KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	Separation of Medical Decision Making and Financial Concerns	**Policy #**	30.63-P
Policy Owner	Utilization Management	**Original Effective Date**	01/01/2026
Revision Effective Date		**Approval Date**	01/06/2026
Line of Business	☐ Medi-Cal ☒ Medicare ☐ Corporate		

I. PURPOSE

To define the process by which Utilization Management (UM) staff affirm that UM decision making is based only on appropriateness of care and service and existence of coverage.

II. POLICY

A. The Utilization Management Affirmative Statement serves as an attestation signed by UM operations staff, reviewing physicians and UM Committee members acknowledging their understanding that all Members receive clinically appropriate, and timely coordination of service of the same quality by utilizing established UM polices, guidelines, processes, and standards when administering organization determinations and that UM Operations does not reward practitioners or other individuals for issuing denials of coverage or service care:

1. Decisions regarding requests for medical care are based on the medical necessity of the request, the appropriateness of care and service and existence of coverage. There is no monetary reward for non-approval of services. Compensation for individuals who provide utilization review services does not contain incentives, direct or indirect, for these individuals to make inappropriate review decisions.

2. Utilization review criteria, based on reasonable medical evidence and acceptable medical standards of practice (i.e. MCG and/or applicable health plan guidelines) are used to make decisions pertaining to the utilization of services. Review criteria are used in conjunction with the application of professional medical judgment, which considers the needs of Member and characteristics of the local delivery system.

B. In accordance with National Committee on Quality Assurance (NCQA) UM Standards and Regulatory requirements, KHS distribute an affirmative statement about incentives to all Members, practitioners, providers, affiliates, and employees who make UM determinations annually.

C. The affirmative statement affirms Kern Health Systems (KHS) decision making is based only on appropriateness of care, service, and the existence of coverage.

D. Additionally, KHS affirms:
    1. It does not award practitioners or other individuals conducting utilization review decision that result in underutilization.
    2. UM decision making is based only on appropriateness of care and service and existence of coverage.
    3. It does not specifically reward practitioners or other individuals for issuing denials of coverage.
    4. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.
    5. Providers and practitioners are not prohibited from acting on behalf of the Member
    6. Physicians cannot be penalized in any manner for requesting or authorizing appropriate medical care.
    7. Practitioners are ensured independence and impartiality in making referral decisions that will not influence the hiring, compensation, termination, promotion, or any similar matters.
        a. All practitioners and licensed UM staff responsible for utilization decisions will sign a statement affirming that utilization decisions are based solely on the appropriateness of care and services.

III. DEFINITIONS

TERMS	DEFINITIONS
Affirmative Statement	An attestation requiring signature of UM Operational Staff Utilization Management (UM) acknowledging UM decision-making is based only on appropriateness of care, service, and existence of coverage.

IV. PROCEDURES

A. On an annual basis KHS utilization management staff and utilization management committee Members will sign a Utilization Management Affirmative Statement affirming that utilization decisions are based solely on the appropriateness of care and services.

    1. KHS will distribute this notification through the following methods:
        a. Internet access- KHS website (policy/procedure)
        b. Provider Manuals - entire network
        c. Utilization Management Committee Meetings
        d. Newsletters

KHS is responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other Centers for Medicare and Medicaid Services (CMS), Department of Healthcare Services (DHCS) , and or Department of Managed Health Care (DMHC) guidance, including applicable All Plan Letters (APLs), Health Plan Management System (HPMS) memos, Policy Letters, and Dual Plan Letters. These requirements must be communicated by KHS to all delegated entities and subcontractors.

I. ATTACHMENTS

Attachment A:	KHS Affirmative Statement for UM Decision Making

II. REFERENCES

Reference Type	Specific Reference
Regulatory	CA H&S Code 1367 (g)
Other	NCQA UM Standard 4, Element F
Regulatory	42 CFR § 422.101(c)(1)
Regulatory	CMS Medicare Managed Care Manual Chapter 4 (Benefits)
Regulatory	CMS Medicare Managed Care Manual Chapter 13 (Appeals)

III. REVISION HISTORY

Action	Date	Brief Description of Updates	Author
Effective	2026-01	New policy created to comply with D-SNP.	UM

IV. APPROVALS

Committees | Board (if applicable)	**Date Reviewed**	**Date Approved**
Choose an item.		

Regulatory Agencies (if applicable)	**Date Reviewed**	**Date Approved**
Choose an item.		