KERN HEALTH SYSTEMS

REGULAR MEETING OF THE QI/UM COMMITTEE

Thursday, May 27th, 2021
At
7:00 A.M.

At
2900 Buck Owens Boulevard
4th Floor Kern River Room
Bakersfield, CA 93308
(Virtual Meeting)

The public is invited

For more information, call (661) 664-5000

Agenda

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, May 27th, 2021

7:00 A.M.

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

COMMITTEE MEMBERS: Jennifer Ansolabehere, PHN; Satya Arya, MD; Danielle C Colayco, PharmD; MS; Allen Kennedy; Philipp Melendez, MD; Chan Park, MD; Maridette Schloe; MS, LSSBB; 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

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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 25th, 2021 – APPROVE

7) Physician's Advisory Committee (PAC) Summary of Proceedings 1st Quarter 2021– RECEIVE AND FILE
   - February 2021
   - March 2021

CA-8) Public Policy and Community Advisory Summary of Proceedings 1st Quarter 2021- RECEIVE AND FILE
   - March 2021

CA-9) Pharmacy & Therapeutics Committee Summary of Proceedings 1st Quarter 2021- RECEIVE AND FILE
   - February 2020
   - May 2020
   - September 2020
   - November 2020

Pharmacy Reports

CA-10) Pharmacy TAR Log Statistics 1st Quarter 2021 – RECEIVE AND FILE
   - Executive Summary

Quality Improvement Department Summary Reports

11) Quality Improvement Department Summary Reports 1st Quarter 2021 – APPROVE
   - Executive Summary
   - COVID-19 Updates
   - Potential Inappropriate Care (PIC) Notifications
   - Facility Site Reviews (FSRs)
   - Quality Improvement Projects
   - MCAS Committee
   - Policy and Procedure and other program documents

Kaiser Reports

CA-12) Kaiser Reports **(PROPRIETARY AND CONFIDENTIAL)**
   - KFHC APL Grievance Report-1st Quarter 2021 – RECEIVE AND FILE
   - KFHC Volumes Report 1st Quarter 2021 – RECEIVE AND FILE
   - Kaiser Reports will be available upon Request

VSP Reports

13) VSP Reports
- VSP DER Effectiveness Report – APPROVE
- VSP- Medical Data Summary- APPROVE
- VSP Monthly Call Response Summary- APPROVE

Member Services

14) Grievance Operational Board Update – APPROVE
- Executive Summary
- 1st Quarter 2021

15) Grievance Summary Reports – APPROVE
- Executive Summary
- 1st Quarter 2021

Provider Relations

16) Re-credentialing Report 1st Quarter 2021 – APPROVE

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

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

CA-19) Provider Relations Network Review Report 1st Quarter 2021 – RECEIVE AND FILE
- Executive Summary

Disease Management

20) Disease Management 1st Quarter 2021 Report – APPROVE
- Executive Summary

Policies and Procedures

CA-21) QI/UM Policies and Procedures- APPROVE
- 3.22- P Referral and Authorization Process
- 3.31-P Emergency Services
- 3.43- P Hospice Services
- 10.01-I Clinical and Public Advisory Committee

Health Education Report

CA-22) Health Education will report in next meeting for 1st Quarter

UM_CM Department Reports

23) Combined UM_CM Reporting 1st Quarter 2021– APPROVE
- Executive Summary

ADJOURN MEETING TO THURSDAY, JULY 29TH , 2021

AMERICANS WITH DISABILITIES ACT
(Government Code Section 54953.2)

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APPENDIX

1. QI_UM Committee Meeting Cover Sheet- Page 1
2. QI_UM Agenda May 27th. 2021- 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 & Therapeutics Committee Summary of Proceedings- Pages 21-34
7. Pharmacy TAR Log Statistics Reports- Pages 35-36
8. Quality Improvement Department Summary Reports- Pages 37-57
9. Kaiser Reports- Page 58
10. VSP Reports- Pages-59-62
11. Member Services Reports - Pages 63-71
12. Provider Relations Reports- Pages 72-170
13. Disease Management Reports- Pages 171-175
14. QI/UM Policies and Procedures- Pages 176-230
15. Health Education- 231
16. Combined UM Report- Pages 232-259

SUMMARY OF PROCEEDINGS

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

Kern Health Systems
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Members Present: Jennifer Ansolabehere, PHN; Satya Arya, MD; Danielle C Colayco, PharmD; MS; Allen Kennedy; Philipp Melendez, MD; Chan Park, MD; Martha Tasinga; MD, CMO

Members Absent: Maridette Schloe; MS, LSSBB

Meeting was 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 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.

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NO ONE HEARD.

COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

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 –

- **Delay in Cal-AIM MCAL RX carve out program - no pending date**
- **Major Organ Transplants under KHS benefits effective 1/1/2022**

CA-6) QI/UM Committee Summary of Proceedings November 12th, 2020 – APPROVED
Park-Arya: All Ayes

7) Physician's Advisory Committee (PAC) Summary of Proceedings 4th Quarter 2020– RECEIVED AND FILED - **Park-Arya: All Ayes**
- October 2020
- November 2020
- December 2020

Pharmacy Reports - Park-Allen: All Ayes
CA-8) Pharmacy TAR Log Statistics 4th Quarter 2020 – RECEIVED AND FILED

Quality Improvement Department Summary Reports - Park-Allen: All Ayes
9) Quality Improvement Department Summary Reports 4th Quarter 2020 – APPROVED

- DHCS Child and Adult Immunization QI Postcard
- Potential Quality Issue (PQI) Notifications
- Facility Site Reviews (FSRs)
    a. Initial Full Site Reviews
    b. Periodic Full Site Reviews
    c. Focus Reviews
        1. Critical Elements Monitoring
        2. IHEBA Monitoring
        3. IHA Monitoring
- Quality Improvement Projects
    a. Performance Improvement Projects (PIPs)
    b. Improvement Projects (IPs)
- MCAS Accountability Set (MCAS) Updates

Jane Daughenbaugh, Director of Quality Improvement, went over the following for the committee:

- **4th Quarter QI reports were reviewed with the committee**
- **KHS QI Department is continuing to complete site and medical record reviews virtually while the PHE for the pandemic continues**
- **Reviewed the volume of PICs by age group and ethnicity.**
    - **The bulk of PICs are for members ages 22 – 55 year followed by those 55 years and older**
    - **The Hispanic community has the highest percentage of PICs followed by Caucasians. Committee member, Ms. Danielle Colayco, PharmD, asked if the data differentiated between race and ethnicity. Ms. Daughenbaugh will follow up and provide an update at the next committee meeting**
- **Two new PIPs were initiated in the 4th quarter and accepted by DHCS/HSAG**
- **An overview of the SWOT Analysis and Action Plan project was provided to the Committee which focuses on development of an infrastructure to improve MCAS measures compliance. This project was initiated in the 4th quarter of 2020 and is anticipated to span a 2-year time frame.**
- **Review of the most current compliance rates for MCAS measures was reviewed with the Committee. Discussion occurred regarding the impact of the pandemic on preventive health services in 2020 and KHS' efforts to encourage and support members to return to receiving those services when it is safe to begin returning to their provider's office.**

Kaiser Reports
CA-10) Kaiser Reports **(PROPRIETARY AND CONFIDENTIAL)**

- KFHC APL Grievance Report-4th Quarter 2020 –RECEIVED AND FILED
- KFHC Volumes Report 4th Quarter 2020 – RECEIVED AND FILED

- Kaiser Reports will be available upon Request

VSP Reports – Melendez-Park: All Ayes

11) VSP Reports
- VSP DER Effectiveness Report – APPROVED
- VSP- Medical Data Summary- APPROVED
- VSP Monthly Call Response Summary- APPROVED

Member Services – Allen-Colayco: All Ayes

12) Grievance Operational Board Update - RECEIVED AND FILED
- 4th Quarter 2020

13) Grievance Summary Reports – RECEIVED AND FILED
- 4th Quarter 2020

Provider Relations - Park-Allen: All Ayes

14) Re-credentialing Report 4th Quarter 2020 – RECEIVED AND FILED

CA-15) Board Approved New Contracts Report – RECEIVED AND FILED

CA-16) Board Approved Providers Report – RECEIVED AND FILED

CA-17) Provider Relations Network Review Report 4th Quarter 2020 – RECEIVED AND FILED

Disease Management – Park-Allen: All Ayes

18) Disease Management 4th Quarter 2020 Report – APPROVED

Policies and Procedures - Park-Allen: All Ayes

CA-19 QI/UM Policies and Procedures -
- 2.22-P Facility Site Review- APPROVED
- 3.01-P Excluded Services- APPROVED
- 3.13-P Supplemental Services and Targeted Case Management- APPROVED
- 11.21-I Population Needs Assessment- APPROVED

Health Education Report – Park-Allen: All Ayes

CA-20) Health Education Activity Report 4th Quarter 2020 – APPROVED

UM Department Reports – Park-Allen: All Ayes

21) Combined UM Reporting 4th Quarter 2020 – APPROVED

Meeting adjourned by Dr. Martha Tasinga, M.D., C.M.O. @ 8:40 A.M.
to Thursday, May 27, 2021 at 7:00 A.M.

AMERICANS WITH DISABILITIES ACT
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SUMMARY OF PROCEEDINGS

PHYSICIAN ADVISORY COMMITTEE (VIRTUAL) MEETING

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

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

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COMMITTEE RECONVENED

Members Present: Hasmukh Amin, M.D., Ph.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 7:02 A.M. by Dr. Martha Tasinga, M.D., C.M.O.

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STAFF RECOMMENDATION SHOWN IN CAPS

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COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

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- **Jane Daughenbaugh, Director of Quality Improvement introduced our new Quality Improvement Manager, Nancy Sharif to the committee.**

ADJOURNED TO CLOSED SESSION @ 7:06 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.**

- **QI Potential Inappropriate Care (PIC) Cases:**
  Jane Daughenbaugh informed the members the responses that have been received, will undergo review by the CMO and presented to the March PAC Meeting.

COMMITTEE TO RECONVENED TO OPEN SESSION @ 7:20 A.M.

CA-4) Minutes for KHS Physician Advisory Committee meeting on December 2, 2020 – APPROVED
Amin-Parmar: All Ayes

5) MCG Guideline Updates and Emerging Criteria – **Will be held until March meeting.**

6) Review KHS policy 3.01-P Excluded Services – APPROVED
Parmar-Lascano: All Ayes

MEETING ADJOURNED BY DR. MARTHA TASINGA, M.D., C.M.O. @ 8:18 A.M. TO WEDNESDAY, MARCH 3, 2021 @ 7:00 A.M.

AMERICANS WITH DISABILITIES ACT
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SUMMARY OF PROCEEDINGS

PHYSICIAN ADVISORY COMMITTEE (VIRTUAL) MEETING

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

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

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COMMITTEE RECONVENED

Members Present: Hasmukh Amin, M.D., Ph.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 7:00 A.M. by Dr. Martha Tasinga, M.D., C.M.O.

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- **Announcements**
  Dr. Parmar announced he is doing the COVID vaccination at all his locations.

ADJOURNED TO CLOSED SESSION @ 7:06 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.**

    - Update – Provider Responses to PIC Information Requests

Jane Daughenbaugh provided the following update on non-response to PIC letters.

- **Final letters requesting the information were sent on January 21, 2021 to the 5 providers presented at the December 2020 PAC meeting on the recommendation from the committee. 3 of the 5 providers sent responses to our requests for additional information related to Potential Inappropriate Care referrals.**
    - **These responses are under review by our CMO.**

- **There are two remaining providers who have not responded to the final request letter.**
    - **Although the cases were referred to PAC for lack of response, committee members did acknowledge these events are known complications of these procedures.**
    - **Jake and Jane will confirm letters were addressed appropriately, and providers will be given until next meeting to reply.**

- **PRV000403 Anomalous Practice Trends – Old Business**
  Yolanda informed the committee we need to finalize the results of the review conducted PRV000403 Group, informing them as having adverse practice trends. Dr. Tasinga gave a brief overview of the events that transpired including, most recently, a list of cases sent to Compliance to be shared with the State as requested. Shannon informed the group that she will summarize her meeting with PRV000403 staff so that this item may be closed.

- **Peer Review Minutes of 2/3/21 were accepted as presented.**

COMMITTEE TO RECONVENED TO OPEN SESSION @ 7:26 A.M.

CA-4) Minutes for KHS Physician Advisory Committee meeting on February 3, 2021 – APPROVED
Lascano-Amin: All Ayes

5) Review MCG Emerging Criteria – APPROVED
Patel-Lascano: All Ayes

6) Review VSP Reports – APPROVED
Amin-Patel: All Ayes
- DER Effectiveness Report
- Medical Data Summary
- Monthly Call Response Summary Report

7) Review KHS Policies – APPROVED
Amin-Parmar: All Ayes
- 2.22-P Facility Site Review
- 3.13-P EPSDT Supplemental Services and Targeted Case Management (TCM)
- 3.23-P Provider Appeals Regarding Authorization
- 14.07-I Incentives Guidelines

MEETING ADJOURNED BY DR. MARTHA TASINGA, M.D., C.M.O. @ 7:54 A.M. TO WEDNESDAY, APRIL 7, 2021 @ 7:00 A.M.

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SUMMARY OF PROCEEDINGS

PUBLIC POLICY/COMMUNITY ADVISORY COMMITTEE

KERN HEALTH SYSTEMS
2900 Buck Owens Boulevard
Bakersfield, California 93308

Regular Meeting
Tuesday, March 30, 2021

11:00 A.M.

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COMMITTEE RECONVENED

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

Members Absent: None

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

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CA-3) Minutes for Public Policy/Community Advisory Committee meeting on December 15, 2020
APPROVED

CA-4) Report on March 2021 Medi-Cal Membership Enrollment
RECEIVED AND FILED

CA-5) Report on Health Education for fourth quarter ending December 31, 2020 RECEIVED AND FILED

CA-6) Report on Disease Management for fourth quarter ending December 31, 2020
RECEIVED AND FILED

CA-7) Report on KFHC Grievance Summary for fourth quarter ending December 31, 2020
RECEIVED AND FILED

All Consent Agenda Items Approved (CA-3 through CA-7)
Hefner-Garcia: All Ayes

8) Report on KFHC Grievances for fourth quarter ending December 31, 2020 and 2020 Member Satisfaction Survey
RECEIVED AND FILED
Hernandez Colin-Wood: All Ayes

9) Report on KFHC COVID-19 Vaccine Communication Plan
RECEIVED AND FILED
Wood-Hernandez Colin: All Ayes

- **COVID Communication Plan overview was provided along with latest available updates. The 2nd mailing is now in progress; to members ages 50+ and members ages 16-49 with qualifying health conditions. A 3rd mailing to all member households was planned when all residents ages 16+ became eligible. Robocalls were planned to begin in mid-April. Committee members shared ideas to communicate with members including billboards, utilizing member testimonials in print, sharing Myths vs Facts flyer from Kern County Public Health Services Department, locations for outreach, and partnering with community organizations targeting the hard-to-reach population.**

10) Report on KFHC Spring and Fall 2021 Member Newsletters
RECEIVED AND FILED
Louey-Bravo: All Ayes

- **Bernardo Ochoa gave a presentation to the committee and shared the upcoming topics and layout for the 2021 Spring & Fall newsletters. He also asked the committee to submit their suggestions for new topics, changes/additions to himself or Isabel Silva.**

11) Report on Case Management for fourth quarter ending December 31, 2020
RECEIVED AND FILED
Garcia-Ochoa: All Ayes

MEETING ADJOURNED BY LOUIE ITURRIRIA,
DIRECTOR OF MARKETING AND PUBLIC RELATIONS @ 12:03 P.M.
TO TUESDAY, JUNE 29, 2021 AT 11:00 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 Committee meeting may request assistance at the Kern Health Systems office, 2900 Buck Owens Boulevard, Bakersfield, California 93308 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 PRCEEDINGS

PHARMACY & THERAPEUTICS (P&T) COMMITTEE

KERN HEALTH SYSTEMS
2900 Buck Owens Blvd.
Sierra Conference Room – 1st Floor
Bakersfield, California 93308

Regular Meeting
Tuesday, February 25, 2020
6:30 P.M.

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

COMMITTEE MEMBERS PRESENT: Alison Bell, Pharm. D; Dilbaugh Gehlawat, M.D.; Kimberly Hoffmann, Pharm. D; Jeremiah (Jay) Josen, Pharm. D; Vasanthi Srinivas, M.D.; Martha Tasinga, M.D., C.M.O.; Bruce Wearda, R.Ph., Director of Pharmacy

COMMITTEE MEMBERS ABSENT: Sam Ratnayake, M.D.; Sarabjeet Singh, M.D.; Joseph Tran, Pharm. D

Meeting called to order at 6:32 P.M. by Bruce Wearda, Director of Pharmacy

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!

- **Joe Brooks, from BI – He thanked the committee for adding Stiolto Respimat to the formulary and shared his opinion based on a study that indicated this was more effective than dry powder inhalers.**

- **Tania Gregorian, from Astrazeneca – presented information on Farxiga regarding type 2 diabetes and cardiovascular disease, and wished for it to be added to formulary.**

- **Jay Joson – shared a request from the Kern Antimicrobial Stewardship Consortium. This will be brought to the agenda for the next meeting in May.**

COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

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

CA-3) Minutes for KHS Pharmacy &Therapeutics Committee meeting(s) on November 20, 2019 – APPROVED

Srinivas-Tasinga: All Ayes (for consent items CA-3 through CA-5)

CA-4) Report of Plan Utilization Metrics – RECEIVED AND FILED

CA-5) Education Articles – RECEIVED AND FILED

6) Review policies –
13.01-P Drug Utilization and Non-Formulary Treatment Requests
13.04-I Formulary Process and Drug Utilization - RECEIVED AND FILED
Hoffmann-Srinivas: All Ayes
- **The committee reviewed and discussed the current policies. Particular attention was directed to how TARS are reviewed for medical necessity based on the definitions found on page 20 of the packet.**

7) Executive Order 1 - DISCUSSION
- **Bruce reviewed and shared Governor Newson's executive order 01-19. Committee member Hoffmann had many questions regarding specific details of the program. Bruce shared that the state has various work groups and they are addressing that throughout 2020.**

8) Review miscellaneous formulary (new generics and indications within therapeutic classes) – APPROVED
Hoffmann-Srinivas: All Ayes
Due to new generics available on the market and new indications, the following drugs were modified:
- **Premarin vaginal cream will now require prior authorization as more cost effective estradiol vaginal cream is available.**
- **ICS/LABA Category will consist of only those drugs that have generic alternatives: Advair, Airduo, Symbicort. Breo Ellipta and Dulera will be removed.**
- **Farxiga will be added to the SGLT-2 class in the same fashion as Jardiance. Farxiga has new FDA indications and the cost is similar to that of Jardiance.**

9) Review formulary oncology – APPROVED
Srinvas-Joson: All Ayes
- **As a requirement with our contract with DHCS, all antineoplastic drugs are available drugs to be considered to be covered. Utilization controls may be in place, but no drug is specifically excluded. Therefore, no changes to the printed formulary were suggested, as there is a statement indicating the same.**

10) Review formulary GI – APPROVED
Hoffmann-Joson: All Ayes
- **Discussion of H2, PPI classes was conducted with committee, concern of possible overutilization was addressed. It was decided to make no changes to the formulary but issue educational letters to the provider network.**
- **With new cost effective data, Mesalamine 1.2 grams will be added to the formulary in step therapy fashion, like other mesalamine products.**

11) Review formulary pain management – APPROVED
Hoffmann-Bell: All Ayes

- **The committee reviewed medications for pain and their restrictions, compared it to CDC, support act, and other DHCS guidelines and regulations, and decided no changes are necessary. Three local pain management doctors provided their thoughts via email, agreeing that current formulary is adequate.**

ADJOURN TO CLOSED SESSION

CLOSED SESSION

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

MEETING ADJOURNED AT 8:30 P.M. BY BRUCE WEARDA, DIRECTOR OF PHARMACY TO WEDNESDAY, MAY 27, 2020 @ 6:30 P.M.

AMERICANS WITH DISABILITIES ACT
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SUMMARY OF PROCEEDINGS

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

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

Virtual Meeting
Wednesday, May 27, 2020
6:30 P.M.

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

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

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

Meeting called to order at 6:32 P.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 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

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NO ONE HEARD.

COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

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CA-3) Minutes for KHS Pharmacy &Therapeutics Committee meeting(s) on February 25, 2020 – APPROVED

Srinivas-Joson: All Ayes (for consent items CA-3 through CA-5)

CA-4) Report of Plan Utilization Metrics – RECEIVED AND FILED

CA-5) Education Articles – RECEIVED AND FILED

6) Executive Order 1 – DISCUSSION
- **Bruce reviewed Governor Newsom's executive order. Bruce shared that the state has various work groups throughout 2020. The state also added new drugs to their contact drugs list (CDL).**

7) COVID-19 – DISCUSSION
- **Bruce shared modifications that health plan had implemented in regards to regulatory announcements for COVID-19.**

8) Review formulary Augmentin: pneumonia – APPROVED
Srinivas-Tran: All Ayes
- **Plan modified Augmentin coverage to allow it to clear for the management of community acquired pneumonia (CAP) with co-morbidities that include chronic heart, lung, liver, or renal disease, diabetes mellitus, alcoholism, malignancy, or asplenia.**

9) Review formulary Pulmonology – APPROVED
   - **Pulmonary and related respiratory medications were reviewed. Updates to the FDA monographs of montelukast were discussed and reviewed. No changes were made regarding montelukast. It was also decided after review, that no modifications were necessary to the other respiratory categories.**

ADJOURN TO CLOSED SESSION

CLOSED SESSION

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

COMMITTEE TO RECONVENE TO OPEN SESSION

MEETING ADJOURNED AT 7:05 P.M. BY DR. MARTHA TASINGA, M.D., C.M.O. TO WEDNESDAY, SEPTEMBER 30, 2020 @ 6:30 P.M.

AMERICANS WITH DISABILITIES ACT
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SUMMARY OF PROCEEDINGS

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

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

Virtual Meeting
Wednesday, September 30, 2020
6:30 P.M.

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COMMITTEE MEMBERS PRESENT: Alison Bell, Pharm. D; Dilbaugh Gehlawat, M.D.; Kimberly Hoffmann, Pharm. D; Jeremiah (Jay) Josen, Pharm. D; Sarabjeet Singh, M.D.; Vasanthi Srinivas, M.D.; Martha Tasinga, M.D., C.M.O.; Joseph Tran, Pharm. D; Bruce Wearda, R.Ph., Director of Pharmacy

COMMITTEE MEMBERS ABSENT: Sam Ratnayake, M.D.

Meeting called to order at 6:38 P.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 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 CAP

PUBLIC PRESENTATIONS

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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

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   - **An announcement was made that all committee members need to complete and send their 700 forms to Amy Daniel as soon as possible.**

CA-3) Minutes for KHS Pharmacy &Therapeutics Committee meeting(s) on May 27, 2020 – APPROVED
Srinivas-Bell: All Ayes (for consent items CA-3 through CA-5)

CA-4) Report of Plan Utilization Metrics – RECEIVED AND FILED

CA-5) Education Articles – RECEIVED AND FILED

6) Non-Opioid Topical Preparations – APPROVED (See detail below)

   - **Approve—Voltaren Gel OTC will be added to the formulary for the management of mild pain as an alternative to opioids. The 50 g, 100 g, 150 g, and 350 g preparations were considered. It was determined to allow up to 300g per 30-days.**
     Joson-Srinivas: All Ayes

   - **Discussion: There were concerns about all sizes being available**

OTC, and it was confirmed that they were all available as OTC products. The committee discussed usual, appropriate, and rational quantities to be allowed in accordance to FDA prescribing guidelines, and common prescription patterns. 300 g was decided to be the common allowance, any quantity greater would require prior authorization demonstrating the medical necessity for that amount.

- **Approve – As an alternative to opioid use for mild pain, OTC Lidocaine patches were considered as possible formulary additions. It was decided 30 patches per month of Lidocaine 4% Menthol 1% (Icy Hot) would be allowed. Srinivas-Bell**

- **Discussion: The committee looked into the possibility of cutting the patches. It was determined that they were labeled by the FDA to be cut if necessary.**

7) Review formulary Cardiology – APPROVED
Srinivas-Joson: All Ayes

- **Cardiology drugs and latest guidelines were reviewed for appropriateness. Up to date clinical practice patterns were shared Local cardiologists provided input on recent expanded indications of cardiology labeling of diabetic drugs.**

- **Modify Farxiga and Jardiance (SGLT-2) coverage to incorporate new roll in Cardiology. Evidence of co-existing heart failure will allow the drugs to clear if Rxed by cardiology. Network cardiologists emphasized that cardiologists should initiate therapy with these agents for the new indications. PCPs could continue the regimen.**

8) COVID-19 – DISCUSSION
- **KHS shared with the committee modifications due to APLs published by DHCS, DMHC, and Federal changes. These changes included modifications such as: allowed day supply, fulfillment/utilization of prescription before next refill, delivery, mail, hand sanitizers. The vaccine utilization and comparison to other years was shared. This led to a brief discussion of "Back to Care" activities the plan is engaging in to help members receive preventative care.**

9) Executive Order 1 – DISCUSSION
- **A presentation explaining the Executive Order N-01-19 was reviewed. An overview of what the transition would entail was outlined. A summary of how other departments and activities would be impacted was relayed. The roles and responsibilities of the staff and KHS was**

presented. A more in-depth discussion about the role of the DUR Committee was going to be discussed at the next P&T meeting. The committee currently completes the role of a P&T and DUR committee.

ADJOURN TO CLOSED SESSION

CLOSED SESSION

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

COMMITTEE TO RECONVENE TO OPEN SESSION

MEETING ADJOURNED AT 8:00 P.M. BY DR. MARTHA TASINGA, M.D., C.M.O. TO WEDNESDAY, NOVEMBER 18, 2020 @ 6:30 P.M.

AMERICANS WITH DISABILITIES ACT
(Government Code Section 54953.2)

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SUMMARY OF PROCEEDINGS

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

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

Virtual Meeting
Wednesday, November 18, 2020
6:30 P.M.

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

COMMITTEE MEMBERS PRESENT: Alison Bell, Pharm. D; Dilbaugh Gehlawat, M.D.; Kimberly Hoffmann, Pharm. D; Jeremiah (Jay) Josen, Pharm. D; Sarabjeet Singh, M.D.; Vasanthi Srinivas, M.D.; Martha Tasinga, M.D., C.M.O.; Bruce Wearda, R.Ph., Director of Pharmacy

COMMITTEE MEMBERS ABSENT: Sam Ratnayake, M.D.; Joseph Tran, Pharm. D

Meeting called to order at 6:40 P.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 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

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   - **NO ONE HEARD.**

COMMITTEE MEMBER ANNOUNCEMENTS OR REPORTS

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CA-3) Minutes for KHS Pharmacy &Therapeutics Committee meeting(s) on September 30, 2020 – APPROVED
Gehlawat-Hoffmann: All Ayes (for consent items CA-3 through CA-5)

CA-4) Report of Plan Utilization Metrics – RECEIVED AND FILED

CA-5) Education Articles – RECEIVED AND FILED

6) Executive Order N-01-19: Medi-Cal Rx Update – DISCUSSION

- **KHS updated the committee that the 01/01/20 start date for the Executive order will now be 04/01/20. KHS outlined the new roles and responsibilities under the Executive Order.**

7) DUR (Drug Utilization Review) Committee – DISCUSSION

- **Under the Executive Order, Health Plans are expected to continue the DUR activities, however the P&T functions will no longer apply. This answers a question raised from the committee as to what the responsibilities would be of the DUR committee going forward.**
- **Another question from the committee was raised regarding the Opioid Coalition, and if it would continue. It was confirmed that all Plans will still carry out those duties.**
- **Another question from the committee was raised regarding what other**

assignments would be required for the DUR committee going forward. It was stated that any new assignments will be shared with the committee as DHCS outlines them.

8) CMS DUR Annual Report – DISCUSSION

- **An example of the CMS DUR annual report was shared with the committee. The Health Plans are expected to complete the CMS DUR report after the transition, for those elements that apply.**

ADJOURN TO CLOSED SESSION

CLOSED SESSION

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

COMMITTEE TO RECONVENE TO OPEN SESSION

MEETING ADJOURNED AT 7:28 P.M. BY DR. MARTHA TASINGA, M.D., C.M.O. TO WEDNESDAY, MARCH 24, 2021 @ 6:30 P.M.

AMERICANS WITH DISABILITIES ACT
(Government Code Section 54953.2)

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KERN HEALTH SYSTEMS | PROVIDER bulletin

QI Executive Summary -- Pharmacy Report – Prior Authorizations

Background

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

Action

For Informational Purposes Only

No items of concern identified.

Quarter/Year of Audit	2021	2021	2021	2021	2021	2021	2021	2021	2021	2021	2021	2021
Month Audited	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Total TAR's for the month	3011	2991	3511	3457								
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	95/95	83/83	92/92	101/101								
Date Stamped	95/95	83/83	92/92	101/101								
Fax copy attached	95/95	83/83	92/92	101/101								
Decision marked	95/95	83/83	92/92	101/101								
DENIED TAR'S												
Timeliness - Reviewed & Returned in 1 business day	40/40	45/45	63/63	54/54								
Initally Denied - Signed by Medical Dir and/or Pharm	40/40	45/45	63/63	54/54								
Letter sent within time frame	40/40	45/45	63/63	54/54								
Date Stamped	40/40	45/45	63/63	54/54								
Fax copy attached	40/40	45/45	63/63	54/54								
Decision marked	40/40	45/45	63/63	54/54								
Correct form letter, per current policies used	40/40	45/45	63/63	54/54								
NOA Commentary Met	40/40	45/45	63/63	54/54								
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	3/3	11/11	9/9	4/4								
Date Stamped	3/3	11/11	9/9	4/4								
Fax copy attached	3/3	11/11	9/9	4/4								

Kern Health Systems
Quality Improvement Department
Executive Summary
1st Quarter 2021

This report provides a summary of key activities and issues related to the Quality Improvement (QI) Department during the 1st Quarter of 2021. The full set of reports follows the executive summary.

I. COVID-19 Updates

The pandemic has continued throughout the 1st quarter of 2021 with stay at home and social distancing orders still in place. Kern County has begun to see a decline in new cases and deaths. KHS' media campaign is underway for members to return to care with their primary care doctor. We continue to complete as many virtual site reviews as possible with anticipation that some or all those reviews may be accepted in lieu of the in-person reviews. All virtual medical record reviews completed will be accepted by DHCS.

II. Potential Inappropriate Care (PIC) Notifications

There was a 16% decrease in PIC referrals compared to the previous quarter. We are not seeing any trends and continue to monitor the rate of referrals. We have been monitoring PICs to identify if any are related to the pandemic. For Q1 2021 no PIC or Death notifications were related to COVID-19.

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

Due to the pandemic and social distancing orders, the QI Department has been conducting facility site and medical record reviews virtually. We are not completing interim reviews due to the pandemic and this is in line with what other MCPs are doing. We anticipate returning to in-person reviews this Fall. As a result of not being able to complete all reviews that would have normally been done if there was not a pandemic, the MCPs are working with DHCS on a plan to address those reviews after the public health emergency (PHE) related to the pandemic has ended.

There have been not significant issues or trends outside of those related to the pandemic. We are working with DHCS to get one of our QI RNs certified as a Master Trainer and anticipate that will happen in August.

IV. Quality Improvement Projects

We have 2 Performance Improvement Projects underway. DHCS requires all plans to have at least 2 projects underway. The 2 in process now are:

1. Health Care Disparity in WCV (Well Care Visits ages 3-21) focusing on annual well care visits. Kern Pediatrics has agreed to partner on us with this project. The overarching goal is to increase compliance with the preventive health service by 10% points.
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.

V. MCAS Committee

A new committee was formed during the first quarter of this year called the MCAS Committee. The purpose of the Committee is to provide direction and oversight of KHS' level of compliance with the MCAS measures. Focus is on the following 3 activities currently:

- Strengths, Weaknesses, Opportunities, Threats (SWOT) Strategic Action Plan
- Member Engagement and Rewards Program
- MCAS Annual Audit Progress & Results
- YTD MCAS Measures Compliance

1. *MCAS Member Engagement and Rewards Program*

The MCAS Committee reviewed the results of the first member engagement and rewards program performed in Q4 of 2020 and approved the following measures for the 2nd campaign that will begin in June of this year:

- Well care visits for ages 0 – 21 years
- Timely Prenatal Care
- Timely Postpartum Care
- Timely Initial Health Assessments

It was difficult to accurately assess the results of the first campaign due to the impact of the pandemic. For that reason, we are continuing with the same focus and the Committee will evaluate the results of this campaign in determining changes to future campaigns. The results YTD or our MCAS measures are also a consideration utilized.

2. *MCAS SWOT Action Plan*

This is a two-year project that kicked off last fall working closely with DHCS. The primary goal of this project is to build a sustainable infrastructure for KHS to meet the minimum performance levels for the MCAS measures we are held accountable.

QUALITY IMPROVEMENT DEPARTMENT

QUATERLY QI-UM COMMIITTEE REPORT

Q1 2021

KERN HEALTH SYSTEMS
Quality Improvement Department Quarterly QI-UM Committee Report
Q1 2021

The purpose of this report is to provide a summary of the quarterly activities and outcomes for the QI department. This provides a window into both compliance with regulatory requirements as well as identifying opportunities for improving the quality of care for our members. Areas covered in the report include:

I. COVID-19 Updates
II. Potential Inappropriate Care (PIC) Notifications
III. Site & Medical Record Reviews
    a. Initial Site & Medical Record Reviews
    b. Initial & Periodic Site & Medical Record Reviews
    c. Periodic Full Site Reviews
    d. Interim/ Focus Reviews
    e. Critical Elements
    f. Initial Health Assessments
    g. Follow up Reviews
IV. Quality Improvement Projects
    a. Performance Improvement Projects (PIPs)
V. MCAS Committee
    a. Member Engagement & Rewards Program
    b. MCAS SWOT Action Plan
    c. MCAS Annual Audit Progress
    d. 1st Quarter 2021 MCAS Measures Compliance Rates
VI. Policy and Procedures and other program documents

I. COVID-Update:

The pandemic has continued throughout the 1st quarter of 2021 with stay at home and social distancing orders still in place. Kern County has begun to see a decline in new cases and deaths. KHS' media campaign is underway for members to return to care with their primary care doctor. We continue to complete as many virtual site reviews as possible with anticipation that some or all those reviews may be accepted in lieu of the in-person reviews. All virtual medical record reviews completed will be accepted by DHCS.

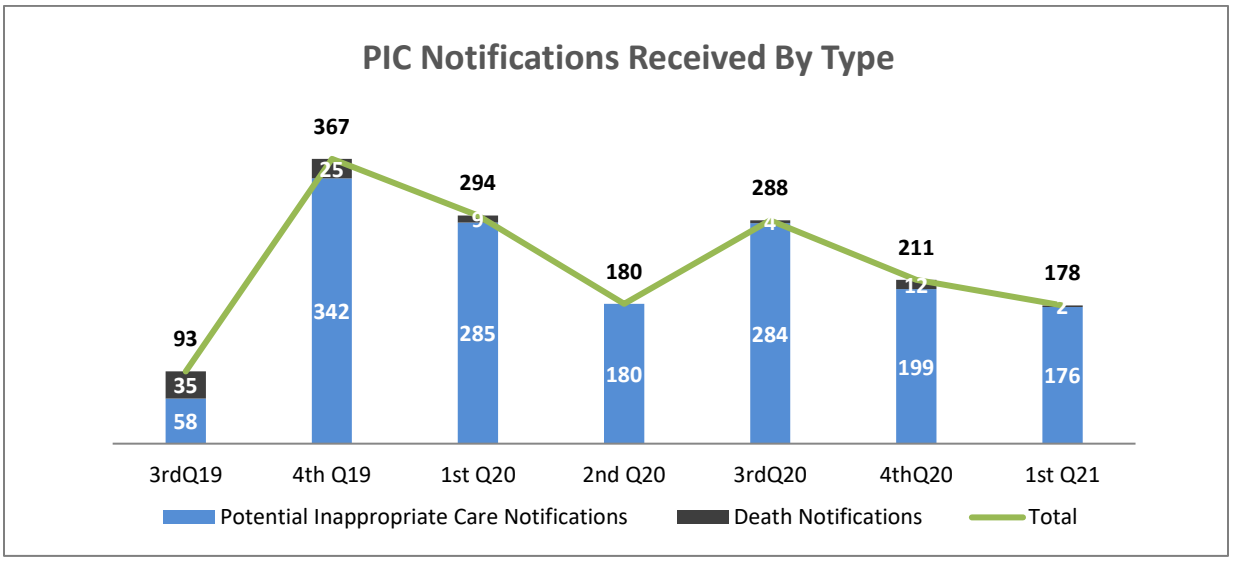
II. Potential Inappropriate Care (PIC) Notifications:

QI receives Notifications from various sources to review for potential inappropriate care issues.

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

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

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



From the above charts, we received a total of 178 notifications for the 1st Quarter of 2021. This is a 16% decrease in the notifications compared to previous quarter. We are not seeing any sustained trends. We will continue to monitor.
The QI Department is monitoring PICs to identify if any are related to the COVID-19 virus and pandemic. For Q1 2021 there were no PIC or Death notifications related to COVID-19.

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

THE DEPARTMENT OF HEALTH CARE SERVICES (DHCS) HAS DELAYED MANAGED CARE PLANS FROM CONDUCTING SITE REVIEWS UNTIL 6 MONTHS AFTER THE COVID-19 EMERGENCY RESPONSE SITUATION HAS ENDED. KHS IS CONDUCTING VIRTUAL SITE AND MEDICAL RECORD REVIEWS DURING THE PANDEMIC.

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

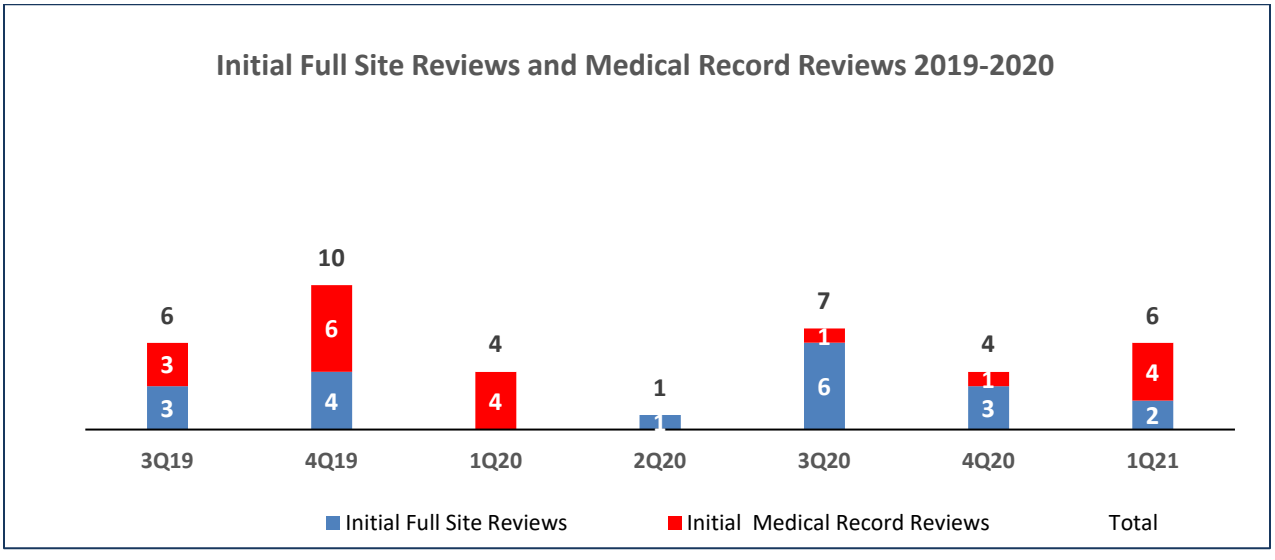
Provider sites that receive an FSR or MRR score with an Exempted Pass (90% or above, without deficiencies in critical elements) are not required to complete a corrective action plan (CAP). All sites that receive a Conditional Pass (80-89%, or 90% and above with deficiencies in critical elements) are 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)

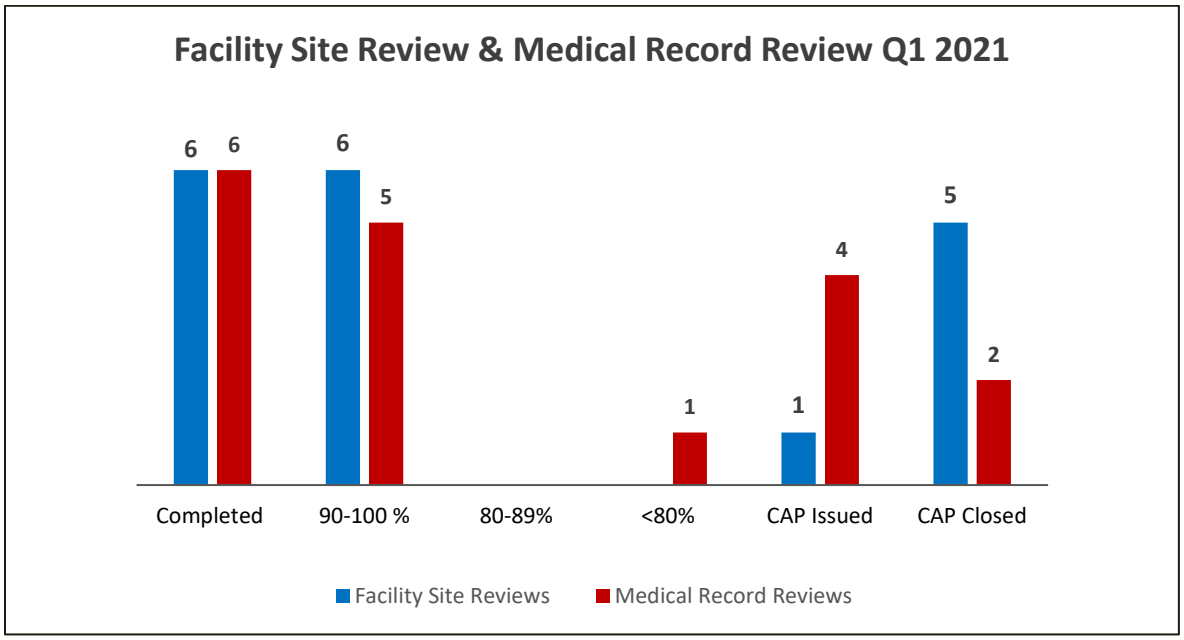
A CAP is issued when an initial, periodic, or focus review has deficiencies identified. DHCS requires follow up at 10 days for failure of any critical element, follow up for other failed elements at 45 days, and if not corrected by the 45 day follow up, at 90 days after a CAP has been issued. Most CAPs 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.

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 two IFSRs and four IMRR was conducted in Q1 of 2021.

Facility Site Review and Medical Record Review Results (Initial & Periodic):

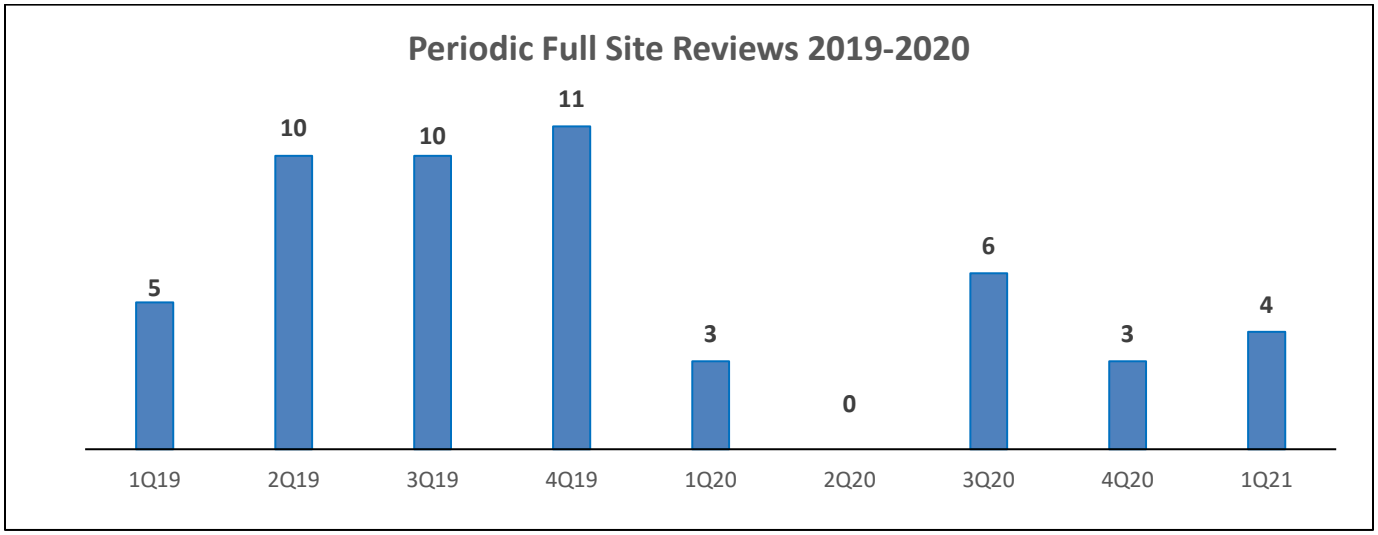


From the above chart:

- A total of 6 site reviews were completed in the Q1 of 2021. Out of the 6 site reviews 2 were initial and 4 were periodic site reviews.
- A total of 6 Medical Record Reviews were completed out of which 4 were initial medical record review and 2 were periodic medical record reviews.
- The total CAPS issued were 4 for Medical Record Reviews and 1 for facility site review conducted.
- There were 6 site review CAPs closed.

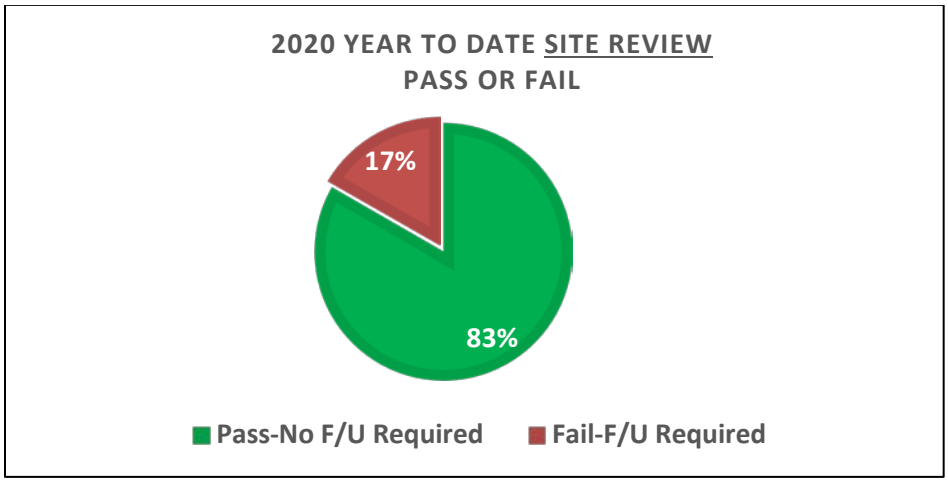
Periodic Full Site Reviews

Periodic Full Site 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.

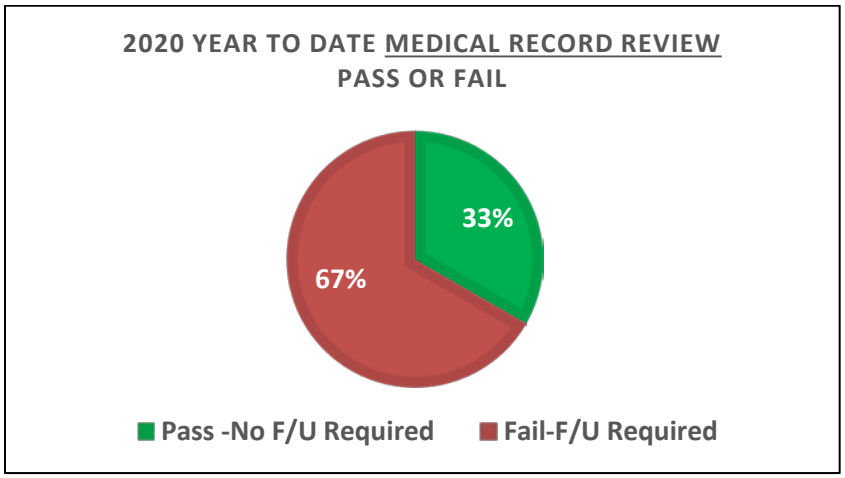


This above chart reflects the number of Periodic Full Site Reviews that were due and completed for each quarter.

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



In 2021 YTD, 83 % of the Initial and Periodic site reviews performed passed and 17% required follow-up. Compared to previous quarter pass percentage decreased by 11% and fail percentage increased by 11%.



For Q1 2021, there were 6 medical reviews conducted and two of these reviews were passed in the first audit. Typically, there are more follow-ups required for Medical Record Reviews. Quality Improvement explores opportunities to improve areas on a broader basis for areas with consistent non-compliance.

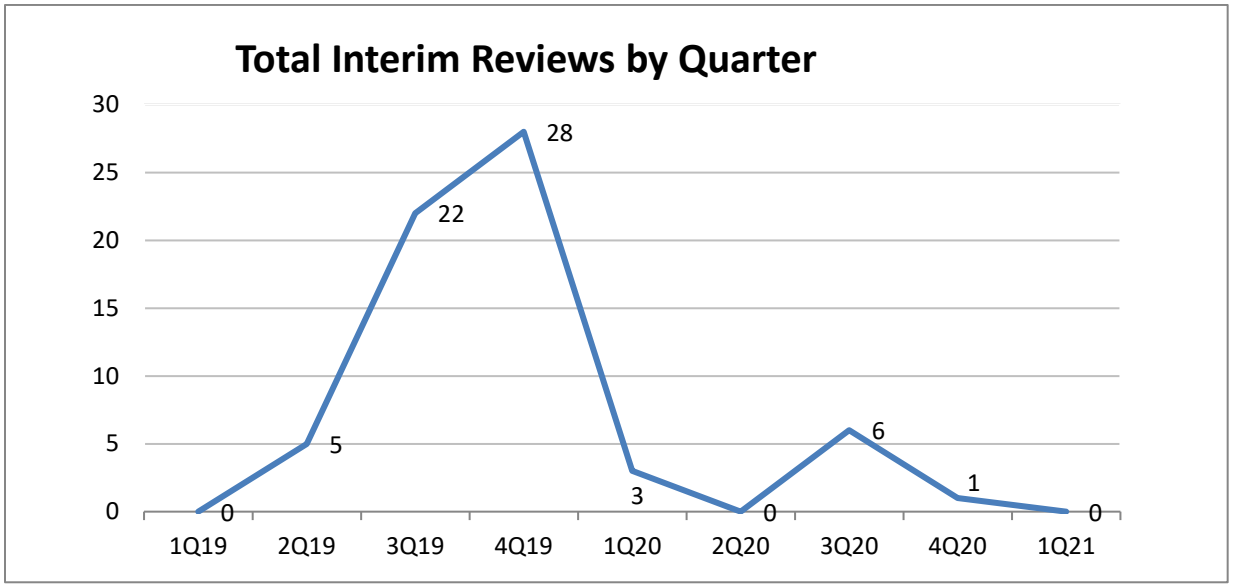
For Q1 2021, there were no deficiencies identified for Opportunities for improvement in site reviews.

