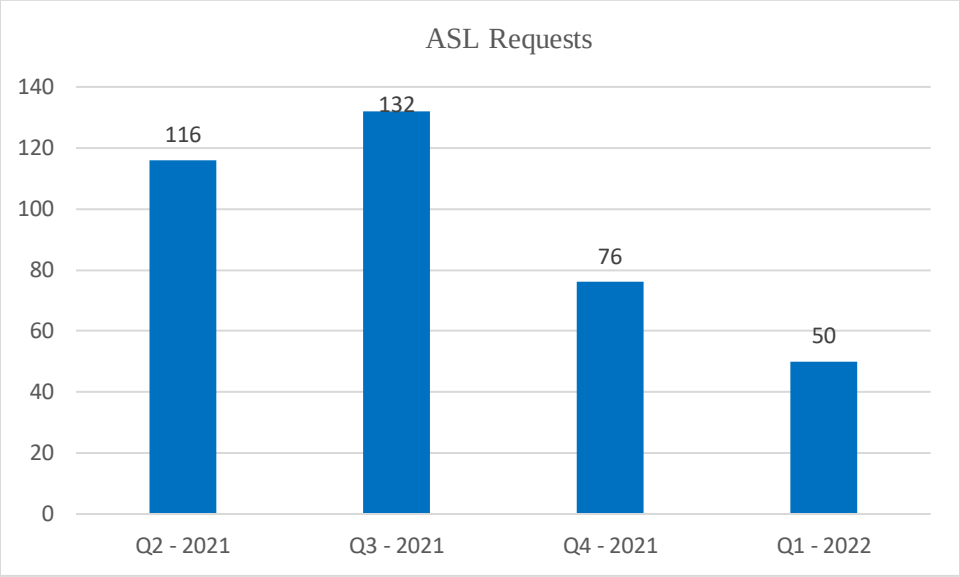
Cultural & Linguistic Services

Interpreter Requests

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

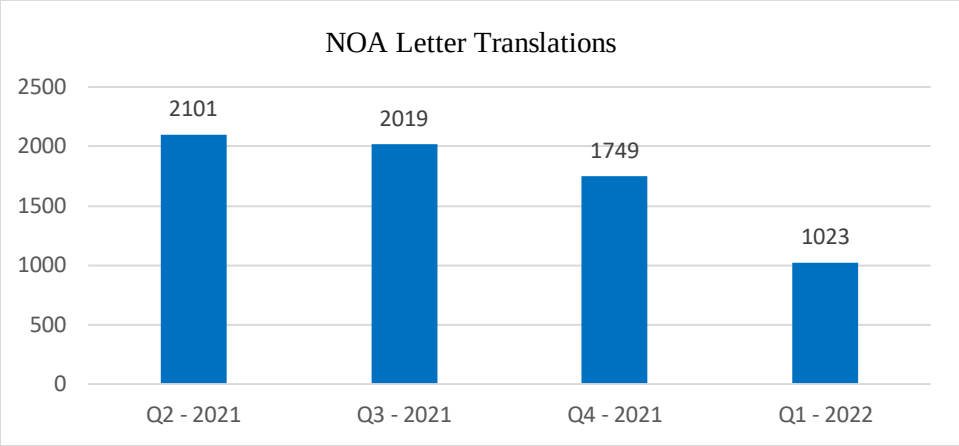
Top Face-to-Face Interpreting Languages Requested			
Q2-2021	**Q3-2021**	**Q4-2021**	**Q1-2022**
Spanish	Spanish	Spanish	Spanish
Vietnamese	Mandarin	Punjabi	Punjabi
Cantonese	Panjabi	Cantonese	Farsi

Top Telephonic Interpreting Languages Requested			
Q2-2021	**Q3-2021**	**Q4-2021**	**Q1-2022**
Spanish	Spanish	Spanish	Spanish
Punjabi	Punjabi	Punjabi	Punjabi
Arabic	Arabic	Arabic	Arabic



Written Translations

The HE department coordinates the translation of written documents for members. Translations are performed in-house by qualified translators or outsourced through a contracted translation vendor. During this quarter, 1023 requests for written translations were received of which 94% were Notice of Action letters translated in- house into Spanish for the UM and Pharmacy departments.



Interpreter Access Survey Calls