For Q1 2021 top #3 deficiencies identified for Opportunities for improvement in medical record reviews are:

- No evidence of follow – up of specialty referrals made, and results/reports of diagnostic tests, when appreciate
- Blood Lead screening test
- Pediatric and adult Immunizations

Interim Reviews:

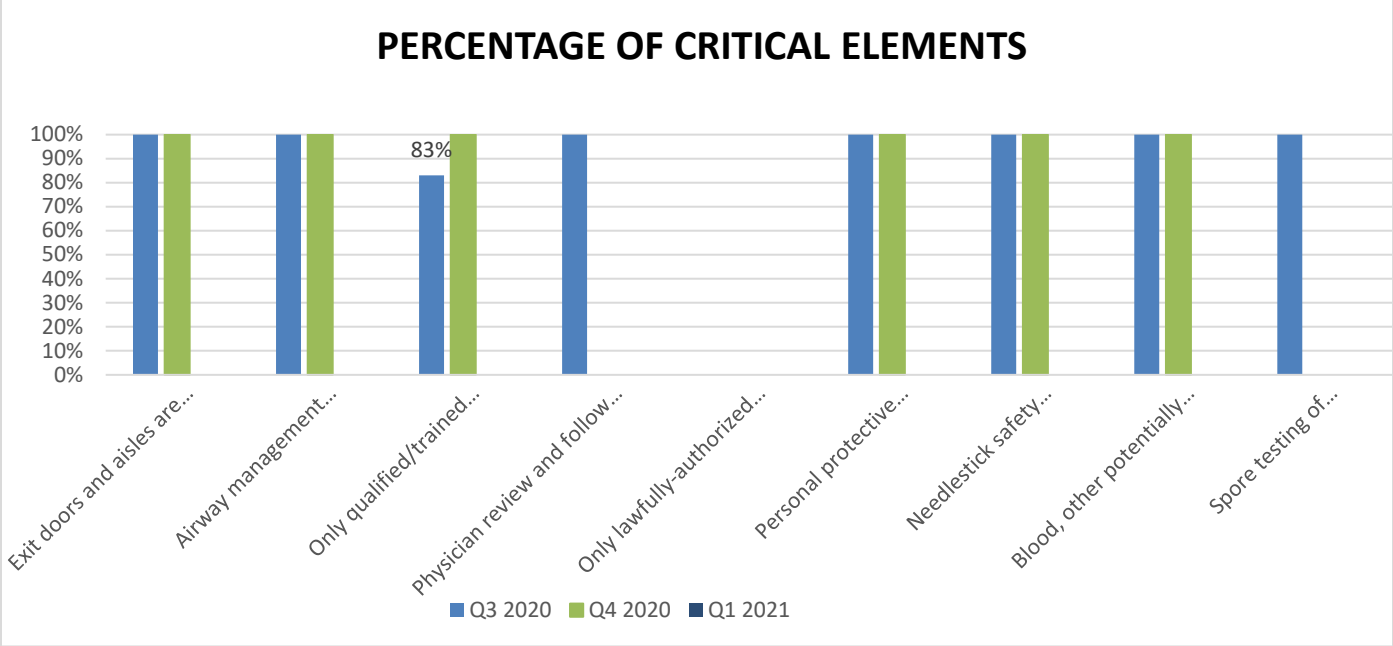
Interim Reviews are conducted between Initial and first Periodic Full Site Reviews or between two Periodic Full Site Reviews. Typically, they occur about every 18 months. These reviews are intended to be a check-in to ensure the provider is compliant with the 9 critical elements and as a follow up for any areas found to be non-compliant in the previous Initial or Periodic Full Site Review.



This above chart reflects the number of Interim Reviews that were due and completed for each quarter. Due to the pandemic our focus has been in completing site and medical record reviews and not interim reviews.

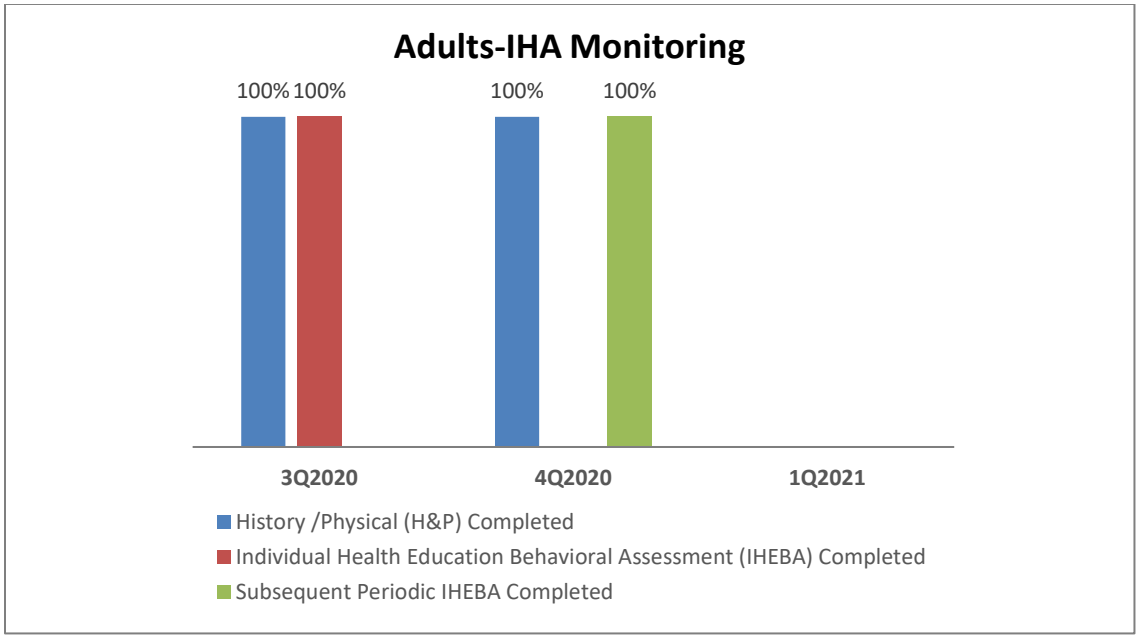
KHS is responsible for systematic monitoring of all PCP and OB/GYN sites between each regularly scheduled, full scope site review surveys. This monitoring includes the nine (9) critical elements. These nine critical survey elements are related to the potential for adverse effect on patient health or safety which have a scored "weight" of two points. All other survey elements are weighted at one point. All critical element deficiencies found during a full scope site review or monitoring visit must be corrected by the provider within 10 business days of the survey date. Sites found deficient in any critical element during a Focus Review are required to correct 100% of the survey deficiencies, regardless of survey score.

Other performance assessments may include previous deficiencies, patient satisfaction, grievance, and utilization management data. The PCP and/or site contact are notified of all critical element deficiencies found during a survey or monitoring visit. The PCP and/or site contact are required to correct 100% of the survey deficiencies regardless of the survey score.

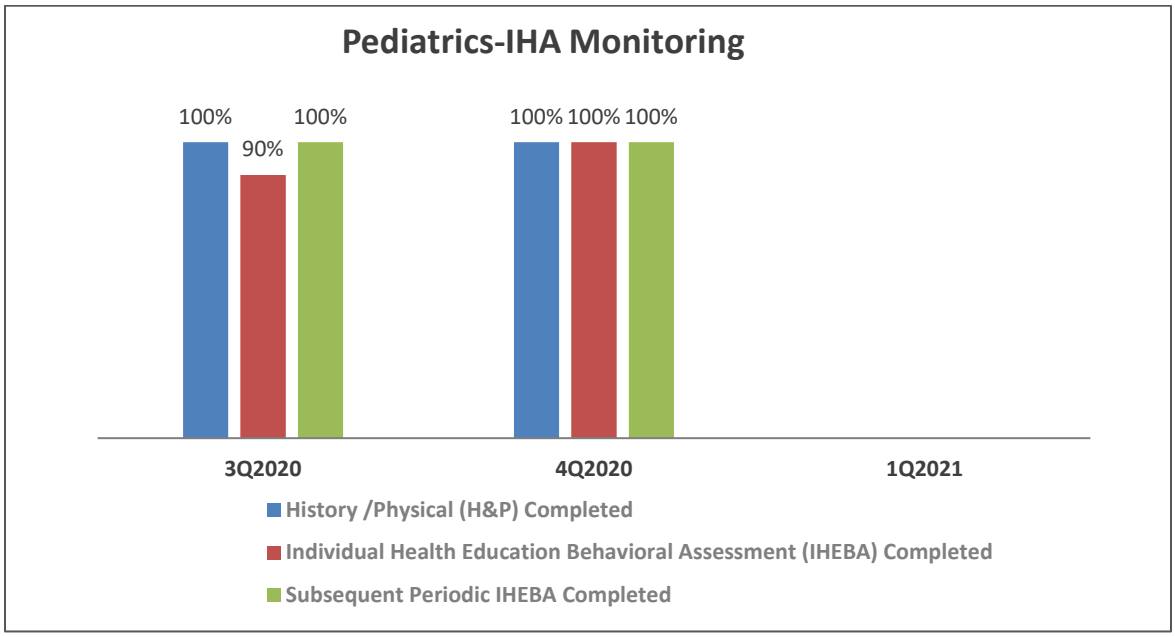


Note: There is no data for Q1 2021 since there were no interim reviews conducted during this time. Due to the pandemic our focus has been in completing site and medical record reviews and not interim reviews.

Initial Health Assessment (IHA) Description: An IHA must be provided to each member within 120 days of enrollment. As PCP's receive their assigned members, the practitioner's office contacts the member to schedule an IHA to be performed within the 120-day time limit. If the practitioner is unable to contact the member, he/she contacts the KHS Member Services Department for assistance. Contact attempts and results are documented by both the PCP and member services staff. The MPL is 80% for this measure, and IHAs are performed on both adult and child members.

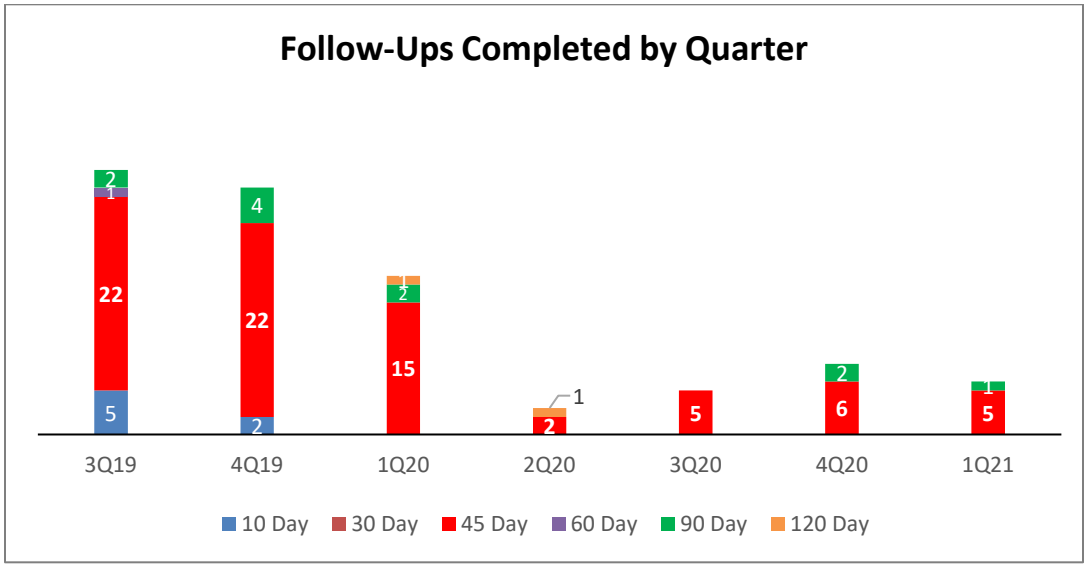


Note: There is no data for Q1 2021 since there were no interim reviews conducted during this time. Due to the pandemic our focus has been in completing site and medical record reviews and not interim reviews.



Note: There is no data for Q1 2021 since there were no interim reviews conducted during this time. Due to the pandemic our focus has been in completing site and medical record reviews and not interim reviews.

Site Review Corrective Action Plans (CAPs):



There were five 45-day and one 90-day follow up completed in Q1 of 2021.

IV. Quality Improvement Projects

a. Performance Improvement Projects (PIPs)

DHCS initiated a cycle of PIPs for 2020-2022 in November through the EQRO, HSAG. KHS opted to continue the PIPs that were stopped in July of 2020. Those 2 PIPs are:

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

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. Module 1 was submitted to HSAG/DHCS on 03/25/2021 and we are currently awaiting feedback. This project is being done in collaboration with Kern Pediatrics. Initial PIP kickoff meeting with Kern Pediatrics is scheduled for 04/06/2021.At this meeting PIP team plans to discuss about the PIP and try to identify interventions that remain relevant and realistic especially considering the COVID-19 pandemic.

Child/Adolescent Health Asthma Medication Ratio (AMR)

KHS did not meet the MPL for the AMR measure for two consecutive years and this is one of the reasons the AMR measure was chosen for the PIP project. PIP team determined that a two-pronged approach would be the best way to capture the most non-compliant members. The PIP Team separated the highest number of non-compliant members into two groups. The first group will utilize the Asthma Mitigation Project (AMP) as its focused intervention. The second group will utilize Asthma Disease Management Program via KHS' Disease Management Department (DM) that will be customized to this focused population. The PIP Team will collaborate with providers to encourage the members to enroll and participate in these two projects. Module 1 was submitted to HSAG on February 26, 2021 and was accepted by HSAG on March 18th, 2021. PIP team plan to begun working on Module 2 by second week on March.

V. MCAS Committee:

In the first quarter of 2021, a new committee was formed called the MCAS Committee. The purpose of the Committee is to provide direction and oversight of KHS' level of compliance with the MCAS measures. This includes direction, input and approval of KHS' strategies and actions to meet or better compliance with the minimum performance level (MPL) for each MCAS measure as set by the Department of Health Care Services (DHCS). The MCAS Committee is the leader, facilitator and coordinator of KHS' MCAS Strategic Action Plan.

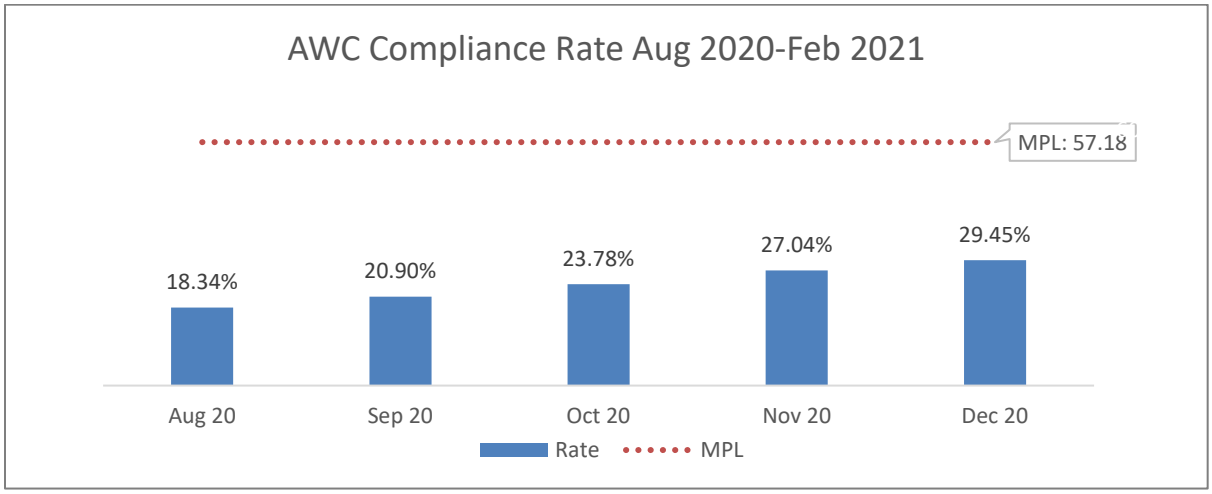
This Committee is currently meeting monthly. Focus is on the following 3 activities currently:

- Strengths, Weaknesses, Opportunities, Threats (SWOT) Strategic Action Plan
- Member Engagement and Rewards Program
- MCAS Annual Audit Progress & Results
- YTD MCAS Measures Compliance

a. MCAS Member Engagement and Rewards Program:

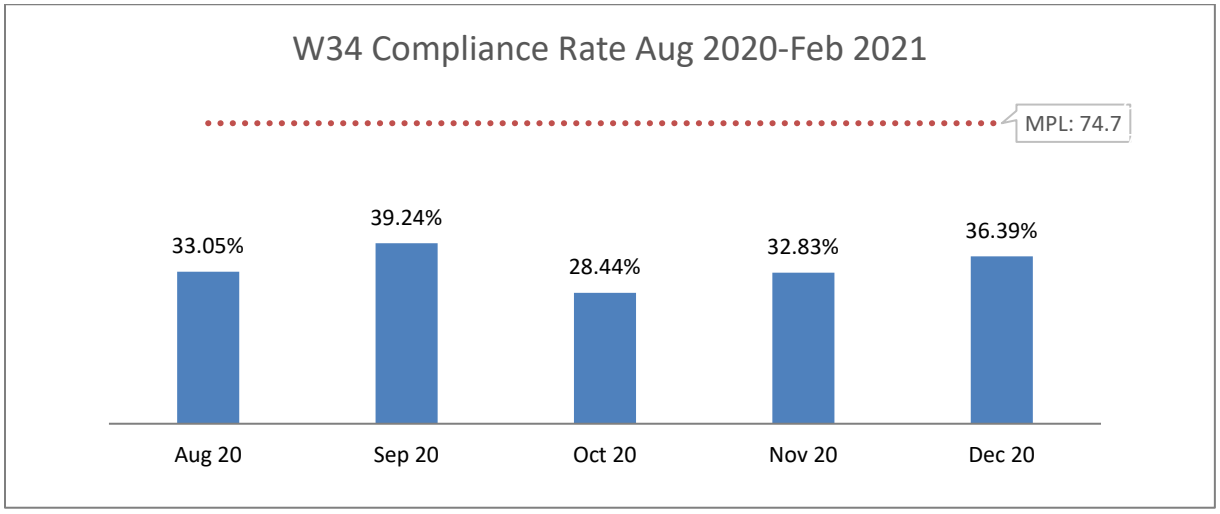
The outcomes of the first campaign were presented at the MCAS Committee Meeting on March 8th. Below are the rates August 2020 to December 2020, for the measures AWC, W34, W15, PPC-PRE and PPC-POST that are part of the campaign. The timing of this first campaign was at the height of the pandemic. The public was advised to continue the stay at home orders which likely negatively impacted the outcomes of the campaign. During the March MCAS Committee meeting a decision was made to conduct a second campaign in May or June of this year. The second campaign will modify the W15, AWC, W34 measures to the new W30 and WCV measures.

Adolescents Well Care visits (AWC):



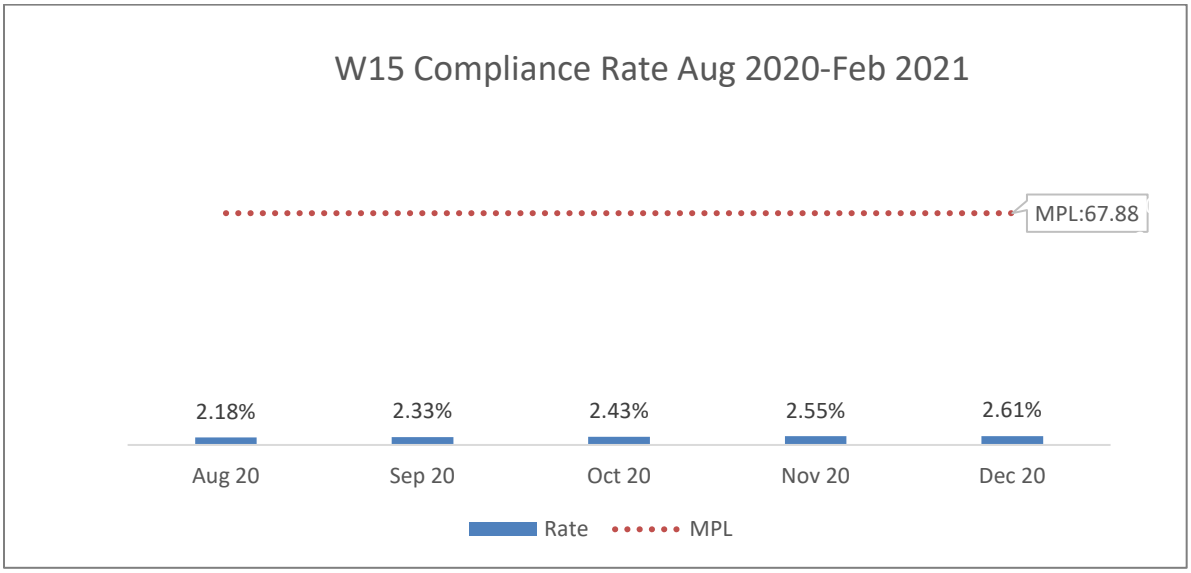
From the above chart, since September to December there is 8.55% increase in the rate.

Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34):



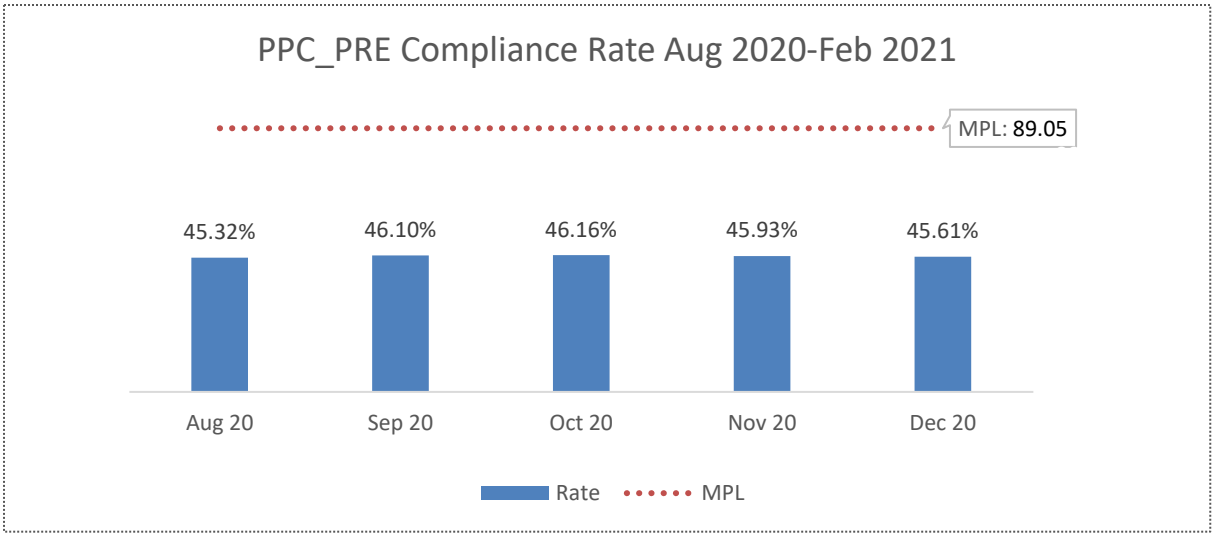
From the above chart, September to October there is decrease and since October to December there is 7.95% increase in the rate.

Well-Child Visits in the First 15 Months of Life (W15):



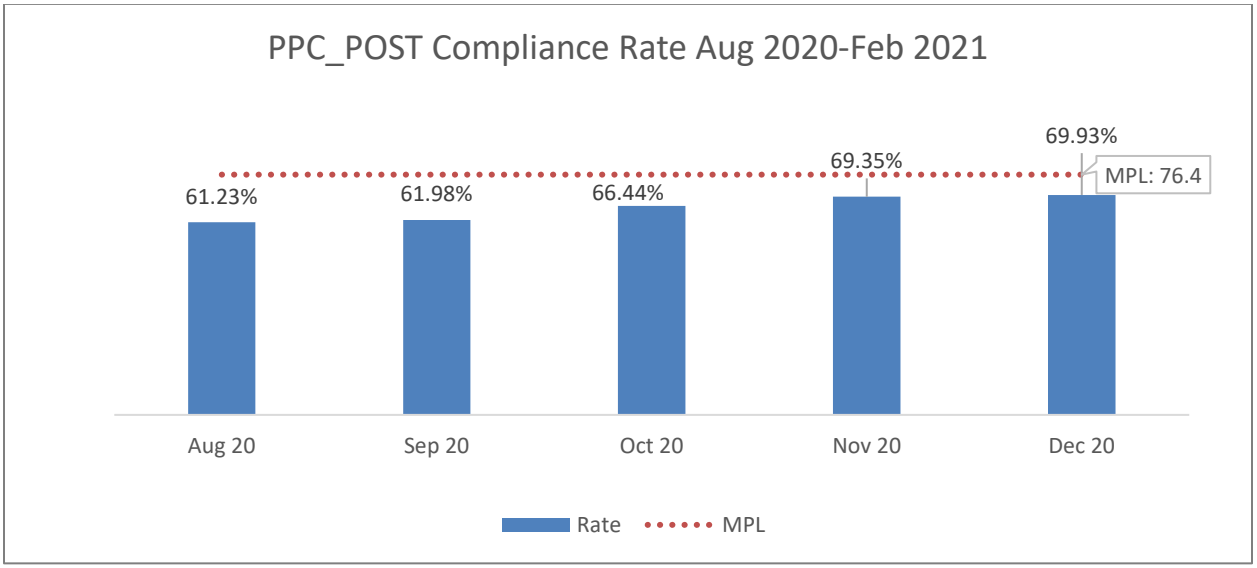
Please note: Due to the newborn eligibility issue the rates are low, Currently BI is working on fixing this issue.

Prenatal and Postpartum Care- *Timeliness of Prenatal Care* (PPC-Pre):



From the above chart, September to December rates are consistent.

Prenatal and Postpartum Care- *Postpartum Care* (PPC-Post):

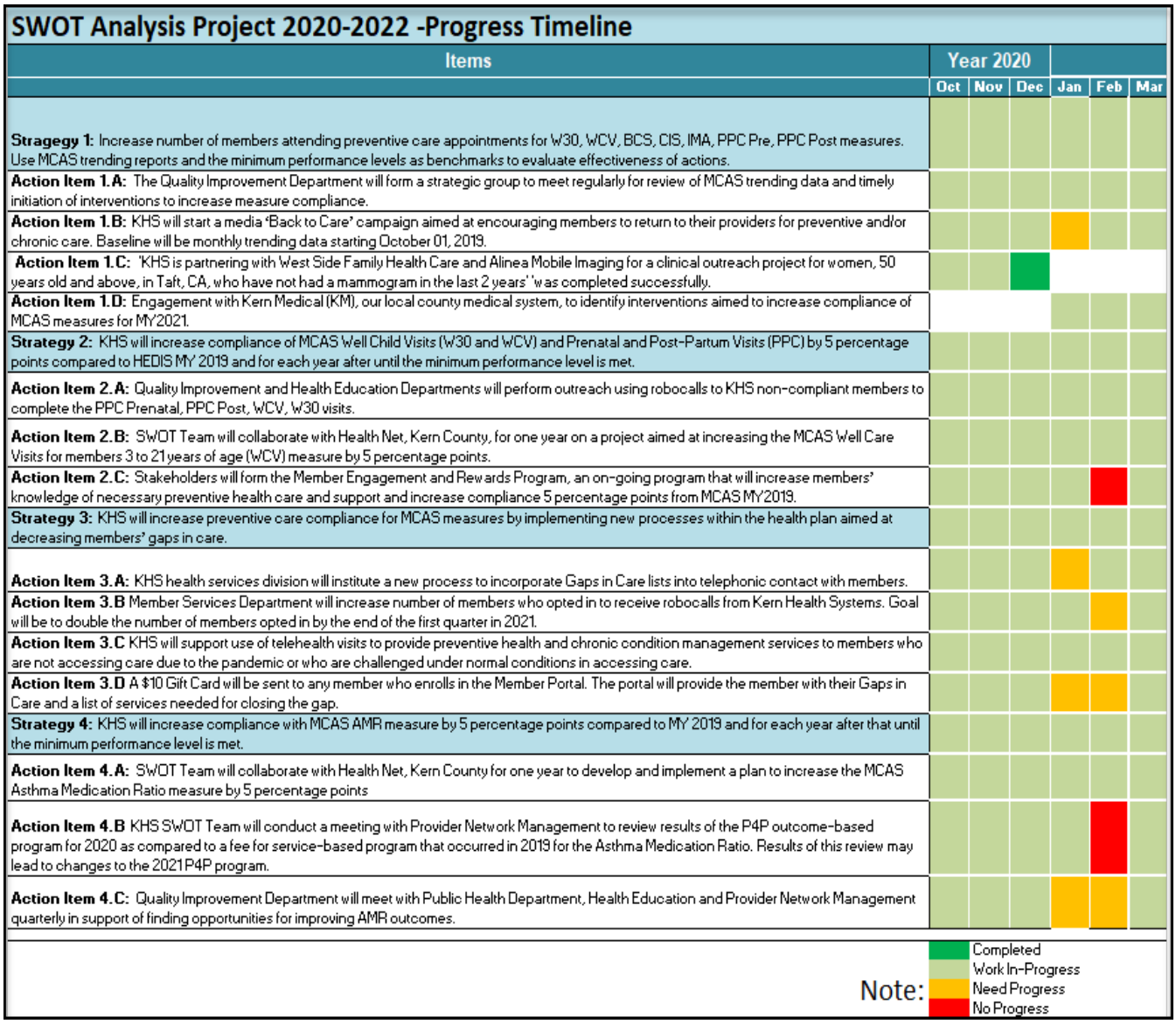


From the above chart, September to December rates have increased 7.95%.

b. MCAS SWOT Action Plan:

Based on MY2019 results, DHCS suggested KHS consider conducting a SWOT analysis to improve scores for multiple measures. KHS opted to move forward with this more expansive evaluation and development of interventions that will improve MCAS measure compliance results. This will be a two-year project working closely with DHCS. Health Net is also conducting a SWOT analysis and there will be coordination between KHS and Health Net.

A collaborative meeting with DHCS is conducted every month to discuss the status of the SWOT project. QI Department is monitoring SWOT project activities weekly and monthly to identify any issues or impediments and resolve them. Below is the SWOT Analysis Project 2020-2022 Monthly Progress Timeline:



Strategy 1: KHS is continuing to work towards increasing preventive services for PPC, WCV, W30, CIS, IMA, BCS and AMR measures for 2021. Projects like the Member Engagement and Rewards program, Gaps in Care lists and P4P are in place to decrease members gaps in care, which will increase MCAS compliance rates. KHS is in the process of collecting and analyzing data for first quarter 2021. The MCAS Committee is prepping for our 3rd meeting to review SWOT action items and results of internal projects. KHS met with Kern Medical for a follow up meeting. PNM and QI are investigating inconsistent data on Gaps in Care Reports and will meet with Kern Medical to update and educate on its use.

Strategy 2: KHS is presently collecting and analyzing data on measures WCV and PPC with a goal of raising scores by 5%. KHS is conducting member outreach robocalls to encourage them to follow-up with their PCP for WCV for children 0-6 years old. Since there has been progress with the Pandemic since February, members are beginning to venture out in public again. KHS and Health Net are collaborating on initiatives such as promotion of telehealth

for preventive health services educating providers on coding for MCAS services virtually including CPT Category 2 codes. Member Engagement and Rewards Project was completed in March and the program was operationalized. The second campaign for MERP is planned for June of this year and will leverage similar MCAS measures as were in the first campaign.

Strategy 3: KHS is actively seeking processes from various departments to support the decrease in Gaps in Care for our members. A meeting with Case Management is set for next week to audit 'Gaps in Care' data during member outreach. Best practices and lessons learned will be shared with other Health Services departments if project proves successful. Member Services continues to encourage members to opt in for robocalls and text messages. We are waiting on the new monthly numbers. KHS and Healthnet are working together to develop Telehealth Flyer. NCQA is including use of telehealth services in the next edition of their HEDIS technical specifications.

Strategy 4: KHS is creating programs to support an increase of 5% for AMR from 2019 to 2020. Health Net is collaborating with Central California Asthma Coalition in Fresno and KHS is working with them here in Kern county with an in-home based project for persistent asthma. KHS PNM are planning to meet with departments to review P4P measures outcomes for the AMR measure. KHS is meeting monthly with the Public Health Department, however they have had to shift their resources to administration of the COVID vaccine. We will continue to meet with them and strategize about the support they may offer once they are able to bring their resources back to regular work.

c. MCAS Annual Audit Progress:

MCAS Measures have been significantly impacted by the current COVID pandemic. Most members are avoiding going to Provider Offices due to the pandemic. The Audit for MCAS MY2020 began in November and final rates will be submitted to DHCS by June 1, 2021.

d. 1st Quarter 2021 MCAS Measures Compliance Results:

MCAS Measures have been significantly impacted by the current COVID pandemic. Most members are avoiding going to Provider Offices due to the pandemic. The Audit for MCAS MY2020 began in November and will continue until July of 2021.

Rates below are not considered typical to our plan because of the reduced services provided during the pandemic. They are preliminary rates reflective of what has been measured as of March 2021 for MY2020. Final rates will be determined by June 1st, 2021.

MY2020 MCAS Rate Tracking Report
As of 2021-03-31
Note: These are preliminary rates awaiting HSAG validation.

Hybrid Measures Held to MPL

Measure		Current MY2020 Rate	MY2020 MPL	MY2019 KHS Rate	Current Vs. MY2020 MPL	Current Vs. MY2019 KHS
CCS	Cervical Cancer Screening	53.28	61.31	56.20	-8.03	-2.92
CIS-10	Childhood Immunization Status	18.98	37.47	29.93	-18.49	N/A
CDC-H9*	HbA1c Poor Control (>9.0%)	58.36	37.47	57.91	-20.89	-0.45
CBP	Controlling High Blood Pressure <140/90 mm Hg	22.38	61.8	38.93	-39.42	-16.55
IMA-2	Immunizations for Adolescents – Combo 2 (meningococcal, Tdap, HPV)	31.63	36.86	41.36	-5.23	-9.73
PPC-Pre	Prenatal & Postpartum Care – Timeliness of Prenatal Care	51.82	76.4	84.18	-24.58	-32.36
PPC-Post	Prenatal & Postpartum Care – Postpartum Care	73.24	89.05	81.02	-15.81	-7.78
WCC-BMI	Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents: Body Mass Index Assessment for Children/Adolescents	44.04	80.5	66.42	-36.46	N/A
WCC-N	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Nutrition	27.01	71.55	NA	-44.54	N/A
WCC-PA	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Physical Activity	19.46	66.79	NA	-47.33	N/A

Note: For CDC H9* A lower rate indicates better performance therefore the number of required numerators must decrease by the number shown.

Administrative Measures Held to MPL

Measure		Current MY2020 Rate	MY2020 MPL	MY2019 KHS Rate	Current Vs. MY2020 MPL	Current Vs. MY2019 KHS
AMM -Acute	Antidepressant Medication Management – Acute Phase Treatment	48.03	53.57	50.24	-5.54	N/A
AMM - Cont.	Antidepressant Medication Management – Continuation Phase Treatment	31.76	38.18	32.64	-6.42	N/A
APM–B	Metabolic Monitoring for Children and Adolescents on Antipsychotics-Blood Glucose Testing	50.00	54.42	NA	-4.42	N/A
APM–C	Metabolic Monitoring for Children and Adolescents on Antipsychotics-Cholesterol Testing	16.67	37.08	NA	-20.41	N/A
APM–BC	Metabolic Monitoring for Children and Adolescents on Antipsychotics-Blood Glucose Testing and Cholesterol Testing	16.67	35.43	NA	-18.76	N/A
AMR	AsthmaMedication Ratio	54.53	62.43	48.78	-7.90	5.75
BCS	Breast Cancer Screening	54.09	58.82	57.29	-4.73	-3.20
CHL	Chlamydia Screening in Women Ages 16 – 24	53.34	58.44	55.29	-5.10	-1.95
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	92.31	82.09	NA	10.22	N/A

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

IV. Policy Updates: There were no new policy updates for 1st quarter 2020.

KAISER REPORTS

(PROPRIETARY AND CONFIDENTIAL)

Available upon Request

Diabetic Exam Reminder Effectiveness Report

Client: KERN HEALTH SYSTEMS - 12049397

Reminder Year:	Reminder Month:	Reminders Sent	Received Exam Within 0-90 Days	Received Exam Within 91-180 Days	Total Exams Within 180 Days
2020	April	6,190	57	91	148
	May	1,677	35	38	73
	June	1,367	52	62	114
	July	436	27	18	45
	August	554	33	33	66
	September	1,095	43	28	71
	October	3,423	81	61	142
	November	841	43	9	52
	December	1,760	71	4	75
2021	January	518	16	0	16
	February	1,393	13	0	13
	March	326	0	0	0
Totals		**19,580**	**471**	**344**	**815**

LTM Effectiveness* : 4 %

12-Month Effectiveness (Oct 2019 - Sep 2020) : 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, 2020 through March, 2021
Prepared for: KERN HEALTH SYSTEMS - (12049397)

Overview

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

Summary of Findings

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

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

Reported Cases

	Members	
Received Eye Exam:	15,695	
Diabetes[1]:	811	5.2%
Diabetic Retinopathy:	163	1.0%
Glaucoma:	244	1.6%
Hypertension:	523	3.3%
High Cholesterol	221	1.4%
Macular Degeneration:	51	.3%

Estimated Number of Cases

Total Members:	282,768	
Diabetes[1]:	7,001	2.5%
Diabetic Retinopathy:	624	.2%
Glaucoma:	1,180	.4%
Hypertension:	30,085	10.6%
High Cholesterol	43,256	15.3%
Macular Degeneration:	388	.1%

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

Call Response Summary Report

FEBRUARY 2021

Kern Health Systems 12049397
On average, for 1,000 members, VSP receives 19 calls per month

Total Client Calls

558

Category	Reasons For Calling	Client Counts	Client Percent	VSP Percent Book-of-Business
Eligibility	IVR Available Services	119	28.74%	20.19%
	Coverage/Relation	30	7.25%	.00%
	ID Number/ID Card Inquiry	12	2.90%	.00%
	Refer to Client	7	1.69%	.00%
	Correcting	6	1.45%	.00%
	Not Active	6	1.45%	.00%
Category Subtotal - Eligibility		180	43.48%	20.19%
Doctor Referral	Email	61	14.73%	.00%
	IVR Doctor Referral	31	7.49%	1.26%
	Doctor Access	5	1.21%	.00%
	Verbal or Mail	2	.48%	.00%
Category Subtotal - Doctor Referral		99	23.91%	1.26%
Member Benefits	Available Services	50	12.08%	.00%
	Benefits Description	25	6.04%	.00%
	Glasses Related	6	1.45%	.00%
	Medically Related	1	.24%	.00%
Category Subtotal - Member Benefits		82	19.81%	.00%
Claims	Claim Status	21	5.07%	1.59%
	Status	3	.72%	.00%
	Adjustments	1	.24%	.00%
	Letter	1	.24%	.00%
	Submission	1	.24%	.00%
Category Subtotal - Claims		27	6.51%	1.59%
Eligibility Not Online	Check Eligibility	4	.97%	.00%
	Member Not Found	3	.72%	.00%
Category Subtotal - Eligibility Not Online		7	1.69%	.00%
Member Website Assistance	Register	4	.97%	.00%
	Find a Doctor	3	.72%	.00%
Category Subtotal - Member Website Assistance		7	1.69%	.00%

Call Response Summary Report

FEBRUARY 2021

Kern Health Systems 12049397
On average, for 1,000 members, VSP receives 19 calls per month

Total Client Calls

558

Category	Reasons For Calling	Client Counts	Client Percent	VSP Percent Book-of-Business
Authorizations	Authorizations	6	1.45%	1.29%
Category Subtotal - Authorizations		6	1.45%	1.29%
Language Lines / Miscellaneous	Spanish	4	.97%	.00%
	Language Line - Phone	1	.24%	.00%
Category Subtotal - Language Lines / Miscellaneous		5	1.21%	.00%
Open Access	IVR OON Info	1	.24%	1.29%
Category Subtotal - Open Access		1	.24%	1.29%
Complaints	None	0	.00%	.00%
Category Subtotal - Complaints		0	.00%	.00%

GRAND TOTAL **414**

Executive Summary for 1st Quarter 2021 Operational Board Update - Grievance Report

When compared to the previous three quarters, there were no significant trends identified as they relate to the Grievances during the 1st Quarter of 2021.

We cannot predict how many Grievances we will receive on any given day. However, we can assess if a certain event may lead to an increase or decrease in the receipt of grievances. For example, during the beginning of the COVID-19 Pandemic, we saw a decrease in Access related grievances. We can theorize that members were scared to leave their homes during this time and therefore, not wanting to make appointments to go to their doctors during the 2nd quarter, 2020.

The decrease in Potential Inappropriate Care (PIC) grievances during the 1st quarter of 2021, can be attributed to not as many care concerns being identified during initial RN review of the grievance cases sent out to the Grievance Committee. Again, we cannot predict when or how many grievances we will receive that are determined to be a PIC; therefore, this number may fluctuate from quarter to quarter.

1st Quarter 2021 Grievance Report

Category	1st Quarter 2021	Status	Issue	Q4 2020	Q3 2020	Q2 2020	Q1 2020
Access to Care	76		Appointment Availability	72	52	33	53
Coverage Dispute	0		Authorizations and Pharmacy	0	0	0	0
Medical Necessity	308		Questioning denial of service	317	288	246	225
Other Issues	11		Miscellaneous	14	10	11	36
Potential Inappropriate Care	156		Questioning services provided. All cases forwarded to Quality Dept.	200	263	207	273
Quality of Service	8		Questioning the professionalism, courtesy and attitude of the office staff. All cases forwarded to PR Department	7	5	8	2
Total Formal Grievances	559			610	618	505	589
Exempt**	1179		Exempt Grievances-	1050	1041	989	1620
Total Grievances (Formal & Exempt)	1738			1660	1659	1494	2209

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Additional Insights-Formal Grievance Detail

Issue	1st Quarter Grievances	Upheld Plan Decision	Further Review by Quality	Overturned Ruled for Member	Still Under Review
Access to Care	48	20	0	12	16
Coverage Dispute	0	0	0	0	0
Specialist Access	28	8	0	9	11
Medical Necessity	308	167	0	67	74
Other Issues	11	6	0	1	4
Potential Inappropriate Care	156	90	65	1	0
Quality of Service	8	4	0	2	2
Total	559	295	65	92	107

Executive Summary for the Grievance Summary Report:

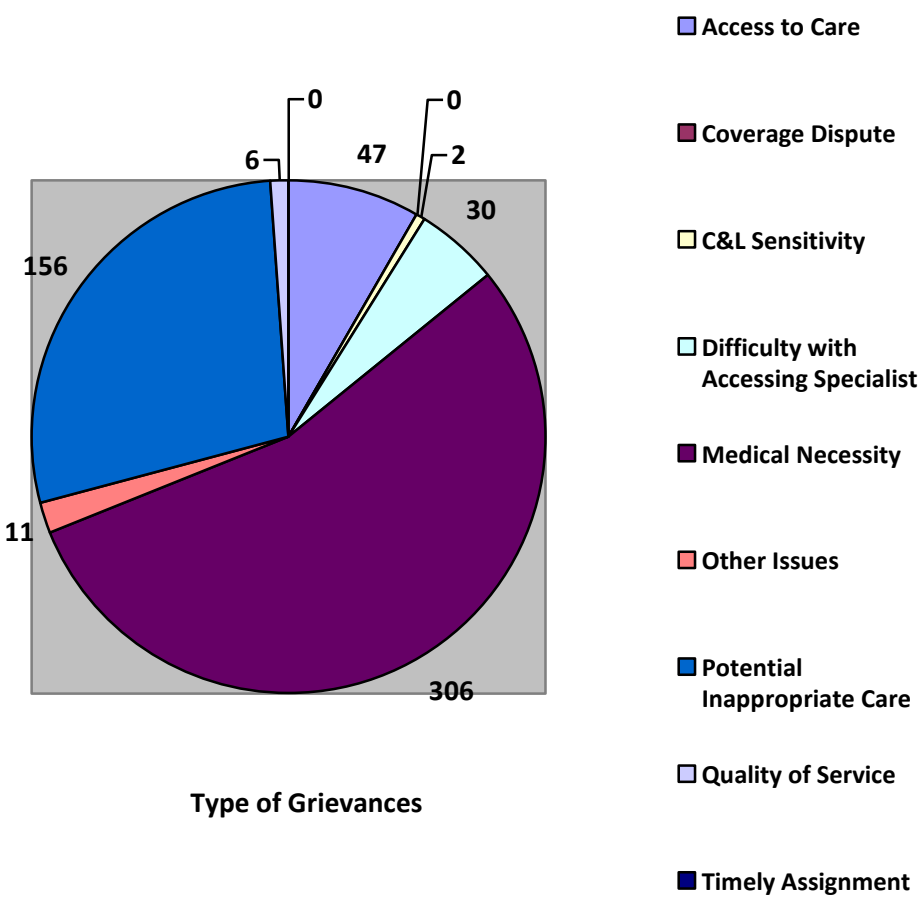
The Grievance Summary Report supports the high-level information provided on the Operation Report and provides a little more detail as to the type of grievances the Plan receives. It also provides insight into the grievance and appeals received by KFHC members assigned to Kaiser Permanente.

Kaiser Permanente Grievances and Appeals

During the first quarter of 2021, there were forty-two grievances and appeals received by KFHC members who were assigned to Kaiser Permanente. Seven cases closed in favor of the Plan. Thirty cases were closed in favor of the Enrollee. Five cases are still open, pending investigation and resolution.

1st Quarter 2021 Grievance Summary

Issue	Number	In Favor of Health Plan	Under Review by Q.I	In favor of Enrollee	Still under review
Access to care	47	30	0	17	0
Coverage dispute	0	0	0	0	0
Cultural and Linguistic Sensitivity	2	1	0	1	0
Difficulty with accessing specialists	30	17	0	13	0
Medical necessity	306	230	0	76	0
Other issues	11	9	0	2	0
Potential Inappropriate care	156	90	65	1	0
Quality of service	6	5	0	1	0
Timely assignment to provider	0	0	0	0	0



Grievances per 1,000 Members =1.97

During the first quarter of 2021, there were five hundred and fifty-eight formal grievances and appeals received. One hundred and eleven cases were closed in favor of the Enrollee. Three hundred and eighty-two cases were closed in favor of the Plan. Sixty-five cases have closed and are under review by Quality Improvement. Of the five hundred and fifty-eight cases, five hundred and forty-nine cases closed within thirty days; nine cases were pended and closed after thirty days.

1st Quarter 2021 Grievance Summary

Access to Care

There were forty-seven grievances pertaining to access to care. Thirty closed in favor of the Plan. Seventeen 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 their Primary Care Provider (PCP). Twelve cases closed in favor of the Plan after the responses indicated the offices provided appropriate access to care based on Access to Care standards. Six 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.

Eighteen members complained about the wait time to be seen for a Primary Care Provider (PCP) appointment. Eleven 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. Seven 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.

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

One member complained about a provider not submitting a referral authorization request in a timely manner. This case closed in favor of the Plan after it was determined the referral authorization request had been submitted in a timely manner.

Coverage Dispute

There were no grievances pertaining to a Coverage Dispute issue.

Cultural and Linguistic Sensitivity

Two members complained about the lack of available interpreting services to assist during their appointments. One case closed in favor of the Plan after the response indicated the member was provided with the appropriate access to interpreting services. One case closed in favor of the Enrollee as a response was not received from the provider indicating the member was provided with the appropriate access to interpreting services.

Difficulty with Accessing a Specialist

There were thirty grievances pertaining to Difficulty Accessing a Specialist. Seventeen cases closed in favor of the Plan. Thirteen cases closed in favor of the Enrollee. The following is a summary of these issues:

1st Quarter 2021 Grievance Summary

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

Four 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. Two 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.

Eight members complained about the telephone access availability with a specialist office. Three 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.

Medical Necessity

There were three hundred and six appeals pertaining to Medical Necessity. Two hundred and thirty cases were closed in favor of the Plan. Seventy-six cases closed in favor of the Enrollee. The following is a summary of these issues:

Two hundred and sixty members complained about the denial or modification of a referral authorization request. One hundred and eighty-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. Seventy-three cases were closed in favor of the Enrollee as it was determined medical necessity was met and the denials were overturned and approved.

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

Other Issues

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

1st Quarter 2021 Grievance Summary

Potential Inappropriate Care

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

Quality of Service

There were six grievances involving Quality of Service issues. Five cases were closed in favor of the Plan. One case closed in favor of the Enrollee. The following is a summary of these issues:

> Three members complained about the service they received from their providers. All cases closed in favor of the Plan after the responses determined the members received the appropriate service from their providers.
>
> Three members complained about the services they received from a transportation vendor and their staff. Two of the cases closed in favor of the Plan after the responses determined the member received the appropriate service from the transportation staff. One case closed in favor of the Enrollee after the response indicated the member may not have been provided with the appropriate service from the transportation employee.

Timely Assignment to Provider

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

Kaiser Permanente Grievances and Appeals

During the first quarter of 2021, there were forty-two grievances and appeals received by KFHC members who were assigned to Kaiser Permanente. Seven cases closed in favor of the Plan. Thirty cases were closed in favor of the Enrollee. Five cases are still open, pending investigation and resolution.

Access to Care

There were four grievances pertaining to Access to Care. The following is a summary of these issues:

Two members complained about the excessive wait time to be seen for an appointment. Both cases closed in favor of the Enrollee.

One member complained about the lack of an available appointment with their primary care provider. This case closed in favor of the Enrollee.

1st Quarter 2021 Grievance Summary

One member complained about the lack of an available appointment with a specialist. This case closed in favor of the Enrollee.

Coverage Dispute

There were eleven appeals pertaining to Coverage Dispute. The following is a summary of these issues:

Eleven members complained about a service they requested; however, the requests were not covered. Seven cases closed in favor of the Plan and the services were not covered. Three of the cases closed in favor of the Enrollee and the services were provided. One case is still open, pending review and resolution.

Medical Necessity

There were no cases pertaining to Medical Necessity.

Quality of Care

There were fourteen cases pertaining to quality of care. The following is a summary of these issues:

Three members complained about the quality of care they received from a hospital. All cases closed in favor of the Enrollee.

Eight members complained about the quality of care they received from a provider. Six of the cases closed in favor of the Enrollee. Two of the cases are still open, pending investigation and resolution.

One member complained about the Plan denying treatment. The case closed in favor of the Enrollee.

Two members complained about a provider denying treatment. One case closed in favor of the Enrollee. One case is still open, pending investigation and resolution.

Quality of Service

There were thirteen grievances pertaining to a Quality of Service. The following is a summary of these issues.

Eleven members complained about the services being inadequate at a facility. All cases closed in favor of the Enrollee.

Two members complained about the poor attitude the received form provider/staff. One case closed in favor of the Enrollee. One case is still open, pending investigation and resolution.

QI/UM

PNM Network Review Quarter 1

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 97%

   Urgent 92%

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

2. Appointment Availability:

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

3. Access Grievance Review:

   In Q4, there were 74 access related grievances. 49 were found in favor of the plan and no further action was needed. 25 were found in favor of the enrollee. Of the 25, no trends were identified.

4. Geographic Accessibility & DHCS Network Certification:

   KHS must request alternative access standards (AAS) from DHCS in zip codes where KHS is non-compliant with time or distance standards. All AAS requests from 2020 have been approved. KHS is in the process of receiving approval from DHCS for AAS 2021.

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.

6. DHCS QMRT (Quarterly Monitoring Report/Response Template)
   DHCS conducts quarterly monitoring of: Provider to Member Ratio, Timely Access, Network Report of Providers, Mandatory Provider Types, Physician Supervisor to Non-Physician Medical Practitioner Ratios. KHS was compliant with all standards.

7. Capacity Report
   Annually, KHS conducts a Provider Capacity review which is comprised of 4 areas to ensure network capacity: Analysis of Provider to Member Ratio, PCP Medical Service Study Area Capacity report, Specialty Provider Network, Mental Health Provider Network. KHS did not experience any substantial changes in comparison to prior year.

8. Provider Satisfaction
   KHS is required to conduct a Provider Satisfaction Survey annually. The survey is sent to all Primary Care, Specialty, Behavioral Health, and Ancillary Providers as well as Hospital, Urgent Care, and Ancillary Facilities. Year over year, KHS results are higher than other plans utilizing the same survey vendor. KHS received an overall satisfaction rate of 88% compared to the National Medicaid Summary Score of 68.6%.

Contracts/Credentialing/Recredentialing

13 New Contracts were approved. 2 of the 13 were retro effective April 1, 2021.
Hospice & Palliative Care
CBAS
4 Specialist (Urology, Orthopedic Surgery, Ophthalmology)
Laboratory
ASC
3 PCP (1 RHC)
Pharmacy
Behavioral Health

All credentialing and recredentialing files were approved.

KERN HEALTH SYSTEMS
1st Quarter 2021
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

Report Date: April 7, 2021

Department: Provider Relations

Monitoring Period: January 1, 2021 through March 31, 2021

Population:

Providers	Credentialed	Recredentialed
MD's	43	26
DO's	4	0
AU's	0	0
DC's	0	0
AC's	0	0
PA's	4	1
NP's	17	6
CRNA's	0	2
DPM's	0	1
OD's	0	0
ND's	0	0
RD's	0	0
BCBA's	7	1
LM's	0	0
Mental Health	11	2
Ocularist	0	0
Ancillary	7	11
OT	0	0
TOTAL	**93**	**50**

Specialty	Providers Credentialed	Providers Recredentialed	Providers Sent to PAC	Providers Not Approved
Acupuncture	0	0	0	0
Allergy & Immunology	0	0	0	0
Anesthesiology / CRNA	0	2	2	0
Audiology	0	0	0	0
Autism / Behavioral Analyst	7	1	8	0
Cardiology	0	3	3	0
Chiropractor	0	0	0	0
Colon & Rectal Surgery	0	0	0	0
Critical Care	0	1	1	0
Dermatology	0	0	0	0
Emergency Medicine	2	1	3	0
Endocrinology	0	0	0	0
Family Practice	17	3	20	0
Gastroenterology	2	0	2	0
General Practice	1	0	1	0
General Surgery	5	2	7	0
Genetics	0	0	0	0

KERN HEALTH SYSTEMS
1st Quarter 2021
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

Specialty	Providers Credentialed	Providers Recredentialed	Providers Sent to PAC	Providers Not Approved
Gynecology	0	0	0	0
Gynecology/Oncology	0	0	0	0
Hematology/Oncology	0	1	1	0
Hospitalist	11	1	12	0
Infectious Disease	1	0	1	0
Internal Medicine	17	3	20	0
Mental Health	11	2	13	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	0	1	1	0
Neurological Surgery	0	0	0	0
Neurology	2	0	2	0
Obstetrics & Gynecology	1	1	2	0
Ocularist	0	0	0	0
Occupational Therapy	0	0	0	0
Ophthalmology	1	3	4	0
Optometry	0	0	0	0
Orthopedic Surgery / Hand Surg	0	0	0	0
Otolaryngology	0	0	0	0
Pain Management	2	0	2	0
Pathology	0	0	0	0
Pediatrics	3	2	5	0
Physical Medicine & Rehab	2	0	2	0
Plastic Sugery	0	1	1	0
Podiatry	0	1	1	0
Psychiatry	0	3	3	0
Pulmonary	0	1	1	0
Radiation Oncology	0	0	0	0
Radiology	13	7	20	0
Registered Dieticians	0	0	0	0
Rheumatology	0	0	0	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	0	0	0	0
KHS Medical Directors	0	1	1	0
TOTAL	**99**	**42**	**141**	**0**

KERN HEALTH SYSTEMS
1st Quarter 2021
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

ANCILLARY	Providers Credentialed	Providers Recredentialed	Providers Sent to PAC	Providers Not Approved
Ambulance	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	1	1	2	0
Hearing Aid Dispenser	0	0	0	0
Home Health	2	0	2	0
Home Infusion/Compounding	0	0	0	0
Hospice	0	1	1	0
Hospital	1	1	2	0
Laboratory	0	1	1	0
Lactation Consultant	0	0	0	0
MRI	0	0	0	0
Ocular Prosthetics	0	0	0	0
Pharmacy	1	2	3	0
Pharmacy/DME	0	1	1	0
Physical / Speech Therapy	0	0	0	0
Prosthetics & Orthotics	0	0	0	0
Radiology	0	0	0	0
Skilled Nursing	1	1	2	0
Sleep Lab	0	0	0	0
Surgery Center	0	0	0	0
Transportation	0	1	1	0
Urgent Care	1	2	3	0
TOTAL	**7**	**11**	**18**	**0**

Defer = 0 **Denied = 0**

KERN HEALTH SYSTEMS
1st Quarter 2021
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

KERN HEALTH SYSTEMS
1st Quarter 2021
CREDENTIALING / RECREDENTIALING SUMMARY REPORT

Kern Health Systems
Board Approved Effective 03/01/21

NAME	LEGAL NAME/ADDRESS	Provider #	Group #	SPECIALTY	CONTRACT STATUS	effective date
Access Specialty Pharmacy	SG Pharma Inc. **dba:** Access Specialty Pharmacy 5555 Business Park S Ste 230 Bakersfield CA 93309 P - 661-489-3500 F - 661-489-3553	PRV067228	PRV067228	Specialty Pharmacy	New Contract	Yes Eff 3/1/21
Hollywood Presbyterian Medical Center	CHA Hollywood Medical Center, LP **dba:** Hollywood Presbyterian Medical Center 1300 N Vermont Avenue Los Angeles CA 90027 P - 213-413-3000 F - 323-660-7952	PRV006329	PRV006329	Tertiary / Acute General Hospital	New Contract	Yes Eff 3/1/21
Kohn, Roger MD	Roger Kohn MD Inc **dba:** Roger Kohn, MD 2920 F Street Ste. C-17 Bakersfield CA 93301 P - 661-322-5435 F - 661-322-4304	PRV038106	PRV067252	Ophthalmology	New Contract	Yes Eff 3/1/21
~~Life Care Home Health~~ Changed dba to: Aasta Home Health	Montebello Home Health Care, Inc. dba: Aasta Home Health 2920 F Street, Ste. I-10 Bakersfield CA 93301 P-661-523-3686 F - 661-523-3746	PRV065175	PRV065175	Home Health	New Contract	Yes Eff 3/1/21
Oak Fence Senior Living, LLC	Oak Fence Senior Living, LLC **dba:** Oak Fence CLHF 6067 Oak Fence Lane Lancaster CA 93536 P - 661-270-2140 F - 661-464-3919	PRV029454	PRV029454	SNF/Congregate Living Facility	New Contract	Yes Eff 3/1/21
Pacific Coast Home Health Services, LLC.	JB & MM Consulting Services, LLC. **dba:** Pacific Coast Home Health Services, LLC. 800 S Victory Blvd Ste. 205 Burbank CA 91502 P - 818-748-3348 F - 818-748-3343	PRV067240	PRV067240	Home Health	New Contract	Yes Eff 3/1/21
Punsalan, Lorelei NP-C	Jey Neuro Center, Inc **dba:** Valley Neurology Group 3400 Calloway Drive Ste. 100 Bakersfield CA 93312 P - 661-776-3876 F - 661-766-3876	PRV011569	PRV067227	Neurology	New Contract	Yes Eff 3/1/21

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Ravi, Vinutha MD	Jey Neuro Center, Inc **dba:** Valley Neurology Group 3400 Calloway Drive Ste. 100 Bakersfield CA 93312 P - 661-776-3876 F - 661-766-3876	PRV006735	PRV067227	Neurology	New Contract	Yes Eff 3/1/21
Vallejo, Kassie LMFT	WeCare Psychology Group Inc. 1430 Truxtun Ave 5th Floor Bakersfield CA 93301 P - 661-262-3335 F - 661-616-1301	PRV067242	PRV067241	Marriage Family Therapy	New Contract	Yes Eff 3/1/21
Wick, Jeffrey MD	Jeffrey S. Wick, MD BHH Center for Wound Healing 3012 Sillect Avenue, Ste. B Bakersfield CA 93308 P- 661-664-0200 F - 661-634-0226	PRV033984	PRV033984	PMR / Wound Care Certified	New Contract	Yes Eff 3/1/21
Maliro, Tennyson MD	Renaissance Imaging Medical Assoc., Inc. 44105 W 15th St Ste 100 Lancaster 38925 Trade Center Dr Ste E Palmdale	PRV063565	PRV000324	Diagnostic Radiology	Existing	Yes Eff 3/1/21
Banihashemi, Behrooz MD	Dignity Health Medical Foundation 420 34th St; 2215 Truxtun & 420 Old River Bakersfield CA	PRV029899	PRV012886	Internal Medicine / Hospitalist	Existing	Yes Eff 3/1/21
Barnett, Selina PhD	Omni Family Health 912 Fremont Street Delano CA 93215	PRV050087	PRV0000019	Psychology	Existing	Yes Eff 3/1/21
Bulgarelli, Cody PA-C	Kern Valley Healthcare District 4300 Birch Street Lake Isabella CA 93240	PRV067229	PRV046034	Family Practice	Existing	Yes Eff 3/1/21
Burns, Nicholas BCBA	Special Explorers Center 401 19th Street Bakersfield CA 93301	PRV067239	PRV047660 PRV038625 PRV045393	Qualified Autism Provider / Behavioral Analyst	Existing	Yes Eff 3/1/21
Caprioli, Pamela NP	SJV Medical Group 5801 Truxtun Avenue Bakersfield CA 93309	PRV006640	PRV066164	Internal Medicine	Existing	Yes Eff 3/1/21
Desai, Dipali NP-C	Carlos A. Alvarez, MD Inc. 8929 Panama Road Ste. A Lamont CA 801 Santa Fe Way Shafter CA	PRV066990	PRV030784 PRV055424	Family Practice	Existing	Yes Eff 3/1/21
Dhillon, Amandeep NP-C	1st Choice Urgent Care *All Locations 6515 Panama Lane Ste. 106-107 Bakersfield CA 93313	PRV067231	PRV042402	Family Practice	Existing	Yes Eff 3/1/21
Dusol, Maurice MD	Ridgecrest Regional Hospital 1041 N China Lake Blvd Ste. B 1081 N China Lake Blvd Ridgecrest CA 93555	PRV029442	PRV000279 PRV029495 PRV030085	Gastroenterology	Existing	Yes Eff 3/1/21

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Fox, Mallory PA-C	Accelerated Urgent Care *All Locations 212 Coffee Road Bakersfield CA 93309	PRV067230	ALL SITES	Family Practice	Existing	Yes Eff 3/1/21
Garcia, Nelson MD	Clinica Sierra Vista (CSV) 2000 Physicians Blvd Bakersfield CA 93301	PRV063401	PRV0000002	Internal Medicine / Infectious Disease	Existing	Yes Eff 3/1/21
Gonzalez, Araselia NP-C	Reedley Community Hospital 406 James Street Shafter CA 93263 1040 7th Street Wasco CA 93280	PRV066097	PRV036581	Family Practice	Existing	Yes Eff 3/1/21
Hantman, David MD	Bartz-Altadonna Community Health Center 9300 N. Loop Blvd California City CA 93505	PRV066543	PRV029961	Internal Medicine	Existing	Yes Eff 3/1/21
Hasan, Nosheen MD	Dignity Health Medical Foundation 420 34th St; 2215 Truxtun & 420 Old River Bakersfield CA	PRV044374	PRV012886	Internal Medicine / Hospitalist	Existing	Yes Eff 3/1/21
Hostetter, Jamie BCBA	Special Explorers Center 401 19th Street Bakersfield CA 93301	PRV067243	PRV047660 PRV038625 PRV045393	Qualified Autism Provider / Behavioral Analyst	Existing	Yes Eff 3/1/21
Huang, Man-Li NP-C	LAGS Spine & Sportscare Medical Ctrs, Inc. 3550 Q Street Ste. 103-105,201,202 Bakersfield CA 93301	PRV067238	PRV000403	Physical Medicine & Rehab / Pain Medicine	Existing	Yes Eff 3/1/21
Kavipurapu, Kiran DO	Kern County Hospital Authority 1111 Columbus Street 1700 Mt Vernon Avenue Bakersfield CA	PRV033629	ALL SITES	OB/GYN	Existing	Yes Eff 3/1/21
Kelley, Judy NP	Accelerated Urgent Care *All Locations 212 Coffee Road Bakersfield CA 93309	PRV066583	ALL SITES	Family Practice	Existing	Yes Eff 3/1/21
Komar, Kristina NP-C	Reedley Community Hospital 406 James Street Shafter CA 93263 1040 7th Street Wasco CA 93280	PRV050536	PRV036581	Family Practice	Existing	Yes Eff 3/1/21
Lavarreda, Charise NP-C	Ridgecrest Regional Hospital 1081 N China Lake Blvd Ridgecrest CA 93555	PRV065730	PRV000279 PRV029495	General Surgery	Existing	Yes Eff 3/1/21
Lee, Benson DO	Kern County Hospital Authority 1111 Columbus Street 1700 Mt Vernon Avenue Bakersfield CA	PRV032719	ALL SITES	Internal Medicine	Existing	Yes Eff 3/1/21
London, Sean MD	Renaissance Imaging Medical Assoc., Inc. 44105 W 15th St Ste 100 Lancaster 38925 Trade Center Dr Ste E Palmdale	PRV065124	PRV000324	Diagnostic Radiology	Existing	Yes Eff 3/1/21

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Magnuson, Deborah NP-C	Ridgecrest Regional Hospital 1111 N China Lake Blvd Ste. 190 1081 N China Lake Blvd Ridgecrest CA 93555	PRV066446	PRV000279 PRV029495	Pediatrics	Existing	Yes Eff 3/1/21
Mangat, Gagandeep MD	Renaissance Imaging Medical Assoc., Inc. 44105 W 15th St Ste 100 Lancaster 38925 Trade Center Dr Ste E Palmdale	PRV066013	PRV000324	Diagnostic Radiology	Existing	Yes Eff 3/1/21
Mangat, Geeteshwar MD	Dignity Health Medical Foundation 420 34th St; 2215 Truxtun & 420 Old River Bakersfield CA	PRV012241	PRV012886	Internal Medicine / Hospitalist	Existing	Yes Eff 3/1/21
McCann, Amy MD	Renaissance Imaging Medical Assoc., Inc. 44105 W 15th St Ste 100 Lancaster 38925 Trade Center Dr Ste E Palmdale	PRV065012	PRV000324	Diagnostic Radiology	Existing	Yes Eff 3/1/21
McMonigle, Edward MD	Renaissance Imaging Medical Assoc., Inc. 44105 W 15th St Ste 100 Lancaster 38925 Trade Center Dr Ste E Palmdale	PRV004431	PRV000324	Diagnostic Radiology	Existing	Yes Eff 3/1/21
Muniz, Oscar BCBA	California Psychcare, Inc. 624 Commerce Drive Unit E Palmdale CA 93551	PRV067184	PRV011225	Qualified Autism Provider / Behavioral Analyst	Existing	Yes Eff 3/1/21
Murphy, Kathleen PhD	Telehealthdocs Medical Corporation *All Locations 2215 Truxtun Avenue Ste. 100 Bakersfield CA 93301	PRV037518	PRV036952 PRV053624 PRV053625	Psychology	Existing	Yes Eff 3/1/21
Murugesan, Chezhiyan MD	Kern County Hospital Authority 1700 Mt Vernon Avenue Bakersfield CA 93306	PRV065725	ALL SITES	Pediatrics / Hospitalist	Existing	Yes Eff 3/1/21
Nabhani, Jamal MD	Ridgecrest Regional Hospital 105 E Sydnor Avenue Ste. 100 1111 N China Lake Blvd Ste. 190 1081 N China Lake Blvd Ridgecrest CA 93555	PRV052637	PRV000279 PRV029495	Urology	Existing	Yes Eff 3/1/21
Nagin, Usha MD	Dignity Health Medical Foundation 420 34th St; 2215 Truxtun & 420 Old River Bakersfield CA	PRV058433	PRV012886	Internal Medicine / Hospitalist	Existing	Yes Eff 3/1/21
Nelson, Lee MD	Accelerated Urgent Care *All Locations 212 Coffee Road Bakersfield CA 93309	PRV035371	ALL SITES	Emergency Medicine	Existing	Yes Eff 3/1/21
Parker, Laurie NP	Adventist Health Medical Center Tehachapi 2041 Belshaw Street Mojave CA 93501 9350 N. Loop Blvd Cal City CA 93505	PRV008940	ALL SITES	Internal Medicine	Existing	Yes Eff 3/1/21
Pat, Verenice NP-C	Clinica Sierra Vista (CSV) 425 Del Sol Parkway *Walk-In Delano CA 93215	PRV065724	PRV000002	Family Practice	Existing	Yes Eff 3/1/21
Patel, Ravi PA-C	Pain Institute of California, Inc 9802 Stockdale Highway Ste. 105 Bakersfield CA 93311	PRV066740	PRV000510	Pain Medicine	Existing	Yes Eff 3/1/21

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Pedi Center Urgent Care	Universal Urgent Care and Occupational Medicine, Inc. 9900 Stockdale Hwy Ste. 105 Bakersfield CA 93311	PRV066195	PRV066195	Urgent Care	Existing	Yes Eff 1/16/21
Perez, Leslie Ann NP-C	Priority Urgent Care 4821 Panama Lane Ste. A-C Bakersfield CA 93313	PRV039195	PRV038192	Family Practice	Existing	Yes Eff 3/1/21
Perez, Norely BCBA	Holdsambeck & Associates, Inc. 2535 16th Street Ste. 215 & 210 Bakersfield CA 93301	PRV067253	PRV031922	Qualified Autism Provider / Behavioral Analyst	Existing	Yes Eff 3/1/21
Puskoor, Akhildeep MD	Dignity Health Medical Foundation 420 34th St; 2215 Truxtun & 420 Old River Bakersfield CA	PRV048280	PRV012886	Internal Medicine / Hospitalist	Existing	Yes Eff 3/1/21
Ramos, Marie NP-C	Priority Urgent Care 4821 Panama Lane Ste. A-C Bakersfield CA 93313	PRV001608	PRV038192	Emergency Medicine	Existing	Yes Eff 3/1/21
Ranganathan, Sudha	Kern County Hospital Authority 1111 Columbus Street 9330 Stockdale Highway Ste. 400 9300 Stockdale Highway Ste. 100 & 300 1700 Mt Vernon Avenue Bakersfield CA	PRV065721	ALL SITES	Family Practice	Existing	Yes Eff 3/1/21
Rodriguez, Lorene MD	Accelerated Urgent Care *All Locations 212 Coffee Road Bakersfield CA 93309	PRV042434	ALL SITES	Family Practice	Existing	Yes Eff 3/1/21
Sachdeva, Meenakshi MD (CURRENTLY NPAR)	Dignity Health Medical Foundation 420 34th St; 2215 Truxtun & 420 Old River Bakersfield CA	PRV001787	PRV012886	Internal Medicine / Hospitalist	Existing	Yes Eff 3/1/21
Sanchez, Amalia LCSW	Omni Family Health 1451 White Lane Bakersfield CA 4600 Panama Ln Ste. 102B Bakersfield CA 912 Fremont Street Delano CA	PRV066741	PRV0000019	Clinical Social Worker	Existing	Yes Eff 3/1/21
Shah, Farhan MD	Dignity Health Medical Foundation 420 34th St; 2215 Truxtun & 420 Old River Bakersfield CA	PRV001425	PRV012886	Internal Medicine / Hospitalist	Existing	Yes Eff 3/1/21
Shaw, Peter MD	Sendas Northwest Urgent Care 9450 Ming Avenue Bakersfield CA 93311	PRV044223	PRV005648	Family Practice	Existing	Yes Eff 3/1/21
Sidhu, Ritam MD	Dignity Health Medical Foundation 420 34th St; 2215 Truxtun & 420 Old River Bakersfield CA	PRV044126	PRV012886	Internal Medicine / Hospitalist	Existing	Yes Eff 3/1/21
Sohrabi, Homayoun MD	Accelerated Urgent Care *All Locations 212 Coffee Road Bakersfield CA 93309	PRV001756	ALL SITES	Family Practice	Existing	Yes Eff 3/1/21

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Suraweera, Duminda MD	Adventist Health Medical Center Tehachapi 105 West E Street Tehachapi CA 93561	PRV065951	ALL SITES	Gastroenterology	Existing	**Yes** **Eff 3/1/21**
Syed, Javed MD	Kern Radiology Medical Group, Inc. *All Locations 2301 Bahamas Drive Bakersfield CA 93309	PRV000949	ALL SITES	Diagnostic Radiology	Existing	**Yes** **Eff 3/1/21**
Thomas, Katherine MD	Dignity Health Medical Foundation 420 34th St; 2215 Truxtun & 420 Old River Bakersfield CA	PRV035691	PRV012886	Internal Medicine / Hospitalist	Existing	**Yes** **Eff 3/1/21**
Verduzco, Monica NP-C	Adventist Health Delano 1201 Jefferson Street Delano CA 93215 2300 7th Street Wasco CA 93280	PRV065726	PRV000190 PRV005653 PRV005640	General Practice	Existing	**Yes** **Eff 3/1/21**

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	NAME	LEGAL NAME/ADDRESS	PROVIDER #	GROUP #	SPECIALTY	CONTRACT STATUS	PAC APPROVED - EFFECTIVE DATE
1	Amajoyi, Barbara NP	Heart Wellness Clinic Inc 1701 Westwind Drive Ste. 215 Bakersfield CA 93301 P - 909-755-5166 F - 909-755-5166	PRV067928	PRV048963	Family Practice	New Contract	Yes Eff 4/1/21
2	Tyson, Brian MD	Heart Wellness Clinic Inc 1701 Westwind Drive Ste. 215 Bakersfield CA 93301 P - 909-755-5166 F - 909-755-5166	PRV048962	PRV048963	Family Practice	New Contract	Yes Eff 4/1/21
3	Pacific Medical, Inc	Pacific Medical, Inc. 1909 16th Street, Ste. 1 Bakersfield CA 93301 P - 661-381-6552 F - 661-885-7994	PRV006490	PRV006490	DME	New Contract	Yes Eff 4/1/21
4	Penuelas, Antonio BCBA	Adelante Behavioral Health ABA LLC 2005 Eye Street Ste. 8 Bakersfield CA 93301 P - 559-759-5060 F - 661-579-1536	PRV067935	PRV067923	Qualified Autism Provider / Behavioral Analyst	New Contract	Yes Eff 4/1/21
5	Russell, Sudha MD	Universal Urgent Care and Occupational Medicine, Inc. dba: Pedi Center Urgent Care 9900 Stockdale Hwy Ste. 105 Bakersfield CA 93311	PRV002719	PRV066195	Pediatrics	Existing	Yes Eff 4/1/21
6	Amin, Amar MD	Renaissance Imaging Medical Assoc., Inc. 44105 W 15th St Ste 100 Lancaster 38925 Trade Center Dr Ste E (661)726-6050 (661)949-5759	PRV033496	PRV000324	Diagnostic Radiology	Existing	Yes Eff 4/1/21
7	Bajaj, Tushar MD	Kern County Hospital Authority 1111 Columbus Street Bakersfield CA 93305	PRV048251	ALL SITES	Internal Medicine	Existing	Yes Eff 4/1/21
8	Bajwa, Rajwinder NP-C	Kern Rural Wellness Center, Inc 146 N. Hill Street Arvin CA 93203	PRV043134	PRV000264	Family Practice	Existing	Yes Eff 4/1/21
9	Blake, Meghan MD	Renaissance Imaging Medical Assoc., Inc. 44105 W 15th St Ste 100 Lancaster 38925 Trade Center Dr Ste E Palmdale	PRV002730	PRV000324	Diagnostic Radiology	Existing	Yes Eff 4/1/21
10	Buckner, Christina PsyD	Omni Family Health 210 N Chester Avenue Bakersfield CA 93308	PRV0067463	PRV000019	Psychology	Existing	Yes Eff 4/1/21
11	Burcovschii, Serghei MD	Kern County Hospital Authority 1111 Columbus Street Bakersfield CA 93305	PRV050641	ALL SITES	Internal Medicine	Existing	Yes Eff 4/1/21

12	Campeas, Susan MD	Renaissance Imaging Medical Assoc., Inc. 44105 W 15th St Ste 100 Lancaster 38925 Trade Center Dr Ste E Palmdale	PRV065156	PRV000324	Diagnostic Radiology	Existing	**Yes** **Eff 4/1/21**
13	Cassaro, Sebastiano MD	Infustion & Clinical Services (PVMG) 5401 White Lange Bakersfield CA 93309	PRV038063	PRV000404	General Surgery	Existing	**Yes** **Eff 4/1/21**
14	Chao, Tzyy MD	Renaissance Imaging Medical Assoc., Inc. 44105 W 15th St Ste 100 Lancaster 38925 Trade Center Dr Ste E Palmdale	PRV063941	PRV000324	Diagnostic Radiology	Existing	**Yes** **Eff 4/1/21**
15	Coleman, Jeffrey MD	Dignity Health Medical Foundation 420 34th St; 2215 Truxtun & 420 Old River Bakersfield CA	PRV042241	PRV012886	Internal Medicine / Hospitalist	Existing	**Yes** **Eff 4/1/21**
16	Contarino, Trisha PsyD	Omni Family Health 210 N Chester Avenue Bakersfield CA 93308	PRV067462	PRV000019	Psychology	Existing	**Yes** **Eff 4/1/21**
17	Davalos, Veronica LCSW	Adventist Health Medical Center Tehachapi 105 West E Street Tehachapi CA 2041 Belshaw Street Mojave CA 93501 9350 N. Loop Blvd Cal City CA 93505	PRV067608	PRV038190 PRV038189 PRV038187 PRV038186	Clinical Social Worker	Existing	**Yes** **Eff 4/1/21**
18	Dierksheide, Julie MD	Kern County Hospital Authority 1700 Mt Vernon Avenue Bakersfield CA 93306	PRV051214	ALL SITES	General Surgery	Existing	**Yes** **Eff 4/1/21**
19	Entezari, Pegah MD	Renaissance Imaging Medical Assoc., Inc. 44105 W 15th St Ste 100 Lancaster 38925 Trade Center Dr Ste E Palmdale	PRV061346	PRV000324	Diagnostic Radiology	Existing	**Yes** **Eff 4/1/21**
20	Eshaghpour, Sharon LCSW	Adventist Health Medical Center Tehachapi 105 West E Street Tehachapi CA 2041 Belshaw Street Mojave CA 93501 9350 N. Loop Blvd Cal City CA 93505	PRV040603	PRV038190 PRV038189 PRV038187 PRV038186	Clinical Social Worker	Existing	**Yes** **Eff 4/1/21**
21	Govea, Christopher MD	Renaissance Imaging Medical Assoc., Inc. 44105 W 15th St Ste 100 Lancaster 38925 Trade Center Dr Ste E Palmdale	PRV007335	PRV000324	Diagnostic Radiology	Existing	**Yes** **Eff 4/1/21**
22	Gutierrez, Edith LCSW	Omni Family Health 659 S Central Valley Highway Shafter CA 93263	PRV067460	PRV000019	Clinical Social Worker	Existing	**Yes** **Eff 4/1/21**
23	Hannon, Matthew MD	Kern County Hospital Authority 1700 Mt Vernon Avenue Bakersfield CA 93306	PRV047117	ALL SITES	General Surgery / Surgical Critical Care	Existing	**Yes** **Eff 4/1/21**
24	Lien, Andrew BCBA	Shih Applied Behavior Analysis 8723 Winlock Street Bakersfield CA 93312	PRV067933	PRV052861	Qualified Autism Provider / Behavioral Analyst	Existing	**Yes** **Eff 4/1/21**
25	Matthews, Carol PsyD	Valley Psychological Group 2100 E Street Bakersfield CA 93301	PRV067932	PRV012902	Psychology	Existing	**Yes** **Eff 4/1/21**
26	McLemore, Christine DO	Omni Family Health 161 N. Mill Street Tehachapi CA 93561	PRV067789	PRV000019	Family Practice	Existing	**Yes** **Eff 4/1/21**

27	Patel, Anik DO	Renaissance Imaging Medical Assoc., Inc. 44105 W 15th St Ste 100 Lancaster 38925 Trade Center Dr Ste E Palmdale	PRV064266	PRV000324	Diagnostic Radiology	Existing	**Yes** **Eff 4/1/21**
28	Rodriguez, Mayra LCSW	Omni Family Health 912 Fremont Street Delano CA 1215 Jefferson Street Delano CA 1530 E Manning Ave Reedley CA 311 W Noble Avenue Visalia CA	PRV067461	PRV000019	Clinical Social Worker	Existing	**Yes** **Eff 4/1/21**
29	Stewart, Sarde BCBA	Shih Applied Behavior Analysis 8723 Winlock Street Bakersfield CA 93312	PRV067934	PRV052861	Qualified Autism Provider / Behavioral Analyst	Existing	**Yes** **Eff 4/1/21**
30	Tirado, Olivia PA-C	Kern County Hospital Authority 1700 Mt Vernon Avenue Bakersfield CA 93306	PRV052246	ALL SITES	General Surgery	Existing	**Yes** **Eff 4/1/21**

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NAME	LEGAL NAME/ADDRESS	PROVIDER PRV	GROUP PRV	SPECIALTY	CONTRACT STATUS	PAC APPROVED - EFFECTIVE DATE
Aasta Hospice	Kern Hospice Care, Inc. dba: Aasta Hospice 2920 F Street Bakersfield CA 93306 Phone -661-523-3686 Fax - 661-523-3746	**PRV066303**	**PRV066303**	Hospice & Palliative Care	**New Contract**	**Yes** **Eff 5/1/21**
Bakersfield Community Health Center, Inc.	Bakersfield Community Health Center, Inc. 1801 Oak Street Bakersfield CA 93301 Phone - 661-327-9800 Fax - 661-327-9810	**PRV068672**	**PRV068672**	Comm. Based Adult Services (CBAS)	**New Contract**	**Yes** **Eff 5/1/21**
C-TON Laboratory	CTON Corporation 3870 Del Amo Blvd Ste 504 Torrance CA C-TON Laboratory (Draw Station) 2920 H Street Ste. 129 Bakersfield CA Phone - 562-945-1220 Fax - 562-945-6166	**PRV043749**	**PRV043749**	Lab - Torrance CA Draw Station - Local	**New Contract**	**Yes** **Eff 5/1/21**
Central Valley Surgical Center	Central Valley Surgical Center, LLC 2120 19th Street Bakersfield CA 93301 Phone - 661-748-1905 Fax - 661-748-1905	**PRV063338**	**PRV063338**	Ambulatory Surgery Center	**New Contract**	**Yes** **Eff 5/1/21**
Muwanga, Mesha LCSW	Rhema Marriage, Family, & Child Therapy Inc 1039 17th Street Bakersfield CA 93301 Phone - 661-404-5181 Fax - 661-404-5375	**PRV063913**	**PRV068326**	Clinical Social Worker	**New Contract**	**Yes** **Eff 5/1/21**
Srivastava, Karan MD	Karan Srivastava, M.D. 432 Lexington Street, Ste. C Delano CA 93215 Phone - 661-544-3352 Fax - 661-544-3432 9610 Stockdale Hwy. Ste. C 93311 P) 661-544-3352 / F) 661-544-3432 3008 Sillect Avenue, Ste. 120 93308 P) 661-544-3352 / F) 661-544-3432	**PRV068582**	**PRV068582**	Orthopedic Surgery	**New Contract**	**Yes** **Eff 5/1/21**
Stone, Bruce DO	Bruce C. Stone dba: Bruce C Stone DO 9500 Stockdale Hwy Ste. 109 Bakersfield CA 93311 Phone - 661-664-4456 Fax - 661-664-4458	**PRV006461**	**PRV006461**	Urology	**New Contract**	**Yes** **Eff 5/1/21**
Tonsekar, Kishore MD	Ridgecrest Regional Hospital - RHC 1041 N China Lake Blvd Ste. B Ridgecrest CA 93555	PRV031441	ALL SITES	General Surgery	Existing	**Yes** **Eff 5/1/21**

Allwein, Alex MD	Ridgecrest Regional Hospital - RHC 1111 N China Lake Blvd Ste. 190 Ridgecrest CA 93555	PRV040193	ALL SITES	General Practice	Existing	**Yes** **Eff 5/1/21**
Bilkhu, Gurtejbir DO	Ridgecrest Regional Hospital - RHC 1111 N China Lake Blvd Ste. 190 Ridgecrest CA 93555	PRV062338	ALL SITES	General Practice	Existing	**Yes** **Eff 5/1/21**
Carter, Scott MD	Ridgecrest Regional Hospital - RHC 1111 N China Lake Blvd Ste. 190 Ridgecrest CA 93555	PRV046375	ALL SITES	Family Practice	Existing	**Yes** **Eff 5/1/21**
Chang, Geraldine MD	Renaissance Imaging Medical Assoc., Inc. 44105 W 15th St Ste 100 Lancaster 38925 Trade Center Dr Ste E Palmdale	PRV039739	PRV000324	Diagnostic Radiology	Existing	**Yes** **Eff 5/1/21**
Chardavoyne, John MD	Bright Heart Health Medical Group 2960 Camino Diablo Ste. 105 Walnut Creek CA 94597	PRV068614	PRV061628	Psychiatry	Existing	**Yes** **Eff 5/1/21**
Chin, Jeremy MD	Renaissance Imaging Medical Assoc., Inc. 44105 W 15th St Ste 100 Lancaster 38925 Trade Center Dr Ste E Palmdale	PRV064136	PRV000324	Diagnostic Radiology	Existing	**Yes** **Eff 5/1/21**
Cho, Anthony MD	Ridgecrest Regional Hospital - RHC 1111 N China Lake Blvd Ste. 190 Ridgecrest CA 93555	PRV0632463	ALL SITES	General Practice	Existing	**Yes** **Eff 5/1/21**
Coffey, Mehgan NP	Kern County Hospital Authority 1111 Columbus Street Bakersfield CA 93305	PRV067601	ALL SITES	Family Practice	Existing	**Yes** **Eff 5/1/21**
Crapo, Stephanie MD	Ridgecrest Regional Hospital - RHC 1111 N China Lake Blvd Ste. 190 Ridgecrest CA 93555	PRV054540	ALL SITES	General Practice	Existing	**Yes** **Eff 5/1/21**
Dalal, Sunit MD	Ridgecrest Regional Hospital - RHC 1111 N China Lake Blvd Ste. 190 Ridgecrest CA 93555	PRV055938	ALL SITES	General Practice	Existing	**Yes** **Eff 5/1/21**
Diaz, Carmelo PA-C	Richard Alexan-Shirabad, MD Inc 4900 Commerce Drive Bakersfield CA 93309	PRV065346	PRV000425	Neurology	Existing	**Yes** **Eff 5/1/21**
Escobar, Tonya NP	Bright Heart Health Medical Group 2960 Camino Diablo Ste. 105 Walnut Creek CA 94597	PRV068552	PRV061628	Psychiatry	Existing	**Yes** **Eff 5/1/21**
Felix, Veronica BCBA	Behavior Frontiers, LLC 5060 California Avenue Ste. 610 Bakersfield CA 93309	PRV068617	PRV046025	Qualified Autism Provider / Behavioral Analyst	Existing	**Yes** **Eff 5/1/21**
Flores-Lopez, Jose MD	Clinica Sierra Vista (CSV) 7800 Niles Street Bakersfield CA 93306	PRV067190	PRV000002	Psychiatry	Existing	**Yes** **Eff 5/1/21**
Frey, Eric MD	Ridgecrest Regional Hospital - RHC 1081 N China Lake Blvd 1041 N China Lake Blvd Ste. B Ridgecrest CA 93555	PRV034621	ALL SITES	Gastroenterology	Existing	**Yes** **Eff 5/1/21**
Gianella, Daniel MD	Renaissance Imaging Medical Assoc., Inc. 44105 W 15th St Ste 100 Lancaster 38925 Trade Center Dr Ste E Palmdale	PRV051494	PRV000324	Diagnostic Radiology	Existing	**Yes** **Eff 5/1/21**
Greenfield, Paula MD	Renaissance Imaging Medical Assoc., Inc. 44105 W 15th St Ste 100 Lancaster 38925 Trade Center Dr Ste E Palmdale	PRV068673	PRV000324	Diagnostic Radiology	Existing	**Yes** **Eff 5/1/21**

Greenhill, Collin PA-C	Kern County Hospital Authority 1700 Mt Vernon Avenue Bakersfield CA 93306	PRV067910	ALL SITES	General Surgery	Existing	**Yes** **Eff 5/1/21**
Hanalla, Youssef MD	Ravi Patel, MD Inc. Comprehensive Blood & Cancer Center 6501 Truxtun Avenue Bakersfield CA 93309	PRV068570	PRV013881	Radiation Oncology	Existing	**Yes** **Eff 5/1/21**
Havistin, Ruby MD	Ridgecrest Regional Hospital - RHC 1081 N China Lake Blvd 1111 N China Lake Blvd Ste. 190 Ridgecrest CA 93555	PRV067583	ALL SITES	Cardiovascular Disease	Existing	**Yes** **Eff 5/1/21**
Hecht, Stephen MD	Kern Radiology Medical Group, Inc. 2301 Bahamas Drive 3838 San Dimas Street Ste. A-120 Bakersfield CA	PRV066993	ALL SITES	Diagnostic Radiology	Existing	**Yes** **Eff 5/1/21**
Lai, Mai MD	Ridgecrest Regional Hospital - RHC 1111 N China Lake Blvd Ste. 190 Ridgecrest CA 93555	PRV032956	ALL SITES	General Practice	Existing	**Yes** **Eff 5/1/21**
Mateo, Ana BCBA	Shih Applied Behavior Analysis 8723 Winlock Street Bakersfield CA 93312	PRV068615	PRV052861	Qualified Autism Provider / Behavioral Analyst	Existing	**Yes** **Eff 5/1/21**
Mitchell, June LCSW	Omni Family Health 4151 Mexicali Drive Bakersfield CA 93313	PRV067464	PRV000019	Clinical Social Worker	Existing	**Yes** **Eff 5/1/21**
Moreno, Jamie BCBA	Center for Autism and Related Disorders 6601 McDivitt Drive Bakersfield CA 93313	NEW	PRV032083	Qualified Autism Provider / Behavioral Analyst	Existing	**Yes** **Eff 5/1/21**
Obando-Cabrejo, Natalia NP-C	Centric Health 2901 Sillect Avenue Ste. 100 Bakersfield CA 93308	PRV061109	PRV000503	Cardiovascular Disease	Existing	**Yes** **Eff 5/1/21**
Olango, Garth MD	Kern County Hospital Authority 1700 Mt Vernon Avenue Bakersfield CA 93306	PRV003977	ALL SITES	Psychiatry / Child Psychiatry	Existing	**Yes** **Eff 5/1/21**
Parada, Jacquelin NP-C	Clinica Sierra Vista (CSV) 7800 Niles Street Bakersfield CA 93306	PRV067041	PRV000002	Psychiatry	Existing	**Yes** **Eff 5/1/21**
Pham, Quy NP-C	Omni Family Health 210 N Chester Avenue Bakersfield CA 93308	PRV067911	PRV000019	Psychiatry	Existing	**Yes** **Eff 5/1/21**
Posey, Jennifer BCBA	Holdsambeck & Associates, Inc. 2535 16th Street Ste. 215 & 210 Bakersfield CA 93301	PRV0668618	PRV031922	Qualified Autism Provider / Behavioral Analyst	Existing	**Yes** **Eff 5/1/21**
Ray, Janice NP-C	Kern County Hospital Authority 1111 Columbus Street Bakersfield CA 93305	PRV001981	ALL SITES	Pediatrics	Existing	**Yes** **Eff 5/1/21**
Rivera, Alexander PA-C	Priority Urgent Care 4821 Panama Lane Ste. A-C Bakersfield CA 93313	PRV049287	PRV038192	General Practice	Existing	**Yes** **Eff 5/1/21**
Sein, Julia MD	California Retina Consultants 5555 Business Park S Ste. 100 Bakersfield CA 93309	PRV065352	PRV000243	Ophthalmology	Existing	**Yes** **Eff 5/1/21**

Starkweather, Chelsea PA-C	Priority Urgent Care 4821 Panama Lane Ste. A-C Bakersfield CA 93313	PRV009962	PRV038192	General Practice	Existing	**Yes** **Eff 5/1/21**
Tolliver, Adrianne NP	Sumeet Bhinder, MD, Inc. 6001-A Truxtun Avenue Ste. 160 Bakersfield CA 93309	PRV040927	PRV000285	Rheumatology	Existing	**Yes** **Eff 5/1/21**
Trask, Chelsea PA-C	Ridgecrest Regional Hospital - RHC 105 E Sydnor Avenue Ste. 100 1111 N China Lake Blvd Ste. 190 1081 N China Lake Blvd Ridgecrest CA 93555	PRV058283	ALL SITES	Family Practice & Dermatology	Existing	**Yes** **Eff 5/1/21**
Woolf, Anthony MD	Ridgecrest Regional Hospital - RHC 1111 N China Lake Blvd Ste. 190 Ridgecrest CA 93555	PRV061339	ALL SITES	General Practice	Existing	**Yes** **Eff 5/1/21**

Kern Health Systems
Board Approved Effective 03/01/21

Legal Name DBA	Specialty	Vendor #	Address	Contract Effective Date
CHA Hollywood Medical Center, LP dba: Hollywood Presbyterian Medical Center	Tertiary / Acute General Hospital	PRV006329	1300 N Vermont Avenue Los Angeles CA 90027 P - 213-413-3000 F - 323-660-7952	3/1/2021
JB & MM Consulting Services, LLC. dba: Pacific Coast Home Health Services, LLC.	Home Health	PRV0067240	800 S Victory Blvd Ste. 205 Burbank CA 91502	3/1/2021
Jeffrey S. Wick, MD	Wound Care	PRV033984	3012 Sillect Ave Ste. B Bakersfield CA 93308	3/1/2021
Jey Neuro Center, Inc dba: Valley Neurology Group	Neurology	PRV067227	3400 Calloway Dr Ste. 100 Bakersfield CA 93309	3/1/2021
Montebello Home Health Care, Inc. **dba: Aasta Home Health**	Home Health	PRV065175	2920 F St, Ste. I-10 Bakersfield CA 93301	3/1/2021
Oak Fence Senior Living, LLC dba: Oak Fence CLHF	SNF/Congregate Living Facility	PRV029454	6067 Oak Fence Lane Lancaster CA 93536	3/1/2021
Roger Kohn MD, Inc.	Ophthalmology	PRV067252	2920 F St Ste. C-17 Bakersfield CA 93301	3/1/2021
SG Pharma Inc. dba: Access Specialty Pharmacy	Specialty Pharmacy	PRV067228	5555 Business Park S Ste. 230 Bakersfield CA 93309	3/1/2021
SJV Medical Group	PCP & Pulmonary Disease	PRV066164	3801 San Dimas St Bakersfield CA 93301	**Retro-Eff 1/1/2021**
Tim H. Nguyen dba: United Eye Care Optometry	Optometry *	PRV067251	6225 Colony St Bakersfield CA 93307 401 N. Central Ave Wasco CA 93280	3/1/2021
WeCare Psychology Group Inc.	Mental Health	PRV067241	1430 Truxtun Ave 5th Flr Bakersfield CA 93301	3/1/2021

Kern Health Systems
Board Approved Effective 04/01/21

Legal Name DBA	Specialty	Address	VENDOR #	Contract Effective Date
Adelante Behavioral Health ABA LLC	BH ABA	2005 Eye Street Ste 8 Bakersfield CA 93301 P - 559-759-5060 F - 661-579-1536	PRV067923	4/1/2021
Heart Wellness Clinic Inc.	PCP	1701 Westwind Dr Ste. 215 Bakersfield CA 93301 P - 909-582-0515 F - 909-755-5166	PRV048963	4/1/2021
James Holland Jr Licensed Clinical Social Worker Inc	Clinical Social Worker	4646 Wilson Rd Ste. 200 Bakersfield CA 93309	PRV052510	4/1/2021
Pacific Medical Inc	DME	1909 16th Street Ste 1 Bakersfield CA 93301 P- 661-381-6552 F - 661-885-7994	PRV006490	4/1/2021

Kern Health Systems
Board Approved Effective 05/01/21

Legal Name DBA	Specialty	Address	Vendor PRV #	Contract Effective Date
Kern Hospice Care, Inc. dba: Aasta Hospice	Hospice & Palliative Care	2920 F Street Bakersfield CA 93306	PRV066303	5/1/2021
Bakersfield Community Health Center, Inc.	Comm. Based Adult Services (CBAS)	1801 Oak Street Bakersfield CA 93301	PRV068672	5/1/2021
Bruce C Stone dba: Bruce C Stone DO	Urology	9500 Stockdale Hwy Ste. 109 Bakersfield CA 93311	PRV006461	5/1/2021
CTON Corporation dba: C-Ton Laboratory	Lab - Torrance CA Draw Station - Local	(Lab) 3870 Del Amo Blvd Ste 504 Torrance CA C-TON Laboratory (Draw Station) 2920 H Street Ste. 129 Bakersfield CA	PRV043749	5/1/2021
Central Valley Surgical Center, LLC	Ambulatory Surgery Center	2120 19th Street Bakersfield CA 93301	PRV063338	5/1/2021
Danny L. Huynh dba: Complete Urology Inc	Urology	~~2120 Truxtun Avenue~~ **New Address eff 4/12/2021** **9330 Stockdale Hwy Ste 500** **Bakersfield CA 93301** **Phone - 661-327-3638** **Fax - 661-327-2869**	PRV068395	5/1/2021
Emerald Family Medical Group Inc dba: Accelerated Family Medicine	Primary Care (PCP)	212 Coffee Road Bakersfield CA 93309 Phone - 661-885-6060 Fax - 661-829-6937	PRV062118	5/1/2021
Gevorgyan Medical Center, Inc	Primary Care (PCP)	3535 San Dimas Street Ste. 14 Bakersfield CA 93301	PRV001506	5/1/2021
Good Samaritan Hospital, LP dba: Good Samaritan Health Center Wasco	Primary Care (PCP) / RHC	1217 7th Street Wasco CA 93280 Phone - 661-758-5500 Fax - 661-758-5511	PRV068674	**Retro-Eff** **4/1/2021**
Ingram's Pharmacy, LLC	Pharmacy	1703 27th Street Bakersfield CA 93301 Phone - 661-864-7216 Fax - 661-843-7368	PRV052323	**Retro-Eff** **4/1/2021**
Karan Srivastava, M.D.	Orthopedic Surgery	432 Lexington Street, Ste. C Delano CA 93215	PRV068582	5/1/2021
Rhema Marriage, Family, & Child Therapy Inc	Clinical Social Worker	1039 17th Street Bakersfield CA 93301	PRV068326	5/1/2021
Sandeep S. Walia MD A Professional Corporation dba: West Coast Eye Institute	Ophthalmology	215 China Grade Loop Bakersfield CA 93308	PRV064010	5/1/2021

KERN HEALTH SYSTEMS

Provider Network Management
Network Review
Quarter 1, 2021

- **After-Hours Survey Report**
- **Appointment Availability Survey Report**
- **Access Grievance Review (Q4, 2020)**
- **Geographic Accessibility & Network Certification**
- **Network Adequacy & Provider Counts**
- **DHCS Quarterly Monitoring Report/Response Template (QMRT) (Q4, 2020)**
- **2020 Network Capacity Report**
- **Provider Satisfaction Survey Results (Calendar Year 2019)**

KERN HEALTH SYSTEMS

After-hours Calls

Quarter 1, 2021

AFTER-HOURS CALLS

Q1, 2021

KERN HEALTH SYSTEMS

Introduction

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

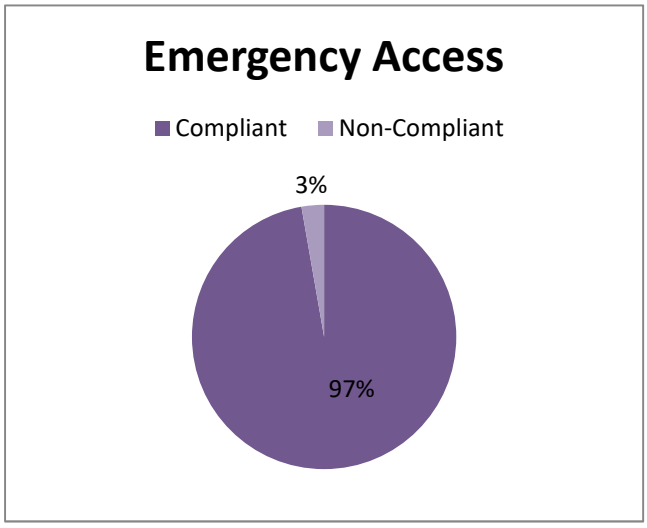
1.) Provider's answering machine or answering service must instruct the member to call 911 if the purpose of the call is a medical emergency.

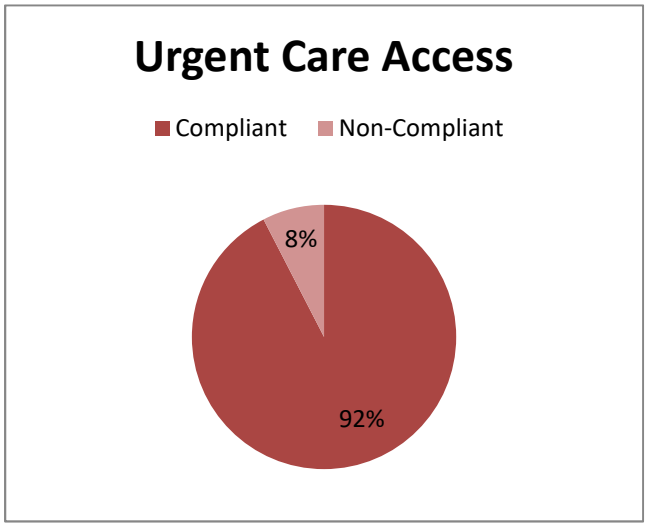
2.) For urgent matters, Provider's answering machine must provide an on-call number. If an answering service is used, the member must receive a call back from an on-call member of your office within 30 minutes of call.

An initial survey is conducted by Health Dialog and then forwarded to the Plan's Provider Network Analysts who make additional calls based on the results received from the survey vendor. Results are to be reported to the KHS QI/UM Committees and to Executive Staff.

Results

145 provider offices were contacted during Q1 2021. Of those offices, 141 were compliant with the Emergency Access Standards and 134 were compliant with the Urgent Care Access Standards.





AFTER-HOURS CALLS

Q1, 2021

Tracking, Trending, and Provider Outreach

The Plan utilizes the after-hours survey calls to monitor compliance at a network-wide level. The Plan found minimal change in compliance with the emergency and urgent care after-hours access standard when compared to prior quarters, with all percentages remaining at or above 90%.

Compliance with after-hours standard	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021
Emergency Access	98%	96%	96%	97%	94%	97%
Urgent Care Access	95%	93%	92%	90%	91%	92%

The Plan will continue to review results of provider groups against prior quarters. Due to the COVD-19 pandemic, the Plan temporarily suspended outreach based on non-compliant results to reduce administrative burden to provider offices. The Plan has resumed provider outreach and quarterly tracking/trending and will report as identified; at this time, the Plan has not identified any potential trends. The Plan is sending letters (template attached) to providers who were identified to be non-compliant during the Q1 after-hours survey; the Plan will also conduct phone outreach/training via the Plan's Provider Network Management Department.

KERN HEALTH SYSTEMS

March 16, 2021

[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

3.9 Facility Hours

Type of Service	Standard
Emergency Care	24 hours per day, 7 days per week
After Hours Urgent and Emergency Care	Primary and specialty care providers must provide or arrange after hours access for treatment of urgent and emergency conditions by telephone and/or personal contact.

Each contracted provider shall offer their KHS Medi-Cal members hours of operation that are no less than the hours of operation offered by the contracted provider to other patients. If the contracted provider only serves Medi-Cal beneficiaries, the hours of operation should be comparable to the hours offered to Medi-Call FFS.

Office hours, including after hours availability, should be posted on the outside entrance of the office with the office daytime and after hours phone numbers.

3.10 Telephone Accessibility

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

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

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

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

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

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

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

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

4.0 MONITORING

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

4.1 Quarterly Access Review

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

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

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

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

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

KERN HEALTH SYSTEMS

Appointment Availability Survey

Quarter 1, 2021

Provider Network Management

Appointment Availability Survey

Q1, 2021

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 this policy. The standard and monitoring process for the availability of a rescheduled appointment shall be equal to the availability of the initial appointment, such that the measure of compliance shall be shared.

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

KHS also utilizes these quarterly calls to monitor contracted provider's **Phone Answering Timeliness.** KHS *Policy 4.30-P Accessibility Standards,* requires "contracted providers must answer or design phone

systems that answer phone calls within six rings." In conducting the quarterly appointment availability survey, KHS staff count the rings prior to a provider answering to gauge compliance.

Appointment Availability Survey Results

A random sample of 15 primary care, 15 specialist, 5 mental health, 5 ancillary, and 5 OBGYN providers were contacted during Q1 2021.

Of the primary care providers surveyed, the plan compiled the wait time in hours to determine the Plan's average wait time for an urgent primary care appointment. The Plan compiled the wait time in days to determine the Plan's average wait time for a non-urgent primary care appointment. The average wait time for an urgent primary care appointment was **19.1 hours** for Q1 2021. The average wait time for a non-urgent primary care appointment was **2.3 days** for Q1 2021. **Based on these results, the Plan was determined to be compliant in both the urgent and non-urgent time standards for primary care appointments in Q1 2021.**

Of the specialist providers surveyed, the plan compiled the wait time in hours to determine the Plan's average wait time for an urgent specialist appointment. The Plan compiled the wait time in days to determine the Plan's average wait time for a non-urgent specialist appointment. The average wait time for an urgent specialist appointment was **57.4 hours** for Q1 2021. The average wait time for a non-urgent primary care appointment was **10.5 days** for Q1 2021. **Based on these results, the Plan was determined to be compliant in both the urgent and non-urgent time standards for specialist appointments in Q1 2021.**

Of the mental health providers surveyed, the plan compiled the wait time in days to determine the Plan's average wait time for an appointment with a mental health provider. The Plan's average wait time for a mental health provider appointment was **2 days** for Q1 2021. **Based on these results, the Plan was determined to be compliant with the time standards for a mental health appointment in Q1 2021.**

Of the ancillary providers surveyed, the plan compiled the wait time in days to determine the Plan's average wait time for an appointment with the ancillary provider. The Plan's average wait time for an ancillary appointment was **1.4 days** for Q1 2021. **Based on these results, the Plan was determined to be compliant with the time standard for an ancillary appointment in Q1 2021.**

Of OB/GYN providers surveyed, the plan compiled the wait time in days to determine the Plan's average wait time for a first prenatal appointment with an OB/GYN. The Plan's average wait time for a first prenatal appointment with an OB/GYN was **10 days** for Q1 2021. **Based on these results, the Plan was determined to be compliant with the time standards for an OB/GYN first prenatal appointment in Q1 2021.**

Appointment Availability Survey

Q1, 2021

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 2021 appointment availability survey against prior quarters, and recognized an increase in the average wait time amongst specialist appointments; this increase was due to a change in the Plan's sampling methodology for this appointment type. The Plan's average wait time remains in compliance with regulatory standards for all appointment types.

Average wait time for an urgent appointment in hours	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021
Primary Care	N/A	N/A	N/A	N/A	N/A	19.1
Specialist	N/A	N/A	N/A	N/A	N/A	57.4

Average wait time for an appointment in days	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021
Primary Care	3.1	4.4	9.8	9	5.2	2.3
Specialist	5.3	3.1	5.4	8.5	5.7	10.5
Mental Health	N/A	N/A	N/A	N/A	N/A	2
Ancillary	N/A	N/A	N/A	N/A	N/A	1.4
OB/GYN	5.4	7	8.8	8	8.9	10

*N/A = Not previously surveyed

The Plan will continue to review results against prior quarters. Due to the COVD-19 pandemic, the Plan temporarily suspended outreach based on non-compliant results to reduce administrative burden to provider offices. The Plan has resumed provider outreach and quarterly tracking/trending and will report as identified; at this time, the Plan has not identified any potential trends. The Plan is sending letters (template attached) to providers who were identified to be non-compliant during the Q1 appointment availability survey.

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 2021 calls were answered within an average of **2.2 rings**.

	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021
Average rings before call was answered	1.4	1.8	3.8	3.2	2.2	2.2

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 Q1 2021, KHS contacted your office and conducted an appointment availability survey in regards to scheduling [STANDARD/SPECIALTY] appointment. Based on the results of the survey, we found your office was not complaint with KHS availability standards. With this letter, I have included a copy of KHS policy that outlines required appointment availability standards.

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

Sincerely,

Melissa Lopez
Provider Relations Manager
661-617-2642

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

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

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

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

Exceptions to Appointment Waiting Time and Scheduling:

KERN HEALTH SYSTEMS

Access Grievance Review

Quarter 4, 2020

Access Grievance Review

Q4, 2020

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.*

Changes to Categorization

During Q2 2020, the Member Service Department made changes to the Grievance Types (or "dispositions") in which grievances are categorized. While the Plan continues to review grievances against prior quarters, the graphs utilized within this review only includes data that is in line with this recent update.

Grievance Totals

The Plan's Member Services Departments utilizes DHCS-recognized Grievance Types when categorizing grievances. Grievances categorized as *Geographic Access*, *Provider Availability*, *Technology/Telephone*, or *Timely Access* are considered access grievances for the purposes of this review.

During Q4 2020 seventy-four (74) access-related grievances were received and reviewed by the KHS Grievance Committee. In forty-nine (49) of the cases, no issues were identified and were closed in favor of the Plan. The remaining **twenty-five (25)**, were closed in favor of the enrollee; the KHS Grievance Department sent letters to the providers involved in these cases, notifying them of the outcome.

The twenty-five (25) 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 Q4 2020 were categorized by the KHS Grievance Department as follows:

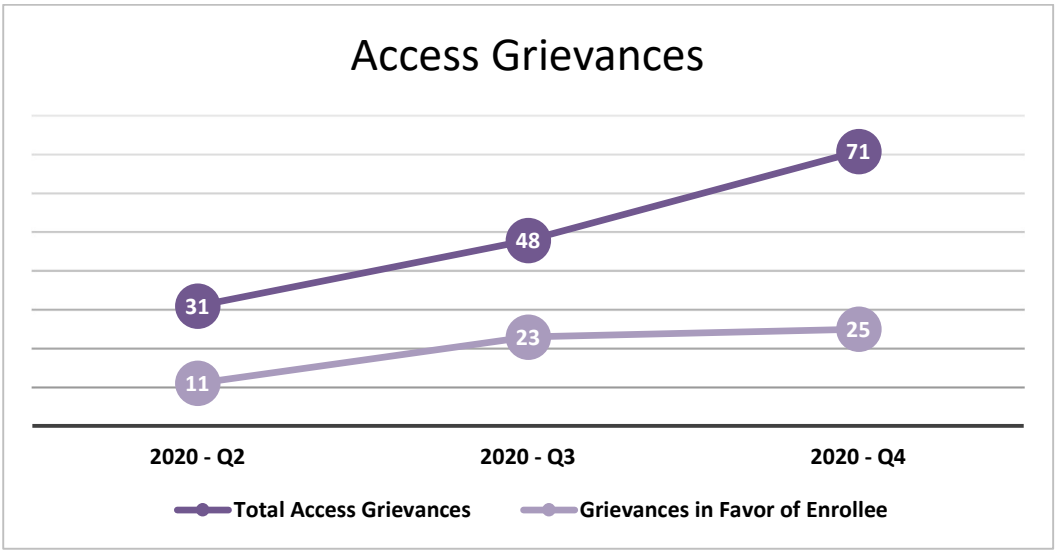
Timely Access	**10**
Provider Availability	**9**
Technology / Telephone	**6**
Geographic Access	**0**

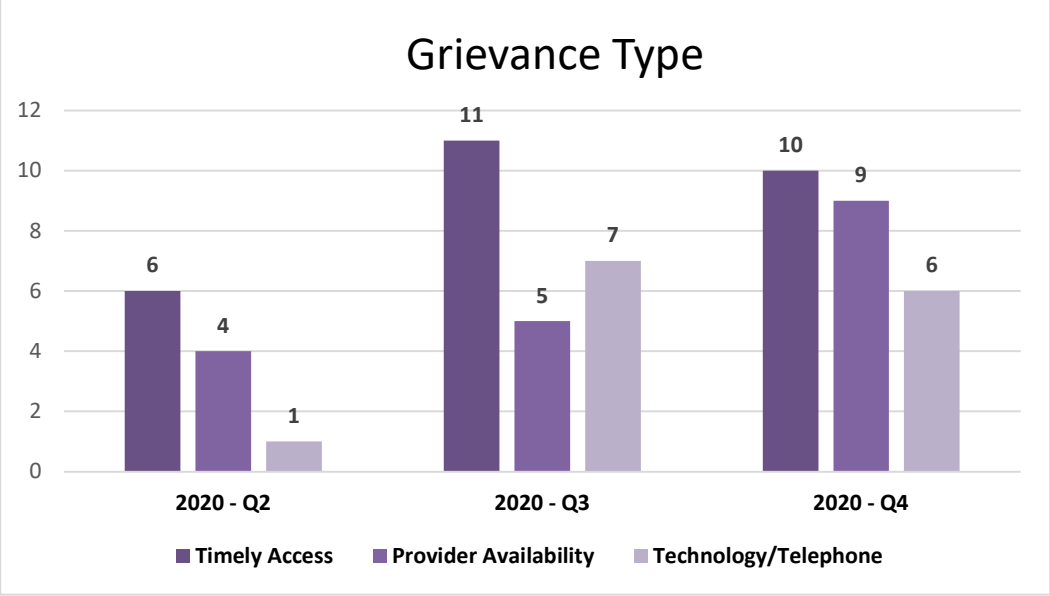
Tracking and Trending

The Provider Network Management Department reviewed all access grievances found in favor of the enrollee received in Q4 2020 to identify any potential access issues or trends within the Plan's network or amongst

the Plan's contracted providers. In addition to a review conducted against prior quarters, the Plan reviews Access Grievances against outcomes of other monitoring conducted as part of the quarterly *Provider Network Management, Network Review* (e.g. Appointment Availability Survey, DHCS' QMRT review, Network Adequacy).

Upon review of Q4 2020 access grievances, the Plan identified a minimal increase in grievances when compared from Q3 2020 and in line with grievances counts from previous quarters. The Plan did not identify this increase as an issue or trend at this time due to the count being in line with prior quarters. As of the Q4 2020 review, the Plan did not identify any trends amongst specific providers, groups, or specialty types. The Plan will continue to monitor access grievances for potential trends via the quarterly access grievance review.





Access Grievance Review

Q4, 2020

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 Q4 2020, there were a total of **1,050** exempt grievances. This count is in line with total exempt grievances identified in Q3 2020, **1095**.

Grievance Type	Q3 Count	Q3 % of Total	Q4 Count	Q4 % of Total
Provider / Staff Attitude	638	58.3%	606	57.7%
Transportation	107	9.8%	135	12.9%
Timely Access	140	12.8%	122	11.6%
Provider Availability	90	8.2%	60	5.7%
Technology / Telephone	50	4.6%	50	4.8%
Authorization	24	2.2%	37	3.5%
Physical Access	2	0.2%	9	0.9%
Referral	9	0.8%	9	0.9%
Billing	7	0.6%	5	0.5%
Language Access	5	0.5%	5	0.5%
Continuity Of Care	11	1.0%	4	0.4%
Member Informing Materials	5	0.5%	4	0.4%
Discrimination	1	0.1%	3	0.3%
Enrollment	1	0.1%	1	0.1%
Case Management / Care Coordination	2	0.2%	0	0.0%
Out-of-Network	2	0.2%	0	0.0%
PHI / Confidentiality / HIPAA	1	0.1%	0	0.0%
Grand Total	**1095**		**1050**	

In reviewing these totals against prior quarters, as of the Q4 2020 review of exempt grievances, the Plan did not identify any potential trends or issues amongst its provider network. The Plan will continue to monitor exempt grievances for potential trends via the quarterly access grievance review.

	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	

KERN HEALTH SYSTEMS

Geographic Accessibility & DHCS Network Certification

Quarter 1, 2021

Provider Network Management

Geographic Accessibility & Network Certification

Q1, 2021

KERN HEALTH SYSTEMS

Geographic Accessibility

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

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

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

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

DHCS Annual Network Certification – 2020

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 20-003, 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 submit an alternative access standard (AAS) request.

The Plan completed required Annual Network Certification reporting during Q1/Q2 2020. The Plan's submission and AAS request were compared against DHCS conducted accessibility analysis and findings were provided to the Plan. After resubmission of the Plan's AAS request utilizing data provided by the DHCS, the Plan was issued a corrective action plan (CAP) pending DHCS approval of the Plan's requested AAS, following processes outlined in APL 20-003.

Geographic Accessibility & Network Certification

Q1, 2021

On 12/29/2020, the Plan received the *Alternative Access Standard (AAS) Request Determination* from the DHCS. During Q1 2021 the Plan reviewed the determination letter and found all AAS requested were approved by the DHCS except in cases in which the DHCS found an AAS was not needed; a summary of the DHCS' AAS Determinations is provided below and a list of all approved AAS is included as Attachment A to this review, as well as posted on the Kern Family Health Care Website.

On February 8, 2021 the Plan received notice from the DHCS all outstanding Annual Network Certification deficiencies has been resolved and the CAP was closed.

As part of its ongoing monitoring the Plan reviews additions/deletions in the provider network against the most recently completed geographic accessibility analysis and as of the end of Q1 2021 has not identified any significant changes.

Summary of DHCS AAS Determinations, 12/29/2020:

Provider Type	Total AAS Submitted to DHCS:	Total Approved:	Total Denied:
Core Specialists	342	195	0
Hospitals	43	32	0
Mental Health (Outpatient)	9	6	0
OB/GYN	5	3	0
PCP	79	60	0
Pharmacies	38	29	0

Attachment A - Initial

County	Zip Code	Provider Type	Pediatric, Adult, or N/A	County Size Standards		MCP Requested		DHCS Determination		DHCS Rationale
				Minutes	Miles	Minutes	Miles	Minutes	Miles	
Kern	93203	Hospital	N/A	30	15	35	30	35	30	Approval
Kern	93203	PCP	Adult	30	10	20	20	20	20	Approval
Kern	93203	PCP	Pediatric	30	10	20	20	20	20	Approval
Kern	93203	Pharmacy	N/A	30	10	155	55	48	28	Approval
Kern	93206	Hospital	N/A	30	15	40	40	40	40	Approval
Kern	93206	PCP	Adult	30	10	20	15	20	15	Approval
Kern	93206	PCP	Pediatric	30	10	20	15	20	15	Approval
Kern	93206	Pharmacy	N/A	30	10	25	25	25	25	Approval
Kern	93224	Hospital	N/A	30	15	45	40	45	40	Approval
Kern	93224	PCP	Adult	30	10	20	20	20	20	Approval
Kern	93224	PCP	Pediatric	30	10	20	20	20	20	Approval
Kern	93224	Pharmacy	N/A	30	10	25	20	25	20	Approval
Kern	93225	Hospital	N/A	30	15	100	75	100	75	Approval
Kern	93225	PCP	Adult	30	10	50	45	50	45	Approval
Kern	93225	PCP	Pediatric	30	10	50	45	50	45	Approval
Kern	93225	Pharmacy	N/A	30	10	55	50	55	50	Approval
Kern	93226	Hospital	N/A	30	15	35	30	35	30	Approval
Kern	93226	PCP	Adult	30	10	25	25	25	25	Approval
Kern	93226	PCP	Pediatric	30	10	25	25	25	25	Approval
Kern	93226	Pharmacy	N/A	30	10	25	20	25	20	Approval
Kern	93238	Dermatology	Adult	75	45	55	50	55	50	Approval

County	Zip Code	Provider Type	Pediatric, Adult, or N/A	County Size Standards		MCP Requested		DHCS Determination		DHCS Rationale
				Minutes	Miles	Minutes	Miles	Minutes	Miles	
Kern	93238	Dermatology	Pediatric	75	45	55	50	55	50	Approval
Kern	93238	ENT/Otolaryngology	Adult	75	45	60	55	60	55	Approval
Kern	93238	ENT/Otolaryngology	Pediatric	75	45	60	55	60	55	Approval
Kern	93238	Hematology	Adult	75	45	60	55	60	55	Approval
Kern	93238	Hematology	Pediatric	75	45	60	55	60	55	Approval
Kern	93238	HIV/AIDS Specialists/Infectious Diseases	Adult	75	45	55	50	55	50	Approval
Kern	93238	HIV/AIDS Specialists/Infectious Diseases	Pediatric	75	45	55	50	55	50	Approval
Kern	93238	Mental Health (non-psychiatry) Outpatient Services	Adult	75	45	175	70	175	70	Approval
Kern	93238	Mental Health (non-psychiatry) Outpatient Services	Pediatric	75	45	55	50	55	50	Approval
Kern	93238	Nephrology	Adult	75	45	60	55	60	55	Approval
Kern	93238	Nephrology	Pediatric	75	45	60	55	60	55	Approval
Kern	93238	OB/GYN	N/A	75	45	175	75	175	75	Approval
Kern	93238	Oncology	Adult	75	45	55	50	55	50	Approval
Kern	93238	Oncology	Pediatric	75	45	55	50	55	50	Approval
Kern	93238	Ophthalmology	Adult	75	45	60	55	60	55	Approval
Kern	93238	Ophthalmology	Pediatric	75	45	60	55	60	55	Approval
Kern	93238	Orthopedic Surgery	Adult	75	45	180	100	180	100	Approval
Kern	93238	Orthopedic Surgery	Pediatric	75	45	180	100	180	100	Approval
Kern	93238	PCP	Adult	30	10	15	15	125	54	Approval
Kern	93238	PCP	Pediatric	30	10	15	15	125	54	Approval

County	Zip Code	Provider Type	Pediatric, Adult, or N/A	County Size Standards		MCP Requested		DHCS Determination		DHCS Rationale
				Minutes	Miles	Minutes	Miles	Minutes	Miles	
Kern	93238	Physical Medicine and Rehabilitation	Adult	75	45	60	55	60	55	Approval
Kern	93238	Physical Medicine and Rehabilitation	Pediatric	75	45	60	55	60	55	Approval
Kern	93243	Hospital	N/A	30	15	90	70	90	70	Approval
Kern	93243	PCP	Adult	30	10	20	20	20	20	Approval
Kern	93243	PCP	Pediatric	30	10	20	20	20	20	Approval
Kern	93243	Pharmacy	N/A	30	10	15	15	15	15	Approval
Kern	93249	Cardiology/Interventional Cardiology	Adult	75	45	65	60	65	60	Approval
Kern	93249	Cardiology/Interventional Cardiology	Pediatric	75	45	65	60	65	60	Approval
Kern	93249	Dermatology	Adult	75	45	65	60	65	60	Approval
Kern	93249	Dermatology	Pediatric	75	45	65	60	65	60	Approval
Kern	93249	Endocrinology	Adult	75	45	65	60	65	60	Approval
Kern	93249	Endocrinology	Pediatric	75	45	65	60	65	60	Approval
Kern	93249	ENT/Otolaryngology	Adult	75	45	65	50	65	50	Approval
Kern	93249	ENT/Otolaryngology	Pediatric	75	45	65	50	65	50	Approval
Kern	93249	Gastroenterology	Adult	75	45	65	55	65	55	Approval
Kern	93249	Gastroenterology	Pediatric	75	45	65	55	65	55	Approval
Kern	93249	General Surgery	Adult	75	45	65	55	65	55	Approval
Kern	93249	General Surgery	Pediatric	75	45	65	55	65	55	Approval
Kern	93249	Hematology	Adult	75	45	75	65	75	65	Approval
Kern	93249	Hematology	Pediatric	75	45	65	55	65	55	Approval
Kern	93249	HIV/AIDS Specialists/Infectious Diseases	Adult	75	45	65	60	65	60	Approval

County	Zip Code	Provider Type	Pediatric, Adult, or N/A	County Size Standards		MCP Requested		DHCS Determination		DHCS Rationale
				Minutes	Miles	Minutes	Miles	Minutes	Miles	
Kern	93249	HIV/AIDS Specialists/Infectious Diseases	Pediatric	75	45	65	60	65	60	Approval
Kern	93249	Hospital	N/A	30	15	65	60	65	60	Approval
Kern	93249	Mental Health (non-psychiatry) Outpatient Services	Adult	75	45	55	50	55	50	Approval
Kern	93249	Mental Health (non-psychiatry) Outpatient Services	Pediatric	75	45	55	50	55	50	Approval
Kern	93249	Nephrology	Adult	75	45	65	55	65	55	Approval
Kern	93249	Nephrology	Pediatric	75	45	65	55	65	55	Approval
Kern	93249	Neurology	Adult	75	45	110	90	110	90	Approval
Kern	93249	Neurology	Pediatric	75	45	110	90	110	90	Approval
Kern	93249	OB/GYN	N/A	75	45	55	50	55	50	Approval
Kern	93249	Oncology	Adult	75	45	75	70	75	70	Approval
Kern	93249	Oncology	Pediatric	75	45	75	70	75	70	Approval
Kern	93249	Ophthalmology	Adult	75	45	65	50	65	50	Approval
Kern	93249	Ophthalmology	Pediatric	75	45	155	100	155	100	Approval
Kern	93249	Orthopedic Surgery	Adult	75	45	65	60	65	60	Approval
Kern	93249	Orthopedic Surgery	Pediatric	75	45	65	60	65	60	Approval
Kern	93249	PCP	Adult	30	10	35	30	35	30	Approval
Kern	93249	PCP	Pediatric	30	10	35	30	35	30	Approval
Kern	93249	Pharmacy	N/A	30	10	35	30	35	30	Approval
Kern	93249	Physical Medicine and Rehabilitation	Adult	75	45	75	70	75	70	Approval
Kern	93249	Physical Medicine and Rehabilitation	Pediatric	75	45	75	70	75	70	Approval

County	Zip Code	Provider Type	Pediatric, Adult, or N/A	County Size Standards		MCP Requested		DHCS Determination		DHCS Rationale
				Minutes	Miles	Minutes	Miles	Minutes	Miles	
Kern	93249	Psychiatry	Adult	75	45	55	50	55	50	Approval
Kern	93249	Psychiatry	Pediatric	75	45	55	50	55	50	Approval
Kern	93249	Pulmonology	Adult	75	45	65	50	65	50	Approval
Kern	93249	Pulmonology	Pediatric	75	45	65	50	65	50	Approval
Kern	93250	Hospital	N/A	30	15	25	20	25	20	Approval
Kern	93250	PCP	Adult	30	10	20	20	20	20	Approval
Kern	93250	PCP	Pediatric	30	10	20	20	20	20	Approval
Kern	93250	Pharmacy	N/A	30	10	20	20	20	20	Approval
Kern	93251	Hospital	N/A	30	15	50	45	50	45	Approval
Kern	93251	PCP	Adult	30	10	25	25	25	25	Approval
Kern	93251	PCP	Pediatric	30	10	25	25	25	25	Approval
Kern	93251	Pharmacy	N/A	30	10	25	25	25	25	Approval
Kern	93252	Hospital	N/A	30	15	100	85	100	85	Approval
Kern	93252	PCP	Adult	30	10	70	55	70	55	Approval
Kern	93252	PCP	Pediatric	30	10	70	55	70	55	Approval
Kern	93252	Pharmacy	N/A	30	10	85	55	85	55	Approval
Kern	93255	ENT/Otolaryngology	Adult	75	45	75	65	75	65	Approval
Kern	93255	ENT/Otolaryngology	Pediatric	75	45	75	65	75	65	Approval
Kern	93255	Hematology	Adult	75	45	70	65	70	65	Approval
Kern	93255	Hematology	Pediatric	75	45	70	65	70	65	Approval
Kern	93255	HIV/AIDS Specialists/Infectious Diseases	Adult	75	45	90	75	90	75	Approval

County	Zip Code	Provider Type	Pediatric, Adult, or N/A	County Size Standards		MCP Requested		DHCS Determination		DHCS Rationale
				Minutes	Miles	Minutes	Miles	Minutes	Miles	
Kern	93255	HIV/AIDS Specialists/Infectious Diseases	Pediatric	75	45	90	75	90	75	Approval
Kern	93255	Hospital	N/A	30	15	110	65	110	65	Approval
Kern	93255	Nephrology	Adult	75	45	70	65	70	65	Approval
Kern	93255	Nephrology	Pediatric	75	45	70	65	70	65	Approval
Kern	93255	Ophthalmology	Adult	75	45	75	70	75	70	Approval
Kern	93255	Ophthalmology	Pediatric	75	45	75	70	75	70	Approval
Kern	93255	PCP	Adult	30	10	140	60	140	60	Approval
Kern	93255	PCP	Pediatric	30	10	140	60	140	60	Approval
Kern	93255	Pharmacy	N/A	30	10	110	65	110	65	Approval
Kern	93255	Physical Medicine and Rehabilitation	Adult	75	45	70	65	70	65	Approval
Kern	93255	Physical Medicine and Rehabilitation	Pediatric	75	45	70	65	70	65	Approval
Kern	93263	Hospital	N/A	30	15	30	30	30	30	Approval
Kern	93268	Hospital	N/A	30	15	40	35	40	35	Approval
Kern	93268	PCP	Adult	30	10	20	15	20	15	Approval
Kern	93268	PCP	Pediatric	30	10	20	15	20	15	Approval
Kern	93268	Pharmacy	N/A	30	10	20	20	20	20	Approval
Kern	93280	Hematology	Adult	75	45	55	50	55	50	Approval
Kern	93280	Hospital	N/A	30	15	35	30	35	30	Approval
Kern	93280	Neurology	Adult	75	45	55	50	55	50	Approval
Kern	93280	Neurology	Pediatric	75	45	55	50	55	50	Approval
Kern	93280	Oncology	Adult	75	45	55	50	55	50	Approval
Kern	93280	Ophthalmology	Pediatric	75	45	55	50	55	50	Approval

County	Zip Code	Provider Type	Pediatric, Adult, or N/A	County Size Standards		MCP Requested		DHCS Determination		DHCS Rationale
				Minutes	Miles	Minutes	Miles	Minutes	Miles	
Kern	93280	PCP	Adult	30	10	20	20	20	20	Approval
Kern	93280	PCP	Pediatric	30	10	20	20	20	20	Approval
Kern	93280	Pharmacy	N/A	30	10	20	20	20	20	Approval
Kern	93280	Physical Medicine and Rehabilitation	Adult	75	45	55	50	55	50	Approval
Kern	93280	Physical Medicine and Rehabilitation	Pediatric	75	45	55	50	55	50	Approval
Kern	93283	ENT/Otolaryngology	Adult	75	45	155	95	155	95	Approval
Kern	93283	ENT/Otolaryngology	Pediatric	75	45	155	95	155	95	Approval
Kern	93283	Hematology	Adult	75	45	170	95	170	95	Approval
Kern	93283	Hematology	Pediatric	75	45	170	95	170	95	Approval
Kern	93283	Hospital	N/A	30	15	25	25	25	25	Approval
Kern	93283	Nephrology	Adult	75	45	160	95	160	95	Approval
Kern	93283	Nephrology	Pediatric	75	45	160	95	160	95	Approval
Kern	93283	Ophthalmology	Adult	75	45	175	105	175	105	Approval
Kern	93283	Ophthalmology	Pediatric	75	45	175	105	175	105	Approval
Kern	93283	PCP	Adult	30	10	70	65	70	65	Approval
Kern	93283	PCP	Pediatric	30	10	70	65	70	65	Approval
Kern	93283	Pharmacy	N/A	30	10	25	25	25	25	Approval
Kern	93283	Physical Medicine and Rehabilitation	Adult	75	45	115	85	115	85	Approval
Kern	93283	Physical Medicine and Rehabilitation	Pediatric	75	45	115	85	115	85	Approval
Kern	93285	ENT/Otolaryngology	Adult	75	45	55	50	55	50	Approval
Kern	93285	ENT/Otolaryngology	Pediatric	75	45	55	50	55	50	Approval
Kern	93285	Hematology	Adult	75	45	55	45	55	45	Approval

County	Zip Code	Provider Type	Pediatric, Adult, or N/A	County Size Standards		MCP Requested		DHCS Determination		DHCS Rationale
				Minutes	Miles	Minutes	Miles	Minutes	Miles	
Kern	93285	Hematology	Pediatric	75	45	55	45	55	45	Approval
Kern	93285	Hospital	N/A	30	15	20	20	161	59	Approval
Kern	93285	Nephrology	Adult	75	45	55	45	55	45	Approval
Kern	93285	Oncology	Pediatric	75	45	55	50	55	50	Approval
Kern	93287	Hospital	N/A	30	15	30	30	30	30	Approval
Kern	93287	PCP	Adult	30	10	30	25	30	25	Approval
Kern	93287	PCP	Pediatric	30	10	30	25	30	25	Approval
Kern	93287	Pharmacy	N/A	30	10	30	25	30	25	Approval
Kern	93306	Hospital	N/A	30	15	20	20	20	20	Approval
Kern	93306	PCP	Adult	30	10	20	20	20	20	Approval
Kern	93306	PCP	Pediatric	30	10	20	20	20	20	Approval
Kern	93306	Pharmacy	N/A	30	10	20	20	20	20	Approval
Kern	93307	Hospital	N/A	30	15	30	30	30	30	Approval
Kern	93307	PCP	Adult	30	10	25	20	25	20	Approval
Kern	93307	PCP	Pediatric	30	10	25	20	25	20	Approval
Kern	93307	Pharmacy	N/A	30	10	20	20	20	20	Approval
Kern	93308	Hospital	N/A	30	15	30	30	30	30	Approval
Kern	93308	PCP	Adult	30	10	30	25	30	25	Approval
Kern	93308	PCP	Pediatric	30	10	85	40	85	40	Approval
Kern	93308	Pharmacy	N/A	30	10	25	25	25	25	Approval
Kern	93311	Hospital	N/A	30	15	30	30	30	30	Approval
Kern	93311	PCP	Adult	30	10	25	20	25	20	Approval

County	Zip Code	Provider Type	Pediatric, Adult, or N/A	County Size Standards		MCP Requested		DHCS Determination		DHCS Rationale
				Minutes	Miles	Minutes	Miles	Minutes	Miles	
Kern	93311	PCP	Pediatric	30	10	25	20	25	20	Approval
Kern	93311	Pharmacy	N/A	30	10	25	20	25	20	Approval
Kern	93313	Hospital	N/A	30	15	45	35	45	35	Approval
Kern	93313	PCP	Adult	30	10	25	20	25	20	Approval
Kern	93313	PCP	Pediatric	30	10	25	20	25	20	Approval
Kern	93313	Pharmacy	N/A	30	10	20	20	20	20	Approval
Kern	93314	Hospital	N/A	30	15	20	20	20	20	Approval
Kern	93314	PCP	Adult	30	10	15	15	15	15	Approval
Kern	93314	PCP	Pediatric	30	10	15	15	15	15	Approval
Kern	93314	Pharmacy	N/A	30	10	15	15	15	15	Approval
Kern	93501	ENT/Otolaryngology	Adult	75	45	110	80	110	80	Approval
Kern	93501	ENT/Otolaryngology	Pediatric	75	45	110	80	110	80	Approval
Kern	93501	Hematology	Adult	75	45	110	80	110	80	Approval
Kern	93501	Hematology	Pediatric	75	45	110	80	110	80	Approval
Kern	93501	Hospital	N/A	30	15	45	40	45	40	Approval
Kern	93501	Neurology	Adult	75	45	80	65	80	65	Approval
Kern	93501	Neurology	Pediatric	75	45	80	65	80	65	Approval
Kern	93501	Oncology	Adult	75	45	75	70	75	70	Approval
Kern	93501	Oncology	Pediatric	75	45	75	70	75	70	Approval
Kern	93501	Ophthalmology	Adult	75	45	80	65	80	65	Approval
Kern	93501	Ophthalmology	Pediatric	75	45	120	90	120	90	Approval
Kern	93501	PCP	Adult	30	10	20	20	20	20	Approval

County	Zip Code	Provider Type	Pediatric, Adult, or N/A	County Size Standards		MCP Requested		DHCS Determination		DHCS Rationale
				Minutes	Miles	Minutes	Miles	Minutes	Miles	
Kern	93501	PCP	Pediatric	30	10	20	20	20	20	Approval
Kern	93501	Pharmacy	N/A	30	10	20	15	20	15	Approval
Kern	93501	Physical Medicine and Rehabilitation	Adult	75	45	110	95	110	95	Approval
Kern	93501	Physical Medicine and Rehabilitation	Pediatric	75	45	110	95	110	95	Approval
Kern	93501	Pulmonology	Adult	75	45	125	85	125	85	Approval
Kern	93501	Pulmonology	Pediatric	75	45	125	85	125	85	Approval
Kern	93505	ENT/Otolaryngology	Adult	75	45	120	100	120	100	Approval
Kern	93505	ENT/Otolaryngology	Pediatric	75	45	120	100	120	100	Approval
Kern	93505	Hematology	Adult	75	45	145	95	145	95	Approval
Kern	93505	Hematology	Pediatric	75	45	145	95	145	95	Approval
Kern	93505	Hospital	N/A	30	15	35	35	35	35	Approval
Kern	93505	Neurology	Adult	75	45	80	65	80	65	Approval
Kern	93505	Neurology	Pediatric	75	45	80	65	80	65	Approval
Kern	93505	Oncology	Adult	75	45	55	50	55	50	Approval
Kern	93505	Oncology	Pediatric	75	45	55	50	55	50	Approval
Kern	93505	Ophthalmology	Adult	75	45	130	110	85	79	Approval
Kern	93505	Ophthalmology	Pediatric	75	45	130	110	101	77	Approval
Kern	93505	Physical Medicine and Rehabilitation	Adult	75	45	120	95	120	95	Approval
Kern	93505	Physical Medicine and Rehabilitation	Pediatric	75	45	120	95	120	95	Approval
Kern	93505	Pulmonology	Adult	75	45	145	95	145	95	Approval
Kern	93505	Pulmonology	Pediatric	75	45	145	95	145	95	Approval
Kern	93518	Hospital	N/A	30	15	100	60	100	60	Approval

County	Zip Code	Provider Type	Pediatric, Adult, or N/A	County Size Standards		MCP Requested		DHCS Determination		DHCS Rationale
				Minutes	Miles	Minutes	Miles	Minutes	Miles	
Kern	93518	PCP	Adult	30	10	110	60	110	60	Approval
Kern	93518	PCP	Pediatric	30	10	110	60	110	60	Approval
Kern	93518	Pharmacy	N/A	30	10	125	85	125	85	Approval
Kern	93523	ENT/Otolaryngology	Adult	75	45	105	90	105	90	Approval
Kern	93523	ENT/Otolaryngology	Pediatric	75	45	105	90	105	90	Approval
Kern	93523	Hematology	Adult	75	45	100	85	100	85	Approval
Kern	93523	Hematology	Pediatric	75	45	85	60	85	60	Approval
Kern	93523	Hospital	N/A	30	15	45	45	45	45	Approval
Kern	93523	Neurology	Adult	75	45	100	95	100	95	Approval
Kern	93523	Neurology	Pediatric	75	45	100	95	100	95	Approval
Kern	93523	Oncology	Adult	75	45	95	85	95	85	Approval
Kern	93523	Oncology	Pediatric	75	45	95	85	95	85	Approval
Kern	93523	Ophthalmology	Adult	75	45	125	105	77	68	Approval
Kern	93523	Ophthalmology	Pediatric	75	45	125	105	77	68	Approval
Kern	93523	PCP	Adult	30	10	20	20	20	20	Approval
Kern	93523	PCP	Pediatric	30	10	20	20	20	20	Approval
Kern	93523	Pharmacy	N/A	30	10	20	20	20	20	Approval
Kern	93523	Physical Medicine and Rehabilitation	Adult	75	45	90	90	90	90	Approval
Kern	93523	Physical Medicine and Rehabilitation	Pediatric	75	45	90	90	90	90	Approval
Kern	93523	Pulmonology	Adult	75	45	105	90	105	90	Approval
Kern	93523	Pulmonology	Pediatric	75	45	105	90	105	90	Approval
Kern	93527	ENT/Otolaryngology	Adult	75	45	190	130	190	130	Approval

County	Zip Code	Provider Type	Pediatric, Adult, or N/A	County Size Standards		MCP Requested		DHCS Determination		DHCS Rationale
				Minutes	Miles	Minutes	Miles	Minutes	Miles	
Kern	93527	ENT/Otolaryngology	Pediatric	75	45	190	130	190	130	Approval
Kern	93527	Hematology	Adult	75	45	180	140	180	140	Approval
Kern	93527	Hematology	Pediatric	75	45	180	140	180	140	Approval
Kern	93527	HIV/AIDS Specialists/Infectious Diseases	Adult	75	45	55	50	55	50	Approval
Kern	93527	HIV/AIDS Specialists/Infectious Diseases	Pediatric	75	45	55	50	55	50	Approval
Kern	93527	Hospital	N/A	30	15	75	50	75	50	Approval
Kern	93527	Nephrology	Adult	75	45	125	110	125	110	Approval
Kern	93527	Nephrology	Pediatric	75	45	155	115	155	115	Approval
Kern	93527	Ophthalmology	Adult	75	45	210	135	210	135	Approval
Kern	93527	Ophthalmology	Pediatric	75	45	210	135	210	135	Approval
Kern	93527	PCP	Adult	30	10	100	50	100	50	Approval
Kern	93527	PCP	Pediatric	30	10	100	50	100	50	Approval
Kern	93527	Pharmacy	N/A	30	10	75	50	75	50	Approval
Kern	93527	Physical Medicine and Rehabilitation	Adult	75	45	115	105	115	105	Approval
Kern	93527	Physical Medicine and Rehabilitation	Pediatric	75	45	170	130	170	130	Approval
Kern	93531	Hospital	N/A	30	15	20	20	20	20	Approval
Kern	93531	PCP	Adult	30	10	20	20	20	20	Approval
Kern	93531	PCP	Pediatric	30	10	20	20	20	20	Approval
Kern	93531	Pharmacy	N/A	30	10	20	20	20	20	Approval
Kern	93536	Cardiology/Interventional Cardiology	Adult	75	45	65	55	65	55	Approval
Kern	93536	Cardiology/Interventional Cardiology	Pediatric	75	45	65	55	65	55	Approval

County	Zip Code	Provider Type	Pediatric, Adult, or N/A	County Size Standards		MCP Requested		DHCS Determination		DHCS Rationale
				Minutes	Miles	Minutes	Miles	Minutes	Miles	
Kern	93536	Dermatology	Adult	75	45	105	60	105	60	Approval
Kern	93536	Dermatology	Pediatric	75	45	105	60	105	60	Approval
Kern	93536	Endocrinology	Adult	75	45	95	60	95	60	Approval
Kern	93536	Endocrinology	Pediatric	75	45	95	60	95	60	Approval
Kern	93536	ENT/Otolaryngology	Adult	75	45	100	90	105	90	Approval
Kern	93536	ENT/Otolaryngology	Pediatric	75	45	85	90	85	90	Approval
Kern	93536	Gastroenterology	Adult	75	45	95	60	95	60	Approval
Kern	93536	Gastroenterology	Pediatric	75	45	95	60	95	60	Approval
Kern	93536	General Surgery	Adult	75	45	65	55	65	55	Approval
Kern	93536	General Surgery	Pediatric	75	45	65	55	65	55	Approval
Kern	93536	Hematology	Adult	75	45	100	90	100	90	Approval
Kern	93536	Hematology	Pediatric	75	45	100	90	100	90	Approval
Kern	93536	HIV/AIDS Specialists/Infectious Diseases	Adult	75	45	95	60	95	60	Approval
Kern	93536	HIV/AIDS Specialists/Infectious Diseases	Pediatric	75	45	95	60	95	60	Approval
Kern	93536	Hospital	N/A	30	15	105	60	105	60	Approval
Kern	93536	Mental Health (non-psychiatry) Outpatient Services	Adult	75	45	65	60	65	60	Approval
Kern	93536	Mental Health (non-psychiatry) Outpatient Services	Pediatric	75	45	65	60	65	60	Approval
Kern	93536	Nephrology	Adult	75	45	85	60	85	60	Approval
Kern	93536	Nephrology	Pediatric	75	45	85	60	85	60	Approval
Kern	93536	Neurology	Adult	75	45	105	90	105	90	Approval

County	Zip Code	Provider Type	Pediatric, Adult, or N/A	County Size Standards		MCP Requested		DHCS Determination		DHCS Rationale
				Minutes	Miles	Minutes	Miles	Minutes	Miles	
Kern	93536	Neurology	Pediatric	75	45	105	90	105	90	Approval
Kern	93536	OB/GYN	N/A	75	45	85	60	85	60	Approval
Kern	93536	Oncology	Adult	75	45	95	90	95	90	Approval
Kern	93536	Oncology	Pediatric	75	45	95	90	95	90	Approval
Kern	93536	Ophthalmology	Adult	75	45	115	100	60	50	Approval
Kern	93536	Ophthalmology	Pediatric	75	45	115	100	64	53	Approval
Kern	93536	Orthopedic Surgery	Adult	75	45	100	60	100	60	Approval
Kern	93536	Orthopedic Surgery	Pediatric	75	45	100	60	100	60	Approval
Kern	93536	PCP	Adult	30	10	70	50	70	50	Approval
Kern	93536	PCP	Pediatric	30	10	70	50	70	50	Approval
Kern	93536	Pharmacy	N/A	30	10	60	45	60	45	Approval
Kern	93536	Physical Medicine and Rehabilitation	Adult	75	45	110	95	110	95	Approval
Kern	93536	Physical Medicine and Rehabilitation	Pediatric	75	45	110	95	110	95	Approval
Kern	93536	Psychiatry	Adult	75	45	95	60	95	60	Approval
Kern	93536	Psychiatry	Pediatric	75	45	95	60	95	60	Approval
Kern	93536	Pulmonology	Adult	75	45	110	90	110	90	Approval
Kern	93536	Pulmonology	Pediatric	75	45	110	90	110	90	Approval
Kern	93560	ENT/Otolaryngology	Adult	75	45	115	80	115	80	Approval
Kern	93560	ENT/Otolaryngology	Pediatric	75	45	115	80	115	80	Approval
Kern	93560	Hematology	Adult	75	45	65	60	65	60	Approval
Kern	93560	Hematology	Pediatric	75	45	65	60	65	60	Approval
Kern	93560	Hospital	N/A	30	15	110	75	110	75	Approval

County	Zip Code	Provider Type	Pediatric, Adult, or N/A	County Size Standards		MCP Requested		DHCS Determination		DHCS Rationale
				Minutes	Miles	Minutes	Miles	Minutes	Miles	
Kern	93560	Neurology	Adult	75	45	85	70	85	70	Approval
Kern	93560	Neurology	Pediatric	75	45	85	70	85	70	Approval
Kern	93560	Oncology	Adult	75	45	125	80	125	80	Approval
Kern	93560	Oncology	Pediatric	75	45	125	80	125	80	Approval
Kern	93560	Ophthalmology	Adult	75	45	100	85	100	85	Approval
Kern	93560	Ophthalmology	Pediatric	75	45	100	85	100	85	Approval
Kern	93560	PCP	Adult	30	10	85	55	85	55	Approval
Kern	93560	PCP	Pediatric	30	10	85	55	85	55	Approval
Kern	93560	Pharmacy	N/A	30	10	70	70	70	70	Approval
Kern	93560	Physical Medicine and Rehabilitation	Adult	75	45	80	75	80	75	Approval
Kern	93560	Physical Medicine and Rehabilitation	Pediatric	75	45	90	80	90	80	Approval
Kern	93560	Pulmonology	Adult	75	45	135	80	135	80	Approval
Kern	93560	Pulmonology	Pediatric	75	45	135	80	135	80	Approval
Kern	93561	ENT/Otolaryngology	Adult	75	45	180	80	180	80	Approval
Kern	93561	ENT/Otolaryngology	Pediatric	75	45	180	80	180	80	Approval
Kern	93561	Hematology	Adult	75	45	180	80	180	80	Approval
Kern	93561	Hematology	Pediatric	75	45	180	80	180	80	Approval
Kern	93561	Hospital	N/A	30	15	130	80	130	80	Approval
Kern	93561	Oncology	Adult	75	45	180	80	180	80	Approval
Kern	93561	Oncology	Pediatric	75	45	180	79	180	79	Approval
Kern	93561	Ophthalmology	Adult	75	45	190	90	190	90	Approval
Kern	93561	Ophthalmology	Pediatric	75	45	190	90	190	90	Approval

County	Zip Code	Provider Type	Pediatric, Adult, or N/A	County Size Standards		MCP Requested		DHCS Determination		DHCS Rationale
				Minutes	Miles	Minutes	Miles	Minutes	Miles	
Kern	93561	PCP	Adult	30	10	20	20	20	20	Approval
Kern	93561	PCP	Pediatric	30	10	20	20	20	20	Approval
Kern	93561	Pharmacy	N/A	30	10	155	70	155	70	Approval
Kern	93561	Physical Medicine and Rehabilitation	Adult	75	45	55	50	55	50	Approval
Kern	93561	Physical Medicine and Rehabilitation	Pediatric	75	45	55	50	55	50	Approval

KERN HEALTH SYSTEMS

Network Adequacy & Provider Counts

Quarter 1, 2021

Provider Network Management

Network Adequacy & Provider Counts

Q1, 2021

KERN HEALTH SYSTEMS

Introduction

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

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

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

Survey Methodology and Results

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

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

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

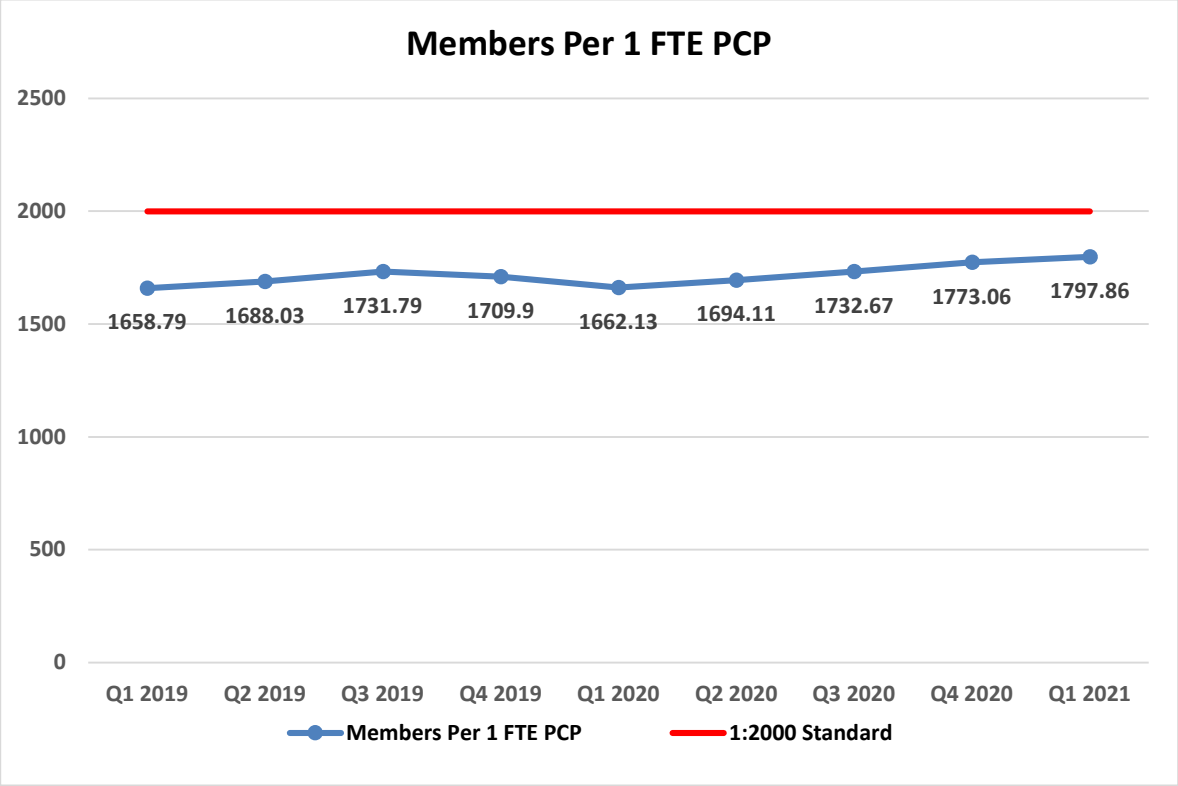
Q1, 2021

Full Time Equivalency Compliance Calculations

Of KHS' 293,640 membership at the close of Q1 2021, 11,376 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 2021, the plan was contracted with 417 Primary Care Providers, a combination of 233 physicians and 184 mid-levels. Based on the FTE calculation process outlined above, with a 48.31% PCP FTE percentage, KHS maintains a total of **157 FTE PCPs**. With a membership enrollment of 282,264 utilizing KHS contracted PCPs, KHS currently maintains a ratio of **1 FTE PCP to every 1797.86 members**; KHS is compliant with state regulations and Plan policy.

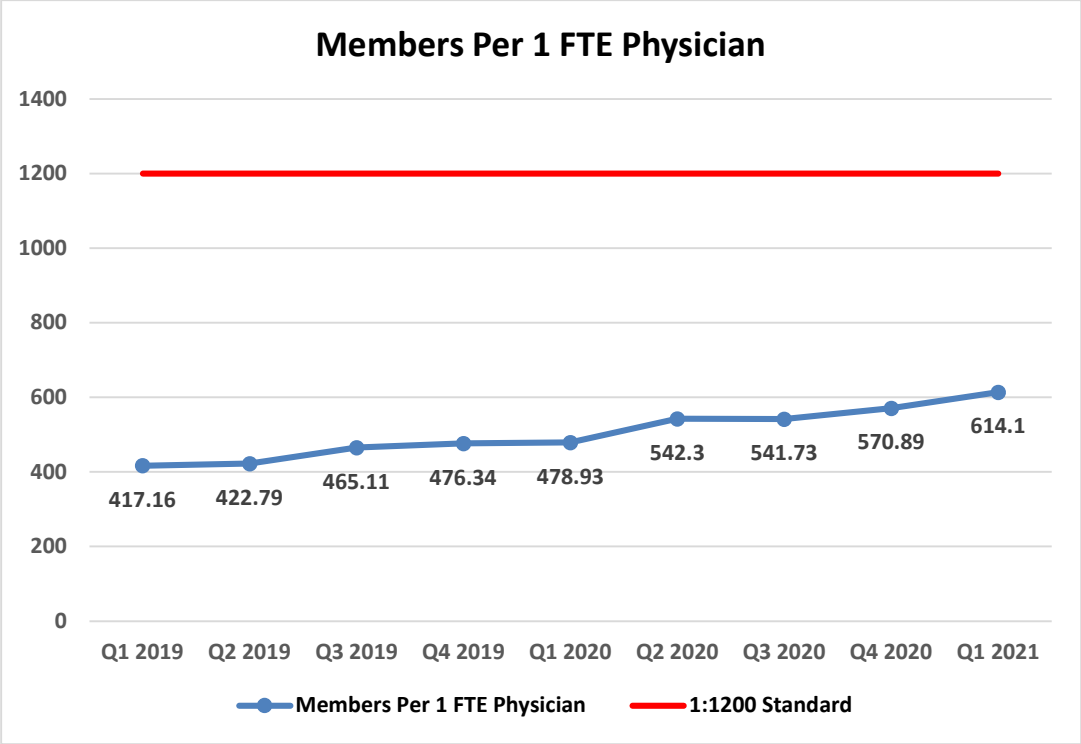
PCP to Member Ratio



As of the end of Q1 2021, the plan was contracted with 1115 Physicians. Based on the FTE calculation process outlined above, with a 41.22% Physician FTE percentage, KHS maintains a total of **459.64 FTE Physicians**. With a total membership enrollment of 282,264 utilizing KHS contracted Physicians, KHS currently maintains a ratio of **1 FTE Physician to every 614.10 members**; KHS is compliant with state regulations and Plan policy.

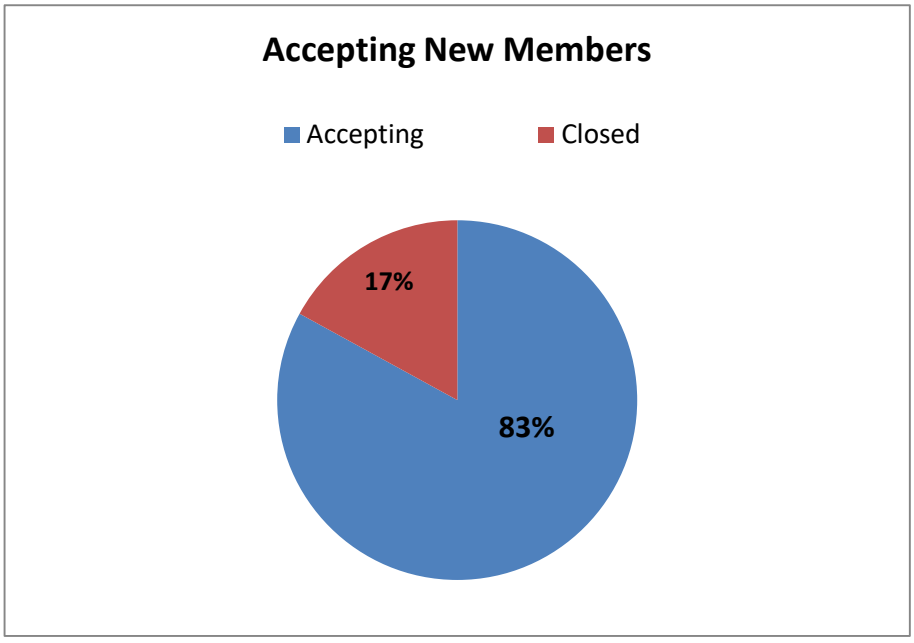
Network Adequacy & Provider Counts

Q1, 2021



Accepting New Members

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

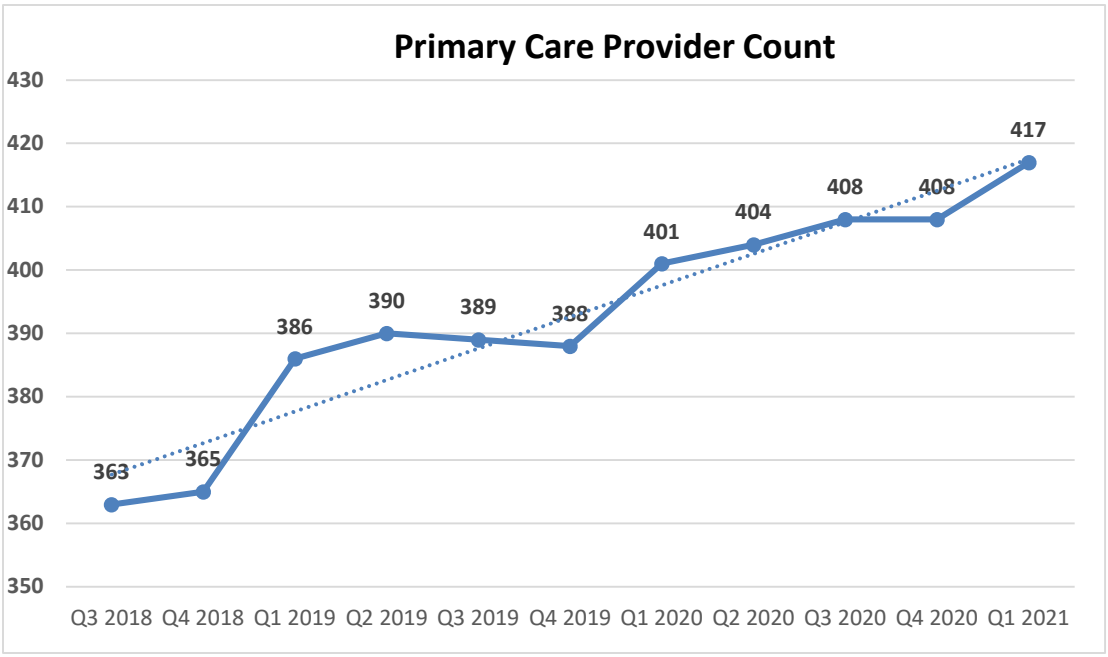


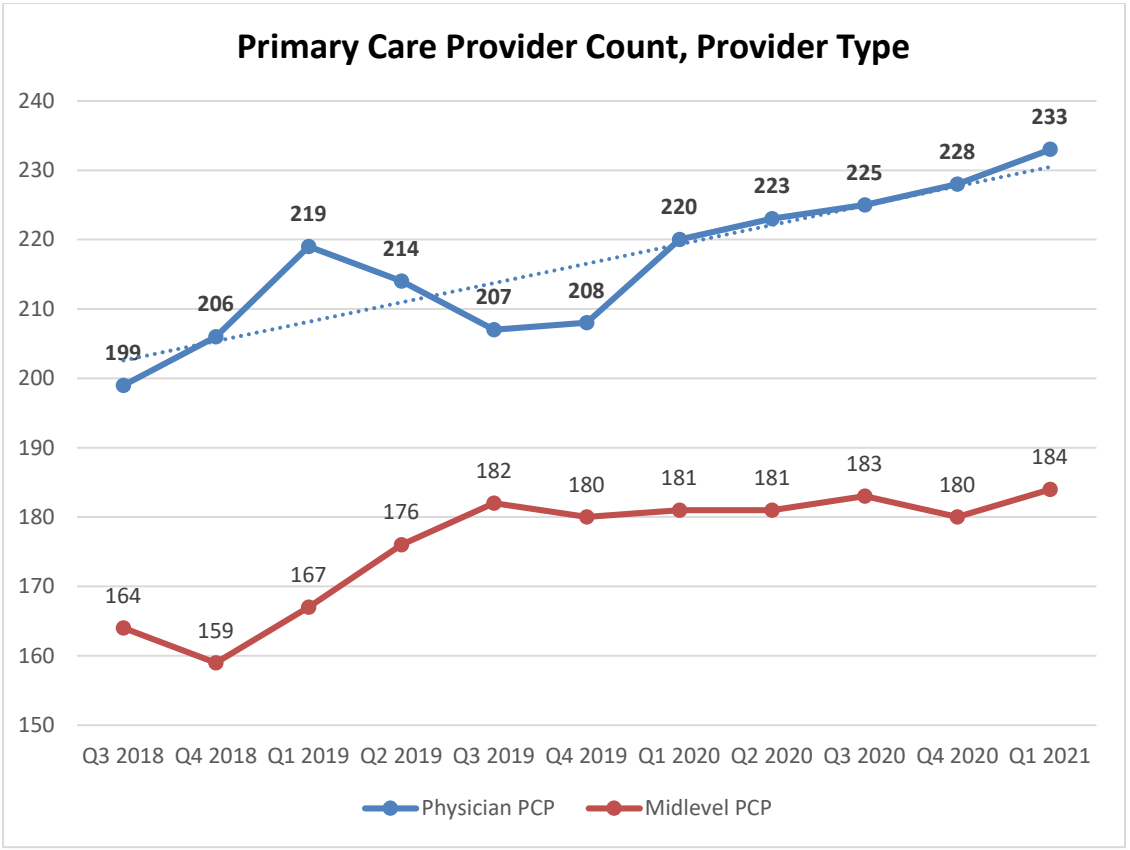
Network Adequacy & Provider Counts

Q1, 2021

KERN HEALTH SYSTEMS

Provider Counts – Primary Care Providers



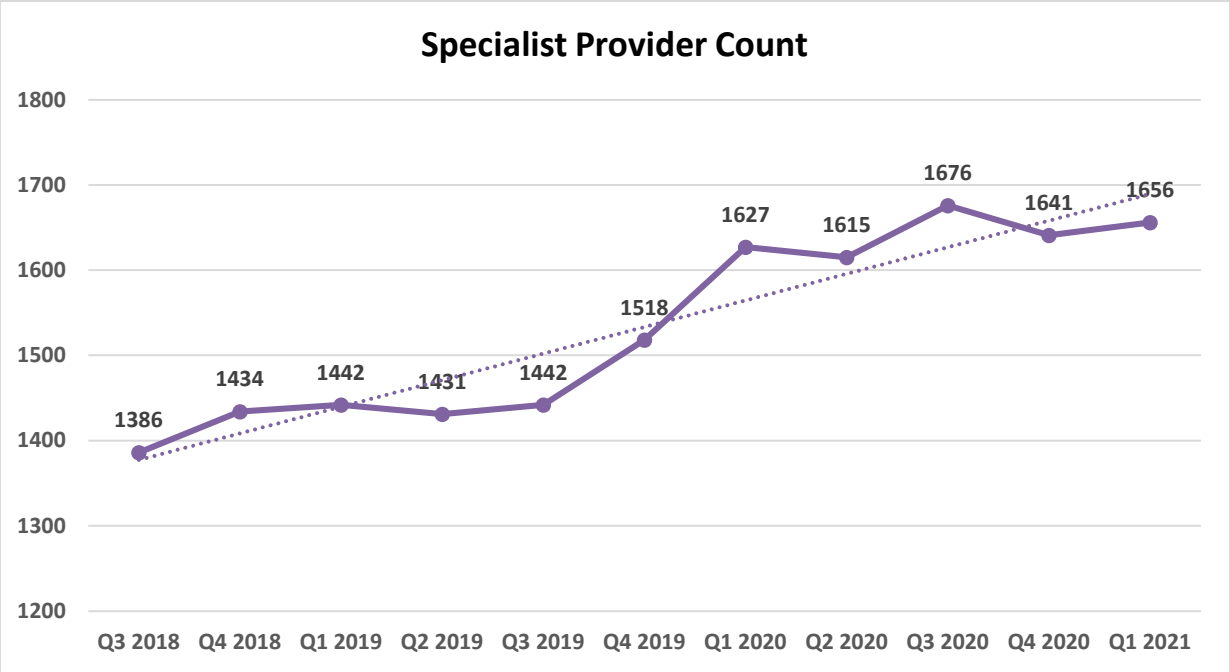


Network Adequacy & Provider Counts

Q1, 2021

KERN HEALTH SYSTEMS

Provider Counts – Specialist Providers



DHCS Core Specialties, Provider Count									
	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021
Cardiology	39	39	39	40	40	38	42	44	43
Dermatology	31	31	31	35	33	36	35	36	33
Endocrinology	16	17	19	20	20	19	20	24	22
Gastroenterology	16	16	18	20	20	22	22	22	23
General Surgery	49	53	59	62	66	70	68	68	67
Hematology	18	18	18	18	17	18	18	20	20
Infectious Disease	10	10	12	10	9	10	10	10	11
Nephrology	23	24	22	22	22	21	22	23	23
Neurology	23	22	23	25	25	26	25	25	26
Oncology	21	22	23	23	22	24	24	26	26
Ophthalmology	29	29	30	32	33	32	30	29	30
Orthopedic Surgery	18	20	19	20	21	20	21	20	20
Otolaryngology	13	14	13	12	12	10	10	10	8
Physical Medicine & Rehab	21	23	23	27	27	24	24	24	24
Psychiatry	46	46	48	54	54	53	54	47	47
Pulmonary Disease	22	21	21	21	20	20	20	19	18

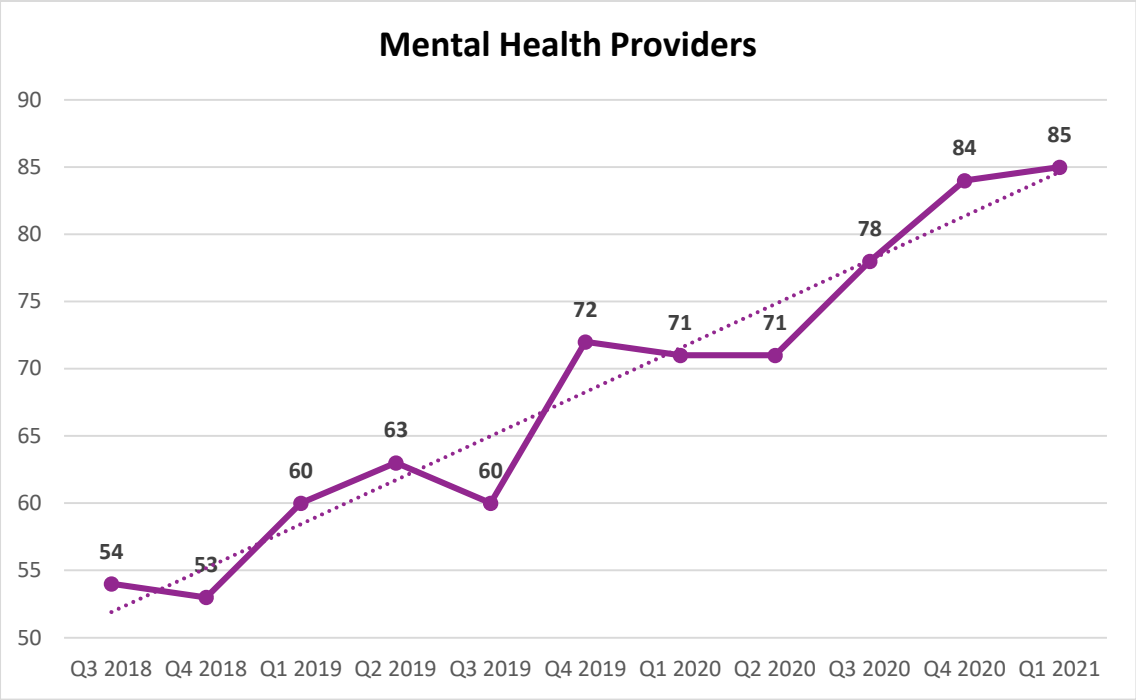
	> 5% Increase		> 5% Decrease
	≤ 5% Increase		≤ 5% Decrease

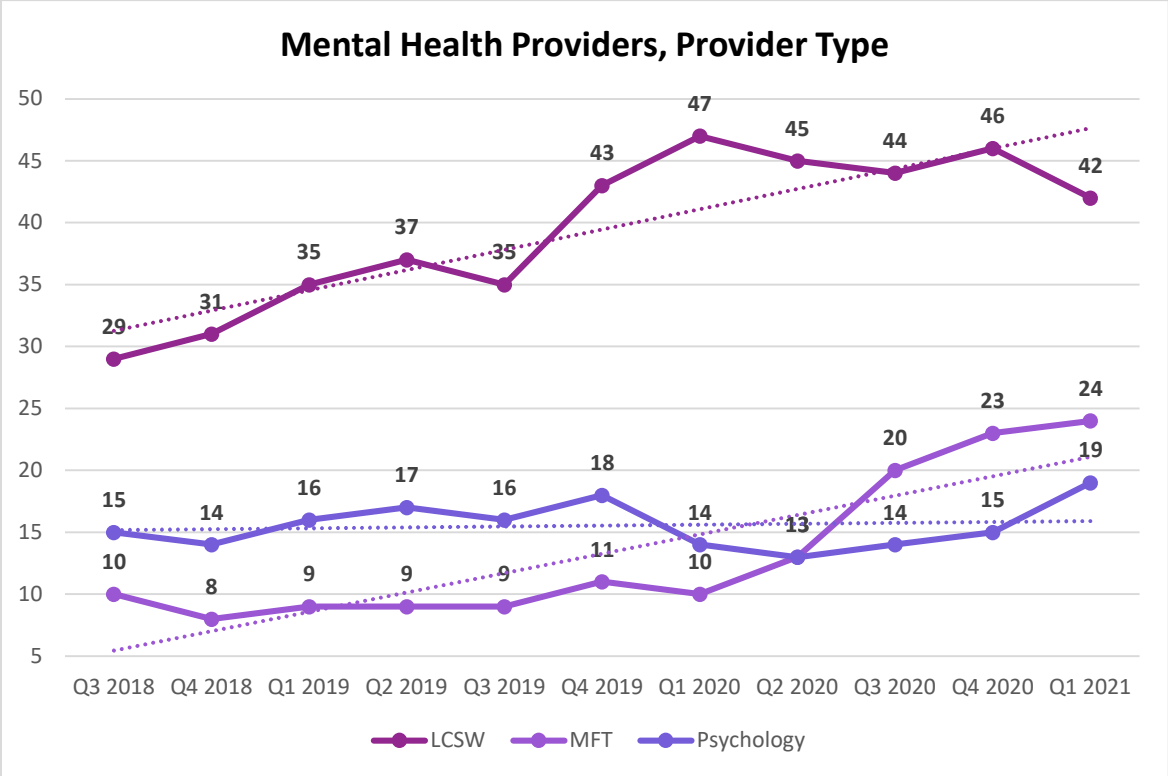
Network Adequacy & Provider Counts

Q1, 2021

KERN HEALTH SYSTEMS

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





Network Adequacy & Provider Counts

Q1, 2021

KERN HEALTH SYSTEMS

Provider Counts – Facilities

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

Provider Counts – Other Provider Types

	2017	2018	2019	2020	Current
Ambulance/Transport	15	15	13	17	18
Dialysis	13	14	16	18	19
Home Health	13	12	13	13	15
Hospice	6	7	11	13	13
Pharmacy	133	136	139	147	148
Physical Therapy	29	29	29	30	29

KERN HEALTH SYSTEMS

DHCS Quarterly Monitoring Report/Response Template (QMRT)

Quarter 4, 2020

Quarterly Monitoring Report/Response Template

Q4, 2020

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 1/8/2021 the Plan received Q4 2020 QMRT and accompanying reports from the DHCS and during Q1 2021 the Plan's Provider Network Management departments reviewed the following categories:

FTE Provider to Member Ratio

DHCS uses the Plan's 274 file submission to calculate and monitor FTE provider to member ratios. For Q4 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	16	43

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 2021*) also found the Plan to be in compliance with regulatory standards.

Timely Access

DHCS' External Quality Review Organization (EQRO) conducts a timely access survey of Plan providers to ensure compliance with provider availability and appointment wait time standards. For Q4 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 2021*) found the Plan to be in compliance with regulatory standards.

Network Report

DHCS uses the Plan's 274 file to generate Network Report in an effort to improve network provider data quality and support compliance with Annual Network Certification and timely access survey. For Q4 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 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 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	8.9

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 2.77 Physicians Supervisors per Non-Physician Medical Practitioner and was in compliance with the standard.

KERN HEALTH SYSTEMS

2020 Provider Network Capacity Report

Background/Scope

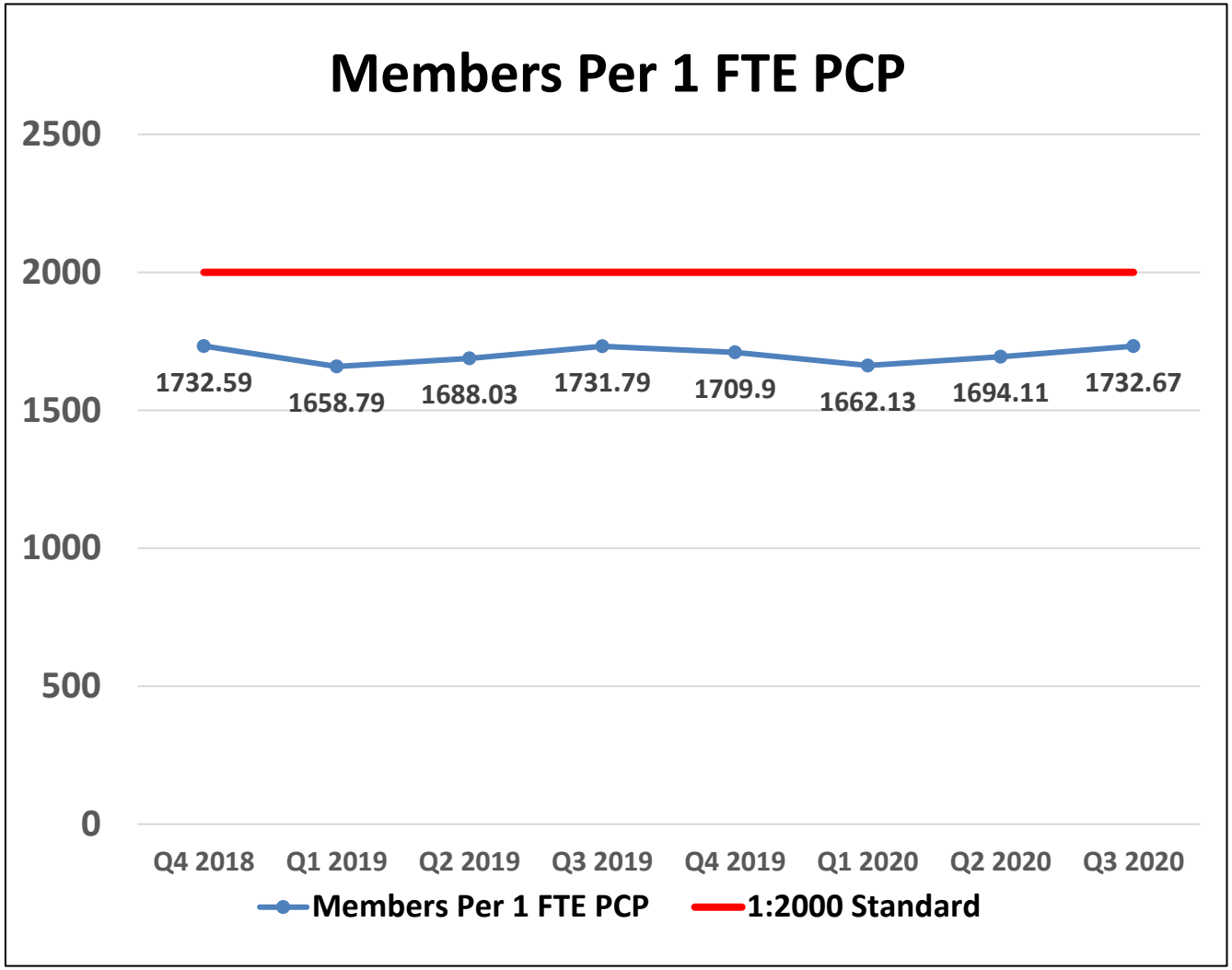
On an annual basis, Kern Health Systems (KHS) reviews network adequacy to ensure members have access to a quality group of providers and specialist that can meet the need in a timely manner.

The following were taken into consideration:

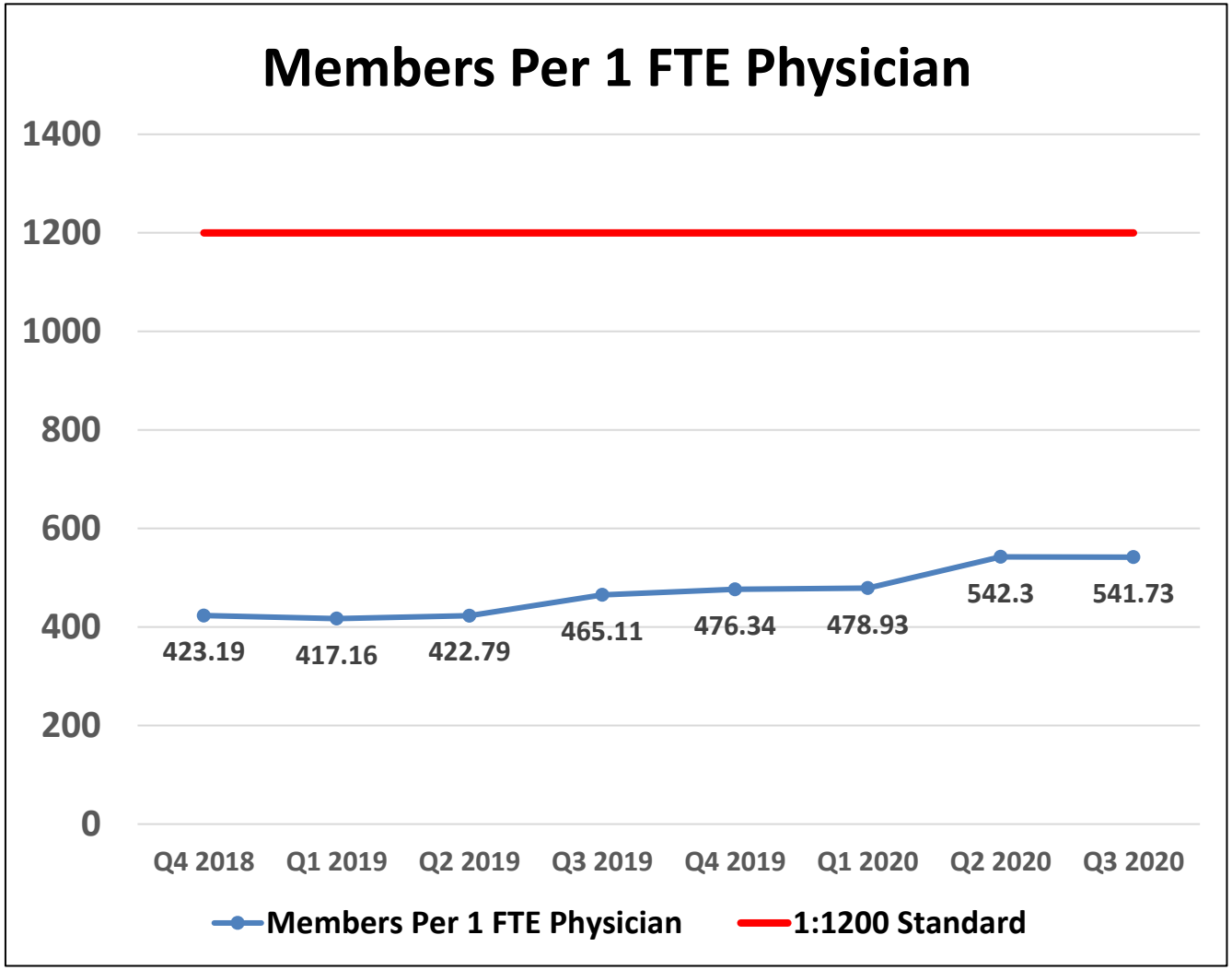
- Analysis of provider to member ratio, per state regulation
- PCP Medical Service Study Area Capacity report.
- Specialty Provider Network
- Mental Health Provider Network

KERN HEALTH SYSTEMS

PCP to Enrollee Ratios



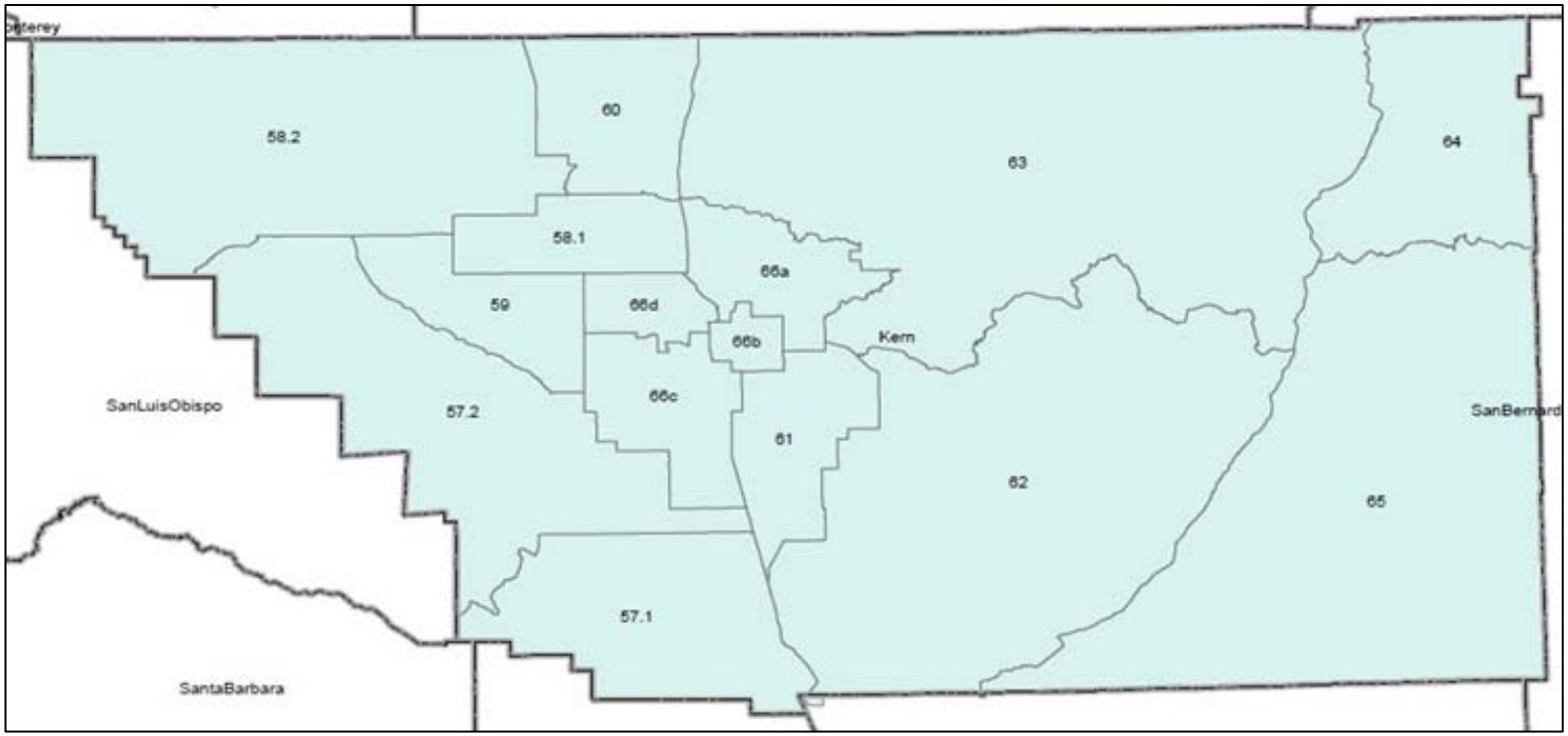
Physician to Enrollee Ratios



KERN HEALTH SYSTEMS

MSSA Map

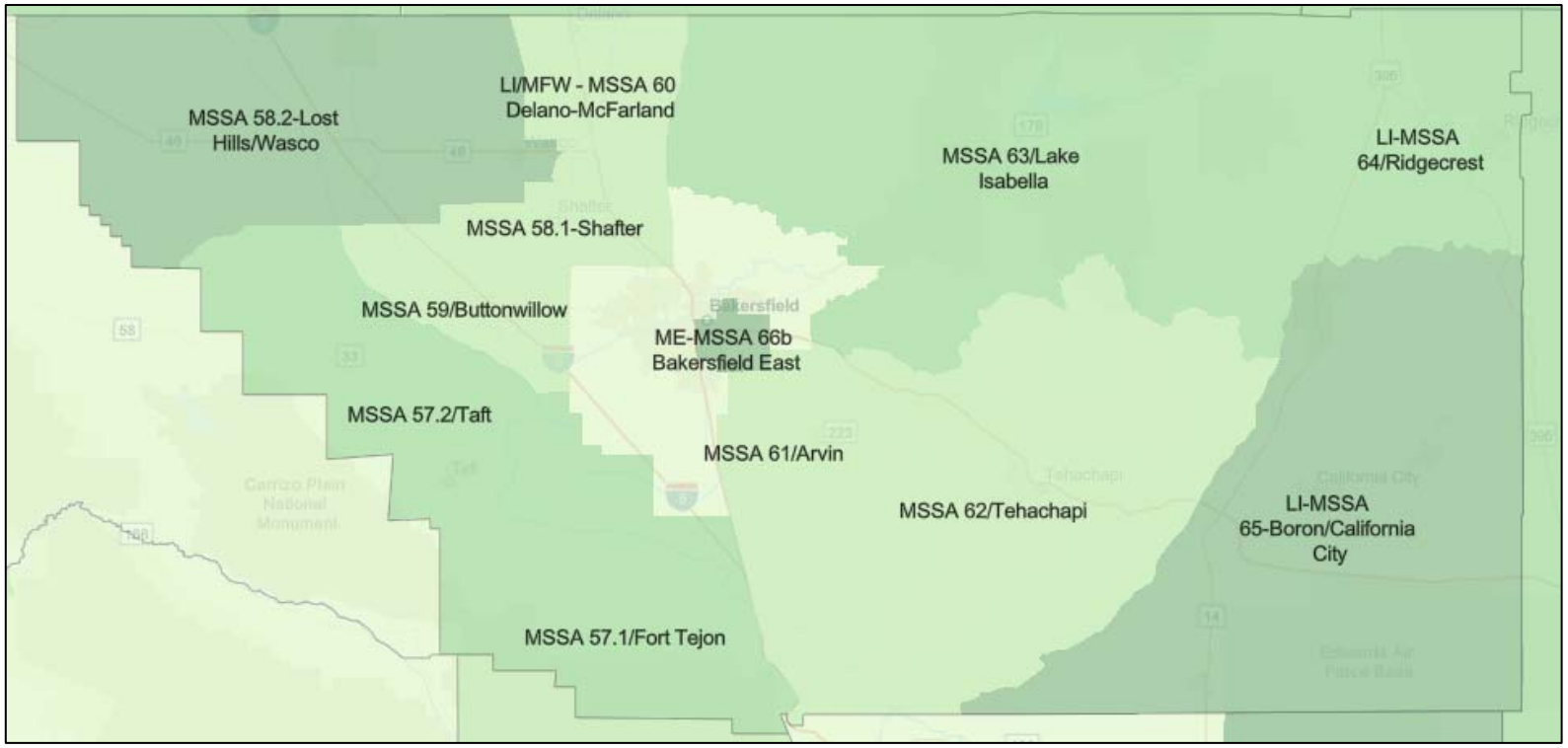
Kern County - Medical Study Service Area (MSSA) Map



KERN HEALTH SYSTEMS

Primary Care - HPSA Map

Kern County – Primary Care Health Professional Shortage Areas (HPSA)



KERN HEALTH SYSTEMS

PCP Capacity, Per MSSA

MSSA	Major Cities	Number of Primary Care Physicians	Number of Primary Care Mid-levels	Total FTE PCP	Membership Q3 2020	Percent of KFHC Members per MSSA	Number of FTE PCPs to Serve Membership	FTE PCP Gap
57.1	Frazier Park, Lebec	1	1	0.74	871	0.32%	0.44	No Gap
57.2	Taft, Maricopa	9	10	6.86	6,991	2.60%	3.50	No Gap
58.1	Shafter	11	24	11.27	8,281	3.08%	4.14	No Gap
58.2	Lost Hills, Wasco	11	19	10.05	10,408	3.87%	5.20	No Gap
59	Buttonwillow	1	2	0.98	805	0.30%	0.40	No Gap
60	Delano, McFarland	32	19	20.34	26,291	9.77%	13.15	No Gap
61	Arvin, Lamont	13	20	11.27	18,484	6.87%	9.24	No Gap
62	Tehachapi	7	10	5.88	4,326	1.61%	2.16	No Gap
63	Lake Isabella, Wofford Heights, Kernville	4	4	2.94	3,417	1.27%	1.71	No Gap
64	Ridgecrest	23	14	14.70	232	0.09%	0.12	No Gap
65	California City, Mojave, Rosamond	2	3	1.72	6,539	2.43%	3.27	-1.55
66a, 66b, 66c, 66d	Metropolitan Bakersfield	140	101	93.35	181,866	67.60%	90.93	No Gap

Specialist Capacity

- KHS is required to maintain a ratio of specialists to “reasonably assure” services are accessible to enrollees on an appropriate basis. Currently, there is no numerically defined ration requirements for specialty providers.

- As a part of Annual Provider Network Reporting, the DMHC reviews the Plan’s ratio of enrollee to providers of certain specialty types. Plans are reviewed against other health plans, and if identified as an outlier, issued a finding.

- The DMCH calculation for specialist ratio’s does not take into account mid-level providers; for MY 2018, the DMHC calculation did not take into account providers offering services via telehealth

KERN HEALTH SYSTEMS

DMHC Specialist Findings

Specialty	MY 2015	MY 2016	MY 2017	MY 2018*	MY2019*
Cardiology	✗	✗	✗	N/A	N/A
Dermatology	O	✗	✗	✗	✗
Endocrinology	✗	O	O	✗	O
Neurology	N/A	N/A	N/A	✗	✗
OB/GYN	O	O	O	N/A	N/A
Oncology	N/A	✗	✗	✗	✗
Ophthalmology	O	O	✗	✗	✗
Orthopedic Surgery	✗	✗	✗	✗	✗
Psychiatry	O	O	O	N/A	N/A
Pulmonology	✗	✗	✗	N/A	N/A
Urology	N/A	N/A	N/A	✗	✗

DMHC Finding - ✗ No Finding - O Not Reviewed – N/A

*DMHC calculation did not take into account providers offering services via telehealth

MY2019 DMHC Deficiencies

Provider Counts

- DMHC calculation did not take into account mid-level providers or providers offering services via telehealth

Specialty	DMHC Count	Midlevel Count	Telehealth Count
		Providers Not Included in DMHC Ratio Calculation	
Dermatology	6	8	17
Neurology	21	2	1
Ophthalmology	31	0	0
Orthopedic Surgery	18	3	0
Urology	8	5	0
Oncology	3	Plan reported an additional 13 “Hematology/Oncology” providers (not midlevel or telehealth) that were not included in the DMHC calculation.	

Quarterly Access Review

Grievance

- Quarterly, the Plan reviews all access grievances found in favor of the enrollee to identify any potential access issue trends. The Plan did not identify any specialist appointment availability issues during 2020.

Grievance Category	Q1 2020	Q2 2020	Q3 2020	Q4 2020
Specialist Appointment Availability Grievances	6	2	1	0

Appointment Availability Survey

- Quarterly, a random sample of 15 specialty providers are surveyed to review the Plan's compliance with the 15 day appointment availability standard.

Specialist Results	Q1 2020	Q2 2020	Q3 2020	Q4 2020
Average wait time for appointment (in days)	3.1	5.4	8.5	5.7

KERN HEALTH SYSTEMS

Specialist Growth

Specialty	2016	2017	2018	2019	2020	5YR %
Cardiology	32	36	39	40	42	31%
Dermatology	30	32	31	35	35	17%
Endocrinology	9	12	17	19	20	122%
ENT/Otolaryngology	6	12	14	12	10	67%
Gastroenterology	16	15	16	20	22	38%
General Surgery	34	36	42	59	68	100%
Hematology	8	15	18	18	19	138%
Infectious Diseases	10	11	11	10	10	0%
Nephrology	25	20	23	25	25	0%
Neurology	23	19	24	25	25	9%
Oncology	11	13	20	23	24	118%
Ophthalmology	30	25	28	32	30	0%
Orthopedic Surgery	14	17	17	20	21	50%
Physical Med & Rehab	22	16	21	27	24	9%
Psychiatry	23	29	45	54	54	135%
Pulmonology	20	23	22	21	20	0%
Urology	5	8	9	13	17	240%

≥5% Increase **≥5% Decrease**

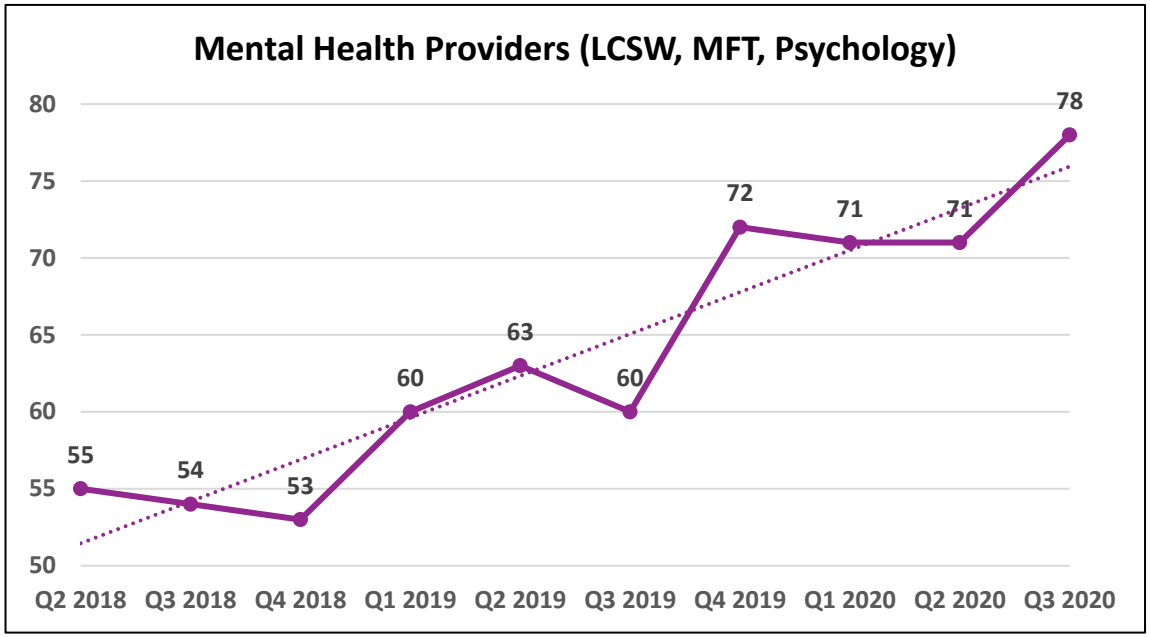
Mental Health Network

- **DMHC Annual Network Report Findings**

Specialty	MY 2015	MY 2016	MY 2017	MY 2018	MY 2019
Mental Health	✖	✖	✖	O	O

DMHC Finding - ✖ No Finding - O

- **Continued Growth**



Planning For Increased Demand

- 2020-21 Provider Grants
  - Provider recruitment
  - New Specialty care locations
- Continuous Provider Network Expansion
- Telehealth Expansion
- Promote Medical & Mental Health Integration
- Continue to Expand Health Home Program
- Diagnosis Specific Clinics
  - Transition of Care Clinic
  - Respite Care Clinic
  - Inpatient Program for Pulmonary Rehab
  - Expanded Diabetic clinics

KERN HEALTH SYSTEMS

Provider Satisfaction Survey Results

Calendar Year 2019

Board of Directors

February 11, 2021

Background & Timeline

- KHS conducts an annual provider satisfaction survey
- The 2020 survey measures CY 2019 KHS performance with network providers
- SPH Analytics (independent survey company) conducts the survey on KHS behalf
- KHS performance is benchmarked to HMO industry performance for similar measures
- Survey was conducted over three (3) waves through Q1/Q3 2020.

KERN HEALTH SYSTEMS

Survey Panel

- Surveys were sent to all provider types:
  - Primary Care Providers
  - Specialists
  - Behavioral Health
  - Hospitals & Urgent Care Facilities
  - Pharmacies
  - Ancillary Provider Types
- 269 Total Surveys were received
  - 303 Surveys received last year
  - Provider's Offices Incentivized for Survey Completion
  - Plan attributes decrease to a side effect of COVID-19 pandemic. During the survey period, provider offices experienced temporary office closures and reduced hours during California stay-at-home orders in response to the COVID-19 outbreak.
- Confidence Level
  - Survey sample at 97% Confidence Level

KERN HEALTH SYSTEMS

Report Highlights

Composites/ Attributes	KHS 2017 Rating	KHS 2018 Rating	KHS 2019 Rating	
Overall Satisfaction	77.0%	86.5%	88.3%	
Other Local Plans	54.4%	59.8%	64.3%	
Compensation	46.8%	51.3%	58.1%	
UM & Quality	45.8%	54.0%	54.1%	
Network/COC	43.2%	50.7%	52.7%	
Pharmacy	24.6%	32.2%	37.9%	
Health Plan Call Center	56.2%	60.0%	55.4%	
Provider Relations	55.6%	64.5%	70.5%	
Recommend to Other MDs	90.5%	93.0%	96.1%	

KERN HEALTH SYSTEMS

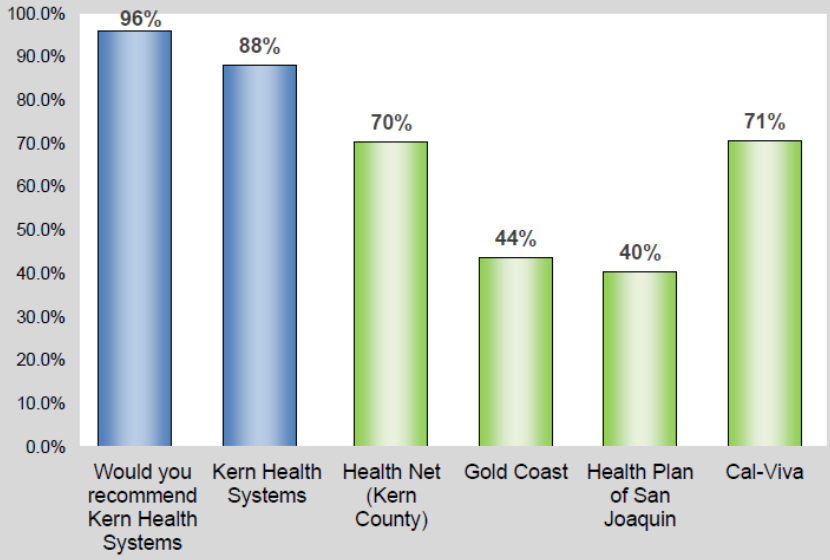
Report Highlights

Composites/ Attributes	KHS 2019 Rating	2019 National Medicaid Summary Scores		90th Percentile Score
Overall Satisfaction	88.3%	68.6%	Favorable F	Above
Other Local Plans	64.3%	34.8%	F	Above
Compensation	58.1%	30.2%	F	Above
UM & Quality	54.1%	32.5%	F	Above
Network/COC	52.7%	28.6%	F	Above
Pharmacy	37.9%	22.7%	F	Above
Health Plan Call Center	55.4%	37.4%	F	Above
Provider Relations	70.5%	35.0%	F	Above
Recommend to Other MDs	96.1%	83.6%	F	Above

KERN HEALTH SYSTEMS

Health Plan Comparison

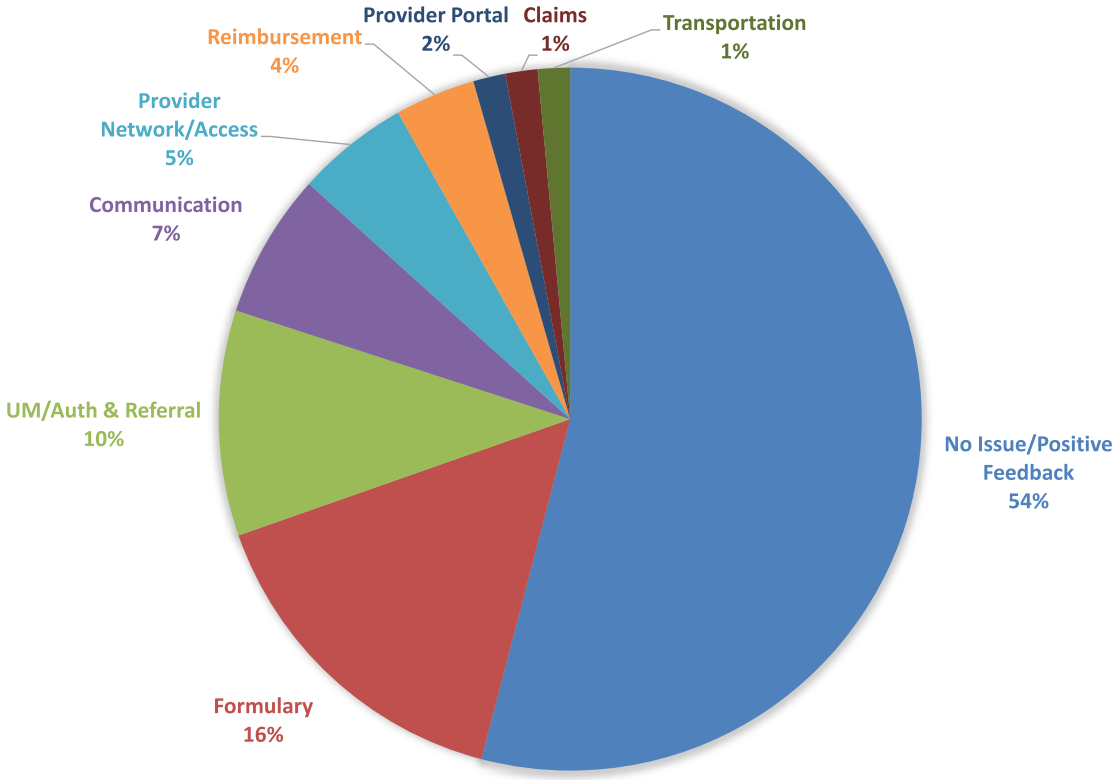
Ratings of Overall Satisfaction



Note: Green columns indicate Kern Health Systems' Overall Satisfaction Rating (Q9B) is significantly higher than the indicated Competitor's rating while Red columns indicate it is significantly lower than the indicated Competitor's rating.

KERN HEALTH SYSTEMS

What Can KHS Do To Improve



KERN HEALTH SYSTEMS

Next Steps

- Evaluate Call Center area, where rating decreased from prior year
- Enhance grant and special program opportunities for providers
- Continue to monitor and address referral and authorization concerns
- Create communication plan for provider education
  - Focus on virtual communication

Questions

For additional information, please contact:

Emily Duran
Chief Network Administration Officer
(661) 664-5000

PROVIDER SATISFACTION SURVEY RESULTS

CALENDAR YEAR 2019

KERN HEALTH SYSTEMS

Call Center Results – Tracking and Trending

Upon review of the Measurement Year (MY) 2019 Provider Satisfaction Survey, the Plan recognized a decrease in Provider Satisfaction within the *Health Plan Call Center*, dropping from 60% in MY2018 to 55.4% in MY2019. The Plan does not believe this decrease is a trend as the MY2019 rate is in line with the Plan's satisfaction rate from MY2017, 56.2%, and is well above the National Medicaid Summary Score for this topic in 2019, 37.4%. The Plan's Provider Network Management and Member Services Departments met to review the results for potential causes and action items.

While the survey is designed to elicit Provider opinion regarding their satisfaction with the Plan during MY2019, the survey is conducted retrospectively and it is important to take into account what the Provider may have experienced during the period in which they completed the survey. For MY2019 the survey was conducted in three waves starting in March 2020 and concluding in August 2020.

On March 19th, 2020, the Governor of California issued his stay at home order to combat the spread of COVID-19; around this time the Plan implemented a work-from-home program for all employees. The shift to work-from-home presented challenges for the Plan's call center, resulting in connectivity/bandwidth issues which lead to an increase in dropped calls between call center staff and providers/members. The Plan believes this is a major factor contributing to the decrease in satisfaction. The Plan's Member Services and IT Departments continue to work to provide call center staff with appropriate tools and technology while working from home. Currently, the Plan has an estimated return to in-office work date of September 2021, which will alleviate the technology and connectivity issues experienced by staff while working from home.

Also during the survey period, the Plan's call center staff was engaged in member outreach projects including EPSDT and COVID outbound call campaigns which resulted in a longer than normal average speed of answer for providers/members attempting to reach a call center staff representative. The Plan had a 14 second average speed of answer for members and an 11 second average speed of answer for providers from November 2020 through March 2021 which is when the above-mentioned outreach projects had closed.

Disease Management Quarterly Report

1st Quarter, 2021

DISEASE MANAGEMENT DEPARTMENT OVERVIEW:

The Disease Management Department conducts outreach calls to members to assist and educate them in the self-management of their medical condition. The four nurses and four diabetes paraprofessionals perform assessments, coordinate care, monitor and evaluates medical services for members with an emphasis on quality of care, continuity of services, and cost-effectiveness. The two program areas of the Disease Management Department are Diabetes and Hypertension and Asthma.

EXECUTIVE SUMMARY:

During the 1st quarter 2021, the Disease Management Department conduced 7,731 telephone calls to members, successfully completing a total of 4,381.

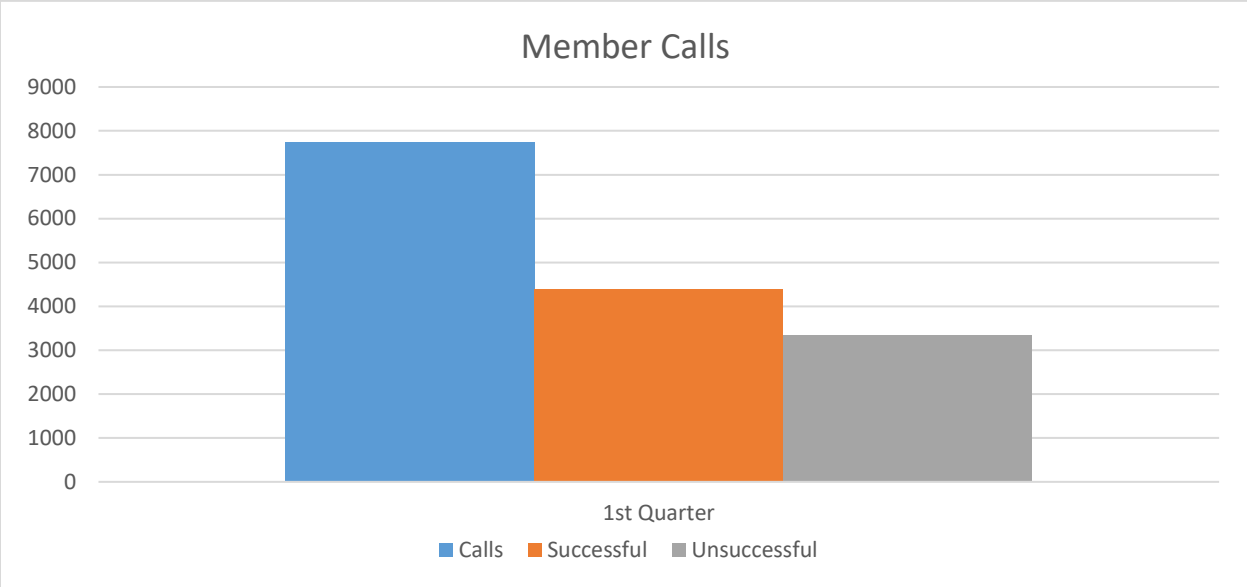
Of the 4,381 members reached, 866 were new and a Diabetes and/or Asthma assessment was completed. 59 of the members who accepted the Disease Management program successfully completed their goals and their Plans of Care were closed.

Diabetes eye exams were scheduled for 92 members and 50 members were referred to the Kern Medical Diabetes clinic. Educational material was mailed to 64 members who declined any of the offered services.

The remote Diabetes Prevention Program was launched in early February. This year-long program consists of 26 classes and with the first eight classes completed at the end of March, 38 members remain enrolled.

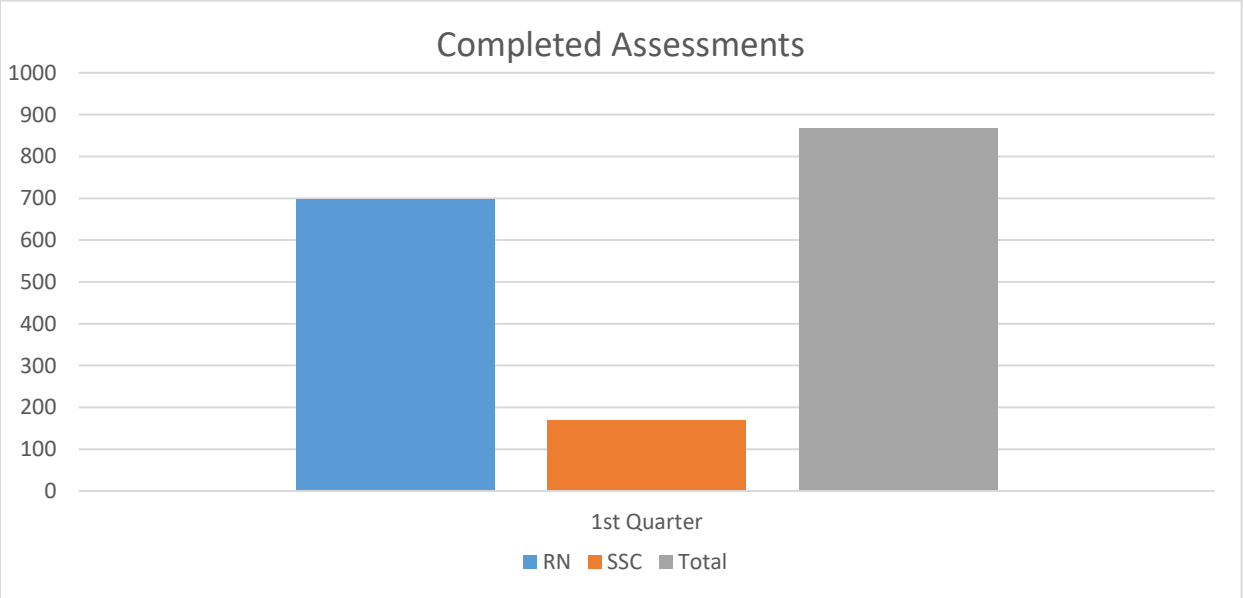
Telephone Calls: A total of 7,731 calls were made by the DM staff during the 4th Quarter, 2020.

Member Calls Attempted	Successful Calls	Unsuccessful Calls	Total Member Calls	% Contacted
RN	2,321	2,052	4,373	53%
SSC	2,060	1,298	3,358	61%
Total	**4,381**	**3,350**	**7,731**	**57%**



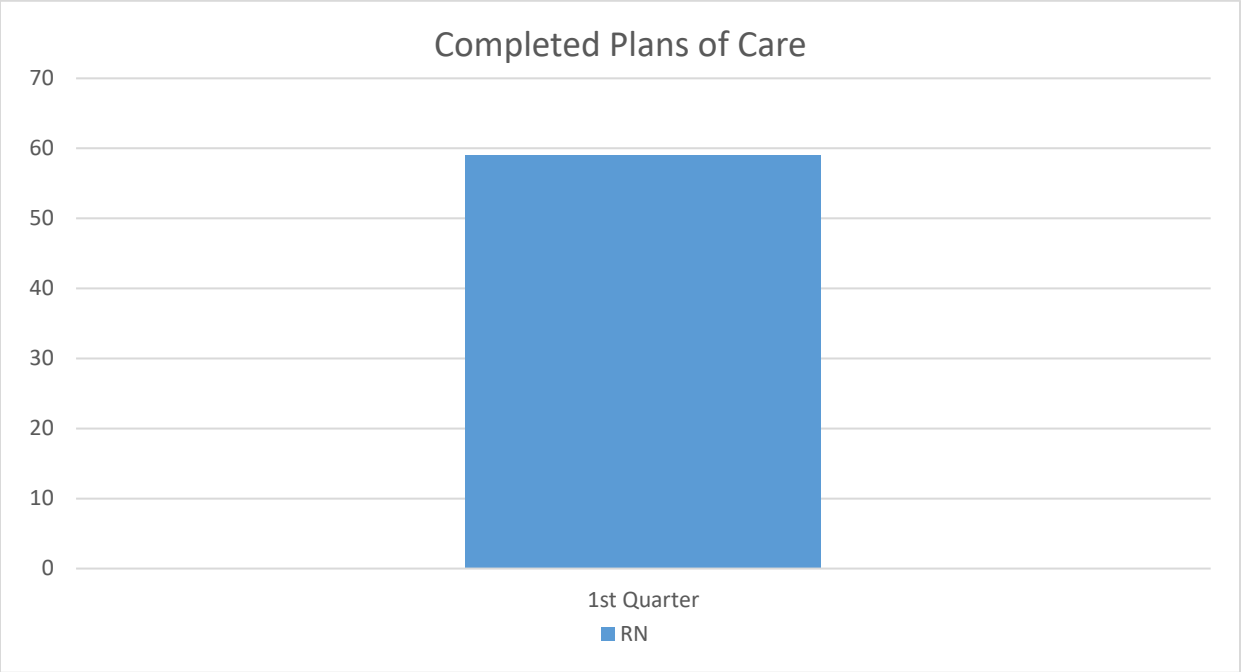
New Assessments Completed.

RN	SSC	Total
697	169	866



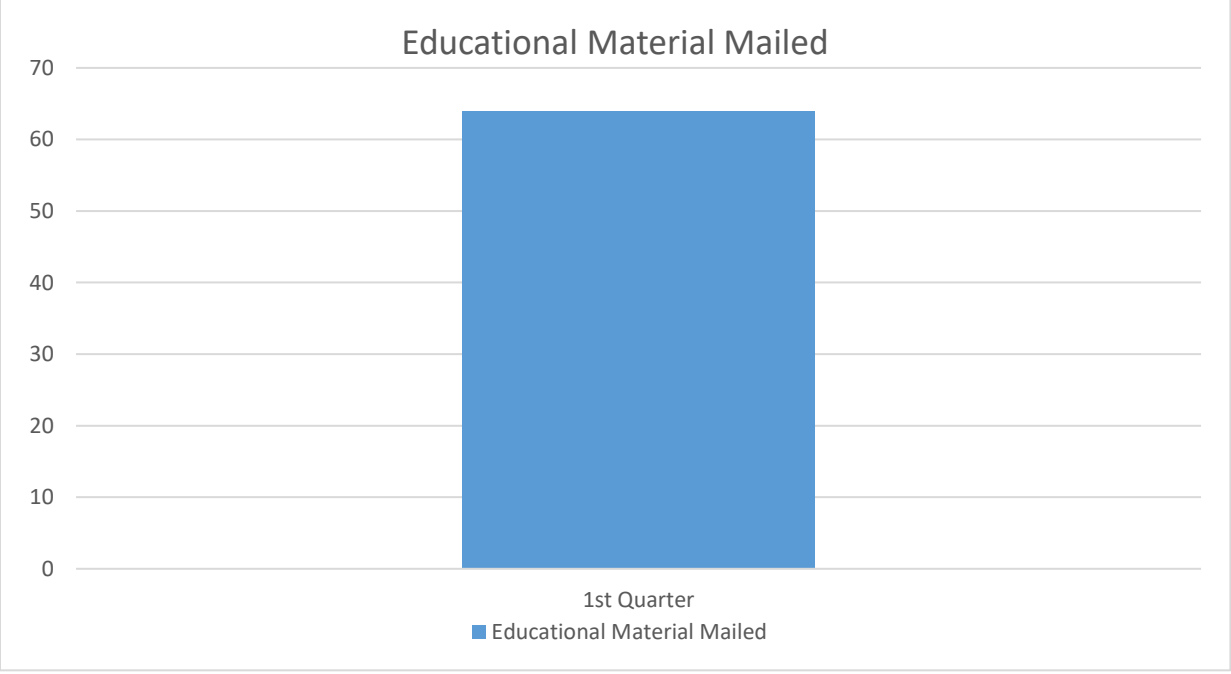
Plans of Care Completed & Closed.

RN
59



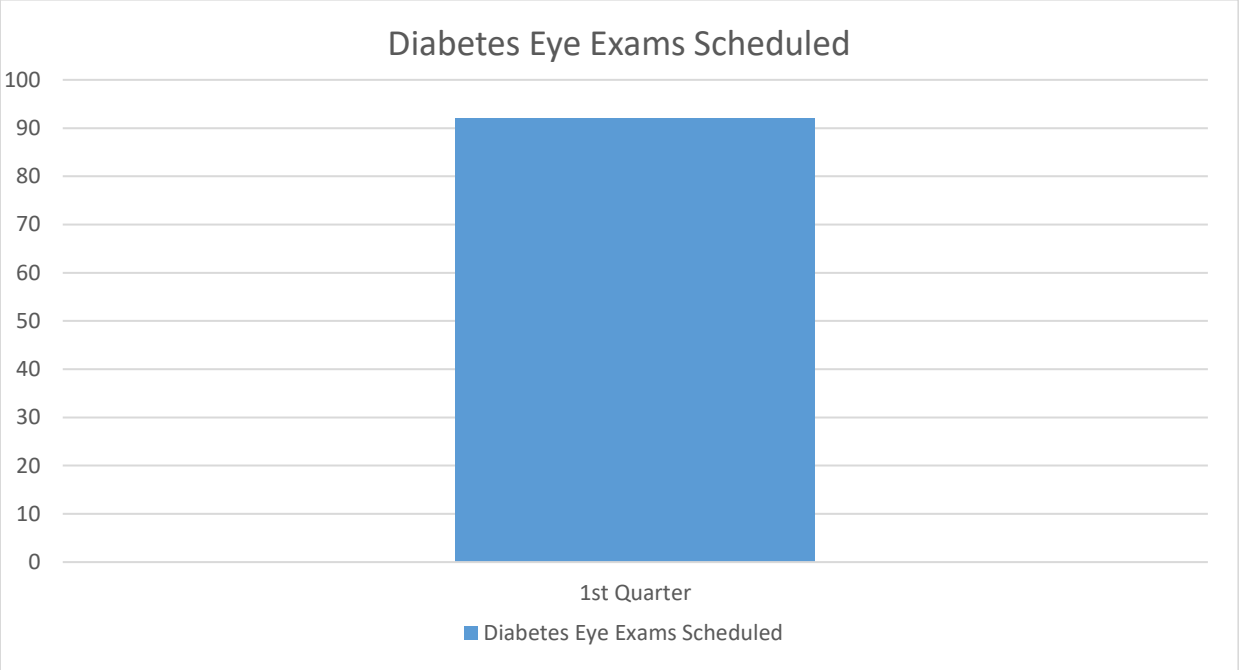
Educational Material Mailed. Mailing of educational material resumed in March, 2021.

64



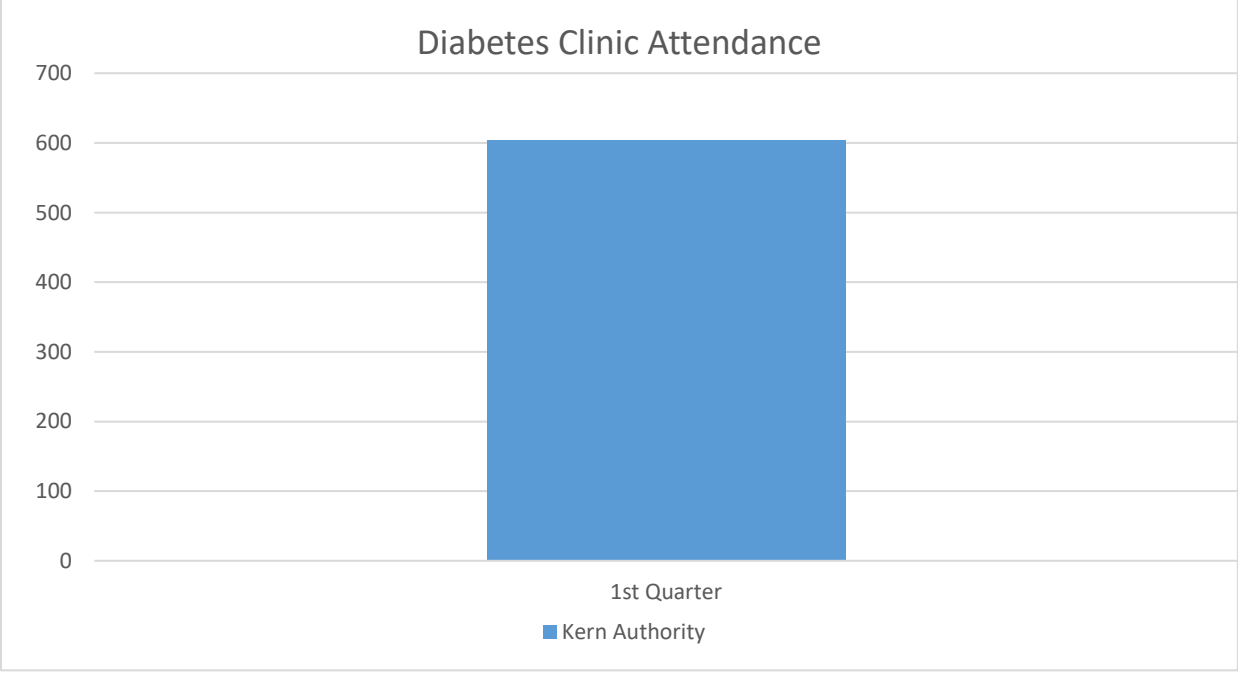
Diabetes Eye Exams Scheduled.

92



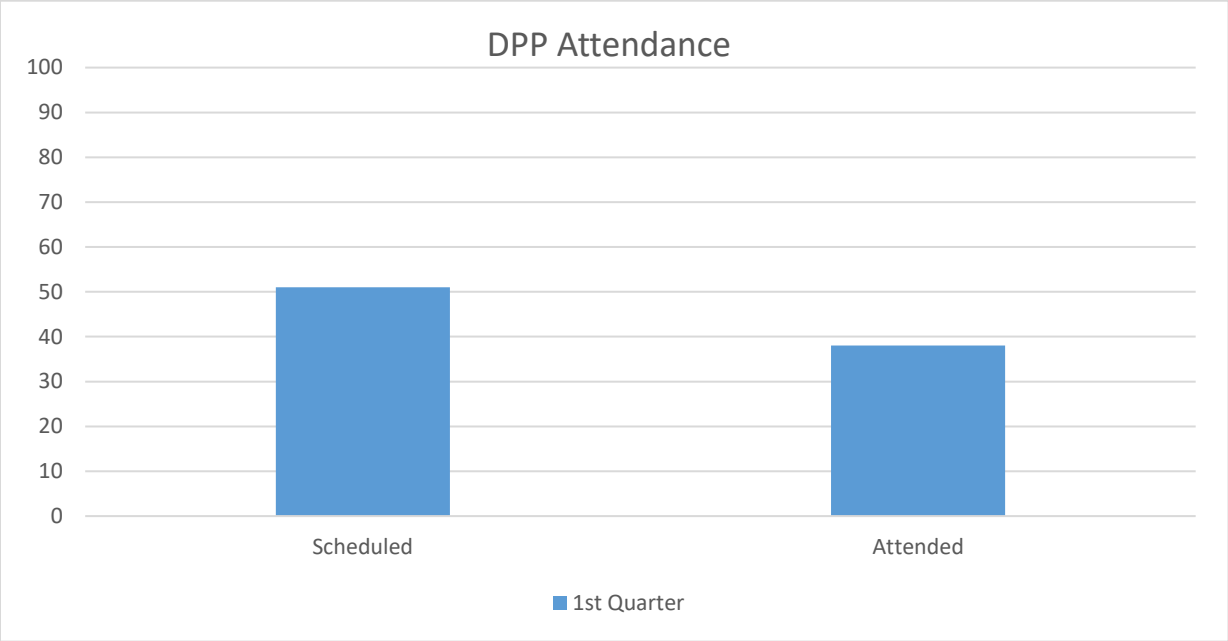
Diabetes Clinic Attendance.

Kern Authority
603



Diabetes Prevention Program: The Disease Management Department launched their 2nd DPP cohort on February, 2nd, 2021. These classes are held remotely until such time that we are able to resume face-to-face meetings. A total of 90 members accepted the invitation to participate and 51 members attended the first session. At the end of March, 2021, 38 members remained enrolled in the program.

Sessions Scheduled to Attend (Feb & Mar)	Remaining Participants (End Mar)
51	38



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: ~~12/13/2018~~	DMHC		PAC	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

_____ Date _____
Douglas A. Hayward
Chief Executive Officer

_____ Date _____
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 Provider Relations~~

_____ Date _____

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Director of Quality Improvement

Date

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.

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

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	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 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 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

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 ~~3 working days.~~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.

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Commented [DM2R1]: Policy page 8 below indicates urgent referrals are processed within 72 hours—not business days like routine—needs prioritization.

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 ~~Associate Medical Director~~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 ~~three (3) working days~~72 hours from receipt of ~~request~~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 ~~three (3) working days~~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~~or their designee~~(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

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.

~~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

~~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. The complaint form shall provide an opportunity for the enrollee to request a conference as part of KHS grievance system.
KHS will provide members conference when requested as part of the grievance process. See *KHS Policy and Procedure #5.01-P: Grievance Process* for additional information.
d. KHS will provide members ~~option for~~ conference when requested as part of the grievance process. See *KHS Policy and Procedure #5.01-P: Grievance Process* for additional information.

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 the 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.

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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.

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 ~~Director of Provider Relations~~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-*

Commented [DM3]: Do we list Emily or Jake or other? Is there a PNM director? CNAO for Emily.

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. MCG (Milliman Care Guidelines)
B. Hospice criteria
C. DME criteria
D. Level of care - skilled vs. custodial guidelines
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

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.

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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 Where indicated a referral to KHS's other medical management programs such as ~~UM, CM and DM~~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]

Commented [DM4]: They can only see the ones they submitted or all?

Commented [SM5R4]: Currently only ones they submitted. I did not change language, only moved placement. Will bring this up for possible consideration of scope addition to PHM or ECM.

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.*

~~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.~~

~~Where indicated a referral to KHS's other medical management programs such as UM, CM and DM will be made to manage complex or challenging member issues. .~~

~~The QI Medical Director or their physician designee may draft a letter requesting further information and/or clarification regarding the issue in question. If a quality of care issue is identified, the Medical Director or designee will inform the involved facility's QI Department or the responsible provider of the findings. Not all identified quality of care issues will require a corrective action plan but all will be tracked for quality purposes.~~

~~12.0 CLOSING CASE~~

~~Based on the outcome of the review, the case may be closed with a Severity Level of:~~

- ~~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 particular 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~~

~~Copies of all written correspondence and pertinent documents are filed in the appropriate, secured Quality Improvement files within the medical management system.~~

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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 1~~3~~4.0 – 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.*

13.0 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.

14.0 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	~~Administrative~~ Director of ~~Health Services~~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, ~~Health Education & Disease Management~~

Commented [DM6]: This role no longer exists

15.0 DELEGATED OVERSIGHT

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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*[53]
Attachment C: *Notice of Adverse Determination - Delay*[54]
Attachment D: *Notice of Adverse Determination - Modify*[55]
Attachment E: *Notice of Adverse Determination - Denial*[56]
Attachment F: *Notice of Adverse Determination - Terminate*[57]
Attachment G: *Your Rights Under Medi-Cal Managed Care*[58]
Attachment H: *Form to File a State Hearing*[59]
Attachment I: *Public Letter – Criteria Request*
Attachment J: *Public Request for Criteria Log*
Attachment K: *Re-classification Letter*

REFERENCE:
REFERENCE:

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~~, 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)

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[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] CAP response for DHS/DMHC Medical Audit (YE Oct03).~~
[53] Must include specific service approved (HSC §1367.01(h)(4)
[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.
[59] Exact letter required by MMCD 04006 and 05005.

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Emergency Services				POLICY #: 3.31-P	
DEPARTMENT: Utilization Management					
Effective Date: 04/2005	Review/Revised Date: 10/19/2020	DMHC		PAC	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

_____ Date _____
Douglas A. Hayward
Chief Executive Officer

_____ Date _____
Chief Medical Officer

_____ Date _____
Chief Operating Officer

_____ Date _____
Chief Health Services Officer

_____ Date _____
Director of Claims

_____ Date _____
Director of Utilization Management

POLICY[1]:
Emergency services may be provided by any qualified emergency provider.

Emergency services will be provided in accordance with the statutory, regulatory, and contractual requirements outlined in the following sources:

- California Health and Safety Code § 1262.8; 1317; 1317.1; and 1371.4
- California Code of Regulations Title 28 §1300.67(g)
- California Code of Regulations Title 22 §§53216; and 53855
- 2004 DHCS Contract Exhibit A-Attachment 5(2) and (3); Exhibit A – Attachment 6 (5) and (9);

Exhibit A – Attachment 9 (6); and Exhibit E - Attachment 1, (31);

- DHCS Letter: Payment for Emergency Services to Non-Contracted Providers (October 1, 2001)

DEFINITIONS:

Emergency Medical Condition[2]	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: A. Placing the member's health (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, B. Serious impairment to bodily functions C. Serious dysfunction of any bodily organ or part; or D. With respect to a pregnant woman who is having contractions, inadequate time to affect a safe transfer to another hospital before delivery, or that transfer may impose a threat to the health and safety of the woman or the unborn child.
Emergency Services and Care[3] [4]	Medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery by a physician necessary to relieve or eliminate the emergency medical condition within the capability of the facility. This includes an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility.
Stabilized[5]	A patient is "stabilized" or "stabilization" has occurred when, in the opinion of the treating provider, the patient's medical condition is such that, within reasonable medical probability, no material deterioration of the patient's condition is likely to result from, or occur during, a transfer of the patient.

PROCEDURES:

1.0 ACCESS

Emergency services and care are available and accessible to members on a 24-hour a day, seven days a week basis within the KHS service area.[6] KHS members have access to all emergency service facilities in Kern County. All emergency services facilities in Kern County provide care on a 24-hour-a-day, 7-day-a-week basis with one or more Physicians and one Nurse on duty in the facility at all times.[7]

KHS does not require prior authorization for emergency services and care.[8] Members may receive emergency services and care from any qualified provider.

Members needing advice or triage to an emergent care center may contact the KHS 24-Hour Telephone Triage Service at 1-800-391-2000.

The KHS Chief Medical Officer or a designee who is licensed as a "physician or surgeon"[9], is available 24 hours per day, seven days per week to coordinate the transfer of care of a member whose emergency condition is stabilized, to authorize medically necessary post-stabilization services, and for general communication with emergency room personnel.[10]

1.1 Out-of-Area Services[11]

For the Medi-Cal Product, emergency services are covered if they are provided within the United States. In addition, emergency care services requiring hospitalization are covered if they are provided in Canada or Mexico. Emergency services provided in any other country are not covered.

2.0 COVERED SERVICES

Members presenting to an emergency department for treatment should be provided with a medical screening examination (MSE) to determine whether or not an emergency condition exists. An MSE may include ancillary services routinely available to the emergency department that are necessary to determine whether an emergency condition actually exists.

If, after completion of the MSE, an emergency medical condition is found to exist, the emergency department shall treat and stabilize the member up to and including admission to the hospital.

If, after the MSE, an emergency medical condition has been determined not to exist or the emergency condition has been stabilized, prior authorization for further services may be obtained as outlined in *KHS Policy and Procedure #3.22-P Referral and Authorization Process*, decisions on such verbal authorization requests will be rendered within 30 minutes, or the request will be deemed approved. [12] KFHC shall not require a non-contracted hospital representative or a non-contracted Physician and Surgeon to make more than one telephone call pursuant to Section 1317.4a (c) (2) to the number provided in advance by KFHC. The representative of the hospital that makes the telephone call may be, but is not required to be, a Physician and/or Surgeon.

KHS does not require transfer to a contracted acute care hospital. The facility shall submit notification of admission either through the KHS provider portal or by faxing the face sheet and clinical documentation to (661) 664-5190. When submitted as outlined in *KHS Policy and Procedure #3.22-P Referral and Authorization Process*, decisions on such verbal authorization requests will be rendered within 30 minutes, or the request will be deemed approved. If there is a disagreement between KHS and the Provider regarding the need for necessary medical care following stabilization of the member, KHS shall assume responsibility for the care of the patient either by having medical personnel contracting with KHS personally take over the care of the patient within a reasonable amount of time after the disagreement, or by having another general acute care hospital under contract with KHS agree to accept the transfer of the patient[13].

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2.1 Emergency Psychiatric Conditions

Emergency services and care for psychiatric conditions are covered by KHS, including initial history and physical within 24 hours after admission to a psychiatric facility. All other psychiatric services with the exception of initial consults occurring while admitted for other medical condition or other outpatient mild to moderate mental health services are carved out of the Medi-Cal Product.

KHS covers all professional services, except the professional services of a mental health specialist, when required for the emergency services and care of a member whose condition meets specialty mental health medical necessity criteria.

KHS covers the facility charges resulting from the emergency services and care of a Plan member whose condition meets MHP medical necessity criteria when such services and care do not result in the admission of the member for psychiatric inpatient hospital services or when such services result in an admission of the member for psychiatric inpatient hospital services at a different facility.

Members in need of urgent and emergency psychiatric care that are identified by KHS, including person-to-person telephone transfers, will to be referred to the county crisis program during their call center hours. A toll free telephone crisis hotline will be maintained for telephonic support as well as guidance for receiving additional treatment. Members needing immediate crisis intervention may self-refer to the Crisis Stabilization Unit where on-site Mental Health staff is available 24 hours a day.

2.2 Emergency Transportation

Coverage includes appropriate ambulance services as described in *KHS Policy and Procedure 3.50-P Ambulance Transportation Services.*[14]

2.3 Emergency Pharmaceuticals

Under emergent circumstances, Provider shall administer and/or dispense a sufficient quantity of medication to the member to last until the member can reasonably be expected to have a prescription filled.

3.0 DOCUMENTATION

Although emergency services do not require prior authorization, practitioners/providers must submit a *Referral/Prior Authorization Form* or the hospital facesheet with any additional clinical documentation to KHS as soon as reasonably possible after care has been provided for tracking purposes. (Form included as an attachment to *KHS Policy and Procedure #3.22-P Referral Process*.) This requirement does not apply to Emergency Room Physicians but only to other types of Providers who perform emergency services.

All requests for authorizations, and all responses to such requests for authorizations, of post-stabilization medically necessary health care services shall be fully documented ~~All calls received for post-stabilization care authorization will be documented~~ in the member's record in the KHS medical management system.~~–~~ All provision of medically necessary health care services shall be fully documented. After hours calls may be initially documented to the *UM On C~~c~~all After-Hours Call Log* and then be entered into the member's record in the medical

management system the following business day.

Documentation must include at a minimum the following information: the date and time of the request, the name of the health care provider making the request, member name, member identification number, and the name of the KHS representative responding to the request.[15]

4.0 COORDINATION OF CARE, MONITORING, AND REPORTING

KHS must provide notification at least annually to all non-participating hospitals within the state of California on KHS contact information for post-stabilization notification.[16]

KHS monitors primary care practitioners for adequate follow-up care for those members who have been screened in the Emergency Room and require non-emergency care through the QI site review process and reporting.[17]

KHS uses *Referral/Prior Authorization Forms* and other documentation received from practitioners/providers to conduct coordination of care, tracking, and case management activities. Providers may contact KHS UM Nurse to discuss a member's care and any coordination of care needs during a hospitalization by calling (661) 664-5083.

5.0 REIMBURSEMENT

Claims must be submitted and are processed in accordance with *KHS Policy and Procedure #6.01-P Claims Submission/Reimbursement*. Provider disputes regarding claims payment must be submitted and are processed in accordance with *KHS Policy and Procedure # 6.04-P Practitioner/Provider Disputes Regarding Claims Payment*.

KHS reimburses all medically necessary emergency claims according to the eligibility of the member at the time of service and the level of care received by the member. At a minimum, reimbursement for a MSE is made to all emergency room practitioners/providers, (professional and facility component and hospital based urgent care facilities).

Contracted providers are reimbursed based on negotiated rate. Non-Contracted providers are reimbursed at Billed charges or Medi-Cal FFS rates, whichever is less. All services are subject to Medi-Cal Correct Coding Editing and Guidelines.

For emergency inpatient services, in the absence of a negotiated rate, claims are reimbursed in accordance with the following guidelines: Applicable Diagnostic Related Group (APR-DRG) reimbursement rates for out-of-network emergency, and post-stabilization acute inpatient services provided to MCP beneficiaries by general acute care hospitals.

6.0 PROVIDER REQUIREMENTS

All non-contract and out-of-area Emergency Departments must follow applicable laws and regulations when KHS members present for care.

7.0 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.

REFERENCE:

[1] **Revision 2021-05:** Clarification of language to comply with HSC §1300.71.4 by Director of Utilization Management. **Revision 2020-07:** Policy updated by Director of Utilization Management based on feedback from the DMHC final report of Routine Survey conducted 8/2019. **Revision 2020-02:** Revised by Director of UM per DMHC comments dated 1/14/2020. Added Section 7.0 for language regarding delegated oversight. **Revision 2014-08:** Revised by Director of Health Services to comply with All Plan Letter 13-004. Revised per DMHC comments dated 9/7/06. Added contract language for dispensing medication in emergency cases. Revised per DMHC Comments dated 09/06/06. **2005-10:** Revised per DHS Workplan Comments 6d (9/1/05) and 6h (9/1/05). Revised to reflect the deletion of external policy 3.15 – Urgent Care/Emergent Care 24 Hour Telephone Triage. **Revision 2005-08:** Revised per DHS Comments (7/12/05). **Revision 2005-04:** Policy reviewed against DHS Contract 03-76165. No revision needed per Lacey Campbell. **Revision 2004-05:** Created as part of routine revision of emergency services policies. Contains elements of the following policies that will be deleted upon the release of 3.23:*#3.12 – Prior Authorization for Urgent Care and Non-Emergent ER Services (2000-05); #6.24 – Emergency/Urgent Care Reimbursement Guidelines (2002-02*). **Formerly #3.23.**

[2] HSC §1317.1(b) and (c) and 2004 DHS Contract Exhibit E – Attachment 1(31). Combines the least restrictive elements of both definitions. Title 22 §51056 also has a similar definition.

[3] HSC §1317.1(a). Definition from DHS Contract Exhibit E-Attachment 1(32) is not included because it is less restrictive.

[4] " For the purposes of Section 1371.4 emergency services and care as defined in this paragraph shall not apply to services provided under managed care contracts with the Medi-Cal program to the extent that those services are excluded from coverage under the contract." HSC §1317.1(a)(2)

[5] HSC §1317.1(j)

[6] CCR Title 28 §1300.67(g)(1); DHS Contract A-6 (5) and A-9 (6)

[7] DHS Contract A-6 (5)

[8] CCR Title 22 §53855(a); DHS Contract Exhibit A-Attachment 5(2)(F) and (3)(A); DHS Contract A-9 (6)(A)

[9] "physician and surgeon" added per DMHC comment 9/6/06.

[10] DHS Contract A-6 (9) and A-9 (6)(C)

[11] CCR Title 22§51006

[12] HSC 1371.4(c); CCR Title 22 §53855(a)

[13] DMHC comment letter dated 9/6/2006

[14] CCR Title 28 §1300.67(g)(1)

[15] HSC § 1262.8; CCR Title 28 § 1300.71.4(d)

[16] HSC § 1268.2(j).

[17] DHS Contract A-9 (6)(B)

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Hospice Services				POLICY #: 3.43-P	
DEPARTMENT: Utilization Management					
Effective Date: 12/2005	Review/Revised Date: ~~08/31/2020~~	DMHC		PAC	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

_____ Date _____
Douglas A. Hayward
Chief Executive Officer

_____ Date _____
Chief Medical Officer

_____ Date _____
Chief Operating Officer

_____ Date _____
Chief Health Services Officer

_____ Date _____
Director of Claims

_____ Date _____
Director of Utilization Management

POLICY:

Kern Health Systems (KHS) shall cover and facilitate the provision of hospice care services. KHS shall fully inform members and their families of the availability of hospice care as a covered service and the methods by which they may elect to receive these services.[1]

Hospice services will be provided in accordance with the statutory, regulatory, and contractual requirements outlined in the following sources:

- California Health and Safety Code[2] §§ 1368.1;1368.2; and 1746[3]
- California Code of Regulations Title 28 § CCR 28 §1300.68.2
- California Code of Regulations Title 22 §§51180; 51180.1; and 51349

- ❖ DHCS Contract Exhibit A-Attachment 5 (3)(I); Attachment 10 (7)(B) and Attachment 11 (17)(A)
- ❖ DHCS MMCD All Plan Letter 05003: Hospice Services and Medi-Cal Managed Care (March 25, 2005)
- ❖ California Code of Regulations Title 22 CCR, Section 51349**,**
- ❖ DHCS MMCD All Plan Letter 13-014: Hospice Services and Medi-Cal Manager Care (October 28, 2013)

Unless otherwise authorized by KHS, hospice services may only be provided by contracted hospice providers.

Members who elect hospice care are not entitled to any other benefits under the plan for the terminal illness while the hospice election is in effect. [4] The hospice election may be revoked at any time.

The amount, duration, and scope of hospice services will be no less than the amount, duration, or scope of services that would be provided under the Medi-Cal fee-for-service program.[5] Hospice care shall at a minimum be equivalent to hospice care provided by the federal Medicare program pursuant to Title XVIII of the Social Security Act.[6]

DEFINITIONS:

Palliative Care[7]	Interventions that focus primarily on reduction or abatement of pain and other disease-related symptoms, rather than interventions aimed at investigation and/or intervention for the purpose of cure or prolongation of life.
Period of Crisis[8]	A period in which the member requires continuous care to achieve palliation or management of acute medical symptoms.
Terminal Illness[9]	A terminal illness is 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 the 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."

PROCEDURES:

1.0 ACCESS

Hospice care is covered for a terminal illness if the services meet all of the following conditions:

- ➢ Ordered by the member's PCP or another authorized provider
- ➢ Performed by a contracted hospice provider or another authorized provider
- ➢ Approved, in the case of general inpatient care, by KHS

The only requirement for initiation of outpatient hospice services is physician certification[10] that a member has a terminal illness and member election of such services.[11] Only general inpatient care is subject to prior authorization if all other requirements regarding prior authorization and associated clinical guidelines have been met.[12]

During regular business hours, providers may request verbal authorization for general inpatient hospice care by calling KHS Utilization Management staff at (661) 664-5083. During weekends, providers may request verbal authorization for hospice care by calling the Weekend On Call Nurse at 661-331-7656. KHS responds to requests for authorization for hospice services within 24 hours. [13]

Covered services are available on a 24 hour basis to the extent necessary to meet the needs of members for care that is reasonable and necessary for the palliation and management of the terminal illness and related conditions.[14] Hospice services may be initiated or continued in a home or clinical setting.[15]

1.1 Election of Hospice

The member or member's representative must file an election statement with the hospice providing the care. The member's election shall include all of the following elements on an appropriate hospice election form[16]:

A. The identification of the hospice
B. The patient's or representative's acknowledgement that:
    1. He or she has full understanding that the hospice care given as it related to the individual's terminal illness will be palliative rather than curative in nature.
    2. Certain specified Medi-Cal benefits are waived by the election.
C. The effective date of the election
D. The signature of the individual or representative

An individual may elect to receive hospice care during one or more of the following periods: (1) an initial 90-day period; (2) a subsequent 90-day period; or (3) an unlimited number of subsequent 60-day periods.[17]

1.2 Special Considerations in Hospice Election

In the event that a member wishes to elect a hospice that is not contracted with KHS, considerations for the case of each member individually for such a choice is made. KHS has the option of immediately initiating a contract (one-time or ongoing) with the hospice provider or referring the patient to another provider for hospice care. On occasion, members receiving hospice at the time they become KHS members may not be able to change their hospice provider, if requested, due to limitations on the number of times there may be a change in the designation of a hospice provider during an election period. In addition, KHS may determine that such a change would be disruptive to the member's care or would not for some other reason be in the patient's best interest. In such instances, KHS should consider a one-time or ongoing contract with the established hospice provider until the new benefit period, or until the end of hospice services.

Hospice care services may be initiated or continued in a home or clinical setting. KHS remains responsible for the provision of, and payment for, all Medi-Cal covered services not related to the terminal illness, including those of the member's primary care physician.

Members who move their legal residence out of the service area must disenroll from the MCP.

1.3 Change of Hospice Provider

A member or representative may change the designation of a hospice provider once each election period.[18]

On occasion, members receiving hospice care at the time of enrollment with KHS may not be able to change their hospice provider, due to limitations during an election period. In such instances, KHS will consider a one time or ongoing contract with the established hospice provider until the member can be transitioned to a contracting hospice provider during a new election period.[19]

[20]Members who move their legal residence out of the service area must disenroll from the associated Medi-Cal Managed Care Plan. Consequently, upon enrollment in a new plan, a "change in designated hospice" must be initiated. This may be done only once per election period.

1.4 Revocation of Hospice[21]

A member's voluntary election may be revoked or modified at any time during an election period. To revoke the election of hospice care, the member or representative must file a signed statement with KHS and the hospice revoking the individual election for the remainder of the election period. The effective date may not be retroactive. Revocation shall constitute a waiver of the right to hospice care during the remainder of the election period.

At any time after revocation, a member may execute a new election, thus restarting the 90/90/unlimited 60-day certification periods of care. An individual or representative may change the designation of a hospice provider once each benefit period.

If a member revokes the hospice benefit, or is discharged by the hospice for cause and later elects hospice and is readmitted to the same or different hospice provider, then the 90/90/unlimited 60-day election periods are initiated as if hospice is starting anew. A member's change from one designated hospice to another is not considered a revocation of the hospice election.

2.0 COVERED SERVICES

Members who elect hospice care are not entitled to any other benefits under the plan for the terminal illness while the hospice election is in effect. [22] The hospice election may be revoked at any time.

Upon member election of hospice services, KHS will facilitate the provision of and provide appropriate payment for covered hospice services provided by a hospice provider or by others under arrangements made by a hospice provider. Covered services include, but are not necessarily limited to, the following[23]:

A. Nursing services when provided by or under the supervision of a registered nurse.
B. Physical, occupational, or speech-therapy for purposes of symptom control, or to

enable the member to maintain activities of daily living and basic functional skills.

C. Medical social services provided by a social worker with at least a Bachelor's degree in Social Work, from a school approved or accredited by the council on Social Work Education, under the direction of a physician.

D. Certified home health aide and homemaker services under the supervision of a qualified registered nurse.[24] Services may include personal care services and such household services as may be necessary to maintain a safe and sanitary environment in the areas of the home used by the patient.

E. Medical supplies and appliances.

F. Drugs and biologicals when used primarily for the relief of pain and symptom control related to the member's terminal illness.

G. Physician services which include:

1. General supervisory services of the hospice medical director.
2. Participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies by the physician member of the hospice interdisciplinary team.

Physician services not described above shall be billed to the MCP separately and include services of the member's attending physician or consulting physician(s) if he or she is not an employee of the hospice or providing services under arrangements with the hospice. Physician visits by a hospice-employed physician, medical director, or consultant are billable separately to the MCP.

H. Counseling services related to the adjustment of the member's approaching death; counseling, including bereavement, grief, dietary and spiritual counseling.

I. Continuous home nursing, home health aide, and/or homemaker services for as much as 24 hours a day during a period of crisis, and only as necessary to maintain the terminally ill member at home.[25] A crisis as the period in which a member requires continuous care for as much as 24-hours to achieve palliation or management of acute medical symptoms.

J. Continuous home care for a minimum of 8 hours of care (aggregate) during a 24 hour day, which begins and ends at midnight.[26]

K. Respite care provided on an intermittent, non-routine and occasional basis for up to five consecutive days at a time in a hospital, skilled nursing or hospice facility.

L. Short term inpatient care for pain control or chronic symptom management which cannot be managed in the home setting.

M. Any other palliative item or service for which payment may otherwise be made under the Medi-Cal program and that is included in the hospice plan of care.

N. Interdisciplinary team care with development and maintenance of an appropriate plan of care.[27]

O. Volunteer services.[28]

2.1 Bereavement Services

Bereavement services include an assessment of the needs of the bereaved family and the development of a care plan that meets these needs both prior to and following the death of the member. These services are available to the surviving family members for one year after the death of the member.[29]

2.2 Home Health Aide Services

Home health aide services include personal care and the performance of related tasks in the home in accordance with the plan of care in order to increase the level of comfort and to maintain personal hygiene and a safe healthy environment. These services are performed by a certified home health aide.[30]

2.3 Social Services and Counseling Services

Social service/counseling services are those counseling and spiritual services that assist the member and his/her family to minimize stresses and problems that arise from social, economic, psychological, or spiritual needs by utilizing appropriate community resources, and maximize positive aspects and opportunities for growth.[31]

2.4 Respite Care

Respite care is short-term inpatient care provided to a member only when necessary to relieve those caring for the member. Respite care is covered on an occasional basis for no more than 5 consecutive days at a time.[32]

3.0 SERVICES NOT COVERED BY HOSPICE PROVIDER

- Private pay room and board or residential care.
- Acute in-patient hospitalization unrelated to the terminal illness.
- Level A or Level B NF for unrelated issues.
- Physician and/or consulting physician services not related to the terminal illness or physician services where the physician is not an employee of hospice or providing services under an arrangement with the hospice.
- Other necessary services for conditions unrelated to the terminal illness.

4.0 PLAN OF CARE[33]

A plan of care must be established by the hospice for each member before services are provided. Services must be consistent with the plan of care. The plan of care must conform to the standards specified in 42 Code of Federal Regulations, Part 418, Subpart C.

5.0 COORDINATION OF CARE

KHS provides coordination of care and joint case management with hospice care providers.[34]

Once a member has elected hospice, KHS contracted providers and case management staff work closely with hospice providers to facilitate the transfer of member services from those directed towards cure and/or prolongation of life to those directed towards palliation.[35] KHS arranges for continuity of medical care, including maintaining established patient-provider relationships, to the greatest extent possible.[36]

Ongoing care coordination is provided and services necessary to diagnose, treat, and follow-up on conditions not related to the terminal illness are provided or initiated as necessary.[37] KHS is responsible for the provision of and payment for all medically necessary services not related to the terminal illness, including those of the member's primary care physician.[38]

5.1 Provision of Hospice Services by Hospice Interdisciplinary Group

Due to the highly specialized services provided by hospices, federal law mandates

that the hospice designate an interdisciplinary group(s) to plan, provide, and/or supervise the care and services offered by the hospice provider. A written plan of care must be established by the attending physician, the medical director or physician designee, and the interdisciplinary group prior to providing care. The plan of care is then reviewed and updated at intervals specified in the plan of care by the attending physician, the medical director or physician designee and interdisciplinary group of the hospice (Title 42, CFR, Section 418.56.)

KHS shall assure coordination of care between the member's health plan and hospice care providers and allow for the hospice interdisciplinary team to professionally manage the care of the patient as outlined in the law.

End of life care for children with a life threatening condition may be substantially different than it is for adults. Hospice care options for children do not fit the traditional adult hospice model. Children can, and often do, live longer with a life threatening condition because of aggressive treatment and their natural resilience.

Children and families may benefit from receiving palliative care services earlier in the course of a child's illness. In addition to hospice care services, a waiver program is available to children and families who may benefit from receiving palliative care services earlier in the course of a child's illness.
For additional information on this subject, please see CCS Numbered Letter (NL): 12-1119 regarding palliative/hospice options for CCS eligible children. This NL can be found on CCS's website at:
https://www.dhcs.ca.gov/services/ccs/Documents/CCS-NL-12-1119.pdf

Policy guidelines and procedural direction on authorization of medically necessary services related to the child's CCS life-limiting condition for children who have elected hospice care can be found at:
http://www.dhcs.ca.gov/services/ccs/Documents/ccsnl061011.pdf

5.2 Hospice Services for Children Served by California Children Services (CCS) for the Terminal Condition[39]

CCS does not offer the range of services provided through hospice for the terminally ill child. Members and their families are clearly advised of the differences between CCS and hospice services and of the potential change in caregivers, should hospice care be elected. KHS will work with CCS to facilitate continuity of medical care, including established patient provider relationships, to the greatest extent possible. Hospice care, if elected for children with terminal diseases, requires close consultation and coordination with CCS and/or other caregivers. Hospice services for CCS recipients are the responsibility of KHS and all hospice policies are applicable.

5.3 Concurrent Hospice Palliative and Curative Care for Children

Under Section 2302 of the Patient Protection and Affordable Care Act, effective March 23, 2010, Medicaid children who have elected to receive hospice services may continue receiving coverage of any payment for other services to treat their terminal illness. Additional information on concurrent care for children can be found at:
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL

2011/PL11-004.pdf

- Medi-Cal's Pediatric Palliative Care Benefit (the Benefit) is designed to assess and demonstrate the advantage of providing community-based palliative care concurrent with life-prolonging therapies. CCS NL 12-1119 defines the principles of palliative care, identifies palliative care services currently available under the state plan, and provides guidelines for timely authorization and payment for these services. This NL can be found at: https://www.dhcs.ca.gov/services/ccs/Documents/CCS-NL-12-1119.pdf

Information on KHS palliative care benefits is referenced in *Policy and Procedure 3.77- Palliative Care.*

6.0 TRANSFER OF MEMBERS

Hospice providers shall provide transferring members with a transfer summary including essential information relative to the member's diagnosis; pain treatment and management, medications, treatments, dietary requirement, rehabilitation potential, known allergies, and treatment plan, which shall be signed by the physician (H&S Code, Section 1262.5). Consequently, upon enrollment in a new health plan, a "change in designated hospice" must be initiated (Title 42 CFR, Section 418.30). This may be done only once per election period.

7.0 REIMBURSEMENT

Of the four levels of hospice care as described in Title 22, CCR, Section 51349 only general inpatient care is subject to prior authorization. Documents to be submitted for authorization include:

- Certification of physician orders for general inpatient care.
- Justification for this level of care.

KHS may not require prior authorization for routine home care, continuous home care and respite care or hospice physician services. Hospices shall notify the KHS of general inpatient care placement that occurs after normal business hours on the next business day. KHS may require documentation following the provision of general inpatient and continuous care for reasons of justification. If the documentation does not support these levels of care, or if the documentation included is inadequate, reimbursement may be reduced to the rate for routine home care. An appeal may be submitted for reconsideration of payment by including additional documentation of the medical necessity for the increased level of care.

Visits made to a member by the hospice Medical Director, hospice physician, or consultant should be billed separately.[40]

7.1 Hospice Services Provided in a Long Term Care Facility[41]

Hospice services are covered services and are not categorized as Long Term Care (LTC) services regardless of the member's expected or actual length of stay in a nursing facility while also receiving hospice care.

KHS shall not require authorization for room and board as described in Title 42, CFR, 418.112 and Section 1902(a)(13)(B) of the SSA.

Section 1905(o)(1)(A) of the SSA allows for the provision of hospice care while an individual is a resident of a skilled nursing facility (SNF) or intermediate care facility. Payment from KHS will be provided to the hospice for hospice care (at the appropriate level of care).

In accordance with the Medicare Benefit Policy Manual Chapter 9 - Coverage of Hospice Services Under Hospital Insurance (Rev. 156, 06-01-12) 20.3 - Election by Skilled Nursing Facility and Nursing Facilities Residents and Dually Eligible Beneficiaries (Rev. 1, 10-01-03) HO-204.2, payment for room and board shall be made directly to the hospice. The hospice shall then reimburse the NF for the room and board at the rate negotiated between the hospice and SNF. Payment for the room and board component must be equal to at least 95 percent of the reimbursement the NF/SNF would have been reimbursed by KHS. Payments by a hospice provider to a nursing home for room and board shall not exceed what would have been received directly from Medi-Cal or the MCP if the patient had not been enrolled in a hospice.

LTC residents who elect the Medi-Cal hospice benefit are not disenrolled from KHS. Hospices will bill the MCPs using the following revenue codes:

- Revenue code 658-Facility Code Type 25.
- Revenue code 658-Facility Code Type 26.

7.2 Medicare[42]

For beneficiaries with both Medicare and Medi-Cal coverage (dual-eligibles), the hospice bills Medicare for the hospice services. The room and board charge is billed to Medi-Cal only. Following payment from Medicare, the hospice then bills the MCP for the co-payment amount; however, the total reimbursed amount cannot exceed the Medicare rate (Title 22, CCR, Section 51544). For Medicare beneficiaries entitled to only Medicare Part B, benefits will be billed directly to the MCP. No Medicare denial will be required.

KHS cannot require authorization for the hospice to bill KHS for the room and board covered by Medi-Cal while the patient is receiving hospice services under Medicare.

The hospice shall notify KHS when a member elects the Medicare hospice benefit.

KHS will then pay the room and board payment to the hospice provider according to the rate outlined above, and the hospice shall be responsible for paying the nursing home. Eligibility for the Medi-Cal nursing home room and board payment continues
to be determined by the nursing home and KHS.

For beneficiaries enrolled in the Coordinated Care Initiate Demonstration Project

(www.calduals.org), referred to as Cal Medi-Connect, DHCS will implement specific billing, claims, and payment procedures if hospice becomes part of Cal MediConnect. Currently, the benefit is covered by Medicare.

7.3 Hospice Rates

The Medicaid hospice rates for hospices' four levels of care are calculated based on the annual hospice rates established under Medicare. These rates are authorized by Section 1814(i)(1)(C)(ii) of the SSA, which also provides for an annual increase in payment rates for hospice care services. KHS must update their rates annually to coincide with changes to the Medicare rates.

KHS may pay more, but not less than, the Medicare rate for hospice services (Section 1902(a)(13)(B) of the SSA). The Medicaid hospice payment rates for each federal fiscal year are printed in the Federal Register.

Inpatient rates (general or respite) shall be paid for the date of admission and all subsequent inpatient days except the day on which a patient is discharged. For the day of discharge, the appropriate home care rate shall be paid unless the patient dies as an inpatient. If the patient dies while an inpatient, the inpatient rate (general or respite) shall be paid for the discharge day.

7.4 Physician Services

Hospice providers must use current Medi-Cal billing code when billing for physician services for pain and symptom management related to a patient's terminal condition and provided by a physician employed by, or under arrangements made by, the hospice. KHS is required to reimburse one visit-per-day, per-patient.

Consulting/special physician services code may be billed only for physician services to manage symptoms that cannot be remedied by the patient's attending physician because of one of the following:

- Immediate need.
- The attending physician does not have the required special skills.

8.0 UTILIZATION REVIEW

KHS may not restrict access to hospice care services any more than the MCAL Fee-For – Service (FFS) program may restrict the same services (Title 42 CFR, §438.210(a)). The FFS program does not require prior authorization of hospice services except for inpatient admissions; therefore, KHS shall adjust their utilization review standards, if necessary, to meet those of the FFS program. Authorizations are entered for tracking purposes only to assist validation of the appropriate documentation requirements are met, i.e. initial physician certification and member election forms. Additional certifications for illness periods (90-day period, subsequent 90-day period, or unlimited 60-day period) will be required for tracking purposes and coordination of services.

Per Chapter 9 of the Medicare Claims Processing Manual, Medicare Hospice Benefit Section 40.1.5 - Short-Term Inpatient Care, general inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management that cannot feasibly be provided in other settings. Skilled nursing care may be needed by a patient whose home support has broken down if this breakdown makes it no longer feasible to furnish needed care

in the home setting. General inpatient care under the hospice benefit is not equivalent to a hospital level of care under the Medicare hospital benefit.

8.1 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 referenced in *Policy and Procedure –3.22 Referral and Authorization Process* for additional information. 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. The complaint form shall provide an opportunity for the enrollee to request a conference as part of KHS grievance system. See *KHS Policy and Procedure #5.01-P: Grievance Process* for additional information.
~~KHS will provide members option for conference when requested as part of the grievance process.~~

9.0 PROVIDER REQUIREMENTS[43]

KHS only contracts with entities licensed pursuant to the California Hospice Licensure Act of 1990[44] or licensed home health agencies with federal Medicare certification[45] for the provision of hospice services. Contracted hospice providers may arrange to provide hospice services with appropriately licensed individuals or entities.

A hospice physician or nurse practitioner (NP) is required to have a *face-to-face encounter with every hospice patient* to determine the continued eligibility of that patient. The face-to-face encounter requirement is satisfied when the following criteria are met:

1. Timeframe of the encounter:
   The encounter must occur no more than 30 calendar days prior to the start of the third benefit period, and no more than 30 calendar days prior to every subsequent benefit period thereafter (refer to item four below for an exception to this timeframe).

2. Attestation requirements
   A hospice physician or NP who performs the encounter must attest in writing that he or she had a face-to-face encounter with the patient, including the date of the encounter.
   The attestation, its accompanying signature and the date signed must be on a separate and distinct section of, or an addendum to, the recertification form, and must be clearly titled.
   Where an NP performed the encounter, the attestation must state that the clinical findings of that visit were provided to the certifying physician for use in determining whether the patient continues to have a life expectancy of six months or less, should the illness run its normal course.

3. Practitioners who can perform the encounter
   A hospice physician or a hospice NP can perform the encounter. A hospice physician is a physician who is employed by the hospice or working under contract with the hospice. A

hospice NP must be employed by the hospice. A hospice employee is one who receives a W-2 from the hospice or who volunteers for the hospice.

4. Timeframe exceptional circumstances for new hospice admissions in the third or later benefit period
   In cases where a hospice newly admits a patient in the third or later benefit period, exceptional circumstances may prevent a face-to-face encounter prior to the start of the benefit period.

   For example, if the patient is an emergency weekend admission, it may be impossible for a hospice physician or NP to see the patient until the following Monday. Or, if CMS data systems are unavailable, the hospice may be unaware that the patient is in the third benefit period. In such documented cases, a face-to-face encounter that occurs within two days after admission will be considered timely. Additionally, for such documented exceptional cases, if the patient dies within two days of admission without a face-to-face encounter, a face-to-face encounter can be deemed as complete.

   The hospice must retain the certification statements, and have them available for audit purposes.

10.0 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.

REFERENCE:

Revision 05/2021: Minor revision by Director of Utilization Management to section 3.0 language. **Revision 07/2020:** Definition of Terminal Illness revised to comply with 2019 DMHC Medical Audit deficiency #6. **Revision 02-2020:** Updated Utilization Review per DMHC comments 1/14/2020. Revisions to section 5.1 and 5.2 with updates to CCS NL reference. Section 10.0 added language for Delegated Oversight. **Revision 03-2015:** New requirements effective February 1, 2015 for face-to-face encounters for every hospice patient. Language added in Section 9.0 Provider Requirements. Revision **2014-12**: Revisions to Section 5.2 to facilitate continuity of care with CCS. Utilization Review added new language for tracking purposes and certification for illness periods. **Revision 2014-06:** Major revisions throughout policy to comply with All Plan Letter (APL) 13-014. Review and revision provided by Director of Health Services. Board of Directors approved at 7/17/2014 meeting.

[1] DHS Contract Exhibit A - Attachment 10 (7)(B)
[2] Includes HSC sections as added/amended by AB892 (1999)
[3] Definitions
[4] CCR Title 22 §51349(f)
[5] MMCD All Plan Letter 05003 III B (page 4) references 42 CFR Section 438.210(a)(2)
[6] HSC 1368.2(b)
[7] HSC 1339.31(b)
[8] CCR28 §1300.68.2(d)(1)
[9] HSC 1368.2 definition used; similar definition found in title 28 Section 1300.68.2 (a)(11). Definition found in CCR Title 22 Section 58810.2 is less strict (6 months).
[10] Certification as outlined in Title 42, CFR 418 Subpart B
[11] MMCD All Plan Letter 05003 I (page 2)
[12] Title 22 Section 51349 (b); MMCD All Plan Letter 05003 I (page 2)

[13] 2004 DHS Contract Exhibit A-Attachment 5(3)(I); MMCD All Plan Letter 05003 I (page 2)
[14] CCR 28 §1300.68.2(c)
[15] MMCD All Plan Letter 05003 III D (page 5)
[16] CCR Title 22 Section 51349 (d); MMCD All Plan Letter 05003 III A (page 3)
[17] MMCD All Plan Letter 05003 III A (page 3). The MMCD letter contradicts Title 22 Section 51349 (e). Per D. Chin (9/26/05) KHS was instructed to follow to MMCD letter.
[18] MMCD All Plan Letter 05003 III C (page 4)
[19] MMCD All Plan Letter 05003 III D (page 5)
[20] MMCD All Plan Letter 05003 III D (page 5) references 42 CFR Section 418.30
[21] CCR Title 22 Section 51349 (e); MMCD All Plan Letter 05003 III C (page 4)
[22] CCR Title 22 §51349(f)
[23] CCR Title 28 Section 1300.68.2 (b); CCR Title 22 Section 51349 (h); MMCD All Plan Letter 05003 III B (page 3)
[24] Addition of "certified" and "under the supervision of…" per Title 28 Section 1300.68.2 (b)(2)(B)
[25] 42 CFR Section 418.204 CCR28; §1300.68.2(d)(1)
[26] Per MMCD All Plan Letter 05003: Section 230.3 of the Medicare Hospice Manual and CMS Transmittal A-03-016
[27] CCR Title 28 Section 1300.68.2 (b)(2)(A)
[28] CCR Title 28 Section 1300.68.2 (b)(2)(F)
[29] Definition included in Member Handbook by DMHC request 04/15/02. CCR28 §1300.68.2(a)(1)
[30] Definition included in Member Handbook by DMHC request 04/15/02. CCR28 §1300.68.2(a)(4)
[31] Definition added to Member Handbook by DMHC request 04/15/02. CCR28 §1300.68.2(a)(10)
[32] CCR Title 28 §1300.68.2(d)(2)
[33] CCR Title 22 Section 51349 (g)
[34] MMDC All Plan Letter 05003 IV C (page 6)
[35] MMCD All Plan Letter 05003 IV (page 5)
[36]DHS Contract Exhibit A - Attachment 10 (7)(B)
[37] MMCD All Plan Letter 05003 IV (page 5) references 42 CFR Section 438.208
[38] MMCD All Plan Letter 05003 III D (page 5)
[39] MMCD All Plan Letter 05003 IV B (page 5)
[40] MMCD All Plan Letter 05003 III B (page 3)
[41] DHS Contract Exhibit A – Attachment 11 (17)(A); DHS Contract Exhibit A - Attachment 10 (7)(B); MMCD All Plan Letter 05003 V A (page 6)
[42] MMCD All Plan Letter 05003 V B (page 6) references Title 22 Section 51544
[43] CCR Title 28 Section 1300.68.2 (b)(1)
[44] HSC Section 1745, et seq
[45] HSC Sections 1726 and 1747.1

KERN HEALTH SYSTEMS

Policy and Procedure Review/ Revision

Policy 10.01-I Clinical and Public Advisory Committee Appointment has been updated and is provided here for your review and approval.

Reviewer	Date	Comment/Signature
Doug Hayward	9/16/20	
Dr. Tasinga	9/15/2020	
Alan Avery	9/8/2020	**Approved via email by Alan Avery**
Emily Duran	9/2/2020	**Approved via email by Emily Duran**
Deb Murr	8/24/2020	
Nate Scott	8/19/2020	**Approved via email Nate Scott**
Louie Iturriria	8/18/2020	**Approved via email Louis Iturriria – following new PP/CAC committee appointments at 8/13/20 KHS Board meeting – attachment revised**
Bruce Wearda	7/20/2020	**Approved via email Bruce Wearda**
Jane Daughenbaugh	6/9/2020	Jane Daughenbaugh

(CEO decision(s))

Board approval required: Yes ___ No ____ QI/UM Committee approval: Yes ___ No ___

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Clinical and Public Advisory Committee Appointment				POLICY #: 10.01-I	
DEPARTMENT: Quality Improvement					
Effective Date: 08/29/1997	Review/Revised Date: 9/16/2020	DMHC		PAC	
		DHCS		QI/UM COMMITTEE	
		BOD	X	FINANCE COMMITTEE	

_____ Date _____
Douglas A. Hayward
Chief Executive Officer

_____ Date _____
Chief Medical Officer

_____ Date _____
Chief Operating Officer

_____ Date _____
Chief Network Administration Officer

_____ Date _____
Chief Health Services Officer

_____ Date _____
Director of Member Services

_____ Date _____
Director of Marketing

_____ Date _____
Director of Pharmacy

_____ Date _____
Director of Quality Improvement

POLICY:

Kern Health Systems (KHS) has established procedures to permit subscribers and enrollees to participate in establishing the public policy of the plan. For purposes of this document, public policy means acts performed by KHS or its employees and staff to assure the comfort, dignity, and convenience of patients who rely on the plan's facilities to provide health care services to them, their families, and the public. KHS will ensure the provision of Public policy appointments to the committee will be made in accordance with statutory, regulatory, and contractual requirements:

- Knox Keene Health Care Service Plan Act of 1975
- Health Maintenance Act of 1973
- California Code of Regulations Title 28 1300.69, Division 1,Chapter 2, Article 8

In order to transact the business of KHS, the Board of Directors recognizes the need to delegate certain authority to specified advisory committees. These committees will serve in the role of reviewing pertinent information and advising the Board with regard to action. This policy will establish the method by which members of the advisory committees of the Board will be appointed Including Fraud, Waste and Abuse and Compliance Committee.

PURPOSE:

To establish the criteria and method by which members of the Physician Advisory (PAC), Quality Improvement/Utilization Management (QI/UM), Pharmacy and Therapeutics (P&T), and other advisory committees are appointed.

PROCEDURE:

1.0 COMMITTEES

KHS has established the following advisory committees:

A. Quality Improvement/Utilization Management (QI/UM) Committee Membership (see Attachment A)
B. Physician Advisory Committee (PAC) Membership (see Attachment B)
C. Pharmacy and Therapeutics (P&T) Committee Membership (see Attachment C)
D. Public Policy/Community Advisory Committee (see Attachment D)

KHS established additional committees to address other operation areas described in *KHS Policy and Procedure 14.04-Fraud, Waste, and Abuse Committee and Policy and Procedure 14.55- Delegated Oversight Committee.*

2.0 COMMITTEE MEMBERS

At the direction of the Board, a list of candidates for membership for each position on the designated committees is developed by KHS staff. This list is presented to the Board for review and selection. Committee members are appointed by the Board of Directors.

2.1 Practitioner Recruitment

Each candidate should be a credentialed contracted practitioner who has indicated an interest in serving on the committee. The list of candidates should be designed to represent the various organizational and geographic constituencies participating in the network.

Special consideration is given to traditional and safety net practitioners with the intention of providing them as much representation on the committee as possible. Practitioners with past experience, demonstrated expertise, or expressed interest in the subject matter of the committee are given particular consideration.

2.2 Non-Practitioner Recruitment

Non-practitioner committee members may include members (current and past), advocacy group representatives, or any other interested individual. Candidates may apply for committee membership by submitting a resume and/or letter to the Chief Medical Officer. In the application correspondence, the candidate should identify the Committee on which they wish to be a member and how they will positively contribute to the committee composition.

3.0 MEMBERSHIP TERM

Committee membership is for two years and reviewed by the Board on a biennial basis at either the January or February Board meeting.

4.0 ATTENDANCE

Committee members must attend a minimum number of committee meetings determined by each committee. Failure to comply with committee meeting attendance may result in Board evaluation of committee appointment including, but not limited to, termination of appointment.

5.0 ADDITIONAL COMMITTEES

Fraud Waste and Abuse

Kern Health Systems (KHS) is committed to preventing and detecting any fraud, waste, or abuse related to the State Medi-Cal health care programs. To this end, KHS maintains a compliance program and strives to educate its work-force on fraud and abuse laws, including the importance of ongoing monitoring of claims and authorizations. KHS maintains a Clinical Oversight Committee for Fraud, Waste, and Abuse to ensure inappropriate claims and /or services are detected early, investigated properly, and reported as required to the DHCS or other regulatory bodies. The committee meets at a minimum of bi-monthly or more often as warranted.

This committee consists of internal KHS clinical staff, including but not limited to:

- Chief Medical Officer, or designee,
- Medical Director(s),
- Senior Director of Health Services,
- Director of Quality Improvement,
- Director of Case and Disease Management, ‘
- Director of Utilization Management,
- Administrative Director of Health Homes,
- Director of Health Education, Cultural and Linguistics, and
- Compliance representative

Compliance Committee

KHS maintains a Corporate Compliance program as a formal system to help the organization maintain compliance in all areas of operation. The committee focuses on upholding policies and procedures that prevent the organization and employees from non-adherence to governing laws and regulations. The Compliance Committee meets at a minimum of quarterly or more often as warranted.

This committee consists of internal KHS clinical staff, including but not limited to:

- Chief Operating Officer,
- Chief Medical Officer,
- Chief Information Officer,
- Director of Compliance,
- Senior Director of Health Services,
- Director of Pharmacy,
- Director of Provider Relations,
- Director of Claims,
- Director of Human Resources,
- Director of Member Services, and
- Controller

ATTACHMENTS:

- ❖ Attachment A – Quality Improvement/Utilization management Committee Membership
- ❖ Attachment B – Physicians Advisory Committee Membership
- ❖ Attachment C – Pharmacy & Therapeutics Committee Membership
- ❖ Attachment D – Public Policy/Community Advisory Committee

Revision 2020-08: PP/CAC Committee appointments approved at 8/13/2020 KHS Board meeting. Added language of Knox-Keen regulations regarding participation by subscribers and enrollees to align with section 1369 of the Knox-Keene Act., Director of Quality Improvement. **Revision 2014-12:** Minor changes provided by Director of Pharmacy. Policy will be presented to KHS Board of Directors. **Revision 2011-08:** Attachment B limited Ex Officio Non-Voting members to Medical Director or Doctor of Osteopathy. **Revisions 2009-02:** Revised by Quality Improvement Manager. **Revision 2005-04:** Change requested by Director of Pharmacy to have P and T Committee Membership changed to voting members. **Revision 2002-08:** Revised per DHS Comment 09/19/01. **Formerly:** 2.05 - Committee Appointment. Changed to Administration Section of policies (10.XX).

Attachment A

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

Voting Membership

1	KHS Chief Medical Officer (Chairperson)
2	Participating Primary Care Physicians
2	Participating Specialty Physicians
1	Participating Home Health Representative
1	Kern County Public Health Officer
1	Participating Mid-Level Practitioner
2	Other Participating Ancillary Representatives
1	Participating Hospital Representative (as selected by KHS)
	QI Manager and staff (Committee staff support)

Meeting Schedule

The QI/UM Committee meets at least quarterly, but as frequently as necessary to demonstrate follow-up on all findings and required actions.

Reporting Relationship

QI/UM Committee reports to the Board of Directors at least quarterly.

Attachment B

PHYSICIANS ADVISORY COMMITTEE (PAC) MEMBERSHIP

Voting Members

1 KHS Chief Medical Officer (Chairperson)
2 General/Family Practitioner
1 General Internist
1 Pediatrician
1 Obstetrics/Gynecologist
1 Noninvasive Specialist
1 Invasive Specialist
1 Practitioner at Large

Ex Officio Non-Voting Members:

1 KHS Board Member (Limited to Medical Doctor (MD) or Doctor of Osteopathy (DO))

Attachment C

PHARMACY & THERAPEUTICS COMMITTEE MEMBERSHIP

Voting Membership

1 KHS Chief Medical Officer (Chairperson)
1 KHS Corporate Pharmacist (Alternate Chairperson)
1 KHS Board Member
1 Retail/Independent Pharmacist
1 Retail Chain Pharmacist
1 Geriatric Practice Pharmacist
1 General Practice Medical Doctor
1 Pediatrician
1 Internist
1 Obstetrics and Gynecology
1 Provider at Large

Meeting Schedule

The P&T Committee meets quarterly – Quorum: 4 voting members

Reporting Relationship

Reports to the QI/UM Committee quarterly

Attachment D

PUBLIC POLICY/COMMUNITY ADVISORY COMMITTEE

The Public Policy/Community Advisory Committee (PP/CAC) shall provide public input in the development of policies for KHS. The Public Policy/Community Advisory Committee shall meet quarterly.

Voting Members:

- 7 Subscribers/enrollees
- 1 Member of the KHS Board of Directors
- 1 Participating Health Care Practitioner
- 1 Kern County Health Officer or Representative
- 1 Director, Kern County Department of Human Services or Representative
- 2 Community Representatives

Ex-officio Non-Voting member:

KHS Director of Marketing (Chairperson)

KERN HEALTH SYSTEMS

HEALTH EDUCATION WILL REPORT IN THE NEXT MEETING FOR 1ST QUARTER

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

Utilization Management Executive QI/UM Committee Report
Reporting Period January 1, 2021 thru March 31, 2021

The membership enrollment reached 294,321 in Q1 2021. Additional benefit coverage and broadening interdisciplinary collaboration to support the membership growth will continue into 2021.

- Targeted programs as part of Population Health initiatives
  - COPD Program
  - Transition of Care Program

- Pharmacy Carve Out State Managed Benefit transition remains on hold pending notification from DHCS

- Cal Aim-Multiyear implementation for MCAL benefits
  - Social Determinants of Health
  - Enhanced Care Management
  - In Lieu of Services
  - Population Health
  - Major Organ Transplant

- COVID impact
  - Inpatient LOS decreasing
  - COVID related admissions significantly decreased
  - Outpatient Referral Volume for 1st Quarter is above pre-pandemic baselines

The following pages reflect statistical measurements for Utilization Management and Case Management detailing the ongoing compliance activity for the 1st Quarter 2021.

Respectfully submitted,

Shannon Miller RN, BSN
Director of Utilization Management
Kern Health System

Utilization Management Reporting

Timeliness of Decision Trending

Summary:

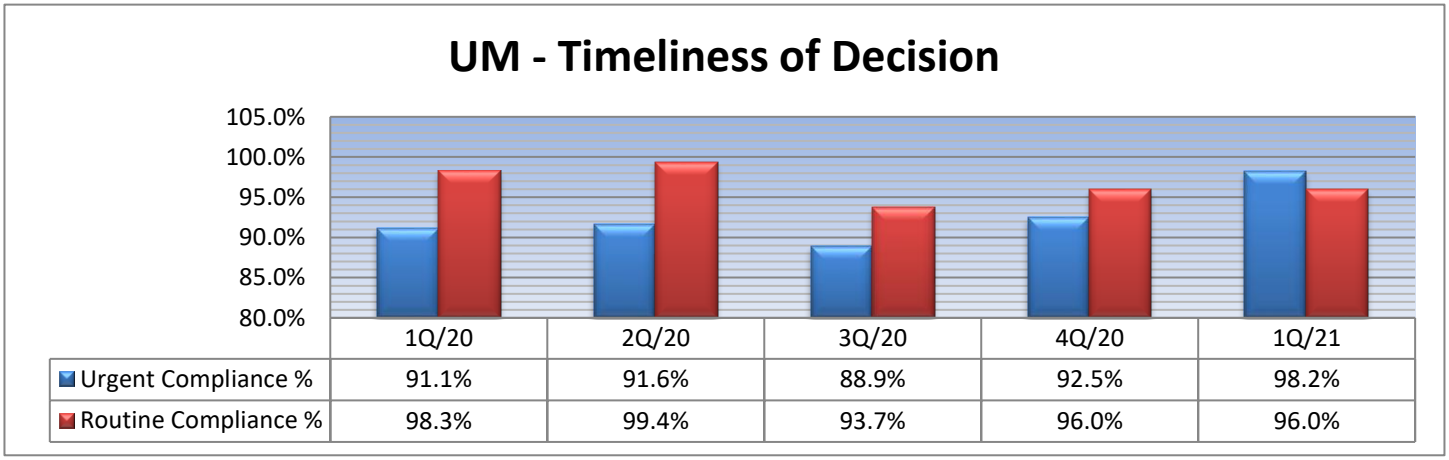
Quarterly audits are conducted to ensure compliance with DMHC requirements, KHS Contractual Agreement with the Department of Health Services, and KHS Policy and Procedures. Referrals are submitted and have specific turn-around-times set for each type of referral.

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

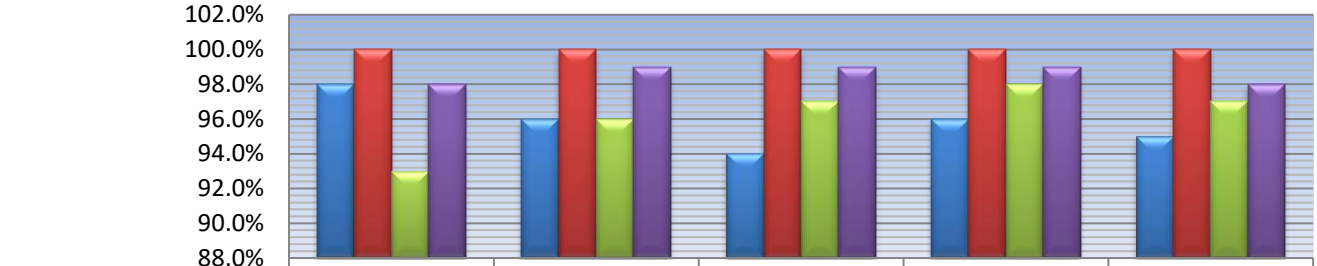
There were 54,224 referrals processed in the 1st quarter 2021 of which 4,988 referrals were reviewed for timeliness of decision. In comparison to the 4th quarter's processing time, routine referrals increased from the 4th quarter which was 96.0% and urgent referrals increased from the 4th quarter which was 92.5% to 96%.



	1Q/20	2Q/20	3Q/20	4Q/20	1Q/21
Urgent Compliance %	91.1%	91.6%	88.9%	92.5%	98.2%
Routine Compliance %	98.3%	99.4%	93.7%	96.0%	96.0%

Audit Criteria:

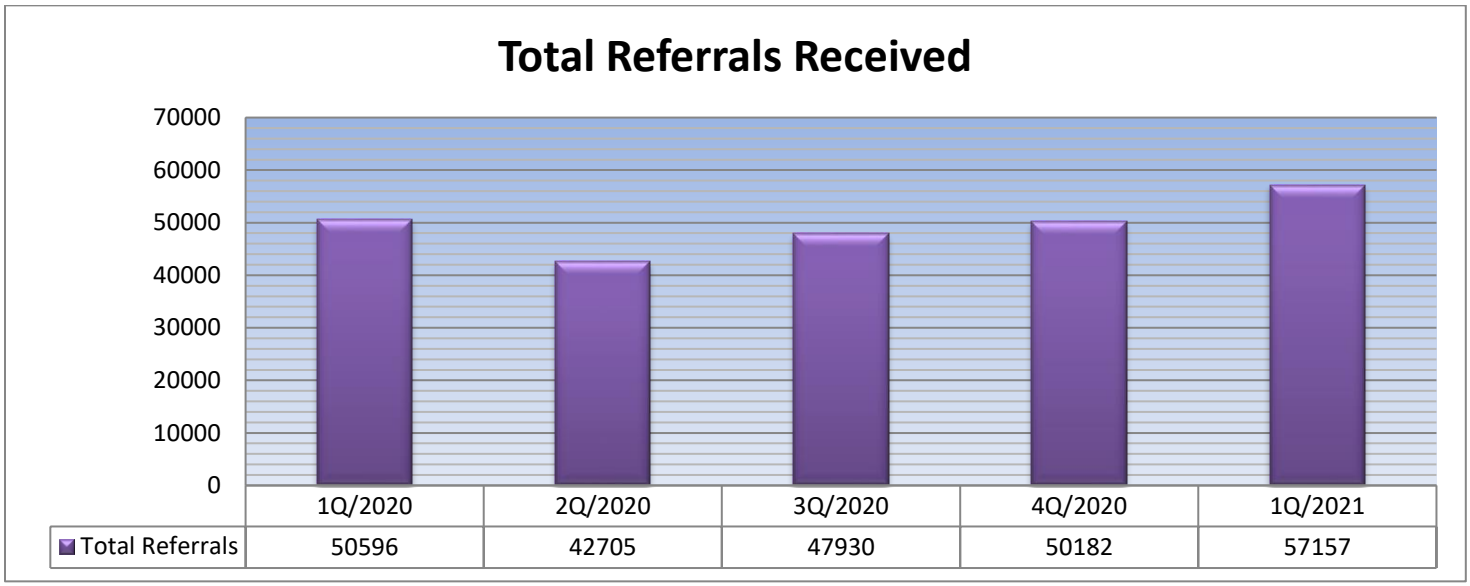
- Member Nofication: Letter of referral decision sent to member within 24 hours
- Provider Notification: Referral is faxed back to the provider with 24 hours of decision
- Criteria Included: Criteria provided to provider on denial reason
- MD Signature: MD Signature included all referrals/NOA letters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

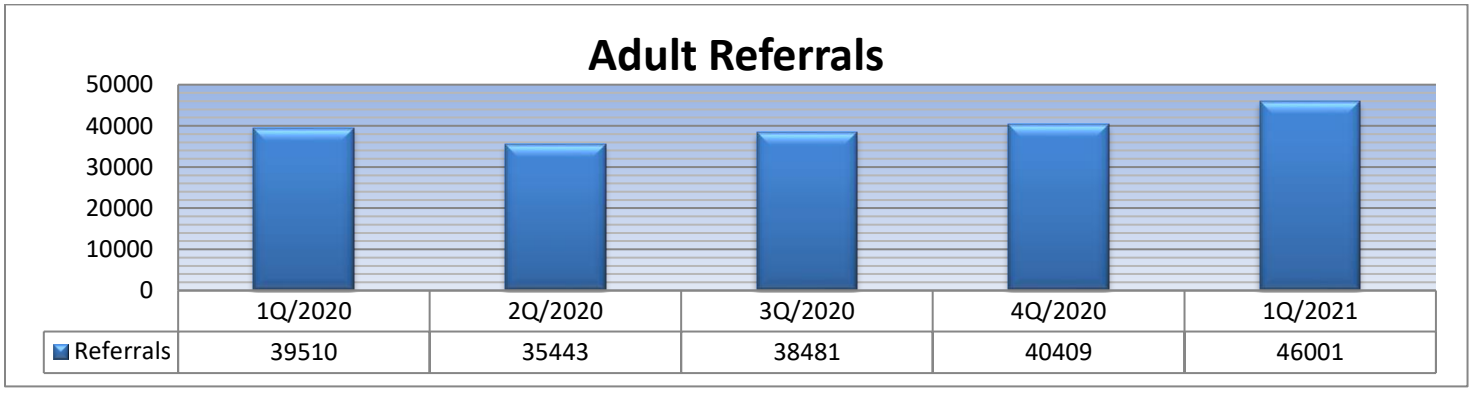


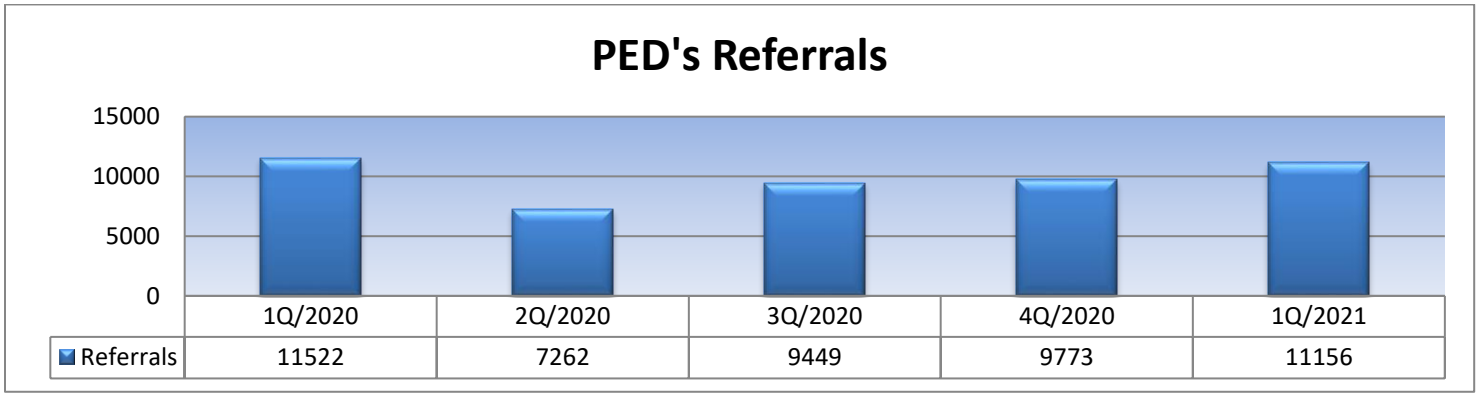
	1Q/20	2Q/20	3Q/20	4Q/20	1Q/21
Member Notification	98.0%	96.0%	94.0%	96.0%	95.0%
Provider Notification	100.0%	100.0%	100.0%	100.0%	100.0%
Criteria Included	93.0%	96.0%	97.0%	98.0%	97.0%
MD Signature Included	98.0%	99.0%	99.0%	99.0%	98.0%

Summary: Overall compliance rate from the 1st Qtr. of 2021 is 98% which remained the same from the 4th Qtr. which was 98%.

Outpatient Referral Statistics







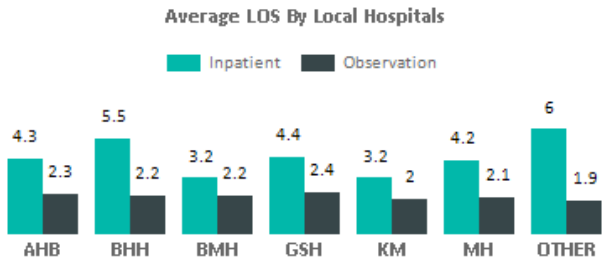
4th Quarter Inpatient and LOS Report

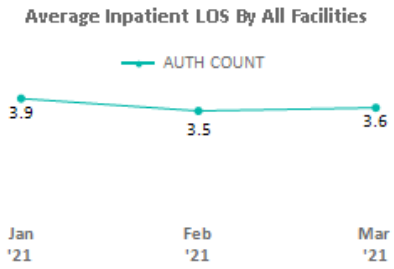
KHS Monthly Inpatient and LOS Report

Report captures Adult Admissions(Inpatient/Observation)

Dates of Discharge Between : 1/1/2021-3/31/2021

Adult Admission(Inpatient/Observation)





Participating Providers

Provider Name	Admit Count	LOS	Avg LOS
ADVENTIST HEALTH BAKERSFIELD	600	2338	3.90
ADVENTIST HEALTH COMMUNITY CAR	25	66	2.64
ADVENTIST HEALTH MEDICAL CENTE	7	45	6.43
ADVENTIST HEALTH ST HELENA	1	15	15.00
ANTELOPE VALLEY HOSPITAL	1	2	2.00
BAKERSFIELD HEART HOSPITAL	96	497	5.18
BAKERSFIELD MEMORIAL HOSPITAL	888	2641	2.97
DELANO REGIONAL MEDICAL CENTER	67	258	3.85
GOOD SAMARITAN HOSPITAL	93	392	4.22
KECK HOSPITAL OF USC	63	330	5.24
KERN COUNTY MEDICAL AUTHORITY	687	2070	3.01
KERN VALLEY HEALTHCARE	13	33	2.54
MERCY HOSPITAL	624	2299	3.68
RIDGECREST REGIONAL HOSPITAL	4	19	4.75
SANTA MONICA UCLA MC AND ORTHO	5	14	2.80
UCLA MEDICAL CENTER	18	145	8.06
USC NORRIS CANCER HOSP	3	13	4.33
USC NORRIS CANCER HOSPITAL	2	42	21.00
USC VERDUGO HILLS HOSPITAL	1	2	2.00
VENTURA COUNTY MEDICAL CENTER	5	23	4.60
Total	**3203**	**11244**	**3.51**

Non Participating Providers

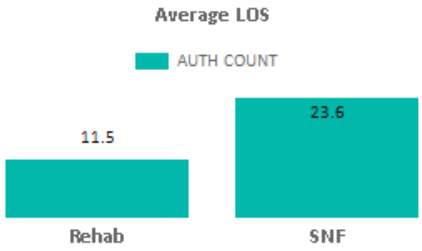
Provider Name	Admit Count	LOS	Avg LOS
ANTELOPE VALLEY HOSPITAL	23	108	4.70
KAWEAH DELTA MEDICAL CENTER	6	49	8.17
HENRY MAYO NEWHALL	5	29	5.80
FRESNO COMMUNITY HOSPITAL AND	5	46	9.20
LOMA LINDA UNIVERSITY MEDICAL	5	26	5.20
RENOWN REGIONAL MEDICAL CENTER	4	14	3.50
ST JOHNS REGIONAL MEDICAL CENT	4	9	2.25
LAC USC MEDICAL CENTER	4	51	12.75
SUNRISE HOSPITAL AND MEDICAL	3	6	2.00
UCSF MEDICAL CENTER	3	18	6.00
PACIFICA HOSPITAL OF THE VALLE	3	12	4.00
KENTFIELD HOSPITAL SAN FRANCIS	3	242	80.67
SHARP MEMORIAL HOSPITAL	3	11	3.67
LANCASTER HOSPITAL CORPORATION	3	15	5.00
Total	**134**	**1003**	**7.49**

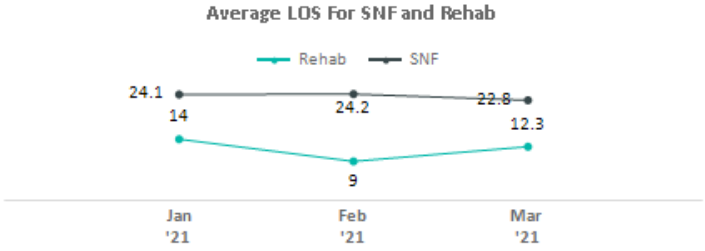
KHS Monthly Inpatient and LOS Report

Report captures Adult Admissions(SNF/Rehabilitation)

Dates of Discharge Between : 1/1/2021-3/31/2021

Adult Admissions (SNF/Rehab)



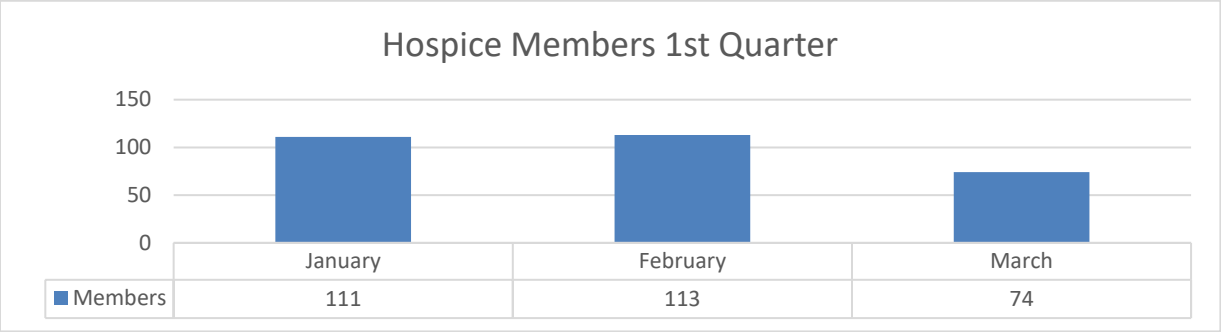


Participating Providers

Provider Name	Admit Count	LOS	Avg LOS
BELLAGIO IN THE DESERT	6	48	8.00
CAPRI IN THE DESERT	6	219	36.50
DELANO POSTACUTE CARE	2	32	16.00
DELANO REGIONAL MEDICAL CENTER	1	10	10.00
ENCOMPASS HEALTH REHABILITATIO	31	357	11.52
GGNSC SHAFTER LP	10	475	47.50
NAPOLI IN THE DESERT	1	62	62.00
PARKSIDE CONGREGATE LIVING, IN	13	240	18.46
ROSE DESERT CONGREGATE	4	87	21.75
SORRENTO IN THE DESERT	10	224	22.40
THE REHABILITATION CENTER	1	39	39.00
UNITED CARE FACILITIES	63	1165	18.49
VFP HOMES	13	205	15.77
Total	**161**	**3163**	**19.65**

Non Participating Providers

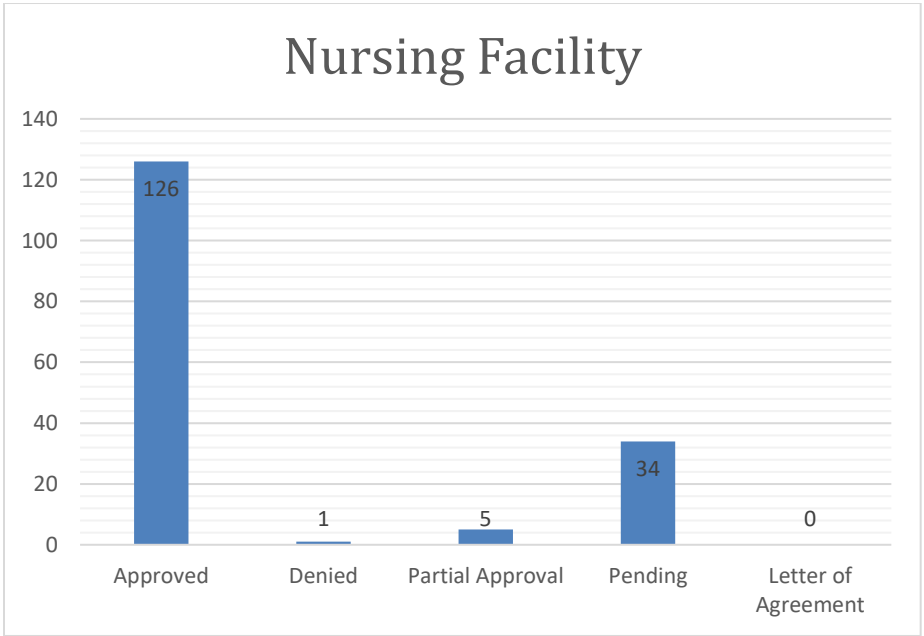
Provider Name	Admit Count	LOS	Avg LOS
VALLEY VIEW CARE CENTER	2	52	26.00
LINK TO CARE CONGREGATE HOME	2	98	49.00
ONE AND ONLY CONGREGATE LIVING	2	106	53.00
MAGNIFIQUE CONGREGATE LIVING I	2	14	7.00
LOS ANGELES CARE CENTER	2	23	11.50
EVERGREEN AT BAKERSFIELD, LLC	2	14	7.00
HEIGHT STREET SKILLED CARE	2	85	42.50
ARCHWOOD HOUSE CLHF, INC.	1	49	49.00
SF VALLEY CONGREGATE LIVING, I	1	49	49.00
EVERGREEN AT ARVIN HEALTHCARE	1	45	45.00
QUALITY CLHF, INC.	1	54	54.00
DELANO REGIONAL MEDICAL CENTER	1	52	52.00
FENTON VILLA	1	45	45.00
WINDSOR BAKERSFIELD HEALTHCARE	1	40	40.00
COUNTRY VILLA SOUTH HEALTHCARE	1	12	12.00
SHAFTER NURSING REHAB LLC	1	28	28.00
Total	**40**	**1210**	**30.25**

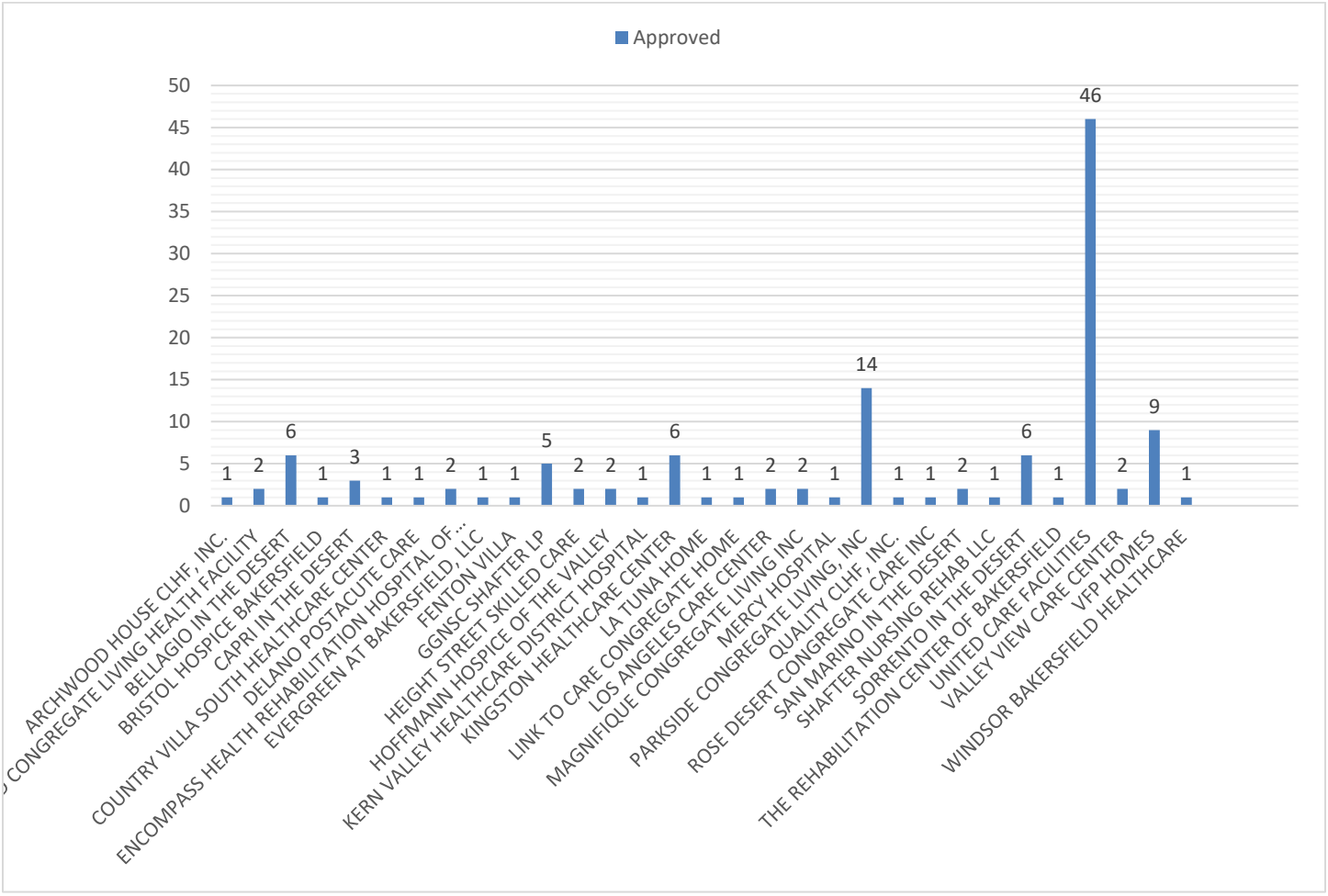


Nursing Facility Services Report

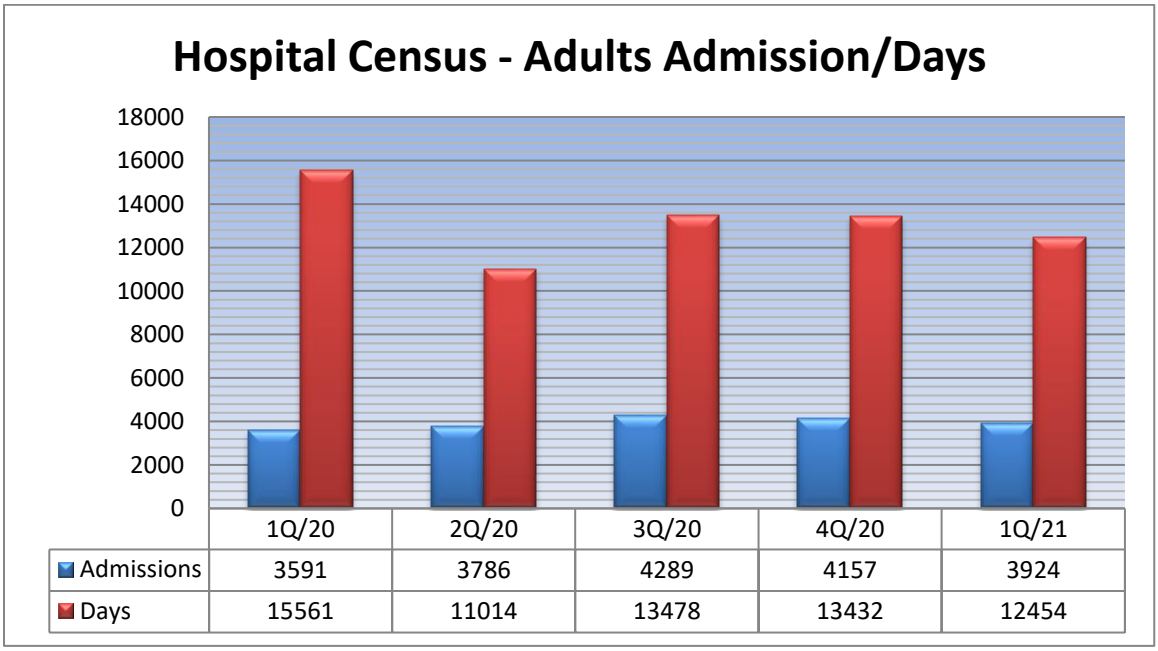
Purpose: Kern Health Systems covers medically necessary Nursing Facility Services for eligible members. KHS members requiring Nursing Facility Services are identified and placed in health care facilities, which provide the level of care most appropriate to the member's medical needs. For members requiring 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 2021, there were 168 referrals for Nursing Facility Services. The average length of stay was 22.8 days for these members. During the 4th quarter there was only 1 denial of the 205 referrals.

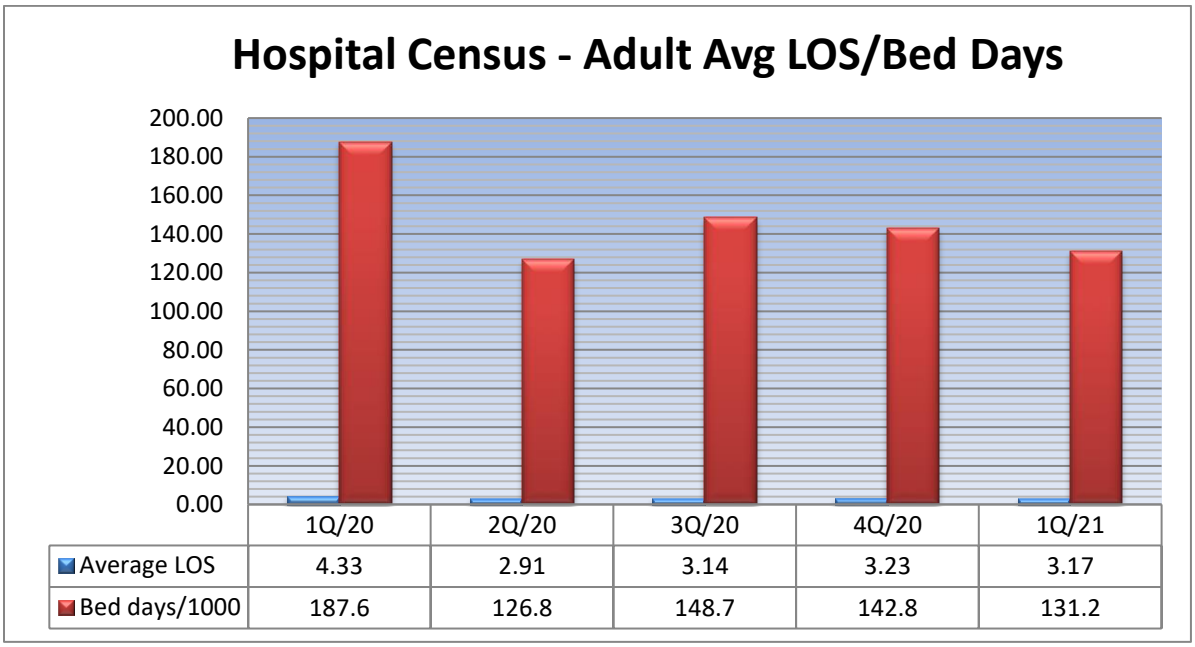



Approved
50
45
40
35
30
25
20
15
10
5
0
1
2
6
1
3
1
1
2
1
1
5
2
2
1
6
1
1
2
2
1
14
1
1
2
1
6
1
46
2
9
1
ARCHWOOD HOUSE CLHF, INC.
CONGREGATE LIVING HEALTH FACILITY
BELLAGIO IN THE DESERT
BRISTOL HOSPICE BAKERSFIELD
CAPRI IN THE DESERT
COUNTRY VILLA SOUTH HEALTHCARE CENTER
ENCOMPASS HEALTH REHABILITATION HOSPITAL OF...
DELANO POSTACUTE CARE
EVERGREEN AT BAKERSFIELD, LLC
FENTON VILLA
GGNSC SHAFTER LP
HEIGHT STREET SKILLED CARE
HOFFMANN HOSPICE OF THE VALLEY
KERN VALLEY HEALTHCARE DISTRICT HOSPITAL
KINGSTON HEALTHCARE CENTER
LA TUNA HOME
LINK TO CARE CONGREGATE HOME
LOS ANGELES CARE CENTER
MAGNIFIQUE CONGREGATE LIVING INC
MERCY HOSPITAL
PARKSIDE CONGREGATE LIVING, INC.
QUALITY CLHF, INC.
ROSE DESERT CONGREGATE CARE INC
SAN MARINO IN THE DESERT
SHAFTER NURSING REHAB LLC
SORRENTO IN THE DESERT
THE REHABILITATION CENTER OF BAKERSFIELD
UNITED CARE FACILITIES
VALLEY VIEW CARE CENTER
VFP HOMES
WINDSOR BAKERSFIELD HEALTHCARE

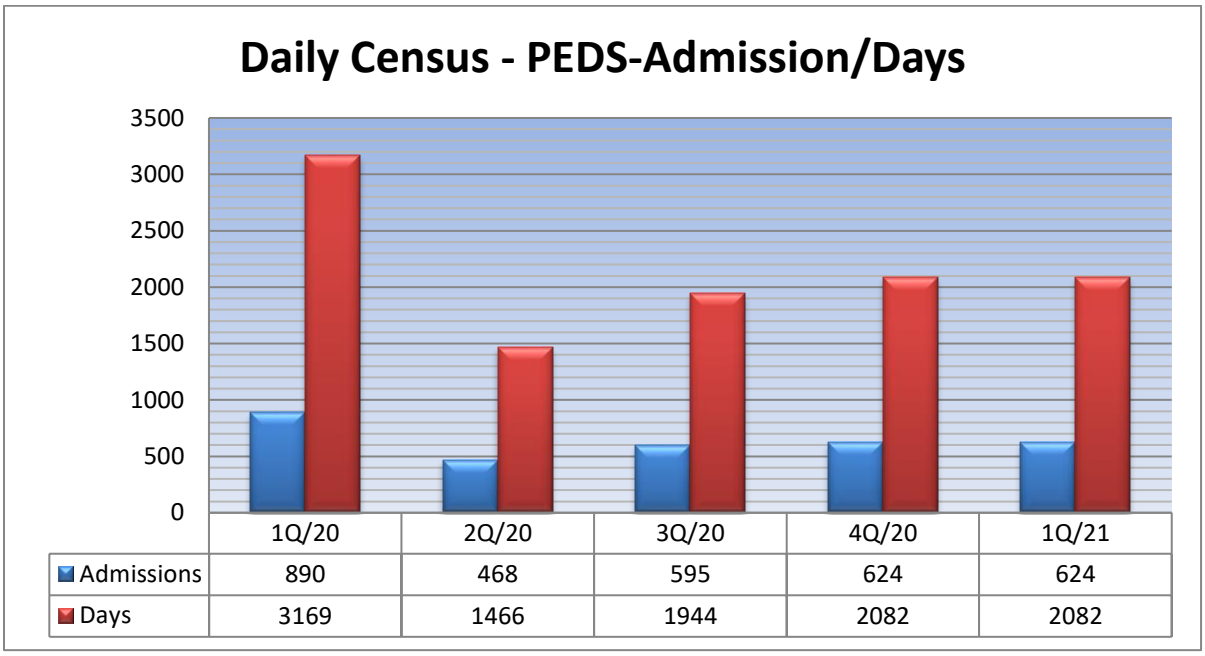
Inpatient 4th Quarter Trending



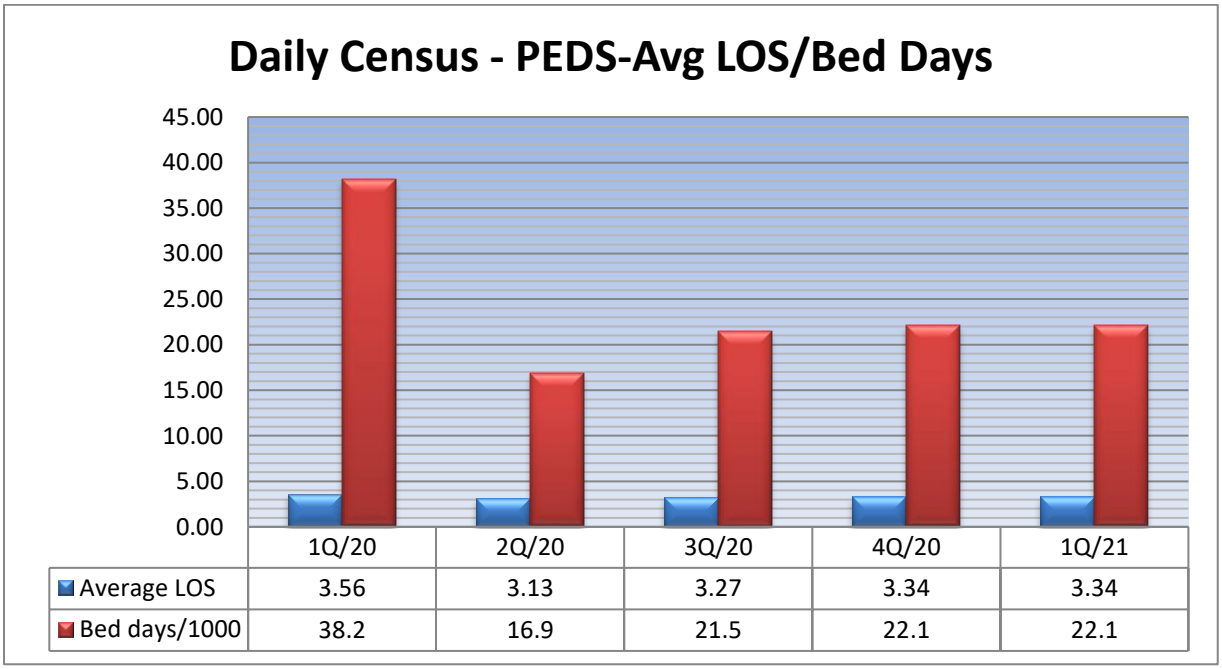
	1Q/20	2Q/20	3Q/20	4Q/20	1Q/21
Admissions	3591	3786	4289	4157	3924
Days	15561	11014	13478	13432	12454



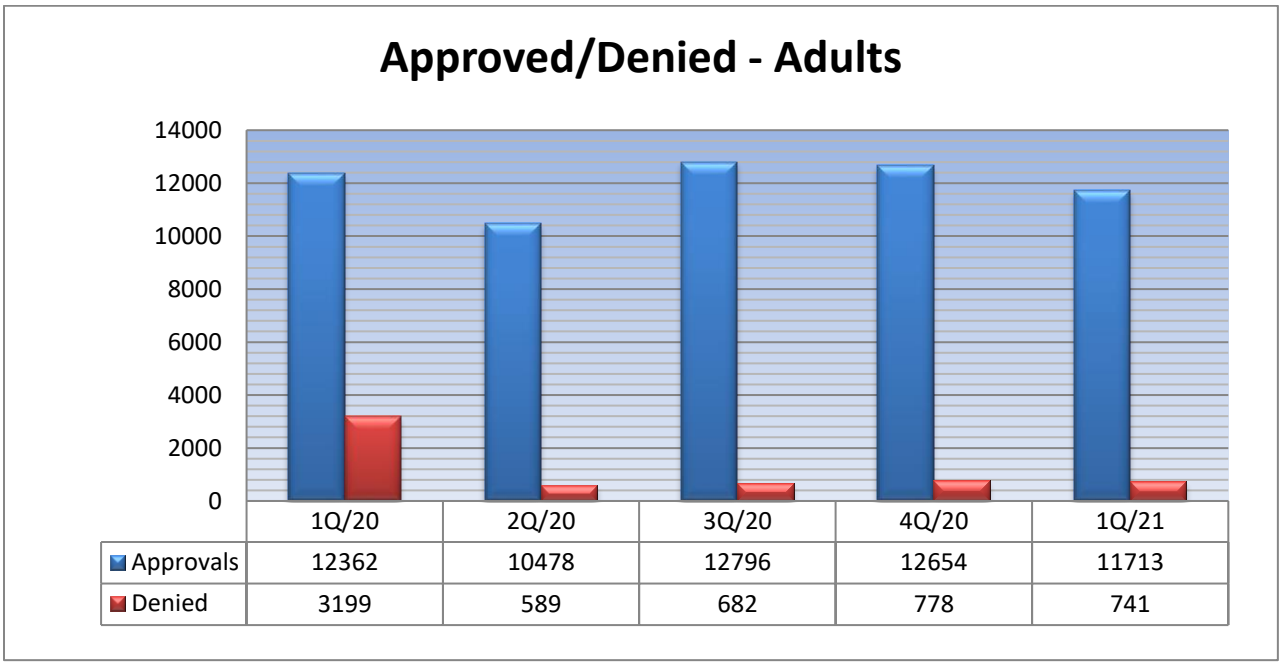
	1Q/20	2Q/20	3Q/20	4Q/20	1Q/21
Average LOS	4.33	2.91	3.14	3.23	3.17
Bed days/1000	187.6	126.8	148.7	142.8	131.2



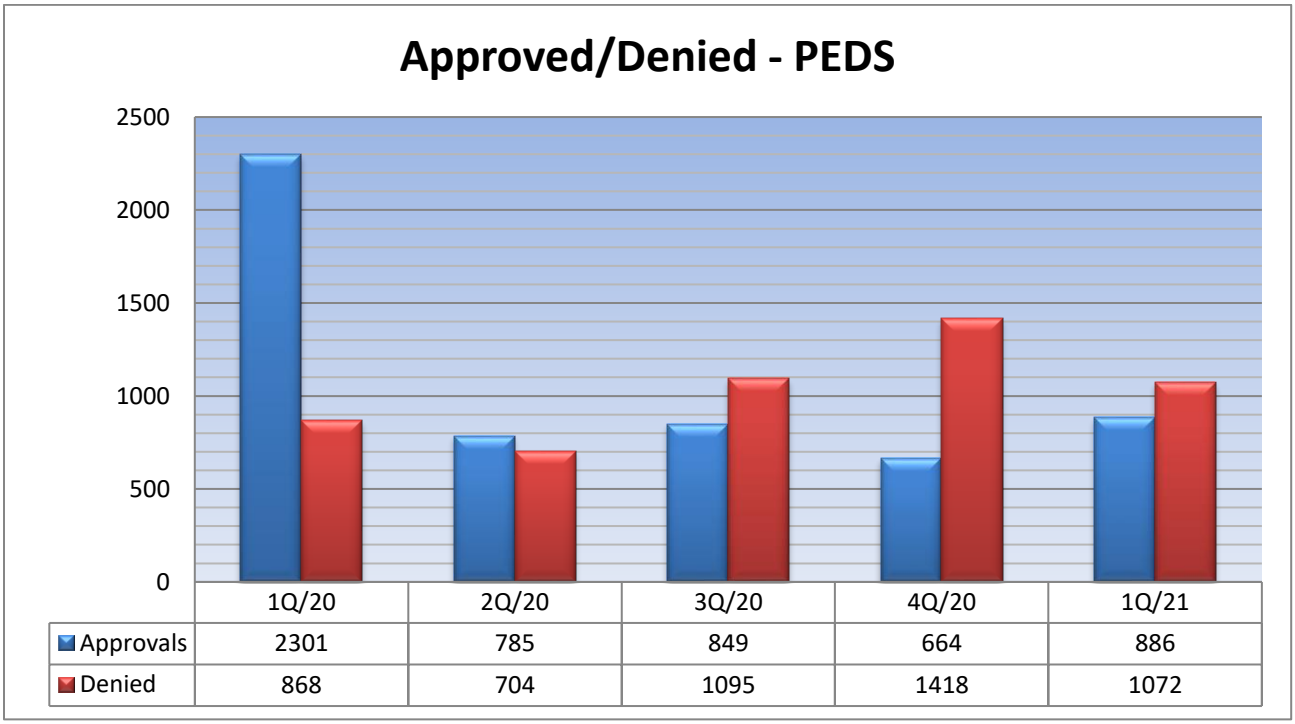
	1Q/20	2Q/20	3Q/20	4Q/20	1Q/21
Admissions	890	468	595	624	624
Days	3169	1466	1944	2082	2082



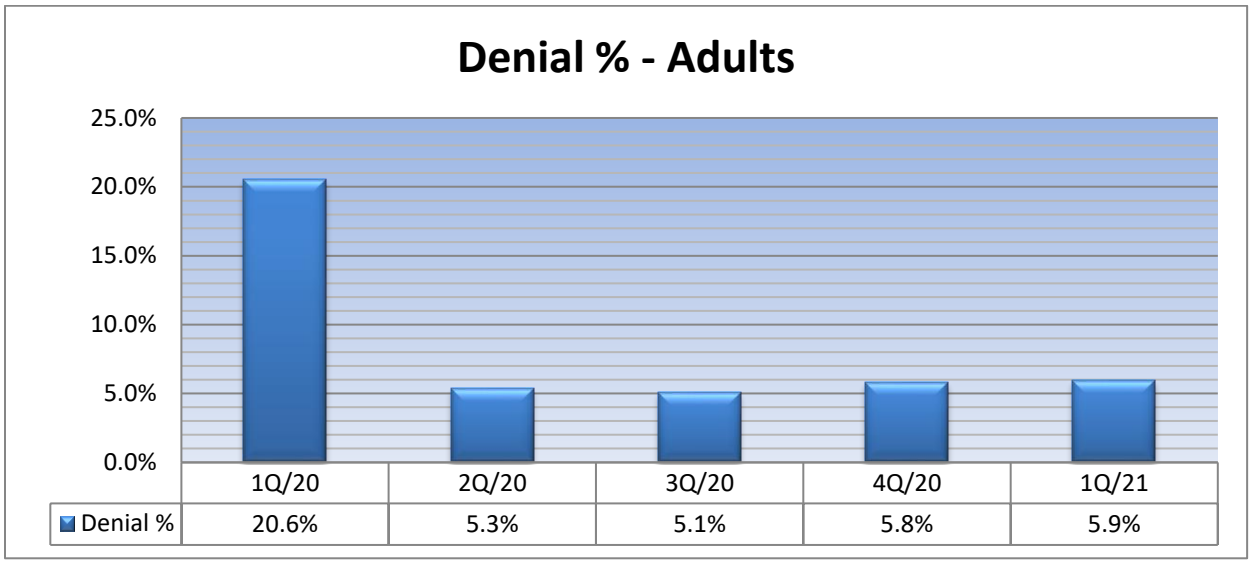
	1Q/20	2Q/20	3Q/20	4Q/20	1Q/21
Average LOS	3.56	3.13	3.27	3.34	3.34
Bed days/1000	38.2	16.9	21.5	22.1	22.1

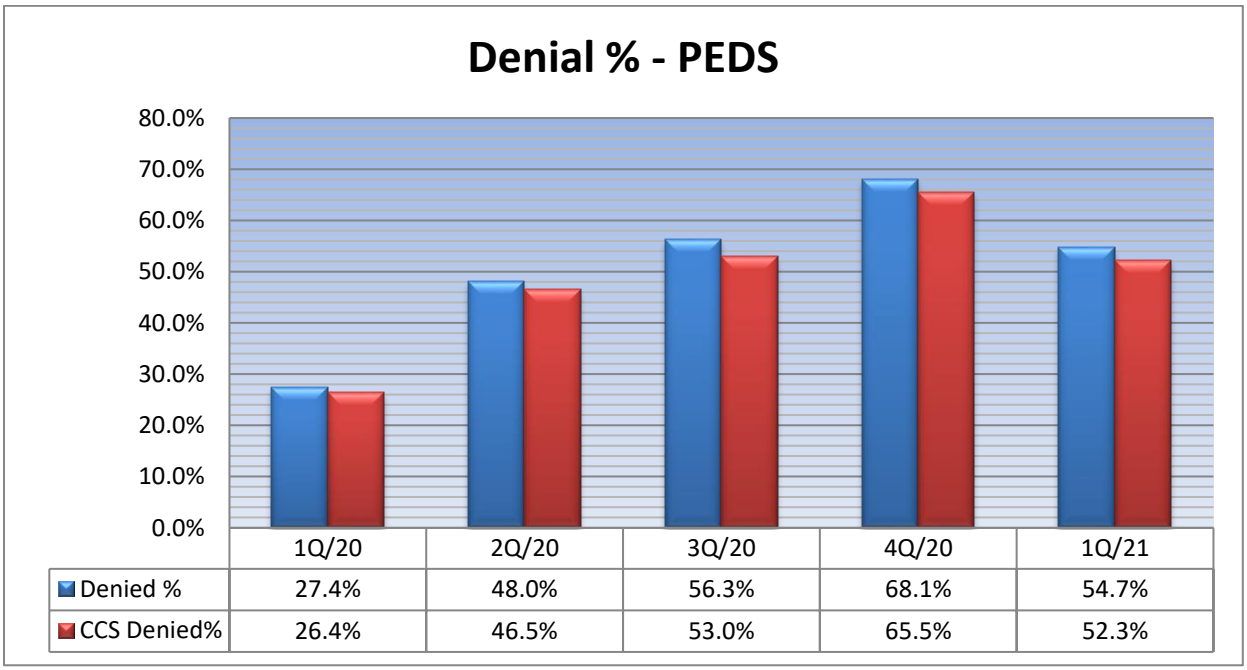


	1Q/20	2Q/20	3Q/20	4Q/20	1Q/21
Approvals	12362	10478	12796	12654	11713
Denied	3199	589	682	778	741



	1Q/20	2Q/20	3Q/20	4Q/20	1Q/21
Approvals	2301	785	849	664	886
Denied	868	704	1095	1418	1072





Continuity of Care

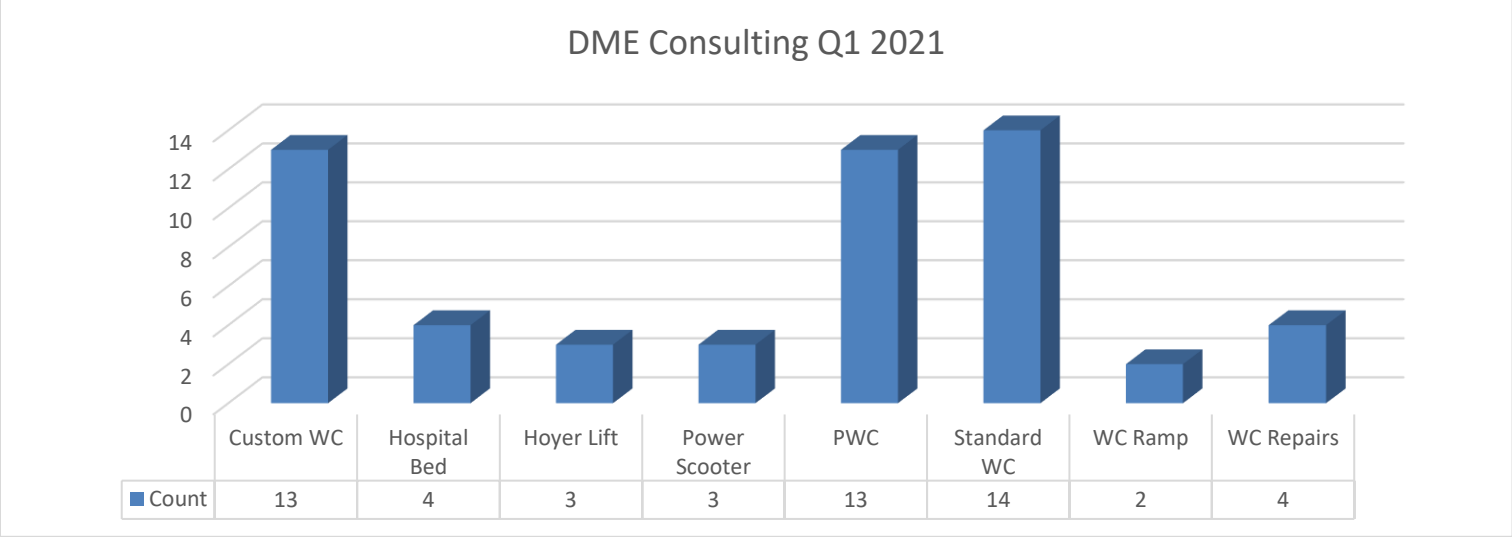
Total Referral – 1

Total Approval – 1

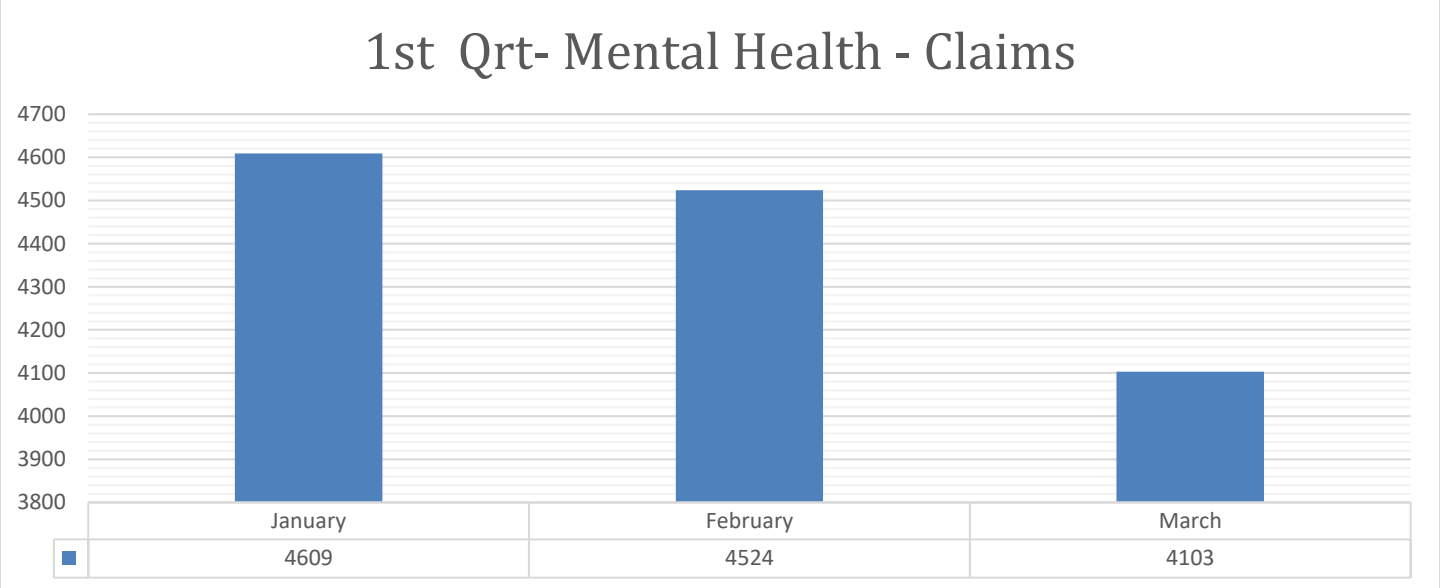
Total Denial - 0

Total SPD COC -0

DME Consulting



Mental Health

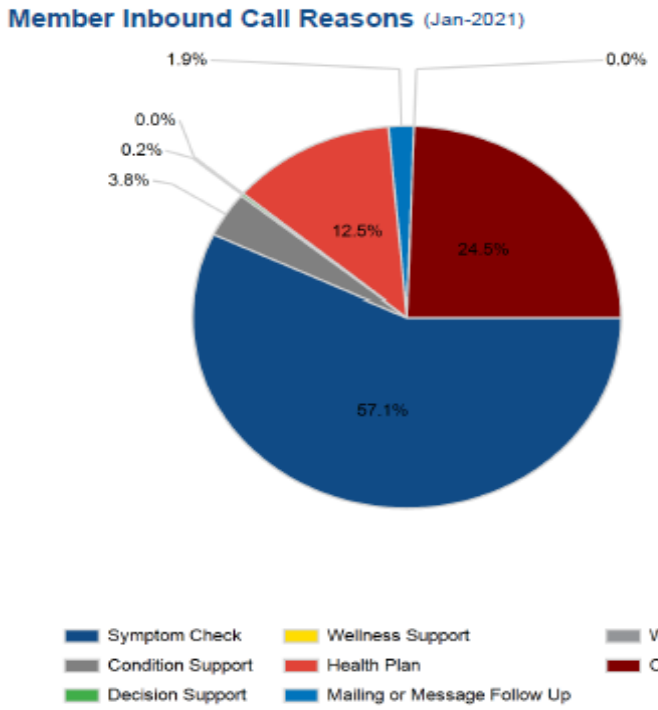


ABA Services

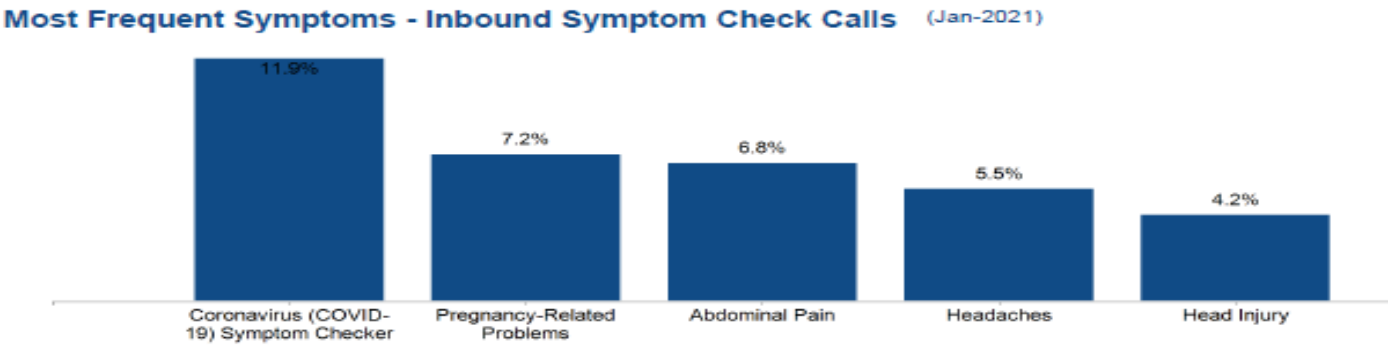
UNIQUE CASES		Mild	Moderate	Severe	Pending Dx	Total
MEMBER COUNT		72	101	27	76	276
Severity %		26.09%	36.59%	9.78%	28%	100%
SEVERITY	Jan	Feb	Mar	Total		
MILD	23	23	31	77		
MODERATE	34	35	40	109		
SEVERE	9	8	12	29		
Approved FBA	64	69	68	201		
Approved Treatment	63	69	73	205		
PENDING DX	29	28	22	79		
	Jan	Feb	Mar	Total		
AGE 7 OR LESS	72	59	78	209		
AGE 8 OR GREATER	23	35	27	85		
TOTAL	95	94	105	294		
% < 7	75.79%	62.77%	74.29%	71.09%		
% > 8	24.21%	37.23%	25.71%	28.91%		

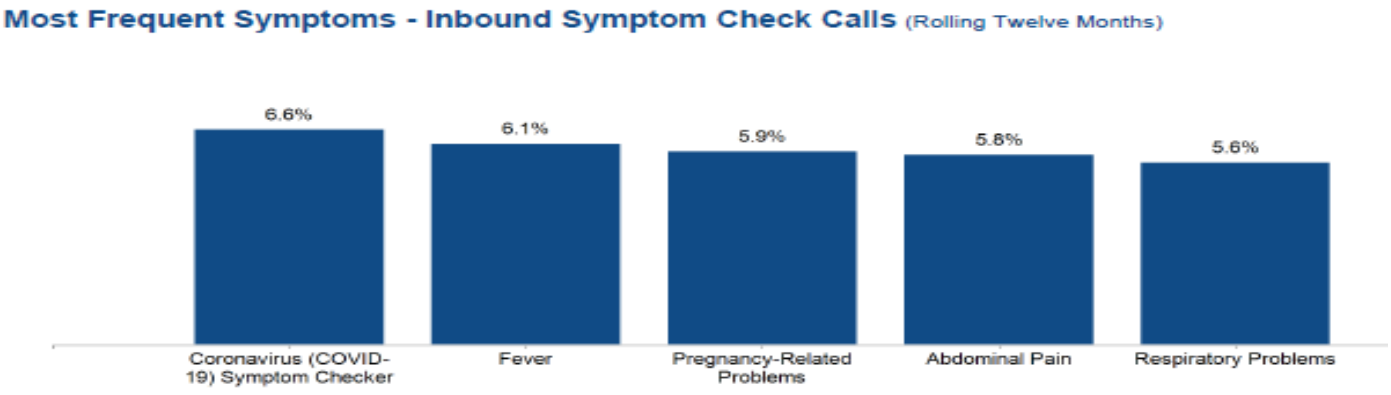
Health Dialog Report

January:



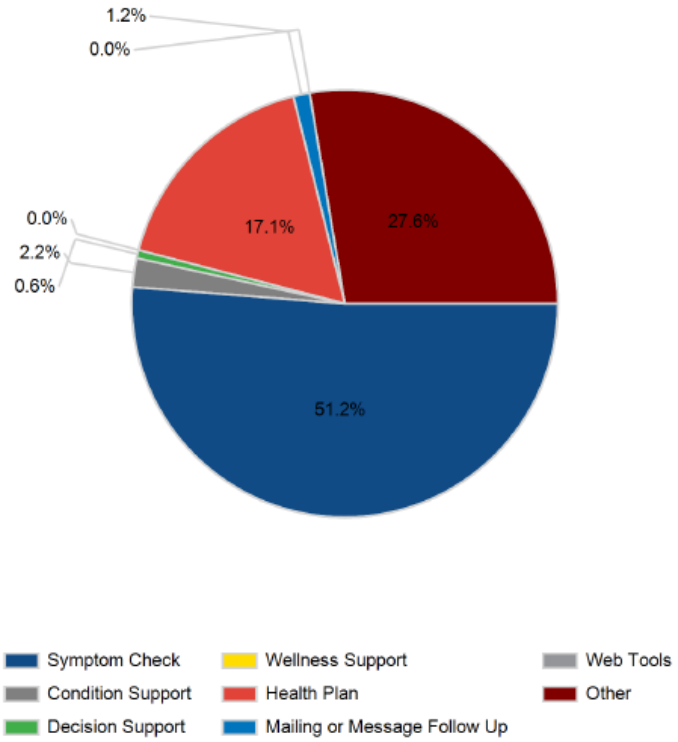
REASON	NUMBER
Symptom Check	238
Condition Support	16
Decision Support	1
Wellness Support	0
Health Plan	52
Mailing or Message Follow Up	8
Web Tools	0
Other	102





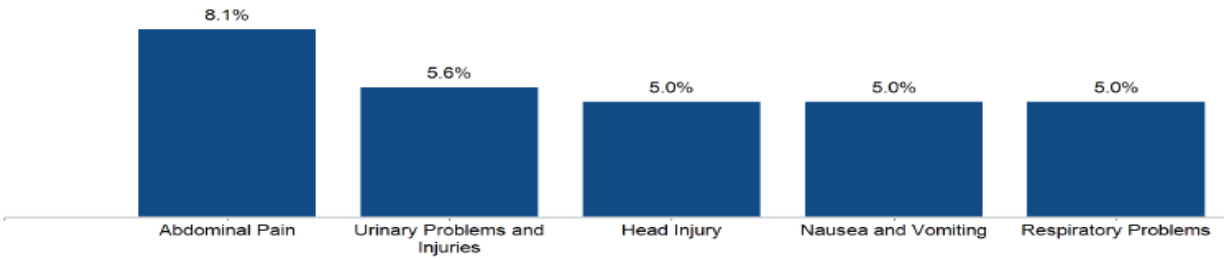
February:

Member Inbound Call Reasons (Feb-2021)

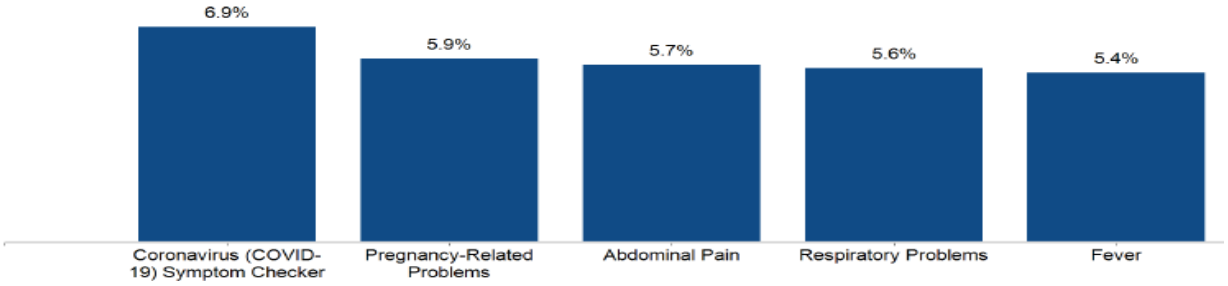


REASON	NUMBER
Symptom Check	165
Condition Support	7
Decision Support	2
Wellness Support	0
Health Plan	55
Mailing or Message Follow Up	4
Web Tools	0
Other	89

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

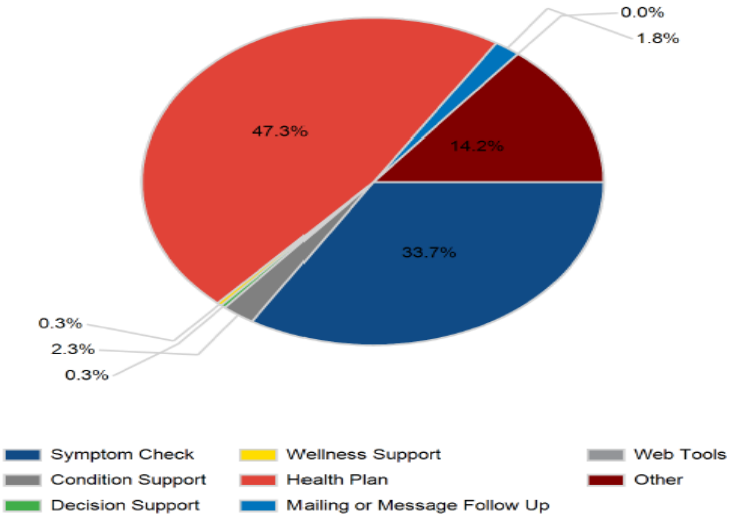


Most Frequent Symptoms - Inbound Symptom Check Calls (Rolling Twelve Months)



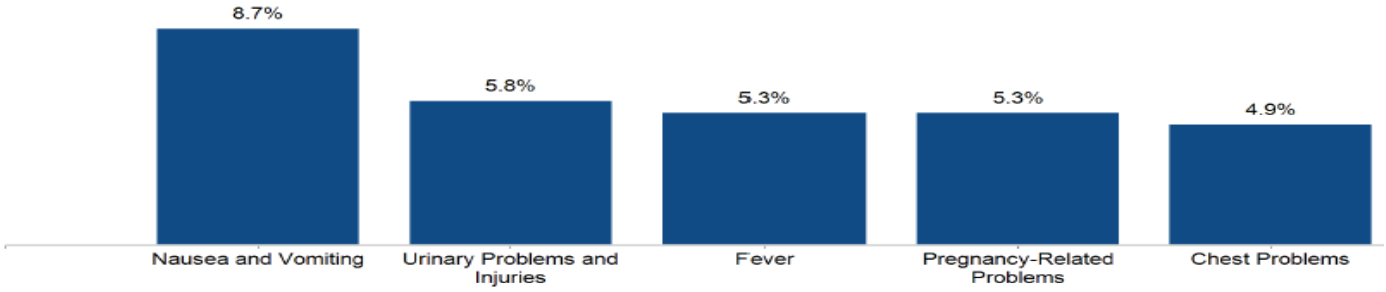
March:

Member Inbound Call Reasons (Mar-2021)

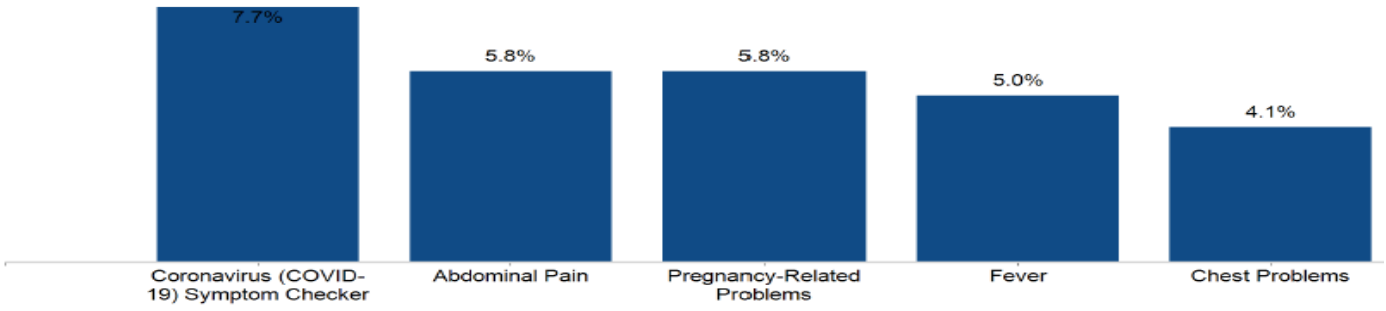


REASON	NUMBER
Symptom Check	204
Condition Support	14
Decision Support	2
Wellness Support	2
Health Plan	286
Mailing or Message Follow Up	11
Web Tools	0
Other	86

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



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



Diabetic Exam Reminder Effectiveness Report

Client: - 12049397

Reminder Year:	Reminder Month:	Reminders Sent	Received Exam Within 0-90 Days	Received Exam Within 91-180 Days	Total Exams Within 180 Days
2020	April	6,190	57	91	148
	May	1,677	35	38	73
	June	1,367	52	62	114
	July	436	27	18	45
	August	554	33	33	66
	September	1,095	43	28	71
	October	3,423	81	61	142
	November	841	43	9	52
	December	1,760	71	4	75
2021	January	518	16	0	16
	February	1,393	13	0	13
	March	326	0	0	0
Totals		**19,580**	**471**	**344**	**815**

LTM Effectiveness* : 4 %

12-Month Effectiveness (Oct 2019 - Sep 2020) : 6 %

Medical Data Collection Summary Report

Period Covered: April, 2020 through March, 2021
Prepared for: KERN HEALTH SYSTEMS - (12049397)

Reported Cases

	Members	
Received Eye Exam:	15,695	
Diabetes[1]:	811	5.2%
Diabetic Retinopathy:	163	1.0%
Glaucoma:	244	1.6%
Hypertension:	523	3.3%
High Cholesterol	221	1.4%
Macular Degeneration:	51	.3%

Estimated Number of Cases

Total Members:	282,768	
Diabetes[1]:	7,001	2.5%
Diabetic Retinopathy:	624	.2%
Glaucoma:	1,180	.4%
Hypertension:	30,085	10.6%
High Cholesterol	43,256	15.3%
Macular Degeneration:	388	.1%

Utilization Summary

VSP Vision care for life

March 2021

Contract Type: *Risk*

KERN HEALTH SYSTEMS

Client Since: *07/01/1996*

Claim Trend

Period	Number Covered	Gross Premium	Claim $	Average Claim Cost	# Claims Paid
2018	2,934,260	$2,945,313	$2,647,034	$63.58	41,630
2019	2,987,512	$3,031,271	$3,026,016	$62.10	48,730
2020	3,122,722	$3,278,858	$1,542,205	$49.82	30,955
APR	250,147	$262,654	$55,806	$46.27	1,206
MAY	254,262	$266,975	$38,015	$47.94	793
JUN	252,742	$265,379	$75,977	$52.87	1,437
JUL	260,715	$273,751	$102,587	$51.09	2,008
AUG	266,422	$279,743	$128,001	$49.38	2,592
SEP	263,580	$276,759	$124,262	$48.94	2,539
OCT	271,891	$285,486	$141,492	$50.30	2,813
NOV	276,783	$290,622	$127,129	$50.23	2,531
DEC	276,870	$290,714	$152,648	$47.16	3,237
JAN	278,995	$292,945	$153,032	$47.60	3,215
FEB	281,177	$295,236	$118,992	$49.85	2,387
MAR	282,768	$296,906	$173,251	$49.27	3,516
LTM	**3,216,352**	**$3,377,170**	**$1,391,191**	**$49.20**	**28,274**
CC	4,723,461	$4,959,634	$2,744,830	$52.68	52,101
YTD	842,940	$885,087	$445,274	$48.83	9,118

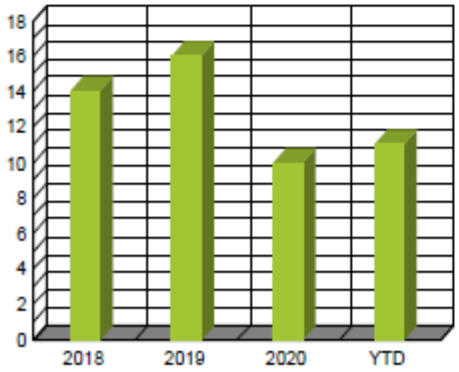
Year over Year

Average Claim Cost has decreased 16.8%

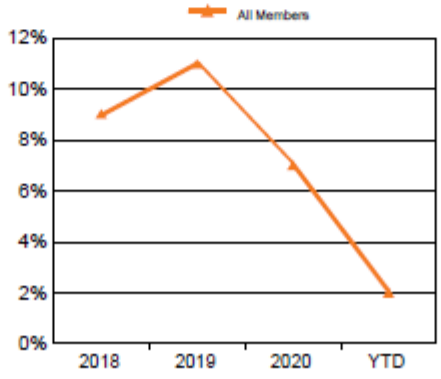
Number of Claims Paid has decreased 43.4%

Number Covered has increased 7.0%

Claim Frequency



Exam Utilization



The average Claim Frequency for VSP book-of-business is 35

The average Claim Frequency for your industry is 12

The average Exam Utilization for your industry is 20%

Client ID: 12049397
Report Generated On: 04/05/21 at 05.05.19
Information Source: FOCUS/UTIL005R

KERN HEALTH SYSTEMS
CASE MANAGEMENT DEPARTMENT MONTHLY REPORT

Reporting Period: January1st, 2021- March 31st, 2021

During the months of January thru March 2021, a total of 1,951 members were managed by the Case Management Department.

Episode Type (including previous members)	Closed Episodes	Open Episodes	Referral Episodes	Total
Case Management	1,028	231	3	1,262
Behavioral Health Case Management	545	143	1	689

Episode Type assigned for January thru March 2021	Closed Episodes	Open Episodes	Referral Episodes	Total
Case Management	1,073	134	73	1,280
Behavioral Health Case Management	436	75	12	523

High ER Utilizers Outcomes	Contacted	Unable to Contact	Total
CMA	79	70	149
Social Workers	50	20	70

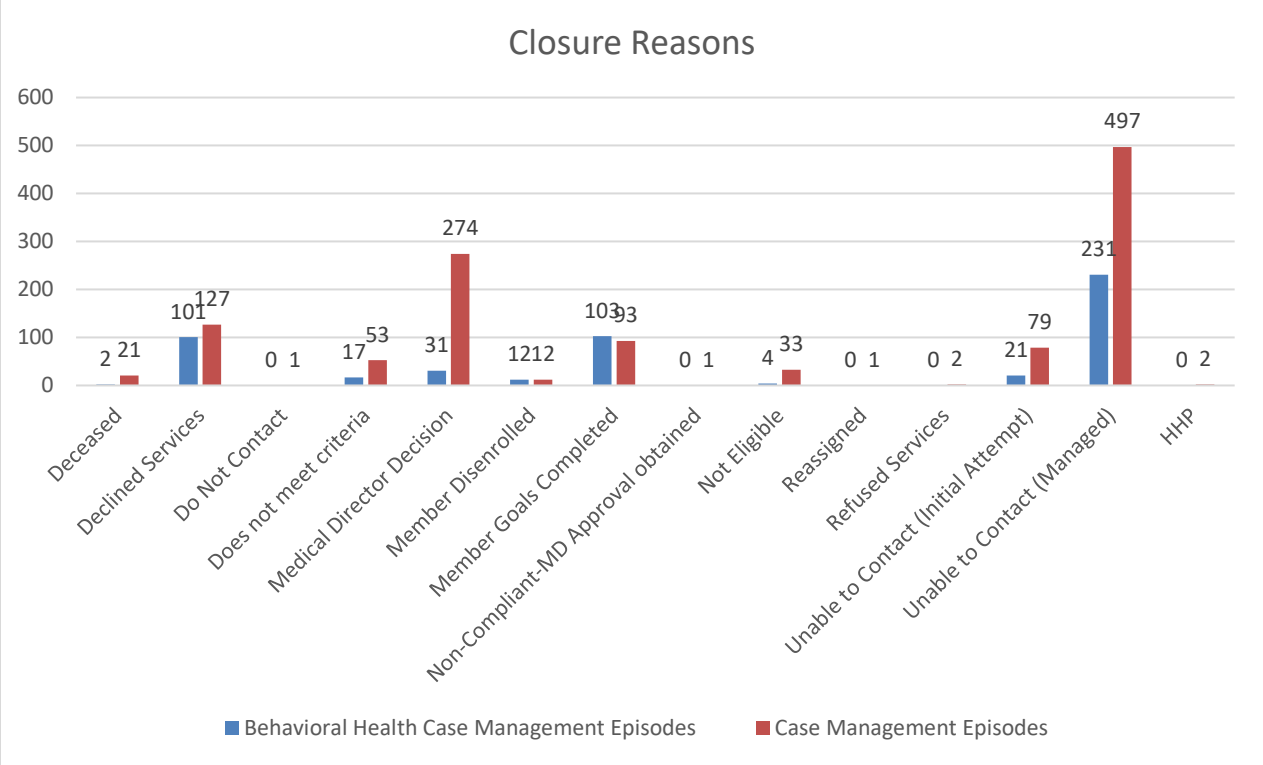
High ER Utilizers Closure Reasons for those Managed by Social Workers	Total
Member Goals Completed	50
Does Not Meet Criteria	4
Unable to Contact	16

Severity Levels for Managed Episodes in Open or Closed Status

Episode Severity Level	Severity-Critical	Severity-High	Severity-Medium	Severity-Low
Case Management	0	70	310	100
Behavioral Health Case Management	0	10	230	61

Episode Source	Behavioral Health Management Episodes	*Percentage*	Case Management Episodes	*Percentage*
ACG Modeler	276	40.1%	980	77.7%
All Internally Generated Complex Case Management	13	1.9%	139	11.0%
All Internally Generated Disease Management	1	0.1%	0	0.0%
All Internally Generated Grievance	1	0.1%	2	0.2%
All Internally Generated Hospital Discharge	0	0.0%	34	2.7%
All Internally Generated Medical Director	1	0.1%	20	1.6%
All Internally Generated Member Request	6	0.9%	11	0.9%
All Internally Generated UM Generated	14	2.0%	10	0.8%
BH Mental Health	35	5.1%	0	0.0%
CM DM HE Facility Based Social Worker	1	0.1%	1	0.1%
CM DM HE Health Education	5	0.7%	1	0.1%
CM DM HE Member Services	14	2.0%	9	0.7%
CM DM HE Provider	5	0.7%	11	0.9%
CM DM High ER Utilizer	152	22.1%	0	0.0%
Critical High Risk SPD	1	0.1%	1	0.1%
DM Facility Nurse	3	0.4%	0	0.0%
DM HE Social Worker Case Management	3	0.4%	7	0.6%
HE Postpartum Claim	20	2.9%	0	0.0%
HE Prenatal Claim	33	4.8%	0	0.0%
High Risk SPD	105	15.2%	36	2.9%

A total of 1,718 Episodes were closed during the months of January thru March 2021. With 522 BH-CM Episode Type closed and 1,196 CM Episode Type closed.



Members Closed and Referred to HHP	Behavioral Health Case Management Episodes	Case Management Episodes
HHP	31	10

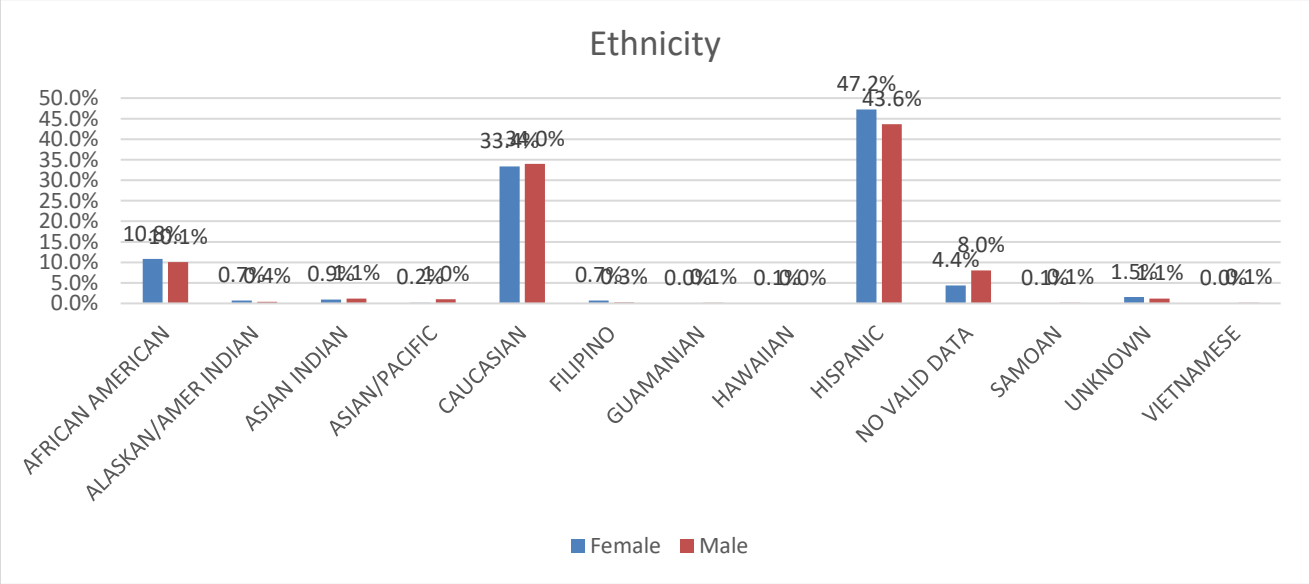
Closed Episodes with Admits within 30 days after Closure	Total
Behavioral Health Case Management	26
Case Management	65
Percentage of closed cases Readmitted	3%

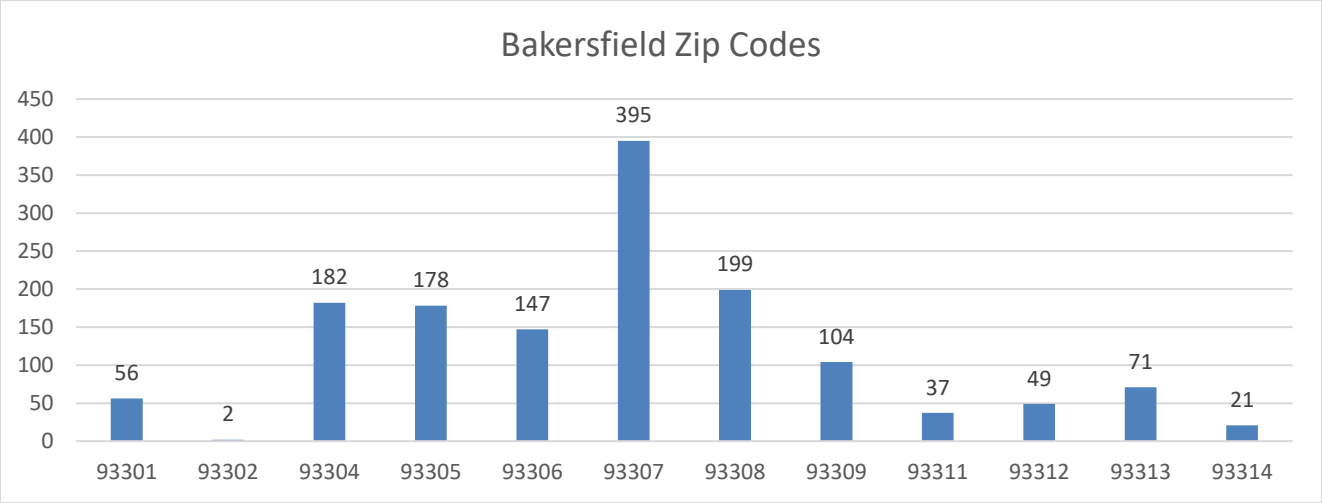
Assessments/Plan of Care	Behavioral Health Case Management Episodes	Case Management Episodes	Total
Assessments	119	233	352
Plan of Care	120	205	325

During the months of January thru March, 95% of the members managed were 65 years of age or younger.

Age	<18	18-40	41-65	>65	Total
Case Management	12	237	937	76	1,262
Behavioral Case Management	27	287	348	27	689

Of the 1,951 members managed during the months of January thru March, the majority of members were female at 60%. The majority of members' ethnicity was Hispanic at 45%.





Outlying Areas

City	Total
ARVIN	44
BEAR VLY SPGS	1
BISHOP	1
BODFISH	9
BORON	5
BUTTONWILLOW	1
CALIENTE	2
CALIF CITY	25
CALIFORNIA CITY	1
DELANO	65
FELLOWS	1
FRAZIER PARK	9
INYOKERN	2
KERNVILLE	1
LAKE ISABELLA	18
LAMONT	32
LANCASTER	1
LEBEC	3
LODI	1
LONG BEACH	1
LOS ANGELES	2
LOST HILLS	2
MARICOPA	6
MC FARLAND	30
MCALLEN	1
MOJAVE	15
N/A	18
ONYX	3
RANDSBURG	1
ROSAMOND	7
SAN DIEGO	1
SHAFTER	39
STOCKTON	1
TAFT	51
TEHACHAPI	57
TERRA BELLA	1
TUPMAN	1
WASCO	41

WELDON	4
WOFFORD HTS	6

Notes Completed

Note Source	Behavioral Case Management Episodes	Case Management Episodes
Activity Note	1692	2026
Add Episode Note	106	99
Care Plan Problem Note	372	775
Change Status Note	1541	3097
Edit Episode Note	72	253
Episode Note	72	243
Goals	245	439
Interventions	830	537

Letters

Letter Template	Behavioral Health Case Management Episodes	Case Management Episodes
Appointment Letter English	61	72
Appointment Letter Spanish	8	38
Consent Form English	2	25
Consent Form Spanish	1	12
Discharge English	37	107
Discharge Spanish	4	29
Educational Material	32	26
Mental Health Alert to PCP	1	0
Unable to Contact	440	844
Welcome Letter Bilingual	116	245

Activities Completed

Activities Completed	Total
CMA's	2,915
Nurses	1,606
Social Workers	728

Activity Type

Activity Type	Behavioral Health Case Management Episodes	Case Management Episodes
Clinical Engagement	0	61
Education	0	22
Fax	129	171
Letter Contact	296	575
Member Services	61	69
Phone Call	1405	2741

Activity Name

Activity Name	Behavioral Health Case Management Episodes	Case Management Episodes
Appointment Reminder Calls	56	96
CEG CM Referral	0	1
Close Episode for CEG	0	53
Close Episode for UTC	29	47
Community Resources	4	14
Contact Member	337	330
Contact Pharmacy	0	28
Contact Provider	122	393
COVID-19 Education	0	21
COVID-19 Vaccine Education	3	53
Create Work Item	75	74
HHP	0	2
Homeless	1	1
ICT	28	54
Incoming Call	0	20
Inpatient Discharge Follow Up	48	156
Language Line	107	201
Mail Appointment Letter	68	48
Mail Authorization	0	2
Mail Consent Letter	6	25
Mail Discharge Letter	56	185
Mail Educational Material	31	27
Mail Pill Box	3	18
Mail Provider Directory	3	7
Mail Unable to contact letter	83	217
Mail Welcome Letter	4	3
Medication Review	0	15
Mental Health Alert to PCP	1	0
Palliative Care	4	0
Plan of care	120	103

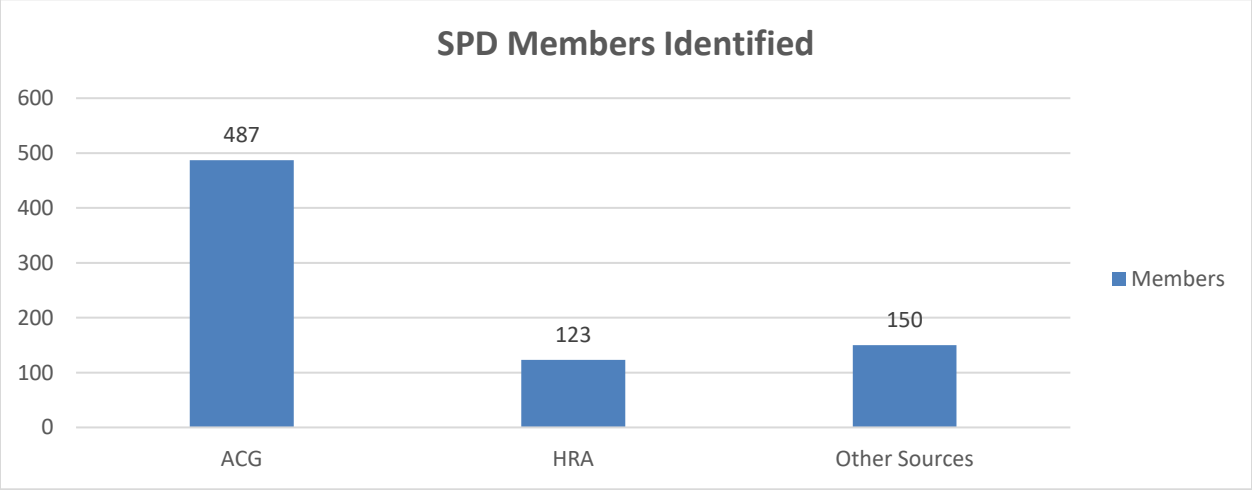
Request Medical Records	36	162
Return Mail	0	4
Schedule Physician Appointment	84	90
Transportation	2	27
Verbal consent to be received	495	966

Seniors and Persons with Disabilities (SPDs):

SPD Members are identified for Complex Case Management through use of the John Hopkins Predictive Modeler, through Health Risk Assessments and other sources including member requests and outside and internal requests.

The SPD population represents a total of 39 percent (760) of the Complex Group during the months of January thru March 2021.

The John Hopkins Predictive Modeler identified SPD's represent 64% percent of the SPD's identified in the Complex Group during the months of January thru March 2021. HRA identified SPD members represent 16% and other sources of SPD members represent 19%.



SPD Health Risk Assessment Information:

During the months of January thru March 2021, a total of 1,458 members were identified for an outside vendor to contact for completion of a Health Risk Assessment.

HRA Summary	Metric	Count	Percentage	Per Day
	Completed (or 2 calls attempted)	1,455	100%	24
	Partial HRA	107	7%	2
	Full HRA	193	13%	3
	Opted out	37	3%	1
	High Risk members	98	7%	2
	Critical Members	13	1%	0
	Members Contacted	1,429	98%	23
	Call Attempts	3,500		
	Total Surveys Attempted	300		
	Avg # of Calls Per Member	2		
	Avg # Calls per Day	57		
	Avg # of Questions Answered	24		
Sent: 1458; Received: 1455				